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**Questions from the Public**

*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 26th March 2018 in order that the Board can ensure the information is available to answer the question raised.*

**Date of next Meeting**

*Date of next meeting - Wednesday 23rd May 2018 at Mount Vernon Hospital*
Present:

Richard Sumray Chair
Soraya Dhillon Deputy Chair and Non-Executive Director
Cheryl Coppell Non-Executive Director
Lis Paice Non-Executive Director
Richard Whittington Non-Executive Director
Keith Edelman Non-Executive Director
Linda Burke Non-Executive Director
Carl Powell Non-Executive Director
Shane Degaris Chief Executive
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

In Attendance:

Jeremy Philpot Director of Strategic Estate Development & Asset Management
Cherma St Clair Freedom To Speak Up Guardian
Mike Sims Trust Secretary
Clare Hazell FOI Officer
Kim Stanford for Patient Story (item 6)

Members of the Public:

Arnelle Thomas
Gurdev Singh
Mandip Tiwana
Vera Cook
Joan Davis

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<td>1  Welcome and Apologies for Absence</td>
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<td>The Chair welcomed all to the meeting and advised there were no</td>
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The Chair congratulated J Walker on her appointment as Director of Patient Experience and Nursing.

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 29th November 2017**

   The minutes were approved as an accurate record of the meeting

4. **Action Log**

   197 - Seven Day Standards - A Khakoo advised the Trust was not compliant with Standard 2 Consultant Review or Standard 8b Daily Review but expected that compliance could be achieved by the date of the next audit, likely to be May 18. The Chair requested that the May 18 Chief Executive report to Board therefore contained an update on progress on achieving both standards.

   198 - Feedback on progress with ensuring continued awareness on End of Life (EoL) on all Wards to take place at February Board Seminar - the Chair advised that the February Board Seminar may not now include EoL and so this item would be reviewed at a future Seminar (date to be agreed).

   200 and 203 – EoL lessons learnt from Patient Story and review of themes – noted will be provided to Board following consideration at the April EoL Board Meeting.

   202 – Increase in the 12 month rolling average for mortality – will be addressed by A Khakoo under Performance Report item – completed.

5. **Declaration of Any Other Business**

   None

6. **Patient Story**

   J Smyth introduced Ms Kim Stanford to the meeting who gave a presentation on the difficulties that her son Malachi, a young man with serious degenerative conditions, and his family faced as he transitioned from children to adult care services within the hospital.

   She explained her son Malachi was born with Aicardi-Gouiteres Syndrome, a very rare degenerative brain condition. Malachi was profoundly disabled and required 24 hours a day care. He was blind, had partial hearing, a lung disease so was oxygen dependent, had dysphagia and was fed via a gastrostomy. Although Malachi was almost 19, he weighed only 24 kilos and was the size of a 7 year old. Despite these challenges Malachi remained very happy but frail.
Ms Stanford explained that, in summary, under Paediatric care she and her family felt listened to and involved in the decisions about the best care planning for Malachi but, following the transition into adult care, she had felt frustrated, exhausted, alone and misunderstood.

In particular, she explained it was clear the family had become less engaged in the care plans being made for Malachi and she gave a number of examples of failings in terms of sensitivity and customer care. Her view on the reason for this was that the nurses in adult care were simply too stretched to be able to find the time to deal as sensitively with all patients and carers as they could in paediatrics.

Ms Stanford explained she was a member of the Trust’s Young People’s Board and said she was pleased that the Trust was now trying to make changes and find ways to listen to the views of families through this forum. She recommended that a Transitional Nurse or Co-coordinator be employed to help with the transfer between services and advise parents, carers and young people of the changes in relation to the law and the adult care as the young person approaches the age of 18.

The Board discussed a number of ways in which these problems could be overcome and service improvements made suggesting:

- Better communication between Paediatric and Adult Consultants at points of handover of care
- Consultants that could work across the boundaries of Children and Adult Services for complicated medical conditions
- Engagement on care planning with primary care
- Earlier planning for transition into adult care
- Agreement that Kim’s proposal to have a Transitional Nurse or Co-coordinator in post should be explored

In particular the Board agreed that the examples provided of insensitivity and poor customer care were unacceptable regardless of the age of the patient or issues of transition. A Khakoo stated he was very disappointed to hear of the attitude of the Junior Doctor and Nurse referred to and he would be very happy to speak to them.

K Edelman made the suggestion that, with Ms Stanford’s permission, a video story of the issues raised would be an excellent way of getting messages across to staff on the issues of transition and J Smyth was asked to take the proposal forward.

The Board welcomed the presentation and asked J Smyth to ensure the suggestions made at the meeting were discussed in more detail at the Young Peoples Board

The Chair thanked Ms Sanford for presenting at the meeting and hoped in the future Malachi’s treatment at the hospital would improve, also remarking that indeed, the transitional care period may need to be a lot longer than
one or two years dependent upon individual circumstances, and the Trust should be sensitive to this.

### Chair's Report

The Chair reported to the Board on;

**The visit to the Trust of the Jeremy Hunt, Health Secretary on 4th January 2018.**

The Chair reported that the Health Secretary was very supportive of the outline proposal for a hospital re-build and had indicated on the day that the Trust was on his shortlist of five priority redevelopments in the country, although he had made it clear that the fact the Trust had not signed its control total remained an issue.

The Trust was now raising the profile of its case for change and further visits from senior officials in the government, NHSE and NHSI would be sought, and that he and S Degaris were also raising the profile across North West London with health partners in order to develop support for the proposal.

**The Trust's Estate**

The Chair stated that discussions relating to the critical nature of estates risks had been the focus of discussion at Audit and Risk Committee and a fuller discussion could take place at this meeting when reviewing the Corporate Risk Register.

The Report was received

### Chief Executive Report

S DeGaris introduced a report for information which updated the Board on;

- Secretary of State for Health visits Hillingdon Hospital
- Car Parking Tariff
- Winter flu
- CQC rescheduling of some routine inspections
- NHS England (NHSE) and NHS Improvement (NHSI) to have cross representation on each other’s boards.

The Chair commented that the Board should be aware that the Trust was ranked third in London on the take up of flu vaccinations. T Roberts confirmed that occupational health team were undertaking vaccinations at workplaces as required as opposed to only at their own offices. J Walker added that in the Maternity Division a number of Midwives had been trained to deliver vaccinations in an effort to maximise the numbers of staff covered.

The Chair reported that it was very likely that the Trust would be inspected by the Care Quality Commission within the next 3 or 4 months as requests for information from them had been sought in December.

The Report was noted
Strategy and Governance

9 Accountable Care Partnership – Governance and Financial Arrangements

J Smyth introduced a report for information asking the Board to;
• Note the position on agreements already approved by the Board
• Note the update on governance arrangements and the delegated authority given to the Accountable Care Partnership (ACP) Provider Board
• Note the update on the transition of the ACP Provider Board into an ACP Delivery Board, which includes Hillingdon Clinical Commissioning Group (CCG)
• Note the proposed services to be included in the new capitated budget of £105m and what this would mean from an operational and governance perspective and how this would be achieved through the Delivery Board.
• Note progress to date being made to agree financial arrangements including proposed risk share agreements with the CCG
• Note the proposal to include within governance arrangements a “Board to Board” arrangements where NEDs would meet the Delivery Board to assess performance, provide support as well as challenge

M Tattersall stated that the financial arrangements were not concluded as there was insufficient funding currently available to deliver a credible financial proposal for the ACP and reported that the CCG had confirmed it would not discuss any revised financial offer until the planning guidance for 2018-19 had been issued.

C Powell sought clarification on the Delivery Board’s reporting proposals to sovereign Boards. S Degaris confirmed that any report on ACP governance arrangements that was for decision would confirm the proposed reporting arrangements.

R Whittington sought clarification on the proposed timescale to move from a “Shadow” delivery Board to a full Board which had originally been proposed for April 2018. The Chair confirmed in current circumstances this could not take place in April 2018.

The Chair summarised the position as follows;
• Currently the Board could not agree the financial arrangements as the majority of the risk would be retained by the Trust, not the CCG as the services were significantly underfunded anyway and the first tranche of any savings made would go to the CCG.
• It was his view that two meetings a year involving NEDs as a form of scrutiny panel represented an insufficient level of NED involvement and that, indeed, the direct involvement of NEDs on the Delivery Board
would strengthen its skill base, not undermine it and that these views should be discussed further by the Delivery Board.

The Report was noted.

10 Quality Report Priorities for 2018/19

J Walker introduced a report for decision asking the Board to agree the proposed priorities that have been put forward as quality priorities for the Quality Report and the key quality indicators to be included taking into consideration the Single Oversight Framework metrics.

She advised that the quality priorities would need to be aligned in the forthcoming year with the objectives outlined in the Trust’s Quality and Safety Improvement (QSI) Strategy 2016/21 and the North West London Sustainability and Transformation Plan (STP).

J Walker explained that the Chair of the Quality & Safety Committee (QSC) had endorsed the proposed Quality Report Priorities and the Committee would consider them in more detail subject to Board approval.

The Board agreed;

The proposed priorities that were put forward as quality priorities for the Quality Report and the key quality indicators to be included taking into consideration the Single Oversight Framework metrics.

11 Capital Programme 2018/19

M Tattersall introduced a report for decision asking the Board to approve the proposed values and schemes for the Capital Programme for 2018/19.

He reported that;

- At its meeting on 18th January 2018, the Finance and Transformation Committee (FTC) had discussed and agreed the recommendations proposed, subject to an explanation of why some very high risk areas were not being proposed even though they were rated as higher risk than some that were in the outlined programme, and this had been included in the report.
- Overall the available capital budget for next year was very similar to that for this year although he was pleased to advise that the Trust had been successful in obtaining £1.5m for the redevelopment of the A&E department from the Department of Health (DOH) which would be “topped up” to £2.2m using some of the available capital programme funding to deliver the total project.
- The Trust recognised the significant estate risk that existed with such a small available fund for repair.
The Chair reminded the Board that currently the Trust’s maintenance backlog was standing at £229.7m, with only £3m funds available for next year and that the Trust was still waiting capital funding of £30m from the Shaping a Healthier Future (SaHF) funding stream for backlog maintenance, and that a decision had still, after three years, not been made by NHSI on this. The Chair stated that the current major capital strategy for the STP was based on SaHF but this does not deal with vast majority of the backlog maintenance nor the new hospital proposal at Brunel University and yet, in the meantime, estate risks continued to escalate.

The Board agreed unanimously that a letter should be sent to NHSI sharing with them the significant estate risks that existed in these financial circumstances.

The Board agreed;
To approve the proposed values and schemes for the Capital Programme for 2018/19.

**Update to Scheme of Reservation and Delegation for Business Cases and Procurements.**

The Chair introduced a report for decision asking the Board to approve a change to the Trust’s Scheme of Reservation and Delegation authorising Finance and Transformation Committee to approve business cases or procurements from £0.25m to £1.0m in value.

The Board agreed;
To approve a change to the Trust’s Scheme of Reservation and Delegation authorising Finance and Transformation Committee to approve business cases or procurements from £0.25m to £1.0m in value.

**Performance & Assurance**

**13 Corporate Risk Register**

J Walker introduced a report for monitoring asking the Board to review and provide challenge as appropriate on the progress of mitigation for risks on the Corporate Risk Register.

She reported that there were five new extreme level risks since the last report to Board in July 2017, three further risks that were not assured and one risk escalated for the Board’s attention from Audit and Risk Committee (ARC), namely Medicine Storage.

The Chair sought clarification on two risks;
- 132 - Communications Rooms Air Conditioning Infrastructure – J Philpott advised that work required would be completed by 31st March
### 2018

- **551 – Medicine Storage** – J Walker advised that elements of electrical and asbestos work still required completion in relation to the installation of the new swipe card system and trialling on Grange Ward was planned for February with rollout thereafter.

He acknowledged the current position but said that clear progress was required on delivering compliance with medical storage regulation, and this should be reported back to the next Board meeting.

C Powell commented on the very significant number of chronic estate risks listed in the Register that continued to grow and the Estates Department should be commended for constantly having to reprioritise projects as risk levels increased.

The Report was noted

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### Board Assurance Framework

J Walker introduced a report for monitoring asking the Board to review and provide challenge as appropriate on the progress of mitigation for risks on the Board Assurance Framework (BAF).

S Dhillon sought clarification on how negotiations or discussions with the CCG were developing given there were risks on the BAF, such as community capacity and demand management, where mitigation was reliant on this relationship. J Smyth responded stating that, in terms of demand management, there was clarity on the areas of responsibility between primary, community and acute providers and, in terms of community capacity, winter funding resources had meant more community beds becoming available but still there was an insufficient number.

The Chair sought clarification on R40 showing on the Estates Heat Map but not referenced elsewhere in the report.

He commented that both the format of the BAF and the CRR reports were fit for purpose and now aided the Board in scrutinising risk more effectively.

The Report was noted

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### Financial Report – Month 9

M Tattersall introduced the report stating that the month 9 financial position showed:

- The Trust had a deficit of £9.2m, £1.3m behind plan
- Agency expenditure of £0.9m in month was a reduction on previous months
- Pay was overspent by £0.7m in month
- Efficiency savings of £1.0m were achieved in month which was on plan.
- Capital expenditure was £0.6m in month, cumulatively £2.7m year to date.
- There was a cash position of £2.8m at month end.

He also stated that:
- Both Nursing and Medical Agency pay saw significant drops during December although, given the pressure on the Trust, it was expected they would increase again in January.
- National Guidance for next financial year had still not been issued causing delay in finalising the 2018-19 financial plan, although this was expected to be ready for March Board.

The Chair said that work to date on the draft plan for the budget for 2018-19 indicated a potential deficit of £15m - £18m and that, bearing this in mind alongside the capital position, a small group of the Board was about to commence work on longer term financial projections to better understand what at a strategic level were the underlying cost drivers and to derive possible solutions. In these circumstances a continued focus on delivering further financial efficiencies in 2018-19 was critical.

**The Report was noted**

### 16 Integrated Quality & Operational Performance December 2017

J Smyth introduced a report for monitoring asking the Board to review the analysis of quality, experience and operational performance as at the end of December 2017 in relation to the Care Quality Commission’s (CQC) intelligent Monitoring systems domains, safe, caring, effective, responsive and well-led.

He drew the Board’s attention to two key areas of risk:
- A&E Performance in relation to the 4 hour standard - the growth in emergency admissions remained problematic with a 10% increase in admissions over the last year with a knock on effect on the 18 week Referral to Treatment Time (RTT) target where resources had been switched to cover emergencies.
- Mixed Sex Accommodation – due to winter pressures the Trust took the decision to permit some mixed sex accommodation on the basis this was less of a patient safety risk than leaving more people in A & E. S DeGaris advised that the Chief Medical Officer had confirmed this was permissible nationally but the consequence was an underperformance on achieving the standard.

The Chair requested that future reports include the case numbers not just the percentages for comparison on infection control, cancer, RTT and A&E.

J Walker pointed out that the Trust had three C Diff Cases in January which
was an increase and that analysis had shown one of the cases was avoidable.

On the increase in the 12 month rolling average for mortality A Khakoo believed this was the result of coding issues, and that he expected the increase to reduce by the year end although he was still to review the position on coding of deaths due to pneumonia.

In response to a query about the increase in emergency C-Section rates, A Khakoo said he would review the reasons for it and report back to the Board.

T Roberts reported that vacancies and staff turnover rates were reducing although sickness rates for January were likely to be reported to Board in March as having increased. L Burke requested that the next report contained some commentary on sickness rates, flu and linkages to staff flu vaccination rates.

The Report was noted

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She said that the aim of the review had been to ensure that ward establishments were appropriate and therefore would provide safe care to patients. The further report to the March Board of the business case was likely to recommend an increase to the current establishment but a reduction in the use of agency staff, as well as proposing other important changes in working practices such as ward managers becoming supernumerary as well as improving management and training capacity on wards.. J Walker explained that this would increase the base budget but reduce the overspend, thus making savings overall..

The Chair sought clarification on the impact on staff numbers for the Acute Medical Unit (AMU) which seemed to be significant. J Walker stated that the AMU and SAU had been operating as two separate units and the proposal recommended their merger, hence the reduction of numbers of staff.

S Dhillon asked how the revisions in structure might assist with the retention of nurses. J Walker view was that the appointment of Practice Development Nurses within medicine and surgery to support newly qualified nurses would enhance retention and reduce the rate of turnover, as would encouraging Health Care Assistants to undertake further training to qualify as nurses.
L. Burke suggested it would be useful to include within the review document the delivery of the objectives and ambitions of the People Strategy that the introduction of these proposals would achieve.

M. Tattersall indicated that confirming the nursing establishment would make analysis of variance to established staffing costs much easier and much more transparent.

The Chair concluded by stating that the review was an excellent and important piece of work which was more scientific than anything done previously and the methodology used would help the Trust more clearly evaluate and benchmark its nursing staffing requirements from now on.

