Imperial College Healthcare NHS Trust

Trust Board – Public

Wednesday, 20th May 2020, 11am to 12.45pm
Virtual meeting via Microsoft Teams Live

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

Attendance is limited to voting Directors only to allow other Directors to focus on operational matters.

The meeting will be live-streamed with members of the public able to submit questions ahead of the meeting to imperial.trustcommittees@nhs.net and a link will be available on the Trust's website to submit questions during the meeting, which will be answered at the end of the meeting.

AGENDA

Time	Item no.	Item description	Presenter	Paper / Oral
1100	**1.**	**Opening remarks**	Paula Vennells	Oral
	2.	**Apologies:**	Paula Vennells	Oral
	3.	**Declarations of interests** *If any member of the Board has an interest in any item on the agenda, they must declare it at the meeting, and if necessary withdraw from the meeting*	Paula Vennells	Oral
1105	**4.**	**Minutes of the meeting held on 25th March 2020** *To approve the minutes from the last meeting*	Paula Vennells	01
	5.	**Record of items discussed in Part II of Board meeting held on 25th March 2020** *To note the report*	Paula Vennells	02
	6.	**Matters arising and review of action log** *To note updates on actions arising from previous meetings*	Paula Vennells	03
1110	**7.**	**Chief Executive Officer's report** *To note the report*	Tim Orchard	04
For discussion				
1125	**8.**	**Response to the Coronavirus pandemic and plans for reset and recovery** *A summary of the Trust response to the Covid pandemic and next steps*	Tim Orchard	05
1140	**9.**	**Finance**		
	9.1.	Approval of annual accounts, annual report and quality account– delegated authority *To approve the delegation of authority to the Audit, Risk and Governance Committee to approve the annual accounts, report and quality account for 2019/20 on behalf of the Board*	Peter Jenkinson	Oral
	9.2.	Finance report *To note and discuss the month 12 position, year end and other financial matters*	Jazz Thind	06
1150	**10.**	**Integrated Quality and Performance report**	Julian Redhead,	07

		To receive the integrated quality and performance report for month 12.	Claire Hook	
For decision / approval				
1200	**11.**	**Annual self-certification for NHS Trusts** *To approve the Trust's self-certification of compliance against the NHS Improvement provider standards*	Peter Jenkinson	08
For noting				
1205	**12.**	**Hotel Services Transition update** *To note the update on the transition and next steps*	Hugh Gostling	09
1210	**13.**	**Infection Prevention and Control Report** *To note the quarter 4 2019/20 report*	Julian Redhead	10
1215	**14.**	**Trust Seal Report** *To note the annual report*	Peter Jenkinson	11
1220	**15.**	**Declarations of interest** *To note the annual report*	Peter Jenkinson	12
1225	**16.**	**Trust Board Committees – summary reports** *To note the summary reports from the Trust Board Committees*		
	16.1.	Audit, Risk and Governance Committee, 29th Aprill 2020	Gerald Acher	13a
	16.2.	Quality Committee, 29th April 2020	Andy Bush	13b
	16.3.	Finance, Investment and Operations Committee, 13th May 2020	Andreas Raffel	13c
	16.4.	Board Redevelopment Committee, 15th April 2020	Paula Vennells	13d
1230	**17.**	**Any other business**	Paula Vennells	Oral
	18.	**Questions from the public (as received by email in advance of the meeting or via livestream)**	Paula Vennells	Oral
Close	**19.**	**Date of next meeting** Trust Board: 29th July 2020, 11am, W12 Oak Suite, Hammersmith Hospital		

Updated: 15 May 2020

Imperial College Healthcare NHS Trust

Public Trust Board
Draft Minutes of the meeting held on 25th March 2020, 11am
Virtual meeting held via Microsoft Teams with voting members and attendees presenting items.
The meeting was video-recorded which was placed on the Trust's website.

Members present

Sir Gerald Acher	Deputy Chair (chaired the meeting)
Ms Paula Vennells	Trust Chair
Mr Peter Goldsbrough	Non-executive Director
Dr Andreas Raffel	Non-executive Director
Prof. Andrew Bush	Non-executive Director
Miss Kay Boycott	Non-executive Director
Prof. Tim Orchard	Chief Executive
Prof. Julian Redhead	Medical Director
Mrs Jazz Thind	Chief Financial Officer

In attendance

Dr Ben Maruthappu	Associate Non-executive Director
Mr Peter Jenkinson	Director of Corporate Governance
Prof. Jonathan Weber	Dean of the Faculty of Medicine, Imperial College London
Ms Michelle Dixon	Director of Communications
Mrs Claire Hook	Director of Operational Performance
Mr Hugh Gostling	Director of Estates and Facilities
Dr Bob Klaber	Director of Strategy, Research & Innovation (item 8)
Mr Kevin Croft	Director of People and Organisational Development (item 12)
Mrs Ginder Nisar	Deputy Trust Secretary (minutes)
Mr Brian Mitchell	Communications Office (Microsoft Teams)

Apologies

Mr Nick Ross	Designate Non-executive Director
Prof. Janice Sigsworth	Director of Nursing
Mr Jeremy Butler	Director of Transformation
Mr Kevin Jarrold	Chief Information Officer
Mr TG Teoh	Divisional Director, Women, Children and Clinical Support
Ms Katie Urch	Divisional Director, Surgery, Cancer and Cardiovascular
Ms Frances Bowen	Divisional Director, Medicine and Integrated Care

Item	Discussion
1.	**Opening remarks** Sir Gerald Acher welcomed everyone to the Board meeting held virtually due to the Coronavirus situation and in keeping with social distancing guidance. Divisional directors and other directors were not present in order to allow them to respond to the pandemic. The Board meeting would be video-recorded and uploaded onto the Trust's website.
2.	**Apologies** Apologies were noted from those listed above.
3.	**Declarations of interests** None other than those disclosed previously.
4.	**Minutes of the meeting held on 29th January 2020** The minutes of the previous meeting were agreed.
5.	**Record of items discussed in part II of Board the Board meeting held on 29th January 2020 and 25 and 26 February 2020** The Board noted the summary of confidential items discussed at the confidential Board meeting held on 29th January 2020 and the Trust Board Seminar on 25th and 26th February

	2020.
6.	**Matters arising and actions from previous meetings** The updates provided via the action log were noted.
7.	**Chief Executive Officer's briefing**
7.1.	Prof. Orchard presented his report, highlighting key updates on strategy, performance, leadership over the month and latterly the focus of Trust business in response to Covid-19.
7.2.	<u>Covid-19</u>
7.2.1.	As at 24th March 2020, the Trust had 143 positive patients with 68 queries; 22 were on ventilation, 3 queries in ICU and sadly, 9 deaths. All confirmed cases were being managed in line with Public Health England guidance to minimise risk to other patients, visitors and staff.
7.2.2.	To respond to the rapidly changing situation nationally and regionally, the Trust had implemented a 'command and control' structure, for which Mrs Hook, Director of Operational Performance, was the Gold Commander. The Trust had implemented a site based Gold command structure. Command and control teams for each site had been established consisting of site-based command triumvirates made up of Hospital Director, Associate Medical Director and Divisional Director of Nursing. They would oversee the management of all staffing, equipment and other resource on each site. All decision making on the management of each site would feed through these structures 24/7.
7.2.3.	A number of workstreams had been established, including people, operations, ward processes and equipment (including personal protection equipment (PPE)) and communications. Daily calls including daily Executive Covid-19 meetings had been established from 12th March 2020.
7.2.4.	All staff were focused, or were being redeployed on work to support essential business as usual and the Trust's response to Covid-19. The Trust was rolling out Microsoft Teams and other support mechanisms to enable many more staff to be able to work flexibly and maintain social distancing to minimise risk of infection. The Trust postponed all non-essential meetings and work that was not business critical.
7.2.5.	Prof. Orchard advised that the Trust had decided to stop patient visiting. It had tried to restrict visiting to one visitor but unfortunately it had been difficult to implement. Visitors would now be considered in exceptional circumstances for patients at end of life; one regular carer for a patient with additional needs; one parent/guardian for a child; and one birth partner.
7.2.6.	In line with national guidance, the Trust had restricted non-urgent activity to help create additional capacity for emergency Covid-19 pathways, especially critical care. Each consultant had reviewed their elective inpatient lists to identify patients who could be safely rescheduled, including assessing clinical harm. From 26th March 2020, the Royal Marsden would triage cancer patients and manage cancer patient surgery. The majority of outpatient appointments have become 'virtual' by telephone or video.
7.2.7.	The risk associated with disruption to business as usual from the pandemic response had been escalated to the corporate risk register and would be reviewed weekly.
7.2.8.	The Board discussed key issues being faced currently. In regard to PPE, supplies were being monitored and guidance for staff clarified. The Trust was working with Imperial College London to identify alternative sources of PPE, including 3D printed visors.
7.2.9.	Prof. Orchard extended his gratitude to all staff for the tremendous amount of work they have done and continue to do to help contain the spread and to be fully prepared. Understandably some staff were concerned about Coronavirus and its impact, and the Trust would continue its focus on protecting them as well as patients and visitors at this difficult time.
7.3.	<u>Operational performance</u> - Field testing of the proposed new Urgent and Emergency Care standards continues.

7.4.	Financial performance - Year to date, the Trust was on plan with a deficit of £8.8m before Provider Sustainability Funding which was being achieved through the use of significant non-recurrent mitigations. However, all efforts were focused on Covid-19 and related costs were being captured.
7.5.	Transformation update - Since January 2020, and as part of the business planning process, the Transformation Team facilitated agreement to an agreed list of focused improvements, projects and programmes for 2020/21, consisting of a mix of operational improvement and strategic topics. Although work was being finalised around detailed plans for launch in Q1 2020/21 including business planning and a prioritised 2020/21 budget in line with the agreed Trust priorities, some of these activities have had to be paused to the Trust's response to Covid-19.
7.6.	Imperial Management and Improvement System - A multi-disciplinary working group, led by the Director of Operational Performance, was established in December 2019 with the purpose of designing an implementation plan for the Imperial Management and Improvement System (IMIS) which would enable the Trust Board to receive performance data for March 2020 in both the existing Integrated Quality and Performance Report format and in the proposed new IMIS format in May, with the hope that the new arrangements could be implemented in full for 2020/21 data. However, there was likely to be delay to this timeline due to the current challenges.
7.7.	Patient focus - The Trust's first patient safety conference was held on 24th February 2020 and at the heart of it was innovative thinking about patient safety and building a just working environment. Over 140 delegates took part in the conference which showcased the safety improvement work taking place across the Trust entitled 'From Strategy to the frontline'.
7.8.	Strategic Development
7.8.1.	Redevelopment – The Trust now has a formal agreement to enter into partnership discussions between the Trust and Great Western Developments Ltd, working with Sellar. The agreement allowed joint work and engagement to take place over the next six months on how the developer could build a new St Mary's Hospital.
7.9.	People
7.9.1.	Hotel Services - operational planning was underway to prepare for 1000 Hotel Services staff to complete a TUPE transfer of employment into the Trust on 1st April 2020, with key workstreams including the preparation for paying staff, transfer of employment, and provision of training and induction. Progress against implementation was on track and Prof. Orchard commended staff efforts during challenging times.
7.9.2.	The report also provided an update on the culture programme, MBA and Masters in leadership and management, nurse recruitment and retention programme, flu campaign, doctor's bank and equality and diversity.
7.10.	Research and innovation
7.10.1.	Research - In light of the Covid-19 pandemic, in conjunction with colleagues within Imperial College and based on national advice, the Trust made the decision to suspend all clinical research trials as its default position. The aforementioned partners set up an exemption process where Principal Investigators could apply to a clinical and academic panel to be granted exemptions on a trial-by-trial basis, and agreed to review this process on a weekly basis to ensure the balance of risks were optimised.
7.10.2.	Strategic planning work continues in preparation for the Trust's re-application to be a Biomedical Research Centre and also for its re-application for hosting its regional Clinical Research Network, both of which were expected to open application processes later in 2020.
7.10.3.	AHSC re-designation – the Trust was interviewed at the end of February 2020 to be considered for Academic Health Science Centre (AHSC) re-designation. It was envisaged that it would hear the outcome of this process within the next few weeks.

7.11.	Stakeholder engagement - A list of meetings held with stakeholders was provided in the report.
7.12.	The Board discussed the CEO's report.
7.12.1.	Dr Raffel commented that the Trust should consider changes to some working practices as some of the changes required in response to Covid-19 could be beneficial. Prof. Orchard concurred and gave the example of virtual outpatients. He informed the Board that Mrs Hook would be leading a 'getting back to business as usual' workstream focusing on priorities and consider beneficial working practices as a result of Covid-19, allowing step changes in processes.
7.12.2.	In regard to changes in flow during the Covid-19 response, Ms Boycott enquired how the Trust was engaging with the broader sector and community. Prof. Orchard advised that he participates in daily sector calls which address issues as they arise. Patients who do not need to be in the acute sector were being transferred to the community sector and teams were talking through issues to ensure community services have the right support. New mechanisms to engage with councils to unblock pathways also established.
7.12.3.	Ms Vennells acknowledged the change in working practices and Prof. Orchard's response. She enquired about post Covid-19 and impact for respiratory services such as the 'healthy hearts and lungs strategy' which would need updating. Ms Boycott commented that currently the lasting damage, physically and mentally, was not known and what services might be needed to cope with the aftermath - researchers would be looking into this. Prof. Orchard welcomed the helpful observation which would need to be considered.
7.12.4.	Prof. Bush commented that before the Trust embraces changes, it would need to assess the damage and be aware of the negative impact on other patients. In the case of childrens services, changes would need to take into consideration other factors such as vulnerability and safeguarding, which could not be easily assessed if appointments conducted virtually or by telephone. Prof. Orchard concurred and assured the Board that the Trust and teams would work out which services could be done virtually and which could not, undertaking a risk assessment of each decision. Dr Klaber added that pan-London discussions were taking place and such factors were also being considered. Sir Gerald Acher advised that once the Trust begins to work towards business as usual, the Quality Committee and other relevant Board Committees would need to pick up such points.
7.12.5.	Sir Gerald Acher summarised, in the short term there would be more audio outpatients and video appointments would be introduced – risk assessments would need to take place as to whether these introduced risks, noting that the risks would be different between with video and telephone methods. Prof. Orchard advised that in the short term, teams would identify people at risk and what particular interventions were required.
7.12.6.	Sir Gerald Acher thanked the Chief Executive and everyone under him and commended operational teams for their response during unprecedented times and daily challenges.
7.13.	**The Board noted the report from the Chief Executive.**
8.	**Business planning 2020/21**
8.1.	The Board received a summary of the proposed priorities for the Trust for 2020/21 as discussed at the February 2020 Board strategy seminar, and noted the impact of the Trust's response to the current Covid-19 pandemic on the priorities.
8.2.	Mrs Thind outlined the financial implications in that Operational planning for 2020/21 was suspended pending further notice and Commissioners were asked to agree block contracts with their NHS providers for the period 1st April to 31st July 2020, providing a guaranteed monthly payment.
8.3.	Irrespective of Covid-19, the Trust's Finance function would continue to review and update its

	financial plan internally to reflect the updated funding considerations which would then allow draft budgets to be set, so that the Trust could monitor its financial performance in the usual manner. The plan would be built using: 'Next steps on NHS response to Covid-19' for April to July 2020; and previous assumptions for August to March 2021. Teams would plan for the first four months of 2020/21 noting that no savings were expected during these months. Covid-19 related costs were being captured. Sir Gerald Acher agreed and advised it was important to have the right checks and balances in place.
8.4.	In response to Sir Gerald Acher, Mrs Thind advised that a number of Trusts did not sign up to the control total therefore ICHT were not out of kilter.
8.5.	Responding to Mr Goldsbrough, Dr Klaber advised that the report provided a brief summary of the areas that were on pause and more detail would have been provided had Covid-19 not occurred. Mr Goldsbrough noted the comment and suggested teams were realistic about the work that could and could not be undertaken during this challenging time, so as not to over stretch capacity. Prof. Orchard welcomed the comment and advised that due consideration had been given to the priorities in light of the Trust's response to Covid-19.
8.6.	Sir Gerald Acher added that new ways of working would have significant benefits and suggested some areas could possibly be brought forward from their original timeline, after the Covid-19 situation begins to settle.
8.7.	**The Board noted the report and the priorities for 2020/21 taking into consideration the evolution of priorities in response to Covid-19. The Board would be kept updated on changes.**
9.	**Sustainable development management plan**
9.1.	The Board was presented with the Sustainable Development Management Plan (SDMP) which set out the Trust's aims, objectives, plans and priorities for improving its local and global environmental and socio-economic impacts through clear and measurable targets, The aim was: through delivering care in a more sustainable way, and supporting staff and patients to live more sustainable lifestyles, the Trust would enable better health outcomes in its communities. The SDMP set out commitments to cut the Trust's environmental impact, reduce operating costs and improve wellbeing, covering each area of the triple bottom line of sustainability.
9.2.	Ms Boycott welcomed the report and was pleased to be the lead Non-executive Director for this project. She acknowledged that the scoping work would take place over the year but likely that the Covid-19 response may impact some areas of work which may have to be paused. Mr Gostling agreed that most of business as usual was currently on pause, as were projects that were not deemed to be a priority at the present time but the Redevelopment Programme would continue.
9.3.	After discussion, the Non-executive Directors requested that further consideration be given to some of the aspirations as the report was not clear on the means to get to the end and correlation with the Trust's strategic vision. Mr Gostling advised that the scoping work would delve into the detail.
9.4.	**The Board endorsed the plan and the ambition, and asked the Executive Team to review and include more granularity around key aspects and then submit to the Board Redevelopment Committee in December 2020. The report to also include it would need a rolling plan as it would evolve over time.**
10.	**Bi-monthly Integrated Quality and Performance report (IQPR)** The Board noted the key headlines relating to performance as at January 2020. Exception slides provided within the report covered other scorecard metrics.
10.1. 10.1.1.	<u>Quality</u> The incident reporting rate was above target and the overall number of incidents reported

	continued to improve. The number of transport related incidents had also reduced. In terms of overall harm profile, the percentage of incidents causing moderate and above harm was within target for 2020/21.
10.1.2.	The Never Event declared in January 2020 under the category 'misplaced oro-gastric tube' was under investigation. The initial review highlighted human error where the incorrect chest x-ray was reviewed when the position was checked.
10.1.3.	In January 2020, 90 cases of hospital-associated C. *difficile* were recorded in total so far this year, and 10 occurred in January 2020. The Trust was above its target of 77 cases for the whole financial year. Of the 90 cases, only one case in October 2019 was associated with a lapse in care, due to cross transmission.
10.1.4.	6 cases of Trust-attributable *E.coli* cases were reported in January 2020 and the Trust was on track to meet its 10% reduction target for 2019/20; there was 1 case of CPE BSI reported in January 2020, bringing the total to 7 cases so far this financial year, compared to 6 this time last year.
10.1.5.	Data for January 2020 showed that 88% of patients received antibiotics within 1 hour of confirmed sepsis diagnosis, below the Trust's target of 90%. The performance remains within tolerance and would be compliance monitored via the deteriorating patient safety workstream. Exception reporting would be provided with a formal improvement plan, should performance not improve.
10.1.6.	The approach to conducting mortality reviews had been amended to refocus on the quality of care and treatment provided to the patient.
10.1.7.	Vacancy rates continued to improve and remain within the 10% target.
10.1.8.	All Friends and Family Test scores remained within tolerances across the care settings, with the exception of patient transport where feedback was still quite limited.
10.2.	<u>Operational performance</u>
10.2.1.	In January 2020, two patients had been waiting for more than 52 weeks for treatment. The overall size of the referral to treatment waiting list size was stable and was meeting the trajectory. The diagnostic target was met following the use of a number of additional sessions in imaging due to sustained increases in demand.
10.2.2.	A final report on the review of the NHS Access Standards, including the outcomes on the national pilot of the proposed Urgent and Emergency Care metrics was expected in Spring 2020.
10.2.3.	Mrs Hook advised that at the current time, the Trust would continue to report externally on the standards. In terms of operational priorities, currently the standards were not directing some of the Trust's decision-making. From an inpatient's perspective the focus was on creating as much capacity as possible, including critical care and being able to isolate patients coming through emergency departments – the latter was a challenge but would be done as much as possible. In terms of the elective care pathway, only critical surgeries were taking place and ensuring the Trust was aware of where patients were on their pathways and next steps, which was being documented. Once the Trust started to go back to business as usual or other avenues considered, the documented patients could be prioritised accordingly.
10.2.4.	The Non-executive Directors suggested a shorter IQPR report for the next few months, if it assisted executive and operational resource. Prof. Orchard acknowledged the thought and advised that it would take longer to re-produce a shorter report and easier to keep to current reporting for now. Ms Vennells added that it may be helpful if the executive outlined what the Board absolutely needed to see to reduce the burden on the Executive team. Professor Orchard would give some thought to this and discuss directly with Ms Vennells. **Action: Prof. Orchard**

