Imperial College Healthcare NHS Trust

Trust Board – Public

Wednesday, 12th May 2021, 11am to 1.30pm (10.45am to 11am join Microsoft Teams)
Virtual meeting via Microsoft Teams

This meeting is not being held in public due to the public health risks arising from the Coronavirus and will be held virtually and video-recorded.

Members of the public are welcome to join this meeting via Microsoft Teams (joining instructions are on the Trust's website) or forward questions to the Trust Secretariat via imperial.trustcommittees@nhs.net. Questions will be addressed at the end of the meeting and included in the minutes.

AGENDA

Time	Item no.	Item description	Presenter	Paper / Oral
1100	**1.**	**Opening remarks**	Bob Alexander	Oral
	2.	**Apologies: Andrew Bush, Jeremy Butler**	Bob Alexander	Oral
	3.	**Declarations of interests** If any member of the Board has an interest in any item on the agenda, they must declare it at the meeting, and if necessary withdraw from the meeting	Bob Alexander	Oral
1105	**4.**	**Minutes of the meeting held on 31st March 2021** To approve the minutes from the last meeting	Bob Alexander	01
	5.	**Record of items discussed in Part II of Board meetings held on 31st March 2021 and Board Seminar 21 April 2021** To note the report	Bob Alexander	02
	6.	**Matters arising and review of action log** To note updates on actions arising from previous meetings	Bob Alexander	03
1110	**7.**	**Patient Story** To note the story	Janice Sigsworth	04
1125	**8.**	**Chief Executive Officer's report** To note the report	Tim Orchard	05
Business planning				

1140	**9.**	**Integrated Business Plan 2021-22** To approve the business plan, financial plan, activity, workforce and strategic priorities	Bob Klaber, Jazz Thind, Claire Hook, Kevin Croft	06
Operations / Performance				
1155	**10.**	**Integrated quality and performance report** To note the month 12 report	Claire Hook Julian Redhead	07
1205	**11.** 11.1.	**Finance report** To note the month 12 report **Annual accounts and annual report** To approve the delegation of authority to the Audit, Risk and Governance Committee to approve the annual accounts and annual report for 2020-21 on behalf of the Board	Jazz Thind Jazz Thind, Peter Jenkinson	08 Oral
1215	**12.**	**Annual self-certification for NHS Trusts** To approve the annual self-certication of compliance against NHS Provider Licence provisions	Peter Jenkinson	09
Quality				
1220	**13.**	**Maternity Quality Assurance Oversight Report** To note the oversight report	TG Teoh	10
1235	**14.** 14.1. 14.2.	**Infection Prevention and Control (IPC)** **Infection Prevention and Control and Antimicrobial Stewardship Quarterly Report** To note the 2020-21 quarter 4 report **IPC Board Assurance Framework Report** To note the report and action plan	Julian Redhead/ Alison Holmes	 11a 11b
1245	**15.**	**Learning from Deaths Quarterly report** To note the 2020-21 quarter 4 report	Julian Redhead	12
Governance and Board Committees				
1250	**16.**	**Annual review of Board Committee Terms of Reference and Board Governance update** To approve the Committee Terms of Reference	Peter Jenkinson	13
1300	**17.**	**Trust Seal Annual Report** To note the annual report	Peter Jenkinson	14
1305	**18.**	**Trust Board Committees – summary reports** To note the summary reports from the Trust Board Committees		
	18.1.	Audit, Risk and Governance Committee, 26th April 2021	Kay Boycott	15a
	18.2.	Quality Committee, 6th May 2021	Andy Bush	15b

	18.3.	Finance, Investment and Operations Committee, 5th May 2021	Andreas Raffel	15d
	18.4.	Redevelopment Board Committee, 6th April 2021	Bob Alexander	15e
	18.5.	People Committee, 4th May 2021	Sim Scavazza	15f
1310	**19.**	**Any other business**	Bob Alexander	Oral
1315	**20.**	**Questions from the public**	Bob Alexander	Oral
1330 Close	**21.**	**Date of next meeting** 14th July 2021, 11am		

Updated: 7 May 2021

Diligent Reading Room material:

Item 16 Committee Terms of Reference

Item 13: Maternity Assurance Report Appendices:

Appendix 1: SI summary of learning
Appendix 2: Monthly report for the Perinatal Mortality Review Tool March 2021
Appendix 3: MSDS scorecard December 2020
Appendix 4: ATAIN report March 2021
Appendix 5: Neonatal Nursing Workforce action plan
Appendix 6: Midwifery Safe Staffing March 21
Appendix 7: Continuity of care action plan April 2021
Appendix 8: NHS England Ockenden assessment
Appendix 9: Maternity Quality Assurance Oversight Report Glossary

Imperial College Healthcare NHS Trust

Public Trust Board
Draft Minutes of the meeting held on 31st March 2021, 11am
Virtual meeting held via Microsoft Teams and video-recorded.

Members present

Ms Paula Vennells	Trust Chair
Mr Bob Alexander	Non-executive Director
Mr Peter Goldsbrough	Non-executive Director
Dr Andreas Raffel	Non-executive Director
Prof. Andrew Bush	Non-executive Director
Mr Nick Ross	Non-executive Director
Mrs Kay Boycott	Non-executive Director
Ms Sim Scavazza	Non-executive Director
Prof. Tim Orchard	Chief Executive
Prof. Julian Redhead	Medical Director
Prof. Janice Sigsworth	Director of Nursing
Mrs Jazz Thind	Chief Financial Officer

In attendance

Dr Ben Maruthappu	Associate Non-executive Director
Ms Beverley Ejimofo	NExT Director
Mr Peter Jenkinson	Director of Corporate Governance
Prof. Jonathan Weber	Dean of the Faculty of Medicine, Imperial College London
Mr Kevin Croft	Director of People and Organisational Development
Mrs Claire Hook	Director of Operational Performance
Dr Matthew Tulley	Director of Redevelopment
Dr Bob Klaber	Director of Strategy, Research & Innovation
Mr Kevin Jarrold	Chief Information Officer
Mr Hugh Gostling	Director of Estates and Facilities
Mr Jeremy Butler	Director of Transformation
Prof. TG Teoh	Divisional Director, Women, Children and Clinical Support
Prof. Katie Urch	Divisional Director, Surgery, Cancer and Cardiovascular
Prof. Frances Bowen	Divisional Director, Medicine and Integrated Care
Mr Guy Young	Deputy Director, Patient Experience
Ms Claire Gorham	Matron, Adult Intensive Care
Mrs Ginder Nisar	Deputy Trust Secretary (minutes)

Apologies

Prof. Alison Holmes	Director of Infection Prevention and Control
Ms Michelle Dixon	Director of Communications

Item	Discussion
1.	**Opening remarks**
1.1.	Ms Vennells welcomed everyone to the meeting which was held virtually and where in person, was in keeping with social distancing guidelines. The Board meeting would be video-recorded and the recording uploaded onto the Trust's website. Members of the public had been invited to submit questions ahead of the meeting or ask questions at the end of the meeting via Microsoft Teams meeting. Members of the public were welcome to submit questions to the Trust Secretary at any time. Mr Jenkinson outlined the etiquette for the meeting.

1.2.	Ms Vennells referred to the one minute silence which would be observed at the start of the Chief Executive's report in recognition of the lives lost during the Covid-19 pandemic including Trust staff.
2.	**Apologies** Apologies were noted from those listed above.
3.	**Declarations of interests** Mrs Boycott declared that she was an independent audit committee member of the London Fire Brigade. There were no other declarations other than those disclosed previously.
4.	**Minutes of the meeting held on 25th November 2020** The minutes of the previous meeting were agreed.
5.	**Record of items discussed in part II of the Board meeting held on 25th November 2020 and 9th December 2020** The Board noted the summary of confidential items discussed at the confidential Board meeting held on 25th November and the Board Seminar on 9th December 2020.
6.	**Matters arising and actions from previous meetings** Updates against the actions arising from previous meetings were noted on the action register and Mr Jenkinson would follow up on the action with Ms Dixon regarding channels of communication. **Action: Mr Jenkinson**
7.	**Patient Story**
7.1.	Mr Young and Ms Gorham joined the meeting and outlined how communicating with families through electronic devices contributed to unforeseen issues for families and staff in the Adult Intensive Care Unit (AICU). The story drew on a number of different patient and staff experiences highlighting how the Trust had learnt from these to refine the use of technology in communicating with families.
7.2.	The Board noted that during the first wave of the pandemic, families of patients in AICU reported issues with privacy, connectivity and the timing of contact via the iPads and guilt for keeping staff away from their duties as often they would need to hold the iPads for the patients. Staff also described that communication in this way carried an additional emotional impact not observed with in-person visiting and the end of life care was particularly challenging for both the patients and staff.
7.3.	Changes had been made to address some of the issues raised by families and patients which included iPad stands therefore negating the need for staff to hold the iPads, thereby provided more privacy for patients and families. The changes continue to be reviewed. The issues faced by staff co-ordinating these conversations had been recognised and training was being revised to prepare them. Visiting restrictions remain in place so these methods were likely to be utilised for the foreseeable future.
7.4.	In response to a question by Ms Ejimofo regarding support for staff, Ms Gorham advised that the staff receive a lot of wellbeing and psychological support from the Trust and that work continues to improve the patient and family experience.
7.5.	The Board thanked Ms Gorham for her courage to describe her own experience and that of her colleagues and patients noting the deep emotion attached to the situations patients and staff found themselves in. The Board were simply humbled by the stories and experiences of patients and staff and asked that their appreciation was conveyed to staff who clearly demonstrated the values of the Trust, particularly the 'kind' value.
7.6.	**The Board noted the report.**
8.	**Chief Executive Officer's briefing**

	Prof. Orchard presented his report, highlighting key updates on strategy, performance, leadership over the month and the focus of Trust business in response to Covid-19.
8.1.	**Covid-19 update**
8.1.1.	Since the last Board report there had been a significant decline in the number of Covid-19 patients with 58 (as at 31st March 2021) who had tested positive on their current admission compared with 476 patients on 25 January 2021. 10 of the 58 patients were in intensive care. At the peak of the second surge, the Trust was caring for 492 patients who had tested positive for Covid-19 on admission to hospital and the Trust had expanded Trust critical care capacity to accommodate up to 150 patients while continuing to maintain about 30 per cent of normal surgical activity in order to provide time-critical care.
8.1.2.	A national day of reflection took place on 23rd March 2021, marking one-year on from the first national lockdown in response to the pandemic. The Trust took part in a one-minute silence at midday on the day, reflecting on all that had happened since last March and remembering everyone who had sadly died, including a number of Trust staff who were named by the Chief Executive. The Board was asked to observe a minute's silence to remember colleagues and patients who had sadly died since the start of the pandemic.
8.1.3.	Prof. Orchard briefly outlined the reset and recovery process as the Trust moves slowly out of the second surge, ensuring it safely resumes all of its planned care services in a way that focuses on the health and wellbeing of both patients and staff.
8.1.4.	The Board noted that the Trust would be expanding plans to safely and fairly work through the significant backlog of elective care that had been a major consequence of the pandemic, and the ongoing work with partners across the North West London (NWL) Integrated Care System (ICS) to build on much greater collaboration and learning throughout the pandemic to support reset and recovery and make longer term improvements to models of care and care pathways. The Trust was also ensuring that it was prepared as a system for a possible third Covid-19 wave or other future pandemics.
8.2.	**Covid-19 vaccinations**
8.2.1.	The operational focus of the Trust's in-house vaccination programme had moved to delivering second doses, and was continuing to provide first doses for Trust staff plus health and social care colleagues across NWL and patients who meet the criteria for vaccination.
8.2.2.	The Trust had delivered more than 21,300 first doses and over 4,500 second doses. Considering staff designated as frontline, 7,958, (81%) had been vaccinated which included staff who had advised that they had been vaccinated outside of the Trust and those not eligible to be vaccinated as per the criteria.
8.2.3.	Further analysis had been conducted of first dose vaccine uptake by different groups of staff and a number of specific groups had been identified where vaccine hesitancy appeared to be greater. The Trust continues to engage with vaccine hesitant staff through a variety of interventions. Prof. Orchard stressed the importance of people taking the vaccine when offered, for the safety of the individual and others.
8.2.4.	The Trust launched and were managing two large vaccination centres as part of the roll out of the public vaccination programme by the NHS in NWL.
8.3.	**Flu vaccination**

	From September 2020 to Christmas, flu vaccinations were delivered by peer vaccinators, complemented by two dedicated flu vaccination clinics per day on each of the Trust three main sites adhering to physical distance guidelines. In addition, bespoke clinics were held for specific groups such as hotel services staff. The campaign ended on 9th March 2021 and 66% of frontline healthcare workers were vaccinated in 2021, compared with 69% in 2020. A lessons learnt session had been arranged.
8.4.	**National NHS staff survey**
8.4.1.	The NHS 2020 staff survey results for the Trust showed that it had largely maintained the progress made in the 2019 survey with the overall engagement score remaining at 7.2 which was above the average for acute Trusts. The Trust had seen a third successive increase in the proportion of its staff who would recommend the Trust as a place to work and as a place to be treated. The survey scores slipped back in three key areas – equality, diversity and inclusion (EDI); immediate managers; and team working. The scores for morale and creating a safe environment (against bullying and harassment) had not changed from last year. The Trust was sharing the survey results across the organisation and drawing on the findings to inform priority developments at all levels, focusing especially on equality, diversity and inclusion; team working; the role of immediate managers; and health and wellbeing.
8.4.2.	Overall, the survey painted a mixed picture of how Trust staff feel about their working lives which reflected other feedback over the past year, including through the Trust's fortnightly all-staff Q&A sessions. Prof. Orchard stressed that everyone had worked incredibly hard in responding to the demands of Covid-19, but much more was to be done to address the underlying challenges in the Trust's workplaces. In particular, the Trust needed to make faster progress on EDI. Black, Asian and minority ethnic colleagues and those with disabilities disproportionately affected by the pandemic, had highlighted and exacerbated the many inequalities that already existed and he was grateful for the strong and influential voice of Trust staff networks in helping the Trust to bring this out into the open. A single item discussion on 'race equality' was being planned for one of the EDI Committee meetings.
8.5.	**Redevelopment** Following initial feedback from the national New Hospital Programme team, the Trust had been progressing the strategic outline (business) case for a full redevelopment of St Mary's Hospital with the aim of re-submitting the case by early summer. The Trust was working in partnership with the New Hospital Programme team to ensure the preferred option delivered the best possible hospital to meet the needs of its patient population with an agreed scope and size. The Trust had appointed a team to progress planning for major refurbishments and some new build at Charing Cross and Hammersmith hospital. The Trust would be resuming its engagement programme with staff, patients and wider stakeholders.
8.6.	**CQC update**
8.6.1.	Since the last Board meeting the CQC had not undertaken any further virtual assessments of Trust services and had not given any indication of virtual assessments planned for the Trust. The CQC held an engagement meeting with the Trust on 27th January 2021, focusing on the Trust's critical care service and how it coped during the pandemic including rapid expansion of capacity, and the concerns raised by the CQC regarding the provision of care for patients with mental health needs whilst attending the Trust's emergency department, following a serious incident which occurred in September 2020. The A&E team attended the January engagement meeting to provide responses to the

	CQC's concerns and submitted additional information as evidence to the CQC's Management Review process.
8.6.2.	The CQC had published a consultation regarding its proposed new regulatory strategy and the proposed changes to how NHS acute Trusts are rated. A more dynamic approach to ratings would mean Trusts would have more frequent opportunities to improve ratings.
8.7.	**Research and innovation**
8.7.1.	The Trust continued to be active in recruiting to Covid-19 research studies while also working to progress its wider portfolio of research. The Trust received positive feedback from the National Institute for Health Research (NIHR) on the 2019/20 Biomedical Research Centre (BRC) annual report submitted in September 2020, with the Trust's work on patient and public engagement and involvement drawing specific recognition.
8.7.2.	The NIHR confirmed that the next BRC competition would be launched in April 2021. The Trust was in the process of drafting a BRC framework / charter for EDI, based on the existing Trust and College policies. This would guide recruitment and selection of all senior positions in the BRC, inform funding decisions, and set the aim for appropriate representation of all protected characteristics in Trust research patient populations.
8.7.3.	The Trust continued to develop a virtual commercial and innovation function and, in partnership with Imperial Health Charity, launched its second round of the 'Innovate' programme.
8.8.	**Stakeholder engagement** The report outlined the meetings and communications with key stakeholders since the last Trust Board meeting.
8.9.	**Celebrating success** The Board was delighted to note that Dr Paquita de Zulueta, GP and a core member of our Schwartz Rounds team since 2015, won a 'shining star' award from the Point of Care Foundation, the national charity that supports organisations to introduce Schwartz Rounds.
8.10.	**Hotel services** Following the Trust decision in January 2020 to bring hotel services in-house on a temporary 24 month period, it was agreed to review after 12 months. The interim period ended on 31 March 2022 and, to allow time to outsource again, if required, recommendations were put to the Board to discuss in its private meeting. The Board agreed to continue to host hotel services in-house instead of reverting to an outsourced model of provision. The Board commended the efforts of the hotel services staff who did an extraordinary job during the Covid-19 pandemic just as they had moved across to Trust employment.
8.11.	**Trust Chair** As this was Ms Vennells last day at the Trust, Prof. Orchard expressed his thanks and that of the executive team for all that Ms Vennells had done for the Trust stating that she had been nothing more than committed, willing and supportive of the Trust and appropriately challenging. He was pleased to confirm that Mr Robert (Bob) Alexander would be stepping in as Acting Chair, bringing a wealth of NHS experience to the Board.
8.12.	Comments from the Non-executive Directors:

8.12.1.	Ms Boycott referred to the many changes that had been made to keep staff safe and commended the effort by everybody. She enquired about health service changes for the public and how the Trust would continue to keep people safe. Prof. Orchard took the opportunity to commend his executive team and Prof. Redhead who chaired daily sector meetings to keep on top of the evolving changes at pace. He commented that as the Trust looked forward to getting services up and running quickly, and although doing a good job, there were challenges in terms of addressing the backlog of patients waiting for treatment which included medium to long term plans utilising all of the healthcare facilities available across NW London. Plans would look to improve how healthcare is provided including specialist advice with aim of getting the best possible patient outcomes for the population of NW London. He commented that if there was a third wave, it was anticipated that healthcare utilisation would be less as a result of the Covid-19 vaccination programme.
8.12.2.	Mr Goldsbrough enquired about the 80% of staff vaccinated figure and asked whether what the figure would be if the 'not eligible staff' were discounted from that figure. Prof. Orchard advised that the approach taken by the Trust was to vaccinate all members of staff and he would check the proportion of staff compared with front line staff which was thought to be approximately identical in percentage. **Action: Prof. Orchard**
8.12.3.	Given the assumption that in future everyone would need to be vaccinated regularly, Mr Goldsbrough asked how confident the Trust was in understanding the reasons why its uptake was at 80% and not 100%. Prof. Orchard and Prof. Redhead advised that as more data becomes available, the knowledge and understanding about the virus and the vaccine increased therefore learning and implementation of actions to increase the uptake. Prof. Orchard advised that the complex social and societal issues were being addressed and efforts continue to build relationships with communities. Individual conversations were proving to be effective.
8.12.4.	Referring to the research and innovation work, Ms Vennells commended the evident enhanced relationship between the Trust and Imperial College London. Both Prof. Orchard and Prof. Weber agreed that the relationship had improved and there was a lot of collaboration between the two organisations with an effective Covid-19 Research Committee which would be important going forward.
8.12.5.	The Board thanked the medical students and educational teams for their working during the pandemic.
8.13.	**The Board noted the report from the Chief Executive.**
9.	**Organisational strategy review and refocus – priorities for the year ahead**
9.1.	Dr Klaber explained that usually at this time of the year the Board would be reviewing and approving objectives for the year ahead. Given the Covid-19 pandemic and a refocus on priorities and the work of the reset and recovery programme, the paper set out the work that had been done to date on the proposed Trust strategic priorities for the year ahead and the programmes and task and finish projects that were being proposed to prioritise. The priorities reflected the changing context in which the Trust was working in, including the significant financial constraints, and planned a focused set of priorities that it believes would best address its current challenges as an organisation and help the Trust to continue to move towards its strategic goals.
9.2.	The programmes and task and finish projects that were being proposed build on the work that has been done over the last 18 months and are the drivers of key outcomes within the priority areas covering the focus on patients, sustainable workforce, finances and the

	ongoing work to manage the cost base and a continued focus on quality as well as proactively and collaboratively developing the ICS, specifically through the development of the acute care programme.
9.3.	A programme of communication and engagement would be developed for all staff, patients and members of the local community, to ensure wide understanding of and involvement in this work.
9.4.	The next iteration of the paper would be presented to the May Trust Board for approval of the integrated business plan and corporate objectives.
9.5.	The Non-Executive Directors noted the important link between developments and finances and the way in which the priorities were proposed to be managed. In the future it was important to ensure resources were deployed appropriately and the extent the work could itself drive benefits. The next iteration to be more explicit, to reference the context of new models of care, and be realistic about what can and cannot be achieved or may take a longer period of time. **Action: Dr Klaber**
9.6.	Ms Vennells was pleased to see the split of the 'programmes, task and finish projects, and focused improvements.' She also referred back to the patient story and the importance of staff wellbeing in the context of priorities.
9.7.	**The Board noted the update, the proposed approach and the comments would be considered for the next iteration of the report.**
10.	**Our Green Plan – Time to act**
10.1.	Following the Board discussion in March 2020 on its Sustainability Development Management Plan the Trust committed to develop a sustainability action plan, namely the Green Plan. The Green Plan recognises the context of the impact that the Covid-19 pandemic has had on staff, patients, and the Trust's operational priorities, and offered a pragmatic balance of short-term actions and the building of foundations that would allow longer-term aspirations when the Trust fully emerges from the impact of the pandemic. The paper set out the principles underpinning our Green Plan approach – to launch in spring 2021, commencing work on the Trust's priority action areas and foundational cornerstones, and synchronising subsequent two-year action plans from the 2022/23 business planning cycle.
10.2.	Dr Klaber explained that the Green Plan would be an aspirational way to connect with staff, patients and the community and that the Trust has the right balance of being pragmatic and aspirational in the context of delivering excellent care mindful of financial challenges. The plan focused on a small number of measures which everybody could contribute to and the benefits would be measured as well as other key areas. Large scale areas included redevelopment opportunities and the availability of grants. Partnerships and relationships were key connections for this innovative work also in the context of the ICS.
10.3.	The Board recognised that this was the beginning of a long journey noting that this was one of the priorities of the New Hospitals Programme which the Trust was a part of. Mr Goldsbrough advised that measurements around what the Trust has was a crucial part of the plan but stressed that opportunities were equally important and he referred to the system in which the Trust operates including the opportunity to offer remote care and substitutions for travel. Mr Butler informed the Board that his team were actively driving the remote care and monitoring of it via a transformation workstream.

10.4.	Mr Ross commented that one of advances that would be made by the Trust was the redevelopment of the estate. He asked whether sub-contractors would embrace this and he also enquired about the financial section of the paper as to make longer term gains.
10.5.	Mr Alexander stressed the importance of redevelopment in this context and that within the NW London ICS there were two major redevelopment plans which suggested the ICS should take the agenda on seriously.
10.6.	Mrs Boycott advised that she was the Board champion for sustainability and commended the diligence of the small team working on this project. She advised that the plan was pragmatic which sought to replicate the ambition of the NHS Net Zero agenda. It would be an agenda that would touch all aspects such as transport, medicine, estates, digital etc. She asked how the Board would seek assurance against progress that the investments were at the appropriate level.
10.7.	Dr Klaber welcomed the comments. He advised that the visible measurement of improvements was important – people need to see and feel the impact of the work they were doing as a key driver for continuous improvement. Mr Ross and Mrs Boycott's points were important and would be covered within the work over the coming months. In terms of the ICS there was emerging energy and focus on equalities and population health - the appendices included some detailed work around equalities. He advised that sustainability and improving the health of the population have to go hand in hand.
10.8.	**The Board approved the principles underpinning 'our Green Plan' approach.**
11.	**Reset and recovery**
11.1.	The report was taken as read and the Board noted the process for restarting services that were reduced or paused as part of the Trust's response to the pandemic. Although essential, the pause of all but the most urgent activity generated a significant backlog for elective care. As the number of patients admitted with Covid-19 was subsiding, the Trust had turned its attention to how it safely and rapidly reinstated those services that were paused, starting with those of the highest clinical priority. The paper set out the process for restarting the services in a way that focused on the wellbeing of staff and the needs of its patients. The plan set out the management of the first six weeks of the recovery phase, which would be reviewed and refined as required.
11.2.	The three aims of the process was for patients to get their care in priority; staff get time to rest; and patients kept at the centre of Trust plans.
11.3.	Since the report, national planning guidance had been received on the national expectation on reset and recovery which Mrs Hook and Mrs Thind were working through to ensure activity and resourcing plans were aligned and to understand the cost base. The national ask was that the Trust returns to 70% of its baseline activity from April which should increase by 5% each month to get to 85% in July. The Trust was not an outlier in NW London or Shelford Group and although this would be challenging, good progress was being made.
11.4.	Mrs Hook advised that the plan was to close much of the surge capacity by the end of April. The Theatre schedule would be fully running from mid-April and focus remained on reducing the number of patients waiting for surgery with the expectation to be back to normal level during April. 92 checklists had been reviewed to restart services which was in recognition of significant learning from wave 1. The paper detailed the activities in terms

	of staff wellbeing. Mrs Hook agreed with Mrs Boycott that the work of the Trust would be communicated with stakeholders honestly and transparently.
11.5.	Mr Ross commended the reset and recovery work but enquired whether the Trust would ever catch up with the back log of patients. Mrs Hook advised that the immediate focus was on patients that were most urgent and then working out the trajectories for other operational standards. The cancer pathways would be straightforward but 52 weeks and those waiting for treatment which was important but not clinically urgent in terms of time period, would be discussed after capacity modelling. Also the approach to GP referrals was unknown which would need to be understood. In terms of how to incentivise, Prof. Orchard advised that there were actions the Trust could take to increase capacity if needed but would be subject to a policy decision including how to deliver those decisions.
11.6.	Mr Alexander added that at some point people would need to look at recovery at a system level and he enquired whether conversations were taking place about the baseline organisations were going to start from and the extent to which conversations were taking place around matching patient needs and system capacity in the future. Prof. Orchard advised that organisations do not know what the financial regime would be for the second half of the year but incentives would be at a sector level not provider level therefore important to understand system plans.
11.7.	In terms of the ICS, Prof. Redhead advised that on a weekly basis NW London providers review the Patient Treatment Lists (PTL) and other meetings to discuss prioritisation based on clinical harm. Prof. Orchard added that an Acute Programme Board had recently been set up and chaired by him at which prioritisation was discussed based on a single PTL list across NW London which enabled the understanding of the level of risk within the waiting list.
11.8.	**The Board noted the report and the Board thanked operational and HR teams for their relentless work over the past 12 months.**
12.	**Integrated quality and performance report**
12.1.	The Board received the integrated quality and performance report for month 11 which was taken as read and the discussion at item 11 was relevant to this item too. The scorecard set out the Board metrics within the Trust's strategic goals, priority programmes and focussed improvements.
12.2.	The Board noted the updates against referral to treatment, diagnostics, cancer waiting time, urgent and emergency care and quality (safe and effective).
12.3.	**The Board noted the report.**
13.	**Finance report**
13.1.	The Board received an update on the financial position for the Trust for the 10 months to the 31st January 2021 and the forecast for the remainder of the financial year. The report had been discussed at the Finance, Investment and Operations Committee.
13.2.	The Board noted that the Trust agreed an outturn position with the NW London ICS for the second half of the financial year of a £15.8m deficit. The deficit was based on the month 5 forecast outturn and was primarily driven by lost non-NHS income. NHS commissioner income had been agreed at a block contract value for months 7-12 and, within this, the Trust received funding for growth to meet elective care targets and the expansion of intensive care capacity bed base. However, costs related to a second Covid-19 surge were excluded from the plan. Central funding had been made available for

	activities such as increased pathology testing and vaccination clinics which occurred in addition to the original block.
13.3.	At the end of January 2021, the Trust met the year to date deficit plan of £7.8m and was forecasting to meet the year end deficit of £15.8m (before cost of annual leave to be carried forward). The current estimate of annual leave outstanding shows this to be an average of seven days, which equated to £14m and was included in the full year forecast. The Trust continued to incur additional costs in relation to Covid-19 but was able to offset these by reductions in costs relating to other activity.
13.4.	Since January reporting, the Trust was informed that it would receive funding for income lost due to the pandemic up to the value of £15.8m. However further validation was to be undertaken with the final settlement to be notified to the Trust in March.
13.5.	The Trust continued to make good progress on delivering its capital programme with year-to-date total spend of £51.8m (82%) against a plan of £63.3m. The cash balance at 31 January was £175.6m with the majority of this linked to block payments made in advance.
13.6.	Since writing the report the Trust received the 2021-22 planning guidance which the finance and operations team were reviewing noting that quarter 3 of 2020-21 would be the envelop allocation baseline. Work was in train to understand what could be delivered in a cost and efficient way within that envelope and understand what step cost change would be required for additional requirements – this would be discussed in detail at the Executive meeting. The submission deadlines were 6th May for the draft plan and the final plan by 3rd June at sector level.
13.7.	Mr Alexander enquired about the national expectation for systems to breakeven at the end of 2021-22. Mrs Thind advised that the guidance was not clear on this point but played into control total discussions pre-Covid and those discussions needed to be revisited. She confirmed that although the guidance was for the first six months, the Trust would plan for a full year with projections for the second half.
13.8.	**The Board noted the report.**
14.	**Update on Ockenden report assurance progress**
14.1.	In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust. The review remains in progress, however the investigation team published an emerging themes report with findings and seven immediate and essential actions for Trusts to implement. A full report with further findings and recommendations would be published at a later date. The paper was therefore based on the emerging themes so far from the investigations.
14.2.	The Trust had provided an immediate response to NHSE/I on 21st December 2020 and the follow up assurance document was submitted on 15th February 2021. The response was approved at the Quality Committee on 20th January 2021 noting that the amber areas were due to lead positions being appointed to in July 2021.
14.3.	A peer review process led by NHSE/I was in progress. ICHT's response was peer reviewed on 8th March 2021 with most elements rated as compliant and some as partially compliant, in line with NW London peers. Some elements would be rated as partially

	compliant across London as they were reliant on NHSE/I system set up. Formal feedback on the final review was expected by 19th March 2021.
14.4.	The date and process for submission of the evidence was yet to be confirmed but anticipated to be in May 2021. Prof. Teoh confirmed that the maternity team had commenced collection and collation of evidence in preparation.
14.5.	**The Board noted the update report and the assurance report.**
15.	**CNST Maternity Incentive Scheme Year 3**
15.1.	CNST Maternity Incentive Scheme Year 3 was re-launched on 1st October 2020. Under this scheme, Trusts that could demonstrate they have achieved all of the 10 safety actions would recover the element of their contribution to the CNST maternity incentive fund and would also receive a share of any unallocated funds. Trusts that did not meet all 10 safety actions would not recover their contribution to the CNST maternity incentive fund, but could be eligible for a small discretionary payment from the scheme to help them to make progress against any actions they did not achieve.
15.2.	On 15th December 2020, NHS Resolution informed the Trust of the extension to the scheme and some of the sub-requirements of the safety actions would be revised. The updated CNST Maternity Incentive Scheme guidance was published in January 2021 with a new deadline for submitting compliance on 15th July 2021 as opposed to May 2021 for submission of the evidence. The requirement for submission of the continuity of care action plan to the Trust Board for oversight was now quarterly and the latest report along with an action plan was shared with the Trust's safety champion in February 2021.
15.3.	The paper was discussed at the Divisional Quality and Safety meeting and the new guidance was being reviewed and an adapted action plan would ensure the Trust was compliant with the new timeframes.
15.4.	The paper was discussed at the March 2021 Quality Committee. The next report to the May 2021 Board would include further evidence. The Board declaration form would be presented for sign-off at the July 2021 Trust Board.
15.5.	**The Board noted that overall good progress had been made to date to ensure compliance with the scheme and noted the CNST Maternity Incentive Scheme safety action compliance report.**
16.	**Infection Prevention and Control (IPC) Report**
16.1.	The Board received the quarter 3, 2020-21 report and noted the following highlights: ▪ IPC expertise continues to be integral to decision making during the Trust management of Covid-19. The NHSE Board Assurance Framework for the Trust's IPC structures and activity related to Covid-19 continues to be updated monthly. Processes for the management of possible Covid-19 outbreaks in patients and staff had been agreed and implemented. ▪ 27 Covid-19 transmission incidents / outbreaks were identified and managed during Q3. ▪ There had been 9 hospital-associated C. difficile cases during Q3, which was below the Q3 ceiling of 18 cases. There had been no lapses in care related to cross-transmission or antibiotic choices. ▪ There was one hospital-associated MRSA BSI (bloodstream infection) during Q3. ▪ The Trust was on target to meet its 10% year-on-year reduction in Trust-attributed E. coli BSIs

	▪ The pandemic triggered a rise in intravenous agents during Q3 2020/21 due to high acuity patients presenting with undifferentiated respiratory infections. In response, the Trust deployed various antimicrobial stewardship initiatives to counteract this shift. ▪ Non-Covid-19 clinical activity included investigating and managing incidents related to Candida auris, chickenpox, shingles, PVL Staphylococcus aureus, parvovirus, E. coli 0157, and norovirus.
16.2.	Responding to a question from Mr Ross about doing anything more if there was another wave, Prof. Redhead advised that teams continue to learn and improve infection control.
16.3.	Responding to Mr Goldsbrough, Prof. Redhead confirmed that a root cause analysis was undertaken for all healthcare associated infections which were reviewed and learning from them.
16.4.	The Board asked Prof. Redhead to relay their appreciation to Prof. Holmes and her team for their tremendous work during the pandemic.
16.5.	**The Board noted the report.**
17.	**Annual review on safe, sustainable and production nursing and midwifery staffing**
17.1.	In line with requirements set out by National Quality Board's 2018 Safe, sustainable and productive staffing: An improvement resource for adult inpatient wards in acute hospitals and NHSE/I 2018 Developing workforce safeguards, the paper provided a summary of the Trust's work to deliver safe and sustainable nursing and midwifery care to its patients and families.
17.2.	Prof. Sigsworth confirmed that the Trust undertakes an annual and mid-year nursing and midwifery establishment review, to provide assurance both internally and externally that ward staffing were safe and that staff were able to provide appropriate levels of care to its patients. In response to the pandemic, staffing had to change significantly to ensure the needs of the patients were met. The Trust undertook a nursing and midwifery establishment review in autumn 2020, with consideration for additional bed capacity and staffing requirement in critical care, general and acute ward areas. Guidance was received from Royal Midwifery College regarding redeployment and risk assessments which had been factored in.
17.3.	Overall, there had been an actual increase of 14.45 whole time equivalents in the nursing and midwifery establishment when compared with the establishment review undertaken in September 2019.
17.4.	Ms Scavazza enquired about support for staff from international recruitment campaigns and how they were made to feel welcome referring to a WRES reset from the centre which suggested that the international workforce experience within the NHS was not a good one, and she asked for assurance that this would not be the case for ICHT and the measures to avoid this. She also enquired how the Trust compared with other Trusts in terms of staff turnover. Prof. Sigsworth advised that their main international recruitment was from Philippines and the Trust ensures adequate support for those groups with funding secured for a Filipino support group. She also advised that the Trust does well on recruitment and more was being done on retention.
17.5.	Mr Alexander advised that there was some money available from the centre for midwifery staffing which the Trust could access. Prof. Sigsworth was already enquiring about the money available which was as a result of the Ockenden review. Prof. Teoh added the Trust had invested in the Birth Rate Plus study.