The Board fully endorsed the Nursing Establishment Review and noted the intention to return a business case for approval to the March Board.

18  NHSE Higher Level Responsible Officer (HLRO) Visit in August 2017 – Action Plan

A Khakoo introduced a report for decision asking the Board to:

- Note the contents of the NHSE HLRO’s Report following the visit on 21st August 2017
- Approve the proposed Action Plan in response to the Report
- Nominate a Lay Representative for the Revalidation Advisory Group, as recommended by NHSE Revalidation London.
- Note that the formal Revalidation Report will be presented to the Trust Board in July 2018.

He pointed out that NHSE’s requirement was that a HLRO report should be undertaken every 3 to 5 years, primarily reviewing the quality of the Trust’s medical revalidation process. A n action plan following the visit was now proposed and guidance now suggested a Lay NED should sit on the Revalidation Advisory Group.

The Board agreed to the Chair’s request to delegate to him the decision to appoint a NED to the Revalidation Advisory Group (post meeting note – C Powell appointed).

The Board agreed;

To approve the proposed Action Plan in response to the Report
To delegate to the Chair the nomination of a NED to the Revalidation Advisory Group

19  Learning from Deaths – Quarter 1 Review

A Khakoo introduced this monitoring report asking the Board to;
- Note that quarterly reporting of deaths falling within certain criteria to the Trust Board is a requirement by NHS Improvement
- Review the report and scrutinise for appropriate scope, learning, quality and improvement
- Note the changes to the Learning from Deaths Policy flowchart

He reported that in quarter 1 (April – June 2017) there were no avoidable deaths identified; there were 8 cases where there were minor lapses in care and 4 cases with more serious lapses in care none of which would have affected the outcome and all were reviewed at the Mortality Surveillance Group. In addition, A Khakoo confirmed that there were no deaths involving patients with learning difficulties.

He also reported that one result of the reviews undertaken that needed to be taken forward was the desirability of the Trust establishing the position of a Mortality Nurse or similar who, on the death of a patient, would be available to discuss any family concerns about treatment or care.

The Chair confirmed that the differences in the procedures between Learning from Deaths and Serious Incidents were now clearer and the Board looked forward to receiving further reports and updates on the learning.

The Report was noted

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His summary of the position on medical staffing was that:
- There were several current medical staffing vacancies, particularly in Medicine and Surgery
- The Trust’s strategy for addressing these included international and domestic recruitment, the development of new clinical and non-clinical roles supporting the traditional medical workforce
- Development ??(of what)would be increasingly funded through greater utilisation of the Apprenticeship Levy supported by partnership working with HEIs
- Divisions were developing models of care to support safer medical staffing and new workforce models

L Burke suggested that delivering the ambitions of the People Strategy would benefit from the Trust ensuring that workforce initiatives were being reviewed holistically and not in separate medical and nursing silos. A Khakoo agreed that doing so was imperative in meeting skill shortages and
gave the example of an Associate Physician in Cardiology who was covering the role of a Senior Nurse Specialist.

L Paice and C Powell referred to the recent case of Dr Bawa-Garba widely reported in the media where reference to her reflective learning led to her conviction. Many doctors believed that her conviction put them at much greater risk at a time when the healthcare system was under great strain. They asked A Khakoo how he was dealing with the fallout. He said that doctors were being told that the approach of the Trust was one of learning from major incidents rather than individuals being held personally liable and that additional support for Junior Doctors such as a Twilight Consultant and an additional Consultant available over the weekends should assist in providing more senior expertise if required.

S Dhillon sought clarification on whether the gaps in staffing levels shown in the report related to the level of service required to meet the seven day standard. A Khakoo confirmed he would need to clarify this and report back to the Board.

The Chair sought clarification on whether the report was suggesting that the sustainable service model for urology was through the use of Physician Associates (PAs) as the way the report was written was unclear on this point. A Khakoo confirmed that in principle this was the case, although there were still a number of issues such as working patterns that needed resolution.

**The Board welcomed the report and endorsed the continued development of strategies to address medical staffing issues**

### 21 Safer Nurse Staffing – update

J Walker introduced the report for information asking the Board to note that:

- Despite ongoing pressures and significant nursing vacancies across inpatient areas, shift fill rates and CHPPD averaged across the month were sufficient to support safe care.
- At Mount Vernon Hospital the average Care Hours Per Patient Day had reduced to levels comparable with Hillingdon Hospital.
- At Hillingdon Hospital 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.
- There was a total of 113.81 Registered Nurse vacancies for the wards covered in the report which was a reduction compared to when last reported in November.
- A January recruitment exercise in India had resulted so far in 145 job offers.
- The SafeCare electronic acuity and dependency and staffing status tool would go live across Phase 1 wards in February 2018.
The Report was noted

22 Freedom To Speak Up – update

C St Clair introduced a report for monitoring asking the Board to note and comment on the work of the Freedom To Speak Up Guardian for the period January – December 2017.

She explained that the report summarised her involvement as Guardian over the period, detailing which groups of staff were speaking up and what the key themes were that arose when concerns were raised. C St Clair reported that nursing staff, not surprisingly, were consistently in the majority for speaking up. 48 cases were about behavioural problems including bullying and harassment, 12 related to patient safety and the remaining 23 were a mixture of other concerns.

The Chair asked whether there was evidence that where cases raised that had been closed, that the staff concerned felt resolution had been reached in a satisfactory manner. S St Clair confirmed that, overall, it was fair to say this was correct.

The Board was made aware that L Paice would be ensuring that all Non-Executive Directors (NEDs) received some basic training on how to deal with the concerns raised directly with them if such happened during the course of their duties.

The Board was happy to see that the Freedom to Speak up Guardian believed that the Trust had taken significant steps to begin to embrace a culture change that will bring about more transparency and less reticence in raising concerns, although it was recognised the project remained in its infancy with significant challenges still ahead.

The Report was noted

Information

23 Reports back from Committees – Finance & Transformation, Quality and Safety, Audit & Risk, Charitable Funds, Nominations, Remuneration.

R Whittington stated that ARC had raised concerns with J Walker on some of the completion dates being proposed in the management response to the Internal Auditors recent update report on CQC compliance, and that this was receiving attention.

S DeGaris said he was reviewing Executive attendance at ARC going forward.
The Report was noted

24 Minutes of Committee Meetings

The Report was noted

25 Use of Trust Seal

None to report

Questions from the Public

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is car parking free today as the barriers are up?</td>
<td>Parking will be free until the new car parking system is installed.</td>
</tr>
<tr>
<td>The number of staff leaving the Trust in the last 12 months has fallen to 11%. Does this include Nursing staff?</td>
<td>Yes, although this is a global figure and the Trust will provide an individual response on the breakdown of Nursing.</td>
</tr>
<tr>
<td>Will the Trust be penalised for not meeting its A&amp;E waiting time target?</td>
<td>The Trust will not be penalised financially but is very aware it is under close scrutiny from the regulators who have also provided support for several months.</td>
</tr>
<tr>
<td>Is the Trust using Ambulance Drivers or Paramedics in A&amp;E to reduce the pressure?</td>
<td>The Trust has not done this.</td>
</tr>
<tr>
<td>Are patients left alone in the ambulance or during handover to the hospital?</td>
<td>All patients are carefully looked after by the Ambulance crews and are also assessed by the A&amp;E staff as they enter the hospital, and if there is someone who comes in that is seriously ill they will bring them to the front of the queue.</td>
</tr>
<tr>
<td>Is the Trust considering sending patients to Calais, France, to assist with catching up on delayed elective operations?</td>
<td>The Trust has not done so and has no plans to do so. Some elective surgery was cancelled in January and the Trust plans to carry out 130 extra elective procedures in February and March in order to address the cancellations it had to make as a result of A&amp;E pressures.</td>
</tr>
</tbody>
</table>

Date of Next Meeting

Wednesday 28 March 2018
At the Hillingdon Hospital
<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>197</td>
<td>Sept 17</td>
<td>Seven Day Standards – Clinical standards report</td>
<td>Give more accurate assessment on estimated dates for achieving early adopter standards – 2, 5, 6, 8</td>
<td>AK</td>
<td>May 18 (Board)</td>
<td>A Khakoo advised the Trust was not compliant with Standard 2 Consultant Review or Standard 8b Daily Review but expected that compliance could be achieved by the date of the next audit, likely to be May 18. The Chair requested that the May 18 Chief Executive report to Board therefore contained an update on progress on achieving both standards.</td>
</tr>
<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>To be agreed</td>
<td>The Chair advised that the February Board Seminar may not now include EoL and so this item would be reviewed at a future Seminar (date to be agreed) which remains the case as of March.</td>
</tr>
<tr>
<td>200</td>
<td>Nov 17</td>
<td>Patient Story</td>
<td>Lessons to be learnt from the story - provide a summary update to the Board on progress with that learning</td>
<td>JW</td>
<td>May 18 (Board)</td>
<td>Noted will be provided to Board following consideration at the April EoL Board Meeting.</td>
</tr>
<tr>
<td>203</td>
<td>Nov 17</td>
<td>Public Questions</td>
<td>Pick up themes raised in Patient Story at an End of Life Board meeting</td>
<td>JW</td>
<td>May 18 (Board)</td>
<td>Noted will be provided to Board following consideration at the April EoL Board Meeting.</td>
</tr>
<tr>
<td>205</td>
<td>Jan 18</td>
<td>Patient Story</td>
<td>Patient story re Malachi - A Khakoo stated he was very disappointed to hear of the attitude of the Junior Doctor and Nurse referred to and he would be very happy to speak to them.</td>
<td>AK</td>
<td>March (Board)</td>
<td>Medical Director will provide an update to Board prior to or at the meeting</td>
</tr>
<tr>
<td>No.</td>
<td>Date</td>
<td>Section</td>
<td>Description of Task</td>
<td>Responsible Person</td>
<td>Board</td>
<td>Status</td>
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<tr>
<td>206</td>
<td>Jan 18</td>
<td>Patient Story</td>
<td>Report back on possible proposal to make a video of the patient story involving Malachi and Kim Stanford</td>
<td>JS</td>
<td>March (Board)</td>
<td>Kim Stanford gave permission but currently funding in communications team unavailable – completed.</td>
</tr>
<tr>
<td>207</td>
<td>Jan 18</td>
<td>Patient Story</td>
<td>Discuss proposals raised in Patient Story at next Young People’s Board</td>
<td>JS</td>
<td>March (Board)</td>
<td>Young people’s board agenda updated. Patient story presenter is a member of that board – completed.</td>
</tr>
<tr>
<td>208</td>
<td>Jan 18</td>
<td>ACP</td>
<td>Request that ACP Delivery Board further debates the proposal that NEDs are included on the Board</td>
<td>S Deg</td>
<td>March (Board)</td>
<td>ACP Board has discussed – no current proposals for NEDs on Board but considering meeting more than twice yearly - completed</td>
</tr>
<tr>
<td>209</td>
<td>Jan 18</td>
<td>Capital Programme 2018/19</td>
<td>Send letter to NHSI sharing with them the significant estate risks that existed in these financial circumstances.</td>
<td>Chair</td>
<td>March (Board)</td>
<td>completed</td>
</tr>
<tr>
<td>210</td>
<td>Jan 18</td>
<td>Corporate Risk Register</td>
<td>Report back on compliance with medicines storage regulation.</td>
<td>JW</td>
<td>March (Board)</td>
<td>Significant preparation for CQC inspection has included improved management of medicines. Improved secure storage solution installed on Grange Ward - completed</td>
</tr>
<tr>
<td>211</td>
<td>Jan 18</td>
<td>BAF</td>
<td>The Chair sought clarification on R40 showing on the Estates Heat Map but not referenced elsewhere in the report.</td>
<td>JW</td>
<td>March (Board)</td>
<td>This was an error and should have read R41 and rated 5x4 on the matrix and will be corrected for Qtr 4 submission - completed</td>
</tr>
<tr>
<td>212</td>
<td>Jan 18</td>
<td>Integrated Quality &amp; Operational Performance</td>
<td>Future reports to include the case numbers not just the percentages for comparison on infection control, cancer, RTT and A&amp;E.</td>
<td>JS</td>
<td>March (Board)</td>
<td>Adjustment made for March report – completed.</td>
</tr>
<tr>
<td>213</td>
<td>Jan 18</td>
<td>Integrated Quality &amp; Operational Performance</td>
<td>On the increase in the 12 month rolling average for mortality A Khakoo believed this was the result of coding issues, and that he expected the increase to reduce by the year end although he was still to review the position on coding of deaths due to pneumonia.</td>
<td>AK</td>
<td>March (Board)</td>
<td>This action is being tracked via Quality and Safety Committee – completed.</td>
</tr>
<tr>
<td>214</td>
<td>Jan 18</td>
<td>Integrated Quality &amp; Operational Performance</td>
<td>In response to a query about the increase in emergency C-Section rates, A Khakoo said he would review the reasons for it and report back to the Medical Director will provide an update to Board prior to or at the meeting following discussion won this issue with CCG.</td>
<td>AK</td>
<td>March (Board)</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Date</td>
<td>Topic</td>
<td>Text</td>
<td>Reader</td>
<td>Meeting Date</td>
<td>Notes</td>
</tr>
<tr>
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</tr>
<tr>
<td>215</td>
<td>Jan 18</td>
<td>Integrated Quality &amp; Operational Performance</td>
<td>Next performance report to contain some commentary on sickness rates, flu and linkages to staff flu vaccination rates.</td>
<td>TR</td>
<td>March (Board)</td>
<td>Not contained in commentary in report – Director of People &amp; OD to provide verbal update at the March Board meeting</td>
</tr>
<tr>
<td>216</td>
<td>Jan 18</td>
<td>Learning from Deaths</td>
<td>A Khakoo reported that one result of the reviews undertaken that needed to be taken forward was the desirability of the Trust establishing the position of a Mortality Nurse or similar who, on the death of a patient, would be available to discuss any family concerns about treatment or care.</td>
<td>AK</td>
<td>March (Board)</td>
<td>Medical Director will provide an update to Board prior to or at the meeting following discussion won this issue with CCG</td>
</tr>
<tr>
<td>217</td>
<td>Jan 18</td>
<td>Safer Medical Staffing</td>
<td>S Dhillon sought clarification on whether the gaps in staffing levels shown in the report related to the level of service required to meet the seven day standard. A Khakoo confirmed he would need to clarify this and report back to the Board.</td>
<td>AK</td>
<td>March (Board)</td>
<td>Intention is to ensure this is reported to Board in the 7 Day Services Annual Report – Completed.</td>
</tr>
<tr>
<td>218</td>
<td>Jan 18</td>
<td>Questions from the Public</td>
<td>Question: The number of staff leaving the Trust in the last 12 months has fallen to 11%. Does this include Nursing staff? Response: Yes, although this is a global figure and the Trust can provide an individual response on the breakdown of Nursing. Provide response to Trust Secretary who will forward</td>
<td>TR</td>
<td>March (Board)</td>
<td>Director of People &amp; OD to provide verbal update at the March Board meeting or action will be completed before meeting</td>
</tr>
<tr>
<td>219</td>
<td>Jan 18</td>
<td>Nursing Establishment Review</td>
<td>Board fully endorsed the Nursing Establishment Review and noted the intention to return a business case for approval to the March Board</td>
<td>JW</td>
<td>March (Board)</td>
<td>The Nursing Establishment Review business case was not ready for consideration at March Board and the intention is to consider the report at the April Finance &amp; Transformation Committee</td>
</tr>
</tbody>
</table>
### Meeting of the Board of Directors – Public Part I session

**Date of meeting:** 28th March 2018  
**Agenda item 8**

<table>
<thead>
<tr>
<th>Report title: Chief Executive Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report author: Michael Sims, Trust Secretary</td>
</tr>
<tr>
<td>Report sponsor: Shane DeGaris, Chief Executive</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Board Action required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Board are asked to:</td>
</tr>
<tr>
<td>Note updates from the Chief Executive.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<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>Business as usual – governance</td>
</tr>
</tbody>
</table>
Care Quality Commission Inspection of Hillingdon Hospitals Foundation Trust and the Use of resources framework

The first part of the Trust’s CQC inspection took place between 6th and 8th March. Some initial high level feedback to the Trust was that the ‘must dos’ and ‘should dos’ from our last inspection had clearly been worked through, and that this had been demonstrated very well in some of our core services.

There will now be a series of unannounced visits followed by the “Well Led” element of the inspection between 24th and 26th April, focusing on eight themes across the Trust.

As part of the CQC Well Led Inspection, the Trust will also be assessed against the ‘Use of Resources’ (UoR) framework. This framework has been introduced to ensure the CQC rating takes a more holistic view of the Trust. The UoR assessment will be undertaken by NHS Improvement on behalf of the CQC and will include a full day visit on May 2nd with the Executive and Senior Leaders. The rating for UoR will form part of the overall ‘Well Led’ rating, which in turn feeds in to the Trusts overall CQC rating.

