Trust Board – Public

Wednesday, 14th July 2021, 11am to 1.30pm (10.45am to 11am join Microsoft Teams)
Virtual meeting via Microsoft Teams

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

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

AGENDA

Time	Item no.	Item description	Presenter	Paper / Oral
1100	1.	**Opening remarks** Welcome James Price, Director of Infection, Prevention and Control, Claire Hook as Chief Operating Officer**,** Andy Worthington, Deputy Director of Nursing (Strategy & Regulation), shadowing Director of Nursing	Bob Alexander	Oral
	2.	**Apologies:** Kevin Jarrold (Matthew Kybert representing), Frances Bowen (Jo Sutcliffe representing)	Bob Alexander	Oral
	3.	**Declarations of interests** If any member of the Board has an interest in any item on the agenda, they must declare it at the meeting, and if necessary withdraw from the meeting.	Bob Alexander	Oral
1105	4.	**Minutes of the meeting held on 12th May 2021** To approve the minutes from the last meeting	Bob Alexander	01
	5.	**Record of items discussed in Part II of Board meetings held on 12th May 2021 and Board Seminar 30th June 2021** To note the report	Bob Alexander	02
	6.	**Matters arising and review of action log** To note updates on actions arising from previous meetings	Bob Alexander	03
1110	7.	**Patient Story**	Janice Sigsworth	04

		To note the story and future plan for patient and staff stories		
1120	**8.**	**Chief Executive Officer's report** To receive an update on a range of activities and events since the last Trust Board	Tim Orchard	05
Operations / Performance				
1135	**9.**	**Acute Programme update (appendix to CEO Board report, item 8)** To receive an update on the activities of the programme	Tim Orchard	06
1145	**10.**	**Integrated quality and performance report** To note the month 2 report	Claire Hook Julian Redhead	07
1155	**11.**	**Annual Emergency Preparedness, Resilience and Response update** To note the annual report	Claire Hook	08
1205	**12.** 12.1.	**Finance report** To note the month 2 report **Estates Capital Projects 2020 – 2021 annual report** To note the annual report	Jazz Thind Hugh Gostling	09a 09b
Quality				
1215	**13.**	**Patient and public involvement: Strategic lay forum 2020/21 annual review and 2021/22 priorities** To note the report and support the Strategic Lay Forum priorities for 2021/22	Michelle Dixon, Trish Longdon , Chair Strategic Lay Forum	10
1230	**14.**	**Maternity quality assurance oversight report and CNST Board Declaration** To note the oversight report and approve the CNST Board Declaration	TG Teoh	11
1240	**15.** 15.1. 15.2.	**Infection prevention and control** **Infection prevention and control (IPC), and antimicrobial stewardship annual report 2020/21** To note the annual report **Infection prevention and control board assurance framework for COVID-19 – self-assessment June 2021** To discuss and note the report	Julian Redhead/ James Price	 12a 12b
1250	**16.**	**Complaints and PALS annual report** To note the annual report	Janice Sigsworth	13

Governance				
1300	**17.**	**Integrated Risk and Assurance report** To note the bi-annual report	Peter Jenkinson	14
1310	**18.**	**Trust Board Committees – summary reports** To note the summary reports from the Trust Board Committees		
	18.1.	Audit, Risk and Governance Committee, 17, 25th June and 7th July 2021	Kay Boycott	15a
	18.2.	Quality Committee, 8th July 2021	Andy Bush	15b
	18.3.	Finance, Investment and Operations Committee, 7th July 2021	Peter Goldsbrough	15c
	18.4.	Redevelopment Board Committee, 9th June and 8th July 2021	Bob Alexander	15d
	18.5.	People Committee, 6th July 2021	Ben Maruthappu	15e
1315	**19.**	**Any other business**	Bob Alexander	Oral
1320	**20.**	**Questions from the public**	Bob Alexander	Oral
1330 Close	**21.**	**Date of next meeting** 15th September 2021, 11am		

Updated: 13 July 2021

Public Trust Board
Draft Minutes of the meeting held on 12th May 2021, 11am
Virtual meeting held via Microsoft Teams and video-recorded.

