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<td>Questions from the Public</td>
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<td>This item is an opportunity for members of the public to ask questions to the Board on matters that relate to the Board agenda. Where possible, questions should be sent to the Trust Secretary, by Monday 24th September 2018 in order that the Board can ensure the information is available to answer the question raised.</td>
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<td><strong>Date of next Meeting</strong></td>
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<td></td>
<td>Date of next meeting - Wednesday 28th November 2018 at Hillingdon Hospital</td>
<td>information Chair</td>
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THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE PART I (OPEN) MEETING OF THE BOARD OF DIRECTORS
HELD ON WEDNESDAY 25th July 2018 AT 2PM
HILLINGDON HOSPITAL
IN THE BOARD ROOM

MEETING HELD IN PUBLIC

Present:
Richard Sumray Chair
Soraya Dhillon Deputy Chair and Non-Executive Director
Lis Paice Non-Executive Director
Carl Powell Non-Executive Director
Richard Whittington Non-Executive Director
Cheryl Coppell Non-Executive Director
Linda Burke Associate Non-Executive Director
Abbas Khakoo Medical Director
Terry Roberts Director of People and Organisational Development
Joe Smyth Chief Operating Officer
Matt Tattersall Finance Director
Jacqueline Walker Director of Patient Experience and Nursing

Apologies:
Keith Edelman Non-Executive Director
Shane DeGaris Chief Executive

In Attendance:
Mike Sims Trust Secretary
Vanessa Saunders Deputy Director of Nursing
Monica Whittle Divisional Director Cancer and Clinical Support Services
Jeremy Philpott Director of Strategic Estate Development & Asset Management

Members of the Public:
A Thomas
V Cook
G Singh
## Introductory

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| 1 | Welcome and Apologies for Absence  
The Chair welcomed all to the meeting and gave apologies for K Edelman and S DeGaris. |
| 2 | Declaration of hospitality, Declaration of amendments to the Register of Interests, Declarations of Interest on items on the Agenda  
None |
| 3 | Minutes of the Part I (Open) meeting 23rd May 2018  
**Accuracy**  
- Page 6 – item 6 - final paragraph should read “Incident investigation” not “Serious Incident”.  
- Page 14 – Drivers of Deficit – the Trust will benchmark with another Trust that is both “best in class” as well as “in surplus”, not two such Trust’s reviewing each separately.  
With these amendments the minutes were approved as an accurate record of the meeting |
| 4 | Action Log  
The following actions were accepted as completed; 197, 219, 237, 242, 245, 246.  

**198 - Feedback on progress with ensuring continued awareness on End of Life (EoL) February Board Seminar** – Noted this was now being considered for the October as opposed to August Board Seminar.  

**206 - Video of patient story; transition from child to adult hospital services** – T Roberts stated the Charity Director had indicated that charity funding for a video was inappropriate but he intended to hold further discussions on this point.  

**216 - Establishing the position of a Mortality Nurse or similar post** – this action required a response to Board at the September meeting.  

**221 – Provide an update on Integrated Care Partnership financial and governance risks** – not due until September meeting.  

**223 – Feasibility of asking staff in return to work interviews on colds and flu about take up of free flu jab** – Chair to discuss offline with T Roberts but a future report required in September on uptake of flu vaccine. |

| J Walker |
| T Roberts |
| A Khakoo |
| J Smyth |
| T Roberts |
226 – **Review way in which HR indicators are reported in relation to seasonal trends** - not due until September meeting

228 – **Use of NEDs as BAME mentors** – BAME Group has been asked to see if any mentors required and awaiting an update and NEDs informed of requirements. Additionally T Roberts confirmed that the next meeting of the Equality & Diversity Committee would review progress on existing mentoring cases to date.

230 – **Use of Physician Associates** – update to be provided to November meeting.

236 - **Developmental Review of Well Led Framework** - Executive meeting with KPMG took place – update on actions to return when Board reconsiders well led proposals post receipt of CQC inspection report

240 – **Quality and Performance Indicators for Board Assurance 2018/19 – Patient mobility** – J Walker to confirm at September Board whether “EndPJParalysis” data is suitable and sustainable as an indicator

241 - **Quality and Performance Indicators for Board Assurance 2018/19** – Future reports will include; percentage of medicines missed of all medicines as well as medicines reconciliation. A Khakoo agreed to review the use of a “quality” medicines indicator and discuss suitability with S Dhillon in advance of September Board.

243 – **Drivers of Deficit – benchmark against a Trust that is both best in class and in surplus** – not due until September Board

244 – **Self-Certifications – produce a FPPT Policy for Governors** – not due until November Board

5 **Declaration of Any Other Business**

None

6 **Patient Story**

V Saunders introduced a patient story that provided an example of excellent medical and nursing care within the surgical division. She confirmed that the patient had given his permission to share the story and would have attended the meeting himself, but since his procedure he had now returned to work. His surname had been changed for reasons of patient confidentiality.

Mr Green arrived at A&E by ambulance on 4 March with a 48 hour history of vomiting bile, a distended, tender abdomen, and fever. He had been experiencing diarrhoea but was no longer opening his bowels at all. A CT scan confirmed diverticular perforation.

He underwent emergency surgery at 22.59. Following the operation the Registrar telephoned Mr Green’s wife to explain the nature of surgery and the ongoing risks in terms of morbidity or mortality.

He was initially place in High Dependency Unit (HDU) after the procedure, and then transferred to the ward with follow up by the Critical Care
Outreach Team. He was also seen by the acute pain nurse. The surgical procedure meant he had a colostomy, so he was seen regularly by the stoma nurse. He made a good recovery and was discharged on 15 March.

On 19 June 2018 Mr Green emailed the PALS team to convey his thanks to the Trust for the treatment he had received saying;

“Yesterday I returned to work on a part time basis. On 4/3/18 I was blue lighted to Hillingdon hospital and ended up having emergency surgery to remove part of my lower bowel which had been perforated although I had no idea.

Mr Slessor and his team saved my life for which my family and I will be eternally grateful. I had eleven days on jersey ward. The operation left me with a stoma and a colostomy bag. It was all shocking and a lot to get used to especially as I had had a full knee replacement six days earlier at Mt Vernon.

This was made a lot easier for me by the colorectal team and especially the stoma nurse Andrea. Her care, advice and general no nonsense attitude was just what I needed. I wasn't overloaded with information as I was already in a confused state but fed what I needed to know when I needed it. It meant that I was always positive in my attitude towards dealing with my stoma and colostomy bag. And from a business point of view probably freed up my bed quicker. My subsequent check-ups with the stoma team are always easy and a pleasure. I don't know whether Mr Slessor will be able to reconnect my bowel in the future but I am prepared if it can't be because of the support my family and I have received. I do hope that you will be able to pass this along accordingly to ALL those that should see it."

The story also provided an opportunity to discuss how the Trust captured compliments. In his email Mr Green had gone on to say;

“My problem is that looking at the website there is plenty of ways to complain but none other than this to give positive feedback and indeed thanks to those who deserve it. I wanted to email the Chief Exec Shane directly but can't. Could you therefore please kindly do it on my behalf and let him know that I'm a happy customer.”

V Saunders stated that this did seem to be a real gap and the Trust was keen to enable a portal for compliments on the website, possibly linked to the “Greatix” IT system as well as the need to find ways of capturing other forms of positive feedback, such as the large number of cards and letters of thanks received on Wards.

L Paice asked whether the experiences shared in the story could be used in the “Always Event” initiative. J Walker confirmed that this experience would be used as part of the “Always event” communication initiatives taking place.
The Chair asked that the Board’s thanks be passed on to the patient for sharing his story as well as wishing him luck with the second stage of treatment.

The Patient Story was noted

7  Chair’s Report

The Chair reported to the Board on;

The visit of Baroness Dido Harding to the Trust and the development of the Pre-Strategic Outline Case for a new hospital site at Brunel University London

He reported that Baroness Dido Harding, Chair of NHS Improvement, had visited the main and children’s A&E departments, the AMU and two wards on 19th July as well as being shown some of the limitations of rebuilding and expanding on the current site, and that he and the CEO also spent time discussing the Trust’s ambitions to build a health campus on land at Brunel University London and updated her on the position with the Pre-Strategic Outline Case for the project.

He told the Board that a final version of the document had now been completed and approved by each of the partnering organisations through Central and Northwest London Foundation Trust’s Executive Board on the 20th of June, Brunel University London’s full council 5th of July and Hillingdon Hospital’s Finance and Transformation Committee on 19th July and that the Pre-Strategic Outline Case would now be subject to final ratification by the Brunel Partnership Board on 31st of July.

He added that the Trust had had planned to share it with Lord O’Shaughnessy, Parliamentary Under Secretary of State at the Department of Health, on a visit scheduled for 18th of July but this had now been postponed due, he understood, to the ministerial changes in the Department of Health and had been rescheduled for early October.

Outcome of the Care Quality Commission’s (CQC) Inspection Report of Hillingdon Hospital

He confirmed to the Board that the CQC Inspection Report had been published on 24th July, that there would be some discussion on the report in the Part I meeting today but that a more detailed reflective discussion would take place at the additional Board meeting now arranged for 14th August.

Departure of Shane DeGaris CEO from the Trust
He reported that the CEO would be leaving the Trust shortly to take up the position of Deputy Chief Executive at Barts Health NHS Trust, and that a process for recruiting both interim and permanent replacements was already underway.

The Report was received

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<th>8</th>
<th>Chief Executive Report</th>
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<tr>
<td>A Khakoo introduced a report for information which updated the Board on;</td>
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<td>• Care Quality Commission (CQC) Inspection of Hillingdon Hospitals Foundation Trust</td>
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<td>• Brunel Development Pre-Strategic Outline Case</td>
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<td>• Seven Day Services</td>
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<td>• Temporary move of the Coronary Care Unit (CCU)</td>
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J Walker pointed out that the temporary move of the CCU had gone very smoothly and staff involved were to be commended. M Tattersall added he had just completed a Board to Ward walkabout with L Paice and the patients they talked to in the CCU confirmed the transfer process had worked extremely well.

The Report was noted

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<th>9</th>
<th>Enforcement Undertakings relating to A&amp;E, finance and governance</th>
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<td>J Smyth introduced a report for information asking the Board to note that the Trust had signed Enforcement Undertakings relating to A&amp;E, finance and governance with NHS Improvement (NHSI) on 20th June 2018.</td>
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He explained to the Board that NHSI had told the Trust that that they had concluded there were reasonable grounds to suspect the Trust was in breach of its provider licence in relation to A&E delivery and medium term financial planning and would be prepared to accept “enforcement undertakings” in respect of A&E and financial issues which, they believed, would help support the Board oversee how plans and actions to deal with both A&E and the medium term financial issues were progressing. He said that, in short, the Undertakings stipulated requirements relating to performance, financial governance reporting and programme management. He reported that Hunter Associates had been employed to support delivery of the A&E standard but that responsibility for A&E performance remained with the Trust and would be delivered by the Chief Operating Officer, Medical Director and the Director of Nursing.

C Powell sought clarification on the consequences should the Trust fail to comply with the conditions. M Tattersall said that it was not clear what the consequences would be for the Trust in these circumstances, although it
was fair to say that it was likely that the level of regulatory oversight would increase even further than already existed.

The Report was noted

10 Committee Self-Assessments

The Chair introduced a report for decision asking the Board to agree recommended changes to the terms of reference (TOR) for Committees and other actions resultant from each Committees’ self-assessment exercise.

He explained that in April and May 2018 Committees were asked to self-assess performance using the Committee’s terms of reference, the organisations’ strategic objectives as well as a commentary from the Trust Secretary on strengths and weaknesses relating to the terms of reference of the Committee and its work in general. He reported that the Charitable Funds Committee review still needed to take place.

The Board agreed;

- Finance and Transformation Committee – To include delegating the authority for “new business” approvals to the Committee up to the value of £1m within the TOR
- Nominations Committee – To include overseeing Board development, (reviewing this annually) within the TOR
- Remuneration Committee - To define “senior management” in relation to approving remuneration as only those officers classified as “Very Senior Managers” (VSM’s)
- Remuneration Committee – To delegate the Chair of the Committee to consider a definition of “consultant staff” having first cross checked the Standing Financial Instructions in relation to remuneration
- Remuneration Committee – To remove “In the event of such case arising” leaving only “to authorise an Executive Director taking on a non-executive directorship of an NHS Foundation Trust or organisation of similar size and complexity” in the TOR
- Quality and Safety Committee – To delegate to the Chair of the Committee the authority to review and amend the wording in relation to attendees as opposed to members having that authority within the TOR
- Quality and Safety Committee – To delegate to the Chair of the Committee whether the balance of agenda items between the review of compliance and assurance as opposed to improvements, initiatives and culture needed consideration in terms of agenda planning and how time was allocated to each at meetings
Outcome of the Care Quality Commission’s (CQC) Inspection Report of Hillingdon Hospital

The Chair gave an introduction to the report explaining that, given the CQC had only released its final inspection report the day before the meeting, the Board had not had the opportunity to consider its findings in detail but was being asked to consider approving an action plan based upon issues identified within the requirement notice and “must do” and “should do” actions for the core services as had been discussed with both NHSI and CQC on 11th July.

He went on to say that the outcomes of the report would require detailed reflection over the coming weeks and, to that end, the Board would begin the process by holding an extraordinary meeting on 14th August to consider its findings and recommendations in full followed by further review at the August Board Seminar and September Away Day.

He stated that the inspection had found areas of poor practice in relation to some safety standards which was unacceptable and had to be improved adding that the ‘Good’ ratings in Maternity, Children & Young People’s Services and End of Life Care demonstrated that improvements made in these areas could be implemented as part of the DNA of the whole Trust.

J Walker then provided an overview of the report which explained that;
- The CQC had rated the Trust overall as requires improvement
- The safety and well-led domains at the Hillingdon Hospital were rated as inadequate, a deterioration from the requires improvement rating from our last inspection in 2015;
- Effective and responsive were rated as requires improvement and caring as good.
- Three of the Trust’s core services were rated as good, three as requires improvement and two services were rated as inadequate.
- In rating the Trust the CQC took into account the current rating of the core services at Mount Vernon which had not been inspected at this time.
- Well-led for the Trust overall, and the use of resources were rated as requires improvement.
- A requirement notice had been received following the well led inspection outlining key requirements that should be met to ensure regulatory compliance for the Urgent and Emergency Care service, Surgery and Outpatients and an action plan was returned to the CQC now being monitored by the Executive Team and progressed via the relevant core services.
- Safety and well led had been rated as inadequate in Urgent and Emergency Services and Surgery which resulted in the inadequate rating for the Hillingdon Hospital site; however four core services were rated as good for safety with two of those services also being rated as good for well-led, and one as outstanding.
The Board provided the following initial feedback and thoughts;

S Dhillon felt that staff morale would clearly be adversely affected by the findings of the report, and that the Executive and Divisional Directors should take time to step back to reflect on the themes of organisational culture, leadership and accountability in the report, as well as considering the impact of a lack of digital enablers in clinical practice.

C Coppell said the final report was very disappointing given how hard staff had worked and agreed with the Chair that the Board’s role now was to take a reflective role, think about smarter ways of working and identify the underlying causes that needed attention. She welcomed the special programme of Board to Ward visits which had now been arranged to take place over the next three months so Non-Executive Directors (NEDs) could share with the Executive a sense of the standard of services as they stood.

C Powell reflected that he felt the report sent two clear messages to the Board; that safety standards were inadequate and the Trust was not, overall, well led.

L Burke commented that it was important that the NEDs shared the same level of responsibility as the Executives in terms of any failings that should and could have been addressed across services, and that the key issue as far as she was concerned was the criticism of some very basic safety standards such as handwashing. She added that she felt the Trust should use the excellent feedback on culture and leadership in Maternity as a model for standards and practices across the Trust.

M Tattersall pointed out in relation to the issue of staff morale that the Trust should not lose sight of the fact that 22 of the 39 services reviewed were rated as acceptable or better and should use this message as a basis to help the 17 services not yet at that standard to improve.

A Khakoo pointed to the fact that there were other Trusts who had similar estates or IT issues yet still achieved better inspection ratings, and that staff could not be allowed to use these as a context for not achieving adequate safety standards.

J Smyth acknowledged that staff would be understandably disappointed, and they too would need a little time to stand back to reflect on the findings and that the Board may need to accept some immediate reactions might be somewhat defensive. He added he felt that in terms of a timeline that all the actions required to put right the findings of the inspection could be achieved within 6 months, but the critical question was being able to sustain improvement thereafter through cultural change.

The Chair summarised the position as follows;
• He was confident that the Trust could turn around what was, overall, a disappointing inspection result
• Critical in this respect was leadership across the Trust which needed to engage in wanting to see improvement and where robust performance action was needed to be taken then it should be
• The Board should recognise its responsibility to sustain staff morale across the Trust and to ensure that over the months ahead it worked with staff collectively to embed the changes needed
• That the Board could accept the actions taken to date in response to the Report pending engaging in the reflective process already referred to

The Board agreed;
The Action Plan relating to issues identified within the requirement notice, and must and should do actions for the core services provided prior to the final inspection report by CQC

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<th>12</th>
<th>National Inpatient Survey 2017</th>
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<tr>
<td>J Walker introduced a report for monitoring explaining that the National Inpatient survey 2017 looked at the experiences of 72,778 adult inpatients involved in 148 acute and specialist NHS Trusts who received overnight care and were discharged in July 2017 and that the report highlighted areas where patients reported positive and poorer aspects of patient experience and outlined the next steps to address areas for improvement.</td>
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<td>She reported in summary that;</td>
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<td>• 373 Hillingdon patients returned a completed questionnaire, giving a response rate of 30%</td>
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<td>• When compared with other organisations, the Trust performed ‘about the same’ as most other trusts that took part in the survey in 10 out of 11 sections</td>
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<td>• The Trust performed ‘worse’ than other trusts in the ‘overall’ section; 77% of patients felt overall, they had a good experience</td>
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<tr>
<td>• The majority of trusts in London ‘scored the same’ in all sections; two London trusts scored worse in one section and two trusts scored worse in two or more sections</td>
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The Chair sought clarification on relative scoring with other Trusts and in particular with the model hospital group Hillingdon belonged to, given the group of trusts used as benchmarks, whilst all in London, appeared random. J Walker confirmed that the definitions provided in the national report of “better”, “about the same “and “worse” provided no detail on the relevant scoring within each category on where a particular trust stood within that ranking, but that it was possible to provide a summary comparison with the Trust’s model hospital group within this confine which would be circulated to Board.

J Walker  suggested that consideration should be given to a campaign to encourage inpatients to "speak up" about their experience of hospital stay. J Walker agreed and the Chair said this proposal should feed into the
forthcoming LEAN programme.

The Report was noted

13 NHSI Performance Undertakings - performance

J Smyth introduced a report for monitoring asking the Board to review the first of monthly reports to either the Board or the Finance & Transformation Committee on compliance with the Enforcement Undertakings relating to A&E, finance and governance undertaken in June as reported earlier in the meeting.

He reported to the Board that activity and plans in relation to these undertakings had met the stated “milestones” in June and that the targets were extremely challenging and the Trust would have to continue to work hard to achieve them.

M Tattersall confirmed that the required actions in relation to financial compliance were already in train prior to the agreement being signed, and that NHSI had now indicated that the review of governance should not, in fact, form part of the Trust’s proposals for inclusion in its overall Well Led governance review and should be commissioned as soon as possible. The Chair sought clarification on the consequences of not meeting the overall financial trajectory currently proposed by the Trust. M Tattersall said that that NHSI was concerned that the current plan did not allow sufficient headroom for meeting the target and that the Finance and Transformation Committee would need to consider options for creating the expected efficiencies capacity at its meeting at the beginning of August which could then be proposed to NHSI.

C Powell asked whether the 90% September trajectory for the A&E four hour standard would be achieved. J Smyth said he felt this was achievable although thereafter the challenge for the Trust was that it would move into the “winter pressures” period which might threaten its sustainability.

The Report was noted

14 Integrated Quality & Operational Performance May and June 2018

J Smyth introduced a report for monitoring asking the Board to review the analysis of quality, experience and operational performance for May and June 2018 in relation to the Care Quality Commission's (CQC) intelligent Monitoring systems domains, safe, caring, effective, responsive and well-led.

He reported that Cancer Services remained under pressure to deliver to target time although there was an improving position on the length of stay. The Chair asked whether the forecast for cancer performance was a
significant risk. J Smyth reported he felt it was significant given the capacity to deliver the required level of MRI scans that were currently required.

S Dhillon remarked that the risk now recognised in relation to cancer performance, together with both the current A&E and referral to treatment time (RTT) performance represented a significant overall risk to the Trust in terms of the perception of NHSI.

J Walker reported that there had been four Colostrum Difficile (CDI) cases identified in June 2018 although none had been identified as lapses in care internally. There were a further four cases to date in July, two of these cases being found in the Stroke Unit which were now the subject of an investigation. The Chair requested a report back on the two cases found in the Stroke Unit.

On Complaints she also reported that performance in June was extremely poor and whilst this had improved in July, June’s performance level was unacceptable and that the merger of the complaints and PALS teams was to progress in order to provide sufficient capacity to manage issues of cover. The Chair stated that there was no assurance on the consistency of complaints performance and there would need to be further reassurance that the proposed merger would clearly make a difference.

The Report was noted

15  Financial Report – Month 3

M Tattersall introduced a report for monitoring stating that the month 3 financial position showed;

- A month 3 deficit of £1.6m, £0.8m behind plan.
- A year to date deficit of £6.5m, £2.8m adverse to plan.
- Agency expenditure of £0.8m in month, down on previous month.
- Pay being overspent by £0.4m in month.
- Efficiency savings of £0.5m in month.
- Capital expenditure of £0.4m in month.
- A cash position of £2.1m at month end.

He told the Board that whilst it was positive to see a continuing decrease in agency expenditure this remained higher than the expected equivalent increase in substantive pay.

The Chair pointed out that future financial reporting would require consideration in terms of the requirements under medium term financial reporting undertakings to NHSI and the existing report format.

T Roberts stated that he had concluded a piece of work on agency costs
which would be shared with the Board with a view to more detailed scrutiny initially at the Finance and Transformation Committee.

The Report was noted

16 Winter Planning 2018/19

J Smyth introduced a report for monitoring asking the Board to consider progress on developing a Winter Plan 2018/19 explaining that the proposed actions should strengthen winter resilience between November 2018 and April 2019.

He explained that the plan had taken account of lessons learnt from last year and had been produced following a system wide winter review hosted by the Trust and Hillingdon Clinical Commissioning Group (CCG) in June which had agreed there was a requirement for a collective approach on A&E capacity, additional escalation/de-escalation beds, patient flows, a system “escalation” process, stronger clinical leadership, change ownership and compliance reporting, weekly “stranded” patient reviews and overall system capacity challenges, and that these themes had been collated in a Hillingdon System Urgent and Emergency Care Improvement Programme (U&EC Programme).

S Dhillon asked for clarification on the proposed new management structure which would see two deputy directors of operations assume day to day responsibility for day to day services. J Smyth explained that one deputy director would have specific responsibility delivery of the U&EC programme. L Burke asked whether the new reporting arrangements would mean that current clinical ADOs would report directly to the deputy divisional directors meaning they could be held to account for the delivery of services. J Smyth explained that this would not quite be the case, and that the four divisions would be combined into two care groups CG 1 – medicine and CCSS, and CG2 – Surgery and W&C. Both CG’s would be led by 2 Clinical Divisional Directors and 1 Director of Operations (DOO). The DOO would oversee all non-medical staff and the Clinical Divisional Directors would manage all medical staff with joint responsibility for effectively managing each care group.

S Dhillon suggested that, as a Board, there was still a requirement to discuss with the CCG their plans for managing winter demands on the Trust through Primary and Community care, and that this should be an item of discussion at the next Board to Board meeting with the CCG in the Autumn.

The Report was noted

17 Corporate Risk Register and Board Assurance Framework
J Walker introduced two reports for monitoring asking the Board to review and provide challenge as appropriate on the progress of mitigation for extreme risks on the Corporate Risk Register (CRR) and all risks on the Board Assurance Framework (BAF).

The Chair pointed out that both registers would need review in light of the CQC Report. C Coppell added that in relation to the CQC Report the CRR should most definitely contain a new risk reflecting the consequences of staff failing to follow documented safety procedures.

Risk 532 – Non compliance and single points of failure with piped medical air systems – J Philpott confirmed that the residual risk level was incorrect and would require review and amendment.

Risk 773 – Life expired single steam main pipe from boiler house to main Hillingdon site – J Philpott explained the target date of 31st July 2018 for reducing the residual risk would require review based upon the report provided by the Trust’s insurance inspector.

R Whittington reported that the that the CQC had felt that the Board Assurance Framework process could be more robust and the Committee was seeking expert input as well as undertaking a review of assurance practices at Trusts who had been inspected and received positive feedback in this area.

The Reports were noted

<table>
<thead>
<tr>
<th>19</th>
<th>Medical Revalidation Report</th>
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<tbody>
<tr>
<td></td>
<td>A Khakoo introduced a report for decision asking the Board to approve sign off of the Compliance Statement and note the Annual Medical Revalidation Report for 2017/2018.</td>
</tr>
<tr>
<td></td>
<td>A Khakoo summarised the key facts as;</td>
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<tr>
<td></td>
<td>• At 31st March 2018, 96.80% of doctors with a connection to the Trust had undergone an appraisal in 2017-18.</td>
</tr>
<tr>
<td></td>
<td>• As the Responsible Officer (RO) he had submitted the Annual Organisational Audit to NHS England in May 2017.</td>
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<tr>
<td></td>
<td>• Dr J Johal had been appointed to the role of Director of Medical Professional Development in October 2017 and supported the process of Medical Appraisals and Revalidation.</td>
</tr>
<tr>
<td></td>
<td>In his capacity as Revalidation Champion C Powell pointed out that the Board could be assured that excellent progress in terms of revalidation had been made in 2017-18.</td>
</tr>
</tbody>
</table>
The Board agreed;
To approve the designated Statement of Compliance

<table>
<thead>
<tr>
<th>20</th>
<th>Safer Nurse Staffing - update</th>
</tr>
</thead>
<tbody>
<tr>
<td>J Walker introduced a report for monitoring asking the Board to note that;</td>
<td></td>
</tr>
<tr>
<td>• Despite ongoing pressures and nursing vacancies across inpatient areas, shift fill rates and Care Hours Per Patient Day (CHPPD) averaged across the month were stable and sufficient to support safe care</td>
<td></td>
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<tr>
<td>• At Hillingdon average fill rates and CHPPD were in line with previous months</td>
<td></td>
</tr>
<tr>
<td>• At Mount Vernon average fill rates and CHPPD were stable. Where these were showing below plan this was associated with flexing staff in line with varying activity on Trinity Ward</td>
<td></td>
</tr>
<tr>
<td>• At Hillingdon the Health Care Assistant (HCA) fill rate continued above plan, the primary driver being use of “specials” to support patients at risk and exhibiting behavioural difficulties</td>
<td></td>
</tr>
<tr>
<td>• The national reporting template would change in August meaning the format of the report would be reviewed for September Board</td>
<td></td>
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The Report was noted

<table>
<thead>
<tr>
<th>21</th>
<th>Royal Marsden Partners (RMP) Update – Cancer Alliance West London</th>
</tr>
</thead>
<tbody>
<tr>
<td>J Smyth introduced a report for information providing the Board with an update on the Trust’s achievements as part of RMP in redesigning a number of high volume cancer pathways to ensure that patients benefited from the latest technologies and innovations that were available in diagnostics and treatment.</td>
<td></td>
</tr>
</tbody>
</table>

The Chair commented that, overall, the Partnership appeared to be working well.

