Imperial College Healthcare NHS
NHS Trust

TRUST BOARD AGENDA – PUBLIC

Clarence Wing Boardroom, St Mary's Hospital

28 March 2018

11:30-13:00

		Presenter	Timing	
1	**Administrative Matters**			
1.1	Chairman's opening remarks and apologies	Chairman	11.00	Oral
1.2	Board member's declarations of interests	Chairman		Oral
1.3	Minutes of the meeting held on 31 January 2018	Chairman		1
1.4	Record of items discussed at Part II of board meeting held on 31 January 2018 and 14 February 2018	Chairman		2
1.5	Action log and matters arising	Chairman		3
2	**Operational items**			
2.1	Patient story	Prof Janice Sigsworth	11:05	4
2.2	Chief Executive Officer's report	Prof Julian Redhead		5
2.3	Integrated performance report	Safe/effective: Medical director Caring: Director of nursing Well-led: Director of P&OD Responsive: DD Medicine & Int care DD surgery, cancer & CV DD Women's, chil'n & CS		6
2.4	Month 11 Finance report	Richard Alexander		7
3	**Items for decision or approval**			
3.1	Quality account indicators	Prof Tim Orchard		8
3.2	Gender pay gap report	David Wells		9
3.3	Corporate risk register and risk appetite	Prof Janice Sigsworth		10
4	**Items for discussion**			
4.1	'Learning from deaths' – quarterly dashboard	Dr Bill Oldfield		11
4.2	Infection prevention and control – quarterly report	Prof Alison Holmes		12
4.3	Staff survey results	David Wells		13
4.4	Healthwatch Central West London report on Charing Cross hospital	Michelle Dixon		14
4.5	CQC update	Prof Janice Sigsworth		15
4.6	Cost improvement plans; quality impact assessment	Prof Janice Sigsworth		16
5	**Items for information**			
5.1				
6	**Committee reports**			
6.1	Finance & investment committee	Committee chair		17
6.2	Quality committee	Committee chair		18
6.3	Redevelopment committee	Committee chair		19
6.4	Audit, risk & governance committee	Committee chair		20
6.5	Remuneration committee	Committee chair		21
6.6	Hammersmith & Fulham integrated care board	Prof Tim Orchard		22
7	**Any other business**			
8	**Questions from the Public relating to agenda items**			
9	**Date of next meeting**			
	Trust board - public: Wednesday 23 May 2018, W12, Hammersmith Hospital			

Imperial College Healthcare NHS Trust

MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

Wednesday 31 January 2018
11.30 – 13.00
New Boardroom, Charing Cross Hospital

Present:	
Sir Richard Sykes	Chairman
Sarika Patel	Non-executive director
Dr Andreas Raffel	Non-executive director
Peter Goldsbrough	Non-executive director
Prof Andy Bush	Non-executive director
Victoria Russell	Non-executive director
Prof Julian Redhead	Interim chief executive officer
Richard Alexander	Chief financial officer
Bill Oldfield	Interim medical director
Prof Tim Orchard	Interim medical director & divisional director, M&IC
Prof Janice Sigsworth	Director of nursing
In attendance:	
Michelle Dixon	Director of communications
Kevin Jarrold	Chief information officer
David Wells	Director of people and organisational development
Dr Katie Urch	Divisional director, SC & CV
Prof TG Teoh	Divisional director, WC&CS
Prof Jonathan Weber	Dean, Imperial College Medical School
Jan Aps	Trust company secretary (minutes)

1	Administrative Matters	Action
1.1	**Chairman's opening remarks and apologies** Sir Richard Sykes welcomed all members, attendees and members of the public to the meeting, particularly noting it was Prof Julian Redhead's first Trust board as interim chief executive. Apologies were noted from Sir Gerry Acher and Nick Ross.	
1.2	**Board member's declarations of interests** There were no additional declarations of interest made at the meeting.	
1.3	**Minutes of the meeting held on 29 November 2017** The minutes were accepted as an accurate record of the Trust board meeting held on 29 November 2017.	
1.4	**Record of items discussed at Part II of board meeting held on 29 November 2017** The Trust board noted the report.	
1.5	**Action Log and matters arising** The Trust board noted the updates provided.	
1.6	**Annual review of declarations of interest** Trust board members confirmed that the declarations provided were accurate, and agreed to continue providing any amendments in-year to the Trust company secretary.	

2	**Operational items**	
2.1	**Patient story** Prof Janice Sigsworth introduced Ms SB, her mother Mrs SB, and Dr Malbon. Ms SB had been a patient in paediatrics since she had been at primary school, suffering from severe allergies, resulting in poor health, including having suffered five anaphylactic attacks. She found that initially this had affected her self-esteem and her confidence, but that she had grown stronger as she dealt with these serious episodes. At sixteen, the medical team had discussed her transitioning to the adult services. This had caused some anxiety given that she would move away from a team by whom she felt supported and cared for; she was concerned that the adult team may not understand her problems. In the early adult appointments, she would have part of the appointment alone with the doctor and part with her mother present; she let her mum speak for her, as when alone she would tend to say "I'm fine". With the continuing support of both teams, her confidence and understanding grew, and she had become able to attend her appointments alone, and feel more of her own person. SB extended many thanks to all those who had, and continued to, care for her. The Chairman thanked Ms SB and Mrs SB for coming to the Trust board and sharing their experiences. Responding to Sir Richard Sykes, Dr Malbon confirmed that many patients transitioned from paediatrics to adult services, but that not all services provided the same level of support in this transitioning; the desired aim was to develop a comprehensive adolescent service to ensure all patients received more holistic support at this difficult time. Whilst there was no space to develop a physical unit, it would be possible to develop a team that supported patients' transition across a wider spread of specialties. Prof Redhead recognised that this issue had been raised in a number of specialties; it should be possible for the Trust to provide an enhanced transition given that patients were accessing services within the same Trust. He also noted that the Trust was in discussion with Great Ormond Street FT with regard to patients moving on from their paediatric services, and that there should be further opportunities in the Trust's engagement with patients transitioning from Chelsea & Westminster Hospital's paediatric services. Prof Weber noted that from a research and academic position, the College should be able to help with identifying and developing good practice. Prof Bush reflected that Ms SB's experience demonstrated that it needed to be a process undertaken over time, rather than a 'one off' transfer. Michelle Dixon commented that transitioning was included in some clinical development workshops currently being developed, and also encompassed in the forthcoming teenage awareness week. The Trust board noted the patient story.	
2.2	**Chief Executive Officer's report** Prof Julian Redhead extended thanks to the executive team and other colleagues in supporting him in his role as interim Chief Executive Officer. He particularly highlighted: • The good progress made towards achieving the financial plan for the year, and noted that for 2018/19 the focus needed to be on achieving savings through transformational improvement, reflecting his belief that better care was more efficient care. • The welcome achievement of ensuring that cancer patients were treated within the target timescales, which helped not only our patients, but also the performance of the wider health economy. • The way in which the Trust and its staff were ensuring that patients were kept safe and cared for during the pressured winter period, whilst recognising that the Trust was not managing to see, treat, admit and discharge as patients within the four hours target as it would wish. He also acknowledged the increased pressure that this was having on being able to admit as many patients as desired for elective procedures; whilst the target was not being achieved, the Trust	

	continued to better its planned recovery trajectory. • That full planning permission had now been granted for the Phase One 'Triangle' building; a business case for funding was now being developed, which may also enable an earlier than planned move of Western Eye services to the St Mary's site. • The Trust's disappointment that its request for judicial review of the Paddington Quarter development (in relation to safe access to the hospital) had not been accepted by the court. Whilst it was now accepted that there was no further legal processes to pursue, the Trust would continue to work with the developer as plans progressed. Sarika Patel commented that it was disappointing to see that continuing concerns relating to the urgent care centre contract were not being addressed effectively by the commissioner. Responding, Prof Tim Orchard noted that the Trust had now had sight of the contract document, and the key performance indicators therein, which included a requirement for streaming which had been set inappropriately low, and which was quantity, not quality based. The Trust continued to influence where possible and to encourage improvement. He noted that the contractor, Vocare, was the subject of a takeover itself, and it was hoped that the new company would seek to achieve good performance in their only London-based unit. It was also noted that the CQC inspection which placed the unit in special measures had identified particular issues in radiology reporting; however, the Trust considered that there were a number of areas where improvements needed to be made. The Trust board noted the report.	
2.3	**Integrated performance report** SAFE and EFFECTIVE: Dr Bill Oldfield reported that there had been six serious incidents in the period, all of which were being investigated; no trends had so far been identified. The recent reduction in reported incidents had resulted from the removal of the need to report all forms of pressure sores; overall reporting remained above average with a low harm to patients, which was as desired. No never events had occurred since July 2017, and that incident had been the only occurrence in the 12 months since January 2017. Compliance with the duty of candour requirements continued to improve, with 96% of incidents being handled appropriately; further improvement remained a focus here. Hospital acquired infections remained low, with no MRSA cases in the period, with only one thus far in 2017/18; six cases of C difficile had occurred, but this remained an improvement on the previous year, and better than the required position. Responding to Sir Richard Sykes, Dr Oldfield reported that no other infections were routinely reported, but that the infection control team kept a very close review of sepsis cases, and that the Trust remained at greater risk of CPE cases given the specialist nature of many of its patients; there was robust screening of patients in place. Noting that there had been reports of an international shortage of some antibiotics, Dr Oldfield reported that clinical teams were preserving stocks where they could, and that it was proving possible to get them when required. Prof Jonathan Weber reflected that the Trust's infection team were leading good work across the clinical, academic and research arenas, and that further international work was required in this area. Prof Andy Bush commented that the Quality Committee kept close oversight of the work of the infection prevention and control team, and noted the positive reduction in overall antibiotic use. Responding to Peter Goldsbrough's query as to potential safety issues arising from the CQC medicines management concerns, Dr Oldfield commented that the twice daily review of all patient prescriptions ensured a reduced safety risk, and that senior clinical intervention (medical and pharmacy) was having a positive impact on patient safety. Prof Janice Sigsworth reflected that the main focus of the CQC concern had been in the storage of drugs, and holding of expired drugs; there had had been no direct patient safety issues.	

	CARING: Prof Janice Sigsworth reported that each of the previous 12 months had seen a reduction in pressure sores, with a total of 13 in the reporting period against 21 in the same period the previous year; attention continued to further enhance this improvement in patient care. Accessing the desired levels of nurse staffing had been difficult in December; this had been addressed where possible with good bank and agency support. Ward staffing levels were reviewed five times a day, with staff being moved between areas where necessary; staff continued to demonstrate a level of commitment to patient care 'above and beyond' their roles. Friends and family (FFT) recommendation rates remained stable, but work continued in A&E to improve the patient response rate; Prof Sigsworth noted that the Department of Health were considering whether the national focus on FTT remained appropriate. Non-emergency patient transport adherence to patient pick-up times was still not at a level considered to be acceptable; work continued with the contractor to improve this. She also reported the continuing problem in timely response to maintenance issues (exacerbated by the aging estate), but again, work continued with the contractor to improve this; further details on this would be reported to a future Trust board. WELL-LED: Although the figures showed a slight increase in the Trust's vacancy rate, David Wells reported that this had resulted from an increase in establishment rather than from an increase in turnover; he noted that a recent parliamentary report on the strategic supply of nursing recognised that the existing problems were likely to worsen in the future. Mr Wells also noted that sickness absence amongst staff, while slightly higher in December, remained amongst the best in the NHS. RESPONSIVE: Prof Tim Orchard commented that the additional pressures of the winter season were being felt across the NHS, impacting as it did on trusts' abilities to see, treat, admit and/or discharge patients in A&E in a timely manner; the Trust's performance against the four-hour target has been at 85% against the 95% target. He was pleased to report that the Trust had allowed no long delays in receiving patients arriving in ambulances; the department preferred to be sure that they could assess each patient and provide appropriate care. The staff had all worked extremely hard to cope with the increased activity (with Charing Cross major trauma patients having increased by 15%, and 'silver' trauma patients having increased by 30%) and he extended thanks to all. He recognised that, as part of improving the flow of patients through the hospital, ensuring patients had safe, appropriate and early discharge was a real challenge, but an area where improvement was being seen. Responding to a query, Prof Orchard commented that staff would complete the same length shifts but that staffing was increased during the busiest times with, where necessary, staff being moved across the hospitals. He then responded to a query from Peter Goldsbrough, noting that whilst 2/3% of patients would be considered to be experiencing delayed transfers of care, there were good working relationships with the CCGs to address this; while success in returning patients to their local hospital following a period of specialist care varied, this was working particularly well with Chelsea & Westminster. Sarika Patel commended the achievement of an average 3.1 days stay and low readmission rates. Prof Redhead commented that the absorption of stroke, major trauma and cardiac patients helped reduce the pressure at other hospitals. Prof TG Teoh reported that the Trust was working to reduce the number of patients waiting more than six weeks for a diagnostic test from 1.5% to less than 1% by the end March 2018. He acknowledged that both the number of patients who did not attend their appointments and hospital initiated appointment cancellations of patient appointments remained high, but that improvement work continued. Responding to a query from the chairman, he considered that 5% would be a good position to achieve, but recognised the difficult in achieving this; innovative opportunities were being sought to initiate change in the way care was provided. Turning to hospital initiated cancellations and responding to a query from Sarika Patel, Prof Teoh reported that the team were cleansing the data, as a number of erroneous entries were being included.	

	Dr Katie Urch reported that the Trust had achieved good performance in ensuring that patients on a cancer referral pathway were seen within two weeks. Unfortunately, this had not been the case for all patients awaiting elective procedures; whilst the position had continued to improve, the winter pressures would require a greater number of cancellations than had been hoped, but all long-wait patients were kept under review until it was possible to complete their care, and, to date, no patient had come to clinical harm (but she recognised the regrettable impact often had on quality of life). Patients' GPs were not directly informed of delays, but senior GP colleagues were provided with regular briefings, and a dedicated GP line was available should there be any concerns. Responding to Dr Andreas Raffel's query, Dr Urch reflected that, following the Secretary of State's statement as to the cancelling of elective patient activity, the Trust had continued to take a case by case approach to relative patient priority. The Trust board noted the integrated performance report.	
2.4	**Month 9 Finance report** Richard Alexander referred the Trust board to the report provided. He particularly noted that after two months of below plan performance, the Trust had returned to an on plan position. He issued a note of caution in that the January results may be affected by the national policy to reduce elective activity to ensure non-elective activity could be accommodated, but reported that he continued to expect the Trust to achieve its planned year-end position. Planning had started for 2018/19, and this would again be challenging for the Trust. The Trust board noted the report.	
3	**Items for decision or approval**	
3.1	**Trust code of accountability and code of conduct** Jan Aps introduced the proposed revised code, noting that the Trust board had not reviewed or updated this for a number of years. The Trust board noted and agreed the proposed code of accountability and code of conduct, and agreed to an individual signed copy being attached to the personal file of all board members.	
4	**Items for discussion**	
4.1	**Bi-annual update on emergency planning, resilience and response (EPRR)** Prof Sigsworth introduced the report which outlined both planning and operational aspects of the Trusts EPRR, with a greater than usual focus on response to major incidents, having responded to a total of nine since the beginning of May 2017. The Grenfell Tower fire had been particularly distressing for staff as well as the wider community, and had left a sombre mood amongst staff, trying to deliver business as usual alongside the response to the tragedy. Within 24 hours of each incident, a 'hot' debrief was held amongst staff to pick up immediate (often emotional) responses to dealing with the incident, with a 'cold' debrief to assess learning for future major incident management. Particular learning from recent incidents had related to more effective handling of embassy staff, and ensuring appropriate support for relatives searching for their loved ones, and the follow-up support for those staff who had cared for the relatives. Alongside a number of table-top exercises there had been a live fire evacuation test at St Mary's, which had provided good experience for staff, and lessons learned for all those involved. The annual assessment of the Trust's compliance identified only one measure requiring further attention – the completion of outstanding business continuity plans – leading to a rating of 'substantial assurance'. In summary, Prof Sigsworth reflected that it had been a challenging year, but that the teams had performed well, and the Trust was in good shape with regards to further preparedness. Peter Goldsbrough welcomed the helpful report, and reflected that the previous year had been a good test of plans and on-call arrangements from which the Trust had	

	emerged well. Responding to his query, Prof Sigsworth noted that the executive team, along with a small number of other senior managers stood as the 'gold' on-call, with the 'silver' rota formed by their deputies and senior divisional teams, in an attempt to not make it too onerous. Where there were less experienced team members, support would be provided, and both internal and external training sessions had been provided. The Trust board noted the updates, the action plan to address the one remaining amber rating in the NHSE assessment, and confirmed that the report provided sufficient assurance for the Trust board in relation to EPRR.	
4.2	**CQC update** Prof Sigsworth introduced the report. Following the CQC unannounced inspection of surgery at the three main sites and urgent and emergency services at both emergency departments in early November, issues had been raised in relation to medicines management and maintenance of medical equipment; Prof Sigsworth was able to confirm that actions to address these had been put in place. She also reported that the Trust had received its first CQC revised well-led inspection in early December. Draft inspection reports had been received on 22 January, and were being reviewed for factual accuracy; it was expected that the final reports, along with all ratings, would be published on the CQC website during February. Prof Sigsworth also reported that the CQC were consulting formally on an increase in fees; the document proposed that the Trust's fee would increase from c£300k to c£1m. This was as a result of CQC being required to move away from central funding, and toward direct funding from fees. The Trust board noted the report.	
4.3	**CQC Children and young people national survey** Prof Teoh introduced the results of the children and young people national survey, and also the action plan developed to address those areas where the results demonstrated that Trust performance could improve. In most areas, results indicated that the Trust performed 'about the same' as expected, but there were two areas where comparison indicated worse performance: in relation to changes to a child's admission date, and the children's view of the food provided. The first of these has been addressed by increasing capacity where possible, the actions relating to improving children's experiences of food were on-going. Of a particularly positive note was the pivotal role that play specialists had in improving the experience of the children. The Trust board noted the report, and looked forward to hearing of improved survey results as the action plan was completed.	
4.4	**CQC Emergency department survey** Noting the methodological and timeliness issues with this survey, Prof Orchard acknowledged the results remained disappointing. The survey was undertaken during a time of major refurbishment at St Mary's, these facilities were now complete, with those at Charing Cross just about to start – this should support improved scores for patient environment and facilities, and, to some extent clinical environment, and privacy and dignity. Sarika Patel reflected that responses suggested that there had been issues with staff interaction and behaviours - whether patients had been offered food and drink, given clear instructions about their care after they left hospital, and the provision of timely pain relief – and wondered if an internal audit of compliance would be helpful. Peter Goldsbrough commented that, through the 'noise' in the findings there were key elements where focus could be provided, for example 'were you able to see a doctor' or 'were you told different things by different people'. Prof Orchard reported on the improved learning being taken from this and other forms of patient feedback; work was on-going to produce a series of indicators to measure and support improvement across the emergency department. The clinical director had brought about a real improvement in culture in the A&E department on	

	both sites, which was seen reflected in more recent patient feedback. Michelle Dixon commented that the patient and public involvement forum was also keen to support a more effective framework for capturing and acting on patient feedback. The Trust board noted the survey results, and welcomed hearing of the on-going focus on improvement.	
5	**Items for information**	
	There were no items for information.	
6	**Board committee reports**	
6.1-6.5	The Trust board noted the reports from the following committees: • Finance and investment committee • Quality committee • Audit, risk and governance committee • Redevelopment committee • Remuneration committee.	
7	**Any other business**	
	There was no other business.	
8	**Questions from the public relating to agenda items**	
	The following responses were given in response to questions: • Following the departure of Ian Dalton, the Trust had appointed Prof Julian Redhead as the interim CEO. Recruitment consultants were seeking a permanent CEO (within the previous fee envelope); further information would be made available as appropriate. • The Trust welcomed its 'patient stories', both those identifying good practice and those where an experience had not been positive and from which the Trust could learn. The patient experience team would follow-up with the member of the public who had a story they wished to share with the Trust board. • The Chairman confirmed that the Trust had no plans to close either the Charing Cross Hospital or the Emergency Department within it; indeed the Trust was about to spend several million pounds on its development. However, he understood the frustration and anxiety brought about by potentially mixed messages from different parts of the health economy. There would be comprehensive engagement and consultation on any future changes. A member of Save our Hospitals Group extended thanks to all Trust staff on behalf of the local community, for continuing to 'go the extra mile' in the delivery of patient care every day; the good results showed in the performance of the Trust, from pressure sores to commitment to cost savings. She queried however, given the continuing pressure from all areas, what more the Trust could be expected to achieve.	
	Date of next meeting	
	Public Trust board: Wednesday 28 March 2018, Clarence Wing Boardroom, St Mary's Hospital	

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	28 March 2018

Record of items discussed at the confidential Trust board meeting on 31 January 2018 and extraordinary Trust board meeting on 28 February 2018

Executive summary:

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

Issues of note and decisions taken at the Trust board's confidential meetings:

Director of strategic development: there was to be a delay in appointing to this post [post meeting note – recruitment would await appointment of a substantive chief executive officer].

Commercial director: options for taking forward this post were being considered; the post would help the Trust manage its contractor relationships more effectively and develop new commercial opportunities.

Resignation of the director of people & OD; the Trust board noted that David Wells had resigned from his post, and would be leaving the Trust in June 2018; recruitment would commence shortly.

Recruitment to the post of Trust company secretary: it was noted that Peter Jenkinson would be commencing in post on 16 April, replacing Jan Aps who was leaving in early April.

CQC inspection reports: draft reports from the most recent inspections had been received, and were being reviewed for factual accuracy.

Month 9 financial results: the return to planned position was welcomed, although the risks facing quarter 4 financial position were recognised.

Application for additional capital financing: the Trust board approved the submission of an application for £35.8m additional capital funding for core (replacement/safety/compliance) projects across 2018-2020, including in the application a request for £7.6m loan funding for more discretionary projects.

Phase 1 (Triangle building) business case: the Trust board agreed to delegate authority to the redevelopment committee such that it could review and approve submission of the proposed business case to NHS Improvement for consideration and approval.

London Genomics hub: the Trust board affirmed its support for the Trust to work in partnership with Great Ormond Street Hospital FT in bidding to form the London Genomic hub.

Recommendation to the Trust board:

The Trust board is asked to note this report.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director
Jan Aps, Trust company secretary	Prof Julian Redhead, Interim chief executive officer

Imperial College Healthcare NHS Trust

TRUST BOARD MEETING IN PUBLIC

ACTION LOG

Action	Meeting date & minute number	Responsible	Status update
Learning from deaths report – the board asked that further reports be brought forward as further learning, from within and without the Trust, was identified.	29 November 2017 4.2	Bill Oldfield	May 2018 agenda (quarterly dashboard on March agenda)

MATTERS ARISING

Minute Number	Action /issue	Responsible	Update

FORWARD PLAN AGENDA ITEMS FROM BOARD DISCUSSIONS

Report due	Report subject	Meeting at which item requested	Responsible

Report to:	Date of meeting
Trust board - public	28 March 2018

Patient Story

Executive summary:

Patient stories are seen as a powerful method of bringing the experience of patients to the Board. Their purpose is to support the framing of patient experience as an integral component of quality alongside clinical effectiveness and safety. This month's patient story focuses on the day case pathway and the importance and impact of coordinated care and good communication.

Isobel has an autoimmune condition called mucous membrane pemphigoid that affects the skin and mucous membranes, causing blisters which leave scars. Although Isobel's voice is weakened by her condition and the treatments she receives, she would like the opportunity to share her experience in person.

Isobel will describe her experience of using our day case services at Charing Cross Hospital. On the day Isobel attended, the hospital was extremely busy. Because the Trust had implemented their winter pressures plan, Isobel was nursed in the private ward post operatively, but cared for by NHS staff.

During her short stay in our hospital, there were a number of areas where Isobel felt her care could have been better coordinated. She will describe the impact of this, that resulted in her going home in her gown and husband's jacket as her clothing could not be located at the time of discharge.

Quality impact:

The board will hear how effective communication and clear pathways of care can transform a patient's experience.
This activity is relevant to the safe and caring CQC domains.

Financial impact:

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

Risk impact:

None

Recommendation(s) to the Committee:

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

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Stephanie Harrison-White Guy Young	Janice Sigsworth	19.01.2018

Patient Story

1. Background

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

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

2. Isobel' story

A study published by the Kings Fund (2015) highlighted the many advantages of day case surgery including:

- Reduced costs with the average day case costing £698 as opposed to the average elective admission £3,375
- Reduced risk of infection due to short hospital admission
- Improved patient experience as less time away from home

Isobel has been treated at the Trust for an on-going autoimmune condition, called mucous membrane pemphigoid that affects the skin and mucous membranes causing blisters which leave scars. As part of this condition, Isobel requires interventional treatments. In December 2017, she attended Charing Cross Hospital as a day patient for a micro laryngoscopy and dilation procedure.

At the time of Isobel's admission, the Trust was already experiencing the impact of winter pressures, with areas such as private patient wards at Charing Cross Hospital, being opened and used to accommodate NHS patients as part of the winter escalation plan.

Isobel will describe how she navigated the snow the morning of her operation and arrived to a cold department with uncomfortable seating. During her journey to the hospital, she made several attempts to speak with someone as she was worried she was going to be late, this proved to be difficult.

Isobel remained in the elective admissions unit on 6 West until she went to theatre. She will describe the process of how she waited from early morning until 14:00 hours before she went to theatre and the subsequent issues with her belongings not being sent to the ward where she was taken post operatively (15 South ward). In addition, Isobel was not offered any food by the staff prior to her discharge home and sought out her own biscuits from the kitchen before she left.

She was discharged home that evening in a hospital gown and her husband's jacket because her personal belongings could not be located. This also meant that she had to return the following day to collect her belongings.

3. Lessons learnt

The current arrangements for the day case pathway do not always offer the best experience for our patients. From Isobel's perspective, she felt she did not need a hospital bed and could have returned to the same area onto a reclining seat. This would have meant her belongings could have remained with her and her husband would have known exactly where she was going.

We have listened to Isobel's story and shared her experience with the areas involved. We recognise that the impact of winter pressures and the need to start using a different area, at relatively short notice, meant that some of the plans such as having a ward hostess were not properly embedded.

The division is currently reviewing this pathway and Isobel has been invited and has kindly accepted, to be part of this process.

Whilst Isobel received ***expert*** clinical treatment and care, we must work in close ***collaboration*** with our patients to understand and develop pathways of care that reflect and promote a positive patient experience.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust Board - public	**28 March 2018**

Chief Executive Officer's Report

Executive summary:

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

1) Financial performance
2) Financial improvement programme
3) Operational performance
4) Stakeholder engagement
5) Update on major building improvements
6) Change of Responsible Officer

Quality impact:

N/A

Financial impact:

N/A

Risk impact:

N/A

Recommendation(s) to the Trust board:

The Trust board is asked to note this report.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Julian Redhead, Chief Executive Officer	Julian Redhead, Chief Executive Officer	22 March 2018

Chief Executive Officer's report

1. Financial performance

In February 2018, the Trust reported an in-month deficit, before sustainability and transformation funding (STF) and winter funding of £5.2m which was £1.7m adverse to plan. Year to date (i.e. the eleven months up to the end of February 2018) the Trust reported a deficit of £29.6m which was £1.7m adverse to plan. The Trust Executive has agreed a number of actions aiming to reduce the overspend and ensure that the control total is met for the financial year (i.e. at the end of March 2018).

STF achievement is monitored on a quarterly basis, 70 per cent on meeting financial targets and 30 per cent on meeting our A&E four hour trajectory (to see, treat and admit or discharge patients within a four hour time scale). The Trust has not achieved the four hour A&E target for quarter 2 or quarter 3. Core STF is therefore £0.85m adverse to plan in month, £5.3m year to date and forecast to be £6.2m adverse to plan for the full year.

2. Financial improvement programme

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

The year to date plan is £47.9m, there has been achievement of £33.5m giving a £14.4m underperformance. This underperformance is due to a combination of slippage against planned schemes and yet to be identified plans. Recent CIP performance has been negatively impacted by the level of winter pressures resulting in the unavailability of beds and elective cancelations. Divisions meet regularly with the programme support office and Trust management team to review progress on identification and achievement of CIPs.

The specialty review programme is continuing across the Trust. This is a clinically-led approach to supporting clinical specialties to develop sustainable plans, including clinical, workforce and financial data.

3. Operational Performance

Cancer 62 day waits: In March 2018, performance was reported for the Cancer waiting times for January 2018. The Trust delivered treated 85.2 per cent of patients within the 62-day standard which is above the national standard of 85 per cent and ahead of trajectory (85.1 per cent).

Accident and Emergency: Performance in February was again challenging; with particularly high numbers of patients attending the department, we were not able to see, treat, admit or discharge patients to the four-hour standard, achieving only 82.4 per cent. This did not meet the 90 per cent Sustainability and Transformation Fund (STF) performance trajectory target for the month. The key issues are as follows:

- Increased demand and acuity within type 1 departments;
- An increase in arrivals via ambulance and daily trauma presentations at St Mary's Hospital;
- Difficulties with late transfer of patients from the Vocare Urgent Care Centre to the Emergency Department at St Mary's Hospital; and
- Particularly high levels of bed occupancy, with Charing Cross Hospital at 97.0 per cent and St Mary's Hospital at 99.3 per cent during February.

Schemes to provide additional urgent and emergency care capacity for winter pressures have continued on track. There was a 3.5 per cent decrease in daily average number of patients in hospital longer than seven days in February. There have also been improvements in the numbers of patients being discharged before noon (a key marker of good patient flow) and this was sustained during January and February. The Trust continues the programme of patient flow improvements which are overseen by the four-hour

Performance Steering Group.

Referral to treatment (RTT):
At end of February 2018, 82.8 per cent of patients had been waiting less than 18 weeks to receive consultant-led treatment, against the standard of 92 per cent (January performance was 82.9 per cent).
There were 256 patients who had waited over 52 weeks for their treatment since referral from their GP. This means that the Trust is currently slightly behind its trajectory, reporting 256 patients who have been waiting more than 52 weeks for their procedure in February 2018 against a trajectory of 254 patients. The temporary postponement of non-urgent elective activity in January and February 2018 (to support the emergency pathways as part of the national response) led to significant numbers of cancellations, with increased numbers of patients waiting.

In consultation with the Trust's external stakeholders, RTT action plans and recovery trajectories for the most challenged specialties have been developed. A RTT recovery trajectory for 2018/19 is being finalised and approved through the appropriate governance routes.

Diagnostic waiting times: At the end of February 2018, only 0.8 per cent of patients had to wait over six weeks, which met the recovery trajectory and returns the Trust to its previous good delivery of the national standard of 1 per cent or less patients waiting.

4. Stakeholder engagement

The Trust's strategic lay forum met on 22 February for the latest of its bi-monthly meetings.

We have continued our regular stakeholder engagement programme. In March we joined up with the Royal College of Anaesthetists (RCoA) to arrange for Shadow Health Secretary Jonathan Ashworth MP to do a work shadow programme with the anaesthetics team at St Mary's Hospital. I was pleased to meet with Mr Ashworth and the RCoA CEO Tom Grinyer before the work shadow programme took place with Dr Helgi Johannsson and Dr Will Harrop-Griffiths. I also held meetings with Westminster Council's Cabinet Member for Health Cllr Heather Acton and our local MPs Karen Buck, Rt Hon Mark Field and Andy Slaughter. In addition, director of communications Michelle Dixon met with Westminster Councillors Patricia McAllister (Deputy Opposition Leader) and Barrie Taylor (Opposition Health Spokesman).

Also in March, together with director of nursing Prof Janice Sigsworth, I attended Hammersmith & Fulham Council's health scrutiny committee to present an update and discuss the findings of the Care Quality Commission inspection report published in February.

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

5. Update on major building improvements

Refurbishment of Main Outpatients Departments – All Sites:

Building works to the Out Patients and Renal Outpatient Departments at Hammersmith Hospital have been completed with minor snagging works being completed. Additional works were identified and instructed which are due to complete by the end of March 2018. Both departments are open to patients.

Works at Charing Cross Hospital Outpatients Department is in progress with phase 1 and phase 2 complete; subject to de-snagging and installation of the children's play area. Works to Phase 3 have commenced with the overall planned project completion date early April 2018.

The whole refurbishment program for Outpatients has been funded by Imperial Health

Charity.

Paediatrics intensive care unit (PICU) at St Mary's Hospital:

Phase 1 – New Paediatrics Research Unit (PRU) on the second floor of Cambridge Wing is complete and the new unit is in use.

Phase 2 – Works to form first half of PICU commenced in January 2018, demolitions have been completed, 1st fix mechanical & electrical is underway, new partitions progressing well and external hoist is in use. Phase 2 handover scheduled for early August 2018

Phase 3 – Due to commence early August 2018 with final completion date scheduled for late February 2019.

The PICU project is funded through both Trust capital and Imperial Health Charity funding.

Thistlewaite Ward at St Mary's Hospital:

Works for the full refurbishment of the ward was completed prior to the Christmas break in December 2017. With the ward opening both female and male beds straight after the new year in January 2018.

The project was funded through Trust capital with contribution from Imperial College Health Charity and estates maintenance backlog programme budgets.

7 North Ward at Charing Cross Hospital:

The refurbishment of 7 North ward to bring up to current standards. This is a four phase project within an occupied ward.

Phases 1 and 2 have been completed and have been re-occupied. Phase 3 will complete on at the end of March 2018. The final phase 4 works will be completed by the end of April 2018.

The project is fully funded through the Trust's capital programme.

Imaging replacement programme:

A programme of works to upgrade and replace five of the existing imaging x-ray suites is underway on all three sites.

At St Mary's Hospital, the upgrade to the existing software system and minor refurbishment of one of the x-ray suites is complete with the second upgrade due to complete at the end of March 2018.

At Hammersmith Hospital, the IR (interventional radiology) machine replacement works are were completed at the beginning of March 2018 and the new changing room, equipment room and nurse store are now all in use.

Works are also progressing at the Charing Cross Hospital imaging suite, with builders work for both electrical & mechanical services upgrades and new imaging suite. Works are due to complete on four of the five upgrades this financial year, 2017-18 with one suite at the Charing Cross site commencing in April 2018.

MRI replacement at Hammersmith Hospital (enabling works):

Construction works are in the final stages for the replacement of one of the MRI machines at Hammersmith Hospital. The works included removal of the existing MRI through the external wall of the A Block at Hammersmith Hospital, with the delivery and installation of the machine having been completed just before Christmas. MRI physics testing was carried out and sign off. MRI suite is currently being commissioned ready for use by the end users.

LINAC Replacement Programme at Charing Cross Hospital:

Trust plans to replace two LINAC (linear accelerator radiotherapy treatment) machines at Charing Cross Hospital have commenced, with the first LINAC room refurbishment

completed with the LINAC machine delivered and installed earlier this month.

The second LINAC machine refurbishment will commence in September 2018 with completion and commissioning due for February 2019.

Emergency Department Re-configuration at Charing Cross Hospital:

Plans for reconfiguring the emergency department at Charing Cross Hospital, achieving an increase in size of the resuscitation unit, have been developed and tenders have been returned. The refurbishment will require an extensive mains power upgrade and tenders for this have also been returned. The full business case was submitted for approval in February 2018, seeking capital funding in 2018/19 and 2019/20. Contractor short listing has commenced and subject to final sign off, the works are planned to commence on site Late April/ early May 2018 on approval.

Some other capital projects currently in the feasibility stage include:

- New sixth Catheter Lab at Hammersmith Hospital.
- Grand Union Ward at St Mary's Hospital
- Western Eye Hospital Reception and Outpatient refurbishment
- Full refurbishment of Multi-disciplinary team (MDT) rooms/space review
- Gynaecology Emergency Room - Winston Churchill
- New parent accommodation
- Development of gym space at St Mary's to support surgical enhanced recovery programme.

6.) Change of responsible officer:

As part of its role to enable oversight of compliance with *The Medical Profession (Responsible Officers) Regulations 2010 (amended 2013),* NHS England requires trusts to adhere to the Framework of Quality Assurance for Responsible Officers and Revalidation (FQA). A key requirement is the appointment of a licensed medical practitioner with appropriate training and suitable capacity as a *responsible officer*. The Trust's responsible officer is currently Prof Julian Redhead; with Prof Redhead now appointed as interim chief executive officer, it is not appropriate for him to continue in this role. Prof Tim Orchard and Dr Bill Oldfield have now completed the required training, and the Trust board is asked to support the appointment of Prof Tim Orchard as the Trust's responsible officer, with Dr Will Oldfield as deputy responsible officer.

The FQA seeks to assist responsible officers in providing assurance to their organisation's board that the doctors working in their organisations remain up to date and fit to practise. All responsible officers are required to present an annual report to their Trust board (July 2018) and, following this, to submit a statement of compliance (with the regulations), which is signed off by the chief executive or chairman.

Imperial College Healthcare NHS Trust

Report to:	Date
Trust board - public	**28 March 2018**

Integrated Performance Report

Executive summary:

This is a regular report which outlines the key headlines relating to the reporting month of February 2018 (month 11).

Recommendation to the Trust board:

The Board is asked to note this report.

Trust strategic objectives supported by this paper:

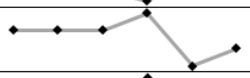
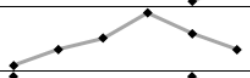
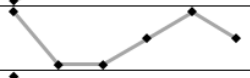
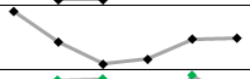
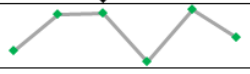
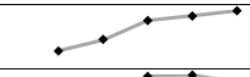
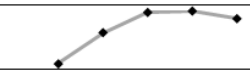
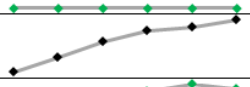
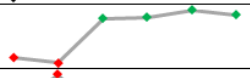
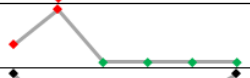
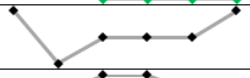
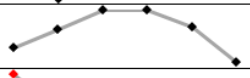
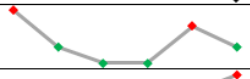
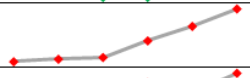
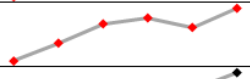
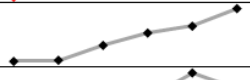
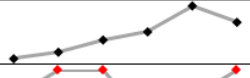
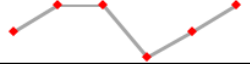
To achieve excellent patients experience and outcomes, delivered efficiently and with compassion.

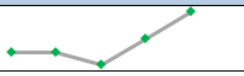
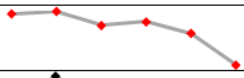
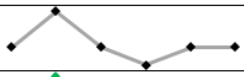
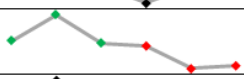
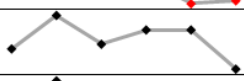
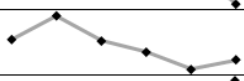
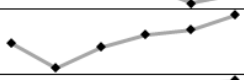
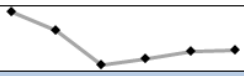
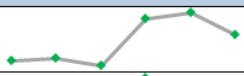
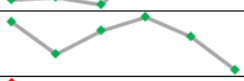
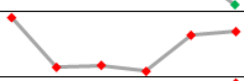
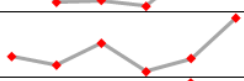
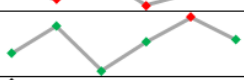
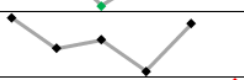
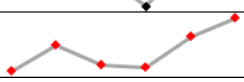
Author	Responsible executive director
Performance Support Team	William Oldfield (acting Medical Director for quality, safety and strategy) Janice Sigsworth (Director of Nursing) David Wells (Director of People and Organisational Development) Catherine Urch (Divisional Director) Tim Orchard (Divisional Director and acting Medical Director for development, education and research) Tg Teoh (Divisional Director)

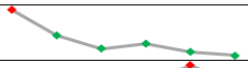
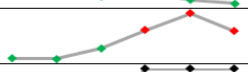
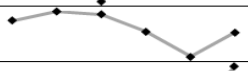
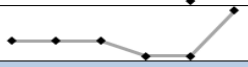
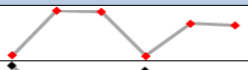
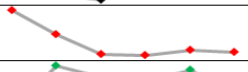
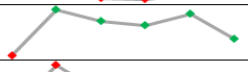
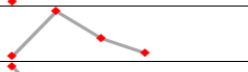
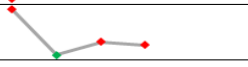
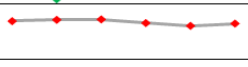
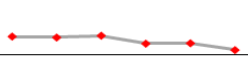
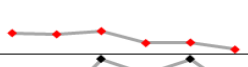
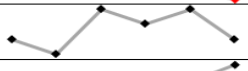
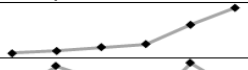
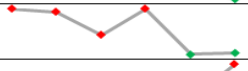
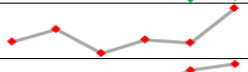
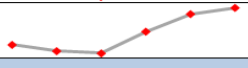
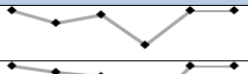
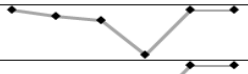
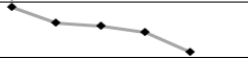
Contents

1. Scorecard

Month 11

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Safe					
Serious incidents (number)	William Oldfield	Feb-18	-	**9**	
Incidents causing severe harm (number)	William Oldfield	Feb-18	-	**0**	
Incidents causing severe harm (% of all incidents YTD)	William Oldfield	Feb-18	-	**0.08%**	
Incidents causing extreme harm (number)	William Oldfield	Feb-18	-	**1**	
Incidents causing extreme harm (% of all incidents YTD)	William Oldfield	Feb-18	-	**0.06%**	
Patient safety incident reporting rate per 1,000 bed days	William Oldfield	Feb-18	44.0	**53.9**	
Duty of candour compliance at 12/03/2018:					
Compliance with duty of candour (SIs)	William Oldfield	Feb-18	100%	**95.0%**	
Compliance with duty of candour (Level 1 - internal investigations)	William Oldfield	Feb-18	-	**69.0%**	
Compliance with duty of candour (Moderate and above incidents)	William Oldfield	Feb-18	-	**74.0%**	
Never events (number)	William Oldfield	Feb-18	0	**0**	
MRSA (number)	William Oldfield	Feb-18	0	**0**	
Clostridium difficile (cumulative YTD) (number)	William Oldfield	Feb-18	62	**53**	
VTE risk assessment: inpatients assessed within 24 hours of admission (%)	William Oldfield	Feb-18	95.0%	**96.0%**	
CAS alerts outstanding (number)	William Oldfield	Feb-18	0	**0**	
Avoidable Pressure Ulcers	Janice Sigsworth	Feb-18	-	**2**	
Staffing fill rates (%)	Janice Sigsworth	Feb-18	tbc	**96.0%**	
Post Partum Haemorrhage 1.5L (PPH) (%)	Tg Teoh	Feb-18	2.8%	**2.8%**	
Core Skills (excluding Doctors in Training) (%)	David Wells	Feb-18	90.0%	**86.4%**	
Core Skills (Doctors in Training) (%)	David Wells	Feb-18	90.0%	**73.7%**	
Core Clinical Skills (excluding Doctors in Training) (%)	David Wells	Feb-18	tbc	**85.1%**	
Core Clinical Skills (Doctors in Training) (%)	David Wells	Feb-18	tbc	**66.1%**	
Staff accidents and incidents in the workplace (RIDDOR-reportable) (number)	David Wells	Feb-18	0	**3**	

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Effective					
Hospital standardised mortality ratio (HSMR)	William Oldfield	Sep-17	100	**72.0**	
Mortality reviews at 09/03/2018:					
Total number of deaths	William Oldfield	Feb-18	-	**176**	
Number of local reviews completed	William Oldfield	Feb-18	-	**87**	
% of local reviews completed	William Oldfield	Feb-18	100%	**49.4%**	
Number of SJR reviews requested	William Oldfield	Feb-18	-	**24**	
Number of SJR reviews completed	William Oldfield	Feb-18	-	**3**	
Number of avoidable deaths (Score 1-3)	William Oldfield	Feb-18	-	**1**	
Clinical trials - recruitment of 1st patient within 70 days (%)	William Oldfield	Sep-17	90.0%	**53.3%**	
Unplanned readmission rates (28 days) over 15s (%)	Tim Orchard	Aug-17	-	**6.6%**	
Unplanned readmission rates (28 days) under 15s (%)	Tg Teoh	Aug-17	-	**4.6%**	
Outpatient appointments not checked-in or DNAd (app within last 90 days)	Tg Teoh	Feb-18	-	**1904**	
Outpatient appointments checked-in AND not checked-out	Tg Teoh	Feb-18	-	**2952**	
Diagnostic and surgical orders waiting to be processed (Add/Set Encounter)	Catherine Urch	Feb-18	0	**1508**	
Caring					
Friends and Family Test: **Inpatient** service - % patients recommended	Janice Sigsworth	Feb-18	95.0%	**97.5%**	
Friends and Family Test: **A&E** service - % recommended	Janice Sigsworth	Feb-18	85.0%	**92.5%**	
Friends and Family Test: **Maternity** service - % recommended	Janice Sigsworth	Feb-18	95.0%	**94.4%**	
Friends and Family Test: **Outpatient** service - % recommended	Janice Sigsworth	Feb-18	94.0%	**92.9%**	
Complaints: Total number received from our patients	Janice Sigsworth	Feb-18	100	**90**	
Non-emergency patient transport: waiting times of less than 2 hours for outward journey	Janice Sigsworth	Jan-18	-	**78.2%**	
Mixed-Sex Accommodation (EMSA) breaches	Catherine Urch	Feb-18	0	**42**	

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Well Led					
Vacancy rate (%)	David Wells	Feb-18	10.0%	**12.3%**	
Voluntary turnover rate (%) 12-month rolling	David Wells	Feb-18	10.0%	**9.2%**	
Sickness absence (%)	David Wells	Feb-18	3.1%	**3.3%**	
Personal development reviews (%)	David Wells	Jul-17	95.0%	-	
Doctor Appraisal Rate (%)	Tim Orchard	Feb-18	95.0%	**88.3%**	
Education open actions (number)	Tim Orchard	Feb-18	-	**3**	
Responsive					
RTT: 18 Weeks Incomplete (%)	Catherine Urch	Feb-18	92.0%	**82.8%**	
RTT: Patients waiting over 18 weeks for treatment (number)	Catherine Urch	Feb-18	-	**10793**	
RTT: Patients waiting 52 weeks or more for treatment (number)	Catherine Urch	Feb-18	0	**256**	
Cancer: 62 day urgent GP referral to treatment for all cancers (%)	Catherine Urch	Jan-18	85.0%	**85.1%**	
Cancelled operations (as % of total elective activity)	Catherine Urch	Jan-18	0.8%		
28 day rebooking breaches (% of cancellations)	Catherine Urch	Jan-18	8.0%		
Theatre utilisation (elective) (%)	Catherine Urch	Feb-18	85.0%	**73.4%**	
A&E patients seen within 4 hours (type 1) (%)	Tim Orchard	Feb-18	95.0%	**59.1%**	
A&E patients seen within 4 hours (all types) (%)	Tim Orchard	Feb-18	95.0%	**82.4%**	
A&E patients spending >12 hours from decision to admit to admission	Tim Orchard	Feb-18	0	**4**	
Discharges before noon	Tim Orchard	Feb-18	35.0%	**14.2%**	
Waiting times for first outpatient appointment (routine) (average weeks waited for attended appointments)	Tg Teoh	Feb-18	-	**7.9**	
Patients waiting longer than 6 weeks for diagnostic tests (%)	Tg Teoh	Feb-18	1.0%	**0.8%**	
Outpatient Did Not Attend rate: (First & Follow-Up) (%)	Tg Teoh	Feb-18	11.0%	**10.8%**	
Hospital initiated outpatient cancellation rate with less than 6 weeks notice (%)	Tg Teoh	Feb-18	7.5%	**8.6%**	
Outpatient appointments made within 5 working days of receipt (%)	Tg Teoh	Feb-18	95.0%	**88.8%**	
Money and Resources					
In month variance to plan (£m)	Richard Alexander	Feb-18		-	
YTD variance to plan (£m)	Richard Alexander	Feb-18		-	
Annual forecast variance to plan (£m)	Richard Alexander	Feb-18		-	
Agency staffing (% YTD)	Richard Alexander	Feb-18		**0.0%**	
CIP % delivery YTD	Richard Alexander	Feb-18		**0.0%**	

2. Key indicator overviews

2.1 Safe

2.1.1 Safe: Serious Incidents

Nine serious incidents (SIs) were reported during February 2018, compared to nineteen last month. All of them are undergoing root cause analysis.

The categories of SIs reported in February are comparable to previous trends, with the highest number relating to the sub-optimal care of a deteriorating patient, with five SIs reported. These SIs showed no specific themes as they were reported across all three clinical divisions. A safety improvement stream is in place for this area.

Two SIs were reported for the category of treatment delay due to a lack of availability of mental health beds. This category is an internally amended version of the StEIS category; 'Treatment Delay' which was introduced to enable the capture of any patient safety risks that are being experienced in the emergency departments due to a lack of downstream mental health beds.

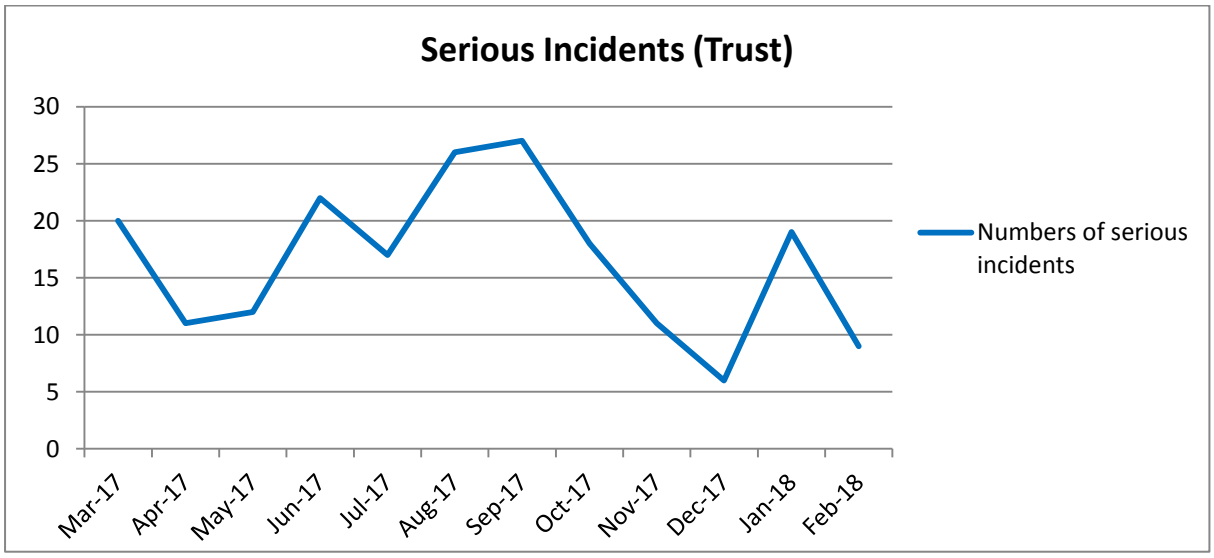


Chart 1 - Number of Serious Incidents (SIs) (Trust level) by month for the period March 2017 – February 2018

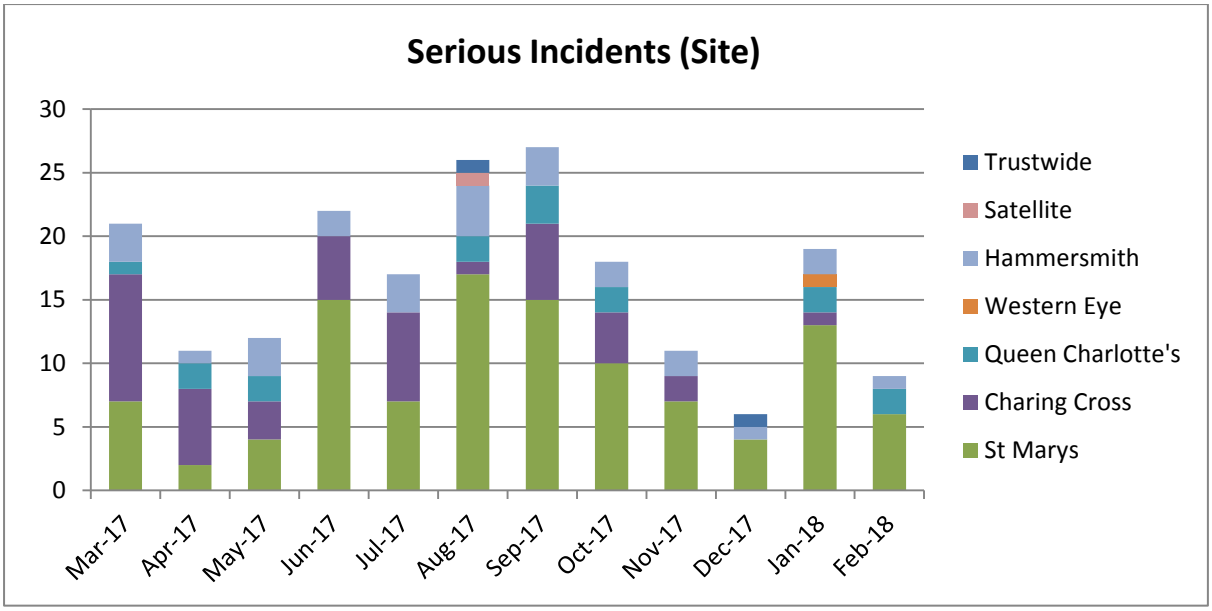


Chart 2 - Number of Serious Incidents (SIs) (Site level) by month for the period March 2017 – February 2018

In the last 12 months there has been an overall increase in the number of SIs reported compared to the preceding 12 month period, from 184 to 199. The increase reflects the Trust's commitment to improving the culture of safety through encouraging transparent identification of issues to enhance the opportunities for learning in a supportive environment. The increases are understood and our harm profile is not raising a specific cause for concern.

2.1.2 Safe: Incident reporting and degree of harm

Incidents causing severe and extreme harm

The Trust reported no severe/major harm incidents and one extreme harm/death incident in February 2018. This incident is being investigated.

There have been thirteen severe and ten extreme harm incidents reported so far this year. This is below average when compared to data published by the National Reporting and Learning System (NRLS) in September 2017 for the October 2016 – March 2017 period.

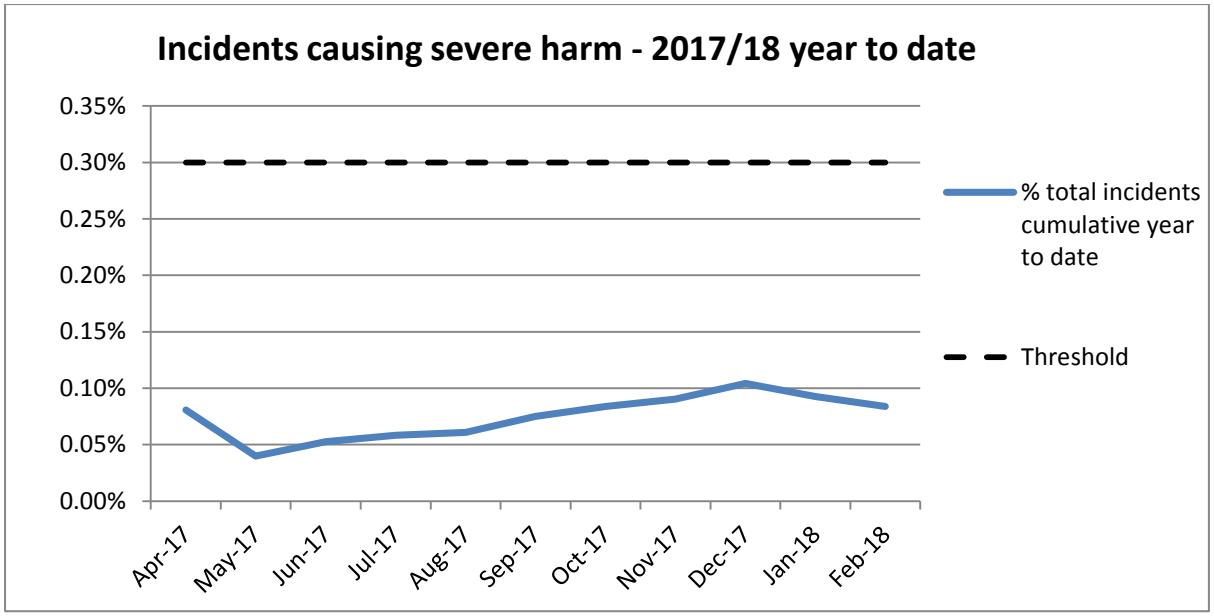


Chart 3 – Incidents causing severe harm by month from the period April 2017 – February 2018 (% of total patient safety incidents YTD). Threshold Source: National Reporting and Learning System (NRLS)

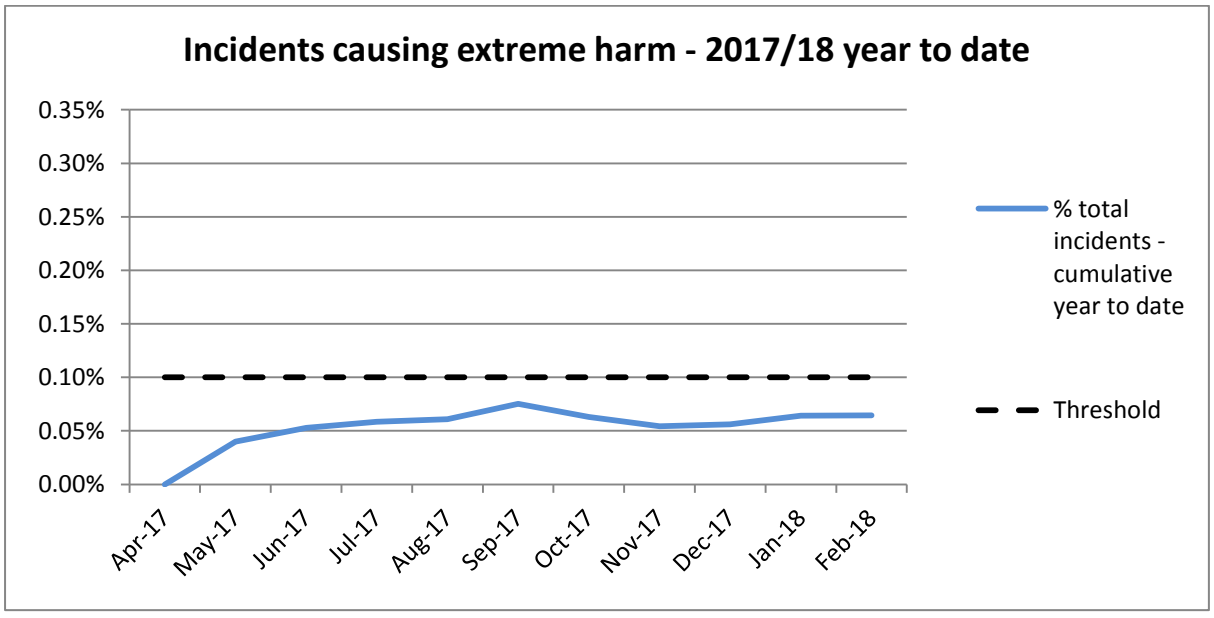


Chart 4 – Incidents causing extreme harm by month from the period April 2017 – February 2018 (% of total patient safety incidents YTD). Threshold Source: National Reporting and Learning System (NRLS)

Patient safety incident reporting rate

The Trust's incident reporting rate for February 2018 is 53.88 which places us within the highest 25% of reporters nationally (34th highest rate). 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. We consistently report 1% of incidents as moderate or above and this has not changed.

Over the last 6 months there has been a steady increase in patient safety incident reporting in a number of directorates as a result of focussed local improvement work.

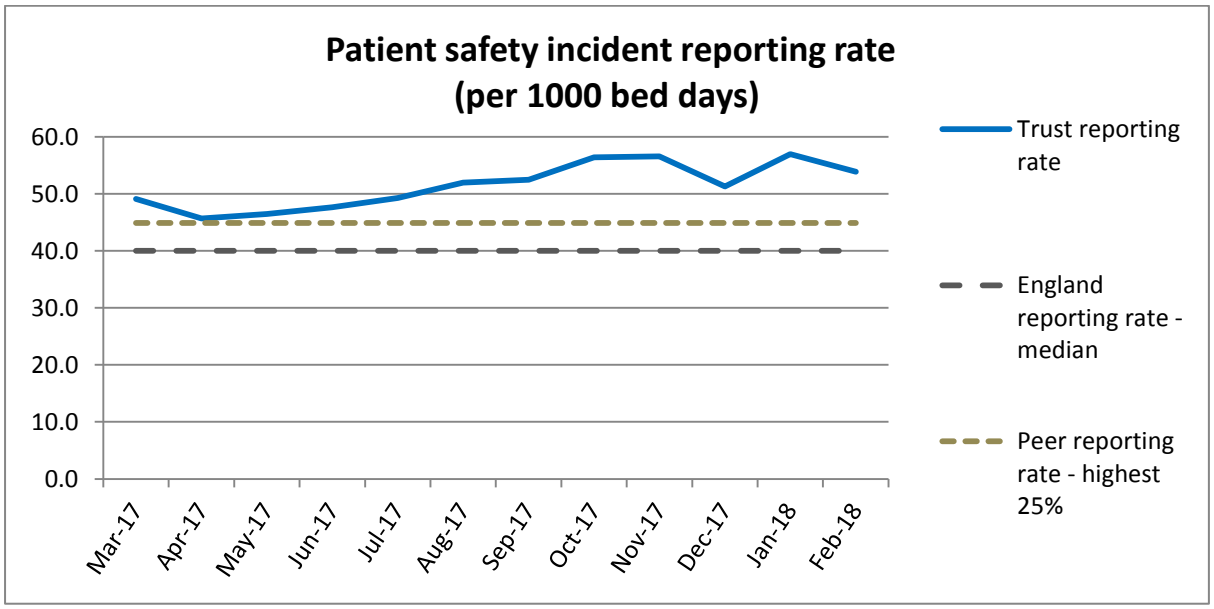


Chart 5 – Trust incident reporting rate by month for the period March 2017 – February 2018

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

2.1.3 Safe: Duty of candour

A full review of duty of candour processes across the Trust was commissioned by the Medical Director in 2017 following limited assurance audit outcomes and specific examples where candour was not found to be adequate. Compliance is now monitored through the medical director's incident review panel. Focussed work is underway with the divisional teams to ensure that the evidence of the duty of candour conversation and copies of the letter sent are uploaded on to Datix as the single repository for compliance data.

The table below shows the number of SIs, internal investigations and cases of moderate harm reported between April 2017 and January 2018, and the percentage of these which have had stage 1 and stage 2 of the duty of candour process completed which are all improving.

The compliance for February 2018 is not yet available as data are reported one month in arrears.

	SIs	Level 1 (internal investigations)	Moderate and above incidents
Number of incidents (Apr 2017 – January 2018)	159	71	54
Total with stage 1 complete	154	50	42
Total with stage 2 complete	151	51	41
Total with both stages complete	151	49	40
Percentage fully compliant with duty of candour requirements	95%	69%	74%

Percentage of incidents fully compliant with duty of candour requirements at 12 March 2018.

2.1.4 Safe: Never events

There have been no further never events declared since the case in July 2017. The surgery, cancer and cardiovascular (SCCS) division have implemented immediate action to minimise recurrence of the July case by using an alert on epidural lines in the form of a printed sticker. This is a short term measure until new products which do not allow connection of epidural lines to inappropriate devices become available (expected in Quarter 4). An implementation plan has been developed and a Task and Finish group has been set up by the SCCS division to review the available devices and manage the roll out trust wide.

An audit of the sticker alert on epidural lines has now taken place in all clinical areas. The audit showed that out of 50 cases audited, 38 were labelled correctly (76%). The results will be presented at the relevant quality committees and a plan will be developed in response to the audit findings. Detailed information will also be included in this month's Quality Report.

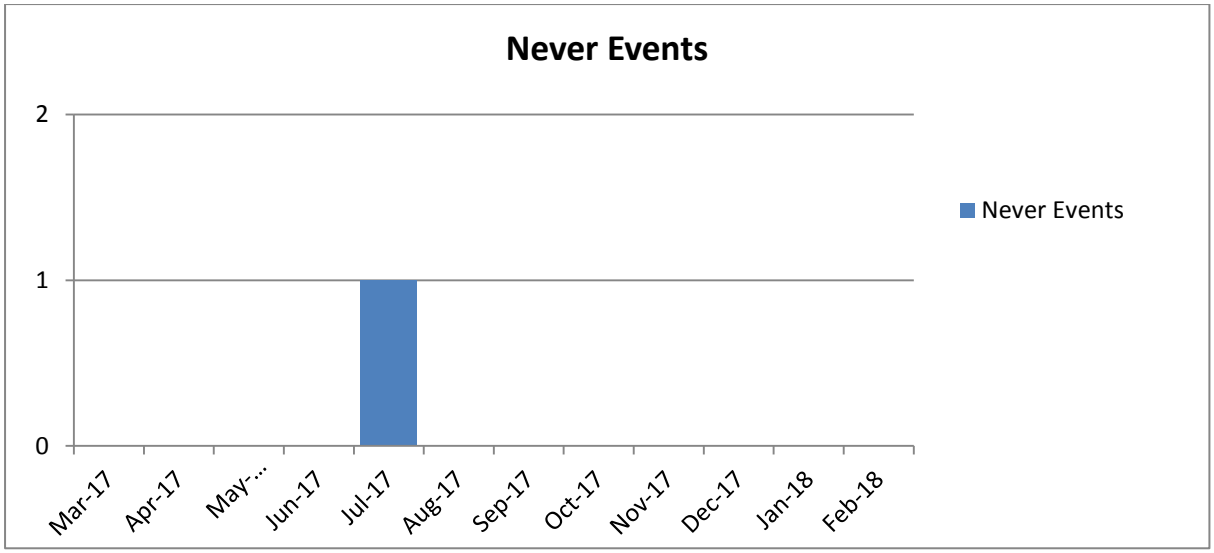


Chart 6 – Trust Never Events by month for the period March 2017 – February 2018

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

There were no cases of MRSA BSI identified at the Trust in February 2018, however since the last report one case of MRSA BSI has been allocated to the Trust for January 2018. Two cases of MRSA BSI have been allocated to the Trust so far in 2017/18; these occurred in April 2017 and January 2018.

2.1.6 Safe: *Clostridium difficile*

Four cases of Clostridium difficile were allocated to the Trust in February 2018; none of these were identified as a lapse in care.

Fifty three cases of Clostridium difficile have so far been allocated to the Trust in 2017/18, which is below trajectory. Four cases have been identified as a lapse in care so far in 2017/18, following multi-disciplinary team review, held monthly. Two of these four cases were related to antibiotic non-compliance; these cases have been discussed with the prescribers and clinical teams involved. The other two cases related to potential transmission and have undergone local investigation.

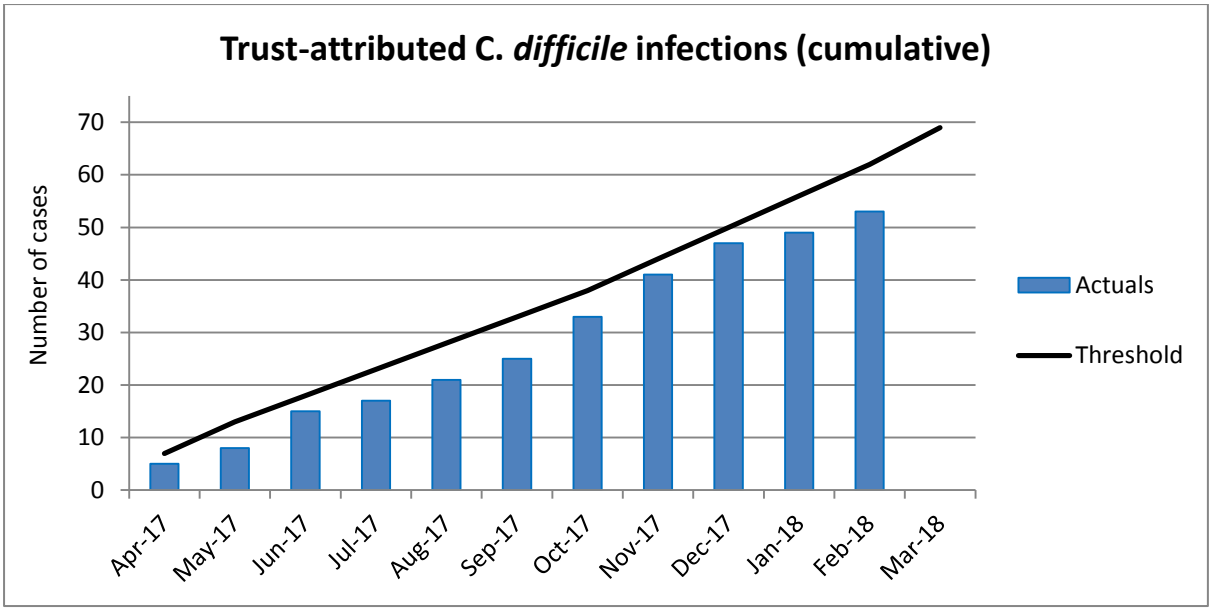


Chart 7 - Number of Trust-attributed *Clostridium difficile* infections against cumulative plan by month for the period April 2017 – February 2018

2.1.7 Safe: Venous thromboembolism (VTE) risk assessment

The Trust performance remained above target at 96.03 per cent at the end of February. Sustained improvements have been seen across all divisions as a result of local action plans and monitoring arrangements. A Trust wide action plan has been in place during this financial year given the difficulties we have experienced and progress reported to Executive Quality Committee through the Trust's Quality Report.

TIAA have now completed their 'Assurance Review of the VTE Risk Assessment' to evaluate the accuracy, completeness and timeliness of VTE data reported both internally and externally. The review concluded that there was substantial assurance and an action plan is in place to address the recommendations of the report.

VTE data quality will also undergo an external audit as part of the indicator testing for the Trust's 2017/18 Quality Account.

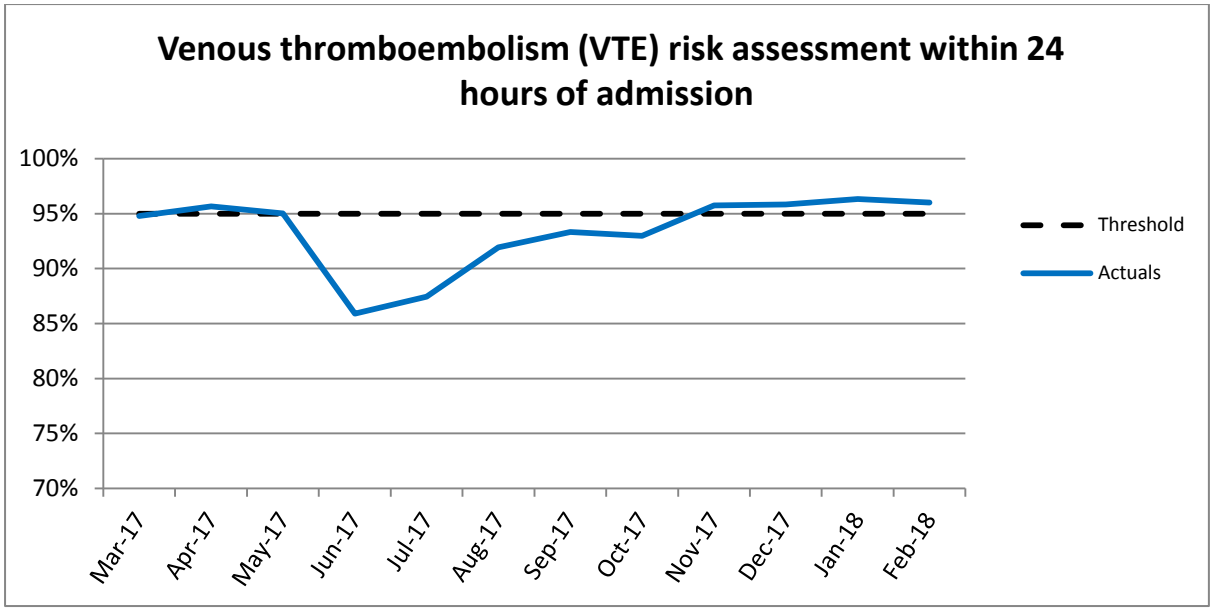


Chart 8 – % of inpatients who received a risk assessment for Venous thromboembolism (VTE) within 24 hours of their admission by month for the period March 2017 – February 2018

2.1.8 Safe: CAS alerts outstanding

The Department of Health Central Alerting System (CAS) is a system for issuing patient safety alerts, public health messages and other safety critical information and guidance to the NHS and others. There are currently no overdue alerts.

2.1.9 Safe: Avoidable pressure ulcers

There were two unstageable pressure ulcers recorded for the month of February 2018. This takes the total of avoidable Trust acquired pressure ulcers to 16 compared with 23 in the same period in 2016/2017. Each pressure ulcer is investigated using a root cause analysis and an action plan is then implemented within the clinical area to avoid further ulcers occurring.

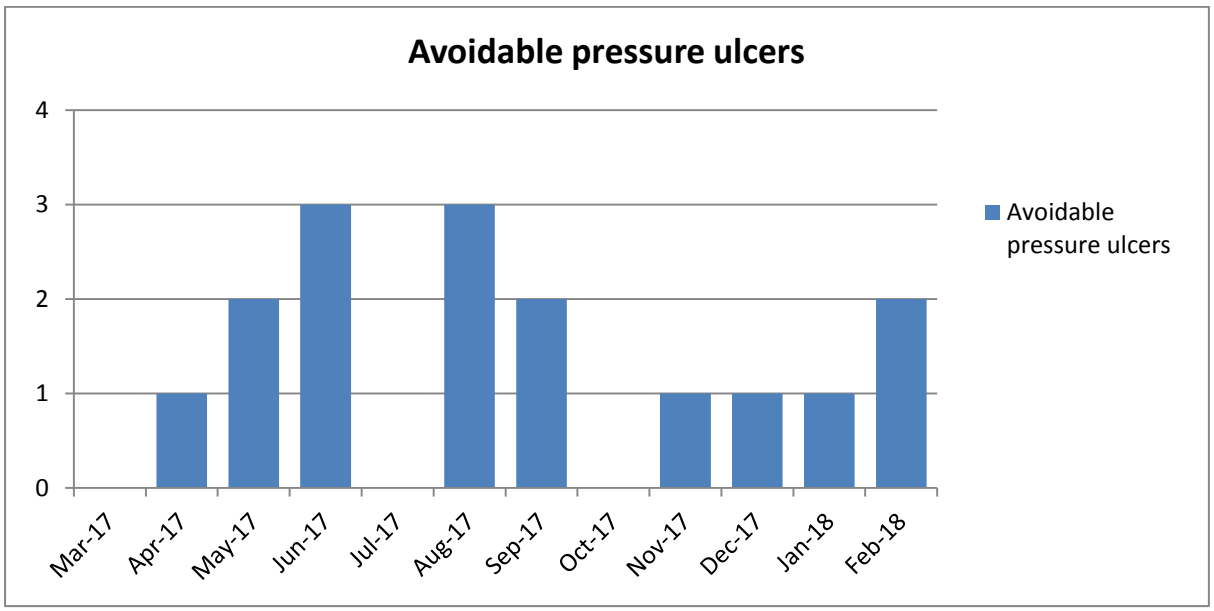


Chart 9 – Number of category 3 and category 4 (including unstageable) Trust-acquired pressure ulcers by month for the period March 2017 – February 2018

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

In February 2018 the Trust met safe staffing levels for registered nurses and midwives and care staff overall during the day and at night. The thresholds are 90 per cent for registered nurses and 85 per cent for care staff.