10.3.	**The Board noted the report.**
11.	**Finance report**
11.1.	The Board noted the key headlines relating to the financial position for the Trust as at 29th February 2020.
11.2.	The actual year to date deficit was £8.8m (on plan) before Provider Sustainability Funding; additional income associated with over performance in activity, mainly in relation to emergency work, was offset by the additional costs of delivery; income payable by NWL CCGs and NHSE in relation to 2019/20 agreed; the Trust remains on track to meet control total through further non-recurrent actions/mitigations (one-offs) which result in a significant pressure being carried forward into 2020/21; all divisions on track to achieve their current forecast outturn position; continued concerted effort to reduce pay exit run rate to support delivery of outturn and 2020/21 financial plan; additional costs associated with COVID-19 were being funded centrally (c£0.6m of revenue costs to 31st March 2020); and unless operational teams are able to close the £4.4 gap to the control total, the total amount of non-recurrent support required would equate to £24m.
11.3.	Key Risks or areas of concern impacting delivery of control total include: as NHS clinical income for the year was fixed, any increase in the cost forecast over the current position was a risk to the Trust; and the additional costs associated with the in-housing of hotel services (capital and revenue) continue to be updated and quantified.
11.4.	Capital expenditure was £2.4m behind plan but forecast to catch up in order that the Trust meets its capital resource limit of £51.9m.
11.5.	Mrs Thind confirmed that the Trust was on plan and not out of kilter on reporting, and the report did not include Covid-19 costs. She informed the Board that she would participate in a London Finance Directors call later in the day to discuss the capital plan and likely that a number of schemes would need to be de-prioritised.
11.6.	**The Board noted the report.**
12.	**Staff survey results**
12.1.	The Board received the summary of the results of the National Staff Survey which was carried out between September 2019 and December 2019 The report outlined the high level Trust-wide results and recommendations for action in both communicating the results and taking action.
12.2.	The Trust undertook a full census survey in 2019, following several years of a 10% sample survey. A total of 52% of staff responded to the survey (5,659 out of 10,988), which was significantly higher than any other staff survey conducted previously. The overall engagement score was 7.2 out of 10, up from last year at 7.0 and above this year's average score for all acute Trusts which was also 7.0.
12.3.	The survey results were split into 11 themes, and scores across all themes improved. Results were above the national average in six out of the 11 themes; immediate managers, quality of appraisals, quality of care, safety culture, staff engagement, team working. However, scores remained below the national average for acute Trusts in four key areas and these were recommended as the four key areas of Trust priority focus, namely: equality, diversity and inclusion; health and wellbeing; morale; and safe environment bullying and harassment.
12.4.	The overall results would suggest that many of the work programmes initiated in 2018/19 were having an impact and potentially contributing to the improvements in survey results.
12.5.	The report outlined the Trust culture work programme which was the overarching programme to drive a range of projects and action in response to the survey feedback.
12.6.	Mr Croft advised that although an action plan had been developed, it was on pause due to the Covid-19 response, however this would be discussed as part of the business as usual

	workstream. Current focus was on supporting staff and their wellbeing during the pandemic.
12.7.	Prof. Orchard was pleased with the engagement with the staff survey and improvements since the last survey. Attention would be diverted to the results and actions after Covid-19. Ms Vennells suggested Mr Croft reviews the data which would usually be segmented by teams or other factors, which may help drill into key areas to help direct effort.
12.8.	Responding to Ms Boycott regarding positive effects after Covid-19, Mr Croft advised that key positive elements would be: good level of commitment, working together, joint working, being able to step change i.e. remote working via virtual and conferencing facilities. Negatives likely to include some staff may leave as too much for them to handle; tension within teams when asked to do things differently.
12.9.	Mr Goldsbrough commented about the necessity of communication during a crisis situation bearing in mind the emotional stress. Mr Croft advised that he and Prof. Orchard had met with the unions and staff representatives to discuss staff wellbeing and would continue to meet weekly in an effort for them to assist management pick up on things that may have been missed.
12.10.	The Non-executive Directors acknowledged the increased rate of engagement and congratulated all on the level of participation and outcome which would provide much more meaningful insight; and also congratulated the Executive on their efforts around staff wellbeing during this challenging time.
12.11.	**The Board noted the report.**
12.12.	**Infection Prevention and Control report** The Board noted the quarter 3 2019/20 report some of which was covered under item 10.
13.	**Trust Board Committees – summary reports**
13.1. 13.1.1.	**Audit Risk and Governance Committee** The Board noted the summary points from the meeting held on 10th March 2020.
13.2. 13.2.1.	**Quality Committee** The Board noted the summary points from the meeting held on 18th March 2020. A report on private practice would be received by the Committee in due course.
13.3.	**Finance, Investment and Operations Committee** The Board noted the summary points from the meeting held on 18th March 2020.
13.4.	**Board Redevelopment Committee** The Board noted the summary points from the meeting held on 4th March 2020.
14. 14.1.	**Any other business** Sir Gerald Acher congratulated the Executive and their teams and all staff involved in the unprecedented response to the Covid-19 pandemic. Prof. Orchard would relay the Board's gratitude to all staff. **Action: Prof. Orchard**
15. 15.1.	**Questions from the public** A question had been received (ahead of the meeting) from a member of public who enquired about the spirit in which the Strategic Lay Forum was set up, who could join it and whether it reflects on the value that the Board of Imperial College Healthcare NHS Trust so often preach. Michelle Dixon advised that the Strategic Lay Forum oversees the patient and public involvement at the Trust and sets a clear vision for effective patient and public involvement across all of its services. Its role is to ensure the Trust takes a patient-centred approach to policy, planning and strategic developments. It is led by a lay chair as well as 13 additional lay partners plus senior staff from across the Trust and its key partners – communications, improvement, patient experience, integrated care, governance, quality and safety, Imperial Health Charity and Imperial College London. The information on the website details how people could join the forum. She added that the Lay Forum does a lot to support the Trust and the Lay Forum Chair also sits on the Redevelopment Programme Board which was helpful.
16.	**Date of next meeting** 20th May 2020, 11am, W12 Hammersmith Hospital

Updated: 12 May 2020

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TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Record of items discussed at the confidential Trust board meeting held on 25 March 2020	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 20th May 2020	**Item 5, report no. 02**
Responsible Executive Director: Professor Tim Orchard, chief executive officer	**Author:** Peter Jenkinson, Director of corporate governance

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

March 2020

Covid-19
The Board received an update on the Covid-19 pandemic and the Trust's response covering critical care capacity, equipment, PPE, workforce, testing, decision making arrangements and financial arrangements.

Managed maintenance service contract
The Board received the proposal to extend the current management services contract with GE Healthcare. The Board approved the contract extension.

Mobilisation of hotel services
The Board received a progress update against implementation for in-house transfer on 1st April 2020. The Board commended the teams' efforts during challenging times and noted the progress report.

Light touch governance arrangements
The Board discussed the proposed light touch governance arrangements for the Trust, whilst it responded to the Covid-19 situation.

Recommendations: The Trust board is asked to note this report.

Imperial College Healthcare NHS Trust

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

Updated: 5 May 2020

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	29 January 2020 17.3	Pathway to excellence	Sir Gerald Acher also congratulated the directorate and suggested this is brought to the attention of North West London colleagues and included in a communications exercise/bulletin. May 2020 update: Oral update	Michelle Dixon	May 2020
2.	29 January 2020 9.5	Integrated Quality and Performance Report – Diagnostics	Prof. Teoh informed the Board that in November and December 2019, the diagnostic target had not been met with a 175% increase in ultrasounds as the seasonable variation had increased. He was working with the CCGs to address this and he would report back to Board on discussions. March 2020 update: Contact made with the CCG but focus currently on Covid-19.	TG Teoh	July 2020
3.	27 November 2019 9 25 March 2020 8	Strategic development – Implementation of a management system (The Imperial Way	November 2019: Claire Hook highlighted that the proposed approach to delivering the Trusts strategy in a standardised way, linking in with the Trusts values and behaviours. Board members discussed the programme and agreed whilst they all supported the proposal, that there needed to be a clear and practical way of delivering it, with it being collectively owned by the executive team. The Board approved the Imperial management system (working title 'the Imperial Way') and noted the process for agreeing priorities for 2020/21 and the process for delivery of the 2019/20 objectives. An update outlining the delivery process and risks would be presented to a future board meeting. March 2020 update: The Board received a summary of the proposed priorities for the Trust for 2020/21 as discussed in the February 2020 Board strategy seminar and taking into consideration the evolution of priorities in response to Covid-19. The Board would be kept updated on changes. Update to Board – July tbc	Tim Orchard/Claire Hook, Bob Klaber, Peter Jenkinson	July 2020 tbc
4.	29 January 2020 14.6	Employee metrics matrix (arising from FTSU item)	Ms Boycott suggested a joined up matrix capturing employee experience such as concerns arising from staff survey, and concerns raised via other sources including FTSU. Other Non-executive Directors agreed and suggested including excellence awards and staff stories to Board in the employee experience piece. Mr Croft would give some thought to this.	Kevin Croft	July 2020
5.	29 January 2020 7.3	Patient story review	January 2020: Prof. Sigsworth welcomed the comments and would discuss a plan with the Strategic Lay Forum, Executive Quality Committee and Quality Board Committee with a next steps plan to Board in summer.	Janice Sigsworth	July 2020

6.	25 March 2020 9.4	Sustainable development management plan	The Board endorsed the plan and the ambition, and asked the Executive Team to review and include more granularity around key aspects and then submit to the Board Redevelopment Committee when ready. The report to also include it would need a rolling plan as it would evolve over time. May 2020 update: Planned for December 2020 Redevelopment Board Committee	Hugh Gostling	December 2020

Items closed at the March 2020 meeting

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	27 November 2019 13.6	Board Assurance Framework	November 2019: Noting the changes to the Board Assurance Framework, Peter Goldsbrough asked whether the amount of time it would take to track assurance had been considered. Peter Jenkinson reflected that it shouldn't take up much more time that it currently did but agreed to discuss this at the following Audit, Risk & Governance Committee and feedback. Discuss the time and resource required for the Board Assurance Framework at the Audit, Risk & Governance Committee on 4 March 2020, and feed back to board members at the Trust Board on 25 March 2020. January 2020 update: on the agenda for the March Audit, Risk & Governance Committee. March 2020 update: Discussed at ARG in March.	Peter Jenkinson	Closed
2.	29 January 2020 8.7.2 25 March 2020 12	Staff Survey	The results of the staff survey would be presented to the March 2020 meeting. March 2020 update: The Board received the summary of the results of the National Staff Survey. The report outlined the high level Trust-wide results and recommendations for action in both communicating the results and taking action.	Kevin Croft	Closed

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

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Chief Executive Officer's Report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 20th May 2020	**Item 7, report no. 04**
Responsible Executive Director: Prof Tim Orchard, Chief Executive Officer	**Author:** Prof Tim Orchard, Chief Executive Officer

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

1) COVID-19
2) Hotel Services direct employment
3) Financial performance
4) Operational performance
5) Strategic development
6) Research and innovation
7) Stakeholder engagement

Recommendations:
The Trust Board is asked to note this report.

This report has been discussed at: N/A

Quality impact: N/A

Financial impact:
The financial impact of this proposal as presented in the paper enclosed: N/A

Risk impact and Board Assurance Framework (BAF) reference: N/A

Workforce impact (including training and education implications): N/A

What impact will this have on the wider health economy, patients and the public? N/A

Has an Equality Impact Assessment been carried out?
☐ Yes ☒ No ☐ Not applicable
If yes, are there any further actions required? ☐ Yes ☐ No

Paper respects the rights, values and commitments within the NHS Constitution.
☒ Yes ☐ No

Trust strategic goals supported by this paper:

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

Chief Executive's Report to Trust Board

1. COVID19

Since the last Board meeting, we had to more than double our intensive care capacity, redeploy hundreds of staff into new roles, and put in place a whole raft of initiatives and new ways of working to respond to the COVID-19 pandemic. At the same time, we did all we could to continue to care for all our patients, including transferring planned surgery and treatment to other NHS providers and private hospitals less impacted by COVID-19. We also transformed our outpatient appointments into primarily telephone and video consultations.

The scale of the effort can be seen in some of the operational data – up to 14 May 2020:

- we have cared for just over 1,300 patients with coronavirus
- around 500 of our patients have required ventilation in our intensive care units
- we have helped over 700 people recover and be discharged home or to local care
- we have reported just over 400 deaths of patients with coronavirus through central reporting to NHS England.

We were able to achieve so much, so quickly, thanks to the huge commitment and expertise of all of our staff, much closer working with our partners across our Integrated Care System, and the support and goodwill of many individuals and businesses, boosted by the efforts of our closest partners, Imperial Health Charity and Imperial College. I am incredibly grateful to everyone but especially to our amazing staff who continue to go well beyond what might be expected of them, even when so many have been personally affected. They have lost family, friends and neighbours – four of our own people have died since the pandemic began. It's really important that we continue to remember and recognise them - Professor Mohammed Sami Shousha, Donald Suelto, Melujean Ballesteros and Jermaine Wright.

We remain concerned that there is a disproportionate impact of COVID-19 on black, Asian and minority ethnic communities (BAME), within the general population and the NHS workforce, and we have put in place additional measures to support and protect our BAME staff.

There have been a whole raft of other, detailed changes and developments in response to COVID-19, some very positive while others have been more difficult to manage, including:

- Establishing a daily Clinical Reference Group led by the medical director to make decisions about changes to pathways and to establish new clinical protocols.
- Making temporary service changes, such as closing our specialist A&E at The Western Eye Hospital overnight to enable staff to be redeployed to support our intensive care expansion.
- Introducing a Trust-wide approach to the procurement and use of personal protective equipment (PPE) to ensure everyone's safety.
- Developing a patient and staff testing approach, drawing especially on the skills and expertise of North West London Pathology.
- Setting up a dedicated HR guidance line, alongside a staff welfare and wellbeing programme.
- Restricting visiting to our hospitals and introducing social-distancing measures.
- Putting in place new staff, patient and public communications, including a daily all-staff email and the roll out of Microsoft Teams, allowing staff to work, engage and collaborate online.

We passed the peak of infections in London in mid-April and we are now stepping down much of our 'surge' intensive care capacity, though we will be maintaining additional capacity longer term as part of wider London plans. We have begun a programme of work to learn lessons from our response so far, including finding out what changes have generated benefits for patients and staff that we should build on. We are working through the implications for patient waiting times and experience and how we best resume planned care and other elements of our overall organisational work given on-going risks from coronavirus and the likelihood of further peaks in infections in the months ahead. We are also analysing some of the unintended consequences of COVID-19 on wider health and care, including a decline in patients attending our A&Es, stroke unit and heart attack centres for care unrelated to COVID-19. We

are supporting a national campaign to raise awareness that we remain open to provide safe care for anyone with urgent and emergency health needs.

2. Hotel Services direct employment

The transition of over 1,000 cleaning and catering staff and porters from employment by Sodexo to direct employment by the Trust on 1 April has gone smoothly. All staff now have NHS basic pay rates and sick leave and access to the NHS pension scheme. The move to directly employ Hotel Services staff follows a review last autumn which aimed to deliver significant improvements in the quality of the service and to make the Trust's cleaners, porters and catering staff feel properly valued as part of the wider team. The Trust will run Hotel Services on a direct management basis for a year in order to establish the long-term viability of the model. An evaluation will then be taken to decide whether to continue to employ Hotel Services staff directly, and bring all staff up to full NHS (Agenda for Change) terms and conditions, or retender the contract with a significantly amended specification.

3. Financial performance

For the financial year 2019/20 the Trust has ended the year £0.1m better than the control total, not including Provider Sustainability Funding (PSF) and allowed adjustments. The Trust has therefore received PSF in year of £16.8m with an additional £1.0m received related to 2018/19.

The Trust has spent £51.7m on capital against a CRL of £51.8m, which is an acceptable variance to the plan. The Trust ended the year with £44.9m of cash in the bank, an increase of £17m in the year and has met the External Financing Limit (EFL).

The Trust received central funding in March for additional costs incurred in relation to managing COVID-19 response. This excludes the estimated cost of £2.6m in relation to additional annual leave carried forward due to COVID-19. This has not been funded centrally for any organisation, and it has been agreed that this will not count towards the delivery of control total.

The draft unaudited version of the 2019/20 accounts were submitted on 27th April (as per agreed deadline), with the final audited position to be available on 16th July.

The finance report provides further detail of the Trust's financial position for the year.

The Trust had previously been working on a business planning process for 2020/21 with a draft submission made in March 2020. However this planning process was paused nationally in response to COVID-19, and the Trust is now subject to a new national financial regime until 31st October. As a result, the Trust has been moved to a block contract arrangement for the first seven months with an expectation that a 'top-up' payment will be received to achieve a break even position. Further COVID-19 related expenditure will continue to be picked up as part of the 'top-up' process. The Trust will need to continue to maintain financial control and demonstrate its decision making, linked to operationally critical expenditure during this time.

4. Operational performance

Operational performance will be covered in the Integrated Performance and Quality Report (IQPR). As anticipated, performance against a number of the responsiveness metrics has declined as a result of COVID-19. Field testing of the proposed new Urgent and Emergency Care standards continues.

5. Strategic development

Redevelopment

The Trust continues to work with Sellar during the exclusivity period to develop the proposals for the new St. Mary's hospital. A design team has been appointed that is working on the response to the Trust's outline brief. This has highlighted a number of expected issues which the design team and the Trust team are working through. Although the teams have been working remotely the use of technology has enabled good progress to be made during the last 8 weeks.

The Trust continues to advance the Business Case and has regular dialogue with colleagues at NHSI. We remain on-track to submit the Strategic Outline Case during the summer with the Outline Business Case programme for early 2021. We are also developing an engagement and involvement strategy that reflects new requirements around social distancing and avoiding contact. This will be kick started by a staff and stakeholder research project that has just been briefed to specialist agencies.

6. Research and innovation

Led by our NIHR Imperial Biomedical Research Centre and Academic Health Science Centre we continue to be very active in research directed towards the diagnosis and treatment of COVID-19 infection.

We are aiming for every patient with COVID-19 disease, who is admitted to our hospitals, to be offered the opportunity to be part of one of the research trials or studies that we are running at Imperial. These include both interventional trials, observational studies and a range of other research activities and to date there have been a total of over 2000 recruits. We have also commenced work at the Hammersmith Clinical Research Facility to support the Oxford Vaccine Centre's COVID-19 vaccine trial, which is being run by the Jenner Institute and Oxford Vaccine Group. It is a phase I/II single-blinded, randomised, multi-centre study to determine the efficacy, safety and immunogenicity of a candidate Coronavirus Disease (COVID-19) vaccine in UK healthy adult volunteers aged 18-55 years. An Imperial led clinical trial on a second vaccine, led by Prof Robin Shattock, is due to commence in June.

The Trust is also engaged in the rapid uptake of innovative approaches to care across many of our clinical teams and support services. These include digital innovations, diagnostic technologies, new ways of working, new partnerships – including with a wide range of groups across Imperial College, and different approaches to communicating with patients and families.

7. Stakeholder engagement

Our programme of contact meetings with key stakeholders has been suspended due to the COVID-19 response. Since the last Trust Board meeting, a summary of significant meetings and communications is below:

- Karen Buck MP and Andy Slaughter MP (via Microsoft Teams): 9 April (followed by regular email updates), and again on 11 May.

- On Friday 24 April we were pleased to welcome Sir Simon Stevens, NHS Chief Executive Officer, to Charing Cross Hospital. Sir Simon was interviewed by BBC News about the NHS campaign to encourage people to use the NHS if they need urgent or emergency care and reassure the public that it is safe to come to hospital or urgent care settings if they need to.

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Response to the Coronavirus pandemic and plans for reset and recovery	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 20th May 2020	**Item 8, report no. 05**
Responsible Executive Director: Tim Orchard, Chief executive officer	**Author:** Peter Jenkinson, Director of corporate governance Claire Hook, Director of operational performance
Summary: The purpose of this report is to outline the actions taken in response to the coronavirus pandemic and to set out next steps for planning reset and recovery.	
Recommendations: The Board is asked to note the report	
This report has been discussed at: N/A	
Quality impact: Quality impacts are outlined in the paper.	
Financial impact: Financial risks are outlined in the paper.	
Risk impact and Board Assurance Framework (BAF) reference: Ref. Corporate risk register.	
Workforce impact (including training and education implications): Workforce impacts are outlined in the paper.	
Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☒ No ☐ Not applicable If yes, are further actions required? ☐ Yes ☐ No The disproportionate impact of COVID on BAME has been recognised as part of the Trust response to the pandemic.	
What impact will this have on the wider health economy, patients and the public? Significant.	
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No	
Trust strategic goals supported by this paper: All ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do	
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No	

Response to the Coronavirus pandemic and plans for reset and recovery

1. Introduction

1.1. The purpose of this report is to outline the actions the Trust has taken in response to the coronavirus pandemic and to set out next steps for planning reset and recovery.

2. Background

2.1. Covid-19 is a high consequence infectious disease which has put the NHS under unprecedented pressure since the beginning of March 2020, presenting it with major safety, demand, capacity, staffing and financial challenges.

2.2. The NHS response has been managed as a level 4 major incident at national, regional and local level. An overall Trust "gold command" structure was established early in the pandemic, supported by site level management arrangements to ensure clear decision making and coordination in each hospital. Trust-wide issues have been overseen through work streams led by Executive Directors, who meet daily. The work streams are; People, Operations, Ward Processes and Equipment, Clinical Oversight Group and Communications and Governance.

2.3. We have maintained this structure, and will do so for the duration of this national emergency, to make sure we are able to continue to respond to the rapidly changing situation.