The Report was noted

<table>
<thead>
<tr>
<th>22</th>
<th>Report back from Committees – Finance &amp; Transformation, Quality and Safety, Audit &amp; Risk, Charitable Funds, Nominations, Remuneration.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Chair added that the Finance and Transformation Committee had approved the additional capital funding of £500k for the A&amp;E expansion project.</td>
<td></td>
</tr>
</tbody>
</table>

The Report was noted

<table>
<thead>
<tr>
<th>23</th>
<th>Minutes of Committee Meetings</th>
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</table>
## Questions from the Public

### 25 Questions from the Public

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical waste used to be stored in cupboards on the Wards? Is this still the case?</td>
<td>It will depend upon the clinical area. Some may be stored at the end of a Ward area or possibly outside the clinical area completely.</td>
</tr>
<tr>
<td>Does the Trust have a Health &amp; Safety Officer?</td>
<td>Yes, there is an Assistant Director of H&amp;S that reports to the Finance Director.</td>
</tr>
<tr>
<td>Is it necessary to have boxes of stationery and other boxes in places stacked up everywhere, all across the Hospital?</td>
<td>The Trust has a Fire Safety officer who inspects the hospital identifying potential fire hazards and all staff receive fire safety training as part of their induction.</td>
</tr>
<tr>
<td>What financial contribution is the company running the Urgent Care Centre to the cost of the refurbishment of the Centre and A&amp;E?</td>
<td>The improvements are principally to the A&amp;E area, not the UCC and they are not making a contribution given they are tenants who rent the space from the Trust.</td>
</tr>
<tr>
<td>What is happening with the suggestion made at the People in Partnership (PIP) meeting that that food in reach of a patient is always cut up?</td>
<td>This should happen as a matter of course in any event and we have a red tray system for patients who need assistance with food.</td>
</tr>
<tr>
<td>What is the attitude of the Board to “John’s Campaign” on carers and family access?</td>
<td>We are fully supportive of the campaign and we have also taken the view this should not just be about support for patients with dementia and so we have developed a carer’s passport scheme for all types of care requirements, so carers can stay outside of normal hours, have access to refreshments and receive an advice pack on discharge.</td>
</tr>
<tr>
<td>Why is the public not being told about your plan to build a new hospital in Brunel?</td>
<td>The Trust is not at the stage of public consultation and when we...</td>
</tr>
</tbody>
</table>
are we will enter a programme of proper local engagement. At this stage we are only submitting what’s called a “Pre-Strategic outline case” to progress planning.

Question: What’s your attitude to the new Health Service Safety Investigations Body and why won’t it talk to patients?  
Response: We welcome the establishment of any investigative body in the health service and it’s our understanding it will talk to patients.

Question: Is there a Board meeting on 14th August?  
Response: Yes, there will be a public Board meeting between 2pm – 4pm on at Hillingdon Hospital on 14th August.
Present:
Richard Sumray   Chair
Soraya Dhillon    Deputy Chair and Non-Executive Director
Lis Paice    Non-Executive Director
Cheryl Coppell    Non-Executive Director
Linda Burke    Associate Non-Executive Director
Shane DeGaris    Chief Executive
Abbas Khakoo    Medical Director
Terry Roberts    Director of People and Organisational Development
Joe Smyth    Chief Operating Officer
Jacqueline Walker    Director of Patient Experience and Nursing

Apologies:
Keith Edelman    Non-Executive Director
Carl Powell    Non-Executive Director
Richard Whittington    Non-Executive Director
Matt Tattersall    Finance Director

In Attendance:
Monica Whittle    Divisional Director Cancer and Clinical Support Services
Jeremy Philpott    Director of Strategic Estate Development & Asset Management
Mike Sims    Trust Secretary

Members of the Public
V Cook
K Gilbey
C Lamb
C Holly
<table>
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<tr>
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<th>Action</th>
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<tbody>
<tr>
<td><strong>Introductory</strong></td>
<td></td>
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<tr>
<td>1</td>
<td><strong>Welcome and Apologies for Absence</strong></td>
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<tr>
<td></td>
<td>The Chair welcomed all to the meeting and gave apologies for;</td>
</tr>
<tr>
<td></td>
<td>Keith Edelman Non-Executive Director</td>
</tr>
<tr>
<td></td>
<td>Carl Powell Non-Executive Director</td>
</tr>
<tr>
<td></td>
<td>Richard Whittington Non-Executive Director</td>
</tr>
<tr>
<td></td>
<td>Matt Tattersall Finance Director</td>
</tr>
<tr>
<td>2</td>
<td><strong>Declaration of hospitality, Declaration of amendments to the Register of Interests, Declarations of Interest on items on the Agenda</strong></td>
</tr>
<tr>
<td></td>
<td>None</td>
</tr>
<tr>
<td>3</td>
<td><strong>Declaration of Any Other Business</strong></td>
</tr>
<tr>
<td></td>
<td>None</td>
</tr>
<tr>
<td><strong>Discussion</strong></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td><strong>Outcome of the Care Quality Commission’s (CQC) Inspection Report of Hillingdon Hospital</strong></td>
</tr>
<tr>
<td></td>
<td>The Chair introduced the discussion by saying that;</td>
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<td>• The meeting should be used to get a sense of direction in terms of how to respond to the report as well as continue the debate at the August Board Seminar and September away day and therefore the meeting should be thought of as part of a longer reflective process</td>
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<tr>
<td></td>
<td>• The Trust already recognised that responding to the CQC report was not a “tick box” exercise and more fundamental organisational issues needed consideration</td>
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<td>• However, what had to be achieved in the short term was the CQC not returning and finding such a mixed picture as the report reflected, particularly in relation to some fundamental safety standards</td>
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<td>• There was also a recognition that the Trust needed to learn from service areas that have been rated as good or outstanding as well as ensuring it had looked at best practice and learning from elsewhere in the acute sector</td>
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<tr>
<td></td>
<td>• Board Members had already circulated between themselves personal reflections on the report and those that had not done so were asked to</td>
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</table>
provide their thoughts in writing via the Trust Secretary

J Walker then set the context for the discussion by reporting that;

- The Care Quality Commission (CQC) had inspected all eight core services provided by the Trust at the Hillingdon Hospital site in March and April 2018 and NHS Improvement (NHSI) had visited the Trust on 2 May 2018 to conduct a ‘Use of Resources’ assessment as part of the revised inspection regime.

- The CQC had rated the Trust overall as ‘Requires Improvement’. The safety and well-led domains for the Hillingdon Hospital site were rated as ‘Inadequate’, the effective and responsive domains were rated as ‘Requires Improvement’ and caring as ‘Good’. Three of the Trust’s core services were rated as ‘Good’, three as ‘Requires Improvement’ and two services were rated as ‘Inadequate’. In rating the Trust the CQC had taken into account the current rating of the core services at the Mount Vernon site which had not been inspected at this time. Well-led for the Trust overall, and the use of resources were rated as ‘Requires Improvement’.

- The ratings assigned to the core services for the five key domains presented a very mixed picture for the organisation, in that:
  - Safety and well led were rated as ‘Inadequate’ in Urgent and Emergency Services and Surgery (a deterioration from ‘Requires Improvement’) which resulted in the ‘Inadequate’ rating for these core services and for the Hillingdon Hospital site overall
  - Three core services were rated as ‘Good’ overall: Maternity, Children and Young People’s services and End of Life Care (this was an improvement from the previous rating of ‘Requires Improvement’). Four core services were rated as ‘Good’ for safety with two of those services also being rated as ‘Good’ for well-led, and one as ‘Outstanding’
  - From the previous inspection in 2015 the Trust has reduced the number of ‘Requires Improvement’ ratings and doubled the number of ‘Good’ ratings
  - There were several areas noted as areas of concern for the inspectors as part of the well-led assessment which were outlined in the report
  - Due to areas of concern in three of the core services a requirement notice was issued to ensure regulatory compliance; these covered requirements under Regulation 12, Safe care and treatment and Regulation 17, Good governance
Although the report outlined, for the core services, 13 ‘must-dos’ - Urgent and Emergency Care (5), Surgery (5), Outpatients (2) and Critical Care (1) there were 61 ‘should-dos’ - (Urgent and Emergency Care (11), Surgery (8), Medical Care (9), Outpatients (5), Critical Care (22), End of Life Care (4) and Maternity (2); there were also several areas for improvement under the areas of well-led and governance.

She added that;

- The Executive Team, the Trust Chair and the Non-Executive Director Chair of the Quality and Safety Committee attended a meeting with senior NHSI and CQC officials on 11th July to discuss the findings of the inspection and the initial, immediate actions being taken and to agree next steps with regard to monitoring and what support may be required

- She had met with the Quality Improvement Team at NHSI to agree immediate support actions to review the robustness of policy and procedures in some key areas of compliance and to provide support and guidance on a strengthened regulatory assurance framework

- A Quality Summit was organised for 25th September 2018 to engage with local key stakeholders on the outcome of the inspection, actions to be taken and the support that may be required with NHSI and the CQC in attendance supporting the summit meeting

- Over 200 staff had attended briefings on the Inspection Report

The Chair asked those present to each provide their reflections on the report.

S DeGaris said;

- The key issues for him were the poor result in A&E which, given pressures, was not necessarily unexpected but its unsatisfactory clinical safety was a shock

- The Surgery rating was also a shock and there was a need to consider how clinical leadership was going to be supported in this area

- The Trust had received a more positive verbal feedback from the CQC on the inspection than the report finally submitted

- He felt it was very much a mixed picture and key issue would be getting leadership teams to support change which would mean being tougher on poor clinical practice, using the LEAN programme to consider thematic change as well as ensuring better Board visibility across the “shop floor”
M Whittle said;
- The Trust had to establish whether there was a fundamental clinical services issue or whether it was only whether when under pressure that they failed
- She accepted that in Cancer and Clinical Support Services there was a weakness in clinical governance on lasers and the Division should have done better in this respect
- She felt the report, in a way, was acting as a positive force for staff in galvanising them to want to prove that excellent services could be provided

L Paice said;
- She believed the report could provide an opportunity to work more closely with external partners to secure more system wide resources, in particular for integrated care and the provision of more services in the community

J Smyth said;
- There had been too detailed a management focus in A&E on overcrowding and patient flow as opposed to monitoring safety standards
- The Trust had not managed to change the culture on safety standards
- The Board needed to see the report as an opportunity not a threat and communicate this to clinical staff
- The Board needed to grasp the challenge to turn around services that had failed in at most six months, although the rest of Board felt three to six months was a more likely timescale for further inspection

C Coppell said;
- Non-Executive Directors (NEDs) had concentrated too much on the detail of assurance checklists and felt there was a need for the Executive to be clearer, and perhaps more realistic, about key areas that were failing that required Board focus if change was going to be achieved
- Whilst the recent increase in the frequency of Board to Ward visits was to be supported, unless there was some estates funding available to get small things fixed then the exercise could backfire and the Board needed to assess the risk of this
- There was a lack of a Surgical Strategy which would assist the Board in making potentially radical decisions about which services the Trust
should or should not be providing given the finite and limited available resources to do so.

- She questioned whether the Board as yet properly understood the real drivers required to deliver cultural change across the Trust

J Walker said;

- She had been shocked at Surgery rating
- She had been disappointed about other safety standards not achieved and needed to understand whether this was just when services were “in extremis” or not
- She was keen to think through in more detail the well-led findings
- The Executive needed to accept that it could not assume clinical staff know and understand existing policy and procedure
- She remained very concerned on the poor rating for Infection Prevention Control (IPC) and suggested a new radical approach to achieving standards was required, and that deep dives into both ICP and Adult Safeguarding as another area of concern were required
- Individually, she would need to be more visible, hold more people to account and, importantly, challenge others on clinical safety standards
- In terms of organisational change there were clinical frameworks of accreditation that could be introduced as a means of attaining and then sustaining excellent quality and safety service standards which needed to be considered

J Philpott said;

- He had not been surprised to see the estate featuring so significantly in the report and wondered to what extent the overall clinical assessments may have been influenced by its poor condition
- He would like to see a dedicated CQC estates budget each year as well as initiating a surgery based approach with the Wards so that minor repairs could be identified, and those that were to be done immediately agreed or otherwise

A Khakoo said;

- He felt some areas of clinical service had in fact improved over the last few years which had led to a degree of complacency within the clinical leadership
- The whole Board needed to own all of the report with, in particular, the Executives both supporting each other as well as providing more robust
challenge to each other on performance management

- On sepsis he should take some personal responsibility for the failure to meet expected standards
- He had already found that being more visible in clinical areas was proving to be more effective
- Personally, he had now changed from three to four Medical Director days a week to focus on management as opposed to clinical commitments and was planning to use a Business Manager to assist in this process

L Burke said;

- The report had highlighted that the Trust was not embracing a culture of safety and the vast majority of the commentary in the report concerned this
- Staff may well be caring but the Trust needed to stop referring to them as “excellent” all the time because, clearly, in terms of ensuring that safe standards were always delivered the report evidenced that this was not the case
- Staff needed to learn from the best in terms of benchmarking and this could be achieved using a combination of the excellent and good internal services as well as external sources
- Critically, staff needed to be more challenging with each other, regardless of superiority, on clinical safety standards

T Roberts said;

- He had been disappointed that some staff were reported as being unaware of the Trust's CARES values
- A number of issues about personal responsibility, attitude and safety were clearly not understood by staff and the challenge remained to make this part of the Trust “DNA”, in particular through achieving the vision of the People Strategy

Soraya Dhillon said;

- The Board should reflect where the Trust was in 2015 and review the Report in that context
- Safety failures in the recent inspection were unacceptable
- The organisation lacked a culture of accountability
- There was a disconnect between middle management in terms of leadership and accountability from the expectations and standards
expected by the Board, and why this was happening needed to be bottomed out

M Hughes reported on M Tattersall’s reflections and said;

- He had been shocked that two services were rated as “Inadequate”
- He had been frustrated at the CQC process and quality of the report
- However, he remained positive in that the Trust had more than doubled the number of individual ‘good’ ratings since the last inspection

- The Board talked about accountability and responsibility, but the evidence suggested slow progress in this respect as well as always referring to the requirement to change culture but not enough about how that would actually be achieved

- The report findings had to be owned by the services so they could build their own solutions and the Board’s role was to find out how it can support them in achieving this

The Chair said;

- There had to be a clearer sense of leadership and ownership both individually and in teams that were working collaboratively for the benefit of each patient journey and there needed to be learning from the approach to leadership and team working from examples like End of Life Care which had exhibited a collective responsibility for developing and improving the service

- The LEAN programme offered the opportunity for a systematic methodology for achieving operation improvement

- The Trust needed to evaluate the quality not just the quantity of its training programmes

- The Board had to be more robust in challenging poor performance

- There needed to be more focus on not only personal development plans but a new focus on team objectives and team development plans to engender a sense of cross-organisational collective purpose

The Chair asked S Degaris for his reflections on the key issues having heard from those present. S DeGaris said;

- He agreed with point made on clearer and more honest evaluation on performance and assurance statements

- He agreed with the requirement for more Board visibility but that this had to be sustainable
- He liked the notion of a CQC estates “fighting fund” and surgeries
- The Executive required more time to think about the service areas where there was apparent poor understanding of the CARES values and how better consistency across the Trust might be achieved
- He agreed that the Executive needed to organise itself to ensure the review of both quality and safety as well as patient flow in particular in A&E took place in equal measure

The Chair asked the Board for any other further reflections. C Coppell said the Board needed to consider whether, in fact, even more investment was required in A&E if the CQC’s return time might only be three months. The Chair commented that this may require considering whether the calibre of clinical staff in A&E was of a standard necessary to achieve the desired outcomes.

J Walker added that there would be a dedicated CQC resource available from September in terms of a post to head the Trust’s management of the work resulting from the report and that she felt a Board Sub-Committee established to review overall accountability in this respect should be considered.

The Chair provided the following summary of the discussion;

- The Trust needed to be tougher on clinical safety standards and dealing with poor performance
- There needed to be much more challenge between staff on clinical safety and a requirement to grow the confidence of staff to challenge upwards where required, not just across or downwards
- The Trust needed to utilise the LEAN framework as the methodology for quality development
- The Board needed to be more visible
- An evaluation of whether there was a fundamental flaw in clinical services or just failures at times of service pressure was required
- The Trust needed to identify and harness the energies of those staff who are unhappy with the outcome of the inspection as a means of motivating wider groups of staff
- That developing services and solutions to improve services in partnership with patients was critical
- All Board members needed to more clearly hold each other to account
- That the Executive needed to exhibit more caution in terms of “optimism bias” i.e. a simpler and more honest approach to assurance and
• That the Trust needed to consider developing “Compacts” between different parts of the organisation as well as the implementation of an accreditation framework

• There should be deep dives into IPC, Adult Safeguarding and the quality of training

• The Estates Division should most definitely consider engaging directly with staff through surgeries

• That there needed to be a programme of learning from the best – both internally and externally

• The Board had to hold a strategic discussion on what services the Trust should or should not be delivering and a Clinical Strategy proposal was required in order to do so.

• Critically, there needed to be thought about the development of a “Team Hillingdon” or similar initiative to promote team objectives with shared knowledge about how the internal system worked across the Trust to prevent Teams from working in silos.

Questions

5 Questions from the Public

**Question**: How will the Trust be able to tell a good story about the hospital?
**Response**: We will need a discussion on explaining the Trust has a majority of good services within the context of some poorly rated services in the CQC report.

**Question**: Could we have an explanation on using handcuffs throughout the hospital?
**Response**: The CQC report refers to one instance of an aggressive patient in A&E who was restrained as he lashed out, providing a risk to other patients and staff in doing so. This action was taken having completed an on the spot risk assessment and was compliant with procedures.

**Question**: What is the attitude of the NEDs on holding monthly or bi-monthly meetings?
**Response**: This will be reviewed at the September Board meeting.

**Question**: How will you address the issues of dangerous nursing staffing levels?
**Response**: We report the nursing fill rates at each public Board meeting providing and recognise the ongoing requirement to recruit more permanent nurses but this is set in the context of a national nursing vacancy rate of between 60,000 to 70,000.

**Question**: What is the Board’s response to the CQC’s view that the Trust has an excessive length of stay for patients?
**Response:** The report is mistaken in quoting the average length of stay for Surgery was 33 days and in fact it is more like 3.5 days.
<table>
<thead>
<tr>
<th>Action No.</th>
<th>Meeting Date</th>
<th>Item</th>
<th>Action</th>
<th>Lead</th>
<th>Due Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>198</td>
<td>Nov 17</td>
<td>Patient Story</td>
<td>Ensure continued awareness about EoLC to all Wards not just the two wards which experienced the most deaths</td>
<td>JW</td>
<td>Oct 18 (Board)</td>
<td>Noted this was now being considered for the October Board Seminar.</td>
</tr>
<tr>
<td>206</td>
<td>Jan 18</td>
<td>Patient Story</td>
<td>Report back on possible proposal to make a video on transition from children to adult services</td>
<td>TR</td>
<td>Sept 18 (Board)</td>
<td>T Roberts stated the Charity Director had indicated that charity funding for a video was inappropriate but he intended to hold further discussions on this point. The charities Director has confirmed this proposal now as finally rejected - completed</td>
</tr>
<tr>
<td>216</td>
<td>Jan 18</td>
<td>Learning from Deaths</td>
<td>Establishing the position of a Mortality Nurse or similar post</td>
<td>AK</td>
<td>Sept 18 (Board)</td>
<td>At the March meeting A Khakoo reported a business case was still being considered, with bank staff currently being used to cover the role with any final recruitment to a permanent post possibly taking until the summer. The September update is that Bank staff from Director of Nursing budget is being used to safely cover the work required and a job description for mortality nurse is with P&amp;OD for job matching, then will require business case to be agreed</td>
</tr>
<tr>
<td>221</td>
<td>Mar 18</td>
<td>Integrated Care Partnership</td>
<td>Provide an update on system risks in terms of governance and finance at the end of the Quarter 1 2018-19</td>
<td>JS</td>
<td>Sept 18 (Board)</td>
<td>Included on Sept Agenda - completed</td>
</tr>
<tr>
<td>223</td>
<td>Mar 18</td>
<td>Performance</td>
<td>On short term sickness relating to colds and flu the Chair asked the Executive to consider whether it was feasible for managers to ask at return to work interviews if staff had received the free Flu</td>
<td>TR</td>
<td>Sept 18 (Board)</td>
<td>Chair to discuss offline with T Roberts but a future report required in September on uptake of flu vaccine required. Flu report on Sept agenda - completed</td>
</tr>
<tr>
<td></td>
<td>Date</td>
<td>Topic</td>
<td>Details</td>
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<tr>
<td>226</td>
<td>Mar 18</td>
<td>People Strategy Update</td>
<td>L Burke asked whether performance reflected seasonal trends. T Roberts said that seasonal trends were reported in the appendices but the way in they were not structured in this way, but performance could be represented would be reviewed to see if they could be made clearer. TR Sept 18 (Board) Included on Sept Agenda - completed</td>
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<tr>
<td>228</td>
<td>Mar 18</td>
<td>Staff Survey 2017</td>
<td>Confirm full utilisation of NEDs as mentors for the BAME mentoring programme TR May 18 (Board) At least 6 BAME members have confirmed they would welcome Board level mentorship. Only 1 NED has to date confirmed formally a willingness to act as a mentor - completed</td>
<td></td>
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<tr>
<td>230</td>
<td>Mar 18</td>
<td>Medical Education</td>
<td>Role of Physician Associates - Medical Director together with the HR Team needed to focus more clearly on mapping out requirements, rather than reverting to continuing to recruit Doctors in a traditional manner. AK Nov 18 (Board) Response will be provided in November</td>
<td></td>
<td></td>
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<tr>
<td>236</td>
<td>Mar 18</td>
<td>Developmental review of Well Led Framework</td>
<td>Clarify a number of the recommendations with KPMG JW Sept 18 (Board) Executive meeting with KPMG took place – update on actions to return when Board reconsiders well led proposals post receipt of CQC inspection outcomes in September. Paper being presented at September Board meeting outlining actions post KPMG review and following receipt of the CQC inspection report - completed</td>
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</tbody>
</table>
| 240 | May 18 | Quality and Performance Indicators for Board Assurance - 2018/19 | Report back on whether patient mobility indicator can be used JW Sept 18 (Board) Data collected during the #EndPJParalysis 70 Day Challenge (patient dressed, patient mobile) is not robust enough to report meaningful data to support critical review of a mobility indicator. There is variability in the quality of data as not all wards either submitted/collected the data or in a reliable fashion (range of 44 – 196 patients per...
Therapies do not as yet capture mobility data separately as such but they have been asked to explore this and this will be reviewed at the EndPJParalysis working group. A final response on whether a patient mobility indicator is feasible is not yet possible and so the action is behind schedule.

| Week | DATE | Task Description | Responsible | Due Date | Status
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</thead>
<tbody>
<tr>
<td>241</td>
<td>May 18</td>
<td>Report back on Medications Safety Indicator that could be reported in KPIs to Board in the Integrated Performance report</td>
<td>AK</td>
<td>Sept 18 (Board)</td>
<td>Future reports will include percentage of medicines missed of all medicines as well as medicines reconciliation. A Khakoo agreed to review the use of a “quality” medicines indicator and discuss suitability with S Dhillon in advance of September Board. This has been delayed to November due to Medication Safety Committee needing more time to review (in light of NED comments) and make recommendations to Medical Director</td>
</tr>
<tr>
<td>243</td>
<td>May 18</td>
<td>Benchmark against a Trust that is both ‘best in class’ and in surplus</td>
<td>MT</td>
<td>Sept 18 (Board)</td>
<td>At the suggestion of NHSI a meeting was held with Kingston Hospital NHSFT. No material differences identified in approach and both Trusts are exploiting similar opportunities. In conjunction with updating the Long Term Financial Model, further benchmarking opportunities will be explored -completed</td>
</tr>
<tr>
<td>244</td>
<td>May 18</td>
<td>Produce a Governors FPPT Policy</td>
<td>MS and TR</td>
<td>Nov 18 (Board)</td>
<td>Update not due until Nov</td>
</tr>
<tr>
<td>246</td>
<td>July 18</td>
<td>Provide a summary comparison with the Trust’s model hospital group</td>
<td>JW</td>
<td>Sept 18 (Board)</td>
<td>Circulated 20/08/18 - completed</td>
</tr>
<tr>
<td>247</td>
<td>July 18</td>
<td>L Paice suggested that consideration should be given to a campaign to encourage inpatients to “speak up” about their experience of hospital stay. J Walker agreed and the Chair said this proposal should feed into the Patient Experience and Engagement Strategy currently being consulted on to be presented to October QSC and November Board; this includes the principle of patients speaking up on safety. A commitment within the strategy is to deliver an active patient engagement model in patient safety</td>
<td>JW</td>
<td>Oct 18 (QSC) Nov 18 (Board)</td>
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</table>
forthcoming LEAN programme.

<table>
<thead>
<tr>
<th>Date</th>
<th>Month</th>
<th>Section/Event</th>
<th>Details</th>
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<tbody>
<tr>
<td>248</td>
<td>July 18</td>
<td>Integrated Quality &amp; Operational Performance May and June 2018</td>
<td>Report back specifically on the 2 CDI cases found in the Stroke Unit in September Performance Report JW Sept 18 (Board) Ribotyping results were received on the two cases that were co-located in time and place on the Stroke Unit – these results showed the same strain, and even though this is the most common circulating strain, it can be assumed that the second case was likely to have been a result of cross infection. The cases have had full RCA investigation and are under review by our commissioners. - completed</td>
</tr>
<tr>
<td>249</td>
<td>July 18</td>
<td>Integrated Quality &amp; Operational Performance May and June 2018</td>
<td>The Chair stated that there was no assurance on the consistency of complaints performance and there would need to be further reassurance that the proposed merger would clearly make a difference. JW Sept 18 (Board) Complaints performance has improved in July and August as outlined in the Quality and Performance report being presented to Board. Performance is being closely monitored with weekly hotlist review by each division and the Complaints Management Team. The merger of the Complaints and PALS team is currently under consultation. <strong>Board will need to determine at Sept meeting if response is sufficient to close off action.</strong></td>
</tr>
<tr>
<td>250</td>
<td>July 18</td>
<td>CRR and BAF</td>
<td>a) CRR to contain risk reflecting the consequences of staff failing to follow documented safety procedures. b) Risk 532 – None compliance and single points of failure with piped medical air systems – J Philpott confirmed that the residual risk level was incorrect c) Risk 773 – Life expired single steam main pipe from boiler house to main Hillingdon site – J Philpott explained the target date of 31st July 2018 for reducing the residual risk would require review based upon the report provided JW Oct 18 (ARC) This risk will be added to CRR in time for October ARC This risk will be added to CRR in time for October ARC This risk will be updated on CRR in time for October ARC</td>
</tr>
</tbody>
</table>
by the Trust’s insurance inspector.

<table>
<thead>
<tr>
<th>#</th>
<th>Date</th>
<th>Source</th>
<th>Issue</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>251</td>
<td>July 18</td>
<td>BAF</td>
<td>R Whittington reported that the CQC had felt that the Board Assurance Framework process could be more robust and the Committee was seeking expert input as well as undertaking a review of assurance practices at Trusts who had been inspected and received positive feedback in this area.</td>
<td>JW</td>
</tr>
<tr>
<td>252</td>
<td>Aug 18</td>
<td>CQC Report</td>
<td>Four NEDs to circulate their personal reflections via Trust Secretary to rest of Board</td>
<td>2 NEDs</td>
</tr>
</tbody>
</table>
Report title: Chief Executive Report

Report author: Michael Sims, Trust Secretary
Report sponsor: Derek Smith, Interim Chief Executive

Board Action required:
The Board are asked to:
Note updates from the Chief Executive.

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

STRATEGIC PRIORITY:
None
Appointment of an Interim and Permanent CEO

With the departure of Shane DeGaris at the end of August, the Trust has appointed both an interim and permanent CEO. Derek Smith took over as Interim CEO on 5th September and Sarah Tedford has been appointed as the new permanent CEO and will commence in her role at the end of November.

Derek has held interim CEO positions in a variety of Trusts. He previously had been an NHS CEO, among others, at Hammersmith Hospitals and Kings College Hospital. Sarah has more than 30 years NHS experience with many of those spent working at a senior level and will be joining us from Manchester Royal Infirmary University Hospital, where she is currently Chief Executive.

Emergency Care

The performance and quality of service in our Accident and Emergency Department continues to be the key priority for the Trust. The Board reports contain a proposal on new governance arrangements which will streamline the activity intended to achieve sustained improvement in the delivery of care to emergency patients. Additionally the papers include a report on progress with the Undertakings the Trust agreed with NHSI in June on reporting performance and governance arrangements to them. Current performance in the week before the Board meeting stood at 85.6% against the 90% target for treating patients within 4 hours.

The building works to expand and refurbish the Department continue on track to be completed in November. The Trust now has additional capital to expand its capacity for ambulatory emergency care, which will also help suitable patients to be directed out of the Emergency Department into ambulatory pathways.

Care Quality Commission (CQC) compliance

The CQC improvement plan containing the ‘must do’ and ‘should do’ actions from the CQC inspection report continues to progress. Work has commenced on the collection of evidence to support the completed actions in the plan. A check and challenge approach is being undertaken by the Interim Assistant Director of Regulatory Compliance to provide assurance that the processes outlined in the action plan are being sustained and embedded.

The Trust has developed an organisation-wide themed action plan to ensure that key areas of focus are addressed instituting a positive culture of continuous quality improvement and strong staff and patient engagement and ownership. This will be enabled by the Hillingdon Improvement Practice programme, supported by NHS
Improvement. The Trust will also implement a Ward and Department Accreditation scheme to develop a cycle of improvement, support and learning across the organisation. This will be complemented by themed Clinical Fridays where key subjects in line with the Fundamental Standards of Care will be assessed, gaps identified and action taken to improve outcomes. These were presented, discussed and endorsed at the Board’s recent away day event.