17.6.	Ms Vennells commented that it was encouraging to see an increase in the nursing associates and she also commented that the Trust welcomed overseas staff noting the continued support they required.
17.7.	**The Board noted the assurance report and the work the Trust was undertaking to deliver safe and sustainable Nursing and Midwifery care.**
18.	**Annual report from the Trust safeguarding committee**
18.1.	The Board noted that the Trust has a responsibility to safeguard children, young people and adults in its care. This requirement was laid out in the Children Act (1989), the Children Act 2 (2004), the Care Act (2014) and also made clear in CQC Regulation 13: Safeguarding service users from abuse and improper treatment.
18.2.	The report outlined the systems and processes in place at the Trust to ensure that it fulfils its responsibilities. Prof. Sigsworth confirmed that based on evidence and reports received during 2019/20, the Safeguarding Committee was assured that the Trust had the infrastructure and appropriate systems in place to provide an effective safeguarding service. The Committee had no significant areas of concern that it wished to advise the Trust about, but would continue to monitor this through 2020/21.
18.3.	The report had been discussed at the Quality Committee who sought further information on the impact of Covid-19 and benchmarking. The 2020-21 report was expected in July which would include these points.
18.4.	Mr Goldsbrough suggested that the Trust think about benchmarking more widely in a systematic way drawing out outcomes to focus attention on. After a conversation regarding processes and outcomes, Ms Vennells commented that good processes may increase the number of safeguarding cases through greater exposure and would be deemed a good outcome as issues would be brought to the surface. Ms Vennells asked how the Trust trained staff around changes they should be looking out for. Prof. Sigsworth advised that all staff were trained are different levels throughout the organisation including refresher training.
18.5.	Dr Maruthappu suggested thinking about how nurses could be made to feel more empowered with their ideas and challenges and opportunities. Prof. Sigsworth advised that pre-Covid the Trust was working on a pathway to excellence project for nurses which had been paused and would be resumed soon.
18.6.	**The Board noted the assurance report.**
19.	**Declarations of interest annual report**
19.1.	As part of the Trust's 'Declarations of Interests and Hospitality Policy' all Trust Board members were required to complete, or update, their declarations of interests submissions to allow this to be reported to the Trust Board on an annual basis and for the declarations to be published on the Trust website.
19.2.	**The Board noted the report.**
20.	**Establishment of a People Committee**
20.1.	Following discussions at the Quality Committee and the growing responsibilities of the Quality Committee/agenda further impacted by the response to the Covid-19 pandemic, and placing focus on the People agenda, the Executive and Non-Executive Directors Group agreed for a People Committee to be established. This would allow sufficient Board focus on the cultural and organisational development of the Trust, and on the strategic

	performance and impact of the Trust as a significant employer, educator and partner in health and care.
20.2.	The Terms of Reference for the People Committee had been discussed and agreed through the Non-Executive Directors Group and key Executive Directors during February 2021 and also noted by the Remuneration and Appointments Committee in March 2021.
20.3.	The Board thanked Ms Scavazza for taking on the chairmanship of the Committee which would commence from May.
20.4.	**The Board noted the Terms of Reference for this Committee.**
21.	**Trust Board Committees – summary reports**
21.1.	**Audit, Risk and Governance Committee**
21.1.1.	The Board noted the summary points from the meetings held on 2nd December 2020, 11th February and 3rd March 2021.
21.1.2.	The Board thanked Mrs Boycott for taking on the chairmanship of this Committee whilst Mr Alexander was Acting Trust Chair.
21.1.3.	The Board noted that Mrs Boycott and Mr Alexander would meet with the new internal audit lead at PwC.
21.2.	**Quality Committee** The Board noted the summary points from the meetings held on 20th January and 17th March 2021.
21.3.	**Remuneration and Appointments Committee** The Board noted the summary points from the meetings held on 2nd and 24th March 2021.
21.4.	**Finance, Investment and Operations Committee** The Board noted the summary points from the meetings held on 20th January and 24th March 2021.
21.5.	**Redevelopment Committee** The Board noted the summary points from the meetings held on 20th January, 17th February and 10th March 2021.
22.	**Any other business**
22.1.	On behalf of the Board, Mr Alexander thanked Ms Vennells for her professional and committed leadership and contributions to the Trust which had coincided with the most challenging time in the history of the NHS, and also for the personal support to all colleagues. The Trust was stronger with her involvement and the Board wished her the very best for the future.
22.2.	Ms Vennells responded with her appreciation and expressed her deep privilege to have worked at the Trust. In particular her appreciation extended to the Trust's patients for their support and also for their criticism from which the Trust learns; to the strategic lay forum who give their time to support the Trust; she recognised the front line staff who were the beating heart of the Trust; to the Executive and Non-Executive teams; colleagues from the college and the charities; to Peter Jenkinson, Ginder Nisar and Philippa Beaumont for their support to her; and lastly to Tim Orchard for his exemplary leadership reflecting on his Covid-19 experience - when he was ill the Trust was well run by executive colleagues because of the collaboration and values the team stepped in effortlessly.
23.	**Questions from the public**
23.1.	Ahead of the Board a member of the public had shared her experience of the antenatal clinic to which the Trust had responded and as requested by the member of the public the response had been shared with the Board ahead of the meeting.

23.2.	A member of the public raised issues concerning her treatment at Charing Cross Hospital with two infections and also the staff behaviour towards her. Prof. Redhead apologised for her experience and advised that the case was known and that learning from this case would be disseminated. The member of public had specifically asked whether the Board had assurance that the care delivered to patients in the future during pandemics would be of high standard. Prof. Redhead gave assurance that the Trust would be doing this and strives to provide the best care to its patients. She asked about the A&E department and the care they provide to neurosurgical patients. He confirmed that the Emergency Department (ED) always strives to have access to the right equipment and correct skills including access to investigations for all patients including neurological patients. Dr Bowen added that when the needs are not met there is always learning and she apologised to the member of the public for her experience in the Trust's ED. Prof. Orchard apologised to the member of public about the care she had received at the Trust and asked if she had any concerns on the current care pathway to email him directly and he would respond.
23.3.	Another member of public enquired about improving services for people with disabilities at Charing Cross Hospital (CXH) and about the low morale of the therapists who end up leaving or work in difficult conditions. He commented that the service was not on the same standard compared with other Trusts like the National Orthopaedic Hospital in Stanmore and Queen Mary Hospital in Roehampton which could be due to financial issues for the Trust. He asked how the Trust would improve the disability services and how the Trust's strategies were compatible with the needs of people with disabilities. Prof. Orchard advised that the Trust improves its services as a result of feedback and the Trust had invested money in the prosthetic department at CXH. He advised that the two hospitals mentioned were specialist hospitals and were different in terms of the service provided at CXH. Prof Orchard asked that the member of public provides his written feedback or to contact the strategic lay forum so that measures could be put in place to resolve such issues.
23.3.1.	The same member of public enquired about his interest in the strategic lay forum for which he was not selected as a member. Ms Vennells advised that he could still contribute and did not have to be a member to contribute.
23.3.2.	The member of public also enquired about what was preventing the Trust to build a cancer diagnostic facility as it would be a benefit to the Trust. Prof. Redhead and Prof. Orchard advised that it was an important area for the Trust and the ICS as the earlier diagnosis could be made, often the outcomes could be improved but that there were funding issues. However they advised there were opportunities now as organisations work more collaboratively across NW London and that the quality of the environment was being improved through the redevelopment programme part of which would cancer diagnostics. The member of public would email his thoughts on funding for projects and Prof. Orchard would respond.
24.	**Date of next meeting** Further to the paper submitted to Board in July 2020 regarding changes to Board routines and bringing them forward in the month to improve reporting, the next meeting of the Board would take place on **12th May at 11am, held virtually via Microsoft Teams.**

Updated: 23 April 2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Record of items discussed at the confidential Trust board meeting held on 31st March 2021 and Board Seminar, 21st April 2021

Agenda item 5 and paper number 02

Executive Director: Professor Tim Orchard, Chief Executive
Author: Peter Jenkinson, Director of Corporate Governance

Purpose: For information

Meeting: 12 May 2021

Executive summary

1. Introduction

1.1. Decisions taken, and key briefings, during the confidential sessions of a Trust board are reported (where appropriate) at the next Trust board meeting held in public. Items that are commercially sensitive are not published.

1.2. The Trust board has met in private on two occasions since the last meeting on 31 March and 21 April 2021.

31 March 2021 Private Trust Board

2. Chief Executive's update

2.1. As part of the Chief Executive's oral update, the Board considered the feedback received from two patients regarding their experience of the Trust's services.

2.2. The Board discussed the financial allocation for the first six months of the year 2021/22.

2.3. The Board discussed the Trust priorities, Green Plan and Reset and Recovery.

3. Hotel services long term provision

3.1. Following the Trust decision in January 2020 to bring hotel services in-house on a temporary 24 month period, it was agreed to review after 12 months. The Board agreed to continue to host hotel services in-house instead of reverting to an outsourced model of provision.

4. MRI Business case

4.1. The Board considered a business case for establishing an interim MRI Hub at Ealing Hospital, to be run by the Trust. The Board approved option 4 of the business case and endorsed the continued development of a business case to establish a permanent Community diagnostic hub, under the governance of the Strategic Imaging Asset Management programme.

5. Our Green Plan

5.1. The Board reviewed the new Green Plan and approach and, recognising the

importance of the sustainability agenda, endorsed the direction of travel.

6. Redevelopment update

6.1. The Board received an update on the redevelopment programme and noted the key areas of work, including the re-submission of the Strategic Outline Case (SOC) for St. Mary's hospital and the first phase of developing options appraisal for Charing Cross and Hammersmith Hospitals. The Board received feedback from a 'round table' meeting between the Trust and the national team on 5th March 2021 which discussed the Trust's approach and options. Draft feedback had been received with final feedback and next steps expected shortly.

21 April 2021 Board Seminar

7. The Board discussed the output from the working group established to consider the development of the North West London Integrated Care System (ICS) governance and the strategy / vision, and the role of a statutory board in this context, and agreed next steps in the Trust's engagement in the development of the ICS and provider collaborative.

8. The Board reviewed the draft component parts of the business plan for 2021/22.

9. The Board participated in the certified cyber security Board training provided through NHS Digital/Templar Executives Ltd.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC) - ACTION POINTS REGISTER, Date of last meeting 31 March 2021

Updated: 10 May 2021

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	25 Nov 2020 8.7.7	New ways of accessing healthcare and information (arising from CEO report)	Ms Boycott enquired whether the Trust was making sure every channel was being used to communicate the messages to educate people around the new ways of accessing healthcare and information. Ms Dixon would provide an update to the Board (via email) around the new ways of accessing healthcare and information. **May 2021 update:** We are leading on communications and engagement for the Acute care programme. Our communications plan for the programme is evolving and includes a range of activities across all audiences to build awareness and understanding of changes that have taken place and to embed involvement in the development of further changes. Immediate priorities for patients and the public include: making changes to patient letters and updating patient information about how we have been prioritising waiting list backlogs and ensuring safety and to let anyone waiting for care know about relevant changes, such as the introduction of 'fast-track surgical hub'; a 'mini' public campaign to promote NHS 111 First; working with outpatient transformation teams to review patient information and 'user journey' for virtual consultations. The latest communications plan is available to provide more detail.	Ms Dixon	May 2021

2.	31 Mar 2021 8.12	Covid-19 vaccinations (arising from CEO report)	Mr Goldsbrough enquired about the 80% of staff vaccinated figure and asked whether what the figure would be if the 'not eligible staff' were discounted from that figure. Prof. Orchard advised that the approach taken by the Trust was to vaccinate all members of staff and he would check the proportion of staff compared with front line staff which was thought to be approximately identical in percentage. **May 2021 update:** Staff who are not eligible are included in the compliance data, therefore already in the percentage. Through our hesitancy calls we have been able to improve data quality with regards to non-eligible colleagues, therefore there is more confidence that the figure is accurate.	Tim Orchard, Julian Redhead	May 2021
3.	31 Mar 2021 9.5	Organisational strategy review and refocus – priorities for the year ahead	The Non-Executive Directors noted the important link between developments and finances and the way in which the priorities were proposed to be managed. In the future it was important to ensure resources were deployed appropriately and the extent the work could itself drive benefits. The next iteration to be more explicit and also include new models of care and be realistic about what can and cannot be achieved or may take a longer period of time. **May 2021 update:** The integrated business plan is an agenda item and paper within this meeting.	Dr Klaber	May 2021

4.	30 Sept 2020 14	WRES report	Mr Croft noted the comments to consider and take forward. A structured programme would be discussed at executive level then back to Board. a) For next year's report, where progress had not been made, provide a narrative explanation. b) Positive progress in some areas noting the need to focus on inclusivity and equality at senior level and harassment and bullying. c) Specific actions were being taken such as the requirements to have a BAME individual on interview panels but work still to be done on providing feedback to unsuccessful interviewees with specific development plans. At senior level need to ensure these recruitment processes are embedded but more importantly, need to ensure there is equality of access to opportunity when staff are lower down in the organisation. d) Embedding work around culture and values and behaviours to change the key metric about 'what does it feel like to work at the Trust' was key. e) Important to ensure the values and behaviours work is taken alongside the strategic work. March 2021 update: The Trust has expanded its Equality, Diversity and Inclusion (EDI) team in early 2021 and re-launched its EDI work following the pandemic. Equality, Diversity and Inclusion is also one of the three high priority people programmes for 2021/2022 and the work programme, informed by the most recent staff survey, will be agreed with the EDI Committee at the end of April. **May 2021 update:** The EDI work programme was agreed by the EDI Committee at the end of April and has been set up as a Trust-wide priority programme with a detailed delivery plan. EDI is expected to be one of the People Committee's deep dive subjects at their July meeting. Close	Kevin Croft	May 2021
5.	25 Nov 2020 8.7.9	Outpatient discussion (arising from CEO report)	The Board suggested discussing outpatients in detail at a future Board or Board Seminar.	Prof. Teoh, Mr Jenkinson	TBA

Items closed at the March 2021 meeting

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	29 July 2020 7.4.2	Keeping our patients and staff safe / risk assessments (arising from CEO report)	Ms Thomas was pleased to see how well the Trust had turned this around so quickly and commented that it would be useful to see the shared learning at the end of July and what further adjustments need to be made, including changes to the risk assessment as needed. November 2020 update: Update at next meeting. March 2021 update: A revised version of the Risk Assessment document is due for launch in March 2021. The updated risk assessment incorporates a best practice framework for assessing the individual risk faced, and protecting those most at risk, now that far more is known about the disease and its pathology.	Kevin Croft	Closed
2.	30 Sept 2020 22.3.1 31 Mar 2021 8.5	Redevelopment: Alternative plans	Awaiting for letter from the government regarding the SOC, and alternative plans need to be considered for the SMH site as plan B. To be discussed at the Redevelopment Committee then updated to Board. November 2020 update: The Trust has received the letter. It supports the redevelopment need at St Mary's but requests further information about the project before a decision can be made on progressing the redevelopment. Alternative plans have not yet been considered whilst resources are focussed on providing the required information to allow the SOC to proceed. March 2021 update: The Trust has been working through the issues raised by the national New Hospital Team (NHP). There was a detailed discussion with NHP on 5th March as part of their overall planning for the 40 Hospitals programme. We are continuing to work with the NHP team to agree the preferred option and programme for delivering the new hospitals at Imperial. Update in CEO report to Board.	Mr Tulley	Closed

3.	29 July 2020 7.19.2	Staff wellbeing (arising from CEO Report)	On behalf of Mr Ross, Ms Vennells enquired, for different cohorts of staff particularly those in vulnerable categories such as obesity, what further help could be provided. Mr Croft advised that the charity award money covered aspects of health and wellbeing which included the physical element as well as the psychological aspect, both would be pulled together to ensure a coherent approach. It was agreed to discuss further as a theme at the Quality Committee as part of the safe staffing report. The Board noted that the executive were considering the appointment of a senior role to bring all of this agenda together. November 2020 update: Update at next meeting. March 2021 update: Updates on the current programmes have been provided to the Quality Committee. Health and well being will be one of 3 high priority people programmes for 2021-22 that will include physical health and be overseen by the newly-created People Committee. As part of a wider senior management team re-design, Sue Grange, Deputy Director of People & OD, has taken on an expanded portfolio to include health and well-being and will become Director of Organisational Development and Well-Being.	Kevin Croft	Closed
4.	25 March 2020 9.4 31 Mar 2021 10	Sustainable development management plan	The Board endorsed the plan and the ambition, and asked the Executive Team to review and include more granularity around key aspects and then submit to the Board Redevelopment Committee when ready. The report to also include it would need a rolling plan as it would evolve over time. May 2020 update: Planned for December 2020 Redevelopment Board Committee March 2021 update: Superseded by the Green Plan.	Hugh Gostling	Closed

5.	29 January 2020 14.6 25 Nov 2020 6.1 31 Mar 2021 20	Employee metrics matrix (arising from FTSU item)	Ms Boycott suggested a joined up matrix capturing employee experience such as concerns arising from staff survey, and concerns raised via other sources including FTSU. Other Non-executive Directors agreed and suggested including excellence awards and staff stories to Board in the employee experience piece. Mr Croft would give some thought to this. July 2020 update: The People and OD team are currently working on setting back up the culture programme and the people metrics that will be used in the Imperial Management and Improvement System. This will include directorate level dashboards relevant to this item. It is proposed this is considered in September once this work has progressed through the executive and the relevant Board Committee. September 2020 update: Deferred to next meeting. November 2020 update: Work was underway to look into how best to incorporate employee metrics in scorecards. The culture programme and the staff survey results would assist in defining the metrics. Ms Vennells and Prof. Orchard were in discussions about reviewing the Board's focus on the 'people agenda' and would share their thoughts for further consideration by the Board in due course. March 2021 update: The People Committee Terms of Reference is on the main agenda. Close	Kevin Croft	Close

6.	25 Nov 2020 7.8	Patient Story / Dementia service	The dementia service has been able to invest in technology to help provide cognitively stimulating activities and the St Mary's Hospital League of Friends has also provided a grant to support this work further. Prof. Orchard reiterated the outstanding dementia work being done by Ms James and her team and he agreed with Mr Alexander's comment about such initiatives being included in the ICS work therefore could be included in the consultation response. March 2021 update: The summary of the response the Trust sent to the ISC leadership team to support their feedback into the NHS England engagement process articulated the importance of partnerships between clinical teams, academic teams and the voluntary sector in delivering truly integrated care that really matters to the patients we serve. These case-studies are a key way to ensure the strategic planning within the ISC is strongly focused on user-focused clinical innovation. Close	Dr Klaber	Close
7.	25 Nov 2020 8.7.6	Freedom to Speak up / Raising Concerns metrics (arising from CEO report)	Current metrics would be emailed to Ms Scavazza. March 2021 update: FTSU / raising concerns metrics were included in the weekly sitrep shared with NEDs during 'governance-lite' in January and February. Moving to BAU, with the establishment of the People Committee, this will be reported regularly through that committee. Close	Peter Jenkinson	Close
8.	25 Nov 8.7.8	Outpatient feedback (arising from CEO report)	Regarding outpatient feedback, Sir Gerry had previously suggested a simple and quick rating survey to obtain feedback. This would be included in the user experience work which was underway. March 2021 update: The current surge of Covid-19 has delayed the formal launch of the user insights function until the spring, but work continues in the background to define the key measures that will enable is to monitor the impact of this work. This will include a number of mechanism for ensuring that we ask for contemporaneous feedback and then use it in near real-time to make improvements. We will keep the Board updated as to the revised launch date of the work and will look to formally report a progress update 4-6 months after that. Added to forward planner (Insights update). Close	Ms Dixon, Prof. Sigsworth, Dr Klaber	Close

9.	25 Nov 2020 12.4	Infection Prevention and Control Board Assurance Framework / Training Records	Ms Vennells referred to section 6.2 of the report regarding training records not being stored electronically with the indication that there will be an electronic resource to capture this. She made the general point about capturing data and the intersectionality between this data and the integration of training records. Prof. Holmes agreed and referenced the approach with hotel services staff and the work that has been done to improve the content of the training. Future reports to Board would expand on this point. March 2021 update: Training records for hotel services staff are now available electronically. Work is being taken forward to ensure that training records for FFP3 respirators and IPC training records for contractors are also stored electronically. Close	Prof. Redhead/Prof. Holmes	Close
10.	25 Nov 2020 14.4	Learning from deaths report	Prof. Redhead advised that a project manager has been identified to review the Trust's current processes and policy as well as support the implementation of changes to the work programme. These changes would be made by the end of quarter 3 2020/21. The amendments would ensure that the Trust's mortality review processes align appropriately with the Medical Examiner service and improve its investigations and learns from deaths which occur in Trust care. Prof. Redhead would confirm the changes are in place by the end of quarter 3. March 2021 update: These changes will be made by the end of Q4 2020/21 as some activity had been put on hold due to resource re-allocation required to support management of the pandemic. Close	Prof. Redhead	Close

After the closed items have been to the proceeding meeting, then these will be logged on a 'closed items' file on the Trust Secretariat shared drive.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Patient Story

Agenda item 7 and paper number 04

Executive Director: Janice Sigsworth, Director of Nursing
Authors: Steph Harrison-White & Guy Young

Purpose: For information

Meeting: 12 May 2021

Executive summary

1. Purpose

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

1.2. The perceived benefits of patient stories are:

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

2. Background

2.1. Patient stories were temporarily suspended during the second wave of the COVID-19 pandemic. As highlighted in our last Patient Story review paper, presented at the January Board (2020), there are a number of ways in which we can bring patient stories to the Board.

2.2. Due to the ongoing risks and restrictions, this paper will be told by Margaret Smedley-Stainer, learning disabilities lead, on behalf of the patient's father. She will describe how through the appropriate use of reasonable adjustments, people with learning disabilities and autism can safely access health care.

2.3. The story will demonstrate that *collaborative* working, drawing on *expert* knowledge can make a positive difference for both the patient, their family and staff.

3. Key findings

3.1. The Autism Act 2009 and the Equality Act 2010, state that reasonable adjustments should be made for people with learning disabilities and autism so that they can safely access

health care. This has been especially challenging during the COVID-19 pandemic for a number of reasons, including the increased risk of attending hospital during this time.

3.2. Reasonable adjustments are individual, determined by the needs of the person and the services they are accessing. They may include extended appointment times, the presence of carers or family or specific communication and sensory aids as an example.

3.3. The learning disabilities and autism team have developed clear pathways referred to as 'purple pathways' to support staff in caring for patients with learning disabilities and autism. Central to these pathways is good communication and collaborative working.

3.4. This patient story will highlight how making reasonable adjustments can positively impact on a person's outcome and experience whilst also equip staff with the skills to deliver care in a safe environment.

4. Next steps

4.1. To develop a learning disability and autism purple pathway for patients receiving complex medical care.

5. Recommendation(s)

5.1. The Board is asked to note the report.

6. Impact assessment

6.1 Quality impact: Learning from good practice will enhance patient care.
6.2 Financial impact: None
6.3 Workforce impact: Positive examples of good practice are motivating for staff
6.4 Equality impact: Organisations are required to make reasonable adjustments for patients with learning disabilities; this paper provides evidence of the Trust doing this
6.5 Risk impact: None

Main report

7. Patient story

7.1. Mr AB is a 31 year-old autistic man with learning disabilities, Attention Deficit Hyperactivity Disorder (ADHD) and end stage renal failure. He had a renal transplant in 2001 when he was 11. The transplanted kidney has now failed and he is receiving dialysis at home 3 days a week, supported by his father and carer.

7.2. Mr AB was referred to the Trust late last year as he needed a second kidney transplant. He does not have capacity to understand why he needs this surgery and he finds hospitals very stressful environments. This can manifest into more challenging behaviours such as 'pushing people away'.

7.3. In November 2020, Mr Frank Dor, consultant transplant surgeon and clinical lead for transplants, contacted the learning disabilities team to inform them of Mr AB's pending pre-assessment appointment. Mr AB was not known to the Trust before this. This enabled

the learning disabilities team to contact their peers at the referral hospital and understand more about his needs before he came to our hospital.

7.4. The consultant liaised with the multidisciplinary team to ensure that Mr AB only needed to attend one clinic appointment and to prepare the family and Mr AB for who they would meet and what would happen. Mr Dor was known as 'Dr Frank, his friend and doctor' before AB came to hospital. Mr AB's father describes Mr Dor as having 'a special power of intuition' to know that his son would cope best with a 'time-concentrated assessment'.

7.5. Mr AB's father commented that it was 'obvious how hard the whole team had worked together', everything was perfectly timed and the assessments were 'artfully conducted so as to create no anxiety or distress' for Mr AB. From the matron, arranging a quiet area in the department away from other patients, to the learning disabilities team and radiographer singing his favourite nursey rhymes, everyone worked together.

7.6. After the appointment, Mr AB's father describes 'sitting happily on a bench' with his son who according to his father, had been 'zestful, engaging with every medical professional' throughout the day.

8. Conclusion and next steps

8.1. Reasonable adjustments rely on good communication and collaboration between staff, families/ carers and the patient. Seemingly small changes or actions can support staff to make a stressful situation for a vulnerable person, more bearable.

8.2. The 'purple pathways' provide a framework to direct staff to resources such as the learning disabilities and autism team and to advise them of what reasonable adjustments they made need to consider.

8.3. This patient story highlights how working together, even when it is a complex medical case requiring input from a number of teams, can make a positive difference to patients and their families. In addition, utilising the experts such as the learning disabilities and autism team in this instance, can equip our staff with the skills to communicate and care for someone with potentially challenging behaviour.

8.4. This story will be used to model a new 'purple pathway' specifically for more complex medical cases.

Steph Harrison-White – Head of Patient Experience
Guy Young, Deputy Director – Patient Experience

4 May 2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Chief executive's report to Trust Board

Agenda item 8 and paper number 05

Executive Director: Prof, Tim Orchard, Chief executive

Purpose: For noting

Meeting date: 12 May 2021

1. Purpose

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

- Reset and recovery/acute care programme
- Covid-19 vaccination programme
- Financial performance
- CQC update
- Research and innovation
- Stakeholder engagement
- Celebrating success

2. Reset and recovery/acute care programme

2.1. As the number of patients with Covid-19 has continued to decline (54 latest), we have made good progress on resuming our planned care services and developing plans to address our waiting list backlog for non-time-critical care and to build on collaboration and improvements achieved through the pandemic. All planned care services are now operational.

2.2. We are working closely with our health and care partners across North West London, especially our three neighbouring acute NHS trusts. We think we can do more to harness our collective resources, join-up our care and reduce unwarranted variations in access and outcomes. This includes establishing a joint Acute Care Board and programme to guide and co-ordinate developments across all key operational areas, including: planned surgery, cancer care, outpatients, intensive care, urgent and emergency care and diagnostics and imaging. The Board includes the chief executives, medical directors, nursing directors and chief operating officers of the acute trusts and the chief executive and chief of staff of the integrated care system as well as two lay partners and lead directors for finance, human resources, digital and communications and engagement. Our programme's immediate focus is on making sure we step services back up in a way that prioritises clinical need and minimises the risk of Covid-19 infection while reducing our waiting times and ensuring all of our patients and local communities understand how best to access care and feel safe and secure in doing so. A first briefing on the programme is attached at Appendix 1.

2.3. In line with the relaxation of national Covid-19 restrictions, the Trust has begun to open up visiting for inpatients over and above the existing exceptions that have been in place during the pandemic. It is important that this is done in a safe and Covid-secure way. Patients will therefore be able to have one named visitor, for one hour each day. Visits are pre-booked with the wards to manage the numbers of visitors in the ward at any one time. Visitors are expected to wear face coverings at all times and to follow any PPE guidance from staff. In addition, both parents are now able to visit children at the same time and the number of relatives able to be with people at the end of life has been increased. The response to date has been largely positive from patients, their visitors and staff. The approach will continue to evolve during May as the national restrictions relax further.

3. Covid-19 vaccination programme

3.1. As of 30 April 2021, we have delivered 40,718 doses in total (23,595 first doses and 17,123 second doses) to our staff, health and social care colleagues across the sector and patients.

3.2. Considering staff designated as frontline, 89.25% have been vaccinated (first dose), this includes staff who have advised us that they have been vaccinated outside of the Trust, and those not eligible to be vaccinated; 83% of staff designated as 'frontline' who received their first dose of the vaccination have now received their second dose. National data released on 29 April shows the rate of vaccination uptake amongst all frontline health care staff in London is 90%.

3.3. We are continuing to facilitate 'vaccine hesitancy' conversations - contacting all our staff not recorded has having had their first dose of the vaccine directly by phone or email, answering questions, signposting to resources and expert advice, and booking them in for a vaccine appointment wherever possible.

3.4. We will continue to provide second doses over the coming weeks while supporting those staff who still need their first dose.

4. Financial performance

4.1. The draft accounts for the 2020/21 financial year were submitted on 27 April 2021. Final audited accounts will be presented on 15 June.

4.2. For the 2020/21 financial year the Trust has achieved a breakeven position. The Trust met the £15.8m deficit plan, with £15.8m additional funding from NHSE/I to cover lost income to bring us to breakeven. The Trust incurred costs in excess of the plan to support the pandemic which was offset by lower costs for other clinical activity.

4.3. The Trust spent 100% of its capital plan of £78.2m in-year and spent a further £7.7m on schemes funded by charity and national donations, resulting in a total capital spend of £85.9m for the year. The Trust's cash balance at the end of March was £149m driven by the funding regime for 2020/21 which included cash to repay loans and deficit funding.

4.4. The Trust is currently conducting a planning round for the first 6 months (H1) of 2021/22 following guidance received from NHSE/I at the end of March 2021, with the first draft submission to be made by our integrated care system (ICS) on 6 May 2021. The ICS has been set a financial funding envelope for H1 and is expected to live within this envelope. The Trust is working with the sector to develop an achievable plan within funding available.

5. CQC update

5.1. Since the last Board meeting, the CQC has not undertaken any further virtual assessments of Trust services and has not given any indication of virtual assessments planned for the Trust at this time.

5.2. The CQC is expected to launch its latest regulatory strategy and framework for NHS Acute Trusts in May 2021.

5.3. The Board will recall from the previous update that the Improving Care Programme Group (ICPG) was reconvening; this has now been confirmed and the ICPG re-launch for 2021/22 will take place on 24 May 2021.

6. Research and innovation

6.1. We are currently working up our stage one application for the latest National Institute for Health Research Biomedical Research Centre (NIHR BRC) open competition which is due to be submitted at the end of May. NIHR BRCs focus on high-quality early translational and experimental research, with their aim to translate scientific breakthroughs with potential to develop into new treatments, diagnostics and medical technologies for the benefit of patients, the public, and the wider health and care system. This stage one process involves the identification of research themes that will add strength to our application, and the recruitment of theme leads and, for the first time this year, co-leads.

6.2. We are also pleased to report that Professor Waljit Dhillo, consultant endocrinologist, has been appointed as the new Dean of the NIHR Academy.

6.3. Supporting our approach to innovation, in partnership with Imperial Health Charity, we have just opened our third round of the 'Innovate' programme to applicants from across the Trust who have innovative ideas and approaches to improving health and care (https://www.imperialcharity.org.uk/grants/Apply-for-funding/innovate-at-imperial).

7. Stakeholder engagement

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

- Cllr Harbi Farah, London Borough of Brent: 1 April 2021
- Healthwatch Hammersmith & Fulham: 7 April 2021
- Karen Buck MP and Andy Slaughter MP: 13 April 2021
- Hammersmith & Fulham Save our NHS with Brent Patient Voice and Ealing Save our NHS: 26 April 2021
- Adults and Public Health Policy and Scrutiny Committee, Westminster City Council: 28 April 2021
- Cllr Tim Mitchell, Westminster City Council: 13 May 2021
- Nickie Aiken MP: 18 May 2021
- Cllr Stephen Cowan and Cllr Ben Coleman , London Borough of Hammersmith & Fulham: 25 May 2021

8. Celebrating success

8.1. Congratulations to Winny Thomas, our matron for quality and Black, Asian and Minority Ethnic (BAME) nurses and midwives network chair, who has been awarded the chief nursing officer for England's gold award for nursing excellence in recognition of her lifetime of achievement in nursing. As co-founder and now chair of the Trust's BAME network, Winny has driven change ensuring there are opportunities for BAME colleagues to develop and generate platforms for them to share their work. She has

continued this work on top of her day job as our matron for quality. With her leadership a more reflective and dynamic culture of equality, diversity and inclusion has evolved at the Trust.

Professor Tim Orchard
Chief executive
6 May 2021

Appendices

Appendix 1 acute care programme briefing

April 2021

Briefing one from Chelsea and Westminster Hospital, The Hillingdon Hospitals, Imperial College Healthcare and London North West University Healthcare:
Ensuring high quality acute care as we emerge from the Covid-19 pandemic

We are really proud of the care we have provided throughout the pandemic and how much improvement we have achieved. We are now emerging from the second wave but with additional challenges – of long waiting times for planned care, exacerbated health inequalities and staff who have been working relentlessly under extreme pressure – on top of many previously existing challenges.

- Our staff have provided the best possible care for thousands of patients with Covid-19 as well as thousands more with other urgent or emergency conditions over the past year. However, like the rest of the NHS, this has meant we have had to postpone planned operations, procedures and outpatient appointments for patients with less urgent needs. Many staff have been redeployed to help care for patients with Covid-19 and we have had to introduce additional infection prevention and control measures that have limited the number of patients we can treat on site.

- We learnt a lot between waves one and two of Covid-19 and we managed to safely maintain more planned care during the second wave, while also successfully treating more Covid-19 patients. But many patients with non-urgent conditions have now been waiting for treatment or advice for a long time and this situation will get worse before it gets better as we continue to prioritise patients with the greatest clinical need and as more people are likely to seek care as we move out of the pandemic.

- Adding to that are our underlying challenges of increasing and changing health and care needs, recruitment and retention, financial pressures, poor estate and, more generally, our commitment to become more ‘user-focused’ and inclusive.

There is much to build on too, though, in terms of learning and collaboration, which is enabling us to plan and work better together to ensure high quality acute care across north west London and to restore all planned care services as quickly, fairly and safely as possible.

- We have developed a huge amount of learning from our response to the pandemic as well as much better ways of collaborating with one another and with other partners across our integrated care system.

- We think we can do more to harness our collective resources, join-up our care and reduce unwarranted variations in access and outcomes. This includes establishing a joint acute care board and programme to guide and coordinate developments across all key operational areas, including: planned surgery, cancer care, outpatients, intensive care, urgent and emergency care and diagnostics and imaging. The board includes the chief executives, medical directors, nursing directors and chief operating officers of the acute trusts and the chief executive and chief of staff of the integrated

care system as well as two lay partners and lead directors for finance, human resources, digital and communications and engagement

- As we come out of the second wave, we are beginning to restart all of our services and offer care to those on our waiting list backlog as quickly, fairly and safely as possible. We are also preparing to maintain more intensive care capacity than pre-pandemic to ensure we are able to respond quickly to a possible third Covid-19 wave or another pandemic and to help us with our waiting list backlog.

- And we want to do all of that while also ensuring our staff get the space and support to fully recuperate, the needs and views of our patients are at the core of our plans and we actively address health inequalities.

Our immediate focus is on making sure we step services back up in a way that prioritises clinical need and minimises the risk of Covid-19 infection while reducing our waiting times and ensuring all of our patients and local communities understand how best to access care and feel safe and secure in doing so.

- **The initial phase of the acute care programme, guided and co-ordinated by the acute care board, therefore includes:**

    - **Planned operations and other procedures**

      Clinical prioritisation: Our clinicians are continuing to review each of their patients to be clear about how urgently treatment is needed. We have continued to provide planned operations and other treatment for patients who we know need treatment within two weeks, either within our own hospitals or in the independent sector. This has allowed us to maintain our urgent cancer care pathways. Our clinicians are also undertaking a systematic 'harm review' to understand whether anyone waiting for care is likely to be suffering – or has suffered - any harm as a result of the delay to their treatment and to identify remedial action.

      Making waiting times fairer: There are differences in waiting times and waiting list management across different specialties and hospitals and so we are exploring the development of a single view of waits across our hospitals. This will help us develop more consistent approaches to how waiting lists are managed and, potentially, to offer patients who have been waiting a while for treatment the opportunity to transfer to a hospital with more capacity, helping to create a fairer approach to access.

      Re-starting our 'fast-track surgical hubs': Last September, as part of a wider NHS initiative, we identified 14 surgical facilities across our hospitals that could have a good degree of separation from other facilities. These facilities were then dedicated to one or more of 29 specific, routine operations (across six specialties) where evidence has demonstrated improved quality and efficiency if a surgical team undertakes high numbers of these procedures following the same process, systematically. We were then able to

offer these procedures at one of the corresponding facilities – sometimes called ‘fast-track surgical hubs’ - to patients from across our hospitals’ waiting lists, in order of clinical priority. These services had to be suspended through wave two but have now begun to restart them, with the aim to have them all running at full capacity again by the end of April.

- **Outpatient services**

  Faster access to acute and specialist advice: We’re putting in place processes to enable GPs to get advice and guidance quickly and easily from specialist colleagues in the acute trusts when needed. Evidence from our pilots indicates that up to a third of patients referred to hospital can get the care and support they need in primary care if specialist advice and guidance is available, avoiding unnecessary waits for an outpatient appointment. Improved processes are also ensuring any blood tests, imaging and other diagnostics needed to inform outpatient consultations are booked and undertaken in advance of the outpatient appointment.

  Telephone and video consultations: We had to quickly move as many outpatient consultations as possible to telephone or video during the pandemic to minimise the risk of Covid-19 infections. They have not always worked smoothly but we are continuing to build in improvements to our processes and ways of working and to find better ways of identifying and supporting patients who have difficulty in accessing care in this way. We would like to maintain high quality, virtual outpatient appointments for a significant proportion of our patients.

- **Urgent and emergency care**

  Urgent and emergency care services have been maintained throughout the pandemic, with adaptations to facilities and ways of working to keep everyone safe. An interim change was made to the urgent treatment centres at Hammersmith and Central Middlesex hospitals, to make them booked appointment only; this will be reviewed later this year.

  NHS 111 First service was introduced in December, enabling patients who need to attend A&E or an urgent treatment centre to be given a timed slot to attend. We have also expanded our ‘same day emergency care’ services. We want to raise awareness and understanding of these services, particularly to make it really clear to everyone in our local communities what to do if they need urgent or emergency care.

- **Enabling developments**

  Improving access and reducing inequalities: We are working up plans to identify and tackle issues that might make it harder for some groups within our patient or local population to get the care they need, especially where we

are introducing new ways of working. We want to look first at improvements to interpreting services.

Supporting staff health and wellbeing: We are developing major programmes of staff support within each of our trusts, including practical improvements – such as refurbishing staff spaces or providing better food options – and psychological support – such as expanded counselling services and tailored mental health resources. Across north west London, we have also introduced 'reset and recovery' days to help ensure staff get a break before they return to more 'business as usual' activities.

Improving patient administration and experience: Changes we have had to make to continue to provide safe care throughout the pandemic have meant that our patient admin processes, letters and information aren't always as clear, consistent or joined up as we would like. We are including a particular focus on our patient communications as we develop improvements to our models of care and care pathways.

On-site safety: We continue to review and improve our range of measures to keep patients, staff and (still limited) visitors safe and to minimise the risk of further Covid-19 infections. We want to anticipate changes, ensuring we keep all of our stakeholders involved and informed.

Even with all of the work underway, we will still be challenged to meet the changing health and care needs of our local communities in a way that is sustainable. So, we also want to progress more strategic improvements, involving patients and wider communities, partners and stakeholders in the development of longer term proposals now so that we don't simply return to 'normal' but draw on the expertise and energy of everyone involved to make real and lasting improvements that will serve us well for the future.

- We're working to return to at least 80 per cent of our pre-pandemic activity by June 2021 – and to continue increasing our capacity from there - which means we will be able to safely treat all urgent patients and many with less urgent needs who have been waiting a long time. But, because we expect to see more people join the waiting list as we emerge from the second Covid-19 wave, we expect our long waits to continue to climb for a while. And we will continue to see growing health and care demand generally, as a factor of population changes and new diagnostics and treatments.