Members present

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

In attendance

Dr Ben Maruthappu	Associate Non-Executive Director
Ms Beverley Ejimofo	NExT Director
Mr Peter Jenkinson	Director of Corporate Governance
Prof. Jonathan Weber	Dean of the Faculty of Medicine, Imperial College London
Mr Kevin Croft	Director of People and Organisational Development
Mrs Claire Hook	Director of Operational Performance
Dr Matthew Tulley	Director of Redevelopment
Dr Bob Klaber	Director of Strategy, Research & Innovation
Mr Kevin Jarrold	Chief Information Officer
Mr Hugh Gostling	Director of Estates and Facilities
Ms Michelle Dixon	Director of Communications
Prof. TG Teoh	Divisional Director, Women, Children and Clinical Support
Prof. Katie Urch	Divisional Director, Surgery, Cancer and Cardiovascular
Prof. Frances Bowen	Divisional Director, Medicine and Integrated Care
Ms Margaret Smedley-Stainer	Learning Disabilities Lead (for Item 7)
Mr Paul Doyle	Deputy Director of Transformation
Mrs Ginder Nisar	Deputy Trust Secretary (minutes)

Apologies

Prof. Andrew Bush	Non-Executive Director
Prof. Alison Holmes	Director of Infection Prevention and Control
Mr Jeremy Butler	Director of Transformation

Item	Discussion
1.	**Opening remarks**
1.1.	Mr Alexander introduced himself as the Acting Chair of the Trust whilst substantive arrangements were being discussed. He welcomed everyone to the meeting which was held virtually and where in person, was in keeping with social distancing guidelines. The Board meeting would be video-recorded and the recording uploaded onto the Trust's website. Members of the public had been invited to submit questions ahead of the meeting or ask questions at the end of the meeting via Microsoft Teams meeting. Members of the public were welcome to submit questions to the Trust Secretary at any time. Mr Jenkinson

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	outlined the etiquette for the meeting.
2.	**Apologies** Apologies were noted from those listed above.
3.	**Declarations of interests** There were no other declarations other than those disclosed previously.
4.	**Minutes of the meeting held on 31st March 2021** The minutes of the previous meeting were agreed.
5.	**Record of items discussed in part II of the Board meeting held on 31st March 2021 and 21st April 2021** The Board noted the summary of confidential items discussed at the confidential Board meeting held on 31st March and the Board Seminar on 21st April 2021.
6. 6.1. 6.1.1.	**Matters arising and actions from previous meetings** Updates against the actions arising from previous meetings were noted on the action register. In regard to a deeper Board discussion regarding outpatients, Mr Jenkinson explained that there had been a 'deep dive' review into outpatients at the Quality Committee, the highlights of which would be included in a future Board Seminar. This item would be closed from the Board action log.
7. 7.1. 7.2. 7.3. 7.4. 7.5. 7.6.	**Patient Story** Ms Smedley-Stainer joined the meeting for this item. She outlined the patient story in which making reasonable adjustments in line with the Autism Act 2009 and the Equality Act 2010, the impact on the patient was positive, whilst also equipping staff with the skills to deliver care in a safe environment, - this had been especially challenging during the Covid-19 pandemic. She commented that reasonable adjustments were individual, determined by the needs of the person and the services they were accessing. The Board noted that the learning disabilities and autism team had developed clear pathways to support staff in caring for patients with learning disabilities and autism, and central to these pathways was good communication and collaborative working. Ms Smedley-Stainer outlined the story of Mr AB who is a 31 year-old autistic man with learning disabilities, Attention Deficit Hyperactivity Disorder (ADHD) and end stage renal failure. He was referred to the Trust late last year as he needed a second kidney transplant. He did not have the capacity to understand why he needed the surgery and finds hospitals stressful environments which could manifest into more challenging behaviours such as 'pushing people away'. In November 2020, Mr Frank Dor, consultant transplant surgeon and clinical lead for transplants, contacted the learning disabilities team to inform them of Mr AB's pending pre-assessment appointment which enabled the learning disabilities team to contact their peers at the referral hospital and understand more about his needs before he came to the Trust. The consultant liaised with the multidisciplinary team to ensure that Mr AB only needed to attend one clinic appointment and to prepare the family and Mr AB for who they would meet and what would happen. Mr AB's father was grateful and had commented that it was obvious how hard the whole team had worked together as everything was perfectly timed and the assessments were 'artfully conducted so as to create no anxiety or distress for Mr AB. **The Board noted the report.**
8.	**Chief Executive Officer's briefing** Prof. Orchard presented his report, highlighting key updates on strategy, performance,

