Imperial College Healthcare NHS Trust

Trust Board – Public

Wednesday, 24th July 2019, 11am to 1.30pm
Oak Room, W12 Conference Suite, Hammersmith Hospital

AGENDA

Time	Item no.	Item description	Presenter	Paper / Oral
1100	**1.**	**Opening remarks**	Paula Vennells	Oral
	2.	**Apologies:** Prof. Bush, Nick Ross	Paula Vennells	Oral
	3.	**Declarations of Interests** *If any member of the Board has an interest in any item on the agenda, they must declare it at the meeting, and if necessary withdraw from the meeting*	Paula Vennells	Oral
1105	**4.**	**Minutes of the meeting held on 22nd May 2019** *To approve the minutes from the last meeting*	Paula Vennells	01
	5.	**Record of items discussed in Part II of Board meeting held on 22nd May 2019** *To note the report*	Paula Vennells	02
	6.	**Matters arising and review of action log** *To note updates on actions arising from previous meetings*	Paula Vennells	03
1110	**7.**	**Patient Story** *To note the story*	Prof. Sigsworth	04
1125	**8.**	**Chief Executive Officer's Report** *To note the report*	Prof. Orchard	05
For decision / approval				
1140	**9.**	**CNST Compliance and Board Declaration** *To approve the action plan and Trust declaration*	Prof. Teoh	06
1145	**10.**	**Imperial College Healthcare NHS Trust Strategy** *To approve the Trust strategy*	Prof. Orchard/ Bob Klaber	07
For discussion				
1200	**11.**	**Bi-monthly Integrated Quality and Performance Report** *To receive the integrated quality and performance report for month 2 (May 2019)*	Prof. Redhead/ Claire Hook	08
1210	**12.**	**Finance Report** *To receive the month 3 (June 2019), year to date and other financial matters*	Janice Stephens	09
1220	**13.**	**CQC Update** *To receive an update on CQC related activity at and/or impacting the Trust*	Peter Jenkinson	10
1230	**14.**	**Verita Report – Implementation of lessons learnt** *To receive an update on the Verita Report actions and the response to the national recommendations*	Kevin Croft	11
For noting				
1240	**15.**	**Values and Behaviours Programme** *To note the overall aims, content and delivery methods of the programme*	Kevin Croft	12

1245	**16.**	**Responsible Officer's Annual Report** *To note this report*	Prof. Redhead	13
1250	**17.**	**Annual update on safe, sustainable and productive nursing and midwifery staffing** *To note the report and the findings from the establishment review*	Prof. Sigsworth	14
1255	**18.**	**Trust Board and Committees' Self-assessment Reviews** *To note the results and next steps*	Peter Jenkinson	15
1300	**19.**	**Trust Board Committee Summary Reports** *To note the summary reports from the Trust Board Committees*		
	19.1.	Audit, Risk & Governance Committee, 3 July 2019	Sir Gerald Acher	16a
	19.2.	Remuneration and Appointments Committee, 19 June 2019 and 17th July 2019	Peter Goldsbrough	16b
	19.3.	Quality Committee, 10 July 2019	Sir Gerald Acher	16c
	19.4.	Finance and Investment Committee, 17 July 2019	Dr Andreas Raffel	16d
1315	**20.**	**Any other business**	Paula Vennells	Oral
1320	**21.**	**Questions from the public**	Paula Vennells	Oral
Close	**22.**	**Date of next meeting** 25th September 2019, 11am, Hammersmith Hospital		

Papers for the following items have been considered by committees of the Board and are for noting. A summary of the discussion at the Board committees is included in the committee summary reports. The papers are published in the Board Reading Room for reference and on the Trust's website under supplementary reading:

1. Learning from Deaths Quarterly Report
2. Annual Complaints Report
3. Trust Strategy

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MINUTES OF THE PUBLIC TRUST BOARD MEETING

Wednesday 22 May 2019
11.00 – 13.00
Clarence Wing Boardroom, St. Mary's Hospital

Present:	
Paula Vennells	Chair
Sir Gerry Acher	Non-executive director
Victoria Russell	Non-executive director
Dr Andreas Raffel	Non-executive director
Peter Goldsbrough	Non-executive director
Prof Tim Orchard	Chief executive officer
Prof Julian Redhead	Medical director
Richard Alexander	Chief financial officer
Prof Janice Sigsworth	Director of nursing
In attendance:	
Dr Frances Bowen	Divisional director, MIC
Jeremy Butler	Director of transformation
Kevin Croft	Director of people & OD
Michelle Dixon	Director of communications
Claire Hook	Director of operational performance
Kevin Jarrold	Chief information officer
Nick Ross	Designate Non-executive director
Prof TG Teoh	Divisional director of operations, WCCS
Dr Katie Urch	Divisional director of operations, SCCS
Prof Jonathan Weber	Dean of the Faculty of Medicine, Imperial College
Peter Jenkinson	Director of corporate governance & Trust secretary (minutes)

1.	**Chairman's opening remarks, apologies and declarations of interests** Ms Vennells welcomed board members, attendees and members of public to her first meeting as Chair. She reminded those present that this was a meeting of the Trust Board held in public rather than a public meeting, but that there would be an opportunity for questions at the end of the meeting.
2.	**Apologies** Apologies were noted from Dr Andy Bush.
3.	**Declarations of interest** There were no declarations made at the meeting.
4.	**Minutes of the meetings held on 27 March 2019** The minutes of the previous meeting, held on 27 March 2019, were confirmed as an accurate record.
5.	**Record of private items discussed at Board** The Board noted a summary of confidential items discussed at the confidential board meetings held on 27 March and 24 April 2019.

6.	**Action log and matters arising** The Trust board noted the action log.
7. 7.1 7.2 7.3	**Patient story** The Board welcomed Cecilia, the mother of a patient with learning difficulties and health problems. Cecilia presented her daughter's story regarding her health and ongoing treatment, focusing on a specific episode in Ruthie's care when she suffered from bilateral pneumonia and sepsis. Cecilia commended the response from the emergency services and the staff at Hammersmith Hospital, and the care provided to both patient and carer. The Board noted that this feedback would be shared with staff in the A&E department. The Board asked Cecilia whether any aspects of Ruthie's care could be improved. Cecilia reported that the A&E department was very busy, although she also noted that everyone was trying their best, and Ruthie's care could have been improved if there had been staff available with sign language skills to assist in communicating with the patient. The Board thanked Cecilia for sharing her and Ruthie's experiences and agreed to pass on the feedback to staff. The Trust board noted the report.
8. 8.1 8.2 8.3 8.4 8.5 8.6	**Chief executive officer's report** Prof Orchard presented his report, highlighting key updates on strategy, performance and leadership. *Financial and operational performance* Prof Orchard summarised year-end performance, noting in particular the achievement of the financial control total and progress against the operational waiting times standards, including the elimination of the backlog of patients waiting for more than 52 weeks for treatment and the improvement in performance against the A&E 4 hour waiting time standard. The Board noted that achieving this level of performance had resulted in the trust receiving additional *Provider Sustainability Fund* funding which meant the Trust ended the year with a £28m surplus. Prof Orchard advised the Board, however, that the trust still faced a significant financial challenge in 2019/20 and would need to deliver a significant transformation programme to address this challenge. The Board noted a similar challenge in maintaining the improvement in operational performance. The Board noted that the Trust had been selected to pilot test new urgent and emergency care standards for three months, as part of a national pilot project. The Board also noted and celebrated the success of Trust teams in national award schemes, including the *British Medical Journal (BMJ)* award for the Flow Coaching Academy and a multi-disciplinary team being awarded the Digital Innovation Team of the year award. The Board discussed whether any of the year-end financial surplus could be reinvested in patient care, noting Prof Orchard's aim to reinvest some of it on improving the environment and facilities for staff. The Board noted, however, the current constraints on capital expenditure in the NHS and noted the ongoing lobbying of NHS Improvement by the Trust to allow the trust to spend some of the surplus. The Board also noted improvements made in procurement and contact management, as reported to the last Finance & Investment Committee, to achieve efficiencies and therefore improvement in the financial position. The Board noted the lessons learned reported at the Finance & Investment Committee from a procurement and implementation project.

	The Trust board noted the report.
9.	**Corporate objectives 2019/20**
9.1	The Board received and noted an update on the process followed for developing and agreeing the annual objectives, and noted the ongoing process to align the objectives to the executive team, and to identify leads for each objective. The Board noted that it had approved a refreshed organisational strategy with three strategic goals setting out a direction of travel for the next five to ten years to achieve our vision of 'better health, for life' at the last meeting, as well as annual objectives for 2019/20.
9.2	The Board reviewed the draft objectives, and the key activities and proposed high level measurements to demonstrate progress and achievement, and discussed the variation across the objectives in terms of detail and effectiveness in driving behaviours. The Board noted that the 'business as usual' financial, operational and quality targets were assumed and that the corporate objectives were developmental objectives designed to support achievement of the strategic goals.
9.3	The Board discussed the external environment, including the sector and the Trust's relationship with partners. The Board noted that these stakeholders were reflected in the objectives but agreed that the objectives should be more specific around the Trust's priorities in respect of developing partnerships during 2019/20, for example the development of networks with primary care.
9.4	The Board noted that the corporate objectives would be reflected in personal objectives of the executive team and that the executive team would be discussing roles and responsibilities, and the collaborative approach to be adopted in delivering these objectives. The Trust board agreed the corporate objectives for 2019/20, subject to amendments.
10.	**Clinical negligence scheme for trusts (CNST) – compliance update**
10.1	The Board reviewed the evidential requirements and self-assessment against three of the ten safety standards that make up the CNST requirements and allow trusts to a refund of financial contributions to CNST. The Board noted the financial incentive for having such processes and action plans in place but also noted the importance of having such processes in order to provide excellent quality of care. The Trust board noted the report and approved the evidence provided of compliance with standards SA1d, SA3d and SA4b of the CNST standards.
11.	**Annual self-certification for NHS trusts**
11.1	The Trust board considered the self-certification declarations of compliance against the two conditions equivalent to foundation trust licence conditions, as required by NHS Improvement.
11.2	The Board discussed the conditions and the regular assurances that it already received through other means, including the regular review of the board assurance framework and risks identified in other board papers. The Board therefore agreed that it was compliant with condition G6(3) that the Trust '…took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution.'
11.3	The Board considered its compliance, and risks to ongoing compliance with condition FT4, and agreed that, despite the improved performance over 2018/19, it could not confirm compliance with condition FT4(4a) 'to ensure compliance with the Licensee's duty

	to operate efficiently, economically and effectively' due to the Trust not achieving the waiting time standards for ED and referral to treatment (RTT), and the Trust continuing to have an underlying financial deficit. The Board noted the actions being taken to address this non-compliance, as reported in the integrated performance report and the financial recovery plan. The Trust board agreed the self-certification declaration.
12. 12.1 12.2	**Approval of annual accounts, annual report and quality account – delegated authority** The Board noted the process for the approval of the annual accounts, annual report and quality account and approved the delegation of authority to the Audit, Risk and Governance Committee to approve the submission of these documents on behalf of the Board. Sir Gerry gave a verbal update from the Audit, Risk and Governance Committee meeting held before the Board meeting and a summary of progress in the audit of the accounts and report. The Board noted the draft audit opinion, noting ongoing discussions between Trust and auditors regarding the progress made by the trust in delivering the agreed undertakings. The Committee had also received and considered the draft Head of Internal Audit opinion. The Board noted the current position and approved the delegation of authority to the Audit, Risk and Governance Committee to approve the submission of these documents on behalf of the Board.
13. 13.1 13.2 13.3 13.4 13.5 13.6	**Integrated Quality and Performance Report (month 12 2018/19)** The Board received the Integrated quality and performance report for month 12, noting exceptions as presented: <u>Safe</u> Incident reporting: The Board noted that the NRLS had published their bi-annual incident reporting data for acute non-specialist trusts for the period April 2018 – September 2018 in March 2019, which showed the Trust's incident reporting rate to be in the top quartile. However the Trust had seen a reduction in reporting rate, due to increased bed occupancy level and a reduction in number of incidents reported. Never events: The Board noted that seven never events had been reported during 2018/19 and an additional never event had been reported in April 2019 – a retained swab in ENT at Charing Cross Hospital. The Board noted the ongoing implementation of a trust-wide action plan, including the expediting of a simulation and coaching programme for all areas which undertake invasive procedures, starting with the specialties which have had never events. Weekly updates on progress with the action plan were being provided to the executive committee and assurance provided to the Quality Committee. Duty of candour: The Board noted that compliance with the completion of duty of candour for all appropriate incidents had continued to improve, with performance now over 90%. Sepsis: The Board noted that in March 2019, 70% of patients diagnosed with sepsis received antibiotics within one hour of diagnosis, compared to 67.9% in February 2019 and against a target of 50%. <u>Effective</u> Mortality rates: The Board noted that for the most recent full year data, the Trust had the lowest Hospital standardised mortality ratio (HSMR) score for acute non-specialist trusts nationally. The Trust was the fourth lowest of acute non-specialist providers for the

	Standardised hospital mortality indicator (SMHI) score.
13.7	Caring Friends and family test response rate: The Board noted that the A&E FFT response rate was 18.1% in March 2019, which is the best performance since collection began and is above the national average.
13.8	Well-led Vacancy: The Board noted the Trust's vacancy rate at the end of March 2019 was 13.5%, which is higher than the 9.9% median for the London University Hospital Association. The majority of the Trust vacancies were within the nursing and midwifery staffing group where good progress was being made to fill the roles. The Board noted the outcome of a recent review of vacant posts that had led to a reduction in vacancy rates. The Board noted the setting of establishment targets for 2019/20 to reduce the overall headcount, and noted the focus on retention of staff past the first year as part of the Trust response to turnover rates.
13.9	Responsive Referral to treatment: The Board noted the improvement in performance resulting in no patients had been waiting for more than 52 weeks for treatment at the end of March, and, following a further reduction in the total number of patients waiting, the Trust had met the trajectory for the overall RTT waiting list size. The Board noted that the performance of the standard to treat patients within 18 weeks of their referral was lower than trajectory at 84.4%, but continued to show an improving trend.
13.10	Accident & Emergency: Performance against the A&E four-hour access target had continued to improve. While the March 2019 performance, at 88.4%, was below the improvement target of 95%, it was 5.2 percentage points higher than performance in March 2018 and type 1 performance was 12.6 percentage points higher. Year-end performance for 2018/19 was 88.2%, a 1% increase compared with 2017/18.
13.11	The Board noted that the improvements in RTT and A&E performance had been achieved in the context of a reduced number of cancellations of elective surgery on the day of admission and improvements in the timeliness of admission to critical care. The Trust board noted the report.
14.	**Referral to treatment (RTT) performance**
14.1	The Board received and considered a 'deep dive' review of the management of performance against the RTT standards, providing a summary of current performance and actions being taken to improve performance against all key RTT metrics. The Board noted the improving trend in performance, including over-performance against the reduction in patient tracking list size trajectory as well as achievement of zero 52 week waits as at March 2019, and noted the assurance provided regarding actions being taken, including the actions being taken in response to the MBI data assurance review. The Board noted that the Audit, Risk and Governance Committee would continue to monitor progress against the MBI data assurance review recommendations during 2019/20.
14.2	The Board discussed the shape of the patient tracking list (PTL), noting the ongoing actions to reduce the longest waits for treatment and the focus on those waiting under 18 weeks in order to manage the PTL. The Trust board noted the report.
15.	**Finance report (month 12)**
15.1	The Board received and noted the finance report for month 12, noting that the final

	management accounts for 2018/19 would be available once the audit of the accounts was complete.
15.2	The Board noted and welcomed the achievement of the financial control total for 2018/19, with a positive variance against plan of £300,000. The Board noted that the Trust had received Provider Sustainability Funding, due to achievement of the A&E waiting time standard across the delivery board and achievement of the control total, resulting in a reported surplus of £28.2m for the year.
15.3	The Board noted that capital spend had been £700,000 less than planned for the year, but that this would be carried forward to 2019/20 following agreement with NHS Improvement. The Trust board noted the report.
16. 16.1	**CQC and Ward Accreditation Programme update** The Board received and noted and update on CQC-related activities and on the Trust's ward accreditation programme (WAP).
16.2	The Board noted that the draft report from the last CQC inspection cycle was expected in the next week for factual accuracy checking, with publication expected in July 2019. The Board also noted that the Trust's GP practices at Charing Cross Hospital and Hammersmith Hospital were expected to be inspected in July. The Board noted ongoing activities being undertaken and planned for other services not inspected in the last CQC inspection, including completion of core service peer reviews and intensive support reviews.
16.3	The Board noted the results from the WAP carried out during 2018/19, noting an continued increase in the number of areas inspected and noting the key themes arising from inspections – environment, medication and leadership. The Trust board noted the report.
17. 17.1	**Infection Prevention and Control (IPC) quarterly report** The Board received and noted the IPC quarterly report for quarter 4, 2018/19. The Board noted highlights and exceptions, including an increase in CPE admission screening, increased compliance with hand hygiene, and an increase in quality indicators in the latest Trust-wide point prevalence survey of antibiotic prescribing. The Board noted summaries of outbreaks managed during the period.
17.2	The Board noted ongoing issues relating to cleaning and estates maintenance, including water hygiene management on the neonatal unit at Queen Charlotte's and Chelsea Hospital, and actions being taken to address risks and issues.
17.3	The Board discussed the action plan to further increase compliance with hand hygiene standards, noting that divisional plans had been submitted and the IPC team would be working with divisions to support their implementation. The Trust board noted the report.
18. 18.1	**Seven day service standards** The Board received and noted an update on the NHS Improvement framework for receiving assurance on a trust's compliance with the seven day service standards introduced in 2016. The Board noted a change in the reporting approach required of trusts, to move to a board assurance framework model requiring boards to sign off self-assessment of compliance with standards prior to submission.

18.2	The Board reviewed the current self-assessment, noting that the Trust continued to meet three of the four priority standards and continued to make improvements in the other six areas. The Board noted the assurance provided that, although the trust did not meet the fourth priority standard the way that the medical model employed by the Trust continued to provide appropriate expertise.
18.3	The Board noted the assurance from the report that the quality of care did not differ significantly between week-day and weekend, and approved the submission of the assurance data. It was agreed to delegate authority to the Quality Committee to sign off future submissions. The Trust board approved the submission of the self-assessment to NHS Improvement and agreed to delegate authority to the Quality Committee to approve future submissions.
19.	**Cost Improvement Programmes (CIP) – Quality Impact Assessments (QIA)**
19.1	The Board received and noted a summary of the outcomes from the post-implementation reviews of QIAs for CIPs. The Board noted the assurance provided regarding the robustness of the QIA process to assess and monitor the quality impact from any financial savings programmes. The Board noted that the schemes evaluated had demonstrate that implementation of the scheme had either improved or maintained quality and the original QIA risk score had not increased during implementation. The Board also noted that additional assurance is provided regarding the impact on quality through the regular review of quality indicators by both Quality Committee and Trust Board. The Trust board noted the report.
20.	**Research & Development – quarterly report**
20.1	The Board received and noted the update report for quarters 3 and 4, 2018/19, noting a summary of research and development activity within the Imperial Academic Health Science Centre (AHSC). The Board noted an increased income from commercial clinical trials and projected further growth, and noted a summary of translational research projects supported by the NIHR Imperial Biomedical Research Centre (BRC).
20.2	The Board discussed the research and development strategy, including the ambition to double the number of patients in commercial clinical trials within the next three years. The Board noted the actions and investment to attract further trials, including the development of new business partnerships. The Board acknowledged the importance of research and development in the Trust's mission and the importance of the relationship between Trust and Imperial College.
20.3	The Board agreed that a further discussion, regarding the BRC and possibilities to extend involvement to other partners, would follow later in 2019.
20.4	The Board also discussed the governance processes for research projects, including the approvals process for trials to safeguard both patients and researchers, noting the role of the Research Ethics Committee. The Trust board noted the report.
21.	**Use of the Trust seal – annual report**
21.1	The Board noted the annual report summarising the use of the Trust seal during 2018/19. The Trust board noted the report.

22. 22.1	**Trust Board committees – summary reports** The Board received and noted reports from the following Trust Board committee meetings: • Audit, Risk and Governance committee meeting held on 23 April 2019 • Quality Committee meeting held 8 May 2019 • Finance & investment committee held on 15 May 2019 • Remuneration and Appointments Committee meeting held on 15 May 2019.
23. 23.1	**Any other business** The Board noted that the Trust had extended Dr Andreas Raffel's term of office as non-executive director until December 2021. It was noted that the recruitment campaign for additional non-executive directors to fill the current vacancies continued and the designated responsibilities for each non-executive director would be reviewed once the new non-executive directors had been appointed.
28. 28.1 28.2	**Questions from the public** The Chairman invited questions from the members of public present. A member of the public, representing the Save our Hospitals group, asked the Board to provide update on the Trust's proposals to close the hydrotherapy pool at Charing Cross Hospital, following discussion at the recent Hammersmith & Fulham Overview and Scrutiny Committee meeting. Prof Orchard provided a summary of provision of community physiotherapy and the use of Trust facilities to provide such services. He confirmed that the Trust was reflecting on comments received through the public consultation, including comments from the Council. He opined that the clinical evidence regarding the benefits of hydrotherapy was not sufficiently strong to merit the required capital resource, but he acknowledged that there was benefit to some patients and therefore the Trust would be considering alternatives.
29.	**Date of next meeting** Public Trust board: Wednesday 24 July 2019 11.00 – 13.00, W12 Conference Centre, Hammersmith Hospital.

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

Summary:

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

March 2019

The Board received a report from the Chief Executive, including an update on discussions regarding the redevelopment of the Trust estate and local environmental developments around St. Mary's Hospital.

The Board also received an update on business planning across the sector.

The Board received and noted an update on the process for developing the Trust strategy, to include the June Board seminar and this meeting of the Board.

June 2019

The Board also met in private in June 2019 for a strategy development seminar. The purpose of the session was to share latest thinking on the key 3-5 year strategic aims, including key challenges, opportunities and choices. The output of that session is being presented to the Board at this meeting.

Recommendations:

The Trust board is asked to note this report.

Trust strategic objectives supported by this paper:

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

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TRUST BOARD (PUBLIC) - ACTION POINTS REGISTER, Date of last meeting 22 May 2019

Updated: 18 July 2019

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	30 Jan 2019 9.4	Estates issues	The Board noted additional actions being taken to improve response to estates maintenance requests, including a weekly review meeting with divisions to review progress and prioritise requests. The Board welcomed the additional action being taken but agreed that this was one of the most significant risks facing the Trust. It was agreed that a validated view of the estate issues and the prioritisation of the resource to resolve would be presented to the next Board meeting. May 2019 update: Deferred to July 2019 Private Board.	Janice Sigsworth	July 2019
2.	26 Sept 2018 8.4	Implementation of e-referrals (arising from CEO report item)	A post-project evaluation would follow in January 2019. January 2019 update: Deferred to May 2019 July 2019 update: The post project evaluation has been completed and presented to the Executive Team. It will now be presented to the next Finance and Investment Committee.	Dr TG Teoh	July 2019

Items closed at the May 2019 meeting

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	30 Jan 2019 11.7	Board members visit arising from CQC update	The Board also noted and welcomed the introduction of the board member visit programme in November, noting the purpose of the visits to promote engagement with staff and board awareness of issues facing staff. The Board also noted the importance of leadership at a local level and divisional directors agreed the positive effect that the reviews and visits were having on local leadership. The Board agreed that consideration should be given to how to share the common themes from these visits with the Board. May 2019 update: The next version of the Board member visit programme will be developed for implementation in June 2019. The governance process around this programme has been revised to include collation and dissemination of key themes from these visits to the Improving Care Programme Board and Quality Committee / Trust Board.	Tim Orchard, Peter Jenkinson	Closed
2.	26 Sept 2018 11.4 22 May 2019 16.3	Ward accreditation programme (WAP)	It was noted that the 2018/19 WAP was currently underway and the results would be reported to the Board in March 2019. March 2019 update: This item will be presented to the Board in May 2019 once the detailed results from the 2018/19 WAP programme are collated. May 2019 update: The Board noted the results from the WAP carried out during 2018/19, noting a continued increase in the number of areas inspected and noting the key themes arising from inspections – environment, medication and leadership.	Janice Sigsworth	Closed
3.	22 May 2019 12.2	Approval of annual accounts, annual report and quality account – delegated authority	The Board noted the current position and approved the delegation of authority to the Audit, Risk and Governance Committee to approve the submission of these documents on behalf of the Board.	Richard Alexander, Prof. Redhead, Michelle Dixon	Audit, Risk & Governance Committee Forward planner May 2019
4.	22 May 2019 18.3	Seven day service standards	May 2019: The Trust board approved the submission of the self-assessment to NHS Improvement and agreed to delegate authority to the Quality Committee to approve future submissions	Prof. Redhead	Added to the Quality Committee Forward planner

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

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Patient Story	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 24 July 2019	**Item 7, report no. 04**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Author:** Stephanie Harrison-White, Head of Patient Experience and Improvement

Summary:
This month's patient story will be presented in person by Alfie. Alfie's wife Clare sadly died in one of our hospitals earlier this year. Clare had battled with cancer for over 30 years.

Alfie will share mixed experiences of care that will highlight the importance of personalised end of life care based on shared decision-making; good communication and patient choice.

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

This report has been discussed at:
None

Quality impact:
Empathic, caring staff who engage and listen to patients and their families promotes compassionate care based on what matters to the individual and their family and so supports an end of life pathway that is their preferred choice.

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

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

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

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

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

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

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

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

Trust strategic goals supported by this paper:

- To develop a sustainable portfolio of outstanding services

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

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

- What should senior managers know?
  Patients and their families must be engaged in advance care planning conversations as the last hours and days of life are approaching to ensure an agreement is reached and patients are supported to die in their preferred place, wherever that may be.

- What (if anything) do you want senior managers to do?
  Continue to promote the use of the 5 priorities of care in practice to support good decision making and care for those in the last hours and days of life.

- Contact details or email address of lead and/or web links for further
  Katherine.buxton@nhs.net

- Should senior managers share this information with their own teams? ☒ Yes ☐ No
  If yes, why?
  To reinforce the importance of excellent compassionate communication with patients and their families especially when surrounding the last hours and days of life.

Imperial College Healthcare NHS Trust

Patient Story

1. Executive Summary

This month's patient story will be presented in person by Alfie. Alfie's wife Clare sadly died in one of our hospitals earlier this year. Clare had battled with cancer for over 30 years.

Alfie will share mixed experiences of care including how kind the nursing staff were and how he felt other members of the team were more focused on 'box ticking' and trying to get Clare home. Alfie and Clare did not want to go home.

This story highlights the importance of personalised care and shared decision making especially at this time. Whilst many people prefer to die at home as illustrated in last year's patient story, this is not always the case. Although developing pathways of care that expedite people going home to die is much needed; the absolute priority is to listen and understand what each person's individual wishes are.

2. Purpose

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

The perceived benefits of patient stories are:

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

3. Background

In July 2018, Dr Buxton, consultant in palliative medicine and the Trust Clinical Lead for End of Life Care shared a patient story about end of life care. The patient in this case had wanted to die at home but sadly despite our best efforts and intentions we had not been able to facilitate this.

Since last year we have developed and tested two tools to affect changes in this area:

- The implementation of the '5 Priorities for Care of the Dying Person' namely, recognise; communicate; involve; support and plan & do. These have been

incorporated into a practical tool for ward staff to use and is one of the key components of the ward-by-ward education programme being delivered by our End of Life Care Educator.

- The development of a rapid discharge process for patients who have a deteriorating condition and wish to die at home or in an appropriate community setting.

There have been key changes to those leading End of life across the organisation within the last 12 months. Dr Buxton is now supported by Guy Young, deputy director of patient experience, who leads the nursing elements of end of life care and by Cynthia Lever, End of Life Care Educator.

Following Dr Buxton's acceptance onto the flow-coaching programme earlier this year, she has recently launched the weekly End of Life Big Room with co-coach Jess Nyman who is an integrated care manager for Hammersmith & Fulham. It is hoped that by utilising the flow coaching methodology we will continue to build upon the work already underway and ensure that our service improvement and delivery will be co-designed both by our patients and their relatives and also by the community teams who we work alongside.

Today, Alfie will share his and Clare's experience of receiving end of life care at our Trust. Clare died in February this year and Alfie is hoping to present in person at the Trust Board, although Dr Buxton will do this if Alfie feels unable to.

4. Summary/Key points

Over Christmas 2018/19, Clare had become increasingly unwell following a reoccurrence and advancement of cancer. Clare had battled with cancer for the past 30 years. On this admission, Clare was much sicker, requiring more support and needing oxygen at times.

Clare and Alfie were married for many years and faced each episode of Clare's illnesses together. Alfie cared for her when she was sick, spending most of his time in hospital with her. Clare was a private and dignified person and having Alfie with her to help was very important.

Alfie will describe the last few weeks of Clare's life whilst she was in hospital. He became her carer and her voice as she became increasingly weak. Alfie describes the nursing staff as being caring, he 'couldn't find fault with them'. He particularly remembers the palliative care clinical nurse specialist who provided great personal support for him and Clare.

Their experience of the rest of the multi-disciplinary team was somewhat varied. Alfie explains that Clare's original consultant was lovely, caring and kind and that no-one could replace her. When she went on maternity leave he felt there was a 'gap' and they did not seem to see the same doctor anymore.

There was always ‘someone different, a different take; people saying different things.’ Alfie describes that some of the consultants were more abrupt. He gave an example where on one occasion he left Clare on her own for a few minutes. Upon his return he found her visibly upset. She informed him that the doctor had just been and had said to her ‘cancer sure loves you’. They were both devastated.

Alfie felt the medical staff were trying hard to get Clare home. He felt they were more interested in getting her out of the ward, it felt as though they needed the bed. He couldn’t understand how they couldn’t see how sick she was. The palliative care nurse did intervene and reassured Alfie and Clare that they weren’t going to go anywhere and could stay.

5. Conclusion and Next Steps

Alfie and Clare’s experience highlights the impact our people have on patients and their families’ experiences and the importance of good communication at all times.

When our staff demonstrate kindness, compassion and caring behaviours this has a lasting positive impact on families. Conversely when staff show a lack of empathy this adds to the angst felt by bereaved families.

Clare and Alfie’s experience also shows the importance not only of demonstrating kindness through living the Trust values but also ensuring that we take time to understand what matters to each person and what they want, for example how or where do they want to die. Whilst the newly developed rapid pathway has enabled patients to die at home, not all patients want to follow this pathway. We need to make time to have these conversations and to listen to what our patients want.

Through the portal of the End of Life Big Room, we will share Alfie and Clare’s story and use their experience to challenge pre-conceptions and reinforce the core principle of treating each person with kindness and as individuals.

Author: Steph Harrison-White
May 2019

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Chief Executive Officer's Report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 24 July 2019	**Item 8, report no. 05**
Responsible Executive Director: Prof Tim Orchard, Chief Executive Officer	**Author:** Prof Tim Orchard, Chief Executive Officer

Summary:

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

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

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

This report has been discussed at: N/A

Quality impact: N/A

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

Risk impact and Board Assurance Framework (BAF) reference:

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

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

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

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

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

Chief Executive's Report to Trust Board

1. Financial performance

The finance report to be considered by the Board provides a summary of the Trust's financial results for the three months ended 30th June 2019. The Board has agreed the control total of £16.0m deficit before Provider Sustainability funding (PSF) and Marginal Rate Emergency Threshold Funding (MRET) for the year. The Trust is on plan in month and for the three months year to date and has reported to NHS Improvement that the Trust is expecting to be on-plan at year end.

However, significant risks remain to achieving the plan, most notably a continuing gap in identification and delivery of the Cost Improvement Programme (CIP) and over-performance in activity. To mitigate the adverse CIP position work is being completed across the Trust to review pay spend including controlling work on temporary staff spend. The Trust is over-performing on NHS clinical income, mainly in non-electives. This over performance puts further pressure into the sector control total, and payment for over performance is not guaranteed and must be agreed across the sector. The Trust is working closely with commissioners and providers in North West London to understand the expected activity for the year and to work together to ensure that this is delivered cost effectively.

The organisation is currently undergoing a process of refreshing the Project Management Office (PMO) function to provide greater oversight of CIPs and support to the Divisions. This support will ensure that the PMO function will help identify further CIP schemes and embed efficiencies.

2. Transformation programme update

The Finance & Investment Committee received an update on the Transformation plan and Specialty Review Programme at its meeting in July, including an update on the new programme management approach being taken to ensure project delivery. The team is largely in place, and progress is being made in defining key areas of opportunity, both operational and strategic. We hosted the Shelford Transformation network in late June, and are sharing our experiences in Virtual Outpatient work, amongst other initiatives. Internal engagement continues, with scoping and prioritisation of projects continuing.

3. Patient focus

Care Quality Commission (CQC) inspections
The Trust is expecting the publication of the quality ratings for a range of services inspected across four of the Trust's hospitals in February 2019 this week.

The report will also include ratings for how 'well-led' the Trust is, reflecting the results of the NHS Improvement inspection of the Trust's use of resources to provide high quality and sustainable care for patients. There were not enough services inspected at this time to change the Trust's overall rating, which is Requires Improvement, but we expect the report to reflect improvements made in the services inspected.

Further details on CQC related activity and inspections are included in the report being presented to the Board.

Non-emergency patient transport
On 1 June 2019, the Trust non-emergency transport provider changed to Falck. Since implementation of the new service a number of incidents have occurred, including transport failing to attend scheduled appointments and delays to patients being discharged. It is very disappointing that the initial service they have provided has fallen significantly short of the standard we expect for our patients. We are sincerely sorry for the distress and delay to some appointments this has caused.

We have been working very closely with Falck to improve the service as quickly as possible though we know that some patients are still having problems with their transport bookings. Our regular renal patients have been especially impacted and we have been putting in place temporary measures wherever we can for these users.

We have identified Falck's dispatch and allocation system to be the primary cause of the ongoing issues and so we are introducing a number of changes to the way bookings are scheduled which we expect to resolve the difficulties for the longer term. I met the CEO of Falck on 12 July 2019 to escalate our concerns regarding current performance and to agree an action plan and improvement trajectory to address the issues. We have also launched a serious incident investigation to review the implementation of this contract to learn lessons.

4. Operational Performance

The Trust Board will consider the integrated quality and performance report and the key headlines relating to operational performance as at May 2019 (month 2).

Exceptions in performance are highlighted in the following key areas:

- **Never events** – No never events were reported in May 2019. The investigation into the never event reported in April is ongoing. The trust wide never event action plan continues to progress, with 23 actions closed and the remaining 16 in progress. Monthly updates are being provided to executive quality committee.

- **Mortality data** – For the most recent full year data, the Trust has the lowest Hospital standardised mortality ratio (HSMR) score for acute non-specialist trusts nationally. The Trust was the second lowest of acute non-specialist providers for the Standardised hospital mortality indicator (SMHI) score.

- **ED waiting time –** In May 2019, the Trust commenced testing of a proposed new A&E standard as one of fourteen hospital trusts in England. In line with the memorandum of understanding with NHS England, figures on the A&E four hour standard will not be published during the pilot period. Throughout the pilot, our focus remains on achieving a good flow of care across our care pathways. The Trust is reporting an increase in the number of patients who were delayed over 12 hours (from decision to admit to admission), also known as a 'trolley wait'. In June 2019, 22 patients were delayed which was up from 7 in the previous month. All were delays to admission for mental health provider beds and the Trust is working closely with commissioners and the mental health providers to minimise breaches.

- **Referral to Treatment (RTT)** – In May 2019, the Trust continued to report that no patients had been waiting for more than 52 weeks for treatment. There was also a continued improvement in our performance against the standard to treat patients within 18 weeks of their referral and the overall RTT waiting list size was maintained below our target of 63,100.

Trust undertakings

The Board will note the latest update on progress against the Trust's updated regulatory undertakings, as agreed last September, attached at Appendix 1. At the last Provider Oversight Meeting with sector partners and regulators, it was agreed that the Trust's regulatory segmentation (rating) and the undertakings would be reviewed to reflect the progress made by the Trust.

EU Exit planning

Following advice from the Department of Health and Social Cate (DHSC) in the last couple of weeks all NHS organisations have been asked to re-focus on EU Exit readiness planning, local risk assessments and to consider updating business continuity plans ahead of the 31st October 2019.

The same planning assumptions are still valid in our preparation. DHSC have requested that our risks are reassessed and plans updated accordingly on the following;

- supply of medicines and vaccines
- supply of medical devices and clinical consumables
- supply of non-clinical consumables, goods and services
- workforce
- reciprocal healthcare
- research and clinical trials and

- data sharing, processing and access

We have initiated the following actions in response:

- updating and refreshing all business continuity plans for the annual NHS EPRR assurance framework 2019/20 – submission due September 2019
- focussed on the seven areas of activity listed above to ensure that there are sufficient business continuity plans to respond to a no deal EU Exit for a minimum of 6 weeks
- worked with suppliers and stakeholders to look at supply chains including supplies that would need to cross EU borders
- reconvened the EU Exit Steering group, chaired by Claire Hook

Further guidance from NHS England is expected during September as well as a further EU Exit regional workshop to align our plans as we head into October. The EPRR team will continue to undertake horizon scanning to ensure that any information through their networks is picked up quickly and responded to rapidly. Should there be a no deal EU exit on 31st October 2019, hawse have well-rehearsed emergency response and business continuity plans to ensure that we are able to respond to any incident, if required to do so. In the meantime, we will continue to follow advice and guidance from NHS England and continue to meet assurance requirements. The risk that significant disruption to the continued provision of service in the event of a "no deal" EU exit remains on the risk register with a score of 8.

5. Strategic development

Strategy development was the focus of the Trust Board's seminar on 26 June and the outputs from that meeting are presented at this meeting.

Collaboration with Chelsea & Westminster NHS Foundation Trust

The *NHS Long Term Plan* encourages and supports all NHS organisations to work more collaboratively, focusing on the needs of local populations to provide the care and support they need, when and where it provides the best outcomes and experience. As the Trust and Chelsea & Westminster NHS Foundation Trust offer a large range of services from seven hospitals within ten miles of each other, providing most of the hospital care for the population of inner north west London, there is much to be gained by us working more collaboratively.

In line with national and local policy, both organisations want to develop more person-centred and joined up care, reduce inefficiencies and improve the opportunities and working lives of our staff. Our initial work programme builds on existing collaborations and is focusing on developing **outstanding and sustainable services,** prioritising pathways where there are particular opportunities and/or challenges**.** We will also be exploring further opportunities for integrated care and how to create more shared learning and innovation.

Current joint initiatives include:

- Pathway collaborations on HIV inpatient care, Dermatology and Ophthalmology
- Service and research integration in Children's care (West London children's initiative) and Cardio-respiratory care
- Foundations and infrastructure projects including the roll out of Cerner electronic patient administration system and exploring opportunities for further partnership work about the use of our estate, corporate functions and other resources, as and where appropriate.

6. People

Ensuring excellent support, development and wellbeing of our people is essential, as reflected in our strategy and priorities presented later in the agenda for approval. We have a range of people-related indicators that are reviewed at divisional level in performance meetings as well as the executive people & OD Committee. A selection of these indicators is reported to the Board via the performance scorecard. However, to clarify and reinforce the full Board people agenda we have set out a forward planner of routine people items on the table below. This will be supplemented by other people items as they emerge. Today is a good example where we have two additional items. Firstly, we have the

values and behaviours programme that has been developed to ensure we live our values and, secondly, the update on our response to the Verita Report and the national recommendations on managing misconduct in the workplace.

Item	Date	Purpose
Workforce key performance indicators	Bi-monthly	Workforce KPIs included in standard Trust Board performance report. Following recent NHSI National Report on Board oversight of disciplinary procedures this will include KPIs on this area (e.g. number of dismissals, suspensions, disciplinary hearings) but detail to be agreed.
Remuneration Committee report	Board following meeting	Standard committee report following most recent meeting. Key dates: • Executive annual performance review and pay report (Apr/May) • Succession plan (Dec)
Annual staff survey results and management plan	Mar/Apr	Provide Board with the Trust's performance in the annual staff survey highlighting positives, negatives and plan for improving performance.
Annual Equalities Report, Gender Pay Gap report and action plan	Sep	Statutory duty to publish equalities data and best practice that there is Board awareness and oversight. Report provides assurance on actions to address statutory duties and issues arising from the data.
General Medical Council survey of Junior Doctors	Sep	Provide Board with the Trust's performance in the annual junior doctors survey highlighting positives, negatives and plan for improving performance.

