Imperial College Healthcare NHS Trust

Trust Board – Public

Wednesday, 16th March 2021, 11.15am to 1.30pm (11am to 11.15am 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
1115	**1.**	**Opening remarks**	Bob Alexander	Oral
	2.	**Apologies:** Peter Goldsbrough	Bob Alexander	Oral
	3.	**Declarations of interests** If any member of the Board has an interest in any item on the agenda, they must declare it at the meeting, and if necessary withdraw from the meeting.	Bob Alexander	Oral
1120	**4.**	**Minutes of the meeting held on 19th January 2022** To approve the minutes from the last meeting	Bob Alexander	01
	5.	**Record of items discussed in Part II of Board meetings held on 19th January 2022 and the Trust Board Seminar held on 23rd February 2022** To note the report	Bob Alexander	02
	6.	**Matters arising and review of action log** To note updates on actions arising from previous meetings	Bob Alexander	03
1125	**7.**	**Patient Story** To note the patient story	Janice Sigsworth, Guy Young	04
1140	**8.**	**Chief Executive Officer's Report** To receive an update on a range of activities and events since the last Trust Board	Tim Orchard	05
Operations / Performance				

1155	**9.**	**Integrated Quality and Performance Report** To note month 10 performance	Claire Hook Julian Redhead	06
Quality				
1205	**10.**	**Infection Prevention and Control Quarterly Report** To note the quarter 3 report	Julian Redhead	07
1210	**11.**	**Infection Prevention and Control Board Assurance Framework** To note the self-assessment for February 2022	Julian Redhead	08
1215	**12.**	**Learning from Deaths Quarterly Report** To note the quarter 3 report	Julian Redhead	09
1225	**13.**	**National Patient Safety Strategy Implementation Update** To note the plans to take the outstanding work forward	Julian Redhead	10
1235	**14.**	**Board Summary Report: Quality Committee, 9th March 2022** To note the summary report	Andy Bush	11
Finance				
1240	**15.**	**Finance report** To note the month 10 report	Jazz Thind	12
1250	**16.**	**Board Summary Report: Finance, Investment and Operations Committee, 9th March 2022** To note the summary report	Andreas Raffel	13
People				
1255	**17.**	**Annual Nursing and Midwifery Establishment Report** To note the annual establishment findings and the ongoing work	Janice Sigsworth	14
1305	**18.**	**Board Summary Report: People Committee, 8th March 2022** To note the summary report	Sim Scavazza	15
Governance				
1310	**19.**	**Approach to Board effectiveness and planning for Committee annual reports**	Peter Jenkinson	Oral
	20.	**Board Summary Report: Audit, Risk and Governance Committee, 10th March 2022** To note the summary report	Kay Boycott	16
1320	**21.**	**Board Summary Report: Audit, Risk and Governance; Finance, Investment and Operations; Redevelopment Board**	Bob Alexander	17

		Governance 'Lite' Committee, 2 February 2022 To note the summary report		
Other Committees				
1320	**22.**	**Board Summary Report: Redevelopment Board Committee, 8th March 2022** To note the summary report	Bob Alexander	18
1325	**23.**	**Any other business**	Bob Alexander	Oral
	24.	**Questions from the public**	Bob Alexander	Oral
1330 Close	**25.**	**Date of next meeting** 25th May 2022, 11am		

Updated: 10 March 2022

Imperial College Healthcare NHS Trust

Public Trust Board
Minutes of the meeting held on 19th January 2022, 10.45am
Virtual meeting held via Microsoft Teams and video-recorded.

Members present

Mr Bob Alexander	Acting Chair
Dr Andreas Raffel	Non-Executive Director
Mr Nick Ross	Non-Executive Director
Mrs Kay Boycott	Non-Executive Director
Mr Peter Goldsbrough	Non-Executive Director
Ms Sim Scavazza	Non-Executive Director
Prof. Andrew Bush	Non-Executive Director (partial attendance)
Prof. Tim Orchard	Chief Executive
Prof. Julian Redhead	Medical Director
Prof. Janice Sigsworth	Director of Nursing
Mrs Jazz Thind	Chief Financial Officer
Mrs Claire Hook	Chief Operating Officer

In attendance

Dr Ben Maruthappu	Associate Non-Executive Director
Ms Beverley Ejimofo	Associate Non-Executive Director
Mr Peter Jenkinson	Director of Corporate Governance
Mr Kevin Croft	Chief People Officer
Dr Matthew Tulley	Director of Redevelopment
Dr Bob Klaber	Director of Strategy, Research & Innovation
Mr Jeremy Butler	Director of Transformation
Mr Kevin Jarrold	Chief Information Officer
Mr Hugh Gostling	Director of Estates and Facilities
Ms Michelle Dixon	Director of Communications
Mr Raymond Anakwe	Medical Director
Prof. TG Teoh	Divisional Director, Women, Children and Clinical Support
Prof. Frances Bowen	Divisional Director, Medicine and Integrated Care
Prof. Katie Urch	Divisional Director, Surgery, Cancer and Cardiovascular
Prof. Jonathan Weber	Dean of the Faculty of Medicine, Imperial College London
Mr James Price	Director of Infection Prevention and Control
Mrs Ginder Nisar	Deputy Trust Secretary (minutes)

Apologies

Ms Saghar Missaghian-Cully	NWL Pathology Managing Director

Item	Discussion
1. 1.1.	**Opening remarks** Mr Alexander welcomed everyone to the meeting which was held virtually and where in person, was in keeping with social distancing guidelines for the NHS. 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.	In line with NHS England guidance, the Trust has been in 'governance-lite' mode during January 2022, to free up resources to respond to the operational pressures faced during December 2021 and January 2022. During that period, the Non-Executive Directors have been kept updated on the situation and Trust response and have held a combined Board Committee meeting focusing on quality and people issues, in order to maintain our assurance mechanisms for essential business. In that context, the Trust Board meeting has been shortened to focus on essential regulatory requirements and the key operational and quality issues arising during this period.
1.3.	Mr Alexander explained that while the current national Covid restrictions remain in place in NHS premises, including social distancing and Covid-secure protocols, the Trust would not be holding face to face Board meetings in order to keep patients, visitors and staff safe. Therefore the Trust Board meetings will continue to be held virtually until April 2022, however, this will be kept under review.
2.	**Apologies** Apologies were noted from those listed above.
3.	**Declarations of interests** There were no additional declarations to those disclosed on the Trust's register of interests.
4.	**Minutes of the meeting held on 10th November 2021** The minutes of the previous meeting were agreed.
5.	**Record of items discussed in part II of the Board meeting held on 10th November 2021 and the Trust Board Seminar held on 8th December 2021** The Board noted the summary of confidential items discussed at the confidential Board meeting held on 10th November and the Trust Board Seminar held on 8th December 2021**.**
6.	**Matters arising and actions from previous meetings** Updates against the actions arising from previous meetings were noted on the action register.
7.	**Chief Executive Officer's report** 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.
7.1.	**Operational update – Covid and winter pressures**
7.1.1.	The Trust, like other hospitals in London, had seen an increase in the number of patients with Covid during December 2021 and into January 2022 as well as a more general increase in operational pressures. On 16th December 2021, the Trust had moved to a site-based 'gold command' operational management structure. As at 18th January 2022, the Trust was treating 197 patients who had tested positive for Covid-19 on their current admission (including patients admitted for unrelated issues who we then discovered were positive on routine testing), of whom 135 were positive at their last test. The Trust peaked at 230 Covid positive patients. The Trust currently has 20 Covid positive patients in ICU of whom 12 were ventilated. For context, the Trust was caring for 492 in-patients who had tested positive on their current admission on 20th January 2021 with 122 patients in critical care. The recent rise in numbers had not translated into significant increased demand for critical care.
7.1.2.	The Trust had experienced an increase in Covid-related staff absences, on top of ongoing staff shortages in some areas. Total sickness levels (Covid and non-Covid related) had reached 6.8 per cent at the beginning of January 2022 but had dropped to 5.5 per cent, as at 11th January 2022, The Trust had asked some staff to move temporarily to support areas that were especially challenged, and staff in some areas had been able to move annual leave or work additional shifts. For context, at the peak of the second wave of hospital admissions, total staff absences were at 8 per cent and, in the first wave, up to 16 per cent.

7.1.3.	Attendances to Trust A&E departments rose rapidly as the Trust moved out of the last wave of Covid-19 infections with 20 per cent more patients in September 2021 compared with the same period pre-pandemic. This increase continued through October and November 2021 and, although attendances had fallen in December 2021, the Trust continued to be busy. The Trust had invested significantly in extra staffing and other initiatives to support effective operational flow. In terms of planned care, although the Trust limited some non-urgent planned surgery for the first half of January 2022, it maintained its diagnostic and care pathways for patients who have, or may have, time-critical needs or conditions, including cancer, as well as antenatal and maternity care and screening services. Although the Trust had maintained levels, there were delays in some areas, and as the Trust looks forward it would look to increase activity in response to that demand.
7.1.4.	The Omicron variant had provided some new challenges – although the Trust had not seen the number of patients in critical care increase, the transmissibility of the virus was higher than previous variants. One of the Trust priorities was to keep vulnerable patients safe, in particular those who were immuno-compromised or have a long term condition and may not have the same response to the vaccine, hence the need to restrict visiting arrangements.
7.1.5.	Teams across the Trust had been working together to enable the Trust to continue to provide safe care for everyone who needs it. The Trust had been able to separate out more areas for high risk (Covid) pathways and to create additional beds temporarily when needed. A small group of Armed Forces personnel were helping at St Mary's Hospital as the Trust responds to increased operational pressures.
7.1.6.	In addition to these operational areas of focus, the Trust was continuing to prioritise investment in staff health and wellbeing. It was expanding its staff spaces improvement programme, providing additional staff counselling sessions, rolling out free breakroom supplies for the new year and progressing with our retail food and shops transformation project. The Trust had also published a booklet with all of the emotional and practical support on offer to staff this winter.
7.1.7.	Prof. Orchard expressed his gratitude to all Trust staff for their continued hard work and flexibility in these challenging times and to patients and other stakeholders for their support and understanding.
7.2.	**Visiting restrictions -** Due to the high number of Covid-19 infections in the community, and to keep patients, staff and visitors safe, Trusts within the North West London sector had re-introduced further visiting restrictions from 31st December 2021. Ward staff continued to support 'virtual' visits and other ways of making sure patients are able to stay in touch with family and friends during their stay in hospital.
7.3.	**Covid-19 and flu vaccination programme**
7.3.1.	The Trust was continuing with its comprehensive programme to support the delivery of Covid-19 vaccines and annual flu vaccination, both for its staff and wider community. The uptake of the vaccinations for Trust staff as at 3rd January 2022 was: ▪ 61 per cent of frontline staff had received their flu vaccination ▪ 90 per cent of frontline staff have received doses one and two of the Covid-19 vaccination ▪ 87 per cent of eligible staff have received their Covid-19 booster.
7.3.2.	Uptake of the flu vaccination was 5 per cent above the London average and 3 per cent above the North West London average. Staff uptake of Covid-19 vaccines was in line with

	the London average overall, and slightly above the London and North West London averages when considering the booster vaccination alone.
7.3.3.	At the end of 2021 the Trust focused on the expansion of the Covid-19 booster programme and opened its existing vaccination centres to members of the public on 29th November 2021 and increased the capacity available in December in response to the national direction for hospital hubs to support the expedited national booster programme. From 16th to 31st December 2021, over 11,000 vaccinations were administered through the Trust's vaccination programme. Demand for vaccination had now reduced and was being met by existing Trust centres, with Trust outpatient departments back to normal working.
7.3.4.	The Trust was refocusing its efforts on supporting staff to access their annual flu vaccination, as well as all eligible Covid-19 doses. In particular, the Trust was planning the implementation of new Government legislation requiring anyone working in a role in the NHS or independent sector that involves contact with patients to be double vaccinated against Covid-19 by 1st April 2022. The Trust had made sure staff were aware of the legislation and, following anticipated further guidance from NHS England, the Trust would be writing to every staff member for whom it did not have a complete vaccination record with detailed information and guidance during the week commencing 17th January 2022. This was currently 1,100 staff, although a significant number of these staff may have been double vaccinated but the Trust does not yet have a record of their vaccination. The Trust had set up a central team to lead and coordinate the implementation of the new legislation, providing support and guidance to affected staff and their managers. The Trust had also established a dedicated helpline, promoted access to confidential one-to-one advice and support and will be holding a range of briefings as part of comprehensive communications and engagement programme.
7.4.	**Acute care programme update -** The North West London acute programme board continues to guide and oversee a collaborative and coordinated programme of developments across all of our key operational areas. The effectiveness of our response to the latest surge of the Covid pandemic has demonstrated that we continue to harness our collective resources, join-up our care and reduce unwarranted variations in access and outcomes. The immediate focus of the acute programme over the past two months had been on our collective response to the latest surge, including maintaining planned activity and ensuring sufficient bed capacity, appropriate discharge and responding to staff shortages.
7.5.	**Financial performance**
7.5.1.	The Trust had agreed a break-even plan for the year with the North West London Integrated Care System. This was based on an agreed block income value with the Trust continuing to be funded for additional elective activity through the national Elective Recovery Fund (ERF). As part of the planning process, the Trust had agreed a £31.5m efficiency target to achieve the break-even plan.
7.5.2.	At the end of the first eight months of the financial year, the Trust achieved a break-even position against a break-even plan. This included £29.8m of ERF with the contribution from this income offsetting the underachievement on the efficiency requirement, Covid costs in excess of funding received and other expenditure agreed as appropriate to support service recovery. The Trust continued to forecast a break-even position and was closely tracking this position alongside identifying and developing schemes to deliver recurrent waste reduction.
7.5.3.	The capital plan for the year is £87.2m of which £28.0m is funded through grants and donations giving a £59.2m Capital Resource Limit (CRL). Year to date the Trust has spent £22.7m (69%) against the CRL and expects to meet its CRL for the year.

7.5.4.	As at 30 November 2021, cash was £221m and, based on the current regime, the Trust expected to maintain a healthy cash balance in the medium term.
7.5.5.	Operational planning guidance for 2022/23 had been issued on 24th December 2021. The ICS with provider organisations was working through this guidance and how the application of this, and any local assumptions and principles, impacts provider funding allocations. In the absence of any detailed financial guidance the Trust has started to develop its draft operational, workforce and financial plan and will be taking this through the internal governance processes over the coming months.
7.6.	**CQC update -** The Trust's routine engagement meeting in January 2022 had been cancelled due to the CQC suspending its routine activity for at least this month in response to Trusts being mandated to redirect resources to support the vaccination programme and the response to the latest surge. The Trust continued to provide appropriate assurance to the CQC regarding the quality of care being provided during this challenging period.
7.7.	**Maternity assurance report -** The Trust provided oversight of quality assurance within the maternity service via a report to each Quality Committee meeting. This included assurance on the progress on achieving compliance with the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme as well as key issues relating to the quality and safety of the maternity service. The Quality Committee had reviewed the detailed maternity assurance documentation in January with assurance gained about the management of risks, incidents and key metrics. Specific highlights to note were that NHSE/I had confirmed Trust achievement of 100 per cent compliance with the submission required following the Ockenden review. The Board commended the result which was a testament to the hard work of the teams involved. Recent neonatal mortality data showed that the Trust's adjusted rate was lower than average and lower when compared to peer Trusts.
7.8.	**Redevelopment**
7.8.1.	The lead of the New Hospital Programme (NHP), Natalie Forrest, with members of the NHP team visited St Mary's Hospital in December 2021. They confirmed support for redevelopment at St Mary's, Charing Cross and Hammersmith hospital, are all included in the national programme. It was anticipated the timescale for the St Mary's redevelopment would be clearer in Spring 2022 when the NHP had finalised the programme business case. In anticipation of the next stage of work, the Trust was undertaking a planning exercise to understand the scale of the total development opportunity on the St Mary's site, including developments on land that would no longer be required for clinical services due to more efficient use of the whole campus. The Trust was engaging closely with Westminster City Council on this work.
7.8.2.	In December 2021, the Trust had been awarded funding to progress with further initial planning work for redevelopment/refurbishment at Charing Cross and Hammersmith hospitals. The Trust hoped to start this work shortly and complete it by the summer.
7.9.	**Temporary relocation of some Western Eye services -** Following a review of safety at the vacant Samaritan Hospital, adjacent to the Western Eye Hospital, the Trust had taken the precaution of immediately relocating some services from the Western Eye while more detailed investigations, and anticipated remedial works, take place. Following receipt of the safety review, the Trust had closed all areas of the Western Eye most at risk, including the lower ground, second and third floors, and put in place a team of 24/7 fire wardens to patrol the two buildings. Trust staff were working hard to minimise the impact on patients and to resolve the situation as soon as possible. The Trust's intention continued to be to sell the Samaritan and Western Eye buildings together to maximise the income to be

	reinvested in the redevelopment programme. It would be disproportionally expensive to bring the Samaritan building back into use, therefore the Trust constantly maintains the Western Eye Building and has made the Samaritan building as weather tight and secure as possible.
7.10.	**Research**
7.10.1.	Following submission of the competitive re-application for our National Institute for Health Research (NIHR) Biomedical Research Centre (BRC), interviews had been confirmed for early April 2022. There are 20 BRC's in England, each of which is a 5-year programme of funding to provide infrastructure for early-phase, experimental medicine research. Outcomes would be announced in summer 2022. Feedback from the most recent BRC annual report was very positive, and the Trust was given a green RAG-rating for overall progress against delivery of its objectives.
7.10.2.	Two other NIHR research infrastructure programmes the Trust hosts (the renamed NIHR Patient Safety Research Collaboration and NIHR Clinical Research Facility were also undergoing re-application, with outcomes to be confirmed within the next 6 months. Despite the challenges of Covid-19, the Trust continues to deliver most of its existing clinical research studies across all specialties. The Trust has increased revenue (£5.5m) and overhead income (£1.03m) from commercially-sponsored clinical trials to their highest ever position (as of M8).
7.10.3.	The Trust was notified of two new NIHR grant awards. Jennifer Crow, Clinical Specialist Occupational Therapist in Stroke and Juliet Albert, Specialist FGM (female genital mutilation) Midwife, were both awarded NIHR Clinical Doctoral Research Fellowships, which each provide up to 3 years of salary and project funding for registered healthcare professionals to undertake a PhD by research and, concurrently, to undertake further professional development and clinical practice. This reflects the Trust's recent emphasis and strategic focus on developing the academic/research careers of Nurses, Midwives, Allied Health Professionals, Healthcare Scientists, Pharmacy Staff and Psychologists.
7.11.	**Equality, diversity and inclusion update**
7.11.1.	The first cohort of the Calibre programme had completed the leadership programme for staff with disabilities. Calibre is a talent development and leadership programme for people who identify as neurodiversity or disabled, or who have a long-term physical or mental health condition. The programme had been developed and delivered by Dr Ossie Stuart, an international disability consultant and academic. A virtual ceremony had been held for the successful graduates, who were joined by representatives from NHS England, and the Trust's EDI Team, hosted by I-CAN staff disability network joint executive sponsors, Professor Katie Urch and Peter Jenkinson.
7.11.2.	As part of the Trust's continued commitment to disability inclusion, it recently held the first training workshop session delivered by the Department for Work and Pension Advisory Group. The responses from managers who attended the programme was positive and a further session would be delivered this year.
7.11.3.	Sim Scavazza, Non-Executive Director, has successfully secured a place on one of three cohorts of the London Workforce Race Equality Standard Advisors programme.
7.12.	**Stakeholder engagement -** A summary of significant meetings and communications held with key stakeholders since the last Trust Board meeting were outlined in the main report.
7.13.	**Chief executive of North West London Integrated Care System -** Rob Hurd had been appointed as Chief executive of the North West London Integrated Care System (ICS). He has held a similar role in the North Central London ICS where he has been on secondment

	from his role as Chief executive of the Royal National Orthopaedic Hospital NHS Trust, jointly leading the North Central London response to the pandemic in partnership with local authorities. He has formally taken up his role this month, taking over from Lesley Watts who had successfully combined her role as Chief executive at Chelsea and Westminster NHS Foundation Trust with being interim ICS Chief executive.
7.14.	**Recognition and celebrating success –** Prof. Orchard was pleased to announce the following recognitions and appointments:
7.14.1.	Dr Justin Roe, Clinical Service Lead at the national centre for airway reconstruction at the Trust, was awarded an MBE in the New Year's Honours for services to speech and language therapy, particularly during Covid-19. Professor Peter Openshaw, Professor of Experimental Medicine at Imperial's National Heart and Lung Institute and honorary consultant physician, also received a CBE for services to medicine and immunology.
7.14.2.	Amongst other notable colleagues of Imperial College London, Professor Wendy Barclay, Head of Imperial College London's Department of Infectious Disease and Chair in Influenza Virology, had been awarded a CBE for her contributions to the study of viruses and her research during Covid-19.
7.14.3.	Professor Onn Min Kon had been appointed president-elect at the British Thoracic Society (BTS). Professor Kon is recognised as one of the UK's leading authorities on the management of complex and multidrug-resistant tuberculosis.
7.14.4.	Lloyd Nunag, team leader for the surgery and oncology research team, had become the first ever nurse to be awarded the prestigious Schwarzman Scholarship; and Claire Hardiman, Head of radiation physics and radiobiology, has been awarded the President's Gold Medal for Exceptional Service by the Institute of Physics and Engineering in Medicine.
7.15.	Comments and questions from the Non-Executive Directors:
7.15.1.	Mr Alexander commended the achievement of 100 per cent compliance with the submission required following the Ockenden review and the research activity and achievements, against the backdrop of the operational challenges faced by the Trust.
7.15.2.	Prof. Bush echoed the impressive achievements and award of the NIHR PHD fellowships which were very competitive and something to be very proud of.
7.15.3.	In response to a question from Mr Alexander in respect of 2022-23 business planning and the addition of an ICS sector layer, Prof. Orchard advised that as a sector and as an acute collaborative, organisations must have a view of the requirements of the whole sector as it tackles the inequalities in healthcare. He advised that every healthcare organisation should have an understanding of what it expects to provide and how it will be remunerated and how the backlog will be tackled – this was being worked through. As a sector he stated that we need to maximise opportunities through collaboration to reduce the backlog. An outline would be available for Board input during February and March 2022.
7.16.	**The Board noted the report.**
8.	**Integrated quality and performance report**
8.1.	The Board received the integrated quality and performance report for month 8, summarising performance against the key performance indicators for data published at November 2021.
8.1.1.	The current wave of Omicron had impacted performance across a number of key metrics.

	In relation to elective recovery, the overall volume of outpatient attendances and elective spells reduced overall for December 2021 as a whole and the trajectories were not met.
8.1.2.	The total size of the Referral to Treatment (RTT) waiting list increased above trajectory. Whilst the 52 week wait recovery plans continued to be met for November 2021, the forecast was that the reduction requirement for December 2021 would not been achieved. The number of patients waiting over 2 years for elective treatment reduced and is forecast to meet the December 2021 target.
8.1.3.	Overall 12 hours waits within the emergency department increased, reflective of increasing pressures on urgent and emergency care pathways.
8.1.4.	In terms of ambulance handover performance, although not at the required level, performance was good in terms of performance across London. While it is as part of the care the Trust provides to its patients, over the last few weeks the Trust had contributed to the wider ambulance system as it operates under considerable pressure. Mrs Hook commended the teams involved for achieving good performance.
8.1.5.	Prof. Redhead advised that Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMIs) had remained low. Incident reporting numbers continue to rise which allows the Trust to keep harm at a low level through a high reporting culture. The Trust continues to work through the never events action plan.
8.1.6.	Mr Alexander added that the Governance 'Lite' Board Committee held on 13th January 2022 had a thorough focus on quality and people items.
8.2.	**The Board noted the report.**
9.	**Trust Board Committees – summary reports**
9.1.	**Governance 'Lite' Quality and People Board Committee, 13th January 2022**
9.1.1.	The Board noted the summary report from the Governance 'Lite' Committee which focused on Operational Sitrep including Covid-19 & Vaccine update; Waiting Lists – Maintaining safety of patients on the waiting list; Quality Performance Report; Maternity Quality Assurance Oversight Report; Infection Prevention & Control (IPC) Board Assurance Framework for COVID-19 self-assessment; and a report covering key aspects of people and OD.
9.1.2.	Ms Scavazza added that the general consensus from the meeting was how well the Trust had dealt with and supported staff, and how positively the support had been received; and the learning from what had been put in place.
9.1.3.	Prof. Bush was pleased to see that incident reporting had increased and the Committee received additional assurance in regard to antibiotic stewardship.
9.1.4.	Mr Ross, in his role as Non-Executive Director champion for Freedom to Speak Up, advised that following a Whistleblower meeting held at the Trust, it was felt more needed to be done to help people to speak up, especially during the pressures of the pandemic. He suggested hearing from staff on issues at Board level. It was agreed Mr Ross, Mr Alexander, Prof. Orchard and Mr Jenkinson would discuss further and how best to address the issues. **Action: Mr Ross, Mr Alexander, Prof. Orchard, Mr Jenkinson**
10.	**Any other business** No other business reported.
11.	**Questions from the public** The following two questions were received from two members of public, in advance of the meeting:

11.1.	**Covid-19 and Flu Vaccination Programme -** We have followed closely the actions taken by Imperial to encourage the uptake of both covid and flu vaccinations by staff at Imperial. We would want to congratulate the Trust for this positive work undertaken and for the encouraging results, particularly for covid. However, with the new legislation, it seems clear that a significant number of staff may have their employment terminated at the end of March 2022. How will the Trust cope with the possible loss of a significant number of staff at one time? What contingency plans are in place? And what areas of provision might be most affected? How will the Trust continue to publicise and encourage staff to also have the flu vaccination?
11.1.1.	Prof. Orchard referred to his report above and advised that it is a legal requirement for staff to be double vaccinated by 1st April 2022. It is important for healthcare staff to be vaccinated for their own protection and for the patients they service. There is an important role to minimise infections for patients and staff themselves adhering to IPC and PPE measures. As indicated in the CEO's report, the Trust was working through the 1,100 staff for whom the vaccination status was unknown and work was underway to contact those staff to determine their vaccination status. The revised data would be available in mid-February which would allow detailed contingency plans to be developed for the areas identified to be impacted more than others in terms of staffing. However, the Trust had been over recruiting in some areas which would provide some reliance. Efforts continue to educate reluctant staff on the benefits of the vaccination and addressing their concerns.
11.2.	**Dealing with the backlog and staff exhaustion -** Noting the updates provided, given the increasing number of patients needing treatment who are unable to be seen (backlog), how confident is the Trust that staff can continue to work under extreme pressure despite tiredness, stress and possible burn-out? What is the ongoing support given to staff who are under such pressure? How is the effectiveness of this support assessed?
11.2.1.	Prof. Orchard commented that this has been a period of unprecedented pressure on staff. Whilst he has been walking around the Trust's hospitals and talking to staff, he noted that staff found the run up to the Omicron wave difficult as they anticipated similar pressures to the previous waves, recognising the first wave was significant as it was the first time anyone had to deal with such an event. However, there had been a sense of relief as the Omicron wave was not like the previous waves and importantly, people had not died the way they did in the first wave. The Trust recognises that people process traumatic events in different ways and at different speeds therefore the Trust has put different support packages in place to allow people to process their emotions at their own pace. Staff have been encouraged to take their annual leave and efforts continue to make the environments in which staff work as pleasant as possible. The Trust and staff recognise that there is a significant backlog to work through – and management will ask people to only do what is reasonable. Mr Croft added that last year, the appraisal discussions were converted to discussions about health and wellbeing and the support staff needed, the same approach would be adopted for this year. Mr Alexander added that he and Non-Executive Directors were supportive of what the Executive Team have and continue to do, which was commendable.
11.3.	The member of public thanked the staff and management for all that they do which was commendable during this challenging time.
12.	**Date of next meeting** 16th March 2022, 11am

Updated: 9 February 2022

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Record of items discussed at the confidential Trust board meeting held on 19th January 2022 and the Board Seminar held on 23rd February 2022

Agenda item 5 and paper number 02

Executive Director: Professor Tim Orchard, Chief Executive
Author: Peter Jenkinson, Director of Corporate Governance and Ginder Nisar, Head of Trust Secretariat

Purpose: For information

Meeting: 16 March 2022

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. Some items may be excluded on the grounds of commercially sensitive or confidentiality.

1.2. The Trust Board has met in private on two occasions since the last meeting on 19 January 2022 and the Trust Board Seminar on 23 February 2022.

19th January 2022 Private Trust Board

2. Chair's briefing

As part of the Chair's oral update, the Board received an update on the recruitment of the Chair-in-common for north west London (NWL) acute providers and the statement of intent for the acute collaborative programme.

3. Chief executive's update

The Chief Executive provided an oral update on Covid-19 and the Trust's operational position. With the number of Covid-positive patients slowly decreasing in all age groups, attention was turning to recovery of 'business as usual' activity, including increasing the elective programme. A&E performance was also improving and focus was on discharges. An update was also provided on staff vaccinations, including implementation of the legislation relating to vaccination as a condition of deployment.

23 February 2022 Board Seminar

4. The Board received an update on key Trust issues and strategic updates, including an update on operational management, performance and business planning. The Board also received an update on the appointment of a Chair-in-common for NWL acute providers. The Board considered how the Trust is developing its strategy around the use of data environments and digitally-enabled change; while working in partnership with NWL ICS and London region. The Board received a presentation from the Improvement Analytics Team at NHS Improvement on building the Board's understanding of how decision making can be improved through better analysis and presentation of data.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC) - ACTION POINTS REGISTER, Date of last meeting 19 January 2022

Updated: 9 March 2022/GN

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	15 Sept 2021 8.10.6	CEO Report	Prof. Orchard advised that the acute care programme report was agreed by the programme, however he would give some consideration to producing an ICHT specific report to include the resource commitments and rationale. November 2021 update**:** A programme report would be produced quarterly and Trust colleagues were discussing how best to provide an ICHT bespoke report/summary. January 2022 update: This action has been deferred due to operational priorities but will be picked up for the next board meeting. **March 2022 update:** The latest acute programme report has been shared as an appendix to the Chief executive's report. Further work is required to consider a trust specific report. This will be considered as part of the development of the governance arrangements for the acute provider collaborative.	Prof. Orchard, Mr Jenkinson	March 2022
2.	19 Jan 2022 9.1.4	Staff speaking up	Mr Ross, in his role as NED champion for FTSU, advised that following a Whistleblower meeting held at the Trust, it was felt more needed to be done to help people to speak up, especially during the pressures of the pandemic. He suggested hearing from staff on issues at Board level. It was agreed Mr Ross, Mr Alexander, Prof. Orchard and Mr Jenkinson would discuss further and how best to address the issues. **March 2022 update:** Staff stories have now been introduced to the People Committee, and People Committee will continue to oversee the development and implementation of the Freedom to Speak Up strategy.	Mr Ross, Mr Alexander, Prof. Orchard, Mr Jenkinson	March 2022

3.	15 Sept 2021 16.10	EDI Annual Report	Mr Alexander requested that the wider Board receives an update on the prioritisation of work. Ms Scavazza concurred and advised that once progress had been discussed and agreed at the People Committee, a summary on priorities and metrics, including risks of not achieving some metrics and timings would be shared with Trust Board. January 2022 update: A workshop to review the Trust's EDI strategies with external experts, People Committee members and internal stakeholders had been posted from January to February. The 2022/23 EDI programme would be presented to the March People Committee. **March 2022 update:** The Workshop was delayed due to Covid-19 and VCOD. The Workshop has been rescheduled for 27th April and will feed into the Annual People and OD plan to be presented to May People Committee.	Mr Croft, Ms Scavazza	March 2022

Items closed at the January 2022 meeting

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	10 Nov 2021 11.2.2	Maternity oversight report	Mr Alexander commented that in the context of collaborative working going forward, it was important to include Trust reporting as well as sector and he would discuss this separately with colleagues. Prof. Orchard confirmed that future reports would include denominators to enable comparison with other Trusts. January 2022 update: The Local Maternity Network System are in the process of compiling an ICS scorecard and once this has been correlated, it will be compared with the Trust's scorecard. Closed	Prof. Teoh	Closed
2.	10 Nov 2021 9.2.1	Integrated quality and performance report / Never events	In Prof. Bush's absence, Prof. Redhead and Mr Alexander would refer the oversight by the Quality Committee on never events and engagement with the Health Investigation Board as suggested by Mr Ross. January 2022 update: HSIB reports and recommendations linked to never events have been reviewed as part of this action. The most recent of these was published in January 2021 in the form of a national learning report analysing the findings of their investigations as a whole. We have compared our work to that which HSIB recommends and confirm that there are no gaps in trust level actions. There are a number of recommendations that have not yet been completed nationally including the Centre for Perioperative Care to review and revise the NatSSIPs policy to increase standardisation of safety critical steps that are common across all procedures and that the Royal College of Anaesthetists evaluate the current practices used to reduce wrong site block incidents with a view to achieving standardisation. Once guidance is released for both we will implement. The HSIB report concludes that the NHS as a whole does not have strong systemic barriers in place to prevent some of these never events from happening which NHSE/I have acknowledged. If any further barriers are identified, we will ensure that we implement them. Closed	Mr Alexander, Prof. Redhead	Closed

3.	10 Nov 2021 19.1	Questions from the public / complaints	A member of the public submitted a question in advance of the meeting: Why are complaints made to nursing staff not documented or replied to. The Complaints Team do not even bother to contact the person making the complaint. Serious matters like patient safety are also not looked into any staff say patient are adults and should take care of safety and social distancing themselves. Prof. Sigsworth provided some background and would contact the member of public and respond to his concerns January 2022 update: A patient raised a concern with the board that he had not received a response to complaints about patient safety in relation to social distancing. It has been confirmed that he has now received two formal responses to his complaints and has also had contact with PALS. He has also been able to discuss his concerns with the lead nurse for the area who will continue to manage his concerns as required. Closed	Prof. Sigsworth	Closed
4.	10 Nov 2021 19.2	Questions from the public / Visitor Policy	A member of public enquired about the visitor policy and the text on the website as well as the issues experienced when with visiting her mother who was an inpatient including, at times, a hostile approach from staff even though she and other family members had written permission to visit. Prof. Orchard and Prof. Sigsworth listened to the circumstances, apologised and agreed that the Trust needed to do more to explain the policy and apply it pragmatically and fairly as well as consistently. January 2022 update: Prof. Sigsworth called the member of the public and spoken twice to arrange for appropriate visiting. The Trust tries on every occasion to accommodate visiting whilst keeping patients and safe. Closed	Prof. Sigsworth	Closed

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

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Patient Story

Agenda item 7 and paper number 04

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

Purpose: For information

Meeting date: 16 March 2022

1. Purpose

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

1.2. The perceived benefits of patient stories are:

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

2. Introduction and background

2.1. This story will be shared by the deputy director of patient experience to highlight the importance and challenges of accessing British Sign Language (BSL) interpreters for our Deaf patients, and the difference they can make. This week is sign language week and the Trust is raising awareness about deafness and BSL during the week.

2.2. Sign language is a means of communicating using gestures, facial expression and body language. It is used mainly by people who are Deaf or to support those who have a hearing loss. In the UK, the most common sign language used is British Sign Language (BSL). It has its own grammatical structure and syntax; as a language, it is not dependent upon or related to English.

2.3. BSL was recognised by the British Government as a language on 18 March 2003. Further legislation including the Equality Act 2010 and the Accessible Information Standard 2016, have provided protection for those with disabilities, to ensure that people with disabilities are not 'at a substantial disadvantage … in comparison with persons who are not disabled' (NHSE 2016).

2.4. The BSL Bill is currently being debated in Parliament to provide protection for BSL users and to ensure that BSL is recognised, protected and promoted in law.

2.5. It is estimated that there are 11 million people in the UK who are Deaf or hard of hearing, with over 151,000 BSL users (ONS estimates 2014). The onus is on health and social care providers to ensure we have resources to provide BSL interpreters for those patients and families that need them.

2.6. We know from feedback through PALS and complaints, that access to BSL interpreters is a challenge under the current arrangements. This is compounded by a national shortage of BSL interpreters and the on-going infection prevention and control restrictions as a result of Covid-19.

2.7. This patient story highlights the challenge when trying to access BSL interpreters at short notice. However, in this particular example, the Trust was able to provide BSL support to this patient at short notice which was essential to being able to deliver the care he needed.

3. Next steps

3.1 The Trust is in the process of re-tendering the contract for interpretation. The provision and accessibility of BSL interpreters is factored into this.

3.2 The Trust is launching a programme of basic BSL and deaf awareness training for staff.

4. Recommendation(s)

4.1. The Board is asked to note this report.

5. Impact assessment

5.1. There is no impact of this paper in itself, but support to ensure that patients and their relatives are able to communicate effectively with staff irrespective of a disability is essential.

Main paper

6. Patient story

6.1. Mr K attended our Emergency department (ED) in November 2021. He is Deaf and uses BSL as his means of communicating. Mr K was supported by his son who is also Deaf.

6.2. Mr K presented with worrying neurological signs that required urgent brain scans. He had a history of visual disturbances in his right eye, deviation of the eye and being unsteady on his feet.

6.3. The ED staff needed a full medical history from Mr K as his presenting symptoms were of concern. An urgent CT scan of the brain was also required but was difficult to communicate without the presence of a BSL interpreter.

6.4. The staff tried to find access to a BSL interpreter using our current interpreting services. Staff were informed that we would not be able to get access to an interpreter for up to 48 hours. Staff did try to communicate through writing but Mr K struggles with reading and this form of communication is restrictive in terms of being able to ask questions and participate in an interactive, engaging conversation.

6.5. The ED nursing staff reached out to a number of colleagues in the trust including the learning disabilities team to try and get some support for Mr K.

6.6. A senior member of the corporate nursing team contacted the interpreting services directly. They explained the urgency of the situation and asked for this to be escalated and for a direct request to be submitted for a BSL interpreter.

6.7. Within an hour, a BSL interpreter was found and an online medical consultation was able to take place with the patient, his son and the doctor. Mr K was able to ask questions and understood the plan and need for the CT scan.

6.8. Mr K and his son were pleased that we had been able to support them in ED and felt they had had the opportunity to ask questions and understood the proposed plan of care.

6.9. The results of Mr K's scan were instrumental in determining his treatment plan and he has now recovered.

7. Conclusion and next steps

7.1. In Mr K's case the outcome was a good one in terms of getting access to a BSL interpreter, but this was only achieved with perseverance. That the need was identified by the emergency department staff and their concerns escalated shows an encouraging level of awareness.

7.2. BSL interpreters are a much sought after commodity and whilst it is usually possible to pre-book them for anticipated appointments, this story highlights that this is more of a challenge in unscheduled situations. It also demonstrates the importance of having such support available to ensure prompt, safe clinical care can be delivered and a full clinical assessment take place.

7.3. It is acknowledged that access to BSL interpreters is a national problem with a shortage of trained interpreters available. This has been compounded by Covid-19 with staff, including BSL interpreters being off sick.

7.4. Routine appointments can be planned for and, in line with the Accessible Information Standard, the need for BSL interpreters can be recorded in the patient records to facilitate future bookings for planned appointments or ward consultations. Mr K has this recorded in his records. It was the unplanned nature of this attendance that caused the issues.

7.5. Current arrangements for BSL interpreters do not provide *immediate* access for urgent or emergency situations. This story highlights that it is possible to facilitate this but it can be difficult and can result in delays at a critical time.

