Imperial College Healthcare NHS Trust

Trust Board – Public

Wednesday, 31st March 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**	Paula Vennells	Oral
	2.	**Apologies:**	Paula Vennells	Oral
	3.	**Declarations of interests** If any member of the Board has an interest in any item on the agenda, they must declare it at the meeting, and if necessary withdraw from the meeting	Paula Vennells	Oral
1105	**4.**	**Minutes of the meeting held on 25th November 2020** To approve the minutes from the last meeting	Paula Vennells	01
	5.	**Record of items discussed in Part II of Board meeting held on 25th November 2020 and 9th December 2020** To note the report	Paula Vennells	02
	6.	**Matters arising and review of action log** To note updates on actions arising from previous meetings	Paula Vennells	03
1110	**7.**	**Patient Story** To note the story	Janice Sigsworth	04
1125	**8.**	**Chief Executive Officer's report (inc. Covid-19 update)** To note the report	Tim Orchard	05

Strategy				
1140	**9.**	**Organisational strategy review & refocus - priorities for the year ahead** To receive an update and to approve the programmes and task and finish projects we are proposing to prioritise	Bob Klaber	06
1150	**10.**	**Our Green Plan – time to act** To approve the principles underpinning the Trust's Green Plan approach; commence work on the priority action areas and foundational cornerstones; and synchronising subsequent two-year action plans from the 2022/23 business planning cycle.	Bob Klaber	07
Operations / Performance				
1200	**11.**	**Reset and Recovery** To note the process the Trust has taken for restarting those services that were reduced or paused as part of the response to the pandemic	Claire Hook	08
1210	**12.**	**Integrated performance scorecard** To note the contents of the performance summary and the integrated scorecard for month 11	Claire Hook	09
1220	**13.**	**Finance report** To note the year to date and month 10 position	Jazz Thind	10
Quality				
1230	**14.**	**Update on Ockenden Report assurance progress** To note the actions taken to date, progress and the next steps	Tg Teoh	11
1240	**15.**	**CNST Maternity Incentive Scheme Year 3** To note the CNST Maternity Incentive Scheme safety action and to have oversight of the 'continuity of care' action plan	TG Teoh	12
1250	**16.**	**Infection Prevention and Control (IPC) and Antimicrobial Stewardship Report** To note the 2020-21 quarter 3 report	Julian Redhead	13
1300	**17.**	**Annual Review on Safe, Sustainable and Productive Nursing and Midwifery Staffing** To note the work the Trust is undertaking to deliver safe and sustainable Nursing and Midwifery care and the latest annual establishment review results.	Janice Sigsworth	14
1305	**18.**	**Annual Report from the Trust Safeguarding Committee**	Janice Sigsworth	15

		To note the 2019/20 annual report		
Governance and Board Committees				
1310	**19.**	**Declarations of Interest annual report** To note the annual report	Peter Jenkinson	16
1315	**20.**	**Establishment of a People Committee, Terms of Reference** For noting	Peter Jenkinson	17
	21.	**Trust Board Committees – summary reports** To note the summary reports from the Trust Board Committees		
	21.1.	Audit, Risk and Governance Committee, 2nd December 2020, 11th February 2021, 3rd March	Bob Alexander	18a
	21.2.	Quality Committee, 20th January 2021 (extraordinary meeting), 17th March 2021	Andy Bush	18b
	21.3.	Remuneration and Appointments Committee, 2nd and 24th March 2021	Peter Goldsbrough	18c
	21.4.	Finance, Investment and Operations Committee, 20th January 2021 (extraordinary meeting), 24th March 2021	Andreas Raffel	18d
	21.5.	Redevelopment Board Committee, 20th January 2021 (extraordinary meeting), 17th February, 10th March 2021	Paula Vennells	18e
1320	**22.**	**Any other business**	Paula Vennells	Oral
1325	**23.**	**Questions from the public**	Paula Vennells	Oral
1330 Close	**24.**	**Date of next meeting** 12th May 2021, 11am		

Updated: 29 March 2021

Diligent Reading Room material:

- Item 10 – Green Plan appendices
- Item 14 – Ockenden report appendices
- Item 17 – Annual review on safe, sustainable and productive nursing and midwifery staffing appendices
- Item 21.2 Referred to in Quality Committee Board Summary: Learning from Deaths Quarterly Report
- Item 21.2 Referred to in Quality Committee Board Summary: Research Q3 Report

Imperial College Healthcare NHS Trust

Public Trust Board
Draft Minutes of the meeting held on 25th November 2020, 11am
Virtual meeting held via Microsoft Teams and video-recorded.

Members present

Ms Paula Vennells	Trust Chair
Sir Gerald Acher	Deputy Chair
Mr Peter Goldsbrough	Non-executive Director
Dr Andreas Raffel	Non-executive Director
Prof. Andrew Bush	Non-executive Director
Mr Nick Ross	Non-executive Director
Miss Kay Boycott	Non-executive Director
Mr Bob Alexander	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
Ms Sim Scavazza	Designate Non-executive Director until 30 November 2020
Mr Peter Jenkinson	Director of Corporate Governance
Prof. Jonathan Weber	Dean of the Faculty of Medicine, Imperial College London
Mrs Claire Hook	Director of Operational Performance
Dr Matthew Tulley	Director of Redevelopment (for item 8)
Dr Bob Klaber	Director of Strategy, Research & Innovation
Ms Michelle Dixon	Director of Communications
Mr Kevin Jarrold	Chief Information Officer
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
Ms Sue Grange	Deputy Director of People and Organisational Development
Mr Guy Young	Deputy Director, Patient Experience
Ms Jo James	Consultant Nurse, Dementia & Delirium
Prof. Alison Holmes	Director of Infection Prevention and Control
Mrs Ginder Nisar	Deputy Trust Secretary (minutes)

Apologies

Mr Kevin Croft	Director of People and Organisational Development

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.	The Board welcomed Ms Scavazza, Designate Non-executive Director (substantive from 1st December 2020).

1.3.	The Board welcomed Esme Blythe, Lead Nurse in Surgery who was shadowing Prof. Sigsworth, and Dr Marie Condon, Renal Head of Service who was shadowing Prof. Bowen.
2.	**Apologies** Apologies were noted from those listed above.
3.	**Declarations of interests** None other than those disclosed previously.
4.	**Minutes of the meeting held on 30th September 2020** The minutes of the previous meeting were agreed.
5.	**Record of items discussed in part II of the Board meeting held on 30th September 2020** The Board noted the summary of confidential items discussed at the confidential Board meeting held on 30th September 2020.
6. 6.1.	**Matters arising and actions from previous meetings** Updates against the actions arising from previous meetings were noted on the action log. Oral updates were provided for the following: • Patient story review – The Board noted the update and that the next thematic annual summary would be presented to the Board in early 2021. • Actions relating to staff risk assessments and staff wellbeing would be addressed within the CEO's report to Board. • Employee metrics matrix – 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. • The remaining actions were either covered under the main agenda items or an update provided within the action log.
7. 7.1.	**Patient Story** Prof. Sigsworth, Mr Young and Ms James outlined the story of Jack who is a patient with complex needs including dementia and is regularly admitted at the Trust with delirium. He had 16 inpatient stays so far this year and his issues with separation from his wife during Covid-19 were highlighted in a story that was received by the executive in August 2020. There had been occasions when these admissions have been distressing for Jack. Since then the Trust has strengthened the use of carer's passports, which enables less stringent visiting restrictions for individuals designated as carers. During a recent admission Jack was given an MP3 music player, which resulted in a dramatic positive change to his mood.
7.2.	Mr Young and Ms James outlined the work in the Trust which supports patients with dementia who develop delirium. Delirium is common in the hospital setting, but greater numbers of patients with delirium had been seen because of Covid-19. The use of cognitively stimulating activities have shown to reduce the negative effects of delirium as has the involvement of families and carers. This was evident in Jack's case which showed the benefits of introducing devices such as an MP3 player and the difference being made to patients including a quicker recovery period. 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.
7.3.	Prof. Bowen commented that Ms James and her team provide expertise to the Medicine and Integrated Care division as and when needed, and that the work the team does makes a real difference.
7.4.	Sir Gerry was moved by the story commenting that such initiatives at a small cost, make great advances and suggested these initiatives could be scaled up across the country for the greater good. Mr Goldsbrough agreed with Sir Gerry commenting how simple interventions improve patient experience. He added that discussions at previous meetings around similar

	issues included identifying the frail and elderly early on in their care pathway and caring for them well and that such interventions could be used for them too.
7.5.	Mr Alexander enquired about the extent to which the Trust would expect to see such beneficial outcomes socialised and rolled out in the Integrated Care Services (ICS), and the opportunity to work with the community and voluntary system to share the learning and benefits in other settings.
7.6.	Ms James advised that her team works with partners such as Royal Central School of Speech and Drama at St John's Wood and local schools to share and spread the knowledge and education. In terms of frailty, her team works closely with the frailty team and hold weekly meetings to problem solve any concerns and link in with care home nurses. Other partners include Age UK in Hammersmith and Fulham where the team hold drop in sessions to share some of the work aiming to integrated work.
7.7.	Prof. Orchard reiterated the outstanding work being done by Ms James and her team and he referred to the 'Excellent Dementia Care in Hospitals' book written by Ms James which was highly commended in the BMJ book awards in 2018. He agreed with Mr Alexander's comment about such initiatives being included in the ICS work therefore could be included in the consultation response. **Action: Dr Klaber**
7.8.	The Board thanked Prof. Sigsworth, Ms James and Mr Young for sharing the story and commended the work of the Dementia team.
7.9.	**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. 8.1.1.	**Covid-19** As at 25th November 2020, 10% of beds were occupied by Covid-19 positive patients. From 81 patients who tested positive at their admission, 44 were positive at their last test. A week ago the total number of patients were 93 therefore the number appeared to be decreasing. 28 patients with Covid-19 were in ICU of which 22 were on mechanical ventilation. In terms of context, during wave one in April 2020, the Trust had 132 patients ventilated and over 300 patients in the hospital with Covid-19. Therefore it appeared that wave two was much more contained than wave one. However other Trusts in London had experienced acute pressures. Prof. Redhead was leading on the clinical response to Covid-19 across the sector and having worked through the first wave the Trust has more clarity around the triggers for escalation. The Trust increased its ICU capacity to assist the sector - this had not yet impacted the Trust's ability to deliver its elective programme. The Trust was working out what it would be measured against in terms of phase 3 targets for elective recovery but it was felt that the Trust was broadly on target to meet those.
8.1.2.	Prof. Orchard reiterated that Phase 3 targets only aim to get the Trust to last year's activity levels and made reference to the back log which the Trust needed to work through. The Trust was ahead on its 52 week waits and teams were working hard to try and get patients who had been waiting for a long period of time treated.
8.1.3.	Although the NHS was at level 4 of its national status, the Trust did not feel it needed to suspend its normal governance arrangements at this point. Trust plans set out trigger points at various intervals which would determine whether it needed to review its position.
8.2. 8.2.1.	**Outpatients** Virtual platforms were preferred and advantageous to many patients however some required face to face appointments and those requests were being met as much as possible. The

	Trust has multiple communication mechanisms which it was trying to simplify. Prof. Orchard acknowledged and apologised to patients about the time delays occurring for virtual appointments and that the Trust was working through these issues as quickly as possible and patients were welcome to contact the Trust about issues they were experiencing.
8.3.	**Culture programme**
8.3.1.	How the Trust does things remains a key focus especially with the changing ways of working and Prof. Orchard advised that teams were continuing to drive culture as much as possible. Ways of working focused on the right values and behaviours in conjunction with the health and wellbeing of its staff, particularly during such pressured times.
	Staff testing
8.4.	Efforts remain around testing. The lateral flow testing was being rolled out to staff which
8.4.1.	would help identify asymptomatic staff. So far 3,500 tests were conducted of which 10 had returned positive results, of which nine had been confirmed by PCR tests. It was helpful to identify asymptomatic staff early and carry out the appropriate actions.
	Covid-19 vaccination
8.5.	None of the vaccines had yet been approved and important to note that the approval process
8.5.1.	would not be 'short-cut' in terms of quality therefore providing assurance that the vaccines would be safe and effective. When approved there would be a sector wide approach to a mass vaccination programme prioritising vulnerable groups and staff groups.
	Flu vaccination assessment
8.6.	The Trust was currently at 54% in terms of uptake of the flu vaccination, 9% more than last
8.6.1.	year. Specific plans were being drawn up to target areas and linking in with the region to ensure the Trust has the required support. Noted that there must be a seven day gap between the flu vaccination and the Covid-19 vaccination. The Board **approved** the submission of the flu assessment checklist.
8.7.	Comments from the Non-executive Directors:
8.7.1.	In terms of Covid-19, Dr Raffel enquired about the 190 beds and whether the Trust could increase to 400 if needed. He also enquired about progress of in-house cleanliness. Prof. Orchard advised that the internal plan for escalation was 191 beds and across the sector, if needed, collectively 431 beds could be available. In terms of cleanliness, Prof. Orchard advised that improvement has been seen including the development of a cohesive relationship between the ward teams and cleaners. Further assurance was provided through audits demonstrating the thoroughness of cleaning.
8.7.2.	Responding to Prof. Bush's question about flu vaccination uptake, Prof. Orchard advised the Trust was ahead of last year's curve and summarised further actions being taken to further increase the uptake.
8.7.3.	Dr Maruthappu commented that it was positive to see the Trust was creating fast track surgical hubs and he enquired about the measures the Trust was taking around avoiding unintended consequences by redirecting efforts from certain procedures/specialisms. Prof. Orchard advised that a team of people were working on programmes such as the urgent and emergency care pathways and how the Trust could optimise patient experience and outcomes from specialist work, and making sure critical care capacity was working and delivering. In terms of the fast track surgical hubs, it was important for the Trust to understand where procedures were being carried out therefore maximising efficiency and comparing with the top decile of GIRFT which measures efficiency - work would need to take place to assess which areas could be consolidated and done so in a considered way assessing the impact and benefit for patients. A group would be set up to review this across the Integrated Care System (ICS) including capital investment with a view to a medium term plan before confirming a long term plan.

8.7.4.	Responding to Mr Ross and Sir Gerry's questions regarding the budget for hotel services and how the staff were doing, Prof. Orchard assured him that the £6m was the expected additional cost for the half year. In terms of staff he advised that some approaches were tailored to hotel services staff who were a difficult to reach group and the estates team had engaged with them well. Mr Gostling added that sickness absence was lower than expected and the commitment of the staff during Covid-19 was commendable and inspiring which showed that the Trust had gained their confidence. Ms Grange added that a pulse survey was conducted in summer which would be repeated to compare results and this staff group had also been asked to complete the staff survey. Other engagement mechanisms included mandatory training and the culture work. The assessment against such indicators would be included in the update report to the Board in March 2021.
8.7.5.	Responding to Mr Goldsbrough's question regarding infection and operational implications should the cases increase to planning and resource, Prof. Redhead confirmed that he receives three weeks in advance the modelling information which allows the Trust to adjust its operational work and take avoiding actions but the aim was to continue with elective work as much as possible. A daily gold call takes place to pre-empt issues. The Trust was in a position to respond to fluctuations approaching Christmas but this would be dependent on level of lockdown in the local boroughs. The indicators around Christmas time would outline a picture of what to expect in the new year.
8.7.6.	In terms of Freedom to Speak up (FTSU) Ms Scavazza enquired whether the focus on the activity led to increased reporting and whether the Trust has metrics. Prof. Orchard advised that an assessment would be undertaken at the end of December 2020 and confirmed that the Trust does have metrics which would be correlated across other raising concerns avenues. A report would be submitted to the next Audit, Risk and Governance Committee. Mr Ross and Mr Jenkinson added that the Trust has a lot of initiatives and work was continuing to make staff aware of the guardians and that the FTSU lead, Ms Johnson, was engaged with the BAME network and the guardians were representative in the diverse characteristics. Mr Jenkinson advised that he was a co-executive sponsor of the I-CAN network and any disability issues arising from raising concerns avenues would be raised as required by the FTSU lead or guardian. Current metrics would be emailed to Ms Scavazza. **Action: Mr Jenkinson**
8.7.7.	In terms of outpatients Ms Boycott commented that one of the emerging issues since the pandemic occurred was NHS ways of contacting patients which had shown gaps, as basic as how patients could access blood test results. She 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. She asked how the Trust was working across the system to get these messages across. Ms Dixon advised that this was a complex area and the positive was that Prof. Orchard was the sector lead for the acute provider change programme, part of which brings the communication leads together and one of the focuses of the group was on how to achieve consistency across Trusts referring to signage as an example. She referred to the sector outpatient transformation work underway which mapped out the outpatient journey from a user perspective which enables a conversation about how to shift from that system to one which is user experience designed. Prof. Orchard added that Trusts was also working with the region regarding the messaging around people being able to call 111 and booking an appointment in Emergency Departments. Ms Dixon would provide an update to the Board (via email) around the new ways of accessing healthcare and information by people. **Action: Ms Dixon**
8.7.8.	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. **Action: Ms Dixon, Prof. Sigsworth, Dr Klaber**

8.7.9.	Prof. Teoh advised that work was underway with the Outpatient Transformation Board to bring together innovation and operations for effective delivery of outpatient services, reporting through models of care, operational network and the NWL Outpatient Transformation Board. Before engaging sector wide, one of the areas of focus was on the integration of Cerner across the majority of Trusts in NWL which would help with information exchange and ensuring patients are reached. He gave the examples of a two-way text back system, innovated by the Trust and the Vestifi system where patients could book their blood tests. In terms of feedback, amongst other routes, this was obtained through complaints (information and formal) and the Friends and Family Test which was being re-established (paused due to Covid-19). He outlined some of the work underway to ensure that the Trust was tracking the correct timings for virtual and face-to-face patients. The Board suggested discussing outpatients in detail at a future Board or Board Seminar. **Action: Prof. Teoh**
8.7.10.	In terms of the approval process for the Covid-19 vaccination programme, Dr Raffel enquired how assurance would be gained ensuring there were no short cuts. Prof Orchard advised corners had not been cut but the approval process condensed and accelerated as explained by Professor Shattock in a recent staff briefing. He outlined that the length of time to develop the vaccine could be truncated as the data was generated much more quickly due to the volume of people with the virus. It could be fast tracked in parallel instead of series, therefore the regulators are able to focus on the data generating a conclusion quickly. Noted that when the vaccine was received locally, it would be delivered in the most appropriate way.
8.8.	Ms Vennells drew the Board's attention to the research and innovation section of the report and the Trust's strategic intent around research and innovation particularly its role in recruiting patients to participate in research.
8.9.	Ms Vennells highlighted and congratulated Winny Thomas, Matron for Quality Improvement and BAME Nurses and Midwives network Chair, who was awarded the British Empire Medal in the Queen's Birthday Honours in recognition of Winny's services to nursing during Covid-19. Congratulations were also extended to Mrs Hook who won the Director of the year award for London and South Institute of Directors for the Public sector. Congratulations were also extended to all who were involved in the award for the 'Hand hygiene improvement initiative of the year, patient safety awards.
8.10.	**The Board noted the report from the Chief Executive.**
9.	**Recovery and Reset Programme**
9.1.	The Board received and noted the update report, noting that aspects of the report had been covered in the Chief Executive's report. Following the progress made in other programme workstreams (models of care, staff support, learning and insights), the key focus of the programme had moved to operational recovery and planning for wave 2.
9.2.	Mr Goldsbrough commended the direction and agreed with the current focus on new models of care. Regarding Covid-19, besides mortality rates which improved for patients who were hospitalised, he enquired whether the Trust was also making progress on other outcome measures for 'recovering Covid-19' patients and how it compared with other Trusts. Prof. Redhead advised that the Intensive Care National Audit and Research Centre (ICNARC) report regarding ITU placed the Trust in the middle of the pack but difficult to interpret around NWL due to patient transfers between hospitals at the time to equalise pressures which makes the comparison complicated. In terms of death rates, Hospital Standardised Mortality Ration (HSMR) and Summary Hospital-level Mortality Indictor (SHMIs) increased which was in line nationally and the Trust maintained its performance levels. For these outcomes the Trust can be confident that it carried out the best treatments for its patients.
9.3.	Prof. Redhead expressed the importance of the increased care the Trust could provide with the use of researched steroids to aid the recovery of Covid-19 patients. In NWL the Trust has been at the forefront of the research and learning across NWL. This was evidenced through

	an improvement in the number of patients required to go to ITU and the length of stay in ITU which had changed compared to wave 1 - wave 2 death rate figures were not yet known. In terms of the Trust's learning from deaths, 10% of the deaths were reviewed and there were no lapses in care. Responding to Mr Goldsbrough, Prof. Redhead was confident that the information was correct and that the care of those patients was of a high standard.
9.4.	**The Board noted the report.**
10.	**Integrated quality and performance report**
10.1.	The Board received the integrated quality and performance report for month 6 and noted highlights and exceptions. The scorecard presents the Board metrics within the Trust's strategic goals, priority programmes and focussed improvements. The report had previously been discussed at the Quality Committee.
10.2.	The Board noted progress being made in recovering 'business as usual' clinical activity and that performance and key operational standards were improving month on month. The Board noted areas of concern and counter measure summaries, including Incident reporting rates; Cancer waiting times – 62-day performance; ambulance handovers which continued as pressures into October. October had shown some pressures in long stay patients and delays in the ED from decision to admit to admission. The Trust was back on track with 52 week waits and on trajectory for November. In terms of incident reporting, Prof. Redhead advised that it was important that the Trust has a culture of high reporting with low harm. The report detailed the work around this.
10.3.	The Trust was above trajectory for C-Difficile last month and below trajectory for quarter 2. There were no lapses in care for the 11 cases reported attributable to C-Difficile.
10.4.	Ms Vennells commented that the counter measure summaries demonstrated the new performance reporting system was working well.
10.5.	In terms of the cancer waiting times, Prof. Urch advised that the team was steadily working through a large back log as a result of the Covid-19 pandemic which had translated into patients waiting for more than 62 days since referral. The Trust was working closely with partners to address this and the numbers were steadily reducing and the service slowly recovering aided by the GPs (now also referring). Noted that it would take some time for the service to recover to pre-Covid-19 levels but good work progressing. Prof. Orchard commended the cancer team for their work and advised that one of the main contributing factors to the delays was diagnostics opposed to treatment and a lot of work was progressing with the sector to address the diagnostics aspects.
10.6.	**The Board noted the report.**
10.7.	**Selection of integrated scorecard metrics** The Board received the report noting the assurance of executive input and Non-executive Directors were asked to submit any comments to Mrs Hook.
11.	**Finance report**
11.1.	The Board received an update on the financial position for the Trust for the six months to the 30th September 2020. The report had been discussed previously at the Finance, Investment and Operations Committee.
11.2.	The Trust reported a breakeven position which required top up funding of £39.6m of which £30.8m was approved and the remaining waiting for approval.
11.3.	Mrs Thind highlighted an error on the report, page 65, commentary section, bullet two, last sentence which should read '…..This is £8.8m in month, an increase since last *month*, not *year'*.

11.4.	The key drivers for the top up funding was due to the additional Covid-19 spend, loss of non-NHS income and standing down some Research and Development activity.
11.5.	Key highlights • Debt position improving and making progress to recover cash • Capital plan on track and colleagues working hard to deliver the plan, noting that the plan had increased since the beginning of the year • Cash balance looked unusually high but these are payments on account which will unwind and come back to reasonable cash balances. • Key focus on year end position and how we deliver the forecast outturn plan agreed with the sector which includes an efficiency ask.
11.6.	Mrs Thind confirmed that the efficiency ask is £6m which equates to 1% of turnover for the six months remaining in the year. The focus on this and CIPs should improve run rates as the Trust enters into the next financial year. The exit run rate was important as significant focus was being placed by the Trust and the sector on opening run rates for the new year as the allocations likely to be sector allocations.
11.7.	**The Board noted the report.**
12.	**Infection prevention and control board assurance framework for Covid-19 self-assessment**
12.1.	The Board received the report which had been extensively discussed at various levels of Trust meetings and most recently at the Quality Committee.
12.2.	The Board noted that in May 2020, NHS England published an Infection prevention and control (IPC) board assurance framework (BAF) to offer assurance to NHS Trust Boards that their approach to the management of Covid-19 is in line with Public Health England (PHE) IPC guidance, and that risks have been identified. The appendix to the paper summarised the outcome of the self-assessment for ICHT for September 2020, which had been updated from the original completion of the framework in May 2020. The IPC BAF self-assessment would be updated monthly and shared with the Health Care Associated Infections (HCAI) sitrep group and Clinical Reference Group (CRG) until further notice.
12.3.	The Board noted that the BAF was reviewed with the Trust's Care Quality Commission (CQC) lead in July 2020 with generally positive feedback. The action points noted from that review were to ensure audits of cleaning commenced and assurance/governance of their outcomes strengthened. This was being taken forward by the estates/facilities team with divisional colleagues. An action plan was now in place to undertake the necessary work that would improve board assurance related to IPC management of Covid-19 infection and was monitored weekly at CRG. It was noted that the document was live and therefore RAG ratings would change particularly due to changing directives. This exercise would aid ongoing improvement, learning and to get this right going forward.
12.4.	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. **Action: Prof. Redhead/Prof. Holmes**
12.5.	Ms Vennells sought assurance regarding FPP3 fit testing (section 10.2). Prof. Holmes and Mrs Hook advised that that a programme was in place to conduct fit testing and records were being monitored centrally. Due to a required change in the supplier and type of mask, the Trust was having to fit test staff again for the new mask. Mrs Hook assured the Board that

	the Trust always have people available to do fit testing. The Trust had subscribed to the national offer of help and have engaged external support to assist with this programme of testing.
12.6.	**The Board approved the self-assessment and noted that an updated report would be received by the Board each month.**
13.	**Infection Prevention and Control (IPC) Report**
13.1.	The Board received the quarter 2, 2020-21 report and noted the following highlights: • IPC expertise continued to be integral to decision making during the Trust management of Covid-19. Processes for the management of possible Covid-19 outbreaks in patients and staff had been agreed and implemented. IPC provided the relevant expertise to support the implementation of the new Public Health England (PHE) IPC guidelines for Covid-19. • There had been 14 hospital-associated C. difficile cases during Q2, which was below the Q2 ceiling of 21 cases. There had been no lapses in care related to cross-transmission or antibiotic choices. • There was one hospital-associated MRSA BSI during Q2, the first in >12 months. • The Trust was on target to meet its 10% year-on-year reduction in Trust-attributed E. coli BSIs. • The rate of Central-Line Associated BSIs remains below benchmark rates in the adult, paediatric, and neonatal ICUs. • The first antibiotic point prevalence study of 2020/21 was conducted in August 2020. Trust-level compliance with all indicators was >90%. • The strategic hand hygiene improvement programme was extended to include encouraging best practice around the use of personal protective equipment.
13.2.	Mr Goldsbrough commended the report and asked Prof. Holmes to comment on the overall theme of antimicrobial stewardship which had been under pressure this year and what the outlook was and when consistent progress could be made. Prof. Holmes advised that despite Covid-19 pressures, the Trust had sustained its focus on appropriate antibiotic prescribing which was an indicator of quality of care. The question around the impact of Covid-19 on antibiotic usage and antimicrobial resistance (AMR) was of particular interest and the Trust was contributing and leading research into this area at a local, national and global level.
13.3.	The Board asked Prof. Holmes to extend the Boards appreciation to the IPC teams for their work during the pandemic taking into consideration the extra work for teams relating to Covid-19. Prof. Holmes referred to the patient safety award mentioned in the CEO's report which was positive for the team.
13.4.	**The Board noted the report.**
14.	**Learning from deaths quarterly report**
14.1.	The Board received quarters 1 and 2 2020-21 Learning from Deaths programme report. The paper outlined activity undertaken as part of the mandated programme, it further provided information regarding the Trust's mortality rate and mortality surveillance activity.
14.2.	Prof. Redhead referenced the changes that the Trust was making to its Learning from Deaths programme and the steps taken to validate the Trusts findings from mortality reviews undertaken since 2017, focussing on the extent to which deaths could have been avoided. So far, none of the deaths which occurred in quarters 1 and 2 2020/21 had been identified as having poor care, or as 'avoidable', through the processes outlined in the report.
14.3.	Prof. Redhead referred to the previous local Level 1 screening review which had been replaced by the Medical Examiner service from 1 April 2020. The Medical Examiner reviews deaths independently working with the Coroner so that the Trust does not have any influence and he outlined the process which was separate to all the learning from the Structured Judgement Review (SJR) and Serious Incident (SI) processes. The Trust had not identified

	any poor care or avoidable harm up to quarter 2. There has been a backlog of SJRs due to Covid-19 but teams were getting back on track as learning from these was important.
14.4.	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. In response to Ms Vennell's question about the project manager's role, Prof. Redhead advised the project manager would manage, co-ordinate and support staff to enable processes such as SJRs to be carried out. Prof. Redhead would confirm the changes are in place by the end of quarter 3. **Action: Prof. Redhead**
14.5.	**The Board noted the report.**
15.	**Equality, diversity and inclusion work programme update**
15.1.	The Board received the mid-year progress report on the Equality, Diversity, and Inclusion (EDI) Work Programme for 2020/2021. This was discussed at the Quality Committee.
15.2.	Ms Grange advised that the Trust has a people strategy with one key theme about EDI which sets out the Trust's vision over the next three years. It included six objectives and the report provided a mid-year update against those objectives. Good progress was made in all of the six objectives for the EDI Work Programme, with three actions completed in full. Recruitment to an expanded EDI team had commenced with interviews to be held in late November.
15.3.	Other areas of good progress included the diversity dashboard; 800 BAME staff trained to participate in recruitment panels and a feedback/learning process in place; designing the race equality training programme; a number of events held to mark Black History month in October; the Trust achieved disability employer status and Ms Grange advised that 3rd December marks international disability day.
15.4.	Comments from the Non-executive Directors:
15.4.1.	In the context of other Board reports on integrated performance metrics, Mr Alexander enquired how some of the quantifiable outputs integrated into those metrics. Prof. Orchard advised that the Trust looked at what would be the single most representative metric to look at as a measure of success. After discussion with staff networks, the Workforce Race Equality Standard (WRES) indicator 2 was agreed 'focused improvement on improving the likelihood of BAME staff being appointed from shortlisting'. The Trust had made some progress around the number of people going into disciplinary processes which changed the ratio to 0.8 indicating that it was more likely that staff going into a disciplinary process would be from a white background instead of from the BAME group which was significant progress.
15.4.2.	Mr Ross made the point about how the Board was unrepresentative of the community it serves and that much of what was done by the Trust was measured mostly by outputs and advised that more needs to be done around outcomes. The Chair pointed out that the presence of Ms Scavazza, Ms Ejimofo, Dr Maruthappu, Prof. Teoh and Ms Thind were significant steps in the right direction.
15.4.3.	Ms Scavazza commended the work being done by the Trust but agreed more needs to be done around outcomes advising that the litmus test would be whether there has been a difference to BAME staff and the question about 'what would it feel like to work here'. Prof. Orchard welcomed the comments and suggested that Ms Scavazza's experience would be helpful particularly around 'what does it feel like to work here?' Ms Grange added that the Trust uses the national staff survey as a barometer for progress and a number of the questions are about how staff feel linking in with protected characteristics. The detail of the survey would be scrutinised in January 2021. She commented that the workplan has been thoughtfully set up with wide engagement and welcomed Ms Scavazza's input.