7. Stakeholder engagement

Below is a summary of significant meetings and communications with key stakeholders since the last meeting:

Meeting with Hammersmith & Fulham Save our NHS group: 28 May
On Tuesday 28 May, I met with Vivienne Lukey, Merril Hammer and Jim Grealy from the Hammersmith & Fulham Save our NHS group (formerly known as the Save our Hospitals group). The main items for discussion were: service change proposal for physiotherapy; financial performance and plans; development of NHS NW London long term plan; integrated care services; information desk at Charing Cross Hospital; and, potential patient story for future Trust board item.

Meeting with Healthwatch Central West London: 3 June
On Monday 3 June, I met with Christine Vigars (Chair) and Olivia Clymer (Chief Executive Officer) from Healthwatch Central West London. The main items for discussion were: testing urgent and emergency care access standards; NHS north west London long term plan; development of primary care networks in Hammersmith & Fulham; joint 'healthier hearts and lungs' proposal; forthcoming CQC inspection reports; and, operational and financial performance.

Meeting with local MPs: 4 June
On Tuesday 4 June, I met with our local MPs Karen Buck and Andy Slaughter. The main items for discussion were: operational and financial performance; joint 'healthier hearts and lungs' proposal; forthcoming CQC inspection reports; estates backlog maintenance and site redevelopment; NHS north west London long term plan; testing new urgent and emergency care access standards; service change proposal for physiotherapy at Charing Cross Hospital; and, London Living Wage.

Meeting with Cllr Heather Acton, Westminster City Council: 11 June
On Tuesday 11 June, I met with Cllr Heather Acton, Westminster City Council's Cabinet Member for Family Services and Public Health. The main items for discussion were: operational and financial performance; CCG developments in NW London; social prescribing service and support for frequent attendees at Emergency departments; redevelopment of St Mary's hospital site; health and wellbeing board priorities for 2019/20; testing new urgent and emergency care access standards; forthcoming CQC inspections reports; and, the joint proposal on 'healthier hearts and lungs'.

London Borough of Harrow Health and Social Care Scrutiny Sub-committee: 12 June
On Wednesday 12 June, Dr Bob Klaber, Deputy Medical Director, attended Harrow Council's Health

and Social Care Scrutiny Sub-committee to discuss the Trust's draft Quality Account for 2018/19.

Meeting with Hammersmith & Fulham Council: 10 July
On Wednesday 10 July, I met with the London Borough of Hammersmith & Fulham's Leader Cllr Stephen Cowan, and Cllr Ben Coleman, Cabinet Member for Health and Adult Social Care.

Meeting with Cllr Heather Acton, Westminster City Council
On Friday 12 July, I met with Cllr Heather Acton, Westminster City Council's Cabinet Member for Family Services and Public Health. The main items for discussion were: redevelopment of St Mary's Hospital site; joint 'healthier hearts and lungs' proposal; joint HIV inpatient care proposal; and, forthcoming CQC inspection reports.

8. Celebrating achievements

Make a difference annual awards
On Thursday 11 July Channel 4's health and social care correspondent Victoria Macdonald hosted an evening to remember, with 300 of our staff members cheering on the 2019 Make a Difference finalists and winners.

The annual Make a Difference awards ceremony – funded by Imperial Health Charity – is a fantastic opportunity to celebrate the outstanding achievements of our staff and volunteers. This year was even more special as we launched a new patient and public involvement award which recognised improvements or developments that best demonstrated notable impact from working in genuine partnership with patients or local people. This award is named in honour of Michael Morton, the founding chair of our strategic lay forum who passed away in November 2018.

The winners included:

- **Individual of the year:** Marie Symonds Dubska, Intensive care unit staff nurse, surgery, cancer and cardiovascular
- **Team of the year, as voted by our staff:** Wolfson Fertility Centre, Women's, children's and clinical support
- **Michael Morton patient and public involvement:** Café Hab, based at St Paul's centre in Hammersmith
- **Unsung hero:**
    - Justina Madunagum, Health care support worker, medicine and integrated care
    - Brian Browne, Radiotherapy booking administrator, surgery, cancer and cardiovascular
    - Susan Giles, Lead risk and audit nurse, women's, children's and clinical support
    - Dierdre McCollin, Manager, Charing Cross Day Nursery, corporate
- **Chair's award:** The North West London Pathology rapid flu testing team

Imperial Health Charity's Research Fellowships programme
Celebrations marking 10 years of Imperial Health Charity's Research Fellowships programme have kicked off a new campaign encouraging NHS staff to get involved in research.

Set up by the charity in 2009, the innovative programme provides funding for members of staff at the Trust to take the first steps in their academic career. Dozens of fellows joined staff from the Trust, Imperial College London, the Royal Marsden NHS Foundation Trust and the Royal Brompton NHS Foundation Trust at the college's South Kensington campus for a celebration event on Tuesday 2 July, marking the programme's 10th anniversary.

Now the charity is encouraging staff across the Trust to start their research journey by applying for a fellowship. Grants, funded by the charity and the NIHR Imperial Biomedical Research Centre, are available for successful applicants, enabling them to take time out of their job or training programme to complete a research project. Some have gone on to become clinical academics lecturing at Imperial College London, while the results of our fellows' work have helped to shape clinical care at the Trust.

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

At 9 June 2019

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
Finances	1.1	Return to underlying surplus with year on year improvements in the underlying position	Start of 2021/22	In progress	We have agreed a framework for identifying the required savings focusing on: • Business as usual CIPs • Income and productivity opportunities • Private patients and commercial • Specialty review opportunities • Other (incl. transformation) Our original recovery plan projected a move from our current deficit to an underlying deficit of £20-£25m by 2021/22, with further improvements thereafter depending on support to address structural issues relating to our estate. Based on 19/20 plan assumptions (including the new tariff structure), on a similar trajectory we would expect the underlying deficit in 2021/22 to be in the region of £5-10m (including MRET funding) We are focussed on identifying and delivering the improvements required to return to surplus. A permanent appointment has been made for the Director of Transformation to lead the delivery of the trust's transformation programme which started at the beginning of September.
	1.2	Develop and submit a financial recovery plan to return to surplus by the start of 2021/22	30 November 2018	Completed	We submitted our plan to our Board for approval at the end of November and to NHSI on 29 November. The agreed 2018/19 plan will form the first year of the recovery plan. Acknowledged by NHSI on 20th December that the submission meets the Undertakings Obligations.

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
	1.3	Take reasonable steps to deliver the Financial Recovery Plan, ensuring adequate capacity and capability in place	30 November 2018	In progress	We are putting in place the appropriate governance through our executive and board committee structure. We have also recruited a Director of Transformation and a supporting team to support delivery of the plan, alongside existing resources in the corporate and clinical divisions.
	1.4	Keep Financial Recovery Plan under review and agree necessary amendments with NHS Improvement		In progress	NHSI have reviewed and acknowledged receipt of our 4 year financial recovery plan. This will be updated later in 2019/20 for consistency with the long term planning guidelines accompanying the NHS 10 year plan
Emergency care	2.1	Take reasonable steps in order to achieve sustainable compliance with the 4 hour A&E target		In progress	A system wide approach is overseen by the Care Journey and Capacity Collaborative which focusses on four main areas of improvement. In addition the Trust continues its focus on reducing long stay patients of over 21 days, reducing ambulance handover delays and reducing type 1 non-admitted 4 hour breaches.
	2.2	Maintain A&E target at or above 90% throughout Winter 2018/19	2018/19	In progress	In May we commenced the testing of a proposed new A&E standard as one of fourteen hospital trusts in England. In line with the memorandum of understanding, we will not be publishing the figures on the A&E four hour standard for the pilot period. Throughout the pilot, our focus will remain on achieving a good flow of care across our care pathways.
	2.3	Maintain A&E performance of 95%	31 March 2019	In progress	As above.
RTT	3.1	Ensure no patients are waiting more than 52 weeks on RTT pathways	March 2019	In progress	RTT long waiters (40+ weeks) are managed by Clinical Directorates and Divisions, supported by the Elective Care Delivery Manager. All long-waiting patients are validated and actively tracked on a weekly basis, and monitored through specialty-led PTL meetings. The Trust reported zero 52 week waiters for May 2019.

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
	3.2	Delivers the RTT incomplete performance target in line with the trajectory agreed in the 2018/19 plan through delivery of the agreed action plan	March 2019	In progress	The Trust continues to work to maintain the PTL size. For May 2019 (M1) there was a slight increase to 63,097, however this remained within the Trust trajectory target for the month of 63,100. The PTL size in March 2019 was 61,371 which met the 2018/19 undertakings. May 2019 performance for the 18w aggregate was 86.1%, which continued the overall trend of improvement over the last eight months.
Data Quality	4.1	Amend the RTT action plan to ensure that it addresses the concerns set out in the independent review of clinical and administrative processes within elective pathways and clinical oversight of avoidable harm	31 October 2018	In progress	The MBI data assurance report was published 31 July 2018. Nine high level recommendations were provided which also have 45 sub-recommendations associated with them. A finalised action plan was presented to the Executive Operational Committee in November 2018 and the Trust Board (ARG) in December 2018. The Trust has reported recent improvements in some of the data quality indicators associated with the management of RTT. The RTT audit high-risk error rate has reduced to 5% and is now within the target threshold. Five of the 10 key priority waiting time data quality metrics have shown improvement when compared with April 2019.
	4.2	Implement the amended RTT action plan	Date to be agreed with NHS Improvement	In progress	
Programme Management	5.2	Trust Board to oversee delivering undertakings, and risks to the successful achievement and hold individuals to account for the delivery of the undertakings	With immediate effect	On-going	From November 2018 the undertakings report will be included in the CEO's report to Board

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: CNST Compliance and Board Declaration	☒ Approval ☐ Decision/Endorsement ☐ Discussion ☒ Information
Date of Meeting: 24th July 2019	**Item 9, report no. 06**
Responsible Executive Director: TG Teoh, Divisional Director	**Author:** Lesley Young, Interim General Manager, Maternity

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

The attached report sets out the evidential requirements for the Safety Actions below that need to be approved or noted for information and formally recorded at the Trust Board meeting on 25th July 2019 in order to meet the timescales requested for CNST.

It also includes the Trust declaration form (Appendix 1) that must be signed and dated by the Trust Chief Executive to confirm that:

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

An assurance report providing narrative on the compliance and evidence for each Safety Action is also attached at Appendix II. Detailed documented evidence for each Standard is available on request. It is not required to be submitted as part of the CNST declaration process.

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

4a) Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps.

Evidence Required - Proportion of trainees formally recorded in Board minutes and the action plan to address lost educational opportunities should be signed off by the trust Board and a copy submitted to the Royal College of Obstetricians and Gynaecologists (RCOG) at workforce@rcog.org.uk

4b) An action plan is in place and agreed at board level to meet Anaesthesia Clinical Services Accreditation.

Evidence Required - Ratified Action Plan by Board on how Trust is working to meet the standards for those areas not met.

Recommendations:
The Board is asked to approve the Action Plan to note for information the evidence requirements for SA4a (Action Plan to address lost educational opportunities due to rota gaps) and SA4b (Action Plan to meet ACSA standards).

The Trust declaration form is submitted for Trust Board approval. An assurance report is also attached at Appendix II. It is not required to be submitted as part of the CNST declaration process. Final submission date for Board Declaration to NHS Resolution is Thursday 15th August 2019 by 12 noon.

This report has been discussed at:

- Maternity Quality and Safety meeting – 2nd July 2019
- Divisional Quality and Safety meeting – 1st July 2019
- Executive Quality Committee – 2nd July 2019
- Quality Committee – 10th July 2019

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

Quality impact:
Meeting the CNST standards focuses on continuing to support delivery of safer maternity care. One of the standards (SA7) requires us to demonstrate that we have a patient feedback mechanism for maternity services and that we regularly act on feedback. All 4 CQC domains; caring, responsive, effective, well-led are improved by meeting the CNST standards.

Financial impact:
The financial impact of this proposal as presented in the paper enclosed can be fully accommodated within the existing departmental budget this year and into the future assuming deliverable levels of efficiency. If we are able to demonstrate full compliance against the standards the Trust may receive £1M net rebate.

Risk impact and Board Assurance Framework (BAF) reference:
Risk to CNST compliance and associated financial incentive if required governance evidence is not provided.

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

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

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

What impact will this have on the wider health economy, patients and the public? Compliance with CNST Maternity Safety Actions will support the delivery of safer maternity care to our patients.

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

Trust strategic goals supported by this paper:

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

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

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

- What should senior managers know? Trust commitment to achieving full compliance of CNST
- What (if anything) do you want senior managers to do? For information and noting
- Contact details or email address of lead and/or web links for further information https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/
- Should senior managers share this information with their own teams? No

Imperial College Healthcare NHS Trust

CNST Maternity Incentive Scheme – Evidential Requirements

1. Executive Summary

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

2. Purpose

2.1. The report below sets out the evidential requirements for the Safety Actions that need to be approved or noted for information and formally recorded at the Trust Board meeting on 25th July 2019 in order to meet the timescales requested for CNST.

2.2. It also includes the Trust declaration form (Appendix 1) that must be signed and dated by the Trust Chief Executive to confirm that:

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

3. Background

3.1. In 2018, NHS Resolution introduced the CNST Maternity Incentive Scheme to support delivery of safer maternity care. Trusts that evidenced their compliance against the safety standards are eligible to receive a rebate of 10% of their CNST maternity premium. In 2018, the Trust was successful in meeting all 10 safety standards and received £1.8M and are endeavouring to meet the revised standards in 2019.

4. Summary/Key points

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

Standard 4a: Evidence Required - Proportion of trainees formally recorded in Board minutes and the action plan to address lost educational opportunities should be signed off by the trust Board and a copy submitted to the Royal College of Obstetricians and Gynaecologists (RCOG) at workforce@rcog.org.uk

- Just over 70% of obstetrics and gynaecology trainees in the trust 'disagreed/strongly disagreed' with the 2018 GMC Training Survey question 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota'
- ICHNT were not an outlier for this metric nationally and did not get a red flag for the rota domain (which would mean we were in the bottom quartile and statistically an outlier in that)
- There were significant rota gaps in the junior doctors rota at QCCH in 2017-18 which led to a number of actions to improve the educational and training opportunities for trainees in O&G:

Imperial College Healthcare NHS Trust

Reasons for rota gaps in 2017-18:

There were significant rota gaps in the junior doctors rota at QCCH in 2017-18 during the time the previous 2018 GMC survey was being completed by trainees. This was for a variety of reasons including:

- trainees taking maternity leave
- trainees taking opportunities to go out of programme to pursue research and to move from the core training programme to subspeciality training programmes
- long term sick leave of 2 of the 3 of the GP VTS trainees

Despite advertising for replacements on several occasions, it was not possible to fully recruit to the vacancies. Additionally there were HR difficulties regarding post numbers leading to successfully interviewed people not been able to be properly recruited. This left significant rota gaps and this was escalated both to the Divisional team and the Executive team.

Actions taken at during 2017-18 to address rota gaps and to improve the educational and training opportunities for trainees in O&G at QCCH:

- junior doctor rotas were redesigned at both SHO and Registrar levels
- consultants who were providing resident cover of labour ward were taken off resident duties and put on the on-call rota, freeing them up to provide consultant led care in day care environments and providing consultant daily ward rounds thereby relieving junior doctors of some of their duties and ensuring safe care for patients
- Teaching sessions on Tuesday mornings, Wednesday mornings and Thursday mornings were maintained, bleep free
- Educational and training opportunities for trainees were prioritised
- Rolling advertisments for junior doctor posts

Rota gaps and educational opportunities 2018-19

College Tutors on both sites have confirmed that in the past year, they have proactively managed foreseeable gaps in the rota with locum appointments where feasible. However, some gaps are inevitable due to short periods between appointments, unexpected leave and a relatively high number of trainees in O&G going on maternity leave or working less than full-time.

With regard to gaps that do occur, we manage in the daytime with cross cover and out of hour shifts are paid at locum rates to trainees who volunteer for extra shifts. Educational and training opportunities are prioritised for all trainees with regular bleep free training sessions, prioritising labour ward with a consultant for training, gynaecology theatre with a consultant for training and subspeciality ATSM sessions for higher training and special interest sessions at all grades where trainees can fulfil any additional individual educational requirements. Local faculty group meetings occur quarterly and trainee feedback is received and acted upon regarding educational and training opportunities. Minutes are available.

- Feedback from SHOs currently has been positive, they have a minimum of 3 sessions of protected teaching each week and are all able to attend some special interest sessions if they wish.
- Feedback from most of the registrars is that they are able to attend a wide range of special interest sessions, are able to attend teaching and from the rota perspective, there has been a fair distribution of activities according to grade.

All trainees attend their compulsory HEE regional monthly training unless they are on night duty, or on leave.
All trainees received either an outcome 1 at their latest ARCP or an outcome 5.
All ST2s wanted to stay on at ICHNT for their ST3 grade at their matching interviews except for one who wished to move for personal social reasons.

Tables 1 and 2 in Appendix III Tables lists the actions we have taken to reduce the adverse impacts of rota gaps in the last year on both sites:

4b) Evidence Required - Ratified Action Plan by Board on how Trust is working to meet the standards for those areas not met.

Standard 1.2.4.6.	Local findings	Action	Lead & Complete	Progress (RAG)
Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff	**QCCH:** There are dedicated theatre and midwifery staff for all elective caesarean sections lists and a dedicated consultant obstetrician (without prospective cover).	Standard fully met for theatre and midwifery staff – no action required	N/A	Complete
	SMH: No dedicated scrub nurse. Dedicated consultant anaesthetist present for elective lists (2 per week).	Dedicated scrub nurse required: Business case or reconfiguration of scrub nurses to ensure dedicated scrub nurse for elective CS lists	HOM / Theatre Nurse Lead 31 March 2020	Discussion underway
	SMH & QCCH - The obstetric consultant is only paid for a 4 hour session whilst the list lasts 5 hours	Investment required to remunerate for a 5 hour session instead of 4 hours	Clinical Director Maternity 31 Dec 2019	Ongoing

	- There is no prospective cover for the list to be covered when consultant obstetrician is away on leave	Obstetric job plans to be reviewed to provide prospective cover for elective CS lists- small investment required	Clinical Director Maternity 31 Dec 2019	
	QCCH - Only one out of five elective CS theatre lists has a dedicated consultant anaesthetist	Business case for anaesthetic investment requires 1.25PAs x 4 elective sessions and prospective cover for 5 sessions	Clinical Director Anaesthetics 31 Mar 2020	

5. Conclusion and Next Steps

5.1. The Chief Executive is asked, on behalf of Trust Board, to sign for approval the Board Declaration form (appendix I). Narrative assurance report for information. (Appendix II)

5.2. Approval for evidence requirements for SA4a (Action Plan to address lost educational opportunities) SA4b (Action Plan to meet ACSA standards).

6. Recommendations

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

Author: Lesley Young, Maternity General Manager **Date:** 17/07/2019

Maternity incentive scheme - Guidance

Resolution

Trust Name	**Imperial College Healthcare NHS Trust**
Trust Code	**T670**

This document **must** be used to complete your trust self certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. Your trust name will populate each tab. **If the trust name box is coloured pink please update it.**

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.** There are three additional tabs within this document:

Tab A - Safety actions entry sheet - Please select 'Yes' or 'No' to demonstrate compliance with each maternity incentive scheme safety action. Note, entering 'Yes' denotes full compliance with the safety action as detailed within the condition of the scheme. The information which has been populated in this tab, will automatically populate onto tab C which is the board declaration form

Tab B - Action plan entry sheet - This must be completed for each maternity incentive scheme safety action which has **not** been met. If you are not requesting any funding to support implementation of your action plan - Please enter 0. **If cells are coloured pink then please update them.**

Tab C - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (Column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution. Once the submission has been discussed and approved at trust board, please add an electronic signature into the document. If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **MIS@resolution.nhs.uk**

Technical guidance and frequently asked questions can be accessed here :
https://resolution.nhs.uk/resources/maternity-incentive-scheme-year-two

Submissions for the maternity incentive scheme must be received no later than **12 noon on Thursday 15 August 2019** to **MIS@resolution.nhs.uk**

You are required to submit this document (and a signed copy of the board declaration form, if there is no electronic signature added). Please do not send evidence to NHS Resolution.

Section A : Maternity safety actions - Imperial College Healthcare NHS Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Yes
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Yes
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Yes
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Yes

NHS Resolution

Section B : Action plan details for Imperial College Healthcare NHS Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the*		
Lead executive director	*Does the action plan have executive*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

NHS Resolution

Maternity incentive scheme - Board declaration Form

Trust name Imperial College Healthcare NHS Trust
Trust code T670

An electronic signature must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Medical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process:

Electronic signature

For and on behalf of the board of Imperial College Healthcare NHS Trust

Confirming that:

The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

The content of this form has been discussed with the commissioner(s) of the trust's maternity services

If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)

We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Name: Professor Tim orchard
Position: Chief Executive
Date:

Board Internal Assurance Report on Imperial College Healthcare NHS Trust compliance against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

APPENDIX II

NB: ***DETAILED DOCUMENTED EVIDENCE TO SUPPORT ASSURANCE STATEMENTS BELOW IS AVAILABLE ON REQUEST FROM MATERNITY GENERAL MANAGER***

SECTION A: Evidence of Trust's progress against 10 safety actions:
Please note that trusts with multiple sites will need to provide evidence of each individual site's performance against the required standard.

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	Both sites use the NPMRT to review perinatal deaths and MBRRACE data is submitted. The returns are completed by a multi-disciplinary clinical team – Obstetrician, Midwife, Neonatologist, Paediatrician as the core members and other specialties as clinically necessary. The following standards have been met: a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death. b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death. c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought. d) Quarterly reports will be submitted to the trust Board that include details of all deaths reviewed and consequent action plans. The first report was presented on	**Yes**

<table>
<tr><td></td><td></td><td>26th May 2019.</td><td></td><td></td></tr>
<tr><td></td><td>2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?</td><td>The 3 mandatory categories needed to pass Safety Action 2 have been successfully completed as follows:

<table><tr><td>Jan 19 data contained at least 90% of HES births expectation, based on number of days in month (unless reason understood)</td><td>Numerator: Number of MAT502 records for deliveries, distinct mothers with BabyBirthDateTime in the reporting period

Denominator: Number of deliveries recorded in Hospital Episode Statistics (HES) using annual 17/18 HES data OR provisional monthly HES data for the reporting period</td></tr><tr><td>MSDSv2 readiness questionnaire completed and returned to NHS Digital within required timescales</td><td>MSDSv2 readiness questionnaire completed and returned to NHS digital by deadline in February 2019.</td></tr><tr><td>Submit MSDSv2 for April 19 by the submission deadline of the end of June 19</td><td>MSDSv2 for April 2019 submitted by 27 June 2019</td></tr></table>In addition 18 of the 19 optional categories have been made. In order to pass compliance 14 of the 19 were required.</td><td>Yes</td><td></td></tr>
<tr><td></td><td>3). Can you demonstrate that you have transitional care services to support ATAIN (Avoiding Term Admissions into Neonatal Units)</td><td>Evidence available includes:
a) Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care.
b) A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2.</td><td>Yes</td><td></td></tr>
</table>

	Programme?	c) An action plan has been agreed at Board level and with our Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews in March 2019. d) Progress with the agreed action plans has been shared with our Board in May 2019 and with our LMS & ODN.		
	4). Can you demonstrate an effective system of medical workforce planning?	a) A formal record has been kept of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: *'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.'* In addition, a plan has been produced by the trust to address lost educational opportunities due to rota gaps and presented at May Trust Board meeting. b) An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation	**Yes**	
	5). Can you demonstrate an effective system of midwifery workforce planning?	The Birthrate Plus Midwifery workforce planning tool is in use at Imperial College Healthcare NHS Trust to assess the midwifery workforce requirements. It has recently been reviewed taking into account birth rates for 2018/19. The recommended midwife:birth ratio of 1:24 for SMH and 1:26 for QCCH is currently being fully met. This ensures that all women receive one-to-one care in labour, the minimum standard Birthrate + is based on. The Midwifery establishments and rosters are reviewed six monthly in line with the Trust Policy for Safe Staffing. The most recent review was undertaken in March 2019. Each roster was reviewed with the budget holder. These were then matched to the funded establishment and approved by the Divisional Director of Nursing and Midwifery and the Head of Midwifery. The labour ward coordinator is rostered as supernumerary. In addition, to support staff at times of high activity/ acuity there is a Maternity Staffing escalation policy that is in use and attached as an appendix.	**Yes**	

	Focused work has been undertaken to embed staffing escalation with the local team, the network and the hospital site team. Red Flags are reported via the 4hourly Birthrate+ Acuity Reporting Tool. Examples include: • Delayed or cancelled time critical activity • Missed or delayed care • Missed medication • Delay of more than 30 minutes in providing pain relief • Delay of 30 minutes or more between presentation and triage • Full clinical examination not carried out when presenting in labour • Delay of >2hrs between admission for induction and beginning of process • Delayed recognition of and action on abnormal vital signs • Midwife unable to provide 1:1 care to a woman in established labour		
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	ICHT is compliant against all 4 elements of the care bundle, and was submitted to NHS England in 2018. The elements are now embedded in routine practice in both units.	**Yes**	
7). Can you demonstrate that you have a patient feedback mechanism for maternity services, and that you regularly act on feedback?	A Maternity Voices Partnership Forum was launched at ICHT 20th of April 2018 and continues to take monthly and is Chaired by a lay person. We have a number of mechanisms for patient feedback and action in the development and improvement of maternity services e.g. • Antenatal Big Room – we now have volunteers in clinic for signposting and display waiting times in clinics, as a response to feedback we received through questionnaire and PDSA • PALS and Complaints – all managed through a dedicated team of investigators • FFT – daily qualitative and quantitative data, shared with management and staff	**Yes**	

<table>
<tr><td></td><td></td><td>• Patience Experience Survey for Maternity</td><td></td><td></td></tr>
<tr><td></td><td>8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?</td><td>A comprehensive MDT programme has been rolled out across the Trust over the last 6 months with over 90% compliance. Training has included fetal monitoring in labour and integrated team-working with relevant simulated emergencies and hands on workshops.

<u>Midwifery& Nursing (including Scrub Nurses): compliance 94.6%</u>

94.6% of 367 midwives and 6 scrub nurses

94% of 100 Maternity Support Workers

The current documented live compliance for completion of mandatory midwifery education is 93.9%, which includes an afternoon of emergency skills and drills, which obstetricians, anaesthetists and the Trust resuscitation team help to facilitate. The compliance reflects those that have completed all 3 days. Our current training needs assessment (TNA) target for completion of midwifery education annually for all midwives is 75% which reflects new starters, those on maternity leave and long term sick.

There is an action plan in place to include neonatal colleagues into wider MDT training – this is currently regularly done as part of the paediatric skills and drills and they take part in routine tests. In addition, the maternity support workers commenced skills and drills training with the midwives in May 2018.

<u>Queen Charlotte’s and Chelsea Hospital Medical Staff: compliance 93%</u>
<table>
<tr><th>Staff Group</th><th>Total Number employed</th><th>Number Trained</th><th>Percentage trained</th></tr>
</table>
</td><td>Yes</td><td></td></tr>
</table>

	Obstetric Drs (Consultants, Registrars, SHOs)	54	51	94%		
	Anaesthetic Drs (Consultants, Registrars, SHOs)	22	20	91%		
	ODPs	13	12	92%		
	TOTAL	**89**	**83**	**93%**		

St Mary's Hospital Medical Staff: compliance 95%

Staff Group	**Total Number employed**	**Number Trained**	**Percentage trained**
Obstetric Drs (Consultants, Registrars, SHOs)	45	44	98%
Anaesthetic Drs (Consultants, Registrars, SHOs)	23	22	96%
ODPs	30	27	90%
TOTAL	**98**	**93**	**95%**

9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate	The Clinical Director of Maternity (Obstetrician) and Head of Midwifery meet with the Divisional Director, Divisional Director of Operations and Divisional Director of Nursing and Midwifery every month for a performance review where locally identified issues are discussed and escalated. The Divisional Director is the Board level maternity safety champion.	**Yes**	

locally identified issues?	In addition, the Clinical Director of Maternity and Head of Midwifery attend the monthly Divisional Quality and Safety Committee, which is attended by the Divisional Director, to discuss quality and safety issues and, in particular, to demonstrate compliance with action plans in response to national guidance and local reviews. We are also actively engaging with the maternal and Neonatal Health Safety Collaborative (MNHSC) to support quality and safety improvement activity within the Trust and Local Learning System (LMS)		
10). Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Eligible babies include those born at term (≥37 completed weeks of gestation), following labour, that had a severe brain injury diagnosed in the first seven days of life. These are any babies that had one or more of the following: • Diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) • Actively therapeutically cooled • Had all three of the following signs: decreased central tone; comatose; seizures of any kind. Since 1 April 2018, using the above criteria, all 16 forms have been completed and submitted ensuring 100% compliance	**Yes**	

Appendix III

Safety Action 4: Can you demonstrate an effective system of medical workforce planning?

The tables below lists the actions we have taken to reduce the adverse impacts of rota gaps in the last year on both sites:

Table 1	
Local rota gaps SMH	**Actions taken**
1 x ST1 /2 trainee was not allocated by HEE in October 2018	We successfully appointed a junior clinical fellow for 12 months (with one month gap only before she started)
We had a 4 month gap when an F2 wasn't allocated	We were given only 2 weeks' notice so could not employ extra staff and we managed with internal cover and paid for out of hours shifts
1 senior trainee left the rotation early for a consultant job	This position in the rota was filled by a trainee coming back from ML with only 2 week gap
1 cross site GP trainee is on leave due to unforeseeable circumstances	there is internal cover for daytime shifts and the on call (which is infrequent) has been offered with paid cover for out of hours shifts
1 senior clinical fellow is starting M/L next week (one year)	we are appointing a locum but the out of hours shifts not worked in late pregnancy have been covered internally with paid locum cover

Table 2	
Local rota gaps QCCH	**Actions taken**
SHO October 2018-Feb 2019	
1.5 WTE ST1-2 vacancies – we were not sent the full complement by HEE in October 2018	Cross cover for daytime duties Successfully appointed locum staff from Dec 2018
1 vacancy of GP VTS trainee due to long term health problems	We were given only 2 weeks' notice so could not employ extra staff and we managed with internal cover and paid for out of hours shifts
Of the remaining 2 GP VTS trainees, one could not do any on calls	Locum shift for on-calls
Feb 2019 to present	GP VTS rota was changed, such that 5 GPs rotate through SMH and QCCH, with 2 GP SHOs at QCCH at any one time. Neither of these SHOs works out of hours at QCCH. One additional trust grade slot created to account for the loss of on call GPVTS activity at QCCH, and this post was appointed to in Feb 2019.
2 people short on SHO on call rota:	Covering these with locums.

• 1 cross site GP VTS trainee on long term absence • 1 cross site GP VTS trainee has taken a large amount of sick leave during time which was allocated to QCCH	Appointed 4 trust grade SHOs for August 2019 to cover vacancies. Awaiting confirmation of allocation of GP VTS trainees- multiple emails sent. Put forward an ERAF for a further trust grade SHO – not yet approved Bid for Fy3 to help with the shortfall of 2 on call slots since the loss of the GP VTS- need to make a post number – awaiting response from deputy GM and escalated to GM All SHOs encouraged to exception report
Registrar rota: • 2 LTFT trainees on maternity leave • 2 other trainees have handed in their notices to leave because they have SST posts- 1 left April 2019, other due to leave end Aug 2019	We have appointed one locum registrar but have been unable to appoint any further locums despite multiple rounds of advertising. Locum gaps on the on call rota have generally all been filled.

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TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Imperial College Healthcare NHS Trust strategy	☒ Approval ☐ Endorsement/Decision ☐ Discussion ☐ Information
Date of Meeting: 24 July 2019	**Item 10, report no. 07**
Responsible executive director: Prof Tim Orchard, Chief executive	**Authors:** Dr Bob Klaber, Deputy medical director Michelle Dixon, Director of communications

Summary

We present for approval a final draft document setting out how our overarching vision and strategic goals, agreed by the Board in March, translate into three-year clinical objectives, enabled by three-year objectives in the key enabling areas of quality improvement, people and digital. An introduction and overview are provided here and the full strategy document is attached separately.

The content of the strategy builds on reviews of our previous clinical, digital and people strategies, the outputs of various workshops and discussions and analysis of the needs and views of our staff, patients and partners as well as consideration of local and national policy. It also reflects discussion and feedback from the Board seminar on strategy in June.

Recommendations:

The Trust board is asked to approve the Trust strategy, now including three-year objectives (to April 2023).

This report has been discussed at: The strategy 'big room' and executive team meeting (and drawing on a range of meetings and engagement described in the paper)

Quality impact: N/A

Financial impact: N/A

Risk impact and Board Assurance Framework (BAF) reference:

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

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

Has an Equality Impact Assessment been carried out?

☐ Yes ☒ No ☐ Not applicable

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

Paper respects the rights, values and commitments within the NHS Constitution.

☒ Yes ☐ No

Trust strategic goals supported by this paper:

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

Imperial College Healthcare NHS Trust strategy

In March 2019, the Board agreed a new Trust strategy, building on work and thinking over the previous four years to set a clearer and more cohesive direction for our organisation. The strategy seeks to deliver our **vision of 'better health, for life'**. It is rooted in **a set of core values – to be kind, aspirational, collaborative and expert** – and is focused around **three strategic goals:**

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

This next iteration of our strategy is organised into three sections. In our core strategy statement (section 1), we set out clearly what our strategic goals mean and what we expect to change in order to achieve them, as agreed earlier this year.

We then consider what these changes will require us to plan for and do, in practical terms, over the three years to April 2023, focusing first on our clinical services, models of care and ways of working. We have arrived at six statements that articulate our strategic clinical approach and we have used them to prioritise eight specific clinical objectives to be achieved by April 2023 (section 2).

Finally, we look at the key enablers of these clinical developments – quality improvement, our people and digital (section 3). For each 'enabler', we set out another layer of detailed objectives that need to be achieved by April 2023 in order to support our clinical objectives and move us closer towards our three overarching strategic goals.

The content of the strategy builds on reviews of our previous clinical, digital and people strategies, the outputs of various workshops and discussions and analysis of the needs and views of our staff, patients and partners as well as consideration of local and national policy.

This strategy document does not try to cover every aspect of the important work we do or address all of our day-to-day challenges; delivering operational and financial commitments will always be part of our 'business as usual'. Our strategy is about the changes we need and expect to deliver on our three overarching strategic goals and, ultimately, our vision of 'better health, for life'.

Overview

We know we provide much great care for over one million people a year, drawing on new research insights and clinical breakthroughs and achieving one of the lowest mortality rates in the UK. However, we also recognise, increasingly, that our systems and processes aren't truly organised around the needs and preferences of our patients and local communities. Our services aren't sufficiently joined up with those of our partners and, often, even within our own organisation. We won't be able to attract and retain enough staff without an improved 'compact'; we can't continue to increase spending at the rate we are; and we know our facilities and wider infrastructure are struggling to keep up with demand.

These issues are common across the NHS and are reflected in the NHS Long Term Plan published earlier this year. Similarly, the response and plans set out in the implementation framework of the NHS Long Term Plan are reflected in our strategy and three-year objectives.

Our three-year objectives are rightly ambitious, though we believe we already have the core of the offer we need to make to deliver them – the expertise, knowledge and commitment of our people. The

change that is required is a fundamental reorientation of how we make our offer and how we behave. **We want to become the most 'user-focused' organisation in the NHS.**

We have made a start at setting out exactly what this will mean in **our new clinical approach**, committing that we will:

- deliver outcomes that matter to patients through co-design of more sustainable, person-centred pathways and models of care
- work with our population and partners to maximise health across all stages of life
- reduce health inequalities within our services and communities
- create the right behaviours to consistently support safe care
- develop genuine partnerships with our patients and local communities to build understanding and support
- embed research, learning, evidence-based practice and innovation in everything we do.

The three-year objectives that will move us to our new clinical approach then become to:

- Ensure all of the care and support each of our patients receives is shaped by actively asking and understanding what matters to them, and measuring outcomes against agreed goals.
- Establish formal partnerships with our primary care networks and other neighbouring providers to enable at least half of our care to be provided through 'place-based' health approaches and new models of care.
- Re-design at least 50 care pathways, derived from our specialty review programme and making appropriate use of our flow coaching programme, to make them as user-friendly and digitally enabled as possible; five of the highest impact pathways to receive additional support to transform at scale.
- Ensure every member of staff is able to participate in improvement, learning, teaching, transformation or research.
- Establish a systematic, evidence-based approach to building two-way relationships with as many patients and local people as possible, offering a range of engagement and involvement opportunities.
- Define and establish a method to measuring inequalities and have started to show the impact of specific interventions.
- Embed a systematic approach to identifying safety priorities, test improvements and scale and sustain what works; including making further improvements to reducing falls, safer surgery and hand hygiene and to how we respond to deteriorating patients and investigate incidents.
- In collaboration with partners, especially Imperial College, improve the speed and scale of the translation of biomedical and data science research into better patient care, and the adoption and spread of innovative ideas, technologies and ways of working.

We will draw particularly on our long track record in research and education and on our more recent achievements in developing our digital capability, establishing a Trust-wide quality improvement approach and creating an active and influential network of lay partners. Importantly, we will also harness the synergies of an increasingly important range of collaborations and partnerships, most notably with Imperial College, our closest acute partner Chelsea and Westminster NHS Foundation Trust, and a number of our sector's emerging primary care networks.

As such, we have also developed another layer of three-year objectives in the areas that are key to enabling our clinical approach – quality improvement, our people and digital.

There are three **three-year objectives we need to achieve in quality improvement** - to:

- Embed how we plan, improve, control and assure the quality of care we provide within a consistent 'quality management system'.
- Spread our improvement methodology across every area of the organisation.
- Use our quality improvement education, training and coaching 'dosing' model to equip all staff across the organisation with the appropriate knowledge, confidence and skills to deliver improvements that help deliver the overarching goals of the organisation.

There are 18 detailed objectives we need to achieve for **our people** that have been summarised into **six strategic themes** for action:

- workforce supply and stability
- new and different ways of working
- compassionate, inclusive and effective leaders at all levels
- skills and capability for all
- equality, diversity and inclusion
- culture and engagement.

There are 28 detailed objectives we need to achieve in **digital** that map to a **seven-step 'roadmap'**:

1. Resilient infrastructure
2. Digital record
3. Data sharing
4. Patient engagement
5. Integrated care
6. Population health
7. Intelligent systems

Finally, it's important to note that we are consciously moving away from previous strategies that have tended to focus on which of our services need to go where and what sort of buildings they should be in. We have also moved on from having a series of standalone strategies. Instead, we are looking to set out what we believe to be the key changes we need to make and how we think change can best be enabled and co-ordinated. We know that will rely on us empowering our people, patients and partners to work together to own and lead the change through incremental improvement locally underpinned by genuine 'transformation' across a few essential aspects of organisational process, technology and culture.

Making it happen

We now have a strategy that provides a clear and cohesive direction for our organisation as well as a set of three-year objectives. Our focus moves on to implementation.

Our approach to determining how we best work to achieve each of our objectives – and how we track and evaluate progress towards them - will build on the components we already have in place for business planning, quality improvement, governance and performance monitoring. By the end of autumn 2019 – in order to shape our business plan for 2020/21 – we will have defined and tested an implementation approach that:

- Ensures our three strategic goals drive progress and action at every level; our business planning and allocation of resources is key to this and will be integrated into the way we implement our strategy.
- Sets out the tactical plan that enables individuals and teams to link the work they are doing to our strategic goals.

- Minimises the waste and low morale that comes from inconsistent direction and poor communication.
- Creates a ‘golden thread’ between senior leadership and staff at every level of the organisation that provides a shared direction of travel and supports effective two-way communications and engagement.
- Gives teams across the organisation the skills, permission and confidence to address local issues that impact quality, knowing that they have the backing of their managers to do so
- Is underpinned by metrics that help us understand how we are doing at all levels in the organisation.

We will also combine our strategy implementation approach with how we work with Imperial College and other partners to leverage the value of our extensive research infrastructure, including the NIHR Imperial Biomedical Research Centre, the North West London NIHR Applied Research Collaboration and Imperial College Patient Safety Translational Research Centre.

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TRUST BOARD -PUBLIC REPORT SUMMARY	
Title of report: Month 2 integrated quality and performance report	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: Wednesday 24 July 2019	**Item 11, report no. 08**
Responsible Executive Director: Julian Redhead (Medical Director) Janice Sigsworth (Director of Nursing) Catherine Urch (Divisional Director) Tg Teoh (Divisional Director) Frances Bowen (Divisional Director) Kevin Croft (Director of People and Organisational Development) Claire Hook (Director of Operational Performance)	**Author:** Submitted by Performance Support Team

Summary:

This is the integrated quality and performance report for data published at month 2 (May 2019).