3. Emergency Response

3.1. Our initial response was supported by our pandemic influenza, major incident and other business continuity plans. We have also implemented, and at times anticipated, national guidance in our response to managing the crisis, and while many risks have been mitigated, others are still been managed while planning for the recovery phase.

3.2. Throughout the pandemic, the Trust has maintained its risk management systems and processes and has used that approach to identify and manage a number of risks and issues. We have developed a programme risk register to collate and track the management of those risks, both during the pandemic response and as we enter into our recovery and reset phase. Some of the key risks and the Trust response are identified below.

3.3. A particular concern has been the disproportionate impact of COVID-19 on black, Asian and minority ethnic communities (BAME), within the general population and the NHS workforce, and we have put in place additional measures to support and protect our BAME staff. We have developed a range of responses and support, including a dedicated BAME network live discussion on Microsoft Teams, additional BAME focus for PPE helpers and freedom to speak up guardians and adapted our staff risk assessment tool to include ethnicity as a risk factor.

3.4. Like all other NHS trusts, we quickly had to make temporary changes to the way our services are organised. For example, in order to create capacity for the increased level of demand, and to minimise the risk of contracting the virus for other patients, we reduced elective capacity to carrying out only those procedures that are time critical. The benefit of having a procedure done has been weighed against the risk of contracting the virus for all affected patients and a harm review process has been established to ensure that no patient is subject to unnecessary harm. Capacity in the independent sector and some other NHS providers has also been used to enable time critical treatment to proceed in some specialties according to an agreed criteria.

3.5. In preparation for managing the peak of the pandemic we were able to successfully increase critical care capacity from 68 to 143 beds and planned additional capacity to increase to up to 300 beds as needed. Almost 700 members of staff from all clinical and non-clinical groups were trained and redeployed to directly support our response.

3.6. Similarly, telephone and video-conference appointments have replaced outpatient appointments and visitor attendance has been restricted to exceptional circumsatnces, including for patients at the end of life, while further effort has been made to keep other patients in contact with their families with virtual media.

3.7. We recognise that the virus has also put at risk the wellbeing of our staff. Emotional wellbeing groups meet at dedicated spaces on the Trust main sites and individual counselling is also available to help staff deal with the challenges presented by the coronavirus. Other support initiatives have been established, including the provision of a range of.free hot food 24/7 on-site free 'shops', shopping collections/deliveries and 'welfare' boxes. We are very grateful to Imperial Health Charity and a range of generous donors and volunteers for making all of this possible.

3.8. Very sadly, to date, four members of staff have died during the pandemic. We have quickly established additional ways of supporting family and colleagues, including working with Imperial Health Charity to ensure financial support for funerals and other immediate needs, targeted counselling for teams and ways of remembering and paying tribute.

3.9. We have consistently followed national guidance for the use of personal protective equipment (PPE) and established the role of 'PPE helper" who operate at ward level and offer advice on the appropriate level of PPE to use as well as the process of donning and doffing. Problems with the availability of PPE has been a national issue and, although we have never run out, supplies of some types of equipment have become very low at times and we have had to use agreed alternatives.

3.10. We have established a growing patient and staffing testing programme, drawing on the expertise of North West London Pathology as well as colleagues at Imperial College.

4. Quality governance

4.1. To support staff dealing with these new ways of working and decision making, the Trust Medical Director chairs a daily meeting of key clinicians – the clinical reference group – to advise and oversee the development of clinical policy and practice in relation to the coronavirus response. The chair of our strategic lay forum also plays an active role in these meetings to help ensure full consideration of the needs of patients and the public.

4.2. This revised structure is intended to provide a strengthened decision-making and clinical governance structure, deliver improved support for ethical decision-making and maximise the pace of assimilation of a rapidly evolving evidence base into practice, in support of an effective organisational response to COVID-19.

4.3. Outcomes for patients are being closely monitored including mortality. The medical examiner service has been fully operational on all sites since the beginning of April and have been able to provide additional support to bereaved relatives during this difficult period.

4.4. Five new groups have been established reporting into the Clinical Reference Group (CRG) chaired by the Medical Director. These include a 24/7 clinical decision support group convened in response to consultant level requests for advice and support with clinical ethics input.

4.5. The clinical decision support group has now received over 40 referrals with support provided for difficult decisions being made across the Trust. Audit has commenced with good evidence of documentation of decisions. Ongoing evaluation of this function will continue through the CRG.

4.6. There have been no changes to the pre-existing governance structures in support of safety and effectiveness within the Medical Director's Office. The weekly Medical Director's incident review panel continues to review all moderate and above harm incident as part of the serious incident framework.

4.7. A revised plan for clinical audit, including the meetings of the Clinical Audit and Effectiveness Group (CAEG) has been agreed. Although the Trust priority audit plan has been suspended, a number of audits are being conducted in response to COVID-19 including documentation of decision making when patients have had their treatment and/or appointments cancelled or rescheduled. The outcomes will be reported to Quality Committee.

4.8. The Medical Examiner, Death Certification and Registration Group have overseen the expansion of the service to provide a seven-day service in response to the increasing number of deaths. This service has been invaluable in supporting bereaved relatives.

4.9. The overall number of deaths reported at the Trust has risen since we reported our first COVID related death in March 2020. This has been reviewed and the only trend is the increase in COVID deaths. Dr Foster are supporting us with this review. We are continually analysing our mortality and benchmarking this against appropriate data sets. Detailed analysis has been presented to the Board Quality Committee.

4.10. Incident reporting numbers have reduced in line with activity. Trends are being monitored with a dedicated COVID dashboard now being presented to the executive committee. There are no specific incident trends for escalation to the board.

Communications and engagement

4.11. We repurposed our intranet to be a central resource for information and guidance for all staff on Covid-19, available to all staff on any mobile device and established a daily bulletin (now three times a week). We have used Microsoft Teams to run regular all-staff briefings and Q&As, drawing almost 1,000 staff to some of the live sessions with many more watching the video recording published afterwards on the intranet. We have created a new inpatient information resource to explain changes in response to Covid-19 and new ways of keeping, including through tablet devices distributed to all wards and benefitting from free premium wi-fi funded by Imperial Health Charity). We have featured in a wide range of media coverage, helping to raise awareness and understanding of Covid-19 and the NHS's response, including the fantastic commitment and expertise of our staff.

5. Corporate governance arrangements

5.1 At its meeting in March, the Board agreed to implement temporary changes in governance arrangements to assist in the Trust response to the pandemic.

5.2 As part of the Gold command response to the pandemic and in line with these principles, the Executive implemented changes (with effect from 12 March 2020) to the executive level governance arrangements, including:

- Daily COVID-19 Executive meeting, with delegated decision-making authority as per existing executive committees.

- Gold Command supported by workstreams including:
  - People
  - Operations (including finance and reporting / monitoring)
  - Clinical reference group (including guidelines, incident reporting and clinical decision making)
  - Communications & governance
  - ICT (in support of above workstreams)
- A daily operations call supporting the operational implementation of decisions made at the executive meeting.
- Existing executive committees and meetings (ERAF and ETM) continue but on a revised timetable, with shortened meetings and agendas, and with reduced attendance – to report by exception and to cover essential business only.

5.3 The model for Board level governance was agreed in line with NHSI guidance, including:

- holding Board meetings, with public excluded and run virtually, with an agenda focused on statutory / mandatory / decision items is an appropriate model.
- recording the public part and publishing the recording (using Microsoft Teams)
- excluding the public, for safety reasons, but inviting any written questions to be submitted prior to the meeting and responding to them in the meeting.
- Board committees have been held in March and May, but with reduced agendas and held virtually. An additional Quality Committee meeting was held in April, focused on the Trust response to the pandemic, with all Board members invited.
- Board seminars have been suspended.
- Weekly written updates have been circulated to non-executive directors by the CEO as part of the weekly NEDs briefing, and in addition there has been weekly calls with the NEDs and the Director of Corporate Governance.
- All Board member visits have been suspended.

5.4 These arrangements will remain in place while the pandemic remains as a level 4 major incident at national, regional and local level. Once the level reduces, these governance arrangements will be reviewed with a view to implementing a 'new norm', in line with the principles of 'recovery and reset' as below.

6. Planning for recovery and reset

6.1. Although we continue to care for a significant number of patients who have tested positive for coronavirus, indications suggest we have now passed the initial peak in cases. As the number of cases reduces, we are now turning our attention to organisational and system recovery.

6.2. The Incident Recovery Group first met on 16th April to begin shaping the Trust approach to recovery, which is likely to take place over several phases. Whilst we will initially focus on configuring our sites and services to facilitate the safe restart of some elective activity, increased non-COVID care and safe working for our staff, we will also actively engage in work across North-West London to maximise opportunities to embed and expand new ways of working. We will reflect on how the NHS achieved the best elements of its response and consider what changes should be kept, recognising that services have been transformed in a short period of time and that the whole NHS has worked across boundaries in ways, and at a speed, many thought impossible.

6.3. Actions to date include:

- Collating feedback from across the organisation on our learning from the pandemic response to date

- Actions taken as part of an initial 'restoration' phase to ensure we are able to quickly adapt our sites and services to best meet the changing needs of our local population
- The development of a longer term 'recovery & reset programme' to allow us to embed and build on positive changes made over the last ten weeks as part of a shift to a 'new normal'

Learning from our response to date

6.4 As part of the initial recovery work, all of our teams across the organisation were invited to complete a short survey to gain insight into what worked well in the Trust response, what lessons we can learn, and what changes we should keep in moving to a 'new normal' way of working and provision of health care. We received 55 responses to the survey from across the organisation, which were grouped into 4 themes – Supporting our Staff, Delivering Patient Care, Improving Clinical Pathways and Improving Ways of Working. This rich and detailed response, including c. 35,000 words, was analysed and a summary of the key findings is below:

- Overwhelming recognition of the extraordinary efforts of staff across the organisation and the resilience, determination and creativity with which teams worked together under unprecedented and challenging circumstances.
- Rapid improvements made to clinical pathways through collaboration across the organisation and system – for example a move from a predominantly face to face to a predominantly virtual model for Outpatients within 48 hours.
- A significant increase in use of digital technologies, especially MS Teams, where we are now one of the largest user of MS Teams anywhere in the NHS.
- Huge appreciation for the organisation-wide focus on staff wellbeing, from practical help with food and groceries to holistic support via Contact and the newly established 'wobble rooms'
- Challenges with the practicalities of staff redeployment to support the increase in critical care capacity
- Challenges with maintaining appropriate supply and keeping all of our staff up to date with guidance on PPE.
- Positive feedback on the role of a newly established 'Clinical Reference Group' and its ability to make quick, evidence-based decisions on new clinical guidelines.

6.5 These findings will help inform the plans for each of the recovery workstreams, along with the output from a range of interviews conducted by the Director of Transformation and input from Board members and other input from the non-executive directors.

6.6 The approach to the Recovery Programme will operate over a number of phases, specifically:

- **Restoration** – c. 4-6 weeks – immediate operational priorities, enhanced support for staff, development of recovery strategy.
- **Phase 1 (transition)** – c. 12 months – reinstating elective activity focusing on patients with greatest clinical need, embed and expand pathway changes that minimise risk to staff and patients, ongoing support to staff and continued readiness for further waves of the Covid-19 pandemic via agreed Covid-19 response teams.
- **Phase 2 (new normal)** – 1st April 2021+ (tbc) –incorporating full breadth of agreed pathway changes.

'Restoration' phase

6.7 The restoration phase is being overseen by the Director of Operational Performance (Claire Hook) under the Gold Command arrangements and is focused on:

- Stepping down escalated capacity whilst remaining alert and ready to step up again if demand escalates
- Coordination of re/de-deployment
- Designing red and green pathways for elective and non-elective care
- Configuring our buildings and practices to minimise risk, including enabling social distancing wherever possible.

Recovery & reset programme

6.8 The Recovery and Reset has been developed in the context of the organisational strategy and an agreed set of objectives, projects & programmes, as agreed at the February board meeting. This was officially put on hold during the first phase of our pandemic response, but some elements were fast tracked, e.g. moving Outpatients to virtual working, Imperial Management & Improvement System (IMIS), and CJCC (front door flow). We have taken the time to reflect on our learning from the last 8 weeks and now need to refine the agreed projects and programmes planned for this financial year.

6.9 The draft programme architecture is shown in Appendix A. The programme is designed to ensure we:

- Reflect the overall Trust strategic priorities agreed at the February board
- Build on the learning from the initial phase of our response to the Covid-19 pandemic
- Are able to quickly respond to changes in our external environment, including the need to be fully engaged and involved in driving forward the Integrated Care System in north west London

6.10 The programme will be led by the Director of Corporate Governance as SRO, overseen by the Executive Team and supported by the Transformation team, who will coordinate delivery of the objectives agreed in each of the workstreams. There are a number of key interdependencies with other Trust programmes, including Redevelopment and the Safe & Sustainable staffing programme. This will require close working across the Trust Executive and clear lines of accountability for the agreed workstreams and projects.

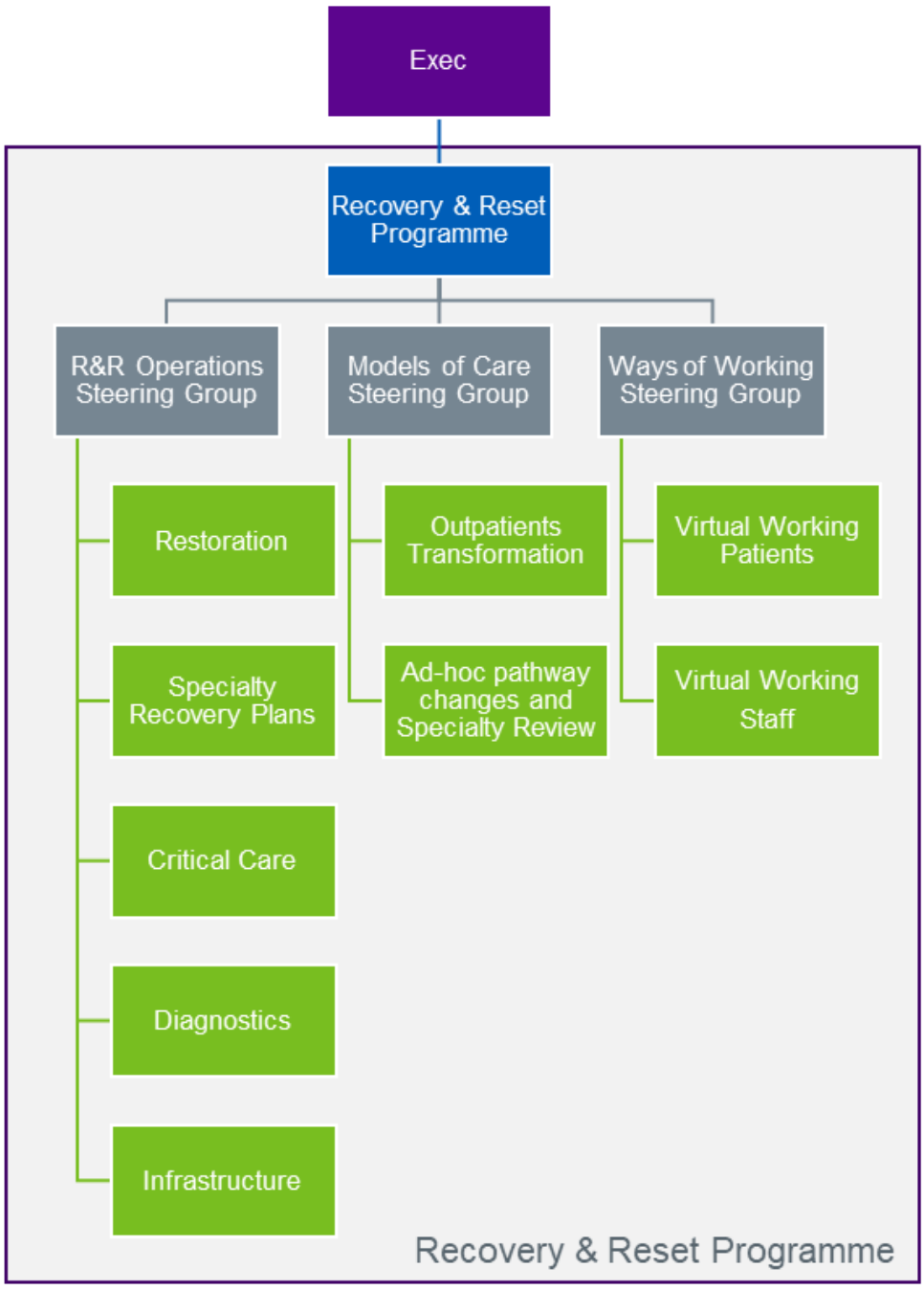
6.11 The Programme was discussed with the Strategic Lay Forum on the 13th May with a specific focus on ensuring we incorporate and build on insights from research being done through Imperial College and Healthwatch to understand the impact of the Covid-19 pandemic on communities across north west London. The draft programme was also discussed with the non-executive directors on 14th May.

6.12 Next steps will be for the Trust's Imperial Way project board to consider the draft structure and the existing programmes, taking into account the comments received and the lessons learned from the pandemic response to date, to agree a recommendation on a revised set of priorities for the Trust including recovery and reset.

7. Recommendation

7.1. The Board is asked to note the report.

Appendix A – Draft Programme Architecture / Trust priorities – Recovery & Reset Programme



Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Finance Report - March 2020	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 20th May 2020	**Item 9.2, report no. 06**
Responsible Executive Director: Jazz Thind, Chief Finance Officer	**Author:** Michelle Openibo – Associate Director Business Partnering Des Irving Brown Deputy Chief Finance Officer

Summary:

The finances in this report reflect the unaudited management accounts of the organisation. The draft unaudited version of the 2019/20 accounts were submitted on the 27th April (as per agreed deadline), with the final audited position to be available on 16th July.

At month 12:-

- The Trust has ended the year £0.1m better than the control total, before PSF and allowed adjustments.
- The Trust has received central funding to reflect additional revenue costs and loss of income relating to the Covid-19 response this year. This excludes the estimated cost of £2.6m in relation to additional annual leave carried forward due to COVID. This has not been funded centrally for any organisation, and it has been agreed that this will not count towards the delivery of control total.
- The Trust has spent £51.7m on capital against a CRL of £51.8m, which is an acceptable variance to the plan.
- The Trust ended the year with £44.9m of cash in the bank, ahead of plan.
- The Trust has met the External Financing Limit (EFL)

	Plan £m	Actuals £m	Variance £m
Year-end position including MRET	**(15.7)**	**(30.0)**	**(14.3)**
Non recurrent mitigations (as per forecast)	10.0	24.4	14.4
NHSI reported position before PSF and annual leave provision	**(5.7)**	**(5.6)**	**0.1**
Annual leave provision		(2.6)	(2.6)
PSF	16.8	17.8	1.0
Reported Surplus after PSF and MRET (CT)	**11.1**	**9.6**	**(1.5)**

2020/21 planning:

- There has been a commitment to Trusts that a breakeven position will be maintained using block and top-up arrangements. This originally covered the four month period to 31st July 2020 but has now extended to 31st October 2020. The detailed guidance is due to published before the end of May to cover this pre winter period, with further guidance expected to cover winter and the rest of the year to 31 March 2021. The new arrangements remain subject to regular review with providers being expected to maintain good financial management and retain a grip on the cost base.
- STPs have been notified of the Capital limits and local systems are expected to manage within this envelop. Where plans fall within specific categories such as HIP 1 and 2 and NHSx, these are excluded from the sector capital limit calculation.
- All Covid related capex will require NHSE/I approval prior to commencement.

Recommendations:

The Trust Board is asked to:

- Note the achievement of the control total and CRL for 2019/20
- Note the revised planning arrangements for 20/21

This report has been discussed at:

Finance, Investment and Operations Committee

Quality impact:

This paper relates the CQC domain well-led.

Financial impact:

The financial impact of this proposal as presented in the paper enclosed has no financial impact

Risk impact and Board Assurance Framework (BAF) reference:

This report relates to risk ID:2473 on the trust risk register - Failure to maintain financial

Workforce impact (including training and education implications): N/A

Has an Equality Impact Assessment been carried out or have protected groups been considered?

☐ Yes ☐ No ☒ Not applicable

If yes, are further actions required? ☐ Yes ☐ No

How have patients, the public and/or the community been involved in this project and what changes were made as a result? N/A

What impact will this have on the wider health economy, patients and the public? N/A

The report content respects the rights, values and commitments within the NHS Constitution

☒ Yes ☐ No

Trust strategic goals supported by this paper:

- To develop a sustainable portfolio of outstanding services

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):

Is there a reason the key details of this paper cannot be shared more widely with senior managers?

☐ Yes ☒ No

If yes, why?.....

