Imperial College Healthcare NHS Trust

Trust Board – Public

Wednesday, 30th January 2019, 11am to 1pm
New Boardroom, Charing Cross Hospital

AGENDA

Time	Item no.	Item description	Presenter	Paper / Oral
1100	**1.**	**Opening remarks**	Sir Gerald Acher	Oral
	2.	**Apologies: Nick Ross**	Sir Gerald Acher	Oral
	3.	**Declarations of Interests** *If any member of the Board has an interest in any item on the agenda, they must declare it at the meeting, and if necessarywithdraw from the meeting*	Sir Gerald Acher	Oral
1105	**4.**	**Minutes of the meeting held on 28th November 2018** *To approve the minutes from the last meeting*	Sir Gerald Acher	01
	5.	**Record of items discussed in Part II of Board meeting held on 28th November 2018 and 12th December 2018** *To note the report*	Sir Gerald Acher	02
	6.	**Matters arising and review of action log** *To note updates on actions arising from previous meetings*	Sir Gerald Acher	03
1110	**7.**	**Patient Story** *To note the patient story*	Professor Sigsworth	04
1125	**8.**	**Chief Executive Officer's Report** *To note the Chief Executive's report*	Professor Orchard	05
1135	**9.**	**Bi-monthly Integrated Quality and Performance Report** *To receive the bi-monthly integrated quality and performance report for month 8*	Professor Redhead	06
1145	**10.**	**Finance Report** *To note and discuss the month 9 position, year to date and other financial matters*	Richard Alexander	07
For decision / approval				
	11.	No items for approval		
For discussion				
1150	**12.**	**CQC Update** *To discuss and note the update on CQC related activity at and/or impacting the Trust*	Professor Sigsworth	08
1200	**13.**	**Never Events – Trust response and action plan** *To note the additional actions planned in response to the recent invasive procedure never events*	Professor Redhead	09
1210	**14.**	**Learning from Deaths: Update on implementation and reporting of data** *To note the dashboard and progress with implementation of the framework*	Professor Redhead	10
1220	**15.**	**Corporate Risk Register and Board Assurance Framework** *To note the changes to the corporate risk register; and agree current ratings within the board assurance framework.*	Professor Sigsworth & Peter Jenkinson	11

1230	**16.**	**Emergency Preparedness, Resilience and Response 2018 Assurance** *To note the updates and confirm that it provides sufficient assurance*	Professor Sigsworth	12
For noting				
1235	**17.**	**Quarterly Research and Development Report** *To note the Quarter 2 2018/19 report report*	Mark Thursz	13
1240	**18.**	**Bi-annual report on the Quality impact Assessments for Cost Improvement Programmes** *To note the update on the outcomes of the CIP QIA meetings*	Professor Sigsworth	14
1245	**19.** 19.1. 19.2. 19.3. 19.4. 19.5.	**Trust Board Committee Terms of References (for approval)** *To approve the updated Committee Terms of Reference* Audit, Risk and Governance Committee Finance and Investment Committee Quality Committee Redevelopment Committee Remuneration and Appointments Committee	Peter Jenkinson	15 15a 15b 15c 15d 15e
1250	**20.**	**Trust Board Committee Summary Reports** *To note the summary reports from the Trust Board Committees*		
	20.1.	Audit, Risk & Governance Committee, 5th December 2018	Sir Gerald Acher	16a
	20.2.	Remuneration and Appointments Committee, 7th December 2018	Peter Goldsbrough	16b
	20.3.	Redevelopment Committee, 12th December 2018	Victoria Russell	16c
	20.4.	Quality Committee, 16th January 2019	Professor Bush	16d
	20.5.	Finance and Investment Committee, 23rd January 2019	Dr Andreas Raffel	16e
1255	**21.**	**Any other business**	Sir Gerald Acher	Oral
	22.	**Questions from the public**	Sir Gerald Acher	
Close	**23.**	**Date of next meeting** 27th March 2019, 11am, Clarence Wing Boardroom, St Mary's Hospital		

Updated: 24 January 2019/GN

Imperial College Healthcare NHS Trust

MINUTES OF THE TRUST BOARD MEETING

Wednesday 28 November 2018
11.00 – 13.00
Clarence Wing Boardroom, St. Mary's Hospital

Present:

Sir Richard Sykes	Chairman
Sir Gerry Acher	Deputy chairman
Dr Andy Bush	Non-executive director
Sarika Patel	Non-executive director
Dr Andreas Raffel	Non-executive director
Victoria Russell	Non-executive director
Prof Tim Orchard	Chief executive officer
Richard Alexander	Chief financial officer
Prof Julian Redhead	Medical director
Prof Janice Sigsworth	Director of nursing

In attendance:

Dr Frances Bowen	Divisional director, MIC
Dr TG Teoh	Divisional director of operations, WCCS
Dr Katie Urch	Divisional director of operations, SCCS
Kevin Croft	Director of people and organisational development
Michelle Dixon	Director of communications
Jeremy Butler	Director of Transformation
Nick Ross	Associate non-executive director
Joanne Hackett	NExT Director
Prof Jonathan Weber	Dean, Imperial College Medical School
Peter Jenkinson	Trust company secretary (minutes)

1.	**Chairman's opening remarks, apologies and declarations of interests** Sir Richard welcomed all members and attendees, and members of the public, to the meeting. The Chairman noted that Sarika Patel was coming to the end of her term as non-executive director on 31 December and thanked her for her contribution to the Trust. Prof Orchard advised that this was also Sir Richard's last public Board meeting as Chairman as he was stepping down at the end of December. The Board thanked Sir Richard for his strategic leadership and guidance over the past 7 years.
2.	**Apologies** Apologies were noted from Peter Goldsbrough and Kevin Jarrold.
3.	**Declarations of interest** There were no declarations made at the meeting.
4.	**Minutes of the meeting held on 26 September 2018** The minutes of the previous meeting, held on 26 September, were confirmed as an accurate record.

5.	**Record of items discussed in private at the Board meeting on 26 September 2018** The Trust Board noted the report.
6. 6.1	**Action log and matters arising** The Board reviewed and noted the action log of matters arising from previous meetings. The Board noted that the Trust was working with NHS Improvement to create a national exemplar from the patient story regarding the Trust's approach to end of life care. The Board also noted that Prof Redhead and Joanne Hackett had discussed other opportunities for the Trust from national programmes to increase the attraction and retention of medical staff. Prof Redhead reported that he was in discussion with Genomics England and was looking at opportunities to bring Genomics into frontline medicine and with the Trust at the forefront. The Trust board noted the action log.
7. 7.1 7.2 7.3 7.4 7.5	**Patient story** The Board welcomed Steph Harrison-White and Nigel, a patient, to the meeting. Nigel presented his story, about his experience of being cared for in the intensive care unit at St. Mary's Hospital, following a life threatening road traffic accident. He described the excellent care he received and thanked all staff involved in his treatment and recovery, but highlighted the importance of sleep and mobility in helping him to recover so quickly. Nigel described his experience of being in a ward at night-time and the factors affecting his ability to sleep, including noise, light and temperature. He welcomed the introduction of 'care packs' to help patients sleep at night. The Board discussed the issues raised regarding wards at night time and the measures introduced to minimise disruption and to improve the environment and care to prevent adverse effect on patients from lack of sleep, including visible aids to remind staff of noise levels, as well as quieter flooring and bins. The Board noted that additional measures, including the distribution of 'care packs' and advice leaflets to patients, were being piloted across several wards and, if successful, would then be rolled out across wards. The Board noted that there was currently no measure recorded in patients' care notes regarding the amount of sleep, but that this would be considered. It was noted that 'eat, move and sleep' formed a key part of the frailty care model employed within the Trust. The Board thanked Nigel for his story. The Board noted the report.
8. 8.1 8.2	**Chief executive officer's report** Prof Orchard presented his chief executive officer's report and highlighted key points, including a summary of financial performance at month 7 and improvements made in performance over the past two months. He also summarised performance against key access standards, highlighting the impact of the Care Journey and Capacity Collaborative on pathways that would deliver a benefit equivalent to circa 35 extra beds. Performance against the waiting time target in Emergency Department had improved as a result of additional focus, resulting in a much improved year on year position and leading to the Trust achieving the October trajectory of 90%. Prof Orchard reported that this improvement in pathways and flow had also had a positive effect on elective performance, with continued reduction in the number of patients waiting more than 52 weeks. The Board noted that additional 50 inpatient beds were also planned, as part of the preparation for winter, and congratulated the executive for this positive example of collaboration and focus leading to improved care for patients.

8.3	Ms Patel asked when the Trust would achieve zero patients waiting more than 52 weeks. Prof Orchard advised that there remained several 'pop-ons' each month, but that increasing earlier validation would help prevent these from occurring.
8.4	Prof Orchard reported that an additional never event had been reported, in addition to the three mentioned in his report, and summarised the actions being taken in response.
8.5	Prof Orchard highlighted the launch of the *Leading Change through Vision and Values* initiative, and feedback from the recent Leadership Forum that included a presentation from Michael West on compassionate leadership and a focus on the impact of values and behaviours on improving care. Prof Orchard reported that staff sessions were now being rolled out, with around 1,000 staff engaged to date against a target of 4,000.
8.6	The Board noted the appointment of Jeremy Butler as substantive Director of Transformation and Claire Hook as Director of Operational Performance. They also noted the launch of the new staff intranet and the support package being implemented for staff who wished to apply for "settled status" in anticipation of Brexit.
8.7	Prof Orchard reported the sudden death of Michael Morton, Chair of the Trust's Strategic Lay Forum. The board recorded its condolences and noted Mr Morton's achievements in being instrumental in the development of the lay partners, ensuring that the patient voice was heard and challenging the Board on their behalf.
8.8	Ms Patel noted the disappointing level of staff take-up of the flu vaccination. Mr Croft advised that the flu campaign had suffered from a delayed start and was therefore behind where it should be, and summarised actions being taken to increase the take-up, including increased awareness, incentives and direct management action at ward-level. Prof Orchard acknowledged the link between level of take-up and the ongoing work on culture, and the need to make the connection between staff actions and patient care. The Trust board noted the report.
9	**Integrated performance report**
9.1	The Trust Board received and considered the Integrated quality and performance report for September 2018 (month 6), noting the exceptions highlighted in the report.
9.2	SAFE and EFFECTIVE: Prof Redhead presented the Safe and Effective section of the integrated performance report.
9.3	The Board noted that three never events had now been reported in the year to date. The Board received a summary of each case, noting that the patients involved suffered no long-term harm, and noted that each incident had been or was being investigated so that learning from each incident could be used to prevent recurrence of the event. The Board noted the importance of identifying any long term action required to change culture, noting that at least one of the incidents involved human factors, as well as short term actions regarding processes.
9.4	The Board also noted improved levels of compliance with the Duty of Candour, and improvement in the number of clinical trials recruiting their first patient within 70 days of a valid research application.
9.5	WELL-LED: Mr Croft presented the Workforce indicators and the Well-led section of the report. The Board noted current levels of compliance with level 3 Safeguarding Children training and noted actions being taken to ensure that compliance levels increased.

9.6	The Board also received an update on initiatives to improve the Trust's recruitment and retention of nurses, including an update on development of nurse training posts and international recruitment. The Board endorsed the approach but agreed that the focus needed to be on workstreams that had proven to be successful and to be on attracting nurses into training posts and then retaining them post-training.
9.7	The Board noted that sickness rates were marginally above target levels and above commercial sector rates, and noted actions being taken to address long-term sickness, including a focus on staff wellbeing and the quality of working environments, as well as following up on feedback included in the annual staff survey.
9.8	CARING: Prof Sigsworth presented the Caring section of the report, highlighting an increase in fire warden training that had then led to a rapid and effective response to the recent fire at Charing Cross Hospital. The Board noted that actions had been taken to increase the level of Friends and Family Test feedback in the ED at St. Mary's Hospital, but that the new kiosk installed in the ED had been vandalised. The team were therefore considering next steps.
9.8	The Board noted that anonymised incident reporting was being piloted across the organisation, as part of the Trust's Safe Culture programme. Currently around 20 incidents per month were being reported via this new mechanism. The Board endorsed the approach and agreed that the timescales for converting this pilot into business as usual would be confirmed. **Action: Julian Redhead**
9.9	RESPONSIVE: The Board considered the exceptions to performance in the Responsive section of the report, noting the current performance against the elective and non-elective waiting time standards, noting improved performance against the four hour waiting time standard. The Board noted the seven 12-hour breaches reported, all of which related to care of patients with mental health issues. The Trust board noted the integrated quality and performance report.
10 10.1	**Finance – monthly financial performance update** The Board received and noted the summary of financial performance at the end of month 7, noting that the Trust was on plan in month and year to date, not including Provider Sustainability Funding (PSF). The Board noted over performance in clinical income offset by underachievement of cost improvement programmes (CIPs) causing expenditure overspends. The Board welcomed the implementation of additional controls to manage emerging cost pressures in September which had led to improved performance and noted that these control measures would remain in place to ensure that the position remained on plan and the control total met for the year. The Trust board noted the report.
11 11.1	**Healthier hearts and lungs: a patient-centred solution for specialist NHS services and research** Prof Orchard reported that Royal Brompton Foundation Trust had submitted a proposal to NHS England for the Royal Brompton Hospital to move to a new site on St. Thomas' Hospital and for the Trust to become part of King's Health Partners. The Trust had worked together with Imperial College and Chelsea & Westminster Foundation Trust to submit an alternative proposal that would ensure access to local specialist cardio-respiratory care for patients in north west London and to maintain key research links to patient care in the sector, should the Royal Brompton Hospital move. Prof Orchard advised that the key principles behind the joint proposal were that the proposals offered a quicker solution, for less cost and provided better care for the population of north west London than patients

	having to travel to the new Royal Brompton Hospital site.
11.2	The Board considered the guiding principles in the proposals developed, noting that the preferred option was for Royal Brompton Hospital to remain as is in north west London. However, the Board agreed that should Royal Brompton Hospital move, the proposals presented the best solution for the population of north west London and offered the most cost effective solution. The Trust board noted the update and approved delegated authority to the Chief Executive to submit the proposal for the provision of cardio-respiratory services should the Royal Brompton Hospital move.
12.	**CQC update**
12.1	The Board received and noted the update on CQC-related activity at and/or impacting the Trust.
12.2	The Board noted that the CQC had met with leads from the core service of critical care in October and this was well received. During the second part of the Trust-level meeting, information about changes to the CQC's inspection scheduling for the remainder of 2018/19 and for 2019/20 had been shared with the Trust.
12.3	The Board noted that the Trust had since received its annual Provider Information Request from the CQC on 21 November 2018, initiating a six month period during which at least one core service would be inspected and concluding with a well-led inspection at Trust-level.
12.4	It was noted that the Trust was refreshing its approach to improving quality and ensuring continual improvement against the CQC standards, including the development of a revised Improving Quality strategy, supported by the Leading Change through Vision and Values programme, and with assurance provided through the *Compliance and Improvement Framework.* It was agreed that this approach would be presented at the next Board seminar. **Action: Janice Sigsworth**
12.5	The Board noted that as well as the preparation of core services for possible CQC inspections, a focus remained on the four key improvement workstreams – medicines management, statutory & mandatory training, hand hygiene and medical devices – and progress was being made across all four.
12.6	The Board noted Trust-level headlines from the Trust's latest CQC Insight report (published October 2018). The Trust board noted the report.
13.	**Infection prevention and control report – Quarter 2 2018/19 report**
13.1	The Board welcomed Eimear Brannigan to the meeting to present the quarterly update report.
13.2	The Board received and considered the update report, noting the highlights. There were two Trust-attributed MRSA BSI cases identified during Q2 (July and September). Actions around clearer record keeping for line insertions were identified and have been addressed. The case in September is still under review. There have been 12 cases of Trust-attributed *C. difficile* identified during Q2, below the Trust ceiling for this period. Three of these 12 cases had a 'lapses in care' identified due to antibiotic choices.
13.3	The Board noted that an outbreak of *Pseudomonas aeruginosa* had occurred whereby

	eight babies became colonised with this organism in the neonatal unit, which has highlighted issues related to water hygiene management and environmental hygiene, and laboratory turnaround times. The Board noted progress being made by the estates team to address the issues and the Trust was engaged with Public Health England regarding the improvements being made.
13.4	The Board noted the concerns raised regarding the general condition of estate not helping in reducing infection, but noted the actions being taken to ensure cleaning standards were being met and to address any variability in compliance. The Trust board noted the report.
14. 14.1	**Mid-year update on safe, sustainable and productive nursing and midwifery staffing** The Board received and noted the mid-year report on nurse establishments, including an update on trust initiatives being undertaken to recruit and develop nursing and midwifery roles in order to mitigate the risk of national nursing and midwifery staffing shortages, and the outcome of the mid-year nursing and midwifery establishment review. The Board noted the report.
15. 15.1	**Verita report update** The Board received and considered an update on actions taken in response to the Verita report – an independent investigation commissioned by the Trust to review the disciplinary process conducted in respect of a member of staff, Mr Amin Abdullah – as reported to the Board at its previous meeting. The Board noted the Trust's actions in response to the recommendations made in the Verita report and the further actions taken by the executive team to strengthen the existing processes for investigations into disciplinary and performance concerns, and the support provided to managers conducting such investigations to ensure fair processes and outcomes. The Board also noted an update on actions taken in respect of individual members of staff named in the Verita report.
15.2	The Board noted that the action being taken in respect of processes would be embedded in the People & OD strategy and monitored by the Executive (P&OD) Committee.
15.3	The Board discussed the agreed actions and the proposals arising from the review of processes, including the development of proposals to centralise investigations to ensure dedicated resource to complete investigations in a timely way. The Board endorsed the approach being taken and agreed the need for a consistent standard of review to be achieved across all staff groups; the Board also supported the concept of external independent input into investigations. The Board noted the report and agreed that a further update would be provided in six months.
16. 16.1	**Board committee reports** The Trust board noted summary the reports from the following Trust Board committees: • Audit, Risk and Governance Committee, held on 3 October 2018 • Redevelopment committee, held on 31 October and 21 November 2018 • Remuneration and Appointments Committee, held on 13 November 2018 • Quality Committee, held on 13 November 2018 • Finance & investment committee, held on 21 November 2018
17. 17.1	**Any other business** No other business was discussed.

18.	**Questions from the public relating to agenda items**
18.1	The following responses were given to questions raised by members of the public present at the meeting:
18.2	A member of the public asked what the impact of the closure of palliative care beds at Pembridge Hospice, due to staffing shortages, would have and what discussions the Trust was having with commissioners regarding out of hours care. Prof Orchard expressed his concern at any proposal that would negatively affect community care and confirmed that the Trust was in discussions with commissioners regarding these concerns.
18.3	A member of the public asked what discussions the Trust was having with local councils regarding their budget for 2019/20 and the impact of any cuts planned. Prof Orchard confirmed that the trust was in regular conversation with the local councils in the region, and confirmed that the trust had been consulted on how to spend the earmarked budget to support discharge from hospital.
18.4	A member of the public asked for a comment regarding a news story regarding treatment of an overseas patient being withheld. Prof Orchard confirmed that a serious incident had been declared and an internal investigation commenced. That investigation would identify any learning required.
19.	**Date of next meeting** Public Trust board: Wednesday 30 January 2019 11:00-13.00 New Boardroom, Charing Cross Hospital

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Record of items discussed at the confidential Trust board meetings held on 28th November and 12th December 2018	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 30th January 2019	**Item 5, report no. 02**
Responsible Non-Executive Director: Professor Tim Orchard, Chief executive officer	**Author:** Peter Jenkinson, Director of corporate governance & trust secretary

Summary:

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

November 2018

The Board received a report from the Chief Executive, including an update on the trust redevelopment programme and the North West London Pathology (NWLP) partnership.

The Board considered and approved the Trust's four year financial recovery plan, noting that this had been developed in accordance with the Trust's undertaking to submit a 4 year financial recovery plan to NHS Improvement (NHSI) by the end of November 2018, and in the context of the consideration of the control total for 2019/20 as part of the business planning process.

The Board received an oral update from the Chief Executive regarding the development of a joint response by the Trust, Imperial College London and Chelsea & Westminster NHS Foundation Trust to proposals submitted to NHS England for the move of the Royal Brompton Hospital to join King's Health Partners. The Board agreed the principle of retaining services in north west London where appropriate and approved delegated authority to the chief executives of Imperial College, Chelsea & Westminster Foundation Trust and the Trust to agree and submit the joint proposal to NHS England. Discussions are now ongoing with NHS England with the aim of achieving a collaborative plan that delivers the best service to patients in north west London.

December 2018

The Board also met in seminar mode in December 2018 and discussed service developments including the frailty pathway and the Connecting Care for Children programme, an initiative created by the Trust to support health professionals and families in the White City area in improving the health of children. This was followed by a visit to clinical areas within the Surgery, Cardiovascular and Cancer Division.

Recommendations:

The Trust board is asked to note this report.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC) - ACTION POINTS REGISTER - Date of last meeting 28 November 2018

Updated: 23 January 2019

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	25 July 2018 3.3.2	Corporate risk register and Board Assurance Framework / Risk Appetite	The Board noted that an update on the Trust's risk appetite would be presented to the next meeting. September 2018 update: Deferred to January 2019 January 2019 update: The risk appetite framework has been agreed by the Board and is being utilised by the executive and senior leadership team when appropriate. An operational framework to support implementation of the framework throughout the organisation is under development and an update on progress with this will be presented to the Board in March 2019.	Prof. Sigsworth	January 2019
2.	28 Nov 2018 9.8	Integrated performance report	The Board noted that anonymised incident reporting was being piloted across the organisation, as part of the Trust's Safe Culture programme. Currently around 20 incidents per month were being reported via this new mechanism. The Board endorsed the approach and agreed that the timescales for converting this pilot into business as usual would be confirmed. January 2019 update: Anonymised reporting was rolled out across the Trust in February 2018 with a communications campaign. It is now business as usual. 175 anonymised reports have been reported so far.	Prof. Redhead	January 2019
3.	28 Nov 2018 12.4	CQC	It was noted that the Trust was refreshing its approach to improving quality and ensuring continual improvement against the CQC standards, including the development of a revised Improving Quality strategy, supported by the Leading Change through Vision and Values programme, and with assurance provided through the Compliance and Improvement Framework. It was agreed that this approach would be presented at the next Board seminar. January 2019 update: added to Trust Board Seminar forward planner.	Prof. Sigsworth	Close
4.	25 July 2018 2.1	Actions arising from Patient story	a) The Board thanked Dr Buxton, noted the report and agreed that this story should be considered as an exemplar story for national learning. b) The Board agreed that it would monitor progress in End of Life Care in 12 months. November 2018 update: a) Noted. b) The core service of end of life care is being monitored through the improving care programme group on a weekly basis to ensure the service is continuing to be 'good' (as rated by the CQC in 2014) with a plan to getting to outstanding. A further update on CQC is presented as a separate agenda item at this meeting.	Prof. Sigsworth	Close

5.	26 Sept 2018 16.1	Freedom to speak up – self assessment	Prof Orchard advised that the Guardians were committed to their roles, but that they needed support in terms of resources and time allocated. It was agreed that this review should also include benchmarking against arrangements employed by other trusts. It was agreed that the output of the review and recommendations would be shared with the Board in December. January 2019 update: Deferred to March 2019	Kevin Croft	March 2019
6.	26 Sept 2018 11.4	Ward accreditation programme (WAP)	It was noted that the 2018/19 WAP was currently underway and the results would be reported to the Board in March 2019.	Janice Sigsworth	March 2019
7.	26 Sept 2018 8.4	Implementation of e-referrals (arising from CEO report item)	A post-project evaluation would follow in January 2019. January 2019 update: Deferred to May 2019 meeting	Dr TG Teoh	May 2019

Items closed at the November meeting

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	26 Sept 2018 8.5	Financial recovery plan (arising from CEO report item)	The financial recovery plan would be presented to the Board for approval in November. November 2018 update: This was discussed and approved in part 1 of the Trust Board.	Richard Alexander	Closed
2.	26 Sept 2018 9.7 28 Nov 2018 6.1	Retention of medical staff (arising from Integrated quality and performance report item)	It was agreed that Prof Redhead and Joanne Hackett would discuss other opportunities for the Trust from national programmes to increase the attraction and retention of medical staff. November 2018 update: Professor Redhead is in discussion with Genomics England and is looking at opportunities to bring Genomics into frontline medicine and ensure ICHT is at the forefront.	Julian Redhead	Closed

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.

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Patient Story	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 30th January 2019	**Item 7, report no. 04**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Author:** Guy Young, Deputy Director, Patient Experience

Summary:
This month's patient story is about a patient's positive experience of using the Care Information Exchange (CIA) to help with her treatment.

Linda was able to access information via the CIE that enabled a consultant make important decisions about her care in another part of the country.

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

This report has been discussed at:
None

Quality impact:
The ability to share patient held clinical information can reduce delays and ensure that clinical staff across the country have access to the most up to date clinical information to support decision making

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

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

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

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

☒ Yes ☐ No

Trust strategic objectives supported by this paper:

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

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):

Is there a reason the key details of this paper cannot be shared more widely with senior managers?
☐ Yes ☒ No

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

- What should senior managers know?
  The Care Information Exchange provides patients with online access to their health records so they can view them anywhere, including from the comfort of their own home or when out and about from their mobile phone. Patients can also share this record with their health and care professionals, family and carers.

- What (if anything) do you want senior managers to do?
  Make staff aware of the CIE and to encourage patients to sign up to it..

- Contact details or email address of lead and/or web links for further
  linda.watts8@nhs.net

- Should senior managers share this information with their own teams? ☒ Yes ☐ No
  If yes, why?
  To encourage increased sign up by patients to the CIE

Imperial College Healthcare NHS Trust

Patient Story

1. Executive Summary

This month's patient story will be presented in person by Linda. Linda works for the trust and is the GDE programme manager the Care Information Exchange (CIE) is one of the projects included in this programme.

The CIE provides patients with online access to their health records so they can view them anywhere, including from the comfort of their own home or when out and about. Patients can also share this record with their health and care professionals, family and carers.

When Linda recently had to attend hospital in Leeds, she was able to share her medical record via the CIE with the consultant managing her care. This meant that decisions about her care were able to be made promptly and avoided an unnecessary stay in hospital.

Around 24,000 of Imperial patients have signed up to the CIE, but there is potential for far more to do so.

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

The CIE is an Imperial led project, supported by Imperial Health Charity, that provides patients with online access to their health records so they can view them anywhere, including from the comfort of their own home or when out and about from their mobile phone or tablet. Patients can also share this record with their health and care professionals, family and carers.

The type of information available through the CIE includes appointments, blood results and radiology results.

Imperial College Healthcare NHS Trust

4. Linda's story

In October 2018, Linda had to be treated in the cardiac catheter lab at Hammersmith Hospital. Because of an unexpected complication during the procedure, Linda ended up having a 6 day inpatient stay but recovered well.

Following discharge, Linda returned home to Leeds to recuperate. Shortly after she returned home, she developed some symptoms that gave her cause for concern and so attended the local hospital where she was admitted for further investigation.

The consultant treating her said that he would like to release her from hospital but needed to run some further blood tests and would also have to contact Imperial to get her most recent results.

Although Linda was able to tell him what her results were when she was in Imperial, he regretted that he was unable to take her word for it. Linda explained that he didn't have to and pulled up her CIE records on her iPad. This apparently greatly impressed the consultant and it meant that he was able to make a decision about Linda's treatment without having to wait to contact Imperial.

As an aside, whilst here, Linda also had a discussion with a patient and their partner in the same ward who were getting frustrated waiting for a decision to be made. They were also very impressed when Linda showed them the CIE application and wished that they had been able to access it too.

5. Conclusion and Next Steps

As programme manager for CIE, Linda is clearly a champion for its use. However, she says that her own experience of using it has really brought home what a difference it can make both to the experience of patients and to the effective management of patient care by clinicians.

There is scope for the uptake of CIE to increase significantly and Linda would appreciate the Board's support in promoting this innovative and valuable initiative.

Author: Guy Young
Date; January 2019

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Chief Executive Officer's Report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 30 January 2019	**Item 8, report no. 05**
Responsible Executive Director: Prof Tim Orchard, Chief Executive Officer	**Author:** Prof Tim Orchard, Chief Executive Officer

Summary:

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

1) Financial performance
2) Financial improvement programme
3) Transformation programme update
4) Operational performance
5) Strategic development
6) Leadership and workforce
7) Stakeholder engagement
8) Risk management
9) Celebrating achievements

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

This report has been discussed at: N/A

Quality impact: N/A

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

Risk impact and Board Assurance Framework (BAF) reference:

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

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

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

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

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

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

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

Chief Executive's Report to Trust Board

1. Financial performance

Year to date (i.e. from April 2018 to December 2018) before Provider Sustainability Funding (PSF) the Trust was on plan with a £25.3m deficit. The Trust receives PSF based on meeting financial plans and the 4 hour A&E trajectory across the delivery board area, this is measured quarterly. The Trust will receive £22.2m of PSF for April to December based on achieving both targets year to date.

Year to Date the Trust is over plan on NHS clinical income on emergency inpatient and day cases activity. There have been costs incurred to meet the additional activity in both pay and non-pay. Year to date there are adverse variances in clinical divisions these are driven by delays in the identification and implementation of cost improvement programmes (CIPs).

The Trust's capital position is £12.3m underspent against the capital resource limit (CRL) of £41.6m year to date. The capital plan for the year is £53.2m and the Trust is expecting to meet the plan. The Trust has received additional funding in year to support the opening of winter beds and improvements to patient flow. The programme continues to be actively managed by the Trust's Capital Expenditure Assurance Group (CEAG) and Capital Steering Group (CSG) to ensure that the Trust does not breach its plan for the year.

The cash position for the Trust is £54m at the end of December. The Trust must maintain a cash balance of at least £3m to meet its loan conditions.

2. Financial improvement programme

The Trust set a challenging £48m cost improvement programme in 2018/19 as part of its overall financial plan, against which there is currently £46.7m of identified programmes (at various stages of planning and implementation).

Against the Month 9 cumulative plan of £30.6m, there has been £25.3m (83%) of CIP delivery year to date (YTD), resulting in a £5.3m adverse variance to plan. The main reasons for this have been underperformance of £1.8m against income and activity based productivity schemes, including private patients; and £2.4m of unidentified CIP plans against target.

The current forecast CIP delivery for the year is £40.7m, a £4.4m improvement from M07. This does not include any other mitigating actions being taken, to meet the overall Trust financial plan – still expected, which can be regarded as CIP.

The Programme Support Office continues to work with Clinical and Corporate teams to support delivery of current programmes; further progress opportunities already identified; as well as identify additional efficiencies, drawing on both internal and external expertise and resources.

3. Transformation programme update

The immediate focus for the transformation programme is on progressing the 'Specialty Review Programme', converting the review recommendations into agreed strategies and tactical plans. Sessions with the clinical teams are beginning in February, and are being held in conjunction with the Deputy CFO. Two members of the new transformation team have been recruited and are due in post in March and April. The Director of Transformation is also assisting with CIPs planning for the next

financial year.

4. Operational Performance

The Trust Board will consider the integrated quality and performance report and the key headlines relating to operational performance as at November 2018 (month 8).

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

For this month 8 report leads were asked to provide brief updates for the new section on return to target / trajectory. Trajectories are not currently in place for all areas or will need to be updated and signed off for 2019/20 with associated actions set.

Exceptions in performance are highlighted in the following key areas:

- **Never events** - Seven never events have now been reported in this financial year. A separate paper will be presented at this meeting outlining the response so far and further actions that will be taken.

- **Flu vaccination campaign** – To date, 49.8% of frontline staff have been confirmed as receiving the vaccination, against a total of 60% achieved last year. The ongoing communications campaign continues to encourage staff to have the vaccine and promotes the various ways in which staff can obtain the vaccine – through peer vaccinators, roaming vaccinators and at occupational health walk in centres. Weekly dashboards are provided to the divisions to support increased uptake which are being reviewed at the executive team meeting with improvement actions in place across all divisions.

- **Accident & Emergency** – Pressure on our services has increased, as expected for this time of year, but our planning is working well with fewer black alerts, on-the-day cancellations of elective surgery and patients staying overnight in recovery than last year. Although we missed our A&E four-hour access target for December – 88.8 per cent performance against the goal of 90% – overall performance was 4% better than in December 2017. Performance for type 1 adults improved by over 10%.

  All of our escalation capacity is now open and we have also opened 22 new beds funded through the additional capital money awarded in September (20 at Hammersmith and 2 at St Mary's). Estates work to create the remaining additional beds is continuing – 33 more will open at St Mary's and Charing Cross between January and March.

5. Strategic development

NHS Long Term Plan

Last summer, the Prime Minister committed an extra £20.5 billion a year to the NHS by 2023/4. The NHS has developed a Long Term Plan, published this month, which shows how the extra money will be used. We're undertaking an analysis of the Long Term Plan as part of our strategy and business planning work. In the meantime, the key themes are:

- Doing things differently through partnership working
- Preventing illness and tackling health inequalities
- Backing our workforce
- Making better use of data and digital technology
- Getting the most out of taxpayers' investment in the NHS.

Strategy refresh

We have launched a programme of work to refresh our organisational strategy and suite of supporting strategies over the next six months. We have recently set out an updated version of our strategic direction – vision, mission, high-level strategic goals and values – and we will use feedback from the

current 'vision and values' engagement programme to produce the final set to go to March Trust board meeting for sign off. We have also set out our current behaviour statements and are seeking more input from staff as part of the engagement programme to amend and improve them. We will produce an updated set also to go to the March Trust board for sign off.

The outcome of this programme will be:

1. Our staff and stakeholders should be able see a genuine 'golden thread' that runs through our decisions and plans, linking the overarching vision to the practical work that is being carried out. We will be able to explain our story and vision in a clear and simple way
2. The strategy work should support a tangible improvement in the way we coordinate different pieces of corporate work across the Trust including:
   a) The way we prioritise between things
   b) The way we join up initiatives once they are started
3. We will have clear statement of how the Trust plans to respond to the key strategic opportunities and challenges in our changing environment, including the NHS Long Term Plan. This will have sufficient granularity that individual pieces of work can act on it.

Streams app

Healthcare professionals at St Mary's Hospital will soon have secure access to their patients' latest test results from their mobile devices via the Streams app. This is the latest way the Trust is using advances in digital technology to provide better care. With real-time, mobile access to test results (such as laboratory and radiology results), clinicians will be able to make faster decisions, without having to leave their patients to log into a computer. The time saved will allow clinicians to have a greater focus on direct patient care.

The company that provides the Streams app, DeepMind, began processing current patients' test results on 21 January. The general surgery team at St Mary's Hospital will be the first in the Trust to begin using the Streams app. Soon after, the secure app will be rolled out so that healthcare professionals across all five of the Trust's hospitals will be able to access their patients' latest test results on the move. We will be conducting a full review of any impacts of the Streams app move from DeepMind to Google's new health unit. We are not anticipating any significant change to our existing contract and we have the right not to enter into a new agreement with Google if we are not satisfied.

Redevelopment programme

In response to the poor state of our estate, we are assessing short, medium and long term options for ensuring safety and capacity across all our sites. This includes options for major redevelopment. Although we are now one year into a three-year planning permission for a new outpatient and ophthalmology building on the St Mary's site, we are not able to actively progress next steps on this project until we get a clearer picture of possible funding options as well as longer-term estate and redevelopment priorities.

Meanwhile, we have been awarded £1.8 million of central funding towards the development of an endovascular hybrid theatre at St Mary's. We are also working up proposals in partnership with Imperial College for a new cardiovascular research centre on the Hammersmith Hospital site.

Healthier hearts and lungs: a patient-centred solution for specialist NHS services and research

Following discussion at the previous Board meeting, the Trust, Chelsea & Westminster NHS Foundation Trust and Imperial College submitted a joint proposal to NHS England, and are now working collaboratively to develop proposals that will achieve the best outcomes for the residents of North West London.

Non-emergency patient transport services

Following approval by the Board at its last meeting, the Trust has now signed a 5 year contract with Falck to provide non-emergency patient transport services. This follows a detailed procurement process which the Trust undertook in conjunction with our commissioners. Falck will take over the service on 1 June 2019.

6. Leadership and workforce

Senior staff changes
Dr Frances Bowen has been appointed as substantive Divisional Director for Medicine and Integrated Care. Claire Hook has been appointed as Director of Operational Performance and will take up her role on 28 January.

Leadership Forum
We have our next Leadership Forum on 12 February. The focus of this forum will be to share, test and reflect on insight from the 'leading change through vision, values and behaviours' engagement to date, to update on organisational strategy development and to test and seek input to a new analysis of our organisational opportunities and challenges, to include impacts of the NHS long term plan and our vision and values work. We will also be seeking input to the development of a set of shared 2019/20 priorities/objectives to guide local 2019/20 business plan objectives.

CQC, Use of Resources and Well led assessments
There is a more detailed paper being presented outlining the Trust's preparation for the pending CQC inspection, expected by April 2019. As part of that inspection process we are also preparing for a trust-wide 'well-led' inspection by CQC and we have a 'use of resources' inspection by NHS Improvement, scheduled for 13 February.

7. Stakeholder engagement

Below is a summary of some significant meetings that I have had with key stakeholders:

Strategic Lay Forum: 12 December
The Trust's strategic lay forum met on Wednesday 12 December for the latest of its bi-monthly meetings.

Department for International Development visit to Queen Charlotte's & Chelsea Hospital: 23 November
On Friday 23 November, we were delighted to welcome Rt Hon Penny Mordaunt MP, Secretary of State for International Development, who visited the Sunflower FGM Clinic at Queen Charlotte's & Chelsea Hospital. The Secretary of State was interested in seeing our service and talking to staff and users as she was announcing a new UK aid package to support the African-led movement to end FGM and provide better protections for vulnerable girls in some of the world's poorest countries.

London Borough of Hammersmith & Fulham: Health, Inclusion and Social Care Policy and Accountability Committee: 4 December
On Tuesday 4 December, I attended the meeting of Hammersmith & Fulham Council's Health, Inclusion and Social Care Policy and Accountability Committee to discuss the 'Healthier hearts and lungs' joint proposal.

Meeting with Cllr Jonathan Glanz, Westminster City Council: 8 January
On Tuesday 8 January, I met with Cllr Jonathan Glanz, Westminster City Council's Chair of the Family and People Services Policy and Scrutiny Committee, when the following issues were discussed: winter operational performance; NHS long term plan; Paddington Square development and St Mary's Hospital redevelopment; staff recruitment and retention; OG cancer surgery service change proposal; joint proposal on 'Healthier hearts and lungs' services; and, Trust Chair position.

Meeting with Cllr Heather Acton, Westminster City Council: 9 January
On Wednesday 9 January, I met with Cllr Heather Acton, Westminster City Council's Cabinet Member for Family Services and Public Health, when the following issues were discussed: integrated care and community services; St Mary's Hospital redevelopment; future CQC inspections; OG cancer surgery service change proposal; joint proposal on 'Healthier hearts and lungs' services; Westminster's Health and Wellbeing Board; and, Trust Chair position.

8. Risk management

Brexit
A working group has been formed with representatives from across the Trust to oversee our preparations for Brexit. Led by Claire Hook, Director of Operational Performance, the group will coordinate the work that is happening Trust-wide to ensure we understand, and are able to respond to, the impact of Brexit in a "no deal" scenario.

While there is still a lot of uncertainty, the group is tasked with reviewing the guidance that has been received from the Department of Health and will be preparing a risk assessment for consideration by the Executive before the end of January.

The emergency preparedness resilience and response team will also be running an exercise on 14 February to ensure that our business continuity plans are able to deal with potential scenarios generated by a no deal Brexit, such as shortage of medicines.

9. Celebrating achievements

Project SEARCH
Project SEARCH provides supported internships with the aim of enabling young people with a learning disability the opportunity of securing employment. It is based mainly on employers' premises, with some time in college or a classroom in the workplace. Support throughout the study programme is provided to both the young person and the employer through a Job Coach. Supported internships should lead to a job for the young person at the end of their programme and should meet a real business need for the employer.

The Project SEARCH programme at the Trust offers 12 interns a year-long placement in which they undertake 10 to 12 week placements around our hospitals. At the end of the last cohort of placements, 10 of the 12 interns secured permanent employment, which is a great credit to the interns and to the staff supporting this programme. We hope that some of the interns will come and present to the Board at a future meeting.

Nurse apprentice award
The Trust works in partnership with London South Bank University (LSBU) to deliver the apprentice nursing associate programme. As part of this programme, LSBU run a Star Pupil prize which is awarded to apprentices who stand out both in their practical work and theory. Pavlina Georgieva, who is on placement on Almroth Wright ward at St Mary's Hospital, was recently named LSBU's Star Pupil, after she received excellent feedback from staff, produced documentation that was clear and concise, and wrote some articulate and insightful pieces for her weekly reflections.

North West London Major Trauma Network
North West London Major Trauma Network, hosted by our Trust, is identified as the best in the country for survival. The improvement in patient survival is as a result of a number of initiatives and projects across the network over the last few years. These include the development of rib fracture management care pathways, improved triaging for accident and emergency trauma calls, enhanced staff education for those providing major trauma care and improved rehabilitation services.

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Bi-monthly Integrated Quality and Performance Report (at month 8)	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 30th January 2019	**Item 9, report no. 06**
Responsible Executive Director: Julian Redhead (Medical Director) Janice Sigsworth (Director of Nursing) Catherine Urch (Divisional Director) Tg Teoh (Divisional Director) Frances Bowen (Divisional Director) Kevin Croft (Director of People and Organisational Development)	**Author:** Terence Lacey (Business Partner, Performance Support Team); Julie ODea (Head of Performance Support)

Summary:
This is the bi-monthly integrated quality and performance report for data published at month 8.

It is based on agreed indicators, goals and targets for 2018/19. By exception, additional slides have been included to highlight issues and related improvement plans and actions.

The report is presented in three main sections:

1. Summary report at month 8
2. Indicator scorecard
3. Exception report slides

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

Recommendations:
The Committee is asked to note the bi-monthly integrated quality and performance report covering months 7 and 8.

This report has been discussed at the following:

- Executive Committee (Quality) 08/01/19
- Quality Committee 16/01/19
- Executive Committee (Finance) 22/01/19

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

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

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

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

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

Workforce impact (including training and education implications):
none

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

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

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

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

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

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

Section 1 Summary report

The key headlines in performance for month 8 are provided below. The committee are asked to note the accompanying exception reports

1.1 Safe

Patient safety - incidents

Degree of harm

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

One case initially reported as extreme harm in April 2018 has since been investigated, confirmed as no harm and downgraded.

Incident reporting rate

The Trust's incident reporting rate for November 2018 was 48.24, placing us above the highest quartile nationally based on the latest published NRLS data (46.96). This is a positive measure of our reporting culture with work in place to encourage reporting including the pilot of 'learning from excellence'. The trial of the reporting app (care report) has been delayed due to contract issues which the PSTRC are working to resolve. It is now expected to go live in the emergency department at St Mary's in Spring 2019.

Never events

Five never events have been reported in this financial year; one wrong route medication incident in May 2018, one retained swab in maternity in July 2018, one retained foreign object in cardiac surgery at HH in September 2018, one wrong site surgery in Urology at CXH in October 2018 and one wrong site block in breast surgery at CXH in November 2018.

The most recent never event was declared on 26th November 2018. A patient was admitted for a left mastectomy and left axillary clearance and breast reconstruction with transverse upper gracilis flap (flap from the leg). The consultant anaesthetist performed an abdominal block, as this is the usual donor site for the flap; however taking the flap from the abdomen was not viable for this patient as the patient was too slim therefore the flap was to be taken from the patient's leg meaning that the incorrect site was blocked. There was no harm to the patient.

The four most recent never events are all related to invasive procedures and have occurred in different specialties and sites. Our annual audit of compliance with the WHO checklist was reported in November 2018 and although shows many areas of improvement also show there is more to be done in relation to following the 5 steps to safer surgery (particularly the brief

and debrief). In addition we have also declared a number of serious incidents where there were issues with the WHO checklist and/or which were related to safety with invasive procedures. When taken together these issues give a general warning that our compliance with safety checks need to be strengthened. Although there are specialty actions for each of the incidents a trust wide approach is being taken to those aspects that are common to all.

A trust wide action plan has therefore been developed. The implementation of this plan will be undertaken through the invasive procedures task and finish group, convened and chaired by the Medical Director. This group meets bi-weekly with a lead from each division in attendance. It is reporting monthly to the quality and safety sub-group, with exception reporting to the executive quality committee.

Governance has been confirmed with divisional directors – the divisions are responsible for implementing and assuring actions taken for each incident, the actions confirmed through the T&F group, as well as in response to the WHO checklist audit. The Medical Director as executive lead will be responsible for assuring that appropriate actions are taken as well as leading the longer term culture programme being tested through the safer surgery safety stream.

A review of whether solutions implemented previously have reduced risk is being undertaken, including an evaluation of each. The list of actions, lead for evaluation and evidence and outcome of review will be confirmed, and presented to the T&F group by the end of January 2019.

Duty of candour

We continue to make progress with compliance with the completion of duty of candour for all appropriate incidents. This is monitored weekly at the medical director's incident panel with additional support in place to improve compliance in North West London Pathology where there are complexities with compliance. The percentage of incidents reported between November 2017 – October 2018 that have had stage 1 and stage 2 of the duty of candour process completed is 87.4% for SIs, 95.2% for internal investigations and 95.8% for moderate and above incidents.

Infection prevention and control

There was one case of MRSA BSI assigned to the Trust in November 2018. A baby in the neonatal unit had an MRSA bacteraemia but has been treated and recovered. Actions taken following the investigation relate to standardisation of vascular access device documentation. This is the third case of trust attributed MRSA BSI this financial year, compared to three in total last year.

There were no cases of *Clostridium difficile* identified as a lapse in care in November 2018. One case initially reported in October 2018 has since been confirmed as not being a lapse in care on investigation. There have therefore been eight identified *C. difficile* lapses in care so

far this year. These have been reviewed and no clear themes emerge. We continue to work with Divisions in reviewing each case and identifying opportunities for preventative action.

There were no cases of BSI caused by CPE in November 2018. We have seen six CPE BSI cases year to date, compared to four cases at this point in 2017/18. Each case undergoes clinical review to optimise management from the infection multidisciplinary team. A review is undertaken of each case and themes collated at intervals to identify learning and opportunities for preventive action. The six cases this year were all high risk patients with advanced malignant disease, or complex liver or urological conditions and found to be colonised with CPE prior to their BSI, which was not preventable due to unavoidable surgical and/ or medical interventions.

Four cases of Trust *E.coli* BSI have been reported for October 2018, with 10 cases for November 2018. This makes a total of 63 cases for 2018/19, compared with 56 cases for this period in 2017/18. This is above trajectory and we are unlikely to meet our target of a 10% reduction in cases compared to last year.

Cases of *E. coli* BSI are reviewed monthly to identify any potential trends. It seems likely that many of the cases of healthcare-associated *E. coli* BSI are a direct result of necessary interventions and are not preventable (e.g. those associated with neutropenia), or related to complex cases in patients with advanced malignant disease (such as those with biliary sources). However, other sources of infection are more likely to be preventable (e.g. *E. coli* BSIs associated with urinary catheters). An internal IPC working group, led by the Deputy DIPC, has been exploring the available Trust resources relevant to reducing Gram-negative BSI through discussions with key stakeholders from the Nursing Directorate, and the Divisions. To date this has focused on hydration, continence, and promotion of early removal of catheters. High risk areas may require more detailed work on understanding the use of specific prophylactic antibiotics. Additional work centres on deciphering community drivers of hospital-onset Gram-negative BSI, done alongside the CCG.

VTE

We have achieved compliance rates above our target of 95% for the assessment of patients for the risk of VTE since April 2018. Compliance data in November 2018 was 95.28%. Performance at divisional level shows performance well above target in WCCS and SCCS however MIC are not meeting the target.

MIC division have reviewed the data and identified neurosciences and acute medicine as the areas where the target is not being met. Local action plans are in place to improve performance in neurosciences, including meetings with the head of specialty for nursing staff and junior doctors to reiterate the requirements, demonstrations for consultants on how to use Cerner to monitor VTE compliance and the newly appointed physician associate for neurology being appointed VTE champion for their ward base. Compliance, and the impact of these actions, is being monitored through the directorate quality and safety committee.

The divisional director of clinical governance is working with acute medicine to develop actions to improve their performance. A verbal update will be given at this committee by the Divisional Director on progress and additional actions.

Questions were raised at the executive committee in August 2018, regarding whether VTE assessment might be preventing positive VTE diagnosis and whether there is an association between increasing assessment and reduced complications. Data available has been reviewed by clinical analytics colleagues, however additional information is needed and not easily available in Cerner as it is recorded in the non-structured notes. The investigation will conclude in January 2019, with the outcomes reported in February 2019.

Flu

By the end of November, 45.2% of frontline staff had had the vaccination. This is above where we were this time last year by 2.5%, although the denominator has reduced by 700 staff so the actual number of staff vaccinated is slightly lower (78 fewer staff). A communications campaign is in place to encourage staff to have the vaccine and there are a number of ways that staff can obtain the vaccine – through peer vaccinators, roaming vaccinators and at occupational health walk in centres. Weekly dashboards are provided to the divisions to support increased uptake which are being reviewed at the executive team meeting with improvement actions in place across all divisions.

Sepsis

This is the first month that the sepsis antibiotic indicator has been reported in the Trust's Integrated Quality and Performance Report. In November 2018, 65.8% of patients received antibiotics within 1 hour of the first live sepsis alert on Cerner, which is above the trust's target of 50%. This figure is for the Emergency Department (SMH and CXH) and acute inpatient areas; 474 patients had a confirmed sepsis diagnosis with 312 of these administered antibiotics within 1 hour of the sepsis alert. Sepsis care in the Trust is now supported by an electronic screening protocol which fires a sepsis alert in the patient record to prompt clinical review and diagnosis. Work to improve the care of patients with suspected sepsis has continued via the use of quality improvement methodology, and most notably the Sepsis Big Room. It is of note that the Trust is currently measuring the time to antibiotics from the point that the sepsis alert triggers on Cerner. Work in underway to identify how the Trust can measure from the specific time of diagnosis by the named senior decision maker. Notwithstanding this it should be noted that by using the time the sepsis alert fires on Cerner as a proxy measure, the Trust are actually seeking to achieve a quicker administration of antibiotics. The improvement work to date has seen a steady improvement in the time to antibiotics metric. A separate paper has been provided to executive quality committee with more information.

Safe staffing

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

Site Name	Day shifts – average fill rate		Night shifts – average fill rate	
	Registered nurses/midwives	Care staff	Registered nurses/midwives	Care staff
Charing Cross	95.70%	95.52%	98.69%	97.56%
Hammersmith	96.72%	91.84%	99.16%	96.47%
Queen Charlotte's	97.33%	95.40%	98.25%	97.41%
St. Mary's	97.22%	95.44%	98.29%	98.66%
Trust wide	**96.66%**	**94.87%**	**98.58%**	**97.88%**

Safeguarding training

At end September 77% of eligible staff were compliant with level 3 safeguarding children training and the figure has plateaued. A schedule of training in place with over 1000 places available to end of financial year. This capacity is capable of exceeding the 90% target by the end of the year, dependent on attendance.

Medical devices

There has been a continual improvement in maintenance compliance figures for medical devices. Although High Risk is improving the target figure was not achieved (November performance was 96% against 98% target).

Estates Maintenance

A series of meetings have been held with the contractor with the intention of achieving an improved performance in December 2018. The performance on reactive tasks is being reviewed and assurance process is being developed to understand the issues that affect performance.

1.2 Effective

Mortality indicators

The Trust's HSMR rate in August 2018 was 54 which is the fifth lowest of all acute non specialist providers in month. Over the last 12 months the Trust has had the lowest HSMR (65.7) for acute non-specialist trusts nationally. The most recent full year data for SHMI (Q1 17/18 to Q4 17/18) shows the Trust to be the third lowest of acute non specialist providers at 74.13.

Last month, we reported that our HSMR rate for July 2018 was 69, placing us thirteenth nationally and therefore below our target of being in the top five for the first time this financial year.

The medical director has asked Dr Paul Aylin to undertake a review of the Trust's mortality data, including CRAB, to ensure that there are no underlying issues. The outcomes of this review will be included in next month's report.

Mortality reviews

Mortality reviews continue to be completed however the data confirms that clinical teams are struggling to complete these within the trust target within a week of the death occurring. Structured judgement reviews (SJRs) are undertaken for all relevant deaths in line with national requirements and Trust policy. One hundred completed reports have been received to date for this financial year with five avoidable deaths reported. Four of these five cases are also subject to serious incident investigation. SJRs should be completed within 30 days, compliance with completion continues to be below target and actions are in place to support improvement. Cases are reviewed at the monthly Mortality Review Group (MRG) with a focus on any avoidable factors and learning themes. A monthly report on overdue reviews is reviewed at MRG.

A review of the mortality processes has been commenced, led by a General Manager in the Office of the Medical Director to look at how we strengthen the governance, compliance and learning from the review process. The review will also look at how we transition to a medical examiner model in 2019/20 which has been nationally mandated. This will require investment in the role of medical examiner and so a full review and proposal will be brought through this committee in Q4. This has been included as a cost pressure for business planning purposes.

PROMs

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

The PROMS NHS Digital dashboard reports that the Trust's submission rate for October was 100%, compared to 0% last month, although 99 pre-surgery questionnaires (43 hip replacement and 56 knee replacement) were submitted to Capita, who are responsible for the data collection post-surgery. There have been issues in the past with data submission from Capita which has affected the overall performance scores. Procurement has shortlisted three external suppliers to address this issue. The delay in tendering and finalising the new supplier has been due to suppliers being accredited by the NJR. This should be completed in January 2019.

National clinical audits

We have made progress in our divisions in the management of national audit outcome reports. The process is more embedded, with reviews being completed however we continue to be challenged in completing these within the internally set target of three months of publication. For this financial year fifteen audits have been published up to the end of October 2018, all of which were relevant to the Trust and in which we participated. The internal review process has been completed for four of these audits, none of which were identified as showing a significant risk. Eleven are overdue and are being managed by the

divisions through their governance processes. There is one audit review outstanding from 2017/18; this is expected to be completed by the end of December 2018.

The monthly CQC insight report includes benchmarking data related to national audits. We are unable to access this data ourselves, as it is not available in most published audit reports, so the report provides useful information on our performance with specific audit indicators compared to our peers. For the majority of indicators the Trust's performance is in line with other organisations. However there are some indicators which are flagging as 'worse' than average. This would not necessarily mean that they are identified as 'significant risk' by the audit leads on review as the review takes into account the whole audit report. The reports where we have indicators showing as 'worse' than average are summarised below, along with the actions that have been taken in response.

• The MBBRRACE study showed that our perinatal mortality rate for 2016 births was 10% higher than the average/median. The department reviewed each case and none were deemed avoidable. An action plan is in place which includes the have introduction of a still birth bundle. Our patient demographic was felt to be more complex although the study says that the figures are 'risk adjusted'.

• PicaNet shows we did not meet the national aspirational standard for qualified nurses per bed which is 7. Only 4 of 30 units did. We were slightly better than average, with 5.6 nurses per bed. The action plan includes recruitment plans.

• For the National Emergency Laparotomy Audit, our data submission / case ascertainment was poor for both CXH and SMH. Since then the department have appointed a new lead surgeon and anaesthetist for each site. We also performed poorly in documenting the risk of death and having consultant surgeons and anaesthetists present for high risk cases. The department have appointed some additional general surgeons and established a consultant of the week system.

• For the National Hip Fracture Database, we do not undertake surgery within 36hrs. Our performance is at 57% compared to a national average of 71% and a target of 100%. There is an action plan with a hip fracture group formed to monitor and improve this.

• RCEM audits: poor indicators for sepsis (observations on arrival and initiating oxygen/treatment). This predates the Trust's sepsis work which should address these issues.

• RCEM audits: Consultant sign off for high risk patients seen. An action plan is in place which involves recording the senior decision maker at every ED board round.

• RCEM audits: Asthma: Improvements being made include an asthma bundle to improve steroid prescription on arrival and discharge and also an asthma lead at SMH.

From January, the insight report audit data will be included at the Clinical Audit and Effectiveness Group to support review of the audit reports and action planning.

Clinical trials recruitment

Good progress has also been made in improving the number of clinical trials recruiting their first patient within 70 days of a valid research application this year. NIHR-validated data for Q1 2018/19 shows 85% compliance against our target of 90%, which compares favourably with Q4 2017/18 (67.6%). Internal data for Q2 shows performance of 95.7%, which is above our target, however this is subject to validation. Confirmed data will be published in December 2018.

1.3 Caring

Friends and Family Test – Response rate

Both Charing Cross A&E (28%) and Western Eye A&E (25%) exceeded the target in November, St Mary's A&E (9%) and the Urgent Care Centres (11%) did not achieve the target.

Mixed sex accommodation

The Trust reported 64 mixed-sex accommodation (MSA) breaches in November 2018. The MSA breaches at SMH site increased in July 18 and then again in Oct 18. All breaches were incurred by patients awaiting step down from critical care to ward areas and whose discharge is delayed. The root cause of EMSA breaches in Critical Care is delayed step down of patients within the national 4 hour target once they have been identified as fit for discharge. An action plan has been detailed in order to improve the performance.

1.4 Well-led

Workforce and people

Doctors' appraisal compliance has increased slightly this month. At 90.89% it is at its highest since April 2018.

Consultant grade compliance is at 92.60% compared to 88.50% in September. Career grade compliance is at 89.81%, from 84.67% in September. All overdue doctors have been written to, and there are plans in place to support individuals that need help to complete their appraisal.

The consultant job planning round for 2018/19 closed in July. Final compliance was 99.5% which is the highest return rate the trust has ever recorded. The job planning round for 2019/20 commenced in October 2018. Data will be reported from March 2019. Training sessions for clinical line managers are being led by the associate medical director for professional development, with a focus on sign-off requirements. All sessions will be completed by February 2019.

1.5 Responsive

RTT

The latest RTT submitted performance position is end November where 82.62% of patients had been waiting less than 18 weeks to receive consultant-led treatment, against the national standard of 92%; this did not meet the trajectory target which was 85.59%. The performance business support team has met with each of the challenged services to update the RTT trajectory action plans monthly meetings are scheduled with each of these services to review the action plans and support where necessary.

In November 2018 the Trust reported 10 patients waiting more than 52 weeks in November; this was a decrease of 12 from the previous month. The Trust is forecasting to achieve the trajectory of zero (with the exception of pop-ons) by end of February 2019.

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

Cancer 62-day waiting times

The Trust continued to meet the 62-day GP referral to first treatment standard in November, reporting performance of 86.8% against the 85% target.

Critical care admissions

The national standard is that 100% of admissions of critically unwell patients should be admitted within 4 hours. In September 2018, 93.1% of patients admitted to critical care were admitted within 4 hours of their referral for all units combined.

Accident & Emergency

Performance for the month of November 2018 was 90.1%. The November A&E performance was 90.1% of patients seen within the four hour standard. This is above the PSF target and slightly below the locally agreed target of 90.4% for the month. Performance of over 90% was maintained from October to November 2018 and November 2018 performance was 2.6% higher than November 2017.

There were four 12-hour breaches in November 2018; this was one fewer than October 2018. All breaches were delays to admission for mental health provider beds.

Diagnostics

Diagnostic test waiting times continued to meet the national standard. In November 2018 the Trust reported 0.47% of patients waiting more than 6 weeks for a diagnostic test, below the tolerance of 1%.

Outpatient DNA

The overall DNA rate was 10.5% in November 2018. While fewer patients are not attending compared to the same period last year it appears that the overall DNA rate has now

plateaued and analysis to inform the next steps for targeted intervention is progressing. Deep dive analysis of Outpatient DNA rate for all services (new and follow up) has been undertaken and a paper will be presented to the executive committee for operational performance for discussion.

Patient Transport

Performance has improved but has now plateaued. The contractor now needs the Trust to collaborate on programmes to achieve improved discharge planning and allow the service to become more of a planned service rather than a reactive one in which transport is booked for patients on the day of travel with a large proportion being booked giving less than one hours' notice. Default notices are issued and monthly deductions made.