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

Site Name	Day shifts – average fill rate		Night shifts – average fill rate	
	Registered nurses/midwives	Care staff	Registered nurses/midwives	Care staff
Charing Cross	94.53%	92.73%	97.32%	96.98%
Hammersmith	95.89%	89.91%	98.75%	94.65%
Queen Charlotte's	96.80%	93.51%	98.05%	98.72%
St. Mary's	96.05%	94.36%	97.33%	96.59%
Trust wide	95.58%	92.85%	97.70%	96.58%

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

<u>Surgery Cancer and Cardiovascular Sciences</u>

- A7 Cardiology

Unfilled care staff shifts for specials equated to 85 hours filled by moving staff around.

- C8 Cardiology

Unfilled registered mental nurse shifts equated to 144 hours and unfilled unregistered staff shifts for specials equated to 104 hours .This was covered my moving staff around the directorate.

- Dacie

One unregistered special shift was unfilled and covered my moving staff from other areas.

- Weston ward

Unfilled registered nurse shifts for vacancies equated to 139 hours covered by the ward manager working in the numbers.Unregistered shifts for specials equated to 83 hours covered by moving staff in the directorate.

- Surgical assessment unit

Unfilled shifts covering vacancies equated to 134 hours covered by the ward manager working in the numbers.

Medicine and Integrated Care

- 11 South

Unfilled unregistered shifts equated to 91.5 hours filled by moving staff around.

- 8 West

Registered nurseunfilled shifts equated to 130.5 hours due to vacancies was covered by the ward manager working in the numbers.

- Acute assessment unit Charing Cross

Registered nurse unfilled shifts for escalation,specials and vacancies equated to 138 hours and were covered by the lead nurse, clinical nurse specialists and educators.

- Acute medical Unit Charing cross

Registered nurse unfilled shifts for escalation.specials, vacancies and sickness equated to 478 hours. Some shifts were covered by staff within the directorate and no harm was recorded as a result of the shortfall.

- Thistle Ward

Unregistered and unfilled special shifts equated to 138 hours.This was covered by other staff in the area and no harm was recorded as a result of the shortfall.

Divisions of Womens and Childrens and Imperial Private Health

- There were no shortfalls in the Divisions of Womens and Childrens and Imperial Private Health.

During the month of February increased activity across NHS Trusts continued which required and initiated a national response from NHS England.

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.

We are exploring apprenticeships, rotation programmes and nursing asccociate development.

All Divisional Directors of Nursing have confirmed to the Director of Nursing that the staffing levels in February 2018 were safe and appropriate for the clinical case mix.

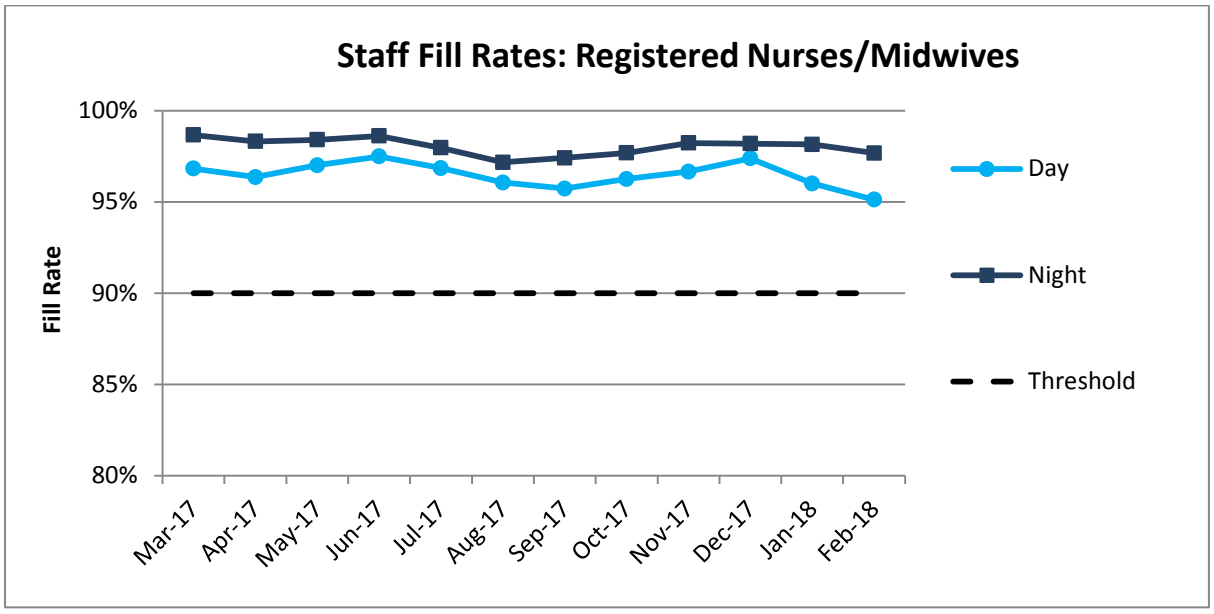


Chart 10 - Monthly staff fill rates (Registered Nurses/Registered Midwives) by month for the period March 2017 – February 2018

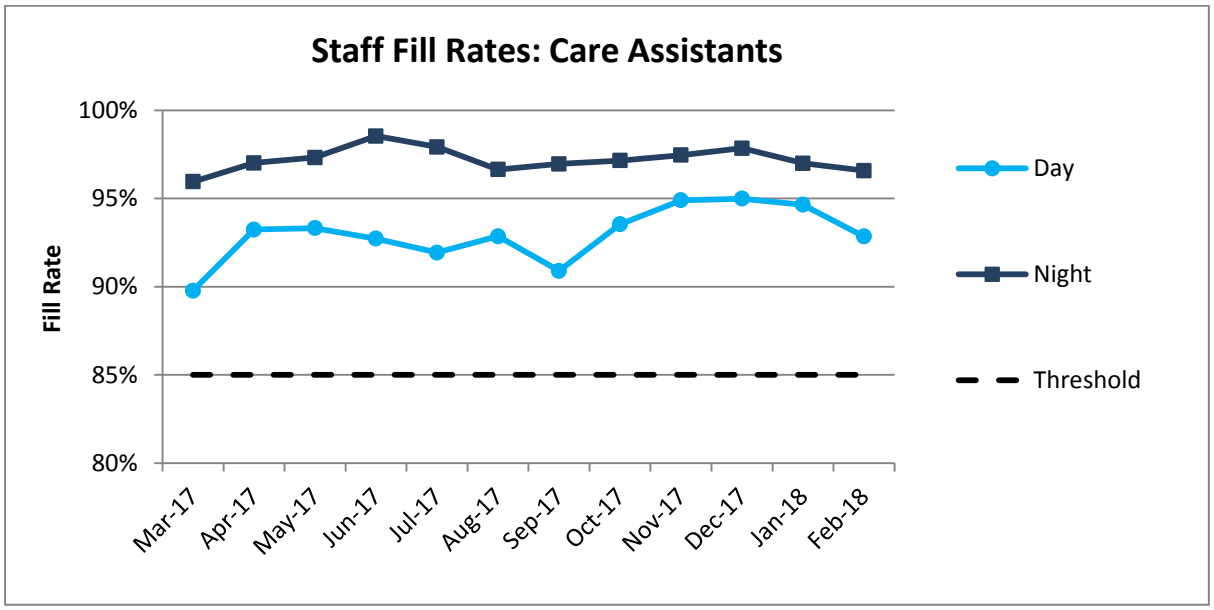


Chart 11 - Monthly staff fill rates (Care Assistants) by month for the period March 2017 – February 2018

2.1.11 Safe: Postpartum haemorrhage

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

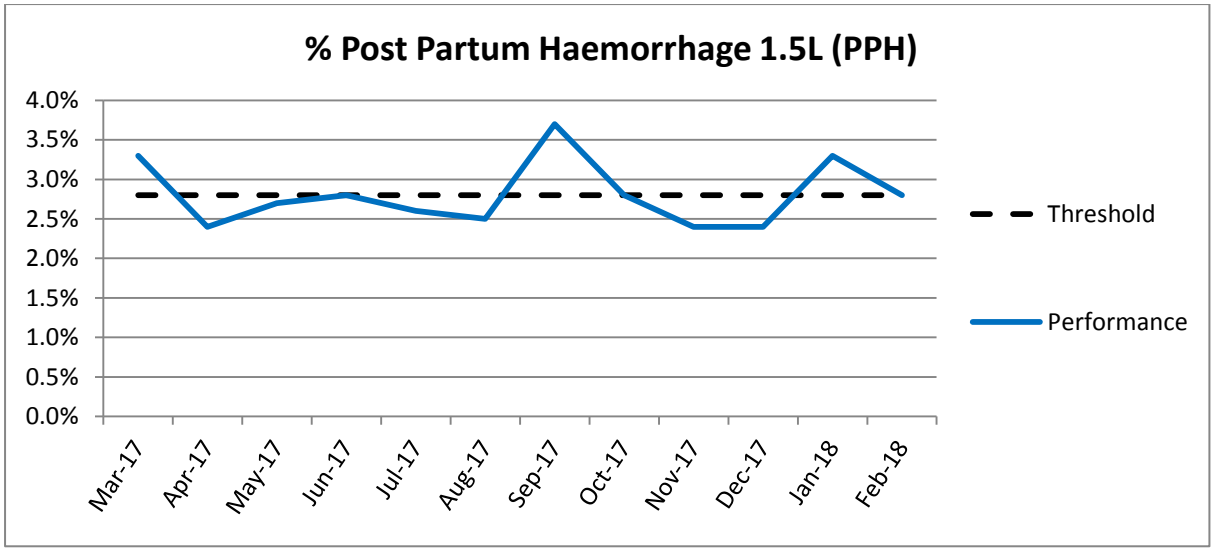


Chart 12 – Postpartum haemorrhage (PPH) for the period March 2017 – February 2018

2.1.12 Safe: Core skills training

Core Skills compliance

At the end of January, the compliance rate for Doctors in Training/Trust Grade was 73.69 per cent and for all other staff, 86.39 per cent

Core Clinical Skills compliance

At the end of January, the compliance rate for Doctors in Training/Trust Grade was 66.11 per cent and for all other staff, 85.12 per cent.

Pilot non-compliance emails – The second phase of the pilot was run within the Imaging department to send all staff that are non-compliant an email with details of the subjects that they need to complete. The compliance rate is expected to improve and this will be monitored the next time WIRED is upload (28th March)

Core skills governance committee - The first 2 meetings of the Core Skills Governance Committee have taken place. The indicator definitions were reviewed for 2018/19 reporting; a report will be presented to the executive committee with proposals that will address duplications, focus the training on key areas and remove some staff from denominators where the training is not required.

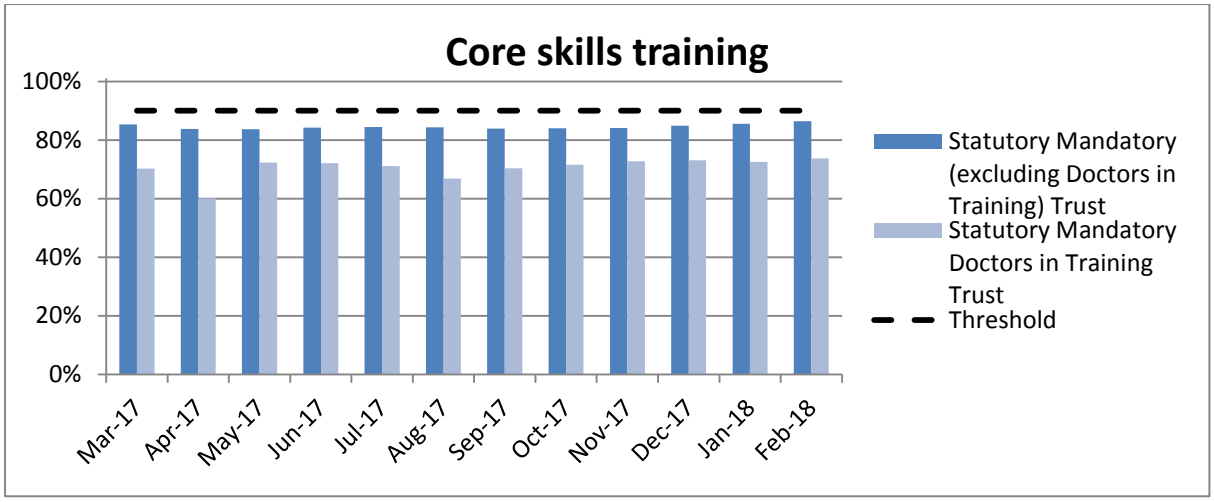


Chart 13 - Statutory and mandatory training for the period March 2017 – February 2018

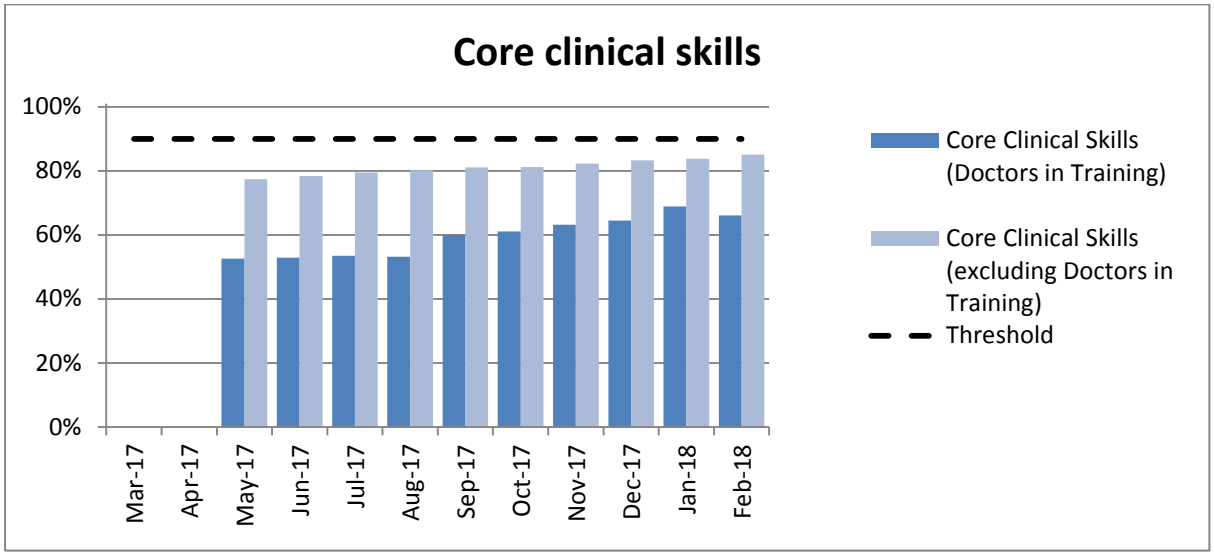


Chart 14 – Core clinical skills training for the period May 2017 (first reported) – February 2018

2.1.13 Safe: Work-related reportable accidents and incidents

There were three RIDDOR-reportable (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) incidents in February 2018.

- The first incident involved a member of staff slipping whilst walking, sustaining a fracture to his arm. The incident was reportable to the HSE as a specified injury (fracture)
- The second incident involved a member of staff sustaining a needle stick injury when delivering care to a patient who was hepatitis C positive. The incident was reportable to the HSE as a dangerous occurrence (exposure to a biological agent)
- The third incident involved a member of staff sustaining a needle stick injury when delivering care to a patient who was hepatitis C positive. The incident was

reportable to the HSE as a dangerous occurrence (exposure to a biological agent).

In the 12 months to 28th February 2018, there have been 40 RIDDOR reportable incidents of which 16 were slips, trips and falls. The Health and Safety service continues to work with the Estates & Facilities service and its contractors to identify suitable action to take to ensure floors present a significantly lower risk of slipping.

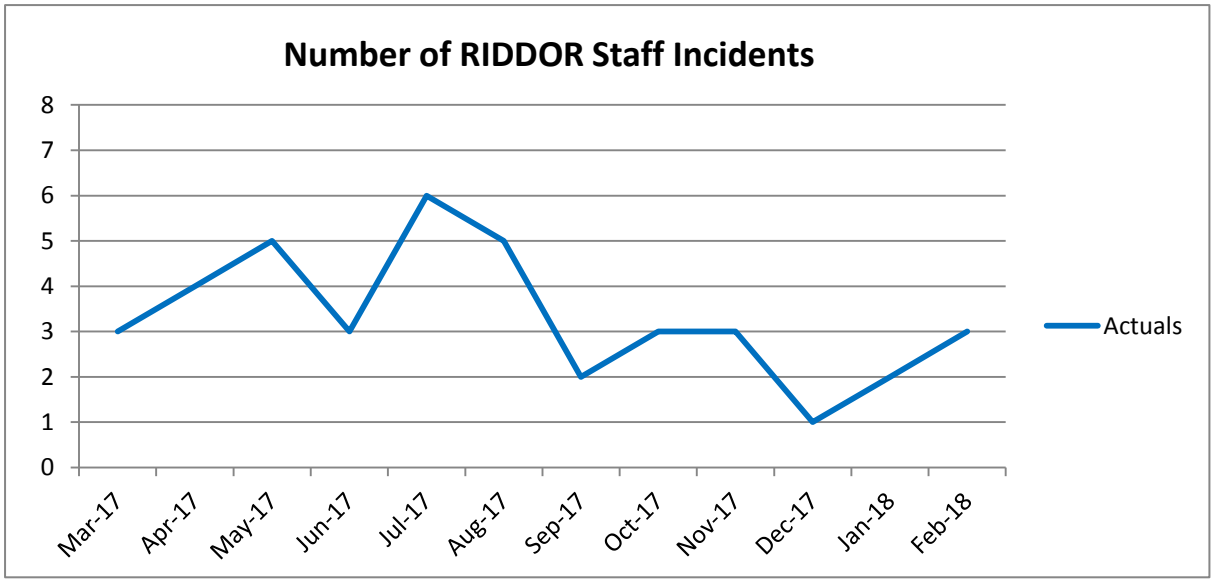


Chart 15 – RIDDOR Staff Incidents for the period March 2017 – February 2018

2.2 Effective

2.2.1 Effective: National Clinical Audits

Since April 2017, a total of 44 relevant HQIP and NCEPOD national study reports have been published. The Trust participated in 43 of these studies and the reports have been issued to the relevant divisions for a full review and are progressing through the specialty and divisional review processes. As reported previously progress is being monitored by the divisional quality and safety committees and reviewed by the quality and safety subgroup. Monitoring has also now commenced at the weekly incident panel meetings to allow greater oversight of progress until the end of the business year.

Twenty reports have been through the full trust process and levels of assurance agreed by the relevant division/directorate quality and safety committee, compared to nine last month. Action plans are in place for each of these audits.

2.2.2 Effective: Mortality data

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

The most recent HSMR is 72 (September 2017). Over the last 12 months the Trust has had the second lowest HSMR for acute non-specialist trusts nationally. The Trust also has the 2nd lowest SHMI of all non-specialist providers in England for Q2 2016/17 – Q1 2017/18.

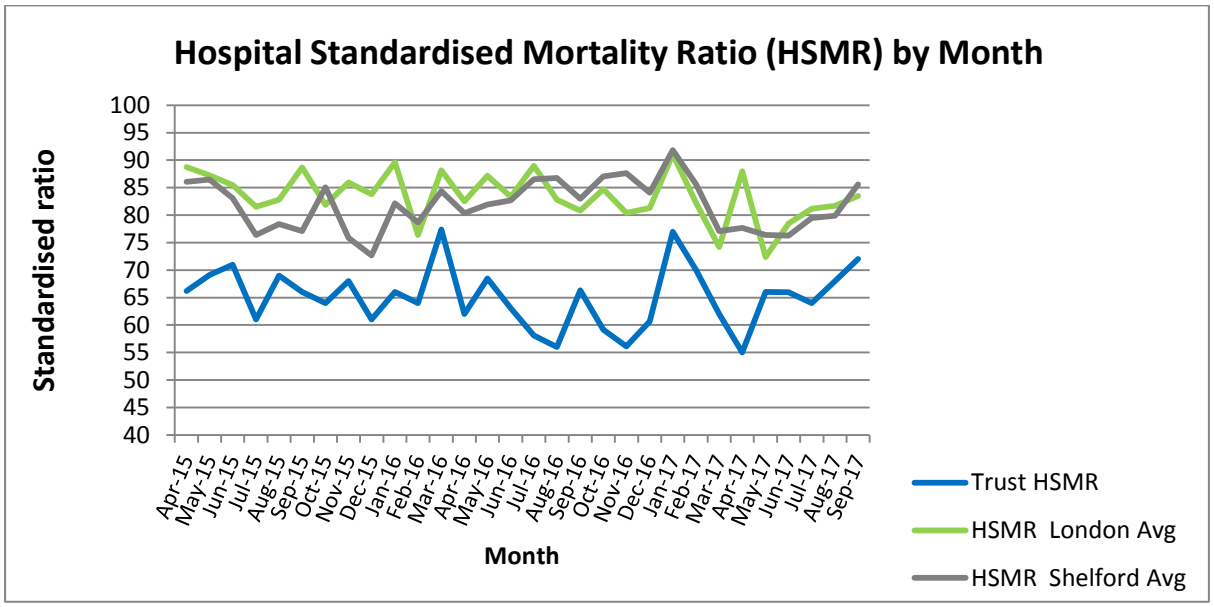


Chart 16 - Hospital Standardised Mortality Ratios for the period April 2015 – September 2017

2.2.3 Effective: Mortality reviews completed

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. 125 completed reports have been received to date, from the 202 requested. Cases are reviewed at the monthly Mortality Review Group (MRG) with a focus on any avoidable factors and learning themes. Early emerging themes map to the 'falls' and the 'responding to the deteriorating patient' safety streams. As more cases are reviewed the group will be able to recommend work streams to be considered as part of the trust improvement programme.

To date, the Trust has confirmed eleven cases of avoidable death. Two cases had already undergone SI investigations, with action plans in place. Four cases have undergone SI investigation as well as the SJR process and will be presented at the March MRG meeting. Five further cases of avoidable death have been through the MRG who have recommended further level 1 (one case) or SI investigations (four cases) to explore wider care and service delivery issues that were identified. These are currently underway.

In order to instigate the SJR process at the earliest opportunity the timeframe for local mortality review has been shortened to 7 days (from 30 days). This came into

effect from September 2017. A weekly performance report is now reviewed at the MD incident panel.

Mortality reviews (at 9 March 2018)

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	YTD
Total number of deaths	120	152	137	138	163	151	161	167	161	191	176	1717
Number of local reviews completed	120	152	136	137	161	143	156	141	141	148	87	1522
% Local Reviews Completed	100%	100%	99%	99%	99%	95%	97%	84%	88%	77%	49%	89%
Number of SJR reviews requested	3	3	2	21	28	22	37	19	19	24	24	202
Number of SJR reviews completed	2	3	2	11	22	16	27	14	14	11	3	125
Number of avoidable deaths (Score 1-3)	1	0	0	1	2	1	3	1	0	1	1	11

Note: The timeframe for local, level 1 review completion was shorted from 30 days to 7 days, effective September 2017

2.2.4 Effective: Recruitment of patients into interventional studies

We did not achieve our target of 90% of clinical trials recruiting their first patient within 70 days of a valid research application for the previous two quarters. Validated data for Q2 2017/18 showed performance at 53.3%. This is an increase on the two previous quarter's performance, but slightly below the national average of 55.6%.

Historically, much of the delay for ICHT studies has been at the contract negotiation stage. As reported last month we have now re-staffed the ICHT JRO with new contracting experts and new leadership. As well as now being fully resourced, the team are taking a more pragmatic and proactive approach to contract and cost negotiation (within agreed negotiation boundaries). Weekly team meetings now take place to review all studies in the pipeline, to identify potential issues and escalate.

Performance has declined nationally following the process and data changes introduced by the DoH in 2016/17. A new 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, which are more robust and which are resistant to different interpretations by NHS Trusts as is currently the case.

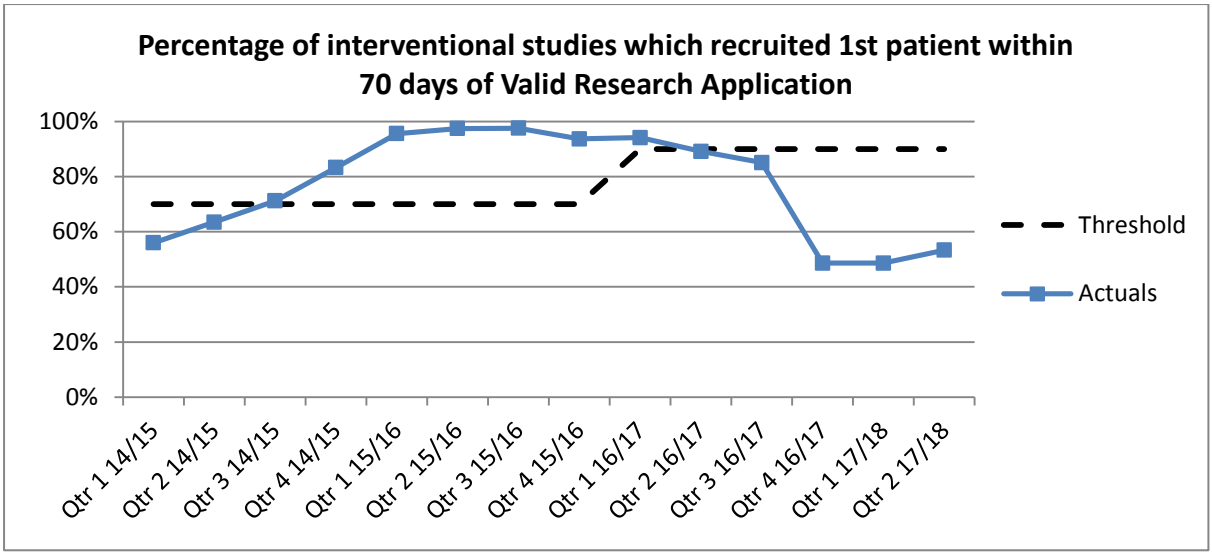


Chart 17 - Interventional studies which recruited first patient within 70 days of Valid Application Q1 2014/15 – Q2 2017/18

2.2.5 Effective: Readmission rates

The most recently reported 28 day readmission rates (through Dr Foster intelligence) continued to be lower in both age groups than the Shelford and National rates.

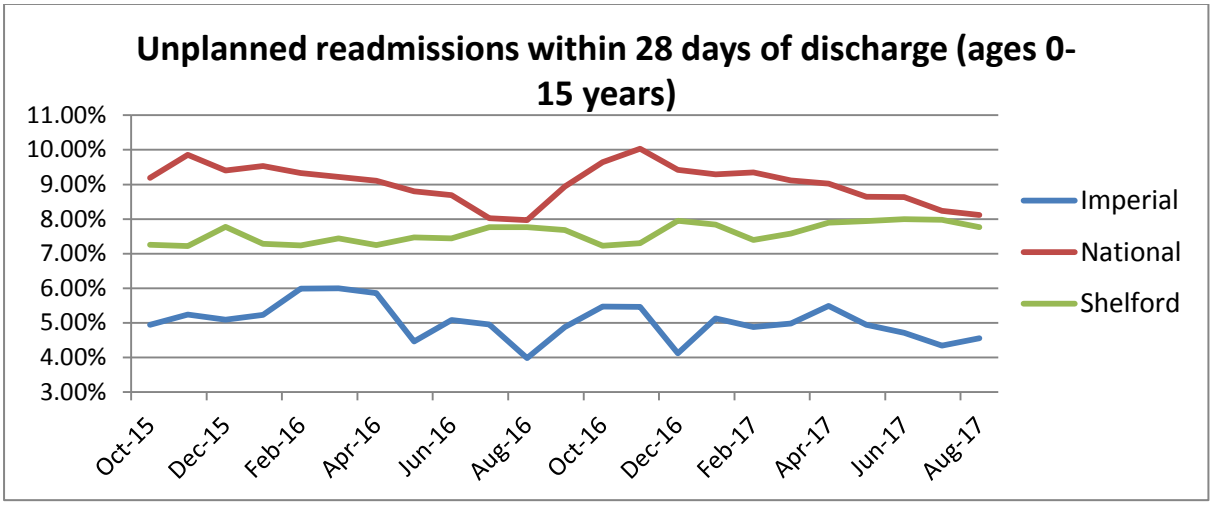


Chart 18 - Unplanned readmissions (to any NHS Trust) within 28 days of discharge from ICHT (ages -15 years) for the period October 2015 – August 2017 (Source: Dr Foster Intelligence)

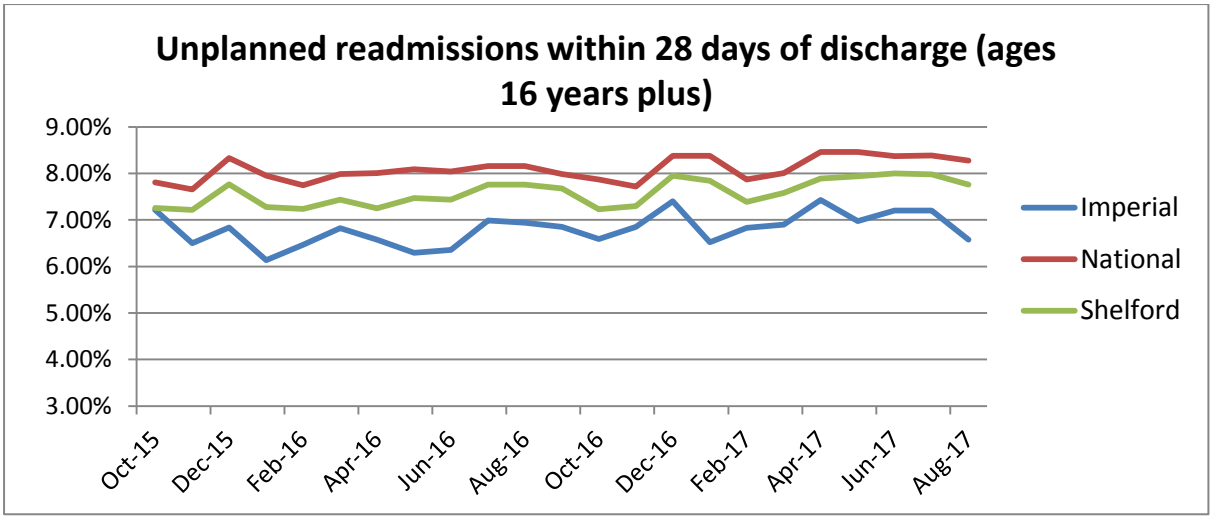


Chart 19 - Unplanned readmissions (to any NHS Trust) within 28 days of discharge from ICHT (ages 16 years plus) for the period October 2015 – August 2017 (Source: Dr Foster Intelligence)

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

This is a key data quality indicator in the trust data quality framework. It measures the number of requests for elective admissions (diagnostic or surgical procedure) placed by the clinical team, but these have not yet been processed by the administration team. Processing orders quickly ensures patients are appropriately placed onto the inpatient waiting list and facilitates the offer of timely treatment in line with RTT targets. The Trust operating standard is that orders should be processed within 2 working days of being placed by the clinician. The data quality action group that is being established will include agreeing local plans to address high numbers of orders that are not being processed quickly enough.

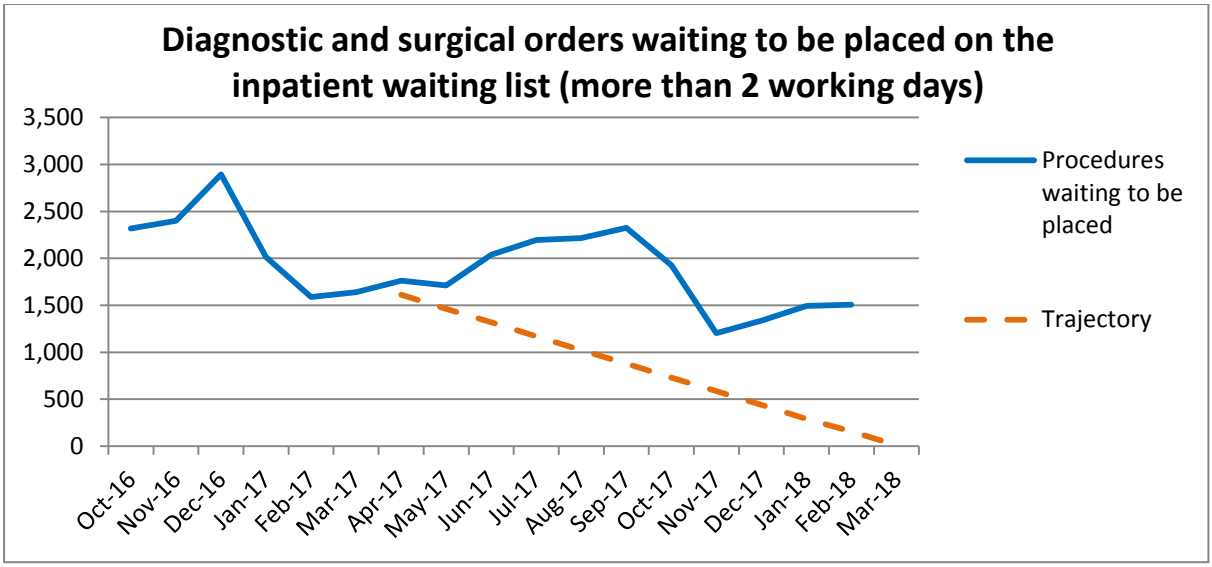


Chart 20 – Number of patients on the Add/Set Encounter request list of more than 2 working days for the period October 2016 – February 2018

2.2.7 Effective: Outpatient appointments checked in and checked out

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

There has been an increase in appointments waiting to be cleared on the system and this is being driven mainly from our non-centralised booking areas. This is being discussed at the newly established waiting times data quality group to understand root causes.

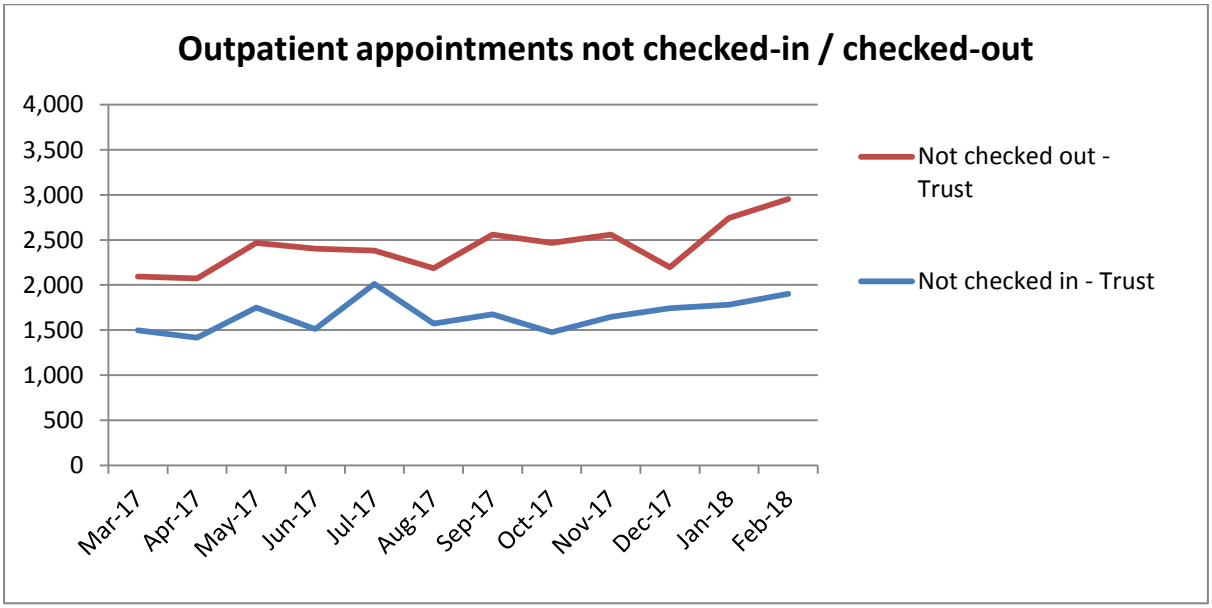


Chart 21 – Number of outpatient appointments not checked-in or DNA'd (in the last 90 days) AND number of outpatient appointments checked-in and not checked-out for the period March 2017 – February 2018

2.3 Caring

2.3.1 Caring: Friends and Family Test

The willingness to recommend remains generally high. The outpatient FFT in February was 93%, the highest it has been since the survey has been collected by text message. There was a small increase in the response rate in the A&E survey; although this is below target the level remains above the national average for emergency departments (c. 12%).

Friends and Family test results

Service	Metric Name	Dec-17	Jan-18	Feb-18
Inpatients	Response Rate (target 30%)	29.9%	35.0%	**35.8%**
	Recommend %	97.9%	98.0%	**97.5%**
	Not Recommend %	0.7%	0.7%	**0.9%**
A&E	Response Rate (target 20%)	14.9%	16.4%	**16.8%**
	Recommend %	94.4%	93.7%	**92.5%**
	Not Recommend %	2.7%	3.3%	**4.1%**
Maternity	Response Rate (target 15%)	26.9%	28.2%	**36.4%**
	Recommend %	93.0%	94.3%	**94.4%**
	Not Recommend %	2.6%	2.1%	**1.3%**
Outpatients	Response Rate (target 6%)	11.4%	14.3%	**15.9%**
	Recommend %	90.9%	91.4%	**92.9%**
	Not Recommend %	4.4%	4.2%	**3.2%**

2.3.2 Caring: Patient transport waiting times

Non-Emergency Patient Transport Service

The performance response times for February were unavailable at time of publication and will be updated in the next report.

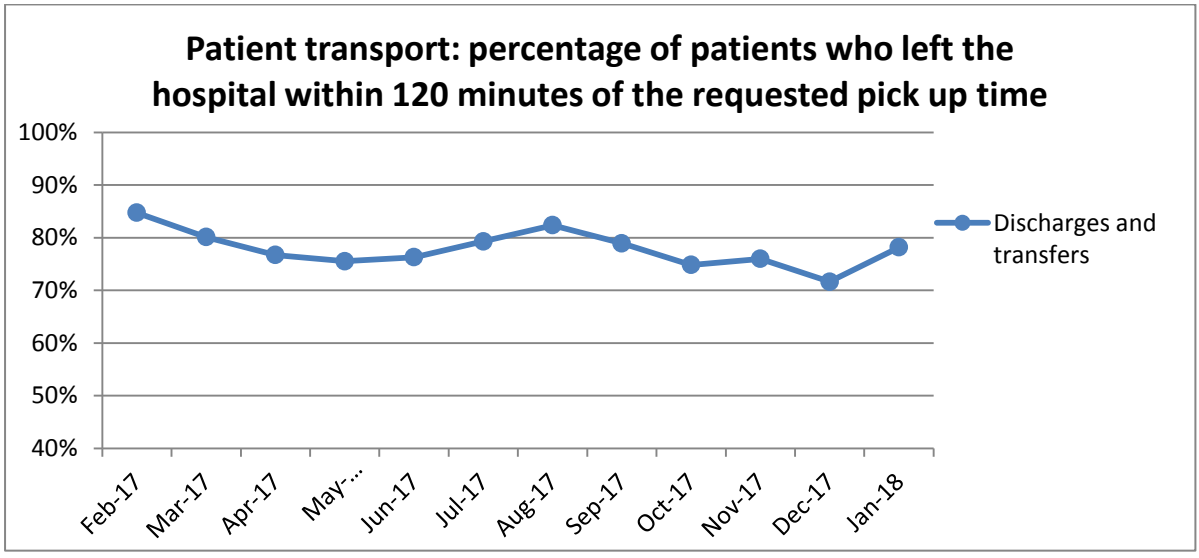


Chart 22 - Percentage of patients who left the hospital as part of the patient transport scheme within 120 minutes of their requested pick up time between February 2017 and January 2018

2.3.3 Caring: Eliminating mixed sex accommodation

The Trust reported 42 mixed-sex accommodation (MSA) breaches for February 2018. As previously reported the increase in breaches since October 2016 has been mainly attributable to breaches occurring within ITU at Charing Cross. For critical care (level 2 and 3) mixing is acceptable as it is recognised nursing acuity requires gender mixing, however in line with national policy it is not acceptable when a patient

in the critical care units no longer requires level 3 or 2 care, but cannot be placed in an appropriate level one ward bed.

The Division of Surgery and Cancer are undertaking a detailed assessment of the situation in discussion with commissioners to understand root causes. This involves gaining an understanding of how other Trusts interpret the policy to report breaches within the context of critical care. The resultant actions with progress will continue to be reported to the Executive Quality Committee.

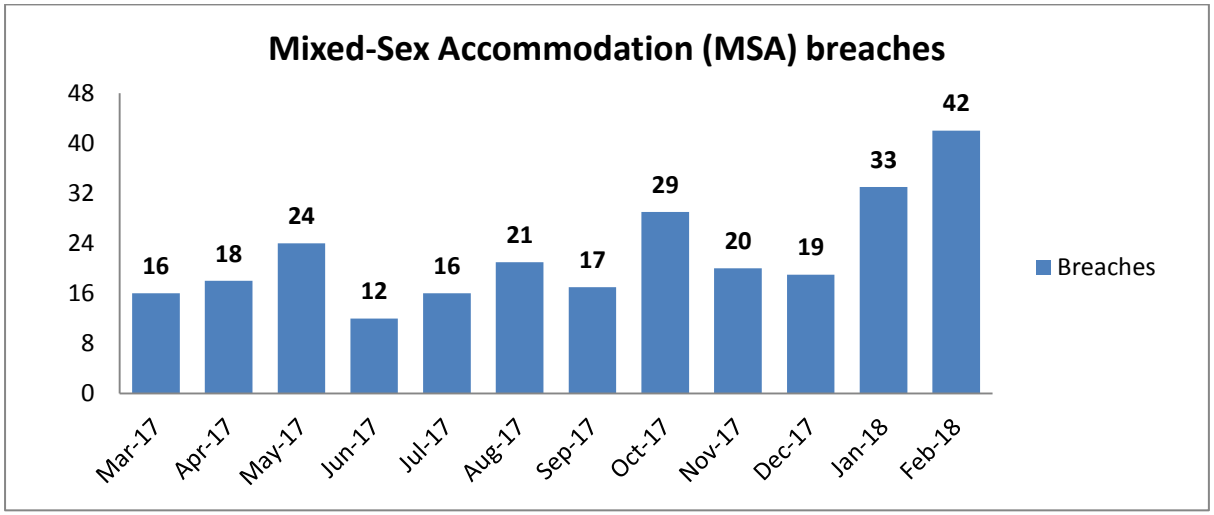


Chart 23 – Number of mixed-sex accommodation breaches reported for the period March 2017 – February 2018

2.3.4 Caring: Complaints

The number of complaints fell back in February. There is no particular category that accounts for this but we continue to see a higher than average number of complaints related to appointments and cancellations.

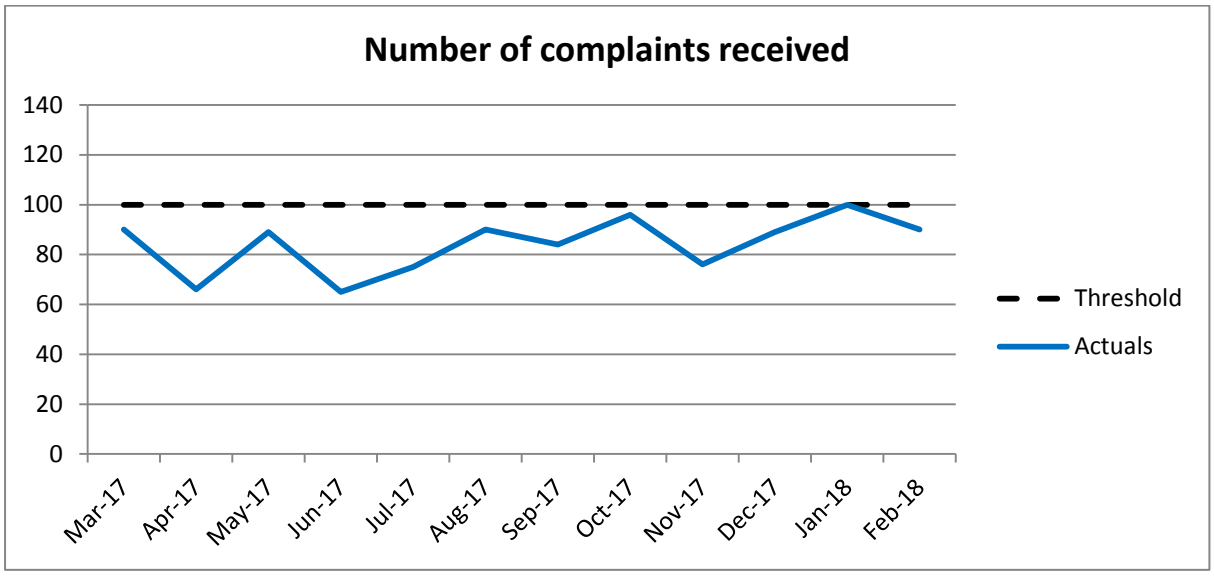


Chart 24 – Number of complaints received for the period March 2017 – February 2018

2.4 Well-Led

2.4.1 Well-Led: Vacancy rate

All roles

At the end of February 2018, the Trust directly employed 9,378 WTE (whole time equivalent) members of staff across Clinical and Corporate Divisions; similar to those employed in January. The contractual vacancy rate for all roles was 12.3 per cent against the target of 10 per cent; remaining below the average vacancy rate of 12.4 per cent across other Acute London Teaching Trusts.

During the month there were a total of 180 WTE joiners and 175 WTE leavers across all staffing groups and the Trusts voluntary turnover rate (rolling 12 month position) stands at 9.2 per cent.

Actions being taken to support reduction in vacancies across the Trust include:

- Bespoke campaigns and advertising are underway for a variety of specialities. Imaging and Radiography are looking to target University Open days and third year students and will be hosting a CPD Open Day/seminar to attract candidates

- A Trust Open Day is being held in Charing Cross on March 29th which will be advertised via RCN, NHS Jobs and various social media channels

- A variety of channels are being used to attract and recruit people including, Open Days, Fairs, social media and print advertising. We have put a Preferred Supplier List in place to support with the hard to recruit areas which have already resulted in a number of placements

- The Careers website content is being redrafted and the design is taking an incremental approach. The new recruitment look and feel is now live and marketing materials have been developed to support recruitment activity. All hard to recruit areas adverts have been redesigned, refreshed and are live to ensure a more compelling and consistent look and feel in the marketplace

All Nursing & Midwifery Roles

At end of February 2018, the contractual vacancy rate for all of the Trusts Nursing & Midwifery ward roles was 13.7 per cent with 699 WTE vacancies across all bands. Within the band 2 – 6 roles of this staffing group, the vacancy rate stands at 15.0 per cent and we continue to work with other London Acute Teaching Trusts to benchmark and share information to support a reduction in these vacancies.

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

- A project group is up and running to address Band 2-6 ward based recruitment & retention. The plan is being refreshed for 2018/2019

- An automatic conditional offer letter was sent out to all of our student nurses who will graduate in February. We have had 39 of our 47 students accept our offer to date. The automatic offer letter has already been sent out to those who complete their qualification in August. There is a 'Student Attraction Strategy' which will build on this activity year on year (including adverts on job boards, attending student fairs and looking at the offer and support we give to newly qualified nurses as part of the Recruitment and Retention plan) to work towards making us an 'employer of choice' for students

- A social media campaign has commenced for Medicine for the Elderly and an Open Day ran on 28th February. A Recruitment and Retention Premium (R&RP) has been agreed for areas which have a vacancy rate above 35% in Medicine. This has been launched for Acute Medicine and Medicine for the Elderly to date and we have seen a boost in applications. The results to date are very successful and a further Open Day is planned for April and a similar campaign will be run for Stroke/Neuro

- Midwifery will be looking to target specific Midwifery events this year and hosting specific recruitment events to attract Band 6 experienced midwives. They are also looking at creating Band 6 developmental pathway roles that can offer career development

- The volume assessment centres have been revised to make them more efficient, effective and to realise a better candidate experience and conversion rate. This will be an iterative process and further changes will be made as needed

- We have agreed to do monthly Open Days for clinical haematology instead of quarterly and we are also currently putting a case together for an R&R Premium. We will be having an Open Day for 7 North when the refurbishment is finished in early April

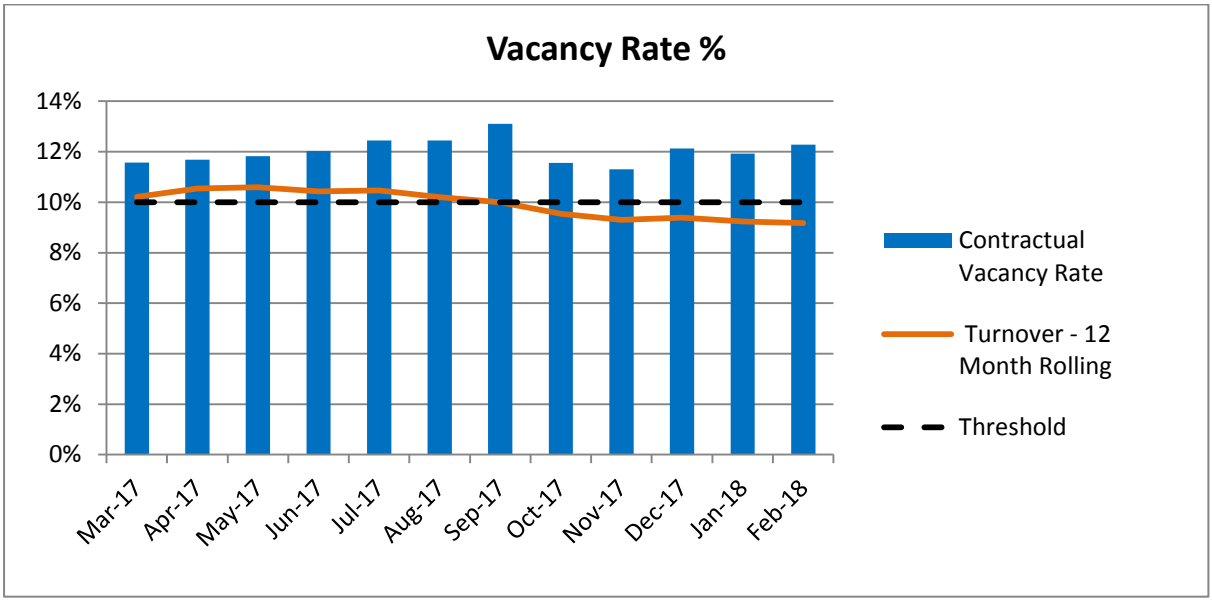


Chart 25 - Vacancy rates for the period March 2017 – February 2018

2.4.2 Well-Led: Sickness absence rate

Recorded sickness absence in February was 3.3 per cent, maintaining the Trusts rolling 12 month sickness position at 2.9 per cent against the year-end target of 3.10 per cent or lower.

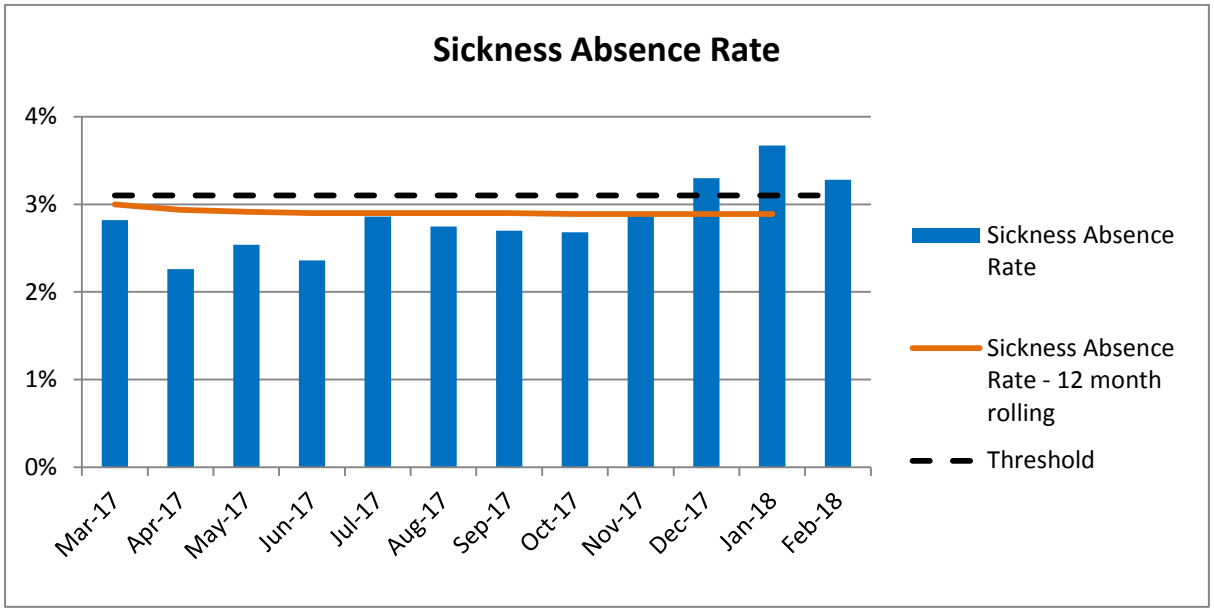


Chart 26 - Sickness absence rates for the period March 2017 – February 2018

2.4.3 Well-Led: Performance development reviews

The PDR cycle for 17/18 began on 1st April 2017 and closed on the 31st July 2017 with 88.5 per cent of staff having completed a PDR with their line manager; reviewing past year performance against objectives and the Trust values, agreeing personal development plans and setting objectives for the year.

2.4.4 Well-Led: Doctor Appraisal Rate

Doctors' appraisal rates are 88.34 per cent this month. Actions being taken to increase compliance include continuing the Professional Development monthly drop-in sessions across all Trust sites, reviewing the automated reminder emails from PREP and reviewing the system to ensure it is user friendly and easy to navigate by doctors. Individual contact continues with doctors who are overdue with application of the trust policy where appropriate. In February, there were 87 consultants and 49 career grades within that category. A breakdown of these doctors by division and directorate will be included in the monthly Quality Report, and support is being increased to divisions to ensure that all overdues are actioned in line with the new policy.

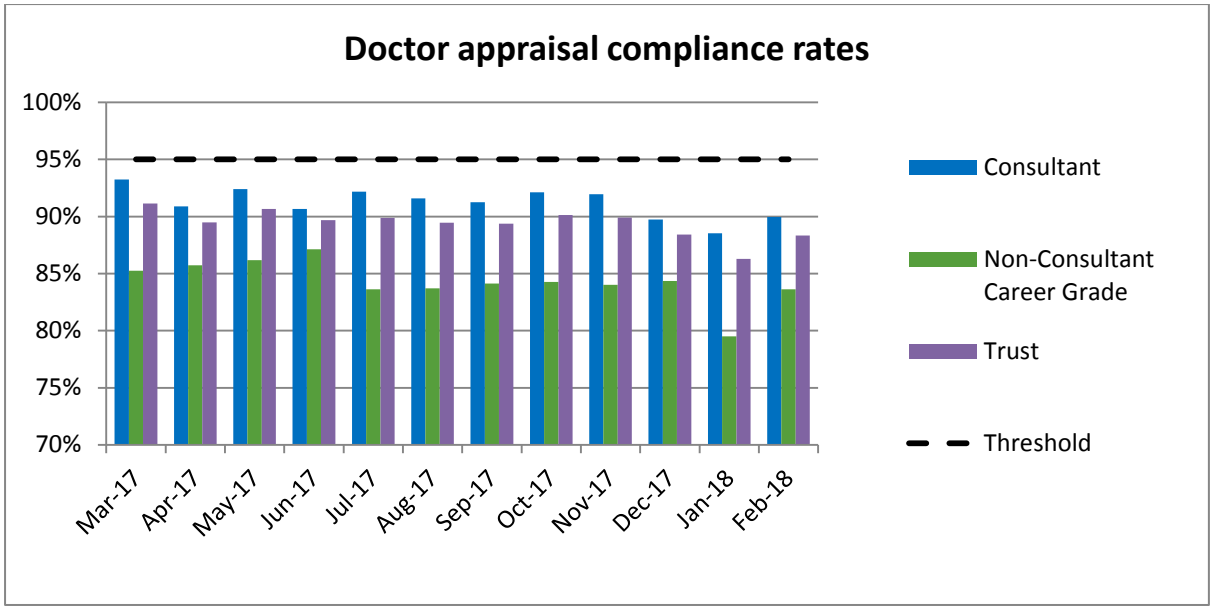


Chart 27 - Doctor Appraisal Rates for the period March 2017 to February 2018

2.4.5 Well-Led: Staff Friends and Family

The overall Engagement score increased from 77% in 2016 to 80% in 2017. The headlines of the Staff Friends and Family test results showed that:

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

The FFT scores were our highest performance to date in the last three years. The Trust has undertaked the 2017 NHS National Staff Survey and the results will be published in March 2018.

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

Health Education England quality visit

The quality visit action plan has now been closed based on the evidence submitted.

2016/17 General Medical Council National Training Survey

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

In 2015 three specialities were put under enhanced monitoring by the GMC – critical care at Charing Cross Hospital, ophthalmology and neurosurgery. Formal actions

plans were put in place with progress monitored at monthly meetings with the Medical Director, and locally through local faculty groups. The 2017 results for both ophthalmology and neurosurgery demonstrated sustained performance and therefore the GMC have removed them from enhanced monitoring. Critical care remains under enhanced monitoring and the recurring red flags triggered a quality review from Health Education England in September which resulted in an additional action plan around developing the workforce, developing MDT simulation opportunities and enhancing supervision.

Health Education England (HEE) requested action plans in response to the survey results with 10 actions remaining outstanding. These are being monitored via the education specialty reviews and local faculty groups and will be reported in this report. A progress report on our actions was submitted to HEE on 19th January 2018.

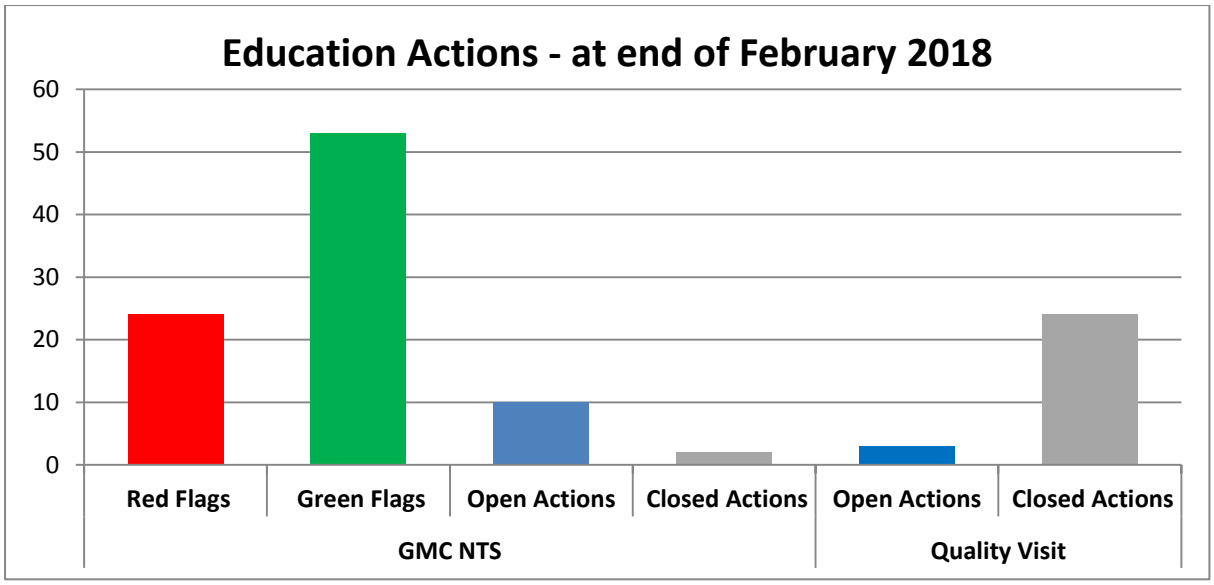


Chart 28 – General Medical Council - National Training Survey action tracker, updated at end January 2018

2.4.7 Well Led: Estates – maintenance tasks completed on time

The metrics for estates maintenance performance are currently under review within the nursing directorate; these will be included as part of the updated integrated performance framework for 2018/19.

2.5 Responsive

2.5.1 Consultant-led Referral to Treatment waiting times

At end of February 2018, 82.8 per cent of patients had been waiting less than 18 weeks to receive consultant-led treatment, against the standard of 92 per cent (January performance was 82.9 per cent). There were 256 patients who had waited over 52 weeks for their treatment since referral from their GP. This means that the Trust is currently slightly behind its trajectory of 254 patients for February 2018.

The temporary postponement of non-urgent elective activity in January and February 2018 (to support the emergency pathways as part of the national response) led to significant numbers of cancellations, with increased numbers of patients waiting and RTT breaches. In consultation with the Trust's external stakeholders, RTT action plans and recovery trajectories for the most challenged specialties have been developed. The RTT recovery trajectory for 2018/19 is being finalised and approved through the appropriate governance routes.

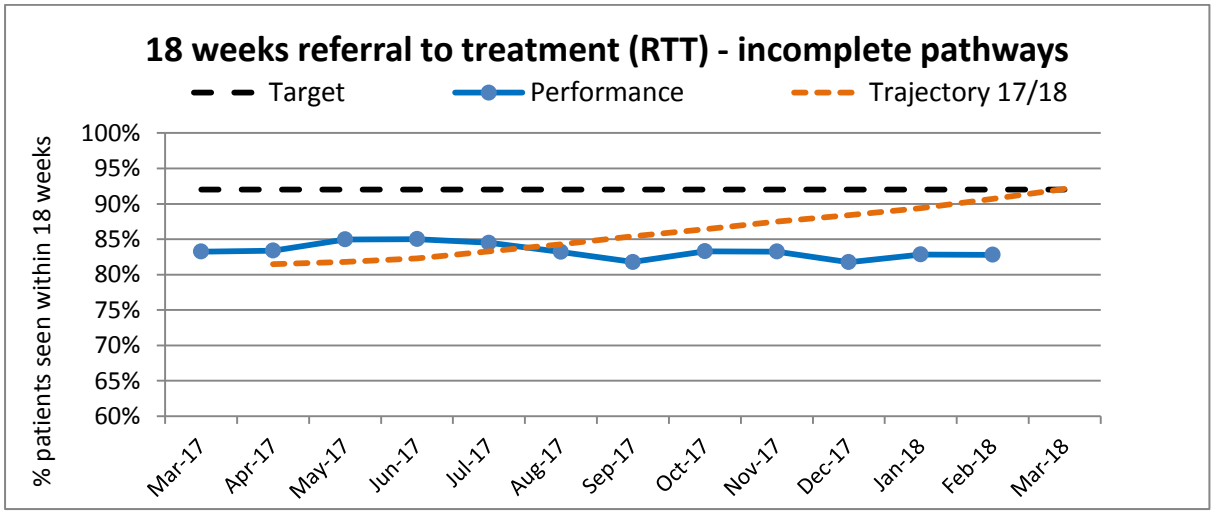


Chart 29 – Percentage of patients seen within 18 weeks (RTT incomplete pathways) for the period March 2017 – February 2018

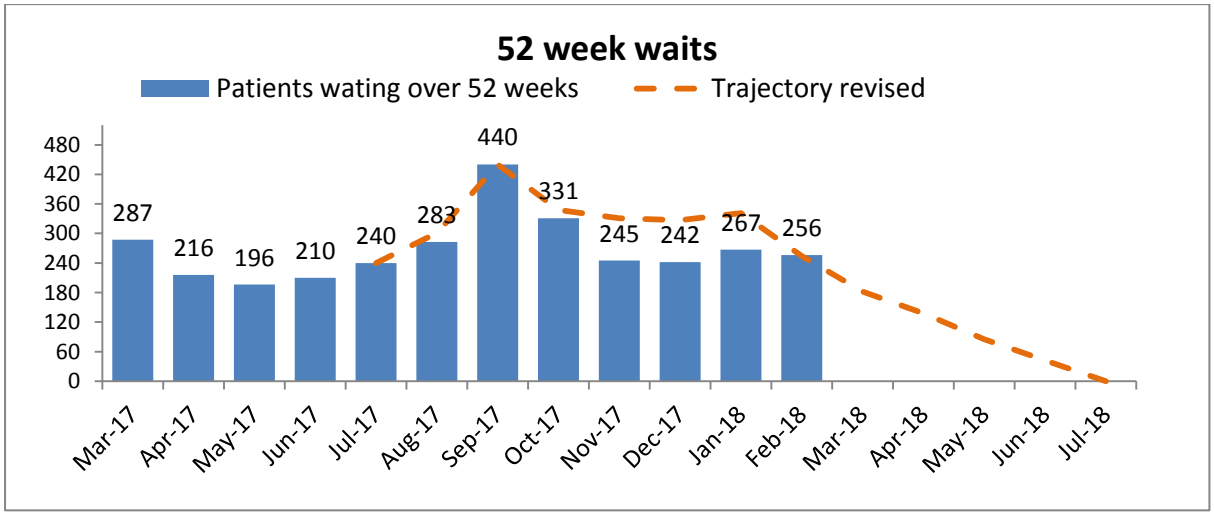


Chart 30 - Number of patients waiting over 52 weeks for the March 2017 – February 2018

2.5.2 Cancer 62 day waits

Due to the timing of submissions cancer performance is reported for January 2018. The Trust achieved the 62-day standard, delivering performance of 85.2 per cent against, above the trajectory target of 85.1 per cent.

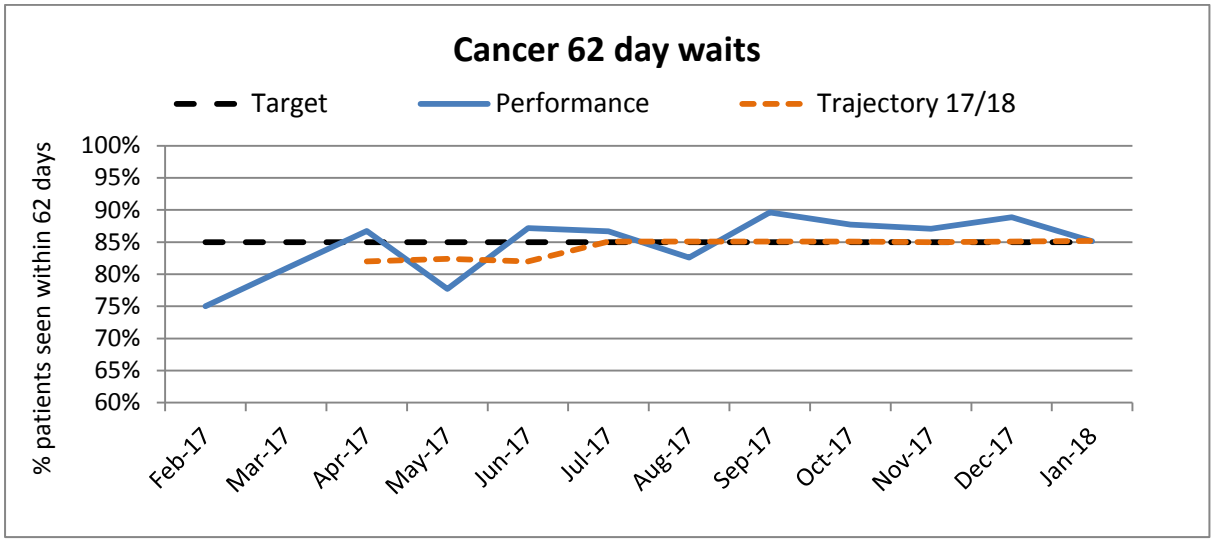


Chart 31 – Cancer 62 day GP referral to treatment performance for the period February 2017 – January 2018

2.5.3 Theatre utilisation

Based on the Trust's current methodology for measuring elective theatre productivity the performance in February 2018 was 73.4 per cent against a target of 85 per cent (Includes elective, trauma and waiting list initiative sessions (excludes emergency and private sessions). In February the executive committee for operational performance agreed a proposal to align the Trust's methodology for measuring elective theatre productivity with the Four Eyes methodology, (as used to benchmark theatre productivity at a national level). The new suite of reporting is being designed and will begin reporting in quarter 1 2018/19.

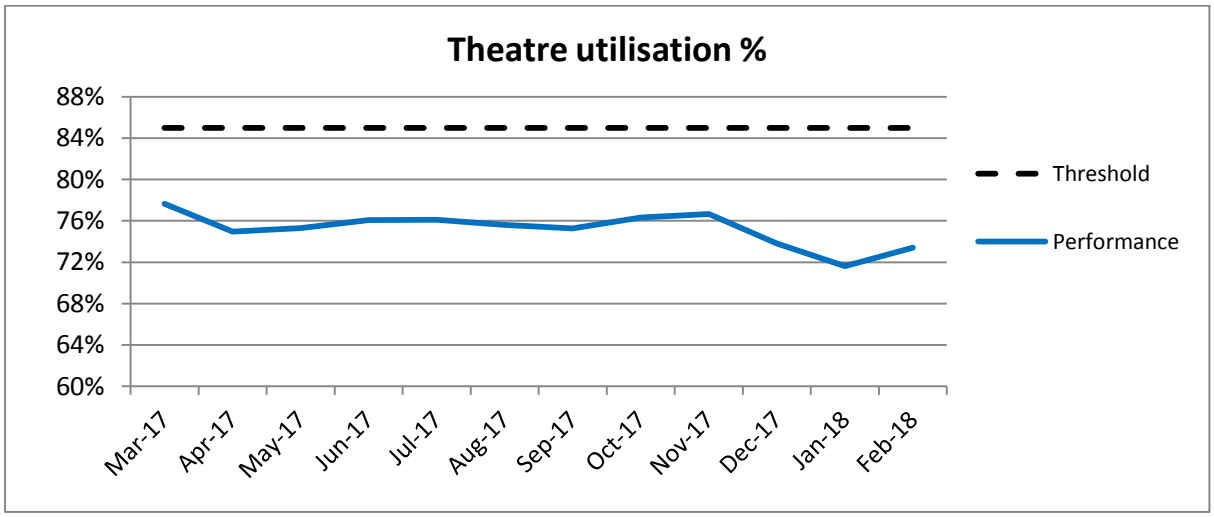


Chart 32 – Average theatre utilisation – elective lists (Trust) for the period March 2017 – February 2018

2.5.4 28-Day Rebookings

Cancelled operations performance is submitted quarterly and a full update will be provided following the quarter 4 submission.

2.5.5 Accident and Emergency

Performance against the four-hour access standard for patients attending Accident and Emergency was 82.4 per cent in February 2018 against the 90 per cent Sustainability and Transformation Fund (STF) target for the month. These figures represent a decrease from January 2018 (85.1%) and lower than February 2017 (87.8%). There were four 12-hour trolley wait breaches for the month (source: monthly A&E SitRep to NHS England).

The Trust continues to experience significant pressures and the key issues remain as follows:

- Increased demand and acuity within type 1 departments
- An increase in arrivals via ambulance and daily trauma presentations at SMH;
- Difficulties with late transfer of patients from the Vocare UCC to the Emergency Department at SMH; &
- High levels of bed occupancy (CXH 97.0% and SMH 99.3% across February).

Schemes to provide additional urgent and emergency care capacity for winter pressures have continued on track, there was a 3.5% decrease in daily average number of stranded patients in February and improvements in discharges before noon have been sustained over January and February. The Trust continues the programme of patient flow improvements which are overseen by the four-hour Performance Steering Group.

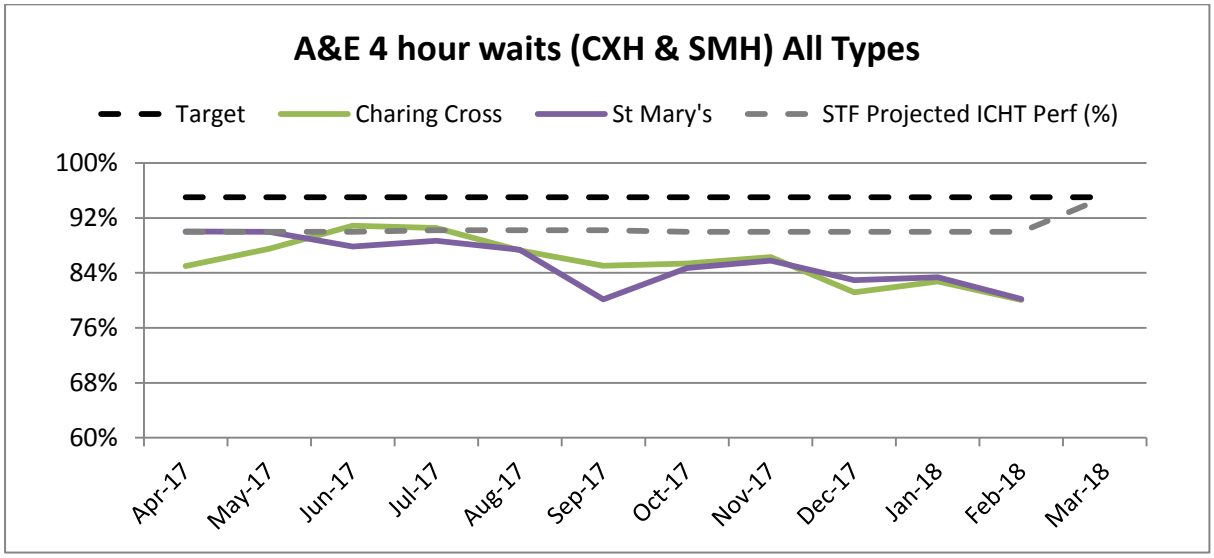


Chart 33 – A&E Maximum waiting times 4 hours (CXH and SMH) for the period April 2017 – March 2018

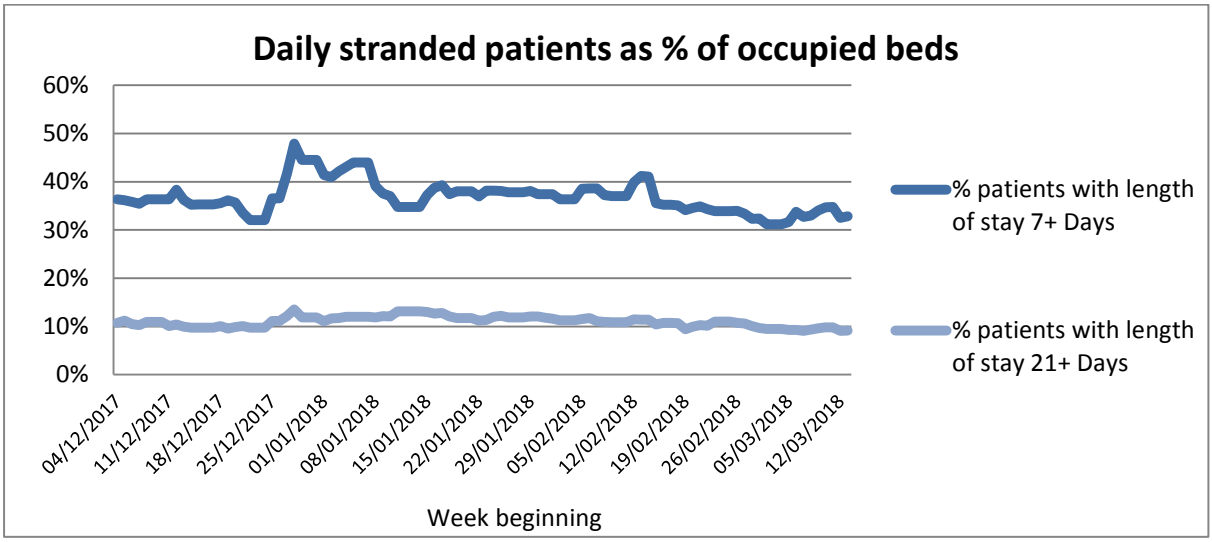


Chart 34 Daily trend in occupied beds that were occupied by patients who have been in hospital 7 days or more (stranded) and patients who have been in hospital 21 days or more (super stranded), from 4 December 2017 The chart shows 'stranded' patients (LOS 7 days or more) and 'super stranded' patients (LOS 21 days or more) (as a subset of the above) as a % of total occupied beds. The source is the daily SitRep report to NHS Improvement.