If the details can be shared, please provide the following in one to two line bullet points:

- At month 12 the Trust has met the control total before adjustments

- The Trust has received additional funding from the centre to offset the additional costs of Covid in year.
- The Trust has spent £51.7m on capital against a CRL of £51.8m, which is an acceptable variance to the plan.
- The Trust ended the year with £44.9m of cash in the bank, an increase of £17m in the year

- Should senior managers share this information with their own teams? ☒ Yes ☐ No
  If yes, why? To support the Trust meeting its financial targets

Imperial College Healthcare NHS Trust

Finance Report – 12 months ended 31st March 2020

1. Introduction

This report provides a brief summary of the Trust's financial results for the 12 months ended 31st March 2020

2. Financial Performance

- The Trust has met the control total of £5.7m deficit before Provider Sustainability Funding (PSF) and allowed adjustments.
- The Trust has met the capital resource limit (CRL), having spent £51.7m on capital against a CRL of £51.8m, which is an acceptable variance to the plan.
- The Trust ended the year with £44.9m of cash in the bank, an increase of £17m in the year. The Trust has met the External Financing Limit (EFL).
- This excludes the estimated cost of £2.6m in relation to additional annual leave carried forward due to COVID. This has not been funded centrally for any organisation, and it has been agreed that this will not count towards the delivery of control total..
- During the year the Trust received additional income associated with over performance in activity, mainly in relation to emergency work, which was offset by the additional costs of delivery
- The Trust has required £24m of non-recurrent benefits to meet the control total giving an underlying position of £30m deficit

	In Month			Full Year		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	101.1	106.6	5.4	1,160.5	1,195.4	34.9
Pay	(54.7)	(61.1)	(6.4)	(649.8)	(671.6)	(21.8)
Non Pay	(42.0)	(49.0)	(6.9)	(483.9)	(503.3)	(19.4)
Internal Recharges	(0.0)	0.0	0.0	(0.0)	0.0	0.0
Reserves	1.7	11.9	10.2	3.8	13.1	9.3
MRET Income	0.9	0.9	0.0	10.2	10.2	0.0
EBITDA	**7.0**	**9.3**	**2.3**	**40.9**	**43.9**	**3.0**
Financing Costs	(3.4)	(2.2)	1.3	(43.0)	(44.7)	(1.6)
SURPLUS / (DEFICIT) inc. donated asset treatment	**3.6**	**7.1**	**3.6**	**(2.2)**	**(0.8)**	**1.4**
Donated Asset Treatment	(0.5)	(1.3)	(0.9)	(3.6)	(2.2)	1.3
Impairment of Assets	0.0	(2.6)	(2.6)	0.0	(2.6)	(2.6)
CONTROL TOTAL	**3.1**	**3.2**	**0.1**	**(5.7)**	**(5.6)**	**0.1**
PSF Income	2.0	2.0	0.0	16.8	17.8	1.0
Annual leave provision		(2.6)	(2.6)		(2.6)	(2.6)
SURPLUS / (DEFICIT) after PSF/MRET Income	**5.0**	**2.6**	**(2.4)**	**11.1**	**9.6**	**(1.5)**

2.1 Provider Sustainability Funding

The Trust achieved 100% of 2019/20 PSF which stands at £16.8m. The Trust has also received an additional £0.97m of PSF relating to 2018/19 which does not contribute to meeting the control total.

2.2 NHS Activity and Income

The Trust ended the year above plan on income for both local and specialist commissioners, mainly due to emergency activity. The Trust reduced elective activity in March in response to Covid-19 requirements, however this loss of income was recovered through Covid funding from the Centre.

2.3 Private Patient Income

Private patient activity was also reduced during March to allow the Trust to use this capacity to respond to Covid, with any loss of income was similarly covered through Covid central funding. The Trust expects that income generation from this source will remain low in 2020/21 and the service is working to understand the effect on the financial position and the impact on recovery planning.

2.4 Clinical Divisions

The financial position by clinical division is set out in the table below. The divisional NHS clinical income position was maintained at the month 11 forecast outturn with any loss accounted for at Trust level.

		In Month			Full Year		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Medicine and Integrated Care	Income	26.4	27.4	1.1	306.5	319.5	13.0
	Expenditure	(18.1)	(20.1)	(1.9)	(222.0)	(240.8)	(18.8)
	Internal Recharges	(1.1)	(1.2)	(0.1)	(12.6)	(12.5)	0.2
	Total	7.2	6.2	(1.0)	71.9	66.2	(5.7)
Surgery, Cancer and Cardiovascular	Income	32.1	31.5	(0.6)	369.4	360.6	(8.8)
	Expenditure	(25.6)	(25.5)	0.2	(308.1)	(307.9)	0.2
	Internal Recharges	1.5	1.4	(0.1)	17.8	18.4	0.6
	Total	8.0	7.4	(0.5)	79.1	71.2	(7.9)
Women, Children & Clinical Support	Income	14.6	14.9	0.3	164.7	165.1	0.4
	Expenditure	(13.8)	(13.2)	0.6	(165.6)	(166.6)	(1.0)
	Internal Recharges	2.0	1.8	(0.2)	23.3	22.6	(0.7)
	Total	2.8	3.5	0.7	22.5	21.1	(1.4)
Imperial Private Healthcare	Income & Expenditure	2.5	1.9	(0.6)	27.9	27.5	(0.5)
	Internal Recharges	(2.5)	(2.0)	0.4	(28.5)	(28.6)	(0.1)
	Total	(0.0)	(0.1)	(0.1)	(0.6)	(1.2)	(0.6)
Total Clinical Division		**17.9**	**17.0**	**(1.0)**	**172.9**	**157.3**	**(15.6)**

MIC was £5.7m behind plan year to date mainly due to unmet efficiencies. There was significant emergency income over performance within the division with additional costs to deliver the activity, especially in nursing.

SCC was £7.9m behind plan. The division underperformed on its elective plan driving the majority of the adverse variance in year.

WCCS was £1.4m behind plan year to date. The key driver of the position is under delivery of efficiency plans of £2.0m.

Imperial Private Health (IPH) is £0.6m adverse to plan, overall income is marginally ahead of plan, though lower than had been forecast due to Covid-19 preparations.

3. Efficiency programme

The Trust set a Cost Improvement Plan (CIP) of £57m for the year against which it achieved £43m. Due to the changes operationally from Covid-19, this position was based on the month 11 forecast and is in line with achievement in previous years.

4. Cash

Cash balances at the end March was £44.9m an increase of £17m since the start of the year, due largely to the receipt of PSF payments from NHSI (including payments for 2018/19).

5. Capital

The Trust spent £51.7m against a CRL of £51.8. The spend in year includes £0.4m of costs relating to Covid-19. The overall capital impact of Covid-19 is expected to be significantly higher than the spend incurred in Month 12, but will fall in the 2020-21 financial year based on when equipment was received.

6. 20/21 Financial Regime

6.1 Capital Costs

The national team has allocated a capital budget to each STP and has asked that all systems manage requirements within their respective limit. Where there is a gap between the draft capital plan submissions (March 2020) and the notified allocation, two things need to happen - a reconciliation process to ensure that only investment which scores against the allocation is included, as there are other national funding streams to deal with specific projects for example HIP 1&2 and NHSX. Any residual shortfall post this work is deemed to be subject to a local sector level prioritisation process. The guidance also refers to the concept of “mutual aid” both within and outside of the sector, however this will require careful thought and alongside the reconciliation process. Furthermore all Covid-19 capex will in future need to be approved by NHSE/I prior to commencement (previously >£250k).

6.2 Revenue Costs

2020/21 planning was paused during March 2020 and NHSE/I issued new guidance relating to the financial regime covering the first four months to 31st July 2020, this has now been extended to 31st October 20 (pre winter), with the period of 1st November 20 to 31st March 21 to be defined as "winter and beyond", with detailed guidance due out by the end of May in relation to the pre-winter phase. The initial block contract value (run rate spend from M8, 9 & 10 of 2019/20 plus inflationary uplifts) plus additional 'top up' (to cover loss of certain income streams) and no efficiencies are expected to help trusts breakeven over this period with recourse to additional 'true-up' payments (expected to relate primarily to Covid-19) should the initial payments prove to be insufficient to cover cost base. The Trust will have a clearer view on whether this will be required once month 1 has been finalised. NHSE/I will continue to review block and top up arrangements and provide regular opportunities for providers to raise any concerns around shortfalls, however, whilst there's a commitment to ensure breakeven positions are achieved, this will only be done where it can be demonstrated that the gap and any related drivers are clearly understood, and that organisations are continuing to maintain good financial management and do not expand the cost base beyond that required to deliver critical activities. Financial sustainability remains a concerns and the need to deliver efficiencies remains front and centre with productivity levels being a key mechanism in meeting this challenge.

7. Conclusion

The Trust met its control total, CRL and EFL for 2019/20, however there was significant non recurrent mitigations required to meet this position. The financial regime for 2020/21 has been changed in response to the requirements on the NHS for Covid-19, with the Trust expecting to receive funding to enable it to break even.

8. Recommendation

The Trust Board is asked to note the report.

NHS
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NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Month 12 integrated quality and performance report	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 20th May 2020	**Item 10, report no. 07**
Responsible Executive Director: Julian Redhead (Medical Director) Janice Sigsworth (Director of Nursing) Catherine Urch (Divisional Director) Tg Teoh (Divisional Director) Frances Bowen (Divisional Director) Kevin Croft (Director of People and Organisational Development) Claire Hook (Director of Operational Performance)	**Author:** Submitted by Performance Support Team

Summary:
See enclosed integrated quality and performance report with key headlines relating to data published at month 12 (March 2020). Performance data is presented in the form of two scorecards, the standard IQPR and in the proposed new IMIS format.

Contents:
1. Performance summary
2. M12 scorecard: Proposed new IMIS version
3. M12 scorecard: Standard 2019/20 IQPR version

Recommendations:
The Board are asked to consider the integrated quality and performance report for month 12.

The March 2020 performance has been discussed at:

Executive Operational Performance Committee
Executive Quality Committee
Board Quality Committee

If this is a business case for investment, has it been reviewed by the Decision Support Panel (DSP)? ☐ Yes ☐ No ☒ Not applicable

Quality impact:
The delivery of integrated quality and performance reporting and scorecards will support the Trust to more effectively monitor delivery against internal and external targets and assess progress towards Trust agreed objectives. All CQC domains are impacted by the paper.

Financial impact:
The financial impact of this proposal as presented in the paper enclosed:

Has no financial impact.

Risk impact and Board Assurance Framework (BAF) reference:

- 2472: Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards
- 2477: Risk to patient experience and quality of care in the ED caused by the significant delays experienced by patients presenting with mental health issues
- 2480: Patient safety risk due to inconsistent provision of cleaning services across the Trust
- 2485: Failure of estates critical equipment and facilities
- 2487: Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae)
- 2942: Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines
- 2937: Failure to consistently achieve timely elective (RTT) care
- 2938: Risk of delayed diagnosis and treatment and failure to maintain key diagnostic operational performance standards
- 2943: Failure to maintain non elective flow
- 2944: Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas
- 2946: Failure to provide timely access to critical care services
- 1660: Risk of poor waiting list data quality

Workforce impact (including training and education implications):
None

Has an Equality Impact Assessment been carried out or have protected groups been considered?
☐ Yes ☐ No ☒ Not applicable

If yes, are further actions required? ☐ Yes ☐ No

What impact will this have on the wider health economy, patients and the public?
Comprehensive performance and quality reporting is essential to ensure standards are met which benefits patients. The report is aligned with CQC domains to ensure the Trust has visibility of its compliance with NHS wide standards.

The report content respects the rights, values and commitments within the NHS Constitution
☒ Yes ☐ No

Trust strategic goals supported by this paper:
Retain as appropriate:

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

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers?
☐ Yes ☒ No
If yes, why?.....

Imperial College Healthcare NHS Trust

Integrated quality and performance report

1. Introduction

1.1. The Board are asked to consider the integrated quality and performance report for month 12. Performance data is presented in the form of two scorecards, the standard IQPR and in the proposed new IMIS format.

2. IMIS scorecard

2.1. At the last meeting of the Trust Board on 25th March 2020 the Board received an update on the implementation plan for the Imperial Management and Improvement System (IMIS) and agreed that performance data for March 2020 would be presented in both the existing IQPR format and in the proposed new IMIS format. In addition, the Board discussed the benefits of providing a reduced performance scorecard as part of the overall efforts to reduce reporting burden during the response to the Covid-19 pandemic.

2.2. We have therefore progressed with the new proposed IMIS format, albeit in a reduced format. The scorecard will be further developed during 2020/21 to include monitoring of the Trust-level focussed improvements and metrics associated with the delivery of priority programmes and projects.

2.3. Once fully implemented, the reporting process will also include 'business rules' against each metric to indicate the type of update required, dependent upon recent performance. This may include sharing success, providing a structured verbal update or presenting a full written countermeasure summary with analysis and improvement actions. Because of the impact of Covid-19 on performance as a whole we are not yet utilising this approach and countermeasure summaries are not provided at present. The performance summary below provides a narrative on the points of note.

3. Performance summary at month 12

3.1. As anticipated, performance against a number of the access standards has been negatively impacted as a result of Covid-19.

3.2. The reporting of Referral to Treatment (RTT) performance data has continued nationally in order to maintain continuity and support recovery of the waiting list position. In March 2020, the overall size of the Trust RTT waiting list reduced by 6%. This reduction was driven by multiple factors linked to our Covid-19 response, including a reduction in referrals, optimised use of advice and guidance to GPs and operational delays with checking patients in and out. In March 2020, ten patients were waiting for more than 52 weeks for treatment and we expect long waiter breaches will increase in the immediate term.

3.3. The size of the cancer waiting list has reduced by approximately 37% and the number of cancer two week wait referrals has reduced by 78% compared with the position at the end of February 2020. Similar reductions in demand have been seen at all of the Trusts in the RMP Alliance.

3.4. The diagnostics waiting times performance reduced to 8% of patients waiting for their diagnostic test. There was also a reduction in referrals and a number of imaging cases being put on hold. Those on hold will reactivate with the original and correct start date as per the clinical review process timeframe.

3.5. The Trust is reviewing all waiting list information to ensure that during the recent extraordinary changes to elective care management, there is consistency in RTT recording and reporting, where patients have had their appointment cancelled or delayed. This is being supported by a Covid-19 waiting list data quality framework. The processes to manage potential risk to patient care are set out and are monitored through Trust clinical policy in relation to our coronavirus response.

3.6. The Trust is also collating and reviewing all elective waiting lists with general managers to understand service level demand. This information is being reviewed as part of a sector-wide approach to recovery. Although continuing to improve elective performance will remain important, booking will be done according to latest assessment of risk and clinical priority and not necessarily in order of length of wait.

3.7. The number of patients waiting for over 12 hours in our emergency departments from the decision to admit to admission increased significantly in March 2020. 122 of the 135 breaches occurred at SMH and were related to the need to isolate patients on admission.

3.8. One of the new metrics within the enclosed IMIS scorecard is bed occupancy. There are a number of ways occupancy can be presented and we are reviewing the best approach for monthly scorecard reporting. The average bed occupancy as taken from our submission to the NHS England daily situation report report was 82% for March 2020 and 73% for April 2020. This level of occupancy reflects a reduction in elective activity and in non-elective activity that was not Covid-19 related. We are also preparing a new metric relating to the transition of hotel services and aim is to report this in the scorecard from next month onwards.

3.9. Incident reporting rates are not provided for March 2020. This is because our incident reporting rate is based on a ratio of incidents to occupied bed days. Given changes in our bed base because of Covid-19 the March incident reporting rate will be erroneously affected. We will update the report next month once revised bed day data is available. Our crude number of incidents reported has reduced this month, 1340 in March 2020 compared to 1579 in February 2020. We have analysed this reduction and it is linked to a reduction in activity across a number of our specialties. We have added in additional corporate support to encourage and support staff to report incidents.

3.10. Our harm profile remains good and the proportion of moderate and above incidents this year is now below the target threshold. A number of incidents have been downgraded following full investigation and the final figure is likely to reduce further after all outstanding investigations are complete.

3.11. NHS Digital has suspended the collection of Family Test (FFT) performance data and therefore figures are not included for March 2020.

4. Recommendation

4.1. The Board is asked to note the contents of the performance scorecard for month 12.

Imperial College Healthcare NHS Trust

IMIS performance scorecard - Trust Board

March 2020

	MetricID	Data reliability	Metric	Target	YTD Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Business rules	SPC variation
Patient experience	IMIS 001		FFT response rate (Inpatients)	>=15%		31.0%	32.2%	32.2%	32.7%	31.7%	34.4%	32.9%	31.2%	30.3%	26.0%	31.9%	-		-
	IMIS 002		FFT response rate (A&E)	>=15%		19.5%	14.9%	17.1%	14.6%	17.3%	16.1%	20.0%	18.6%	18.8%	14.1%	13.3%	-		-
	IMIS 003		FFT response rate (Outpatients)	>=15%		19.3%	17.7%	18.5%	17.9%	17.2%	18.1%	18.5%	18.8%	19.0%	19.1%	21.4%	-		-
	IMIS 004		FFT response rate (Maternity)	>=15%		30.1%	41.9%	29.6%	38.0%	35.1%	40.4%	34.7%	37.2%	42.3%	47.5%	45.4%	-		-
	IMIS 005		FFT % recommended (Inpatients)	>=94%		97.2%	97.1%	97.2%	97.2%	97.3%	97.3%	96.9%	97.8%	96.9%	96.9%	98.0%	-		-
	IMIS 006		FFT % recommended (A&E)	>=94%		93.3%	92.8%	93.1%	92.5%	93.5%	94.4%	94.4%	92.3%	92.2%	93.0%	91.5%	-		-
	IMIS 007		FFT % recommended (Outpatients)	>=94%		94.2%	94.1%	94.1%	94.5%	94.0%	93.9%	94.1%	94.1%	95.2%	94.6%	95.1%	-		-
	IMIS 008		FFT % recommended (Maternity)	>=94%		91.2%	94.0%	94.7%	92.5%	93.4%	95.2%	94.7%	91.4%	90.2%	92.7%	92.4%	-		-
	IMIS 009		Formal complaints	<100		88	104	96	136	87	98	100	83	87	80	80	**67**		-
Quality	IMIS 010		Patient safety incident reporting rate	>=50.38		43.38	48.46	56.43	57.10	47.73	51.04	54.26	54.19	47.31	53.91	50.28	-		-
	IMIS 011		Trust-attributed MRSA BSI	0		0	2	1	0	0	0	0	0	0	0	0	**0**		-
	IMIS 012		Trust-attributed C. difficile	8		5	9	11	12	10	6	10	7	10	12	3	**6**		-
	IMIS 013		E. coli BSI	3		8	6	5	8	3	5	10	9	7	6	3	**3**		-
	IMIS 014		CPE BSI	0		0	0	2	1	3	0	0	0	0	1	1	**0**		-
	IMIS 015		% of incidents causing moderate and above harm	<1.68%		1.56%	1.26%	1.02%	1.04%	1.04%	1.88%	1.82%	1.59%	1.62%	1.65%	0.95%	**0.97%**		-
	IMIS 016		HSMR (rolling 12 months)	<100		63	63	62	63	63	68	66	68	68	67	66	**67**		-
People	IMIS 017		Vacancy rate	<10%		11.4%	11.7%	11.7%	12.0%	11.7%	11.1%	10.3%	9.7%	10.0%	9.7%	9.1%	**8.9%**		-
	IMIS 018		Core skills training	>=90%		91.9%	91.8%	91.9%	92.5%	93.5%	93.8%	93.8%	94.3%	94.3%	93.4%	93.2%	**92.7%**		-
	IMIS 020		Staff Sickness (rolling 12 month)	<=3%		3.15%	3.17%	3.19%	3.20%	3.18%	3.18%	3.24%	3.26%	3.29%	3.29%	3.29%	3.70%		-
	IMIS 021		Staff turnover (rolling 12 months)	<12%		11.3%	11.6%	11.3%	11.8%	11.7%	11.8%	11.8%	11.8%	11.8%	12.0%	11.7%	12.1%		-

	MetricID	Data reliability	Metric	Target	YTD Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Business rules	SPC variation
Access	IMIS 022	6%	RTT waiting list size	63,099		62,546	63,097	63,088	63,098	62,918	62,664	60,992	63,036	62,608	62,583	62,932	**59,324**		SC
	IMIS 023		Diagnostics waiting times	1.0%		1.00%	0.90%	0.75%	0.90%	1.00%	0.50%	0.69%	1.15%	1.67%	0.79%	0.51%	**8.50%**		SC
	IMIS 024		Wait to first OP appointment (routine)	tbc		-	-	-	-	-	-	-	-	-	-	-	-		-
	IMIS 025	5%	Cancer 2 week wait	>=93%		92.4%	92.5%	91.0%	85.8%	82.9%	84.5%	89.1%	91.7%	89.6%	86.2%	93.5%	**89.1%**		CC
	IMIS 026		Cancer 62 day wait	>=85%		88.2%	91.5%	86.7%	87.3%	86.9%	86.3%	83.7%	87.4%	89.1%	80.8%	78.4%	**86.1%**		CC
	IMIS 027		Cancer 28 day faster diagnosis	tbc		-	-	-	-	-	-	-	-	-	-	-	-		-
	IMIS 028		Ambulance handover delays	100%		89.0%	89.0%	90.0%	90.6%	90.6%	91.4%	92.7%	92.7%	89.3%	89.5%	88.3%	**84.4%**		CC
	IMIS 029	1%	No. patients waiting >12 hours in ED	0		12	7	22	17	8	7	8	5	11	16	21	**135**		SC
	IMIS 030	3%	Long length of stay	tbc		236	235	234	218	212	212	208	206	233	224	229	**205**		SC
	IMIS 031		Bed occupancy	tbc		-	-	-	-	-	-	-	-	-	-	-	-		-
Finance	IMIS 032		YTD position £m			-0.59	0.05	0.97	0.97	1.09	1.03	4.80	3.19	1.01	1.01	0.97	**-1.47**		-
	IMIS 033		Forecast variance to plan			-	-	-12.58	-18.11	-11.34	-9.14	-5.02	-6.51	-3.52	-2.62	-3.43	-		-
	IMIS 034		CIP variance to plan			74.5%	66.5%	65.7%	64.6%	66.0%	74.1%	73.5%	74.8%	75.0%	74.4%	75.7%	**75.7%**		-
	IMIS 035		Agency staffing			3.5%	3.4%	3.1%	3.2%	3.1%	2.9%	2.8%	2.8%	2.7%	2.6%	2.5%	**2.5%**		-

COVID-19	Number of confirmed Covid-19 inpatients (snapshot)	159	At 11/05/2020	Source: Cerner - command centre
	Number of confirmed Covid-19 patients being ventilated (snapshot)	43	At 11/05/2020	Source: Site team
	Total cumulative number of inpatients with confirmed Covid-19 who have died (confirmed Covid-19 cause of death)	402	At 11/05/2020	Source: Medical Directors Office / Datix
	Total cumulative number of inpatients with confirmed Covid-19 who have been discharged (excl. deaths)	803	At 11/05/2020	Source: Cerner

Notes

1. The national data submission process for FFT is currently paused and figures are not provided at present.

2. Data feeds for three metrics are in design: (i) Waiting times to first OP appointment; (ii) Cancer 28 day faster diagnosis; and (iii) Bed occupancy.