Quality Summit

As part of the key interventions that the Trust Board is taking to meet CQC requirements a Quality Summit will take place with key stakeholders on 25th September. This event includes participation from our commissioners, CQC, NHS Improvement and NHS England. The Summit will provide an opportunity to discuss the support and actions that the key stakeholders can offer to support the Trust with its transformation plans in the immediate and longer term future. Key themes to be discussed are:

• Infection prevention and control
• Managing activity pressures and capacity
• Improving culture and accountability
• Supporting our workforce
• Managing an aged estate

A Board report providing an outline of the Trust’s improvement plan will be presented at the November 2018 meeting.

Annual Members Meeting 2018

The Annual Members Meeting took place on 17th September with a themed discussion on the potential for the Trust to build a new acute and healthcare facility on the Brunel University site. Paul Thomas, Chief Operating Officer and Professor Paul Hellewell, Dean of College for Health and Life Sciences, both from the University, gave presentations on the partnership’s work to date on developing plans for a this new site. There was, overall, great support from Members and members of the public present to continue to develop a business case for the proposal. The Chair will provide more detail on the meeting in his report to Board.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 26th September 2018
Agenda item 9

Report title: Developmental review of leadership and governance

Report author and sponsor: Jacqueline Walker, Director of the Patient Experience and Nursing

Board Action required:

The Board is asked to:

1. Note the information within the report on the requirement for an independent review of leadership and governance in line with NHS Improvement guidance on developmental reviews using the Well Led Framework (NHS Improvement, 2017).

2. Approve the recommendation that the Trust proposes to NHS Improvement the extension of the current ‘Undertakings’ review to support the Trust’s well led developmental review. This will support a more cost-effective approach in relation to the completion of these two reviews. The Audit and Risk Committee will need to approve this extension on behalf of the governors.

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

STRATEGIC PRIORITY:

e) Delivery Area 5: Ensure we have safe, high quality sustainable acute services  
f) Improving the present - A&E 4 hour standard - 18 week Referral to Treatment - Meet cancer targets - Complete CQC action plan - Implement year 2 of Quality and Safety Improvement Strategy - Maintain finance and use of resources score of 3 - Meet control total
1. Introduction

The boards of NHS foundation trusts and NHS trusts are responsible for all aspects of the leadership of their organisations. They have a duty to conduct their affairs effectively and demonstrate measurable outcomes that build patient, public and stakeholder confidence that their organisations are providing high quality, sustainable care. Robust governance processes are essential in giving the leaders of these organisations, those who work in them, and those who regulate them, confidence about their capability to maintain and continuously improve services.

In-depth, regular and externally facilitated developmental reviews of leadership and governance are good practice across all industries. Rather than assessing current performance, these reviews identify areas of leadership and governance of organisations that would benefit from further targeted development work to secure and sustain future performance.

NHS Improvement (NHSI) strongly encourage all NHS trusts to carry out externally facilitated, developmental reviews of their leadership and governance using the well-led framework every three to five years, according to their circumstances (NHSI, 2017); this is now due for the organisation.

The guidance on the well-led framework for leadership and governance developmental reviews sets out the process and content of these reviews. It supports providers to maintain and develop the effectiveness of their leadership and governance arrangements. The structure of the framework is wholly shared with the Care Quality Commission (CQC), and underpins CQC’s regular regulatory assessments of the well-led question.

The well-led framework is structured around eight key lines of enquiry (KLOEs), as below; the scope of the developmental review should cover the eight KLOEs at an appropriate level.

<table>
<thead>
<tr>
<th>KLOE</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is there the leadership capacity and capability to deliver high quality, sustainable care?</td>
</tr>
<tr>
<td>2</td>
<td>Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?</td>
</tr>
<tr>
<td>3</td>
<td>Is there a culture of high quality, sustainable care?</td>
</tr>
<tr>
<td>4</td>
<td>Are there clear responsibilities, roles and systems of accountability to support good governance and management?</td>
</tr>
<tr>
<td>5</td>
<td>Are there clear and effective processes for managing risks, issues and performance?</td>
</tr>
<tr>
<td>6</td>
<td>Is appropriate and accurate information being effectively processed, challenged and acted on?</td>
</tr>
<tr>
<td>7</td>
<td>Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?</td>
</tr>
<tr>
<td>8</td>
<td>Are there robust systems and processes for learning, continuous improvement and innovation?</td>
</tr>
</tbody>
</table>
2. **Self-Review of governance and leadership using the well-led framework**

The NHSI guidance advises that regular self-review, outside of an externally facilitated developmental review, helps to promote self-knowledge, reflection and vigilance, and the development and improvement of leadership and governance. As with the scope of the developmental review, boards are responsible for setting the scope of regular self-reviews, but it is suggested that they should cover the full scope of the well-led framework (as above) at an appropriate level. Ideally, self-reviews are to be carried out annually but providers should determine this for themselves.

The Trust commissioned KPMG as a nominated provider lead to undertake an assessment as part of the self-review exercise via a desktop inspection in early 2018. The inspection used three sources of data:

- KPMG’s own external assessment of 2014
- Previous governance self-assessments from January 2016 and 2017
- A Board survey of well led characteristics carried out in late 2017

The output of the review included the self-review questionnaire, ratings and rationale for the ratings and a development action plan. Areas of good practice and areas for improvement were noted in the report as presented to and signed off by the full Board at its March 2018 meeting.

The Executive Team considered the options outlined to the Board on how it was to progress the development of leadership and governance using the eight key characteristics of the framework. It was agreed that the decision to commission an external review of leadership and governance under the well-led development review guidance would be deferred until such time as the Trust has been advised of the findings of the well-led element of the CQC inspection, which had recently taken place at that time, and which would in turn inform any decision on the timing and scope of an external review. This was agreed by the Board at that time and that this decision would be referred back to the Board once the outcome of the CQC inspection was received.

The CQC rated well-led for the trust overall as requires improvement, however this was rated as inadequate for the Hillingdon Hospital site. The CQC noted 16 areas of concern under the well-led domain for the trust overall however there were also 16 areas under well-led that were deemed as demonstrating good practice.

The outcome of the review undertaken by KPMG will be presented to the appointed external facilitator for comments and further discussion as part of the Trust’s well-led developmental review to agree areas for further scrutiny with the Board, as outlined below.

3. **Commissioning an external facilitator**

Boards need to assure themselves that the appointed external facilitator is independent and able to provide a robust and reliable judgement of a provider’s leadership and governance. The facilitator should demonstrate experience in
supporting healthcare providers to develop their leadership and governance with an understanding of continuous quality improvement and methodologies.

The Trust is currently being required by NHSI to appoint an external facilitator to undertake an independent review of governance through the ‘Undertakings’ process in relation to the Trust’s performance on A&E, financial performance and quality. Deloitte LLP has been commissioned, in agreement with NHSI to assist the Trust with the provision of this review.

The scope of this review also includes assurance in relation to quality, patient safety and any CQC actions, and includes consideration of the adequacy of risk management at the Trust, including the use of the Board Assurance Framework and Corporate Risk Register. The Trust will therefore be proposing the extension of the current ‘Undertakings’ review to support the Trust's well-led developmental review to NHSI. This would support a more cost-effective and efficient approach in relation to the completion of these two reviews.

The findings from the review will be presented to the Board covering areas of good practice or weakness against which to plan improvement actions. It is important that issues or concerns are prioritised but plans for maintaining good practice should also be considered. The Board will be accountable for delivering the improvements, and therefore action-planning and consideration of how to track actions and the timeframe for resolution will involve the whole board. The ‘Undertakings’ already agreed include the timing of delivery of the recommendations of the governance review being approved by NHSI; in addition the Trust will need to provide assurance to NHSI if requested on progress with delivery of its developmental review action plan.

**Equalities & Finance**

- Equality and diversity considerations: there are no equality and diversity implications arising from this report.
- Financial implications: there are financial implications arising from the report in relation to the cost of the governance review agreed as part of the ‘Undertakings’ to review A&E, finance and quality and the additional cost of the developmental review of well-led. This will need approval by NHSI and the Trust’s CEO.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 26th September 2018
Agenda item 29

<table>
<thead>
<tr>
<th>Report title: Review of Board and Sub-Committee Meetings</th>
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<tbody>
<tr>
<td>Report author: Richard Sumray, Chair</td>
</tr>
<tr>
<td>Report sponsor: Richard Sumray, Chair</td>
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<table>
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<tr>
<th>Board Action required:</th>
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<tr>
<td>The Board are asked to:</td>
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<tr>
<td>Approve the recommendation to retain meetings of the Board every two months but return to Monthly as opposed to two monthly Quality and Safety Committee meetings</td>
</tr>
<tr>
<td>Approve the recommendation to change the terms of reference of the existing Finance and Transformation Committee to form a Finance, Performance and Transformation Committee</td>
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<table>
<thead>
<tr>
<th>Link to the Hillingdon Hospitals Strategic Plan 2017/21:</th>
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<tbody>
<tr>
<td>STRATEGIC PRIORITY:</td>
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<tr>
<td>None</td>
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1. At the Board away-day in May 2017 there was a discussion about we could reduce the meeting workload, especially for executive directors, to enable them to have more time to plan and think.

2. We had previously discussed a reorganisation of committees and had decided from April 2017 to merge the committees dealing with financial recovery, capital investment and transformation. This committee, called Finance and Transformation (F&TC) it was agreed would meet monthly.

3. A decision was made to reduce Board meetings to once every two months and also to reduce the numbers of Board seminars to once every two months, these to be held on alternative months to the Board. In order to deal with urgent business that couldn’t wait for the bi-monthly Board meetings, the terms of reference for F&TC were altered so that it could be delegated decision making in place of the Board in these circumstances. Membership of F&TC included more than half of the non-executive directors and the majority of executive directors. Papers to the Board it was also agreed should be restricted to four pages; everything else would go into appendices.

4. Implementation started from September 2017 and we agreed that it would be reviewed after a year.

5. The CQC in its recent report on Hillingdon Hospital commented as follows:
   ‘We noted that while the trust had taken the decision to reduce the frequency of board meetings to bi-monthly and that, given the trust’s quality and performance indicators, this did not assure us that the board were suitably sighted on the operational and quality issues.’

6. Here are two questions to be posed in this review: has the reduction in board meetings had the desired effect of freeing up time especially for the executives and has the reduction led to any reduction in appropriate governance of the Trust?

7. Feedback from the executive directors indicate their strong preference to keep the bi-monthly meetings of the Board to continue to free up time that relates to the production of papers as much as the meeting times but with provisos that relate to the second question.

8. Although the focus of the monthly F&TC has very much been on finance over the past year, there has been no ‘home’ for performance except the bi-monthly board meetings. This has led to a loss of oversight on general performance issues. Some aspects of performance that relate to quality and safety have been covered in the Quality and Safety Committee (QSC) but that committee has also continued to meet on a bi-monthly basis.
9. If we are going to ensure that, especially at a time when performance on some key metrics is under pressure and some safety issues have been highlighted in the CQC report, we need to keep these under closer review. Consequently, there are two options: to revert to the monthly meetings of the Board or to add to the terms of reference of F&TC, performance, and to increase the frequency of QSC to monthly meetings.

10. In coming to a view, it needs to be recognised that one or two members of the public raised objections when the proposal was first made to public board meetings reducing in number and decisions being made ‘behind closed doors’. In the event only one decision has been delegated to F&TC rather than the Board because of time pressures.

11. On balance, taking into account the different views, I believe that the greatest benefit to both the smooth operation of the Trust and to the appropriate level of scrutiny would be gained through maintaining bi-monthly meetings of the Board whilst increasing the frequency of QSC to monthly meetings and changing the existing Finance and Transformation Committee (FTC) into a Finance, Performance and Transformation Committee (FPTC).

12. There will need to be further discussions to resolve any areas of duplication around monitoring performance between FPTC and QSC with the Chairs of those committees and relevant executives and any changes to the terms of reference brought back to the Board for approval.

13. Other aspects of the performance of the Board will be brought back at the conclusion of the well-led review.

The Board is asked to agree to the proposals outlined in paragraphs 11 and 12.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 26 September 2018
Agenda item 11

<table>
<thead>
<tr>
<th>Report title: Structure of the A&amp;E Delivery Programme</th>
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</thead>
<tbody>
<tr>
<td>Report author: Imran Devji, Director of Operations</td>
</tr>
<tr>
<td>Report sponsor: Joe Smyth, Chief Operating Officer</td>
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</table>

**Board Action required:**

1. Approve the new structure to delivery A&E performance.

**Link to the Hillingdon Hospitals Strategic Plan 2017/21:**

**STRATEGIC PRIORITY:**

Delivery Area 3: Achieve better outcomes and experiences for people
1.0 Background
The Trust has been working with an external partner, Hunter Consulting, to improve its position against the 4-hr emergency access standard. The support from Hunter started in June, for an initial 6-week period, and since then the Trust has sought to work with Hunter for a further 4 months in order to complete the full improvement programme.

After an initial increase, the Trust has seen a drop in performance over the last 4 weeks, with only one week above 83.3% in that period. All parties have been frustrated by this and, as such, have agreed to bring all current recovery/improvement plans into one place. The aim is to ensure that the high impact areas are consolidated and that the approach taken by the Trust and Hunter both complements the plan and achieves the desired outcomes.

Along with the plan, Hunter have proposed some adjustments to the current governance arrangements, via an improvement framework (see appendix 1). The purpose is to:

a) Align the governance framework to the revised plan

b) Provide absolute clarity on who is responsible for each area and where they be held to account

The ultimate goal of the improvement framework is to ensure the appropriate individuals can be held to account for the delivery of the programme, therefore providing assurance around the impacts and improvement in performance.

The approach will be that of small cycles of improvement to ensure the design and implementation of all the workstreams is co-owned and embedded as business as usual by the end of the programme. It also ensures that the right issues are being dealt with at the right time.

2.0 Improvement Framework
2.1 Structure

The improvement framework is made up of four layers:

i. Trust Board and A&E Delivery Board
ii. Emergency Care Delivery Group (ECDG)
iii. Steering Groups
iv. Task & Finish Groups

The structure is depicted in Appendix I to this report. The ECDG will be chaired by the CEO and will hold the Executive Sponsors of each Steering Group to account. The Hunter Oversight Lead will also attend.
The Steering Groups will include the Executive Sponsor, the Operational Lead, the Hunter Lead and a Clinical Lead. The Executive Sponsor will hold the Operational and Clinical Lead to account for delivery of the project. The Hunter Lead for that Steering Group will also attend.

The Task & Finish Groups will include the Project Lead and the Clinical Lead, as well as all Operational, Nursing or Medical staff whom are required to deliver specific milestones or take actions where required to achieve outcomes linked to the plan. The Operational Lead will hold the members of the Task & Finish Group to account for delivery of actions and/or outcomes. The Hunter Lead will also attend.

Each group will receive Project Management support from Hunter Consulting and the Trust’s PMO. Whilst Hunter will lead the Project Management to begin with, this will transfer to the Trust over the long-term (October-November).

The PMO will be responsible for completing the weekly reports that provide an update on progress as well as any barriers requiring escalation to the Executive.

2.2 Projects

The programme will consist of four projects, each with an executive sponsor leading them, as per the improvement framework above. These are:

1. Improve Emergency Department Flow
2. Improve Site Team Function
3. Improve Discharges
4. Design and Implement a New Medical Model

Each project will have a Steering Group with at least one Task & Finish Group feeding into it. Hunter Consulting will support the delivery of these projects and the Improvement Plan clearly outlines which individuals from both the Trust and Hunter are responsible for what milestones.

2.3 Improvement Plan

The Improvement Programme is supported by the Plan, where each project is broken down into workstreams to highlight key areas for delivery. Each critical milestone under is each workstream is highlighted with a Trust name, Hunter Lead, the impact expected, a key performance indicator and delivery dates.

3. Board Action

The Board is asked to approve the revision to the A&E Recovery Programme structure and agreed the new combined Action Plan, titled A&E Improvement Programme.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 26\textsuperscript{th} September 2018
Agenda item 12

**Report title:** Hillingdon Health and Care Partners

**Report author:** Keith Spencer, Director of Integration and Delivery, HHCP

**Report sponsor:** Joe Smyth, Chief Operating Officer

**Board Action required:**

1. Agree the proposal to provide more Non-Executive oversight through a revised structure.
2. Note the proposal to focus on five key areas for delivery

**Link to the Hillingdon Hospitals Strategic Plan 2017/21:**

**STRATEGIC PRIORITY:**

Delivery Area 3: Achieve better outcomes and experiences for older people
1. Purpose

The purpose of this paper is to provide an update to Boards regarding progress with the development of Hillingdon Health and Care Partners (HHCP). Specifically:

- The proposed focus on 5 priorities to improve system urgent care performance
- Changes to HHCP Governance arrangements including plans for greater Non-executive oversight and engagement.
- Future strategic direction for integrated care in Hillingdon

2. Background

Hillingdon Health and Care Partners is a partnership of four local organisations which was set up in 2013 to better integrate health care around the patient. The partnership was initially focussed on people over the age of 65 in order to enable care to be delivered in the most appropriate, least restrictive setting and to tackle the growth in inappropriate non-elective episodes for people of this age. It was developed as a first step towards implementation of a capitated budget for the over 65 population in Hillingdon and is part of the growing national trend towards the development of integrated care systems. The partner organisations are Central and North West London NHS FT (CNWL), The Hillingdon Hospital NHS FT (THH), Hillingdon GP Confederation and H4All, a community interest company of local third sector organisations.

HHCP is currently governed through an alliance agreement signed by all four provider partners and its work is overseen by a Delivery Board composed of Executive representatives from each constituent organisation including the Hillingdon CCG with delegated authority to act on behalf of their respective sovereign Boards of Directors who, however, remain ultimately responsible.

The work of HHCP was initially focussed on improving care to the over 65 population (with a value of in scope services circa £90m). The key feature of its operating model to date has been the setting up of 15 Care Connection Teams across Hillingdon responsible for proactively case managing the care of 650 patients with 2 or more long term conditions who are most at risk of a non-elective episode. The outcome of this work has seen a discernible reduction in non-elective activity for this small cohort. HHCP is widely regarded as an exemplar of good practice across NW London.

3. Review of HHCP and the Five Priorities

The HHCP Partners wish to build on the early success of the CCT’s (Care Connection Teams) and accelerate progress particularly in tackling the emerging challenges in the urgent care system in Hillingdon. Consequently, the HHCP Delivery Board has recently undertaken a review of its work to date and as a result has agreed to make a number of changes to the HHCP Programme in order to maximise its impact. These include:

1. Developing an overarching ‘Hillingdon Whole System Plan’ that defines what an integrated care system would look like including a 3-5-year system financial plan that articulates and addresses the system financial gap and how risk and gain will be shared going forward
2. Widening the focus of the HHCP integrated service model to the 18+ age cohort in order to better move the needle on urgent care performance across the system.

3. Focusing on five key priorities that will improve urgent care performance and potentially deliver savings of up to £10m to the system – see appendix 1.

4. Developing a robust Implementation plan with clear timelines and accountabilities that is implemented at pace focused on those five key priorities.

5. Making changes to how out of hospital services work together by building from CCT’s to develop Primary Care led ‘Locality Neighbourhood Teams ‘that embeds multi-disciplinary working based on an integrated workforce spanning primary, secondary, mental health, community care, social care and the voluntary sector.

6. Strengthening the current HHCP Governance Structure to enable HHCP to move more rapidly from ideas to benefits realization whilst ensuring that there are clear lines of accountability to sovereign boards, which will include Non-Executive oversight.

4. HHCP Governance

The HHCP Delivery Board have also reviewed current governance arrangements to enable HHCP to move more rapidly from ideas to benefits realization whilst ensuring that there are clear lines of accountability to sovereign boards.

The key features of the revised arrangements are set out below:

- Simplified system meeting arrangements to ensure there is a single focus across the system on the proposed priorities, effective decision making and a culture of delivering at pace.
- Revised membership of each governance tier to ensure clear accountability and reduce duplication.
- Creation of 6 Task and Finish groups to deliver the Priorities with an emphasis on co-production between commissioner and providers across health and social care.
- Deploying clinical and operational leaders from across the system to lead each proposed Task and Finish Group as set out.
- Pooling transformation resource across the system to ensure that the Programme is supported and integrated.
- Recognising that accountability remains with sovereign boards. Executive Leads will operate within their scheme of delegation and are responsible for reporting recommendations and outcomes to their respective Boards. This will be supported by the introduction of a Non-Executive Oversight Group which will meet on a quarterly basis commencing October 2018. These arrangements are set out in more detail in appendix 2.

It is proposed to develop a single integrated business case (SIBC) covering the outcome of the work relating to the 5 HHCP priorities. This is to ensure a consistent joined up approach, maintain transparency, reduce duplication and ensure that benefits are not double counted or overly optimistic. A 4-stage approval process for the SIBC is proposed:
• Delivery Board Checkpoint Review of SIBC at the HHCP Summit (26 September 2018)
• Validation of the financial assumptions within SIBC by System Finance Strategy Group (4 October 2018)
• Presentation of the Draft SIBC for approval to the HHCP Delivery Board and NED oversight group (18 October 2018)
• Presentation of SIBC to HHCP Partner Boards for approval (October/November 2018)

5. Future Strategic Direction of HHCP

The Hillingdon CCG has indicated its intention to move towards a whole system contract on a phased basis by 2021/22. Phase 1 commencing in 2019/20 would involve the letting of an ‘Interim Integrated Care Contract’ to HHCP. This would include all ages and cover 30-40% of current system spend including community, third sector, primary care at scale, mental health and elements of acute care. The timelines for phases 2 and 3 are to be confirmed but the current intention is to seek to reach a full ICS contract for Hillingdon by 2021/22.

The CCG have indicated that they would seek:

• A single entity to hold and manage the contract
• Integrated management across function
• To ensure that resources are shifted across setting/sector to reflect the new models of care
• Agreement on risk and gain share based on the principles of one system, one budget and the concept of an overarching system control total.

The HHCP Delivery Board have a summit scheduled for the morning of the 26th September 2018 at which it is intended to discuss these issues and others related to the future strategic direction of HHCP in more detail. This will clearly require wider engagement from Boards going forward and future reports will reflect this. In the meantime, the first NED Oversight meeting will be scheduled for October 2018.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 26th September 2018
Agenda item 13

Report title: Quality Impact Assessment (QIA) process for Financial Improvement Process (FIP) schemes

Report author(s): Sally Martin, Senior Programme Manager
Report sponsor(s): Abbas Khakoo, Medical Director

Board Action required:
The Board are asked to:

1. Approve the response to NHSI. This paper arises from a direct request from NHSI.

Link to the Hillingdon Hospitals Strategic Plan 2017/21:
STRATEGIC PRIORITY:
f) Improving the present - A&E 4 hour standard - 18 week Referral to Treatment - Meet cancer targets - Complete CQC action plan - Implement year 2 of Quality and Safety Improvement Strategy - Maintain finance and use of resources score of 3 - Meet control total
Ratification of the Quality Impact Assessment (QIA) process for Trust
Financial Improvement Process (FIP) schemes

1. Purpose
The purpose of this paper is to agree the response to a query arising from NHSI (NHS Improvement) in relation to the management and reporting of risks identified through the Quality Impact Assessment (QIA) process. The draft response to NHSI is included in Appendix I and the specific changes to current processes are outlined in Section 3, Proposed System Updates.

2. Background
In July 2018 THH (The Hillingdon Hospitals NHS Foundation Trust) were asked by NHS Improvement (NHSI) to explain how visibility of FIP (Financial Improvement Process) project risks is maintained once a FIP scheme has been launched, including the identification and management of cumulative risk arising from multiple changes.

THH has been targeted to achieve £12m FIP savings for 2018/19. Oversight of the FIP scheme delivery is through the fortnightly FIP Board, with oversight of clinical quality risks from the monthly Clinical Assurance Panel (CAP), chaired by the Medical Director.

Each division is tasked with completing and having authorised a four part Project Initiation Document (PID), which comprises:
   a) Project Summary
   b) Financial Appraisal
   c) Quality Impact Assessment
   d) Project Plan

Once approved within the relevant division all FIP schemes must be approved by both the Medical Director as well as the Director of Nursing. Any schemes with cross divisional impacts or that have a mitigated risk score of 10 or more are referred to the Clinical Assessment Panel (CAP) for consideration.

3. Proposed System Updates
In response to the NHSI query, the following changes are proposed to the QIA process:

   a) A Risk Matrix will be maintained by the Project Management Office (PMO) to record all project risks identified via the QIA and aim to identify compound risks by noting:
      i. potential responses,
      ii. root causes of the risks, and
      iii. risk categories.
   
   b) Where compound risks are identified that are Low / Moderate risk for individual schemes (i.e. they will not have been recorded on the Risk Register) but High risk when considered jointly, these will be recorded on the Trust Risk Register by the PMO and assigned to multiple owners (i.e. the scheme owners).
c) The process for the approval of FIP scheme QIAs via the Clinical Assurance Panel has been updated, a flowchart is included in Appendix II.

d) The CAP terms of reference have been updated to reflect that the CAP will report progress to the Finance & Transformation Board via an annual report.

e) The QIA template is to include a Patient Experience domain. (Appendix III).

f) A standing item has been added to the FIP Board meeting agenda for divisions to report if any scheme risks have changed following the launch of the scheme.

5. Recommendations and Next Steps

Comments are requested from the Board relating to the proposed process changes and responses to NHSI. Once received, the PMO will update the process to incorporate comments, and respond to NHSI.

The Board is asked to note that this work has not considered change driven from other areas and there is currently no mechanism to identify and manage other Trust wide compound risks. The board is also asked to consider whether we have a joined up approach and take a decision as to whether further action is to be undertaken.
Meeting of the Board of Directors – Public Part I session
Date of meeting: 26th September 2018
Agenda item 14

Report title: NHS Improvement Undertakings: progress update and assurance

Report author(s): Imran Devji (Director of Operations) and Matt Tattersall (Director of Finance)

Report sponsor(s): Joe Smyth (Chief Operating Officer) and Matt Tattersall (Director of Finance)

Board Action required:
The Board are asked to:
1. Note the progress and assurance provided in the report

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

STRATEGIC PRIORITY:
f) Improving the present - A&E 4 hour standard - 18 week Referral to Treatment - Meet cancer targets - Complete CQC action plan - Implement year 2 of Quality and Safety Improvement Strategy - Maintain finance and use of resources score of 3 - Meet control total
UNDERTAKINGS

This report provides oversight to the Trust Board (through the Finance and Transformation Committee on alternative months) on progress against the undertakings made by the Trust to NHS Improvement. These undertakings relate to A&E; Finance; Governance and Programme Management. The report includes detail in relation to the Hillingdon Emergency Care improvement Programme.

A&E

1. The Trust will provide to NHS Improvement a Board-approved plan for A&E performance recovery (“the A&E Plan”) by a date to be agreed with NHS Improvement. This will include:
   A. the key milestones and how they will be achieved;
   B. what resources the Trust has in place to deliver the A&E Plan;
   C. the key risks to delivery, monitoring and mitigations;
   D. the key performance indicators (KPIs) to monitor the A&E Plan; and
   E. how the Board will have oversight and overall governance over the A&E Plan.

   A. The current Urgent and Emergency care Improvement Plan for the Hillingdon system sets out the key milestones and how they will be achieved is attached at appendix 1. The plan has been refreshed to incorporate further milestones in conjunction with Hunter consulting as part of their Trust commissioned support for improving Emergency Care performance.

   B. The Trust has invested additional managerial staff within the A&E, provided a senior programme manager and commissioned Hunter Consulting to resource delivery of the A&E action plan.

   C. Risks and mitigations are outlined below.

   D. The critical success factors which details the key performance indicators is attached as appendix 3. This includes the stranded patients.

   E. The Board receives reports either at the Board meeting (every other month) or through the Trust Finance and Transformation Committee, which meets monthly.

2. The Trust will provide to NHS Improvement a monthly Board approved report on progress against the A&E Plan, which includes the following:
   • progress being made against the key milestones;
   • if there are any areas of slippage against milestones, how performance will be recovered and monitored; and,
   • Any key risks to delivery of the Plan, and the related mitigations.

The table below provides an update on the milestones for August 2018 and actions taken where these were not achieved.

<table>
<thead>
<tr>
<th>Milestones</th>
<th>Achieved (Y/N)</th>
<th>Assurance for variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED rota reviewed for skill mix and will be effective from September 18</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Patient time standards re-enforced and accountability strengthened in ED</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>
Escalation process within and outside of ED in place. Learning captured to develop Standard Operating Procedures

New daily site situation Report introduced and in place now

Escalation threshold triggers and action cards developed. On call manager training provided with the revised action cards and expectations

10 by 10 data capture sheet implemented on test and learn wards to inform site. Nerve centre to be used as the Trust develops a real time solution

Board rounds on test and learn wards commenced with good result.