7.6. In line with the current legislation and potential future legislation (currently being discussed in Parliament) it is imperative that we address the issue that many NHS Trusts face in providing access to BSL services when it is needed, in real time. There are options that involve video BSL interpreters, thus providing a more flexible and responsive service. This is one option being considered. We have just kicked off a project to review our wider

approach to interpreting across the Trust – prompted to a large degree by community feedback, with a significant expansion of our engagement with our communities during the pandemic We have pushed back the retendering of our existing interpreting service contract to enable this project to be undertaken and inform our overall approach.

7.7. In December 2021 the Trust delivered some pilot Deaf awareness training that included basic BSL instruction to around 30 staff, which was evaluated very positively. As a result, the Communications team, in conjunction with the I-CAN staff disability network and patient experience teams, has commissioned similar training which will be delivered to around 250 staff initially. The training will teach basic sign language and useful phrases which will support staff to assist patients and the public. Staff who work in areas with unplanned attendances, such as A&E, acute admission wards and front of house teams, will be given priority as this will provide the most impact. This project will be supported by awareness raising through communications and the Trust intranet.

7.8. The Communications team has also undertaken a review of hearing loops in the Trust and is purchasing additional resources for our imaging and outpatient departments.

7.9. In addition, the Trust is purchasing 1000 more “blue bands”, which are wrist bands that can be given to patients who are Deaf or hard of hearing and that indicate to staff that the person may need additional support during communication. The blue band initiative was developed by a Deaf patient in conjunction with the patient experience team. The patient, Jeanette, told her story to the Board in September 2018. Sadly Jeanette died last year, so it is fitting to report that her initiative continues to be used to support Deaf patients at ICHT.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Chief executive's report

Agenda item 8 and paper number 05

Lead Executive Director: Prof Tim Orchard, Chief executive

Purpose: For noting

Meeting date: 16 March 2022

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:

- Operational performance and key issues (including visiting restrictions, Covid-19 and flu vaccination programme and vaccination as a condition of deployment)
- Acute care programme update
- Financial performance
- CQC update
- Maternity assurance report
- Redevelopment
- Western Eye Hospital
- Research
- Equality, diversity and inclusion update
- Stakeholder engagement
- Joint chair appointment
- Other developments

1. Operational performance and key issues

1.1. The number of patients we are caring for with Covid-19 has stabilised and is slowly starting to reduce. However, Covid-19 still remains a significant presence in our hospitals – about 13% of our available beds are occupied by patients with Covid-19 currently.

1.2. This position, combined with the usual challenges of winter, means we continue to experience significant operational pressures. Over the last few weeks we have triggered a number of internal operational alerts across our sites and services. The alerts are an important way for us to work together to actively tackle the pressures and ensure everyone is safe. I am very grateful to all our staff for their hard work and flexibility during this busy time. It has made a huge difference for patients and staff in the areas experiencing the immediate impacts.

1.3. Notwithstanding the operational challenges we currently face, the NHS as a whole must now have a renewed focus on tackling the backlog of elective care. We continue to increase the amount of non-urgent planned care that we are able to deliver and are currently running at 90% of our pre-pandemic activity for elective and day case care and over 100% for diagnostics and outpatients.

1.4. Building on our #BetterTogether campaign, a week (23 to 29 January) was dedicated to 'keeping care flowing'. We ran our hospitals as if we were on alert to prioritise improving the way care flows, making the most of our time and resources for the benefit of patients and colleagues. The week also provided an opportunity to encourage as many teams as possible to try out ideas to help solve operational challenges. Small changes - especially lots of them - often make a big difference. There was an amazing amount of collaboration between staff from all parts of our organisation and with our partners, with some great results including a drop in the number of patients in hospital longer than 21 days and an increase in the number of patients discharged from our discharge lounges.

Visiting restrictions

1.5. At the end of January 2022, in light of the relaxation of the Government's Plan B Covid-19 restrictions and the reducing rate of infection in the community, the North West London sector reverted to the pre-January visiting restrictions in hospitals. This took effect from 4 February 2022 and means that all patients can have one visitor, for one hour, once a day. In a change from the previous restrictions it is not necessary for the visitor to be the same one throughout the patient's stay. Visits do still need to be pre-arranged with the ward and visitors continue to be required to wear a face mask at all times and follow any other PPE requirements that are in place.

1.6. Visitors are encouraged to take a lateral flow test (LFT) prior to visiting and not visit if it is positive or they have Covid-19 symptoms. The advice to take an LFT prior to visiting will be kept under review in light of reported plans to remove free access to these tests. Flexibility in exceptional circumstances, such as for patients who are dying, continues. These exceptional arrangements are agreed locally with the ward or department.

1.7. The national guidance for the public in relation to Covid-19 continues to change and so hospital visiting arrangements are under continuous review. The aim is to keep patients and staff at low risk of infection from people visiting the hospital sites, so it is likely that some form of restrictions will continue in hospitals even if there are none required in the public space. The Trust will ensure that any ongoing restrictions are clearly communicated.

1.8. The relaxation in visiting has been welcomed by patients, their friends and relatives and staff.

Covid-19 and flu vaccination programme

1.9. The Trust is continuing to provide a comprehensive vaccination programme for our staff and wider community. Uptake of vaccinations in our frontline staff on 2 March is as follows:

- 61.12 per cent had received their flu vaccine
- 91.72 per cent had received doses one and two of the Covid-19 vaccine
- 88.37 per cent of those eligible had received their Covid-19 booster.

1.10. Flu vaccination uptake is tracking at 6 per cent above the London NHS trust average and 1 per cent above the North West London average. Uptake of Covid-19 vaccines is in line with the London average overall, and slightly above the London and North West London averages when considering the booster vaccination.

1.11. A new vaccination clinic for 5-11 year olds who are most at risk of Covid-19 and their siblings has been established on the St Mary's site. Communications have been sent directly to the parents and guardians of 350 eligible children identified by our paediatric team to inform them how to access their vaccinations, including the offer to book an appointment with us.

1.12. The vaccination hub is now able to offer an Overseas Validation Vaccination Service for staff and those in the wider community who have been vaccinated overseas. This enables people to have their GP records and NHS Covid pass updated with their overseas vaccination

information. The service is also able to offer advice and administration of suitable follow-up vaccinations if needed.

1.13. NHSE have provided planning guidance for the next phase of the national vaccination programme. We are working with the North West London vaccination programme team to plan how the Trust can best support the ongoing needs of our staff and local communities, including how to support the spring Covid-19 booster campaign recently recommended by the JCVI for over 75 year olds and any clinically extremely vulnerable person over the age of 12. Surge contingency planning is included in this sector activity.

Vaccination as a condition of deployment

1.14. On 31 January 2022, the Government announced its intention to revoke the regulations making Covid-19 vaccination a condition of deployment in health and social care, subject to consultation and parliamentary process.

1.15. The outcome of the consultation has now been published and the Government has formally ended its legal requirement for health and social care staff to be double vaccinated against Covid-19.

1.16. In response to the Government's earlier decision to reconsider the requirement, we had already paused all of our employment processes to implement the legislation which was due to have come into force on 1 April 2022.

1.17. We will continue discussions with partners across North West London to shape our approach to staff vaccination for the longer term. In the meantime, we continue to encourage all staff to be fully vaccinated against Covid-19, including having the booster dose.

2. Acute care programme update

2.1. Our collaborative approach to working across our 12 acute and specialist hospitals in North West London is becoming increasingly embedded. It has enabled us to maintain more planned (elective) care during the third wave of Covid-19 infections than in the second wave when, in turn, we had seen an improvement on the first wave.

2.2. As we look to the new financial year and hopefully emergence from the pandemic, we are collectively focusing on immediate measures to increase emergency, urgent and planned care capacity while continuing to minimise the risks of Covid-19. We are also focusing on longer term plans to develop better ways of working to reduce waiting times, improve our care and outcomes and help tackle underlying health inequalities. A briefing can be found at Appendix 1, which provides an overview of key developments, challenges and opportunities, as well as an update on progress.

3. Financial performance

3.1. At the end of the first ten months of the financial year, the Trust achieved a break-even position against a break-even plan and the Trust continues to forecast a break-even position to 31 March 2022.

3.2. The capital plan for the year is £104.3 of which £24.0m is funded through grants and donations giving a £80.2m Capital Resource Limit (CRL). Year to date the Trust has spent 71% against plan and currently expects to meet its CRL for the year.

3.3. As at 31 December, cash was £199m and, based on the current regime, the Trust expects to maintain a healthy cash balance in the medium term.

3.4. Operational planning for 2022/23 is underway. The Trust plan will form part of the ICS submission with a draft and final plan required to be submitted on 17 March 2022 and 28 April 2022 respectively.

4. CQC update

4.1. Following a government mandate, non-essential working was suspended from mid-December 2021 through January 2022. As a result, the CQC's quarterly engagement meeting with the Trust scheduled in January 2022 was cancelled. The next quarterly engagement meeting is scheduled to take place in June 2022.

5. Maternity assurance report

5.1. The Trust provides oversight of quality assurance within the maternity service via a report to each Quality Committee meeting. This includes assurance on the progress on achieving compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) as well as key issues relating to the quality and safety of the maternity service.

5.2. On 10 February 2022, NHS England wrote to all trusts, with a requirement to submit an update to the regional team regarding actions identified to meet the recommendations of both the Morecambe Bay and Ockenden reports, along with the further self-assessment assurance tool request.

5.3. Evidence submitted included: an updated Ockenden audit action plan, which collated actions from Saving Babies Lives audit reports and evidence submitted as part of compliance against the Ockenden immediate and essential actions; an updated benchmarking exercise against the Morecambe Bay recommendations; and, the maternity self-assessment document.

5.4. The Quality Committee reviewed the detailed maternity assurance documentation in March with assurance gained about the management of risks, incidents and key metrics. Specific highlights to note are that NHS Resolution have confirmed that we have achieved compliance with all ten safety actions within year 3 of the CNST MIS. Although year 4 is paused due to the ongoing Covid-19 pandemic, we continue to apply the principles of the ten safety actions to support the delivery of safer maternity care. Assurance was submitted to NHSE in February regarding actions in place to address the Morecambe Bay and Ockenden report recommendations. As previously reported we have achieved 100% compliance with the immediate and essential actions required following the Ockenden review, and are undertaking on-going actions to provide assurance that robust pathways of care are maintained. The outstanding action in response to the Morecambe Bay benchmarking exercise relates to the refurbishment of our theatre suite at Queen Charlotte's & Chelsea Hospital, which began in February 2022.

6. Redevelopment

6.1. With the support of the New Hospital Programme, the Trust has begun the next phase of redevelopment planning work for its three main hospital sites, all of which are included in the 40 new hospitals the government has committed to build by 2030. While the Trust awaits a decision on its strategic outline case for St Mary's, it is continuing to work up options for phasing the redevelopment to explore whether it can accelerate key aspects of delivery and benefit realisation and spread the costs. The Trust is also now looking to create a high-level masterplan for the whole St Mary's site, exploring the scale of the total development opportunity including on land that will no longer be required due to more efficient use of the space. There will be more opportunities for staff, patients and local communities and others to get involved in the planning and preparation work over the coming weeks and months.

6.2. The next phase of work at Charing Cross and Hammersmith hospitals involves creating and evaluating a longlist of options for delivering the improvements and capacity required for each site. The Trust has already confirmed that both hospitals will need to have at least the same

number of beds as now and that there will continue to be a full A&E at Charing Cross. The options will be evaluated and developed with input from a wide range of patients, staff and the local communities, as well as formal partners and stakeholders, before a preferred way forward is identified for each site. This is the first step in creating a costed redevelopment plan for each site which will inform a strategic outline case for both hospitals.

7. Western Eye Hospital

7.1. In November 2021, a review of the vacant Samaritan Hospital, which is adjacent to the Western Eye Hospital, raised fire safety concerns. The Trust took the immediate precaution of closing some areas of the Western Eye while more detailed investigations took place.

7.2. The majority of services displaced from the Western Eye have been temporarily rehomed at Charing Cross Hospital and more outpatient appointments are taking place by video or telephone. Charing Cross already provides some specialist ophthalmology care. In addition, a further mobile operating theatre has been set up on the Charing Cross site and is expected to be fully operational by 14 March 2022.

7.3. The detailed investigations of the Samaritan and Western Eye buildings have now been completed and we have concluded that it is feasible to undertake building works to allow us to return to full use of the Western Eye. As this will be the most effective and quickest way to restore all of the planned care capacity lost due to the partial building closure, the Trust is now developing a short business case for the investment, anticipating it will be funded through NHSE's 'targeted invest fund' (TIF.

8. Research

8.1. As part of the selection process in the competitive re-application for our National Institute for Health Research (NIHR) Biomedical Research Centre (BRC), we will attend an interview at the beginning of April. It was confirmed last month that the NIHR Imperial Clinical Research Facility (CRF) will receive a further 5 years of funding, after undergoing a similar application process. The CRF will receive an increase in budget on the previous 5 years. Another NIHR research infrastructure programme – the NIHR Imperial Patient Safety Research Centre (PSTRC) – has also been submitted for re-application, and the outcome of this is awaited.

8.2. Despite the challenges of Covid-19 and associated operational and workforce pressures, we continue to deliver many of our existing clinical research studies across all specialties. To date this financial year, we have recruited more than 10,000 participants to 342 individual NIHR Portfolio studies (cf. 11,100 in 2020/21 and 12,300 in 2019/20). We have increased revenue (£5.88m) and overhead income (£1.08m) from commercially sponsored clinical trials to their highest ever position (as of M9).

8.3. A project is underway to refresh the research section of the Trust website.

9. Equality, diversity and inclusion update

9.1. Our staff networks have continued to focus on raising awareness, including celebrating International Women's Day, designing the I-Can buddy scheme and preparations for Disability History Month. Our LGBTQ+ network progressed with the second stage application for NHS Rainbow Badge Scheme, which includes a self-assessment by general managers, patient and staff surveys. The People and Organisational Development team has rescheduled a number of education events and has a full calendar over the next few months including 22 departments booked on the Trust's Race Equity programme, personalised training for neuro diverse staff using assistive technology, bespoke training on Access to Work for HR and a women's personal safety event.

10. Stakeholder engagement

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

- Karen Buck MP for Westminster North and Andy Slaughter MP for Hammersmith: 7 January 2022
- Cllr Tim Mitchell, Westminster City Council: 3 February 2022
- Cllr Stephen Cowan and Cllr Ben Coleman, London Borough of Hammersmith & Fulham: 7 February 2022
- Stuart Love and Bernie Flaherty, Westminster City Council: 7 February 2022
- Healthwatch Hammersmith & Fulham: 8 February 2022
- Healthwatch Central West London: 14 February 2022
- Nickie Aiken MP for Cities of London & Westminster: 3 March 2022
- Hammersmith & Fulham Save our NHS, Brent Patient Voice and Ealing Save our NHS: 7 March 2022

11. Joint Chair appointment

11.1. I am delighted to announce the appointment of Matthew Swindells as the new Chair-in-common for Chelsea and Westminster Hospital NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust. Matthew has over 30 years' experience in healthcare and is the former Deputy Chief Executive and Chief Operating Officer for NHS England. He will take up his position on 1 April 2022.

11.2. The four trusts have begun to embed closer partnership working through a joint Acute Care Programme Board focusing on expanding planned care capacity and tackling waiting times in the wake of the pandemic. It was set up in March 2021 after our response to the first wave of Covid-19 infections demonstrated how much more could be achieved through greater collaboration. The appointment of a chair-in-common is a key next step in strengthening collaboration as we move towards becoming a formal acute care collaborative in line with national NHS policy. While remaining separate organisations, we will seek to maximise our potential for joint working for the benefit of our local population, patients and staff.

12. Other developments

12.1. Three fully refurbished staff 'rest nets' have opened at the Trust, marking a major milestone in our staff spaces improvement programme supported by Imperial Health Charity and design company Taylor Howes. Rest nests are full refurbishments and fit-outs of staff breakrooms, professionally designed to transform them into relaxing sanctuaries of calm for staff on busy shifts. The first teams to benefit are the pharmacy team at Hammersmith Hospital, the intensive care team at St Mary's Hospital and the Marjory Warren ward at Charing Cross Hospital, with a combined staff of around 250. The rest nests are acting as pilots to inform the planned roll out of premium breakrooms across the organisation.

12.2. The Trust has been involved in the production of two new television series being broadcast in February/March 2022:

- *Emergency* is a new series for Channel 4 and filming took place across the major trauma network in London for two weeks, 24 hours a day, during the summer of 2021. The crew followed our staff and patients on the major trauma pathway, documenting their stories from pre-hospital care right through to rehabilitation.
- *Your Body Uncovered* is a new 6 part factual series for BBC2. The series helps patients understand their medical conditions using augmented and virtual reality images of their scans.
- Viewing figures and audience and critic feedback have been very positive, with high levels of social media engagement.

Professor Tim Orchard, Chief executive
11 March 2022

Acute care programme briefing 3 - planned care recovery and development, March 2022

Chelsea and Westminster Hospital, The Hillingdon Hospitals, Imperial College Healthcare and London North West University Healthcare

1 Introduction

Our collaborative approach to working across our 12 acute and specialist hospitals in north west London is becoming increasingly embedded. It has enabled us to maintain more planned (elective) care during the third wave of Covid-19 infections than in the second wave when, in turn, we had seen an improvement on the first wave. As we look to the new financial year and hopefully emergence from the pandemic, we are collectively focusing on both immediate measures to increase emergency, urgent and planned capacity while continuing to minimise the risks of Covid-19 and longer term plans to develop better ways of working to reduce waiting times, improve our care and outcomes and help tackle underlying health inequalities.

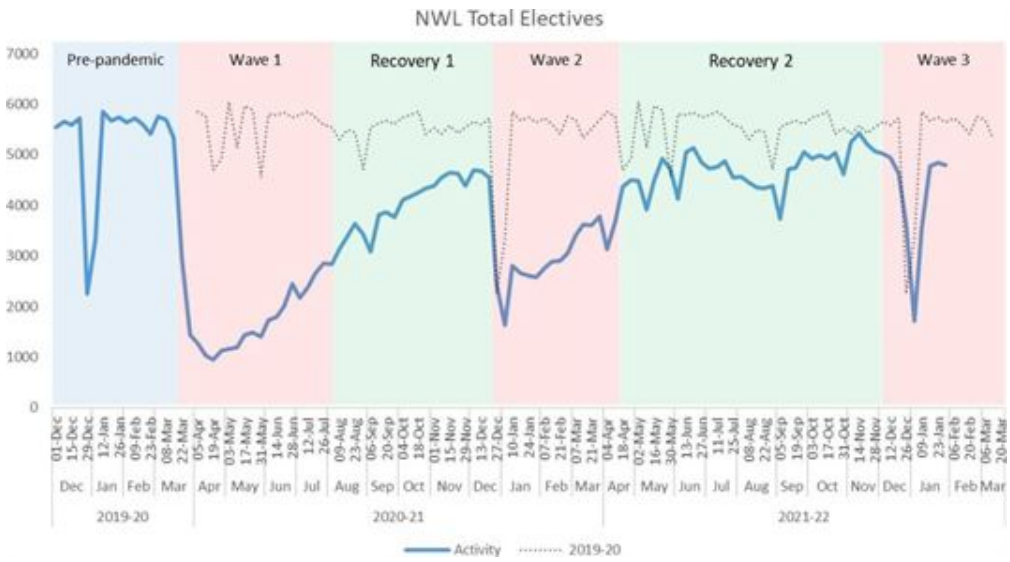


Figure 1: Total number of patients receiving planned care in north west London. Source: NHS England weekly activity report.

During the third wave, we were able to maintain 85 per cent of our pre-pandemic levels of planned care, peaking at 95 per cent – a significant increase from the 60 per cent maintained during the second wave and the 15 per cent maintained in the first wave.

This briefing provides an update on key performance measures and targets for acute care across north west London and our main collaborative developments.

2 Planned care

In December 2021 (latest fully validated data), there was a total of 205,657 patients on our (inpatient and outpatient) waiting lists. This represents a continuing increase against a national ambition to maintain the number of people waiting at September 2021 levels. However, given the impact of the third wave of the pandemic on planned care capacity and anticipating that more patients willcome forward for treatment as we emerge from the pandemic, we expect the size of the waiting list to increase further before we are able to achieve a sustainable reduction.

Figure 2: Total number of patients on north west London waiting lists. Source: Monthly 'consultant-led referral to treatment waiting times' dataset published on NHSE Statistics

As of February 2022, we have managed to achieve 87 per cent of pre-pandemic planned care activity and we are working towards the national target of 104 – 110 per cent for 2022/23.

2.1 Embedding 'fast-track surgical hubs' and making best use of theatre capacity
One of the ways in which we have been able to maintain more planned care through later waves of the pandemic has been through the establishment of 'fast-track surgical hubs'. Part of a wider NHS initiative, we identified 14 surgical facilities across our hospitals that could have a good degree of separation from urgent and emergency care pathways. We then focused surgery in these facilities on so-called 'high volume, low complexity' procedures where evidence has demonstrated improved quality and efficiency when a surgical team undertakes a high number of these procedures in a systematic way. Most high volume, low complexity procedures are within six specialties – gynaecology, urology, ophthalmology, orthopaedics, ears, nose and throat and general surgery – which also represent our longest waits.

We are regularly monitoring theatre utilisation across all sites, drawing on comparative data nationally and regionally. We are working to ensure best practice and reduce unwarranted variations so that we can increase the amount of surgery we offer from within existing facilities. We are particularly looking at how our 'green' sites – our facilities that do not include A&E departments and so where planned care is less impacted by urgent demand – can best support longer term elective recovery. In parallel, we are working to understand best practice and variations in pre-operative pathways to help develop common approaches that are better for patients and more efficient, including establishing a process for enabling pre-operative assessments undertaken by one provider to be recognised across all providers to avoid duplication.

We have also recently made a £2million investment in surgical equipment to help increase theatre capacity, particularly for gynaecology.

2.2 Exploring a north west London elective orthopaedic centre
Building on the concept of fast-track surgical hubs, we have begun to develop a more strategic, larger-scale approach to improving our provision of 'high volume, low complexity' surgery across the sector. The driver is to improve quality as well as to significantly expand access and shorten waiting times over the next few years.

We believe there is a good case for beginning with orthopaedic surgery. While the pandemic has led to longer waiting times across all specialties, orthopaedics has been particularly impacted as it accounts for more than 25 per cent of all surgical interventions undertaken nationally. Without some further intervention, the number of people waiting for orthopaedic surgery in north west London is expected to increase by just under a fifth by 2030, from the current position of just over 12,000 waiting for outpatient or inpatient care.

In addition, while we have some of the best outcomes for orthopaedic surgery, including being in the top ten per cent nationally for readmission rates on a number of our sites for specific procedures, we need to achieve this consistently across the sector and we can do more to improve patient-reported outcome measures and lengths of stay across the board.

There is a strong evidence-base for elective care centres, especially for the provision of orthopaedic surgery. These centres are dedicated and purpose-designed facilities, entirely separated from urgent and emergency care services, where specialist teams provide 'systematised' surgery for a small number of common procedures. A well-established example is the South West London Elective Orthopaedic Centre where approximately 5,000 orthopaedic procedures are carried out every year with lower than average length of stays and good feedback from patients and staff.

We have been exploring how we might best establish an elective orthopaedic centre for north west London alongside maximising our planned surgery capacity overall. We think the best existing location is likely to be the Central Middlesex Hospital – it is amongst our best quality estate, it is one of only two sites that do not provide urgent and emergency care services at all and there is good potential to expand and remodel existing facilities. It also has the shortest average travel times of all our hospitals to all of the boroughs in north west London.

There is a large amount of work to do to explore the case for an elective orthopaedic centre. This includes establishing the best location and working through improved, end-to-end orthopaedic pathways (including continuing to provide pre and post-surgical care at our other hospitals and in the community), understanding and responding to the views and needs of patients and other stakeholders, analysing potentially differential impacts on different groups of patients to address potential health inequalities, and identifying the capital and revenue funding and workforce requirements. We also need to consider the wider implications – and opportunities – of using the Central Middlesex site.

We are in the process of establishing a project management and governance structure to explore our various options and develop proposals for wider consideration. This will also include considering options for other specialties as we look to prioritise improvements to reflect areas of greatest need. We are also developing a communications and engagement programme to ensure staff, patients and wider stakeholders help shape all aspects of this work as early as possible.

2.3 Supporting patients who are waiting and offering faster care where possible
In line with the rest of the NHS, many of our patients have now been waiting a long time for their care as a result of the pandemic and increasing need. As of December 2021, there were a total of 53 patients in north west London who had been waiting two years for their treatment compared with 1,200 across London as a whole. Our number is down from a peak

of 127 in July 2021 and we are working to have no one waiting for two years by the end of March 2022.

As of December 2021, there were a total of 4,075 patients in north west London who had been waiting 52 weeks for treatment, down from a peak of 6,802 in February 2021. Our number equates to two per cent of our waiting list, compared with three per cent for London as a whole and five per cent across England. NHS England has set the ambition to stabilise the waiting list size for patients waiting over 52 weeks and we have set a further ambition to reduce the number of patients in this cohort.

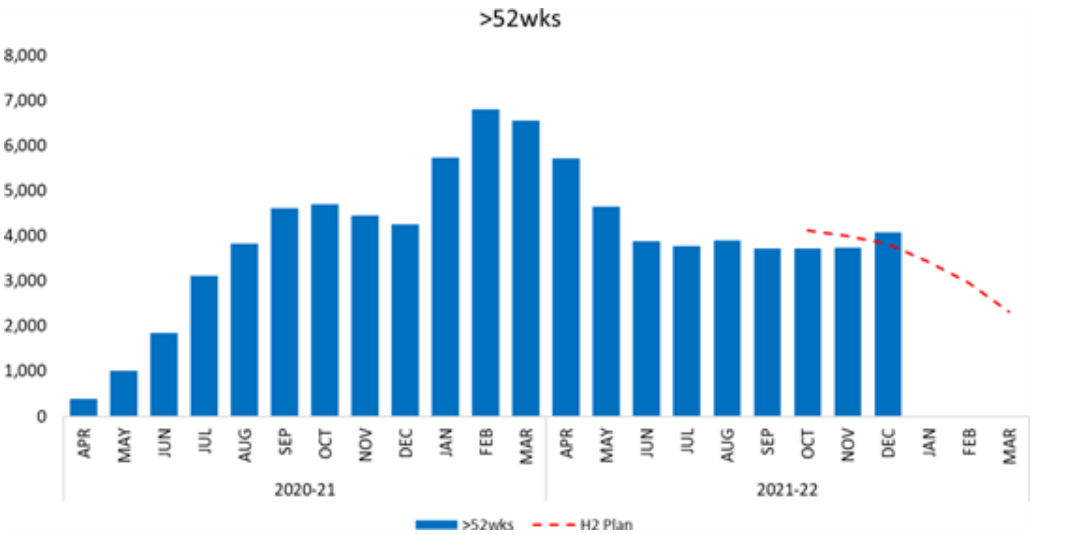


Figure 1 Total number of patients waiting one year or more for treatment in north west London. Source: Monthly 'consultant-led referral to treatment waiting times' dataset published on NHSE Statistics

Even with our focus on reducing long waits, it's clear that many patients will have to wait longer for care than before the pandemic for some years to come. We have put in place new ways of working, and we are continuing to explore new approaches, to ensure we keep patients safe, support them while they are waiting and tackle inequalities and unfairness.

We have an agreed set of principles and review meetings in place across primary and secondary care in north west London to help ensure we take a consistent approach to clinical prioritisation and to identify issues, such as the possible deterioration of a patient's condition. We have developed protocols for transferring patients to another provider with more capacity to prevent particularly long waits wherever possible, helping to address inequalities in access to care. One example has been the transfer of gynaecology patients with complex endometriosis who were waiting more than 104 weeks – of the patients identified as suitable and who consented to being transferred, 95 per cent have now been treated.

We have established a common data infrastructure with a single view of our waiting lists and we have also begun to pilot a new digital platform to give clinicians – and eventually, we hope, patients – better visualisation of demand and capacity data and greater ability to use that data to schedule work and priorities within their services.

One further work area is the development of better information and engagement approaches to ensure patient awareness and understanding of how we are managing waits and new ways of working, making sure we reach all parts of our population.

2.4 Other strategic developments

With partners in north west London, we are beginning to explore how we can develop improved models of care across all key specialties. One priority is ophthalmology care as the specialty has high waiting times and there is potential for much more integrated working across different teams and services. We also have a particular challenge with ophthalmology capacity currently with fire safety issues causing the temporary, partial closure of the Western Eye Hospital. We are working through a programme of repairs at the Western Eye – and the adjacent, vacant Samaritan Hospital building – so that we can return services to the site and we have put in place a mobile operating theatre at Charing Cross to restore some of the capacity temporarily in the interim.

3 Outpatient care

We had managed to achieve 102 per cent of our pre-pandemic outpatient activity following the second Covid-19 wave but this has dipped slightly during the third wave. As of February 2022, we are now at 101 per cent of our pre-pandemic outpatient activity, and working towards the national targets of 104 – 110 per cent for 2022/23.

3.1 Specialist advice and guidance

We are progressing plans to facilitate collaboration between clinicians across primary care and our acute hospitals. We have invested in a new sector-wide digital platform that once fully implemented will provide hospital teams with a single, more reliable and time-efficient route for managing GP advice requests and all referrals. Similarly, it will provide GPs with a single, more reliable and time-efficient route to specialist advice, and it also has the potential to support further alignment and integration of referral management processes in the future.

3.2 ‘One stop’ care pathways

We are exploring opportunities to create more ‘one-stop’ care pathways to provide faster diagnoses and routes to treatment, bringing together multi-disciplinary teams to organise care around the patient and reduce the number of separate appointments. We already have many of these pathways in place for patients with potential cancer symptoms and will be looking to extend them to specialties such as ear nose and throat, gynaecology and ophthalmology.

4 Diagnostic services

4.1 Developing community diagnostic centres

Community diagnostic centres are a national initiative to build diagnostic capacity for planned care, based in the community and separated from urgent and emergency pathways. This ‘one stop’ approach for checks, scans and tests will be more convenient for patients and help to improve outcomes for patients with cancer and other serious conditions.

National funding of £2.3bn has been allocated for developing diagnostic services and a national assurance and business case approval process has been issued for schemes to deliver new community diagnostic centres. We are looking to have new community diagnostic centres situated in at least two areas of north west London where there are significant clusters of deprivation – including one in the area of Hanwell, Southall and Greenford; and another in the area of Neasden, Stonebridge, Harlesden, North Hammersmith and Fulham, North Kensington, Queen’s Park and Church Street in North Westminster.

We are working up plans and business cases to progress new community diagnostic centres with capital investment from 2022/23. We are also developing plans to involve patients, staff

and other stakeholders in the development of the centres and the business cases over the coming months.

5 Cancer care

Urgent cancer referrals (on the 'two-week' pathway) have increased since March 2021 - across north west London, between 12 and 25 per cent more patients were seen on an urgent cancer pathway in November and December 2021. Performance against the national'faster diagnosis' standard is stable at 72 per cent against the target of 75 per cent of patients being informed whether they have cancer or not within 28 days of urgent referral asof December 2021.

Overall, as of December 2021, cancer first treatments are up 9 per cent against the 2019/20baseline. An additional 449 surgeries have been undertaken from March to December 2021compared with the same time period in 2019/20. This increase in demand is creating capacity and operational pressures and longer waits for cancer care than planned.
Performance against the 62-day wait (between an urgent referral and the start of treatment has dropped to 75 per cent in December 2021 from 78 per cent in July 2021. The impact of the Omicron variant pre-Christmas resulted in reduced capacity across acute trusts due to staffing sickness and so there was a downturn in activity for diagnostics particularly at this time. Together with RMP Cancer Alliance and wider partners across the integrated care system, we are working through how we can best achieve greater, sustainable improvementwith a particular focus on 62-day and faster diagnosis standard attainment.

We continue to have a major sector-wide focus on increasing awareness amongst local communities, GPs and other partners of the importance of investigating cancer symptoms assoon as possible. The overall 'gap' (between actual and expected cancer diagnoses and 'first treatments') for the population of north west London has recovered since March 2021 - from a starting deficit of 471 patients to 277 more patients seen in December 2021 against the pre-pandemic baseline, however at tumour site level there are remaining deficits in breast and urology.

For more information, please contact:

Imperial College Healthcare - mick.fisher@nhs.net
London North West University Healthcare - tracey.beck@nhs.net
Chelsea and Westminster Hospital – emer.delaney1@nhs.net
The Hillingdon Hospitals - justine.mcguinness@nhs.net

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Integrated quality and performance report scorecard month 10

Agenda item 9 and paper number 06

Lead Executive Director: Claire Hook, Director of Operational Performance
Authors: Performance Support Team

Purpose: For discussion

Meeting date: 16 March 2022

1. Purpose of this report

1.1. This enclosed scorecard summarises performance against the key performance indicators (KPIs) for data published at January 2022.

1.2. Countermeasure reporting is being reinstated. For month 10, summaries are included for five of the national operational standards where performance has fallen outside of the target level. The Countermeasure for incident reporting is being reviewed and will be available from next month.

1.3. The Board are asked to note increased use of statistical process control (SPC) charts within the Countermeasures to view trends and highlight any significant changes in the variation. This approach will continue to be developed. Options to update the visualisations in the integrated scorecards are also being explored.

2. Executive Summary

2.1. Outpatient attendances stood at 105% of the trajectory for January 2022. Elective spells stood at 84% of the trajectory.

2.2. The number of patients waiting over 12 hours waits within the emergency department remained significantly high, reflective of continued pressures on urgent and emergency care pathways and the system as a whole.

2.3. The incident reporting rate reduced but this was in line with previous drops during Covid-19 surges. No CPE blood stream infections (BSIs) or C. difficile lapses in care were reported in January 2022 however one MRSA BSI case was reported. A fourth never event occurred in January 2022. The investigation is underway and the patient did not come to harm as a consequence.

2.4. A summary of the performance headlines is provided in the main section below and countermeasure summaries are enclosed for information.

3. Approval process

3.1. Elements of this integrated quality and performance report were discussed at Divisional oversight and Executive Management Board (EMB) Quality subgroup meetings in advance of EMB and the Board.

4. Recommendation(s)

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

5. Next steps

5.1. The Countermeasure summaries set out progress against the actions being put into place for areas where performance is below the trajectory.

6. Impact assessment

6.1. Quality impact: This report highlights areas where there may be a risk or potential issues to the delivery quality of care and operational performance. Improvement plans are monitored through the Executive Management Board and its subgroups and the Board committees. This report will contribute to improvement of all CQC quality domains, providing oversight into key indicators and statutory requirements.

6.2. Financial impact: Integrated Care Systems (ICSs) are responsible for delivering plans for elective activity, through a combination of core funding and extended funding that has been made available via the national Elective Recovery Fund (ERF). Systems that achieve completed RTT pathway activity above a 2019/20 threshold of 89% will be able to draw down from the ERF, payable at a system level for achieving minimum activity levels above 2019/20 baseline levels.

6.3. Workforce impact: Plans to deliver activity trajectories and performance metrics have been developed in a way that also supports the health and wellbeing of our staff

6.4. Equality impact: To quality for ERF funding, ICSs are required to demonstrate the impact of plans for elective recovery in addressing disparities in waiting lists.

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

Main report

7. Month 10 (January 2022) performance

Operating plan 2021/22 – elective recovery position for January 2022

7.1. The volume of outpatient attendances increased during January following and stood at 105% of the trajectory target for the month as a whole. The volume of elective spells (day cases and overnight elective admissions) stood at 84% of the trajectory target for January as a whole.

7.2. The overall size of the RTT waiting list decreased and the trajectory for completed RTT activity pathways (clock stops) continued to be met. The reduction targets for patients waiting 52 weeks and 104 weeks were not met, although the overall 52 week wait backlog reduced by 10%.

Referral to Treatment

7.3. 79,218 patient pathways were reported for January month end, a reduction of 1,449 pathways (1.8%) on the previous month, although behind trajectory to achieve 78,728 or less.

7.4. 1,605 patients were waiting over 52 weeks for treatment. This is a reduction of 176 (10%) on the previous month although behind the trajectory of 1,538 for January. Unfortunately, 26 patients were waiting over two years against the trajectory of 9.

7.5. We anticipate reducing 104 week waits to zero by the end of March 2022 as planned. We also anticipate that performance against the 52 week wait trajectory will continue to improve by the end of March 2022 and the overall national policy aim for H2 of holding or where possible reducing the number of patients waiting over 52 weeks by March 2022 should still be met.

Diagnostics

7.6. In January 2022, 18.6% of patients were reported as waiting more than 6 weeks for their diagnostic test, which was above our internal trajectory of 9% for the month. However, the overall improvement in diagnostic waiting times has continued and January 2022 was the best performance since beginning of the pandemic. The Endoscopy and Neurophysiology services both continued to report significant improvement in the waits over 6-weeks.

Cancer waiting times

7.7. There has been a significant decline in cancer 2-week wait performance which is expected to remain non-compliant with the 93% target for the remainder of 2021/22. This is due to sustained 2-week wait referral demand increases across specialties, prostate and breast diagnostic pathway capacity. The 62-day GP referral to first treatment performance was 62.6% against the 85%, also a significant decline.

7.8. The new 28-day faster diagnosis standard was launched in October 2021, allowing patients with suspected cancer to be informed of their diagnosis as quickly as possible. In December the performance was 64% against the operational standard of 75%.

Urgent and Emergency care

7.9. The Trust's Ambulance handover performance (within 30 minutes) remained below trajectory with a significant increase in handover breaches over recent months at the SMH site. Overall, our handover performance continues to benchmark well across the London sector.

7.10. The Trust also reported 21 Ambulance handover delays over 60 minutes (down from 38 in the previous month). We will continue to report this metric to the Board until performance is recovered.

7.11. The number of patients waiting over 12 hours within the emergency department from time of arrival remains very high with 905 such patients in January 2022, the equivalent of 4% of attendances. Significant increases have been seen across both the CXH and SMH sites. The national requirement during 2022/23 is to reduce 12-hour waits to no more than 2% (NHS operating plan).

7.12. The overall length of stay remained high with an average of 205 patients with a stay of 21 days or more.

Quality – safe and effective

7.13. As expected, performance across a range of our quality metrics was affected by the recent surge, with increases in Covid-19 infection incidents and incidents related to the

impact of operational pressures in January 2022. However, our harm profile remains good with a lower than average 12-month percentage of incidents causing moderate and above harm.

7.14. Our incident reporting rate reduced in line with previous drops in incident reporting during the surges, although the number of incidents reported remains higher than in both previous waves, which is positive. Now that we are out of surge, focused improvement work has re-started with the areas nominated by the divisions, and countermeasure summaries will be reinstated in March as we have formally moved out of governance lite.

7.15. No CPE blood stream infections (BSIs) or C. difficile lapses in care were reported in January 2022 however one MRSA BSI case was reported. This is our ninth case so far this financial year; five of these were attributable to direct care at the Trust. A key theme is suboptimal line care. In addition to local actions and targeted support from our infection prevention and control (IPC) team, a trustwide action plan is in place which includes a point-prevalence survey, monthly MDT review of all healthcare-associated BSIs to identify themes and improvement areas, and a gap analysis of national BSI reduction recommendations. As part of the work to improve the safety of line insertions in response to two recent never events, we are developing a new programme of education and competency assessment for line care, which will include a focus on on-going management of lines. We are also rolling out a new approach to IPC training, education and competency assessment from April 2022, which will provide an improved online training package and quarterly observational audits, enhanced by a rolling programme of structured education and training visits across every area of the trust.