Pay deal for 1.3 million NHS staff

The deal has been formally agreed by union leaders and ministers on Wednesday 22 March and will cost over £4.2bn. Staff will now be asked to vote on the deal with rises backdated to April if they agree by the summer.

The deal is tiered with the lowest paid in each job receiving the biggest rise.

The agreement covers all staff on the Agenda for Change contract - about 1.3m across the UK - which is the entire workforce with the exception of doctors, dentists and senior leaders.

The agreement is complex. It means that:

- half will get a 6.5% pay rise over three years
- the other half will receive rises of between 9% and 29% because they are not at the top of their pay bands
- the lowest full-time salary - paid to the likes of cleaners, porters and catering staff - will rise by 15% to more than £18,000
- these groups will get an immediate £2,000 rise this year
- a nurse with one year's experience would see their basic pay rise by 21% over three years, giving them a salary of up to £27,400
- the deal includes a commitment on both sides to reduce the high rate of sickness absence in the NHS

Sara Gorton, lead negotiator for the 14 health unions, said: "It won't solve every problem in the NHS but it will go a long way towards making dedicated health staff feel more valued, lift flagging morale and help turn the tide on staffing problems."
Danny Mortimer, chief executive of NHS Employers, said "compromises" have had to be made but he predicts the deal will make the NHS a "desirable" employer once again.

**North West London CCGs Collaborative and Accountable Officer recruitment**

Currently there are two Accountable Officers responsible for the eight CCGs on the North West London Collaborative (split with responsibility five and three). The commitment made last year to moving to a single Accountable Officer for the eight CCGs is moving forward with interviews for a single Accountable Officer possibly taking place in April.

The North West London Collaboration of CCGs has, however, confirmed that this role would not involve the postholder acting as the Executive Lead for the North West London STP. Where that executive function would sit has yet to be determined.

**Local Authority Elections – Pre election period**

The Pre-Election Period in Hillingdon commences on 12th April 2018. During the pre-election period the Trust should;

- Not make new decisions or announcements of policy or strategy
- Not make decisions on large and/or contentious procurement contracts
- Not participate in debates and events that may be politically controversial, whether at national or local level.
Meeting of the Board of Directors – Public Part I session

Date of meeting: Wednesday 28th March 2018
Agenda item 9

Report title: Operational Plan - Refresh 2018/19


Report sponsor: Joe Smyth, Chief Operating Officer

Board Action required:

The Board are asked to:

Approve the elements of the refreshed Operational Plan FY2018-19 as currently presented

Grant delegated authority for final sign off of the Operational Plan by the Chair and Chief Executive subsequent to the agreement of the 2018/19 contract

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

The Refreshed Operational Plan supports all strategic priorities

Equalities & Finance

Resourcing the refreshed operational plan has financial implications. On behalf of the Trust, the Director of Finance oversaw our contract negotiations with Hillingdon CCG and the final settlement was agreed by him.

Implementing the refreshed operational plan has implications for staffing and workforce. These will be managed in accordance with the Trust’s People and Development processes to ensure equity of approach.
1. Overview

As the Trust approaches the mid-point in a two-year planning cycle (2017-2019); it is required, by NHS Improvement, to submit a refreshed plan for the remaining term. The original Operation Plan 2017-19 can be found on the Trust intranet, under Business Planning.

The refreshed operational plan consists of three elements;

- Updated estimates of activity, workforce and finance submitted via templates through a shard-planning portal
- A narrative detailing the changes made to the templates
- The updated summary strategy for 2018/19.

This paper sets out the submission timetable for the refreshed plan, the process and rationale for changes made to the plan and the summary strategy, and identifies the ongoing process for board assurance of progress against the summary strategy.

The paper also addresses delays in the contracting process, and as a result seeks delegated authority for approval of the final operating plan.

The purpose of this paper is to provide the board with an opportunity to review the changes made to the operating plan narrative and summary strategy.

The narrative statement and the updated summary strategy are attached as appendices to this document.

Submission Timings and 2018/19 Review Timetable

The timetable for developing and submitting the Refreshed Operational Plan FY2018/19 is given below. The table incorporates our schedule for reporting progress against strategic objectives in the coming year.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Draft Refreshed Operational Plan FY 2018/19 submitted</td>
<td>8th March 2018</td>
</tr>
<tr>
<td>THH contract with Hillingdon CCG signed for FY 2018/19</td>
<td>23rd March 2018</td>
</tr>
<tr>
<td>Board approve draft narrative statement and summary strategy FY 2018/19</td>
<td>28th March 2018</td>
</tr>
<tr>
<td>Final, board-approved, Operational Plan for FY 2018/19 submitted</td>
<td>30th April 2018</td>
</tr>
<tr>
<td>Full year report Progress against Summary Strategy FY 2017/18, to Board</td>
<td>30th May 2018</td>
</tr>
<tr>
<td>Half year report Progress against Summary Strategy FY 2018/19, to Board</td>
<td>28th Nov 2018</td>
</tr>
<tr>
<td>Full year report Progress against Summary Strategy FY 2018/19, to Board</td>
<td>29th May 2019</td>
</tr>
</tbody>
</table>

2. Rational for changes to the Plan

1.1 Updated Planning Templates

The refreshed plan chiefly consists of updated estimates of activity, workforce, and finance. This information is submitted on templates, which are uploaded through a
shared-planning portal. These templates will be completed and submitted at the conclusion of the contract negotiation process.

1.2 Narrative statement

The refreshed plan must include a narrative statement. Although no template has been issued for this document, it is expected to provide an overview of any key changes in terms of activity, quality, workforce and finance. The narrative statement has been produced with the responsible executives for each of the four areas, and summarises the position and priorities for 2018/19. It is expected that the finance section of the narrative will be updated following the conclusion of the contracting round. The narrative statement which accompanies the refreshed Operational Planning templates FY18/19 is presented in Appendix 1.

1.3 Summary Strategy

The Summary Strategy is framed by the 5 delivery areas and 3 enablers of the Sustainability and Transformation Plan (STP) for North West London. All of the 5 Delivery Areas are relevant to the Trust’s strategy, but not to the same extent. As an acute provider, the Trust will be centrally involved in realising shared objectives in some delivery areas, whilst playing more of a supporting role in others.

Under each of the STP delivery areas the Trust has developed and agreed areas of focus, which set out where the Trust’s particular response will lie. Underneath each area of focus, sit the in-year objectives and measures of success for 2018/19, along with the executive responsible for the delivery of that area. While some areas of work fit under multiple executive directors, there will be only one named lead for each, to ensure focus on delivery and reporting against each objective.

The summary strategy separates out strategic objectives, labelled as “Creating a Better Future” and ongoing performance, labelled “Improving the Present”.

The updated Summary Strategy is an important component of our refreshed Operational Plan and is presented in Appendix 2.

3. Reporting

To provide assurance of implementation, progress against strategic objectives will continue to be monitored quarterly, and reported to the Board every 6 months. Each report provides commentary on what progress has been achieved against strategic objectives to date, and what more needs to be done. The next board report on progress against strategic objectives will be presented in May 2018. Please note that this paper does not provide this update.

4. Contracting Progress

Following a review meeting between NHS England, NHS Improvement and the STP, commissioners have been invited to revisit their assumptions for 2018/19. It is anticipated that this review process will narrow the current gap in commissioner /
provider negotiating positions. This means, however, that the contract will not be signed in accordance with the above timetable, resulting in a potential need to further revise the narrative statement, particularly in regard to the financial section.

1.4 Delegated Authority
As there is no public board in April 2018, delegated authority is sought for the final approval of the operational plan submission following the conclusion of the current contracting process. It is intended that an updated position will be brought to the Finance and Transformation committee in April, but it is not certain that the contract will be agreed at this point. Therefore the board is requested to approve final sign-off of the plan by the Chief Executive at the point at which the contract is finalised.

5. Appendices
Appendix I - Narrative Statement Refreshed Operational Plan FY2018/19

Appendix 2 – Summary Strategy 2018/19
Meeting of the Board of Directors – Public Part I session

Date of meeting: 28th March 2018
Agenda item 10

Report title: Accountable Care Partnership – Governance and Financial Arrangements

Report authors: J Smyth COO and M Tattersall FD
Report sponsor: S DeGaris CEO

Board Action required:
The Board are asked to:

Note the update on governance arrangements and the delegated authority given to the ACP Provider Board and discuss and comment on the key issues arising from these updates

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

STRATEGIC PRIORITY:
b) Delivery Area 2: Eliminate unwarranted variation & improve LTC management
e) Delivery Area 5: Ensure we have safe, high quality sustainable acute services
Introduction

In November 2017 and in January 2018 the Board received reports on the progress being made on establishing governance arrangements, financial considerations and development of clinical pathways within the Accountable Care Partnership (ACP), “Hillingdon Health & Care Partners” (HHCP). The report also advised the Board of the initial steps towards pooling resources between the partners with a capitated budget of circa £105m.

The January paper set out the current governance arrangements and delegated authorities which had been previously agreed. These arrangements are summarised below.

Previous Board Agreements

- The Board has already formally agreed and signed an Alliance Agreement to become a member of the ACP / HHCP. This Alliance Agreement commits the Trust to working with the partners of HHCP but it does not create a separate legal entity.

- The Board has also agreed to delegate the ongoing strategic development of the ACP to the HHCP Provider Board.

- In October 2017 the Board accepted a timeline to increasing the size of the HHCP capitated budget.

- The Board also agreed to give delegated authority to the Director of Finance to negotiate revised financial arrangements to agree a capitated budget for 2018/19. These new arrangements (when agreed) will require Trust Board approval.

- The Trust Board agreed to delegate authority to the provider board to develop the ACP. Part of this development was to integrate the role and function of the CCG into the ACP. The January paper explained that a significant step on this journey would be achieved in April 2018 through the disestablishment of the Provider Board. This will be replaced with the ACP Delivery Board which will include an extended membership to include the CCG.

- The Delivery Board was given delegated authority to make recommendations to advance the ACP. This includes altering service models, changing reporting structures and reallocating financial resources. This delegated authority to make these decisions comes via the respective Chief Executives who will operate in this context within their own organisations standing financial instructions.

Update to January Paper

The paper in January set out the expectation that the ACP would assume responsibility for £105m of services through a capitated budget in April 2018. The paper explained that this move meant that more decisions would need to be made (through the Chief Executives delegated authority) at the ACP Delivery Board.

The paper explained that services integral to the day to day operation of the Trust will now be part of the ACP. Operational changes may be required to fully integrate these services with the community and again these decisions would need to be made at the delivery board. The Trust accepted these recommendations.
Unfortunately, HHCP have not been able to agree a satisfactory contractual arrangement with Hillingdon CCG for 2018/19. As such, there will not be a capitation budget in place from April 2018.

Financial Arrangements and Risk Share

As outlined in the previous Board paper, HHCP and the CCG have been working intensively to resolve the outstanding financial issues. However, the fundamental issue remains, that HHCP is being asked to take on additional risk without the resources to manage or mitigate the risk. Specifically, the CCG has proposed a capitation budget that has already been reduced for a level of transformational savings that HHCP has not got plans in place to deliver. The financial risk of non-delivery of the savings would sit with HHCP.

Whilst the CCG had proposed a risk share in 2018/19 to share the financial risk 50:50, the proposal still removes the very incentive that capitation budgets are designed to deliver. i.e. to create a virtuous circle of investment to deliver future patient benefits and savings.

HHCP recognise that the financial pressure the CCG is under, however, it cannot simply allow that pressure to be handed over to the providers to manage.

Despite the failure to agree a contractual way forward for the ACP, both the CCG and HHCP have committed themselves to continue the work of integrating services across Hillingdon. The Alliance Agreement between the HHCP providers still provides a vehicle for agreeing how money could move around the system and how risks could be shared. All parties will work with a ‘shadow’ capitation budget in 2018/19, with a view to introducing a ‘live’ capitation funding model once the financial risks are better understood.

Next Steps

Despite not agreeing a capitated budget the ACP will continue to develop and commission new service for the benefit of patients and the health economy. It is intended to focus on clinical and transformation priorities for older people. To strengthen the relationships between Hillingdon CCG and the HHCP and accelerate progress in delivering priority programmes. The ACP will bring together priority transformation programmes across providers and commissioners to deliver system wide improvements. It will continue to develop and align clinical leadership across all organisations to undertake comprehensive system wide transformation that addresses the cultural and workforce changes.

To achieve these goals the ACP Delivery Board will need to continue to operate within its current delegated authority.

In January the Board agreed to delegate responsibilities to the ACP Delivery Board, it agreed to a revised structure and that NED oversight would be provided to through regular Board to Board meetings. However, these delegations were given with the understanding of HHCP and the CCG agreeing a capitated budget for 2018/19. As this has not occurred the Board is now asked to reaffirm its approval of the delegations given (with the exclusion to those offered specifically to achieve a capitated budget) at previous meetings.

Summary

The Board is asked to note delegated authority previously given to the ACP Delivery Board and support the continued direction of travel in developing services for the benefit of patients and the health economy. The Board is asked to note that it has not been possible to agree a capitated budget with the CCG for the coming financial year.
The Board is asked to therefore note that no change is required to the current governance arrangements. However, the Board is asked to reaffirm its support for these arrangements.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 28th March 2018
Agenda item 11

Report title: Developmental review of leadership and governance using the well led framework

Report author: Michael Sims Trust Secretary
Report sponsor: Jacqueline Walker Director of Patient Experience and Nursing

Board Action required:

The Board are asked to:

Note the findings of the KPMG self – assessment of the leadership and corporate governance arrangements of the Trust.

Approve the proposal to defer any decision on commissioning an external review of leadership and governance until such time as the Trust has been advised of the findings of the Well Led element of the CQC inspection which would in turn inform any decision on the timing and scope of an external review.

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

STRATEGIC PRIORITY:

None specific
Context

Monitor’s Quality Governance Framework (QGF) was replaced in April 2015 by Monitor’s ‘Well-Led Framework’ as a result of collaborative work by the Care Quality Commission (CQC), Monitor and the Trust Development Authority (TDA).

That framework required that a Trust commissioned an external review of its “Well – Led” arrangements every three years. The last external review of the framework was last conducted by KPMG in March 2014.

Regulatory Change

These reviews were introduced by NHSI in 2014 in response to its observation of serious governance failings in foundation trusts, often several years post-authorisation. New guidance was issued in June 2017; ‘Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts’, the key changes being;

- No mandatory ratings
  Reviews are now explicitly labelled ‘developmental’ and as a visible manifestation of that, the previously mandatory ratings (ie ‘green’, ‘amber/green’, ‘amber/red’ and ‘red’) have gone from the framework. NHSI have stated that ratings can be used if trusts and reviewers agree, but their removal is aimed at avoiding any appearance of a ‘tick box’ review process as opposed to a developmental one.

- A change from 10 questions to 8 key lines of enquiry (KLOEs)
  In terms of the content of the framework, there has been a general tidying up and a modest updating. The previous 10 questions become eight key lines of enquiry (KLOEs) with the trickier overlaps in the old framework (e.g. between risk management and performance management, and between information and data quality) softened. The eight KLOEs are; Leadership, Vision and strategy, Culture, Roles and accountability, Risk and performance, Information, People and partners and Learning.

- Acknowledgement of system governance
  The new framework touches on the complexities and potential contradictions of reviewing governance in individual organisations that have to operate within a system such as implied by sustainability and transformation partnerships (STPs). While the framework, and indeed regulation, remains necessarily focused at organisational level until legal responsibilities change, there is a recognition that participation in and understanding of the strategic system level is a characteristic of a well-led organisation.

Independence and frequency

Reviews must still be independent but self-evaluation is recognised as a key starting point for any external assessment. Timescales remain three-yearly although this may
be extended to five years by agreement with NHSI, based on the regulator’s view of the organisation’s performance and leadership.

**Costs**

Typically an external review of this nature is in the region of £50,000.

**Our baseline self – assessment; sources and outcomes.**

KPMG were commissioned to provide a baseline assessment of corporate governance arrangements in relation to the Well Led framework, primarily focused on the Board and its leadership from a desktop inspection. The inspection used three sources of data in making that assessment;

- 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

A quick summary of the findings is;

**Areas of good practice**

- Comprehensiveness, timeliness and clarity of performance reporting, including use of graphs, RAG rating, trends and other graphics;
- Ensuring Board is aware of key developments, internal and external: eg. post-project implementation reviews; patient story to ensure continued focus on patient experience; CEO’s monthly report, including external developments; work on joint working arrangements;
- Commitment and challenge of NEDs; Board skills gap analysis; succession planning for key Board roles; regular Board seminars and away days interspersed with Board meetings;

**Areas for improvement**

- Connecting strategy, organisational priorities, BAF, risk register and performance reporting at a high level. Key risks identified should be those preventing achievement of the strategy and operational goals; performance would report against these risks; the Board would then focus its work on this higher, more strategic level.
- The Trust would also benefit from a greater focus on evaluation of effectiveness of current processes and activities. Two low level recommendations were also raised.
- There are a number of other areas such as update and review of the terms of reference for the Board Committees which have not been updated and reviewed presently.
KPMG’s full assessment is contained in Appendix I to the report in the Appendices Supplement.