The report is presented as follows:

- Summary report of key headlines
- A first version of the new updated scorecard for 2019/20
- Appendix 1: Scorecard glossary provided as a one off
- Appendix 2: Exception reporting slides provided for information

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

The information presented in this scorecard has been discussed at the following meetings:

- Executive (Operational Performance) Committee
- Executive (Quality) Committee
- Executive (People and OD) Committee
- Board Quality Committee
- Executive (Finance) Committee

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

Quality impact:
The delivery of the full integrated quality and performance report will support the Trust to more effectively monitor delivery against internal and external targets and service deliverables. All CQC domains are impacted by the paper.

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

Risk impact and Board Assurance Framework (BAF) reference:

- 2472: Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards
- 2477: Risk to patient experience and quality of care in the ED caused by the significant delays experienced by patients presenting with mental health issues
- 2480: Patient safety risk due to inconsistent provision of cleaning services across the Trust
- 2485: Failure of estates critical equipment and facilities
- 2487: Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae)
- 2490: Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines
- 2937: Failure to consistently achieve timely elective (RTT) care
- 2938: Risk of delayed diagnosis and treatment and failure to maintain key diagnostic operational performance standards
- 2943: Failure to maintain ED trajectories
- 2944: Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas
- 2946: Failure to provide timely access to critical care services
- 2974: Risk of RTT reporting inconsistencies due to intermittent issues with reporting effecting delay times of RTT reporting
- 2975: Risk of reputational damage due to poor data quality

Workforce impact (including training and education implications):
None

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

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

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

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

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

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

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

Imperial College Healthcare NHS Trust

Integrated quality and performance report

1. Introduction

1.1. The Board are asked to consider the integrated quality and performance report and the key headlines relating to performance as at May 2019 (month 2).

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

2. Reporting performance in 2019/20

Timeliness of scorecard reporting

2.1. The majority of the metrics in the scorecard are subject to a set submission dates; performance data only become available on the second or third week for the preceding month. The current process ensures discussion of all performance data at the relevant executive committee, with opportunity to investigate concerns if needed, prior to final publication.

2.2. The recommendation is to retain the current approach to sequencing the scorecard so that it is published for the Board and our public after the executive committees have reviewed it. More recent data and issues for attention to the Board will be highlighted in the summary section below where appropriate.

New indicator scorecard

2.3. A first version of the new updated scorecard is presented for month 2 performance (covering May 2019).

2.4. A new scorecard glossary is also provided for information in appendix 1. This will be available for future reference on request. The glossary captures measurement definitions and tolerances for exception reporting. For some metrics, any variation from the overall target or from an agreed formal trajectory would produce an exception report. For other metrics, a pragmatic 5% tolerance will be used to indicate where closer monitoring and assurance may be needed. In practice, exception reports and escalations are requested through a combination of factors and information.

2.5. Exception slides for the month 2 are provided for information in appendix 2 and cover the following scorecard metrics:

- Incident reporting rate
- Patient safety incidents
- Never events
- Compliance with duty of candour
- VTE
- Infection prevention and control: MRSA BSI; E.Coli
- Vacancy rates

- National clinical audits
- Mortality reviews
- Mixed sex accommodation
- Doctor appraisal rate
- Consultant job planning compliance
- Theatre utilisation
- A&E patients waiting more than 12 hours
- Extended length of stay

3. Key headlines

The key highlights from the May-19 (month 2) integrated performance scorecard are provided. Updates on the June-19 performance data are given where appropriate.

Quality

3.1. The Trust incident reporting rate improved slightly in May 2019 however it was below our target. To increase incident reporting, a range of improvement plans and actions have been agreed with our divisions with particular focus on areas with low incident reporting. Alongside this a Trust wide communications campaign commenced June 2019.

3.2. No never events were reported in May 2019. The trust wide never event action plan continues to progress, with 23 actions closed and the remaining 16 in progress. Monthly updates are being provided to executive quality committee.

3.3. Duty of candour fell for all types of appropriate incidents. The percentage incidents reported between May 2018 – April 2019 (the latest full 12 months of data) that have had stage 1 and stage 2 of the process completed was 91% against a target of 100%. There were issues relating to completion of both parts of the process (the initial conversation and the follow up letter) by the consultant responsible for the patient's care. The expectation is that all outstanding cases will have Duty of Candour requirements completed by the week commencing 8 July 2019.

3.4. In May 2019,

- Nine cases of *C. difficile* were attributed to the Trust; 7 were hospital onset, two were community onset. This was within our trajectory and none of the cases have been related to lapses in care.

- There were 2 Trust-attributable MRSA BSI cases compared to 3 in total in 2018/19.

- There were 6 cases of Trust E.coli BSI bringing the total to 14 cases this financial year which is slightly above trajectory by 2 cases. Work is currently focusing on preventable sources of infection e.g. urinary catheter-associated Gram-negative bacteraemias.

- No cases of CPE BSI have been reported this financial year.

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

3.6. Improvements in the number of clinical trials recruiting their first patient within 70 days of a valid research application are being sustained and the latest performance was 94% against our target of 90%.

3.7. The Trust's vacancy rate at end May 2019 was 11.7%, which is higher than the median for the London University Hospital Association. The majority of the Trust vacancies are within our nursing and midwifery staffing group where the vacancy rate was 14.6% (840 whole time equivalent vacancies) and good progress is being made to fill the roles.

Operational performance

3.8. In May 2019, the Trust commenced testing of a proposed new A&E standard as one of fourteen hospital trusts in England. In line with the memorandum of understanding, figures on the A&E four hour standard will not be published for the pilot period. Throughout the pilot, our focus remains on achieving a good flow of care across our care pathways.

3.9. The Trust is reporting an increase in the number of patients who were delayed over twelve hours (from decision to admit to admission), also known as a 'trolley wait'. In June 2019, 22 patients were delayed which was up from 7 in the previous month. All were delays to admission for mental health provider beds and the Trust is working closely with commissioners and the mental health providers to minimise breaches. The performance is reported via the Trust-CCG A&E delivery board. The expectation is that 12-hour breaches for patients requiring an ICHT bed will remain at zero.

3.10. In May 2019, the Trust continued to report that no patients had been waiting for more than 52 weeks for treatment. There was also a continued improvement in our performance against the standard to treat patients within 18 weeks of their referral and the overall RTT waiting list size was maintained below our target of 63,100.

3.11. In May 2019, the Trust delivered six of the eight national cancer standards. The two areas performing below the standard (cancer 2 week waits and the 62 day screening standard) are being reviewed by the service and the trajectory is being developed.

3.1. Currently all our key operational waiting times datasets are showing a 'green' rating for data quality, which is an important marker of getting processes right first time. The RTT dataset error rate has reduced to 5% and is now within the target threshold, something we have been working hard to improve. In June 2019, the Trust moved to a weekly audit of all long waiters removed from an active waiting list at 38 weeks (sometimes referred to as RTT clock stops). This weekly process has commenced on an initial pilot basis and from September 2018 the RTT audit has included a review of all patients removed who had waiting over 50 weeks.

4. Recommendation

The Board is asked to note the contents of the integrated performance report for month 2.

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Monthly target	Same period last year May-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Latest reported performance May-19
FYTD = Financial Year to Date											
Safe											
Patient safety - incident reporting											
Serious incidents	-	May-19		10	13	3	5	23	18	13	34
Incidents - moderate harm (FYTD)	<1.78%	May-19		1.49%	1.32%	1.27%	1.27%	1.26%	1.29%	2.23%	1.84%
Incidents - severe/major harm (FYTD)	<0.24%	May-19		0.07%	0.04%	0.04%	0.04%	0.04%	0.04%	0.00%	0.00%
Incidents - extreme harm/death (FYTD)	<0.10%	May-19		0.10%	0.04%	0.04%	0.04%	0.03%	0.04%	0.08%	0.19%
Incident reporting rate (per 1,000 beds)	>=48.98	May-19		53.01	44.67	42.39	48.28	43.71	46.89	40.42	45.19
Never events	0	May-19		1	1	0	2	0	0	1	0
PSAs open and overdue (FYTD)	0	May-19		-	-	-	-	-	-	0	0
Incidents with DoC completed	100%	May-19		-	-	-	-	-	-	93.9%	90.8%
Infection prevention and control											
Trust-attributed MRSA BSI (FYTD)	0	May-19		0	3	3	3	3	3	0	2
Trust-attributed C. difficile (FYTD)	77	May-19	15	-	-	-	-	-	-	5	14
Trust-attributed C. difficile (lapses in care) (FYTD)	0	May-19		-	-	-	-	-	-	0	0
E. coli BSI (FYTD)	75	May-19	12	13	63	68	74	80	83	8	14
CPE BSI (FYTD)	0	May-19		3	6	6	6	6	7	0	0
VTE											
VTE risk assessment	>=95%	May-19		95.8%	95.3%	94.5%	93.8%	94.3%	93.8%	93.8%	93.8%
Sepsis											
Sepsis - Antibiotics	>=90%	May-19		-	93.2%	93.1%	92.8%	91.3%	93.8%	94.0%	91.6%
Maternity standards											
Puerperal sepsis	<=1.5%	May-19		0.4%	1.1%	1.0%	0.4%	1.0%	0.3%	1.4%	1.2%
Safe staffing											
Safe staffing - registered nurses	>=90%	May-19		97.4%	97.5%	96.6%	96.7%	97.1%	96.9%	97.8%	98.0%
Safe staffing - care staff	>=85%	May-19		95.9%	96.2%	94.1%	94.8%	95.8%	95.3%	97.0%	96.4%

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Monthly target	Same period last year May-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Latest reported performance May-19
FYTD = Financial Year to Date											
Safe											
Workforce and people											
Core skills training	>=90%	May-19		**87.6%**	90.2%	90.2%	90.5%	91.9%	92.1%	91.86%	**91.81%**
Safeguarding children training (level 3)	>=90%	May-19		-	77.2%	81.3%	83.3%	90.6%	90.1%	91.1%	-
Vacancy rate - Trust	<10%	May-19		**13.1%**	12.7%	13.4%	13.3%	13.0%	13.5%	11.4%	**11.7%**
Estates and Facilities											
Cleanliness audit scores (very high risk)	>=98%	May-19		-	90.0%	90.0%	80.0%	89.0%	88.0%	84.0%	**87.0%**
Cleanliness audit scores (high risk)	>=95%	May-19		-	93.0%	94.0%	89.0%	92.0%	91.0%	91.0%	**90.0%**
Reactive maintenance	>=70%	May-19		-	34.9%	44.0%	26.0%	35.3%	33.2%	31.8%	-

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Monthly target	Same period last year May-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Latest reported performance May-19
FYTD = Financial Year to Date											
Effective											
Mortality indicators											
HSMR: Trust ranking	top 5 lowest risk	Feb-19		**4th lowest**	5th lowest	5th lowest	17th lowest	4th lowest	3rd lowest	3rd lowest	**4th lowest**
HSMR ratio	top 5 lowest risk	Feb-19		**62.0**	54.0	61.0	74.0	60.0	53.0	59.0	**57.0**
SHMI: Trust ranking	top 5 lowest risk	Q2 17/18–Q1 18/19		**-**	-	3rd lowest	3rd lowest	3rd lowest	4th lowest	4th lowest	**2nd lowest**
SHMI ratio	top 5 lowest risk	Qtr 3 18/19		**-**	66.1	70.1	73.2	78.6	69.1	66.8	**68.1**
Mortality reviews (at 07/06/2019)											
Total number of deaths	-	Apr-19		**155**	162	133	145	153	124	164	**175**
SJR requested as % of number of deaths (FYTD)	>=15%	Apr-19		**-**	-	-	-	-	-	14.9%	**14.6%**
Number of avoidable deaths (Score 1-3) (FYTD)	0	Apr-19		**2**	6	6	6	7	9	11	**1**
SJRs not completed within 30 days (FYTD)	0%	Apr-19		**-**	-	-	-	-	-	58.6%	**58.4%**
Readmissions (unplanned)											
under 15 yr olds	<9.33%	Nov-18		**5.7%**	3.9%	4.5%	3.8%	4.0%	5.3%	4.7%	**5.0%**
over 15 yr olds	<8.09%	Nov-18		**6.4%**	6.7%	6.7%	7.0%	7.6%	7.1%	7.1%	**6.9%**
National Clinical Audits											
Participation in relevant NCAs (FYTD)	100%	Feb-19		**94.0%**	86.7%	88.2%	88.9%	83.3%	84.4%	86.5%	**87.2%**
High risk/significant risk audits with action plan (FYTD)	100%	Feb-19		**100.0%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**100.0%**
Review process not completed within 90 days	0	Feb-19		**35**	5	6	6	8	8	11	**12**
Clinical trials				**Qtr 4 16/17**	Qtr 1 17/18	Qtr 2 17/18	Qtr 3 17/18	Qtr 4 17/18	Qtr 1 18/19	Qtr 2 18/19	**Qtr 3 18/19**
Recruitment of 1st patient within 70 days	>=90%	Qtr 1 18/19		**85.1%**	48.6%	53.3%	53.3%	67.6%	85.1%	95.7%	**93.9%**

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Monthly target	Same period last year May-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Latest reported performance May-19
FYTD = Financial Year to Date											
Caring											
Friends and Family											
A&E - % recommended	>=94%	May-19		91.5%	96.8%	96.5%	95.4%	94.9%	93.6%	93.3%	92.8%
A&E - % response rate	>=15%	May-19		11.7%	15.9%	13.9%	12.2%	13.9%	18.1%	19.5%	14.9%
Inpatients - % recommended	>=94%	May-19		96.9%	97.7%	98.0%	97.7%	96.7%	97.7%	97.2%	97.1%
Outpatients - % recommended	>=94%	May-19		92.9%	92.5%	93.3%	93.8%	94.6%	94.2%	94.2%	94.1%
Maternity - % recommended	>=94%	May-19		94.5%	94.7%	92.7%	93.6%	93.5%	92.9%	91.2%	93.98%
Patient Transport - % recommended	>=90%	May-19		85.0%	88.4%	93.1%	92.4%	93.4%	95.7%	91.9%	94.3%
Mixed sex accommodation											
Mixed-sex accommodation breaches	0	May-19		42	64	34	50	33	50	34	35
Well led											
Workforce and people											
Voluntary staff turnover rate (12m rolling)	<12%	May-19		11.9%	11.9%	11.7%	11.7%	11.6%	11.3%	11.3%	11.6%
Sickness absence rate (12m rolling)	<=3%	May-19		2.97%	3.13%	3.12%	3.13%	3.13%	3.13%	3.15%	3.17%
Personal development reviews	>=95%	May-19		18.1%	-	-	-	-	-	2.0%	8.6%
Doctor appraisal rate	>=95%	May-19		86.0%	90.1%	91.0%	91.7%	88.0%	93.0%	93.6%	92.3%
Consultant job planning completion rate	>=95%	May-19		94.1%	99.5%	-	-	-	-	-	78.2%

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Monthly target	Same period last year May-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Latest reported performance May-19
FYTD = Financial Year to Date											
Responsive Data reliability rating											
Referral to treatment (elective care)											
RTT patients waiting > 18 weeks	>=92%	May-19	83.1%	85.2%	83.8%	83.9%	84.6%	84.3%	84.4%	85.0%	86.1%
RTT waiting list size (5%)	63,099	May-19	63,100	67,023	66,953	67,860	64,660	62,848	61,371	62,546	63,097
RTT patients waiting > 52 weeks	0	May-19		147	10	11	44	91	0	0	0
Cancer waiting times											
Cancer - 62 day waits (1%)	>=85%	May-19	85.33%	80.6%	86.8%	86.8%	82.4%	86.2%	86.8%	88.2%	91.5%
Theatre utilisation											
Theatre touchtime utilisation	>=85%	May-19		81.2%	79.3%	79.8%	75.1%	79.4%	78.6%	80.0%	80.6%
Critical care											
Critical care patients admitted within 4 hours	100%	May-19		91.0%	92.6%	92.3%	92.5%	91.8%	95.8%	92.2%	98.1%
Urgent and emergency care											
A&E patients seen within 4 hours (all types)	>=95%	May-19	90%	86.9%	90.1%	88.4%	86.7%	88.1%	88.4%	88.4%	-
A&E patients seen within 4 hours (type 1)	>=95%	May-19		68.6%	76.9%	73.9%	69.3%	72.6%	74.6%	73.3%	-
A&E patients waiting > 12 hours from DTA (1%)	0	May-19		7	4	5	10	4	10	12	7
A&E ambulance handover delays 30 minutes	100%	May-19	91%	96.0%	92.0%	90.0%	85.0%	89.0%	87.0%	89.0%	89.0%
Length of stay											
Patients with LoS >= 21 days (3%)	tbc	May-19		-	-	-	244	236	233	236	235
Discharges before noon	>=33%	May-19		13.2%	16.0%	16.5%	15.4%	14.3%	14.5%	15.4%	15.1%
Diagnostics											
Diagnostic test waits > 6 weeks (3%)	<1%	May-19		0.73%	0.47%	2.10%	0.78%	0.50%	0.61%	0.998%	0.90%

Key to data reliability scores:

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

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

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

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Monthly target	Same period last year May-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Latest reported performance May-19
FYTD = Financial Year to Date											
Responsive											
Outpatients											
DNA	<10%	May-19		**10.4%**	10.5%	11.2%	11.1%	10.5%	10.2%	10.5%	**10.4%**
HICs (Appt moved to a later date)	<7%	May-19	7.5%	**6.7%**	6.2%	7.0%	6.9%	7.8%	7.2%	7.5%	**7.4%**
Complaints management											
Complaints - formal	<90	May-19		**68**	91	89	89	100	88	88	**104**
Complaints – average days to respond	40 days	May-19		**-**	26.5	28.0	28.6	28.4	27.9	29.0	**29.8**
Complaints - patient satisfaction with handling	>=70%	May-19		**-**	-	-	-	89.0%	84.0%	86.0%	**84.0%**
Patient transport											
All Journeys: Collection Time (60 Mins)	>97%	May-19		**92.7%**	93.0%	95.0%	94.2%	93.4%	94.1%	93.6%	**93.3%**
Data quality											
Data Quality Maturity Index	>98%	Mar-19	95%	**-**	95.0%	95.2%	95.1%	96.7%	96.7%	96.1%	**96.1%**
Use Of Resources											
Finance KPIs											
Monthly finance score (1-4)	-	May-19		**3**	3	3	3	3	3	3	**3**
In month Position	-	May-19		**1.35**	-0.44	-0.52	-3.61	2.33	0.32	-0.59	**0.85**
YTD Position £m	-	May-19		**-3.00**	6.04	5.62	7.59	8.72	10.68	0.00	**4.58**
Annual forecast variance to plan	-	May-19		**0.00**	-3.86	-1.92	-4.00	-1.64	0.32	-	**-**
Agency staffing	-	May-19		**4.1%**	4.3%	4.1%	4.2%	4.1%	4.1%	3.5%	**3.4%**
CIP (FYTD)	-	May-19		**75.6%**	73.6%	73.8%	77.5%	76.9%	-	-	**-**

Appendix 1 Indicator scorecard glossary at 16 July 2019

This document captures information on definitions, responsible executive director and the tolerances for exception reporting for the metrics within the Trust integrated scorecard.

Key

The main categories for the tolerances are as follows:

Tolerance for exception reporting	Description
Same as target	Variation from the overall target would initiate an exception report.
Trajectory	Any variation from an agreed trajectory would initiate an exception report. This includes formal trajectories agreed with commissioners / regulator as part of our undertakings, or trajectories that have been developed for internal use within the Trust (marked as ICHT).
5%	For some metrics, a pragmatic 5% tolerance would indicate the need for closer monitoring and assurance.

In practice, escalations and exception reports are requested through a combination of factors and information.

This includes use of statistical process control (SPC) to highlight special cause variation for further investigation.

FYTD = financial year to date

Glossary

Indicator short name	Unit	Exec Lead	Full definition	Scope	Target	Tolerance for exception reporting
Safe						
Patient safety - incident reporting						
• Serious incidents	n	Julian Redhead	Serious incidents on Datix reported to StEIS (Strategic Executive Information System). **Datix is the system that allows all employees to record a safety incident.*	Incidents included are those with a StEIS number and a date reported to StEIS. Exclusions are de-escalated SIs and incidents with an approval status of rejected or learning from excellence.	N/A	-
• Incidents - moderate harm (FYTD)	%	Julian Redhead	The number of patient safety incidents reported on Datix with a level of harm recorded as major since the start of the financial year as a proportion of the total patient safety incidents reported on Datix since the start of the financial year.	Incidents that are reported to the NRLS, excluding incidents with an approval status of rejected or learning from excellence.	< national avg	Same as target
• Incidents - severe/major harm (FYTD)	%	Julian Redhead	The number of patient safety incidents reported on Datix with a level of harm recorded as extreme death since the start of the financial year as a proportion of the total patient safety incidents reported on Datix since the start of the financial year.	Incidents that are reported to the NRLS, excluding incidents with an approval status of rejected or learning from excellence.	< national avg	Same as target
• Incidents - extreme harm/death (FYTD)	%	Julian Redhead	The number of patient safety incidents reported on Datix with a level of harm recorded as moderate since the start of the financial year as a proportion of the total patient safety incidents reported on Datix since the start of the financial year.	Incidents that are reported to the NRLS, excluding incidents with an approval status of rejected or learning from excellence.	< national avg	Same as target
• Incident reporting rate (per 1,000 beds)	rate	Julian Redhead	The number of patient safety incidents reported on Datix as a proportion of the number of occupied overnight bed days from the most recent bed occupancy return (KH03 report), multiplied by 1,000.	Incidents that are reported to the NRLS, excluding incidents with an approval status of rejected or learning from excellence. KH03 data is estimated monthly based on a quarterly figure.	Top quartile	Same as target
• Never events	n	Julian Redhead	Never events on Datix reported to StEIS (Strategic Executive Information System).	Excluding incidents with an approval status of rejected or learning from excellence.	0	Same as target

Indicator short name	Unit	Exec Lead	Full definition	Scope	Target	Tolerance for exception reporting
• PSAs open and overdue (FYTD)	n	Julian Redhead	Patient safety alerts on the Central Alerting system that are not complete and are past the completion deadline.	Includes all patient safety alerts on the central alerting system.	0	Same as target
• Incidents with DoC completed	%	Julian Redhead	The number of SIs, level one incidents and any other moderate or above harm incident where stage 1 or 2 of duty of candour (DoC) is incomplete on Datix, as a proportion of the total number of SIs, level one incidents and any other moderate or above harm incident reported to Datix.	Applies to stage 1 and 2 of duty of candour only, excludes incidents where the MDO panel agreed that DoC is not applicable, excludes SIs with a mental health treatment delay. This is reported 1 month in arrears to allow 30 days for the duty of candour process to be complete.	100%	Same as target
Infection prevention and control						
• Trust-attributed MRSA BSI (FYTD)	n	Julian Redhead	The number of laboratory confirmed Methicillin-Resistant Staphylococcus aureus (MRSA) blood stream infection (BSI) cases attributed to the Trust (sample taken >= 48 hours post patient admission)	Includes all laboratory confirmed Trust-attributable cases of MRSA BSI where the patient sample is tagged as an ICHNT sample.	0	Same as target
• Trust-attributed C. difficile (FYTD)	n	Julian Redhead	The number of laboratory confirmed C.difficile PCR and toxin positive cases defined as Trust cases (sample taken >= 48 hours post patient admission) which under FY19/20 definitions are called 'hospital onset-healthcare associated' cases, in addition to C.difficile PCR and toxin positive cases defined as Non-Trust (sample taken <48 hours post patient admission) but where the patient has had a previous ICHNT admission within the past 4 weeks, defined as 'community onset - healthcare associated' cases.	Excludes C.difficile Non-Trust cases where the patient has had a previous admission > 4 weeks prior to their current admission.	77 for 2019/20	Trajectory (ICHT)
• Trust-attributed C. difficile (lapses in care) (FYTD)	n	Julian Redhead	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.	Applies to both 'hospital onset - healthcare associated' and 'community onset - healthcare associated' C.difficile PCR and toxin positive cases.	0	Same as target
• E. coli BSI (FYTD)	n	Julian Redhead	The number of laboratory confirmed Escherichia coli (E. coli) blood stream infection cases attributed to the Trust (sample taken >= 48 hours post patient admission).	Includes all laboratory confirmed Trust-attributable cases of E.coli BSIs where the patient sample is tagged as an ICHNT sample.	75 for 2019/20	Trajectory (ICHT)

Indicator short name	Unit	Exec Lead	Full definition	Scope	Target	Tolerance for exception reporting
• CPE BSI (FYTD)	n	Julian Redhead	The number of laboratory confirmed Carbapenemase-Producing Enterobacteriaceae (CPE) blood stream infection cases attributed to the Trust (sample taken >= 48 hours post patient admission).	Includes all laboratory confirmed Trust-attributable cases of CPE BSIs where the patient sample is tagged as an ICHNT sample.	0	Same as target
VTE						
• VTE risk assessment	%	Julian Redhead	The proportion of patients (aged 16 and over) admitted to the hospital in the month who were assessed for risk of Venous thromboembolism (VTE) within 24 hours of their admission.	Includes all patients 16 years of age or older (including private patients) admitted, including daycases and maternity admissions. Excludes inpatients deemed low risk by a consultant or patients who already have a diagnosis of Deep Vein Thrombosis or Pulmonary Embolism.	>=95%	Same as target
Flu						
• Flu vaccination for frontline healthcare workers	%	Kevin Croft	Seasonal influenza vaccine uptake in frontline healthcare workers.	All patient-facing staff.	TBC for 2019/20 season	Same as target
Sepsis						

Indicator short name	Unit	Exec Lead	Full definition	Scope	Target	Tolerance for exception reporting
• Sepsis - Antibiotics	%	Julian Redhead	The percentage of patients who receive antibiotics within one hour of a new sepsis diagnosis.	Inclusions: • Patients Diagnosed with Sepsis • Administered Antibiotics (12hrs Before or 24hrs after diagnosis) • Ward where the Sepsis Alert Fired is A&E - (SMH and CXH) OR Inpatient areas where the alert is live Exclusions: • Patients not confirmed sepsis are excluded • Patients who did not receive antibiotics within 12hrs Before or 24hrs after diagnosis are excluded from the denominator • Patients who did not receive antibiotics within 60mins Before or 24hrs after diagnosis are excluded from the numerator	>= 90%	Same as target
Maternity standards						
• Puerperal sepsis	%	Tg Teoh	-	-	<=1.5%	Same as target
Safe staffing						
• Safe staffing - registered nurses	%	Janice Sigsworth	The total number of Day & Night shift hours worked by nurses as a percentage of Total planned hours to be worked by nurses.	-	>=90%	Same as target
• Safe staffing - care staff	%	Janice Sigsworth	The total number of Day & Night shift hours worked by care staff as a percentage of Total planned hours to be worked by care staff.	-	>=85%	Same as target
Workforce and people						
• Core skills training	%	Kevin Croft	The number of core skills topics completed as a percentage of the total required core skills modules.	All staff including Doctors on honorary contracts. This does not include bank staff, where mandatory training is include in the contract with the provider.	>= 90% (from 85% in 18/19)	5% tolerance

Indicator short name	Unit	Exec Lead	Full definition	Scope	Target	Tolerance for exception reporting
• Safeguarding children training (level 3)	%	Janice Sigsworth	The percentage of eligible staff compliant with level 3 safeguarding children training.	Staff identified as requiring level 3 training in line with the 2019 intercollegiate document.	>=90%	85% or less in a single month, or, 86% - 89% for more than one month consecutively
• Vacancy rate - Trust	%	Kevin Croft	The number of whole time equivalent vacancies as a percentage of the total staffing establishment (monthly).	All vacancies across the Clinical & Corporate Divisions within the Trust	<10%	Greater than 10.5% (5% tolerance on target)
Estates and Facilities						
• Cleanliness audit scores (very high risk)	%	Janice Sigsworth	TBC		>=98%	TBC
• Cleanliness audit scores (high risk)	%	Janice Sigsworth	TBC		>=95%	TBC
• Reactive maintenance	%	Janice Sigsworth	TBC		>=70%	Estates team have confirmed that they will agree a trajectory with the service provider, this will include improving data quality to reflect true compliance. No timeframes provided.
Effective						
Mortality indicators						
• HSMR: Trust ranking	rank	Julian Redhead	The rank of the Hospital Standardised Mortality Ratio (HSMR) from lowest to highest value of all national acute non-specialist providers.	This covers the latest month of data, provided to Dr Foster via HES (Hospital Episode Statistics) from the NHS. Due to submission deadlines and data validation, data is three months behind reporting month.	top 5 lowest risk	Same as target

Indicator short name	Unit	Exec Lead	Full definition	Scope	Target	Tolerance for exception reporting
• HSMR ratio	ratio	Julian Redhead	HSMR (Hospital Standardised Mortality Ratio) is a summary mortality indicator. It is based on a subset of 56 diagnosis groups that give rise to approximately 85% of in hospital deaths. Measuring hospital performance is complex – HSMRs are one key indicator of overall mortality. Statistical models are created for each diagnosis group taking into account factors such as age, gender, comorbidities, palliative care coding, deprivation, month of admission, method of admission, admission source, number of previous emergency admissions, and the year in which the patient is discharged. Each patient has a 'risk' of death based on these factors. Risks are aggregated to give an expected number of deaths. The model is updated once each year and national benchmark re-baselined. Figures in this report are given against the latest benchmark year. It is expressed in terms of a ratio: HSMR = observed deaths/expected deaths X 100	This covers the latest month of data, provided to Dr Foster via HES (Hospital Episode Statistics) from the NHS. Due to submission deadlines and data validation, data is three months behind reporting month. The national benchmark is 100. Anything less than 100 is a HSMR lower than the national benchmark, anything higher than 100 is higher HSMR. Confidence intervals are then applied to assess whether a HSMR is significantly higher or lower than the national benchmark.	top 5 lowest risk	Same as target
• SHMI: Trust ranking	rank	Julian Redhead	The rank of the Summary Hospital Mortality Indicator (SHMI) from lowest to highest value of all national acute non-specialist providers.	This covers the latest month of data, provided to Dr Foster via HES (Hospital Episode Statistics) from the NHS. Due to submission deadlines and data validation (including in this case for out of hospital deaths), data is usually six months behind reporting month.	top 5 lowest risk	Same as target

Indicator short name	Unit	Exec Lead	Full definition	Scope	Target	Tolerance for exception reporting
• SHMI ratio	ratio	Julian Redhead	SHMI (Summary Hospital Mortality Indicator) is a ratio of observed number to expected number of deaths for acute providers. It covers all deaths in-hospital or within 30 days post discharge from hospital. The expected number of deaths is calculated from a risk adjusted model using a patient case-mix of age, gender, admission method, comorbidity and diagnosis group. HSMR adjusts for more factors in risk modeling than SHMI, notably: palliative care, diagnosis sub-group, past history of admissions and month and source of admission. Because SHMI adjusts for deaths post discharge, there is a time lag between data submission for this and the HSMR. SHMI is rebased quarterly using a rolling 12 month period. SHMI allocates the death to the last non-specialist provider within the patient superspell. As with HSMR, it is expressed as a ratio. As both cover different factors and patients, combined analysis allows for robust mortality reporting. Expressed in terms of a ratio: SHMI = observed deaths/expected deaths X 100. The national benchmark is 100- anything less than 100 is a SHMI lower than the national benchmark, anything higher than 100 is a higher SHMI. Confidence intervals are then applied to assess whether a SHMI is significantly higher or lower than the national benchmark.	This covers the latest month of data, provided to Dr Foster via HES (Hospital Episode Statistics) from the NHS. Due to submission deadlines and data validation (including in this case for out of hospital deaths), data is usually six months behind reporting month.	top 5 lowest risk	Same as target
Mortality reviews						
• Total number of deaths	n	Julian Redhead	All inpatient deaths including paediatric and perinatal mortality (including stillbirths). Excluding out of hospital deaths/ post discharge deaths.	Data uses the number of mortality records recorded in the Datix system.	n/a	Same as target
• SJR requested as % of number of deaths	%	Julian Redhead	The number of structured judgement reviews (SJRs) requested as a proportion of the total number of deaths. It is expected that around 15% of deaths will have an SJR.	A structured judgement review is recorded as requested if there is a trigger for review recorded for the death in the Datix mortality module.	15%	Same as target

Indicator short name	Unit	Exec Lead	Full definition	Scope	Target	Tolerance for exception reporting
• SJRs not completed within 30 days	n	Julian Redhead	The number of structured judgement reviews that were not complete within 30 days of their start date over the last 12 months as a proportion of the total number of SJRs requested over the last 12 months. Data is reported 1 month in arrears to allow 30 days for the SJR to be completed.	This includes SJRs that are not yet complete but the 30 day deadline has passed.	0%	Same as target
• Number of avoidable deaths (FYTD)	n	Julian Redhead	These are deaths where a structured judgement review took place which determined that the death was avoidable. Each SJR is given an avoidability score on a scale of 1 to 6, from most to least avoidable. Deaths that have an SJR score of 1-3 are classed as avoidable.	This only includes SJRs that have been approved by the mortality review group. Avoidability scores of 1-3 are included.	0	Same as target
Readmissions (unplanned)						
• under 15 yr olds • over 15 yr olds	%	Tg Teoh Frances Bowen	This Dr Foster metric measures the number of 28 day readmissions. A readmission is allocated to a trust, and this is given as a percentage of the total number of patients discharged. As this is superspell based (and superspells can go across more than one provider), the patient doesn't necessarily have to have been discharged by a provider to incur a readmission for that provider. (E.g. patient admitted to Imperial, transferred to a local general district hospital and discharged from there; if patient readmits within 28 days to local general district hospital then readmission is assigned to Imperial AND local DGH.	Non-elective emergency readmissions to any acute provider within 28 days of a patient being discharged from a spell of care.	to remain lower than national average	Same as target
National Clinical Audits						
• Participation in relevant NCAs (FYTD)	%	Julian Redhead	Participation in relevant published national clinical audits as a proportion of the total relevant published national clinical audits (% cumulative FYTD)	Data is reported 3 months in arrears to give 90 days for audit review to be complete.	100%	Same as target
• High risk/significant risk audits with action plan (FYTD)	%	Julian Redhead	Audits that have been RAG rated as significant risk with an action plan in place as a proportion of the audits RAG rated as significant risk (% cumulative FYTD)	Data is reported 3 months in arrears to give 90 days for audit review to be complete.	100%	Same as target

Indicator short name	Unit	Exec Lead	Full definition	Scope	Target	Tolerance for exception reporting
• Review process not completed within 90 days	n	Julian Redhead	The number of audit reviews that were not completed within the stipulated 90 day timeframe within the finanical year. The 90 days is calculated from the date the division was notified that the audit review is required, not from the date the audit was published (FYTD)	Data is reported 3 months in arrears to give 90 days for audit review to be complete.	0	Same as target
Clinical trials						
• Recruitment of 1st patient within 70 days	%	Julian Redhead	The Performance in Initiating (70-day) benchmark is a single measure taken from the date of receipt of Valid Research Application to the date of First Patient Recruitment. The benchmark is divided in to two parts: 1) assess, arrange and confirm capacity to deliver the study – 40 days, and 2) site activation and recruitment of first participant – 30 days.	Includes all interventional trials within ICHT. Non-interventional trials are excluded.	>=90%	Same as target
Caring						
Friends and Family						
• A&E - % response rate	%	Janice Sigsworth	Family and friends Test - response rate	As per NHS England guidance*	>=15%	5% tolerance for more than one month consecutively
• A&E - % recommended	%	Janice Sigsworth	Family and Friends Test- likely to recommend	As per NHS England guidance *	>=94%	5% tolerance for more than one month consecutively and below national average
• Inpatients - % recommended	%	Janice Sigsworth	Family and Friends Test- likely to recommend	As per NHS England guidance*	>=94%	As above
• Outpatients - % recommended	%	Janice Sigsworth	Family and Friends Test- likely to recommend	As per NHS England guidance*	>=94%	As above
• Maternity - % recommended	%	Janice Sigsworth	Family and Friends Test- likely to recommend	As per NHS England guidance*	>=94%	As above
• Patient Transport - % recommended	%	Janice Sigsworth	Family and Friends Test- likely to recommend	As per NHS England guidance*- reported on behalf of contractor	>=90%	As above
Mixed sex accommodation						

Indicator short name	Unit	Exec Lead	Full definition	Scope	Target	Tolerance for exception reporting
• Mixed-sex accommodation breaches	n	Janice Sigsworth	The total occurrences of patients receiving care that is in breach of the mixed sex accommodation sleeping guidelines.	Justified occurrences of MSA and unjustified mixing in relation to bathroom / toilet facilities (including passing through) are outside of the scope of the MSA return. Includes Critical Care - once the patient no longer needs the level of critical care, they become an unjustified breach.	0	Same as target
Well led						
Workforce and people						
• Voluntary staff turnover rate (12m rolling)	%	Kevin Croft	The number of leavers over the past 12 months expressed as a percentage of the average number of staff employee over that same 12 months (12 month rolling).	All voluntary leavers from the Clinical & Corporate Divisions across the Trust.	<12%	Greater than 12.6% (5% tolerance on target)
• Sickness absence rate (12m rolling)	%	Kevin Croft	The number of working hours lost to sickness absence expressed as a percentage of total contracted hours (12 months rolling).	All recorded sickness absence for employees within Clinical & Corporate Divisions across the Trust.	<=3%	Greater than 3.15% (5% tolerance on target)
• Personal development reviews	%	Kevin Croft	The number of completed staff PDR's expressed as a percentage of the total eligible staff (monthly April - July).	All non-medical staff.	>=95% at end of PDR window	Same as target
• Doctor appraisal rate	%	Julian Redhead	All doctors, with a prescribed connection to the Trust, need to be compliant with the contractual requirement for an annual appraisal.	Data reported includes consultants, SAS grades and Trust grades.	>=95%	Same as target
• Consultant job planning completion rate	%	Julian Redhead	All consultants undertaking NHS and college work within the Trust, need to complete an annual job plan.	Consultants in post for more than three months.	>=95%	Same as target
Responsive						
Referral to treatment (elective care)						
• RTT patients waiting > 18 weeks	%	Katie Urch	Of total number of incomplete pathways waiting for treatment in the reporting period, the percentage that were waiting over 18 weeks with no clock stop.	Consultant led pathways including cancer pathways without a clock stop in the reporting period. Excludes AHP pathways and Maternity/Obstetrics.	>=92%	Formal trajectory agreed with commissioners / regulator

Indicator short name	Unit	Exec Lead	Full definition	Scope	Target	Tolerance for exception reporting
• RTT waiting list size	n	Katie Urch	The total number of referral to treatment pathways without an end date (clock stop) during the reporting period.	Consultant led pathways including cancer pathways without a clock stop in the reporting period. Excludes AHP pathways and Maternity/Obstetrics.		Formal trajectory agreed with commissioners / regulator
• RTT patients waiting > 52 weeks	n	Katie Urch	The total number of referral to treatment pathways waiting over 52 weeks without an end date (clock stop) in the reporting period.	Consultant led pathways including cancer pathways without a clock stop in the reporting period. Excludes AHP pathways and Maternity/Obstetrics.	0	Formal trajectory agreed with commissioners / regulator
Cancer waiting times						
• Cancer - 62 day waits	%	Katie Urch	There are currently nine cancer waiting time standards that have been in place in their current form since 2009, measuring the time taken to see a specialist following an urgent referral from a GP, and the time to receive treatment from diagnosis. This standard measures the expectation to start treatment within a maximum of two months from referral.	All 2WW referrals patients who have a NHS funded FDT.	>=85%	Formal trajectory agreed with commissioners / regulator
Theatre utilisation						
• Theatre touchtime utilisation	%	Katie Urch	Touchtime is the time taken to complete a surgical procedure. It is measured from the start of anaesthesia through to the patient entering recovery. Touchtime is a composite of both surgical and anaesthetic time.		>=85% (revised to align with benchmark used within the NHS model hospital.	Trajectory (ICHT)
Cancelled elective operations						
• Cancellation rate	%	Katie Urch	Elective operations cancelled by the hospital for non-clinical reasons on the day of admission, as a proportion of total elective activity.		>national avg	Same as target
• 28 day rebooking breach rate	%	Katie Urch	Patients not treated within 28 days of their cancellation as a percentage of reportable cancellations.		>national avg	Trajectory (ICHT)
Critical care						
• Critical care patients admitted within 4 hours	%	Katie Urch	TBC		100%	Trajectory to be agreed (ICHT)

Indicator short name	Unit	Exec Lead	Full definition	Scope	Target	Tolerance for exception reporting
Urgent and emergency care						
• A&E patients seen within 4 hours (all types)	%	Frances Bowen	The percentage of people who attend Accident & Emergency Department who are assessed, treated and discharged or admitted within four hours of their arrival. *A new approach to measuring average waiting times within urgent and emergency care is being tested as part of the national clinically-led reviewed of NHS Access Standards.*	Covers all types of A&E attendance.	>=95%	-
• A&E patients seen within 4 hours (type 1)	%	Frances Bowen	This indicator covers Type 1 A&E attendances only. A Type 1 department is a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.	Type 1 A&E (SMH or CXH)	>=95%	N/A
• A&E patients waiting > 12 hours from DTA	n	Frances Bowen	The total number of patients who remained in A&E 12 hours after the decision to admit was made	All patients who have been given a Decision to Admit (DTA) and then remain in A&E for 12 hours.	0	Same as target
• A&E ambulance handover delays 30 minutes	%	Frances Bowen	The start time of the handover is defined as the ambulance's time of arrival at the A&E department. The end time of the handover is defined as the time of handover of the patient to the care of A&E staff.	All accident, emergency and urgent patients destined for A&E (either Type 1, 2 or 3) are counted. This includes GP urgent patients brought by ambulance to A&E. Non-emergency patients are NOT counted.	100%	Formal trajectory agreed with commissioners / regulator
Length of stay						
• Patients with LoS >= 21 days	n	Frances Bowen	The number of patients with a Length of Stay (LoS) of 21 or more days.	Only NHS Patients included, All Maternity patients excluded,	40% reduction from baseline	Formal trajectory being finalised with commissioners / regulator
• Discharges before noon	%	Frances Bowen	Percentage of all patients discharged from base inpatient wards that were discharged before midday.	Time of transfers to a Discharge Unit is taken as the discharge time. These are wards where patients typically stay overnight, so excluding daycase, assessment units & discharge units.	>=33%	Trajectory to be agreed (ICHT)
Diagnostics						

Indicator short name	Unit	Exec Lead	Full definition	Scope	Target	Tolerance for exception reporting
• Diagnostic waits > 6 weeks	%	Tg Teoh	The percentage of patients referred for diagnostic tests who have been waiting six weeks or longer.	Inclusions: all patients waiting for a diagnostic test/procedure funded by the NHS. Waits for 15 key diagnostic tests. Exclusions: The patient is waiting for a planned (or surveillance) diagnostic test/procedure and the patient is recorded on a planned waiting list; the patient is waiting for a procedure as part of a screening programme; the patient is an expectant mother booked for confinement; the patient is currently admitted to a hospital bed and is waiting for an emergency or unscheduled diagnostic/test procedure.	<1%	Formal trajectory agreed with commissioners / regulator
Outpatients						
• DNA	%	Tg Teoh	The percentage of booked outpatient appointments (including diagnostics) where the patient did not attend (new and follow-up appointments).	NHS Patients Only; DNA Numbers include template redesigns; Exclude Test Clinics; All Appointment Types (including Telephone and Diagnostic Appointments); All Clinic types, including MDT, TAS, Navigator.	<=10%	Greater than 10.5%
• HICs (Appt moved to a later date)	%	Tg Teoh	Of all appointments which were booked to occur in month, the proportion that were subsequently cancelled by the hospital and were then rebooked to a date after the initial booked appointment.	As above	<=7%	Phased target for 2019/20 (Q1 7.5%; Q2 7.4%; Q3 7.2%; Q4 7.0%)
Complaints management						
• Complaints - formal	n	Janice Sigsworth	The total number of formal complaints received during the month.	All complaints logged as formal on Datix during the reporting month.	<90	5% tolerance
• Complaints – average days to respond	days	Janice Sigsworth	The average number of days taken to respond to complaints.	Based on complaints closed during the reporting month.	40	Same as target
• Complaints - patient satisfaction with handling	%	Janice Sigsworth	Patient satisfaction with complaint handling.	Completed surveys received by the complaints team during the reporting month.	>=70%	Same as target
Patient transport						

Indicator short name	Unit	Exec Lead	Full definition	Scope	Target	Tolerance for exception reporting
• All Journeys: Collection Time (60 Mins)	%	Janice Sigsworth	TBC		>98%	A trajectory to be developed on commencement of the new contract at June 2019.
Data quality						
• Data Quality Maturity Index	-	Claire Hook	The DQMI measures overall data quality on the basis of completeness, validity, default values and coverage of core data items.	Covers these relevant datasets: Accident and Emergency; Admitted Patient Care ; Diagnostic Imaging; Maternity Services; Outpatient.	>=98%	95%
Use Of Resources *Finance KPIs*						
• Monthly finance score (1-4)	n	Richard Alexander	NHS Improvement risk rating bringing together 5 separate metrics, capital service cover, liquidity ratio (days), I&E margin, I&E margin distance from plan and agency spend.		-	-
• In month Position	£m	Richard Alexander	The difference from the planned surplus/deficit to the actual surplus/deficit in month.	The position is on a control total basis and so does not include Provider Sustainability funding.	-	-
• YTD Position £m	£m	Richard Alexander	The difference from the planned surplus/deficit to the actual surplus/deficit for the financial year to date.	The position is on a control total basis and so does not include Provider Sustainability funding.	-	-
• Annual forecast variance to plan	£m	Richard Alexander	The difference from the planned surplus/deficit to the forecasted surplus/deficit for the financial year.	The position is on a control total basis and so does not include Provider Sustainability funding.	-	-
• Agency staffing	%	Richard Alexander	Year to date cost of Agency in relation to total pay cost.	Figures are based on only cost relating to the clinical division. Non-clinical, central and Research and development costs are excluded.	-	-
• CIP (FYTD)	%	Richard Alexander	-	-	-	-
There will be further inclusion of Use of Resources metrics during 2019/20						

Appendix 2 IQPR exception report slides summary at month 2

In the development of the integrated performance report, exception slides are produced for the relevant executive committee to detail the key issues and actions where performance is outside the agreed tolerances / target.