15.4.4.	Dr Raffel enquired about the detail and timeline of objective one relating to aspirational goals. Prof. Orchard advised that the aspirational goal is one that had been set by the WRES task force with the aim of over a 10 year period, to completely equalise across the whole of NHS workforce, the proportionality of ethnic diversity across every single grade particularly senior grades and he suggested it would be helpful to have Ms Scavazza's input into this work.
15.5.	**The Board noted that this was central to the people agenda and conveyed their thanks to all involved.**
16.	**Trust Board Committees – summary reports**
16.1.	**Audit, Risk and Governance Committee** The Board noted the summary points from the meeting held on 7th October 2020 which covered some important points on hotel services.
16.2. 16.2.1.	**Quality Committee** The Board noted the summary points from the meeting held on 11th November 2020.
16.2.2.	Prof. Redhead added that the Committee discussed the Paterson and Cumberlege report in detail. Although the recommendations were national, the Trust was able to link more locally to take into account the recommendations to gain assurances.
16.2.3.	Ms Boycott added that it was very reassuring to see the amount of work that was being done by the Trust and producing reports to Board to provide the assurance around excellent quality of patient care, despite the pressures of the pandemic. She referred to the time taken to review and assess the Trust against the Paterson and Cumberlege report recommendations to gain assurance. The qualitative understanding of quality and the cultural aspects of that were commendable and people should be reassured as it is an excellent Committee.
16.3. 16.3.1.	**Finance, Investment and Operations Committee** The Board noted the summary points from the meeting held on 18th November 2020 and a detailed review of Cost Improvement Programmes (CIPs) would be covered at the next meeting.
16.4. 16.4.1.	**Redevelopment Committee** The Board noted the summary points from the meeting held on 22nd October and 18th November 2020.
17. 17.1.	**Any other business** Ms Vennells thanked Sir Gerry for his contributions to the Trust over the past 12 years as he was stepping down. She extended her personal gratitude to him and his family, and that of the external auditors reading out a complimentary email from the auditors.
17.2.	The Board thanked Sir Gerry and members expressed their personal thanks.
17.3.	Sir Gerry expressed his thanks to the Board and other members of staff for an enjoyable time at the Trust and wished everyone and the Trust the best.
18. 18.1.	**Questions from the public** Questions to the Trust Board from Mr Dhuhulow:
18.1.1.	**I disagree with the board's conclusion about not building cancer diagnostic facility and their plans. I do not understand why the Imperial NHS Trust would need to partner with smaller Trusts in the hope of sourcing cancer diagnostic services for its patients, when in fact the Imperial NHS Trust has bigger platform, budgets and prestige than those small Trusts? How many cancer patients should die before the board change their minds and build cancer diagnostic facility? And how the doctors will do their jobs and help their patients, if they cannot define what the problem is?** Professor Redhead commented that it is important that the Trust thinks of itself as caring for the entire population of North West London and it is true for ICHT as it is a significant provider of care and its local population extends to a large population base. The Trust aims to work as part of a network to provide the care to all of its citizens which includes equity of access

18.1.2.	and making sure the Trust doesn't have a huge variation or variability in care across different parts of the healthcare systems – which it currently does and became more evident during Covid-19. In terms of a cancer centre, the Trust needs to work as an Integrated Care System (ICS) to make sure there is equity of access to all diagnostics, access to early diagnosis and to all the different treatment options which would be available. Building a large cancer unit on one site may benefit some of the population, but not necessarily all. Therefore nothing is ruled out in terms of how the ICS will respond to ongoing aspects of cancer care. It is worth noting that many of the Trust's clinicians are leaders across the ICS in terms of this field. ICHT needs to make sure it is working as an ICS to develop the plans and to see how they are best managed for the entire population. **When the disabled community will have representatives at the Trust's board and its subsidiary committees to play their part in the decision making process of the Trust and to fight for their rights?** Aspects of the question were covered as part of the Equality, Diversity and Inclusion (EDI) Board Report and during conversations at the Board meeting around how the Trust supports its staff with disability, one of the avenues being the I-CAN Network which helps the Trust support those members of staff. Ms Grange reflected on watching the growth of the Trust's disability network (I-CAN) for staff over the past year. The I-CAN Network meets regularly and have been influencing some of the decisions that are being made by the Trust. Examples of conversations they have brought to the network include: • PPE – the need for transparent masks for those who are hard of hearing; and • Virtual meetings – making online meetings more accessible through the available functionalities in the system by making people more aware of them. The I-CAN Network leads attends the EDI Committee and have a scheduled item on the agenda where they can any raise any issues they are concerned about for the Trust to take forward. There is a lot more to do to help and support the network grow further. In terms of representation at Board level, Ms Vennells advised that NHS Improvement/England (NHSI/E) are committed to improving the diversity of Board members and Lay members, and had established a group to drive improvement in Board level involvement and advise on disability. The letter received from NHSI/E regarding this had been shared with Trish Longdon, Chair of the Strategic Lay Forum (SLF) as a number of Lay partners identify as disabled and Trish Longdon was hopeful the SLF would support NHSEI's initiative; the Trust Board would welcome SLF members to attend Board meetings. Ms Vennells commented that not all disabilities are visible or declared and the Trust should consider this at Board and Executive level. Ms Vennells congratulated Ms Grange on achieving 'Disability Confident' status for the Trust, this was a good base from which to improve further, and she thanked Mr Dhuhulow for asking this important question.
19.	**Date of next meeting** 27th January 2021, 11am, Virtual meeting via Microsoft Teams

Updated: 31 December 2020

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TRUST BOARD (PUBLIC)

Paper title: Record of items discussed at the confidential Trust board meeting held on 25th November and Board Seminar, 9th December 2020

Agenda item 5 and paper number 02

Author and lead Executive Director: Peter Jenkinson, Director of Corporate Affairs and Trust Secretary and Professor Tim Orchard, Chief Executive

Purpose: For information

Meeting: 31 March 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 25 November 2020 and 9 December 2020. The Board did not meet in January 2021 due to the exceptional circumstances of the COVID-19 pandemic.

25 November 2020 Private Trust Board

2. Chief Executive's update

2.1. As part of the Chief Executive's oral update, the Board received an update on the work of the Integrated Care System Plan and the merger of the Royal Brompton and Guys and St Thomas' Hospital.

3. Fleming Centre

3.1. The Board welcomed Lord Darzi who shared his views on research, innovation and the proposed development of a clinical research centre on the St Mary's campus.

4. St Mary's Hospital Redevelopment Strategic Outline Case

4.1. The Board received an update on the feedback received from the Department of Health and Social Care regarding the Strategic Outline Case for the redevelopment of St Mary's Hospital and the further work that would be required of the Trust. The Board also noted the inclusion of our hospitals in the New Hospitals Programme.

9 December 2020 Board Seminar

5. The Board approved the Bed Management Contract.

Imperial College Healthcare NHS Trust

6. The Board received a presentation from Professor Martin Lupton and Dr Amir Sam updating the Board on joint work with Imperial College in relation to undergraduate medical education. The Board also received a presentation updating on the Trust education and development of nursing, midwifery and Allied Health Professionals (AHPs).

7. The Board reviewed NHS England's proposals for the development of the Integrated Care System and a response to the consultation would be prepared.

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TRUST BOARD (PUBLIC) - ACTION POINTS REGISTER, Date of last meeting 25th November 2020

Updated: 24 March 2021

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 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. Close	Kevin Croft	March 2021
2.	30 Sept 2020 22.3.1	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. Close	Matt Tulley	March 2021

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 wellbeing 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. Close	Kevin Croft	March 2021
4.	25 March 2020 9.4	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 which is on the main agenda for discussion. Close	Hugh Gostling	March 2021

5.	29 January 2020 14.6 25 Nov 2020 6.1	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 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:** Refer to the main agenda item regarding the establishment of a People Committee. Close	Kevin Croft	March 2021

6.	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. Close	Kevin Croft	March 2021

7.	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	Bob Klaber	March 2021
8.	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	March 2021
9.	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. **March 2021 update:** Oral update	Michelle Dixon	March 2021

10.	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	Michelle Dixon, Janice Sigsworth, Bob Klaber	March 2021
11.	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	Julian Redhead/ Alison Holmes	March 2021

12.	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	Julian Redhead	March 2021
13.	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.	TG Teoh, Peter Jenkinson	TBA

Items closed at the November 2020 meeting

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	30 Sept 2020 10.4	Links between strategic papers (arising from learning and insights paper)	Mr Goldsbrough enquired how the four priority areas from October 2020 to April 2021 relate to the five recovery and reset workstreams and how resources would be aligned to deliver those five programmes and redevelopment. Prof. Orchard advised that the five areas are the Trust's priorities for the rest of the year noting there would be some variability with those for next year. Work programmes would also consider how key points are incorporated into the way things are done as well as how they are done. Dr Klaber would send an email to the Board to articulate the links between these papers. November 2020 update: The Recovery and Reset (R&R) paper provides an update on the review of the workstreams within the R&R programme. An update on prioritisation of programmes will be provided through that discussion.	Dr Klaber	Closed
2.	30 Sept 2020 7.4	Financial performance (arising from CEO report)	An update on financial performance was provided as part of a substantive agenda item. The revised guidance and contract arrangements for the next six months had been received. The allocation of money would be agreed via the Integrated Care System (ICS) and Trusts would meet to discuss further. A summary would be shared with the Board when ready. November 2020 update: The Trust developed and submitted its financial plan as part of the ICS submission. However the timings and process did not allow for a formal update to the Trust Board and an extra-ordinary meeting of FIOC (extended to all NED and Executive Directors) was called to scrutinise and approve the plan.	Mrs Thind	Closed

3.	29 January 2020 7.3 29 July 2020 6.2 25 Nov 2020 6.1	Patient story review	January 2020: Prof. Sigsworth welcomed the comments and would discuss a plan with the Strategic Lay Forum, Executive Quality Committee and Quality Board Committee with a next steps plan to Board in summer. July 2020 update: The patient stories had been well received by the Board and Prof. Sigsworth's team were exploring the logistics around how to share patient stories with the Board in light of the Covid-19 pandemic. Sir Gerry suggested it would be useful to review the patient stories received so far and assess how the Trust's behaviour had changed as a result and whether that behaviour had been sustained – as the benefit must be changed behaviour. Ms Vennells added that one of the recommendations from the Board effectiveness review was around greater visibility of metrics relating to patient experience as well as stories and Ms Boycott had some helpful input which would be discussed with Prof. Sigsworth. This would be discussed further with Board members and the Strategic Lay Forum and a proposal would be provided to the September or November Board. September 2020 update: Report: Mrs A's story November 2020 update: The metrics used to report patient experience in the scorecard have been reviewed and two new indicators have been added to increase the level of insight. The first is a net sentiment score which is derived from the free text comments received in local surveys. The second is a composite score derived from questions about trust and confidence in staff, how well looked after patients feel, respect and dignity and the cleanliness of the environment in which they are cared for. These can be analysed down to ward and department level and provide a good indication of where there may be concerns. The learning and insights work, led by Bob Klaber, has also provided extensive feedback from citizens and local communities. This means that we are able to pull feedback from a wide range of sources to identify key areas for improvement. We aim to provide an annual summary report of stories that the board has received which sets out themes, learning and an update on actions. The last summary was presented to the board in January 2020 and another one will be presented in early 2021. The Board noted the update and that the next thematic annual summary would be presented to the Board in early 2021.	Janice Sigsworth	Added to Board forward planner

4.	30 Sept 2020 11.5 – 11.7	Integrated quality and performance report	a) The Board discussed whether the 'maximum number of formal complaints per year' was the right indicator as the Trust should hear every complaint that is to be made and not limit them. Mrs Hook advised that the purpose of the scorecard was to look at trends and investigate areas off trajectory, but acknowledged that the complaints indicator could be expressed differently. b) The Board discussed the limited number of indicators provided at Board level and enquired what determined which indictors should feature in the Board report and what the trade-offs were. Mrs Hook advised that she has the visibility of the detail and suggested at some point the Board may find it helpful to have a session to review the indictors and how they are cascaded and decide which should be presented at Board level. She would also think about how to share this information with the Board to aid transparency. c) Mr Ross acknowledged that everything on the list was important but posed the question as to whether the performance measures provide a view of the outcome measures. He enquired whether by concentrating on Covid-19 patients this was causing more harm than good; and as there were many people who had not been seen due to the pandemic whether the consequences were good such as remission or patients coping with their ailments. Outcome measures would be helpful to assess this. Prof. Redhead advised that the Trust has a robust risk stratification and reprioritisation of patients based on criticality of care and was also doing a harm review which would be discussed at the Quality Committee. The points made by Mr Ross would be discussed with the Sector. November 2020 update: a) The Head of Patient Experience has confirmed that the figure of 100 complaints is intended to be a threshold (not a target) to prompt further investigation if the figure is exceeded in any one month. The themes are reported quarterly at divisional quality meetings and the EMB Quality Group. Any significant issues should be highlighted in the Quality Committee report to the Board. The Board also receive the annual complaints report which provides more detail and learning from themes. A scorecard metric could be considered for future updates, relating to overall patient satisfaction with the handling of their complaint. The Trust already surveys people 6 weeks after they are sent the final response. b) Agenda item c) Prof Redhead has discussed this with the Sector. All hospitals confirmed that	Mrs Hook Mrs Hook Prof. Redhead	Closed

			they have a robust clinical prioritisation system.		

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

Author and lead Executive Director: Steph Harrison-White & Guy Young and Janice Sigsworth. Director of Nursing

Purpose: For information

Meeting date: 31 March 2021

Executive summary

1. Introduction and background

1.1. 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.

1.2. Due to the ongoing risks and restrictions, this paper will be told by a staff member who will describe how communicating with families through electronic devices can contribute to unforeseen issues for families and staff in the Adult Intensive Care Unit (AICU).

1.3. The story will draw on a number of different patient and staff experiences and will highlight how we have learnt from these to refine the use of technology in communicating with families.

2. Purpose

2.1. 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.

2.2. 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

3. Executive Summary

3.1. During the COVID-19 pandemic, patient visiting has been severely restricted. This meant that staff had to quickly find alternative ways to communicate with families and for families to have contact with their loved ones.

3.2. Technology, particularly the use of iPads, became a useful tool to support face-to-face communication. This approach was adopted by the majority of clinical areas.

3.3. During the first wave of the pandemic, families of patients in Adult Intensive Care Unit (AICU) reported issues with privacy, connectivity and the timing of contact via the iPads.

3.4. Staff also described that communication in this way carried an additional emotional impact not observed with in-person visiting.

4. Next steps

4.1. Changes have been made to address the issues raised by families and patients and these continue to be reviewed. Visiting restrictions remain in place so these methods are likely to be utilised for the foreseeable future.

4.2. Even if visiting returns to pre-COVID arrangements, there are still potential benefits for this type of contact and this will be explored in more detail.

4.3. The issues faced by staff co-ordinating these conversations has been recognised and training is being revised to prepare them for that.

5. Recommendation(s)

5.1. The Board is asked to note the report.

Main paper

6. Patient story and staff reflections

6.1. The use of iPads and other technology has been used extensively in AICU during the COVID-19 pandemic. Thousands of interactions have taken place in this way. This has enabled contact between families and their loved ones, which would not have otherwise been possible. Overwhelmingly this has been a positive experience, but as is often the case with the rapid introduction of a new system that have been some unintended and unanticipated consequences. This story focuses on those and steps taken to address them.

6.2. The story incorporates feedback from three patients as well as members of the clinical staff.

6.3. A family described the video calls as the ‘precious few minutes’ they had to see their father, watch him move and tell him they loved him’. They described the calls as a ‘lifeline’ for the family, providing ‘solace in these dark dark days’.

6.4. There were a number of technical and privacy issues that the families raised. Initially we did not have stands for the equipment, so nursing staff would hold the iPads for patients. This could affect the quality of the picture and as one relative describes this resulted in a ‘wobbly picture, a complete lack of privacy, and worst of all, a consciousness that we are keeping the nurse from their work’.

6.5. One patient described having to wait for staff to help him make calls to his family as he wasn't strong enough to hold the iPad and make the call himself.

6.6. Nursing staff would facilitate the end of life family video calls after the medical staff had spoken with the family. This remote, albeit unavoidable, way of communicating in such stressful circumstances left some more junior staff describing feelings of guilt in that they couldn't provide the emotional support to families they would normally do if they were present and the impact of ending conversations in such distressing circumstances.

7. Conclusion and next steps

7.1. Technology has been vital during the COVID-19 pandemic to support communication with families and to help keep families connected when visiting was not always possible. We are most grateful to Imperial Charity for their donation of iPads and premium WiFi.

7.2. The introduction of technology had to be rapid in response to the sudden demand for new ways of communicating. The use of iPads whilst being a positive action has highlighted areas for learning and unintentional consequences for patients, families and staff.

7.3. The issue of privacy, highlighted by patients and families, was improved through the purchasing of iPad stands. One patient 'gifted' a number of stands to the unit on his discharge, with the unit purchasing more to enable private conversations to be held.

7.4. The issues with the quality of the connectivity were addressed two-fold; the use of the stands and through working with our ICT department.

7.5. The unit reflected on the impact of delays in calling families. Initially, daily calls were scheduled to take place at a fixed point in the day. It became apparent that due to clinical pressures this was not always possible. Staff changed how they communicated the timing of calls to families, setting more realistic expectations. This was also important for our staff to reflect upon and to help them in prioritising those calls that needed to be made first or earlier.

7.6. Intensive care training will inevitably include aspects related to communication with relatives of critically ill patients. Pre-COVID this would focus generally on situations where the family members would be physically present. The shift to communication via iPads identified new issues, which will now be built into training such as the *foundation to critical care* programme.

7.7. It is likely that visiting restrictions will continue for some time, particularly in areas such as AICU, and this approach, as it continues to be developed and refined, will provide a valuable connection between patients and their families. Even when visiting starts to return to pre-COVID arrangements there will be advantages to continuing to communicate in this way. The scope to roll this out further to less highly dependent areas is also being explored.

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

18 March 2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Chief executive's report

Agenda item 8 and paper number 05

Executive Director: Prof Tim Orchard, Chief executive

Purpose: For noting

Meeting date: 31 March 2021

Chief executive's report to Trust Board

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

- Our Covid-19 response, including reset and recovery
- Covid-19 vaccination programme
- Flu vaccination
- Financial performance
- National NHS staff survey
- CQC update
- Redevelopment
- Research and innovation
- Stakeholder engagement
- Celebrating success

1. Our Covid-19 response (including reset and recovery)

At the last public board, we reported 476 patients as of 25 January who had tested positive on their current admission, 123 of whom were being cared for in intensive care and with a total of 136 patients in our intensive care units. As of 22 March, we have 77 patients who have tested positive on their current admission, 24 of whom are in intensive care, and we have a total of 79 patients in intensive care.

At the peak of this second surge we were caring for 492 patients who had tested positive for Covid-19 on admission to hospital and had expanded our critical care capacity to accommodate up to 150 patients while continuing to maintain about 30 per cent of our normal surgical activity in order to provide time-critical care.

A national day of reflection took place on 23 March 2021, marking one-year on from the first national lockdown in response to the pandemic. We took part in a one-minute silence at midday on the day, reflecting on all that has happened since last March and remembering everyone who has sadly died, including a number of our own colleagues. We recognise and remember our colleagues who have died since the start of the pandemic. It is not always appropriate to share the cause of death and so we include here our colleagues who have died – whether or not linked to Covid-19 - over this time period:

- Melujean Ballesteros
- Melanie Barcelona
- Pedro Barte
- Jill Blowers
- Dax Daantos
- Jennifer Emodi
- Daniela Gheorghe
- Theresa Kolo
- Lizzie Lobeck
- Kumaran Manickan
- Lesley Moran
- Professor Mohammed Sami Shousha
- Professor Nigel Standfield
- Donald Suelto
- Jermaine Wright

We also shared a brief data stock take of our Covid-19 response since the start of the pandemic as per figure 1 below.

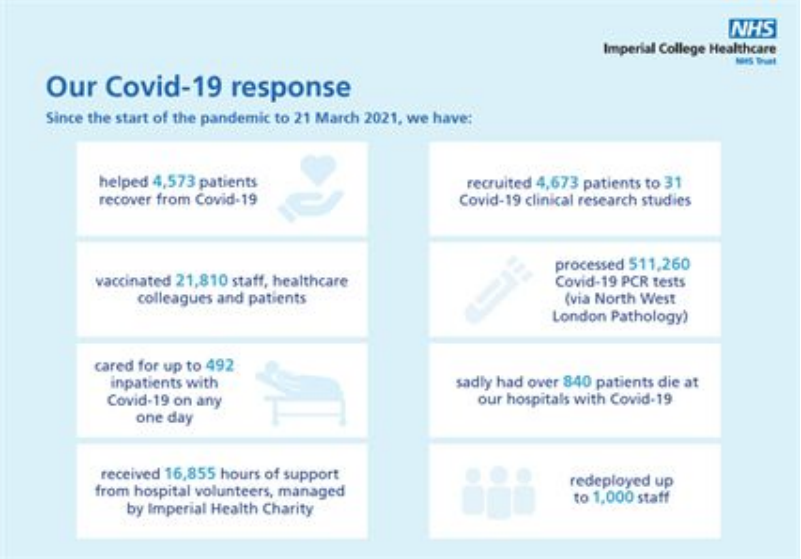


Figure 1 Covid-10 response data

As we move slowly out of this second surge, mindful of the continuing additional demand on intensive care services, we have established a 'reset and recovery' process to ensure we safely resume all of our planned care services in a way that focuses on the health and wellbeing of both our patients and our staff. Our operational focus for the next few weeks is on prioritising patients who need treatment within four weeks. From there, we will be expanding plans to safely and fairly work through the significant backlog of elective care that has been a major consequence of the pandemic and working with our partners across the North West London Integrated Care System 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. We are also ensuring that we are prepared as a system for a possible third Covid-19 wave or other future pandemics.

Our reset and recovery work draws on the major focus on staff health and wellbeing that we have had throughout the pandemic as well as a range of initiatives to create long-term improvements for staff. This includes the £1.7m staff support Covid-19 legacy programme,

made up of refurbishments to staff spaces and the creation of staff lounges on each of our main sites; a full review of our on-site food and retail offer; and a doubling of our staff counselling resource.

A separate paper, on the agenda at this meeting, sets out our initial reset and recovery phase in more detail.

2. Covid-19 vaccination programme

The operational focus of our in-house vaccination programme has now moved to delivering second doses, though we are continuing to provide first doses for our staff plus health and social care colleagues across North West London and patients who meet the JCVI criteria for vaccination.

We will need to move to a different operating model in the coming weeks due to de-deployment of staff who have been supporting the programme. Plans for short-term support have been agreed with the clinical divisions and a review is underway to confirm the longer term operating model and staffing.

We have now delivered more than 21,300 first doses and over 4,500 second doses. Considering staff designated as frontline, 7,958, (81%) have been vaccinated, this includes staff who have advised us that they have been vaccinated outside of the Trust and those not eligible to be vaccinated. National data, released on 11 March 2021, shows the rate of vaccination uptake amongst frontline health care staff in London remains the lowest in the country at 80.8%, our rate of 81% is comparable.

Further analysis has been conducted of first dose vaccine uptake by different groups of staff, a number of specific groups have been identified where vaccine hesitancy appears to be greater. We continue to engage with vaccine hesitant staff through a variety of interventions. Plans for the next few weeks include:

- individual conversations and personalised letters for all unvaccinated staff
- line manager information sessions – to provide line managers with the information to support local conversations about the vaccination programme
- focused engagement sessions led by chaplaincy and local faith leaders.

We have also launched, and are managing, two large vaccination centres as part of the roll out of the public vaccination programme by the NHS in North West London. They are at the Novotel London West in Hammersmith, in collaboration with Hammersmith and Fulham Council and the Accor hotel group, and at a centre in Edgware Road, in collaboration with Westminster City Council and etc.venues.

3. Flu vaccination

From September 2020 to Christmas, flu vaccinations were delivered by a record number (445) of peer vaccinators, complemented by two dedicated flu vaccination clinics per day on each of our three main sites. To help ensure physical distancing, attendance at the vaccination clinics was by appointment only. In addition, bespoke clinics were held for specific groups such as hotel services staff.

From January 2021, the campaign moved into a second phase, given the commencement of the Covid-19 vaccination programme. From that date, flu vaccinations were still available but only from divisional peer vaccinators and divisions.

The campaign ended on 9 March 2021 and 66% of frontline healthcare workers were vaccinated this year, compared with 69% in 2020. A lessons learnt session is scheduled to take place in late March.

4. Financial performance

The Trust agreed an outturn position with the North West London Integrated Care System for the second half of the financial year of a £15.8m deficit. The deficit was based on the month 5 forecast outturn and is primarily driven by lost non-NHS income. NHS commissioner income has 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 has been made available for activities such as increased pathology testing, vaccination clinics etc. which have been occurred in addition to the original block.

At the end of January 2021, the Trust met the year to date deficit plan of £7.8m and is 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 7 days, which equates to £14m and is included in the full year forecast. At the time of writing this report, confirmation of additional funding has been received with the final payment to be determined before 31 March. 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.

Since January reporting, the Trust has also been informed that it will receive funding for income lost due to the pandemic up to the value of £15.8m. However further validation is to be undertaken with the final settlement to be notified to the Trust in March.

The Trust has 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.

The Trust has received a high level overview of the 2021/22 planning arrangements, and the North West London Integrated Care System has started to review the assumptions whilst we await detailed planning instructions from NHSE/I.

5. National NHS staff survey

We received the NHS 2020 staff survey results in early March 2021 we have largely maintained the progress that we made in last year's survey with our overall engagement score remaining at 7.2 which is above the average for acute Trusts. Positively, we have seen a third successive increase in the proportion of our staff who would recommend the Trust as a place to work and as a place to be treated. Recommend as place to work increased to 71.4 per cent (from 67.4 per cent in 2019 and against a 2020 acute Trust average of 66.9 per cent). Recommend for care and treatment increased to 79 per cent (from 75.8 per cent in 2019 and against an acute Trust average of 74.3 per cent). Our particular focus on ensuring the health and wellbeing of our staff over the past year has coincided with an improved survey score in this area.

At the same time, survey scores have slipped back in three absolutely key areas – equality, diversity and inclusion; immediate managers; and team working. Though for team working, we remain above the acute trust average score. The scores for morale and creating a safe environment (against bullying and harassment) have not changed from last year.