**Commissioning an External Review**

The Board has options about how it now progresses the development of leadership and governance using this eight key characteristics of the framework;

- Option one - using the self-assessment, go immediately to tender and commission an external review of leadership and governance
- Option two - using the self-assessment and the forthcoming findings of the CQC Well Led / Use of Resources inspections in April and May, then go to tender and commission an external review of leadership and governance providing the external assessor with the evidence of the self – assessment and CQC inspection
- Option three – await the outcome of the findings of the CQC Well Led / Use of Resources inspections, consider any improvement recommendations being made in tandem with the KPMG self-assessment and refer back to Board a proposal at that stage on whether to move to external review in 2018 or, alternatively, work on implementing the KPMG / CQC inspection outcomes with a view to commissioning an external review following implementation.

The Executive Team considered these options at its meeting on 21st March and recommended that the most prudent course of action was to await the findings of the CQC inspection and then refer back to Board for a decision on the timing and scope of an external review as both would be influenced by the CQC’s conclusions.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 28th March 2018
Agenda item 12

Report title: Emergency Preparedness Resilience and Response

Report author: Vikas Sharma, Head of Corporate Governance/ Jayne Austin
Emergency Planning Liaison Officer

Report sponsor: Joe Smyth, Chief Operating Officer

Board Action required:

The Board are asked to:

Approve the statement that the Trust has met core standards as assessed annually
by the EPRR Department of NHSE (London Region)

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

STRATEGIC PRIORITY:

Improving the present
Emergency Preparedness Resilience and Response (EPRR)

1. Introduction

The NHS must be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient safety. These could be anything from severe weather to an infectious disease outbreak or a major transport accident. Under the Civil Contingencies Act (2004) (CCA 2004), the Trust must demonstrate that we can effectively respond to emergencies and business continuity incidents while maintaining services to patients. This work is referred to as Emergency Preparedness, Resilience and Response’ (EPRR).

Under the definition of the CCA 2004, all Acute Trusts are classed as Category 1 Responders by being organisations at the core of health emergency response. To be compliant with the Act the Trust has to meet a set of core standards that are assessed annually by the EPRR Department of NHSE (London Region) who in turn report to the national team and thence to the Secretary of State. The Trust is a member of the North West London Network for EPRR.

2. Key Statutory Obligations of the CCA 2004 for the Trust.

1) Have a nominated Director level Accountable Emergency Officer who will be responsible for EPRR, a designated Emergency Planning Liaison Officer and a Business Continuity Manager.
2) Contribute to area planning for EPRR through local health resilience partnerships and other relevant groups.
3) Have suitable, proportionate and up to date plans to cover the Trust response to Major and Critical (Internal) Incidents,
4) Have business continuity plans as identified in national and community risk registers.
5) Training and exercising must include:
   i. a communications exercise every six months
   ii. a desktop exercise once a year
   iii. a major live exercise every three years
6) Have appropriately trained competent staff and suitable facilities available round the clock to effectively manage an emergency and business continuity incident.
7) Share resources as required to respond to an emergency or business continuity incident.
8) Have arrangements in place to inform, warn and advise the public during an incident.
3. EPRR Highlights/Exercising in 2017/18

**Fire Evacuation Exercise**
In October 2017 the Trust conducted a multi-agency live fire evacuation exercise to test the organisations ability to safely evacuate the Tower Block in line with the Trusts Fire Evacuation plans. The exercise highlighted key learning points which were presented to the Trust Management Executive and the Audit and Risk Committee An action plan has been developed relating to the findings of the exercise and evaluation of the equipment and progress is being monitored via the Trusts EPRR Committee. Overall the exercise provided assurance on the Trusts ability to respond to an incident requiring evacuation.

4. Trust Compliance

1. The Chief Operating Officer holds the post of the Accountable Emergency Officer. The Executive Director of the Patient experience and Nursing has responsibility for the management and delivery of business continuity. A part time dedicated Emergency Planning Liaison Officer (EPLO) is in post and the Acting Head of Corporate Governance (at approx. 0.1wte allocated resource) to deal with the Trusts EPRR
2. The Trust has an overarching EPRR policy which outlines key responsibilities and the Trust process for dealing with EPRR
3. The Trust has in place an EPRR Committee chaired by the Director of Operations, with senior staff from all key areas in attendance thus ensuring cohesive and inclusive planning and to oversee and operationally manage the EPRR agenda and Trust action plan
4. The Trust has developed a number of plans to ensure its resilience in line with the CCA 2004 including Major and Critical (Internal) Incidents, Heatwave, VIP Plans, Flu Pandemic, Major Incident Communication Plan, Evacuation plans, Business continuity plans (overarching, service level, threat specific and ICT)
5. As part of the 2017/18 assurance process NHSE conducted a deep dive into the Trusts EPRR Governance arrangements
6. The Trust maintained a rating of substantial assurance against the Core Standards review for 2017/18
Meeting of the Board of Directors – Public Part I

Date of meeting: 28\textsuperscript{th} March 2018
Agenda item 13


Report author: Ritu Sharma, Information Governance Manager
Report sponsor: Matt Tattersall, Finance Director and SIRO

Board Action required:

The Board are asked to:

Approve the recommendation made to formally submit the Information Governance Toolkit self-assessment for 2017/18

Note that the current IG Toolkit is being replaced by the Data Security and Protection (DSP) Toolkit from April 2018

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

\textit{STRATEGIC PRIORITY:}

\textit{h) Enabler: Workforce}
1. Introduction

The Information Governance Toolkit is an online self-assessment which allows organisations to assess themselves against Information Governance standards by combining legal rules, principles and guidance into a set of 45 requirements. The results of Trusts’ Toolkit submissions are shared with NHS Digital. All NHS organisations are required to demonstrate compliance with at least Level 2 attainment against each requirement.

This report sets out the scoring for the Information Governance Toolkit (IGT) v.14 Assessment. See Appendix A for requirement and scoring details.

2. Peer Review

A Peer Review of the IGT requirements was undertaken on the 26th March 2018 with the Information Security Officer to validate the evidence provided and to confirm the requirements as being ‘complete’ prior to the final submission required on 31st March 2018.

3. Final Assessment

The Trust score for the final assessment submission is 82%. This is recorded as ‘satisfactory’ as the Trust has provided sufficient evidence to support Level 2 or above for all the 45 requirements (level 1 being the lowest attainment level and 3 being the highest attainment level). 16 requirements have been evidenced at level 3, 28 requirements evidenced at level 2 and 1 requirement has been marked not relevant to the organisation.

4. Gaps

The requirement at risk is:

Req. 112 - Information Governance training programme.

This requirement states that 95% of all staff must have completed or be in the process of completing annual information governance training by March 2018. The Board will note this exceeds the current Trust target for statutory/mandatory training of 80%.

Compliance level as of 14th March 2018 is 92.94% (3188 staff compliant out of a total of 3430). A great improvement has been noted in compliance since December 2017 when compliance was at 83%.

- A final drive has taken place during the remaining weeks of March to see if the training compliance figures can be pushed further towards the 95% goal.
• Those staff who do not completed their training by the end of March 18 will be automatically booked into face to face training session in April 2018.

• Regular monthly refresher sessions are held in the Education Centre and the training is also available for staff to access via the I Develop system.

• Human resources have continued to provided additional resources to assist in targeting the Temporary staff / Bank compliance

5. Independent Assessment

The IG Toolkit (version14.1) was not on the Internal Audit programme for 2017/18. The Board should be aware that the IG toolkit requirements have not changed materially from the previous year, so the work required this year has been to update current evidence to maintain level 2 and 3 attainments.

6. Monitoring compliance and implications of non-compliance

There are no financial penalties in the Commissioning contract as no requirements have been evidenced as being below level 2.

7. New Data Security and Protection (DSP) Toolkit

The Board is asked to note that from April 2018 all organisations will be required to complete the new Data Security and Protection (DSP) Toolkit. The DSP Toolkit will replace the Information Governance Toolkit the Trust currently completes. The DSP toolkit is an online tool that will enable organisations to measure their performance against the data security and information governance requirements mandated by the Department of Health and Social Care. Developed following the National Data Guardian's (NDG) review (July 2016) and the government's subsequent response.

8. Board Action Required

The Board is asked to approve the 2017/18 Information Governance Toolkit submission to NHS Digital and note that the Trust will be required to use the new Data Security and Protection Toolkit from April 2018 onwards.
## Appendix A

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Description</th>
<th>Baseline / Update Score Oct 17</th>
<th>Final Score March 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>101</td>
<td>There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>105</td>
<td>There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>110</td>
<td>Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>111</td>
<td>Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>112</td>
<td>Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>200</td>
<td>The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation’s assessed needs</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>201</td>
<td>The organisation ensures that arrangements are in place to support and promote information sharing for coordinated and integrated care, and staff are provided with clear guidance on sharing information for care in an effective, secure and safe manner</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>202</td>
<td>Confidential personal information is only shared and used in a lawful manner and objections to the disclosure or use of this information are appropriately respected</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>203</td>
<td>Patients, service users and the public understand how personal information is used and shared for both direct and non-direct care, and are fully informed of their rights in relation to such use</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>205</td>
<td>There are appropriate procedures for recognising and responding to individuals’ requests for access to their personal data</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>206</td>
<td>Staff access to confidential personal information is monitored and audited. Where care records are held electronically, audit trail details about access to a record can be made available to the individual concerned on request</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>207</td>
<td>Where required, protocols governing the routine sharing of personal information have been agreed with other organisations</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>209</td>
<td>All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines</td>
<td>Not Relevant</td>
<td>Not Relevant</td>
</tr>
<tr>
<td>210</td>
<td>All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>300</td>
<td>The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation’s assessed needs</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>301</td>
<td>A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>302</td>
<td>There are documented information security incident / event reporting and management procedures that are accessible to all staff</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>303</td>
<td>There are established business processes and procedures that satisfy the organisation’s obligations as a Registration Authority</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>304</td>
<td>Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>305</td>
<td>Operating and application information systems (under the organisation’s control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>307</td>
<td>An effectively supported Senior Information Risk Owner takes ownership of the organisation’s information risk policy and information risk management strategy</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>308</td>
<td>All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>309</td>
<td>Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Item</td>
<td>Description</td>
<td>2</td>
<td>3</td>
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<td>------</td>
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</tr>
<tr>
<td>310</td>
<td>Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>311</td>
<td>Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>313</td>
<td>Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>314</td>
<td>Policy and procedures ensure that mobile computing and teleworking are secure</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>323</td>
<td>All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>324</td>
<td>The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>400</td>
<td>The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>401</td>
<td>There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>402</td>
<td>Procedures are in place to ensure the accuracy of service user information on all systems and/or records that support the provision of care</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>404</td>
<td>A multi-professional audit of clinical records across all specialties has been undertaken</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>406</td>
<td>Procedures are in place for monitoring the availability of paper health/care records and tracing missing records</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>501</td>
<td>National data definitions, standards, values and data quality checks are incorporated within key systems and local documentation is updated as standards develop</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>502</td>
<td>External data quality reports are used for monitoring and improving data quality</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>504</td>
<td>Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>505</td>
<td>An audit of clinical coding, based on national standards, has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last 12 months</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>506</td>
<td>A documented procedure and a regular audit cycle for accuracy checks on service user data is in place</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>507</td>
<td>The secondary uses data quality assurance checks have been completed</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>508</td>
<td>Clinical/care staff are involved in quality checking information derived from the recording of clinical/care activity</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>510</td>
<td>Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national clinical coding standards</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>601</td>
<td>Documented and implemented procedures are in place for the effective management of corporate records</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>603</td>
<td>Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>604</td>
<td>As part of the information lifecycle management strategy, an audit of corporate records has been undertaken</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total (%)</td>
<td></td>
<td>70%</td>
<td>82%</td>
</tr>
</tbody>
</table>
Meeting of the Board of Directors – Public Part I session

Date of meeting: 28 March 2018
Agenda item 14

<table>
<thead>
<tr>
<th>Report title: Appointments to Committees 2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report author: Michael Sims Trust Secretary</td>
</tr>
<tr>
<td>Report sponsor: Richard Sumray Chair</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Board Action required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Board are asked to:</td>
</tr>
<tr>
<td>Approve the membership of Committees for 2018-19</td>
</tr>
</tbody>
</table>

<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>h) Enabler: Workforce</td>
</tr>
</tbody>
</table>
Committee Memberships

The Scheme of Delegation authorises the Board to establish the membership of its Committees.

The table below sets out the proposed membership of Committees as recommended by the Chair.

The proposed changes from 2017-18 are:

- T Roberts joins the Charitable Funds Committee as the Director of Charities now reports to him
- L Burke had already been attending Nominations and Remuneration Committee meetings which would now be formalized for 2018-19

<table>
<thead>
<tr>
<th>Committee</th>
<th>Members</th>
<th>Other Board Member attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance &amp; Transformation Committee</td>
<td>R Sumray, S Dhillon, K Edelman, C Powell, C Coppell, S Degaris, M Tattersall, J Smyth, A Khakoo or J Walker</td>
<td>T Roberts – when required Medical Director / Director Patient Experience and Nursing – to alternate</td>
</tr>
<tr>
<td>Audit &amp; Risk Committee</td>
<td>R Whittington, S Dhillon, K Edelman, C Powell</td>
<td>M Tattersall</td>
</tr>
<tr>
<td>Charitable Funds Committee</td>
<td>R Sumray, C Powell, C Coppell, M Tattersall, J Walker, T Roberts</td>
<td></td>
</tr>
<tr>
<td>Nominations Committee</td>
<td>R Sumray, S Dhillon, L Paice</td>
<td>T Roberts</td>
</tr>
</tbody>
</table>
| Remuneration Committee | R Sumray  
S Dhillon  
L Paice  
K Edelman  
C Powell  
C Coppell  
R Whittington  
L Burke | S DeGaris  
T Roberts |

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

Committee Action required:

The Committee are asked to:

1. Note 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
1. EXECUTIVE SUMMARY

Key Points to note at Month 11:

- Trust has a deficit of £13.0m, £4.5m behind plan.
- Agency expenditure of £1.1m in month down on January expenditure.
- Pay overspent by £1.0m in month.
- Finance and Use of Resources score of 4.
- Efficiency savings of £1.2m achieved in month, - slightly ahead of plan.
- Capital expenditure of £0.9m in month, £4.3m year to date
- Cash position of £1.1m at month end.

The in-month position as at the end of February is a deficit of £2.6m, £1.4m behind plan. EBITDA was (£1.2m), (5.9%) of revenue. The year-to-date position is a deficit of £13.0m, behind plan by £4.5m.

<table>
<thead>
<tr>
<th>Annual Plan</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>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
<td>£000s</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operating Income</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Clinical Income</td>
<td>217,468</td>
<td>198,855</td>
<td>202,503</td>
<td>3,648</td>
<td>17,482</td>
<td>18,327</td>
</tr>
<tr>
<td>Non-NHS Clinical Income</td>
<td>4,125</td>
<td>3,769</td>
<td>2,936</td>
<td>(833)</td>
<td>339</td>
<td>327</td>
</tr>
<tr>
<td>Other Operating Income</td>
<td>28,062</td>
<td>25,716</td>
<td>25,234</td>
<td>(482)</td>
<td>2,348</td>
<td>2,189</td>
</tr>
<tr>
<td><strong>Total Operating Income</strong></td>
<td><strong>249,655</strong></td>
<td><strong>228,340</strong></td>
<td><strong>230,673</strong></td>
<td><strong>2,333</strong></td>
<td><strong>20,169</strong></td>
<td><strong>20,843</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operating Expenses</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Expenses</td>
<td>(166,590)</td>
<td>(152,688)</td>
<td>(161,357)</td>
<td>(8,669)</td>
<td>(13,903)</td>
<td>(14,934)</td>
</tr>
<tr>
<td>Drugs</td>
<td>(18,339)</td>
<td>(16,817)</td>
<td>(17,833)</td>
<td>(1,016)</td>
<td>(1,518)</td>
<td>(1,561)</td>
</tr>
<tr>
<td>Clinical Supplies and Services</td>
<td>(24,328)</td>
<td>(22,642)</td>
<td>(23,636)</td>
<td>(994)</td>
<td>(1,986)</td>
<td>(2,841)</td>
</tr>
<tr>
<td>Other Operating Expenses</td>
<td>(32,503)</td>
<td>(29,358)</td>
<td>(31,540)</td>
<td>(2,182)</td>
<td>(2,557)</td>
<td>(2,751)</td>
</tr>
</tbody>
</table>

| EBITDA | 7,895 | 6,835 | (3,693) | (10,528) | 205 | (1,244) | (1,449) |

| Depreciation | (10,295) | (9,452) | (8,547) | 905 | (854) | (765) | 89 |
| PDC Dividend Expense | (4,004) | (3,668) | (3,757) | (89) | (334) | (342) | (8) |
| **Surplus(Deficit) before Exceptionals** | **(8,752)** | **(8,459)** | **(18,370)** | **(9,911)** | **(1,172)** | **(2,565)** | **(1,393)** |

| Gains/(Loss) on Investment Properties | 0 | 0 | 5,365 | 5,365 | 0 | 0 | 0 |
| Profit/(Loss) on the Disposal of Assets | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Surplus(Deficit) after Exceptionals** | **(8,752)** | **(8,459)** | **(13,005)** | **(4,546)** | **(1,172)** | **(2,565)** | **(1,393)** |

Clinical Income was marginally above plan, however, winter pressures funding of £386k was included, enhancing the position, costs against these schemes were above this level causing an in month pressure. Emergency admissions were high during February causing pressure throughout the hospital, up 227 on the plan for the month. Despite this pressure Elective Inpatients were on plan, however Day cases down by 42, and Outpatients down by 860. The Trust cancelled 11 Electives and 15 Day cases due to operational pressures. This would have an impact of lost income of £52k, however 11 Emergency admissions at marginal rate would only generate £12k.