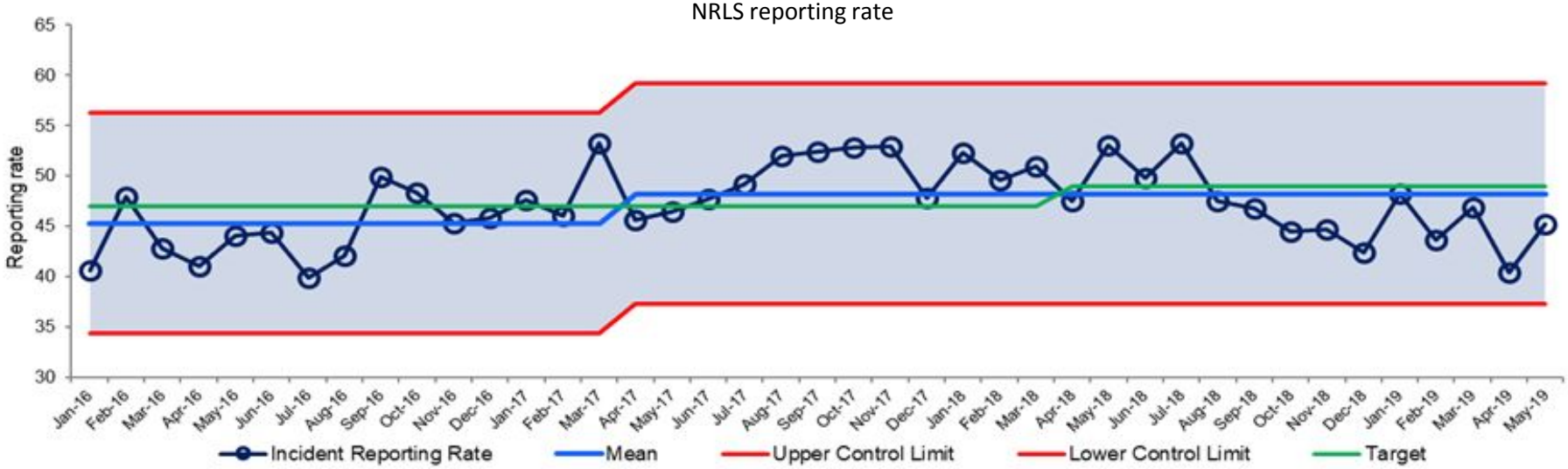
The exception reports for the month 2 integrated scorecard are provided for information in appendix 1 and cover the following metrics:

Domain	Report
Safe	Incident reporting rate
Safe	Patient safety incidents
Safe	Never events
Safe	Compliance with duty of candour
Safe	VTE
Safe	MRSA BSI
Safe	E.Coli
Safe	Vacancy rates
Effective	National clinical audits
Effective	Mortality reviews
Caring	Mixed sex accommodation
Well led	Doctor appraisal rate
Well led	Consultant job planning compliance
Responsive	Theatre utilisation
Responsive	A&E patients waiting more than 12 hours
Responsive	Extended Length of Stay

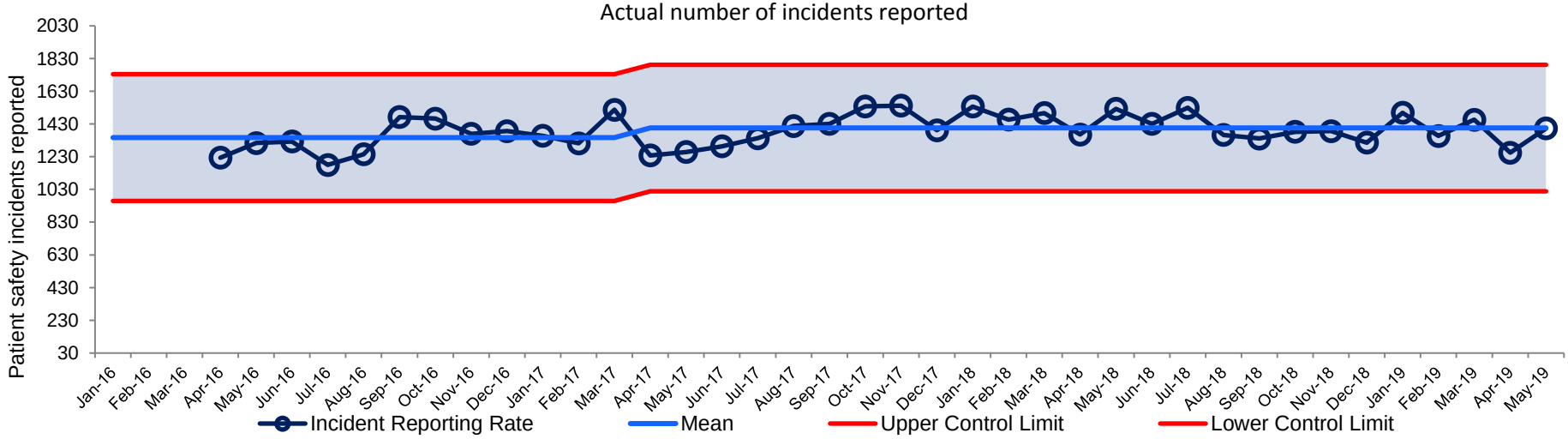
Safe – Patient safety incident reporting

Indicator	Target	Latest data	Executive lead	Report author(s)
We will maintain our incident reporting numbers and be within the top quartile of trusts	In top quartile (48.98)	40.42 – April 2019 45.19 – May 2019	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance

NRLS reporting rate



Actual number of incidents reported



Safe – Patient safety incident reporting

Latest performance	Our reporting rate for May 2019 is 45.91 against the target of 48.98. The overall number of incidents reported has improved since last month, with 1,403 reported compared to 1,255 however this is still below our target.
Key issues	• Historically, we have been in the top quartile for incident reporting rates published by the National Reporting and Learning Service (NRLS); • Our reporting rate for April 2019 (incidents per 1000 bed days, calculated using the NRLS methodology) was 40.61 against the target of 48.98. The rate has increased slightly for May (45.19) but is still below target; • Between August 2018 and May 2019, we reported fewer incidents than the same period August 2017 and May 2019. The monthly total fell below the mean for eight of those months

Improvement plans and actions	Lead	Timescale	Progress update
Divisional plans for local department increases to be submitted to MD	DDNs	31/05/19	Initial plans have been received which include a local (speciality) focus on incident reporting, discussions at divisional/directorate Q&S meetings and back to the floor Thursday to understand barriers to reporting and agree actions required.
Share data on reporting activity with the divisions	Head of Quality Compliance and Assurance	On-going from July 2019	Analysis of reporting activity at divisional and directorate level now shared monthly. The first report will be reviewed at sub-group in July where next steps will be agreed with the divisions.
Trust wide communications campaign	Improvement Manager for Safety Head of Quality Compliance and Assurance	30/06/19	Safety briefing sent out in June with a focus on incident reporting - complete. To encourage consultants to report information was included in June's Responsible Officer newsletter - complete. A new safety page is being developed for the intranet which will provide information on incidents and highlighting that any incident, no matter how small should be reported – planning meeting complete; network architecture being built and copy for pages currently being drafted. Comms campaign to share examples of what incidents should be reported as well as improvements made in response being worked up with Comms team. This will also focus on encouraging staff to positive report via the 'Learning from Excellence' mechanism.

Safe – Patient safety incident reporting

Improvement plans and actions	Lead	Timescale	Progress update
A review of the training available is underway with a view to training team members in identification and reporting	Head of Quality Compliance and Assurance	30/06/19	Corporate welcome and junior doctor sessions have been refreshed to encourage staff to report. Review of the other training available is in progress.
90 day improvement cycles being planned with lower reporting wards in SCCS	Deputy DDN Improvement Manager for Safety	30/09/19	5 areas have been identified to participate in the pilot (ITU at HH, Cardiac Cath Labs at HH, Dacie at HH, WEH, and 6S and 6E at CXH). Leads from each area have been identified. Opportunities to shadow key staff groups to identify incidents that may not be reported planned as part of this.
Undertake improvement sprint with pharmacy	Improvement Manager for Safety	11/07/19	Sprint happened on 11th July. Plan for improvement being confirmed with team.
Incident reporting and governance seminar for NWL Pathology planned for July	NWL Pathology Quality & Governance Manager	17/07/19	Governance day for scientists in NWLP developed by the Q&G manager. This includes a presentation on incident reporting by the Trust's head of quality compliance and assurance.

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

Safe – Patient safety incidents

Indicator	Target	Latest data	Executive lead	Report author(s)
We will reduce the number of incidents causing harm to patients	Below national average Moderate harm – 1.78% Severe harm – 0.24% Extreme harm – 0.10%	**Moderate harm** April – 28 incidents May – 21 incidents % YTD – 1.84% **Severe harm** April – 0 May – 0 **Extreme harm** April – 1 May – 4 % YTD – 0.19%	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance

Latest performance	During 2018/19, we reported 220 moderate harm incidents, which is 1.3% of all incidents reported and below national average (1.78%). In April and May the number of moderate harm incidents has increased, with 49 reported in total. With our overall number of incidents reducing, this has resulted in a YTD rate of 1.84% which is above national average (1.78%). Many of these incidents are recognised complications which we have been encouraging teams to report in line with duty of candour requirements. In April we reported 1 extreme harm incident (2 were reported initially but 1 has since been downgraded on investigation) and 4 were reported in May. Our YTD rate for extreme incidents is therefore also above national average (0.19% compared to 0.1%). Of the four reported in May, two are currently being investigated as SIs – the actual harm level will be confirmed once the investigations are complete. For the remaining two cases, additional information is required before the type of investigation and the level of harm can be agreed. In one case, the post-mortem report is awaited from the coroner to ascertain the cause of death and for the other case further clinical input is needed as part of the initial review. However we have reported 0 incidents in the severe harm category with the average being 0.24%.
Return to target / trajectory	The data will be reviewed at month three and any additional actions will be identified to bring us back to target in Q2.

Safe – Patient safety incidents

Key issues	We have seen an increase in the number of moderate and extreme harm incidents reported in April and May compared to 2018/19, while our incident reporting rate has decreased. This means that we are above average for the percentage of moderate and extreme harm incidents reported. The national average is based on one year's data, which we are comparing in this case to two months. As our denominator (number of incidents reported) increases each month we expect our performance to improve. Also the harm levels of incidents change during their investigation cycle as more information becomes available.

Improvement plans and actions	Lead	Timescale	Progress update
Analysis of the types and location of incidents will be undertaken monthly to highlight any areas of concern or changes to types of incidents being reported. Subsequent actions will be put in place.	Head of quality compliance and assurance	July 2019	Initial review has shown an increase in moderate harms being reported in NWLP, action taken is reported below. Data will be reviewed each month and any areas of concern will be investigated and actions taken.
Ensure issues highlighted through investigating moderate and extreme harm incidents are fully understood and the learning points are shared across all divisions	Head of quality compliance and assurance	August 2019	This information will be included in the incident monitoring report from August 2019 (July data).
A review of themes from moderates (that are not SIs/L1s) will be undertaken to highlight any themes for action and learning.	Head of quality compliance and assurance Improvement programme manager - safety	August 2019	Work has already commenced to review incidents related to absconding patients / security issues on wards/departments. This work will be expanded to include other actions not linked directly to existing safety streams.
Quality review meeting to be held with North West London Pathology in response to increase in incidents	MD	19 June 2019	Quality review meeting held on 19 June, with actions and next steps agreed. A follow up meeting has being arranged.

Risk

- Is it on the (divisional / corporate) risk register? To be considered once month 3 data has been reviewed.

Safe – Never Events

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

Latest performance	One never event was declared in April 2019, a retained swab in ENT at Charing Cross Hospital. A patient underwent a procedure and was transferred to the ITU where they coughed up a surgical swab. Initial investigation shows that the swab was inserted in the mouth after completion of the final swab count, without all relevant members of the team being aware (to stem bleeding). The swab count was not repeated, nor was the retained foreign object procedure followed. Immediate actions include locally changing to the use of throat packs which are coloured and have a tail when intentionally retaining, as well as direct communication to staff about the need to repeat a swab count and to follow the intentionally retained policy. A 'conversation café' was undertaken with the team involved on 3rd May and the specialty had their first coaching session as part of the 'HOTT' programme on 3rd June. Following discussion with NHSI the CCG have agreed to re-categorise the retained swab incident from July 2018 to an SI. An assurance meeting with the commissioners took place on 8th July 2019.
Return to target / trajectory	As we declared one never event in April 2019, we will not meet our target (0) for 2019/20. We anticipate seeing a reduction in the number of invasive procedure related never events as a results o of the trust wide action plan in place.

Safe – Never Events

Issues and root causes	Seven out of the eight never events which we have reported since May 2018 are related to invasive procedures, with the most recent one occurring in ENT. The completed investigations have found different root causes for each incident, however common themes include failure to follow trust policy and processes.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Undertake engagement with clinical workforce	Medical Director	Complete	Communication regarding the most recent never event circulated within the division. Email to all staff sent from the medical director Conversation café with the staff involved took place on 3rd May
Deliver simulation and coaching programme to all invasive procedure staff	Trust lead surgeon	December 2020	Programme expedited using risk based approach; the first 5 specialties where there have been never events were prioritised and completed their first sessions by 15 May. Roll out to other specialties started in June 2019.
External review of actions and response to Never events	Medical Director	Complete	Meeting with national director of patient safety took place on 21st March. Dr Fowler was supportive of the actions and approach we are taking.
Ensure 100% compliance for all staff with the invasive procedure electronic training module	Divisions	Overdue	There are currently 7 staff members who the divisions have confirmed still need to complete the invasive procedures training, two from IPH and five from SCC. The two from IPH have had their contracts suspended until they have completed their training. We are awaiting an update from SCC on their five staff members, however the medical director has previously been assured that they are not carrying out invasive procedures.

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

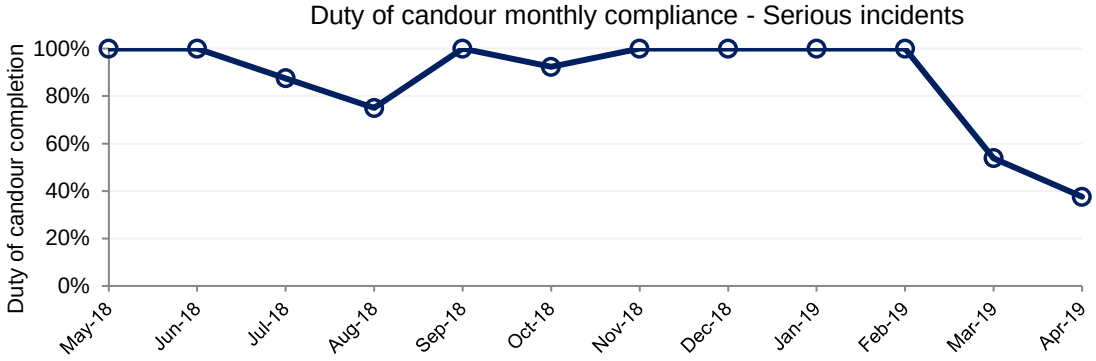
Safe – Never Events

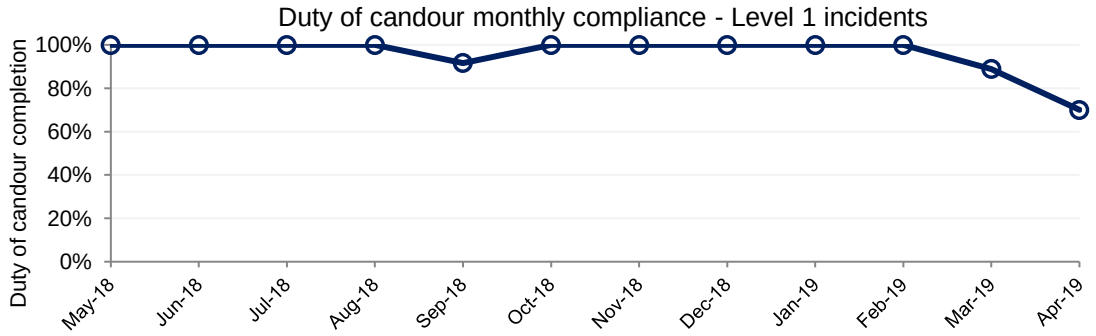
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Review all Trust policies and guidelines relating to invasive procedures to ensure they are in line with national guidance and are audited	Divisions	August 2019	Count, Consent and Invasive procedures and site marking policies have been approved. The maternity adapted count guideline and site marking policy will be approved by the end of June. The preparation for invasive procedures policy is being reviewed as part of a working group looking at pre-operative handover – it is likely that this will be incorporated into the invasive procedures policy. Divisions have plans in place to finalise and approve any outstanding LocSSIPs. The majority of these should be completed by the end of June 2019. The trustwide audit of the WHO checklist, count policy and Stop Before You Block commenced on 3rd June.
Review and evaluation of all actions taken previously in response to never events	Divisions	July 2019	The PSTRC have undertaken a review of all actions taken as a result of previous never events to determine their effectiveness and support identification of further actions. A meeting is taking place on 1st July with the PSTRC and the medical director's office to discuss next steps.

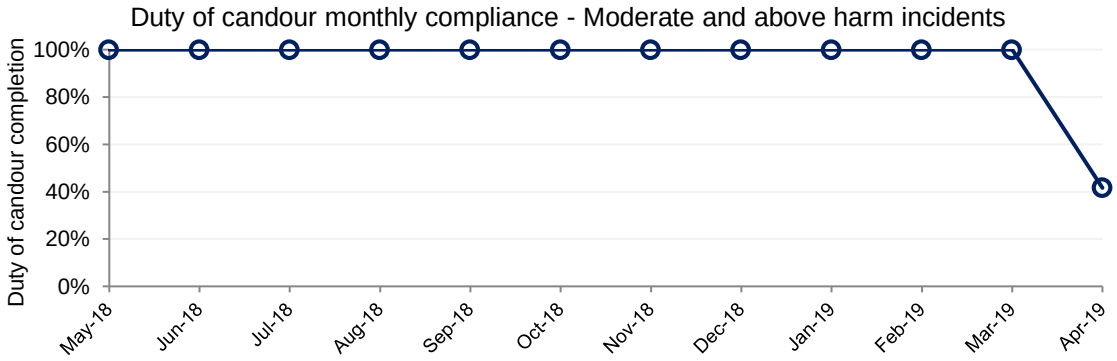
Risk
• Is it on the (divisional / corporate) risk register? YES (Corporate Risk ID 2942 Potential harm to patients caused by a failure to follow invasive procedure policies and guidelines)

Safe – Compliance with duty of candour

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure 100% compliance with duty of candour requirements for every appropriate incident graded moderate and above	100%	Total: 90.8% SIs: 84.4% Internal investigations: 95.4% Moderate and above incidents: 91.7% (cumulative data for incidents reported May 2018 – April 2019)	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance







Latest performance

Serious Incidents
Mar 2019 – 6 SIs out of 13 have not had DoC completed. In month compliance is therefore 53.8%.
Apr 2019 – 5 SIs out of 8 have not had DoC completed. In month compliance is therefore 37.5%.

Level 1s
Mar 2019 – 1 level 1 out of 3 has not had DoC completed. In month compliance is therefore 88.9%.
Apr 2019 – 3 level 1s out of 14 have not had DoC completed. In month compliance is therefore 70%.

All other moderate and above incidents
Mar 2019 – all moderate and above incidents have had DoC completed. In month compliance is therefore 100%
Apr 2019 – 7 out of 12 moderates and above have not had DoC completed. In month compliance is therefore 41.7%.

Return to target / trajectory

When this data was pulled there were 14 SIs, 5 Level 1s and 9 moderate and above incidents reported between March 2017 and April 2019 which had not had DoC completed. Weekly exception reports are provided to the divisions. Where cases are overdue, the AMD for patient safety will write to the consultants responsible for the patient's care to ask them explain their rationale for not completing the DoC. The expectation is that all outstanding cases will have DoC completed by w/c 8th July.

Safe – Compliance with duty of candour

Issues and root causes	Duty of candour compliance has decreased in month for all types of incident. Issues remain around completion of both parts of the DoC process (Part 1 – the initial conversation, and part 2 – the follow up letter) by the consultant responsible for the patient's care. Following review by the divisions, a number of DoC letters (recorded as outstanding) have been sent by the consultants but not appropriately recorded on Datix.

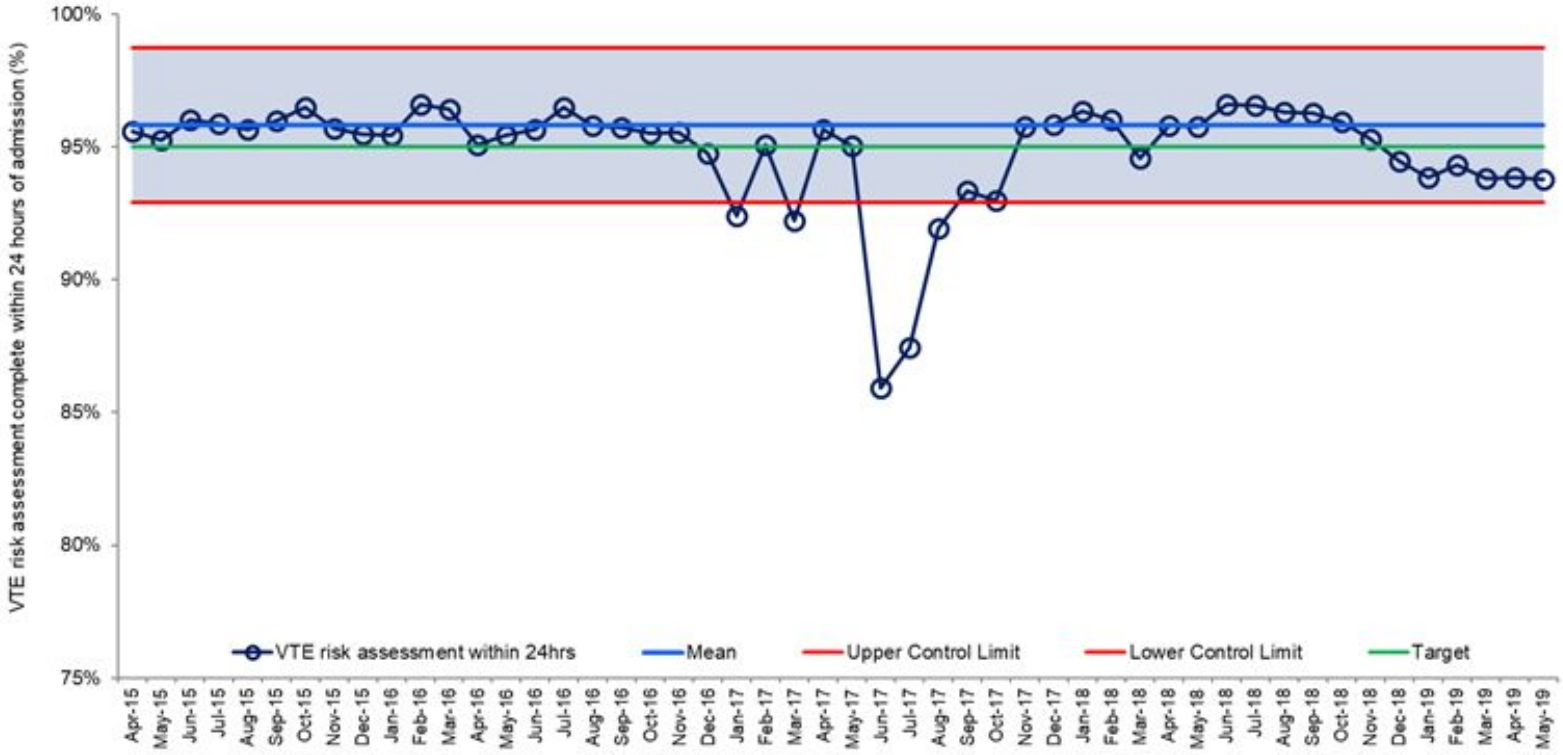
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Outstanding duty of candour is followed up and monitored at the weekly Medical Director's Incident Meeting.	Head of Quality Compliance & Assurance	Ongoing	All outstanding cases continue to be reviewed at the weekly MD panel. Weekly exception reports are provided to the divisions.
A review of systems and processes for recording compliance of DoC will be undertaken	Divisions Head of Quality Compliance & Assurance	End of June	A review of the Datix form for recording DoC has commenced by the DiHub. The SOP for recording of DoC letters will be refreshed and circulated.
Where cases remain overdue, the AMD for patient safety will write to the consultants responsible for the patient's care to ask them explain their rationale for not completing the DoC.	AMD for patient safety	End of June 2019	Letters to be sent by the end of June.
90% compliance with mandatory online duty of candour training for nurses at Band 7 and above and all consultants.	Divisions	March 2018 - overdue	The divisions confirmed that compliance for consultants has improved significantly, and is now over 90%. Non-compliant consultants are being written to by their line managers and will be subject to HR processes if they remain non-compliant. Reminder that appraisals should not be signed off without confirmation of compliance with all core skills modules included in RO newsletter in June. Issues remain with the denominator for nursing staff, with staff members who have left still being included – this will be reviewed through the core skills group once reports from the new LEARN system are available.
Duty of candour letter templates to be reviewed	Head of Quality Compliance &	Complete	Complete. Templates were approved at sub-group in March.

Risk

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

Safe – VTE

Indicator	Target	Latest data	Executive lead	Report author(s)
We will assess at least 95% of all patients for the risk of VTE within 24 hours of their admission, and maintain zero cases of avoidable harm	95%	April 2019 – 93.85% May 2019 – 93.79%	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance



Latest performance	VTE assessment compliance rates have been below the target of 95% since December 2018. Performance at divisional level is above target in WCCS, however MIC and SCCS are not meeting the target.
Return to target / trajectory	Preliminary data for June 2019 shows performance remains below target. The most recent data available is for w/c 17th June and is 92.58%. We are expecting compliance to return to 95% in July once the changes to Cerner described on the next slide have taken affect.

Safe – VTE

Issues and root causes	A review of the data highlighted that the prescribing lock which prevents staff from prescribing until the risk assessment has been completed was not in place in Cerner. This has now been resolved.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Review cohorting of low risk patients	Clinical Lead – VTE	Complete	Complete.
Amend Cerner so that the prescribing module is locked until a VTE assessment is completed	Clinical Lead – VTE	Complete	Completed on 19th June 2019. Once performance data is available, the divisions will be asked to provide action plans to review any remaining non-compliant episodes.
Review metric in light of new NICE guidance	Clinical Lead – VTE	August 2019	Updated NICE guidance indicates VTE assessment to be completed by first consultant review (standard 14 hours) as opposed to the 24 hours we currently report. This has not been amended in the standard contract. It has been agreed that we will continue to report on performance against the 24 hour target set out in our policy. A report showing assessment at 14 hours is being developed by BI.
Review data to see whether VTE assessment might be preventing positive VTE diagnosis and whether there is an association between increasing assessment and reduced complications.	Data analytics team	August 2019	The GDE Clinical Analytics team is reviewing the value of increasing VTE assessment completion from 95% to 100%. The first step was to understand whether there is any correlation between VTE episodes, risk assessment completion and prophylaxis administration. Although this is work in progress, the initial analysis implies that in those inpatients who have been assessed as being at Risk of Thrombosis (and have NO Bleeding risk OR Contraindication to medications or Stockings), there is over a two-fold increased incidence of VTE in patients who were not given appropriate prophylaxis within 24 hours of the risk assessment being undertaken. An audit is currently being undertaken to understand whether the patients who have not had a VTE assessment are at increased risk of VTE. The outputs of this will be reported once available.

Risk

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

Safe – MRSA BSI

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure we have no avoidable MRSA BSIs and cases of *C.difficile* attributed to lapses in care	0	MRSA BSI: 0 – April 2019 2 – May 2019 MRSA BSI YTD: 2 *C.difficile* lapse in care: 0 – April 2019 0 – May 2019 *C.difficile* lapse in care YTD: 0	Julian Redhead, Medical Director	Jon Otter, General Manager IPC

Latest performance	There were no Trust-attributable MRSA cases reported in April 2019, however two cases were reported in May 2019.
Return to target / trajectory	Target for MRSA is zero, therefore no return to target this FY 18/19

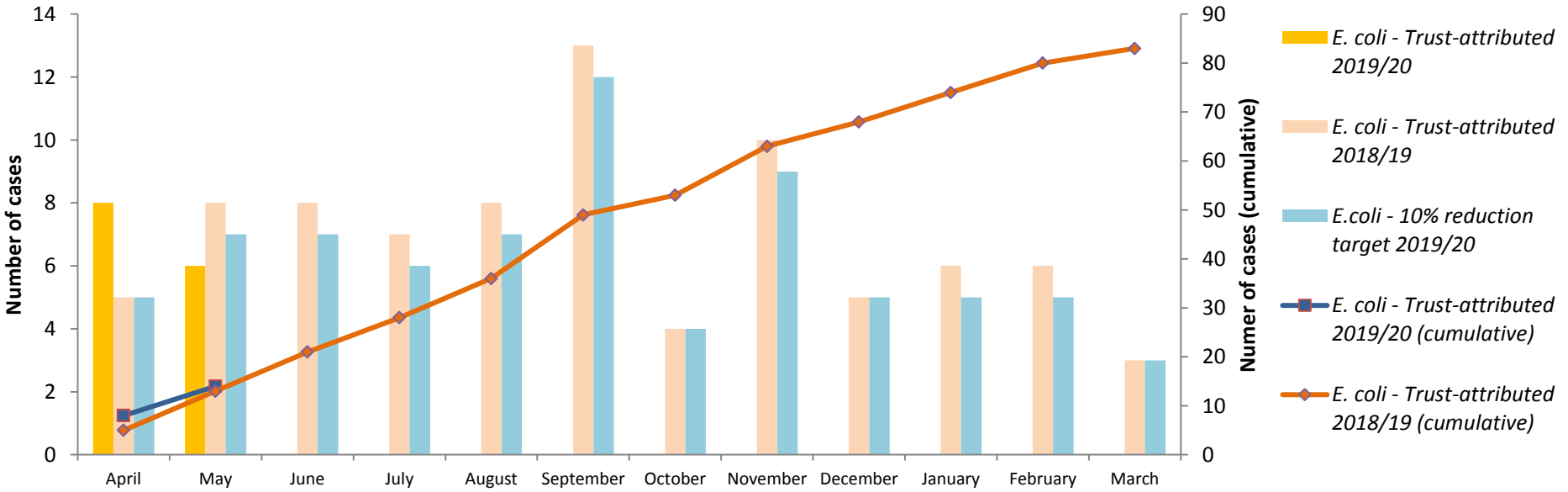
Key issues	There were two Trust-attributable MRSA BSI cases in May 2019 compared to three in total in 2018/19. One case on an oncology ward concerns a patient admitted for a presumed malignant choriocarcinoma. The source of the BSI is due for finalisation at the end of June 2019, with a tentative assessment that it is associated with a peripheral vascular access device. The second case on a surgical ward concerns a patient admitted for investigations for coeliac artery bypass. The source of BSI is due for finalisation at the end of June 2019, with a tentative assessment linking it to a central line, specifically a PICC. Key actions addressing issues raised around each BSI will be finalised at the end of June in collaboration with the relevant specialties. Preliminary assessment suggests actions will be around vascular device care and documentation.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Plans to improve vascular access practice and documentation.	Jan Hitchcock, Lead Nurse for Vascular Access	July 2019	Clinical reviews of the two recent cases as almost complete, and indicate that vascular lines were involved in both; these reviews need to be completed.

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

Safe – *E.coli*

Indicator	Target	Latest data	Executive lead	Report author(s)
We will achieve a 10% reduction in healthcare-associated BSIs caused by *E. coli*	10% reduction (n=65)	8 – April 2019 6 - May 2019 YTD = 14	Julian Redhead, Medical Director	Jon Otter, General Manager IPC



Latest performance	• Eight cases of Trust *E.coli* BSI have been reported for April 2019, with six cases for May 2019. This makes a total of 14 cases in 2019/20. • Of the 14 cases in 2019/20, 4 had a urinary source, of which 2 were urinary catheter associated, 2 were gastrointestinal, 1 was associated with a vascular access device, and the remaining case is indeterminate.
Return to target / trajectory	• 10% reduction target was not met at the end of May 2019

Safe – *E.coli*

Key issues	There were 14 cases of Trust attributable *E.coli* BSI in April and May 2019. Cases of *E. coli* BSI are reviewed monthly to identify any potential trends. It seems likely that many of the cases of healthcare-associated *E. coli* BSI are a direct result of necessary interventions and are not preventable (e.g. those associated with neutropenia), or related to complex cases in patients with advanced malignant disease (such as those with biliary sources). However, other sources of infection are more likely to be preventable (e.g. *E. coli* BSIs associated with urinary catheters).

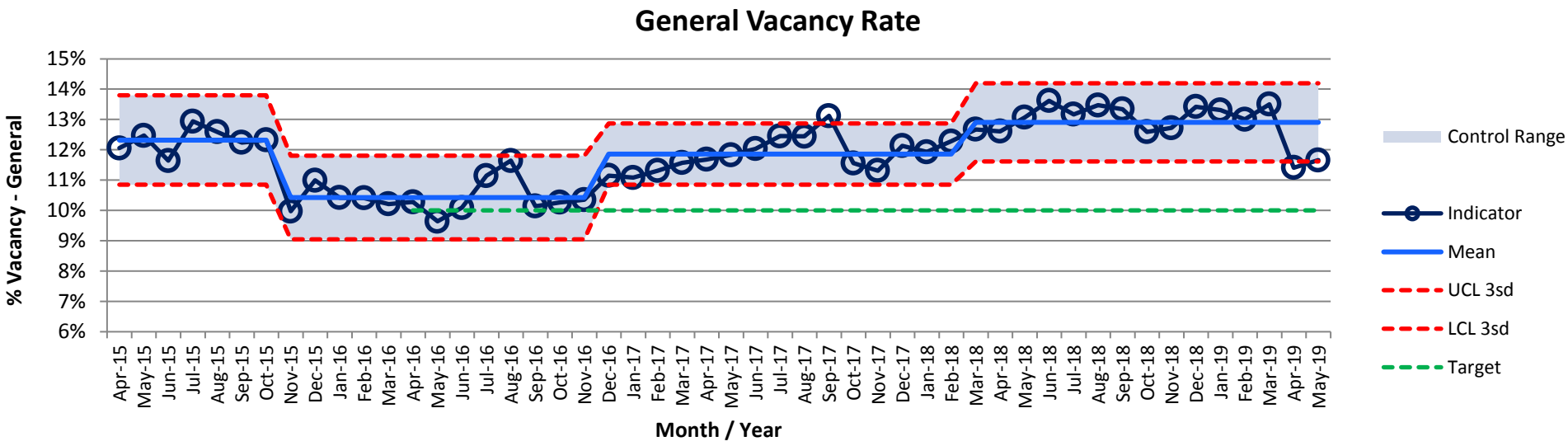
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Identify those cases with potential for prevention interventions.	Eimear Brannigan, Deputy DIPC	Closed	Urinary catheter-associated Gram-negative bacteraemias to be initial focus, along with interventions aimed at neutropaenic patients.
Establishing an enhanced Gram-negative BSI review process via a monthly MDT group.	Eimear Brannigan, Deputy DIPC	July 2019	First formal monthly MDT group meeting to discuss Gram-negative BSI review process will take place in July. Members of the CCG are attending to promote collaborative working across acute and non-acute care.
Improve the management of urinary cathertisation and patient hydration	Tracey Galletly	On-going	Establish current infrastructure and resourcing for the management of urinary catheters and patient hydration in the Nursing Directorate.
Identify potential preventative initiatives in high risk areas (haematology, renal, NICU and post-surgical wards) for Gram-negative bacteraemias and identify potential prevention initiatives.	Eimear Brannigan, Deputy DIPC	July 2019	The planning of interventions aimed at preventing E. coli BSIs in specialist patient groups within these high risk areas is currently on-going.