Overall, the survey paints a mixed picture of how our staff feel about their working lives which very much reflects other feedback over the past year, including through our fortnightly all-staff Q&A sessions. Everyone has worked incredibly hard in responding to the demands of Covid-19, but we still have much more to do to address the underlying challenges in our workplaces. It is clear that policies are not always applied consistently within and across teams, staff do not always get the support they need and we still have further to go in ensuring we live our values and appropriately challenge colleagues who do not. In particular, we have to make faster

progress on equality, diversity and inclusion. That Black, Asian and minority ethnic colleagues and those with disabilities have been disproportionately affected by the pandemic has highlighted and exacerbated the many inequalities that already existed and I am grateful for the increasingly strong and influential voice of our staff networks in helping us to bring this out into the open.

We are 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; health and wellbeing.

6. Redevelopment

Following initial feedback from the national New Hospital Programme team, we have been progressing our strategic outline (business) case for a full redevelopment of St Mary's Hospital with the aim of re-submitting the case by early summer. We are working in partnership with the New Hospital Programme team to ensure the preferred option delivers the best possible hospital to meet the needs of our patient population with an agreed scope and size. There was a 'round table' meeting between the Trust and the national team on 5 March 2021 which discussed our approach and options. Further feedback and next steps are expected shortly.

The Trust has appointed a team to progress planning for major refurbishments and some new build at Charing Cross and Hammersmith hospital. The first phase, which focusses on information gathering and discovery, is programmed for completion at the end of March. The second phase will then focus on working up redevelopment options. We will also be resuming our engagement programme with staff, patients and wider stakeholders.

7. CQC update

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.

The Board will recall from the previous update that the CQC held an engagement meeting with the Trust on 27 January 2021, focusing on the Trust's critical care service and how we coped during the pandemic including rapid expansion of capacity, and 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 we submitted additional information as evidence to the CQC's Management Review process. That process continues.

The CQC has published a consultation regarding its proposed new regulatory strategy and proposed changes to how NHS acute trusts are rated. The main change proposed to its strategy is to move away from ratings only being awarded following onsite inspections, moving to a system where desktop / virtual assessments will take place in addition to onsite inspections, all of which can lead to a change in ratings. This means more frequent activity with the CQC, including engagement meetings, assessments that do not involve a site visit, inspections (with a site visit), and other requests for data and information outside of these activities. A more dynamic approach to ratings will mean trusts will have more frequent opportunities to improve ratings.

8. Research and innovation

We have continued to be very active in recruiting to Covid-19 research studies while also working to progress our wider portfolio of research. We received very 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 our work on patient and public engagement and involvement drawing specific recognition. We submitted more than 1,318

peer-reviewed research publications in our 2019/20 annual report, which represented 14.7% of the national total for all BRC's (8,986).

The NIHR has confirmed that the next BRC competition will be launched in April this year. We expect a two-stage process, with an initial pre-qualifying questionnaire to be submitted in May and full submission by October. Applications will be capped at £100m, and the distinction between research and cross-cutting themes has been removed. We are in the process of drafting a BRC framework / charter for equality, diversity and inclusion, based on the existing Trust and College policies. This will guide all recruitment and selection of all senior positions in the BRC, inform all funding decisions, and set the aim for appropriate representation of all protected characteristics in Trust research patient populations.

We are continuing to develop a virtual commercial and innovation function and, in partnership with Imperial Health Charity, have just launched our second round of the 'Innovate' programme which is supporting a further cohort of teams from across the Trust to explore innovative ways of improving health and care (https://www.imperialcharity.org.uk/grants/innovate-at-imperial).

9. Stakeholder engagement

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

- Healthwatch Central West London: 15 February 2021
- Nickie Aiken MP: 17 February 2021
- Cllr Tim Mitchell, Westminster City Council: 19 February 2021
- Cllr Stephen Cowan and Cllr Ben Coleman, London Borough of Hammersmith & Fulham: 22 February 2021
- Hammersmith & Fulham Save our NHS: 23 February 2021
- Karen Buck MP and Andy Slaughter MP: 4 March 2021
- Cllr Marwan Elnaghi, Royal Borough of Kensington and Chelsea: 16 March 2021
- Cllr Rachael Robathan and Cllr Tim Mitchell, Westminster City Council: 16 March 2021
- Cllr Rachael Robathan, Westminster City Council, visit to Edgware Road vaccination centre: 17 March 2021
- Brent Council Community and Wellbeing Scrutiny Committee: 24 March 2021
- Cllr Tim Mitchell, Westminster City Council: 30 March 2021

10. Celebrating success

I am delighted to report that Dr Paquita de Zulueta, GP and a core member of our Schwartz Rounds team since 2015, has won a 'shining star' award from the Point of Care Foundation, the national charity that supports organisations to introduce Schwartz Rounds.

Professor Tim Orchard
Chief executive
26 March 2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Organisational strategy review & refocus - priorities for the year ahead

Agenda item 9 and paper number 6

Author: Hannah Fontana, programme manager for strategy, research & innovation
Executive Director: Bob Klaber, director of strategy, research & innovation

Purpose: For discussion and approval

Meeting date: 31 March 2021

Executive summary

1. Introduction and background

1.1. As we have begun to emerge from the peak of the second wave of the COVID-19 pandemic, we have reflected on the changing context in which we are working to plan a focused set of priorities that we believe will best address our current challenges as an organisation and help us to continue to move towards our strategic goals.

2. Purpose

2.1. The purpose of this paper is to update the Board on the work that has been done to date on our strategic priorities for the year ahead and to approve the programmes and task and finish projects we are proposing to prioritise.

3. Executive Summary

3.1. Central to our strategic planning has been to consider, upfront, how the context within which we are all working has changed, and continues to change, in light of the pandemic. Understanding this context has given us clear focus on some core priority areas of work. The programmes and task and finish projects we are proposing to run build on the work we have done over the last 18 months and are the drivers of key outcomes within these priority areas.

3.2. Recognising the importance of focused attention on a small number of areas, and making best use of Executive time for oversight and collective effort, we have placed renewed emphasis on the time-bounded nature of our task and finish projects and on the synchronisation of the different areas of work over the next 12 months. The proposed priority programmes and task and finish projects for 2021/22 can be found within the main body of the paper.

4. Next steps

4.1. Finalise the new priority programmes and task and finish projects and ensure each is fully scoped with Executive-level leads, metrics for success and timelines.

4.2. Use the existing Executive meeting structure to oversee the priority work and report on progress.

4.3. Undertake a similar piece of work for our focused improvements - linked to the new CQC approach which is due to be published within the next few weeks.

4.4. Develop a programme of communication and engagement with all staff, as well as patients and members of our local community, to ensure wide understanding of and involvement in this work.

5. Recommendation

We are asking the Board to agree on our proposed approach to prioritising programmes and task and finish projects for 2021/22.

6. Impact assessment

6.1. Quality impact: This strategic planning work has a key impact on quality. We have been clear in the paper that quality will continue to be the defining outcome of the work that we are prioritising.

6.2. Financial impact: Our strategic planning work defines the priorities towards which we are placing our collective Executive oversight and focus and, through that, the prioritisation of resource from across the organisation to ensure delivery of the key outcomes.

6.3. 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.

6.4. 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.

6.5. Risk impact: No new risks arising from these priorities.

Main report

7. Organisational strategy review & refocus - priorities for the year ahead

7.1. Last year, we brought two strategy papers to the board which, drawing upon a wide range of insights, data and learning from the changing context within which we are working, described the approach we are taking towards achieving the Trust's three strategic goals:

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

7.2. As we have begun to emerge from the peak of the second wave of the COVID-19 pandemic, we have reflected on the changing context in which we are working to plan a focused set of priorities that we believe will best address our current challenges as an organisation and help us to continue to move towards our strategic goals.

Imperial College Healthcare NHS Trust

8. Our current context

8.1. Reflecting on how the context within which we are all working has changed, and continues to change, in light of the pandemic, our planning work needs to sit within a number of key considerations:

- How our staff are currently feeling a year into the pandemic
- How COVID-19 as a disease, and the treatments we have for it, are likely to evolve
- How we best tackle the significant backlogs in patients waiting for specialist care
- The growing focus on inequity of access, experience and outcomes across our communities
- How our integrated care system (ICS) in NWL is continuing to develop and mature, and with the establishment of an acute care programme within the ICS.
- How we continue to make progress with redeveloping our estate
- And underpinning it all - how we keep our values and behaviours central to everything we do

9. Our priorities for the year ahead

9.1. Understanding this context has given us clear focus on the core priority areas of work that we believe will best address these considerations and help move us further towards our organisational strategic goals. The programmes and task and finish projects we are proposing to run build on the work we have done over the last 18 months and are the drivers of key outcomes within these priority areas.

9.2. Our core priorities for the year ahead are to:

- Ensure all our patients who are waiting for specialist care get the advice, guidance and/or treatments/operations they need as quickly as possible
- Maintain a sustainable workforce – through a deep focus on improving the health & wellbeing of staff, as well as making improvements to recruitment, equality, diversity & inclusion, career pathways & support, retention etc.
- Advance our plans to redevelop our estates across each of our sites

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

- Proactively play our part in collaboratively developing our integrated care system, specifically through the development of 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)
- Take a strong user focus from patients, staff and local communities

9.3. We will use the routines and rigour of the Imperial Management and Improvement System (IMIS) as our operational mechanism to deliver these core priorities.

10. Defining our priority programmes, task and finish projects and focused improvements

10.1. The table below is a reminder of the definition, objectives and delivery timeframes for programmes, task & finish projects and focused improvements. Within this we will be placing a renewed emphasis on the time-bounded nature of our task and finish projects.

Delivery mechanism	Definition	Delivery timeframe
Programme	"Must do, can't fail" priority programmes that will have a significant impact on strategic goals. These will be programmes that most benefit from Executive involvement, oversight and focus, and will incorporate a number of phased time-bound projects.	1 – 3 years
Task & Finish projects	Task and finish corporate or complex projects that need to be delivered over a timeline of a few weeks or months. These are time-bound projects that will benefit from the central oversight and allocation of support/resources that Executive team huddles can give.	3 – 4 months
Focused Improvements	Direct improvement energy on improving a small number of recognisable metrics that the majority of the organisation can influence. These metrics will have important links into the emerging CQC focus on continuous improvement. These are changes that will be delivered by local teams, using continuous improvement methods.	6 – 12 months

11. Our proposed priority programmes and task and finish projects for 2021/2022

11.1. Recognising the importance of focused attention on a small number of areas, and making best use of Executive time for oversight and collective effort, we have placed renewed emphasis on the time-bounded nature of our task and finish projects and on the synchronisation of the different areas of work over the next 12 months.

11.2. The proposed priority programmes and task and finish projects for 2021/22 are described in the table below. We have segmented this into programmes and projects that are ongoing, or that we will start immediately, and those that we will be begin to scope in preparation for starting them at different points over the next 18 months.

	Ongoing/starting immediately	Scoping Pipeline
Programmes	• Patient access to specialist advice, guidance & treatment • Quality and safety improvement programme	• Population health, inequalities & our role as an anchor institution

	• Redevelopment • Improving equality, diversity and inclusion • Staff health and well-being • Management skills & behaviours (including values & behaviours) • Implementation of IMIS	
Task and Finish Projects	• Clinical prioritisation & harm reviews • Care journey planning – to support redevelopment • Implementing our approach to using user insights • Staff spaces, food & shops	• Data quality • Replacement of DATIX incident reporting system • Interpreting services • End of life care • Operationalise remote working policy

11.3. Once the overall direction and prioritisation has been agreed, each programme and task and finish project will need a full review and sign-off of its scope. This will include defining:
- Ownership (including the executive lead, SRO and clinical lead)
- The problem statement
- Goals and scope of the programme or project
- Metrics and deliverables
- Resourcing requirements
- Governance and reporting
- Detailed timelines for commencing and finishing the work

12. Focused improvements

12.1. Following this work to determine our priority programmes and task and finish projects, we will complete the planning work around our chosen focused improvements for 2021/22 over the forthcoming weeks. This review of our focus improvements will also give us the opportunity to understand, and align with, the upcoming refreshed CQC approach to inspections which we understand will be taking a much stronger interest in continuous improvement.

13. Next steps

13.1. Following approval from the Board on the areas of prioritisation described in this paper, the next steps will be to:

- Finalise the new priority programmes and task and finish projects and ensure each is fully scoped with Executive-level leads, metrics, deliverables, governance arrangements and timelines.
- Use the existing Executive meeting structure to oversee the priority work and report on progress.
- Undertake a similar piece of planning work for our focused improvements - linked to the new CQC approach which is due to be published within the next few weeks.
- Develop a programme of communication and engagement with all staff, as well as patients and members of our local community, to ensure wide understanding of and involvement in this work.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Our Green Plan – time to act

Agenda item 10 and paper number 07

Authors: Darshan Patel and Gareth Thompson

Lead Executive Directors:
Bob Klaber; director of strategy, research & innovation; Michelle Dixon; director of communications / Hugh Gostling; director of estates / Matt Tulley; director of redevelopment and member of the national NHS Net Zero Expert Panel. With input into the task and finish group from Kay Boycott; non-executive director and member of the national NHS Net Zero Expert Panel

Purpose: For discussion and approval

Meeting date: 31 March 2021

1. Introduction and background

1.1. The NHS is one of the largest contributors to global heating and air pollution in the UK. The climate crisis and air pollution have serious consequences for individual and population health, disproportionately affecting disadvantaged and vulnerable populations, and worsening population health inequalities. Government, NHS England and NHS Improvement are now increasingly focusing on the issue, and the Climate Change Act legally compels us to take action.

2. Purpose

2.1. In March 2020, we discussed our Sustainability Development Management Plan (SDMP) at the Board and committed to return with an action plan, our Green Plan. Our Green Plan recognises the impact that the COVID-19 pandemic has had on staff, our patients, and our operational priorities, and offers a pragmatic balance of short-term actions and the building of foundations that will allow longer-term planning when we have fully emerged from the impact of the pandemic.

2.2. The papers sets out the principles underpinning our Green Plan approach – to launch in spring 2021, commencing work on our priority action areas and foundational cornerstones, and synchronising subsequent two-year action plans from our 2022/23 business planning cycle

3. Executive Summary

3.1. In October 2020 *Delivering a Net-Zero NHS* committed the NHS to become the world's first carbon net-zero national health system by 2045. Despite reducing aspects of our greenhouse gas emissions (GHGE) by 24% since 2007/08 most of this has come from grid decarbonisation. We have not to date put significant focus on sustainability issues and if we continue at the current pace of change, we will fall well short of NHS interim targets for an 80% reduction in our GHGE that will begin to bite from 2028. It is now time for us to act.

3.2. Our Green Plan will give us the base from which to make rapid progress towards legally binding GHGE targets. Our Green Plan actions from 2021/22 will make a visible start on tackling some of the key areas we need to improve and will also help us to establish seven key foundational cornerstones that will give us a future-proof infrastructure to accelerate progress across every part of our organisation – see Appendix 1 and 2. In our first year we will prioritise actions that will reduce our GHGE related to energy consumption, anaesthetic gases, inhalers and procurement.

3.3. 73% of our staff (n=5,317) responding to the NHS Staff Survey 2020 felt that we should prioritise working in ways that supports the environment, even if it costs more in the short term. We will leverage this passion and focus on inspiring, enabling, empowering and supporting all staff to act. And our role as an anchor institution means we must aspire to operate to the highest ethical and environmental standards possible. Delaying action will prove more expensive in the long term.

3.4. Our Green Plan is our commitment to reduce our impact on the environment and to deliver sustainable healthcare, helping to secure better health, for life for generations to come. We will work with patients, staff, local communities and partners to put our organisation on a path to a cleaner, greener, healthier and more equitable future.

4. Next steps

4.1. Our Green Plan capitalises on this pivotal moment for the NHS, the country and our redevelopment ambitions to galvanise cross-organisational action. To realise our ambitions, we are establishing a 2.5 FTE Sustainability Team to lead and implement our Green Plan. This small team will horizon scan external funding to support our ambitions, will utilise existing expertise from our estates and facilities, redevelopment, communications, improvement, and finance departments, and will establish a green network and Big Room that taps into the passion of many of our staff, patients and local communities to accelerate our journey towards meaningful impact.

5. Recommendation(s)

5.1. The Board is asked to approve the principles underpinning our Green Plan approach – to launch in spring 2021, commencing work on our priority action areas and foundational cornerstones, and synchronising subsequent two-year action plans from our 2022/23 business planning cycle.

6. Our Green Plan – time to act

6.1. In June 2020 we commenced a consultation exercise – see Appendix 3 – to prioritise the actions needed implement an ambitious Green Plan to get us to being a net zero organisation by 2045.

WHY now?

6.2. Delivering high-quality health and care places numerous demands on natural resources and the environment. **NHS organisations have a significant impact on the environment** and are some of the largest contributors to global heating and air pollution. The NHS is responsible for 40% of public sector GHGE and for 3.5% of all road travel in England[1].

6.3. **The climate crisis and air pollution have serious direct and indirect consequences for health**. In the UK, climate change is expected to cause more severe and frequent adverse weather events, with heat-related deaths projected to more than triple to 7,000 a year by the 2050s[2]. Toxic air pollution, caused by the combustion of fossil fuels, is associated with 40,000 premature deaths annually in the UK, and this could be twice as high[3]. In London the economic and social cost caused by air pollution[4] is estimated to be £10 billion. And, in December 2020, we saw the human face of this when, in a landmark ruling, air pollution was recorded as a cause of death of 9-yr old Ella Adoo-Kissi-Debrah who lived near the South Circular Road in Lewisham.

6.4. **Global heating and air pollution also disproportionately affect disadvantaged and vulnerable populations and worsens health inequalities**. In North West London, around 40% of the reduced life expectancy for the most deprived people in our communities can be attributed to circulatory and respiratory reasons[5] – see Appendix 4. Our role as an anchor institution means we must aspire to operate to the highest ethical and environmental standards possible, alongside

[1] https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf
[2] https://publications.parliament.uk/pa/cm201719/cmselect/cmenvaud/826/826.pdf
[3] https://www.seas.harvard.edu/news/2021/02/deaths-fossil-fuel-emissions-higher-previously-thought
[4] https://epha.org/wp-content/uploads/2020/10/final-health-costs-of-air-pollution-in-european-cities-and-the-linkage-with-transport.pdf
[5] https://analytics.phe.gov.uk/apps/segment-tool/

proactive prevention of illness to promote population and staff health and wellbeing, whilst being economically and financially sustainable. **Our partnerships with local authorities in North West London are key to this – all 8 of them have now declared a climate emergency[6].**

6.5. **73% of our staff (n=5,317) responding to the NHS Staff Survey 2020 feel that we should prioritise working in ways that supports the environment**, even if it costs more in the short term: this issue matters to our staff. We are compelled morally and legally[7] to act.

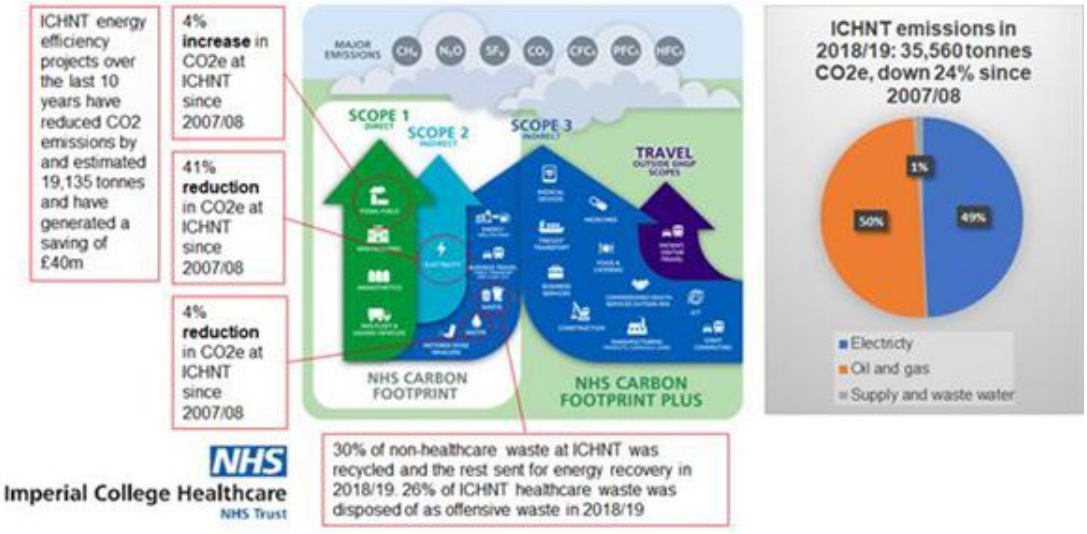
6.6. Greta Thunberg, in her 2019 address to the European Parliament, articulated where we are as an organisation *"…it is still not too late to act. It will take a far-reaching vision. It will take courage. It will take fierce determination to act now, to lay foundations when we may not know all the details about how to shape the ceiling. In other words, it will take cathedral thinking."*

WHAT we need to do

6.7. In October 2020 *Delivering a Net-Zero NHS* **committed the NHS to become the world's first carbon "net-zero" health system by 2045**, with challenging interim 80% GHGE reduction targets that bite from 2028. It also directs the NHS to contribute towards improving air quality, and to reduce waste and single-use plastics. The GHGE targets are absolute in nature and there is no leeway for increases in GHGE arising from increased demand for care, presenting a compounded long-term challenge exacerbated through inaction or delay – see Appendix 5.

6.8. Our GHGE can be split into **our NHS carbon footprint** and **our NHS carbon footprint plus**. Our NHS carbon footprint includes scopes 1, 2 and 3 and are GHGE that we can directly act upon; our larger NHS carbon footprint plus adds other scope 3 and travel GHGE that we can act in ways to influence others to decarbonise their processes, organisations and outputs – see figure 1.

Figure 1: GHG scopes in the context of the NHS and a snapshot of progress to date at ICHNT



6.9. Since 2007/08 we have reduced components of our net[8] NHS carbon footprint by 24% – most of this came from the reduction in the carbon intensity of grid electricity. And, in early 2021 we secured a £26.9 million award to fund energy related improvements that will reduce our carbon footprint by 8,800 tonnes a year. Despite this **we are still likely to fall well short of the 2028 interim 80% GHGE reduction target for our carbon footprint** – see Appendix 6. Importantly, this progress does not include the GHGE associated with our much larger carbon footprint plus

[6] https://www.climateemergency.uk/blog/list-of-councils/
[7] https://www.legislation.gov.uk/ukpga/2008/27/contents
[8] Our CO2e information is based on net consumption figures, excluding tenants.

which on average makes up around 76% of all NHS GHGE[9]. It is critical that we develop a better understanding of our larger carbon footprint plus GHGE to inform how we will formulate the actions and partnerships that will bring us to net zero by 2045 – see Appendix 2.

6.10. The DHSC 40-hospitals programme have been clear that we, as an organisation, need to commit to net zero standards as we rebuild our hospitals, and our redevelopment will be key to us achieving our net zero ambitions. Our clinical and non-clinical workstreams, for example virtual care, care closer to home and remote working, will **contribute to systemic change and behaviour change that will ultimately lead to reductions in our GHGE** over the next 25 years – see Appendix 7. And we are actively contributing to influencing emerging initiatives such as our food and retail transformation programme to ensure that sustainability is considered early to avoid solutions that may significantly increase our carbon footprint plus.

Our Vision

6.11. Our Green Plan is our commitment to reduce our impact on the environment and to deliver sustainable healthcare, helping to secure ***better health, for life*** **for generations to come**. We will work with patients, staff, local communities and partners to put our organisation on a path to a cleaner, greener, healthier and more equitable future. As it takes root and matures, our Green Plan's symbiotic relationship with our values and vision of *better health, for life* and our strategic goals will deepen – see Appendix 8.

HOW we plan to achieve our long-term goal and priority action areas from 2021/22

Our priority action areas over the first 18 months[10]	
	To develop and implement a pragmatic **data and measurement plan** that allows us to better understand our carbon footprint plus and the data needed to: monitor progress, make projections; prioritise actions; and assess the impact of actions.
	To support estates and facilities colleagues to deliver an **energy efficiency programme** (estimated to be 10% of NHS GHGE) to install an air source heat pump that will reduce our carbon footprint by 8,800 tonnes a year & to implement local behaviour change improvement projects (we estimate the potential to save around £230k pa in energy bills[11])
	To engage clinical teams to lead **focused improvements that reduce the impact of harmful anaesthetic gases and inhalers** (estimated to be 5% of NHS GHGE) and to increase recycling of walking aids and inhalers. In 2018/19 if ratio of volume use of desflurane to sevoflurane was 10% we could save around £50k pa and reduce GHGE as desflurane is 20 times more potent a GHG than sevoflurane.
	To work with procurement colleagues to explore how to **build sustainability into tender documents and business cases** at the Trust and to begin normalise our Green Plan ambitions and our expectations of suppliers via contract management (around 62% of NHS GHGE are related to procurement and supply chain).
	To horizon scan the sustainability and net zero funding landscape, and where appropriate to work in partnership with local councils and Imperial College academics, to **secure grants** that can support research and innovation and facilitate accelerated actions.
	To work with staff to **co-produce and establish a green network** or community at the Trust that will raise awareness, connect like-minded staff, identify ideas for improvements and generate insight and learning.
	To work with staff and Flow Coaches to co-produce and establish a **Big Room** that will lead on the implementation of ideas for local improvement and build awareness of sustainability considerations into other clinical pathway improvements.
	To collaborate with others to deliver education on climate change and to support local improvements with **improvement method and coaching** to generate insight and learning and allow us to showcase success and celebrate staff and teams.

[9] https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf
[10] We will onboard priorities expected from the centre in summer 2021 e.g. estates and facilities, medicines, supply chain and travel
[11] https://www.sduhealth.org.uk/news/214/barts-health-nhs-trust-saves-100000-with-a-bit-of-tlc/

6.12. We will also work to establish **seven key foundational cornerstones** in 2021/22 to ensure we have a future-proof infrastructure that is mindful and adaptive to our operating environment. These are leadership and capacity; data, measurement, and impact; communication; engagement and learning; visible action and improvement; partnerships; and governance – see Appendix 1.

WHAT it will look and feel like for staff

6.13. **Staff will be empowered and inspired to act:** Staff will see committed leadership, collaboration, and co-production. They will experience collective progress and will feel that they have the permission and support to take local ownership for action on a shared journey. **Actions:** We will increase awareness of our Green Plan from the ward to the Board and beyond; we will co-produce a green network; we will engage staff to take ownership for NHS priority improvement areas; we will facilitate learning spaces for staff to share insights; and we will showcase successes

6.14. **Staff will be equipped to act:** Staff will see a clear point of contact and opportunities for education to upskill in sustainability and will feel confident to act knowing that it is everybody's business to act. **Actions:** We will co-produce a Big Room and create education modules for all staff; we will support staff with opportunities that facilitate meaningful connections; and we will have a dedicated, content rich microsite on our Intranet to support action.

6.15. **Staff will be celebrated for their contributions:** Staff will see their own and their colleague's successes recognised and will feel part of a team with a shared purpose. **Actions:** We will collate case studies and promote and share these widely; we will celebrate together with an annual event; we will encourage staff to submit stories of improvement for external awards; we will signpost staff to external funding opportunities; and we will look to partner with Imperial Healthcare Charity to make funding available for staff to support innovation towards our Green Plan ambitions.

WHAT it will look and feel like for the Executive and Board

6.16. **The Executive Management Board (EMB) and Trust Board will be assured of progress:** This will include seeing regular and improving metrics and stories of progress and more decisions being made with sustainability as a criterion. **Actions:** We will produce updated two-year action plans, the first synchronised with our 2022/23 business planning cycle; we will implement a robust measurement approach and will implement a well understood GHGE measure into the executive scorecard; we will implement a coordinated approach for collating data; and we will implement a governance and reporting framework that ensures progress against the areas of priority action will be tracked and reported into our Executive Measurement Board and then up to Trust Board.

6.17. **The work will be recognised as a key vehicle for leveraging partnerships, collaboration and system leadership:** The EMB and Board will see new partnerships forming that overcome difficult shared challenges and build confidence in delivering on our public commitments to reducing our GHGE. **Actions:** We will contribute insights and awareness of NHS strategic targets into internal work streams; we will build relationships with our patients and communities and involve them; we will connect with local, regional and national NHS partners including the 40 hospitals programme; we will collaborate with Imperial College (e.g. on air quality measurement); and we will participate in national and pan-London networks to inform national policy.

Resourcing our Green Plan

6.18. COVID-19 has exposed deep inequalities and stark differences in life expectancy[12]. Despite pressures on our resources, we cannot ignore the environmental damage we are causing because we do not see or feel its effect as much as other more immediate demands on our resources. **There is good evidence that delaying action will be more expensive in the long term** through needing to implement more rapid and stringent actions[13]. Our room for manoeuvre will further constrict if NHS financial settlements incorporate net zero targets or tighter regulations.