	leadership over the month and the focus of Trust business in response to Covid-19.
8.1.	**Reset and recovery**
8.1.1.	As the number of patients with Covid-19 continued to decline (54 latest), the Trust made good progress on resuming its planned care services and developing plans to address its waiting list backlog for non-time-critical care and to build on collaboration and improvements achieved through the pandemic. All planned care services were now operational.
8.1.2.	In line with the relaxation of national Covid-19 restrictions, the Trust had started to open up visiting for inpatients over and above the existing exceptions that had been in place during the pandemic in a safe and Covid-secure way. Patients would be able to have one named visitor, for one hour each day. Visits would be pre-booked with the wards to manage the numbers of visitors in the ward at any one time and in adherence with Personal Protective Equipment (PPE) guidance. In addition, both parents were now able to visit children at the same time and the number of relatives able to be with people at the end of life had been increased. The approach would continue to evolve during May as the national restrictions relax further.
8.2.	**Acute care programme**
8.2.1.	The Trust continued to work closely with its health and care partners across North West London to do more to harness collective resources, join-up care and reduce unwarranted variations in access and outcomes. This included establishing an Acute Care Programme Board across acute providers to guide and co-ordinate developments across all key operational areas with an immediate focus on making sure services were stepped back up in a way that prioritised clinical need and minimised the risk of Covid-19 infection while reducing waiting times and ensuring patients and local communities understand how best to access care and feel safe and secure in doing so. A first briefing on the programme was provided to the Board.
8.3.	**Covid-19 vaccination programme**
8.3.1.	As at 30th April 2021, the Trust had delivered 40,718 doses in total (23,595 first doses and 17,123 second doses) to its staff, health and social care colleagues across the sector and patients. For staff designated as frontline, 89.25% had received a first dose and 83% of these staff had received their second dose. National data released on 29th April showed the rate of vaccination uptake amongst all frontline health care staff in London at 90%.
8.3.2.	The Trust continued to facilitate 'vaccine hesitancy' conversations - contacting all its staff not recorded has having had their first dose of the vaccine.
8.4.	**Financial performance** An update was provided within the report and summarised at item 11 of these minutes.
8.5.	**CQC update**
8.5.1.	Since the last Board meeting, the CQC had not undertaken any further virtual assessments of Trust services and had not given any indication of virtual assessments planned for the Trust at this time. The CQC was expected to launch its latest regulatory strategy and framework for NHS Acute Trusts in May 2021. The Trust's Improving Care Programme Group would reconvene from 24th May 2021.
8.6.	**Research and innovation**
8.6.1.	The Board noted that the Trust was working on its stage one application for the latest National Institute for Health Research Biomedical Research Centre (NIHR BRC) open

	competition which was due to be submitted at the end of May 2021. NIHR BRCs focus on high-quality early translational and experimental research, with their aim to translate scientific breakthroughs with the potential to develop into new treatments, diagnostics and medical technologies for the benefit of patients, the public, and the wider health and care system. The Board noted the appointment of Prof. Waljit Dhillo, consultant endocrinologist, as the new Dean of the NIHR Academy.
8.6.2.	Supporting the Trust's approach to innovation, in partnership with Imperial Health Charity, the third round of the 'Innovate' programme had been opened to applicants from across the Trust who have innovative ideas and approaches to improving health and care.
8.7.	**Stakeholder engagement** The report outlined the meetings and communications with key stakeholders since the last Trust Board meeting.
8.8. 8.8.1.	**Celebrating success** The Board congratulated Ms Winny Thomas, Trust matron for quality and Black, Asian and Minority Ethnic (BAME) nurses and midwives network Chair, who was awarded the Chief Nursing Officer for England's gold award for nursing excellence in recognition of her lifetime of achievement in nursing. As co-founder and now Chair of the Trust's BAME network, Ms Thomas had driven change ensuring there were opportunities for BAME colleagues to develop and generate platforms for them to share their work. She has continued this work on top of her day job as the Trust's matron for quality. With her leadership, a more reflective and dynamic culture of equality, diversity and inclusion had evolved at the Trust.
8.9.	Comments from the Non-Executive Directors:
8.9.1.	Dr Maruthappu congratulated Ms Thomas and also the Trust on achieving 90% of the vaccination programme. He enquired about plans to get to 100% uptake, particularly those in the BAME group. Prof. Orchard and Prof. Redhead advised that teams were engaging with those groups of staff who were hesitant and were going above and beyond national guidelines to persuade people to have the vaccine, noting that the requirement could not be mandatory as not mandated by the Government. They advised that those staff who were not vaccinated would need to be risk assessed in terms of the area they worked in.
8.10.	**The Board noted the report from the Chief Executive.**
9. 9.1.	**Integrated Business Plan 2021-22** The report outlined the 2021-22 national priorities and operational planning guidance which set out the priorities for the year ahead, against a backdrop of the challenge to restore services, meet new care demands and reduce the care backlogs that were a direct consequence of the pandemic, whilst supporting staff recovery and taking further steps to addressing inequalities in access, experience and outcomes. These priorities strongly aligned with the strategic direction of the Trust, and the priority areas of work set out in the March 2021 Trust Board strategy update paper.
9.2.	National planning guidance issued on 25th March 2021 set the approach to the 2021/22 planning round.
9.3.	The Board noted that effective partnership working across systems was deemed critical with the financial framework arrangements designed to support a system-based approach to funding and integrated business planning. The Trust plan would form part of the overall