2.5.6 Effective: Discharges before noon

The Trust is supporting wards to implement the SAFER flow bundle which combines five elements of best practice to improve patient flow and prevent unnecessary waiting for patients. This includes early discharge to make beds available on the wards to admit new patients from A&E. There has been a sustained improvement over recent months; the February performance was 14 per cent of patients discharged before noon. The aim is to achieve the national standard of 33 per cent as set out in the SAFER bundle.

Regular reports on discharge by noon data by ward are being published on the source to show where good patient flow is being achieved and where improvements need to be prioritised. Several wards already have board rounds in place and more are expected to implement these as part of the roll out of SAFER. Multidisciplinary engagement is required from across the Trust to ensure SAFER board rounds are embedded as business as usual.

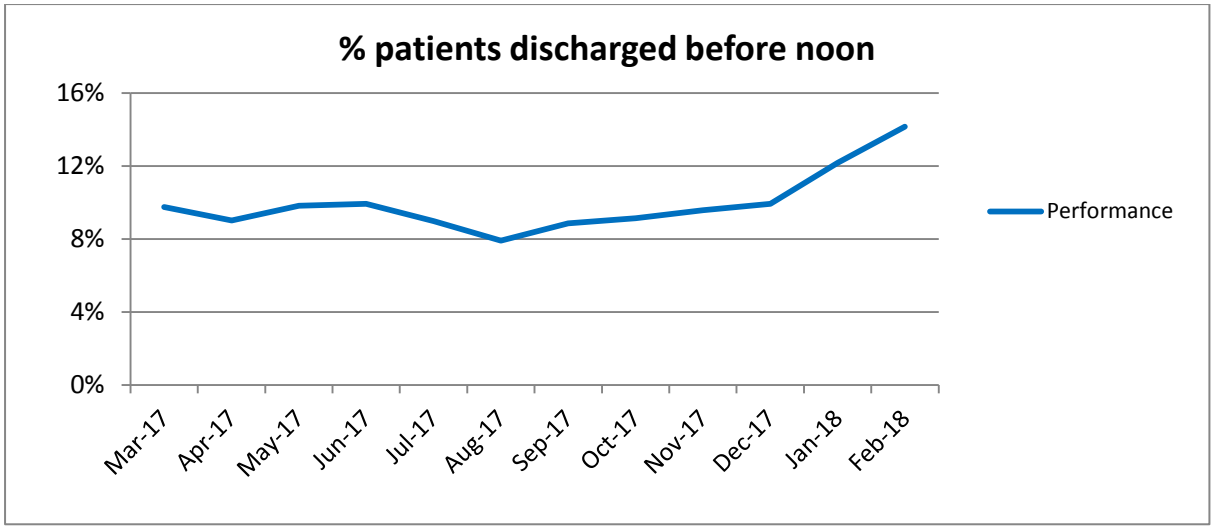


Chart 35 – Patients discharged before noon as a % of total discharges between March 2017 and February 2018

2.5.7 Diagnostic waiting times

In February 2018, the diagnostics waiting times performance was recovered to deliver 0.83 per cent of patients who had waited over six weeks for their diagnostic test, meeting the national target of less than 1 per cent.

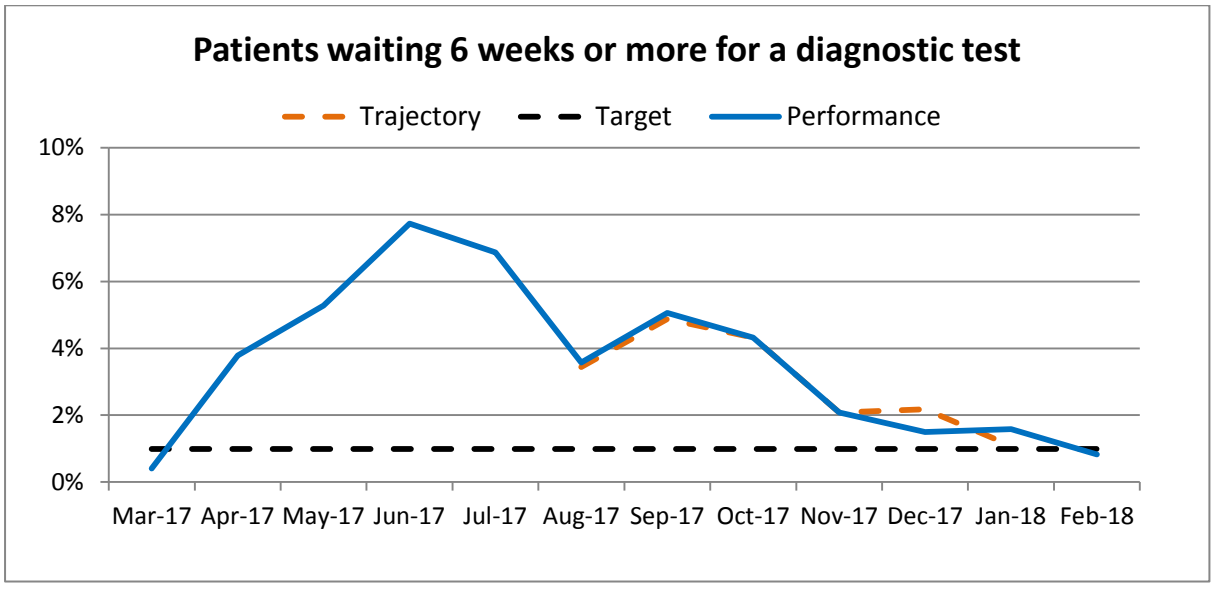


Chart 36 – Diagnostic waiting times for the period March 2017 – February 2018

2.5.8 Outpatient DNA

The overall DNA rate was 10.8 per cent in February 2018. This represented a continuation of the 10.8 per cent DNA rate in January 2018.

A sustained reduction in the DNA rate has been delivered in January and February 2018, following an update to the text reminder service to include clinics that were previously excluded.

The priority is to reduce the numbers of patients not attending their appointments to less than 11 per cent with a target of 10 per cent in 2018/19. Actions include:

- Promoting option for patients to receive appointment letters via email providing instant notification of appointments;
- Deliver a single point of access for appointment handling and queries; &
- Informing patients of the cost to the Trust of missed appointments, through patient communications

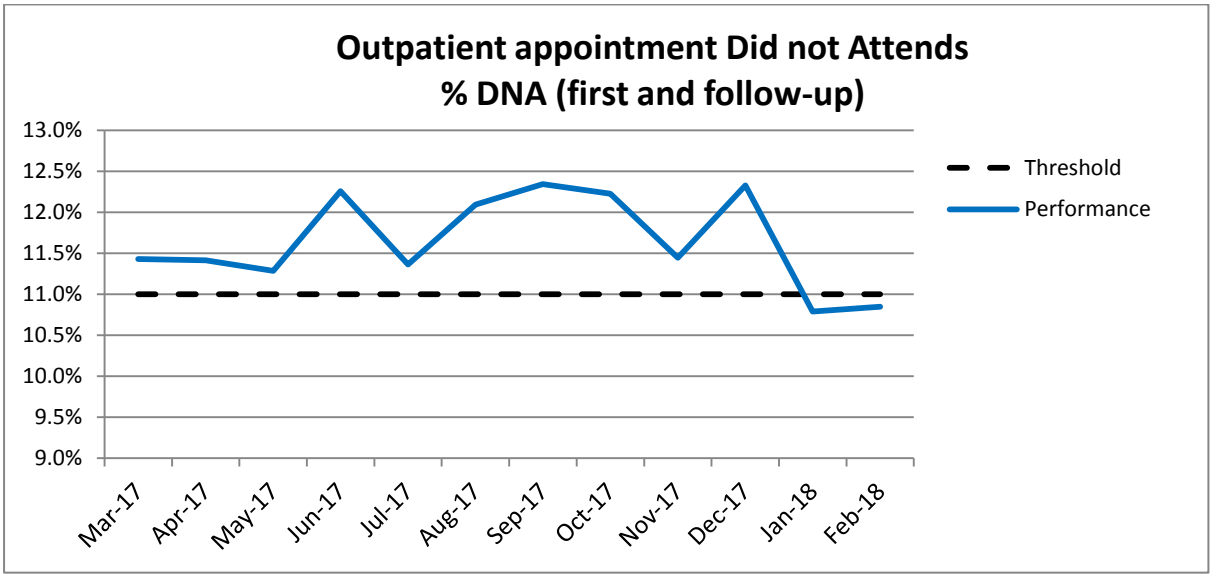


Chart 37 – Outpatient appointment Did not Attend rate (%) first and follow appointments for the period March 2017 – February 2018

2.5.9 Outpatient appointments made within 5 days of receipt

Appointments made within 5 working days are continuing to improve. With the roll-out of e-vetting the turnaround time for the vetting processes can be reduced and consequently further improvements in booking turnaround times are achievable.

Further improvements are expected when the introduction of capacity escalation is added to the e-vetting product.

Outsourcing can have a negative impact on this KPI as we do not routinely book those services that outsource until 14+ days after referral receipt date. This is to give the outsourcing team time to liaise with the outsourcing provider and patient. If a patient is not outsourced, they will return to the outpatient waiting list at 14+ days and are booked in excess of the 5 working day target.

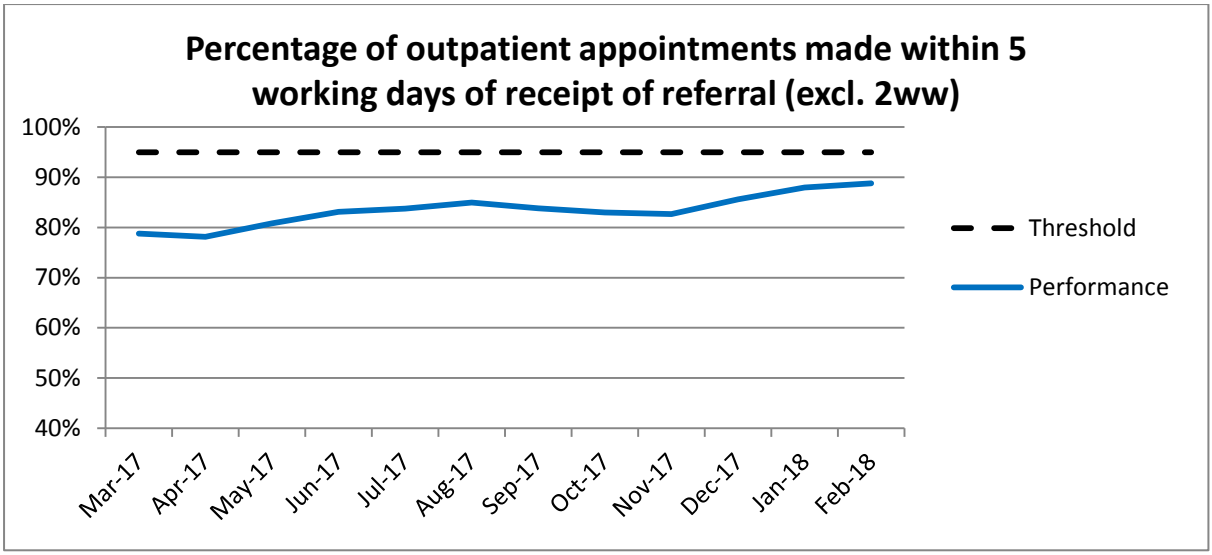


Chart 38 – % of outpatient appointments made within 5 working days of receipt of referral (excluding 2 week waits) for the period March 2017 – February 2018

2.5.10 Outpatient appointments cancelled by the Trust

The hospital initiated cancellation rate (less than 6 weeks' notice) was 8.6 per cent in February 2018. A deep dive assessment into this indicator has been to understand the main drivers and results will be reported April 2018 following further discussion.

The HICs assessment also included how long it takes for patients to be rebooked following a hospital initiated cancellation. New daily reports for staff are being drafted and trialled with operational staff to identify and confirm the management of patients whose appointments are cancelled but are still not rescheduled.

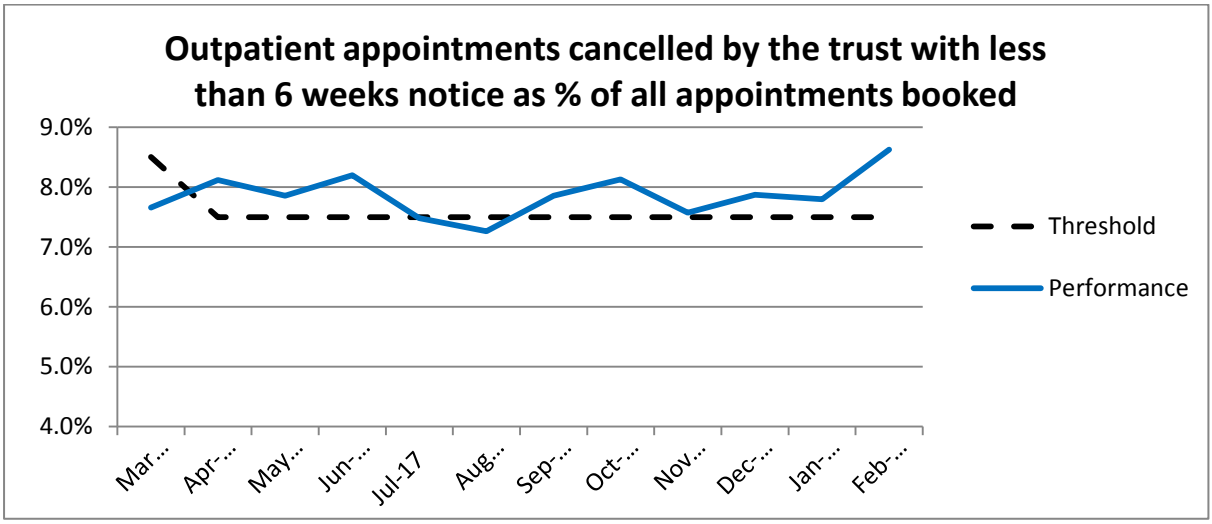


Chart 39 – Outpatient appointments cancelled by the Trust with less than 6 weeks' notice for the period March 2017 – February 2018

2.5.11 Waiting times for first outpatient appointment

A key milestone of the 18 week RTT pathway is the first outpatient appointment. This is where the patient will be assessed by a specialist and decisions on whether further

tests are needed and the likely course of treatment are made. This indicator shows the average number of weeks that patients waited before attending their first outpatient appointment following a referral for routine appointments only. The average waiting time in February 2018 was 7.9 weeks to attending first appointment from referral (it was 8.8 in the same period last year). The waiting times vary widely between clinical services, ranging from 4 – 13 weeks.

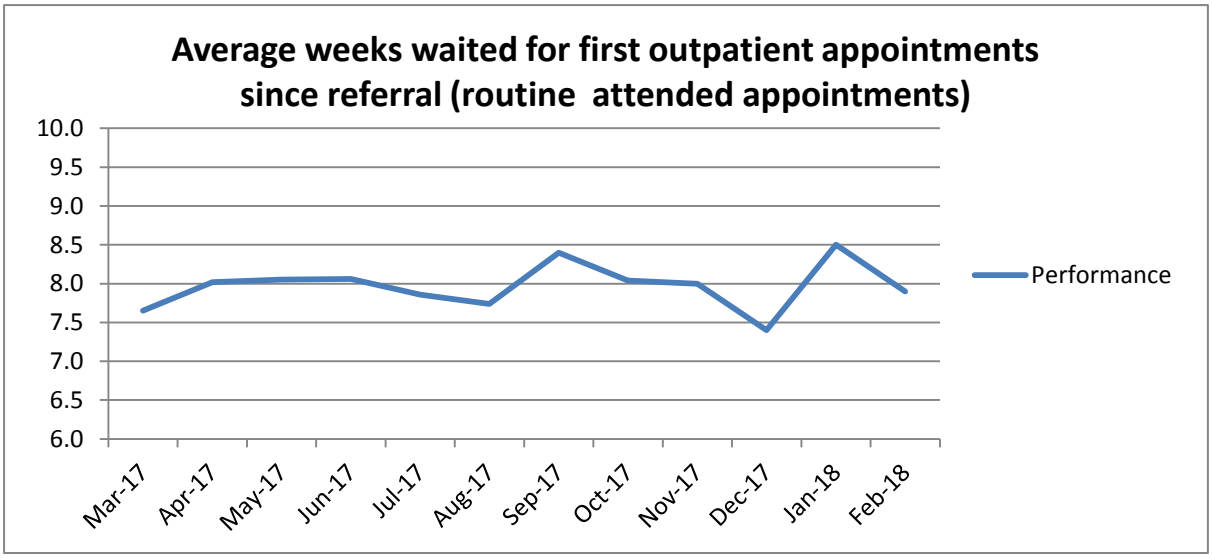


Chart 40 – Average weeks waiting time from referral to first outpatient appointment for the period January 2017 – February 2018 (routine appointments)

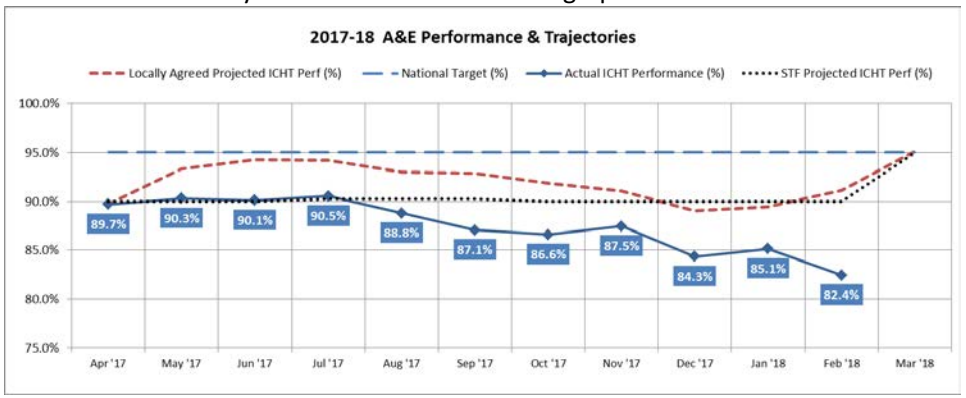
3. Finance

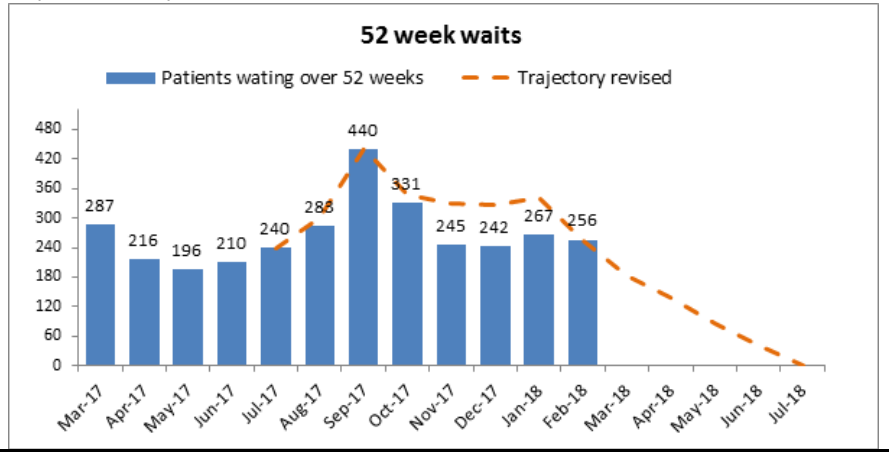
Please refer to the Monthly Finance Report to Trust Board for the Trust's finance performance.

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

At 20 March 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. An interim Director of Strategic Development will be in post shortly (with permanent recruitment to follow appointment of a permanent CEO). This post will coordinate the work, and we are going through a process to put in place the resources and structures to support delivery of the plan.
	1.2	Develop a financial recovery plan to return to surplus by the start of 2021/22	31 March 2018	In progress	By 31 march we anticipate being close to having a 'firm' 2018/19 plan with a proposal to go to FIC and the board for 2019/20.
	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	Work is on-going to produce the Trust plan for 2018/19, including agreeing income with commissioners. As part of that we are currently proposing to develop a challenging CIP programme of £43m. .

	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%	Throughout Winter 2017/18	In progress	Performance for the year to date is shown in the graph below.  Actions to improve A&E performance are managed both internally through the Improving Patient Flow Programme and for the wider health economy through the ICHT A&E Delivery Board. Specifically for winter additional schemes of work are in place to increase the acute bed base, staffing and support service resources. A refreshed structure for the Improving Patient Flow Programme has been agreed with the Trust executive and the priorities for 2018/19 are being worked up. The plan will be presented on 26 March.
	2.3	Maintain A&E performance of 95%	31 March 2018	Not started	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	A scorecard has been developed for the Improving Patient Flow Programme and is shared regularly 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, and monitored by the Trust's Waiting List Improvement Programme (WLIP). All long-waiting patients are validated and actively tracked on a weekly basis. The Elective Care Delivery Manager, reporting jointly to ICHT and to NHSI, has the remit to support the Trust in focusing on delivery of > 52 week trajectory. The Trust-level 52 week recovery trajectory was agreed and circulated in November 2017, and disaggregated to specialty level in December 2017. The Trust is currently slightly behind its trajectory, reporting 256 patients >52 weeks in February 2018 against a trajectory of 254 patients. The temporary postponement of non-urgent elective activity in January and February 2018 (to support the emergency pathways as part of the national response) led to significant numbers of cancellations which impacted the position. 
	3.2	Develop and submit an RTT recovery plan to deliver RTT incomplete performance target	To be confirmed in February 2018	Submitted; final review in April	The Trust submitted a draft RTT trajectory for 2018/19 to NHSE on 2nd March in line with national deadlines. The draft may change subject to the final outcomes of 2018/19 planning discussions.

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
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	A helpful initial report has been received by the project sponsor; before further circulation, this is being checked for factual accuracy
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

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	28 March 2018

Finance Report for February

Executive summary:

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

In February the Trust was adverse to plan by £1.7m in month and year to date before winter funding and Sustainability and Transformation Funding (STF). The Trust executive has discussed mitigating actions to improve the financial position and meet the control total of £25.2m deficit for the year.

Year to date the Trust has not met A&E performance targets and therefore is assuming that it will not receive this element of the STF funding (£5.3m to end of February).

Gross capital spend is behind plan year to date by £4.2m. Spend has increased in February and the Trust is forecasting to be within the Capital Resource Limit for the year.

There was £41.3m in the bank at the end of February. The Trust is not anticipating drawing down further working capital and expects to live within its external financing limit, and to hit is cash plan.

Financial impact:

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

Risk impact:

Risks are highlighted in the summary pages

Recommendation(s) to the Committee:

The Committee is asked to note the paper, including the risks and issues highlighted.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Michelle Openibo, Associate Director: Business Partnering Janice Stephens, Deputy CFO	Richard Alexander, CFO	21 March 2018

Finance report – 11 months ended 28th February 2018

1. Introduction

This report provides a brief summary of the Trust's financial results for the 11 months ended 28th February 2018.

2. Financial Performance

Before Sustainability and Transformation Funding (STF) and winter funding the Trust reported an in-month adverse variance to plan of £1.7m and year to date adverse of £1.7m. This is mainly due to adverse variances to plan in the clinical divisions, somewhat offset by favourable variances within central and corporate budgets. Work is being undertaken within the Trust to help bring the financial position back to the control total of a £25.2m deficit before STF by year end.

STF of £20.7m for the year is obtained on achievement of two targets. Financial performance accounts for 70% and A&E 4 hour performance accounts for 30%. The Trust is expecting to meet its financial control total so has shown the financial element of STF as achieved. However the Trust has failed to achieve the A&E target year to date and is therefore showing a £5.3m adverse variance on STF.

	In Month			Year To Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	88.85	87.24	(1.61)	990.25	996.33	6.07
Pay	(48.94)	(50.48)	(1.54)	(538.06)	(541.72)	(3.66)
Non Pay	(37.23)	(39.69)	(2.47)	(417.64)	(432.01)	(14.38)
Reserves	(2.04)	1.56	3.61	(17.03)	(10.68)	6.35
EBITDA	0.64	(1.37)	(2.01)	17.53	11.92	(5.61)
Financing Costs	(3.64)	(3.96)	(0.32)	(39.79)	(41.67)	(1.88)
SURPLUS / (DEFICIT) inc. donated asset treatment	(3.00)	(5.33)	(2.33)	(22.26)	(29.75)	(7.49)
Donated Asset treatment	(0.51)	0.09	0.60	(5.61)	(5.65)	(0.04)
Impairment of Assets	-	-	-	-	5.80	5.80
SURPLUS / (DEFICIT)	(3.51)	(5.24)	(1.73)	(27.87)	(29.60)	(1.73)
STF Income	2.83	1.98	(0.85)	17.82	12.47	(5.34)
Winter Pressures	-	-	-	-	1.25	1.25
SURPLUS / (DEFICIT) after STF and winter income	(0.68)	(3.26)	(2.58)	(10.05)	(15.87)	(5.82)

Year to date income is above plan due to NHS activity based income. Productive work has been done with commissioners to reduce unnecessary spend on high cost drugs and devices resulting in £8.7m less income than planned for pass through drugs and devices offset by reduced costs. Education and research income is above plan and this income is offset with costs to deliver the services.

Pay costs are overspent year to date, mainly where CIPs have not been delivered. There have also been additional costs incurred above plan on winter pressures and to support the waiting list improvement programme. Non pay costs are overspent in month and year to date, there have been overspends on clinical supplies and outsourcing to meet the additional activity in the Trust.

2.1. NHS Activity and Income

The summary table shows the position by division

Divisions	Year To Date Activity			Year To Date £m		
	Plan	Actual	Variance	Plan	Actual	Variance
Division of Medicine & Integ. Care	782,755	789,304	6,549	235.12	240.54	5.42
Division of Surgery, Cancer & Cardiov.	647,889	639,120	(8,770)	281.00	285.32	4.32
Division of Women, Children & Clin. Support	2,402,779	2,275,068	(127,710)	146.08	141.63	(4.45)
Central Income				125.04	118.70	(6.35)
Clinical Commissioning Income	3,833,423	3,703,492	(129,931)	787.24	786.18	(1.06)

Year to date the Trust is underperforming on NHS clinical commissioning income; however this consists of a £8.7m shortfall on pass through drugs and devices and a £7.6m over performance on other commissioning income. The largest area of over performance for the Trust is on non-elective. This is offset by underperformance on maternity, community and unbundled diagnostics.

Medicine and Integrated Care (MIC) is over performing driven by non-elective activity. There has been over performance in Stroke and Neurosciences activity and in acute care at St Mary's. There is some under performance in renal due to lower than planned dialysis sessions.

Within Surgery, Cancer and Cardiovascular (SCC) there is over performance on day cases within clinical hematology and on critical care activity. There is underperformance in cardiology due to the community activity. Within the division there have been cancellations of elective activity to help support non elective winter pressures. This has caused under performance on activity in some surgical specialties, especially in January, though this effect has reduced in February.

Women, Children and Clinical Support underperformance is mainly due to maternity. There has been a reduction in births seen across London and the service is undertaking a review based on this lower level of activity. There is also underperformance in pathology income; this activity is undertaken by North West London Pathology.

2.2. Private Patients Income

This year there has been significant growth in private patient's income. Year to date income is £3.7m higher than the same period in the previous financial year. This has been due to the introduction of the Trust's IVF service and increased activity in clinical hematology, oncology and cardiology. Despite this private income is underperforming against plan. There has been reduction in activity for the paediatric bone marrow transplant service which drives the majority of this underperformance.

2.3. Clinical Divisions

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

	In Month			Year To Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Clinical Divisions						
Income	21.79	22.84	1.04	251.45	255.92	4.47
Expenditure	(17.20)	(18.42)	(1.22)	(193.22)	(200.16)	(6.94)
Medicine and Integrated Care	4.59	4.41	(0.17)	58.23	55.76	(2.47)
Income	26.02	26.09	0.07	287.69	293.11	5.42
Expenditure	(22.13)	(23.38)	(1.25)	(245.52)	(256.34)	(10.82)
Surgery, Cancer and Cardiovascular	3.89	2.71	(1.19)	42.17	36.77	(5.40)
Income	14.93	12.40	(2.53)	167.20	155.67	(11.53)
Expenditure	(16.35)	(16.25)	0.10	(181.11)	(179.34)	1.76
Women, Children & Clinical Support	(1.41)	(3.85)	(2.43)	(13.90)	(23.68)	(9.77)
Imperial Private Healthcare	0.78	1.09	0.31	12.48	14.42	1.94
Total Clinical Division	7.85	4.37	(3.48)	98.97	83.27	(15.70)

Within MIC there has been additional income above plan with an associated cost of delivery, which has caused an expenditure overspend. Unidentified CIPs were planned to be cost reduction and therefore the failure to achieve these CIPs is also causing an adverse variance on expenditure. SCC also has a large level of over performance on income, driving overspends in expenditure. The division has also incurred additional costs due to management of the Trust's waiting list improvement programme, which has been in place longer than planned. WCCS have an adverse variance to plan year to date on income. As well as reduced NHS activity there has also underperformance on paediatric private patients and non-NHS pathology contracts. Within private patients directorate there has been income over performance with additional costs.

3. Efficiency programme

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

The year to date plan is £47.9m there has been achievement of £33.5m giving a £14.4m underperformance year to date. This underperformance is due to a combination of slippage against planned schemes and yet to be identified plans. Recent CIP performance has been negatively impacted by winter pressure work which has resulted in the unavailability of beds and the cancelation of elective activity. A number of actions and workstreams continue across the organisation, in order to further close the gap, mitigate against further slippage and strengthen the current deliverables supported by the Project Support Office

4. Cash

The Trust closed Month 11 with a cash position of £41.3m. It is currently anticipated that the Trust will not require further draw down of working capital. The closing cash balance for the year is forecast to be £26.7m. The Trust continues to develop opportunities to further improve the Trust's cash position and avoid additional borrowing.

5. Capital

In-month gross capital expenditure was £11.45m against a planned spend of £4.9m and cumulatively the gross spend is £45.1m against a planned spend of £42.3m. The overspend in month was to help the Trust meet the capital plan for the year. The Trust is forecasting to be within £0.4m of the Capital Resource Limit and the Capital Expenditure Assurance Group meets weekly to provide oversight and assurance on capital spend.

6. Conclusion

The Trust has incurred additional costs to meet the high level of over performance, mainly in non-electives but also in some elective specialties. Meeting this demand has put constrains on the ability of clinical divisions to meet cost reduction CIPs. Overall the Trust is behind plan year to date. The Executive has discussed and is implementing mitigating actions within clinical and corporate areas to meet the control total. However there remains risk to the delivery of the control total if there are additional financial risks which cannot be mitigated.

7. Recommandation

The Trust Board is asked to note the report.

Appendix

Statement of Comprehensive Income – 11 months to 28th February 2018

	In Month			Year To Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Clinical (excl private patients)	73.1	69.8	(3.3)	817.6	811.3	(6.3)
Private Patients	3.8	3.9	0.0	46.1	45.6	(0.5)
Research, Development and education	8.3	9.4	1.1	91.2	95.3	4.1
Other non-patient related income	3.6	4.2	0.6	35.4	44.1	8.7
Total Income	88.9	87.2	(1.6)	990.3	996.3	6.1
Pay - in post	(45.0)	(43.9)	1.1	(499.6)	(474.7)	24.9
Pay - Bank	(0.6)	(4.3)	(3.7)	(6.7)	(44.3)	(37.7)
Pay - Agency	(3.3)	(2.2)	1.1	(31.8)	(22.7)	9.1
Drugs and Clinical supplies	(20.7)	(21.8)	(1.1)	(228.7)	(227.1)	1.6
General Supplies	(2.8)	(2.9)	(0.1)	(31.5)	(32.9)	(1.4)
Other	(13.7)	(14.9)	(1.2)	(157.5)	(172.0)	(14.6)
Total Expenditure	(86.2)	(90.2)	(4.0)	(955.7)	(973.7)	(18.0)
Reserves	(2.0)	1.6	3.6	(17.0)	(10.7)	6.4
Earnings before Interest, Tax, Depreciation and Amortisation	0.6	(1.4)	(2.0)	17.5	11.9	(5.6)
Financing Costs	(3.6)	(4.0)	(0.3)	(39.8)	(41.7)	(1.9)
SURPLUS / (DEFICIT) including financing costs	(3.0)	(5.3)	(2.3)	(22.3)	(29.8)	(7.5)
Donated Asset treatment	(0.5)	0.1	0.6	(5.6)	(5.6)	(0.0)
SURPLUS / (DEFICIT) including donated asset treatment	(3.5)	(5.2)	(1.7)	(27.9)	(35.4)	(7.5)
Impairment of Assets	0.0	0.0	0.0	0.0	5.8	5.8
SURPLUS / (DEFICIT)	(3.5)	(5.2)	(1.7)	(27.9)	(29.6)	(1.7)
STF	2.8	2.0	(0.8)	17.8	12.5	(5.3)
Winter Funding	0.0	0.0	0.0	0.0	1.3	1.3
SURPLUS / (DEFICIT) after STF and winter income	(0.7)	(3.3)	(2.6)	(10.1)	(15.9)	(5.8)

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	28 March 2018

Progress report on development of the 2017/18 Quality Account & the new Quality Strategy

Executive summary:

The purpose of this paper is to update the Trust Board on progress with the development of the new quality strategy and describe the approach for the 2017/2018 quality account. It also outlines the proposed targets to be taken forward for the 2018/19 quality account.

Quality accounts are annual reports to the public from NHS healthcare providers about the quality of services they deliver. Their primary purpose is to encourage boards and leaders of healthcare organisations to demonstrate their commitment to continuous, evidence-based quality improvement, to assess quality across all of the healthcare services they offer and to explain their progress to the public.

As well as reporting on mandatory measures, the Trust's quality account has reported on progress with our quality strategy since its launch in 2015. This year's document will outline progress with the third and final year of our current 2015-2018 quality strategy.

Each year the quality account also sets out the priority programmes and targets for delivery during the following year. The Trust's new quality strategy is currently under development and will outline our direction and plan for how we get to a CQC rating of 'good', and on the road to 'outstanding'. The 2017/18 CQC report has just been published following the well-led inspection in December 2017 which will help to inform priorities in the quality strategy. The Trust's vision and objectives are also currently under review and development of the quality strategy will complement and be complemented by this work. The strategy will be launched as close as possible to the publication of the quality account in June.

For the aforementioned reasons, the quality strategy will not be finalised in time to be included in full in the quality account. However, we will instead describe its development including our improvement plans. The quality account will therefore describe the targets and work that we are either doing now or will do in the coming year and the metrics will be those that are included in the 2018/19 integrated scorecard. The improvement priorities and plans identified in the new quality strategy can then be fully integrated into the quality account.

There are a number of areas where we are not meeting our targets and goals, some of which we have not met since they were introduced into the quality account. It is important for these areas that we agree achievable and time bound improvement plans and commit to improving in these areas – for example, departmental safety co-ordinators. This will allow us to transition these into business as usual during 2018/19.

In light of the evidence scan for the new quality strategy it is also proposed that the trust goals for each of the five domains are changed to become the CQC definitions for 'safe', 'effective', 'caring', 'responsive' and 'well-led' rather than having Trust goals that are distinct from the CQC descriptions. We will do this in the quality account.

A period of consultation with the executive directors commenced on 16th January 2018 to define the quality account targets and programmes for 2017/18. The outputs of this process are included in **appendix A**. This year we have done this in conjunction with the performance team as part of their annual review of the integrated performance report indicators. The proposal is that we move to an integrated performance scorecard and report rather than the current scorecard and quality report going forward.

Quality impact:

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

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

Financial impact:

This paper has no financial impact.

Risk impact:

There are numerous risks associated with delivery of the quality strategy goals, programmes and targets, which are described in the trust's corporate risk register. The annual quality account provides assurance to internal and external stakeholders that plans to improve quality in the Trust are robust.

Recommendation(s) to the Board:

The committee is asked to:

- Note progress with the development of the 2017/18 Quality Account and the new Quality Strategy
- Review the proposed targets to be taken forward for the 2018/19 Quality Account in **appendix A**.

Trust strategic objectives supported by this paper:

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

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

As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care.

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

Author	Responsible executive director	Date submitted
Eleanor Carter, Compliance and Assurance Improvement Lead Ralph Critchley, Programme Manager – Quality Improvement	Dr William Oldfield, Interim Medical Director	16 March 2018

Progress report on development of the 2017/18 Quality Account & the new Quality Strategy

PURPOSE OF THE REPORT

The purpose of this paper is to update the Trust Board on progress with the development of the new quality strategy and describe the approach for the 2017/2018 quality account. It also outlines the proposed targets to be taken forward for the 2018/19 quality account in **appendix A**. The priority improvement programmes which will support delivery of the Safe and Effective aims and targets in 2018/19 are included as examples. Priority improvement programmes for all other domains are to be confirmed.

INTRODUCTION

Quality accounts are annual reports to the public from NHS healthcare providers about the quality of services they deliver. Their primary purpose is to encourage boards and leaders of healthcare organisations to demonstrate their commitment to continuous, evidence-based quality improvement, to assess quality across all of the healthcare services they offer and to explain their progress to the public.

As well as reporting on mandatory measures, the Trust's quality account has reported on progress with our quality strategy since its launch in 2015. This year's document will outline progress with the third and final year of our current 2015-2018 quality strategy.

Each year the quality account also sets out the priority programmes and targets for delivery during the following year. The final CQC reports will not be published until the end of February and it is important that we fully consider the reports with our people and our commissioners as part of the development of the strategy. Therefore the quality strategy will not be finalised in time to be included in full in the quality account (draft due to board in April). However, we will instead describe its development including our improvement plans. The quality account will therefore describe the targets and work that we are either doing now or will do in the coming year and the metrics will be those that are included in the 2018/19 integrated scorecard. The improvement priorities and plans identified in the new quality strategy can then be fully integrated into the quality account.

There are a number of areas where we are not meeting our targets and goals, some of which we have not met since they were introduced into the quality account. It is important for these areas that we agree achievable and time bound improvement plans and commit to improving in these areas – for example, departmental safety co-ordinators. This will allow us to transition these into business as usual during 2018/19.

A period of consultation with the executive directors commenced on 16th January 2018 to define the quality account targets and programmes for 2017/18. This year we have done this in conjunction with the performance team as part of their annual review of the integrated performance report indicators. The outputs of this process are included in the paper for review. The proposal is that we move to an integrated performance scorecard and report rather than the current scorecard and quality report going forward.

2018-2023 QUALITY STRATEGY

The Trust's new quality strategy is currently under development and will outline our direction and plan for how we get to a CQC rating of 'good', and on the road to 'outstanding'. The 2017/18 CQC report was recently published following the well-led inspection in December 2017 which will help to inform priorities in the quality strategy. The Trust's vision and objectives are also currently under review and development of the quality strategy will complement and be complemented by this work. The strategy will be launched as close as

possible to the publication of the quality account in June.

The quality improvement programme had not been launched when the 2015-2018 strategy was written. The new strategy will allow us to clearly articulate how our improvement methodology is at the heart of our approach to quality and how we plan to further strengthen and develop this going forward. It is also an opportunity for us as an organisation to explore the improvement journey that we want to set for the coming five years i.e. how we will deliver our aims for quality using our agreed methodology rather than the current list of projects and targets.

We have been undertaking an evidence scan of quality strategies and frameworks in organisations rated 'outstanding' or 'good' by the CQC to inform development of the new strategy, including Salford Royal, Northumbria Healthcare, East London, Sheffield Teaching Hospitals and NHS Scotland. Some of the key learning points are detailed below and have been incorporated into the design of our own quality strategy:

- The strategy will need to reflect and incorporate a broad range of perspectives; engaging with staff, patients and community groups in understanding what quality means to them and their priorities for improving quality;
- The strategy needs to outline a transparent, consistent and logical approach to agreeing improvement priorities on an annual basis;
- There needs to be a clear distinction between the purpose of the quality strategy and quality accounts;
- There needs to be an agreed organisational definition of quality; most good strategies use the CQC domains, but also include a local perspective (patients and staff);
- The strategy needs to outline the organisation's approach to quality management; describing the structure, processes and mechanisms for quality assurance, quality control and quality improvement.

In December 2017, we commenced a listening campaign in partnership with Citizens UK to understand different ideas and perspectives from our staff, patients and communities. A thematic analysis from this will be used in the strategy. In addition we are:

- Undertaking a review of current reporting arrangements to identify and prioritise changes to improve analysis and reporting of quality indicators.
- Reviewing intelligence sources to understand strengths, weaknesses, opportunities and threats to identify changes and priorities for improving quality.
- Running co-design workshops involving executive leads to develop strategic and annual operational plans for each CQC domain of quality. These will take place in March and April 2018.

A quality strategy design group was held on the 14 February 2018 with representatives from across the Trust as well as representatives from our Lay Partners Forum, CCGs, Healthwatch and Citizens UK to share initial and early findings from the listening campaign as well as discuss progress with the strategy.

2017/18 QUALITY ACCOUNT: STRUCTURE

The quality account will be developed using the Department of Health Quality Account Toolkit and will comply with the mandatory requirements, in the following structure:

- Part 1: Statement from the Chief Executive and About Our Trust.
- Part 2: Our quality improvement plan and priorities for 2018/19
  - Safe targets and programmes for 2018/19
  - Effective targets and programmes for 2018/19
  - Caring targets and programmes for 2018/19

- Responsive targets and programmes for 2018/19
- Well-led targets and programmes for 2018/19

- Part 3: Statements of assurance from the Trust Board
- Part 4: Review of our quality progress 2017/18
  - Safe performance 2017/18
    - Safe – quality highlights
    - Safe – quality challenges
  - Effective performance 2017/18
    - Effective – quality highlights
    - Effective – quality challenges
  - Caring performance 2017/18
    - Caring – quality highlights
    - Caring – quality challenges
  - Responsive performance 2017/18
    - Responsive – quality highlights
    - Responsive – quality challenges
  - Well-led performance 2017/18
    - Well-led – quality highlights
    - Well-led – quality challenges
- Part 4a: Performance against 2017/18 Acute Quality Schedule metrics
- Part 4b: Performance against NHS Outcomes Framework indicators 2017/18
- Part 5: Statements from Stakeholders and independent auditor's assurance report
- Part 6: Glossary

2017/18 QUALITY ACCOUNT: CONTENTS

Part 1: Statement from the chief executive and 'about our trust'
The statement will summarise our quality performance over the last year, and provide an introduction to the quality account.

The 'about our trust' section will outline some background to the organisation, the governance framework, our vision and objectives as well as some of the key strategies that are driving improvement in all areas across the organisation.

Part 2: Our plans for the future and priorities for 2018/19

This section will outline our priority areas for quality improvement in 2018/19 under each of the five quality domains.

Given that the Trust is in the process of transitioning to a new quality strategy and developing operational plans to deliver that strategy, the quality account will describe the targets and work that we are either doing now or will do in the coming year. The improvement priorities and plans identified in the new quality strategy can then be fully integrated into the quality account.

There are a number of areas that we are not meeting and have not met since they were introduced into the quality account. It is important for these areas that we agree achievable and time bound improvement plans and commit to improving in these areas – for example, departmental safety co-ordinators.

In light of the evidence scan for the new quality strategy it is also proposed that the Trust goals for each of the five domains are changed to become the CQC definitions for 'safe', 'effective', 'caring', 'responsive' and 'well-led' rather than having Trust goals that are distinct from the CQC descriptions. We will do this in the quality account.

A period of consultation with the executive directors commenced on 16th January 2018 to define the quality account targets and programmes for 2017/18. The outputs of this process are included in **appendix A**. The priority improvement programmes which will support delivery of the Safe and Effective aims and targets in 2018/19 are included as examples. Priority improvement programmes for all other domains are to be confirmed.

Part 3: Statements of assurance from the Trust Board
In this section of the quality account, we are required to present mandatory statements relating to the quality of our services. This information is common to all quality accounts and can be used to compare our performance with that of other organisations. It includes items such as participation in clinical research, CQUIN performance and information governance toolkit compliance.

Part 4: Review of our quality progress 2017/18
This section will be divided into the five quality domains and a summary of performance against the goal, targets and programmes for each domain provided. We will divide each of the five quality domains into two parts: one of which summarises the 'quality highlights' for the year, the other which describes the 'quality challenges' (i.e. areas where we have not achieved our targets).

This section will be drafted using papers, proposals and reports presented throughout the year to board and committee meetings. If required, additional information will be sought directly from the teams responsible.

This section also incorporates the performance against key metrics in the commissioner's Quality Schedule and the NHS outcomes framework indicators 2017/18. These are a core set of indicators mandated by NHS England which we must report against in the quality account in a standardised table format.

Part 5: Statements from stakeholders
As part of the process, the Trust is required to seek engagement from internal and external stakeholders.

In addition, we are required to offer our commissioners, Healthwatch and the local Overview & Scrutiny Committees the opportunity to comment on the draft report. The draft will be circulated to these external stakeholders in April and comments collated. Where appropriate, any additions or changes requested as part of this process will be included in the document.

Our external stakeholders are also invited to provide a formal statement ahead of publication. These will be sought in May 2016 and will be inserted in the document prior to publication.

The quality account will be subjected to both internal and external auditing, with the external auditors' statement also included in the published document.

Appendix A: Draft Section – Our quality improvement plans for 2018/19

Quality Domain 1: Safe

Aim/CQC Definition: People are protected from abuse and avoidable harm

The priority improvement programmes which will support delivery of the Safe aim and targets in 2018/19 are as follows:

- Safety culture programme including the incident and SI improvement projects;
- 8 safety streams - Recognition of the deteriorating patient (including sepsis)
  Optimising Hand hygiene & campaign
  Safer Medicines & management
  Safe mobility and prevention of falls with harm
  Fetal monitoring
  Safer surgery
  Abnormal results
  Positive patient confirmation
- Nurse and midwifery supply strategy;
- Statutory & mandatory training improvement & compliance programme;
- Medical device management workstream.

Target	**Changes made to this target for 2018/19**
To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing severe/major harm	No
To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing extreme harm/death	No
We will maintain our incident reporting numbers and be within the top quartile of trusts	No
We will have zero never events	No
We will have a general vacancy rate of 10% or less	No
We will have a vacancy rate for all nursing and midwifery staff of 12% or less	No
We will promote safer surgery by ensuring 100% compliance with all elements of the WHO checklist in all relevant areas	This indicator will no longer be reported monthly but quarterly through the safer surgery safety stream.
We will have no serious incidents where failure to follow the WHO checklist properly is a factor	This indicator will no longer be reported monthly but quarterly through the safer surgery safety stream.
We will ensure we have no avoidable MRSA BSIs and cases of *C. difficile* attributed to lapse in care	**Target under review** This target will be expanded to include PHE mandatory reporting of EColi & MSSA BSI.CPE metric will also be added – TBC.

We will maintain 90% for anti-infectives prescribed in line with our antibiotic policy or approved by specialists from within our infection teams	This indicator will no longer be reported monthly but bi-annually through our IPC report.
We will reduce avoidable category 3 and 4 trust-acquired pressure ulcers by at least 10%	This target has been removed for 18/19 as we have made sustained improvements.
We will assess at least 95% of all patients for the risk of VTE, and reduce the number of avoidable cases from x to x (can only be added at year end)	Target reworded. We will use CRAB outcome data going forward which should be more specific.
We will maintain the percentage of shifts meeting planned safe staffing levels at 90% for registered nurses and 85% for care staff	No
We will ensure 100% compliance with duty of candour requirements for every appropriate incident graded moderate and above	Target rephrased from 'we will ensure that we comply with duty of candour' to 'we will ensure 100% compliance with duty of candour'. The word 'appropriate' has also been added as there are cases where it is not including estate incidents.
We will roll out the cerner sepsis alert to all areas and set an improvement trajectory to achieve 100% of our patients receiving antibiotics within 1 hour of the sepsis alert being triggered.	New targets in development.
Medicines management	**Proposed new target** New target being considered – this is a safety stream and will report on the overall programme accordingly however it may be appropriate to add a metric re errors for example.
Medical devices	**Proposed new target** Estates and Facilities are discussing priority indicators for this & wider issues.
We will achieve compliance of 90% with core skills training	**Target under review** This target description remains under review by the Senior P&OD team.

We are proposing a number of changes to our Safe targets and metrics in the scorecard for 2018/19.

We have removed our target to reduce avoidable category 3 and 4 trust-acquired pressure ulcers as we have consistently met our target level of reduction for the last three years. We have also removed two metrics which relate to the WHO checklist which will continue to be monitored as part of the safer surgery safety stream.

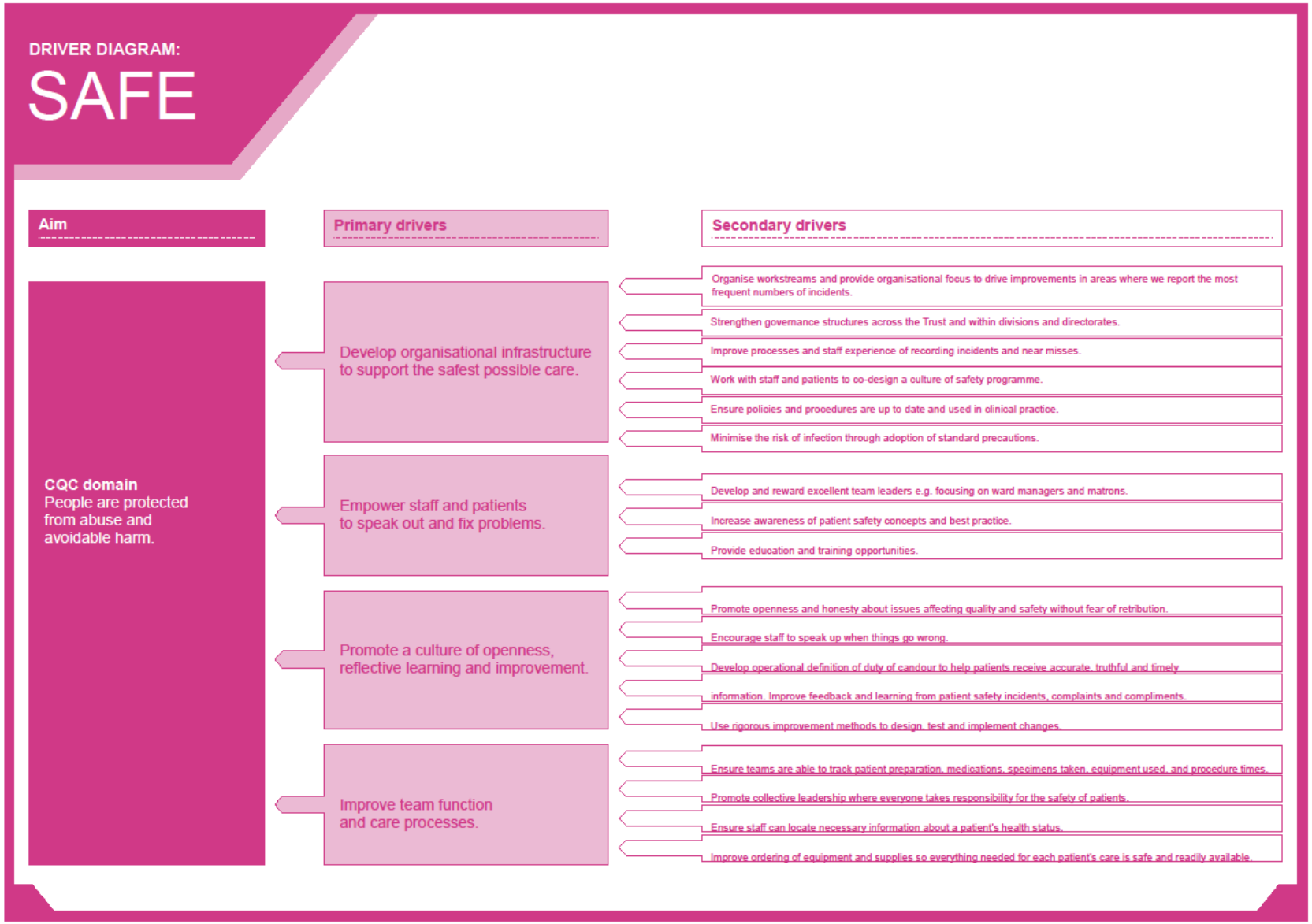
The final metric we have removed is to maintain 90% for anti-infectives prescribed in line with our antibiotic policy or approved by specialist from within our infection teams. Whilst we will continue to monitor this, it is a bi-annual audit which we will instead report when the data is available through our IPC reporting structure.

One target previously under the Well led domain is now included in the Safe domain for 2018/19. This is in line with the CQC key lines of enquiry and it is the target relating to core skills training compliance.

We have included three new targets for 2018/19 relating to sepsis, medicines management and medical devices.

The targets relating to infection control and medicines management are still under review by the Medical Director's Office, and the target relating to medical devices is still under review by the Estates and Facilities department in the Nurse Director's Office. The target relating to compliance with core skills training remains under review by the senior P&OD team.

The driver diagram developed last year for the 2017/18 quality account will be used again this year. New versions of the driver diagrams will be developed as part of the 2018-2023 quality strategy.


DRIVER DIAGRAM:
SAFE
Aim
Primary drivers
Secondary drivers
CQC domain
People are protected from abuse and avoidable harm.
Develop organisational infrastructure to support the safest possible care.
Organise workstreams and provide organisational focus to drive improvements in areas where we report the most frequent numbers of incidents.
Strengthen governance structures across the Trust and within divisions and directorates.
Improve processes and staff experience of recording incidents and near misses.
Work with staff and patients to co-design a culture of safety programme.
Ensure policies and procedures are up to date and used in clinical practice.
Minimise the risk of infection through adoption of standard precautions.
Empower staff and patients to speak out and fix problems.
Develop and reward excellent team leaders e.g. focusing on ward managers and matrons.
Increase awareness of patient safety concepts and best practice.
Provide education and training opportunities.
Promote a culture of openness, reflective learning and improvement.
Promote openness and honesty about issues affecting quality and safety without fear of retribution.
Encourage staff to speak up when things go wrong.
Develop operational definition of duty of candour to help patients receive accurate, truthful and timely
information. Improve feedback and learning from patient safety incidents, complaints and compliments.
Use rigorous improvement methods to design, test and implement changes.
Improve team function and care processes.
Ensure teams are able to track patient preparation, medications, specimens taken, equipment used, and procedure times.
Promote collective leadership where everyone takes responsibility for the safety of patients.
Ensure staff can locate necessary information about a patient's health status.
Improve ordering of equipment and supplies so everything needed for each patient's care is safe and readily available.

Quality domain 2: Effective

Aim/CQC Definition: People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

The priority improvement programmes which will support delivery of the Effective aim and targets in 2018/19 are as follows:

- National audit programme;
- Trust priority audit programme;
- Local and NICE guidance;
- Mortality structured judgement review themes and learning;
- Getting it right first time

Target	**Changes made to this target for 2018/19**
To show continuous improvement in national clinical audits with no negative outcomes	**Target under review** Trust reporting of outcomes is not consistent, is delayed and often is only available for the quality account rather than during the business cycle. New information on this is included in the CQC insight report but it is not currently included in our indicators. However, there are many outcomes in every national audit so consideration to the most appropriate reporting is underway including a scan of how other trusts manage this.
We will improve our mortality rates as measured by SHMI (summary hospital-level mortality indicator) to remain in the top five lowest-risk acute trusts	No
We will improve our mortality rates as measured by HSMR (hospital standardised mortality ratio) to remain in the top five lowest-risk acute trusts	No
We will ensure that palliative care is accurately coded	No
We will ensure mortality reviews are carried out in all cases and report specified information on deaths in line with national requirements, including those that are assessed as more likely than not to be due to problems in care, and	**Target under review** Target to be refocussed on reducing the number

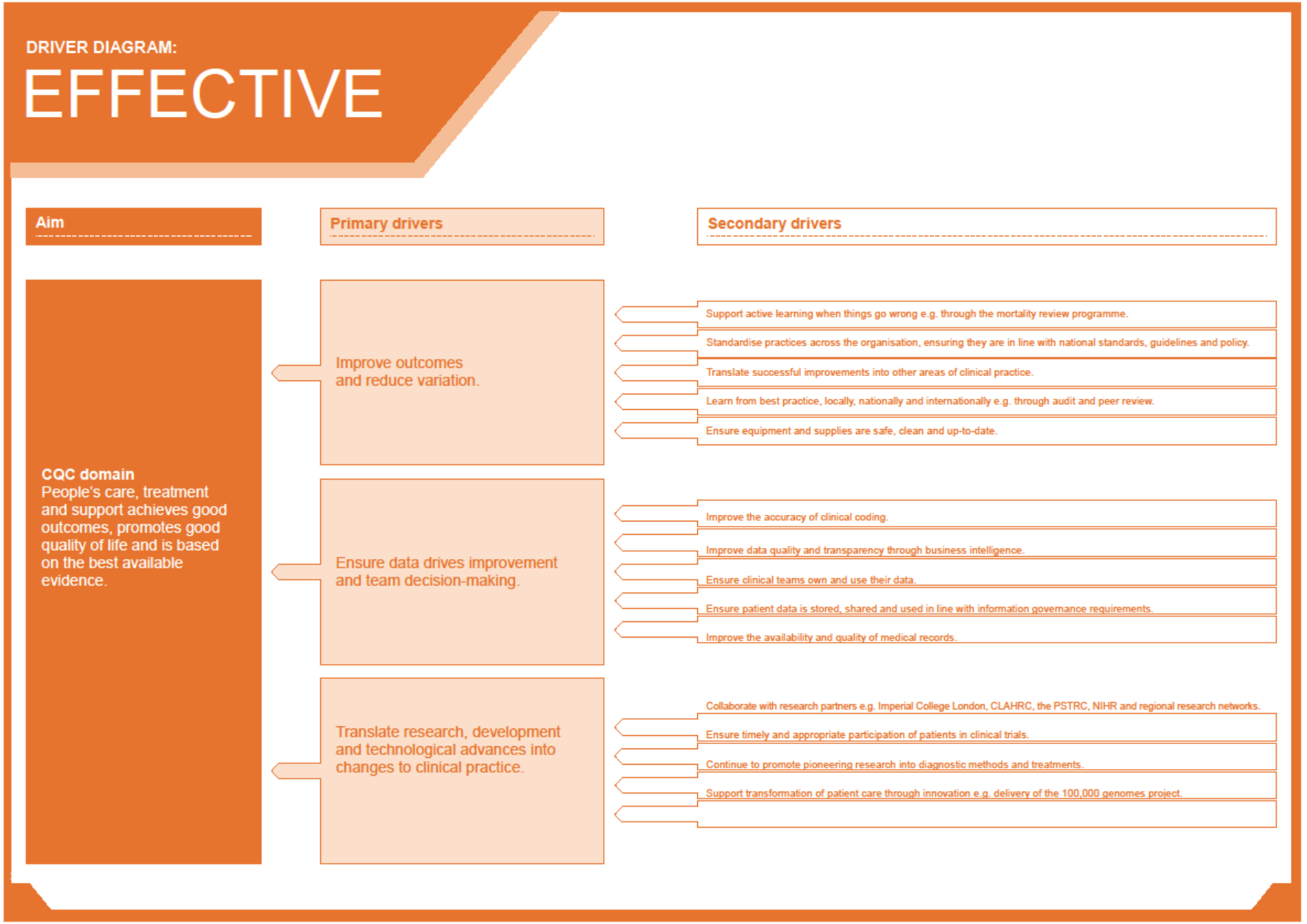
ensure learning and action as a consequence.	of confirmed avoidable deaths identified through the SJR process.
We will increase PROMs participation rates to 80%	No changes have been made to this target for 18/19 although it will no longer apply to varicose veins surgery or groin hernia surgery as this mandatory PROMs collection has been discontinued by NHSE
We will improve PROMs reported health gain to be better than national average	No changes have been made to this target for 18/19 although it will no longer apply to varicose veins surgery or groin hernia surgery as this mandatory PROMs collection has been discontinued by NHSE
We will review all out-of-ICU/ED and coronary care unit cardiac arrests for harm and deliver improvements as a result	This target has been removed as a monthly indicator for 18/19 but will continue to be monitored through our normal incident reporting process and as part of our deteriorating patients safety stream.
We will ensure that 90% of clinical trials recruit their first patient within 70 days	No
We will reduce the unplanned readmission rates for patients aged 0-15 and be below the national average	No
We will reduce the unplanned readmission rates for patients aged over 16 and be below the national average	No

We are proposing to remove one target from 2017/18 relating to the review of out-of-ICU/ED and coronary care unit cardiac arrests. This metric would continue to be monitored through our normal incident reporting process and as part of our deteriorating patients safety stream.

Two metrics previously listed under the Responsive domain are now included in the Effective domain for 2018/19. This is in line with the CQC key lines of enquiry and relates to readmission rates.

The targets relating to the outcomes of national clinical audit and mortality reviews remain under review by the Medical Director's Office.

The driver diagram developed last year for the 2017/18 quality account will be used again this year. New versions of the driver diagrams will be developed as part of the 2018-2023 quality strategy.


DRIVER DIAGRAM:
EFFECTIVE
Aim
Primary drivers
Secondary drivers
CQC domain
People's care, treatment and support achieves good outcomes, promotes good quality of life and is based on the best available evidence.
Improve outcomes and reduce variation.
Support active learning when things go wrong e.g. through the mortality review programme.
Standardise practices across the organisation, ensuring they are in line with national standards, guidelines and policy.
Translate successful improvements into other areas of clinical practice.
Learn from best practice, locally, nationally and internationally e.g. through audit and peer review.
Ensure equipment and supplies are safe, clean and up-to-date.
Ensure data drives improvement and team decision-making.
Improve the accuracy of clinical coding.
Improve data quality and transparency through business intelligence.
Ensure clinical teams own and use their data.
Ensure patient data is stored, shared and used in line with information governance requirements.
Improve the availability and quality of medical records.
Translate research, development and technological advances into changes to clinical practice.
Collaborate with research partners e.g. Imperial College London, CLAHRC, the PSTRC, NIHR and regional research networks.
Ensure timely and appropriate participation of patients in clinical trials.
Continue to promote pioneering research into diagnostic methods and treatments.
Support transformation of patient care through innovation e.g. delivery of the 100,000 genomes project.

Quality domain 3: Caring

Aim/CQC Definition: The service involves and treats people with compassion, kindness, dignity and respect.

The priority improvement programmes which will support delivery of the Caring aim and targets in 2018/19 are being confirmed.

Target	Changes made to this target for 2018/19
To maintain the percentage of inpatients who would recommend our trust to friends and family to 94%	No
To maintain the percentage of A&E patients who would recommend our trust to friends and family to 94%	No
To increase the percentage of outpatients who would recommend our trust to friends and family to 94%	No
We will achieve and maintain a FFT response rate of 30% in inpatient departments	This target will no longer be reported on monthly as response rates have remained stable for the last three years. They will continue to be monitored and exceptions reported through our internal governance structures.
We will achieve and maintain a FFT response rate of 20% in A&E	This target will no longer be reported on monthly as response rates have remained stable for the last three years. They will continue to be monitored and exceptions reported through our internal governance structures..
We will achieve and maintain a FFT response rate of 6% in outpatients	This target will no longer be reported on monthly as response rates have remained stable for the last three years. They will continue to be monitored and exceptions reported through our internal governance structures.
We will improve our national cancer survey scores year-on-year	This indicator will no longer be reported monthly but as it is an annual survey. Results will be shared when they are published each year.
We will improve our score in the national inpatient survey relating to responsiveness to patients' needs	This indicator will no longer be reported

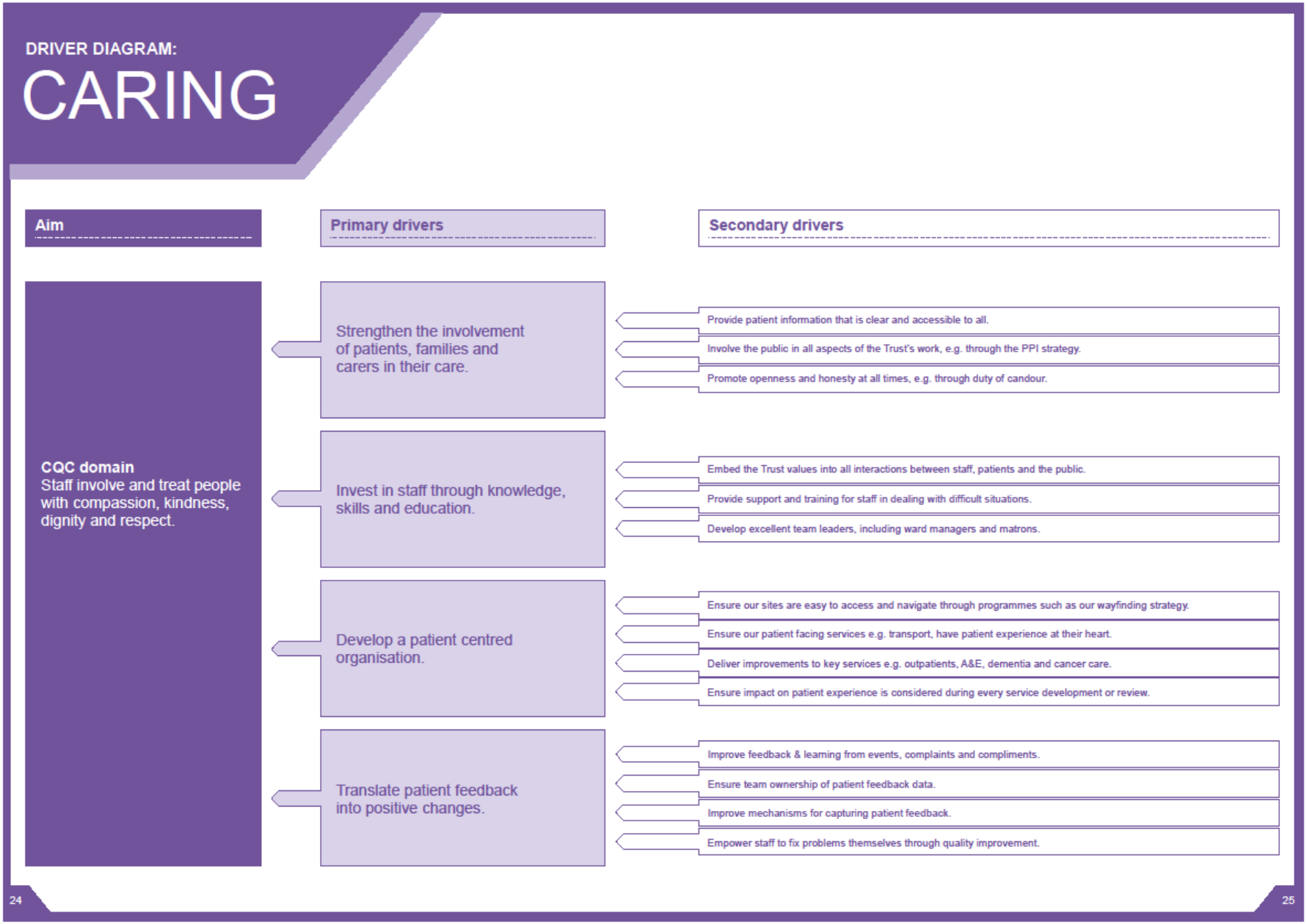
	monthly but as it is an annual survey. Results will be shared when they are published each year.

We are proposing a number of changes to our Caring targets and metrics in the scorecard for 2018/19.

We have removed the two metrics relating to national surveys. This is because they are annual surveys and whilst we will continue to review and learn from our results, this will be shared when the results are published each year.

We have also removed the three response rate metrics for the FFT in our inpatient, A&E and outpatients departments. This is because they have remained stable for the last three years and it has now become business as usual for the Trust and whilst the response rates will not be included in our quality account targets, they will continue to be monitored and exceptions reported through our internal governance structures.

The driver diagram developed last year for the 2017/18 quality account will be used again this year. New versions of the driver diagrams will be developed as part of the 2018-2023 quality strategy.


DRIVER DIAGRAM:
CARING
Aim
Primary drivers
Secondary drivers
CQC domain
Staff involve and treat people with compassion, kindness, dignity and respect.
Strengthen the involvement of patients, families and carers in their care.
Provide patient information that is clear and accessible to all.
Involve the public in all aspects of the Trust's work, e.g. through the PPI strategy.
Promote openness and honesty at all times, e.g. through duty of candour.
Invest in staff through knowledge, skills and education.
Embed the Trust values into all interactions between staff, patients and the public.
Provide support and training for staff in dealing with difficult situations.
Develop excellent team leaders, including ward managers and matrons.
Develop a patient centred organisation.
Ensure our sites are easy to access and navigate through programmes such as our wayfinding strategy.
Ensure our patient facing services e.g. transport, have patient experience at their heart.
Deliver improvements to key services e.g. outpatients, A&E, dementia and cancer care.
Ensure impact on patient experience is considered during every service development or review.
Translate patient feedback into positive changes.
Improve feedback & learning from events, complaints and compliments.
Ensure team ownership of patient feedback data.
Improve mechanisms for capturing patient feedback.
Empower staff to fix problems themselves through quality improvement.
24
25

Quality domain 4: Responsive

Aim/CQC Definition: Services meet people's needs

The priority improvement programmes which will support delivery of the Responsive aim and targets in 2018/19 are being confirmed.

Target	**Changes made to this target for 2018/19**
We will have no patients waiting over 52 weeks for their treatment since referral from their GP and implement our agreed clinical validation process.	Yes - target rephrased and the aim to 'reduce the number of patients waiting over 40 weeks' removed.
We will reduce the proportion of outpatient clinics cancelled by the trust with less than 6 weeks' notice to 7.5% or lower	**Target under review** WCCS are currently reviewing the indicator definition. The quality account target will be aligned with any newly defined metric (and target) for the integrated performance scorecard when agreed. Expected to be completed by end March 2018.
We will reduce the proportion of patients who do not attend outpatient appointments to 10%	No
We will ensure 95% of outpatient appointments are made within 5 working days of receipt of referral	No
We will improve our PLACE scores year-on-year; aiming to maintain our score above national average for cleanliness; meet the national average for food; be above the bottom 20% for condition, appearance and maintenance and for privacy and dignity; and improve our scores compare to last year for dementia and disability.	This indicator will no longer be reported monthly but annually when the results are available.
We will discharge at least 35% of our patients on relevant pathways before noon	Yes - target changed. We have changed the percentage from 35% to 33% to reflect the target in the SAFER patient flow bundle.
We will ensure 100% of critical care patients are admitted within 4 hours.	Yes - target changed to align with the professional standard (*Guidelines for the Provision of Intensive Care Services 2015*) and CQC KLOE for Core services critical care

	inspection framework, 2016.
We will reduce the percentage of patients waiting over 18 weeks to receive consultant-led treatment in line with trajectories.	New target
Safeguarding	**Proposed new target** It has been proposed that a new target is considered for inclusion this year related to safeguarding training.
We will ensure that at least 70% of complainants are satisfied with the overall handling of their complaint	Yes – target has changed to be focussed on patient satisfaction with the process instead of response rate timeframes. The new target will be measured by responses to a complaint survey that will be sent to all complainants after the process has been completed.

We are proposing a number of changes to our Responsive targets and metrics for 2018/19.

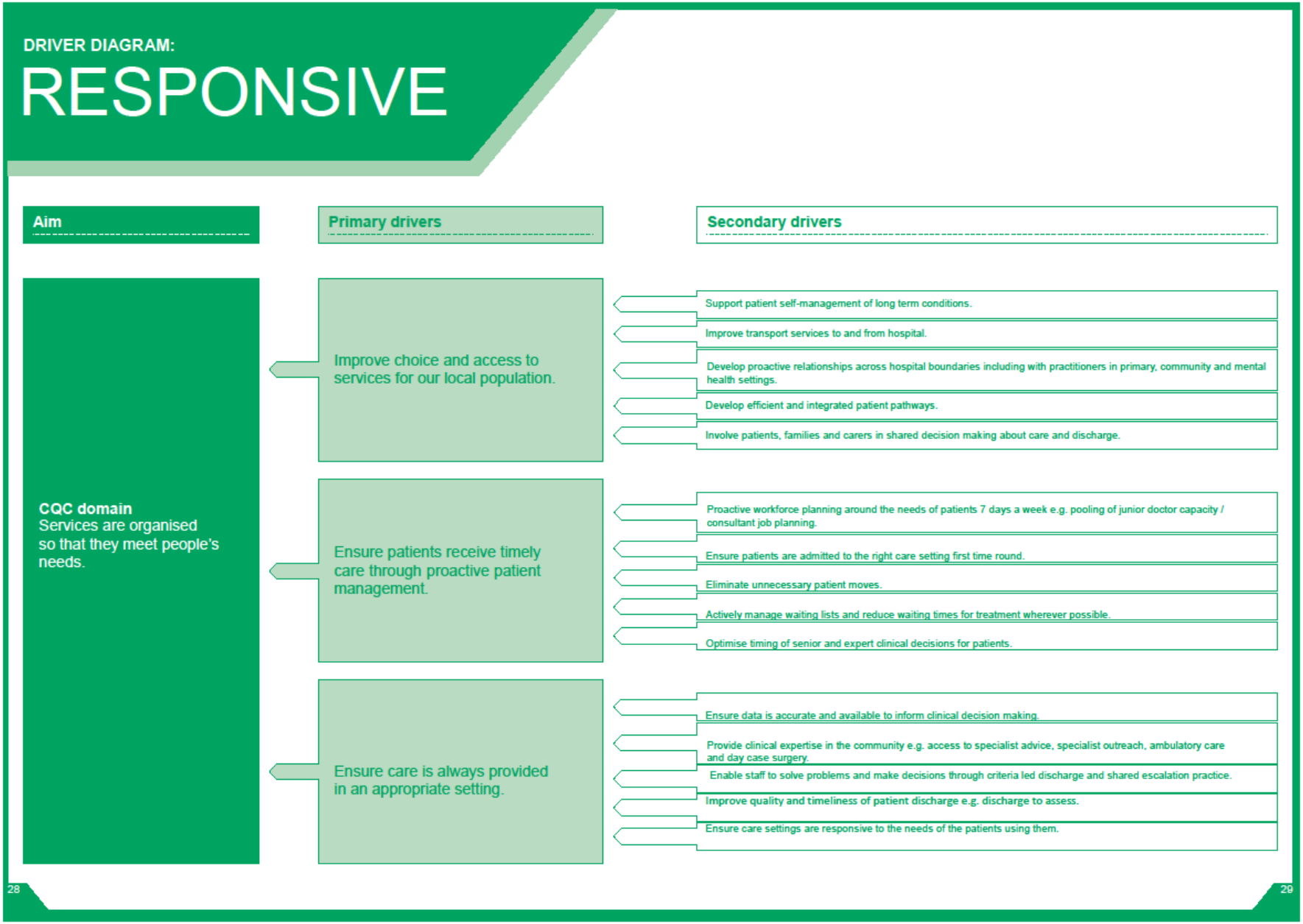
We have removed the target related to improving our PLACE scores as this is an annual rating which can be monitored and reported annually through our internal reporting structures instead of including it in our monthly performance indicators.

We are recommending two new targets for 2018/19. The first relates to patients waiting less than 18 weeks to receive consultant-led treatment, with a trajectory to achieve xx per cent in 2018/19, against a national standard of 92%. The second will relate to safeguarding training compliance, where there has been consistently poor performance across the Trust. This metric is currently under review by the Deputy Director of Patient Experience.