Other operating income is below planned levels due to loss of 2 weeks car parking income when the barriers were being replaced (£45k) and drop in training income (offset by reduction in costs of courses).
Pay is above plan in month by £1m, Agency saw a reduction in month from the high levels reported in January, of £120k. Nursing agency was down by £63k but medical was up by £20k. The Trust was under enormous pressure in A&E during February, and had to increase additional medical shifts by £52k in the month, nursing agency increased by £12k.

Clinical Supplies and Services are above plan in month due the Winter Pressures costs from Adult Social Care and CNWL (£400k) coming in and an estimate of additional cost from the NWL Pathology Joint Venture of £300k for centralised expenditure.

Other Operating Expenses are above budget due to the CQUIN 0.5% provision being held in a central reserve as instructed by NHSI; this will be released in March (£874k).

**Key Performance Indicators**

<table>
<thead>
<tr>
<th>Surplus/(Deficit)</th>
<th>(£1,286k)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Rating</td>
<td>4</td>
</tr>
<tr>
<td>Agency expenditure</td>
<td>£1,211k</td>
</tr>
<tr>
<td>Efficiency Savings</td>
<td>£1,197k</td>
</tr>
<tr>
<td>Pay Variance</td>
<td>(£1,031k)</td>
</tr>
</tbody>
</table>

**2. Charts**

**Commissioned Income Total**
3. FIP PERFORMANCE

In month 11, the Trust’s forecast outturn QIPP position is £10.2m, a reduction of 45k compared to month 10. This is a gap of £2.3m to the target QIPP value of £12.5m.

Year to date, the Trust has delivered £9.0m against a planned value of £10.2m. In February £1.2m was delivered (over delivery of £77k).
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 February remains at 4, though is forecast to improve to a 3 at year end.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Plan</th>
<th>Rating for February</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Service Capacity</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Liquidity</td>
<td>4</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>3</td>
</tr>
<tr>
<td>Agency spend</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Weighted Average</strong></td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>Overall Rating after Overrides</strong></td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

The ‘Underlying Financial Performance’ risk on the Corporate Risk Register remains at a 15 (extreme). This reflects the on-going challenge in closing the financial gap on the FIP forecast; the need to use non cash means to deliver the plan this year; the on-going overspend on pay, and the challenge to the Trust’s liquidity.

5. Key Messages

- The forecast remains at £8.1m however the Trust will utilise the CQUIN provision and some release of balance sheet items in order to achieve it.

- The Month 11 position has shown further deterioration with increased cost of delivering additional activity. The forecast remains at £8.1m deficit, however the release of the CQUIN provision will be an enabler in reaching our plan.

- The cash position has been eased by the additional £7.5m working capital support received in March.

- The FIP programme delivered £1,122k in month; focus is now on developing schemes for 2018/19, of which £8.9m has been identified.

- The A&E Capital scheme commenced in February, the funding has been included in our 2018/19 plan as PDC carried forward.

Equalities & Finance

Equality and diversity considerations: none.

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

Date of meeting: 28th March 2018
Agenda item 16

Report title: 2018/19 Financial Plan

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

Board Action required:

The Board are asked to:

1. Approve the draft 2018/19 Financial Plan.
2. Confirm that the Trust will reject the proposed Control Total from NHS Improvement of £1.1m surplus in the final plan submission in April.
3. Delegate authority to the chair and Chief Executive to agree any changes required to the plan following agreement of commissioner contracts. All changes will be reported to the Finance & Transformation Committee. Any change that increases financial risk or impacts the planned deficit will be reported back to the Board.

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

In line with the requirements for a refreshed Operational Plan (covered elsewhere on the Board agenda), the Trust has been setting its budget for 2018/19.

NHS Improvement (NHSI) issued the Trust with its Control Total in February, this required the Trust to achieve a £1.3m surplus. At its seminar in February the Board agreed to reject this Control Total when it submitted the draft plan in March. Instead it agreed to set a budget deficit of c£15m in 2018/19, including a stretching savings target of £12m.

Subsequent to submitting the draft plan the key assumptions have not changed, namely we are proposing a savings target of £12m and a deficit of £15.3m. However, negotiations with commissioners have not been concluded. Once contracts are agreed NHSI require us to refresh our plans and resubmit. Consequently, the budget cannot be finally agreed at this point. The current draft financial plan is included at Appendix I in the appendices supplement.

The Board is asked to:
1. Approve the draft 2018/19 Financial Plan.
2. Confirm that the Trust will reject the proposed Control Total from NHS Improvement of £1.1m surplus in the final plan submission in April.
3. Delegate authority to the Chair and Chief Executive to agree any changes required to the plan following agreement of commissioner contracts. All changes will be reported to the Finance & Transformation Committee. Any change that increases financial risk or impacts the planned deficit will be reported back to the Board.
Meeting of the Board of Directors – Public Part I session
Meeting date: 28th March 2018
Agenda item 17

Report title: Integrated Quality & Performance Report

Report authors:
Imran Devji (Director of operational Performance)
Vanessa Saunders (Deputy Director of Nursing and Patient Experience)
Rachel Stanfield (Deputy Director of People and Organisational Development)

Report sponsors:
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:
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>
<thead>
<tr>
<th>Infection Control</th>
<th>Target</th>
<th>2016/2017</th>
<th>2017/2018</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Last Month</td>
<td>YTD</td>
<td>Model Hospital Peers</td>
</tr>
<tr>
<td>Clostridium Difficile Infection: Trust Attributable</td>
<td>8 (Lapses in Care)</td>
<td>12 Cases (7.8 Cases per 100,000 Beddays)</td>
<td>3 Cases (22.0 Cases per 100,000 Beddays)</td>
<td>17 Cases (10.9 Cases per 100,000 Beddays)</td>
</tr>
<tr>
<td>MRSA: Trust Attributable</td>
<td>0</td>
<td>1 Case (0.7 Cases per 100,000 Beddays)</td>
<td>0 Cases</td>
<td>1 Case (0.6 Cases per 100,000 Beddays)</td>
</tr>
<tr>
<td>Cancer</td>
<td>93%</td>
<td>98.0%</td>
<td>88.3%</td>
<td>95.1%</td>
</tr>
<tr>
<td>Maintain two week cancer waits (all cancers)</td>
<td>93%</td>
<td>95.7%</td>
<td>98.5%</td>
<td>97.6%</td>
</tr>
<tr>
<td>Maintain two week cancer waits (breast symptoms except suspected cancer)</td>
<td>96%</td>
<td>99.3%</td>
<td>97.5%</td>
<td>98.9%</td>
</tr>
<tr>
<td>31 days diagnosis to treatment for cancer (1st Treatment)</td>
<td>94%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>31 days diagnosis to treatment for cancer (2nd or Subsequent Treatment - Surgery)</td>
<td>98%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>98.5%</td>
</tr>
<tr>
<td>31 days diagnosis to treatment for cancer (2nd or Subsequent Treatment - anti cancer drug treatments)</td>
<td>85%</td>
<td>92.2%</td>
<td>83.3%</td>
<td>85.7%</td>
</tr>
<tr>
<td>62 days urgent GP referral to treatment for cancer</td>
<td>90%</td>
<td>98.4%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>62 days urgent referral to treatment for cancer (Screening)</td>
<td>92%</td>
<td>92.4%</td>
<td>90.7%</td>
<td>91.4%</td>
</tr>
<tr>
<td>Referral To Incomplete Pathways within 18 weeks</td>
<td>92%</td>
<td>92.4%</td>
<td>90.7%</td>
<td>91.4%</td>
</tr>
<tr>
<td>Accident &amp; Percentage of Patients Meeting 4 Hour Standard (All A&amp;E Types)</td>
<td>95%</td>
<td>84.0%</td>
<td>79.5%</td>
<td>85.4%</td>
</tr>
</tbody>
</table>
## Trust Overview

### February-2018

<table>
<thead>
<tr>
<th>Domain</th>
<th>Ref</th>
<th>Theme</th>
<th>Management Priority</th>
<th>Forecast Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Last Month</td>
<td>This Month</td>
</tr>
</tbody>
</table>

### [1] Safe
- **1.01** HCAI: Minor | Minor | Stable
- **1.02** Stroke & TIA: Excellent | Excellent | Stable
- **1.03** FNOF: Minor | Minor | Stable
- **1.04** Maternity: Minor | Minor | Stable
- **1.05** Falls: Minor | Minor | Stable
- **1.06** Medication: Excellent | Excellent | Stable
- **1.07** VTE: On Track | Minor | Stable
- **1.08** Pressure Ulcers: Minor | On Track | Stable
- **1.09** Safety Thermometer: On Track | On Track | Stable
- **1.10** Serious Incidents: On Track | On Track | Stable
- **1.11** Never Events: On Track | On Track | Stable
- **1.12** Patient Safety: On Track | Minor | Stable
- **1.13** Mortality: Moderate | On Track | Stable

### [2] Effective
- **2.1** Readmissions: On Track | On Track | Stable
- **2.2** ONAs: On Track | On Track | Stable
- **2.3** ASIs: Significant | Significant | At Risk

### [3] Caring
- **3.1** FFT (Admitted Care): On Track | On Track | Stable
- **3.2** FFT (A&E Care): Moderate | Significant | At Risk
- **3.3** FFT (Maternity Care): On Track | On Track | Stable
- **3.4** Complaints: Moderate | Minor | At Risk
- **3.5** PALS: Minor | On Track | Stable

### [4] Responsive
- **4.1** Accident & Emergency: Significant | Significant | At Risk
- **4.2** RTT: Moderate | Moderate | At Risk
- **4.3** Cancer: Excellent | Minor | Stable
- **4.4** Mixed Sex Accommodation: Excellent | Excellent | Stable

- **5.1** PDR, Medical Appraisal & STAM: On Track | On Track | Improving
- **5.2** Sickness: Minor | Moderate | At Risk
- **5.3** LTR, Vacancy & TtR: On Track | On Track | Improving
- **5.4** Temporary Staffing Usage: On Track | On Track | Stable
- **5.5** Staff in Post: On Track | On Track | Improving
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

Clostridium difficile

<table>
<thead>
<tr>
<th>Performance analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>There were a further three c. difficile (CDI) Trust attributed cases in February resulting in 17 cases reported YTD; this reflects nine more cases when compared with the same period in 2016/17. There has clearly been an increase over the past four months which may be due to the number of flu cases resulting in more chest infections requiring antibiotics (although not proven). The IP&amp;C team are looking into other factors such as antibiotic prescribing to observe any changes in trends as well as, increased activity and capacity management. A full root cause analysis has been completed on all cases to date, with nine agreed as no lapses in care and six awaiting commissioner review. Lapses in care have been noted in two cases; one related to poor compliance with antimicrobial prescribing and the second a potential cross infection. There were three cases of CDI with indistinguishable typing in which cross infection is suspected; this is under review and a CDI incident meeting was held with Public Health England. Further in depth typing has been requested and results are pending.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key risks and challenges:</th>
<th>High impact improvement actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Continued increase in cases some of which may indicate lapses in care.</td>
<td></td>
</tr>
<tr>
<td>• Increased antibiotic usage due to seasonal influences.</td>
<td>• Robust root cause analysis investigation.</td>
</tr>
<tr>
<td></td>
<td>• Application of improvement actions following each case.</td>
</tr>
<tr>
<td></td>
<td>• C. difficile action log from RCAs being presented at quarterly ICC meetings.</td>
</tr>
</tbody>
</table>

Fractured neck of femur patient in theatres within 36 hours:

<table>
<thead>
<tr>
<th>Performance analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>January is at 88.2% (17 patients, 2 breaches) with YTD at 86.3% (168 patients, 23 breaches). In January, 2 patients failed to receive their treatment within the national standard of going to Theatres within 36 hours. No patient came to harm due to the delay.</td>
</tr>
</tbody>
</table>
Dedicated Trauma lists continue on a 7 day basis to ensure consistent access.

**Inpatient Falls**

<table>
<thead>
<tr>
<th>Performance analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of falls in February is at 4.3 per 1000 bed days against a Trust target rate of 3.9. This is a slight improvement compared to December; year-to-date position is 4.6, which has been largely unchanged all year. Rate of falls resulting in harm showed an upward trend in February, at 2.1 per 1000 bed days however none has been recorded as resulting in a patient sustaining a fracture; with 7 fractures year to date there is currently an improvement in trend compared to last year.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key risks and challenges:</th>
<th>High impact improvement actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Trust target rate will not be achieved</td>
<td>• Patient risk factors assessed on admission and individualised care plan implemented</td>
</tr>
<tr>
<td>• Target rate not in line with benchmark rate of 6.6 (RCP, 2015)</td>
<td>• Additional staffing in place where required to provide enhanced observation and assistance</td>
</tr>
<tr>
<td>• Inherent risk of falling among large section of patient cohort</td>
<td>• Root cause analysis undertaken for patients falling frequently or where a fracture is sustained</td>
</tr>
<tr>
<td>• Need to maintain mobility and independence requires a risk-minimising approach rather than total risk avoidance</td>
<td>• Lead Nurse Quality and Clinical Standards to implement recommendations arising from Round 2 of National Inpatient Falls Audit</td>
</tr>
</tbody>
</table>

**Caesarean section rate (emergency)**

<table>
<thead>
<tr>
<th>Performance analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target: 29%; Performance – 29.6%. The non-elective c-section rate reduced in February to 19.4% with a year to date performance of 19.2%. The elective c-section rate remains below the 13% target at 10.2%. A review has been undertaken of all non-elective caesarean sections over the last 4 months. All identified learning and recommendations will be implemented.</td>
</tr>
</tbody>
</table>

**Mortality (HSMR)**

<table>
<thead>
<tr>
<th>Performance analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>The rolling 12 Month HSMR (Dec-2016 to Nov-2017) for all admissions is 97.7 (101.5 – 105.4) and the rolling 12 Month HSMR (Dec-2016 to Nov-2017) for weekend Admissions is 100.2 (85.8 – 116.5), both of which are as expected. This shows a significant downward trend, and coincides with more robust palliative care coding (clinical coders reconciling their lists with the palliative care team) which is running nearer (but still below) national average. This shows how sensitive the HSMR is to the Palliative Care Coding rate, and the importance of data quality. As pneumonia deaths were identified as an outlier, a consultant review using the Dr Foster toolkit (Investigating a high HSMR - best practice) reviewed the notes of 54 out of the 56 patients and could find no avoidable deaths, and only 3 of the 17 patients who were receiving palliative care were coded as such. A detailed report on clinical coding and pneumonia deaths was presented at the February Mortality Surveillance Group (MSG), chaired by the Medical Director, which has one of the Quality and Safety NEDs in attendance, and was also attended by the Quality and Safety Deputy Medical Director for NHSI (London). The MSG will continue to monitor overall, weekend and specialty HSMR,</td>
</tr>
</tbody>
</table>
and investigate any issues. The April meeting of the Quality and Safety Committee will receive a more detailed report as part of Aim 3 of the Quality and Safety Improvement Strategy 2017-2021: Working towards no preventable deaths.