7.16. A fourth never event occurred in January 2022; a patient was issued the wrong blood by the lab and one unit was transfused on the ward, despite use of the electronic bedside checklist. The investigation is underway and the patient did not come to harm as a consequence. This is the second blood transfusion never event this financial year. A large amount of work was undertaken in 2020, led by an active working group, in response to three previous blood administration incidents, one of which was a never event, including the roll-out of the electronic checklist and training for staff. As part of the on-going work of this group, an improved e-learning module had been developed for launch in March. This will now be rolled out as a ward-by-ward approach starting with the higher usage/higher risk areas to allow for targeted support and to test further improvements.

Appendices:

1. Trust Board integrated performance scorecard – month 10
2. Trust Board Countermeasure summaries – month 10

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard - Board Version

Imperial Management and Improvement System (IMIS)

FI = Focussed improvement

M10 - January 2022

Section	FI	Metric	Watch or Driver	Target / threshold	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Reporting rules	SPC variation
To develop a sustainable portfolio of outstanding services																			
Quality safety improvement	FI	Patient safety incident reporting rate per 1,000 bed days	Driver	**>=65.6**	53.81	50.45	52.90	47.50	54.58	58.73	58.00	54.08	53.94	54.63	61.12	57.49	51.84	CMS	-
		Healthcare-associated (HOHA + COHA) Trust-attributed MRSA BSI	Watch	**0**	2	1	0	0	1	2	0	0	1	3	0	1	1	Note performance / SVU if statutory	-
		Healthcare-associated (HOHA + COHA) Trust-attributed C. difficile	Watch	**8**	4	8	7	3	7	6	6	10	4	7	4	2	8	-	-
		Healthcare-associated (HOHA + COHA) E. coli BSI	Watch	**12**	7	5	6	7	4	6	12	6	15	11	8	12	11	-	-
		CPE BSI	Watch	**0**	1	1	1	0	0	0	0	0	0	0	0	0	0	-	-
		% of incidents causing moderate and above harm (rolling 12 months)	Driver	**<2.67%**	1.41%	1.46%	1.55%	1.53%	1.40%	1.33%	1.30%	1.31%	1.32%	1.31%	1.25%	1.27%	1.42%	Promote to Watch	-
		Hospital Standardised Mortality Ratio (HSMR) (rolling 12 months)	Watch	**<=100**	72	72	73	76	76	76	76	71	71	70	67	68	67	-	-
		Formal complaints	Watch	**<=100**	66	74	95	77	53	77	83	75	83	96	73	67	66	-	-
Response and Recovery		Elective spells (overnight and daycases) as % of trajectory target	Watch	**100%**	-	-	-	103.3%	97.6%	115.0%	88.2%	88.4%	91.6%	94.1%	90.8%	84.9%	84.2%	Switch to Driver	-
		Outpatient attendances (all) as % of trajectory target	Watch	**100%**	-	-	-	106.9%	101.9%	117.8%	100.2%	105.6%	101.0%	103.5%	109.1%	92.8%	105.0%	-	-
		Completed RTT Pathways (Total clock stops)	Watch	**14,598**	-	-	-	14,872	14,929	17,315	16,820	14,360	15,081	17,331	18,250	16,225	19,070	-	-
		RTT waiting list size	Watch	**78,728**	57,334	57,991	62,763	65,753	68,242	72,362	74,437	75,500	76,585	78,533	80,050	80,667	79,218	Note performance / SVU if statutory	CC
		RTT 52 week wait breaches	Driver	**1,538**	1,667	2,278	2,374	2,157	1,837	1,467	1,464	1,516	1,515	1,605	1,650	1,781	1,605	CMS	CC
		% clinical prioritisation (RTT inpatient waiting list – surgical)	Watch	**>=85%**	88.7%	90.0%	89.4%	89.4%	89.2%	91.3%	91.6%	91.7%	92.0%	94.7%	93.9%	86.4%	88.7%	-	-
		Diagnostics waiting times	Driver	**9.0%**	50.5%	47.7%	38.8%	36.4%	36.6%	36.9%	33.2%	29.8%	27.0%	22.9%	20.6%	22.1%	18.6%	CMS	SC

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard - Board Version

Imperial Management and Improvement System (IMIS)

FI = Focussed improvement

M10 - January 2022

Section	FI	Metric	Watch or Driver	Target / threshold	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Reporting rules	SPC variation
continued		Cancer 2 week wait	Watch	>=93%	94.1%	95.3%	94.9%	93.4%	95.0%	93.4%	93.1%	94.2%	91.5%	86.8%	80.4%	71.7%	-	Note performance / SVU if statutory	SC
		Cancer 62 day wait	Driver	>=85%	77.3%	73.0%	79.1%	80.6%	78.7%	74.7%	73.8%	81.0%	73.9%	76.3%	66.7%	62.6%	-	CMS	SC
		Cancer 28-day Faster Standard Diagnosis	Watch	75%	-	-	-	65.0%	64.0%	66.2%	65.5%	60.6%	62.5%	67.9%	66.6%	63.8%	-	Note performance / SVU if statutory	-
		Ambulance handovers - % within 30 minutes	Driver	95.6%	89.5%	95.1%	96.0%	95.8%	96.9%	96.1%	92.5%	90.6%	89.0%	87.0%	85.1%	84.7%	87.9%	CMS	SC
		Number of patients spending more than 12 hours in ED from time of arrival	Driver	230	632	199	156	165	147	180	356	541	642	785	966	1,074	905	CMS	SC
		Long length of stay - 21 days or more	Driver	<=150	165	210	180	158	140	145	172	169	170	180	180	187	205	CMS	SC
Safe and Sustainable Staffing		Vacancy rate	Watch	<=10%	9.8%	9.8%	9.9%	10.6%	11.0%	11.5%	12.0%	12.4%	12.3%	12.7%	12.6%	13.0%	12.9%	Switch to Driver	-
		Agency expenditure as % of pay	Driver	tbc	1.8%	2.7%	2.4%	3.1%	2.4%	2.0%	1.9%	1.5%	2.2%	2.0%	2.37%	2.7%	2.9%	-	-
		BAME % of workforce Band 7 and above	Driver	tbc	38.3%	38.4%	39.8%	41.9%	40.2%	39.94%	40.1%	40.4%	40.4%	41.1%	41.45%	41.7%	40.9%	-	
		Staff Sickness (rolling 12 month)	Driver	<=3%	4.50%	4.54%	4.18%	3.79%	3.74%	3.67%	3.70%	3.79%	3.87%	3.96%	4.05%	4.21%	4.26%	CMS	-
		Staff turnover (rolling 12 months)	Watch	<=12%	10.1%	9.9%	9.8%	9.9%	10.6%	10.4%	10.4%	11.1%	11.1%	11.4%	11.6%	12.1%	11.9%	-	-
Finance		Year to date position (variance to plan) £m	Watch	£0	-0.66	10.48	5.07	-3.18	0.50	0.75	1.00	1.25	0.00	0.00	0.00	0.00	0.00	-	-
		Forecast variance to plan	Watch	£0	-13.85	1.91	5.07	0.00	18.51	1.51	0.00	0.00	-14.50	0.00	0.00	7.00	0.00	-	-
		CIP variance to plan YTD	Watch	£0	-	-	-	-	-	-6.15	-6.09	-5.73	-4.08	-4.68	-4.76	-3.65	-5.30	Switch to Driver	-
To build learning, improvement and innovation into everything we do																			
	FI	Core skills training	Watch	>=90%	91.6%	91.5%	92.2%	93.0%	93.8%	94.5%	94.0%	92.7%	92.2%	91.7%	90.3%	90.9%	92.2%	-	-

Abbreviations

MRSA BSI - Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infection (BSI)
E. coli BSI - Escherichia coli (E. coli) bloodstream infection (BSI)
CPE BSI - Carbapenemase-Producing Enterobacteriaceae (CPE) bloodstream Infection (BSI)
HOHA - Healthcare Onset Healthcare Associated; COHA - Community Onset Healthcare Associated

Reporting rules
CMS - Countermeasure summary
SVU - Structured verbal update

Imperial College Healthcare NHS Trust

Appendix 2

Integrated quality and performance report:

Countermeasure summaries at month 10 (January 2022 data)

Imperial College Healthcare NHS Trust

Contents

Five countermeasure summaries are enclosed covering national operational performance standards:

Diagnostic waiting times

Cancer waiting times 62-day performance

Ambulance handovers (within 30 minutes)

Patients spending more than 12 hours in the emergency department

Long length of stay

Imperial College Healthcare NHS Trust

SPC charts

The summaries use statistical process control (SPC) charts to plot data over time.

SPC is a way to understand variation in the underlying data and can help guide the most appropriate actions to be taken.

- In summary
    - SPC alerts us to a situation that may be deteriorating or improving, where significant variation has occurred
    - SPC shows us how capable a system is of delivering a standard or target
    - SPC shows us if a process that we depend on is reliable and in control
- The charts are based on templates published by NHS Improvement and NHS England which automatically highlight the different types of variation.
    - **orange** indicates **special cause variation** of particular concern and needing action;
    - **blue** where improvement appears to lie;
    - **grey** data indicates no significant change (**common cause variation**)

Adapted from: Making Data Count (NHS Improvement & NHS England)

Available at www.england.nhs.uk/publication/making-data-count/

Imperial College Healthcare NHS Trust

CMS

Diagnostic waiting times (DM01) – the percentage of patients waiting 6 weeks or more for a diagnostic test

Countermeasure Summary: DM01 Diagnostic waiting times

Imperial College Healthcare NHS Trust

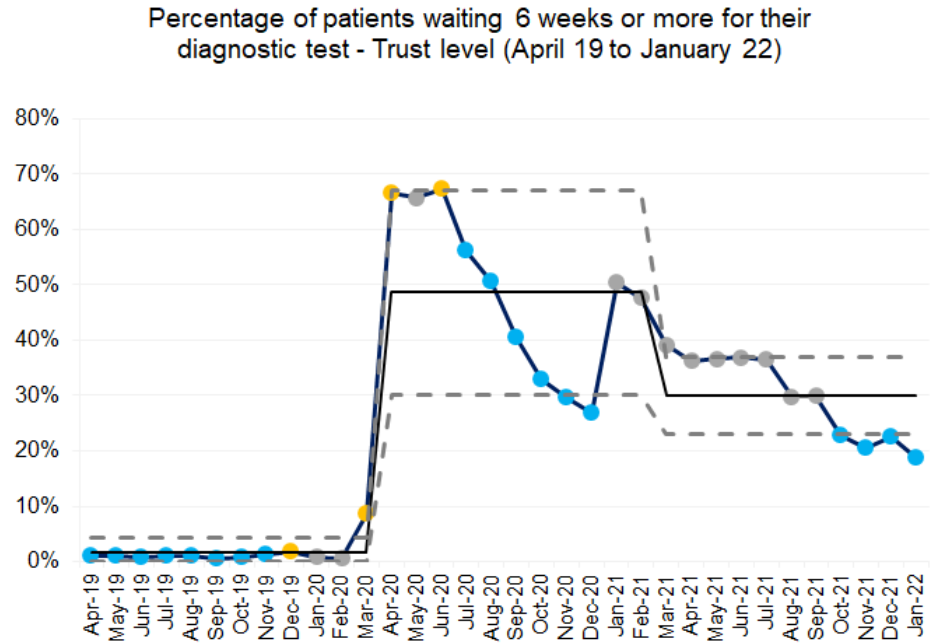
Problem Statement:

- Performance against the DM01 standard deteriorated for all modalities at the start of the pandemic, with significant backlogs accumulated due to the cancellation and reduction of services. Many patients continue to wait too long (over 6 weeks) for their diagnostic test. Failure to meet the diagnostic target adversely impacts patient experience and can delay treatment.

Metric Owner: Prof Tg Teoh
Metric: % of patients waiting 6 weeks or more for a diagnostic test
Desired Trend:

Performance

- In January 2022, 18.6% of patients were reported as waiting more than 6 weeks for their diagnostic test, which was above our internal trajectory of 9% for the month.
- However, the overall improvement continued to be sustained, highlighting as special cause improvement and the best performance since beginning of the pandemic.
- The Endoscopy and Neurophysiology services both continued to report significant improvement in the waits over 6-weeks.

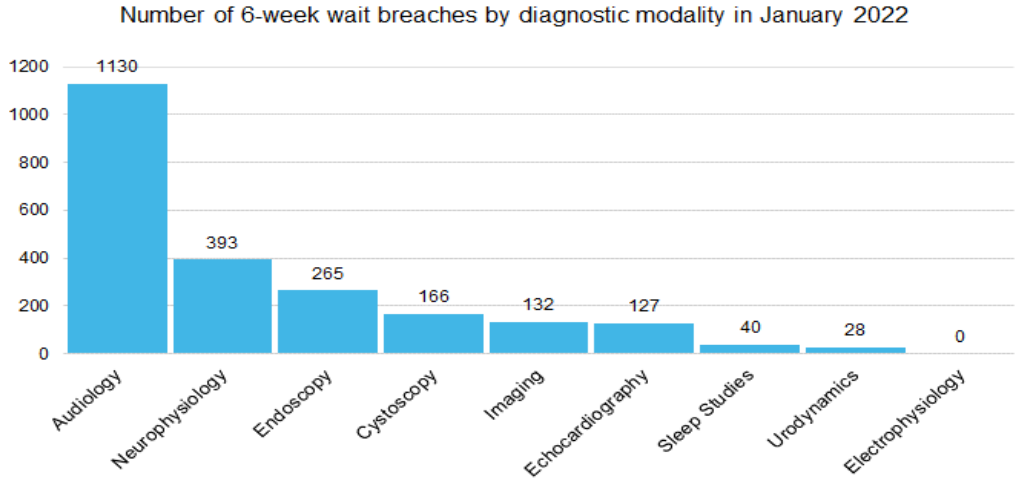


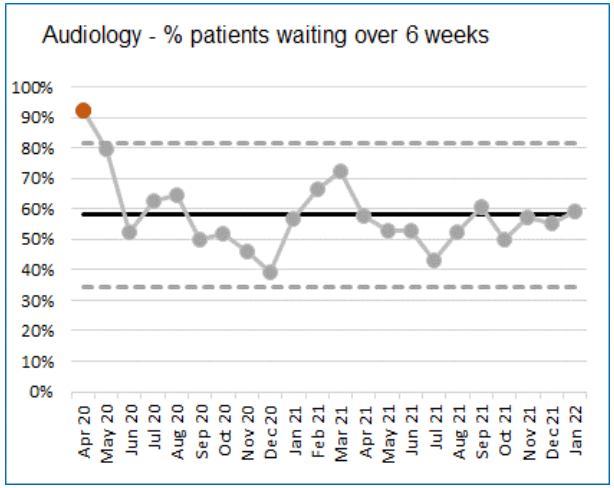
Countermeasure Summary: DM01 Diagnostic waiting times

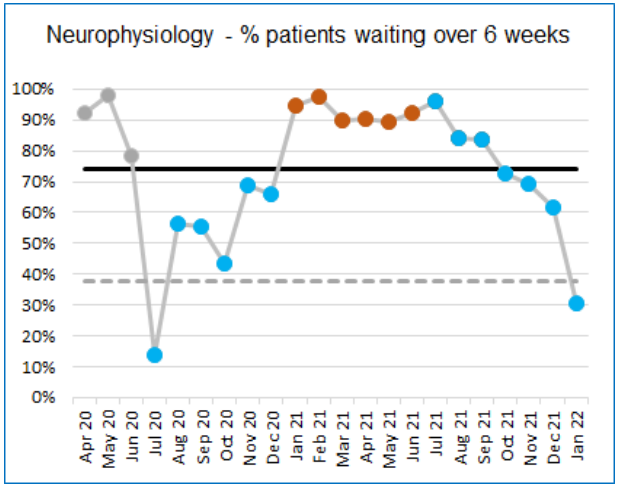
Imperial College Healthcare NHS Trust

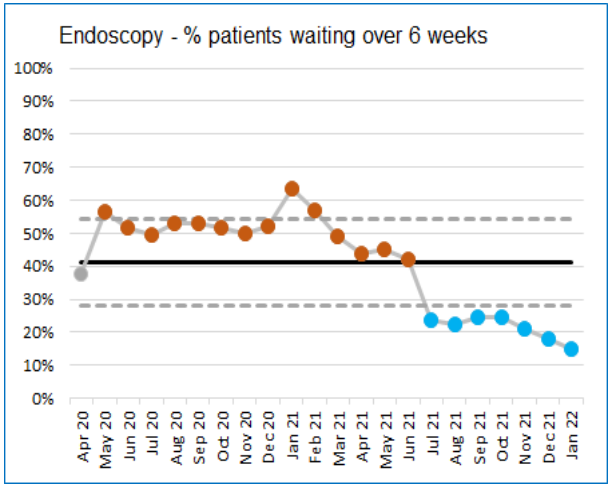
Top contributors

- Of the total number of 6 week diagnostic wait breaches in January 2022 (2281 breaches), nearly 80% (1788) are confined to three services:
  - Audiology (1130) (50% of breaches)
  - Neurophysiology (393) (22% of breaches)
  - Endoscopy (265) (15% of breaches)
- SPC performance charts for these services are provided below, showing % patients waiting over 6 weeks









Mean
Performance
Process Limit
Concerning special cause
Improving special cause

Countermeasure Summary: DM01 Diagnostic waiting times

NHS
Imperial College Healthcare
NHS Trust

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Audiology	• Loss of capacity due to staff sickness and redeployment • Increased demand	• Recruitment to vacant roles – to be fully established by Mid-February 2022. • Continued use of locum staff to mitigate against loss in capacity • From April 2022, planned increase in Direct Access capacity through withdrawal of the community audiology Any Qualified Provider (AQP) contract and reallocation of capacity	Harry Monaghan	February 2022 {complete} April 2022
Neurophysiology	• Loss of capacity due to vacant posts and staff sickness • Inability to source locum physiologists or additional admin staff to provide additional capacity	• Additional bank staff to book patients in the evenings and weekends. • Additional sessions allocated for January 22 through to March 22 to tackle remaining back log and maintain timely P2/INPT/Paed tests. • Clinical Physiologist vacancies all recruited (Feb 22) and training in progress to deliver the required skill mix and complex tests.	Heena Asher	February 2022 March 2022
Endoscopy	• Insufficient prospective bookings, impacting upon utilisation	• Work continues to improve the booking process and therefore list utilisation through the centralisation of the admin team in the Patient Service Centre with all scheduler working under PSC management from the 28th February 2022. • Prospective bookings have improved to at or near the target level of 1000 patients and weekly activity has returned to predicted levels in recent weeks.	Andrew Angwin	March 2022

Imperial College Healthcare NHS Trust

CMS

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

Countermeasure Summary: Cancer Waiting Times 62-day Performance

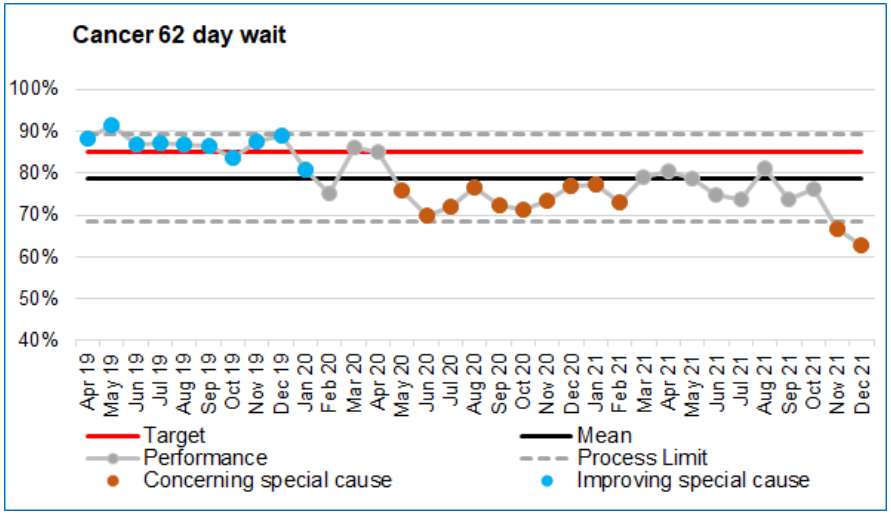
Imperial College Healthcare NHS Trust

Problem Statement:

- Performance against the standard has been non-complaint for 20 consecutive months. December 2021 was reported at 62.6% against the 85% standard, a significant decline.
- Compliant performance is required by March 2023 – included in Trust trajectories
- The patient impact is longer waiting times to access diagnostics and treatment for cancer. The performance impact is reputational and increased pressure on clinical and supporting admin team

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

Performance



Standards	Jul	Aug	Sep	Oct	Nov	Dec
3.1 - Cancer Plan 62 Day Standard (Tumour)	74.1%	81.0%	73.9%	76.3%	66.7%	62.6%
Acute leukaemia	100.0%		100.0%		100.0%	
Brain/Central Nervous System			100.0%			
Breast	65.8%	86.5%	90.5%	84.8%	75.0%	64.9%
Gynaecological	81.0%	84.2%	68.2%	83.3%	87.1%	56.3%
Haematological (Excluding Acute Leukaemia)	81.8%	75.0%	90.0%	100.0%	100.0%	100.0%
Head and Neck	100.0%	100.0%	75.0%	100.0%	100.0%	71.4%
Head and Neck - Thyroid	60.0%	100.0%		100.0%	66.7%	
Lower Gastrointestinal	58.8%	33.3%	44.4%	25.0%	43.5%	50.0%
Lung	40.0%	100.0%	75.0%	75.0%	25.0%	50.0%
Other	100.0%	100.0%			100.0%	0.0%
Paediatric						
Sarcoma				100.0%		
Skin	88.9%	84.6%	100.0%	75.0%	100.0%	100.0%
Testicular	100.0%		100.0%	100.0%		100.0%
Upper GI - HpB	33.3%	85.7%	50.0%	60.0%		75.0%
Upper GI - OG	50.0%	0.0%	33.3%	37.5%	0.0%	77.8%
Urology - Prostate	100.0%	89.5%	70.6%	57.1%	45.8%	50.0%
Urology - Renal	71.4%	0.0%	66.7%	0.0%	75.0%	75.0%
Urology - Urothelial	100.0%		100.0%	100.0%		100.0%

Key dependencies for performance recovery:

- Recovery of RAPID prostate diagnostic pathway (Rapid Access to Prostate Imaging and Diagnosis)
- Reduction and stabilisation of endoscopy waiting times
- Restoration of additional breast triple assessment clinics
- Reduction of diagnostic-only biopsies for suspected skin cancers
- Consistent delivery of 7 day turnaround times for cancer diagnostic pathology samples

Performance is not expected to be compliant with the standard before April 2022

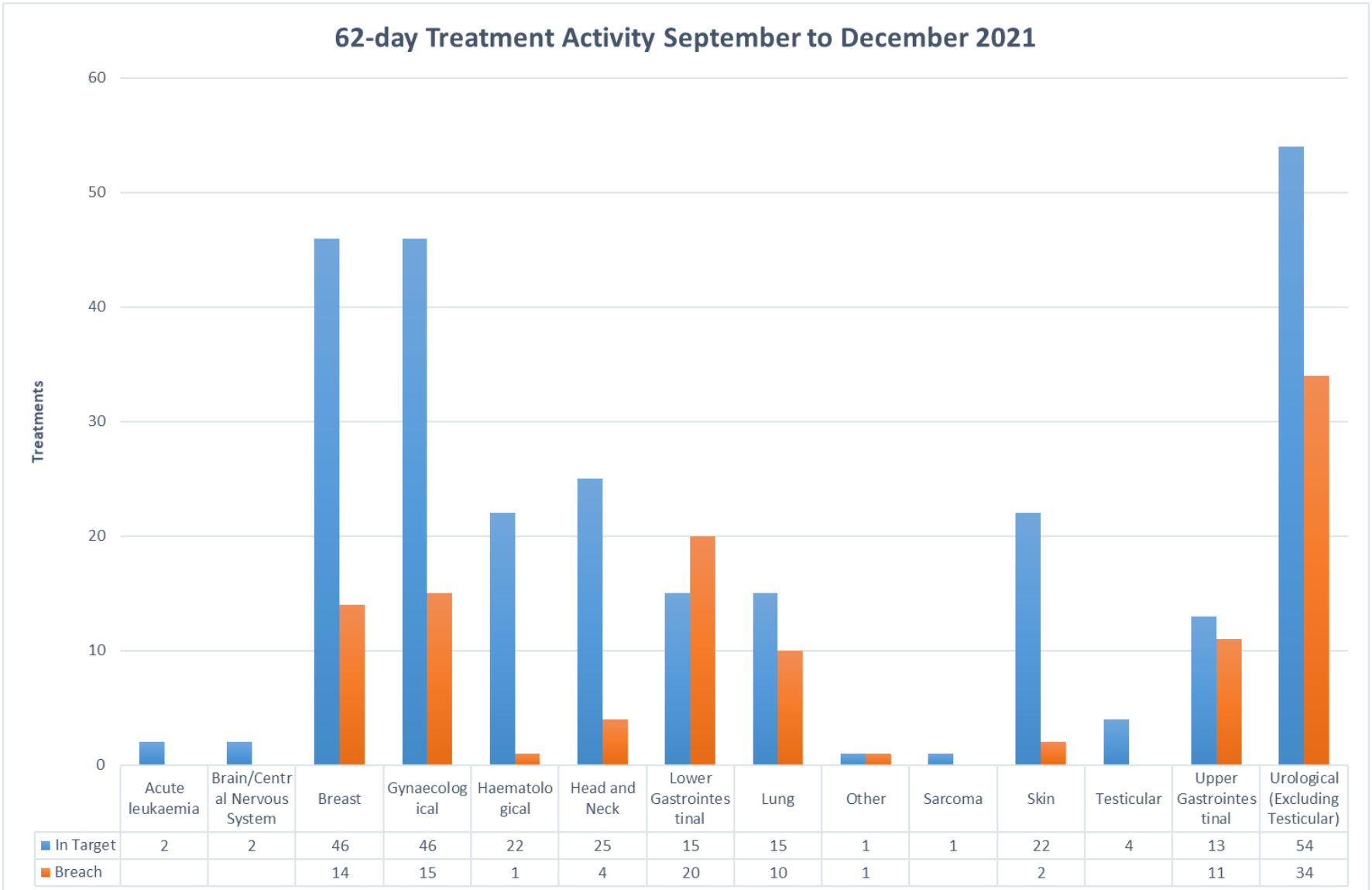
Key associated metrics to watch against trajectory:

- 2WW performance – December performance was 71.7% against 93% target – a significant decrease. Performance expected to remain non-compliant until March due to sustained 2WW referral demand increases across specialties, prostate and breast diagnostic pathway capacity;
- 104+ day PTL backlog – 75 patients at 16/02//2022 – decrease from 110 in November. Pressure in breast, GI, gynae and prostate;
- PTL 63+ day tip over rate increased significantly over Christmas. Drivers – GI diagnostic pathway capacity, pathology reporting time delays, prostate RAPID diagnostic pathway compliance, skin biopsy capacity, breast radiology capacity

Countermeasure Summary: Cancer Waiting Times 62-day Performance

Imperial College Healthcare NHS Trust

Stratified Data



	Acute leukaemia	Brain/Central Nervous System	Breast	Gynaecological	Haematological	Head and Neck	Lower Gastrointestinal	Lung	Other	Sarcoma	Skin	Testicular	Upper Gastrointestinal	Urological (Excluding Testicular)
In Target	2	2	46	46	22	25	15	15	1	1	22	4	13	54
Breach			14	15	1	4	20	10	1		2		11	34

Countermeasure Summary: Cancer Waiting Times 62-day Performance

NHS
Imperial College Healthcare
NHS Trust

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
RAPID prostate pathway	• Biopsy capacity insufficient to deliver diagnostic pathway within Faster Diagnostic Standard of 28 days. • Clinic capacity impacting treatment decision making times.	• Advance Nurse Practitioner (ANP) training programme to be implemented to restore pre-Covid biopsy capacity – to restore 1 RAPID clinic per week (total 3). • Outpatient capacity across the full pathway audited – triage and DTT clinic capacity to increase.	Urology Urology	February 2022 Pending – due 21/01/2022
Pathology	• > 7 day waits for cancer diagnostic sample analysis – affecting most tumour groups • Service has no prioritisation system or visibility of patient waiting times • Significant impact on patient experience through delayed communication of diagnosis and MDT discussion deferral • Particular impact in gynae, urology, GI and skin pathways	• Business case agreed on 10/01/2022 to increase staffing resource – recruitment timelines to be agreed • North West London-wide working group established to agree maximum turnaround times by tumour group, escalation and ordering processes and improve reporting visibility.	Path RMP/ NWL trusts	Not confirmed March 2022
GI diagnostic pathways	• Endoscopy waiting times 12.2 days for UGI and 14.3 days for colorectal in December 2021 – target 10 • CTC waits at 16 days in December	• Service to share scheduling and capacity utilisation improvement plan • Imaging turnaround times of 10 days agreed	Endoscop y Imaging	Pending – requested 15/10/2021 April 2022
Breast diagnostic pathway	• Sustained high referrals during Covid recovery • A reduction in the number of clinics we have been able to provide	• Additional MDTC and tracker resource agreed to manage inflated PTL • Recruitment started for new triage pathway to reduce TAC demand – start dates expected May 2022	Spec. Surg. Cancer Spec. Surg.	Jan-Mar 2022 March 2022 May 2022

Imperial College Healthcare NHS Trust

CMS

Ambulance handover times (within 30 minutes)

Countermeasure Summary: Ambulance handovers

Imperial College Healthcare NHS Trust

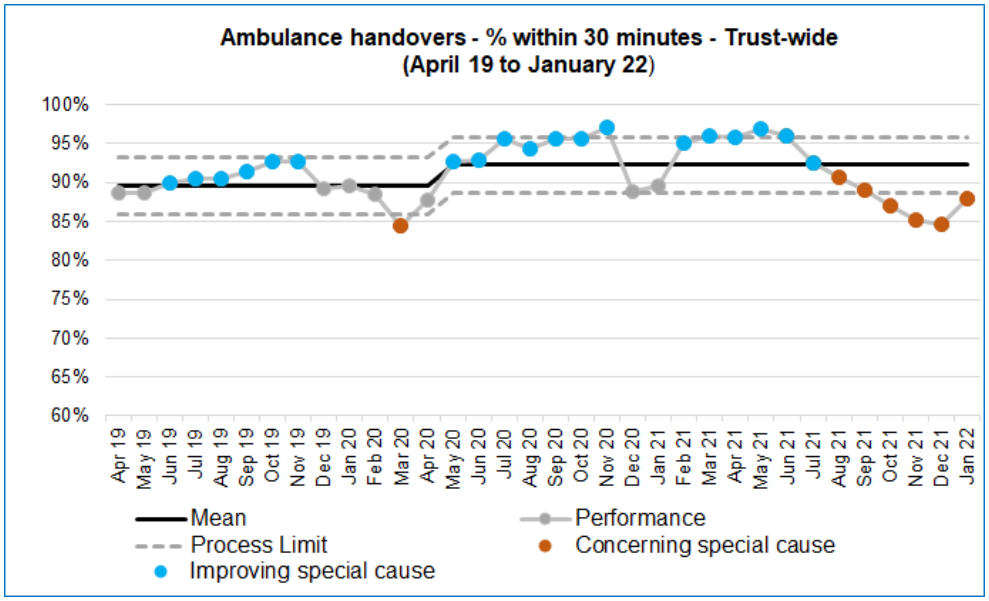
Problem Statement: The national target is 100% in order to reduce the time London Ambulance Service (LAS) crews spend in Emergency Departments (ED) and therefore freeing them up to respond to other calls. Delays have a knock on effect to overcrowding in the Emergency Departments.

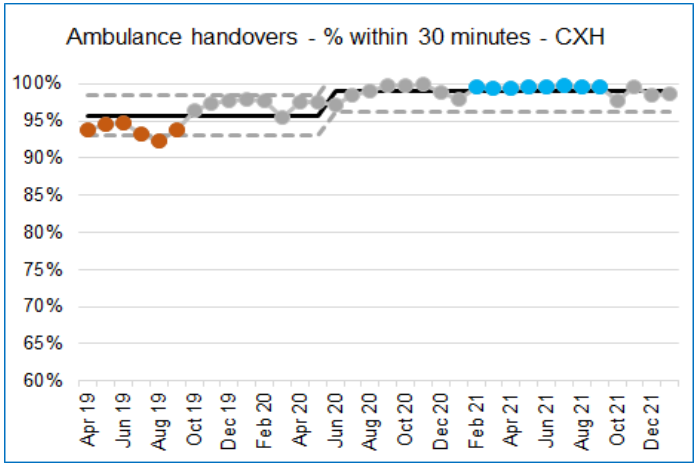
Metric Owner: Ben Pritchard-Jones
Metric: % of ambulance arrivals with a handover time < 30 minutes - target 100% (2021/22) (95% for 2022/23)

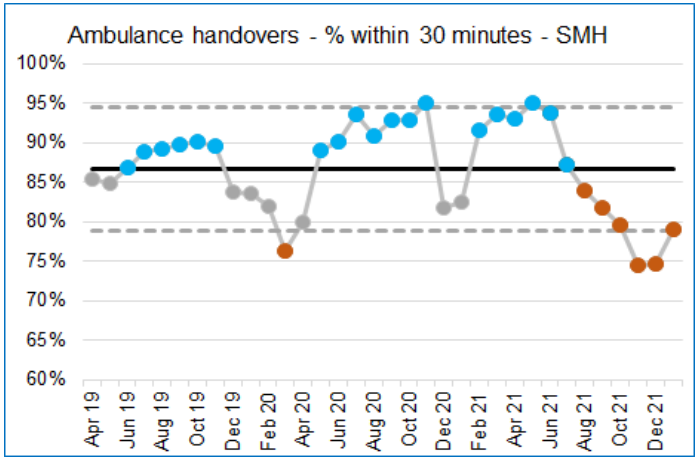
Desired Trend: ↑

Performance

- Ambulance handover performance (within 30 minutes) continued to be highlighted as special cause variation with performance of 88% for January 2022. Our internal trajectory was 95.6% for the month.
- The downturn in handover performance is being seen at the SMH site, illustrated in the SPC chart in the bottom right hand side. Performance at the CXH site remains stable.
- Restoring ambulance handover times is a key aim of the 2022/23 NHS operating plan, which includes ensuring 95% of handovers take place within 30 minutes.







Countermeasure Summary: Ambulance handovers

Imperial College Healthcare NHS Trust

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Ambulance Handover Delays	• Number of ambulances arriving to department that is already full	• LAS / ED Escalation plans reshared with Site and ED teams and Silver oncall teams • Divert of renal patients to CXH agreed and in place since 18/10 Impact to be reviewed in March '22 • NWL peer review process involvement for learning and actions • Reset of expectations and targets in line with 2022/23 NHS operating plan requirements • Update plus one policy to include rapid plus one if ambulance alert levels increase to level 4 or if 60 minute breach imminent	Ben Pritchard-Jones Iain Taylor Jane Fisher Jo Sutcliffe/ Frances Bowen Ben Pritchard-Jones Iain Taylor	April 22
Lack of space to offload ambulances whilst social distancing	• Slow flow out of the ED • Estate too small prior to pandemic now even more constrained	• E-mandate submitted for feasibility of reconfiguration of triage facility at front door to create 2 additional spaces. Costs above Divisional Minor Works budget are being reworked to go through DSP and CSG as part of 2022/23 plan • Regular update of CMS from ED and Site to support Intelligent Conveyancing	Ben Pritchard-Jones/ Andy Angwin Ali Sanders Iain Taylor/Ben Pritchard-Jones	April 22

NHS
Imperial College Healthcare
NHS Trust

CMS

The number of patients spending more than 12 hours in the emergency department from time of arrival

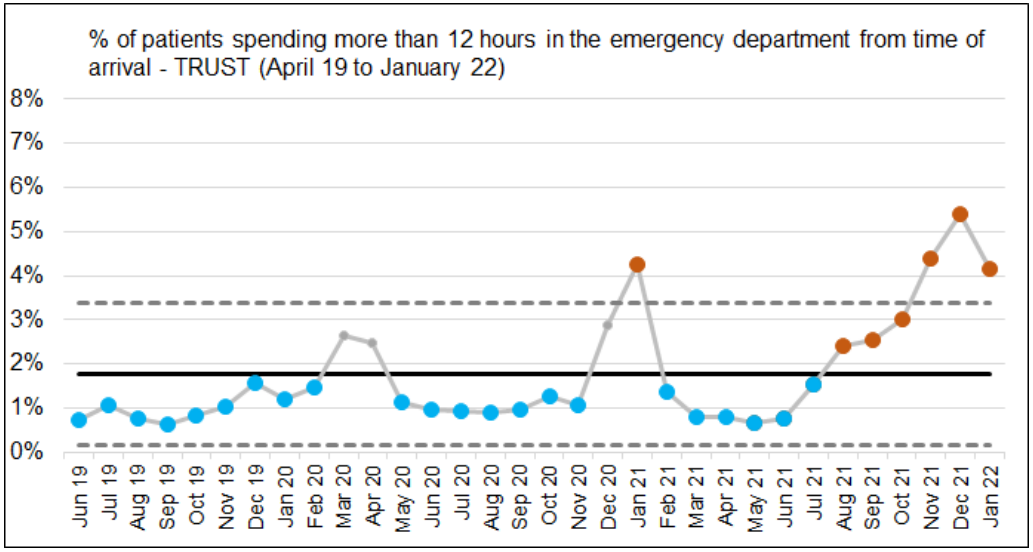
Countermeasure Summary: >12 Hour waits in Department

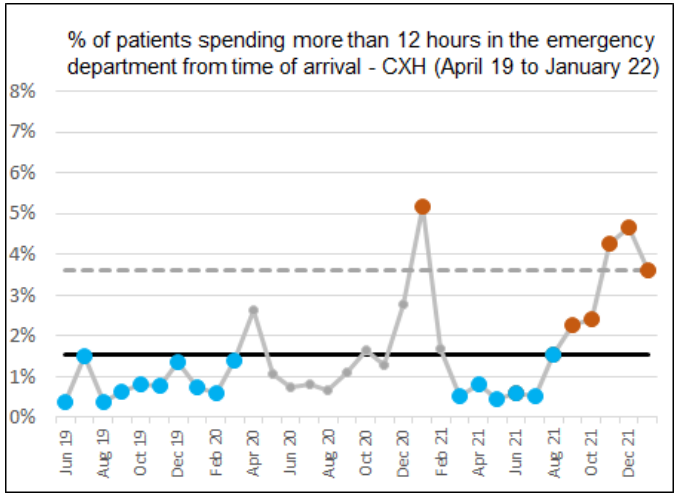
Imperial College Healthcare NHS Trust

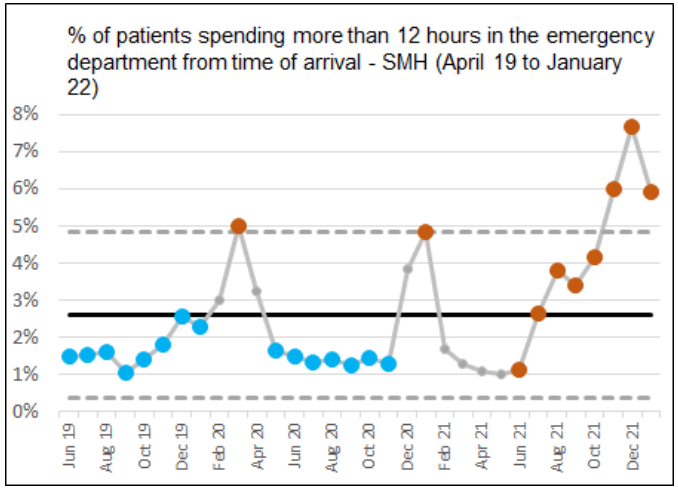
Problem Statement: Extended length of time patients are in an emergency department environment is detrimental for patient experience and quality and also impacts on staffing resource (ED staff, RMNs and security), cubicle capacity and the ability to manage flow through the department.	**Metric Owner**: **Frances Bowen** **Metric**: patients waiting > 12 hours in department (Target no more than 2% during 2022/23) **Desired Trend**: ↓

Performance

- The number 12 hours waits from time of arrival remains very high with 905 such patients in January 2022, the equivalent of 4% of attendances.
- The significant upturn in extended waits has been across both the CXH and SMH sites, reflecting increased pressures within the system as a whole. Of the total 12 hour waits, 77 were mental health patients.
- Going forwards, the national requirement is to reduce 12-hour waits in emergency departments towards zero and no more than 2% during 2022/23 (NHS operating plan)..