[12] https://www.kingsfund.org.uk/press/press-releases/covid-19-stark-differences-life-expectancy
[13] https://scholar.harvard.edu/files/stock/files/cost_of_delaying_action.pdf

6.19. We recognise the significant tension around resourcing an ambitious sustainability programme in the context of multiple other priorities and financial pressures. Our conclusion is that while a small number of other NHS Trusts have been able to invest significant resource on this agenda, we will need to start our sustainability journey with a modest investment that will be focused on delivering our priority actions from 2021/22 and building our foundational cornerstones. Our proposal is to establish a minimum core Sustainability Team of a part-time Clinical Lead, a senior programme manager and a project manager with data analytic skills (2.5 FTE in total), with a modest non-pay budget for engagement work. The investment in this team is being fully mitigated across the first two years by recurring cash releasing efficiencies in the use of electricity and adaptations to how we use anaesthetic gases – two of our priority areas of work in our action plan.

Impact

6.20. **Quality.** Our Green Plan will positively impact many aspects of quality, e.g. improving staff health and wellbeing, reducing waste, improving efficiency, and ultimately improving population health.

6.21. **Financial**. As laid out in the Stern Review[14] delay in stabilising the climate will be much more costly than acting now. There will be short-term impact around some of the investments that will need to be made to make longer term gains. Through the empowerment of a green network, a focus on reducing waste and energy use at a local level can lead to significant savings.

6.22. **Workforce impact**. National work on the NHS Net Zero report suggests that a very high proportion of NHS staff are motivated and mobilised by this issue, and our staff are frequently driving us as an organisation to do more. Our Green Plan will tap into staff energy, expertise and passion to co-produce a movement that will drive the organisation towards the changes we need to make and can potentially reduce staff turnover. We will embed education, training and support within our work.

6.23. **Equality impact**. Appendix 4 demonstrates the impact this work will have on reducing inequalities across the communities and population we serve.

6.24. **Risk impact**. The short-term risks around not acting are reputational, both with our staff and increasingly with key external organisations. In the medium term there are likely to be financial and regulatory penalties associated with the Net Zero agenda within the NHS, and in the longer-term failure to act risks the health and wellbeing of the populations we are here to serve.

7. Conclusion

7.1. We must act now. Tackling climate change could be the greatest global health opportunity of the 21st century[15]. In making the 2019 documentary Our Planet, Sir David Attenborough starkly points out that **"What we do in the next 20 years will determine the future for all life on Earth"**.

Appendices available in the Diligent Reading Room
Appendix 1: Our action plan and cornerstone development in year one
Appendix 2: Our data, measurement and impact plan
Appendix 3: Our consultation exercise and the key themes and principles that emerged
Appendix 4: Impact of climate change and air pollution on pop health and health inequalities
Appendix 5: Delivering a "Net Zero" NHS
Appendix 6: ICHNT energy consumption and emissions 2007-08 to 2018-19
Appendix 7: Existing initiatives that contribute towards becoming net zero
Appendix 8: The symbiotic relationship between our strategic goals and our Green Plan
Appendix 9: Driver diagram: articulating the key drivers of our Green Plan

[14] https://www.lse.ac.uk/granthaminstitute/publication/the-economics-of-climate-change-the-stern-review/
[15] Watts N, Adger WN, Agnolucci P, et al. Health and climate change. Lancet. 2015; 386: 1861-1914

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Reset and recovery

Agenda item 11 and paper number 08

Authors: Sue Grange, Deputy Director of People and OD and Claire Hook, Director of Operational Performance

Executive Directors: Kevin Croft, Director of People and OD and Claire Hook, Director of Operational Performance

Purpose: Information

Meeting date: 31st March 2021

Executive summary

1. Introduction and background

1.1. In December 2020 it became necessary to implement measures outside of our existing business as usual arrangements to respond to both winter pressures and an increasing number of admissions for Covid-19. This involved instigating our pre-agreed surge plan and pausing all but time-critical care until the end of February 2021.

2. Purpose

2.1. The purpose of this paper is to describe the 'reset and recovery' process we have taken for restarting services that were reduced or paused as part of our response to the pandemic, taking into account pressures affecting the health and wellbeing of our staff and health inequalities, both exacerbated by the pandemic.

3. Executive summary

3.1. Although essential, the pause of all but the most urgent activity has generated a significant backlog for elective care. Over the last month, and as the number of patients admitted with Covid-19 has subsided, we have turned our attention to how we safely and rapidly reinstate those services that were paused, starting with those of the highest clinical priority.

3.2. This paper sets out the process for restarting these services in a way that focuses on the wellbeing of our staff and needs of our patients and dovetails with a careful, staged de-deployment of those supporting our critical care units. It is a plan for managing the first six weeks of the recovery phase, which can be reviewed and refined as required. The imperative for this initial period is to ensure that all patients prioritised for treatment within four weeks receive a date to come in within that timescale.

3.3. The process has been operating since 1st March 2021 and is overseen by a sub-group of the Executive Management Board.

4. Recommendation(s)

The Trust Board is invited to note the report.

Imperial College Healthcare NHS Trust

Main paper

5. Background

6.3. In December 2020 it became necessary to implement measures outside of our existing business as usual arrangements to respond to both winter pressures and an increasing number of admissions for Covid-19. A key element of this was to pause all but time-critical care until the end of February 2021 to accommodate additional Covid-19 demand, whilst maintaining enough capacity to treat patients that needed surgery within 14 days within our own sites or in the independent sector, and formed part of a wider response for the North West London integrated care system.

6.4. At the peak of the surge we were caring for 492 patients who had tested positive for Covid-19 on admission to hospital, had expanded our critical care capacity to accommodate up to 150 patients and continued to maintain about 30% of our usual surgical workload. Up to 1,000 staff were redeployed in some form, with more than 500 staff redeployed into critical care, our vaccine clinics, a virtual ward/ home oximetry service and other essential elements of our response.

6.5. Although essential, this response has generated a significant backlog for elective care, with more than 2,200 patients waiting in excess of 52 weeks for treatment at the end of February 2021 and more than 12,000 patients on the waiting list for a diagnostic test.

6.6. Over the last month, and as the number of patients admitted with Covid-19 has subsided, we have turned our attention to how we safely and rapidly reinstate those services that were reduced or paused, starting with those of the highest clinical priority.

7. Reset and recovery framework

7.1. The reset and recovery framework has three aims:

- To maximise our collective resource and expertise to ensure patients waiting for specialist care get the advice, guidance and/or treatment they need as quickly as possible and in accordance with clinical priority;
- To ensure we balance the above with a requirement to look after staff wellbeing, including rest, leave and the breadth of support available across the Trust; and
- To ensure that patients are kept at the centre of our plans for elective recovery and that we are communicating how we are managing the next phase of our operational response in a clear and transparent manner.

7.2. The reset and recovery process is set out in Figure 1 and runs to a weekly cycle. A checklist and decision-making matrix have been designed to assist services in navigating it. The process has been live since 1st March 2021.

7.3. The process is overseen by a sub-group of the Executive Management Board, with clinical support from the Clinical Reference Group (CRG), who ensure that it dovetails with a careful, staged de-deployment of staff supporting our critical care units as the number of patients we are caring for with Covid-19 slowly reduces. The sub-group has representation from operations, nursing, the office of the medical director, people and organisational development, finance, communications and a lay partner.

7.4. It is vital that de-deployment and returning to more usual ways of working is managed fairly and smoothly as we come out of surge. To facilitate this we have developed new guidance

for managers. All staff have a "de-deployment interview" with their host manager before returning to their substantive role, covering recognition and feedback, practical issues and wellbeing. They will have a wellbeing conversation with their line manager on return to their home departments, signposting them to further support where needed.

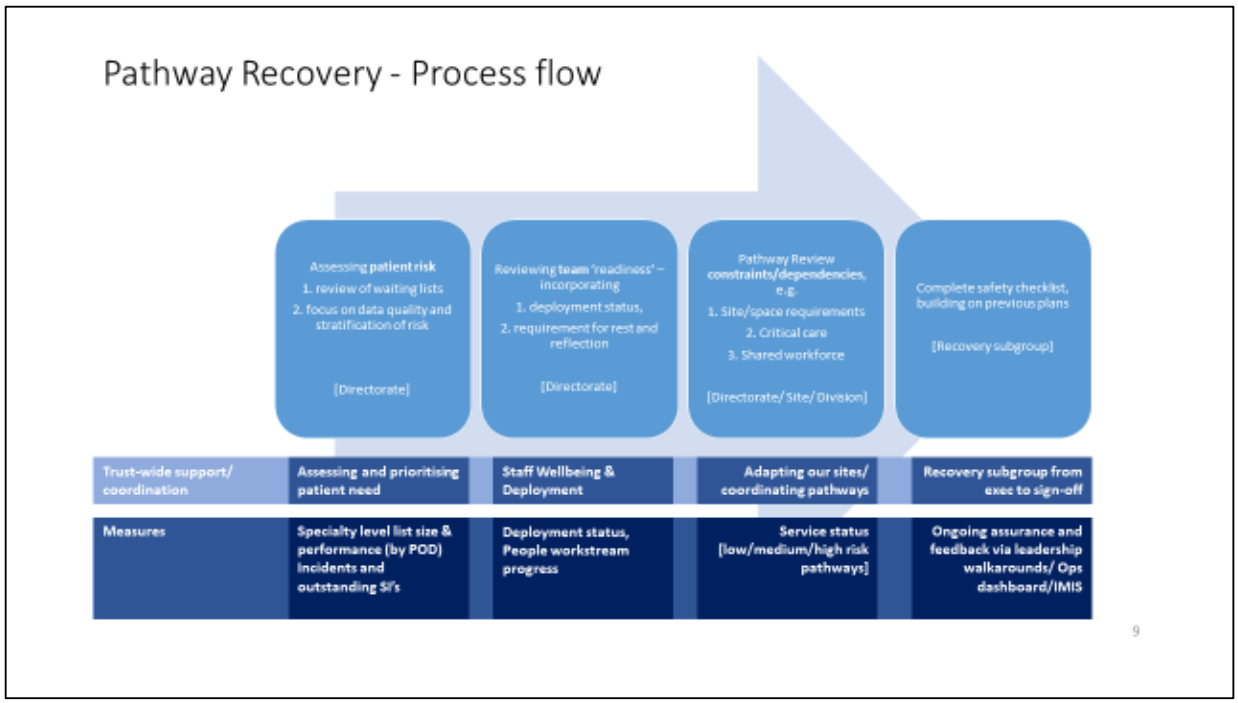


Figure 1 reset and recovery process

8. Wellbeing

8.1. We have developed a wellbeing plan to support our staff during the reset and recovery phase and beyond. It is critical that we recognise everyone who worked through the latest and previous surge, including those who worked in critical care and on our wards, those who remained in their substantive roles or were redeployed. The plan is informed by best practice and centres around the following key principles:

- Individuals have very different needs so there is no "one size fits all"
- Staff need to be secure and have a sense of permission to take leave and access support
- With the right support and care, staff may "grow " as a result those who are exhausted and ill will be more likely to return[1].

Emotional and psychological support

8.2. All staff have access to counselling through our CONTACT service. This is supplemented by a North West London psychological team and a range of free apps and online/hard copy resources and helplines. High priority areas have facilitated emotional wellbeing groups weekly and these will continue through into "ending groups" as the number of patients we are caring for with Covid-19 reduces. In addition, a bespoke offer is being implemented for all staff who worked in critical care, which includes proactive offer of a wellbeing appointment with a staff counsellor. We have also established a Filipino support network as this group

[1] N. Greenburg 2020 "Going for Growth- An outline NHS staff recovery plan post-COVID19"

have unique needs, with funded time for nurses to run the network. We continue to run weekly webinars for those who are shielding to provide information and emotional support.

Reset and recovery days

8.3. Evidence is clear that the importance of leave and a break as we move into the reset and recovery phase is crucial. Managers have been asked to make sure that their staff can have a break/annual leave before returning to business as usual activity and we have offered all staff an additional two days of leave. One of these is to be taken between April and June to directly support individual wellbeing, rest and recovery, and all staff are invited to take the second on or near their next birthday as a small gesture of our appreciation for all their efforts over the last year.

Interventions for managers, teams and individuals

8.4. To support managers, individuals and teams we have launched a range of interventions to help wellbeing. These include:

- A wellbeing conversation toolkit to help guide managers to have high quality conversations about wellbeing with team members;
- Psychological First Aid Training – a 90 minute training underpinned by the REACT framework to help mangers have "psychological savvy" conversations;
- Leadership Circles – nationally endorsed reflective space to discuss leadership experiences through Covid-19;
- Schwartz Rounds – reflective spaces for clinicians to discuss the emotional aspects of work;
- Mental Health First Aid training for managers; and
- A "supporting my team, supporting each other toolkit" – 50 pages of curated tools and techniques that staff can use with no/low facilitation across leadership, communication, wellbeing and ways of working.

8.5. All of these measures have been developed based on national guidance and evidence and will be kept under continual review. To support this we will launch a new monthly NHS Pulse survey in April 2021 that will provide feedback in real-time to supplement our annual survey and enable us to flex and adapt our wellbeing offer accordingly.

8.6. We are also developing a recognition plan to publically acknowledge the contribution staff have made during the recent surge. This has started with the birthday day off and other events are being developed for roll out in early summer.

9. Progress with service restart to date

9.1. Services need to reopen gradually as redeployed staff are released, de-briefed and given some respite and, as such, critical capacity is a key enabler for elective recovery. Our current modelling suggests that approximately 100 critical care beds will be required during the initial reset and recovery phase to accommodate urgent elective demand and the emergency workload. Whilst this means that it has been possible to de-deploy circa 300 staff, a full step down of our surge capacity is unlikely to occur before Easter. The sub group has therefore needed to prioritise de-deployment to support services where restart is most clinically urgent.

9.2. A key element of the reset and recovery process is reinstating the elective theatre schedule. The sub group has approved a phased plan for the reopening of theatres, with the full timetable anticipated to be operational from the week commencing 12th April 2021. Theatre

booking will be completed on the basis of clinical urgency, with patients requiring surgery within the next 4 weeks scheduled as a priority. Any unused or un-booked capacity will be allocated for patients who have been waiting in excess of 52 weeks.

9.3. The restart of outpatient services is following exactly the same process and the majority of clinics returned to a near-normal schedule from the middle of March. In addition to the checklist and decision making matrix, services have also been provided with guidance about managing the backlog of outpatient appointments. This covers the provision of advice and guidance, maintaining a mix of face to face and virtual appointments and managing patient flow in clinic areas.

9.4. As at 19th March 2021, 88 checklists had been submitted to the sub group for review covering a range of services. Of these, 76 have been approved and will restart as soon as feasible and 12 are approved for go-live pending further de-deployment.

9.5. The restart process will continue to be coordinated as outlined above, with weekly reports on service status provided to the executive alongside a live tracker of elective waiting list numbers.

10. Risk

10.1. Of the 26 risks on the corporate risk register, there are 7 risks that are to be managed as part of the reset and recovery process. These risks are monitored via the monthly Executive Management Board. In addition, there are 17 risks across divisional risk registers that are being managed as part this plan. The themes common to these risks include patient harm due to delays and cancellations, impact on staff wellbeing, delivery of operational performance standards and failure to meet financial targets and objectives.

11. Conclusion

11.1. The Trust Board is invited to note the arrangements for managing the initial period of the 'reset and recovery' phase and the progress made to date. The main imperative is to ensure that all patients prioritised for treatment within four weeks receive a date to come in within that timescale and that services recommence in a way that focuses on the health and wellbeing of both our patients and our staff.

Sue Grange, Deputy Director of People and OD
Claire Hook, Director of Operational Performance
23rd March 2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Integrated performance scorecard (month 11 - February data)

Agenda item 12 and paper number 09

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

Purpose: For information

Meeting date: 31 March 2021

Executive summary

1. Introduction and background

1.1. 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 11 (February 2021).

1.2. Due to the impact of the pandemic and the associated governance 'lite' arrangements, the IMIS Countermeasure reports are not provided. Full reporting will resume from next month. The performance summary below provides a narrative on the points of note.

2. Month 11 performance

Referral to Treatment

2.1. The RTT waiting list closed at 57,991 patient pathways, an increase of 1.1% on the previous month. Performance against the RTT waiting time standard was 70.6% of patients waiting less than 18 weeks for treatment (down from 73.0% the previous month).

2.2. The Trust reported 2,278 patients reported waiting over 52 weeks for their treatment (+611 on the previous month). The number of patients waiting longer than 52 weeks is anticipated to continue to rise until end June 2021, as a result of reduced elective capacity and patients being put on hold as part of the pandemic response. Twelve patients were waiting longer than 90 weeks. 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 as priority 4.

2.3. In our latest monthly submission to the national clinical prioritisation programme, 85.4% of all patients on an RTT elective admission list were reported as having had a clinical prioritisation review. The latest weekly report shows further improvement, with 88.8% of patents with a clinical prioritisation review.

Imperial College Healthcare NHS Trust

Diagnostics

2.4. The Trust reported a small improvement in diagnostics waiting times, with 47.7% of patients waiting more than 6 weeks for their diagnostic test at end of February (from 50% in January). The total waiting list size increase by c2,000 patients which aligns to expected increased demand.

Cancer waiting times

2.5. Due to the lag in the national reporting timelines for cancer waiting times, data for January 2021 are reported in March 2021. The Trust delivered 7 of the 8 national standards in January. The 62-day GP referral to first treatment performance was 77.3% against the 85% standard. 62-day performance is expected to remain below 85% until at least April 2021.

Urgent and Emergency care

2.6. The Trust's Ambulance handover performance (within 30 minutes) improved by 5.8% in February 2021 to 95.3%. Ambulance handover delays over 60 minutes continued to recover with 4 breaches reported in February 2021, down from 11 the previous month.

2.7. The number of patients waiting over 12 hours from decision to admit to admission improved significantly from the previous month (94 to 8), with only 1 breach relating to delays in acute pathways. The number of breaches from mental health pathways decreased from 12 to 6 from the previous month.

Quality – safe and effective

2.8. Our patient safety incident reporting rate per 1,000 bed days is below our top quartile target at 48.57. The decrease is largely due to the impact of the pandemic and resultant changes in activity. The number of incidents reported in ICU increased due to efforts made by the Surgery division to ensure high levels of reporting were maintained, including using 'bed buddies' within ICU to report incidents. The majority of the incidents reported in ICU were low harm, no harm or near miss. Incident reporting is a focused improvement for the Trust and an action plan is in place.

2.9. Our current rolling 12 month percentage for incidents causing moderate and above harm is 1.6%, which is below our upper threshold of 2.13% (national average). There was one Trust-attributable MRSA BSI and one CPE BSI in February 2021. Both cases are currently being investigated.

3. Recommendations

3.1. The Board members are asked to note the contents of this performance summary and the enclosed integrated scorecard for month 11 (February data).

List of appendices

Appendix 1 Integrated performance scorecard – month 11

Imperial College Healthcare NHS Trust

IMIS integrated performance scorecard - Board version

FI = Focussed improvement

M11 - February 2021

Section	FI	Metric	Watch Or Driver	Target / threshold	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Reporting rules	SPC variation
To help create a high quality integrated care system with the population of North West London																			
	FI	Workforce Race Equality Standard (WRES)		tbc	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
To develop a sustainable portfolio of outstanding services																			
Quality safety improvement	FI	Patient safety incident reporting rate per 1,000 bed days	Driver	>=55.09	55.31	54.17	48.73	50.52	52.91	58.60	51.70	54.35	55.43	61.71	62.92	52.90	48.57	CMS	-
		Trust-attributed MRSA BSI	Watch	0	0	0	0	0	0	1	0	0	0	0	1	2	1	Note Performance/SVU if Statutory	-
		Trust-attributed C. difficile	Watch	7	3	6	8	6	3	1	2	11	4	5	0	4	8	Note Performance/SVU if Statutory	-
		E. coli BSI	Watch	5	3	3	2	5	5	6	4	3	8	3	6	7	5	-	-
		CPE BSI	Watch	0	1	0	0	1	0	0	0	0	1	0	0	1	1	Note Performance/SVU if Statutory	-
		% of incidents causing moderate and above harm (rolling 12 months)	Driver	<2.13%	1.43%	1.37%	1.39%	1.53%	1.60%	1.61%	1.62%	1.55%	1.57%	1.60%	1.65%	2.15%	1.60%	Share Sucess	-
		HSMR (rolling 12 months)	Watch	<=100	60	65	66	63	73	87	71	69	58	76	71	65	67	-	-
		Formal complaints	Watch	<=100	80	67	32	53	56	60	51	71	76	68	55	66	74	-	-
Reset and recovery		RTT waiting list size	Watch	-	62,932	59,324	53,774	50,570	50,550	52,270	54,924	55,225	55,790	57,226	57,699	57,334	57,991	-	SC
		RTT 52 week wait breaches	Driver	0	1	10	90	258	533	834	1072	1259	1160	990	1,050	1,667	2,278	CMS	SC
		Diagnostics waiting times	Watch	1.0%	0.51%	8.50%	66.6%	65.7%	67.4%	56.3%	50.7%	40.5%	32.9%	29.6%	26.8%	50.5%	47.7%	SVU	SC
		Cancer 2 week wait	Watch	>=93%	93.5%	89.1%	92.9%	96.4%	93.6%	86.8%	85.1%	83.5%	94.3%	88.8%	95.8%	94.1%	-	-	CC
		Cancer 62 day wait	Driver	>=85%	75.3%	86.1%	85.0%	75.9%	69.9%	72.1%	76.4%	72.3%	71.4%	73.4%	76.8%	77.3%	-	CMS	CC
		Ambulance handovers - % within 30 minutes	Driver	100%	88.3%	84.4%	87.7%	92.6%	92.9%	95.6%	94.3%	95.7%	95.6%	97.1%	88.8%	89.5%	95.3%	CMS	CC
		Ambulance handovers - number of delays over 60 minutes	Watch	0	0	6	0	0	0	0	0	0	0	2	21	11	4	SVU	
		Patients waiting >12 hours from decision to admit to admission	Watch	0	21	135	39	5	7	13	7	11	23	18	61	94	8	SVU	CC
	FI	Long length of stay - 21 days or more	Driver	<=142	229	191	131	143	127	131	129	145	154	165	166	165	210	CMS	SC
		Bed occupancy	Watch	90%	85.3%	68.6%	51.5%	49.6%	58.3%	62.3%	64.5%	71.7%	75.4%	74.1%	74.6%	78.4%	75.4%	-	
Safe and Sustainable Staffing		Vacancy rate	Watch	<10%	9.1%	8.9%	8.4%	7.1%	7.1%	8.2%	8.5%	9.5%	9.7%	9.8%	10.0%	9.8%	9.8%	-	-
		Staff Sickness (rolling 12 month)	Driver	<=3%	3.29%	3.70%	4.17%	4.30%	4.32%	4.33%	4.36%	4.39%	4.39%	4.39%	4.43%	4.50%	4.54%	-	-
		Staff turnover (rolling 12 months)	Watch	<12%	11.7%	12.1%	11.0%	11.8%	11.1%	11.1%	11.1%	11.0%	10.9%	10.8%	10.7%	10.1%	9.9%	-	-

Imperial College Healthcare NHS Trust

IMIS integrated performance scorecard - Board version

FI = Focussed improvement

M11 - February 2021

Section	FI	Metric	Watch Or Driver	Target / threshold	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Reporting rules	SPC variation
Finance		YTD position (variance to plan) £m	Watch		0.97	-1.47	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	10.27	-	-
		Forecast variance to plan	Watch		-3.43	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		CIP variance to plan	Watch		75.7%	75.7%	-	-	-	-	-	-	-	-	-	-	-	-	-
To build learning, improvement and innovation into everything we do																			
		Core skills training	Watch	>=90%	93.2%	94.0%	94.0%	94.5%	94.6%	89.8%	91.8%	92.4%	92.0%	91.6%	91.8%	91.6%	91.5%	-	-

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Finance report for January 2021 (Month 10)

Agenda item 13 and paper number 10

Executive Director and author: Jazz Thind, Chief Financial Officer

Purpose: For Information

Meeting date: 31 March 2021

Executive summary

1. Introduction and background

1.1. The finance report for January outlines the financial position of the Trust year to date and the forecast for the remainder of the financial year.

2. Executive Summary

2.1. For October to March the Trust has agreed a £15.8m (deficit) plan with the Sustainability and Transformation Partnership (STP). This is based on the divisional month 5 position plus agreed additional costs including the expansion of the Intensive Care Units (ICU) bed base, endoscopy & imaging. The plan did not include the effect of the second surge.

2.2. The Trust's forecast at month 10 shows a deficit of £15.8m, on plan. There have been additional costs of a second surge but this has been offset by lower costs where non Covid activity has reduced. All additional costs relating to Covid are taken to the daily executive huddle for review and approval.

2.3. There is additional funding from NHS England/Improvement (NHSE/I) for specific Covid costs, which includes pathology testing, SIREN Research and Development studies and vaccination hub costs (both mass vaccination and hospital hubs).

2.4. Annual Leave Accrual – additional activities and requirements resulting from Covid have resulted in many staff having to defer their annual leave in 20/21. At present the Trust has calculated that the impact of this equates to £14m of additional costs / an average of 7 days of additional leave. In recognition of the fact additional backfill will now be required for some staff to take this built-up leave, NHSE/I has agreed a payment of additional income and cash (5 days of this value) will be made on the 15th March (£11.2m i.e. 80%). This is an interim payment and the final value and treatment will be confirmed closer to year end. If it subsequently transpires that an organisation has been over paid this value will be repayable.

2.5. Lost non-NHS income – where Trusts have lost non NHS income, cash payments have been made to support this. The Trust is currently over performing on non NHS income

against the NHS I/E plan, mainly due to higher than expected private activity, additional research and education funding, offset by additional costs to deliver the activity. The trust received £15.8m funding for lost income in mid-February with further validation to be made from the month 11 financial return and a final settlement notified to the Trust in March.

2.6. Progress has been made on the delivery of the capital programme with the year-to-date total spend equating to £51.8m (82%) against a plan of £63.3m. The Trust continues to track delivery and all things being equal, expects to meet its current capital resource limit (CRL). However this may be subject to change.

2.7. The Trust continues to have high cash balances linked to payments made in advance which are expected to unwind in March. Cash balance at 31st January was £175.6m.

2.8. The national team has provided a high level overview of the 21/22 planning arrangements, and the NWL Sector has started to agree assumptions and produce bridges whilst we await detailed planning instructions from NHSE/I.

3. Recommendation

3.1. The Board is asked to note this report.

Board 31st March 2021

Finance Report January 2021

Scorecard

Imperial College Healthcare NHS Trust

	Year to Date		
	Plan £m	Actual £m	Variance £m
Year to date Position before Covid-19 expenditure and True Up	(69.2)	(65.5)	3.7
Covid-19 expenditure	(38.9)	(42.6)	(3.7)
Top up Month 1-6	21.7	21.7	0.0
Retrospective top up Month 1-6	39.6	39.6	0.0
STP top up Mon th 7 - 12	39.1	39.1	0.0
Reported Position	**(7.8)**	**(7.8)**	**(0.0)**

Risks

- **Covid Costs** – under the "phase 3" planning process, the Trust does not receive specific funding for these costs. The centre has indicated that it expects increases in Covid costs to be offset by reductions in non Covid activity costs, which has been the case for the Trust in month. The Trust continues to report Covid related spend data in the monthly financial submissions.
- **Activity** – although the Trust is being paid on a block, from September, an elective incentive scheme (EIS) is in place under which a adjustment may be made based on sector performance against the phase 3 trajectories. The EIS is currently suspended for the trust due to the high level of Covid patients. The Trust has not included any adjustment for this and based on sector discussions does not expect any loss of income at present.
- **Month 1-6 Retrospective top up** – the funding of (£0.6m) withheld from the Trust relating to the previously forecast PDC overspend has now been offset by a reduction in PDC costs.

Commentary

- **Year to date** - the Trust has met its plan (£7.8m deficit). This includes the additional costs to support the Covid response (£3.7m above plan) being offset by additional income and a reduction in clinical supplies, drugs and clinical staffing costs in non Covid services.
- Although the Trust is paid on a block contract for patient care income from NHSE and CCGs, drugs and devices continue to be settled on a pass through basis.
- **Forecast** – the forecast has been updated based on the current position. Clinical divisions have forecast a reduction in cost in line with reduced non Covid activity. Services have made a determination of expected activity recovery in February and March and, where appropriate, have increased costs accordingly. This brings the overall Trust position to plan for the year excluding any additional outstanding annual leave accrual (below the line adjustment).
- **Annual Leave Accrual** – the Trust is required to account for any annual leave entitlement not taken at the end of the financial year. An estimate of annual leave outstanding in Health Roster shows this to be an average of 7 days, which equates to £14m and is included in the forecast. Since writing this report additional funding of £11.2m (5 days) has been made available to support the in-year additional carry forward of leave.
- **Activity** – the Trust has seen a decrease in activity in January. Compared to January last year the Trust has seen a 51% drop in elective/daycase activity, 27% in outpatients attendances and 21% reduction A&E attendances and non electives.
- **Capital** – year to date the Trust has incurred 82% of plan and continues to forecast meeting its CRL. This forecast continues to be reviewed in conjunction with sector performance. The Trust has received confirmation of funding for the additional Covid capital costs of £5.6m.
- **Cash** at 31st January was £176m driven by the upfront payment from commissioners. This is now expected to unwind in March 21.