Delay codes for discharges used in a test and learn environment. Weekly stranded reviews to lead the validation of pathways and delay reasons as appropriate

Single Emergency Care Improvement plan completed

Review of the governance structure for the emergency care Improvement programme

<table>
<thead>
<tr>
<th>Risks</th>
<th>Mitigations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Leadership and engagement to affect change in processes within A&amp;E.</td>
<td>Daily breach analysis meetings (supported by Hunter) and reported through to the oversight group.</td>
</tr>
<tr>
<td>Confusion between Trust, ECIP and Hunter about who is leading on which aspect of the programme</td>
<td>Single action plan developed with clear lines of accountability and responsibility. This will be complete in August (milestone)</td>
</tr>
<tr>
<td>Structure will become cumbersome with additional meetings being added, lack of clarity on TOR of each group and repetitive meetings wasting time and resource.</td>
<td>Review of structure and each meeting including TOR to be complete in August (milestone)</td>
</tr>
<tr>
<td>Gap in Hunter support while phase two of the plan is commissioned.</td>
<td>Trust issued letter of comfort to allow work to continue.</td>
</tr>
<tr>
<td>It is unclear about the goals, KPI’s in phase 2.</td>
<td>Hunter to provide full proposal for phase 2 including KPI’s. To be complete in August (milestone)</td>
</tr>
<tr>
<td>Clinical leadership of the SAFER best practice team is currently at risk due to clinical commitments.</td>
<td>The Medical director is working with the Divisional Director in Medicine to support back fill arrangements.</td>
</tr>
<tr>
<td>Daily breach analysis is not getting to the root cause of non-admitted breaches.</td>
<td>Additional support from Hunter for daily breach analysis and report to oversight group.</td>
</tr>
<tr>
<td>Loss of operational grip in the department due to ability of band 7’s to manage the department during surge</td>
<td>Hunter to provide additional coaching and development support to the band 7’s</td>
</tr>
<tr>
<td>Overcrowding in the department continues to adversely impact operational grip.</td>
<td>Additional ambulatory capacity to be created by reducing follow ups in clinic. Actions agreed with CCG for implementation in September.</td>
</tr>
<tr>
<td>Department remains overcrowded, delaying</td>
<td>New build to expand department to open in late 2018</td>
</tr>
</tbody>
</table>
While the implementation of the recovery programme is proceeding according to plan, the impact is not as expected. Performance is not recovering in line with the trajectory agreed between the Trust and Hunter Healthcare and subsequently reported to NHSI. Performance in August fell far short of expectations, due to reduced bed capacity and engagement with new processes and procedures. The actual performance was 8.8% below the trajectory of 90% (see Table 1).

Bed capacity was an issue in August with additional escalation capacity used for the latter part of the month. The bed days associated with the stranded cohort increased in August with 80% of the stranded bed days occupied by the extended LoS group (>20 days). Due to the holiday period, community capacity was reduced showing delayed decision making subject to assessment for discharges that caused a number of beds being occupied beyond an acceptable time (Appendix 3). September has seen a marked reduction in the bed days within the stranded patient cohort. Delivery was also impacted by slow adoption of new methods of working especially during out of hours. This is being challenged on a daily basis and further action will be taken to ensure compliance.

<table>
<thead>
<tr>
<th>Undertaking</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Finance</strong></td>
<td></td>
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</tbody>
</table>
| 3. The Trust will develop a financial plan to March 2020  
("the Financial Plan") which includes: | • A drivers of deficit paper has been provided to NHSI |
| • an understanding of the underlying financial position and a detailed analysis of the causes of the underlying position; | • The existing FIP plan takes account of opportunities as identified in the Model Hospital. The plan to March 2020 will further explore these opportunities |
| • a well-developed CIP plan which takes into account all relevant operational productivity opportunities; and | • The Trust’s Long Term Financial Model is being updated |
| • a link to workforce optimisation.                                        | • The Trust’s People Strategy will be embedded within the financial plan |
| 4. The Trust will keep both the Financial Plan under review and provide regular highlight reports including key performance indicators and attend regular update meetings, the content and timing of which will be agreed with NHS Improvement. | • The Trust continues to engage with NHSI through fortnightly calls; monthly returns; monthly oversight meetings; and at other times as required. |
### Governance

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<table>
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<tbody>
<tr>
<td>5.</td>
<td>The Trust will undertake an externally commissioned governance review to inform the strengthening of governance arrangements to be completed by a date to be agreed with NHS Improvement. The scope and supplier will be agreed with NHS Improvement.</td>
</tr>
<tr>
<td></td>
<td>The Trust has commissioned Deloitte to carry out the Governance Review.</td>
</tr>
<tr>
<td>6.</td>
<td>The Trust will address the findings of the governance review. The timing of delivery of the recommendations will be agreed by NHSI and the Trust will provide assurance to NHS Improvement if requested on progress with delivery.</td>
</tr>
<tr>
<td></td>
<td>NHS Improvement has not as yet made any such appointment.</td>
</tr>
<tr>
<td>7.</td>
<td>The Trust will work with a Senior Board Advisor who may be appointed by NHS Improvement to assist the trust’s executive team with the delivery of the Plans identified within these undertakings.</td>
</tr>
<tr>
<td></td>
<td>NHS Improvement has not as yet made any such appointment.</td>
</tr>
<tr>
<td>8.</td>
<td>The Trust will co-operate and work with such partner organisations (this may include one or more ‘buddy trusts’) which may be appointed by NHS Improvement to support and provide expertise to the Trust and to assist the Trust with the delivery of one or more of the Plans identified within these undertakings and the quality of care the Trust provides. The scope and scale of any such support will be directed by NHS Improvement.</td>
</tr>
<tr>
<td></td>
<td>NHS Improvement has not as yet made any such appointment.</td>
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</table>

### Programme management

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<tr>
<td>9.</td>
<td>The Trust will ensure adequate senior management (PMO resource) to support the executive team to deliver the undertakings above.</td>
</tr>
<tr>
<td></td>
<td>The Trust has already appointed to the Associate Director of PMO role that supports the Financial Improvement Programme</td>
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<td></td>
<td>The Trust has engaged Hunter Healthcare in discussion with NHSI to ensure adequate senior management exists to support the delivery of the programme</td>
</tr>
<tr>
<td>10.</td>
<td>The Trust will implement sufficient programme management and governance arrangements to enable delivery of these undertakings.</td>
</tr>
<tr>
<td></td>
<td>The development of the financial plan will be overseen by the Finance &amp; Transformation Committee</td>
</tr>
<tr>
<td>11.</td>
<td>The Trust will attend meetings or, if NHS Improvement stipulates, conference calls, at such times and places, and with such attendees, as may be required by NHS Improvement.</td>
</tr>
<tr>
<td></td>
<td>Agreed</td>
</tr>
<tr>
<td>12.</td>
<td>The Trust will provide such reports and access to any of the trust’s advisors in relation to the matters covered by these undertakings as NHS Improvement may require.</td>
</tr>
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<td></td>
<td>Agreed</td>
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Meeting of the Board of Directors – Public Part I session

Date of meeting: 26th September 2018
Agenda item 15

Report title: Integrated Quality & Performance Report

Report author(s)
Imran Devji (Director of Operational Performance - Emergency)
Vanessa Saunders (Deputy Director of Nursing and Patient Experience)
Rachel Stanfield (Deputy Director of People and Organisational Development)
Melissa Mellet (Director of Operational Performance - Planned)
Jay Dungeni (Interim Deputy Director of Nursing and Integrated Governance)

Report sponsor(s):
Joe Smyth (Chief Operating Officer)
Dr Abbas Khakoo (Medical Director)
Jacqueline Walker (Director of the Patient Experience and Nursing)
Terry Roberts (Director of People and Organisational Development)

Board Action required:
The Board are asked to:

1. Note the report and monitor the performance of the Trust for assurance

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

**STRATEGIC PRIORITY:**
f) Improving the present - A&E 4 hour standard - 18 week Referral to Treatment - Meet cancer targets - Complete CQC action plan - Implement year 2 of Quality and Safety Improvement Strategy - Maintain finance and use of resources score of 3 - Meet control total
<table>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Clostridium Difficile Infection: Trust Attributable</strong></td>
<td>n/a</td>
<td>19 Cases (11.1 Cases per 100,000 Beddays)</td>
<td>2 Cases (14.6 Cases per 100,000 Beddays)</td>
<td>11 Cases (15.7 Cases per 100,000 Beddays)</td>
<td>11.7 Cases per 100,000 Beddays</td>
</tr>
<tr>
<td><strong>MRSA: Trust Attributable</strong></td>
<td>0</td>
<td>1 Case (0.6 Cases per 100,000 Beddays)</td>
<td>0 Cases</td>
<td>0 Cases</td>
<td>0.6 Cases per 100,000 Beddays</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Maintain two week cancer waits (all cancers)</td>
<td>93%</td>
<td>95.1%</td>
<td>95.4%</td>
<td>94.8%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Maintain two week cancer waits (breast symptoms except suspected cancer)</td>
<td>93%</td>
<td>95.2%</td>
<td>92.0%</td>
<td>88.1%</td>
<td>93.8%</td>
</tr>
<tr>
<td>31 days diagnosis to treatment for cancer (1st Treatment)</td>
<td>96%</td>
<td>98.9%</td>
<td>98.9%</td>
<td>99.4%</td>
<td>99.0%</td>
</tr>
<tr>
<td>31 days diagnosis to treatment for cancer (2nd or Subsequent Treatment - Surgery)</td>
<td>94%</td>
<td>98.7%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.1%</td>
</tr>
<tr>
<td>31 days diagnosis to treatment for cancer (2nd or Subsequent Treatment - anti cancer drug treatments)</td>
<td>98%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.7%</td>
</tr>
<tr>
<td>62 days urgent GP referral to treatment for cancer</td>
<td>85%</td>
<td>85.9%</td>
<td>81.7%</td>
<td>83.1%</td>
<td>85.5%</td>
</tr>
<tr>
<td>62 days urgent referral to treatment for cancer (Screening)</td>
<td>90%</td>
<td>96.5%</td>
<td>100.0%</td>
<td>95.2%</td>
<td>95.8%</td>
</tr>
<tr>
<td><strong>Referral To Treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incomplete Pathways within 18 weeks</td>
<td>92%</td>
<td>91.1%</td>
<td>86.0%</td>
<td>87.3%</td>
<td>90.4%</td>
</tr>
<tr>
<td><strong>Accident &amp;</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of Patients Meeting 4 Hour Standard (All A&amp;E Types)</td>
<td>95%</td>
<td>84.7%</td>
<td>81.2%</td>
<td>81.7%</td>
<td>89.4%</td>
</tr>
<tr>
<td>Report</td>
<td>Domain</td>
<td>Ref</td>
<td>Theme</td>
<td>Management Priority</td>
<td>Forecast Status</td>
</tr>
<tr>
<td>--------</td>
<td>--------</td>
<td>-----</td>
<td>-------</td>
<td>---------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>[4] Safe</td>
<td>National</td>
<td>1.01</td>
<td>HCAI</td>
<td>On Track</td>
<td>On Track</td>
</tr>
<tr>
<td>[4] Responsive</td>
<td>National</td>
<td>4.1</td>
<td>Accident &amp; Emergency</td>
<td>Significant</td>
<td>Significant</td>
</tr>
<tr>
<td>[4] Responsive</td>
<td>National</td>
<td>4.2</td>
<td>RTT</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>[4] Responsive</td>
<td>National</td>
<td>4.3</td>
<td>Cancer</td>
<td>Moderate</td>
<td>Minor</td>
</tr>
<tr>
<td>[5] Safe</td>
<td>Contractual</td>
<td>1.02</td>
<td>Stroke &amp; TIA</td>
<td>Excellent</td>
<td>Excellent</td>
</tr>
<tr>
<td>[5] Safe</td>
<td>Contractual</td>
<td>1.03</td>
<td>FNOF</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>[5] Safe</td>
<td>Contractual</td>
<td>1.04</td>
<td>Maternity</td>
<td>Minor</td>
<td>Minor</td>
</tr>
<tr>
<td>[3] Caring</td>
<td>Contractual</td>
<td>3.1</td>
<td>FFT (Admitted Care)</td>
<td>On Track</td>
<td>On Track</td>
</tr>
<tr>
<td>[3] Caring</td>
<td>Contractual</td>
<td>3.2</td>
<td>FFT (A&amp;E Care)</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>[3] Caring</td>
<td>Contractual</td>
<td>3.3</td>
<td>FFT (Maternity Care)</td>
<td>On Track</td>
<td>On Track</td>
</tr>
<tr>
<td>[3] Caring</td>
<td>Contractual</td>
<td>3.4</td>
<td>Complaints</td>
<td>Moderate</td>
<td>On Track</td>
</tr>
<tr>
<td>[3] Caring</td>
<td>Contractual</td>
<td>3.5</td>
<td>PALS</td>
<td>Minor</td>
<td>On Track</td>
</tr>
<tr>
<td>[3] Caring</td>
<td>Contractual</td>
<td>3.7</td>
<td>Dementia</td>
<td>On Track</td>
<td>On Track</td>
</tr>
<tr>
<td>[1] Safe</td>
<td>Contractual</td>
<td>1.13</td>
<td>Mortality</td>
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<td>On Track</td>
</tr>
<tr>
<td>[1] Safe</td>
<td>Local</td>
<td>1.05</td>
<td>Falls</td>
<td>On Track</td>
<td>Minor</td>
</tr>
<tr>
<td>[1] Safe</td>
<td>Local</td>
<td>1.06</td>
<td>Medication</td>
<td>Minor</td>
<td>Minor</td>
</tr>
<tr>
<td>[1] Safe</td>
<td>Local</td>
<td>1.07</td>
<td>VTE</td>
<td>Minor</td>
<td>On Track</td>
</tr>
<tr>
<td>[1] Safe</td>
<td>Local</td>
<td>1.08</td>
<td>Pressure Ulcers</td>
<td>Excellent</td>
<td>On Track</td>
</tr>
<tr>
<td>[1] Safe</td>
<td>Local</td>
<td>1.09</td>
<td>Safety Thermometer</td>
<td>Minor</td>
<td>On Track</td>
</tr>
<tr>
<td>[1] Safe</td>
<td>Local</td>
<td>1.10</td>
<td>Maternity Safety Thermometer</td>
<td>Minor</td>
<td>Minor</td>
</tr>
<tr>
<td>[1] Safe</td>
<td>Local</td>
<td>1.11</td>
<td>Serious Incidents</td>
<td>On Track</td>
<td>On Track</td>
</tr>
<tr>
<td>[1] Safe</td>
<td>Local</td>
<td>1.12</td>
<td>Never Events</td>
<td>Minor</td>
<td>On Track</td>
</tr>
<tr>
<td>[2] Effective</td>
<td>Local</td>
<td>2.1</td>
<td>Readmissions</td>
<td>Minor</td>
<td>Minor</td>
</tr>
<tr>
<td>[2] Effective</td>
<td>Local</td>
<td>2.2</td>
<td>DNAs</td>
<td>Minor</td>
<td>Minor</td>
</tr>
<tr>
<td>[2] Effective</td>
<td>Local</td>
<td>2.3</td>
<td>ASIs</td>
<td>Significant</td>
<td>Significant</td>
</tr>
<tr>
<td>[5] Well Led</td>
<td>Local</td>
<td>5.2</td>
<td>Sickness</td>
<td>On Track</td>
<td>On Track</td>
</tr>
<tr>
<td>[5] Well Led</td>
<td>Local</td>
<td>5.3</td>
<td>LTR, Vacancy &amp; TtR</td>
<td>On Track</td>
<td>On Track</td>
</tr>
<tr>
<td>[5] Well Led</td>
<td>Local</td>
<td>5.4</td>
<td>Temporary Staffing Usage</td>
<td>On Track</td>
<td>On Track</td>
</tr>
<tr>
<td>[5] Well Led</td>
<td>Local</td>
<td>5.5</td>
<td>Staff in Post</td>
<td>On Track</td>
<td>On Track</td>
</tr>
</tbody>
</table>
1. Summary

The format of the performance dashboard reflects the core principles of the five Domains set out in the Care Quality Commission's Intelligent Monitoring System (Caring, Well-led, Effective, Safe and Responsive). This is an exception report with full analysis of the data contained within the appendices that are in the appendix supplement. The Model Hospital group comparators for performance are: Ashford & St Peters Hospitals NHS Foundation Trust, Barnsley Hospital NHS Foundation Trust, Burton Hospitals NHS Foundation Trust, Croydon Health Services NHS Trust, Gateshead Health NHS Foundation Trust, Harrogate and District NHS Foundation Trust, James Paget University Hospitals NHS Foundation Trust, Kingston Hospital NHS Foundation Trust, Mid Cheshire Hospitals NHS Foundation Trust, Milton Keynes University Hospital NHS Foundation Trust, North Middlesex University Hospital NHS Foundation Trust, Northern Devon Healthcare NHS Trust, Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, Salisbury NHS Foundation Trust, South Tyneside NHS Foundation Trust and Southport and Ormskirk Hospital NHS Trust.

2. Key Highlights

2.1 Safe
Fractured neck of femur patient in theatres within 36 hours:

<table>
<thead>
<tr>
<th>Performance analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>July performance was at 85.7% against 90% target (14 patients in total with 2 breaches of the standard). In July 2018, 2 patients did not receive treatment within the national standard of going to Theatre within 36 hours. The treatment for both patients was delayed for clinical reasons.</td>
</tr>
</tbody>
</table>

HCAI

<table>
<thead>
<tr>
<th>Performance analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of C Difficile cases for 2018/19 (April to August) has been higher than the same period in 2017/18. Although none of them were identified as lapses in care on RCA investigation this is outside of normal seasonal trends. In addition the two CDI cases linked in time and place, reported at the July Board meeting have subsequently been found to be of the same ribotyping indicating possible cross infection in relation to one of those cases. The RCA investigations for Q2 are under review by the Trust’s commissioners.</td>
</tr>
</tbody>
</table>

Key risks and challenges: High impact improvement actions:

- Risk of over reporting due to inappropriate sampling  
- Risk of higher incidence which may outstrip the number of isolation facilities  
- Ensure that all staff groups are compliant with the training  
- Bespoke training being delivered in areas where cases have been reported  
- Reiterated (via memo) the correct sampling process

Inpatient Falls

<table>
<thead>
<tr>
<th>Performance analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Trust achieved a rate of 4.7 falls per 1000 bed days in August against a target of 4.6.</td>
</tr>
</tbody>
</table>

Key risks and challenges: High impact improvement actions:

- Patient demographic will continue to have large number of at risk patients  
- Need to prevent deconditioning and promote mobility among all patients carries inherent associated risk of increased falls  
- Internal target a stretch compared to national benchmark  
- Published process and timelines for RCAs not consistently adhered leading to backlog.  
- Action plan in place in response to findings of Round 2 of National Falls Audit  
- Assistant Director of Health and Safety and Lead Nurse for Quality Improvement developing training package for clinical staff  
- Overview of falls data, root cause analysis findings from RCAs and emerging trends continues via trust wide falls group, led by Deputy Director of Nursing and Patient
Experience, in association with lead clinician and attended by senior nursing and therapy staff from across the divisions.

- Root Cause Analysis for all falls resulting in fracture with associated action plans formulated and driven by divisions
- Time-driven pathway for RCAs in line with published policy re-instated, with allocation of Governance Facilitator to tackle backlog and increased support from corporate nursing team to ensure robust reviews and actions in place. Backlog now significantly reduced and RCAs for newly identified fractures convened to time.
- Findings for RCAs for incidents over last 12 months to be reviewed as cluster to identify recurrent themes for learning and action

<table>
<thead>
<tr>
<th>Caesarean section rate (emergency)</th>
<th>Performance analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>The service continues to over perform against the elective caesarean standard at 12.66% and 11.91% year to date, however the emergency caesarean section rate remains high, 19.79% at month 5. A further deep dive review is being designed by the multidisciplinary team</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mortality (HSMR)</th>
<th>Performance analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>The rolling 12 month HSMR to May 2018 for all admissions is 91.0 (range 84.5-97.9) and for weekend only admissions is 85.5 (range 73.4-99.2) both of these are below expected. As with the last report this continues to show a downward trend as coding changes are embedded following the introduction of these in October 2017. The change involved coding of palliative care (Z51.5) – latest data, to May 2018, shows the Trust rate of 3.0 (range 2.8-3.3) against the National comparison of other acute non-specialist Trusts which is 2.4 (2.4-2.4). A review has taken place of mortality of cancers of the rectum and anus as these were identified as an outlier. The results of this review were presented to the Mortality Surveillance Group in August 2018 and no clinical concerns were identified.</td>
<td></td>
</tr>
</tbody>
</table>

2.2 Caring
Friends and Family Test

<table>
<thead>
<tr>
<th>Performance analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Admitted Care:</strong> Response Rate 28.4% (target 30%); Satisfaction 96.3% (target 94%).</td>
</tr>
<tr>
<td><strong>A&amp;E Care (A&amp;E and MIU combined):</strong> Response Rate 7.7% (target 20%); Satisfaction 96.9% (target 94%). Response rate improved compared to July and is second highest year-to-date. Responses mostly collected in MIU (353), with only 96 generated from adult A&amp;E and 23 from paediatric A&amp;E.</td>
</tr>
<tr>
<td><strong>Outpatient Care:</strong> Satisfaction 95.8% (target 94%) Total 1090 responses received, representing 4.82% for currently included areas (target 6%) Year-to-date 5.26% achieved.</td>
</tr>
<tr>
<td><strong>Maternity Care (all touch points):</strong> Response Rate 32.7% (target 20%) Satisfaction 97.0% (target 94%). Consistently achieving targets.</td>
</tr>
</tbody>
</table>

**Key risks and challenges:**  **High impact improvement actions:**

- A&E (ED and MIU combined) continue to obtain response rates significantly below target
- Collection of ED responses to be increased to weekly to enable increased monitoring of performance and awareness among staff
- Processes in ED not embedded across team. Key staff will be leaving Trust, putting performance at increased risk
- Risk of contractual performance notice
- Admitted Care target high at 30%; achieving year-to-date but variability across months
- OPD response rate improving but proves challenging

- ADoN to personally drive improved collection of survey cards
- Head of PPE to increase visibility of survey cards and collection point to facilitate patient-led completion
- Head of PPE to meet with information Team and leads for CCSS to review inclusion criteria for OPD
- Wards able to access results directly, also receive hard copy from Patient Experience team for display on ward
- Triangulation of comments from FFT reviewed on quarterly basis at Experience and Engagement Group

Complaints

Performance analysis

Response rate: 91.3% of the responses due were completed within agreed timeframe (target 90%). Target achieved in-month, however remains at risk with YTD at 64.2% (improving).

CCSS, Medicine and Women and Children divisions all achieved 100%; Surgical division achieved 60% with 2 breeches.

Key risks and challenges: | High impact improvement actions:
---|---
- Continued high operational demands impact on ability for divisional teams to complete investigations
- Dependency on specific individuals within divisions to complete investigations
- Complaints Team is lean, resulting in high pressure when staff absent/on leave
- Risk of contractual performance notice
- Weekly meeting between Division of Surgery and Complaints team embedded. This has strengthened communication between the teams and has significantly improved performance compared to the same period last year.
- Weekly meeting with Medicine re-establishing
- Daily tracking of performance, with retrieval actions for investigations not running to time
- Head of PPE to formally take over line management of complaints Manager from October 2018, enabling increased support
- Consultation to complete formal merger of Complaints and PALS team, as a component of Patient Experience Team due to commence October

2.3 Responsive
18 weeks Referral To Treatment (RTT) – Incomplete standard

Performance analysis

Current performance is 86.5% in July against the 92% incomplete pathways standard. 2018/19 contractual target with the CCG is to maintain last year’s waiting list size. The total waiting list size was 24752 in July against the target of 22773 (2017/18). The Trust is 1979 patients above waiting list target. This is due to a significant increase in the non-admitted waiting list and day case and elective activity being behind plan. There is a recovery plan in place to get activity and backlog in place by December.

Key risks and challenges: | High impact improvement actions:
---|---
- The waiting list size of patients over 18 weeks. Patients being booked for first time
- Governance - Clarification of performance management framework and accountabilities
appointment passed 18 weeks.
- The total number of day case and elective activity behind plan
- Vacancies in Dermatology department
- Lack of robust demand and capacity plans
- Recovery plan in place to pull back the backlog of elective activity to plan by December
- The (polling time) is being changed. Which means we will ensure that 1st appointments are being booked into achievable pathways from the 10.09.2018.
- IST (NHSI) commenced support on the 11.09.2018 in relation to supporting demand management, Outpatient processes (receipt of referral and OP bookings, In patient booking processes and review of RTT recovery plans.

Cancer performance

Performance analysis

In July 2018 the trust failed the 62 day standard performance 81.7%, this was an improvement on the June performance of 73%. The trust is working on a recovery plan to a sustainable recovery trajectory. National Standards were achieved 2WW, 31 day decision to treat to treatment, subsequent treatment, and consultant upgrade. The Trust did not achieve the Breast Symptomatic 2WW standard due to patient choice therefore this was an unavoidable breach of the standard.

Key risks and challenges:  
- Diagnostic capacity in both CT and Endoscopy
- Backlog of patients waiting over 62 days

High impact improvement actions:
- Second CT will be partially staffed from October 2018.
- Planned reduction of the backlog has commenced.

Four Hour Emergency Care Transit Time Standard

Performance analysis

The Trust delivered 81.2% All Type performance with type 1 at 53.8% in August 18. Ambulance handovers within 30 minutes was delivered for 72.1% of patients resulting in 96.5% handed over within 60 mins and a further 3.5% went over an hour.

Key risks and challenges:  
- Reduced ED flow especially out of hours due to assessment and treatment times
- Reduced cubicle space as a result of decision delays and reduced bed capacity causing congestion in ED
- Ambulance handover delays due to Pitstop cubicles being used for patients waiting treatment in ED despite fit to sit
- Non-admitted breaches high due to limited physical assessment spaces due to poor flows causing excessive breaches

High impact improvement actions:
- 2 hourly ED board rounds and timely escalation re-enforced
- Senior operations lead presence 08:00 to 20:00 (Monday – Friday) in ED to tackle flow challenges in support of the department with escalation to the Director of Operations as per action cards
- Nurse led streaming in place
- Further scrutiny around reduction of UCC breaches
- New site situation report in place
- Escalation triggers and action cards finalised for use across site
- Best practice board rounds introduced on the 2 “Test and Learn” wards by the Hunter team
- Discharge delay codes now used in weekly stranded review meetings
- ED expansion on schedule for November 2018. This will provide 7 additional cubicles, a Mental Health consulting room and 3 ambulance streaming spaces
## Emergency admissions and Length of Stay (LoS)

**Performance analysis**

LoS at 4.6 days. Stranded patients on average in August 18 stood at 152 patients with 61 at extended LoS (>20 days). This is a marked improvement and continues to be one of the main areas to focus. On average, the Trust had 152 patients over the 7 day LoS. The target is less than 165. The extended (>20 days) LoS was at 61 patients on average. The target for this cohort allocated the Trust from NHSI/E is 73 (from an initial baseline of a 100).

<table>
<thead>
<tr>
<th>Key risks and challenges:</th>
<th>High impact improvement actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in stranded patients especially the extended (20+ days) LoS due to inconsistent use of the SAFER principles across the wards. This is being mitigated through the SAFER Best Practice Team on the wards</td>
<td>Increase in stranded patients especially the extended (20+ days) LoS due to inconsistent use of the SAFER principles across the wards. This is being mitigated through the SAFER Best Practice Team on the wards</td>
</tr>
<tr>
<td>Increased escalation needs due to delays in discharge and clinical decisions</td>
<td>Increased escalation needs due to delays in discharge and clinical decisions</td>
</tr>
</tbody>
</table>

## 2.4 Well Led

### PDR Compliance

**Performance analysis**

The latest PDR compliance for August was 97.60%, lower than the same period last year.

<table>
<thead>
<tr>
<th>Key risks and challenges:</th>
<th>High impact improvement actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieving 100% PDR completion across all directorates/divisions</td>
<td>Continued weekly/daily reports to service managers of staff without submitted PDRs.</td>
</tr>
<tr>
<td></td>
<td>On-ward support from P&amp;OD to assist with submitting PDRs online</td>
</tr>
<tr>
<td></td>
<td>Input from the People Solutions Partners (HR Business Partners) at the monthly DTM and 1-2-1 sessions to support the Division to identify issues with increasing compliance and support resolution of these.</td>
</tr>
</tbody>
</table>

## Mandatory Training

**Performance analysis**

Compliance has fallen for a fifth consecutive month to 86.95%. (NB. This had improved to 88.6% at the time of report submission).