The metric for cancellation of outpatient clinics with less than 6 weeks notice is under review by the WCCS division.

Our metric relating to our responsiveness to complaints has been moved from the Caring domain to the Responsiveness domain for 2018/19. This is in line with the CQC key lines of enquiry.

The driver diagram developed last year for the 2017/18 quality account will be used again this year. New versions of the driver diagrams will be developed as part of the 2018-2023 quality strategy.


DRIVER DIAGRAM:
RESPONSIVE
Aim
Primary drivers
Secondary drivers
CQC domain
Services are organised so that they meet people's needs.
Improve choice and access to services for our local population.
Support patient self-management of long term conditions.
Improve transport services to and from hospital.
Develop proactive relationships across hospital boundaries including with practitioners in primary, community and mental health settings.
Develop efficient and integrated patient pathways.
Involve patients, families and carers in shared decision making about care and discharge.
Ensure patients receive timely care through proactive patient management.
Proactive workforce planning around the needs of patients 7 days a week e.g. pooling of junior doctor capacity / consultant job planning.
Ensure patients are admitted to the right care setting first time round.
Eliminate unnecessary patient moves.
Actively manage waiting lists and reduce waiting times for treatment wherever possible.
Optimise timing of senior and expert clinical decisions for patients.
Ensure care is always provided in an appropriate setting.
Ensure data is accurate and available to inform clinical decision making.
Provide clinical expertise in the community e.g. access to specialist advice, specialist outreach, ambulatory care and day case surgery.
Enable staff to solve problems and make decisions through criteria led discharge and shared escalation practice.
Improve quality and timeliness of patient discharge e.g. discharge to assess.
Ensure care settings are responsive to the needs of the patients using them.
28
29

Quality domain 5: Well led

Aim/CQC Definition: The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

The priority improvement programmes which will support delivery of the Well led aim and targets in 2018/19 are being confirmed.

Goal/Target	Changes made to this target for 2018/19
To increase the percentage of staff who would recommend this trust to friends and family as a place to work	**Target for discussion** Senior P&OD team have asked to make this target relate to the results of the annual national survey with a 2% increase on performance last year (68%). A decision needs to be made about whether this indicator should be removed and instead reported to the exec committee in a report when the annual results are published as we have agreed for annual indicators under the other domains.
To increase the percentage of staff who would recommend this trust to friends and family as a place for treatment	**Target for discussion** Senior P&OD team have asked to make this target relate to the results of the annual national survey with a 2% increase on performance last year (TBC%). A decision needs to be made about whether this indicator should be removed and instead reported to the exec committee in a report when the annual results are published as we have agreed for annual indicators under the other domains.
We will achieve a voluntary turnover rate of 10%	**Target under review** The percentage target remains under review by the Senior P&OD Team.
We will maintain our sickness absence rate at below 3%	Yes – the target percentage has been changed from 3.10% to 3% this year.

We will achieve a performance development review rate of 95%	No
We will achieve a non-training grade doctor appraisal rate of 95%	No
We will further develop our ward accreditation programme to ensure it links with other quality initiatives and has quality improvement at its heart	This target has been removed for 18/19 as it is now fully embedded across the Trust.
We will reduce the number of programmes with red flags in the GMC's national trainee survey by 5%	This indicator will no longer be reported monthly as it is an annual report which we would continue to monitor when the data is available through our education reporting structure.
We will increase the overall number of green flags in the GMC's national trainee survey by 5%	This indicator will no longer be reported monthly as it is an annual report which we would continue to monitor when the data is available through our education reporting structure.
We will obtain a minimum score of 0.5 for placement satisfaction for all student placements as measured by SOLE	This indicator will no longer be reported monthly as it is an annual report which we would continue to monitor when the data is available through our education reporting structure.
We will have a departmental safety coordinator in 75% of clinical wards, clinical departments and corporate departments	**Target for discussion** Yes – the percentage target has been increased from 60% to 75% to align with our trajectory for improvement
We will ensure at least 10% of our staff are trained as fire wardens.	No
We will ensure we respond to all exception reports from junior doctors within 14 days of an application being made and that we deliver improvements as a result	This target has been removed for 18/19
We will achieve a consultant job planning completion rate of 95%	New target
We will have a general staff retention rate of 85% or more	New target

We are proposing a number of changes to our Well led targets and metrics in the scorecard for 2018/19.

We have removed three education metrics relating to the GMC's national trainee survey and SOLE results. These are annual results which we would continue to monitor when the data is available through our education reporting structure. We have also removed the target in connection with our

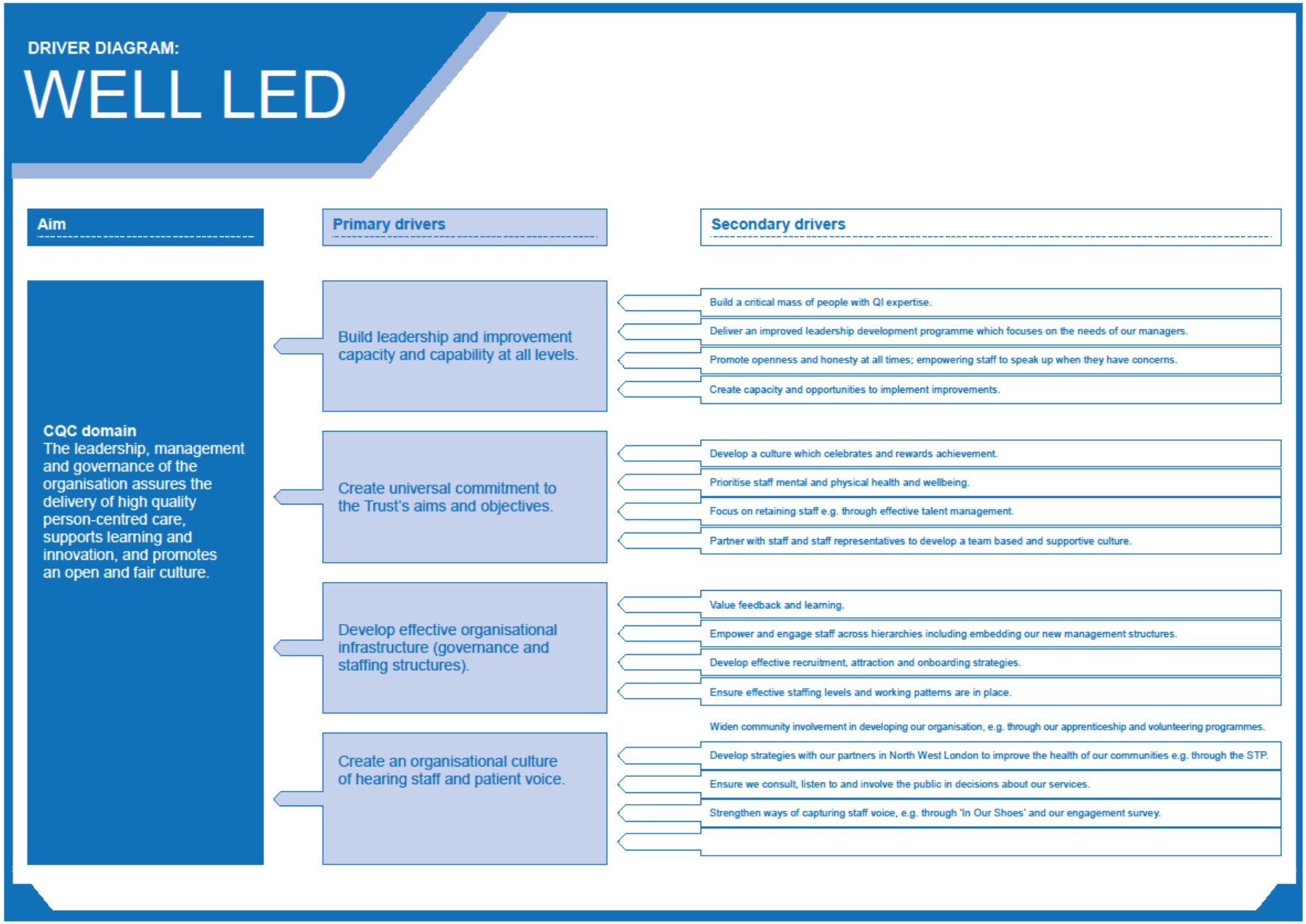
ward accreditation programme as it is now fully embedded across the Trust, and our response times to junior doctor exception reports.

We are recommending two new metrics for 2018/19. The first is 'to achieve a consultant job planning completion rate of 95%' which the Trust did not achieve last year and a new workforce metric relating to staff retention rate. The staff retention rate tells you the percentage of your staff that have more than one years service; an indication of retention of knowledge, and experience within the Trust. Used in conjunction with staff voluntary turnover rate it can be used to consider the stability of the Trust's workforce.

The target relating to voluntary turnover rate remains under review by the senior P&OD team.

There are three metrics for discussion by the executive team. These are whether to include the two targets connected to the annual national staff survey in the 2018/19 metrics, as well as the proposed safety coordinator percentage target for next year.

The driver diagram developed last year for the 2017/18 quality account will be used again this year. New versions of the driver diagrams will be developed as part of the 2018-2023 quality strategy.


DRIVER DIAGRAM:
WELL LED
Aim
Primary drivers
Secondary drivers
CQC domain
The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.
Build leadership and improvement capacity and capability at all levels.
Build a critical mass of people with QI expertise.
Deliver an improved leadership development programme which focuses on the needs of our managers.
Promote openness and honesty at all times; empowering staff to speak up when they have concerns.
Create capacity and opportunities to implement improvements.
Create universal commitment to the Trust's aims and objectives.
Develop a culture which celebrates and rewards achievement.
Prioritise staff mental and physical health and wellbeing.
Focus on retaining staff e.g. through effective talent management.
Partner with staff and staff representatives to develop a team based and supportive culture.
Develop effective organisational infrastructure (governance and staffing structures).
Value feedback and learning.
Empower and engage staff across hierarchies including embedding our new management structures.
Develop effective recruitment, attraction and onboarding strategies.
Ensure effective staffing levels and working patterns are in place.
Create an organisational culture of hearing staff and patient voice.
Widen community involvement in developing our organisation, e.g. through our apprenticeship and volunteering programmes.
Develop strategies with our partners in North West London to improve the health of our communities e.g. through the STP.
Ensure we consult, listen to and involve the public in decisions about our services.
Strengthen ways of capturing staff voice, e.g. through 'In Our Shoes' and our engagement survey.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	28 March 2018

Gender Pay Gap Report 2017/18

Executive summary:

Background:

Gender pay gap reporting requirements were introduced in 2017 for employers with at least 250 staff. An organisation's gender pay gap refers to the difference between the average earnings of men and women, expressed relative to men's earnings. This is a broad measure of the difference in the average earnings of men and women, regardless of the nature of their work.

All gender pay gap calculations relate to the pay period in which the snapshot day falls. The snapshot date is the specific date each year that the figures will be drawn from to make gender pay gap calculations. 31 March is the snapshot date for public sector organisations.

The 2017/18 report must be publically accessible on the Trust website by 30 March 2018.

The below are the 6 mandatory calculations that the report details:

1. Proportion of males and females in each quartile band
2. Mean gender pay gap for ordinary pay
3. Median gender pay gap for ordinary
4. Mean gender pay gap for bonus pay
5. Median gender pay gap for bonus pay
6. Proportion of males and females receiving a bonus payment

Summary of gender pay gap calculations 2017/18

There are a higher proportion of male employees in the upper pay quartile of the Trust compared to proportions of male and female employees at lower levels.

When considering ordinary pay, the mean hourly rate of male employees is **19%** higher than that of female employees. When median calculations are used, the hourly rate of male employees' ordinary pay is **13%** higher than that of female employees.

The only relevant bonus pay relates to Clinical Excellence Awards (CEA) for consultants. When looking at the mean differences, there is a **27%** pay gap between male and female consultants' bonus pay. When looking at the median differences, this is higher, with male consultants receiving **40%** more bonus pay than female consultants.

When considering all Trust consultants eligible to receive CEA bonus pay, **4%** more male consultants receive bonus payments compared to female consultants.

Quality impact:

This report relates to the Well-led CQC domain.

Financial impact:

Has no financial impact.

Risk impact:

If the Trust does not take action to address gender pay gap identified then the position could worsen and have a negative impact on staff morale.

Recommendation(s) to the Committee:

It is recommended that the Trust board:

1. The attached report is published on the Trust website to coincide with statutory publication of the gender pay gap data

2. Gender pay gap data is incorporated into the annual equality and diversity report going forward with relevant actions explored

Trust strategic objectives supported by this paper:

- 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.

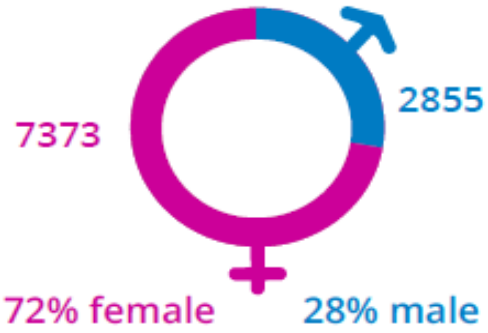
Author	Responsible executive director	Date submitted
Mia Hull, HR Manager & Barbara Britner, Associate director of Employee Relations	David Wells, Director of P&OD	22 March 2018

GENDER PAY GAP 2017/18 ANNUAL REPORT

This report is published in line with gender pay gap reporting requirements for organisations with more than 250 staff. All calculations relate to the pay period in which the snapshot day falls, which is 31 March 2017.

A gender pay gap is the difference between the average earnings of men and women across an organisation, expressed relative to men's earnings. This is different to equal pay for equal value work, please see below for further definitions. The Trust operates within a national pay structure and job evaluation system for staff on agenda for change terms and conditions and those on Medical and Dental terms and conditions.

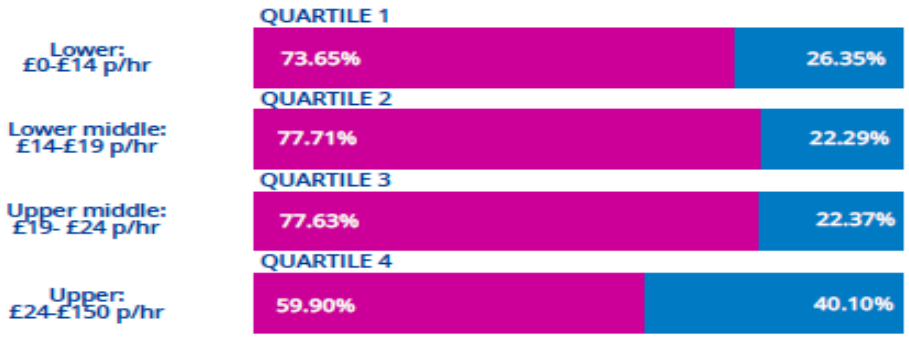
Organisation gender mix



Overall, **72%** of Trust employees are female, while **28%** are male. These percentages relate to the 10,228 staff included for the purposes of this calculation.

Quartile bands are determined by ranking all staff members from lowest to highest hourly rates, dividing this into four quartiles and determining the percentage of men and women in each of the four parts.

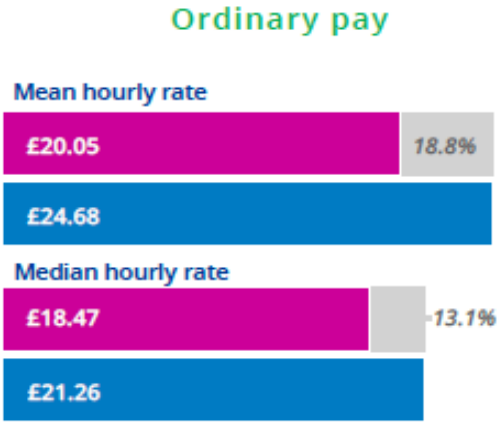
Quartile pay band gender representation



Within the lowest range of pay scales (Q1), the proportions are similar to that of the overall organisation, varying by 2%.

In comparison, within both middle quartiles (Q2 and 3), there are slightly higher proportions of female employees and lower proportions of male employees, with broadly **78%** female and **22%** male employees.

However, within the upper quartile (Q4), there are fewer women compared to the overall Trust proportions, with broadly 60% female and 40% male employees. This suggests that the gender pay gap can be partly explained by an underrepresentation of women in the upper quartile band.



The mean average refers to the sum of hourly rates in each gender, divided by the count. During the defined pay period that includes the snapshot date of 31 March 2017, the mean hourly rate of male employees was **18.8%** higher than that of female employees.

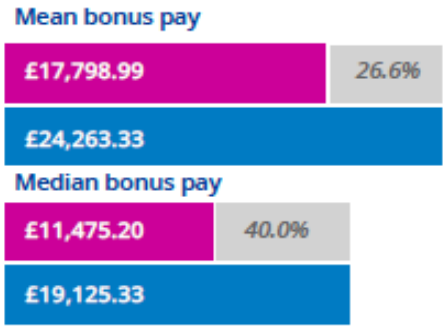
The median refers to the hourly rate at the midpoint of all values.

The median is included because it is not affected by exceptionally high or low values. During the defined pay period that includes the snapshot date, the median hourly rate of male employees was **13.1%** higher than that of female employees.

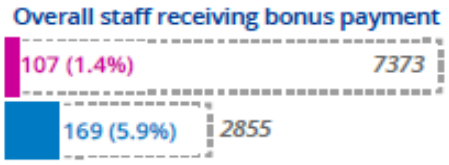
Clinical Excellence Awards (CEAs) are the only bonus payments made within the Trust. CEAs are awarded to medical consultants to recognise clinical excellence at a local level within the Trust and at a national level by the Department of Health.

Eligible consultants are those in substantive posts with more than one year's trust service at the time of the application.

When considering proportions of CEAs for eligible consultants only, **48.6%** of male consultants receive CEA payment, compared to **44.8%** of female consultants.



There is a **26.6%** pay gap between male and female consultants' bonus pay. When looking at the median difference, this is higher, with male consultants receiving **40.0%** more bonus pay than female consultants.



Bonus payments are only made to medical consultants who are in substantive posts with more than one year's trust service at the time of the application.

5.9% of male employees receive bonus payment, while **1.4%** of female employees do. Therefore**, 4.5%** more men receive bonus payments compared to women across the Trust.

Imperial College Healthcare NHS Trust recognises the gender pay gaps identified by this report and will take action as a result. This will be conducted as part of the annual equality and diversity report which will incorporate:

1. Exploring the gender differences within each quartile and taking action to redress the balance
2. Further analysis of the data by occupational groups
3. Improving the representation of women in higher paid roles
4. Reviewing the local clinical excellence award process, including what factors are driving the differences in mean and median bonus pay of local and national awards which are made at a set number of different levels.

Definitions

Gender pay gap: The difference between the average earnings of men and women, expressed relative to men's earnings. This is a broad measure of the difference in the average earnings of men and women, regardless of the nature of their work.

Equal pay: A legal requirement that within an organisation, male and female staff members who are engaged in equal or similar work or work of equal value must receive equal pay and other workplace benefits. This definition is included for clarification purposes as this report relates to the gender pay gap, and not equal pay.

Ordinary pay: Basic pay, paid leave, including annual, sick, maternity, paternity, adoption or parental leave (except where an employee is paid less than usual or nothing because of being on leave), high cost area and other allowances, shift premium pay, and pay for piecework. This would include on call framework and banding supplement in Doctor's pay, for example.

Bonus pay: For the purposes of this report, the only relevant bonus pay relates to Clinical Excellence Awards (CEA). The CEA scheme is intended to recognise and reward those Consultants who contribute most towards the delivery of safe and high quality care to patients and to the continuous improvement of NHS services. While CEA payments are also captured within ordinary pay calculations, in line with NHS Employers guidance, they are additionally included in bonus pay calculations to allow for further analysis.

Inclusion Criteria

A wider definition of who counts as an employee is used for gender pay gap reporting. This means staff who are employed under a contract of employment, a contract of apprenticeship or a contract personally to do work. This includes those under Agenda for Change terms and conditions, medical staff, very senior managers and Trust bank workers.

Agency workers are excluded from the Trust's calculations, but counted by the agency providing them. Apprentices at the Trust are employed by an apprentice training agency, therefore the contract of apprenticeship is with the agency. Doctors under honorary contracts are also excluded from calculations, but counted by their academic institution

Self-employed workers and contractors of the Trust are also excluded as it is not reasonably practicable to obtain the data to include within the calculations. This is in line with Regulation 2(3) of the Gender Pay Gap Information Regulations 2017.

References

Gender pay gap reporting – Government Guide (2017)
Gender pay gap reporting- NHS Employers Guide (2017)
Imperial College Healthcare NHS Trust Annual Equality and Diversity Report (2017)

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	28 March 2018

Corporate Risk Register and Risk Appetite

Executive summary:

PART 1: Corporate Risk Register

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

At present, there are 19 corporate risks within the risk register. The highest risks are scored as 20 and the lowest are scored as 8.

Key themes include:

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

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

- Two risks have been de-escalated from the corporate risk register to the relevant divisional risk register:
  - *Risk 2478 - Risk of excess organisational pressure associated with major malicious attack*.
  - *Risk 2479 - Risk of fire delayed evacuation within older parts of the Trust Estate needs enhanced level of assessment and on-going management due to building age, infrastructure and layout of the buildings.*

- Four new risks have been escalated onto the Corporate Risk Register:
  - *Risk 1660 - Risk of delayed treatment to patients due to poor data quality*
  - *Risk 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
- *Risk 2557 - Risk of using medical devices that are out of testing date due to lack of scheduled maintenance.*
- *Risk 2538 – Risk of medication safety being adversely affected by poor adherence to medication safety policies*

- The risk score for the following risk has increased:
  - *Risk 2472 - Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC*
- The risk score for the following risks has decreased:
  - *Risk 2475 - Risk of failure to actively identify educational issues and develop actions in response before they result in negative feedback/poor results*
  - *Risk 2481 – Failure to implement, manage and maintain an effective Health and Safety management system.*
- The target risk score dates for a number of risks have changed.
  - *Risk 2476 - Failure to currently meet some of the core standards and service specifications (as set out by the CQC) for High Dependency areas within the Trust*
  - *Risk 2480 - There is a risk to patient safety and reputation caused by the inconsistent provision of cleaning services across the Trust*
  - *Risk 2490 - Failure to deliver safe and effective care*

PART 2: Risk Appetite

Following discussion at the Trust board seminar in December 2017 and at the Executive Redevelopment Committee in February 2018, the proposed Risk Appetite statement and framework have been reviewed and were presented to the Audit Risk and Governance Committee on 21 March 2018. Main changes include:

- A definition of risk appetite with regard to staff related risks has been added to the risk appetite statement
- Contextual narrative related to financial and operational performance
- The risk appetite matrix has been simplified to include 4 appetite levels instead of 5.
- A document is being developed to operationalize the implementation of the risk appetite, which will be finalized later in the year.

Update for leadership briefing:

- The Trust is currently developing a risk appetite statement
- Describing our risk appetite helps our staff and stakeholders understand; the level of risk that we are prepared to accept in any given area and reduces the likelihood of erratic or inopportune risk taking, which could expose the organisation to a risk that it cannot tolerate, or prevent it from exploiting opportunities it should take.
- Following approval at the Trust Board in March 2018, an operational framework will be developed to support staff in its application.

Quality impact:

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

Financial impact:
Some of the mitigation outlined in Appendix 1 will have a financial impact and this is considered as part of existing work streams in relation to the risks.
Risk impact:
The impacts of each risk are captured within Appendix 1.
Recommendation(s) to the Committee:
The Committee is asked to: • Note the agreed changes and updates to the risk register since it was presented to the Trust board in November 2017 • **Approve** the risk appetite statement and framework
Trust strategic objectives supported by this paper:
To achieve excellent patients experience and outcomes, delivered with care and compassion. To educate and engage skilled and diverse people committed to continual learning and improvements. To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

Author	**Responsible executive director**	**Date submitted**
Valentina Cappo, Corporate Risk Manager Priya Rathod, Deputy Director of Quality Governance	Janice Sigsworth, Director of Nursing	21 March 2018

PART 1: Corporate Risk Register

1. Purpose

The following report summarises the changes to the Corporate Risk Register since it was reviewed by the Trust board in November 2017.

2. Background

The Trust board reviewed the Corporate Risk Register at its meeting on 29 November 2017. The following governance process for risk management is in place within the Trust:

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

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

3. Changes to the Corporate Risk Register

A number of changes have been made to the Corporate Risk Register since the last update to the board in November 2017. Please refer to **Appendix 1** for a copy of the Corporate Risk Register, which reflects the changes summarised in this paper.

3.1 Risks that have been de-escalated

- ***Risk 2487*** - ***Risk of excess organisational pressure associated with major malicious attack***.
- When the Audit, Risk and Governance Committee reviewed the Corporate Risk Register in December 2017, it was satisfied that robust contingency plans are in place to mitigate organisational pressure in case of a malicious attack in London and to effectively respond to this.
- The risk scoring is determined by the current threat level for international terrorism in the UK, which is outside our organisational capacity to measure or control.
- Subsequently the Executive Committee agreed to de-escalate the risk from the Corporate Risk Register to the Site Operations and Emergency Planning Risk Register in December 2017.

- ***Risk 2479*** - ***Risk of fire delayed evacuation within older parts of the Trust Estate needs enhanced level of assessment and on-going management due to building age, infrastructure and layout of the buildings***.
- When the Audit, Risk and Governance Committee reviewed the Corporate Risk Register in December 2017, it was satisfied with the current risk mitigation and felt that the risk could be de-escalated from the Corporate Risk Register to the Facilities, Estates, Nursing and Site Divisional Risk Register.
- There has not been any recent incident of note and the fire evacuation exercise carried out with the Fire Brigade in October 2017 demonstrated good response in case of fire.
- Subsequently the Executive Committee agreed to reduce the risk score from 16 (C4 x L4) to 9 (C3 x L3) and the risk was de-escalated from the Corporate Risk Register to the Facilities, Estates, Nursing and Site Divisional Risk Register in December 2017.

3.2 New risks escalated to the Corporate Risk Register

- ***Risk 1660*** - ***Risk of delayed treatment to patients due to data quality problems***
- A Data Quality Framework and new governance framework is being implemented.
- The latest version of the Elective Access Policy was published in October 2017 and the underpinning Standard Operating Procedures for entry and validation of waiting times data on the Patient Administration System was launched in October 2017.
- An Elective Care Operating Framework is also being designed, which will be underpinned by staff training and digital optimisation.
- The Executive Digital Strategy Committee approved escalation onto the Corporate Risk Register in January 2018.
- The current risk score is 20 (C4 x L5).

The board will recall that in the paper presented in November 2017, it was advised that a number of risks areas would be considered for inclusion onto the corporate risk register going forward, as a result of the recent CQC core service inspections. To this end, the following new risks have been escalated onto the corporate risk register:

- ***Risk 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***
- A range of mitigating actions have been put in place, including:
  - Link to performance development review (PDR) and Consultant appraisal; up to date compliance is a pre-requisite for a “Good” PDR rating and a successful consultant appraisal.
  - Communication campaigns to promote topics via In Brief, Leadership briefing and other communication tools.
  - Restriction to study leave allowance for staff that have not completed their mandatory training.
- A Core Skills Governance group has been established to review all denominators and core skills topics.
- An upgrade/replacement of the current learning management systems has also been agreed.
- The Executive Digital Strategy Committee approved escalation of this risk onto the Corporate Risk Register in January 2018.

- The current risk score is 9 (C3 x L3).

- ***Risk 2557 - Risk of using medical devices that are out of testing date due to lack of scheduled maintenance***
- All outstanding devices are planned to be checked and tested by the end of April 2018.
- A Radio Frequency Identification (RFID) system has been introduced to track medical devices.
- Medical devices have been risk assessed so that the ones that are most at risk have been prioritised for maintenance and testing.
- An e-learning package will be introduced in April 2018 to inform users of safety issues when using medical devices.
- The Executive Digital Strategy Committee approved escalation of the risk onto the Corporate Risk Register in January 2018.
- The current risk score is 9 (C3 x L3)

- ***Risk 2538 – Risk of medication safety being adversely affected by poor adherence to medication safety policies***
- A Medicines Management Improvement Group was established October 2017.
- There is support from the Quality Improvement (QI) team in this stream.
- The action plan is being managed through the Medicine Management Improvement Group.
- The Executive Redevelopment Committee approved escalation of this risk onto the Corporate Risk Register in February 2018.
- The current risk score is 12 (C4 x L3).

- **Compliance with Hand Hygiene requirements**
- A risk associated to low level of hand hygiene compliance has been added to the Divisional Risk Register for the Office of the Medical Director and it is not felt that it needs to be escalated to the corporate risk register at this stage.

The above risks highlighted from the CQC inspections are being managed through a number of work streams that have been established with support from the QI team and a monthly update on progress is provided to the Executive Quality Committee.

At the Audit, Risk and Governance Committee on 21 March 2018, there was discussion with regards to the potential risk related to the lack of a substantive CEO at the Trust at present. The risk associated with this is currently captured on the CEO office's risk register and further discussion will take place to determine if this should be escalated onto the corporate risk register.

3.3 Changes to risk scores

3.3.1 Increase in score

- ***Risk 2472 - Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC***
- The Trust's inspection reports from Surgery, Urgent and Emergency Services, and Well-led at Trust level, published in February 2018, have shown some improvement, but further improvement is yet to be achieved.
- The CQC has rated the Trust as 'Requires Improvement' for the Trust level Well Led inspection that took place in December 2017.
- The risk score has subsequently been increased from 12 (C4 x L3) to 16 (C4 x L4).

- The target risk score date has also been changed to September 2018, to allow time to embed the required improvements.

3.3.2 Decrease in score

- ***Risk 2475 - Risk of failure to actively identify educational issues and develop actions in response before they result in negative feedback/poor results***
- Work continues to try and actively identify and respond to educational issues before they result in negative feedback or poor results.
- High risk specialties are under surveillance through regular deep dives and education review follows ups planned between February and April 2018. All other specialties will complete education reviews by July 2018.
- The risk score has subsequently decreased from 12 (C4 x L3) to 8 (C4 x L2).
- The target risk score has also been decreased from 8 (C4 x L2) to 6 (C3 x L2).

- ***Risk 2481 - Failure to implement, manage and maintain an effective health and safety management system***
- A number of improvements have been achieved; these include:
  - Full complement of Health and Safety Managers now in post
  - 30% reduction in slips trips and falls incident rates compared to this time last year
- Draft proposals agreed to secure effective control over non-safe sharps and, therefore, compliance with the Sharps Regulations 2013
- The risk score has subsequently decreased from 12 (C3 x L4) to 9 (C3 x L3).
- Following discussion at the Audit, Risk and Governance Committee on 21 March 2018, further consideration will be given as to how best to reflect the impact of wider health and safety issues (e.g. the estate) across the Trust, on the corporate risk register.

3.4 Changes to target risk score dates

- ***Risk 2476 - Failure to currently meet some of the core standards and service specifications (as set out by the CQC) for High Dependency areas within the Trust***
- The target risk score date has been changed to June 2018 to align with the current action plan.

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

- ***Risk 2490 - Failure to deliver safe and effective care***
- The target risk score date has been changed to May 2018 to align with the current action plan.

PART 2: Risk Appetite

1. Purpose

Following discussion at the Trust Board Seminar in December 2017 and the Executive Redevelopment Committee in February 2018, the proposed risk appetite statement and framework were reviewed and presented to the Audit, Risk and Governance Committee on 21 March 2018. This paper reflects relevant changes and is presented to the Committee for approval.

2. Background

The Trust has been working towards defining a risk appetite framework and statement. Following review of best practice, a proposed risk appetite statement was developed in November 2017 and an iterative process of review was initiated at the Executive Operational Performance Committee on 21 November 2017.

The proposed risk appetite statement and framework were subsequently reviewed and discussed at the Audit Risk and Governance Committee on 6 December 2017, at the Trust Board Seminar on 13 December 2017. They were then brought back to the Executive Redevelopment Committee in February 2018 and to the Audit Risk and Governance Committee on 21 March 2018. A number of changes were agreed at these times, which are reflected on this paper.

3. Introduction

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

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

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

4. Proposed Risk Appetite Statement

Main changes to the proposed risk appetite statement that was reviewed by the board in December 2017 include:

- A definition of risk appetite with regard to staff related risks has been added to the risk appetite statement
- Contextual narrative related to financial and operational performance

The revised risk appetite statement is proposed overleaf:

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

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

5. Risk appetite matrix

- When the proposed risk appetite framework was discussed at the board seminar in December 2017, it was suggested to consider re-defining the risk appetite levels as 'low, medium, high'.
- It is recognised that the matrix for Risk Appetite for NHS Organisations proposed by the Good Governance Institute can be simplified; however, it is recommended that applying a 'low, medium, high' scoring approach would be too simplistic.
- Subsequently, a simplified matrix has been developed, which merges some of the scores from the Good Governance Institute and reflects when the appetite would be low, medium or high. This is reflected in the table below.
- This proposal was agreed at the Executive Redevelopment Committee in February 2018 and at the Audit, Risk and Governance Committee in March 2018.

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

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

6. Proposed risk appetite framework

- The proposed risk appetite framework is outlined in **Appendix 2**. This has been developed from our established documents, but using the new strategic objectives currently under development.
- It takes the existing risks from the corporate risk register and further risk areas highlighted in the Board Assurance Framework, not identified in the CRR (these are not risks per se but areas within which risk can exist).
- This forms an illustration of our current risk exposure, by taking into account: the length of time a risk has existed on the register, the score it has held for that period and the target score (e.g. if a target score is 12 or 15, this suggests that the Trust's risk appetite in this area is high).

7. Operational framework for risk appetite implementation

- At the Trust Board Seminar in December 2017 it was agreed that a document should be developed to operationalize the implementation of the risk appetite. This will support managers to understand how to respond to different areas of risk and also consider relative priorities during business planning.
- It was recommended at the Audit, Risk and Governance Committee in March 2018, to liaise with internal and external audit to support this process and to consider how better the Trust can align its corporate risk register with the risk appetite and Board Assurance Framework.
- The operational framework will be developed and disseminated later in the year.

8. Next steps and future reporting

- The corporate risk register will be presented to the Executive Redevelopment Committee on 24 April 2018.
- Meet with internal and external audit to look at best practice
- Following final approval of the Trust Risk Appetite, the Trust Risk Appetite Statement and Framework will be shared over the coming months as follows:
  - The Risk Appetite will be presented to the Divisional Quality & Safety Committee meetings and to the various divisional forums with responsibility for risk management in the corporate divisions;
  - The Risk Appetite will also be published on the Trust website together with current strategies on the 'About us' page of the website
  - A risk appetite operational framework will be developed later in the year and distributed with the approved Trust risk appetite statement and framework.

9. Recommendations to the board

- Note the agreed changes and updates to the corporate risk register since it was presented to the Trust board in November 2017
- **Approve** the risk appetite statement and framework.

10. Trust strategic objectives supported by this paper

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

APPENDIX 1

Corporate Risk Register

Trust Board – March 2018

Scoring Matrix

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

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

Key:

Initial Score: The score of the risk when first identified

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

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

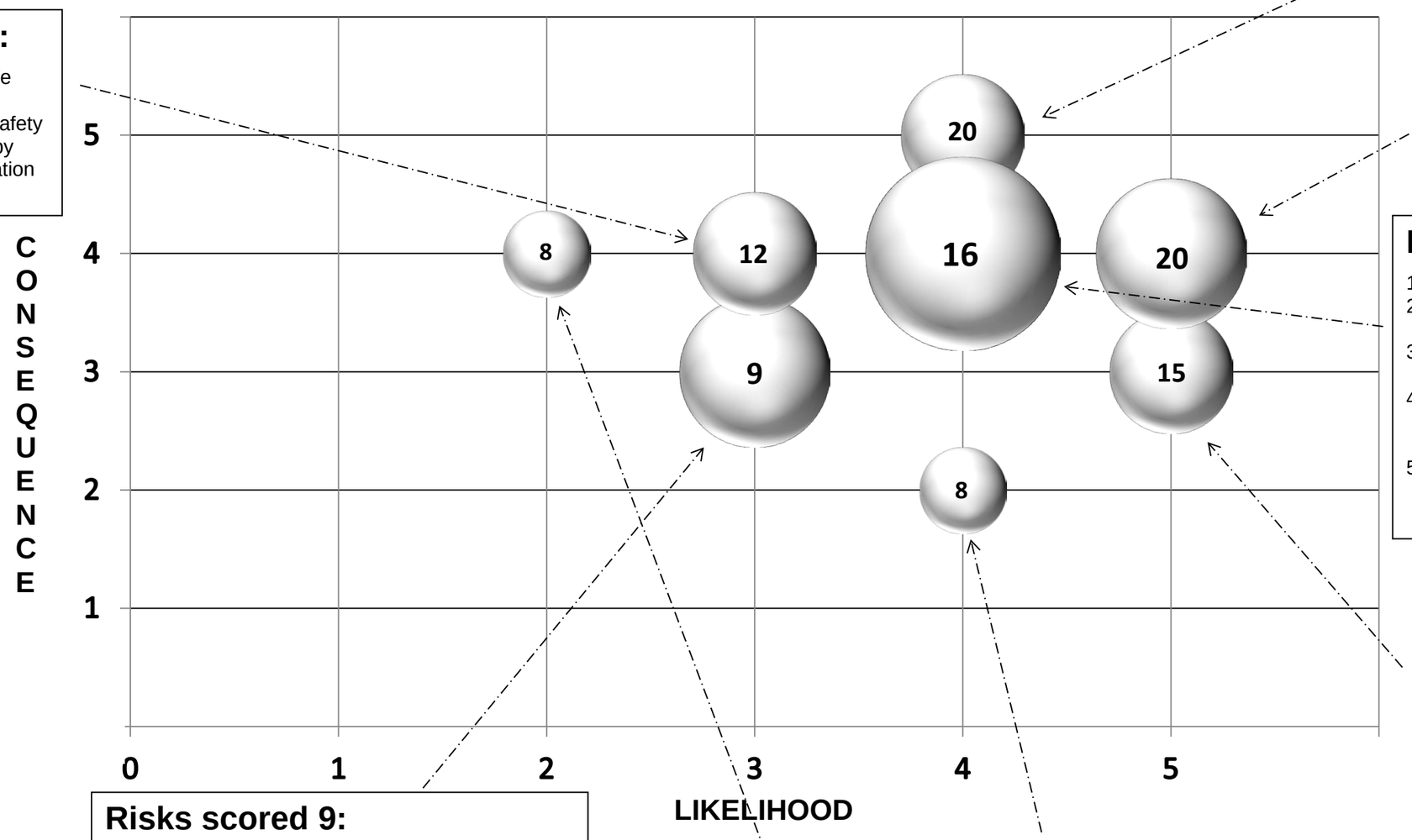
Corporate Risk Profile

Risks scored 20:

1. 2479 Failure of estates critical equipment and facilities (5x4)
2. 2473 Failure to maintain financial sustainability (5x4)
3. 2510 Failure to maintain key operational performance standards (4x5)
4. 2487 Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae) (4x5)
5. 1660 Risk of delayed treatment to patients due to poor data quality (4x5)

Risks scored 12:

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



Risks scored 16:

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

Risk scored 15:

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

Risks scored 9:

1. 2481 Failure to implement, manage and maintain an effective health and safety management system (3x3)
2. 2540 Risk of negative impact on patient and staff safety due to failure to achieve and/ or maintain full compliance to core skills training amongst substantive staff (3x3)
3. 2557 Risk of using medical devices that are out of testing date due to lack of scheduled maintenance (3x3)

Risk scored 8:

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

Corporate Risk Register Dash Board

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

Key:

→ Arrow indicates movement since last report

● Circle indicates target risk score

¡ Indicates initial risk score

* Star indicates new risk since last report

♦ Diamond indicates current score

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

Current Risk Controls

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

Mitigation Plan

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

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

Action:
Deliver the Waiting List Improvement Programme *Due Date:* 27/04/18
Update on action:
1)Daily / weekly GM portfolio review
2)Continued weekly CEO RTT meetings
3)Monthly MD office review clinical harm review / monthly divisional Q&S review
4)Monthly CCG/NHSI/E WLIP review meetings – service level trajectories / overview of legacy issues / ECOF and other work streams
5)Monthly POM meetings –
6)CCG /NHSE submission
7)External RTT submissions

Contingency Plans

• Agreed remedial action plan with commissioners for RTT and choose and book
• Agreed trajectories for achieving RTT standard and reducing 52 week waits with external and internal stakeholders
• ED recovery plan • Diagnostic trajectory plan being reviewed
• Additional elective activity focused on CXH / HH sites • Validation of closed pathways on-going. Patients to be contacted as appropriate
• Increased senior (executive) scrutiny of the emergency pathway and in patient discharge planning
• Outsourcing of US and PET-CT has been introduced to mitigate against increased waits due to lack of capacity in US and increased downtime on PET-CT machines
• Waiting List Improvement programme in place to manage improvement to delivery against the RTT standards • Trust Data Quality Framework implementation.

Key Summary Updates & Challenges

The Trust DMO1 position across all services in January 2018 was 1.58% against a target of 1%. Imaging DMO1 position in January and February 2018 was 1% and 0.4% respectively.
The number of unreported imaging examinations rose to 2933 in February 2018; however the directorate remained just under the target of <3000. Of these unreported examinations, 313 were >2 weeks which was above our trajectory target of 0.
Outsourcing continues; a total of 364 patients and 282 patients were outsourced in January and February 2018 respectively. Weekly RTT meeting with Modality Leads to assess and monitor current demand is ongoing.

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

Current Risk Controls	Mitigation Plan
• Policy for Security, Safe Storage and Transport of Medicines includes a section on the safe storage of medicines • Annual bedside locker audit undertaken • Induction training • Medicines management mandatory training module • Pharmacy assistant checks stock cupboard for medicines expiry dates on a monthly basis • Application of a green expiry sticker if expiry is due in less than 6 months • Six-monthly control drug audits • Six-monthly safety and security audits • Monthly audit of fridge temperature monitoring.	**Action:** Delivery of the Medicine Management Improvement Plan *Due Date:* 30/04/18 **Update on action:** In progress. Comprehensive plan of work in place which is monitored monthly by the Medicines Management Group. Regular updates are presented to the executive Quality Committee.

Contingency Plans	Key Summary Updates & Challenges
• Areas found to be significantly out of temperature range - consider relocation of Medicines,Increase stock rotation to reduce impact to individual medicine lines through prolonged exposure • Security issues; prioritise with estates for action • Increase monitoring in areas where expired medications are found.	Medicines management improvement group has met in February and March. Highlights include: - 14 out of 31 actions now complete. - QI focus groups undertaken in January and February 2018 - Medicines management communications planned as part of QI sprint 11th April 2018 - Quick reference materials being produced for ward staff to support adherence to core medicines management practices - these will be tested at QI sprint

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

Mitigation Plan

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

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

Current Risk Controls

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

Contingency Plans	Key Summary Updates & Challenges
Management within department with existing controls, ongoing investigation of serious incidents for 12 hour trolley wait incidents.	The target date has been extended to December 2018 since there has been no substantial decrease in the number of incidents being reported and therefore the risk cannot be said to have been reduced. Although the Trust carries the risks of having the patients remain in the Emergency Departments for an extended period of time, it can only influence and not resolve the primary cause of the delays (a lack of mental health beds). Incidents continue to be investigated as they arise, with a view to making improvements to the aspects that the Trust has some control over (parallel assessment, the escalation aspects, documentation and transport) and there are individual action plans addressing these aspects within the Serious Incident reports; however these only represent a small proportion of the total delay. There has been an increasing trend in terms of incidents involving CAMHS beds as there appears to be a greater capacity problem with these than with adult mental health presently. The division works closely with adult and CAMHS mental health colleagues when investigating and developing actions. The continued declaration of these incidents ensures that they have a high profile with the commissioners and within various cross-organisational meetings.

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

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

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

Current Risk Controls

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

Mitigation Plan

Action:
Develop SOP for the management of the new High Dependency Units *Due Date:* 29/06/18
Update on action:
SOP has been developed and circulated. Work has also commenced on the following clinical working groups – Vascular, General Surgery, Major Trauma/Neuro/Ortho/Spine, Post operative short stay environment.

Action:
Recruitment to fill vacant posts on ward *Due Date:* 29/06/18
Update on action:
Majority of nursing posts filled for the co-located HDU/ICU unit. 2 consultants appointed and recruitment ongoing for remaining clinician posts, expected to be completed March 2019.

Action:
Critical Care to take over management of HDUs Trustwide *Due Date:* 29/06/18
Update on action:
Co-location of HDU areas on SMH site to be completed 8th June 2018.

Contingency Plans	Key Summary Updates & Challenges
Continue to work towards an integrated model and utilisation of current services provided by the Site team and outreach.	Clinical teams from medicine and ICU meeting daily to discuss inpatient cases to form a processes/relationships. Planning for 8th June implementation date for Critical Care co-location at SMH site. Project board meetings commenced for HH Critical Care planning.

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

Current Risk Controls

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

Mitigation Plan

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

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

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

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

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

Contingency Plans

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

Key Summary Updates & Challenges

• Key work streams (Medicines Management, Medical Devices, Statutory and Mandatory training and Hand hygiene) have been established with support from the QI team and a monthly update on progress will be provided to the Executive Quality Committee.
• Divisional colleagues will take forward the specific 'must do' actions and will also take forward recommended 'should do' actions that are designed to get core services to 'good' and beyond.
• The CQC did not set any action that the Trust 'must' take in relation to well-led at Trust level.
• Some 'should-do' actions were recommended for the Trust to consider
• Work is already underway in the areas identified
• Colleagues are also engaging with other Trusts who have improved their CQC ratings, to share any learning.
• A series of events are planned over the coming months to allow for a fuller discussion about the Trust's approach to meeting CQC requirements and how we drive improvement at the core service level.

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

Current Risk Controls	Mitigation Plan
• Contract with Sodexo to provide cleaning services in line with National Specification for Cleanliness in the NHS • Trust Cleaning Policy detailing responsibilities, methods and materials with reference to detailed procedures for specific tasks. • Comprehensive training schedule and modules provided by domestic services contractor Sodexo. • Scheduled regime of cleaning and auditing of standards conducted and reported on a weekly basis. Timetables are in place for cleaning within departments. Regular cleaning audits are performed with oversight from area clinical manager. • Advising on specific / specialist cleaning requirements. Educating staff about the importance of following the correct processes for decontamination and cleaning. • Escalation of issues by users to Cleaning provider and Facilities team. • Monthly contract review meetings between Facilities and Sodexo to monitor, review and agree any necessary actions related to quality and performance against contract. • Monthly report provided by Sodexo detailing results of cleaning audits including if audits are conducted in partnership with clinical staff. • Cleaning outcomes will be regularly monitored and reviewed to ensure the appropriate cleaning services are provided to each clinical activity. • Bi-monthly quality meetings between service providers and cross section of multi-disciplinary Trust staff • Additional senior cleaning resource from Sodexo in place since September 2017. New Contract Manager commenced on site 5th February 2018	**Action:** Raise Cleaning Standards to agreed standard *Due Date:* 12/01/18 **Update on action:** Improvement has been evidenced but this need to be sustained Detailed Action Plan submitted to Executive Committee. **Action:** Maintain and raise standards of cleaning *Due Date:* 31/12/18 **Update on action:** In progress.

Contingency Plans	Key Summary Updates & Challenges
Increase resources and provision	New contact Manager from Sodexo commenced on 5th February 2018, risk remains. Whilst cleaning standards have improved they are not yet consistent to reduce the risk score.

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

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

Contingency Plans	Key Summary Updates & Challenges
• Capital plan to align to clinical strategy within financial abilities • Major incident plan / sector wide contingency plans • Development and implementation of integrated business continuity plan • NHSLA insurance cover • Estates Strategy with contingency plans agreed. • Mitigation of 'single points of failure' and improved infrastructure resilience providing improved business continuity planning. • Trust is reviewing options to utilise potential land receipts to use to re-invest in modernising the estate in addition to the Capital Programme will need to continue to increase, reflecting the degree of depreciation that is attributable to estates buildings and equipment and will continue to be targeted on the highest risks.	Thistlewaite now back in use and Haematology have relocated to Mint Wing. Allowing further investigation of Grafton Ward. Works continue under the Backlog Maintenance Capital programme.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
• Risk of medical devices not having scheduled maintenance. • Failure of users using medical devices that have not been through a registration process. • Increase in inventory results in increased maintenance activity together with increased cost of managed maintenance service contract • Medical device training ineffective • Delay in patient treatment due to lack of medical device. **Cause:** • Users not aware of responsibility when using medical devices • Communication between maintenance providers and users ineffective • Devices arriving in Trust through loans, trials and revenue purchases without the knowledge of Clinical Technical Services • Lack of agreement on the use of Key Trainers • Unable to identify location of required medical device **Effect:** • Out of date maintenance of medical devices resulting in not meeting CQC requirements. • Poor patient experience due to delay of treatment leading to increased incidents reported	**12**	**9**	**3**	*NEW*	**Director of Nursing**	98% of all Trust equipment categorised as high risk will have received planned maintenance 75% of all Trust equipment categorised as medium risk will have received planned maintenance 50% of all Trust equipment categorised as low risk will have received planned maintenance (performance to be reviewed through the integrated performance scorecard)

Current Risk Controls

• Medical device policy on management and training ratified and issued.
• Training and Procurement & Standardisation MDMG subgroups implemented.
• Introduced High, Medium and Low risk categories of medical devices to focus attention in key areas.
• Radio Frequency Identification (RFID) introduced to track medical devices.
• Implemented loan/trial process to regulate devices coming into the Trust.

Mitigation Plan

Action:
Introduce Radio Frequency Identification (RFID) to track medical devices in all areas *Due Date:* 30/04/18
Update on action:
Majority of CHX completed with just a few areas to have a second sweep to capture as much as possible. SMH and WE started and plan is to complete by end of April.

Action:
Introduce e-learning package to inform users of safety issues when using medical devices *Due Date:* 30/04/18
Update on action:
MDMG training subgroup are developing the eLearning package and is due April 2018. This is reported to main MDMG on a monthly basis

Contingency Plans

• Agency staff recruited to undertake backlog maintenance.
• Arrange for suppliers to provide medical device training (potential cost).
• Purchase/Loan additional medical devices.

Key Summary Updates & Challenges

RFID labelling has been completed in most of CHX with only a few areas to have a final sweep. Labelling started in SMH and WEH and aim to be completed by end of April. Safety notice issued to make staff aware of responsibilities. E-Learning package being developed and scheduled for use in April. Due to improved communication with users more equipment being returned to workshops for maintenance resulting in improved KPI's.

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

Current Risk Controls

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

Mitigation Plan

Action:
Progress SRP & conclude clinical strategy workshops *Due Date:* 30/03/18
Update on action:
Clinical strategy workshops completed for 33 out of 37 specialties as of 08/03/2018 with 16 having completed all three workshops. It is anticipated that all clinical strategy workshops will be completed by the end of April 2018 with associated sustainability & workforce workshops continuing after this.

Action:
Use outputs from SRP to develop a draft Clinical Strategy *Due Date:* 30/06/18
Update on action:
The format for consolidated outputs from the 3 workshops was agreed at ExTra in September. 7 specialty plans have been reviewed by a core group at the 'SRO Approval to Proceed' and either recommendations have been made back to the specialty leadership teams about how the opportunities identified by the SRP should be taken forward or where further work might be required to develop the specialty specific plans in more detail before progression. SRO 'Approval to Proceed' meetings are now held as part of the fortnightly Executive Transformation sessions to facilitate the SRP outputs to progress through the 'approvals process' with increased pace.
An outline Clinical Strategy is currently being developed, utilising intelligence gathered from the SRP workshops to date, and will be presented to ExTra in at the end of Quarter 1 2018/19 following the completion of the Clinical Strategy SRP workshops in April 2018. This will include a draft approvals timeline and communications plan for the clinical strategy which will be developed in conjunction with relevant internal stakeholders.
It is anticipated that a series of 'wash-up' meetings will be required between specialties where critical interdependencies have been identified. As a result the specialty specific plans will need to be iterated to ensure that they are aligned with the refreshed clinical strategy. This will form part of the continuing programme of specialty review as part of the wider sustainability and transformation programme.
Due Date: 30/06/2018 (previously 30/04/2018). Revised to reflect plan for outline clinical strategy to go to ExTra by the end of Quarter 1 2018/19)

Action:
Engage & consult with relevant internal and external stakeholders on the draft Clinical Strategy and make revisions where appropriate *Due Date:* 31/08/18
Update on action:
Due Date: 31/08/2018 (previously 15/06/2018). Updated to reflect the plan to take the outline clinical strategy to ExTra during Quarter 1 2018/19)

Action:
Gain approval for the Clinical Strategy from the Executive Committee & Trust Board within the Trust's defined governance arrangements. *Due Date:* 28/09/18
Update on action:
An approval timeline will be developed in conjunction with relevant internal stakeholders. A paper outlining the approach to developing the Clinical Strategy will be presented to the Executive Committee for approval which will include approval timescales and communications plan.

Action:
Publish refreshed Clinical Strategy and communicate to staff, patients, the public and Trust partners *Due Date:* 01/10/18
Update on action:
The approach will be developed and agreed with the Director of Communications. An approval timeline will be developed in conjunction with relevant internal stakeholders. A paper outlining the approach to developing the Clinical Strategy will be presented to the Executive Committee for approval which will include approval timescales and communications plan.

Contingency Plans

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

Key Summary Updates & Challenges

Development of a refreshed Trust Clinical Strategy is underway. The Specialty Review Programme continues and it is anticipated that the final clinical strategy session will be completed by the end of April 2018. 7 specialty plans have been reviewed by a core group at the 'SRO Approval to Proceed' and either recommendations have been made back to the specialty leadership teams about how the opportunities identified by the SRP should be taken forwards or where further work might be required to develop the specialty specific plans in more detail before progression. SRO 'Approval to Proceed' meetings are now held as part of the fortnightly Executive Transformation sessions to facilitate the SRP outputs to progress through the 'approvals process' with increased pace.
An outline Clinical Strategy is currently being developed, utilising intelligence gathered from the SRP workshops to date, and will be presented to ExTra during Quarter 1 2018/19 following the completion of the Clinical Strategy SRP workshops in April 2018. This will include a draft approvals timeline and communications plan for clinical strategy which will be developed in conjunction with relevant internal stakeholders.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
The number of patients presenting to the Trust who are infected or colonised with CPE is likely to increase in line with global and national trends. The risk is uncontrolled spread of CPE within the Trust. **Cause:** • CPE will spread if it is not controlled through infection prevention and control interventions, chiefly screening and isolation, hand hygiene, environmental hygiene, and optimised use of antibiotics. • Easy transmission from patient to patient if correct IPC procedures are not followed. • With increased cases of CPE presenting to the Trust there is a risk for potential transmission and in particular in the renal, vascular and haematology cohorts with frequent admissions and outpatient appointments. • Current isolation capacity (sideroom capacity) insufficient to implement the PHE toolkit recommendations. • Recent changes in the spectrum of CPE producing organisms with increasing identification of CPE in Citrobacter and Enterobacter species with increased pressure on isolation facilities and teams to trace potential transmission • Location of services across the Trust for diagnostics and treatments, resulting in a frequent need for cross-site transfer. Estates • Capacity to address estates issues in clinical areas. **Effect:** • Failure to contain the spread of CPE will result in endemicity of CPE within our patient population, which will lead to more limited antibiotic choices for treatment and ultimately worse patient outcomes. • Increased demand for isolation facilities, potentially exceeding available capacity more frequently. • This will result in direct and indirect financial losses to the Trust (including bed and ward closures with resulting lower throughput, and increased costs of litigation), and reputational damage. • Increased movement of patients and possible transmission during these movements for diagnostics and treatments. Estates issues being addressed slowly where transmission of CPE has occurred means increased risk of further transmission, particularly in toilets and bathrooms.	**12**	**20**	**9**	⇔	**Medical Director**	• No endemicity of CPE within our patient population • No increase in demand for isolation facilities • Sufficient isolation facility capacity.

Current Risk Controls

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

Mitigation Plan

Action:
6 monthly antibiotic point prevalence audit to monitor correct antibiotic use *Due Date:* 28/02/18
Update on action:
The antibiotic point prevalence was performed in Feb 2018; results are pending.

Action:
Revised Trust CPE action plan to be developed and implemented due to the recent increase in risk score *Due Date:* 30/04/18
Update on action:
Revised action plan already complete.
Target date updated to April 2018 to reflect that implementation is in progress.

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

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

Action:
Implementation of a CPE screening tool through Cerner *Due Date:* 30/04/18
Update on action:
Some progress with Cerner but not yet implemented - target date has been changed to April to reflect that. A target level of compliance for CPE screening has been agreed.

Contingency Plans

• The Trust has in place a local contingency plan to implement ward-level cohorting in the renal speciality. This is currently being reviewed.
• Pods may provide additional single room capacity suitable for isolating patients with CPE in some areas.
• Seek guidance and support from NHSE and PHE.
• Plans to add CERNER prompt for CPE on screening.

Key Summary Updates & Challenges

CPE screening rate compliance has improved to 81% of all admissions eligible for screening.
Several new smaller CPE outbreaks have been identified and controlled. There are three current outbreaks of CPE: Citrobacter sp. in 8N, Klebsiella pneumoniae OXA-48 on 8W and Zachary Cope. Outbreaks will be declared closed when there are no new cases in a four week period. Actions are in place to improve infection control practices in each area.

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

Current Risk Controls

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

Mitigation Plan

Action:
Achieve 95% compliance for Duty of Candour online training for consultants *Due Date:* 31/03/18
Update on action:
Mandatory online training has been in place for nurses at Band 7 and above, and all consultants since June 2017. However. a Trustwide review of all core skills training is currently taking place which includes work to cleanse denominators. Until this piece of work is completed it has been agreed with the divisions that we will only report on consultant compliance (who are ultimately responsible for DOC). Divisions are responsible for ensuring compliance and it was agreed with them that 100% compliance should be achieved by March 2018 as part of the annual appraisal cycle. Data is being circulated to divisions on a monthly basis so that they can track progress and meet the target as agreed.

Action:
100% compliance with duty of candour requirements for all serious incidents *Due Date:* 30/04/18
Update on action:
Completion of duty of candour for SIs has been monitored through the medical director's incident review panel since April 2017, with improvements seen. This commenced in July for incidents graded moderate and all level one investigations. DoC compliance as evidenced on Datix isf 94% for all SIs reported between April and December 2017. Compliance for incidents graded moderate and level one investigations is 72% and 66% respectively. If significant improvement is demonstrated following the 2018/19 Trust wide audit this risk will be downgraded to divisional risk register. The due date for this action has been amended to allow for data reconciliation.

Action:
Action plan to be put into place to ensure implementation of the Learning from Deaths framework within the timeframe stipulated by NHSE *Due Date:* 30/03/18
Update on action:
We have implemented the new structured judgement review process. The first 'learning from deaths dashboard' was shared with the Trust Board in November 2017 and the second one in March 2018. As of March 2018 the Trust has identified and trained 25 consultants to undertake the function of structured judgement reviewers

Action:
SI process review *Due Date:* 31/05/18
Update on action:
The entire SI process is currently under review through a multi-stakeholder quality improvement programme; this work commenced in June 2017 which aims to increase our capability and capacity to undertake robust and high quality investigations of serious incidents. The externally commissioned investigator training commenced in December 2017, three cohorts have completed the training, with additional training sessions being planned for 2018/19. A revised SI template is being piloted in March and April; the finalised version will be implemented May 2018.

Action:
Retrospective look-back of compliance with NICE guidance *Due Date:* 30/04/18
Update on action:
The divisions continued to undertake the look-back exercise to determine compliance with NICE guidance published in 2016/17 as well as the guidance published so far during 2017/18. WCCS have now completed their review of all NICE guidance from 2016/17. MIC and SCCS still have guidance reviews outstanding. A number of issues have been faced including ownership of reviews being passed between divisions.

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

Action:
Assess at least 95% of all patients for risk of venous thromboembolism *Due Date:* 01/05/18
Update on action:
Progress is monitored through the Quality Report and the VTE performance for Q3 was 95.53% which is above the 95% target. Performance will continue to be tracked through the quality report. Once compliance has been achieved for 6 months in a row and the TIAA audit results have been received, this action on the corporate risk will be downgraded to the divisional risk register – the action due date has been extended to reflect this (from December 2017 to May 2018). Trustwide VTE performance for January 2018 was 96%.

Action:
Safer surgery task and finish group and action plan *Due Date:* 30/12/17
Update on action:
Trust level results of the WHO checklist observational audit carried out in Q1 2017/18 showed varied performance, with some specialties making significant improvements in particular areas, and other areas which are more challenged. The safer surgery task and finish group ended in December 2017 as planned with leadership continuing by the trust lead surgeon as part of the safety stream. This will focus on a review of the 'de-brief', audit programme for challenged areas, progress with Locsips and the on-going education and training needs. A final plan was due to be presented to the Executive Committee in March 2018 but this has been deferred to April.

Contingency Plans	Key Summary Updates & Challenges
Process to be managed through the Medical Director's office with nominated clinical leads	Work continues across a number of areas. Compliance with duty of candour requirements and VTE assessment has shown ongoing improvement. If improvements are maintained these actions will be closed on this register, and continue to be monitored on the divisional risk register.

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

Current Risk Controls

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

Mitigation Plan

Action:
Enhance the reward & benefits scheme to support recruitment and retention strategies. To include further developing flexible recruitment & retention premium (RRP), exploring flexible benefits as part of RRP and benchmarking Trust offer with competitors *Due Date:* 31/12/17
Update on action:
Action complete. This was circulated for comment and the key option that we are progressing with is the Recruitment and Retention Premium. It was agreed that each Division will need to seek Executive approval if they want to Board implement this.
This has been piloted for Medicine for the Elderly and launched in February 2018.

Action:
Develop accurate establishment, staffing, sickness & turnover information ensuring clear procedures in place to manage this. Include an SOP for switching off posts and develop accurate benchmark data for all N&M band 2-6 staff in London Acute Hospitals *Due Date:* 30/06/17
Update on action:
Action complete.

Action:
Ensure staff feel they can grow and develop with the Trust and opportunities are made available 'internally first' to increase staff retention. This will be delivered by a number of workstreams, including careers clinic and students' automatic offers. *Due Date:* 30/09/17
Update on action:
Action complete.

Action:
Review brand & attraction strategy; ensure recruitment process for high volume roles (including HCA and Band 5) delivers right quality & volume of candidates. Design attraction strategy for newly qualified nurses, and enhance international recruitment *Due Date:* 31/08/17
Update on action:
Action complete.

Action:
Implement a range of tool and interventions internally to encourage current Band 5/6 to stay longer. This will be supported by the implementation of a Steering Group for Nurse leadership Band 5/6 development and new exit interviews *Due Date:* 30/11/17
Update on action:
Action complete. The new Springboard leadership programme for Band 5/6 nurses has been launched and the take up is good. The Engagement toolkit and workshop is being well received. The extended version of the Pulse magazine in July 2017 was well received, the Great Place to Work week in September was a huge success and the automatic offer for students has increased student retention to over 70% which is 10% higher than target.

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

Action:
Develop a 3-5 year workforce plan for the Band 2-6 N&M population *Due Date:* 30/03/18
Update on action:
This has been produced and presented to the Executive Operational Performance Committee on 20 February 2018 for approval and funding.

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

Contingency Plans	Key Summary Updates & Challenges
• Continue to monitor impact of changes and implement further corrective measures as needed • Use of Bank & Agency staff • Reduction in activity • Escalation of staffing issues through divisional management structure and site team • Early identification of staffing issues with shifts put out to bank and agency. • Reed introducing a "refer a friend" scheme to attract more bank workers.	The overall vacancy rate for all Nursing & Midwifery at the end of February was 13.71% (accounting for 699 vacancies). The overall vacancy for Band 2-6 N&M staff was 15.04% (accounting for 628 vacancies). The Recruitment and Retention Plan is being updated for 2018/2019 and a revised plan will be available by the end of March 2018.

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

Current Risk Controls

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

Mitigation Plan

Action:
Clarify escalation processes for education issues identified within specialties and ensure process is in place *Due Date:* 29/03/18
Update on action:
Medical Education Governance guidance developed with escalation process and risk management process defined
Faculty Development programme in place to provide training which has been enhanced to include refreshers and undergraduate firm lead modules. Approximately 130 consultants have been trained since March 2017. A further three dates have been planned so far for 2018 and all are fully booked with 40 consultant educators planned to attend.
Phase one of education specialty reviews completed in February. Action plans are being developed and monitored through local faculty groups

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

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

Contingency Plans	Key Summary Updates & Challenges
Re-establish annual educational specialty review process for all specialties chaired by the medical director	Work continues to try and actively identify and respond to educational issues before they result in negative feedback or poor results. Specialties which have had education reviews are being monitored through the local faculty group meeting. High risk specialties are under surveillance through regular deep dives and education review follows ups planned between February and April. All other specialties will complete education reviews by July 2018 The education team continues to encourage the election of senior specialty trainees at Local Faculty Groups. SOLE response rate is low (usually 1 or 2 student responses per attachment) no specific concerns been raised in any attachment. The education team continue to host feedback sessions for students

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

Current Risk Controls

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

Mitigation Plan

Action:
Implement all aspects of the slips, trips and falls incident reduction action plan *Due Date:* 29/06/18
Update on action:
The likely completion date for this action will slip to the end of June. The Trust is managing Sodexo robustly because of contractual performance issues. This slips, trips and fall work is fare lower priority compared to improving the performance of the contract

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

Action:
Devise and implement appropriate sharps incidents reduction plan *Due Date:* 30/03/18
Update on action:
The new procedure for authorising the purchase of non-safe sharps will be rolled out before the end of March

Action:
Recruit to the vacant H&S Manager post *Due Date:* 26/01/18
Update on action:
Successful applicant appointed and started in February

Contingency Plans

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

Key Summary Updates & Challenges

Workplace inspection regime to be trialled in P&OD and parts of Women and Childrens Division. This will be done by the end of February 2018

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

Current Risk Controls

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

Mitigation Plan

Action:
Complete Business case to upgrade/replace current learning management systems *Due Date:* 31/01/18
Update on action:
Business case submitted at the beginning of March; further amendments have been required for submission in April

Action:
Secure funding for a Data cleanse of Medical staff data on ESR to provide better management of junior doctors compliance data *Due Date:* 30/04/18
Update on action:
Funding secured at the beginning of March.

Action:
Establish Core Skills Governance group to review al denominators and core skills topics with a view to reducing total number of topics and make denominators more targeted that staff that need to complete them *Due Date:* 30/03/18
Update on action:
Group established. Meetings occurred in January and February; due to report progress to the Executive Quality Committee in April.

Action:
Roll our use of iPDF for Junior doctors to minimise need for re-doing training that has bene done at previous rotation *Due Date:* 30/03/18
Update on action:
In progress

Action:
Divisional directors to confirm local plans for achieving compliance, which will be reflected on the next mandatory training paper to ExCo *Due Date:* 30/03/18
Update on action:
In progress

Contingency Plans

Key Summary Updates & Challenges

There has been an overall improvement in compliance to statutory and mandatory training since November 2017. The latest figures recorded on the 15th March 2018 are:
Core 10 = 86.39% (+ 2.52 %)
Core Clinical = 85.12% (+2.93%)
Core 10 Doctors in Training = 62.72 (+1.26%)
Core Clinical Doctors in Training = 55.36 (+4.63%)
Further improvement is required to achieve the compliance target is required. The action plan is on track

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

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

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

Current Risk Controls

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

Mitigation Plan

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

Action:
Production of Strategic Outline Case (SOC) for SMH Masterplan *Due Date:* 31/03/18

Contingency Plans

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

Key Summary Updates & Challenges

Outpatient & Ophthalmology facility:
• Planning permission received on 04 January. Six week period of judicial review period has ended. No challenges received. Therefore full planning is now active. The permission is granted for three years.
• The Outline Business Case for the facility was approved on behalf of Trust Board by Redevelopment Committee at the meeting on 28 February. The business case has been submitted to NHS Improvement, NHS England and the CCGs.
SMH redevelopment:

Paddington Cube planning application:
• Liaison with developers has recommenced as part of transport steering group for the area to ensure the Trust is able to run St. Mary's Hospital without hindrance.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to maintain financial sustainability **Cause:** • Loss of DH/NHS England (Diamond) income for complex specialist treatments • CCG affordability pressures and difficulties in delivering QIPP demand reduction targets may put payment for over performance at risk • Historic dependence on non-recurrent funding sources masked underlying financial picture • Failure to increase private patient income as planned • Annual reductions in Education and Training funding, very significant cut to 2018/19 funding threatened • Correction of historic usage of R&D funding for clinical subsidy • Additional costs of operating across three sites & with outdated estate and aged equipment • Slower-delivery of Clinical Strategy Implementation Plan • Agency costs (at premium rates) incurred to cover substantive roles • Investments in Acute medical model • Investment in implementation costs of Cerner including data validation • Continuing dependence upon significant non-recurrent financial gains to deliver Control Total targets & receipt of STF funding masks underlying deficit **Effect:** • Q1 STF funding of £6m lost (but wasn't budgeted) • Failure to deliver a financial surplus • Reputational risk of being in deficit • Loss of financial autonomy & reputational damage associated with the risk of being put into Financial Special Measures should we fail to deliver the stretching target • Dependence upon DH revolving working capital facility • Dependence upon SaHF for site redevelopment project costs & Charity for required capital investments	**20**	**20**	**15**	⇔	**Chief Finance Officer**	Year to date performance vs plan: As at end Jan 2018, Income and expenditure of £(24.4)m vs plan of £(24.4)m. Cash balance never less than £3m – monitored monthly and reported to Exec and Board. Internal forecast outturn (monthly refreshed.

Current Risk Controls

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

Mitigation Plan

capital arrangements, improvement in effectiveness of forecasting and further action to recover income and manage accounts payable

Action:
Working capital *Due Date:* 06/04/16
Update on action:
Agreement of revolving working capital facility up to £65m from the Department of Health
Implementation of 13 week cash flow management and weekly cash committee to review working capital position
Effective management of all working capital arrangements, improvement in effectiveness of forecasting and further action to recover income and manage accounts payable

Action:
PWC commissioned to support trusts use of Model hospital benchmarks (work referenced under key controls) *Due Date:* 29/03/18
Update on action:
PWC work is close to completion and headline analysis was presented to Extra 09/01/2018.

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

Action:
Presentation of outline plan for return to financial sustainability to Sept 27th Board & October board seminar *Due Date:* 27/09/17
Update on action:
Action complete. Board accepted the programme outline; further work required to develop the overall programme and resourcing and scope quick start projects. This programme is also overseen by the Regulator via the Financial Recovery Oversight Group (FROG) which now meets monthly.

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

Contingency Plans	Key Summary Updates & Challenges
Revolving working capital facility provides cash support cover of up to £26m (£16m has been drawn down YTD) – with the ability to extend the limit up to £65m. (However, note that these national arrangements are interim while a permanent process is being agreed between DH and NHSI)	On a Month 10 year to date basis, the Trust is on plan. The forecast outturn for the year is behind plan and meeting the control total will be challenging.

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

Current Risk Controls

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

Mitigation Plan

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

Action:
Cerner 7 24 PCs: A pilot project funded from 2016/17 capital has configured a new Cerner 7 24 PC which is more resilient to Cyber threat. Funding request to deploy this new configuration are in 2017/18 Capital Plans. *Due Date:* 31/12/18
Update on action:
Replacement infrastructure has been specified, ordered and received. Planning phases are in progress for replacement.

Action:
Process Controls: Continual deployment critical and security patches to Servers and Desktops in accordance with the following ITIL Standard? *Due Date:* 31/03/20
Update on action:
The Trust is continuing to engage with vendors to automate the patching of the server environment.

Action:
Security Software Investment: Multi Layered Security Software currently in the process of being tendered *Due Date:* 31/12/18
Update on action:
The Trend Micro security suite is being implemented. As of 13th of March, almost 5000 workstations have the new antivirus installed.

Contingency Plans

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

Key Summary Updates & Challenges

Ensuring that we secure sufficient capital funding to maintain and update our ICT infrastructure to minimise our exposure to cyber threat. The projected allocation of ICT capital for 2018/19 will be insufficient to do this.
Work is continuing to implement the new multiple security solutions.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of delayed treatment to patients due to data quality problems (e.gg NHS Number, elective waiting times), which can also result in breach of contractual and regulatory requirements **Cause:** • Inaccurate,incomplete or delayed data entry • Failure to comply with standard workflows and/or operating procedures • Lack of data validation and correction • Incorrect design/build of system or reports • Reduced clinical coding capacity/capability **Effect:** • Possible delay to treatment of patients • Possible failure of governance • Possible (criminal) investigation of Trust/individuals • Loss of Trust reputation • Possible financial penalty for Trust or loss of income • Breach of contractual and regulatory requirements.	**20**	**20**	**12**	*NEW*	**Chief Information Officer**	• Operational Data Quality Dashboard and reports for services to monitor their data quality performance directly. Trajectories agreed for some priority data quality indicators. • Data quality indicators included in Trust Board and Divisions' scorecards so aligned with Trust's performance framework and shared with commissioners. • Routine audits of reasons for removing patients from waiting lists by dedicated team. • Internal Audit Plan for 17/18.

Current Risk Controls

• A Data Quality Framework and new governance was approved by the Executive Committee in June 2017 and presented to the Audit, Risk and Governance Committee of the Trust Board in July 2017. It is being implemented during 2017/18. The framework includes 150 data quality indicators (DQIs) across 32 datasets and also includes in its scope the optimisation of the 10 systems used to collect them and the data processing involved. 15 key DQIs have been agreed as the priority focus for 17/18. The data quality indicators underpin the Trust's integrated performance framework - responsiveness and money/use of resources domains only.
• A managed service for Referral to Treatment Pathway validation was commissioned in July 2016 to supplement existing validation resources to undertake data clean up of waiting lists.
• Latest version of Elective Access Policy published October 2017 and underpinning Standard Operating Procedures for entry and validation of waiting times data on the Patient Administration System launched in October 2017.

Mitigation Plan

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

Action:
Recruit to clinical coding vacancies or outsource *Due Date:* 31/03/18
Update on action:

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

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	28 March 2018

Learning from Deaths: Update on implementation and reporting of data

Executive summary:

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

This paper is to update the Trust Board on progress since the last report and includes the second 'learning from deaths dashboard' (appendix A). The dashboard includes data for Q1, Q2, Q3 and the first month of Q4. In future we will only present information in the dashboard when we have data for the full quarter.

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;
- 25 members of staff have undergone structured judgment review (SJR) training;
- SJRs have commenced in line with the policy and completed reports are starting to be received;
- Mortality reporting metrics have been incorporated into both trust and divisional scorecards since November 2017.

Quality impact:

Implementation of this framework will support improved learning from deaths that occur in the Trust, therefore supporting the safe, effective and well-led quality domains.

Financial impact:

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

Risk impact:

There is potential for reputational risk associated with the ability to deliver reviews within the specified time periods, thus impacting on national reporting.

Recommendation(s) to the Board:

The Board is asked to note the progress made since July 2017 to ensure full implementation of the learning from deaths framework and the information in the 'learning

from deaths dashboard'
Trust strategic objectives supported by this paper:
To achieve excellent patient experience and outcomes, delivered efficiently and with compassion. To educate and engage skilled and diverse people committed to continual learning and improvements.

Author	Responsible executive director	Date submitted
Trisha Bourke Mortality Auditor Ian Maconochie Associate Medical Director for Patient Safety	Dr William Oldfield Interim Medical Director	21 February 2018

Learning from Deaths: Update on implementation and reporting of data

Purpose
The purpose of this paper is to update the Trust Board on progress with ensuring Trust compliance with the mandatory framework on learning from deaths since the previous report in November 2017. The 'learning from deaths' dashboard is also being reported to the Board in line with the mandated reporting requirements.