Strategy and Forecast

- Planning for 21/22 has been suspended until the start of the 21/22 financial year. Further information on the finance planning regime is expected by the end of March 21.

Statement of Comprehensive Income

Imperial College Healthcare NHS Trust

	Year to date			Full Year		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	985.4	959.7	(25.7)	1,181.3	1,150.9	(30.4)
Pay	(609.2)	(621.5)	(12.3)	(731.9)	(764.3)	(32.3)
Non Pay	(439.4)	(402.1)	37.3	(530.5)	(467.9)	62.6
EBITDA	**(63.1)**	**(63.9)**	**(0.7)**	**(81.2)**	**(81.3)**	**(0.1)**
Financing cost and donated asset treatment	(45.2)	(44.5)	0.7	(54.7)	(54.6)	0.1
Impairment of assets	0.0	0.0	-	0.0	0.0	-
Surplus/deficit before top up	**(108.3)**	**(108.3)**	**(0.0)**	**(135.9)**	**(135.9)**	**0.0**
Top up Month 1-6	21.8	21.8	0.0	21.8	21.8	0.0
Retrospective top up Month 1-6	39.6	39.6	0.0	39.6	39.6	0.0
STP top up Month 7 - 12	39.1	39.1	0.0	58.7	58.7	0.0
Annual Leave provision					(14.0)	(14.0)
Surplus/deficit	**(7.8)**	**(7.8)**	**(0.0)**	**(15.8)**	**(29.8)**	**(14.0)**

- **Annual Leave –** The Trust has included an incremental provision for annual leave carried forward in 21/22 of £14m
- **Income** – Income in the Trust is adverse to plan year to date due to reductions in private patient and research income in the first half of the year as well as lower than planned pass through high cost drugs and devices (£1.2m year to date and £2.0m in the forecast). NHSE/I has confirmed in February 21 that the original budgeted £15.8m loss of income will be covered by cash, however this is subject to finalisation in March with any overpayment recoverable.
- **Pay** – pay costs are lower than forecast in clinical divisions mainly in nursing. There has been an increase in bank and agency costs relating to covid activity and covering covid related sickness. The forecast for pandemic related pay costs has increased although this is offset by reduction in pay costs within clinical divisions.
- **Non Pay** – overall non pay forecast has reduced in clinical supplies and drugs costs in clinical divisions due to reductions in activity.

Divisional Overview

Imperial College Healthcare NHS Trust

		Year to Date			Full Year			Change in FOT Var
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	£m
Medicine and Integrated Care	Income	273.00	273.36	0.36	327.60	328.13	0.52	(0.05)
	Expenditure	(201.08)	(197.69)	3.40	(242.74)	(240.03)	2.71	3.52
	Internal Recharges	(10.30)	(10.30)	0.00	(12.38)	(12.38)	0.00	0.00
	Total	**61.62**	**65.38**	**3.76**	**72.48**	**75.72**	**3.24**	**3.47**
Surgery, Cancer and Cardiovascular	Income	308.86	309.29	0.43	370.63	371.27	0.64	(0.15)
	Expenditure	(247.85)	(251.89)	(4.04)	(301.52)	(305.36)	(3.84)	2.45
	Internal Recharges	15.28	15.28	(0.00)	18.36	18.36	0.00	0.00
	Total	**76.28**	**72.67**	**(3.61)**	**87.47**	**84.27**	**(3.20)**	**2.30**
Women, Children & Clinical Support	Income	140.73	140.04	(0.68)	168.87	168.32	(0.56)	(0.11)
	Expenditure	(141.76)	(140.66)	1.10	(172.84)	(171.72)	1.13	0.90
	Internal Recharges	18.83	18.83	0.00	22.64	22.64	0.00	0.00
	Total	**17.80**	**18.22**	**0.42**	**18.67**	**19.24**	**0.57**	**0.79**
Imperial Private Healthcare	Income	45.21	22.55	(22.65)	54.36	26.29	(28.07)	(0.61)
	Expenditure	(44.03)	(17.50)	26.52	(52.68)	(20.93)	31.75	0.55
	Internal Recharges	(23.88)	(23.88)	0.00	(28.70)	(28.70)	0.00	0.00
	Total	**(22.70)**	**(18.83)**	**3.87**	**(27.02)**	**(23.34)**	**3.69**	**(0.06)**
Total Clinical Division		**133.07**	**137.50**	**4.43**	**151.68**	**155.97**	**4.29**	**6.49**
Non- Clinical Division	Medical Directorate	(8.84)	(8.28)	0.57	(10.64)	(10.08)	0.56	0.04
	Education	30.01	33.07	3.06	36.01	37.89	1.88	0.32
	R&D	(5.48)	(6.97)	(1.49)	(4.13)	(5.97)	(1.83)	(0.78)
	Nursing	(3.70)	(3.68)	0.02	(4.44)	(4.37)	0.07	0.00
	Estates	(70.88)	(71.36)	(0.48)	(84.74)	(85.44)	(0.70)	0.00
	Finance	(11.31)	(11.08)	0.23	(13.58)	(13.58)	0.00	0.02
	People & Org. Devel.	(7.77)	(7.22)	0.56	(9.85)	(9.05)	0.80	0.08
	Information & Technology	(20.80)	(20.79)	0.01	(24.99)	(24.88)	0.11	0.00
	Communication	(1.86)	(1.93)	(0.07)	(2.27)	(2.23)	0.04	0.05
	Office of the CEO	(9.27)	(8.66)	0.61	(11.07)	(10.38)	0.69	0.66
Total Non- Clinical Division		**(109.91)**	**(106.89)**	**3.02**	**(129.69)**	**(128.08)**	**1.61**	**0.40**
NHS Income	Clinical Commissioning	109.25	109.00	(0.25)	128.42	125.20	(3.21)	(1.88)
	Drugs & Devices (Cost)	(86.45)	(86.66)	(0.20)	(105.67)	(105.50)	0.18	(0.71)
Other Income	Central Income	1.11	1.17	0.06	2.61	2.76	0.15	1.46
Central Costs	CNST & Other Central Costs	(36.90)	(43.21)	(6.32)	(44.23)	(45.02)	(0.79)	0.63
	Pathology Residual	(30.04)	(27.41)	2.63	(36.05)	(33.81)	2.24	0.42
	Hosted Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Reserves	(4.30)	(4.30)	(0.00)	(6.06)	(2.35)	3.71	2.71
	Covid 19	(38.94)	(43.05)	(4.11)	(42.20)	(50.45)	(8.25)	(8.08)
Total Central Income and Costs		**(86.29)**	**(94.46)**	**(8.18)**	**(103.19)**	**(109.17)**	**(5.98)**	**(5.44)**
Financing Donated Asset + Impairment Adj		(45.18)	(44.46)	0.72	(54.69)	(54.61)	0.08	0.10
Surplus/deficit before top up		**(108.31)**	**(108.32)**	**(0.00)**	**(135.90)**	**(135.90)**	**0.00**	**1.56**
Top up Month 1-6		21.84	21.84	0.00	21.84	21.84	0.00	0.00
Retrospective top up Month 1-6		39.59	39.59	0.00	39.59	39.59	0.00	0.00
STP top up		39.12	39.12	0.00	58.70	58.70	0.00	0.00
Annual leave provision		0.00	0.00	0.00	0.00	(14.00)	(14.00)	0.00
SURPLUS / (DEFICIT)		**(7.76)**	**(7.76)**	**(0.00)**	**(15.77)**	**(29.77)**	**(14.00)**	**1.56**

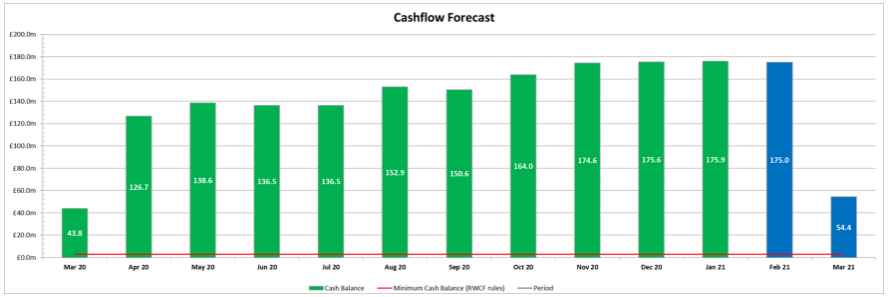
- **MIC** - there has been a favourable movement in the forecast. This is due to reductions in costs in clinical supplies and services and nursing across the division. There has been a reduction in specials due to additional mental health support. The forecast for endoscopy insourcing costs have not been incurred. The division is forecasting an increase in costs in the February and March related to expected recovery in activity.
- **SCC** – there has been a £2.3m favourable movement in the forecast. There has been a decrease in activity based costs in month. The division has assumed a similar level of costs in February to January. Services have estimated activity increases in March and forecast cost increases.
- **WCCS** – has reduced spend due to reduced activity. There has been a reduction in the forecast costs of Imaging recovery in the divisional position. The Division has forecast an increase in activity from February.
- **IPH –** there has been a reduction in private income forecast in line with the current operational position. The division has assumed a higher level of activity than that seen in April or May 2020 based on current activity levels
- **Education** – Forecast is favourable to plan, HEE funding for Q4 has been received and is represented in the position
- **CEO office** some costs relating to redevelopment have been moved to capital, this has improved the position and the forecast
- **Covid** - costs are showing £3.7m adverse to plan year to date, £8m adverse in forecast, further detail in Appendix 6
- **Central income** – the reduction in forecast income reflects the challenges raised on pass through drugs, this has been escalated with NHS London.
- **Pathology** forecast is based on the North West London Pathology forecast. This does not include the costs of additional testing, costs and related income are held centrally in Covid costs.
- **Annual Leave** – the Trust has included £14m additional costs for annual leave accrual expected at M12.

Statement of Financial Position (Balance Sheet)

Imperial College Healthcare NHS Trust

	31-Mar-20	31-Jan-21	Movement YTD
Property plant and equipment	538.2	548.7	10.5
Intangible assets	4.3	9.1	4.8
Total Non-current assets	**542.5**	**557.8**	**15.3**
Inventories	15.3	15.3	(0.0)
Trade and other receivables	125.5	99.8	(25.7)
Cash and cash equivalents	43.9	175.8	131.9
Total current assets	**184.7**	**290.9**	**106.2**
Trade and other payables (<1 year)	(229.6)	(328.9)	(99.3)
Total current liabilities	**(229.6)**	**(328.9)**	**(99.3)**
Non Current Liabilities	(18.1)	(17.7)	0.4
Total non current liabilities	**(18.1)**	**(17.7)**	**0.4**
Net Assets employed	**479.5**	**502.2**	**22.7**

Public Divided Capital	720.8	752.3	31.5
Revaluation Reserve	2.5	2.5	(0.0)
Income and expenditure reserve	(243.8)	(252.6)	(8.8)
Total tax payers' and other equity	**479.5**	**502.2**	**22.7**



Non-Current Assets

Non-current assets have increased in line with movements on capital expenditure and depreciation – depreciation is now forecast to be more than plan, driven by the timing of asset completion and unplanned Covid-19 related spend. There are specific funding and scheduling challenges in the fixed asset programme which need to be monitored closely to ensure capital resources are fully and appropriately deployed within the financial year.

Current Assets

Trade and other receivable balances have reduced by £25.7m 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. A process of consolidated billing between providers has been established this year.

There is limited movement on inventory owing largely to national and sector arrangements for securing clinical supplies to support the pandemic response.

Cash

Cash balances are unusually high (at £175.8m) due to the temporary funding arrangements in place as part of the response to Covid-19. The favourable cash position is expected to unwind during the year and the position should be seen in this context – the Trust is forecasting on the basis that the forward funding of SLA payments is withdrawn in March 2021. The Trust expects to be able to manage this whilst retaining an adequate cash position. The year end cash balance is forecast at £54.4m which is an improvement of £17m from Month 8 and accounts prudently for expected outflows particularly around payments to suppliers – though this does not negate the longer-term cash risks inherent in an underlying deficit position.

Current Liabilities

Trade payables make up £153m of the current liabilities balance having decreased by £9.9m year to date as outstanding balances with suppliers are settled. Excluding trade payables, other current liabilities (which includes borrowings and provisions) have increased due to the deferral of SLA & contract income for which cash is received in advance (approximately £82m).

Taxpayers' and Other Equity

Public Dividend Capital balances have increased by £30m, driven by the debt-PDC conversion of the working capital loan and receipt of PDC for capital investment. Further significant receipts of PDC are anticipated in line with the expected funding for the capital programme.

Capital – Month 10

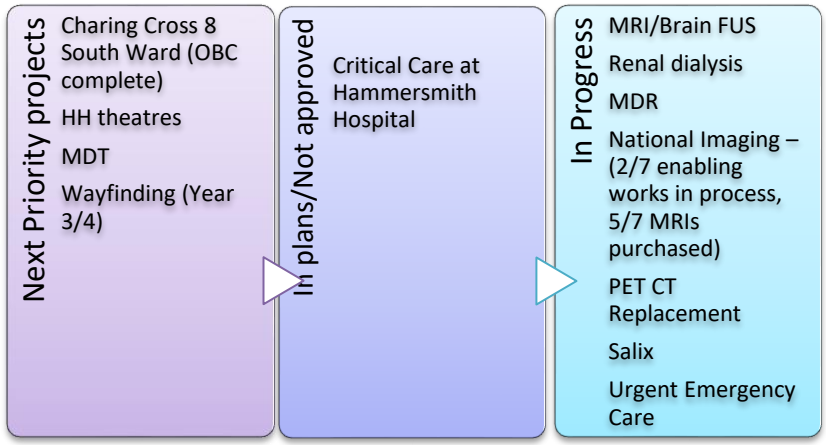
Imperial College Healthcare NHS Trust

Sources of Funds	£m
Depreciation (NWL sector allocation)	40.5
Confirmed external funding inc. PDC	31.7
Charitable Funds	1.5
Unconfirmed external funding inc. PDC	8.4
Total	**82.1**

Applications	Annual Plan £m	Year to Date Plan £m	Year to Date Actual £m	Year to Date Var £m	
Backlog Maintenance	18.0	15.2	16.5	-1.3	🟡
ICT	7.0	5.9	5.0	0.9	🟡
Replacement of Med Equip.	5.1	5.1	3.1	2.0	🔴
Other Capital Projects	41.8	28.1	19.2	8.8	🔴
Redevelopment	5.0	4.1	3.3	0.8	🟡
Covid-19	5.3	4.9	4.6	0.2	🟢
Total	**82.1**	**63.3**	**51.8**	**11.5**	
Actual spend as a % of plan			**82%**		

🟢 up to 10% off plan 🟡 10-20% off plan 🔴 >20% off plan

Capital project pipeline (>£1m / multi year)



Summary

The Trust has continued to make good progress on delivering its current capital programme. At Month 10, capital spend was £7.4m in-month bringing the year-to-date total spent to £51.8m against a plan of £60.1m. Schemes which were delayed earlier in the year due to the pandemic are expected to complete prior to the end of the year.

The capital programme has evolved dramatically over the year with an additional £22.1m added to date. The spend required to meet the plan level in the final quarter is £30.3m, which represents a considerable challenge however this also includes large single scheme items which are clearly signed posted as on track to complete by March including £8m on MRI scanners and associated facilities, and £11m on other ICT and equipment programmes.

The Trust is closely monitoring delivery of all projects and is confident that plans are deliverable. Delivery is being closely monitored through the Capital Expenditure Assurance Group (CEAG).

The Trust only received formal confirmation in February 2021 from NHS Improvement of funding for certain schemes, of which the Covid-19 related costs (incurred or committed) totalling £4.8m are the most significant. As the Trust needed to hold contingency plans to absorb this Covid-related expenditure, there will be a challenge to ensure that these plans can be fully deployed within the time remaining before 31st March 2021.

Beyond this, the capital programme remains subject to delivery risks because of the exceptional circumstances around the pandemic, on top of the level of delivery risk inherent in such activities in any normal year.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Update on Ockenden Report assurance progress

Agenda item 14 and paper number 11

Executive Director: Professor Tg Teoh, Divisional Director
Author: Scott Johnston

Purpose: Information

Meeting date: 31 March 2021

1. Introduction and background

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 have published an emerging themes report with findings and seven Immediate and Essential Actions for Trusts to implement.

This report is based on the emerging themes so far from the investigations. A full report with further findings and recommendation will be published at a later date. Some of the key findings were:

- Poor governance across a range of areas, especially board oversight and learning from incidents
- Lack of compassion and kindness by staff
- Poor assessment of risk and management of complex women
- Failure to escalate
- Poor fetal monitoring practice and management of labour
- Suggestion of reluctance to perform LSCS - women's choices not respected
- Poor bereavement care
- Obstetric anaesthetic provision
- Neonatal care documentation and care in the right place

The investigation so far has looked at maternal and neonatal harm between the years 2000 and 2019. Including cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and new-born babies. The total number of families to be included in the final review and report is 1,862. This first report arising from the 250 cases reviewed to date. The number of cases considered so far include the original cohort of 23 cases.

Imperial College Healthcare NHS Trust

2. Purpose

The purpose of this report is to:

- Provide a summary of the background and key findings of the report
- Update the Board on the Trust response to NHSE to date
- Present the current response request and future evidence requirements for NHSE
- Propose next steps

3. Summary

To date the Trust has provided an immediate response to NHSE on 21st December 2020 and the maternity Directorate and Corporate Colleagues collated the follow up assurance document. This response (Appendix 1) was approved at the Quality Committee on 20th January 2021.

A peer review process led by NHSE is 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 NWL peers. Some elements will be rated as partially compliant across London as they are reliant on NHSE system set up. Formal feedback on the final review is expected by 19th March 2021.

The date and process for submission of the evidence is yet to be confirmed but is anticipated to be in May 2021. The maternity team have commenced collection and collation of evidence in preparation.

The Ockenden Emerging Themes report is available via the link-
https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

3.1 Immediate and essential actions:

The review panel identified important themes which must be shared across all maternity services as a matter of urgency and have formed Local Actions for Learning and make seven early recommendations for the wider NHS, labelled 'Immediate and Essential Actions'. These are:

- Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight

- Listening to Women and Families. Maternity services must ensure that women and their families are listened to with their voices heard

- Staff training and working together. Staff who work together must train together.

- Managing Complex Pregnancy. There must be robust pathways in place for managing women with complex pregnancies through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre

- Risk assessment throughout pregnancy. Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- Monitoring fetal wellbeing. All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

- Informed Consent. All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

3.1.1 Trust response to the Immediate and Essential Actions to date

NHSE/I requested a response in two phases:

1. An initial letter of response from the CEO by 21st of December 2020. This has been completed and was submitted in collaboration with the Local Maternity System, Maternity Services and CEOs across NWL
2. A full assurance document was submitted on the 15th of February 2021 (appendix 1). This was peer reviewed on the 8th of March 2021 with most elements rated as compliant and some as partially compliant, in line with NWL peers. Some elements will be rated as partially compliant across London as they are reliant on NHSE system set up. Formal feedback on the final review is expected by the 19th of March 2021.

4. Conclusion

Maternity services will continue to engage with the required actions and recommendations from this report and will update the Quality committee with regards to actions and implementation dates when the assurance document from the peer review is returned and recommendations are finalised.

5 Recommendation(s)

The Board is asked to note the actions taken to date, progress and the next steps.

6 Next steps

- Formal feedback from the peer review is expected by the 19th of March 2021. Along with the formal feedback from NSHE which will then outline the next steps and follow up process.
- Although the date and process for submission of the evidence is yet to be confirmed, the maternity team have commenced collection and collation of evidence in preparation. The submission date is anticipated to be in May 2021.
- The Maternity Directorate will continue to progress areas of partial compliance in alongside NWL services.
- Future reporting of progress will be included in the Maternity Assurance report in May 2021.
- The full report is expected to be published by December 2021.

Imperial College Healthcare NHS Trust

7 Impact

Quality The implementation of the recommendations is designed to improve the quality of patient care

Financial At present there is no financial impact however this will need to be reconsidered when the peer review of the submitted full assurance document is received as there may be a further requirement.

Workforce impact No impact at present.

Equality impact None.

Risk impact This will be reviewed when the peer review of the assurance submission is received.

Author: Scott Johnston, Head of midwifery, WCCS
Date: 24 March 2021

Appendices:
Appendix 1 – Trust response to NHSE in Dec 2020 (in the Diligent Reading Room)

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: CNST Maternity Incentive Scheme

Agenda item: 15 and paper number 12

Executive Director: TG Teoh – Divisional Director WCCS
Author: Louise Frost, Lead Midwife

Purpose: For noting

Meeting date: 31 March 2021

Executive summary

1. Introduction and background

CNST Maternity Incentive Scheme (MIS) Year 3 was re-launched on 1st October 2020. Under this scheme, Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Trusts that do not meet all ten safety actions will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against any actions they have not achieved. Such a payment would be at a much lower level their original 10 per cent contribution.

On 15th December 2020, NHS Resolution (NHSR) informed the Trust of the extension to the scheme and some of the sub-requirements of the safety actions will be revised.

2. Purpose

To inform the Board on progress made to date and to note the change in date for submission of compliance.

3. Executive Summary

The updated CNST Maternity Incentive Scheme guidance was published in January 2021 with a new deadline for submitting compliance on15th 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 is now quarterly and the latest report along with an action plan was shared with the Trust's safety champion in February 2021.

The CNST update paper (appendix 1) was discussed at the Divisional Quality and Safety meeting and the new guidance is being reviewed and an adapted action plan will ensure the Trust is complaint with the new timeframes.

This report was discussed at the March 2021 Quality Committee.

Further evidence will be submitted to the May 2021 Trust Board. The Board declaration form will be presented for sign-off at the July 2021 Trust Board.

Imperial College Healthcare NHS Trust

4. Conclusion

Overall, good progress has been made to date to ensure compliance with the scheme.

5. Recommendation(s)

The Board is asked to note the update and the CNST Maternity Incentive Scheme safety action compliance detailed in appendix 1.

6. Next steps

- Divisional commitment to continue to work towards improving quality and safety
- Maternity services at ICHT has appointed a lead for CNST to enhance collaboration with NHS Resolution and other national bodies
- Ensure continued good progress to ensure compliance

7. Impact

7.1. **Quality** Maternity incentive scheme supports the delivery of safer maternity care through an incentive element to Trusts contributions to the CNST. The scheme is developed in partnership with the national maternity safety champions and rewards Trusts that meet ten safety actions designed to improve the delivery of best practice in maternity and neonatal services. Now in the third year, the scheme will further incentivise ten maternity safety actions from previous year as per recently published guidance.

7.2. **Financial** This is an incentive scheme based on reduction of our insurance premium of we meet all 10 safety actions.

7.3. **Workforce impact** This will be included in the evidence for submission and declaration of compliance with CNST safety actions.

7.4. **Equality impact** Integral to compliance with CNST standard is to ensure an equitable service is provided to anyone who either access maternity services or is part of the workforce.

7.5. **Risk impact** Compliance with all 10 safety actions will optimise delivery of safe maternity service provision that is sustainable.

Author: Louise Frost

Appendices:

Appendix 1: Divisional Quality and Safety – CNST update report
Appendix 2: MIS letter – submission extension
Appendix 3: January 2021 PMRT update report
Appendix 4: Transitional Care (TC) and Avoiding Term Admissions into Neonatal (ATAIN) – January update report

Imperial College Healthcare NHS Trust

Divisional Quality and Safety Meeting

Date of Meeting: 8th February 2021	**Paper no:**
Reporting period: 2020/21	**Date of report:** 2nd February 2021
Author: Louise Frost - Interim Lead Midwife	

Report title: CNST Maternity Incentive Scheme Year 3 - Compliance Update

Summary:

CNST Maternity Incentive Scheme (MIS) Year 3 re-launched on 1st October 2020.
15 December 2020 - NHS Resolution communication informed the trust that there is an extension to the scheme and some of the sub-requirements of the safety actions will be revised.

NHS Digital Maternity Services Data Set (MSDS) in line with safety action two will continue to be assessed on December 2020 data, submitted by 28 February 2021. (MIS letter – submissions extension in appendix 2).

The trust must submit the completed board declaration form to NHSR by 12 noon on Thursday 15 July 2021.

Further guidance and timetable for results and appeals will be circulated in the forthcoming weeks.

Email communication from NHSR confirmed:

- 12.01.2021 - In order to support and encourage trusts to continue to work towards improving quality and safety during the pandemic, the scheme's submission deadline for board declaration forms has been extended with the submission period changed from May 2021 to 15 July 2021. Multiple safety actions standards have also been revised or removed in order to support Trusts during this time. Frequency of some of the sub-requirements e.g. reports/ audits have also been amended.
- The CAG continue to monitor the impact of the pandemic and the ongoing impact on Trusts and will meet again in February 2021.
- 15.01.2021 - There is ongoing discussion between NHS R and other national bodies re Covid-19 and MIS.
- In view of this, the guidance will not be published this week, but in the forthcoming weeks before end of January.

- 01.02.2021 – Email sent to NHSR requesting an update on expected publish date for guidance. Website has been updated but no further information available of changes.

Safety Action updates:

1. **National Perinatal Mortality Review Tool (PMRT)**
   January 2021 PMRT update report included separately in appendix 3.

2. **Maternity Services Data Set (MSDS)**
   September 2020 data – complaint 11 criteria.

3. **Transitional Care (TC) and Avoiding Term Admissions into Neonatal (ATAIN) units programmes**
   Action plan continues following weekly ATAIN review meetings. January 2021 update included separately in appendix 4.

4. **Medical Workforce planning (Obstetric, anaesthetic, neonatal & neonatal nursing)**
   Anaesthetic medical workforce review of updated standards compliance in progress.
   Neonatal medical workforce compliance to be formally recorded in trust board minutes.
   Neonatal nursing standards compliance and action plan to be formally recorded in trust board minutes.

5. **Midwifery Workforce planning**
   Bi-annual midwifery staffing oversight report due February 2021. To be submitted to March 2021 trust board.

6. **Saving Babies Lives Care Bundle Version 2**
   Audits direct from Cerner are in development with a plan to review data. Action plans to be developed where performance does not meet thresholds.

   Element 1 – reducing smoking in pregnancy
   One You smoking cessation support advisor for Imperial has started in post to support pregnant women.
   Element 2 – risk assessment, prevention and surveillance of pregnancies at risk of Fetal Growth Restriction (FGR)
   Element 3 – Raising awareness of Reduced Fetal Movement (RFM)
   Element 4 – Effective fetal monitoring during labour
   Fetal monitoring midwives – recruitment in progress.
   Midwifery education paused in line with trust guidance from 11.01.2021.
   Element 5 – Reducing preterm birth

7. **Maternity Voices Partnership (MVP)**
   Posters displayed for the National Maternity survey 2021 on behalf of the CQC.

8. **Multi-professional maternity emergency training**
   PROMPT & neonatal resuscitation training paused in line with trust guidance from 11.01.2021.

9. **Safety Champions**
   Continuity of Care (CofC) action plan submitted to January 2021 trust board. Update has been sent to trust safety champion for February 2021.
   Meeting planned 8.02.2021 to review current plans and further developments to ensure target of 35% women from BAME backgrounds and 35% women from areas of high deprivation included within the report. Data collection is in progress to review all women booked and those received care by the continuity of care teams. Discussions planned to address 2021/22 target of 51% of all women booked onto a continuity of care team.

10. **NHS Resolution Early Notification Scheme**
    Reporting of all cases to HSIB for 2020/21 continues. Risk team continue to notify the

legal department of all EN reportable cases.
Confirmation required that the Trust board have sight of legal services and maternity clinical governance records of qualifying EN incidents and numbers reported to NHSR EN scheme.

Addition – For qualifying cases 01.10.20 to 31.03.21 the Trust Board are assured that:

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

15 December 2020

Dear colleague,

Changes to submission deadline for maternity incentive scheme board declarations

Following the relaunch of year three of the maternity incentive scheme on 1 October 2020, NHS Resolution has been continuing to monitor the ongoing situation in relation to Covid-19. We appreciate that the pandemic continues to place a significant strain on all NHS services, including maternity services, and we have been working with trusts and key stakeholders to understand how the situation continues to impact on the ability of trust maternity departments to deliver on the maternity incentive scheme ten safety actions. The scheme's Collaborative Advisory Group (CAG)* met on 25 November 2020 to discuss a range of options, to support Trusts during the continuing pandemic.

The CAG have agreed that the deadlines for the maternity incentive scheme will be extended, and some of the sub-requirements of the safety actions will be revised. This decision has been made to support Trusts and also encourage Trusts to continue to work towards improving quality and safety during this critical time. As such, the submission deadline for board declaration forms has been extended with a submission period **from Thursday 20 May 2021 to noon on Thursday 15 July 2021**. Revised guidance and timetable for results and appeals will be circulated in the forthcoming weeks.