Risk

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

Safe – Vacancy rates

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have a general vacancy rate of 10% or less; We will have a nursing and midwifery vacancy rate of 13% or less.	10% target for overall Trust vacancies and 13% for overall N&M vacancies	May 2019 position was; All Trust 11.7 % All N&M 15.8%	Kevin Croft, Director of People and Organisational Development	Dawn Sullivan, Deputy Director of People and Organisational Development



Latest performance	• at the end of May 2019 the vacancy rate was 11.7% reflective of 1,283 WTE vacancies; 208 WTE non-clinical roles and 1,075 WTE clinical roles • the number of staff directly employed, across all of the Trusts Clinical and Corporate Divisions was 9,716 WTE; an increase of 58 WTE from those employed in March 2019 • for all nursing & midwifery roles, the vacancy rate was 14.6% (840 WTE vacancies); a 1.1% reduction from March 2019
Return to target / trajectory	• the projection is that we will hit the 13% N&M vacancy rate target by the end of August/early September 2019 based on current activity and establishment. This is based on the current growth projected • the 10% overall trust vacancy rate target is projected to be met at the same time as the above

Safe – Vacancy rates

Issues and root causes	• Workforce is a key issue across the NHS – in 2017 more nurses left the profession than joined. Imperial has an overall nursing and midwifery vacancy rate of 15.8% - a reduction of 1.1% from March 2019. There are a wide range of recruitment initiatives in place however these maintain our position rather than reduce the vacancy rate significantly • There are a number of factors that are compounding the workforce issue and making recruitment and retention of staff very difficult: the removal of the bursary, the sustained low pay increases, contractual issues with the trainee doctors, the pressure of work and the reduction in CPD funding • The London recruitment market is very difficult and there is more demand than supply. The majority of London trusts have been actively involved in international recruitment for many years and this is reflected in their vacancy rate e.g. Kings and UCL • There are national skills shortages and workforce planning across the NHS has not been a high priority to date • High vacancy rates impact on patient safety and on staff engagement and morale

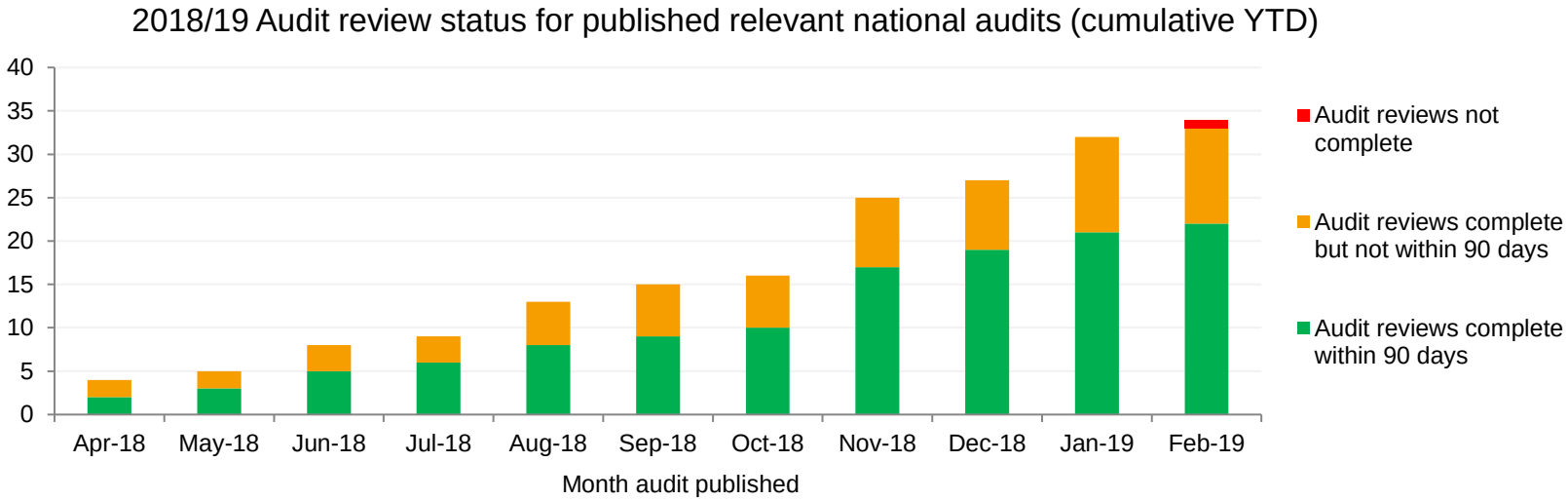
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
There is a Recruitment & Retention Action Plan in place for Band 2-6 N&M staff	Dawn Sullivan	1-3 years	• The plan has been refreshed for 2018/2019 and to date has delivered an increase in student retention to 70% an increase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

Risk register

Corporate risk register id 2944: Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas

Effective – National clinical audit

Indicator	Target	Latest data	Executive lead	Report author(s)
We will participate in all appropriate national clinical audits and evidence learning and improvement where our outcomes are not within the normal range	Participation in 100% of relevant national clinical audits Number of audits that have not completed the review process within 90 days	87% – February 2019 12 - as at February 2019 (of which 11 have been completed but not within 90 days, and 1 is overdue and has not yet been completed)	Julian Redhead, Medical Director	Louisa Pierce, Clinical Auditor



Latest performance	The graph above demonstrates performance against Quality Account reportable national audit activity up to February 2018 for the financial year 2018/19. Data is reported on a monthly basis, but the data presented here is three months in arrears to allow time to go through the Trust ratification process. There have been 39 national audits published up until the end of February 2019 which were relevant to the Trust, of these we participated in 34. The review process was completed within 90 days for 22 of these audits. Of the remaining 12, 11 reviews have now been completed, but were not done in 90 days and one is overdue and not yet completed.
Return to target / trajectory	Progress is tracked weekly at the MD incident panel.

Effective – National clinical audit

Issues and root causes	Improvements continue to be made with the review and risk assessment of audit reports by divisions within the internally set target of 90 days. Between April 2018 to Feb 2019, 65% of reviews were completed within 90 days, compared to 24% in 2017/18. Of the 34 audits published between April 2018 - February 2019 in which we participated, 33 have completed reviews. Twenty-two of these were completed within the required timeframe. Two audits have been identified as significant risk and have action plans in place (see action plan below). Our participation rate for national clinical audits published up to February 2019 is 87% (34 / 39 audits). This is because we did not participate in the five audits run by the British Associate of Urological Surgeons (BAUS) due to the time taken for data entry and the quality of the audit outputs nationally making meaningful comparison difficult (manual data entry, requiring up to 30 minutes per patient). The division have recommended that we do not participate during 2019/20 either given the issues and the planned change to the audit in 2020/21 when data will be collated through an autonomous system using HES data. This was approved at ExQu in July with assurance on outcomes to be provided through a separate report using CRAB data which is due for review in Q2.

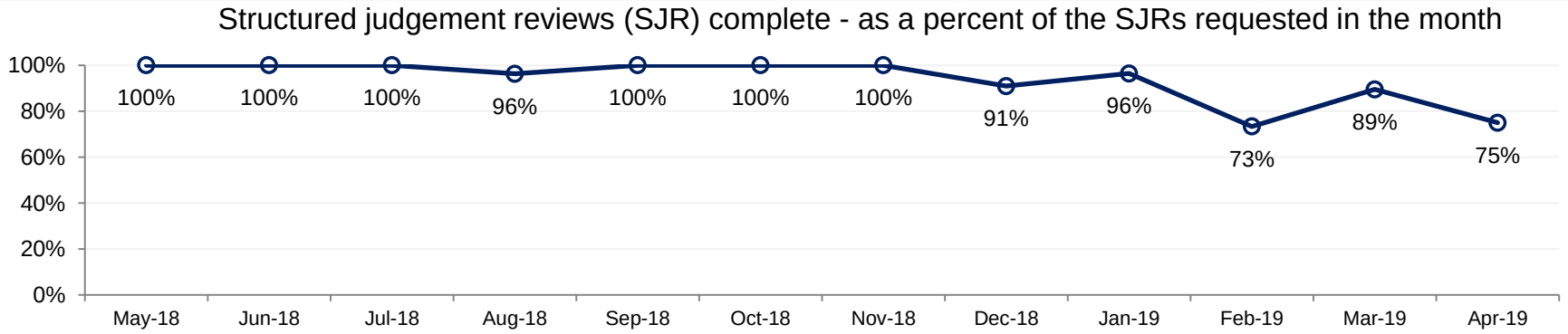
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
All significant risk audits to have an action plan in place that is presented to the quality & safety subgroup.	Raymond Anakwe/ Audit Leads	On-going	There are 2 audits from 2018/19 have been identified as significant risk so far. These are Serious Hazards Of Transfusion (SHOT) and the Case Mix (Intensive Care National Audit & Research Centre (ICNARC)), that sit within SCCS. SHOT identified issues with nurse training and the use of a checklist. Both reports and associated action plans were signed off at divisional Q&S in February and reviewed at sub-group in May. Progress with the action plans will continue to be monitored at the divisional Q&S committee, with exception reporting to sub-group.
Low risk and acceptable risk audits to be presented at divisional quality and safety committees.	Audit Leads	On-going	33 out of the 34 audits published in 2018/19 and in which we participated (to February 2019) have completed the review process.
Overdue audits escalated at the weekly Friday MD panel for review.	Clinical Auditor	Weekly – On-going	Divisions provide regular updates based on discussions at divisional quality & safety meetings.

Risk

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

Effective – Mortality reviews

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure structured judgement reviews are undertaken for all relevant deaths in line with national requirements and Trust policy and that any identified themes are used to maximise learning and prevent future occurrences.	100% of all relevant deaths	SJRs requested as a % of deaths: 14.6% SJRs not complete within 30 days of request: 58.4% Avoidable deaths: 1 (April 2019)	Julian Redhead, Medical Director	Trish Bourke Mortality Audit Manager



Latest performance	• The graph above shows the percentage of SJRs which have been completed based on when the SJR was requested. Data is refreshed on a monthly basis as SJRs are requested and completed. • This data is reported 1 month in arrears to allow time for the SJR cycle to be completed. • For financial year 2018/19, 278 completed reports have been received to date, out of 292 requested, meaning 95.2% of SJRs have been completed. • For April 2019 (month 1), 12 SJRs have been completed out of 16 requested, meaning 75% of SJRs have been completed. • One of the deaths reviewed in April has been confirmed as 'avoidable' (score 3 – probably avoidable – more than 50:50). This case is being investigated as a SI.
Return to target / trajectory	We are continuing to recruit additional SJR reviewers in order to deliver more capacity. SJRs are being reassigned where there is a delay in order to deliver timely outcomes. A trajectory is being agreed through the mortality review group

Effective – Mortality reviews

Issues and root causes	Improvements are being seen in the completion of SJRs, with 14 outstanding from 2018/19. We are not meeting our internal target for SJR completion, with 58.4% not completed within 30 days.

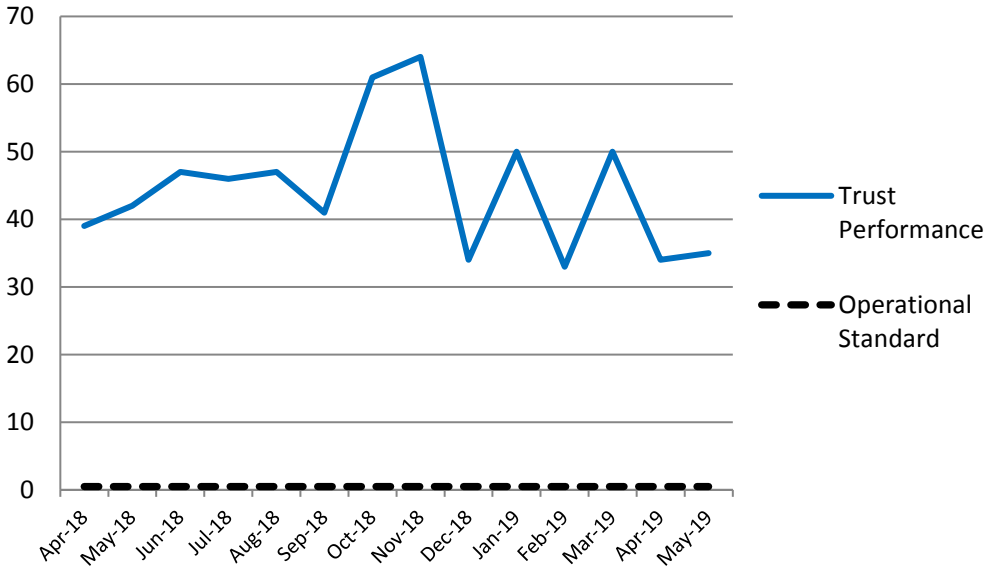
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Recruitment of additional structured judgement reviewers.	Mortality Auditor	June 2019	To increase capacity, recruitment of additional structured judgment reviewers to increase capacity is underway. This includes inviting expressions of interest from consultants via the Responsible Officer's newsletter and via an email from the medical director's office. The divisions have also been asked to nominate senior nurses as potential reviewers. Overdue cases are also escalated to the divisions and reallocated to different reviewers where necessary.
Strengthen and formalise the process for triangulating data from cases that have both SJRs and SI investigations undertaken, this includes the recording and accessibility of the data generated.	Head of Quality Compliance & Assurance	Complete	Changes were made in April 2019 to our processes to ensure that these two investigatory processes, whilst independent of one another, are linked appropriately. These include presentation of all SJRs with a score of 1-3 at the MD panel, and a new decision making group being convened
Review of the issues highlighted from the incident investigations (SI/level 1) and SJRs for each case since April 2018.	Mortality Auditor	Complete	We have completed this exercise for all 29 avoidable deaths reported as at March 2019. Themes and learning from these cases are outlined in the quarterly learning from deaths report. This will be undertaken for all cases on an on-going basis and reported in the quarterly report.
Undertake review of the mortality processes	General Manager, MDO	Complete	Review completed in January 2019. A Learning from Deaths steering group is overseeing the implementation of all recommendations.

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

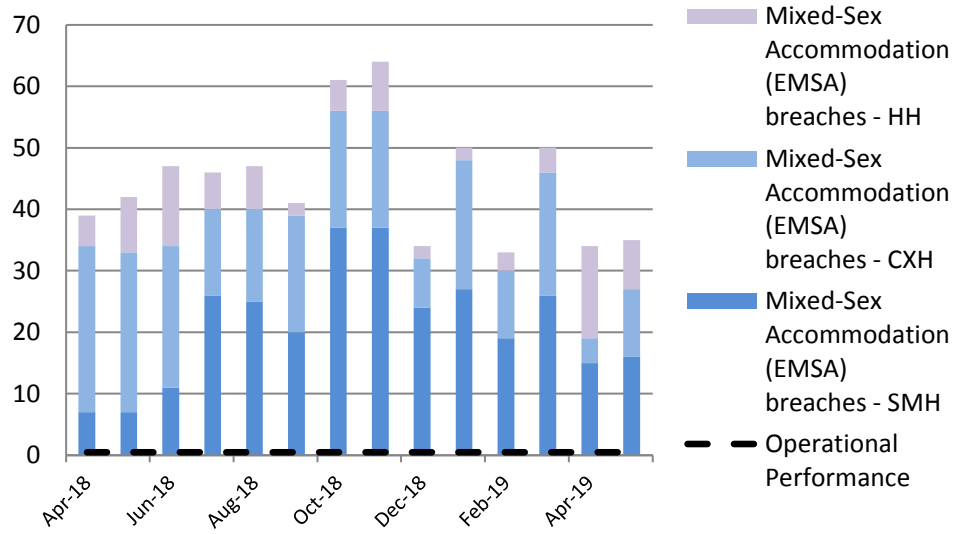
Caring - Eliminating Mixed Sex Accommodation (EMSA)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have zero mixed-sex accommodation breaches	0	35 breaches CXH – 11, HH – 8, SMH – 16, HH Cardiac - 0 (May 2019)	Janice Sigsworth	Melanie Denison Senior Nurse, Critical Care

Mixed sex accommodation breaches



Mixed sex accommodation breaches (Site Breakdown)



Latest performance	The national standard is to eliminate all mixed sex breaches for Level 1/0 patients. Inability to care for patients in a same sex environment can have a detrimental effect on patient experience. The Trust reported 35 mixed-sex accommodation (MSA) breaches in May 2019, which arose exclusively in the ICU's (Intensive Care Units), with patients awaiting discharge to a ward area. The most notable increase in breach rates in 18/19 occurred at the SMH site from July 18, following the co-location of HDU beds to ICU, resulting in all discharges from ICU being at Level 1 or 0 (where previously patients were discharged from ICU to HDU as a L2).
Return to Trajectory	The target for this metric is zero breaches. In order to achieve this, all discharges from ICU must be stepped down within 4 hours. In order to create a trajectory, updates on key actions related to flow within the Trust are required, as level 1 delayed discharges within ICU remain an issue. Downstream delayed discharges from L1 areas further exacerbate this problem.

Caring - Eliminating Mixed Sex Accommodation (EMSA)

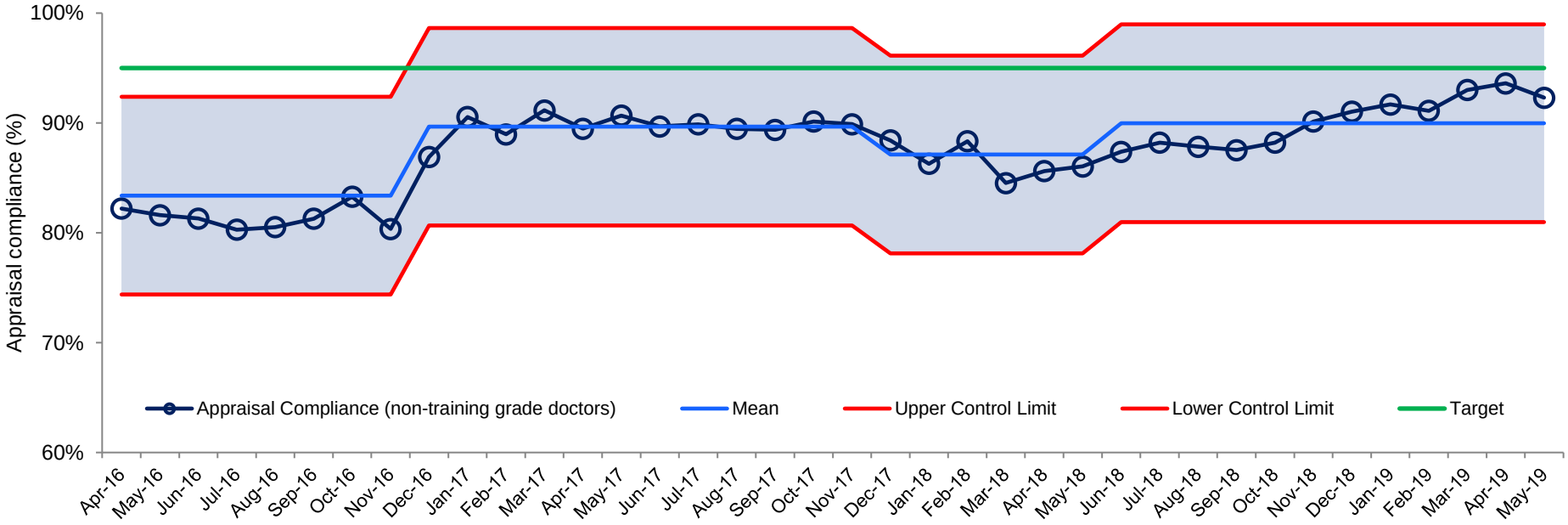
Issues and root causes	Breaches at Imperial are incurred by patients awaiting discharge from the ICUs to ward areas. Downstream flow is the main obstacle. Imperial appear an outlier for reported MSA breaches in London. Most other London hospitals report discharge delays from ICU but report fewer or no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

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Comparison of reporting methodologies and mitigations at other Trusts	Mary Mullix	Next update 8th July 2019	• Following presentation at CQG, a review is to take place on MSA reporting in other Trusts to ensure all are following the same reporting methodology. • Telephone meeting with CQG on the 8th July to discuss and update.
In conjunction with the Hospital Directors, discussions to be held to review the prioritisation of discharges from ICU.	Felicity Bevan; Roseanne Meacher	On going	• Clinical Director / General Manager attendance at Trust Care Journey Capacity Collaboration (CJCC) meeting, to raise profile of delayed discharge situation in ICU and to highlight this impact on EMSA. • Delayed discharges and MSA breaches focused on in site management meetings.
Patient Information Leaflets	Melanie Denison	July 2019 (extended from April-19)	• Develop literature to provide information to patients on MSA in ICU. • Examples from other Trust identified. • Communications team contacted to discuss options and suitable content. • Still awaiting publication of the latest NHSI guidance to inform content.
Gain an understanding of the impact of MSA breaches on patients that meet criteria within the ICU setting	Melanie Denison	June 2019 (extended from April-19)	• Working with the Head of Patient Experience & Improvement to devise a suitable question to add to the existing patient experience survey to assess the impact on patients that are a MSA breach in ICU.

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

Well led – Doctor Appraisal Rate

Indicator	Target	Latest data	Executive lead	Report author(s)
We will achieve a non-training grade doctor appraisal rate of 95%	>=95%	93.6% - April 2019 92.3% - May 2019	Julian Redhead, Medical Director	Andrew Worthington, General Manager MDO



Latest performance	Overall compliance has dropped slightly from 93.6% in April to 92.3% in May. This is due to a number of career grade doctors being overdue – compliance for this group is 87.6% compared to 92.4% in April. Consultant compliance remains the same at 94%. The total number of appraisals overdue by more than six months is currently 29.
Return to target / trajectory	The target date for achieving the 95% compliance rate was September 2018. This has been added to the risk register as we have not met our internal compliance target. An improvement plan has been developed and is being implemented.

Well led – Doctor Appraisal Rate

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

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Continue to target individual overdue doctors via the AMD for Professional Development	Geoff Smith, AMD Andrew Worthington, GM	February 2019	Complete
Arrange external appraiser training	Andrew Worthington, GM	May 2019	Second appraisal training day is scheduled for 18th June following a successful and well evaluated training day in May. Two further dates scheduled for autumn.

Risk

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

Well led – Consultant Job Plan compliance

Indicator	Target	Latest data	Executive lead	Report author(s)
We will achieve a non-training grade doctor appraisal rate of 95%	>=95%	78.2%	Julian Redhead, Medical Director	Andrew Worthington, General Manager MDO Geoff Smith, AMD

Latest performance	Compliance at time of reporting is 78.2%. There are a further 18% of job plans that have been submitted but are awaiting sign-off by the relevant clinical directors/heads of specialty.
Return to target / trajectory	Two areas of focus: Improved Head of Specialty and Clinical Director sign off of the 18% complete and unsigned, through direct reminders to individuals is underway. The remaining 4% are being contacted to identify why the job plan is incomplete and whether escalation to Division or Medical Director's office is required.

Issues and root causes	Job plans have been agreed and submitted but have not completed the final sign off process ahead of the deadline. Job plans will continue to be agreed and signed off after the round deadline has officially ended and final compliance reported.

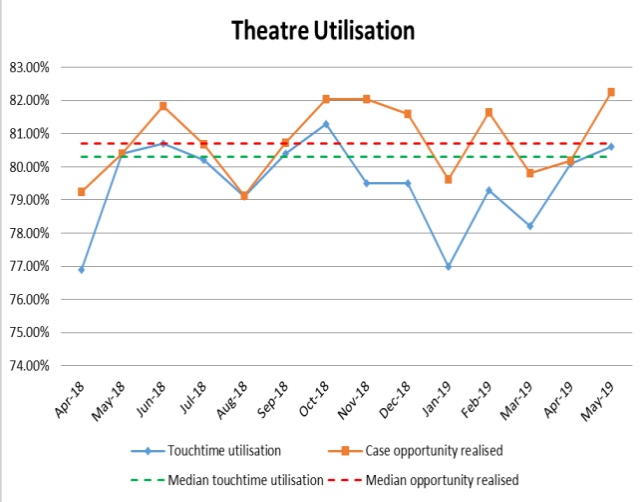
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Job planning workshop to be held with for CD and HoS before the next round starts	Geoff Smith, AMD	September 2019	Workshops are currently being set up for July and September
Automatic transfer of job plans from previous round to make sign off easier for staff	Geoff Smith, AMD	September 2019	Software solution being sought with the provider (SARD)

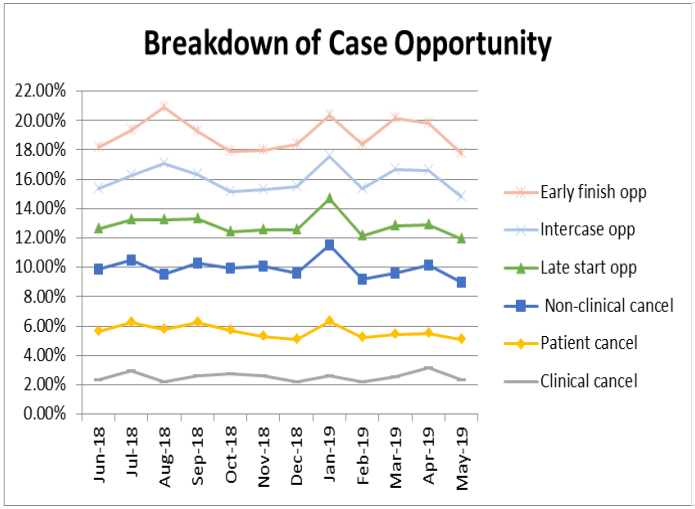
Risk

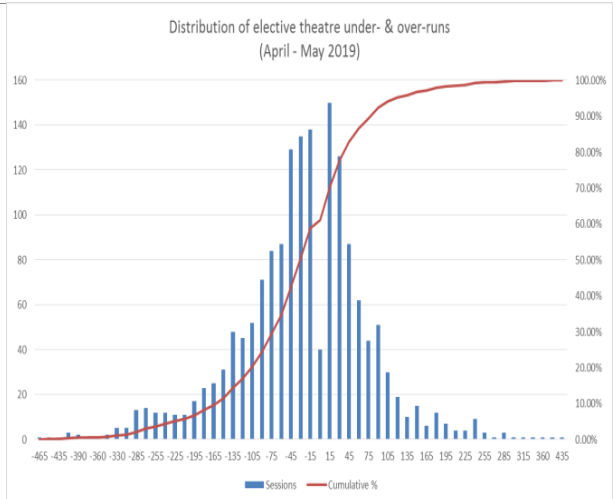
- Is it on the (divisional / corporate) risk register? Yes (Risk ID 2465 – job planning compliance)

Responsive – Theatre management (touchtime utilisation)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will increase elective theatre touchtime utilisation to 95% in line with trajectories	95%	80.6% May 2019	Prof Catherine (Katie) Urch	David Woollcombe-Gosson (Programme manager surgical productivity)







Division	Baseline sessions	Used baseline sessions	Extra sessions within theatres baseline	Extra sessions outside theatres baseline	Session utilisation within theatres baseline
MIC	135	114	3	4	86.67%
SCC	960	854	30	22	92.08%
WCCS	172	165	0	0	95.93%
Trust total	1267	1133	33	26	92.03%

Latest performance	Touchtime utilisation of NHS elective theatre lists improved to 80.6% in May (+0.8% on April). Overall, 92.03% of baseline elective sessions ran, which equates to a combined 74.2% utilisation of planned elective theatre hours. The utilisation chart also shows cases completed as a percentage of perfect opportunity. This tends to be very slightly higher than time utilisation, but illustrates that broadly touchtime utilisation is a decent proxy for opportunity realised. Case opportunity for May was 17.75%. At Trust level this remain broadly equally split between on-the-day cancellations and unused/unscheduled time. Early finishes accounted for 2.9% opportunity. In time terms, 50.5% of sessions underran and 19.7% overran. The mean of all sessions was a 26 minute underrun. Of those sessions that finished early, the mean was 85 minutes under. Of those sessions that overran, the mean was 60 minutes.
Return to target / trajectory	Specialty-level trajectories have been developed. Once aligned with the 19/20 activity plans a aggregated Trust-level trajectory can be generated.

Responsive – Theatre management (touchtime utilisation)

Improvement Initiatives: Surgical Productivity Programme

Programme Aim:	Surgical pathway management efficiently and sustainably enables the delivery of high quality, timely care for patients.	Current status against final state	Partially functioning

Done since last report

- Recovery dashboard for SMH MT
- Theatre brief/de-brief templates (aligned with Safer Surgery)
- Staff consultation on revised POA structure

Doing

- Review & amplify '6-4-2' SOP, including adapted process for urgent elective lists (30 Jun)
- OTD cancellations SOP (30 Jun)
- Piloting 'day by the hour' boards in SIC (30 Jun)
- Medium-term review of anaesthetic workforce requirement (30 Jun)
- Interim scheduling aides memoire (31 July)
- Roll out recovery dashboard for other sites (31 July)
- Piloting Nurse ring & remind at CXH MT
- Piloting adjusted admissions start time at CXH (improving flow through 3W)
- Update procedure times for scheduling in Cerner

Stalled

- Updated cancellation reasons in Cerner (awaiting response from Chel West)
- Finalised 'forward look' report (pending procedure times update in Cerner)

To Do

- Refresh list review process at SMH
- Revised cancellation reporting & monitoring
- Implement POA restructure & patient pathways (following consultation)
- Develop patient optimisation element of POA service

Scoping

- Cerner 'flag' and pathway protocols for vulnerable patients
- Develop pathway with Primary Care for patients unfit for surgery
- Scheduling of emergency patients at HH
- Review of case criteria & SOPs for Riverside theatres
- Improving processes & start times in SMH trauma theatres
- Improving coordination & patient flow to critical care at SMH

Parked

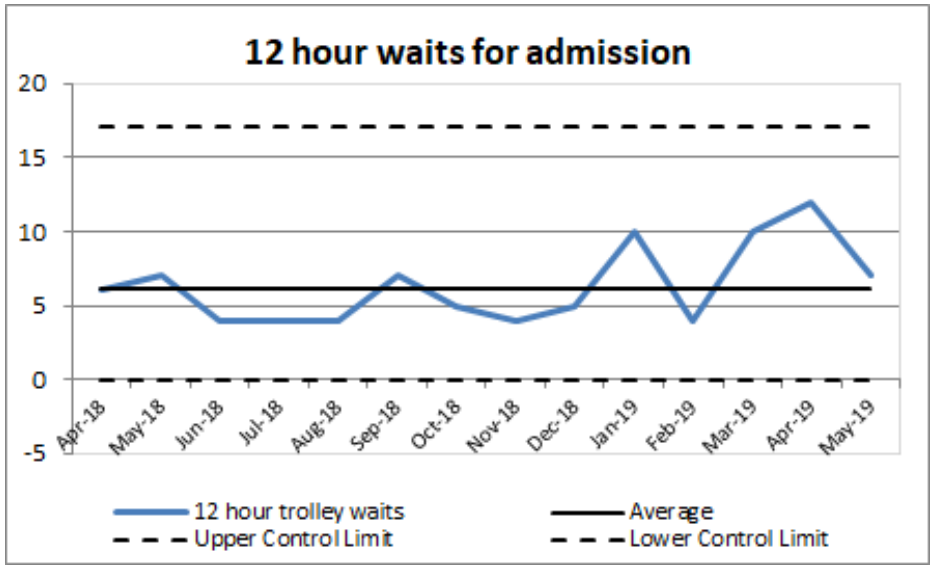
- Expand POA service to other specialties
- Review opportunities for greater use of Care Information Exchange

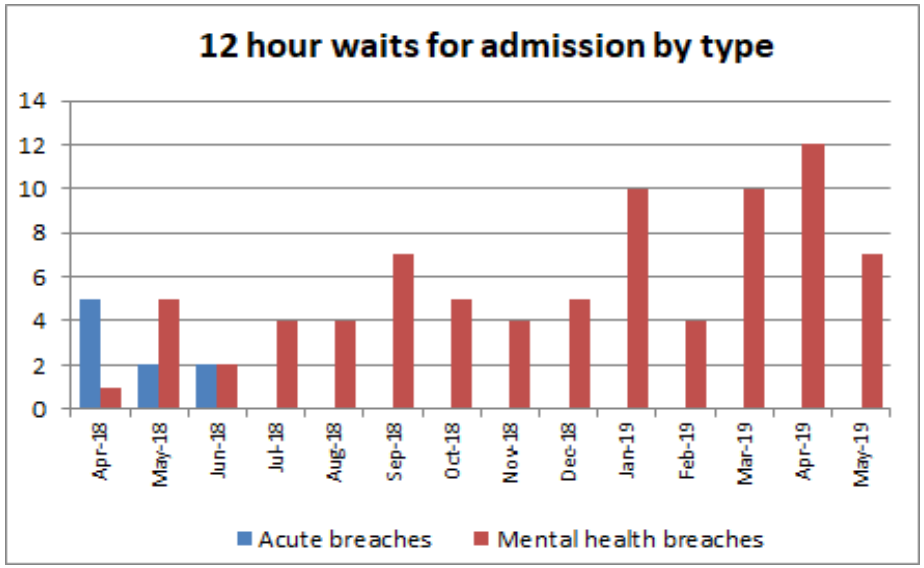
Risk register

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

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

Indicator	Target	Latest data	Executive lead	Report author(s)
Number of waits for admission over 12 hours from decision to admit (DTA)	0 breaches	7 breaches – May 12 breaches – Apr	Dr Frances Bowen	Sarah Buckland





Latest performance	• The number of twelve hour breaches of wait from DTA to admission decrease from 12 in April 2019 to 7 in May 2019. • All breaches in May were delays to admission for mental health provider beds. • 6 breaches occurred at SMH and 1 at CXH; 5 patients were transferred to beds within the greater London area, and 2 outside of greater London.
Return to target / trajectory	• The A&E department is working closely with the two mental health providers to minimise avoidable breaches of this metric. • There is an expectation that trolley breaches for patients requiring an ICHT bed will remain at zero.

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

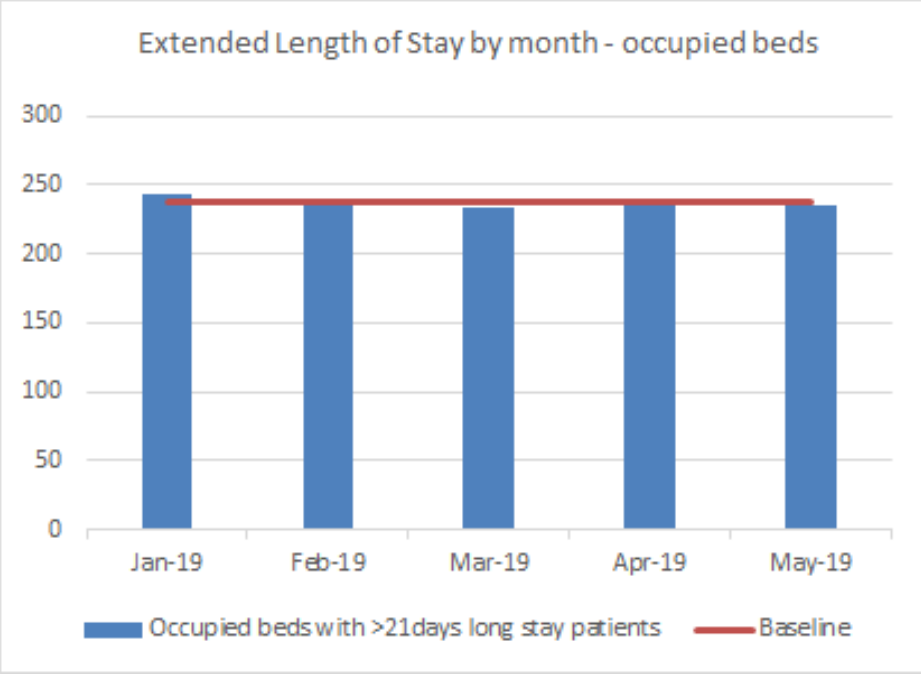
Issues and root causes	• Lack of available mental health beds • Delays with provision of out of hours HTT (Home Treatment Team) and AMHP (approved mental health professional) resource at SMH • Increasing proportion of out of area patients with more complex pathways requiring facilitated transfer to local organisation

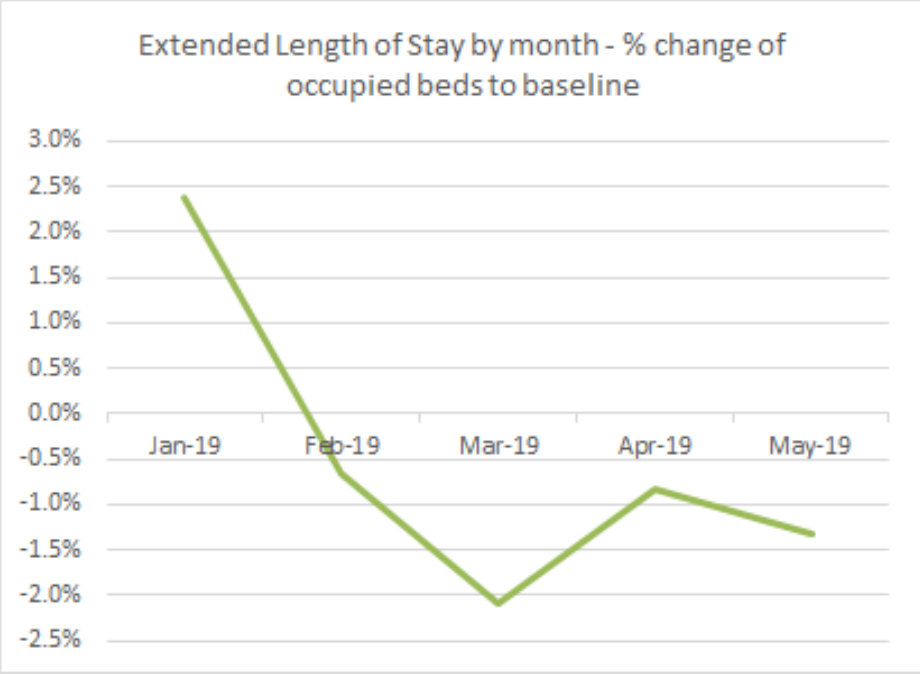
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
CCG to ensure rapid escalation process when funding issues become an obstacle	Milan Tailor (CCG)	In progress	Support from Surge Hub much improved – rapid escalation occurring when necessary
Implement actions from SI reports and monitoring of themes arising.		In progress	Monitored through MIC Q&S Committee
NWL Mental Health Compact agreed standard waiting times for assessment and wait for admission and clarified course of action for homeless and out of area patients.	Lizzy Bovill (NWL CCGs)	In progress	Go live date for compact to be agreed
Joint working group (Big Room) focusing on mental health delays in ED in place.	Barbara Cleaver (ICHT)	In progress	The group have improved documentation, created the new Section 136 suite, ran an education conference for staff and set up the joint meeting at SMH focused on homelessness and rough sleepers in the ED.
Mental Health Delays Improvement safety stream	Trish Ward and Karen Doherty	In progress	Focusing on discharge documentation; ED environment and PEX; availability of MH Beds, AMHPs and HTT; and mental health patients absconding.

Risk register
This performance metric is on the risk register and linked to corporate risk 2493; failure to maintain ED trajectories which includes 12 hour trolley waits, the risk score is currently graded at 20 with a target of 12. It is also linked to corporate risk 2477 risk to patient experience and quality of care in the Emergency Departments caused by the significant delays experienced by patients presenting with mental health issues.

Responsive – Extended Length of Stay

Indicator	Ambition	Latest data	Executive lead	Report author(s)
Reducing long length of stays (LoS) for inpatients	40% reduction in over 21 day LoS	235 – May 2019 236 - April 2019	Dr Frances Bowen, Divisional Director, MIC	Sarah Buckland, Performance Support Business Partner





Latest performance	• In May 2019 there were 235 occupied beds with patients with a length of stay greater than 21 days, this equates to 25.3% of occupied beds (excluding paediatrics and maternity). • Data shows a small improvement from April to May 2019 and a general downwards trend.
Return to target / trajectory	• A national ambition has been set to reduce over 21 days length of stay patients by 40% in 2019/20. This represents a reduction down to 143 occupied beds. • A long length of stay discharge tracking list (LLOS DPTL) is being introduced having been piloted outside of London. This applies to all national Trusts which are being phased into the return ICHT are due to go-live from 19th July 2019.