3. A metric on Emergency Department waiting times will be added once the outcomes of the national UEC field testing are made clear.

4. Further development of this scorecard will include monitoring performance against the focussed improvements, as well as the KPIs and milestones associated with our strategic objectives.

5. Data quality scores are applied to selected datasets. Above 5% informs a Red rating. 5% error rate of below informs a Green rating.

6. SPC (statistical process control) is applied to selected metrics. CC - denotes common cause variation and no significant change. SC - denotes special cause variation.

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Trajectory	Same period last year: Mar-19	Latest reported performance: Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
FYTD = Financial Year to Date											
Safe											
Patient safety - incident reporting											
Serious incidents	-	Mar-20		9	15	25	22	18	34	17	**6**
Incidents - moderate harm (FYTD)	<1.68%	Mar-20		1.27%	1.29%	1.37%	1.40%	1.42%	1.45%	1.40%	**1.37%**
Incidents - severe/major harm (FYTD)	<0.23%	Mar-20		0.04%	0.02%	0.02%	0.02%	0.02%	0.03%	0.02%	**0.03%**
Incidents - extreme harm/death (FYTD)	<0.09%	Mar-20		0.03%	0.06%	0.06%	0.06%	0.06%	0.06%	0.06%	**0.05%**
Incident reporting rate (per 1,000 beds)	>=50.38	Mar-20		48.39	51.04	54.26	54.19	47.31	53.91	50.28	-
Never events	0	Mar-20		0	0	0	2	0	1	0	**0**
PSAs open and overdue (FYTD)	0	Mar-20		-	0	0	0	0	0	0	**0**
Incidents with DoC completed	100%	Feb-20		-	96.1%	96.9%	94.9%	92.0%	96.8%	97.5%	**98.1%**
Infection prevention and control											
Trust-attributed MRSA BSI (FYTD)	0	Mar-20		3	3	3	3	3	3	3	**3**
Trust-attributed C. difficile (FYTD)	77	Mar-20	77	-	53	63	70	80	92	95	**101**
Trust-attributed C. difficile (lapses in care) (FYTD)	0	Mar-20		-	0	1	1	1	1	1	**1**
E. coli BSI (FYTD)	75	Mar-20	75	83	35	45	54	61	67	70	**73**
CPE BSI (FYTD)	0	Mar-20		7	6	6	6	6	7	8	**8**
VTE											
VTE risk assessment	>=95%	Mar-20		93.8%	98.5%	97.9%	97.6%	97.2%	97.5%	97.5%	-

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Trajectory	Same period last year: Mar-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Latest reported performance: Mar-20
FYTD = Financial Year to Date											
Safe											
Flu											
Flu vaccination for frontline healthcare workers	>=75%	Mar-20		-	-	34.0%	55.8%	61.5%	62.1%	69.2%	-
Sepsis											
Sepsis - Antibiotics	>=90%	Mar-20		93.8%	90.7%	88.6%	90.5%	89.8%	87.8%	88.6%	**88.2%**
Maternity standards											
Puerperal sepsis	<=1.5%	Mar-20		0.3%	0.9%	1.1%	1.0%	1.0%	1.2%	1.4%	**0.3%**
Safe staffing											
Safe staffing - registered nurses	>=90%	Mar-20		96.9%	97.2%	97.0%	97.0%	96.7%	97.2%	97.5%	-
Safe staffing - care staff	>=85%	Mar-20		95.3%	96.3%	96.3%	95.4%	95.0%	95.7%	95.3%	-
Workforce and people											
Core skills training	>=90%	Mar-20		92.1%	93.8%	93.8%	94.3%	94.3%	93.4%	93.2%	**92.7%**
Safeguarding children training (level 3)	>=90%	Mar-20		90.1%	86.0%	85.0%	85.0%	89.0%	88.0%	87.0%	**86.0%**
Vacancy rate - Trust	<10%	Mar-20		13.5%	11.1%	10.3%	9.7%	10.0%	9.7%	9.1%	**8.9%**
Estates and Facilities											
Cleanliness audit scores (very high risk)	>=98%	Mar-20		88.0%	88.5%	92.1%	90.2%	89.9%	89.8%	-	-
Cleanliness audit scores (high risk)	>=95%	Mar-20		91.0%	93.1%	91.1%	94.1%	93.9%	96.1%	-	-
Reactive maintenance	>=70%	Mar-20		33.2%	67.0%	57.0%	65.0%	72.0%	70.0%	-	-

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Trajectory	Same period last year: Mar-19	Latest reported performance: Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
FYTD = Financial Year to Date											
Effective											
Mortality indicators											
HSMR: Trust ranking	top 5 lowest risk	Dec-19		3rd Lowest	Lowest	5th Lowest	24th Lowest	24th Lowest	Lowest	5th Lowest	**6th Lowest**
HSMR ratio	<100	Dec-19		53.0	60.0	55.0	72.0	79.0	60.0	60.0	**65.0**
SHMI: Trust ranking	top 5 lowest risk	Dec-19		2nd Lowest	Lowest	Lowest	Lowest	Lowest	Lowest	Lowest	**Lowest**
SHMI ratio		Dec-19		66.8	70.3	70.3	69.7	67.8	68.7	69.8	**68.5**
Mortality reviews											
Total number of deaths	-	Feb-20		124	160	162	138	146	151	186	**159**
Overall Quality Of Care (Very Poor/Poor) (FYTD)	0	Feb-20		-	-	-	-	-	0	0	**0**
SJRs not completed within 30 days (FYTD)	0%	Feb-20		-	62.6%	60.9%	60.4%	65.1%	64.9%	63.0%	**65.1%**
Readmissions (unplanned)											
under 15 yr olds	<9.33%	Sep-19		5.3%	4.4%	4.6%	5.1%	4.3%	5.1%	5.0%	**4.4%**
over 15 yr olds	<8.09%	Sep-19		7.1%	7.1%	8.1%	7.1%	7.7%	7.7%	7.9%	**8.1%**
National Clinical Audits											
Participation in relevant NCAs (FYTD)	100%	Dec-19		84.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**100.0%**
High risk/significant risk audits with action plan (FYTD)	100%	Dec-19		100.00%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**100.0%**
Review process not completed within 90 days	0	Dec-19		8	11	18	19	30	34	35	**46**
Clinical trials				Qtr 4 17/18	Qtr 1 18/19	Qtr 2 18/19	Qtr 3 18/19	Qtr 4 18/19	Qtr 1 19/20	Qtr 2 19/20	**Qtr 3 19/20**
Recruitment of 1st patient within 70 days	>=90%	Qtr 3 19/20		67.6%	85.1%	95.7%	93.9%	96.0%	96.3%	100.0%	**92.8%**

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Trajectory	Same period last year: Mar-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Latest reported performance: Mar-20
FYTD = Financial Year to Date											
Caring											
Friends and Family											
A&E - % recommended	>=94%	Mar-20		93.6%	94.4%	94.4%	92.3%	92.2%	93.0%	91.5%	-
A&E - % response rate	>=15%	Mar-20		18.1%	16.1%	20.0%	18.6%	18.8%	14.1%	13.3%	-
Inpatients - % recommended	>=94%	Mar-20		97.7%	97.3%	96.9%	97.8%	96.9%	96.9%	98.0%	-
Outpatients - % recommended	>=94%	Mar-20		94.2%	93.9%	94.1%	94.1%	95.2%	94.6%	95.1%	-
Maternity - % recommended	>=94%	Mar-20		92.9%	95.2%	94.7%	91.4%	90.2%	92.7%	92.4%	-
Patient Transport - % recommended	>=90%	Mar-20		95.7%	44.4%	49.5%	68.2%	57.1%	68.0%	76.4%	-
Mixed sex accommodation											
Mixed-sex accommodation breaches	0	Mar-20		50	28	45	42	47	47	34	-
Well led											
Workforce and people											
Voluntary staff turnover rate (12m rolling)	<12%	Mar-20		11.3%	11.8%	11.8%	11.8%	11.8%	12.0%	11.7%	**12.1%**
Sickness absence rate (12m rolling)	<=3%	Mar-20		3.13%	3.18%	3.24%	3.26%	3.29%	3.29%	3.29%	**3.70%**
Doctor appraisal rate	>=95%	Mar-20		93.0%	94.0%	94.8%	95.1%	95.3%	95.3%	95.5%	**95.5%**
Consultant job planning completion rate	>=95%	Mar-20		-	91.6%	91.6%	91.6%	55.1%	61.5%	65.9%	**65.9%**

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

Indicator	Data reliability rating	Overall target	Latest Period	Trajectory	Same period last year: Mar-19	Latest reported performance: Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
FYTD = Financial Year to Date												
Responsive												
Referral to treatment (elective care)												
RTT patients waiting < 18 weeks	6%	>=92%	Mar-20	84.0%	84.4%	83.6%	81.8%	81.4%	80.4%	79.5%	79.4%	**74.3%**
RTT waiting list size		63,099	Mar-20	63,100	61,371	62,664	60,992	63,036	62,608	62,583	62,932	**59,324**
Long waiters												
RTT patients waiting > 52 weeks	4%	0	Mar-20		0	3	2	4	8	2	1	**10**
Cancer waiting times												
Two Week Wait	5%	>=93%	Mar-20		90.8%	84.5%	89.1%	91.7%	89.6%	86.2%	**93.5%**	**89.1%**
62 Day Screening Standard		>=90%	Mar-20		93.0%	92.0%	81.5%	82.0%	76.1%	70.2%	**69.4%**	**80.3%**
62 Day Wait (start of treatment)		>=85%	Mar-20	85.3%	86.8%	86.3%	83.7%	87.4%	89.1%	80.8%	**78.4%**	**86.1%**
Theatre utilisation												
Theatre touchtime utilisation		>=85%	Mar-20	85.2%	78.6%	82.2%	79.5%	78.1%	74.2%	75.0%	-	-
Critical care												
Critical care patients admitted within 4 hours		100%	Mar-20		95.8%	94.6%	96.4%	93.6%	96.4%	93.6%	93.6%	
Urgent & Emergency Care (UEC)												
A&E patients waiting > 12 hours from DTA	1%	0	Mar-20		10	7	8	5	11	10	14	**135**
A&E ambulance handover delays 30 minutes		100%	Mar-20	100%	87.0%	91.4%	92.7%	92.7%	89.3%	89.5%	88.3%	**85.9%**
Length of stay												
Patients with LoS >= 21 days	3%	tbc	Mar-20		233	212	208	206	233	224	229	**205**
Discharges before noon		>=33%	Mar-20		14.5%	16.1%	16.0%	16.2%	15.0%	16.1%	16.5%	-
Diagnostics												
Diagnostic test waits > 6 weeks	0.4%	<1%	Mar-20		0.61%	0.50%	0.69%	1.15%	1.67%	0.79%	0.51%	**8.50%**

Key to data reliability scores:

Data reliability scores are currently provided for the above RTT, Cancer, Emergency care, Diagnostics and Long stay patient datasets

Above 5% error rate to inform a Red data quality rating.

5% error rate or below to inform a Green data quality rating.

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Trajectory	Same period last year: Mar-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Latest reported performance: Mar-20
FYTD = Financial Year to Date											
Outpatients											
DNA	<10%	Mar-20		10.2%	10.8%	10.7%	10.1%	10.7%	10.3%	10.1%	**10.5%**
HICs (Appt moved to a later date)	<7%	Mar-20	7.0%	7.2%	7.4%	7.3%	6.3%	7.7%	6.9%	7.0%	**10.6%**
Complaints management											
Complaints - formal	<90	Mar-20		88	98	100	83	87	80	90	**67**
Complaints – average days to respond	40 days	Mar-20		27.9	36.3	35.7	33.3	32.2	34.0	36.5	**31.0**
Complaints - patient satisfaction with handling	>=70%	Mar-20		84.0%	82.0%	82.0%	72.0%	78.0%	73.0%	75.0%	
Patient transport											
All Journeys: Collection Time (60 Mins)	>85%	Mar-20		94.1%	68.7%	86.2%	74.7%	89.3%	93.3%	94.7%	**95.9%**
Data quality											
Data Quality Maturity Index	>98%	Dec-19	95%	96.7%	99.3%	99.3%	99.2%	99.3%	99.3%	99.3%	-

Use Of Resources

Finance KPIs

Monthly finance score (1-4)	-	Mar-20		3	3	3	3	3	3	3	**3**
In month Position	-	Mar-20		0.32	-0.05	3.80	-1.60	-2.19	0.00	-0.03	
YTD Position £m	-	Mar-20		0.32	1.03	4.80	3.19	1.01	1.01	0.97	**1.47**
Annual forecast variance to plan	-	Mar-20		0.32	-9.14	-5.02	-6.51	-3.52	-2.62	-3.43	-
Agency staffing	-	Mar-20		4.1%	2.9%	2.8%	2.8%	2.7%	2.6%	2.5%	**2.5%**
CIP (FYTD)	-	Mar-20		76.4%	74.1%	73.5%	74.8%	75.0%	74.4%	75.7%	**75.7%**

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Annual self-certification for NHS Trusts	☒ Approval ☐ Endorsement/Decision ☐ Discussion ☐ Information
Date of Meeting: 20th May 2020	**Item 11, report no. 08**
Responsible Executive Director: Tim Orchard, Chief executive officer	**Author:** Peter Jenkinson, Director of Corporate Governance

Summary:

Background

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

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

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

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

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

Self-certification - assessment

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

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

- Regulatory inspection and oversight, including CQC and NHS Improvement
- Risk-based annual internal audit plan, including review of key systems of internal control and a review of the risk management arrangements and board assurance framework, culminating in the Head of Internal Audit opinion

- External audit opinion on annual accounts, annual report and quality account
- Quality account
- Corporate risk register
- Executive director reports to Trust board
- Board committee reports to Trust board
- Board seminar presentations from divisions and areas of interest (eg education; research; integrated care), bi-monthly.

The Trust agreed on a series of undertakings with NHS Improvement in November 2017 in response to breaches of licence conditions. The delivery of the undertakings forms a key element of regulatory requirement, and NHS Improvement oversee the Trust's progress against the undertakings as part of the monthly Provider Oversight Meetings. These undertakings were removed by NHS Improvement during 2019/20, to reflect the progress made by the Trust in achieving the undertakings and the Trust's improved operational and financial performance.

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

It is recommended that the Trust confirms compliance with Condition G6 *'Following a review for the purpose of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution.'*

Despite the progress made by the Trust in performance, recognised by NHSI/E through removal of the Trust undertakings and improvement of the Trust segmentation, there are continuing risks to the Trust ensuring compliance with the Trust's duty to operate efficiently, economically and effectively. The recommendation is therefore for the Trust to declare 'not confirmed' against Condition FT4 (4a) – *'The Trust board is satisfied that the Licensee has established and effectively implements systems and/ or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively',* as summarised in Appendix 1.

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

- Condition G6(3)
  "Not later than two months from the end of the Financial Year (by 31 May 2020), the Trust board ('the Licensee') is required to self-certificate to the effect that it "Confirms" or "Does not confirm" that it has taken all precautions necessary to comply with the licence, NHS acts and the NHS Constitution."
  It is recommended that the Trust board formally sign-off the Self-Certification for Condition G6 as "Confirmed".
- Condition FT4 (4)
  "By 30 June 2020, the Trust board is required to self-certificate "Confirmed" or "Not confirmed" to compliance with required governance standards and objectives."
  It is recommended that the Trust board formally sign-off the Self-certification for Condition FT4 as "Not confirmed for (a) and confirmed for (b-h)".

This report has been discussed at: N/A

Quality impact: No impact.

Financial impact: No impact.

Risk impact and Board Assurance Framework (BAF) reference: N/A

Workforce impact (including training and education implications): No impact

Has an Equality Impact Assessment been carried out or have protected groups been considered?
☐ Yes ☐ No ☒ Not applicable

If yes, are further actions required? ☐ Yes ☐ No
What impact will this have on the wider health economy, patients and the public? No impact.
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: N/A
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No If yes, why?

Appendix 1

Trust self-certification statements – May 2020

FT4 declaration for Imperial College healthcare NHS Trust

Corporate governance statement (FTs and NHS Trusts)		
The Trust board is required to respond 'confirmed' or 'not confirmed' to the following statements, settings out any risks and mitigating actions for each one where it is 'not confirmed'		
Corporate governance statement	**Response**	**Risks and mitigating actions**
1 The Trust board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of heat care services to the NHS	Confirmed	
2 The Trust board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	
3 The Trust board is satisfied that the Licensee has established and implements: (a) effective board and committee structures (b) clear responsibilities for its Trust board, for committees report to the Trust board and for staff reporting to the Trust board and those committees and (c) clear reporting lines and accountabilities throughout its organisation	Confirmed	
4 The Trust board is satisfied that the Licensee has established and effectively implements systems and/ or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively (b) For timely and effective scrutiny and oversight by the Trust board of the Licensee's operations (c) To ensure compliance with healthcare standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of healthcare professions (d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/ or processes to ensure the Licensee's ability to continue as a going concern) (e) To obtain and disseminate accurate, comprehensive, timely and up-to-date information for the Trust board and committee decision-making (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence (g) To ensure compliance with all legal requirements	**Not confirmed**	Not confirmed for (a). The Trust continues to strengthen its systems and processes to ensure it operates efficiently, economically and effectively, demonstrated by the decision in October 2019 by NHS Improvement to close all remaining regulatory undertakings and to amend the Trust's rating from segment three to segment two. However, the Trust continues to face operational and financial challenges, and this has increased due to impact of the Trust's response to the COVID-19 pandemic. The Trust is not currently achieving the national standard with respect to referral to treatment (RTT) within 18 weeks. Ten patients were waiting for 52+ weeks and we expect 52 week breaches will increase further as a result of patients currently being on hold for treatment due to the COVID-19 pandemic. The Trust has not been meeting the two-week wait standard for Cancer referrals due to an increase in demand for colorectal and dermatology pathways, although it met the standard in March 2020. The Cancer 62 day screening standard has not been met. This is because national breast screening service guidelines do not align with national cancer waiting times guidelines and breast screening pathways have therefore not been designed to meet

		this standard. An RM Partners working group has been established to review delivery of the breast screening pathway across NWL. The Trust achieved its financial targets for 2019/20 in terms of meeting control total; external financing limit and capital resource limit. However this required managing a deterioration in the underlying position compared to 2018/19, linked mainly to the increased expenditure of delivering activity above plan and the mobilisation costs associated with the in-housing of hotel services pre go-live on the 1 April 2020. The Trust Board was not able to accept its financial trajectory target for 2020/21 at the draft submission stage as there was further work required to close a residual unmitigated CIP gap of less than 1% of its turnover. The aim was to close this down before final submission. Due to the outbreak of COVID-19, 2020/21 planning was suspended in March 2020 and all NHS Providers will be subject to a new finance regime, the details of which at present only cover first seven months to 31 October 2020. All NHS trusts and foundation trusts will move to block contract payments with top up facilities to ensure financial balance. The Trust awaits the publication of further guidance from the regulator on what arrangements will be put in place thereafter. There is limited capacity to focus on the business transformation aimed at delivering the improvement in the underlying deficit.
5 The Trust board is satisfied that the systems and/or processes referred to in paragraph 4 should include but not be restricted to systems and/ or processes to ensure: (a) That there is sufficient capability at Trust board level to provide effective organisational leadership on the quality of care provided (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and	Confirmed	

(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		
6 The Trust board us satisfied that there are systems to ensure that the Licensee has in place personnel on the Trust board, reporting to the Trust board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence	Confirmed	
Signed on behalf of the Trust board Signature . . . . . Signature . . . . . Name . . . . . Name		

G6 declaration for Imperial College Healthcare NHS Trust

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

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Hotel Services: Transition	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 20th May 2020	**Item 12, report no. 09**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Author:** Hugh Gostling, Director of Estates and Facilities

Summary:

The programme to bring hotel services in-house was set out in the four stages described below. This report focuses on the completion and close out position of Stage One, giving an overview of the impact of COVID-19, the activities that took place on day of transfer and the immediate days after; and then the work planned as the project enters Stage Two.