Countermeasure Summary: >12 Hour waits in Department

Imperial College Healthcare NHS Trust

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Admitted pathway bed availability	Delayed discharges downstream/lack of beds earlier in the day	• Update boarding / plus 1 policy with feedback from wards and LAS escalation • Acute locum consultant being interviewed SMH March 2022 • Analysis of trend of 12 hrs admitted patients by speciality and if possible by theme • Cross site transfers and delays for IPC to be reviewed for understanding of impact more broadly • Reinvigorate specific actions per directorate on time of discharge and usage of lounge through performance meetings and UEC board • Support focussed improvement on board rounds on 6 first wards, support increased training and release of coaches to do more, support clarity of message for all on board round expectations • Transformation team focus on Albert ward to look at routine leading up to discharge day and work on improving • Regular engagement and shared data from transport and pharmacy teams on actions taken the day before - wards areas needing greatest support in pipeline for transformation or FI coaching. • Engage in/drive and promote any site based scheme which helps create bed, CDU or ED capacity on site at SMH • Continue to support new specialties to SMH to ensure that impact of the move is neutral on beds	Iain Taylor Adam Hughes Jo Sutcliffe/ Frances Bowen Ben PJ/ Ali Sanders Jo Edwards / Adam Hughes / Anne Hall MDO Transformation team Jo Sutcliffe Frances Bowen/Jo Sutcliffe	April 22
Mental Health Pathway Delays	• AMHP Provision • Lack of bed capacity • Lack of urgency • Specific CAMHS pressures	• Mental health pathways - work with ICS on shifting focus and performance metrics for MH trusts to reduce stays in ED • Advertise lead MH Nurse and drive bank RMN recruitment • Focus on medical clearance speed, earlier escalation between CNWL and WLMHT and AMHP delays • Developing joint proposal for Emergency Assessment MH Lounge at SMH, in discussions with Estates teams on options scoping	Barbara Cleaver Jo Sutcliffe	April 22
Urgent & Emergency pathways	• CDU closure SDEC expansion, Staffing levels	• Recruitment pipeline prioritising key areas of greatest need – target of <3 down on any shift • Consider conversion back from ED to CDU (saves cost, reduces numbers of 12 hour stays, however complicates IPC abilities in ED) • Analysis of types of 12 hour stays and focus on those who are not referred to a speciality (%) • Treat 12 hour breaches from Decision to Admit (DTAs) in the same manner as a never event for site, wards and ED. Implement plus ones to avoid a 12 hour DTAs	Ben Pritchard-Jones Frances Bowen/Ali Sanders	April 22

Imperial College Healthcare NHS Trust

CMS

Improving long length of stay (LLOS)

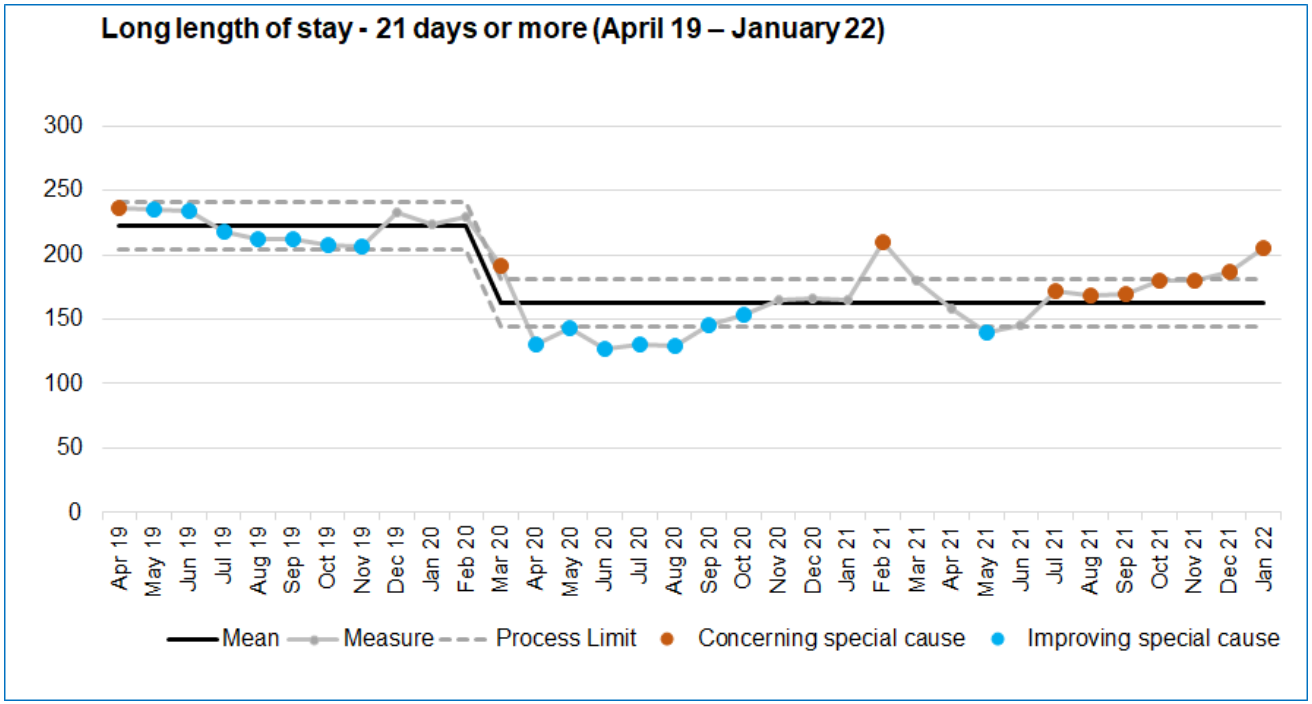
Countermeasure Summary: Improving Long Length of Stay (LLOS)

Imperial College Healthcare NHS Trust

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

Performance

The overall length of stay stayed remains high with an average of 205 patients with a stay of 21 days or more in January 2022. From April 2022 our performance will be measured against a new improvement trajectory which is being agreed with the sector as part of the 2022/23 NHS operational planning process.



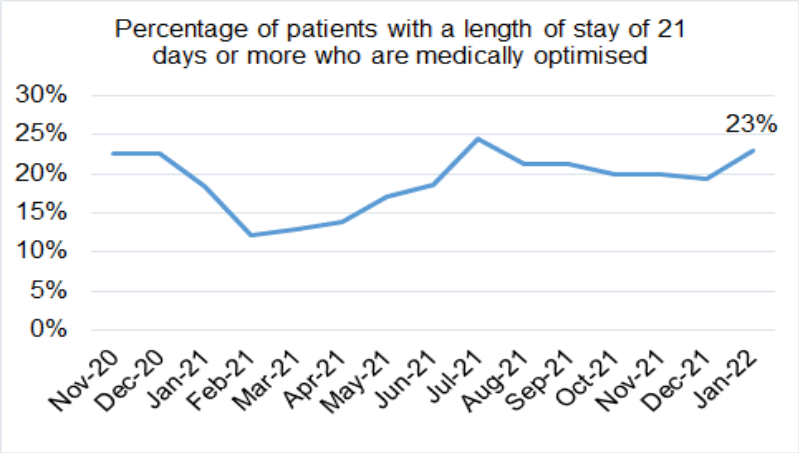
Countermeasure Summary: Improving Long Length of Stay (LLOS)

Imperial College Healthcare NHS Trust

Stratified Data:

The percentage of all long length of stay patients (21 days or more) who were Medically Optimised was at 23% in January 2022.

Challenged performance in last two months has continued partially due to effect on staff capacity of Covid isolation requirements across ward staff, discharge team, therapies, community and hospital social work teams



The trend in MO delays is primarily driven by:

- ICHT's atypical portfolio of tertiary services where LoS is expected to be longer (Major Trauma and slow stream rehab at SMH, HASU and specialist neurosciences at CXH and clinical haematology and cardiology at HH)
- 15-20 patients daily awaiting repatriation to their local hospital once their tertiary care is completed – significantly higher impact than on other Trusts in NWL
- Compared with other Trusts nationally, ICHT faces the complexity of local partnerships with eight London Boroughs, two Mental Health Trusts and three community health providers in multi-agency discharges
- Tertiary services attract higher than average numbers of patients from further afield, and discharges with post-discharge care needs can be longer to arrange with agencies with whom relationships are less strong and local provision less well known
- The prevalence of homelessness in Westminster means ICHT treats small but significant numbers of homeless patients who are 2.6 times more likely to attend A&E and stay in hospital 3 times longer than those with a secure home

Countermeasure Summary: Improving Long Length of Stay

NHS
Imperial College Healthcare
NHS Trust

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
High number of patients with Reason to Reside	• Sub-optimal speed of clinical decision making • Sub-optimal coding accuracy and completeness in Cerner • Variable process for managing repatriations to other acute Trusts • Insufficient range of alternative options for safe management of LTCs in the community	• Improve daily ward routines through Board Rounds focussed improvement; baselining complete, improvement actions started with small number of wards, some evidence of success on 9S, improvement team capacity has limited recent progress, resourcing and leadership model to be reviewed	Fran Cleugh & Raymond Anakwe	Update to ICPG 14/3 End Dec 22
		• Improve completeness and accuracy of ADD/R2R/MO; stably >90% complete for G&A patients >7 days LoS; now focussing on c.100 patients <7 days LoS on downstream wards	Anna Bokobza	End April 22
		• Implement plan to automate repatriation process in Cerner	Iain Taylor & James Bird	Mid-April 22
		• Develop and expand early supported discharge model with virtual ward and remote monitoring for suitable specialties	Sarah Elkin & James Bird	End May 22

Notes:

- LLOS Taskforce Terms of Reference have been refreshed for 2022 to better engage bed-based directorate leadership teams, celebrate good practice and cross-fertilise innovations
- The planned improvement actions will impact on all inpatients, regardless of LoS, so should improve performance against 7, 14 and 21 day metrics

Countermeasure Summary: Improving Long Length of Stay

Imperial College Healthcare NHS Trust

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
High number of Medically Optimised LLOS patients	• Constrained senior capacity in historical discharge structure to support complex discharges • Variable relationships with system partners in different boroughs • Sub-optimal quality of Discharge to Assess referrals from ICHT to system partners • Hospital social work teams do not always get early sight of complex post discharge needs • Growing numbers of homeless patients who have longer LoS on average • Demand for specialist neuro rehab beds in NWL outstrips supply • Care home market dynamics make behaviourally complex patients hard to place • Demand for community health and social care P1 support sometimes outstrips supply • Insufficient upstream management of patient/family expectations around discharge and choice	• Implement NWL integrated discharge structure – all in post except one 8b starting in April. Full skill mix review planned for completion by July • Iterate improvements to daily discharge hub routines; hub lead sign off of all D2As implemented in December, QI programme for 22/23 to be agreed end April • Level up medequip ordering rights across acute sites and boroughs; delayed by SMH ward leadership capacity • Trial joint screening meetings 3 x daily with 3B ASC to improve P1 and P3 speed; success during Better Together Week so now embedding • Implement NWL D2A form in Cerner with auto-notifications to LA teams (delayed by need for further changes to Power Form following testing phase in November) • Deliver 12 month Inclusion Health proof of concept; went live 29 Nov, Q1 impact report shared, generating further evidence for mid year review • Hold system partners to account for delivery of sector plan to source additional neuro rehabilitation beds • Review and adapt commissioned step down model • Commission Homelink extension for SCC 22/23 and run two month for Acute & Specialist Medicine at SMH • Review and strengthen patient letters and train MDTs in confident usage	Anna Bokobza Annabel Rule Liz Wordsworth Annabel Rule James Bird Anna Bokobza Jo Sutcliffe & Anna Bokobza Linda Jackson (LBHF) Anne Hall & Adam Hughes Annabel Rule	Complete July 22 End April 22 End April 22 September 22 May 22 April 22 November 22 End April 22 End May 22

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Infection Prevention and Control and Antimicrobial Stewardship Quarterly 3 (2021/22) Report

Agenda item 10 and paper number 07

Lead Executive Director: Professor Julian Redhead and Mr Raymond Anakwe, Medical Director
Author: Dr James Price, Director of Infection Prevention and Control

Purpose: Information

Meeting date: 16th March 2022

1. Purpose of this report

1.1. This paper provides a quarterly update of key indicators and infection rates, indicative of effective infection prevention and control (IPC) practice. The indicators and activity noted in the paper relates to quarter 3 2021/22 (Q3).

1.2. This report is designed to provide assurance to the board across all infection indicators, with a focus on those areas where concerns have been identified during the preceding quarter, and to note areas of concern or risk and associated plans and mitigations.

2. Executive summary

2.1. The focus of the IPC team in Q3 has been on responding to the latest pandemic surge. This drove increases in admission of patients, unwell with Covid-19 or admitted due to another reason while also infected with Covid-19. In turn, we observed and responded to an increased incidence of healthcare-associated Covid-19 (HOCI) infection, as well as outbreaks and incidents associated with Covid-19, a trend paralleled nationally as Omicron sread through the country. NHSE data on HOCI rates showed that our rate of HOCI oper 100,000 bed days was in line with the London mean (NHSE data, Jan 2022).

2.2. High community prevalence of Covid-19 across London led to a significant number of staff testing positive for Covid-19, reducing staffing levels across the Trust. This alongside the increased demand on our services, particularly over the Christmas period, necessitated the Trust on occasion to derogate from national IPC guidance relating to managing Covid-19 (presented to EMQ in Jan 22) to ensure that we could safely maintain our services - all derogations were risk assessed and agreed via our Clinical Reference Group (CRG).

2.3. We have continued to monitor and respond to all healthcare-associated infections (HCAI).

2.4. The current trajectory of healthcare-associated *C. difficile* infection (including those flagged as lapses in care) and healthcare-associated *E. coli* and *P. aeruginosa* bloodstream infections (BSI) indicates that we will not exceed our annual thresholds, and therefore do not flag as a cause for concern.

2.5. Our observed incidence of healthcare-associated *Klebsiella spp*. BSI is in line with our anticipated incidence for Q3, however due to an increased incidence in Q1 we are likely to surpass the annual threshold set. Increased incidence of healthcare-associated *Klebsiella spp*. BSI have been noted nationally. Further detail on this is included in this paper.

2.6. In Q3 four healthcare-associated MRSA BSI were identified, totalling eight cases for 2021/22 year to date, compared to a total of five reported in 2020/21. A detailed review of all MRSA BSI cases and actions is included in this paper.

2.7. In Q3 all metrics associated with Covid-19 screening improved and while overall Trust compliance against pre-admission patient testing remains below 90%, this to largely a facet of how tertiary screening takes place in the community and does not link to Cerner. We will audit compliance with this metric in Q4 to identify any new concerns and to explore how we may be able to remedy this reporting issue moving forward.

2.8. Carbapenemase-producing Enterobacterales (CPE) and MRSA screening compliance has fallen below the threshold for some divisions. This is monitored through the HCAI sitrep with divisional actions in place to improve.

3. Approvals process: Quality Committee noted the update and endorsed the actions being taken in response to the increase in bloodstream infections and the proposed changes to IPC education and training.

4. Recommendation: The board is asked to note the report.

5. Next steps: These are detailed in the body of the report.

6. Impact assessment

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

6.2. Financial impact: no direct financial impact.

6.3. Workforce impact: no workforce impact.

6.4. Equality impact: no specific equality impact.

6.5. Risk impact**:** risks associated with the content of this report are recorded on the IPC or directorate/divisional risk registers. The report does not identify any new risks.

Main Paper

7. Covid-19 related incidents and outbreaks

7.1. In Q3 we observed 34 incidents and 23 outbreaks related to Covid-19.

7.2. This compared to 36 incidents and 11 outbreaks in Q2. Owing to the increased transmissibility of the Omicron variant, and the rate of community prevalence in Q3, figures are not comparable to those seen during surge two. This increase in Covid-19 activity is also reflected in the rise in incidents of HOCI across the Trust - 798 in Q3 compared to 612 in Q2 (Table 1). NHSE data on HOCI rates showed that our rate of HOCI oper 100,000 bed days was in line with the London mean (NHSE data, Jan 2022).

7.3. The focus of the IPC team in Q3 has been on responding to the latest pandemic surge, most notably:

7.3.1. Navigating and interpreting frequent changes in national guidance pertaining to management of Covid-19, including guidance around personal protective equipment (PPE).

7.3.2. Working closely with clinical specialities to implement these changes and developing clear messaging for our staff.

7.3.3. Working closely with clinical specialities seeing a rapid escalation of Covid-19 cases, particularly in relation to challenging situations where patients tested negative on admission subsequently testing positive on 'low risk' pathways.

7.3.4. Managing patient-led Covid-19 incidents and outbreaks across the Trust, with regular outbreak meetings held and weekly updates submitted to CRG and the sector.

7.3.5. Responding to an observed increase in the number of patients identified with community-onset Covid-19 through routine screening across our renal satellite units in Q3. These incidents have been investigated and managed internally under the outbreak management process, with IPC supporting local renal specialities closely.

7.3.6. Responding to the initial requirements for cases of suspected Omicron to be managed differently to other cases of Covid-19. This involved close work with colleagues in North West London Pathology (NWLP) to identify cases, and a number of complex incident meetings at the start of December as we responded to Omicron as a new Variant of Concern.

8. Healthcare-associated infection surveillance and mandatory reporting

8.1. ***C. difficile*** **infections:** the annual threshold for healthcare-associated *C. difficile* infection has been increased (FY 2021/22 compared to 2020/21) and we remain on target not to exceed this. This is also the second quarter in a row that we have reported zero lapses in care owing to transmission or lack of adherence to antibiotic policy.

8.1.1. ***E.coli*** **and** ***P. aeruginosa*** **BSI** remain below the threshold and do not flag as a cause for concern.

8.1.2. ***Klebsiella spp*****. BSI**: Whilst Q3 sees the incidence of healthcare-associated cases in line with the quarterly threshold, the current trajectory suggests we will surpass the annual threshold (60 cases at the end of Q3, against a year end ceiling of 68) (Table 1, Figure 1a).

8.1.2.1. *Klebseilla spp.* BSI have increased nationally. We rank 3rd lowest amongst the Shelford group based on Apr – Dec 2021 data (Figure 1b).

8.1.2.2. Local investigation of *Klebseilla spp.* BSI indicate 26% are attributable to vascular access devices and 12% to urinary (including urinary catheter) sources.

8.1.2.3. An action plan is being developed and comprises: (i) a Trustwide point-prevalence survey (PPS) with outcomes of interest including vascular access device use and rate of line-associated BSI by speciality (currently planned for mid-Feb 2022), ii) monthly MDT to review all healthcare-associated BSIs to understand commonalities in sources of infection, areas of high incidence, lapses in care, and (iii) gap analysis of national BSI reduction recommendations.

8.1.2.4. This plan builds on the current robust surveillance and clinical investigation process which accompanies the reporting of each bacteraemia.

8.1.2.5. In addition, as part of the work to improve the safety of line insertions in response to recent never events, we are developing a new programme of education and competency assessment for line care. The options appraisal will include how we provide training related to on-going management of lines for our staff. This will initially be targeted to high risk/high prevalence areas.

8.2. **MRSA BSI:** In Q3 there has been four MRSA BSI meeting UKHSA criteria of healthcare-associated (Table 1, Figure 2a).

8.2.1. As at the end of Q3, we have identified eight healthcare-associated MRSA BSI (4 in Q1/2), against an annual threshold of zero.

8.2.2. Based on Apr–Dec 2021 data we rank highest amongst the Shelford Group (Figure 2b). Six out of ten Shelford Trusts report an MRSA rate higher than the national mean, suggesting a higher burden of healthcare-associated MRSA BSI across larger Acute Trusts.

8.2.3. Table 2 details each case, source of bacteraemia and key outcomes and related learnings from each post-infection review. In summary:

8.2.3.1. Three clinically represented community-acquired infection (including two persistent deep infections and one linked to endocarditis/chest source identified on admission) despite meeting the UKHSA epidemiological criteria to be reported as healthcare-associated. As these criteria apply to all NHS Trusts these discrepancies in clinical and epidemiological definitions are likely to have a proportional impact nationally and as such do not explain the observed increase in our rate.

8.2.3.2. Of the 5 remaining patients, one had a community-acquired Covid pneumonitis and developed a MRSA BSI during their hospital admission.

8.2.3.3. The remaining four infections were confirmed as being attributable to a vascular access device, with sub-optimal line care practices including inadequate hand hygiene, imperfect decontamination of needle-free devices and inconsistent use of anti-septic patches

contributing. Each were successfully managed with targeted education and assessment by the vascular access team and divisions.

8.2.3.4. Four of the cases occurred in paediatric haematology, and we temporarily closed the paediatric BMT unit in response in October.

8.2.4. Alongside the actions relating to vascular-access device associated *Klebsiella sp.* BSI, we are taking the following actions:

8.2.4.1. ongoing observation and targeted education and assessment of aseptic non-touch techniques including vascular access device management including decontamination and appropriate use of antiseptic patches;

8.2.4.2. regular review of line infection surveillance data at the Trust's weekly HCAI sit-rep;

8.2.4.3. implementation of the updated IPC practice eduction and training programme (see next section);

8.2.4.4. Review MRSA screening compliance (see below);

8.2.4.5. Audit timing of suppression therapy to identify targeted actions in response to potential delays in prescriptions

9. IPC education, training and competency assessment

9.1. In September 2021 the IPC team outlined plans to undertake a Trust-wide hand hygiene and PPE audit, and plans to review our overall approach to IPC education and training – including the IPC competency assessment currently in place (commonly known as ANTT (aseptic non-touch technique) assessment).

9.2. Following the annual Trust-wide hand hygiene (HH) and personal protective equipment (PPE) audit that was conducted in October 2021 we had planned to meet with divisional colleagues to discuss the shared results, to identify areas to pilot alternative approaches to IPC education and training. This has been delayed as a result of the most recent surge of Covid-19 and the operational impact that this has had on the IPC team and wider Trust.

9.3. In light of new learning as a result of the most recent Covid-19 surge, and observed increase in central line associated blood stream infections (CLABSIs), we are proposing a slightly different model to change our IPC education and training – and to do so more quickly than the original plan.

9.4. Over the past six-months we have seen the positive impact of (i) front-loading education and training, and (ii) hands on support to clinical teams to when challenges with standard IPC practices are observed through infection-related incidents. With this in mind we are proposing we make some changes across the entire Trust, rather than a small number of pilot areas. We have reviewed the education and training undertaken by other Shelford Group Trusts (two other Trusts undertake an 'ANTT competency assessment') and across North West London and the proposals outlined here are in line with the practice of our contemporaries.

9.5. We are proposing that we implement the following by April 2022:

9.5.1. Cease delivery of our current IPC training and competency assessment process, including ANTT training and competency assessment.

9.5.2. Put in place enhanced level two IPC e-learning in line with the 'Skills for Health Framework' with additional training around the principles of asepsis, and central/peripheral line care for those staff undertaking line care. Currently level two IPC training is undertaken three-yearly by clinical staff. This is not aligned to the Skills for Health framework which recommends clinical staff should undertake level two IPC training annually. In making these changes and investing in an enhanced and high-quality e-learning platform we will ask all clinical staff to undertake this training between April and June 2022 as a baseline and then yearly moving forward.

9.5.3. Using capacity released by the stopping of ANTT assessment, implement a rolling programme of structured education and training visits across every area of the trust by the IPC team and divisional colleagues.

9.5.4. Undertake a trustwide quarterly focus on IPC practices linking in observation of practice, education, and training through the new Better Together Thursady initative.

9.5.5. We will commission support to explore the use of behavioural insights and positive reinforcement strategies/approaches in all clinical areas to support enhanced IPC practice. This requires further scoping, which is underway, but we plan to explore how we can use behavioural insights to make practical changes to improve IPC practice, and to also make more generalised recommendations.

9.5.6. In addition to the above we will meet with all clinical divisions to formally review the findings of the Trust-wide hand hygiene and PPE audit, with the aim to identify and agree on specific areas of concerns and specific actions for these areas.

9.5.7. In implementing this new approach we will continue to regularly monitor our rate of HCAI as well as maintain surveillance of other key indicators such as CLABSI, contaminated blood cultures and screening to ensure that we identify any consequence, positive or negative, of this change.

10. Screening

10.1. Compliance with infection screening metrics and progress with divisional actions to improve are reviewed weekly at the HCAI sit rep.

10.2. In Q3, one (elective screening compliance) out of five Covid-19 screening metrics (elective admissions) was below the 90% internal target, a marked improvement compared to Q2, where four of five were below 90% target (Figure 3a).

10.2.1. Covid-19 elective admissions compliance was 76% (average over the quarter), whihch is lower than expected. Contributing factors include re-opening of patient pathways, and patients screened at community/tertiary prior to admission not being recorded on CERNER automatically. We will audit compliance in Q4 to identify any additional issues and improvement plans.

10.3. CPE screening compliance remains good with minimal fluctuations below our internal threshold of 90%. Following targeted action, compliance in WCCS has improved but remains below our internal threshold (49% to 73%, Q2 vs Q3 respectively). SCCS compliance fell from 89% in Q2 to 82% in Q3 (Figure 3c).

10.4. Compliance with MRSA admission screening was 90% for Q3, marginally up from 89% for Q2, and at par with the internal target of 90% (Figure 3b). We will review the cases where MRSA screening did not occur in order to identify any specific themes or learning to support improvement.

10.5. We recognise the pressures clinical colleagues have been under over the last quarter which is likely to impact screening. As we move out of surge we will monitor these metrics closely and address any which fail to meet our internal target by March 2022.

11. Antimicrobial stewardship (AMS)

11.1. We continue to see an increase in the narrow spectrum antimicrobials prescribed within the Trust and are on target to meet 2021/22 NHSE/I antimicrobial metrics.

11.2. There is continued focus around highlighting and intervening on carbapenem prescribing and prolonged durations of antimicrobials. Patients within these two areas are discussed weekly within infection MDTs and liaison with specialities.

11.3. The antibiotic point prevalence survey took place in January 2022. Results are expected in February 2022.

11.4. A review of the AMS programme has taken place including an assessment against NICE AMS standards. We are on target to meet two out of the three 2021/22 NHSE/I antimicrobial metrics, with an action plan in place to ensure we achieve full compliance with the third (NICE AMS guidance - currently 88%).

12. Key updates in clinical activity, incidents, and lookback investigations

12.1. Surgical site infections (SSI) are reviewed quarterly with surgical specialities submitting information on SSI rates to PHE's national surveillance platform. SSI rates following orthopaedic surgery (knee, hip) remain below the UKHSA national benchmark figure of 0.6%, with zero SSIs flagged over the period six quarters (Jul 2020 – Dec 2021). One SSI post non-CABG procedure was flagged in Q3 – an endocarditis patient who developed a deep sternal

wound infection, resulting in an SSI rate of 2.9% which is over the UKHSA national average of 1.3%. Local speciality team investigations are currently underway.

12.2. We are currently reviewing our SSI work plan and will present this to EMBQ in March 2022.

13. Conclusion

13.1. This report summarises IPC activity in Q3 2021/22, plans in place and progressing in response to IPC-related issues, with particular emphasis on dealing with the latest Covid-19 surge.

13.2. In addition to this the report outlines our continued emphasis on working closely with speciality and divisional colleagues in managing incidents and outbreaks, ultimately helping deliver a high quality of patient care.

13.3. Q3 continued to flag the importance of antimicrobial stewardship initiatives to tackle multi-drug resistant infections, line-associated infection surveillance, and understanding ways in which to tackle healthcare-associated, particularly MRSA and GNR BSIs.

13.4. IPC continues to develop new approaches to training, assessment and support for staff for core IPC competencies and the paper outlines our plans to change our current apporach.

Author: James Price, Director of Infection Prevention and Control

Contributors: Tracey Galletly, Mark Gilchrist, Ian Bateman, Yeeshika Shersing, Carol Hernandez and Sid Mookerjee

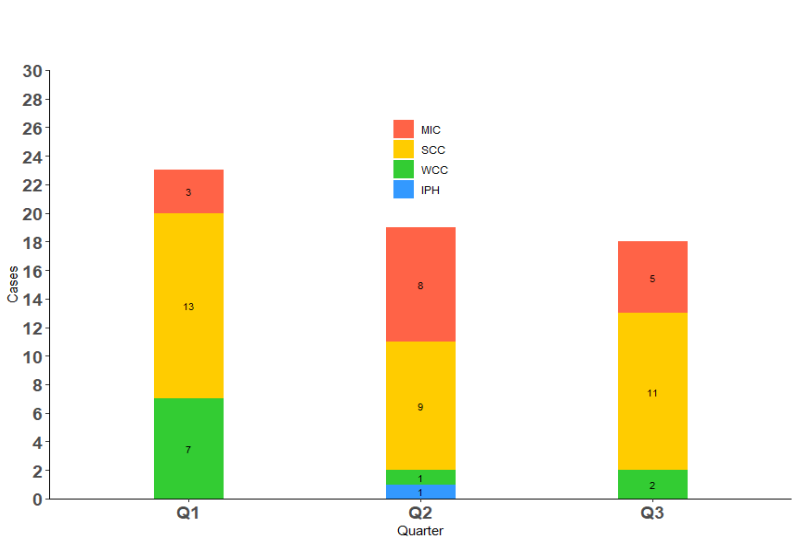
Date: 9 March 2022

Table 1: A cumulative summary of healthcare-associated infection and antimicrobial stewardship indicators, adopting a RAG rating to flag key areas of concern.

Section		Indicators	Q1	Q1 ceiling	Q2	Q2 ceiling	Q3	Q3 ceiling	Year end ceiling 21/22
Infections	Mandatory reportable infections	**Methicillin-resistant *Staphyloccocus aureus* (all healthcare-associated cases, HOHA + COHA)**	3	0	1	0	4	0	0
		Methicillin-sensitive *Staphyloccocus aureus* (all healthcare-associated cases, HOHA + COHA)	9	-	8	-	13	-	-
		***E.coli* (all healthcare-associated cases, HOHA + COHA)**	17	38	29	42	31	36	152
		***Klebsiella spp. (* all healthcare-associated cases, HOHA + COHA)**	23	16	19	18	18	18	68
		***P. aeruginosa* (all healthcare-associated cases, HOHA + COHA)**	9	13	16	14	10	12	51
		***C.difficile* (all hospital-associated cases, HOHA + COHA)**	16	25	20	26	13	24	99
	COVID-19	Hospital-Onset Indeterminate Healthcare Associated	7	-	17	-	49	-	-
		Hospital-Onset Probable Healthcare-Associated	3	-	5	-	38	-	-
		Hospital-Onset Definite Healthcare-Associated	0	-	6	-	56	-	-
		Incidents	8	-	36	-	34	-	-
		Outbreaks	0	-	11	-	23	-	-
	Surgical site infection	Knee Replacement	0.0%	0.6%	0.0%	0.6%	0.0%	0.6%	0.6%
		Hip Replacement	0.0%	0.6%	0.0%	0.6%	0.0%	0.6%	0.6%
		CABG	3.2%	3.8%	0.0%	3.8%	1.4%	3.8%	3.8%
		Other Cardiac	1.9%	1.3%	0.0%	1.3%	2.9%	1.3%	1.3%
	CLABSI	ICU CLABSI rate per 1000 line days	2.4%	3.6%	3.4%	3.6%	2.9%	3.6%	
		PICU CLABSI rate per 1000 line days	6.6%	3.6%	0.0%	3.6%	3.6%	3.6%	
		NICU CLABSI rate per 1000 line days	2.4%	4.4%	2.7%	4.4%	1.8%	4.4%	

Section		Metrics/Division	Q1	Q1 target	Q2	Q2 target	Q3	Q3 target
Screening metrics	COVID-19 Screening	Metric 1: NonElec 12 hr testing	89%	90%	87%	90%	90%	90%
		Metric 2: 5 day preadmission testing - inpatient electives only	75%	90%	71%	90%	76%	90%
		Metric 3: 72 hr pre discharge testing	96%	90%	82%	90%	98%	90%
		Metric 4: Inpatient 7 day testing	91%	90%	92%	90%	90%	90%
		Metric 5: Inpatient 3 day testing	89%	90%	88%	90%	90%	90%
	MRSA Screening	Medicine and Integrated Care	90%	90%	88%	90%	86%	90%
		Surgery, Cancer and Cardiovascular	90%	90%	90%	90%	87%	90%
		Womens, Childrens and Clinical Support	88%	90%	88%	90%	89%	90%
		Imperial Private Healthcare	98%	90%	99%	90%	97%	90%
	CPE Screening	Medicine and Integrated Care	96%	90%	96%	90%	92%	90%
		Surgery, Cancer and Cardiovascular	90%	90%	89%	90%	82%	90%
		Womens, Childrens and Clinical Support	59%	90%	49%	90%	73%	90%
		Imperial Private Healthcare	100%	90%	97%	90%	94%	90%

Figure 1a and 1b (left and right respectively): (Left) Healthcare-associated *Klebsiella spp* BSI by quarter, FY 2021/22, split by Division, (Right) Healthcare-associated *Klebsiella spp* BSI rate per 100,000 bed days, comparison across Shelford trusts (UKHSA, Apr – Dec 2021)



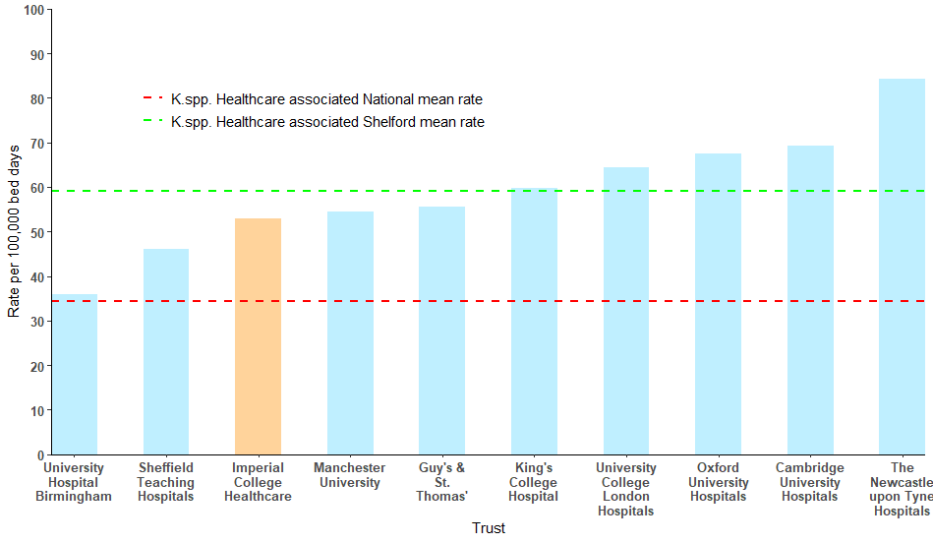
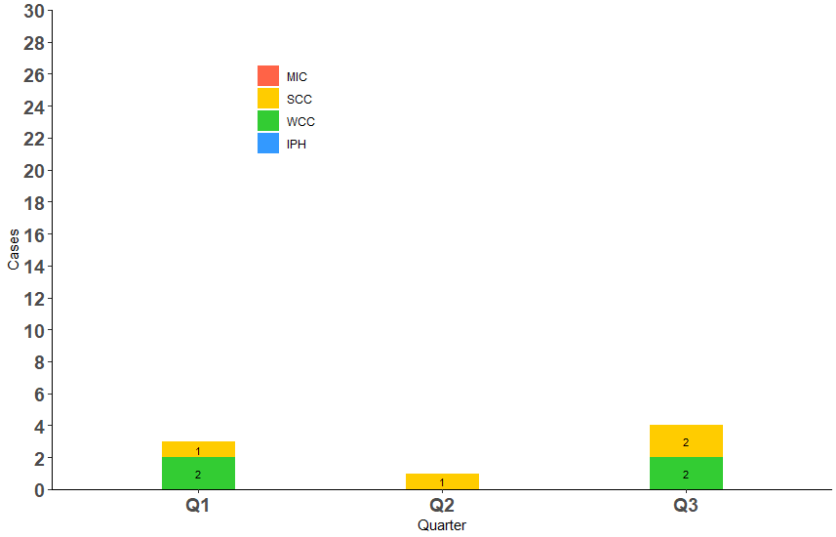


Figure 2a and 2b (left and right respectively): (Left) Healthcare-associated MRSA BSI by quarter, FY 2021/22, split by Division, (Right) Healthcare-associated MRSA BSI rate per 100,000 bed days, comparison across Shelford trusts (UKHSA, Apr – Dec 2021)



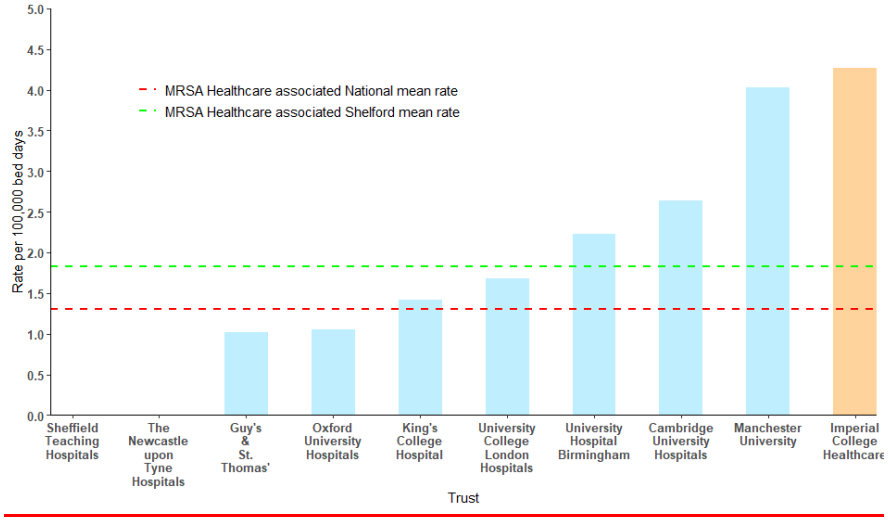
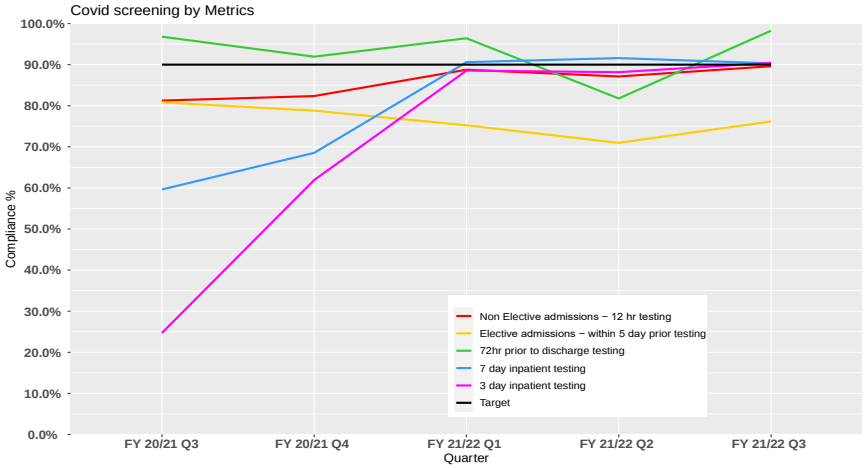
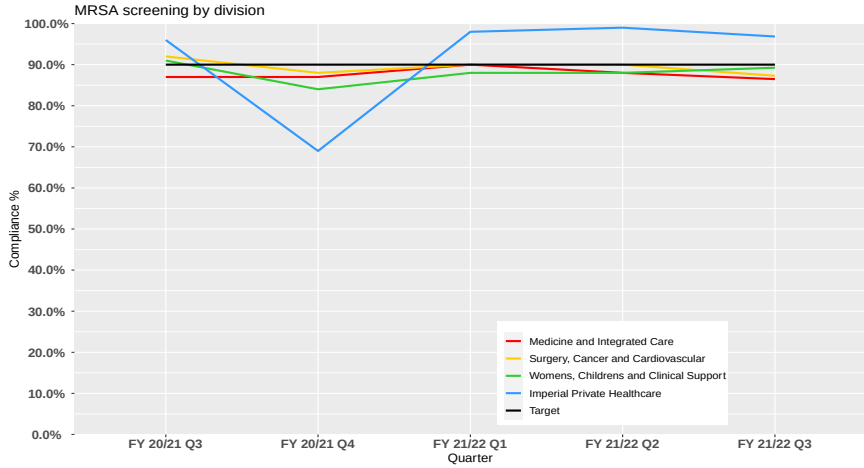


Figure 3a, 3b and 3c (left to right clockwise) Covid-19 screening compliance by metric, MRSA admission screening compliance by Division, CPE screening compliance by Division.