	North West London Health and Care Partnership Integrated Care System (NWL ICS) plan which would include all NHS providers and commissioners in NWL with final submission due on 3rd June 2021.
9.4.	The Board received a summary in respect of the components of the Integrated Business Plan, namely, activity and operational performance; financial performance (including income expenditure and capital); and workforce. The overall risks and mitigations were set out in the paper underpinned by the core priorities of the Trust and in the context of the ICS, as well as continuing to place quality as the defining outcome of Trust work and strong user focus. These three cross-cutting approaches would significantly strengthen the Trust's response to the new CQC strategy. The Trust would use the routines and rigour of the Imperial Management and Improvement System (IMIS) as its operational mechanism to deliver these core priorities.
9.5.	The Executive Team continue to review and refine the plan with a view to formulating a final position by 19th May 2021.
9.6.	The Board was asked to approve the next steps of the development of the Trust's Integrated Business Plan, and to approve the current draft financial plan of a deficit of £6.6m noting that NWL ICS required that all providers within the sector achieve a breakeven position for the first half of the year. A draft version of the Integrated Business Plan had been discussed at the Finance, Investment and Operations Committee (FIOC).
9.7.	Comments from the Board:
9.7.1.	In respect of diagnostic waiting times, Dr Raffel enquired why waiting times were holding the Trust back and commented that the bed occupancy situation appeared to be relaxed, therefore enquired about the reconciliation between the two. Mrs Hook advised that the overall diagnostic waiting time data included some complexities and although there were no concerns in imaging within diagnostics, the areas of pressures, predominately those that were stood down during the pandemic, were neurophysiology, sleep studies and endoscopy - actions were in train to work through these areas in a prioritised way. In terms of bed occupancy, Prof. Orchard added that beds were not the limiting factor and over the last two/three weeks the Trust had seen an increase in its Emergency Department (ED) activity. The issues that were holding the Trust back in regard to elective care were theatre activity as well as other areas of the pathway.
9.7.2.	Mrs Boycott commented that it was helpful to see the plan through the different lenses. Noting that it would be a challenging year ahead, she sought to understand what it would feel like in December form a user's perspective, taking into account their experience during the Covid-19 surge phases.
9.7.3.	In terms of the risks and mitigations, Mrs Scavazza enquired how the Trust would continue to support staff whilst balancing reset and recovery and asked for a temperature check on how staff were feeling and whether the health and wellbeing initiatives were working.
9.7.4.	Responding to the questions from the Non-Executive Directors, Dr Klaber advised that one of the Trust's strategic goals was to be an organisation that was continuously learning and agreed it was important to ascertain the negatives and positives for patients and staff through feedback and to then take different approaches to how the Trust delivered care, mindful of community settings for staff and users.
9.7.5.	Prof. Orchard added that winter would present a number of challenges including how the