All participating trusts are required to provide clinical and financial contacts to receive and send communications relating to the maternity incentive scheme. If your Trust's contact details have changed for your nominated maternity incentive scheme leads, please let us know in order to ensure continuity of communications. Please upload their new details here and alert us here.

*Royal College of Obstetricians and Gynaecologists, Royal College of Midwives MBRRACE-UK, NHS England & Improvement, the Care Quality Commission, NHS Resolution and the Healthcare Safety Investigation Branch (HSIB)

We would like to draw your attention to the importance of achieving all safety actions as a whole, and in particular reporting data to the NHS Digital Maternity Services Data Set (MSDS), in line with safety action two. The majority of the requirements for safety action two will be assessed on the trusts' MSDS submission for December 2020 made by 28 February 2021.

We would like to take this opportunity to thank you all for your continued commitment and dedication to meeting the objectives of the maternity incentive scheme at this difficult and unprecedented time.

Yours sincerely

Helen Vernon

Chief Executive
NHS Resolution

Prof Jacqueline Dunkley-Bent

Chief Midwifery Officer
National Maternity Safety Champion

Dr Matthew Jolly

National Clinical Director

National Maternity Safety Champion

Imperial College Healthcare NHS Trust

Monthly Report on the Perinatal Mortality review tool January 2021.

Imperial college Healthcare NHS trust, SMH and QCCH, started reporting on the PMRT tool from 23.12.2018 – 30.04.2020

This report includes:

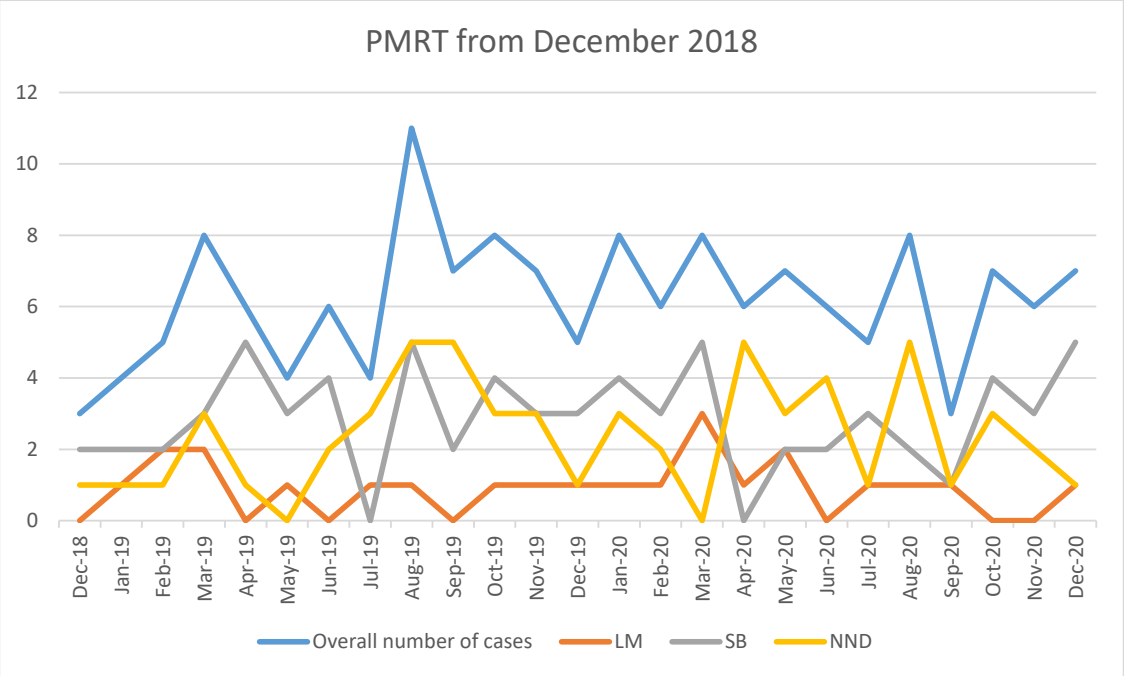
- Late fetal losses where the baby is born between 22^{+0} and 23^{+6} weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g.
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life.
- All neonatal deaths where the baby is born alive from 22^{+0} but dies up to 28 days after birth.
- Post-neonatal deaths where the baby is born alive from 22^{+0} but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

The PMRT is not designed to support the review of the following perinatal deaths:

- Termination of pregnancy at any gestation.
- Babies who die in the community 28 days after birth or later who have not received neonatal care.
- Babies with brain injury who survive.

(https://www.npeu.ox.ac.uk/pmrt/faqs#governance)

The total number 132 babies that fell into these categories across site since reporting began on the 20th December 2018. The graph below shows all late miscarriages, stillbirths and neonatal deaths per month since reporting started.



Nora Farrelly December 2020

Imperial College Healthcare NHS
NHS Trust

Audit period

The PMRT timeframe started on from 20 December 2018 and new standards were introduced on the 1st October 2020. The standards are below.

Required standards (all cases must be suitable for review using the PMRT)

All perinatal deaths eligible to be notified to MBRRACE-UK from Thursday 1 October 2020 onwards must be notified to MBRRACE-UK within seven working days

Surveillance information where required must be completed within four months of the death

A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 to Wednesday 30 September 2020 will have been started by Thursday 31 December 2020. This includes deaths after home births where care was provided by your Trust staff and the baby died.

A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Thursday 1 October 2020 will have been started within four months of each death. This includes deaths after home births where care was provided by your Trust staff and the baby died

At least 75% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Friday 31 July 2020 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool by Thursday 31 December 2020

At least 40% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool

Before they are discharged home all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of neonatal deaths parents should also be told that a review will be undertaken by the local Child Death Overview Panel (CDOP). Verbal information can be supplemented by written information

Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion

Minimum evidential requirement for the Trust Board
The perinatal mortality review tool must be used to review the care and draft reports should be generated via the PMRT.
A report will be submitted to the Trust Board each quarter from 20 December 2019 until 17 September 2020. This includes details of the deaths reviewed and the subsequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met.

Validation process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form.
NHS Resolution will use data from the PMRT, provided by MBRRACE-UK, to cross-reference against Trust self-certification. Cross referencing will be used to check that the PMRT has been used to review eligible perinatal deaths and that standards a), b) and c) have been met using the PMRT between 20 December 2019 until 17 September 2020. A total of 56 cases were reported in the new audit standards since December 20th 2019.

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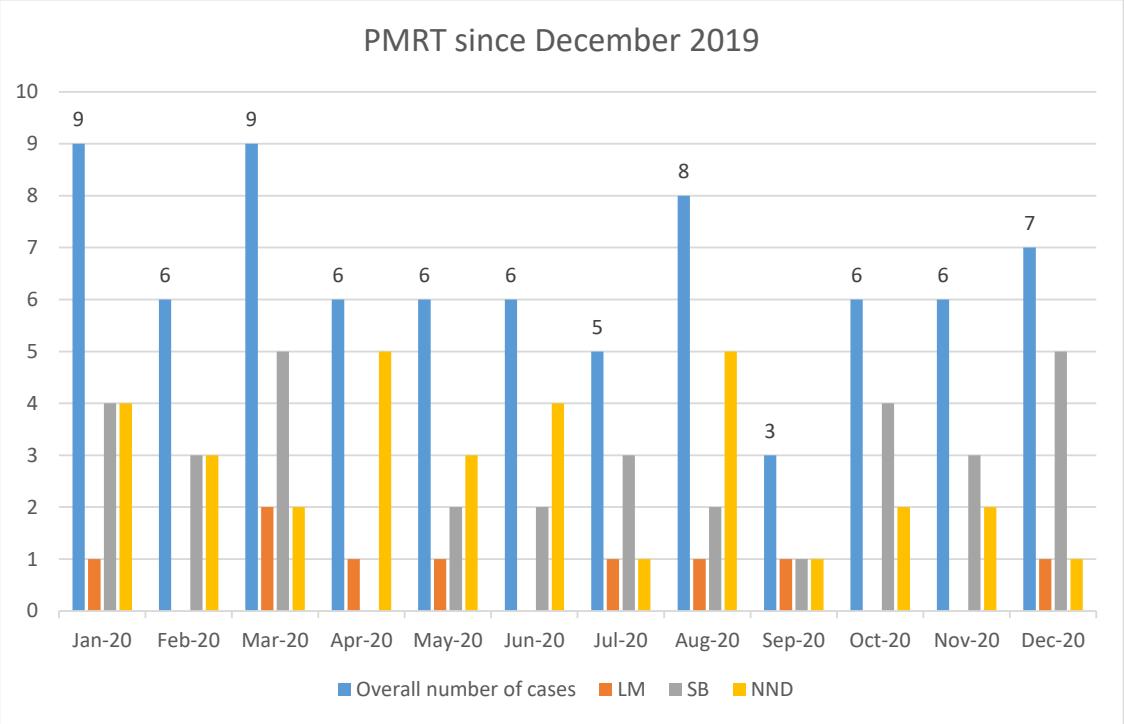

Audit of standards from October 1st 2020.

Standards	Percentage achieved
All perinatal deaths eligible to be notified to MBRRACE-UK from Thursday 1 October 2020 onwards must be notified to MBRRACE-UK within seven working days and the	100% 12 babies meet this criteria and 12 babies have been reported in 7 days
Surveillance information where required must be completed within four months of the death	100%
A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 to Wednesday 30 September 2020 will have been started by Thursday 31 December 2020. This includes deaths after home births where care was provided by your Trust staff and the baby died.	100% compliance
A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Thursday 1 October 2020 will have been started within four months of each death. This includes deaths after home	100% compliance

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births where care was provided by your Trust staff and the baby died	
At least 75% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Friday 31 July 2020 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool by Thursday 31 December 2020	100% compliance. The child death panel have a member present at each PMRT. Chelsea and Westminster continue to support the team and where there are two sites involved in the PMRT case a member of that Trust is invited to meeting
At least 40% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool.	Of the 78 cases eligible for PMRT review from December 2019, 10 cases (12.8%) were NN transfers from other units that are investigated in those trusts. 68 cases are eligible for investigation by Imperial, of those 18 (26%) are intrauterine transfers which are completed jointly by other hospitals. Overall 85.45% compliance for all PMRT reviews. 96% for babies who are born and die in the Trust.
For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion.	100%. Leaflets given to parents in bereavement pack.
Before they are discharged home all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of neonatal deaths parents should also be told that a review will be undertaken by the local Child Death Overview Panel (CDOP).	100%

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Verbal information can be supplemented by written information.	
Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion	100% PMRT reported to Quality and Safety meetings and Quarterly reports pulled off the database for Trust Board. Next due in January
External member present for review	80% compliance

We aim to have a full multi-disciplinary review every two weeks to review all PMRT cases.

Although the PMRT standards do not specifically mention external members we hope to continue to invite colleagues from other Trusts to support our review.

Action from cases

Action from cases fed back to risk meetings and Quality and Safety meeting. The box below includes action from all the PMRT completed by the Trust. From September 2020

Issue PMRT	Number of cases	PMRT action plan
Asking about DV at any opportunity - preferably using a separate not to document this	**1**	Discussed at the Community Meeting (9.6.20 and 10.11.20) and ANC QC (11.10.20). DW Lead MW at SMH. Followed up with email to Lead MWs
Making sure that the correct risk allocation is put onto Cerner at booking	**1**	Discussed at the Community Meeting (9.6.20) and ANC QC (11.10.20). DW Lead MW at SMH. Followed up with email to Lead MWs
MSU at booking and follow up of results	**1**	Change in Trust policy in progress, now taken routinely. Discussed at the Community Meeting (9.6.20 and 10.11.20) and ANC QC (11.10.20). DW Lead MW at SMH. Followed up with email to Lead MWs
Gap chart ID's being in a separate note at 16/40	**1**	Discussed at the Community Meeting (9.6.20) and ANC QC (11.10.20). DW Lead MW at SMH. Followed up with email to Lead MWs 10.11.20
Using translators at all appointments if required especially when talking about	**1**	Discussed at the Community Meeting (9.6.20) and ANC QC (11.10.20). DW

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maternal and fetal well being and when/how to seek help		Lead MW at SMH. Followed up with email to Lead MWs
Using FM leaflets in other languages and documenting that there have been given in the notes. These can be accessed here - https://www.tommys.org/pregnancy-information/health-professionals/free-pregnancy-resources/leaflet-and-banner-feeling-your-baby-move-sign-they-are-well	**1**	Discussed at the Community Meeting (9.6.20) and ANC QC (11.10.20). DW Lead MW at SMH. Followed up with email to Lead MWs 10.11.20
Making sure that if patients have been to MDAU then their results and plans have been followed up/actioned	**1**	Discussed at the Community Meeting (9.6.20) and ANC QC (11.10.20). DW Lead MW at SMH. Followed up with email to Lead MWs 10.11.20
If a patient has been an in-patient on AN ward considering if they need to see a Dr in ANC to follow up their care/plan	**1**	Discussed at the Community Meeting (9.6.20) and ANC QC (11.10.20). DW Lead MW at SMH. Followed up with email to Lead MWs 10.11.20
Reviewing previous care plans to make sure that the care has been organised as advised	**1**	Discussed at the Community Meeting (9.6.20) and ANC QC (11.10.20). DW Lead MW at SMH. Followed up with email to Lead MWs 10.11.20 - with link to ANC guidelines table for MW information /guidance
Referring women with pre existing conditions/social history using AN clinic guidelines especially for things like previous SGA that might not be obvious until GAP chart is generated	**1**	Discussed at the ANC QC (11.10.20). DW Lead MW at SMH. Followed up with email to Lead MWs. Community Matron has led this project and is working to have this included in the mother and baby app
It is important that any missed appointment is followed up and action is documented on Cerner	**1**	Discussed at the Community Meeting (9.6.20) and ANC QC (11.10.20). DW Lead MW at SMH. Followed up with email to Lead MWs 10.11.20
Partogram in Labour BC	**1**	BC Matron emailed staff 8.10.20 IT MW emailed staff with instructions 28.7.20 (SMH) 10.8.20 (QC). Labour ward matrons aware and asked to discuss in safety huddles and meetings 21.7.20

Nora Farrelly December 2020

		Emailed LW Matrons 21.7.20. UPDATE -
Partogram in Labour LW	**1**	BC Matron emailed staff 8.10.20 IT MW emailed staff with instructions 28.7.20 (SMH) 10.8.20 (QC). Labour ward matrons aware and asked to discuss in safety huddles and meetings 21.7.20 Emailed LW Matrons 21.7.20

Nora Farrelly December 2020

Imperial College Healthcare NHS Trust

Appendix 4 ATAIN admissions December 2020

	QCCH	SMH	Avoidable
Admissions	11	8	
ELCS	1	2	No
EMCS	2	4	No
SVD from BC	1 (72 hour report, ? level of investigation)		No
Ventouse for suspicious CTG	1		No
Forceps – sepsis in labour	1		No
SVD with grunting	1		No
Postnatal admission due to bilious vomiting	1		No
Postnatal admission for jaundice	1	1	No
Postnatal admission due to low sats. ? T21	1		Possibly – overnight admission
Postnatal dropped baby	1 (SI investigation)		No
Postnatal admission for genetic condition but not planned		1	No

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Infection Prevention and Control (IPC) and Antimicrobial Stewardship Quarterly 3 Report 2020/21

Agenda item 16 and paper number 13

Executive Director: Julian Redhead, Medical director

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

Purpose: information

Meeting date: 31 March 2021

Executive summary

1. Introduction and background

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

2. Purpose:

2.1. This paper summarises the activity of IPC team for quarter 3 (Q3) 2020/21.

3. Summary

3.1. IPC expertise continues to be integral to decision making during the Trust management of COVID-19. The NHS England (NHSE) Board Assurance Framework (BAF) for a Trust's IPC structures and activity related to COVID-19 continues to be updated monthly. There is a new version of the BAF from NHSE, which has been extended to cover more key lines of enquiry (KLOE). Processes for the management of possible COVID-19 outbreaks in patients and staff have been agreed and implemented.

3.2. 27 COVID-19 transmission incidents / outbreaks were identified and managed during Q3. 10 of these 27 affected only two individuals. 12 of these outbreaks affected only staff, and 15 affected patients or both patients and staff. The mean rate of hospital-onset COVID-19 infection at Imperial between 27/12/2020 and 07/02/2021 (the range when data are available at the time of writing) ranked 13th lowest among 31 NHS providers in London.

3.3. There have been 9 hospital-associated C. difficile cases during Q3, which is below the Q3 ceiling of 18 cases. There have been no lapses in care related to cross-transmission or antibiotic choices.

3.4. There was one hospital-associated MRSA BSI (bloodstream infection) during Q3.

3.5. We are on target to meet our 10% year-on-year reduction in Trust-attributed E. coli BSIs (an internal performance metric).

3.6. We are unable to report on the Catheter line-associated bloodstream infection (CLABSI) rate in the adult intensive care units (ICU) or neonatal intensive care units (NICU) during Q3 due to pathway changes and surge ICU activity related to COVID-19.

3.7. 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.

3.8. Non-COVID-19 clinical activity has included investigating and managing incidents related to Candida auris, chickenpox, shingles, PVL Staphylococcus aureus, parvovirus, E. coli 0157, and norovirus.

4. Recommendation(s)

4.1. The Board is asked to note the report.

Main Paper

5. Discussion/key points

5.1. 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 27 COVID-19 outbreaks were identified and managed during Q3. 10 of these 27 affected only two individuals. 12 of these outbreaks affected only staff, and 15 affected patients or both patients and staff.
- We have reported the most outbreaks of COVID-19 in our Integrated Care System, but continue to have the lowest rate of hospital-onset COVID-19 of the acute providers in the sector.
    - The mean rate of hospital-onset COVID-19 infection at Imperial between 27/12/2020 and 07/02/2021 (the range when data are available at the time of writing) ranked 13th lowest among 31 NHS providers in London.
- IPC play 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 the World Health Organization (WHO) and National Institute of Health Research (NIHR) on projects related to COVID-19.

5.2. Key actions to prevent healthcare-associated COVID-19

- An IPC board assurance framework (BAF) continues to be updated monthly. There is a new version of the BAF from NHS England, which has been extended to cover more key lines of enquiry (KLOE). Full assurance has been provided against most of the new KLOEs. The Clinical Reference Group (CRG) is currently devoting 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.
- A self-assessment of assurance has been undertaken against the Key actions on infection prevention and control for organisations and systems.
- We have an established surveillance system for hospital-onset COVID-19 infections (HOCI) within the Trust (See Appendix 1, Figure 1).
- IPC, in partnership with occupational health, have developed and established systems to identify and manage possible outbreaks of COVID-19 amongst staff.

- IIMARCH (Information, Intent, Method, Administration, Risk Assessment, Communications and Humanitarian Issues) forms related to each new outbreak are presented to the CRG.
- The Trust's clinical incident management systems are used to investigate and learn from COVID-19 outbreaks and related incidents. Our harm profile has changed with an increased number of incidents reported to be causing moderate harm as a consequence of COVID related infections. Each incident will be reviewed by the Medical Director's Incident Panel to decide on the level of harm and whether a Serious Incident should be declared. We expect the number of moderate incidents to reduce however a full triangulation of IPC related data is underway, which will be reported to the executive in May.
- 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).
- Systematic ward visits by IPC have been undertaken to make sure that COVID-19 risk pathways are embedded and understood by front-line staff.
    - Posters have been developed and implemented to make it clear which COVID-19 risk pathway is in operation, and provider reminders about the correct PPE (personal protective equipment) required in each part of clinical and non-clinical areas.
    - In response to challenges in implementing Public Health England (PHE) guidance around eye protection for staff, eye protection was made mandatory during patient care in all patient pathways from September 2020.
    - In response to the increasing prevalence of COVID-19 in our hospitals in December 2020 and January 2021, low-risk pathways have been suspended and all pathways are either medium or high risk. This means that FFP3 respirators will be used for all aerosol generating procedures.
- Potential contributory factors to COVID-19 outbreaks at Imperial and in other healthcare providers in the North West London (NWL) sector have been reviewed at CRG and used to inform communications for all staff. Recurring potential contributory factors have included challenges related to PPE and physical distancing in non-clinical areas, PPE during patient care, compliance with routine patient testing for COVID-19, and operational bed pressures influencing the management of COVID-19 contacts. Communications to staff have included:
    - A safety alert for all staff related to prevent hospital-acquired COVID-19 (December 2020).
    - Intranet pages on preventing hospital-acquired COVID-19 ("Preventing COVID-19 transmission: everybody's business") (December 2020).
- 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. The programme was relaunched in the summer, and PPE helpers are visiting clinical areas daily to observe PPE use and support best practice.
    - There are currently 8 full time PPE helpers undertaking daily visits to clinical areas, including as part of outbreak investigations.
    - The "Back to the floor Thursday" sessions were used to undertake PPE practice audits weekly across the organisation from December 2020.

5.3. **Healthcare-associated infection surveillance and mandatory reporting**

- There have been 9 hospital-associated **Clostridioides difficile** cases during Q3 (5 Hospital-Onset, Healthcare-Associated (HOHA) and 4 Community-Onset, Healthcare-

Associated (COHA) against a ceiling of 18 HOHA and COHA cases combined (Appendix Figure 1). Hospital-associated C. difficile cases were detected in 0.7% of 1293 stool specimens tested during Q3. There were no lapses in care identified in Q3. The rate of healthcare-associated C. difficile (HOHA and COHA) cases was the third lowest in the Shelford group based on figures from April to November 2020/21. In comparison, the rate of C.difficile was third highest in 2019/20. The rate of specimens tested for C. difficile remains broadly constant at Imperial.

- There has been one healthcare-attributable **MRSA BSI** during Q3. Compliance with MRSA admission screening was 91% for Q3.
- There have been eight cases of Trust-attributed **MSSA BSI** during Q3, with no evidence of patient-to-patient transmission.
- The number of Gram-negative **Escherichia coli, Pseudomonas aeruginosa,** and **Klebsiella pneumoniae BSI** increased towards pre-pandemic levels in parallel with the gradual increase in elective and emergency patient admissions over Q3. Our E. coli BSI rate ranks second 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. These plans will be redeveloped in Q4.
- **Contaminants**[1] accounted for 2.8% of 8493 blood cultures taken during Q3, which is below our local benchmark of 3%.[2] An increase in blood culture contaminants was observed across adult ICUs during the COVID-19 peak, likely related to challenges with hand hygiene and ANTT (Aseptic Non-Touch Technique) whilst wearing additional PPE. IPC and vascular access continue to support ICU in addressing these issues. The peak in contaminants occurred in April 2020 and has since returned to below benchmark levels.
- **Catheter line-associated BSI (CLABSI):**
    - We are unable to report on the CLABSI rate in the adult ICU or NICU during Q3 due to data unavailability related to COVID-19.
    - In the 12-month period (Jan 2020 – Dec 2020) there have been 2 CLABSI cases in the paediatric intensive care unit (PICU). Due to COVID-19 level 3 capacity expansions, 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. The Q3 rate stands at 3.6 per 1000 line days, on par with the ECDC benchmark figure of 3.6 per 1000 line days.
- Rates of **surgical site infection (SSI)** following CABG (coronary artery bypass grafting) and non-CABG procedures remained consistently above the national average over the period Apr 2019 to Mar 2020. However, SSI rates for the most recent surveillance period (Jul - Sept 2020) have since returned to below the national average (Appendix Section 8.2).
- 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 7.2)
- An overall decreasing trend in the number of new patients identified as carrying **carbapenemase-producing Enterobacterales (CPE)** has been observed between August 2019 and December 2020 (Appendix Figure 3). The number of new patients

[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.

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 corresponded with fewer inpatients requiring testing during the first surge of COVID-19. Increasing Trust activity during July to October 2020 corresponded with a gradual increase in case numbers, declining once again in Q3, corresponding with a fall in elective and emergency admissions owing to the COVID-19 winter surge. CPE admission screening was maintained throughout the COVID-19 pandemic. Although Trust-wide compliance dipped during the first surge of COVID-19, it has now returned to and stable at pre-COVID-19 levels at 88%.

5.4. **Antimicrobial stewardship**

- There was an expected rise in antimicrobial consumption during Q3 2020/21 (Appendix Figure 2) in keeping with changes seen during the winter months.
- The COVID-19 pandemic triggered a shift in antimicrobial use in Q1 2020/21 during the first wave and again in Q3 2020/21 with a rise in intravenous agents. This change was a direct result of high acuity patients presenting to our organisation with undifferentiated respiratory infections. In response, the Trust deployed various antimicrobial stewardship initiatives to counteract this shift including:
    - Utilisation of the Antimicrobial Stewardship Dashboard to support weekly stewardship rounds, with an initial focus on carbapenem use and protracted courses (>7days).
    - Monitoring of antimicrobial usage on a monthly basis by the Infection Pharmacy team, such that areas of high use can be proactively targeted.
- 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 (Commissioning for Quality and Innovation) which is part of the wider Medicines Optimisation CQUIN.
- The next biannual antibiotic point prevalence survey was due in January 2021 but will be postponed in light of the COVID-19 pandemic.

5.5. **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 83.3% (7222/8672 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.

5.6. **Clinical activity, incidents, and lookback investigations during Q2**

- Much of the capacity of the IPC service has been directed towards the response to the COVID-19 pandemic.
- A patient on critical care was identified with **Candida auris** in their urine in November 2020. The patient had neurological surgery in Kuwait prior to arrival in the UK and additional surgery whilst an inpatient. An investigation including contract tracing was undertaken and no other patients were identified with this organism.
- There has been a national alert about the emergence of Burkholderia aenigmatica associated with contamination of ultrasound gel. One baby was identified with this

organism in December 2020, and an investigation of the ultrasound gel undertaken in partnership with PHE.
- In Q3, a total of 13 communicable disease 'look back' investigations were undertaken related to potential exposures to chickenpox, shingles, PVL Staphylococcus aureus, parvovirus, E. coli 0157, and norovirus. This has reduced from 18 during Q2.

5.7. **Compliance, policies, and risks**
- The quarterly Trust Infection Prevention and Control Committee was held in November 2020, and approved four policies and guidelines.
- There have been no new **IPC risks** identified in Q3. All risks in the IPC risk register have been updated to reflect the challenges related to COVID-19.

5.8. **Other**
- Members of the IPC team have produced 5 peer-reviewed **publications** relating to applied research in Healthcare Associated Infection (HCAI) and Antimicrobial Resistance (AMR) during Q3.
- 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.

6. Key points

6.1. Impact

6.1.1. **Quality**
IPC and careful management of antimicrobials are critical to the quality of care received by patients at our Trust, 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.

6.1.2. **Financial**
No direct financial impact.

6.1.3. **Workforce impact**
No workforce impact

6.1.4. **Equality impact**
N/A

6.2. Risk impact

This report includes a summary update of the IPC risk register.

Jon Otter, General Manager, IPC
Professor Alison Holmes, Director, IPC
Date: 11.02.2021

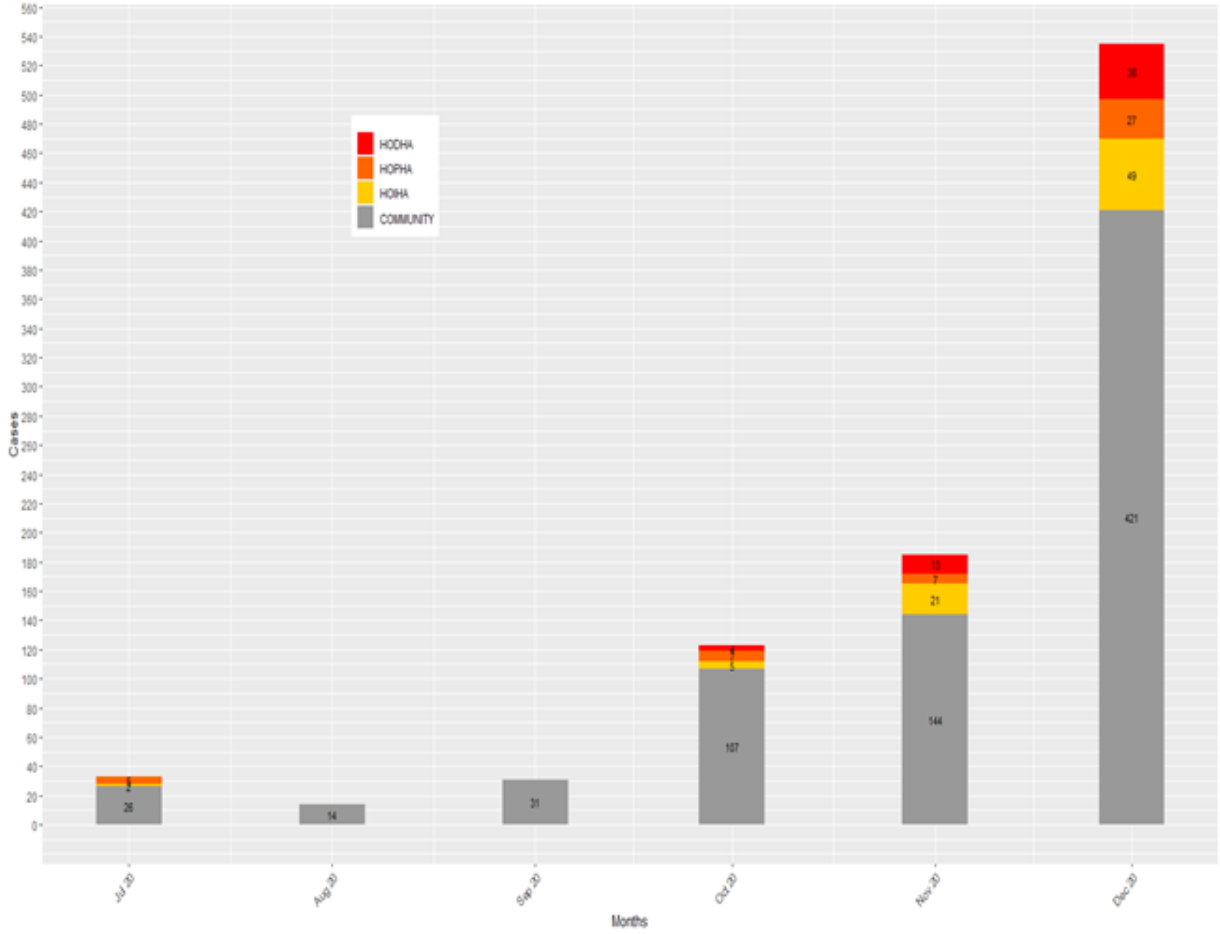
Imperial College Healthcare NHS Trust

7. Appendix 1

7.1 Hospital-onset COVID-19 infection

We have an established surveillance system for hospital-onset COVID-19 infections (HOCI) within the Trust. The HOCI SITREP (situation report) 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.