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 35.8% (target 30%); Satisfaction 96.6% (target 94%)</td>
</tr>
<tr>
<td>Response rate has increased since January; satisfaction score showing little variability across the year, maintaining above target throughout.</td>
</tr>
<tr>
<td><strong>A&amp;E Care (A&amp;E and MIU combined):</strong> Response Rate 6.8% (target 20%) Satisfaction 96.3% (target 94%).</td>
</tr>
<tr>
<td>In February, there was a 2.7% drop in response rate compared to December 2017. Satisfaction score continued to remain above target despite high operational and environmental challenges.</td>
</tr>
<tr>
<td><strong>Outpatient Care:</strong> Response Rate 4.4% (target 6%) Satisfaction 97.2% (target 94%)</td>
</tr>
<tr>
<td>Response rate below target however a total of 1.016 responses were received therefore feedback is meaningful. Satisfaction score increased for sixth consecutive month.</td>
</tr>
<tr>
<td><strong>Maternity Care (all touch points):</strong> Response Rate 21.9% (target 20%) Satisfaction 97.6% (target 94%)</td>
</tr>
<tr>
<td>Response rate decreased compared to previous months but maintained above target; satisfaction score increased for second consecutive month.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key risks and challenges:</th>
<th>High impact improvement actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Survey is administered on discharge, may not be seen as priority for patients at that time</td>
<td></td>
</tr>
<tr>
<td>• Fast throughput areas have reduced opportunity to discuss survey and encourage completion</td>
<td></td>
</tr>
<tr>
<td>• Intense operational and clinical pressures in A&amp;E remain priority for staff compared to encouraging completion of survey</td>
<td></td>
</tr>
<tr>
<td>• A&amp;E Matron has introduced a “Welcome” letter for all patients, advising importance of patient feedback. This is given on arrival together with FFT card</td>
<td></td>
</tr>
<tr>
<td>• Results displayed in departments for staff and patients to view</td>
<td></td>
</tr>
<tr>
<td>• Ward staff/ clinical teams increasingly accessing results electronically to view, and learn from all free text comments</td>
<td></td>
</tr>
<tr>
<td>• Quarterly thematic reviews of comments at Experience and Engagement Group</td>
<td></td>
</tr>
</tbody>
</table>

Complaints

<table>
<thead>
<tr>
<th>Performance analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response rate was 87% of those due completed within agreed timeframe, just short of 90% target. This was the highest performance since October 2017. Only division of surgery failed to achieve 100% performance however they delivered a significantly improved position (70% compared to 36.4% in January).100% of new complaints received in February were acknowledged within requisite three working days.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key risks and challenges:</th>
<th>High impact improvement actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Annual performance target will not be met</td>
<td></td>
</tr>
<tr>
<td>• Operational divisions are vulnerable to periods of sustained high activity, with clinical care being prioritised over complaint investigations</td>
<td></td>
</tr>
<tr>
<td>• Complaints Management Unit outreaching to Surgical Division to review their processes and support coordination of investigations</td>
<td></td>
</tr>
<tr>
<td>• Weekly meetings between Division of Surgery and Complaints Management</td>
<td></td>
</tr>
</tbody>
</table>

60
• Complaints Management unit vulnerable to periods of unplanned leave
• Surgical division performance
• Continued delay in transferring responsibility for managing voluntary services away from PALS teams limits capacity for flexing staff between PALS and Complaints

Unit, robustly facilitated by Head of PPE, introduced to track and manage progress of complaints within the division
• Annual leave coordinated across PALS and Complaints teams to minimise impact of absences

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

<table>
<thead>
<tr>
<th>Performance analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>The RTT performance trend continues to improve with February delivering, 90.7%. The Trust’s RTT improvement plan is in progress to clear the backlog with the delivery for 92% standard now in June 18 from March 2018 due to emergency care pressures.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key risks and challenges:</th>
<th>High impact improvement actions:</th>
</tr>
</thead>
</table>
| • Emergency care pressures continue resulting in both Female and Male day case areas used as temporary inpatient escalation capacity
• Planned works in theatres over the Easter period and June 18 will affect the initial improvement plan due to loss of capacity in January and February to mitigate emergency pressures | • Continue with elective activity at MVH site and increase cases to deliver the improvement trajectory
• Female and Male Day Case areas to de-escalate from inpatient capacity in March 18
• Continue to pool lists and maximise throughput to increase backlog clearance |

Cancer performance

<table>
<thead>
<tr>
<th>Performance analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer performance in January 18 fell short of the national standards for 2 week waits (88.3%) and the 62 day urgent GP referral (83.3%). For the 2WW standard this was largely due to a lack of capacity in dermatology in December. Additional permanent capacity has been added and skin performance has significantly improved. For the 62 day standard this was due to a combination of patient choice, complex pathways, delay in diagnostic work up and delays at external trusts. The Trust is expected to be back on trajectory to deliver the standards in line with previous months.</td>
</tr>
</tbody>
</table>

Four Hour Emergency Care Transit Time Standard

<table>
<thead>
<tr>
<th>Performance analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1 performance in February 18 was at 51.1% resulting in an All Type performance of 79.5%.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key risks and challenges:</th>
<th>High impact improvement actions:</th>
</tr>
</thead>
</table>
| • February saw a 1.2% increase in all type activity compared to last year. Type 1 activity decreased (when compared to last year) – however the decrease was reflected in paediatrics and patients between 18 and 64. There was a 7% increase in the age range 65-79 and a 6.6% increase in the over 80s | • Pathway Appropriate Care and Treatment (PACT) week in February led by clinical teams reinforcing existing pathways (Pitstop, Ambulatory Care, Assessment Areas, CDU and SAFER with 10 discharges by 10 am)
• Focus on reducing non-admitted breaches via ED clinical teams and |
- There has been a shift in blue light ambulance conveyances since January with February seeing an increase of 19.4% reflecting higher acuity and use of resus facilities (increase of 13.9% use compared to last year)
- Emergency admissions increased by 7.3% and 15.1% YTD compared to last year
- Exit block from ED experienced throughout the month resulting in 11 to 24 patients waiting for beds in ED every morning
- ED overcrowding experienced with delays in off-loading ambulances
- The lack of beds also resulted in 1 Trust related 12 hour trolley wait. Action plan in place
- There were a further 2 Mental Health related 12 hour trolley waits. This was reported to the NWL sector by the CNWL team

<table>
<thead>
<tr>
<th>Emergency admissions and Length of Stay (LoS)</th>
<th>Performance analysis</th>
</tr>
</thead>
</table>
| LoS at 4.87 days in February. This is 0.4 days lower than previous year and 0.8 days lower YTD compared to 2016/17. | **High impact improvement actions:**
- Monthly focus on PACT week to support learning and deliver sustained changes to patient flow management
- Consistent focus on clinical teams to deliver the SAFER/Red2Green principles on a daily basis
- AMU LoS improved by 14.8% YTD
- Continued focus on the 6 principles of patient flow management (promoting and protecting assessment capacity, earlier transfers to wards from assessment areas for patients with >48 hrs LoS, 10 discharges by 10 am and SAFER/Red2Green principles)

2.5 Well Led
PDR Compliance

<table>
<thead>
<tr>
<th>Performance analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>PDR compliance remains at 98.34% comfortably above the target of 90%.</td>
</tr>
</tbody>
</table>
| **Key risks and challenges:** | **High impact improvement actions:**
- Preparation for the new PDR reporting | The Trust will be using an electronic
Mandatory Training

<table>
<thead>
<tr>
<th><strong>Performance analysis</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance has picked up to 89.74% for February following a dip in January.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Key risks and challenges:</strong></th>
<th><strong>High impact improvement actions:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Expanding the use and familiarity of iDevelop to complete, book and report on Statutory/Mandatory training to further increase compliance to levels experienced with WIRED.</td>
<td>Utilisation of iDevelop to more accurately track shortfalls by subject areas.</td>
</tr>
<tr>
<td>Maintaining compliance above Trust target for Safeguarding and IP&amp;C topics following the recent CQC visit.</td>
<td>SMEs to provide blended learning to ward environments.</td>
</tr>
<tr>
<td>Increasing compliance to with Trust target for Information Governance.</td>
<td>StaM training to be undertaken before new starters join the Trust.</td>
</tr>
</tbody>
</table>

Vacancy and Turnover Rates

<table>
<thead>
<tr>
<th><strong>Performance analysis</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>February has seen further decreases in both vacancy and turnover rates to 12.45% and 13.10% respectively.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Key risks and challenges:</strong></th>
<th><strong>High impact improvement actions:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintaining the time to recruit to within target as a means of further increasing staff numbers.</td>
<td>Continue to focus on student, domestic and international recruitment.</td>
</tr>
<tr>
<td>Reducing the numbers of monthly leavers particularly approaching historically high times of the year; March/April and September/October.</td>
<td>Increased use of apprenticeships.</td>
</tr>
<tr>
<td></td>
<td>Implement the NHSI Recruitment &amp; Retention Plan and People Strategy initiatives.</td>
</tr>
</tbody>
</table>

Sickness Absence

<table>
<thead>
<tr>
<th><strong>Performance analysis</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickness has reduced from January to 4.54% yet is still the second rate of the year.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Key risks and challenges:</strong></th>
<th><strong>High impact improvement actions:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bring short-term sickness down to more manageable levels.</td>
<td>Sickness absence discussed with managers at monthly DTM/KPI meetings.</td>
</tr>
<tr>
<td>As medical staff are moved onto the roster, a focus on preserving the historical trend in low sickness absences.</td>
<td>Sickness reports and OH referrals are sent to managers and actions are monitored and chased.</td>
</tr>
<tr>
<td></td>
<td>Update the Sickness Absence Policy in order to focus on short-term sickness absence.</td>
</tr>
</tbody>
</table>

Temporary Staffing Usage and Price Caps

<table>
<thead>
<tr>
<th><strong>Performance analysis</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary staff spend has reduced for February, yet price cap breaches have increased.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Key risks and challenges:</strong></th>
<th><strong>High impact improvement actions:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Maintaining further reductions in temporary staffing usage.</td>
<td>• Increase controls on A&amp;C agency expenditure.</td>
</tr>
<tr>
<td>Meeting of the Board of Directors – Public Part I session</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Date of meeting: 28\textsuperscript{th} March 2018</td>
<td></td>
</tr>
<tr>
<td>Agenda item 18</td>
<td></td>
</tr>
<tr>
<td><strong>Report title:</strong> People Strategy 2017-22: - Update</td>
<td></td>
</tr>
<tr>
<td><strong>Report author:</strong> Rachel Stanfield, Deputy Director People and Organisational Development</td>
<td></td>
</tr>
<tr>
<td><strong>Report sponsor:</strong> Terry Roberts, Director of People and Organisational Development</td>
<td></td>
</tr>
<tr>
<td><strong>Board Action required:</strong></td>
<td></td>
</tr>
<tr>
<td>Note progress against the People Strategy 2017-22: Year One</td>
<td></td>
</tr>
<tr>
<td><strong>Link to the Hillingdon Hospitals Strategic Plan 2017/21:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>STRATEGIC PRIORITY:</strong></td>
<td></td>
</tr>
<tr>
<td>Enabler: Workforce</td>
<td></td>
</tr>
</tbody>
</table>
This report updates on the five ‘pillars’ of the People Strategy 2017-22 (Year One) (see also Appendix)

**By March 2018 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
- 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

**We have …**

- Defined our EVP with over 300 staff – all based on our CARES values: [https://vimeo.com/253695350](https://vimeo.com/253695350)  
  [https://www.thh.nhs.uk/documents/_Jobs/Hillingdon_Cares_values.pdf](https://www.thh.nhs.uk/documents/_Jobs/Hillingdon_Cares_values.pdf)
- Promoted the VAP across social media
- Developed a VBR framework along with values-based interview questions
- Streamlined recruitment processes for internal appointments; enforced interview dates at advert stage; put in place daily monitoring of the recruitment SLA and Time to Hire at Divisional review meetings and the Workforce Transformation Steering Board (WTSB)
- Implemented Whatsapp communication for bank staff
- Put in place Division-specific recruitment initiatives to support hard to recruit to roles, e.g. Recruitment & Retention Premia (RRP) and the development of inter-organisation rotations for medical staff
- Implemented domestic recruitment initiatives including: recruitment Saturdays through to July 2018; extended range of application methods; move to a ‘direct interview and offer’ approach; rapid candidate follow up
- Recruited Indian nurses: 239 offers made and accepted - 21 are already IELTs-passed; first cohort (3 nurses) due to arrive in August 2018
- Student nurses are now routinely offered conditional posts subject to completion of clinical placements and academic work; 15 accepted and commenced working for Trust February/ March and April 2018; 26 offers have been made to the February 3rd year intake

**Impact on key metrics**

- A reduction in our vacancy rate from 15.32% (July 2017) to 12.45% (February 2018)
- A reduction in agency spend from £1,156,175 (July 2017) to £974,842 (February 2018)
- A reduction in Time to Hire from 57 days (July 2017) in to 53.3 days (February 2018)
By March 2018 we said we would ...

- Implement a new LMS supporting e-learning and on-boarding
- Embed clinical and non-clinical apprenticeships training into the whole hospital
- 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
- Evaluate and improve Leadership In Action

We have ...

- Launched the LMS – iDevelop - in January 2018, with all level 1 statutory and mandatory training is now available online
- Reduced Corporate Induction been from four days to two days: onboarding is now one day for all staff, two days for clinical staff
- Started 19 Apprenticeships across Business administration Level 3; Recruitment Consultant Level 3; Pharmacy Level 3; HCA Level 3; HCA Level 2; and Facilities Management Level 3
- Completed the procurement process for Business Administration, Customer Care Leadership and Management and facilities management Apprenticeships
- Held preliminary discussions with Brunel with regards to Advance Nurse Practitioner and advanced Allied Health Professional
- Discussion taken place with HEI’s Brunel and BNU, particularly with BNU
- Modules agreed include diabetes and tissue viability
- The Leadership In Action showcase event took place in February 2018 and the content of the programme has been reviewed; Year Two content and delivery has been updated to reflect the feedback received

Impact on key metrics

- A reduction in turnover from 14.75% (July 2017) to 13.10% (February 2018)
- STaM compliance is 89.74% (February 2018), which is a slight increase on the baseline figure of 89.63% (July 2017)
By March 2018 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
- Collaborate across NWL and Pan-London to reduce agency rates and increase bank usage

We have …

- 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 by the end of 2018
- 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 9 April 2018

Impact on key metrics

- A reduction in agency spend from £1,156,175 (July 2017) to £974,842 (February 2018)
- Delivered a saving of £231,818 from the 247Time direct engagement scheme (from June 2017)
- Sickness absence rates have increased from 3.22% (July 2017) to 4.54% (February 2018)
By March 2018 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 ...

- Submitted a business case for BSc Nursing and Nursing Associate Apprenticeship funding, due for consideration in March 2018
- Delivered OSCE preparation for overseas workforce
- Supported HEI partner in recruitment initiatives
- Identified gaps in the workforce locally and bottom up through Divisional planning and action planning
- Provided a Safer Medical Staffing update to the Board in January 2018, which highlighted work to progress future models including: Physician Associates; Advanced Practitioners; Clinical and non-clinical administrative support roles; and utilising the funds and opportunities available through the Apprenticeship Levy to ‘grow’ advanced practitioner
- 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 12.45% (February 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 2018 we said we would …

• Ensure EDI interventions are standard in recruitment
• Put in place a Development Centre for BAME staff and a BAME network
• 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 …

• Developed a process to ensure trained Equality Champions are on the interview panels for 8a and above roles across the board
• Agreed content of Development Centre and first one is scheduled to take place in April 2018
• Developed a coaching strategy in conjunction with NED Lis Paice
• Coaching skills training for managers is being offered once a month
• Developed a100-Day retention survey
• 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 13.10% (February 2018)
• **Fewer new starters leaving within 12 months** -12% in February 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

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*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: 28th March 2018
Agenda item 19

Report title: Staff Survey 2017 Key Findings

Report authors: Rachel Stanfield, Deputy Director of People and Organisational Development / Pallavi Sharma, Interim Head of Organisational Development

Report sponsors: Terry Roberts, Director of People and Organisational Development

Board Action required:

The Board are asked to:

Note and comment on the report

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

STRATEGIC PRIORITY:
Enabler: Workforce
1. **Introduction**

This report presents the key messages from The Hillingdon Hospitals NHS Foundation Trust National Staff Survey 2017, together with the current action plan and next steps.

2. **Survey construction and response rate**

53% of staff completed the 2017 survey, an improvement of 7% from 2016.

Responses to individual questions in the survey are categorised into 32 key findings. Each finding is composed of responses to specific questions relevant to the finding. Findings are then grouped under 10 themes.

This report highlights the issues where the Trust should focus its efforts in acting and therefore refers to performance against key finding and specific questions where relevant.

3. **Summary Results: Staff Engagement and Key Findings**  
(See Appendix)

3.1 **Staff engagement**

Staff engagement: 3.83 (3.85 in 2016) – not statistically significant to last year.