<table>
<thead>
<tr>
<th>Key risks and challenges:</th>
<th>High impact improvement actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall compliance continues to decline as more subjects become non-compliant.</td>
<td>Explore the possibility of using an audit day to enable medical staff to attend.</td>
</tr>
<tr>
<td></td>
<td>Input from the People Solutions Partners in the development of template trajectory and action plan for the service managers/matrons to complete and present at the STaM compliance meetings (Medicine)</td>
</tr>
<tr>
<td></td>
<td>Directly booking staff onto</td>
</tr>
</tbody>
</table>
### Training/Holding Divisional Training
- Arrangement of in-house training sessions for Fire Safety
- Arrangement for HH staff to attend Basic Life Support (BLS) training at MV if HH sessions are fully booked
- Utilisation of the Divisional PA to actively chase non-complaint staff and book them onto training.

### Vacancy and Voluntary Turnover Rates

#### Performance analysis
Vacancy and voluntary turnover rates have both reduced in August to 12.76% and 12.17% respectively.

#### Key risks and challenges:  
- Maintaining the downward trend.
- Achieving the 11% Trust target for both metrics.

#### High impact improvement actions:
- Cohorts of overseas nurses arriving every month, with a pipeline through to 2019 of up to 12 per month
- Ongoing monthly Saturday recruitment events
- Focus group with regular agency staff to be held with matrons to find out what would attract them to work at the Trust
- Working with Finance to review budgeted establishment to ensure that they are correct following reconfigurations of wards
- Creation of developmental roles to improve retention (bands 2-3 support roles in A&E and Therapies and Bands 6-7 in Pharmacy)
- Continued implementation of NHSI Retention Programme initiatives, e.g. Career Maps for nursing, flexible working options and additional support to develop respect in the workplace.

### Sickness Absence

#### Performance analysis
Sickness has reduced on July to 3.71% for August.

#### Key risks and challenges:  
- Maintaining the downward trend particularly as the Trust approaches autumn/winter.

#### High impact improvement actions:
- People Solutions Partners are analysing the Healthroster data on agency bookings for sickness cover and are working with Matrons to confirm the reasons the agency cover was required and to proactively ensure that sickness is being managed
- Monthly case conferences with OH to discuss and resolve difficult sickness
cases

- Monthly 1-2-1 meetings between the HR Consultant and the departmental Manager to discuss current sickness cases and proposed actions to be taken to manage them
- Attending training days for supervisory Band 7s to ensure they are aware of policy e.g. triggers and all P&OD support available

### Temporary Staffing Usage and Price Caps

<table>
<thead>
<tr>
<th>Performance analysis</th>
<th>Key risks and challenges:</th>
<th>High impact improvement actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency and bank spend has increased to over £2m in total for the second time this year.</td>
<td>Temporary staffing spend continues to increase particularly on agency usage.</td>
<td>People Solutions Partner attending Safer Staffing meetings and to monitor publication of rosters within 6 week timescale improve bank bookings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ongoing review and communication of bank and agency approvals processes, particularly in light of the eroster roll out across medics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P&amp;OD oversight of bank and agency requests at the weekly DTM to ascertain as to whether or not other methods can be used to fill shifts/vacancies.</td>
</tr>
</tbody>
</table>
Meeting of the Board of Directors – Public Part I session

Date of meeting: 26th September 2018
Agenda item 16

Report title: Financial Performance Report

Report author(s): Mel Hughes, Deputy Director of Finance
Report sponsor(s): Matt Tattersall, Director of Finance

Committee Action required:

The Board are asked to:

1. Monitor the report for assurance

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

STRATEGIC PRIORITY:

f) Improving the present - A&E 4 hour standard - 18 week Referral to Treatment - Meet cancer targets - Complete CQC action plan - Implement year 2 of Quality and Safety Improvement Strategy - Maintain finance and use of resources score of 3 - Meet control total
1. **EXECUTIVE SUMMARY**

Key Points to note at Month 05:
- M5 deficit of £2.8m, £2.4m behind plan.
- Year to date deficit of £11.0m, £7.0m adverse to plan.
- Agency expenditure of £0.9m in month, an increase on previous month.
- Pay overspent by £1.6m in month.
- Finance and Use of Resources score of 3.
- Efficiency savings of £0.5m in month.
- Capital expenditure of £0.3m in month.
- Cash position of £1.0m at month end.

In August, the arrears associated with the Agenda for Change pay award were processed causing a £1.0m overspend on Employee Expenses, offset by £0.9m additional Clinical Income. Therefore, the ‘real’ variance on Clinical Income in month is a £1.1m underperformance.

The August elective activity plan was slightly lower than that for July with lower numbers of Inpatients. Despite an actual increase of 77 daycases, this was still 111 cases below plan for the month and resulted in an underperformance of £163k. The specialties most impacted are T&O – 60 behind, Clinical haematology 34 behind and Dermatology 18 behind. Elective inpatient activity dropped by 12 compared to July and underperformed by £50k. The Inpatient electives behind plan are; T&O (16) and Gynaecology (11).

The surgery division have produced a recovery plan for elective work which shows that they will be ahead of plan by 40 from December onwards. A full explanation included as appendix 1.

Emergency activity is again below plan in August by 542 episodes. However, due to the more complex casemix the financial value is on plan in month, (year to date position is £237k behind). This month we have seen less activity than previous months but financial values have held.

---

### Operating Income

<table>
<thead>
<tr>
<th></th>
<th>Plan to-date</th>
<th>Actual to-date</th>
<th>Variance to-date</th>
<th>Plan In Month</th>
<th>Actual In Month</th>
<th>Variance In Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>NHS Clinical Income</td>
<td>220,643</td>
<td>91,905</td>
<td>91,643</td>
<td>(262)</td>
<td>18,690</td>
<td>18,453</td>
</tr>
<tr>
<td>Non-NHS Clinical Income</td>
<td>2,763</td>
<td>1,145</td>
<td>1,315</td>
<td>170</td>
<td>229</td>
<td>310</td>
</tr>
<tr>
<td>Other Operating Income</td>
<td>28,820</td>
<td>11,970</td>
<td>11,600</td>
<td>(370)</td>
<td>2,386</td>
<td>2,351</td>
</tr>
<tr>
<td><strong>Total Operating Income</strong></td>
<td><strong>252,226</strong></td>
<td><strong>105,020</strong></td>
<td><strong>104,558</strong></td>
<td><strong>(462)</strong></td>
<td><strong>21,305</strong></td>
<td><strong>21,114</strong></td>
</tr>
</tbody>
</table>

### Operating Expenses

<table>
<thead>
<tr>
<th></th>
<th>Plan to-date</th>
<th>Actual to-date</th>
<th>Variance to-date</th>
<th>Plan In Month</th>
<th>Actual In Month</th>
<th>Variance In Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>Employee Expenses</td>
<td>(168,103)</td>
<td>(70,087)</td>
<td>(73,694)</td>
<td>(3,607)</td>
<td>(13,863)</td>
<td>(15,421)</td>
</tr>
<tr>
<td>Drugs</td>
<td>(18,452)</td>
<td>(7,796)</td>
<td>(8,056)</td>
<td>(260)</td>
<td>(1,547)</td>
<td>(1,552)</td>
</tr>
<tr>
<td>Clinical Supplies and Services</td>
<td>(29,070)</td>
<td>(12,051)</td>
<td>(13,427)</td>
<td>(1,376)</td>
<td>(2,454)</td>
<td>(2,889)</td>
</tr>
<tr>
<td>Other Operating Expenses</td>
<td>(33,622)</td>
<td>(13,882)</td>
<td>(13,704)</td>
<td>176</td>
<td>(2,791)</td>
<td>(2,882)</td>
</tr>
</tbody>
</table>

### EBITDA

<table>
<thead>
<tr>
<th></th>
<th>Plan to-date</th>
<th>Actual to-date</th>
<th>Variance to-date</th>
<th>Plan In Month</th>
<th>Actual In Month</th>
<th>Variance In Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>EBITDA</td>
<td>2,979</td>
<td>1,204</td>
<td>(4,323)</td>
<td>(5,527)</td>
<td>650</td>
<td>(1,430)</td>
</tr>
<tr>
<td>Depreciation</td>
<td>(9,722)</td>
<td>(3,990)</td>
<td>(3,815)</td>
<td>175</td>
<td>(813)</td>
<td>(765)</td>
</tr>
<tr>
<td>Interest Income/Expense</td>
<td>(3,448)</td>
<td>(1,379)</td>
<td>(1,260)</td>
<td>119</td>
<td>(287)</td>
<td>(250)</td>
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<tr>
<td>PDC Dividend Expense</td>
<td>(3,749)</td>
<td>(1,593)</td>
<td>(1,593)</td>
<td>0</td>
<td>(308)</td>
<td>(308)</td>
</tr>
<tr>
<td><strong>Surplus(Deficit) before Exceptionals</strong></td>
<td><strong>(13,940)</strong></td>
<td><strong>(5,758)</strong></td>
<td><strong>(10,991)</strong></td>
<td><strong>(5,233)</strong></td>
<td><strong>(758)</strong></td>
<td><strong>(2,753)</strong></td>
</tr>
<tr>
<td>Provider Sustainability Funding</td>
<td>6,181</td>
<td>1,751</td>
<td>0</td>
<td>(1,751)</td>
<td>412</td>
<td>0</td>
</tr>
<tr>
<td><strong>Surplus(Deficit) after Exceptionals</strong></td>
<td><strong>(7,759)</strong></td>
<td><strong>(4,007)</strong></td>
<td><strong>(10,991)</strong></td>
<td><strong>(6,984)</strong></td>
<td><strong>(346)</strong></td>
<td><strong>(2,753)</strong></td>
</tr>
</tbody>
</table>

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### Financial Report

**AUGUST 2018 (MONTH 05)**

---

72
Outpatient activity was significantly below plan in month, (3,389 attendances) reversing much of the year to date overperformance in activity. However, the financial impact of this was just a £117k underperformance. Year to date the position remains £702k above plan. The casemix of outpatients can vary considerable with procedures being paid at a much higher tariff than follow up appointments.

Overall the activity based income is £2.4m behind as at August year to date.

The surgery division have produced a recovery plan for elective work which shows that they will be ahead of plan by 40 from December onwards.

Employee expenses included 3 months arrears in August contributing to a total pay award overspend of £984k. The difference between these actual costs and the funding received (as described above) was £96k. Over the year this represents an unfunded cost pressure of £280k.

Agency expenditure increased in August by £64k.

Included in the plan is £2m of unallocated CIP plans that have not been achieved trustwide, (£300k in month)

This is adding to the overspends that are occurring in medical staff due to:

- Gaps in rotas in anaesthetics where consultants are covering junior shifts and increase usage of junior doctors agency staff
- Waiting List Initiative payments in Ophthalmology, Oral Surgery and ENT to meet activity plan
- Significant gaps in the deanery rota for Junior and Middle grade doctors particularly in A&E, AMU and COTE. This has driven up bank and agency costs because we have not been able to recruit enough Trust Grade doctors to cover the gaps.
- Agency expenditure on Pinewood Ward and AMU where we have been unable to recruit substantively to medical vacancies
- Medical Locums in Radiology and Dermatology

Nursing staff and HCAs

- High vacancy rates in Kennedy/ Jersey wards plus use of specials to support confused patients. Unfunded training posts across all wards
- Medicine HCA overspend (£870k) is mainly due to costs of specials and 1:1 support for elderly and other vulnerable patients particularly on the medical wards, Fleming and AMU.

Drugs were on plan in month, but year to date PbR excluded drugs are overspent by £315k, however this is offset by over recovery on Clinical Income. In tariff drugs are underspent year to date by £55k.

Clinical Supplies are overspent largely due to the Pathology Joint Venture overspend of £367k, (of which £81k is unidentified savings). However, there is offsetting direct access income of £120k on Clinical Income. The finance team are working with the JV to resolve the funding of the service. There remains a dispute over how the loss of the Hounslow contract is treated with a risk to the trust of having to absorb the whole of the loss of the margin. Discussions are ongoing to reach a mutually agreeable conclusion.

Other Operating expenses are underspent by £178k year to date this is due to an underspend on consultancy which is offsetting overspends in Estates on legionella works, contract maintenance and utilities (£380k in total). There is still the non recurrent benefit of the pension reduction received in Month 1 of £315k.
The Trust has assumed that it will not receive Provider Sustainability Fund (PSF) in month as financial performance is below plan and A&E achievement is below trajectory, this has impacted the position by £1,751k year to date.

### Key Performance Indicators

<table>
<thead>
<tr>
<th>Category</th>
<th>Impact</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus/(Deficit)</td>
<td>↓</td>
<td>(£2,753k)</td>
</tr>
<tr>
<td>Risk Rating</td>
<td>↔</td>
<td>3</td>
</tr>
<tr>
<td>Agency expenditure</td>
<td>↑</td>
<td>£875k</td>
</tr>
<tr>
<td>Efficiency Savings</td>
<td>↓</td>
<td>£537k</td>
</tr>
<tr>
<td>Pay Variance</td>
<td>↑</td>
<td>£1,558k</td>
</tr>
</tbody>
</table>

### 2. FINANCE IMPROVEMENT PROGRAMME

The Trust has developed plans totalling £10.9m against a target of £12.03m. In addition, the Trust is currently processing a further £2.2m of schemes identified through the Recovery Plan process. These will be incorporated into FIP reporting once full validation and QIA process is completed. It is unlikely the programme will increase by the full £2.2m once double counts and updated forecasts have been incorporated as part of the current reforecast exercise (see below).

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Plan £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce – A&amp;C</td>
<td>688,308</td>
</tr>
<tr>
<td>Workforce – Medical</td>
<td>1,403,913</td>
</tr>
<tr>
<td>Workforce – Nursing</td>
<td>1,123,234</td>
</tr>
<tr>
<td>Outpatient Productivity</td>
<td>319,025</td>
</tr>
<tr>
<td>Theatre Productivity</td>
<td>473,797</td>
</tr>
<tr>
<td>Beds</td>
<td>1,424,898</td>
</tr>
<tr>
<td>Non-pay</td>
<td>1,480,683</td>
</tr>
<tr>
<td>Other</td>
<td>4,008,545</td>
</tr>
<tr>
<td><strong>Total Value of Current Schemes</strong></td>
<td><strong>10,922,403</strong></td>
</tr>
<tr>
<td>Recovery plan</td>
<td>2,200,000</td>
</tr>
</tbody>
</table>

M5 delivered £537k (64%) against M5 of target £842k, key areas of under-performance are Beds (£180k) and Medical Productivity (£86k).

YTD the Trust has delivered £2.37m against a plan of £3.04m which equates to 78% of plan. Areas of concern continue to be Beds and Medical Productivity which equate to £613k of the under-delivered value YTD.

### 3. FORECAST

The Trust is currently revising its forecast in light of the lower levels of activity and on-going shortfall on the savings plan. A revised position will be submitted to NHS Improvement as part of the quarter 2 submission.
4. **RISK RATING**

The “Finance and use of resources metric” forms part of NHS Improvement’s Single Oversight Framework. It is scored between 1 (best) and 4 (worst). The rating for August is a 3:

<table>
<thead>
<tr>
<th>Metric</th>
<th>Plan</th>
<th>Rating for August</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Service Capacity</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Liquidity</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>I&amp;E margin</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Variance from Plan</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Agency spend</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Weighted Average</strong></td>
<td><strong>2.4</strong></td>
<td><strong>3.4</strong></td>
</tr>
<tr>
<td><strong>Overall Rating after Overrides</strong></td>
<td><strong>3</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

The ‘Underlying Financial Performance’ risk on the Corporate Risk Register is rated 20 (extreme). The year to date financial position is worse than anticipated and exposes a gap in control on the underlying financial run rate.

5. **CASH & CAPITAL**

The month end cash balance was £1.0m. The Trust did not receive any deficit support in August, £1.3m will be received in September. Cash remains under considerable pressure, the Accounts payable team are prioritising those suppliers that are chasing for payment as necessary.

The capital programme expenditure was £466k in month, £1.8m year to date. The Trust was notified that it would receive £1m for the expansion of Emergency Ambulatory Care, this has to be implemented before the end of December.

6. **KEY MESSAGES**

- Month 5 results continue to cause concern due to the low levels of activity, although activity was higher than that seen in July it was not at the plan level for August. The Elective and Daycare work needs to overachieve for the rest of the year to recover planned levels. The emergency admissions which were holding their own financially are now behind plan, exacerbating the situation.
- Pay has shown an upturn in trend, only partly due to the Pay award, but also to an increase in agency, this will need to be closely monitored to ensure it doesn’t continue.
- FIP achievement is behind plan and the Trust will need to find further mitigations to offset this.
- NHS Improvement is requiring the Trust to reforecast and provide a revised recovery plan.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 26th September 2018
Agenda item 17

Report title: Safeguarding People Annual Report 2017/18

| Report author(s) | Vanessa Saunders, Deputy Director of Nursing  
Anna Fernandez, Head of Adult Safeguarding  
Tendayi Sibanda, Lead Nurse Safeguarding Children  
(Nurse)Named |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Report sponsor(s):</td>
<td>Jacqueline Walker, Director of Patient Experience and Nursing</td>
</tr>
</tbody>
</table>

Board Action required:

The Board are asked to:

1. Note the report.

2. Note that the Trust has requested NHS Improvement to undertake a deep dive into Mental Capacity Act and Deprivation of Liberty Safeguards requirements and governance arrangements to ensure these are as robust and effective as they can be following the outcome of the Care Quality Commission inspection where concerns were raised about staff knowledge and awareness and the completion of mental capacity assessments.

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

<table>
<thead>
<tr>
<th>STRATEGIC PRIORITY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery Area 5: Ensure we have safe, high quality sustainable acute services</td>
</tr>
</tbody>
</table>

Equality and Diversity: There are no implications arising from the report.

Financial Impact: There are no financial implications arising from the report.
Executive summary

1. Introduction

The Safeguarding People annual Report 2017/18 provides assurance to the Board that necessary frameworks are in place and appropriate actions have been taken to ensure the Trust fulfils its statutory obligations in regards to Safeguarding Children and Adults.

The report gives an account the safeguarding activity across The Hillingdon Hospitals NHS Foundation Trust between 1st April 2017 and 31st March 2018. It outlines reporting and monitoring arrangements, training and compliance levels and examples of practice change as a result of learning from safeguarding incidents. Key achievements are noted and priority actions for 2018/19 identified.

2. Policy updates

Safeguarding Adult and Children processes within the Trust continued to be compliant with statutory guidance and legislation including the Care Act 2014, Mental Capacity Act 2005, the Children Act 1989 & 2004.

Policies revised in 2017/18:
- MCA and DoLS Policy
- Restraint Policy
- Was Not Brought Policy

New policies developed in 2017/18:
- Policy to Manage Allegations Against Staff
- Safeguarding Supervision.

3. Key achievements

- Compliance achieved at Trust level for all mandatory Safeguarding training
- Compliance with WRAP training improved from 0% to 48%
- Consolidation of links with CNWL Learning Disability Team
- Tier 2 dementia training programme established and delivered
- Adult Safeguarding Supervision commenced
- LeDER process (Learning Disability Mortality Review) implemented
- Inter-agency work with Ealing Social Care and Community Health evaluated and gaps reduced
- Safeguarding Children Supervision documented and robustly monitored
- Learning from Child Deaths, Domestic Homicides and Serious Case Reviews disseminated; learning events held
- Child Protection –Information Sharing (CP-IS) system implemented
- Establishment of the Topaz team in maternity to case manage women with complex needs
4. Priorities 2018/19

To further strengthen the service a clear programme of work has been identified for 2018/19, with the following key priority actions:

**Whole service:**
- Publication of Trust Safeguarding Strategy 2018 – 21 and delivery of year 1 of the associated annual work plan
- Clarify accountability and roles regarding support for patients with mental health issues accessing services from the Trust
- Implement and monitor safeguarding supervision in line with Trust policy
- Review approaches to record safeguarding incidents and alerts to ensure processes are in line with risk management requirements and that there is synergy between safeguarding adults and safeguarding children

**Safeguarding Children:**
- Improve the care of 16-17 year olds within the organisation by ensuring in their discharge of duties, staff safeguard and promote their welfare.
- Work with partner agencies to review and improve the care of children and young people presenting with Mental Health and related needs
- Fully implement the NHS England Female Genital Mutilation –Information Sharing system.
- Review safeguarding children training and to develop a safeguarding children guideline
- Update the safeguarding and related policies to in line with new statutory guidance Working Together to Safeguard Children 2018 and Children and Social Care Act 2017.

**Safeguarding Adults:**
- Ensure Safeguarding Adults Committee is provided with comprehensive data regarding Section 42 enquiries, with outcomes and learning implemented
- Strengthen analysis of underlying reasons for DoLS applications not authorised working with the local authority to resolve process blocks, and escalating to senior managers/directors as required
- Achieve 85% compliance target for WRAP training
- Implement the Northwest London Pressure Ulcer Safeguarding Performa
- Scope and seek resources to provide robust and appropriate service to support people with Learning Disability and those lacking mental capacity who access services from the Trust
- Ensure learning from LeDER reviews is shared across organisation
- Revise safeguarding adults’ policies and training as required following publication of intercollegiate guidance for safeguarding adults.

5. Conclusion

The Safeguarding People Annual Report 2017-18 demonstrates that the annual safeguarding work programme has been delivered, and that the Trust continues to ensure it achieves effective arrangements in line with statutory safeguarding duties.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 26th September 2018
Agenda Item 18


Summary:
The main aim of the Infection Control team is to support the organisation in achieving compliance with the Health and Social Care Act (2008) and the Department of Health and Social Care (DHSC) directives and guidance in relation to infection prevention and control.

The report provides an outline of progress of work against this key strategic aims referencing the priorities outlined in the QSI strategy.

Key Points to note:

- There was one Trust-apportioned Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia case reported against the national zero tolerance. Learning points from the Post Infection Review (PIR) were addressed. Following updated guidance on the MRSA PIR process issued by NHS Improvement, the Trust is no longer required to carry out a PIR investigation but will carry out formal local reviews of MRSA cases.
- There were eight Trust-apportioned Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia cases, three more cases more than those reported for 2016/17.
- There were 19 Trust-apportioned Clostridium difficile cases, three of which were classed as a ‘lapse in care’ against a ceiling target of eight.
- There were 32 Trust-apportioned E.coli bacteraemia, one more than the number of cases reported for 2016/17.
- Following the implementation of modified admission MRSA screening guidance for the NHS (2014) the MRSA screening compliance for the year was 67 % (measured Dec – Mar 2018).
- There were two outbreaks of diarrhoea and vomiting between October and November 2017 affecting 21 patients on two wards of which Norovirus was confirmed. A further two episodes of diarrhoea and vomiting resulted in two wards being closed between December and January. Eight patients affected on one ward in January and three on the other ward in February. In these episodes none of the cases tested positive for Norovirus.
- The Trust continued to participate in the Public Health England mandatory orthopaedic surgical site infection surveillance system (SSISS) reporting on total hip replacement (THR) and repair of fractures of the neck of femur (NoF). The results have of the surveillance have not yet been released.
- The Care Quality Commission (CQC) inspected the Trust between the 6th and 9th of March 2018. The detail of the inspectors’ findings in relation to IPC will be shared in the next IPC Annual Report however it must be noted that the Trust continues to have a requirement notice for IPC and cleanliness.
The Learning and Development department switched the e-learning from WIRED to iDevelop leading to an improved accurate reflection of training compliance. As of 31st March 2018, 91% of non-clinical staff had completed Level 1 mandatory infection control training and 92% of clinical staff had completed Level 2 mandatory infection control training.

Priorities for the Year Ahead:

- Continue to work to reduce the number of healthcare associated infections and achieve the requirement of remaining below the *Clostridium difficile* threshold of seven (avoidable cases) cases.
- Continue to strive to achieve zero MRSA bacteraemia.
- Work towards embedding revised MRSA screening requirements, incorporating DHSC guidance by monitoring and achieving screening compliance.
- Maintain and improve hand hygiene compliance, including improving patient and staff perceptions regarding availability of hand hygiene facilities.
- Continue to raise awareness and ensure adequate preparedness relating to emerging multidrug resistant organisms including Carbapenemase Producing Enterobacteriaceae.
- Review the recognised aseptic non-touch technique (ANTT) programme to ensure that training is consistent Trust wide, competence is captured and regularly reviewed plus ensuring that data relating to this is validated.
- Undertake in-depth infection control environmental audits in all augmented clinical care environments and throughout the Trust in line with the annual audit calendar.
- Provide IPC training sessions for Student Nurses.
- Gain a more visible supportive presence on wards and departments.
- Support clinical and managerial staff to improve facilities and work processes to ensure infection prevention and control standards are optimised and embedded in practice, demonstrating positive compliance to our CQC inspectors.

Board Action required:

- Review and comment on the detail outlined in the annual report that demonstrates evidence of progress against the key priorities under this quality and safety strategic aim (Appendix I)

**Report from:** Jay Dungeni, Interim Deputy Director of Nursing and Integrated Governance

**Report sponsor:** Jacqueline Walker, Director of the Patient Experience and Nursing
Link to the Hillingdon Hospitals Strategic Plan 2017/21:

**Strategic Priority:**
Delivery Area 5: Ensure we have safe, high quality sustainable acute services

**Previous consideration at Board or Committees:**
Annual report to the Quality and Safety Committee, September 2018

**Equality and diversity considerations:**
None.

**Financial implications:**
There are no financial implications arising from this report.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 26th September 2018
Agenda item 19

Report title: Research & Development Annual Report 2017/18

Report author(s): Geraldine Landers, R&D Manager

Report sponsor(s): Dr Gulamabbas Khakoo, Medical Director

Board Action required:

The Board are asked to:

1. Note the Annual Report
2. Note that the key changes from the last report are:

• There are minimal changes to report this year in terms of R&D funding, numbers of research studies and patient recruitment. The Trust continues to have an active R&D department with an extensive research portfolio covering a wide range of clinical specialities even though there has been a reduction in NIHR funding in recent years.
• Challenges for R&D in 2017/2018 were to do with having limited office space, no clinic room to see patients, no appropriate storage for our fridges and freezers and lack of easy access to a laboratory. The R&D Manager post of WTE 0.8 is now inadequate. These issues have yet to be resolved.
• The key plan for 2018/2019 is to write an R&D Strategy for 2019-2023 which will address these challenges. The projected outcome of this would be an expansion of R&D resources and increased activity, successful collaboration with partners such as Brunel Partners Academic Centre for Health Sciences (BPACHS), Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) and Imperial College Healthcare Partners (ICHP) Discover project.

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

STRATEGIC PRIORITY:
e) Delivery Area 5: Ensure we have safe, high quality sustainable acute services
1. Summary
The Hillingdon Hospitals NHS Foundation Trust's main research activity is recruiting patients into high quality non-commercial and commercial National Institute for Health Research (NIHR) portfolio adopted multi-centre studies. We receive funding from the NIHR Clinical Research Network (CRN) North West London (NWL) to support this activity.

2. Research Income 2017/18
The Activity Based Funding (ABF) for 2017/18 from the CRN NWL was based on previous research activity, predicted activity and a performance premium based on the number of closed studies that Recruited to Time and Target (RTT). There are also study complexity weights funding ratios - 11 for interventional, 3.5 for observational and 1 for large scale studies. Fig 1 shows our recruitment to different complexity study types.
In addition, there is targeted investment for cancer, maternity and pharmacy and an allowance for Research Set-up & Management (formally called Research Management and Governance (RM&G)).
In 2017/18, the Trust received a total of £334,398.25 from the CRN NWL to support NHIR portfolio adopted research activity. We did not qualify for the capacity building funding of £20,000 from the Department of Health (DoH) in 17/18 as a minimum of 500 patients had to be recruited in a specific time frame to be eligible. Commercial and non-commercial research income (from sponsors) is also included in Table 1 below.
Our research funding is broken down as follows:

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Funding Stream</th>
<th>Funding 2017/18</th>
<th>Projected funding 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRN NWL</td>
<td>Research Activity-Based Funding (ABF)</td>
<td>219,109</td>
<td>209,743</td>
</tr>
<tr>
<td></td>
<td>Research Set-up &amp; Management</td>
<td>£26,484</td>
<td>23,781</td>
</tr>
<tr>
<td></td>
<td>CRN targeted investment</td>
<td>£40,272 (partially supports 3 research posts in cancer)</td>
<td>£40,272 (partially supports 3 research posts in cancer)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>£23,003.25 (Research Midwife x 9 months)</td>
<td>£28,500 (0.6 WTE Research Midwife)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>£25,530 (0.5 WTE clinical trials pharmacist)</td>
<td>£25,530 (0.5 WTE clinical trials pharmacist)</td>
</tr>
<tr>
<td>Total CRN</td>
<td></td>
<td><strong>334,398.25</strong></td>
<td><strong>327,826</strong></td>
</tr>
<tr>
<td>Department of Health</td>
<td><strong>Capacity Building funding from DoH</strong></td>
<td>0</td>
<td>£20,000</td>
</tr>
<tr>
<td>Commercial Income</td>
<td></td>
<td>64,049</td>
<td>47,000</td>
</tr>
<tr>
<td>Other Income from Non-commercial studies</td>
<td></td>
<td>15,400</td>
<td>15,412</td>
</tr>
<tr>
<td>Grand Total R&amp;D Income</td>
<td></td>
<td><strong>413,847.25</strong></td>
<td><strong>410,238</strong></td>
</tr>
</tbody>
</table>

Table 1
**A funding stream from the DoH to support research capacity building**

The above funding supports seven WTE R&D staff (mainly research nurses and trial coordinators) (Appendix 3). The workload demands on the R&D team are increasing just to
maintain the current level of activity e.g. there are increased levels of reporting and performance management by the CRN.