Figure 1: COVID-19 identified in inpatients.



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7.2 Healthcare-associated infection surveillance and mandatory reporting

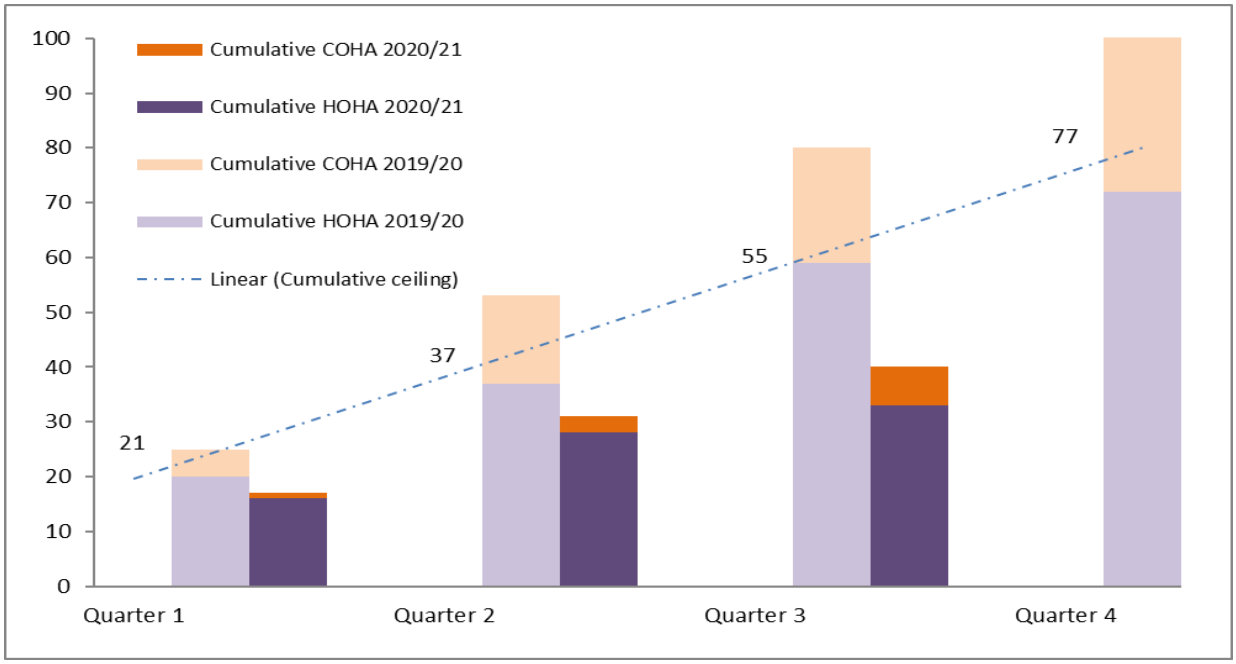
A summary of healthcare-associated infection (HCAI) that is reported to Public Health England is shown in Table 1.

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
Hospital onset-Healthcare associated (HOHA)	8	-	6	-	2	-	0	-	2	-	10	-	4	-	1	-	0	-							**33**	-
Community onset-Healthcare associated (COHA)	0	-	0	-	1	-	1	-	0	-	1	-	0	-	4	-	0	-							**7**	-
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							**40**	55
Trust *Escherichia coli* BSI	2	-	5	-	5	-	6	-	4	-	3	-	8	-	3	-	6	-							**42**	-
Trust MSSA BSI	4	-	0	-	0	-	2	-	3	-	3	-	1	-	3	-	4	-							**20**	-
Trust CPE BSI	0	-	1	-	0	-	0	-	0	-	0	-	1	-	0	-	0	-							**2**	-
Trust *Pseudomonas aeruginosa* BSI	4	-	3	-	2	-	2	-	10	-	5	-	3	-	5	-	3	-							**37**	-
Trust *Klebsiella* BSI	5	-	0	-	4	-	4	-	3	-	3	-	3	-	3	-	4	-							**29**	-

'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.

Figure 2: Healthcare-associated C. difficile cases by FY and quarter (2019/20 to 2020/21).



7.3 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 reduced during Q2 due to COVID-19 management.

7.3.1 Cardiothoracic

The latest quarter with finalised submitted data (Jul-Sept 2020 finalised data) has seen:

- CABG: 3 SSI (3.7%) in 81 procedures; 12-month average is 7.4% (21 SSI in 283 procedures); national average is 3.8%.
- Non-CABG: 0 SSI (0.0%) in 50 procedures; 12-month average is 0.0% (0 SSI in 200 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 (Jul – Sept 2020) have since returned to below the national average.

7.3.2 Orthopaedic

The latest quarter with finalised submitted data (Jul-Sept 2020 finalised data) has seen:

- Knee replacement: 0 SSI (0.0%) in 31 procedures; 12-month average is 0.5% (1 SSI in 197 procedures); national average is 0.6%.
- Hip replacement: 0 SSI (0.0%) in 35 procedures; 12-month average is 0.6% (1 SSI in 160 procedures); national average is 0.6%.

7.3.3. 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:

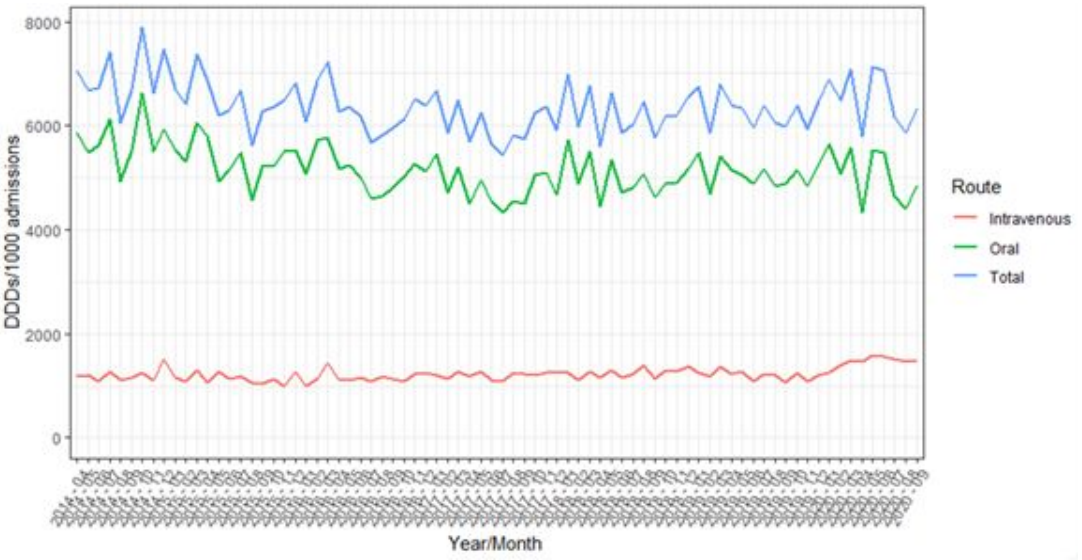
- Determine baseline SSI rates following all elective and emergency neurosurgery through a pilot surveillance scheme.
- Establish a sustainable platform for neurosurgery SSI surveillance, including post-discharge surveillance.
- Provide actionable audit data on compliance with evidence-based SSI prevention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

Imperial College Healthcare NHS Trust

7.4 Antimicrobial stewardship

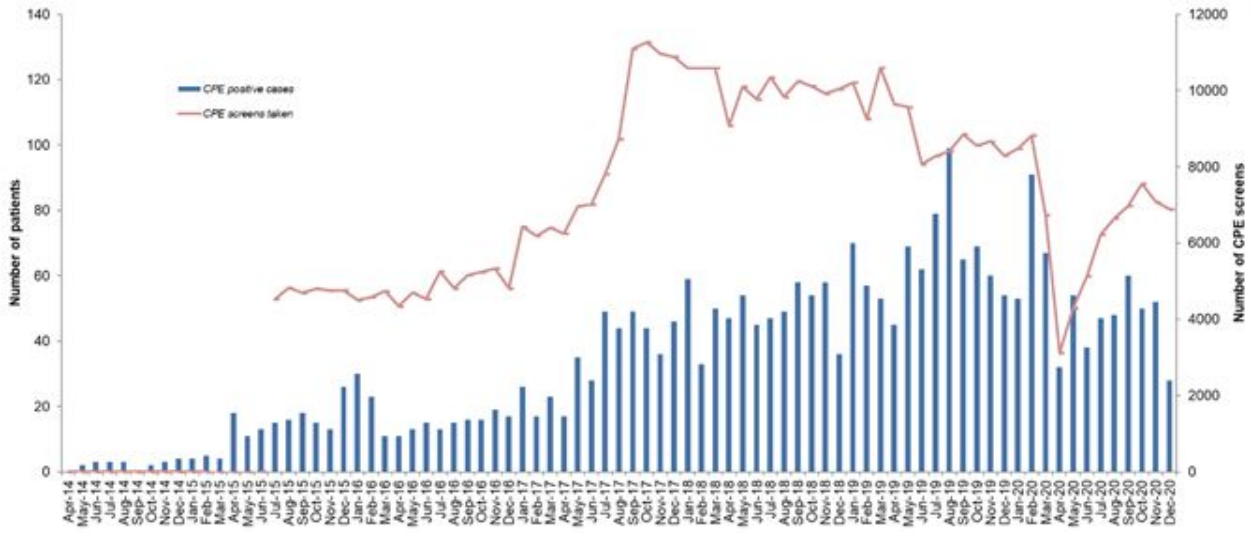
7.4.1 Antimicrobial consumption

Figure 3: Trust-wide antimicrobial consumption (DDD / 1000 admissions) 2014/15 present, including the split between intravenous and oral administration.



7.5 CPE trends

Figure 4: 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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TRUST BOARD (PUBLIC)

Paper title: Annual Review on Safe, Sustainable and Productive Nursing and Midwifery Staffing

Agenda item 17 and paper number 14

Executive Director: Janice Sigsworth, Director of Nursing

Author: Sinead O' Neill, Senior Nurse Workforce, Regulation and Revalidation

Purpose: For information

Meeting date: 31 March 2021

Executive summary

1. Introduction and background

In line with requirements set out by National Quality Board's (NQB) 2018 Safe, sustainable and productive staffing: An improvement resource for adult inpatient wards in acute hospitals and NHS England / Improvement (NHSE/I) 2018 Developing workforce safeguards this paper provides a summary of the Trusts' work to deliver safe and sustainable Nursing & Midwifery care to our patients and families.

2. Purpose

The Trust undertakes an annual and mid-year nursing and midwifery establishment review, to provide assurance both internally and externally that ward staffing is safe and that staff are able to provide appropriate levels of care to our patients. In response to the pandemic, staffing has had to change significantly to ensure to the needs of our patients are met. We 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.

3. Recommendation(s)

The Board is asked to note the work the Trust is undertaking to deliver safe and sustainable Nursing and Midwifery care and the latest annual establishment review results.

Main report

4. The findings of the review

The following table presents the trust level findings of the autumn 2020 review, with further divisional breakdown within Appendix 1 (available in the Diligent Reading Room).

Overall, there has been an actual increase of 14.45 whole time equivalents (WTE) in the nursing and midwifery establishment when compared with the establishment review undertaken in September 2019. This is predominantly a result of:

- Increase within imaging department to allow for effective cover on Charing Cross and St Marys sites.
- Increase in maternity to ensure adequate cover within the community and antenatal care services.

Table 1: findings of annual establishment review

Clincial Division	Total registered nurse and unregistered care staff WTE September 2019	Total registered nurse and unregistered care staff WTE September 2020	WTE Change to establishment September 2019 to September 2020	September 2019 Registered nurse and unregistered care staff breakdown WTE	
				RN	CS
Women's children's and clincial support	897.37	911.78	14.41	77%	23%
Surgery, Cancer and Cardiovascular sciences	1549.43	1545.58	-3.85	82%	18%
Medicine and Integrated care	1708.47	1711.24	2.77	73%	27%
Imperial Private Healthcare	198.38	199.5	1.12	79%	21%
GRAND TOTAL	4353.65	4368.1	14.45	77%	23%

5. National and Local Context

In England, nursing shortages have been well documented with ongoing national and local initiatives to fill these vacancies. Imperial College Healthcare NHS Trust (ICHT) vacancy rate for nursing and midwifery staff is 12.4% with the highest rate amongst staff nurses (band 5).

At the Trust a set of detailed schemes have been implemented to mitigate the impact of the anticipated nursing shortages as outlined below:

5.1. International Recruitment

To date we have successfully recruited 178 Internationally Educated Nurses (IENs) into our clinical areas. Due to the Covid-19 pandemic and the associated travel restrictions, this recruitment was delayed in 2020. Nonetheless, forty-four IENs have since joined the Trust in

the latter part of 2020. The Trust's aim is to continue and expand this approach. We have been successful in being awarded nearly £0.5m of central funding to support this work.

5.2. Nursing Associates

The Nursing Associate is a registered role, educated to diploma level and regulated by the Nursing and Midwifery Council (NMC). The 'NHS People Plan' places a significant importance on the role of the nursing associate as part of the plan to address the shortage of nurses. At the Trust, we currently have twenty three qualified Nursing Associates working within clinical services with a further thirteen undertaking the apprenticeship programme. The Trust have agreed a target of one hundred trainee nursing associates per year from 2021 and we will work with our university partners to achieve this.

5.3. Registered Nurse Degree Apprenticeships (RNDA)

The Trust is currently training forty staff through apprenticeships programmes, who will qualify as registered nurses in the next four years. The aim is to continue to recruit thirty nurses annually through this route. This programme has proved to be a very popular opportunity for our health care assistants.

5.4. Automatic Offer

Student nurses and midwives who undertake their training at the Trust are provided an automatic offer of employment when they complete their studies. Despite disruption and changes to student placements in response to Covid-19, we maintained an 85% recruitment rate of our students into newly qualified nursing jobs.

5.5. Placement Capacity and Expansion Project

As part of the national and local response to the increasing demand and numbers of nursing students, there is a need to increase the availability of clinical areas where these students can train. The Trust is working collaboratively across North West London (NWL) to assess and increase the placement capacity.

5.6. Retention

The Trust continues to focus on the retention of our staff and significant amount of work has been carried out in the Trust as part of the 'Nursing and Midwifery Strategic Workforce Programme'. A target has been set to reduce the current turnover rate to 14.5% by December 2025 for band 5 staff, that is, 0.5% year on year for the next five years. The retention action plan for 2021/022 will focus on four thematic areas:

- Improve induction and on boarding,
- Create clear career development pathways
- Develop initiatives to promote greater flexibility
- Strengthen leadership and management capability through our preceptorship and springboard programmes to support our newly qualified staff nurses.

In addition, twelve of our staff nurses have commenced a one year development programme with 'CapitalNurse' aimed at supporting our Black Asian Minority Ethnic (BAME) talent.

6. Review of Trusts Safe Staffing Approach

The Trust has an established safe staffing group chaired by the Director of Nursing. This group is focussing on the recommendations set out by NHS England /Improvement. A more recent publication in February 2021 Deployment and Assurance framework of the nursing workforce during the COVID 19 emergency outlines some additional guidance to support nursing workforce during our response to the pandemic. The main areas of focus are as follows:

- Ensuring an escalation process is in place for when nursing and midwifery staffing levels fall below the requirement – this is set out in the Trust's Policy for the Provision of Safe Nurse Staffing and Skill Mix Establishments. This process includes the ability for staff to raise concerns using a red flag system within our electronic rostering system. This has been successfully trialled and will be rolled out trust wide later in 2021.
- Continued reporting of staffing levels and skill mix requirements, which are reviewed at daily operational meetings. The Trust captures this using our electronic rostering system and the data is submitted each month through a mandated safe staffing return. The return is approved and signed off by the Director of Nursing.

7. Impact assessment

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

7.2 Financial impact: No additional financial impact outside of divisional budgets

7.3 Workforce impact: The impact is captured within the detail of the paper

7.4 Equality impact: N/A

7.5 Risk impact: Corporate risk ID2944 - Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas across the Trust and areas where there is a national shortage of nurses.

Author: Sinead O'Neill, Senior Nurse workforce, regulation & revalidation

Appendices
Appendix 1: Breakdown of staffing establishment by division

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: 2019/2020 Annual Report from the Trust Safeguarding Committee

Agenda item 18 and paper number 15

Executive Director: Janice Sigsworth, Director of Nursing
Author(s): Guy Young & Nicci Wotton

Purpose: For information

Meeting date: 31 March 2021

1. Introduction

The Trust has a responsibility to safeguard children, young people (C&YP) and adults in its care. This requirement is laid out in the Children Act (1989), the Children Act 2 (2004), the Care Act (2014) and is also made clear in CQC Regulation 13: Safeguarding service users from abuse and improper treatment.

This report outlines the systems and processes in place at Imperial College Healthcare NHS Trust (ICHT) to ensure that it fulfils its responsibilities.

2. Trust governance arrangements for safeguarding

2.1 Executive leadership

The Director of Nursing is the Trust Executive Lead for Safeguarding. The Deputy Director of Patient Experience is the managerial lead and chairs the ICHT Safeguarding Committee.

2.2 The safeguarding team

The team sits within the corporate nursing division and consists of three named professionals (nurse, doctor and midwife), specialist nurses and midwives, an independent domestic violence adviser (IDVA) and two administrators. The trust provides a 7-day safeguarding service.
The three named professionals are mandated posts within NHS organisations and all had people in position during 2019/2020.

Following a review of workload and capacity additional resource was identified for the 2020/21 financial year.

2.3 The ICHT Safeguarding Committee

The committee oversees the provision of safeguarding services across the trust and seeks assurance that these services are in place and effective. The committee is chaired by the Deputy Director of Patient Experience and membership includes all trust named professionals, designated professionals from the CCG, local authority safeguarding representatives and senior nurses from the clinical divisions. The committee focuses on assurance and key decision-making.

The committee met four times in the year and was quorate on each occasion with good attendance from the named professionals. A safeguarding health outcomes document (SHOF) required by the CCG is produced each quarter and received by the committee. The SHOF and minutes of the safeguarding committee are received by the Quality & Safety Subgroup.

2.4 Policy framework

Practice during the year was supported by a comprehensive suite of policies and procedures designed to help safeguard C&YP and adults. During the year three key policies were revised, updated and ratified by the Executive Committee:

- Safeguarding children and young people operational policy (2019)
- Deprivation of Liberty Safeguards policy and procedure (2019)
- Learning disabilities and autism policy and procedure (2020)

2.5 Training

ICHT has a requirement to provide training at different levels for safeguarding children and adults. This has been done in line with national intercollegiate guidance, ensuring that staff get the level of training most appropriate to their role. Training is delivered through a combination of e-learning and face-to-face sessions. During the year, compliance targets for all levels of training were achieved.

2.6 Safeguarding Supervision

Staff involved in dealing with safeguarding concerns are required to have or be offered safeguarding supervision to enable them to talk through their experience. Safeguarding team members have this built into their work plans and ad-hoc supervision and drop in sessions are available for other staff. For the wider staff cohort this can be difficult to manage and track, but alternative ways to provide it are constantly being explored.

2.6 Safer recruitment

NHS trusts are required to ensure that staff are recruited using *safer recruitment practice* in accordance with NHS Employers' guidance. ICHT complies with this by carrying out either enhanced or standard DBS (Disclosure & Barring Service) checks on new employees as well as rigorous checking of identity and referencing.

2.7 Child Protection – Information Sharing project (CP-IS)

CP-IS, introduced by NHS Digital, helps health professionals and social care to work together to share information when children or pregnant women attend an unscheduled healthcare setting. CP-IS was in use in the trust during the year for patients attending the emergency departments, urgent care centres, the children's' ambulatory unit, maternity triage and the labour ward.

3. Safeguarding activity

3.1 Referrals

During the year the trust safeguarding team received in excess of 8000 safeguarding concerns of which a quarter required formal referral to local authority safeguarding services. Increased complexity of concerns was seen which resulted in a greater number of meetings and interventions to keep people safe. These included strategy meetings with external agencies,

discharge planning meetings and case conferences. The key themes emerging from cases are described below.

3.2 Maternity

There was a rise in the number of women with learning disabilities booking at Imperial for their care. This has led to the development of a new *Pregnancy and learning disability policy*. Other themes included, homeless women with no recourse to public funds, complex teenage pregnancies, migrant displaced women, women whose partners have criminal history and, most commonly, parental mental health and domestic abuse.

3.3 Children and young people

There are a number of themes in relation to safeguarding children. These include mental health issues, assaults, serious youth violence, criminal exploitation and children not being brought to planned appointments. Serious youth violence has been increasing and has had a significant impact in the trust not only on the safeguarding team, but also on services such as security.

3.4 Adults

Neglect and self-neglect accounted for the majority of safeguarding adult concerns raised with the team. These are mostly in relation to older people or those with dementia, but also include patients with learning disabilities. Domestic abuse referrals also increased during the year.

3.4 Multi-agency working

The team works closely with a range of other agencies such as local authorities, CCGs, domestic abuse organisations and the police.

The Deputy Director – Patient Experience and the Nurse Consultant (named nurse) sit on the Bi-Borough and Hammersmith & Fulham safeguarding boards and both chair board subgroups. Team members are active participants in the work of the board subgroups.

4. Covid-19

During March 2020 the safeguarding team was able to maintain a fully functioning 7 day service although there were changes to the way in which this was delivered. Most obvious was the move to virtual meetings with trust staff and external agencies. This was found not to have a detrimental effect on the handling of cases and it is likely that this approach will continue, at least in part, on the other side of the outbreak.

5. Summary

Based on evidence and reports received during 2019/20, the safeguarding committee is assured that the trust had the infrastructure and appropriate systems in place to provide an effective safeguarding service. The committee has no significant areas of concern that it wishes to advise the trust about, but will continue to monitor this through 2020/21.

6. Recommendation

The Board is asked to note this report.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Declaration of Interests annual report

Agenda item 19 and paper number 16

Executive Director: Peter Jenkinson, Director of Corporate Governance & Trust Secretary
Author: Stephanie Goddard, Corporate Governance Manager

Purpose: For information

Meeting date: 31st March 2021

Executive summary

1. Introduction and background

1.1 As part of the annual process all board members were asked to confirm, and update where required, their declaration of interest submissions. This is part of an annual cycle of reporting to the Trust Board.

2. Purpose of this report

2.1. To promote openness and adherence to national guidance in ensuring the Trust Board have an up to date and accurate record of their declaration of interests.

3. Executive Summary

3.1 As part of the Trust's 'Declarations of Interests and Hospitality Policy' all Trust Board members are 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.

4. Next steps

4.1. The Trust Board declarations will be published on the Trust website within their biographies.

5. Recommendation(s)

5.1. The Board are asked to note the report.

6. Impact assessment

6.1 Quality impact: This report is part of the Well-Led CQC domain, ensuring all Trust Board members are open and transparent with roles they undertake outside of their substantive post.

6.2 Financial impact: No financial impact.

6.3 Workforce impact: None applicable.

6.4 Equality impact: None applicable.

6.5 Risk impact: None applicable.

Main paper

7. **The Process**

7.1 All Executives, Non-Executives, Consultants and staff Band 8a and above are requested to complete their declarations of interests annually.

7.2 As part of the Trust's 'Declarations of Interests and Hospitality Policy' all Trust Board members are 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.

7.3 This process also supports the Annual Report and Annual Governance Statement processes.

8. Appendices:
Appendix 1 Trust Board Declaration of Interests

Stephanie Goddard, Corporate Governance Manager
31.03.2021

Imperial College Healthcare NHS Trust

Appendix 1

Trust Board Declaration of Interests

Paula Vennells – Chair

- **Outside Employment:** Morrisons / PLC Dunelm
- **Clinical and Private Practice:** Nil
- **Shareholding and Other Ownership Interests:** Morrisons Shares / ISAs
- **Loyalty Interests:** Nil
- **Sponsored Posts:** Nil
- **Other:** Nil

Bob Alexander – Non-Executive Director

- **Outside Employment:** Independent Chair – Sussex Health and Care Partnership / Non-Executive Director – Community Health Partnership
- **Clinical and Private Practice:** Nil
- **Shareholding and Other Ownership Interests:** Nil
- **Loyalty Interests:** Advisor – CIPFA / Trustee – Demelza Children's Hospice.
- **Sponsored Posts:** Nil
- **Other:** Nil

Kay Boycott – Non-Executive Director

- **Outside Employment:** Private Healthcare Information Network – Board Member / London Fire Brigade - Independent Audit Committee – Board Member Advisory - Various
- **Clinical and Private Practice:** Nil
- **Shareholding and Other Ownership Interests:** Johnson & Johnson Shares
- **Loyalty Interests:** Durham University - Lay Member of Council / King's Fund - General Advisory Council / Digitalhealth.London – Mentor / Husband is an IBM Employee (Healthcare and Life Science Consulting);
- **Sponsored Posts:** Nil
- **Other:** Nil

Peter Goldsbrough – Non-Executive Director

- **Outside Employment:** Non-Executive Director – R J Young (Properties) Ltd / Non-Executive Director – Jenkinsons Holding Ltd
- **Clinical and Private Practice:** Nil
- **Shareholding and Other Ownership Interests:** Nil
- **Loyalty Interests:** Senior Advisor – The Boston Consulting Group / Visiting Professor – Institute of Global Health Innovation, Imperial College London / Spouse - Trustee, Cancer Research UK / Non-executive director - Vitality UK / Trustee, Fidelity UK Foundation.
- **Sponsored Posts:** Nil
- **Other:** Nil

Professor Andrew Bush – Non-Executive Director

- **Outside Employment:** Nil
- **Clinical and Private Practice:** Nil
- **Shareholding and Other Ownership Interests:** Nil

- **Loyalty Interests:** Chairman – Publications Committee of the European Respiratory Society (Executive and Steering Committees) / Senior Investigator: NIHR.
- **Sponsored Posts:** Nil
- **Other:** Nil

Dr Andreas Raffel – Non-Executive Director

- **Outside Employment:** Member of the International Advisory Board – Cranfield School of Management / Deputy Chair – Change Grow Live (CGL) / Member of Board of Trustees – University of Bristol
- **Clinical and Private Practice:** Nil
- **Shareholding and Other Ownership Interests:** Nil
- **Loyalty Interests:** Senior Advisor – Rothschild / Senior Advisor – Flagstone Investment Management / Senior Advisor – Moonfare / Senior Advisor – 2rsquared.
- **Sponsored Posts:** Nil
- **Other:** Nil

Nick Ross – Non-Executive Director

- **Outside Employment:** Freelance Journalist / Broadcaster / Conference Moderator
- **Clinical and Private Practice:** Nil
- **Shareholding and Other Ownership Interests:** Nil
- **Loyalty Interests:** Member, RCS Clinical Research Initiative Steering Committee / Director: Imperial College Health Charity / President: Healthwatch (the charity promoting evidence-based medicine – not Healthwatch England) / Member: RCP Committee of Ethical Issues in Medicines / Trustee: UK Stem Cell Foundation / Member, UK Biobank Ethics Advisory Committee / Affiliate: James Lind Alliance / Trustee: Sense About Science / Vice President: Institute of Advance Motorists / President: The Kensington Society / Chairman: UCL Jill Dando Institute of Crime Science / Trustee: Crimestoppers / Member: Police Foundation inquiry into the future of policing / Chair: Westminster City Council Hate Crime Commission
- **Sponsored Posts:** Nil
- **Other:** Nil

Sim Scavazza – Non-Executive Director

- **Outside Employment:** Nil
- **Clinical and Private Practice:** Nil
- **Shareholding and Other Ownership Interests:** Nil
- **Loyalty Interests:** Governor - University of the Arts London
- **Sponsored Posts:** Nil
- **Other:** Nil

Dr Ben Maruthappu – Non-Executive Director

- **Outside Employment:** CEO - Cera Care
- **Clinical and Private Practice:** Nil
- **Shareholding and Other Ownership Interests:** Cera Care Ltd

- **Loyalty Interests:** Board Member & Trustee – Skills for Care / Board Member – NHS Innovation Accelerator / Senior Advisor – Bain & Company / Advisory Group Member – Centene UK.
- **Sponsored Posts:** Nil
- **Other:** Nil

Beverley Ejimofo – Non-Executive Director

- **Outside Employment:** Curate St Mary's Church Shortlands. 2 days per week
- **Clinical and Private Practice:** Nil
- **Shareholding and Other Ownership Interests:** Nil
- **Loyalty Interests:** Nil
- **Sponsored Posts:** Nil
- **Other:** Nil

Professor Tim Orchard – Chief Executive Officer

- **Outside Employment:** Director – Imperial College Health Partners; Professor – Imperial College London / Director – Shelford Group
- **Clinical and Private Practice:** ICHT
- **Shareholding and Other Ownership Interests:** Nil
- **Loyalty Interests:** Pharmaceutical Advisory Boards (Adhoc): Vifor Pharma, AbbVie, Biogen / Member – NICE Panel of Experts.
- **Sponsored Posts:** Nil
- **Other:** Nil

Professor Julian Redhead – Medical Director

- **Outside Employment:** Royal Society Prevention Accidents / Medical Director – Fortius / Medical Director – Polaris / London Ambulance Service – Major Incident Doctor / Chelsea Football Club.
- **Clinical and Private Practice**: Fortius Clinic / Lindo Wing.
- **Shareholding and Other Ownership Interests:** Stadium Doctors Ltd / Fortius Clinic / Opus Clinic.
- **Loyalty Interests:** CQC Inspector / Trustee Imperial Health Charity / London Clinical Senate Board / London Clinical Leaders Group.
- **Sponsored Posts:** Nil
- **Other:** Nil

Professor Janice Sigsworth – Director of Nursing

- **Outside Employment:** Nil
- **Clinical and Private Practice:** Nil
- **Shareholding and Other Ownership Interests:** Nil
- **Loyalty Interests:** Honorary Professional Appointments at King's College London, Bucks New University, and Middlesex University / Trustee – General Nursing Council Trust / Clinical Adviser to the NMC of Pre-Registration Midwifery Standards / Chair – Shelford Safer Care Nursing Tool (SNCT) Committee / Co-Chair – National Safer Care Faculty / National Lead – Embedding genomics into nursing and midwifery practice / Chair – national blended learning, nursing and midwifery programme / NHSI Safe staffing Faculty Group / National professional lead for nursing and midwifery genomics.