	Trust would be funded which impacted planning for the second half of the year. In terms of how patients would feel, it was hoped that the Trust, through early engagement with communities around their expectations in winter, would address potential challenges. He stated that if ED activity continued to increase it would present a problem therefore vital that the ED remains decompressed compared to two years ago. This would be achieved through active engagement with the local population through different approaches to appointments and procedures to clear the back log and keep ED's clear. He stressed that equity of access would not be compromised through these changes as they developed and that risks and mitigations would be clearly determined.
9.7.6.	In terms of staff, Prof. Orchard informed the Board that regular staff briefings, pulse surveys, the new 'improve well tool' amongst other avenues would continue as mechanisms for feedback and that the people metrics would be closely monitored weekly as well as at the bi-monthly People Committee. He commented that Teams was a helpful tool and enabled extended reach of the senior management. Prof. Redhead added that from feedback to him, staff were grateful for the focus on their health and wellbeing from the Trust and the public.
9.7.7.	Ms Dixon commented that the scale of the challenges within the pandemic had presented an opportunity to engage more with staff and partners and it was important to maintain these channels of communication and engagement whilst adapting to changes. The increased level of engagement and interest from staff had not been previously seen. In terms of the ICS changes, two lay members were members on the Acute Care Programme Board.
9.7.8.	Mr Ross commented that how staff were feeling was variable and that it was important for staff to see senior management around the hospital and he suggested restarting the Board member visits programme which was a helpful engagement tool for the Board and staff. Mr Alexander agreed that it was important to commence these visits as soon as practically possible. Prof. Orchard advised that as the government restrictions ease, he and Mr Jenkinson would revisit this but it would be essential for the Non-Executive Directors to have had both vaccinations and adhere to social distancing and PPE guidelines before commencing with the programme of visits. **Action: Prof. Orchard and Mr Jenkinson**
9.7.9.	Mr Alexander commented that it was important to note that planning for 2021-22 had been driven by national circumstances and the particular approach taken by the sector of what was expected. He stressed that it was important that the Trust identifies some dedicated time to focus on the medium term resource perspectives such as CQC, redevelopment and bring those together in a planned way mindful of the sector ask.
9.8.	**The Board approved the direction of travel and the development of the Integrated Business Plan and approved the initial deficit plan for the first half of the year.**
10.	**Integrated quality and performance report**
10.1.	The Board received an update on the Board metrics covering the Trust's strategic goals, priority programmes and focussed improvements. The scorecard was for data published at month 12 (March 2021).
10.2.	The Board noted the updates against referral to treatment, diagnostics, cancer waiting time, urgent and emergency care and quality (safe and effective) and also noted the counter measure summaries for incident reporting rate; patients waiting over 52 weeks for treatment; cancer waiting times 62-day performance; ambulance handovers; and long length of stay.

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10.3.	The Board were asked to note that from the following month, key metrics from the NHS operational planning guidance for 2021/22 would be added to the Board scorecard with a small number of existing metrics removed. Further metrics would also be added in-year from the internal review of priority programmes and projects.
10.4.	Mrs Hook summarised the performance which was broadly as expected after a challenging year. There was a significant backlog of elective care and the Trust was anticipating an increase in the number of patients waiting for more than 52 weeks until July after which time some of the work underway would come to fruition. Work was ongoing around the trajectories for other performance standards which would be available for the next report to Board. Good progress was being made and all services which had restarted at the end of April. The Trust cancer performance data for March indicated some improvement against the standard.
10.5.	Focusing on Quality, Prof. Redhead summarised that the Trust was one of the safest Trusts in the country with the lowest SHMI and HSMR rates. The harm profile, although having seen a small increase, remained within tolerance levels and cases predominately related to pressure ulcers during the pandemic and learning from these was underway. Due to a change in regulations with falls reporting, the rate had increased. He stressed that it was important for the Trust to maintain a culture of high reporting and low harm and this remained a focus. He reported three never events, none of which had caused any harm and had been reported timely and openly by staff which was an important feature of a safety culture. Immediate and wider actions were underway including learning from the incidents.
10.6.	Comments from the Board:
10.6.1.	Mr Ross commended the efforts of staff and senior management over the past year. He enquired about contingency arrangements in the event of another surge. Prof. Redhead and Prof. Orchard assured the Board that planning was underway for another wave referencing local and national modelling. They advised that the vaccination programme uptake had been good with research evidencing reduced hospital admissions, reduced transmission and reduced levels of sickness and that currently there was no evidence that the vaccine was not effective against the Covid-19 variants.
10.6.2.	In regard to cancer waiting times, Dr Raffel commented that there were differences in performance for the different cancer types and asked whether there was an underlying reason. Prof. Urch advised that most of the delays were as a consequence of alterations in the cancer diagnostic pathways from wave 1 and wave 2 creating capacity problems and confirmed that some were a small number of tumour types. The Surgery, Critical care and Cancer (SCC), Medicine Integrated Care (MIC) and diagnostics teams (particularly in Gastrointestinal pathways) were working closely looking at streamlining and maximising diagnostics and importantly telling patients they do not have cancer. Breast referrals had increased by 200% and the Trust had exceeded its capacity to manage the two week pathway. Therefore sometimes the numbers were small and sometimes high and it was a case of remodelling the diagnostic pathways accordingly.
10.6.3.	Mr Alexander enquired about the 30 day action plan for 7 day working in pathology and whether there was something the executive could assist with further. Prof. Urch advised that funding had been secured for 7 day working in pathology which had improved the turnaround position significantly, including recruiting staff to support the histopathology pathway. Weekly meetings continue to monitor.