Stage One: Transition
The hotel services contract for helpdesk, portering, cleaning and patient dining for the Trust, including Imperial Private Healthcare successfully transferred in-house on the 1st April 2020 after 9 weeks of intensive planning, preparation and mobilisation. Stage One has now been closed and the transition team and project committee have moved into Stage Two.

Stage Two: Stabilise
The completion of all stage two milestones as stated in the implementation plan no later than 31st July 2020 in order to stabilise the service ensuring that all elements of an in-house implementation plan are delivered. Two substantive actions to be achieved in advance of stage three:

- Preparation of service improvement and KPI monitoring plan
- Establish a compliance team which will develop and implement the above as the project moves into stage three.

Stage Two stabilisation plan continues to be finalised with the work stream leads. A final draft will be reviewed in detail at the next project committee meeting on 22 May.

Stage Three: Achieving required standards and service performance
Refinement and development of services through to 31 March 2021 with a review of the preceding 12 months performance and delivery of mobilisation project.

Stage Four: Future
Recommendation for the long term provision of hotel services.

Recommendations:
The following recommendations were noted and approved by the Executive Operational Committee on 5 May 2020 and the

- Note the successful transition of hotel services in house on 1st April 2020 with the enhanced pressures of COVID-19
- Note the close out position of Stage One and the move into Stage Two: Stabilisation
- Confirm this project remains an organisational priority for 2020/21
- Approve the continued secondment of existing transition team members for the duration of Stage Two
- Note the next Hotel Services Project Committee meeting will be on 22 May 2020

This report has been discussed at:
Executive Committee (ExOps), 5 May 2020.
Circulated, reviewed and approved using email by the Hotel Services Project Committee

Quality impact:

The delivery of Hotel Services have a considerable impact on Patient Experience and Safety. Transferring these services in house is expected to benefit patient care and experience through appropriate and timely soft facilities management services, such as delivery of patient meals, cleanliness of the patient environment and timely transfer of patients to and from other clinical services.

An in-house service delivery is expected to provide the greatest opportunity to improve service standards and performance whilst maintaining maximum control, flexibility and responsiveness, future proofing these services. One of the primary focuses of Stage Two is the development of systems and processes to achieve and deliver on these opportunities during Stage Three.

In general terms there has been no reported reduction in the quality of any of the services as a result of the transition on 1st April, other than known specific transition issues. The impact of COVID19 has and continues to create operational resource issues that do impact quality of service.

Financial impact: Expenditure for delivering this transition and future planning continues to be collated and will be included in future reports to Executive and Trust Board Committees.

Risk impact and Board Assurance Framework (BAF) reference:
A full and comprehensive risk register was in place and used as one of the fundamental management tools in delivering this project. Of the 45 risks during implementation, 16 have been closed as no longer a risk. The 29 remaining risks have been managed or transferred under the following headings: transferred to either the Stage Two stabilisation risk register, or to the business as usual risk register.

Workforce impact (including training and education implications):

This project involved the TUPE transfer of circa 1,000 staff from currently out-sourced services to the Trust and the operational delivery of all equipment, IT systems and consumables to deliver cleaning, portering, patient and visitor dining and helpdesk.

Upon transfer on 1st April 2020 a small number of management and non-front line staff positions either did not transfer, or remained vacant. The vacancies include; site specific service managers for portering, domestics and catering as well as a general manager for St. Mary's. The majority of the service manager roles were vacant prior to transition and therefore have not changed what was business as usual, however where possible these roles are being supported by the existing facilities team. An increase in work load, support function requirements and subsequent budget implications of services outside of Estates and Facilities is addressed in the previously circulated Facilities structures with specific dedicated roles covering administrative and procurement duties, trainers, scheduling and roster support as well as HR functions.

Has an Equality Impact Assessment been carried out or have protected groups been considered?
☐ Yes ☐ No ☒ Not applicable
If yes, are further actions required? ☐ Yes ☐ No

How have patients, the public and/or the community been involved in this project and what changes were made as a result?
Given the 9 week period in which to undertake transition it was not possible to involve patients and others.

What impact will this have on the wider health economy, patients and the public? None at this time.

The report content respects the rights, values and commitments within the NHS Constitution
☒ Yes ☐ No

Trust strategic goals supported by this paper:
- To help create a high quality integrated care system with the population of north west London
- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers?
☐ Yes ☒ No

The Project Stages Detailed update

1. Stage One - Transition

Hotel services to be brought in-house ready for 1st April 2020 with minimal service disruption. Full completion of all stage one milestones as stated in the implementation plan including continuation of service at current level and transfer of all contracted staff to the Trust The hotel services contract for helpdesk, portering, cleaning and patient dining for the Trust, including Imperial Private Healthcare successfully transferred in-house on the 1st April 2020 after 9 weeks of intensive planning, preparation and mobilisation.

407 tasks were due for completion as of week 9 (31/03/20); 93% of tasks were completed leaving close out position of Stage One as 27 tasks outstanding.

All tasks due for completion during weeks 1, 2, 3, 5 and 6 have now been completed.

The final close out position summary page for Stage One: Transition is included as appendix 1.

All outstanding Stage One tasks will move to Stage Two to ensure continued monitoring and delivery. Each of these line tasks will have a risk score associated against it to minimise any risk of moving from implementation to stabilisation stage. Tasks with high risk scores will auto-populate into the summary page which forms the agenda for review at the weekly transition team meetings.

Thus stage one has been closed.

This decision was made following the assurance that all outstanding tasks not completed were moved to the stage two plan to ensure continued monitoring and completion. Residual areas of focus from stage one to highlight:

- Embed processes and procedures across all services and functions ensuring that responsibilities are clearly understood for all functions including establishing authorised and competent persons and budgetary approvals.
- Recruitment of frontline and management positions having assessed the gaps identified following the TUPE transfer.
- Actions required following training needs analysis

1.1 Impact of COVID-19

The impact of COVID-19 began to be felt by the facilities business as usual services as well as the transition team from early March, disrupting implementation and mobilisation.

Various members of the transition team and front line work force had to self-isolate both through sickness and personal circumstances forcing the transition team to narrow their focus even further to ensure resources focused on the most project critical elements. The team prioritised key day one delivery “showstoppers”, accepting that some tasks within the initial implementation plan were no longer going to be achieved on the planned dates.

This has resulted in a slightly wider gap than initially proposed to this committee between target number of tasks due to be completed in implementation plan and tasks actually completed.

Each of these tasks were monitored to assess the risk of any delays and escalated by exception for agreement and resolution, adapting the process initially proposed as the Trust changed their operating model to deal with COVID-19.

One of the impacts of COVID was the decision to postpone some of the remaining face to face staff induction sessions. These had been well attended with all attendees receiving welcome pack tote bags and goodies, however such gatherings of people in a single location was no longer considered safe or essential.

Wherever possible messages were delivered by alternative means including posters in clocking in areas, messages through existing management and supervision structures and also when staff

collected their uniforms. However it is acknowledged that these methods are not as effective as the face to face induction sessions which remain an outstanding task to take into Stage Two.

Distribution of staff uniforms was also impacted by COVID and as a result took longer than anticipated. This task was planned in collaboration with our uniform provider and for their team to be on site co-ordinating the distribution.

The transition team were extremely grateful to the volunteers across the Trust who gave up their time to step in and help in this process.

The transition team organised for the manufacture and delivery of 270 new cleaning trolleys to launch on Day One. The Supplier was planning to have teams of people on site to roll out training on the new equipment, however a quarter of the trolleys were commandeered to go direct to The Nightingale and the Supplier could no longer provide on-site training. Combined, these developments would have left the Trust with a mix of new and old equipment, operating two cleaning systems with no training support. The decision was made to postpone distribution of this new equipment until replacement deliveries arrive and full effective training can be delivered.

1.2 Transition Day 1

Transition Day was overseen using a Gold, Silver, Bronze command centre approach supported by the wider transition team. Each site was allocated a Bronze and Silver lead who reported in four times daily on day one and two.

One of the most challenging aspects of day one and the remaining first week was the development, printing and completing of rosters and sign in attendance sheets. These rosters were as accurate as possible within the confines of Sodexo not sharing existing rosters with individuals allocated against shifts and the higher than usual levels of sickness, casual workers and agency staff due to COVID.

Some of the other issues that arose included: temporary manual paper ordering for patient dining whilst final configuration of electronic tablets was completed; set up issues with new tills and chip and pin machines resulting in food being given “on the house” in staff & visitor restaurants on day one then on and off for the following week; procurement team rapidly sourcing alternative providers following the collapse of our bread supplier due to COVID.

Some of the highlights were the amazing collaborations of the teams involved, working together to overcome these issues and find solutions using their knowledge, expertise and contacts.

Access to Sodexo staff prior to transition and availability and capacity due to COVID made it difficult to provide the level and detail of training on Trust IT systems really necessary. Despite this, the newly transferred managers and supervisors demonstrated real commitment to working as a team, putting their newly acquired skills to work and attending further short notice training. This was particularly evident for using e-rostering to effectively roster staff, record hours worked and ensure staff could get paid.

1.3 Payroll

The second major milestone for the transition was the first weekly payroll on 9 April 2020, compounded by this being Easter Bank Holiday weekend.

In person payroll clinics staffed by facilities and volunteers were set up on all three sites with payroll colleagues being available by Microsoft Teams for queries, including over the Bank Holiday weekend for escalations.

The payroll clinics escalated incidences of no payment or underpayments that would cause hardship which enabled emergency payments to be authorised and processed as appropriate.

Having transferred circa 1,000 new staff, there were only 2% who were set up late or incorrectly and required some form of emergency payment.

1,4 Staff and structure

Upon transfer on 1st April 2020 a small number of management and non-front line staff positions either did not transfer, remained vacant or were not subject to transfer because they were a central Sodexo function.

Some of the most pressing vacancies are those for site specific service managers for portering, domestics and catering as well as a general manager for St. Mary's.

These positions are in line with the new facilities structure presented in the ExCo paper dated 24 March 2020; however at the time of writing that paper exact numbers of existing Sodexo vacancies and personnel were unconfirmed.

To ensure continuity of services and allow the new structure to function as quickly and effectively as possible, recruitment to these vacant positions has been initiated and will continue to progress over the coming weeks.

Recruitment to front line staff (cleaners, porters and catering staff) was initiated prior to the first day of transition and continues to be carried out directly with the P&OD team as vacancies are established.

As stated in the March ExCo paper, the Private Patient's Sodexo staff transitioned as a replica of the existing Sodexo structure under the head of programme, an operational lead supported by the facilities structure and functions. This ensured minimum disruption and continuity of service for stage one and will be reviewed during stage two as they move into stabilisation and business as usual.

1.5 Staff communications and engagement

An area of continued learning is the changes we as a Trust may need to make to fully integrate, interact and communicate with this group of staff. Due to the nature of their work they do not have access to computers and some have very little experience of using such. This has proved challenging especially for everyone to gain access to their electronic payslip via MyESR and resulted in last minute decisions to print and distribute hard copy payslips for the first two weeks.

2. Stage Two - Stabilise

Stage Two stabilisation plan continues to be finalised with the work stream leads. The template and a few example tasks is included in appendix 2. A final draft of this plan will be reviewed in detail at the next project committee meeting on 22 May to enable finalisation.

Stage Two includes numerous business critical actions and requires the continued support from the wider organisation as well as the existing transition team and to remain a priority within the Trust.

At this time it is anticipated that the existing transition team members already seconded to the project will be retained for the duration of Stage Two, however once the stabilisation plan is finalised an informed review of necessary resources for Stage Two will be conducted and confirmed.

Of particular note is the increased work load, support function requirements and subsequent budget implications of services outside of Estates and Facilities which have started to become a reality over the last few weeks. This is especially so within procurement and a variety of HR areas such as training, H&S, payroll and e-rostering.

The previously circulated Facilities structures address these areas of concern with specific dedicated roles covering administrative and procurement duties, trainers, scheduling and roster support as well as HR functions.

Stage Two will include previously agreed approaches for areas of statutory compliance such as DBS, Right to Work and training where a staged approach will be implemented and prioritised based on staff group and patient contact.

As per the terms of reference for the hotel services project committee, stages three and four are to be further defined as we become clear on exactly what is required in stage two. This piece of work is planned to be delivered through the project committee during June and July of 2020.

Appendix 1: Summary Close Out Position Report for Stage One

	Week 4		Week 5		Week 6		Week 7		Week 8		Week 9	
Workstreams	**Should**	**Actual**	**Should**	**Actual**	**Should**	**Actual**	**Should**	**Actual**	**Should**	**Actual**	**Should**	**Actual**
Catering	2	0	0	0	20	20	7	7	0	0	87	81
Cleaning	7	7	1	1	9	9	11	11	0	0	13	11
Communications & Engagement	1	1	3	3	1	1	0	0	4	2	2	2
Equipment and Assets	0	0	0	0	0	0	1	1	0	0	8	5
Finance	0	0	1	1	0	0	0	0	0	0	6	3
Health & Safety	0	0	4	4	0	0	4	0	0	0	0	0
Helpdesk & IT	2	2	1	1	1	1	0	0	3	3	3	3
HR Workstream	2	2	5	5	6	6	0	0	3	3	10	10
Portering	2	2	1	1	2	2	5	5	6	4	4	3
Procurement	0	0	1	1	2	2	1	1	5	5	2	2
Progress Meetings	1	1	1	1	1	1	1	1	1	1	1	1
Sodexo Exit Management meetings	1	1	1	1	1	1	1	1	1	1	1	1
Strategic Milestones	2	2	1	1	2	2	3	3	1	0	14	14
Workwear and PPE	4	4	3	3	1	1	0	0	1	1	4	4
Private Patients	0	0	2	2	0	0	2	2	0	0	6	5
Day 1	0	0	0	0	4	4	0	0	7	7	0	0
Grand Total	24	22	25	25	50	50	36	32	32	27	161	145

Cumulative Total	Week 4		Week 5		Week 6		Week 7		Week 8		Week 9	
	Should	**Actual**	**Should**	**Actual**	**Should**	**Actual**	**Should**	**Actual**	**Should**	**Actual**	**Should**	**Actual**
	103	101	128	126	178	176	214	208	246	235	407	380

Cumulative total for week 4 also includes all actions due for completion in weeks 1, 2 and 3.

		Outstanding Actions	Cumulative Outstanding
Week 1	COMPLETE	**0**	**0**
Week 2	COMPLETE	**0**	**0**
Week 3	COMPLETE	**0**	**0**
Week 4	2 actions remain outstanding until till and payment system functionality for restaurants are resolved	**2**	**2**
Week 5	COMPLETE	**0**	**2**
Week 6	COMPLETE	**0**	**2**
Week 7	4 actions related training, training records and H&S	**4**	**6**
Week 8	2 related to Comms – induction sessions and people profiles, kept 1 payroll error action open to ensure continued focus, 2 porter staffing actions to review requirement and initiate recruitment	**5**	**11**
Week 9	6 actions related to restaurants (tills & payments, menus and promotions). Development of restaurant offer related actions considered no longer critical to Day One delivery. 6 actions relating to assets and equipment and 4 actions related to finance and licencing which were all de-prioritised for Day One.	**16**	**27**

Appendix 2: Sample Stage Two Stabilisation Action Plan Template

Retearn ION ACTION PLAN — Imperial College Healthcare NHS Trust

		Rationale	Associated Current Risk: Likelihood	Impact	Score	Actions	Update	Owner	Dependency	Milestone
1	Structure and Reporting Lines									
1.1	Agree service delivery KPIs	Critical to delivery	4 - Going to happen	3 - Medium	12	Capture existing KPI's and document, sign off then implement, build dashboard	In line with Trust Divisions.			31/07/2020
1.2	Agree service delivery SLAs	Critical to delivery	4 - Going to happen	3 - Medium	12	Capture existing SLA's and document, sign off then implement, build dashboard	In line with Trust Divisions.			31/07/2020
1.3	Meeting Schedule	Improve delivery								
2	Porterage									
2.2	Van Hire/Lease -27days ends of 27th April	Critical to delivery	4 - Going to happen	2 - Low	8	Current monthly rental extended	Trust Insurance TBC	Stuart Walmsley	Mark Wicks	01-May
						Long term hire solution agreed	Quotations with commercial	Stuart Walmsley	Procurement	Monthly
3	Catering									
3.1	HACCP Yearly audit	Compliant	3 - Likely	3 - Medium	9	Confirm processes are in place and being adhered to	27/04: Check for CXH to be completed by 1/5	Andrew McNeil	Kathleen Gallag	01-Jun
3.2	Saffron Tablets	Affecting delivery	3 - Likely	3 - Medium	9	Processes, roles and responsibilities	27/04: Need to confirm FTE and requirements. This was previously completed by a central Sodexo function who was not completely allocated to the contract.	Andrew McNeil		
						Developing the reporting in line with useful information and KPI requirements	27/04: Awaiting confirmation around the KPIs. Identified that not all of the previous KPIs were useful.	Andrew McNeil	Marcus Hill	
						Andriod devices roll out	27/04: On hold until software development	Andrew McNeil	IT	
3.3	Till terminals, Chip and Pin	Affecting delivery	4 - Going to happen	2 - Low	8	Resolve Current Issues	27/04: Call held previous week with PaymentSense. Keeping note of issues encountered	Andrew McNeil	IT	
3.4	Branding	Improve delivery	5 - Already happening	1 - Very Low	5	Replacing Restaurant Signage removed by Sodexo	27/04: To confirm if in stage 2 or 3 (also if repairs to walls or cover with new signage)	Comms	Andrew McNeil	
3.5	Back of House flooring works	Compliant	4 - Going to happen	4 - High	16	Carrying out the Actions identified by EHO audits	27/04: MT to confirm the process for life cycle replacements within the CBRE contract	Estates	Andrew Murray	01-Jul
3.9	Hospitality Process	Improve delivery	3 - Likely	2 - Low	6	Develop and Sign off	27/04: Re charging system not changing.	Andrew McNeil	Alexi Adas	01-Jun
4	Cleaning									
4.1	Rollout of Equipment	Improve delivery	5 - Already happening	2 - Low	10	Ensure training is completed	28/04: Equipment awaiting tagging process prior to being able to roll out and train. PAT testing underway and will be completed prior to asset tagging.	Zoe Bergin		
						Switch over of old / new	28/04: Awaiting roll out date	Zoe Bergin	Andrew Murray	
						Removal of old redundant equipment from site	28/04: Asset workstream to identify prior to roll out any equipment to be kept.	Zoe Bergin	Waste Team	
						Update asset list and PAT testing date (confirm PAT policy)	28/04: will liaise into the asset workstream	Andy Dawson	Stuart Walmsley	
4.2	Changeover of COSHH data sheets	Compliant	5 - Already happening	1 - Very Low	5	Create non Sodexo-ised COSHH data sheets and rollout.		Zoe Bergin		
4.3	Recommencing of Audits and confirmation around Innovise	Improve delivery	5 - Already happening	2 - Low	10	Ensure innovise is ready to be rolled out	28/04: Missing at CXH (confirming with Sodexo), numbers are not as high as we thought (MT checking against the transferred asset list). Devices we do have that are working have been configured.	Zoe Bergin	IT	
						Implement		Zoe Bergin		
4.4	Task Cards	Improve delivery	5 - Already happening	1 - Very Low	5	Ensure Task Cards are available and trained out accordingly	28/04: Mario has identified task cards we can modify for use.	Zoe Bergin		
5	H&S									
5.1	Structure to be finalised against The Trust H&S Policy and Governance identified and communicated	Compliant	3 - Likely	5 - Critical	15	Trust to structure department roles and responsibility and reporting lines		Andrew Murray	Trust Strategy v	TBC
5.2	Confirm appointment of Duty Holder, Authorised and Competent Persons structure and appoint	Affecting delivery	3 - Likely	5 - Critical	15	Trust to structure department roles and responsibility and reporting lines		Andrew Murray	Trust Strategy v	TBC

Additional columns not shown here include: Status of task, previously recorded risk score, previously recorded actions and aspects of task that move into Stage Three.

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Infection Prevention and Control (IPC), and Antimicrobial Stewardship Quarterly Report: Q4 2019/20	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 20th May 2020	**Item 13, report no. 10**
Responsible Executive Director: Professor Julian Redhead, Medical Director	**Author:** Jon Otter, General Manager, IPC Professor Alison Holmes, Director, IPC Dr Eimear Brannigan, Deputy Director, IPC

Summary:
The IPC team have played a central role in the Trust's response to the COVID-19 pandemic. Definitions for hospital-onset COVID-19 infection (HOCI) have been developed and systems established for surveillance and investigating HOCIs and HOCI clusters.

Antimicrobial stewardship activity directly related to COVID-19 includes managing the impact of national supply chain shortages for multiple antibiotics, and the development and launch of interim guidance for antimicrobial management when treating patients with suspected for confirmed COVID-19.

A number of IPC-related workstreams were modified or put on hold during the peak of the COVID-19 pandemic but will be restarted during recovery, including the bi-annual hand hygiene auditing and improvement programme, strategic plans to reduce Gram-negative bloodstream infections (BSIs), changes to the way that water hygiene management is conducted, surveillance for central line-associated BSIs, and plans to improve the identification and management of surgical site infection. These changes have been reflected on the IPC risk register.