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

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

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

Although the trust had an established mortality review process and associated policy, adjustment to these and the requisite reporting structures, processes and timelines to ensure compliance with the new requirements were required and have been implemented.

Progress
As reported previously there were a number of key milestones required within Q1, Q2 and Q3 to ensure the Trust was in a position to fully implement the framework and report the required data set within Q3 2017/18.

Good progress was made through the task and finish group led by the Associate Medical Director for Patient Safety to review all aspects of the Learning from Deaths framework and ensure Trust policies and processes are compliant. This group has now concluded its work.

Process review
A number of key principles have been agreed, that we are now working to, including:

- In line with recommendations, at least 15% of hospital deaths will undergo SJR.
- Any case may be referred for SJR, either at the discretion of the clinical team, because concerns have been raised, or because the case falls within pre-selected cohorts of patients as set out in the policy. These cohorts include:
  - Where concerns have been raised by the bereaved family;
  - Where concerns have been raised by staff;
  - Where first stage case record review suggests a more in-depth review may be helpful or where the death is judged to have a greater than 50:50 chance of being avoidable;
  - Patients with a learning disability (in-line with the national LeDeR process);
  - Patients detained under the Mental Health Act;
  - Any case that is subject to a coroner's Inquest or enquiry;
  - Any case that is subject to a serious incident (SI) investigation;

  - Deaths in patients aged between the ages of 16 and 25;
  - Cases of maternal death;
  - Stillbirths, neonatal and paediatric deaths;
- Any mortality alert from Care Quality Commission, via benchmarking systems including the HES system (for SHMI and HSMR) or the CRAB Clinical Informatics system (we will review a random sample of deaths identified with 4 or more medical triggers);
- Historic mortality reviews undertaken under the previous trust mortality review process will not be re-reviewed under the SJR process;
- Q1 2017/18: SJR has been completed in cases identified through local review as having suboptimal care;
- From Q2 onwards: SJR will be completed in cases in the designated groups listed above.

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

Reporting

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

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

The dashboard for ICHT is included in appendix A. This was developed using available guidance however the national dashboard remains under development by NHS Improvement and the Department of Health and the reporting portal is not yet available. Trusts have been asked to publish data in their public board papers until final guidance is released. The final format is expected to include addition information on cases where a serious incident has been declared either as a result of SJR or concurrently and the key themes, learning and actions as a result.

Review of data

The full data set is in the dashboard in appendix A. The dashboard includes data for Q1, Q2, Q3 and the first month of Q4. In future we will only include data in the dashboard when we have information for the full quarter. Key points for the Board to note are outlined below:

Data Field	Data Definition	Commentary
Total Deaths	Number of in hospital deaths	Reported numbers are in line with previous trends.
Total Deaths Reviewed	The number of completed SJR reviews.	To date 80 reviews have been undertaken. This represents a significant increase since the previous report. Reviewers continue to become more confident in SJR making reviews increasingly timely.

Deaths Avoidable	The number of cases which have been deemed avoidable following SJR completion (scored 1-3 on the RCP tool).	7 avoidable deaths have been reported to date.
LD Deaths	Number of in hospital deaths in which the patient had an identified Learning Disability	The trust has reported 11 cases to LeDeR year to date.
LD Deaths Reviewed	The Trust is awaiting allocation of cases for review from the LeDeR programme board on the portal. Once allocated these reviews will be completed within the mandatory time frames.	2 LeDeR reviews have been completed, with the remaining 9 assigned to reviewers outside of the trust.
LD Deaths Avoidable	Number of deaths deemed avoidable following a LeDeR review process	There are currently no cases of avoidable LD deaths.

Two cases that have completed SJR have undergone SI investigations.

LeDeR – Learning Disabilities Mortality Review (LeDeR)
The Trust is actively participating in the LeDeR programme, reporting all deaths of patients with a Learning Disability to the national database. At ICHT these cases will all have an SJR completed, in addition to the external LeDeR review. Cases that require a LeDeR review are assigned by a national team to a named reviewer, usually outside of the trust. The trust has reported 11 deaths to LeDeR this financial year. To date, 2 reviews have been completed.

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

	Apr 17	May 17	Jun 17	Jul 17	Aug 17		Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	YTD
Total number of deaths (17/18):	120	152	137	138	163		151	161	167	162	190	1541
No. Level 1 Reviews Completed	120	152	135	137	161		142	150	134	122	99	1352
Percentage of deaths reviewed locally (Level 1):	100%	100%	99%	99%	99%		94%	93%	80%	75%	52%	88%
Number of SJR reviews requested:	3	3	2	21	26		22	35	18	17	20	167

Number of SJR reviews completed:	2	2	1	8	19	[redacted]	13	19	8	6	2	80
Number of confirmed avoidable deaths (Score 1-3):	1	0	0	0	2	[redacted]	1	2	1	0	0	7

Data is refreshed on a monthly basis as local reviews and SJR reviews are completed. In order to instigate the SJR process at the earliest opportunity the timeframe for local, Level 1 review completion has been shortened to 7 days, from the previous 30 days, effective from Sept 2017 which is reflected in the lower percentage of reviews completed that month. Compliance with the 7 day reviews is improving despite it being difficult to achieve.

It is planned for mortality data and SJR outputs to go through divisional Quality and Safety boards. This is particularly important for the outcomes of those deemed to be avoidable to ensure the themes and actions are triangulated with those from the divisional SIs to ensure learning.

Mortality Review Group

The Mortality Review Group (MRG) is now well established and to date there has been good attendance from the divisions and SJR reviewers. The group is considering how the outcomes of maternity and neonate reviews are best linked given their specialist nature.

Training

The trust currently has 11 trained reviewers in MIC, 8 in SCCS and 6 in WCCS. The focus is currently on identifying additional surgeons (cardiac, general, orthopaedic), as well as an additional medicine for the elderly consultant to undertake the training. Reviewers have requested a further half day workshop to consolidate their learning, receive additional training specific to Cerner issues, and to review ideas and issues in relation to feeding back information to teams from reviews. This workshop will be organised for the end of April, by which time we hope to have recruited the additional reviewers, and completed a sufficient number of reviews to start formulating themes.

Involving families

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

The complexity of achieving this in a meaningful way both logistically, and also at an emotional and distressing time has been recognised nationally. A two-day workshop facilitated by NHS England was held in November 2017, which brought families together with clinicians involved in mortality review, as well as CQC, NHS Improvement, and the National Quality Board. This workshop further demonstrated the complexity that is involved. A draft script has been issued that trusts are being asked to incorporate into their bereavement literature. Once this has gone through the national consultation process and has been formally ratified the trust will adopt this. However, until then we have included guidance in the bereavement pack for families on how to raise concerns, and the new learning from deaths policy includes a quick reference guide on how to involve families.

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

Next steps

- Report quarterly to Trust Board – commenced and on-going;
- Await publication of national guidance on involving families in the review process and develop processes and procedures to ensure we comply with this guidance - outstanding;
- Await confirmation of national reporting procedures, including all metrics once finalised - outstanding;
- An updated framework will be published by the National Quality Board in early 2018 and is likely to contain a number of alterations to the current process. We will need to implement these once confirmed, and may be required to make alterations to the current process that is in place - outstanding;
- Divisions to embed mortality data and reporting within divisional and directorate quality and safety boards – in progress;
- Training workshop to be organised to embed learning for SJR reviewers – in progress;

Attached – Appendix A: NQB Learning from Deaths Dashboard

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

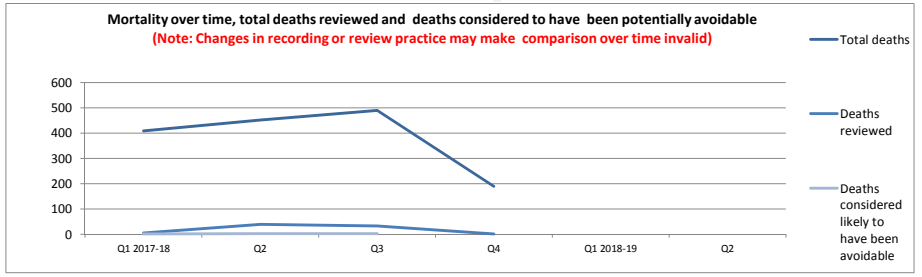
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
190	162	2	6	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
190	490	2	33	0	3
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1541	0	80	0	7	0

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



Total Deaths Reviewed by RCP Methodology Score

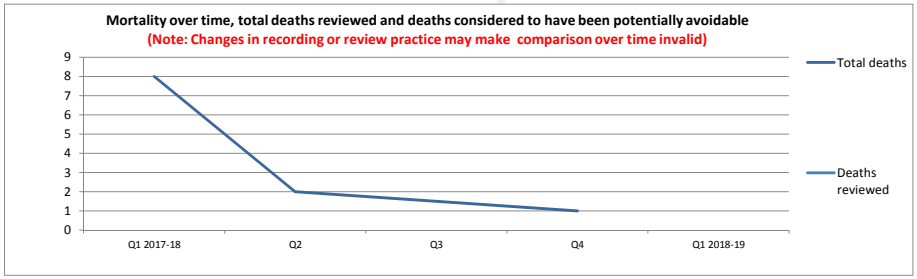
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	2	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	100.0%
This Year (YTD)	1	1.3%	This Year (YTD)	3	3.8%	This Year (YTD)	3	3.8%	This Year (YTD)	7	8.8%	This Year (YTD)	14	17.5%	This Year (YTD)	52	65.0%

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
11	0	2	0	0	0

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



Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	**28 March 2018**

Infection Prevention and Control (IPC), and Antimicrobial Stewardship Quarterly Report: Q3 2017/18

Executive summary:

- No cases of Trust-attributed MRSA BSI were identified at the Trust during Q3. There has been only one Trust-attributed MRSA BSI in the past 12 months.
- There has been an overall 8.4% decrease in antibiotic consumption from 2016/17 to 2017/18.
- Plans are in place to overhaul the way that hand hygiene compliance monitoring is performed in the Trust, transitioning from monthly ward-led hand hygiene auditing to expert and multi-professional auditing undertaken by IPC and senior Divisional staff with focussed improvement in high risk and low-performing areas.
- A higher than expected rate of SSI in patients following vascular surgery was reported by the GIRFT SSI audit (14% against a national average of 2%). This has prompted a review of SSI-prevention measures in vascular surgery, and a number of interventions.

Quality impact:

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

Financial impact:

No direct financial impact.

Risk impact:

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

Recommendation(s) to the Board:

To note.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Alison Holmes, DIPC Jon Otter, Interim Head of Operations, IPC Jan Hitchcock, IPC Interim General Manager	Dr William Oldfield, Interim Medical Director	28 February 2018

1 Healthcare-associated infection (HCAI)

1.1 *HCAI mandatory reporting summary*

	Apr-17		May-17		Jun-17		Jul-17		Aug-17		Sep-17		Oct-17		Nov-17		Dec-17		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**	YTD (ceiling)
Trust MRSA BSI	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**	**0**
Trust *C.difficile*	5	7	3	6	7	5	2	5	4	5	4	5	8	5	8	6	6	6	**47**	**50**
Trust *E.coli* BSI	6	-	8	-	6	-	5	-	5	-	5	-	10	-	10	-	5	-	**60**	**-**
Trust MSSA BSI	3	-	3	-	2	-	2	-	4	-	4	-	7	-	1	-	3	-	**29**	**-**

'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		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**	YTD (ceiling)
Trust MRSA BSI	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**	**0**
Trust *C.difficile*	5	7	3	6	7	5	2	5	4	5	4	5	8	5	8	6	6	6	**47**	**50**
Trust *E.coli* BSI	6	-	8	-	6	-	5	-	5	-	5	-	10	-	10	-	5	-	**60**	**-**
Trust MSSA BSI	3	-	3	-	2	-	2	-	4	-	4	-	7	-	1	-	3	-	**29**	**-**

'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 47 Trust-attributed cases to date this financial year (FY), against a Q3 ceiling of 50 cases to reach an annual ceiling of 69 cases; Trust-attributed *C. difficile* was detected in 1.2% of 1861 stool specimens tested during Q3 (Figure 1). The Trust has a comprehensive set of measures in place to minimise antibiotic usage, especially antibiotics that are associated with *C. difficile* infection, and to reduce the transmission of *C. difficile*. This includes multidisciplinary clinical review of all cases, rapid feedback of lapses in care to prompt ward-level learning, and, for some cases, use of the Trust's serious incident framework to investigate lapses in care related to transmission of *C. difficile* or inappropriate

antibiotic usage contributing to *C. difficile* infection. To reduce the risk of transmission of *C. difficile*, CPE, and other pathogens and to maximise the efficient use of resources, a business case for introducing an on-site hydrogen peroxide vapour (HPV) / ultraviolet (UV) room decontamination service has been approved.

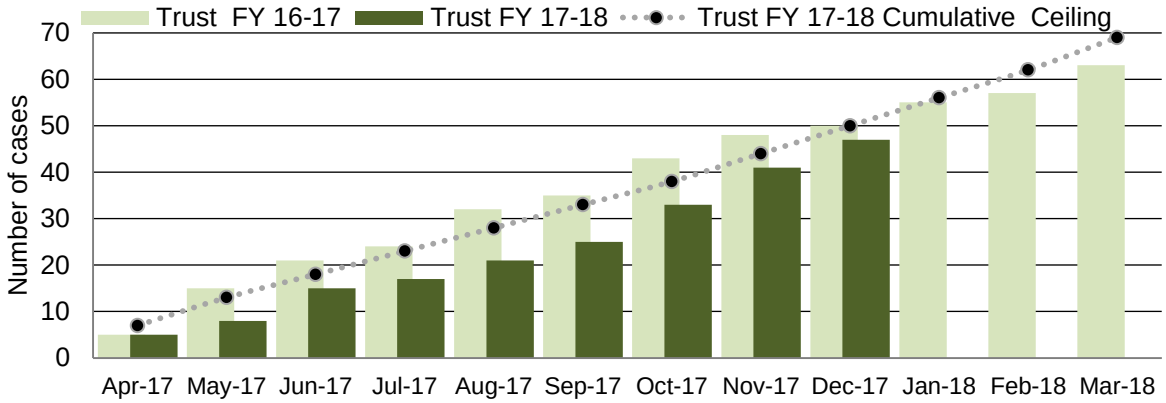


Figure 1: Cumulative monthly Trust-attributed C. difficile (PCR+/EIA+) in FY 17-18 (dark green bars) compared with FY 16-17 (light green bars).

1.2.1 *C. difficile*: lapses in care

There have been three *C. difficile* cases with a lapse in care in Q3, and four YTD, compared to eight cases of *C. difficile* with lapses in care at the same time last year. A patient in Oct-17 on a ward in the Division of Surgery was found to have a lapse in care related to antibiotic non-compliance; this was discussed with the prescriber involved. A patient in Nov-17 on a ward in the Division of Medicine had pathway crossover with another patient with *C. difficile* of the same ribotype – this potential transmission has undergone local investigation and the actions were included in the investigation into the CPE transmission on the same ward. A patient in Dec-17 on a ward in the Division of Medicine with a history of severe *C. difficile* received broad spectrum antibiotics that should have been avoided in his case. This has been discussed with the prescriber and clinical team involved (Table 2).

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total number of toxin positive cases 17/18	5	3	7	2	4	4	8	8	6
Specimens sent for *C. difficile* testing	547	615	558	553	551	589	682	597	582
Antibiotics									
No exposure	0	0	1	1	0	0	1	0	0
Prescribed as per policy	5	3	6	1	4	4	7	8	3
Outside of policy and action taken	0	0	0	0	0	0	0	0	3
Transmission									
No contact with other patients with *C. difficile*	3	2	6	1	2	4	5	5	4
Had contact with other patients with *C. difficile*	2	1	1	1	2	0	3	3	2
Lapse in care*	0	0	0	0	1	0	1	1	1

*The definition of a lapse in care associated with toxin positive *C. difficile* disease is non-compliance with the ICHT antibiotic policy, or potential transmission. Potential transmission is identified if, following a review of the patient's journey prior to the positive test, there is a point at which the patient shared a ward with a patient who was symptomatic with *C. difficile* positive diarrhoea of the same ribotype. Where there is patient contact but no lapses in care, this is because the patients had different *C. difficile* ribotypes.

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

1.2.2 *C. difficile*: time to isolation

The Trust has a policy in place to isolate patients who develop diarrhoea within two hours of the start of their symptoms. Compliance with this policy has improved compared with FY 16/17 (Figure 2). Lack of policy awareness, poor documentation around time to isolation, and lack of available side rooms for isolation are the main reasons for non-compliance with this standard. This improvement has been supported by targeted real-time education delivered by the IPCNs. This seeks to address the specific reason for non-compliance and is reinforced by a one-page training sheet, which is disseminated to the ward team. The importance of improving rapid isolation of patients with diarrhoea has also been discussed with Divisions on the weekly HCAI Taskforce call, which has prompted Divisional action to improve compliance with this policy. Lack of policy awareness and cases where the reason for failing to isolate within two hours was not documented have improved sequentially throughout this FY, suggesting that these actions are taking effect. This highlights that lack of available single rooms is now the most common reason for failure to isolate patients who develop diarrohea within two hours of the start of their symptoms.

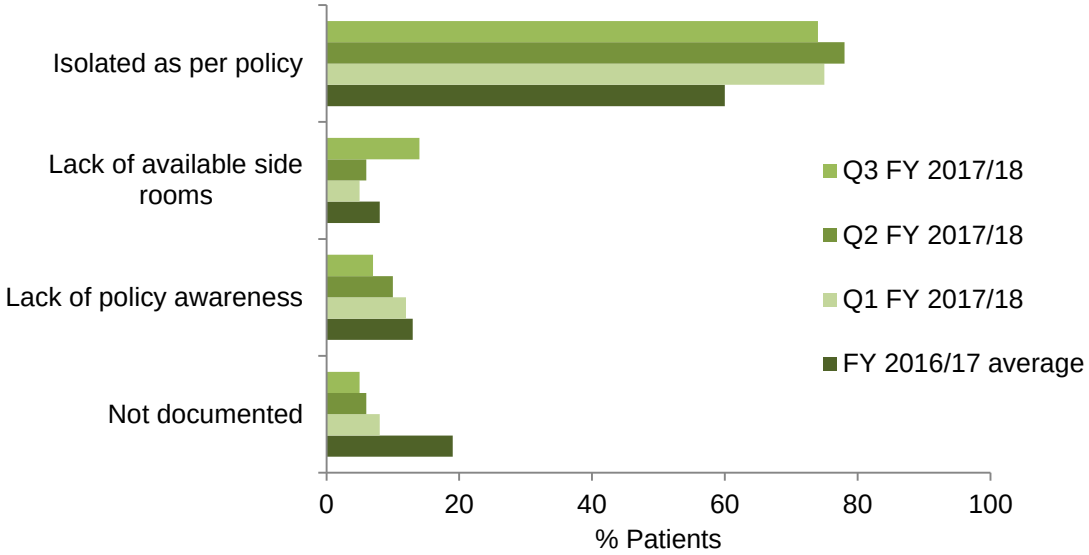


Figure 2: Compliance with isolation and reasons for non-compliance with the policy to isolate cases of diarrhoea within two hours of symptom onset for patients with C. difficile *diarrhoea.*

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

Imperial has the fifth lowest Trust-attributed *C. difficile* rate in the Shelford group of hospitals, based on 41 cases for the period Apr to Nov-17 (using the latest available data from PHE); this has improved from the last FY, where Imperial ranked 4th highest. The rate of specimens tested for *C. difficile* in the other Trusts is unknown, but remains broadly constant at ICHT.

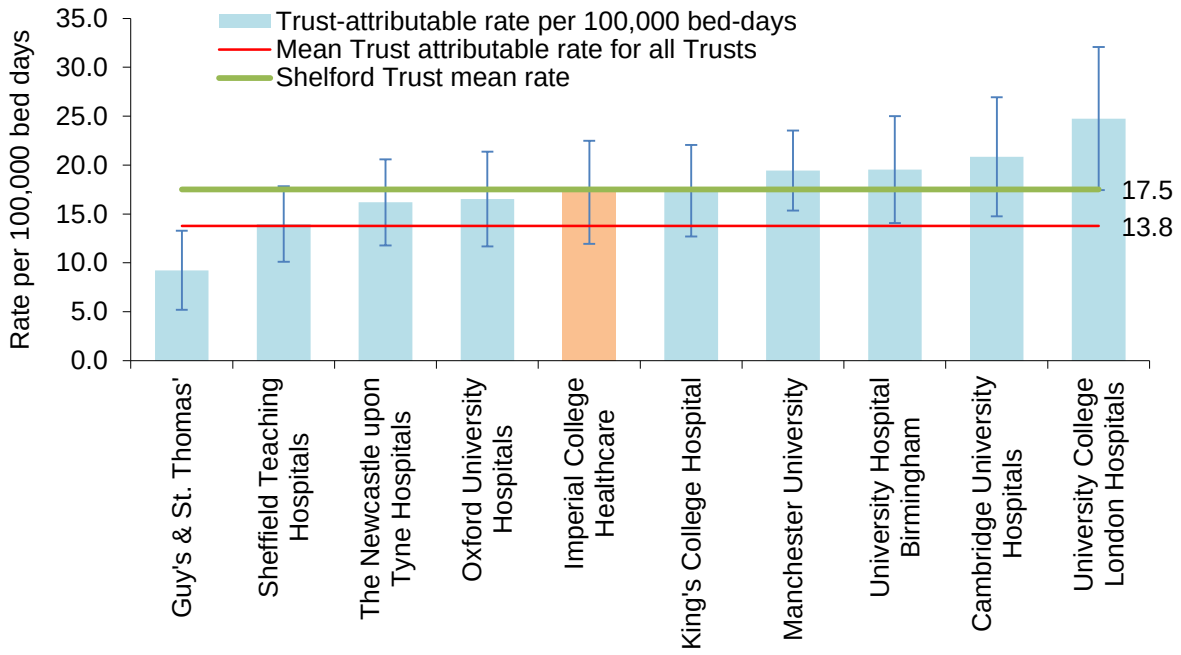


Figure 3: C. difficile *Shelford Group comparison, FY 17/18. Error bars denote the 95% confidence interval around the rate for each hospital.*

1.3 MRSA BSI

8,223 blood cultures were tested during Q3. No cases of Trust-attributed MRSA BSI were identified at the Trust during Q3. This means that there has been only one Trust-attributed MRSA BSI in the past 12 months (this case occurred in April 2017). MRSA admission screening continues to be monitored monthly via the IPC Scorecard; compliance for Q3 was 89% (8985 of 10099 patients were screened). Patient-level validation exercises of MRSA admission screening data are in progress in several clinical areas and will be concluded during Q4 to improve compliance with MRSA admission screening.

1.4 MSSA BSI

There have been 11 cases of Trust-attributed MSSA BSI in Q3, and 29 cases this FY, compared with 23 in Q1-3 of the last financial year. There is no national threshold for MSSA BSI at present. Seven cases were associated with a vascular access device (four associated with peripheral cannulae, one with an acute central venous access device, and two with an arterial catheter). Investigations suggest that practice around the insertion and maintenance of vascular access devices and non-adherence to guidelines is a contributing factor for this increase. The relevant clinical areas have local action plans in place to address this.

1.5 *E. coli* BSI

There have been 25 cases of Trust-attributed *E. coli* BSI in Q3, compared with 26 cases in Q3 FY 16/17 (Figure 4). Of these 25 cases, 9 had urinary sources (6 associated with urinary catheters), 5 were related to neutropenic patients, 5 with abdominal sources (1 biliary, 2 ischaemic bowel, and 2 intra-abdominal). The remaining 6 cases included 1 peripartum maternal sepsis, 1 case possibly related to a femoral intravascular device, 1 case in an extremely premature infant, 1 case in the perioperative period following orthopaedic surgery with no clear source found, and 2 unknown sources. In each case, clinical management was advised by a microbiologist at the time of the result becoming available. There is no national threshold for *E. coli* BSI at present. Cases of *E. coli* BSI are reviewed monthly to identify any potential trends. 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).

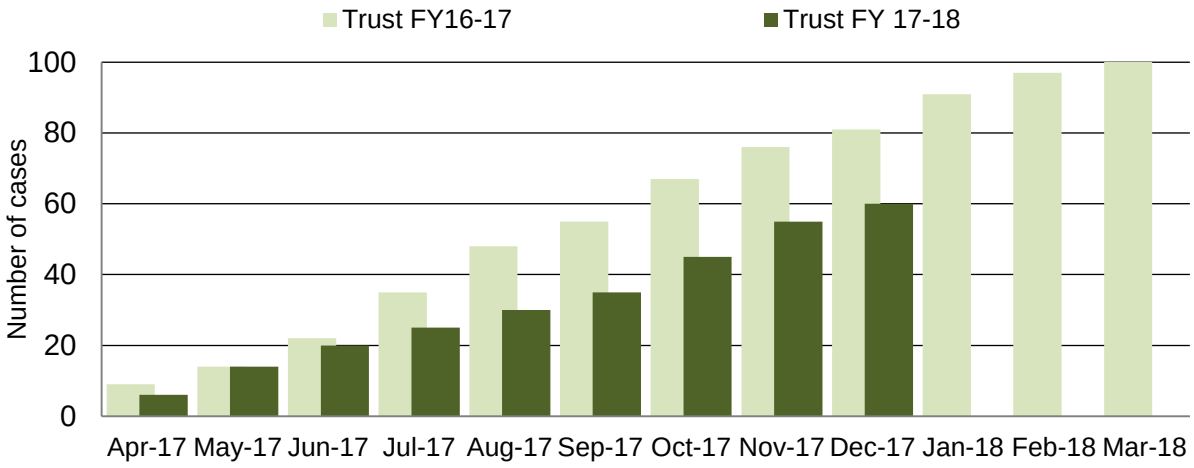


Figure 4: Cumulative monthly FY 17-18 Trust-attributed E. coli BSI (dark green bars) compared to FY 16-17 (light green bars).

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

Imperial has the fourth highest rate in the Shelford group of hospitals for the combined rate of healthcare and community-associated *E. coli,* based on 260 cases for the period Apr to Nov-17; this is the same rank as for the last FY.

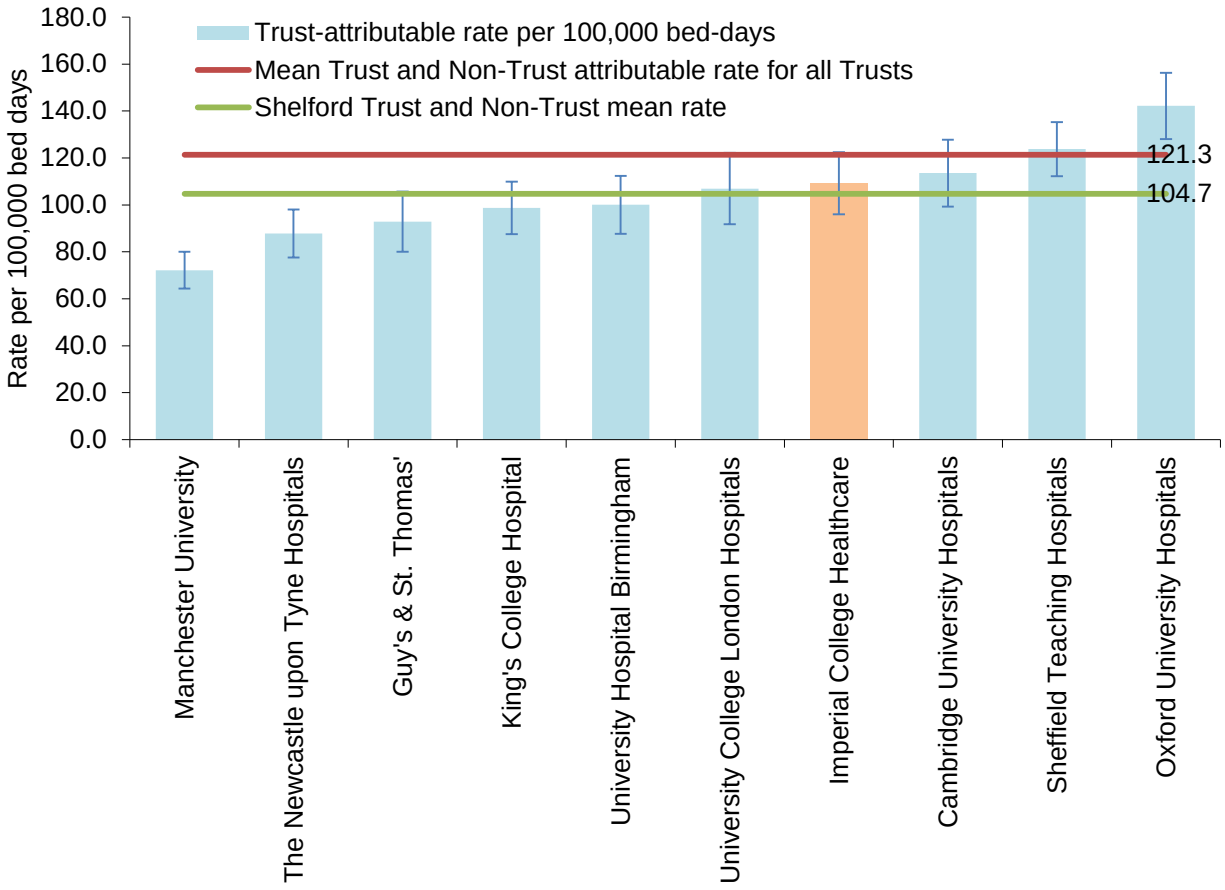


Figure 5: E.coli BSI Shelford Group comparisons, FY 16/17. Error bars denote the 95% confidence interval around the rate for each hospital.

1.6 BSI summary

The trend in BSIs (all positive blood cultures, Trust and community attributable) by organism / organism-group for Q1 – Q3 FY 17-18 is presented in Figure 6. Gram-negative bacteria predominate, with *E. coli*, accounting for approximately 37 BSI per month (median 39, range 22 to 43), and for 18.0% of all positive blood cultures. *Staphylococcus aureus* accounted for 10.0% of all positive blood cultures; MRSA accounts for 0.1% of all BSIs. Bacteraemia caused by bacteria usually associated with patients' skin and not representing infection ('contaminated blood cultures') accounted for 2.5% of 25,082 blood cultures taken during this period (Q1 – Q3 FY 17-18), which is below our local benchmark of 3%[1]. We have an ambition to assess all clinical staff for competency in aseptic non-touch technique (see section 3) to further reduce contaminants.

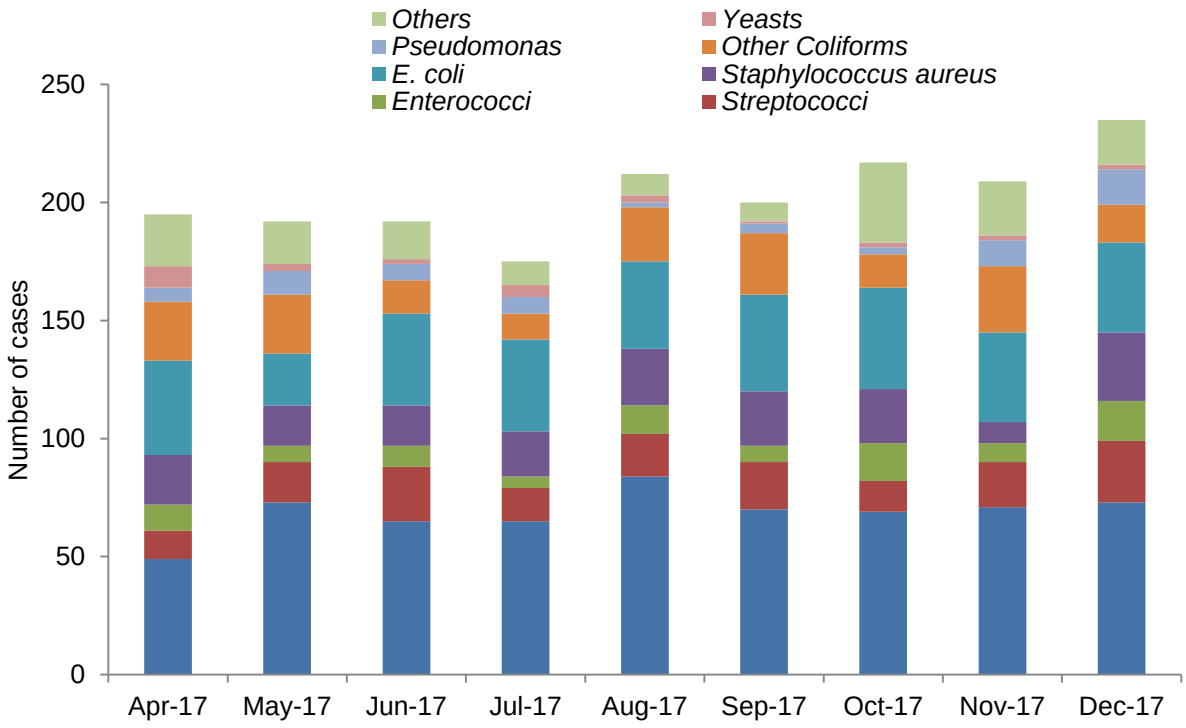


Figure 6: All positive blood cultures (Trust and community attributable) by organism / organism-group Q1 – Q3 FY 17-18.

1.6.1 Antibiotic resistance in Gram-negative BSI

The rate of antibiotic resistance in Gram-negative BSIs remains largely unchanged: 20% are resistant to extended-spectrum beta-lactams (ESBLs), 12% to gentamicin, and 23% to ciprofloxacin. There were four cases of CPE BSI in Q3 (two OXA48 (haematology and vascular) and two NDM (oncology and medicine)), bringing the total to 10 cases in FY17-18 to date. One patient with NDM bacteraemia died within 30 days, but unrelated to the infection. There were three MDR *Pseudomonas* species BSIs in Q3; none of these were 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.

1.6.2 Gram-negative BSI reduction target

[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.

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 detailed in the 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, a planning new prevention initiatives in partnership with high-risk clinical areas (for example haematology, renal, NICU, and post-surgical wards).

1.6.3 Bloodstream infection (BSI) surveillance in ICUs

1.6.3.1 BSI summary in Trust ICUs

Adult ICUs: The catheter line-associated BSI (CLABSI) rate over the past 12 months (Jan – Dec 17) is 1.3 per 1000 catheter line-days (Figure 7), which is below the benchmark of 3.0 per 1000 catheter-line days (ECDC benchmark). Split by site, the CLABSI rate is 1.2 for Charing Cross Hospital, 1.6 for Hammersmith Hospital, 1.2 for St. Mary's Hospital. There have been four CLABSI episodes during Q3 FY17-18 for all three ICUs, with the one case in Nov-17 and two cases in Dec-17 also identified as a CRBSI (Catheter-Related Blood stream infection). We continue with detailed surveillance, weekly ward rounds, ANTT competency assessments, and infection discussions with clinicians (MDT) in maintaining the low rate of CLABSI in our intensive care units.

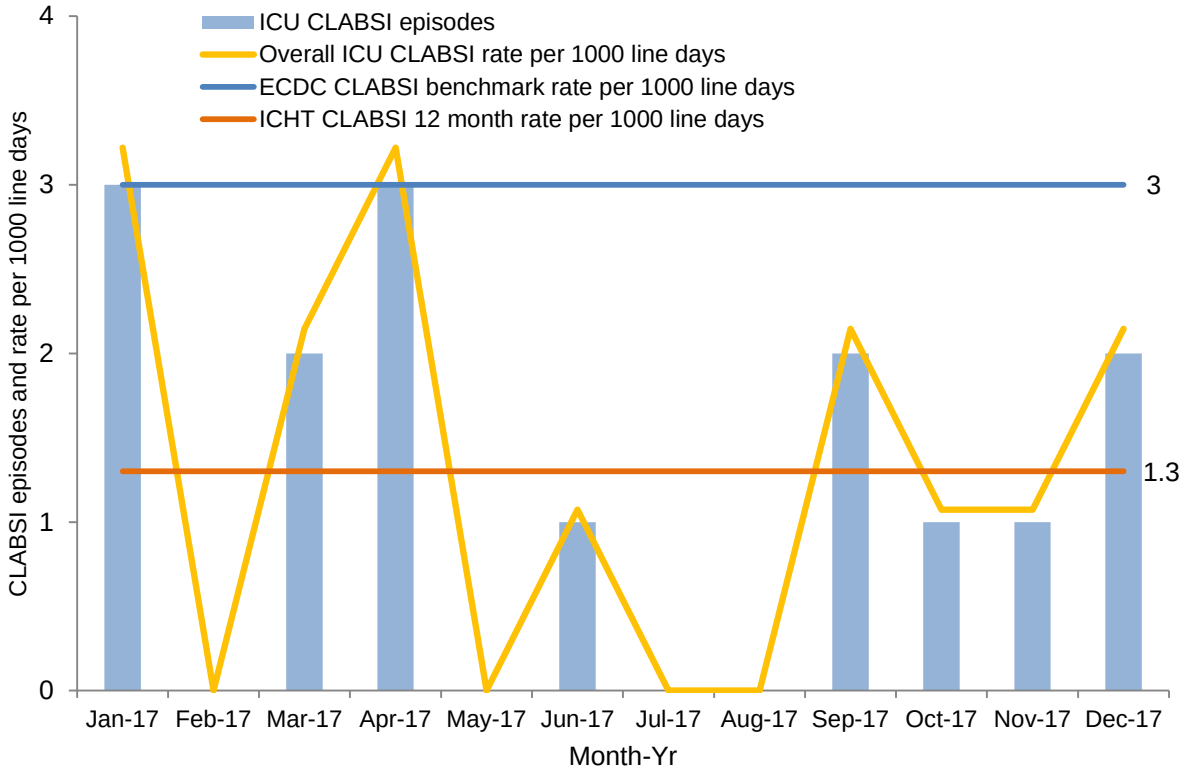


Figure 7: CLABSI episodes on the adult ICUs against the benchmark rate.

Paediatric ICU (PICU): In the 12 month period, Jan – Dec 17, PICU has seen two CLABSI episodes in 1407 catheter-line days. Both CLABSI cases were in Dec-17, with one of the CLABSI cases also a CRBSI. The 12-month rate of 1.4 per 1000 catheter-line days is below the ECDC European benchmark of 3.0 per 1000 catheter line days.

Neonatal ICU (NICU): In the 12 month period, Jan – Dec 17, the CLABSI rate on the neonatal ICU (NICU) at SMH and QCCH combined was 5.0 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 6.5 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 (Oct – Dec 17) has seen:

- Zero SSI in 85 knee procedures so far recorded.
- Zero SSI in 50 hip procedures so far recorded.

The 12-month average for knee procedures is 0.0% (zero SSI of 352 operations) (national average 0.6%). The 12-month average for hip procedures is 0.9% (2 SSI of 204 operations) (national average 0.6%).

1.7.2 Cardiothoracic

The latest quarter (Oct – Dec 17) has seen:

- 1 SSI of 63 CABG operations so far recorded.
- 1 SSI of 35 non-CABG operations so far recorded.

The 12-month average for CABG procedures is 3.8% (12 SSI of 317 operations) (national average 3.7%). The 12-month average for non-CABG procedures is 1.2% (2 SSI of 223 operations) (national average 1.2%).

1.7.3 Getting It Right First Time (GIRFT) SSI audit

The GIRFT SSI audit concluded in October 2017. Final data from the participating specialities (obstetrics and gynaecology, breast, ENT, general, ophthalmology, paediatrics, and vascular) has been reviewed at the Surgical Infection Group. The audit has prompted the development of a surgical wound review form in Cerner, due to be launched in the coming weeks, which will provide a mechanism for Trust-wide surveillance of SSI.

1.7.4 Vascular SSIs

A higher than expected rate of SSI in vascular was reported by the GIRFT SSI audit (14% against a national average of 2%). This first came to light in July 2017 when the interim results of the GIRFT SSI audit were published, and was finalised in November 2017, when the GIRFT SSI audit was completed. This has prompted a review of SSI prevention measures in vascular surgery that began based on the interim results of the GIRFT SSI

audit. A number of interventions around improving patient bathing prior to surgery (including implementing chlorhexidine bathing), providing assurance around antibiotic prophylaxis, and improvements in wound care post operatively have been implemented. The resulting action plan has been presented at the Surgical Infection Group and will be included in the SI related to this issue and cross transmission of CPE on the vascular surgery ward at SMH (STEIS 2017/19226).

1.7.5 SSI: implementing semi-automated surveillance

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

1.8 *Carbapenemase-producing Enterobacteriaceae (CPE)*

1.8.1 Detection of CPE

Risk-factor based screening of all admissions was introduced in June 2015 to extend universal screening that was being performed in high-risk specialties. Figure 8 provides a breakdown of CPE detected at the Trust by bacterial species and mechanism of resistance. The majority of cases are from screens, without evidence of clinical infection (Figure 9). The number of screens taken each month increased sharply over Q1 and Q2 but plateaued during Q3.

1.8.2 CPE admission screening compliance

CPE admission screening compliance is summarised in Figure 9. CPE admission screening compliance is included by ward in the monthly Harm Free Care report, providing a mechanism to prompt ward-level action to address areas of low compliance. A target of 90% compliance with CPE admission screening has been agreed. Whilst the trend overall is improving compliance, compliance has fallen in some high-risk specialities (vascular and private patients) in December 2017. Vascular and private patients are reviewing patient level data for December 2017 to understand why this dip in compliance has occurred in order to develop local actions to improve compliance.

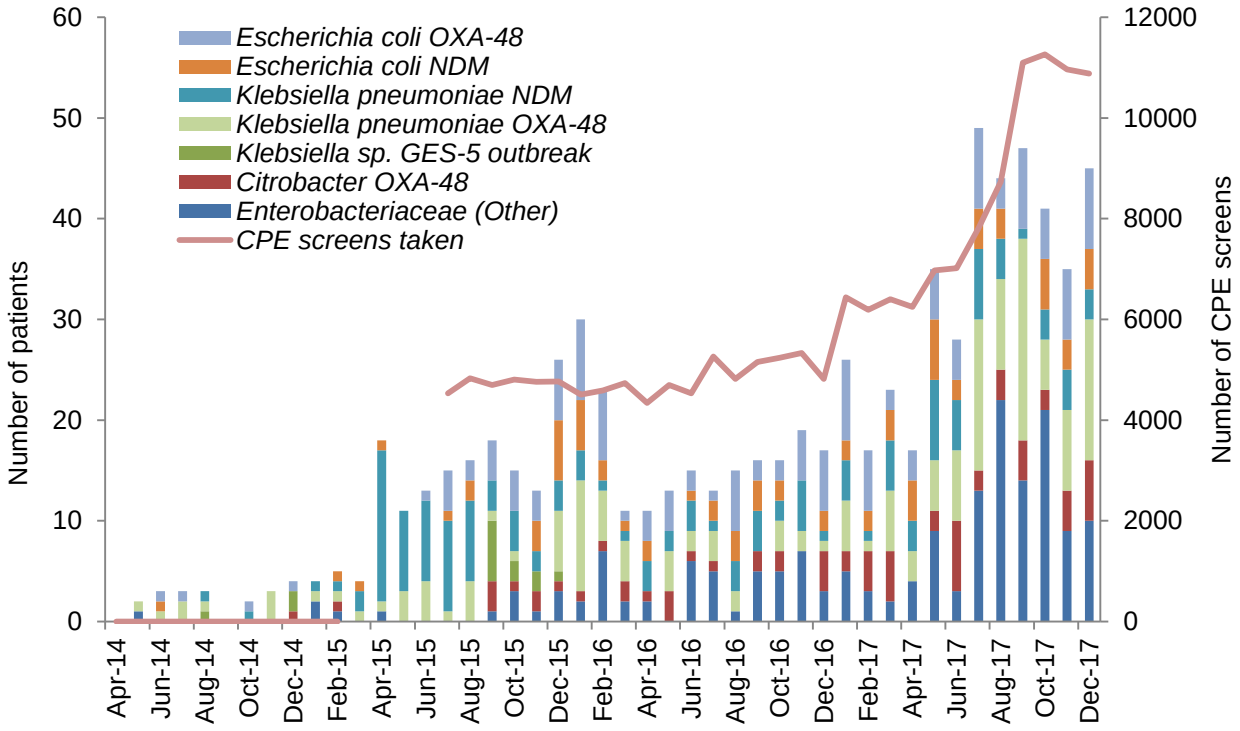


Figure 8: CPE detected at the Trust, by bacterial species and mechanisms, deduplicated by patient.

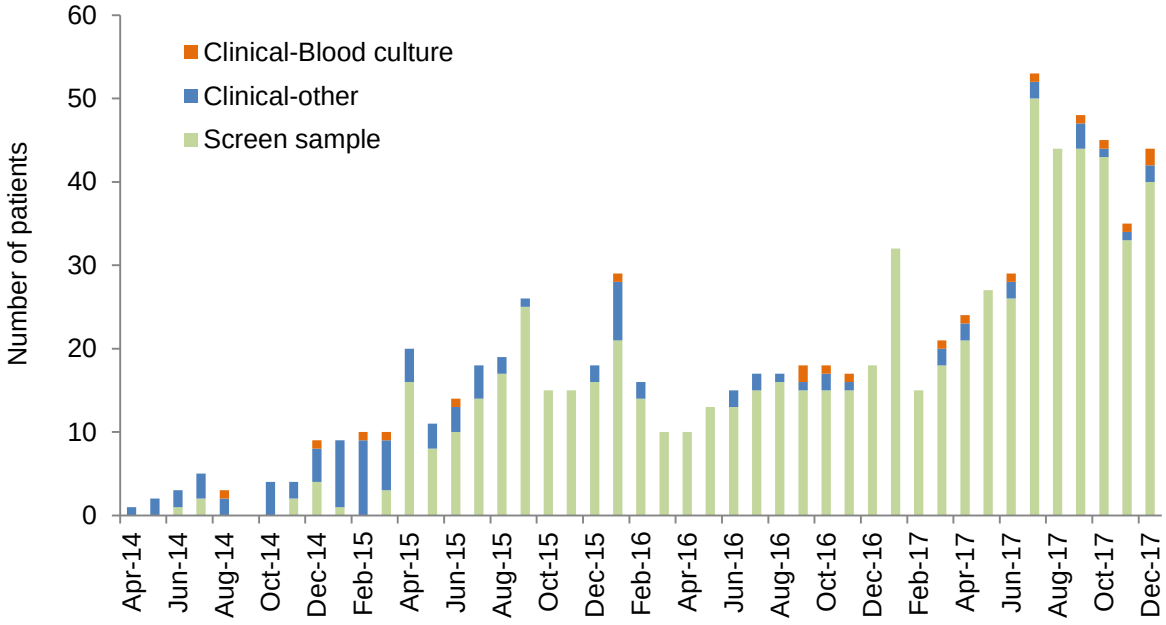


Figure 9: CPE detected at the Trust by culture type.

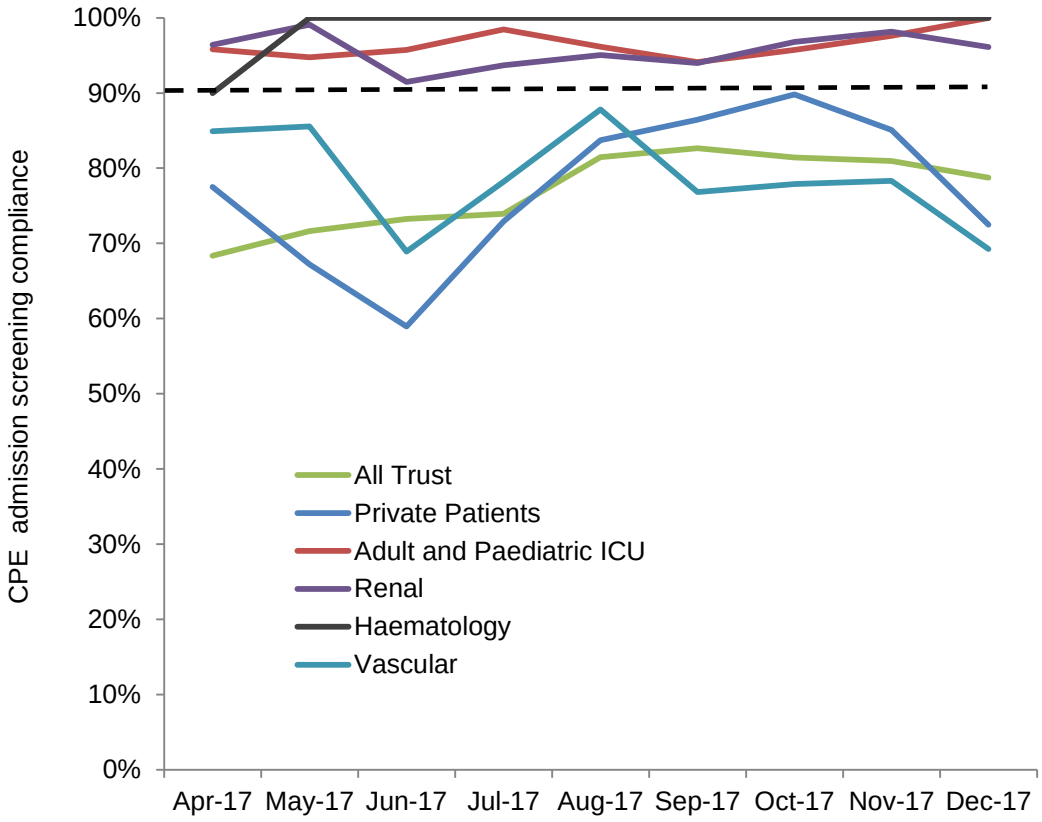


Figure 10: CPE admission screening compliance. Adult and paediatric ICU, renal, haematology, and vascular are performing universal admission screening; private patients and the rest of the Trust are performing risk-factor based admission screening. The dotted line represents the target of 90% compliance.

1.8.3 Increased incidence of CPE detection across the organisation.

There has been an increased incidence in detection of CPE across the Trust in Q3. Several different epidemiologically-linked clusters have been identified, where isolates from routine screening samples were found to be indistinguishable on typing and cross transmission is suspected:

- In October two patients on a medical ward had *Citrobacter* species KPC (a type of CPE) identified.
- In November four patients on a medical ward had *Citrobacter freundii* OXA-48 (a type of CPE).
- In November two patients on a medical ward had *Enterobacter cloacae* OXA-48 (a type of CPE).
- In December three patients on a medical ward had *Klebsiella pneumoniae* OXA-48 (a type of CPE).
- In December three patients on a vascular surgical ward had *Klebsiella pneumoniae* OXA-48 (a type of CPE). Typing is pending but it is likely that this incident is related to a previously known cross transmission incident on this ward in Q2.
- In December four patients on a medical ward had *Klebsiella pneumoniae* OXA-48 (a type of CPE). These were found to be linked to a previous cross transmission incident on this ward in Q2. None of the patients had CPE infections. Patient outcomes are assessed during incident investigations.

1.8.4 CPE Action Plan

In response to the Trust-wide increase in the detection of CPE, the CPE Action Plan has been revised. This is to provide additional focus on reducing acquisition; improving screening; optimising laboratory methods for CPE detection; enhanced epidemiology and surveillance (including a focus on increasing compliance with CPE admission screening); improving ward-level IPC practice (including the development of specific criteria for ward re-opening in the event of a CPE outbreak, reviewing toilet ratios, usage and access, and reviewing cleaning standards); and optimising antimicrobial strategies for CPE management and treatment (including the implementation of a new report from Cerner relating to patients on carbapenem antibiotics).

2 Antibiotic stewardship

2.1 *Assurance regarding quality of antibiotic prescribing*

The next biannual antibiotic point prevalence study (PPS) will be undertaken in February 2018. The last PPS was undertaken in August 2017 and showed an average compliance of 93% with antimicrobial prescribing and quality indicators (against a target of 90%).

2.2 *Antibiotic consumption*

2.2.1 Antimicrobial shortages

The Trust continues to experience critical antimicrobial shortages of a number of agents including piperacillin/tazobactam, ceftriaxone, amikacin, meropenem, gentamicin, cefuroxime, ceftazidime and vancomycin. The Infection Pharmacy team are managing these shortages together with microbiology colleagues and releasing stock where appropriate on a patient by patient basis.

We continue to report our antibiotic usage to Public Health England (PHE) and participate in their national programme, facilitating benchmarking and helping to drive improvement. Antibiotic consumption data from 2016 up to the end of Q3 has been submitted to PHE and a 2% reduction in consumption (as measured by total antibiotic DDDs/1000 admissions) for piperacillin/tazobactam and carbapenems has been requested for 2017/18. The Trust continues to take part in the 'Reducing the impact of serious infections CQUIN' supported by a fixed term infection pharmacist position.

In Q3, the Trust had an increase in its overall consumption of antibiotics compared with Q2 with a total of 6912 defined daily doses (DDD) per 1000 admissions. Similar increases in antimicrobial consumption were observed in Q3 in previous years and it is thought that this is to do with increased acuity of patients and increased antibiotic procurement in December (Figure 11).

Despite the seasonal increase, we are still on trajectory for achieving our 2% CQUIN target reduction for total antimicrobial DDDs/1000 admissions. Overall there has been an 8.4% decrease in the CQUIN-reported antibiotic consumption from 2016/17 to 2017/18 (YTD).

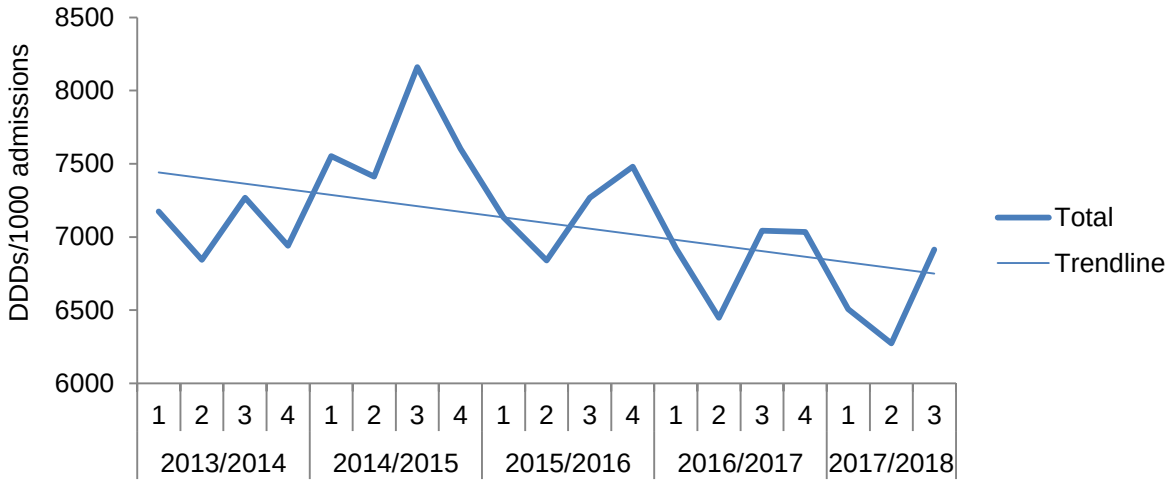


Figure 11: Trust wide antibiotic consumption (DDD / 1000 admissions) 2013 – present.

2.2.2 Investigations to understand reasons for variation in antibiotic consumption

In order to understand what is causing the Q3 increase and to develop focussed actions to reverse the trend, the CQUIN-funded pharmacist has developed new analytical methodology to provide a breakdown of antibiotic usage by the classes of antibiotics used, by speciality, and by route of administration (inpatient or outpatient). This has been shared with the Divisions. The following areas are within the top 10 antimicrobial users and may benefit, subject to appropriate resourcing, of targeted stewardship rounds: stroke and neurosciences, acute and general medicine (CXH) and Emergency Department. These areas have been discussed within the Medicine IPC group and work is planned to examine the data and identify areas for improvement.

The greatest increase in antimicrobial consumption during Q3 was for oral antibiotics (Figure 12). However the overall trend is that oral antimicrobial consumption is decreasing but intravenous (IV) usage remains steady. This may reflect the increased complexity of infections and lack of effective oral agents available to treat multidrug resistant bacteria. However this needs further investigation to ensure that opportunities for intravenous to oral switch are exploited where clinically appropriate. This data has and will continue to be used along with antibiotic resistance data and local point prevalence findings to help target stewardship interventions and work with the Divisions to drive improvement through their IPC and quality committee governance structures.

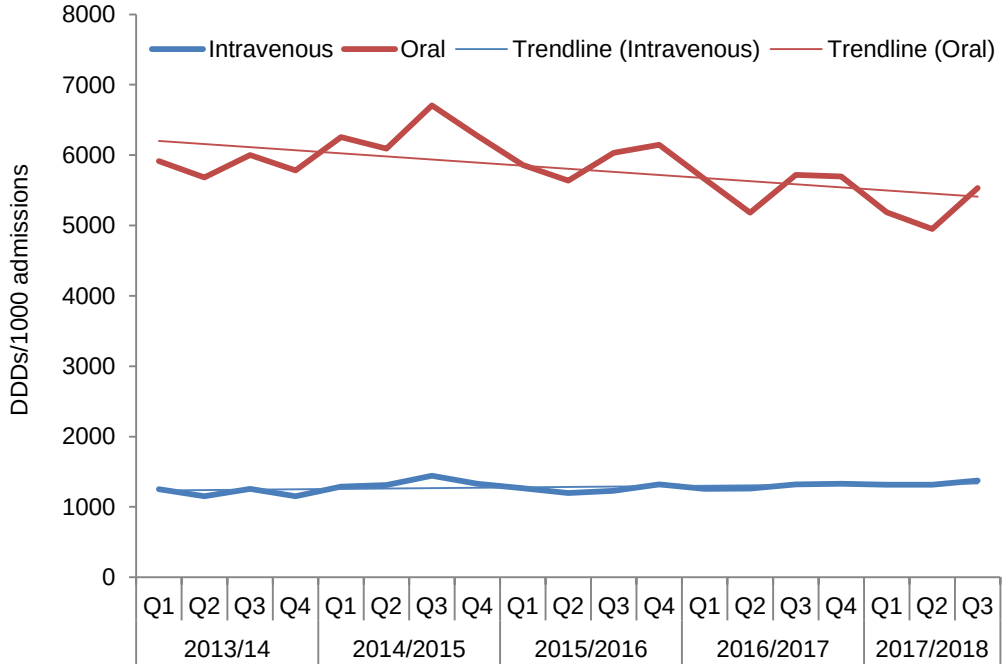


Figure 12: Trust wide antimicrobial DDD / 1000 admissions 2013 – present by route.

2.2.3 Piperacillin/ Tazobactam (Tazocin®) / Carbapenem consumption

A 2% reduction in consumption of Piperacillin/Tazobactam (Tazocin®) and carbapenems by the end of the 2018/19 financial year has been requested as part of the CQUIN. Piperacillin/Tazobactam has reduced by 96% in Q1, 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. As a result use of Piperacillin/Tazobactam has increased in Q2 and Q3 (Figure 3). In order to ensure that the use of Piperacillin/Tazobactam does not return to pre-shortage levels, its usage (outside of the treatment of neutropenic sepsis in haematology and oncology patients) must be authorised by the infection team.

Compared with Q3 2016/17, the Trust has seen a 20% increase in carbapenem consumption, most likely due to antimicrobial shortages and lack of alternative agents in Q1 17/18 combined with the challenge of treating multidrug resistant Gram-negative infections. In order to address the overall increasing trend of carbapenem usage in recent years, it is expected that the Trust will have electronic Cerner antimicrobial patient specific reports in Q4. This will highlight patients prescribed carbapenems for review to aid efforts to reduce carbapenem consumption.

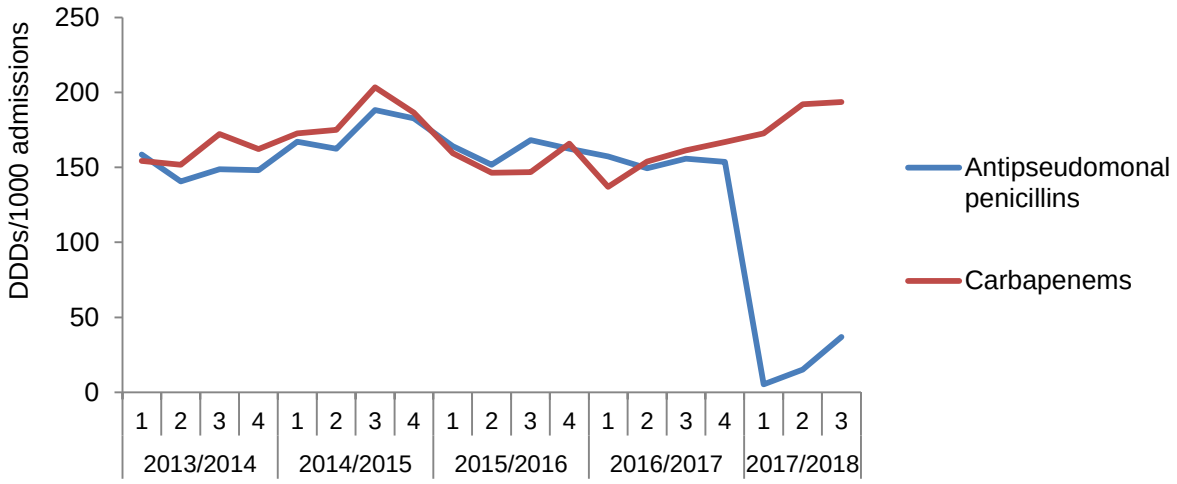


Figure 13: Trust wide Piperacillin/Tazobactam and carbapenem DDD / 1000 admissions 2013 – present. The two year CQUIN began in Q1 2017/18 and runs to the end of the 2018/19 FY.

2.3 *Antibiotic expenditure*

Trust-wide there was an average spend of £864k per quarter on antibacterials and £648k on antifungals in 2017/18 YTD. The increase in antibacterial costs in Q2 and Q3 (Figure 14) is due to the antibacterial drug shortages, which led to the need to procure a number of agents off-contract to provide access to alternatives in line with the Trust's antibiotic guidelines. However, this cost pressure related to antibactieral shortages would have been considerably larger (projected to be £965k) if the restriction and re-introduction of Piperacillin/Tazobactam had not been tighly controlled. This £965k in averted cost combined with the financial value of the overall reduction in antibiotic usage is likely to have improved the finanical position of the Trust for the 201718 FY by £1.1 million.

Further, there is a pan-London contract for echinocandins where cost is calculated on a volume based matrix of drug usage. From 1st September 2017, the cost of anidulafungin and micafungin decreased. There has been a corresponding decrease in antifungal expenditure in Q3. The high cost antifungals are funded by NHS England with the exception of patients within 90 days of renal transplant or bone marrow transplant.

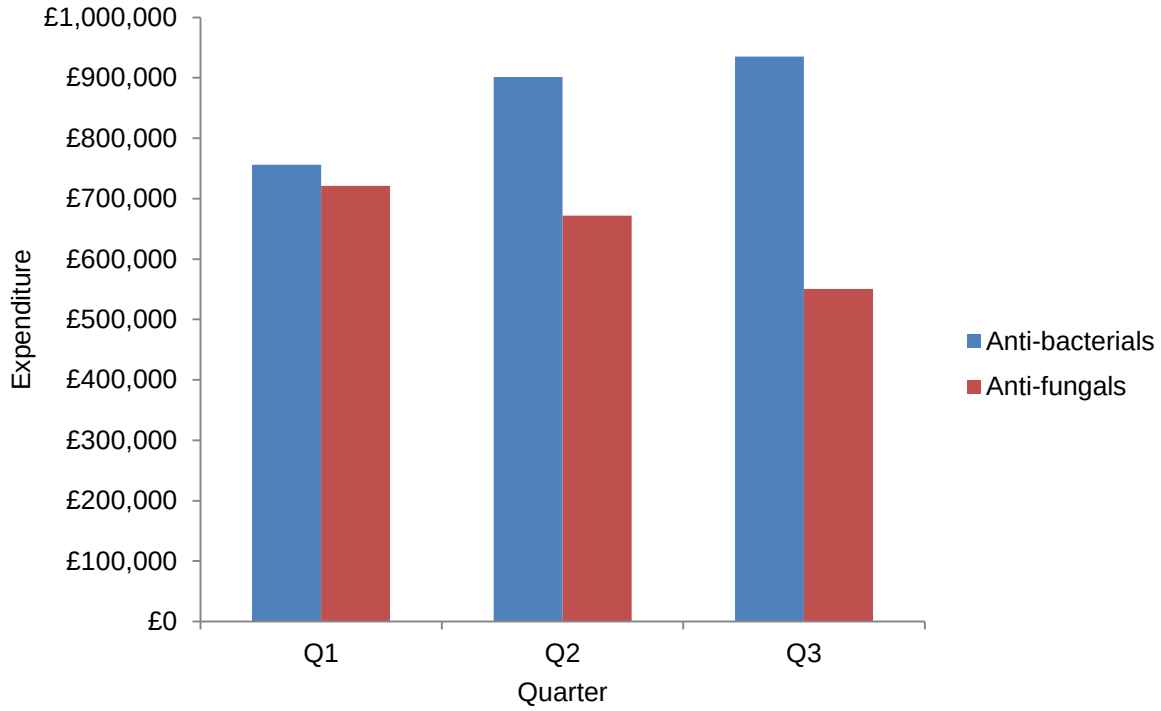


Figure 14: Antibiotic expenditure for inpatients and outpatients by quarter 2017/18 FY to date.

2.4 *Antibiotic Review Group*

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

In Q3 the ARG reviewed the following:

- Trust antimicrobial therapeutic substitution guideline.
- Anti-infective Guideline – First Line Drug choice for Children presenting with Specific Infectious Syndromes.
- Anti-infective drug dose table for children.
- Updated Trust antifungal guideline.
- PGD for the administration of metronidazole in patients undergoing hystero-salpingogram.
- PGD for the administration of azithromycin to patents undergoing hystero-salpingogram.
- PGD for Piperacillin/Tazobactam in neutropenic sepsis.
- Occupational Health Patient Group Directives (PGD):
  - Bacillus Calmette-Guerin (BCG) vaccine.
  - Hepatitis B vaccine.
  - Influenza vaccine.
  - MMR vaccine.
  - Varicella zoster vaccine.
  - Tuberculin purified protein derivative for Mantoux testing.

The Adult Treatment of Infection guideline was due for full review in December 2017 but the review date of the guideline was extended by ARG to June 2018 following an interim review of the guidelines. The interim review resulted in the inclusion of a recommendation that patients with CPE requiring antibiotic treatment are discussed with the infection team. This is to avoid mono-therapy treatment, resistance and treatment failure for this cohort of patients. The delay in reviewing the guideline has been caused by staffing pressures within the

Infection service, laboratory service contract changes due to the launch of North West London Pathology, and delays in the provision of antibiotic resistance data. There is now a process in place for North West London Pathology to provide access to antibiotic resistance data, although this will require analysis to put into a usable format.

2.5 *Sepsis*

The identification and clinical management of sepsis remains a Trust priority. The National Early Warning Score (NEWS) provides a standardised Trust approach for the identification and management of sepsis. In order to support this process, a sepsis module in Cerner is currently being piloted within the Trust and will be followed by a Trust-wide launch and post-launch improvement work. The module supports clinical staff in early recognition and management of sepsis, incorporating Trust Adult Treatment of Infection Guidelines and sepsis management principles. Reports from the module related to the time to prescribing antibiotics and other metrics are now available to help drive improvement around sepsis management, thus supporting antimicrobial consumption reduction.

The number of sepsis alerts, review forms completed, and confirmed cases of sepsis in the pilot areas (emergency departments at CXH and SMH) from October 2017 to January 2018 is shown in Figure 15. This shows that the number of sepsis alerts has increased over this period, which may be related to seasonal changes in A&E admissions and acuity. Figure 16 shows the proportion of patients who received antibiotics within one hour of the alert firing in all areas where the alert is live (emergency departments and acute admissions wards at CXH and SMH, and haematology wards at HH). This shows that around 50% of patients in whom the sepsis alert fires receive antibiotics within one hour (or were already on antibiotics prior to the alert firing). The initial CQUIN target for this metric is 50%. These metrics are being fed back to ward areas where the sepsis alert is live to provide a feedback loop for local improvement initiatives.

A revision of the Trust sepsis policy is being undertaken via a multi-stakeholder engagement process. The alert will be rolled our across the organisation during Q1 of the 2018/19 financial year. There is currently no additional resource allocated to support this roll-out.

The Cerner sepsis module is currently being evaluated by a team of academic researchers working in collaboration with ICHT sepsis and Infection clinical theme leads. The BRC-funded research aims to model and quantify outcomes for a patient cohort to determine the impact of introduction of the sepsis module.

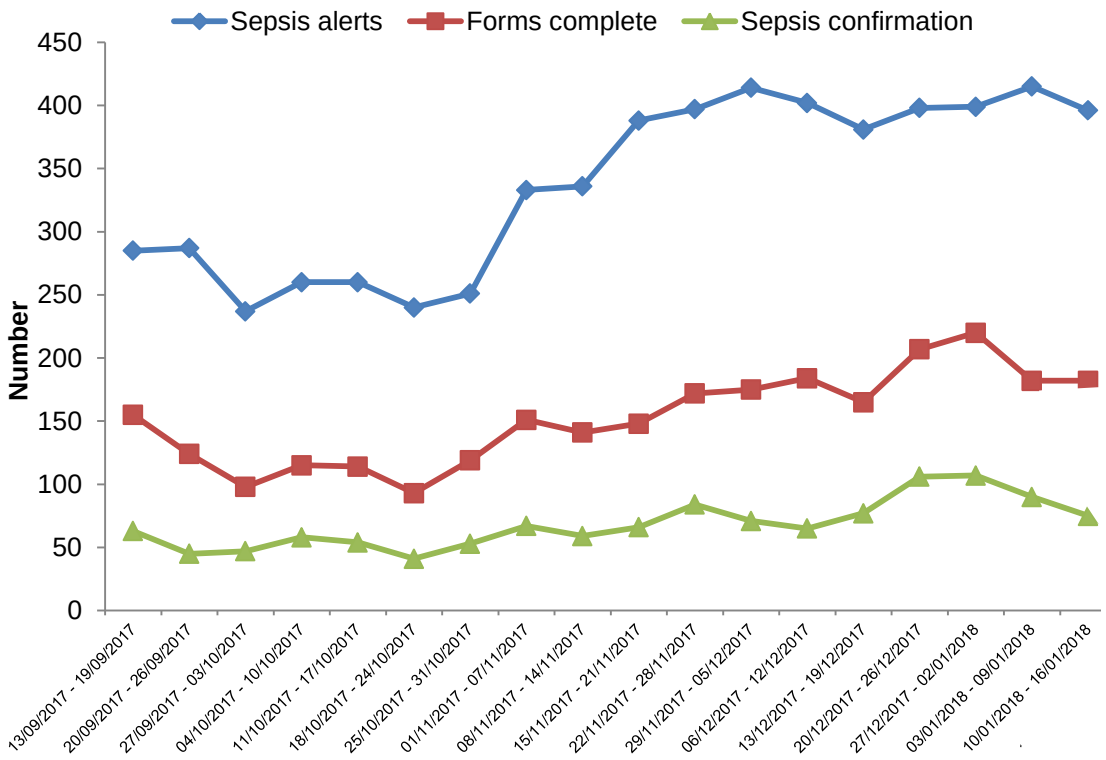


Figure 15: Sepsis identification – the number of sepsis alerts, review forms completed, and confirmed cases of sepsis in the emergency departments at CXH and SMH from October 2017 to January 2018.

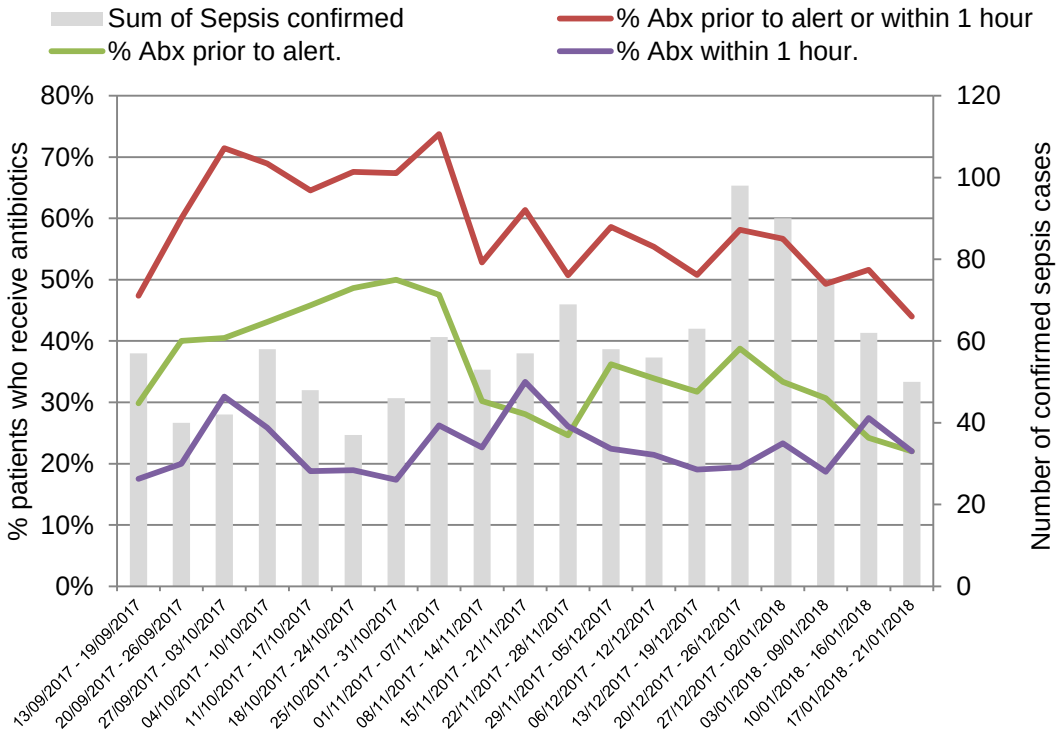


Figure 16: Sepsis management – the proportion of patients who receive antibiotics within one hour of the alert firing in all areas where the alert is live (emergency departments and acute admissions wards at CXH and SMH, and haematology wards at HH).

3 Aseptic Non Touch Technique (ANTT)

The Trust has a requirement that ANTT assessment is undertaken and documented for all staff working in a clinical environment. ANTT has become the term to describe an umbrella of local competency assessment approaches including i) practical assessment of hand hygiene ii) the use of personal protective equipment for all staff who work in a clinical setting, and iii) assessment of Aseptic Non-Touch Technique (ANTT) for staff who require this skill. The target for compliance with ANTT training for Trust clinical staff is set at 95%; currently the compliance rate has plateaued at 75.8% (5986/7897 clinical staff). During Q3, 1250 clinical staff were assessed, which is an average of 416 per month. The revised policy for ANTT has been agreed. The management of ANTT compliance for staff has been devolved to the Divisions, so that they can have increased visibility of individual-level compliance to drive improvement. Initial plans to improve compliance are focussing on cleansing the HR database to ensure that staff who are no longer in the Trust and those with honorary contracts are not included in the assessment of compliance with ANTT and other core skills. ANTT improvement plans for each Division will be developed during Q4.

4 Hand hygiene

4.1 *Moving from auditing Moment 1 to auditing all 5 Moments for hand hygiene*

The Hand Hygiene Steering Group (HHSG), a multidisciplinary group of doctors, nurses, data scientists, led a pilot implementation and improvement audit of the WHO 5 Moments (Figure 17) in three wards on the St. Mary's site in 2016. This demonstrated feasibility of auditing all 5 Moments on a routine basis, and suggested that the result would be lower levels of compliance initially followed by improvement. However, when the 5 Moments auditing was rolled out across the Trust in April 2017, despite a focussed effort around education of hand hygiene auditors and the proposed use of peer-auditors, compliance remained high: overall compliance for hand hygiene for May – September 2017 was 97% (n=32,505 observations). These audit findings were not consistent with observed practice during inspections by the CQC and others, and by IPC during outbreak investigations.