2. Indicator scorecard

See below.

3. Additional slides by exception

See below.

Section 2: Indicator scorecard for Month 8

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 8

Domain	Indicator	Unit	Target	Latest Period	Exec Lead	ExCo	#	Reported performance at: Aug-18	Sep-18	Oct-18	Nov-18
								E = Exception report available for Month 8			
Safe											
Patient safety - incident reporting	Serious incidents	number	-	Nov-18	Julian Redhead	ExQu	-	2	17	21	**13**
	All Incidents (cumulative financial YTD)	number	-	Nov-18	Julian Redhead	ExQu	-	7,213	8,557	9,925	**11,311**
	Incidents causing severe/major harm	number	-	Nov-18	Julian Redhead	ExQu	-	1	1	0	**0**
	Incidents causing severe/major harm (cumulative financial YTD)*	number	<14	Nov-18	Julian Redhead	ExQu	-	3	4	4	**4**
	Incidents causing severe/major harm (cumulative financial YTD)**	%	<0.25%	Nov-18	Julian Redhead	ExQu	-	0.04%	0.05%	0.04%	**0.04%**
	Incidents causing extreme harm/death	number	-	Nov-18	Julian Redhead	ExQu	-	0	0	0	**0**
	Incidents causing extreme harm/death (cumulative financial YTD)*	number	<13	Nov-18	Julian Redhead	ExQu	-	4	4	4	**4**
	Incidents causing extreme harm/death (cumulative financial YTD)**	%	<0.10%	Nov-18	Julian Redhead	ExQu	-	0.06%	0.05%	0.04%	**0.04%**
	Patient safety incident reporting rate (against top quartile of trusts)	incidents / 1,0	>=40.83	Nov-18	Julian Redhead	ExQu	E	47.44	46.78	47.62	**48.24**
	Never events	number	0	Nov-18	Julian Redhead	ExQu	E	0	1	1	**1**
	PSAs overdue (by month)	number	0	Nov-18	Julian Redhead	ExQu	-	0	0	0	**0**
	PSAs closed late in the preceding 12 months	number	0	Nov-18	Julian Redhead	ExQu	-	0	0	0	**0**
	MDAs overdue (by month)	number	0	Nov-18	Janice Sigsworth	ExQu	-	0	0	0	**0**
	MDAs closed late in the preceding 12 months	number	0	Nov-18	Janice Sigsworth	ExQu	-	15	15	6	**6**
	Compliance with duty of candour (SIs)	%	100%	Oct-18	Julian Redhead	ExQu	E	75.0%	75.0%	85.7%	**73.3%**
	Compliance with duty of candour (SIs) (rolling 12 month)	%	100%	Oct-18	Julian Redhead	ExQu		92.0%	91.1%	91.4%	**87.4%**
	Compliance with duty of candour (Level 1)	%	100%	Oct-18	Julian Redhead	ExQu		90.9%	91.7%	91.7%	**90.0%**
	Compliance with duty of candour (Level 1) (rolling 12 month)	%	100%	Oct-18	Julian Redhead	ExQu		89.4%	89.8%	90.0%	**95.2%**
	Compliance with duty of candour (Moderate)	%	100%	Oct-18	Julian Redhead	ExQu		100.0%	80.0%	100.0%	**100.0%**
	Compliance with duty of candour (Moderate) (rolling 12 month)	%	100%	Oct-18	Julian Redhead	ExQu		88.9%	93.6%	97.3%	**95.8%**
	**Total Incidents for 17/18*										
	*** NRLS Apr17 -Sep17*										
Infection prevention and control	Trust-attributed MRSA BSI	number	0	Nov-18	Julian Redhead	ExQu	E	0	1	0	**1**
	Trust-attributed MRSA BSI (cumulative financial YTD)	number	0	Nov-18	Julian Redhead	ExQu		1	2	2	**3**
	Trust-attributed Clostridium difficile	number	5	Nov-18	Julian Redhead	ExQu		2	2	3	**2**
	Trust-attributed Clostridium difficile (cumulative financial YTD)	number	43	Nov-18	Julian Redhead	ExQu		28	30	33	**35**
	Trust-attributed Clostridium difficile (related to lapses in care)	number	0	Nov-18	Julian Redhead	ExQu		0	1	0	**0**
	Trust-attributed Clostridium difficile (related to lapses in care) (cumulative)	number	0	Nov-18	Julian Redhead	ExQu		7	8	8	**8**
	E. coli BSI	number	9	Nov-18	Julian Redhead	ExQu	E	8	13	4	**10**
	E. coli BSI (cumulative financial YTD)	number	51	Nov-18	Julian Redhead	ExQu		36	49	53	**63**
	CPE BSI	number	0	Nov-18	Julian Redhead	ExQu	E	0	1	1	**0**
	CPE BSI (cumulative financial YTD)	number	0	Nov-18	Julian Redhead	ExQu		4	5	6	**6**
Medicines Management	Fridge temperature (fridges containing medicines in clinical areas)	%	>=95%	Nov-18	Julian Redhead	ExQu	-				
	Controlled drugs checks	%	100%	Nov-18	Julian Redhead	ExQu	-				

Section 2: Indicator scorecard for Month 8

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 8

Domain	Indicator	Unit	Target	Latest Period	Exec Lead	ExCo	#	Reported performance at: Aug-18	Sep-18	Oct-18	Nov-18
							E = Exception report available for Month 8				
VTE	VTE risk assessment	%	>=95%	Nov-18	Julian Redhead	ExQu	-	96.3%	96.3%	96.0%	**95.3%**
Flu	Flu vaccination for frontline healthcare workers	%	>=75%	Nov-18	Kevin Croft	ExQu	E	-	-	26.5%	**45.2%**
Sepsis	Sepsis - Antibiotics	%	>=50%	Nov-18	Julian Redhead	ExQu	-	-	-	-	**65.8%**
Maternity standards	Ratio of births to midwifery staff	ratio	1:30	Nov-18	Tg Teoh	ExQu	-	1.26	1.26	1.26	**1.26**
	Puerperal sepsis	%	<=1.5%	Nov-18	Tg Teoh	ExQu	-	0.40%	1.00%	1.14%	**1.10%**
Safe staffing	Safe staffing - registered nurses	%	>=90%	Nov-18	Janice Sigsworth	ExQu	-	96.1%	95.6%	96.1%	**97.5%**
	Safe staffing - care staff	%	>=85%	Nov-18	Janice Sigsworth	ExQu	-	95.9%	96.3%	95.4%	**96.2%**
Workforce and people	Core skills training	%	>=85%	Nov-18	Kevin Croft	ExPOD		89.2%	89.5%	89.9%	**90.2%**
	Core clinical skills training	%	>=85%	Nov-18	Kevin Croft	ExPOD		88.6%	89.2%	89.8%	**90.2%**
	Safeguarding children training (level 3)	%	>=90%	Nov-18	Janice Sigsworth	ExQu	E	79.9%	79.3%	78.0%	**77.2%**
	Vacancy rate - Trust	%	<10%	Nov-18	Kevin Croft	ExPOD	E	13.5%	13.3%	12.6%	**12.7%**
	Vacancy rate - nursing and midwifery	%	<13%	Nov-18	Kevin Croft	ExPOD		16.5%	16.6%	15.4%	**15.3%**
Health and safety	Departmental safety coordinators	%	>=75%	Nov-18	Kevin Croft	ExQu	-	66.9%	71.5%	77.0%	**80.0%**
	RIDDOR	number	0	Nov-18	Kevin Croft	ExQu	-	4	7	6	**3**
	Fire warden training	%	>=10%	Nov-18	Janice Sigsworth	ExQu	-	11.0%	12.0%	12.0%	**13.0%**
	Medical devices maintenance - high risk	%	>=98%	Nov-18	Janice Sigsworth	ExQu	E	94.0%	94.0%	95.0%	**96.0%**
	Medical devices maintenance - medium risk	%	>=80%	Nov-18	Janice Sigsworth	ExQu	-	86.0%	96.0%	88.0%	**89.0%**
	Medical devices maintenance - low risk	%	>=70%	Nov-18	Janice Sigsworth	ExQu	-	88.0%	88.0%	91.0%	**91.0%**
Estates and Facilities	Cleanliness audit scores (very high risk patient areas)	%	>=98%	Nov-18	Janice Sigsworth	ExQu	-				
	Cleanliness audit scores (high risk patient areas)	%	>=95%	Nov-18	Janice Sigsworth	ExQu	-				
	Lifts in service (main passenger and bed lifts)	%	>=90%	Nov-18	Janice Sigsworth	ExQu	-	94.0%	96.0%	97.0%	**97.0%**
	Reactive maintenance tasks completed within the allocated timeframe	%	>=70%	Nov-18	Janice Sigsworth	ExQu	-	36.9%	44.7%	44.0%	**34.9%**
	Planned maintenance tasks completed within the allocated timeframe	%	>=70%	Nov-18	Janice Sigsworth	ExQu	-	72.0%	61.0%	56.6%	**50.0%**
	Compliance with statutory and mandatory estates requirements	%	>=85%	Nov-18	Janice Sigsworth	ExQu	-	89.0%	98.8%	99.7%	**99.9%**

Section 2: Indicator scorecard for Month 8

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 8

Domain	Indicator	Unit	Target	Latest Period	Exec Lead	ExCo	#	Reported performance at: Aug-18	Sep-18	Oct-18	Nov-18
								E = Exception report available for Month 8			
Effective											
Mortality indicators	Trust ranking as per monthly data (HSMR)	rank	top 5 lowest risk acute Trusts	Aug-18	Julian Redhead	ExQu	-	2nd	4th	13th	**5th**
	HSMR	ratio		Aug-18	Julian Redhead	ExQu	-	52.00	55.00	69.00	**54.00**
	Trust ranking as per most recent full year data (SHMI)	rank		Q2 17/18–Q1 18/19	Julian Redhead	ExQu	-	3rd	3rd	3rd	**3rd**
	SHMI	ratio		Qtr 1 18/19	Julian Redhead	ExQu	-	70.10	73.18	78.62	**78.62**
	Palliative care coding	%	100%	Aug-18	Julian Redhead	ExQu	-	100.0%	100.0%	100.0%	**100.0%**
Mortality reviews (at 04/12/2018)	Total number of deaths	number	n/a	Oct-18	Julian Redhead	ExQu	E	159	118	131	**162**
	Number of local reviews completed	number	n/a	Oct-18	Julian Redhead	ExQu		150	107	116	**149**
	Local reviews completed	%	100%	Oct-18	Julian Redhead	ExQu		94.3%	90.7%	88.5%	**92.0%**
	SJR reviews requested	number	n/a	Oct-18	Julian Redhead	ExQu		23	19	13	**15**
	Number of SJR reviews completed	number	n/a	Oct-18	Julian Redhead	ExQu		19	17	6	**13**
	SJR reviews completed	%	100%	Oct-18	Julian Redhead	ExQu		82.6%	89.5%	46.2%	**86.7%**
	Avoidable deaths	number	0	Oct-18	Julian Redhead	ExQu		1	0	0	**0**
	Avoidable deaths (cumulative financial YTD)	number	0	Oct-18	Julian Redhead	ExQu		5	5	5	**5**
Readmissions	Unplanned readmission rates - under 15 yr olds	%	<9.33%	May-18	Tg Teoh	ExQu	-	5.5%	5.0%	6.8%	**3.9%**
	Unplanned readmission rates - over 15 yr olds	%	<8.09%	May-18	Frances Bowen	ExQu	-	6.3%	6.5%	5.3%	**6.7%**
Patient reported outcomes	PROMs - participation rates (Hips)	%	>=80%	Oct-18	Julian Redhead	ExQu	E	100.0%	100.0%	0.0%	**100.0%**
	PROMs - reported health gain (Hips)***	-	>national avg	April17–Mar18	Julian Redhead	ExQu		EQ-5D Index:**0.462**	EQVAS:**19.588**	Oxford Hip score:**23.060**	
	PROMs - participation rates (Knees)	%	>=80%	Oct-18	Julian Redhead	ExQu		100.0%	100.0%	0.0%	**100.0%**
	PROMs - reported health gain (Knees)***	-	>national avg	April17–Mar18	Julian Redhead	ExQu		EQ-5D Index:**0.304**	EQVAS:**8.402**	Oxford Knee score:**13.918**	
	****Reported Bi-Annually*										
National Clinical Audits	Participation in relevant national clinical audits (cumulative financial YTD)	%	100%	Aug-18	Julian Redhead	ExQu	E	100.0%	100.0%	100.0%	**100.0%**
	High risk/significant risk audits with action plan in place (cumulative financial `	%	100%	Aug-18	Julian Redhead	ExQu		100.0%	100.0%	100.0%	**100.0%**
	Review process not completed within 90 days	number	0	Aug-18	Julian Redhead	ExQu		4	6	8	**11**

								Qtr 4 17/18	**Qtr 1 18/19**
Clinical trials	Clinical trials - recruitment of 1st patient within 70 days (%)	%	>=90%	Qtr 1 18/19	Julian Redhead	ExQu	E	67.6%	**85.1%**

Section 2: Indicator scorecard for Month 8

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 8

Domain	Indicator	Unit	Target	Latest Period	Exec Lead	ExCo	#	Reported performance at: Aug-18	Sep-18	Oct-18	Nov-18
								E = Exception report available for Month 8			
Caring											
Friends and Family	FFT A&E service - % recommended	%	>=94%	Nov-18	Janice Sigsworth	ExQu	-	93.8%	93.9%	95.8%	**96.8%**
	FFT inpatients - % recommended	%	>=94%	Nov-18	Janice Sigsworth	ExQu	-	97.7%	97.2%	97.5%	**97.7%**
	FFT outpatients - % recommended	%	>=94%	Nov-18	Janice Sigsworth	ExQu	-	92.8%	92.1%	92.3%	**92.5%**
	FFT maternity - % recommended	%	>=94%	Nov-18	Janice Sigsworth	ExQu	-	95.7%	93.1%	92.8%	**94.7%**
	FFT A&E service - % response rate	%	>=20%	Nov-18	Janice Sigsworth	ExQu	E	13.2%	10.8%	11.1%	**15.9%**
	FFT PTS service - % recommended	%	>=90%	Nov-18	Janice Sigsworth	ExQu	-	90.4%	92.7%	92.0%	**88.4%**
Mixed sex accommodation	Mixed-sex accommodation breaches	number	0	Nov-18	Catherine Urch	ExQu	E	47	41	61	**64**
Well led											
Workforce and people	Staff retention (Stability)	%	>=80%	Nov-18	Kevin Croft	ExPOD	-	85.5%	86.0%	85.6%	**84.8%**
	Voluntary staff turnover rate (12-month rolling)	%	<12%	Nov-18	Kevin Croft	ExPOD	-	11.5%	11.5%	10.6%	**11.9%**
	Sickness absence rate (12-month rolling)	%	<=3%	Nov-18	Kevin Croft	ExPOD	-	3.05%	3.06%	3.10%	**3.13%**
	Doctor appraisal rate	%	>=95%	Nov-18	Julian Redhead	ExQu	E	86.5%	87.5%	88.21%	**90.13%**
	Consultant job planning completion rate	%	>=95%	Nov-18	Julian Redhead	ExQu	-	94.5%	99.5%	99.5%	**99.5%**
NHSI segmentation	NHSI - provider segmentation	number	-	Nov-18	Richard Alexander	ExOp	-	3	3	3	**3**
Responsive											
Referral to treatment (elective care) 7%	RTT incomplete pathways 18 weeks performance	%	>=92%	Nov-18	Catherine Urch	ExOp		83.4%	82.6%	83.0%	**83.8%**
	RTT variance against 2018/19 trajectory target	%	86.3%	Nov-18	Catherine Urch	ExOp	E	*-1.8%*	*-3.0%*	*-2.9%*	***-2.5%***
	RTT total waiting list (incomplete PTL)	number	n/a	Nov-18	Catherine Urch	ExOp		65,718	64,342	65,985	**66,953**
	RTT patients waiting 52+ weeks****	number	0	Nov-18	Catherine Urch	ExOp	E	40	46	22	**10**
	RTT patients waiting 52+ weeks reviewed for clinical harm	%	100%	Nov-18	Catherine Urch	ExOp	-	100.0%	100.0%	100.0%	
	RTT cases of clinical harm found after the clinical harm review	number	0	Nov-18	Catherine Urch	ExOp	-	0	0	0	
Cancer waiting times 1%	Cancer - 62 day urgent GP referral to treatment	%	>=85%	Nov-18	Catherine Urch	ExOp	-	85.4%	85.8%	86.2%	**86.8%**
Theatre utilisation	Theatre Touchtime Utilisation (elective)	%	>=95%	Nov-18	Catherine Urch	ExOp	-	79.1%	80.6%	81.4%	**79.3%**
Cancelled operations	Cancelled operations (elective)	%	<=0.9%	Sep-18	Catherine Urch	ExOp	-	0.9%	1.1%	0.8%	**0.8%**
	28 day rebooking breach rate	%	<=8%	Sep-18	Catherine Urch	ExOp	-	18.9%	11.9%	18.6%	**17.9%**

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

***** Cancelled ops target based on England national average for quarter to Sep-18

Next quarterly submission end January 2019, covering quarter to Dec-18

Section 2: Indicator scorecard for Month 8

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 8

Domain	Indicator	Unit	Target	Latest Period	Exec Lead	ExCo	#	Reported performance at: Aug-18	Sep-18	Oct-18	Nov-18
							E = Exception report available for Month 8				
Critical Care	Critical care patients admitted within 4 hours	%	100%	Nov-18	Catherine Urch	ExOp	E	93.0%	92.7%	93.1%	**92.6%**
Urgent and Emergency Care 1%	A&E patients seen within 4 hours (all types)	%	>=95%	Nov-18	Frances Bowen	ExOp	-	89.0%	89.0%	90.6%	**90.1%**
	A&E variance against 2018/19 trajectory target	%	90.4%	Nov-18	Frances Bowen	ExOp	-	*0.1%*	*-1.2%*	*0.4%*	***-0.3%***
	A&E patients seen within 4 hours (type 1)	%	>=95%	Nov-18	Frances Bowen	ExOp	-	73.6%	73.8%	78.0%	**76.9%**
	A&E patients spending >12 hours from Decision to Admit	number	0	Nov-18	Frances Bowen	ExOp	E	4	7	5	**4**
Bed management	Patients with length of stay over 7 days	%	tbc	Nov-18	Frances Bowen	ExOp	-	33.6%	33.6%	33.4%	**33.0%**
	Patients with length of stay over 21 days	%	50% from baseline	Nov-18	Frances Bowen	ExOp	-	10.4%	10.5%	13.8%	**14.4%**
	Delayed transfer of care	%	3.50%	Nov-18	Frances Bowen	ExOp	-	2.6%	2.7%	2.1%	**3.1%**
	Discharges before noon	%	>=33%	Nov-18	Frances Bowen	ExOp	-	13.80%	12.65%	13.96%	**16.00%**
Diagnostics 3%	Diagnostic waits – over 6 weeks	%	<1%	Nov-18	Tg Teoh	ExOp	-	0.97%	0.75%	0.59%	**0.47%**

Key: Data reliability score

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

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

Outpatient management	Waiting times for first outpatient appointment	weeks	<8	Nov-18	Tg Teoh	ExOp	-	7.2	7.9	7.4	**7.5**
	Outpatient DNA	%	<10%	Nov-18	Tg Teoh	ExOp	E	11.0%	10.8%	10.5%	**10.5%**
	Outpatient HICS rate with less than 6 weeks' notice	%	<7.5%	Nov-18	Tg Teoh	ExOp	-	8.2%	7.8%	7.8%	**7.6%**
	Outpatient appointments within 5 working days of receipt	%	>=95%	Nov-18	Tg Teoh	ExOp	-	96.2%	97.2%	98.0%	**97.2%**
Complaints management	PALS concerns	number	<250	Nov-18	Janice Sigsworth	ExOp	-	240	199	220	**242**
	Complaints - formal complaints	number	<90	Nov-18	Janice Sigsworth	ExOp	-	83	65	99	**91**
	Complaints – the average number of days to respond	days	40	Nov-18	Janice Sigsworth	ExOp	-	**37**	31	35	**27**
	Patient satisfaction with overall handling of complaints	%	>=70%	Nov-18	Janice Sigsworth	ExOp	-				
Data quality indicators	Orders waiting on the Add/Set Encounter request list	number	586	Nov-18	Catherine Urch	ExOp	E	1,376	1,680	964	**1,067**
	OP appointments 'not checked-in' or DNA'd	number	1,051	Nov-18	Tg Teoh	ExOp	E	1,999	2,299	2,413	**2,682**
	OP appointments 'not checked out'	number	871	Nov-18	Tg Teoh	ExOp	E	1,340	1,768	2,118	**2,451**
Patient Transport	All Journeys: Collection Time (60 Mins)	%	>97%	Nov-18	Janice Sigsworth	ExOp	-	94.0%	94.7%	93.9%	**93.0%**
	All Journeys: Collection Time (150 Mins)	%	100%	Nov-18	Janice Sigsworth	ExOp	-	99.5%	99.6%	99.6%	**99.3%**
	Journeys 0-5 Miles: Time On Vehicle (60 Mins)	%	>95%	Nov-18	Janice Sigsworth	ExOp	-	93.9%	92.9%	92.5%	**91.6%**
	Journeys 5-10 Miles: Time On Vehicle (60 Mins)	%	>85%	Nov-18	Janice Sigsworth	ExOp	-	80.3%	78.1%	76.7%	**75.4%**

Section 2: Indicator scorecard for Month 8

Month 8

Domain	Indicator	Unit	Target	Latest Period	Exec Lead	ExCo	#	Reported performance at: Aug-18	Sep-18	Oct-18	Nov-18

E = Exception report available for Month 8

Use Of Resources

Finance KPIs	Monthly finance score (1-4)	number	-	Nov-18	Richard Alexander	ExFin	-	3	3	3	**3**
	In month Position	£m	-	Nov-18	Richard Alexander	ExFin	-	-1.67	3.21	-0.30	**-0.44**
	YTD Position £m	£m	-	Nov-18	Richard Alexander	ExFin	-	3.43	2.04	7.59	**6.04**
	Annual forecast variance to plan	£m	-	Nov-18	Richard Alexander	ExFin	-	-7.10	-6.13	-4.23	**-3.86**
	Agency staffing	%	-	Nov-18	Richard Alexander	ExFin	-	4.1%	4.1%	4.2%	**-**
	CIP (cumulative financial YTD)	%	-	Nov-18	Richard Alexander	ExFin	-	77.8%	75.8%	65.2%	**73.6%**

Additional information on Use of Resources, using the NHS Improvement Model Hospital will be included over 2019/20.

See below for additional information on CQC Insight reporting.

CQC Insight Report at December 2018 (extracts)

A. OVERVIEW

Trust level rating:	Safe	Effective	Caring	Responsive	Well led	Overall
Date of last inspection: 07/12/2017	RI 28/2/2018	G 28/2/2018	G 28/2/2018	RI 28/2/2018	RI 28/2/2018	RI 28/2/2018

Trust composite of key indicators Sep-17 to Dec-18

- The current composite indicator score is similar to other acute trusts that were more likely to be rated as requires improvement
- This trust's composite score is within the middle 50% of acute trusts

Outliers, trust wide and core service indicators

- There are currently 1 active outliers for maternity and 0 for mortality. For maternity 0 are with the panel and 1 are with the regional team. For mortality 0 are with the panel and 0 are with the regional team.

Of the 77 trust wide indicators, 6 (8%) are categorised as much better, 5 (6%) as better, 2 (3%) as worse and 0 (0%) as much worse. 43 indicators have been compared to data from 12 months previous, of which 3 (7%) have shown an improvement and 2 (5%) have shown a decline

Much better compared nationally

- Hospital Standardised Mortality Ratio (Weekend)
- Hospital Standardised Mortality Ratio (HSMR)
- Hospital Standardised Mortality Ratio (Weekday)
- Sick days for medical and dental staff-[set target 3.5%] (%)
- Deaths in Low-Risk Diagnosis Groups
- Summary Hospital-level Mortality Indicator (SHMI)

Much worse compared nationally

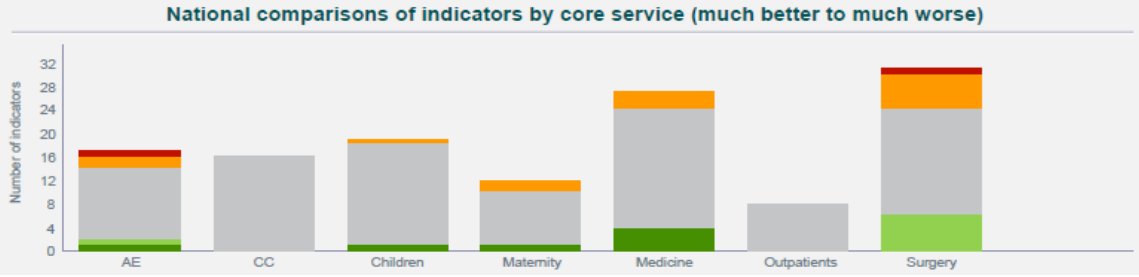
Improved

- Confidence and trust in the nurses
- Flu vaccination uptake (%)
- CAS alerts closed late in preceding 12 months

Declined

- Never Events (total events with statistical comparison to bed days)
- Never Events (total events with rule-based risk assessment)

For each core service, there are different numbers of indicators. When compared nationally, each has been categorised as much better, better, about the same, worse or much worse. The graph shows the number of Indicators for each core service and the number within each category:

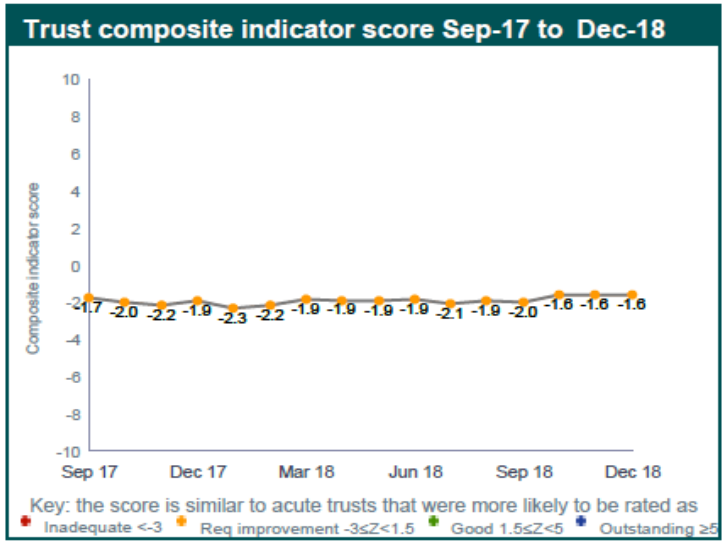


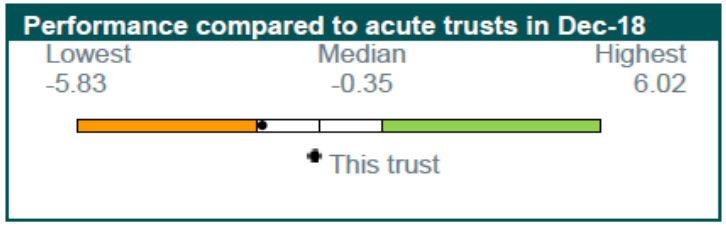
B. TRUST COMPOSITE INDICATOR

The trust composite is a pilot indicator created from **12 specific indicators** within Insight. The composite indicator score helps to assess a trust's overall performance but it is not a rating nor a judgement. The composite is intended to be used alongside other evidence in monitoring trusts.

Some of the data in the CQC Insight report is not recent so may not be reflective of our actual current position.

• At December 2018, the Trust's composite score is within the middle 50% of acute trusts





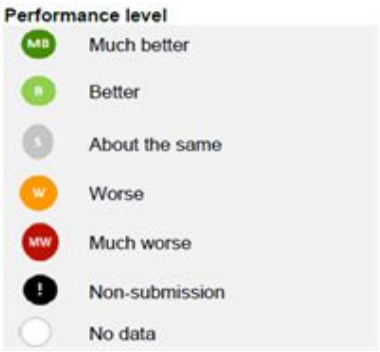
Indicator	Performance			National comparison
	Previous	Latest	Change	
Patients spending less than 4 hours in major A&E (%) NHS England - A&E SitReps (28 Nov 2018)	68.9% Oct 17	78.0% Oct 18	↑	W
Flu vaccination uptake (%) NHS England - Flu Vac (22 Jun 2018)	31.0% Sep 16 - Feb 17	60.5% Sep 17 - Feb 18	↑	S
Patient-led assessment of privacy, dignity, and well being (%) NHS Digital - PLACE (01 Sep 2018)	74.7% Mar 17 - Jun 17	75.5% Mar 18 - Jun 18	→	S
Support from immediate managers (1-5) NHS Staff Surveys - NHS Staff Survey Weighted (26 Apr 2018)	3.75 Sep 16 - Dec 16	3.69 Sep 17 - Dec 17	→	S
Ambulances remaining at hospital for more than 60 minutes (%) National Ambulance Information Group - Ambulance Turnaround (24 Nov 2018)	6.2% Oct 17	6.2% Oct 18	→	S
Fairness and effectiveness of reporting (1-5) NHS Staff Surveys - NHS Staff Survey Weighted (26 Apr 2018)	3.73 Sep 16 - Dec 16	3.73 Sep 17 - Dec 17	→	S
Advice at the start of labour Care Quality Commission - Maternity Survey - Benchmarking (16 Apr 2018)	8.2 Feb 15	8.8 Feb 17	→	S
Cancelled operations as a percentage of elective activity (%) NHS England - FFCEs (20 Nov 2018)	1.0% Jul 17 - Sep 17	0.9% Jul 18 - Sep 18	→	S
Communication between senior management and staff (%) NHS Staff Surveys - NHS Staff Survey Unweighted (26 Apr 2018)	36.4% Sep 16 - Dec 16	34.3% Sep 17 - Dec 17	→	S
Treatment with respect and dignity PICKER - Inpatient Survey - Benchmarking (02 Aug 2018)	8.9 Jul 16	9.1 Jul 17	→	S
In-hospital mortality: Infectious diseases Hospital Episode Statistics - HES - Mortality by CCS group (03 Dec 2018)	96.9 Jul 16 - Jun 17	97.5 Jul 17 - Jun 18	→	S
Confidence and trust in the doctors PICKER - Inpatient Survey - Benchmarking (02 Aug 2018)	9.0 Jul 16	9.1 Jul 17	→	S

Integrated quality and performance scorecard - additional information

Month 8

CQC Insight Report - Key to charts

When compared nationally, each indicator has been categorised as much better, better, about the same, worse or much worse.

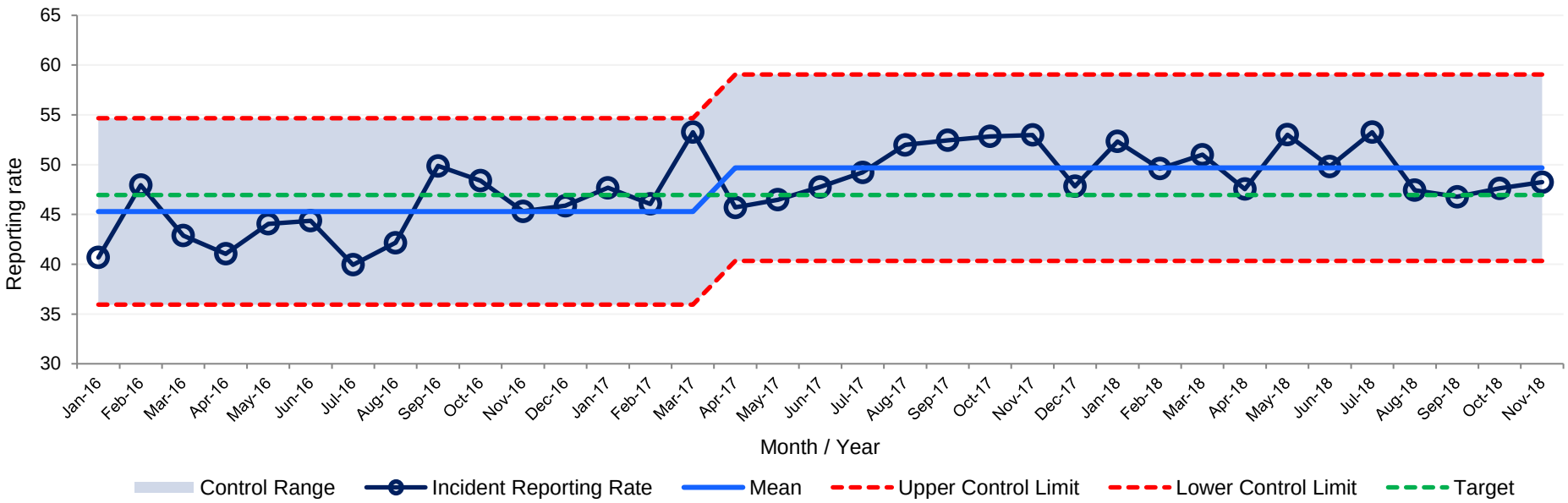


Section 3 Exception report slides summary at month 8

Domain	Report	Executive committee
Safe	Patient safety incident reporting	ExQu
Safe	Never events	ExQu
Safe	Compliance with duty of candour	ExQu
Safe	MRSA BSI and C.difficile	ExQu
Safe	E.Coli	ExQu
Safe	CPE	ExQu
Safe	Flu vaccination	ExQu
Safe	Safeguarding training	ExQu
Safe	Vacancy rates	ExPOD
Safe	Medical devices maintenance	ExQu
Effective	National clinical audits	ExQu
Effective	Mortality reviews	ExQu
Effective	PROMs	ExQu
Effective	Clinical Trials Recruitment	ExQu
Caring	FFT A&E service - % response	ExQu
Caring	Mixed sex accommodation	ExQu
Well led	Doctor appraisal rate	ExQu
Responsive	RTT 18 week waits	ExOp
Responsive	RTT 52 week waits	ExOp
Responsive	Theatre touchtime utilisation (elective)	ExOp
Responsive	Critical care admissions	ExOp
Responsive	A&E 12-hour waits	ExOp
Responsive	Data quality indicator: inpatient orders waiting to be processed	ExOp
Responsive	Data quality indicator: outpatient appointments not checked in / not checked out on the system	ExOp

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 (46.96)	47.62 – October 2018 48.24 – November 2018	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance



Latest performance	Our incident reporting rate in November was 48.24 and the rolling 12 month average reporting rate (December 2017 to November 2018) was 49.54 . This puts the Trust in the top quartile according to data published by the National Reporting and Learning System (NRLS) for the October 2017 – March 2018 period. National bed day data is released 6 months in arrears. Therefore we use the previously known data as a proxy until new data is available.
Return to target / trajectory	We are meeting our target for incident reporting. However actions are being taken to improve further. A high reporting rate with low levels of harm is one indicator of a positive safety culture and is one of the key focus areas for the safety culture improvement programme launched in July 2016.

Safe – Patient safety incident reporting

Issues and root causes	A high reporting rate with low levels of harm is one indicator of a positive safety culture and is one of the key focus areas for the safety culture improvement programme launched in July 2016. Actions being taken to further improve our incident reporting rate are outlined below.

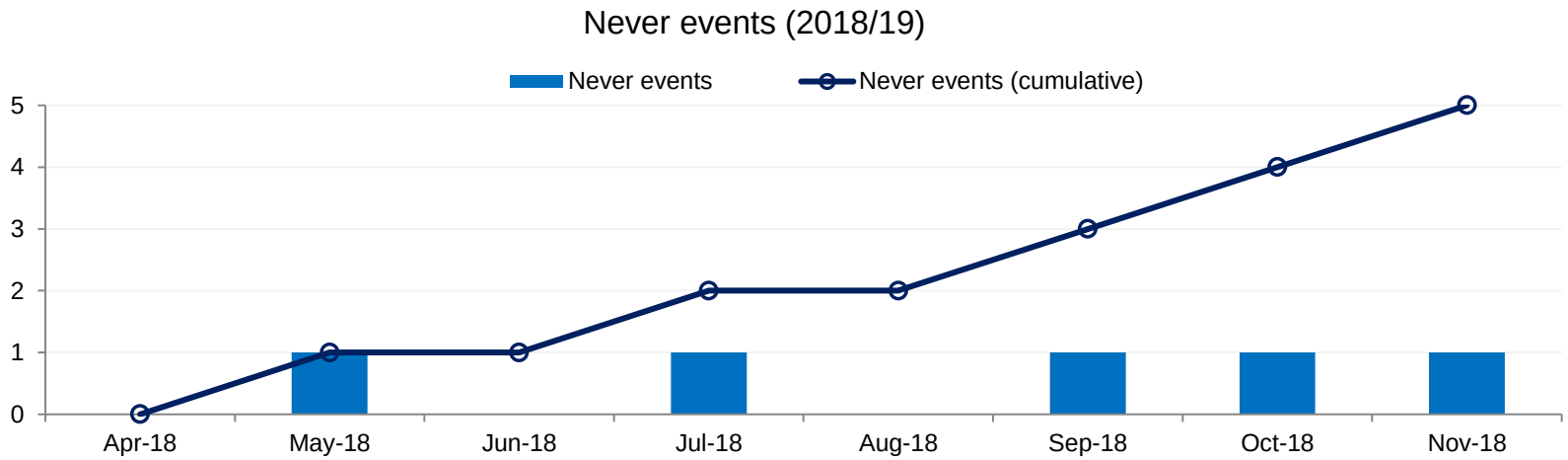
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
'Safety shorts' to be developed as an outcome of the 'trigger list' pilot	Improvement Programme Manager, Safety	Ongoing	Integrating safety shorts into the education and training programme offered by the improvement team, is being considered as part of an end-to-end review being conducted in 2019/20
Introduction of anonymous incident reporting in response to feedback from staff	Head of Quality Compliance and Assurance	March 2018	Complete. The ability to report incidents anonymously was introduced in the Trust on 1st March 2018. Since 1st March 2018, 174 anonymous incidents have been reported.
Learning from excellence communications and roll out	Improvement Lead	November 2018	Successful 3 month pilot completed end of Oct with 44 LfE reports submitted. A project manager has been appointed and will lead on rolling this out Trust wide.
Pilot of Care Report	Head of Quality Compliance and Assurance	December 2018	The technical specification for CareReport has now been agreed, and the full pilot plan has been agreed with the Trust and PSTRC, however there is a delay due to contract issues. The pilot is now expected to commence in Spring 2019.

Risk

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

Safe – Never Events

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have 0 never events	0	October 2018 – 1 November 2018 – 1 (YTD – 5)	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance



Latest performance	Five never events have been reported in this financial year; one wrong route medication incident in May 2018, one retained swab in July 2018, one retained foreign object incident in September 2018, one wrong site surgery in October 2018 and one wrong site block in November 2018. The two most recent never events are outlined on the following slide.
Return to target / trajectory	A trustwide action plan has been developed in response to the four recent invasive procedure never events. Once implemented, this should support us to meet our objective of having no never events in the next financial year.

Safe – Never Events

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have 0 never events	0	October 2018 – 1 November 2018 – 1 (YTD – 5)	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance

Latest performance	Five never events have been reported in this financial year; one wrong route medication incident in May 2018, one retained swab in July 2018, one retained foreign object incident in September 2018, one wrong site surgery in October 2018 and one wrong site block in November 2018. The latest two are both under investigation. **Wrong site surgery – October 2018** The October incident involved a ureteric stent being inserted on the right side instead of the left despite the consent form, skin marking, team brief and WHO checklist all appropriately performed and indicating the planned surgery to be on the left side. Second surgery was performed on 24th October to remove the incorrectly inserted right sided ureteric stent and insert the required left sided ureteric stent. The patient has recovered well. Immediate actions include the side (laterality) of any invasive procedure being written on the count whiteboard during the time out. A safety alert has been issued to all staff outlining this. **Wrong site block – November 2018** The most recent never event was declared on 26th November 2018. A patient was admitted for a left mastectomy and left axillary clearance and breast reconstruction with transverse upper gracilis flap (flap from the leg). The consultant anaesthetist performed an abdominal block, as this is the usual donor site for the flap; however taking the flap from the abdomen was not viable for this patient as the patient was too slim therefore the flap was to be taken from the patient's leg meaning that the incorrect site was blocked. There was no harm to the patient. A safety alert has been issued to all staff highlighting the 'stop before you block' protocol.

Safe – Never Events

Issues and root causes	The four most recent never events are all related to invasive procedures. Our audit of WHO checklist (November 2018) also shows there is more to be done in relation to following the 5 steps to safer surgery (particularly the brief and debrief). In addition we have also declared a number of serious incidents where there were issues with the WHO checklist and/or which were related to safety with invasive procedures .

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Establish invasive procedure task and finish group	Medical Director	Complete	Complete – bi-weekly group established with a lead from each division in attendance. Governance has been confirmed with the divisional directors.
Develop and implement trustwide action plan to reduce the risk of never events and improve patient safety for interventional procedures	Medical Director	March 2019	Action plan developed and agreed with executive committee 18/12/18. Plan is being presented at ExQu 08/01/19. This is being monitored through the IP T&F group with monthly reporting to quality and safety sub-group and exception reporting to executive quality committee.

Risk

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

Safe – Never Events

Issues and root causes	Actions remain outstanding for two wrong route medication never events, one reported in July 2017 and the other in July 2018. Progress is shown below.

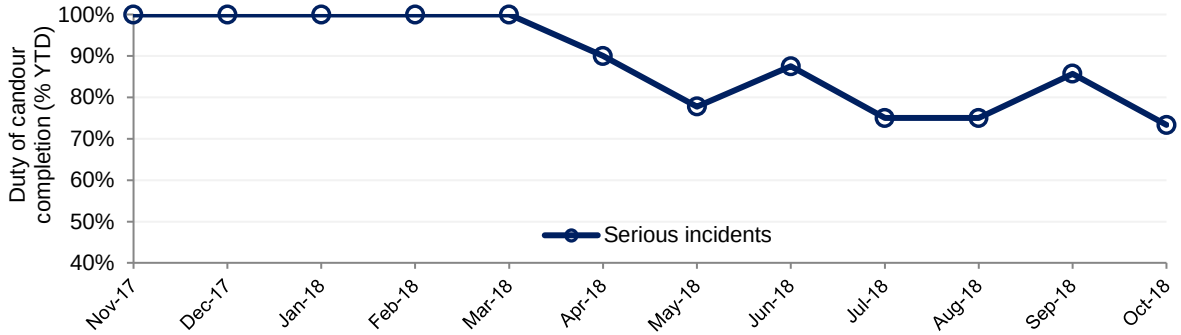
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Introduction of a standardised product that will prevent epidural lines from being connected to the inappropriate access device e.g. a peripheral cannula	Division of SCC	ASAP	A full suite of NRFit connectors are still not available from our suppliers and as an interim measure yellow stickers which state “epidural” have been placed on the epidural line near to the port connection to highlight the route in all clinical areas. The epidural compliance audit completed by the pain service in October 2018 showed improved results, with 95% of patients being compliant with NPSA guidance for labelling epidural infusions compared to 44% in the last audit. There were also improvements with storage. Until the NRFIT connectors are available, actions have been developed to increase compliance with labelling, storage of epidural infusions and nurse training, including the purchase of epidural labels that are more robust, continued drive by educators and ward managers to complete epidural competencies, and development of defined standards for training and competencies in areas where these are not currently available (paediatrics and maternity private patients).
Update the current enteral feeding policy following oral and enteral medication audit	Chief Pharmacist	November 2018	A full oral and enteral medication audit was completed in July 2018 and divisional action plans were presented to the quality & safety subgroup in September. The Trust’s Chief Pharmacist has updated the administration of medicines policy which was approved at sub-group in December.

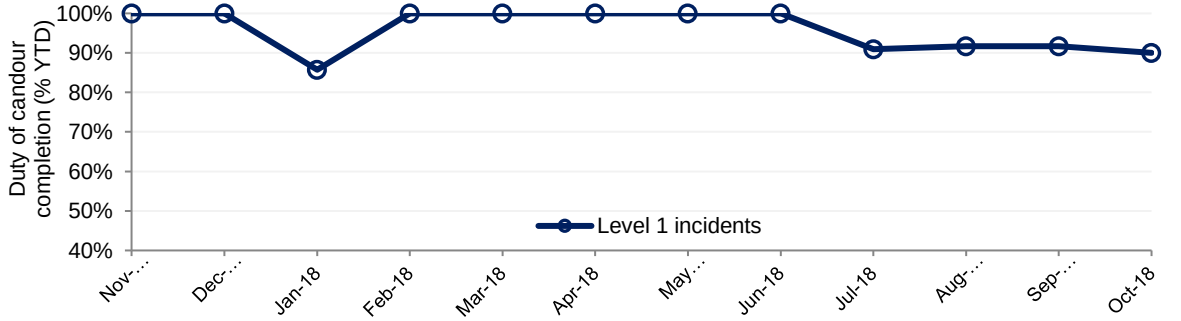
Risk

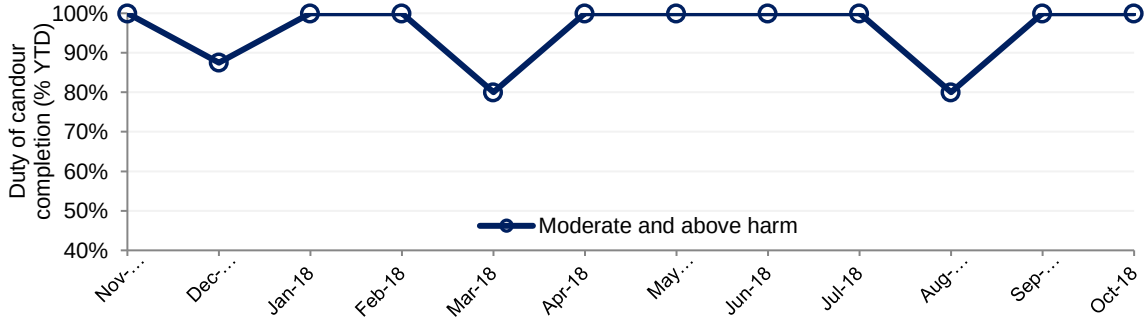
- Is it on the (divisional / corporate) risk register? YES (Corporate Risk ID 2490 Failure to deliver safe & effective care)

Safe – Compliance with duty of candour

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure 100% compliance with duty of candour requirements for every appropriate incident graded moderate and above	100%	SIs: 87.4% Internal investigations: 95.2% Moderate and above incidents: 95.8% (cumulative data for incidents reported Nov 2017 – Oct 2018)	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance







Latest performance

In month performance as follows:

Serious Incidents
85.7% compliance for Sept 2018 and 73.7% compliance for Oct 2018

Level 1s
91.7% compliance for Sept 2018 and 90% for Oct 2018

All other moderate and above incidents
100% compliance for both Sept and Oct 2018

Return to target / trajectory

Increased focus on corporate areas and NWL pathology to clear outstanding cases will bring us back on trajectory for January 2019.

Safe – Compliance with duty of candour

Issues and root causes	A number of the outstanding duty of candour cases are for cases in NWL Pathology and the Trust's corporate area (private patients). These incidents are now being discussed at the weekly MD panel in line with other divisions. This should support improved performance. We are expecting to see improvements from January 2019.

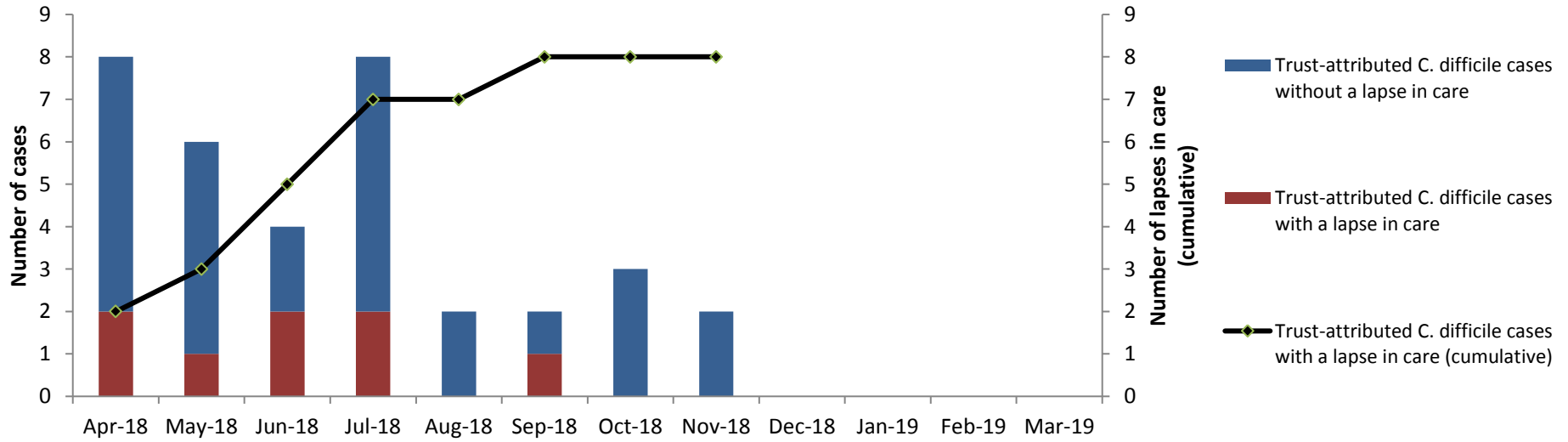
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Outstanding duty of candour is followed up and monitored at the weekly Medical Director's Incident Meeting.	Head of Quality Compliance & Assurance	Ongoing	Progress has been made over the past year, all outstanding cases are reviewed at the weekly MD panel. A reminder to consultants of the required timeframe to complete the DoC letter has been written and will be sent in the next RO newsletter (due to be sent out by end of December).
Review of duty of candour policy.	Head of Quality Compliance & Assurance	Autumn 2018	Complete. The policy was approved at Quality & Safety Subgroup in October, with a six month review period to align with new national guidance due to be issued.
95% compliance with mandatory online duty of candour training for nurses at Band 7 and above and all consultants.	Divisions	March 2018	Overdue. Divisions continue to be below the 95% target. As of 14th December 2018 consultant compliance is 82% (MIC), 82% (SCC) and 88% (WCCS). Issues with non-compliance are being addressed by the divisional directors.
Duty of candour letter templates to be reviewed	Head of Quality Compliance & Assurance	End November 2018	Templates are being reviewed centrally to develop a comprehensive library of standardised letter templates to support consultants when dealing with complex cases. These will be approved at sub-group in Jan 2018.

Risk

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

Safe – MRSA BSI and *C.difficile*

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure we have no avoidable MRSA BSIs and cases of *C.difficile* attributed to lapse in care	0	MRSA BSI: 0 – October 2018 1 – November 2018 MRSA BSI YTD: 3 *C.difficile* lapse in care: 0 – October 2018 0 – November 2018 *C.difficile* lapse in care YTD: 8	Julian Redhead, Medical Director	Jon Otter, General Manager IPC



Latest performance	• One case of Trust-attributed MRSA BSI has been reported for November 2018, with no cases for October 2018. There have been three cases reported so far for 2018/19. • October 2018 saw three cases of Trust-attributable *C.difficile*, none of which was identified as a lapse in care. • November 2018 saw two cases of Trust-attributable *C.difficile*, none of which was identified as a lapse in care.
Return to target / trajectory	• Target for MRSA and *C.difficile* is zero, therefore no return to target this FY 18/19

Safe – MRSA BSI and *C.difficile*

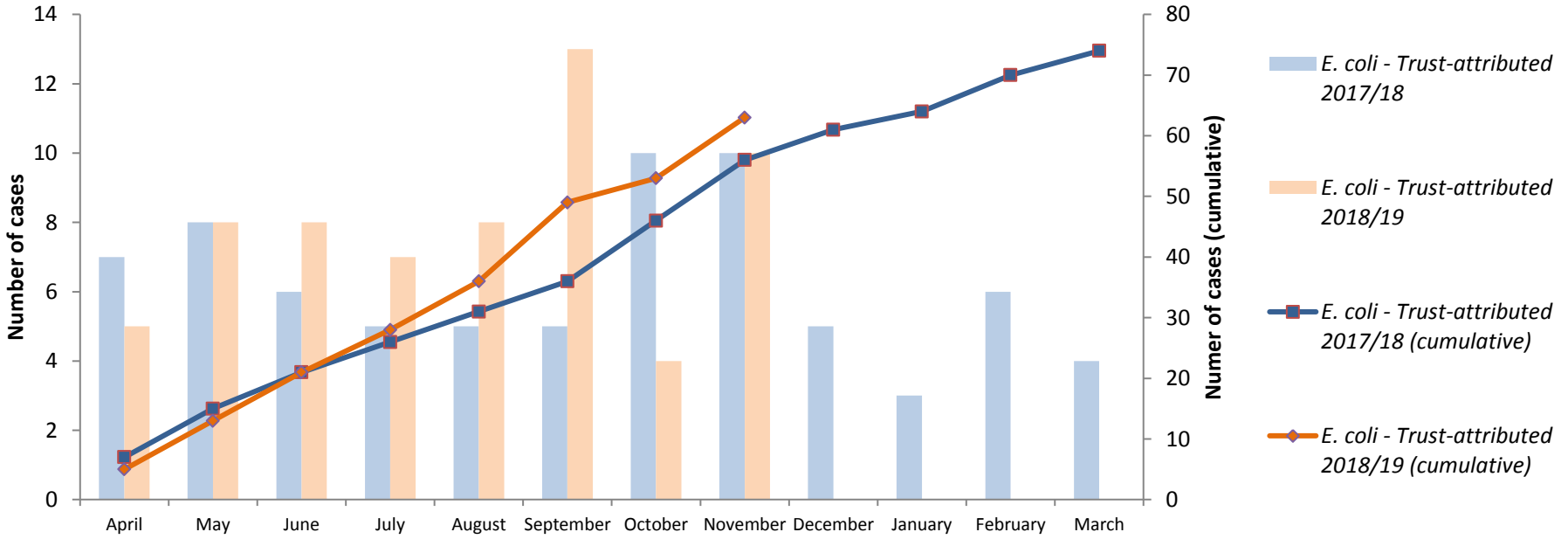
Issues and root causes	**MRSA BSI**: A baby in the neonatal unit had an MRSA bacteraemia, has been treated and recovered; actions following the investigation relate to standardisation of vascular access device documentation; a Datix was submitted as the bacteraemia occurred in the context of transmission among 3 babies, the other two of whom had colonisation only. ***C.difficile*:** October 2018 saw three cases of Trust-attributable *C.difficile,* with November 2018 seeing two cases, none of which was a lapse in care.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Develop and implement hand hygiene improvement and communications plan	Jon Otter General Manager IPC	Ongoing	The hand hygiene improvement plans are now in progress. Implementation progress is being monitored through the Improving Care Programme Group.
Ongoing review of potential themes arising from lapses in care related to *C. difficile.*	Eimear Brannigan, Deputy DIPC	Ongoing	The lapses in care so far during 2018/19 have been reviewed and no clear themes emerge. We continue to work with Divisions in reviewing each case and identifying opportunities for preventative action.

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

Safe – *E.coli*

Indicator	Target	Latest data	Executive lead	Report author(s)
We will achieve a 10% reduction in healthcare-associated BSIs caused by *E. coli*	10% reduction (n=65)	4 - October 2018 10- November 2018 YTD = 63	Julian Redhead, Medical Director	Jon Otter, General Manager IPC



Latest performance	• Four cases of Trust *E.coli* BSI have been reported for October 2018, with 10 cases for November 2018. This makes a total of 63 cases for 2018/19, compared with 56 cases for this period in 2017/18. • Of the 14 cases in October and November 2018, 1 was in a premature baby who had recurrent E. coli sepsis following E. coli meningitis. 5 episodes had biliary sources, 2 had other intra-abdominal sources, 1 had neutropenic sepsis, 2 urinary sources both having had recent removal or manipulation of urinary catheter, and 1 each had endometritis, and a complex post-renal transplant collection. 1 further complex case had no identifiable source. The main theme that emerges from our investigation of these cases in Q3 is *complexity of cases.* No suspected clusters were identified.
Return to target / trajectory	• 10% reduction target is unlikely to be met this FY 18/19

Safe – *E.coli*

Issues and root causes	There were 14 cases of Trust attributable *E.coli* BSI in October and November 2018. Cases of *E. coli* BSI are reviewed monthly to identify any potential trends. It seems likely that many of the cases of healthcare-associated *E. coli* BSI are a direct result of necessary interventions and are not preventable (e.g. those associated with neutropenia), or related to complex cases in patients with advanced malignant disease (such as those with biliary sources). However, other sources of infection are more likely to be preventable (e.g. *E. coli* BSIs associated with urinary catheters). An internal IPC working group, led by the Deputy DIPC, has been exploring the available Trust resources relevant to reducing Gram-negative BSI through discussions with key stakeholders from the Nursing Directorate, and the Divisions. To date this has focused on hydration, continence, and promotion of early removal of catheters. High risk areas may require more detailed work on understanding the use of specific prophylactic antibiotics. Additional work centres on deciphering community drivers of hospital-onset Gram-negative BSI, done alongside the CCG.

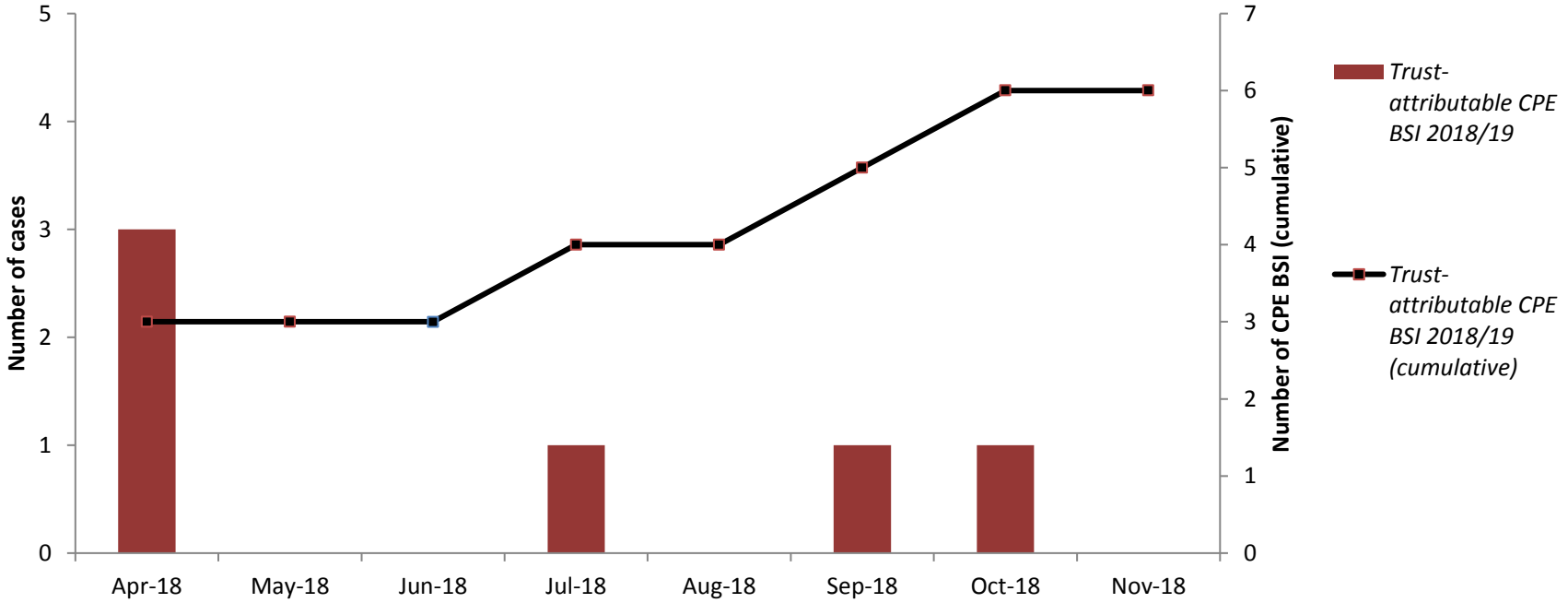
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Identify those cases with potential for prevention interventions.	Eimear Brannigan, Deputy DIPC	January 2019	Urinary catheter-associated Gram-negative bacteraemias to be initial focus. Scoping of current Trust monitoring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

Risk

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

Safe - CPE

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have no healthcare-associated BSIs caused by CPE	0	1 - October 2018 0 - November 2018 YTD = 6	Julian Redhead, Medical Director	Jon Otter, General Manager IPC



Latest performance	One Trust attributable CPE was identified in October 2018, from a haematology patient. We have seen six CPE BSI cases YTD 18/19 as compared to four cases this time last year 17/18. The 6 cases this year were all high risk patients with advanced malignant disease, or complex liver or urological conditions and found to be colonised with CPE prior to their BSI, which was not preventable due to unavoidable surgical and/ or medical interventions. The case reviews have not identified any specific learning points.
Return to target / trajectory	• Target for CPE BSI is zero, therefore no return to target this FY 18/19

Safe - CPE

Issues and root causes	There have been six CPE BSI cases this FY 2018/19. Each case undergoes clinical review to optimise management from the infection multidisciplinary team. A review is undertaken of each case and themes collated at intervals to identify learning and opportunities for preventive action. The Trust CPE action plan is in place and has been updated in light of an increase in cases of positive screens; this includes implementation of admission and regular CPE screening of patients on wards in which there have been transmission incidents, improving ward-level IPC practice (including the development of specific criteria for ward re-opening in the event of a CPE outbreak, reviewing toilet ratios usage and access, and reviewing cleaning standards), improving and supporting ward level screening through the development and launch of a Cerner CPE screening tool, optimising antimicrobial strategies for CPE management and treatment (including the implementation of a new report from Cerner relating to patients on carbapenem antibiotics), use of electronic patient record to flag affected patients to clinical staff, and use of serious incident processes to investigate and learn from clusters. Additionally we aim to develop a daily report of the number of patients with CPE currently in the hospital, and their location, with support from the Cerner/IT and microbiology teams. A review of six CPE BSIs this year have identified that all occurred in patients with advanced malignant disease or complex urological or hepatic conditions, and that no specific preventive action could have been taken.