10.7.	**The Board noted the report.**
11. 11.1.	**Finance report** The Board received an update on the year-end reported financial position of the Trust for the full financial year, subject to audit. The financial performance had been discussed previously at FIOC.
11.1.1.	For the 2020-21 financial year the Trust achieved a breakeven position. The Trust met the £15.8m deficit plan, with £15.8m additional funding received from NHS England and NHS Improvement (NHSE/I) to cover lost income to bring the Trust to breakeven. The Trust incurred costs in excess of the plan to support the pandemic which was offset by lower costs for other clinical activity.
11.1.2.	The Trust spent 100% of its capital plan of £78.2m in-year and spent a further £7.7m on schemes funded by charity and national donations, resulting in a total capital spend of £85.9m for the year. The Trust's cash balance at the end of March was £149m driven by the funding regime for 2020-21 which included cash to repay loans and deficit funding.
11.1.3.	The draft accounts for the 2020-21 financial year were submitted on 27th April 2021. Final audited accounts would be presented on 15th June 2021.
11.1.4.	The Trust was currently conducting a planning round for the first six months (H1) of 2021-22 following guidance received from NHSE/I at the end of March 2021, with the first draft submission made by the ICS on 6th May 2021. The ICS had been set a financial funding envelope for H1 and was expected to live within this envelope. The Trust was working with the sector to develop an achievable plan within the funding available.
11.1.5.	**The Board noted the report.**
11.2. 11.2.1.	**Annual accounts and annual report** The Board **approved** the delegation of authority to the Audit, Risk and Governance Committee (ARG) to approve the annual accounts and annual report for 2020-21 on behalf of the Board. ARG would sign off on 11th June 2021 and would bring to the Board's attention any significant issues arising between now and then.
12. 12.1.	**Annual self-certification for NHS Trusts** Mr Jenkinson summarised the annual self-certification which provided assurance that NHS providers were compliant with the conditions of their NHS provider licence. Compliance with the licence was routinely monitored through the NHS Oversight Framework but, on an annual basis, the licence required 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 ▪ <u>for NHS Foundation Trusts only</u>, the required resources available if providing commissioner requested services (CRS) (condition CoS7).
12.2.	Through the 'business as usual' governance arrangements in place across the Trust, including Executive and Board Committees, assurance had 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 Executive team reviewed these assurance statements and the proposed compliance declarations, and agreed to recommend the proposed declarations for the two conditions. The Board was therefore asked to approve the proposed declaration of compliance as follows:

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	▪ Condition G6(3) - “Not later than two months from the end of the Financial Year (by 31 May 2021), the Trust Board (‘the Licensee’) is required to self-certificate to the effect that it “Confirms” or “Does not confirm” that it has taken all precautions necessary to comply with the licence, NHS acts and the NHS Constitution.” It was recommended that the Trust Board formally sign-off the Self-Certification for Condition G6 as “Confirmed”. ▪ Condition FT4 (4) - “By 30 June 2021, the Trust Board is required to self-certificate “Confirmed” or “Not confirmed” to compliance with required governance standards and objectives.” It was recommended that the Trust Board formally sign-off the Self-certification for Condition FT4 as “Not confirmed for (a) and confirmed for (b-h)”.
12.3.	Responding to Mr Alexander’s question regarding the implications of taking a fully compliant approach in the context of regulation, Mr Jenkinson advised that from a system oversight perspective and from an NHSI perspective, the Trust had in the past been subject to regulatory undertakings but that these had been removed in the last couple of years and the Trust’s segmentation had improved, both of which reflected the performance and improvements made by the Trust. The impact of the Trust declaring partial compliance would not affect the Trust’s overall regulatory position and was in line with other Trust submissions around business planning and its risk profile.
12.4.	**The Board approved the proposed declaration compliance statements.**
13.	**Maternity Quality Assurance Oversight Report**
13.1.	The Board received the assurance report on quality of care and an update on the progress against achieving compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) year 3 and progress against achieving compliance with the seven Ockenden immediate and essential actions (IEAs) noting that the peer review process was completed and an action plan was in place to enable evidence submission along with a risks and mitigation register. The CNST MIS declaration would be presented to the July 2021 Board for approval. The report had been discussed at the Quality Committee.
13.2.	Prof. Teoh added that following audit assessments, even though the Trust had reduced its Band 6 midwife vacancy rate, he was concerned with regard to the future workforce impact on midwives. The reason being that following the Ockenden Report, there was a call for additional midwifery recruitments to be funded. Recruitment of these midwives would be from a small pool, therefore would be competitive and may affect the vacancy rate. He also informed the Board that there had been three serious incidents as reported within the report. All three were sadly unavoidable.
13.3.	Mrs Boycott relayed her comments from the Quality Committee in that there was a large volume of information and the need to focus the work looking at this from different lenses with the aim of producing a dashboard. Prof. Teoh and Prof. Redhead would review the presentation of the information and report (action already captured within the Quality Committee action log) in the context of a learning organisation. The information provided assurance as did the outstanding rating for maternity services which places the service in good standing and attractive to potential employees.
13.4.	**The Board thanked the midwifery team for producing the comprehensive report during operational pressures and noted the assurance report.**
14.	**Infection, Prevention and Control (IPC)**
14.1.	**IPC and Antimicrobial Stewardship Quarterly Report**