Q3 FY 2020/21 – Q3 FY 2021/22





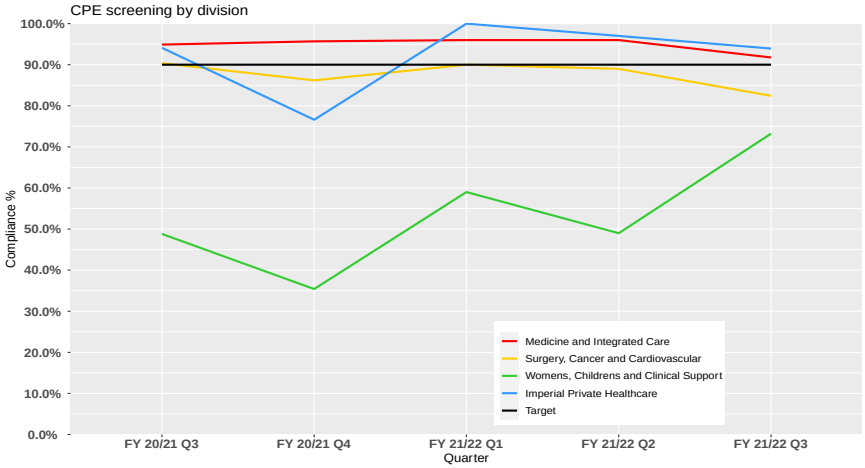


Table 2: Healthcare-associated MRSA BSI summarise compliance against 'investigation themes', source of infection and key learnings.

Key: BC = blood culture

Date	Division	MRSA colonisation known prior to this BC	MRSA screening issues	MRSA suppression issues	Were invasive devices managed appropiately	Were antimicrobials managed appropiately pre BC	Were any skin/soft tissue issues managed appropiately	Was the BC taken appropiately	Source	Key learnings
May-21	Surgery, Cancer, & Cardiovascular	Y	N	N	Y	Y	Y	Y	Persistent bacteraemia owing to community onset spinal abscess	None identified
Jun-21	Women's and Children's	Y	Y	Y	Y	Y	N/A	Y	Pneumonia and vascular access device associated	Delays in reporting the positive BC and initiation of suppression therapy
Jun-21	Women's and Children's	Y	Y	Y	Y	Y	N/A	Y	Persisent bacteraemia owing to Pneumonia and vascular access device associated	As above
Sep-21	Surgery, Cancer, & Cardiovascular	N	N	N	Y	Y	N/A	Y	Community acquired Covid pneumonitis with co-bacteraemia	None identified
Oct-21	Women's and Children's	Y	N	Y	N	Y	N/A	Y	Vascular access device associated	Education regarding the correct management of needle free connectors used for vascular access devices
Oct-21	Women's and Children's	N	N	N	N	Y	N/A	Y	Vascular access device associated	Education regarding the correct management of needle free connectors used for vascular access devices
Oct-21	Surgery, Cancer, & Cardiovascular	Y	N	Y	N	Y	N/A	Y	Endocarditis/Chest	Education regarding 1) the importance of completing full course of suppression therapy and 2) Consistent documentation of VA devices
Dec-21	Surgery, Cancer, & Cardiovascular	Y	N	Y	N	Y	Y	Y	Vascular access device associated	Education regarding 1) the importance of completing full course of suppression therapy and 2) Consistent documentation of VA devices

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Infection prevention and control board assurance framework

Agenda item 11 and paper number 08

Executive Director: Professor Julian Redhead Medical Director

Author: Dr James Price, Director of Infection Prevention and Control

Purpose: Information

Meeting date: 16 March 2022

1. Purpose of this report

1.1. This document provides an update on progress with completion of the actions required to provide assurance with all elements of the infection prevention and control (IPC) board assurance framework (BAF). This is a live document including the self-assessment from February 2022.

2. Executive summary

2.1. In June 2020, NHS England (NHSE) published an IPC BAF to support the provision of assurance to Trust boards that their approach to the management of Covid-19 is in line with national IPC guidance that risks have been identified and are mitigated.

2.2. In December 2021 the BAF was re-issued, revising previous key lines of enquiry (KLOE). The BAF now contains 125 KLOE over 10 domains; 42 KLOE remain unchanged from the previous BAF and 83 are either new or significantly revised and cover aspects of IPC practice beyond specifically Covid-19 as was previously the case.

2.3. The recommended approach is to undertake a self-assessment against the ten domains in the framework. This paper sets out actions and risk mitigations to KLOE that are not RAG rated as green.

2.4. The new KLOE are outlined in Appendix 1. In summary there are:

Domains aligned to the codes of practice in the Health & Social Care Act	No. of new / Revised KLOE	No. of unchanged KLOE	Total KLOE
1. Systems to manage and monitor the prevention and control of infection	11	4	**15**
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	17	0	**17**
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	3	2	**5**

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	6	2	**8**
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	15	4	**19**
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	10	2	**12**
7. Provide or secure adequate isolation facilities	7	0	**7**
8. Secure adequate access to laboratory support as appropriate	1	12	**13**
8. Secure adequate access to laboratory support as appropriate	3	3	**6**
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	10	13	**23**
Total	**83**	**42**	**125**

2.5. An action plan is in place to undertake the necessary work that will improve board assurance related to IPC management. This is being monitored weekly at the Clinical Reference Group (CRG) reporting to the Executive management board quality group (EMB-Q).

2.6. There are no red rated KLOEs. Following discussion and agreement at CRG, nineteen KLOE remain RAG rated as amber with actions in progress and designated leads for each area. This is more than the previously reported eight on the last version of the BAF, however this is reflective of the increase in KLOE rather than an escalation in risk or missing assurance.

3. Approval process

3.1. This self-assessment against the revised IPC BAF has been reviewed at CRG where the RAG ratings for each KLOE were agreed. Following sign off by the executive, it was presented to the Quality Committee in March which endorsed the actions being taken.

4. Recommendation(s)

4.1. The Board is asked to note the IPC BAF self-assessment for February 2022.

5. Next steps

5.1. The IPC BAF self-assessment will continue to be undertaken weekly and monitored through CRG and EMB-Q monthly.

6. Impact assessment

6.1. Quality impact: IPC and careful management of antimicrobials are critical to the quality of care received by patients at Imperial College Healthcare NHS Trust, crossing all CQC domains. This report provides assurance that IPC within the Trust related to COVID-19

is being addressed in line with the 'Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance.

6.2. Financial impact: N/A
6.3. Workforce impact: N/A
6.4. Equality impact: N/A
6.5. Risk impact: this report is a self-assessment based on the NHSE IPC BAF. Gaps in assurance and mitigating actions against each KLOE are outlined in the full document (appendix 1).

Main paper

7. Discussion/key points

7.1. The updated BAF action plan for February 2022 is attached as Appendix 1. Since the last report was presented to quality committee in January 2022 the BAF has been re-issued and is now substantially different to previous versions.
7.2. Considering the revised IPC BAF, we took the opportunity to re-review all previous KLOEs to ensure that our level of assurance remains appropriate, and to identify any additional actions that were required.
7.3. There are no KLOE currently rated as red. 106 KLOE have been rated as green on the revised BAF.
7.4. The following KLOEs are rated as amber:

- Hierarchy of controls (KLOE 1.3, 1.6, 2.12, 2.13, 2.14, 2.15, and 2.16): relating to using hierarchy of controls to support IPC risk assessments. Whilst we do conduct risk-based assessments, the hierarchy of control is a structured risk assessment for controlling exposure to occupational hazards using different risk avoidance or mitigation strategies in decreasing order of effectiveness. The hierarchy consists of hazard control measures grouped into five categories: elimination, substitution, engineering controls, administrative controls, and PPE. Following discussions with ICS, to align to the sector approach all prospective risk assessments will take place using hierarchy of control. Retrospective review of risk assessments will not take place. A number of these KLOE relate to actions around optimising ventilation on which Estates continue to lead a trust wide review. Our systematic approach to working through ventilation assessments and risk mitigations is comparable to other Trusts.
- Reporting (KLOE 1.9): relates to reporting to the executive leadership on a regular basis, via a daily sitrep, on Covid-19, other seasonal respiratory infections, and hospital onset cases. Work is on-going with NWLP to formalise reporting of influenza metrics to the daily operational sitrep.
- Signage and information (KLOE 4.6 and 5.1): relate to trust wide signage, providing sufficient information to visitors, staff and other patients about recognition and management of respiratory symptoms. Information is available to external visitors via the trust website, and current work is underway to optimise displayed signage.
- Screening (KLOE 5.3): relates to staff knowledge of appropriate screening question to ask patients and visitors as they attend appointments. Staff in relevant departments have local measures in place to coordinate screening attendees. To support this, we will publish a standardised screening template on the intranet for all staff. The template is currently being reviewed to incorporate recent national changes to guidance.
- Patient testing (KLOE 5.7): relates to compliance with routine patient testing for Covid-19. Several interventions have been introduced to meet internal targets of 90% set for each screening metric. These continued to be monitored by Divisional leads and compliance is reported at the weekly HCAI sit-rep.
- Compliance with mask wearing (KLOE 5.8. and 7.1): relates to inpatient compliance with wearing surgical masks. Following an audit revealing limited compliance the medical director's office is undertaking a review with divisional directors of nursing

to understand barriers to inform targeted interventions. This will continue to be monitored via CRG where actions are being discussed.

- Asymptomatic staff testing (KLOE 6.10): relates to the monitoring of staff-based compliance on asymptomatic testing. Whilst we receive some reporting metrics from the national reporting system this is not at a granular level, and so does not provide us with actionable information. This is a national challenge experienced by all providers and is outside the control of the organisation currently. Extensive discussions are on-going nationally regarding possible reporting metrics.
- Pathology test turnaround times (KLOE 8.4): relates to reporting sample turnaround times (TAT). Whilst we receive reporting time from laboratory receipt to results, there is incomplete information regarding timing of sample collection from patient to laboratory receipt. Work is on-going with colleagues in business intelligence and NWLP to address this and provide the TAT for the full sample journey.
- Staff break areas and changing facilities (KLOE 9.3): there is an extensive on-going trust wide development programme currently underway to address issues related to the provision of these facilities.
- Enhanced respiratory protective equipment (KLOE 10.13): specifically relates to those staff required to wear FFP respirators being fit tested for at least 2 different masks. 40% of staff require fitting for a second mask, and the emergency preparedness team have an action plan to address this.
- Enhanced respiratory protective equipment (KLOE 10.16): relates to the provision of reusable respiratory hoods for those staff that fail fit testing. Significant work has been undertaken to identify a product that can be appropriately decontaminated to maintain patient safety. The trust's emergency preparedness and decontamination teams are working through the necessary steps for implementation.

8. Conclusion

8.1. The IPC BAF has been completed for February 2022. The CRG will continue to devote part of its agenda to the BAF to ensure implementation of the actions required to provide full assurance.

Author Dr James Price, Director of IPC

Contributing Authors
Ian Bateman, Deputy Chief of Staff, Office of the Medical Director
Patricia Bourke, Deputy General Manager, Office of the Medical Director

Date: 10th March 2022

Appendix 1. IPC BAF February 2022

Domain	No.	Key Line of Enquiry	New or updated	RAG	Evidence	Gaps in assurance	Mitigating actions	Lead	Due	Outstanding actions	Progress update
1. Systems to manage and monitor the prevention and control of infection	Systems and processes are in place to ensure that:										
	1.1	a respiratory season/winter plan is in place: o that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services o to enable appropriate segregation of cases depending on the pathogen. o plan for and manage increasing case numbers where they occur. o a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan	Yes	Green	Thrice weekly executive huddles to discuss operations. Daily sit ops meetings ICHT winter plan. Multiplex testing in place		Laboratory multiplex PCR testing with TAT for 13.5hours after receipt in lab.	Site Operations / ED / Virology	Complete		
	1.2	health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	Yes	Green	COVID secure dashboard of workspaces have been assessed for 'covid security' is regularly reviewed; and 81% of workspaces have been assessed as being covid-secure. In particular, the clinical divisions have assessed over 99% of their workspaces. 99.3% of Estates and Facilities workspaces have now been assessed.	Timeframe for completion of 0.7% workspace remain unassessed. Mitigations in place for the 19% workspaces are not covid secure	Information to staff provided via Comms have been disseminated on covid-secure areas Information available on intranet. Updates given at all staff briefings	Occupational Health and Safety / Estates	Complete	No firm timeframe for assessment of those outstanding non-clinical workspaces Those non-clinical workspaces which have been identified as not covid-secure (should) have local mitigation plans and action plans drawn up to make them, in due course, covid secure. H&S is contacting the managers of those workspaces to check on any	
	1.3	Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: o based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. o applied in order and include elimination; substitution, engineering, administration and PPE/RPE. o communicated to staff.	Yes	Amber	COVID-19 patient assessment pathways agreed at the CRG and widely communicated. +Risk assessment of patients for COVID-19 during emergency admission pathways is embedded in the organisation. +Pathway breaches are reported on Datix and trigger incident investigation. +An audit of patient notes was completed in December	Evaluation of ventilation in clinical areas Retrospective risk assessment is not possible at present due to capacity. Commincation of processes pending crib sheet for HoC	An exercise is taking place to clarify the extent to which HoC assessments need to be carried out, including whether this needs to be done for every clinical area. It should be noted that if there is a requirement to roll the HoC process out widely this will have resource implications. New guidance is due to be released with likely updates on HoC. Decision to review these guidelines prior to implementation. Risk assessments in plan as mitigation.	Occupational Health and Safety / HR	31/03/2022	Remain amber whilst HoC integreated	
	1.4	safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	Yes	Green	Risk assessments reviewed at CRG and ICS			H&S	Complete		
	1.5	If the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	Yes	Green	All proposals for deviation from nationally recommended practices are reviewed and agreed through CRG. Current deviations include: (i) Staff with household contacts return to work with negative LFD test but prior to PCR result. (ii) LFT instead of PCR in outbreak testing (iv) mixing different risk level pathways (v) not adopting newest national IPC guidance		Regular review at CRG	MDO	Complete		
	1.6	risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.	Yes	Amber	Clinical areas have been reviewed by IPC and site teams Non-clinical areas, as per 1.2 / 1.3	As per 1.2 /1.3	As per 1.2/1.3	Occupational Health and Safety	31/03/2022	No firm timeframe for assessment of those outstanding non-clinical workspaces Those non-clinical workspaces which have been identified as not covid-secure (should) have local mitigation plans and action plans drawn up to make them, in due course, covid secure. H&S is contacting the managers of those workspaces to check on any	
	1.7	if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	Yes	Green	RPE in place in clinical areas where AGPs may occur, ventilation is not assessed, or when managing suspected or confirmed Covid-19 cases	Ventiltion assessment in clinical areas outstanding	FF3 use optional for those caring for patients with confirmed or suspected seasonal respiratory virus where ventilation is unknown	Estates / Communications	Complete		
	1.8	ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	Yes	Green	Audit of internal transfer documentation completed in Dec 2020 to provide this assurance	Re-audit required - up to date		Site Operations	Complete	Need to repeat audit	
	1.9	the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	No	Amber	""Daily sit rep of COVID-19 cases provided Pathology (NWLP), provide daily COVID-19 list but does not segregate hospital onset cases as this information sits with the Trust. This includes a daily list for all rapid COVID-19 tests performed in ED together with follow-up PCR performed. Seasonal Respiratory infections - Currently there is no daily list shared with Trust. A daily list	Confirm HOCI and other seasonal respiratory infection are provided on a daily basis		IPC - Epidemiology / NWLP	31/03/2022	05.01.22: Confirm with MD they receive daily updates of all three metrics Epi/BI/NWLP to provide data on seasonal respiratory infections SM/IB - conversation with BI to add figures to daily operational sitrep	
	1.10.0	there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	No	Green	The methodology for the daily COVID-19 sitrep has been agreed with IPC, and the Director of Operations Performance signs off the	Execs and senior leadship teams undertake regular rounds in clinical and non-clinical areas providing opportunities to check and challenge		Exec Board	Complete		

	1.11	resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	Yes	Green	Annual PPE and hand hygiene audit Reviews at incident meetings • Trust PPE guidance updated in line with PHE guidance regularly, approved at the CRG and communicated on the Intranet and via all-staff emails. • There is a bi-weekly Strategic PPE Planning group chaired by the Director of Nursing and including the Director of Finance.		Re-developing IPC practices education and competency assessments	Clinical Divisions	Complete		
	1.12	the application of IPC practices within this guidance is monitored, eg: o hand hygiene. o PPE donning and doffing training. o cleaning and decontamination.	Yes	Green	IPC practice education and assessment	Further action is required to obtain assurance on staff adherence to hand hygiene, staff physical distancing across the workplace, and staff adherence to wearing fluid resistant surgical facemasks (FRSM) in non-clinical settings.		Clinical Divisions	Complete		
	1.13	the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	No	Green	The Board Assurance Framework is RAG rated, updated monthly, and reviewed by the Executive Team at EMB Quality and the Trust Board. In addition, an associated action plan is			IPC - DIPC	Complete		
	1.14	the Trust Board has oversight of ongoing outbreaks and action plans.	No	Green	The Board Assurance Framework is RAG rated, updated monthly, and reviewed by the Executive Team at EMB Quality and the Trust Board. In addition, an associated action plan is			IPC - DIPC	Complete		
	1.15	the Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Made FFP3 masks are available to users as required.	Yes	Green	Daily SitReps include details on the supply of required PPE and consistently report sufficient stock levels. The PPE strategic planning group has responsibility for ensuring that we have a secured supply of PPE as needed and for responding to changes in PPE from a supply line perspective. PPE can be ordered by all teams as needed.	Of the six types of disposable FFP3 masks that the Trust provides, five are UK manufactured and one brand is *not*.		Procurement	Complete		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	Systems and processes are in place to ensure that:										
	2.1	the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.	Yes	Green	Trust has fully implemented the new cleaning standards, and has a full audit schedule and new audit team structure to comply with			Facilities - Stuart Walmsley	Complete		
	2.2	the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	Yes	Green	There are standard notification processes in			Facilities	Complete		
	2.3	cleaning standards and frequencies are monitored in clinical and non- clinical areas with actions in place to resolve issues in maintaining a clean environment.	Yes	Green	•Clear guidance for cleaning and disinfection in non-clinical areas has been issued, and posters are in place to remind staff of the new for frequent environmental hygiene. •The frequency of monitoring cleaning in non-clinical areas has been increased from 6 monthly to		Non-clinical environments	Facilities	Complete		
	2.4	increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.	Yes	Green	Trust guidance, which is based on national guidance, has been produced and published on the Intranet			Facilities	Complete		
	2.5	Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.	Yes	Green	2.6 •In all medium and high risk pathways, cleaning and disinfection is undertaken using Actichlor plus (a chlorine-based detergent disinfectant). •Disinfection of some items is undertaken using Clinell Green detergent/disinfectant wipes, which are effective against non-enveloped			Facilities / IPC - Decontamination	Complete		
	2.6	if an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	Yes	Green	Manufacturers' guidance and recommended product 'contact time' are followed for all cleaning/disinfectant solutions/products.			IPC - Decontamination / Facilities	Complete		
	2.7	manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	Yes	Green	Manufacturers' guidance and recommended product 'contact time' are followed for all cleaning/disinfectant solutions/products.			Facilities / IPC - Decontamination	Complete		
	2.8	a minimum of twice daily cleaning of: o patient isolation rooms. o cohort areas. o Donning & doffing areas o 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails. o where there may be higher environmental contamination rates, including toilets/commodes particularly if patients have diarrhoea.	Yes	Green	This applies to medium and high risk pathways. Trust guidance, including the need for increased cleaning in some areas, has been produced and published on the Intranet. Each site maintains a record of which ward areas are undergoing enhanced			Facilities / IPC - Decontamination	Complete		

	2.9	A terminal/deep clean of inpatient rooms is carried out: o following resolutions of symptoms and removal of precautions. o when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens); o following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room)	Yes	Green	Trust guidance, which is based on national guidance, has been produced and published on the Intranet.			Facilities / IPC - Decontamination	Complete			
	2.10.0	reusable non-invasive care equipment is decontaminated: o between each use. o after blood and/or body fluid contamination o at regular predefined intervals as part of an equipment cleaning protocol	Yes	Green	Trust guidance for the use of single use items is included in the Trust Decontamination Policy. All PPE items are either decontaminated using manufacturer instructions or single use. Appropriate items are sent to equipment library, items which remain on the wards are cleaned per protocol. Equipment inspections form part of teh IP&C environmental reviews and are a particular			Clinical Divisions	Complete			
	2.11	Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	Yes	Green	Trust guidance for the use of single use items is included in the Trust Decontamination Policy. All PPE items are either decontaminated using manufacturer instructions or single use. Cleaning scores are monitored through the quality scorecard to EMBQ. We get countermeasure summaries when we're below target from the EAE team			Clinical Divisions / Facilities	Complete			
	2.12	As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities.	Yes	Amber / Red			Gap analysis against 04-01 Patient Care Health Building Note	Estates / Health & Safety	31/03/2022	amber whilst HoC are incorporated. Clarity provided that all areas require assessment but starting with all inpatient areas		
	2.13	the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.	Yes	Amber				Estates / Health & Safety	31/03/2022	amber whilst HoC are incorporated. Clarity provided		
	2.14	a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	Yes	Amber	Review of windows and doors has taken place As per	Formal ventilation assessments required.	RPE according to HoC	Estates / Health & Safety	31/03/2022	amber whilst HoC are incorporated. Clarity provided that all areas		
	2.15	where possible air is diluted by natural ventilation by opening windows and doors where appropriate	Yes	Amber	The importance of ventilation has been communicated to staff. A review enhanced ventilation in admission and waiting areas is now required	The review is complete in all clinical and non-clinical areas	Need to see evidence of review	Estates / Divisions	31/03/2022	amber whilst HoC are incorporated. Clarity provided that all areas require assessment but starting with all inpatient areas		
	2.16	where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	Yes	Amber				Estates	31/03/2022	amber whilst HoC are incorporated. Clarity provided		
	2.17	when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	Yes	Green	•Screens are used in some non-clinical areas to improve segregation of staff. •Staff working in clinical areas continue to wear surgical masks, even if they are behind a screen			Estates	Complete			
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance		System's and process are in place to ensure that:										
	3.1	arrangements for antimicrobial stewardship are maintained	No	Green	Arrangements for AMS are maintained - Regular Antimicrobial Review Group & TIPCC meetings & documented minutes and action plans - NICE AMS Compliance audit – completed in 2021 - Antibiotic App in operation to aid prudent selection at the point of prescribing			IPC / AMS	Complete			
	3.2	previous antimicrobial history is considered	Yes	Green	- Cerner Previous Antimicrobial History is considered - Electronic patient records enable previous therapeutic history to be reviewed at any time point. - Electronic patient records enable link to primary care GP records through NHS spine - Antimicrobial stewardship ward rounds in operation to			IPC / AMS	Complete			
	3.3	the use of antimicrobials is managed and monitored: o to reduce inappropriate prescribing. o to ensure patients with infections are treated promptly with correct antibiotic.	Yes	Green	Use of antimicrobials is managed/ monitored at individual patient level , but not at trust level, which would provide great levels of assurance against NICE guidelines - Monthly review of antimicrobial consumption (bacterial and fungal) to ensure within NHSE/ PHE / WHO criteria for prudent antimicrobial use - Point Prevalence		lack of regular antimicrobial resistance data (trust level) leading to potentially excessive or sub-optimal empirical therapies.	IPC / AMS	Complete			

	3.4	mandatory reporting requirements are adhered to, and boards continue to maintain oversight.	No	Green	Mandatory reporting requirements are adhered to and boards continue to maintain oversight - Quarterly reporting of AMS within IPC &AMS EMB quality report. - GAP – Previous used to report quarterly to CCG to share best practice. This needs to be re-energised			IPC/AMS/EPI	Complete		
	3.5	risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	Yes	Green	Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens – on the basis of resistance data which is a clinical risk - Standing agenda for unintended consequences within ARG for changes in policies - Quarterly DATIX report from Medication Safety with any antimicrobial		lack of regular antimicrobial resistance data leading to potentially excessive or sub-optimal empirical therapies.	IPC/AMS/EPI	Complete		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	Systems and processes are in place to ensure that:										
	4.1	visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors	Yes	Green	Trust policy & guidance reflects this and is under regular			Corporate Nursing	Complete		
	4.2	national guidance on visiting patients in a care setting is implemented.	No	Green	Trust policy & guidance reflects this			Corporate Nursing	Complete		
	4.3	restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	Yes	Green	All visiting restrictions considered and where appropriate recommended suspended non-essential visitors in active outbreak situations. Does not apply to designated essential carers FGI etc		Comms to patients and visitors Use of virtual visits	Corporate Nursing	Complete		
	4.4	there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing.	Yes	Green	•The communications team have produced signage to designate areas used to care for patients with confirmed or suspected COVID-19, and for designated COVID-protected pathways. •Clear signage has also been designed to designate COVID-secure non-clinical workspaces.		Discrepencies in face mask / face covering	Corporate Nursing	Complete		
	4.5	If visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	Yes	Green	•Each hospital entrance has a welcome station with signage to encourage 'hands, face, space.' Ward areas have entrance signage. Guidance for vistors is alsso published on our trust website and is regularly reviewed		Gaps in comms for relatives at ward level	Corporate Nursing / C	Complete		
	4.6	visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	Yes	Amber	Covered in policy, guidance and patient information		policy in place but recent evidence shows gaps in application - challenges on exemptoin etc	Corporate Nursing / C	31/03/2022	signage does not cover this - but internet does state that you should not come to hospital if you are symptomatic - remain amvber whilst signage is updated	
	4.7	visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian.	Yes	Green	These restrictions are in place. clinical areas where AGPs take place are aware of IPC requirements included visitors not present. Only occurs when essential such as parents of young			Corporate Nursing	Complete		
	4.8	Implementation of the Supporting excellence in infection prevention and control behaviors implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	No	Green	Review of each of the resources noted in the toolkit is taking place. Decision on whether the implementation of these on ICHT or alternatives in place			IPC - DIPC	Complete		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	Systems and processes are in place to ensure that:										
	5.1	signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Yes	Amber	5.2 •COVID-19 patient assessment pathways approved at CRG and widely communicated for the Emergency Department and Admission wards. These included physical segregation of patients with confirmed COVID-19 or symptoms from		need evidence	Communications	31/03/2022	amber whilst signage is updated	
	5.2	infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.	Yes	Green	•Patients are tested 48 hours prior to discharge. •COVID-19 status is automatically included in patient discharge summaries. •Compliance with discharge testing is monitored electronically		Internal comms	Clinical Divisions	Complete	need to re-audit	
	5.3	staff are aware of agreed template for screening questions to ask.	No	Amber	•Staff are aware of agreed template for triage questions to ask. Compliance was audited in late 2020."	Sample screen tool for use in Covid-19 in healthcare settings	New up to date audit required	Clinical Divisions / Communications	31/03/2022	Screening template and questions are in place, however are not available on intranet. ** to be checked and then reviewed and updated pending UKHSA guidance re: removal of government	

	5.4	screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.	Yes	Green	Triaging and testing processes are in place and embedded in all care pathways.	Compliance with admission testing is <100%.	Compliance with routine patient testing is monitored weekly (Divisional leads). Patients who have tested negative on/before admission and are not COVID-recovered have been tested daily for the first 7 days of their admission. Weekly discussion at HCAI sit rep. Divisions actioned with understanding reason why some metrics remain below 90% to support targeted interventions	Clinical Divisions	Complete		
	5.5	front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.	Yes	Green	COVID-19 patient assessment pathways approved at CRG and widely communicated for the Emergency Department and Admission wards. These included physical segregation of patients with confirmed COVID-19 or			Clinical Divisions / Site Operations	Complete		
	5.6	triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	Yes	Green	COVID-19 patient assessment pathways including the triggers for patient testing approved at CRG and widely communicated. Processes in place about allocation to appropriate			Clinical Divisions	Complete		
	5.7	there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	Yes	Amber	•Compliance with patient testing pre-admission, on admission, on day 3, day 7, weekly, and prior to discharge (if required) is monitored automatically.	Compliance remains <100%.	Patients who have tested negative on/before admission and are not COVID-recovered have been tested daily for the first 7 days of their admission Weekly discussion at HCAI sit rep. Divisions actioned with understanding reason why some metrics remain below 90% to support targeted interventions	Clinical Divisions	31/03/2022	appropriate testing protocols in place but need aligning to HoC	
	5.8	patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.	Yes	Amber	5.7 •Clear advice is provided to all patients to encourage the use of surgical facemasks unless they are eating, drinking, or sleeping. •If a patient is unable to wear a surgical mask, this is documented in Cerner.		re-audit or not doing ?	Clinical Divisions	31/03/2022	Discussion at CRG re: proportinate review and ?audit with focus on offer of mask rather than wearing one. Not currently happening in all areas. This will form part of changing to symptom based pathways	
	5.9	patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result.	Yes	Green	Rapid identification and testing of patients along with contact tracing is in place.			Site Operations / Clinical Divisions / ED	Complete		
	5.10.0	patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.	Yes	Green	Discussion on-going with site operations and clinical divisional colleagues to obtain evidence			Site Operations / Clinical Divisions / ED	Complete		
	5.11	patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their	Yes	Green	Face masks are available for patients with respiratory symptoms. Patients are advised to wear surgical masks unless they are eating, drinking, or sleeping. If a patient is not able to wear a surgical mask, this is documented in Cerner		At the point of admission and throughout their stay in hospital all patients are managed against our bed base on the basis of their clinical presentation, risk factors and comorbidities/vulnerabilities. This took place prior to Covid-19 are remains standard clinical practice	Site Operations / Clinical Divisions / ED	Complete		
	5.12	families and carers accompanying them for treatments/procedures must be considered.	Yes	Green	Face coverings are required by all outpatients and visitors and this is reinforced by welcome station staff. •PPE Helpers have spent some time in welcome stations to			Site Operations / Clinical Divisions / ED	Complete	to develop guidance for visitors as part of new visiting criteria	
	5.13	where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	Yes	Green	•Patients attending for routine appointments are triaged to make sure they don't have symptoms consistent with COVID-19. •Patients that are not tested prior to their admission are managed on medium risk pathways. •Recovery plans are scrutinised to ensure face-to-face is the exception not the rule. •All recovery plans are approved by the site IPC lead			Site Operations / Clinical Divisions / ED	Complete		
	5.14	face masks/coverings are worn by staff and patients in all health and care facilities.	Yes	Green	•Clear advice is provided to all patients to encourage the use of surgical facemasks unless they are eating, drinking, or sleeping. •If a patient is not able to wear a surgical mask, this is documented in Cerner	There are systems and processes in place. Staff adherance os regularly monitored by ward based leadership, and PPE helpers as well as IPC colleagues. Patient compliance with face mask wearing has not been audited.	Monitoring compliance with patient mask wearing (clinical audit team). An audit of patient compliance with face mask wearing has been completed and results shared with divisions. This exercise will be re-assessed in light of new guidance	Clinical Divisions / Corporate Nursing	Complete		
	5.15	where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.	Yes	Green	•Clear guidance has been given to staff about the need to maintain physical distancing of at least 2m wherever possible. •Beds and patient chairs should be spaced >2m apart when possible (bed centre to bed centre). •"Chair, bed, locker" arrangement of furniture is in place. Review of entire trust took place and 2m distanced confirmed. Process in place	Some bed / trolley spaces are not >2m apart.	Bed spacing across the Trust has been reviewed. The areas where bed spacing is <2m are the neonatal units at QCCH and SMH, parts of labour recovery at HH, and parts of AB2 (maternity) at SMH. A risk assessment has been undertaken (approved at CRG) in these areas to document the mitigations in place. The mitigation measures for these areas are now in place.	Site Operations / Clinical Divisions / ED	Complete	Need to align boarding policy	

	5.16	patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff.	Yes	Green	•Screens are used in some non-clinical areas to improve segregation of staff. •Staff working in clinical areas continue to wear surgical masks, even if they are behind a screen			Site Operations / Clinical Divisions / ED	Complete		
	5.17	patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly.	No	Green	•COVID-19 patient assessment pathways widely communicated. •Pathway breaches are reported on Datix and trigger incident investigation.	Pre-emptive isolation of patients who develop symptoms following a negative test are not always available due to lack of single room availability.	Situations are managed on a case-by-case basis with input from the IPC team, usually be establishing cohorts of confirmed or suspected patients. There is a risk on the IPC risk register related to limited isolation facilities in the Trust.	Site Operations / Clinical Divisions / ED	Complete		
	5.18	isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative.	No	Green	Rapid identification and testing of patients along with contact tracing is in place.			Site Operations / Clinical Divisions / ED	Complete		
	5.19	patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	No	Green	•Patients attending for routine appointments are triaged to make sure they don't have symptoms consistent with COVID-19. •Patients that are not tested prior to their admission are managed on medium risk pathways. •Recovery plans are scrutinised to ensure face-to-face is the exception not the rule. •All recovery plans are approved by the site IPC lead			Clinical Divisions / OPD	Complete		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	Systems and processes are in place to ensure that:										
	6.1	appropriate infection prevention education is provided for staff, patients, and visitors.	Yes	Green	Staff have been trained to follow PHE guidance on PPE usage and have had donning and doffing training, there are posters in all clinical areas, and advice readily available on the Trust intranet. All staff are asked to complete Infection Prevention Training at Induction – Level 1 for Non-Clinical – Level 2 for Clinical. Clinical Staff Complete			IPC - DIPC	Complete		
	6.2	training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	Yes	Green	•All staff undergo electronic IPC training (IPC Level 1), with clinical staff receiving a more detailed session	Compliance is >90% for Level 1 and Level 2.	The need for high compliance with this (and other) mandatory training is a Trust priority.	IPC - DIPC	Complete		
	6.3	all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	Yes	Green	•All staff receive training on appropriate use of PPE.	Ward-based training records are not routinely stored electronically.	The content of mandatory training for clinical staff has been reviewed and it covers the selection of appropriate use of PPE and how to safely don and doff. Compliance with this training ("IPC Level 2") is reviewed at the Executive People and Organisational Development Committee. An updated electronic resource for training staff related to PPE has been produced and will be launched in the coming weeks	IPC - DIPC	Complete		
	6.4	adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	Yes	Green	•PPE helper programme provide ward-level support for staff to use the correct PPE, and to use it safely. •The PPE helper programme provides an assessment of adherence to national guidance around PPE in clinical areas. •The safe and effective use of PPE is a strategic objective of the Hand Hygiene and PPE Improvement Group, which meets monthly		PPE helpers are visiting clinical areas daily to observe PPE use and support best practice.	IPC - DIPC - Divisions	Complete		
	6.5	gloves are worn when exposure to blood and/or other body fluids, non- intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	Yes	Green	reviewing IPC practice and training, discussion with clinical divisions		need audit data - check with tracey HH audit	IPC - DIPC - Divisions	Complete		
	6.6	the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance.	No	Green	•Hand driers are not used in clinical areas. •Hands are dried using disposable paper towels in clinical areas.		Some public toilet spaces withi main outpatient areas have handdryer, but there are not considered clinical soaces	Estates / IPC - Decontamination	Complete		
	6.7	staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	Yes	Green	Clear guidance has been given to staff about the need to maintain physical distancing of at least 2m wherever possible.			Clinical Divisions	Complete		
	6.8	staff understand the requirements for uniform laundering where this is not provided for onsite.	No	Green	•The Trust Uniform Policy provides specific information about laundering uniforms. Scrubs were used in more areas during the peak of the pandemic and increased laundry facilities provided to ensure safe laundering			Clinical Divisions	Complete		