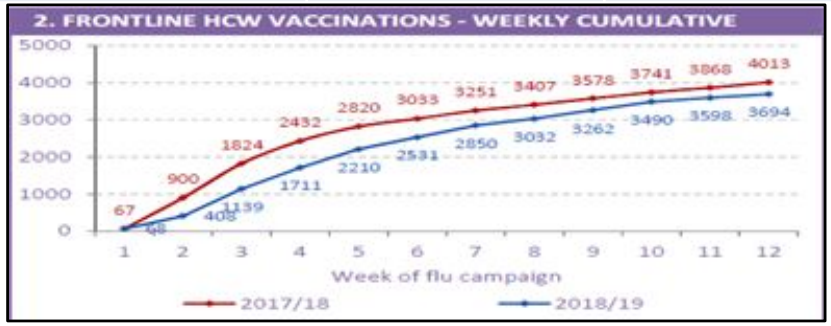
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Case review of BSIs to identify learning	Eimear Brannigan, Deputy DIPC	January 2019	The initial findings of the review of the CPE BSI cases during the FY will be included in the Q3 IPC report.
Develop and launch Cerner CPE screening tool to promote and support implementation of CPE screening.	Tracey Galletly, Lead Nurse IPC	January 2019	The tool offered by Cerner does not meet the original specification and need to be redesigned. An update will be included in the January report.

Risk

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

Safe – Flu vaccination

Indicator	Target	Latest data	Executive lead	Report author(s)
We will meet flu vaccination targets for frontline workers	75%	45.2%	Kevin Croft, Director of P&OD	Elaine Fry, Flu campaign programme manager



Latest performance	Although all staff within Imperial can be vaccinated it is only frontline staff vaccination rates that are reported to NHSe on a monthly basis. The values submitted to NHSe; for the 2018/19 campaign over the last two months are: MONTH / FRONTLINE STAFF / VACCINATED / % OCTOBER 8330 2208 26.5% NOVEMBER 8712 3938 45.2% Uptake at the end of November 2018 was 45.2%. In 2017/ 18 at the same point we had achieved 42.7%, showing an increased uptake of 2.5% for this year. Although last years denominator was 700 eligible staff higher the difference in those vaccinated is only 78. The graph above demonstrates the take up rate over the last two years and reflects data up to week 12 (Tuesday 10th December) Of the 8,372 frontline staff within Imperial College Healthcare, we have vaccinated 3,694 staff; A further 2,585 members of staff would need to be vaccinated to attain 75%, which equates to 328 vaccinations per week , over the next 7.9 weeks. The 3694 frontline staff vaccinated is broken down as, Nurses (40.7%) 1477, Doctors (50.1%) 98, Support (43.6%) 631 and Other professionals (53.7%) 597.
Return to target / trajectory	The final submission to NHSe is the 11th March 2019 for this years flu Campaign. Up to this point, communication to staff and availability of Flu vaccinators will continue to be managed through the weekly Flu huddle and campaign teams to enable the trust to attain its goal.

Safe – Flu vaccination

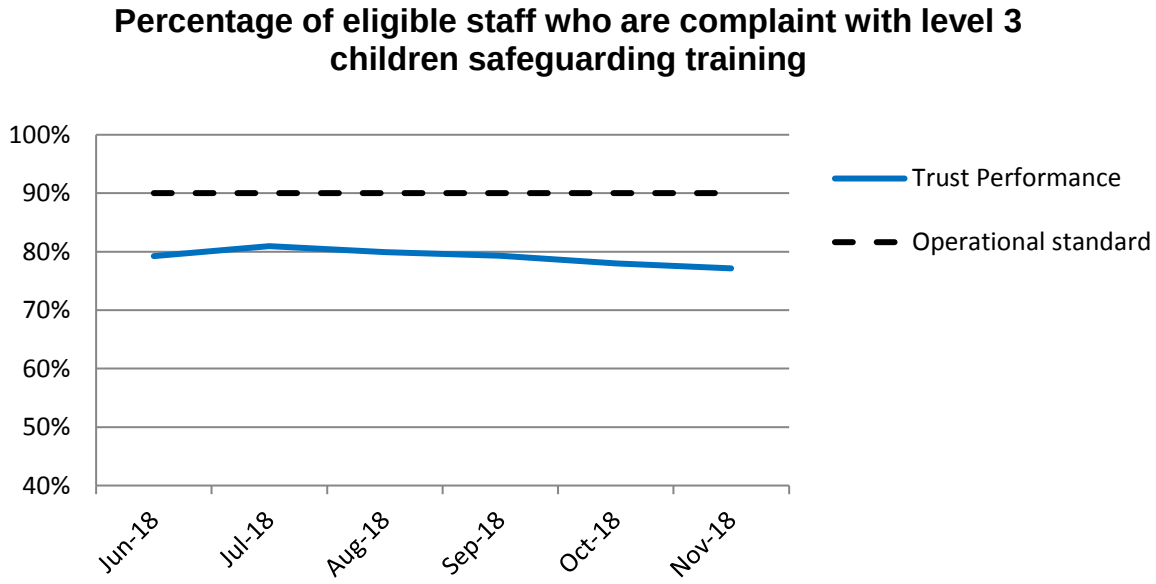
Issues and root causes	Take up of the vaccination across London has been low this year particularly in critical care and maternity specialities, a milder climate has reduced any major out breaks of the flu, both are contributing to lower vaccination number this year, NHSe are looking at how they can support trusts to encouraging staff to have the vaccination. Internal Communication (emails and myth Busters) will be used to encourage staff to have the vaccination, who have not had the vaccination or have had a poor experience with the vaccine in the post.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Maintain and develop ongoing staff communication plans. Including Emailing staff who have not had the vaccination. Updated screen savers and Intranet with regular Flu updates and posters	Business intelligent (emails) Intranet (communications) Flu Campaign team	December 2018 - and January 2019 Life of the campaign	• Email to go out on the 19th December with a follow up email in January. • Campaign team will follow up respondents with the appropriate actions and vaccinator bookings • Campaign team working with communications to ensure an ongoing synchronised communication plan
Co-ordinate attendance of roaming and Peer vaccinators to areas with low take up, including any off site locations	Flu Campaign team	Life of the campaign	• On going proactive booking and co-ordination of vaccinators attending: • Corporate events, team meetings, wards, clinics, remote units, training event, ad hoc request
Undertake weekly briefing sessions with Divisional Flu leads to discuss progress and actions plans for the upcoming week, providing the executive (ETM, EPOD) with regular updates on progress	Kevin Croft	Life of the campaign	• Progress is tracked and documented at the weekly huddles. • Further targeted plans including targeting low take up Cost Centers are planned for January 19
Addressing myths and reasons staff are declining vaccinations	Flu Campaign team/ Occupational Health	Life of the campaign	• Liaising with NHSe for initiatives that have worked in other trust. • Writing and maintaining a myth busters which are included in communications out to staff

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

Safe – Safeguarding children training (level 3)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure that 90% of eligible staff are compliant with level 3 safeguarding children training	90% or greater	November 2018 performance was 77.2%	Janice Sigsworth	Guy Young Deputy Director – Patient Experience



Latest performance	• The level of compliance fell by 1% compared with the previous month. This is likely due to new starters in November who require level 3 being added to the denominator.
Return to target / trajectory	• At the time of writing there are 320 nurses, midwives, AHPs and 90 doctors in training who are recorded as non compliant. In November 99 staff were trained. Maintaining this number each month will only keep the compliance rate from falling further. Over 1000 places are available between now and April which is more than sufficient to achieve the 90% if people attend.

Safe – Safeguarding children training (level 3)

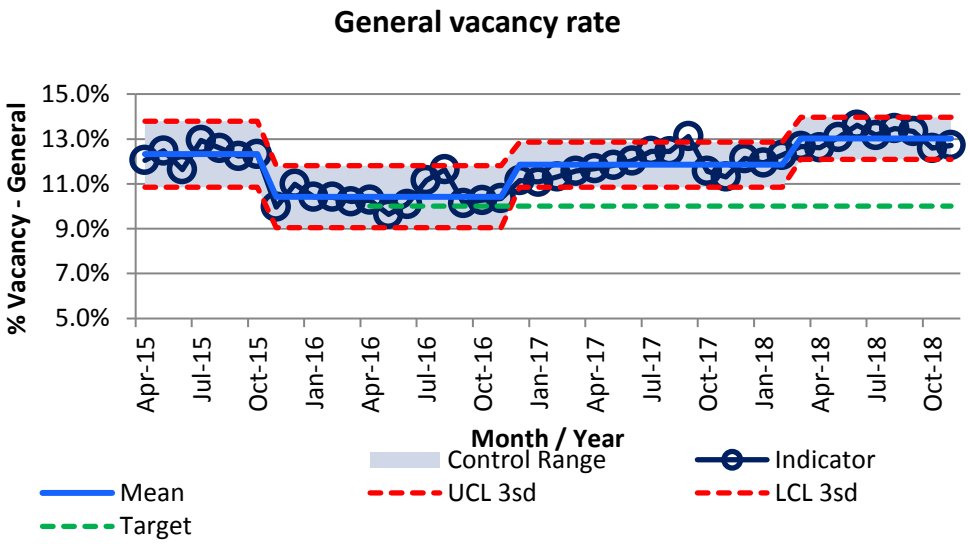
Issues and root causes	Level 3 training requires attendance at a classroom based session. We are providing the shortest session possible to meet the current Intercollegiate requirements, but it seems to be a challenge for staff to be released.

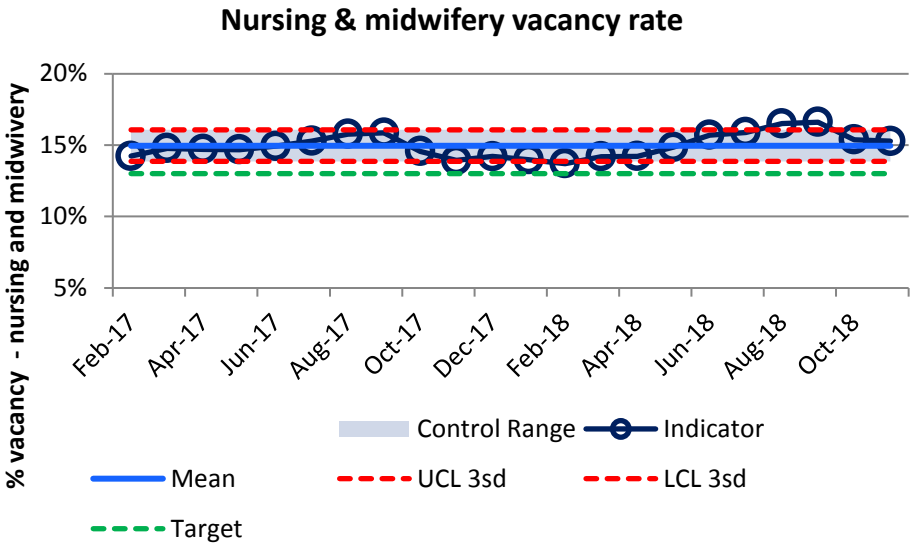
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Provide adequate training places to meet requirement	SG children's team	By April 2018	• Sessions planned and set up on Moodle (i.e ready to be booked on)
Ensure staff and managers know who is non-compliant	All	By Jan 2018	• Reports available on Wired
Explore alternative methods of training	Deputy director – patient experience	By Jan 2018	• Reviewing e-Learning for Health module and others • Explore blended learning option that meets intercollegiate requirements, but potentially reduces the length of required classroom attendance

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

Safe– Vacancy rates

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have a general vacancy rate of 10% or less; We will have a nursing and midwifery vacancy rate of 13% or less.	10% target for overall Trust vacancies and 13% for overall N&M vacancies	November 2018 position was; All Trust 12.7% All N&M 15.3%	Kevin Croft, Director of People and Organisational Development	Dawn Sullivan, Deputy Director of People and Organisational Development





Latest performance	• at the end of November the vacancy rate was 12.7% reflective of 1,398 WTE vacancies; down from 13.3% in September (month 6) • the number of staff directly employed, across all of the Trusts Clinical and Corporate Divisions was 9,595 WTE; an increase of 93 WTE from those employed in September • for all nursing & midwifery roles, the vacancy rate was 15.3% (800 WTE vacancies); down from 16.6% in September (month 6)
Return to target / trajectory	• the projection is that we will hit the 13% N&M vacancy rate target by the end of March 2019 based on current activity and establishment • the 10% overall trust vacancy rate target is projected to be met by the end of March 2019

V2. Updated Dec 2018.

Safe– Vacancy rates

Issues and root causes	• Workforce is a key issue across the NHS – in 2017 more nurses left the profession than joined. Imperial has an overall nursing and midwifery vacancy rate of 15.3%. There are a wide range of recruitment initiatives in place however these maintain our position rather than reduce the vacancy rate significantly • There are a number of factors that are compounding the workforce issue and making recruitment and retention of staff very difficult: Brexit, 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 146 recruits to date. Effective on-boarding will be key to its success
Participation in Cohort 3 of the NHSI Direct Support for Retention	Dawn Sullivan/ Sue Burgess	1 year	• A plan was submitted in August, NHSI are visiting on 24th July to discuss the plan
10-point recruitment plan	Dawn Sullivan	1 year	• The Trust is recruiting on average 85 N&M staff each month against an average t/o of 65 N&M staff each month. The big ticket items in the plan are students, international recruitment and Band 5 and HCA talent pools

Risk register

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

Safe – Medical Devices Maintenance (high risk)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will improve medical devices maintenance compliance according to risk categorisation	98% for High risk, 80% for Medium Risk and 70% for Low risk	November compliance was as follows: High risk = 96% Medium risk = 89% Low risk = 91%	Janice Sigsworth (Director of Nursing)	Max McClements (Head of Clinical Engineering)

Risk category	Target	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18
High risk	98%	76%	77%	89%	89%	91%	94%	94%	95%	96%

Latest performance	• There has been a continual improvement in maintenance compliance figures for medical devices. • Although High Risk is improving the target figure was not achieved. This was due, in part, to hoists being transferred to Clinical Engineering and these are classed as High Risk devices. • Clinical Engineering are working with supplier to action the required work to improve maintenance and reliability of hoists.
Return to target / trajectory	It is expected that all target KPI's will be achieved by January 2019.

Safe – Medical Devices Maintenance (high risk)

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

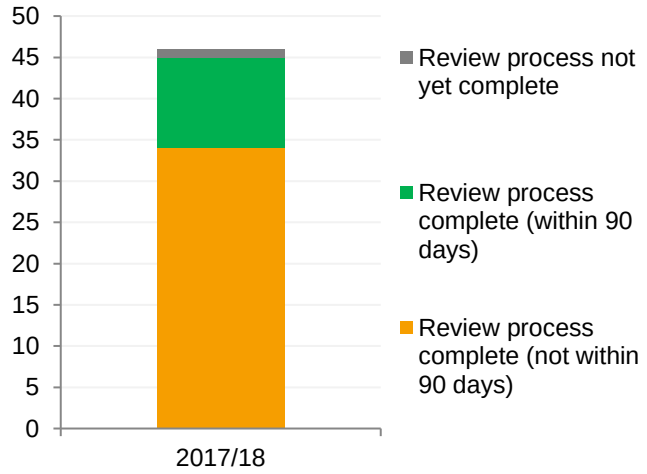
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Introduction of medical device categorisation	Aheed Syed (Operations Manager)	October 2018	• Completed
Radio-frequency identification (RFID) Implementation	Aheed Syed (Operations Manager)	January 2019	• Interaction between IT systems being developed and connectivity issues being addressed • Workshops and libraries have active system installed to monitor equipment movement
Training process for staff	Drushtee Ramah (Medical Device Principal)	January 2019	• e-Learning package developed and will be rolled out January 2019 • Checklist being issued to inform staff of responsibilities when using medical devices
Introduction of Equipment libraries	Max McClements (Head of CTS)	March 2019	• SMH and CHX libraries open and successfully introduced. HH library staff being recruited and refurbishment scheduled for January/February 2019.

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

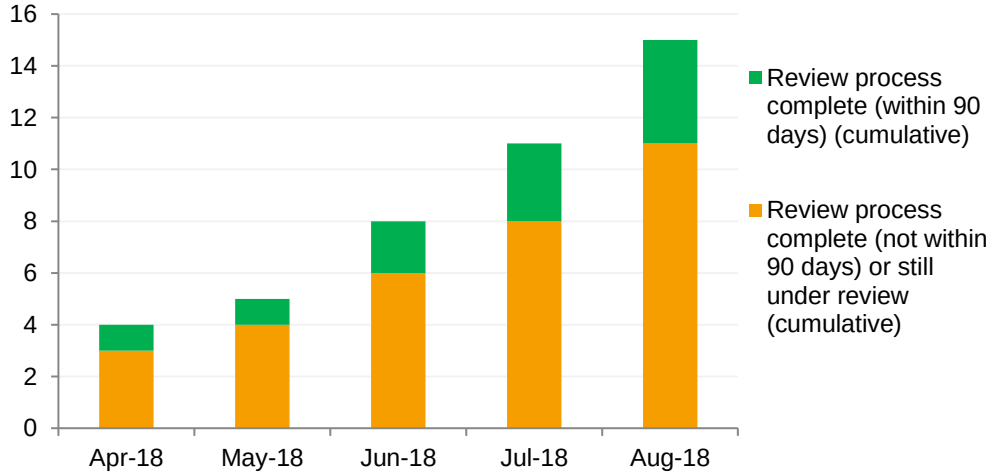
Effective – National clinical audit

Indicator	Target	Latest data	Executive lead	Report author(s)
We will participate in all appropriate national clinical audits and evidence learning and improvement where our outcomes are not within the normal range	Participation in 100% of relevant national clinical audits Number of audits that have not completed the review process within 90 days	100% - August 2018 11 – August 2018 (for audits reported in 2018/19)	Julian Redhead, Medical Director	Louisa Pierce, Clinical Auditor

2017/18 Audit review process status



2018/19 Audit review process status (cumulative)



Latest performance	The first graph demonstrates performance against Quality Account reportable National audit activity for the previous financial year 2017/18. 45 National audits have completed the review process (as of 10.11.2018) however, one remains outstanding. The second graph demonstrates performance against Quality Account reportable National audit activity up to August 2018 for the financial year 2018/19. The number of National audits will increase as the financial year progresses as further national audit reports are published. Data is reported on a monthly basis, but the data presented here is three months in arrears to allow time to go through the Trust ratification process. Fifteen National audits were published up until the end of August 2018. All of these were relevant to ICHT. ICHT participated in 100% of the relevant national clinical audits. Four audits have completed the review process and eleven audits have not completed the internal review process within 90 days.
Return to target / trajectory	Progress is tracked weekly at the MD incident panel.

Effective – National clinical audit

Issues and root causes	Whilst the Trust submitted data for all national audits published in 2017/18 (15), audits reports are not being consistently reviewed and risk-assessed by divisions within the internally set Trust target of 90 days (11 reviews/risk-assessments remain outstanding in August 2018). There is one audit review outstanding from 2017/18, which is in the division of Medicine and Integrated Care – National diabetes foot care audit. This is under review by the Trust lead and is expected to be completed by the end of December.

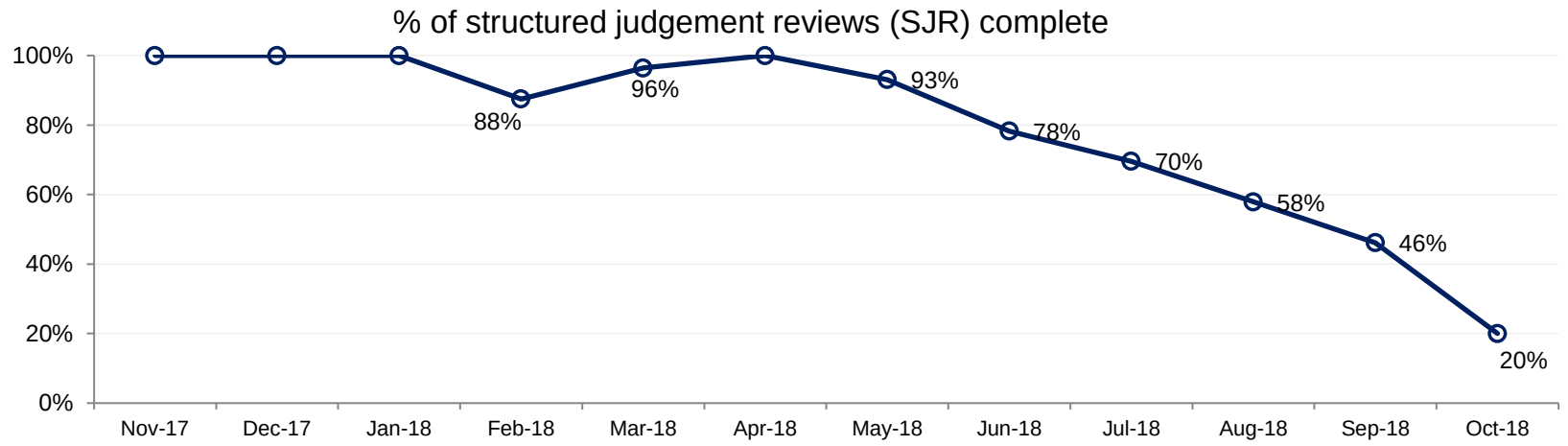
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
All significant risk audits to have an action plan in place that is presented to the quality & safety subgroup.	Raymond Anakwe/Audit Leads	On-going	Four audits from 2017/18 were identified as 'significant risk/little assurance'.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

Risk

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

Effective – Mortality reviews

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure structured judgement reviews are undertaken for all relevant deaths in line with national requirements and Trust policy and that any identified themes are used to maximise learning and prevent future occurrences.	100% of all relevant deaths	SJR reviews completed: 46% September 2018 20% October 2018	Julian Redhead, Medical Director	Trish Bourke Mortality Audit Manager



Latest performance	• Data is refreshed on a monthly basis as SJRs are requested and completed. This data is now reported 1 month in arrears to allow time for the SJR cycle to be completed. 100 completed reports have been received to date for this financial year (18/19), with 5 avoidable deaths reported. Trust compliance for SJRs is 46% for September and 20% for October 2018, against a target of 100%. • Trust compliance for local level 1 mortality review is 88% for September and 88% for October 2018, against a target of 100%. • Following feedback at board quality committee, we are reviewing how this data is presented so that progress in completing the reviews is better represented
Return to target / trajectory	Data is reviewed at the weekly incident panel. Trajectories are being set for improvement by division.

Effective – Mortality reviews

Issues and root causes	Cases are reviewed at the monthly Mortality Review Group with a focus on any avoidable factors and learning themes. A review of how data and intelligence from the mortality reviews could be utilised more effectively to inform safety improvement work and reduce avoidable harm as part of the quality account improvement priorities is currently underway.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Recruitment of additional structured judgement reviewers.	Mortality Auditor	Dec 2018 (originally Sept 2018)	37 members of staff have undergone structured judgment review (SJR) training, which includes 4 new reviewers. 2 reviewers are currently on maternity leave. Recruitment continues to ensure we have at least one reviewer in each specialty to facilitate local feedback of findings and divisions have been asked to provide nominations. These additional reviewers will support with increasing the SJR completion rates.
Strengthen and formalise the process for triangulating data from cases that have both SJRs and SI investigations undertaken, this includes the recording and accessibility of the data generated.	Head of Quality Compliance & Assurance	End Nov 2018 (originally Oct 2018)	A SOP to formalise the process for triangulating data was reviewed at the meeting. Issues were raised including the need to modify the SI process when there's a death to ensure the SJR and SI investigations are joined up. This is being taken forward as part of a review of the mortality processes, led by a General Manager in the Office of the Medical Director to look at how we strengthen the governance, compliance and learning from the review process. The review will also look at how we transition to a medical examiner model in 2019/20 which has been nationally mandated. This will require investment in the role of medical examiner and so a full review and proposal will be brought through executive quality committee in Q4.
Review of the issues highlighted from the incident investigations (SI/level 1) and SJRs for each case since April 2018.	Mortality Auditor	End Oct 2018	Report presented to the October Quality & Safety subgroup with a number of actions required from the divisions before this action can be closed. This will be monitored through the sub-group with the next report due in February 2019.

Risk

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

Effective – Patient reported outcome measures PROMs

Indicator	Target	Latest data	Executive lead	Report author(s)
We will increase PROMs participation rates to 80% and report above average health gain	80% Above average	As detailed below	Katie Urch, Divisional Director	Anne Hall, General Manager Trauma Services Dharma Shenoy, Data Lead T&O

	October Position			
	Hip replacement		Knee replacement	
	Participation Rate	Reported Health gain	Participation Rate	Reported Health gain
Sep-18	0%	EQ-5D Index:0.462 EQVAS:19.588 Oxford Hip score:23.060 (Apr17-Mar 18)	0%	EQ-5D Index:0.304 EQVAS: 8.402 Oxford Knee score:13.918 (Apr17-Mar 18)
Oct-18	100%		100%	

Latest performance

PROMs M7 data released on NHS Digital reports the participation rate for Hip and Knee replacement procedures at 100%.

The health gain scores reported for this financial year has been amended to reflect the Adjusted Average Health Gain score across the four index measures for Hip and Knee replacement. This measure of Adjusted average health gain score takes into consideration the different case mix of each hospital and allows for a fair comparison of Trust performance.

Comparison of Adjusted average health gain score, Improved and Worsened score for Trust and England:

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

Effective – Patient reported outcome measures PROMs

Latest performance

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

The difference between the previously reported scores and the amended scores is marginally different, without diverting from the previous narratives significantly.

Return to target / trajectory

On-going process

Effective – Patient reported outcome measures PROMs

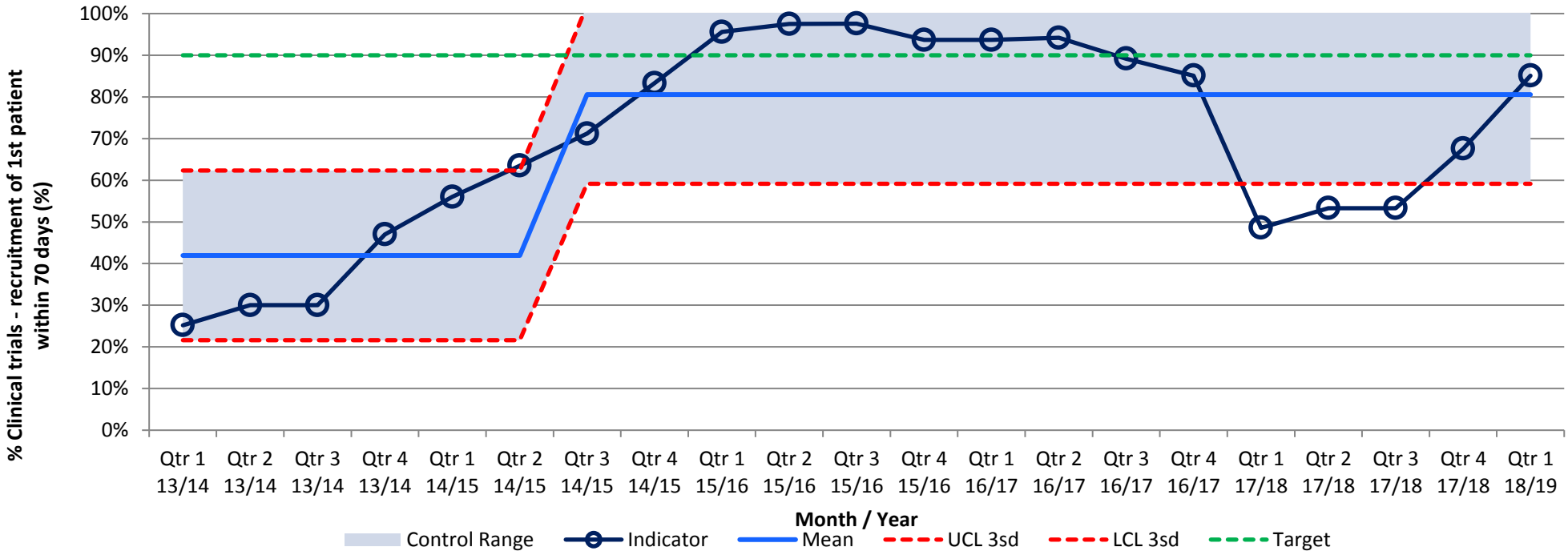
Issues and root causes	Following the initiative to improve PROMs data management, a dedicated Band 7 nurse oversees the process to ensure submission rates are above 80% and contacting eligible patients to remind them to complete post op questionnaire. There were issues with Capita, the external agency responsible for data collection post surgery which affected the overall health gain score of the Trust. Procurement has shortlisted 3 external suppliers to address this issue. The delay in tendering and finalising the new supplier has been due to suppliers being accredited by the NJR.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Proposal being developed to contract new external supplier to replace Capita.	Anne Hall- GM /Lee Matthews – Procurement	January 2019	Three external suppliers shortlisted to present to Directorate. The delay in tendering and finalising the new supplier has been due to suppliers being accredited by the NJR. This should be completed in January 2019.

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

Effective – Clinical Trials Recruitment

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure that 90% of clinical trials recruit their first patient within 70 days	Above 90%	Q1 2018/19: 85.1%	Julian Redhead, Medical Director	Heidi Saunders (Head of Clinical Research Operations) and Paul Craven (Head of Research Operations)



Latest performance	Good progress has also been made in improving the number of clinical trials recruiting their first patient within 70 days of a valid research application this year. NIHR-validated data for Q1 2018/19 shows 85% compliance against our target, which compares favourably with Q4 2017/18 (67.6%).
Return to target / trajectory	Internal data for Q2 shows performance of 95.7%, which is above our target, however this is subject to validation. Confirmed data will be published in December 2018.

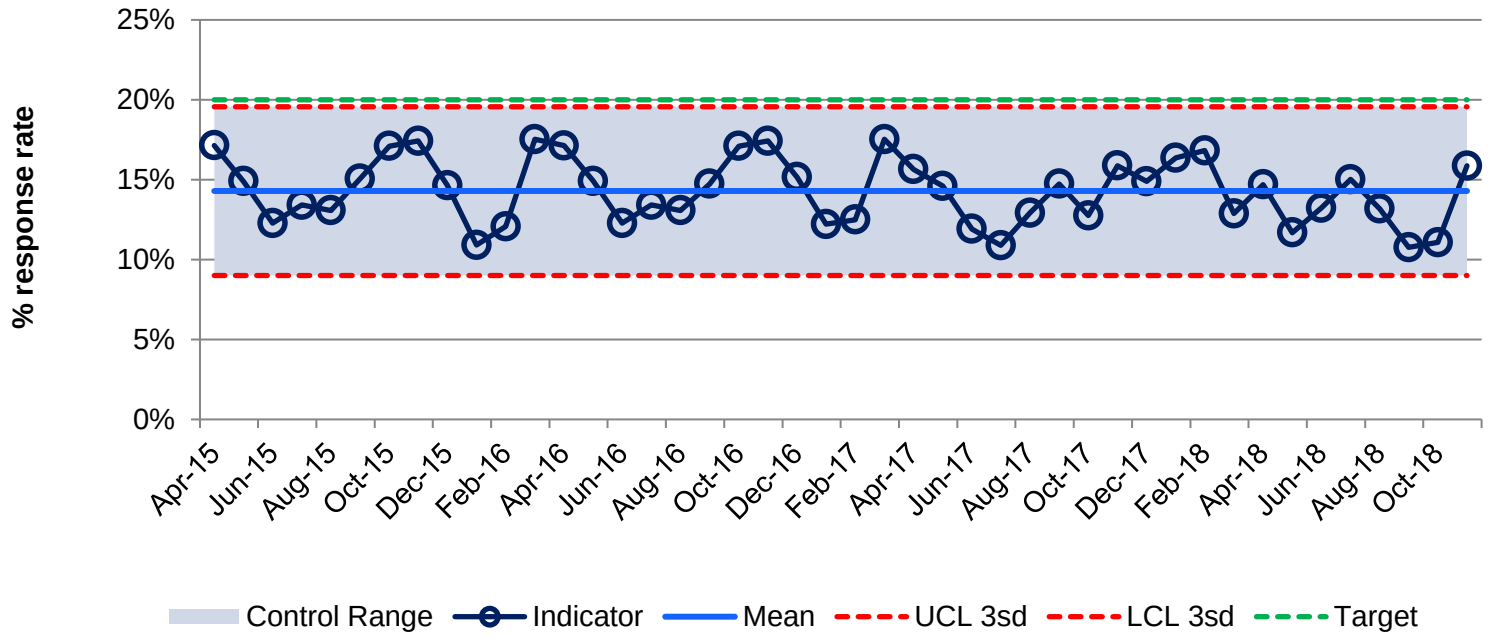
Effective – Clinical Trials Recruitment

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

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

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

Indicator	Target	Latest data	Executive lead	Report author(s)
We will achieve and maintain an FFT response rate of 20% in A&E	20% or greater	November 2018 performance was 15.9%	Janice Sigsworth	Guy Young Deputy Director – Patient Experience



Latest performance	• Both Charing Cross A&E (28%) and Western Eye A&E (25%) exceeded the target in November, St Mary's A&E (9%) and the Urgent Care Centres (11%) did not achieve the target.
Return to target / trajectory	• If Charing Cross and Western Eye maintain current performance and SMH & UCC's make modest month on month improvements, the target could be achieved by the end of the financial year.

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

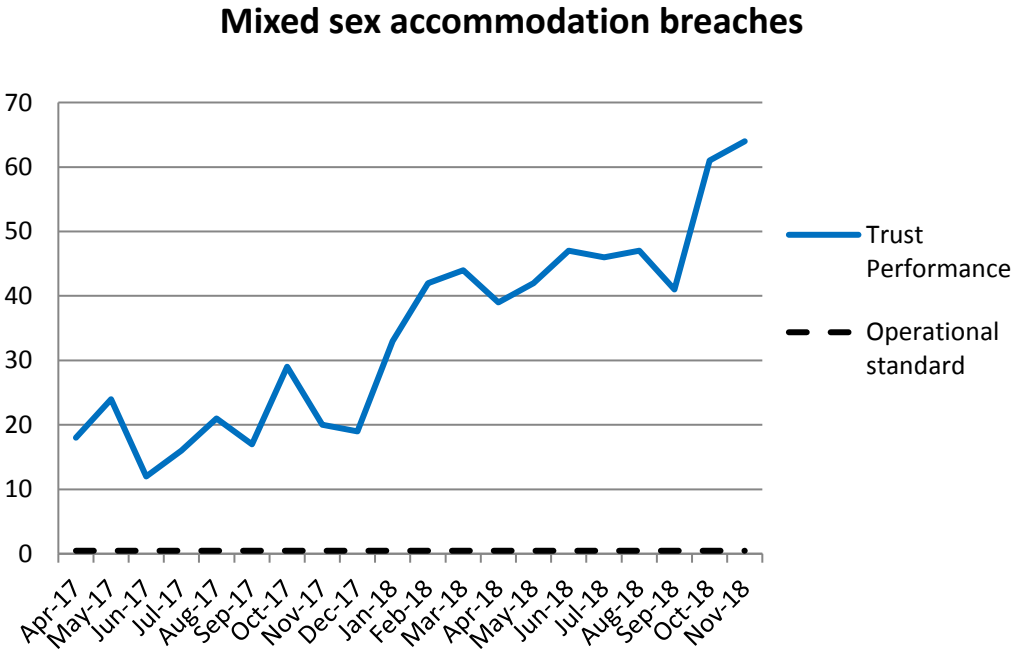
Issues and root causes	A paper setting out the challenges and issues was presented to ExQual in October. This paper included plan setting out a number of actions to improve the rate, particularly at SMH. These are now in progress.

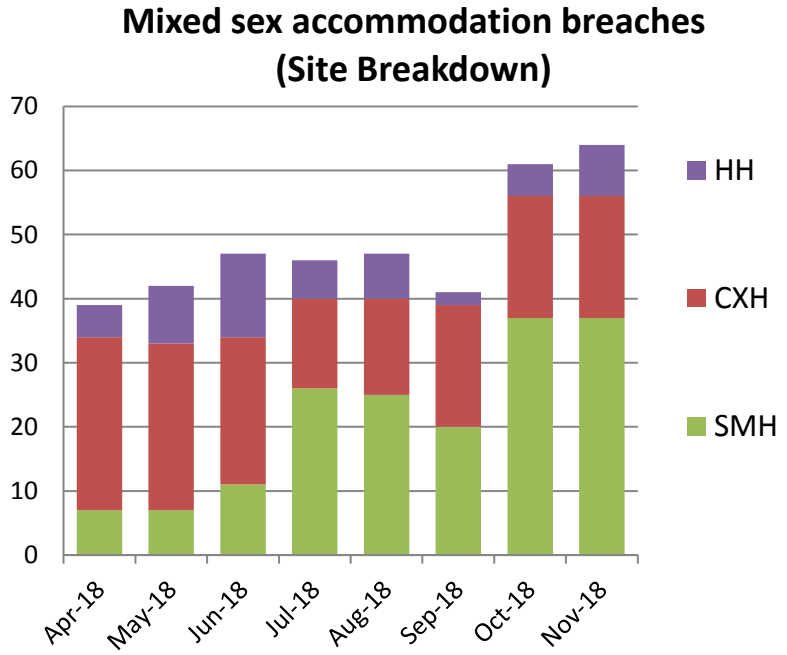
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Increase range of collection methods at SMH A&E	A&E and PEx team	Dec 2018	• Kiosk now installed and functioning • PALS volunteers visiting and collecting feedback
Raise awareness of importance collecting feedback	A&E team	Dec 2018	• Posters displayed in the department • Staff reminded at team meetings/handovers • Local incentives for staff who collect the most replies

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

Caring - Eliminating Mixed Sex Accommodation (EMSA)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have zero mixed-sex accommodation breaches	0	64 breaches (November 2018)	Dr Catherine (Katie) Urch	Melanie Denison Senior Nurse, Critical Care





Latest performance	The national standard is a target of 0% for mixed sex breaches for Level 1/0 patients. Inability to care for patients in a same sex environment can have a detrimental effect on patient experience. The Trust reported 64 mixed-sex accommodation (MSA) breaches in November 2018. The MSA breaches at SMH site have increased from July 18, following the co-location of HDU beds to Critical Care, and then again in Oct 18 as a result of increased activity, reducing capacity across the Trust limiting downstream bed availability.
Return to Trajectory	In order for the directorate to achieve this standard, intervention and support is required within the system in order to prioritise Critical Care step downs. This will enable the directorate to achieve the national target of 4 hour discharge from Critical Care and avoid mixed sex breaches.

Caring - Eliminating Mixed Sex Accommodation (EMSA)

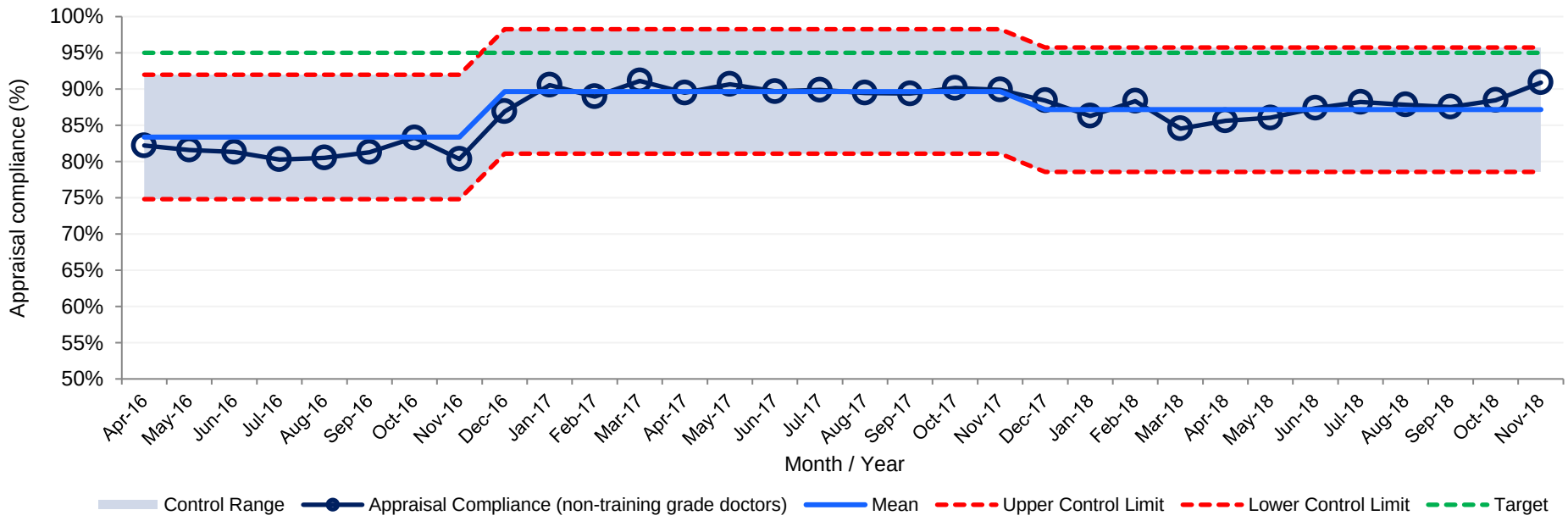
Issues and root causes	Breaches are incurred by patients awaiting step down from the Critical Care units to ward areas. Imperial appears to be an outlier for reported MSA breaches. Other Trusts report discharge delays from Critical Care but report fewer or no MSA breaches. The reason for this is unclear,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

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Comparison of reporting methodologies and mitigations at other Trusts	Mary Mullix	tbc	• Following presentation at CQG, a review is to take place on MSA reporting in other Trusts to ensure all are following the same reporting methodology.
DDN and Senior Nurse meeting with NHSI	Julie Oxton Melanie Denison	December 2018	• National EMSA policy is currently out for consultation.
In conjunction with the Site Director, discussions to be held to review the prioritisation of discharges from Critical Care.	Melanie Denison; Felicity Bevan; Roseanne Meacher	On going	• Clinical Director attendance at Trust Patient Flow – 4 Hour meeting to raise profile of delayed discharge situation in CC and highlight impact on EMSA.
Patient Information Leaflets	Melanie Denison	Jan 2019	• Develop literature pack to provide information for patients on their right to be cared for in single sexed accommodation and explanation on why this is disrupted with delayed discharges in Critical Care.
Patient experience feedback	Melanie Denison	Jan 2019	• Develop a questionnaire for patients on step down wards to assess the impact of MSA breaches during their time on Critical Care.

Risk register
This risk is on the directorate risk register (ID 2457). Impact due to the performance of this target is monitored through the Critical Care Patient Satisfaction survey.

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%	88.46% - Oct 2018 90.89% - Nov 2018	Julian Redhead, Medical Director	Andrew Worthington, General Manager MDO



Latest performance	Performance has improved slightly in November 2018. At 90.89% it is the highest since April 2018. Consultant grade compliance is at 92.60% compared to 88.50% in September. Career grade compliance is at 89.81%, from 84.67% in September. The total number of appraisals overdue by more than six months is currently 35.
Return to target / trajectory	The target date for achieving the 95% compliance rate was September 2018 (M6). This has been added to the risk register as we have not met our internal compliance target. An improvement plan has been developed and implemented.

Well led – Doctor Appraisal Rate

Issues and root causes	The appraisal rate for non-training grade doctors continues to improve although it is still below target of 95%. All overdue doctors have been written to, and there are plans in place to support individuals that need help to complete their appraisal. One doctor has been referred to the GMC for non-engagement. The team have developed a more robust tracker which records the actions that have been taken and which level of escalation the overdue consultants are at.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Improved process in place for monitoring overdue appraisals and the actions that have been taken	Andrew Worthington, GM	Monthly from October 2018	Completed for the first cohort of doctors with overdue appraisals. Next cohort of overdue appraisals in escalation process.
Quality of PreP data - Professional Development team to perform data cleanse.	Victoria Ward, Prof Dev Team Manager	December 2018	Complete
Letters to be sent from MD to all doctors who have exceeded their appraisal due date this month. This will allow us to monitor whether this approach has a direct impact on appraisal performance.	Andrew Worthington, GM	End of October 2018	Complete

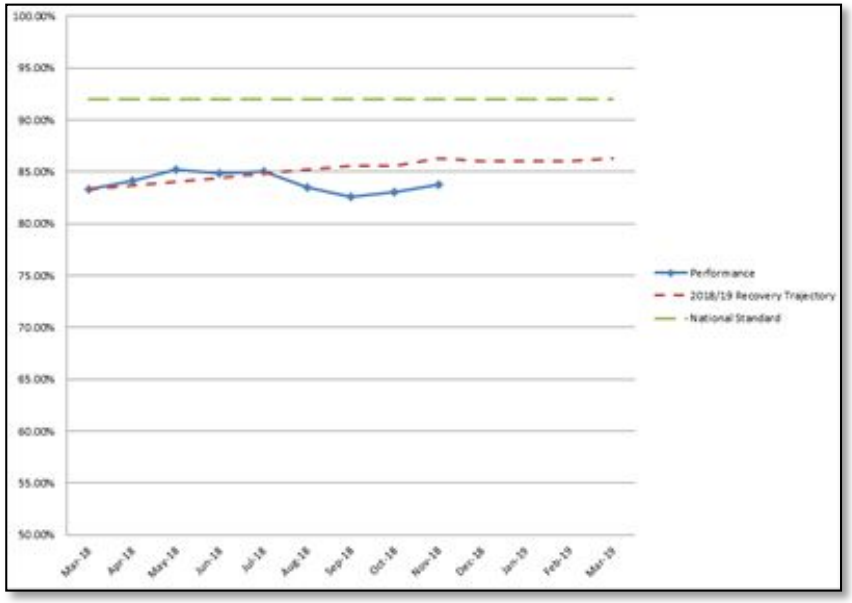
Risk

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

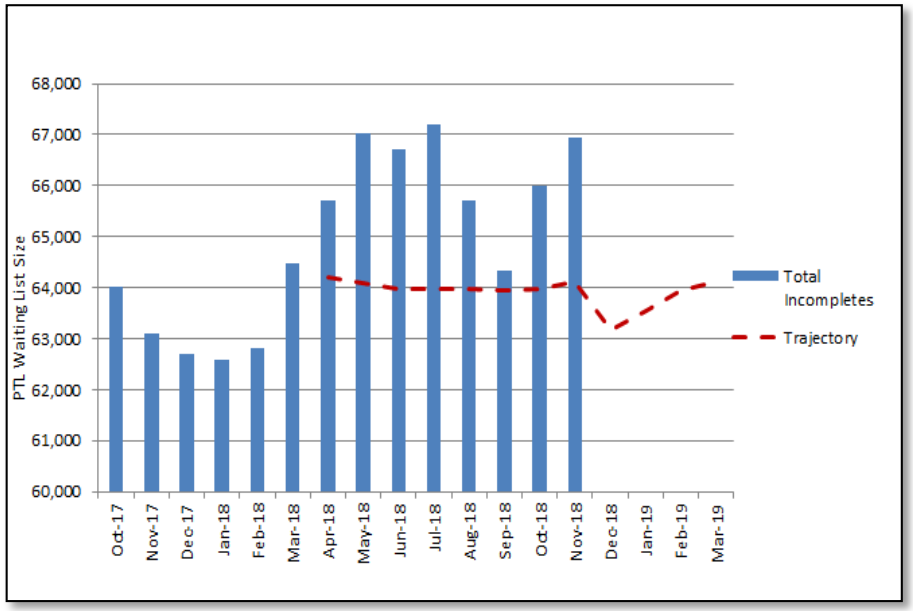
Responsive – 18 weeks referral to treatment (RTT)

Indicator	Target	Latest data	Executive lead	Report author(s)
RTT incomplete performance target in line with the agreed trajectory for 2018/19	86.30% at end November 2018	83.8% at end November 2018	Dr Catherine (Katie) Urch	Steven Crouch, Performance Support Business Partner

RTT 18 Weeks



RTT waiting list size



Latest performance	The latest RTT submitted performance position is end November 2018 where 83.05% of patients had been waiting less than 18 weeks to receive consultant-led treatment, against the national standard of 92%; this did not meet the trajectory target which was 86.30%.

Responsive – 18 weeks referral to treatment (RTT)

Return to target / trajectory	• The performance business support partner has met with each of the "challenged" services to update the RTT trajectory action plans and has scheduled monthly meetings with each of these services to review the action plans and support where necessary.
	• A document highlighting key themes with recommendations has been shared with the SCCS Division.
	• To support the revision of the Action logs, monthly review meetings have been established with the 12 challenged services, as well as being requested by Cardiology to support them to improve their RTT performance.
	• In line with improving monitoring non-compliance the Performance Support Team have developed two Exception Reports, one for 52WW patients and one for RTT non-compliance.
	  • The 52WW exception report is already in use.
	  • The RTT non-compliance exception report is being reviewed for implementation. It is hopeful that these two documents will help the services to focus on recurring and/or key themes and issues.

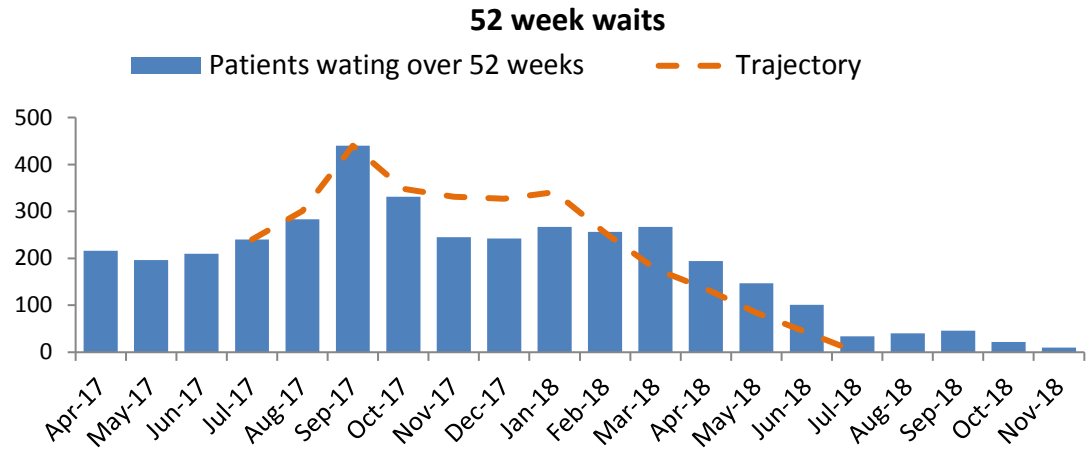
Key issues and actions	<u>Reporting downtime</u> • Following the extended period of RTT patient Tracking List (PTL) downtime the Trust returned to business as usual for RTT PTL reporting in November 2018 (October data). <u>PTL size</u> • A separate piece of work focussing on reducing the PTL size is being designed to give services improved understanding of the tasks required. This will also link into the validation teams workload. <u>System errors</u> • The number of system errors has reduced every month since the extended down time which is encouraging. The patch installed in October did not have the immediate impact on the backlog of system errors but reduced the number being created from that point onwards. Targeted retriggers of records has continued to reduce the number of tracked system errors removed form the PTL. These actions are reducing the number of system errors. • Further dialogue with Cerner has identified additional fixes to resolve more scenarios of system errors but a timeline for this has not been agreed.

Risk register

- 2510 Failure to maintain key operational performance standards

Responsive – RTT patients waiting 52+ weeks

Indicator	Target	Latest data	Executive lead	Report author(s)
We will reduce the number of patients waiting over 52 weeks to zero in line with trajectories and implement our agreed clinical validation process	0 at end November 2018	At end November 2018 10 patients were waiting 52+ weeks	Dr Catherine (Katie) Urch	Jan Palmer, Elective Care Delivery Manager; Steve Crouch, Performance Support Business Partner



Latest performance	The Trust reported 10 patients waiting >52-week in November; this was a decrease of 12 from the previous month. • Of the 10 patients over 52 weeks at the end of November, 6 had tipped-over in the month (a tip-over is defined as a pathway previously known on the PTL that tipped over 52 weeks in the month leading up to the census date) and there were 2 over 52 week pop-ons (a pop-on is defined as a pathway not on the previous month's submission) in November.
Return to target / trajectory	The Trust is forecasting to be 0 (with the exception of pop-ons) by the end of February 2019 Forecast breakdown: December: 9 January: 4 February: 0

Responsive – RTT patients waiting 52+ weeks

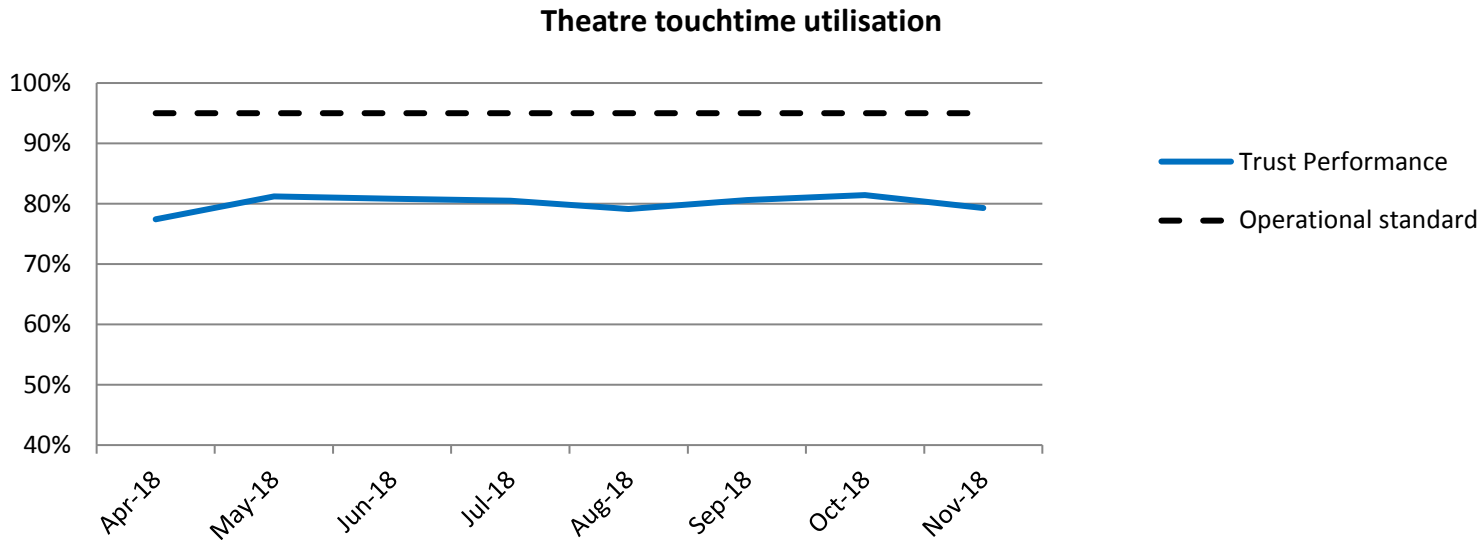
Issues and root causes	• Some challenges to reach the zero trajectory target due to patient choice and deferring surgery until the New Year • A number of complex pathways which involve expertise or equipment not currently available at ICHT • Patient initiated cancellation or reschedule of appointments • Incorrect clock stops being corrected , administrative error and pop-ons. • The number of 'system errors' appearing through the validation process is a cause for concern – multiple checks are in place to review these and system solutions are being sort where possible to eradicate them. However: • The sustained review and provision of RTT training aims to improve knowledge and application of RTT • The use and development of validation tools is providing greater visibility of progress within services • There is on-going review and monitoring of the Trust's 52 week wait position and weekly SRO oversight • All patients waiting over 52 weeks continue to be reviewed for clinical harm in line with the agreed validation process. The clinical harm review of the October 52 week breach patients did not identify any incidences of patients receiving clinical harm due to their extended wait for treatment.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
SCC Division hold a weekly touch-point meeting with WCCS and MIC Divisions	Martina Dinneen	Weekly January 2018	• Improved oversight and monitoring of forecast and provisional position at Elective Care Delivery meeting to ensure that both NHSI, CCG and Trust are informed and appraised
SRO meetings in place for challenged services	Catherine Urch/Martina Dinneen	Weekly January 2018	• Challenged specialties are forecasting an improved position by end of January 2019 with significant progress in November.

Risk register
• 2510 Failure to maintain key operational performance standards

Responsive – Theatre management (touchtime utilisation)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will increase elective theatre touchtime utilisation to 95% in line with trajectories	95%	79.3% November 2018	Dr Catherine (Katie) Urch	David Woollcombe-Gosson (Programme manager theatre productivity)



Latest performance	• At end November 2018, elective theatre touchtime utilisation 79.3%, slightly below the current mean performance of 80.4%. • Individual site performance was: SMH – 76.13%, CXH – 78.19%, HH – 84.66%, WEH – 89.58%. • Across the 3 months ending in November, SMH and CXH showed a slight upward trend in performance. WEH showed a slight downward trend, but this was relative to a very good September performance (96.7%). HH also showed a very slight downward trend, due principally to a poor end to November relative to the site's usual performance.
Return to target / trajectory	An improvement trajectory is under development. A slight but steady improvement in performance of approximately 1% p.a. is apparent since mid 2016. Workstreams within the theatre improvement and subsequent surgical productivity programmes have accelerated this trend during the second half of 2018, but it is not yet clear to what extent and how quickly a step-change in productivity can be achieved.

Responsive – Theatre management (touchtime utilisation)

Issues and root causes	• Currently systems and processes in the pathway prior to theatres are the principal constraints on efficient delivery of elective activity. Within this the principal issues are:
	  • Underbooking of theatre lists. This is due, in turn, to a lack of resilience (and to some extent experience) in the devolved and PSC scheduling function, and to sub-optimal waiting lists and Cerner workflows to support list planning and scheduling.
	  • An inefficient pre-operative pathway which contributes to underbooking and on-the-day cancellations.
	  • Inconsistent compliance with theatre planning and coordination processes (6-4-2 rules), which contributes to underbooking due to reduced scheduling time, and contributes to on-the-day cancellations and reduced theatre efficiency due to last minute changes in theatre lists.
	  • A higher than desirable level of on-the-day cancellations and DNAs for reasons across the whole pathway.
	  • A lack of automated and easily accessible data and reports to support monitoring and decision making to actively address the issues above.