14.1.1.	The Board received the quarter 4, 2020-21 report and noted the following highlights. The report had been discussed at the Quality Committee. ▪ IPC expertise continued to be integral to decision making during the Trust management of Covid-19. The NHSE Board Assurance Framework for the Trust's IPC structures and activity related to Covid-19 was updated monthly. Processes for the management of possible Covid-19 outbreaks in patients and staff were agreed and implemented. ▪ 61 Covid-19 transmission incidents/outbreaks were identified and managed since July 2020, when formal Trust reporting commenced. ▪ 19 hospital-associated C. difficile cases reported during quarter 4, this was below the quarter 4 ceiling of 22 cases. There had been one lapse in care related to cross-transmission. ▪ 3 Hospital-associated MRSA BSI reported during quarter 4. A review of key contributory factors and development of an action plan was in progress. ▪ The Trust met its 10% year-on-year reduction in Trust-attributed E. coli BSIs, and continue to report the lowest rate of Trust-attributed E. coli BSI in the Shelford group of hospitals. ▪ The rate of central line-associated bloodstream infections (CLABSI) in the neonatal and paediatric ICUs remained below benchmark levels. The Trust was unable to report on the CLABSI rate in the adult ICU for the quarter 3 and 4 period due to Covid-19 surge management. ▪ The antimicrobial stewardship initiatives introduced during quarter 4 to counteract a rise in overall antimicrobial consumption and especially in intravenous agents, reduced overall and intravenous consumption during. ▪ Non-Covid-19 clinical activity and incidents included a number of incidents involving likely cross-transmission of different organisms in the ICUs across the Trust, an increased incidence of Pseudomonas aeruginosa in the neonatal ICU, and 13 communicable disease 'look back' investigations. A total of 18 serious incidents were declared during quarter 4, three of which related to non-Covid-19 outbreaks in the ICUs. A bi-weekly review of actions to manage IPC risk in the ICUs was ongoing. An Estates-led task and finish group had been commissioned to explore ways to tackle the contaminated water outlets in the neonatal ICU at St Mary's hospital. ▪ The Trust responded to two external directives in quarter 44, one related to promoting best-practice use of ultrasound gel, the other a national alert related to Becton-Dickenson (BD) intravenous administration sets.
14.1.2.	Mr Alexander enquired about the interventions in quarter 4 to address rises in antimicrobial consumption and whether those interventions would be recurrent or one-offs. Prof. Redhead advised that the intervention would be recurrent with the aim of ensuring not to overuse antibiotics as during surge of Covid-19 there had been an increase in the use.
14.1.3.	As services begin to open, Mr Alexander enquired whether there were any concerns around community infections. Prof. Redhead advised that the NHS have been asked to adhere to the two meter rule until advised otherwise. National guidance would be kept under review and the Trust would continue to monitor community and hospital acquired infections.
14.1.4.	**The Board noted the report.**
14.2.	**IPC Board Assurance Framework (BAF) Report**
14.2.1.	This report provided an update on progress with completion of the actions required to provide assurance with all elements of the BAF. This was a live document including the