Responsive – Extended Length of Stay

Issues and root causes	• Medically unfit patients • Patient on rehabilitation pathways • Internal delays within the hospital • External delays within in STP

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Using analytics to ensure focus and resource is deployed to high impact areas, maintaining visibility and senior oversight, improving reporting accuracy and utilising QI approach to affect incremental improvements.	Toby Hyde	Initial analysis completed, monitoring ongoing.	• Daily reporting of all long stay patients is in place • Process is being worked up to report the long length of stay discharge ptl from mid-July, reporting all over 21 day stay patients with ECIST status codes.
Improving governance and clinical ownership by clarifying ownership of discharge process for long stay patients, addressing gaps in the long stay review processes, aligning with ECIST guidance, and having an exec-level oversight of the programme and escalation of issues.	Toby Hyde	Ongoing	• Identification of named 'owners' for top-20 wards completed with long-stay reviews in place on the majority of these wards and the remainder being actioned • Regular reporting and feedback overseen by executive operational committee
Implementing ward-level processes to address underlying issues driving led by the discharge team, providing targeted support with long stay patients and using a consistent coding methodology and reporting on issues driving long lengths of stay.	Toby Hyde	Reporting on drivers on long lengths of stay by 17th May Other area ongoing	• Discharge improvement plan established across Trust and with external partners • Support from site, discharge & therapy teams with long stay reviews (either MDT, roving or site-based) • Common coding approach identified to inform analysis and escalation of recurrent themes
Escalations of recurrent themes through the use of existing internal governance to address sources of 'red days'/internal delays, and the creation of an external group with pan-NWL representation to address recurrent issues as part of an agreed action plan	Toby Hyde	Ongoing	• Internal delays to be aggregated, analysed and reported to the SAFER working group for resolution and escalation • External delays to go to the Urgent Care Working Group that has a dedicated focus on discharge to resolve recurrent causes of external delays

Risk register
• There is no applicable risk related to this standard on the corporate risk register.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Finance Report for June 2019	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 24th July 2019	**Item 12, report no. 09**
Responsible Executive Director: Richard Alexander, Chief Financial Officer	**Author:** Janice Stephens, Deputy Chief Finance Officer Michelle Openibo, Associate Director: Business Partnering

Summary:

This paper provides the Board with an update on the financial position for the Trust as at the end of June 2019.

At month 3 the Trust is on plan year to date and will therefore receive £6.1m of central funding.

The Trust is behind plan with cost improvement programmes and further work is being undertaken to ensure that the full year control total of £16.0m deficit is met.

Capital is behind plan year to date but forecast to catch up in order that the Trust meets its capital resource limit.

Recommendations:
The Committee is asked to note this paper

This report has been discussed at: N/A

Quality impact:
This paper relates the CQC domain well-led.

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

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

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

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

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

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

The report content respects the rights, values and commitments within the NHS Constitution

☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No Should senior managers share this information with their own teams? Yes

FINANCE REPORT – 3 MONTHS ENDED 30th June 2019

1. Introduction

This report provides a brief summary of the Trust's financial results for the 3 months ended 30th June 2019

2. Financial Performance

The Trust has set a plan to meet the control total of £16.0m deficit before Provider Sustainability funding (PSF) and Marginal Rate Emergency Threshold Funding (MRET). After these funding sources the Trust is planning to deliver a £11.1m surplus.

The Trust is on plan in month and for the 3 months year to date i.e. April to June 2019 before central income (PSF and MRET).

	In Month			Year to Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	93.51	91.98	(1.54)	281.90	286.75	4.86
Pay	(53.86)	(54.92)	(1.07)	(160.95)	(164.41)	(3.46)
Non Pay	(39.92)	(38.66)	1.26	(122.83)	(119.60)	3.23
Internal Recharges	0.00	0.00	(0.00)	0.00	(0.00)	(0.00)
Reserves	(0.96)	0.56	1.52	(0.02)	(4.46)	(4.44)
EBITDA	(1.22)	(1.05)	0.17	(1.90)	(1.72)	0.18
Financing Costs	(3.76)	(3.95)	(0.19)	(11.29)	(11.04)	0.24
SURPLUS / (DEFICIT) inc. donated asset treatment	(4.99)	(5.00)	(0.01)	(13.19)	(12.76)	0.43
Donated Asset Treatment	(0.12)	(0.15)	(0.03)	(0.37)	(0.79)	(0.42)
Impairment of Assets	-	-	-	-	-	-
CONTROL TOTAL SURPLUS / (DEFICIT)	(5.11)	(5.15)	(0.04)	(13.55)	(13.55)	0.01
PSF Income	0.84	1.81	0.97	2.53	3.49	0.97
MRET Income	0.85	0.85	-	2.56	2.56	-
SURPLUS / (DEFICIT) after PSF/MRET Income	(3.41)	(2.49)	0.92	(8.47)	(7.50)	0.97

2.1 Provider Sustainability Funding

PSF is assessed on a quarterly basis on achievement of the control total. At quarter 1 the Trust has achieved 100% of PSF. In 2019/20 the Trust has been notified that it will receive additional £0.97m of PSF relating to 2018/19 which explains why PSF is £0.97m better than plan year to date. This funding cannot be used to help meet the control total.

2.2 NHS Activity and Income

The summary table shows the position by division

Divisions	Year To Date Activity			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Total Division of Medicine & Integ. Care	240,182	220,742	(19,440)	70.78	71.26	0.48
Total Division of Surgery, Cancer & Cardiov.	191,651	195,371	3,720	88.48	86.82	(1.66)
Total Division of Women, Children & Clin. Support	646,680	717,369	70,689	40.44	41.01	0.57
Central Income				30.35	37.35	6.99
Clinical Commissioning Income	1,078,192	1,134,933	56,741	230.05	236.44	6.39

The Trust is over performing on income year to date for both local and specialist commissioners. In this year's contract with NWL commissioners, the Trust is paid a marginal rate on over performance. Payment for over performance is not guaranteed and must be agreed across the sector. This contracting arrangement aims to bring closer working within the sector between commissioner and providers helping us to meet he sector control total. The Trust is working closely with other providers and commissioners in North West London to understand the key drivers behind the activity increases and the likely outturn position for the financial year.

Medicine and Integrated Care (MIC) is over performing on non-elective activity. Surgery, Cancer and Cardiovascular (SCC) has underperformed on activity in cardiac. There has also been a reduction in the acuity of clinical hematology patients causing under achievement of income. WCCS is broadly on plan with some over performance in Children's services with increased activity and acuity of patients.

2.3 Private Patient Income

Private patient income is on plan in month bringing the overall position slightly behind plan year to date. The private patient's income target has been increased in year by c£2m. There is income over performance in MIC with additional Neurosurgery activity, there has also been over performance in general medicine. Within SCC there has been over performance on cardiac activity. There continues to be an increase in private imaging activity in the Trust.

2.4 Clinical Divisions

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

		In Month			Year to Date		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Medicine and Integrated Care	Income	24.91	24.47	(0.45)	74.86	75.34	0.48
	Expenditure	(19.61)	(19.88)	(0.26)	(58.76)	(59.49)	(0.73)
	Internal Recharges	(1.05)	(1.19)	(0.13)	(3.16)	(3.08)	0.08
		4.25	3.40	(0.85)	12.95	12.77	(0.18)
Surgery, Cancer and Cardiovascular	Income	29.30	26.85	(2.45)	89.65	87.85	(1.80)
	Expenditure	(25.75)	(24.97)	0.79	(77.17)	(76.74)	0.43
	Internal Recharges	1.48	1.48	(0.01)	4.45	4.83	0.38
		5.03	3.36	(1.67)	16.92	15.93	(0.99)
Women, Children & Clinical Support	Income	14.17	14.22	0.05	42.63	42.75	0.12
	Expenditure	(17.61)	(18.29)	(0.68)	(52.67)	(53.61)	(0.94)
	Internal Recharges	1.88	2.00	0.12	5.64	5.67	0.03
		(1.56)	(2.07)	(0.50)	(4.40)	(5.19)	(0.79)
Imperial Private Healthcare	Income & Expenditure	2.34	2.01	(0.32)	7.11	5.98	(1.13)
	Internal Recharges	(2.31)	(2.29)	0.02	(6.94)	(7.42)	(0.48)
		0.02	(0.28)	(0.31)	0.17	(1.44)	(1.61)
Total Clinical Division		7.74	4.42	(3.32)	25.65	22.07	(3.58)

Clinical Divisions are £3.6m behind plan year to date. The adverse variance to plan is mitigated by favorable positions in corporate areas, mainly estates and medical directorate, and in central income.

MIC is slightly adverse to plan year to date. This reflects costs associated with delivering additional non-elective activity above planned levels; until payment is agreed with commissioners the income over-performance has not been reported in the division.

SCC is adverse to plan year to date. This is mainly due to income underperformance on NHS clinical activity. The division is working to understand the likely future activity profile for the remainder of the year.

WCCS is behind plan year to date and in month. The service has developed a revised establishment and this is being brought to the Trust Executive for review; subject to the outcome of this discussion budgets will be adjusted to reflect expected activity and staffing levels.

Imperial Private Health (IPH) is behind plan on income due to unmet CIPs within the division. There is further investigation being undertaken into the underlying causes of the position.

3. Efficiency programme

The organisation is currently undergoing a process of refreshing the Project Management Office (PMO) function to provide greater oversight of the cost efficiency programme and support to the Divisions. This support will ensure that the PMO function will help identify further CIP schemes, embed efficiencies and set the Trust up to deliver the Specialty Review Programme in future years.

The Trust is £1.4m adverse to plan YTD on CIPs. To mitigate the adverse position work is being completed across the Trust to review pay spend including controlling all temporary staff spend.

4. Cash

Cash balances have increased by £11.6m year-to-date and stand at £38.3m at the end of June. The increase is largely driven by settlement of year-end debtors. Cash has decreased during June driven by increased levels of payments to suppliers and an expected drop in cash receipts.

5. Capital

The Trust's capital programme is focused on tackling the significant challenges arising from the age and condition of the estate whilst continuing to invest in equipment and ICT required to deliver effective services.

The Trust has incurred capital expenditure of £7.5m in the year to date. This is an underspend against the plan of £4.1m which is driven by specific delays on projects around buildings and medical equipment but these are not expected to result in a full year underspend.

The Trust is forecasting to remain within its Capital Resource Limit (CRL) for the year. The final value of the CRL and capital programme is dependent on issues still to be resolved with NHS Improvement and the programme is being managed in line with this requirement.

6. Conclusion

The Trust is on plan year to date. The Trust must identify and deliver the cost improvement programme for the year in order to meet the control total.

7. Recommendation

The Trust Board is asked to note the report.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: CQC Update	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 24 July 2019	**Item 13, report no. 10**
Responsible Executive Director: Peter Jenkinson, Director of Corporate Governance	**Authors:** Kara Firth, Head of Regulation

Summary:

The Board is asked to note an update on CQC-related activity at and/or impacting the Trust. Highlights / exceptions include:

- Following the NHS Improvement use of resources assessment and CQC core service inspections in February 2019, and the CQC inspection of well-led at Trust level in April 2019, the reports and ratings are due to be published on the CQC website in week commencing 22 July 2019.

- The CQC inspected radiology-based imaging services at St Mary's Hospital under the Ionising Radiation (Medical Exposure) Regulations 2017 on 20 June 2019.

  - As a result of a regulatory breach being identified during the inspection, the CQC served the Trust an Improvement Notice.
    - The CQC publishes Improvement Notices on its website.
    - The Trust submitted an action to the CQC on 8 July as required.
    - The Trust must achieve compliance with the regulation no later than 26 August 2019.
  - The CQC will carry out a follow up inspection to confirm the Trust has achieved compliance with the requirements of the Notice; however, at the time of this update, no timeframe has been set for this.

- The CQC inspected the Trust's GP practice on 8 and 9 July 2019. Feedback from the inspection was generally positive and there were no urgent or immediate actions for the Trust to take.

- The Improving Care Programme Group continues to oversee preparations for possible further CQC inspections during 2019/20.

- Since the previous update the CQC's Insight report for May and June 2019 were produced.

- In November 2017 the Trust participated in a national review carried out by the CQC in relation to radiology reporting times. In response to this review, in January 2019 the Royal College of Radiologists undertook a national survey and has now shared the outcomes, which include benchmarking for the Trust.

- There have been several CQC publications since the previous update which are relevant to the

Trust.
Recommendations: To note the updates
This report has been discussed at: The contents of this report have been discussed at the executive (quality) committee and the Trust's Quality Committee.
Quality impact: This paper applies to all five CQC domains.
Financial impact: This paper has no financial impact.
Risk impact and Board Assurance Framework (BAF) reference: This paper relates to Risk 81 (corporate risk register): *Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC.*
Workforce impact (including training and education implications): None
Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☐ No ☒ Not applicable
What impact will this have on the wider health economy, patients and the public? As declared in the Trust's strategic goals below.
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do ▪
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No All aspects of this paper can be included in leadership briefings and can be shared by leaders with all staff.

CQC Update

1. Purpose

1.1 This report is the regular update to the Trust board for CQC-related activity at and/or impacting the Trust.

2. Inspections

2018/19 Inspections

2.1. Following NHS Improvement's use of resources assessment and CQC core services inspections in February 2019, and the CQC's inspection of well-led at Trust level in April 2019, the CQC was due to publish the reports and ratings on its website no later than 19 July 2019.

- The CQC uses an external company to manage its website and there are occasionally delays in publication. Therefore, although the correct link is provided here, the new reports may not appear on the CQC website ahead of this meeting.

2.2. The board is aware that the CQC and NHS Improvement have introduced a new combined rating for acute trusts. The presentation of the new ratings is confusing, however, and the following description of how the Trust's ratings will be presented may help clarify:

- The CQC continues to award ratings based on the outcomes of its inspections, in the same manner as it has previously in terms of domains, core services, overall site and overall Trust ratings. CQC ratings are referred to as 'quality ratings'.
- CQC inspections are wholly separate from the NHS Improvement (NHSI) use of resources assessment (UoR), and the UoR rating awarded by NHSI is wholly separate to the Trust's CQC quality ratings.
- Following the agreement between the CQC and NHSI to share a framework for well-led, they have also agreed that the CQC quality ratings for each domain at the Trust overall (i.e. the Trust's overall ratings) are combined with the NHSI use of resources rating, to generate a combined rating for the Trust.
- It is important to be clear that the combined rating is not the 'overall rating' for the Trust from a CQC perspective:
  - The combined rating is a summary of the sustainability as well as the quality of the care being provided.
  - The CQC's overall quality rating is the summary of the CQC's judgement of the quality of care as experienced by patients. As far as the CQC is concerned, it is their overall quality rating which is the Trust's overall rating.
    - This means that a trust's combined rating may be different from the CQC's overall rating for the trust, as is the case for this Trust - **the combined rating is 'Good' but the CQC's overall rating remains 'Requires improvement'**.

Inspection of Radiology-based Imaging Services at St Mary's Hospital

2.3. The Ionising Radiation (Medical Exposure) Regulations (IRMER) 2017 set legal requirements for the safe and effective use of ionising radiation when exposing patients, and the health and safety of persons working with ionising radiation, in England, Scotland and Wales.

- The CQC is the authority for IRMER in England; its authority for IRMER is conferred under the Health and Safety at Work Act 1974.

2.4. The CQC inspected radiology-based imaging services at St Mary's Hospital under IRMER on 20 June 2019.
- The inspection was to assess compliance with IRMER only. It was **not** an inspection of any CQC core service and did not involve inspection against the CQC standards.

2.5. On 24 June 2019 the Trust was issued with an Improvement Notice as a result of a regulatory breach being identified during the inspection, in relation to Regulation 6 - Employer's duties: establishment of general procedures, protocols and quality assurance programmes. This was because the CQC considered:
- The Trust's IRMER procedures were not detailed enough.
- The underpinning governance framework did not provide sufficient assurance that procedures were ratified and disseminated to staff effectively.
- Lack of evidence that the Trust monitors compliance with IRMER procedures.
- Variation in ways of working among staff, including some practice which was not in line with Trust procedures.

2.6. The Improvement Notice requires the Trust to take action which enables it to be in compliance with Regulation 6 at St Mary's Hospital no later than 26 August 2019.
- The Trust's action plan in response to the Notice was submitted to the CQC on 8 July 2019. Implementation of the action plan will be monitored by the Improving Care Programme Group (ICPG).
- When an Improvement Notice is service the CQC will carry out a follow up inspection to confirm that the Notice has been complied with by the deadline; at the time of this update, the CQC has not indicated when the follow up inspection may take place.

2.7. IRMER inspections are not reported in the same format as other services; rather, they are in letter form.
- The Trust's report letter was received on 28 June 2019.
- The CQC does not publish IRMER letters; however, it does publish enforcement notices and the Trust's Improvement Notice was published on the CQC's website on 17 July 2019.

2.8. No rating is given in relation to an IRMER inspection, nor do the outcomes of an IRMER inspection impact the rating of any core service.

GP Practice Inspection

2.9. The CQC inspected the Trust's GP practice on 8 and 9 July 2019; both sites of the practice, Charing Cross and Hammersmith hospitals, were inspected.
- Feedback was generally positive.
- No concerns were raised which required urgent or immediate action.
- Some aspects which relate to the practice being inside an acute trust, rather than a standalone practice, will be considered further before conclusions are drawn and judgements are made.
- As with all inspections, some aspects require further review of evidence before conclusions are drawn and judgements are made; this is because data and information were submitted after the visit.

2.10. Next steps:
- A single report will be produced which covers both sites where the practice operates.
- The draft version of this report will arrive between four and eight weeks after the inspection.

  - This means the draft report may arrive any time during August 2019.
  - As with all draft CQC inspection reports, the Trust will have 10 working days to identify any factual inaccuracies in the report.
- The CQC will make any amendments to the report as required following the Trust's factual challenges and will publish the final report, including all ratings, on its website.
  - At the time of the inspection, the Trust was advised that the overall ratings for each domain for the practice will be counted along with the Trust's core services, into site and the Trust's overall ratings.
    - The domains are the same for all health services: Safe, Effective, Caring, Responsive and Well-led.
    - Each site and Trust level ratings will be updated when the GP practice inspection report is published.
- At the time of this update, the final report and all ratings for the GP practice are expected to be published sometime in September 2019.

3. CQC Insight

3.1. Two CQC Insight report were produced since the previous update, for May and June 2019.

3.2. The only Trust level highlight from the May report was that the Trust had continued to improve its performance relating to patients spending less than 4 hours in major A&E. Although performance was worse than other trusts on this measure, the Trust had previously been performing much worse than other trusts. However, The Trust's overall A&E performance compared quite well.

3.3. Trust-level highlights for the June 2019 report were:

- The Trust's performance relating to patients spending less than 4 hours in major A&E decreased since May; when compared nationally in June the Trust was again performing much worse than other trusts.
  - However, our overall A&E performance continues to compares quite well.
- The Trust now has fewer ward staff who are registered nurses; previously were performing better when compared nationally, we were performing the same as other trusts.
- The committee will be aware that another never event has been declared; however, this hasn't changed how we compare nationally on both measures: we are worse than other trusts with rule-based risk assessment and the same as other trusts with statistical comparison to bed days.
- Data for the 2018/19 year has shown a decrease in the reporting of certain incidents; the Trust was performing worse than other trusts when compared nationally, for potential under reporting of patient safety resulting in death or severe harm (previously we were the same as other trusts).
- Three more whistleblowings were made to the CQC by Trust staff; we continued to perform much worse than other trusts in relation to this when compared nationally.

4. CQC Publications

4.1. The CQC has published a report from its review of medicines management in health and social care which identifies themes which are specific to acute hospitals, case studies of good practice in acute hospitals, and actions that all acute providers should take.

4.2. The CQC published its annual Adult inpatient survey on 20 June 2019. The outcomes of this survey are managed by the Trust's Patient Experience team, which will report to the board about the survey in due course.

4.3. Earlier this year the CQC launched a year-long programme focusing on four key population groups which research shows have lower awareness about the CQC and in particular, may not raise any concerns about their care.

- The CQC has now published its research specifically relating to people with a black and minority ethnic (BME) background.; however, the CQC has not yet published any reports relating to its research, which means that at present there are no recommendations for the Trust to consider.

5. The Trust's 2019/20 *Improving Care and Assurance Framework*

5.1. 'Intense support' visits focusing on medicines, consumables and equipment have now been completed for the Trust's five main sites (St Mary's, Western Eye, Charing Cross, Hammersmith and QCCH).

5.2. Work is currently underway to carry out its first 'dry run' of the CQC's Provider Information Request (PIR), which will be completed in August 2019, based on data and information for quarter 1 (Q1).

- Going forward, the aim is to refresh the PIR on a quarterly basis, to provide on-going intelligence to the Trust in the format used by the CQC.

5.3. Divisions continue to undertake actions as agreed via the Improving Care Programme Group (ICPG).

- Leads for each core service met with the CEO in July 2019 to discuss the actions they are taking / plan to take to support inspection readiness and to identify current issues for which support will be needed to be prepared.
- Oversight of inspection preparations continues to be overseen by the ICPG.

6. Royal College of Radiologists Position Statement in Response to CQC Review of Radiology Reporting Times

6.1. In November 2017 the Trust participated in a national review carried out by the CQC in relation to radiology reporting times, and published its report from this review in July 2018.

6.2. The Royal College of Radiologists (RCR) took action in response to the CQC's report, including undertaking a UK-wide survey in January 2019 about reporting times and the Trust participated in this. When compared to other services nationally, the Trust is performing:

- Better than all but one other responding organisation for the A&E target.
- Eighth out of 68 responding organisations for the non-urgent target.

6.3. The RCR's survey outcomes were not published; organisations received them via email.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Response to Verita Report and National Recommendations on Managing Misconduct in the Workplace.	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 24th July 2019	**Item 14, report no. 11**
Responsible Executive Director: Kevin Croft, Director of People &Organisation Development	**Author:** Barbara Britner, Divisional Director of People

Summary:

A report outlining the Trust's response to the independent investigation into the death of Amin Abdulla, the Verita Report, was presented to the Trust Board in November 2018. This paper provides an update on those actions as well as performance data on misconduct cases since the publication of the independent investigation in August 2018.

Following publication of the Verita Report NHS Improvement set up a national advisory group to examine issues raised in disciplinary cases in a number of other trusts in order to identify issues and share best practice for all NHS trusts. From this work NHSI have produced national guidance. This paper summarises the Trust's current position in each area and improvements that will be made to meet the recommendations of both the national advisory group and the independent investigation.

The updates and additional recommendations have been reviewed and approved by the Executive People and Organisational Development Committee which, in some cases go further than the national recommendations.

In terms of governance, the new People and Organisational Development structure has strengthen governance at divisional level so that divisional management teams are getting a standardised and structured set of management information to help them manage cases, identify hot spots and intervene pro-actively to reduce the number of formal cases. In addition to divisional governance, oversight at Trust level will continue through the Executive People and Organisational Development Committee.

Recommendations:
The Trust Board are asked to note the update on the Verita Report actions and the response to the national recommendations.

This report has been discussed at:
Executive People and OD Committee

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

Quality impact: Effective performance improvement processes which support staff but also protect patients are critical to our organisation being safe, caring and well-led.
Financial impact: There is no financial impact.
Risk impact and Board Assurance Framework (BAF) reference: The actions delivered so far which are outlined in this paper mitigate risks in the formal approaches to improving performance and deployment of the disciplinary procedures.
Workforce impact (including training and education implications): The updates in this paper are designed to demonstrate the improvements in processes for the workforce.
Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☐ No ☒ Not applicable If yes, are further actions required? ☐ Yes ☐ No
What impact will this have on the wider health economy, patients and the public? Recommendations have been agreed that will apply to all NHS organisations.
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To build learning, improvement and innovation into everything we do
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No If yes, why?..... Most of this information has already been shared via the intranet.

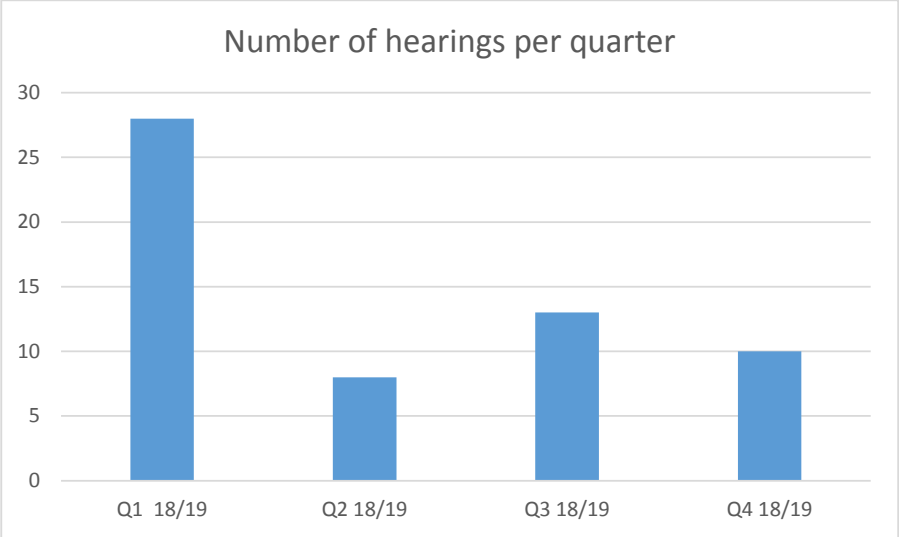
1. Introduction

Following publication of the independent investigation in 2018 into the disciplinary case involving Amin Abdullah, NHS Improvement set up an advisory group. The purpose was to examine the findings as well as issues raised in disciplinary cases in a number of other trusts in order to identify and share best practice for all NHS trusts. This report provides an update on the actions taken in response to the recommendations from the independent investigation alongside those from the national advisory group. Included for information is an overview of the performance data in relation to misconduct cases since the publication of the independent investigation in August 2018. In the ten months since the publication of the independent investigation a significant amount of work has taken place to deliver improvements in the disciplinary procedures at the Trust. They include:

- two new checklists have been introduced into the disciplinary policy. They are carried out by a senior manager at 8c level and above both at the pre investigation stage and should the case progress then again at the post investigation stage.
- all staff involved in a disciplinary procedure are offered access to a staff liaison officer who provides pastoral support.
- managers who undertake investigations or chair a disciplinary hearing attend a bespoke training session designed to equip them for their role in the process.
- monthly executive oversight meetings take place to review live cases, ensure delays are minimised and communication is happening.
- A business case to implement a central investigation team was approved in March 2019 and recruitment is almost complete to establish the team.
- following extensive engagement throughout the Trust a people strategy has been developed with a particular focus on building the capability and confidence of managers to deal with performance issues without relying on formal HR procedures
- the HRBP and employee relations services have been merged and devolved to divisional clusters which became effective from June 2019.
- the Trust has been a key stakeholder on the national advisory project group and played a pivotal role in designing the recommendations to improve disciplinary processes across the NHS.

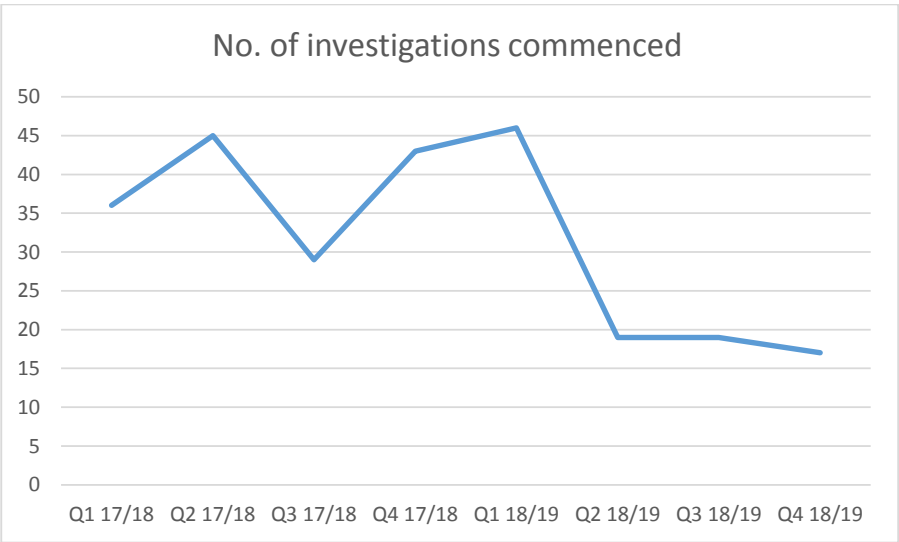
2. Misconduct performance data

There has been a significant reduction in the number of cases that are heard at a formal disciplinary hearing. In 2018/9 there were 59 cases that proceeded to a disciplinary hearing whereas in the previous year there were 89 cases.



The timing of the reduction in hearings coincides with the publication of the independent investigation and the introduction of the two checklists into the disciplinary process.

The number of disciplinary related investigations taking place are declining. Data taken from ER tracker case management system shows that the number of formal investigations initiated in Q2, Q3 and Q4 2018/2019 compared to Q2, Q3 and Q4 2017/2018 have reduced as per the chart below:



The reduction may be as a result of the introduction of the two checklists in the disciplinary process. Further analysis and review over a longer period is required to establish the driver for the reductions in the number of disciplinary hearings and investigations.

3. National Recommendations

The People Committee (which is a sub-committee of the NHS England and NHS Improvement Board) have now endorsed the recommendations of the advisory group and they have been published and are available at appendix 1.

The new national guidance recommends that all Trusts:

- follow current best practice in disciplinary procedures, especially to ensure and be seen to ensure complete independence and objectivity
- apply a rigorous decision-making methodology that provides for full and careful consideration of context and prevailing factors when determining next steps
- ensure everyone involved in a disciplinary process is fully trained to carry out their role
- assign sufficient resource to ensure that disciplinary processes are timely and thorough
- ensure any decision to suspend or exclude an individual is not taken by one person alone or by anyone who has an identified or perceived conflict of interest
- safeguard people's health and wellbeing
- have Board-level monitoring and oversight of disciplinary processes.

The recommendations build on learning from the independent investigation commissioned by the Trust last year. As such, many of the recommendations have already been acted on and we are in the process of making further improvements to ensure they are fully implemented. The additional recommendations have been reviewed and approved by the Executive People and Organisational Development Committee. In some aspects, we are looking to go even further in terms of demonstrating independence and fairness. For example:

- using nationally-recognised expertise, in the form of ACAS, to train Chairs of disciplinary panels
- a dedicated central investigations to improve the quality, reduce bias and speed up investigations
- unconscious bias training for disciplinary panel members
- panel members external to the Trust for the most serious cases where dismissal could be the outcome
- appeals against dismissal to be chaired by an Executive Director
- additional checks and assurance for decisions to suspend
- pastoral support from the Trust's Contact service (counselling and mediation service) for all those involved in disciplinary cases
- executive review of case management to ensure timely completion of cases

Appendix 1 is a summary of the work already undertaken to implement both sets of recommendations from the independent investigation and the national advisory group as well as the planned future work to ensure full implementation.

4. Governance

In terms of governance, the new People and Organisational Development structure has strengthen governance at divisional level so that divisional management teams are getting a standardised and structured set of management information to help them manage cases, identify hot spots and intervene pro-actively to reduce the number of formal cases. In addition to divisional governance, oversight at Trust level will continue through the Executive People and Organisational Development Committee.

5. Recommendation

The Trust Board are asked to note the update on the Verita Report actions and the response to the national recommendations.

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Appendix 1 - National advisory group and Verita Report recommendations with Trust response for implementation:

(R – indicates recommendations from the independent investigation commissioned by the trust. All others are taken from the national advisory group recommendations).

	Current position	Proposed future improvements
Adhering to best practice guidance		
a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published). b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).	Trust disciplinary policy written in line with ACAS code of practice. Core members of the Central investigations team been appointed and will begin taking on cases from September.	Standard operating procedures for the Central Investigations Team will be based on ACAS code of practice. Review the Maintaining Higher Professional Standards process with medical director's office and identify any gaps when compared to GMC principles of a good investigation. Unconscious bias training for those involved in formal procedures and then rolled out throughout the Trust.
Applying a rigorous decision-making methodology		
a) Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps. b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.	Pre and post investigation checklists used to promote a consistent and fair approach and identify at an early stage the extent to which systems failures or procedural flaws are a contributing factor.	Disciplinary hearings will be chaired by a restricted cohort of senior managers. They will receive rigorous training and the number will be limited to ensure that they have the opportunity to develop their skills in making decisions about formal outcomes. Clinical divisions will be asked to nominate 5 senior managers and corporate divisions will be asked to nominate 2 senior managers. They will need to be at 8b and above to

R11 Managers conducting disciplinary hearings should show greater rigour in evaluating evidence, particularly when allegations are poorly defined. R13 Management responses to appeal letters should not be overly defensive and should allow for the fact that evidence is open to different interpretations. R14 Communications after a hearing where a punishment has been imposed should make clear that this is not the end of the process and that the appeal process is a genuine one, which will look at all representations fairly.		comply with the trust disciplinary policy. Future disciplinary hearing panels will have more than one person on the panel. The possibility of having an external panel member when deemed serious misconduct or potential outcome of hearing could be dismissal will be explored in the future. Appeals against decisions to dismiss under the disciplinary procedure will be chaired at director level within the Trust.
Decisions relating to the implementation of suspensions/exclusions		
Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, time bound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.	These principles are already explicit within the current Trust policy and approach.	The process for suspension will be amended. Where a suspension lasts more than 3 days the suspending manager, having already obtained expert advice from P&OD, will need to review the decision with a member of the divisional management team (DDO, DD, DDN or DDP).
Assigning sufficient resources		
Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.	Two training modules are currently provided by P&OD. One for investigators and the other for chairs of disciplinary hearings. In all cases they are not able to progress unless the relevant training has been undertaken.	The advisory, conciliation and arbitrations service (ACAS) a government funded service, has been commissioned to provide future training for chairs of disciplinary hearings. Future disciplinary hearing panels will

R10 The trust should ensure that investigations are given sufficient resources, that reports are of good quality and that allegations are properly defined. R12 Better training should be provided to those who conduct investigations and hearings about how to ask questions, gather evidence, record, classify and evaluate it. Such training should ensure that staff are aware of the danger of relying too heavily on impressions of how people come across at interview. R16 The trust should provide regular written updates to staff under investigation if their case is not dealt with within the agreed time. R18 The trust should give higher priority to ensuring that records of disciplinary cases are properly stored for future reference.	Core members of the Central investigations team been appointed and will begin taking on cases from September.	have more than one person on the panel. Unconscious bias training will be rolled out across the Trust. Central investigation team with expertise will conduct all future investigations into allegations of misconduct. Administration support incorporated into the central investigations team to improve record keeping.
Safeguarding people's health and wellbeing		
Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support. b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate. c) Where a person who is the subject of an investigation or	Pastoral support is offered to all staff involved in a disciplinary procedure. The disciplinary policy is now explicit in the requirement to communicate in person and only use other modes where requested or in exceptional circumstances. Both pre and post investigation checklists prompt consideration of the health of the individual concerned and whether an	All relevant parties will be kept up to date by the central investigation team with progress and key performance indicators will be set to ensure timely conclusions to investigations. Amend the procedure for clinical 'never events' to govern how we respond when a member of staff who is subject to an investigation/disciplinary process suffers serious harm in the same way. For example, include a process for an independent investigation delivered directly to the board. P&OD to work

disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes. R15 The trust should take active steps to support staff going through a disciplinary process. R17 The trust should provide clear guidance on the purpose of internal reviews which should be carried out professionally and with objectivity. It needs to be made clear to authors that their primary objective is to determine the truth rather than tell the organisation what they think it wants to hear.	occupational health review should be undertaken.	with the medical directors' office to make the necessary adjustments. Where an employment tribunal case is lost by the Trust the solicitors will be asked to provide feedback on the case. A review meeting will then take place with the relevant people involved in the case and the Director of People & Organisational Development to identify any lessons learned.
Board-level oversight		
Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.	A quarterly scorecard is produced that has activity and performance data by division.	A detailed report will be prepared on a quarterly basis for the board. It will contain the number of disciplinary hearings that have taken place, reasons and outcome. It will also include information on suspensions.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Values and Behaviours Programme	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 24 July 2019	**Item 15, report no. 12**
Responsible Executive Director: Kevin Croft, Director of People and OD	**Author:** Sue Grange, Deputy Director of People and OD Nate Johnston, Head of Leadership, Talent and Engagement

Summary:
The purpose of this paper is to share the planned values and behaviours programme to be implemented the Trust 2019-20. The programme forms part of the Trust "Leading Change through Vision, Values and Behaviours" programme and follows the launch of the new behaviours framework in April 2019. **Appendix 1** provides a more detailed outline of the programme design.

The programme design has been informed by feedback and evidence from a number of sources including

- The People and OD Strategy and feedback collected during its design
- The content of the behavioral framework itself
- The feedback and 8 themes of the values and behaviours engagement phase between October 2018 and Jan 2019
- The ideas generated from the values and behaviours "big room" to date

It has been designed using a series of design principles based on cultural change best practice, and will focus on a range of interventions directed at the level of

- Individual
- Leader
- Team
- Between team
- Trust

The proposed programme comprises a number of core elements :

1. The identification and development of 100 - 150 plus **Champions** to drive the programme
2. A **CORE module** experienced by ALL staff in the first year delivered by Champions/facilitators
3. A suite of more bespoke **diagnostic tools, interventions and training**, some of which are new and some which are pre-existing, all linked to a specific behaviour to support teams and individuals to work on their local areas of focus.

There is great synergy with the Improvement work programme, including the training programmes, tools and Champions, and the programme would seek to exploit all possible synergies between programmes and dovetail both as closely as possible. It will also directly support the work within the People Strategy to drive forward a culture of Equality, Diversity and Inclusion.

A number of new interventions, tools and training are proposed. The priority areas for implementation are :-

- Pilot the "Active Bystander programme", designed to help individuals challenge negative behaviours and equip individuals with strategies for intervention
- Develop one day training programme on "giving and receiving feedback"
- Developing the champions role, training and recruitment of champions

The key milestones for delivery are:-

Date	Milestone
July 16	Executive agreement
July 24	Board agreement
July –August	Design of tools and interventions Pilot test Active Bystander programme
Late August – mid September	Recruitment of pilot champions
W/C 23 Sept	Training of pilot champions
W/C 30 Sept	Great Place to Work week - Launch Values and behaviours programme via 5 days of 90 minute sessions for leaders
Oct - Nov	Launch of other interventions and tools

The paper was discussed at the Executive Finance Committee on 16 July 2019 and a number of improvements were made to the proposal including:

- Further links to be made to the Equality, Diversity and Inclusion work programme; the aim to *"roll out of a culture where staff from all backgrounds feel included, values and free from discrimination"* has been included in the aims and objectives more explicitly
- Making explicit links to Consultant appraisal and Clinical Excellence Awards to ensure all medical staff engage with the programme
- To develop more specific methods to ensure that the Champions are truly representative of the whole workforce when recruited

Recommendations:
The Trust Board are asked to note the overall aims, content and delivery methods of the programme

This report has been discussed at: Executive Finance Committee

Quality impact: Staff engagement has an indirect impact on the quality of patient experience.

Financial impact: Has no financial impact: Funding has already been identified.

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

Workforce impact (including training and education implications):
The values and behaviours programme aims to have a positive impact on staff engagement. It will comprise a range of training opportunities for staff and is expected to have positive benefit for staff.

Has an Equality Impact Assessment been carried out or have protected groups been considered?
☐ Yes ☒ No ☐ Not applicable
If yes, are further actions required? An impact assessment will be undertaken as the implementation plan is developed in more detail

What impact will this have on the wider health economy, patients and the public?
The Values and Behaviours programmes aims to improve the behaviours of all our staff, and this would directly experience that all our patients, relatives or visitors have when visiting our hospitals or using our services.

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

Trust strategic goals supported by this paper:

- To build learning, improvement and innovation into everything we do

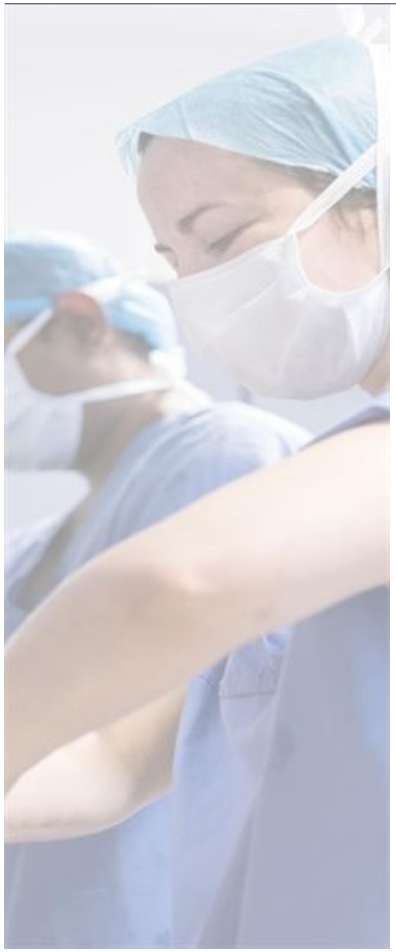
Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No

Appendix 1:
Values and Behaviours Programme

Leading change through vision, values and behaviours

A proposal for the Values and Behaviours programme elements
July 2019

How will this programme help change our culture?