- It's therefore really important that we also plan for longer-term, more strategic and sustainable improvements. We want to work with patients and wider stakeholders, drawing on evidenced best-practice and deeper collaboration, to build further on improvements to models of care and care pathways.

- We had to make some interim changes to our services and ways of working during the height of the pandemic with little patient or stakeholder involvement, though we have considered wider patient impact as part of those decisions. We are committed

to involving patients and wider communities, as well as our partners and stakeholders, in the development of longer term proposals now so that we don't simply return to 'normal' but draw on the expertise and energy of everyone involved to make real and lasting improvements that will serve us well for the future.

Key facts

1 We increased our **intensive care capacity** from a baseline of around 147 beds to up to 289 beds at the peak of the pandemic.

2 A the end of January 2021, 40,298 patients had been **waiting for treatment**, from referral, for over 18 weeks - 5,737 of them over 52 weeks. This compares with 36,805 and 20, respectively, in January 2020.

3 In January 2021, the proportion of patients receiving their first definitive **treatment for cancer** within 62 days of an urgent GP referral was 73.8%. This compares with 82.0% in January 2020% and the national standard of 85%.

4 In January 2021, the proportion of patients **waiting for a diagnostic test** for six weeks or more was 20%. This compares with 0.7% in January 2020 and the national standard of 1 per cent.

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Integrated business plan for 2021-22

Agenda item 9 and paper number 06

Lead Executive Directors and Authors:
Bob Klaber, Director of strategy, research & innovation
Jazz Thind, Chief Finance Officer
Claire Hook, Director of operational performance
Kevin Croft, Director of people & OD

Purpose: For approval

Meeting date: 12 May 2021

Executive summary

1. Purpose

This report seeks to provide the Trust Board with an update on our integrated business planning process and outputs as of 5th May 2021 and to agree the governance arrangements that will oversee the Trust's plan submission to be included in the NWL ICS final submission on the 3rd June 2021.

2. Background

The 2021/22 national priorities and operational planning guidance set out the priorities for the year ahead, against a backdrop of the challenge to restore services, meet new care demands and reduce the care back logs that are a direct consequence of the pandemic, whilst supporting staff recovery and taking further steps to address inequalities in access, experience and outcomes. These priorities strongly align with the strategic direction of the Trust, and the priority areas of work set out in the March 2021 Trust Board strategy update paper. National planning guidance issued on the 25th March 2021 set the approach to the 2021/22 planning round and included:-

- 2021/22 priorities and operational planning guidance
- 2021/22 priorities and operational planning guidance: Implementation guidance
- Guidance on finance and contracting arrangements for H1 2021/22

Effective partnership working across systems is deemed critical with the financial framework arrangements designed to support a system-based approach to funding and integrated business planning. The Trust plan will form part of the overall North West London Health and Care Partnership Integrated Care System (NWL ICS) plan which will include all NHS providers and commissioners in North West London with final submission due on the 3rd June. This takes account of both national and local reporting timelines and

ensures the work required is undertaken in a timely manner and signed off as appropriate before final submission.

3. Next steps

3.1. The Executive will continue to review and refine the plan with a view to formulating a final position by 19th May 2021. This will include:

- re-reviewing all proposed cost pressures to ensure only those that are unavoidable are approved for inclusion in final plan;
- continuing to undertake negotiations with the NWL ICS team regarding funding for the gap identified to date;
- identifying, as a matter of urgency, appropriate plans to deliver the current efficiency requirement and being prepared to go beyond this level should the NWL ICS mandate a break-even position;
- reviewing the capital pipeline plans to prioritise these against the yet 'to be allocated' pot
- submitting funding requests against the NWL ICS held resources specifically designated for system transformation programmes;
- reviewing the current activity assumptions and trajectories and the associated workforce and financial impacts to achieve as much as possible for our patients.

4. Recommendation

The Board is asked to approve the next steps of the development of our integrated business plan, and to approve the current draft financial plan of a deficit of £6.6m.

5. Impact assessment

5.1 **Quality impact:** This integrated business planning work has a key impact on quality, which will remain the defining outcome of the work that we are prioritising.
5.2. **Financial impact:** Deficit plan leads to the need for further identification of cash releasing efficiencies over and above the unmitigated gap against the 2.3%
5.3. **Workforce impact:** Recognising the direct impact of the last year, three of our main programmes have a direct impact on maintaining a sustainable workforce and improving the health and well-being of staff.
5.4. **Equality impact:** Both through the specific focus on equality, diversity and inclusion, and in recognising equity as one of the defining components of quality, we intend our priority programmes to have an important impact on improving equality.
5.5. **Risk impact**: No new risks arising from these priorities.

Main report

6. Activity and operational performance

Recognising that the pandemic has had a significant impact on the delivery of elective care and, as a result, on the lives of many patients who are waiting for treatment, it

encourages Integrated Care Systems to be ambitious and plan to recover towards previous levels of activity and beyond where achievable. Systems are asked to plan for the highest possible level of activity whilst also being required to meet a minimum threshold level set against a baseline value of all elective activity delivered in 2019/20. For April 2021 the threshold is set at 70% of pre-pandemic activity, rising by 5 percentage points in subsequent months to 85% from July. Other key assumptions include: no specific performance requirements except cancer 63 day backlog and new faster diagnostic standard by Q3; non-elective admissions are at 100% of pre-pandemic activity; general and acute beds occupied by patients with Covid will remain at less than 5%; and 25% of all outpatient consultations are conducted via virtual clinics. Our Trust, and the NWL ICS as a whole, is planning on the basis that it can meet the activity requirements within the resources available.

In addition, the Government has made further funding available to allow systems to step activity back up more quickly and those systems that achieve activity levels above the set thresholds will potentially be able to draw down from the additional £1bn Elective Recovery Fund (ERF) for 2021/22. Work is already underway to identify opportunities to exceed the minimum requirements, as well as to understand the impact on the waiting list backlog and operational performance trajectories across the NWL ICS. As at the end April 2021, all Trust services had resumed business as usual activities and critical care had returned to the baseline bed base, albeit with a high level of occupancy, hence we are well placed to increase elective and outpatient activity. Indicative analysis suggests that we will exceed the minimum activity threshold in April 2021 and have significant scope to continue to do so during May, June and July 2021. Activity and performance trajectories will be finalised during May and embedded within the integrated performance scorecard for ongoing monitoring.

We have already submitted a draft 52 week wait recovery trajectory. It is expected that the total number of patients waiting more than 52 weeks will peak in July 2021, reducing to 890 patients in March 2022, although this position may improve if we are able to further exceed planned levels of activity. We are also planning on the basis that attendances to the emergency department and non-elective admissions will return to 100% of the baseline level by September 2021.

7. Financial Plan

Income and Expenditure: To date, planning guidance only covers the first six months of the financial year April-September 2021 (H1). Sectors have been given financial envelopes similar to H2 of 2020/21 and are expected to breakeven within that. Provider envelopes are based on quarter 3 20/21 actuals, and NWL ICS requires that all providers within the sector achieve a breakeven position for H1, with the previously agreed block contract funding arrangements for the second half of 20/21 remaining in place for this initial planning period.

This breakeven expectation is based upon a number of high-level sector wide assumptions, including that activity trajectories are achievable within the financial envelope; a minimum of 2% efficiency is delivered; no new cost pressures are introduced, and that non-NHS income should return to 2019/20 levels from quarter 2 2021/22.

Having considered all of the agreed assumptions, the Trust financial modelling delivers a break even plan excluding loss of non-NHS income (where recovery against the sector assumption is not deemed achievable) and costs associated with two system wide business cases (where funding negotiation is required), which together drive a £6.6m deficit positon. The plan is underpinned by the need to deliver an increased efficiency target of 2.3% (£15.8m); with the additional stretch of 0.3% required to mitigate agreed unavoidable cost pressures. Work is on-going to: identify sufficient appropriate schemes to fully close the current unmitigated efficiency gap for the first half of the year; forward plan any further efficiencies required for the second half, and put forward proposals should the Trust be mandated to deliver a breakeven plan. The current position does not take account of the cost response or additional income associated with the Trust exceeding the minimum operational delivery requirements (including reduction in waiting list backlogs and operational performance trajectories), these will be modelled and reflected in the next iteration of the plan. Any additional income available from the ERF would provide non-recurrent support to the plan. As was the case in 2020/21, there is no requirement for signed contracts.

Capital: For the financial year 2021/22, the NWL ICS was allocated £233m of national capital funding to distribute to its constituent organisations. The Trust's share of this equates to £52.4m, which aligns with the internal assessment of the sources of funds available for capital investment. As in previous years, to ensure affordability is maintained, the Trust undertook a prioritisation exercise that ultimately resulted in the immediate work programme focussing on patient safety, staff safety and care improvement. The Trust will be submitting funding requests against the sector held resources specifically designated for system transformation programmes, with any approved scheme increasing the Trust Capital Resource Limit by an equal amount. It is assumed however that the Trust will need to provide internal cash funding to support these investments. The Trust income and expenditure plan currently allows for £2,5m (£5m FYE) of capital plan related revenue impact in 2021/22. A pipeline of key programmes has been identified to ensure the Trust is clear on, and ready to make the best use of, all funding opportunities as they arise e.g. slippage in main programme, access to new funding pots etc.

A rolling programme of capital investment has been kick started to allow the Trust to establish as a minimum a 3 year capital planning cycle. This will allow longer term and more costly programmes of work to be incorporated into future planning and ensure a clear and robust prioritisation ahead of time. This is particularly critical as the Trust moves into a period where consideration must be given to enabling the work required for the redevelopment, particularly looking to technological advances and maintenance as enablers for schemes across all sites.

8. Workforce

People priorities have been identified which align with the national and North West London people plan but predominantly driven by local priorities and staff survey feedback. The priorities are all being managed as improvement programmes with project charters which include metrics, delivery plans and clear governance arrangements. Three of our people priorities have been further prioritised as Trust-wide high priority programmes (in bold below):-

- **Equality, diversity and inclusion**
- **Health and well-being**
- **Immediate manager development**
- Developing a sustainable workforce
- Remote, flexible and agile working
- Values, behaviours and managing conflict
- North West London working

Workforce is additionally an integral part of the financial and cost improvement plan with the initial focus on temporary staffing price and volume control as well as recruitment into vacancy hotspots that drive high cost agency usage. This is reflected in the workforce part of the Trust's operating plan submission.

9. Risks and mitigation

As set out above, the plan is underpinned by a range of key assumptions and, given they are just that, they contain some key risks. The below sets out the key actions that the Trust needs to take forward with the NWL ICS to ensure the Trust plan represents and is aligned with the agreements reached :-

- NWL ICS CFOs and COOs to agree the process of allocating funding, even if the sector as a whole does not manage to deliver the trajectories in the final plan submission;
- Agree with the ICS how any significant increase in referrals is dealt with in the context of already long waiting lists;
- Agree how we continue to support the health and wellbeing of our staff and ensure they are able to achieve the recovery trajectories;
- Given the Trust plan sits within the ICS operating plan, the next iteration and submission thereof may need to be revised to reflect regional/national feedback.

10. Our priorities for the year ahead

The March 2021 Board strategy update paper described the strategic context we are operating in and articulated our initial thinking on the core priorities for the year ahead. This integrated business plan gives the operational, financial and workforce underpinning to these core priorities which are to:

1) Ensure all our patients who are waiting for acute and specialist care get the advice, guidance and/or treatments/operations they need as quickly as possible
2) Build a sustainable workforce – through improvements in: health and wellbeing;, recruitment; equality, diversity and inclusion; career pathways and retention
3) Advance our plans to redevelop our estate across each of our sites

And across our work on each of these core priorities, we will ensure that we:

- Proactively and collaboratively, play our full part in developing our NWL ICS, specifically through the Acute care programme
- Continue to place quality as the defining outcome of our work (Quality meaning: safe, effective, caring, responsive, well-led, good use of resources, equitable)

- Have a strong user focus, including through significant involvement and engagement with patients, staff and local communities

Focusing on these three cross-cutting approaches across all of our work will significantly strengthen our response to the new Care Quality Commission (CQC) strategy. We will use the routines and rigour of the Imperial Management and Improvement System (IMIS) as our operational mechanism to deliver these core priorities.

11. Conclusion

The Trust plan is an integrated document that takes account of our key priorities and operational delivery requirements, as well as the financial envelope within which we will need to deliver them. This remains a work in progress with a number of clear next steps, as set out above, to achieve its conclusion.

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TRUST BOARD (PUBLIC)

Paper title: Integrated quality and performance report - month 12 (March 2021 data)

Agenda item 10 and paper number 07

Executive Director: Claire Hook (Director of Operational Performance)
Author: Submitted by Performance Support Team

Purpose: For discussion

Meeting date: Wednesday 12 May 2021

Executive summary

1. Purpose

1.1. This paper presents the integrated quality and performance report for month 12, summarising performance against the key metrics.

2. Background

2.1. The enclosed scorecard presents the Board metrics covering the Trust's strategic goals, priority programmes and focussed improvements. The scorecard is for data published at month 12 (March 2021).

2.2. Five countermeasure summaries (CMS) are enclosed:

- CMS 1: Incident reporting rate
- CMS 2: Patients waiting over 52 weeks for treatment
- CMS 3: Cancer waiting times 62-day performance
- CMS 4: Ambulance handovers
- CMS 5: Long length of stay

3. Key findings

3.1. A summary of performance headlines is provided in the main section below.

4. Recommendation(s)

4.1. The Committee members are asked to note this report.

5. Impact assessment

5.1. Quality impact: This report highlights areas where there may be a risk or potential issues to the delivery quality of care and operational performance. Improvement plans are monitored through the Executive Management Board and its subgroups and the Board committees.

5.2. Financial impact: N/A

5.3. Workforce impact: N/A

5.4. Equality impact: N/A

5.5. Risk impact: The plans in place should help mitigate risks associated with delivery of performance against the metrics.

Main paper

6. Update on proposed changes for reporting in 2021/22

6.1. The Board are asked to note that from next month key metrics from the NHS operational planning guidance for 2021/22 will be added to the Board scorecard with a small number of existing metrics removed. Further metrics will also be added in-year from the internal review of priority programmes and projects.

7. Month 12 performance

Referral to Treatment

7.1. Between March and May 2020 the overall size of the Referral to Treatment (RTT) waiting list fell by 20% as referrals dropped off due to the impact of the pandemic. In March 2021, the waiting list closed at 62,763 patient pathways which was the largest monthly increase since July 2020 when referrals started to increase. The March 2021 upturn also returned the overall size of the waiting list to pre-Covid levels (February 2020 was 62,933 patient pathways).

7.2. At the end of March 2021, 2,374 patients were waiting over 52 weeks for their treatment (+96 on the previous month). In February 2020 there was one patient waiting over 52 weeks. The patterns in the elective care waiting list and rise in long waiters are in step with the other North West London Trusts.

7.3. All long waiters are treated in line with their clinical prioritisation outcome and agreed timescales. The majority of over 52 week waiters have been prioritised according to the national priority 4.

7.4. NHS England and NHS Improvement published the priorities and operational planning guidance for 2021/22 on 25 March 2021. Trajectories for the Trust are being produced as part of the North West London system-wide activity and performance planning submission. The Trust has submitted its draft 52 week wait recovery trajectory. It is expected that the total number of patients waiting more than 52 weeks will peak in July 2021, reducing to circa 890 patients in March 2022. As at end April 2021, all services have resumed business as usual activities and critical care has returned to the baseline bed base.

Diagnostics

7.5. The Trust reported an improvement in diagnostics waiting times, with 38.8% of patients waiting more than 6 weeks for their diagnostic test at end of March 2021 (from 47%

the previous month). The total waiting list size continued to increase in line with the expected increased demand as services resume.

Cancer waiting times

7.6. Due to the lag in the national reporting timelines for cancer waiting times, data for February 2021 are reported in April 2021. The Trust delivered 7 of the 8 national standards in February. The 62-day GP referral to first treatment performance was 73.0% against the 85% standard.

7.7. The 104+ day totals plateaued during the second wave but have started to reduce again. Significant improvements in the colorectal backlog are expected during April 2021. As part of the planning guidance for 2021/22, three trajectories for cancer have been submitted:

- Pathways of 63 days or more (backlog)
- 2 week wait referral volumes
- First treatment volumes

Urgent and Emergency care

7.8. The Trust's Ambulance handover performance (within 30 minutes) improved by 0.9% in March to 96.0%. The Ambulance handover delays over 60 minutes continued to recover and no breaches were reported for March.

7.9. The number of patients waiting over 12 hours from decision to admit to admission remained stable with 8 breaches reported, all relating mental health pathways.

7.10. The performance of long length of stay improved in March 2021 with an average of 180 patients with a long length of stay of 21 days or more.

Quality – safe and effective

7.11. The Trust incident reporting rate (per 1,000 bed days) for March is 50.48 with numbers of incidents being reported increasing across two of the three clinical divisions compared to last month.

7.12. Three never events occurred in March 2021 (one of these was not reported until April, but is summarised here for information). These have all had after action reviews (AAR) completed; the root causes of each appear to include human factors but this will be confirmed once the investigations are complete. The incidents were two wrong route medications in the intensive care units and a retained central venous catheter guidewire (Theatres). Immediate actions have been taken to support staff and to remind teams of the safety interventions to reduce risks of these occurring.

7.13. One CPE BSI was reported in March 2021 which related to a patient, who was transferred here from another hospital, and was confirmed as CPE colonised via admission swabs. This patient was subsequently confirmed as bacteraemic, 72 hours post admission.

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7.14. Three MRSA BSI cases were reported in Quarter 4 2020/21, two of which were in intensive care. This is an increase compared to previous years. The outcomes of the investigations of these cases is being reviewed and actions implemented in response.

7.15. Overall the Trust has seen a reduction in number of cases Trust attributed C. difficile infections, with 59 reported for the full financial year 2020/21 against a target of 77. Trust attributed E. Coli bloodstream infections reduced by 18% across 2020/21 and met the trust improvement target.

Appendices:

Appendix 1 Integrated quality and performance scorecard – month 12
Appendix 2 Countermeasure summaries

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Integrated quality and performance scorecard - Board version

Imperial Management and Improvement System (IMIS)

FI = Focussed improvement

M12 - March 2021

	FI	Metric	Watch or Driver	Target / threshol	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Reporting rules	SPC variation
To develop a sustainable portfolio of outstanding services																			
Quality safety improvement	FI	Patient safety incident reporting rate per 1,000 bed days	Driver	>=54.9	54.17	48.62	50.52	52.91	58.60	51.75	54.35	55.43	61.59	62.22	50.68	47.60	50.48	CMS	-
		Trust-attributed MRSA BSI	Watch	0	0	0	0	0	1	0	0	0	0	1	2	1	0	-	-
		Trust-attributed C. difficile	Watch	5	6	8	6	3	1	2	11	4	5	0	4	8	7	Note performance / SVU if statutory	-
		E. coli BSI	Watch	7	3	2	5	5	6	4	3	8	3	6	7	5	6	-	-
		CPE BSI	Watch	0	0	0	1	0	0	0	0	1	0	0	1	1	1	Note performance / SVU if statutory	-
		% of incidents causing moderate and above harm (rolling 12 months)	Driver	<2.13%	1.35%	1.36%	1.50%	1.56%	1.57%	1.57%	1.49%	1.50%	1.51%	1.48%	1.46%	1.50%	1.64%	Promote to Watch	-
		Hospital Standardised Mortality Ratio (HSMR) (rolling 12 months)	Watch	<100	65	66	63	73	87	71	69	58	76	71	65	67	71	-	-
		Formal complaints	Watch	<=100	67	32	53	56	60	51	71	76	68	55	66	74	95	-	-
Response and Recovery		RTT waiting list size	Watch	-	59,324	53,774	50,570	50,550	52,270	54,924	55,225	55,790	57,226	57,699	57,334	57,991	62,763	-	SC
		RTT 52 week wait breaches	Driver	830	10	90	258	533	834	1072	1259	1160	990	1,050	1,667	2,278	2,374	CMS	SC
		Diagnostics waiting times	Watch	<=1.0%	8.50%	66.6%	65.7%	67.4%	56.3%	50.7%	40.5%	32.9%	29.6%	26.8%	50.5%	47.7%	38.8%	Note performance / SVU if Statutory	CC
		Cancer 2 week wait	Watch	>=93%	89.1%	92.9%	96.4%	93.6%	86.8%	85.1%	83.5%	94.3%	88.8%	95.8%	94.1%	95.3%	-	-	CC
		Cancer 62 day wait	Driver	>=85%	86.1%	85.0%	75.9%	69.9%	72.1%	76.4%	72.3%	71.4%	73.4%	76.8%	77.3%	73.0%	-	CMS	CC
		Ambulance handovers - % within 30 minutes	Driver	98%	84.4%	87.7%	92.6%	92.9%	95.6%	94.3%	95.7%	95.6%	97.1%	88.8%	89.5%	95.1%	96.0%	CMS	CC
		Ambulance handovers - number of delays over 60 minutes	Watch	0	6	0	0	0	0	0	0	0	2	21	11	4	0	-	-
		Patients waiting >12 hours from decision to admit to admission	Watch	0	135	39	5	7	13	7	11	23	18	61	94	8	8	Note performance / SVU if statutory	CC
	FI	Long length of stay - 21 days or more	Driver	<=142	191	131	143	127	131	129	145	154	165	166	165	210	180	CMS	CC
		Bed occupancy	Watch	<=90%	68.6%	51.5%	49.6%	58.3%	62.3%	64.5%	71.7%	75.4%	74.1%	74.6%	78.4%	75.4%	74.2%	-	-

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Integrated quality and performance scorecard - Board version

Imperial Management and Improvement System (IMIS)

FI = Focussed improvement

M12 - March 2021

	FI	Metric	Watch or Driver	Target / threshol	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Reporting rules	SPC variation
Safe and Sustainable Staffing	FI	Vacancy rate	Watch	<10%	8.9%	8.4%	7.1%	7.1%	8.2%	8.5%	9.5%	9.7%	9.8%	10.0%	9.8%	9.8%	9.9%	-	-
		Agency expenditure as % of pay	Driver	tbc	-	1.0%	1.2%	1.1%	1.3%	1.1%	1.4%	1.6%	1.6%	2.3%	1.8%	2.7%	2.4%	-	-
		Staff Sickness (rolling 12 month)	Driver	<=3%	3.70%	4.17%	4.30%	4.32%	4.33%	4.36%	4.39%	4.39%	4.39%	4.43%	4.50%	4.54%	4.18%	CMS	-
		Staff turnover (rolling 12 months)	Watch	<12%	12.1%	11.0%	11.8%	11.1%	11.1%	11.1%	11.0%	10.9%	10.8%	10.7%	10.1%	9.9%	9.8%	-	-
Finance		Year to Date position (variance to plan) £m	Watch	£0	-1.47	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	10.27	17.15	-	-
		Forecast variance to plan	Watch	£0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		CIP variance to plan	Watch		75.7%	-	-	-	-	-	-	-	-	-	-	-	-	-	-
To build learning, improvement and innovation into everything we do																			
		Core skills training	Watch	>=90%	94.0%	94.0%	94.5%	94.6%	89.8%	91.8%	92.4%	92.0%	91.6%	91.8%	91.6%	91.5%	92.2%	-	-

Abbreviations

MRSA BSI - Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infection (BSI)
E. coli BSI - Escherichia coli (E. coli) bloodstream infection (BSI)
CPE BSI - Carbapenemase-Producing Enterobacteriaceae (CPE) bloodstream Infection (BSI)

Reporting rules
CMS - Countermeasure summary
SVU - Structured verbal update

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Appendix 2 of the Integrated quality and performance report - Countermeasure summaries

Month 12 (March 2021 data)

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Contents

Five countermeasure summaries are enclosed:

- CMS 1: Incident reporting rate
- CMS 2: Patients waiting over 52 weeks for treatment
- CMS 3: Cancer waiting times 62-day performance
- CMS 4: Ambulance handovers
- CMS 5: Long length of stay

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CMS 1
Improving our incident reporting rate

Countermeasure summary: Improving our incident reporting rate

Problem Statement:

- Incident reporting is one of the most important sources of patient safety information, helping us to identify risks to patients and staff. High rates of incident reporting enable us to identify with more accuracy actual or potential harm; analysing this data alongside other sources of intelligence, helps us to learn and continuously improve. We believe that high rates of incident reporting is an important measure of how we are embedding our values and behaviours, supporting staff to be open and to report.
- Pre-pandemic, the numbers of incidents we reported were variable and during the first surge in spring 2020 reporting dropped across all divisions.
- We have also seen a decrease in the number of incidents reported during the most recent surge, however the numbers overall have remained higher this time.
- The decrease over the last 3 months can be partly attributed to the impact of the pandemic, and to the changes in activity as a result, however we have more work to do to improve how we report incidents and sustain a high reporting rate.
- Our rate per 100 WTE (whole time equivalent) is 13.85 for March, which is a slight improvement compared to last month (13.47), although low compared to pre-surge rates. Our patient safety incident reporting rate per 1,000 bed days is also below our top quartile target at 50.48 (compared to 47.60 in February).

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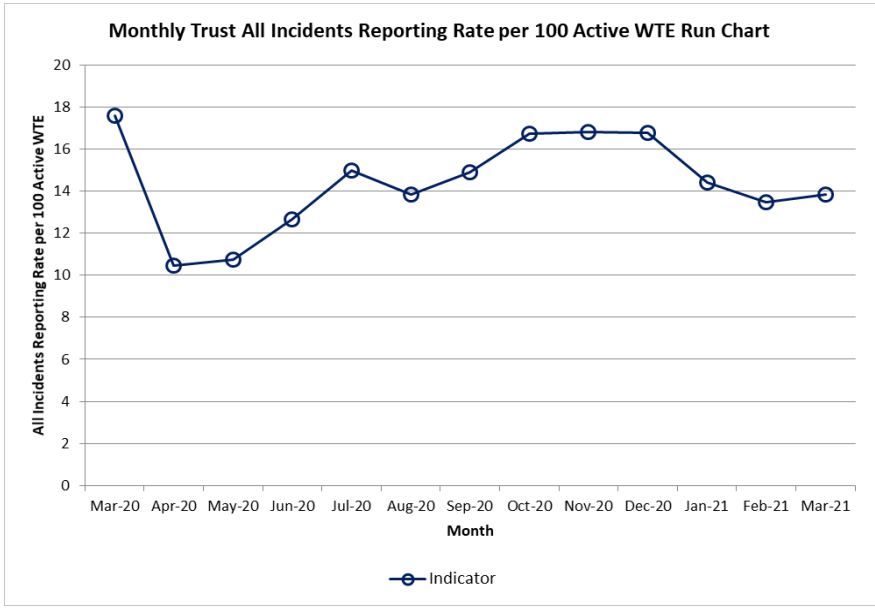
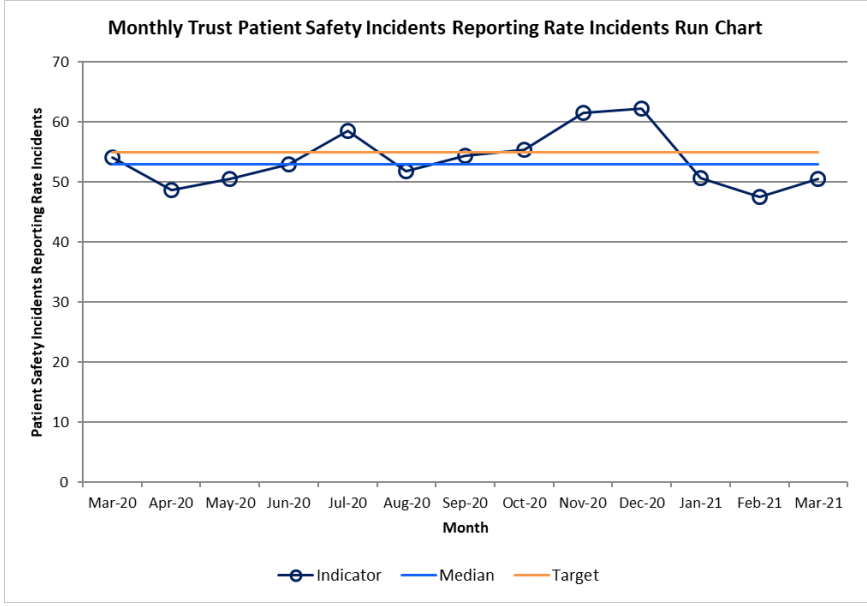
Metric Owner: Shona Maxwell, chief of staff
Metric: Incident reporting rate

Desired Trend: ⬆

Historical performance:





Countermeasure summary: Improving our incident reporting rate

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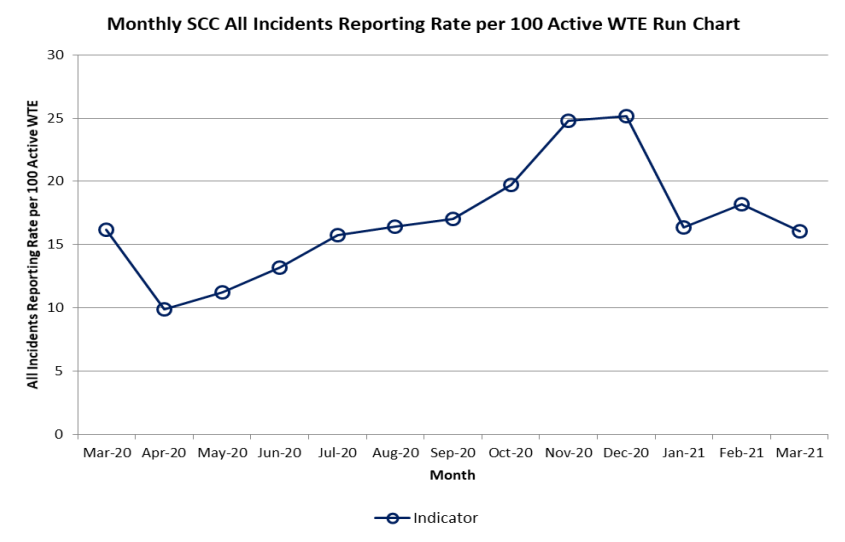
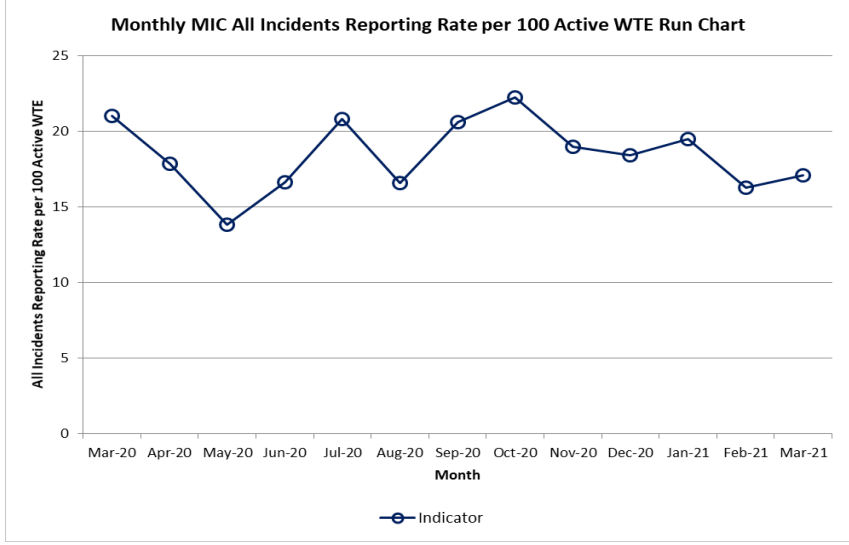
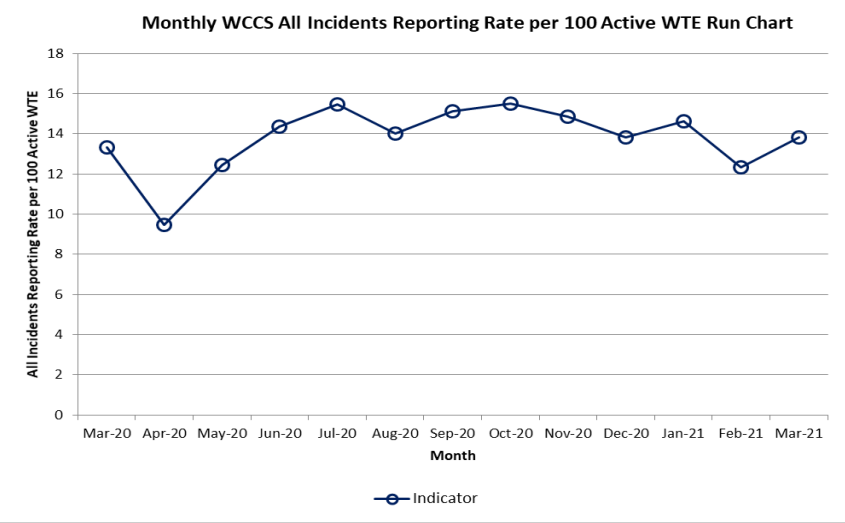
Stratified Data:







- The graphs show the incident reporting rate per 100 WTE for each of the main clinical divisions, showing dips that coincide with the pandemic surges, although the impact has been much less this surge, compared to spring 2020.
- All divisions have seen an increase in reporting rates and in the numbers of incidents reported compared to last month, except for Surgery, Cancer & Cardiovascular (SCC) which saw a small decrease (564 reported in March compared to 638 in February).
- The biggest decreases in March 2021 were in critical care and in the number of pressure ulcers reported, which is consistent with the changes in activity leading up to the end of the current surge.

Countermeasure summary: Improving our incident reporting rate

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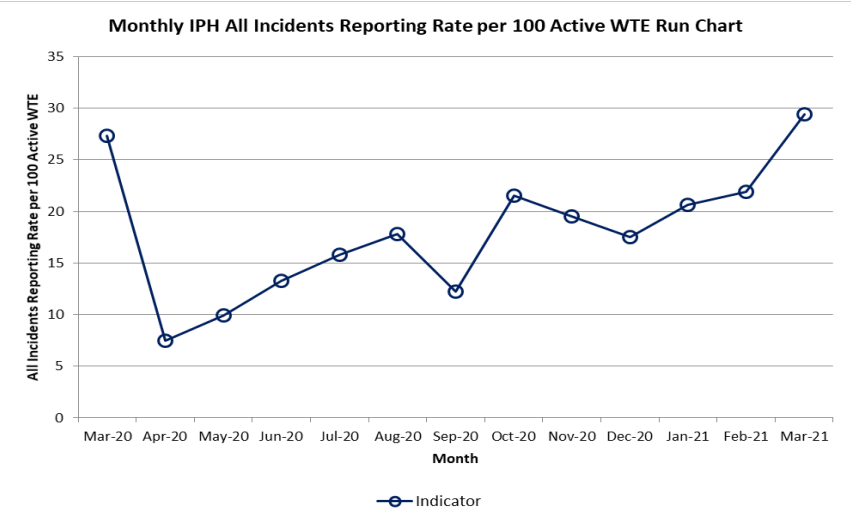
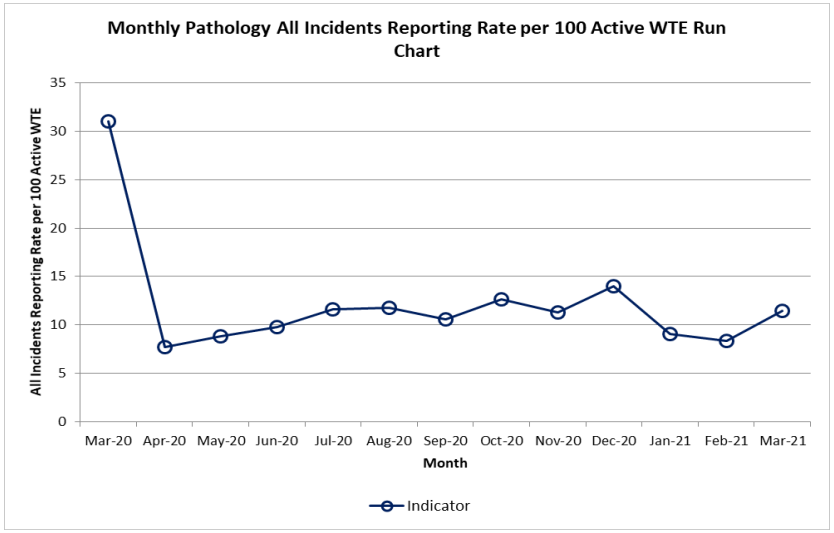
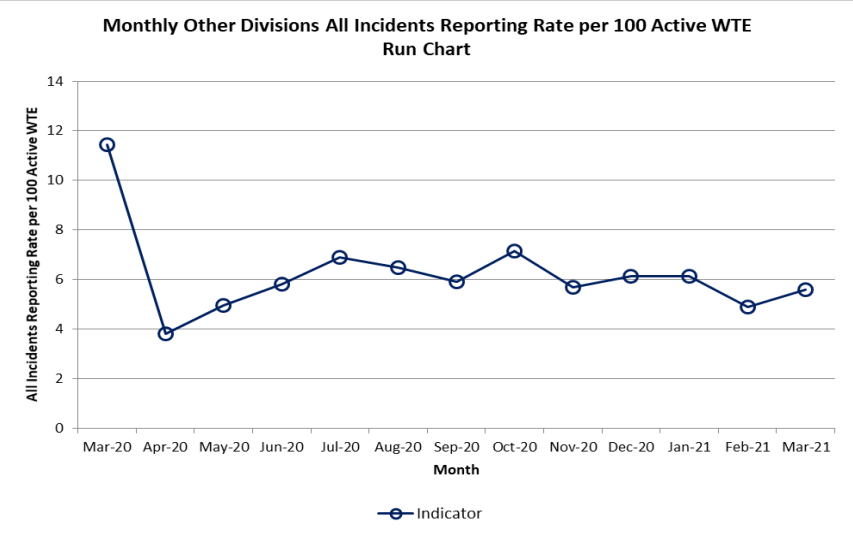
Stratified Data:







The reporting rates for Imperial Private Health, North West London Pathology and corporate areas (‘other divisions’) show dips which coincide with the first surge of the pandemic. In addition, the bringing in house of hotel services in April 2020 increased the number of active WTE in Estates and Facilities (captured in ‘other divisions’) and in IPH, which has affected their reporting rate since. The latest surge seems to have had minimal impact on reporting rates for these areas.