Fig 1

Our projected funding for 2018/19 is lower than previous years (Appendix 1). NWL CRN was expecting a 5% increase in their funding from the DoH for 18/19. All the NWL CRN finance modelling that was done prior to the announcement of the regional allocation was that Hillingdon’s funding allocation was expected to stay the same or increase slightly.

However, the regional allocation had a reduction of 3.8% rather than an increase from the previous year. Unfortunately, we have had a knock-on decrease of 4% equiv to £12,070. The regional decrease appears to be down to two factors;

- The DoH added a deprivation score index into the national modelling. This meant that all 3 London regions had a reduction and money was directed to the North.

- A greater amount of the national pot was allocated to performance (and consequently less to activity where our region does well). Our region had a year of poor delivery to time and target the year before which impacted on the allocation.

The London CRNs are having discussions with the DoH in order to avoid this decrease in future.

In order to continue to maintain/increase funding from Research we need to;

- increase our patient recruitment into NIHR adopted clinical trials
- supplement income by participating in commercial trials
- continuing to explore research options in specialities which are not research active
- use the CRN Strategic Work Force (no cost to us) to help increase our recruitment
- carry out thorough feasibility so that studies reach targets
- submit business cases to the CRN for additional income when opportunities arise.

3. Research Activity 2017/18

During 2017/18 we had 70 open studies of which, 85.7% were NIHR portfolio adopted non-commercial studies. Commercial research made up 11.4% of our activity. Student research projects accounted for 2.9% which is unfunded.
We recruited 485 patients into a total of 43 studies (Appendix 4). In addition, 124 staff took part in Health Services & Delivery research surveys. When compared to other similar sized Trusts in London, our activity appears to be on par. We exceeded our target by 33% which was greatly helped by taking part in the following studies; High-Intensity Specialist-Led Acute Care (HiSLAC), NICE guidelines and the place of the Faecal Immunochemical Test as a triage tool for predicting bowel cancer (NICE FIT) and the Pregnancy Lifestyle study in Maternity. A letter of thanks was received from the NIHR NWL CRN Clinical Director (Appendix 5). Figure 2 below shows the research activity in our research active specialities for 2017/18. The remainder of the 27 open studies are either now closed to recruitment with patients in follow-up, awaiting close-out visits, having queries being resolved or archiving is in progress.

### Table 2

<table>
<thead>
<tr>
<th>NIHR portfolio adopted non-commercial studies (ABF funding)</th>
<th>66 (83.5%)</th>
<th>60 (85.7%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhD and Masters studies (Unfunded)</td>
<td>2 (2.5%)</td>
<td>2 (2.9%)</td>
</tr>
<tr>
<td>Commercially funded studies*</td>
<td>11 (14%)</td>
<td>8 (11.4%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>79</strong></td>
<td><strong>70</strong></td>
</tr>
</tbody>
</table>

*Most commercial studies are also NIHR portfolio adopted*

4. Research Management & Governance
Since the Health Research Authority (HRA) approval process was introduced on 1st April 2016 our focus is now on assessing, arranging and confirming our capacity and capability to deliver studies. The NIHR CRN has set us a local objective that 80% of studies achieve set up within 40 calendar days (from “Date Site Selected” to “Date Site Confirmed”). This is
usually achievable with simple observational studies but presents more of a challenge with interventional studies that involve contracts, costings, collaboration with other hospital services etc. We achieved 65% as opposed to 66% in NWL (Appendix 2). The R&D Manager is the only person in the dept who carries out this task which can mean longer set up time during periods of annual leave or other demands. It would not be practical to have other research staff (nurses, trial coordinators) cover as it involves a different skill set and would take them away from recruiting to their own studies which would reduce our accruals. If our ambition is to increase the number of new studies being initiated in the Trust and to meet the 80% target then additional support will be required for the R&D Manager.

The local Governance arrangements include an R&D steering group, attended by the Medical Director, and reporting into the Regulation and Compliance Committee. A review of all facilities and procedures was undertaken prior to the CQC inspection to ensure there were no concerns around facilities or storage of specimens.

5. Workforce Development
The Trust regularly reviews its R&D workforce deployment to allow it to be responsive to the organisation and researchers. This ensures that local researchers have the skills and resources to recruit patients in a timely manner. Trust R&D staff are encouraged and supported to attend CRN training courses and conferences appropriate to their areas of work. Senior staff within the R&D team mentor and train junior staff. We provide face-to face and electronic Good Clinical Practice (GCP) training.

6. Supporting Life Sciences Industry (commercially funded research)
One of the Department of Health’s primary research objectives is to support the pharmaceutical industry in developing new drugs and treatments. We have eight open commercial studies with one new Ophthalmology study in set-up. Many of these commercial studies involve blood sampling and use of a laboratory to process the samples and freeze them at very low temperatures to maintain their integrity. R&D previously had access to the Trust pathology laboratory to do this. Since the switch over to North West London Pathology we no longer have easy access to this service and we will now be required to pay for its use. In order to support such commercial studies R&D will need its own laboratory room, a minus 80°C freezer, capability to centrally monitor freezer temperatures continuously, deal with temperature excursions, and have the ability to recall historical data. Without these resources we will be unable to participate in many commercial and non-commercial genetic studies.

Our performance RTT for Commercial open studies was below target (Appendix 2). Unfortunately, recruitment into our interventional commercial Haematology Cancer studies was very low mainly due to very strict inclusion/exclusion criteria and changes to those criteria since opening one of the studies due to urgent safety measures. One commercial observational ophthalmology study that was behind target at the time of the results has now exceeded target. We had two closed commercial studies one of which did not RTT. Failure to meet these targets will be addressed by carrying out very thorough feasibility for new commercial interventional studies to ensure that we meet this target and asking Principal Investigators to attend Feasibility Committee meetings.

7. The Future
The Trust’s ambition is to increase research activity, collaborate with Brunel Partners Academic Centre for Health Sciences (BPACHS) and others. This is building on Research and Quality Improvement being two of the five workstreams within the BPACHS partnership. In order to realise these ambitions, it will be imperative for R&D to have;

- additional office space
- additional R&D staff especially for research management
• a clinical consultation room to see research patients
• an R&D laboratory room
• a -80°C freezer
• capability to centrally monitor freezer temperatures and deal with excursions out-of-hours
• research to be a greater priority for trust divisions and support departments

We are currently writing an R&D Strategy that addresses the above points which will be presented to the Trust Board in the near future.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 26th September 2018
Agenda item 20

Report title: Medical Education Report

Report author(s): Dr Stella Barnes, Director of Medical Education (DME)
Report sponsor(s): Dr Gulamabbas Khakoo, Medical Director

Board Action required:

The Board are asked to: Note the report.

The key changes from the last report are as follows:
1. Greater concerns about communication from Health Education England (HEE) about changes in Foundation Year training, and late notice of vacancy gaps
2. The need to establish a more inclusive junior doctors representative body using a recently published Faculty of Medical Leadership & Management document (supported by NHS Improvement and NHS England) to ensure quality of training and support to all junior doctors (training and non-training posts) is improved.
3. Latest GMC trainee survey results show a deterioration, particularly in foundation years and acute medical specialties, mostly (but not exclusively) related to “out of hours” work, although no threat to withdraw trainees from HEE
4. Two new extreme risks just added to the Corporate Risk Register relating to junior doctor rota gaps and out of hours work, and a review of the Hospital at Night.

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

STRATEGIC PRIORITY:

h) Enabler Workforce
1. **Introduction**

Working and training at Hillingdon Hospital has been extremely challenging this year for many of our doctors in training, particularly in the acute specialties and this is reflected in both the CQC report and the GMC National Training Survey. The increase in workload from acute admissions, not just throughout the year, with only a small and temporary increase in staffing has significantly affected trainees’ experience of working here and learning effectively from their experiences. More detail about the GMC report and actions in response to this will be covered in the report.

**Health Education England (HEE)**

The organizational changes within the Health Education Team (HET) continue to affect trainees and local education teams. In the spring, Foundation Year 1 doctors (FY1) were informed that their jobs had changed for their FY2 year and that they had to re-rank posts and go through another matching procedure. Communication about this from the Foundation School was poor and inconsistent, leaving many trainees feeling angry and upset. The trust education team spent time supporting those affected here and communicating with the School.

Communication about other aspects of training has also been poor with many questions submitted to the HEE portal going unanswered in the advertised time frame, or being closed without having been answered. Our concerns have been fed back to HEE, as have those from other trusts. A business manager from HET has been given the task of liaising with trusts to improve information sharing.

**Challenges identified in the last report and progress against them**

- To continue to provide consistent, high quality training across all specialties in the face of unprecedented levels of activity
  - This has remained challenging and will be addressed throughout the report
- To improve the consistency of simulation training provision across the year
  - This is work in progress but the staffing changes outlined in the last report have now been actioned and the team are developing new teaching programmes. More information is included in section 3.
- To work with relevant stakeholders across the organisation to implement the “8 High Impact Actions to improve the working environment for junior doctors”
  - A group was convened to address these actions and this is progressing (details in Appendix 1)
- To clarify the role of Physician Associates as part of the medical support workforce.
  - This work is ongoing. There are currently 3 PA posts in medicine. The use of PAs is being explored in surgery and to support the medical on call team. A further update on this will come to November Trust Board.

2. **Quality Assurance and Governance Process of Education**

**The GMC Survey 2018 (Summary included in Appendix 2)**

Results were poor for the trust this year, particularly in the acute specialties. As a result, Health Education England is carrying out an inspection visit on Thursday 26th September. They will inspect Foundation training in medicine & emergency medicine, the medical part of the GP programme and higher training in acute medicine, care of
the elderly and gastroenterology.
Red and pink outliers were seen in a number of domains for each of these specialties. Common themes across the specialties included poor feedback for overall satisfaction, clinical supervision, especially out of hours, work load and supportive environment.
In addition, several patient safety alerts were raised about safety of patients being seen at evenings and weekends and the belief by the trainees that staffing was insufficient to safely attend to patients, made worse by rota gaps. Speaking to trainees, it is clear that their concerns relate almost entirely to out of hours on call work rather than their experiences within their individual specialty. One particular source of concern is the frequency of National Early Warning Score (NEWS) calls which require urgent attendance by doctors, who are at the same time expected to attend to acutely sick patients in the emergency department and acute medical unit or the wards across the hospital.

Trainees in Emergency Medicine report variable support from their middle & senior grades, difficulty referring to specialties and concerns about the level of staffing & the layout & capacity of the physical space available.
All doctors report an increase in short term rota gaps due to the pan-London bank and agency caps.

The DME is ensuring that actions relating to induction, supervision and curriculum coverage are urgently progressed.

Work done so far to address these concerns:
Medical staffing out of hours is on the department of medicine & corporate risk registers as an extreme level risk, rota gaps has been added as another extreme level risk.

During the winter months, winter money was used to employ extra junior staff, with a “twilight” registrar, an extra SHO during the day on Saturday & Sunday & an extra night SHO (all in Medicine) and an extra daytime Registrar (General Surgery).
Medical consultants have been doing extra weekend shifts, 7.00-13.00

Exploration of staffing at night and establishment of a Hospital at Night team
The Divisional Director (DD) and Assistant Director of Operations (ADO) for Women & Children's Services have reviewed current out of hours staffing and developed a costed model for a Hospital at Night team, where there is a site-wide approach to caring for patients out of hours, including NEWS calls and cross professional working to improve safety & efficiency. This includes the use of technician and administrative support to perform some of the functions that don’t need a doctor or nurse. The junior doctors have been actively involved in this review which has also been supported by HEE.
A number of costed options for additional medical or physician associate staffing have also been drawn up and discussed by the department of medicine.
Both these pieces of work will be used to inform business cases to be presented through the Business case process.

In addition, the action plan will be refined as a result of the survey and following the inspection visit, which will have clear timelines, ownership and accountability.
Of note, Ophthalmology received a very good report, following a negative one last year. The survey for Anaesthetics was also better this year, showing two green outliers, following a negative report last year. Paediatrics and psychiatry for foundation doctors also had good reports.

There were no red outliers for educational supervision and an overall improvement in educational supervision compared to last year’s survey.

**Risk Based Review (Education Lead Conversation) in Ophthalmology**

An action plan has been submitted to HEE in response to the visit, with some of the actions already closed. As mentioned above, ophthalmology had a very good GMC report this year.

**3. Simulation Centre and Training**

The Centre now has a permanent manager and a senior clinical fellow to oversee the annually appointed simulation fellow. This will facilitate the provision of simulation training more consistently throughout the year and facilitate the development of new potentially revenue generating courses. In particular, the Centre is working towards incorporating simulation training into the medical student experience at Hillingdon, which will set us apart from other trusts within the region and help attract more students. To date, a simulation pilot has been run for year 6. This was well received and is now incorporated into the year 6 induction programme.

The trust SIM lead is a co-chair of the North West London Simulation group of HEE, working to standardize training & share resources across the region.

**4. Junior Doctors Contract- Education Exception Reports**

2 exception reports were logged for missed opportunities in the last 6 months, both in Trauma & Orthopaedics where trainees had to cover rota gaps, causing them to miss scheduled theatre sessions. These reports have been closed.

**5. Supporting Trainers to Train**

**GMC National Trainers Survey**

Returns were only received for a few specialties. Of note, the trainer survey for paediatrics was very positive with green outliers for all but 3 of the domains. In contrast, the survey for trauma and orthopaedics (T&O) was very negative with red outliers in several domains. This has been discussed in the T&O local faculty group and the dissatisfaction is about rota gaps, how this is managed within the department and how it affects trainees, being pulled out of training opportunities and consultants who have also had to provide cover at short notice.

To support trainers, the DME developed & delivered educational workshops for educational supervisors on “Supporting Trainees through Career Decisions” & “Recognising, Supporting & Managing Trainees in Difficulty” in May with excellent feedback. The topics were chosen by surveying supervisors on a range of possible courses. They will be repeated in the autumn. The DME also developed and
delivered a session for the new consultants group on giving effective feedback & having effective conversations with trainees with excellent feedback.

A number of experienced educational supervisors have relinquished their role this year due to having insufficient time in their job plans. Some new consultants have been recruited to take their place, but there was a delay in some trainees being allocated a supervisor following the August rotations.

6. **Undergraduate Medical Course - Imperial College**

Imperial College are undergoing a major change to their curriculum which will affect Hillingdon Hospital over the next 2 years. The replacement of Orthopaedics & Rheumatology with Specialty Choice Placements (SCP), has already had an impact on the SIFT budget for 2018-2019. Although many of our consultants agreed to provide SCP modules, Hillingdon did not receive any placements for this year. The Year 3 placement students at Hillingdon have been reduced due to the roll out of the GP programme for this academic year. However, the Year 3 intake numbers are projected to increase for the next academic year 2019-2020.

The Annual Governance and Education Monitoring Report (GEMV) from Imperial College School of Medicine in March 2018 was excellent with positive comments relating to clinical teaching fellows, support from the Medical Education team, and high quality formal teaching.

The interim action plan includes visibility of educational programmed activities for consultants, ensuring robust processes for student absenteeism, and specific actions related to improving Obstetric teaching.

7. **Physician Associate Masters Programme - Brunel University**

Dr Bassam Aweid, consultant stroke and care of the elderly physician, has been appointed as medical director to the course. Recruitment is underway for lecturers to teach on the first year of the course to replace Dr Aweid’s previous role and to increase the use of practicing clinicians in delivering the course. Feedback from the PA students has been positive, however there has been some feedback from the medical students from Imperial and consultants that there are now too many students on one firm. The trust is taking fewer PA students this year, with only 1 or 2 per firm whereas last year, we took extra students as Imperial did not have places for them.

8. **Plans for 2018/19**

1. To reduce the medical staffing out of hours risk on the Corporate Risk Register by implementing the Hospital at Night recommendations.

2. Establishing an effective junior doctors representative body, to address concerns affecting all junior doctors, including those not in training posts. This should incorporate the learning and tools from the FMLM report.

3. The Divisions working with People and Organisational Development and HEE to ensure that in specialties with repeated rota gaps, there is a proper and robust recruitment plan, which does not involve a “like for like” replacement, and urgently explore international recruitment, taking advantage of the Brunel University link.

4. Clear messaging and implementation of the bank and agency rates, and using...
solutions such as e-rostering across the Trust, to reduce short term rota gaps using the Trust Bank. This has reduced rota gaps by nearly 50% in the specialties where it has been implemented and a Trustwide rollout and timeline has been agreed.

5. Implement the action plan agreed as a response to the GMC survey to ensure that quality of training improves in areas where there were concerns.

6. Building on simulation training and the high impact actions such as rewarding excellence, and promoting wellbeing and support for our trainees. Furthermore, equipping our trainers with the techniques for delivering high quality training and supervision.

7. Ensure trainers continue to be in place in all specialties (with good succession planning) and are equipped with the tools to provide high quality training, and being clear what the latter looks like.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 26th September 2018
Agenda item 21

Report title: Seven day Clinical Standards and the Trust participation in the North West London Early Adopter Programme

Report authors: Nikki Jackson, Clinical Lead for 7 Day Services, Divisional Director Women & Children
Report sponsor: Abbas Khakoo, Medical Director

Board Action required:

The Board are asked to:

Note the results of the April 2018 National 7 Day Services Audit
Note that whilst this program is supported centrally, commissioning and delivery are the responsibility of CCG’s and providers

Key changes from the 2017 report:

• Compliance with all 4 core standards (not compliant with standards 2 and 8 in 2017) except weekend ultrasound and weekend MRI which need a formal risk assessment and Standard 8b at weekends (on-going review)
• Compliance was significantly dependent on winter funding with additional senior surgical and medical staff at weekends
• The maternity standards have been revised for senior consultant presence (new standard is 12 hours on site presence 7 days per week)
• The Seven day services clinical lead post has been disestablished, and the work incorporated into one of the Improving Patient flow workstreams (R2G/SAFER chaired by the Medical Director)
• There remains uncertainty about the National audit process from October 2018

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

STRATEGIC PRIORITY:

f) Improving the present - A&E 4 hour standard - 18 week Referral to Treatment - Meet cancer targets - Complete CQC action plan - Implement year 2 of Quality and Safety Improvement Strategy - Maintain finance and use of resources score of 3 - Meet control total
Background

This report is the annual update to the Board regarding the Trust’s progress with the national 7 day Clinical Standards and the Trust participation in the North West London Early Adopter Programme.

Ensuring that patients receive a consistent, high standard of care is a priority for the NHS. The National Seven Day Services programme seeks to ensure that emergency and acute care is of that same high standard whichever day of the week a patient is admitted to hospital. The improvement of 7 day services is also a key part in the Urgent and Emergency Care (UEC) Improvement Collaborative, optimising the UEC patient flow throughout the hospital journey. Consistent services seven days a week are an integral part of the ambition to get Londoners the right care at the right time and in the right place.

The National 7 Day Clinical Standards
The ten national 7-day Clinical Standards are listed in Appendix 1. The 4 priority Standards, with which we, as an early adopter, were meant to demonstrate compliance by April 2017 are:
Standard 2: Time from admission to Consultant Review
Standard 5: Access to Diagnostics
Standard 6: Access to Consultant-directed Interventions
Standard 8: On-going Review

These 4 Standards have been audited nationally every 6 months since March 2016, with the most recent audit taking place in April 2018. Until now, we have not been compliant with Standard 2, partially compliant with Standards 8 and 5, and compliant with Standard 6.

The previous 7DS Audit in September 2017 had focussed on Standard 2, the standard that was proving the most challenging to implement. National results from that audit were not published. The last full audit was therefore March 2017. Since early 2017 there have been multiple changes within the hospital to address the challenges of increased levels of activity through the Emergency Department, improving patient flow through the hospital and the worst winter we have seen at Hillingdon.

The ward reconfigurations that took place in the 2nd half of 2017 aimed to co-locate Specialty patients on their appropriate ward, as well as the development of a Frailty Unit on Lister Ward. AMU is staffed by dedicated acute consultants, including two additional posts. Specialty doctors provide input into AMU as necessary, but are freed up from attending the acute handover, being able to concentrate on their own wards. SAU has been co-located within AMU. Winter monies allowed the temporary appointment of an additional medical consultant weekend mornings, to concentrate on patient review on the Specialty wards at the weekend. This allows the acute consultant to concentrate on new admissions and the post-take ward round. In addition there was an additional daily twilight shift medical registrar providing support over the busiest time of day.

Other steps proposed in the Board paper of September 2017 are still ongoing:

• The roll-out of Nervecentre e-handover tool across the hospital has been
completed for the nursing staff, but is still being developed and rolled out for medical staff, so the anticipated improvement in ease of identifying and locating patients who need daily or twice daily consultant review has not yet been fully realized.

- The Business Case to support introduction of 7-day therapies is still being considered.

**April 2018 National Audit**

This Audit was, for the first time, undertaken prospectively covering admissions across a 7 day period from 00.01 on Wednesday 18th April to 23.59 on Tuesday 25th April. At THH this included 194 patients.

Prospective data collection resulted in increased clinical engagement and was less cumbersome than in previous audits. All emergency admissions had a data collection form added to their clinical notes on admission, for daily completion by the clinicians. Because at that stage the length of stay was unknown (patients with less than 14 hour stay were excluded), this meant that data was collected for many more patients than were necessary, and was time-intensive during the 12 days of the audit, but minimised the need for the audit department to obtain the notes after discharge in order for the form to be completed. In previous audits this process had encompassed the vast majority of the audit department workload for several weeks.

**Results:**

Results are still provisional, but are shown in Appendix 2. We do not yet have any comparator results for the rest of the sector / London for April 2018. Compliance cut-off is 90%.

**Standard 2:** For the first time we are Compliant with Standard 2.

The majority of this change is due to a large improvement in timely patient review in the Department of Medicine. This was significantly aided by the additional medical staff supported by resource from the Winter Bid. These posts are no longer funded, so sustained compliance is uncertain.

Within medicine there was no difference in time to first review whether a patient was admitted in the week or at the weekend. All medical emergency admissions are seen by the acute physicians initially, so dividing medical admissions out by Specialty for this Standard does not make sense within our current model of care. The presentation of results in this way has been continued purely for comparison with previous audits.

Paediatrics has 24/7 Consultant cover of A&E and so should remain compliant. Obstetrics also has 24/7 resident consultants for 4 weekdays, and has shown a significant improvement in first review during the week. This is due to improved processes at handover, highlighting any recent ward admissions who still need Consultant review. At weekends, obstetrics, along with gynaecology and surgery do not have resident consultants, but operate an on-call system with routine hospital attendance only once daily. Gynaecology and surgery also do not have extended hours of consultant presence in the week.

**Standard 8 – ongoing clinical review. Subdivided into:**

8A – twice daily consultant review of acutely unwell patients.
8B – daily consultant review once transferred to a general ward, unless this review would not affect clinical care. May be delegated by the consultant to another doctor or health professional.

Overall we remain compliant with this Standard, although we are still not compliant with 8B at weekends. There appear to be two main reasons for this:

The workload within the Department of Medicine out of hours has increased significantly, and despite the increase in number of hours of acute consultant presence, there are still not enough medical or skilled nursing staff to manage the workload appropriately. Alternatives to employing further doctors, such as increasing the availability of Critical Outreach nurses, use of Physician Associates etc are being investigated as part of the Hospital at Night workstream.

Documentation within the clinical notes regarding need for clinical review over the weekend remains suboptimal. A significant number of patients, particularly on Care of the Elderly wards, do not require consultant review over the weekend, as they are undergoing therapy or rehabilitation. This is still not clearly and categorically stated in their notes – whilst this doesn’t necessarily detract from the patient’s care, it makes it impossible to exclude them within the audit from need for daily review.

Standard 5 – Access to diagnostics
We are compliant with the Standard overall, although weekend access to MRI and echocardiograms are the areas which remain non-compliant. The introduction of weekend in-patient MRI slots was considered in a business case, but not thought to be cost effective. There are pathways for transfer to another unit for the investigation if CT is thought to be unsuitable. The current level of clinical need for echocardiogram at the weekend is not felt to warrant further investment.

We continue to work with NWL to develop and implement Clinical Decision Support Systems and a Radiology Network throughout the sector. There have been significant improvements in radiology reporting turnaround times. One of the major hurdles in improving access to diagnostics is the lack of trained personnel, particularly sonographers and NWL is working with HENWL to address this.

Standard 6 – Access to Consultant-directed Interventions
THH and NWL compliant with this Standard

Next steps

- Standards 2 and 8 – Maintenance of the staffing levels present during the audit is necessary in order to maintain compliance
- Business cases for more medical staff need to be focussed on areas with highest impact on patient safety and patient flow, and in conjunction with consideration of alternatives, eg use of other staff groups in addition to doctors
- The continued roll-out of Nervecentre e-handover tool across the hospital should also help identify and document those patients who need daily or twice daily consultant review
- Business cases for 7 day therapies to be progressed
- Formal risk assessment of weekend MRI and echocardiography non-provision
- To continue engaging in the NWL/ National Audits and maintain existing compliance
• Revised London Maternity Standards require 12 hours dedicated Labour Ward cover 7 days per week, so a service review will be required
• The Seven Day Services work is part of the SAFER / Red2Green workstream, overseen by the Emergency Care Recovery Board. New emergency care models of care need to take account of the 7 day standards
• The Clinical Lead for Seven Day Services post has been dis-established, so the Divisional Directors and Audit team will need to support future audits.
• Future audits – there is a proposal from NHSE to move towards a Board Assurance model for Trusts compliant with the 4 core standards. We may need to undertake smaller Divisional audits to confirm compliance maintained, which could be run through the Clinical Audit and Effectiveness Committee. Maintaining medical staffing levels is likely to be a pre-requisite to assurance.

Equality and Diversity considerations - None at this stage

Financial implications - It is still likely that future investment will be required, particularly to maintain Standard 2. Achievements to date referenced in this and previous reports have mainly been met either via Winter Bid money, CQUIN (Commissioning for Quality and Innovation) allocation or via business planning within divisions. The exceptions to this are the Radiology Deep Dive and the pilot studies, which were commissioned by the North West London (NWL) Collaboration of CCGs.

Appx 1 – Clinical Standards Feb 2017

Appx 2 – April 2018 THH provisional results
Report title: People Strategy 2017-22 update

Report author(s) Rachel Stanfield, Deputy Director People and Organisational Development

Report sponsor(s): Terry Roberts, Director of People and Organisational Development

Board Action required:
Note progress against the People Strategy 2017-22 objectives and milestones

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

STRATEGIC PRIORITY:
Enabler: Workforce
This report updates on the five ‘pillars’ of the People Strategy 2017-22 (Year One)

By March 2019 we said we would …

• Clearly define our Employee Value Proposition (EVP) through staff engagement
• Reflect the EVP across a range of media including social media
• Develop values-based recruitment (VBR) with our managers
• Maximise our end to end recruitment system so that time to hire is in the top quartile
• Implement new initiatives to improve recruitment to our staff bank
• Put in place bespoke Divisional recruitment action plans
• Lead recruitment campaigns in the UK and abroad as needed
• Maximise student recruitment

Impact on key metrics

• A reduction in our vacancy rate from 15.32% (July 2017) to 12.76% (August 2018)

• A reduction in agency spend from £1,156,175 (July 2017) to £874,972 (August 2018)

• A reduction in Time to Hire from 57 days (July 2017) in to 33 days (August 2018)*

We have …

• Actively promoted our EVP: https://vimeo.com/253695350
  https://www.thh.nhs.uk/documents/Jobs/Hillingdon_Cares_values.pdf including across social media (#JoinaTeamThatCARES)

• Developed a VBR framework along with values-based interview questions and established a values screening question on our end to end recruitment system (TRAC)

• Continued to reduce Time to Hire even further, e.g. by enabling daily shortlisting by managers and developing more streamlined processes for internal appointments

• Implemented Whatsapp communication for bank staff and streamlined the process for re-joining the staff bank when people leave

• Implemented recruitment initiatives including: monthly recruitment Saturdays; local shopping centre events; targeting of agency nurses to offer them incentives to join the Trust; developing bespoke recruitment plans for hotspot areas

• Recruited Indian nurses: 239 offers made and accepted – the first nurses have arrived and we expect a total of 33 by the end of Dec 2018, with a steady pipeline expected after that (up to 12 per month)

• Student nurses are routinely offered conditional posts subject to completion of clinical placements and academic work; a minority of offers made to last year’s final year students were accepted. We are doing a deep dive to understand and address the reasons for this, including detailed review of student feedback. We are also closely monitoring the experience of current 3rd year students and will be holding a Student Nurse Forum meeting by the end of October in order to support engagement with this group

* Reporting since April 2018 has been in working days
By March 2019 we said we would ...