- **Sponsored Posts:** Nil
- **Other:** Nil

Jazz Thind – Chief Financial Officer

- **Outside Employment:** Nil
- **Clinical and Private Practice:** Nil
- **Shareholding and Other Ownership Interests:** Nil
- **Loyalty Interests:** Nil
- **Sponsored Posts:** Nil
- **Other:** Nil

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Establishment of People Committee, Terms of Reference

Agenda item 20 and paper number 17

Executive Director and author(s): Peter Jenkinson, Director of Corporate Governance and Trust Secretary, Kevin Croft, Director of People & OD and Ginder Nisar, Deputy Trust Secretary

Purpose: For noting.

Meeting date: 31st March 2021

Executive summary

1. Introduction and background

1.1. Ensuring excellent support, development and wellbeing of our people is essential, as reflected in our strategy and priorities. We have a range of people-related indicators that are reviewed at divisional level in performance meetings, the newly established Executive Management Board and the Quality Committee. A selection of these indicators is reported to the Board via the performance scorecard.

2. Purpose of this report

2.1. Following discussions at the Quality Committee and the growing responsibilities of the Quality Committee/agenda further impacted by the response to the COVID pandemic, and placing focus on the People agenda, the Executive and Non-Executive Directors Group have agreed for a People Committee to be established. 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.

2.2. The Terms of Reference for the People Committee have been discussed and agreed through the Non-Executive Directors Group and key Executive Directors during February 2021 and noted by the Remuneration and Appointments Committee in March 2021.

2.3. The Terms of Reference for the People Committee is attached at appendix 1.

3. Next steps

3.1. The membership of the People Committee will be agreed and established from May 2021.

4. Recommendation(s)

4.1. The Board is asked to note the establishment of the People Committee and note its Terms of Reference.

Imperial College Healthcare NHS Trust

5. Impact assessment

5.1. Quality impact: Improved patient experience and outcomes through improvements in the supply, engagement and skills of the workforce and a more conducive working environment.

5.2. Financial impact: Improved financial performance through effective and efficient use of human resources as well as the performance benefits of a more engaged workforce

5.3. Workforce impact: Enhances staff experience and engagement leading to improved retention and performance improvement.

5.4. Equality impact: Advances opportunities and improves the experience of staff with protected characteristics leading to improved experience and outcomes for patients and users that have such protected characteristics.

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

6. Conclusion

6.1. Establishment of a People Committee.

7. Appendices:

7.1. Appendix 1 - Terms of Reference for the People Committee

Peter Jenkinson, Director of Corporate Governance and Trust Secretary and
Ginder Nisar, Deputy Trust Secretary
22 March 2021

Appendix 1

Imperial College Healthcare NHS Trust

Terms of Reference – People Committee

1. Constitution

1.1. The Board hereby resolves to establish a Committee of the Board to be known as the People Committee ("the Committee"). The Committee is a Non-Executive Committee and as such has no delegated authority other than that specified in these terms of reference.

2. Authority

2.1. The Committee has the following delegated authority:

2.1.1. The authority to seek any information it requires from any employee of the Trust in order to perform its duties, and to call any employee to a meeting of the Committee as and when required.

2.1.2. The authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, via the Trust company secretary.

3. Role (objective)

3.1. To monitor, review and report to the Board 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. To receive and provide the Board of Imperial College Healthcare NHS Trust ("the Trust") with assurance with regard to:

3.1.1. the identification of strategic people and workforce priorities for the Trust as a significant employer and as a partner in training, education, and development of health and care capacity in the locality.

3.1.2. the organisation's understanding of strategic workforce needs (including well-being, recruitment, retention, development of people, and organisational capacity) and the quality and effectiveness of plans to deliver them.

3.1.3. the implementation of key HR controls, including recruitment and retention, and performance management including appraisal systems.

3.1.4. the commitments of the NHS Constitution and the stated values of the Trust and standards of behaviour are being practiced at all levels of the organisation, based on evidence.

3.1.5. The achievement of key deliverables in relation to the equality, diversity and inclusion (EDI) plan, and to monitor key metrics in relation to EDI.

3.1.6. the Trust's legislative and regulatory compliance as an employer, including anticipation of, and planning for, future requirements.

3.1.7. the development of staff governance in the organisation, including staff engagement processes, with the Committee acting as the oversight Committee.

3.1.8. strategic issues relating to ethics and duty of care in the conduct of Trust affairs (including whistleblowing) and to the Trust's equality duty.

4. **Membership**

4.1. The Committee chair (a non-executive director) and Committee members will be appointed by the Trust Chair. The Committee will comprise three non-executive directors, the chief executive, director of people and organisational development, medical director, director of nursing, director of communications, and the divisional directors.

4.2. Only members of the Committee have the right to attend and vote at meetings; officers of the Trust and other individuals may be required to attend all or any part of Committee meetings. Non-executive directors are invited to attend any Board Committee they wish and will notify the secretary of the Committee when they have a specific meeting that they would like to attend.

4.3. In the absence of the Committee chair, members present will agree that one among them will chair the meeting.

5. **Quorum**

5.1. The meeting quorum is three members, of which two are non-executive directors; the meeting will then be competent to exercise all or any of the authorities, powers and discretions vested in, or exercisable by, the Committee.

6. **Frequency of meetings and attendance requirements**

6.1. The Committee will normally meet six times a year; additional meetings can be convened by agreement with the Committee Chair.

6.2. Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of scheduled meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

7. **Declarations of Interest**

7.1. All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required to not participate in a discussion or otherwise limit their involvement in the meeting. The Director of Corporate Governance can provide advice on reporting Declarations of Interests.

8. **Duties -** The Committee duties include:

8.1. **People Strategy**

8.1.1. Review the development and delivery of the Trust's sustainable workforce strategy, focusing on:

- Strategic workforce information and planning.
- Recruitment and retention.
- Staff experience and engagement, reward, recognition, health and wellbeing
- Education, learning and organisational and leadership development.
- Equality and diversity.

8.1.2. Provide assurance that the Trust's People Strategy and policies effectively respond to national and regional people strategies and policies.

8.1.3. Review strategic intelligence and research evidence on people and work, and distil their relevance to the Trust's strategic priorities.

8.2. **Culture & Values**

8.2.1. The role of the committee would be to oversee the development and delivery of the programme of work related to culture, including oversight of the measures of culture, including sources of staff feedback.

8.2.2. Oversee the coherence and comprehensiveness of the ways in which the Trust engages with staff and with staff voices, including the staff survey, and report on the intelligence gathered, and its implications to the Board. This includes raising concerns and freedom to speak up reports to the People Committee and Board.

8.2.3. Oversee the development and delivery of the Trust's strategy and improvement programmes on Equality, Diversity and Inclusion ensuring full compliance with statutory duties in this area.

8.3. **Organisational Capacity**

8.3.1. The role of the People Committee would be to oversee the development and delivery of a strategy regarding a sustainable workforce (more generally). That would include development of new roles, recruitment and retention etc. The safe staffing report would be an example of a source of assurance.

8.3.2. Assess the workforce strategies and plans to support transformational change, service redesign and pathways of care that make best use of new technologies, the use of apprenticeships, introduction of new roles and innovative working across traditional professional and organisational boundaries.

8.3.3. Review plans for ensuring the development of leadership and management capability, including the Trust's approach to succession planning and talent management.

8.4. **Education and training**

8.4.1. Review the Trust's strategy and performance as a provider and enabler of health and care education.

8.4.2. Review the Trust's current and future educational and training needs to ensure they support the strategic objectives of the organisation in the context of the wider health and care system.

8.4.3. Review the Trust's strategic contribution to the development of the health and care workforce.

8.4.4. Secure the necessary assurances about the Trust's compliance with the practice requirements of professional and regulatory bodies for all staff.

8.5. **Staff Health and Well-Being**

8.5.1. Oversee the development and delivery of a Trust Staff Health and Well-being Strategy

8.5.2. Review the accessibility and impact of the health and well-being strategy and improvement programmes, in particular, for staff with protected characteristics.

8.6. **Performance and Progress Reporting**

8.6.1. Establish a succinct set of key performance and progress measures relating to the full purpose and function of the Committee, including:

- the Trust's strategic priorities on people
- national performance targets
- organisational culture
- equality, diversity and inclusion
- workforce utilisation
- staff health and well-being
- health and safety
- strategic communications

8.6.2. Review progress against these measures and seek assurance around any performance issues identified, including proposed corrective actions.

8.6.3. Receive and review reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being taken to address these.

8.6.4. Ensure the credibility of sources of evidence and data used for planning and progress reporting to the Committee, and to the Board in relation to the Committee's purpose and function.

8.6.5. Ensure alignment of the Board assurances and consistent use of data and intelligence, by working closely with the Audit & Risk, Quality & Safety and Finance & Performance Committees.

8.6.6. Review and shape the quality-related content of periodic workforce reports to the Board.

8.6.7. Review the following formal reports to the Board as part of the Annual Cycle of Business:

- Annual People Report
- Equality and Diversity Annual report

8.7. **Statutory Compliance**

8.7.1. Ensure statutory and regulatory compliance and reporting requirements in people related areas.

9. **Reporting responsibilities**

9.1. The Committee will report to the Trust Board on its proceedings after each meeting.

9.2. The Committee will make whatever recommendations to the Trust Board it deems appropriate on any area within its remit where action or improvement is needed.

10. Engagement with stakeholders

10.1. The Committee chair should attend the annual general meeting to answer any stakeholder questions on the Committee's activities.

11. **Meeting administration**

11.1. The Trust company secretary or their deputy shall act as the secretary of the Committee.

11.2. Meetings of the Committee may be called by the secretary at the request of any of its members or where necessary.
11.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.
11.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.
11.5. Minutes of Committee meetings should be circulated to all members of the Committee and, once approved, to all members of the Trust Board (unless a conflict of interest exists).

12. **Other matters**
12.1. The Committee will:
12.1.1. The Committee will discuss any matter which any member of the Committee believes to be of such importance that it should be brought to the attention of the Committee, by agreement of the Committee chair.
12.1.2. Have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required.
12.1.3. Be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members.
12.1.4. Give due consideration to legislation and regulations.
12.1.5. Review both its effectiveness and terms of reference on an annual basis, and recommend to the Trust Board for approval, any changes it considers necessary.

13. **Work Programme**
13.1. The Committee will prepare an annual work programme detailing the items expected to be considered at each meeting.
13.2. The Work Programme is to be a living document, updated for each meeting.
13.3. Review of the Work Programme is to be a standing agenda item.

14. **Monitoring and review**
14.1. The Trust Board will monitor the effectiveness of the Committee through receipt of the Committee's minutes and any further written or verbal reports that the chair of the Committee might provide.
14.2. The secretary will review all agenda items to ensure they align with the Committee's responsibilities.

Updated: 25 February 2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Audit, Risk & Governance Committee report

Agenda item 21.1 and paper number 18a

Author and lead Executive Director: Jessica Hargreaves, Deputy Trust Secretary/Bob Alexander, Non-Executive Director

Purpose: For information

Meeting date: 31 March 2021

1. Summary:
Audit, Risk & Governance Committee meetings were held on 2 December 2020 and 3 March 2021. Key items to note from these meetings include:

1.1 External Audit: The Committee received the external audit update on planning for the 2020/21 audit, noting initial consideration of significant audit risks to be covered in the audit.

Committee members noted the audit status update and sector developments particularly the recent changes to the International Standards on Auditing (ISA) including ISA 540 'Auditing accounting estimates and related disclosures' which would have implications on this year's audit.

Committee members were pleased to note that the audit was progressing with no areas of concern to report at the current time. It was noted that more detail on key judgements and estimates would be discussed at the April Committee

1.2 Year-end accounts/annual report approach and reporting timetable: Committee members reviewed the proposed approach for the 2020/21 year end process noting that the timescales the Trust would be working to was for draft submission of accounts to be on 27 April 2021 and final submission on 15 June 2021.

The Committee supported the proposed approach and timetable.

1.3 Internal Audit and Counter Fraud: The Committee received the proposed outline internal audit plan for 2021/22 noting that this would be discussed and developed with the executive team, with final version to be agreed at the next meeting.

Committee members noted the progress made against the 2020/21 plan and it was confirmed that the data security and protection toolkit audit would commence the following week after new guidance had been received; and that this would be completed on time to ensure that the Head of Internal Audit Opinion is completed within the required timescales.

Committee members received the counter fraud progress report noting the publication of new NHS counter fraud authority Government Functional Standards which replaced the previous Provider Standards for Counter Fraud. These standards would form the basis for the annual self-assessment due for submission on 30 April 202 and would provide a baseline measurement that would enable organisations to identify work required to progress towards compliance by March 2022.

One of the new requirements is to have a senior management Fraud Champion role in the Trust, who is not the Chief financial officer. It was been agreed that Peter Jenkinson, Director of corporate governance, will fulfil this role.

1.4 Risk and assurance report including deep dive on patient transport: The Committee received and reviewed the risk management report and noted that the revised approach to the assurance framework, including risk and assurance deep dives, had been implemented in September 2020. Summaries of deep dives completed by other board committees were noted and the Committee were pleased to note that the board committees had embraced the new process.

Committee members noted that the impact of Covid-19 continued to increase the risk exposure of the Trust and this had been reflected in the increased score on the corporate risk register.

Committee members reviewed the key risks and were pleased to note the improvements made in reducing the cleaning risk.

The Committee discussed the deep dive into non-emergency patient transport and were pleased to note the improved performance of the patient transport provider with the contract being delivered consistently since March 2020. The service had continued to improve with close monitoring of delivery between the Trust and provider with on-going monthly meetings. Following serious incidents reported at the beginning of the contract, processes had been implemented including improved training and standard operating procedures. The Committee agreed that whilst performance had been improving, due to the reduced demand on the service, the risk would continue to be monitored until March 2021 which would allow further assurance to be gathered before reducing the risk.

Committee members noted that in August 2020, an audit of risk management practice during the acute phase of the COVID-19 pandemic was undertaken as part of the Learning and Insight Programme; it looked at risk management activities between March and May 2020. Committee members were pleased to note that overall, reasonable assurance was found that risk management activities were maintained at the Trust during the audit timeframe and the impact of COVID-19 was captured on the Trust risk registers. Committee members were also pleased to note that quality and safety had remained a key focus of the Trust; quality and safety meetings had continued throughout and risk registers continued to be reviewed and updated regularly.

Non-executive Committee members extended thanks to the executive team for providing robust assurance, helpful data and meaningful discussions with the Non-executives during the weekly NED calls over the course of the pandemic.

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1.6 Raising concerns update: The Committee received the raising concerns update and noted the significant increase in demand on the Freedom To Speak Up (FTSU) service between April and June 2020 during the first wave of the Covid-19 pandemic.

1.7 Cyber security dashboard: The Committee received and reviewed the cyber security dashboard and agreed that in order to gain assurance from it, a broader session would be required to enable the board to understand fully the risks and assurances against those; a Trust board session had been scheduled for April 2021 and a deep dive into cyber security would be discussed by the Committee following this.

1.8 Risks associated with EU exit: The Committee noted the preparations that the Trust were making alongside NHSE/I and the Department of Health and Social Care to plan for EU exit, noting that all NHS organisations had been requested to undertake local EU exit readiness planning to mitigate any potential risk when the transition period ends on 31 December 2020.

1.9 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.

1.10 Terms of reference annual review: The Committee approved the terms of reference acknowledging that the Audit, Risk and Governance Committee was dynamic and may evolve over the following year in the context of the wider governance focus going forward; the terms of reference would be reviewed as appropriate in light of this.

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

Author: Jessica Hargreaves, Deputy Trust Secretary
Date:23.03.2021

NHS
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NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Quality Committee Board Summary Report

Agenda item 21.2 and paper number 18b

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

Purpose: Information

Date of meeting: Wednesday 31st March 2021

1. Summary

Quality Committee meetings were held on 20th January 2021 and 17th March 2021. Key items to note from these meetings include:

2. 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. The Committee discussed and acknowledged the key risks and issues being faced by the Trust in the second surge and noted the planning in progress to commence recovery and restart services suspended during the pandemic. The Committee were reassured that the executive team were managing the risks associated with the recovery phase and surge planning as far as is possible given the rapid and continuing changes in the situation. The Non-executive directors thanked the executive team for their dedication and hard work throughout each stage of the pandemic.

The Committee noted the Trust had commenced the covid-19 vaccination programme. 81% of frontline staff had received the covid-19 vaccine.

3. Outpatients Reset & Recovery

The Committee noted that in response to Covid-19, there was a requirement to provide virtual appointment slots but no immediate ability to rebuild clinic templates to include a different set of appointment types for patients to select. This had led to a number of patients receiving incorrect information about their appointment.

The Committee were pleased to note the work undertaken by the Women's, Children's & Clinical Support Division to rebuild clinic templates as part of the Trust's response and recovery work in the outpatients department. This would ensure that patients are booked into the appropriate appointment type and therefore receive the appropriate corresponding communications. The Committee noted that at the onset of the pandemic, a large number of changes had to be made rapidly in response, and the current challenge would be to retain the best of these changes, and remove those aspects which it transpired after the event had worked less well; the changes would vary considerably between specialities.

The Committee also noted an update on the outpatient's transformation programme, with the aim of transforming the model for outpatient services in the future.

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4. Key Divisional Quality Risks

The Committee noted the key divisional and corporate risks which were largely focused on the reset & recovery following the second surge of Covid-19.

5. Month 10 Performance Scorecard (Quality)

The Committee noted the quality aspects of the performance report.

6. 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 (refer to Reading Room papers).

7. Infection Prevention & Control and Antimicrobial Stewardship Quarterly Report

Committee members received the quarterly infection prevention and control report and noted that nine of Trust attributed C. difficile cases had been reported in quarter 3; this was a decrease on previous quarters. The Committee were pleased to note that the Trust was on target to meet its 10% year on year reduction in Trust attributed E coli bloodstream infections.

8. Update on Ockenden Report assurance progress

The Committee received an update on the Ockenden assurance progress report and noted that the Trust had provided an immediate response to NHS England on 21 December 2020. The Committee noted that a peer review process led by NHS England was in progress. Formal feedback on the final review was expected by the 19 March 2021.

9. CNST Maternity Incentive Scheme

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

10. Regulatory Compliance report

The Committee received the regulatory compliance report noting that the CQC had published a consultation on its regulatory strategy to come into effect in 2021. The revised strategy signalled a proposed change in approach, moving away from trust-wide inspections to more focused inspections, based on risks or national priorities, and leading to more dynamic changes in ratings.

Committee members noted that the Improving Care Programme Group (ICPG) had been suspended during the pandemic but had a 'soft' relaunch on 9 March 2021with the full ICPG restarting from April 2021. The focus of ICPG would be to align the CQC standards with the Trust Quality Improvement team priorities, to support clinical services in ensuring continual improvement in quality.

11. Research report

The Committee noted the progress of various clinical research initiatives and areas of key focus. The Committee congratulated all those who had contributed to the quite extraordinary recruitment of patients to research studies.

12. Recommendation(s)

Trust Board is asked to note this summary.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Summary report from the Remuneration and Appointments Committee

Agenda item 21.3 and paper number 18c

Non-Executive Director and author: Peter Goldsbrough, Non-Executive Director (Committee Chair) and Ginder Nisar, Deputy Trust Secretary

Purpose: For noting.

Meeting date: 31st March 2021

Executive summary

1. Introduction

1.1. In line with the Remuneration and Appointments 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.

2. Purpose of this report

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

3. Summary report

3.1. Since its last meeting in July 2020, the Committee met on 2nd and 24th March 2021 and the following items were discussed:

3.1.1. The Committee considered and approved the remuneration for Chief Executive and Executive Directors.

3.1.2. The Committee approved the Chair's recommendation of the Chief Executive's performance assessment 'outstanding' and rating of 'A' which would be submitted to NHS England and Improvement (NHSEI).

3.1.3. The Committee noted the substantive appointment and remuneration for the Chief Financial Officer.

3.1.4. The Committee agreed the approach for the appointment of a Chief Operating Officer with the recommendation this role becomes a voting Board Director.

3.1.5. The Committee received feedback from the Chief Executive on the Executive Director appraisals and the objective setting process.

3.1.6. The Committee also agreed recommendations regarding remuneration for Very Senior Managers.

3.1.7. The Committee noted the approach to succession planning for Executive positions.

3.1.8. The Committee received the annual Trust Board composition report.

3.1.9. The Committee noted the establishment of the People Committee and its Terms of Reference.

3.1.10. The Committee approved the annual review of the Remuneration and Appointments Committee Terms of Reference.

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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

Ginder Nisar, Deputy Trust Secretary
25 March 2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Finance, Investment & Operations Committee report

Agenda item 21.4 and paper number 18d

Author and lead Executive Director: Jessica Hargreaves, Deputy Trust Secretary
Dr Andreas Raffel, Non-executive Director

Purpose: For information

Meeting date: 31 March 2021

1. Summary:

The Finance, Investment & Operations Committee held meetings on 20 January 2021 and 24 March 2021. Key items to note from these meetings include:

1.1 Response and recovery update: The Committee received an update on the Trust's response and recovery process for restarting services following the pause of all but the most urgent activity as a response to the second surge of the Covid-19 pandemic in December 2020 to the end of February 2021. A key focus for the Trust is how it safely and rapidly reinstates the services that were paused, starting with those of the highest clinical priority. The Committee discussed the plan and timescales to get services back up and running. Committee members agreed that it was important that the restarting of these services including a focus on the wellbeing of staff and would dovetail with a careful, staged de-deployment of those supporting the Trust's critical care units. The recovery process continued to be overseen by a sub-group of the Executive Management Board.

1.2 Finance report and business planning update: The Committee received the finance report for month 10 and was reminded that for October 2020 to March 2021 the Trust had agreed a £15.8m (deficit) plan with the ICS based on the divisional month 5 position plus agreed additional costs including the expansion of the ICU permanent bed base, endoscopy & imaging. This position did not include the effect of the second surge. The Trust reported that year to date it had met its plan (£7.8 deficit) and was on track to meet the agreed forecast deficit for the year. The additional costs to support the Covid response had been offset by additional income and the reduction in expenditure in non-Covid activity. Committee members noted that all additional costs relating to Covid were taken to the daily executive huddle for review and approval.

The latest update from the national team was that additional funding would be allocated to deal with the loss of non-NHS income which if fully funded, would equate to £15.8m and move the Trust to a break even position. In addition the Trust was required to account for any annual leave entitlement not taken at the end of the financial year. For 20/21 the Covid response had meant that the number of days had increased to an average of 7 days per person equating to £14m of additional cost. This cost had been agreed as an allowable miss against plan and would be partially mitigated by additional income and cash; a payment of £11.2m (5 days/80%)

was received in March. The final funding for both these items would be finalised before year end.

The Committee was also sighted on the principles/assumptions the national team were looking to apply with regards to the 2021/22 planning round. This included the construction of funding envelopes; payments and contracts; capital funding and a set of indicative planning timelines and submissions thereof. As a NWL ICS a high level initial financial plan had been developed however this was embryonic and continued to be refined as new guidance was made available. In the meantime the Trust was also commencing an internal micro business planning exercise to assess the level of activity deliverable within the cost base incurred in quarter 3 of 2020/21 (start position for roll forward funding in 2122). This would provide a better understanding of the gap to revised activity trajectories and the additional cost 'ask' to mitigate any under-delivery. The Committee debated the expectations with regards to the achievement of previously issued control totals and the efficiency gains required in 2021/22 and noted this would be better understood once the detailed guidance was received.

1.3 Hotel services: The Committee reviewed the summary of the review of hotel services which sought to evaluate how bringing hotel services in-house had impacted on quality of service, morale and wellbeing of both Trust and hotel services staff as well as patient experience.

1.4 MRI hubs business case: The Committee considered the business case for the establishment of two interim MRI Hubs at Ealing Hospital and West Middlesex Hospital. This will be discussed further by the Trust Board on 31 March 2021.

1.5 National cost collection submission: The Committee reviewed the Trust's approach and process for the 2019/20 National Cost Collection (NCC) submission. It was noted that the NCC comprises aggregated unit costs of providing defined services to NHS patients, and patient-level costs based on the specific interventions a patient experiences. All NHS provider Trusts were required to submit an NCC on an annual basis; results were published nationally with each trust benchmarked against peers and the national average and the Committee would review the results once available. Committee members noted that the costing system would be re-launched over the coming months to improve the Patient Level Information Costing Systems (PLICS).

1.6 Payroll consolidation update: The Committee received an update on the proposed consolidation of payroll service noting that a detailed project plan would be developed by end of March 2021. It was agreed that the Committee would receive regular updates as to how the work was progressing including issues, opportunities, and exit strategies should they be required.

1.7 Summary of business cases approved by the Executive: The Committee received and noted the business cases that had been approved by the Executive.

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

Author: Jessica Hargreaves, Deputy Trust Secretary
25.03.2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Report from the Redevelopment Committee on 16th December 2020, 17th February and 10th March 2021

Agenda item 21.5 and paper number 18e

Author and lead Executive Director: Philippa Beaumont, EA to the Chair/Paula Vennells, Trust Chair and Committee Chair

Purpose: For noting

Meeting date: 31st March 2021

Summary

The Redevelopment Committee held meetings on 16th December 2020, 17th February and 10th March 2021. Key items to note from these meetings include:

1. The Programme Director's reports to the Committee meetings highlighted updates on key activities which included the St Mary's SOC re-submission, project planning, commercial, communication and stakeholder engagement and budget.

2. Preliminary work and key milestones have been established to develop a master plan and strategic case for Charing Cross and Hammersmith Hospitals. Phase 1 of the master planning work commenced.

3. The Committee on 16th December 2020 received a report on the Benefits Cost Ratio, an update on J Block, the SOC re-submission and potential decant options for St Mary's Hospital.

4. The Committee on 17th February 2021 received a separate report on the SOC re-submission, potential decant options in relation to Paddington Square and a report on communications and engagement activities to support the redevelopment programme.

5. The Committee on 10th March 2021 received the strategic roadmap, which set out the key milestones for redevelopment activities, and a paper which outlined the Trust's approach to developing a life sciences proposition. The Committee also received feedback from a Roundtable meeting on 5 March 2021.