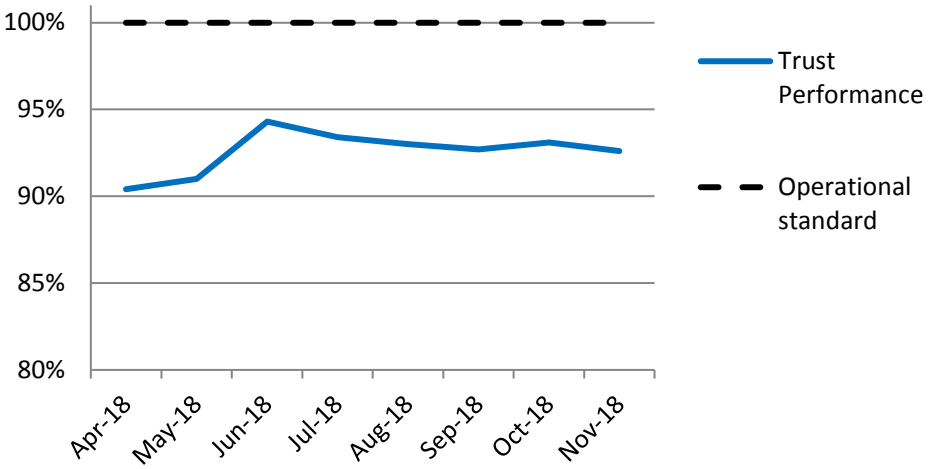
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Surgical productivity programme (overall coordination – high-level workstreams shown below)	Prof C Urch (Executive SRO)	Established June 2018	• Alongside programme analysis and planning, Q3 focussed on consolidating performance improvements from earlier Four Eyes programme
Theatre planning	Adam Hughes	Phase 2 – Sep 18 – Mar 19	• '6-4-2' processes reinvigorated and compliance monitored. Downward trend evident in both late-notice list closures and change of surgeon
Pre-operative assessment	Nick Lawrance	Phase 1 – Nov 18 to Mar 19	• New processes introduced to improve staff/team coordination. Demand analysis and pathway/service redesign commenced
Scheduling	Ruby Sultana (PSC)	Phase 1 – Nov 18 to Apr 19	• PSC management structure & processes reinvigorated. Coordination with theatre planning improved. Work commenced to formalise & strengthen coordination with specialties
Theatre coordination	David Woollcombe-Gosson	Phase 1 – Jan to Mar 19	• Modest improvements in start and intercase times evident so far. Next step is focussed work at SMH & CXH to deliver step change.
Planning & reporting support	David Woollcombe-Gosson	Phase 1 – Oct 18 to Mar 19	• Theatres performance metrics reviewed and 'forward look' report introduced. Work commenced on improving theatres dashboard and cancellation reporting.

Risk register
• 2510 Failure to maintain key operational performance standards

Responsive – Critical care admissions

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure 100% of critical care patients are admitted within 4 hours	100%	92.6% (November 2018)	Dr Catherine (Katie) Urch	Melanie Denison Senior Nurse, Critical Care

Percentage of critical care admissions, admitted within 4 hours



Site	October 2018 performance	November 2018 performance
CXH Critical Care	96.0% (YTD 91.9%)	94.4% (YTD 92.2%)
HH General Critical Care	95.5% (YTD 93.5%)	78.9% (YTD 91.3%)
SMH Adult Critical Care	94.1% (YTD 94.1%)	97.6% (YTD 94.6%)
All Units Combined	**95.0% (YTD 93.1%)**	**92.6% (YTD 93.0%)**

Latest performance	The national standard is that 100% of admissions of critically unwell patients should be admitted within 4 hours. Delays to admission are harmful to critically ill patients who need to be urgently managed within a specialised environment with expert medical and nursing care. In November 2018, 92.6% of patients admitted to critical care were admitted within 4 hours of their referral for all units combined. The site level performance is shown above. Overall trend is an improvement in this metric. The exception was a deterioration in Month 8 at HH due to increased demand on Critical Care capacity in month which resulted in escalation to recovery. One of the key benefits of the Critical Care co-location at SMH has been the improvement in ICU admission time (of patients within 4 hours).
Return to Trajectory	In order for the directorate to achieve this standard, intervention and support is required within the system in order to prioritise Critical Care step downs. This will enable the directorate to achieve the national target of 4 hour discharge from Critical Care and maintain flow on the units.

Responsive – Critical care admissions

Issues and root causes	The main reasons for delayed admission to critical care are as follows: • Units running at high occupancy - usually >90% • A large number of CC patients unable to be discharged to the wards in a timely fashion due to lack of ward beds, disrupting flow. • The high occupancy in both the hospital and critical care units can result in a "one-in-one out" situation with ward beds not being allocated unless there is pressure to admit/patient waiting. The units then have to "turn around" the bed. • ED patients taking priority • Delays can also result from cleaning and portering. Other delays on discharge can occur where wards are not fully comfortable with the discharge or particular ward facilities are not available e.g. tracheostomy beds **Summary of proposed improvement areas requiring development** • Improvement is centred around reducing step down delays which is dependent on downstream bed availability and bed allocation prioritisation. • As highlighted within the EMSA exception report the delayed discharges from the ICUs will form part of the on-going Trust capacity and flow work. • We are also working to improve 'turn around' times for each bed, preparing ahead as much as possible including de-escalation of patient care, timely discharge documentation and cleaning.

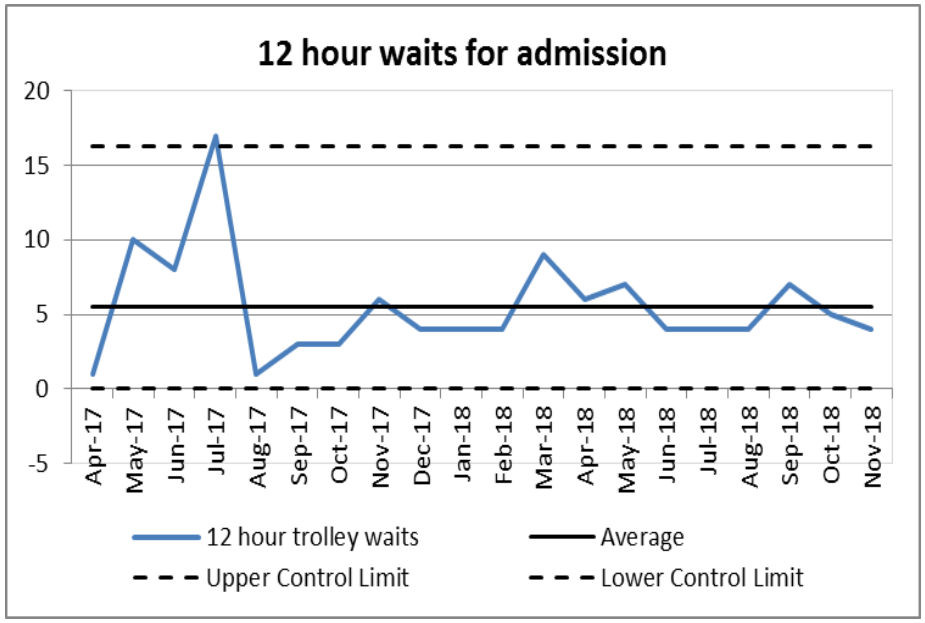
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Early preparation of potential and confirmed discharges in Critical Care	Claire Gorham	Feb 2019	• SOP being developed to define clear process for de-escalation of care in preparation of discharge
Identification of surgical pathways with quick turnaround and discharge straight home	Felicity Bevan	March 2019	• Identify and develop a pathway for pathways whom require monitoring on Critical Care post surgery for several hours until fit for discharge. These patients become bed blockers
Review and management of patients with delayed admission to Critical Care	Roseanne Meacher	Jan 2019	• Medical review of any patients with over 4 hour delayed admission onto a Critical Care ward. With responsibilities and plan for managing patients to be clearly detailed in cc. escalation policy
Trust wide of prioritisation of Critical Care flow.			• Agreement within the system to prioritise admissions and discharges within Critical Care with increased priority when Critical Care on black capacity status.

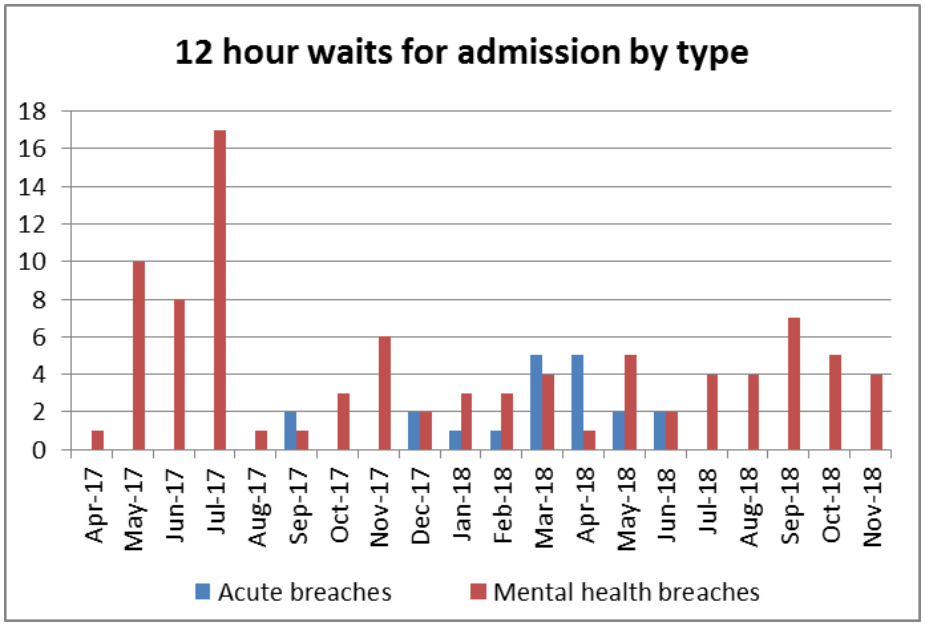
Risk register

This risk is on the directorate risk register (ID 2560) as a risk of delay to admission to Critical Care. The Critical Care escalation policy has been developed to detail process should Critical Care escalation occur. This also details the process of Critical Care support to patients awaiting admission into the unit where use of escalation areas is required. Data is collected for all breaches, any that lead to adverse incidents are reported on datix and reviewed at the directorate Quality and Safety meeting.

Responsive – A&E 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	4 breaches – Nov 5 breaches - Oct	Dr Frances Bowen	Sarah Buckland





Latest performance	• The number of twelve hour breaches of wait from DTA to admission was 4 for November, this was 1 fewer than October. • All breaches were delays to admission for mental health provider beds. • 3 breaches occurred at SMH; patients were transferred to the Gordon Hospital, Bethlem Royal Hospital and to Milton Keynes. • 1 breach occurred at CXH for CAMHs; patient was transferred to St George's Hospital.
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	Mental Health Issues • Lack of available mental health beds • Extended waits for AMHPs (Approved Mental Health Professional) due to availability of staff • Delays with provision of out of hours HTT (Home Treatment Team) at SMH, due to end of night time cover in Westminster • Increase in general walk-in patients presenting to the Emergency Department • Increasing proportion of out of area patients with more complex pathways requiring facilitated transfer to local organisation Acute Issues • Bed availability and high occupancy levels at SMH

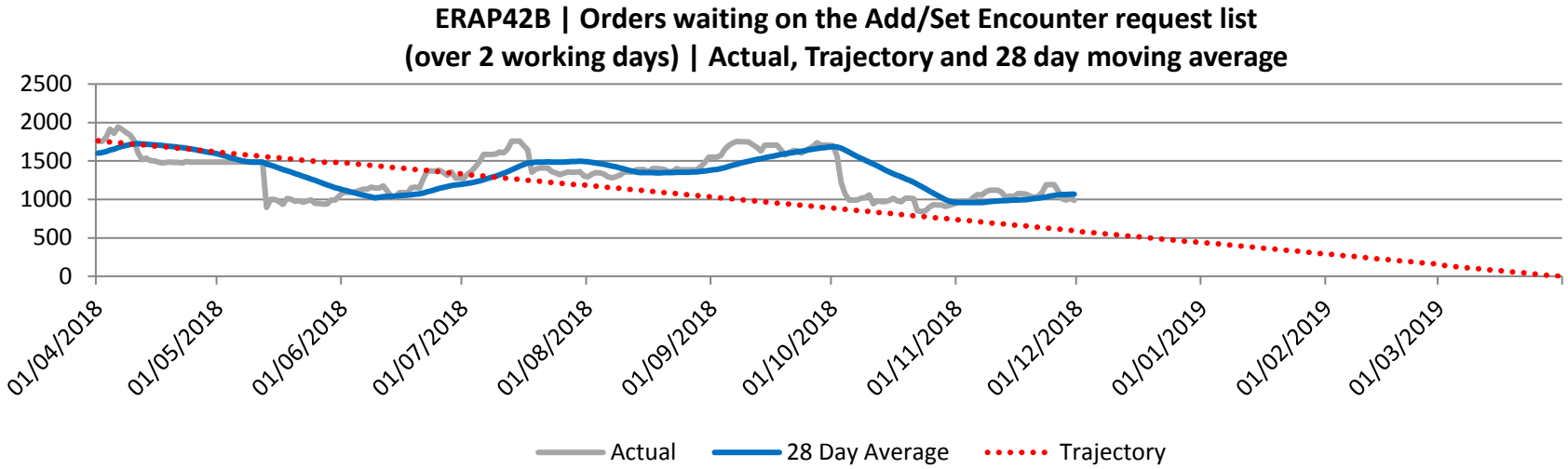
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Review escalation procedures for acute delays	Sarah Grace	Completed	No further acute breaches since action completed.
Presentation of RCA reports to the A&E Delivery Board	Claire Hook	Completed	Reports regularly presented.
Agreement of breach reduction trajectory for the 4 hour standard for mental health	Sarah Grace	Completed	Joint agreement on a 10% reduction of the number of mental health patients waiting over 4 hours in the ED.
Development of reporting SOP	Sarah Buckland	Q3 2018/19	In progress.
Creation of 2 crisis calming rooms in CXH ED (part of the ED redevelopment & 136 compliance)	Sarah Grace	December 2018	On track for delivery.
Improvement of the ED environment for mental health patients at SMH	Sarah Grace	Q4 2018/19	5k grant awarded and plan of work agreed, further funding being sourced.
Joint working between psychiatric liaison service & ED to develop golden pathway to streamline flow	Sarah Grace & James Hughes	Q3/Q4 2018/19	BP-J met with James Hughes from CNWL, outcome to agree expectations & time limits for this patient group.
Ensuring both organisations recognise & agree 12hr wait data	Sarah Grace & James Hughes	Q4 2018/19	
Establish task and finish group to focus on system wide actions to support mental health pathways	Toby Hyde	Q4 2018/19	
Joint agreement on actions to reduce number of mental health patients waiting over 4 hours in the ED by 10%	Sarah Grace & James Hughes	Q4 2018/19	2% reduction ytd to end November (4% increase at CXH and 5% reduction at SMH).
CCG to ensure rapid escalation process when funding issues become an obstacle	Milan Tailor	Q3/Q4 2018/19	

Risk register

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

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

Indicator	Target	Latest data	Executive lead	Report author(s)
We will improve data quality by reducing orders for diagnostic and surgical procedures waiting to be processed on our system in line with trajectories	596	1067	Katie Urch	Caroline O'Dea, (Performance Support Team Business Partner)



Latest performance	In November 2018, an average total of 1067 orders across the Trust remained on the add/set encounter list in Cerner over 2 working days. This number has decreased by 669 orders since the end of September 18 due to improvement processes implemented through the monthly Waiting Times Data Quality Group, a particular shift has been seen in the Oncology department and learning is being shared across divisions via the monthly meeting. However overall Trust performance still remains over trajectory by 471 orders.
Return to target / trajectory	The Trust is still not meeting trajectory for this DQI, however we have seen improvement mainly due to new processes in place in Oncology. Work is in progress with high volume areas with adverse performance to agree recovery plans.

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

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

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Reported to elective care via the control of legacies update.	Karina Malhotra	Weekly	Current process currently in place
New DQI dashboard reviewed on a monthly basis with operational representatives, with a focus on driving improvement across top 3 TFCs with the highest volume of orders on the add/set list over 2 working days.	Caroline O'Dea	March 19	Process agreed with each division for highlight reports to go via relevant senior level divisional meetings to ensure the information on high volume areas is shared with senior directorate colleagues for action.
Focus on add/set DQI in specialty training deep dives.	Gareth Gwynn	On-going	All priority specialty deep dives completed and plans for training now in place
Agree recovery plans with high volume specialities	Caroline O'Dea	End February 2019	Commenced in January with proposal due to go to data quality steering group for approval.

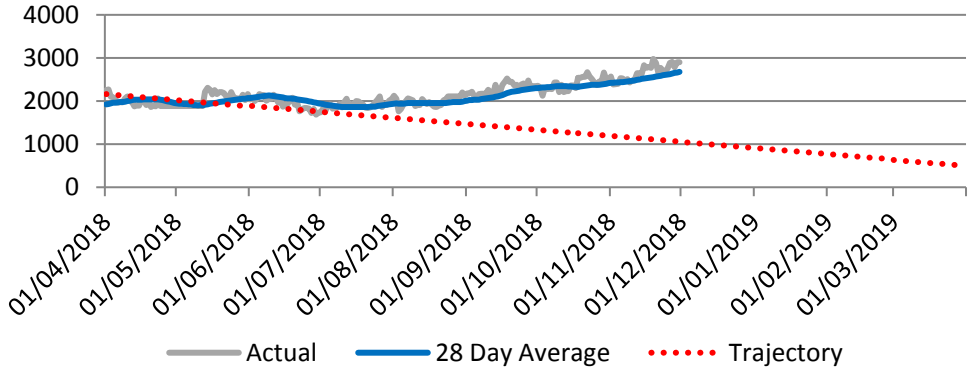
Risk

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

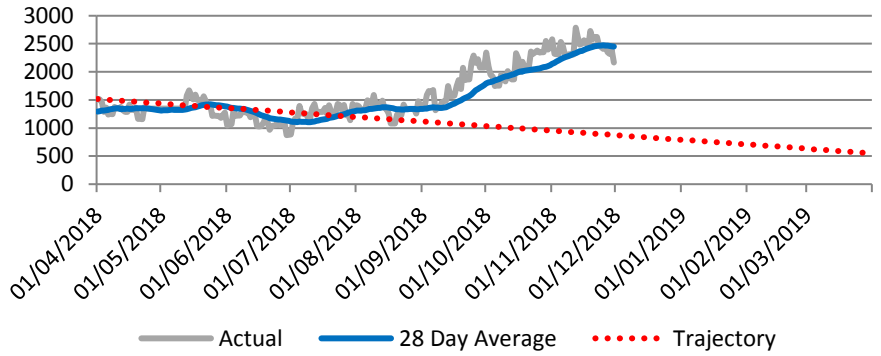
Responsive – DQI: Outpatient appointments not checked in / not checked out

Indicator	Target	Latest data	Executive lead	Report author(s)
We improve data quality by reducing outpatient appointments not checked-in or checked-out on our system in line with trajectories	Not checked in: 1061 Not checked out: 877	November 2018: • 2681 OP appointments not checked in; • 2451 OP appointments not checked out	Tg Teoh	Caroline O'Dea, (Performance Support Team Business Partner)

OPCL78B01 | OP appointments 'not checked in' or DNA'd (appt within last 90 days) | Trust Total | Actual, Trajectory & 28 day moving average



OPCL83B01 | OP appointments 'not checked out' (appt within last 90 days) | Trust Total| Actual, Trajectory & 28 day moving average



Latest performance	In November 2018, an average total of 2681 outpatient appointments were not checked in or DNA'd across the Trust. This is an increase on the previous month by 304 appointments. Performance did not meet trajectory by 1620 appointments. Of the total number of not checked in or DNA'd appointments across the Trust, 93% are from decentralised outpatient departments. In addition to the above, an average total of 2451 outpatient appointments were checked in but not checked out across the Trust. This is an increase on the previous month by 632 appointments. Performance did not meet trajectory by 1574 appointments. Of the total number of appointments checked in and not checked out across the Trust, 82% are from decentralised outpatient departments.
Return to target / trajectory	The Trust is still not meeting trajectory for these DQIs. Work is in progress with high volume areas with adverse performance to agree recovery plans.

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

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

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
New DQI dashboard reviewed on a monthly basis with operational teams with a focus on driving improvement across top 3 TFCs with highest volume of appointments unresolved.	Caroline O'Dea	March 19	Process agreed with each division for highlight reports to go via relevant senior level divisional meetings to ensure the information on high volume areas is shared with senior directorate colleagues for action.
Specialty training deep dives led by ECOF programme.	Gareth Gwynn	On-going	All priority specialty deep dives completed and plans for training now in place
Weekly monitoring process in place for central OPD with communication to specialties as per OPWL SOP	Damien Bruty	On-going	New tracking process in place for outcome forms not returned – November 18.
Weekly PTL management meetings to include DQIs for areas off track in their performance.	Hina Khalid	November 18	Implemented in high volume areas, new specialty level SOPs being developed to support devolved OPDs.
Agree recovery plans with high volume specialities	Caroline O'Dea	End February 2019	Commenced in January with proposal due to go to data quality steering group for approval.

Risk

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

Appendix 1 Exception report slides tracker at M8

Domain	Indicator heading	Executive Committee Reporting	Progress update
Safe	Serious incidents	ExQu	Within tolerance / target
	Incidents causing severe/major harm	ExQu	Within tolerance / target
	Incidents causing extreme harm/death	ExQu	Within tolerance / target
	Patient safety incident reporting rate	ExQu	**Exception report slides provided**
	Never events	ExQu	**Exception report slides provided**
	Patient safety alerts and medical devices	ExQu	Within tolerance / target
	Compliance with duty of candour (SIs)	ExQu	**Exception report slides provided**
	MRSA BSI and C.difficile	ExQu	**Exception report slides provided**
	E. coli BSI	ExQu	**Exception report slides provided**
	CPE BSI	ExQu	**Exception report slides provided**
	Ratio of births to midwifery staff	ExQu	Within tolerance / target
	Puerperal sepsis	ExQu	Within tolerance / target
	VTE risk assessment	ExQu	Within tolerance / target
	Safe staffing	ExQu	Within tolerance / target
	Core skills training	ExPOD	Within tolerance / target
	Safeguarding children training (level 3)	ExQu	**Exception report slides provided**
	Vacancy rate	ExPOD	**Exception report slides provided**
	Departmental safety coordinators	ExQu	Within tolerance / target
	RIDDOR	ExQu	Within tolerance / target
	Fire warden training	ExQu	Within tolerance / target
	Medical devices maintenance	ExQu	**Exception report slides provided**
	Estates maintenance	ExQu	Report being developed – narrative included in summary report
	Sepsis	ExQu	Within tolerance / target
	Flu	ExQu	**Exception report slides provided**
Effective	HSMR and SHMI	ExQu	Within tolerance / target
	Palliative care coding	ExQu	Within tolerance / target
	Mortality reviews	ExQu	**Exception report slides provided**
	Unplanned readmission rates	ExQu	Within tolerance / target
	PROMs	ExQu	**Exception report slides provided**

Domain	Indicator heading	Executive Committee Reporting	Progress update
	National Clinical Audits	ExQu	**Exception report slides provided**
	Clinical trials - recruitment	ExQu	**Exception report slides provided**
Caring	FFT - % recommended	ExQu	Within tolerance / target
	FFT A&E service - % response	ExQu	**Exception report slides provided**
	Mixed-sex accommodation (EMSA) breaches	ExQu	**Exception report slides provided**
Well led	Staff retention	ExPOD	Within tolerance / target
	Voluntary staff turnover rate	ExPOD	Within tolerance / target
	Sickness absence rate	ExPOD	Within tolerance / target
	Personal development reviews	ExPOD	Within tolerance / target
	Doctor appraisal rate	ExQu	**Exception report slides provided**
	Consultant job planning completion rate	ExQu	Within tolerance / target
	NHSI - provider segmentation	ExOp	Within tolerance / target
Responsive	RTT 18 weeks performance	ExOp	**Exception report slides provided**
	RTT 52+ weeks	ExOp	**Exception report slides provided**
	RTT 52+ weeks clinical harm reviews	ExOp	Within tolerance / target
	Cancer - 62 day waits	ExOp	Within tolerance / target
	Cancelled operations	ExOp	Next quarterly performance submission is end January 2019
	Theatre touchtime utilisation (elective)	ExOp	**Exception report slides provided**
	Critical care admissions	ExOp	**Exception report slides provided**
	A&E 4 hour waits	ExOp	Within tolerance / target
	A&E 12 hour trolley waits	ExOp	**Exception report slides provided**
	Discharges before noon	ExOp	Threshold is being set
	Stranded and super stranded	ExOp	Threshold is being set
	DTOC rate	ExOp	Within tolerance / target
	Diagnostic waits – over 6 weeks	ExOp	Within tolerance / target
	Waiting times for first Op appointment	ExOp	Within tolerance / target
	Outpatient HICS	ExOp	Metric being reviewed and update for 2019/20 IQPR
	Outpatient DNA	ExOp	Subject to paper to executive committee for operational performance
	Outpatient apps within 5 working days	ExOp	Within tolerance / target
	PALS concerns	ExOp	Within tolerance / target

Domain	Indicator heading	Executive Committee Reporting	Progress update
	Complaints - formal complaints	ExOp	Within tolerance / target
	Complaints – the average number of days to respond	ExOp	Within tolerance / target
	Orders waiting on Add/Set Encounter list	ExOp	**Exception report slides provided**
	OP apps not checked-in or DNAd	ExOp	**Exception report slides provided**
	OP apps checked In AND not checked out	ExOp	**Exception report slides provided**
	Patient transport	ExOp	Report being developed – narrative included in summary report
	Critical care patients admitted within 4 hours	ExOp	Report being developed

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

At 11 December 2018

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

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
	1.4	Keep Financial Recovery Plan under review and agree necessary amendments with NHS Improvement		In progress	Meetings were held with NHSI on 10th October and 5th November to review status of recovery plan. We will keep the plan under review as part of POM.
Emergency care	2.1	Take reasonable steps in order to achieve sustainable compliance with the 4 hour A&E target		In progress	A number of additional measures were introduced in quarter two with the support of 2020 Delivery and the Trust QI team, many of these are continuing. These include the sustainability phase of mentoring and coaching individuals to drive local improvements in the areas of ED flow, SAFER and faster moves. The additional performance review aspect of the 12:30 site capacity calls has been continuing and plans to do so through the winter months. The Trust is on track to open additional inpatient capacity this winter with the support of capital funding secured. A number of beds have been opened in the past week the full plan is to open c. 50 extra beds; with 20 beds at HH, 22 at CXH, and 13 at SMH. In addition the ED will create an additional 5 trolley spaces. The Trust achieved the ED performance trajectory for October and November.
	2.2	Maintain A&E target at or above 90% throughout Winter 2018/19	2018/19	In progress	Performance against the 4 hour standard for November 2018 was 90.1%. The Trust achieved the 90% PSF target and narrowly missed the local trajectory of 90.4%, the Trust remains on track to meet the quarter performance target. November 2018 performance was 2.6% higher than performance in November 2017 of 87.5%. System wide performance (this includes 100% ICHT and 52% CLCH activity and breaches) for the month of November 2018 is predicted to be above the 90% required to achieve quarter three PSF funding.
	2.3	Maintain A&E performance of 95%	31 March 2019	In progress	As above.

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
RTT	3.1	Ensure no patients are waiting more than 52 weeks on RTT pathways	31 October 2018	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 continued to experience some challenges to achieving its trajectory for 52WW. For end November the Trust is forecasting an end position of 10; however, the Trust has sought clarification from NHSI on one other potential 52WW which may change the final value to 11. This will be confirmed at data sign off on 19 December when the RTT submission is finalised. Taking a worst case position the number of 52WW patients has reduced by 11 in November, as 22 were reported in October. This is still above the Trust's zero trajectory target and continued progress towards zero is expected in December. The performance team has met with the 12 challenged specialties to support action plans to improve performance against trajectories. This is expected to have a positive impact on the trajectories going forward.
	3.2	Delivers the RTT incomplete performance target in line with the trajectory agreed in the 2018/19 plan through delivery of the agreed action plan	March 2019	In progress	The Trust submitted an updated RTT trajectory for 2018/19 to NHSE on 20th April, in line with national deadlines. This was a revision of the 2nd March draft, based on an 18/19 activity model developed with our CCGs. This activity plan was converted to RTT performance in the context of ongoing system challenges around demand & capacity, data quality and operational responsiveness. Additionally, an adjustment was made to projected waiting list size and performance over the winter period to reflect recent experience and anticipated impact in 18/19. The Performance Team has met with all of the 12 specialties reviewed and is in the process of updating the action plans for 18/19.

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
Data Quality	4.1	Amend the RTT action plan to ensure that it addresses the concerns set out in the independent review of clinical and administrative processes within elective pathways and clinical oversight of avoidable harm	31 October 2018	In progress	The MBI data assurance report was published 31 July 2018. Nine high level recommendations were provided which also have 45 sub-recommendations associated with them. A finalised action plan was presented to the Executive Operational Committee in November 2018 and the Trust Board (ARG) in December 2018.
	4.2	Implement the amended RTT action plan	Date to be agreed with NHS Improvement	In progress	As above. The Trust is setting up the governance structure to oversee the recommendations delivery of the actions will be tracked through the RTT improvement steering group.
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: Finance Report for December 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 30th January 2019	**Item 10, report no. 07**
Responsible Executive Director: Richard Alexander, CFO	**Author:** Michelle Openibo – Associate Director of Finance

Summary:

This report provides a brief summary of the Trust's financial results for the 9 months ended 31st December.

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

The Trust closed the month with £53.7m cash, there are no plans to access any further working capital facility.

Gross capital spend is £12.3m underspent against plan year to date. The Trust expects to meet the Capital Resource Limit (CRL) for the year.

Recommendations:
The Committee is asked to note the report.

This report has been discussed at:

Quality impact: N/A

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

1) Has no financial impact.

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

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

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

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

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

Trust strategic objectives supported by this paper:

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

FINANCE REPORT – 9 MONTHS ENDED 31st December 2018

1. Introduction

This report provides a brief summary of the Trust's financial results for the 9 months ended 31st December 2018.

2. Financial Performance

The Trust is on plan in month and for the 9 months year to date i.e. until the end of December. In previous months the Trust was showing an overspend on budget, additional controls were put into place to help manage spend. Review meetings were also held with the Executive and overspending directorates to identify actions to bring these areas back to plan. These controls seem to have had a positive effect on the position.

	In Month			Year to Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	90.41	88.77	(1.64)	839.52	851.12	11.61
Pay	(51.81)	(52.37)	(0.55)	(467.74)	(469.14)	(1.40)
Non Pay	(37.31)	(34.55)	2.76	(349.53)	(361.66)	(12.13)
Internal Recharges	-	(0.00)	(0.00)	-	0.00	0.00
Reserves	(2.01)	(2.15)	(0.14)	(12.55)	(12.05)	0.50
EBITDA	(0.72)	(0.29)	0.42	9.70	8.28	(1.42)
Financing Costs	(3.46)	(4.41)	(0.94)	(34.21)	(33.08)	1.13
SURPLUS / (DEFICIT) inc. donated asset treatment	(4.18)	(4.70)	(0.52)	(24.51)	(24.802)	(0.29)
Donated Asset treatment	(0.42)	0.10	0.52	(0.75)	(0.46)	0.29
Impairment of Assets	-	-	-	-	-	-
SURPLUS / (DEFICIT)	(4.60)	(4.60)	0.00	(25.26)	(25.26)	0.00
PSF Income	3.42	4.95	1.54	22.21	22.206	-
SURPLUS / (DEFICIT) after PSF income	(1.19)	0.35	1.54	(3.05)	(3.05)	0.00

2.1 Provider Sustainability Funding

PSF is assessed on a quarterly basis, 30% is achieved for meeting the 4 hour A&E target and 70% for achieving the control total. At quarter 1 the Trust was slightly below the A&E four hour target compared to the same quarter in the last year, and therefore did not achieve the £1.5m A&E element of PSF. Year to date at quarter 3 the Trust has recovered this position and therefore is eligible for all the year to date PSF.

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
Division of Medicine & Integ. Care	712,536	662,644	(49,891)	202.26	207.38	5.11
Division of Surgery, Cancer & Cardiov.	546,472	571,618	25,147	249.05	252.22	3.17
Division of Women, Children & Clin. Support	1,943,607	1,978,902	35,295	120.74	120.69	(0.04)
Central Income			0	105.47	107.76	2.29
Clinical Commissioning Income	3,202,614	3,213,165	10,550	677.52	688.05	10.54

The Trust is over performing on income year to date; this is mainly in non-electives and day cases, with underperformance in maternity and outpatients. The current income over performance will be a cost pressure for commissioners. The Trust has received challenges on the income position from commissioners above the amounts challenged in previous years. The Trust is working closely with the commissioners to understand the basis of their challenges and agree a position for the year.

Medicine and Integrated Care (MIC) is over performing on non-elective activity across all sites. Surgery, Cancer and Cardiovascular (SCC) has over performance on cardiology and clinical haematology with underperformance in specialist surgery and ophthalmology. There was a decrease in surgical activity in December over the Christmas period but the division expects activity to increase in the rest of the financial year. Women, Children and Clinical Support (WCCS) is slightly below plan, an improvement from the position earlier in the year. There has been a reduction in maternity activity over the past two years but this appears to have stabilized over the last few months. There has also been an improvement in the position in the Children's directorate which is now over performing.

2.3 Private Patient Income

Private patient income is below plan in month bringing the overall position £1.5m adverse year to date. There are budgeted plans to increase income in SCC, these have not yet happened causing under performance in this division. WCCS has seen an increase in reproductive medicine in line with planned growth in that new service. There has also been some recovery in the private paediatric bone marrow transplants which had reduced activity last year.

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	23.97	25.87	1.90	216.32	219.80	3.49
	Expenditure	(18.43)	(19.30)	(0.87)	(167.51)	(170.43)	(2.92)
		5.54	6.57	1.02	48.81	49.37	0.57
Surgery, Cancer and Cardiovascular	Income	27.42	25.91	(1.51)	260.88	257.60	(3.29)
	Expenditure	(24.61)	(24.34)	0.27	(220.14)	(223.96)	(3.82)
		2.81	1.57	(1.24)	40.74	33.63	(7.11)
Women, Children & Clinical Support	Income	14.73	12.66	(2.07)	134.25	131.87	(2.39)
	Expenditure	(16.40)	(14.90)	1.50	(149.93)	(150.33)	(0.40)
		(1.67)	(2.24)	(0.56)	(15.68)	(18.46)	(2.78)
Imperial Private	Income & Expenditure	1.22	1.51	0.29	10.57	12.78	2.21
Total Clinical Division		7.89	7.41	(0.48)	84.44	77.32	(7.12)

Clinical Divisions are £7m behind plan year to date. This adverse variance to plan is being mitigated by favorable positions in central budgets where there has been additional income for the injury cost recovery scheme (sometimes known as Road Traffic Accident income) and overseas visitor activity.

MIC is favorable to plan year to date and in month. The division has seen over performance in activity, mainly in non-electives, offset by the additional costs to deliver these services.

SCC is adverse to plan in month, there was lower than expected activity over Christmas in surgical specialties causing this adverse position. Year to date the division is over plan with underperformance on income and expenditure over spends. Income is below plan due to private income growth schemes that have not been achieved. Expenditure is over plan as a result of additional costs of outsourcing and the costs of the waiting list improvement programme which is above budget.

WCCS is behind plan year to date and in month. Year to date the division is behind plan mainly on income with underperformance in NHS maternity activity; there is also underperformance within the WCCS division on private activity for imaging and maternity. The Division has been able to offset unidentified CIPs through earning an additional discount on the maternity clinical negligence scheme costs. Under this scheme Trusts are able to receive a reduction on clinical negligence insurance costs if they can demonstrate that they meet a number of maternity quality targets.

Imperial Private Health (IPH) is above plan due to additional private activity. This income mainly relates to gynaecology over performance with smaller movements in other specialties.

3. Efficiency programme

The Trust is £5.3m adverse to plan YTD, which is largely due to under performance on income related schemes and gaps for unidentified schemes.

The forecast is £7.3m adverse to plan, largely due to £4.5m of income backed productivity schemes, £1.3m of unidentified schemes and £1.5m additional risk against pay and non-pay savings. This represents an improvement of £4.5m from M07.

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

Work is being completed within procurement to unlock further savings and efficiencies where possible and understand and mitigate risk. The current focus is on controlling Pay and Non-Pay spend but these may not meet the requirements for CIP classifications.

4. Cash

The cash position at the end of December was £53.7m. In-month cash has increased by £40.2m from the opening balance. There was a change in the finance system in the trust in November, a large number of invoices were paid in advance of the change in system reducing the cash balance at the end of November below usual levels. The Trust is required to keep a balance of £3m cash to meet the requirements of the working capital facility agreement. The Trust does not anticipate requiring any further draw down of the facility.

5. Capital

Against the Capital Resource Limit (CRL) capital expenditure is £1.4m underspent in month. Year to date against the CRL the Trust is £12.5m behind plan mainly on backlog maintenance, the bed capacity project for winter pressures and ICT projects.

The Trust is expecting to meet the CRL spend in year and the programme is actively managed by the Capital Expenditure Assurance group and Capital Steering Group. Where necessary and appropriate elements of next year's capital pipeline are being brought-forward to ensure full in-year utilisation.

6. Conclusion

The Trust is on plan year to date but there remain risks to the achievement of the Control Total for the year. The level of NHS clinical income over performance, which is then challenged by commissioners, is a key risk to the Trust's deliverability of the Control Total. The Trust must also continue to deliver cost savings and improve the expenditure position.

7. Recommendation

The Trust Board is asked to note the report.

Appendix

Statement of Comprehensive Income – 9 months to 31st December 2018

	In Month			Year to Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Clinical (excl private patients)	74.9	75.1	0.2	699.9	707.8	7.9
Private Patients	4.4	3.9	(0.5)	40.0	38.7	(1.3)
Research, Development and education	7.8	8.1	0.3	69.8	71.1	1.3
Other non-patient related income	3.3	1.6	(1.7)	29.9	33.6	3.7
Total Income	90.4	88.8	(1.6)	839.5	851.1	11.6
Pay - in post	(48.9)	(46.4)	2.5	(441.4)	(410.9)	30.5
Pay - Bank	(0.6)	(4.3)	(3.7)	(5.5)	(39.6)	(34.0)
Pay - Agency	(2.3)	(1.7)	0.6	(20.8)	(18.6)	2.2
Drugs and Clinical supplies	(19.8)	(18.8)	1.0	(189.1)	(183.3)	5.8
General Supplies	(2.9)	(3.0)	(0.1)	(26.2)	(28.0)	(1.8)
Other	(14.6)	(12.8)	1.8	(134.2)	(150.3)	(16.1)
Total Expenditure	(89.1)	(86.9)	2.2	(817.3)	(830.8)	(13.5)
Reserves	(2.0)	(2.1)	(0.1)	(12.5)	(12.0)	0.5
Earnings before Interest, Tax, Depreciation and Amortisation	(0.7)	(0.3)	0.4	9.7	8.3	(1.4)
Financing Costs	(3.5)	(4.4)	(0.9)	(34.2)	(33.1)	1.1
SURPLUS / (DEFICIT) including financing costs	(4.2)	(4.7)	(0.5)	(24.5)	(24.8)	(0.3)
Donated Asset treatment	(0.4)	0.1	0.5	(0.8)	(0.5)	0.3
SURPLUS / (DEFICIT) including donated asset treatment	(4.6)	(4.6)	0.0	(25.3)	(25.3)	0.0
Impairment of Assets	0.0	0.0	0.0	0.0	0.0	0.0
SURPLUS / (DEFICIT)	(4.6)	(4.6)	0.0	(25.3)	(25.3)	0.0
PSF	3.4	5.0	1.5	22.2	22.2	0.0
SURPLUS / (DEFICIT) after PSF	(1.2)	0.4	1.5	(3.1)	(3.1)	0.0

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: CQC Update	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 30 January 2019	**Item 12, report no. 08**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Authors:** Priya Rathod, Deputy Director of Quality Governance Kara Firth, Head of Regulation

Summary:

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

The Trust received notice to complete the CQC PIR on 21 November 2018 and submitted this on 12 December 2018. The PIR initiates the Trust's six month time period for CQC inspections, which runs to mid-May 2019. During this time the following will be undertaken: NHS Improvement (NHSI) use of resources assessment, CQC core service inspection/s and a CQC inspection of the well-led domain at Trust level.

During the Trust's routine quarterly engagement meeting with the CQC on 16th January 2019, the following further information was given:

- The CQC will not inspect more than four core services between now and the well led inspection,
- These inspections will be unannounced.
- All inspections will be undertaken at the same time (i.e. in one week)
- The GP practice at Hammersmith and Charing Cross Hospitals will not be inspected as part of the 2018/19 inspection cycle.
- The above will be finalised by the CQC at their planning meeting on 25th January 2018.

The Trust's use of resources assessment will be carried out by NHS Improvement on 13th February 2019.

The date of the Trust's CQC inspection of the well-led domain at Trust level will be confirmed to the Trust on 28th January 2019. A further verbal update will be given at the Board meeting.

In light of the above, please refer to **Appendix 1** for a Trust timetable.

The improving care programme group now meets weekly and a programme of peer reviews for each core service commenced week of 14th January 2019.

Inspection preparation continues for key core services

A number of general updates are included within the paper.

Recommendations: To note the updates.

Quality impact: This paper applies to all five CQC domains.
Financial impact: This paper has no financial impact.
Risk impact and Board Assurance Framework (BAF) reference: This paper relates to **Risk 81 (corporate risk register):** Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC.
Workforce impact: None
Has an Equality Impact Assessment been carried out? ☐ Yes ☐ No ☒ Not applicable
Paper respects the rights, values and commitments within the NHS Constitution. ☒ Yes ☐ No
Trust strategic objectives supported by this paper: ▪ To achieve excellent patients experience and outcomes, delivered with care and compassion. ▪ To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.
Update for the leadership briefing and communication and consultation issues: All aspects of this paper can be included in leadership briefings and can be shared by leaders with all staff.

CQC Update

1. Purpose

1.1. The following report is the regular update to the Board on CQC-related activity at and/or impacting the Trust.

2. Annual Provider Information Request

2.1. The Trust received its annual Provider Information Request (PIR) on 21st November 2018 from the CQC.

2.2. The PIR was submitted on 12 December 2018 (the submission deadline date).

3. CQC Inspection Programme for the Trust

3.1. The notice to complete the PIR initiates the CQC's inspection programme for a trust each year.

3.2. The inspection programme is based on a maximum six month timeframe which includes the following:

- CQC analysis of the Trust's PIR submission.
- A CQC planning meeting to decide the service(s) to be inspected
- CQC inspection of the well led domain at Trust level
  - This takes place within six months of the Trust receiving the PIR.
  - The latest date therefore for the Trust to have the well led inspection would be 21st May 2019.
  - The CQC aims to give trusts eight weeks written notice prior to carrying this out, though the notice period may be less than this.
- CQC core service inspections
  - Core service inspections must take place before the inspection of the well-led domain at Trust level.
- NHS Improvement (NHSI) use of resources assessment
  - The NHS Improvement use of resources assessment, which is independent of CQC inspection, must take place before the inspection of well-led at Trust level.
  - NHSI have confirmed that the Trust's use of resources assessment will take place on 13 February 2019.
- The Trust's final CQC inspection reports, the use of resources report, and all ratings are published on the CQC's website.
  - The CQC awards a quality rating for well-led at trust level.
  - NHS Improvement awards a rating for use of resources.
  - A combined well-led rating is awarded which reflects both the CQC quality rating for well-led and the use of resources rating.

3.3. During the Trust's routine quarterly engagement meeting with the CQC on 16th January 2019, the following information was given:

- The CQC will **not** inspect more than four core services between now and the well led inspection,
- These inspections will be **unannounced.**

- All inspections will be undertaken at **the same time** (i.e. in one week)
- The GP practice at Hammersmith and Charting Cross Hospitals will **not** be inspected as part of the 2018/19 inspection cycle.
- The above will be finalised by the CQC at their planning meeting on 25th January 2018.
- A further verbal update will be given at the Board meeting.

In light of the above, please refer to **Appendix 1** for a Trust timetable.

4. Inspection preparation

4.1. The board will recall that a bi-weekly improving care programme group (ICPG) has been in place since July 2018 to oversee the progress of the 'Big 4' work streams as well as preparations for anticipated CQC inspections.

4.2. Since 7th January 2019, these meetings have been taking place weekly and are now chaired by the CEO.

4.3. A 'look back' exercise of all 'must do/should do' actions from CQC inspections that have been undertaken since 2014 has been completed and the outputs presented to the ICPG on 21st January 2019.

4.4. A programme of executive walk around is in place and soft feedback has indicated that common areas that need a focus include; hand gel dispensers, clutter, out of date photo boards and leaflets. This has been discussed at the ICPG and a range of actions agreed to address the findings.

A programme of weekly core service peer reviews have been introduced since 14th January 2019 and progress against the findings is tracked through the weekly ICPG meeting.

- At the time of writing this paper, the folloiwing reviews have been completed:
  - Critical care
  - Services for children and young people
  - Urgent and emergency services
- The review teams have included internal and external staff (where available).
- Common findings that require improvement include; resolution of estates issues, appearance of general environment and a continued focus on medicines management and hand hygiene.
- Examples of good and outstanding practice have also been observed during these visits.
- The remaining reviews are now being organised and are expected to be completed the week commencing 4 March 2019.
- Review teams have had good representation from professional / staff groups and most teams include external reviewers, for example from NHS Improvement and/or NHS England.
- Outcomes of the reviews will be discussed at the Improving Care Programme Group and reported to the board in due course.

4.5. Work continues within the core services of children's and young people and critical care.

4.6. The core service of End of life care is now receiving support from the Trust's CQC team and is reporting its inspection preparations to the Improving Care Programme Group. A similar approach has also been established for the Western Eye Hospital.

4.7. An 'improving estates plan' is also under development focusing on process, people and reviewing the backlog maintenance programme. A bi-weekly meeting chaired by the Director of Nursing has been established to take this forward.

5. CQC Insight

- Trust-level headlines from the latest CQC Insight report (published in December 2018) include: The Trust is 'Much better compared nationally' in:
  - Hospital Standardised Mortality Ratio
  - Sick days for medical and dental staff
  - Deaths in Low-Risk Diagnosis Groups
  - Summary Hospital-level Mortality Indicator (SHMI)
- There are no indicators where the Trust is 'much worse compared nationally'.
- Further detail on the Trust level metrics is included in the integrated performance report which is a separate agenda item at this meeting.

6. General updates

- **CQC Consultation on its Fees for 2019/20**

6.1. In October 2018 the CQC launched its annual consultation on its regulatory fees for 2019/20.

6.2. No changes are proposed for the fee structure for NHS acute trusts; fees will continue to be calculated based on turnover (this is the same as the current year).

6.3. The consultation closed on 17 January 2019.

- **Changes to Assessments of Performance in Relation to Equality and Diversity**

6.4. In January 2018, NHS England and the CQC published a framework for joint working, supported by NHS Clinical Commissioners. This the same as joint working protocols, memoranda of understanding, and information sharing agreements the CQC has with a wide range of other bodies.

6.5. The Workforce Race and Equality Standards (WRES) team within NHS England has taken the position that failure to implement is a breach of the NHS Constitution.

6.6. The CQC has recently been working with the WRES team within NHS England on ways to improve assessments of equality and diversity among staff.

6.7. Although no timeframe has been identified for proposed changes to take effect, it is reasonable to expect they will begin from quarter 4 of 2018/19, i.e. from January 2019.

- All inspectors are receiving dedicated training in relation to the WRES.
- The CQC may hold a focus group for BME staff either during a quarterly engagement meeting or during inspection.
- Information in the annual Provider Information Request (PIR) will be used to identify concerns with implementation of the WRES.
  - Inspectors will focus on concerns during inspections of core services, and of well-led at Trust level.
  - If the concerns are serious, the inspection team may include an Equality and Diversity Specialist Advisor.
  - Inspections of both core services and well-led at Trust level may include staff in related roles, such as an Equality and Diversity lead, BME lead, etc.
- As with any concern identified during inspection, the CQC may set a 'must-do' or 'should-do' action for the Trust to take in relation to WRES. However, additionally:
  - The CQC will share any concerns with NHS England.
  - An overall rating cannot be Outstanding if there are any concerns about WRES.
  - If the CQC determines that the equality duty is not being met, it will refer the organisation to the Equality and Human Rights Commission.

6.8. The Trust is undertaking a number of actions with regards to equality and diversity and WRES and these include:

- Having a well-established equality and diversity committee in place
- A developed draft WRES plan
- Briefings to non-executive directors regarding the national WRES agenda
- Staff undertaking national WRES expert training (currently one member fully trained and a further two in training)
- A ward sister joining the national WRES frontline staff forum
- An established nursing and midwifery BAME network with a closed schwartz round for this staff group in January 2019.
- Inviting the national WRES lead to an upcoming Trust Board seminar

6.9. Progress against the above actions will continue to be overseen by the equality and diversity steering group and the Executive People and Organisation Development Committee.

- **Update of CQC Inspection Frameworks**

6.10. In October 2018 the CQC published updated versions of all its inspection frameworks; the board is aware that there is a framework for each core service and for the well-led domain at Trust level.

6.11. No material changes were made to how the CQC will inspect any core service or the well-led domain at Trust level. The changes all relate to new or updated national and industry standards and guidelines.

- **CQC Publications**

6.12. On 19 December 2018 the CQC published a report following its national review of never events occurring at NHS trusts. This review was undertaken during 2018 at the request of the Secretary of State for Health and Social Care.

6.13. The report makes six recommendations for national health organisations, trusts and itself (**Appendix 2**). In terms of the latter, the report will inform changes to how the CQC assesses safety during inspections of NHS trusts and the recommendation will facilitate this.

- **NHS Trust Fined by the CQC for Breaching the Duty of Candour**

6.14. The board is aware that one of the CQC's regulations, called the Duty of candour, sets out specific requirements for actions trusts must take when certain types of incidents occur.

6.15. As with a breach of any CQC regulation, the CQC can take enforcement action if the Duty of candour is not met by trusts.

6.16. On 17 January 2019, the CQC published a press release indicating that it had issued a fixed penalty notice (including a fine) to an NHS trust for breach of the Duty of candour in relation to a specific incident.

6.17. In this particular case the breach was largely related ot the Trust not apologising to the family in a timely manner for the incident that occurred.

6.18. The Board will be aware that the Trust has a programme of work in place regarding duty of candour and compliance with the requirements are captured in the integrated performance report.

7. Next Steps

7.1. Weekly meetings of the ICPG will continue.

7.2. Support to prepare for possible inspections will continue to be provided to core services.

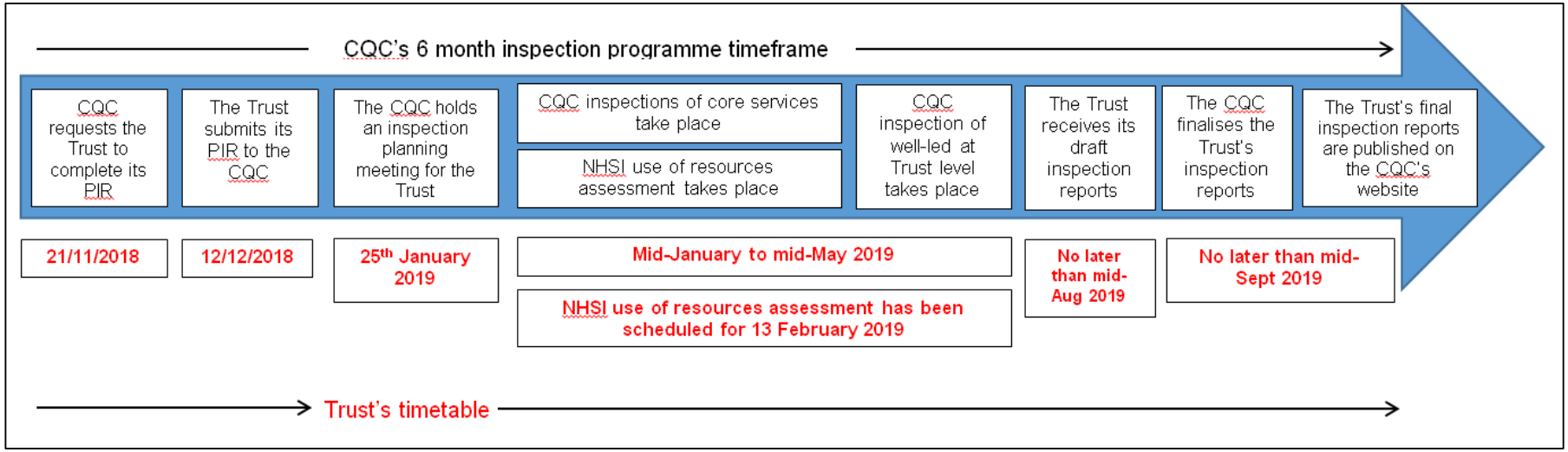
8. Recommendations

8.1. To note the updates.

Authors: Priya Rathod, Deputy Director of Quality Governance
Kara Firth, Head of Regulation

30 January 2019

Appendix 1: CQC Inspection Programme Timeline for Imperial College NHS Trust



Appendix 2: Recommendations from CQC national review of never events

Following the CQC's national review of never events carried out during 2018, the following recommendations were made. The full recommendations are contained in the report.

1. NHS Improvement should work in partnership with Health Education England and others to make sure that the entire clinical and non-clinical NHS workforce has a common understanding of patient safety and the skills and behaviours and leadership culture necessary to make it a priority.

2. The recently announced National Patient Safety Strategy should be developed in partnership with professional regulators, royal colleges, frontline staff and patient representatives.

3. Leaders with a responsibility for patient safety must have the appropriate training, expertise and support to drive safety improvement in trusts.

4. NHS Improvement should work with professional regulators, royal colleges, frontline staff and patient groups to develop a framework for identifying clinical processes and other elements, such as equipment and governance processes, that could benefit from standardisation, how this will happen and where the standardisation should apply.

5. The National Patient Safety Alert Committee (NaPSAC) should oversee a new patient safety alerts system that aligns the processes and outputs of all bodies and teams that issue alerts, and make sure that they set out clear and effective actions that providers must take on safety-critical issues.

6. NHS Improvement should review the Never Events framework and work with professional regulators and royal colleges to take account of the difference in the strength of different kinds of barrier to errors (such as distinguishing between those that should be prevented by human interactions and behaviours such as using checklists, counts and sign-in processes, and those that could be designed out entirely, such as through removing equipment or fitting/using physical barriers to risks).

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Never Events – Trust response and action plan	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 30th January 2019	**Item 13, report no. 09**
Responsible Executive Director: Julian Redhead, medical director	**Author:** Shona Maxwell, chief of staff

Summary:

The Trust has declared seven never events so far this financial year; the most recent six are all related to invasive procedures. The integrated quality performance report which is presented separately to this board includes details on the trust level action plan developed in response to the four invasive procedure related never events declared between June and November 2018. Since this was presented to executive quality committee on 8th January 2019, a further two invasive procedure related never events have been declared, one wrong site block in interventional radiology at St Mary's Hospital on 11th January 2019 and one retained swab in maternity at Queen Charlotte's & Chelsea Hospital on 21st January 2019.

Additional actions are being taken in response, and the action plan has been updated to include these (appendix 1).

Recommendations:

The Board is asked to note the additional actions planned in response to the recent invasive procedure never events.

This report has been discussed at:

☒ Executive Financial Committee
☒ Quality & Safety sub-group
☒ Invasive Procedure task and finish group
☒ Executive Quality Committee

Quality impact:

The actions described in this paper will deliver improvements in safety in invasive procedures across the Trust, in particular in improving uptake of the five steps to safer surgery.

Financial impact:

Being scoped by divisions (safer surgery simulation training and coaching requires staff release from duties and directorate facilitators need time to undertake training and in-situ coaching).

Risk impact and Board Assurance Framework (BAF) reference:

Risks related to invasive procedures are on the divisional risk registers and are managed through the Trust's risk management process. In addition, an overall risk related to safe care which includes never events is on the Trust's corporate risk register.

Workforce impact (including training and education implications):

In-situ simulation, coaching rounds and human factors training is required – implementation plan in development.

Imperial College Healthcare NHS Trust

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? ☒ Yes ☐ No ☐ Not applicable This work will have direct impact on the safety of patients undergoing invasive procedures in all areas.
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic objectives supported by this paper: ▪ To achieve excellent patient experience and outcomes, delivered with compassion. ▪ To educate and engage skilled and diverse people committed to continual learning and improvements.
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No

Imperial College Healthcare NHS Trust

Never Events – Trust response and action plan

1. Executive Summary

1.1 The Trust has declared seven never events so far this financial year; the most recent six are all related to invasive procedures.

1.2 The integrated quality performance report which is presented separately to this Board includes details on the trust level action plan developed in response to the four invasive procedure related never events declared between June and November 2018. Since this was presented to executive quality committee on 8th January 2019, a further two invasive procedure related never events have been declared bringing our total to seven never events during this financial year, the most recent six of which are related to invasive procedures.

1.3 In response to the continued and increasing number of never events, additional actions are being taken. The trust action plan has been updated to include these and is included as appendix 1.

2 Purpose

The purpose of this paper is to brief the Board on the two never events that have been declared in January 2019 that relate to invasive procedures and the additional actions being taken in response.

3 Background

3.1 In 2016/17 the Trust reported four never events related to practice in surgery. In response the medical director established a safer surgery task and finish group which undertook a number of actions including:

- a baseline information collection, audit and observation process
- review of all policies to ensure compliance with national guidance
- introduction of 'no brief, no start' (both the senior surgeon and anaesthetist must be present for the team brief)
- establishment of an annual, comprehensive trustwide audit programme.

3.2 The task and finish group completed its work in August 2017 and oversight returned to business as usual governance in the divisions. The longer term culture change related actions were included in the Safer Surgery improvement stream work, led by the Trust Lead Surgeon.

3.3 There were no invasive procedure related never events in 2017/18.

3.4 The four invasive procedure never events declared between May and November are described in more detail in the integrated quality and performance report.

- one retained swab in July 2018 (maternity at QCCH);
- one retained foreign object incident in September 2018 (cardiac at HH);
- one wrong site surgery in October 2018 (urology at CXH);
- one wrong site block in November 2018 (breast surgery at CXH);

3.5 In addition, a number of serious incidents have also been declared related to the WHO checklist this financial year.

3.6 A trustwide action plan was developed by the Medical Director, which was presented to executive quality committee on 8th January 2019. To oversee development of the action plan and its implementation an invasive procedures task and finish group was convened, chaired by the Medical Director. This group meets bi-weekly with a lead from each division in attendance.

3.7 Since the action plan was drawn up and presented to the committee, we have declared two more never events related to invasive procedures. These are:

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

3.8 The root causes of these incidents do not point to one issue to solve. They span retained foreign objects, wrong site, swab count, implants and include genuine human factors for example error in interpretation. However common to all is the steps across the system that could have prevented them.

3.9 When taken together these incidents give a general concern about compliance with safety processes and may point to a pattern of behaviour or a cultural issue that needs to be addressed.

3.10 The never events have happened in different specialties and sites with no pattern until the most recent case, which is the second in maternity at QCCH. A deep dive with maternity at QCCH has been arranged by the Medical Director. This will be chaired by the Medical Director with the Chief Nurse, Divisional Director, Divisional Director of Nursing, Divisional Director of Operations and the maternity triumvirate.

4 Actions being taken

4.1 The action plan presented to executive quality committee on 8th January 2019 included a number of actions to improve, monitor and provide assurance around compliance with key safety checks, including the five steps to safer surgery, the Count policy and ‘Stop Before You Block’, a review of all Trust policies and processes related to invasive procedures, as well as plans to roll out a simulation and coaching programme.