Countermeasure summary: Improving our incident reporting rate

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Top Contributors:

EXHIBIT 1: Barriers and facilitators to incident reporting[1] https://www.imperial.ac.uk/media/imperial-college/institute-of-global-health-innovation/IMPJ4219-NRLS-report_010316-INTS-WEB.pdf

In 2019, a pilot of incident reporting improvement projects commenced in 3 wards in surgery, cancer and cardiovascular sciences identified as some of the lowest reporting (ranked by total number of incidents by ward by month). Ward teams were asked to review their barriers and enablers to incident reporting using those set out in the research literature. This then formed the basis of local improvement plans.

In the pilot wards, these included frontline staff 'owning' their data, reporting cultures amongst professional groups, leadership for reporting, education & training, locally held beliefs around the utility of incident reporting, feedback and genuine commitment to learn from incidents. The key findings of the pilot were the importance of local ownership and the culture within teams.

This pilot reported to quality and safety sub-group in November 2019. There were small but significant increases in incident reporting in the three pilot wards. If this was replicated at scale, it may have the potential to impact on overall reporting rates Trust wide, with most impact in those areas that currently under-report.

The findings of the pilot helped develop the programme and driver diagram for the trust's focused improvement. A trustwide programme of work is underway including a re-tendering of Datix (our incident reporting system), and the divisions have action plans in place. However the focused improvement work to implement local huddles focusing on incident reporting and learning had not started before the recent surge and was then put on hold. We plan to restart this with the other IMIS focused improvements in the summer.

Countermeasure summary: Improving our incident reporting rate

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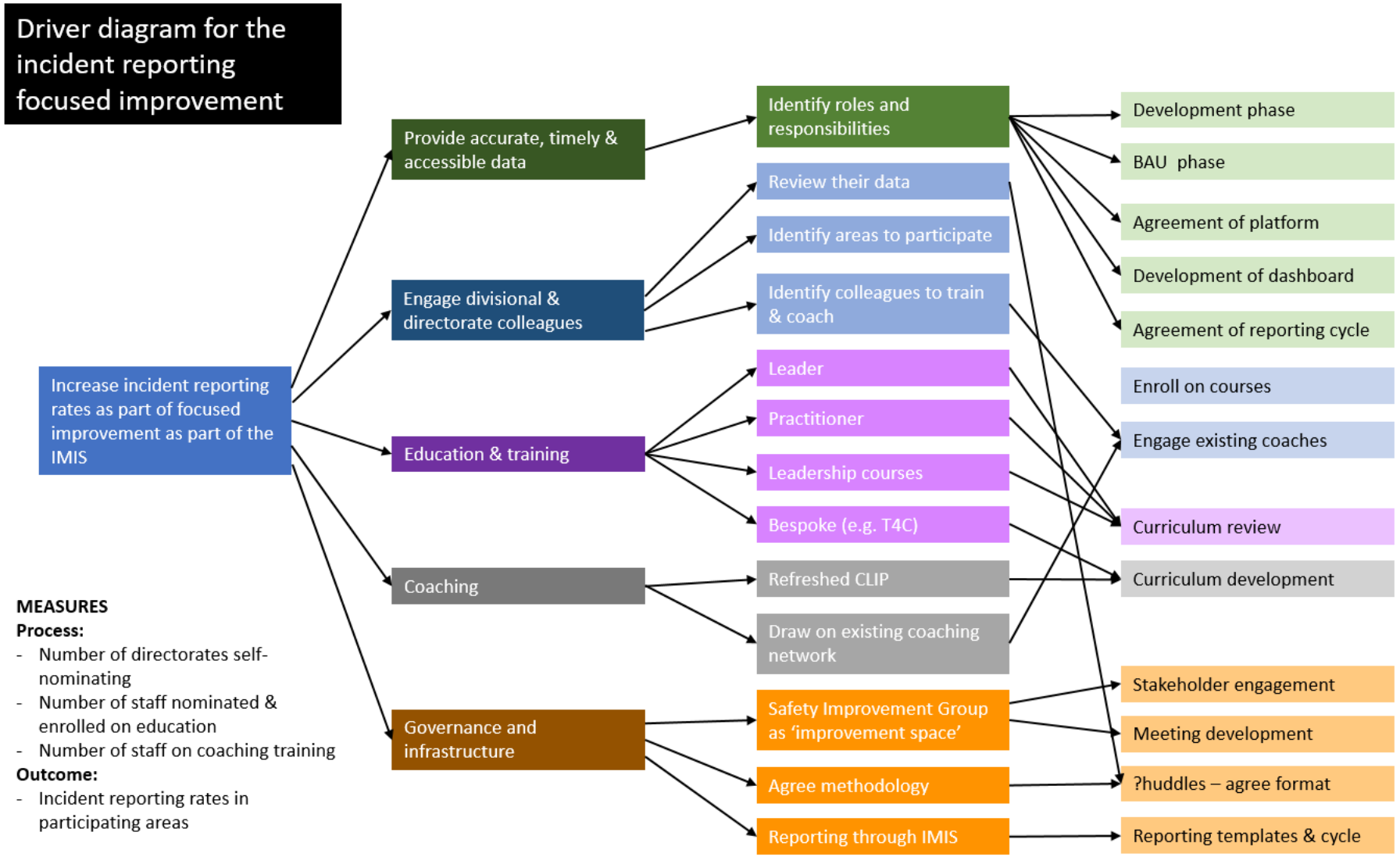
Overall programme driver diagram:



Countermeasure summary: Improving our incident reporting rate

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30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Data visualisation – data is not easy to access from Datix in a visually meaningful way to support local use e.g. in huddles	• Datix functionality does not support visual data usage.	• Business case to retender for a Digital Incident and Risk Management system will be finalised and submitted to execs for approval in Q2. • Launch dashboards in Qliksense to help make data more available to frontline teams (currently under development).	Head of quality compliance and assurance Data & Intelligence Hub / Business Intelligence	Q2 2021 Summer 2021
Local data comparisons – comparison data uses bed days which is not widely applied at local level making comparison difficult.	• Bed day data at local level has not historically been applied to incident data in a meaningful way.	• Review of options for calculating incident reporting rates complete. Agreement to use active WTE confirmed at EMB quality group in November. This data is now in the quality scorecard. Target agreed at the EMB quality group in December. Original date to meet the target was end of September to coincide with the impact of the improvement work planned for early 2021/22 which has been delayed. Target will be reviewed and confirmed at next EMB quality group meeting.	DiHub / Divisional Directors of Nursing and Divisional Directors of Governance	May 2021

Countermeasure summary: Improving our incident reporting rate

Imperial College Healthcare NHS Trust

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Divisional/directorate engagement	• Incident reporting is a focused improvement as part of the management system. This is a new way of working and plans to take this forward are still in development within the divisions.	• Divisional action plans in place and monitored through Executive Management Board (EMB) quality group. • Communications regarding the trust strategy and strategic priorities (including the focused improvements) developed through the IMIS programme board.	Divisional Directors of Nursing and Divisional Directors of Governance Director of communications	Ongoing Summer 2021
Local clinical engagement – both the research literature and our pilot to improve incident reporting show that the majority of barriers and enablers to incident reporting are local. In order to be successful, improvement plans need to be developed and progressed locally	• Identification of local areas to focus on improving incident reporting not yet complete and although it was suggested that we target low reporting areas, we have not had agreement to this from the divisions.	• Agree the focus areas for 2021/22 with the divisions through business planning. • Coaching programme redesigned to support virtual delivery. It will be ready to launch in summer 2021. Divisions are asked to nominate staff to take part.	Divisional Directors of Nursing and Divisional Directors of Governance	Summer 2021

Countermeasure summary: Improving our incident reporting rate

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30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Negative perception of incident reporting – staff have reported a number of barriers and that they do not see Datix as a tool for improvement.	• Messaging regarding the importance of incident reporting not reaching frontline staff	• Communications regarding the trust strategy and strategic priorities (including the focused improvements) developed through the IMIS programme board.	Improvement team / Communications	Summer 2021
		• Small project launching in collaboration with behavioural insight experts at the PSTRC to look at techniques to improve incident reporting and look at influencing behaviour to improve patient safety with junior doctors.	Improvement team	May 2021
		• Implementation of new model to manage SIs, moving away from current investigation process towards using after action review (AAR) following a successful pilot. Now in place for all newly declared SIs as appropriate.	Head of quality compliance and assurance	Complete

Countermeasure summary: Improving our incident reporting rate

Imperial College Healthcare NHS Trust

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Potential under-reporting of near miss/low harm incidents – Anecdotal evidence suggests that staff feel too busy to report, which was exacerbated by COVID-19, and therefore de-prioritise reporting of near miss/low harm incidents.	• Perceived amount of time taken to complete incident reports	• Review of alternatives to Datix system including possible incident reporting app (this will be part of the re-tendering process) • Plan to develop automatic reporting from CERNER alongside implementation of a new incident reporting system (following re-tendering). This will be developed throughout 2021/22. Key themes where this would be possible include pressure ulcers, PPID, PPH and falls.	Head of quality compliance and assurance Office of the medical director with chief clinical information officer	March 2021 March 2022

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CMS 2
Patients waiting over 52 weeks for treatment

Countermeasure Summary: RTT 52 week waits

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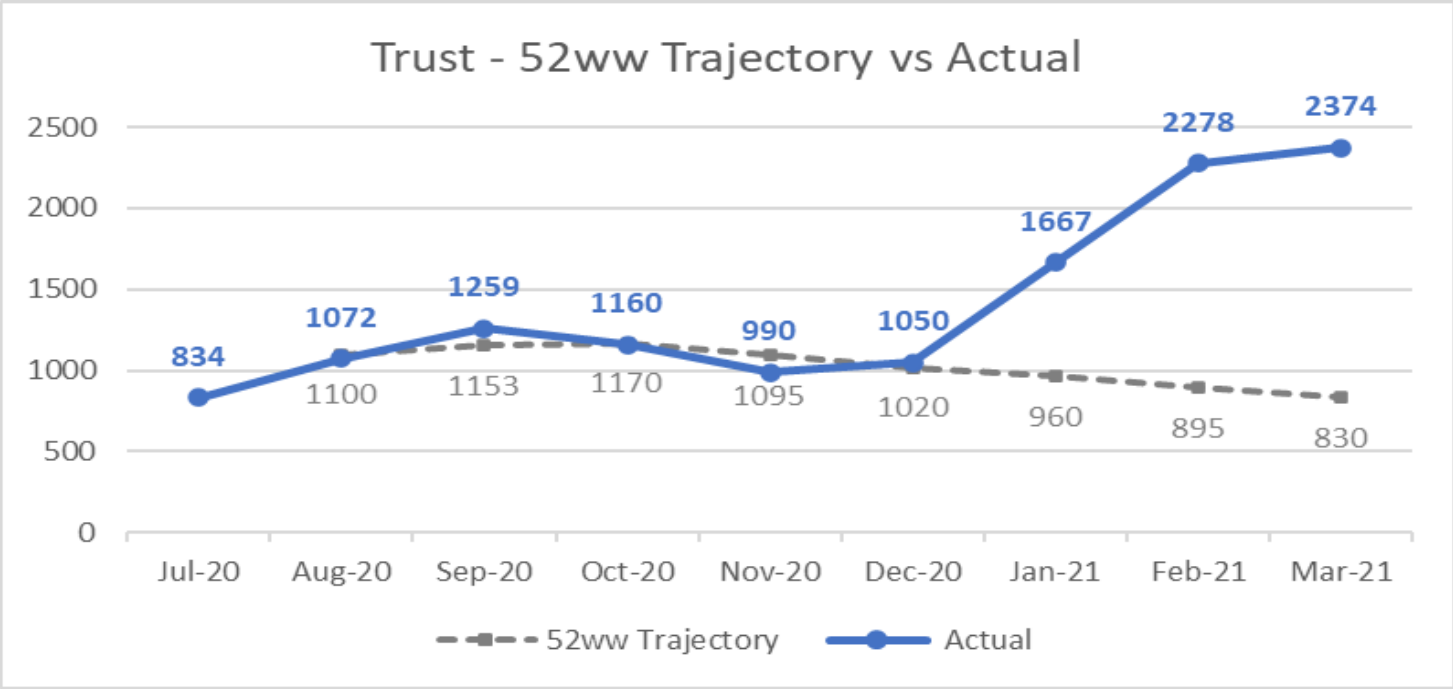
Problem Statement: Cancellation of elective care during Covid-19 has resulted in a backlog of patients waiting over 52 weeks.	**Metric Owner**: Professor Katie Urch **Metric**: RTT 52 week wait breaches **Desired Trend**: ⬇

Historical performance:

- For Phase 3 recovery, the Trust performed well against the trajectory until December 2020 when elective activity was once again suspended in response to a second surge in the number of Covid-19 related hospital admissions.
- In March 2021, 2,374 patients were reported as waiting over 52 weeks for their treatment at month end (+96 on the previous month). The forecast is that the number of patients waiting longer than 52 weeks will continue to rise until the end of July 2021.



Countermeasure Summary: RTT 52 week waits

Imperial College Healthcare NHS Trust

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Elective capacity reduction (outpatient, diagnostic, treatment)	• Reduction in capacity including loss of internal theatre capacity • Suspension of elective outpatient face-to-face appointments and some diagnostic services as staff redeployed to support surge in hospital admissions • Scheduling based on clinical priority	• Capacity and demand analysis of theatre requirements • Deliver and maintain Priority 2 clearance and offer mutual aid with expectation to return to baseline theatre schedule (19/04) • Assess need for additional capacity in the Independent Sector and/or in house additional weekend/evening to treat Priority 2 patients and long-term support Priority 3 and Priority 4 backlog clearance • Clinical harm reviews completed in line with guidance • Long waiter weekly oversight and escalation • Long waiter recovery trajectory planning for 2021/22	David Woollcombe-Gosson Michelle Knapper Jan Palmer Jan Palmer	30/04/21 30/04/21 30/04/21 30/04/21 30/04/21 07/05/21
Critical Care Surge	• Increased number of hospital admissions	• Critical care de-escalation: Weekly respond and recovery escalation and resumption of pathways in line with plan	David Kovar	30/04/21

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CMS 3
Cancer waiting times - percentage of patients who start first treatment within 62 days of a GP urgent referral

Countermeasure Summary: Cancer Waiting Times 62-day Performance

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Problem Statement: Performance against the standard has been non-complaint for 10 consecutive months. February was reported at 73.0% against the 85% standard, a deterioration from the previous month (77.3%). The impact is longer waiting times to access diagnostics and treatment for cancer.

Metric Owner: Prof Katie Urch
Metric: CWT 62-day GP referral to first treatment – operating standard 85%
Desired Trend: ↑

Historical performance:

Under performance in January and February 2021 related to elective capacity reductions for key diagnostics and internal theatre capacity as a result of the second surge in Covid admissions. Patient choice delays were also a significant contributor, and late referrals from partner trusts in NWL to ICHT for treatment. Patient choice delays are expected to reduce in line with increased patient confidence resulting from the vaccine programme and reduction of social restrictions.

						2021	
Standards	Aug	Sep	Oct	Nov	Dec	Jan	Feb
3.1 - Cancer Plan 62 Day Standard (Tumour)	**76.4%**	**72.3%**	**71.4%**	**73.4%**	**76.8%**	**77.3%**	**73.0%**
Acute leukaemia	100.0%						100.0%
Brain/Central Nervous System			100.0%			100.0%	
Breast	81.3%	70.4%	69.6%	86.7%	81.8%	84.6%	64.3%
Gynaecological	45.5%	45.9%	65.4%	67.9%	91.3%	58.3%	61.5%
Haematological (Excluding Acute Leukaemia)	57.1%	71.4%	66.7%	85.7%	60.0%	100.0%	100.0%
Head and Neck	100.0%	100.0%	92.9%	33.3%	100.0%	100.0%	100.0%
Head and Neck - Thyroid		100.0%	50.0%	50.0%	100.0%		75.0%
Lower Gastrointestinal	62.5%	57.1%	21.1%	37.5%	33.3%	33.3%	50.0%
Lung	100.0%	33.3%	75.0%	55.6%	62.5%	58.3%	72.7%
Other	100.0%	100.0%	100.0%	100.0%	100.0%		33.3%
Paediatric					0.0%		
Sarcoma	60.0%			0.0%			
Skin	100.0%	100.0%	66.7%	66.7%	89.5%	60.0%	71.4%
Testicular	100.0%	100.0%	100.0%	100.0%			
Upper Gastrointestinal					100.0%		
Upper GI - HpB	60.0%	75.0%	100.0%	40.0%	60.0%	72.7%	71.4%
Upper GI - OG	50.0%	20.0%	100.0%	0.0%	33.3%	100.0%	60.0%
Urology - Prostate	100.0%	93.5%	83.7%	92.3%	91.7%	94.4%	93.3%
Urology - Renal	0.0%	66.7%	100.0%	50.0%	70.0%	100.0%	90.0%
Urology - Urothelial	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Key associated metrics to watch against trajectory:

- 2 week wait (2WW) performance – February performance 95.3% against 93% target. Performance expected to be delivered in February but breast under pressure from increased 2 week wait referral demand;
- 104+ day backlog – 125 patients at 15/04/2021. Continued improvement expected as Priority 3 surgery work commences and endoscopy capacity increases;
- 63+ day tip over drivers – Gastrointestinal (GI) diagnostic pathway capacity and process, late referrals from other North West London trusts and patient choice delays.

Countermeasure Summary: Cancer Waiting Times 62-day Performance

Imperial College Healthcare NHS Trust

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Elective diagnostic and treatment capacity reduction	• Reduction in capacity for key diagnostics and loss of internal theatre capacity increased waits to diagnosis and treatment; • Scheduling has been based on clinical priority rather than performance standard breach dates; • Pathology reporting capacity	• Additional Independent Sector endoscopy capacity is being agreed to support recovery. Further endoscopy improvement actions on scheduling processes, triage processes, patient tracking list report changes are pending • Funding to move to 7 day working in pathology agreed with Royal Marsden Partners (RMP) (West London cancer alliance) • Scoping to identify diagnostic pathway recovery objectives with all tumour groups	Elective care directorates RMP Endoscopy Pathology Corporate Cancer	April 2021 TBC 30/04/2021
Late inter-trust referral from NWL trusts	• Elective capacity reductions at partner trusts in NWL are resulting in delayed diagnosis and later transfer of care to ICHT	• Local elective capacity improvement plans	NWL trusts ICS	On-going
National policy on clock stops for patients placed on hormone therapy prior to surgery	• NHSE issued an instruction in December 2020 that patients on hormones prior to Priority 3 surgery to remain on open 62-day cancer pathway until surgery date	• Priority 3 cancer surgical work to recommence on site	Elective care directorates	April 2021

NHS
Imperial College Healthcare
NHS Trust

CMS 4
Ambulance handovers within 30 minutes

Countermeasure Summary: Ambulance Handovers

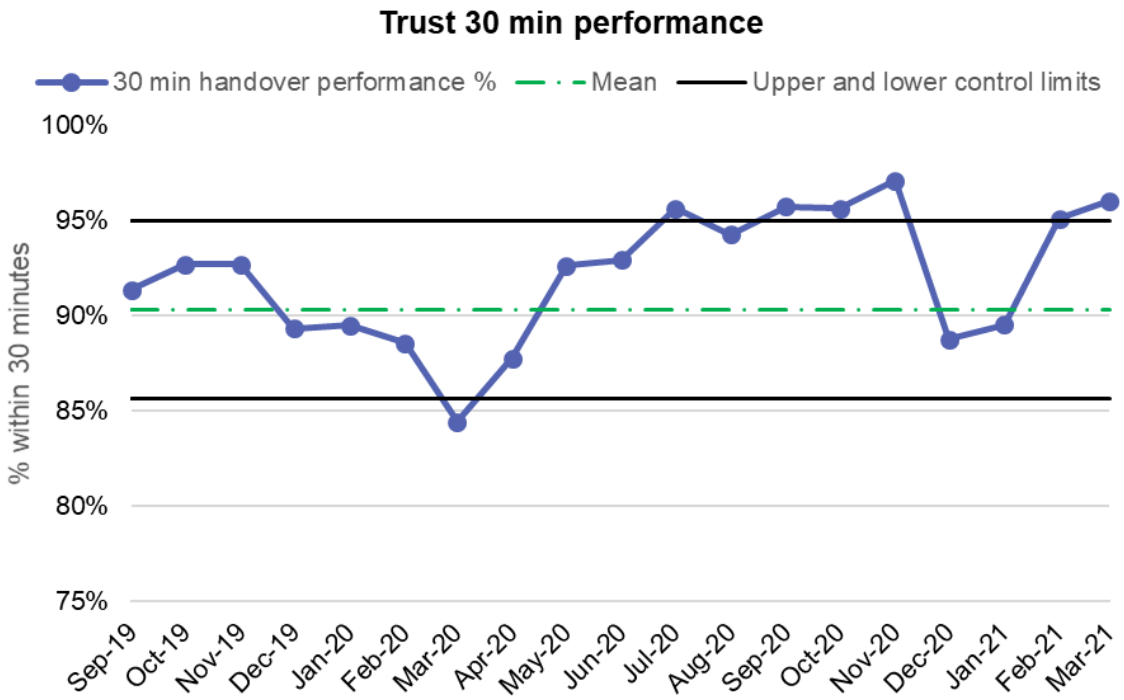
Imperial College Healthcare NHS Trust

Problem Statement: The national target is 100% in order to reduce the time London Ambulance Service (LAS) crews spend in Emergency Departments (ED) and therefore freeing them up to respond to other calls. Delays have a knock on effect to overcrowding in the Emergency Departments.

Metric Owner: Ben Pritchard-Jones
Metric: % of ambulance arrivals with a handover time < 30 minutes - target 100%
Desired Trend:

Historical performance:

After another drop in performance against the percentage (%) of 30 minute ambulance handovers during the recent wave of Covid-19, performance has recovered back above 95% and continues to improve. Performance (within 30 minutes) improved by 0.9% in March to 96.0%.



Countermeasure Summary: Ambulance Handovers

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30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Slow flow out of the ED	• Delayed discharges downstream • Speciality delays	• Review of project scopes for SAFER* & Admitted Mean Time & redefining milestones /dates	Frances Bowen and Jo Sutcliffe	May-21
Long waiting psychiatric patients	• Unavailability of psychiatric beds leading to long waits in the department	• Performance Support Team completing analysis of Mental Health pilot audit to identify additional themes for dept. delays & potential areas of improvement	Trish Ward and Barbara Cleaver and Jo Sutcliffe	May-21
Lack of space to offload ambulances whilst social distancing	• Slow flow out of the ED • Estate too small prior to pandemic now even more constrained	• Review/revision of existing project to agree timelines & actions for delivery	Ben Pritchard-Jones	April-21
SDEC reaching full capacity	• Previous staffing resource does not account for expanded footprint and increased patient numbers	• Business case presented at Decision Support Panel on 12th April. • Outcome pending and recruitment to follow	Andy Angwin	April 21

*SAFER – A tool used to reduce the delays for patients who are on an adult inpatient ward

Imperial College Healthcare NHS Trust

CMS 5
Improving long length of stay (LLOS)

Lead name(s) and position

Countermeasure Summary: Improving Long Length of Stay (LLOS)

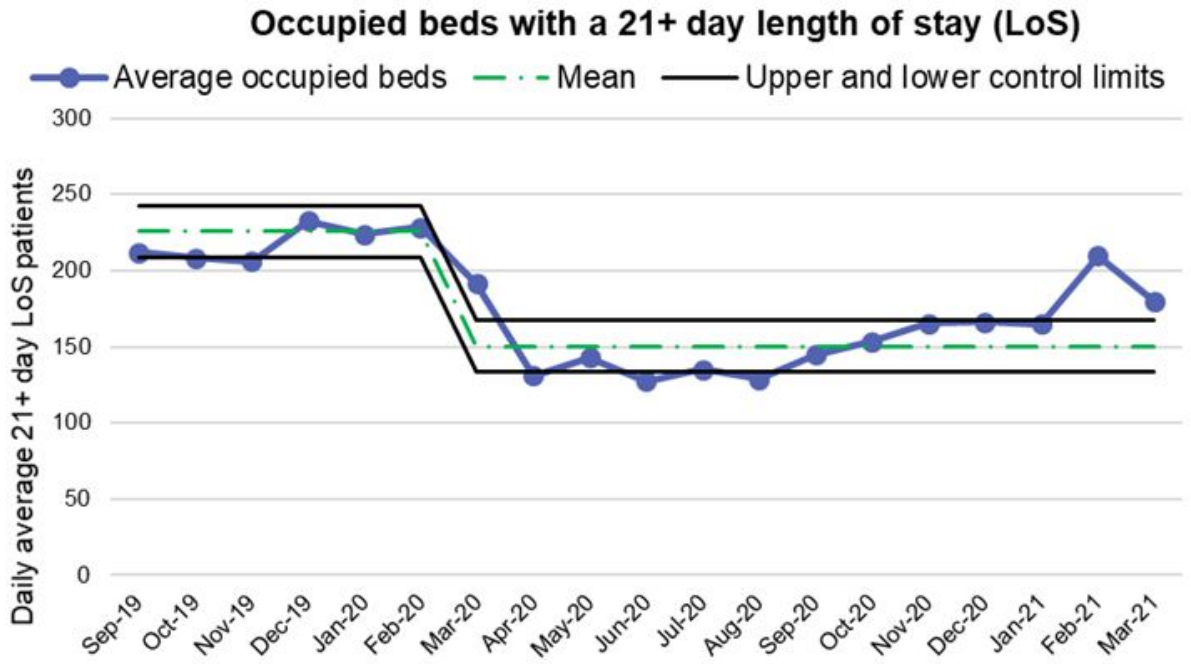
Imperial College Healthcare NHS Trust

Problem Statement: High numbers of patients with a Long Length of Stay (LLOS) is an indicator of poor patient flow and sub-optimal use of resource.	**Metric Owner**: Anna Bokobza **Metric**: Number of patients with >20 days Length of Stay (LOS); Number Medically Optimised patients with >20 days LOS **Desired Trend**: ↓

Historical performance:

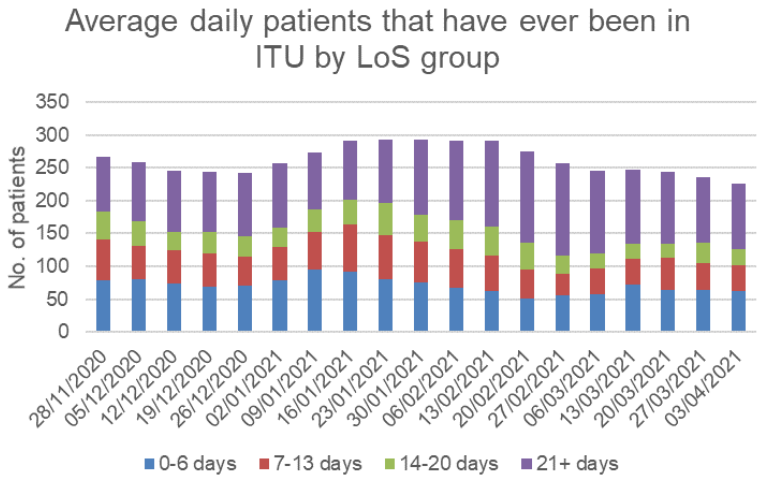
During 19/20, there were an average of 220 LLOS patients, this figure fell to less than 110 in April 2020.

During 20/21 there has been a gradual increase in numbers peaking in February 2021 at 210 due to the increased numbers and acuity of Covid patients, this has began to decrease again in March 2021 to 180 patients.

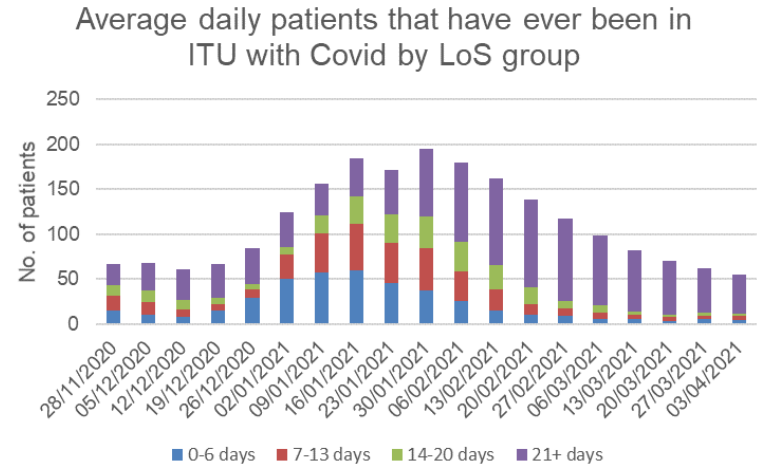


Top Contributors:

A high proportion of beds occupied by Covid patients during the second surge was a top contributor to LLOS performance in January and February. In March, as the second surge subsided, there is a tail effect of LLOS patients that have received intensive care.



The total number of patients receiving intensive care peaked in the second half of January. Whilst the total is decreasing the number in the 21+ day group remains high.



The daily average number of patients that have ever been in Intensive Care Unit (ITU) with Covid shows a surge from January-21 for patients in this cohort. Whilst the total number of patient's is decreasing the long length of stay group accounts for the majority of patients in week ending 03/04/21.

Countermeasure Summary: Improving Long Length of Stay

NHS
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30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
All internal drivers of exit flow and LOS	• Pursuit of best in class ward processes to facilitate flow not possible during pandemic • Long term variation in practice	• Participation in Alliance 16 programme; next step to agree ward focus at CXH & HH and scope • Completion of phase 1 SMH flow improvement projects	Anna Bokobza & Shuli Levy Anne Kinderlerer	30 April 15 May
All external drivers of exit flow and LOS	• Risk of loss of talent/experience and improved relationships, processes and systems reverting to pre-Covid models if hubs dissolve due to lack of funding	• Development and approval of business case for substantiation of integrated discharge hubs from Quarter 2	Anna Bokobza (in partnership with sector Senior Responsible Officer)	30 June
Accuracy of data and reporting	• Differential recording practice between acute Trusts invalidates benchmark comparisons • Ward and directorate teams spending considerable time on manual processing of discharge referrals and reporting	• Finalise plan to remove specialist rehab beds from reported performance • Implement plan to migrate daily reporting to pull from Cerner replacing manual returns • Implement plans to embed Discharge to Assess form in Cerner	Anna Bokobza Monica Sobham Anna Bokobza & James Bird	30 April 30 April TBC
Homeless/no right of recourse to public funds/no place to discharge to	• High prevalence of tri-morbidity and evident need for multi-agency approach to case management • Homeless patients not always easily recognisable on admission • Staff not always clear on Duty to Refer and how to support navigation to relevant statutory and voluntary services	• Submit bid for 2nd wave central government funding for inclusion/homeless health specialist discharge team	Anna Bokobza (in partnership with Joe Ngyuyen, sector SRO)	16 April

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Finance report for March 2021 (Month 12)

Agenda item 11 and paper number 08

Executive Director: Jazz Thind, Chief Financial Officer
Author: Des Irving-Brown, Deputy Chief Financial Officer

Purpose: For Information

Meeting: 12 May 2021

Executive summary

1. Purpose

1.1. The finance report for March sets out the year-end reported financial position of the Trust for the full financial year, subject to audit.

2. Key findings

2.1. The Trust agreed a £15.8m (deficit) plan with the STP for the second half of 2020/21 which included agreed additional costs to cover the expansion of the ICU bed base, endoscopy & imaging and excluded the effect of any subsequent surge. The Trust has however now been funded for reductions in non-NHS income (key driver of the deficit plan) bringing the overall actual position to breakeven.

2.2. Other key highlights:-

- The additional costs to support the Covid response (£6.3m above plan) being fortuitously offset by other additional income and a reduction in clinical supplies, drugs and clinical staffing costs linked to non Covid services;

- Each year the Trust is required to account for any annual leave entitlement not taken at the end of the financial year. For 2020/21 this increase is higher than usual due to employees being allowed to carry forward additional days if they were unable to take annual leave due to operational reasons. The additional cost has attracted national funding of an equal and opposite amount to offset this movement;

- In line with the NWL sector agreement the reported position also takes account of the cost of the two days of additional special leave in relation to “rest and recovery” day and birthday. The cost impact of this has been fully funded at sector level;

- The position recognises the additional costs of £34m for increased pension and other pay provisions. As in prior years, these have been funded nationally by NHSE/I and is only adjusted for in the month 12 position;

- Additional funding from NHSI/E in relation to specific Covid costs (pathology testing, SIREN R&D studies and vaccination hub costs (both mass vaccination and hospital hubs)) has been included in the reported positon.

2.3. Capital – the Trust spent 100% of its CRL (£78.2m) in-year and spent a further £7.7m on schemes funded by charity and national donations resulting in a total capital spend of £85.9m for the year.

2.4. Cash – at 31st March cash was £149.1m which is an improved position due to the 2020/21 funding regime.

2.5. Activity - Comparing the in-month period with the equivalent period last year: day case/elective activity is 3% lower, outpatient attendances are 8% higher and non-electives 18% higher, though in March 2020 we saw the effect of the first wave of the Covid pandemic on activity. Overall YTD activity is 17% lower than the previous year, though for planned care we have seen a reduction of 40%.

3. Recommendation

3.1. The Board is asked to note this report.

Imperial College Healthcare NHS Trust

Trust Board 12th May 2021

Finance Report March 2021

Imperial College Healthcare NHS Trust

Scorecard

	Year to Date		
	Plan £m	**Actual £m**	**Variance £m**
Year to date Position before Covid-19 expenditure and True Up	(93.7)	(86.7)	7.0
Covid-19 expenditure	(42.2)	(48.5)	(6.3)
Top up Month 1-6	21.8	21.8	0.0
Retrospective top up Month 1-6	39.6	39.0	(0.6)
STP top up Month 7 - 12	58.7	58.7	0.0
"Lost income" funding		15.8	15.8
Annual leave accrual		(11.2)	(11.2)
Annual leave funding		11.2	11.2
Reported Position	**(15.8)**	**0.0**	**15.8**

Commentary

- The position presented represents a draft pending finalisation of funding from NHS I/E.
- The draft accounts will be sent to auditors on the 27th April.
- Final audited accounts will be presented on the 15th June.
- The Trust has been funded for reductions in non NHS income bringing the overall actual position to breakeven (£15.8m better than plan).
- This year end positon includes the additional costs to support the Covid response (£6.3m above plan) being offset by additional income and a reduction in clinical supplies, drugs and clinical staffing costs linked to non Covid services.

- The Trust is required to account for any annual leave entitlement not taken at the end of the financial year. For 2020/21 national funding of an equal and opposite amount has been provided to offset this movement.

- The Trust has recognised additional costs of £34m, for increased pension and other pay provisions. These have been funded nationally by NHSE/I, as has been the case in previous years.

- **Capital** – the Trust spent 100% of its CRL (£78.2m) in-year and spent a further £7.7m on schemes funded by charity and national donations giving a total capital spend of £85.9m for the year.

- **Cash** – at 31st March cash was £149.1m driven by the funding regime for 2020/21.

- **Activity** - Comparing the in-month period with the equivalent period last year: day case/elective activity is 3% lower, outpatient attendances are 8% higher and non-electives 18% higher, though in March 2020 we saw the effect of the first wave of the Covid pandemic on activity. Overall YTD activity is 17% lower than the previous year, though for planed in patients we have seen a reduction of 40%.

Statement of Comprehensive Income

Imperial College Healthcare NHS Trust

	Full Year		
	Plan £m	Actual £m	Variance £m
Income	1,181.9	1,229.9	47.9
Pay	(732.6)	(800.7)	(68.1)
Non Pay	(530.6)	(508.2)	22.3
EBITDA	**(81.2)**	**(79.1)**	**2.1**
Financing cost and donated asset treatment	(54.7)	(74.5)	(19.9)
Impairment of assets	0.0	18.4	18.4
Surplus/deficit before top up	**(135.9)**	**(135.2)**	**0.7**
Top up Month 1-6	21.8	21.8	0.0
Retrospective top up Month 1-6	39.6	39.0	(0.6)
STP top up Month 7 - 12	58.7	58.7	0.0
Lost Income Funding	0.00	15.77	15.77
Annual Leave Income	0.00	11.2	11.20
Annual Leave Accrual	0.0	(11.2)	(11.20)
Surplus/deficit	**(15.8)**	**0.0**	**15.8**

- **Income** – income is favourable to at year end with reductions in private patient and research income offset by a number of national allocations associated to offset cost increases
- **Pay** – pay costs increased due to the accounting for a number of year end items: annual leave entitlement not taken; reset and recovery days, additional employers NHS pension costs all of which were offset in income as per above.
- **Non Pay** – this now includes a year end adjustment in relation to centrally procured and supplied PPE during 20/21 also offset by income. The annual internal stock take has also resulted in a favourable movement of £1.3m. This mainly relates to stock within the SCC Division and the Trust share of stock held by NWL pathology.
- **Financing Costs** – although the Trust has incurred £18.4m of impairments in financing costs, this does not count towards the surplus/deficit position and is therefore not included in the tables for the purposes of this report.