There have been 21 hospital-associated *C. difficile* cases during Q4, and 104 for 2019/20, which is above the ceiling of 77 cases. There has only been one lapse in care.

The Trust has met its 10% year-on-year reduction in Trust-attributed *E. coli* BSIs (an internal performance metric), with 73 cases during 2019/20, compared with 83 cases during 2018/19. Imperial's *E. coli* BSI rate ranks lowest in the Shelford group.

The biannual antibiotic point prevalence study (PPS) (that reviewed1,279 inpatients) was undertaken in January 2020 (see Appendix Table 2). Two of three prescribing quality indicators were above the 90% target. Also, the audit included surgical prophylaxis prescribing for the first time

Recommendations:
The Board is asked to note the report.

This report has been discussed at: N/A

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

Financial impact: No direct financial impact.

Risk impact and Board Assurance Framework (BAF) reference:
This report includes a summary update of the IPC risk register.

Workforce impact (including training and education implications): None.
Has an Equality Impact Assessment been carried out? ☐ Yes ☐ No ☒ Not applicable If yes, are there any further actions required? ☐ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do

Infection Prevention and Control (IPC), and Antimicrobial Stewardship Quarterly Report: Q4 2019/20

1 Response to the pandemic of COVID-19

The IPC team have played an integral role in supporting all clinical and corporate areas in effective IPC for patient and staff safety during the COVID-19 pandemic, including:

- Personal Protective Equipment (PPE):
  - Interpreted national guidelines to develop local guidance and maintained this through changes in national guidance.
  - Worked with the Trust communications team and external designers to create clear graphics.
  - Developed a programme of "PPE Helpers" to support staff who may have been feeling anxious and confused about PPE, to support and help staff to doff and don safely, and to provide or signpost staff to key information.
  - Provided PPE training to specific staff groups (e.g. cleaning staff, porters).
- Hand hygiene
  - Developed new hand hygiene locations and communications materials to encourage hand hygiene at the point of entry to our hospital.
- Environmental hygiene (cleaning)
  - Issued recommendations around enhanced environmental cleaning in clinical areas used to manage patients with COVID-19 in line with national guidelines.
- Performed environmental sampling to understand potential risk from surfaces and air
- Antimicrobial stewardship (AMS) and treatment
  - Investigated the impact of the COVID-19 pandemic on trends in antimicrobial prescribing, and intervened to ensure that the use of antimicrobial agents was optimised
  - Ensured that key messages around identifying and treating bacterial infection using antibiotics continued to be reinforced during the pandemic.
  - Supported applied research to investigate effective therapies for COVID-19.
- Applied epidemiology
  - Implemented a daily "sitrep" for the number of new cases and number of current inpatients.
  - Implemented a forecast of the projected number of inpatients at various levels of care to support operational planning.
  - Developed a definition for "hospital-onset COVID-19 infections" (HOCIs), and implemented systems for the detection and management of HOCI clusters.
- Communications
  - Supported the communications team in providing effective messaging to all staff around the issues of consequence to the IPC/AMS service throughout the pandemic. This included the development of a series of "IPC/AMS" messages of the day as a vehicle to ensure that IPC/AMS messages remained prominent throughout the pandemic.
  - Participated in all-staff broadcasts.
  - Supported the communications team in developing and keeping the Intranet COVID-19 pages clear, accurate, and up-to-date.
  - Ensured that good IPC practice was followed during visits from journalists / film crews and others.
- Pathway development
  - Developed pathways for the identification and management of patients with possible or confirmed COVID-19, and modified these pathways in light of the current pandemic.
  - Developed strategies for discharge and deisolation of patients affected with COVID-19.
  - Reviewed the physical space of proposed isolation rooms, cohorting areas, emergency admission, inpatient, outpatient, 'red' and 'green', CPAP, critical care pathways.
- Staff testing

  - Supported the development of processes and procedures for the testing of symptomatic staff.
  - Developed plan for the testing of asymptomatic staff.
- Advice and guidelines
  - Supported decision making around IPC and AMS related issues and guidelines (e.g. specific PPE recommendations).
- Contribued to national and international expert advisory groups.
- Estates & facilities
  - Reviewed the need and provision of strategies (including physical barriers) to assist with social distancing in public / reception areas.
  - Developed mitigating plans for water hygiene management in conjunction with the Authorising Engineer for Water through the Water Hygiene Group.
  - Provided advice and support for specialist ventilation / modification.
- Supported the redeployment of Imperial College London researchers to clinical service or clinical service support roles (including critical care redeployment, pharmacy redeployment, microbiology redeployment, and co-ordinating COVID-19 research trials).

2 Healthcare-associated infection surveillance and mandatory reporting

There have been 21 hospital-associated ***C. difficile*** cases during Q4 (13 Hospital Onset, Healthcare-Associated (HOHA) and 8 Community-Onset, Healthcare-Associated (COHA) against a ceiling of 22 HOHA and COHA cases combined (Appendix Table 1; Figure 1). Overall, there have been 101 cases of hospital-associated *C. difficile,* against a ceiling of 77 for the period April to March 2019/20. There has been a single lapse during 2019/20 (in October 2019), compared with eight lapses in care during 2018/19. The rate of hospital-associated (HOHA and COHA) *C. difficile* cases was the second highest in the Shelford group based on April to February 2019/20 cases.

We have a comprehensive set of measures to minimise the risk of *C. difficile* infections. Our investigations have concluded that neither changes in patient demographics and associated risk factors, nor an increase in lapses in care related to transmission or antibiotic choices explain the increase in *C. difficile* infections during 2019/20. Some evidence emerged that use of proton-pump inhibitors (which increase the risk of *C. difficile* infection) in the community may have contributed to the increase in *C. difficile* infection; this is being explored in conjunction with the CCG.

There were no cases of Trust-attributed **MRSA bloodstream infection (BSI)** during Q4 from 8177 blood cultures tested. There have been three Trust-attributed MRSA BSI during 2019/20 (which is the same as during 2018/19). Compliance with MRSA admission screening was on target at 90% for Q4: 5813 of the 6488 patients identified as requiring MRSA screening were screened.

There have been nine cases of Trust-attributed **MSSA BSI** during Q4, compared with twelve during Q4 2018/19. There is no national threshold for MSSA BSI. Each case is reviewed by a multidisciplinary group (including the clinical team looking after the patient), and those related to a vascular access device are reviewed by vascular access specialists, in order to identify and implement learning from these cases. This has prompted additional teaching on the wards in relevant areas around vascular access device care, record keeping and promoting contacting the vascular access team for support. There has been no evidence of patient-to-patient transmission.

The number of Gram-negative ***E. coli*****, *Pseudomonas aeruginosa*****,** and ***Klebsiella pneumoniae*** **BSI** cases during Q4 2019/20 is summarised in Appendix Table 1. The Trust has met its 10% year-on-year reduction in Trust-attributed *E. coli* BSIs (an internal performance metric), with 73 cases during 2019/20, compared with 83 cases during 2018/19. Imperial's *E. coli* BSI rate ranks lowest in the Shelford group.
There were two Trust-attributed **Carbapenemase-producing Enterobacterales** (**CPE**) BSIs in Q4; a total of eight cases have been identified during 2019/20, compared with seven cases during

2018/19. Strategic plans to tackle Gram-negative BSIs have been largely put on hold due to the management of the COVID-19 pandemic; plans for Q1 of 2020/21 include:

- Continue to support NWL CCGs in developing plans to reduce Gram-negative BSI.
- Developing a series of interventions to improve urinary catheter management in order to prevent *E. coli* BSIs secondary to urinary catheter-associated UTI. This will include communications to staff around urinary catheter management and hydration, and working with the CCG to improve the antibiotic treatment of UTIs in the community by moving away from trimethoprim towards nitrofurantoin.
- Planning of interventions aimed at preventing *E. coli* BSIs in patients with cancer following the findings of the national audit.

The rate of **catheter line-associated BSI (CLABSI)** for Q4 has been delayed by COVID-19 and will be reported during Q1 2020/21. In the meantime, the rates of BSIs and 'contaminants'[1] continue to be monitored.

Rates of **surgical site infection (SSI)** remain below national benchmark rates following the selected elective orthopaedic procedures included in the mandatory national surveillance scheme (Appendix Section 8.2). The SSI rate following CABG and non-CABG procedures remains consistently above the national average over the past 12 months. Regular task-and-finish group meetings chaired by a cardiothoracic surgeon will recommence during Q1 2020/21.

Members of the new SSI surveillance and prevention team have been reallocated to COVID-19 management. We plan for them to return to SSI surveillance and prevention during Q1 2020/21.

The number of CPE identified each month has plateaued at between 50 and 80 each month. More than 95% of these samples are from screening specimens rather than from clinical specimens.

- CPE screening was maintained throughout the COVID-19 pandemic. Overall compliance with CPE admission screening was 83%, and >90% in the four specialties performing universal admission screening. CPE admission screening compliance is included by ward in the monthly *Harm Free Care* report. This provides a mechanism to prompt targeted improvement at ward level to address areas of low compliance.
- The results of the point prevalence screen of all inpatients for CPE will be shared following completion of analysis during Q1 2020/21.

3 Antimicrobial stewardship

The biannual antibiotic point prevalence study (PPS) of all 1,279 inpatients (based on a review of inpatients) was undertaken in January 2020 (see Appendix Table 2). Two of the three prescribing indicators were about the 90% target, and the % of antibiotic durations in line with policy or approved by microbiology/ID was 88% in the audit. For the first time, surgical prophylaxis was included as a prescribing quality indicator. 89% of the 71 patients received antibiotic prophylaxis prior to surgery.

Antimicrobial consumption has increased during Q4 (see Appendix Figure 3). An increase in Q3 and Q4 is in line with historical trends due to winter pressures; pressures related to COVID-19 may also have contributed to this increase.

Specific AMS activity related to COVID-19 includes:

- Managing the impact of national supply chain shortages for multiple antibiotics.
- Developing and launching: *Interim Guidance for initial antimicrobial management of adult patients with suspected or confirmed COVID-19 being admitted to ICHNT.*
- The Antibiotic Stewardship Cerner Dashboard has been used to target antimicrobial stewardship activities

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

The AMR and antifungal CQUINs have been suspended; however, data has been collected and will be submitted when the national submission site is reactivated.

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

We have a requirement that **ANTT competency assessment** is undertaken and documented for all clinical staff. Currently the compliance rate is 85.2% (7275/8538 clinical staff). The face-to-face ANTT competency assessment for new clinical staff has been temporarily replaced with a training video – this will return to face-to-face competency assessment as soon as is practicably possible.

The strategic work around improving **hand hygiene** compliance has been put on hold during the COVID-19 pandemic. This means that the bi-annual hand hygiene compliance audits have been deferred until later in the year.

5 Clinical activity, incidents, and lookback investigations during Q4

Most of the capacity of the IPC service has been directed towards the response to the COVID-19 pandemic. In addition to this:

- Two clusters of CPE were identified and managed in January 2020. These clusters included three patients colonised with *Citrobacter freundii* OXA-48 on a haematology ward and two patients colonised with *Citrobacter freundii* OXA-48 on a surgical ward.
- In January 2020 four patients developed infections associated with intraventricular devices. This investigation, led by neurosurgery, has been delayed due to the COVID-19 pandemic.
- In January 2020 two patients developed symptoms of norovirus whilst inpatients on a medical ward. Both patients were isolated and recovered quickly. A bay was closed for 4 days and no further cases were identified.
- In January 2020 four patients and two staff members developed symptoms of influenza on a medical ward. All recovered and there have been no further cases.

6 Compliance, policies, and risks

Issues with **cleaning** and **estates** standards continue to be identified. These have proved challenging during the COVID-19 pandemic, when cleaning demands have increased. IPC have supported the transition to the new in-house cleaning service.

We have two tiers of annual **core skills IPC training**: Level 1 for all staff and Level 2 for clinical staff. Compliance with Level 1 is 93% and 92% for Level 2. These improvements are in line with increases in compliance in all core skills, which is an output of focussed efforts by Divisions and Corporate services supported by the core skills team.

There have been no new **IPC risks** identified. Updated risks include:

- The water hygiene management risk has been updated to include the mitigating actions put in place to manage the risk of water hygiene during the COVID-19 pandemic.
- The hand hygiene risk has been updated to reflect the changes to the hand-hygiene improvement programme during the COVID-19 pandemic.
- The surveillance for HCAI risk has been updated to reflect changes to the plans to reduce Gram-negative BSIs, delayed surveillance for central line-associated BSIs, and plans to improve the identification and management of surgical site infection.

7 Other

Members of the IPC team have produced 7 peer-reviewed **publications** relating to applied research in HCAI and AMR during Q4.Members of the IPC/AMS team are also supporting a range of COVID-19 related national and international expert groups and committees.

Appendix

Healthcare-associated infection surveillance and mandatory reporting

	Apr-19		May-19		Jun-19		Jul-19		Aug-19		Sep-19		Oct-19		Nov-19		Dec-19		Jan-20		Feb-20		Mar-20		YTD	
	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	**No. cases**	YTD (ceiling)
Trust MRSA BSI	0	0	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**3**	0
Hospital onset- Hospital associated (HOHA)	3	-	7	-	10	-	6	-	6	-	5	-	9	-	6	-	7	-	8	-	1	-	4	-	**72**	-
Community onset-Hospital associated (COHA)	2	-	2	-	1	-	6	-	4	-	1	-	1	-	1	-	3	-	4	-	2	-	2	-	**29**	-
Total Hospital associated C.difficile cases (HOHA + COHA)	5	8	9	7	11	6	12	6	10	5	6	5	10	5	7	6	10	7	12	7	3	7	6	8	**101**	77
Trust *Escherichia coli* BSI	8	-	6	-	5	-	8	-	3	-	5	-	10	-	9	-	7	-	6	-	3	-	3	-	**73**	-
Trust MSSA BSI	2	-	1	-	1	-	5	-	2	-	1	-	3	-	3	-	5	-	2	-	3	-	4	-	**32**	-
Trust CPE BSI	0	-	0	-	2	-	1	-	3	-	0	-	0	-	0	-	0	-	1	-	1	-	1	-	**9**	-
Trust *Pseudomonas aeruginosa* BSI	2	-	4	-	2	-	5	-	4	-	2	-	5	-	3	-	5	-	1	-	1	-	1	-	**35**	-
Trust *Klebsiella* BSI	2	-	3	-	6	-	3	-	10	-	5	-	5	-	5	-	3	-	5	-	5	-	2	-	**54**	-

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

Table 1: HCAI mandatory reporting summary.

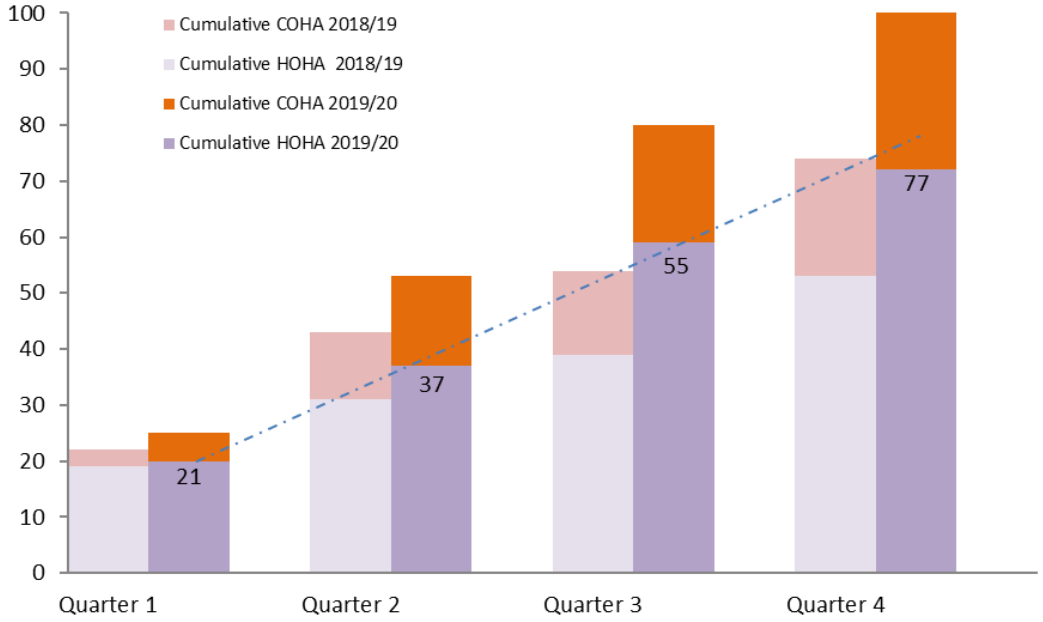

Figure 1: Cumulative hospital-associated C. difficile cases, by quarter 2019/20 (dark purple bars = HOHA, orange bars = COHA) compared with the corresponding categories in 2018/19 (light purple bars = HOAH, light orange bars = COHA).

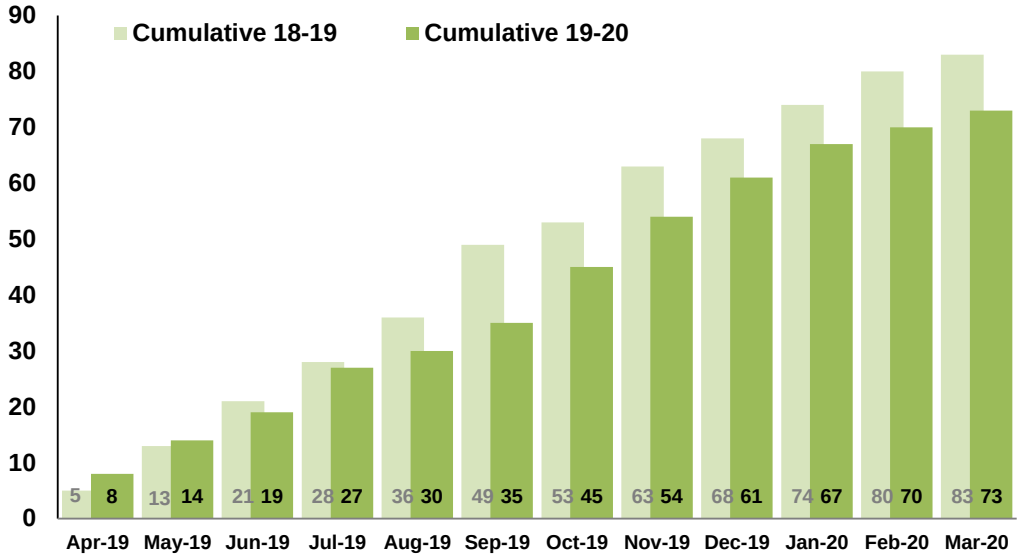

Figure 2: Cumulative monthly 2019/20 Trust-attributed E. coli BSI (dark green bars) compared to 2018/19 (light green bars).

Surgical site infection

Orthopaedics

The latest quarter with finalised submitted data (Oct-Dec 19 finalised data) has seen:

- Knee procedures: 0 SSI in 85 procedures; 12-month average is 0.3% (1 SSI in 361 operations); national average is 0.6%.
- Hip procedures: 1 SSI in 73 procedures; 12-month average is 0.4% (1 SSI in 283 operations), national average is 0.6%.

Cardiothoracic

The latest quarter with finalised submitted data (Jul-Sept 19 finalised data) has seen:

- CABG: seven SSI (7.8%) of 90 procedures; 12-month average is 8.0% (24 SSI in 299 procedures); national average is 3.8%. All six were superficial incisional SSIs.
- Non-CABG: zero SSI (0.0%) of 65 procedures; 12-month average is 2.5% (5 SSI in 199 procedures); national average is 1.3%.