- Implement a new LMS supporting e-learning and on boarding
- 1:1s the norm for all staff
- Embed clinical and non-clinical apprenticeships training into the whole hospital
- Identify gaps in Apprenticeship standards and develop trailblazers
- Become an employer provider organisation
- Hold discussions with HEI partners regarding establishing a clinical school, with joint shared posts across THH and HEI
- Decide upon viable CPD modules and appropriate pathways to benefit the organisation and its future service provision
- Location venue for Hillingdon Clinical School defined and costed
- Leadership Framework in place
- Targeted talent management and succession planning for key roles
- Evaluate and improve Leadership In Action

We have ...

- iDevelop is established and all Level 1 STaM is available online
- 1:1 policy developed, with supporting forms for use in iDevelop being piloted
- Reduced Corporate Induction been from four days to two days: on boarding is now one day for all staff, two days for clinical staff. Further development of the process is underway to ensure full compliance with StA of all staff before they complete induction
- Apprenticeships: 61 Apprenticeship starts forecast by year end; Advanced Nurse Practitioner and Advanced Clinical Practitioner Standards developed with Brunel - validation in September; funding secured from HEE for Nursing Associate Apprentices; cohort of 15 agreed; procurement in progress
- Hillingdon Clinical school: Joint working especially with regards to placements with CNWL; in-house OSCE programme for overseas nurses established with pass rate of 90%; dedicated clinical skills lab now in place for teaching
- Preceptorship and rotational programmes established and supporting nurses in transition and aiding retention
- Nursing Career Map developed and available for staff on intranet
- Competencies for career development written and available on the intranet for nursing staff Bands 5-7
- Work shadowing programme for Health and Social Care students from local FE successful and developing future home grown nursing workforce
- The Leadership in Action programme has been re-designed in line with evaluation feedback and now includes sessions on coaching and the Hillingdon Improvement Practice

Impact on key metrics

- A reduction in turnover from 14.75% (July 2017) to 12.17% (August 2018)
- STaM compliance is 86.95% (August 2018), which is a decrease on the baseline figure of 89.63% (July 2017)
By March 2019 we said we would …

- Ensure management controls in place to reduce agency expenditure, including ‘no-PO, no pay’
- Embed rostering across all clinical areas
- Develop a suite of interactive reporting tools and make them available for managers to manipulate workforce information
- Maximise use of direct engagement model maximised
- Collaborate across NWL and Pan-London to reduce agency rates and increase bank usage

We have …

- Developed a comprehensive Consolidated Temporary Staffing Plan 2018-19 based on NHSI Best Practice and monitored monthly via the Workforce Transformation Steering Board (WTSB)
- Improved controls for Medical Staff through the centralised locum bank
- Improved management information to support controls - available through the 247Time system
- Ensured regular monitoring of the medical agency spend/usage against vacancies, through the fortnightly Medical Productivity meetings
- Rolled out Health Roster in Medicine with a plan to roll out to all clinical areas for medics 31 January 2019
- Developed a range of interactive workforce information reporting tools with improved granularity, including vacancy trajectories, recruitment SLA data and a comprehensive workforce dashboard
- Made these tools available to all managers via the Trust Intranet
- Included all staff groups in the direct engagement model (247Time)
- Signed up to Local London Rates (LLR) for agency staff from October 2017 and bank LLR rates from 3 September 2018

Impact on key metrics

- A **reduction in agency spend** from £1,156,175 (July 2017) to £874,972 (August 2018)
- **Delivered a saving of £342,181** from the 247Time direct engagement scheme (from June 2017)
- **Sickness absence rates have increased** from 3.22% (July 2017) to 3.71% (August 2018)
By March 2019 we said we would …

- Understand future supply levels working with HEIs
- Identify gaps in workforce
- Define future models required
- Ensure routine processes for skill mix review and analysis of vacant posts
- Work with HEIs and Health Education England (HEE) and others to develop new models and roles
- Anticipate, plan and implement for recruitment and retention implications of the ACP and AHSC with Brunel including the likely need to upskill the residual hospital workforce

We have …

- Secured funding from Health Education England to support 15 Nurse Associate Apprentices
- Designed and delivered OSCE training for overseas workforce with a pass rate of 90%
- Supported HEI partner in recruitment initiatives
- Identified gaps in the workforce locally and bottom up through Divisional planning and action planning
- Reviewed skill mix on ad hoc basis around vacancies as they arise
- Participated in trailblazer groups for both BSc Nursing and Nursing Associate standards
- Developed an OD Strategy for ACP which includes recruitment and retention, people development initiatives.

Impact on key metrics

- A reduction in our vacancy rate from 15.32% (July 2017) to 12.76% (August 2018)
- New roles in key areas include: four physician associates; eight extended scope practitioners; three nurses in training to support nurse-led AMU clinics
By March 2019 we said we would …

- Ensure EDI interventions are standard in recruitment
- Put in place a Development Centre for BAME staff and a BAME network
- Member of Stonewall Index
- Develop a Coaching strategy and deliver a coaching for managers training pilot
- Develop tailored retention actions via pulse surveys
- Ensure Staff Survey action plans are in place on a rolling basis
- Put in place organisation-wide online stress risk assessment folders
- Streamline routine health screening for new recruits

We have …

- Senior BaME staff trained and process in place to ensure presence at all Band 8a + interviews
- First BaME development centre has run and been evaluated; second centre ran in August 2018
- BaME network re-launched with new Chair and to be called Equality Diversity Network
- Signed up as members of Stonewall and developed three priority areas to address in our first 12 months
- 35 managers have attended Coaching skills training in 2018 (57 since the middle of last year). Programme being evaluated.
- Coaching being introduced in Leadership in Action programme and will also key element of the Hillingdon Improvement Practice
- 100-Day retention survey piloted across the organisation (starters from April 2018) and is being refined for further roll out
- Taken forward the ‘Happy App’ working with NHSI
- Developed action plans to address the Staff Survey 2017 findings and are further developing actions with the Divisions
- Actions are aligned with existing People Strategy goals and initiatives where possible, to ensure that the Staff Survey is addressed as part of business as usual and monitored as part of the Divisional Review process
- Developed the stress section for the Health and Safety Folders
- Launched the Health and safety folders in limited number of areas of the Trust, with a plan to roll out to all clinical and non-clinical areas of the Trust in Year Two
- Moved Occupational Health recruitment health assessment to the end to end recruitment system

Impact on key metrics

- A reduction in turnover from 14.75% (July 2017) to 12.17% (August 2018)
- Fewer new starters leaving within 12 months – 8.4% in August 2018 compared to 15% in July 2017
- National data analysis indicates that we may perform better than others against WRES Indicators 3 and 7*
- Staff Engagement Score (NHS National Staff Survey) in the above average range

* WRES Indicator 3 = Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation; WRES Indicator 7 = Percentage believing that trust provides equal opportunities for career progression or promotion
Meeting of the Board of Directors – Public Part I session

Date of meeting: 26th September 2018
Agenda item 23

Report title: Occupational Health Staff Flu Vaccination Plan 2018-19

Report author(s) Saghir Siraj, Occupational Health Manager

Report sponsor(s): Terry Roberts, Director of People and Organisational Development

Board Action required:

The Board are asked to:

Note the report for assurance purposes

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

STRATEGIC PRIORITY:

e) Enabler: Workforce
1. Introduction
This plan has been drafted to give clear guidance on the process for providing access for all staff to receive the influenza vaccine.

2. Aims and objectives
This winter the Trust will be running a staff vaccination campaign, open to all Trust staff. The objectives of the plan are to:

- Provide simple and easy access.
- Help to promote high uptake equally among all departments.
- Clearly communicate where and when staff can receive their vaccination.
- Encourage an early uptake of the vaccine before the winter flu season commences.
- Coordinate clinics and publicity with Flu Champions in all patient facing departments
- Coordinate a coherent and effective publicity campaign with the Communications team

3. Learning from Last Year
Last year saw the largest uptake of staff flu vaccinations ever in the Trust and this placed Hillingdon with the 4th highest uptake out of the 36 London NHS Trusts. In order to build on this success we have reviewed learning from last year’s campaign.

Positives:

- Staff liked the walk in clinics with a target of them waiting no more than 5 minutes
- The all user e-mail asking staff if they would like to have the vaccine or not, helped to concentrate minds into making a decision and improved uptake.
- Staff liked the friendly conversational approach in occupational health rather than a preachy approach which health care workers can find condescending.
- Staff who had the vaccine the year before were more likely to have it the year after, resulting in a cohort of staff who were compliant with having the vaccine.
- Occupational health nurses were able to deliver a high volume of vaccines as long as staff came forward to have the vaccines in an organised manner.
- Relationships between occupational health and the wider staff population was good and showed some excellent examples of working together to deliver the vaccine. The vaccine is not compulsory and therefore goodwill is an important ingredient to an effective campaign.

Negatives:

- Visits to the clinical areas were often not effective. Occupational Health staff were left standing with no engagement from staff and no areas provided to give the vaccine to staff.
- Training ward staff to provide flu vaccines was not effective. We trained 4 staff who altogether only administered 6 vaccines. This was due to competing responsibilities on the ward staff’s time and also lack of experience of delivering this type of campaign.
• Departmental engagement was directly linked to leadership within departments. Leaders who were negative about the flu vaccine could have a tremendous impact on uptake within their teams and vice versa.

• Communication feedback and updates regarding the flu vaccine both top down and bottom up was concentrated on the occupational health department and therefore direct links to the departments were not formed.

• Occupational health were required to suspend all none emergency workload for September and October to concentrate on delivery of the vaccine.

• Funding for a dedicated flu nurse that was available in 2016 was declined in 2017.

4. Campaign and Flu Champions 2018
Occupational health will coordinate with flu vaccine champions in all patient facing departments. Assistant Directors of Nursing and Medical Clinical Speciality Leads will provide OH and other clinical leads with Manager/Ward Manager, Consultants from each department to assist with coordinating vaccinations in their areas. A Flu Champion will also be required from other patient facing departments i.e. Radiology, Therapies and Domestic staff.

The “Flu Champions “responsibilities will be:

1. Liaise with occupational health to organise flu vaccine clinics for their areas. At least 2 visits will need to be arranged.

2. Provide a point of contact and an area for the OH Nurse to work with when they arrive on the ward.

3. To coordinate OH flu visit to maximise the number of staff that undertake the vaccination and let staff know OH are on the ward and encourage vaccinations.

4. Departmental point of contact for publicity materials on the staff flu vaccinations.

5. To be part of the wider “Flu Champions” e-mail group. To share experiences and success and answer concerns or suggestions from interested parties.

6. Train as a flu vaccinator if they find this useful intervention for their department, however this is not essential.

5. Vaccination Campaign
Access to the vaccine will initially be provided to the clinical areas followed by the vaccine being available to all staff in the Trust. The visits to the areas will be at least twice and more often if demand requires it. This is to ensure early access to the higher risk areas and to ensure that if there are any breaks in supply of vaccine; those at higher risk are vaccinated first. The responsibility for organising these visits will be with the Flu Champions to arrange.

For those who are not on duty at the time of the departmental visits the vaccine will be available from the occupational health department on a walk in basis. Staff will also be encouraged to attend flu vaccines clinics that are happening in other clinical areas other than their own, if they find this more convenient with their shift pattern.

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Action</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2018</td>
<td>Order supply of appropriate Flu vaccines in appropriate quantities</td>
<td>Occupational Health Manager Pharmacy lead</td>
</tr>
</tbody>
</table>
### Timeline

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Action</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2018</td>
<td>Business case for Flu Nurse funding</td>
<td>Occupational Health Manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deputy Director of P&amp;D</td>
</tr>
<tr>
<td>June 2018</td>
<td>Flu plan submitted to Pandemic Flu Group</td>
<td>Occupational Health Manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pandemic Flu Group</td>
</tr>
<tr>
<td>September 2018</td>
<td>Flu plan to Trust Board for approval</td>
<td>Director of P&amp;OD</td>
</tr>
<tr>
<td>August 2018</td>
<td>ADN and Clinical Leads to be asked to provide a list of Flu Champions, 1 per department and one Consultant per speciality to OH.</td>
<td>ADN</td>
</tr>
<tr>
<td>August 2018</td>
<td>Communications plan</td>
<td>Occupational Health Manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Head of Comms</td>
</tr>
<tr>
<td>September/October 2018</td>
<td>Receipt of first supplies of Flu Vaccines. Flu Champions to be informed to organise clinic visits in their departments.</td>
<td>Occupational Health Manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Flu Coordinators</td>
</tr>
<tr>
<td>Winter period</td>
<td>Flu clinics in the OH department and visits as organised by Flu Champions</td>
<td>Occupational Health Manager</td>
</tr>
<tr>
<td>March 2019</td>
<td>Final figures for NHS England</td>
<td>Occupational Health Manager</td>
</tr>
</tbody>
</table>

6. Responsibilities

**Director of People and Organisational Development**: Executive lead on the staff flu vaccination campaign. Responsibility for organising and delivering the campaign delegated to the Manager of Occupational Health.

**Executive Team**: To promote the uptake of the flu vaccine and monitor uptake by division.

**Occupational Health**: Provide access to the vaccine for all staff during office hours. Compile the statistics both for the Trust and NHS London.

**Pharmacy**: Provide up to date information on the supply of the vaccine both in terms of timelines and quantity and recommended product.

**Managers**: Ensure that staff are informed of the importance of having the vaccines and provide support to their staff so that they are allowed the time needed to have the vaccine. To arrange at least 2 flu vaccination visits to their departments and to provide a positive environment for vaccinations.

**Employees**: Are expected to consider having the vaccine unless contraindicated for health reasons.

**Communications**: Liaise with OH and infection control in promoting the message through posters, e-mail, pop ups, intranet, social media and other forms of communication. Assist in providing a league table of vaccinations between the divisions and placed on the intranet.
Assistant Directors of Nursing/ Senior Clinical Managers / Medical Clinical Speciality Leads: Provide a list of Flu Champions for each of the patient facing areas and to take responsibility for encouraging uptake in their areas.

Flu Champions: As stated in section “2018 campaign and Flu Champions”

7. Vaccination Supply
The vaccine supply is expected in the Trust in the last week of September/first week of October; however this date is not absolute and may change at short notice.

8. Expectations for this Year’s Uptake
We are hoping to replicate or improve on the last year’s high uptake. Last year’s uptake placed Hillingdon as the 4th highest uptake out of the 36 London NHS Trusts. The CQUIN target for 2017/2018 was for a 70% uptake. This was achieved by THH. The CQUIN target for 2018/2019 is for a 75% uptake which has a value to the Trust of £117,418.

9. Review
OH will review the success of the campaign regularly with the infection control team and the Flu Planning meeting in order to identify if the campaign is successful and if any adaption’s in strategy need to be put in place.

10. Conclusion
Access to the vaccine will be available within a 7 minute walking distance to anyone in the Trust throughout the winter period. Managers and staff are expected to assist the Occupational Health department in making this a successful campaign and protecting themselves, their families, patients and colleagues from the affects of influenza.

The three key messages for this year’s campaign are:

- Protects yourself and your patients
- Reduced spread of influenza leads to reduced hospitalisation and reduced pressure on the winter health service
- Reduces staff absences during the busy winter period

11. Equalities

Equality and diversity considerations: To ensure that all staff groups have adequate access to the flu vaccinations i.e. part time workers, night workers, disabled

12. Finance

Financial implications: None
Meeting of the Board of Directors – Public Part I session

Date of meeting: 26th September 2018
Agenda item 24

Report title: Learning from Deaths (LFD), Quarters 2 and 3 2017/18

Report authors: Abbas Khakoo, Medical Director
Karin Dawson-Smith, Clinical Audit and Effectiveness Manager

Report sponsor: Abbas Khakoo, Medical Director

Board Action required:

The Board are asked to:
1. Note that quarterly reporting of deaths falling within certain criteria to the Trust Board is a requirement from NHS Improvement
2. Review the report and scrutinise for appropriate scope, learning, quality and improvement

The Board are also asked to note the following changes from the last report:-

3. Good progress has been made to catch up on outstanding mortality reviews and no new trends have been observed in terms of numbers or themes
4. From April 2018 the New Structured Judgment Review (SJR) is in place with the previous CESDI process for all cases up to April 2018 now complete
5. A new Learning from Deaths (LfD) policy incorporating the SJR process is in the process of being reviewed.
6. The link between the LfD and SI process is working well as is the Learning disability process for mortality reviews
7. Temporary/bank resources are now in place whilst job description and a Business Case for Mortality Lead nurse are being progressed
8. The requests from NHS Improvement relating to investigating and assuring the outlying HSMR status identified in 2017 have all been completed
9. There will be a further resource requirement for the Medical Examiner role to be in place by April 2019. This is compounded by the fact that unlike most organisations the Hillingdon Hospital Trust Lead for mortality is the Medical Director.

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

STRATEGIC PRIORITY:
f) Improving the present – Implement year 2 of the Quality and Safety Improvement Strategy: Aim 3 - Working towards no preventable deaths
Learning from Deaths Final Figures for 2017/18 Q1 – Q4 NQB Framework

All in-hospital deaths are reviewed in accordance with the Trust Learning from Deaths (LFD) Policy which was approved by public Board in Sept 2017 in line with the National Quality Board Framework (NQBF) (March 2017) based on the CQC report Learning, Candour and Accountability (Dec 2016).

This paper outlines the final closing figures for the 2017/18 Learning from Deaths Audit and the first quarter Q1 2018/19 of the new Structured Judgemental Reviews

Learning from Deaths Audit 2017/18

Only those cases that fitted specific criteria listed in the Learning from deaths policy were sent out for review. The purpose of reviews and investigations of deaths in which problems in care might have contributed to is to learn in order to prevent recurrence.

The figures and dashboard for this report are as follows:

Learning for Deaths Audit final figures for 17/18.

<table>
<thead>
<tr>
<th></th>
<th>Total No. Deaths</th>
<th>Total notes sent for review</th>
<th>Total No. Deaths Reviewed</th>
<th>CESDI3</th>
<th>CESDI2</th>
<th>CESDI1</th>
<th>CESDI0</th>
<th>LD* Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>191</td>
<td>146</td>
<td>146 (76%)</td>
<td>0</td>
<td>3</td>
<td>8</td>
<td>135</td>
<td>0</td>
</tr>
<tr>
<td>Q2</td>
<td>173</td>
<td>126</td>
<td>122 (71%)</td>
<td>1</td>
<td>3</td>
<td>9</td>
<td>109</td>
<td>1</td>
</tr>
<tr>
<td>Q3</td>
<td>219</td>
<td>153</td>
<td>151 (69%)</td>
<td>0</td>
<td>3</td>
<td>14</td>
<td>134</td>
<td>0</td>
</tr>
<tr>
<td>Q4</td>
<td>260</td>
<td>162</td>
<td>157 (60%)</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td>143</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>843</td>
<td>587</td>
<td>576 (68%)</td>
<td>1</td>
<td>9</td>
<td>45</td>
<td>521</td>
<td>1 (0.2%)</td>
</tr>
</tbody>
</table>

*LD=learning disability

During 2017/18, 587 patients reached the criteria for review. The total number of deaths reviewed (576) are those cases that were reviewed by Consultants and proformas completed and returned. There were 11 cases that were sent out for review but not returned.

The majority of deaths 521 (90%) were Grade 0: Unavoidable Death, No suboptimal care.

There were a further 45 cases (8%) Grade 1: Suboptimal care, but different management would not have made a difference to the outcome. All of these cases were reviewed by Consultants and further reviewed by the specialist nurse to identify learning and learning themes.

Of the cases reviewed 9 (1.6%) were Grade 2: Suboptimal care, but different care MIGHT have affected the outcome. These cases were reviewed by the Consultant responsible for the case and presented at the governance meeting to share learning.
However in Q2 there was one case that was initially graded a CESDI 2 that after review by the Divisional Director was deemed to be a Grade 3: Suboptimal care, different care WOULD REASONABLY BE EXPECTED to have affected the outcome, (probable avoidable death). This case was declared and SI and went to the SI Assurance Panel on 19/7/18. An amber NEWS call went out when it should have been a Red NEWS call.

The new key learnings from the Grade 1 and Grade 2 cases will continue to be shared at the meeting of the Mortality Surveillance Groups attended by all Divisions and disseminated to their Divisional Governance meetings (as detailed before to Trust Board). The key themes are:

Delayed discussions regarding ceilings of care and a subsequent comfort care plan, inability to discharge end of life patients due to lack of community support, delay in doctors attending amber NEWS calls, and delays in making therapy referrals.

There are no concerning trends in terms of numbers of cases at CESDI 1-3 level, nor any new themes in terms of suboptimal care.

There was 1 Learning Disability (LD) death in in Q2 (August 17) – This was Reviewed by Safeguarding team under LeDeR (LD reporting system) and reported to the Safeguarding Board: The lessons for the Trust were:

1) Giving a good clear handover from hospital to carers, i.e. how to manage her breathing difficulties when she gets home.
2) For staff to be clear on the difference between a Learning Difficulty & a Learning Disability.
3) To ensure that staff document that they have considered MCA for someone with LD and possibly a DoLs.
4) Notable good practice including a joint meeting took place on the ward with the patient, which included the consultant and the liaison nurse, and the consultant completing a referral to the LD team.

All relevant actions have been completed.

Structured Judgemental Review process 2018/19

From April 2018 the Structured Judgement Review (SJR) as recommended by the Royal College of Physicians was introduced. Level 1 screening is performed for all deaths by a doctor and any concerns regarding care are escalated to an SJR, as are a certain number of pre-defined conditions (eg peri-operative death, sepsis, VTE). Finally, a random selection of notes are subjected to the SJR. The aim is to complete the majority (>75%) of SJRs within a 30 day timescale recommended by the LFD process, the remainder within 60 days. The Learning from Deaths policy has been updated to reflect the new process and criteria.

As part of the level 1 review other factors are also recorded for the End of Life Care board and these are reported in Appendix 1. It is known that 46% of patients were receiving palliative care and were therefore considered to be end of life.

Consultants trained to do SJR reviews received notes that fulfilled criteria for review. Each SJR takes 60-90 minutes, considerably longer than the current proforma and the outcome is graded 1 – 6

Score 1 Definitely avoidable
Score 2 Strong evidence of avoidability
Score 3 Probably avoidable (more than 50:50)
Score 4 Possibly avoidable but not very likely (less than 50:50)
Score 5 Slight evidence of avoidability
Score 6 Definitely not avoidable

Learning from Deaths Table

<table>
<thead>
<tr>
<th>2018-19</th>
<th>Total no. Deaths</th>
<th>Total no. identified for SJR</th>
<th>Total no. sent out to consultants (none overdue)</th>
<th>Total no. returned</th>
<th>Avoidability of death judgement score: 6: Definitely not avoidable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>181</td>
<td>25</td>
<td>14</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

Even though all deaths reviewed so far via SJR were definitely not avoidable, there are lessons identified, some of these still need to be presented by SJR reviewer to the next Mortality Surveillance Group.

Medical Examiners will be introduced in April 2019, the lead nurse for mortality will be attending a Medical Examiners Conference at The Royal College of Pathologists, on 20/09/2018 when the Medical Examiners role will be made clearer.

Other outstanding items from Mortality Surveillance Group (MSG)

In 2017, the Trust was identified as an outlier for HSMR (an index of standardised mortality). Whilst this has now significantly improved, a number of audits have been carried out against specific conditions identified as outliers, and ensuring correct coding particularly palliative care coding. This has been overseen by NHS Improvement. No clinical concerns have been identified, and the coding audits have given reassurance, so all the requests have been completed and reports sent. The MSG continues to review HSMR at specialty / condition level detail, along with the rate of palliative care coding compared with peers.

Actions from the Further Plans for 2018 (from previous Trust Board reports) and progress:

1. Embed Structured judgment review (SJR) process
   Largely complete, 22 SJR reviewers trained
2. Introduce and embed a system for consultants to present their findings and ensure the presentations are forwarded to the Learning from Deaths Lead
   Completed
3. Deal urgently with backlog of 2017-18 cases so that in the next quarterly report to the Trust Board the 2017-18 cases will all have been reviewed using the previous CESDI process, and aim to present Q1 2018-19 using the SJR process
   This has now been completed and report attached
4. Await further guidance from NHSI and the Department of Health regarding reporting criteria, and reporting portal
   Still awaited
5. Introduce a system of appropriate family involvement
   In progress
6. Work with CCG to identify community deaths and share learning across the health system
   In progress, discussed at Clinical Quality Group
7. Ensure learning is strong with evidence of actions
   Clear cascading of the learning in place
8. Substantiate Learning from Deaths Lead Nurse - Job description with job matching, then
   needs business case, interim nurse in place on Bank

Further Plans for 2018:

   1. Understand the role of the Medical Examiner, likely to need a Business Case.
Meeting of the Board of Directors – Public Part I session

Date of Meeting: 26th September 2018
Agenda item 25

Report title: Safer Staffing – Planned and Actual Staffing Levels (nursing)

Report author(s): Vanessa Saunders, Deputy Director of Nursing
Report sponsor(s): Jacqueline Walker, Director of Patient Experience and Nursing

Board Action required: The Board is asked to note the report, specifically:

- The analysis of this paper is that despite ongoing pressures and nursing vacancies across inpatient areas, shift fill rates and Care hours Per Patient Day (CHPPD) averaged across the month were sufficient to support safe care.

- THH: Average fill rates for RNs showed slight downward trend across both day and night shifts. HCA fill rate continued to be above plan due baseline budget/template adjustments identified in Establishment Review not being implemented. Upward trend, compared to previous months, noted for HCA average fill rates at night, partially off-set by downward trend in average RN fill rate.

- Average CHPPD at THH skewed due to impact of day units and birthing unit. NHSI protocol requires patient count to be taken at 23.59, when numbers are low for these units. Work is underway to understand how other Trusts are approaching this issue.

- MVH: Average fill rates and CHPPD were stable. Where these are showing below plan this is associated with flexing staff in line with varying activity on Trinity Ward.

- Increase in RN vacancies at THH noted in July, stabilised in August. RN vacancies at MVH reduced slightly in both July and August.

- the Board is advised that implementing supervisory status for Ward Managers will increase RN vacancies by 1 whole time equivalent across each ward within the scheme. This is being introduced in a phased approach to avoid increased use of agency staff pending recruitment.

Reporting is by exception (Appendix 2) where indicators have varied significantly from target and/or increased management action is required to mitigate risk.

Link to the Hillingdon Hospitals Strategic Plan 2017/21:
STRATEGIC PRIORITY: Delivery Area 5: Ensure we have safe, high quality sustainable acute services

Equality and Diversity: There are no implications arising from the report.

Financial Impact: There are no financial implications arising from the report.
1. Overview

The report provides the Board with an overview of the average nurse staffing levels (actual levels against planned levels, expressed as a percentage) for June, together with average Care Hours Per Patient Day (CHPPD). CHPPD is calculated by adding hours of registered nurse/midwives (RN/RM) and the hours of health care assistants (HCA) and dividing by the number of patients at 23.59 hours; it is reported split by RN/RM and HCA, and as a total.

To provide context, vacancy and turnover data for the areas covered is also provided; a suite of Nurse Sensitive Outcome Indicators (NSOIs) for each ward is detailed in Appendix 1. This information is triangulated with other intelligence and where there is a need for enhanced surveillance or scrutiny, this is reflected in the R.A.G. rating. Wards scored as amber in August were unchanged from June:

- Jersey; rationale includes high vacancy rate with associated reliance on temporary staffing, FFT satisfaction scores
- Kennedy; rationale includes high patient dependency resulting in increased staffing requirement in addition to high vacancy rate with associated reliance on temporary staffing, of which a significant proportion were filled by agency staff
- Fleming ward; rationale includes a proportion of the beds being escalation capacity with associated reliance on temporary staffing and short-notice requirement to open additional beds.

Actions underway to mitigate pressures and risk are summarised in the exception report (Appendix 2).

2. Staffing levels against plan

Average fill levels remained overall stable across both sites, as demonstrated in the graphs and tables below.

There was a slight downward trend in RN fill rates at THH across both day and night shifts, with average fill rates for RN shifts at 91% of plan during the day and 91.9% at night. HCA fill rate however continued to be above plan; the Establishment Review undertaken in 2017/18 identified the need to revise establishments to support the increased number of dependant patients. The continued use of additional duties continues pending budgetary changes, which are currently being finalised. There was an additional upward trend, compared to previous months, noted for HCA average fill rates at night, partially off-set by downward trend in average RN fill rate.