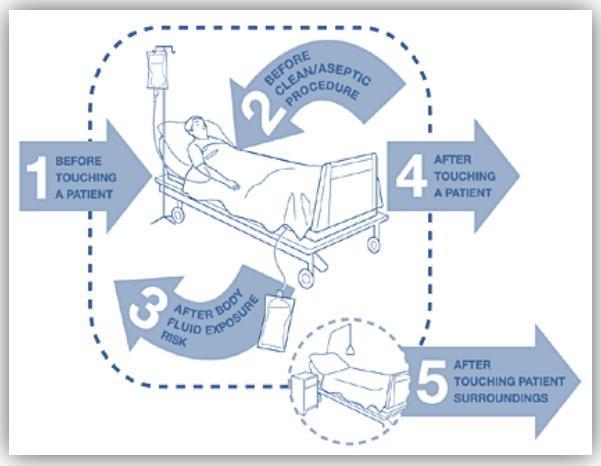


Figure 17: The WHO's 5 Moments for Hand Hygiene.

4.2 *IPC validation audits*

The IPC team performed validation hand hygiene audits over the month of September 2017 in a selection of wards across the Divisions. This was to compare compliance reported by wards with audits performed by the IPC team. Overall compliance was 56% in the IPC audits (122 compliant observations from a total of 223), compared with 97% (457 compliant observations from a total of 471 observations) as reported by clinical areas on Synbiotix (Figure 18). IPC and the DDNs agree that the monthly hand hygiene audit data recorded on

Synboitix by ward staff in most clinical areas is not an accurate marker of good hand hygiene practice, and so is likely to be offering false assurance. These findings suggest that a new approach to hand hygiene auditing is required.

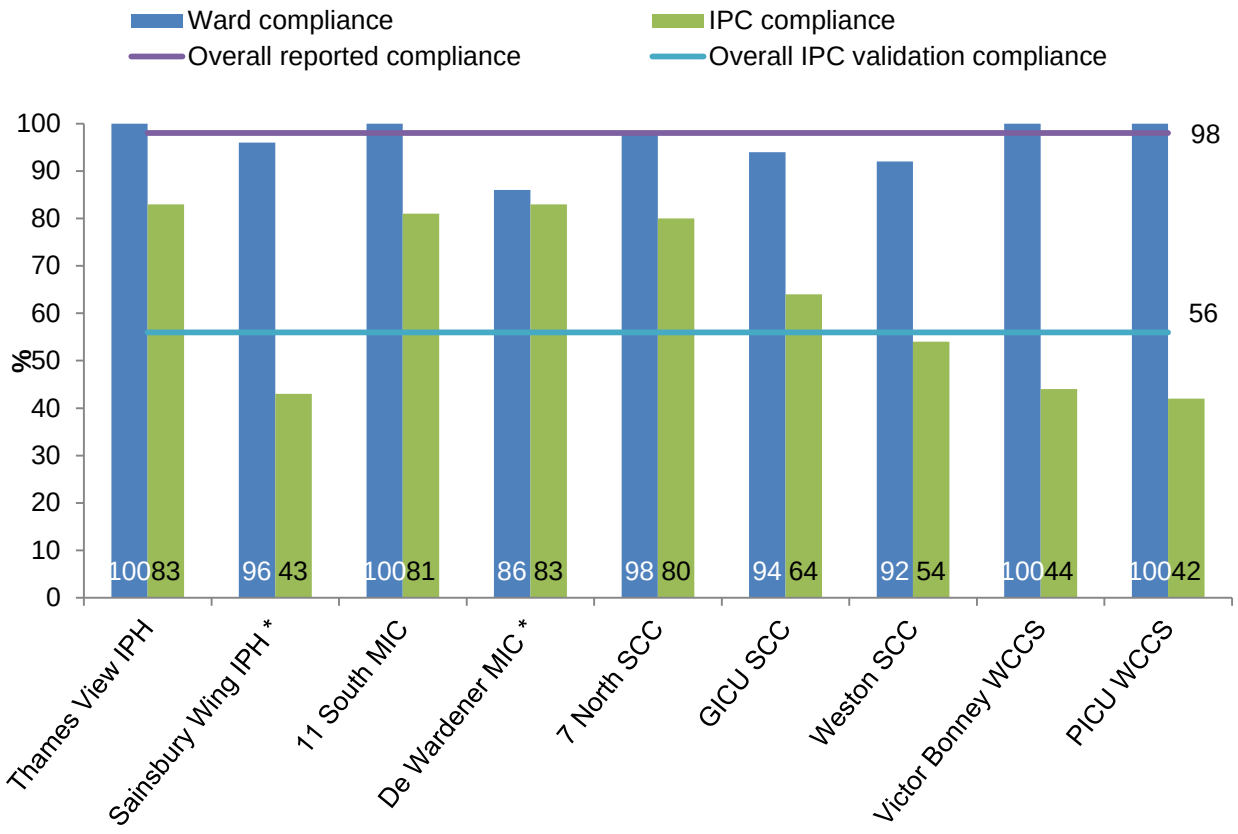


Figure 18. Hand hygiene compliance in September 2017: ward audits versus IPC audits (n=223 observations for the IPC validation audits, and n=471 for the data on reported from clinical areas on Synbiotix).

Discussions with peer Shelford organisations has identified hand hygiene audit programmes ranging from regular auditing in all clinical areas (with similar concerns around data validity as expressed in this paper), to no Trust-wide hand hygiene audit programme but instead a specific focus on a small number of clinical areas only.

4.3 *Next steps*

Discussion between IPC, the Divisions, and the Improvement Team has concluded that an overhaul of hand hygiene compliance monitoring is required to obtain valid compliance data in order to support improvement initiatives. The proposal is to transition away from monthly ward-led hand hygiene auditing to expert auditing undertaken by IPC and senior Divisional staff.

The principles of the new hand hygiene auditing approach will be as follows. IPC and senior staff from each clinical area (at the lead nurse, GM, and Head of Specialty level) will undertake an audit covering each clinical area once each year. In order to reduce operational impact, the clinical areas in the Trust will be divided into four and the audit data collected and reported quarterly. High risk areas will be prioritised in the first round of auditing. Ward-led hand hygiene auditing will continue in a small number of high risk areas (e.g. the ED at SMH).

In clinical areas where hand hygiene compliance is found to be low, a variety of improvement packages will be implemented. The hand hygiene steering group, with appropriate Divisional representation, will be vital for improving hand hygiene practice, and ensuring that learning is captured and shared. Improvement measures will be tailored to each clinical area, but key principles will be conserved. We will build on the pilot improvement work at the SMH ED and in other areas, including regular feedback of audit data, new communications materials, and some qualitative work to understand barriers to effective hand hygiene. The improvement package will include some additional costs around new promotional materials. This programme will commence in April 2018.

5 Serious incident investigations

Serious incidents (SIs) reported during Q3 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 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 81% (up from 76% in Q2), and with Level 2 is at 82% (up from 79% in Q2). 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 Q3:

- CJD policy.
- Decontamination policy.
- Infection prevention clinical competency assessment for patient safety, including hand hygiene, the use of personal protective equipment, and aseptic non touch technique policy.
- Skin-tunnelled catheter central venous access device for adults guideline.
- Non-tunnelled central venous catheter (acute CVC) guideline.
- Peripheral venous catheter guideline (adult).
- Implantable port central venous access device guideline.
- Midline continuing care guideline (adult).

Policies and Guidelines requiring review during Q4:

- Viral haemorrhagic fever policy, and Ebola virus disease clinical guideline.
- Blood culture guideline.

Table 3: HCAI-related SIs reported during Q3.

STEIS	Location	Summary	Date reported	Lessons learnt
2017/11780	7N	CPE (*Klebsiella pneumoniae* NDM)	19/04/2017	1. Ensuring enhanced ward cleaning is implemented effectively and reflected in scheduled and unannounced cleaning audits 2. Awareness of the policy and practice relating to the management of patients with CPE organisms 3. Improve the environment to enable effective cleaning and IPC practice
2017/11143	NNU	Parainfluenza	19/04/2017	1. Development of a flow chart for processing urgent samples, and their transport to the virology laboratory at Charing Cross Hospital. 2. Training at junior doctor induction for respiratory virology samples
2017/17331	HJW	CPE (*Citrobacter freundii* OXA48)	19/06/2017	1. Improve the process for microbiology cross infection turnaround times 2. Improve the practice relating to the isolation of patients with infections in single rooms 3. Awareness of the policy and practice relating to the use of personal protective equipment
2017/16902	15N	CPE (*Citrobacter freundii* OXA48)	08/05/2017	1. Inconsistent approach to CPE screening. 2. ANTT compliance was deteriorating and this was not addressed in a timely manner. 3. Replace the furniture and furnishings that were not compliant with cleaning/IPC recommendations
2017/17894	11W	2 CDT in 7 days VRE Transmission	11/06/2017	1. Pre-emptive isolation and testing patients for C difficile if they have risk factors for C.difficile in line with Trust policy 2. Management of clinical waste with regard to full bowel management system equipment 3. Ensuring enhanced ward cleaning is implemented effectively and reflected in assurance measures reviewed
2017/19226	ZCO/Albert	CPE (*Klebsiella pneumoniae* OXA48) x8 (same as ALB)	25/07/2017	Panel due January 2018
2017/22957	SLA	CPE (*Enterobacter cloacae* OXA48) x2	07/08/2017	None identified
2017/22986	RPO	CPE (*Klebsiella pneumoniae* OXA48) x2	15/08/2017	1. Process of use of computers on wheels in isolation rooms and how these are then cleaned/decontaminated
2017/22053	Weston	CPE (*Klebsiella pneumoniae* NDM) x2 CPE (*Enterobacter*	23/08/2017	Panel due January 2018

		cloacae VIM) x3 CPE (Enterobacter cloacae IMP1) x2		
2017/25234	8W	CPE (*Klebsiella pneumoniae* OXA48) x 13	22/09/2017	1. Timely completion of IPC recommendations made as a result of IPC outbreak meetings 2. A joint investigation should be undertaken with the mental health Trust into the management of patient 2. 3. Estates & Facilities review to provide a response to the recommended renewal work for 8 West.
2017/22962	JHW	2 CDT in 7 days	08/09/2017	1. Awareness of the policy and practice relating to the management of patients requiring isolation
2017/26464	CBW	CPE (*Citrobacter freundii* OXA48) x2	24/09/2017	1. Reiterate the importance of hand hygiene and adhering to the five moments and reaudit
2017/24672	7N	CPE Bloodstream infection	16/09/2017	Panel due January 2018
2017/25258	OPAT/Albert	CPE Bloodstream infection	17/09/2017	1. All management decisions should be clearly documented in main clinical notes to avoid confusion surrounding MDT treatment decisions

7 Risks

New risks:

- Low level of hand hygiene and inappropriate use of gloves. Poor infrastructure or practice results in low levels of hand hygiene and inappropriate use of gloves, which introduces infection risk.

Updated risks:

- Lack of appropriate patient care facilities and high use of bank/agency staff. This risk highlights the inability to provide adequate isolation requirements, lack of appropriate bathroom : patient ratios, overcrowding of beds, and inappropriate staffing levels / skill mix in some areas.
- Trust-wide antibiogram data. This risk has been downgraded now that IPC have access to antibiogram data.
- Lack of Level 3 negative pressure single rooms at the Charing Cross site. This risk has been downgraded now that Level 3 negative pressure single rooms are available on this site.

On-going risks:

- The shortage of key antimicrobials due to national supply problems continues to present a major clinical challenge and is being considered for escalation to the corporate risk register. Mitigation is in place in that all appropriate guidelines have been updated and have been communicated across the Trust.
- Risk of the spread of CPE. This risk is on the corporate risk register, to ensure that this issue has the appropriate level of organisational focus.
- Occupational Health service capacity. This issue has improved now that a clinical lead of the Occupational Health service has been appointed, but remains on the IPC risk register.
- Challenges within Estates related to responsiveness, ventilation and water hygiene management. Estates has been asked to provide a monthly report to the HCAI Taskforce group, providing exception reports of areas of concern in terms of water hygiene and ventilation.
- A limited capacity to perform surveillance of HCAI, specifically related to surgical infections. A business case to build an SSI surveillance team is under development.
- Inflexible IT infrastructure. The Trust has an inflexible IT infrastructure, particularly related to Cerner developments, which means that innovate IT solutions take time to be implemented.
- Inappropriate use of antibiotics. Poor understanding of antimicrobial policy and strategy, and poor prescribing behaviour can create short-term risk to patients, and medium to long term risk of antibiotic resistance developing.
- Poor practice related to vascular access. Inadequate training or competency assessment, or poor practice related to vascular access risks higher rates of line-related infection and delays to intravascular therapy.
- Prolonged high capacity. Increased use of additional ‘surge capacity’ bed spaces in wards and non-clinical areas for prolonged periods and the inability to isolate at risk patients due to increased demand on isolation facilities introduces infection risk.

8 Other issues

8.1 *Respiratory virus trends*

The number of respiratory viruses reported, by week, is summarised in Figure 19. This shows the expected increases in winter respiratory viruses, such as Rhinovirus. The number of cases of influenza has risen sharply since the beginning of December, in line with national trends.

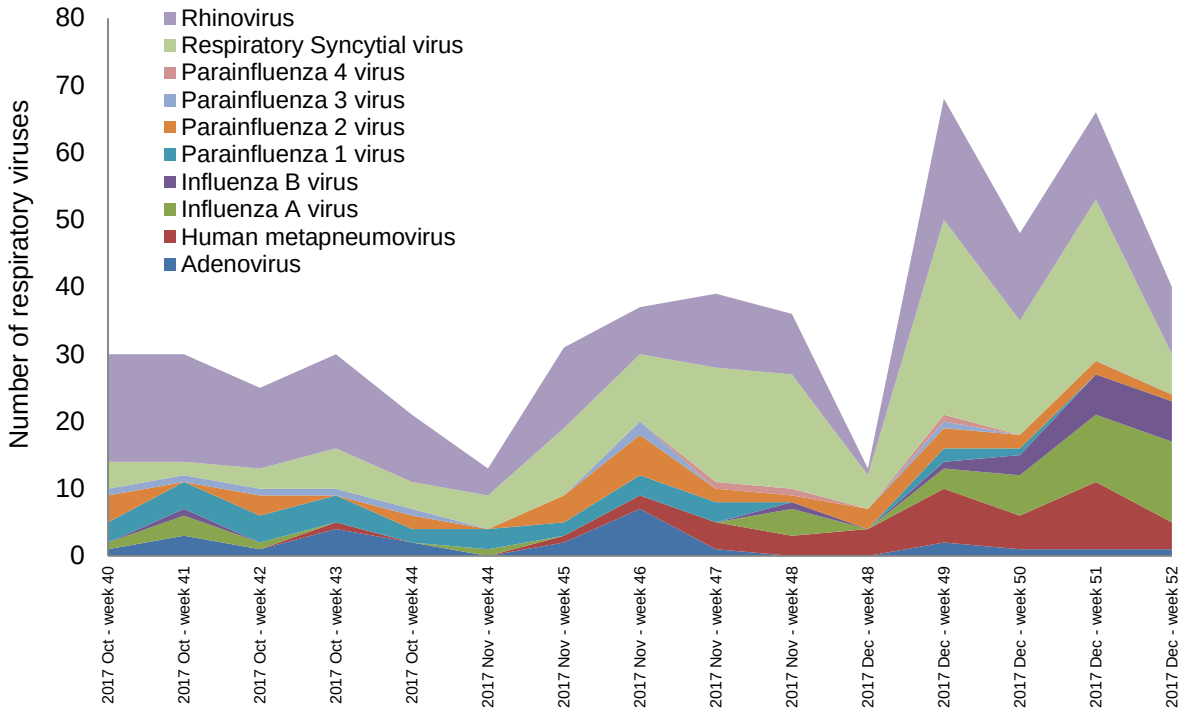


Figure 19: Number of respiratory viruses detected, by week.

8.2 *Neonatal PVL-positive MSSA*

Twins on the neonatal unit have been identified with PVL-positive *Staphylococcus aureus* on routine screening in November 2017. Neither became unwell with the organism. Typing has indicated that this is the same organism as those found in three babies between December 2016 and February 2017. A thorough investigation was undertaken earlier in the year with actions that included administering suppression therapy to all staff across both units. Following the identification of these two new cases and discussion with Public Health England and the Trust Occupational Health Service, further suppression with an alternative product was undertaken as recommended by PHE because of possible reduced susceptibility to the original agent used to decolonise all staff earlier in the year..

8.3 *Diarrhoea and vomiting on the ICU at Charing Cross*

Seven patients and four staff members (three clinical and one non-clinical) developed symptoms of diarrhoea and / or vomiting in December 2017, which was presumed to be due to norovirus (although this was not laboratory confirmed). The unit was closed for four days to ensure that no patients or staff were incubating gastrointestinal infection. The unit was reopened on the fifth day and no further cases occurred.

9 Publications in Q3

Hernandez B, Herrero P, Rawson TM, Moore LSP, Evans B, Toumazou C, Holmes AH, Georgiou P. Supervised learning for infection risk inference using pathology data. BMC Med Inform Decis Mak 2017;17:168.

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. 2017 Dec 4.

Tosas Auguet O, Stabler RA, Betley J, Preston MD, Dhaliwal M, Gaunt M, Ioannou A, Desai N, Karadag T, Batra R, Otter JA, Marbach H, Clark TG, Edgeworth JD. Frequent undetected MRSA ward-based transmission linked to patient sharing between hospitals. Clin Infect Dis. 2017 Oct 31.

Otter JA, Doumith M, Davies F, Mookerjee S, Dyakova E, Gilchrist M, Brannigan ET, Bamford K, Galletly T, Donaldson H, Aanensen DM, Ellington MJ, Hill R, Turton JF, Hopkins KL, Woodford N, Holmes A. Emergence and clonal spread of colistin resistance due to multiple mutational mechanisms in carbapenemase-producing Klebsiella pneumoniae in London. Sci Rep. 2017 Oct 5;7:12711.

Mitchell BG, Russo PL, Otter JA, Kiernan MA, Aveling L. What Makes a Tweet Fly? Analysis of Twitter Messaging at Four Infection Control Conferences. Infect Control Hosp Epidemiol. 2017 Nov;38:1271-1276.

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

Charani E, Tarrant C, Moorthy K, Sevdalis N, Brennan L, Holmes AH. Understanding antibiotic decision making in surgery-a qualitative analysis. Clin Microbiol Infect. 2017 Oct;23:752-760.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - private	28 March 2018

National Staff Survey 2017 Results

Executive summary:

This paper summarises the results from the 2017 National Staff Survey which ran between October and December 2017.

The headlines of the report are that:

- The Trust has seen its overall engagement score in the National Staff Survey rise for a second year from 3.80 (average) in 2016 to 3.84 (above average) in 2017.
- This is against a national overall decline in engagement scores for Acute Trusts for the first time since 2012 (national average of 3.79)
- The Staff Friends and Family Test scores have improved and are above the Acute Trust average with 73% recommending us for treatment and 66% recommending us as a place to work

The paper provides a range of additional breakdown information on the survey results including division and directorate data as well as demographic results. The results are currently being disseminated across the Trust and action plans will be refreshed during April and May.

Update for leadership briefing:

The survey results have been shared with Internal Communications for inclusion in the March leadership briefing

Quality impact:

There is growing research identifying a link between staff engagement/staff well-being, and patient well-being, hospital acquired infections, mistakes, outcomes, mortality rates and patient experience. The Staff Engagement Strategy links to aspects of CQC domains, but in particular to Well-led.

Financial impact:

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

1) Has no financial impact.

Risk impact:

There are a number of risks associated with low staff engagement. Low staff engagement correlates strongly with retention and the associated vacancy rates.

Recommendation(s) to the Committee:

The committee is asked to

1) Note the results of the Staff Survey

Trust strategic objectives supported by this paper:

2. To educate and engage skilled and diverse people committed to continual learning and improvement.

Author	Responsible executive director	Date submitted
Sue Grange, Associate Director of HR	David Wells, Director of People & OD	22 March 2018

Imperial College Healthcare NHS
NHS Trust

Summary of 2017 National NHS Staff Survey results

National NHS Staff Survey 2017
Contents

This presentation will summarise the results of the 2017 National NHS Staff Survey which was carried out between October and December 2017. This presentation includes the following information:

1. Methodology
2. Staff engagement score and FFT data
3. Shelford and London benchmarks
4. Local question data
5. Demographic data
6. WRES data
7. Summary

National Context

The NHS National Survey results unsurprisingly show a decrease in overall engagement in 2017. Of the 32 key findings in the survey 21 worsened and 11 improved.

The overall key finding on whether staff are willing to recommend the NHS as a place to work or be treated fell from 3.65 to 3.64. The key finding on whether staff feel satisfied with the quality of care they are able to deliver also fell from 3.93 to 3.90. Nationally the overall staff engagement index fell from 3.82 to 3.80 which represents the first decrease in overall engagement in many years.

The Trust survey was conducted between September - December against the backdrop of a year with many challenges including activity, acuity, major incidents and estate.

National NHS Staff Survey 2017
Methodology

National NHS Survey	
Dates survey conducted	8th October – 1st December 2017
Methodology	Direct email to randomly selected sample group
Response rate	41.5% (495 respondents)
Length	88 questions

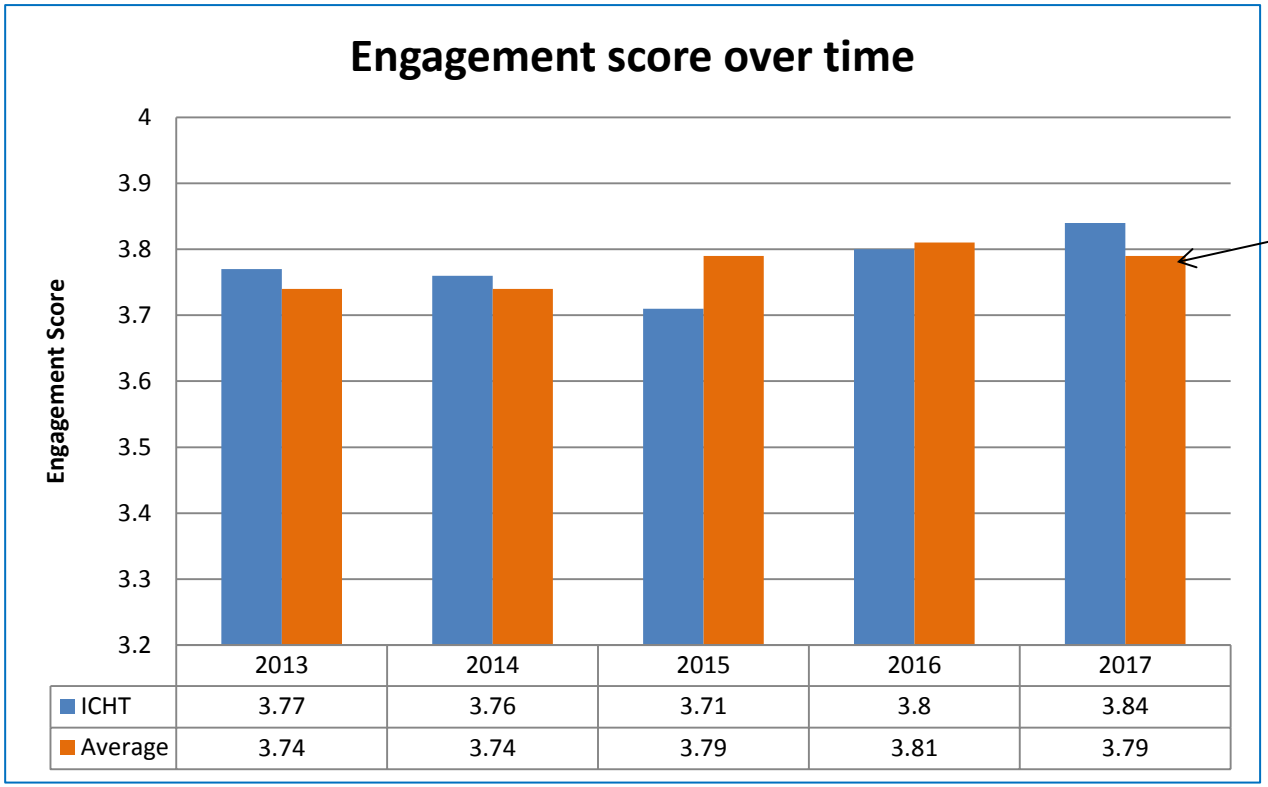
Locality	Eligible Sample	Respondents	Response Rate
Trust-wide	1194	495	41.5%
Women's, Children's & Clinical Support	271	105	38.7%
Medicine & Integrated Care	324	142	43.8%
Surgery, Cancer & Cardiovascular	345	138	40.7%
Information & Comms Technology	35	15	42.9%
Nursing Directorate	29	14	48.3%
People & Organisational Development	14	9	64.3%
Finance Directorate	17	11	64.7%
Pathology	94	28	29.8%
Private patients	27	10	37.0%

Throughout this report we refer to the National Staff Survey as 'NSS'

Overall engagement score and FFT data

National NHS Staff Survey 2017
Overall engagement score

Our overall engagement score is calculated using 3 Key Findings (9 individual questions).
-KF1 Staff recommendation of the Trust as a place to work
-KF4 Staff motivation at work
-KF7 Staff ability to contribute towards improvements at work
Our overall score has improved from 3.8 to 3.84 and we have moved from “Average” to “Above average”



The **national** engagement score has dipped for the first time since 2013

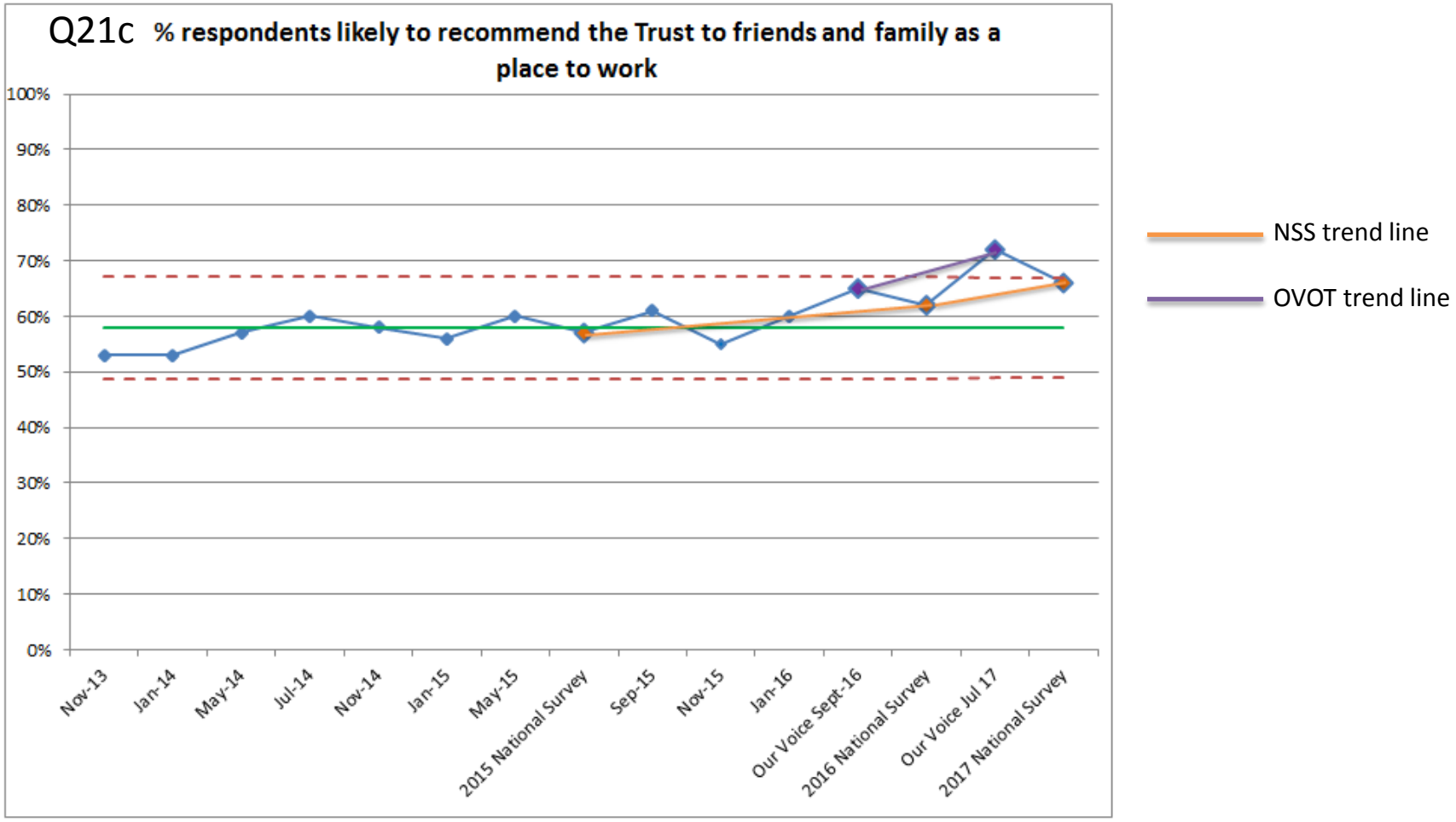
Above (better than) average	Above (better than) average	Lowest (worst) 20%	Average	Above (better than) average

National NHS Staff Survey 2017
Comparison of results of Friends and Family (FFT) questions

	2013	2014	2015	2016	2017	Average for Acute Trusts 2017
Key Finding 1: Staff recommendation of the organisation as a place to work or receive treatment (Q21a,Q21c, Q21d)	**3.72**	**3.72**	**3.67**	**3.76**	**3.84** ↑	**3.79**
Questions within Key Finding 1						
Question 21a: Care of patients is my organisation's top priority	**72%**	**72%**	**72%**	**76%**	**81%** ↑	**71%**
Question 21c: I would recommend my organisation as a place to work	**58%**	**62%**	**57%**	**62%**	**66%** ↑	**61%**
Question 21d: If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	**69%**	**71%**	**68%**	**70%**	**73%** ↑	**71%**

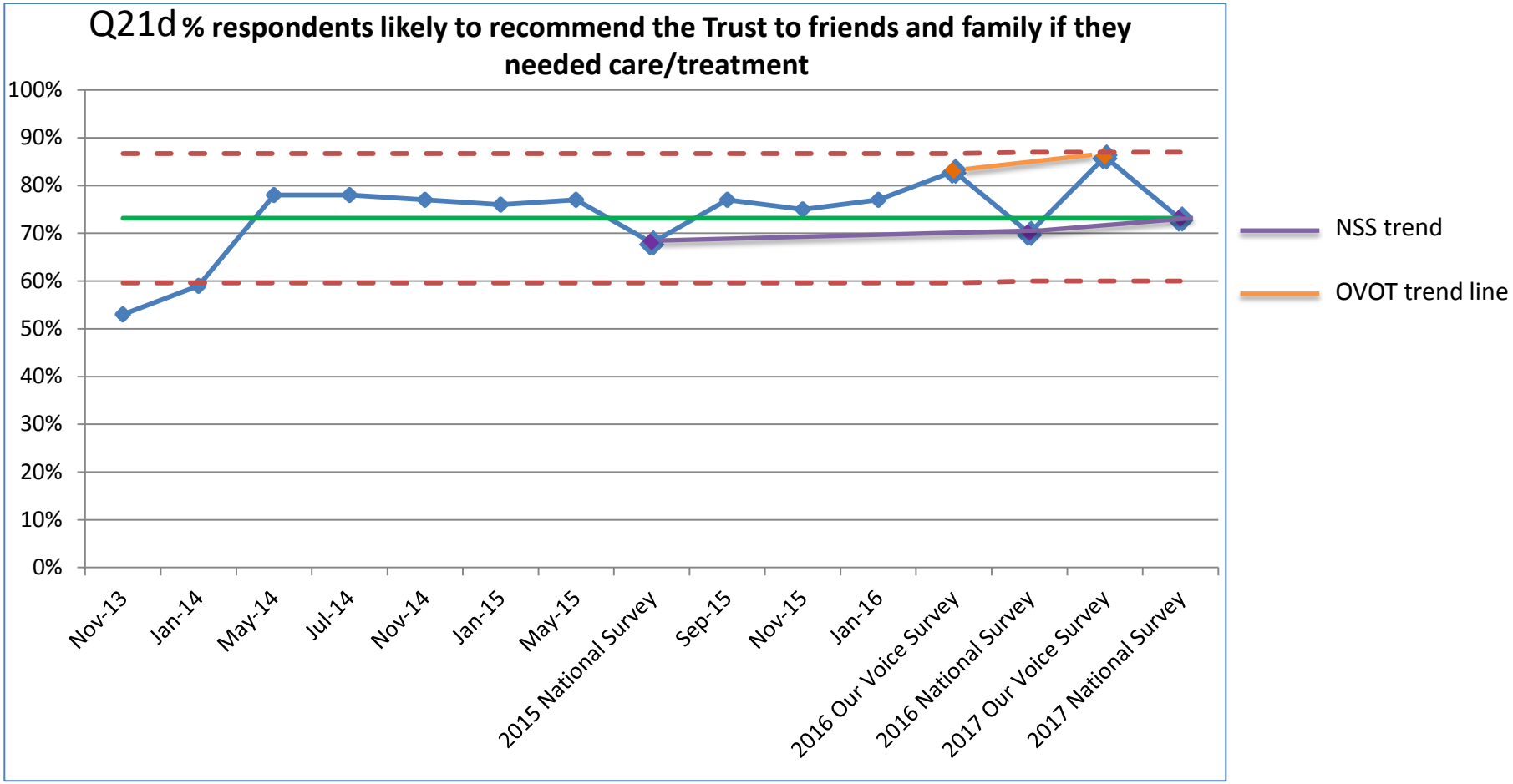
Throughout this report we refer to 'Questions' and 'Key Findings'. Key Findings are a collection of one or more questions, into themes, that we are measured on.
In total there are 88 questions collected into 32 key findings.

National NHS Staff Survey 2017
Comparison of results of Friends and Family (FFT) questions



The 2017 national staff survey results (orange) show the continue the upward trend in our engagement score since 2015. This upward trend is also reflected in the 2016 and 2017 Our Voice engagement surveys (purple). It will be determined whether this trend is of sustained statistical significance when we have seven consecutive points above the mean (we currently have 5). However, any point on or above the control limit red line is statistically significant as this is not an expected in the normal range of result.

National NHS Staff Survey 2017
Comparison of results of Friends and Family (FFT) questions



The 2017 NSS results (orange) show the continue the upward trend in our engagement score since 2015. This upward trend is also reflected in the 2016 and 2017 OVOT engagement surveys (purple).
It is not as easy to determine whether this trend is leading to statistical significance as two out of three NSS data points remains under the mean, however the data available does indicate a statistical improvement.

Shelford and London Benchmarks

National NHS Staff Survey 2017
Overall engagement score compared to other Trusts

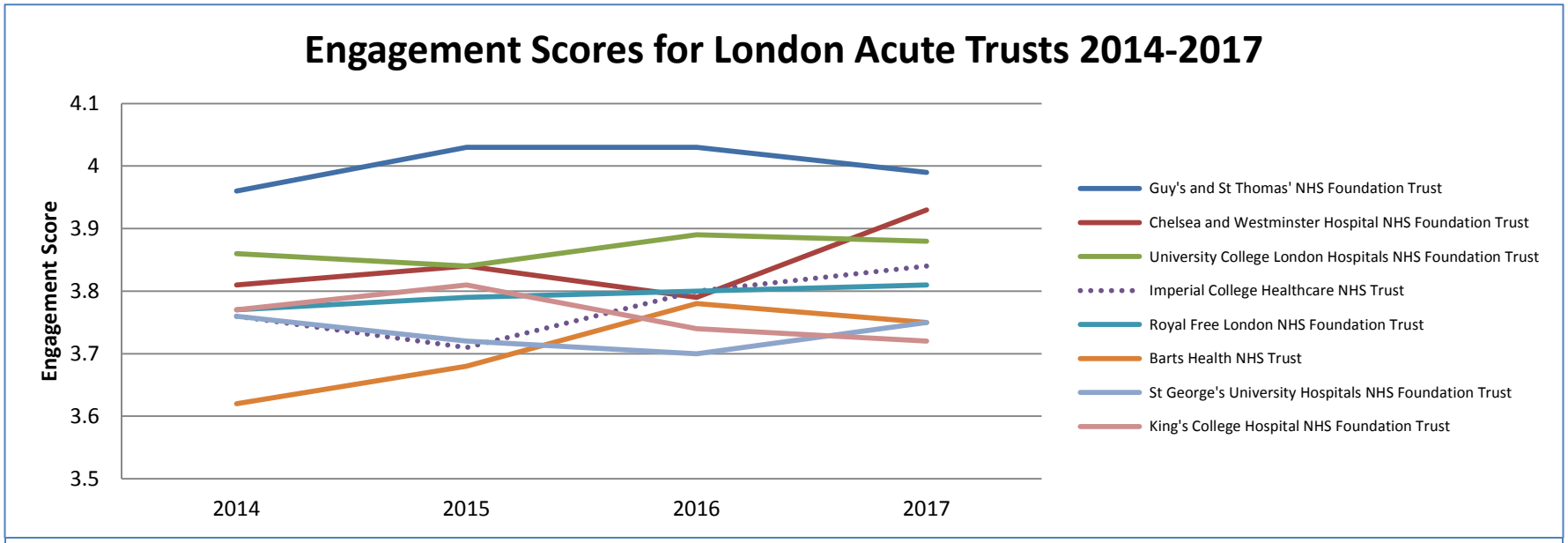
London Acute Trusts	Overall engagement score 2017	Overall engagement score 2016	Ranking 2017
Guy's and St Thomas' NHS Foundation Trust	3.99↓	4.03	Top 20%
Chelsea and Westminster Hospital NHS Foundation Trust	3.93↑	3.79	Top 20%
University College London Hospitals NHS Foundation Trust	3.88↓	3.89	Top 20%
Imperial College Healthcare NHS Trust	**3.84↑**	**3.80**	**Above Average**
Royal Free London NHS Foundation Trust	3.81↑	3.80	Average
Barts Health NHS Trust	3.75↓	3.78	Average
St George's University Hospitals NHS Foundation Trust	3.75↑	3.70	Average
King's College Hospital NHS Foundation Trust	3.72↓	3.74	Below Average

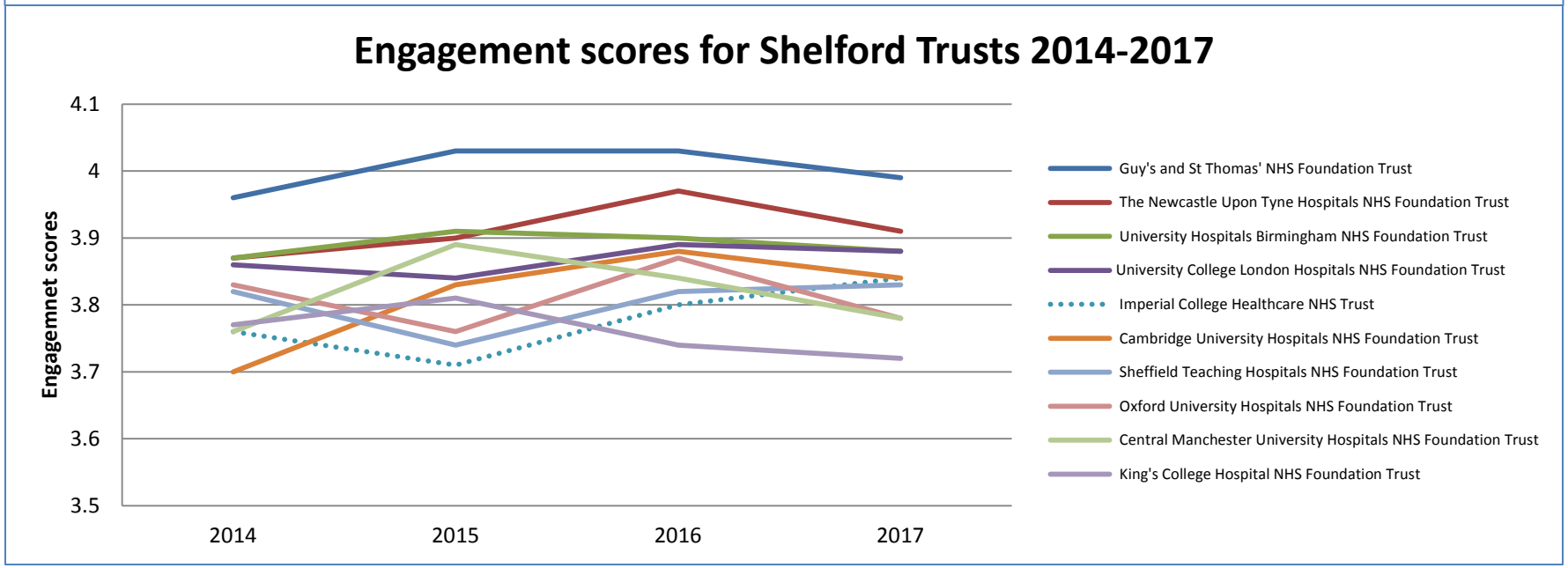
In 2016 Imperial was joint 3rd with the Royal Free. Following a large increase in the engagement score for Chelsea & Westminster we are now placed at 4th. 4 Trusts saw their engagement score increase and 4 saw their score decrease.

Shelford Trusts	Overall engagement score 2017	Overall engagement score 2016	Ranking 2017
Guy's and St Thomas' NHS Foundation Trust	3.99↓	4.03	Top 20%
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	3.91↓	3.97	Top 20%
University Hospitals Birmingham NHS Foundation Trust	3.88↓	3.90	Top 20%
University College London Hospitals NHS Foundation Trust	3.88↓	3.89	Top 20%
Imperial College Healthcare NHS Trust	**3.84 ↑**	**3.80**	**Above Average**
Cambridge University Hospitals NHS Foundation Trust	3.84↓	3.88	Above Average
Sheffield Teaching Hospitals NHS Foundation Trust	3.83↑	3.82	Above Average
Oxford University Hospitals NHS Foundation Trust	3.78↓	3.87	Average
Central Manchester University Hospitals NHS Foundation Trust	3.78↓	3.84	Average
King's College Hospital NHS Foundation Trust	3.72 ↓	3.74	Below Average

In 2016, Imperial was 2nd from bottom in the Shelford Group and we now rank as joint 5th with Cambridge. Within the Shelford Group only Imperial and Sheffield saw their engagement scores increase in 2017.

Engagement score trend-lines compared to other Trusts





The engagement score axis has been reduced to enhance the graphical presentation of the data. Note this makes the GSST score look exceptionally higher.

National NHS Staff Survey 2017
Overall engagement score compared to North West London Trusts

Trust	2017 score	2016 Score	Rank	Sector
Chelsea & Westminster	3.93↑	3.79	Highest (20%)	Acute
Imperial	3.84↑	3.80	Above average	Acute
Hillingdon	3.83↓	3.85	Above average	Acute
West London Mental Health	3.82↑	3.75	Average*	Mental Health/Learning Disability
CNWL	3.78↓	3.83	Average*	Mental Health/Learning Disability
North West London	3.78↑	3.75	Average*	Acute and Community

**Mental health Trusts and Community Trusts use a different average score compared to Acute Trusts*
**We are sourcing previous years data in order to populate the trend lines*

Local Question Data

National NHS Staff Survey 2017
Top and bottom ranking questions

Scores in brackets are the 2016 scores

Top 5 ranking questions	Imperial	Average Acute Trusts
% of staff/ colleagues reporting most recent experience of violence (was in bottom 5 in 2016)	74% (59%)	66%
Staff satisfaction with the quality of work and care they are able to deliver (in top 5 in 2016)	3.99 (4.04)	3.91
Quality of non-mandatory training, learning or development (in the top 5 in 2016)	4.17 (4.10)	4.05
Quality of appraisals	3.20 (3.20)	3.11
% of staff agreeing their role makes a difference to patients	91% (90%)	90%

Bottom 5 ranking questions	Imperial	Average Acute Trusts
% staff experiencing discrimination at work in last 12 months (in bottom 5 in 2015 and 2016)	19% (21%)	12%
% of staff experience harassment, bullying or abuse from patients/relatives/public in the last 12 months	35% (32%)	28%
% of staff experience harassment, bullying or abuse from staff in the last 12 months (in bottom 5 in 2016)	29% (31%)	25%
% staff witnessing potentially harmful errors, near misses or incidents	37% (30%)	31%
% of staff working extra hours	75% (73%)	72%

- Two of our top 5 questions were in the top 5 in 2016 (Satisfaction with care delivered and Quality of training)
- Two of our bottom 5 questions were in the bottom 5 in 2016 (Experiencing discrimination and B&H from staff)
- Staff reporting violence has moved from bottom 5 in 2016 to top 5 in 2017

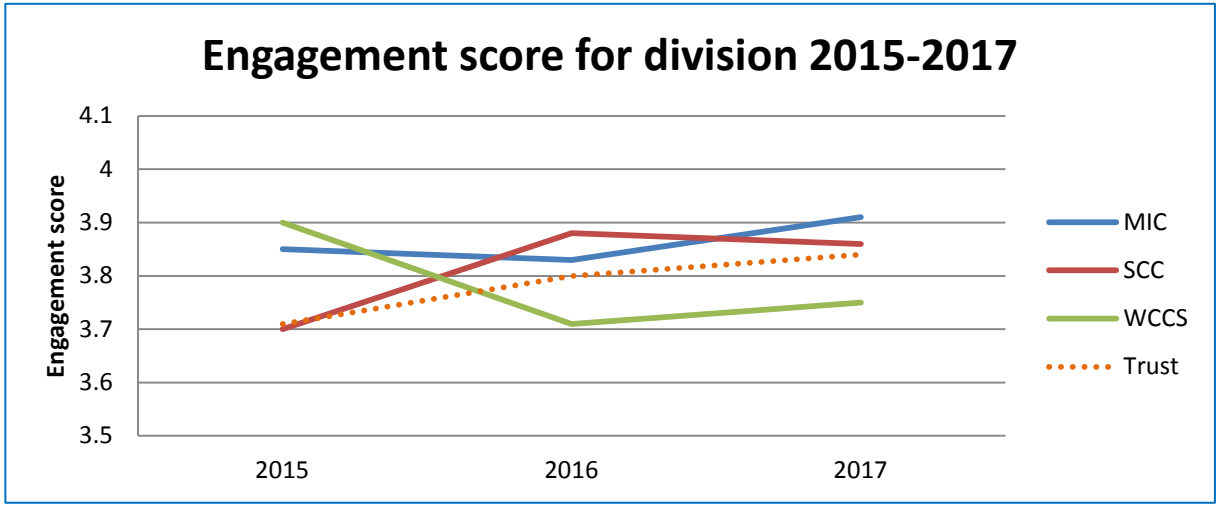
Notable observations:

- Response to “% staff witnessing potentially harmful errors” is our largest local change (worsened) since the 2016 survey
- “% staff believing organisation provides career progression” has previously been in the bottom 5 (2015 and 2016) but this has improved from 80% to 86% and is no longer in the bottom 5
- “Staff experiencing physical violence from staff” is no longer a bottom 5 score and is now at the Acute Trust median level

National NHS Staff Survey 2017
Clinical division and corporate directorate engagement score

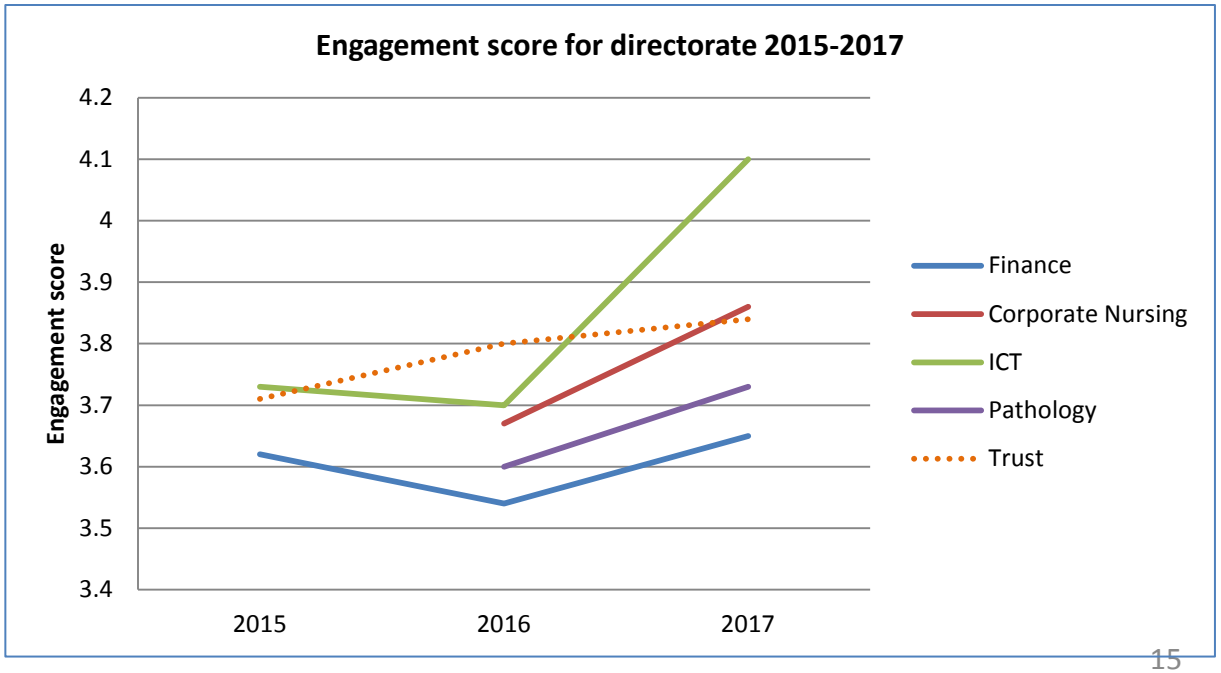
	2015	2016	2017
MIC	3.85	3.83	3.91
SCC	3.70	3.88	3.86
WCCS	3.90	3.71	3.75

The OVOT survey data shows:
WCCS 82% engaged
SCC 80% engaged
MIC 77% engaged



	2015	2016	2017
Finance	3.62	3.54	3.65
Corporate Nursing	-	3.67	3.86
ICT	3.73	3.70	4.10
Pathology	-	3.60	3.73

Due to sample size/ response rate we do not have trend data for P&OD, Press & Communications, OMD , OCE, Private patients



National NHS Staff Survey 2017
Question heatmap - change in results against 2016 survey

Number (%) of Questions	Movement
39 (44%)	Improvement
11 (13%)	No change
38 (43%)	Worsened

44% of questions have seen an improved position over the last 12 months.

Number (%) of Key findings	Movement
12 (37%)	Improvement
8 (25%)	No change
12 (37%)	Worsened

37% of key findings have improved and 37% have worsened over the last 12 months.

Key Findings are a collection of one or more questions, into themes, that we are measured on. In total there are 88 questions collected into 32 key findings.

National NHS Staff Survey 2017
Breakdown of key Findings against national average

Theme	2017 rank compared with Acute Trusts (change since 2016 +/- levels of change)	2016 rank
Appraisals for support and development		
KF11. % appraised in last 12 months	**Above (better than) average (worsened -1)**	**Highest (best) 20%**
KF12. Quality of appraisals	**Above (better than) average (no change)**	**Above (better than) average**
KF13. Quality of non-mandatory training, learning or development	**Highest (best) 20% (improvement +1)**	**Above (better than) average**
Equality and diversity		
KF20. % experiencing discrimination at work in last 12 months	**Highest (worst) 20% (no change)**	**Highest (worst) 20%**
KF21. % believing the organisation provides equal opportunities for career progression / promotion	**Average (improvement +1)**	**Lowest (worst) 20%**
Errors and incidents		
KF28. % witnessing potentially harmful errors, near misses or incidents in last month	**Highest (worst) 20% (worsened -1)**	**Below (better than) average**
KF29. % reporting errors, near misses or incidents witnessed in last month	**Below (worse than) average (worsened -1)**	**Average**
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	**Average (worsened -1)**	**Above (better than) average**
KF31. Staff confidence and security in reporting unsafe clinical practice	**Average (no change)**	**Average**

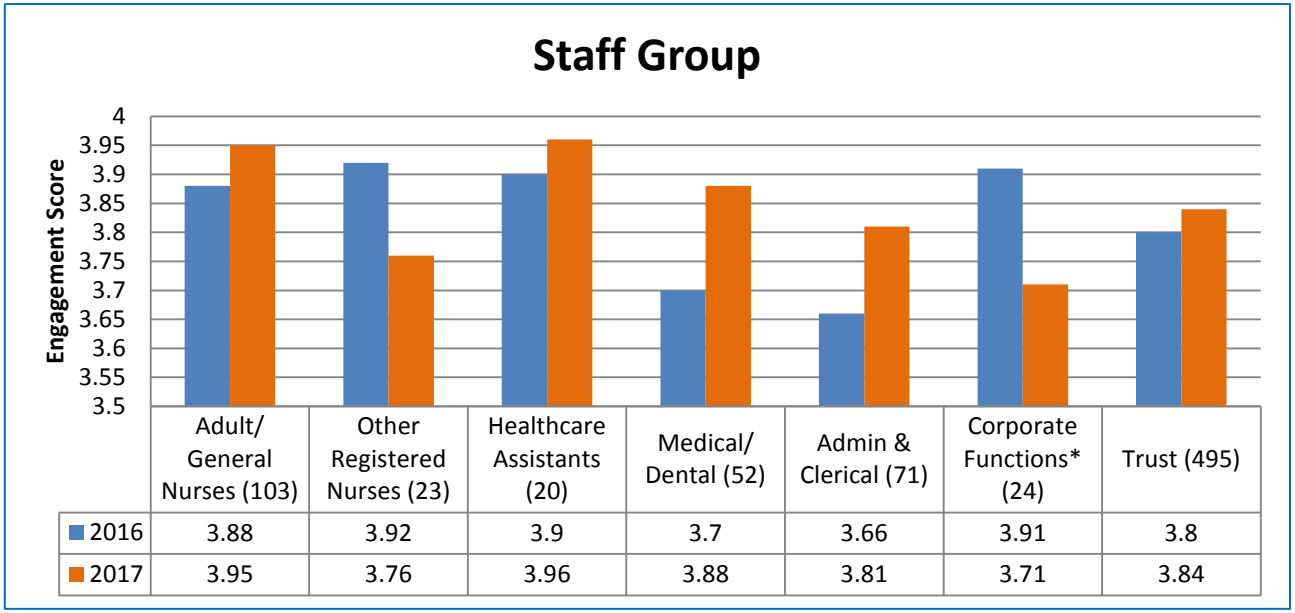
National NHS Staff Survey 2017
Imperial against national average per survey theme

Theme	2017 rank compared with Acute Trusts (change since 2016)	2016 rank
Health and wellbeing		
KF17. % feeling unwell due to work related stress in last 12 months	**Above (worse than) average (worsened -1)**	Average
KF18. % attending work in last 3 months despite feeling unwell because they felt pressure	**Average (worsened -1)**	Below (better than) average
KF19. Org and management interest in and action on health and wellbeing	**Below (worse than) average (no change)**	Below (worse than) average
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	**Above (better than) average (improved +1)**	Average
KF16. % working extra hours	**Highest (worst) 20% (worsened -3)**	Above (worst than) average
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	**Above (better than) average (improved +1)**	Average
KF4. Staff motivation at work	**Average (worsened -1)**	Above (better than) average
KF7. % able to contribute towards improvements at work	**Average (no change)**	Average (no change)
KF8. Staff satisfaction with level of responsibility and involvement	**Average (improved +2)**	Lowest (worst) 20%
KF9. Effective team working	**Average (improved +1)**	Below (worst than) average
KF14. Staff satisfaction with resourcing and support	**Above (better than) average (improved +2)**	Below (worst than) average

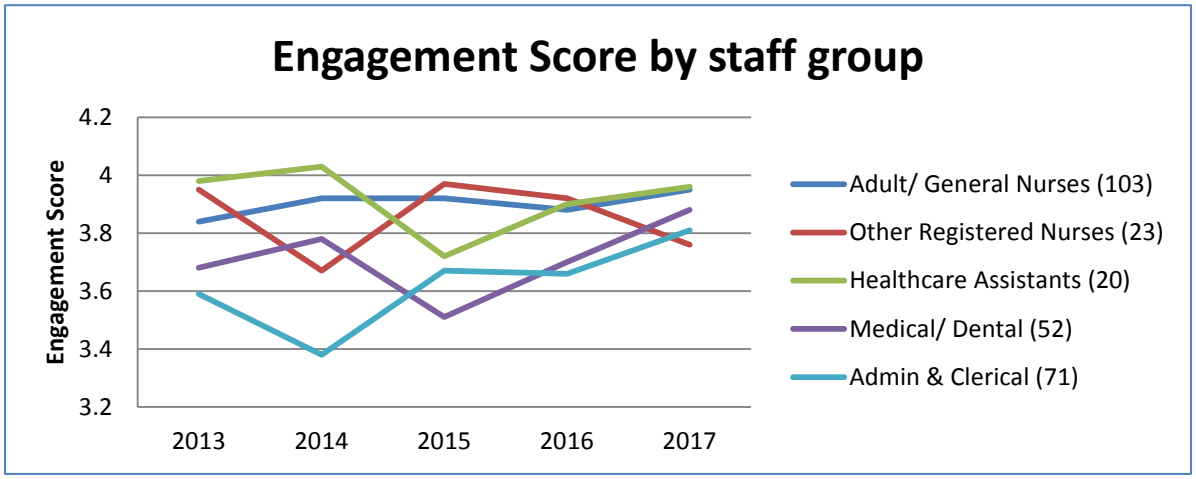
National NHS Staff Survey 2017
Imperial against national average per survey theme

Theme	2017 rank compared with Acute Trusts (change since 2016)	2016 rank
Managers		
KF5. Recognition and value of staff by managers and the organisation	**Average (improved +1)**	Below (worse than) average
KF6. % reporting good communication between senior management and staff	**Average (worsened -1)**	Better than average
KF10. Support from immediate managers	**Below (worse than) average (worsened -1)**	Average
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	**Above (better than) average (worsened -1)**	Highest (best) 20%
KF3. % agreeing that their role makes a difference to patients / service users	**Highest (best) 20% (Improved +2)**	Average
KF32. Effective use of patient / service user feedback	**Average (improved) +1**	Below (worse than) average
Violence, harassment & bullying		
KF22. % experiencing physical violence from patients, relatives/ public in last 12 months	**Above (worse than) average (worsened -2)**	Below (better than) average
KF23. % experiencing physical violence from staff in last 12 months	**Above (worse than) average (improved +1)**	Highest (worst) 20%
KF24. % reporting most recent experience of violence	**Highest (best) 20% (improved +4)**	Lowest (worst) 20%
KF25. % experiencing harassment, bullying or abuse from patients, relatives/ public in last 12 months	**Highest (worst) 20% (no change)**	Highest (worst) 20%
KF26. % experiencing harassment, bullying or abuse from staff in last 12 months	**Highest (worst) 20% (no change)**	Highest (worst) 20%
KF27. % reporting most recent experience of harassment, bullying or abuse	**Below (worse than) average (no change)**	Below (worse than) average

National NHS Staff Survey 2017
Overall engagement score by staff group



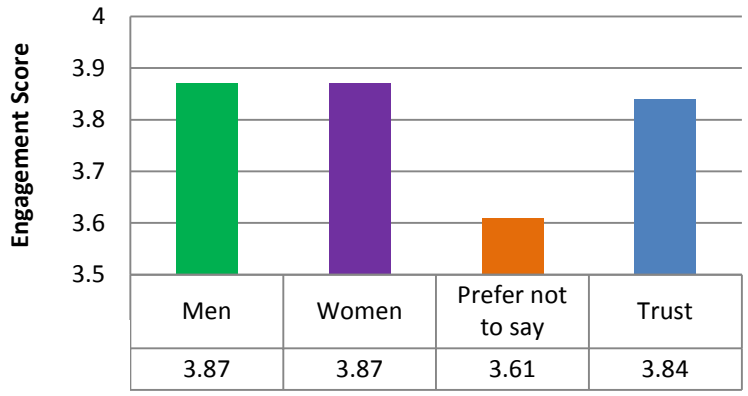
	Adult/ General Nurses (103)	Other Registered Nurses (23)	Healthcare Assistants (20)	Medical/ Dental (52)	Admin & Clerical (71)	Corporate Functions* (24)	Trust (495)
2016	3.88	3.92	3.9	3.7	3.66	3.91	3.8
2017	3.95	3.76	3.96	3.88	3.81	3.71	3.84



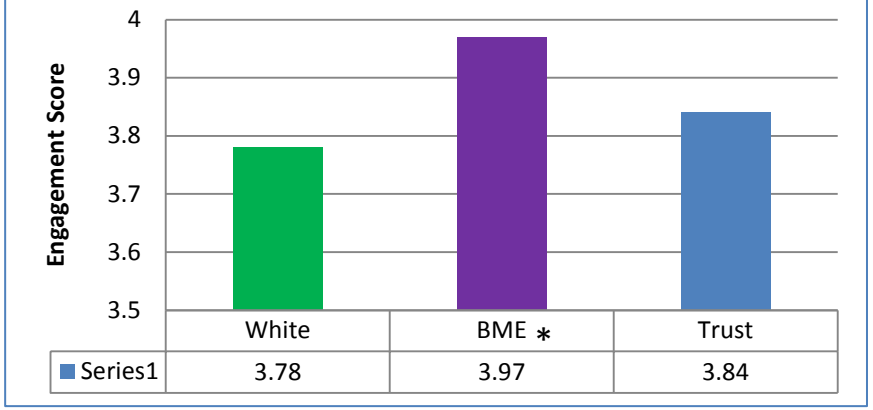
- Most groups have seen an improvement in engagement levels apart from 'Other registered nurses' and 'Corporate functions'
- We have not included engagement scores for AHPs and Scientific and Technical as the data categorisation has changed and therefore we can not show trend data
- We have seen a strong improvement in Admin and Clerical and Medical and Dental which were previously the lowest scoring staff groups
- It is not easy to do a compare and contrast with the Our Voice survey as the staff groups are termed and grouped differently
- *Corporate functions was not a staff group in 2016 and was previously known as "general management"
- There is a general downwards trend for 'Other registered nurses' since 2015 (this group includes paediatrics and midwifery)

National NHS Staff Survey 2017
Overall engagement score by demographic data

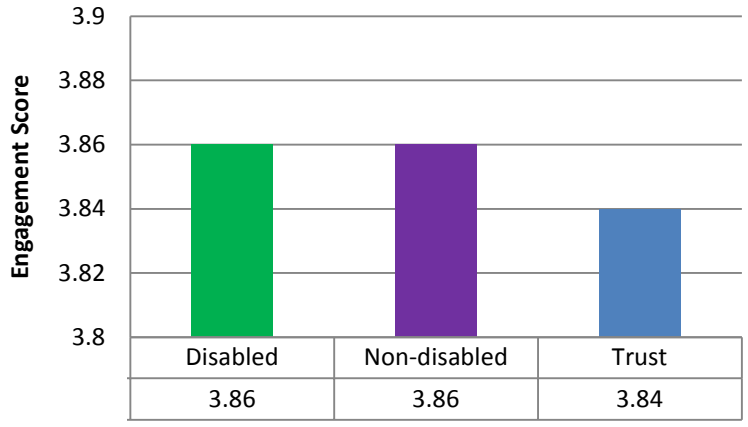
Gender



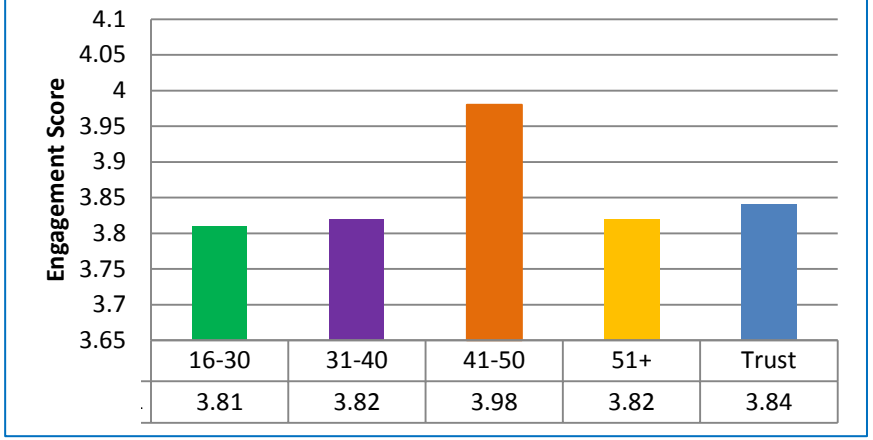
Ethnicity



Disability **



Age Group



*BME: black and minority ethnic, includes all ethnic groups except: 'White British', 'White Irish' and 'White Other'

** We do not have prefer not to say data for ethnicity or disability

National NHS Staff Survey 2017
WRES data

			Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	35%	27%	33%
		BME	30%	28%	31%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	28%	25%	32%
		BME	28%	27%	32%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	88%	87%	87%
		BME	83%	75%	74%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	5%	7%	7%
		BME	17%	15%	19%

- A fuller report on the WRES will be submitted in Q1 of 18/19 alongside the annual diversity plan.
- Each staff survey question within the WRES has seen an improvement for BME staff
- However three of the questions are still higher (worse than) average
- There has been large improvement for KF21 “% staff believing the organisation provides equal opportunities for progression”

National NHS Staff Survey 2017
Summary

Things to celebrate:

- Against the context of the high pressure and challenges we have faced in 2017, we have improved our engagement score from 3.8 in 2017 to 3.84 (our highest score since before 2013)
- FFT scores are above the national average for Acute Trusts
- Moved from 'lowest 20%' in 2015 to 'average' in 2016 to 'above average' in 2017
- Appraisals and support for development has scored strongly as a key finding
- Improvements in engagement levels for Admin & Clerical and Medical and Dental staff groups

Areas for focus:

- 2 out of 5 lowest performing areas have been in lowest performing for the last 3 surveys i.e. discrimination and bullying/abuse [KF20 & KF25]
- Theme between our lowest performing questions to discrimination, violence and harassment/bullying
- 'Health and Wellbeing' and 'Errors and Incidents' themes have not seen improvements in any key findings
- Age demographic data shows lower engagement scores in staff aged 16-40

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	28 March 2018

Healthwatch Central West London report on Charing Cross Hospital

Executive summary:

In February 2018, Healthwatch Central West London published the report "Charing Cross Hospital: Experiences of Today, Questions for Tomorrow" and asked for its contents and findings to be considered by the Trust board.

The Trust has already issued our response which welcomes the report and we helped Healthwatch to facilitate a range of patient engagement activities in its development. We also responded to a set of questions relating to Charing Cross Hospital which Healthwatch put to us and the North West London of Collaborative Clinical Commissioning Groups in November 2017.

Healthwatch found that most patients were "extremely satisfied" with their experience of Charing Cross Hospital overall. This was followed by high levels of "very satisfied" or "satisfied".

Healthwatch also asked patients about future plans for Charing Cross which elicited mixed views, reflecting a lack of clarity on the plans. Patients were asked about their role in shaping the future of the hospital and a large majority said they wanted or may want to be involved.

The Trust accepts that there is a lack of clarity currently as in 2016 we - and our local clinical commissioning groups - paused development and engagement on the 'local hospital' model that forms part of the 'Shaping a healthier future' service plans for north west London. This was because increasing demand for acute hospital services has highlighted the need to focus first on the development of new models of care to help people stay healthy and avoid unnecessary and lengthy inpatient admissions.

We also acknowledge Healthwatch's recommendations for a clear and robust communications and engagement strategy on the future of Charing Cross Hospital and for more clarity about decision-making structures and lines of responsibility and accountability. This is in line with our own approach and follows on from our well-received 'open door' event at Charing Cross in November 2017.

The Trust issued its most recent response to media coverage about the future of Charing Cross Hospital on 27 February 2018 which stated:

"Plans to develop Charing Cross as a 'local hospital' were paused in 2016. The continuing rise in acute demand means that we are focusing first on the development of new models of care to help people stay healthy and avoid unnecessary hospital stays.

"Since 2016, we've committed over £20 million for building improvements and new imaging and radiotherapy equipment at Charing Cross. We've also developed new services and employed extra doctors, nurses and other healthcare staff. More investment is already planned for 2018 and 2019, including an expansion of the A&E department."

Quality impact:

It is important that patients, their families and carers, and our local residents are involved in informing and shaping everything we do, at all levels of our organisation. We believe that wider patient and public involvement can help us provide better care and ensure we play our

part locally in creating strong and healthy communities.

Financial impact:

The paper has no direct financial impact.

Risk impact:

The paper has no direct risk impact.

Recommendation(s) to the Trust board:

The Trust board is asked to:

- Consider the contents and findings of the Healthwatch Central West London report
- Put any questions to the Chief Executive Officer of Healthwatch Central West London who will be attending the meeting to hear the Trust board's feedback directly
- Note the Trust's response to the report and recent statement in response to media coverage about the future of Charing Cross Hospital

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered with compassion.
To pioneer integrated models of care with our partners to improve the health of the communities we serve.
To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

Author	Responsible executive director	Date submitted
Mick Fisher, head of public affairs	Michelle Dixon, director of communications	21 March 2018

Healthwatch Central West London report on Charing Cross Hospital

1. Introduction

Healthwatch Central West London (covering the local boroughs of Hammersmith & Fulham, Kensington & Chelsea and Westminster) is as an independent charity and membership organisation established under the provision of the Health and Social Care Act 2012 to represent the voices of local people in health and social care. There is a Healthwatch in every local authority area across England and local Healthwatch groups provide vital feedback into shaping and improving local health and care services.

Healthwatch Central West London is an important Trust partner and helps us ensure the views of patients and the public are understood and acted upon. For example, the team at Healthwatch Central West London organise patient-led assessment of the care environment (PLACE) inspections. These assessments involve local people going into hospitals to assess how the environment supports patients' privacy and dignity, how food is provided, general cleanliness and state of repair.

In February 2018, Healthwatch Central West London published the final version of its report "Charing Cross Hospital: Experiences of Today, Questions for Tomorrow" and asked for its contents and findings to be considered by the Trust board. The report focuses on patient views on the future of Charing Cross Hospital and their experiences of using the hospital.

The full Healthwatch report is set out as an appendix.

In its draft stage, the report was presented at Hammersmith & Fulham Council's Health, Adult Social Care and Social Inclusion Policy and Accountability Committee in late January. The Trust also published a link to the draft report on our website.

The Trust has already issued our response which welcomes the report and helped Healthwatch to facilitate a range of patient engagement activities in its development. We also responded to a set of questions relating to Charing Cross Hospital which Healthwatch put to us and the North West London of Collaborative Clinical Commissioning Groups in November 2017.

2. Trust summary of report

Healthwatch found that most patients were "extremely satisfied" with their experience of Charing Cross Hospital overall. This was followed by high levels of "very satisfied" or "satisfied".

Healthwatch also asked patients about future plans for Charing Cross. Under the 'Shaping a healthier future' service strategy for north west London, Charing Cross is envisaged as becoming a 'local hospital' within a network of services, building on its role as a growing hub for integrated care offered in partnership with local GPs and community providers.

The Healthwatch survey found no clear consensus about whether people felt that their health needs would be met by Charing Cross becoming a 'local hospital'. Just over 40 per cent said that their health needs would not be met, while just over 50 per cent said that their health needs would or may be met. Analysis of comments showed that most patients do not understand what a 'local hospital' means and how this is going to affect the services they currently receive.

When asked, more specifically, if they would be happy to receive the service they used at Charing Cross Hospital at a different setting close to their home, for example at their GP surgery, patients again gave a mixed response. Of patients from across the whole north west London area, 42 per cent said 'no', while 52 per cent said 'yes' or 'maybe'.

A large majority of patients were interested in shaping the future of Charing Cross Hospital, with 79 per cent of patients surveyed saying they wanted or may want to be involved, and only 21 per cent saying they did not want to be involved.

3. Trust response to Healthwatch report

The Trust welcomed Healthwatch Central West London's report into patient views on the future of Charing Cross Hospital and their experiences of using the hospital, when it was published on 20 February 2018. Our response also confirmed that the report would be discussed at the Trust's next public Board meeting to be held on 28 March 2018.

The Healthwatch report and our response have been publicised through the Trust website and the February editions of our e-newsletters to members, GPs and key stakeholders.

The Trust accepts that there is a lack of clarity currently as in 2016 we - and our local clinical commissioning groups - paused development and engagement on the 'local hospital' model that forms part of the 'Shaping a healthier future' service plans for north west London. This was because increasing demand for acute hospital services has highlighted the need to focus first on the development of new models of care to help people stay healthy and avoid unnecessary and lengthy inpatient admissions. It's encouraging, though, that the responses to the Healthwatch survey do indicate a real willingness to consider and help shape new models of care.

The Trust acknowledges Healthwatch's recommendations for a clear and robust communications and engagement strategy on the future of Charing Cross Hospital and for more clarity about decision-making structures and lines of responsibility and accountability.

This is in line with our own approach and follows on from our well-received 'open door' event at Charing Cross in November 2017 for patients and the public that aimed to mark and celebrate the hospital's past, share and clarify current plans and to look to the future.

The Trust is also actively encouraging and enabling involvement in all aspects of our work, including with the Hammersmith and Fulham integrated care partnership, mentioned in the Healthwatch report, and which includes a number of other NHS and local authority partners as well as the Trust.

We look forward to continuing to work with all our stakeholders on these very important issues.

4. Healthwatch report recommendations

While the full Healthwatch report forms an appendix to this report, the section on 'Recommendations' is set out below.

Recommendations

To ensure that everyone who values Charing Cross Hospital as an important part of their community, or who has used, or may use, it in the future is able to have their say on its future, we recommend that:

1. A clear and robust communications and engagement strategy should be developed and implemented. This should clearly set out:

a. The process by which decisions about the future of Charing Cross Hospital will be made
b. How this will be communicated to local people and others that use the hospital
c. How local people and others who use the hospital will be involved in the decision-making process
d. Clear routes for patients to have their say
e. A timeframe for engagement.

At the time of writing this report, changes are taking place in the governance structure across the North West London STP area. Some decisions about local health provision that will be implemented by Hammersmith and Fulham CCG are now taken by North West London Collaborative CCGs. Healthwatch CWL has raised concerns and questions regarding the new governance structures and routes of accountability for local people with regards to decisions made at NW London Collaborative CCG level. The lack of clarity about decision making structures and lines of responsibility and accountability adds to the confusion surrounding the future of Charing Cross Hospital.

Therefore, our second recommendation is:

2. North West London Collaborative CCGs, Imperial College Healthcare NHS Trust and Hammersmith and Fulham CCG should provide clear information about how, by what criteria and by whom decisions about the future of Charing Cross Hospital will be made and who is responsible for local communication and engagement on its future.

Due to the lack of information about the timeline of changes in governance we are not able to suggest a specific deadline. Therefore, we suggest that North West London Collaborative CCGs, Imperial College Healthcare NHS Trust and Hammersmith and Fulham CCG should indicate by when they will be able to implement Healthwatch CWL recommendations.

5. Recent Trust statement on Charing Cross Hospital

In response to recent media coverage about the future of Charing Cross Hospital, on 27 February 2018 the Trust issued a statement which is set out in full below.

A spokesperson for Imperial College Healthcare NHS Trust said:

“Plans to develop Charing Cross as a ‘local hospital’ were paused in 2016. The continuing rise in acute demand means that we are focusing first on the development of new models of care to help people stay healthy and avoid unnecessary hospital stays.