The staff engagement indicator is a composite of three key findings:

- Staff members’ perceived ability to contribute to improvements at work (where the Trust is average compared with other acute trusts)
- Staff willingness to recommend the Trust as a place to work or receive treatment (where the Trust is average compared with other acute trusts); and,
- Staff motivation – looking forward to going to work and enthusiastic and absorbed in their jobs (where the Trust scores in the best 20% of all acute Trusts)

3.2 **Key Findings: Top 5 indicators compared with other acute trusts**

The Trust continues to perform well compared to all acute trusts in some key areas:

<table>
<thead>
<tr>
<th>Top Five Indicators Compared to all Acute Trusts</th>
<th>In the best 20%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff motivation at work</td>
<td>(4.02 v. 3.92)</td>
</tr>
<tr>
<td>% of staff appraised in the last 12 months</td>
<td>(93% v. 86%)</td>
</tr>
<tr>
<td>Quality of appraisals</td>
<td>(3.20 v. 3.11)</td>
</tr>
<tr>
<td>% of staff experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>(13% v. 15%)</td>
</tr>
<tr>
<td>% of staff/colleagues reporting most recent experience of violence</td>
<td>Better than average (71% v. 66%)</td>
</tr>
</tbody>
</table>
3.2 Key Findings: Bottom 5 indicators compared with other acute trusts

The areas where the Trust performs worst compared to others are:

<table>
<thead>
<tr>
<th>Bottom Five Indicators Compared to all Acute Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. % of staff reporting errors, near misses or incidents witnessed in the last month</td>
</tr>
<tr>
<td>2. % of staff experiencing discrimination at work in the last 12 months</td>
</tr>
<tr>
<td>3. % of staff experiencing physical violence from staff in the last 12 months</td>
</tr>
<tr>
<td>4. % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td>
</tr>
<tr>
<td>5. % of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
</tr>
</tbody>
</table>

3.3 Key findings: Biggest changes compared to 2016

In addition to top and bottom performing areas, the areas where we have seen the biggest change from 2016 are shown below. These are all adverse changes.

<table>
<thead>
<tr>
<th>Largest changes from 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. % of staff working extra hours</td>
</tr>
<tr>
<td>7. % of staff feeling unwell due to work related stress in the last 12 months</td>
</tr>
<tr>
<td>8. % of staff experiencing harassment, bullying or abuse from staff in the last 12 months</td>
</tr>
<tr>
<td>9. Staff satisfaction with resourcing and support</td>
</tr>
<tr>
<td>10. Staff satisfaction with the quality of work and care they are able to deliver</td>
</tr>
</tbody>
</table>

Together, these two areas make the top ten areas for action at the generic, corporate level.

4. Analysis

The Trust has important strengths to build on, including its higher than average staff engagement score and levels of staff motivation in the top 20%. These are strengths that can be developed and leveraged in tackling the areas where performance is poor and where there have been adverse changes since 2016.

It is important to recognise the drivers that are likely to have influenced the adverse results and explain the relative worsening of our position in some key findings. Most notable is the tightened financial climate in 2017, particularly the internal Financial Improvement Programme (FIP). This represents a break from past relative financial stability and has led to an increase in accountability and responsibility and managers making tougher and harder decisions.
5. **Our response: Corporate, targeted and Divisional actions**

5.1 Corporate actions

Since the 2017 survey period, the Trust has begun implementation of the People Strategy 2017-22. The Strategy provides the framework and a set of core actions to respond to the Staff Survey 2017. All five pillars of this Strategy (although particularly ‘Educate, train and develop’ and ‘Nurture our people’) include corporate initiatives that will both build on the positive findings and address the negative findings in the Survey.

**People Strategy: corporate actions to address the Staff Survey 2017**

- Ensuring 1:1s are the norm and address the issues staff face
- Ensuring more effective PDRs delivered through a coaching approach
- Providing more learning and development opportunities through the Apprenticeship Levy and the LMS

Supporting areas 5, 6, 9 and 10

- Embedding a coaching culture
- Reward schemes including CARES monthly
- Implementing Development Centres from April 2018
- Hillingdon’s ‘Listening Into Action’
- Achieving Healthy Workplace Charter Level 2

Supporting areas 1, 2, 3, 5, 7, and 8

- Values based recruitment to further embed our CARES values and culture
- International and domestic recruitment
- Improving the efficiency of our recruitment processes

Supporting areas 4, 6, 9, 10

- Ensuring best managerial practice
- Maximising use of e-systems
- Better workforce information available for managers to support staff & address resourcing issues

Supporting areas 1, 6, 7, 9, 10
5.2 Targeted corporate action

Some of the Survey areas for action will require additional targeted support.

- The Trust scores below average for staff being given feedback about changes made in response to reported errors. We will ask the Quality & Safety Committee how their current actions address this and what further actions need to be taken.

- Triangulation of data shows that many incidents related to violence and aggression. We have established a group as part of the NHSI Retention Programme who have actions to review & encourage Datix reporting:
  - We are reinforcing an organisational messages of Zero Tolerance to violence, bullying & harassing behaviour.
  - We are equipping staff to cope with violence, bullying and harassing behaviour through resilience training and Conflict Resolution as part of core skills training.

- The biggest changes since 2016 in individual questions relate to survey areas 9 and 10. These questions were: having adequate materials, supplies & equipment to do my job (down 10%); no training, learning or development in the last 12 months (down 9%); and training being identified in appraisal (down 5%). We will need to address this through more innovative ways of working with partners including the Hillingdon Hospitals Charity as well as through increasing training and development.

5.3 Divisional actions

In addition to the corporate actions, each Division has specific actions to address.

<table>
<thead>
<tr>
<th>Division</th>
<th>Specific issues (in addition to issues identified at corporate level)</th>
<th>Ideas being explored</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>Visibility of senior managers</td>
<td>Meet and greet with senior managers for new starters</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarterly tea and coffee meetings for Division with senior managers</td>
</tr>
<tr>
<td>CCSS</td>
<td>Had training, learning or development in the last 12 months</td>
<td>Review skill mix</td>
</tr>
<tr>
<td>Surgery</td>
<td>% seen errors/near misses/incidents that could harm patients</td>
<td>Ensure errors/ near misses/ incidents are reported</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review Datix reports to identify any themes and ensure learning is cascaded</td>
</tr>
<tr>
<td>Women’s and Children’s</td>
<td>Team members often meet to discuss team effectiveness</td>
<td>Ensure regular team meetings take place conducted in a coaching manner</td>
</tr>
<tr>
<td>Estates</td>
<td>Specific issues identified across the survey areas of personal development; the job; managers; health, wellbeing &amp; safety at work</td>
<td>Equip all managers to demonstrate good management practice consistently</td>
</tr>
</tbody>
</table>

Next steps are to ensure that:

- Divisions are delivering on their actions plans at Monthly Performance Reviews.
- Members of the NHSI Retention Working Groups are prioritising attendance and delivery of the plan.
- We develop a Communications Strategy that engages staff.
- The Coaching Strategy is funded and implemented.
**Meeting of the Board of Directors – Public Part I session**

Date of meeting: 28th March 2018  
Agenda item20

<table>
<thead>
<tr>
<th>Report title:</th>
<th>Biannual Medical Education Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report author:</td>
<td>Dr Stella Barnes, Director of Medical Education (DME)</td>
</tr>
<tr>
<td>Report sponsor:</td>
<td>Dr Abbas Khakoo, Medical Director</td>
</tr>
</tbody>
</table>

**Board Action required:**

The Board are asked to:

Note and comment on the report

<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>Enabler - Workforce</td>
</tr>
</tbody>
</table>
1. Introduction
Training across the trust remains of good quality but is currently being influenced by the following changes.

**Continued Increase in Activity and Rota Gaps**
The unprecedented rise in hospital admissions has affected training and morale in a number of acute specialties, particularly in medicine, often compounded by rota gaps. This is being reflected to some extent in exception reporting for both hours and education.

**Changes to Study Leave**
From the end of March, there will be a change to the way that study leave and funding is arranged, to make it more centralized with the budget being held by HEE rather than individual trusts. Trainees will apply for funding to the trust education department as usual, who will then claim the money back. Details of how this will work are not yet available. Trainees will only be able to take leave for certain approved courses and the London Schools are developing lists of appropriate activities.

**Foundation School Post Reconfiguration**
The trust will lose 3 foundation year 2 posts from next year as required by the foundation school. After consultation and exploring all the options, the decision has been made to remove 3 of the trust funded posts from the programme, 1 in surgery, 2 in emergency medicine. These have not always been filled by national recruitment. The impact on the relevant departments will be that the posts will need to be recruited to locally.

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

1. Maintain quality of training & education for all students & postgraduate trainees, in light of the HEE changes and changes in working pattern due to the new Junior Doctors contract.
   Organizational changes to HEE have had little direct impact on trainees, except in the way that they communicate with HEE, via a new portal.
   Issues related to the contract are considered in section 5 and the guardian of safe working hours report.

2. Work with HEE and the Foundation TPDs to identify the 3 FY2 posts to be lost to the programme from August 2018
   Described above

3. Change the working patterns in gastroenterology to improve the results in the next GMC survey
   Progress described in section 2

4. Clarify the role of Physician Associates as part of the medical support workforce.
This work is ongoing and is considered as part of the Safe Medical Staffing paper.

5. To provide the above in the context of significant changes in staff
   A new full time deputy medical education manager has commenced in post this month and there are changes planned to staffing in simulation, described in section 3.

2. Quality Assurance and Governance Process of Education

   The GMC Survey
   This was reported on in detail in the last report and progress on areas of concern is reported here.
   Following the survey, an informal meeting was been held with the deputy postgraduate dean, the director of medical education (DME) and educational lead for anaesthetics to address concerns raised. An action plan is in place and being reviewed regularly at the local faculty group (LFG.)

   Risk Based Review (Education Lead Conversation) in Ophthalmology
   This was held on 13th March following some negative feedback in last year’s survey.
   Some good practice was noted with regular LFGs and the current trainees are happy and getting good experience, exceeding the minimum requirements for surgical cases.

   Areas of improvement
   The allocation of type of clinic and number of patients seen should take training need and stage in mind in line with Royal College of Ophthalmologists guidance.
   The department needs to find an educational lead to cover the current lead for when she goes on maternity leave.
   Educational supervision of trainees should be shared between consultants.
   0.25 pa per trainee should be allocated for educational supervision (of note, although this is the national recommendation, the trust allocation is 0.125 pa per trainee.)
   All changes to trainee timetable should have the approval of the educational lead.

   Gastroenterology
   Feedback from current trainees suggests that the employment of clinical fellow and trust grade staff has improved their workload. All trainees spoken to had had local induction and teaching.

   Specialty focused visit 2016
   There is just one outstanding action from this visit which relates to trainees involved in Serious Incidents (SIs) and the feedback and support they received. A new policy has been agreed between the education centre and governance to address this, and has been tested out on 3 trainees so far. HEE have requested feedback after 10 trainees have been supported through this process and the action will remain open until then.
GP School Visit 2018
Trainees were reported to be happy at Hillingdon and well supported. No concerns were raised.

3. Simulation Centre and Training
Use of the simulation centre and simulation training continues to grow, providing training across all specialties from emergency care to general practice. New courses include the "Med Reg Ready" course and procedural skills for core medical trainees.
Money has recently been secured from a competitive bidding process with HEE to start a simulation programme to improve patient safety around the prescription of intravenous fluids. This is a multidisciplinary and cross-site initiative with North West London Healthcare.
Following a reconfiguration of staff roles with the medical education department, the centre will have a permanent manager from the end of May. In addition, the department is currently progressing a business case for a senior clinical fellow to oversee the simulation fellow. These changes will facilitate the provision of simulation training more consistently throughout the year and work towards producing more external, potentially revenue generating courses.

4. Improving the Working Lives of Trainees
In response to the widely reported low morale in junior doctors, NHS Improvement have produced a document called “Eight High Impact Actions to Improve the Working Environment for Junior Doctors” (Appendix A.) This highlights a range of areas for improvement, including tackling work pressure, better engagement between trainees & the board and attention to welfare. A group has been set up to address this in the trust, including the DME, guardian of safe working hours, deputy director of people and junior doctors.
Initiatives following this include resilience training, arranged for 2 dates in May and attendance of junior doctors at the Quality & Safety Committee.
Junior doctors continue to attend the medical education committee, local faculty groups and the junior doctors forum and have recently attended the deteriorating patient group and an SI panel.

5. Junior Doctors Contract- Education Exception Reports
12 exception reports for missed educational opportunities were logged in the last 6 months. All of these were for trainees in medicine, in some cases where trainees were looking after extra patients in Winter pressure beds. In other cases it was related to staff being on sick leave and trainees looking after acutely sick patients. In one case a higher trainee was asked to be on call, thus missing a radiology meeting, grand round and a training endoscopy list.

6. Educational Supervision
A trust educational supervisors’ guide has been produced, linking to trust & external sources and in house training is being planned for later this year on providing career guidance and on managing trainees in difficulty.
Some supervisors report that they do not have protected time to provide
educational supervision and this has been raised with the divisional directors and the medical director to inform appropriate job planning.

7. **Quality Improvement (QI) Prize**
   To improve the profile of QI work across the trust, a QI prize for trainees is to be awarded this year, at the medical education prize presentations on 18th July. All shortlisted prizes will be presented, to be judged by a panel including the DME and the director of nursing.

8. **Undergraduate Medical Course- Imperial College**
   Imperial College are undergoing a major change to their curriculum which will affect Hillingdon Hospital over the next couple of years. The biggest change will be that Orthopaedics & Rheumatology will be moved from fifth year to final year. During this transition, there will be no students in this firm for one academic year, with a significant financial loss of 3.8 FTE Students. In the following year, Imperial will no longer offer any Ophthalmology firms so we will no longer have any Ophthalmology Students. Senior Medicine will drop from 4 weeks to 3 weeks, with one week in Renal Medicine, which we currently do not offer at Hillingdon.
   To mitigate this drop in student places, a number of our consultants have agreed to provide specialty choice modules. Spaces have been identified in Anaesthetics, Paediatrics, Ophthalmology care of the Elderly and Orthopaedics.
   Eduroam (student cross site wifi provision) has been successfully rolled out trust wide as required by the last annual Governance and Education Monitoring visit. This will benefit medical students, as well as students from other disciplines.

9. **Physician Associate Masters Programme- Brunel University**
   Trust consultants continue to lecture on year one of the course and supervise 2nd year students on their clinical attachments. Informal feedback from students has been very good but Brunel has no formal system of feedback.

10. **Challenges for 2018/19**
    1. To continue to provide consistent, high quality training across all specialties in the face of unprecedented levels of activity
    2. To improve the consistency of simulation training provision across the year
    3. To work with relevant stakeholders across the organisation to implement the 8 High Impact Actions
    4. To clarify the role of Physician Associates as part of the medical support workforce.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 28th March 2018
Agenda item 21

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

Report author: Vanessa Saunders, Deputy Director of Nursing

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

Board Action required:

The Board are 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 CHPPD averaged across the month were sufficient to support safe care

- MVH: Average Care Hours Per Patient Day remained comparable to THH

- THH: HCA fill rate continued above plan, the primary driver being use of “specials” to support patients at risk and exhibiting behavioural difficulties

- Increase in RN and HCA vacancies for the wards covered in the report, with upward trend over last two months.

- SafeCare electronic acuity and dependency and staffing status tool went live across the four Phase 1 wards in February, with two Phase 2 wards implementing ahead of plan

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 December, 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. Where there is a need for enhanced surveillance or scrutiny, this is reflected in the R.A.G. rating. Wards scored amber were:

- Drayton due to relatively high number of hospital acquired pressure ulcers (6; all grade 1 or 2)
- Kennedy due to high vacancies, associated reliance on temporary staffing and in light of suboptimal staffing incidents
- ITU in light of suboptimal staffing incidents

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

2. Staffing levels against plan

Fill levels and CHPPD remained stable across both sites, as demonstrated in the graphs and tables below.

For the Hillingdon site average fill rates for RN shifts were 94.3% during the day and 98.8% at night. HCA deployment continued to be above the level planned, the primary driver being the use of “specials” to support patients at risk of harm or exhibiting behavioural difficulties. The consistent use of more HCAs than provided for in the funded establishment suggests the templates are not in line with need. A detailed establishment review has taken place and templates will be reviewed for the new financial year.

Mount Vernon Hospital site fill rate was in line with plan, and has been stable over a period of months. Average Care Hours Per Patient Day at Mount Vernon was comparable with Hillingdon despite the absence of high acuity areas such as ITU or maternity services. This is influenced by the overall availability of staff: medical staffing is reduced at Mount Vernon when compared to Hillingdon, particularly at night; this requires mitigation via the nursing workforce.