	6.9	all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance.	Yes	Green	Test and Trace service work and existence, including contact tracing Staff response to being contacted Covid Helpline Intranet info Work of Trust contact managers (e.g. with CBRE) to raise awareness Whoever has been liaising with the Trust Charity re volunteers			Occupational Health	Complete		s Note that OH/ Test & Trace is responsible mainly for reactively dealing with this agenda e.g. in contact-tracing and outbreak management Test & Trace working collectively with other departments (e.g. Medical Directors Office, IP&C and Comms) is responsible for proactive mangaement of this area e.g. for ward-based outbreaks and PCR testing
	6.10.0	to monitor compliance and reporting for asymptomatic staff testing	Yes	Amber	•Routine testing using lateral flow testing has been implemented and is available to all patient-facing staff. •For staff who participate, positive and negative results are recorded using an electronic system, with automated reminders in place if results are not logged twice weekly. •Staff who report a positive lateral flow test are contacted to arrange a PCR confirmatory test.		National reporting issues	MDO	31/03/2022	Amber - we are able to monitor and report based on the data we receive from the governmental reporting system, but this does not provide granular information. This is a national challenge.	
	6.11	there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	Yes	Green	•IPC review each new case of COVID-19 to identify possible cross transmission. •The rate of hospital-onset COVID-19 infection at ICHT and across London is reviewed weekly at CRG. •Occupational Health review each new case of COVID-19 in staff to identify possible cross-transmission			IPC - DIPC	Complete		
	6.12	positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	Yes	Green	•Robust procedures are in place for the identification and management of COVID-19 outbreaks in patients and/or in staff. •Learning is captured from local and regional COVID-19 outbreaks			IPC - DIPC	Complete		
7. Provide or secure adequate isolation facilities	Systems and processes are in place to ensure:										
	7.1	that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or	Yes	Amber	•Clear advice is provided to all patients to encourage the use of surgical	Patient compliance with face mask wearing has not been audited.	Monitoring compliance with patient mask wearing (clinical audit team). An	Clinical Divisions	31/03/2022	As above to be fed into new symptomatic pathway - partially	
	7.2	separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.	Yes	Green	The Trust has adopted a risk pathway system for all areas, designating the area based on patient status and PPE requirements to safely manage that cohort. Includes use of symptom checker			Outpatients / Clinical Divisions	Complete		
	7.3	patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	Yes	Green	•COVID-19 patient assessment pathways approved at CRG and widely communicated, including the preferable use of single rooms for patients with confirmed or suspected COVID-19	There are limited single rooms in our Trust, so patients with confirmed COVID-19 have been cohorted together in clearly designated areas according to the guideline approved at CRG	IPC have advised on when it is appropriate to cohort patients together. There is a risk on the IPC risk register related to limited isolation facilities in the Trust.	Site Operations / Clinical Divisions	Complete		
	7.4	patients are appropriately placed ie, infectious patients in isolation or cohorts.	Yes	Green	•IPC review each new proposed cohort area to ensure compliance with PHE national guidance			Site Operations / Clinical Divisions	Complete		
	7.5	ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	Yes	Green	•Clear guidance has been given to staff about the need to maintain physical distancing of at least 2m wherever possible. We undertake assessment of areas and have processes in place to discuss any derogation.	Some bed / trolley spaces are not >2m apart.	Bed spacing across the Trust has been reviewed. The areas where bed spacing is <2m are the neonatal units at QCCH and SMH, parts of labour recovery at HH, and parts of AB2 (maternity) at SMH. A risk assessment has been undertaken (approved at CRG) in these areas to document the mitigations in place. The mitigation measures for these areas are now in	Site Operations / Clinical Divisions / Estates	Complete		
	7.6	standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	Yes	Green	reviewing IPC practice and training, discussion with clinical divisions			Clinical Divisions	Complete		
	7.7	the principles of SICPs and TBPs continued to be applied when caring for the deceased	Yes	Green	Mortuary staff follow UK Health Security Agency & HSE guidance on care of the deceased			Corporate Nursing	Complete	Corporate Nursing	
8. Secure adequate access to laboratory support as appropriate	There are systems and processes in place to ensure:										
	8.1	testing is undertaken by competent and trained individuals.	No	Green	•Testing is performed in accredited laboratories.			MDO	Complete		
	8.2	patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance;	No	Green	Pathways for testing symptomatic patient and staff have been established and outlined on the Trust Intranet. Trust Test and Trace processes are in place. We comply with national guidance on covid As the national guidance on other respiratory viruses in interpreted locally we do this. we offer testing for all viruses all year round and step up when we need to based		promptly	NWLP	Complete		

	8.3	staff testing protocols are in place	No	Green	•Pathways for testing symptomatic patient and staff have been established and outlined on the Trust Intranet. Trust Test and Trace processes are in place			MDO	Complete		
	8.4	there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available.	No	Amber	Pathology TATs are monitored from sample receipt in the pathology specimen reception. Monitoring can extend to the when the order was placed (referred in our system as collection date) but this has been shown to be unreliable since physical sample collection is often different from the time the electronic test		lab based not pt based	NWLP	31/03/2022	We have data from sample request but these may not always accurately reflect the time taken from the patient. Discuss with Sid about what data we have from COVID swabs metrics and can these be used as surrogate markers	
	8.5	there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data).	No	Green	•The laboratory have clear SOPs and quality assurance systems in place. Results are reported through Cerner.			NWLP	Complete		
	8.6	screening for other potential infections takes place.	No	Green	•The laboratory have clear SOPs and quality assurance systems in place. Results are reported through Cerner.	Compliance with MRSA admission screening was on target at 90% for Q4: 5813 of the 6488 patients identified as requiring MRSA screening were screened. Overall compliance with CPE admission screening was 83%, and >90% in the four specialties performing universal admission screening.	Screen for COVID MRSA CPR Gram negatives in neonates	NWLP	Complete		
	8.7	that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	No	Green	Requesting of these tests is down to the Clinical teams. NWLP offers rapid screening in each hospital for COVID-19 as well as Influenza-A, Influenza-B and RSV during the seasonal periods for these viruses. Testing for a more extending respiratory viruses panel takes place in the main pathology Hub at Charing Cross.	Compliance with testing is monitored electronically and is <100%.	Patients who have tested negative on/before admission and are not COVID-recovered have been tested daily for the first 7 days of their admission. Weekly discussion at HCAI sit rep. Divisions actioned with understanding reason why some metrics remain below 90% to support targeted interventions.	NWLP	Complete		
	8.8	that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise.	No	Green	Requesting of these tests is down to the Clinical teams. NWLP offers rapid screening in each hospital for COVID-19 as well as Influenza-A, Influenza-B and RSV during the seasonal periods for these viruses. Testing for a more extending respiratory viruses panel takes place in the main pathology Hub at Charing Cross. Staff are encouraged to re-test when ever symptoms emerge or clinical suspicioun	Compliance with testing is monitored electronically and is <100%.	Patients who have tested negative on/before admission and are not COVID-recovered have been tested daily for the first 7 days of their admission. Weekly discussion at HCAI sit rep. Divisions actioned with understanding reason why some metrics remain below 90% to support targeted interventions. Need to audit time from symptom onset to test collection	NWLP	Complete		
	8.9	that all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission.	No	Green	Requesting of these tests is down to the Clinical teams. NWLP offers rapid screening in each hospital for COVID-19 as well as Influenza-A, Influenza-B and RSV during the seasonal periods for these viruses. Testing for a more extending respiratory viruses panel takes place in the main pathology Hub at Charing Cross.	Compliance with testing is monitored electronically and is <100%.	Patients who have tested negative on/before admission and are not COVID-recovered have been tested daily for the first 7 days of their admission. Weekly discussion at HCAI sit rep. Divisions actioned with understanding reason why some metrics remain below 90% to support targeted interventions.	Clinical Divisions	Complete		
	8.10.0	that sites with high nosocomial rates should consider testing COVID-19 negative patients daily.	No	Green	•Contacts of a known positive case are testing daily through their 14 day isolation period. •Patients who have tested negative on/before admission and are not COVID-recovered are tested daily for the first 7 days of their		currently restricted to Live outbreak areas only	IPC - DIPC	Complete		
	8.11	that those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge.	No	Green	Homes request up to date swabs before admitting. These requests are processed through the discharge hub emails. Wards have access to rapid swabs when a bed has been confirmed and their existing swab is out of date. We keep a record of most up to date swab result in the Complex discharge tracker. Discharge teams ensure prompts are done to wards on weekends when	No programme of regular audits yet in place - done on ad hoc basis	Complete small sample audit	MIC - Discharge Team	Complete	Complete small sample audit	
	8.12	those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	No	Green	Discharge to Assess forms have specific request for isolation dates. These dates are monitored on the complex discharge tracker. All patients requiring rehab bed or care home bed are referred to Designated Units via the discharge hub inbox. They remain on those waiting lists for the duration of their isolation period	No programme of regular audits yet in place - done on ad hoc basis	Complete small sample audit	MIC - Discharge Team	Complete	Complete small sample audit	

	8.13	there is an assessment of the need for a negative PCR and 3 days self- isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	Yes	Green	Discussed with appropriate clinical teams and decision made not to implement LFTon day of admission across the trust at that time			Clinical Divisions	Complete		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections	Systems and processes are in place to ensure that											
	9.1	the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	Yes	Green	The IPC Team perform regular Quality Ward Walks on all wards in the Trust. If a ward has been identified as an outbreak ward, then an enhanced Quality Ward walk will be completed. This observes adherence to Hand Hygiene, social distancing and adherence to wearing surgical facemasks in both clinical and non-clinical			IPC - DIPC	Complete		
	9.2	staff are supported in adhering to all IPC policies, including those for other alert organisms.	Yes	Green	•IPC policies are published on the Trust Intranet and promoted via various channels. IPC support staff in implementation			IPC - DIPC	Complete		
	9.3	safe spaces for staff break areas/changing facilities are provided.	Yes	Amber	we do not universally provide appropriate staff break area/changing facilities.			HR / Estates / H&S / Divisions	31/03/2022	On-going trust wide improvement plan to address this	
	9.4	robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	No	Green	•Robust procedures are in place for the identification and management of COVID-19 outbreaks in patients and/or in staff. •Learning is captured from local and regional COVID-19 outbreaks			IPC - DIPC	Complete		
	9.5	all clinical waste and linen/laundry related to confirmed or suspected COVID- 19 cases is handled, stored and managed in accordance with current national guidance.	No	Green	•A guideline for managing clinical waste related to COVID 19 has been created and published on the Trust Intranet. Our waste management procedures are audited regularly as part of contract arrangements and KPIs indicate no issues			Facilities	Complete		
	9.6	PPE stock is appropriately stored and accessible to staff who require it.	No	Green	Some PPE stock is held centrally in the Stores area of each main site. Additional stock held in warehouse in Milton Keynes.Staff order Mon-Fri via Eleanor Helpdesk.If ordered by 12midday, the area will receive their order by 4pm on the same day.If PPE is required out of hours, a small quantity is held in the Site Managers office			Procurement	Complete		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	Systems and processes are in place to ensure that:											
	10.1	staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	Yes	Green	Occupational Health service/ HR intranet webpages Recruitment policy Absence management policy		Staff are directed to OH for personal queries, IPC support OH colleagues where required	Occupational Health	Complete		
	10.2	bank, agency, and locum staff follow the same deployment advice as permanent staff.	Yes	Green	Recruitment policy Staff Bank			Occupational Health	Complete		
	10.3	staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)	Yes	Green	Test and trace service work.			HR / OH	Complete		
	10.4	staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	Yes	Green	•Trust PPE guidance updated in line with PHE guidance regularly, approved at the CRG and communicated on the Intranet and via all-staff emails. •There is a bi-weekly Strategic PPE Planning group chaired by the Director of Nursing and including the Director of Finance. •The monthly Hand Hygiene Improvement Group has become the Hand Hygiene			IPC - DIPC	Complete		
	10.5	a fit testing programme is in place for those who may need to wear respiratory protection.	Yes	Green	Fit testing programme is in place			Emergency Preparedness	Complete		
	10.6	where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: - lead on the implementation of systems to monitor for illness and absence. - facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce - lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 - encourage staff vaccine uptake.	Yes	Green	IP&C policy Immunisation policy OH service procedures Medical Director's office work re covid and flu vaccine programme 2021/22 People Planning service work (re monitoring illness etc)			Occupational Health	Complete		
	10.7	staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	Yes	Green	*Trust PPE guidance updated in line with PHE guidance regularly, approved at the CRG and communicated on the Intranet and via all-staff emails*			HR / OH	Complete		
	10.8	a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. • A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups; • that advice is available to all health and social care staff, including specific advice to those at risk from complications. • Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. • A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff	Yes	Green	Trust covid individual risk assessment arrangements (see intranet)			Occupational Health	Complete		

	10.9	vaccination and testing policies are in place as advised by occupational health/public health.	Yes	Green	Immunisation policy (Covid vaccination and any testing in relation to covid is overseen by servin			HR	Complete			
	10.10.0	staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records.	No	Green	•Reusable FFP3 masks are issued through procurement to staff. Over 1000 masks have so far been issued and a record of each issue is available. Mask maintenance information is available on intranet and issued with the reusable mask. Application development is in progress and lead by Health & Safety to capture mask maintenance, filter expiry and fit testing in one location. Emergency	Training records (aside from fit testing) are not maintained.	New EPRR member to start later this month to support training. Records held on cerner.To remain amber until EPRR started and confirmation that all staff requiring FFP reusable respirators have undergone training. Records of staff been fit tested are held on Health roster (rather than Cerner). Staff who have a record been tested on a reusable mask means have received the relevant training too. Regardless of the new EPRR	Emergency Preparedness	Complete		
	10.11	staff who carry out fit test training are trained and competent to do so.	No	Green	•Staff who carry out fit test training are trained and competent to do so.. Training programme is in place and conforms to HSE requirements.			Emergency Preparedness	Complete			
	10.12	all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	No	Green	•All staff required to wear an FFP respirator have been fit tested for the model being used and this is repeated each time a different model			Emergency Preparedness	Complete			
	10.13	all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	No	Amber	Fit testing for a second mask is in progress. Pending the recruitment of the fit testing team to roll out in all areas.	40% of fit tested staff need to be tested for a second mask.	Recruitment of the fit testing team in progress. Engagement & provision for the high risk areas already in place. DHSC fit testing continues to mitigate the gap in recruitment	Emergency Preparedness	31/03/2022	There are processes in place but complaince metrics are low		
	10.14	a record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	No	Green	•A record of the fit test and result is given to and kept by the trainee and held centrally within the organisation.			Emergency Preparedness	Complete			
	10.15	those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	No	Green	•For those who fail a fit test, there is a record given to and held by the trainee and centrally within the organisation of repeated testing on alternative			Emergency Preparedness	Complete			
	10.16	that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	Yes	Amber	Several different masks are available and staff are fit tested as many times as required to find a mask which fits. Alternative equipment does not include hoods as these are not available in the Trust at the moment. This means that staff with facial hair or specific headwear are not fitted with a resp	Staff with beards or headwear for religious reasons are not fitted for a RPE	IPC to approve a hood. IPC to provide cleaning instructions for the hood. Procurement to source tubing covers.	Emergency Preparedness	31/03/2022	single person use hood identified. Decon lead working with EP team on SOP and procurement		
	10.17	members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	No	Green	For members of staff who fail to be adequately fit tested, a discussion is had regarding redeployment opportunities and options commensurate with the staff members' skills and experience and in line with nationally agreed algorithm. This fits with standard			HR	Complete			
	10.18	a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	No	Green	For members of staff who fail to be adequately fit tested, a discussion is had regarding redeployment opportunities and options commensurate with the staff members' skills and experience and in line with nationally agreed algorithm. This fits with standard (SI			HR	Complete			
	10.19	boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	No	Green	Weekly report is available to board on the fit testing compliance.			Emergency Preparedness	Complete			
	10.20.0	consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance.	No	Green	Staff are allocated to a particular care pathways to the extent possible. It continues whereever possible and is practicable. Staffing cover is considered in situations of pathway mixing			Divisions / HR / IPC	Complete	CRG		
	10.21	health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	No	Green	Local self assessments is the H& S approved process and has executive level approval			Occupational Health and Safety	Complete	CRG - self nomination, HS independent		
	10.22	staff absence and well-being are monitored and staff who are self -isolating are supported and able to access testing.	No	Green	Staff absence and their wellbeing monitored by People and Planning and the line manager In relation to covid, Test and Trace do some (limited) follow-up monitoring of well being for those who are self-isolating See intranet re their ability to access testing			HR	Complete			
	10.23	staff who test positive have adequate information and support to aid their recovery and return to work.	No	Green	OH/ Test and Trace service/ covid intranet page Test and Trace email content to affected staff Covid Helpline Contact Service referencing			Occupational Health	Complete			

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Learning from deaths quarterly report – quarter three 2021/22

Agenda item 12 and paper number 09

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

Purpose: For information

Meeting date: 16th March 2022

1. Purpose of this report

1.1. This paper provides an update to the board on our Learning from Deaths (LfD) programme.

2. Executive summary

2.1. The Trust's established mortality review process and associated policy was reviewed in line with the new national requirements set out in the National Quality Board framework published in March 2017. This included Structured Judgment Review (SJR) for selected deaths. As part of the requirements, trusts should regularly report to the board on mortality data and surveillance and any learning identified through this process.

2.2. Our mortality rates remain statistically significantly low. Our rolling 12-month HSMR (Hospital Standardised Mortality Ratio) has improved; against an expected relative risk of 100 our HSMR is 66.8 (for the period October 2020 to September 2021), compared to a relative risk of 72.0 (for December 2019 to November 2020). However, when previously we were the acute non-specialist trust with the lowest HSMR in the NHS, we are now sixth. Due to this small regression in our ranking, we are progressing an in-depth review of our mortality rates which will report to Quality Committee in May.

2.3. So far, none of the deaths which occurred in Q3 2021/2022 have been identified as 'avoidable' through the processes outlined in this report, however this is likely to change once the sector-wide decision is made regarding classification of harm for Hospital Onset COVID Infection (HOCI) deaths.

2.4. All cases of 'poor care' and any other SJRs where there are additional concerns are reviewed at the Medical director's weekly incident panel (MD panel). Eight SJRs were reviewed at MD panel in Q3, one has been investigated as a level one and no care and services delivery issues were identified and one is currently being investigated as a serious incident and the outcome will be reported in the next quarterly report. The remaining six cases required no further investigation and any learning points have been sent onto the learning from deaths group for appropriate ongoing dissemination.

2.5. Learning from the SJRs completed in Q3 is summarised in the report. The main themes are previously known issues with trustwide improvement plans in place.

3. Approvals process

3.1. This report was presented to EMBQ and EMB in February 2022 and Quality Committee in March 2022, which noted the report and approved it for onward submission to Trust Board.

4. Recommendation(s)

4.1. The Board is asked to note the findings from our mortality surveillance programme in Q3 2021/2022.

5. Next steps

5.1. The findings from Q3 2021/22 will be submitted to NHS England following review at the quality committee on behalf of trust board.

6. Impact assessment

6.1. Quality impact: improving how we learn from deaths in our care will support all quality domains, but particularly safe, effective and well-led.
6.2. Financial impact: N/A
6.3. Workforce impact: N/A
6.4. Equality impact: N/A
6.5. Risk impact: There is potential for reputational risk associated with the ability to deliver reviews within the specified time periods, thus impacting on national reporting. Learning from Deaths is on the divisional risk register (ID. 2439).

Main paper

7. Mortality rates

7.1. Our mortality rates remain statistically significantly low. Our rolling 12-month HSMR has improved; against an expected relative risk of 100 our HSMR is 66.8 (for the period October 2020 to September 2021), compared to a relative risk of 72.0 (for December 2019 to November 2020). However, when previously we were the acute non-specialist trust with the lowest HSMR in the NHS, we are now sixth.
7.2. Due to this small regression in our ranking, we are progressing an in-depth review of our mortality rates. Dr Foster analysis has emphasised that our HSMR is improving, but not as quickly as some other providers, which is affecting our ranking. The analysis highlighted some additional areas which we are now investigating, including a review of potential coding issues and a look-back review of mortality alerts over the last 12 months. A full report will be presented to quality committee in May.
7.3. We receive mortality alerts via the Dr Foster analytics services. These alerts do not infer clinical issues but indicate that the data for the diagnosis group is significantly different at Imperial to similar diagnosis groups in the NHS. The alert triggers may change over time with modification of the overall data resulting from coding audits and corrections by Imperial and/or changes in the overall NHS data set. Where a coding issue is identified this is corrected. However if the coding is correct, the individual cases are reviewed to identify if there are any clinical themes or trends that should undergo further investigation or action.
7.4. A review of 14 individual cases has been undertaken in the following diagnosis groups which were alerting between April and June 2021:
- **Cancer of pancreas:** Of the four patients in the alert, two have been reviewed with no care issues identified. One was subject to a SI investigation which was confirmed as major harm. A quality review meeting was held with the medical director with hepatobiliary surgery in response to this, and another similar SI. Actions include improvements to multidisciplinary team meetings and consultant ward rounds. The fourth case will be reviewed at MD panel to determine next steps.
- **Respiratory disease syndrome in neonate:** There were no clinical concerns highlighted through review of the 7 patients in this alert. All neonatal deaths are reviewed through the PMRT process (see section 11).
- **Crushing or Internal Injury:** Of the three patients in the alert, one was a patient admitted with multiple stab wounds. Two were patients admitted after falls with trauma whose primary diagnosis and cause of death was hospital-onset Covid-19.

7.5. Alerts for the period July 2021-October 2020 are under review; the outcomes will be reported in the Q4 report.

8. Summary of learning from deaths data – Q3 2021/2020

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

8.2. There were a total of 524 deaths in Q3, compared to 474 in Q2 2021/2022.
8.3. Of the total 524 deaths in the last quarter, 89 died with a positive COVID-19 swab within 28 days of death or had COVD-19 on the medical certificate of cause of death, compared to 60 out of the 474 deaths in Q2 2021/2022. This is reflective of the increasing background rates in the community due to the onset of the Omicron variant and the beginning of the recent surge.
8.4. There were 18 deaths in Q3 2021/2022 where the patient's infection met the Public Health England definition of Hospital Onset COVID Infection (HOCI) because they tested negative for COVID-19 on admission and subsequently tested positive. These deaths are currently being reviewed through our HOCI death review process (see section 9).
8.5. Appendix B shows the total number of deaths and ratio between COVID and non-COVID deaths from March 2020 (start of pandemic) to the end of January 2022. We have reported 1079 COVID-19 deaths.
8.6. 39 SJRs have been allocated so far for deaths which occurred during Q3. The triggers for these can be seen in Table 2 below.

Table 2 – Triggers for SJR by quarter

Triggers by Quarter	**Q1 20-21**	**Q2 20-21**	**Q3 20-21**	**Q4 20-21**	**Q1 21-22**	**Q2 21-22**	**Q3 21-22**
Medical Examiner Concern	6	5	7	3	3	16	11
Clinical Concern	5	3	6	3	1	5	2
Family Concern	5	4	5	3	6	13	6
Score 1-3	0	0	0	0	0	0	0
Coroner/Inquest	15	0	1	0	0	0	0
SI / Incident	0	1	0	0	0	0	0
Vulnerable group	13	4	6	9	4	9	3
Age Range	20	16	5	3	1	6	1
Specialty /Condition	0	6	13	36	38	34	11
Other	9	35	9	4	5	16	17

(Note: there may be multiple triggers for a SJR)

8.7. The automatic trigger following a coronial referral was removed in December 2020 and the PMRT process commenced at the end of 2020 which has reduced the number of cases triggered under the age category. The majority of cases that have triggered under 'other' are HOCI deaths.
8.8. 51 SJRs were completed in Q3 2021/2022. (Note: these SJRs do not all relate to deaths within Q3 2021/2022).
8.9. Of the 51 SJRs completed rating of global care scores were as follows:-

Number of cases	Rating of Global Care
2	2 - Poor care
10	3 - Adequate care
35	4 - Good care
4	5 - Excellent care

8.10. There were two SJRs completed with an overall score of 'poor' care in Q3 2021/22, which is a decrease compared to last quarter when eight were reported. This is likely to be partly due to the increase in SJRs completed in Q2 2021/22 while the new SJR reviewers worked to clear the backlog of overdue SJRs (82 compared to 51 in Q3 and 50 in Q1).

8.11. A list of all completed SJRs is reviewed weekly at the Medical director's weekly incident panel (MD panel). If any concerns are highlighted or when the rating of care is poor, the full SJR report is presented by the division at the panel. A decision is then made on whether there are aspects of care which should be reported as an incident and are brought back for review with a 72 hour report for a decision to be made on the level of investigation, i.e. Local, Level 1 or Serious Incident (SI).

8.12. In Q3 2021/2022, 8 SJRs have been reviewed at MD panel, one has been investigated as a level one and no care and services delivery issues were identified and one is currently being investigated as a serious incident and the outcome will be reported in the next quarterly report. The remaining six cases required no further investigation and any learning points have been sent onto the learning from deaths group for appropriate ongoing dissemination.

9. Hospital onset Covid infection (HOCI) death review update

9.1. All deaths of patients who have died after a HOCI with a negative swab on admission and first positive swab more than 8 days after admission are subject to enhanced mortality review.

9.2. There were 32 HOCI deaths identified for review in the first surge, 58 in the second, and 35 identified so far in the third surge (18 of which occurred in Q3 2021/22).

9.3. The 90 cases from the first two surges have been fully reviewed through the process set out on the previous slide, and nine cases (2 from wave 1 and 7 from wave 2) were confirmed as not HOCI deaths, leaving 81 cases in total. Harm levels have been agreed for each case, pending a sector-wide decision on final harm allocation to ensure consistency. This will have an impact on our harm profile when agreed.

9.4. A report setting out the outcomes of the review process and the learning identified was presented to EMB Quality Group in December 2021. This found that the key Covid-specific learning points from these reviews have already been picked up through other processes and have been incorporated into new and updated guidance and processes as part of our evolving response to the Covid-19 pandemic e.g. changes to inpatient testing, or have trustwide improvement plans in place e.g. Hand hygiene and PPE use.

9.5. Of the 35 HOCI deaths which have occurred so far during the current surge, 22 have had SJRs completed. These will be reviewed through the same process as the deaths which occurred during the other surges, and a full report provided to EMBQ when the process is complete.

9.6. Initial review of the SJRs completed so far has not identified any new themes, although this may change once the full review process is complete.

10. Themes and Learning

10.1. Learning from Deaths is now a standard agenda item at all the divisional quality and safety meetings where the learning is being fed back to be disseminated across all the division and directorates for local learning.

10.2. Trustwide improvement themes from SJRs which occurred in Q3 2021/22 include ownership of care and oversight from senior clinicians, communication across the MDT, timely referral to palliative care and early confirmation of ceilings of care, ordering and checking of results, and issues related to documentation.

10.3. These are all themes which have been previously identified, both through SJRs and our incident reporting and investigation processes.

10.4. Trustwide improvement plans are in place including:

- A workstream to improve end of life care has been established and following agreement at EMBQ in December a business case, focused on improving education and training will now be developed and taken through the appropriate approvals process.
- A trustwide focused improvement was launched in November 2021 to ensure regular MDT board rounds are occurring, and to improve the quality of them. This was one of the main focuses of 'Better Together' week.
- Trustwide actions are underway in response to the risk around radiology results not being endorsed, which can lead to abnormal findings not being acted upon in a timely manner. This includes the implementation of a trustwide standard of endorsement within 1 week of

results and addition of endorsement rates to the quality scorecard to allow for monitoring through EMBQ (this will be implemented once a data quality review is complete).

10.5. A quarterly learning from deaths newsletter is being implemented to share learning across the trust; the first will be published by the end of the month.

10.6. A recent complaint has highlighted improvements we need to make in how we involve families in our learning from deaths process, including ensuring they are aware of the outcomes of SJRs. We are planning an audit of evidence that formal feedback has been given to families where they raised concerns; this will be included in our trust priority audit programme for 2022/23.

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

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

11.2. The safety standards for PMRT for maternity services are that all PMRT reviews are starting within four months of the death, and completed and closed within six months.

11.3. The Trust received communication on 23 December 2021 that the CNST MIS year 4 has been paused with immediate effect for a minimum of 3 months. We continue to apply the principles of the ten safety actions to support the delivery of safer maternity care.

11.4. The maternity service continue to utilise the Perinatal Mortality Review Tool as advised by CNST MIS where possible during the pause. Staffing challenges and delays on information required from other Trusts has resulted in some cases remaining open and therefore a report will be submitted in March 2022 with the findings of the reviews and required actions.

11.5. Between May and November 2021, 21 stillbirth reviews were started and six have been completed. For neonatal deaths 17 reviews were started and 5 have been completed. The key learning and trends from these found that MSU samples at the booking appointments were not taking place as per national guidance. This have been reviewed and there is now compliance with this at bookings.

11.6. As a result of learning from previous cases around the impact of languages and translations on the outcome of care, we now provide more written information and leaflets available to women in different languages, and more utilisation of the translation service when delivering care. There has also been the development of a NW London Maternity App that has improved access to languages and information for women.

12. Conclusion

12.1. Our harm profile remains low and there were no confirmed avoidable deaths identified so far through the processes outlined in this report, however this will change once the sector-wide decision is made regarding classification of harm for HOCI deaths.

12.2. Themes from SJRs completed in Q3 reflect previously known issues with trustwide improvement plans in place.

Author: Darren Nelson, head of quality compliance and assurance
Date: 9th March 2022

List of appendices

Appendix A - Learning from Deaths Dashboard
Appendix B – Number of trust deaths from March 2020 to January 2022

Learning from Deaths Dashboard Quarter 3 2021-22

Up to: **Quarter 3**

*SJRs completed within 30 days is reported 1 month in arrears.

Latest Quarter

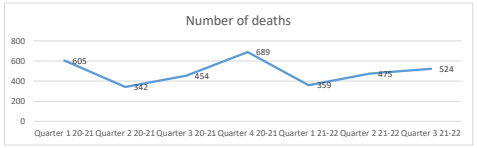
Deaths	Last Quarter	Neonatal Deaths	Last Quarter	Very Poor/Poor Overall Quality of Care	Last Quarter
524	475	Suspended	Suspended	2	8

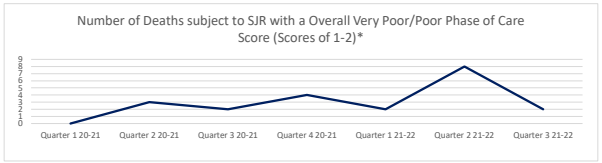
Latest Quarter

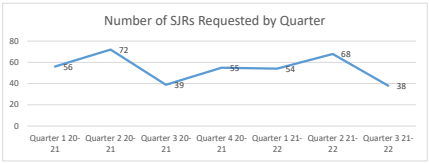
SJRs Requested	Last Quarter	SJRs completed	Last Quarter	Not complete <30 days (%)	Last Quarter
38	68	51	82	13.16%	29.85%

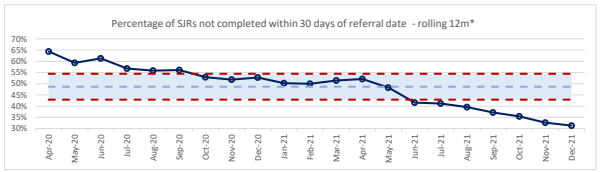
Latest Quarter

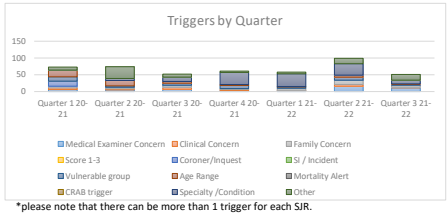
PMRTs requested	Last Quarter
4	21









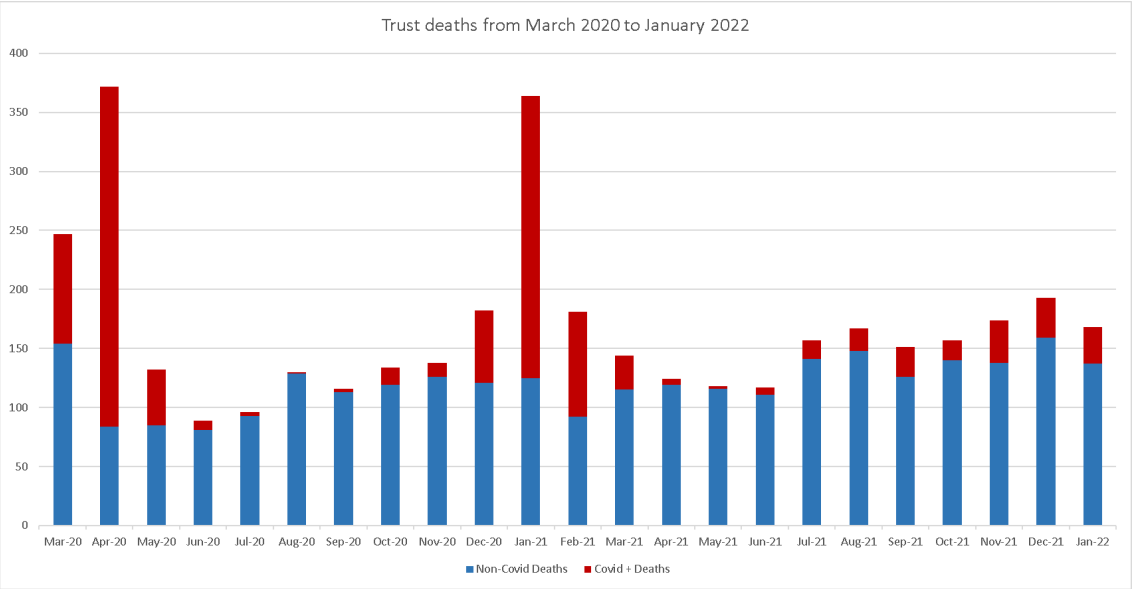


Suspended neonatal reporting

The SPC above currently shows that a special cause variation occurred from June 21 to December 21 (trend).
* This data is reported 1 month in arrears

*please note that there can be more than 1 trigger for each SJR.
A bigger version of this is available in the Triggers Tab

Appendix B Number of trust deaths from March 2020 to January 2022



Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: National patient safety strategy implementation update

Item 13 and paper number 10

Lead Executive Director: Julian Redhead, medical director
Author(s): Shona Maxwell, chief of staff, Clemmie Burbidge, improvement lead – compliance and assurance

Purpose: For information

Meeting date: 16th March 2022

1. Purpose of this report

1.1. In line with the requirements set out in a letter to medical and nurse directors from the National Director of Patient Safety at the end of August 2021, we are required to undertake a dedicated board-level discussion by April 2022 on implementation of the NHS patient safety strategy.

1.2. A deep dive was undertaken at quality committee in September in preparation for this. It provided an overview of the strategy and how our safety improvement work aligns to it and identified next steps.

1.3. To facilitate the board-level discussion, which occurred at Quality Committee in March, this paper provides an update on our progress with implementation, in particular with the eight key areas of the national strategy set out in the guidance alongside the letter from the national team, which were the priority areas during 2021/22.

2. Executive Summary

2.1. The NHS Patient Safety Strategy focuses on how the NHS can continuously improve safety by building on two foundations: a patient safety culture and a patient safety system. It sets out three strategic aims for the NHS as a whole (Insight, Involvement and Improvement), with actions under each of these aims (see appendix 1).

2.2. Our safety improvement programme has followed this model since the strategy was first developed so we are in a good position for implementation.

2.3. While gaps at national level mean we cannot currently progress work in some areas, e.g. implementation of the patient safety incident response framework, we are making good progress with implementing other key elements, and much of our safety improvement work is aligned to that expected of us in the strategy including our focus on investigations and our improvement priorities.

2.4. Training is a fundamental part of the strategy. A new patient safety syllabus was launched in 2021 which includes online training which will be required for all staff across the NHS. An implementation plan is being developed and reporting on compliance through the quality scorecard will commence in quarter one 2022/23.

2.5. We are also progressing implementation of the framework for involving patients in patient safety. The initial action is the development of our policy, role profile and recruitment plan for 'Patient Safety Partners' with support from the strategic lay forum. Recruitment is expected to commence in May 2022.

2.6. Patient Safety Specialists, defined as the lead patient safety experts in healthcare organisations, are key to the delivery of the national strategy. One of the purposes of this presentation as set out by the national team is to facilitate board members 'to work with your patient safety specialist(s) to reflect on the board's expectations and responsibilities in patient safety'. The

national strategy expectation for PSS is that all NHS organisations have one full time in post, or more than one full time post, across large organisations. Given the original deadline of April 2021, it was agreed that we would initially have one PSS, who would be Shona Maxwell within the office of the medical director, with the plan to review this to ensure we have the right model in place for our trust. Given the scale of the work, and the size and complexity of our trust, we have agreed with the divisions that we should aim to implement a mixed model of corporate oversight and management of the overall strategy with divisionally based specialists. Development of this requires a review of existing structures and resource to identify the roles which are already undertaking some of this work as well as any potential gaps. An options appraisal will then be worked up and presented to Executive Management Board Quality Group (EMBQ) for discussion and approval; this may include the requirement for additional resource.

3. Approvals process

3.1. The actions and plans for implementation were agreed at the EMB Quality Group and endorsed at the Executive Management Board in February 2022 and Quality Committee in March 2022.

4. Recommendation(s)

4.1. The Board is asked to note the agreed plans to take outstanding work forward.

5. Next steps

5.1. We will continue our work to implement the required elements of the strategy, with regular updates on progress provided to EMBQ, and to EMB and quality committee through the quality assurance report.

6. Impact assessment

6.1. Quality impact: The NHS Patient Safety Strategy, published in July 2019, focuses on how the NHS can continuously improve safety by building on two foundations: a patient safety culture and a patient safety system. It focuses on establishing a culture of psychological safety, sharing safety insight and empowering people – patients and staff – with the skills, confidence and mechanisms to improve safety. Successful delivery should support improvements in all quality elements, but especially Safe and Well-led.

6.2. Financial impact: N/A

6.3. Workforce impact: Plans are being drawn up for the implementation of the national patient safety syllabus within the trust, as well as the key roles of patient safety specialist and patient safety partner.

6.4. Equality impact: EQIAs will be undertaken for key workstreams, including introduction of patient safety partners.

6.5. Risk impact: There are no concerns identified through this report which require addition to the risk register. The risks to delivery of our safety improvement programme relate to engagement, resourcing and the impact of the pandemic. These are managed through the Medical director's office risk register.

Main report

7. Introduction

7.1. Appendix 2 sets out the aims and actions of the NHS patient safety strategy, alongside the progress we have made with local implementation and next steps. A summary of this was presented to Quality Committee in September 2021.

7.2. In line with the requirements for this board-level presentation, this section of the report provides more detail on our delivery of the eight areas of the national strategy identified by the national team as the priority areas for 2021/22.

8. Just Culture

8.1. The strategy requires that local systems set out how they will embed the principles of a safety culture on an ongoing basis. These should include monitoring and response to NHS staff survey

results and any other safety culture assessments, [and] adoption of the NHS England and NHS Improvement 'A Just Culture Guide' or equivalent.

8.2. We have already adopted the just culture guide as part of our HR policies and for incident reporting; it is included in our serious incident policy and underpins our investigations. We are now using after action review as our main method of investigation; this allows a systems approach to investigation, with all staff involved coming together to discuss the incident in a structured and facilitated manner. This ensures staff are fully supported when they are involved in an incident, the learning is rapidly shared and any immediate action is taken to mitigate recurrence.

8.3. The national team suggests we ensure the safety sections of the NHS Staff Survey are reviewed and discussed and agree any actions needed to improve patient safety culture. The responses related to safety culture have been improving year-on-year, but recognising we have further work to do to, one of the organisation's focused improvements is to improve incident reporting. This is our key safety culture metric and an important measure of how we are embedding our values and behaviours, supporting staff to be open and to speak up without fear of blame. A trustwide programme of work underway, with regular reporting to EMBQ and to EMB and Quality Committee through the quality assurance report.

8.4. The National survey for 2021 did not include the safety sections, so we will be undertaking a Pulse survey so we can monitor changes and improvements going forward.