4.2 Additional actions have been implemented and added to the action plan in response to the two most recent never events (appendix 1) which were declared after the action plan was presented to executive quality committee. These are described below. It is

recognised that local actions to each incident are also being taken; this paper does not set these out but they are being overseen through normal governance processes.

4.3.3 **Engagement with the clinical workforce**

Communication and engagement has occurred through divisional management and governance routes as well as through an all staff email from the Medical Director and Chief Nurse which went out on 11th January. The Medical Director has visited theatres at St Mary's, Charing Cross and Hammersmith Hospitals and met with team members there to discuss the never events and immediate actions taken and required. Similar visits to Western Eye Hospital and maternity theatres are taking place on 25th and 30th January.

An extraordinary meeting with the clinical directors has been arranged for 24th January with the Medical Director (Divisional Directors have been invited to attend). A letter has been written to all consultants and one for the non-consultant doctors from the Medical Director. The Chief Nurse will write to the lead nurses in all interventional procedure based areas and presentations are planned on the never events and actions in response at Back to the Floor sessions.

Meetings are being arranged with the Director of Communications regarding the integration of safety 'nudges' into the values and behaviours programme being implemented.

4.3.2 **Simulation training and coaching**

Learning from other organisations, a simulation and coaching programme for interventional procedures areas has been developed. This has been tested in a number of areas across the divisions and was planned for roll out over 2019/20. Given the increasing number and frequency of never events an extraordinary meeting was held on 18th January with divisions and a plan for expedited roll out using a risk based approach has been agreed. A detailed implementation plan is being worked through by the divisions and a follow up meeting has been set for 24th January 2019. This plan, with dates for delivery will be presented to executive quality committee on 5th February 2019.

4.4. To provide assurance that the actions we are taking are sufficient, we are also undertaking the following:

4.4.1 **Assurance audits**

Immediate assurance audits are being conducted to review whether the two most recent never events are symptoms of wide spread issues. This includes the following:

- The imaging department have taken action to ensure WHO checklists are readily available in the CT departments and an audit has been completed.
- Maternity have undertaken a retrospective audit of midwifery led deliveries (50 on each site) to look at completion of the swab count pro-forma so we can be assured this was a one off event.

The results of these audits will be reported in the weekly update to the executive next week.

4.1.4 **External review of actions**

The national director of patient safety (Dr Aidan Fowler) has agreed to undertake a site visit with a team from his office to review the actions we are taking and to give advice on what else we should consider. Dr Fowler has been advised of our actions and his immediate feedback was that given the varied causation that we should focus on culture and psychological safety (which is what the simulation and coaching interventions will do), governance of processes, to test multiple potential solutions (e.g. laterality actions) and to make sure everyone in the team has a voice (again simulation and coaching should do this). He also suggested we look at the design ideas that are coming out nationally as well as consider introducing an executive led "hot debrief" when never events happen. We have now written to Dr Fowler to firm up arrangements.

4.4.2 **Review of actions from previous never events**

The Patient Safety Translational Research Centre (PSTRC) are undertaking a review of all actions taken as a result of previous never events to determine their effectiveness and support identification of further actions. This is expected to be completed by the end of January 2019.

5 Individual Accountability

In the two most recent never events the initial investigations show that standard safety procedures may not have been followed. In the previous four events the safety procedures were followed however human error/factors led to mistakes happening. Therefore issues will be investigated through root cause analysis as well as through standard professional investigation processes. It is important that any investigation process is completed in a fair and transparent way; if during the investigation it is found that any individual failed to follow policy or procedure then disciplinary investigation would follow with appropriate action. This is consistent with our management of previous never events. All staff involved are being supported through their professional and managerial leads. All patients have been informed and are being supported through the duty of candour and investigation processes.

6 Programme Support

6.1 As executive director for safety, the Medical Director is overseeing implementation of this programme. The action plan is being delivered through the divisions reporting to the invasive procedure task and finish group, with monthly reporting to the quality and safety sub-group and the executive quality committee. A weekly update on implementation of the action plan is now being brought to executive committee until it is progressing given the complexity.

6.2 Given the expediting of the training and coaching programme and the additional actions required to give assurance internally as well as externally, a senior programme manager from the Office of the medical director has being mobilised to take on overall programme management.

6.3 The patient safety structure in the Office of the Medical Director has been reviewed since these new never events have been declared. It has been agreed that Shona

Imperial College Healthcare NHS Trust

Maxwell, chief of staff, will take on overall responsibility for the co-ordination of all safety related work as the Trust lead for patient safety, reporting to the Medical Director. The clinical leadership model needed to support this structure is now being reviewed and an update will be provided to the executives once this has been completed.

7 Conclusion and Next Steps

7.1 A trust level action plan was developed in response to four invasive procedures related never events declared between June and November 2018. This was presented to executive quality committee on 8th January. Since this, a further two invasive procedure never events have been declared. Additional actions are being taken in response, including the expediting of the training and coaching programme, and the action plan has been updated to include these (appendix 1).

7.2 Programme management support has been put in place by the Medical Director, given the expediting of the training and coaching programme and the additional actions required to give assurance internally as well as externally.

7.3 Given the complexity, a weekly update on implementation of the action plan is now being brought to executive committee.

7.4 Additional actions will be added to the plan if they are identified through audit, external visit by the national director of patient safety or the review of our actions in response to previous never events.

7.5 An assurance programme to monitor the effectiveness of our action plan will be developed and implemented in 2019/20.

8 Recommendations

8.1 The Board is asked to note the additional actions planned in response to the recent invasive procedure never events.

Author: Shona Maxwell, chief of staff
Date: 24 January 2019

Appendices
Appendix 1 – Never event action plan

Appendix 1
Never event action plan - December 2018 (updated 24th January 2019)

Theme	Action	Owner	Due	Evidence	Status	Progress as at 24/01/19
Leadership and governance	Ensure sufficient programme management support	Medical Director	25/01/2019	Senior programme manager in place	Complete	A senior programme manager from the MD office, Teena Ferguson, has been mobilised to take on overall programme management
	Review safety leadership structures	Medical Director	05/02/2019	Clear structures in place for patient safety	In progress	The patient safety structure in the MD office has been reviewed since these new never events have been declared. It has been agreed that Shona Maxwell will take on overall responsibility for the co-ordination of all safety related work reporting to the Medical Director. The clinical leadership model needed to support this structure is now being reviewed and an update will be provided to ETM once this has been completed.
	Ensure delivery of never event action plan	Medical Director	31/03/2019	Evidence of completion of all actions	In progress	This action plan is being delivered through the divisions reporting to the invasive procedure task and finish group, with monthly reporting to the quality and safety sub-group and the executive quality committee. Weekly updates are being provided to executive committee.
Share solutions	Issue internal never event safety alerts	Improvement Programme Manager - Safety / Head of Quality Compliance and Assurance	Within week of NE occurring	Safety alerts issued on the Trust intranet	In progress	Complete for first four never events. Alerts for most recent never events being drafted. Communication outlining the never events and actions to be taken sent to all Trust staff by MD and DoN 11/01/2019.
	Communication sent to all staff by MD and ND	Medical Director	11/01/2019	Email circulated to all staff	Complete	Email sent 11/01/19
	Provide evidence that safety alerts are being used in clinical areas	Divisional Directors of clinical governance / divisional directors of nursing	11/01/2019	Safety alerts displayed in relevant clinical areas and confirmation emailed to MD office that they have been circulated and discussed at team meetings	Complete	Confirmation received from IPH, WCCS, SCC and MIC
	MD and DD to attend theatre suites on all sites to discuss never events and immediate actions	Medical Director / Divisional Director of SCC and Divisional Director of WCCS	31/01/2019	Dates for site visits in place and completed	In progress	HH visit complete (occurred 13/12/18), SMH visit complete (occurred 18/12/18), CXH visit complete (08/01/18). Visits to WEH and QCCH are planned on 25th and 30th Jan.
	Undertake extraordinary meeting with the clinical directors	Medical Director	25/01/2019	Meeting occurred with good attendance	Complete	Meeting took place 24/01/2019
	Communications sent to all doctors from the MD: - Consultants - Non-consultants	Medical Director	25/01/2019	Email sent to all doctors	In progress	Letter to be sent following meeting with the clinical directors
	Communications sent to midwifery leads, theatre nursing leads and IR lead nurses by Chief Nurse	Chief Nurse	25/01/2019	Email sent to all nurses	In progress	Letter being drafted
	Presentations on the never events and action plan at Back to the Floor	Chief Nurse	28/02/2019	Presentations given at back to the floor Thursday on all sites	In progress	Presentation being drafted
	Undertake deep dive with maternity at QCCH	Medical Director	31/01/2019	Meeting completed and action plan developed in response	In progress	Meeting arranged for 28/01/19 - will be chaired by MD with the ND, DD, DDN, DDO and the maternity triumvirate
	Present summary of incidents and actions to STP clinical board in January to share learning	Medical Director	14/02/2019	Paper presented to committee, opportunities for cross-trust work considered and learning for Trust taken back through T&F group	In progress	Next clinical board in February 2019. This action plan to be submitted for presentation.
	External review of actions and response	Medical Director	28/02/2019	Site visit by national director of patient safety and team undertaken and actions developed in response to their views	In progress	National director of patient safety (Dr Aidan Fowler) has agreed to undertake a site visit with a team from his office to review the actions we are taking and to give advice on what else we should consider. MD has written to Dr Fowler to firm up arrangements
Safety culture and speaking up	Roll out insitu simulation, with areas determined to be high risk prioritised	Medical Director (coordination taken over from divisions 18/01/19)	31/03/2019	High risk areas identified with dates in place for training to be delivered. Training completed and training records provided to T&F. Rolling simulation programme in place to ensure each IP area of the trust is covered.	In progress	Learning from other organisations, a simulation and coaching programme for interventional procedures areas has been developed. This has been tested in a number of areas across the divisions and was planned for roll out over 2019/20. Given the increasing number and frequency of never events an extraordinary meeting was held on 18th January with divisions and a plan for expedited roll out using a risk based approach has been agreed. A detailed implementation plan is being worked through by the divisions and a follow up meeting has been set for 24th January 2019. This plan, with dates for delivery will be presented to executive quality committee on 5th February 2019.
	Roll out coaching rounds, with areas determined to be high risk prioritised	Medical Director (coordination taken over from divisions 18/01/19)	31/03/2019	High risk areas identified with dates in place for coaching to be delivered. Coaching rounds completed and training records provided to T&F. Rolling programme in place to ensure each IP area of the trust is covered.	In progress	
	Roll out human factors training, with areas determined to be high risk prioritised	Medical Director (coordination taken over from divisions 18/01/19)	31/03/2019	High risk areas identified with dates in place for human factors training to be delivered. Training completed and training records provided to T&F. Rolling programme in place to ensure each IP area of the trust is covered.	In progress	
	Develop and introduce safer surgery champions	Trust Lead Surgeon	31/03/2019	Defined role and governance arrangements for safety champions. Pilot areas chosen and champion role tested. Scheme evaluated and rolled out across the Trust. Named safer surgery champion in each speciality/theatre.	In progress	Facilitators' rather than 'champions' being identified for each specialty to support the training programme.
	Trial Schwartz round style session on the de-brief	Trust Lead Surgeon	31/03/2019	Schwartz round done and impact evaluated	In progress	In planning phase.
	Consider implemeting a 'hot line' for staff to raise issues	Medical Director	31/03/2019	TBC	In progress	To be discussed at the meeting with Dr Fowler
	Integrate safety 'nudges' into the values and behaviours programme	Medical Director	31/03/2019	TBC	In progress	Meetings being arranged with director of communications regarding the integration of safety 'nudges' into the values and behaviours programme being implemented
Safety checks and handover	Divisional action plans developed and implemented in response to trustwide audit results	Divisional directors of clinical governance / divisional directors of nursing	16/01/2019	Action plans presented to and approved at sub-group on 16/01/19. Implementation of actions monitored through T&F group, with monthly reporting to sub-group.	Complete	Action plans reviewed at sub-group on 16/01/19.
	Implement 'stop before you block'	Clinical Director for Theatres	31/03/2019	Develop plan to ensure implementation of SB4YB, including monitoring and audit	In progress	SB4YB included in Trust invasive procedure policy. Never event alert issued highlighting the process. Audit of compliance planned for Q1 2019/20.
	Evaluate impact of displaying intended site of surgery on the wipe board in theatre	Directorate triumvirate - CD theatres/GM theatres and Senior Nurse for Theatres	31/03/2019	Evaluate impact and ensure roll out in all areas	In progress	Evaluation being planned
	Review and re-launch count policy	Divisional Governance Lead for SC&CS	28/02/2019	Count policy review complete with simplified policy in line with national guidance and best practice. Policy ratified and published. Communications campaign in place to support re-launch of policy	In progress	Count policy review being led by division of SC&CS
	Audit compliance with the count policy	Divisional Directors of clinical governance / Divisional Directors of Nursing	Q1 2019/20	Audit tool signed off. Audit completed and reports shared. Action plans developed in response.	In progress	Audit tools reviewed at T&F 14/12/18. Detailed audit plan being worked up with the divisions with the aim of the count audit being completed in Q1 2019/20.
	Undertake audit for CT Root Nerve lists to provide assurance that the WHO checklist is being used	Divisional director of nursing (WCCS)	29/01/2019	Audit completed and results shared. Actions developed in response as required.	In progress	Results of this audit will be reported in the weekly update report to the executives next week.
	Undertake retrospective audit of midwifery led deliveries (50 on each site) to look at completion of the swab count pro forma	Divisional director of nursing (WCCS)	29/01/2019	Audit completed and results shared. Actions developed in response as required.	In progress	Results of this audit will be reported in the weekly update report to the executives next week.
	Audit compliance with preparation for an anaesthetic block	Divisional Directors of clinical governance / Divisional Directors of Nursing	Q1 2019/20	Audit tool signed off. Audit completed and reports shared. Action plans developed in response.	In progress	Audit tools reviewed at T&F 14/12/18. Detailed audit plan being worked up with the divisions with the aim of the block audit being completed in Q1 2019/20.
Reduce interruptions and distractions	Implement 'Don't interrupt the anaesthetist when the patient is in the anaesthetic room across all sites	Directorate triumvirate - CD Theatres/GM Theatres and Senior Nurse for Theatres (to ensure implemented across all areas conducting invasive procedures with anaesthetic involvement)	31/03/2019	Develop plan to ensure implementation including monitoring and audit	In progress	Improvement team supporting evaluation in January 2019
Site marking	Roll out the use of radiopaque markers trustwide	Directorate triumvirate as applicable to area conducting invasive procedures - CD, GM and Senior Nurse	31/03/2019	Pilot complete and evaluated. Plan for roll out in place. Roll out completed and markers used for all relevant procedures as evidenced by audit	In progress	Testing in place in urology at CXH with improvement team support. Target completion of test is end of January with a plan to roll out trust wide following evaluation.
Operative treatment plan	Audit compliance with treatment plans for each patient (should include the procedure, the site, the side and direction of surgery and any calculations)	Directorate triumvirate as applicable to area conducting invasive procedures - CD, GM and Senior Nurse	28/02/2019	Audit tool signed off. Audit completed and reports shared. Action plans developed in response.	In progress	Planning phase being undertaken
Mixed paper and electronic records	Develop plan to switch to electronic records for the safer surgery checklists	Consultant Anaesthetist and Clinical Director for Theatres	Q1 2019/20	Approved plan in place based on learning from other organisations. Plan implemented.	In progress	Visit planned to an organisation that has undertaken this work to better understand the possible issues and risks prior to developing a plan to implement this at the Trust.
Trust policies and guidelines	Review of all policies relating to invasive procedures to ensure they are in line with national guidance and are audited	Improvement Programme Manager - Safety / Head of Quality Compliance and Assurance	28/02/2019	All policies reviewed and re-published. Audits in place as part of trust priority audit plan for 2019/20	In progress	Count policy currently being reviewed, Invasive procedures policy out for consultation - due for approval at T&F on 23 Jan. Audits for areas of risk (e.g. count and anaesthetic block) will be audited in Q1 2019/20.
	Ensure LocSSIPs are in place for all appropriate procedures	Divisional directors of clinical governance / Divisional directors of nursing	Q1 2019/20	All areas which require them have approved LocSSIPs in place with evidence that they are being used through audit	In progress	LocSSIP review of NHSI guidance and national examples being completed to inform development of the documents. List of all procedures that should have a LocSSIP compiled by the divisions. Process for approval agreed through T&F group.
Equipment with covers and caps	Undertake review of theatre processes for regularly checking equipment integrity, replacement and for removing equipment where faults are suspected to be undertaken	Directorate triumvirate as applicable to area conducting invasive procedures - CD, GM and Senior Nurse	28/02/2019	Approved processes for checking equipment in place in all areas. Regular checks being undertaken with evidence that all equipment meets the required standards, or plans are in place to ensure this is the case.	In progress	Planning phase being undertaken
Storage	Undertake review of storage in all theatres of equipment that is "sided" to ensure they are separated, clearly labelled and in distinguishable containers	Directorate triumvirate as applicable to area conducting invasive procedures - CD, GM and Senior Nurse	28/02/2019	Review completed with actions in place in areas requiring improvement. Improvement evidenced through audit.	In progress	Planning phase being undertaken

Training	Ensure 100% compliance for all doctors with safer surgery e-learning module with non-compliant doctors not being able to operate until they complete their training	Divisional directors	28/01/2019	WIRED reports showing 100% compliance for doctors	In progress	Divisions receiving regular reports of compliance. Letter from MD/DoN confirmed that staff will be stopped from operating if they have not completed their training by 25/01/19.
Review of previous actions	Review all previous invasive procedure never events and evaluate of actions taken as a result	Improvement Programme Manager - Safety / PSTRC	31/01/2019	Review completed for all actions taken in response to NE since 2016. Actions confirmed as closed and their implementation evaluated.	In progress	Actions from the two most recent completed invasive procedure never event investigations are included below. Investigations for the other events are still in progress. A review of actions taken is being undertaken by the PSTRC. The intial review will be completed by 31/01/19. A further in depth analysis will then be undertaken.
	Retained swab action 1: Safety alert to be sent to all staff reinforcing the pink wristband guideline	Divisional Governance Lead for WC&CS	Oct-18	Copy of safety alert	Complete	Complete
	Retained swab action 2: Complete individual doctor learning	Education supervisor/Head of Specialty	Dec-18	Reflective piece within doctors' appraisals. Audit of next 3 cases	Complete	Complete
	Retained swab action 3: Learning for staff: Detail of NE to be included in next risk business newsletter. Discussion to occur at maternity safety huddle. Ensure that when distributing emails to all staff administrators have all the email groups	Risk management midwife	Oct-18	Copy of risky business. Copy of maternity safety huddle. Email evidence that missing groups have been added by administrators	Complete	Complete
	Retained swab action 4: Included within agenda for junior doctor induction.	Medical Education Lead	Oct-18	Agenda	Complete	Complete. Medical education has confirmed this has been embedded in induction.
	Retained swab action 5: Update guideline to include recommendation that the removal of retained items is witnessed by 2 appropriately trained staff	Guideline Lead	Oct-18	Copy of guideline	Complete	Complete
	Retained swab action 6: Update MOH guideline	Guideline Lead	Nov-18	Copy of guideline	Complete	Guideline uploaded to the new intranet
	Retained swab action 7: Midwife reflection	Risk management midwife	Sep-18	Confirmation from risk midwife	Complete	Complete
	Retained swab action 8: Ensure SBAR proforma freely available on LW and inform staff on requirement of use	LW Matron / LW lead	Aug-18	Random audits of use of SBAR on shifts	Complete	Complete
	Retained foreign object action 1: Review the existing count training programme in order to ensure it covers the points raised	SCCS Director of Clinical Governance	30/01/2019	New training materials obtained and deployed	In progress	Count policy and training programme under review.
	Retained foreign object action 2: Review of admission clerking proforma with specific focus on avoidance of retained instruments	GICU and CICU leads	30/01/2019	Correspondence and review documentation	In progress	Documentation under review.
	Retained foreign object action 3: Safety bulletin to be cascaded to all specialty Quality & Safety Committees.	SCCS Director of Clinical Governance	30/01/2019	Safety bulletin	Complete	Complete. Tabled as agenda item at SCCS Q&S Committee on 08/01/18.
	Retained foreign object action 4: Staff to be sent copy of SI investigation report and to be reminded to reflect on this incident	SCCS Director of Clinical Governance	30/01/2019	Correspondence with staff	Complete	Complete

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Learning from Deaths: Update on implementation and reporting of data	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 30th January 2019	**Item 14, report no. 10**
Responsible Executive Director: Dr Julian Redhead, Medical Director	**Author:** Dr Ian Maconochie, Associate Medical Director for Patient Safety

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

This paper is to update the Board on progress since the last report and includes an updated 'learning from deaths dashboard' (appendix A). The dashboard includes data for the financial year 2017/18 to Q2 2018/19.

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

- We are compliant with reporting requirements as set out by NHS Improvement
- 37 members of staff have undergone structured judgment review (SJR) training. Further recruitment continues, the idea being to having one per specialty.
- 338 SJR report have been completed to date from September 2017 (2017/2018 = 241, 2018/19 = 97).
- There have been 17 avoidable deaths to date all reviewed in financial year 2017/2018 with 5 this year to date.
- Data reporting is 1 month in arrears, to allow for the reporting cycle.
- Mortality reporting metrics have been incorporated into both trust and divisional scorecards since November 2017. No trust specialties are currently causing concern in respect to avoidable deaths.
- Early emerging themes map to six of the Trust's safety streams 'falls and mobility (3)' and the 'responding to the deteriorating patient' (9), 'abnormal results (2)', 'safer medication (1)', 'safer surgery (1)', and 'fetal monitoring (5)' safety streams. Cases have been shared with the safety work streams aligned to these topics. Data fields have now been incorporated within the online module to facilitate thematic reporting into the future.
- The Trust continues to report any applicable cases to the LeDeR programme, and complies with all reporting requirements for LeDeR.

Recommendations:
This paper is being presented to the Board for noting.

This report has been discussed at:
☒ Executive People & Organisational Development Committee
☒ Quality Committee

Quality impact: This process supports improved learning from deaths which occur in the Trust, therefore supporting the safe, effective and well-led quality domains.
Financial impact: There is a financial impact and resource requirement in terms of medical time to conduct structured judgment review of deaths, which divisions have agreed to and is included in their forecasts.
Risk impact and Board Assurance Framework (BAF) reference: There is potential for reputational risk associated with the ability to deliver reviews within the specified time periods, thus impacting on national reporting. Learning from Deaths is on the divisional risk register for the medical director's office.
Workforce impact (including training and education implications): Six staff received Tier 1 training provided externally by the Royal College of Physicians, the remaining staff were then trained internally in a mixture of individual or small group sessions, dependent on need. Training remains available via the Mortality Auditor.
What impact will this have on the wider health economy, patients and the public? The aim of this work is to identify avoidable factors in the deaths of patients, provide learning opportunities, and guide future improvement works to reduce avoidable deaths.
Has an Equality Impact Assessment been carried out? ☐ Yes ☐ No ☒ Not applicable If yes, are there any further actions required? ☐ Yes ☐ No
Paper respects the rights, values and commitments within the NHS Constitution. ☒ Yes ☐ No
Trust strategic objectives supported by this paper: ▪ To achieve excellent patient experience and outcomes, delivered with compassion. ▪ To educate and engage skilled and diverse people committed to continual learning and improvements.

Imperial College Healthcare NHS Trust

Learning from Deaths: Update on implementation and reporting of data

1. Executive Summary

1.1. This paper is to update the Board on progress since the last report (September 2018) and includes an updated 'learning from deaths dashboard' (**appendix A**) with data for the financial year 2017/18 to Q2 2018/19.

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

- We are compliant with reporting requirements as set out by NHS Improvement.
- 37 members of staff have undergone structured judgment review (SJR) training, which is a slight increased from previously reported. Further recruitment continues, with the aim of confirming at least one trained reviewer per specialty.
- There have been 338 SJR reports that have been completed since commencing the review programme in September 2017 (17/18=241, 18/19=97)
- This financial year to date there has been 5 avoidable deaths reviewed and signed off via the Mortality Review Group (as of 04/12/18).
- There were 17 cases of avoidable death in financial year 17/18.
- 19 of these cases have undergone SI investigations, with the remaining 3 cases having been subject to internal investigations.
- Data reporting is 1 month in arrears, to allow the reporting cycle to complete, and for performance data to more accurately reflect compliance.
- Since November 2017 mortality-reporting metrics have been incorporated into both Trust and divisional scorecards.
- The avoidable deaths are not clustered by specialty and therefore no individual specialty concerns have been raised.
- Early emerging themes are linked to six of the Trust's safety streams. 'falls and mobility (3)', 'abnormal results(2)', 'responding to the deteriorating patient (9)', 'safer medication (1)', 'safer surgery(1)', and 'fetal monitoring(5)'. Cases will continue to be shared with the safety workstream leads to ensure the improvement work covers the findings of the SJRs. Case specific actions are recorded and tracked through the Datix actions module. Trust-wide non-patient specific actions are managed and reviewed through the monthly MRG. (communication 1)
- Data fields have now been incorporated within the online mortality module to facilitate thematic reporting into the future.
- The Trust continues to report any applicable cases to the LeDeR programme, and complies with all reporting and reviewing requirements for LeDeR.

1.3. A review of the Trust's mortality processes has been undertaken by one of the General Managers in the Office of the Medical Director and a number of recommendations have been made in relation to the process and governance

arrangements as well as the compliance and learning aspects of SJRs. The outputs from this review will also support the Trust's transition to a Medical Examiner model during 2019/20. This will require investment in the role of medical examiner and so a full review and proposal will be brought through executive quality committee in Q4. This has been included as a cost pressure for business planning purposes.

1.4. A Learning from Deaths steering group will be established to oversee the implementation of all recommendations made following the review and will include how learning is disseminated across directorates and specialties.

2. Purpose

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

3. Background

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

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

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

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

4. Summary/Key points

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

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

4.3. All clinical teams are required to provide a review of mortality cases within their specialty areas. All cases undergo a Level 1 review, which consists of a short number of questions, followed by assigning an avoidability score within 7 days of death. Based on that review, cases may proceed to a team based Morbidity & Mortality (M&M) meeting, which should occur within 30 days. Where local teams have highlighted issues in the care of a patient, an independent SJR review should be undertaken. Charts demonstrating the trust performance, both for local review as well as SJR, for 2017/18 and for Q1-Q2 2018/19 can be found in **Appendix B**. For deaths occurring in Q1-Q2 2018/19, 95% of local reviews had been undertaken with 126 SJR's requested. Of these, 97 SJR's have been completed with 5 avoidable deaths confirmed. N.B. Data included here covers Q1-Q2 2018/19 for external reporting requirements. More recent monthly data for October 2018 is included in the integrated quality and performance scorecard.

4.4. Data is refreshed monthly, in order to update all reporting metrics. This is particularly important when reviewing SJR requests which are made a significant period after the death. Delays occur due to SJRs being requested more than 30 days after death, e.g. as a result of coronial requests being confirmed, or concerns being raised by clinical teams from local M&M procedures, or are commenced as a response to the formal complaints.

4.5. Overdue SJR reviews are being managed where reviewers are struggling to complete them, for example due to capacity, by reallocating them to another reviewer. Additional dates for the mortality review group (MRG) have been provided as the availability of investigators to the monthly meeting is limited, removing a factor that had caused delay.

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

4.7. The Trust target is to review 15% of hospital deaths using the SJR methodology. Cases are selected using the principles set out in the Trust policy.

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

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

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

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

4.12. The Trust reports all deaths of patients with a learning disability to the national database. We reported 12 deaths in 2017/18, of which 2 were subjected to a full review. We have reported 4 cases in Q1 and Q2 2018/19. At ICHT these cases all have an SJR completed, in addition to the external LeDeR review. To date those SJR reviews have not revealed any concerns in relation to deficiencies in care, and do not form any of the reported avoidable deaths. LeDeR reports are held at CCG level and not actively shared with acute providers unless issues or concerns are identified relating to the Trust.

5. Options appraisal including financial appraisal (as relevant)

Not applicable

6. Conclusion and Next Steps

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

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

6.3. A review of the Trust's mortality processes has been undertaken by one of the General Managers in the Office of the Medical Director a number of recommendations have been made in relation to the process and governance arrangements as well as the compliance and learning aspects of SJRs. The outputs from the review will also support the Trust's transition to a Medical Examiner model during 2019/20. This will require investment in the role of medical examiner and so a full review and proposal will be brought through executive quality committee in Q4. This has been included as a cost pressure for business planning purposes.

Imperial College Healthcare NHS Trust

6.4. A Learning from Deaths steering group will be established to oversee the implementation of all recommendations made following the review and will include how learning is disseminated across directorates and specialties.

7. Recommendations

7.1. This paper is being presented to the Board for noting.

Author: Ian Maconochie, Associate Medical Director
Date: 21st January 2019

Appendices as relevant (referenced in summary)

Appendix A: NQB Learning from Deaths Dashboard

Appendix B: Trust Performance Dashboard

- 2017/18
- 2018/19

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

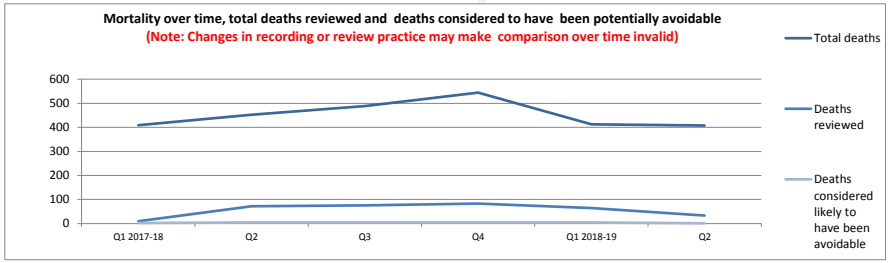
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
131	118	6	11	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
408	413	33	64	1	4
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
821	1895	97	241	5	17

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



Total Deaths Reviewed by RCP Methodology Score

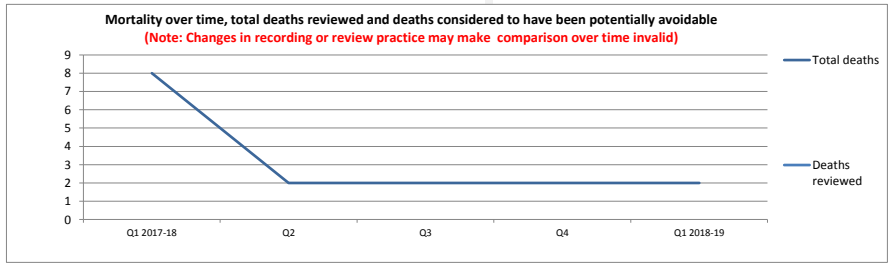
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	16.7%	This Month	1	16.7%	This Month	4	66.7%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	3.0%	This Quarter (QTD)	6	18.2%	This Quarter (QTD)	2	6.1%	This Quarter (QTD)	24	72.7%
This Year (YTD)	0	0.0%	This Year (YTD)	1	1.0%	This Year (YTD)	4	4.1%	This Year (YTD)	7	7.2%	This Year (YTD)	12	12.4%	This Year (YTD)	73	75.3%

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	2	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
4	12	0	2	0	0

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



Appendix B – Trust Performance Dashboard

Trust Level Performance 2017-18

Trust Total	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD
Total Deaths	120	152	137	138	163	151	161	167	161	191	176	178	1895
No. Level 1 Reviews Completed	120	152	137	138	163	150	161	166	160	189	176	178	1890
% Level 1 Reviews Completed	100%	100%	100%	100%	100%	99%	100%	99%	99%	99%	100%	100%	100%
No. of SJR Reviews Requested	3	3	4	21	30	22	36	19	21	28	32	28	247
No. of SJR Reviews Completed	3	3	4	21	29	22	36	19	21	28	28	27	241
% SJR Reviews Completed	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	88%	96%	98%
No. of Avoidable Deaths (Score 1-3)	2	0	0	2	2	1	3	2	0	2	2	1	17

Trust Level Performance 2018-19 (Q1 – Q2)

Trust Total	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	YTD
Total Deaths	155	136	122	159	118	131	821
No. Level 1 Reviews Completed	153	135	116	150	107	115	776
% Level 1 Reviews Completed	99%	99%	95%	94%	91%	88%	95%
No. of SJR Reviews Requested	19	29	23	23	19	13	126
No. of SJR Reviews Completed	19	27	18	16	11	6	97
% SJR Reviews Completed	100%	93%	78%	70%	58%	46%	77%
No. of Avoidable Deaths (Score 1-3)	2	1	1	1	0	0	5

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Corporate Risk Register and Board Assurance Framework	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 30 January 2019	**Item 15, report no. 11**
Responsible Executive Directors: Janice Sigsworth, Director of Nursing Tim Orchard, Chief Executive Officer	**Authors:** Valentina Cappo, Corporate Risk Manager Priya Rathod, Deputy Director of Quality Governance Peter Jenkinson, Trust Company Secretary

Summary:

This is a joint risk management report including updates from the Corporate Risk Register (CRR) and the Board Assurance Framework (BAF).
The report provides a summary of key changes made to the CRR and the BAF since they were last reviewed by the Trust Board on 25 July 2018.
Please refer to **Appendix 1** for the Trust's Corporate Risk Register.
Please refer to **Appendix 2** for the Board Assurance Framework.

PART 1: Corporate Risk Register

The Trust Board reviewed the Corporate Risk Register at its meeting in July 2018. A number of changes have been made to the Corporate Risk Register since then, which have been discussed and approved by the Executive Committee and the Audit, Risk and Governance Committee.

There are 24 corporate risks within the risk register; these include 2 risks that are commercial in confidence. The highest risks are scored as 20 and the lowest are scored as 6.

Key themes include:

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

Changes to the Corporate Risk Register

Since the last meeting, risk appetite ratings have now been included against each corporate risk. This will support the Board considering the current level of residual risk in the context of the agreed level of risk appetite.

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

- ***Risk 2697*** *- Impact of Paddington Square development on Trust services at St. Mary's Hospital.*
- The initial risk score was 12 (C3 x L4). The current risk score remains 12 (C3 x L4). The target risk score is 9 (C3 x L3)
- One risk that is commercial in confidence was escalated onto the Corporate Risk Register in

September 2018.
- The initial risk score was 15 (C3 x L5). The current risk score is 12 (C3 x L4). The target risk score is 9 (C3 x L3).
- Risks that are commercial in confidence have been reviewed by the Audit, Risk and Governance Committee as part of the complete corporate risk register.

The following risks have been de-escalated from the Corporate Risk Register:
- **Risk 2714** - Failure to successfully implement the 2017/18 NHS e-Referral Service within timeframe.
- The initial risk score was 16 (C4 x L4). The current risk score is 9 (C3 x L3). The target risk score is 3 (C3 x L1).
- The Executive Finance Committee was assured of the effectiveness of the controls in place and has agreed that this risk can be de-escalated to the Women's, Children's and Clinical Support divisional risk register until the target score is achieved.
- **Risk 2489** - Failure to develop and publish a refreshed Trust Clinical Strategy which outlines the direction of travel for all clinical services and which is recognised and accepted by leaders of clinical services.
- The initial risk score was 8 (C4 x L2). The current risk score remains 8 (C4 x L2). The target risk score is 4 (C4 x L1).
- The Executive Finance Committee was assured of the progress made with managing this risk and has agreed that this risk can be de-escalated to the divisional risk register of the Office of the Medical Director, until the target score is achieved.
- **Risk 2557** - Risk of using medical devices that are out of testing date due to lack of scheduled maintenance.
- The initial risk score was 12 (C3 x L4). The current risk score is 6 (C3 x L2). The target risk score is 3 (C3 x L1).
- The Executive Finance Committee was assured of the effectiveness of the controls in place and has agreed that this risk can be de-escalated to the Facilities, Estates, Nursing and Site divisional risk register until the target score is achieved.

The score for the following risk has changed:
- ***Risk 2490*** *– Failure to deliver safe care*
- The initial risk score was 12 (C4 x L3). The current risk score is 16 (C4 x L4) The target risk score is 8 (C4 x L2)
- The current risk score has increased due to an increased number of never events.

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

Outcome from the internal audit of risk management

An internal audit of risk management was carried out by PwC between June and July 2018.

Overall, the report was classified as 'Low risk', which is the best classification the Trust can be awarded for an internal audit, according to the internal auditors' ratings matrix.

Next steps
- A deep dive of all corporate risks will be undertaken by the end of February 2019.
- As part of this work a review of the Trust Risk Appetite framework will also take place.
- The layout of the Corporate Risk Register summary will also be reviewed based on best practice and the dashboard will reflect movement of corporate risks scores over the previous year.
- The new template will be presented to the Executive Finance Committee in February 2019 and to the Audit, Risk and Governance Committee in March 2019.

Imperial College Healthcare NHS Trust

PART 2: Board Assurance Framework

The purpose of the Board assurance framework is to enable the Board and its committees to ensure that it receives assurance that all key risks are being effectively managed and to commission additional assurance where it identifies a gap in assurance. This process enables the Board to, inter alia, have confidence in its self-assessment of compliance with regulatory standards and in the year-end reporting.

The framework seeks to demonstrate the way in which the Trust seeks assurance from its reporting arrangements rather than an approach taking assurance from the direct control of individual risks.

The latest version of the framework, attached at Appendix 2, reflects amendments made since the last review by the Board. The framework was reviewed by the Audit, Risk and Governance Committee in December 2018.

Recommendations:
The Committee is asked to:
- Note the changes to the corporate risk register
- Note and agree current ratings within the board assurance framework.

This report has been discussed at:
- The Corporate Risk Register and the Board Assurance Framework have been discussed at the Audit, Risk and Governance Committee on 5 December 2018.
- The Corporate risk register will be discussed at the Executive Committee on 22 January 2019.

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

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

Risk impact and Board Assurance Framework (BAF) reference:
Evidence of assurance to the effectiveness of controls for risks included onto the Corporate Risk Register is reflected on the Board Assurance Framework.

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

What impact will this have on the wider health economy, patients and the public?
Individual risks have different impact on the above topics, as reflected within each risk description.

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

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

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

Imperial College Healthcare NHS Trust

effective governance.
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Please use the detail outlined in the Executive Summary.

Imperial College Healthcare NHS Trust

Corporate Risk Register and Board Assurance Framework

1. Background and purpose

- In July 2018 the format of this report was changed and since then this has been a joint report, including updates on the Corporate Risk Register (CRR) and the Board Assurance Framework (BAF).
- The report seeks to align the BAF and CRR more closely, which is in line with best practice.
- The report provides an update on the Corporate Risk Register and the BAF and includes a summary of key changes made since these were reviewed by the Trust Board on 25 July 2018.
- Please refer to **Appendix 1** for the Trust's Corporate Risk Register.
- Please refer to **Appendix 2** for the Trust's Board Assurance Framework.

Imperial College Healthcare NHS Trust

PART 1: Corporate Risk Register

1. Background

- The Trust Board reviewed the Corporate Risk Register at its meeting on 25 July 2018.
- A review of the Executive Committee structure was undertaken in September 2018; following this, it was agreed that the Executive Finance Committee will act as the Executive Risk Committee.
- The risk management reporting structure has also been reviewed to ensure greater visibility of key divisional risks by the Audit, Risk and Governance Committee.
- The following risk management governance process is in place within the Trust:

  - **Directorate risk registers**; these are in place for all clinical directorates and are discussed and approved at directorate quality and safety meetings or equivalent; risks that cannot be managed locally are escalated to the divisional risk register.
  - **Divisional risk registers;** these are discussed and approved at the designated forums with responsibility for risk within all clinical and corporate divisions. In the clinical divisions these are the divisional Quality and Safety Committees.
    - Key quality divisional risks are escalated to the Executive Quality Committee each month.
    - At each meeting of the Quality Committee, a summary of the key quality divisional risks are presented.
    - All key divisional risks are presented to the Executive Finance Committee monthly and to the Audit, Risk and Governance Committee quarterly.
  - **Corporate risk register:** This is discussed and approved monthly at the Executive Finance Committee and is presented quarterly at the Audit, Risk and Governance Committee and six-monthly at the Trust Board.

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

Imperial College Healthcare NHS Trust

2. Changes to the Corporate Risk Register

- The Board will recall that it approved the Trust's risk appetite statement and ratings in March 2018.
- A risk appetite rating has been included against each of the corporate risks on the corporate risk register.
- This will support the Board in considering the current level of residual risk in the context of the agreed level of risk appetite.
- The following changes have been made to the corporate risk register and approved by the Executive Committee since it was last presented to the Board in July 2018.

2.1. Risks escalated onto the Corporate Risk Register

The following risks have been escalated onto the risk register which the Board were alerted to at the meeting in July 2018:

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

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

- This risk was escalated in July 2018.
- There is an on-going risk of disruption to clinics and administrative work due to high levels of noise, dust and vibration expected from the Paddington Square demolition programme. The number of complaints regarding this has been increasing.
- The demolition programme is expected to be complete by the end of February 2019.
- The extent of the Paddington Square construction programme is currently unknown and the total demolition and construction period is likely to be 4 years.
  - A number of mitigations have been agreed between the developer and the Trust that have been implemented over the few months.

- ***Risk -*** *Commercial in confidence risk*

Initial Risk Score	Current Risk score	Target Risk Score
15 (C3 x L5)	12 (C3 x L4)	9 (C3 x L3)

- One risk that is commercial in confidence was escalated onto the Corporate Risk Register in September 2018.
- Risks that are commercial in confidence are discussed and reviewed at the Audit, Risk and Governance Committee as part of the complete corporate risk register.

2.1.1. Risk escalated and subsequently de-escalated

- ***Risk 2714*** *- Failure to successfully implement the 2017/18 NHS e-Referral Service within timeframe.*

Initial Risk Score	Current Risk score	Target Risk Score
16 (C4 x L4)	9 (C3 x L3)	3 (C3 x L1)

- This risk was escalated in July 2018 and was discussed at the Audit, Risk and Governance Committee in October and December 2018.
- A new provision, which forms part of the current 2017/19 Contract, was implemented in October 2018and states that all GP referrals for first outpatient appointments are to be made electronically and if this is not done, the Trust should not accept the referral.
- Failure to successfully implement this could result in inefficient capacity management and subsequent increased Appointment Slot Issues (ASI), increased costs and potential loss of income.
- All GP referrals that should be referred via e-RS are now being referred or rejected since paper switch off in October 2018.
- All 2 week referrals that are rejected are followed up with a call to the GP practice and updates given to the CCGs.
- ASIs, which had originally increased, have been gradually decreasing.
- In light of the above and the likelihood of the risk materialising decreasing, it was agreed at the Executive Finance Committee on 22 January 2019 that the risk be de-escalated from the corporate risk register and continues being monitored on the Women's Children's and Clinical Support divisional risk register, until the target risk score is achieved.

2.2. Risks de-escalated from the corporate risk register

- **Risk 2489** *- Failure to develop and publish a refreshed Trust Clinical Strategy which outlines the direction of travel for all clinical services and which is recognised and accepted by leaders of clinical services.*

Initial Risk Score	Current Risk score	Target Risk Score
8 (C4 x L2)	8 (C4 x L2)	4 (C4 x L1)

- Initial work around the development of the Trist organisational strategy, including the clinical strategy has taken place.
- Further iterations, incorporating feedback and comments will be developed as part of the engagement and consultation process and the strategy is expected to emerge over the coming months.In view of the above, the Executive Finance Committee agreed the de-escalation of this risk from the corporate risk register, at its meeting on 22nd January 2019. The risk will continue being monitored on the divisional risk register for the Office of the Medical Director.

- **Risk 2557** - *Risk of using medical devices that are out of testing date due to lack of scheduled maintenance.*

Initial Risk Score	Current Risk score	Target Risk Score
12 (C3 x L4)	6 (C3 x L2)	3 (C3 x L1)

- The Trust is consistently demonstrating month on month sustained and achieved performance against the agreed maintenance KPIs.
- The implementation of the equipment libraries remains on track.
- A launch pack for the "Medical Devices BE Safe" module will be issued in January together with a FAQ and 'Checklist' that will enable all users to know and understand their responsibilities.
- At the Audit, Risk and Governance Committee in December 2018 it was discussed if this risk should be de-escalated from the corporate risk register to the Facilities, Estates, Nursing and Site Operations divisional risk register.
- This was discussed and agreed at the Executive Finance Committee on 22nd January 2019.

2.3. Change to risk score

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

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

- The risk score was increased from 12 (C4 x L3) to 16 (C4 x L4) in November 2018 due to an increased number of never events and the likelihood of this risk materialising.
- The Medical Director has since reviewed and updated this risk in light of further never events.
- As part of this review, the risk description and title has been amended from '*Failure to deliver safe and effective care' to 'Failure to deliver safe care'* so it appropriately reflects the actual risk.
- The Divisions of Surgery and Women's and Children's have also included a risk regarding never events on the divisional risk registers.
- An update on never events and the action being undertaken is presented as a separate item at this meeting.
- The target risk score date has been extended from October 2018 to March 2019 to allow for the actions to be undertaken and the risk to achieve its target score.

- **Risk 2540** - *Risk of negative impact on patient and staff safety due to failure to achieve and/ or maintain full compliance to core skills training amongst substantive staff*.

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

- Compliance with core skills training has been increasing consistently and now remains above 90%.
- The current risk score has subsequently decreased from 9 (C3 x L3) to 6 (C3 x L2), thus achieving the target risk score.
- The Executive Finance Committee will review if the risk should be de-escalated from the corporate risk register in March 2019.

- ***Risk -*** *Commercial in confidence risk*

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

- The current score for one risk that is commercial in confidence has reduced from 16 (C4 x L4) to 9 (C3 x L3).
- The risk will remain on the corporate risk register at present.

2.4. In-depth risk review following independent review

- ***Risk 1660*** - *Risk of delayed treatment to patients due to poor data quality*

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

- Following the publication of an independent review by MBI in June 2018, this risk was extensively reviewed in September 2018.
- The risk title has changed to: *Risk of delayed treatment to patients and loss of Trust reputation due to poor data quality* and the risk description has also been amended.
- The action plan has been expanded to include recommendations from the MBI review, which are expected to address relevant issues.
- An audit of all submissions to external organisations to identify these and ensure senior authorisation before data is shared externally was undertaken and presented to the Executive Operational Performance Committee in November 2018.
- The current risk score remains at 20 (C4 x L5).

Imperial College Healthcare NHS Trust

2.5. Changes to Target Risk Score Dates

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

- ***Risk 2538 -*** *Risk of medication safety being negatively affected due to poor adherence to medication safety policies*

Initial Risk Score	Current Risk score	Target Risk Score
16 (C4 x L4)	12 (C4 x L3)	6 (C3 x L2)

- A number of improvements have been implemented as part of the Medication Safety Improvement Programme and a new audit format was launched in September 2018, which is expected to provide more robust assurance of compliance to medication policies.The target risk score date has been changed from September 2018 to the end of February 2019 to allow time for the audits to demonstrate that improvement has been achieved and sustained.
- The risk will be reviewed after the findings from all of the internal peer reviews have taken place in March 2019.

- ***Risk 2487*** *- Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae)*
- New actions have been agreed following the most recent positive CPE screening in various locations within the organisation.

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

- The target risk score date for this risk has changed from September 2018 to January 2019 to allow completion of the outstanding actions that are in place to mitigate this risk.

- ***Risk 2499*** *- Failure to meet required or recommended Band 2-6 vacancy rate for Nursing & Midwifery staff*

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

- The current risk score is reflects the national nursing recruitment shortage.
- Progress is being made to the recruitment and retention programme.
- A number of activities have been implemented, which include:
  - Recruitment and retention premiums have been applied to hard to fill areas
  - Career coaching has been made available to staff.
  - A number of overseas recruitment events took place between September and December 2018 and 313 offers were made as part of these.
  - Work continues on the automatic student offer and student nurse strategies.
- The impact of the six point recruitment and retention strategy is being assessed and the outcome of this review will be presented to the Executive POD Committee..There continues to be a London and national shortage of nursing staff. This will continue to be monitored to ensure the Trust staffing position does not worsen.

- The target risk score date has changed from September 2018 to March 2020 to take account of the local and national work being undertaken to address the shortage.

- ***Risk 2475*** *- Risk of failure to actively identify educational issues*

Initial Risk Score	Current Risk score	Target Risk Score
12 (C4 x L3)	8 (C4 x L2)	6 (C3 x L2)

- A new governance process and structure have been implemented, the success of which will be determined by the results of the next GMC National Training Survey which will report in September 2019.
- The target risk score date has been extended to October 2019 after assurance of the improvement achieved with the new structure will be gathered.

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

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

- Following the latest review of mental health breaches some areas of local improvement have been identified.
- A Safety Stream has subsequently been established for the care of mental health patients in the Emergency Department.
- The Trust has also been involved in the drafting of a joint statement to NHS Improvement regarding Mental Health bed availability.
- The target risk score date has been postponed from December 2018 to March 2019 to allow the above actions to progress.

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

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

- The Trust received its Provider Information Return (PIR) in November 2018, which kicks off a 6 month timetable of CQC inspection activity.
- The target date for this risk has therefore been changed from April 2019 to August 2019 to reflect the timeframes for this year's inspections and receipt of inspection reports, which will provide assurance as to whether the risk has successfully been mitigated.

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

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

- Sodexo have now recruited additional staff and there is indication of improving standards.
- However, further assurance that improvement is sustained is needed before the risk score is reduced.
- The target risk score date has subsequently been extended from December 2018 to March 2019.

- ***Risk 2482*** *- Risk of cyber security threats to Trust data and infrastructure*.

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

- There are now two permanent staff members in the ICT Security Team.
- Knowledge transfer of the Trust's security controls and systems are in-progress.
- The target risk score date has been extended from December 2018 to June 2019 to allow for implementation of all systems and controls that are expected to support reduction of the likelihood of this risk materialising.

3. Outcome of the internal audit of risk management

- An internal audit of risk management was carried out by PwC between June and July 2018.
- The audit scope was to assess the design and operating effectiveness of risk management controls in place at a divisional level, and the consistency of processes across divisions.
- Overall, the report was classified as 'Low risk' and included three 'minor' findings
- 'Low risk' is the best classification the Trust can be awarded for an internal audit, according to the internal auditors ratings matrix
- The audit was presented to the Executive Committee in September 2018, where a number of actions were agreed.
- The audit and action plan were subsequently presented to the Audit, Risk and Governance Committee in October 2018.
- The majority of the action plan has now been delivered and an update on progress will be presented to the Audit, Risk and Governance Committee in March 2019.

4. Next steps

- A deep dive of all corporate risks will be undertaken by the end of February 2019 to ensure the corporate risk register accurately reflects the Trust's risk profile.
- This work has already started within the Information and Communication Technology (ICT) division and it is likely that a number of ICT risks will be de-

escalated from the corporate risk register to the ICT divisional risk register at the Executive Finance Committee in February 2019.

- As part of this work, a review of the Trust Risk Appetite framework will also take place.
- The layout of the Corporate Risk Register summary will also be reviewed based on best practice and the dashboard will reflect movement of corporate risks scores over the previous year.
- The outputs of the above work will be presented together with the corporate risk register to the Executive Finance Committee in February 2019 and to the Audit, Risk and Governance Committee and Trust Board in March 2019.

Imperial College Healthcare NHS Trust

PART 2: Board Assurance Framework

1. Background

1.1 Assurance goes to the heart of the work of any NHS Trust board. The Trust risk management policy and procedures provide the Board and the Committee with a robust framework by which they ensure that risk is successfully controlled and mitigated. Assurance is then the bedrock of evidence that gives confidence to the Board that risk is being effectively managed, or conversely, highlights that certain controls are ineffective or there are gaps that need to be addressed. The purpose of the Board assurance framework is therefore to enable the Board and its committees to ensure that it receives assurance that all key risks are being effectively managed and to commission additional assurance where it identifies a gap in assurance. This process enables the Board to, inter alia, have confidence in its self-assessment of compliance with regulatory standards and in the year-end reporting.

1.2 The framework seeks to demonstrate the way in which the Trust seeks assurance from its reporting arrangements rather than an approach taking assurance from the direct control of individual risks.

1.3 The framework was last reported to the Board in July 2018 and to the Audit, Risk and Governance Committee in December 2018. This version reflects amendments made since that date. Following approval by the Trust board in March 2018 of the risk appetite statements, risk appetite ratings are included on the board assurance framework, allowing the Board to consider the current level of residual risk in the context of the agreed level of risk appetite.

1.4 For example, the current level of residual risk for 'recruitment and retention' is high, yet the risk appetite is low. The Committee should therefore consider the effectiveness of controls in place to mitigate this risk and the assurance being provided.

2. Changes to the Board Assurance Framework – additional assurances received

2.1 During the period since the last presentation of the framework, the Trust has received additional 2nd line and 3rd line assurances, summarised below:

- Data quality – the Audit, Risk and Governance (ARG) Committee and Board have received the MBI data assurance report reviewing the quality of the Trust's data with regard to RTT reporting. Progress against the action plan was presented to the Committee at its meeting in December.
- Data quality – the Audit, Risk and Governance (ARG) Committee considered at its meeting the findings and recommendations from internal audit reviews of PIC and Radiology, both providing limited assurance. The Committee noted the management actions being taken in response. Internal audit reports have also been published for Estates and Facilities Contracting (part 1), and Data Security and Protection Toolkit, to be considered at the next ARG meeting.

- Financial planning – the Trust's financial recovery plan has been endorsed by NHS Improvement, as reported to the last Trust Board meeting.
- Operational performance – the Trust continues to meet with NHS Improvement regularly, including the monthly Performance Oversight Meeting, to review operational performance. Progress in achieving the Trust's undertakings has been recognised by NHS Improvement and the undertakings amended, as approved by the Board in November.
- General Medical Council National Training Survey (GMC NTS) – the results of the 2018 General Medical Council National Training Survey (GMC NTS) were published on 9 July 2018 and reported to Trust Board in September. The results for Imperial College Healthcare NHS Trust (ICHNT) showed a deterioration in the results with a 56% increase in red flags and 33% less green flags. The Board noted actions being taken in response,

2.2 During the next period additional 2nd and 3rd line assurances are expected from the CQC inspection regime, including the Use of Resources assessment in February and the trust-wide well-led assessment.

2.3 As part of the Provider Information Return (PIR) submitted by the Trust to the CQC in November, the Trust submitted details of external assessments completed during the last year. To ensure Trust compliance with external regulatory requirements and lessons learned from these assessments, the Trust is completing a 'look back' exercise at the findings of these assessments and completion of associated improvement action plans. Going forward, as part of the development of the Board Assurance Framework, this record of assessments will be maintained and reported on a quarterly basis.

3. Developing the BAF

3.1 The process for the updating of the Board Assurance Framework is being reviewed, with a view to making the Board Assurance Framework more 'live'. Including a summary of actual assurances received during a given period, will ensure that all elements of internal and external assurance, positive or negative, are captured to show whether the processes in place are effective, and therefore provide greater assurance regarding the effectiveness of risk management controls.

3.2 The executive team have agreed a process for developing corporate objectives for 2019/20 and they will form the basis of the assurance framework – the objectives will be risk assessed and the risks added to the assurance framework, and then progress in achieving those objectives and the level of assurance received in terms of managing the risks to achieving the objectives can then be considered on a quarterly basis. The BAF will be closely linked to the Corporate Risk Register and where assurances are provided they will be mirrored across both.

3.3 The revised assurance framework will therefore be developed for implementation from April 2019.

Imperial College Healthcare NHS Trust

3. Next Steps

- The Corporate Risk Register will be presented to the Executive Finance Committee on 19 February 2019.
- The Corporate Risk Register and Board Assurance Framework will go to the Audit, Risk and Governance Committee in March 2019.
- The Corporate Risk Register and Board Assurance Framework will be presented to the Trust Board in July 2019.

4. Recommendations

- Note the changes to the Corporate Risk Register
- Note and agree the current ratings within the Board Assurance Framework.

Authors: Valentina Cappo, Corporate Risk/ Project Manager
Priya Rathod, Deputy Director of Quality Governance
Peter Jenkinson, Director of Corporate Governance & Trust Secretary

Date: 23 January 2019.