Average CHPPD for RNs at Mount Vernon reduced following the increase noted in April. The patient dempgraphic at Mount Vernon site, with no ITU or maternity unit, would suggest a lower average CHPPD is required compared to at the Hillingdon site. This change therefore does not give cause for concern.

Underlying the monthly averages reported in the data, there have been individual shifts where available staffing was not considered to be in line with actual demand. There was a total of 17 suboptimal staffing incidents raised during the month; none
have been recorded as “low harm” incidents. Matrons have confirmed that where they identified staffing to below optimum levels, staff were redeployed from other areas where possible.

a) Average fill rates and monthly trends

<table>
<thead>
<tr>
<th>Site Summary Data</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>August 2018</td>
<td>Day</td>
<td>Night</td>
<td>Day</td>
<td>Night</td>
<td></td>
</tr>
<tr>
<td>Average fill rate</td>
<td>Average fill</td>
<td>Average fill</td>
<td>Average fill</td>
<td>Average fill</td>
<td></td>
</tr>
<tr>
<td>RN/RM</td>
<td>rate Care</td>
<td>rate Care</td>
<td>rate Care</td>
<td>rate Care</td>
<td></td>
</tr>
<tr>
<td>Hillingdon</td>
<td>91%</td>
<td>91.9%</td>
<td>91.9%</td>
<td>152.5%</td>
<td></td>
</tr>
<tr>
<td>Mount Vernon</td>
<td>81.4%</td>
<td>81%</td>
<td>96.6%</td>
<td>96.6%</td>
<td></td>
</tr>
</tbody>
</table>

b) Average Care Hours Per Patient Day and monthly trends

<table>
<thead>
<tr>
<th>Site Summary Data</th>
<th>Care hours Per Patient Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2018</td>
<td>Cumulative count of patients @ 23.59</td>
</tr>
<tr>
<td>THH</td>
<td>11340</td>
</tr>
<tr>
<td>MVH</td>
<td>729</td>
</tr>
</tbody>
</table>
3. Vacancies and turnover

The tables and graphs below show the number of vacancies (budgeted establishment minus filled posts), new starters and leavers for the inpatient areas covered by this report, over the last six months. The data is provided by Workforce Information and the Head of Resourcing, and is in relation to the clinical areas listed in Appendix 1 and does not represent the vacancy or turnover position for the entire nursing and midwifery staff group.

c) Vacancy and turnover trends for inpatient areas

4. Conclusion

Average shift fill rates and Care Hours Per Patient Day were stable, although continued reliance on temporary staffing to achieve these rates is noted. Reported suboptimal staffing incidents were assessed and actioned by senior nursing staff to maintain patient safety; all were recorded as not causing harm. Nurse-sensitive outcome indicators were in line with previous months. It is reasonable to conclude that nurse staffing levels across inpatient areas in August were adequate to maintain safety.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 26th September 2018
Agenda item 26

<table>
<thead>
<tr>
<th>Report title: Freedom to Speak Up Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report author(s) Cherma St Clair; FTSU Guardian</td>
</tr>
<tr>
<td>Report sponsor(s): Terry Roberts; Executive Director of People &amp;OD</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Board Action required:</th>
</tr>
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<tbody>
<tr>
<td>The Board are asked to: Note the report for assurance purposes</td>
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</table>

<table>
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<tr>
<th>Link to the Hillingdon Hospitals Strategic Plan 2017/21:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STRATEGIC PRIORITY:</strong></td>
</tr>
<tr>
<td>h) Enabler: Workforce</td>
</tr>
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</table>
1.0 Introduction

Speaking Up matters. It is vital as it helps to keep improving our services for all patients; the working environment and experience of our workers and visitors. Nationally the Speaking Up agendas are evolving at a dynamic pace and we are tasked to keep abreast of the developments and address directives locally.

2.0– Key Update on Freedom To Speak Up (FTSU)

In May, 2018, NHS Improvement and the National Guardian Office jointly published two documents: Guidance for Trust Boards on Freedom To Speak Up and Freedom To Speak Up self-review Tool aimed to help boards create a culture that is responsive to feedback and focus on learning. The Guidance outlined in details what is expected of all NHS Trust and NHS Foundation Trust in relation to Freedom To Speak Up (FTSU); to include having a structured approach with a clear vision that is then translated into a robust realistic FTSU strategy; linking speaking up with patient safety, staff experience and continuous learning. Within the Guide individuals’ responsibilities are defined, including that of the FTSU Guardian and specifics for FTSU board papers.

The Freedom To Speak Up self-review Tool accompanying the guide, is set to enable boards to carry out in-depth reviews of Leadership and Governance arrangements in relation to FTSU and identify areas to develop and improve. The Board considered this at its August Board Seminar. It is the expectation that following completion of the self-review, an improvement action plan will be developed which will help the Trust to evidence its commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust’s speaking up culture is. The Trust appointed FTSU Guardian together with the executive and the non-executive leads for FTSU must have focus on learning and continual improvement.

The National Guardian Office (NGO) has launched October 2018 as the Speaking Up month and have asked all Guardians to take this opportunity to come up with plans to promote speaking up locally and nationally. Planned activities are contained in Appendix I. The NGO continues to publish case reviews report, of which recommendations and learning are applicable to all organisation nationally. The NGO have also published a revised version of the Guidance for Freedom to Speak Up Guardians on Recording Cases and Reporting Data. The revised version defines more clearly the data categories guardians are ask to record, help distinguish between data that is being collected quarterly, to other information that guardians will need to record to help manage cases and enable ‘pharmacists’ to be identified as a separate group of staff who speak up.

3.0 Key updates from Trust FTSU Guardian

3.1 Progress review of last paper recommendation.

Looking back at the last six months plans, the FTSU Guardian have engaged with key stakeholders and work is on the way to addressed what was set out then.
• Speaking Up session continues to be delivered on request to various staff groups.
• Walk arounds visits to departments continues. These visits are most productive as it is at these times that most concerns are raised.
• The FTSU Guardian has contributed to several department newsletters and quarterly articles in the Nurse Ed Focus newsletter.
• Freedom to Speak Up intranet page is now set up and will be updated regularly.
• All NEDs have participated in a seminar session on raising concerns and are now speaking up advocates. Work is on the way to recruit Freedom to Speak Up Champions.
• Attendance at divisional Governance meetings has begun and continues.
• Close working with Clinical Governance and People and organizational Development has commenced.

3.2 No of concerns & themes - January to June, 2018.

For the period January to June 2018, the FTSU Guardian received a total of forty-two concerns, eleven with elements of patient safety and sixteen behaviour issues. Quarterly breakdown are illustrated in Graph 1 below. The remaining 15 cases varied from, relationship breakdown with colleagues and managers to those wanting to be the solution to situation and requesting advice and signposting.

Graph 1 Q4 = January –March, 2018, Q1 = April – June, 2018

Analysis by percentage shows a fluctuating trend for patient safety, Q4=30% & Q1=20% whereas the picture for behaviour issues is an upward trend Q4=37 % & Q1=40%

Patient safety issues have been escalated to the relevant clinical lead and or manager. Bullying have been escalated to P&OD and relevant senior leader. A number of approaches have been applied to tackle other issues

Patient safety issues included inadequate communication, training and competence, practice and staffing. All concerns escalated were addressed and strategies employed to resolve.

Graph 2 -Cases breakdown by division
Further breakdown of the medical division

From the total number of concerns raised in medicine 52% came from emergency care (AMU 23.53%; A&E 29.41%) in Q4 and 55.56% in Q1 (AMU). There were no concerns raised from outpatient setting within medicine.

Graph 3- Professional group of staff speaking up

This trend remains unchanged where Nursing staff are in the majority for speaking up. None were raised by Pharmacy staff.

In addition 13% (2) of staff speaking up were male during Q1 and 7% (2) during Q4.

3.3 Trends of Concerns reported to date

This final graph (4) shows the total number of cases to date since the appointment of the FTSU Guardian; drop in the number of cases in the last period ((Q1-18/19).
Except for one staff, all workers have said that they will speak up in future. I include some feedback quotes received: “impartial responsive support”, “wrongdoing must not be tolerated” “thanks for information and direction”.

Barriers to speaking up are now emerging. Feedback from staff highlighted that not knowing what was happening to concerns raised or not receiving timely feedback discourages themselves and others from speaking up. Workers have said that when concerns are raised to seniors’ responses such as “that’s how they are”; “we know; there is nothing we can do”; or “let see they are good with their work” are unhelpful. Managers appear to be reluctant to address staff behavioural issues. This failure to hold staff to account is seen as barriers to raising concerns. A few staff revealed that they were asked by HR to produce evidence when they report behavioural issues which of putting. For some, fear of suffering detriment if they speak up is real whilst others are still unclear about the purpose and role of the FTSU Guardian.

4.0 Trust response to National directive and emerging Local themes

4.1 Approach to address the national directives:
- The Executive team completed the self-assessment, engaged in seminar workshop and gave suggestion for FTSU vision. Further consultation with key stakeholders at every level within the Trust is now ongoing.

4.2 Plans for FTSU Month - Refer to appendix 1

4.3 Approach to address barriers to Speaking:
- People and OD have reviewed and implemented process in handling concerns raised.
- Information for handling concerns is accessible on FTSU Webpage for managers.

5.0 Recommendation
- FTSU Guardian will continue work and engage with Clinical Governance and People &OD; Divisional Governance to triangulate speaking Up data.
- Develop assurance framework to demonstrate learning and improvement from concerns; Shift in culture.
- The FTSP Guardian will actively work with the Executive team in developing the Trust FTSU vision and Strategy aiming to launch in March, 2019
Meeting of the Board of Directors – Public Part I session

Date of meeting: 26th September 2018
Agenda item 27

Report title: Board to Ward Safety Walkabouts – July to September 2018

Report author(s): Lis Paice, Non-Executive Director
Report sponsor(s): Lis Paice, Non-Executive Director

Committee Action required:
The Board are asked to: Note for assurance purposes progress to date.

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

STRATEGIC PRIORITY:
e) Delivery Area 5: Ensure we have safe, high quality sustainable acute services
1. Background

The 2018 CQC inspection report rated Hillingdon Hospital as Inadequate for Safety on the basis of observed failures in certain areas. The report questioned the safety culture of the hospital and commented on lack of visibility of Board members in areas such as outpatient.

Safety walkabouts are a well-recognised way of assessing and supporting a safety culture. International research tells us that most of the variation in safety culture occurs at unit level (e.g., ward level), rather than at hospital level.

Safety walkabouts were already undertaken by Board members, in particular by the CEO and chair, but they did not include a safety checklist and did not cover all areas. Following the CQC report, the non-executive directors agreed to lead programme of safety walkabouts encompassing all areas in the trust where patients went, using a checklist of safety questions focusing on issues raised by the CQC.

2. Objectives of the Walkabouts

- Safety walkabouts provide an opportunity for staff to raise safety concerns in their area.
- While not an inspection, they provide an opportunity for the visitors to question staff about safety issues and observe any lapses in standards.
- They are designed to educate the Board on what is happening at the service front line and to support individuals with resolving safety issues.
- The aim is to identify themes that arise and unblock barriers to support staff in achieving what is expected of them.
- The inclusion of patients and governors helps ensure a user's perspective.

3. Implementing the Walkabouts

The walkabouts were led by non-executive directors accompanied by an executive or senior manager and a governor or patient from the Lay Strategic Forum. A brief paper outlining their roles and responsibilities was sent to each visitor. A list of questions was provided and visitors were asked to identify four to five safety issues in each area and ask what action had already been taken to resolve the issue. An on-line survey tool was provided for ease of reporting findings. 87 areas across the trust (64 in HH and 23 in MtV) were identified. The areas were grouped into bundles of 2-3 areas, taking an expected 2 hours to visit.

The walkabouts were scheduled for between 20 July and 25 September 2018. The visitors included 7 non-executives, 5 executives, 6 senior managers, and 15 governors or patients. The area manager was contacted shortly before the visit. On arrival the visitors explained the purpose and emphasised that this was an opportunity for the staff to raise concerns. After going through the safety checklist with the manager, the visitors toured the area and spoke with other staff and patients, asking if they had safety concerns.
4. Safety Issues Reported

At the time of this report only the HH visits have been completed, so the following findings refer to HH. Safety issues reported in at least 4 areas in HH are set out in the following chart.

Space limitations created problems especially with storing equipment, mobilising patients and providing a suitable environment for waiting. Limited space made purchase of modern equipment problematic even with a good business case.

Staffing was a frequently reported issue, with the surgical wards reporting 47% vacancy levels. There were issues with log-ins and induction for locum or agency staff. Ward sisters personally participated in the recruitment process in order to secure staff.

Security was a concern in many areas. It was easy for the public to enter and exit the Emergency Department and Radiology. It was impossible to secure some areas from inside. Panic buttons were not available in all reception areas. Staff felt insecure when working late.
Medicines security and COSHH were checked wherever relevant and occasional issues were noted eg iv solutions or cleaning fluids stored in unlocked cupboards. In some cases the cupboards or locks were of poor quality.

Maintenance jobs were often the subject of frustration. Examples were failure to fix macerators, stop leaks or replace lightbulbs. Frustration was expressed that the only way to get jobs done was to escalate or make repeated calls.

The heat this summer created a difficult working environment. Few areas had air-conditioning and temperatures rose to uncomfortable levels. The environment for patients and staff in ED and in ENT and Ophth OPD was particularly trying.

Reports about cleaning varied from satisfaction in areas with a dedicated cleaner who was part of the team to frustration in areas where cleaning was inconsistent and unreliable. The visitors saw examples of dirt or mess that staff had walked past.

Clutter was usually due to lack of space to store equipment, but sometimes was created by mobility aids at the bedside, ward rounds and visitors. Clutter affected access in some areas.

Hand hygiene was explored in all areas. Most had training, a monthly audit, plenty of hand sanitisers and handwashing points. Staff spoke of challenging others if they did not comply with hospital policy about Bare Below Elbows. Mostly it was nurses who challenged doctors. Several staff were observed wearing wrist watches in clinical areas.

Staff facilities were generally poor. Few areas had staff rooms with lockers for staff and where they existed they were often small and poorly furnished or maintained. The patients and governors were particularly concerned that staff were expected to work without comfortable places to take breaks, change or leave their things.

Equipment that was broken, unsuitable or unavailable was an issue in some areas. One ward did not have a hoist and when a heavy patient fell the staff were unable to lift him without borrowing a hoist from another ward. Radiology had a problem with a business case for more modern equipment because the fabric of the building is so poor the case has to cover replacement lighting, electrical, drainage issues.

Notes security was generally good with patient records kept in locked trolleys, but in some areas nurses had to challenge doctors to put notes back or to lock the trolley before going to see a patient.

Fire hazards were more often pointed out by the visitors than raised as an issue by staff. They included blocked fire exits and fire doors wedged open.

Electrical wires were occasionally found on the floor or dangling.

Sepsis, confidence with using IT, and CARES values were on the list of issues explored. Ward managers were covering these topics with their staff and extra training had been provided where necessary.

5. Good practice
Many of the reports commented on the dedication of the nursing staff, examples of excellent teamwork, ward manager leadership of their area, and communication with patients and relatives.

The visitors spoke to patients during the walkabouts, asking if they felt safe and well looked after. The replies were uniformly positive, patients praising the care they received from nurses and doctors.

6. Action

Some issues were sorted out on the spot following a conversation with the visitors. Some have been escalated to the appropriate support teams.

A list of the safety issues reported has been sent to the Chief Operating Officer, who has undertaken to ensure that the issues are forwarded to the appropriate managers for investigation and action. A further review will ask staff in each area what has changed as a consequence of the walkabouts.

7. Evaluation of the Walkabouts

The visitors were sent a questionnaire asking for their views on the usefulness of the visits, how we could improve the walkabouts and how we can improve the safety culture of the hospital.

15/33 visitors responded. Thirteen respondents strongly agreed the walkabouts were useful both to the visitors and to the staff visited and that they should be continued. Two were not sure they added value. Most respondents thought they should occur quarterly and all respondents were willing to participate in the future.

To improve the walkabouts, it was suggested that doctors should participate, that the questions should reflect the findings of the previous round and explore whether anything had changed, and that there should be a scoring system.

To improve the safety culture, it was suggested that staff should be encouraged to challenge each other more, that there should be incentives like ‘ward of the month’, that staff not complying with ‘bare below elbows be excluded, that leaders of the ‘good’ wards should help those of the ‘requires improvement’ or ‘inadequate’ wards, and that patients be empowered and encouraged to speak up.

8. Future Steps

The Board is asked to agree
a. that after a brief interval the managers of the areas visited should be thanked, sent a copy of this report, and be invited to comment on whether anything has changed with respect to the issues raised since the previous visit
b. that safety walkabouts should take place quarterly, although areas without safety issues in this round could be visited less frequently
c. training should be developed to prepare new visitors for their role
d. themes from the last round should form the basis of an updated set of questions and progress on issues previously raised in an area should be reviewed
e. the walkabouts should cover all areas of the Trust, not just clinical areas
f. future reports should go to the Quality and Safety Committee in the first instance.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 26<sup>th</sup> September 2018
Agenda item 8

<table>
<thead>
<tr>
<th>Report title: RTT Recovery Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report author(s): Melissa Mellet, Director of Operational Performance</td>
</tr>
<tr>
<td>Report sponsor(s): Joe Smyth, Chief Operating Officer</td>
</tr>
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**Board Action required:**

The Board are asked to:

1. Note the Report

<table>
<thead>
<tr>
<th>Link to the Hillingdon Hospitals Strategic Plan 2017/21:</th>
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</thead>
<tbody>
<tr>
<td><strong>STRATEGIC PRIORITY:</strong> f) Improving the present - 18 week Referral to Treatment</td>
</tr>
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</table>
1.0 **Background on Elective Programme**

The Trust has underperformed on elective activity to the end of July 2018. The activity plan was set based upon activity in 2017/2018. During the first quarter of 2018/19, the division of Surgery and Anaesthetics had frozen all but essential (cancer patients) waiting list initiative activity. The main drivers were:

- Organisational capacity challenges impacting cancellations and day case capacity.
- The move of all elective orthopedic operating to the Mount Vernon did not yield the expected outcomes.
- Pain interventions were halted during June due to the impact of contract variation for lower back pain and acupuncture.
- Maintenance within the theatre department took 2 theatres out of action for 6 weeks.

### 1.1 Financial Recovery of the Elective Programme:

In order to recover this activity and therefore income the Division will

- Ensure the use of every fallow list prioritising high volume; low cost activity
- Add additional WLIs on the same principle
- Monitor numbers of bookings and number of actual cases performed on a weekly basis
- Continue with the successful work of the theatre productivity product
- Ensure that all consultants have provided 42 weeks of activity
- Optimise the day case facility on both sites

<table>
<thead>
<tr>
<th></th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
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<td>Plan</td>
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<td>1011</td>
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<td>-151</td>
<td>-102</td>
<td>40</td>
<td>40</td>
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2.0 **RTT Recovery**

Current plans for the 92% RTT standard do not deliver a sustainable Trust aggregate RTT admitted position. This is driven by the conversion of additional non-admitted activity to admitted in some key specialties, where teams have not been able to identify the further capacity needed.

NHS Elective Care Intensive Support Team (IST) started on the 11th September, 2018 to help support the Trust to understand the drivers of poor performance which will support the development of a recovery and sustainability plan to identify interventions needed to reduce the number of long waiting patients and the list as a whole.

2.1 **Current Performance:**

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<tr>
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<tr>
<td>4.2 RTT</td>
<td>RTT - Incomplete Pathways Perf.</td>
<td>92%</td>
<td>87.1%</td>
<td>86.5%</td>
<td>n/a</td>
<td>87.7%</td>
<td></td>
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<tr>
<td>4.2.4</td>
<td>RTT - 52 Week Waiters</td>
<td>0</td>
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<td>0</td>
<td>n/a</td>
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<td>4.2.5</td>
<td>RTT - Waiting List Size</td>
<td>22773</td>
<td>24303</td>
<td>24497</td>
<td>n/a</td>
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</table>

- The RTT position was at 86.5% in July against the 92% incomplete pathways.
2018/19 contractual target with the CCG is to maintain last year’s waiting list size. The target is 22773 (2017/18) and as of July there were 24752. The Trust is 1979 patients above waiting list target. This is due to a significant increase in the non-admitted waiting list and day case and elective activity being behind plan. The above recovery plan for elective activity will clear the admitted backlog by December.

There are no 52 week waiters.

Over the last year, the Trust’s speciality level and aggregate RTT performance has deteriorated, meaning there are more patients waiting and the number waiting for extended periods has increased. Current performance remains a significant challenge to the organisations.

Less than half the reportable specialties are achieving the required 92% standard (table 1).

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Waiting&lt;18</th>
<th>Waiting 18+</th>
<th>Performance</th>
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<td>(101) Urology</td>
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<td>(110) Trauma &amp; Orthopaedics</td>
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<td>698</td>
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<td>(120) ENT</td>
<td>1753</td>
<td>95</td>
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<td>(130) Ophthalmology</td>
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<td>(140) Oral Surgery</td>
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<td>(142) Paediatric Dentistry</td>
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<td>(143) Orthodontics</td>
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<td>(160) Plastic Surgery</td>
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<td>(191) Pain Management</td>
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<td>(257) Paediatric Dermatology</td>
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<td>(300) General Medicine</td>
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<td>(301) Gastroenterology</td>
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<td>(400) Neurology</td>
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<td>116</td>
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<td>(410) Rheumatology</td>
<td>456</td>
<td>64</td>
<td>87.7%</td>
<td>22</td>
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<tr>
<td>(420) Paediatrics</td>
<td>806</td>
<td>19</td>
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<td></td>
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<tr>
<td>(430) Care of the Elderly</td>
<td>111</td>
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<td>99.1%</td>
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<td>(502) Gynaecology</td>
<td>980</td>
<td>32</td>
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<tr>
<td>other</td>
<td>1865</td>
<td>138</td>
<td>93.1%</td>
<td></td>
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<tr>
<td>Total</td>
<td>21165</td>
<td>3138</td>
<td>87.1%</td>
<td>1452</td>
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</table>
Much of this is due to the difficulties faced at speciality level with significant numbers of medical vacancies in some critical areas and increased referral demand. A weekly Patient Tracking List (PTL) meeting is now in place with all specialities accounting for their position, reviewing all long waiters and agreeing priority areas for validation.

Our overall waiting list is increasing (see table 2) with a growing problem in the back end of our PTL (table 3), which puts risk of potential 52 week breaches.

Table 2

<table>
<thead>
<tr>
<th>Year</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
</tr>
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<tbody>
<tr>
<td>2018/19</td>
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<td>24490</td>
<td>24393</td>
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Table 3

<table>
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<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
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<tbody>
<tr>
<td>2017/18</td>
<td>23143</td>
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</table>
2.2 Delivering a realistic trajectory.

The NHS Improvement Intensive Support Team recommends that an accurate recovery trajectory must be built on a ‘clean waiting list’. It is therefore essential a data quality improvement process is carried out and capacity and demand planning is based on an accurate current position. Based on current position, it is estimated that this will be completed during October with a realistic delivery trajectory being produced and agreed with NHS Improvement, NHS England and Commissioners by the end of November. Indicatively, given the size and scale of the backlogs in some specialities, it is envisaged that recovery will likely take in excess of 12 months once the deteriorating position has been addressed. This will be accurately mapped at speciality level on a month-by-month basis to enable robust specialty level performance management.

2.3 Work Programme to November 2018

There are a number of critical areas which require focussed work to enable the Trust to improve from the current position, before moving to sustainable longer term delivery. An overarching work programme will follow the Intensive Support Team recommendations. A summary of the initial work programme focuses on:

- A technical review of Data Quality and subsequent validation of the full PTL
- Enhanced performance management arrangements
- The recently instigated weekly PTL review meeting will monitor key actions at the Trust is working with “clean” data
- Capacity and demand using the nationally recommended tool at speciality and subspeciality level
- Policy/process review and associated training programme
- The Trust’s Access Policy is in the process of being reviewed/updated and any new standard operating procedures will also developed. A training programme linked to implementation will be in place.
- Whole System Review - A Single Joint Recovery Plan meeting should be established with CCG colleagues. The focus of this meeting should be on both the internal actions that the Trust is taking and the necessary system wide actions to support the Trust to deliver.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 26th September 2018
Agenda item 29

<table>
<thead>
<tr>
<th>Report title: Committee Chairs – Reports back to Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report author: Michael Sims Trust Secretary</td>
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<tr>
<td>Report sponsor: Richard Sumray Chair</td>
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<table>
<thead>
<tr>
<th>Board Action required:</th>
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<tbody>
<tr>
<td>The Board are asked to:</td>
</tr>
<tr>
<td>Note the reports back on assurances from Committees that key areas of compliance or progression of strategic objectives for the Committees were being achieved subject to any stated escalations to Board;</td>
</tr>
<tr>
<td>Finance &amp; Transformation Committee – Richard Sumray</td>
</tr>
<tr>
<td>Quality &amp; Safety Committee – Lis Paice</td>
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<tr>
<td>Audit &amp; Risk Committee – Richard Whittington</td>
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<tr>
<td>Charitable Funds Committee – Richard Sumray</td>
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<tr>
<td>Nominations Committee – Richard Sumray</td>
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<tr>
<td>Remuneration Committee – Soraya Dhillon</td>
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<table>
<thead>
<tr>
<th>Link to the Hillingdon Hospitals Strategic Plan 2017/21:</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRATEGIC PRIORITY:</td>
</tr>
<tr>
<td>None</td>
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</table>
Finance and Transformation Committees August and September 2018 – Chair R Sumray

Financial position, financial improvement and recovery

Detailed scrutiny of the Trust’s financial position and delivery of the Financial Improvement Plan has continued.
The Committee has focused on finalising a Recovery Plan, approving schemes that could yield an additional £4m efficiency savings above the existing efficiency programme of £12m as had been directed by NHSI in July. To this end, the Committee has held two additional meetings to keep the development of the programme under review and a final report on the financial position has been prepared for Part II of the Board meeting in September.

Transformation Projects

LEAN Improvement Programme – detail of the project methodology and a first early progress report have been received.

Business Cases
Following agreement at July Board on the scope of the terms of reference of the Committee the Board can be assured that a decision to enter into a bid for acute services being commissioned by Ealing CCG received sufficient scrutiny prior to approval to proceed was granted.

Escalations to the Board by the Committee – the Committee has escalated a decision on the new financial projections to the end of the year to the September Board recognising that more work was needed following the meeting of F&TC.

Quality and Safety Committee August 2018 – Chair L Paice

Strategy
Quality and Safety Improvement monitoring focused on the theme of improving systems to reduce harm.

Divisional Review
There was feedback on Surgery with a focus on overall quality performance, learning from audits and divisional risk.

Performance
Assurance was provided on compliance with progress on the CQC Action Plan serious incidents and progress with the implementation of IT for NEWS. The committee wished to take a review of whether the current SI management process, agreed in September 2017 by Board, was working or required change which will take place in October. Whilst reports on the implementation of IT for NEWS are being received there is no sufficient assurance that the project is being implemented as quickly as the Committee would wish to see.
Compliance and Assurance
The Committee reviewed compliance sources, both internally and externally through sub-committees for Patients Safety, Regulation and Compliance and the CCG’s own exception report and an update on the implementation of the Hillingdon Healthwatch discharge Action plan.
It also scrutinised the Annual Reports for both Safeguarding and Infection Control in readiness for presentation to the September Board.

Escalations to the Board by the Committee – none

Nominations Committee August 2018 – Chair R Sumray

Chief Executive Succession Planning
The Committee confirmed appointments for both the Interim and Permanent Chief Executive Officer.

Escalations to the Board by the Committee – none

Remuneration Committee August 2018 - Chair S Dhillon

Executive Performance Development Review
The Committee confirmed remuneration arrangements for both the Interim and Permanent Chief Executive Officer.

Escalations to the Board by the Committee - none

Audit & Risk Committee - Chair R Whittington

No meetings of the Committee since last report to Board.

Charitable Funds Committee – Chair R Sumray

No meetings of the Committee since last report to Board.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 26th September 2018
Agenda item 30

Report title: Minutes of Committee Meetings

Report author: Michael Sims, Trust Secretary

Report sponsor: Richard Sumray, Chair

Board Action required:

The Board are asked to:

Note the minutes of meetings of Committees of the Board since last reported in November (minutes included in the separate Appendices pack)

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

STRATEGIC PRIORITY:
None

<table>
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<th>Committee</th>
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<tr>
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USE OF THE TRUST SEAL

The Board is asked to note the following use of the Trust Seal:

Ref No 208: Variation of the Lease re Incinerator Site for SRCL at Hillingdon Hospital to that signed on 29th March 2018

Date seal applied: 28th August 2018

Seal applied by: The Hillingdon Hospitals NHS Foundation Trust

Signatories: Shane DeGaris and Richard Sumray

Location of sealed document: Capsticks Solicitors

Signed under delegated authority to the Chief Executive.

Shane DeGaris
Chief Executive