9. National patient safety alerts (NatPSAs)

9.1. The strategy requires that providers identify appropriate escalation routes for National Patient Safety Alerts to ensure organisation-wide coordination and senior oversight and that they embed process for ensuring senior oversight and actioning of NatPSAs.

9.2. We have a trustwide policy in place which sets out how we respond to Central Alerting System (CAS) alerts and national patient safety alerts, with improved oversight and management via exception reporting through EMB quality group and the medical director as executive lead (the chief nurse is the executive lead for CAS alerts). We introduced internal safety briefings and alerts to keep staff informed of new issues and the actions required.

9.3. However, the number of NatPSAs have increased since their introduction in November 2019 due to changes in the way they are identified (e.g. there were 5 patient safety alerts issued in 2019, 7 in 2020 and 10 in 2021). The actions required are also often more complex and involve multiple teams across the trust.

9.4. The head of quality compliance and assurance is therefore reviewing the governance and resources required to manage these to ensure improved oversight and better assurance of implementation.

9.5. This work is being done jointly with the head of clinical technical services and will also include a review of the process for all other types of alert.

9.6. The proposals for this will be put forward to EMBQ in April for discussion and approval.

10. Incident reporting

10.1. The strategy requires that we focus on improving the quality of incident reporting as one of the principles of improving safety culture. This includes improving how incidents are captured and most effectively described to the board. One of the suggested actions is to improve how incidents are described in local reports to support local and national learning, and to ensure the degree of harm is in line with national guidance. We have a trustwide programme of work in place to improve incident reporting. Our current focus is on encouraging staff to report more; as part of this we will provide support and guidance on the type of information to include in their reports. We are also developing automatic reporting from Cerner for key patient safety events e.g. falls, antibiotics not administered to patients with diagnosed sepsis within 1 hour, which will improve consistency and allow our staff to focus on reporting other types of incident.

10.2. In terms of harm levels, all incidents which are reported as moderate or above harm are reviewed at the medical director's incident review panel, where decisions are made regarding the type of investigation and the appropriate level of harm in line with national guidance. The final harm level is confirmed following investigation and amended on Datix. We are currently reviewing how we report harm levels for falls with fractures to ensure consistency.

10.3. The national guidance suggests using our NRLS explorer reports to help improve how incidents are captured locally and most effectively described to the board: the most recent report available is for October 2019 to March 2020. It sets out our reporting rates, harm levels and the most frequent types of incidents we are reporting. We monitor this information regularly and use it to develop improvement plans where necessary. Once the latest report is published we will review this to identify any additional actions we can include in our incident reporting improvement work. In September 2021, we reinstated a monitoring and assurance report for serious incidents, which reports to EMB and quality committee via the quality assurance report. We will now review how we are reporting themes and issues emerging from incidents which are not declared SIs to ensure these are being appropriately reviewed and monitored.

11. Support transition from NRLS and STEIS to Learn from patient safety events (LFPSE) service (previously called the Patient Safety Incident management system)

11.1. NHSE are in the process of replacing the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (STEIS) with a new system called Learn from patient safety events (LFPSE).

11.2. The new LFPSE service is descried as 'a major upgrade, creating a single national NHS system for recording patient safety events. It introduces improved capabilities for the analysis of patient safety events occurring across healthcare, and enables better use of the latest technology, such as machine learning, to create outputs that offer a greater depth of insight and learning that are more relevant to the current NHS environment.'

11.3. In line with the national guidance, we will transition to the new system once our local risk management system (currently Datix) is compatible with the LFPSE. This is anticipated to be by mid-2022.

11.4. We are in the process of retendering Datix in response to staff feedback – the aim is to implement a more user-friendly system which supports better identification of themes and sharing of learning. We will ensure that any proposed suppliers have full compatibility with the LFPSE as part of our requirements for tender.

12. Involvement in implementing the new Patient Safety Incident Response Framework (PSIRF)

12.1. The national evaluation of the PSIRF pilot, which will replace the current Serious Incident framework, has been completed and implementation is expected to be a gradual process starting from April 2022.

12.2. The national team have confirmed that trusts do not need to begin formal planning for the implementation now as the framework is not yet finalised. Once further detail is available we will develop an implementation plan in response.

12.3. Some of the elements which the national patient safety team recommend we consider in advance include ensuring we are taking a systems approach to investigation, we are only using trained investigators with dedicated time to lead investigations, and we have systems in place to encourage reporting and subsequent learning and improvement.

12.4. We have some of this in place/being implemented already, with the use of after action review and our central investigations team, and our approach to improving incident reporting. We are therefore in a good position to align our policies and processes with the new framework once it is published.

12.5. However we do not consistently have clinical investigators with dedicated time to undertake investigations. This will be considered as part of the resource review with the divisions (see section 16). This will likely need additional resource to achieve.

13. Implement the Framework for Involving Patients in Patient Safety

13.1. The framework was published in July 2021. It includes some examples of how we can ensure patients are partners in their own healthcare safety, including encouraging them to ask questions, undertaking individual information sharing sessions, information campaigns for patients e.g. on hand hygiene, supporting them to report incidents and raise concerns, and involving them in patient safety investigation.

13.2. We have good processes in place to help patients raise concerns and to act upon them when they do through PALS. Key developments such as the care information exchange are helping patients take ownership of their care, while our strategic lay forum, lay partners and use of patient focus groups mean that we are involving patients and local communities increasingly in the business of the organisation. However this doesn't fully address the aim of this section of the strategy. A plan will be required on how we are going to take all of this forward.

13.3. The initial action is to introduce two Patient Safety Partners by June 2022 in line with national requirements. The framework sets out that PSP involvement in organisational safety relates to the role that patients and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety. These roles will be instrumental in supporting implementation of the framework as a whole.

13.4. Following discussions in December with the director of communications and the chair of the strategic lay forum, and at the lay partner away day in January, we have an agreed plan which is progressing.

13.5. A working group, which currently includes representatives from the MDO, Communications and three lay partners, is developing the policy, role profile and recruitment plan for PSPs, using templates developed by the national team and adapted for our trust. Colleagues from P&OD have also been requested to join. Recruitment is expected to commence in May 2022.

13.6. We are looking at PSP involvement at EMBQ in the first instance, and in our safety improvement priorities. Our three lay partners attended the February EMBQ meeting to observe and provide feedback on how best to facilitate this. Once our PSPs are in post, we will then look to expand their involvement into other safety-related areas in the long-term, specifically incident investigation panels. This will require specific training and support.

14. Patient safety education and training

14.1. The NHS patient safety syllabus was published in May 2021. It is designed for all NHS staff and is structured to provide both a technical understanding of safety in complex systems and a suite of tools and approaches that will: Build safety for patients; Reduce the risks created by systems and practices; and Develop a genuine culture of patient safety.

14.2. The first on-line training package went live on 27th October. It includes:

- Level 1: Essentials of patient safety – the national aim is that all NHS staff should complete this, even those in non-patient facing roles, by April 2023
- Level 1: Essentials of patient safety for boards and senior leadership teams – this module will be for non-executives, executives and divisional leadership teams to complete
- Level 2: Access to practice – this is intended for those who have an interest in understanding more about patient safety and those who want to go on to access the higher levels of training.
- Levels 3-5 are not yet available.

14.3. The available modules have now been launched on LEARN. As agreed with the Core Skills Governance Committee, level 1 will be mandatory for all our staff in line with national requirements. This level also includes a module specific for board members which we will roll-out at the same time. Level 2 is for roles that are specifically involved in patient safety. An implementation plan is being developed and uptake will be monitored through EMBQ.

15. National Patient Safety Improvement Programmes

15.1. The national patient safety programme consists of five priority areas, which providers should focus on with support provided by the national team and the local patient safety collaborative. These are:

- Managing deterioration
- Maternity and neonatal
- Adoption and spread
- Medicines safety
- Mental health

15.2. Our internal safety improvement programme is focusing on our key areas of clinical risk, some of which are aligned with the national patient safety programmes, including:

- Improvement work around our response to sepsis – this includes review of the sepsis algorithm and we are working with the associate medical director for St Mary's and divisional director of nursing for surgery cancer and cardiovascular (SCC) on the programme going forward, with plans to recruit a medical lead with dedicated time for this to work with the DDN for SCC.
- End of life care – following agreement at EMBQ, a business case is being developed to improve education and training and provide additional resource to support staff with advance care planning and other end of life skills. This work will include a focus on improving treatment escalation plans.

15.3. Work is also continuing in the following areas:

- Improving medicines safety though priorities identified by our medicines safety committee, and the trustwide focused improvement to improve safe medicines management.
- Delivery of our maternity quality and safety improvement strategy which includes the improvement priorities of the Maternity and Neonatal safety improvement programme.
- Delivery of the system wide action plan to improve access for patients with mental health needs which will in turn reduce the time patients wait in our emergency departments.

15.4. The adoption and spread priorities are detailed in appendix 3. There is work being undertaken by the services to progress elements of these, and overall our performance in national audits related to these areas is better than/in line with national average. However, these need improved oversight so we can identify any additional support required, share and spread good practice and identify any areas that needs to be prioritised as part of our safety improvement programme. The divisions will provide reports to April EMBQ with a summary of the work undertaken so far, planned actions and any gaps so that we can agree next steps; this was postponed in January/February due to governance lite.

16. Patient safety specialist model for the Trust

16.1. Patient Safety Specialists (PSSs), defined as the lead patient safety experts in healthcare organisations, are key to the delivery of the national strategy.

16.2. Given the scale of the work, and the size and complexity of our trust, we are currently reviewing our model for PSSs. We have agreed with the divisions that we should aim to implement a mixed model of corporate oversight and management of the overall strategy with divisionally based specialists.

16.3. The PSS role description is wide-ranging, and while it includes many elements that corporate and divisional teams do as part of business as usual (e.g. incident investigations, duty of candour, our priority improvement workstreams) the work that will be needed should not be underestimated and the reporting requirements require further clarity. We will now review of existing structures and resource to identify the roles which are already undertaking some of this work as well as any potential gaps (corporately and divisionally). An options appraisal will then be worked up and presented to EMBQ for discussion and approval, this may include the requirement for additional resource.

17. Conclusion

17.1. While we are making good progress in most of the priority areas, there is a significant amount of work associated with the roll out of the national strategy. We also need to deliver our own safety improvement programme, which though aligned to the national strategy, has its own priority workstreams identified as our key areas of risk internally.

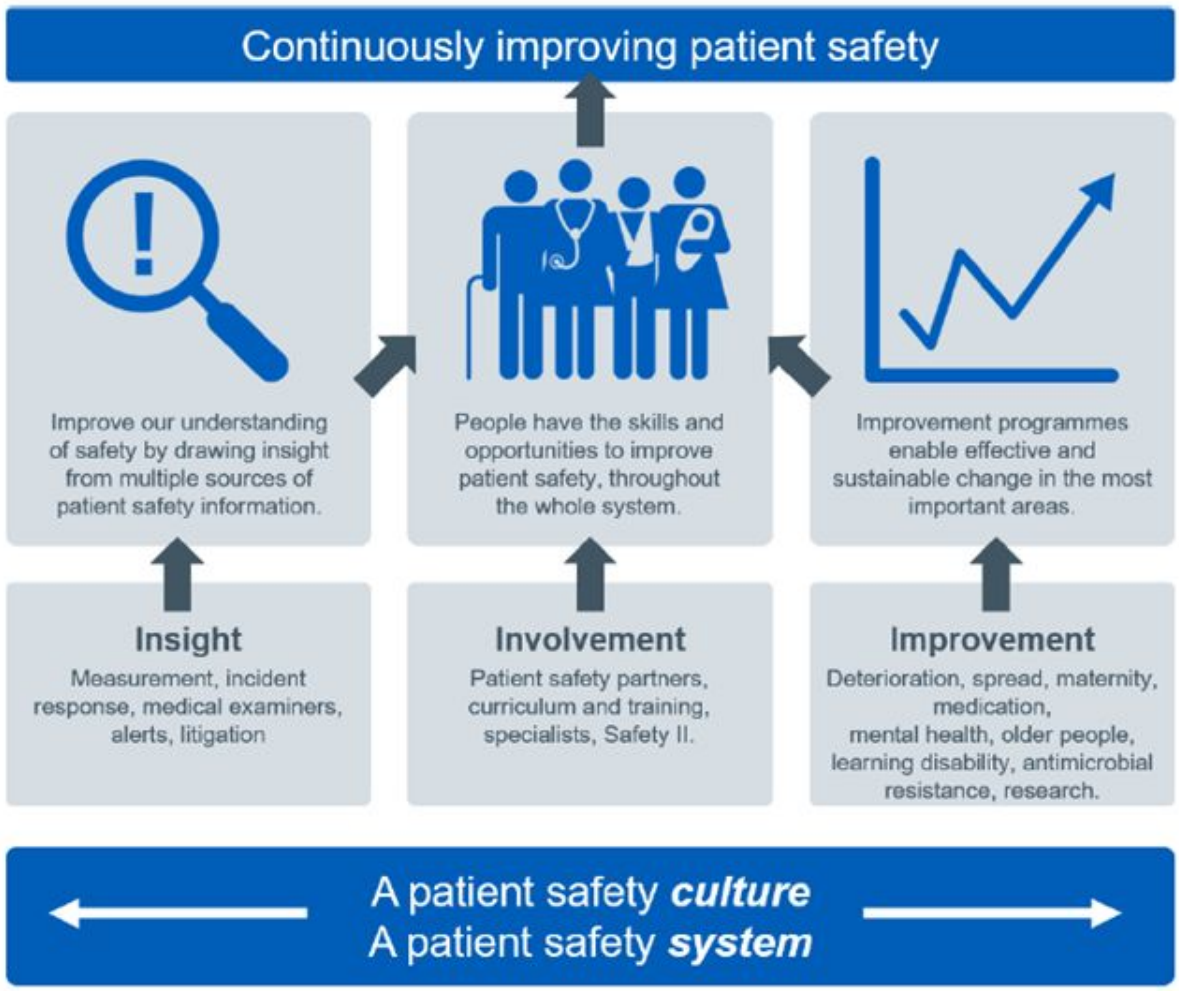
17.2. Key to our continued progress will be the development of a new model for patient safety specialists which we will now take forward.

Appendices:

Appendix 1: National Patient Safety Strategy Aims
Appendix 2: National Patient Safety Strategy actions and progress summary
Appendix 3: Adopt and Spread Programme

Authors: Shona Maxwell, Chief of Staff, Clemmie Burbidge, improvement lead – compliance and assurance, 9th March 2022

Appendix 1: National Patient Safety Strategy aims



Appendix 2: National Patient Safety Strategy actions and progress summary

Insight		
'Insight' work aims to improve understanding of safety across the whole system by drawing intelligence from multiple sources of patient safety information		
The NHS will:	**Summary of progress and current status**	**Gaps identified and next steps:**
Adopt and promote key safety measurement principles and use culture metrics to better understand how safe care is	In 2020, we implemented IMIS as the way in which we manage, monitor and problem solve the delivery of our priorities from board to ward. This involved a review of our scorecards and measures using measurement for improvement principles. The IMIS integrated scorecard is already in place for divisions and directorates and is currently being rolled out at specialty level. We also introduced a separate IMIS quality scorecard, which includes a broader mix of key process metrics related to quality and safety and patient outcome metrics aligned to our safety improvement programme. This, along with improvement plans in response to areas of variance, is monitored through EMBQ and reported to EMB and quality committee for assurance. In 2019, we added a question to the staff survey so that it covers issues related to perceptions of safety culture, with improvements seen year-on-year. Our key safety culture metric is our incident reporting rate. Improving how we report, investigate and learn from incidents is a focused improvement (FI), with a trustwide programme of work underway	We are currently developing an online dashboard for our quality and safety metrics, which will improve local ownership of data and support the development of local improvement plans. Due to be implemented in Q1 2022/23. The National survey for 2021 did not include the safety sections, so we will be undertaking a Pulse survey so we can monitor changes and improvements going forward.
Use new digital technologies to support learning from what does and does not go well, by replacing the NRLS with a new safety learning system	We are currently re-tendering the Datix system, with the view of implementing a new system for managing incidents which will be more user-friendly and support better identification of themes and sharing of learning. We are also exploring app based reporting systems, including a pilot of CareReport in collaboration with the Patient Safety Translational Research Centre.	In line with the national guidance, we will transition to the new national system once our local risk management system (currently Datix) is compatible with the LFPSE. This is anticipated to be by mid-2022. We will ensure that any proposed suppliers for our new risk management system have full compatibility with the LFPSE as part of our requirements for tender.
Introduce the patient safety incident response framework to improve the	Following a successful pilot in 2019, we now use after action review as our primary method for investigating incidents. This ensures staff are better	We will ensure that our processes and policies are aligned with the national framework when it is published.

response to, and investigation of incidents	supported, learning is rapidly shared and immediate action is taken to mitigate recurrence. We also restructured our safety team to create a central investigation team. This team is starting to embed, with improvements in the quality of reports and a reduction in overdue investigations. We also have trained investigators from each division.	We do not consistently have clinical investigators with dedicated time to undertake investigations. This will be considered as part of the resource review with the divisions being undertaken to develop our PSS model for the trust. This will likely need additional resource to achieve.
Implement the new medical examiner (ME) system to scrutinise deaths	In 2020, we successfully implemented the ME service and are fully compliant with national guidance.	We will continue to improve our learning from deaths processes.
Improve the response to new and emerging risks, supported by the new national patient safety alerts committee	We have a trustwide policy in place which sets out how we respond to national patient safety alerts. We have improved oversight and management of these alerts, with exception reporting through EMB quality group and the medical director as executive lead (the chief nurse is the executive lead for CAS alerts). We introduced internal safety briefings and alerts to keep staff informed of new issues and the actions required. We do not record NatPSAs as complete on the CAS website unless all actions have been completed.	The head of quality compliance and assurance is therefore reviewing the governance and resources required to manage these to ensure improved oversight and better assurance of implementation. This work is being done jointly with the head of clinical technical services and will also include a review of the process for all other types of alert. The proposals for this will be put forward to EMBQ in April for discussion and approval.
Share insight from litigation to prevent harm	Metrics related to inquests and claims are included in the quality scorecard and any issues or concerns are escalated through the quality function report.	We will develop a formal process to share and triangulate insight and learning from claims and inquests with other forms of patient safety intelligence to support the prevention of future harm.
Involvement		
'Involvement' work aims to ensure that patients, staff and our partners have the skills and opportunities to improve patient safety		
The NHS will:	**Summary of progress and current status:**	**Gaps identified and next steps:**

Establish principles and expectations for the involvement of patients, families, carers and other lay people in providing safer care	We have good processes in place to help patients raise concerns and to act upon them when they do through PALS. Key developments such as the care information exchange are helping patients take ownership of their care, while our strategic lay forum, lay partners and use of patient focus groups mean that we are involving patients and local communities increasingly in the business of the organisation.	A plan will be required on how we are going to take implementation of the framework forward. The initial action is to introduce two Patient Safety Partners by June 2022 in line with national requirements. Following discussions in December with the director of communications and the chair of the strategic lay forum, and at the lay partner away day in January, we have an agreed plan which is progressing. A working group, which currently includes representatives from the MDO, Communications and three lay partners, is developing the policy, role profile and recruitment plan for PSPs, using templates developed by the national team and adapted for our trust. Colleagues from P&OD have also been requested to join. Recruitment is expected to commence in May 2022.
Create the first system-wide and consistent patient safety syllabus, training and education framework for the NHS	Our quality improvement methodology and education programme is well-established, and we have a team to specifically support safety improvement. We have developed innovative training programmes including the Helping our Teams Transform programme. The NHS patient safety syllabus was published in May 2021. The first on-line training package went live in October. The training is now available on LEARN and will be mandatory for all staff.	We are developing plan for the launch at the Core Skills Group in February. Uptake will be monitored through EMBQ, with training rates included in the quality scorecard.
Establish 'patient safety specialists' to lead safety improvement across the system	All trusts were required to have identified at least one PSS by April 2020. Our PSS is the chief of staff in the medical director's office. We are reviewing the model for PSSs in our trust with the divisions. We will adopt a divisional based model, with corporate leadership and oversight provided by the MDO.	To take this forward we will review the existing structures and resource within the divisions to identify the roles which are already undertaking some of this work as well as any potential gaps. An options appraisal will then be worked up and presented to EMBQ for discussion and approval.
Ensure people are equipped to learn from what goes well as well as to respond appropriately to things going wrong	Implementation of 'learning from excellence' (positive reporting).	We have good processes to respond when things go wrong, but further work to do to ensure we learn from what goes well. We introduced positive reporting in 2019 but need to maximise its potential. We will relaunch this as part of our incident reporting focused improvement work.
Ensure the whole healthcare system is involved in the safety agenda	One of the key messages of our safety improvement work is 'safety is everyone's business'. As part of	We aim to make the most of all communication methods, including social media, blogs and videos, to develop a more

	this, we have a trustwide safety awareness campaign in place. Over the last 2 years, our communications have focused on our response to Covid-19 and on ensuring safety of staff and patients remains paramount despite the pressures of the pandemic. We continue to work closely with the sector, sharing intelligence related to risks and emerging issues and developing standardised processes.	engaging safety communications plan and ensure all staff and patients are involved. A trustwide campaign focusing on incident reporting will commence in March 2022.
Improvement		
'Improvement' work aims to develop and support safety improvement programmes that prioritise the most important safety issues and employ consistent measurement and effective improvement methods		
The NHS will:	**Summary of progress and current status:**	**Gaps identified and next steps:**
Deliver the national patient safety improvement programme (NPSIP), building on the existing focus on preventing avoidable deterioration and adopting and spreading interventions	We have had a safety improvement programme in place since 2018, with evidence of improvement. The programme is regularly reviewed and refreshed to ensure that we are focusing on our key areas of clinical risk. The priorities align well with the national strategy. There is work being undertaken by the relevant services to progress elements of the national 'spread' priorities, and overall our performance in national audits related to these areas is better than/in line with national average.	The spread priorities need improved oversight so we can identify any additional support required, share and spread good practice and identify any areas that needs to be prioritised as part of our safety improvement programme. The divisions will provide reports to April EMBQ with a summary of the work undertaken so far, planned actions and any gaps so that we can agree next steps; this was postponed in January/February due to governance lite.
Deliver the maternity and neonatal safety improvement programme to support reduction in stillbirth, neonatal and maternal death and neonatal asphyxia brain injury by 50% by 2025	Our maternity service has a quality and safety improvement strategy in place which includes the improvement priorities of the MatNeoSIP. Progress with this, and with mandated actions including the Ockenden recommendations, is reported through the maternity assurance oversight report.	There is a proposal plan for a PAN London approach to the MatNeoSOP with a refreshed driver diagram that focuses on three clinical themes in antenatal, peripartum and postnatal and neonatal care: • Improve the optimisation and stabilisation of preterm infants • Improve the early recognition and management of deteriorating women and babies • Improve the proportion of smoke free pregnancies
Develop the medicines safety improvement programme to increase the	We have a medicines safety committee in place who have previously focused on the management of high risk medicines (anti-coagulation and insulin), with a	Work will continue to progress the medicines improvement priorities.

safety of those areas of medication use currently considered high risk	reduction in related harm as a result. The group has identified improvement priorities based on our key risks. These include discharge medication on transfers of care, re-launch of good prescribing tips, and a review of mandatory medicines management training. In addition, one of our four trustwide focused improvements is to improve safe medicines management by increasing positive patient identification through the roll-out of an electronic barcode system.	
Deliver a mental health safety improvement programme to tackle priority areas, including restrictive practice and sexual safety	The national programme is primarily focused on mental health settings. We are supporting delivery of the system wide action plan to improve access for patients with mental health needs which will in turn reduce the time patients wait in our emergency departments.	We will continue to progress this work.
Work with partners across the NHS to support safety improvement in priority areas such as safety of older people, the safety of those with learning disabilities and the continuing threat of antimicrobial resistance (AMR)	Our safety improvement programme focuses on the areas we have identified as priorities for our trust, this includes falls prevention and a workstream to improve end of life care. Improvement work related to pressure damage, frailty, AMR, nutrition and hydration continues.	We will optimise how we use the learning disabilities mortality review process (LeDeR) to improve care, reporting learning and actions through the quarterly learning from deaths report.
Work to ensure research and innovation support safety improvement	We have strong collaborative links with the Patient Safety Translational Research Centre (PSTRC) and Imperial College Health Partners (ICHP). We are also using digital solutions to improve safety, both by continuing to maximise the potential of our electronic patient record, and through new technologies e.g. Concentric (electronic consent system).	We will work to increase the use of digital technologies, artificial intelligence and machine learning to further support improvements in patient safety.

Appendix 3: Adoption and Spread Programme

The aim of the Adoption and Spread Safety Improvement Programme (A&S-SIP) is to identify and support the adoption and spread of effective and safe evidence-based interventions and practice across England. The key ambitions are:

- to support an increase in the proportion of patients in acute hospitals receiving every element for which they are eligible of the BTS COPD discharge care bundle to 80% by March 2022. Overall, we have 90% compliance with completion of the care bundle according to the latest audit data. We have work to do to improve our compliance with each individual element, although we are above national average for most.
- to support an increase in the proportion of eligible sites (i.e. acute hospitals in England that care for patients with tracheostomies) adopting three evidence-based tracheostomy safety interventions (bedhead signs, availability of emergency equipment, daily care bundle) to 90% by March 2021 – we are part of the NWL Safe Tracheostomy Care Collaborative which aims to improve patient safety by embedding a range of safety interventions across ICU and ward settings. An airway review group is in place which is taking forward these, and other safety improvements.
- from April 2021, to support an increase in the proportion of patients in acute hospitals receiving every element for which they are eligible of the asthma discharge care bundle to 80% by March 2023: overall, we have 94% compliance with completion of the care bundle at Charing Cross and 73% at St Mary's according to the latest audit data. We have work to do to improve our compliance with each individual element, although we are above national average for most. The service are working with the Cerner change team (including colleagues from Chelsea and Westminster) to create an Asthma care flow set which will incorporate the elements of the bundle. The most recent Children and young people asthma audit (2019/20) highlighted concerns related to the implementation of the discharge bundle in paediatrics. Support for the discharge of asthma patients, specifically around inhaler use, remains on the directorate risk register and an action plan has been agreed that will be monitored at divisional Q&S and reported through EMBQG.
- from April 2021, to support an increase in the proportion of patients receiving all elements for which they are eligible of the emergency laparotomy care bundle to 90% by October 2022 – we have a similar pathway in place which incorporates most of the elements of the care bundle. We have good assurance with the latest NELA audit being assessed as 'low risk/satisfactory assurance', with standards of care and outcomes being demonstrably good, although there is scope for improvement in adherence to best practice process measures which is being taken forward through an action plan.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Quality Committee Report

Agenda item 14 and paper number 11

Committee Chair: Professor Andy Bush, Non-Executive Director
Author: Amrit Panesar – Trust Secretariat Officer

Purpose: Information

Date of meeting: 9th March 2022

1. Purpose of this report

1.1. To ensure statutory and regulatory compliance and reporting requirements to the Trust Board.

2. Introduction

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

3. Key points

3.1. The key items to note from the Quality Committee meeting held on 9th March 2022 include:

3.1.1. **Update on Covid-19 including Covid-19 vaccination and Flu update**

The Committee received a presentation on the Trust's response to Covid-19 and the sector position across North West London which included an update on the Flu Campaign and the Covid-19 vaccine vaccination programme. The Committee noted that 91.74% of frontline staff had received the Covid-19 vaccination and 61% of staff had received the flu vaccination. The Committee noted that the number of Covid-19 infections across the UK remained high, however a number of patients admitted into hospital for other reasons incidentally tested positive for Covid-19. The Committee noted potential impact of the conflict in Ukraine on the NHS and Trust, noting ways in which the Trust could support patients being evacuated out of Ukraine to nearby countries. The Committee were pleased to note that the Trust provided substantial support for a critical incident following a case of Lassa fever where as a result critical care capacity was compromised. The Committee were assured that the executive team were managing the risks associated with the Covid-19 pandemic and operational pressures, but as yet, there was no central guidance as to what the NHS would be doing on 1 April when the new living with Covid-19 Government guidelines come in. The Non-executive directors thanked the executive team for their dedication and hard work throughout each stage of the pandemic.

3.1.2. **Risk and Assurance Deep Dive – National Patient Safety Strategy Implementation update**

The Committee received the National Patient Safety Strategy Implementation update noting that the NHS Patient Safety Strategy focuses on how the NHS can continuously improve safety by building on two foundations which are: a patient safety culture and a patient safety system - setting out three strategic aims for the NHS as a whole such as insight, involvement and Improvement. The Committee noted that the Trust's safety improvement programme has followed this model since the strategy was first developed and the Trust was in a good position for implementation, but although good progress was being made with the implementation, there were aspects which required further work. Committee members were pleased to note the progress and were keen to explore how the Trust could collaboratively work with trusts across the sector to create a standard governance approach.

3.1.3. **Quality Performance Report**

The Committee noted the Quality performance report, noting exceptions against quality key performance indicators and measures being taken to address areas of variance against target. The Committee received a summary covering incident reporting, never events, patient experience metrics, mental health investigations, overdue level 1 serious incidents, clinical guidelines, MRSA blood stream infections, sepsis antibiotics, national clinical audit, inquests, and quality risks covering staffing and divisional risks. The Committee was pleased to note that the Trust had one overdue level 1 serious investigation reports outstanding.

3.1.4. **Learning from Deaths Quarterly report**

The Committee received the report noting the findings from the Trust's Mortality Surveillance Programme quarter 3. The findings would be submitted to the Trust Board and NHS England.

3.1.5. **Infection Prevention and Control and Antimicrobial Stewardship Quarterly report**

Committee members received the quarterly infection prevention & control report noting that the Trust's current trajectory of healthcare-associated C. difficile infection and healthcare associated E. Coli and P. aeruginosa bloodstream infections indicates that the Trust will not exceed the annual thresholds, and therefore do not flag as a cause of concern. Klebsiella infections were highlighted as a concern, especially intravascular line care to prevent sepsis. The Committee noted that the Trust has implemented a monthly review of all healthcare-associated BSIs, including MRSA, and through this will include internal post infection reviews. The Committee were pleased to note that the Trust continues to see an increase in the narrow spectrum antimicrobial metrics.

3.1.6. **Infection Prevention & Control Board Assurance Framework for COVID-19 self-assessment.**

The Committee received the report noting that the Board Assurance Framework was re-issued in December 2021, revising previous key lines of enquiry. The Committee noted the report which contains 125 key lines of enquiry over 10 domains of which 42 remain unchanged from the previous board assurance framework and 83 are either new or significantly revised and cover aspects of Infection Prevention & Control practice beyond specifically Covid-19 as previously the case.

3.1.7. **Maternity Quality Assurance Oversight Report**

The Committee reviewed and accepted the Maternity Quality Assurance Oversight report. The Committee noted: that the final response had been received from NHS England following the Ockenden evidence submission which confirmed 100%

compliance for the Trust. The Committee noted that the CNST MIS year four remains paused. The Committee noted that on 25 January 2022 NHS England requested that each maternity service provide assurance to the Trust Board regarding actions in place to address the Morecambe Bay and Ockenden report recommendations. NHS England previously confirmed the Trust achieved 100% compliance in regard to the evidence submitted to address the immediate and essential actions within the Ockenden recommendations. The Committee acknowledged that on-going audits are in place to assess performance and identity areas for improvement.

3.1.8. **North West London Pathology Report**

The Committee members received the report noting the activities of North West London Pathology in line with the requirements of the joint venture requirements for pathology services. Committee members noted that the service would continue to prepare for upcoming accreditation body inspections and focus on improvements to the service. The Committee congratulated the Team on the progress made to date.

3.1.9. **Medical Devices Strategy**

The Committee received the Medical Devices Strategy report noting that Medical Equipment Management involves a myriad of aspects, rarely seen by users that are essential to ensure medical devices are purchased, maintained, safe to use and replaced to minimise disruption to clinical services and all actioned and monitored by Clinical Engineering. Committee members noted that despite the increasing quantity of medical devices in use of the managed maintenance contract provided by General Electric has remained relatively static. This has been through the efforts of Clinical Committee members. The Committee thanked the teams for their hard work in implementing the medical devices strategy, and also for a really clearly presented paper.

4. Recommendation(s)

Trust Board is asked to note this summary.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Finance report for January 2022 (Month 10)

Agenda item 15 report number 12

Lead Executive Director: Jazz Thind – Chief Financial Officer
Author: Des Irving-Brown, Michelle Openibo, Alistair Cullen

Purpose: For noting

Meeting date: 16th March 2022

1. Purpose of this report

1.1. The finance report for January sets out the reported financial position of the Trust for the six months from April to January 2022.

2. Executive Summary

2.1. The Trust has achieved a break even position year to date at 31st January 2022 and is forecasting to maintain this position to year end.

2.2. The Trust expects to meet a revised CRL of £80.2m and continues to closely manage the programme internally and in dialogue with the NWL sector.

2.3. The Trust's cash position at 31st January 2022 was £199.2m.

3. Recommendation(s)

3.1. The Trust Board is asked to note the finance report.

4. Impact assessment

4.1. Quality impact: No impact
4.2. Financial impact: No impact
4.3. Workforce impact: No impact
4.4. Equality impact: No impact
4.5. Risk impact: No impact

Appendix 1 – Detailed finance report

Imperial College Healthcare NHS Trust

Public Board 16th March 2022

Finance Report January 2022 (M10)

Finance Overview

Imperial College Healthcare NHS Trust

	Year to Date April 21 -January 22		
	Plan £m	Actual £m	Variance £m
Income	1,082.6	1,140.8	58.1
Pay	(640.6)	(650.1)	(9.4)
Non Pay	(390.0)	(441.1)	(51.1)
EBITDA (Earnings before Interest Depreciation and Amortisation)	52.0	49.6	(2.4)
Financing costs and donated asset treatment	(52.0)	(49.6)	2.4
Surplus/(deficit) internal	**0.0**	**0.0**	**0.0**

Income and Expenditure

- Year to date the Trust has achieved a break even position (on plan) and is forecasting to maintain this position to year-end (on plan). A increased focus on elective recovery with a view to reducing waiting lists has resulted in additional elective recovery income which has offset in year pressures.

Capital

- The full year capital plan equates to £104.3m of which only £80.2m scores against the Trust Capital Resource Limit (CRL), with the balance funded by donations or other sources. Year to date the Trust has spent £42.6m (71%) of its total capital plan and continues to forecast to meet its CRL.

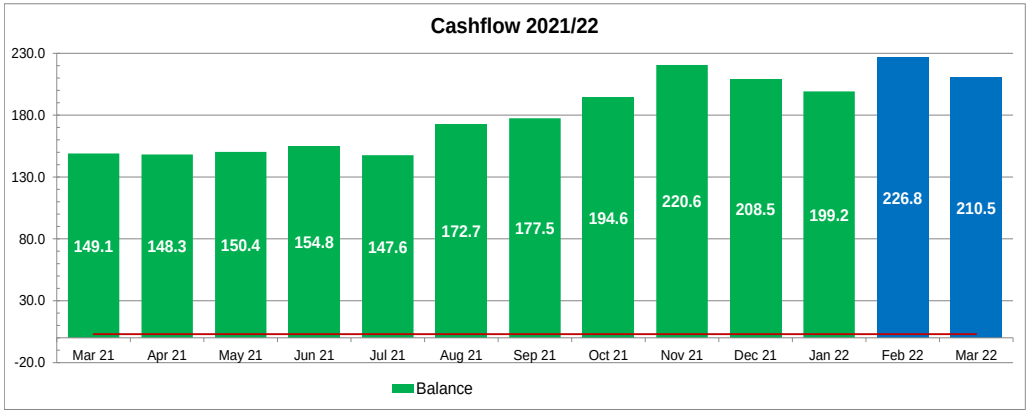
Cash

- At 30th September, cash was £199m. The future cash outlook remains resilient for the remainder of the financial year, assuming achievement of a break even position for the full year.

Statement of Financial Position (Balance Sheet)

Imperial College Healthcare NHS Trust

	31-Mar-21	31-Jan-22	Movement
Property plant and equipment	550.6	554.3	3.7
Intangible assets	14.1	10.9	(3.2)
Other Non Current Assets	3.2	3.2	0.0
Total Non-current assets	**567.9**	**568.4**	**0.5**
Inventories	17.1	17.4	0.3
Trade and other receivables	90.6	79.2	(11.4)
Cash and cash equivalents	149.1	199.2	50.1
Total current assets	**256.7**	**295.8**	**39.1**
Trade and other payables (<1 year)	(281.5)	(313.3)	(31.8)
Total current liabilities	**(281.5)**	**(313.3)**	**(31.8)**
Non Current Liabilities	(21.2)	(20.0)	1.2
Total non current liabilities	**(21.2)**	**(20.0)**	**1.2**
Net Assets employed	**521.9**	**530.9**	**9.0**
Public Dividend Capital	773.9	773.9	0.0
Revaluation Reserve	2.4	2.4	0.0
Income and expenditure reserve	(254.4)	(245.4)	9.0
Total tax payers' and other equity	**521.9**	**530.9**	**9.0**



Non-Current Assets

The decrease year-to-date is driven by depreciation of £42.1m offset by capital expenditure of £42.6m.

Current Assets

Receivable balances have decreased by £11.4m year-to-date following settlement of balances.

Cash

Cash balances were £199.2m at Month 10, which is an increase of £50.1m from the start of the year. The cash position at year end is forecast to be around £210.5m and reflect revised forecasts regarding expected timing of cash flows relating to capital expenditure.

Current Liabilities

Trade and other payables balances have increased by £31.8m in the year to Month 10. The Trust has in the year to date paid 98% of invoices within Better Payment Practice Code timelines, though this represents 96% by value of invoices.

Taxpayers' and Other Equity

To date, no public dividend capital (PDC) equity has been drawn down but the year end position is expected to be around £24m pending final clarifications. Draw downs of funding will be made by year end – most of the expected PDC was awarded in December 2021 and related expenditure is expected in Months 11 and 12.

Capital

Imperial College Healthcare NHS Trust

Sources of Funds	£m
Internal Financing (NWL allocation)	51.7
Confirmed external funding inc. PDC	17.0
Charitable Funds & Grants	24.0
Unconfirmed external funding inc. PDC	11.6
Total	**104.3**

Applications	Annual Plan £m	Year To Date Plan £m	Year To Date Actual £m	Year To Date Var £m
Backlog Maintenance	15.6	13.1	12.7	-0.4
ICT	7.4	6.1	6.5	0.4
Replacement of Med Equip.	6.9	6.0	4.2	-1.8
Decarbonisation	22.8	19.4	9.8	-9.7
Other Capital Projects	48.3	13.8	8.1	-5.8
Redevelopment	3.2	1.8	1.4	-0.5
Total Expenditure	**104.2**	**60.4**	**42.6**	**-17.8**
Income & Donation	**-24.0**	**-19.5**	**-10.6**	**8.9**
Capital Resource Limit	**80.2**	**40.9**	**32.0**	**-8.8**
Actual spend as a % of plan			**71%**	

£5.9m of 2021-22 capital programme expenditure has been incurred in Month 10, bringing year-to-date expenditure to £42.6m, 71% of the planned figure of £60.4m.

The position on capital funding has altered significantly over the last two months. and the Trust's expected Capital Resource Limit (CRL) is now £80.2m, up from £59.2m at Month 8.