Statement of Financial Position (Balance Sheet)

Imperial College Healthcare NHS Trust

	31-Mar-20 £m	31-Mar-21 £m	Movement
Intangible assets	4.3	14.1	(9.8)
Property, plant and equipment	538.2	550.6	(12.4)
Total non-current assets	**542.5**	**564.7**	**(22.2)**
Inventories	15.3	146.9	1.6
Trade and other receivables	125.5	88.9	(36.6)
Cash and cash equivalents	43.9	149.1	105.2
Total current assets	**184.7**	**254.9**	**70.2**
Trade and other payables (<1 year)	(229.6)	(280.4)	(50.8)
Total current liabilities	**(229.6**	**(280.4)**	**(50.8)**
Non current Liabilities	(18.1)	(18.0)	0.1
Total Non current Liabilities	**(18.1)**	**(18.0)**	**0.1**
Net Assets employed	**479.5**	**521.1**	**41.6**
Public Dividend Capital	720.8	773.0	52.2
Revaluation Reserve	2.5	3.0	0.5
Income and expenditure reserve	(243.8)	(254.9)	(11.1)
Total tax payers' and other equity	**479.5**	**521.1**	**41.6**

Non-Current Assets
Non-current assets have increased by £22.2m in the year. This includes capital expenditure of £85.9 incurred in the year offset by depreciation (£45.8m) and net reduction in asset values arising from the annual revaluation of land and buildings (£17.9m).

Current Assets
Trade and other receivable balances have reduced by £36.6m in the year, in particular relating to other NHS bodies as the current funding arrangements have stabilised payment patterns and older debts have been settled

Cash
Cash balances were £149.1m at the year end driven by the funding regime for 2020/21.

Current Liabilities
Trade payables have increased by £41.5m year to date, including an increase in the amount accrued for annual leave entitlement not taken at 31st March 2021 and approximately £7.4m in accrued capital expenditure. The Trust maintains a focus on effective payment of suppliers and paid 98% of invoices within the Better Payment Practice Code guidelines.

Capital – Month 12

Imperial College Healthcare NHS Trust

Sources of Funds	£m
Depreciation	40.5
Confirmed external funding inc. PDC	38.5
Charitable Funds	1.9
Donation of DHSC-procured assets	5.8
Unconfirmed PDC funding	(0.8)
Total	**85.9**

Applications	Annual Plan £m	Plan £m	Actual £m	Variance £m
Backlog Maintenance	18.7	18.7	18.7	0.0
ICT	8.2	8.2	8.3	0.1
Replacement of Medical Equipment	7.3	7.3	7.2	(0.1)
Other Capital Projects	42.2	42.2	42.5	0.3
Redevelopment	4.2	4.2	4.2	0.0
Covid-19	5.3	5.3	4.9	(0.3)
Total Expenditure	**85.9**	**85.9**	**85.8**	**0.0**
Income and Donation	**(7.7)**	**(7.7)**	**(7.7)**	**0.0**
Capital Resource Limit	**78.2**	**78.2**	**78.2**	**0.0**

The Trust has successfully delivered its capital programme for the year, with capital expenditure of £28.9m in Month 12 taking the full year total to £85.9m.

The Trust has been effective in maximising its capital expenditure whilst remaining within its expected capital resource limit (gross spend less donation funding).

The capital programme evolved dramatically over the year with an additional £22m added in-year, largely financed by Public Dividend Capital awards, with the timing of confirmation of some of these awards presenting particular challenges.

Total capital expenditure included £5.8m of centrally-procured imaging and other assets provided by the DHSC as part of the pandemic response. These assets form part of the total capital expenditure but are effectively donated and do not count against the Trust's Capital Resource Limit. Similarly the Trust received £1.9m in funding from the Charity.

Capital planning is increasingly being co-ordinated at the NWL sector level going into 2021/22 and the Trust's capital programme for the new year has been set within a sector envelope, whilst still relying on internal funding sources.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Annual self-certification for NHS Trusts

Agenda item 12 and paper number 09

Executive Director: Tim Orchard, Chief Executive
Author: Peter Jenkinson, Director of Corporate Governance

Purpose: For approval

Meeting date: 12 May 2021

Executive summary

1. Purpose

2. The assurance statements and the proposed compliance declarations are being presented to Trust board for approval.

3. **Background**

3.1. Introduced in April 2017, NHS Improvement require that NHS trusts, as foundation trusts (FT) have always been required to do, self-certify compliance against a number of specific declarations. Providers must publish their self-certification by 30 June.

3.2. The self-certification declarations in this paper are, in essence, FT Licence requirements. However, the introduction of NHS Improvement's (NHSI) Single Oversight Framework in 2016/17, subsequently replaced by the NHS Oversight Framework in 2019/20, bases its oversight along similar lines, and NHS trusts are required to comply with conditions equivalent to the licence that NHS Improvement has deemed appropriate.

3.3. The annual self-certification provides assurance that NHS providers are compliant with the conditions of their NHS provider licence. Compliance with the licence is routinely monitored through the NHS Oversight Framework but, on an annual basis, the licence requires NHS providers to self-certify as to whether they have:

- effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6);
- complied with governance arrangements (condition FT4); and
- for NHS foundation trusts only, the required resources available if providing commissioner requested services (CRS) (condition CoS7).

3.4. In response to the COVID pandemic, NHSI have relaxed the requirement for trusts to submit their declarations centrally, but the requirement for self-certification remains.

4. Key findings

4.1. Through the 'business as usual' governance arrangements in place across the Trust, including executive and Board committees, assurance has been provided to the Trust board during the year (and continues to be provided) to inform the Trust board's decision regarding the declarations in respect of conditions G6 and FT4.

4.2. The Trust board and its committees are informed and receive assurance in relation to the requirements of the specified conditions in a number of ways through the year. These include:

- Regulatory inspection and oversight, including CQC,NHS Improvement, NW London ICS and NHS London
- Risk-based annual internal audit plan, including review of key systems of internal control and a review of the risk management arrangements and board assurance framework, culminating in the Head of Internal Audit opinion
- External audit opinion on annual accounts, annual report and quality account
- Quality account
- Corporate risk register
- Executive director reports to Trust board
- Board committee reports to Trust board
- Board seminar presentations from divisions and areas of interest (eg education; research; integrated care).

4.3. The executive team have reviewed these assurance statements and the proposed compliance declarations and have agreed to recommend the proposed declarations for the two conditions contained within Appendix 1 to the Trust Board for approval.

- It is recommended that the Trust confirms compliance with Condition G6 *'Following a review for the purpose of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution.'*
- Despite the progress made by the Trust in performance, recognised by NHSI/E through removal of the Trust undertakings and improvement of the Trust segmentation, there are continuing risks to the Trust ensuring compliance with the Trust's duty to operate efficiently, economically and effectively. The recommendation is therefore for the Trust to declare 'not confirmed' against Condition FT4 (4a) – *'The Trust board is satisfied that the Licensee has established and effectively implements systems and/ or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively',* as summarised in Appendix 1.

5. Next steps

5.1. Subject to Board approval, the declaration will be submitted to NHSE/I.

6. Recommendation(s)

6.1. The Board is asked to approve the proposed declaration of compliance as follows:

- Condition G6(3)
  "Not later than two months from the end of the Financial Year (by 31 May 2021), the Trust board ('the Licensee') is required to self-certificate to the effect that it "Confirms" or "Does not confirm" that it has taken all precautions necessary to comply with the licence, NHS acts and the NHS Constitution."
  It is recommended that the Trust board formally sign-off the Self-Certification for Condition G6 as "Confirmed".
- Condition FT4 (4)
  "By 30 June 2021, the Trust board is required to self-certificate "Confirmed" or "Not confirmed" to compliance with required governance standards and objectives."
  It is recommended that the Trust board formally sign-off the Self-certification for Condition FT4 as "Not confirmed for (a) and confirmed for (b-h)".

7. Impact assessment

7.1. Quality impact: Not applicable
7.2. Financial impact: Not applicable
7.3. Workforce impact: Not applicable
7.4. Equality impact: Not applicable
7.5. Risk impact: Not applicable

Appendices:
Appendix 1 Trust self-certification statements

Trust self-certification statements – May 2021

FT4 declaration for Imperial College healthcare NHS Trust

Corporate governance statement (FTs and NHS Trusts)		
The Trust board is required to respond 'confirmed' or 'not confirmed' to the following statements, settings out any risks and mitigating actions for each one where it is 'not confirmed'		
Corporate governance statement	**Response**	**Risks and mitigating actions**
1 The Trust board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of heat care services to the NHS	Confirmed	
2 The Trust board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	
3 The Trust board is satisfied that the Licensee has established and implements: (a) effective board and committee structures (b) clear responsibilities for its Trust board, for committees report to the Trust board and for staff reporting to the Trust board and those committees and (c) clear reporting lines and accountabilities throughout its organisation	Confirmed	
4 The Trust board is satisfied that the Licensee has established and effectively implements systems and/ or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively (b) For timely and effective scrutiny and oversight by the Trust board of the Licensee's operations (c) To ensure compliance with healthcare standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality	**Not confirmed**	Not confirmed for (a). The Trust continues to strengthen its systems and processes to ensure it operates efficiently, economically and effectively, demonstrated by the decision in October 2019 by NHS Improvement to close all remaining regulatory undertakings and to amend the Trust's rating from segment three to segment two, now monitored via the System Oversight Meetings (SOMs).

Commission, NHS England and statutory regulators of healthcare professions (d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/ or processes to ensure the Licensee's ability to continue as a going concern) (e) To obtain and disseminate accurate, comprehensive, timely and up-to-date information for the Trust board and committee decision-making (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence (g) To ensure compliance with all legal requirements		However, the Trust continues to face operational and financial challenges, and this has increased due to impact of the Trust's response to the COVID-19 pandemic. The Trust is not currently achieving the national standard with respect to referral to treatment (RTT) within 18 weeks and reported 2,374 patients as waiting over 52 weeks for their treatment at the end of March 2021. It is anticipated that the number of patients waiting longer than 52 weeks will continue to rise until the end of July 2021 as a result of delays for elective treatment due to the COVID-19 pandemic. All long waiters are treated in order of clinical priority. Similarly, delays relating to the COVID-19 pandemic mean that the Trust is not currently meeting the standard to provide diagnostic tests within 6 weeks of referral. . Due to the lag in the national reporting timelines for cancer waiting times, data for February 2021 are reported in April 2021. The Trust delivered 7 of the 8 national standards in February. The 62-day GP referral to first treatment performance was 73.0% against the 85% standard. The Trust achieved its financial targets for 2020/21 in terms of delivering against the financial plan agreed with the North West London Integrated Care System ; remaining within its external financing limit and achieving its capital resource limit. However, the Trust does still need to continue to focus on improving its underlying financial sustainability. Due to the outbreak of COVID-19, 2021/22 planning has been delayed and all NHS Providers will be subject to a new finance regime, the details

		of which at present only cover first six months to 30th September 2021. The Trust awaits the publication of further guidance from the regulator on what arrangements will be put in place for the balance of the 2021/22 financial year as these will be key to determining the underlying financial position and the improvement trajectory to breakeven.
5 The Trust board is satisfied that the systems and/or processes referred to in paragraph 4 should include but not be restricted to systems and/ or processes to ensure: (a) That there is sufficient capability at Trust board level to provide effective organisational leadership on the quality of care provided (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	
6 The Trust board us satisfied that there are systems to ensure that the Licensee has in place personnel on the Trust board, reporting to the Trust board and within the rest of the organisation who are sufficient in	Confirmed	

number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence		

Signed on behalf of the Trust board

Signature . . . . . Signature . . . . . .

Name . . . . . Name . . . . . .

G6 declaration for Imperial College Healthcare NHS Trust

Declaration required by General condition 6 of the NHS provider licence
The Trust board are required to respond 'Confirmed or Not confirmed to the following statements
1&2 General condition 6 – Systems for compliance with license conditions (FTs and NHS Trusts)
1. Following a review for the purpose of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution. **Confirmed** Signed on behalf of the Trust board of directors Signed . . . . . Signed . . . . Name . . . . . Name . . . . Capacity . . . . . Capacity . . . . Date . . . . . Date . . . .

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Maternity Quality Assurance Oversight Report

Agenda item 13 and paper number 10

Executive Director: Tg Teoh, Divisional Director
Author: Louise Frost

Purpose: For discussion

Meeting date: 12 May 2021

Executive summary

1. Purpose

1.1. To request the Board's oversight on the quality assurance reports.
1.2. To inform the Board of progress on achieving compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) year 3.
1.3. To inform the Board of progress achieving compliance with the 7 Ockenden immediate and essential actions (IEAs).

2. Background

2.1. A single quality assurance oversight report has been developed including all relevant information and actions in place to address performance of the maternity service.
2.2. The CNST MIS Year 3 re-launched on 1st October 2020. Trusts who can demonstrate achievement of all 10 safety actions will recover the additional 10% of their contribution. Guidance has since been updated in March 2021.
2.3. The Ockenden report was published in 2020. NHS England mandate each trust complete a gap analysis of the 7 IEAs.

3. Key findings

3.1. Quality assurance report – One new risk (3462) added to the risk register in March 2021. 24 risks on the directorate risk register. Risk 2019 increased due to a recent incident. 3 serious incidents (SI) declared in March 2021. 1 finalised SI report in March 2021. 72 overdue incidents on 7th April 2021. Downward trend and on-going work to improve timeliness of reviews. 3 on-going national audits. All national audits are in date. All guidelines in date. Targeted approach to core skills compliance below set thresholds. March 2021 - 6 compliments, 10 formal complaints and 9 complaints via PALS. All responded to within the required timeframe.
3.2. CNST MIS – on track to meet compliance by 15 July 2021 deadline.
3.3. Ockenden recommendations - The peer review process was completed and an action plan is in progress to meet compliance with the 7 IEA's to enable evidence submission.

4. Next steps

4.1. Divisional commitment to continue to work towards improving quality and safety.
4.2. Continued progress with meeting compliance for the CNST MIS by deadline 15/07/21.
4.3. Collation of evidence for Ockenden submission to NHS England – date TBC.

5. Recommendation(s)

5.1. The report was discussed at the Quality Committee.
5.2. For Board oversight of the submitted monthly update reports.
5.3. To receive the CNST declaration form at the next Trust Board on 14 July 2021.

6. Impact assessment

6.1. Quality impact - The maternity service have developed a quality and safety strategy which aims at improving the quality of the service for women and their families.
The CNST MIS supports the delivery of safer maternity care and contributes towards meeting 7 IEA's recommended from the Ockenden report.
6.2. Financial impact - Robust oversight of the maternity quality and safety strategy will improve outcomes and experience. This aims to reduce litigation claims for the trust.
The CNST MIS is an incentive scheme. Meeting the Ockenden 7 IEA's will contribute to compliance. Level of investment is required to meet Ockenden recommendations.
6.3. Workforce impact - A proposal was presented to support the recruitment of permanent staffing to meet compliance with the CNST MIS and Ockenden recommendations. Workforce reviews are included in the MIS and Ockenden.
6.4. Equality impact - To ensure an equitable service is provided to anyone who either access maternity services or is part of the workforce.
6.5. Risk impact - Compliance with all 10 CNST safety actions and Ockenden 7 IEA's will optimise the delivery of safe maternity service provision that is sustainable.

Main report

1. Quality Assurance report

1.1. Maternity Dashboard/ Score card – currently in development.

1.2. Risk register*:* One risk (3462) added in March 2021 to the maternity risk register. There are currently 24 risks on the directorate's risk register with risk levels of 1 extreme, 16 high and 6 moderate. Effectiveness of the mitigations are reviewed at local Quality and Safety (Q&S) meetings and feeds in to the divisional Q&S committee.

Top risk summaries (score 16 to 12 rated extreme to high):

- 3462 Risk of compliance with Continuity of care models offered to vulnerable adults booked for maternity care (score 9).
- 2019 State of Labour ward theatres at QCCH (score 20). This risk was increased this month due to a recent incident.
- 2504 Failure of the lockable automatic doors on Operating Theatres on QCCH Labour Ward (score 16).
- 1195 Delay in transfer of maternity patients in an emergency due to lift failure in Cambridge wing at SMH (score 8). This risk was reduced from 12 as new lifts are now in place.
- 2162 Poor environment in some of the USS areas related to estates (score 12).
- 2663 Financial risks associated with the risk of fall in birth-rates in NWL (score 12).
- 2338 Failure in call bell system on Edith Dare Ward (score 8). This was reduced as a new system in now in place on Labour Ward, however the risk remains.

1.3. Incidents*:* Total reported incidents in March 2021 SMH: 60, QCCH: 99. Less reported incidents at SMH compared to February 2021. Similar number at QCCH. Majority of incidents reported from labour wards. Highest incident reporting category continues to be labour/ delivery, followed by admission, diagnostic investigation, implementation of care, and infrastructure. The highest incident reporting sub categories are post-partum

haemorrhage, unexpected term admission to neonatal unit, un-expected readmission, cord pH <7.1 and failure to follow procedure/ guideline. On 07/04/21 there were 72 datix reported from 02/11/20 to 08/03/21 overdue for review. This figure is less than the previous month and is being addressed by the relevant managers.

Severity of incidents: (no severity documented for 5 cases reported on Datix)

March 2021	Near miss	No harm	Low harm	Moderate harm	Total
Affecting patient	7	84	46	2	139
Affecting staff	0	5	0	0	5
Affecting organisation	0	10	0	0	10
Total	7	99	46	2	154

Serious incidents – All incidents reported to HSIB are reported as SI's from January 2021

	19/20 total	2020/21												20/21 total
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
HSIB	8	2	0	0	0	1	0	2	1	0	1	2	2	10
SI total	12	3	0	3	1	2	2	3	2	3	1	2	3	24

*SI total includes HSIB cases reported as SI's

1.4. Serious incidents declared in March 2021:

- SI number TBC. Spontaneous vaginal delivery Queen Charlotte's and Chelsea Hospital Birth Centre. Major obstetric haemorrhage (3.8L total), transferred to labour ward for evacuation of retained products in theatre. Cardiac arrest during general anaesthetic, stabilised and transferred to Intensive Care Unit. Discharged home.
- SI number TBC. Induction of labour for reduced fetal movements. CTG monitoring classified pathological on the antenatal ward, transferred to labour ward and a Grade 1 emergency caesarean section performed. Baby born with low Apgar scores and cord gases requiring full resuscitation. Baby actively cooled on the neonatal unit and MRI after 72hrs demonstrated mild hypoxic ischaemic encephalopathy.
- SI number TBC. Multiparous woman, gestation at term, arrived in labour but unable to auscultate fetal heart.

The following serious incident report has been finalised and shared with the woman involved (summary and learning in appendix 1):

- Retained swab post catheterisation incident.

1.5. Audits: 3 on-going national audits relating to perinatal and maternal mortality, and maternity and neonatal provision.

1.6. Guidelines: all guidelines in date.

1.7. Complaints & Compliments
Communication is the on-going theme of complaints.

Complaints and compliments

	Jan 21		Feb 21		Mar 21	
	SMH	QCCH	SMH	QCCH	SMH	QCCH
Formal complaints	1	1	2	4	4	6
Total number of breaches	0	0	0	0	0	0
% responded to within timeframe	100	100	100	100	100	100
PALS issues & complaints	11		7	6	4	5

Formal compliments	5	3	6

1.8. Patient experience: Friends and Family Test has recently been resumed.

1.9. Core skills compliance: (reported 06/04/21) 10 out of 21 achieved the threshold. Those not meeting compliance are being targeted as training has recently resumed.

1.10. Care Quality Commission (CQC)/Ward Accreditation Programme: The CQC rating for all maternity services across sites and Lindo Wing is Outstanding. Business as usual continues and there are plans to perform internal reviews to ensure information is up to date and visible to patients and staff.

1.11. Workforce metrics

- Vacancy and turnover - Band 6 Midwives currently 19 WTE vacancies (8%) (Down from 27 WTE one year ago). Band 2 and 3 Support Workers 11 WTE vacancies (12%).
- Recruitment - Retention of our student midwives upon qualification remains good with the majority of our students choosing to stay with us. Rolling adverts in place for experienced midwives as well as newly qualified midwives. Support worker vacancies, sickness and shielding have impacted on staffing locally, but safety has been maintained by staff redeployment and the use of bank staff. Maternity engage in local recruitment as well as Trust wide band 2 and 3 recruitment. Maternity have been engaged with the new Deputy Director People & Organisation Development - HR Operations & Resourcing to further strengthen our recruitment and retention plans.
- Sickness 4.5% (February 2021)

2. CNST MIS safety action update report

2.1. **National Perinatal Mortality Review Tool (PMRT)** Next quarterly report (April 2021) has been submitted for trust board oversight. Monthly compliance update report (appendix 2).

2.2. **Maternity Services Data Set (MSDS)** Compliant and on-going data submitted (appendix 3).

2.3. **Transitional Care (TC) and Avoiding Term Admissions into Neonatal (ATAIN) units programmes** Weekly ATAIN review meetings. Action plan reviewed and signed-off monthly by safety champions (appendix 4).

2.4. **Clinical Workforce planning (obstetric, anaesthetic, neonatal & neonatal nursing)** Anaesthetic medical workforce review - compliant with ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6. Scrub nurse cover currently in place at SMH. Long term funding is included within the CNST investment plan. Neonatal medical workforce review - Compliant with BAPM national standards of junior medical staffing. To be formally recorded in trust board minutes. Neonatal nursing workforce review - Action plan to address neonatal nursing standard requirements to be formally recorded in trust board minutes (appendix 5). Action plan emailed to the Royal College of Nursing.

2.5. **Midwifery Workforce planning** Bi-annual midwifery staffing oversight report completed for February 2021 and includes action plan to address 1:1 care in labour (appendix 6).

2.6. **Saving Babies Lives Care Bundle Version 2** Quarterly care bundle surveys completed and submitted to NHS England for September 2020 and January 2021. Full implementation completed. Audits in progress including action plan development to address performance of each element. MSDS requirements currently under review to

enable data reporting. Collaboration with North West London Local Maternity System (LMS) Maternal and Neonatal Health Safety Improvement Programme to contribute to improving element 1 – reducing smoking in pregnancy. Guidelines updates in progress to provide assurance to the trust board of standards implementation. Fetal wellbeing midwives started in roles 08/03/2021. Midwifery education reinstated 08/03/2021. Virtual full day fetal monitoring training has been restarted by MDT attendance on fetal monitoring session and PRactical Obstetric Multi-Professional Training (PROMPT). There is commitment to facilitate local, in-person, fetal monitoring training when this is permitted. Staff are also required to complete K2 training and assessments. Half day (K2 assessment completion and pass mark 85%) meets CNST compliance. Plan to achieve 90% target for each staff group by July 2021:

Staff group	K2 assessments	Training session
Midwives	85.5%	35.5%
Obstetric consultants	13.9% (6)	43%
Obstetric doctors	44% (30)	30%

2.7. **Maternity Voices Partnership (MVP)** Terms of Reference currently under review. Agreed with Head of Midwifery.

2.8. **Multi-professional maternity emergency training** Virtual PROMPT & neonatal resuscitation training reinstated 8/3/2021. There is a commitment to facilitate local, in-person, MDT training when this is permitted. Covid-19 specific e-learning has been made available to the multi-professional team within the PROMPT session. Plan in progress to ensure PROMPT and neonatal resuscitation training target 90% of each staff group:

Staff group	PROMPT	Neonatal resuscitation
Midwives	104 (26%)	104 (26%)
Obstetric consultants	19 (43%)	N/A
Obstetric doctors	20 (30%)	N/A
Obstetric anaesthetic consultants	10 (27%)	N/A
Obstetric anaesthetic doctors	15 (83%)	N/A
Critical care staff (ODP's)	TBC	N/A
Maternity support workers	69 (62%)	N/A
Neonatal consultants	N/A	100%
Neonatal junior doctors	N/A	96.5%
Neonatal nurses	N/A	93.8%

2.9. **Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?** Quality and safety strategy document being finalised. Plans to circulate to all staff. SCORE culture survey results to inform maternity clinical, quality and safety strategy**.** Continuity of Care (CoC) action plan (appendix 7) monthly reviews continue with development of data capture to review ability to prioritise women from Black and Asian backgrounds and areas of high deprivation. The trust is working to meet the 35% target of women being placed onto a CofC pathway and ensure that this meets the national definition of CofC. Data reported for women booked in January 2021 was 29%.

2.10. **NHS Resolution Early Notification Scheme** Trust board will continue to receive oversight of EN incidents and numbers reported to NHSR EN scheme and HSIB. For qualifying cases 01/10/20 to 31/03/21 the Trust Board are assured that:

a. The family have received information on the role of HSIB and the EN scheme
b. There has been compliance where required with duty of candour

3. Ockenden Immediate and Essential Actions (IEA)

3.1. Peer review assessment completed 8/3/21. NHS England response 19/03/21 (appendix 8).

3.2. Evidence submission required as part of NHS England oversight – awaiting confirmation of the process and submission date.

3.3. Actions to address recommendations are listed below for each IEA:

IEA1 – Enhanced Safety
- Summary report of serious incidents to be presented at each trust board & Local Maternity and Neonatal System.
- Implementation of Perinatal Clinical Quality Surveillance model.

IEA2 – Listening to women and families
- Non-Executive director appointed as maternity safety champion.
- Continue collaboration with the MVP for service review and development.

IEA3 – Staff training and working together
- Meet training compliance CNST safety action 8.
- Training compliance to be validated through LMNS 3 times per year.

IEA4 – Managing complex pregnancy
- Continue involvement in development of tertiary maternal medicine service.
- Full implementation of SBL care bundle CNST safety action 6.
- Audit to be performed ensuring correct consultant allocation for complex pregnancy.

IEA5 – Risk assessment throughout pregnancy
- Cerner changes approved to document antenatal risk assessment and intended place of birth at each appointment.
- Audit of Personalised Care and Support Plan (PCSP) compliance.

IEA6 – Monitoring fetal wellbeing
- Substantive recruitment of fetal wellbeing midwives on each site.
- Job description reflecting the role of the obstetrician and midwife.

IEA7 – Informed consent
- Planned review of maternity pathways information on trust website.

Workforce planning
- No Director of Midwifery (Qualified Midwife). Additional consultant midwife required.

4. Conclusion

4.1. Board to note the update report and ongoing progress with required actions.

Appendices (available in the Reading Room)

Appendix 1: SI summary of learning
Appendix 2: Monthly report for the Perinatal Mortality Review Tool March 2021
Appendix 3: MSDS scorecard December 2020
Appendix 4: ATAIN report March 2021
Appendix 5: Neonatal Nursing Workforce action plan
Appendix 6: Midwifery Safe Staffing March 21
Appendix 7: Continuity of care action plan April 2021
Appendix 8: NHS England Ockenden assessment
Appendix 9: Maternity Quality Assurance Oversight Report Glossary

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Infection Prevention and Control (IPC) and Antimicrobial Stewardship Quarterly Report Q4 2020/21

Agenda item 14.1 and paper number 11a

Executive Director: Professor Julian Redhead, Medical Director
Author: Jon Otter, General Manager, IPC and Professor Alison Holmes, Director, IPC

Purpose: For information

Meeting date: 12 May 2021

Executive summary

1. Purpose

1.1. This paper summarises the activity of IPC team for Q4 2020/21.

2. Background

2.1. This is the quarterly IPC and antimicrobial stewardship quarterly report.

3. Key findings

3.1. IPC expertise continues to be integral to decision making during the Trust management of COVID-19. The NHSE Board Assurance Framework for a Trust's IPC structures and activity related to COVID-19 has been updated monthly. Processes for the management of possible COVID-19 outbreaks in patients and staff have been agreed and implemented.

3.2. A total of 61 COVID-19 transmission incidents / outbreaks have been identified and managed since July 2020, when formal Trust reporting commenced, 31 of which occurred during Q4. 24 of these 61 incidents affected only staff and 37 affected patients or both patients and staff. 18 of these 61 incidents affected only two individuals.

3.3. There have been 19 hospital-associated *C. difficile* cases during Q4, which is below the Q4 ceiling of 22 cases. There has been one lapse in care related to cross-transmission.

3.4. There were three hospital-associated MRSA BSI during Q4. A review of key contributory factors and development of an action plan is in progress which will report to executive huddle during week commencing 3rd May.

3.5. We have met our 10% year-on-year reduction in Trust-attributed *E. coli* BSIs (an internal performance metric), and continue to report the lowest rate of Trust-attributed *E. coli* BSI in the Shelford group of hospital.

3.6. The rate of CLABSI in the neonatal and paediatric ICUs remains below benchmark levels. We are unable to report on the CLABSI rate in the adult ICU for the Q3 and Q4 period due to COVID-19 surge management. Prospective surveillance is resuming fully from 1st April 2021, and retrospective analysis for the Q3 and Q4 2020 periods is currently in progress.

3.7. The antimicrobial stewardship initiatives introduced during Q4 to counteract a rise in overall antimicrobial consumption and especially in intravenous agents has reduced overall and intravenous consumption during Q4.

3.8. Non-COVID-19 clinical activity and incidents have included a number of incidents involving likely cross-transmission of different organisms in the ICUs across the Trust, an increased incidence of *Pseudomonas aeruginosa* in the neonatal ICU, and 13 communicable disease 'look back' investigations. A total of 18 SIs have been declared during Q4, three of which are related to non-COVID-19 outbreaks in the ICUs. A bi-weekly review of actions to manage IPC risk in the ICUs is ongoing. An Estates-led task and finish group has been commissioned to explore ways to tackle the contaminated water outlets in the neonatal ICU at SMH.

3.9. The Trust has responded to two external directives in Q4, one related to promoting best-practice use of ultrasound gel, the other a national alert related to Becton-Dickenson (BD) intravenous administration sets.

4. Next steps: Details regarding next steps are outlined within the body of the report.

5. Recommendation(s): The report was discussed at the Quality Committee and the Board is asked to note the report.

6. Impact assessment

6.1. Quality impact: IPC and careful management of antimicrobials are critical to the quality of care received by patients at ICHT, crossing all CQC domains. This report provides assurance that IPC within the Trust is being addressed in line with the 'Health and Social Care Act 2008: code of practice on the prevention and control of infections' and related guidance

6.2. Financial impact: No direct financial impact.

6.3. Workforce impact: No workforce impact.

6.4. Equality impact: N/A

6.5. Risk impact: This report includes a summary update of the IPC risk register.

7. <u>Main Report</u>

7.1. **Response to the pandemic of COVID-19**

- Infection Prevention and Control (IPC) expertise continues to be integral to decision making during the Trust management of COVID-19 including in the provision of advice, guidelines, clinical pathway development and patient safety.
- A total of 61 COVID-19 transmission incidents / outbreaks have been identified and managed since July 2020, 31 of which occurred during Q4.
  - 24 of these 61 incidents affected only staff and 37 affected patients or both patients and staff. 18 of these 61 incidents affected only two individuals.
- IPC plays a key role in developing and implementing the Trust-wide strategy for patient and staff testing.
- A focus on antimicrobial stewardship (AMS) and treatment of both COVID-19 and other infections continues to be maintained during the pandemic.
- Experts from IPC joined a range of expert advisory groups and undertook applied research to support decision making in the Trust.
  - We are collaborating with the COVID-19 Genomics UK Consortium (COG-UK) to investigate the role of whole genome sequencing in understanding the transmission of COVID-19. We also are also collaborating with WHO and NIHR on projects related to COVID-19.

7.2. **Key actions to prevent healthcare-associated COVID-19**

- An IPC board assurance framework has been updated monthly, and an action plan related to the framework is reviewed weekly at the Clinical Reference Group (CRG).
- We have an established surveillance system for hospital-onset COVID-19 infections (HOCI) within the Trust (Appendix 1, Figure 1).

- The rate of HOCI in the Trust for the period Dec 2020 – Mar 2021 is at par with the mean London Acute-Trust average rate and Imperial ranks 13/30 providers in London. (Appendix 1, Figure 2).
- IPC, in partnership with occupational health, have developed and established systems to identify and manage possible outbreaks of COVID-19 amongst staff.
- IPC, in partnership with our internal colleagues at virology and external colleagues at PHE continue to closely monitor strains, including novel variants, causing infection at our Trust.
- IIMARCH forms related to each new outbreak were presented to the CRG.
- Our clinical incident management systems are used to investigate and learn from COVID-19 outbreaks and related incidents.
- A review is undertaken for each individual case of hospital-onset COVID-19 infection in a patient >7 days after their day of admission (that is not part of an outbreak).
- PHE updated their national guidelines for the prevention and management of COVID-19 in January 2021. The following changes have been made in response to these guidelines:
  - All contacts of COVID-positive individuals tested daily for 14 days following exposure.
  - All patients who test COVID-negative on admission are tested daily for the first 7 days of their admission, and weekly thereafter.
  - Guidance on managing elective and emergency admissions, including how best to care for "COVID-recovered" patients and identifying possible reinfection.
  - Changes to pre-procedure isolation for elective procedures.
  - PPE guidance for visitors.
  - A process for phasing out valved FFP3 respirators in clinical areas where sterile procedures are undertaken.
- In response to the decreasing prevalence of COVID-19 in our hospitals in March 2020, low-risk pathways are being reinstated.
- Key contributory factors from COVID-19 outbreaks at Imperial has been reviewed and is summarised in (Appendix 2).
- A platform has been jointly developed to capture COVID-19 cases in previously vaccinated individuals, aligned with PHE voluntary passive surveillance recommendations.
- The 'PPE helper programme' was launched during the first wave of COVID-19 to provide ward-level support for staff to use the correct PPE, and to use it safely. There are currently 8 full time PPE helpers undertaking daily visits to clinical areas, including as part of outbreak investigations.

7.3. Healthcare-associated infection surveillance and mandatory reporting

- There have been 19 hospital-associated ***Clostridioides difficile*** cases during Q4 (15 Hospital-Onset, Healthcare-Associated (HOHA) and 4 Community-Onset, Healthcare-Associated (COHA) against a ceiling of 22 HOHA and COHA cases combined (Appendix Figure 1). Hospital-associated *C. difficile* cases were detected in 1.8% of 1048 stool specimens tested during Q4. There was one lapse in care identified in Q4, related to cross-transmission. The rate of healthcare-associated *C. difficile* (HOHA and COHA) cases was the second lowest in the Shelford group based on figures from April 2020 to January 2021. In comparison, the rate of *C.difficile* was third highest in 2019/20. The rate of specimens tested for *C. difficile* fell by 18% during Q4, probably owing to a reduction in activity as a result of the COVID-19 surge.
- There have been three healthcare-attributable **Methicillin-Resistant Staphylococcus Aureus** (**MRSA) Bloodstream Infection (BSI)** during Q4, bringing the total to five healthcare-attributable MRSA BSI cases in FY 2020/21. Compliance with MRSA admission screening was 85% for Q4. The rate of healthcare-associated MRSA BSI cases was the fourth highest in the Shelford group based on figures from April 2020 to January 2021.
- There have been 11 cases of Trust-attributed **Methicillin-Susceptible Staphylococcus Aureus (MSSA) BSI** during Q4, with no evidence of patient-to-patient transmission.

- The number of Gram-negative ***Escherichia coli*****,** ***Pseudomonas aeruginosa*****,** and ***Klebsiella* spp. BSI** increased towards pre-pandemic levels in parallel with the gradual increase in elective and emergency patient admissions over Q4. Our *E. coli* BSI rate ranks lowest in the Shelford group.
- The activities to support the Government's ambition to halve healthcare-associated Gram-negative BSI by 2021 have been interrupted by the management of COVID-19 and will be restarted in Q1 2021/22.
- **Contaminants**[1] accounted for 3.4% of 8318 blood cultures taken during Q4, which is marginally above our local benchmark of 3%.[2] An increase in blood culture contaminants was observed across adult ICUs during the 1st and 2nd COVID-19 peaks, likely related to challenges with hand hygiene and ANTT whilst wearing additional PPE. IPC continue to support the ICU in addressing these issues.
- **Catheter line-associated BSI (CLABSI):**
  - We are unable to report on the CLABSI rate in the adult ICUs for Q3 and Q4 due to data unavailability related to COVID-19 surge management. We aim to report on this in Q1 2020/21.
  - In the 12-month period (Apr 2020 – Mar 2021) there has been one CLABSI case reported in the PICU. Due to COVID-19 level 3 capacity expansions over the 1st and 2nd surge, the activity data for PICU over the COVID-19 period is uninterpretable as it is a mixture of adult and paediatric patients, and so a 12-month rate is unavailable.
  - During Q4 there were two CLABSI episodes reported across the NICUs (QCCH SMH), a Q4 rate of 4.9 per 1000 line days, and a cross-site 12-month rolling rate of 4.1 per 1000 line days, against the National Neonatal Audit Programme (NNAP) benchmark of 4.4 per 1000 line days. The two CLABSI episodes in Q4 were identified in Very Low Birth Weight (VLBW) babies. The 12-month rolling CLABSI rate for this sub-cohort of babies is 4.1 per 1000 line days, below the Nosocomial Infection Surveillance Project (NEO-KISS) benchmark figure of 8.6 per 1000 line days.
- Rates of **Surgical Site Infection (SSI)** following CABG and non-CABG procedures remained consistently above the national average between April 2019 and March 2020. However, SSI rates for the most recent surveillance periods (Jul - Sept 2020 and Oct – Dec 2020) have since returned to below the national average (Appendix Section 7.3).
- We continue to make progress in supporting our Divisions to embed prospective surveillance in the specialities identified as priority areas, starting with Caesarean section, neurosurgery, cardiothoracic, and vascular (Appendix Section 7.3)
- An overall decreasing trend in the number of new patients identified as carrying **Carbapenemase-Producing Enterobacterales (CPE)** has been observed between August 2019 and March 2021 (Appendix Figure 3). The number of new patients identified with CPE in April 2020 fell to a 3 year low of 33, despite single room isolation for CPE carriers being suspended due to COVID-19 during this period. The fall in detection of CPE corresponds with fewer inpatients requiring testing during the 1st and 2nd surge of COVID-19. CPE admission screening was maintained throughout the COVID-19 pandemic. Trust-wide compliance for the quarter was 79%, which is lower than usual (around 85%). The dip corresponds with the 2nd COVID-19 surge, similar to the dip observed during the 1st surge of COVID-19.