“Since 2016, we’ve committed over £20 million for building improvements and new imaging and radiotherapy equipment at Charing Cross. We’ve also developed new services and employed extra doctors, nurses and other healthcare staff. More investment is already planned for 2018 and 2019, including an expansion of the A&E department.”

Key proposals and decisions:
In 2012, the local healthcare commissioners for north west London (then called primary care trusts) published the ‘Shaping a healthier future’ service strategy. They undertook a full public consultation on plans for a more integrated approach to care, with the consolidation of specialist services onto fewer sites, where this would improve quality and efficiency, and the expansion of care for routine and on-going conditions, especially in the community, to improve access.

Charing Cross was envisaged as a 'local hospital' within this network of services, building on its role as a growing hub for integrated care offered in partnership with local GPs and community providers.

After developing the proposals further with feedback from the consultation, the local commissioners put forward their service change strategy for approval to the Secretary of State for Health. In October 2013, on the recommendation of the Independent Reconfiguration Panel, the Secretary of State supported the proposals in full, though adding that Charing Cross Hospital should continue to offer an A&E service, even if it was a different shape or size to that currently offered. He also made clear that there would need to be further engagement to develop detailed proposals.

The Trust published its own clinical strategy and estates plans in 2014 that included outline proposals for Charing Cross to become a 'local hospital'.

Since then, the Trust and local commissioners (now called clinical commissioning groups or CCGs) have put a hold on subsequent work to develop detailed plans for Charing Cross due to increasing demand for acute hospital services. This continuing rise has meant we need to focus first on the development of new models of care to help people stay healthy and avoid unnecessary and lengthy inpatient admissions.

Current position:
A commitment to NOT progress plans to reduce acute capacity at Charing Cross unless and until we could achieve a reduction in acute demand was formalised in the North West London Sustainability and Transformation Plan (STP) published in 2016. STPs are five-year plans for the development of health and care services across geographic areas produced by a range of NHS, local authority and third sector organisations.

The STP for north west London added that Charing Cross will continue to provide its current A&E and wider services for at least the lifetime of the plan, which runs until April 2021.

Given that attendances across all of our A&E departments and urgent care centres have increased by six per cent over the past two years – and urgent admissions by 11 per cent – we can predict that it will be some years into the future before acute demand has reduced sufficiently for us to look to reduce inpatient bed numbers or A&E capacity.

Recent and planned investment:
We've recently seen some of our largest ever investments in new facilities and equipment, much of which has been made possible by the support of Imperial Health Charity.

Since 2016, we've committed over £20 million for building improvements and new imaging and radiotherapy equipment at Charing Cross. This includes: Riverside theatres; main outpatient clinics; a new acute medical assessment unit; our first patient service centre; and the main new facility for North West London Pathology. We're also replacing imaging equipment and installing two state-of-the-art LINAC radiotherapy machines so we can provide the most advanced cancer treatments. And we have an active 'backlog maintenance' programme that covers developments such as new lifts.

We've also developed new services and employed extra doctors, nurses and other healthcare staff.
More investment is already planned for 2018 and 2019, including a refurbishment and expansion of the A&E department.
(Statement Ends)

healthwatch
Central West London

Healthwatch Central West London

Charing Cross Hospital: Experiences of Today, Questions for Tomorrow

February 2018

Contents

1. Introduction

The continued uncertainty around the future of Charing Cross Hospital has been raised repeatedly by residents to Healthwatch Central West London.

Discussions about future models of healthcare and what this means for Charing Cross Hospital have been dominant in the London Borough of Hammersmith and Fulham and more widely for many years both on the ground and on a strategic level.

This report provides patient views on the future of Charing Cross Hospital and their experiences of using the hospital. We heard very strongly that residents want to be at the heart of the way health and care services are being shaped and delivered.

It is not the purpose of this report to either record or analyse the history of this debate, nor to explore its socio-political manifestations and implications but we hope that our findings will be used to inform these discussions.

Healthwatch CWL carried out specific work around Charing Cross during October and November 2017 that included:

- Submission of questions to Hammersmith & Fulham Clinical Commissioning Group; Imperial College Healthcare NHS Trust; and North West London Collaboration of Clinical Commissioning Groups. A joint response to these questions was received on 9th November 2017.
- Outreach survey work to collect outpatients' experiences of using Charing Cross Hospital and their views on its future. In total, 218 surveys were collected over four full days, morning and afternoons: Friday 17th, Tuesday 21st, Wednesday 22nd and Thursday 23rd November 2017.

The report focuses on analysing the joint response from Imperial College Healthcare NHS Trust (ICHT) and North West London Collaboration of Clinical Commissioning Groups (CCGs), and the survey responses.

The report aims to:

- Build a comprehensive picture of the current situation at Charing Cross Hospital, captured within the timeframes that our project work took place.
- Provide patients' views and experiences for key decision makers, responsible bodies, as well as residents and groups to inform their position and future actions.

Main themes explored are:

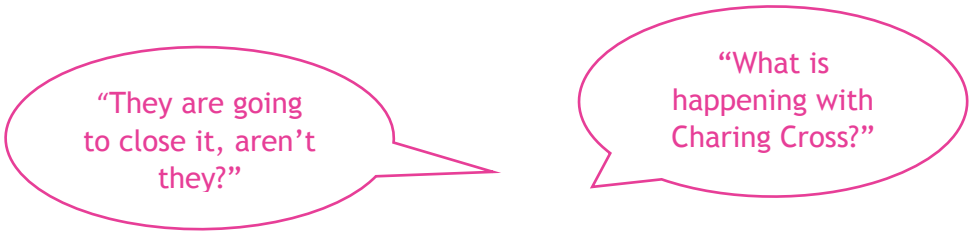
- Patient involvement in the future provision of Charing Cross Hospital.
- Patient experience of the hospital in terms of
    - a) treatment,
    - b) communications with staff,
    - c) waiting times, and
    - d) travel distance.
- Evaluating the importance of Charing Cross Hospital for patients.

- Exploring patients' perceptions of ‘local hospital’ definition.
- Testing patient preference of using ‘out of hospital’ services.

This report was presented as a draft to the Hammersmith and Fulham Health, Adult Social Care and Social Inclusion Policy and Accountability Committee (PAC) meeting on the 30th January. Slight amendments have been made to this final version to include this and reflect comments received. The Committee welcomed the report and recommended that it should be presented to the Board Meetings of Imperial College NHS Healthcare Trust Board and Hammersmith and Fulham CCG and at the Joint Health and Social Care Scrutiny Committee.

2. Methodology

A key aspect of Healthwatch Central West London's work is to provide information to the public about healthcare and changes in local provision. We also listen to people's experiences of accessing healthcare and whilst doing this we have heard concerns about the future provision of Charing Cross Hospital from residents on a number of different occasions.



To help local people get the answers they need, we put forward questions regarding the future of Charing Cross Hospital to the relevant responsible bodies.

The questions were formulated in collaboration with the Healthwatch Local Committee in Hammersmith and Fulham. Local Committee members submitted their questions by e-mail and in a special meeting held on Friday 4th August 2017. Further changes to questions occurred through e-mail communications in which Healthwatch representatives at Imperial College Healthcare Trust were also included.

The questions covered the following themes:

- Communications and Involvement
- A&E and Wider Services
- Beds, community services and accessibility
- Charing Cross in the national context
- Funding
- Technical infrastructure

The questions were submitted directly in writing to Hammersmith and Fulham Clinical Commissioning Group; Imperial College Healthcare NHS Trust; and North West London

Collaboration of Clinical Commissioning Groups on the 5th October 2017. By law organisations who plan, run, and regulate health and social care services must listen to our comments and respond within 20 working days.

On 6th November 2017 we received a joint response addressing most of the questions signed by Imperial College Healthcare Trust and North West London Collaborative of Clinical Commissioning Groups. We received the outstanding responses on Thursday 9th November 2017.[1]

Along with their response, Imperial College Healthcare Trust informed us that it was organising a public event on 27th November 2017 with special focus on Charing Cross Hospital. We believe that this was an immediate outcome of Healthwatch pointing out local concerns and uncertainty of the future of Charing Cross.

Following this, we designed a survey to collect people's experiences of using Charing Cross Hospital and their views on its future.[2] As a main reference point for the design of the survey we used the joint response received. We asked people to complete the survey during outreach at Charing Cross Hospital where we held a stall on the 1st floor for four full days: Friday 17th, Tuesday 21st, Wednesday 22nd and Thursday 23rd November 2017.

We collected a total number of 218 responses from outpatients, with an average of 50 each day.

The survey focused on the following themes:

- Identifying patients geographical spread.
- Capturing patient experience of the hospital in terms of
    - a) treatment,

[1] To read the questions and the joint response go to Appendix a, p. 27
[2] To read the survey questionnaire go to Appendix b, p. 45

    - b) communications with staff,
    - c) waiting times, and
    - d) travel distance.
- Evaluating whether and why Charing Cross is important for patients.
- Testing patient preference of using “out of hospital” services.
- Exploring what turning Charing Cross into a “local hospital” means for patients.
- Identifying if patients want opportunities to be involved in shaping the future of the Charing Cross Hospital.

The survey statistics include “no answer” data, as in some cases patients chose not to respond to all the questions. When appropriate, this information has been included in the data, as it helps to build the picture of how patients currently view and experience Charing cross Hospital.

Most of the people we surveyed identified themselves as patients (85.4%), although a small percentage identified themselves as carers (6.85%) and visitors (7.3%). For the purposes of this report, when we refer to patients, we refer to everyone surveyed.

We have also collected demographics and these are available on request.

3. Summary and Key Findings

As outlined in the introduction, this report aims to build a comprehensive picture of the current situation for Charing Cross Hospital that will provide stakeholders with evidence about patients' views and experiences to help them inform their future decisions and actions.

The main findings that this report focuses on analysing in the following chapters are:

- **Patient Involvement:** Patients want more opportunities to be involved in shaping the future of Charing Cross Hospital.
- **Patient Experience of Charing Cross on the Day:** Patients are extremely satisfied overall with their experience, especially in terms of satisfaction of treatment and staff communication.
- **Patient Information:** Patients are confused about the definition of what a ‘local hospital’ might be and want more information to help them inform their position.
- **Patient Perception of Charing Cross:** Patients value Charing Cross Hospital for both its services and its role in the community.
- **Patient Preference on Out of Hospital Services:** Patients would prefer to continue using Charing Cross Hospital instead of their GP practice.

Our analysis also takes into consideration patient flow. It shows, where appropriate and possible, distinctions between all patients, those living in the STP North West London area and Hammersmith and Fulham residents.

When we refer to patients in this report, we are referring to outpatients. We acknowledge in both the introduction and methodology chapters that surveying inpatients or patients waiting for A&E treatment could provide different results.

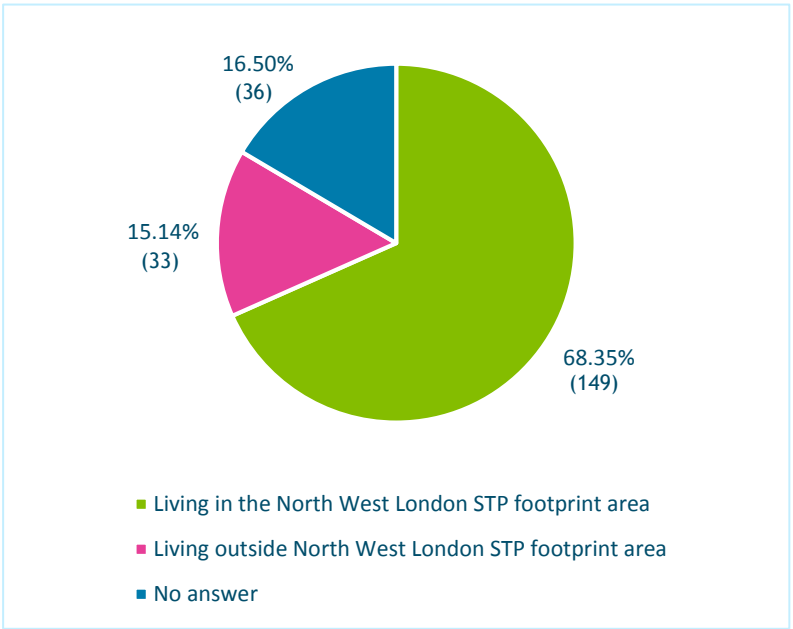
The main finding of this report is the high number of people indicating that they would like opportunities to be involved in the future of Charing Cross Hospital and what type of provision it might be after 2021.

Further findings on a) positive patient experience, b) the importance that Charing Cross Hospital has for patients, c) the need to clarify what is meant by "local hospital", and d) further work on understanding patients' preference for out of hospital services provide useful information that stakeholders can explore to ensure patient involvement can happen at an early stage.

4. Patient Flow

Healthwatch Central West London's role is to capture patient experience of people using services in Royal Borough of Kensington and Chelsea, City of Westminster and Hammersmith and Fulham. This includes all patients that are using health or social care services that are based within these Boroughs, regardless of whether they are local residents.

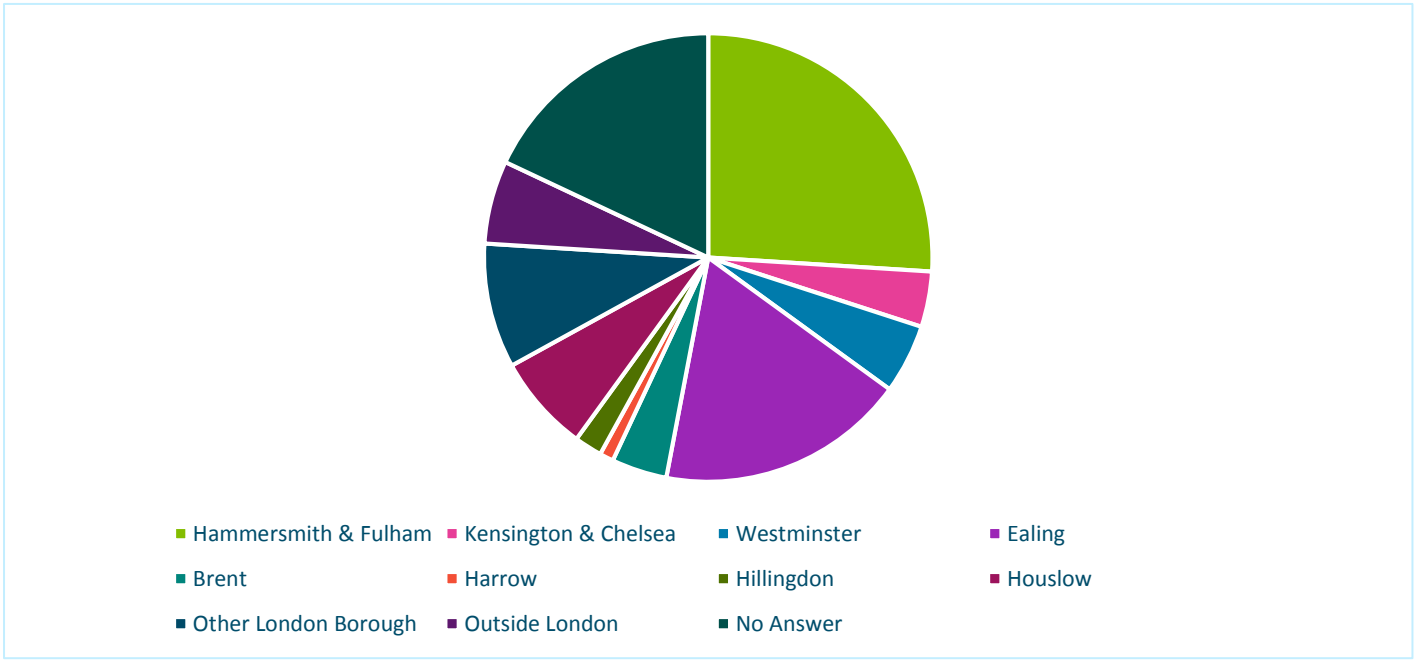
To get a better understanding of who uses Charing Cross Hospital, we asked the patients we spoke to provide us with their home postcode where possible.

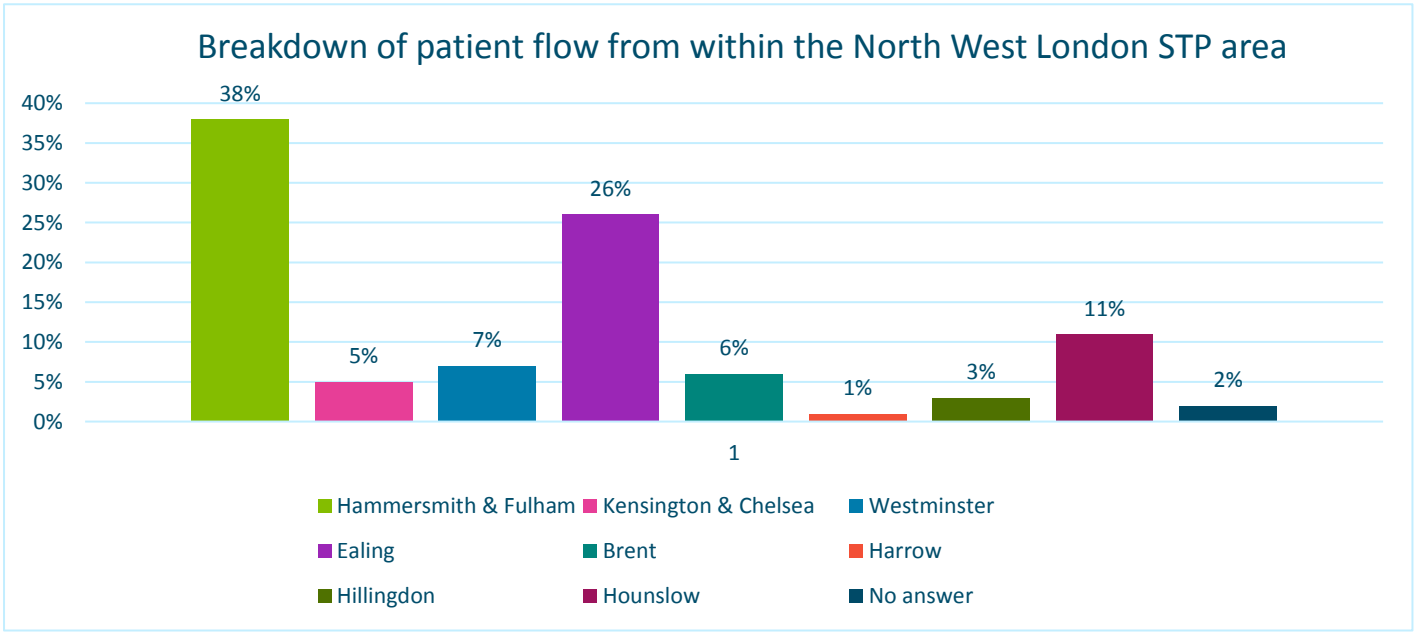


As we can see in the pie chart, although most patients lived within the STP North West London area (68.35%), a significant number visiting Charing Cross Hospital on the days we were there, live either in other parts of London or across the country (15.14%).

This could indicate that the future of Charing Cross Hospital will be of wider interest than local and North West London stakeholders.

The pie chart below provides a better sense of the geographical distribution of patients.





This diagram, focused on patients from within the North West London STP area, shows that patients came mainly from Hammersmith and Fulham (37%), followed by Ealing (26%) and then Hounslow (11%).

The results of the survey do not change dramatically when we look at patient experience according to a breakdown of areas (Hammersmith & Fulham, North West London STP area and all patients surveyed). However, where appropriate the report breaks our findings down to different areas for comparison.

5. Analysis of findings

A) Patients ask for involvement

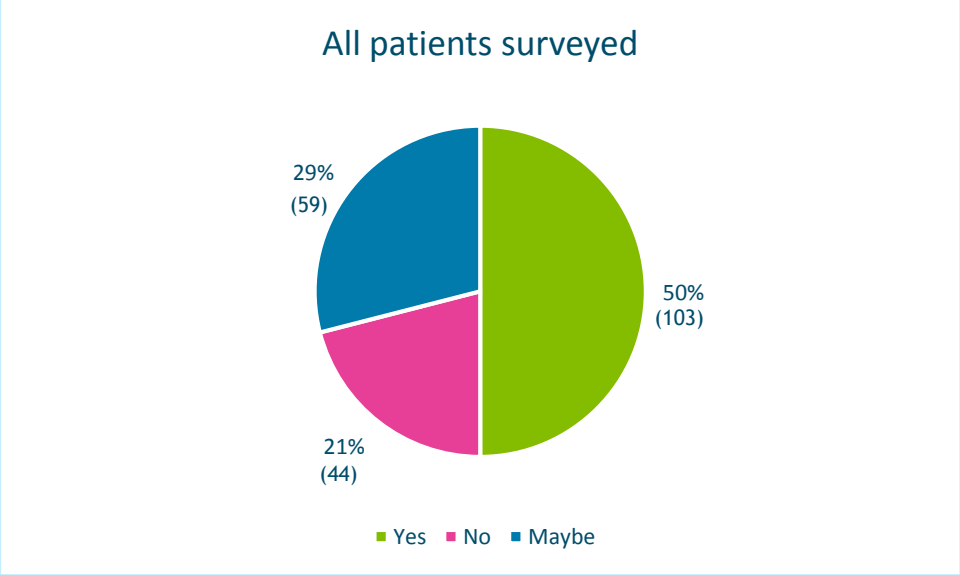
Our survey highlighted Imperial College Healthcare NHS Trust (ICHT)'s position that no changes are going to happen until 2021 and asked patients if they would like to be involved in shaping the future of Charing Cross Hospital. The main finding of this report is that a high number of patients responded yes and requested involvement opportunities.[3]

What did patients tell us about involvement in the future of Charing Cross Hospital?

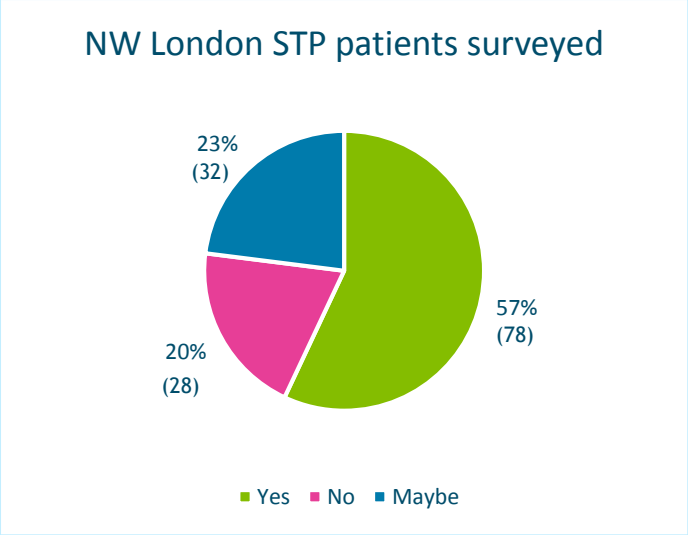
From the 218 people surveyed, of those who answered the question on whether they would like opportunities to be involved in the future of Charing Cross Hospital (206), 50% said they would like opportunities to be involved; 29% said maybe and 21% said no.

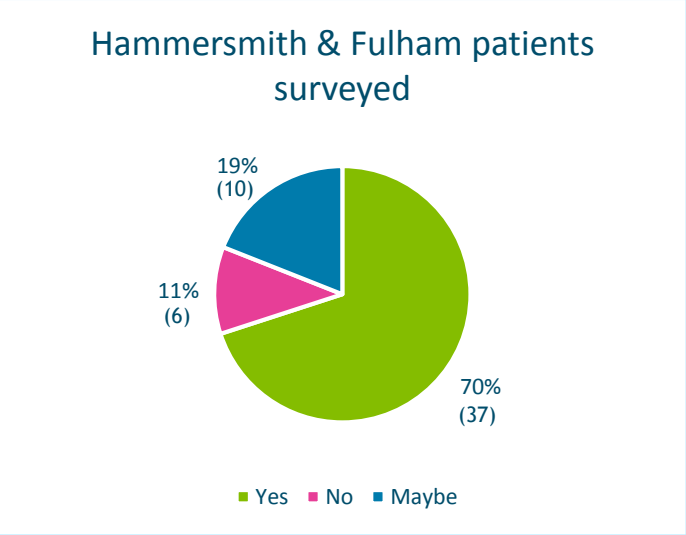
The numbers rise slightly when the question is applied to patients living in the STP North West London footprint area; 57% yes, 23% maybe and 20% no.

Looking specifically at the data from Hammersmith & Fulham, the request for involvement rises, with 70 % saying that they would like opportunities to be involved, 19% maybe, and 11% replying no.



[3] Appendix b, Question 8, p. 46





In addition, from the 218 people surveyed, 16% (35) said that they would be happy to be contacted by Healthwatch for a face-to-face or phone interview to talk more about their experiences of Charing Cross and share their views on its future.

What did ICHT and North West London Collaborative tell us about plans for public involvement in the future of Charing Cross Hospital?

In their joint response, ICHT and North West London Collaborative clearly stated that they want to engage and involve patients for future developments. ICHT organised an event on Monday 27th November 2017 to inform patients about their current position on Charing Cross and they said that a series of events will take place in 2018 to mark 200 years since the birth of Charing Cross Hospital.

The joint response emphasised a need for public engagement and referred to the communications and engagement plan that has been put forward by Hammersmith and Fulham CCG (Appendix a., p. 29). However, the response also pointed out that engagement with patients specifically around Charing Cross has been put on hold until plans are unveiled (Appendix a., p. 34).

In addition, Imperial is part of a collaboration of organisations – the Hammersmith and Fulham Integrated Care Partnership – that is working together to develop "a radically better way of providing care for the population of Hammersmith and Fulham through an integrated/accountable care approach" (Appendix a., p. 38). Healthwatch CWL is also represented part of this collaboration. Based on the data gathered through our survey, we suggest that more information is required to ensure that residents can be fully aware of this partnership, how it works and how people can be involved. In addition, patients from different sectors of the community should be invited to participate and help shape this partnership. The results from our outreach should encourage stakeholders to involve patients at this very early stage in the future of Charing Cross Hospital.

The following chapters provide more information on the elements that could be considered in a new patient involvement plan for the future of Charing Cross Hospital.

B) Patient Experience

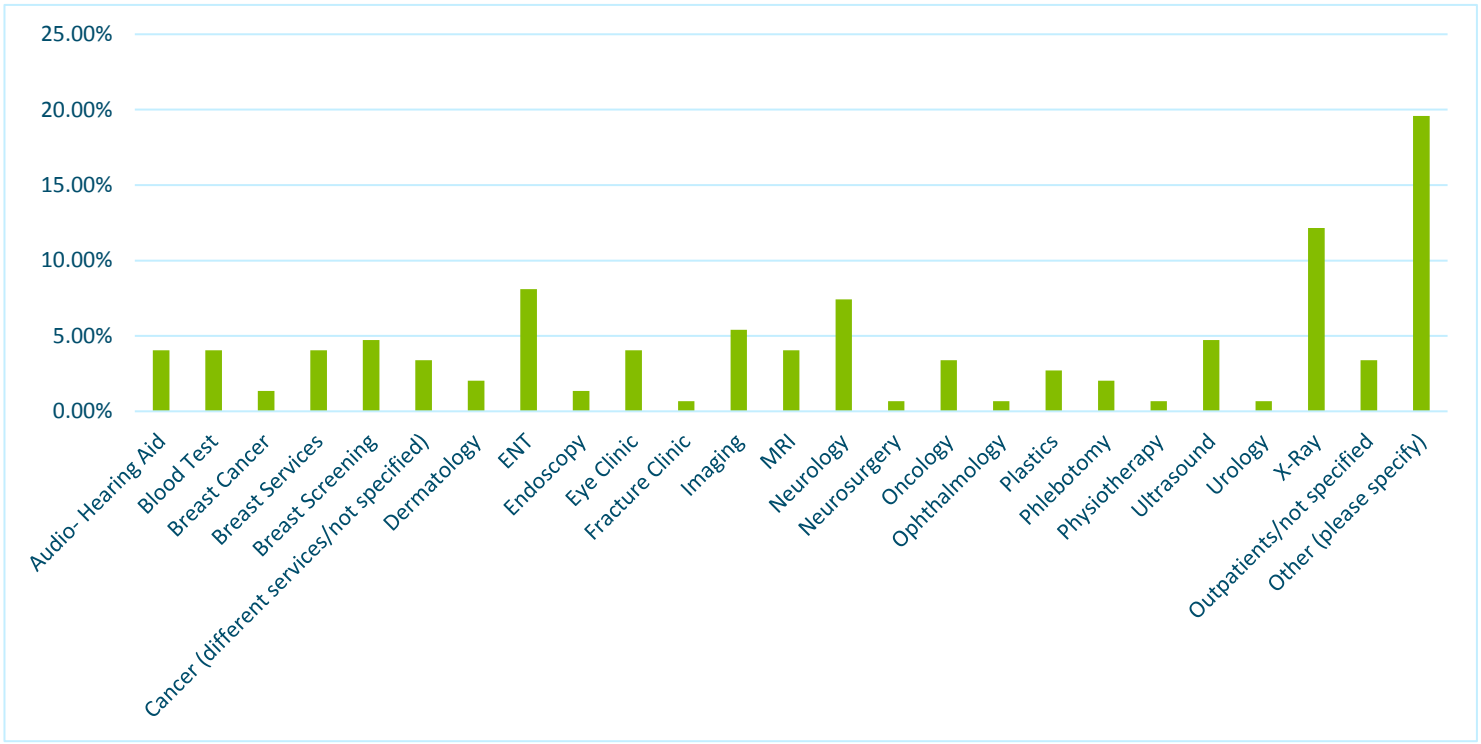
We asked patients to share their experiences of using services in Charing Cross Hospital on the specific day that they visited the Hospital[4].

Patients were invited to tell us how satisfied they were with their experience of using the hospital in four different categories:

- the time they waited to be seen,
- the distance they had to travel to get to the Hospital,
- the treatment they received,
- the communication from staff members.

Most patients said they were “extremely satisfied” with their experience overall. This was followed by high levels of “very satisfied” or “satisfied”. Very few people chose “not satisfied” or “not satisfied at all” in all cases.

The patients we met on the days of the survey were at the Hospital to use a variety of different services and specialist support, such as ENT, breast screening, neurology, audio-hearing, attending mainly regular or pre-scheduled appointments with different referrals times, varying from one day to more than 6 months.



[4] Appendix B, Question 4, p. 45

Treatment and communication from staff

As is evident from the data shown in the table on page 13, the two areas that scored particularly highly in the "extremely satisfied" option are communication from staff (58%) and treatment received (59.36%).

Nearly 90% of patients said they were satisfied with their treatment and the communication they had with staff; whilst no patient chose the "not satisfied at all" option with regards to their treatment.

The results complement the Care Quality Commission (CQC)'s recent report that found outstanding practices in Charing Cross Hospital: "*Without exception, patients told us they were treated with kindness, dignity, respect and compassion. There was a high standard of care provided for patients on the medical wards, and we saw that staff went to great lengths to respect and accommodate the wishes of patients and their loved ones. There was a strong, caring and visible-centred culture, which was fully rooted on all the medical wards visited*".[5]

The quantitative data is complemented by comments made by patients, some of which are listed below.

Comments made by patients on treatment and staff:

"Very efficient, friendly staff and was seen immediately even though I was early."

"The staff and doctors are always kind, courteous and helpful. Couldn't ask for more!"

"Friendly, professional, approachable staff."

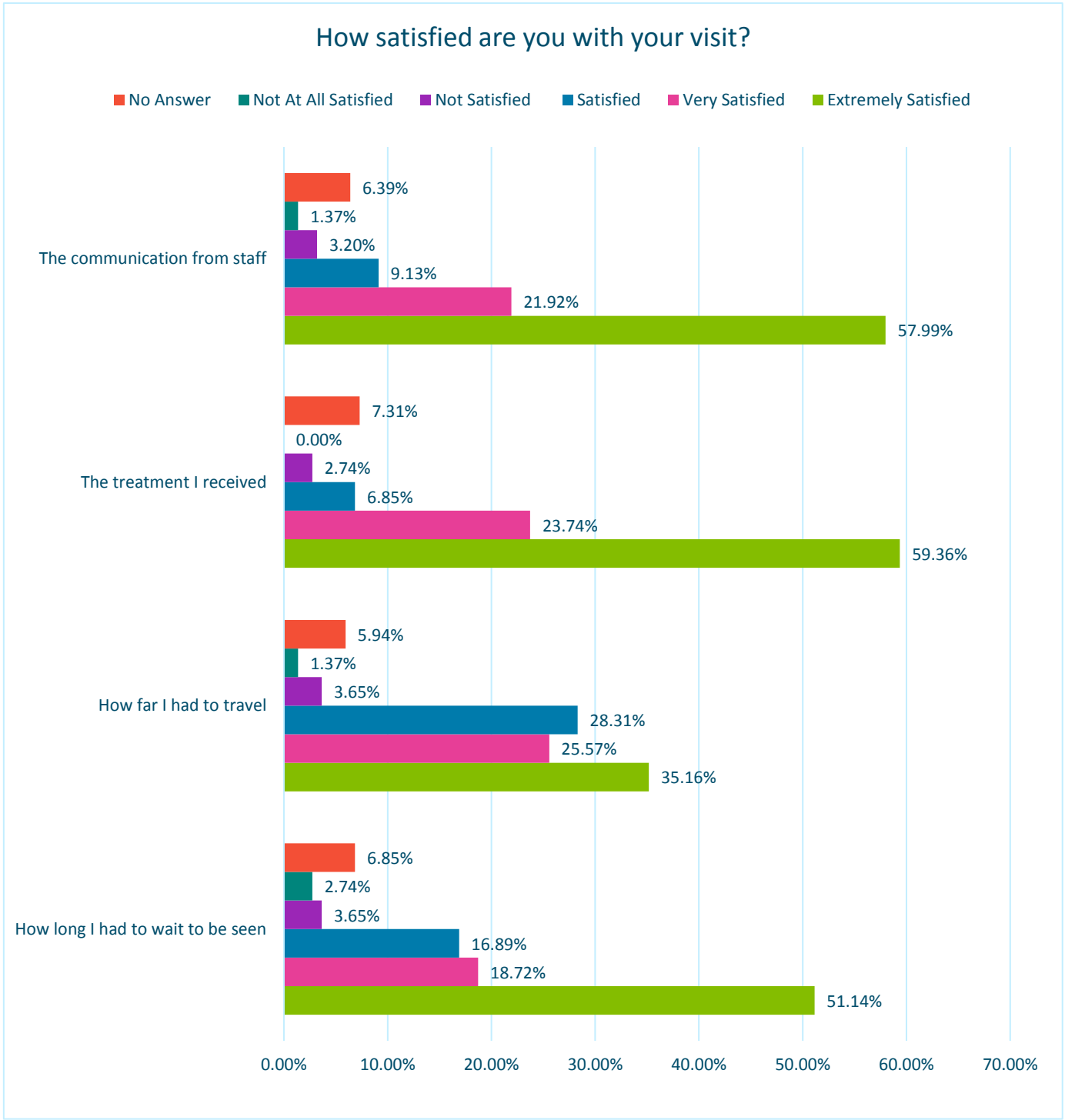
"The atmosphere at Charing Cross is very nice, comforting."

"The treatment care and expertise I have received through a really difficult time by the Neurology and stroke teams has been excellent."

"The professionalism of the specialist nurse is superb."

"Impressive and consistently high standard, well done Charing Cross."

[5] Charing Cross Hospital Quality Report, Date of inspection visit: 7th-9th March 2017, Date of publication: 19/10/2017, p. 4



Waiting times

In this report, patient satisfaction about the time waiting to be seen refers to the time from the moment they arrived at the hospital to when they were seen. As shown in the table on page 12, the levels of satisfaction are high, with 75% of patients saying that they were extremely, very or just satisfied. However, as we saw from our question on treatment received, most appointments were regular appointments or pre-scheduled, and this will have a bearing on responses. Further work and analysis on patient referrals could be done by ICHT to look at the waiting times for outpatients.

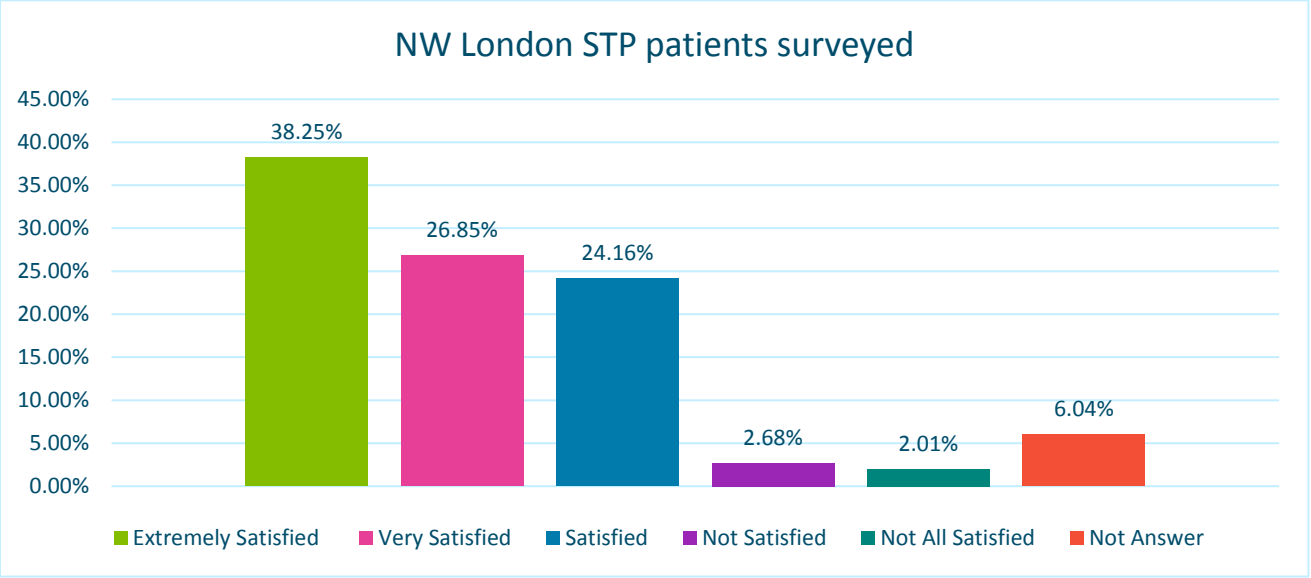
The only question for which the “extremely satisfied” option scores below 50%, at 35.16%, was about patients' feelings regarding the time they had to travel. Even for this question it was the highest scoring choice. The overall levels of satisfaction reach nearly 90%.

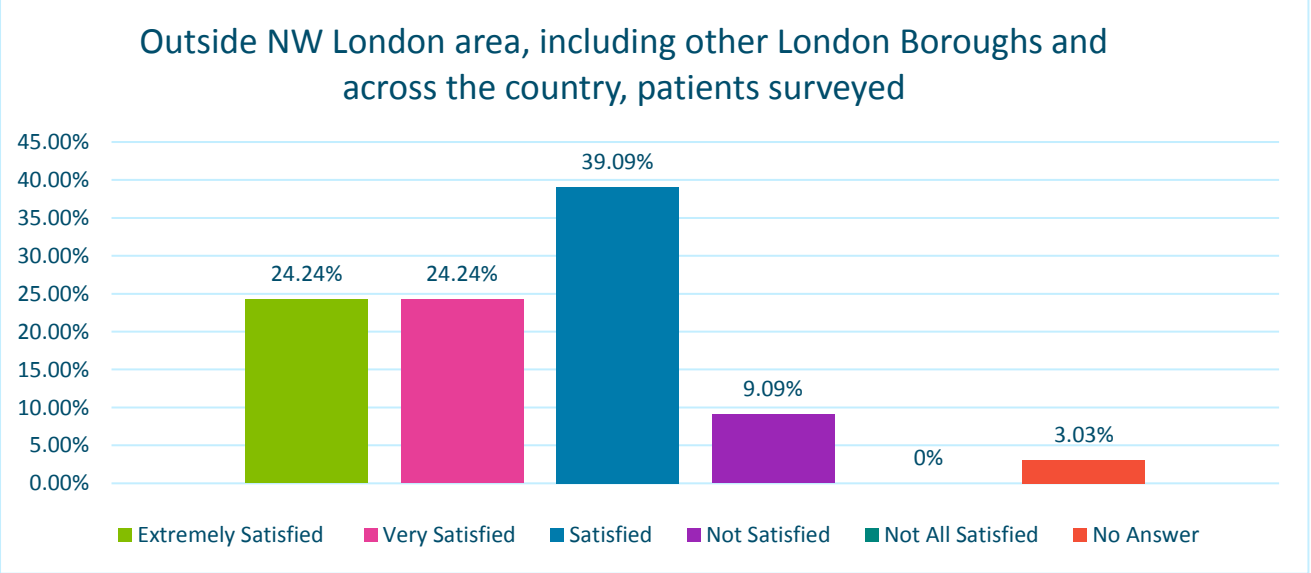
Travel distance

Looking at the data gathered for this question for within the North West London STP area and residents outside that area (other London Boroughs and across the country) separately, there is a slight difference but not as high as might be expected. This may imply that travel distance is not necessarily experienced according to miles, but rather is open to personal interpretation and may also be related to the quality of the experience.

As one patient put it:

“It's so good. Oncology. Moved out of London and come 30 miles-that's how important it is.”





However, there will always be room for improvement. Despite the high levels of patient satisfaction outlined in this chapter, we identified the following two areas that ICHT could look at more closely.

- **Concerns about levels of cleanliness in the inpatient units**

As we have already highlighted the survey was done with outpatients. However, we received a few comments and concerns from people who were either visiting a family member in the inpatient unit or have recently used the inpatient units about the levels of cleanliness.

- **Lack of appropriate signage for outpatients**

During our outreach, a high number of patients who completed our survey were people who had initially asked us for directions to the Clinic where their appointment was. This was due to a lack of proper signage on the 1st floor for outpatients.

C) Importance of Charing Cross Hospital for Patients

The picture of positive patient experience demonstrated in the previous chapter is complemented by comments received by patients about their general experience of Charing Cross Hospital.

> *"Charing X is one of the best hospitals in the world. Expertise and the care was outstanding. It works to prevent and tackle the illness. Brilliant at coordinating treatment in the hospital"*

Patients were asked to indicate what was important for them about Charing Cross Hospital.[6] The could select as many options as they liked from the following categories:

- A&E Department
- Urgent Care Centre
- Outpatient services
- Impatient Services
- Charing Cross Hospital is an important part of my community
- Charing Cross Hospital is not important to me

The combination of quantitative and qualitative results from the survey show high appreciation of specialist care, the variety of services offered, and a strong recognition of its importance for the community.

[6] Appendix b, Question 6, p. 46

Comments reveal an attachment to Charing Cross Hospital that is based on previous treatment received, the continuity of care, and recalling memories of significant moments in their lives when they were patients.

Below, we have separated some of the comments received into different categories, giving an indication of where the patient lives for each, to build a full picture of Charing Cross Hospital and its importance for patients. It seems to have a historic significance that goes beyond geographical boundaries.

Part of the community and beyond:

"CXH is and have always been an important part of the community." (H&F resident)

"I am 76 years old and I have lived in Hammersmith for 45 years. This Hospital has always been very good for me and my husband" (H&F resident)

"Charing Cross not important to me -unthinkable. The spirit of ethos of Charing Cross Hospital was carried to this site by staff from the strand location -always the best." (H&F resident)

"This hospital is very important to my community, Definitely" (Hounslow resident)

"I have been coming to this hospital for many years, it is my hospital." (H&F resident)

A&E:

"It is important (vital for my condition) that there are good fast communications between A&E and my hospital consultant. This why I chose to come to A&E here." (Kingston resident)

"Visited A&E and was an in-patient when I had pneumonia. Diagnosis saved my life and have used the resources here a lot!" (Ealing resident)

"I attend regularly to see various consultants and have had bad asthma and lungs, so I need A&E and all the consultants in one Hospital." (Hounslow resident)

"Hammersmith Hospital doesn't have an A&E only UCC but it isn't well equipped for emergencies such as asthma attack. When I had one I was sent to Charing X A&E." (H&F Resident)

General and specialist services:

"I have used this hospital a lot for many services and it's brilliant" (Ealing resident)

"There is a high stand of specialised multidisciplinary care at Charing X" (Hounslow resident)

"My experience is (related) to my mum's treatment for cancer. I think the hospital does a good deal for the patient and its care and the staff and nurses go above and beyond." (Westminster resident)

"Everything is well planned. I feel that everything is focused on me. I feel special!!" (no postcode provided)

Specialist services such as cancer services, the stroke unit, as well as the A&E department and the value people give to the hospital as an important part of the local community and its historical significance, are key elements of the patient experience that should inform any future changes.

D) A Local Hospital?

The plans for Charing Cross to become a local hospital were set out in *Shaping a Healthier Future* service reconfiguration for North West London document which was published in 2012.[7] This document is a key marking point in the debate around Charing Cross Hospital.

Imperial College Healthcare NHS Trust (ICHT) and the North West London Collaborative of CCGs (NW London Collaborative CCGs) have repeatedly said, including in their answers to Healthwatch CWL, that Charing Cross will continue to provide A&E and wider services for at least the lifetime of the Sustainability and Transformation Plan (STP) for North West London which runs until 2021.[8]

STPs are part of governmental plans for changes to the healthcare system; their aim is to change the way healthcare is being designed and delivered, moving from a reactive approach to a more proactive model. They promote a increased focus on prevention and primary care to keep people healthy closer to where they live (i.e. GPs, community services and the voluntary sector) with the aim of reducing pressure on secondary care (i.e. inpatient units at hospitals). Consequently, future changes to Charing Cross Hospital's provision will be influenced by the way that the STP is delivered in North West London.

[7] Shaping a Healthier Future: https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/Shaping%20a%20Healthier%20Future%20Consultation%20Document%20Updated%20August%202012.pdf

[8] The STPs, part of governmental plans, were published in 2016 aiming to provide a strategic framework of how healthcare is going to be designed across a big geographical area and they are planned to run until 2021. The STP for NW London footprint area: https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/stp_june_submission_draft.pdf

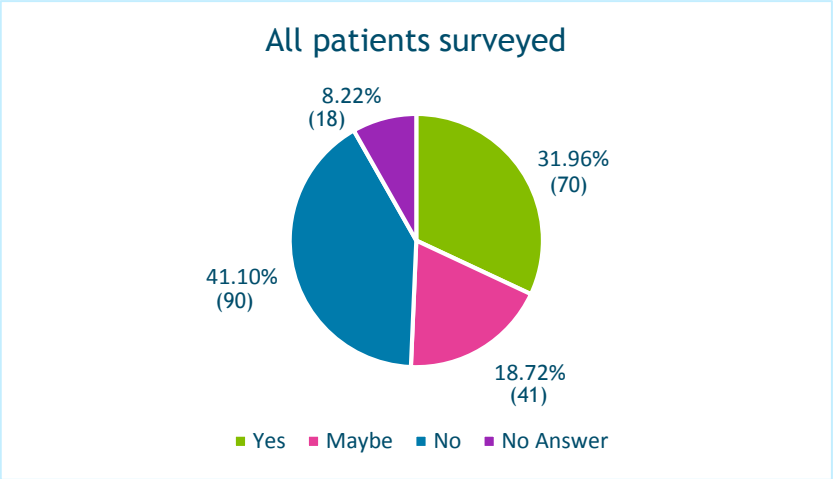
The definition of a "local hospital" which was set out in *Shaping a Healthier Future* (and repeated by ICHT and North West London Collaborative of CCGs in their response to Healtwatch CWL) is as follows:

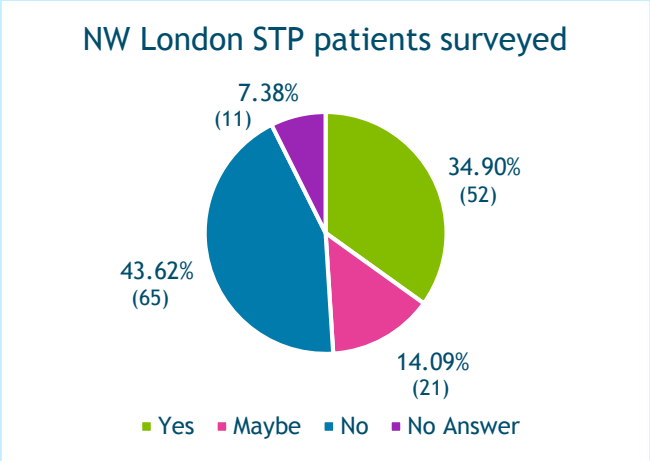
"A type of hospital that provides all the most common things people need hospitals for, such as less severe injuries and less severe urgent care, nonlife threatening illnesses, care for most long-term conditions such as diabetes and asthma, and diagnostic services. It basically provides the kinds of services that most people going to hospital in NW London currently go there for."

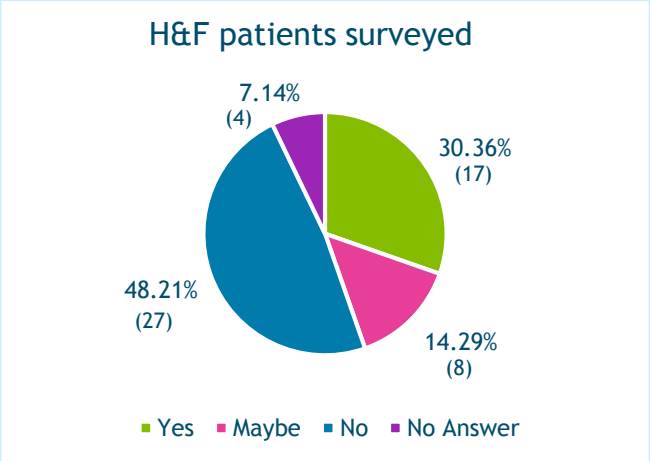
What did patients tell us about turning Charing Cross into a "Local Hospital"?

Our survey asked patients if they feel that their health needs and those of others in their local area, will be fully met by Charing Cross becoming a local hospital (after 2021) as described above.[9]

As the three pie charts below show, there was no clear consensus about whether people felt that their health needs would be met by Charing Cross becoming a local hospital. When looking at all patients surveyed, **just over 40%** said that their health needs **would not** be met, **just over 30%** said that their health needs **would** be met and nearly 19% saying maybe, while around 8% did not answer this question.







[9] See Appendix b, Survey, Question 7, p. 46

The number of patients who do not think that their health needs will be fully met by Charing Cross becoming a local hospital gets slightly higher if we look at patients living in the STP North West London area, at just over 43% and slightly higher still when examining the data from Hammersmith and Fulham patients only, at about 48%.

Examining the comments received to this question gives us a fuller picture of the concerns that people have regarding changes to Charing Cross Hospital. Most show that people do not understand what a local hospital means and how this is going to affect the services they currently receive.

"I do not know, if I don't know what local hospital is."

"It is a very vague statement. We need A&E, we need a cardiovascular ward, breast screening. As we live longer and develop more illness in later life we need a hospital to care for us."

"They want to change it into a clinic. That's how it sounds. What are they going to do with emergencies?"

"The explanation is rubbish: not accurate, not informative."

"I will decide when plans are ratified. Things will change to meet changing needs and funding."

"It's not really clear what local hospital means; could be a bad or good thing."

There were a number of comments from people that did not support Charing Cross becoming a "Local Hospital", expressing concerns about which services are going to be kept, raising doubts about the need for change and stating that Charing Cross should stay as it is.

" 'Local' suggest routine problems. Most people recognise Charing Cross as a centre of excellence."

"It should stay exactly like it is because it is an asset to this neighbourhood and other boroughs."

"The history and the medical standards and training at Charing X would not support this."

"Very big NO. Keep it like it is and A&E."

"Absolute rubbish. They should not be allowed. It is a major hospital for the community. Leave it alone. Disgraceful! I paid for 45 years. It's a government plan to privatize NHS-leave it alone!"

There were a few comments where patients stated that they would support a change under specific circumstances and for different reasons.

"Yes, As long as they don't turn it into hotels/flats."

"Yes, but I have a more local A&E at St Georges."

The combination of our quantitative and qualitative data indicates that the "local hospital" definition is open to interpretation.

All the comments received in this question can be found at Appendix 3.

What did ICHT and North West London Collaborative tell us about the future of Charing Cross Hospital?

At the ICHT event on Charing Cross on the 27th November 2017 the Trust representatives stated that they did not know what a local hospital is. However, they made it very clear that no changes will happen to the acute and inpatient units of Charing Cross until and unless there is evidence of reduced clinical need.[10] At the time of writing this report it was unclear what this evidence would include.

With 2021 only four years away, patients are confused as to **why** these changes are taking place and **what** is going to change exactly. This reflects gaps identified in the joint response we received by Imperial and North West London Collaborative.[11] Although the aim of making changes to future provision of Charing Cross has been set, a series of steps towards its implementation are yet to be taken. These include:

- **The Outline Business Case and Financial Business Care.** As stated in the response: "As we progress from the SOC (Strategic Outline Case) to Outline Business Case and Financial Business Case, all details will be refined including the equality impacts and the actions required to mitigate these. Full equality impact assessments will be undertaken in line with best practice for all relevant programmes and projects as part of their development" (Appendix a. p. 28).
- **Engagement work with residents.** As stated in the response: "The subsequent work to engage patients and the public in the development of detailed plans for Charing Cross Hospital was paused as increasing demand for acute hospital services highlighted the need to focus first on the development of new models of care to help people stay healthy and avoid unnecessary and lengthy inpatient admissions. Our approach of actively not progressing plans to reduce acute capacity at Charing Cross Hospital unless and until we could achieve a reduction in acute demand was formalised in the North West London STP published in 2016. The plan made a firm commitment that Charing Cross Hospital will continue to provide its current A&E for at least the lifetime of the plan, which runs until April 2021. We also made the commitment to work jointly with staff, communities and councils on the design and implementation of new models of care. At this stage, therefore, before the engagement process with the residents of Hammersmith & Fulham, it is too early

[10] The presentation and a video from the event can be seen here: https://www.imperial.nhs.uk/about-us/events/charing-cross-hospital-open-door-event
[11] See Appendix a, p.27

to specify the details of services Charing Cross Hospital would offer in the future." (Appendix a. p. 34)

- **Staffing.** As stated in the response: "Nothing has been 'set in stone' with regard to overall staff levels across the five years of the STP. Any changes in workforce will be part of the detailed service plans that are developed at a local level". (Appendix a. p. 41)
- **Out-of-hospital provision and reduction of demand on hospital services.** The joint response says that nationally there is evidence that supports the case for reduction in demand on hospital services through out of hospital provision. However, it states that: "Locally, we have yet to secure the capital required for the majority of the hub developments. Of the hubs which we have developed the evidence is just emerging. We are in the process of compiling this and anticipate having this available later this year. We have a full strategy for this work". (Appendix a. p. 33)

The lack of documentation along with the results of the survey and the comments people made about the lack of information provided to them raise inevitably questions regarding the future of Charing Cross provision, as the pieces that could reveal how it could look like after 2021 in the "Local Hospital" puzzle have not been revealed yet.

E) Testing Preference of Out of Hospital Services

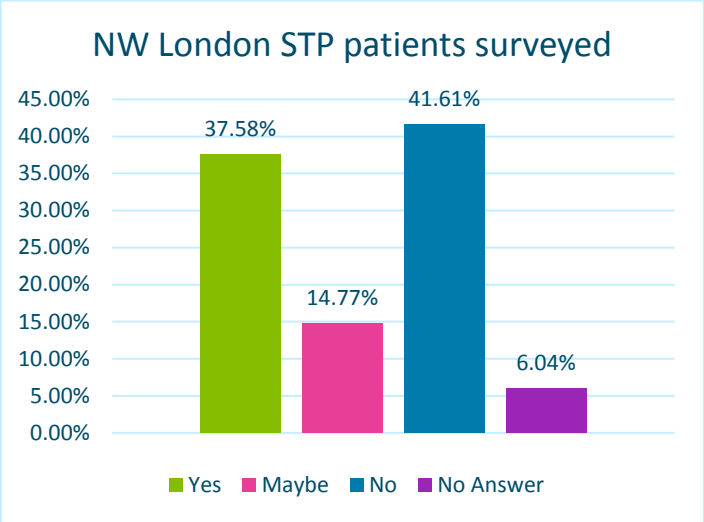
It is clear from the joint response and Imperial College Healthcare NHS Trust (ICHT) position at the event on the 27th November 2017 that no changes will be made to Charing Cross Hospital unless and until clinical need is reduced. A key component to this, as we saw at the end of the previous chapter, will be the evaluation of the out of hospital services. At the time of writing this report, there is no local evidence that the out of hospital services are decreasing hospital demand.

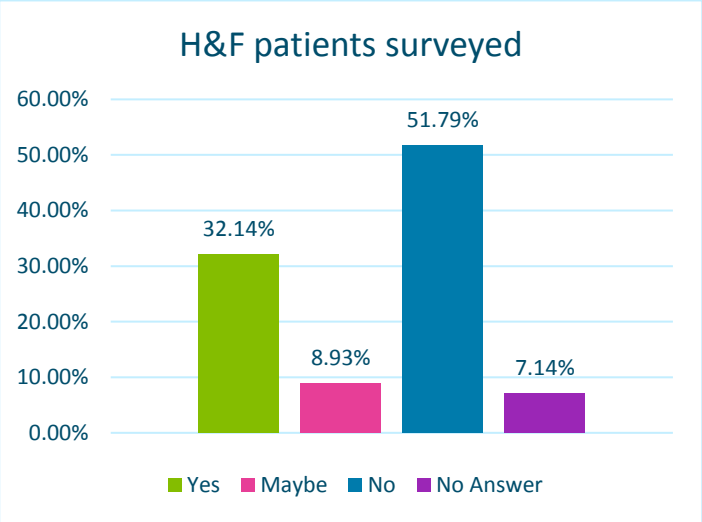
Taking into consideration the importance of out of hospital services for the future provision of healthcare and the implications this might have for Charing Cross Hospital, we thought it would be useful to test people's preferences. To get an understanding of how people feel about of hospital services, we asked patients if they would be happy to receive the service they used at Charing Cross Hospital at a different setting close to their home, for example at their GP surgery.[12]

As shown in the following two diagrams, a slightly higher number of patients from the North West London STP area would prefer to continue receiving treatment at Charing Cross Hospital than would be happy to receive treatment somewhere else, with 41.6% choosing "no" and just over 37% choosing "yes". A greater number of patients from Hammersmith and Fulham would prefer to continue receiving treatment at Charing Cross

[12] See Appendix b, Survey, Question 5, p. 45

Hospital than to receive treatment in a setting closer to their home, with just over half choosing “no” as a response and about 32% choosing “yes”.





The results are similar to the ones discussed in the previous chapter, with patients’ answers indicating mixed feelings regarding a transfer of services from hospital to their GP surgery.

The people that supported delivery of the service they used at Charing Cross Hospital in primary care, stated travel distance as main reason. However, a lot of people stated that Charing Cross is close to them.

“If the service would be closer to home, I would prefer it.”

“I live nearby the hospital. The hospital staff had always been a great help.”

For those that would not support it, the main reasons stated are:

- The lack of expertise at GP surgeries.
- The lack of equipment at GP surgeries.
- GPs are already overcrowded.
- The value of specialists at Charing Cross Hospital.
- The relationship built with staff over their time of care and treatment.

This is shown by the comments below:

“Hermodialysis is very specialised and must be done in hospital setting.”

“I have confidence in the multidisciplinary offer at Charing Cross and I am under the rheumatology department.”

“GP not specialist.”

"I prefer to visit Charing X, as I feel safe that the treatment I will get will be the best."

"Impossible for GP services, which I use and value to equal London teaching hospital standards."

"GP does not provide the same service a hospital can provide. For example dealing with emergencies."

"As long as people are qualified."

"I would rather have it here because I like the hospital."

"I have faith in CCH. They saved my life 9 years ago and have looked after me extremely well since then."

"I prefer to have it here because they are more efficient and they know what they are doing."

"Charing Cross hospital is my hospital. I am happy coming here."

"The choice is not mine. I am here for breast cancer yearly check-up."

"Can I pick up hearing aids batteries at my GP? I don't know."

"I think the complexity of my case means hospital setting needed."

"Treatment is specialised. The GP is oversubscribed and although uncertain I am sure the hospital is the best choice."

"Don't believe the GP could provide that level of service."

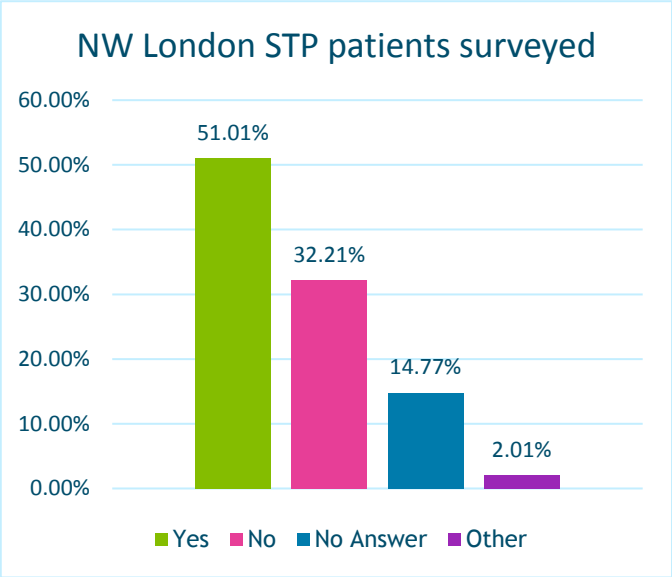
"It makes sense to separate GP clinics from hospitals. Providing citizens with options is a sign of civilisation. GPs often get it wrong."

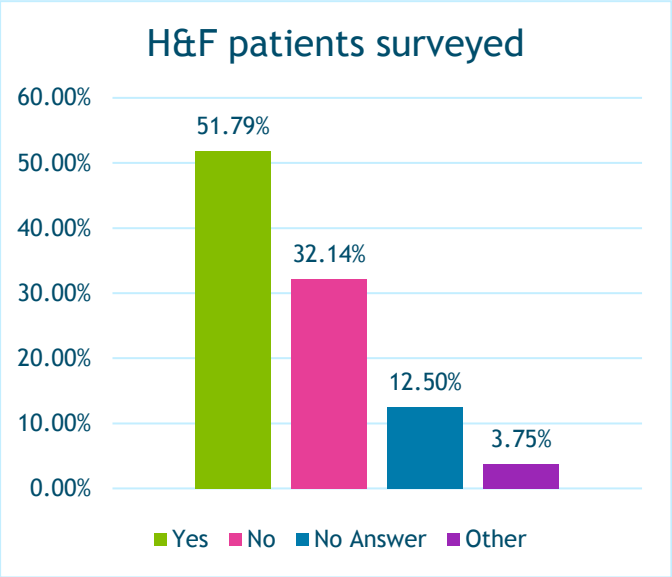
The hospital is actually closer to my home than my GP Practice. Also, I am more comfortable in a hospital setting, more expertise etc."

Hospital services are more specialized and staff have more experience of range issues as they see more patients."

For further analysis, the above results could be looked alongside the tables below that indicate that the majority of patients surveyed identified themselves as having a long term health condition. As we saw at chapter 5.b on patient experience, patients were at Charing Cross Hospital to use a variety of different services. We asked patients to tell us about their preference of using out of hospital services based on the service the visited the hospital on the day of the survey. However, we are unable to tell if they were thinking of support and treatment needed for their long term health condition or the specific service they used on the day we met them when answering the survey.

Do you consider yourself to have a long-term health condition?





Current and future plans for healthcare changes could benefit by looking more closely into patient's sentiments of out-of-hospital services to inform future work.

6. Conclusion & Recommendations

This report provides a picture of the experiences of patients using Charing Cross Hospital and their views on its future.

Patients told us very clearly that Charing Cross Hospital is an important part of their local community and for some, it brought back memories of previous visits to the hospital for them and family members. We heard that patients want opportunities to be involved in shaping the future of Charing Cross Hospital and that they need more information so that they can understand plans for future service provision.

The report also takes into account the position of the North West London Collaborative CCGs, Hammersmith and Fulham CCG and Imperial College Healthcare Trust and we have included their position on patient information and involvement as outlined in their joint response to the questions we asked them.

We believe that this report provides stakeholders with an opportunity to look at how they are communicating with local people and others who use Charing Cross Hospital and to plan how they will involve people in any decisions that are made about the hospital's future.

Conclusion

Charing Cross Hospital is very important part of the community for local people and others who use the hospital. They value the continuity of care that they have received

from the hospital at different stages in their lives, recalling memories of significant moments when they were patients.

Local people and others who use the hospital are concerned about its future and want opportunities to be involved in decision making process.

Recommendations

To ensure that everyone who values Charing Cross Hospital as an important part of their community, or who has used, or may use, it in the future is able to have their say on its future, we recommend that:

1. A clear and robust communications and engagement strategy should be developed and implemented. This should clearly set out:
    a. The process by which decisions about the future of Charing Cross Hospital will be made
    b. How this will be communicated to local people and others that use the hospital
    c. How local people and others who use the hospital will be involved in the decision-making process
    d. Clear routes for patients to have their say
    e. A timeframe for engagement.

At the time of writing this report, changes are taking place in the governance structure across the North West London STP area. Some decisions about local health provision that will be implemented by Hammersmith and Fulham CCG are now taken by North West London Collaborative CCGs.[13] Healthwatch CWL has raised concerns and questions regarding the new governance structures and routes of accountability for local people with regards to decisions made at NW London Collaborative CCG level.[14] The lack of clarity about decision making structures and lines of responsibility and accountability adds to the confusion surrounding the future of Charing Cross Hospital.

Therefore, our second recommendation is:

2. North West London Collaborative CCGs, Imperial College Healthcare NHS Trust and Hammersmith and Fulham CCG should provide clear information about how, by what criteria and by whom decisions about the future of Charing Cross Hospital will be made and who is responsible for local communication and engagement on its future.

Due to the lack of information about the timeline of changes in governance we are not able to suggest a specific deadline. Therefore, we suggest that North West London

[13] North West London CCGs' Governing Body Paper: Developing further collaborative working across North West London CGGs: http://www.hammersmithfulhamccg.nhs.uk/media/116666/GB-26-Sept-North-West-London-Draft-Governing-Body-Paper-Final_v2.pdf

[14] Visit our website for our questions: https://healthwatchcwl.co.uk

Collaborative CCGs, Imperial College Healthcare NHS Trust and Hammersmith and Fulham CCG should indicate by when they will be able to implement Healthwatch CWL recommendations.

7. Appendices

Appendix a

The joint response signed by Imperial College Healthcare Trust and North West London Collaborative of Clinical Commissioning Groups to Healthwatch Central West London questions.

Dear Olivia

Thank you for your letter setting out a range of questions around the future of Charing Cross Hospital.

Before we get to the questions themselves, we think it useful to note the overall aim of the work we are doing here in Hammersmith & Fulham and across North West London. We want to flip the model of care from a reactive one, where we wait for people to get sick and then attend A&E, to a proactive one, which focuses on keeping people well and out of hospital, providing care in settings much closer to home wherever possible.

The *Shaping a healthier future* service reconfiguration for north west London, and the Trust's clinical strategy, set out plans for Charing Cross to evolve to become a new type of local hospital, offering a wide range of specialist, same-day, planned care, as well as integrated care and rehabilitation services, particularly for older people and those with long-term conditions. It would retain a 24/7 A&E appropriate to a local hospital.

However, we have been clear that we will not reduce acute capacity at the hospital, including within its A&E, unless and until we can achieve a sufficient reduction in acute demand. The Sustainability and Transformation Plan published in 2016 made a firm commitment that Charing Cross will continue to provide its current A&E and wider services for ***at least*** the lifetime of the plan, which runs until April 2021.

We have also made the commitment to engage with our local community, including with Healthwatch, as we start to develop the detail around the plans at Charing Cross. Your involvement in that process is essential and we look forward to continuing to work with you.

It's also worth highlighting that you raise a number of questions around the use of digital services within healthcare. Most people use health services in a local community setting where there has already been significant developments in the use of digital technology to improve patient benefits. Through the 'Care Information Exchange' Imperial College Healthcare is also leading a major initiative to build an online care record for patients and those providing their care across North West London.

Turning then to the questions themselves, please find detailed answers set out on the following pages. If you would like any further detail please let us know.

Clare Parker, Chief Officer – CWHHE, SRO – Shaping a Healthier Future

Ian Dalton CBE, Chief Executive, Imperial College Healthcare NHS Trust

A) COMMUNICATIONS AND INVOLVEMENT

Q1) What negative impacts for patients have been captured as part of your planning for this major change for example during an options appraisals?

A) The Strategic Outline Case (SOC) as the enabler for the North West London Sustainability and Transformation Plan (STP) offers an excellent opportunity to further address health inequalities and ensure a positive impact of any proposed service changes for our protected groups. We have a thorough understanding of the demographics and particular health challenges of our residents to support our inequalities work, and are of course working closely with our local authority colleagues to share and update our knowledge of specific groups and any emerging issues.

To date two Equality Impact Reviews have been completed. The first was undertaken when the Shaping a Healthier Future (SaHF) strategy was produced. This included, based on the available evidence to date, how the SaHF programme meets with the aims of the Public Sector Equality Duty.

The second was an STP-wide health inequalities impact screening analysis, which provides a framework for the detailed equalities impact assessments likely to be needed. This approach is in line with other STP regions.

The Equality Impact Reviews identify potential adverse impacts. These are all stated within the documents attached with indications of how these are or will be addressed. As we progress from the SOC to Outline Business Case and Financial Business Case, all details will be refined including the equality impacts and the actions required to mitigate these.

Full equality impact assessments will be undertaken in line with best practice for all relevant programmes and projects as part of their development.

It's also worth making the point here that there have been some really positive steps forward in the way we have transformed care across NW London as a part of the SaHF and STP plans – for example the maternity and paediatric transitions which have taken place have seen real benefits to our patients and residents. We continue to monitor and evaluate both of these transformations to ensure they remain successful. We are committed to ensuring that all service developments have effective and thorough monitoring and evaluation going forward.

Q2) Do you have evidence to demonstrate that patients and communities can be assured that possible negative impacts from future changes will be mitigated? If yes, please provide a copy of your evidence. If not, please provide us with information regarding how you are going to test and measure possible negative impacts.

A) As set out in the previous answer we have conducted Equality Impact Reviews which are available online at:

SaHF EIA
https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/Equalities%20Impact%20-%20Strategic%20Review%20%20vf.pdf

STP EIA
https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/stp_equality_impact_analysis_april_2017.pdf

Q3) What steps have you taken to communicate with the local population, your plans for Charing Cross hospital in a clear, accessible and easy to understand manner and how are you monitoring the progress? Please provide a breakdown of steps and monitoring mechanisms.

A) As indicated above, we have been very explicit about the fact that no major changes will take place at Charing Cross during the lifetime of the STP. This is a commitment that has been made publically and has not changed. At the 'town hall' style meeting held in October 2016, the CCG also committed to improving engagement with local residents more generally. To this end the CCG approved a new communications and engagement strategy at its meeting in September which sets out very clear objectives for future engagement with local people.

Additionally, the Trust uses its website and social media channels (eg Facebook and Twitter) to communicate with audiences about developments and issues regarding Charing Cross Hospital. We also use the Trust's electronic newsletters which are tailored to specific audiences: stakeholders; GPs; and patients and the public. Commissioners use the Healthier NW London website as well as the CCG twitter feeds to help keep people updated.

The Trust chief executive has regular meetings with local MPs and with Hammersmith & Fulham Council's Cabinet Member for Health and Health Scrutiny Committee Chair. The Trust chief executive also meets formally with representatives of the Save our Hospitals group. Similarly, senior officers from both Hammersmith & Fulham CCG and NW London routinely meet with the local MP, councillors and representatives from patients' groups to talk through our plans.

In addition, the Trust is planning a public event at Charing Cross Hospital at the end of November 2017 to set out the current position on Charing Cross and to share updates on recent and planned investments.

Q4) Will you be able to produce a briefing, for wide circulation, that explains what your plans are and what they mean for local people? The briefing should refer to policies from different documents to inform local people, but also provide them with the opportunity to track down the progress you are making moving forward.

A) We are happy to discuss an update which brings together all the plans (SaHF, Trust strategies and plans, STP etc) and explains where we are and the current position on Charing Cross. We would welcome involvement from Healthwatch in developing that update to ensure we make it as user friendly as possible for local people.

We will produce a concise briefing on the current position on Charing Cross and its future as part of the Trust's public event at Charing Cross being planned for November 2017.

Again, we also make the point that major change at Charing Cross is not planned until there has been sufficient reduction in acute demand, which will not be within the lifetime of the STP, that is not before April 2021. Any proposed changes will also include equalities impact assessments and opportunities for local people to be informed and involved.

Q5) How are you going to involve members of the public, as well as health professionals in the development of the plans for Charing Cross hospital? Healthwatch Central West London would like to be fully involved in the planning and consultation process and work with the Trust to ensure that any changes result in an enhanced level of healthcare provision for the local population.

A) As our plans for Charing Cross progress, we have been clear that we are committed to involving patients and the public in their development. We envisage that Healthwatch, as well as our own lay partners, will be integral to that process.

B) A&E AND WIDER SERVICES

Q1) What is the evidence that suggests that Charing Cross should become a local hospital and what is the definition of a local hospital? Please provide us with any supporting documents.

A) The case for Charing Cross to become a local hospital was set out in the SaHF consultation document. We believe that this will help us deliver services which are right for the people of Hammersmith & Fulham, matching their needs.

The consultation document (August 2012) for the plans to improve local NHS services in North West London as part of the SaHF programme, identified eight different settings for care. Section 10 of the consultation described a 'Local hospital' as follows:

"Local hospital – this type of hospital provides all the most common things people need hospitals for, such as less severe injuries and less severe urgent care, nonlife threatening illnesses, care for most long-term conditions such as diabetes and asthma, and diagnostic services. It basically provides the kinds of services that most people going to hospital in NW London currently go there for."

There is also further reference to this case within the SOC – Part 1. The strategic case in the SOC sets out a list of factors which point in the same direction:

1. Our current system is unsustainable. We cannot achieve our vision without major changes to how we deliver care, given the population health trends, coupled with our current model of care and health infrastructure. This is therefore an opportunity for us to do something different and better for our residents.
2. We have a strategy to meet our residents clinical and social care needs in the right place at the right time. We will reconfigure health services so they are: localised where possible; centralised where necessary and in all settings integrated across health and social care providers to improve patient care.

3. We are confident that based on our experience of successfully delivering change and identified opportunities; our new model of care will address the key issues. Our strategy is to focus resources to keeping the population well through management of long term conditions, rapid access and treatment via local services with high quality acute specialist care when it matters most. This will achieve financial and clinical effectiveness.
4. Our new model of care requires major changes. Our SaHF proposals deliver much of this vision. Approved by the Secretary of State in 2013, SaHF is an inter-connected model of care which:
    - Retains activity in the community, enabled by out of hospital hubs where services are co-located and primary care is delivered at scale
    - Reconfigures our acute services to deliver high quality care and provide clinical and financial sustainability. This is principally achieved by concentrating valuable clinical capability across fewer sites

It is also important to recognise that in Hammersmith & Fulham, as well as across North West London as a whole, we face the following major challenges:

- An ageing population with increasingly complex and resource intensive health needs, with an increase in the overall population.

- Over 30 per cent of inpatient beds in acute hospitals are occupied by patients whose care would be better provided elsewhere in their own home or community. Clinical audits regularly show that over 30 per cent of patients in an acute hospital bed do not need acute care.[15] It is best for patients if they are able to return home at the optimal time for them, to be subsequently cared for in the most appropriate setting, preferably their own homes.