Culture

An organisation's culture can be defined as the values lived by its employees every day – they may not be the same as the stated values. The lived values can be seen as

"The way we do things around here"

Values and Behaviours

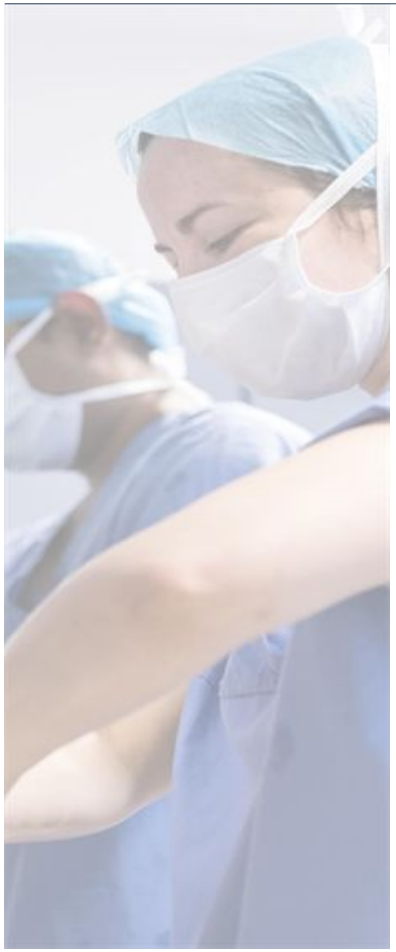
The importance of values and behaviours is neatly summed up in the NHSI Culture and Leadership programme document

"to nurture a high performance culture, we need leaders, leadership behaviours and leadership collaboration aligned around reinforcing the vision, values and behaviours, that are core to the desired culture….. An organisation's values are fundamental to determining how people behave –in particular whether the focus is consistently on ensuring high quality patient care"

NHSI Culture and Leadership Programme Phase 2: September 2017

Through a suite of targeted training, OD interventions and activities, this programme aims to change the culture by embedding the values and behaviours as the way we do things around here

Five key elements of a high quality care culture which encompass values and behaviours



Evidence shows that there are five key elements in high quality care cultures. In collective leadership everyone works to create and support these five elements across an organisation.

Cultural Elements	Values	The way we do things
Vision and values	Constant commitment to quality of care	Everyone taking responsibility in their work for living a shared vision and embodying shared values
Goals and performance	Effective, efficient, high quality performance	Everyone ensuring that there are clear priorities and objectives at every level and intelligent data constantly informing all about performance
Support and compassion	Support, compassion and inclusion for all patients and staff	Everyone making sure all interactions involve careful attention, empathy and intent to take intelligent helping action
Learning and innovation	Continuous learning, quality improvement and innovation	Everyone taking responsibility for improving quality, learning and developing better ways of doing things
Teamwork	Enthusiastic cooperation, team working and support within and across organisations.	Everyone taking responsibility for effective team-based working, interconnectedness within and across organisations, systems thinking and acting

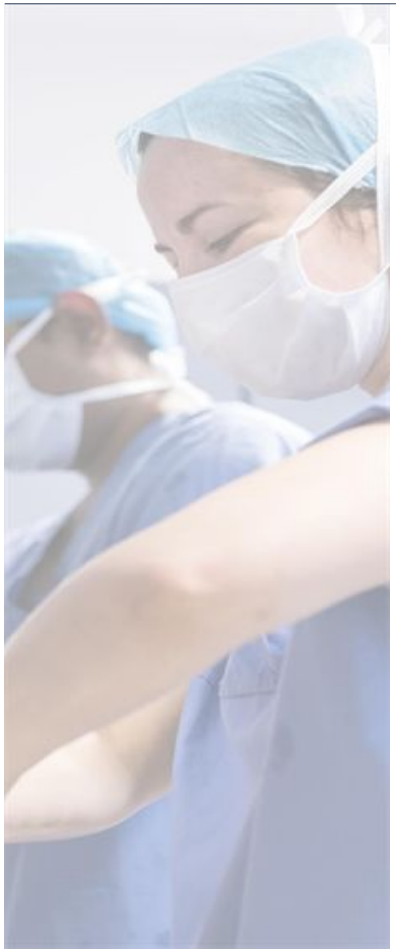
NHSI culture and leadership programme Sept 2017

A summary of our design principles for implementation based on best practice for culture change programmes

Following principles of organisational culture change (i.e. Katzenburg model shown here)

- The programme will reach every substantive member of staff through at least one intervention
- Recruit Local Values Champions to drive roll out (authentic informal leaders)
- The programme should be available to all other people who deliver care to our patients including bank and agency staff, volunteers, honorary staff, contractors
- A range of delivery methods should be available to suit all learners, but the primary focus will be on face to face interactive methods, to foster collaboration and learning
- The programme will be delivered on site in as flexible way as possible, recognising the demands of releasing front line staff
- The focus will be on multi disciplinary experiences to maximise collaboration

What could be the agreed aims and objectives of the programme?



The original aims of a values and behaviours programme proposed to Ex-POD were:

- **To ensure our values and behaviours are at the centre of everything that we do**
- **To encourage the adoption of new behaviours and mindsets**
- **To develop the skills, knowledge and attitudes to support values and behaviours**

Additional suggestions from the Big Room discussions have included:

- **To normalise exceptional behaviours**
- **To enable staff to give feedback**
- **To achieve visible signs that things are different**
- **To ensure new recruits , staff and students are made aware of the values, behaviours and expectations**
- **To help develop a culture where staff from all backgrounds feel included valued and free from discrimination**

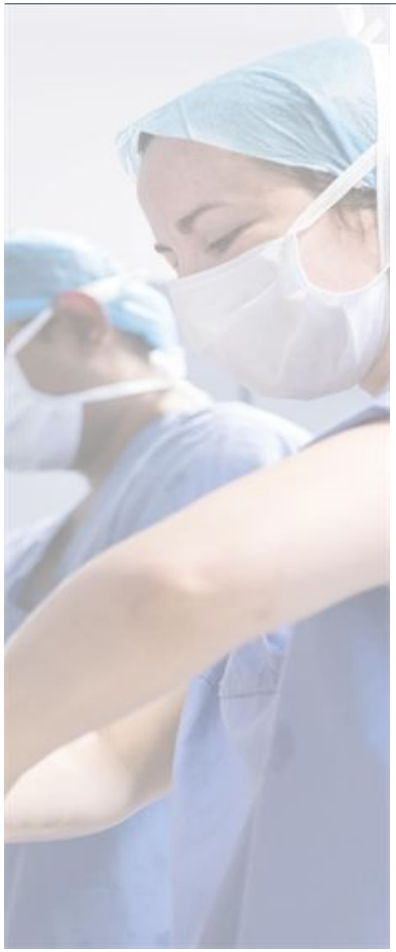
What does success look like?

Feedback from the Big Room included

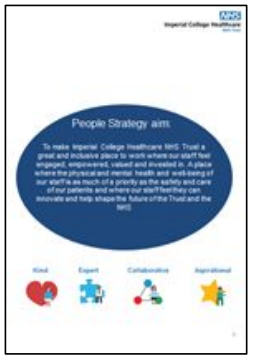
- If asked staff would say we do live our values and be able to describe that to others
- Patients choose to come HERE
- We say hello
- Thinks look different – corporate processes, emails, meetings
- People are offering supportive challenge
- We would see something as soon as we enter the hospital as visitors – welcoming, kind
- People would feel confident to challenge “most of the time” not “some of the time”
- Diversity would be part of what we do
- The values ad behaviours define us , not our role, job title, profession

- People feel this safe to do things without asking permission
- Patent get better communication and feel more looked after
- Staff survey result get better
- Fewer vacancies , improve people working lives, reduce agency expenditure, reduce sickness
- Less use of formal conflict management processes (reduce grievances, disciplinary and bullying and harassment
- Better multi disciplinary working that would improve patient care

The evidence that has been used to inform the programme design and content



The priorities for year 1 have been informed by



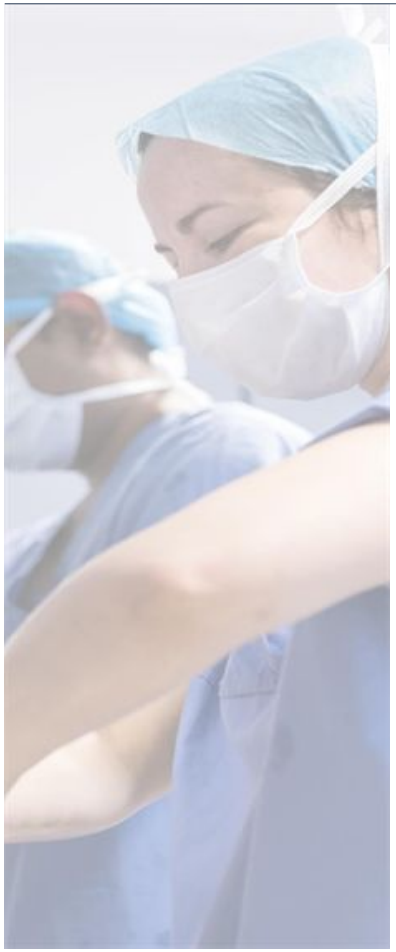
The People and OD Strategy and the feedback collated during its design

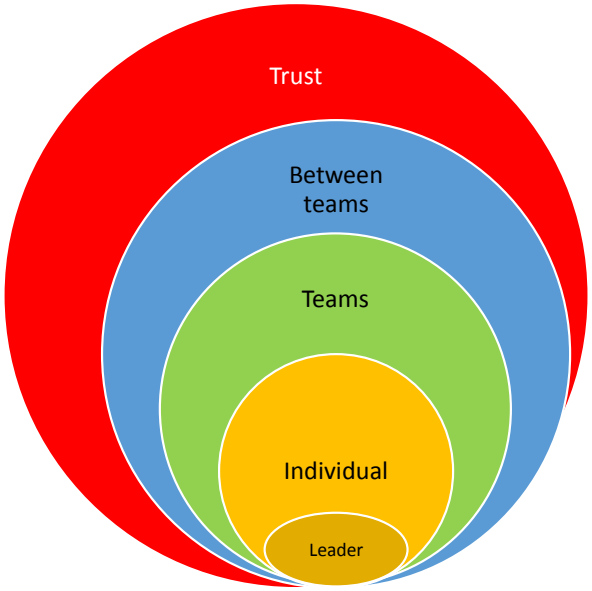
The content of the Behavioural framework and the specific behaviours

The feedback collected during the engagement phase Oct 2019– Feb 2019

The ideas generated in the Values and Behaviors big room to date

The Programme will deliver interventions at 5 levels





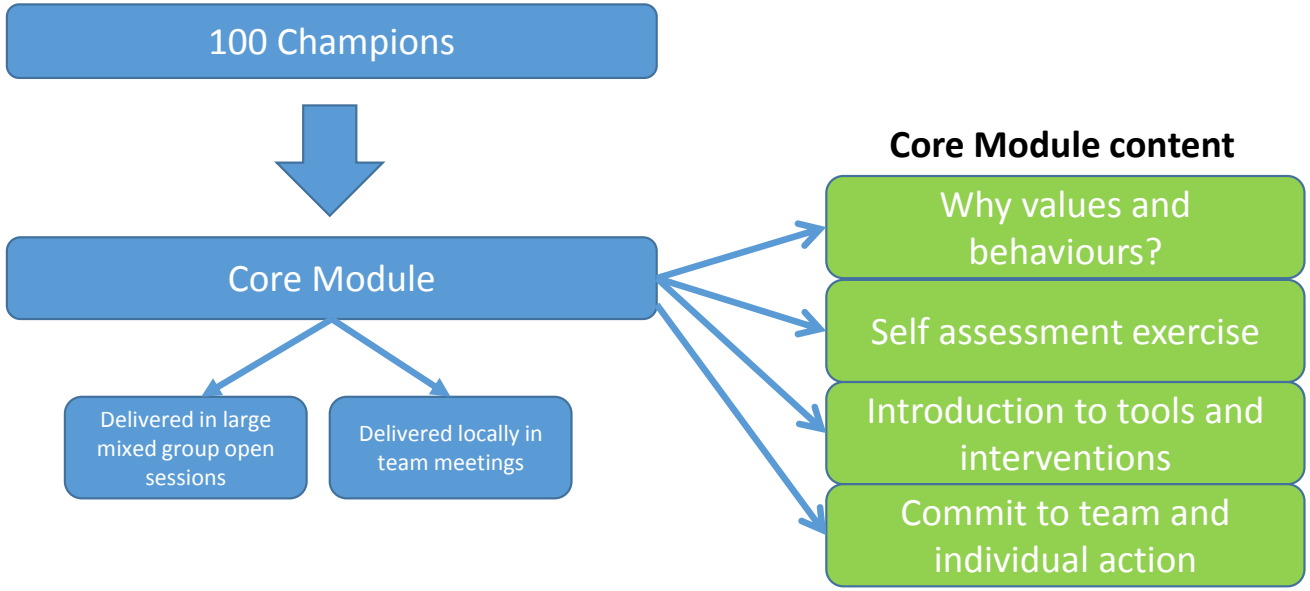
The design of the programme will encompass interventions at the 4 levels shown below, as well as the specific needs of a leader

Trust	Our systems, processes and senior leader behaviours
Between teams	How teams work with each other, especially under pressure
Teams	How staff work with colleagues in their team
Individual	The behaviours and mind sets of individuals
Leader	How managers role model the values, reinforce the good and manage the unwanted

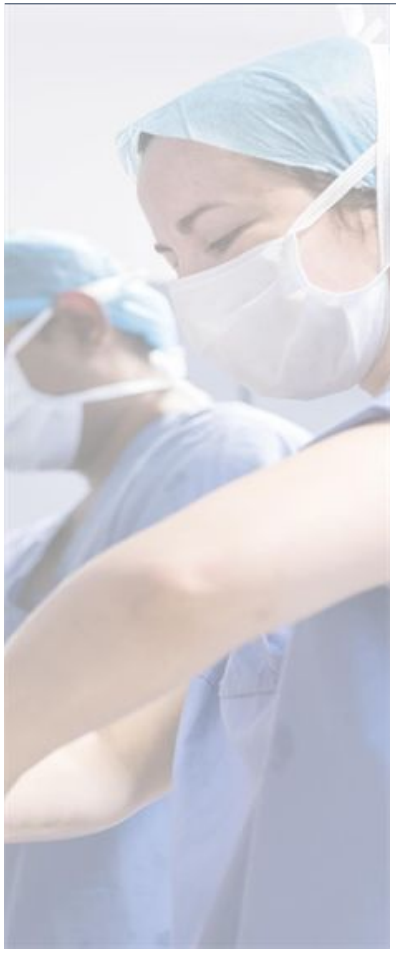
At the core will be 90 minute session experienced by ALL staff – the immersion

- The programme will seek to recruit 100 – 150 plus "Champions" who will engage in bespoke training to undertake the role. Champions should be a diverse range of individuals who are representative of the whole organization

- Each Champion will be allocated 100-150 people to which they will deliver the CORE MODULE and provide follow up support and facilitation



The Programme will include a number of new and existing diagnostic tools to help individuals and teams establish where they are now and how to improve



Diagnostic Tools: How am I doing? How are we doing?

Self assessment Exercise	A self assessment activity which can be done individually or in a one to one setting enable individuals to self rate against the behaviours framework and identify priority areas where they seek to work on/improve	Ready now
Team Diagnostic Tool	An assessment tool to enable teams to assess areas of strength and development against the values and behaviours currently and identify priorities for action	
Multi rater feedback tool/360	A simple tool to enable any staff to collect multi rater feedback	
In our Shoes	A facilitated workshop to identify “what makes a good day” “what makes a bad day”, which includes feedback on behaviours, and enables action planning or improvement at team/dept level	Ready now
Staff Survey feedback	A revised platform will be available to review staff survey feedback from Autumn national survey	

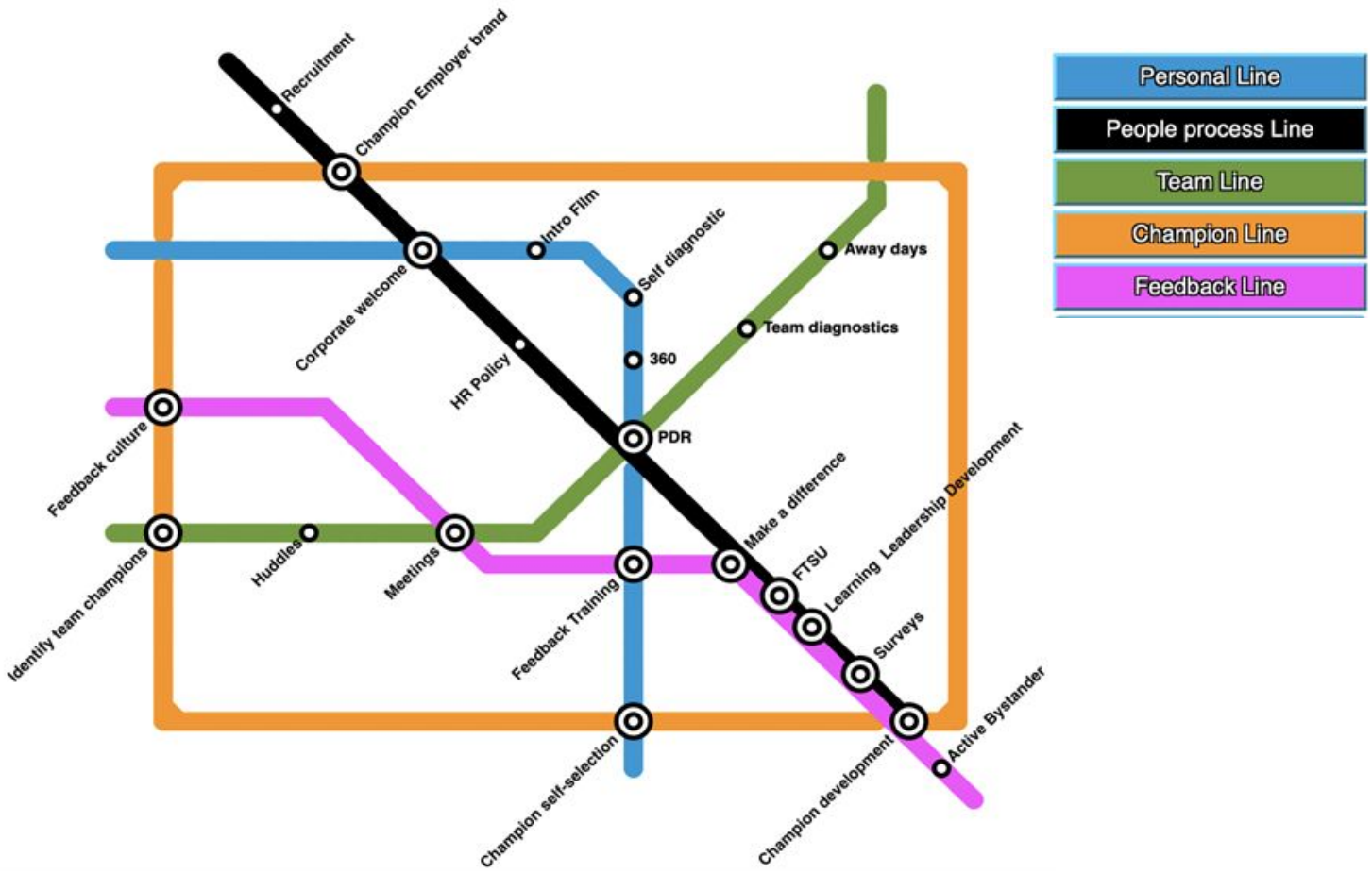
The programme will draw on a wide range of existing or new tools to provide a comprehensive set of interventions

N New programme

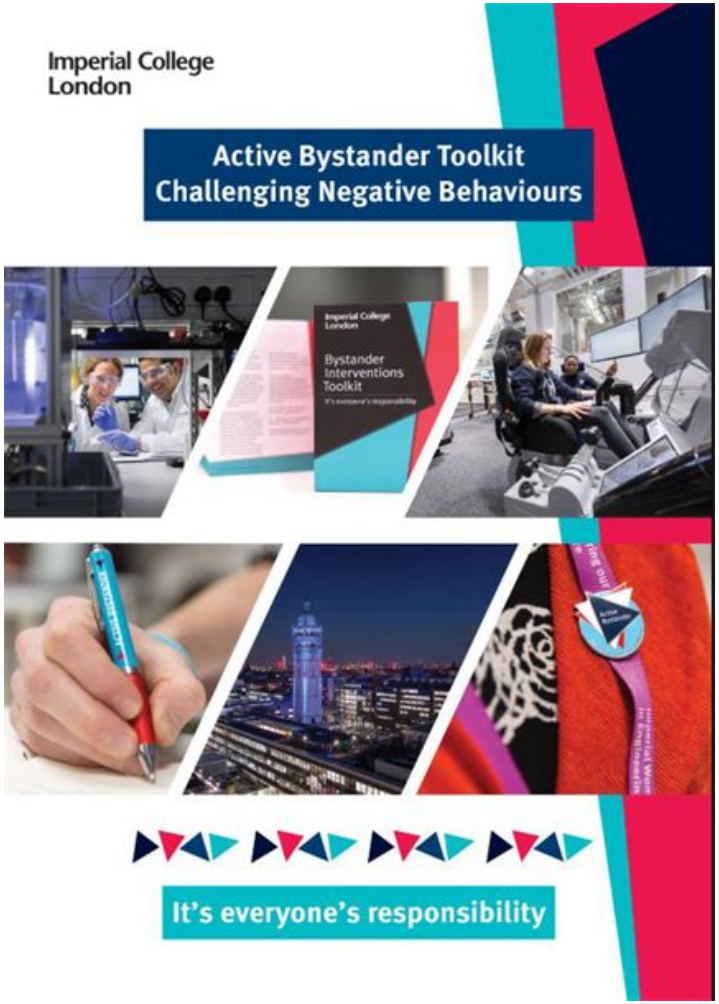
C Programme **Complete** and already available

Individual	Team	Between Teams	Leader	Trust
Self assessment exercise C	Team assessment tool N	In our shoes workshop C	SMART effective meetings training C	Values based MAD scheme
360/multi rater feedback N	In our shoes workshop C	Greatix feedback/MAD feedback N	Greatix feedback/MAD feedback N	Trust Champion network
Active Bystander training N	HOTT programme C	OD Toolkit: "a Fresh look exercise" C	Values based Leadership programmes C	Values based leadership programmes
Greatix feedback/MAD feedback N	Active Bystander training N	Shadowing programme N	Values based PDR training N	Greatix feedback/MAD feedback
Hello my name is…… C	Values Champions N	HOTT programme C	Giving and Receiving Feedback training N	
Unconscious Bias Training N	Huddles C	CLIP training C	Running team devt day training & toolkit N	
OD Toolkit exercises C	Tools for Change (Improvement) C		"Engage" toolkit and workshop C	
Values based PDR N			Values Champion training and CPD N	
Values based recruitment N			CLIP training C	
Values based induction N			Flow coaching academy C	
Improvement training C			HOTT Coaching programme C	

The “Connections” map showing how the different elements of the programme connect to each other



Examples of new interventions



When to be an Active Bystander

- Bullying
- Harassment
- Micro-inequities/Micro-aggressions [1]Small events which are hard to prove, often unintentional and frequently unrecognised by the perpetrator and occurs wherever people are perceived to be different (race/gender, etc.). Individuals may be singled out or overlooked
- Interrupting a person mid-sentence constantly
- Taking more questions from men than women
- Rolling eyes at meetings
- Sighing loudly
- Consistently ignoring emails for no good reason
- Inappropriate or offensive behaviour
- Raising voices in anger and frustration, or losing temper
- Rude, mean, inconsiderate, or unprofessional/ unacceptable behaviour
- Swearing in a professional environment
- Disrespectful or derogatory comments about others, or spreading rumours
- Violation of ethical standards
- Threats or potential violence
- Practices and procedures that may be deemed unfair or have detrimental impact
- Sending aggressive emails or emails sent unnecessarily to large groups with the aim of embarrassing or belittling the target

[1] Rowe, Mary, "Barriers to Equality: the Power of Subtle Discrimination" The Employee Responsibilities and Rights Journal, June 1990, Vol. 3, No. 2, pp. 153-163

The **Active Bystander programme** is a pre written and researched programme developed by an external expert for Imperial College. It has rolled out to 4000 there to date and now organizations around the UK and globally. In a 1 hour session it aims to give delegates the tools, Skills and confidence to challenge Negative behaviours. It can be tailored to our Scenarios (ie patient safety, etc) and rolled out Via "train the trainer" in house

Giving and Receiving Feedback Training Programme

Aims and objectives
To provide staff with the skills , tools and confidence to both give and receive feedback to and from others in the organisation (i.e. manager, peers and team members. Links to our Values and Behaviours Framework

Learning outcomes
- Understand the definition and importance of feedback
- Learn a practical definition of feedback
- Learn how to give positive feedback
- Learn how to give constructive feedback
- Understand how to receive feedback
- Use a simple framework/6 step plan for giving feedback
- Try the techniques and receive feedback on approach and style
- Apply the techniques to "in the moment " feedback as well as performance conversations
- Develop a personal action plan for implementing learning

Delivery
- Designed by external training specialist
- Pilot delivered by external specialist and handed over to Trust for internal delivery

A: 1 day Classroom course
Aimed at all team leaders and managers

B: Half Day course
Aimed at experienced staff with pre existing levels of competency?

C: Interactive Digital learning
Aimed at all staff

Behaviour Link	
KIND	• Help others to challenge unkind or disrespectful behaviour and to understand its impact
EXPERT	• Promote a culture of delivery: highlight issues, challenges and risk in delivery and help find solutions and mitigations • Constantly find improvement opportunities in every aspect of your work
COLLABORATIVE	• Pro actively seek diverse views and feedback in all aspects of your work
ASPIRATIONAL	• Create a culture where achievement is proactively identified and celebrated • Promote a culture of feedback and role model high quality feedback conversations as part of daily practice

Key Milestones

Date	Milestone	Lead
July 16	Executive agreement	Kevin Croft
July 24	Trust board agreement	Kevin Croft
July - August	Design of tools and interventions Pilot test Active Bystander programme (8 August)	POD – Sue Grange
Late August – mid Sept	Recruitment of pilot champions	Divisions
W/C 23 Sept	Training of pilot champions	POD – SG
W/C 30 Sept – 4 October	Great Place to work– Launch Values and behaviours programme via 5 days of 90 minute sessions for leaders	
Oct - Nov	Launch of other new interventions and tools	POD - SG

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Responsible officer's annual report	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 24 July 2019	**Item 16, report no. 13**
Responsible Executive Director: Julian Redhead, medical director	**Author:** Andrew Worthington, general manager

Summary:
The responsible officer is mandated to produce an annual report for submission to the Trust board. The purpose of this report is to detail the activity, policies and procedures in place to manage the process of doctor's appraisals and revalidation. The chief executive officer will then sign a statement of compliance to confirm that the core standards as mandated by NHS England are being met by the organisation.

This report is being presented for review at Trust board, following approval at executive people and organisational development committee (ExPOD) and board quality committee in July 2019. The board is asked to note this report and confirm they are satisfied that "the organisation, as a designated body, is in compliance with the framework of quality assurance (FQA) regulations" to enable sign off and submission to the higher-level responsible officer by 27th September 2019 to NHS England. The full report which includes the statement of compliance is included as an appendix.

Recommendations:
The Board is asked to note this report and confirm that they are satisfied that "the organisation, as a designated body, is in compliance with the FQA regulations" to enable sign off and submission to the higher-level responsible officer by 27th September 2019 to NHS England.

This report has been discussed at (delete/tick as relevant):
☒ Executive people and organisational development committee
☒ Board quality committee

Quality impact:
There is a statutory requirement for the RO to produce an annual report. Medical revalidation aims to improve standards, safety and promote trust in the medical profession. The CQC domains that will be improved from this paper are safe, effective and well-led.

Financial impact:
There is no financial impact associated with this report

Risk impact and Board Assurance Framework (BAF) reference:
There are no risks attached to this report as it demonstrates compliance with the standards. There are two identified risks that may impact on the current financial year's performance - appraisal compliance and honorary contracts/employment checks.

Workforce impact (including training and education implications):
The Trust is strengthening its commitment to the training and development of clinicians by commissioning courses specifically to enhance the appraisal and revalidation process, and increasing the number of independently trained case investigators.

What impact will this have on the wider health economy, patients and the public? None
Has an Equality Impact Assessment been carried out or have protected groups been considered? (see report writing guidance attached for further information) ☒ Not applicable
What impact will this have on the wider health economy, patients and the public? ☒ Not applicable
The report content respects the rights, values and commitments within the NHS Constitution ☒ **Yes**
Trust strategic goals supported by this paper: ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do

Imperial College Healthcare NHS Trust

Responsible Officer's Annual Report 2019

1. Executive Summary

1.1. The responsible officer is mandated to produce an annual report for submission to the Trust board. The purpose of this report is to detail the activity, policies and procedures in place to manage the process of doctor's appraisals and revalidation.

1.2. The report provides assurance of the Trust's compliance with the framework of quality assurance standards as set out by NHS England's responsible officer regulations. The Trust is required to submit an annual report on the activities of the responsible officer, and a statement of compliance signed by the CEO.

2. Purpose

The purpose of this report is to:

2.1. provide the board with an annual report on compliance with the framework of quality assurance (FQA) standards.

2.2. provide assurance of the Trust's compliance with the FQA standards. This will allow the board to approve the statement of compliance (appendix A) required to be submitted to NHS England by the end of September 2019.

3. Background

3.1. The background to the requirement of this report is described in detail within **appendix 1**.

3.2. NHS England monitors compliance with responsible officer regulations via quality assurance audit. As part of this, designated bodies are to adhere to a set of core standards. The Trust is required to submit the following as evidence of performance against these standards:

- An annual report to the Trust board on compliance with these standards (see appendix 1);
- the annual statement of compliance made by the Trust board to NHS England, due by 27 September 2019 (included in appendix 1);
- the annual organisational audit (AOA) end of year questionnaire return to NHS England.

3.3. The annual report has been updated this year to contain items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.

3.4. By providing more qualitative responses, the designated body can demonstrate not only basic compliance but continued improvement over time, and the report should also:

- help the designated body in its pursuit of quality improvement;
- provide the necessary assurance to the higher-level responsible officer;
- act as evidence for CQC inspections.

Imperial College Healthcare NHS Trust

4. Summary/Key points

4.1. The full RO annual report is included as **appendix 1**. The report demonstrates that the Trust meets the requirements for compliance with the FQA and that it meets its statutory duty to support the RO to discharge their duties. The report describes how the standards are met by the organisation and this should provide the assurance required for the Trust board to sign the statement of compliance.

4.2. The annual report was approved at the executive people and organisational development committee (ExPOD) and board quality committee in July, with no amendments required.

4.3. As a designated body, the Trust is reporting an improvement in the number of appraisals completed within the timeframe covered by the AOA (last financial year). The Trust is also stating compliance with the standards required of a designated body.

4.4. There are outstanding challenges that still need to be addressed during this year, most notably reducing the number of overdue appraisals. There are also successes to note, such as not having made any late recommendations during the last financial year. The Trust is also strengthening its commitment to the training and development of clinicians by commissioning courses specifically to enhance the appraisal and revalidation process, and increasing the number of independently trained case investigators.

5. Conclusion and next steps

5.1. This report provides a detailed response to the Framework of Quality Assurance standards as determined by the Responsible Officer regulations and NHS England.

5.2. Once approved by the board, the statement of compliance will be signed by the CEO and submitted to NHS England.

6. Recommendations

6.1. The board is asked to note this report and confirm that they are satisfied that “the organisation, as a designated body, is in compliance with the FQA regulations” to enable sign off and submission to the higher-level responsible officer by 27th September 2019 to NHS England.

Author **Andrew Worthington, General Manager**
Date 17 July 2019

Appendix 1

Responsible Officer's Annual Report – Revalidation & Appraisal

Purpose of the report:

- To provide the Board with an Annual Report on compliance with the Framework of Quality Assurance (FQA) standards;
- To provide the Board with assurance of the Trust's compliance with the FQA standards to allow them to approve the Statement of Compliance (Appendix A) required to be submitted to NHS England.

1. Background

Revalidation is the process by which all doctors with a license to practice are required to provide evidence they are up to date, fit to practice in their chosen field and able to provide a good level of care.

Revalidation strengthens the way doctors are regulated, improves the quality of care provided to patients and patient safety, and increases public trust and confidence in the medical system. Licensed doctors revalidate by having an annual appraisal (based on the GMC core guidance for doctors, *Good medical practice*), and a five-yearly recommendation from their Responsible Officer.

A designated body is the organisation that provides doctors with regular appraisals and support for revalidation. The Trust is a designated body and must have an appointed Responsible Officer (RO) who submits revalidation recommendations to the GMC for all doctors with a prescribed connection to the organisation, based on the output of their annual appraisal. The Trust's primary RO is the Medical Director.

Provider organisations have a statutory duty to support the RO in discharging their duties under the Responsible Officer Regulations. Revalidation recommendations for doctors in training are dealt with by Health Education England.

NHS England monitors compliance with RO regulations via quality assurance audit. As part of this, designated bodies are to adhere to a set of core standards. The Trust is required to submit the following as evidence of performance against these standards:

- An Annual Report to the Trust Board on compliance with these standards (this report);
- the Annual Statement of Compliance made by the Trust Board to NHS England, due by 27 September 2019;
- the Annual Organisational Audit (AOA) End of Year Questionnaire return to NHS England.

The annual report has been updated this year to contain items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.

By providing more qualitative responses, the designated body can demonstrate not only basic compliance but continued improvement over time, and the report should also:

- help the designated body in its pursuit of quality improvement,
- provide the necessary assurance to the higher-level responsible officer,
- act as evidence for CQC inspections

1.1. Statement of Compliance

Each core standard is outlined below with the Trust assurance response and the Chief Executive is asked to sign a Statement of compliance with these standards which can be found at the end of this report.

Section 1 - General

***Statement 1* – The Annual Organisational Audit (AOA) for this year has been submitted**.

The Annual Organisational Audit was submitted to NHS England on 5 June 2019. This showed an overall appraisal rate of 90% for doctors completing their appraisal within 28 days of the due date in the last financial year. The aim is to improve this figure during this financial year.

***Statement 2* - An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.**

Professor Julian Redhead is the Trust's Responsible Officer. Dr Geoff Smith, Associate Medical Director for Professional Development, was appointed as the delegate RO in May 2018 dealing with daily revalidation and operational issues. Both Professor Redhead and Dr Smith have completed RO training and have participated in RO network events over the last year.

***Statement 3* - The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.**

There have been no funding or resourcing issues to report in the last year and none anticipated in the current year. The Trust is committed to ensuring the RO carries out the responsibilities of the role effectively.

***Statement 4* - An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained.**

The Professional Development (PD) Team is part of the Medical Director's Office and reports to the General Manager. The PD Team maintains and verifies an accurate electronic record of all doctors with a prescribed connection to the Trust using the GMC Connect database.

***Statement 5* - All policies in place to support medical revalidation are actively monitored and regularly reviewed.**

The Trust Appraisal/Revalidation policies have been widely disseminated and are located on the intranet. The Appraisal and Revalidation policy was ratified in 2018 and is set for review in February 2021.

***Statement 6* - A peer review has been undertaken of this organisation's appraisal and revalidation processes.**

It is a requirement for the NHS England Higher Level RO (HLRO) to review services once in every five year appraisal cycle. The HLRO Quality Review Visit was completed in 2018. The key recommendations following this visit were to appoint a number of appraisal leads, ensuring they are supported in their roles; and to develop a strategy to tackle overdue appraisals.

Six appraisal leads have been appointed and this has been communicated via the RO newsletter. The Trust has a focussed plan to reduce the number of overdue appraisals, and performance is reported monthly.

The RO and PD team have continued to target the number of overdue appraisals and made significant improvements in reducing the number of appraisals overdue by more than six months.

This will remain a priority for this financial year.

***Statement 7* – A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.**

The Trust takes a pro-active approach to the professional development of all doctors, regardless of the nature of their employment or prescribed connection. All employed doctors have access to study leave and support from the PD team for appraisal and revalidation and job planning if required, regardless of the length of their employment. The PD team provide both 1:1 advice and facilitate drop-in sessions monthly across all of the Trust sites.

There is regular communication and a focussed set of actions for those within the group who are overdue.

Section 2 – Effective Appraisal

***Statement 1* – All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.**

The PREP revalidation e-system is used by the Trust and it offers doctors a platform which encompasses the GMC domains and requirements for revalidation. This includes the doctor's full scope of work, fitness to practise, complaints, significant events and outlying clinical outcomes. Datix reports are also used to strengthen the portfolio of evidence for revalidation. As part of the assurance process for revalidation, the PD team ensures that appraisals are robust and meet the GMC requirements.

***Statement 2* - Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.**

Since its inception in 2012, revalidation/appraisal has evolved and through national and Trust promotion and support, doctors have become more knowledgeable and familiar about the processes and more proficient at completing a robust appraisal on schedule. In the event that an appraisal lacks the requirements to meet the GMC standards, the team would alert the RO who would review and make a recommendation to the individual doctor.

The PD team maintains a list of overdue appraisals, and suitable action is taken if the RO deems that the individual is not engaging. The electronic system records special circumstances which is used to provide mitigation for late or overdue appraisals and includes long-term leave such as maternity or sick leave.

***Statement 3* - There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).**

The Appraisal and Revalidation policy was ratified and published in 2018 and is set for review in February 2021.

***Statement 4* - The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.**

In 2018/2019 the Trust had 227 active appraisers which met the recommended ratio of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners (1:5/6). The PD team are working closely with clinical divisions to ensure there are enough appraisers within each directorate.

The Trust supports appraisers to fully undertake their role through the provision of accredited training courses. For this financial year, four one-day courses on 'Appraisal for Revalidation' were commissioned from the Royal College of Physicians and offered to 100 existing and aspiring appraisers. Two days have been delivered in this financial year, with 50 appraisers participating, and two further days are scheduled in autumn.

Statement 5 **- Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).**

Following the HLRO visit, the Trust has appointed six appraisal leads, which provides additional scope for peer review and support of appraisers. The RO is working closely with the appraisal leads on programmes supporting the development of appraisers, raising the profile of professional development and establishing focus groups for key pieces of work, such as the procurement for a single electronic system for appraisal and job planning. The appraiser's appraisal is also a forum through which there can be reflective discussion on performance. In March, the anonymous feedback from the appraisee was shared with all appraisers who had completed more than five appraisals in the last two years, which can be used as evidence for their own appraisal. As previously noted, the Trust offers training/refresher courses to consultants, the most recent delivered by the RCP.

Statement 6 **– The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.**

In 2018, NHS England conducted their Higher Level R.O. Quality Review Visit. The outcome and actions were reported in last year's annual report. The Trust has also participated in the NHS England AOA and annual report.

Section 3 – Recommendations to the GMC

Statement 1 - **Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.**

Since last year's AOA the Trust has made 320 GMC revalidation recommendations and 24 deferrals. Completed appraisal rates are reported on a monthly basis to the Trust board.

Revalidation notices are sent via internal email six months ahead of the doctor's revalidation date and at this stage the doctor becomes 'under notice'. There is focussed communication from the PD team to support the doctor in gathering their evidence and preparing for their final appraisal before revalidation. By targeting doctors individually, the PD team effectively manage the revalidation

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

process and are able to highlight any potential deferrals in advance. All deferrals are made in exceptional circumstances and are all sanctioned by the RO. In the last financial year, The RO did not make any late recommendations.

Statement 2 - **Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.**

Submitted recommendations are confirmed via email or phone conversation, and the consultant will receive a notification from the GMC. If deferral is indicated, it is discussed in advance of any action between the individual doctor and RO, and the doctor is made aware of the requirements for a positive recommendation. Although there is a policy in place for doctors who do not engage with the revalidation process, the RO did not make any referrals for non-engagement since the last AOA.