7.4. Antimicrobial stewardship

- During Q4 2020/21 the overall consumption of antimicrobials and the use of intravenous agents reduced (Appendix 1- Figure 4). Various antimicrobial stewardship (AMS) were introduced during Q4 to counteract the increases in consumption noted in Q3. Key AMS initiatives during Q4 2020/21 that supported this reduction include:

[1] Bacteria identified in blood cultures that are associated with patients' skin and considered not to be representing infection.
[2] Benchmark for contaminated blood cultures set based on published literature, which suggests a rate of 3%: Self et al. *Acad Emerg Med* 2013; 20:89-97.

- Antimicrobial stewardship rounds have been initiated on all sites using the AMS dashboard to identify carbapenem use and prolonged antibiotic durations. Work is underway to assess their effectiveness.
- ITU microbiology ward rounds are now also attended by the Infection Pharmacy team on all sites to optimise prescribing in critical care.
- The Infection Pharmacy team are now reporting and analysing antimicrobial consumption on a monthly basis. This will allow site based AMS teams to develop a more focused stewardship strategy that targets high use areas.

- The Trust continues to promote the "Access" group as recommended by PHE and WHO to curb the threat of resistance.
- The Infection Pharmacy Team together with Infection colleagues are managing the impact of national antimicrobial shortages for a number of agents. There is no evidence of patient harm as a result of these shortages.
- We continue to participate in the *NHSE Anti-fungal CQUIN* which is part of the wider *Medicines Optimisation CQUIN* and await further information on how this will continue into 2021/22. The biannual antibiotic PPS was due in January 2021 and was postponed in light of the COVID-19 pandemic.

7.5. Hand hygiene and Aseptic Non-Touch Technique (ANTT) competency assessment

- We have a requirement that **ANTT competency assessment** is undertaken and documented for all clinical staff. Currently the compliance rate is 82.6% (7154/8664 clinical staff), below our 90% target. The competency assessment was suspended during the COVID-19 peak and replaced with an ANTT training video. Clinical areas have restarted ANTT competency assessments with existing staff.
- The strategic monthly *PPE and Hand Hygiene Improvement Group* will recommence during Q1.

7.6. Clinical activity, incidents, and lookback investigations during Q4

- Much of the capacity of the IPC service has been directed towards the response to the COVID-19 pandemic.
- As part of a National investigation of a novel COVID-19 'Variant Under Investigation' (VUI), IPC collaborated with PHE to investigate two VUI isolates at our Trust in Feb 2021.This concluded that the Trust had undertaken all appropriate infection prevention and control measures, and no further action was required. No additional cases were identified.
- There have been a number of incidents involving likely cross-transmission of different organisms in the ICUs across the Trust. These include MDR *Pseudomonas aeruginosa,* MRSA*, Corynebacterium striatum, Stenotrophomonas maltophilia, Klebsiella pneumoniae* OXA-48, VRE and *C. difficile.* The investigation has identified some shared underpinning themes and risks across the ICUs and actions are focussed on hand hygiene, PPE use an management of vascular access devices. These are being addressed through a weekly cross-site ICU meeting co-led by IPC and the ICU team.
- *Pseudomonas aeruginosa* on Winnicott Baby Unit at SMH. Antibiotic-sensitive *P. aeruginosa* has been identified on rectal screens from four babies in March 2021. *Pseudomonas* has been identified through routine testing of several outlets, all of which are fitted with a point-of-use filter. None of the patient isolates are available for typing. An Estates-led task and finish group has been commissioned to explore ways to tackle the contaminated water outlets.
- CPE (*Klebsiella pneumoniae* VIM) on Zachary Cope at SMH. Three patients were identified with CPE colonisation in February/March 2021. Typing is indistinguishable for the isolates from these three patients suggesting that cross-transmission has occurred.
- A PHE briefing in February 2021 highlighted an excess of invasive *Staphylococcus capitis* infections impacting neonates across London over the last 18 months (n=80). We have

identified a neonate in the NICU at HH meets the PHE case definition; PHE have been informed.

- Communications materials have been produced to promote best-practice use of ultrasound gel in response to the national alert about *Burkholderia contaminans* (and related organisms).
- A national alert was received related to Becton-Dickenson (BD) intravenous administration sets. A small number of clinical areas have used the affected sets (PICU and NICU). Unused sets in these areas have been replaced. There is no evidence that any patient has come to harm related to using one of these sets.
- In Q4, a total of 13 communicable disease 'look back' investigations were undertaken related to potential exposures to shingles, tuberculosis, Hepatitis E, invasive group A *Streptococcus* and *E. coli* 0157. There were also 13 communicable 'look back' investigations in Q3.
- A total of 18 SIs have been declared during Q4, 15 of which relate to COVID-19 outbreaks.

7.7. **Compliance, policies, and risks**

- The quarterly *Trust Infection Prevention and Control Committee* was held in February 2021, and approved five guidelines.
- There have been no new **IPC risks** identified in Q4. All risks in the IPC risk register have been updated to reflect the challenges related to COVID-19.

7.8. **Other**

- Members of the IPC team have produced 5 peer-reviewed **publications** relating to applied research in HCAI and AMR during Q4.
- Members of the IPC/AMS team are also supporting a range of COVID-19 related national and international expert groups and committees.
- External directives received related to the management of the COVID-19 pandemic were actioned.

8. Conclusion:

8.1. To conclude, this report summarises the activity for IPC team for Q4 2020/2021.

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Appendix 1

1. Hospital-onset COVID-19 infection

We have an established surveillance system for hospital-onset COVID-19 infections (HOCI) within the Trust. The HOCI SITREP utilises the NHS England (NHSE) four category definitions to report on COVID-19 positive inpatients. Surveillance systems for HOCIs are an important aspect of our plans to prevent hospital transmission of COVID-19. NHSE define four categories of COVID-19 when identified in patients in hospitals.

- Community onset (positive sample <= 2 days)
- Hospital-Onset Indeterminate Healthcare Associated (HOIHA, positive sample 3-7 days)
- Hospital-Onset Probable Healthcare-Associated (HOPHA, positive sample 8-14 days)
- Hospital-Onset Definite Healthcare-Associated (HODHA, positive sample >= 15 days)

Figure 1: COVID-19 identified in inpatients.

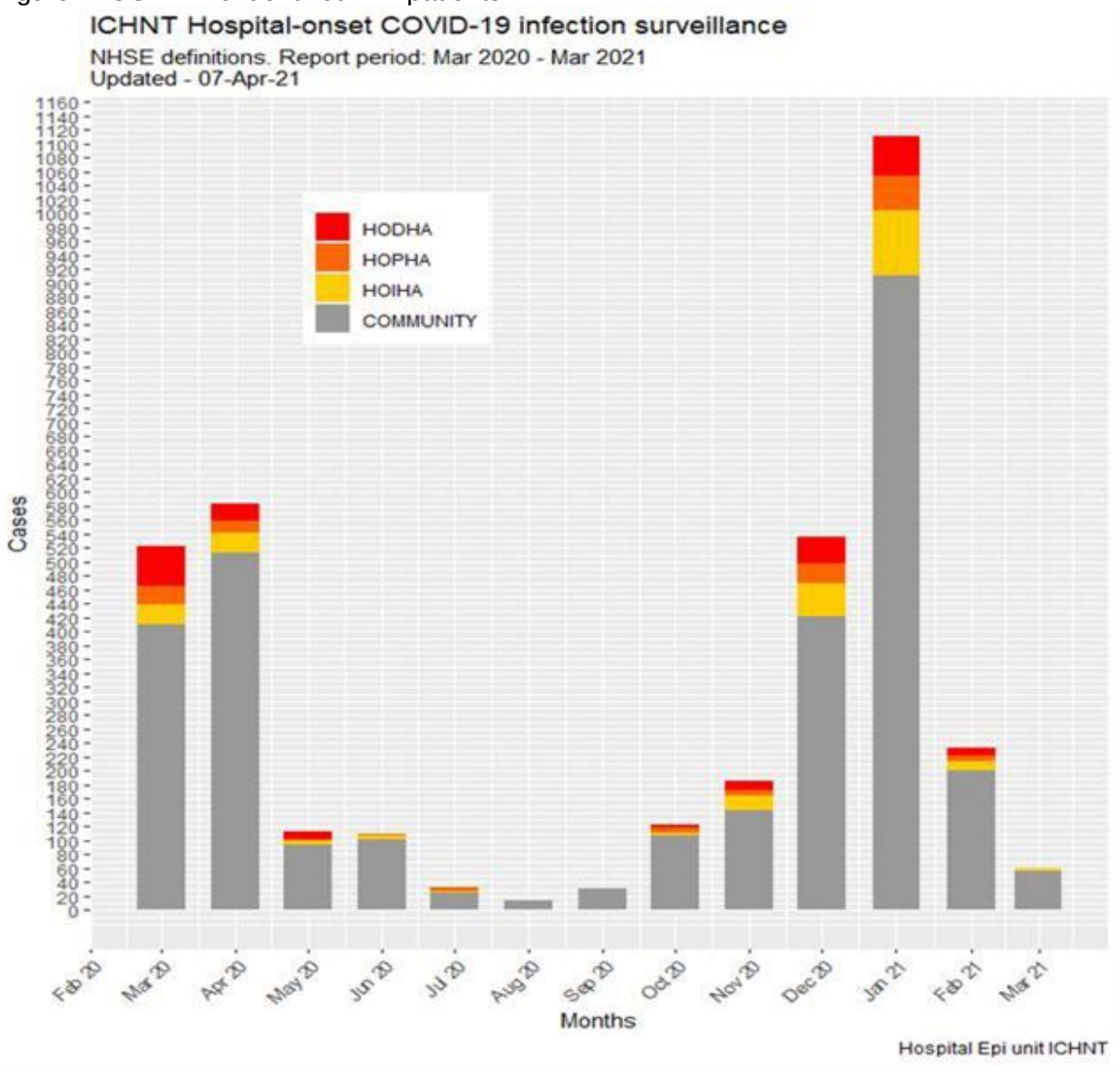

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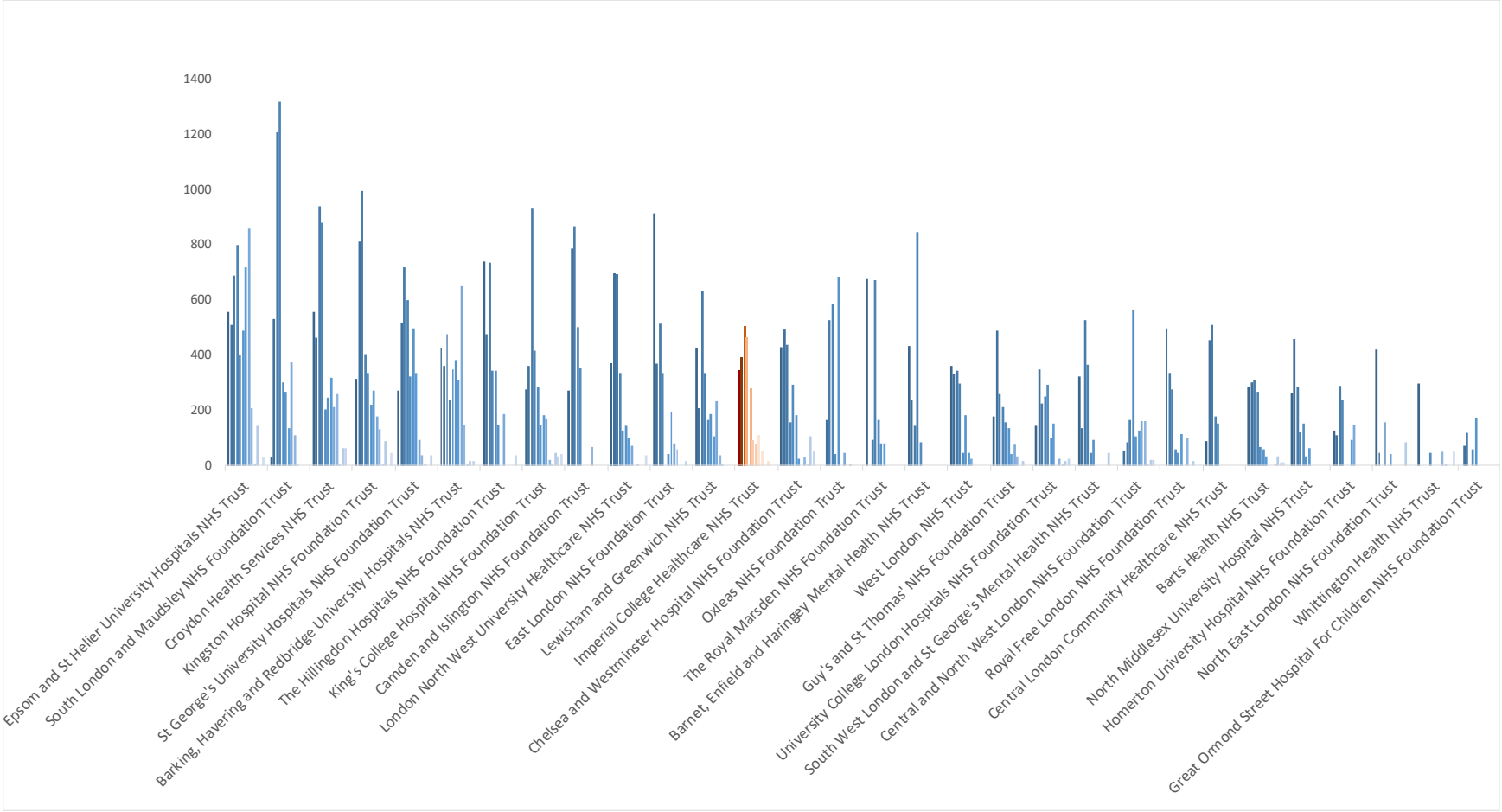
Figure 2: Trend in weekly HOCI rate trend-comparison across London Acute Trusts (Dec 2020 – Mar 2021), sorted by highest average rate from left to right.



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2. Healthcare-associated infection surveillance and mandatory reporting

A summary of healthcare-associated infection (HCAI) that is reported to Public Health England is shown in Table 1.

Table 1: HCAI mandatory reporting summary.

	Apr-20		May-20		Jun-20		Jul-20		Aug-20		Sep-20		Oct-20		Nov-20		Dec-20		Jan-21		Feb-21		Mar-21		YTD	
	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	**No. cases**	YTD (ceiling)
Trust MRSA BSI	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	2	0	1	0	0	0	**5**	0
Hospital onset-Healthcare associated (HOHA)	8	-	6	-	2	-	0	-	2	-	10	-	4	-	1	-	0	-	1	-	7	-	7	-	**48**	-
Community onset-Healthcare associated (COHA)	0	-	0	-	1	-	1	-	0	-	1	-	0	-	4	-	0	-	3	-	1	-	0	-	**11**	-
Total Healthcare associated C.difficile cases (HOHA + COHA)	8	8	6	7	3	6	1	6	2	5	11	5	4	5	5	6	0	7	4	7	8	7	7	8	**59**	77
Trust *Escherichia coli* BSI	2	-	5	-	5	-	6	-	4	-	3	-	8	-	3	-	6	-	7	-	5	-	6	-	**60**	-
Trust MSSA BSI	4	-	0	-	0	-	2	-	3	-	3	-	1	-	3	-	4	-	5	-	3	-	3	-	**31**	-
Trust CPE BSI	0	-	1	-	0	-	0	-	0	-	0	-	1	-	0	-	0	-	1	-	1	-	1	-	**5**	-
Trust *Pseudomonas aeruginosa* BSI	4	-	3	-	2	-	2	-	10	-	5	-	3	-	5	-	3	-	3	-	3	-	4	-	**47**	-
Trust *Klebsiella* spp. BSI	5	-	0	-	4	-	4	-	3	-	3	-	3	-	3	-	4	-	10	-	4	-	6	-	**49**	-

'Trust' refers to cases that are identified after two days of hospitalisation and so are defined epidemiologically as "healthcare-associated". A further delineation is made for C. difficile whereby non-Trust toxin (EIA)-positive cases where the patient has had a previous hospitalisation within 4 weeks are classified as 'Community-Onset Healthcare-Associated (COHA), distinguishing it from 'Healthcare-Onset Healthcare-Associated' (HOHA) cases. National thresholds are set for MRSA BSI and C. difficile infection.

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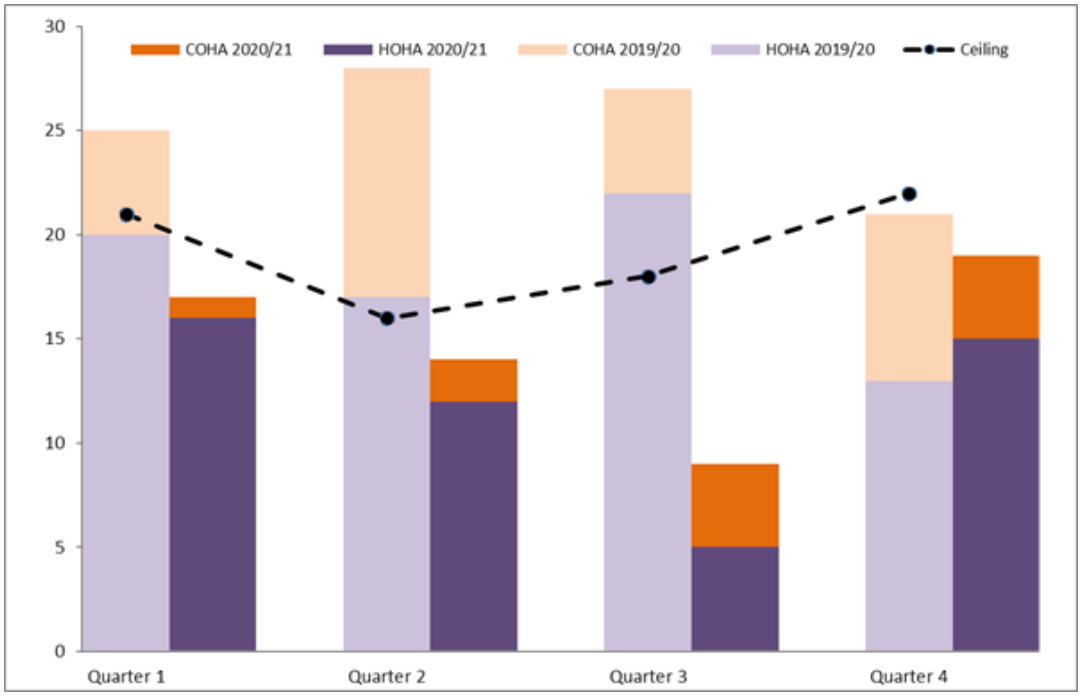
Figure 3: Healthcare-associated C. difficile cases by FY and quarter (2019/20 to 2020/21).



3. Surgical site infection

We report SSI in selected orthopaedic procedures in line with the national mandatory reporting scheme, and selected cardiothoracic procedures in a national voluntary reporting scheme. Elective orthopaedic survey was suspended and the number of cardiothoracic procedures has reduced due to COVID-19 management.

3.1 Cardiothoracic

The latest quarter with finalised submitted data (Oct-Dec 2020 finalised data) has seen:

- CABG: 1 SSI (1.3%) in 78 procedures; 12-month average is 5.5% (15 SSI in 271 procedures); national average is 3.8%.
- Non-CABG: 2 SSI (6.5%) in 31 procedures; 12-month average is 1.2% (2 SSI in 166 procedures); national average is 1.3%.

We had observed the SSI rate in CABG procedures consistently above the national average over the period Apr 2019 to Mar 2020. However, SSI rates for the most recent surveillance period (Oct – Dec 2020) have since returned the national average.

3.2 Orthopaedic

The latest quarter with finalised submitted data (Oct-Dec 2020 finalised data) has seen:

- Knee replacement: 0 SSI in 92 procedures; 12-month average is 0.5% (1 SSI in 204 procedures); national average is 0.6%.
- Hip replacement: 0 SSI in 72 procedures; 12-month average is 0.0% (0 SSI in 159 procedures); national average is 0.6%.

3.3 Expanded SSI surveillance and prevention

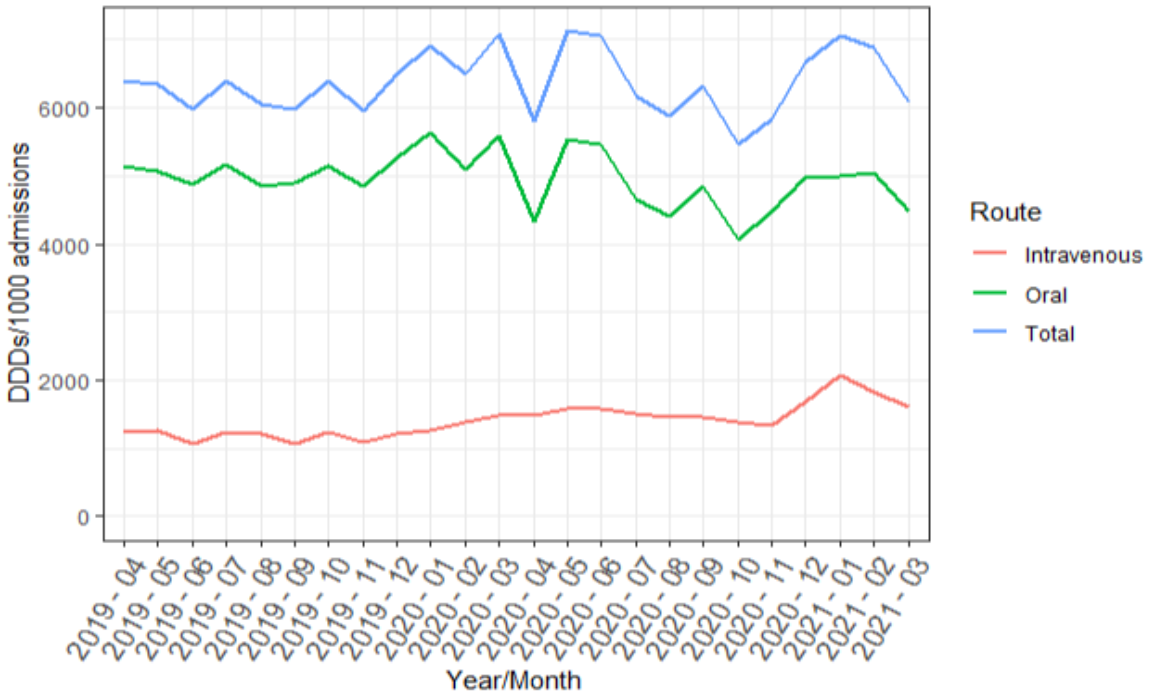
We continue to make progress in supporting the Divisions to embed prospective surveillance in the specialities identified as priority areas (Caesarean section, vascular, neurosurgery, and cardiothoracic). Following completion of the SSI audit in Caesarean section patients, we are currently working with neurosurgery team to undertake a joint audit aiming to:

- Determine baseline SSI rates following all elective and emergency neurosurgery through a pilot surveillance scheme.
- Establish a sustainable platform for neurosurgery SSI surveillance, including post-discharge surveillance.
- Provide actionable audit data on compliance with evidence-based SSI prevention measures.

4. Antimicrobial stewardship

4.1 Antimicrobial consumption

Figure 4: Trust-wide antimicrobial consumption (DDD / 1000 admissions) 2019/20 present, including the split between intravenous and oral administration.



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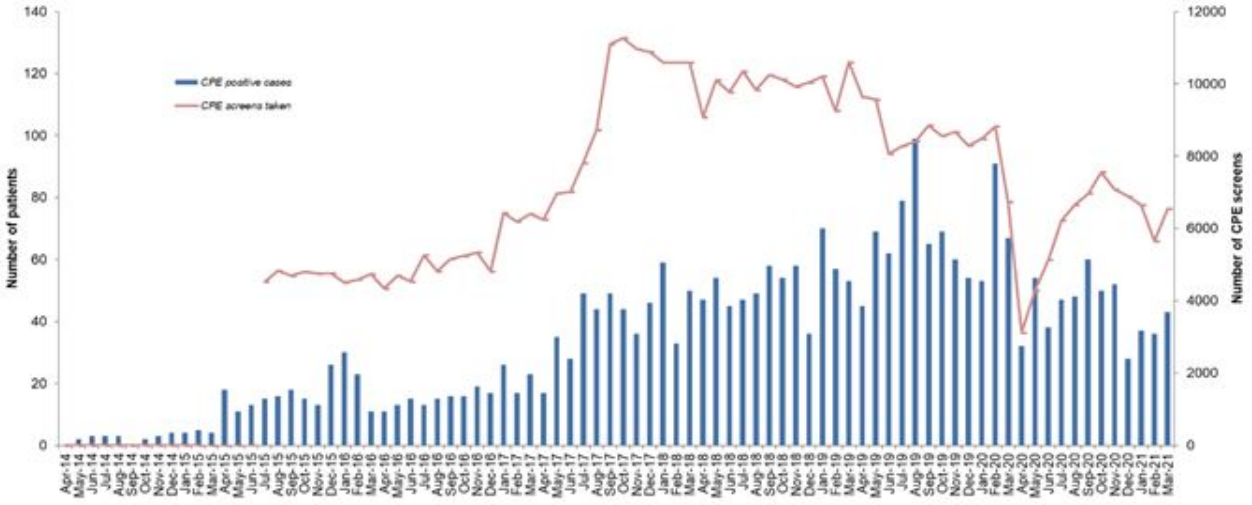
5. 12.5 CPE trends

Figure 5: CPE positive cases detected at the Trust, deduplicated by patient (meaning that each patient appears only once). The line represents the total number of screens taken each month. 78% of positive cases in the past six months are from screening specimens.



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Appendix 2 – Potential contributory factors identified from COVID-19 outbreaks

				Potential contributory factors														
Setting	Date	Patients affected (number with HOPHA and HODHA*)	Staff affected	Hand hygiene	PPE during patient care	PPE/physical distancing in non-clinical areas	Staff coming to work with symptoms	Missed patient testing	Patient mask wearing	Transmission in a bay	Transmission to single rooms	Patient bed spacing	Managing patients with cognitive impairment	Visitors / carers	Environmental hygiene	Staffing levels	Managing contacts	Other
Outbreaks involving only staff																		
Laboratory staff, HH	Aug '20	0	2															Improve integration of Pillar 2 (out of hospital) and Pillar 1 (in hospital) staff testing results.
Midwifery staff, SMH	Sept '20	0	2			●												
Paediatric outpatients, SMH	Sept '20	0	2			●												
Paediatric staff, SMH	Oct '20	0	2			●												
PICU, SMH	Nov '20	0	11			●												Reinforced the need to avoid gatherings outside of the workplace.
Interventional radiology, CXH	Nov '20	0	2															No contributory factors identified.
Renal medical secretaries, HH	Nov '20	0	2			●												
NWLP lab staff, C&W	Nov '20	0	3			●												PPE and physical distancing lapses reported during night shifts.
Renal dialysis staff, HH (Auchi)	Dec '20	0	2			●									●			
Neonatal unit staff, QCCH	Dec '20	0	9		●	●	●											
Cardiology staff, HH	Dec '20	0	6		●	●												
Pharmacy staff, HH	Dec '20	0	4			●	●											
ICU staff, SMH	Jan '21	0	13			●												
Histopathology staff, CXH	Jan '21	0	15			●												
Palliative care staff, SMH	Jan '21	0	2			●												
Stroke ward, CXH	Jan	0	9		●	●									●			

				Potential contributory factors														
Setting	Date	Patients affected (number with HOPHA and HODHA*)	Staff affected	Hand hygiene	PPE during patient care	PPE/physical distancing in non-clinical areas	Staff coming to work with symptoms	Missed patient testing	Patient mask wearing	Transmission in a bay	Transmission to single rooms	Patient bed spacing	Managing patients with cognitive impairment	Visitors / carers	Environmental hygiene	Staffing levels	Managing contacts	Other
(9N)	'21																	
Gynaecology Outpatients, HH	Jan '21	0	3		•	•												
Eleanor staff	Jan '21	0	5			•												
Hepatology staff, SMH	Jan '21	0	4			•												
Security Staff	Jan '21	0	4			•									•			
Endoscopy staff, HH	Jan '21	0	2			•												
Pick & Pack staff	Jan '21	0	4			•									•			
AAU staff, CXH	Jan '21	0	8			•												
Patients Service Centre	Jan '21	0	13			•									•			
Outbreaks involving patients																		
Surgical ward, SMH (Valentine Ellis)	Jul '20	3 (3)	0							•		•						- Prompted agreement on triggers for staff testing as part of outbreak investigation.
Renal ward, HH (Peters)	Oct '20	2 (1)	0		•					•						•		
Stroke ward, CXH (9N)	Oct '20	2 (1)	0							•								
Oncology ward, CXH (6N)	Oct '20	2 (1)	0					•		•								
Elderly medicine / gynaecology, SMH (Lilian Holland)	Oct '20	3 (3	3		•			•		•								
Medicine for the elderly, CXH (8S)	Oct '20	4 (1)	0					•		•								
Renal ward, HH (HJW)	Oct '20	13 (12)	3							•	•		•			•		
Renal ward, HH	Nov	17	5		•				•	•	•		•	•		•		

				Potential contributory factors															
Setting	Date	Patients affected (number with HOPHA and HODHA*)	Staff affected	Hand hygiene	PPE during patient care	PPE/physical distancing in non-clinical areas	Staff coming to work with symptoms	Missed patient testing	Patient mask wearing	Transmission in a bay	Transmission to single rooms	Patient bed spacing	Managing patients with cognitive impairment	Visitors / carers	Environmental hygiene	Staffing levels	Managing contacts	Other
(Peters)	'20	(7)																
Gastroenterology ward, SMH (Almroth Wright)	Dec '20	2 (1)	0	•							•				•		•	
Surgical wards, SMH (MTW/VAL)	Dec '20	10 (9)	3		•			•	•	•		•			•		•	Managing visiting teams
Satellite Dialysis Unit, Northwick Park Hospital	Dec '20	37 (0)	4			•				•		•			•			Communicated with patients to improve physical distancing when outside the unit.
Satellite Dialysis Unit, St. Charles	Dec '20	39 (0)	3				•					•						Reviewed whether patient segregation during transportation can be improved.
Surgical rehab ward (Albert)	Dec '20	41 (36)	16	•	•			•	•	•	•		•		•		•	
Stroke ward, CXH (9S)	Dec '20	8 (7)	15	•	•	•				•	•			•		•		
Medicine for the elderly ward, CXH (8W)	Dec '20	8 (2)	7		•			•		•			•	•	•		•	
Orthopaedic ward, CXH (7S)	Dec '20	2 (1)	1							•							•	
Medicine for the elderly ward, CXH (8S)	Dec '20	9 (5)	9		•	•		•	•	•			•		•		•	
Respiratory Medicine, SMH (Manvers)	Dec '20	3 (2)	0							•								
Medicine for the elderly ward CXH (8N)	Jan '21	6 (4)	5		•		•		•	•		•				•		
Major Trauma Ward, SMH	Jan '21	7 (4)	6	•						•		•				•		
Surgical ward, SMH (Charles Pannett)	Jan '21	10 (10)	5			•				•						•		Bathroom access / environmental layout.
Satellite Dialysis Unit, Watford	Jan '21	13 (0)	2									•						
Surgical ward, SMH (Paterson)	Jan '21	3 (3)	8		•	•				•						•		

				Potential contributory factors															
Setting	Date	Patients affected (number with HOPHA and HODHA*)	Staff affected	Hand hygiene	PPE during patient care	PPE/physical distancing in non-clinical areas	Staff coming to work with symptoms	Missed patient testing	Patient mask wearing	Transmission in a bay	Transmission to single rooms	Patient bed spacing	Managing patients with cognitive impairment	Visitors / carers	Environmental hygiene	Staffing levels	Managing contacts	Other
Medicine for the Elderly Ward, SMH (Lewis Lloyd)	Jan '21	9 (5)	1			•				•		•	•					Bathroom access / environmental layout.
Satellite Dialysis Unit, Hayes	Jan '21	22 (0)	0									•				•		
Surgical ward, SMH (Zachary Cope)	Jan '21	1 (0)	2		•													
Renal ward, HH (Kerr ward)	Jan '21	2 (2)	0							•								
Surgical ward, CXH (10S)	Jan '21	5 (2)	3							•			•					
Medicine for the Elderly, CXH (5W)	Jan '21	5 (4)	2														•	
Neurology ward, CXH (10N)	Jan '21	7	9	•	•					•								
Surgical ward, CXH (7W)	Jan '21	9	1	•	•					•							•	
Medical ward, SMH (Thistlethwayte)	Jan '21	10 (6)	4							•		•				•		
Surgical ward, CXH (Riverside)	Jan '21	9 (8)	3		•					•		•					•	
Neuro Rehabilitation, CXH (9W)	Feb '21	2 (2)	0	•	•					•						•		
Renal ward, HH (Peters)	Feb '21	2 (2)	2	•						•						•		
Satellite Dialysis Unit, Ealing	Feb '21	4	0							•		•				•		
ICU, SMH	Feb '21	2 (1)	0							•						•		

* HOPHA = Hospital-Onset Probable Healthcare-Associated (positive sample 8-14 days); Hospital-Onset Definite Healthcare-Associated (positive sample >= 15 days).

Imperial College Healthcare NHS Trust

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Date: 12.04.2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Infection prevention and control board assurance framework for COVID-19 – self-assessment April 2021

Agenda item 14.2 and paper number: 11b

Executive Director: Professor Julian Redhead, Medical Director

Author: Jon Otter, General Manager, IPC and Professor Alison Holmes, Director, IPC

Purpose: For information

Meeting date: 12 May 2021

Executive summary

1. Purpose

1.1. This document provides an update on progress with completion of the actions required to provide assurance with all elements of the BAF. This is a live document including the self-assessment from April 2021. It is being presented to this committee for information.

2. Background

2.1. In May 2020, NHS England published an infection prevention and control board assurance framework to support the provision of assurance to Trust boards that their approach to the management of COVID-19 is in line with PHE infection prevention and control (IPC) guidance, that risks have been identified and are mitigated.

2.2. The recommended approach is to undertake a self-assessment against the 10 domains in the framework. This paper sets this out for ICHT with "RAG" ratings for each line.

3. Key findings

3.1. An action plan is in place to undertake the necessary work that will improve board assurance related to IPC management of COVID-19 infection. This is being monitored weekly at the Clinical Reference Group (CRG) reporting to the Executive management board through the Medical Director as executive lead.

3.2. Good progress is being made in general but two areas that remain "red" rated have been highlighted as requiring additional executive support (FFP3 mask management and COVID secure management of non-clinical areas). A review meeting took place on 4th May. The agreed actions and next steps were presented to executive huddle on 5th May and are now being taken forward. A revised checklist will be developed for local areas to complete to confirm their COVID-secure status. A four-week schedule of assurance visits will begin in mid-May to check compliance. Feedback will be monitored at executive huddle. A plan for FFP3 mask management will be in place by 7th May.

3.3. The BAF for April is attached as Appendix 1.

4. Next steps

4.1. The IPC BAF self-assessment will continue monthly until further notice.
4.2. The CRG will continue to devote part of its agenda to the BAF to ensure implementation of the actions required to provide full assurance.
4.3. The Divisions are developing individual implementation plans for some aspects of the BAF as agreed at CRG.
4.4. The BAF will continue to be reported monthly to the EMB Quality group, EMB, and bi-monthly to Quality Committee and the Trust Board.

5. Recommendation(s)

5.1. The report was discussed at the Quality Committee. The Board is asked to note progress with the IPC BAF self-assessment for April 2021.

6. Impact assessment

6.1. Quality impact
IPC and careful management of antimicrobials are critical to the quality of care received by patients at Imperial College Healthcare NHS Trust, crossing all CQC domains. This report provides assurance that IPC within the Trust related to COVID-19 is being addressed in line with the 'Health and Social Care Act 2008: code of practice on the prevention and control of infections' and related guidance.

6.2. Financial impact
N/A

6.3. Workforce impact
N/A

6.4. Equality impact
N/A

6.5. Risk impact
This report is a self-assessment based on the NHSE/I COVID-19 BAF. Gaps in assurance and mitigating actions against each KLOE are outlined in the full document (Appendix 1).

Main report

7. Discussion/key points

7.1. The updated BAF for April 2021 is attached as Appendix 1. Key changes since the last monthly update include:

- Full assurance has been provided against most of the new KLOEs.
- Specific evidence has been cross-referenced and included where possible.
- The following KLOEs are rated as red:
  - 1.4 and 10.13. Physical distancing and Monitoring COVID-19 prevention measures in non-clinical areas (Occupational Health and Safety). The response to this KLOE will ensure that actions outlined by the HSE report of key findings from inspections in other hospitals are met.
  - 10.3 A new process is being developed to ensure that training for FFP3 respirators is undertaken and records maintained (PPE strategic group).
- These areas rated as "red" have been highlighted as requiring additional executive support. A review meeting took place on 4th May. The agreed actions and next

steps were presented to executive huddle on 5th May and are now being taken forward. A revised checklist will be developed for local areas to complete to confirm their COVID-secure status. A four-week schedule of assurance visits will begin in mid-May to check compliance. Feedback will be monitored at executive huddle. A plan for FFP3 mask management will be in place by 7th May.