- Unacceptable variation in the quality and delivery of all services. There are variations in the quality of care and the proportion of patients who need to be readmitted after receiving a number of procedures varies considerably from one hospital to another. Senior doctors' availability in acute medicine and emergency general surgery at the weekends is more than halved at many sites compared to cover during the week.

- A reactive health service where resources are still focused on getting patients better rather than keeping people well to start with.

- Workforce capacity with shortages in supply expected in many professions and expected increases in demand, combined with the need for a skilled workforce to deliver a 7-day service under the current model across multiple sites. The lack of skilled workforce to deliver a seven-day service under the current model across multiple sites is an issue in North West London. Workforce shortages are expected in many professions under current supply assumptions and expected increases in demand making the provision of services more fragile.

[15] NW London Sustainability and Transformation Plan v01 21 October 2016.

- We have more A&E departments per head of population than other parts of the country and insufficient capacity to meet demand as senior staff and resources are spread too thinly across multiple sites.[16]

- Poor quality estate in our hospitals and primary care which is increasingly costly to maintain, does not meet modern standards and is not fit for purpose for delivery of care. NW London has more poor quality estate and a higher level of backlog maintenance across its hospital and primary care sites than any other sector in London. For example, a detailed survey and compliance audit (called a six-facet survey) undertaken in 2015, suggested total investment / project costs of £1.3 billion to bring all the Imperial College Helathcare Trust estate to an acceptable condition (Source: Imperial College Healthcare NHS Trust Annual Report 2016/17, p49)

- Too many small hospitals resulting in a compromise of clinical productivity for the residents of North West London, with valuable clinical resources being spread too thinly and the inability to drive high quality specialist care which can be achieved by concentrating care into fewer large hospitals:

    - The total population in North West London is 2,086,000 as of 2015/16.[17] With a growing population in North West London it is increasingly hard to provide a broad range of appropriate specialist services at the existing nine acute hospital sites to the standards our patients expect and deserve.

    - This is because specialist teams gain skills as a result of the numbers of people they diagnose and treat. There is evidence that the more specialised doctors and other professional staff become, the better the results for patients.[18] If treated by a specialist, patients are at a lower risk of death, are likely to have fewer complications and are likely to benefit from shorter stays in hospital.[19]

    - Units therefore need to serve a sufficiently large population so they are busy enough for clinical staff in a variety of specialities and subspecialties to maintain their clinical skills for the best outcomes for patients.

    - For example, guidance from the Royal College of Surgeons[20] recommends that for emergency surgery to be of high quality, activity from a population of 500,000 needs to be undertaken on one site. Even with the current configuration of A&E services nationally, the seven A&E departments in North West London hospitals each have a catchment population smaller than average.

[16] "Delivering High-quality Surgical Services for the Future", a consultation document from the Royal College of Surgeons reconfiguration working party, March 2006.

[17] Office for National Statistics (ONS) population estimates.

[18] Hall, Hsiao, Majercik, Hirbe, Hamilton, The impact of Surgeon Specialization on Patient Mortality; Annals of Surgery 2000.

[19] Chowdhury, Dagash, Pierro. A systematic review of the impact of volume of surgery and specialisation on patient outcome; British Journal of Surgery, 2007.

[20] "Delivering High-quality Surgical Services for the Future", Royal College of Surgeons, March 2007.

- And clinical evidence has highlighted that for emergency care services, early involvement of senior medical personnel in the assessment and subsequent management of many acutely ill patients improves outcomes.

- It is known that in North West London, our hospitals are only sometimes meeting the seven-day services standards guidelines of emergency general surgery admissions seeing a consultant within 14 hours.

Q2) What evidence is there that GP hubs and other out-of-hospital provision are reducing demand on hospital services?

A) There is national evidence from the work being undertaken by Vanguards which supports the case for reduction in demand. I attach an NHS presentation from the national new models of care team which is presenting early evaluation of vanguards. Slide 5 quotes 30% reduction in NEL admissions. Locally, we have yet to secure the capital required for the majority of the hub developments. Of the hubs which we have developed the evidence is just emerging. We are in the process of compiling this and anticipate having this available later this year. We have a full strategy for this work in enclosed in these two documents.


NW London Local Services Strategy Ful


NW London Local Services Strategy Pre

Q3) "No reduction of A&E and wider services" – this term has been used in the Trust's responses to concerns regarding a closure plan for Charing Cross Hospital. Please provide a breakdown of all services with clarification what is included and what is not in "wider services".

A) Charing Cross Hospital provides a range of acute and specialist care services, it also hosts the hyper acute stroke unit for the North West London region and is a growing hub for integrated care in partnership with local GPs and community providers. Information on all the services at Charing Cross Hospital is provided on the Trust website.

Our approach of actively not progressing plans to reduce acute capacity at Charing Cross Hospital unless and until we could achieve a reduction in acute demand was formalised in the North West London STP published in 2016. The plan made a firm commitment that Charing Cross Hospital will continue to provide its current A&E for at least the lifetime of the plan, which runs until April 2021. We also made the commitment to work jointly with staff, communities and councils on the design and implementation of new models of care.

The Trust does consider specific proposals for service changes from time to time in response to quality, safety and/or efficiency issues. On these occasions we are very mindful of our duty to engage with patients, the public, their elected representatives and our other partners in order to develop the best proposals and reach the right decisions for patients. We followed this approach with the successful move of the stroke unit at St Mary's Hospital to Charing Cross Hospital in 2015.

We will continue to engage with people on specific service proposals and we will also undertake equality impact assessment related work for any such proposals.

Q4) If the Shaping a Healthier Future plans go through, please clarify: a) Will there be A&E and consultants on site at Charing Cross? And b) Will there be a blue light ambulance service at Charing Cross?

A) In 2012, the NHS published plans for a reconfiguration of health services across North West London to respond to rapidly changing health and care needs. A full public consultation set out plans for a more integrated approach to care, with the consolidation of specialist services onto fewer sites, where this would improve quality and efficiency, and the expansion of care for routine and on-going conditions, especially in the community, to improve access.

Charing Cross Hospital was envisaged as a local hospital within this network of services, building on its role as a growing hub for integrated care offered in partnership between hospital specialists, local GPs and community providers..

In October 2013, the Secretary of State for Health supported the proposals in full, adding that Charing Cross Hospital should continue to offer an A&E service, even if it was a different shape or size to that currently offered. He also made clear that there would need to be further engagement to develop detailed proposals for Charing Cross Hospital.

The subsequent work to engage patients and the public in the development of detailed plans for Charing Cross Hospital was paused as increasing demand for acute hospital services highlighted the need to focus first on the development of new models of care to help people stay healthy and avoid unnecessary and lengthy inpatient admissions.

Our approach of actively not progressing plans to reduce acute capacity at Charing Cross Hospital unless and until we could achieve a reduction in acute demand was formalised in the North West London STP published in 2016. The plan made a firm commitment that Charing Cross Hospital will continue to provide its current A&E for at least the lifetime of the plan, which runs until April 2021. We also made the commitment to work jointly with staff, communities and councils on the design and implementation of new models of care.

At this stage, therefore, before the engagement process with the residents of Hammersmith & Fulham, it is too early to specify the details of services Charing Cross Hospital would offer in the future.

C) BEDS, COMMUNITY SERVICES AND ACCESSIBILITY

Q1) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: a) How many beds will there be and what type will they be when compared to now?

A) As indicated previously it is too early to specify the details of services Charing Cross Hospital would offer in the future.

Charing Cross Hospital currently has just over 400 inpatient and day-case beds.

Successful programmes have shown that high-quality interventions that support patients before they become acutely unwell can reduce non-elective admissions and slow progression of a disease. This can contribute to a reduction in overall care costs through the removal of acute beds when out-of-hospital solutions are in place. It does not necessarily mean planning to treat fewer people – it means treating people in a different way or different place.

The NHS is already working closely with local residents and patients at CCG level as we implement new services that help people stay as healthy as possible, avoid unnecessary stays in hospital (especially older patients) and support patients to return home as quickly with the support they need. We will build on this engagement activity to engage further with stakeholders specifically about the services Charing Cross Hospital should offer in the future.

The Trust's current clinical strategy was published three years ago in 2014. We see each of our three main hospitals developing their own distinctive and interconnecting character: with Hammersmith continuing on its path as a specialist hospital with a strong focus on research; St Mary's being the acute/emergency hospital for North West London; and Charing Cross as a pioneering local hospital with planned/elective surgical innovation and integrated care services. All the Trust's main hospital sites will continue to provide local services as well as their particular unique function.

At the time of the clinical strategy being published the proposed number of beds at our main hospital sites by 2020 was shown (with the July 2014 numbers in brackets) shown in the table below:

Hospital	**Total**	**Inpatient beds**	**Day-case beds**
Charing Cross	150*	24 (360)	86 (41)
Hammersmith	466	427 (406)	39 (39)
St Mary's	540	507 (401)	33 (40)
Total	1,156*	958 (1,167)	158 (120)

* In the space requirements and costings for Charing Cross Hospital, we also allowed for a further approximately 40 beds to support a new integrated care offering.

Since then, the work to engage patients and the public in the development of detailed plans for Charing Cross Hospital has been paused as increasing demand for acute hospital services at the site highlighted the need to focus first on the development of new models of care to help people stay healthy and avoid unnecessary and lengthy inpatient admissions.

Our approach of actively not progressing plans to reduce acute capacity at Charing Cross Hospital unless and until we could achieve a reduction in acute demand was formalised in the North West London STP published in 2016.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: b) If there is a reduction of beds, how will demand be met and managed?

A) Demand will be met and managed through a combination of increased capacity at other local trusts, reduced demand for services through better management of long term conditions such as diabetes, earlier intervention when people become ill and new ambulatory models in hospitals so that less people are conveyed or admitted, and discharging people home at the right time with full community support becomes the norm.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: c) If there is a reduction of beds, how are you measuring safety issues given the high bed occupancy figures at ICHT hospitals?

A) NHS England Chief Executive Simon Stevens announced earlier this year that hospital bed closures arising from proposed major service reconfigurations will in future only be supported where a new test is met that ensures patients will continue to receive high quality care.

From 1 April 2017, local NHS organisations have to show that significant hospital bed closures subject to the current formal public consultation tests can meet one of three new conditions before NHS England will approve them to go ahead:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
- Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme)

All bed reduction proposals will, therefore, be subject to being evaluated against these conditions. The assessments made against these conditions will form part of any documentation that is put forward to NHS England and will be included in documents considered at Trust Board and CCG Governing Body meetings in public.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: d) Are there any estimates as to how many in-hospital patient visits that requiring bed and clinic capacity will be replaced by community based services?

A). We have made estimates in the past, for example during the 2012 consultation, and we will be updating all figures once we have implemented and evaluated the out of hospital services so that they reflect real activity and demand in the future.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: e) How many of these community based services depend on the enhanced digital capabilities and interoperability strands referred to in Local Digital Roadmap – STP January 2017?

A) Full realisation of the integrated health and care services envisaged in the local area will require a shared digital patient record, which allows transfers of care between different settings to be automated. Where these settings use different clinical IT systems, the shared digital record is dependent on interoperability between those systems.

Community based services in the area are currently supported by TPP's SystmOne Community clinical IT system, which is a common platform with the GPs in the three local CCGs, all of which use SystmOne; so the shared record is already available between primary and community healthcare.

Between primary and acute care, there are some existing interfaces between SystmOne in primary care and the Cerner acute clinical IT system in use at Imperial College Healthcare (and due to be implemented at Chelsea & Westminster): referrals can be transmitted electronically from SystmOne using the NHS E-Referrals Service (e-RS) and discharge information at the end of acute episodes of care is sent electronically from Cerner to SystmOne.

However, full realisation of the shared digital patient record will require more comprehensive interfaces between community and acute services, either directly or via the NW London Care Information Exchange currently under development. These interfaces do not yet exist in SystmOne, but fortunately TPP has recently announced that it will develop an open interface capability, and we would expect links to Cerner to be developed and in place well before 2021.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: f) In Shaping a Healthier Future 2012, there were plans to develop a separate elective orthopaedic hospital on the lines of the one in Epsom. Is this still planned and how will it affect Charing Cross?

A) There are no plans in place to develop a separate elective orthopaedic hospital. The Provider Board considered the benefits of an orthopaedic centre(s) in April 2017 and made two recommendations. Firstly to approach the Elective Orthopaedic Centres (EOC) in two phases and not assess the feasibility of an EOC in 2017/18. The first phase will be to drive up productivity and quality within each Trust and to measure performance against a sector score card, informed by existing measures that Trusts use. It was noted that the MSK clinical network will be key to supporting delivery. Secondly it was agreed to review the data in April 2018 to assess the need for a NW London EOC. This two-part approach is driven in part by the need for capital funding for an EOC.

Q) Healthwatch Central West London has received concerns raised by local residents of what Charing Cross hospital will look like after 2021. Please clarify: g) How will Charing Cross, as a local hospital be complemented by integrated care and an Accountable Care Partnership

A) NHS commissioners across North West London have agreed that Accountable Care Partnerships are the preferred model for delivering an integrated care system. Accountable care approaches are a potential way of overcoming dispersed responsibility for the commissioning and provision of care.

Imperial College Healthcare is part of a collaboration of organisations - the Hammersmith & Fulham Integrated Care Partnership - working to develop a radically better way of providing care for the population of Hammersmith & Fulham through an integrated/accountable care approach.

The programme also involves lay partners in the co-design of all aspects of the emerging care model. Healthwatch representation in the programme structure is provided by Olivia Freeman, who is a member of the steering group and a valued lay partner.

During 2017/18, the partnership plans to test its shared principles in practice by redesigning a number of care pathways for a sample of the population. The partnership is also working closely with Hammersmith & Fulham social care services.

Q2) Given that we have a growing, ageing population who live longer with periods of chronic illness and disability how can you in practice reduce planned admissions without rationing access to operations such as cataract removal, knee and hip replacements? Isn't there now an additional pressure on the STP to limit access to these procedures given their inclusion on the list of areas whose finances are deemed to require increased control through the Capped Expenditure Process?

A. The Capped Expenditure Programme (CEP) is not about cutting services - but making sure we balance our books across the NHS in North West London. We have to reduce waste and cut inefficiency across North West London and it is important we do that in a sensible, planned way, so as to avoid any unplanned cuts at a later date. By taking this approach we can ensure that we continue to deliver high quality healthcare services. The overall approach we are taking to healthcare in NW London is all about better management of long term conditions and earlier interventions to ensure that we can deal sensibly with the growing and ageing population.

D) CHARING CROSS IN THE NATIONAL CONTEXT

164,000 disabled people this year in England have had some or all of their Personal Independence Payments withdrawn and Employment Support Allowances have been cut by 33.3%. Between 2010 & 2015 there was a 31% cut, i.e. £4.6bn in English social care budgets and 400,000 fewer people receive social care in 2015 compared to 2009-10 (Association of Directors of Social Services Budget Survey 2015).

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: a) Have you measured how these changes on a national level have impacted residents across North West London?

A) The planning work around the SOC has not addressed this in detail as the nature of the SOC is to focus on high level growth based on historic trends and the individual plans from each Trust and each provider. If this is addressed it would be in the detail of those plans rather than in the SOC. Plans for specific service change will be influenced by the analysis of local needs and services designed in ways that meet those needs.

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: b) How this national landscape has been taken into account to inform your plans for the future of Charing Cross hospital services?

A). Our planning is based on actual data and the use of past trends to influence future planning. The impact of social care cuts is reflected in our planning. Also its important to point out that integrated care gives us an opportunity to mitigate the impact.

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: c) Given this collapse in funding, how can you ensure that STP plans are realistic

A) It is not clear what impact, if any, the changes in national policy for Personal Independence Payments (PIP) and Employment Support Allowances (ESA) will have on health needs. As the STP is very much a high level document it is the detailed planning of individual services that will need to take account of the specific needs highlighted during the service design phase.

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: d) How have you tested the assumptions that integrating community health and social care can generate enough extra capacity to compensate for potential loss of services?

A) The integration of community health and social care involves changing the model of care from a reactive one, where we wait for people to get sick and then attend A&E, to a proactive one, which focuses on keeping people well and out of hospital, providing care in settings much closer to home wherever possible. This will require new funding and evaluation approaches which will require modelling and testing prior to rolling out. We have made real inroads in reducing our non elective admissions across NW London – which bucks both the London and the national trend – see the graph at Appendix II for more detail.

We are continuing to work with our social care partners to develop better integrated services. The joint strategic needs assessment outputs will support the decisions made about what services are provided and how best they can be delivered to ensure that those most in need receive the level of care and support that they require.

As mentioned earlier, through the Hammersmith & Fulham Integrated Care Partnership, in addition to social care and community services Imperial College Healthcare is working with other healthcare providers - West London Mental Health Trust, the Hammersmith and Fulham GP Federation and Chelsea and Westminster Hospital - on new models of care.

Q) Given this context and how it is reflected in the areas served by Charing Cross Hospital please answer the following: e) Have you measured the impact these changes at the national level will have in the local context regarding Charing Cross provision for people that are not in employment?

A) The planning around Charing Cross is in the very early stages. We are not planning on making any changes to Charing Cross within the lifetime of the STP.

E) FUNDING

Q1) According to this article *http://www.nationalhealthexecutive.com/Health-Care-News/go-ahead-given-to-support-15-stp-areas-with-325m-capital-investment?dorewrite=false/Page-1345* ***from 19.07.2017, NW London STP is not going to participate in a share of the £325m, funding which NHS England has targeted to "strongest and most advanced schemes in STPs" How will losing out on this bid affect the delivery of the STP and, in particular, Charing Cross hospital provision? What are the current steps taken to face the financial challenge?***

A) The £325 million was the first cohort of STP capital funding which was for schemes due to be completed within the next twelve months. We are still progressing our bid for funding and understand further funds will be available. Our bid is following an approval process requiring regulator (NHS England and NHS Improvement approval) and Department of Health approval prior to being considered by the Treasury. This is still progressing. We are still anticipating our plans being funded in due course.

Q2) On page 42, Local Digital Roadmap January 2017 states in the last sentence: "Funding for the programme is still under discussion within NHSE, and full details of programme costs and the associated funding will be published in due course." Please clarify "due course" and inform us when you will be able to provide a timeline related to the funding. Which systems will be prioritised? What are the clinical and demand implications of not providing the technology systems that cannot be funded?

A) NHSE has clarified that there will be no funding for the Local Digital Roadmap (LDR) in 2017/18. It is expected that the funding for 2018/19 will be announced at some point after the Autumn Budget and that the bidding process will be clarified in February 2018. The North West London Digital Portfolio Board will be responsible for agreeing a list of prioritised projects within the context of the national investment levels available. The implication is that aspiration to be paperless by 2020 will not be realised.

Q3) Local residents are concerned that saving £1.3bn from NW London's budget over the next 5 years could lead to job redundancies or downgrading of skills. How are you going to measure labour cost against the budget and what are the steps you are taking to show that you mitigate possible negative impacts on the quality of healthcare?

A) In 2016/17, the Trust invested £600 million in staff benefits (pay and pension contributions) from a total annual expenditure of £1,091.5 million. Appendix 1 shows the annual growth in Trust staff benefits over the past three years.

The Trust's clinical staff (including consultants, doctors and senior nurses) often work across more than one of our hospital sites and so the Trust does not hold information for the number of clinical staff by specific hospital site.

The Trust currently employs nearly 11,000 staff in total, of which around 2,500 are doctors including consultants. Five years ago the Trust had a total headcount of nearly 10,000, of which around 2,000 were doctors including consultants.

As healthcare changes so the roles our staff perform will change and people will do their jobs in different ways. However while we expect the ways of working to change we would always ensure that we had the right numbers of staff to deliver safe care.

While the savings target is challenging, it is also recognised that changing the way services are delivered should achieve economies of scale that will enable significant savings to be made. North West London is looking at the experiences in other places where efficiencies have been achieved and service quality and levels maintained. Part of service reconfiguration does involve reviewing how services are delivered and the skill mix required. This will also happen across North West London in order to ensure that the right staff at the right level and in the right quantity are available. Some staff will almost certainly be doing things in different ways in the future which could mean that certain services require fewer people. Nothing has been 'set in stone' with regard to overall staff levels across the five years of the STP. Any changes in workforce will be part of the detailed service plans that are developed at a local level.

F) TECHNICAL INFRASTRUCTURE

Q1) How robust is the technical infrastructure being put in place, which the move to the community model of service provision relies upon. How can assurance be demonstrated to the community?

A) The NHS network (N3) provides a secure and robust means to enable teams working in community locations access to the Trust's full range of clinical systems. This is demonstrated through the existing community and acute services already provided across North West London.

Q1a) How many systems that need to, can share data now and how many will be able to by 2021?

A) Community healthcare services in the three boroughs covered by Healthwatch Central West London are currently delivered by Central London Community Healthcare (CLCH) and Imperial College Healthcare, mainly using TPP's SystmOne clinical system. Other care settings which will be relevant are Urgent & Emergency Care and federated primary care services; most of these settings are also served by SystmOne, including all practices in the tri borough

Cerner is the electronic patient records system in use at Imperial College Healthcare and being implemented at Chelsea and Westminster sites. It has an interoperability tool to enable sharing of data with other clinical systems. The providers of SystmOne, which is widely used in primary care, have recently announced that they will be enabling information sharing. This will allow us to build on the work already done to develop the Care Information Exchange to create an information sharing platform that incorporates clinical information from systems across all care settings in North West London.

Q1b) What are the implication for the STP if the underlying systems cannot share data? What will be the effect of removing the productivity tools required to provide to healthcare remotely?

A) Communication between care settings is less effective and efficient if it relies on manual processes to effect transfers of care. More effective working is dependent on the ability of systems to share data between acute (Cerner), community (mainly SystmOne) and primary care (SystmOne). This capability already exists between community and primary care. SystmOne does not currently share data with acute systems, but the supplier TPP has recently announced a commitment to develop open interfaces to SystmOne and we would expect interoperability to be developed in the next one or two years.

We are not entirely clear what is meant by the second part of the question. Clinicians in primary and community care are already able to work remotely via mobile devices such as laptops and tablets – this is what is normally meant by 'productivity tools'. These are not being removed.

Q1c) What is the state of cyber security across all systems?

A) Imperial College Healthcare remained free from virus infection during the global cyber-attack on 12 May 2017. The Trust continues to maintain and strengthen its ability to protect our systems against cyber security threats.

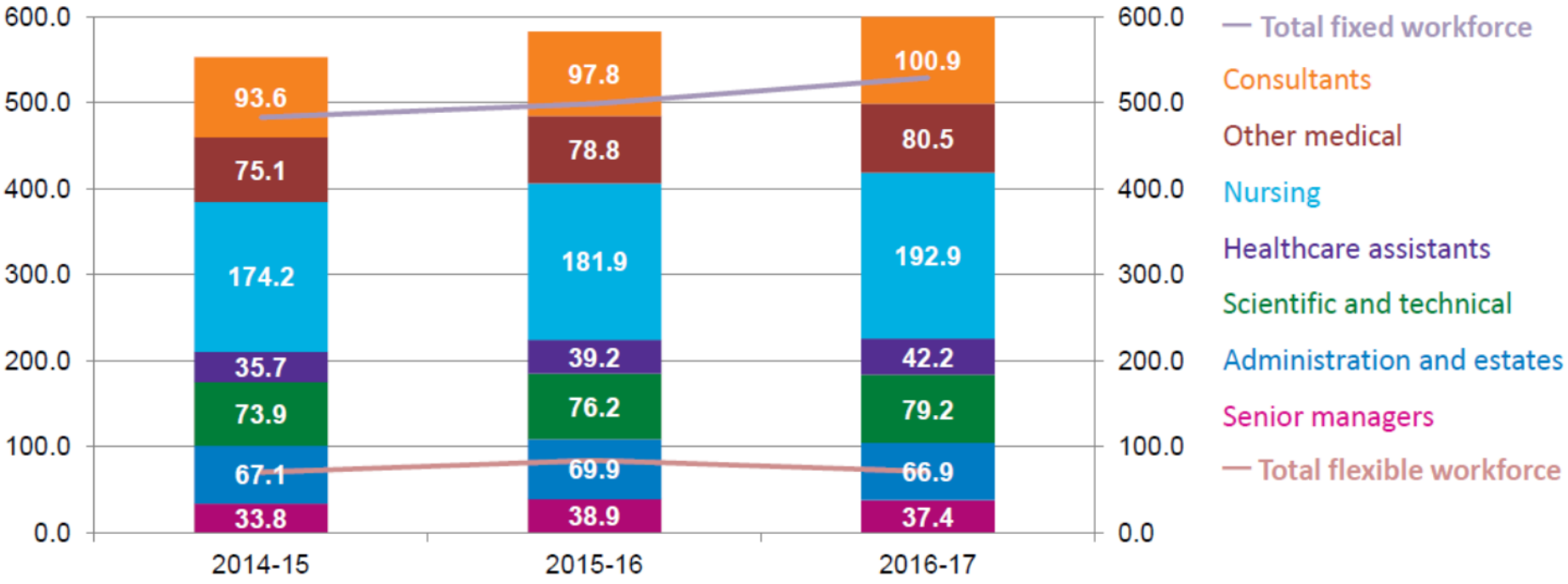
Q1d) What is the timeline for improving or rendering obsolete technology that can be economically improved?

A) During 2016/17, Imperial College Healthcare invested a total of £6.1 million in Information, Communications & Technology (ICT) infrastructure. We are one of 16 acute Trusts that have been nominated Global Digital Exemplars with a commitment to drive digital innovation for our patients

Q1e) What are your plans for raising data standards to improve interoperability of the IT infrastructure?

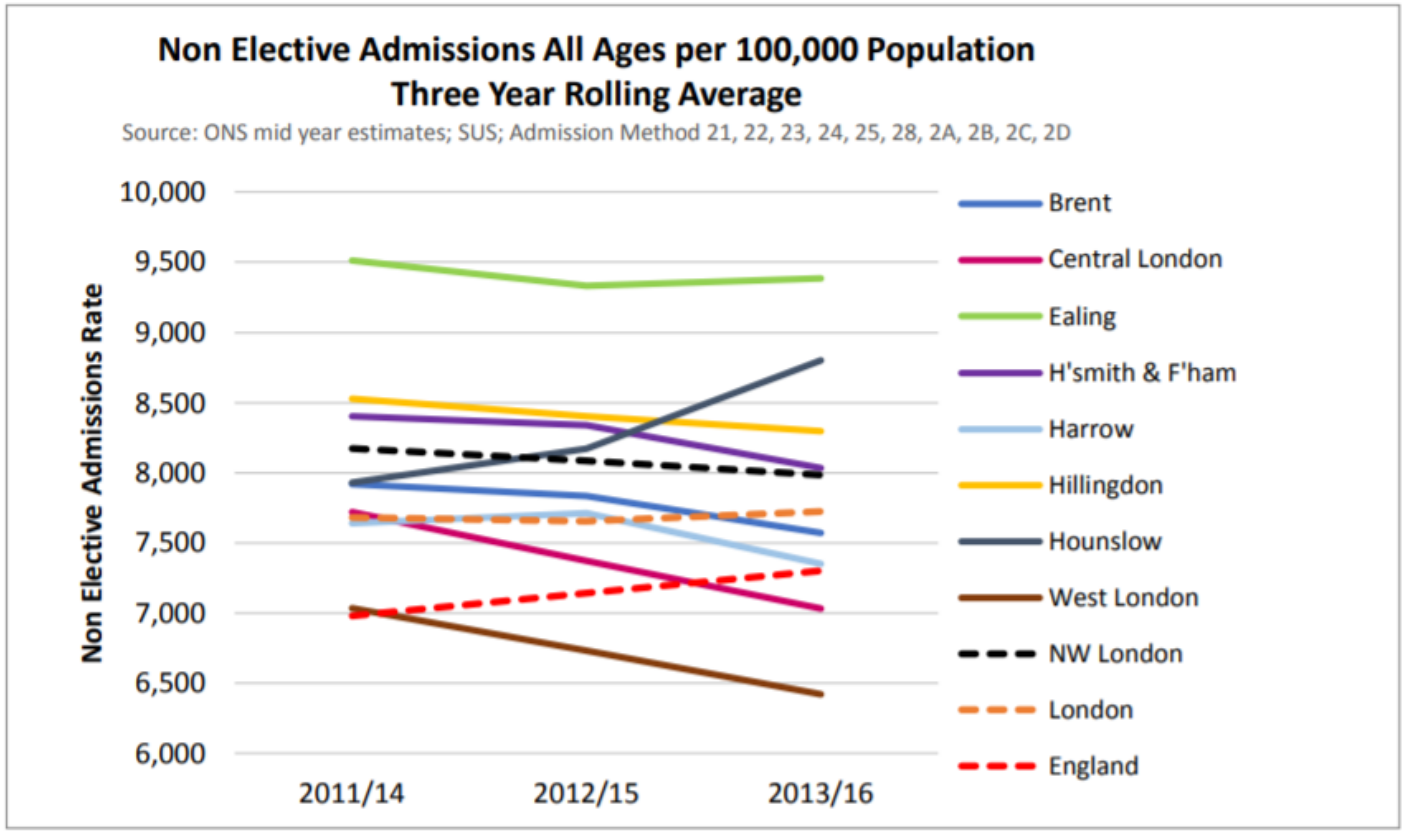
A) To most effectively share information between systems the data must be recorded in a structured way that is common to all systems. Snomed is the coding standard that is being adopted across the NHS to facilitate this and is being implemented across North West London.

2016/17 investing in staff (£m)



Appendix II

Figure 15: Non-elective admissions all ages per 100,000 population three year rolling average 2011/12 to 2015/16



Source: Strategic Outline Case (SOC) Part 1 – p.4

Appendix b – Survey

Questionnaire used to gather patients views and experiences, including demographics questions.

Tell us your experience to help shape the future of Charing

healthwatch Central West London

Healthwatch wants to learn more about your experience of using Charing Cross hospital and your views on the future on the hospital.

Your Postcode:

1. Why are you at the hospital today? Please tick ONE option or tell us more by writing in 'other'.

Patient ☐ Visitor ☐ Carer ☐

Other, please specify:

2. Which service are you visiting today?

Name of service:

3. How long did you have to wait to get a hospital appointment?

4. How satisfied are you with your visit? Please select the option that applies most by ticking the box in each line.

	Extremely satisfied	Very satisfied	Satisfied	Not satisfied	Not at all satisfied
How long I had to wait to be seen					
How far I had to travel					
The treatment I received					
The communication from staff					

Tell us more

Comment:

5. If the service you used today was available closer to your home in a different setting (for example at your GP practice) would you be happy to receive it there instead of Charing Cross Hospital? Please tick.

Yes ☐ Maybe ☐ No ☐

Please tell us more about why you made this choice:

6. Please tell us what is important about Charing Cross Hospital for you? Please select all that apply and use the comment box if you wish to tell us more.

A&E Department ☐ Urgent Care Centre ☐

Inpatient services (this is when you have to say in the hospital for a night or more) ☐

Outpatient services (this is when you visit a service but don't have to spend the night in) ☐

Charing Cross Hospital is an important part of my local community ☐

Charing Cross Hospital is not important to me ☐

Please tell us more about your choice/s

7. The NHS and Imperial Trust that run Charing Cross Hospital said that there are no plans to make any major changes at least until 2021. Plans are for "Charing Cross to evolve to become a new type of local hospital". They described a 'local hospital' as: ***"a type of hospital that provides all the most common things people need hospitals for, such as less severe injuries and less severe urgent care, nonlife threatening illnesses, care for most long-term conditions such as diabetes and asthma, and diagnostic services. It basically provides the kinds of services that more people going to hospital in North West London currently go there for."***

Do you feel that your health needs, and those of others in your local area, will be fully met by Charing Cross becoming a local hospital as described above?

Yes ☐ Maybe ☐ No ☐

Comment:

8. Would you like there to be opportunities for you to be involved in future plans for Charing Cross Hospital?

Yes ☐ Maybe ☐ No ☐

Demographics Monitoring

This section asks questions about you. The data you share with us will not be used to personally identify you, and will not be passed on to anyone else. **It is optional to complete this page.**

What is your age? (please circle)

0-15 16-25 26-45 46-59 60-74 75+

To which gender do you most identify with?

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Other: _____
- ☐ Prefer not to say

What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay
- ☐ Lesbian
- ☐ Heterosexual
- ☐ Other: _____
- ☐ Prefer not to say

To which ethnicity do you most identify with?

- ☐ White British
- ☐ Black British
- ☐ Asian British
- ☐ Other non-white British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ White & Asian
- ☐ White & Black African
- ☐ White & Black Caribbean
- ☐ Any other mixed/multiple ethnic background, please describe
- ☐ African
- ☐ Caribbean
- ☐ Indian
- ☐ Pakistan
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background, please describe
- ☐ Arab

Please describe: _____

Do you consider yourself to have a disability? (please circle) Yes / No

Do you consider yourself to have a long term health condition? (please circle) Yes / No

Do you look after someone? (please circle) Yes / No

If you wish to be kept up to date from Healthwatch please leave us your contact details and we will add you to our mailing list. Your details will be kept separate from your answers. We can also arrange a face to face or phone call interview with you if you wish to tell us more about your Charing Cross views and experiences. Please tick all that apply.

I would like to be added to the Healthwatch Central West London mailing list ☐

I would like to tell you more about my views and experience of Charing Cross Hospital ☐

Name:

Email:

Telephone:

Address:

Postcode:

Borough:

Appendix c – All patient's comments on "Local Hospital"

All comments received by patients in response to question 7 (See Appendix b).

- The explanation is rubbish: not accurate, not informative
- We need all facilitates under one roof
- We need this hospital as it is with all it's services and especially A&E
- It should stay exactly like it is because it is an asset to this neighbourhood and other boroughs.
- Very vague, don't know
- I will decide when plans are ratified. Things will change to meet changing needs and funding.
- I am not sufficiently qualified to know if this is a good description/plan.
- This is an excellent hospital. Keep it that way.
- The hospital should remain as it is.
- We need this Hospital, as I need most my consultants in one hospital.
- Charing Cross is a fine hospital. However, this is not our local hospital, so we don't feel qualified to comment on future needs.
- This hospital has major units to treat specific things and its saves so many people lives a day
- I live nearby and I used this hospital on many occasions. I want this hospital to carry on serving people of the UK
- I do not know if I do not know what local hospital is
- very close by, it meets our requirements as family
- Very important to keep services at Charing Cross Hospital and excellent staff
- A question in the future. It's a manufactured expression of cottage hospitals.
- Yes, As long as they don't turn it into hotels/flats
- Not sure I like the idea of a local hospital in general
- Yes, but I have a more local A&E at ST Georges
- We need more help
- I do not know what 'local hospital' services entail/include.
- Very vague

- I'm happy with the services I receive here and prefer it to stay as it is.
- What about cancer? What about operations?
- It is a very vague statement. We need A&E, we need a cardiovascular ward, breast screening. As we live longer and develop more illness in later life we need a hospital to care for us.
- Charing Cross should stay the way it is currently. There is a huge influx of people coming to live in the Borough. I personally umbellic tied to dialysis unit there.
- I am happy with my hospital and the service I get from.
- I had oncology and breast reconstruction at Charing Cross. I benefited from having experienced specialist plastic surgeons here.
- The facilities of the hospital is essential for the local communities.
- The history and the medical standards and training at Charing X would not support this
- It's not really clear what local hospital means; could be a bad or good thing.
- As we get older we may need more specific treatment and therefore travelling far from home will become difficult and expensive.
- "Local" suggests routine problems. Most people recognise Charing Cross as a centre of excellence.
- It has specialist departments which will be a shame to lose
- A cottage hospital by another name is inadequate to the current needs of the catchment area, people get really sick and need expert care. As if they would pay any attention (for involvement)
- IF what they say comes to fruition then it would be great.
- Please do not close vital services like A&E and the specialist cancer services
- I don't understand.
- They want to change it into a clinic. That's how it sounds. What are they going to do with emergencies?
- Leave it as it is.
- The halfway house described above is no good to patients and staff. This hospital should remain as a fully functional unit.
- It would be a shame to lose the excellent full service.
- As long as it stays as it is.
- Why would they do that/

- Concerned about A&E/more serious incidents.
- This area need a full hospital. Number of people in hospital is growing. We need hospital in this area.
- When something is successful don't change it.
- Will they do the screening? If yes, it will be ok. It is longer to go to Hammersmith.
- That would be useless for me. I use it for urgent health needs
- Every hospital needs A&E
- Leave things as they are!
- I had knee surgery and it was good. Every service is very good. I would like to keep it as it is. 12/4/2017 11:34 AM
- Leave the hospital the way it is. All my family coming here, it has good reputation. Why change?
- Are they keeping A&E?
- We need A&E, it is very important for this area
- I have kidney condition which requires a center with specialists
- Being leaders in the field in a specialist capacity must also be important?
- Less is WORSE for patients
- We need to have maternity, hart, strokes
- Where all the specialist can move to?
- It would be a real shame to be without the hospital, it would be greatly missed.
- They should continue to do operations, always seem brilliant. I don't quite understand. That could be a gray area.
- It is not clear if this new hospital will have my specialists
- The proposal to change to a local hospital is very disappointing. It is our local hospital and we need urgent care including A&E.
- I am happy if they add services. It's very important to keep the facilities that they have, because I already need to come from Harrow.
- It is important to have all the services
- We need more information
- I want present facilities to continue

- Absolute rubbish. They should not be allowed. It is a major hospital for the community. Leave it alone. Disgraceful! I paid for 45 years. It's a government plan to privatize NHS-leave it alone!
- I like it as it is now. We need urgent care places.
- No, it will not be a good idea becoming a local hospital. This hospital should stay as it is.
- What about cancer?
- It depends if other hospitals gave these services. We need all the facilities here.
- I don't really know
- What about Maggie and the treatment for cancer that people come all over the country for? Where are they supposed to go?!
- Need specialized input at times. Links with others need to result in a smooth transition.
- I cannot answer this question because my "local" A&E is at Kensington and Chelsea Hospital.
- I need Charing Cross Hospital to provide all the services of a big hospital.
- Better to keep it the way it is now.
- They should take care of the building and the staff because they work hard.
- This is an important hospital in the area which is very busy and big population, and close to transport links that is more accessible.
- If there are alternatives nearby for the services that are going to be moved then it's fine. But if those services are too far then it's not fine.
- With respect, don't trust what I have heard to date. Cost Cutting thinly veiled as transformation.
- This is my first referral to CXH ENT (recommended by A&E Register at CWH), so I don't have enough experience/exposure to CXH to comment further.
- I think the oncology department is vital.
- Don't know enough about the proposed changes.
- This is a general hospital and the only other nearest hospital is St Mary's (Paddington).
- I would expect to visit whichever Imperial hospital has a neurology clinic.
- We cannot tell what re-arrangements of services across the Trust may happen. Thereby keeping urgent care etc accessible in the area.
- More focus on elderly care

- Services such as cancer diagnosis and treatment will apparently no longer be available
- The statement above appears to imply a scaling down of service to exclude the most services of most urgent conditions.
- Urgent care and A&E must be local! The world being urgent.
- I have no idea what the blurb cited above actually means in real terms. Generally, I think the hospital should serve the needs of the community and there's no need to get clever about it.
- This Would mean travelling to St Marys or Charing Cross on a more regular basis, which is not always possible or practical for all.
- There are very few A&E units in the area. Long queues at Chelsea and Westminster. It has world class cancer care and is a vital teaching hospital.
- Stop cutting hospital services in West London.
- Read it, says no-urgent. It should have an A&E at all times. Sounds like the care is going to be reduced.

8. Contact Us

Get in Touch

Healthwatch Central West London
5.22 Grand Union Studios
332 Ladbroke Grove
London, W10 5AD

Website: www.healthwatchcwl.co.uk

Email: info@healthwatchcentralwestlondon.org

Phone: 020 8968 7049

Social

Twitter: @healthwatchcwl

Facebook: www.facebook.com/HWCWL

Instagram: @healthwatchcwl

LinkedIn: Healthwatch Central West London

This report is going to be published on the 20th February and has been shared with Hammersmith & Fulham Health, Adult Social Care and Social Inclusion Policy and Accountability Committee (PAC), North West London Collaborative of Clinical Commissioning Groups, Hammersmith & Fulham Clinical Commissioning Group, Imperial College Healthcare NHS Trust, the London Borough of Hammersmith & Fulham Council, Save Our Hospitals, the Care Quality Commission, local Healthwatchs in North West London, and Healthwatch England.

If you require this report in an alternative format please contact us at the address above.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	28 March 2018

CQC Update

Executive summary:

- The final reports for the well-led inspection and the surgery and urgent and emergency core service inspections (carried out in November 2017) were published on the CQC's website on 21 February 2018.
- The ratings for the surgery and urgent and emergency core services by hospital site were given as 'requires improvement' apart from, the rating for surgery at the Hammersmith site which improved from 'requires improvement' (in 2014) to 'good' (2017).
- The rating for urgent and emergency services at Charing Cross went from 'good' (2014) to 'requires improvement' (2017)
- Three requirement notices were set by the CQC following the inspections and broadly relate to; medical devices, medicines management, cleaning, statutory and mandatory training, disposal of clinical/hazardous waste, the state of repair of theatres and performance monitoring.
- Following the Trust's first well led inspection in December 2017, the domain was rated overall at the Trust as 'Requires improvement'.
- The CQC did not set any action that the Trust 'must' take in relation to well-led at Trust level.
- The Trust's current ratings, updated in February 2018, are presented in **Appendix 1**.
- Key updates to note for the ratings since 2014 are:
    - The Trust has no Inadequate ratings
    - Out of the 67 tiles:
        - The Trust has improved its rating in 20 tiles
            - Two of the tiles are rated as 'outstanding'
        - The Trust has worsened its rating in 9 tiles
        - The ratings for 38 tiles have remained the same
            - 19 of the tiles are rated as Good
            - 19 of the tiles are rated as requires improvement
    - The overall ratings for St Mary's, Charing Cross and Hammersmith hospitals remain 'Requires improvement'.
    - The Trust's overall ratings for each domain and for the Trust overall, remain the same as they were in 2014.

Quality impact:

This paper applies to all five CQC domains.

Financial impact:

This paper has no financial impact.

Risk impact:

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

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

Recommendation(s) to the Committee:		
• To note the updates		
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.		
Author	**Responsible executive director**	**Date submitted**
Priya Rathod, Deputy Director of Quality Governance	Janice Sigsworth, Director of Nursing	21 March 2018

CQC Update

1. Purpose

The following report is an update on CQC-related activity at and/or impacting the Trust since the previous update to the Trust Board in January 2018.

2. Inspections

- The final reports for the well-led inspection and the surgery and urgent and emergency core service inspections (carried out in November 2017) were published on the CQC's website on 21 February 2018.

2.1. Urgent and emergency services and Surgery

2.1.1. Ratings

- **Urgent and emergency services**
  - **St. Mary's Hospital**
  - The rating for the well-led domain has improved from 'Inadequate' to 'Requires improvement'.
  - **Charing Cross Hospital**
  - The ratings for all domains except Caring went down from 'Good' to 'Requires improvement, as did the overall rating for the service at this site.
- **Surgery**:
  - The rating for the well-led domain has improved at all three sites, from 'Requires improvement' to 'Good'.
  - **Hammersmith Hospital**
  - The rating for the Responsive domain improved from 'Requires improvement' to 'Good'.
  - The overall rating for Surgery at this site improved from 'Requires improvement' to 'Good'.

2.1.2. Findings

- Three requirement notices (previously called 'compliance actions') were set by the CQC following the inspections.
- These broadly relate to; medical devices, medicines management, cleaning, statutory and mandatory training, disposal of clinical/hazardous waste, the state of repair of theatres and performance monitoring.
- The Trust has submitted to the CQC a high level summary of the action it will take to address the requirements, which the Executive Committee has approved.

2.1.3. Taking actions forward

- The following work streams have been established with support from the QI team and a monthly update on progress will be provided to the Executive Quality Committee.

Work stream	Lead/s
Medicines Management	Chief Pharmacist and Divisional Director of Nursing for Imperial Private Healthcare (Director of Nursing)
Medical Devices	Director of Nursing
Statutory and Mandatory training	Director People and Organisation Development
Hand hygiene	Director of Infection Prevention and Control

- Divisional colleagues will take forward the specific 'must do' actions (Appendix 1) and will also take forward recommended 'should do' actions that are designed to get core services to 'good' and beyond.

2.2. Well-led inspection

2.2.1 Ratings

- The overall rating for the well-led domain is based on findings from the trust level well led inspection and also on the outcomes of core service inspections
- Following the Trust's first well led inspection in December 2017, the domain was rated overall at the Trust as 'Requires improvement'. The main reasons given for the rating were:
  - Limited improvement in the core services inspected during the previous 12 months.
  - The Trust level structures, systems and processes at executive and board level, to support the delivery of its strategy, had not resulted in achieving significant improvement in the services provided to patients.
  - There were limited staff networks in place supporting or promoting diversity of staff, and there was variable evidence about how staff felt equality and diversity were promoted in their day to day work and when looking at opportunities for career progression.
  - The Trust had made limited progress with its patient and public involvement strategy and the Trust acknowledged there was not a fully shared view across the whole Trust of the value and risks.
  - The CQC did however note outstanding practice such as; the Trust's role as a leader in the adoption of digital technologies to improve patient care.

2.2.2 Findings

- The CQC did not set any action that the Trust 'must' take in relation to well-led at Trust level.
- Four 'should-do' actions were recommended for the Trust to consider as follows:

Should do action	Lead
The trust should ensure it continually improves the quality of its services and safeguards high standards of care.	CEO
The trust should improve systems for board oversight of risk to ensure identified risks are eliminated or reduced.	Director of Nursing
The trust should ensure progress is made with the patient and public involvement strategy to promote engagement	Director of Communications
The trust should review and improve their performance for people with characteristics protected by the Equality Act 2010 *(this is in relation to staff)	Director of People and Organisation Development

2.2.3 Taking actions forward

- Some work is already underway in the areas identified above such as equality and diversity and patient and public involvement.
- The Trust is also currently developing its risk appetite and will commission an internal audit on risk management later in the year to gain assurance about how effective board oversight of risk is at the Trust.
- Colleagues are also engaging with other Trusts who have improved their CQC ratings, to share any learning. Examples of these include;

- *Cambridge University Hospitals NHS Foundation Trust*
  - Went from Special Measures to 'Good' in under 2 years
  - The CQC report can be found here
- *University Hospitals Bristol NHS Foundation Trust*
  - Went from Requires Improvement to 'Outstanding' in 2 years
  - The CQC report can be found here
- *Chelsea and Westminster Hospital NHS Foundation Trust*
  - Recently undergone a comprehensive and well led CQC inspection

- A series of events are planned over the coming months to allow for a fuller discussion about the Trust's approach to meeting CQC requirements and how we drive improvement at the core service level. These are planned as follows:
  - *Executive away day (April 2018):* Focus on 'getting to outstanding'
  - *Leadership Forum (May 2018):* The previous Medical Director from University Hospitals Bristol NHS Foundation Trust (currently head of medical leadership at NHSI) to be invited as a keynote speaker
  - *Board seminar* – A focus on CQC and Board Development relating to this.

3. Updated trust wide CQC ratings

- The overall ratings for sites and the Trust will be updated each year following the Trust level well-led inspection, to reflect all inspections carried out during the year.
- The Trust's current ratings, updated in February 2018, are presented in **Appendix 1**.
- Key updates to note for the ratings since 2014 are:
- The Trust has no Inadequate ratings
- Out of the 67 ratings tiles:
  - The Trust has improved its rating in 20 tiles
  - Two of the tiles are now rated as 'outstanding'
  - The Trust has worsened its rating in 9 tiles
  - The ratings for 38 tiles have remained the same
  - 19 of the tiles are rated as Good
  - 19 of the tiles are rated as requires improvement
- The overall ratings for St Mary's, Charing Cross and Hammersmith hospitals remain 'Requires improvement'.
- The Trust's overall ratings for each domain and for the Trust overall, remain the same as they were in 2014

4. Publications

- The CQC publishes 'inspection frameworks' for each core service within NHS acute trusts; these set out the key lines of enquiry (KLOEs) alongside specific standards relating to each service and key evidence used to assess compliance.
- The CQC has now also published an inspection framework for its well-led domain at trust level.

5. Changes to Regulatory Requirements

- A new General Data Protection Regulation takes effect on 25 May 2018 and will become the new standard to which the Trust is held accountable by the CQC.
- The Trust's information governance team are taking this piece of work forward.

6. Next Steps

- Executive team to undertake a fuller discussion about the Trusts approach to CQC during 2018/19 and beyond.

- Refresh and implement the Trust's approach to CQC over the coming months.

7. Recommendations to the committee

- To note the updates

Appendix 1: Current Trust CQC Ratings (as at March 2018)

*Dates in the ratings grids reflect the date of publication of the related inspection report.

Appendix 1a: Trust overall ratings

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔➔ Feb 2018	Good ➔➔ Feb 2018	Good ➔➔ Feb 2018	Requires improvement ➔➔ Feb 2018	Requires improvement ➔➔ Feb 2018	Requires improvement ➔➔ Feb 2018

Appendix 2b: Site overall ratings

	Safe	Effective	Caring	Responsive	Well-led	Overall
St Mary's Hospital	Requires improvement ➔➔ Feb 2018	Good ➔➔ Feb 2018	Good ➔➔ Feb 2018	Requires improvement ➔➔ Feb 2018	Requires improvement ↑ Feb 2018	Requires improvement ➔➔ Feb 2018
Charing Cross Hospital	Requires improvement ➔➔ Feb 2018	Good ➔➔ Feb 2018	Good ➔➔ Feb 2018	Requires improvement ➔➔ Feb 2018	Requires improvement ➔➔ Feb 2018	Requires improvement ➔➔ Feb 2018
Hammersmith Hospitals	Requires improvement ➔➔ Feb 2018	Good ➔➔ Feb 2018	Good ➔➔ Feb 2018	Requires improvement ➔➔ Feb 2018	Requires improvement ➔➔ Feb 2018	Requires improvement ➔➔ Feb 2018
Queen Charlottes and Chelsea Hospital	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Good Dec 2014

Appendix 1c: Ratings for St Mary's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ➔➔ Feb 2018	Requires improvement Feb 2018(CQC did not rate in 2014)	Requires improvement ➔➔ Feb 2018	Requires improvement ➔➔ Feb 2018	Requires improvement ↑ Feb 2018	Requires improvement ➔➔ Feb 2018
Medical care (including older people's care)	Requires improvement ➔➔ Oct 2017	Good ➔➔ Oct 2017	Good ➔➔ Oct 2017	Requires improvement ➔➔ Oct 2017	Good ➔➔ Oct 2017	Requires improvement ➔➔ Oct 2017
Surgery	Requires improvement ➔➔ Feb 2018	Good ➔➔ Feb 2018	Good ➔➔ Feb 2018	Requires improvement ➔➔ Feb 2018	Good ↑ Feb 2018	Requires improvement ➔➔ Feb 2018
Critical care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014
Maternity	Requires improvement ↓ Oct 2017	Good ➔➔ Oct 2017	Good ➔➔ Oct 2017	Requires improvement ↓ Oct 2017	Requires improvement ↓ Oct 2017	Requires improvement ↓ Oct 2017
Services for children and young people	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
End of life care	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Outpatients and diagnostic imaging	Good ➔➔ May 2017	CQC does not rate May 2017	Good ➔➔ May 2017	Requires improvement ↑ May 2017	Good ↑↑ May 2017	Good ↑↑ May 2017

Appendix 1d: Ratings for Charing Cross Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↓ Feb 2018	Requires improvement Feb 2018	Good ➔➔ Feb 2018	Requires improvement ↓ Feb 2018	Requires improvement ↓ Feb 2018	Requires improvement ↓ Feb 2018
Medical care (including older people's care)	Requires improvement ➔➔ Oct 2017	Outstanding ↑ Oct 2017	Outstanding ↑ Oct 2017	Requires improvement ➔➔ Oct 2017	Good ↑ Oct 2017	Good ↑ Oct 2017
Surgery	Requires improvement ➔➔ Feb 2018	Good ➔➔ Feb 2018	Good ➔➔ Feb 2018	Requires improvement ➔➔ Feb 2018	Good ↑ Feb 2018	Requires improvement ➔➔ Feb 2018
Critical care	Requires improvement Dec 2014	CQC felt it could not rate Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Requires improvement Dec 2014	Requires improvement Dec 2014
End of life care	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Outpatients and diagnostic imaging	Requires improvement ↓ May 2017	CQC does not rate May 2017	Good ➔➔ May 2017	Requires improvement ↑ May 2017	Requires improvement ↑ May 2017	Requires improvement ↑ May 2017

Appendix 1e: Ratings for Hammersmith Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement ➔🡐 Oct 2017	Good ➔🡐 Oct 2017	Good ➔🡐 Oct 2017	Requires improvement ➔🡐 Oct 2017	Good ↑ Oct 2017	Requires improvement ➔🡐 Oct 2017
Surgery	Requires improvement ➔🡐 Feb 2018	Good ➔🡐 Feb 2018	Good ➔🡐 Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Critical care	Requires improvement Dec 2014	CQC felt it could not rate Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Requires improvement Dec 2014	Requires improvement Dec 2014
Services for children and young people	Good Dec 2014	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Requires improvement Dec 2014
End of life care	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Outpatients and diagnostic imaging	Good ➔🡐 May 2017	CQC does not rate May 2017	Good ➔🡐 May 2017	Requires improvement ↑ May 2017	Good ↑↑ May 2017	Good ↑↑ May 2017

Appendix 1f: Ratings for Queen Charlotte's and Chelsea Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Neonatal services	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Requires improvement Dec 2014

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	28 March 2018

Update on the outcomes of Quality Impact Assessments (QIAs) of Cost Improvement Plans (CIPs)

Executive summary:

This paper provides an update on the outcomes of the CIP QIA meetings undertaken since it was last reported to the Trust board in November 2017.

- Since the last update, the Interim Medical Director and Director of Nursing have met with the three clinical divisions and some of the corporate areas to review the QIAs for 2017/18 cost improvement programmes.
- All QIAs were approved
- Each year, a sample of schemes from the previous financial year is selected from each division for a formal post implementation evaluation (PIE) to be undertaken in accordance with the Trust's CIP QIA policy.
- To this end, each division has undertaken a PIE for a range of 2016/17 CIP schemes
- In summary, of the 17 schemes evaluated, each review demonstrated that the implementation of the scheme had improved quality and that the original QIA risk score had reduced once the scheme was started.
- The next routine quarterly meetings with divisions are scheduled to take place throughout April 2018.
- An update on the outcomes of the next round of meetings will be presented to the Trust Board in July 2018.

Update for leadership briefing:

Not required to be included

Quality impact:

This paper describes the approach on-going within the Trust to minimise the likelihood of a risk to quality from the implementation of cost improvement programmes and aligns with all five CQC domains.

Financial impact:

This paper has no financial impact other than those associated with delivering the CIP schemes.

Risk impact:

Corporate risks:

- **Risk 71:** Failure to deliver safe and effective
- **Risk 48:** Failure to maintain financial stability

Recommendation(s) to the Committee:

The Committee is asked to note the report.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Priya Rathod, Deputy Director, Quality Governance	Janice Sigsworth, Director of Nursing	21 March 2018

Imperial College Healthcare NHS
NHS Trust

Update on the outcomes of Quality Impact Assessments (QIAs) of Cost Improvement Plans (CIPs)

1. Purpose

The agreed reporting schedule for CIP QIA outcomes is; quarterly to the Executive quality committee and three times a year to the Quality Committee and Trust Board. This paper provides an update on the outcomes of the CIP QIA meetings undertaken since it was last reported to the Trust Board in November 2017.

2. Outcomes from CIP QIA meetings undertaken (November 2017 to February 2018)

Since the last update to the Trust Board, the Interim Medical Director and Director of Nursing have met with the following areas to review the QIAs for CIP schemes. The outcomes of these meetings are summarised below.

2.1 Clinical Divisions

- **Medicine and Integrated Care:**
- Schemes for the division had a QIA score of 6 or below and were approved

- **Surgery, cancer and cardiovascular:**
- Schemes for the division had a QIA score of 6 or below and were approved

- **Women's, Children's and Clinical Support**:
- Schemes for the division had a QIA score of 9 or below and were approved

2.2 Corporate areas

- The CIP QIAs for the following corporate areas were all scored between 1 and 6 and were all approved:
    - Communications
    - Finance
    - ICT
    - Nursing Directorate

3. Post-implementation evaluations

- As part of the Trust's CIP QIA process it is important that once a scheme has been implemented, the on-going impact on quality is monitored. This is carried out locally within directorates and divisions.
- Each year, a sample of schemes from the previous financial year is selected (based on different scheme categories e.g. pay, non-pay, productivity and income) from each division for a formal post implementation evaluation (PIE) to be undertaken in accordance with the Trust's CIP QIA policy.
- To this end, each division has undertaken a PIE for a range of 2016/17 CIP schemes which have been shared with the Director of Nursing and Interim Medical Director.

- In summary, of the 17 schemes evaluated, each review demonstrated that the implementation of the scheme had improved quality and that the original QIA risk score had reduced once the scheme was started.
- One of the schemes reviewed by the women's and children's division related to holding a Quality Manager post within pharmacy for 12 months. Whilst the scheme did not have an adverse impact on quality, on reflection when undertaking the evaluation, it was recognised by the division that the post was held vacant for too long, which has resulted in an increased workload for the incoming post-holder.
- The post has been recruited to.

4. Next steps

- The next routine quarterly meetings with divisions are scheduled to take place throughout April 2018
- An update on the outcomes of the next round of meetings will be presented to the Trust Board in July 2018.

Imperial College Healthcare NHS Trust

Report to**:** **Trust board**

Report from**:** **Finance & Investment Committee (21 March 2018)**

KEY ITEMS TO NOTE

The Committee:

- Noted that of the additional £2m identified (in month 10) as potential additional savings, £1m had been delivered, but that with worsening figures elsewhere there remained a gap of nearly £2m. Dr Katie Urch commented that the income position for the division of surgery, cancer and cardiovascular had been adversely affected by approximately £1.4m in January and £1m in February, as a result of the necessary cancellation of elective procedures due to winter pressures; the balancing increase of non-elective activity would not attract the same level of contribution. Paul Doyle reported that work continued to identify any further in-year savings which would help towards achieving the control total, but there remained a risk of approximately £1m-£2m (this could change further). Dr Andreas Raffel extended thanks to the whole team for real achievement in having delivered a much improved position against budget thus far in 2017/18, in very difficult circumstances.
- Noted progress thus far with the business plan for 2018/19, and the key milestones that needed to be completed before the final submission to NHS Improvement by 30 April 2018; and noted that achievement of the plan would be challenging.
- Noted progress in developing a longer term recovery plan, the aim of which was to improve the underlying deficit and bring the Trust back to financial sustainability by 2021. The executive team expressed some confidence that the planned margin improvement of £10m p.a. in the medium term was not unrealistic.
- Was pleased to note that the Trust were on track to ensure that all consultants had job plans in place prior to the new year (2018/19); further consideration was needed as to how job planning could be used in alignment with the specialty reviews to identify efficiencies.
- Noted the capital expenditure update, and that there was a reasonable level of confidence that the full year spend would be on target. It was noted that approximately £17m had been spent on backlog maintenance in-year.
- Considered the business plan for the refurbishment of the Charing Cross Hospital emergency department, for onward review by the Trust board.
- Noted the summary of business cases approved by the executive.

The Trust board is requested to:

- Note the report.

Report from: Dr Andreas Raffel, Chair, Finance & Investment Committee
Report author: Jessica Hargreaves, Deputy Board Secretary
Next meeting: 16 May 2018

Imperial College Healthcare NHS
NHS Trust

Report to**: Trust board**

Report from: **Quality Committee (7 March 2018)**

KEY ITEMS TO NOTE

Divisional director's risk register update: The Committee reviewed the divisional risks:
Emergency Department - the Committee recognised that winter pressures continued to impact the emergency department; the Committee extended their thanks to the staff for ensuring that patient safety and dignity was maintained at all times.
Increase in elective procedure cancellations – increases in the number of patients requiring emergency care during the extreme Winter pressures had unfortunately impacted patients awaiting elective procedures; wherever possible this is being minimised.
Fire safety – the Committee was pleased to note the timely response to fire safety issues at the Western Eye Hospital.
Continuing high levels of demand in imaging – the Committee noted that achieving the diagnostic target was, due the need to outsource, placing increased financial pressure on the division.
Estates – the age and condition of the Trust's estate continued to be a concern; management focus and appropriate mitigation sought to minimise the risks to patients and staff.

Serious Incident (SI) monitoring report: The Committee noted that there had been 19 serious incidents in the reporting period; which had included delays in transfer to an appropriate care setting for five mental health patients. The Committee was pleased to note the reduction in SIs relating either to the care of the deteriorating patient or to pressure ulcers. A report on outstanding actions following SIs would be provided to the next meeting; greater clarity of action description was reducing the number of these.
The new epidural connectors were not yet available nationally, but arrangements were in place to introduce these once available.

Learning from deaths update: The Committee noted that 25 consultants had been trained to undertake structured judgement reviews, with a total of 80 reviews now completed. The Committee noted that the Healthcare Safety Investigation Branch would be taking over the investigation of maternal and perinatal deaths; the Trust would seek to ensure clear communications with patients and their families in such circumstances.

CQC update: The Committee noted the Trust's CQC rating following the recent series of inspections remained the same at 'requires improvement'; an action plan to drive further improvement was being developed.

Health & safety report: The Committee was pleased to note the eight per cent reduction in slips and trips amongst staff following a focus in this area; an update on staff on staff violence and aggression would be presented to the Committee in May 2018.

Quality account 2017/18: The Committee noted the proposed approach to the account, noting that the metrics were being reviewed with the performance team to reduce duplication in reporting; it was noted that further medics were to be added in relation to medicines management.

Flu plan: The Committee noted that, at the end of the reporting period, nearly 60% of staff had received the flu vaccine, and acknowledged that it was important to ensure learning from this year's programme in order to continue to see improvement year on year.

Imperial College Healthcare NHS
NHS Trust

Gender pay gap report: The Committee reviewed the report, and noted that further work would be undertaken to improve the accuracy of the data, before the report was published in the public domain at the end of March 2018. This area of work would be considered further as part of the equality and diversity agenda.

RECOMMENDATION:
The Trust board is requested to:

- Note the report

Report from: Prof Andy Bush, Chair, Quality Committee
Report author: Jan Aps, Trust Company Secretary
Next meeting: 9 May 2018

Quality Report: report to Trust board on additional indicators

Following discussion and request at the Board seminar in October 2017, additional information on indicators within that the Quality report that are not included in the Trust board scorecard will now be reported as part of the Quality committee report as follows:

Quality Report Targets and Goals	Frequency	Data type	Information for Board Report
We will promote safer surgery by ensuring 100% compliance with all elements of the WHO checklist	Monthly	Monthly data per element from divisional audit process	**<u>January 2018 (M10)</u>** Briefing – 80% Sign in – 97% Time out – 99% Sign out – 99% Debrief – 97% Monthly observational audits of WHO checklist compliance is conducted by the division of surgery, cancer and cardiovascular. A random audit of 50 cases was completed in January 2018 by theatre staff. The data is included below. Although this gives an overall picture, it is not sufficiently targeted to allow focused improvement work. A plan has now been developed which will target specialities that have shown a decrease in performance in the Trustwide audit. This specialty auditing commenced in February 2018 focussing on General Surgery and Orthopaedics and we will include the data in the next report. SCC have now devised an ongoing plan for specialty auditing, reviewing two specialties per month and aiming to audit 30 to 50 cases per month.
We will have no serious incidents where failure to complete the WHO checklist properly is a factor	Monthly	Monthly data from STEIS	**<u>January 2018 (M10)</u>** 0 (YTD=1)
We will maintain 90% for anti-infectives prescribed in line with our antibiotic policy or approved by specialists from within our infection teams	Six monthly	Trustwide percentage	This is reported every 6 months. The last result was 91% in September 2017

Quality Report Targets and Goals	Frequency	Data type	Information for Board Report
We will ensure that palliative care is accurately coded	Monthly	Palliative care coding rate as per HSMR (supplied by Dr Foster)	**<u>October 2017 (M7)</u>** 100%
We will increase PROMs participation rates to 80%	Monthly	Monthly internal participation data	There has been an on-going issue with the NHS Digital website which has now been resolved but the process has changed and the information is now stored on a monthly dashboard on SharePoint to which we are awaiting access. As an interim measure whilst we await access, the backlog of monthly data is being provided via email by NHS Digital. This information is currently being reviewed for accuracy and will be shared in this report next month. As reported previously, as of 1st October 2017 NHSE discontinued mandatory varicose veins surgery and groin hernia surgery PROMs collection.
	6 monthly	6 monthly participation as published by HSCIC	
PROMs reported health gain above national average (groin hernia, hip replacement, knee replacement, varicose veins)	6 monthly	6 monthly health gain for all indexes as published by HSCIC	April 2016 – March 2017: Participation rates above 80% for 2/4 procedures Health gain unable to be calculated for groin hernia and hip replacement Health gain below average for 2/3 indexes for knee replacement and varicose veins
We will review all out-of-ICU/ED and coronary care unit cardiac arrests for harm and deliver improvements as a result	Monthly	Total number, percentage reviewed and cases of potential harm.	**<u>December 2017 (M9)</u>** <u>– data reported one month in arrears</u> 100% 11 out of 11 out of ICU/ED/Cardiac Catheter lab and Heart assessment centre cardiac arrests reported in December 2017, have had a review completed by the resuscitation team. The reviews found no care or service delivery issues
We will have no inpatients waiting over 52 weeks for elective surgery, and reduce the number of patients waiting over 40 weeks and implement our agreed clinical validation process	Monthly	Number of patients coming to harm while waiting YTD	**<u>December 2017 (M9)</u>** <u>– reported one month in arrears</u> Clinical harm reviews have been completed for all patients waiting over 52 weeks in December. None of the patients required an ‘on admission’ clinical harm review and none of these patients have experienced clinical harm whilst waiting for treatment. The required clinical harm reviews identified within January data are currently being

Quality Report Targets and Goals	Frequency	Data type	Information for Board Report
			completed.
We will ensure 98% of admissions to an intensive care bed occur within 2 hours of the decision to admit/completion of surgery	Monthly	% of admissions within 2 hours of decision	**<u>January 2018 (M10)</u>** 77.7% In January 2018 77.7% of patients were admitted within 2 hours of the decision. Although not hitting our target of 98% this was an improvement from the previous month despite occupancy for all three units being extremely high, 93.3%. Charing Cross also increased the number of open beds for a limited period of time to accommodate the demand on Critical Care beds. There is still the on-going difficulty with delayed discharges, with the number of delays > 24 hours increasing in January at St. Mary's and Charing Cross.
We will improve our PLACE scores year-on-year; aiming to maintain our score above national average for cleanliness; meet the national average for food; be above the bottom 20% for condition, appearance and maintenance and for privacy and dignity; and improve our scores compared to last year for dementia and disability	Annually	Score as per published PLACE results	N/A - annual
We will have a departmental safety coordinator in 60% of clinical wards, clinical departments and corporate departments	Monthly	% of DCSs - all departments	**<u>January 2018 (M10)</u>** 44.4%
We will ensure at least 10% of our staff are trained as fire wardens	Monthly	% of staff trained as fire wardens	**<u>January 2018 (M10)</u>** 8% In January, 9 Fire warden courses were delivered. 180 members of staff were trained as fire wardens to add to the running total. Bespoke courses have been delivered at WEH

Quality Report Targets and Goals	Frequency	Data type	Information for Board Report
			and Dacie Ward HH. 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 this has now increased to 8% (January 2018). To increase the number of staff trained as fire wardens, the fire safety team have developed a more concise training package. The aim of the training is to reach more staff by making use of the core skills sessions, and the requests for ad hoc training by staff groups. The approach has now started to show more staff trained with a significant increase in numbers. Feedback has been positive. The plan is to increase the numbers of fire wardens being trained each month from 35 to 50. Managers will still need to nominate staff in their respective departments to attend training.
We will ensure we respond to all exception reports from junior doctors within 14 days of an application being made and that we delliver improvements as a result	Quarterly	Number of exception report and number responded to within 14 days	**<u>January 2018 (M10)</u>** 45% (YTD) A total of 79 exception reports were received in January 2018. Fifty eight in total are closed, 21 remain open. Of the 58 closed, 33 of these were closed within 14 days and 25 were closed over the 14 days. Outcomes of the 58 exception reports closed in January are as follows: 2 – not agreed 1 – no action required 12 – TOIL (17 standard hours + 1.5 night time hours) 43 – Payment for additional hours (75.45 standard hours + 12.25 night time hours) So far, no fines have been issued in relation to any exception reports.

Imperial College Healthcare NHS Trust

Report to**:**	**Trust board**
Report from**:**	**Redevelopment committee report 21 March 2018**

KEY ITEMS TO NOTE

The Committee discussed a number of potential options for the development of St Mary's Hospital site; these would be discussed further with NHS Improvement.

RECOMMENDATION:

The Trust board is requested to:

- Note the report
- Note that some of the discussion held at the Committee was considered 'commercial in confidence'.

Report from: Sir Richard Sykes, Chairman
Report author: Jan Aps, Trust company secretary
Next meeting: 25 April 2018

Imperial College Healthcare NHS Trust

Report to: **Trust board**

Report from: **Audit, Risk & Governance Committee (21 March 2018)**

KEY ITEMS TO NOTE

External audit update
The Committee noted the work to date on interim accounts and the proposed timetable for the end of year accounts preparation.

Internal audit progress report including limited assurance audit reports and management progress against previous limited assurance audit reports
The Committee noted the progress report and were pleased to note the significant progress with the Trust's VTE compliance. The action plan to improve mandatory training was noted and it was agreed that an update on improvements would be presented to the Committee in July.

Counter fraud progress report
The Committee noted that the training programme continued and that the Trust board training would be completed annually, in order to ensure that the board met their statutory obligations. The progress on current investigations and the latest fraud alerts were noted.

Draft internal audit plan and counter fraud plan for 2018/19
The Committee reviewed the draft internal audit and counter fraud plans for 2018/19, noting that discussion with the executive leads continued; the final plan would be presented to the Committee for approval in April 2018.

Tender waiver report
The Committee was pleased to note the continued reduction in number and value of waivers.

Losses and special payments
The Committee noted that there had been a £450k increase in losses between quarter two and quarter three. This related to the writing off of monies owed by historic overseas patients; the Committee acknowledged the strengthening of arrangements now in place which would demonstrate improvement in the future. An update on overseas patients would be presented to the Committee in July.

Corporate risk register and risk appetite
The Committee noted that four new risks had been escalated to the corporate risk register, while two risks had been de-escalated. The Committee welcomed the proposed risk appetite statement which would be presented to the Trust board for adoption; a plan as to how the risk appetite statement would be cascaded and used throughout the organisation would be presented to the Committee in July. Auditors commented that the proposed risk appetite statement demonstrated a mature approach to risk management.

Business continuity programme update
The Committee noted that good progress had been made, while noting that plans for NWL Pathology, finance and estates had yet to be finalised. The Committee were pleased to note that plans were regularly tested, and the learning from these tests was added to the plan.

Data quality framework
The Committee noted the updated data quality framework and recognised that this would support further improvement in broader data quality issues. Noting with concern the data quality error rate, it was confirmed that a comprehensive training programme was being introduced to address gaps in training of both clinical and administrative staff.

Cyber security update
The Committee noted that the cyber security risk to the Trust remained significant, but acknowledged that there were substantial and robust processes in place to mitigate and manage

the risks. The Committee recognised the risk of a growing number of PCs that were over five years of age, particularly that system upgrades became more difficult with age. The Committee agreed that the relative risks of different types of aging equipment and environment needed to be considered when prioritising the capital programme.

Update on CQC inspection outcomes

The Committee noted the final reports received from the CQC following the recent inspections. It was pleased to note improvements in outpatients and the *well-led* domain for surgery on all sites, and also noted that robust improvement action plans were in place and being monitored monthly by the executive against each of the four improvement notices.

NHS England changes to declarations of interests reporting

The Committee was pleased to note that the Trust was compliant with the new reporting requirements of declarations of interests.

Action requested by Trust board:

The Trust board is requested to:

Note the report.

Report from: Sir Gerry Acher as Chairman, Audit, Risk & Governance Committee
Report author: Jessica Hargreaves, Deputy board secretary
Next meeting: 4 July 2018

Imperial College Healthcare NHS Trust

Report to**:** **Trust board**

Report from**:** **Remuneration Committee (14 March 2017)**

Key points to note:

Draft performance development review objectives: The Committee considered and agreed the chief executive officer's objectives, which were similar in nature to those in place for 2016/17, reflecting the Trust's two-year business plan; minor amendments would add further references to timescale and measurability, and also to improvement in the Trust's racial equality.

Appointments: The Committee approved the extension of interim appointments for Prof Julian Redhead (chief executive officer) and Prof Tim Orchard and Dr Bill Oldfield (medical directors) until substantive appointment, subject to three monthly review. Recruitment continued for a substantive chief executive officer; it was expected that interviews would be held in April 2018.

The Committee agreed to make an interim internal appointment; external recruitment for a substantive post would commence once a permanent chief executive had been appointed.
The Committee approved the process, timeline and remuneration package for recruitment for a director of people and OD following David Wells' recent resignation.

Divisional director succession - The Committee supported a proposal which focused on improving the pool of clinical leaders to ensure a good field of candidates for future divisional director roles. The proposal also included additional profession support to the divisional director when in post, and in returning to clinical practice.

Executive director take-up of non-executive director (or similar) roles: The Committee requested the preparation of 'principles required prior to approval' for executive directors seeking to undertake non-executive director (or similar) roles.

Recommendation:

The Trust Board is requested to:

- Note the report.

Report from: Sarika Patel, chairman, Remuneration committee
Report author: Jan Aps, Trust board secretary
Next meeting: tbc

Imperial College Healthcare NHS Trust

Report to**: Trust board**

Report from: **Hammersmith & Fulham integrated care partnership board (24 January 2018)**

KEY ITEMS TO NOTE

Highlight report and risk register: The board noted that a new risk had been added to the risk register regarding commissioners other than H&F CCG commissioning key services to the H&F Integrated Care Partnership who are not part of the partnership's conversations. Jess Nyman reported that the communications workstream was being delayed; the Management Group had agreed to divide the workstream between a strategic communications strand and an operational communications strand. The board agreed that a greater focus should be given in meetings to delays in the programme, to enable the board to leverage project leads and unblock issues. The board considered it appropriate that any slippage in deadlines be reported with a plan of action to mitigate and manage the risk.

Terms of Reference: The board agreed the new Terms of Reference, which states that all trusts must be represented at all meetings. The board agreed to have Dr David Wingfield, Chair of the H&F GP Federation as the Chair of the board.

Staff organisational development workshops: The board endorsed the programme and agreed to ask relevant members of staff to attend.

Development of an alliance contract: The board noted that the Finance and Contracts workstream were developing an alliance contract which would be between the Trust and the other partners in the H&F Integrated Care Partnership with H&F CCG. A number of aspects of an alliance contract would require local specification, in order to provide the partnership with the mechanisms to enact the programme, including the ability to revise incentives. Other alliance contracts in place nationally were using the generic NHS England template, in which the risk and reward mechanism was more straightforward than in a capitated budget.

A shared outcomes framework was being developed which will be in line with outcomes frameworks across North West London, as well as a common North West London approach to capitation. In order to progress to a fully capitated budged, the Integrated Support and Assurance Process (ISAP) would need to be followed, which will take in excess of 12 months. The board endorsed the approach of aiming for a fully capitated budget in April 2019 if this was technically possible within the ISAP process.

RECOMMENDATION:
The Trust board is requested to:

- Note the report

Report from: H&F Integrated Care Partnership Board
Report author: Jessica Nyman, ICP Programme Manager
Next meeting: 28 March 2018