Appendices: Appendix 1 - Corporate Risk Register
Appendix 2 - Board Assurance Framework

APPENDIX 1

Corporate Risk Register
Trust Board Committee
January 2019

Scoring Matrix

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

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

Key:

Initial Score: The score of the risk when first identified

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

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

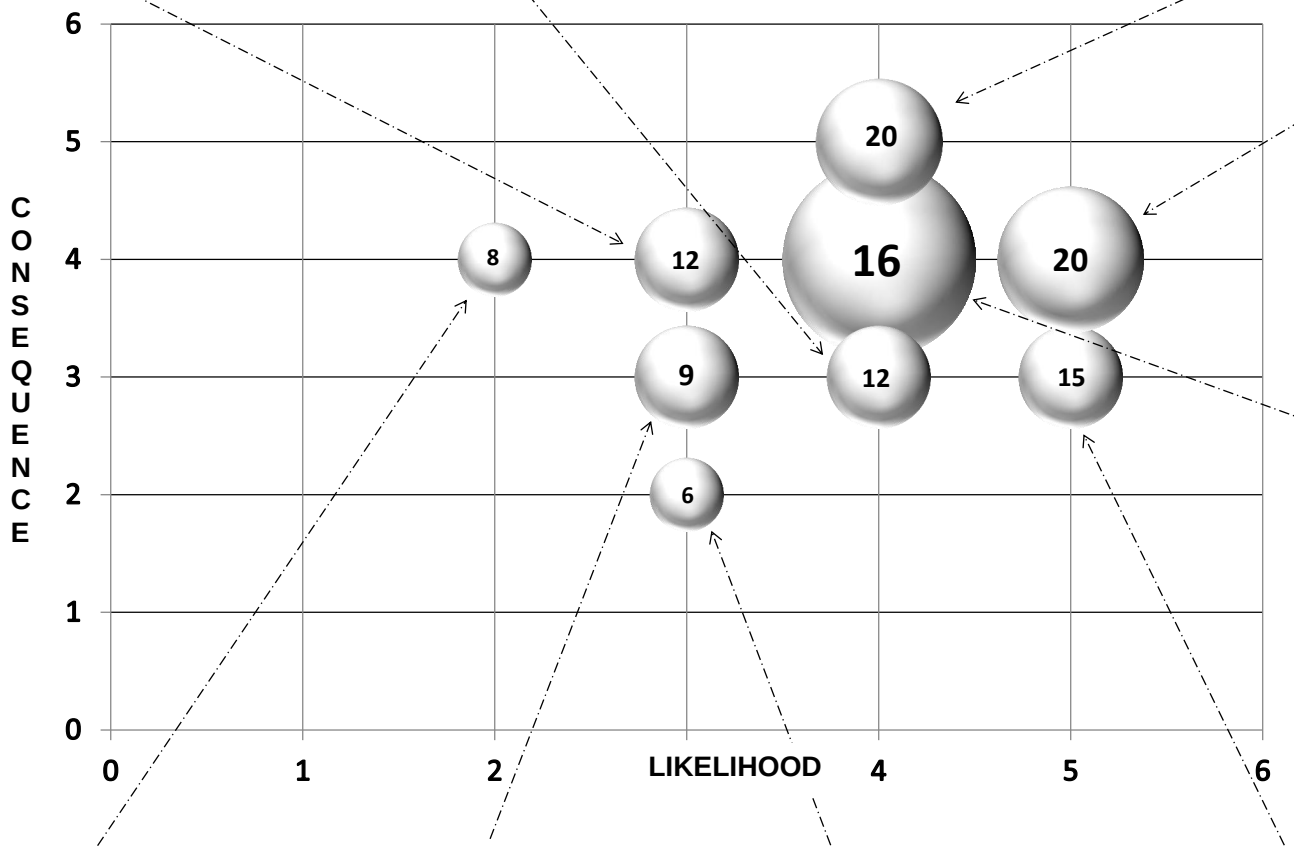
Corporate Risk Profile

Risks scored 12:

1. 2697 Impact of Paddington Square development on Trust services at St. Mary's Hospital (3x4)
2. *One risk that is commercial in confidence* (3x4)
3. 2538 Risk of medication safety being adversely affected by poor adherence to medication safety policies (4x3)

Risks scored 20:

1. 2485 Failure of estates critical equipment and facilities (5x4)
2. 2473 Failure to maintain financial sustainability (5x4)
3. 2677 Risk of failure of Network Core devices as they reach End of Life
4. 2510 Failure to maintain key operational performance standards (4x5)
5. 1660 Risk of delayed treatment to patients and loss of Trust reputation due to poor data quality (4x5)
6. 2681 Loss of system availability due to Windows 7 end of life
7. 2680 Increased risk of PC failure due to delay in PC Replacement Programme



Risks scored 16:

1. 2482 Risk of Cyber Security threats (4x4)
2. 2476 Failure to currently meet some of the High Dependency core standards (4x4)
3. 2498 Failure to gain funding approval for the redevelopment programme (4x4)
4. 2499 Failure to meet required or recommended Band 2-6 vacancy rate for N & M staff (4x4)
5. 2472 Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards (4x4)
6. 2487 Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae) (4x4)
7. 2613 Compliance with General Data Protection Regulation (GDPR) (4x4)
8. 2490 Failure to deliver safe care (4x4)

Risk scored 8:

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

Risks scored 9:

1. 2481 Failure to implement, manage and maintain an effective health and safety management system (3x3)
2. *One risk that is commercial in confidence* (3x3)

Risk scored 6:

1. 2540 Risk of negative impact on patient and staff safety due to failure to achieve and/ or maintain full compliance to core skills training amongst substantive staff (2x3)

Risk scored 15:

1. 2477 Risk to patient experience and quality of care in the ED caused by the significant delays experienced by patients presenting with mental health issues (3x5)
2. 2480 Patient safety risk due to inconsistent provision of cleaning services across the Trust (3x5)

Corporate Risk Register Dash Board

Page n.	Risk ID	CQC Domain	Risk Description	Lead Director	Date risk identified	≤6	8	9	10	12	15	16	20	25	Target Date	Risk Appetite
Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion																
Page 4	2510	Responsive	Failure to maintain key operational performance standards	Divisional Director of MIC Divisional Director of SCC Divisional Director of WCCS	Jun-07					●	¡		♦		Mar-19	Low
Page 5	2538	Safe	Risk of medication safety being adversely affected by poor adherence to medication safety policies	Divisional Director of MIC Divisional Director of SCC Divisional Director of WCCS	Nov-17	●				♦		¡			Feb-19	Low
Page 6	2477	Responsive	Risk to patient experience and quality of care in the Emergency Departments caused by the significant delays experienced by patients presenting with mental health issues	Divisional Director of MIC	Jun-16			●			¡ ♦				Mar-19	Low
Page 7	2476	Safe Effective	Failure to currently meet some of the core standards and service specifications for High Dependency areas within the Trust	Divisional Director of SCCs	Jun-16	●						¡ ♦			Mar-19	Low
Page 8	2472	Well Led	Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC	Director of Nursing	Dec-14		●					¡ ♦			Aug-19	Medium
Page 9	2480	Safe Responsive	There is a risk to patient safety and reputation caused by the inconsistent provision of cleaning services across the Trust	Director of Nursing	Sep-17	●					¡ ♦				Mar-19	Low
Page 10	2485	Safe	Failure of estates critical equipment and facilities that prejudices trust operations and increases clinical and safety risks	Director of Nursing	Mar-11						●		¡ ♦		Mar-20	Medium
Page 11	2487	Safe	Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae)	Medical Director	Jul-15			●		¡		♦			Mar-19	Low
Page 12	2490	Safe Effective	Failure to deliver safe care	Medical Director	Oct-14		●			¡ →		♦			Mar-19	Low
Page 13	2499	Safe	Failure to meet required or recommended Band 2-6 vacancy rate for Nursing & Midwifery staff	Director of People & OD	Nov-16		●			¡		♦			Mar-19	Medium
Page 14	2697	Caring	Impact of Paddington Square development on Trust services at St. Mary's Hospital	Chief Executive Officer	Jun-18			●		¡ ♦					Mar-19	Low
Trust Objective 2. To educate and engage skilled and diverse people committed to continual learning and improvement																
Page 15	2475	Effective	Risk of failure to actively identify educational issues and develop actions in response before they result in negative feedback/poor results	Medical Director	Aug-17	●	♦			¡					Oct-19	Medium
Page 16	2481	Safe	Failure to implement, manage and maintain an effective health and safety management system	Director of People & OD	Oct-13	●		♦		¡					Mar-19	Low
Page 17	2540	Safe Well Led	Risk of negative impact on patient and staff safety due to failure to achieve and/ or maintain full compliance to core skills training amongst substantive staff	Director of People & OD	Dec-17	♦ ● ←				¡					Mar-19	Low
Trust Objective 4. To pioneer integrated models of care with our partners to improve the health of the communities we serve																
Page 18	2498	Well Led	Failure to gain funding approval from key stakeholders for the redevelopment programme resulting in continuing to deliver services from sub-optimal estates and clinical configuration	Chief Executive	Oct-14		●			¡		♦			Dec-20	Medium
Trust Objective 5. To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance																
Page 19	2473	Well Led	Failure to maintain financial sustainability	Chief Financial Officer	Mar-12						●		¡ ♦		Mar-21	Medium
Page 20	2482	Caring Well Led	Risk of cyber security threats to Trust data and infrastructure	Chief Information Officer	Jul-15		●					¡ ♦			Jun-19	Low
Page 21	1660	Well Led	Risk of delayed treatment to patients and loss of Trust reputation due to poor data quality	Chief Information Officer	Jul-11					●			¡ ♦		Mar-19	Medium
Page 22	2613	Well Led	Compliance with General Data Protection Regulation (GDPR)	Chief Information Officer	Feb-18		●					♦	¡		Mar-21	Low
Page 23	2681	Well Led	Loss of system availability due to Windows 7 end of life	Chief Information Officer	Jun-18				●				¡ ♦		Nov-19	Low
Page 24	2680	Well Led	Increased risk of PC failure due to delay in PC Replacement Programme	Chief Information Officer	Jun-18	●							¡ ♦		Dec-20	Medium
Page 25	2677	Well Led	Risk of failure of Network Core devices as they reach End of Life	Chief Information Officer	Jun-18				●				¡ ♦		Nov-19	Medium

Key: → Arrow indicates movement since last report ● Circle indicates target risk score ♦ Diamond indicates current score ¡ Indicates initial risk score * Star indicates new risk since last report

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

Current Risk Controls

• Escalation to mental health providers | • Implementation of full capacity protocol
• Extended operational hours for ambulatory emergency care services at St Mary's and Charing Cross
• Escalation of ongoing issues with Vocare service to commissioners.
• Monthly Waiting List Improvement programme (WLIP) Steering Groups including Intensive Support Team (IST) NHSE and NWL CCG commissioners.
• Weekly WLIP management meetings and RTT meetings with General Managers to help ensure progress against actions and trajectories.
• Fortnightly CEO RTT meetings
• WLIP's development of 'Control of Current and Legacy Issues Framework' with regular tracking through the programme governance
• WLIP Programme Governance and oversight from Executive.
• RTT recovery planning and assurance process | • Development of Elective Care Operating Framework
• 3 year MOU and funding agreement with Macmillan into cancer services
• Twice a year (May and November) internal peer review with all cancer MDTs
• Increased investment in cancer MDT Coordinators
• Investment into Somerset System (Cancer tracking tool
• Imaging Reporting - Additional radiologist sessions to report on images and reduce turnaround time
• Monitoring forums | • Senior input into site operations | • Information peer review | • Clear escalation plans
• Participation in weekly sector operations executive
• Development and implementation of site/clinical strategy
• Imaging Modalities - Additional ad hoc sessions based on voluntary overtime
• Prioritising of urgent inpatient and cancer 2WW patients.
• Fortnightly Task and Finish Group to support improved recruitment
• Outsourcing of MRIs to Alliance and the Steiner unit
• Weekly RTT Planning meetings held cross site for improved work flow co-ordination, service escalations, potential breach alerts and validation, resolution of in week challenges and sign off for 6 week and beyond capacity planning and review
• RTT IT utilisation project on-going to link service needs and IT capability of informing patient progression on pathways. Coupling efforts from Business Intelligence and Imaging data management processes
• Increased work of pathway reviews being undertaken through modality meetings led by Heads of Service.
• Endoscopy – Additional capacity in place to reduce backlog
• IT team have escalation process in place with Cerner through weekly meetings for managing system issues
• The development of RTT recovery and sustainability workstream within WLIP to address demand and capacity issues
• The development of Clinical Harm review workstream within WLIP
• Outsourcing of elective pathways to Independent sector to manage demand.
• Deployment of validation tool (Qubit phase1)
• Clinical Harm Standard Operating Procedure.
• Funding allocated to the Trust for 50 additional downstream beds in order to assist with winter pressures.

Mitigation Plan

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

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

Action:
Deliver the Waiting List Improvement Programme *Due Date:* 18/01/19
Update on action:
1) Daily / weekly GM portfolio review
2) Fortnightly CEO RTT meetings
3) Monthly MD office review clinical harm review / monthly divisional Q&S review
4) Monthly CCG/NHSI/E review meetings – service level trajectories / overview of legacy issues / ECOF and other work streams
5) Monthly POM meetings
6) CCG /NHSE submission
7) External RTT submissions
8) Key escalations to the Data Quality Steering Group for digital enhancement and action
   a. The increase in system errors on RTT PTL – working group established
   b. Cerner RTT clocks not starting on referral registration on outpatient encounters – Working Group established
   c. Progress on rationalising regular day attenders and diagnostics only pathways on the inpatient waiting list
   d. Follow up waiting list to be developed
   e. Next steps to make Outpatients waiting list operational to be completed
9) Workforce consultation in progress to centralise the Validation Team
10) Training and education plan pilot complete – deep dives at speciality level ongoing for targeted training
11) Working towards a performance management framework
   a. Metrics delivered for IPWL, RTT PTL and OPWL
   b. Diagnostics metrics in progress
   c. Phase 2 – metrics to be used in weekly PTL meetings
12) Greater focus on patients waiting over 40 weeks to deliver trajectories by end of August
13) The next phase of the programme will focus on people, systems and processes.
14) Details of all referrals booked from the ASI work list should be sent to Cerner back office for data correction.

Contingency Plans

• Agreed remedial action plan with commissioners for RTT and choose and book
• Agreed trajectories for achieving RTT standard and reducing 52 week waits with external and internal stakeholders
• ED recovery plan
• Diagnostic trajectory plan being reviewed

Key Summary Updates & Challenges

The NHS Improvement trajectory for A&E 4 Hour performance was met for Quarter 2 but narrowly missed in Quarter 3 2018/19.

A total of 27 and 35 breaches were declared with regard to Diagnostic target in October and November 2018 respectively, both of which remained below the Trust tolerance of 1%. Previously, There were 28 and 27 breaches declared in August & September 2018 respectively (0.4% against a Trust tolerance of 1% for both months). The weekly RTT meetings continue to monitor demand.

As at 28/11/2018 the number of unreported examinations demonstrated a decrease to 2878, which is below our local target of 3000. Of these, 1001 were >2 weeks which also shows a decrease when compared to the previous month (n=1126), when number had increased due to the priorisation of ED and IP work with the implementation of the evening duty rota.

A total of 156 and 127 patients were outsourced in October and November 2018 respectively

ID: 2538 **Title: Risk of medication safety being negatively affected due to poor adherence to medication safety policies** **Page 5**

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

Current Risk Controls	Mitigation Plan
• Policy for Security, Safe Storage and Transport of Medicines includes a section on the safe storage of medicines • Annual bedside locker audit undertaken • Induction training • Medicines management mandatory training module • Pharmacy assistant checks stock cupboard for medicines expiry dates on a monthly basis • Application of a green expiry sticker if expiry is due in less than 6 months • Six-monthly control drug audits • Six-monthly safety and security audits • Monthly audit of fridge temperature monitoring.	**Action:** Delivery of the Medicine Management Improvement Plan *Due Date:* 28/02/19 **Update on action:** Significant progress has now been made against the plan, with the lunch of the medicines matters phase 1 materials and synbiotix audit programme. Phase 2 of the medicines matters programme is scheduled for completion at end of February 2019 which will complete this action.

Contingency Plans	Key Summary Updates & Challenges
• Areas found to be significantly out of temperature range - consider relocation of Medicines,Increase stock rotation to reduce impact to individual medicine lines through prolonged exposure • Security issues; prioritise with estates for action • Increase	CD POD register now in pilot phase on a number of wards across the Trust - Compliance with medicines management statman training now >90% - Revised synbiotix audit tool being utilised and completion rates now increased to approximately 90%: Completion of audits for week of 19th November 2018 • Controlled Drugs 88% completed (↑ from 78% in Oct) • Fridge Audit 90% completed (↑ from 74% in Oct) • Medicines Storage 90% completed (↑ from 72% in Oct) - Medicines matter phase II materials now in draft for consultation, including returns and disposal guidance, key fob, ambient temperature monitoring and action guidance. - Ambient temperature monitoring is still done by snapshot 6/12 whilst a continuous / daily monitoring system is developed and temperature monitoring equipment sourced. Risk score target date set to end February 2019 to allow for analysis of synbiotix audit data to inform assurance level.

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

Current Risk Controls

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

Mitigation Plan

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

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

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

Contingency Plans

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

Key Summary Updates & Challenges

Trust involved in the drafting of a joint statement to NHS Improvement regarding the situation for Mental Health bed availability. Slight reduction in overall numbers of breaches recorded.
CAMHS have established a 12 bed unit at Chelsea and Westminster Hospital.

Latest set of 15 mental health breaches investigations completed in November 2018 and identified some areas of local improvement that can be made. Safety Stream established for care of mental health patients in the emergency department.

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

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to currently meet some of the core standards and service specifications for High Dependency areas within the Trust **Cause:** • Poor Environment • Poor equipment • Insufficient level of staff trained to meet some of the standards set out by the CQC • Lack of Staffing on the St Mary's Hospital Medical HDU • Lack of Level 2 beds at Hammersmith Hospital • Current level of medical cover does not meet standard for critical care • Absent of Critical Care outreach team on the Hammersmith site • Lack of medical cover on the medical high dependency unit at SMH and CXH, which does not meet the standard for Critical Care **Effect:** • Delivery of care provided to patients • Patients being nursed in inappropriate areas (C8 ward) due to lack of level 2 beds • Inability to meet critical care standards on medical HDU with consequent impacts on patient safety. • Inability to open additional capacity on demand and potentially impacts on staff activity and morale and patient safety. • Possible unannounced CQC inspection	**16**	**16**	**6**	⇔	**Divisional Director SCCS**	Weekly reports to the project board on progress against the standards

Current Risk Controls

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

Mitigation Plan

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

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

Action:
Critical Care to take over management of HDUs Trustwide *Due Date:* 29/03/19
Update on action:
Co-location has occurred at CXH and SMH. HH colocation and the extension of the HDU outreach services are currently being planned. The action due date should be reviewed in March when a final plan of this work will be available.

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

Action:
Through the work of the Improving Care programme group, an update on review of compliance against the GPICS by ICUs *Due Date:* 29/03/19
Update on action:
To start

Action:
Plan in discussion for Hammersmith Hospital *Due date:* 28/02/19
Update:
In progress.

Contingency Plans

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

Key Summary Updates & Challenges

Colocation successfully achieved at CXH and SMH sites with an outreach service implemented at HH. Plan under review regarding colocation of HDU are cardiac ITU areas at HH.
Need for Critical Care delivery group and KPI's to monitor effect of co-location raised.
Continue to work towards an integrated model and utilisation of current services provided by the Site team and outreach.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC	16	16	8	⇔	Director of Nursing	CQC inspections outcome and reports CQC Insight report and benchmarking data contained within it Performance on key quality indicators outlined in the Trust's quality report/Trust scorecard Outcomes from internal reviews and audits Outcomes from external reviews, e.g. inspections by other regulators, accreditation bodies, professional bodies and peer reviews Patient feedback. e.g. FFT result, local and national surveys Staff engagement survey results (local and national)

Cause:
• Lack of organisational understanding and experience of the 2017/18 CQC regulatory approach which includes the 'well led' inspection and the annual provider information return.
• Lack of robust systems and processes which enable the trust to achieve regulatory compliance and to drive improvement
• Failure of staff to adhere to trust and local area policies, procedures, guidelines, etc.
• Failure of staff to:
  o Seek and take account of regulatory advice
  o Participate in the trust's Improvement and Assurance Framework, and ensure action is taken in response to recommendations resulting from framework activities
  o Participate in the trust's Improvement and Assurance Framework
• Lack of resource to support work and improvements relating to identified non-compliances and failures to deliver improvements

Effect:
• Reduction in the quality and safety of patient care:
  o Greater number of incidents relating to patient safety, and of potentially greater severity
  o Increase in poor patient experiences and complaints
• Breach of regulatory requirements and failure to achieve regulatory standards

Current Risk Controls

• The trust has a dedicated Regulation Manager with a significant background in healthcare regulation, including experience with CQC inspections and the CQC's current regulatory approach
• A framework for managing CQC compliance has been in place at the trust since April 2015. The framework is aligned with the CQC's inspection methodology for NHS acute trusts and is adapted when the CQC make changes to their regulatory approach.
• Activities carried out under the framework include:
  o Quarterly checks to ensure the trust's CQC registration is kept up to date with services delivered by the Trust
  o Regular meetings with the Trust's CQC relationship manager
  o Managing preparation and submission to the CQC of the Trust's annual Provider Information Return (PIR)
• The PIR includes a self-assessment of core services and the Trust overall, against the CQC's domains
• Self-assessed ratings were debated and agreed by the Executive (Quality) Committee and Quality Committee
  o A Ward accreditation programme for inpatient areas and main outpatient services
  o Central management of CQC inspections and support to areas to respond to inspection findings
• Delivery of the framework and outcomes of framework activities are reported via divisional governance processes as well as to an Improving Care Programme Group, the Executive (Quality) Committee and Quality Committee, and the Trust board
• Other trusts that have improved their CQC ratings have been engaged to share learning

Mitigation Plan

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

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

Action:
To address core service inspection findings, a Trust wide work stream for statutory and mandatory training has been established with support from the QI team and a monthly update on progress is to be provided to the Executive Quality Committee *Due Date:* 29/03/19
Update on action:
Action complete. A Core Skills Governance Group was established and work stream delivered. Regular updates have been presented to the Executive Quality Committee. Compliance to core skills training has been increasing consistently and sustained and now remains above 90%.

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

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

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

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

Contingency Plans

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

Key Summary Updates & Challenges

In response to the Trust's December 2018 provider oversight meeting (POM) with NHS Improvement, where concerns were raised about the Trust's performance against the CQC's standards, changes are being made to the Improving Care Programme Group. The group will now meet weekly instead of fortnightly, and a new programme of 'rapid' core service review is being undertaken of all Trust services between 14 January and 22 February 2019 (external partners are being sought to support these reviews).
These changes are in addition to the on-going support that key areas are being provided to prepare for a possible CQC inspection between now and April 2019, and to the development of the Trust's Improving Care Assurance Framework as outlined in the previous update.

ID: 2480 **Title: There is a risk to patient safety and reputation caused by the inconsistent provision of cleaning services across the Trust** **Page 9**

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

Current Risk Controls

• Contract with Sodexo to provide cleaning services in line with National Specification for Cleanliness in the NHS
• Trust Cleaning Policy detailing responsibilities, methods and materials with reference to detailed procedures for specific tasks.
• Comprehensive training schedule and modules provided by domestic services contractor Sodexo.
• Scheduled regime of cleaning and auditing of standards conducted and reported on a weekly basis. Timetables are in place for cleaning within departments. Regular cleaning audits are performed with oversight from area clinical manager.
• Advising on specific / specialist cleaning requirements. Educating staff about the importance of following the correct processes for decontamination and cleaning.
• Escalation of issues by users to Cleaning provider and Facilities team.
• Monthly contract review meetings between Facilities and Sodexo to monitor, review and agree any necessary actions related to quality and performance against contract.
• Monthly report provided by Sodexo detailing results of cleaning audits including if audits are conducted in partnership with clinical staff.
• Cleaning outcomes will be regularly monitored and reviewed to ensure the appropriate cleaning services are provided to each clinical activity.
• Bi-monthly quality meetings between service providers and cross section of multi-disciplinary Trust staff
• Additional senior cleaning resource from Sodexo in place since September 2017.
• New Contract Manager commenced on site 5th February 2018
• Invoking contractual clauses to remedy failures

Mitigation Plan

Action:
Raise Cleaning Standards to agreed standard *Due Date:* 12/01/18
Update on action:
Improvement has been evidenced but this need to be sustained

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

Contingency Plans

• Invoke the terms and clauses of the Hotel Service Contract to impose escalations, rectifications and as appropriate breach of contract leading to possible termination of contract as follows:
• Without prejudice to any other right or remedy it might have

Key Summary Updates & Challenges

Sodexo have recruited additional staff and there is indication of improving standards, but further assurance is required to ensure this is sustained. Improved audit data for Charing Cross and Hammermith Hospital. Performance at St Mary's Hospital remains inconsistent.

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

Current Risk Controls

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

Mitigation Plan

Action:
Implementation of the 2017/18 Backlog Maintenance Programme *Due Date:* 30/03/18
Update on action:
Good progress at Month 9

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

Action:
Establish Estate Improvement Plan (EIP), to make recommendation options to get better reactive maintenance times. EIP to include:
- Process review
- Workforce Review
- Bi-monthly backlog review and prioritisation.

Due date: 28/02/19
Update on action:
First meeting held on the 18 February 2019. Priority list out to divisions week commencing 21 February 2019.
Process mapping review underway.

Contingency Plans

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

Key Summary Updates & Challenges

Outcome of bid awaited, discussions between Trust Finance and NHSI on going. A visit by HM Treasury was hosted to explain and view the Trust estate condition.

ID: 2487 **Title: Risk of spread of CPE (Carbapenemase-Producing Enterobacteriaceae)** **Page 11**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
The number of patients presenting to the Trust who are infected or colonised with CPE is likely to increase in line with global and national trends. The risk is uncontrolled spread of CPE within the Trust.	12	16	9	⇔	Medical Director	• High level of compliance with CPE admission screening(>90%) • High level of compliance with CPE admission screening (>90%) • No increase in CPE BSIs • Reduction in the use of carbapeneme antibiotics where there is no indication

Cause:
• CPE will spread if it is not controlled through infection prevention and control interventions, chiefly screening and isolation, hand hygiene, environmental hygiene, and optimised use of antibiotics.
• Easy transmission from patient to patient will occur if correct IPC procedures are not followed.
• With increased cases of CPE presenting to the Trust there is a risk for potential transmission and in particular in the renal, vascular and haematology cohorts with frequent admissions and outpatient appointments.
• Current isolation capacity (sideroom capacity) insufficient to implement the PHE toolkit recommendations.
• Recent changes in the spectrum of CPE producing organisms resulting in increasing identification of CPE in Citrobacter and Enterobacter species resulting in increased pressure on isolation facilities and infection teams to trace potential transmission
• Location of services across the Trust for diagnostics and treatments, resulting in a frequent need for cross-site transfer. • Estates not ideal for IPC practice, compounded by backlog maintenance issues.

Effect:
• Failure to contain the spread of CPE will result in endemicity of CPE within our patient population, which will lead to more limited antibiotic choices for treatment and ultimately worse patient outcomes.
• Increased demand for isolation facilities, potentially exceeding available capacity more frequently, and risking the spread of other organisms between patients.
• This will result in direct and indirect financial losses to the Trust (including bed and ward closures with resulting lower throughput, and increased costs of litigation), and reputational damage.
• Increased movement of patients and possible transmission during these movements for diagnostics and treatments.
• Increased risk of further transmission due to estates issues, particularly in toilets and bathrooms.

Current Risk Controls

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

Mitigation Plan

Action:
6 monthly antibiotic point prevalence audit to monitor correct antibiotic use *Due Date:* 28/09/18
Update on action:
The Q2 antibiotic point prevalence survey has been completed. 40% of inpatients were scheduled to receive an antibiotic. Three of four antibiotic prescribing indicators were above target (>/=90%) with the remaining indicator (relating to documented review within 72 hours of prescribing) at 89%. Results have been shared in IPC quarterly reports and each Divisional Director has been sent Divisional results for dissemination and discussion at relevant Divisional forums. IPC will continue to work closely with each Division to develop and maintain improvement across all four indicators. The overall consumption of antibiotics continues to decline.
The next audit is due in Q1 2019/20.

Action:
Revised Trust CPE action plan to be developed and implemented due to the recent increase in risk score *Due Date:* 28/02/19
Update on action:
The action plan is implemented in the main, with a small number of actions still in progress. An update is reviewed bi-monthly at the Quality and Safety Sub-Group. Action due date amended to end of February 2019 to allow for outstanding actions to be delivered.

Action:
Development of an in-house HPV decontamination service *Due Date:* 31/01/19
Update on action:
The tender process for the HPV UV decontamination service is in progress.

Action:
Implementation of a CPE screening tool through Cerner *Due Date:* 31/01/19
Update on action:
A technical issue has been identified with the tool. IPC are working with Business Intelligence system developer to make necessary changes. Update on progress will be provided in the Q3 2018/19 report.

Action:
Develop a daily 'sitrep' report on current known CPE patients and their locatio *Due Date:* 31/01/19
Update on action:
Actions pertaining to setting up a patient pathway raw data feed are close to resolution.
Work with Microbiology dept in setting up a formalised CPE result reporting code is in progress.

Action:
Review the cost and feasibility of performing a one-off point prevalence survey (PPS) of all inpatients and associated environmental surfaces for CPE carriage *Due Date:* 31/01/19
Update on action:
The cost and feasibility of the proposed PPS will be developed.

Action:
Ensure processes for cleaning sink and shower drains are in place and being implemented on all sites *Due Date:* 31/01/19
Update on action:
Due to ongoing outbreaks of CPE in haematology at HH and in vascular at SMH, the need for a consistent and regular programme for cleaning sink and showers has been flagged to Trust Estates to reduce the transmission of pathogens. Work closely with Trust Estates colleagues and their contractors to ensure the process is being followed

Action:
Review the value of rapid screen for CPE using PCR to support outbreak management *Due Date:*31/01/19
Update on action:
In progress

Contingency Plans

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

Key Summary Updates & Challenges

The current risk score remains unchanged. The CPE screening tool and inpatient status list cannot currently be implemented because of IT challenges; these are being worked through. There continues to be a number of patients who screen positive for a CPE organism in various locations within the organisation The target risk score date has been extended to January 2019 to complete the outstanding actions. CPE outbreaks are in progress in haematology at HH and in vascular at SMH.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to deliver safe care in respect of: • Investigation processes • Incident reporting and Serious Incidents • Occurrences of Never Events • VTE assessment	12	16	8	⇔	Medical Director	Incidents | Incident reporting rates | Duty of Candour | Integrated quality and performance scorecard Succesful delivery of quality account priorities related to safe

Cause:
• Appropriate governance process not in place
• Visibility of current compliance not available or known
• Non-compliance with Trust policies and procedures
• Non-compliance with surgical WHO checklist

Effect:
• Unable to demonstrate that practice is evidence based
• Increase in SIs and Never Events
• Risk of increased level of harm
• Reduced patient confidence
• Delays to investigations

Current Risk Controls

• Medical Director is executive lead for safety
• Associate Medical Director for Safety in post
• A centralised safety structure was implemented in September 2016 in the Office of the Medical Director to ensure streamlined management and governance
• Compliance and improvement monitoring governance process through the Executive Quality Committee (ExQu) in place
• Training programme for root cause analysis
• Weekly incident review meeting with Medical Director
• Quality Account published in June 2018 (aligned with the 2015/2018 Quality Strategy)
• 2019-2023 Quality Strategy currently under development (due to be published Q1 2019/20)
• QI methodology in place
• Trust Quality & Safety Sub-group established in June 2016, reporting to Executive Quality Committee
• Action plans for areas of key risk in place and monitored through sub-group.
• Safety culture programme in place - key programmes of work include SI improvement, incident reporting improvement and the nine priority 'safety streams'.
• Trustwide action plan in response to never events

Mitigation Plan

Action: Develop and deliver trustwide action plan in response to recent invasive procedure never events *Due Date:*31/03/19
Update on action:
Action plan developed and signed off at Executive Quality Committee on 8/01/19. Additional actions included in response to the two most recent never events. Final action plan reported to Trust Board 30/01/19. A senior programme manager within the office of the medical director has been mobilised to take on overall programme management from 25/01/19. The action plan is being delivered through the divisions reporting to the invasive procedure task and finish group, with monthly reporting to the quality and safety sub-group and the executive quality committee. A weekly update on implementation of the action plan is now being brought to executive committee until it is progressing given the complexity.

Action: Undertake engagement with clinical workforce in response to never events *Due Date:1/31/2019*
Update on action:
• All staff email sent from the Medical Director and Chief Nurse on 11/01/19.
• The Medical Director has visited theatres at SMH, CXH and HH. Similar visits to WEH and maternity theatres are taking place on 25/01/19 and 30/01/19.
• Extraordinary meeting with clinical directors arranged for 24/01/19
Letter will be sent to all consultants and non-consultant doctors from the medical director, and to appropriate lead nurses from the chief nurse.

Action: External review of actions and response to never events *Due Date:*28/02/19
Update on action:
The national director of patient safety (Dr Aidan Fowler) has agreed to undertake a site visit with a team from his office to review the actions we are taking and to give advice on what else we should consider. The Medical Director has written to Dr Fowler to firm up arrangements.

Action: Deliver simulation training and coaching programme to all invasive procedure staff *Due Date:*31/03/19
Update on action:
A simulation and coaching programme for interventional procedures areas has been developed and was planned for roll out in 2019/20. Expedited roll out using a risk based approach has now been agreed. A detailed implementation plan is being worked through by the divisions. This plan, with dates for delivery will be presented to executive quality committee on 05/02/19.

Action: Review all Trust policies and guidelines relating to invasive procedures to ensure they are line with national guidance and are audited*Due Date:*31/03/19
Update on action:
• Count policy currently being reviewed, Invasive procedures policy out for consultation. Audits for areas of risk (e.g. count and anaesthetic block) will be audited as part of the Trust priority audit plan 2019/20.
• Review of NHSI guidance and national examples being completed to inform development of the documents to ensure LocSSIPs are in place for all appropriate procedures.

Action: Review and evaluation of all actions taken previously in response to never events *Due Date:*31/03/19
Update on action:
• Evaluation of 'don't interrupt the anaesthetist when the patient is in the anaesthetic room' underway.
• Testing of radiopaque markers in radiology underway. Plan to roll out trustwide following evaluation.
• Review of actions being undertaken by PSTRC.

Action: Ensure 100% compliance for all doctors with the invasive procedure electronic training module *Due Date:* 31/03/19
Update on actions:
- Divisions receiving regular reports of compliance.
- Letter from MD/ND confirmed that staff would be stopped from operating if they have not completed their training by 25/01/19.

Action: Review patient safety structure in the Medical Director's office *Due Date:* 05/02/19
Update on action:
It has been agreed that the chief of staff will take on overall responsibility for the co-ordination of all safety related work as the Trust lead for patient safety, reporting to the Medical Director. The clinical leadership model needed to support this structure is now being reviewed and an update will be provided to the executives once this has been completed.

Action: SI process review *Due Date:* 31/03/19
Update on action:
A programme of training and development for SI investigations and quality assurance of reports commenced in December 2017 and is on going. Further training dates commissioned for early 2019, at which point over 200 members of staff will have completed the training. This training will ensure more consistent processes for investigations and the development of SMART actions to mitigate recurrence. A paper detailing 'next steps' for managing the allocation of SI investigators to newly declared SIs was agreed at the Q&S Subgroup in December 2018. A further review of the SI process is underway. This includes an audit against the milestones in the policy and qualitative interviews with those involved and who have completed training to inform next steps on how we move to a more independent investigation process. For completion by mid-February 2019, with a report to sub-group in March.

Action: 100% compliance with duty of candour requirements for all serious incidents *Due Date:* 31/03/19
Update on action:
The Duty of Candour annual audit has been completed and the overall assessment showed limited assurance, although there was reasonable assurance for the legislative requirements and areas of very good practice identified in the content of the letters. The DoC policy has been amended and published to reflect the findings and subsequent actions of the audit. 12 month rolling compliance rate for Nov 2017 - Oct 2018 is 87.4% (SIs), 95.2% (Level 1) and 95.8% (moderate).

Action: Achieve 95% compliance for Duty of Candour online training for consultants *Due Date:* 31/03/19
Update on action:
Divisions are responsible for ensuring compliance and it was agreed with them that 100% compliance should have been achieved by March 2018 as part of the annual appraisal cycle. Data is being circulated to divisions on a monthly basis so that they can track progress and meet the target as agreed, however, Divisions continue to be below the 95% target. Small improvements continue to be made; as of 12th December consultant compliance is 82% (MIC), 82% (SCC) and 88% (WCCS).

Action: Assess at least 95% of all patients for risk of venous thromboembolism *Due Date:* 31/03/19
Update on action:
We have achieved compliance rates above our target of 95% for the assessment of patients for the risk of VTE since April 2018. Compliance data in November 2018 was 95.28%. Performance at divisional level is well above target in WCCS and SCCS however MIC are not meeting the target. Areas where the target is not being met have been identified and local action plans are in place to improve performance. Compliance, and the impact of these actions, is being monitored through the directorate quality and safety committee. Updates will continue to be provided in the IPQR

Contingency Plans

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

Key Summary Updates & Challenges

• The risk score was increased from 12 (C4 x L3) to 16 (C4 x L4) in November 2018 due to an increased number of never events and the likelihood of this risk materialising.
• The Medical Director has since reviewed and updated this risk in light of further never events.
• As part of this review, the risk description and title has been amended from 'Failure to deliver safe and effective care' to 'Failure to deliver safe care' so it appropriately reflects the actual risk.
• Aspects related to effective care and infection prevention and control have been removed from the risk as there is greater assurance around these areas. Any risks related to these are on the divisional risk register for the medical director's office and are managed through the Trust's risk management process.
• The Divisions of Surgery and Women's and Children's have also included a risk regarding never events on the divisional risk registers.
• An update on never events and the action being undertaken is presented as a separate item at the Board.
• The target risk score date has been extended from October 2018 to March 2019 to allow for the actions to be undertaken.

ID: 2499 **Title: Failure to meet required or recommended Band 2-6 vacancy rate** **Page 13**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to meet required or recommended vacancy rate for Band 2-6 Nursing & Midwifery staff	12	16	8	⇔	Director of P&OD	Workforce Establishment & Vacancy Indicators (QlikView) People KPI (QlikView) Benchmarking ICHT performance against neighbouring organisations, with a target to 13% vacancies across all nursing and midwifery

Cause:
- National shortage of N&M in some disciplines
- Conflicting operational priorities slowing down recruitment process.
- Competition from neighbouring Trusts attracting potential employees
- High turnover especially for Band 2 & 6 & N&M staff
- High turnover of Band 5& 6 N&M staff within two years of joining
- Tier 2 visa requirements
- The increase in emergency activity has resulted in additional capacity which requires the recruitment of staff.
- Additional beds opened
- Planning for additional posts is reactive compared to planning for additional beds

Effect:
- Reduced staff morale /increased turnover /Increased rates of sick absence – vicious circle
- Increased bank and agency usage
- Poor patient experience
- Poor organisational performance
- Inability to recruit high quality candidates
- Potentially increased incidents

Current Risk Controls

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

Mitigation Plan

Action:
Enhance the reward & benefits scheme to support recruitment and retention strategies. To include further developing flexible recruitment & retention premium (RRP), exploring flexible benefits as part of RRP and benchmarking Trust offer with competitors *Due Date:* 31/01/19
Update on action:
Action complete.

Action:
Develop a 1-3 year workforce plan for the N&M population. *Due date:* 30/09/18
Update on action:
Action complete.

Action:
Implement a range of tool and interventions internally to encourage current Band 5/6 to stay longer. This will be supported by the implementation of a Steering Group for Nurse leadership Band 5/6 development and new exit interviews *Due Date:* 30/11/17
Update on action:
Action complete. Relevant tools implemented include the Springboard leadership programme for Band 5/6 nurses, an extended version of the Pulse magazine, an engagement toolkit and workshop, etc.

Action:
Review current development and support for nurses during and after Preceptorship, through a review of the Preceptorship scheme and Capital Nurse Rotation Programme *Due Date:* 30/11/17
Update on action:
Action complete.

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

Contingency Plans

- Continue to monitor impact of changes and implement further corrective measures as needed
- Use of Bank & Agency staff
- Reduction in activity
- Escalation of staffing issues through divisional management structure and site team
- Early identification

Key Summary Updates & Challenges

The overall vacancy rate at the end of November for all staff was 12.7% and 15.3% for Nursing & Midwifery. The overall project is progressing well. An overview of the key highlights since the last are listed below:

- Managing trends & hotspots: the workstream objective is to develop accurate establishment, staffing & turnover information to support its management and maintenance. Monthly and quarterly workforce reports are created to provide a comprehensive picture of establishment, staffing and turnover. The last quarterly report was presented at the October Steering Group meeting. The leavers process has been reviewed to improve the take up and completion of the leavers survey and exit interview. Leavers reports are produced on a quarterly basis
- Delivering competitive rewards & benefits: the workstream objective is to further enhance existing reward and benefits schemes that can be adapted to support recruitment and retention strategies. A market sensitive supplement policy (including recruitment and retention premiums) has been developed and is now available on the intranet. For example recruitment and retention premiums have been applied to attract candidates to posts that have previously been vacant for a long time (hard to fill areas). Outside of nursing and midwifery, the recruitment and retention premium has improved the vacancy rate for sonographers across Imaging (27% in March 2018 compared to 62% in April 2016). A Refer a friend scheme was launched on 10 October covering hard to fill roles in a number of specialities across all divisions. This was advertised widely via social media and posters. A number of refer a friend requests have already been submitted and are being processed. A review of the current accommodation policy will be conducted to support the retention of N&M staff by 31 March 2019. Benchmarking work will also be conducted to compare the Trust's travel support offering to that of other trusts by 31 March 2019
- Enhancing the offer for staff at different career stages: the workstream objective is to map out the needs of staff at different stages of their careers (including new starters, staff who are mid career and those winding-down). A data gathering exercise has been conducted to identify the needs of staff at different career stages (a total of 100 staff were consulted via focus groups, interviews and surveys). Proposals for a new staff offer will be developed by the end January 2019. Work will be conducted to explore how PDR conversations can be improved to ensure staff have the opportunity to discuss ways of working with their managers and explore flexible working options. The scheduled completion date for this work is February 2019
- Providing career opportunities: the workstream objective is to create and promote opportunities for staff to ensure they are aware of what is available and to ensure staff receive careers support through the careers clinic or other channels. An interim careers clinic for N&M staff was run from September 2018 - December 2018. These were advertised on the Source and InBrief. To date 27 N&M staff received careers coaching. The careers clinic will be reviewed in January 2019 and will be adapted further. The internal transfer scheme will be reviewed and revised from January 2019 onwards. An internal careers portal will be developed for all staff groups by April 2019
- Maximising recruitment: the workstream objective is to further develop the Trust's brand & employment offer and maximise recruitment to help the Trust recruit at pace and scale. Work continues on the automatic student offer and student nurse strategies (to be delivered for end January 2019). A task and finish group has been set up to review student engagement. A tea party was also held to engage newly qualified students in September. An International Recruitment Manager has been appointed. 313 offers were made as part of the September and December overseas recruitment events. 3 international nurses joined the Trust in November 2018. Further trips are due to take place in February and March. Work to enhance the brand, career site & marketing materials continues. A new recruitment system will be available by end of March 2019, this will enhance the candidate and line manager experience and transform the recruitment process
- Delivering strategic supply of nurses: the workstream objective is to develop a 3-5 year workforce plan to make the supply of N&M staff more sustainable. The first recruitment round for nursing associate apprenticeships took place in July produced 19 offers to internal staff of which 7 met the functional skills requirements. The second recruitment round in September produced 3 offers from 12 applicants. The programme at London Southbank started on 29 October with 7 nursing associate apprentices from Imperial. A further cohort started on 10 December, where a further 6 people has joined the programme. There is a planned intake of graduate nurse apprentices for May 2019

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of disruption to clinics and administrative work due to high levels of noise, dust and vibration expected from the Paddington Square demolition programme. The Paddington Square development has a demolition programme of a minimum of 7 months - phase 1. The substructure demolition will follow this. Construction programme unknown (total demolition and construction period likely to be 4 years). Trust buildings likely to be affected by the development include the three Outpatients buildings owned by the Charity, Mint Wing, Mary Stanford, and part of the Clarence Wing.	12	12	9	⇔	Chief Executive Officer	• Protocol note produced which sets out how SPG will ensure that the Trust will be provided with advance notification and kept informed of the scaffolding, demolition works and subsequent construction programme for the Paddington Square development on an on-going basis to assess the implications for and assist the Trust with managing its day to day operations and to keep its own stakeholders informed. • Communications strategy being developed for Trust staff, and patients/visitors. • Weekly meetings with developer, SPG.

Cause:
Extended demolition and construction programme working next to live hospital buildings may cause noise, vibration and dust

Effect:
• Unsuitable environment for clinicians to effectively deliver clinical services
• Unsuitable environment for administrative and managerial practices
• Poor patient experience
• Delays to appointment times, or stopping of clinics or relocation of services to another site due to impact of demolition and construction
• Potential loss of income and activity
• Loss of market share
• Lower staff morale

Current Risk Controls

• Public and staff consultation held (add date).
• CEO briefings.
• Weekly internal Project Group.
• Weekly Trust, advisor and developer meeting.
• Discussion at Redevelopment Committee, and Executive Committee.
• Discussions with Westminster City Council.

Contingency Plans

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

Mitigation Plan

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

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

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

Key Summary Updates & Challenges

Paddington Cube, now known as Paddington Square:
• The planning application recommended the establishment of a transport steering group for the area, the Trust is represented in the group. Our objective is to ensure the Trust is able to run St. Mary's Hospital without hindrance. The Paddington Square scheme is progressing, with all demolition works expected to complete by January 2019. Sellar aim to have a stopping up (closure) order relating to London Street ahead of closure 2020. They presented three initial options of how this would work to Trust representatives on 26 October, however, the Trust is yet to receive all necessary information to assure its self of the ability to continue to run the hospital in both demolition and construction stages. Communication continues.
• Mitigation plans: Clinical services will continue to operate from the surrounding buildings. A number of mitigation measures have been agreed between Sellar and the Trust:
- Working outside of Trust operational hours for scaffolding on outpatient buildings and in the bay adjacent to the buildings to be demolished at weekends has been secured.
- Information on the intranet and Trust website provided for patient and staff and communications cascaded across Trust.
- Escalation Protocol agreed between developer and Trust
- Weekly meetings held between developer and Trust. Westminster City Council in attendance as required.
- A Project Steering Group has been set up to discuss the impact of the development on the operation of the hospital. This group currently meets weekly, and has representation from each clinical division, PALS, and appropriate corporate and support functions.
- Thresholds and alerts agreed locally.
- Noise and vibration monitors installed in buildings were services are likely to affected and monitored daily to ensure no breaches.
- Developer will need to stop work if breached
- Regular reports to Executive Committee and Redevelopment Committee
• Demolition of the Former Post Office block adjacent to Winston Churchill completed 27/28 October. Demolition of the Sorting Office blocks directly behind Jefferiss and Outpatients, and adjacent to Mint commenced 30 October. Due for completion February 2019.
• The Trust's equipment management company, CTS, have assessed all areas in the impacted buildings, and anti-vibration mats have been installed as required.
• CBRE have re-instated existing plant, air flow, and air con in the three outpatient buildings to ensure they now function normally.
• Phase one installation of air con units in Winston Churchill and Outpatients and Jefferiss has been completed. Work to install four additional air con units is due to complete by November 2018. Work to install air transfer grilles, as part of a complete solution to maintain ventilation in impacted buildings, to start once grilles have been delivered and access arrangements have been agreed with impacted services.
• An assessment of existing air vent/air con in Mint, Mary Stanford Wing, and Clarence Wing Building (phase two) has been completed. The Trust have been provided with draft mitigation proposals which require finessing
• Redevelopment team continue to monitor impact of site activity on Trust business and log for discussion with developer/contractor as necessary.
• Disruption schedule created and updated weekly. This is shared with appointed clinical leads and site manager.

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

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

Current Risk Controls

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

Mitigation Plan

Action:
Further development of the education reviews process underway with the aim to embed within the specialty and enhance divisional oversight of improvement plan *Due Date:* 31/01/19
Update on action:
New process has been implemented and five specialties identified for review by the Medical Director. Two out of five of these have taken place with actions noted being taken through the divisional committees. The three remaining reviews are taking place in January 2019.

Action:
Develop action plans for areas of concern in NTS and monitor through LFGs, with reporting to Medical Education Committee *Due Date:* 30/09/18
Update on action:
Action complete - action plan submitted to HEE on 28/09/2018 and awaiting feedback

Action:
Ensure clarity of all opportunities for all trainees/medical students to provide feedback throughout the year *Due Date:* 30/11/17
Update on action:
Action closed

Action:
Education report part of performance review of Divisions *Due Date:*31/01/19
Update on action:
SCC divisional committee presentation including new divisional scorecard delivered in October 2018 and future action planned regarding rotations and vacancy mapping. Presentations for MIC and WCCS postponed to Q4 2018/19.

Action:
All specialties to have elected, or have an election in progress, for senior specialty trainees *Due Date:*31/01/19
Update on action:
Process of senior specialty trainee representation is currently subject to review as part of the wider junior doctor engagement work programme on education and service matters. Possible options for trainee representation have been defined with junior doctors and are being outlined in a paper to ExPOD in January for approval. It is anticipated that the new model for junior doctor reps will be in place by April 2019.

Action:
Review of education structure to ensure adequate support for clinical leaders and strengthen accountability. *Due Date:*31/01/19
Update on action:
Action complete. New structure implemented in January 2019.

Contingency Plans

Re-establish annual educational specialty review process for all specialties chaired by the medical director

Key Summary Updates & Challenges

New governance process and structure implemented, the success of which will be determined by the results of the next GMC National Training Survey which will report in September 2019. Target risk score date has therefore been extended to October 2019.

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

Current Risk Controls

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

Mitigation Plan

Action:
Implement all aspects of the slips, trips and falls incident reduction action plan *Due Date:* 29/03/19
Update on action:
Delayed indefinitely due to dispute with Sodexo.

Action:
Complete roll out of AssessNET Safety Audit module *Due Date:* 01/02/19
Update on action:
Roll out and training underway.

Action:
Implement effective Violence incidence reduction plan *Due Date:* 30/03/18
Update on action:
Action complete.

Action:
Devise and implement appropriate sharps incidence reduction plan *Due Date:* 30/04/18
Update on action:
Action complete.

Action:
Recruit to the vacant H&S Manager post *Due Date:* 26/01/18
Update on action:
Action complete.

Contingency Plans

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

Key Summary Updates & Challenges

Roll out of the Safety Audit module continues. This is the key item to progress, as it facilitates proactive (workplace) inspection.
A reviewed of the risk content and score will be undertaken based on relevant KPIs.

ID: 2540 **Title: Risk of not achieving full compliance for Core Skills Training** **Page 17**

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

Current Risk Controls

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

Mitigation Plan

Action:
Complete Business case to upgrade/replace current learning management systems *Due Date:* 31/01/18
Update on action:
Business Case approved and procurement process is now underway.

Action:
Secure funding for a Data cleanse of Medical staff data on ESR to provide better management of junior doctors compliance data *Due Date:* 28/09/18
Update on action:
Action complete.

Action:
Establish Core Skills Governance group to review all denominators and core skills topics with a view to reducing total number of topics and make denominators more targeted that staff that need to complete them *Due Date:* 28/09/18
Update on action:
Action complete.

Action:
Roll our use of iPDF for Junior doctors to minimise need for re-doing training that has been done at previous rotation *Due Date:* 28/09/18
Update on action:
Action complete.

Action:
Divisional directors to confirm local plans for achieving compliance, which will be reflected on the next mandatory training paper to ExCo *Due Date:* 28/09/18
Update on action:
Action complete. Divisional Directors report to ExQual monthly on their local action plans.

Contingency Plans

Where staff are non-compliant they are to complete the necessary training before they can undertake their duties.

Key Summary Updates & Challenges

Trust-wide core skills compliance has achieved and remains above 90%. It is proposed that the risk be de-escalated from the corporate risk register.

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

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

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

Current Risk Controls

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

Mitigation Plan

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

Action:
Review all redevelopment options for the trust *Due Date:* 30/04/19
Update on action:
Trust exploring options. Action due date changed to April 2019.

Action:
Agree scope of works sufficient to protect existing planning approval leading to certificate of lawfulness. *Due Date:* 04/01/20
Update on action:
Project on hold, however, scope of works needs to be agreed with WCC planners and executed on site ahead of expiry of planning permission on 04/01/2021.

Contingency Plans

Contingency to be developed at later stage in project

Key Summary Updates & Challenges

Condition of SMH has deteriorated. A strategic planning vision document was approved by Trust Board in March 2018 and was submitted to NHSI, CCG's and DH for consideration.
Outpatient & Ophthalmology building: on hold
Structural issues in Cambridge Wing and associated works, impact on the decant space required for the phase 1 project. Further review required once permission to proceed has been given.
Planning permission has two years left as of 04/01/2019.
Trust wide options: under consideration

ID: 2473 **Title: Failure to maintain financial sustainability** **Page 19**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to maintain financial sustainability **Cause:** • Loss of DH/NHS England (Diamond) income for complex specialist treatments • CCG affordability pressures and difficulties in delivering QIPP demand reduction targets may put payment for over performance at risk • Historic dependence on non-recurrent funding sources masked underlying financial picture • Capacity limitations constrain activity growth, especially in private patients • Annual reductions in Education and Training funding, significant cut to 2018/19 funding • Correction of historic usage of R&D funding for clinical subsidy • Additional costs of operating across three sites & with outdated estate and aged equipment • Delays to Transformation programme caused by CEO role instability • Agency costs (at premium rates) incurred to cover substantive roles • Investments in Acute medical model • Investment in implementation costs of Cerner including data validation • Continuing dependence upon significant non-recurrent financial gains to deliver Control Total targets & receipt of STF funding masks underlying deficit • Deterioration in Estate limits ability to deliver activity plan **Effect:** • Failure to deliver a financial surplus • Reputational risk of being in deficit • Loss of financial autonomy & reputational damage associated with the risk of being put into Financial Special Measures should we fail to deliver the stretching target • Dependence upon DH revolving working capital facility • Dependence upon external initiatives e.g. SaHF and STP for site redevelopment project costs & Charity for required capital investments	**20**	**20**	**15**	⇔	**Chief Financial Officer**	Trust met its control total in 2017/18 and received a full payout of STF. The plan for 2018/19 is to deliver a control total surplus of £13.6m after £34.2m of STF funding support. Year to date the Trust was on plan at the end of month 6, compared to £3.4m adverse to plan in month 5, before Provider Sustainability Funding (PSF). This gives us access to PSF funding for Q2, which is determined on a quarterly basis. Cash balance never less than £3m – monitored monthly and reported to Exec and Board. Internal forecast outturn (monthly refreshed).

Current Risk Controls

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

Mitigation Plan

Action:
Fortnightly meeting of STP CFOs to facilitate sector-level change and sharing of gains *Due Date:* 29/09/19
Update on action:
CFO team have: proposed business rules to remove the financial barriers to joint working; set-up team focusing on sector-wide analytics to support sector wide decision-making; aligned provider contracts

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

Action:
Trust wide engagement in SAHF & STP programme (including consideration of long term financial modelling, sustainability and site strategy) *Due Date:*31/03/19
Update on action:
Not due.

Action:
Phase 2 SRP merging into the transformation programme is expected to bring greater rigour to the implementation of Model Hospital and GIRFT learnings *Due Date:*29/03/19
Update on action:
Not due.

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

Contingency Plans

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

Key Summary Updates & Challenges

In month 8, the Trust is on plan in month and year to date before Provider Sustainability Funding (PSF). The Trust has maintained a position on plan since September compared to the adverse variances reported in the summer. If the Trust remains on plan in December then we will be able to access quarter 3 PSF.

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

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

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

Current Risk Controls

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

Mitigation Plan

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

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

Action:
Security Software Investment: Multi Layered Security Software currently in the process of being tendered *Due Date:* 30/06/19
Update on action:
The old on-premise email gateway has been fully migrated to the new Trend Micro email gateway. The due date for this action is being extended as not all products and controls have been implemented.

Action:
Process Controls: Continual deployment critical and security patches to Servers and Desktops in accordance with the following ITIL Standard? *Due Date:* 31/03/20
Update on action:
Automated patching of servers is progressing well with 160 servers patched in the last maintenance window. Workstation patching compliance is good.

Contingency Plans

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

Key Summary Updates & Challenges

There are now two permanent staff members in the ICT Security Team. Knowledge transfer of the Trust's security controls and systems are in-progress.
The target risk score date is being extended as not all products and controls have been implemented.

ID: 1660 **Title: Risk of delayed treatment to patients and loss of Trust reputation due to poor data quality** **Page 21**

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

Current Risk Controls

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

Mitigation Plan

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

Action:
Delivery of recommendations in MBI Report on Waiting List Management & Reporting *Due Date:* 31/12/19
Update on action:
Existing programme of work has been mapped to MBI recommendation - being led by SCC Division.

Action:
New digital learning strategy HRIS *Due Date:* 31/10/18
Update on action:
The RTT Training Deep Dives project has delivered Phase 1 of training to the Top 13 specialties on the key data quality indicators in October 2018. Remaining services will receive training by
December 2018. Service specific classroom training is in design as well and is expected to be delivered by December 2018. A Steering Group to lead the overarching Education & Training work stream will commence in December 2018 to provide further governance and clinical input.

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

Action:
Design and implement Elective Care Operating Framework underpinned by staff training and digital optimisation *Due Date:* 31/03/19
Update on action:

Action:
Review of the Trust's validation resources supplemented by a managed service for Referral to Treatment Pathway validation to undertake data clean up of waiting lists *Due Date:* 31/03/19
Update on action:

Action:
ECOF training programme and SOP roll out *Due Date:* 31/03/19
Update on action:
The RTT Training Deep Dives project has delivered Phase 1 of training to the Top 13 specialties on the key data quality indicators in October 2018. Remaining services will receive training by December 2018. Service specific classroom training is in design as well and is expected to be delivered by December 2018. A Steering Group to lead the overarching Education & Training work stream will commence in
December 2018 to provide further governance and clinical input.

Contingency Plans

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

Key Summary Updates & Challenges

MBI Assurance Report update provided to ARG in December 2018.

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

Cause:

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

Effect:

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

Current Risk Controls

• The Trust Data Protection Structure has been evolving to meet the challenges of the current threat environment and the current legislation.
• Trust has submitted satisfactory IG Toolkit Returns since 2012/13 (meeting a minimum of Level 2) in each IG Toolkit Standard
• Information Governance and Cyber Security Committee (IGCS) meets on a monthly basis to review Cyber Security Dashboard, ICT Risk Register, Informatics audit and IG Compliance Issues
• GDPR (TPP) Business case and Investment Plan has been developed to manage implementation of GDPR.
• Prioritisation of requirements in the implementation plan.

Mitigation Plan

Action:
GDPR Films - Part 1 All Staff - Part 2 Managers *Due Date:* 12/07/18
Update on action:
Action complete. Film has been held up in post production due to issues with presentation and content. Further work is indicated to bring the film into order.

Action:
Submission of GDPR (TPP) Business Case and Investment Plan *Due Date:* 29/03/18
Update on action:
Action complete.

Action:
Launch of the Trust Privacy Programme (TPP) to deliver compliance to GDPR *Due Date:* 02/09/18
Update on action:
Action complete. The TPP is launched and ongoing.

Action:
Implementation of ONE TRUST Data Protection Management Console *Due Date:* 31/12/18
Update on action:
Records of Processing Manager appointed and working through the various stages of the project plan to bring the ONETRUST facility onstream.

Contingency Plans

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

Key Summary Updates & Challenges

Posts have been recruited to but there were some delays leading to a start date at the end of October 2018.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
The trust currently has 10,300 desktop computers that currently run on Windows 7. Microsoft support for Windows 7 ends on the 14th of January 2020. As a result of the above, Microsoft will no longer provide security patches for known vulnerabilities to Windows 7 PCs after this date. Running windows 7 after this date probability of a major cyber security incident resulting in loss of access to systems and/or loss of Trust or patient data. Clinical and Corporate application suppliers are no longer designing applications for windows 7 - the Trust will not be able to leverage benefits of new functionality in applications with Windows 7 moving forwards. **Cause:** Microsoft no longer support Windows 7 from 14th January 2020 Windows 7 cannot be protected from above date New applications and updates to existing are not designed for windows The Trust PC estate has 10,300 Windows 7 devices ICT capital allocation is currently not sufficient to fund the upgrade to Windows 10 **Effect:** Increased cyber security risk Increased risk of loss of clinical and corporate system availability Risks to patient care and safety as a result of loss of IT systems Risk of loss of status as "Global Digital Exemplar" Hospital	**20**	**20**	**10**	⇔	**Chief Information Officer**	Confirmation that Windows 10 licences have been secured received (NHS digital) Full asset inventory of PCs in place Basic testing of compatibility with existing applications have shown positive results Issue log for Windows 10 established Windows 10 support training for ICT staff commenced

Current Risk Controls	Mitigation Plan
Windows 10 and VDI business case to migrate all desktops to Windows 10 currently in progress. Trust has secured Windows 10 licences Basic Windows 10 testing has commenced Basic application compatibility testing in progress Limited to rollout to Trust laptops and selected ICT Workstations	**Action:** Submit draft business case to finance *Due Date:* 26/10/18 **Update on action:** Action complete. Business case Windows 10 with VDI approve. Secured funding for 18/19 and review for the 19/20 to mitigate risk. **Action:** Secure funding for 19/20 *Due Date:* 12/04/19 **Update on action:** Submitted as part of ICT capital planning process
Contingency Plans	**Key Summary Updates & Challenges**
Harden anti-virus protection Implement restricted network access Put share drives into "read only" Highly restrict internet access Clinical and corporate application upgrades will be put on hold Seek custom support contracts with each software vendor to s	Limited funding for 2018/19 secured to initiate mitigating action.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
ICHT are currently running a desktop estate of 10,300 devices. Due to a lack of capital investment the programme is now seriously behind schedule and as things stand the trust has over 3567 desktop PCs which are over 5 years old in April 2018. By March 2019 this figure will reach up to 6000 PC devices. This figure includes 800 "computers on wheels" (COW) which are now beyond their recommended production life and now display persistent and frequent problems. **Cause:** Continued lack of funding for PC replacement programme ICT have zero stock of replacement devices **Effect:** Over 6000 will be over 5 years old at end of 18/19 FY These PCs run slowly and are prone to complete failure Multiple complaints and risks raised over slow and unreliable PCs in clinical and corporate areas	20	20	6	⟺	Chief Information Officer	the 5 year business case exists and has been approved by the executive. Paper to approve the spend for PC replacement in 18/19 and subsequent years as per the business case will be tabled at CSG on Septemeber 14th 2018.

Current Risk Controls

Business case is approved in 17/18, but capital funding for ICT is insufficient in 18/19 to continue as planned.
Computer on Wheels (COW) hardware refresh has started - 200 have been remediated.
Escalation to Executive that the proposed capital for ICT will be insufficient to address this risks and other ICT related infrastructure risks and therefore a request for emergency funds has been submitted to NHSI - awaiting response.

Mitigation Plan

Action:
Re-submit Business Case *Due Date:* 28/09/18
Update on action:
Business case re-submitted via DSP, CSG and ExOp. Approval at ExOp on 25/09/2018 - subject to funding. Now awaiting confirmation from executive that ICt capital limit will increase to accommodate.