- The following KLOEs are amber:
  - 1.2. Whilst unnecessary patient bed moves have been reduced, further work is required to ensure that all bed moves are clinically imperative (Site Directors). A further audit will be undertaken to determine the reasons for bed moves and identify areas for improvement.
  - 1.8. IPC training for contractors (Core skills). A review of the IPC training for contractors is being undertaken with Estates and Facilities with a view to including this in their contract and ensuring evidence is available electronically.
  - 2.9. Cleaning of electronic equipment (Communications / DDNs). A communications plan is under development to ensure staff are aware of this requirement.
  - 2.14. Monitoring cleaning standards in non-clinical areas (Facilities). Cleaning standards are monitored in non-clinical areas twice each year, as per the national cleaning standards. Plans are being developed to increase the frequency of monitoring.
  - 2.15. Measures to ensuring good ventilation in admission and waiting areas are being reviewed (Estates). The Estates department are conducting walkarounds in conjunction with IPC to review current compliance and identify areas for improvement.
  - 4.1. Visitor guidance (Patient Experience). Trust visiting guidance is being reviewed at CRG and will be updated in line with new national guidance if agreed.
  - 5.1, 5.13, 8.7. Compliance with routine patient testing is monitored weekly. Patients who have tested negative on/before admission and are not COVID-recovered have been tested daily for the first 7 days of their admission from 22/03/2021. Compliance with Day 3 testing has risen to 80% and with 7 day testing to 70%.
  - 5.8. Monitoring compliance with patient mask wearing (Divisional leads). Audits of patient compliance with face mask wearing are currently being planned.
  - 5.10. Divisional reviews of bed spacing have identified a small number of beds / trolleys where >2m spacing cannot be achieved. Mitigations in place are being reviewed.
  - 6.9. New signage to encourage best-practice hand hygiene in public toilets is being developed and implemented (Communications).
- The following KLOEs are now green:
  - 2.4. Terminal cleaning sign-off evidence (Facilities). Facilities has confirmed that sign-off sheets are routinely stored. These are now be available electronically.
  - 8.8. Daily testing of patients in areas with high nosocomial infection. Contacts of a known positive case are testing daily through their 14 day isolation period. Patients who have tested negative on/before admission and are not COVID-recovered are tested daily for the first 7 days of their admission.

7.2. **Options appraisal**
N/A

8. Conclusion

8.1. The IPC BAF has been completed for April 2021. The CRG will continue to devote part of its agenda to the BAF to ensure implementation of the actions required to provide full assurance. The divisions are developing individual implementation plans for the BAF as agreed at CRG. The two areas where the assessment remains red were escalated to an

executive level review meeting with the Medical Director to agree actions to mitigate the risks and improve compliance, which took place on 4th May. Actions have been developed and are now being taken forward, with monitoring at executive huddle.

4

Appendix 1 – IPC BAF April 2021

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				
Key lines of enquiry; systems and processes are in place to ensure:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Status**
1.1. Infection risk is assessed at the front door and this is documented in patient notes	• COVID-19 patient assessment pathways agreed at the CRG[1] and widely communicated. • Risk assessment of patients for COVID-19 during emergency admission pathways is embedded in the organisation. • Pathway breaches are reported on Datix and trigger incident investigation. • An audit of patient notes was completed (in December 2020) and returned substantial assurance that infection risk is assessed and	-	-	Ongoing

[1] The Clinical Reference Group (CRG) is a cross-Divisional multi-disciplinary group to review and make decisions around COVID-19 management.

	documented in patient notes. • An electronic system for reviewing compliance with patient admission testing for COVID has been implemented, and shows good compliance with COVID admission testing.			
1.2 There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative	• An audit of internal transfer documentation (in December 2020) has been completed and provides reasonable assurance that patient moves are justified. • When contacts from separate exposures are cohorted together, this is investigated via Datix.	• Despite reasonable assurance from the audit that bed moves have been minimised, some unjustified bed moves continue. • Internal patient transfers (especially of contacts of known cases) has been identified as a root cause in some outbreaks.	• Limiting the movement of patients with pathogens associated with HCAI is included in various IPC policies, and is reinforced in COVID-19 specific guidance. • The need to limit the movement of patients was reinforced during pathway remobilisation in the summer of 2020. • Specific guidance for moving patients between low, medium, and high risk pathways has been agreed at CRG. • Further work is necessary to monitor and reduce unnecessary patient movement.	In progress

			• A further audit of patient moves will be undertaken to determine whether they were clinically imperative.	
1.3 That on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	• Cohorting patients with COVID-19 in routine practice. • Cohort areas are disinfected using chlorine as per the ***Infection Prevention and Control Management of COVID-19 Policy***. • IPC advise when COVID-19 cohort bays are established and discontinued.			Completed
1.4 Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice: ○ *staff adherence to hand hygiene* ○ *staff social distancing across the workplace* ○ *staff adherence to wearing fluid resistant surgical facemasks (FRSM) in:*	• Each Division has structures in place to monitor IPC practice and identify areas of concern for escalation. • IPC visit clinical areas regularly to review practice. • IPC visit clinical areas where possible cross-transmission has been identified to reinforce best-practice.	Limited assurance around COVID-prevention measures in non-clinical settings.	• Processes for monitoring COVID-prevention measures in COVID-secure areas are being reviewed by the Health & Safety Committee. • Actions agreed following executive level review meeting on 4th May. A revised checklist will be developed for local areas to complete to confirm their COVID-secure status. A four-week schedule of assurance visits will begin	In progress

• *a) clinical* • *b) non-clinical setting*	• PPE Helpers visit clinical areas regularly to review and support best practice. • Hand hygiene auditing is undertaken regularly across the Trust in clinical areas. • PPE Helpers visit some non-clinical areas including public areas and staff restaurants. • Staff in non-clinical areas have been provided information and access to surgical face masks, hand gel, and cleaning wipes to enable the management of COVID-secure offices.		in mid-May to check compliance. Feedback will be monitored at executive huddle.	
1.5 Monitoring of compliance with PPE, within the clinical setting consider implementing the role of PPE guardians/safety champions to embed and encourage best practice.	• A PPE Helper programme was developed during the first wave of COVID-19, and PPE Helpers have been active in clinical areas since the summer of 2020.			Completed
1.6 Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include	• Routine testing using lateral flow testing has been implemented and is available to all patient-facing staff.			Completed

organisational systems in place to monitor results and staff test and trace.	• For staff who participate, positive and negative results are recorded using an electronic system, with automated reminders in place if results are not logged twice weekly. • Staff who report a positive lateral flow test are contacted to arrange a PCR confirmatory test. • Staff with COVID-19 symptoms undergo PCR testing which feeds into trace and isolate •			
1.7 Additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team.	• Targeted testing of all staff in areas where outbreaks are identified			Completed
1.8 Training in IPC standard infection control and transmission-based precautions are provided to all staff	• All clinical staff undergo a competency assessment for ANTT[2], hand hygiene, and PPE when they join	Compliance with IPC training for contractors staff is not managed electronically.	IPC training provision for all Trust contractors is being reviewed with Estates and Facilities, with the aim of ensuring this is included in	In progress

[2] ANTT = aseptic non-touch technique.

	the Trust and every three years. • All staff undertake mandatory IPC training, which covers transmission-based precautions every three years. • Contractors receive IPC training as part of their contract.		their contract, and managed electronically	
1.9 IPC measures in relation to COVID-19 should be included in all staff induction and mandatory training	• IPC measures in relation to COVID-19 are included in mandatory IPC training for all staff.			Completed
1.10 All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	• Trust PPE guidance updated in line with PHE guidance regularly, approved at the CRG and communicated on the Intranet and via all-staff emails. • There is a bi-weekly Strategic PPE Planning group chaired by the Director of Nursing and including the Director of Finance. • The monthly Hand Hygiene Improvement Group has become the	•	•	Completed

	Hand Hygiene and PPE Improvement Group. • PPE donning and doffing is included in mandatory training. • All clinical staff undergo a competency assessment for ANTT, hand hygiene, and PPE when they join the Trust and every three years. • Contractors receive IPC training as part of their contract. • Guidance updated regularly and communicated to staff. • A review of each clinical area completed to review pathways and PPE usage. • PPE Helpers are now actively reviewing clinical practice related to PPE.			
1.11 There are visual reminders displayed communicating the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	• Messages about COVID-19 prevention measures are reinforced through posters, intranet pages, regular all-staff communications, and in relation to specific issues.			Completed

1.12 National IPC PHE guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• Trust IPC guidance is updated in line with changes to PHE guidance. This process includes review and scrutiny at the CRG, and communication of changes through the all-staff email and through Divisional networks. • Pathway remobilisation checklists were completed and reviewed by CRG. Low risk pathways are operating as medium risk due to the high level of community prevalence.	-		Completed
1.13 Changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• Changes to guidance are discussed at CRG and the BAF updated accordingly which reports ultimately to the Board.			Completed
1.14 Risks are reflected in risk registers and the Board Assurance Framework where appropriate.	The appropriate risks on the IPC risk register have been updated to reflect the COVID-19 situation. A COVID risk is on the corporate risk register as well as at divisional levels. These are reported to the	-		Completed.

	executive committees and the board quality committee. This board assurance framework highlighting any gaps in assurance will be shared with the Executive Team following each update and then Trust Board through the Quality Committee and quarterly DIPC report. Risk registers have been updated to better reflect the emerging risks associated with COVID-19.			
1.15 Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens.	• The Trust Infection Prevention and Control Committee (TIPCC) continues to meet quarterly. • TIPCC receives updates from IPC-related groups and committees. • There is also a weekly HCAI sitrep call, which includes representatives from IPC, clinical Divisions, and relevant support services to discuss current and strategic IPC and			Completed.

	antimicrobial stewardship priorities. • The Trust will publish the IPC annual report. • The IPC service will continue to provide real-time data for all alert organisms and HCAI rates. • Regular input from our PHE CCDC. • The Trust receives quarterly reports which monitor progress against national targets for MRSA bacteraemia and *C. difficile* infection and the mandatory reporting of MSSA and *E.coli* BSI and any significant IPC issues. • IPC activity and data is reported to the Trust Board and CCG in the monthly Quality and Safety report, and quarterly in the IPC and Antimicrobial Stewardship report. • The Trust's divisional and corporate risk register will continue to identify and			

	monitor any Trust wide risks in relation to IPC.			
1.16 The Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	• The methodology for the daily COVID-19 sitrep has been agreed with IPC, and the Director of Operations Performance signs off the returns.			Completed
1.17 This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	• The Board Assurance Framework is RAG rated, updated monthly, and reviewed by the Executive Team at EMB Quality and the Trust Board. In addition, an associated action plan is reviewed weekly at CRG.			
1.18 Ensure Trust Board has oversight of ongoing outbreaks and action plans.	• A summary of COVID-19 outbreaks is included in IPC reports to the board. • Each new outbreak is discussed at CRG prior to external reporting.			Completed

	• Action plans related to areas of concern around COVID-19 outbreaks are discussed at CRG.			
1.19 There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas.	• The senior leadership and executive teams regularly visit clinical and non-clinical areas to speak to staff and allow them to raise concerns.			

2 Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				
Key lines of enquiry; systems and processes are in place to ensure:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Status**
2.1. Designated teams with appropriate training care for and treat patients in COVID-19 isolation or cohort areas	• All staff required to clean in medium and high risk wards are provided with specific training. • Training undertaken and training records available for all facilities staff working in COVID-19 isolation or cohort areas.	-	-	Completed
2.2. Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	All staff required to clean in medium and high risk wards are provided with specific training. This model was chosen so that cleaning staff who are used to working in a certain clinical area and have established links with staff are not moved to work in unfamiliar clinical areas.	-	-	Completed
2.3. Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE national guidance	Trust guidance, which is based on national guidance, has been produced and published on the Intranet.	-	-	Completed

2.4. Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	Each terminal decontamination process is signed off and documented by facilities and ward staff both as part of routine practice and during outbreaks. The sign-off sheets for terminal cleaning are available electronically.	-	-	Completed
2.5. Increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE national guidance	This applies to medium and high risk pathways. Trust guidance, including the need for increased cleaning in some areas, has been produced and published on the Intranet. Each site maintains a record of which ward areas are undergoing enhanced cleaning.	-	-	Completed.
2.6. Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT)	• In all medium and high risk pathways, cleaning and disinfection is undertaken using Actichlor plus (a chlorine-based detergent disinfectant). • Disinfection of some items is undertaken using Clinell Green detergent/disinfectant wipes, which are effective against non-enveloped viruses including SARS-CoV-2.	-	-	Completed

should be consulted on this to ensure that this is effective against enveloped viruses				
2.7. Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance	Manufacturers' guidance and recommended product 'contact time' are followed for all cleaning/disinfectant solutions/products.	-	-	Completed
2.8. 'Frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids	In medium and high risk pathways, each area receives at least one full clean (including frequently touched surfaces) and two touch-point cleans each day.	-	-	Completed
2.9. Electronic equipment e.g. mobile phones, desk phones, tablets, desktops &	In medium and high risk pathways, each area receives at least one full clean (including frequently touched surfaces) and two touch-	Limited assurance that electronic frequently touched items are cleaned at least twice daily.	Communications being developed to remind staff of the need to clean all	In progress

keyboards should be cleaned a minimum of twice daily	point cleans each day including electronic equipment.		electronic equipment, including mobile phones.	
2.10. Rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	In medium and high risk pathways, each area receives at least one full clean (including frequently touched surfaces) and two touch-point cleans each day.	-	-	Completed
2.11. Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Trust guidance for the management of linen from possible and confirmed COVID-19 patients has been produced and published on the Intranet. The process for managing infectious linen is monitored through an external contract with KPIs in place to manage the contract.	-	-	Completed
2.12. Single use items are used where possible and according to Single Use Policy	Trust guidance for the use of single use items is included in the Trust Decontamination Policy. Disposable cloths and mops are used as routine practice in areas managing suspected or confirmed COVID-19 patients.	-	-	Completed

2.13. Reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	Trust guidance for the use of single use items is included in the Trust Decontamination Policy. All PPE items are either decontaminated using manufacturer instructions or single use.	•	-	Completed
2.14. Ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	Clear guidance for cleaning and disinfection in non-clinical areas has been issued, and posters are in place to remind staff of the new for frequent environmental hygiene.	Monitoring officers have been redeployed as part of the wider support to the Trust during surge and therefore no scheduled independent routine monitoring is currently in place.	• Cleaning standards are monitored in non-clinical areas twice each year, as per the national cleaning standards. • Plans are being developed to increase the frequency of monitoring.	In progress
2.15. Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	The importance of ventilation has been communicated to staff.	Enhanced ventilation has not been specifically reviewed in admission and waiting areas.	The Estates department are conducting walkarounds in conjunction with IPC to review current compliance and identify areas for improvement.	In progress

2.16. Monitor adherence to environmental decontamination with actions in place to mitigate any identified risk.	• Cleaning audits are undertaken in clinical areas across the Trust, with actions put in place by Facilities Quality Managers to address any issues or risks identified.	-	-	-
2.17. Monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk.	• Clear guidance for staff have been issued on the decontamination of shared equipment. • Decontamination of shared equipment is routinely audited as part of the national cleaning standards audits.	-	-	Completed.

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Key lines of enquiry; systems and processes are in place to ensure:	Evidence	Gaps in Assurance	Mitigating Actions	Status
3.1. Arrangements around antimicrobial stewardship are maintained	• The bi-annual point prevalence study of antimicrobial prescribing was conducted in January 2020, and showed good compliance with prescribing indicators. • Interim guidance for initial antimicrobial management of adult patients with suspected or confirmed COVID-19 being admitted to ICHNT	-	-	Completed

	and changes to the management of HAP have been produced, approved through the CRG, and published on the Trust Intranet. • The Antibiotic Stewardship Cerner Dashboard has been used to target antimicrobial stewardship activities. • Working across HCID centres nationally to determine AMS strategies being deployed + manage fragile supply chains • Introduction of COVID trails in line with CMO requests.			
3.2. Mandatory reporting requirements are adhered to and boards continue to maintain oversight	Mandatory reporting requirements related to antimicrobial consumption and CQUINs have been maintained in the IPC quarterly report to the Trust board.	-	-	Completed

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion

Key lines of enquiry; systems and processes are in place to ensure:	Evidence	Gaps in Assurance	Mitigating Actions	Status
4.1 Implementation of national guidance on visiting patients in a care setting	This was implemented in line with national guidelines.	Visiting guidance has been updated to allow visitors in a careful and controlled way.	Trust visiting guidance is being reviewed at CRG and will be updated in line with new national guidance if agreed.	In progress.
4.2 Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas marked with appropriate signage and where appropriate with restricted access	• The communications team have produced signage to designate areas used to care for patients with confirmed or suspected COVID-19, and for designated COVID-protected pathways. • Clear signage has also been designed to designate COVID-secure non-clinical workspaces.	-	-	Completed.
4.3 Information and guidance on COVID-19 is available on all Trust websites with easy read versions	• The Trust website has dedicated COVID-19 management pages on the homepage of the site.A booklet for patients admitted during the COVID-19 pandemic has been produced. • Easy Read versions have been produced and published.	-	-	Completed.

4.4. Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• Discharge guidance for patients with COVID-19, including the need to communicate COVID-19 status, has been produced and published on the Trust Intranet. • COVID-19 status is routinely included in patient discharge summaries. • An audit of internal transfer documentation has returned substantial assurance that infection status is communicated during internal patient transfers of patients with COVID-19.	Documentation of compliance with protocol for internal transfers has not been audited.	The results of tests for COVID-19 are in Cerner (electronic patient record) and should be routinely reviewed by receiving clinical teams during internal transfers.	Completed.
4.5. There is clearly displayed and written information available to prompt patients, visitors and staff to comply with hands, face and space advice	• Each hospital entrance has a welcome station with signage to encourage 'hands, face, space.'	-	-	Completed.

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				
Key lines of enquiry; systems and processes are in place to ensure:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Status**
5.1 Screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.	Triaging and testing processes are in place and embedded in all care pathways.	Compliance with admission testing is <100%.	Compliance with routine patient testing is monitored weekly. Patients who have tested negative on/before admission and are not COVID-recovered have been tested daily for the first 7 days of their admission from 22/03/2021. Compliance with Day 3 testing has risen to 80% and with 7 day testing to 70%.	In progress
5.2 Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from non-COVID-19 cases to minimise the risk of cross-infection as per national guidance	COVID-19 patient assessment pathways approved at CRG and widely communicated for the Emergency Department and Admission wards. These included physical segregation of patients with confirmed COVID-19 or symptoms from those without.	-	-	Completed

5.3 Staff are aware of agreed template for triage questions to ask	Staff are aware of agreed template for triage questions to ask. Compliance was audited in late 2020.	-	-	Completed
5.4 Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	• COVID-19 patient assessment pathways including the triggers for patient testing approved at CRG and widely communicated.	-	-	Completed
5.5 Face coverings are used by all outpatients and visitors	• Face coverings are required by all outpatients and visitors and this is reinforced by welcome station staff. • PPE Helpers have spent some time in welcome stations to review practice.	-	-	Completed
5.6 Face masks are available for all patients and they are always advised to wear them.	Face masks are available for patients with respiratory symptoms. Patients are advised to wear surgical masks unless they are eating, drinking, or sleeping. If a patient is not able to wear a surgical mask, this is documented in Cerner.	-	-	Completed

5.7 Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	• Clear advice is provided to all patients to encourage the use of surgical facemasks unless they are eating, drinking, or sleeping. • If a patient is unable to wear a surgical mask, this is documented in Cerner.	-	-	Completed
5.8 Monitoring of inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so).	• Clear advice is provided to all patients to encourage the use of surgical facemasks unless they are eating, drinking, or sleeping. • If a patient is not able to wear a surgical mask, this is documented in Cerner.	Patient compliance with face mask wearing has not been audited.	Audits of patient compliance with face mask wearing are currently being planned.	In progress
5.9 Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	• Screens are used in some non-clinical areas to improve segregation of staff. • Staff working in clinical areas continue to wear surgical masks, even if they are behind a screen.	-	-	Completed
5.10 To ensure 2 metre social & physical distancing in all patient care areas.	• Clear guidance has been given to staff about the need to maintain physical distancing of at least 2m wherever possible. • Beds and patient chairs should be spaced >2m apart when	Some bed / trolley spaces are not >2m apart.	• Divisional reviews of bed spacing have identified a small number of beds / trolleys where >2m spacing cannot be achieved. Mitigations in	In progress

	possible (bed centre to bed centre). • "Chair, bed, locker" arrangement of furniture is in place.		place are being reviewed.	
5.11 For patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	Rapid identification and testing of patients along with contact tracing is in place.	-	-	Completed
5.12 Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly.	• COVID-19 patient assessment pathways widely communicated. • Pathway breaches are reported on Datix and trigger incident investigation.	Pre-emptive isolation of patients who develop symptoms following a negative test are not always available due to lack of single room availability.	Situations are managed on a case-by-case basis with input from the IPC team, usually be establishing cohorts of confirmed or suspected patients. There is a risk on the IPC risk register related to limited isolation facilities in the Trust.	Completed
5.13 There is evidence of compliance with routine patient testing protocols in line with 'Key actions: infection prevention and control and testing document.'	• Compliance with patient testing pre-admission, on admission, on day 3, day 7, weekly, and prior to discharge (if required) is monitored automatically.	Compliance remains <100%.	Compliance with routine patient testing is monitored weekly. Patients who have tested negative on/before admission and are not COVID-recovered have been tested daily for the first 7 days of their admission from 22/03/2021. Compliance	In progress.

			with Day 3 testing has risen to 80% and with 7 day testing to 70%.	
5.14 Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• Patients attending for routine appointments are triaged to make sure they don't have symptoms consistent with COVID-19. • Patients that are not tested prior to their admission are managed on medium risk pathways. • Recovery plans are scrutinised to ensure face-to-face is the exception not the rule. • All recovery plans are approved by the site IPC lead before approval at CRG and then the Trust executive team.	-	-	Completed.

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				
Key lines of enquiry; systems and processes are in place to ensure:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Status**

6.1 Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	Each pathways was reviewed at CRG to optimise the separation of patients, staff, and visitors in the summer of 2020.	-	-	Completed
6.2 All staff (clinical and non-clinical) have appropriate training, in line with latest PHE guidance, to ensure their personal safety and working environment is safe	All staff undergo electronic IPC training (IPC Level 1), with clinical staff receiving a more detailed session (IPC Level 2).	Compliance is >90% for Level 1 and Level 2.	The need for high compliance with this (and other) mandatory training is a Trust priority.	Ongoing/sustain via HR with IPC support.
6.3 All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it.	All staff receive training on appropriate use of PPE.	Ward-based training records are not routinely stored electronically.	The content of mandatory training for clinical staff has been reviewed and it covers the selection of appropriate use of PPE and how to safely don and doff. Compliance with this training ("IPC Level 2") is reviewed at the Executive People and Organisational Development Committee. An updated electronic resource for training staff related to PPE has been produced and will be	Completed.

			launched in the coming weeks.	
6.4 A record of staff training is maintained.	Electronic records are kept for the Level 1 and Level 2 training modules.	-	-	Completed
6.5 Adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	• PPE helper programme provide ward-level support for staff to use the correct PPE, and to use it safely. • The PPE helper programme provides an assessment of adherence to national guidance around PPE in clinical areas. • The safe and effective use of PPE is a strategic objective of the Hand Hygiene and PPE Improvement Group, which meets monthly.	-	PPE helpers are visiting clinical areas daily to observe PPE use and support best practice.	Ongoing/sustain via Hand Hygiene and PPE Improvement Group
6.6 Hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as:	• Each hospital entrance has a welcome station with signage to encourage 'hands, face, space.' • Specific guidance has been produced for managing COVID-secure non-clinical areas, including specific			

• hand hygiene facilities including instructional posters • good respiratory hygiene measures • staff maintain physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care • staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace • frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	signage to promote physical distancing, and hand, respiratory (including the use of masks), and surface hygiene. • Separate signage has been produced for clinical areas to promote physical distancing, and hand, respiratory (including the use of masks), and surface hygiene. • Staff are clear that car sharing should be avoided (but may be the safest route to travel). • Reminders to reinforce these key prevention messages are sent regularly to all staff. • The Trust Intranet has key information on COVID-19 prevention measures.			

6.7 Staff regularly undertake hand hygiene and observe standard infection control precautions	The bi-annual hand hygiene audits were planned for April but postposed given the pandemic and the need to minimise non-COVID related activity on wards.	Limited surveillance on current standards of hand hygiene practice.	Hand hygiene audit data undertaken since the last Trust-wide audit has been collated and review, and a Trust-wide hand hygiene audits will be scheduled for Q1 2021/22.	Completed
6.8 The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	• Hand driers are not used in clinical areas. • Hands are dried using disposable paper towels in clinical areas.	-	-	Completed
6.9 Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	Guidance on hand hygiene is displayed in staff areas.	Public toilets have been reviewed and whilst there is some information on hand hygiene, specific signage is being	New signage for public toilets is being developed and implemented.	In progress
6.10 Staff understand the requirements for uniform laundering where this is not provided for on site	The Trust Uniform Policy provides specific information about laundering uniforms. Scrubs were used in more areas during the peak of the pandemic and increased	-	-	Completed

	laundry facilities provided to ensure safe laundering.			
6.11 All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms	The Trust Intranet COVID-19 pages provide information for staff about actions to take when they or a family member display symptoms.	-	-	Completed
6.12 A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	• IPC review each new case of COVID-19 to identify possible cross transmission. • The rate of hospital-onset COVID-19 infection at ICHT and across London is reviewed weekly at CRG. • Occupational Health review each new case of COVID-19 in staff to identify possible cross-transmission.			
6.13 Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an	• Two or more cases of COVID-19 in patients linked in time or space trigger an investigation by IPC. • Two or more cases of COVID-19 in staff linked in time or			

outbreak investigation and are reported.	space trigger an investigation by IPC. • A daily review meeting occurs including IPC and Occupational Health. • Outbreaks are reported using the IIAPRIL system. • Each new IIAPRIL form is reviewed at CRG prior to submission.			
6.14 Robust policies and procedures are in place for the identification of and management of outbreaks of infection	• Robust procedures are in place for the identification and management of COVID-19 outbreaks in patients and/or in staff. • Learning is captured from local and regional COVID-19 outbreaks.			

7. Provide or secure adequate isolation facilities

Key lines of enquiry; systems and processes are in place to ensure:	Evidence	Gaps in Assurance	Mitigating Actions	Status
7.1 Restricted access between pathways if possible (depending on size of the facility, prevalence/incidence rate low/high) by other	Restricted access between pathways is in place where possible.	-	-	Completed

patients/individuals, visitors or staff				
7.2 Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	Areas/wards are clearly signposted to ensure that patients/visitors and staff understand the different risk areas.	-	-	Completed
7.3 Patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate.	COVID-19 patient assessment pathways approved at CRG and widely communicated, including the preferable use of single rooms for patients with confirmed or suspected COVID-19.	There are limited single rooms in our Trust, so patients with confirmed COVID-19 have been cohorted together in clearly designated areas according to the guideline approved at CRG	IPC have advised on when it is appropriate to cohort patients together. There is a risk on the IPC risk register related to limited isolation facilities in the Trust.	Completed
7.4 Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance.	IPC review each new proposed cohort area to ensure compliance with PHE national guidance.	-	-	Completed

7.5 Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.	Usual guidance has been followed unless it has not been feasible to do so. The routine isolation of patients colonised with CPE has been reinstated. Compliance with MRSA and CPE screening is monitored monthly.	-	-	Completed

8. Secure adequate access to laboratory support as appropriate				
Key lines of enquiry; systems and processes are in place to ensure:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Status**
8.1 Ensure screens taken on admission given priority and reported within 24hrs	Laboratory turnaround times for all specimens remain <24 hours.	-	-	Completed
8.2 Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	Laboratory turnaround times are monitored and reported.			Completed
8.3 Testing is undertaken by competent and trained individuals	Testing is performed in	-	-	Completed

	accredited laboratories.			
8.4 Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Pathways for testing symptomatic patient and staff have been established and outlined on the Trust Intranet. Trust Test and Trace processes are in place.	-	-	Completed
8.5 Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	The laboratory have clear SOPs and quality assurance systems in place. Results are reported through Cerner.			Completed
8.6 Screening for other potential infections takes place	Screening for other potential infections (such as CPE and MRSA) has continued. Weekly screening for key organisms continues in the ICUs.	Compliance with MRSA admission screening was on target at 90% for Q4: 5813 of the 6488 patients identified as requiring MRSA screening were screened. Overall compliance with CPE admission screening was 83%, and	Ward level results from MRSA and CPE screening programmes are fed-back to wards to prompt local investigation and improvement planning.	Completed

		>90% in the four specialties performing universal admission screening.		
8.7 • That all emergency patients are tested for COVID-19 on admission. • That those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise. • That those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission. • That all elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	• Emergency admissions are tested on day 0, 3, 7, and weekly thereafter. • Inpatients are tested 48 hours prior to discharge to another care facility. • Elective admissions are tested 3 days prior to their admission and self-isolate from the time of the test. A pre-admission test for an elective admission taken within 5 days of admission is acceptable, provided self-isolation has been adhered to.	Compliance with testing is monitored electronically and is <100%.	Compliance with routine patient testing is monitored weekly. Patients who have tested negative on/before admission and are not COVID-recovered have been tested daily for the first 7 days of their admission from 22/03/2021. Compliance with Day 3 testing has risen to 80% and with 7 day testing to 70%.	In progress.

	• Patients are tested whenever symptoms consistent with COVID-19 develop.			
8.8 That sites with high nosocomial rates should consider testing COVID negative patients daily.	• Contacts of a known positive case are testing daily through their 14 day isolation period. • Patients who have tested negative on/before admission and are not COVID-recovered are tested daily for the first 7 days of their admission.	-	-	In progress
8.9 That those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to	• Patients are tested 48 hours prior to discharge. • COVID-19 status is automatically included in patient discharge summaries.	-	-	-

receiving organisation prior to discharge.	• Compliance with discharge testing is monitored electronically			
8.10 That those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation.	• Patients who are identified as contacts are transferred to designated care settings.			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

Key lines of enquiry; systems and processes are in place to ensure:	Evidence	Gaps in Assurance	Mitigating Actions	Status
9.1 Staff are supported in adhering to all IPC policies, including those for other alert organisms	IPC policies are published on the Trust Intranet and promoted via various channels. IPC support staff in implementing them.	-	-	Completed

9.2 Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Trust PPE guidance is updates in line with changes to PHE guidance.	-	-	Completed
9.3 All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	A guideline for managing clinical waste related to COVID-19 has been created and published on the Trust Intranet. Our waste management procedures are audited regularly as part of contract arrangements and KPIs indicate no issues.	-	-	Completed
9.4 PPE stock is appropriately stored and accessible to staff who require it	The supply and storage of PPE management during COVID-19 is done by site-based command centres. PPE stock levels are shared on a daily dashboard to identify upcoming potential shortages.	-	-	Completed

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Key lines of enquiry; systems and processes are in place to ensure:	Evidence	Gaps in Assurance	Mitigating Actions	Status
10.1 Staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and psychological wellbeing is supported	• All staff who are identified as being "at risk" are now beginning to return to work. • Also, the Trust has developed and widely shared wellbeing advice and resources. This has included group videoconferences and redeployment to tasks that can be accomplished for staff shielding at home.		A Trust-wide COVID-19 risk self-assessment for all staff has been undertaken.	Completed.
10.2 That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	Risk assessments have been completed for all staff.			Completed
10.3 Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally	Reusable FFP3 masks are issued through procurement to staff. Over 1000 masks have so far been issued and a record of each issue is available. Mask maintenance information is available on Intranet and issued with the reusable mask. Application	Training records (aside from fit testing) are not maintained.	Escalated to an executive level review meeting with the Medical Director to agree actions to mitigate the risks and improve compliance. A plan for management will be in place by 7th May.	Ongoing and monitored via Emergency Planning and Strategic PPE Group.

	development is in progress and lead by Health & Safety to capture mask maintenance, filter expiry and fit testing in one location. Emergency planning provides mask fit testing, training on individual fit check and provides information on how to don the mask. Fit testing records are held centrally.			
10.4 Staff who carry out fit test training are trained and competent to do so	Staff who carry out fit test training are trained and competent to do so.	-	-	Completed
10.5 All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	All staff required to wear an FFP respirator have been fit tested for the model being used and this is repeated each time a different model is used.			Completed
10.6 A record of the fit test and result is given to and kept by the trainee and centrally within the organisation	A record of the fit test and result is given to and kept by the trainee and held centrally within the organisation.	-	-	Completed
10.7 For those who fail a fit test, there is a record given to and held by the trainee and centrally within the organisation of repeated	For those who fail a fit test, there is a record given to and held by the trainee and centrally within the organisation of repeated	-	-	Completed

testing on alternative respirators and hoods	testing on alternative respirators.			
10.8 For members of staff who fail to be adequately fit tested, a discussion should be had regarding redeployment opportunities and options commensurate with the staff members' skills and experience and in line with nationally agreed algorithm	For members of staff who fail to be adequately fit tested, a discussion is had regarding redeployment opportunities and options commensurate with the staff members' skills and experience and in line with nationally agreed algorithm.	-	-	Completed
10.9 A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational Health	A documented record of this discussion is available for the staff member and held centrally within the organisation, as part of employment record including Occupational Health.	-	-	Completed
10.10 Following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and	Following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational Health service record.	-	-	Completed

Occupational Health service record.				
10.11 Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	The board regularly reviews fit testing records.	-	-	Completed
10.12 Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance	Staff are allocated to a particular care pathways to the extent possible.	-	-	Completed
10.13 All staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas	The use of surgical masks by staff is now embedded practice, except when they are working alone in an office or physically distanced from others in their COVID-secure office.	Physical distancing is challenged in some non-clinical areas.	Work is being led by the Health & Safety Committee to improve physical distancing in non-clinical areas. Actions agreed following executive level review meeting on 4th May. A	In progress

			revised checklist will be developed for local areas to complete to confirm their COVID-secure status. A four-week schedule of assurance visits will begin in mid-May to check compliance. Feedback will be monitored at executive huddle.	
10.14 Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	COVID-secure offices have been established, with detailed guidance on the intranet and a documented risk assessment for each COVID-secure office.	-	-	Completed
10.15 Staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	Surgical masks are worn when staff are unable to maintain physical distancing in their COVID-19 secure office.	-	-	Completed
10.16 Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	A process has been established to ensure that line managers communicate daily with staff who are self-isolating.	-	-	Completed
10.17 Staff that test positive have adequate information and support to aid their recovery and return to work	There is good quality information on the Internet.	-	-	Completed

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Learning from deaths quarterly report – Q4 2020/21

Agenda item 15 and paper number 12

Executive Director: Julian Redhead, medical director
Author: Darren Nelson, head of quality compliance and assurance

Purpose: For noting

Meeting date: 12 May 2021

Executive summary

1. Purpose

1.1. This paper provides an update to the Board on our Learning from Deaths (LfD) programme. It includes an updated dashboard outlining activity undertaken as part of the programme in Q4 2020/2021, for approval ahead of submission to NHS England.

2. Background

2.1. The Trust's established mortality review process and associated policy was reviewed in line with the new national requirements set out in the National Quality Board framework published in March 2017. This included Structured Judgment Review (SJR) for selected deaths.

2.2. As part of the requirements, trusts are required to produce a quarterly report to the board on mortality data and surveillance and any learning identified through this process.

3. Key findings

3.1. The paper outlines activity undertaken as part of the mandated programme, and provides information regarding our mortality rates and mortality surveillance activity as a Trust. The paper outlines the steps that we have taken to validate our findings from mortality reviews undertaken since 2017, focussing on the extent to which deaths could have been avoided.

3.2. So far, none of the deaths which occurred in Q4 2020/2021 have been identified as 'avoidable' through the processes outlined in this report.

4. Next steps

4.1. The findings from our mortality surveillance programme from Q4 2020/21 (appendix A) will be submitted to NHS England following approval by the executive and sign off by the Quality Committee on behalf of Trust Board.

4.2. A new learning from deaths process is currently being implemented which will improve how we investigate and learn from deaths in our care and ensure that our mortality reviews and processes align appropriately with the Medical Examiner service. This has been delayed due to the recent surge, but will be completed in Q1 2021/22.

5. Recommendation(s)

5.1. The Board is asked to note the findings from our mortality surveillance programme in Q4 2020/2021 which has been approved by the Quality Committee for submission to NHS England.

6. Impact assessment

6.1. Quality impact: improving how we learn from deaths in our care will support all quality domains, but particularly safe, effective and well-led.

6.2. Financial impact: N/A

6.3. Workforce impact: N/A

6.4. Equality impact: N/A

6.5. Risk impact: There is potential for reputational risk associated with the ability to deliver reviews within the specified time periods, thus impacting on national reporting. Learning from Deaths is on the divisional risk register (ID. 2439).

Main paper

7. Mortality rates

7.1. Compared to other non-specialist acute providers we have the second lowest HSMR across the last year of data (January 2020 – December 2020), and the third lowest SHMI (November 2019 – October 2020). For the latest available month of data (December 2020), our HSMR is 71, which is significantly low relative risk and the sixth lowest compared to peer trusts.

7.2. We receive mortality alerts via the Dr Foster analytics services. These alerts relate to cases where death(s) have occurred that require further investigation, either because there is a possible trend/pattern, or the death(s) is an outlier compared to other organisations.

7.3. For December 2020 (the latest available data, which was published in April 2021), the following diagnosis & procedure groups had a high relative risk:

7.3 1. Diagnosis group(s): Viral infection (37 patients). *Note: Covid-19 deaths are coded under viral infection, and the second surge in hospital admissions starts in December 2020. 94% of NHS providers have an alert in this diagnosis group which appears to be related to the Covid-19 surge in December 2020.*

7.3 2. Procedure group(s): Clip and coil aneurysms (3 patients).

7.4. The cases associated with these alerts are being reviewed and outcomes will be included in the next report. SJRs will be completed if appropriate.