Antimicrobial stewardship

Antimicrobial point prevalence survey (PPS)

Division	Number of patients on antimicrobial(s)/total patients seen (%)		Number of antimicrobials prescribed		INDICATOR A % antimicrobials in line with policy or approved by Microbiology/ID		INDICATOR B % review within 72 hours of initial prescribing		INDICATOR C % duration in line with policy or approved by Microbiology/ID		*INDICATOR D % surgical prophylaxis administered for patients who had surgery in the past 24 hours Jan 2020			
	Aug 2019	Jan 2020	*Aug 2019*	Jan 2020	*Aug 2019*	Jan 2020	*Aug 2019*	Jan 2020	*Aug 2019*	Jan 2020	Single dose	1 pre-op dose and 2 post op doses administered and stopped prior to audit	Surgery within past 24 hours and currently on antibiotics	No antibiotics administered
Trust Results	*533/1313 (41%)*	**570/1279 (45%)**	*899*	**1004**	*92%*	90%	94%	94%	94%	88%	**24/71 (34%)**	**4/71 (6%)**	**35/71 (49%)**	**8/71 (11%)**
Medicine	*252/632 (40%)*	**254/590 (43%)**	*375*	**423**	*92%*	91%	95%	94%	96%	91%	0/4 (0%)	0/4 (0%)	3/4 (75%)	1/4 (25%)
SCC	*186/380 (49%)*	**208/426 (49%)**	*353*	**389**	*89%*	88%	93%	93%	92%	85%	12/40 (30%)	4/40 (10%)	19/40 (48%)	5/40 (13%)
WCCS	*80/246 (33%)*	**87/213 (41%)**	*147*	**162**	*98%*	91%	98%	97%	95%	91%	10/20 (50%)	0/20 (0%)	9/20 (45%)	1/20 (5%)
Private	*15/55 (27%)*	**21/50 (42%)**	*24*	**30**	*87%*	89%	80%	81%	83%	80%	2/7 (29%)	0/7 (0%)	4/7 (57%)	1/7 (14%)
Trust Target					**90%**		**90%**		**90%**		(*: new indicator, no previous result)			

Table 2: Results from the bi-annual point prevalence survey of antimicrobial indicators

7.1.1 Antimicrobial consumption

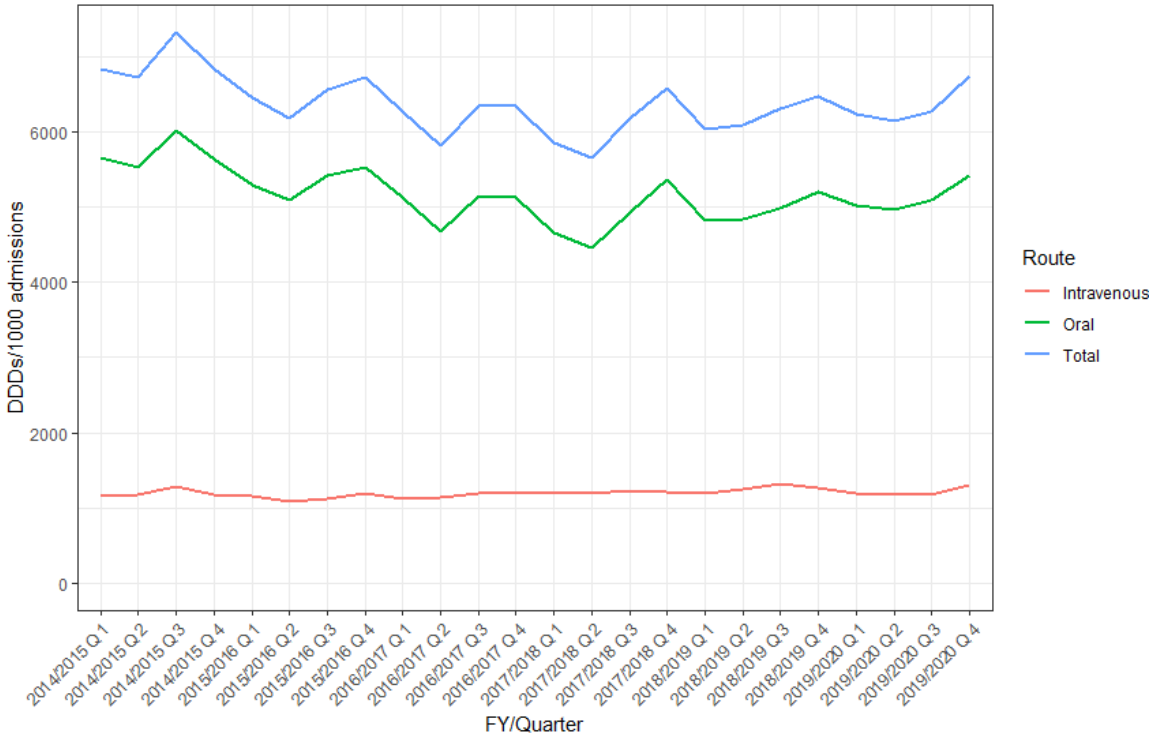

Figure 3: Trust-wide antimicrobial consumption (DDD / 1000 admissions) 2014/15 – present, including the split between intravenous and oral administration.

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TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Annual report of use of the Trust seal	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 20 May 2020	**Item 14, report no. 11**
Responsible Executive Director: Peter Jenkinson, Director of Corporate Governance and Company Secretary	**Author:** Jessica Hargreaves, Deputy Trust Secretary
Summary: The Trust's standing orders require that the use of the Trust seal is reported to the Trust board on an annual basis.	
Recommendations: The Trust board is asked to note the report.	
This report has been discussed at: N/A	
Quality impact: N/A	
Financial impact: No financial impact	
Risk impact and Board Assurance Framework (BAF) reference: Reporting use of the Trust seal enables review of the contracts, property agreements and other documentation that has been entered into during the year, acting as a control to reduce risk of misuse.	
Workforce impact (including training and education implications): N/A	
Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☐ No ☒ Not applicable	
What impact will this have on the wider health economy, patients and the public? N/A	
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No	
Trust strategic goals supported by this paper: ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do	
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No	

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Use of the Trust common seal April 2019- March 2020

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

Seal number	Parties ICHT and…	Nature of transaction requiring affixment of seal	Witnesses to affixment of seal	Date of affixment of seal
220	Imperial College Healthcare NHS Trust and Great Western Development Limited (GWDL)	Landowners agreement right of light release	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	3 June 2019
221	Imperial College Healthcare NHS Trust and Lauder and Rees Ltd	Lease agreement for premises at Charing Cross Hospital and Western Eye Hospital	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	10 June 2019
222	Imperial College Healthcare NHS Trust and AHSC	Joint working agreement to add Institute of Cancer Research to the AHSC	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	11 July 2019
223	Imperial College Healthcare NHS Trust and UK Broadband Ltd	A deed of variance to lease for an aerial cabin on the roof of Charing Cross Hospital tower	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	26 September 2019
224	Imperial College Healthcare NHS Trust and UK Broadband Ltd	A deed of variance for existing lease on the roof of QEQM at St Mary's Hospital by a telecoms operator.	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	26 September 2019
225	Imperial College Healthcare NHS Trust and Great Western Developments Ltd (GWDL)	An agreement of wavier and consent relating to rights of light from which the St Mary's Hospital site benefits over adjoining land owner by GWDL.	Professor Tim Orchard, Chief Executive Kevin Croft, Director of People & Organisational Development	18 October 2019
226	Imperial College Healthcare NHS Trust and UK Research and Innovation (UKRI) and London Borough of Hammersmith and Fulham	S106 agreement for land known as site of former cyclotron building and land adjacent Hammersmith Hospital (deed of indemnity).	Professor Tim Orchard, Chief Executive Kevin Croft, Director of People & Organisational Development	18 October 2019
227	Imperial College Healthcare NHS Trust and Children of St Mary's Intensive Care (COSMIC)	A lease of occupation for 15 years for parent accommodation.	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	8 November 2019
228	Imperial College Healthcare NHS Trust and National Westminster Bank PLC	A three year lease for an ATM at Hammersmith Hospital	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	6 February 2020

Seal number	Parties ICHT and…	Nature of transaction requiring affixment of seal	Witnesses to affixment of seal	Date of affixment of seal
229	Imperial College Healthcare NHS Trust and West Hertfordshire Hospitals NHS Trust	A three year lease for premises at Watford General Hospital to provide renal services.	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	6 February 2020
230	Imperial College Healthcare NHS Trust and Children of St Mary's Intensive Care (COSMIC)	New legal entity	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	6 February 2020
231	Imperial College Healthcare NHS Trust and Cuffe PLC	Power infrastructure upgrade contract at Charing Cross Hospital	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	6 February 2020
232	Imperial College Healthcare NHS Trust and ME Construction	Procurement and phased construction of new hybrid theatre	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	6 February 2020
233	Imperial College Healthcare NHS Trust and Cuffe PLC	A&E expansion and refurbishment at Charing Cross Hospital	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	6 February 2020
234	Imperial College Healthcare NHS Trust and Forest Gate Construction Ltd	Renal dialysis unit at Charing Cross Hospital	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	18 February 2020
235	Imperial College Healthcare NHS Trust and Sodexo Ltd	Settlement of contractual amount due to Sodexo on expiry of contract	Professor Tim Orchard, Chief Executive Jazz Thind, Chief Financial Officer	31 March 2020

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Trust Board – Declarations of Interests	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 20 May 2020	**Item 15, report no. 12**
Responsible Executive Director: Chief Executive Officer	**Author:** Peter Jenkinson, Trust Company Secretary

Summary:
As part of the annual process all board members were asked to confirm, and update where required, their declaration of interests submissions. This is part of an annual cycle of reporting to the Trust Board and publishing on the Trust's website.

Recommendations:
The Committee is asked to note this report.

This report has been discussed at: N/A

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

Financial impact: No financial impact.

Risk impact and Board Assurance Framework (BAF) reference: N/A

Workforce impact (including training and education implications): N/A

Has an Equality Impact Assessment been carried out or have protected groups been considered?
☐ Yes ☐ No ☒ Not applicable

If yes, are further actions required? ☐ Yes ☒ No

What impact will this have on the wider health economy, patients and the public? None.

The report content respects the rights, values and commitments within the NHS Constitution
☒ Yes ☐ No

Trust strategic goals supported by this paper:
- To build learning, improvement and innovation into everything we do

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers?
☐ Yes ☒ No
If yes, why?.....

Imperial College Healthcare NHS Trust

Trust Board – Declarations of Interests Report

1. Executive Summary

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

2. Purpose

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

3. Background

3.1. As part of the Trust's 'Declarations of Interests and Hospitality Policy' all Trust Board members are required to complete, or update, their declarations of interests submissions to allow this to be reported to the Trust Board on an annual basis and for the declarations to be published on the Trust website.

4. Summary/Key points

4.1. Paula Vennells – Chair:

- Morrisons PLC - NED 20 days per year from 2016;
- Dunelm PLC;
- Morrisons, Whitbread Shares.

4.2. Sir Gerald Acher – Deputy Chair:

- Chairman: Brooklands Museum Trust;
- Chairman: Chatterbus CIO;
- Chairman: Cobham Conservation and Heritage Trust;
- Trustee: Motability 10th Anniversary Trust.

4.3. Mr Peter Goldsbrough – Non-Executive Director:

- Non-Executive Director: R J Young (Properties) Ltd;
- Non-Executive Director: Jenkinsons Holding Ltd;
- Senior Advisor: The Boston Consulting Group;
- Visiting Professor: Institute of global Health Innovation, Imperial College London;
- Spouse: Non-Executive Director, NHS England.
- Trustee, Fidelity UK Foundation.

4.4 Ms Kay Boycott – Non-Executive Director:

- Chief Executive, Asthma UK & British Lung Foundation Partnership;
- Johnson & Johnson Shares;
- Asthma UK is a funder of research. Imperial College is a grant holder and may use ICHNT staff or facilities;
- Director and Trustee of Association of Medical Research Charities;
- Lay Member of Council for Durham University;
- Member of Public Health England Health at Work Advisory Board;
- Member of King's Fund General Advisory Council;
- Partner is an IBM employee (Healthcare and Life Science Consulting);
- Member of NHS Net Zero Expert Panel.

Imperial College Healthcare NHS Trust

4.5 Professor Andrew Bush – Non-Executive Director:

- Chairman: Publications Committee of the European Respiratory (Executive and Steering Committees);
- Emeritus Senior Investigator: NIHR;
- Various research grants (information available upon request).

4.6 Dr Andreas Raffel – Non-Executive Director:

- Member of the International Advisory Board – Cranfield School of Management;
- Deputy Chair – Change Grow Live (CGL);
- Member of Board of Trustees – University of Bristol
- Senior Advisor – Rothschild; Flagstone Investment Management; Moonfare

4.7 Ben Maruthappu – Non-Executive Director:

- CEO - Cera Care
- Board Member & Trustee – Skills for Care;
- Board Member – NHS Innovation Accelerator;
- Senior Advisor – Bain & Company;
- Advisory Group Member – Centene Uk.

4.8 Nick Ross – Non-Executive Director:

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

4.9 Professor Tim Orchard – Chief Executive Officer:

- Director: Imperial College Health Partners;
- Pharmaceutical Advisory Boards (adhoc): Vifor Pharma, Celgene, Abbvie and Ferring;
- Medical Advisor: NW London Crohn's and Colitis UK.
- Member of Panel of Experts - National Institute of Clinical Excellence.

4.10 Professor Julian Redhead – Medical Director:

- Outside employment with The Royal Society for the Prevention of Accidents;
- Medical Director: Fortius;
- Major Incident Doctor; London Ambulance Service;
- Outside employment with Chelsea Football Club;
- Shareholding and Ownership interests with Stadium Doctors Ltd;
- Shareholding and Ownership interests with Fortius Clinic;
- Shareholding and Ownership interests with Opus Clinic;

- CQC Inspector;
- Trustee: Imperial Health Charity;
- Private Practice: Fortius Clinic;
- Private Practice: Lindo wing.
- MD NWL Partnership
- Chair NWL Urgent and Emergency care Board
- Chair NWL Advice and guidance Board
- London Clinical Senate Board
- London Clinical Leaders Group

4.11 Jazz Thind – Chief Financial Officer:

- Substantive Finance Director of Oxleas NHS Foundation Trust
- Director – SARD JV
- Director – Oxleas Prison Services
- Director – The Oxleas Property Partnership

4.12 Professor Janice Sigsworth – Director of Nursing:

- Honorary professional appointments at: King's College London; Bucks New University; and Middlesex University;
- Trustee of General Nursing Council Trust and Clinical Adviser to the NMC of pre-registration midwifery standards;
- Chair of Shelford Safer Nursing Care Tool Board;
- Joint Chair Safer Nursing Care Faculty Steering;
- Member of Shelford Chief Nurses Group.
- National Lead – Embedding genomics into nursing and midwifery practice
- Chair – national blended learning, nursing and midwifery programme

5 Options appraisal including financial appraisal (as relevant)

5.1 None applicable.

6 Conclusion and Next Steps

6.1 None applicable.

7 Recommendations

7.1 None applicable.

Peter Jenkinson, Trust Company Secretary
25 March 2020

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC SUMMARY REPORT	
Title of report: Audit, Risk & Governance Committee **–** report from meeting on 29 April 2020	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 20 May 2020	**Item 16.1, report no. 13a**
Responsible Non-Executive Director: Sir Gerald Acher, Deputy Chair	**Author:** Jessica Hargreaves, Deputy Trust Secretary

Summary:

The Audit, Risk and Governance Committee was held on 29 April 2020. Key items to note from that meeting include:

External Audit
The Committee received an update on the status of the external audit and on key sector developments which would be considered as part of the planning and risk assessment. Committee members discussed the significant risks including 'going concern' and the impact that the COVID 19 pandemic would have on the Trust and sector as a whole.
Committee members noted the impact to the original submission dates and it was agreed that the draft accounts and report would be submitted to the external auditors on Monday 11 May 2020.

Internal audit
Committee members noted the annual reports for both internal audit and counter fraud for 2019/20 which included the proposed Head of Internal Audit annual opinion required by the Public Sector Internal Audit Standards, which was consistent with the previous year. It was noted that the COVID 19 pandemic had caused delays in the finalising of some reports throughout quarter 4 of 2019/10. The follow up audit into IT disaster recovery had been moved to quarter 1 of 2020/21 due to the pressures on the Trusts IT team in responding to the pandemic and getting Trust staff onto the remote working network. The Committee also reviewed and discussed the internal audit and counter fraud plan for the 2020/21 year.

Draft annual accounts
The Committee reviewed the draft annual accounts which had been submitted to NHSI on 27 April 2020, noting that all figures were subject to final management review and possible amendment before final submission, but that the reported outturn position included in the draft was not anticipated to change. Committee members were pleased to note that the Trust had met its external financing requirement and its capital resource limit. Committee members also noted that by delivering on its financial performance requirements, specifically improving on the control total target (before technical adjustments), the Trust will receive its core PSF (provider sustainability funding).

Draft annual report sections including draft accountability report, governance statement and quality account
Committee members were asked to review the draft annual report and provide comments back to the executive prior to submission to the external auditors. Committee members were pleased to note the more concise approach being taken this year and thanked the executive team for bringing the report together despite the current pressures.

Management of the risks emerging from the COVID 19 pandemic
Committee members noted the approach being taken to manage and report COVID 19 related risks and the adaptations to financial policies and processes during this time.

Tender waiver & Losses and special payments reports
The Committee received and noted a summary of the number of tender waivers since April 2019 and the controls in place.

The Committee will next meet on 27 May 2020.

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

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC BOARD SUMMARY	
Title of report: Report from Extraordinary Quality Committee meeting held on 29 April 2020	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 20 May 2020	**Item 16.2, report no. 13b**
Responsible Non-Executive Director: Professor Andy Bush, Non-Executive Director (Committee Chair)	**Author:** Amrit Panesar, Corporate Governance Assistant

Summary:

The Quality Committee met on 29 April 2020. Key items to note from that meeting include:

Update on COVID-19 and Recovery Planning
This was the main item of the Extraordinary Quality Committee focused. The Committee received a presentation on the Trust's response to COVID-19 and its recovery plan. The Committee discussed the presentation and acknowledged the key risks and issues being faced by the Trust during the pandemic but were reassured that the executive team were managing them. The Non-executive directors thanked the executive team for their dedication and hard work and Professor Bush commented that he was deeply impressed with the quality of the approaches being taken.

The papers for the remainder of the agenda items were noted but not discussed in detail.

Integrated Quality and Performance Report
The Committee noted the quality aspects of the performance report including; due to COVID-19 and changes in bed base, the reporting rate for March would be erroneously affected, therefore the incident reporting rate had not been reported for that month. An update would be provided the following month when bed day data would be available.

Key Divisional Quality Risks
The Committee noted that Divisional and Corporate key risks were largely focusing on the impact of COVID-19 and recovery planning.

Quality Section of the Annual Report
The Committee noted the quality section of the annual report. This year's Quality Account outlined progress against the eight quality improvement priorities agreed by the Board in May 2019. It also confirmed the priorities and targets for delivering the following year and the six improvement priorities for 2020/21 which mirror the Trust focussed improvement priorities agreed as part of the Imperial Management and Information System and the "Imperial way".

Revised Decision-making and Clinical Governance Structure in the Medical Director's Office in support of the Organisational Response to COVID-19
The Committee noted that five new work streams had been established to coordinate and direct the organisational response to COVID-19 which would be led by Professor Redhead. This revised structure was intended to provide and strengthen decision making and clinical governance, deliver improved support for ethical decision making and maximise the pace of assimilation of a rapidly evolving evidence base into practice, in support of an effective organisational response to COVID-19.

The five work streams are:
- The Clinical Reference Group
- Clinical Decision Support

- Junior Doctor and Medical Students Working group
- Medical Examiner, Death Certification and Registration Group
- CRG Working Group

Recommendations:
Trust Board is asked to note this summary.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC BOARD SUMMARY	
Title of report: Report from the Finance, Investment and Operations Committee meeting held on 13 May 2020	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 20 May 2020	**Item 16.3, report no. 13c**
Responsible Non-Executive Director: Dr Andreas Raffel, Non-executive Director (Committee Chair)	**Author:** Jessica Hargreaves, Deputy Trust Secretary

Summary:
The Finance Investment & Operations Committee met on 13 May 2020. Key items to note from those meetings include:

Financial performance, strategic plan update and STP capital update
Committee members noted the finance report for month 12 which highlighted that the Trust had ended the year £0.1m better than the control total, before provider sustainability funding (PSF) and an increase in the annual leave provision. The Trust had received £5.3m of funding to reflect additional revenue costs and loss of income relating to the COVID 19 response. The Committee were pleased to note that the Trust had met the external financing limit and its capital resource limit.

The Committee also reviewed the latest NHSI/E capital guidance and funding limits noting that there were separate processes in place to fund capital requirements related to the COVID 19 response which the Trust had followed for 19/20 and 20/21 expenditure. The North West London STP had been issued a capital envelope for 20/21 and Trusts were reviewing their capital plans; reassessing their draft submission and considering current circumstances, to see what, if any of the plans could be rationalised to close the gap.

The Committee reviewed and discussed the 'post COVID' view of the 20/21 plan, acknowledging that the national finance regime continued to unfold and noting the much stronger than usual uncertainty regarding next years' financial performance due to the COVID impact on operations, the possible reconfiguration of services within the sector and the evolving financial regime from the centre.

Business cases approved by the Executive
The Committee noted the business cases that had been approved by the executive from 1 March 2020 including business cases for capital expenditure related to the Trust's COVID 19 response which were reviewed by the executive at the daily gold command meeting and submitted to NHSI/E for funding approval in line with national policies.

Finance ledger system contract extension
The Committee noted the extension to the contract of the shared ledger system by 3 years which was part of the work streams of the NWL Provider and System Recovery Board was seeking to progress. This extension would support a seamless transition to a shared ledger system across the sector at a future date.

Recommendations:
To note this summary.

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TRUST BOARD – PUBLIC BOARD SUMMARY	
Title of report: Report from the Board Redevelopment Committee 15th April 2020	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 20th May 2020	**Item 16.4, report no. 13d**
Responsible Non-Executive Director: Paula Vennells, Committee Chair	**Author:** Ginder Nisar, Deputy Trust Secretary

Summary:

The Committee discussed the Terms of Reference for the Redevelopment Programme Board and the Board Committee, and the action to review the focus of the Programme Board with the aim of transitioning it into a Stakeholder Steering Committee to allow wider stakeholder engagement and focus on key streams of programme work.

The Committee reflected on discussions at the Programme Board covering the Programme Director's report on key activities which included updates on the business case, commercial activities, technical design, capital cost, planning and decant.

The Committee briefly discussed 'The Shaping Patient Experience with Patients' report, opening it up for comments and the subject of a future workshop.

Recommendations:
To note this summary.