Section 4 – Medical governance

Statement 1 **- This organisation creates an environment which delivers effective clinical governance for doctors.**

There are systems in place in the organisation that support and promote the protection of patients. This includes clinical incident reporting, a serious incident investigation framework, clinical audit and NICE guidance, regulation, complaints, and concerns raised via other bodies, such as the GMC. Doctors are encouraged to reflect on all aspects of their practice, including complaints, concerns and clinical incidents, at any time, but specifically as part of their annual appraisal.

When responding to any GMC queries, or ahead of a revalidation recommendation, all Trust information systems (e.g. Datix) are consulted. The Medical Director's Office maintains a database of outcomes from GMC enquires and investigations and shares this information with the relevant doctor to ensure there is the required reflection.

Statement 2 **- Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.**

The Trust has access to several information systems which are used to monitor performance locally, nationally and against peer groups. The Getting It Right First Time (GIRFT) programme can be used to highlight individual clinical issues, while CRAB and Dr Foster intelligence look at both individual and specialty performance and outcomes. Other local examples include the Surgical Outcomes Group and the Mortality Review Group. By combining high level data with local date, such as Datix, the Trust is able to effectively monitor the performance of doctors which can be used as part of the appraisal process.

Statement 3 - **There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.**

The Trust has a policy for responding to concerns about a doctor's practice, 'Handling Concerns About Doctors and Dentists' Conduct, Performance and Health' which is based on the Maintaining High Professional Standards (MHPS) framework. This policy was ratified in 2018 and provides details, including flow charts, on every stage of the process. The policy also describes the key personnel required in the membership of panels for hearings, the appeals procedure and the role of external or independent panel members.

***Statement 4* - The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].**

There are several processes in place to ensure that concerns about a doctor are handled appropriately. The first point of call is with the GMC Employer Liaison Service (ELS) and the RO has a regular review meeting with the named individual for the organisation. There are routine discussions with Practitioner Performance Advice (PPA) about all excluded or restricted doctors, and the RO will seek advice from PPA even if the case does not warrant exclusion. There is a designated non-executive director who has a direct link to the RO to provide advice and support. The RO will convene decision making panels, including lay representation as required, to decide on case management on an ad hoc basis.

Internally, there is a monthly case review meeting with the HR Consultant, HR Director, RO, GM and AMD PD to review all active cases, and to ensure progress is being made against timelines. Reports are submitted to executive committees which detail disciplinary cases on a quarterly basis. Restrictions and exclusions, number of live cases, outcomes and protected characteristics all need to be reported to the board more formally during this financial year.

***Statement 5* - There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].**

The organisation is fully committed to working in partnership with other organisations, and to cooperate with investigating any concerns raised about doctors. There are systems in place to share information with external organisations when required, ensuring principles for data protection are adhered to. The records of local investigations and management of concerns are stored electronically. All appraisal and revalidation information is managed by an electronic system (PREP).

Direct RO to (external) RO discussions between organisations are by initial email or telephone contact, with a scheduled telephone discussion followed by email follow-up. Key decisions are communicated by letter to support telephone conversations. The RO and deputy RO arrange cover for leave to ensure a named person is available at all times.

***Statement 6* - Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).**

The organisation utilises both the GMC ELS and PPA to discuss concerns, and there is a full-time HR consultant within the Medical Director's Office to support the MHPS, grievance and disciplinary processes.

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Decision making panels with lay representation and NED involvement for recommendations on how to proceed with cases and to confirm or scrutinise investigation findings. The organisation is increasing the number of available trained case investigators to approximately thirty by hosting a bespoke two-day training programme led by PPA in July 2019.

The Trust has access to a number of Freedom To Speak Up guardians.

As detailed in response to statement 4, there is a monthly case review meeting with the HR Consultant, HR Director, RO, GM and AMD PD to review all active cases.

Section 5 – Employment Checks

Statement 1 **- A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties**.

There are systems in place within the organisation to ensure pre-employment checks are undertaken for all doctors, including locums and doctors in short-term employment, which is managed by the Medical Staffing department of HR.

The PD team undertake further verification of the correct contract, licence to practice and revalidation details takes place when the doctor connects to the Trust.

Local departments will review CV's for locums to ensure they have the required skills and undertake local inductions prior to undertaking their role.

Overseas doctors are supported to pass English language tests prior to taking up employment and encouraged to participate in GMC-run courses which provide a welcome and overview to practicing in the UK.

Section 6 – Summary of comments and overall conclusion

This report provides a detailed response to the Framework of Quality Assurance standards as determined by the Responsible Officer regulations and NHS England.

As a designated body, the Trust is reporting an improvement in the number of appraisals completed within the timeframe covered by the Annual Organisation Audit (last financial year). The Trust is also stating compliance with the standards required of a designated body.

There are outstanding challenges that still need to be addressed during this year, most notably reducing the number of overdue appraisals. There are also successes to note, such as not having made any late recommendations during the last financial year. The Trust is also strengthening its commitment to the training and development of clinicians by commissioning courses specifically to enhance the appraisal and revalidation process, and increasing the number of independently trained case investigators.

Overall conclusion:

The Board is asked to note this report and confirm that they are satisfied that "the organisation, as a designated body, is in compliance with the FQA regulations" to enable the Statement of compliance to be submitted to the Board for sign off and submission to NHS England by 27 September 2019.

Section 7 – Statement of Compliance

The Board of Imperial College Healthcare NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).
Signed on behalf of the designated body

(Chief executive or chairman)

Official name of designated body: Imperial College Healthcare NHS Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _
Role: _ _ _ _ _ _ _ _ _ _ _ _
Date: _ _ _ _ _ _ _ _ _ _

APPENDIX A

Designated Body Statement of Compliance

The executive management team of Imperial College Healthcare NHS Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments: Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: Yes

4. Medical appraisers participate in on-going performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments: Yes

5. All licensed medical practitioners[4] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners, which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments: Yes

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments: Yes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible of-

[4] Doctors with a prescribed connection to the designated body on the date of reporting.

ficer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments: Yes

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[5] have qualifications and experience appropriate to the work performed; and

Comments: Yes

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: Yes

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Signed: _

[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

[5] Doctors with a prescribed connection to the designated body on the date of reporting.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Annual update on safe, sustainable and productive nursing and midwifery staffing	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 24 July 2019	**Item 17, report no. 14**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Author:** Priya Rathod, Deputy Director of Quality Governance Sinead O'Neill, Senior Nurse Workforce, Regulations and Revalidation

Summary:

The following paper is split into two parts:

Update on key initiatives being undertaken by the Trust

- The future supply of the nursing and midwifery workforce is a well-documented challenge for all NHS Trusts in the UK at the present time.
- Since May 2018, the Imperial 'strategic supply of nursing' business case outlined the number of key initiatives that are being undertaken in light of the current national nursing and midwifery staffing landscape.
- The Trust has developed a comprehensive set of schemes to help mitigate the impact of the anticipated skills shortages, which is being led by the Director of People and Organisation Development.
- A safe staffing task and finish group led by the Director of Nursing, are driving forward the key work streams in response to the publication of 'Developing workforce safeguards'
- The Trust has successfully undertaken a range of actions to grow and develop its nursing and midwifery workforce and include the introduction of; the nursing associate role, apprenticeships in nursing and advanced clinical practitioner roles.

Annual nursing and midwifery establishment review

- A range of national guidance/recommendations on safe staffing has published over the recent years. More recently, the publication by NHSI of Developing workforce safeguards in October 2018 outlined a number of new recommendations designed to support Trusts in making informed, safe and sustainable workforce decisions.
- In particular, it is important to note that from 2019/20, NHSI will annually assess Trusts' compliance with the 'triangulated approach' to deciding staffing requirements as described in the NQB's guidance.
- An annual establishment review has been undertaken for nursing and midwifery in March 2019
- All clinical areas (inpatient, outpatient, theatres, endoscopy, renal satellite units, support services etc.) have been included.
- Overall, there has been a reported increase of 142.68 WTE in the nursing and midwifery establishment when compared with the data from the establishment review undertaken in March 2018.
- A detailed breakdown of the data by division can be found in **Appendix 1.**
- The next mid-year establishment review will take place by September 2019 and reported to Trust Board in November 2019.

Recommendations:
The Board is asked to note the report and the findings from the establishment review.

This report has been discussed at:
- Executive Committee (People and Organisation Development) – 9 July 2019
- Quality Committee – 10 July 2019

Quality impact:
Ensuring we have the right nursing and care staff in place to respond to patient's needs positively impacts the 'Safe', 'Caring' and 'Well-led' CQC domains.

Financial impact:
The financial impact of this proposal as presented in the paper enclosed:
- No additional financial impact outside of divisional budgets

Risk impact and Board Assurance Framework (BAF) reference:
Corporate risk rating 12

Workforce impact (including training and education implications):
The impact is captured within the detail of the paper

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

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

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

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

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
- A number of sustainable, productive and safe nursing and midwifery staffing initiatives are underway at the Trust.
- A mid-year establishment review of nursing and midwifery has taken place.

Annual Update on Safe, Sustainable and Productive Nursing and Midwifery Staffing

1. Introduction

The annual establishment review forms part of a process by which the Trust and its nursing and midwifery staff ensure that we have the right number and skill mix of staff to provide safe nursing and midwifery care.

The establishment review is in two main parts. The annual detailed review and a mid-year desk top review. The establishment can be reviewed at any time during the year if there are service changes, concerns about safety or if acuity is increased or reduced.

The establishment is the planned number of staff needed to ensure the correct number of staff are available to cover the care patients require. We also monitor the actual staff required as well as the care hours per patient day on a daily basis.

2. Background

The supply of nursing and midwifery staff has been an emerging problem over recent years. The growing demand for nursing and midwifery staff caused by an ageing population with multiple co-morbidities, coupled with advances in drug therapies and technology, has put pressure on Trusts' abilities to recruit enough nursing and midwifery staff to meet demand. The Trust vacancy level is 15.5% and 25% for Band 5 nurses.

Innovative solutions like the introduction of nursing associates and apprenticeship nurse training will go some way to meet this demand and reducing vacancies. However, there still remains a big challenge to fill vacancies. The Trust has in place a number of work streams to recruit to vacancies, e.g. Recruitment and Retention premium, student direct offer and overseas recruitment. We also have a number of retention initiatives, e.g. careers clinics and an internal transfer scheme. The plan is under review and will be refreshed and revised by the Executive Committee in August.

3. Background and policy context

Trust Boards have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. These rights are set out within the NHS Constitution, and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18.

A range of national guidance/recommendations on safe staffing has published over the recent years and includes:

- The National Quality Board's (NQB) guide to nursing, midwifery and care staffing capacity and capability(2013) which was subsequently updated in 2016 and more recently in January 2018;
- NICE guidelines 'Safe Staffing for nursing in adult inpatient wards in acute hospitals' (2014);
- The Lord Carter report (2016) recommends the implementation of care hours per patient day (CHPPD) as the preferred metric to provide NHS trusts with a single consistent way of recording and reporting deployment of staff working on inpatient wards/units.

More recently, the publication by NHSI of Developing workforce safeguards in October 2018, outlined a number of new recommendations designed to support Trusts in making informed, safe and sustainable workforce decisions across all groups (including; doctors, AHPs and scientists).

The document offers advice on governance issues related to redesigning roles and responding to unplanned changes in workforce, and it describes NHS Improvement's role in helping providers achieve high quality, sustainable care by assessing the effectiveness of workforce safeguards

annually.

In particular, it is important to note that from 2019/20, NHSI will annually assess Trusts' compliance with the 'triangulated approach' to deciding staffing requirements as described in the NQB's guidance which combines evidence-based tools, professional judgement and outcomes.

As part of the annual assessment, NHSI will also seek assurance through the standard operating framework (SOF), in which a provider's performance is monitored against five themes. In addition, Trusts will be required to confirm their staffing governance processes are safe and sustainable in their annual governance statement.

4. The process

The Trust undertakes an annual and mid-year nursing and midwifery establishment review to provide assurance both internally and externally that ward establishments are safe and that staff are able to provide appropriate levels of care to patients. The annual nursing and midwifery establishment review follows the mid-year review which was undertaken in September 2018 and presented to this Committee and Trust Board in November 2018.

The following part of this report presents the outputs of the annual establishment review undertaken in March 2019.

4.1 Establishment review process

- The establishment reviews for all areas have been undertaken by Directorate teams and approved by the Divisional Directors of Nursing (DDN) and the Divisional triumvirates during March - June 2018.
- Since completing the establishment reviews, each of the DDNs have met with the Director of Nursing to discuss their approach, the findings, the assurances that they have taken with regard to clinical quality and patient outcomes and the level of engagement and involvement they have had with their staff during the process.
- They have also confirmed that any change in the establishments is reflected in the divisional baseline budgets.
- All clinical areas (inpatient, outpatient, theatres, endoscopy, renal satellite units, support services etc.) have been included.

4.2 Establishment review findings

- Overall, there has been a reported increase of **142.68 WTE** in the nursing and midwifery establishment when compared with the data from the establishment review undertaken in March 2018.
- A detailed breakdown of the data by division can be found in **Appendix 1.**

4.2.1 Division of Women's, Children's and Clinical Support Services

TABLE 1 - Division of women's, children's and clinical support services							
March 2018	September 2018	March 2019	March 2018 to March 2019	March 2019			
Establishment WTE	Establishment WTE	Establishment WTE	Annual change to establishment WTE	Registered nurse/midwife and unregistered care staff WTE		Registered nurse to unregistered care staff ratio	
				RN	CS	RN	CS
872.07	879.04	888.07	+16.00	692.39	195.68	78%	22%

Overall there has been a reported increase of 16.00 whole time equivalents (WTE) when

compared to the establishment data reported for March 2018.
Key reasons for this are:

- Additional staff to support the new paediatric intensive care unit (PICU);
- An increase in the establishment within the imaging service as part of an approved business case to support additional activity.

Whilst the establishment has increased overall within the division, there has been a reduction in the number of whole time equivalents (WTE) over the past 12 months in some areas such as maternity and outpatients due to a review of skill mix and roles.

4.2.2 Division of Surgery, Cancer and Cardiovascular Sciences

TABLE 2 - Division of surgery, cancer and cardiovascular sciences							
March 2018	September 2018	March 2019	March 2018 to March 2019	March 2019			
Establishment WTE	Establishment WTE	Establishment WTE	Annual change to establishment WTE	Registered nurse and unregistered care staff WTE		Registered nurse to unregistered care staff ratio	
				RN	CS	RN	CS
1,546.01	1572.45	1,620.51	+74.50 reported (+56 actual)	1,340.20	280.31	83%	17%

Overall there has been a reported increase of 74.50 WTE when compared to the establishment data reported for March 2018. However, it is important to note that the **actual** increase is 56 WTE.

The reported increase of 74.5 WTE is broken down as follows:

- An actual increase of 56 WTE due to:
  - A review and change in skill mix due to a reduction in activity in some areas that has created new Advance Nurse Practitioner and pre-assessment nursing roles.
  - Increased acuity of patients due to the co-location of the ITU and HDU at the St. Mary's site.
  - An increase in the bed base and therefore activity in Fraser Gamble ward.
  - An increase in GI and private patient activity
- An 'increase' of approximately 18.5 WTE can be attributed to an establishment reconciliation exercise where posts that were previously incorrectly assigned as 'scientific and technical', have now been correctly assigned as nursing posts. These are *not* new or additional posts but are nursing posts that were not previously included in the establishment figures.

4.2.3 Division of Medicine and Integrated Care

TABLE 3 - Division of Medicine and integrated care							
March 2018	September 2018	March 2019	March 2018 to March 2019	March 2019			
Establishment WTE	Establishment WTE	Establishment WTE	Annual change to establishment WTE	Registered nurse and unregistered care staff WTE		Registered nurse to unregistered care staff ratio	
				RN	CS	RN	CS

1,659.59	**1667.47**	**1703.10**	**+43.5**	**1,273.97**	**429.13**	**75%**	**25%**

Overall there has been a reported increase of 43.50 WTE when compared to the establishment data reported for March 2018.

Key reasons for this are:

- The bed base on AAU has increased from 13 to 24 as of April 2019 and therefore the establishment has been increased by 25.53 to support this.
- Additional staff to support bed 'flexing' on Peters Ward.
- A range of skill, case and band mix reviews to ensure appropriate staffing.

4.2.4 Imperial Private Healthcare

	TABLE 4 – Imperial Private Healthcare						
March 2018	**September 2018**	**March 2019**	**March 2018 to March 2019**	**March 2019**			
Establishment WTE	**Establishment WTE**	**Establishment WTE**	**Annual change to establishment WTE**	**Registered nurse and unregistered care staff WTE**		**Registered nurse to unregistered care staff ratio**	
				RN	**CS**	**RN**	**CS**
188.11	**196.58**	**196.78**	**+8.67**	**153.87**	**42.91**	**78%**	**22%**

Overall there has been an increase of 8.67 WTE when compared to the establishment data reported for March 2018.

Key reasons for this are:

- Review of skill mix
- Increased activity
- Provision of additional services

5. Next steps

A mid-year establishment review will take place in September 2019 and the outputs reported to Trust Board in November 2019.

6. Recommendations

The Board is asked to note the report and findings from the establishment review, which have been discussed and approved at Executive Committee (People and Organisation Development) and Quality Committee.

Appendix 1 – Divisional summary of annual establishment review findings

	March 2018	September 2018	March 2019	March 2018 to March 2019	March 2019		March 2019	
Clincial Division	Total registered nurse and unregistered care staff WTE	Total registered nurse and unregistered care staff WTE	Total registered nurse and unregistered care staff WTE	Annual WTE Change to establishment	Registered nurse	Unregistered care staff	Registered nurse to unregistered care staff ratio	
							RN	CS
Women's children's and clincial support	872.07	879.04	888.07	16.00	692.39	195.68	78%	22%
Surgery, Cancer and Cardiovascular sciences	1,546.01	1,572.45	1,620.51	74.50	1,340.20	280.31	83%	17%
Medicine and Integrated care	1,659.59	1,667.47	1,703.10	43.51	1,273.97	429.13	75%	25%
Imperial Private Healthcare	188.11	196.58	196.78	8.67	153.87	42.91	78%	22%
GRAND TOTAL	4,265.78	4,315.54	4,408.46	142.68	3,460.43	948.03	78%	22%

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Trust Board and Committee self-assessment review of effectiveness 2018-19	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 24th July 2019	**Item 18, report no. 15**
Responsible Executive Director: Peter Jenkinson, Director of Corporate Governance	**Author:** Ginder Nisar, Deputy Trust Secretary

Summary:

Best practice guidance, The Healthy NHS Board 2013 states that the purpose of NHS Boards is to govern effectively and in doing so build patient, public and stakeholder confidence that their health and healthcare is in safe hands. Effective NHS Boards demonstrate leadership by undertaking three key roles: formulating strategy; ensuring accountability; and shaping a healthy culture. Effective Board and Committees are a key part of an effective governance accountability structure and compliance with best practice.

This report deals with the effectiveness of the Trust Board in discharging its duties in line with the Trust's Standing Orders and also provides a summary of the Board Committees' effectiveness reviews in line with their Terms of Reference (ToRs).

The questionnaire developed by the Audit Commission to aid as a tool to reflect on the effectiveness of Committees was used for the self-assessment of the Trust Board and its Committees. Members were invited to complete the questionnaire reflecting on 2018/19 and rate the effectiveness of the Trust Board in response to 24 statements, using the scale set out in appendix 1. Out of 22, 13 responses were received and the results are attached at appendix 1. It should be noted that in quarter 3 of 2018/19 there were changes in the Trust Chair and Non-Executive Directors.

When compared with the previous year's results, the scores improved in the Non-executive Directors (NEDs) and Executive Directors categories except for the processes section of the Executive Directors where the score decreased. The standing attendee means decreased more notably. Areas of particular strength are:

- Understanding of key financial issues
- Reaction to bad news
- Perceived to have a positive impact
- Right people invited to attend and present at meetings
- Sufficient commitment to undertake responsibilities

The lowest overall mean score was given to 'concise and relevant information' (3.2). Actions have already been taken for Board papers to be more concise with more pertinent information. A low score was also give to 'adequate resources' (3.4) which will be explored further to understand the resource issues.

General comments included consideration of the timing of the private Trust Board meeting; and

diversity amongst the Board members across the protected characteristics as well as life and work experience. The former will be discussed as part of the wider review by the Chair and the Trust Secretary, and the latter is being addressed as part of the NED recruitment campaign currently underway.

The summary of the mean results are:

	Non-executive director mean (4/8 respondents)	Executive director/Team mean (7/12 respondents)	Standing attendee mean (2/2 respondents)
Behaviours	4.6 2017/18 – 4.2 2016/17 – 4.3	4.0 2017/18 – 3.8 2016/17 – 3.9	3.3 2017/18 – 4.1 2016/17 – 4.0
Processes	4.3 2017/18 – 4.2 2016/17 – 4.2	3.6 2017/18 – 3.9 2016/17 – 4.0	3.9 20/1718 – 4.2 2016/17 – 4.0
Mean result of all questions	4.4 2017/18 – 4.2	3.8 2017/18 – 3.9	3.6 2017/18 – 4.2
All mean	4.0 2017/18 – 4.1		

Board Committee effectiveness

A similar process of self-assessment has been completed for all Board committees, and the feedback and recommendations from this process has been reported to the respective Committees for their respective consideration. The Redevelopment Committee will receive the results at its next meeting and a review of the Appointments and Remuneration Committee did not take place due to only one original remaining member for the year of review. A summary of all the mean scores is attached at appendix 2.

The areas of strengths and weaknesses arising from the reviews are shown below. The results from the Committees show a general improvement in effectiveness, in both behaviours and processes. Common themes across committees show positive responses in a number of areas and those requiring improvement also identified.

Audit, Risk & Governance Committee

Areas of particular strength (4.3 and above):

- Appointment and independence of external audit
- Rigour of debate
- Clear terms of reference
- Sufficient number and timing of meetings
- Understanding of core business, business model and risks
- Quality interaction with internal auditors and counter fraud
- Role in relation to whistleblowing

Scores 3.5 and below:

- Feeding back to board meetings

Redevelopment Committee

Areas of particular strength (4.3 and above):

- Rigour of debate
- Frank, open working relationship with exec directors

- Open channels of communication
- Clear terms of reference
- Right people invited to attend and present at meetings

Scores 3.5 and below:
- Understanding of the risk management framework
- Understanding of key financial issues
- Appropriate links with other board committees

Finance and Investment Committee

Areas of particular strength (4.3 and above):
- Understanding of core business, business model and risks
- Reaction to bad news
- Frank, open working relationship with exec directors
- Impact at board level
- Clear terms of reference
- Right people invited to attend and present at meetings

Scores 3.5 and below:
- Appropriate links with other board committees

Quality Committee

Areas of particular strength (4.3 and above):
- Sufficient number and timing of meetings

Scores 3.5 and below:
- Concise and relevant information
- Members with appropriate skills and experience

Next steps

It is considered good practice to reflect on effectiveness of the conduct of the Trust Board and its Committees in order to assess how well the Board and its Committees are performing against their remits as set out in the Trust's Standing Orders and Committee Terms of Reference (ToR). The results of this questionnaire will be taken into consideration when the Committees review their ToRs in September 2018, however several activities are planned or underway which is likely to bring the review of TORs forward. These activities include the recruitment of NEDs to fill the current NED vacancies on the Board thereby bringing a new set of skills and experiences to the Board; new Trust Chair who will take a view over the next few months of the remits of the Committees – both of these activities will entail reallocation of NED Chairs to Committees. The review of the Terms of reference will also take into consideration the recommendations of the internal audit report of divisional and Board governance which took place in March/April 2019 as well as the results of the effectiveness reviews.

Recommendations:

The Board is asked to:
- note the results of the surveys
- note the next steps to consider the outcomes
- consider if there are any particular areas of further improvement you would wish to see

This report has been discussed at:

The outcomes have been discussed at the respective Committee. The Redevelopment Committee will discuss its results at its next meeting.

Quality impact:

No direct impact on quality of service, but related to the Well-led domain within CQC framework.

Financial impact: The paper has no direct financial impact.
Risk impact and Board Assurance Framework (BAF) reference: Ensuring an annual self-assessment of the effectiveness of the Board Committees lessens the risk that the Committees' contribution to assurance and oversight is reduced.
Workforce impact (including training and education implications): N/A
Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☐ No ☒ Not applicable If yes, are further actions required? ☐ Yes ☐ No
What impact will this have on the wider health economy, patients and the public? N/A
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To build learning, improvement and innovation into everything we do
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No

Appendix 1

Results of the Trust Board effectiveness review 2018/19

2019 Trust Board	NED mean	Exec mean	Attendee mean	***ALL mean***
Behaviours	**4.6**	**4.0**	**3.3**	**4.0**
1. Understanding of core business, business model and risks	**4.5**	**4.1**	**4.0**	**4.2**
2. Understanding of the risk management framework	**4.5**	**4.1**	**4.0**	**4.2**
3. Understanding of how assurance is gained	**4.3**	**4.1**	**2.0**	**3.5**
4. Focus on appropriate areas	**4.3**	**3.9**	**3.5**	**3.9**
5. Understanding of key financial issues	**4.3**	**4.1**	**4.5**	**4.3**
6. Rigour of debate	**4.8**	**3.9**	**3.5**	**4.0**
7. Reaction to bad news	**4.8**	**4.0**	**4.0**	**4.3**
8. Quality of chairmanship	**4.5**	**4.0**	**2.5**	**3.7**
9. Frank, open working relationship with exec directors	**5.0**	**4.0**	**1.5**	**3.5**
10. Open channels of communication	**4.8**	**4.3**	**2.0**	**3.7**
11. Perceived to have a positive impact	**4.5**	**4.3**	**4.0**	**4.3**
12. Impact at board level	**4.5**	**4.1**	**4.0**	**4.2**
13. Appropriate links with other board committees	**5.0**	**3.4**	**4.0**	**4.1**
Processes	**4.3**	**3.6**	**3.9**	**4.0**

14. Clear terms of reference	**5.0**	**3.6**	**4.5**	**4.4**
15. Sufficient number and timing of meetings	**4.8**	**3.3**	**4.5**	**4.2**
16. Right people invited to attend and present at meetings	**4.8**	**3.6**	**4.5**	**4.3**
17. Concise and relevant information	**3.0**	**3.7**	**3.0**	**3.2**
18. Timely information	**3.8**	**4.0**	**4.5**	**4.1**
19. Sufficient commitment to undertake responsibilities	**4.8**	**4.0**	**4.0**	**4.3**
20. Contribution at meetings	**4.5**	**3.7**	**3.5**	**3.9**
21. Feeding back to board meetings	**4.5**	**4.3**	**3.5**	**4.1**
22. Adequate resources	**4.8**	**3.4**	**2.0**	**3.4**
23. Members with appropriate skills and experience	**4.0**	**3.0**	**4.5**	**3.8**
24. Role in relation to whistleblowing	**3.8**	**3.6**	**4.5**	**3.9**
MEAN OF ALL QUESTIONS	**4.4**	**3.8**	**3.6**	**4.0**

Scale
n/a = Not applicable or unknown
1 = Hardly ever/Poor
2 = Occasionally/Below average
3 = Some of the time/Average
4 = Most of the time/Above average
5 = All of the time/Fully satisfactory

Appendix 2
Summary of all reviews

Summary sheet - Trust board and committees self-assessment 2019

	Non-executive directors		Executive directors		Attendees		All	
Committee	Behaviours	Processes	Behaviours	Processes	Behaviours	Processes	Behaviours	Processes
Trust board	4.6	4.3	4.0	3.6	3.3	3.9	4.0	4.0
Audit, risk & governance	4.5	4.2	4.3	4.2	3.6	4.0	4.1	4.1
Finance & investment	4.6	4.6	4.2	4.2	3.7	3.7	4.2	4.2
Quality	4.2	4.1	4.0	4.1	3.7	3.9	4.0	4.0
Redevelopment	4.2	4.5	3.8	4.4	3.8	3.9	3.9	4.3
Remuneration	N/A							

1 - Hardly ever / Poor
2 - Occasionally / Below average
3 - Some of the time / Average
4 - Most of the time / Above average
5 - All of the time / Fully satisfactory

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC SUMMARY REPORT	
Title of report: Audit, Risk & Governance Committee **–** report from meeting on 3 July 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 24 July 2019	**Item 19.1, report no. 16a**
Responsible Non-Executive Director: Sir Gerald Acher, Deputy Chair	**Author:** Jessica Hargreaves, Deputy Trust Secretary

Summary:

The Audit, Risk and Governance Committee met on 3 July 2019. Key items to note from that meeting include:

External Audit report
The Committee received an update from the Trust's external auditors, and reviewed the draft annual audit letter and the draft management letter which outline the main findings and conclusions of the external audit work undertaken in 2018/19.

Internal audit progress report
The Committee received the internal audit progress report, noting progress of work against both the 2018/19 and 2019/20 audit plans. The Committee were pleased to note improvements in data quality but felt it was important to have a deep dive review into data quality across the Trust to gain a deeper understanding of where the current gaps and risks were for the organisation.

Local Counter Fraud Service (LCFS)
The Committee received the counter fraud update and were pleased to note that the Trust was on schedule against the annual plan. In terms of reactive work, eight fraud referrals were carried forward from 2018/19, of which five had been closed by quarter 1. Five new referrals had been received to date one of which had been closed in quarter 1.

Corporate risk register, key divisional risks and board assurance framework
The Committee reviewed the corporate risk register and agreed changes as recommended by the executive. We also noted the key risks for each division. The continuing risk relating to band 2-6 nursing and midwifery vacancies was discussed and committee members noted the work ongoing to improve this. The board assurance framework was reviewed and committee members noted that the updated version of the framework had been mapped to the new strategic objectives of the Trust. The next step would be to map individual risks to the appropriate board committee but for the Audit, Risk & Governance Committee to have the oversight of the complete framework; committee members welcomed this approach.

Raising concerns
The Committee received an update on concerns raised by staff directly to the HR team (including concerns raised through the 'freedom to speak up' process) and chief executive's office from October to March 2019. Each of the concerns raised has been – or is being – reviewed to ensure proper process and outcomes.

Committee self-assessment
The Committee reviewed the annual self-assessment findings and next steps.

Tender waiver & Losses and special payments reports
The Committee received and noted a summary of the number and value of waivers for 2018/19, and noted a summary of losses and special payments made in the previous year. Committee members were pleased to note improved billing and income processes in line with the legislation and noted that further work looking at a weekend overseas' team was in progress.

The Committee will next meet on Wednesday 2 October 2019.

Recommendations: The Trust Board are requested to note this report.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Remuneration and Appointments Committee – report from meeting on 19th June 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 24th July 2019	**Item 19.2, report no. 16b**
Responsible Non-Executive Director: Peter Goldsbrough, Chair of Remuneration Committee	**Author:** Peter Jenkinson, Director of Corporate Governance & Trust Secretary

Summary:
The Remuneration and Appointments Committee met on 19th June 2019. Key points to note include:

CEO annual review of performance 2018/19 and objectives for 2019/20
The Committee received and considered the completed NHS Improvement appraisal form for the CEO, noting in particular the difficult context in which Prof Orchard took on the role and the impact that he had had over the year.

The Committee noted that discussions were ongoing to confirm Prof Orchard's objectives for 2019/20, including personal development objectives, noting the challenges faced by the Trust and Prof Orchard in the next year.

Executive team appraisals
The Committee received a summary of individual 2019/20 objectives for executive team members and received a verbal summary of the outcome of appraisal discussions regarding 2018/19 objectives.

The Committee noted that the CEO and Chair had discussed the executive team and their objectives for 2019/20. The Committee noted the timing of the sign-off of objectives for 2019/20, and agreed that the annual business planning cycle would be reviewed to bring forward the agreement of annual corporate and individual objectives.

Executive remuneration
The Committee considered Shelford Group benchmarking information for executive director salaries and agreed that there should be no increase in salaries for executive team members. The Committee will consider whether to apply a 'cost of living' uplift to *'Very Senior Manager'* (VSM) salaries once a recommendation from NHS Improvement is published later in Summer 2019.

NHS Pension update
The Committee considered an update on the issues relating to tax on NHS Pension Benefits and how the changes to the annual and lifetime allowances affects staff in the NHS Pension scheme. The Committee considered an update on action being taken at a national level and options for the Trust response, noting that the Trust continued to raise awareness among staff, and doctors in particular.

The Committee considered anecdotal evidence of the impact on operational performance, including adverse impact on waiting times. It was agreed that an impact assessment would be completed to quantify the impact.

Recommendations:
The Trust Board is asked to note the report.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC BOARD SUMMARY	
Title of report: Report from Quality Committee – report from meeting held on 10 July 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 24 July 2019	**Item 19.3, report no. 16c**
Responsible Non-Executive Director: Professor Andy Bush, Non-Executive Director (Committee Chair)	**Author:** Jessica Hargreaves, Deputy Trust Secretary

Summary:
The Quality Committee met on 10 July 2019. Key items to note from that meeting include:

CNST Maternity Incentive Scheme – evidential requirements
The Committee reviewed and approved the action plan in place to meet the evidential requirements against the ten safety standards for the CNST maternity incentive scheme. This would be completed and presented to the Trust board for final approval.

Integrated Quality and Performance Report
The Committee reviewed the integrated quality and performance report focusing on the quality aspects within the report. In particular the Committee discussed the progress against the Never Events action plan; the CCG had recently downgraded one of the reported never events and were satisfied that the Trust had taken appropriate action. Duty of Candour compliance continued to slowly improve; Committee members were concerned that letters were still being sent out late but were assured that progress was being made to address this, noting that a change in culture can take some time, and that initial conversations with patients and their families were taking place in a timely manner. The Committee were pleased to hear that VTE compliance was currently at 97%.

Key Divisional Quality Risks
The Divisional Directors and Corporate Directors provided an update on their key divisional risks which remained largely the same as previous meeting. A key risk affecting the Trust were issues relating to the new transport provider. This had been escalated to the provider's CEO and both immediate and medium term actions were in place to address these. Estates issues continued to be an issue for all divisions but Committee members were pleased to note the priority plan that was in place.

CQC Update
The Committee received an update on CQC activity noting that the final reports following the February inspection of core services, including maternity, neonatal and critical care would be available on 22 July. Committee members were concerned to hear that an improvement notice had been served following an unannounced inspection of Trust compliance with IRMER regulations at St. Mary's Hospital. The feedback on quality of care was good but there was insufficient evidence that the procedures had been updated to reflect changes in the regulations and insufficient evidence of training in the revised procedures. Committee members were assured that immediate actions were being undertaken to address and improve this, and that lessons had been learned for when future regulatory changes are made.

Incident Monitoring Report
The Committee considered the regular incident monitoring report, noting that incident reporting rates have improved since last month but were still below target; actions have been developed with the divisions to increase the number of incidents and targeted communications and improvement support commenced in June. The Committee reviewed the Serious Incidents (SI's) that had been reported, noting that these were currently under investigation; Committee members were pleased to

note that the number of overdue SI's had reduced and the quality of the reports were continuing to improve, leading to fewer queries from the CCG. Progress against the safety streams was noted.

Complaints annual report
The Committee reviewed the annual complaints report and were pleased to note the continuing positive performance against the range of quality indicators, particularly that there were fewer complaints being reopened, investigated and upheld by the Parliamentary & Health Service Ombudsman.

Learning from deaths quarterly report
The Committee received an update on the Trust's learning from deaths programme including updates on actions relating to the processes and reporting of data within the Trust.

Annual establishment review
The Committee reviewed the findings from the annual establishment review of nursing and midwifery posts noting that all clinical areas had been included and overall there had been a reported increase of 142.68 whole time equivalents (WTE) in the nursing and midwifery establishment compared to the review undertaken in 2018. The Committee were pleased to note the range of actions that the Trust had taken to grow and develop its nursing and midwifery workforce which includes the introduction of the nursing associate role, apprenticeships in nursing and advanced clinical practitioner roles.

Responsible Officer's annual report
The Committee reviewed the Responsible Officer's annual report which will be presented to the Trust board for sign off of the statement of compliance. The outstanding challenges relating to reducing the number of overdue appraisals continued to be of focus; work to address this was being overseen by the Medical Director's Office.

Improvement Team Update
The Committee received an update on its key highlights of the previous quarter as well as an overview of the strategic objectives and activities for 2019/20. Committee members were pleased to note the positive engagement and feedback from staff and welcomed the work to increase patient involvement in quality improvement projects.

Clinical Research Network annual report
The Committee reviewed the Clinical Research Network annual report for 2018/19 and were pleased to note that despite a reduction in funding allocated to North West London, the network was ahead of the recruitment target by 11% and was delivering generally good performance against the performance metrics set by the Department of Health & Social Care and upon which our annual funding allocation is determined.

Medical education and Trust education reports
The Committee reviewed the medical education and Trust education reports and were pleased to note the improvements highlighted in the 2018 GMC survey. There had been six complaints relating to bullying and undermining and these were all being investigated. Following discussion, it was agreed that the terms of reference for the two meetings would be reviewed with a view to pull the meetings together to form an overarching Trust Education Committee.

Gosport final report
Committee members were pleased to note the significant progress and closure of all actions as part of the Trust's response to the Gosport enquiry; exception reports would continue to be monitored through the Quality and Safety sub-group. Shona Maxwell was complimented on the superb work she had done on responding to the report

Committee self-assessment
The Committee discussed the annual self-assessment findings and agreed that it would be good for all Non-Executive directors to be invited to attend Quality Committee.

Recommendations:
Trust Board is asked to note this summary.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC BOARD SUMMARY	
Title of report: Report from Finance and Investment Committee meeting held on 17 July 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 24 July 2019	**Item 19.4, report no. 16d**
Responsible Non-Executive Director: Dr Andreas Raffel, Non-executive Director (Committee Chair)	**Author:** Jessica Hargreaves, Deputy Trust Secretary

Summary:

The Finance and Investment Committee met on 17 July 2019. Key items to note from that meeting include:

Financial performance – month 3
The Committee reviewed the finance report for month 3 noting that the Trust was on plan in-month and year to date and had reported to NHS Improvement that the Trust was expecting to be on-plan at year end. However Committee members noted the significant risks in achieving the plan and the work required to continue to meet the plan. We noted in particular the increased levels of non-elective activity and the risk of the Trust not being funded for such additional activity. We discussed the financial position of the sector, the impact on the Trust's financial planning and the ways in which the Trust is working with other sector partners.

The Committee noted the work being done internally to control expenditure and particularly its pay costs; we welcomed the introduction of pay run rate targets for divisions and corporate directorates to contain pay costs below last year's outturn less 3% through delivery of pay efficiencies. This will be monitored through fortnightly financial performance reviews with each division.

Committee members noted that the capital spend was behind plan year to date but forecast to catch up in order that the Trust meets its capital resource limit. We noted the potential risks arising from a sector-wide reduction in capital funding.

Transformation update
The Committee welcomed the update on progress with the Trust's transformation programme and specialty review programme and were pleased that both programmes introduced new ways of working for staff. Committee members agreed that the next step would be to focus the new ways of working to address Trust issues both locally and strategically. Populated project plans will be presented with a further update at the Committee's meeting in December.

Post project evaluation – Thrombectomy business case update
The Committee were pleased to note progress with the implementation of the Thrombectomy service particularly the positive patient outcomes (higher than original trial data) and the collaboration across North West London and the Home Counties. The current challenges were acknowledged and whilst activity had been lower than anticipated in the original business case, Committee members were assured that this would increase with the implementation of the 24/7 service which was due to be rolled out at the end of the summer, in conjunction with broader eligibility criteria recently approved by NICE and adopted by NHS England. Next steps included further collaboration across the sector. The

Committee congratulated the team on progress to date.

North West London Pathology (NWLP) performance review
The Committee reviewed the financial performance of NWLP since 2018/19 and the financial implications of NWLP performance for the Trust. Concerns around the operating deficit and delays in implementation of the transformation plan were discussed and the Committee were assured by NWLP colleagues that activity and performance would increase following the initial delays in delivery. It was noted that the governance structures had been strengthened, in particular in the clinical governance and the hosting arrangements but it was agreed that the owners' view of the partnership should be better aligned with the other roles of customer and host; this is currently being addressed. A further update on the financial performance of NWLP would be provided to the Committee in November.

Staff bank re-tender
The Committee approved the outcome of the tender process and agreed to recommend the award of the workforce managed service contract for temporary staffing to the proposed provider to the Trust Board. This will be considered as a separate paper at this Trust board meeting.

Lessons learnt from the 2018/19 planning process and looking ahead
The Committee considered the lessons learnt from the Trust's business planning process for 2019/20, which would be used to inform future planning cycles. We were pleased to note that winter planning had already started with the divisions and operational performance teams, and that this capacity planning would form a key part of the business planning process.

Committee self-assessment review
Committee members reflected on the annual self-assessment findings and next steps.

The Committee will next meet on 18 September 2019.

Recommendations:
To note this summary.