This is driven by confirmation of PDC funding in relation to digital schemes, clinical engineering, and the Trust redevelopment plan which forms part of the national new hospital programme. It is not uncommon for capital funding to emerge at this stage of the financial year, however the volume and timings have been are particularly challenging in this financial year.

The Trust continues to dynamically manage to its CRL in the year with appropriate governance forums reviewing the detailed project delivery.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Finance, Investment & Operations Committee report

Agenda item 16 and paper number 13

Committee Chair: Andreas Raffel, Non-executive Director
Author: Philippa Beaumont, Business Manager / EA to the Chair

Purpose: For information

Meeting date: 16 March 2022

1. Purpose

To ensure statutory and regulatory compliance and reporting requirements to the Board.

2. Introduction

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

3. Key points

The key items to note from the Finance, Investment and Operations Committee held on 9 March 2022 include:

3.1 Finance report

The Committee received and reviewed the finance report for month 10 noting that the Trust had delivered a breakeven position to date at 31 January 2022 (on plan) and forecasts to maintain this position to year end.

3.2 Productivity and Efficiency Programme Board update

The Committee received an update on progress of the Productivity and Efficiency programme, outlining the revised timeline to support the build of an efficiency plan spanning a number of financial years. The Committee noted the original timeline had slipped by approximately 3 months due to operational pressures around the pandemic. In line with initial financial planning assumptions for 2022/23, the Trust's opening efficiency requirement would be c£37m (c3%). A process of 'long listing' by divisions and corporate teams had identified schemes to date with a potential value of £11.9m and work continues to close the remaining gap. The Committee noted the update and discussed how the Trust could maximise ideas generation from all staff.

3.3 Deep dive: Business Planning 2022/23

The Committee had a deep dive discussion regarding the Trust's 2022/23 draft business plan covering operations, finances and workforce, updated for any further changes since the version shared at the February Board seminar. The Executive would continue to review and refine the plan with a view to formulating a draft and final plan for 17 March 2022 and 28 April 2022 respectively.

The Committee noted that the current plan assumptions (which include a 3% efficiency challenge) result in a deficit plan which will increase further once hyper-inflation costs of £10m were taken account of. Further work and discussions continue to assess the Trust's route to delivering a breakeven plan with the next update to be discussed with the Board in due course.

3.4 **Scheme of delegated financial authorities (SoDFA)**

The Committee received a report setting out the outcome of the review of the Trusts' SoDFA. The Committee noted that the scheme formed a key element of the Trust's financial governance and set out the authorities given to individuals and Committees in respect of committing the Trust's financial resources and entering into agreements with financial implications.

The Committee noted the changes but requested that a simplified operational version be developed to support staff in understanding the content, their responsibilities etc. The Committee also requested that a proposal be brought to the next meeting with regards to the level of financial authority that could be delegated to the Committee to facilitate more agile decision making and avoid the need for all approvals to be escalated to the Trust board. The committee noted the Chair in Common may have a view on this.

The Committee recommended the scheme of delegated financial authorities for onward approval by the Audit, Risk and Governance Committee.

3.5 **Redevelopment financials**

The Committee noted the update with regards to the expenditure against the redevelopment plan. The Trust had in December 2021, been awarded £5.1m of public dividend capital (PDC) from the New Hospitals Programme. Due to the cautious approach the Trust has had to take to funding the costs of the redevelopment and timing of the award, the Trust forecast is currently below this award and conversations are in train as to how the variation is dealt with.

3.5 **West London Children's Healthcare**

The Committee received a paper, setting out the strategic and financial case for the West London Children's Healthcare (WLCH) initiative along with the proposed governance structure and operating model to underpin it. The signed Memorandum of Understanding setting out the terms of engagement between the two organisations (Chelsea and Westminster NHS Foundation Trust and the Trust) is what WLCH has been working in partnership with the clinical divisions responsible for children's services in both Trusts to begin a process of integrating those services and realising the benefits of joint work.

Building on progress made to date and the appointment of a joint Medical Director and joint Director of Nursing for children and young people, it was proposed to take the next steps towards unifying children's services under a common leadership structure and implement the proposed operating structure from April 2022.

The Committee noted the good progress made, but stressed the need for the strategic objectives to be set out, including any benefits arising from achieving such objectives and any investment required to achieve them. The Committee agreed to recommend to the Board to move forward to the next stage of this integration but for the strategy, objectives and 'business case' around these to come back in due course.

3.6 **Estates Hard FM Contract Extension**

The Committee approved the recommendation to extend the existing Estates Hard FM contract for a further period of 12 months in recognition of the fact that colleagues had to refocus on operational pressures during the Omicron wave and confirmation that the

incumbent supplier continues to provide a good level of service. The work to undertake the Trust procurement exercise will commence in due course. The approval allows the Trusts to initiate negotiations with the incumbent supplier to agree extension terms and conditions.

3.7 **Community Diagnostic Centres (CDCs) programme**
The Committee received an update on the recent national guidance set out by NHSE/I on the CDC programme and implications for North West London and the Trust. The Committee was informed there was a profound deficit between the demand and capacity for diagnostics. The Committee approved the recommendation for the Trust to act as the host organisation for the two CDCs (Wilsden Centre for Health and Wembley Centre for Health and Care) to enable subsequent business cases to be developed for each.

3.8 **Hotel Services – Food Supply contracts**
The Committee approved the proposed procurement strategy for retendering food supply contracts.

3.9 **NWL Pathology Finance report**
The Committee received noted the update on the financial results of North West London Pathology to December 2021 (month 9).

3.10 **Summary of business cases approved by the Executive**
The Committee noted the business cases approved by the Executive.

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

Philippa Beaumont, Business Manager / EA to the Chair
11 March 2022

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

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

Agenda item 17 and paper number 14

Lead Executive Director: Janice Sigsworth, Director of Nursing
Authors: Jenny Ekstrom, Lead Nurse Safe Staffing, Professional Regulation and Revalidation

Purpose: For information

Meeting date: 16th March 2022

1. Purpose

This paper is in two parts. Part A provides a summary of findings from the annual nursing & midwifery establishment review and reports on WTE changes to the nursing and midwifery establishment that have happened since the last review. Part B provides a summary of workforce plans, recruitment, and retention initiatives, to support safe and sustainable staffing, and address nursing and midwifery shortages.

2. Executive Summary (key messages)

Our standard practice is to carry out biannual nursing and midwifery establishment reviews to provide assurance of safe and sustainable staffing, in line with national safe staffing guidelines. This incorporates a comprehensive annual review which forms the basis for any permanent changes in establishment and/or skill mix, and a mid-year desktop review to provide assurance that ward staffing remains safe and is utilised as planned. This usually includes the collection of two sets of acuity and dependency data for all our in-patient and acute assessment areas, using the Safer Nursing Care Tool (SNCT).

This year we carried out the establishment review process against a backdrop of ongoing pressures in departments caused by the Covid-19 pandemic, and therefore adapted these processes in agreement with the executive. The annual nursing and midwifery establishment review took place in autumn 2021 and was presented to the People Committee in March 2022. One set of acuity and dependency data was collected in September, which was benchmarked with the data collected in the previous year. The review took into account any planned changes to service delivery, additional bed capacity and stretch staffing requirements, and any quality-of-care related issues. The annual review highlighted that the clinical needs of our patients and staffing requirements are constantly changing, and the Board is asked to keep this in mind.

The establishment is the baseline total of staff required to deliver care, based on the acuity and dependency of patients using our services. This provides the total planned numbers of staff which we operationally strive to achieve and is used to set staffing levels, deployment against these levels are measured daily. We also monitor and report monthly on our actual versus planned staffing levels.

2.1. The annual establishment review highlighted **an increase of 37.2 WTE** in the nursing and midwifery workforce when compared with the mid-year establishment review. This increase reflects the correct establishment needs as of September 2021.

2.2. Some services are subject to ongoing review, with establishment requirements still emerging. These will be reflected in the next mid- year review and this paper does not seek approval for any forward look proposals.

2.3. The Trust is continuing to deliver against comprehensive strategic workforce plans for nursing and midwifery, which support evidence-based establishment and skill-mix reviews. We have made some progress against these plans, which as discussed at the People Committee, will be refreshed to strengthen our focus on retention.

3. Approvals process

3.1. The report was discussed at the Executive Management Board (EMB) and EMB People Group in February and the People Committee in March 2022.

4. Recommendations and next steps

4.1. The Board is asked to note the annual establishment findings and the ongoing work of the Trust to deliver safe, effective, and sustainable nursing and midwifery care.

5. Impact assessment

5.1. Quality impact: Part A: No impact. This work supports the safe domain and demonstrates compliance with national workforce safeguards. Quality impact assessments are carried out as part of any changes to services and/or the nursing and midwifery skill mix. This is dependent on filling vacant posts, supported by the work outlined in part B.

5.2. Financial impact: All changes captured in the Sept 2021 establishment data are funded within existing budgets or approved business cases. Forward look plans are subject to annual business planning.

5.3. Workforce impact: The annual review highlights an increase in the nursing and midwifery establishment to support safe and sustainable staffing.

5.4. Equality impact: There is no impact associated with this paper.

5.5. Risk impact: Part A: no risks. Part B: filling of vacant posts is dependent on progress against the measures outlined in part B.

Main paper

PART A: ANNUAL NURSING AND MIDWIFERY ESTABLISHMENT REVIEW

6. Process

The annual establishment reviews were carried out in accordance with Developing Workforce Standards (NHSEI, 2018) and 'Safe, Sustainable and Productive Staffing' (NQB, 2016). The Trust uses evidence-based tools such as the Safer Nursing Care Tool (SNCT) and Birth Rate Plus, to accurately assess patient acuity and dependency and apply nursing and midwifery ratios. In conjunction with professional judgement and quality indicators, this forms the basis of the annual review and enables a systematic and triangulated approach to inform safe establishment requirements.

In November 2021, Key actions – winter 2021 preparedness: nursing and midwifery safer staffing assurance framework (NHSEI) was shared with us, which required us to stocktake our progress against best practise safe staffing standards in view of current staffing challenges. We have met a large proportion of these standards, with further work being undertaken operationally to ensure we meet all standards.

7. SNCT data collection

There are a range of tools available to assess the acuity and dependency of patients, including the Adult In-Patient Wards SNCT, Acute Assessment Unit SNCT, and Children's and Young People SNCT. This is supplemented by national guidance on staffing ratios, i.e., hyper acute stroke. Some clinical areas use other national guidelines to inform their establishment and staffing ratios, i.e.,

critical care, neonatal services. The methodologies and guidelines used for specific clinical areas are summarised in the Trust Policy for the Setting of Safe Nurse Staffing and Skill Mix Establishments.

In line with our Standard Operating Procedure, the acuity and dependency of patients in our in-patient and acute assessment areas was assessed using the SNCT, daily for a minimum of 20 days, with weekly validation by a senior nurse. This took place in September 2021. Training was delivered to SNCT assessors and validators with assessments being carried out for all staff new to this role. This process was overseen by the Safe Staffing Steering Group, which is chaired by the Executive Director of Nursing. SNCT findings at the ward level is available to members of the Board. These can be obtained on request by contacting janice.sigsworth@nhs.net.

8. Findings

Overall, there has been an **increase** of **37.2 WTE** reported in the nursing and midwifery establishment of September 2021, when compared with the data from March 2021. This is mainly as a result of:

- Increased activity in critical care
- Expansion of the emergency departments
- An increase in the maternity establishment in line with Ockenden recommendations.

All Divisions	Total registered nurse and unregistered care staff WTE March 2021	Total registered nurse and unregistered care staff WTE September 2021	WTE Change to establishment March 2021 to September 2021	March 2021 Registered nurse and unregistered care staff WTE ratio		September Registered nurse to unregistered care staff ratio	
				RN	CS	RN	CS
Grand Total	4,519.8	4,557.0	37.2	3536.8	983.0	3567.5	989.4
				78%	22%	78%	22%

The data for each division has been validated by the Divisional Director of Nursing, and any increases in WTE were approved via established financial processes.

9. Division of Women's, Children's, and Clinical Support Services

There has been an **increase** of **7.2 WTE** when compared to the mid-year establishment data reported for March 2021.

Division	Total registered nurse and unregistered care staff WTE March 2021	Total registered nurse and unregistered care staff WTE September 2021	WTE Change to establishment March 2021 to September 2021	March 2021 Registered nurse and unregistered care staff ratio		September Registered nurse to unregistered care staff ratio	
				RN	CS	RN	CS
Women's children's and clinical support	1,001.2	1,008.4	7.2	798.4	202.8	807.3	201.1
				80%	20%	80%	20%

Key Reasons for Change:

- Maternity services are subject to findings from the Ockenden Review. There has been an increase in posts in midwifery and foetal medicine (6.7 WTE), in line with recommendations made in the Ockenden Report (DHSC, 2020). These posts are externally funded.

9.1. Forward look

9.1.1. Maternity Services

Birth Rate Plus is a nationally recognised tool which is used to determine the number of midwives and support staff required to ensure safe staffing of maternity units. This is carried out every three years with the last comprehensive review taking place in 2018, and a desk-top review in 2019. The Birth Rate Plus recommendations for our services are midwives: birth ratios 1:24 (SMH) and 1:25 (QCCH), which we are currently meeting. The difference in midwife: birth ratios between sites is due to differences in the complexity of procedures carried out. A Birth Rate Plus assessment has been commissioned and preparation began in December 2021. We expect the results to be available in H1 2022/23.

10. Division of Surgery, Cancer, and Cardiovascular Sciences

Overall, there has been a reported **increase** of **14.8 WTE** when compared to the establishment data reported for March 2021.

Division	Total registered nurse and unregistered care staff WTE March 2021	Total registered nurse and unregistered care staff WTE September 2021	WTE Change to establishment March 2021 to September 2021	March 2021 Registered nurse and unregistered care staff ratio		September Registered nurse to unregistered care staff ratio	
				RN	CS	RN	CS
Surgery, Cancer, and Cardio-vascular sciences	1,574.8	1,589.6	14.8	1293.2	281.6	1303.4	286.2
				82%	18%	82%	18%

Key Reasons for Change:

- The critical care establishment has increased (8.9 WTE) to support ongoing increased critical care capacity.
- An increase in trauma and orthopaedic rehabilitation beds at SMH (2 WTE).
- Flexible posts utilised as fluctuating capacity increases in clinical haematology (-3.9 WTE).
- Increased night activity and expansion of skill-mix in specialist surgery (10 South) at CXH (5.6 WTE).

All changes to establishment are supported by approved business cases and any changes to skill mix are subject to quality impact assessments. The critical care units have pioneered new and innovative multidisciplinary support roles which enable new ways of working.

10.1. Forward Look

10.1.1. Critical Care

Critical care and other services continue to be subject to ongoing review against the need for increased surge capacity. Therefore, establishment requirements are still emerging, and details of

additional business case development being determined. The critical care bed base is under further review pending agreement of a sector staffing model.

11. Division of Medicine and Integrated Care

Overall, there has been a reported increase of 15.9 WTE when compared to the establishment data reported for March 2021.

Division	Total registered nurse and unregistered care staff WTE March 2021	Total registered nurse and unregistered care staff WTE September 2021	WTE Change to establishment March 2021 to September 2021	March 2021 Registered nurse and unregistered care staff breakdown WTE		September Registered nurse to unregistered care staff ratio	
				RN	CS	RN	CS
Medicine and Integrated care	1,751.5	1,767.4	15.9	1292	459.5	1304.6	462.8
				74%	26%	74%	26%

Key Reasons for Change:

- Expansion of the emergency department (ED) and ambulatory care footprint at SMH. The baseline establishment has increased by 16.5 WTE since March 2021. This includes 10.6 WTE posts in our EDs, and 5.9 WTE posts in ambulatory emergency care at SMH.

The ED has been subject to several reviews of Covid pathway management. Any changes to staffing were underpinned by Royal College of Emergency Medicine/Royal College of Nursing (2020) recommendations on safe staff ratios, and NICE (2015) guidance on ED establishment setting.

11.1. Forward look

Some MIC services continue to be subject to ongoing review. Therefore, establishment requirements are still emerging, and details of additional business cases are being determined. i.e., endoscopy services, ARU, stroke and neurosciences; some of which are aligned to quality issues.

11.1.1. Urgent and Emergency Medicine

There are several unbudgeted proposed posts and business cases being developed and are subject to review. A review of the ED establishment is planned for later in 2022, using the recently launched ED SNCT. This is the first evidence-based national safer staffing decision support tool for ED and will be rolled out in line with the annual and mid-year establishment review cycle. We are in the process of clarifying the details of this

12. Imperial Private Healthcare

Overall, there has been a reported **decrease** of **0.70 WTE** when compared to the establishment data reported for March 2021.

Division	Total registered nurse and unregistered care staff WTE March 2021	Total registered nurse and unregistered care staff WTE	WTE Change to establishment March 2021 to September 2021	March 2021 Registered nurse and unregistered care staff breakdown WTE	September Registered nurse to unregistered care staff ratio

		September 2021		RN	CS	RN	CS
Imperial Private Healthcare	192.3	191.6	-0.7	153.2	39.1	152.2	39.4
				80%	20%	79%	21%

Key Reasons for Change:

- Transfer of budgeted post to renal services partially offset by a small increase to private maternity establishment.

13. Financial Impact

All substantive increases to the nursing and midwifery establishment are funded within agreed business planning or business cases. Temporary funded posts and planned changes are not reflected in the establishment data and may be subject to new business planning requests.

14. Staffing Deployment

Decisions on the daily deployment of staffing are supported by a new locally developed Staff Patient Ratio Information Tool (SPRITe). The daily operational review of staffing levels ensures staffing related risks are assessed in real-time and staffing is titrated accordingly by site.

PART B: KEY NURSING AND MIDWIFERY WORKFORCE INITIATIVES

15. National and Local Context

The Board will be aware of the ongoing local and national shortages and challenges within the nursing and midwifery workforce, and the actions we are taking across the Trust to address this. National progress against these challenges were addressed recently in a 50,0000 nurses delivery update (GOV.UK, March 2022). As a result of our strategic approach to improve the supply of the nursing and midwifery workforce, our overall vacancy rate for nursing and midwifery staff has decreased from 13.5% to 12.2%.

The Trust has comprehensive workforce plans in place to meet the supply and demand challenges and address any identified risks. Progress against these initiatives is scrutinised via the monthly Nursing and Midwifery Workforce Strategy Meeting, which is chaired by the Chief Nurse. These plans are being refreshed to strengthen our focus on retention, in line with the recent national recommended actions. Our current programmes include the following.

15.1. Domestic and International Recruitment.
15.2. Automatic offers for students on completion of their studies.
15.3. The New to Care training programme for Healthcare Assistants which supports local community recruitment, and development of a Healthcare Support Worker (HCSW) Strategy.
15.4. Strengthening retention activities, including through use of personalised training budgets, shared decision making (Pathway to Excellence®) and supporting internal career progression for BAME nurses and midwives.
15.5. Developing new roles, including Nursing Associates and Registered Nurse Degree Apprenticeships (RNDA).
15.6. Pre-registration clinical placement expansion.
15.7. Participation in NW London ICS programmes. For example, the Trust is leading an ICS programme to identify and support individuals with overseas nursing qualifications to achieve nurse registration in the UK.

Author: Jenny Ekstrom, Lead Nurse for Safe Staffing, Professional Regulation and Revalidation
9th March 2022

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Summary report from the People Committee

Agenda item 18 and paper number 15

Committee Chair: Sim Scavazza, Non-Executive Director
Executive Director: Kevin Croft, Chief People Officer
Author: Ginder Nisar, Head of Trust Secretariat

Purpose: For noting

Meeting date: 16 March 2022

Executive summary

1. Purpose

1.1. To ensure statutory and regulatory compliance and reporting requirements to the Trust Board.

2. Introduction

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

3. Key points

3.1. The key items to note from the People Committee held on 8th March 2022:

4. Equality, Diversity and Inclusion In Focus: Disability

4.1. Staff story - The Committee heard the story told by a Senior Category Manager in Procurement. His story related to his experiences of having a hidden disability and how he overcame the many challenges of this at his time at Imperial College Healthcare NHS Trust. He outlined his journey starting with when he was diagnosed with dyslexia in the late 1970s and how he has developed a successful career in procurement, in the knowledge of his dyslexia. In 2016/17 he was finally diagnosed with Asperger Syndrome (now known as Autism spectrum disorder). He talked about his experience of the impact of his condition on him and always living in fear of a disciplinary, or worse for fear of being criticised for doing something wrong, and ultimately being dismissed for something he either had no control over or didn't realise was an error. He talked about recent job applications and the encouragement and support available to applications from people with disabilities, in which process he came to understand that he was classed as an individual with hidden disabilities. He outlined some of the positive events that had taken place to support him and some challenges around reasonable adjustments.

4.1.1. The Committee welcomed this insightful story and noted the ongoing work regarding Equality, Diversity and Inclusion, including improving support for staff with disabilities; plans to review and improve Trust recruitment and the on-boarding process for

disabled staff; promoting the existing disability toolkit; offering in-house disability awareness training and promoting additional training.

4.2. Staff Networks - The Committee also heard from the co-chair of the I-CAN Disability Network who provided background to the Network and its commendable work, particularly the positives and challenges encountered during the work so far. The Committee commended the work of the Network and recognised the support it required and the actions underway by the Trust.

4.3. Calibre Programme - The Committee received an update on the Calibre programme which is a talent development and leadership programme for disabled people, developed and delivered by Dr Ossie Stuart, an international disability consultant and academic. The Committee noted that the programme had been well received with interesting feedback and that understanding the workforce was important which was just the beginning of a journey for the Trust and staff in self-identification and becoming leaders. The growth in the network and budget requirement would be an indication that the Trust's direction is right.

5. People Priorities, Performance and Risk Report

5.1. The Committee received a consolidated update on the core people priorities, performance, risk and mitigation for Month 10, January 2022. The report provided a summary of performance against the Trust's seven people priorities and the associated performance metrics, identifying areas requiring focus and improvement as well as the actions being taken to enable that improvement. The paper also provided detail of the corporate and divisional People & OD risks, linked to the seven people priorities, and actions being taken to mitigate these risks. The highlights from the report were summarised in the report.

6. People and OD Risk Deep Dive: Nursing and Midwifery Workforce

6.1. The Committee received a comprehensive update on how the nursing and midwifery workforce is safely established and resourced; detail on the assurance and governance processes in place to monitor safe staffing levels and to mitigate any risks. Committee discussions included the ongoing work in respect of recruitment and retention.

6.2. Annual Nursing & Midwifery Establishment Review Report **-** The Committee received the annual report which provided a summary of findings from the annual nursing & midwifery establishment review and reported on WTE changes to the nursing and midwifery establishment that have happened since the last review (part A); part B highlighted workforce plans, recruitment, and retention initiatives, to support safe and sustainable staffing, and address nursing and midwifery shortages. The review took place in autumn 2021 and highlighted an increase of 37.2 WTE in the nursing and midwifery workforce when compared with the mid-year establishment review. This increase reflected the correct establishment needs as of September 2021. The Trust continues to deliver against comprehensive strategic workforce plans for nursing and midwifery, which support evidence-based establishment and skill-mix reviews. This report was also discussed as part of the deep dive.

7. People Assurance Report

7.1. The Committee received the assurance report for the People Committee which included an update on the GMC Doctors Survey; Covid vaccination as a Condition of employment (VCOD); NHS People Promise regarding embedding the seven promises within organisations; update on the NHS Staff Survey; workforce priorities from the NWL ICS; a proposal on the PDR process for 2022/2; a proposal for the use of the

Apprenticeship levy for management and Leadership apprenticeships. It also summarised Winter preparedness guidance for Nursing and Midwifery staffing; Pathway to Excellence; and the mid-year Nursing and Midwifery Establishment all of which were also part of the People Committee deep dive for this month.

7.2. The results of the 2021 General Medical Council National Training Survey were presented to the People Committee in September 2021. Overall the Trust's trainee results showed a sustained position compared to 2019, however the trainer results showed a slight deterioration. Programmes/specialities have developed focused action plans in response to the results which are being monitored for implementation and impact through the local faculty groups and Medical Education Committee. There are some specialties where there are on-going or recurring concerns. Key themes include workforce and workload, consultant supervision, feedback and support; these have also been highlighted as issues through triangulation with other quality insights. Education review meetings have been held with the Medical Director to provide further support at divisional and executive level and additional actions identified as a result are being implemented.

8. Health and Safety Report

8.1. The Committee received an update on aspects of the Trust occupational health and safety arrangements, including the Trust's statutory duty to investigate certain covid 19-related incidents and the performance of the Occupational Health (OH) service. Covid-related matters are now 'business as usual' for both the occupational health (including test and trace) and health and safety services. Following a review of the Trust health and safety governance arrangements at the September 2021 meeting of the Audit, Risk and Governance committee, a number of recommendations were being implemented with a key focus is on creating a health and safety 'audit universe', which would be an exhaustive list of all the areas and topics and the subject of periodic reports to the Trust.

9. Recommendation(s)

9.1. The Board is asked to note this report.

10. Impact assessment

10.1. Quality impact: N/A for this report
10.2. Financial impact: N/A for this report
10.3. Workforce impact: N/A for this report
10.4. Equality impact: N/A for this report
10.5. Risk impact: N/A for this report

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Audit, Risk & Governance Committee Summary Report

Agenda item 20 paper number 16

Committee Chair: Kay Boycott, Non-Executive Director
Author: Debbie Arney, Corporate Governance Assistant

Purpose: For information

Meeting date: 16 March 2022

1. Purpose of this report

1.1. To ensure statutory and regulatory compliance and reporting requirements to the Board.

2. Introduction

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

3. Key points

3.1. The key items to note from the Audit, Risk and Governance Committee held on 10 March 2022:

3.1.1 External Audit

The Committee received an update on the plan for the year-end audit from Deloitte. The Committee noted the plan and received assurances that there were sufficient resources and robust plans to ensure the audit is completed according to deadlines, subject to any material issues arising. The Committee noted that the lessons learned from the previous year's audit process had been shared and embedded into this year's process.

3.1.2 Annual report approach and timetable

The Committee noted a report setting out the management approach to develop the annual report for 2021/22 and the timescales for approval and submission. It was highlighted that the draft accounts deadline for NHS bodies is 26 April 2022 and the final submission due on 22 June 2022. Subject to approval by the Trust Board, the Audit, Risk & Governance Committee will have the delegated authority for signing off the annual report and accounts prior to submission. The Quality Committee will be reviewing and recommending the Quality Accounts section for approval. Two extraordinary Audit Committees, have been scheduled on 25 April and 15 June 2022 for this purpose.

3.1.3 Accounting Treatments

The Committee noted the report outlining the approach to several significant accounting judgements which may be taken for year-end accounting purposes, and

indicates, where possible, the applicable accounting standards that underpin these treatments.

3.1.4 **Assurance planning 2022/23**

The Committee received a report outlining proposals regarding assurance planning for 2022/23, including the development of assurance frameworks for areas of strategic risk, subjects for Board committee risk and assurance deep dives, and to consider possible sources of assurance including the use of internal audit as possible sources of assurance.

The Committee noted that the Trust is revising its risk and assurance strategy, and as part of this process this Committee and committee chairs will be asked to agree the main areas of assurance work for the next year. The output of this work will be reviewed at the next meeting.

3.1.5 **Internal audit and counter fraud progress report**

The Committee received an update on the Internal Audit progress and activity throughout the year, noting progress against the 2021/2022 plan. The Committee noted that completion of the plan by year-end will provide sufficient coverage of the Trust's key risks to enable PwC to provide the Head of Internal Audit Opinion.

3.1.6 The committee also received an update on the Counter fraud progress.

3.1.7 **Internal audit review - Subject Access Request Audit**

The Committee noted the findings of the internal audit review of the management of Data Subject Access Requests under the UK-GDPR 'Right of Access', commissioned with the support of the Caldicott Guardian and SIRO via the Data Security and Protection Committee. The Committee noted the high risk areas in the findings but were assured that management had developed a clear action plan in response to the recommendations, that would be overseen by the Data Protection Office with engagement from the Health Records department and relevant DSAR Hubs.

3.1.8 The committee requested that an update on the implementation of the action plan is presented to the Committee in July.

3.1.9 **Deep Dive: IT Disaster recovery**

The Committee received an update on progress against the agreed actions from the previous internal audit review of ICT Disaster Recovery. It was noted that the resourcing for the medium term action plan is still under discussion as part of 22/23 budgeting and planning. The Committee requested to be updated if resourcing impacted the planned actions.

3.1.10 **Cyber Security Dashboard**

The committee received an update on work being undertaken by the Trust to mitigate and manage cyber security related risks, including the cyber security dashboard for the period of November 2021-January 2022. The Committee noted the recent increased risk of cyber attack and welcomed the actions taken by the Trust to mitigate risk, including additional investment in Trust systems. They suggested it may be helpful to align future reports against the National Cyber Security Centre (NCSC) priority areas, and asked for more clarity on trust aspiration on key actions e.g. patching.

3.1.11 **ICS & Acute Programme governance – risk register**

The committee noted the latest version of the NW London Acute Programme risk register, noting an ongoing exercise to refresh the strategic objectives of the acute programme and then to revise the programme risk register accordingly. The Committee also noted an update on the development of governance arrangements for the acute provider collaborative in north west London, following the appointment of Matthew Swindells as Chair-in-common.

3.1.12 **Risk and Assurance report**

The committee received a report on risk management and assurance at the Trust, providing updates on the corporate risk register, the corporate risk profile and board assurance framework process. The Committee noted that during the 'governance-lite' period during January-February, the Trust had focused on essential risk management activity only; however the Trust had now returned to 'business as usual' activity. The executive team has revised the Trust risk and assurance strategy, setting out the focus of risk and assurance work for the next year. It was requested that further consideration be given to the criteria considered when rating the estates strategic risk. This will be considered by committee chairs in a separate meeting in April before being presented to the next meeting of this Committee.

3.1.13 **Emergency Preparedness Resilience & Response (EPRR)**

The committee noted the annual report providing an update on the EPRR related activity, incidents during the year and the assurance provided by NHS England as to the Trust's preparedness. The Committee was pleased to note that the Trust met all requirements of the NHS England and Improvement EPRR Core Standards and duties under the Civil Contingencies Act. The Committee also noted that the national threat Level had been reduced from 'Highly likely' to 'Substantial'.

3.1.14 **Western Eye Hospital Fire Improvement Notice**

The committee received a report outlining the Notification of Fire Safety Deficiencies (NOD) for the Western Eye Hospital (WEH) building from the London Fire Brigade (LFB). The Committee noted the action plan in response and noted that actions associated with the 14 findings would be completed by 1st August 2022, unless there is significant structural works required, in which case the mitigation and timeline for those works will be submitted to LFB. The Notification of Fire Safety Deficiencies carries no statutory force but may result in formal action being considered if the agreed improvements do not take place. The executive team will oversee the implementation of the action plan and this Committee will receive assurance regarding progress at its meeting in July.

3.1.15 **Review of Standing Orders, Standing Financial Instructions, Scheme of Delegated Financial Authorities and Scheme of Reserved and Delegated Powers**

The Committee reviewed the amendments made to the suite of governance documents following a bi-annual review. Then Committee noted that the Finance, Investment and Operations Committee (FIOC) had also reviewed the Scheme of Delegated Financial Authorities. The Committee agreed the amendments and the recommendations arising from the FIOC discussion.

3.1.16 **Losses and special payments / tender waivers**

The committee noted updates on losses and special payments as well as tender waivers.

4 Recommendations:

4.1 The Trust Board are requested to note this report.

5 Impact assessment

5.1 Quality impact: N/A for this report
5.2 Financial impact: N/A for this report
5.3 Workforce impact: N/A for this report
5.4 Equality impact: N/A for this report
5.5 Risk impact: N/A for this report

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Audit, Risk and Governance; Finance, Investment and Operations; Redevelopment Board Governance Lite Committee

Agenda item 21 and paper number 17

Committee Chair: Bob Alexander, Acting Chair
Author: Philippa Beaumont, Business Manager / EA to the Chair

Purpose: For noting

Date of meeting: 16 March 2022

1. Purpose of this report

1.1. To ensure statutory and regulatory compliance and reporting requirements to the Trust Board.

2. Introduction

2.1. In response to the Covid-19 pandemic and wider winter operational pressures, the Trust operated under 'gold command' governance from early January to mid-February, with two 'governance-lite' Board Committees arranged over January and February to replace the normal, fuller Board committees. They included key assurance and other essential items only. In line with national guidance, the Board Committee in February has focussed on key items in relation to finance, audit, risk and redevelopment.

2.2. In line with the Audit, Risk and Governance, Finance, Investment and Operations, and the Redevelopment Committees' reporting responsibilities, as detailed in their Terms of Reference, a summary of the items discussed at the combined Board Committee on 2 February 2022 are summarised below.

3. Key points

The key items to note from the Audit, Risk and Governance, Finance, Investment and Operations, and Redevelopment Committees' held on 2 February 2022 include:

3.1. Operational Sitrep including Covid-19 & Vaccine update

3.1.1. The Committee received a presentation on the Trust's response to the latest surge in the Covid-19 pandemic. The Committee considered the national and regional Covid-19 position, noting that the infection rates and levels of hospitalisation had plateaued in London, albeit the community transmission rate remained at a high level. Staff sickness had marginally reduced which was encouraging, however the Trust continued to face significant operational pressures. The Committee commended the efforts of staff, particularly those in clinical and operation teams, to manage the day to day pressures. Planning for 2022/23 was underway, including elective performance and standing back up some of the areas paused for Covid-19 wave 4.

3.1.2. The Committee received an update on the Covid-19 vaccination programme and noted the overall roll-out success across North West London. An update on the current position was given with regards to Vaccination on Condition of Deployment (VCOD)

which had been put on hold, with a consultation launched by central government to formally revoke the requirements. This Trust would continue to provide support to affected colleagues.

3.1.3. The Committee noted the update and were assured the Trust's continued response to Covid-19, operational issues and staff vaccination would continue to be monitored through the People and Quality Committees, and by the Trust Board as appropriate.

3.2. **Contingency plans approach to St Mary's Hospital estate risk**

3.2.1. The Committee received an update regarding the Trust's approach to evaluating the potential impact on the Trust and sector activity in the case of significant failure of the Trust's estate, and developing contingency plans to mitigate the risks and potential impact prior to the completion of the redevelopment of St Mary's Hospital. The Committee noted the update and agreed the approach, with the outcome of the work to be presented to the Redevelopment Committee in March.

3.3. **Western Eye Hospital (WEH) update**

3.3.1. The Committee received an update on mitigating actions being taken to ensure continuity of care at the Western Eye Hospital (WEH), following an expert review of fire safety at the vacant Samaritan Hospital, adjacent to the Western Eye Hospital. The Committee considered options to resolve estates issues in order to enable services to be restored at WEH, noting their concern over the major estates risks for this building and noting that these had been escalated to NHS England/Improvement. The Committee endorsed the action taken to ensure continuity of care and to mitigate risks, and noted that the Redevelopment Committee would monitor progress in managing the estates risks.

3.4. **Internal Audit – progress report**

3.4.1. The Committee received the internal audit progress report noting the progress against the internal audit plan for 2021/22. The Committee noted completion and recommendations arising from audits of the Use of HealthRoster, Covid-19 reset and recovery, capital development and key financial systems.

3.4.2. The Committee noted that two audits, including the second part of the review on Data Security Protection Toolkit and Partnership working were no longer required, resulting in some uncommitted audit time. The Executive would review and agree appropriate use of this time in 2021/22 and suggested items for the Internal Audit Plan in 2022/23.

3.5. **External Audit Procurement**

3.5.1. The Committee were informed that, following the publication of the invitation to tender (ITT) for the appointment of external auditors, the Trust had unfortunately received no bids. Members noted the lack of response to the ITT showed a reflection of the market nationally. Discussions had taken place with the Trust's incumbent provider who agreed to continue as the Trust's external auditor for two years. The Committee supported the recommendation to renew the external audit contract for a further two years.

3.6. **Procurement of Internal Audit Services and update on Counter Fraud Services Procurement**

3.6.1. The Committee received an update following the recent evaluation of bids for the Trust's internal audit service. Five bids were received and presented to the procurement panel and, following evaluation, a preferred bidder was recommended to the Committee. The Committee noted next steps, including some additional due diligence and approved the recommendation of the preferred bidder subject to the assurances noted above.

3.6.2. The Trust were also in a position to make an award for the provision of the Local Counter Fraud Service (LCFS) and this would be discussed further by the Executive Team. It was anticipated this would be delivered within timescales for the new financial year.

3.7. **Risk Management report**

3.7.1. The Committee received an update on risk and assurance activities, noting that non-essential risk management activities had been paused during the governance-lite period but that this would now recommence. A fuller report would be presented to the Audit, Risk and Governance Committee in March, which would include a revised risk management strategy and approach to risk management. The Committee noted that the Trust risk profile remained the same and this reflected the current operational pressures. The Corporate Risk Register included VCOD as an emerging risk and this would be updated to reflect the changes recently announced.

3.8. **Finance report**

3.8.1. The Committee received an overview of the year to date financial position at month 9 which currently showed a breakeven position. The forecast outturn showed a £7m surplus against the breakeven plan. The Committee noted the report.

3.9. **Business planning 2022/23**

3.9.1. Financial planning for 2022/23 was underway and would evolve over time as the Trust reviews current performance. The key challenge would be the level of efficiency required and the development of opportunities to deliver against this. Members noted the complexity and risks around the business planning, and the significant decrease in the allocation of non-recurrent Covid-19 funding for 2022/23. The implications for this needed to be considered.

3.9.2. The draft plan including operational financial and workforce aspects, would be discussed further at the Trust Board seminar on 23 February 2022 and then Finance, Investment and Operations Committee.

3.10. **Consolidated Payroll project**

3.10.1. The Committee were informed that the first stage of the payroll consolidation project was on track for North West London, which involved the transitioning of payroll processing for Chelsea and Westminster NHS Foundation Trust, who currently outsourced their payroll, to this Trust. Processes and policies had been agreed and, whilst there were a few outstanding items, there were good assurances and planning in place to go ahead on 1 April 2022. The Committee noted the report.

4. Recommendation(s)

Trust Board is asked to note this summary.

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Report from the Redevelopment Committee on 7 March 2022

Agenda item 22 and paper number 17

Lead Executive Director(s): Bob Alexander, Interim Trust Chair
Author(s): Philippa Beaumont, Business Manager / EA to the Chair

Purpose: For noting

Meeting date: 16 March 2022

1. Purpose of this report

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

2. Introduction

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

3. Key points

3.1. The key items to note from the Redevelopment Committee meeting held on 8 March 2022 include:

3.1.1. The Programme Director's report to the Committee highlighted updates on a number of activities including the St Mary's Strategic Outline Case (SOC) re-submission and phasing options for the St Mary's site, communication and stakeholder engagement, Charing Cross and Hammersmith Hospitals redevelopment, patients pathways and population update, life sciences, finance and key milestones and risks for the redevelopment programme.

3.1.2. The focus of the Committee meeting was on contingency planning to understand the potential impact on services arising from major failure of any of the hospital buildings and the associated contingency planning required.

3.1.3. The Committee received a verbal update on the Western Eye Hospital.

3.1.4. The Committee also received an update and noted progress on the public sector Decarbonisation Programme. The Committee noted that a more detailed update on the Trust's Green Plan would be presented to the next meeting, including the results of a Trust wide carbon baselining exercise.

3.2. Recommendation

3.2.1. The Board is asked to note this report.