8. Summary of learning from deaths data – Q4 2020/21

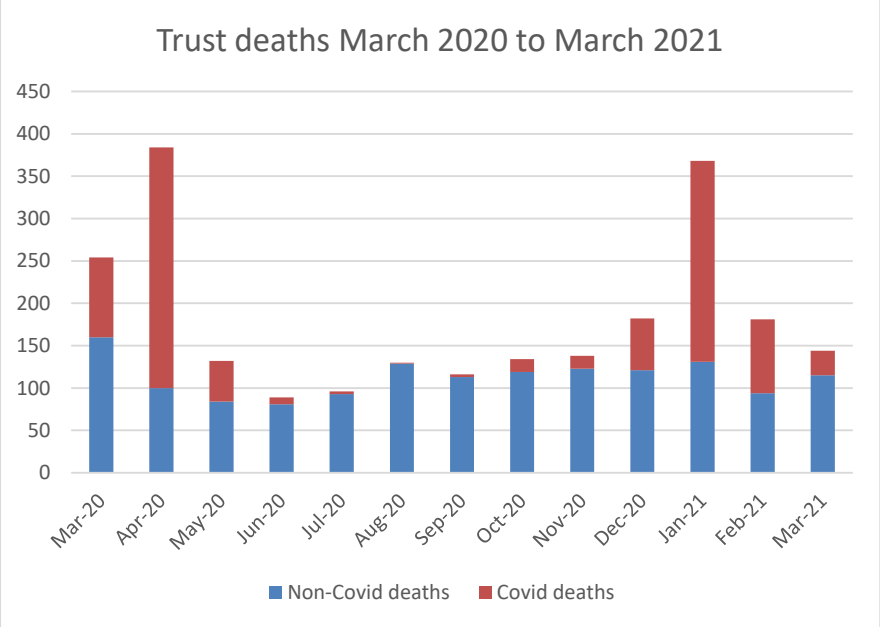
8.1. We are required to submit data on learning from deaths to the Trust Board, for onward submission to NHSE. The data in Appendix A will be the basis of our submission to NHSE.

8.2. There were a total of 688 deaths in the reporting period.

8.3. Of these 688, 363 were in January 2021, at the peak of the second wave of the pandemic, with 181 and 144 in February and March respectively.

8.4. Of the 688 deaths, 357 patients died with a positive COVID-19 swab within 28 days of death or COVD-19 was recorded on the medical certificate of cause of death.

8.5. The table below shows the total number of deaths and ratio between COVID and non-COVID deaths from March 2020 (start of pandemic) to the end of March 2021. We have reported 890 COVID-19 deaths. Current data does not suggest that our mortality rate is being disproportionately affected by any other factor beyond COVID-19.



8.6. There were 39 deaths in Q4 2020/21 where the patient's infection met the Public Health England definition of Hospital Onset COVID Infection (HOCI) because they tested negative for COVID-19 on admission and subsequently tested positive more than 7 days after their admission to hospital.

8.7. SJRs are being undertaken for all of these cases. The outcome of the SJR is triangulated with information from Infection Prevention & Control (IPC), and post

infection reviews (PIR) and outbreak SI investigations in order to confirm causation and the level of impact/harm from the cross transmission. Closure requires completion of each review. Two cases have been closed and the harm level has been confirmed as low for both. The remainder will be closed as SJRs, SIs and PIRs are completed.

8.8. A SJR has been requested for 75 (11%) of all the deaths that occurred in the reporting period, including the 39 HOCI deaths.

8.9. 46 SJRs were completed in Q4 2020/2021. (Note: these SJRs do not all relate to deaths within Q4 2020/2021)

8.10. Of the 46 the rating of global care were as follows:-

Number of cases	Rating of Global Care
4	2 – Poor care
13	3 – Adequate care
19	4 - Good care
10	5 - Excellent care

8.11. The four cases with a poor care rating have been reviewed at the weekly MD panel and are currently having 72 hour reports completed to determine if further investigation is required. Themes from these cases include:-

- Ceilings of care not agreed promptly;
- Delay to identification of an acetabular fracture;
- COVID swabs not timely in two cases.

8.12. A list of all completed SJRs is reviewed weekly at the MD panel. If any concerns are highlighted or when the rating of care is poor the full SJR report is presented by the division at the panel.

8.13. The completed SJRs are provided to the directorates with the expectation that the learning is shared locally. The new process, which will be implemented in Q1 2021/22 will ensure that learning is shared more effectively across the Trust (see section 10).

8.14. Where applicable, learning from SJRs is shared with the relevant improvement programme, to inform their improvement work. The following learning identified from SJRs in Q4 2020/2021 has been shared with the End of Life Steering group:

- Importance of discussing and agreeing ceilings of care in a suitable time frame to avoid possible inappropriate escalations and distress to the patient and family.
- Decisions about ceilings of care and DNAR are not always comprehensively documented.

8.15. There was also some learning related to COVID-19 which will be included in our improvement work to ensure compliance with the IPC BAF:

- COVID-19 swabs were not always carried out as frequently as guidelines set out.
- Avoiding delayed discharges which increased the risk of cross transmission of COVID-19.

- Effective communication with patients to explain need to minimise movement around the ward and hospital when there is risk of COVID-transmission. This was especially notable in patents with dementia or where there were language barriers impacted on effective communication.

8.16. The records of ME discussions with bereaved families and SJRs are reviewed and elements of good practice are identified. Some themes were:-

- Empathetic and caring discussions with patients and their families;
- Keeping patients and families in touch even during COVID restrictions;
- Good use of Learning Disability team.

9. Summary of Perinatal Mortality Reviews using the national tool (PMRT)

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened because carbon monoxide testing was paused due to COVID-19	8	Action has been undertaken to improve the screening for carbon monoxide testing for mothers. This information has been shared with clinicians. The Trust has an action plan in place to improve compliance but carbon monoxide testing has been on hold nationally since spring 2020
The baby had to be transferred elsewhere for the post-mortem	5	No Actions Noted
It is not possible to tell from the notes whether during the early bereavement period use of a cold cot was offered/available	3	The use of the Cold cot is being added to the electronic checklist to make it easier to tell if it has been offered or used in future.
It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	2	Inform Bereavement team
It was not possible to ask this mother about was not asked about domestic abuse at booking as she was seen remotely and was not alone	2	Clinicians to be reminded that women should be asked sensitive questions at each contact appointment.
Placental histology was performed but was not carried out by a perinatal/paediatric pathologist	2	No action planned beyond local communication
This mother's progress in labour was not monitored on a partogram	2	Remind staff of importance of monitoring women's progress in labour on a partogram
During this mother's labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out	1	Remind staff of importance of timely measurement of maternal observations as well as clear documentation
From information identified earlier in the tool this mother met the national guideline criteria for screening for	1	To remind clinicians to chase blood results, and to act upon results that appear to not have been sent.

gestational diabetes but this does not appear to have been identified and she was not offered screening		
It is not possible to assess from the notes whether the parents were kept informed about the progress of the resuscitation of their baby	1	No action planned beyond local communication

9.1. A separate process is in place for perinatal mortality. Perinatal deaths are reviewed in designated Trust PMRT meetings in which each aspect of care is scored and action plans to address any issues are approved. These are recorded on the national PMRT database and the generated reports are collated and analysed nationally and within the Trust for trends and themes to facilitate learning. Key issues, themes and actions required are reported to the EMB Quality Group, Quality Committee and Trust Board via this report on a quarterly basis.

9.2. The latest collated data available is for the period October to December 2020. The total number of perinatal deaths reported to MBRRACE-UK in this period was 20.

9.3. Issues identified as relevant to the deaths reviewed were:-

10. Changes to our current learning from deaths process

10.1. We are working to improve our processes so that we can ensure we are reviewing deaths more quickly, and better identifying, and sharing learning and implementing actions to improve as a result. This has been delayed due to the pandemic, but will be fully implemented in Q1 2021/22.

10.2. The amended process includes a new structure for SJR reviews. Six consultants from various specialties have been appointed as dedicated SJR reviewers and will take over from the existing reviewers at the end of April, following training. This will help ensure more consistency and timely completion of SJRs, the target timescales of which will be reduced from 30 to 7 days from date requested.

10.3. A new learning from deaths forum has been established and will be chaired by an AMD, the purpose of the group is to review and identify themes for learning and draw on identified best practice. The first meeting will be held at the beginning of May 2021 and then each week until the process is more embedded.

10.4. The forum will report to the EMB quality group and will also oversee the reporting of data at speciality level.

10.5. The revised policy will be circulated at the end of April for consultation.

11. Conclusion

11.1. We continue to have some of the lowest mortality rates in the country. There were no ‘avoidable’ deaths identified in Q4 2020/21 by the processes outlined in this report. Improvements to our learning from deaths processes, which were delayed by the pandemic, are currently being implemented and will be completed in Q1 2021/2022.

Appendices: Appendix A – Learning from Deaths Data – Q4 2020/2021

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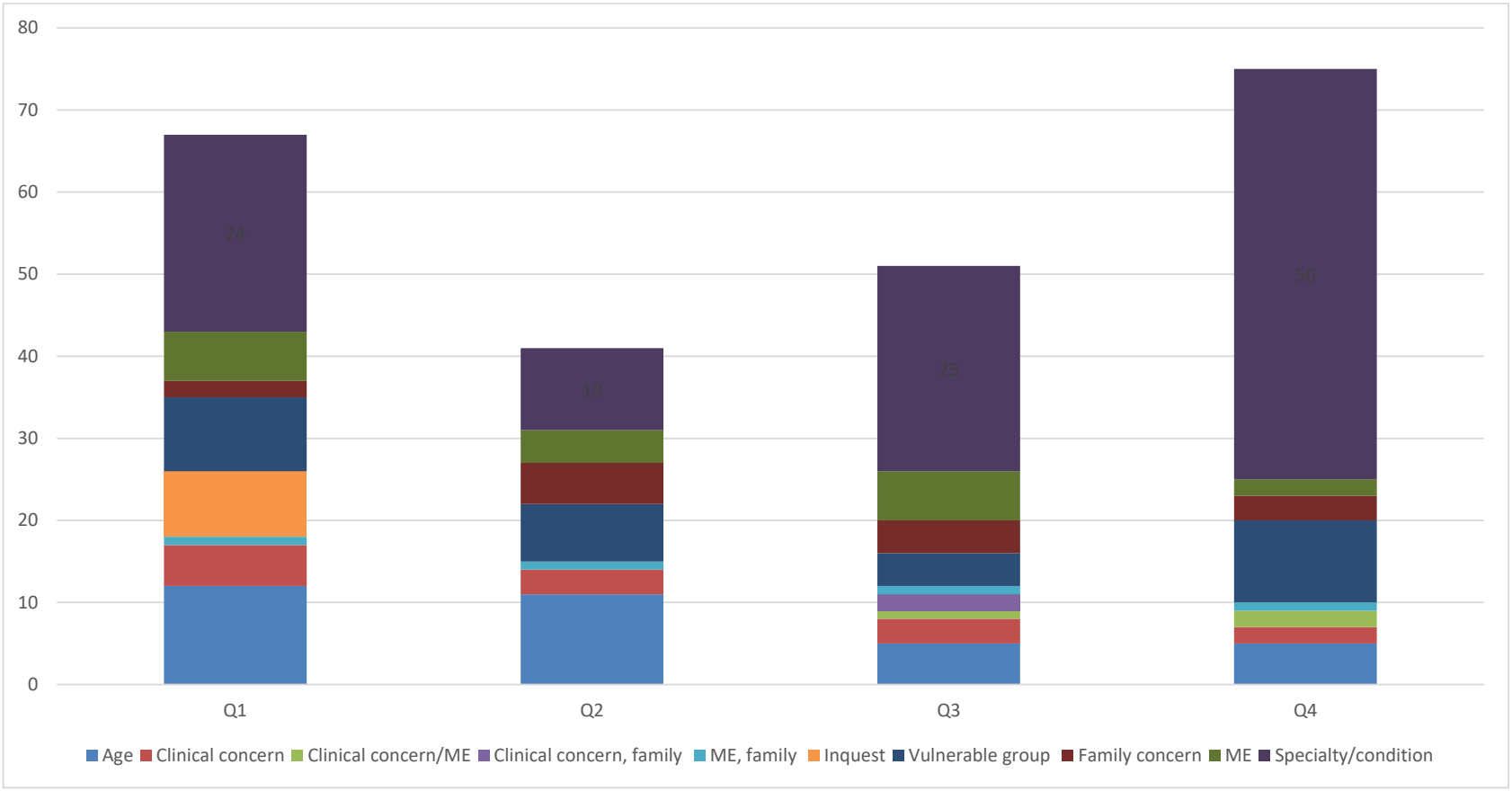
APPENDIX A – LEARNING FROM DEATHS DATA Q4 2020/2021

Trust Total	Jan 21	Feb 21	March 21	**Total Q 4 2020/2021**
Total Deaths	**363**	**181**	**144**	**688**
No. of SJRs Requested	43	22	10	**75**
No. of SJRs Completed in Q 4 Note the SJRs completed in Q4 do not all relate to deaths in Q4 as there is a time lag for completion	12	21	13	**46**
No. of SJR or deaths with poor or very poor global care score	2	1	0	**3**
No. of Avoidable Deaths confirmed via senior decision maker review	**0**	**0**	**0**	**0**

Of the 2111 deaths that occurred during 2020/2021, all deaths were subject to ME review. 275 were referred for SJRs. Of the 2111 deaths, 802 were patients who had died within 28 days of a positive COVID-19 swab or COVID-19 was recorded on the medical certificate of cause of death. These were 346 in Q1; 7 in Q2; 92 in Q3 and 357 in Q4. The high numbers in Q1 and Q4 correlate with the national first and second waves of the pandemic and account for the higher number of overall deaths in Q1 and Q4.

Imperial College Healthcare NHS Trust

APPENDIX B – QUARTERLY TRIGGERS FOR SJR 2020/2021



Key to triggers

Age	0-25 years
Clinical concern	Concerns about care raised by clinical staff
Family concern	Concerns about care raised by the patient's family/stated next-of-kin
Inquest	Referral to coroner/inquest
ME	Referral by ME for identified concerns
Specialty/condition	Sepsis, out of ITU cardiac arrest/HOCI
Vulnerable group	Learning disability, detained under Mental Health Act or in police custody/custodial sentence

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TRUST BOARD (PUBLIC)

Paper title: Annual review of Trust Board Committees and Board Governance update

Agenda item 16 and paper number 13

Sponsor: Bob Alexander, Chair
Executive Director: Peter Jenkinson, Director of Corporate Governance
Author: Ginder Nisar, Deputy Trust Secretary

Purpose: For decision

Meeting date: 12 May 2021

Executive summary

1. Purpose

1.1. This report provides an update to the Trust Board on its governance, effectiveness review process and to request Trust Board approval of the Board Committee TORs.

2. Background

2.1. It is good practice to undertake an annual review of the Board Committee Terms of References (TORs) to ensure that they are fit for purpose and reflect any changes made to the Committee in-year, and to also undertake a review of the effectiveness of the Trust Board and its Committees.

3. Key issues

3.1. The Trust Board considered and agreed the recommendations arising from the 2020 review of effectiveness in July 2020. Since then a number of changes have been made.

- All terms of reference have been reviewed to reflect specific points raised via the respective Committee effectiveness reviews. Terms of reference have been brought into line with standard guidelines and forward planners were also reviewed to ensure they reflected the TORs.
- The statutory, mandatory and best practice business that the Trust is required to ensure oversight of at Board level have been reviewed and cross referenced against Board and Board Committee TORs and forward planners.
- Statutory and mandatory items, requiring a Board member (NED/Executive) champion/lead have also been identified and these areas mapped to relevant Committees with the Chair of the Committee as the default champion/lead unless otherwise required or appropriate.
- A new report template and protocol has led to improved report writing with shorter and more concise papers however this is an area for continued improvement.
- Risk and assurance deep dives have been introduced across all Committees to ensure the Board receives assurance that those risks that could have an impact on the achievement of Trust objectives and priorities are being effectively managed. The outcome of these risk and assurance deep dives is reported by Committees to

the Trust Audit, Risk and Governance Committee which has overall responsibility for oversight of the Trust risk and assurance framework.

3.2. The paper to the July 2020 Board also outlined the introduction of the Imperial Management and Improvement System (IMIS) programme to establish the way in which the Trust manages the development and delivery of its priorities from Board to ward, including cascaded strategic objectives and bottom-up identified local initiatives, in a consistent and transparent manner. This was a key component in establishing the systems and processes to support the delivery of the strategic goals and as part of this it was important that the organisation has the appropriate governance routines to support the delivery of the strategic goals. The paper set out the approach to changes in Executive and Board level governance arrangements.

3.3. The changes to Executive and Board routines launched in September 2020 did not require changes to the Board Committee TORs per se, however it was agreed to amend the Board and Board Committees schedule in order to shorten the performance cycle and reporting to Board and enable the Trust Board and Committees to receive the most up to date information as possible.

3.4. During the last year, the Board has also recognised the importance of Board level oversight of the strategic workforce agenda, in particular the health and wellbeing of staff, the continued improvement in staff equality and diversity, and the continued strengthening of the capability of our managers. The Board therefore agreed to establish a new People Board Committee. This will allow sufficient Board focus on the cultural and organisational development of the Trust, and on the strategic performance and impact of the Trust as a significant employer, educator and partner in health and care.

4. The TORs for each Committee were approved at the following meetings and a copy available from the Trust Secretariat or the Reading Room for this meeting.

- Audit, Risk and Governance Committee, 2nd December 2021
- Finance, Investment and Operational Committee, 5th May 2021
- Quality Committee, 6th May 2021
- Redevelopment Committee, 6th April 2021
- People Committee, 4th May 2021
- Remuneration and Appointments Committee, 2nd March 2021

5. Next steps

5.1. An annual report will be produced for each Committee, in quarter 1 to coincide with the drafting of the Trust annual report. This annual report will include a summary of the business conducted during the year, mapped against the agreed terms of reference, and recommendations from the Committee effectiveness review.

5.2. Given the recent review of the terms of reference and forward planners and the implementation of the new meeting routines from April 2021, it is proposed to allow the Committees to run for a six month period and begin the effectiveness review after quarter 2. This would allow feedback to reflect the new routines. For this year, therefore, the outcome of the Committee effectiveness review will be reported separately from the committee annual reports.

5.3. The terms of reference will need to be kept under review during 2021/22, to reflect any changes required to reflect the development of governance arrangements in relation to the North West London Integrated Care System (ICS) and acute provider collaboration. A review will be completed following the completion of the effectiveness review.

5.4. The Committee annual reports will be reported to the Audit, Risk and Governance Committee which has overall responsibility for oversight of the Trust assurance framework.

6. Recommendation

6.1. The Trust Board is asked to note this report and to:

- Agree the amended Terms of Reference for the Board Committees
- Note the delay to this year's effectiveness review in order to allow a more informed overview. A report on this review will be provided to the Trust Board in September 2021.

7. Impact assessment

7.1. Quality: Regular review of terms of references and effectiveness reviews support good assurance and oversight arrangements.

7.2. Financial: N/A

7.3. Workforce impact: : N/A

7.4. Equality impact: : N/A

7.5. Risk impact: Good governance supports the reduction of risk to the Trust overall.

Authors

Peter Jenkinson, Director of Corporate Governance and Ginder Nisar, Deputy Trust Secretary
29 April 2021

Appendices

1. Audit, Risk and Governance Committee, 2nd December 2021
2. Finance, Investment and Operational Committee, 5th May 2021
3. Quality Committee, 6th May 2021
4. Redevelopment Committee, 6th April 2021
5. People Committee, 4th May 2021
6. Remuneration and Appointments Committee, 2nd March 2021

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC

Paper title: Use of the Trust Seal annual report 2020/21

Agenda item 17 and paper number 14

Executive Director: Peter Jenkinson, Director of Corporate Governance & Trust Company Secretary
Author: Jessica Hargreaves, Deputy Trust Secretary

Purpose: For information

Meeting date: 12 May 2021

Executive summary

1. Purpose

1.1 The Trust's standing orders require that the use of the Trust seal is reported to the Trust board on an annual basis. The report includes the use of the Trust seal during FY 2020/21.

2. Recommendation

2.1. The Board is asked to note the report and the use of the Trust Seal.

3. Impact assessment

3.1. Quality impact: Not applicable
3.2. Financial impact: Not applicable
3.3. Workforce impact: Not applicable
3.4. Equality impact: Not applicable
3.5. Risk impact: Reporting use of the Trust seal enables review of the contracts, property agreements and other documentation that has been entered into during the year, acting as a control to reduce risk of misuse

Author: Jessica Hargreaves, Deputy Trust Secretary
Date: 5 May 2021

Imperial College Healthcare NHS Trust

Use of the Trust common seal April 2020- March 2021

This table is a record of the use of the Trust seal as required by the Trust Standing Orders

Seal number	Parties ICHT and…	Nature of transaction requiring affixment of seal	Witnesses to affixment of seal	Date of affixment of seal
236	Imperial College Healthcare NHS Trust and Vamed Management and Service GM Bn Deutschland & Berudsen UK Ltd	Contract for a new parent company performance guarantee	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	8 April 2020
237	Imperial College Healthcare NHS Trust and Adaptive Group Ltd	Agreement for services for provision of Help NHS Heroes services at Trust sites	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	5 June 2020
238	Imperial College Healthcare NHS Trust and ETA Projects and Walter Lilly & Co	Consultant collateral warranty	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	23 June 2020
239	Imperial College Healthcare NHS Trust and Dharmesh Yadar and Bhavini Yadar	Deed for gift shop at Charing Cross Hospital	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	01 October 2020
240	Imperial College Healthcare NHS Trust and AMT Coffee Ltd	Lease of 10 years for premises at Hammersmith Hospital	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	01 October 2020
241	Imperial College Healthcare NHS Trust and AMT Coffee Ltd	Lease of 10 years for premises at Charing Cross Hospital	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	01 October 2020
242	Imperial College Healthcare NHS Trust and Westminster City Council	Deed to create supplement of section 106 arrangement to confirm the drainage infrastructure works constitute valid commencement of development permitted by planning permission (Triangle, St Mary's)	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	7 October 2020
243	Imperial College Healthcare NHS Trust and ISS Mediclean Ltd	Deed of surrender for coffee shop retail units at St Mary's Hospital	Professor Tim Orchard, Chief Executive Jazz Thind, Chief Financial Officer	28 October 2020
244	Imperial College Healthcare NHS Trust and Medtronic Ltd	Cardiology cath lab Medtronic Managed Services 3 year contract extension.	Professor Tim Orchard, Chief Executive Jazz Thind, Chief Financial Officer	30 October 2020

Seal number	Parties ICHT and…	Nature of transaction requiring affixment of seal	Witnesses to affixment of seal	Date of affixment of seal
245	Imperial College Healthcare NHS Trust and Cerner	Change control note for contract extension to include London North West Hospitals and Hillingdon Hospital NHS Trusts.	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	23 December 2020

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Audit, Risk & Governance Committee report

Agenda item 18.1 and paper number 15a

Committee Chair: Kay Boycott, Non-Executive Director
Author: Jessica Hargreaves, Deputy Trust Secretary

Purpose: For information

Meeting date: 12 May 2021

1. Purpose of this report

1.1. Ensure statutory and regulatory compliance and reporting requirements to the Board.

2. Introduction

2.1. In line with the Audit, Risk and Governance Committee's reporting responsibilities as detailed in its Terms of Reference, a summary of the items discussed since the last meeting is provided in this report.

3. Key points

3.1. The key items to note from the Audit, Risk and Governance Committee meeting held on 26th April 2021 include:

3.1.1. **External Audit:** The Committee received the external audit update on progress with the 2020/21 audit, noting the timescales for completing the audit and issuing the audit opinion and certificate of completion.

3.1.2. **Draft annual accounts and draft annual report sections:** Committee members reviewed the draft annual accounts and draft annual report sections and reflected on the extraordinary year it had been for the Trust; it was noted that an updated draft would be circulated to Executive and Non-Executive Director's on 29 April for review and feedback prior to submission to the auditors on 11 May.

The Trust Board is asked to approve delegated authority to the Audit, Risk and Governance Committee to approve the final accounts and annual report prior to submission on 15 June 2021.

3.1.3. **Internal Audit and Counter Fraud:** The Committee received the draft internal audit and counter fraud annual reports for 2020/21 which gave a satisfactory overall opinion and were pleased to note that there were no significant issues that would affect the head of internal audit opinion.

Imperial College Healthcare NHS Trust

The Committee also received the draft risk assessment and internal audit and counter fraud plans for 2021/22 which would be further updated to reflect the risk discussions at both executive and board level.

3.1.4. **Risk management update:** The Committee discussed the changes made to the corporate risk register since March 2021.

Noting the revised risk appetite, it was confirmed that an executive risk management reset workshop to review the risk register and consider the implementation of the risk appetite would take place at the Executive Transformation session on 24 May 2021.

The Committee noted progress with the risk and assurance deep dives re-mapping following the impact that the pandemic had had on the Trust over the past year. The deep dives had been assigned to the various Board committees with the Audit, Risk & Governance Committee having overall oversight.

3.1.5. **Tender Waivers and losses and special payments reports**: The Committee received and noted a summary of the number of tender waivers and the controls in place.

4. **Recommendations:** The Trust Board are requested to note this report.

Jessica Hargreaves, Deputy Trust Secretary
5 May 2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Quality Committee Report

Agenda item 18.2 paper number: 15b

Committee Chair: Professor Andy Bush, Non-Executive Director
Author: Amrit Panesar – Corporate Governance Assistant

Purpose: Information

Date of meeting: Wednesday 12 May 2021

1. Purpose of this report

1.1. Ensure statutory and regulatory compliance and reporting requirements to the Board.

2. Introduction

2.1. In line with the Quality Committee's reporting responsibilities as detailed in its Terms of Reference, a summary of the items discussed since the last meeting is provided in this report.

3. Key points

3.1. The key items to note from the Quality Committee meeting held on 6 May 2021 include:

3.1.1. **Quality Committee Terms of Reference**

The Committee reviewed the Committee terms of reference. Committee members noted that the terms of reference had been amended to remove workforce specific items following the establishment of the People & Organisational Development Committee, although there would be cross-over between the two committees where workforce related systems and processes had an impact on quality. The Committee agreed that the terms of reference were currently appropriate for the Committee but agreed that the Committee would monitor the terms of reference more frequently as the integrated Care System and development of acute provider collaborative working within the sector evolves. It was agreed that the Committee will receive and review a thematic summary of the lessons learned from serious adverse incidents rather than all individual incident reports, and the Terms of Reference will be amended accordingly.

3.1.2. **SMH SOC Strategic Case**

The Committee reviewed the SMH SOC Strategic case for the redevelopment of St. Mary's hospital.

3.1.3. **Draft Quality Account 2020/21**

The Committee noted the Draft Quality Account 2020/21. This year's Quality Account outlined progress against the six quality improvement priorities agreed by the Board in May 2020. It also confirmed the priorities and targets for delivering the following year and, the six improvement priorities for 2021/22 which have been identified following a

review of incidents (including serious incidents), structured judgement reviews, medical examiner outcomes, national reviews and national audits. Committee members were pleased to note progress made by the Trust in providing patients with extensive information about their care in advance of their appointments by post and email.

3.1.4. **Quality performance report**
The Committee noted the Quality performance report, noting exceptions against quality key performance indicators and measures being taken to address areas of variance against target. The Committee were notified of three 'never events' by Professor Redhead.

3.1.5. **Update on COVID-19**
The Committee received a presentation on the Trust's response to COVID-19 and the sector position across North West London, noting an update on the Trust staff vaccination programme. The Committee discussed and acknowledged the key risks and, noted the planning in progress to restart services suspended during the pandemic. The Committee were reassured that the executive team were managing the risks associated with the recovery phase and planning for a potential third wave. The Non-executive directors thanked the executive team for their dedication and hard work throughout each stage of the pandemic.

3.1.6. **Risk and assurance deep dive – Estates maintenance**
The Committee reviewed the Estates deep dive noting that the estates risk was a long standing risk which could not be fully mitigated until the Redevelopment Programme is delivered. Committee members agreed that the risk will be reviewed further as part of the Trusts Risk and Assurance refresh programme to ensure the risk accurately reflected the risk to patient safety across all sites and the controls in place to manage that risk, in the context of the long-term redevelopment needs for each site. The Committee noted that excellent care was being delivered despite the poor quality of the estates, but that there was only a very limited time before the efforts to keep things going would inevitably fail. The Committee was also deeply concerned about the effects on the workforce, including future recruitment and retention, of what is in many places a very poor workplace. The Committee thanked the Director of Estates & Facilities for the paper, and the efforts of himself and his team.

3.1.7. **Key Divisional Risks**
The Committee noted the key divisional and corporate risks which were largely focused on the reset & recovery, and restarting of services following the second surge of Covid-19.

3.1.8. **Maternity Quality Assurance Oversight Report**
The Committee reviewed the Maternity Quality Assurance Oversight report noting that the Maternity Services had a large number of frameworks and initiatives within the Trust and it was not always reflected in the reports submitted to the Committee. The Committee agreed to review the reporting format to reflect the great work and achievements undertaken by the Trust.

The Committee noted the progress to date to ensure compliance against all of the ten safety actions contribution to the CNST maternity incentive fund.

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3.1.9. **Learning from Deaths Quarterly report**
The Committee received the report noting the findings from the Trust's Mortality Surveillance Programme. The findings would be presented to the Trust Board and NHS England.

3.1.10. **Infection Prevention & Control Quarterly report Q4**
Committee members received the quarterly infection prevention and control report and noted that nineteen of Trust attributed C. difficile cases had been reported in quarter 4; which is below the ceiling of 22 cases in Q4. There were three hospital-associated MRSA BSI reported in Q4. The Committee noted the rise in MRSA BSI but acknowledged that this was similar to other Trusts across London.

3.1.11. **Infection Prevention and Control Board Assurance Framework for COVID-19 self-assessment April 2021**
The Committee received the report noting that good progress was being made but two areas remained "red". The Committee noted that this framework was a dynamic review of assurance regarding the Trust's infection prevention and control and, further work was ongoing to improve ratings in the two areas in red.

4. Recommendation(s)
Trust Board is asked to note this summary.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Finance, Investment & Operations Committee report

Agenda item 18.3 and paper number 15d

Committee Chair: Dr Andreas Raffel, Non-executive Director
Author: Jessica Hargreaves, Deputy Trust Secretary

Purpose: For information

Meeting date: 12 May 2021

Executive summary

1. Purpose

1.1. Ensure statutory and regulatory compliance and reporting requirements to the Board.

2. Introduction

2.1. In line with the Finance, Investment and Operational Committee's reporting responsibilities as detailed in its Terms of Reference, a summary of the items discussed since the last meeting is provided in this report.

3. Key points

3.1. The key items to note from the Finance, Investment and Operational Committee held on 5th May 2021 include:

3.1.1. **Finance report and deep dive into business planning and financial budget for 2021/22:** The Committee received the finance report for March which outlined the year-end financial position of the Trust noting that the Trust had agreed a £15.8m deficit plan with the STP for the second half of 2020/21 which included agreed additional costs to cover the expansion of the ICU bed base, endoscopy, imaging and excluded the effect of any subsequent surge. The Trust had now received £15.8m of funding, bringing the overall actual position to breakeven.

Committee members had a deep dive discussion into the planning for 2021/22 noting that planning guidance for the first six months of 2021/22 had been issued by NHSE/I towards the end of March 2021, which included a set of assumptions for financial planning, as well as activity trajectories which were required to be met during this period. A presentation of these assumptions and key risks within the plan had been shared at the Trust board strategy day on 21 April 2021; the Committee noted the update on progress made since this strategy day with attention drawn to the following: CIPs had increased from 2% to 2.3% (£15.8m); further work was on-going to develop sufficient schemes that close the current unmitigated savings gap and the sector requirement to achieve a breakeven positon. The Committee proceeded to approve the Trust's intended draft submission to the sector of £6.6m deficit for the first six months of 2021/22.

The Committee also discussed the sector and Trust capital funding allocation and noted the Trust's capital assurance/prioritisation process and the outputs of this against its £52.4m capital resource limit. The positon was consistent with that shared previously at the Board strategy day with the key highlights being that: some pipeline schemes would not be assigned to the unallocated element of the plan and that the Trust had been invited and would be submitting bids against the £23.2m of ICS resources specifically designated for system transformation programmes.

3.1.2. **St Mary's Hospital Strategic Outline Case (SOC) resubmission: economic and finance case:** The Committee reviewed and approved the economic and finance case within the SOC for the St Mary's Hospital redevelopment with the key discussion focussing on the financial bridge with a request that the Executive review the 'benefits realisation' and test the assumptions against the revised 20/21 financial regime.

3.1.3. **NWLP Molecular Procurement:** The Committee approved the proposal to appoint the preferred supplier for the provision of a Molecular pathology diagnostics service for Infection and Immunity Sciences, for a 5-year contract with an option to extend for a further 2 years.

3.1.4. **Payroll consolidation update:** The Committee received an update on the North West London sector payroll consolidation initiative noting that the first stage of the project involved transitioning of payroll processing for Chelsea & Westminster NHS Foundation Trust (CWFT), who currently outsource their payroll to NHS Shared Business Systems, to Imperial College Healthcare NHS Trust. Committee members noted that a project manager had been appointed and a working group established which included members from both Trusts with project management costs being funded by CWFT. The Committee agreed that there should be clear benefits for sector wide projects and that these should be tracked in future updates including how financial benefits are shared across organisations should they fall in one Trust.

3.1.5. **Transformation update:** The Committee received an update on the work of the Transformation Team noting that the team's work had changed in response to the Covid pandemic and that it had assisted in a range of areas including the operational response to Covid, bed surge planning and supporting newly introduced 'Gold command' ways of working at site level. Since March 2021, many of these Covid surge related projects had ended and the transformation projects restarted with a focus on the specialty review programme, outpatients' transformation programme and SMH flow programme. It was agreed that a further focus on the financial impact of these programmes would be reviewed in further detail at the Committee meeting in July 2021.

3.1.6. **Terms of reference annual review:** The Committee approved the terms of reference.

3.1.7. **Imperial Private Healthcare International Affiliate Network:** The Committee discussed the development of the Imperial Private Healthcare International Affiliate Network as part of its long-term strategy which would involve the development of direct international partner networks. The Committee was supportive of the

establishment of this network and an update on progress would be presented to the Committee in November 2021.

3.1.8. **Summary of business cases approved by the Executive:** The Committee received and noted the business cases that had been approved by the Executive and noted the pipeline of contracts requiring action as some had expired and some were due to expire. There was an acceptance that this may lead to incumbent contracts being extended and single tender waivers being issued in the interim.

3.1.9. **Recommendations:** The Trust Board are requested to note this report.

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TRUST BOARD (PUBLIC)

Paper title: Report from the Redevelopment Committee on 6th April 2021

Agenda item 18.4 and paper number 15e

Committee Chair: Bob Alexander, Acting Trust Chair
Author: Philippa Beaumont, EA to the Chair

Purpose: For noting

Meeting date: 12th May 2021

1. Purpose of this report

1.1. Ensure statutory and regulatory compliance and reporting requirements to the Board.

2. Introduction

2.1. In line with the Redevelopment Committee's reporting responsibilities as detailed in its Terms of Reference, a summary of the items discussed since the last meeting is provided in this report.

3. Key points

3.1. The key items to note from the Redevelopment Committee meeting held on 6th April 2021 include:

3.1.1. The Programme Director's report to the Committee highlighted updates on a number of activities including draft feedback from the New Hospital Programme (NHP) roundtable, the St Mary's Strategic Outline Case (SOC) re-submission and site options, project planning, commercial, life sciences, communication and stakeholder engagement.

3.1.2. The Committee noted the development of options for Charing Cross and Hammersmith Hospitals continued and was due to complete shortly.

3.1.3. The Committee received a report on potential decant options for the redevelopment of St. Mary's hospital, a proposed approach to reviewing the patient care pathways, an update on J Block at the Hammersmith Hospital and demand and capacity modelling.

3.1.4. The Committee also received updated Terms of Reference for the Committee and agreed to move the meetings to every two months, in line with other Board committees.

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TRUST BOARD (PUBLIC)

Paper title: Summary report from the People Committee

Agenda item 18.5 and paper number 15f

Committee Chair: Sim Scavazza, Non-Executive Director
Author: Ginder Nisar, Deputy Trust Secretary

Purpose: For noting

Meeting date: 12 May 2021

Executive summary

1. Purpose of this report

1.1. Ensure statutory and regulatory compliance and reporting requirements to the Board.

2. Introduction

2.1. In line with the People Committee's reporting responsibilities as detailed in its Terms of Reference, a summary of the items discussed since the last meeting is provided in this report.

3. Key points

3.1.1. The key items to note from the Inaugural People Committee held on 4th May 2021 include:

3.1.2. The Committee approved the People Committee Terms of Reference.

3.1.3. The Committee discussed the People Strategy and priority objectives. Following a review of external and regulatory strategic documents in relation to people and local intelligence, seven People Priorities for 2021-22 were recommended to the People Committee. Three of the priorities will be part of the Trust wide "priority programmes". Following discussions the priorities would be further refined for approval at the next meeting.

3.1.4. The Committee received an update on month 12 workforce performance and indicators. The summary provided an overview of the areas of good performance across the key workforce performance indicators as well as those requiring focus and action to improve. The report would be developed further as the Committee matures.

3.1.5. The Committee noted the staff survey results from 2020 and the planned actions. The results by theme indicated three key areas which should be prioritised for action in 2021/22, namely Equality Diversity and Inclusion, Health and well-being and Immediate Managers. The Committee noted the direct link with the outcomes of the survey with the People Strategy priorities.

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3.1.6. As part of the Trust's deep dive into risks programme, the Committee discussed its first deep dive into 'Risk of staff developing COVID-19 infection as a result of exposure at work and the subsequent impact on their health'. The Committee noted the controls, assurances, gaps and actions to address the gaps.

3.1.7. The Committee noted the report from the Health and Safety Committee which covered aspects of the Trust's occupational health and safety arrangements, including 'Covid secure', the Trust's statutory duty to identify and report certain Covid-19 related incidents and the performance of the Occupational Health service.

4. Recommendation(s)

4.1. The Board is asked to note this report.

5. Impact assessment

5.1. Quality impact: N/A
5.2. Financial impact: N/A
5.3. Workforce impact: N/A
5.4. Equality impact: N/A
5.5. Risk impact: N/A