Underlying the monthly averages reported in the data, there have been individual shifts where fill rates where available staffing was not considered to be in line with actual demand. Matrons have confirmed that where this was the case, staff were redeployed from other areas where possible; on occasions where this could not be achieved, care delivery focussed on safety priorities with non-essential tasks postponed.
a) Average fill rates and monthly trends

<table>
<thead>
<tr>
<th>Site Summary</th>
<th>Data</th>
<th>February 2018</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Average fill rate RN/RM</td>
<td>Average fill rate Care staff</td>
<td>Average fill rate RN/RM</td>
</tr>
<tr>
<td>Hillingdon</td>
<td></td>
<td>94.3%</td>
<td>112.7%</td>
<td>98.8%</td>
</tr>
<tr>
<td>Mount Vernon</td>
<td></td>
<td>94.8%</td>
<td>88.9%</td>
<td>94.2%</td>
</tr>
</tbody>
</table>

b) Average Care Hours Per Patient Day and monthly trends

<table>
<thead>
<tr>
<th>Site Summary</th>
<th>Data</th>
<th>February 2018</th>
<th>Care hours Per Patient Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Cumulative count of patients @ 23.59</td>
<td>RN/RM hours per patient day</td>
</tr>
<tr>
<td>THH</td>
<td></td>
<td>11517</td>
<td>5.7</td>
</tr>
<tr>
<td>MVH</td>
<td></td>
<td>783</td>
<td>5.2</td>
</tr>
</tbody>
</table>

Hillingdon Hospital

<table>
<thead>
<tr>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN/RM</td>
<td>5.6</td>
<td>5.9</td>
</tr>
<tr>
<td>HCA</td>
<td>3.7</td>
<td>3.7</td>
</tr>
<tr>
<td>Overall average</td>
<td>9.3</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Mount Vernon Hospital

<table>
<thead>
<tr>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN/RM</td>
<td>5.9</td>
<td>4.8</td>
</tr>
<tr>
<td>HCA</td>
<td>3.9</td>
<td>3.4</td>
</tr>
<tr>
<td>Overall average</td>
<td>9.4</td>
<td>7.9</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 three 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

Vacancies and turnover for inpatient areas

<table>
<thead>
<tr>
<th></th>
<th>THH 2017/18</th>
<th>MVH 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dec Jan Feb</td>
<td>Dec Jan Feb</td>
</tr>
<tr>
<td>RN/RM Vacancies</td>
<td>100.91 102.6 105.64</td>
<td>12.9 11.9 12.29</td>
</tr>
<tr>
<td>HCA Vacancies</td>
<td>42.24 38.3 44.16</td>
<td>7.69 5.69 6.05</td>
</tr>
<tr>
<td>RN/RM Starters</td>
<td>10 8 15</td>
<td>1 1 1</td>
</tr>
<tr>
<td>RN/RM Leavers</td>
<td>4 5 4</td>
<td>1 1 0</td>
</tr>
<tr>
<td>HCA Starters</td>
<td>2 5 7</td>
<td>1 2 0</td>
</tr>
<tr>
<td>HCA Leavers</td>
<td>2 0 3</td>
<td>1 0 0</td>
</tr>
</tbody>
</table>

4. Conclusion

Average shift fill rates and Care Hours Per Patient Day were stable, although 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. Nurse-sensitive outcome indicators were in line with previous months and Friends and Family feedback was overall positive.

Matrons have confirmed that where staffing was under pressure on specific shifts, care was prioritised to focus on maintaining patient safety. It is reasonable to conclude
that nurse staffing levels across inpatient areas in February were safe and available resources used effectively.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 28 March 2018
Agenda item 22

Report title: Winter 2017/18 review and A&E Trajectory 2018/19

Report authors: Imran Devji – Director of Operational Performance
Report sponsor: Joe Smyth Chief Operating Officer

Board Action required:
The Board are asked to:

Note lessons learnt as a result of winter review and the action plan being implemented to assist in achieving the A & E 95% trajectory for March 2019.

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

STRATEGIC PRIORITY:
b) Delivery Area 2: Eliminate unwarranted variation & improve LTC management
e) Delivery Area 5: Ensure we have safe, high quality sustainable acute services
1. **Purpose**  
The Trust’s performance against the A&E standard has deteriorated over the past two years. During the summer of 2016, emergency activity in the department began to increase by 9% with a corresponding decrease in performance. By the end of 2016, the Trust was not achieving the 95%.

In March 2017, the Trust and CCG relaunched the A&E recovery programme and appointed a system wide director of emergency care. Both organisations committed to a new structure and approach to delivering the recovery programme. Over the summer of 2017, a number of key projects were delivered which helped improve safety and performance. These projects included the implementation of “fit to sit” and “Pitstop” to improve ambulance handover; the two hourly board rounds in A&E were introduced along with the early first assessment and management (EFAM) model to improve patient treatment times. On the wards, the Trust re-introduced Red2Green/SAFER clinical model and successfully reconfigured the bed base to create a co-located AMU (Acute Medical Unit) and SAU (Surgical Assessment Unit) as well as a dedicated frailty and an emergency gynaecology unit. Cardiology ward was relocated to create more acute and short stay capacity on AMU/SAU. There was an incremental improvement in performance from March through to October 17.

2. **Winter Reflection**  
The Trust has undertaken a comprehensive review of the A&E recovery programme and performance over the past six months and identified a number of key factors. These are outlined below in turn.

2.1 **A&E Capacity**  
The lack of physical space in the department and the shortage of beds were the biggest contributing factors towards the drop in performance across winter. The Analysis below undertaken by North West London demonstrates the number of ambulance arrivals each month per cubicle.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Majors</th>
<th>Resus</th>
<th>Total</th>
<th>Ambulances</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charing Cross</td>
<td>12</td>
<td>5</td>
<td>17</td>
<td>1692</td>
<td>99.53</td>
</tr>
<tr>
<td>St Marys</td>
<td>17</td>
<td>6</td>
<td>23</td>
<td>2805</td>
<td>121.96</td>
</tr>
<tr>
<td>Chelsea and West</td>
<td>20</td>
<td>6</td>
<td>26</td>
<td>1430</td>
<td>55.00</td>
</tr>
<tr>
<td>West Mid</td>
<td>30</td>
<td>4</td>
<td>34</td>
<td>2389</td>
<td>70.26</td>
</tr>
<tr>
<td>NWP</td>
<td>34</td>
<td>7</td>
<td>41</td>
<td>3476</td>
<td>84.78</td>
</tr>
<tr>
<td>Ealing</td>
<td>14</td>
<td>4</td>
<td>18</td>
<td>1614</td>
<td>89.67</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>15</td>
<td>4</td>
<td>19</td>
<td>2218</td>
<td>116.74</td>
</tr>
</tbody>
</table>

The analysis shows that Hillingdon has the second busiest ambulance arrivals per cubicle in Northwest London.

2.2 **Bed Capacity**  
The deteriorating performance can also be clearly linked to an increase in emergency admissions and availability of beds. Throughout January and February 18, the Trust continued to open additional areas to accommodate demand. Male day care on Jersey ward (8 beds) was the first area to be occupied followed by
placing additional beds on AMU and SAU (6 extra beds). Despite the additional escalation capacity, there were 8-10 patients as a minimum waiting for beds in A&E most days of the week throughout the whole of January 2018.

During February 18, the Trust transferred inpatients to the female day care unit (up to 15 spaces) but was still unable to clear the exit block from A&E. The average number of patients waiting for beds increased to between 12 and 18 per day. The maximum escalation capacity was increased to 51 beds by the end of February.

Last year, a comprehensive bed modelling analysis was undertaken. This demonstrated that unless there was a 1 day reduction in the length of stay (LoS), the Trust would need 60 additional beds to meet the emergency demand. The Trust achieved a 0.8 day reduction in LoS absorbing some of the growth in emergency admissions but remained insufficient to fully mitigate the growth thus adversely affecting performance throughout the winter.

2.3 Patient Discharge Time
Another significant factor compromising performance was the lack of timely patient discharges from the wards. Throughout the winter period only 15% of discharges occurred before 12 pm. The Trust set a goal of discharging 33% of patients before midday. This remains one of the key indicators of the SAFER/Red2Green programme. Despite a comprehensive relaunch and a PACT week (Pathway Appropriate Care and Treatment) focusing on discharges, the Trust was unable to achieve its goal of 10 daily discharges before 10 am.

2.4 Full Hospital Protocol
The Trust has an agreed “Full Hospital Protocol” in place. This allows the Director of Operational Performance to safely transfer patients from AMU and SAU to the wards before the ward discharges have occurred. In reality, this proved very difficult to implement and wards often refused sighting the clinical acuity of patients on the wards and the inability to sit out patients who were due to be discharged.

2.5 Discharge Lounge
Despite best efforts of the operational and ECIP teams, alongside several initiatives and focused weeks; the use of the discharge lounge remained low. While the location and facilities of the lounge are sub-optimal, the main reason for the low usage is a general reluctance of wards to use the lounge.

2.6 Processes in A&E
The congestion within the department often meant that the new processes (board rounds and safety huddles, safety check lists and Pitstop) were not consistently implemented. This compounded the situation causing further congestion and significant 4 hour transit time breaches.

2.7 Escalation
The Trust has a comprehensive escalation process which if followed, alerts the operational and medical teams to increasing pressure within the organisation. There needs to be further work around ensuring a consistent understanding and application of these policies at front line level with leadership from the department leads. Often
this action was insufficient to remedy the situation and the escalation policy offered few other alternatives given physical capacity constraints within the existing footprint.

2.8 Delivery of the A&E Recovery Programme
As congestion within the hospital (A&E and the Wards) increased, safety became a growing concern. To ensure the continued safety of all patients’ operational resource was diverted to the front line and most meetings were cancelled. Operational and ECIP teams that should have been delivering improvement programmes were instead supporting daily flow. While this was the correct course of action to ensure patient safety within the Trust, the net effect was a slowing of changes that might have helped improve the situation prospectively.

3. Recovery Plan
The CCG, NHSI, ECIP and the Trust all agree that the action plan to deliver A&E recovery covers all the right areas and contains the necessary actions. However, given the recent performance, some additions will need to be made to the plan to ensure successful delivery based on the current challenges. It has also been agreed that there needs to be review of the resources required to ensure the plan is implemented consistently and is delivered in a sustained way. NHSI have agreed to fund this review and support its implementation.

3.1 A&E Capacity
The recovery programme has been updated to reflect the expansion plans for the A&E department. This will provide 8 additional cubicles and a larger dedicated ambulance handover area. It is anticipated that this will improve performance by 4-5%. The majority of non-admitted breaches occur due to delays in medical assessment and treatment. Additional capacity will only be effective in tandem with improved downstream flow to the wards preventing patients waiting for beds in A&E.

3.2 Capacity Beds / Downstream Flows
Emergency admissions have increased by 15% over the past year. The CCG and Trust will undertake further analysis to better understand the drivers behind this increase.

It is clear from the waiting times for admission that the Trust has insufficient bed stock to meet the current demand limiting any further absorption of emergency growth.

The modelling will also look at providing enhanced ambulatory assessment area to reduce emergency admissions.

Addressing the bed capacity constraints (through admission avoidance and some expansion) is imperative if the Trust is to deliver the 95% 4 hour transit time trajectory by March 2019. Without tangible plans for the reduction in emergency admissions and expansion of the bed base, the Trust will not be able to meet the emergency demand in winter 2018/19.

3.3 Leadership and Engagement
Clinical/Medical leadership and engagement with Full Hospital Protocol, SAFER/Red2Green and patient flow principles such as the consistent use of the
discharge lounge needs to be improved with urgency. The Medical Director, Director of Nursing and Chief Operating Officer in conjunction with ECIP are developing a comprehensive programme of engagement. Actions will be tracked on a daily basis and an escalation process will be developed for any ward/team that does not identify timely discharges or appropriate use of the discharge lounge.

The appointment of a deputy to the Divisional Director would allow more capacity to support other areas that require greater clinical leadership. In particular this will provide more time to ensure that A&E processes and procedures as well as the Internal Professional Standards are adhered to. Other organisations have improved the Emergency Care performance by up to 5% through the successful implementation of “SAFER” and “10 B4 10” schemes.

3.4 Escalation
The escalation policies have recently been updated to reflect some of the learning from winter. However further work is required to develop a more comprehensive response to an escalating situation.

3.5 Delivery of the A&E Programme
The current structure relies heavily on the Chief Operating Officer to support the divisional day to day operation of the hospital. The Divisional Directors and Operational Managers within the divisions report through to the COO and not to the Director of Operations. This means that the COO becomes very involved with daily operations and this leaves little time to oversee the strategic delivery of the recovery programme.

The COO is considering options for restructuring the operational management team with two Directors of Operations responsible for the day to day delivery through the divisions. One director will be responsible for emergency care and the other for the elective programme. They will jointly manage all the resources in the division with a Clinical Divisional Director(s). This will free up the COO to ensure that there is more traction on delivery of the recovery programme and to drive strategic changes in the organisation.

4. Impact
A summary of all actions within the proposed Recovery Programme and the anticipated impact has been set out in appendix 1.

It is expected that this series of actions, together with the expansion of the department will support the achievement of the 95% trajectory by March 2019.
Meeting of the Board of Directors – Public Part I session

Date of meeting: 28th March 2018
Agenda item 23

Report title: Committee Chairs – Reports back to Board

Report author: Michael Sims Trust Secretary
Report sponsor: Richard Sumray Chair

Board Action required:

The Board are asked to:

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;

Finance & Transformation Committee – Richard Sumray
Quality & Safety Committee – Lis Paice
Audit & Risk Committee – Richard Whittington
Charitable Funds Committee – Richard Sumray
Nominations Committee – Richard Sumray
Remuneration Committee – Soraya Dhillon

Link to the Hillingdon Hospitals Strategic Plan 2017/21:

STRATEGIC PRIORITY:

Business as usual – governance
Finance and Transformation Committees February and March 2018 – Chair R Sumray

Financial position and Financial Improvement Plan 2017-18
Close scrutiny of the Trust's financial position and success in delivering the Financial Improvement Plan has continued. Detailed review of the Medical Divisions costs and drivers has taken place.

Draft Financial Plan 2018-19
Development of the 2018-19 Financial plan has been discussed in detail in preparation for a proposal to be received by the March Board.

Capital Programming
Assurance has been received on the change in the Trust's reported backlog total.

Transformation Projects
Assurance reports on progress with the four workstreams were provided.

Escalations to the Board by the Committee - none

Quality and Safety Committee February – Chair L Paice

Strategy
Quality and Safety Improvement monitoring focused on the theme of safer staffing.

Divisional Review
Focused on Maternity and Paediatrics with a focus on overall quality performance, leaning from audits and divisional risk.

Performance
Assurance was provided on compliance with progress on the CQC Action Plan.

Improvement initiatives
Assurance was provided on the theme of staff speaking up freely on quality and patient safety.

Compliance and Assurance
The Committee reviewed compliance sources, both internally and externally through sub-committees for Patients Safety, Regulation and Compliance, the CCG’s own exception report and an update on the implementation of the Hillingdon Healthwatch discharge Action plan.

Escalations to the Board by the Committee - none

Charitable Funds Committee March – Chair R Sumray

Assurance and compliance
Review of investments and income / expenditure was satisfactory. Progress has been made in reducing the number of specific spend accounts into a general account for charity expenditure.
Strategy and budget profile
A new Charities Strategy was presented and accepted subject to some changes of emphasis required as opposed to content, with a Fundraising Strategy to be presented in June.

Volunteering
No significant developments as yet pending permanent recruitment of a Volunteer Manager.

Escalations to the Board by the Committee - none

Audit & Risk Committee - Chair R Whittington
No meeting since report to Board in January 2018 – next meeting April 2018

Nominations Committee 30/11/17 – Chair R Sumray
No meeting since report to Board in January 18 – next meeting May 2018

Remuneration Committee 30/11/17 – Chair S Dhillon
No meeting since report to Board in January 18 – next meeting May 2018
Meeting of the Board of Directors – Public Part I session

Date of meeting: 28th March 2018
Agenda item 24

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:
Business as usual – governance

Summary of Meetings - update for March 2018

<table>
<thead>
<tr>
<th>Committee</th>
<th>Meeting date 2017</th>
<th>Minutes included in Part I Board Papers</th>
<th>Notes on exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charitable Funds</td>
<td>24 October</td>
<td>Yes – in appendices pack (on website)</td>
<td>No exclusions</td>
</tr>
<tr>
<td>Quality and Safety</td>
<td>11 December</td>
<td>Yes – in appendices pack (on website)</td>
<td>No exclusions</td>
</tr>
<tr>
<td>Audit &amp; Risk</td>
<td>15 January</td>
<td>Not Yet</td>
<td>Awaiting clearance next meeting 16/4/18</td>
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<tr>
<td>Finance &amp; Transformation</td>
<td>18 January</td>
<td>Yes – in appendices pack (on website)</td>
<td>No exclusions</td>
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<tr>
<td>Quality and Safety</td>
<td>19 February</td>
<td>Not Yet</td>
<td>Awaiting clearance 9 April</td>
</tr>
<tr>
<td>Finance &amp; Transformation</td>
<td>21 February</td>
<td>Yes – in appendices pack (on website)</td>
<td>Redacted in relation to contractual matter</td>
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<tr>
<td>Finance &amp; Transformation</td>
<td>20 March</td>
<td>Not Yet</td>
<td>Awaiting clearance 19 April</td>
</tr>
<tr>
<td>Charitable Funds</td>
<td>21 March</td>
<td>Not Yet</td>
<td>Awaiting clearance 18 June</td>
</tr>
</tbody>
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