Action:
Ensure backlog funding is secured for 19/20 capital planning cycle *Due Date:* 12/04/19
Update on action:
Submitted in first round of star chamber. Under funded project with large backlog. Tactical work to replace low numbers of olders PCs and WOWs have commenced using 18/19 capital funds.

Contingency Plans

Spare PC parts
Reliable agency for staff to support more non-electronic working
Windows 10 with VDI business case (pending approval and funding) will deliver additional life from older assets.

Key Summary Updates & Challenges

Action plan to use 18/19 capital funds to replace a limited number of the olders WOWs and PCs has commenced.

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

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

Current Risk Controls

The Network Core is currently under support and will come to end of life in Nov 2019. ICT will need funding in 18/19 to ensure we have enough time to complete the ITT, procurement and get it approved, run through the procurement and tender process, appoint, design/scope, resource, implement, test and handover to BAU.
Business case approved at ExOp in August 2018. Funding levels insufficient to procure and implement mitigations.

Mitigation Plan

Action:
Business Case Approval and secure funding *Due Date:* 28/09/18
Update on action:
Network replacement business case has been approved at DSP, CSG and ExOp.

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

Contingency Plans

The Trust will need to fast-track the procurement, installation, configuration and testing of all 10 network cores costing approximately £1.5M and taking approximately 6 weeks to complete.
During this 6 week period, the Trust will have no IT network, acc

Key Summary Updates & Challenges

Tender for new network and support services has been published and closed. Reviews in progress with robust project plan.

Board Assurance Framework

Revised January 2019 (v3.6 - Trust Board January 2019)

Corporate objectives

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

CQC domain	Areas of activity	Corporate objective	Lead	Area of risk	Corporate risk register reference	Sources of assurance			Principal assurance committee(s)	Timetable of assurance reporting	Board reporting		Risk score		Risk appetite
						1st line Reporting	2nd line Internal assurance	3rd line External assurance			What	When	Inherent assurance risk	Residual assurance risk	Risk appetite
Safe	**Patient safety: Infection control**	1	DIPC	Risk of spread of CPE	2487	Reports on outbreaks reports against key metrics	Quarterly report to quality committee	CQC inspection	Quality Committee	Quarterly	Quality committee report to the board	Bi-monthly	High	Medium	Low
Safe	**Patient safety: Medicine management**	1 5	Medical director / chief pharmacist	Failure to: - adhere to medication safety policy - adopt best practice may lead to sub-optimal treatment - controlled medicines usage may lead to unnecessary costs	Following CQC inspection report, this is being added to CRR	Incidents raised on Datix, and investigated at directorate and division	Six monthly report to the executive committee	MRHA annual submission and review CQC inspection	Quality Committee	Six-monthly report	Update by exception through the quality committee report	Bi-monthly	Medium	Medium	Medium
Safe	**Patient safety: Staff: Fire**	1	Director of estates & facilities	Failure to ensure that required fire prevention and management systems are in place, including effective evacuation systems	2479	Incidents raised on Datix, and investigated at directorate and division	Six monthly report to the executive committee	Review and on-going oversight by London Fire Brigade	Quality Committee	Six-monthly report	Update by exception through the quality committee report	Bi-monthly	High	Low	Low
Safe Effective	**Patient safety: Critical care**	1	Divisions directors, DDC & MIC	Failure to achieve specific standards and specifications in delivering critical care standards	2476	Reporting to executive committee of issues and potential resolution. Any patient risk issues would be covered in	The Quality report (which reviews performance in all areas of quality) is presented to Executive monthly.	CQC inspections	Quality Committtee	Bi-monthly	Update by exception through the quality committee report	Bi-monthly	High	Medium	Low
Safe Effective	**Patient safety: Clinical governance**	1 5	Medical director	Failures of quality governance may allow poorer standards of care and may lead to non-compliance with statutory /contractual obligations	On local RR	Divisional governance leads review directorate and divisional arrangements	The Quality report (which reviews performance in all areas of quality) is presented to Executive monthly. Internal	Commissioner Quality Group have oversight CQC inspections	Quality Committee	Bi-monthly	Update by exception through the quality committee report	Bi-monthly	Medium	Low	Medium
Safe Effective	**Patient care**	1	Medical dir / dir of nursing/ divisional directors	Failure to safe and effective care affects CQC rating / incurs penalties/ impacts support for Trust strategic plans	2472 2490	Incidents raised on Datix Complaints Whistleblowing Service line self-assessments	Board member visits Core service reviews Deep dive reviews Internal audit support to core service reviews	CQC inspections PLACE audits	Quality Committee Ad-hoc risk reports are reported to the ARG Comm)	Bi-monthly	CQC report to Trust board CQC inspections	Bi-monthly	High	Medium	Medium
Safe	**Patient safety: Mental health**	1	Divisional director, MIC	Failure to maintain high quality patient care and experience in ED due to extended delays expereiencd by mental health patients awaiting transfer	1992	Incidents raised on Datix Regularly reported at executive committee	Core service reviews	CQC inspections	Quality Committee	Bi-monthly	CQC report to Trust board CQC inspections	Bi-monthly	High	Medium	Low
Safe Effective Well-led	**Patient safety: Safeguarding**	1	Director of nursing	Failure of systems and processes (including training of staff) may under-identify safeguarding issues and/or may lead to a failure to respond appropriately	On Local RR	Incidents raised on Datix	Six monthly report to the executive committee	Serious case review outcomes Ofsted reports	Quality Committee	Six-monthly report	Update on safeguarding cases and position	Six-monthly	Medium	Low	Medium
Safe Caring Well-led	**Staff: Recruitment and retention**	1 2	Dir P&OD	Inability to recruit and retain appropriately skilled staff poses risk to quality of patient care Inability to deliver a workforce that enables the required changes for the clinical model	2499	Vacancy rates Time to recruit	Executive committee monitoring programme looks at the efficiency and effectiveness of the recruitment process Internal audit	Safe staffing reported to Commissioners and NHSI at Commissioners Quality Group	Quality Committee receives report on safer staffing and by exception on other risks associated with shortage of appropriate staff Also ARG	Bi-monthly	Safer staffing figures published monthly Update by exception through the quality committee report	Bi-monthly	High	High	Low
Safe Caring Well-led	**ICT: Data quality**	1 2 5	CIO, CFO, Divisional directors, Dir P&OD	Technology / human interface: failing to enable staff to input data in a consistently accurate manner Poor quality of patient information may undermine patient care Poor data quality of Trust information may undermine strategic and contractual	1660	Standardised business and reporting rules that are aligned to national policy with standard definitions and robust change control processes	Snap-shot audits via carried out at team and individual level Monthly audit of backing data at patient level and cross checking against clinical systems Programme of internal audit DQ Steering Group reporting to	The external auditors provide a limited audit of information reported as part of their work on annual report and accounts	Audit, risk & governance committee	Quarterly	ARG committee report to the board	Quarterly	High	High	Medium
Safe Responsive Well-led	**Patient safety: Availability of necessary equipment**	1	Dir of estates & facilities Divisional directors	Failure to provide safe equipment impacts patient and staff safety Equipment failure reduces ability to achieve operational targets	2479 2557	Incidents raised on Datix	Capital steering group oversees prioritisation of critical equipment spend Medical devices management group & quarterly report to ExQual Internal audit	Oversight of IRMER Regulations	Quality committee Finance & investment committee	Bi-monthly	Update by exception through the committee reports	Bi-monthly	High	Medium	Medium
Safe Responsive Well-led	**Patient safety: Staff safety: Management of estates**	1 5	Director of estates & facilities	Failure to: - provide safe estate impacts patient and staff safety - provide an appropriate environment (including cleaning impacting patient experience and outcomes - manage property portfolio impacts on financial position	2479 2480	Incidents raised on Datix Trust's outsourced hard FM have clear procedures for responding to priorities issues	Capital programme reports to executive committee External review of backlog maintenance identified £1.3bn of which £130m of high risk; programme in place to continually monitor priorities as issues are addressed	NHSI aware of external review outcome, and Trust's approach to managing the risk	Finance and investment committee	Bi-monthly capital report toF&I Comm	Update by exception through the report of the F&I Comm, the report of the Redevelopment Comm Specific report on Backlog maintenance	Bi-monthly	High	High	Medium

Safe Well-led	**Patient & staff experience: Stakeholder support for site redevelopment**	4 1 5 2 3	Dir of redevelopment	Failure to: - secure redevelopment support and approval from STP , NHSI etc - secure redevelopment funding - secure support for moving services	2498	Project board oversight and reporting	Reporting to executive committee and board redevelopment committee and commercila sub-group	Approval and programme oversight by NHS Improvement / STP / NHS England	Redevelopment Committee	Monthly	Update by exception through the redevelopment committee report	Bi-monthly	High	High	Medium
Safe Responsive Well-led Caring	**Staff: Health & safety**	5	Dir P&OD	Failure to ensure: - appropriate arrangements in place to protect staff - that staff are immunised fully against biological agents to which they may be exposed	2481	Incidents raised on Datix Incidents reported by Occ Health	Bimonthly report to the executive committee	HSE inspections CQC inspections Internal audits	Quality committee	Bi monthly	Update by exception through the quality committee report	Bi-monthly	Medium	Low	Low
Safe Well-led	**Research**	3	Medical director	Failure to: - secure development of NIHR BRC - ensure research embedded in divisions - to develop AHSC to potential	Held on medical director's risk register	Research lead in each division reporting through management reporting structure	Research and AHSC reports to executive committee	National research oversight bodies	Quality committee	Six monthly research report	Overview of AHSC and other research activity	Annual Six monthly	Medium	Low	High
Effective	**Patient pathway: Development of ACP arrangements & other STP arrangements**	4,1	Chief executive	Failure to deliver the clinical strategy programme to enhance acute services and support out of hospital care	2489	Clear governance arrangements across STP, with H&FGPF, and within Trust	Regular reports to Executive Committee	NHSI and commissioners have oversight of the plans, and engaged in development of ACP arrangements	Audit, risk & governance committee	Propose an annual review of governance arrangements	Annual seminar on integrated care developments; regular updates in CE report	Annual Bi-monthly	Medium	Low	Medium
Effective Caring	**Staff: Education and training (including mandatory training)**	2,3	Medical director / Dir POD / Dir of nursing	Failure to: - adequately train staff poses risk to quality of patient care - achieve benchmark levels of medical education performance	2475 2540	On-line register for all staff	Monthly reporting to the executive committee Internal audits of the systems and processes	Various Royal College and and GMC inspections and visits	Quality committee	Annual report of validation; performance report	Annual seminar on educational activities; mandatory elements in performance report; revalidation report	Annual Bi-monthly	Medium	Medium	Low
Effective Well-led	**Finance: Short-term financial performance**	5	Chief financial officer	Failure to deliver financial plan	2473	Divisional reporting Review financial review meetings for each division	The F&I scrutinise the financial position of the Trust The Exec Comm monitor delivery of achievement against savings plans, and performance against NHSI targets	External audit review during annual accounts preparation NHSI oversight, particularly in relation to Undertakings assurances	Finance and investment committee	Bi-monthly	Monthly finance report circulated Full reporting every other month in Finance report F&I Committee reports every other month	Monthly Bimonthly	High	Medium	Medium
Effective Well -led	**Finance: Long term sustainability**	5	Chief executive	Failure to deliver the transformation programme required to achieve long term efficiencies and financial sustainability	2473	Reporting arrangements will be developed on the appointment of a Director of Strategic development	Regular reports to Executive Committee and Trust board	External audit review during annual accounts preparation NHSI oversight, particularly in relation to control total and the STF	Finance and investment committee	Bi-monthly	Transformation programme report to be developed	Bi-monthly	High	High	Medium
Responsive	**Operational performance**	5 1	Divisional directors	Failure to deliver: - against NHSI targets (particular ED performance & emergency flow & RTT & elective performance)	2410	Divisional review / ICT reporting Senior level committees in place addressing ED / emergency flow, RTT/elective activity, and outpatient improvement	Executive committee reviews performance each month, including reports from committees	NHSI and commissioners - monthly reporting	Executive committee	Bi-monthly	Operations performance report reported to Trust board	Monthly	High	High	Medium
Well-led	**Finance: Financial control**	5	Chief financial officer	Failures of financial control risk leads to unanticipated budget overspends	Finance RR	Standing financial instructions; scheme of delegated authorities; discretionary spend controls	SFIs; SoDFA reviewed annually at executive and relevant board committee	External audit opinion CQUIN achievement	Audit, Risk & Governance Committee	Quarterly, and annual	Audit opinions reported as part of the annual accounts	Annual April/May	High	Medium	Medium
Well-led	**Counter fraud**	5	Chief financial officer	Poor systems and processes lead to financial loss	Finance RR	Cases raised Cases pursued	Internal audit	LCFS reports National benchmarking Home Office feedback	Audit, risk & governance committee	Quarterly	ARG committee report to the board	Bimonthly	Medium	Low	Low
Well-led	**ICT: Programmes & systems**	5 1	Chief information officer	Failure to: - optimise use of GDE award - maintain control may lead to overspend on major investments - potential distraction of shared ICO	ICT risk register	Clear governance arrangements within ICT and between Imperial and C&W to ensure planned progress achieved, and manage risk of 'shared ICO'	Dedicated Executive Digital Strategy Comm monitors delivery against key ICT projects, and ensure engagement Business cases and post-	NHS England - Global Digital Excellence oversight	Finance and investment committee / ARG Committee	Bi-monthly	Reports of the F&I Committee to each Trust board	Bi-monthly	Medium	Low	Medium
Well-led	**ICT: Information security and cyber crime**	5	Chief information officer / SIRO	Breaches indicate a detriment to patients or staff. Serious breaches may incur financial penalties Ransomware challenges Failure to comply with GDPR requirements	2482	Process in place for reporting breaches Clear awareness and actions in place to minimise the impact of cyber crime	Annual report on performance in the Annual governance statement Exception reports on serious breaches IG annual return	DH Information Governance return NHSIC have overview of all cyber crime issues External audit oversight of processes	Audit, risk & governance committee	Quarterly	Annual performance in the Annual governance statement Exception reports on serious breaches IG annual return	Annual	High	Medium	Low
Well-led Responsive	**Finance: Commissioning environment**	5	Chief financial officer	Failure to secure contracts impacts on the financial security of the Trust and may adversely affect quality of service	2473	Clear direction and guidance in place within commissioning team	Executive and F&I Comm receive regular updates on contract position Review as part of the Business	Monthly NHSI oversight, and review of contracts agreed with Commissioners	Finance and investment committee	Bi-monthly	Exception reporting through Committee report Considered as part of	Bi-monthly Annual	High	Low	Medium

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Bi-annual update from the Trust's Emergency Planning, Resilience and Response (EPRR) team	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 30th January 2018	**Item 16, report no. 12**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Author:** Merlyn Marsden, Hospital Director

Summary:

The purpose of this report is to provide an update and assurance in relation to the Trust's Emergency Preparedness, Resilience and Response (EPRR) arrangements and plans. The paper contains the following updates for the Trust Board:

1. Current Threat Level
2. EPRR Activity and Incidents
3. EPRR Exercises and Training
4. Updates post NHS England Assurance rating and Action Plan for 2018/19

The Executive Committee was updated on18 December 2018.

Recommendations:

The Trust Board is asked to:

- Note the updates
- Confirm that it provides sufficient assurance for the Trust Board in relation to EPRR
- Confirm the NHS England EPRR Assurance outcome and Action Plan to maintain the rating.

This report has been discussed at:

Executive Finance Committee, 18 December 2018

Quality impact:

In addition to our statutory requirements through the Civil Contingencies Act (2004), the NHS Act 2006 as amended by the Health and Social Care Act 2012, the NHS funded organisations must also meet the EPRR requirements within NHS Standard Contract, the NHS England Core Standards for EPRR and NHS England Business Continuity Management Framework. EPRR also forms part of the Patient Safety and Quality Agenda of Care Quality Commission Regulation.

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:

EPRR risks are raised through the Trust's internal risk process.

Workforce impact (including training and education implications):

Has no workforce impact

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

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

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

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

If yes, why?.....

EPRR Assurance 2018/19

1. Introduction and Context

1.1. The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient safety. These could be anything from extreme weather conditions to an infectious disease outbreak, a major transport accident or a terrorist act.

1.2. The Civil Contingencies Act (2004) requires NHS organisations and providers of NHS funded care to demonstrate that they can effectively respond to incidents and emergencies whilst maintaining appropriate services to patients. This work is referred to in the health service as 'Emergency Preparedness, Resilience and Response' (EPRR).

1.3. The Civil Contingencies Act (2004) places a legal obligation upon emergency services and local authorities (defined as Category 1 responders under the Act), including Imperial College Healthcare NHS Trust, to assess the risk of, plan, and exercise for emergencies, as well as to undertake Business Continuity Management. It also places legal obligations for increased co-operation and information sharing between different emergency services and also to non-emergency services that might have a role in an emergency.

1.4. NHS organisations are also required to adhere to NHS England's EPRR Core Standards (2015) setting out the minimum criteria which NHS organisations and providers of NHS funded care are required to meet.

2. Threat Level

2.1. The current threat level for international terrorism in the UK is SEVERE which means that an attack is highly likely. The terrorist related incidents in recent years locally and around the world continue to drive our work in relation to Major Incident, Trauma, Mass casualties and ensuring staff are aware of their role should a Major Incident occur.

3. EPRR Activity and Incidents in February 2018 – January 2019

3.1. Successful response and activation of the following emergency plans to these incidents;

3.1.1 March 2018

- Large network failure led to Trustwide telecoms and IT issues.
- Internal incident was declared to ensure support from all divisions in incident response.
- Trust and Departmental Business Continuity plans were activated.

3.1.2. July 2018

- Central vacuum pump failure at Charing Cross led to ICHT Business Continuity plan activation

3.1.3. September 2018

- Datacentre core failure at Hammersmith hospital led to intermittent IT issues across the Trust and both Business continuity and IT Downtime plan activation.
- Clarence wing patient lift failure at St Mary's hospital led to Internal incident declaration. Departments activated successfully Business Continuity plans and the patient services

were provided safely at Queen Charlotte's and Chelsea and other neighbouring hospitals for two weeks.

3.1.4. November 2018

- Overnight fire in the Minimal Care Dialysis unit led to the Evacuation and Business Continuity plan activation at Charing Cross Hospital. The debrief process has been completed identifying lessons to be acted upon and to ensure good practise is transferred into appropriate Trust plans. The exemplary response from the Trust Security staff was noted by the attending London Fire Brigade and the Renal teams activated their Business Continuity plans early ensuring patient services continued almost uninterrupted.

3.2. Learning from all of the above incidents following debriefing sessions have been included within EPRR Steering Group agenda to ensure progress is monitored and reported appropriately to the Executive Committee. The following plans have been updated:

- Command and Control Overarching Strategy
- Evacuation Plan
- ICHT Business Continuity Plan

4. EPRR Exercises & Training

- A Fire Evacuation Table Top organised at the Western Eye successfully tested the newly implemented fire alarm system and existing Evacuation plans.
- A Cyber attack Table Top exercise held for the Trust and attended by the Chelsea and Westminster hospital's EPRR team highlighted areas to address to ensure system-wide resilience. The Trust also attended a national Cyber exercise along few other selected NHS Trusts across the country.
- An NHS England Recovery exercise tested both Business Continuity and Recovery plan arrangements confirming robust preparations are in place following an incident.
- The Trust's 6-monthly Internal Communication Exercises were held in May and November and tested successfully that the Trust's key staff are contactable should an incident occur.
- On-going Silver and Gold on-call Training including Strategic Leadership in a Crisis training for our Executive run by NHS England.
- Loggist and Major Incident Training for all staff continues across the organisation.

5. Updates post NHS England Assurance rating and Action Plan for 2018/19

5.1. As part of the NHS England EPRR Assurance arrangements, the Trust's level of compliance is measured against a set of Core standards. These standards enable NHS organisations across the country to share a common purpose, practice and co-ordinate EPRR activities. It also provides a consistent, cohesive framework for self-assessment, peer review and assurance process across the NHS.

5.2. The Core standards for EPRR were revised in 2018 including e.g. addition of Business Continuity as a separate domain expanding focus on this topic. The revised EPRR Core standards are split into ten domains listed below;

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control

5. Training and exercising
6. Response
7. Warning and informing
8. Cooperation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRNe) and Hazardous Material (HAZMAT)

5.3. Each year the EPRR Assurance includes also a separate deep dive section. This year's deep dive topic was command, control and coordination, for which all organisations were assessed against 8 specific standalone standards.

5.4. Annually all NHS organisations are required to participate in the EPRR Assurance process by providing a self-assessment in the Autumn of the current EPRR status within the organisation against EPRR Core standards. In addition to the self-assessment NHS organisations in London are subject to a formal review by a team of experts comprising of the NHS England EPRR, CCG, London Ambulance Service and a peer reviewer from a relevant NHS Trust. All 10 Core standards and associated 69 detailed evidential measures were peer reviewed, assessed by CCG and validated by NHS England, London in November.

5.5. The NHS England agreed with the self-assessment giving the Trust's EPRR Assurance level of compliance as Fully Compliant which is an improvement from previous years.

5.6. Each year the Trust is required to complete an action plan to address any deficiencies in planning. As the Trust is fully compliant the action plan for 2018/19 include as a priority to maintain the achieved fully compliant status. NHS England recommended 8 further actions to be addressed within coming year.

Action identified by NHS England	Trust Action plan 2018/19
NHS England (London) to formulate wording for inclusion in the response plans in respect of request for Military Aid to the Civil Authority (MACA).	*NHS England to complete.*
Meeting to review Action Cards and the text of both the Major Incident and Business Continuity Plans with NHS England in fine detail e.g. typos.	NHS England to provide details of recommendations within scheduled quarterly meetings. *NHS England to complete.*
Review new guidance and incorporate/change Mass Counter-measure Plan where necessary.	Plan elements incorporated into appropriate plans. ***Action completed.***
The Trust to identify areas/departments within the support services that would benefit from specific exercise scenarios especially their roles in recovery.	Exercise with P&OD planned and to be delivered in Winter 18/19.
Continue the work-stream to review new guidance and incorporate into plans.	Continue EPRR business as usual. ***Action completed.***
Cordon control to be reviewed in relation to CBRN decontamination.	Cordons reviewed. ***Action completed.***

The Charing Cross CBRN decontamination site faces several residential properties. The Trust should proactively engage with the residents to provide the necessary assurance that there are no significant risks to them and their properties.	Support from the police and local authority agreement in place in relation to neighbours. Public board meetings and papers available to all the residential neighbours. ***Action completed.***
Trust to speak with powered respirator suit suppliers for the CBRN decontamination to ensure remaining suits are scheduled for delivery.	Supplier contacted. Suits been manufactured. ***Action completed.***

Delivery and completion of the EPRR 2018/19 EPRR Assurance Action Plan will be overseen by the Trust's EPRR Steering Group which is chaired by the Site Director.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Research and Development Quarterly Report (Q2 2018/19)	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 30 January 2019	**Item 17, report no. 13**
Responsible Executive Director: Julian Redhead, Medical Director	**Author:** Paul Craven, Head of Research Operations Mark Thursz, Director of Research

Summary:

This quarterly scheduled report presents a summary of recent progress with respect to various clinical research initiatives within the Imperial Academic Health Science Centre (AHSC). It covers:

A) Recently-approved plan to increase the number of commercial clinical trials at ICHT;
B) Details of recent performance in initiating clinical trials;
C) Developing capacity: a strategic plan for nurses, allied health professionals and clinical research practitioners
D) Translational research highlights and outputs from the Imperial BRC.

Recommendations:

The Board is asked to note the Q2 2018/19 Research and Development report.

This report has been discussed at:

☒ Executive Digital, Strategy and Transformation Committee
☒ Quality Committee

Quality impact:

The benefits of an active clinical research environment for NHS Trusts are well documented. ICHT currently benefits from a number of important NIHR infrastructure awards which form the basis of our joint clinical research strategy with Imperial College London Faculty of Medicine. The quality and scale of biomedical and clinical research carried out across the Imperial Academic Health Sciences Centre (AHSC) will impact patient care in the future in terms of innovative treatments, diagnostics and devices. Research activity includes many specific examples of patient benefit. Patient and public involvement in research is enabled through the Imperial Patient Experience Research Centre (PERC).

Financial impact:

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

1) Has no financial impact

Overall research income to ICHT is valued at ~£48m per annum. Delivery of high quality clinical research (experimental and applied) for the benefit of patients is essential to future revenue streams, to the reputation of the AHSC, and to the continuation of a culture of innovation and continuous improvement.

Risk impact and Board Assurance Framework (BAF) reference:

Imperial College Healthcare NHS Trust

There are no specific risks attached to this report. The general risks associated with research are financial and reputational. Competition for research funds is extremely high and Imperial must continue to demonstrate a high level of high-quality research outputs and activity, as well as value for money.
Workforce impact (including training and education implications): Part of this report summaries our new strategy for the training and professional development of non-medical staff groups, including research nurses, allied health professionals (AHPs) and clinical research practitioners, namely to encourage research-active careers with a view to embedding research throughout ICHT, and engendering a culture of improvement through innovation.
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 quality and scale of biomedical and clinical research carried out across the Imperial Academic Health Sciences Centre (AHSC) will impact patient care in the future in terms of innovative treatments, diagnostics and devices. Research activity includes many specific examples of patient benefit.
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic objectives supported by this paper: ▪ As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care.
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?..... • Senior managers should note in particular those successful examples of translational research, moving from the laboratory into the clinic, and share any appropriate examples with their own teams. • Further info here: https://imperialbrc.nihr.ac.uk/

A) Commercial Trials Growth: Implementation Progress

The Department of Health considers the support and delivery of commercial industry-funded and sponsored research to be a key priority (Plan for Growth, March 2011). Commercially-sponsored clinical trials offer patients access to new treatments and diagnostics well before they become generally available on the NHS. They are also a valuable source of additional revenue and cost savings for NHS organisations. It is important therefore that we consider whether there are sufficient incentives in place at ICHT to promote participation in commercial/industry-sponsored research.

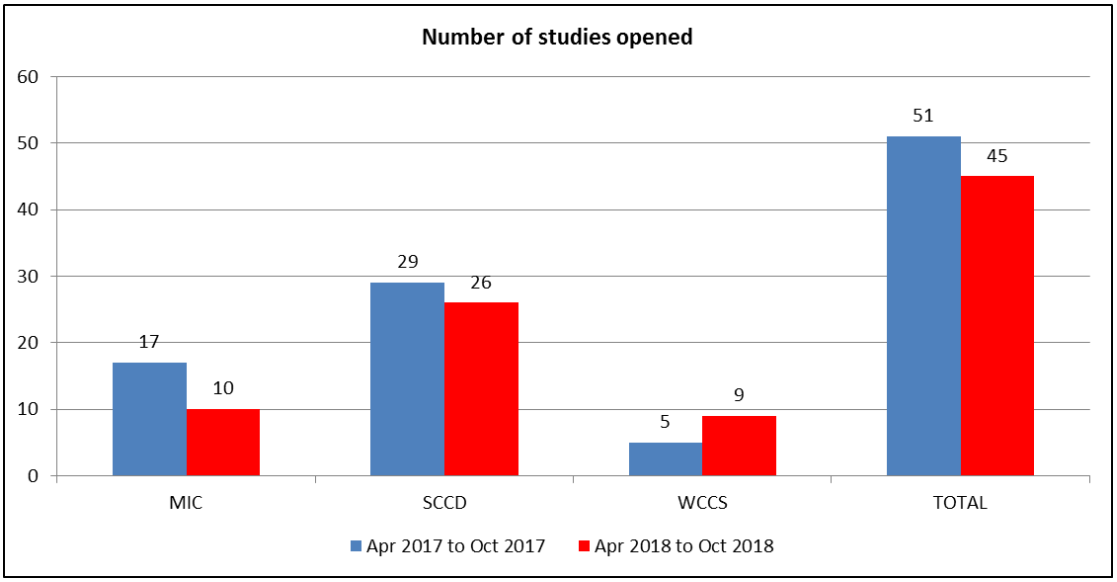
It is also a key principle that this income is available to be used where possible to develop capacity for new research within the Trust and to support future R&D income generation. Whilst it is important that investigators are incentivised to carry out commercial research, this must be balanced with protecting the interests of potential study participants, as well as the requirements of the Trust to recover their costs wherever appropriate.

In terms of commercially-sponsored trials activity ICHT is currently performing below what might be expected of an acute NHS Trust of this size and reputation, and there is a heavy burden in terms of account management and administration.

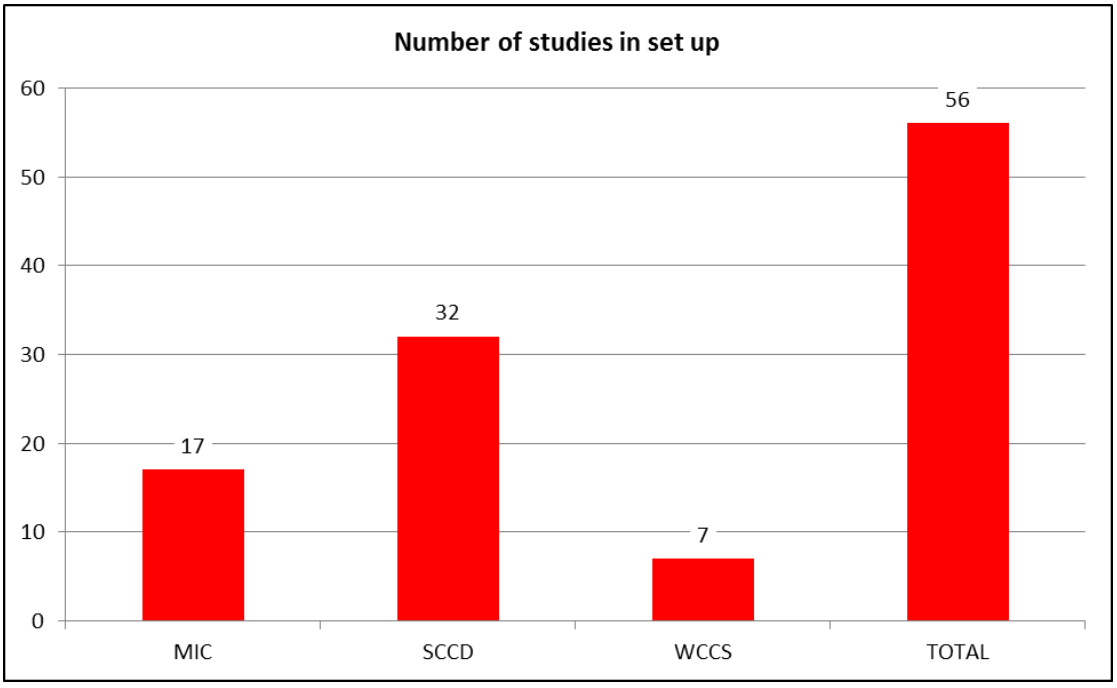
In June this year, the ICHT Executive Committee approved a specific plan to double existing activity (and associated revenue) from commercially-sponsored trials within 4 years. Specifically this involves:

1) An initial investment in new trial coordination and research support posts;
2) Establishment of commercially-sponsored trials activity targets for specialties and Divisions, and an overall growth target of doubling the number of patients recruited into such studies by 2021/22;
3) Immediate implementation of a new simplified accounting structure to manage commercial trials activity, with cost centres managed/governed by Divisions and specialties;
4) A transition period to ‘wind down’ other existing cost centres and deferred balances;
5) Going forward, a new model for distributing reimbursed elements of commercial trials between specialties, Divisions and R&D central;
6) Aims to generate ~£588k contribution by 2021/22, with further savings on standard-of-care drug costs used in trials, access to innovative medicines for patients and investment in R&D to attract further NIHR infrastructure income;

Details of the implementation of this plan are reported on a regular basis to the Medical Director in monthly meetings, and to the ICHT Research Committee. Recent performance indicators (end of October 2018) in relation to commercial clinical trial activity, are provided below, together with brief commentary.

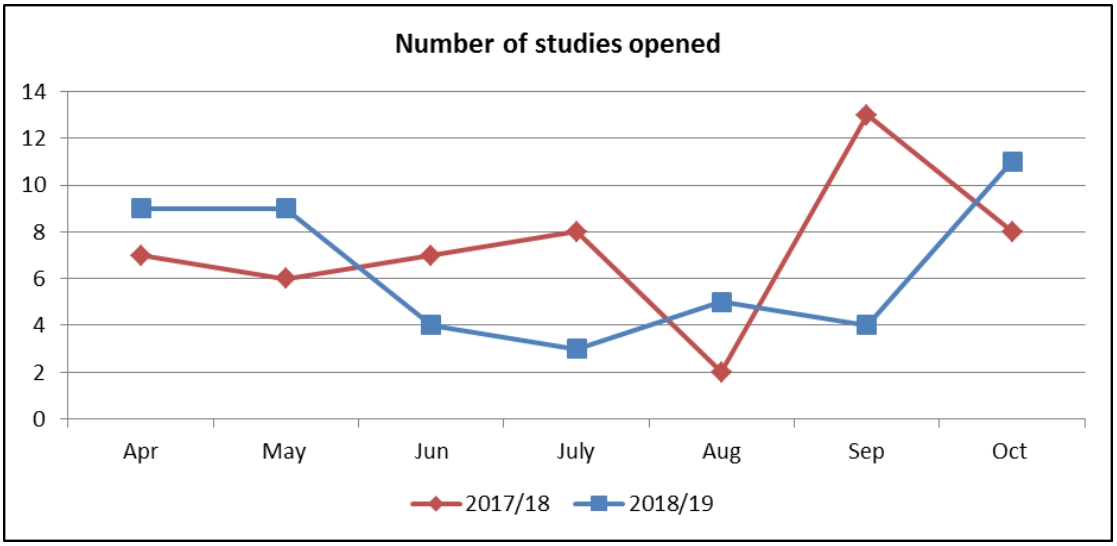


a) No. of new commercial studies opened as of end of Oct 2017 and 2018.

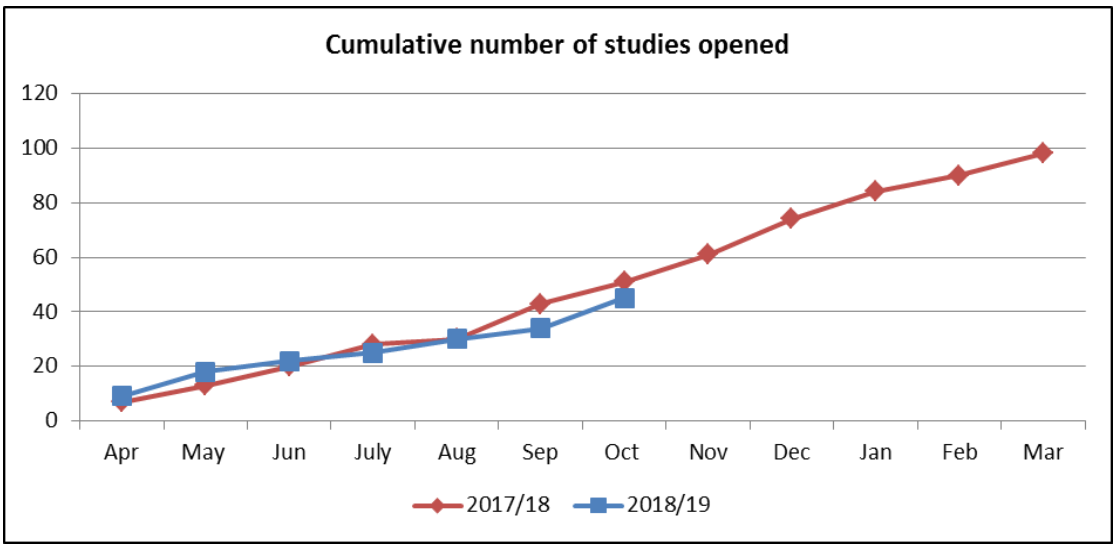


b) No. of new commercial studies in set up as of end of October 2018.

ICHT are slightly behind in terms of the number of commercial studies opened by the end of October 2018 (45), compared to the same point in time last year (51) – see graph a). However, there are 56 studies currently in set-up, all of which should have opened by the end of this FY – see graph b). This would indicate that we will slightly exceed last year's number of commercial studies opened (99).

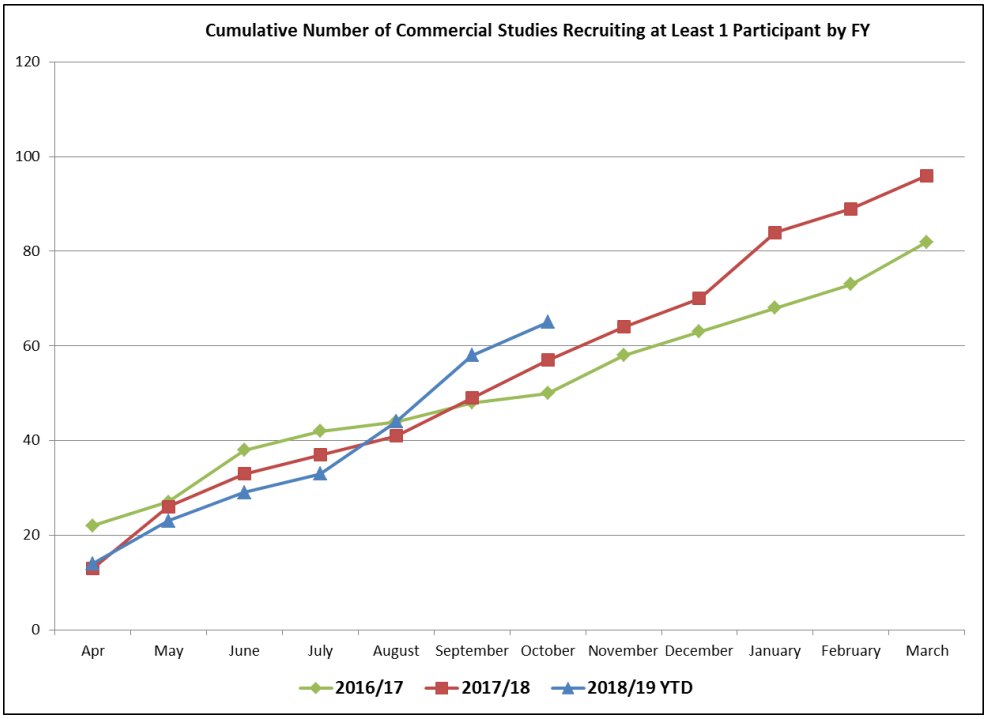


c) No. of new commercial studies opened per month in 17/18 and 18/19.

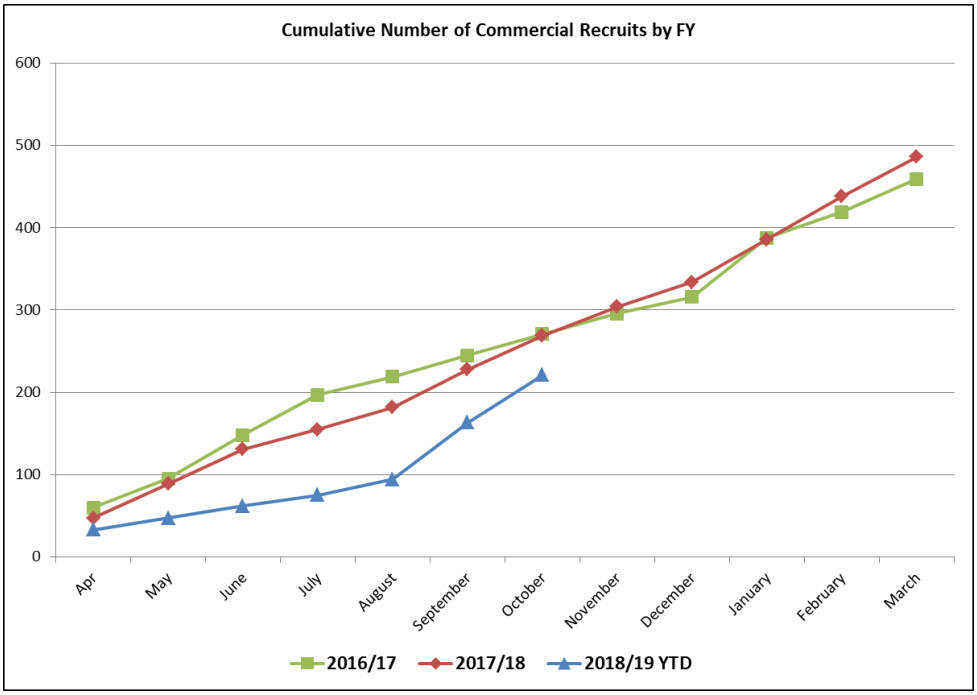


d) Cumulative no. of new commercial studies opened per month in 17/18 and 18/19.

A total of 99 commercial studies opened in 17/18 – see graph d). Currently we are forecasting a minimum of 101 studies opened in 18/19 (45 to date + 56 in set up). It is likely that other new studies will arrive and be opened before end of this FY.



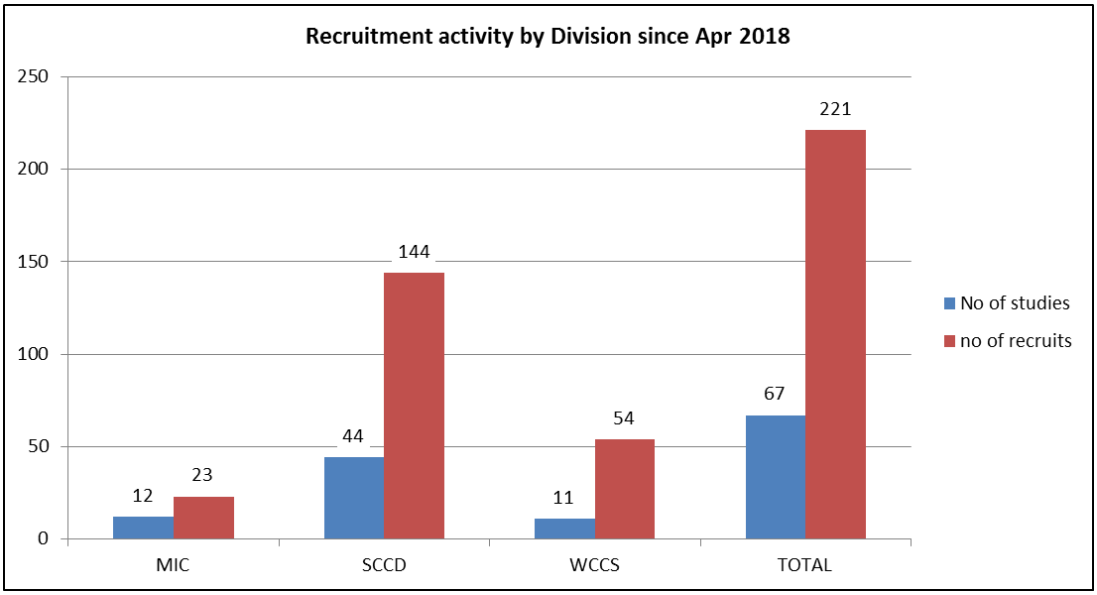
e) Cumulative no. of new commercial studies recruiting >= 1 participant per FY.



f) Cumulative no. of recruitment into commercial trials by FY.

At this point in the FY, we are showing that more commercial trials have recruited at least 1 participant (a key indicator of how quickly these are set up, compared to other sites), than in either 2017/18 or 2016/17 – graph e).

After initially slow recruitment in the first 5 months of the FY (possibly reflecting staff disruption/transition in the JRO in 2017/18), the number of participants taking part in commercial trials has begun to increase more rapidly in Sep and Oct – graph f).



g) Commercial trials activity by Division in 2018 YTD.

SCCV Division is responsible for the bulk of commercial trials activity. M&IC is showing unusually low activity and we are investigating why this may be (possibly due to declining industry market in some specialties). WCCS are showing higher than usual commercial activity and have been actively approaching sponsors.

In recent months we have working towards setting up active framework agreements with large pharma companies, with a view to increasing the number of studies offered to ICHT.

Overall income from commercial trials at this point in the FY is higher than in the two previous years. This was helped by a proactive invoicing 'push' early in the FY. Actual income per month has slowed slightly in recent months, due to new staff taking over related admin tasks, the need to establish better income tracking systems, and the transition to the new account structure – income shares for all trials need to be updated and reflected in the finance system. It is a JRO priority to bring this up to date – and on target – by end of March.

Summary of Progress to Date

Our original agreed trajectory for growing commercially-sponsored trials activity was as follows, with the ultimate aim of doubling activity within 4 years:

The actual start date for true implementation of the project has been slightly delayed beyond that intended. The business plan was only agreed in September 2018, and the recruitment of new staff into post takes some time. Despite this, YTD activity for 18/19 is at least comparable to previous years, and is likely to show an improvement over 17/18 by year end. We are still aiming to demonstrate a 10% increase in activity by year end, given that:

- Divisional Directors of Research are now in post and actively planning with each specialty;
- Funding has been released and is being invested in new support posts;
- Several commercial sponsors are approaching us to put in place framework agreements;
- The Joint Research Office (JRO) is now fully staffed in terms of contracts and costings resource, following a period of disruption in 2017/18.

We are focusing on setting up / opening existing studies in the pipeline as quickly as possible, and in parallel putting plans in place to grow new areas of demand. Speed of set up was recently demonstrated by achieving recruitment of the first patient globally for a Novartis haematology oncology study.

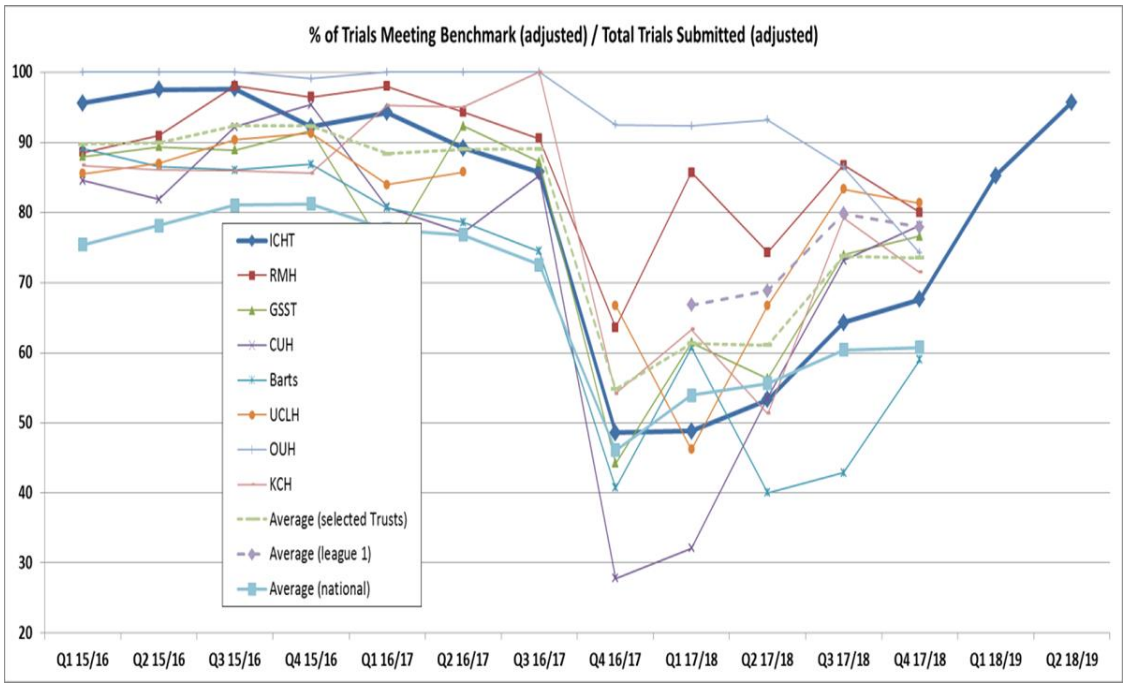
We propose to continue focusing on speedy set up / opening and on transitioning from the old to the new financial model and ensuring activity tracking, invoicing and income sharing is being carried out accurately and effectively.

We will continue to implement the plan we specified in the business case and, at 18/19 year-end, we will take stock of performance. If it is then decided that the growth trajectory needs to be amended, we will put in place measures to achieve this. While the original intended trajectory was assumed to be linear with time, it may be more realistic to assume a more exponential growth curve by year. However, we will assess at year end before proposing any changes to the implementation plan.

Performance in Initiating Clinical Trials

Our performance for initiating clinical trials (70-day target) is much improved. The confirmed figure for Q2 18/19 is 95.7%. This improvement is due to re-staffing and new leadership in ICHT JRO team, who now conduct weekly study review meetings with all Divisions, identify issues, and escalate as appropriate.

It is difficult to compare directly with peer organisations now, as NIHR no longer publish % compliance data (for the 70-day metric) for each NHS Trust. However, the most recently available data is shown in the graph below.



B) Developing capacity: a strategic plan for non-medical clinical academics

Dr Caroline Alexander (Chair of the Clinical Academic Research Committee for Healthcare Professionals and lead clinical academic for therapies) and Professor Mary Wells (Chair of the Nursing and Midwifery Research Committee and lead nurse for research) have developed a new strategy to develop our capacity for research led by non-medical staff communities, including research nurses, allied health professionals and clinical research practitioners.

In partnership with Imperial College London, ICHT has a world-class reputation for research. At any one time there are around 1200 research studies that are actively recruiting patients at the Trust.

However, the majority of health research undertaken at Imperial is currently led by doctors. There are a growing number of healthcare professionals outside of medicine, who are developing, delivering and leading high quality research aligned to patient and health service priorities. These healthcare professionals also support and deliver much of the research that is medically led.

The recently developed strategic plan aims to build on our existing strengths and develop a research culture across the Trust which enables, values and celebrates the impact that research has on patient care. People at all levels and roles can be involved in enabling and carrying out research, therefore this strategic plan is aimed at all staff, whether they are working in clinical, managerial, educational or research roles. It aims to support and build research awareness, research involvement, research activity and research leadership across the Trust.

Individuals will develop from being research aware (understanding and applying research in practice), through to participation in research studies, delivering research, and ultimately to becoming an independent and leading researcher in their own right.

The ultimate, longer-term goal is to ensure that 1 per cent of ICHT healthcare professionals are working within a clinical academic role (which equates to ~53 staff members). The plan sets out how we will achieve that goal and provide leadership in the development of meaningful clinical academic careers across this workforce, with the aim of improving patient care. It addresses the expectations of the CQC for safe, effective, caring, responsive and well-led services.

The plan is based around 4 pillars;

- Developing research awareness
- Leadership and career structures
- Enabling and facilitating research networks and collaborations
- Identifying, developing and supporting healthcare professional staff to be research active

Imperial College Healthcare NHS Trust

C) Translational research highlights from the Imperial BRC

i) AI Clinician for sepsis - 'convergence science' from Imperial

Imperial BRC researchers have developed an Artificial Intelligence system that could be used to personalise the treatment of patients with sepsis in real time. The computational model, known as 'AI Clinician', learned the best individual treatment strategy from medical records of almost 100,000 sepsis patients in the US, and provided recommendations that proved more reliable than decisions made by human doctors.

Imperial researchers 'trained' an AI system to analyse individual patient's vital signs and recommend the best treatment strategy. The results, published in Nature Medicine, revealed that 98% of the time, the AI system matched, or was better than, the treatment decision made by a human doctor, with lowest mortality in patients where the human doctor's doses of fluids and vasopressor matched the AI system's suggestion. On the contrary, when the doctor's decision differed from the AI system, a patient had a reduced chance of survival.

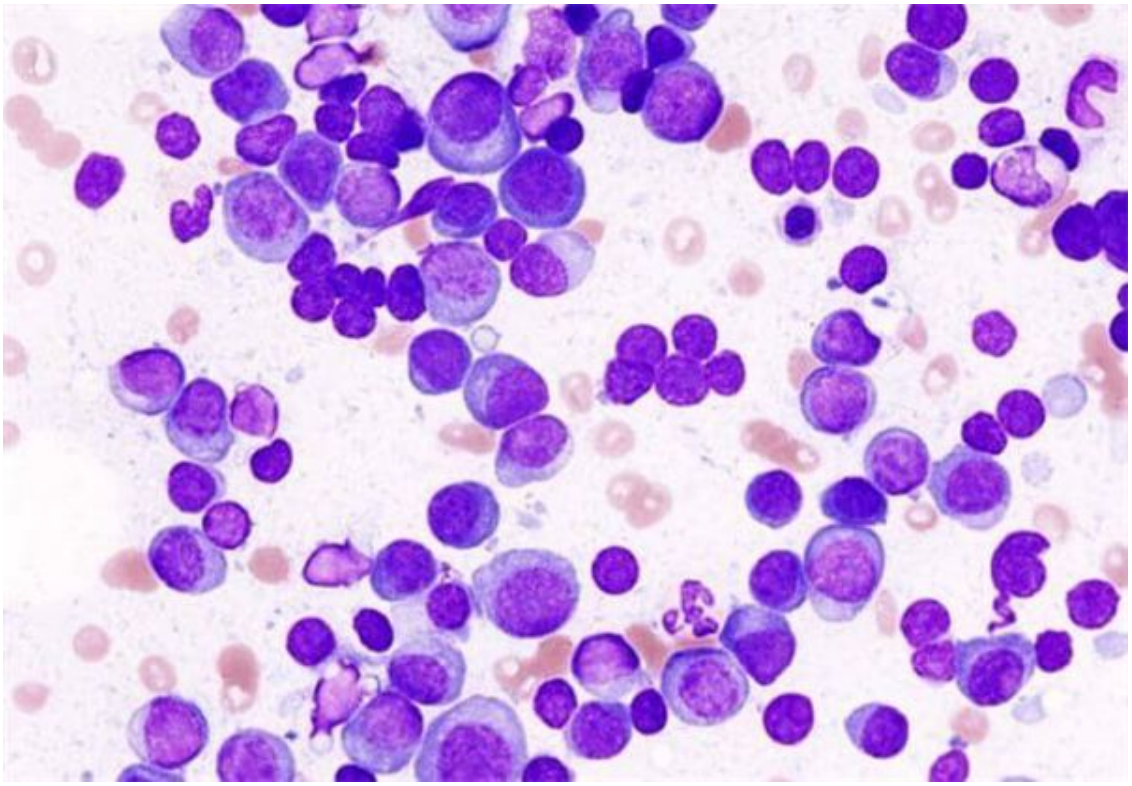
While AI Clinician was created using US datasets, it was validated using NIHR HIC data, and will be trialled it in UK hospitals to prospectively assess decision making using real-time data. This cutting-edge work is a direct result of the Imperial ethos that brings together engineers and clinicians to solve real health problems and improve healthcare. This study was led by Dr Matthieu Komorowski, a clinician who obtained a PhD in Artificial Intelligence with supervisors Dr Also Faisal and Professor Anthony Gordon.

The Artificial Intelligence Clinician learns optimal treatment strategies for sepsis in intensive care

Nature Medicine

Imperial College Healthcare NHS Trust

ii) Novel promising treatment strategy for multiple myeloma



Imperial BRC researchers, led by Professor Guido Franzoso, developed a first-in-class inhibitor of NF-κB pathway, called DTP3, which selectively activates apoptosis in cancer cells while sparing the normal tissue. DTP3 was investigated in the first-in-human phase I/IIa clinical trial, to evaluate safety, tolerability, pharmacokinetics and pharmacodynamics of this novel therapeutic.

Multiple myeloma remains incurable and displays deregulation of NF-κB pathway. Three patients with progressive multiple myeloma received increasing doses of the drug intravenously, three-times a week, for 28 days. The trial took place at five multiple myeloma sites located in the UK: NIHR Clinical Research Facility at Imperial College Healthcare NHS Trust , The Royal Marsden Hospital, King's College London, Barts and The London School of Medicine, and University College London Hospitals.

Results of the study showed that the drug was well tolerated in all patients, with no notable adverse effects or toxicity. One patient who received a higher dose of the drug had cancer progression halted for three months, and two out of three patients demonstrated activation of apoptosis at a molecular level selectively in cancer cells, and not in healthy tissues, thereby replicating pre-clinical findings.

Clinical proof of concept for a safe and effective NF-κB-targeting strategy in multiple myeloma

The British Journal of Haematology

Imperial College Healthcare NHS Trust

iii) Faecal microbiota transplantation: effective treatment of gut infections

In 2014, Imperial established an FMT service at St Mary's Hospital (one of the first in the country at the time), with support from the NIHR Imperial BRC and Imperial Health Charity. A number of patients with severe antibiotic-resistant *C. difficile* infections returned to improved health and normal wellbeing after a single dose of FMT. Recently, the first-ever UK FMT Guidelines were published (which Imperial FMT clinicians significantly contributed to), providing evidence-based advice of best clinical FMT practice.

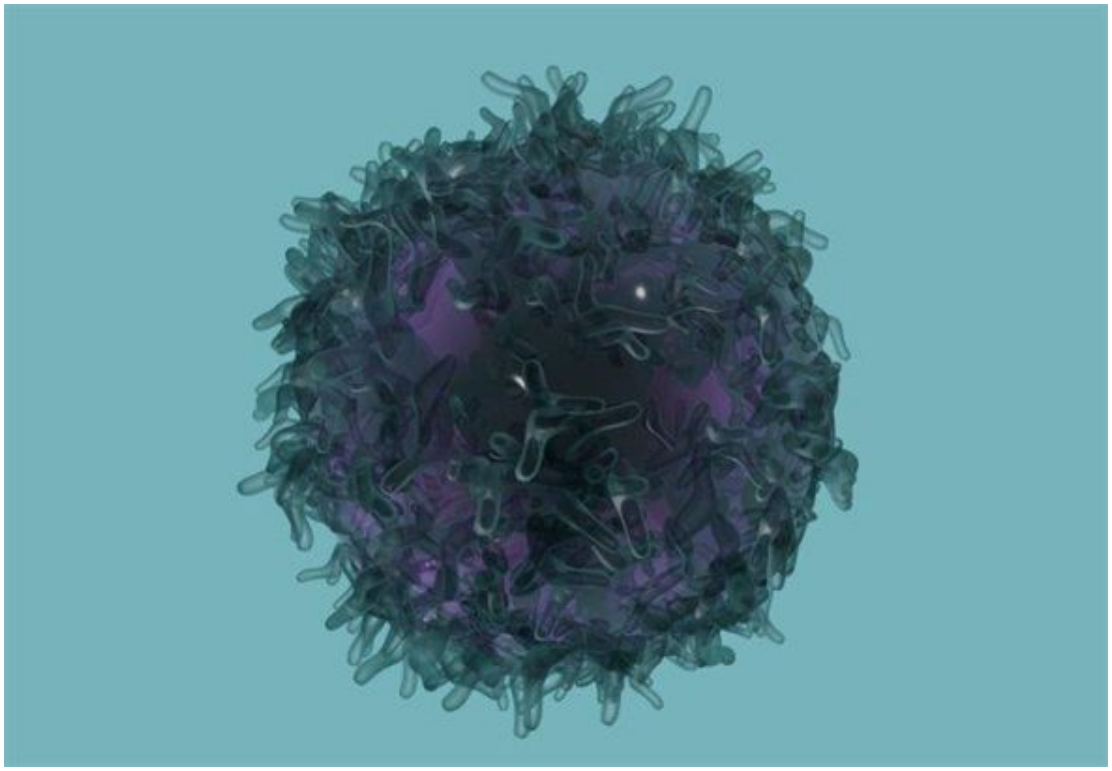
With new support from the BRC, Imperial researchers are also beginning to research whether FMT may be useful in the treatment of conditions other than CDI. One major area of interest is whether FMT can help people who have guts colonised with microbes that are resistant to multiple antibiotics; this work is at an early stage, but there are already some promising data suggesting that FMT may be able to successfully remove ('decolonise') such microbes from the gut of affected patients.

Effective fecal microbiota transplantation for recurrent Clostridioides difficile infection in humans is associated with increased signalling in the bile acid-farnesoid X receptor-fibroblast growth factor pathway

Gut Microbes

Imperial College Healthcare NHS Trust

iv) 'Off-the-shelf' immunotherapy



Prof Tassos Karadimitris' group successfully completed pre-clinical evaluation of a unique immunotherapy approach developed at Imperial.

Albeit highly efficacious, CAR-T therapy is very expensive (~£300,000 per patient), as it must be tailored to every patient. Prof Karadimitris' group used invariant natural killer T-cells (iNKT), to engineer a unique version of this type of therapy, called CAR19-iNKT. The USP of this therapy is that iNKTs can be sourced from healthy individuals, and unlike T cells, they don't need to be matched to the patient, meaning that this therapy can be used 'off-the-shelf'.

So far, this approach proved feasible for treatment of lymphoma, with potential applications in treating solid tumours including brain cancer (as CAR19-iNKT crosses the BBB), and infection.

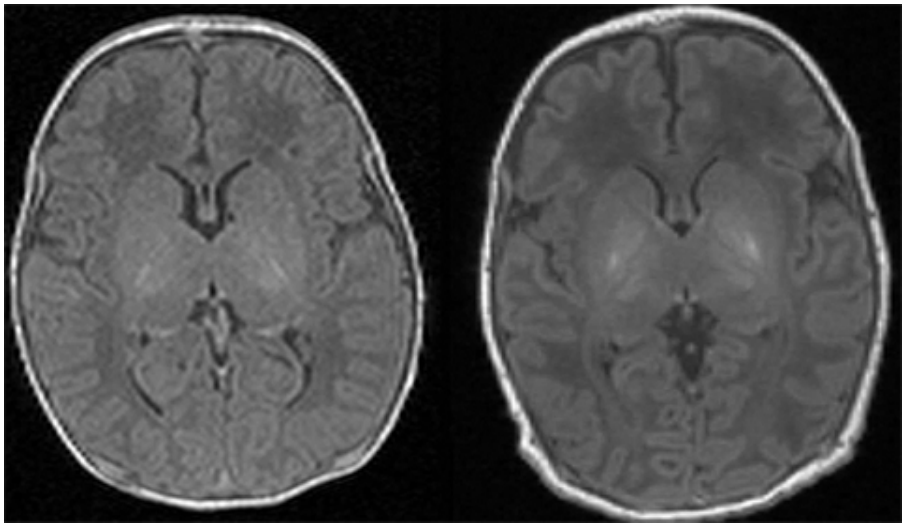
The study was supported in early stages by Imperial's Confidence-in-Concept scheme and was developed and matured with funding from Bloodwise. Imperial Innovations, the College's technology commercialisation partner, has patented the underlying cell engineering technology and current BRC funding is being used to bring this treatment into first-in-human clinical trial at ICHT (forecasted for 2020-21).

Enhanced Anti-lymphoma Activity of CAR19-iNKT Cells Underpinned by Dual CD19 and CD1d Targeting

Cancer Cell

Imperial College Healthcare NHS Trust

v) 15-minute scan could help diagnose brain damage in newborns



A 15-minute scan could help diagnose brain damage in babies up to two years earlier than current methods. The study, supported by the NIHR Imperial BRC and the MRC, involved scanning over 200 babies at 7 hospitals across the UK and USA, and predicted brain damage with 98% accuracy.

Brain damage affects around one in 300 births in the UK and is usually caused by oxygen deprivation. Currently, doctors are unable to accurately assess the extent of a newborn baby's brain damage, with any child suspected of having some type of damage given an MRI scan shortly after birth. However, this method is only between 60-85% accurate, and relies heavily on the radiologist's individual judgement, meaning the prognosis can vary depending on who assesses the scan, and where the scan is done. This means that health professionals can only confirm if a child has lasting brain damage when they reach two years old, by assessing whether a youngster has reached their development goals such as walking and talking.

In the new study, scientists used MR spectroscopy to assess the health of brain cells in an area called the thalamus, which coordinates a number of functions including movement, and is usually most damaged by oxygen deprivation. The technology only requires the baby to spend an additional 15 minutes in the MRI scanner, and in this study was performed at the same time as the routine MRI scan when a baby was between 4-14 days old. The scan does not carry any additional cost to the NHS, and the data can be easily analysed using special software by any radiographer. In the trial, all of the babies had received so-called cooling therapy immediately after birth. The babies then had their brain scan soon after this therapy, and detailed developmental assessment at two years of age. The results suggested the MR spectroscopy at 2 weeks accurately predicted the level of toddler's development at two years old.

Magnetic resonance spectroscopy assessment of brain injury after moderate hypothermia in neonatal encephalopathy: a prospective multi-centre study

Lancet Neurology

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Bi-annual report on the Quality impact Assessments for Cost Improvement Programmes	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 30 January 2019	**Item 18, report no. 14**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Authors:** Priya Rathod, Deputy Director of Quality Governance

Summary:

This paper provides a second update on the outcomes of the Cost Improvement Programme Quality Impact Assessment meetings undertaken since it was last reported to the Board.

- Since the last update to the Board, the Medical Director and Director of Nursing have met with the three clinical divisions and some of the corporate areas to review the QIAs for 2018/19 cost improvement programmes.
- Of the QIAs reviewed, no QIA was scored greater than 9.
- Each year, a sample of schemes from the previous financial year is selected from each division for a formal post implementation evaluation (PIE) to be undertaken in accordance with the Trust's CIP QIA policy.
- To this end, each division will undertake a PIE for a range of 2018/19 CIP schemes going forward.
- The next routine quarterly meetings with divisions are scheduled to take place during quarter four 2018/19.
- An update on the outcomes of these meetings as well as the findings from the post-implementation evaluations for 2018/19 schemes, will be presented to the Board in May 2018.

Recommendations: To note the updates.

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

Financial impact: This paper has no financial impact.

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

Workforce impact: None

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

Imperial College Healthcare NHS Trust

Paper respects the rights, values and commitments within the NHS Constitution. ☒ Yes ☐ No
Trust strategic objectives supported by this paper: ▪ To achieve excellent patients experience and outcomes, delivered with care and compassion. ▪ To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.
Update for the leadership briefing and communication and consultation issues: All aspects of this paper can be included in leadership briefings and can be shared by leaders with all staff.

Imperial College Healthcare NHS Trust

Bi-annual report on the Quality impact Assessments for Cost Improvement Programmes

1. Background and Purpose

The Board will recall that the Trust has a comprehensive CIP QIA process in place to understand the risk to quality (aligned to the 5 CQC domains) as a result of introducing a cost improvement programme. As part of this process, the Medical Director and Director of Nursing periodically meet with divisions to review the QIAs presented.

This paper provides an update on the outcomes of the CIP QIA meetings undertaken since this item was last reported to the Board.

2. Outcomes from CIP QIA meetings undertaken (April 2018 to November 2018)

2.1 Clinical Divisions

The schemes presented for review by divisions have been a mixture of income and cost saving schemes. Common types of schemes within these two areas have been related to; additional activity/growth/new services and with regards to cost savings, relating to; pay and non-pay.

The outcomes of the review meetings are summarised below:

- **Surgery, cancer and cardiovascular:**
- Schemes for the division had a QIA score of 6 or below and were approved

- **Women's, Children's and Clinical Support**:
- Schemes for the division had a QIA score of 9 or below and were approved

- **Medicine and Integrated Care:**
- Schemes for the division had a QIA score of 8 or below and were approved

2.2 Corporate areas

- The CIP QIAs for the following corporate areas were all scored between 1 and 6 and were all approved:
    - CEO Office
    - Communications
    - Finance
    - ICT
    - People and Organisation Development

- Medical Director's Office
- Corporate Nursing

- A range of QIAs have been reviewed for Estates and Facilities.
- The committee may recall from the previous update that one scheme related to the introduction of smart scrubs had a QIA score of 9 which had not previously been approved due to the uniform policy needing to be amended to reflect the change in practice.
- The uniform policy was subsequently revised and approved through the appropriate governance structure.
- The scheme therefore has been approved.
- A scheme related to the introduction of disposable curtains and another regarding waste management require further work and detail before the QIA can be approved.

3. Post-implementation evaluations

- As part of the Trust's CIP QIA process it is important that once a scheme has been implemented, the on-going impact on quality is monitored. This is carried out locally within directorates and divisions.
- Each year, a sample of schemes from the previous financial year is selected (based on different scheme categories e.g. pay, non-pay, productivity and income) from each division for a formal post implementation evaluation (PIE) to be undertaken in accordance with the Trust's CIP QIA policy.
- To this end, each division will be undertaking a PIE for a range of 2018/19 CIP schemes going forward and the outputs reported to the Board in the next update.

4. Next steps

- The next routine quarterly meetings with divisions are scheduled to take place during quarter four 2018/19.
- An update on the outcomes of these meetings as well as the findings from the post-implementation evaluations will be presented to the Board at the next update.

5. Recommendations

- To note the updates.

Authors: Priya Rathod, Deputy Director of Quality Governance

30th January 2019

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Trust Board Committee Terms of Reference	☒ Approval ☐ Endorsement/Decision ☐ Discussion ☐ Information
Date of Meeting: 30th January 2019	**Item 19, report no. 15**
Responsible Executive Director: Peter Jenkinson, Director of Corporate Governance	**Author:** Peter Jenkinson, Director of Corporate Governance, Ginder Nisar, Deputy Trust Secretary

Summary:

It is good practise to review the Committee Terms of Reference on an annual basis to ensure that they are fit for purpose and reflect any changes made to the Committee in-year.

The following Board Committees reviewed their Terms of Reference during September to November 2018 and no material changes were made:

- Audit, Risk & Governance Committee
- Finance and Investment Committee
- Quality Committee
- Redevelopment Committee
- Remuneration and Appointments Committee

Recommendations:

The Board Committee Terms of Reference are attached for Trust Board approval.

This report has been discussed at:

- Audit, Risk & Governance Committee, 3rd October 2018
- Finance and Investment Committee, 19th September 2018
- Quality Committee, 12th September 2018 & 16th January 2019
- Redevelopment Committee, 31st October 2018
- Remuneration and Appointments Committee, 13th November 2018

Quality impact:

Regular review of terms of references support good assurance and oversight arrangements.

Financial impact:

No impact

Risk impact and Board Assurance Framework (BAF) reference:

Good governance supports the reduction of risk to the Trust overall.

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 If yes, briefly outline. ☐ Yes ☐ No **……**
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic objectives supported by this paper: ▪ To achieve excellent patients experience and outcomes, delivered with compassion. ▪ To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Not relevant.

Imperial College Healthcare NHS Trust

AUDIT, RISK & GOVERNANCE COMMITTEE

TERMS OF REFERENCE

Role

To provide the Trust board with the assurance that an adequate processes of corporate governance, risk management, audit and internal control are in place and working effectively. The Committee will operate in two parts, Part I: Audit, and Part II: Risk and Governance.

1 Membership and quorum

1.1 Members of the Committee shall be appointed by the Chairman on behalf of Trust board.

Part I - Audit

1.1.1. The Committee shall be made up of a minimum of three members. Only non-executive directors shall be members of the Committee.

1.1.2. The chief financial officer, director of nursing and medical director will attend all meetings

1.1.3. The chief executive will be invited to attend any meeting and should attend at least annually to discuss with the Committee the process for assurance that supports the annual governance statement.

Part II – Risk & Governance

1.2.1 The Committee shall be made up of a minimum of three non-executive directors, chief finance officer, director of nursing, and medical director.

1.2.2 Members may not appoint a deputy to represent them at a Committee meeting. The Chairman of the Trust is not a member of the Committee.

1.2.3 Only members of the Committee have the right to attend and vote at Committee meetings. The Committee may require other officers of the Trust and other individuals to attend all or any part of its meetings.

1.2.4 The chair of both parts the Committee will be an independent non-executive director. In the absence of the Committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.2.5 The quorum for the meeting will be two non-executive director members for Part I and Part II and the addition of two executive directors for Part II; the meeting will then be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

1.2.6 Internal and External Audit representatives will always attend both parts of the meeting. The Committee shall meet privately with the Internal and External Auditors at least once a year.

2 Frequency of meetings and attendance requirements

2.1 The Committee will normally meet at least four times a year at appropriate times in the reporting cycle and otherwise as required;

2.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of scheduled meetings. The secretary of the Committee shall maintain a register of attendance which will be published in the Trust's annual report.

3 Meeting administration

3.1 The Trust company secretary will attend each meeting and they or their nominee shall act as the secretary of the Committee.

3.2 Meetings of the Committee may be called by the secretary of the Committee at the request of any of its members or where necessary.

3.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda and supporting papers shall be forwarded to each member of the Committee, any other persons required to attend and all other non- executive directors, no later than five working days before the date of the meeting.

3.4 The secretary will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance.

3.5 Members and those present should state any conflicts of interest and the secretary should minute them accordingly.

3.6 Minutes of Committee meetings should be circulated promptly to all members of the Committee and, once agreed, to all members of the Trust board unless a conflict of interest exists.

4 Duties

4.1 The Committee (across Part I and Part II) should carry out the following duties for the Trust:

4.2 Governance, Risk Management and Internal Control

4.2.1 The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. In relation to the management of risk, the Committee will:

- Review the process under which the trust sets its risk appetite;
- Oversee and advise the Trust board on the current risk exposures of the Trust, and the effectiveness of the Trust's risk management systems;
- Keep under review the effectiveness of the Trust's risk management and risk assessment processes ensuring the use of both qualitative and quantitative measures in assessment;
- Refer to the Quality Committee any clinical risks that require further scrutiny by its membership;
- Review the effectiveness and timeliness of actions to mitigate critical risks including receiving exception reports on overdue actions;
- Review the statements to be included in the Annual Report concerning risk management;
- Review the governance arrangements in place to ensure effectiveness of learning from incidents trust-wide is achieved.

4.2.2 The Committee will seek assurance that the monitoring of due diligence on any integration or partnership arrangement is appropriate.
arrangements, reviewing the risk assessment and decision-making processes to ensure all control issues are addressed.

4.2.3 The Committee will seek assurance on behalf of the Trust board that the design and application of the control environment in core financial processes are fit for purpose and reflect both public and commercial sector best practice.

4.2.4 In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with CQC Standards), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors;
- an effective system of management of performance and finance across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;
- the Board Assurance Framework and the underlying integrated assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant reglatory, legal and code of conduct

requirements;
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State directions and as required by NHS Protect.

4.2.6 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

4.2.7 This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

4.3 Internal Audit

4.3.1 The Committee shall ensure that there is an effective Internal Audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Chief Executive and Board of Directors. This will be achieved by:
- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
- review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
- consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- annual review of the effectiveness of Internal Audit.

4.4 External Audit

4.4.1 The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:
- appointment of the External Auditor, as far as the relevant rules and regulations permit;
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy;
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Organisation and associated impact on the audit fee;
- review all External Audit reports (together with the appropriateness of management responses), including agreement of the annual audit letter before submission to the Trust board.

4.4.2 The Committee will review any proposal considered for commissioning work outside the annual audit plan (in its role as the Audit Panel) prior to approval.

4.5 Auditor Panel

4.5.1 NHS trusts are required to appoint their own external auditors and directly manage the resulting contract and the relationship; trusts are required to have an auditor panel to advise on the selection, appointment and removal of external auditors and on maintaining an independent relationship with them;

4.5.2 In accordance with The Local Audit and Accountability Act 2014, and The Local Audit (Health Services Bodies Auditor Panel and Independence) Regulations 2015, the Trust has nominated the Committee (Part I) as the Auditor Panel for the Trust;

4.5.3 The Auditor Panel will advise the Trust board on the selection and appointment of the external auditor;

4.5.4 The Trust board must consult and take account of the Auditor Panel's advice on the selection and appointment of the Trust board on the appointment of external auditors, and publish a notice on the website within 28 days of appointing the auditor providing details of appointment, and noting auditor panel advice;

4.5.5 The Auditor panel must advise on the Trust's policy on use of auditors for the provision

of non-audit services;

4.5.6 Auditor panel business must be identified clearly and separately on the agenda.

4.6 Whistleblowing and counter fraud

4.6.1 The Audit, Risk and Governance Committee will review the adequacy of the Trust's arrangements by which staff may, in confidence raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern including patient care and safety and bullying (including the Freedom to Speak up Guardian).

4.6.2 In particular the Committee will:

- review the adequacy of the policies and procedures for all work related to fraud and corruption as required by the counter fraud and security management service;
- approve and monitor progress against the operational counter fraud plan;
- receive regular reports and ensure appropriate action in significant matters of fraudulent conduct and financial irregularity;
- monitor progress on the implementation of recommendations in support of counter fraud;
- receive the annual report of the local counter fraud specialist.

4.7 Other Assurance Functions

4.7.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

4.7.2 These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (for example the NHS Litigation Authority), professional bodies with responsibility for the performance of staff or functions (for example Royal Colleges and accreditation bodies).

4.7.3 In addition, the Committee will be cognisant of the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work.

4.8 Management

4.8.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

4.8.2 They may also request specific reports from individual functions within the organisation (eg clinical audit) as they may be appropriate to the overall arrangements.

4.9 Financial Reporting

4.9.1 The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

4.9.2 The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness, integrity and accuracy of the information provided to the Trust Board.

4.9.3 The Committee shall review the Annual Report and Financial Statements before recommending them to the Trust Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee;
- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- major judgmental areas; and
- significant adjustments resulting from the audit.

4.10 Standing Orders and Standing Financial Instructions

4.10.1 The Committee will review on behalf of the Trust board any proposed changes to the Standing Orders and Standing Financial Instructions;

4.10.2 The Committee will examine the circumstances of any departure from the requirements of Standing Orders and Standing Financial Instructions;

4.10.3 The Committee will monitor the Declarations of Interest & Hospitality policy with

reference to the codes of conduct and accountability thereby providing assurance to the Board of probity in the conduct of business;

4.10.4 The Committee will review schedules of losses and compensations annually.

5 Reporting responsibilities

5.1 The Committee will report to the Trust board on its proceedings after each meeting;

5.2 Minutes of Part I will be reported to the public Trust board; minutes of Part II shall be reported to the private Trust board, with a report of proceeding to Part II;

5.3 The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

6 Other matters

6.1 The Committee will:

- have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;
- be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;
- give due consideration to laws and regulations;
- at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Trust board for approval, any changes it considers necessary; and.
- The chair of the Committee will normally attend the Annual General Meeting prepared to respond to any questions on the Committee's activities.

7 Authority

7.1 The Committee is a Committee of the Trust board, and has no powers, other than those specifically delegated in these Terms of Reference. The Committee is authorised to:

- seek any information it requires from, or the attendance of, any employee of the Trust in order to perform its duties
- obtain outside legal or other professional advice on any matter within its terms of reference via the trust company secretary.

8 Monitoring and Review

8.1 The Trust board will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the Chair of the Committee might provide.

8.2 The Secretary will assess agenda items to ensure they comply with the Committee's responsibilities.

Reviewed: September 2018

Imperial College Healthcare NHS Trust

FINANCE AND INVESTMENT COMMITTEE

TERMS OF REFERENCE

Role

To undertake on behalf of the Trust board thorough and objective reviews of financial policy and financial performance issues, reviewing the risks to the financial position; to review the Trust's financial performance and identify the key issues and risks requiring discussion or decision by the Trust board; to review the Trust's financial strategy, business plans and budgets, and advise the Trust board on their acceptance of such; and to advise the Trust board on finance issues and investment strategy, including those relating to the Trust's estate.

1 Membership and quorum

1.1 Members of the Committee shall be appointed by the Chairman, on behalf of the Trust board. The committee shall be made up of five members; three non-executive directors, the chief executive, and chief financial officer.

1.2 Only members of the Committee have the right to attend and vote at Committee meetings; other officers of the Trust and other individuals may be required to attend all or any part of the Committee's meetings.

1.3 The chair of the Committee will be an independent non-executive director. In the absence of the Committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.4 In addition to the Members, the Deputy Chief Financial Officers (two posts), Director of Transformation and divisional directors are expected to attend Committee meetings; others may be invited on an as needs basis.

1.5 The meeting quorum is three members, of which two are non-executive directors; the meeting will then be competent to exercise all or any of the authorities, powers and discretions vested in, or exercisable by, the Committee.

2 Frequency of meetings and attendance requirements

2.1 The Committee will normally meet six times a year at appropriate times in the reporting cycle and otherwise as required.

2.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

3 Meeting administration

3.1 The Trust company secretary or their nominee shall act as the secretary of the Committee.

3.2 Meetings of the committee may be called by the secretary of the Committee at the request of any of its members or where necessary.

3.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda and supporting papers, shall be forwarded to each member of the committee, and any other person required to attend, no later than five days before the date of the meeting.

3.4 The secretary shall minute the proceedings of all meetings of the Committee, including recording the names of those present, and any conflicts of interest.

3.5 Minutes of committee meetings should be circulated to all members of the Committee, and once approved, minutes are reported to the private Trust board.

4 Duties

4.1 The Committee should carry out the following duties for the Trust:

- advise the Trust board on financial policies;
- recommend to the Trust board, the Trust's medium and long term financial strategy (capital and revenue) including the underlying assumptions and methodology used, ahead of review and approval by the Trust board;
- review the Annual Plan including the annual revenue and capital budget prior to submission to the Trust board for approval;
- review the Trust's financial performance and forecasts (including performance against Cost Improvement Programmes) and identify the key issues and risks requiring discussion or decision by the Trust board;
- review compliance with the self-assessment quality checklist for the annual reference cost submission;
- review, at the request of the Trust board, specific aspects of financial performance where the Trust board requires additional scrutiny and assurance;
- review the Trust's projected and actual cash and working capital;
- approve and keep under review, on behalf of the Trust board, the Trust's investment and borrowing strategies and policies;
- ensure the Trust operates a comprehensive budgetary control and reporting framework (but acknowledging that the Audit, Risk & Governance committee is responsible for systems of financial control); and
- review the financial risks;
- establish the overall methodology, processes and controls which govern the Trust's investments;
- evaluate, scrutinise and monitor investments, including regular review of the capital programme;
- review post project evaluations for capital projects (above £5million) and for revenue projects (above £9 million per annum). All projects will have a two stage review that will be presented to the FIC; shortly after implementation to assess project or contract completion, and approximately 12 months later to review whether anticipated outcomes/savings had been achieved;
- review, and recommend to Trust board, the Trust's treasury management, working capital and estates strategies;
- evaluate and scrutinise the financial and commercial validity of individual investment decisions over £5m recommended for approval by the executive committee, including the review of outline and final business cases, and service development tenders, for onward recommendation for approval by the Trust board. The current delegated limit for the Trust is £15 million;
- bi-annually review business cases approved by the executive committee of a value between £2m and £5m.

5 Reporting responsibilities

5.1 The Committee will report to the Trust board on its proceedings after each meeting.

5.2 The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

5.3 The chair of the committee will normally attend the Annual General Meeting prepared to respond to any questions on the committee's activities.

6 Other matters

6.1 The committee will:

- have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;
- be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;
- give due consideration to laws and regulations;
- at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Trust board for approval, any changes it considers necessary.

7 Authority

7.1 The Committee is a committee of the Trust board and has no powers other than those specifically delegated in these Terms of Reference. The Committee is authorised:

- to seek any information it requires from any employee of the Trust in order to perform its duties;
- to obtain, outside legal or other professional advice on any matter within its terms of reference via the Trust company secretary;
- to call any employee to be questioned at a meeting of the committee as and when required.

8 Monitoring and Review

8.1 The Trust board will monitor the effectiveness of the committee through receipt of a written report following each meeting and the Committee's minutes.

8.2 The secretary will assess agenda items to ensure they comply with the Committee's responsibilities.

Reviewed: September 2018

Imperial College Healthcare NHS Trust

QUALITY COMMITTEE

TERMS OF REFERENCE

Role

To obtain assurance that high quality care is being delivered across Imperial College Healthcare NHS Trust. The committee will also obtain assurance that the quality strategy is being implemented and that continuous improvement is evidenced; To ensure that robust clinical governance structures, systems and processes (including those for clinical risk management and service user safety) are in place across all services and are line with national, regional and commissioning requirements; Onward referral of appropriate issues to relevant committees (including the operational and management committees) for further review or action; and review and approval (or recommendation for approval by the Trust board) of required quality-related annual reports (for example the Quality Account).

1 Membership and quorum

1.1 The Committee chair (an independent non-executive director) and Committee members will be appointed by the Trust Chair. Members may not appoint a deputy to represent them regularly at meetings. The Committee will comprise three non-executive directors, the medical director, the director of nursing, the divisional directors, and the director of infection prevention and control.

1.2 Only members of the Committee have the right to attend and vote at meetings; officers of the Trust and other individuals may be required to attend all or any part of Committee meetings.

1.3 In the absence of the Committee chair, members present will agree that one among them will chair the meeting.

1.4 The meeting quorum is two, of which one is a non-executive director; the meeting will be considered competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

2 Frequency of meetings and attendance requirements

2.1 The committee will normally meet bi-monthly; the Committee chair has the power to increase the frequency to monthly if considered necessary.

2.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of scheduled meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

3 Meeting administration

3.1 The Trust company secretary or their deputy shall act as the secretary of the Committee.

3.2 Meetings of the Committee may be called by the secretary at the request of any of its members or where necessary.

3.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

3.4 The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

3.5 Minutes of Committee meetings should be circulated to all members of the committee and, once approved, to all members of the Trust board (unless a conflict of interest exists).

4 Duties - The committee should carry out the following duties for the Trust:

4.1 Safety

4.1.1 Obtain assurance that the Trust has effective mechanisms for managing clinical risk, including clinical risk associated with clinical trials and improving service user safety, learning from incidents, and taking action to reduce risks and improve clinical quality;

4.1.2 Receive and review reports on individual serious adverse incidents; individual 'never' events; coroners' post-mortem reports; medico-legal cases and trend analysis of clinical incidents and be assured that actions are being taken to address issues and share learning;

4.1.3 Obtain assurance that robust safeguarding structures, systems and processes are in place to safeguard children and young people and vulnerable adults;

4.1.4 Obtain assurance that the Trust is compliant with the Mental Health Act and its associated Code of Practice and the Mental Capacity Act;

4.1.5 Obtain assurance that the Trust has appropriate arrangement in place to remain compliant with all aspects of Health and Safety legislation.

4.2 Effective

4.2.1 Approve and assure delivery of the annual programme of Trust-wide clinical audits;

4.2.2 Obtain assurance that NICE Guidelines and Technology Appraisals are implemented;

4.2.3 Obtain assurance that there are robust systems for undertaking nationally mandated audits, receive summary results and monitor the implementation of recommendations;

4.2.5 Oversee the Trust's work on Care Quality Commission's improvement reviews.

4.2.4 Report to the audit, risk and governance committee any ongoing concerns or risks being overseen by the Committee, and to refer other matters to other committees as appropriate.

4.3 Well-led

4.3.1 Obtain assurance that robust quality governance structures, systems, and processes, including those for clinical risk management and service user safety, are in place across all services, and developed in line with national, regional and commissioning requirements;

4.3.2 Approve and monitor delivery of the Trust's equality delivery system so that essential principles of equality are embedded into the culture, behaviour and decision making process of the organisation;

4.3.3 Receive assurance that clinicians, managers and staff promote and advance equality and diversity, whilst working closely with patients, the public, local communities, voluntary organisations, staff and staff side organisations.

4.3.4 Obtain assurance that efficiency programmes are not having a detrimental effect on quality through the cost improvement process (CIP);

4.3.5 Approve and assure delivery of all quality governance plans including CQC inspection action plans, and quality improvement methodology;

4.3.6 Obtain assurance that the divisional quality groups are effectively coordinating quality and clinical governance activity within the Trust;

4.3.7 Ensure that board assurance framework reflects the assurances for which the committee has oversight, and that risks highlighted are appropriately reflected on the risk registers.

4.4 Caring

4.4.1 Approve and assure delivery of the Trust's patient and public engagement plans, and the patient experience plans/strategy, and obtain assurance that these plans are keys element of the work of quality and clinical governance teams across the Trust;

4.4.3 Receive assurance that appropriate safeguarding arrangements are in place and effectively monitored;

4.4.4 The chairman of the committee shall be the Trust's Duty of Candour champion.

4.5 Responsive

4.5.1 Obtain assurance that patient access targets are being delivered;

4.5.2 Obtain assurance that effective channels are in operation for communicating and managing issues of clinical governance to relevant managers, staff and external stakeholders;

4.5.3 Obtain assurance that clinical recommendations resulting from complaints including those investigated by the Parliamentary and Health Service Ombudsman have been implemented.

5 Reporting responsibilities

5.1 The Committee will report to the Trust board on its proceedings after each meeting.

5.2 The Committee wiall make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

5.3 The chair of the Committee will normally attend the annual general meeting prepared to respond to any questions on the committee's activities

6 Other matters

6.1 The Committee will:

- Have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;
- Be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;
- Give due consideration to legislation and regulations;
- Review both its effectiveness and terms of reference on an annual basis, and recommend to the Trust board for approval, any changes it considers necessary.

7 Authority

7.1 The Committee is a Committee of the Trust board and has no powers other than those specifically delegated by the schedule of reserved and delegated powers, as described in these terms of reference. The Committee is authorised:

7.1.1 to seek any information it requires from any employee of the Trust in order to perform its duties, and to call any employee to be questioned at a meeting of the committee as and when required.

7.1.2 to obtain outside legal or other professional advice on any matter within its terms of reference via the Trust company secretary.

8 Monitoring and review

8.1 The Trust board will monitor the effectiveness of the Committee through receipt of the Committee's minutes and any further written or verbal reports that the chair of the Committee might provide;

8.2 The secretary will review all agenda items to ensure they align with the Committee's responsibilities.

Reviewed: September 2018

Imperial College Healthcare NHS Trust

REDEVELOPMENT COMMITTEE

TERMS OF REFERENCE

Role

To undertake, on behalf of the Trust board, thorough and objective reviews of the redevelopment transformation programme, including performance issues and financial issues, and to review investment requirements and risks associated with the overall redevelopment transformation programme. To identify the key issues and risks requiring discussion or decision by the Trust board and advise accordingly.

1 Membership and quorum

1.1 Members of the Committee will be appointed by the Chairman, on behalf of the Trust board. The Committee shall be made up of three non-executive directors, the chief executive officer, the chief financial officer, and the Medical Director.

1.2 Only members of the Committee have the right to attend and vote at Committee meetings.

1.3 The chair of the Committee will be an independent non-executive director. In the absence of the Committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.4 In addition to the Members the following are required to attend meetings of the Committee: the chief executive, Imperial Health Charity, director of planning & redevelopment, and the deputy medical director. The Committee may require other directors or officers of the Trust to attend Committee meetings.

3.1 The meeting quorum is four members, of which two are non-executive directors; the meeting will then be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

2 Frequency of meetings and attendance requirements

2.1 The Committee will normally meet monthly at appropriate times in the reporting cycle and otherwise as required.

2.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The secretary of the Committee shall maintain a register of attendance which will normally be published in the Trust's annual report.

3 Meeting administration

3.1 The Trust company secretary or their nominee shall act as the secretary of the Committee.

3.2 Meetings of the Committee may be called by the secretary of the Committee at the request of any of its members or where necessary.

3.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, any other person required to attend and all other non-executive directors, no later than five working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

3.4 The secretary shall minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance.

3.5 Members and those present should state any conflicts of interest and the secretary should minute them accordingly.

3.6 Minutes of Committee meetings should be circulated promptly to all members of the Committee and, once agreed, to all members of the Trust board unless a conflict of interest exists.

4 Duties

4.1 The Committee should carry out the following duties for the Trust:

4.2 Redevelopment programme assurance

4.2.1 The Committee shall make recommendations to the Trust board on the redevelopment transformation programme, performance issues, financial issues, including investment and risks associated with the overall redevelopment programme.
Specifically the Committee will:

- review the redevelopment programme and identify key issues with progress and assess the impact on the trust business that requires discussion or decision by the Trust board;
- review partnership arrangements between trust and key stakeholders and advise the trust board of impact and issues that require discussion or decision by the Trust board;
- review the quality of the healthcare facilities being developed to ensure trust transformational objectives are being met and advise the Trust board of issues that require discussion or decision by the Trust board;
- review the redevelopment programme risk register and identify the key issues and risks requiring discussion or decision by the Trust board;
- ensure the redevelopment programme operates a comprehensive budgetary control.

4.3 Redevelopment programme management and reporting

4.3.1 The Committee shall review and recommend to the Trust board:

- the Trust's investment strategy in so far as this is relevant to the redevelopment of the Trust sites, including:
- establish the overall methodology, processes and controls which govern the approach to site redevelopment;
- evaluate, scrutinise and monitor investment relating to site redevelopment; prepare post project evaluations for capital projects and for revenue projects related to redevelopment which have a whole life contract value of £5 million and above;
- review and recommend to Trust board the Trust's estate strategies;
- within limits set out in the standing orders, standing financial instructions, scheme of delegation and matters reserved to the Trust board, the Committee shall approve, evaluate and scrutinise the financial and commercial validity of relevant individual investment decisions, including the review of outline and final business cases. The current delegated capital limit for the Trust is £15million.

5 Reporting responsibilities

5.1 The Committee will report to the Trust board on its proceedings after each meeting.

5.2 The Committee shall make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

5.3 The Committee will produce an annual report to the Trust board.

6 Other matters

6.1 The Committee will:

- have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;
- be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;
- give due consideration to laws and regulations;
- at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Trust board for approval, any changes it considers necessary.
- The chair of the Committee will normally attend the annual general meeting prepared to respond to any questions on the Committee's activities.

7 Authority

7.1 The Committee is a Committee of the Trust board and has no powers other than those specifically delegated in these terms of reference. The Committee is authorised:

- to seek any information it requires from any employee of the Trust in order to perform its duties;
- to obtain, outside legal or other professional advice on any matter within its terms of reference via the Trust company secretary;
- to call any employee to be questioned at a meeting of the Committee as and when required.

8 Monitoring and Review

8.1 The Trust board will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the chair of the Committee might provide.

8.2 The secretary will assess agenda items to ensure they comply with the Committee's responsibilities.

8.3 The secretary will monitor the frequency of the Committee meetings and the attendance records to ensure minimum attendance figures are complied with. The attendance of members of the Committee will be reported in the annual report.

Reviewed: September 2018

Imperial College Healthcare NHS Trust

REMUNERATION & APPOINTMENTS COMMITTEE

TERMS OF REFERENCE

Role

To act on behalf of the Trust board in:

- determining the appointment, remuneration, terms of service and performance of the executive director members of the Trust board (executive directors) as listed in the Appendix;
- Agreeing and overseeing the process for appointing non-executive and executive directors and other direct reports to the chief executive as listed in the Appendix;
- Agreeing the remuneration and terms of service of executive directors and all other director level reports to the chief executive officer, and noting the remuneration of all other very senior managers (VSM);
- Monitoring the performance and the development of executive directors;
- Ensuring that Equality and Diversity had appropriate priority in leadership development and succession;
- Review, and recommend approval to the Chairman where appropriate, requests by executive directors to act as non-executive directors in other organsiations or in similar roles;
- Ensuring that effective plans are in place to provide continuity of leadership in the event of extended executive director absence or vacancy;
- Approving any severance payments that are proposed for executive directors, for direct reports to the chief executive officer, and any other very senior managers and others as may be required by NHS Improvement and the Department of Health.

1. Membership and quorum

1.1. Members of the committee shall be appointed by the Chair of the Trust board. The committee shall be made up of three members:
- The Chair of the Trust board
- Two non–executive directors.

1.2. Only members of the Committee have the right to vote at the Committee meetings; other officers of the Trust and other individuals may be required to attend all or any part of its meetings.

1.3. The chair of the Committee will be an independent non-executive director, and appointed by the Chair of the Trust board.

1.4 In addition to the Members, the following are required to attend all meetings of the Committee:
- Chief executive
- Director of people & OD
- Trust company secretary.

1,5 A quorum necessary for the transaction of business shall be two members. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

2. Frequency of meetings and attendance requirements

2.1 The committee will meet as required and at least twice a year. The timetable of meetings will be agreed between the Chair of the Committee and the Director of people & OD.

2.2 Members are expected to attend at least 75 per cent of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

3. Executive lead and meeting administration

3.1 The director of people and OD shall support the Committee in advising the Committee on employment issues and procedures, and shall agree agendas and papers with the committee Chair.

3.2 The Committee shall be supported administratively by the Trust company secretary, who will distribute papers, take the minutes and keep a record of matters arising and issues to be carried forward.

4. **Duties -** The Committee shall carry out the following duties for the Trust:

4.1 Trust board composition

- regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Trust board and make recommendations to the Trust board with regard to any changes.
- give full consideration to and make plans for succession planning for the chief executive officer and other executive directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed, in particular on the board in future.
- be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.
- be responsible for identifying and nominating a candidate, for approval by the Trust board, to fill the position of chief executive officer.
- before an appointment is made evaluate the balance of skills, knowledge and experience on the Trust board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates the Committee will use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; consider candidates on merit against objective criteria.

4.2 Appointment of executive directors

- nominate one or more members to be actively involved with the chief executive officer in the appointment of specific executive director posts, and in the design of the selection process on behalf of the Committee.
- ensure that the selection process is based on: an agreed role and person specification; the use or other involvement of any third party recruitment professionals; an interview panel to include the chief executive officer, an agreed non-executive director or directors, an external assessor representing NHS Improvement/DH or successor bodies and such other persons as may be agreed to be helpful.
- ensure that posts are openly advertised and that the appointment procedure at all times complies with the Trust's policies, standards and general procedures on recruitment and selection. This will include ensuring compliance with fit and proper person regulations (FPP).
- keep the Trust board informed of the process, procedures and timetable to which it is working, as appropriate.

4.3 Remuneration of executive directors

- agree on behalf of the Trust board the remuneration and terms of service of the Executive directors and that the executive directors are fairly rewarded for their contribution to the Trust, having proper regard to its circumstances and performance, and to the provision of any national arrangements or directives for such staff where relevant.
- agree and review annually a policy framework for the pay of very senior managers (VSM) not on national contracts, including executive directors.
- establish the parameters for the remuneration and terms of service for the appointment of executive directors, with delegated authority of the chief executive officer to agree starting salaries within the agreed parameters.

- determine the salaries of very senior managers other than executive directors is delegated to the chief executive officer or relevant executive director advised by the director of people & OD and working within the agreed policy framework. The committee will review annually the earnings of such managers including senior clinicians and clinical managers.
- agree the termination of contract of executive directors and the payment of any redundancy or severance packages in line with prevailing national guidance.

4.4 Performance and Succession Planning

- monitor and evaluate the performance both individually and collectively of the executive directors in the context of their responsibilities and objectives.
- ensure the capability of potential or nominated deputies for executive directors to effectively deputise during periods of extended absence on the part of the Executive directors.
- oversee an assessment of the capability and succession potential of the top 100 -150 Trust leaders in order to identify any strategic gaps requiring appropriate intervention.

4.5 Employee engagement

- to monitor the annual results of the employee engagement surveys and provide oversight of the Trust action plan for continuous improvement.
- to provide oversight of the Trust's action plan to improve staff retention.

5. Reporting responsibilities

5.1 The Committee shall make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

5.2 The Committee shall oversee the production of an annual report of the Trust's remuneration policy and practices which will be part of the Trust's Annual Report.

6. Other matters

6.1 The Committee will:

- have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;
- he provided with appropriate and timely training, both in the form of an induction programme for new members and on an on-going basis for all members
- give due consideration to laws and the regulatory framework within which the Trust operates;
- at least once every two years review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Trust board for approval, any changes it considers necessary.

7. Authority

7.1 The Committee is a committee of the Trust board and has no powers other than those specifically delegated in these Terms of Reference. The Committee is authorised to:

- seek any information it requires from any employee of the Trust in order to perform its duties;
- obtain outside legal or other professional advice on any matter within its terms of reference via the director of people and OD;
- call any employee to be questioned at a meeting of the Committee as and when required.

7.2 In order to ensure the business of the Committee is not unduly held up between meetings, the Chair may take Chair's action between meetings. Any such decisions thus taken will be reported to the next meeting. This may include authorisation of contractual severance payments to staff other than Executive Directors as required by NHS Improvement or the Department of Health. Where substantive or sensitive decisions are required outside of scheduled meetings then the Chair may convene an extraordinary meeting of the Committee.

Reviewed: September 2018

Appendix 1
Posts for which the Committee has responsibility

EXECUTIVE DIRECTORS
Chief executive
Chief finance officer
Medical director
Director of nursing
Transformation director (once post and title confirmed)
OTHER DIRECTOR LEVEL DIRECT REPORTS TO CHIEF EXECUTIVE
Divisional directors
Director of people & organisation development
Chief information officer
Director of communications
Director of redevelopment
Director, Imperial Private Healthcare

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD - PUBLIC SUMMARY REPORT	
Title of report: Audit, Risk & Governance Committee report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 30th January 2019	**Item 20.1, report no. 16a**
Responsible Non-Executive Director: Sir Gerald Acher	**Author:** Peter Jenkinson, Director of Corporate Governance & Trust Secretary

Summary:

The Audit, Risk and Governance Committee met on 5 December 2018. Key items to note from that meeting include:

North West London Pathology
The Committee discussed the effectiveness of governance arrangements for the North West London Pathology (NWLP) partnership, noting actions being taken to strengthen the arrangements, including the establishment of a Host Committee to oversee the Trust's compliance with its responsibilities as host of the partnership, and regular top-team meetings between NWLP senior management and the chief executive and members of the executive team, focused on the outcome of an external investigation into concerns raised by members of staff regarding leadership within NWLP and communication between NWLP management and staff. The Committee noted that other roles within the partnership governance, 'owners' and 'customers', were defined and aligned through the NWLP Board. Quality and financial assurance was also being provided through reporting through Trust governance arrangements.

The Committee noted that positive progress was being made overall by NWLP, deriving benefits for other partners. Implementation of the transformation plan had been delayed due to estates and technology issues, but this was being managed by the NWLP Board.

The Committee considered the risks to the Trust from the partnership and from its responsibilities as host of the partnership, and agreed that consideration should be given to adding NWLP into the 2019/20 internal audit plan. It was agreed that the audit should be carried out early in 2019/20 so the report could be presented to the Committee in July. The Committee also agreed that the NWLP risk register should be presented to the Committee at its next meeting.

The Committee agreed that North West London Pathology should be added to the forward planner for a future Board seminar, for NWLP to present their business plan to the Board, including the strategic context for pathology services, the vision for the future of the NWLP service and the resource and capability within management arrangements to take any opportunities arising. The timing of this presentation should be aligned with the development of governance arrangements following the outcome of the Genomics tender. This will also be a standing agenda item for the Committee until adequate assurance was received that the risk relating to governance arrangements was being managed.

External Audit report
The Committee received and considered the external audit progress report, including an update on accounting standards. The Committee received and noted a summary of changes in accounting standards, and considered the implication of such changes on the Trust's year-end accounts.

The Committee noted the guidance that NHS trusts were being encouraged to select a local quality indicator to be included in the audit of the quality account, in addition to the mandated indicators. It was agreed that Prof Redhead would meet with auditors to discuss further before presenting a recommendation to the Quality Committee for approval. The Committee noted the additional cost to be incurred in auditing the local indicator.

The Committee considered the Value for Money (VFM) risks identified by the auditors ahead of the year-end audit. It was noted that progress had been made in achieving the Trust undertakings, including the development of the financial recovery plan. The Committee discussed cash flow and risks to going concern, and the connection with the risks arising from the condition of the Trust estate that were being escalated externally with NHS Improvement. The Committee also noted financial risks arising from changes in the NHS financial model that might impact, including changes to tariffs and market forces factor contribution.

Internal Audit progress report
The Committee received and noted the internal audit progress report, including the status of audit work against the plan and progress to date in closing actions from previous audit reviews. The Committee welcomed the progress made in closing down outstanding actions, noting that 31 actions had been closed and a further 9 due to be closed by end of December. It was noted that the auditors would validate the closure of actions as part of their routine work.

Local Counter Fraud Service (LCFS) progress report
The Committee received and noted the counter fraud progress report, including a summary of the dashboard, showing progress in proactive work and number of referrals. It was noted that a number of risks had been identified through risk assessment activity that would be shared with the Trust to inform future proactive work.

The Committee discussed the lessons learned from closed cases and actions being taken to close any risks identified. It was noted that no detailed reports had been published to date as investigations were still ongoing, but that any investigation would result in a report and appropriate recommendations.

Corporate risk register and Board assurance framework
The Committee considered the corporate risk register and board assurance framework report, noting the summary of the output of discussions at the Executive (Finance) Committee regarding changes to the corporate risk register, including increased and decreased levels of risk.

The Committee noted the common themes from the divisional risk registers and noted progress made in managing the divisional risks. It was agreed that the update to the next meeting would include an update on the implementation of the recommendations arising from the internal audit review of risk management. The Committee also agreed that the corporate risk register should be reviewed with a view to reducing the number of risks on the register.

The Committee reviewed the Board Assurance Framework and agreed the proposed approach to develop and strengthen the use of the framework.

MBI Data Assurance report
The Committee received and noted a summary of progress in responding to the recommendations arising from the MBI review of data assurance, noting that while the review had focused on RTT data quality the report had identified wider data quality issues. The Committee noted that all but nine actions would be completed in 2018/19, and that those outstanding nine actions would be addressed through business planning as they depended on additional Business Intelligence (BI) resources.

The Committee welcomed the progress being made in improving data quality, but acknowledged the level of risk remaining until all actions had been completed and this would take until December 2019. In particular the Committee noted the remaining risk surrounding the management of the waiting list for follow-up appointments – the clinical risk around these was low but lack of management of the waiting list meant there was a risk of continued ‘pop-ons’. These waiting lists were being managed locally

which meant there was no trust-wide view of number of patients waiting for follow-up appointments.

Raising Concerns – update report
The Committee received and considered the update report, including a six-monthly summary of concerns raised. The Committee noted that this report did not provide a complete picture of all concerns raised as other routes existed by which staff could raise their concerns. The Committee also noted the length of time taken to complete actions. The Committee discussed the follow-up of concerns raised and how assurance is provided that staff are satisfied with the way their concern is managed, noting that feedback mechanisms were being considered, similar to the complaints process, which would involve the member of staff being asked whether their concerns had been addressed.

The Committee welcomed the approach being taken to ensure that the organisational culture encouraged staff raising concerns and ensured that those staff members raising concerns were treated fairly. The next report in July 2019 will include a report on the process, and controls in place to mitigate risks.

Tender waiver report
The Committee received and noted a summary of the number and value of waivers for Q2 2018/19.

Committee forward planner

The Committee discussed the use of risk 'deep dive' reviews and agreed that they should be added to the forward planner for future meetings. The themes for the risk reviews will be derived from the divisional risk registers and it was agreed that the theme for the next meeting in March 2019 would be cleaning standards.

The Committee will next meet on 6 March 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 7 December 2018	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 30 January 2019	**Item 20.2, report no. 16b**
Responsible Non-Executive Director: Sarika Patel, Chair of Remuneration Committee	**Author:** Peter Jenkinson, Director of Corporate Governance & Trust Secretary

Summary:

The Remuneration and Appointments Committee met on 7 December 2018. Key points to note include:

Mid-year review of Chief Executive
Sir Richard Sykes reported the outcome of his mid-year review of progress against objectives with Tim Orchard, Chief executive, in accordance with Trust governance processes for evaluating the performance of the CEO.

The mid-year review included an assessment of progress across the performance objectives and support and development actions agreed with NHS Improvement in May 2018, including:

- Operational performance objectives, including elective and non-elective performance
- Quality improvement, including agreeing a plan and governance arrangements to achieve a 'good' rating by the CQC
- Development of a financial plan to achieve the control total for 2018/19 and a transformation plan to achieve transformational change in 2019/20
- Staff recruitment and retention, including appointments to the executive team
- Site redevelopment, and
- Implementation of the global digital strategy.

The Committee was satisfied that the Trust has achieved, or is making good progress towards achieving, these objectives. The Trust has achieved continued improvement in the Trust's elective and non-elective performance, is on target to achieve the financial control total at year-end and Tim has overseen the implementation of an approach to drive the Trust's readiness for a CQC inspection and 'Well-led' assessment sometime in the first few months of 2019. The Committee have also noted that there is an appropriate development plan and support mechanisms in place for the Chief executive.

Recommendations:
The Trust Board is requested to note the report.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Redevelopment committee report – report from meeting held on 12 December 2018	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 30 January 2019	**Item 20.3, report no. 16c**
Responsible Non-Executive Director: Victoria Russell, Non-executive director	**Author:** Peter Jenkinson, Director of Corporate Governance & Trust Secretary

Summary:

The Redevelopment Committee met on 12 December 2018. Key topics of discussion in this meeting included:

- strategic updates from the Chief Executive, including updates on the development of a London estates strategy and the work of the new London Estates Board and of Sir Robert Naylor, and feedback from recent visits to the Trust by representatives from central government departments.
- updates on key initiatives within the Trust's redevelopment programme.
- updates from Imperial Health Charity.
- updates on the management of the risk of adverse impact on patient services from the Paddington Square redevelopment, noting ongoing actions to mitigate the impact.

The next meeting of the Committee will be held on 27 February 2019.

Recommendations:

The Trust board is requested to:

- Note the report
- Note that some of the discussion held at the Committee was considered 'commercial in confidence'.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC
BOARD SUMMARY

Title of report: Report from Quality Committee, 16th January 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 30th January 2019	**Item 20.4, report no. 16d**
Responsible Non-Executive Director: Professor Andrew Bush	**Author:** Sir Gerald Acher, Interim Chairman, Professor Andrew Bush, Non-executive Director Ginder Nisar, Deputy Trust Secretary

Summary:

The Quality Committee met on 16th January 2019. Key items to note from that meeting include:

Integrated Quality and Performance Report
The report was noted for month 8 by exception, additional slides were included with the report to highlight issues and related improvement plans and actions. In particular the Committee discussed the (as then) six never events and the priority actions underway. An update was provided to the National Patient Safety team and their input awaited. Other key areas highlighted included Duty of Candour, VTE, Sepsis and Mortality.

The Committee discussed the progress with the flu campaign and the activities underway to increase the uptake. Learning from this year's campaign will be important to improve the uptake next year.

Bi-annual report on the Quality impact Assessments (QIA) for Cost Improvement Programmes (CIP)
The Committee noted the outcomes of the CIP QIA meetings undertaken since March 2018. An update on the outcomes of these meetings as well as the findings from the post-implementation evaluations for 2017/18 schemes, will be presented to the Committee in April 2019.

Divisional Quality Risks
There were no new quality risks reported by the divisions. The Committee discussed the divisional quality risks report in some detail particularly those that have been on the register for a period of time and the explanations. The Committee discussed the type of report that should be presented to the Quality Committee and the Committee Chair and Director of Nursing would meet to discuss further as well as discussion at the Audit, Risk & Governance Committee.

CQC
The Committee received an update on CQC related activity at and/or impacting the Trust since the last report to the Committee. The Trust submitted its annual CQC Provider Information Request (PIR) on 12 December 2018. The PIR initiates the Trust's six month time period for CQC inspections which runs to mid-May 2019. Preparations are underway for the inspection.

Incident Monitoring Report
The incident reporting rate at the Trust for November 2018 was 48.24, and the rolling 12 month average reporting rate (December 2017 to November 2018) is 49.54. This is a slight increase compared to October 2018. 13 Serious incidents (SI) were declared with 46 ongoing (open) SI investigations and there are ten overdue investigations, which is one more than last month. Seven level one/internal investigations were declared. All cases are currently under investigation. One never event was declared in November 2018, under the category of wrong site block. Improvement programmes (safety streams) are in place for the SI categories that have been reported most.

Learning from Deaths
The Committee noted the progress since the last report and the 'learning from deaths dashboard' which included data for the financial year 2017/18 to Q2 2018/19. Key points regarding progress made with implementation of the framework included:

- The Trust is compliant with reporting requirements as set out by NHS Improvement
- 338 Serious Judgment Reviews have been completed to date from September 2017.

- There have been 17 avoidable deaths to date all reviewed in financial year 2017/2018 with five this year to date.
- Mortality reporting metrics have been incorporated into both Trust and divisional scorecards since November 2017. No Trust specialties are currently causing concern in respect to avoidable deaths.
- Early emerging themes map to six of the Trust's safety streams 'falls and mobility (3)' and the 'responding to the deteriorating patient' (9), 'abnormal results (2)', 'safer medication (1)', 'safer surgery (1)', and 'fetal monitoring (5)' safety streams. Cases have been shared with the safety work streams aligned to these topics.
- The Trust continues to report any applicable cases to the LeDer programme, and complies with all reporting requirements for LeDeR.

Research and Development Quarterly Report
The quarterly report summarised progress with various clinical research initiatives within the Imperial Academic Health Science Centre (AHSC) and included the plan to increase the number of commercial clinical trials at ICHT; good performance in initiating clinical trials; an update on developing capacity: a strategic plan for nurses, allied health professionals and clinical research practitioners. Translational research highlights and outputs from the Imperial BRC were noted and commended by the Committee.

National Cancer Patient Experience Report
The 2017 National Cancer Patient Survey (NCPES) results were published in September 2018. The results indicate small changes to individual questions but the majority were not considered to have changed in a statistically significant way. Imperial College Healthcare NHS Trust is rated about the same as other Trusts and had marginally improved from its 2016 results. As aggregate score, ICHT ranks 139/145 respectively. However overall score of 8.7 is the same as other London Trusts (Range 8.9 to 8.3 - mean score of 8.5). The two different calculations paint two different pictures. The Director of Nursing and Divisional Director would review the data.

The partnership with Macmillan, the development of the CNS team and the introduction of the navigator service have all delivered benefits.

Hospital Initiated Cancellations – Revised Metric
In May 2018, a deep dive on the Hospital Initiated Cancellations (HICs) was shared with the Executive Committee which outlined the complexities of the HICs metric in existence at the time. The deep dive was requested by the executive as the HIC rate reported to the Executive Committee differed from the HIC rate reported to the Outpatient Improvement Steering Group; regardless of the method of calculation, the hospital initiated cancellation rate was unacceptably high and not improving; and HIC data may not be a good indicator of an adverse impact on patient care.

Overall, the HIC deep dive indicates some positives in relation to hospital cancellation management such as 45% of hospital cancellation events are not detrimental to or delay patient care, but the disruption to the patient's life may be significant; where cancellation does delay patient care, 62% of delayed appointments are delayed by less than 5 weeks; and where appointments are significantly delayed, audit suggests the delayed appointment is subsequently rescheduled a second time for the majority of patients, to bring the appointment forwards again.

The report included the comprehensive report and the actions required including redefining the HICS metric.
To support the understanding of the cancellations, a quarterly deep dive will be scheduled to analyse the reasons for the cancellations and identify the top five service areas contributing to the overall HIC rate.

North West Pathology
An update was received on key issues. Reporting arrangements in terms of the Board gaining assurance were agreed.

Improvement Team Update
The Committee noted the update on activities of the Improvement Team since October 2018. The programme is well-embedded and their priorities are reviewed by the Executive Committee.

Recommendations:
To note this summary.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC
BOARD SUMMARY

Title of report: Report from Finance and Investment Committee, 23rd January 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 30th January 2019	**Item 20.5, report no. 6e**
Responsible Non-Executive Director: Chairman	**Author:** Andreas Raffel, Non-executive Director Ginder Nisar, Interim Deputy Board Secretary

Summary:

The Finance and Investment Committee met on 23rd January 2019. Key items to note from that meeting include:

Finance Report (Month 9)
Before accounting for Provider Sustainability Funding (PSF) the Trust is on plan, reporting a £4.6m deficit in month 9. The Trust also improved its year-end forecast by £2.6m, taking the forecast to £1.2m adverse to plan. The improvement in the forecast reflects the work that has been done by clinical and corporate teams to make improvements in the Trust run rate. The Committee noted that early intervention with the divisions regarding their financial positions and forecasting proved to be effective.

As the Trust has met the control total for the end of the quarter it is eligible for PSF funding of £10m. The Trust has met the required year to date target for A&E performance at the delivery board level. The Trust has been informed that it is therefore eligible for PSF for quarters 1-3, previously the Trust had been showing £1.5m adverse for Quarter 1 A&E PSF. The Trust is assuming that it will meet its control total and A&E target for PSF purposes for the remainder of the year. The Committee noted the key risks to the current forecast position.

2019/20 Business Planning update
The Committee noted the progress of the 2019/20 planning cycle. On 10th January 2019, following the publication of the NHS 10 year plan, NHS Improvement/England released 2019/20 planning guidance. The Trust was advised of its control total on 15th January 2019 and the Trust is working to fully understand the changes and implications.

Use of Resources Assessment
The Use of Resources Assessment (UoR) is conducted by NHSI in advance of and as part of the CQC well-led assessment. The Trust's UoR assessment has been set for 13th February 2019. The UoR assessment is more analytical than other CQC inspections and also quite strictly focused on the actual performance and measures taken in the prior 12 months with less focus on governance and future steps which fall into the Well-led CQC domain. The UoR assessment arose to a large extent following Lord Carter's review on productivity and it focuses considerably upon the outputs of the Model Hospital which fed into the Trust's Specialty Review Programme. The time table to prepare was noted.

Financial Recovery Plan Update – loss making specialties
The Committee noted that the next phase of the Specialty Review Programme (SRP) is being taken forward by the Director of Transformation and Deputy Chief Financial Officer, following staff changes during 2018. An updated analysis of turnover and profitability by speciality was shared with the Committee noting that specialities are at different stages in the existing process with 11 which are ready for the next stage, where the recommendations are translated into strategies and tactical plans to implement during 2019/20. The next report to the Committee will provide further detail including timelines and link with the Cost Improvement Programme.

Reflections on the NHS 10 Year Plan
The NHS long term plan was published following last June's announcement of a £20.5bn annual real terms uplift for the NHS by 2023/24. The Plan sets out ambitions for ensuring the NHS is fit for the future and covers a ten year window. An engagement period will now begin on the Plan, running until the summer. The high level NHS summary of the plan was noted by the Committee as was the briefing document from NHS Providers which summarises key content included in each chapter of the Plan: a new service model, action on prevention and

health inequalities, progress on care quality and outcomes, the NHS workforce, digitally-enabled care, value for money and the next steps in implementing the plan.

The Committee noted that the Trust is refreshing its strategy framework to take into account internal and external changes.

Summary of Capital spending progress as at 31st December 2018
The Committee noted that the Trust has spent a total of £30.941m against a planned position of £43.389m year to date at month 9. There is a risk of full year underspends against the Capital resource limit in certain areas and will be mitigated by bringing forward projects from 2019/20 as agreed by the Executive Team.

Included in the Capital Resource Limit (CRL) for the year is the increase in the Trust's CRL for the year by £6.7m which has been agreed with NHSI and will be funded from internal cash reserves. In addition the Trust has received £5m Winter Pressures capital funding to invest in additional bed capacity. The Trust has been awarded £1.865m in STP wave 4 capital funding for the Hybrid Theatre for the project to proceed in 2019/20. It is not expected that any additional emergency capital loan via NHSI will be approved in 2018/19.

Strategic Imaging Asset Programme
The Committee received an update on the challenges faced by the imaging service including the risks presented by an aging asset base, meeting growth in demand, and the need to maintain an acceptable environment for patients and staff. To meet these challenges and take advantage of the opportunities such as looking at models of service delivery, working more closely with the NWL sector and benefiting from new technologies, the Trust needs to invest in, and implement an Imaging asset replacement programme. This would consider both service and financing models and seek innovative solutions to both. The Committee were supportive of progressing this project further.

Post-implementation Plan Review – Replacement of MRI / Gamma Cameras
The Committee noted the 12 month Post Project Evaluation of asset replacement of MRI & Gamma Camera's at Hammersmith Hospital. The business case was approved in 2016 with a mixed finance model of NHS supply chain lease for equipment and capital for enabling works to facilitate installation. The final piece of equipment has been fully operational since March 2018. The report outlined the success of project goals for MRI capacity within the Trust and also acknowledges the changes in demand for Nuclear medicine had affected the anticipated financial benefit. The qualitative benefit of offering a resilient high quality service using the latest technology has been realised.

Summary of Business Cases Approved by the Executive Quarter 3
The Committee noted that 26 business cases have been approved by the Executive since the start of the 2018/19 financial year, with five of these cases being worth more than £2m and less than £5m in either expenditure and or capital.

Recommendations:
To note this summary.