	self-assessment from April 2021. The report had been discussed at the Quality Committee.
14.2.2.	An action plan was in place to undertake the necessary work that would improve Board assurance related to IPC management of Covid-19 infection. This was being monitored weekly at the Clinical Reference Group reporting to the Executive Management Board through the Medical Director as the Executive lead.
14.2.3.	Good progress was being made in general but two areas that remain "red" rated were highlighted as requiring additional executive support (FFP3 mask management and Covid secure management of non-clinical areas). A review meeting had taken place on 4th May 2021 and the agreed actions and next steps presented to the Executive huddle were being taken forward. A revised checklist would be developed for local areas to complete to confirm their Covid secure status. A four-week schedule of assurance visits would begin in mid-May to check compliance. Feedback would be monitored by the Executive huddle. A plan for FFP3 mask management was in place.
14.3.	**The Board noted the report.**
15.	**Learning from Deaths Report**
15.1.	The Board received the updated dashboard outlining activity undertaken as part of the Learning from Deaths programme in quarter 44 2020-21. The report had been discussed at the Quality Committee.
15.2.	The Trust receives mortality alerts via the Dr Foster analytics services. These alerts relate to cases where death(s) had occurred that required further investigation. Two alerts had been received regarding: viral infections which included Covid patients – the Medical Director's office discussed the measure for that alert and the Trust was not an outlier in this respect. Overall mortality rates for expected outcomes in respect of deaths during the first wave had been shared by Dr Foster with the Trust and were being reviewed. The second alert was around clip and coil aneurysms - the cases associated with these alerts were being reviewed and outcomes would be included in the next report.
15.3.	There were a total of 688 deaths in the reporting period. Of these, 363 were in January 2021, at the peak of the second wave of the pandemic, with 181 and 144 in February and March respectively. Of the 688 deaths, 357 patients died with a positive Covid-19 swab within 28 days of death or Covid-19 was recorded on the medical certificate of cause of death. So far, none of the deaths which occurred in quarter 4 2020-21 were identified as 'avoidable' through the processes outlined in the report. The Board noted that the Trust continued to have the lowest mortality rates in the country.
15.4.	There were 39 deaths in quarter 4 2020-21 where the patient's infection met the Public Health England definition of Hospital Onset Covid-19 Infection because they tested negative for Covid-19 on admission and subsequently tested positive more than seven days after their admission to hospital. Structured Judgment Reviews (SJRs) were being undertaken for all of these cases. The outcome of the SJR was triangulated with information from IPC, and post infection reviews (PIR) and outbreak serious incident investigations in order to confirm causation and the level of impact/harm from the cross transmission - closure requires completion of each review. Two cases had been closed and the harm level had been confirmed as low for both. The remainder would be closed as SJRs, SIs and PIRs were completed.
15.5.	The Board noted that the Trust was working to improve its processes so that it could ensure deaths were reviewed more quickly, and better identifying, sharing learning and

	implementing actions to improve as a result. This had been delayed due to the pandemic, but would be fully implemented in quarter 1 2021-22.
15.6.	The findings from the Trust's mortality surveillance programme from quarter 4 2020-21 would be submitted to NHS England following approval by the Executive and sign off by the Quality Committee on 6th May on behalf of Trust Board.
15.7.	**The Board noted the report.**
16.	**Annual Review of Board Committee Terms of Reference and Board Governance Update**
16.1.	The report provided an update to the Trust Board on its governance, effectiveness review process and to request Trust Board approval of the Board Committee Terms of References. The recommendations arising from the 2020 review of effectiveness in July 2020 had been considered and a number of changes were made to the Terms of References and the cycle of business and in addition, new Board routines and the People Committee were established.
16.2.	Next steps would include the production of annual reports for each Committee and the effectiveness review which would be undertaken after quarter 2 to allow the Committees to run for a six month period which would allow feedback to reflect the new routines. For this year, the outcome of the Committee effectiveness review would be reported separately from the Committee annual reports. The Committee annual reports would be reported to the Audit, Risk and Governance Committee which has overall responsibility for oversight of the Trust assurance framework.
16.3.	The Terms of Reference would be kept under review during 2021-22, to reflect any changes required to reflect the development of governance arrangements in relation to the ICS and acute provider collaboration. A review would be completed following the completion of the effectiveness review.
16.4.	It was agreed to invite all Non-Executive Directors to the Board Committees as attendees where they were not formal members or regular attendees.
16.5.	Mrs Boycott commented about the number of attendees at meetings and the time spent in meetings by Executive and Non-Executive Directors, suggesting assessing this across Committees over a six week cycle. She questioned this in terms of time commitment, particularly in light of people's involvement with the ICS programme. Mr Alexander asked that Committee Chairs in their first cycle of 2021-22 consider attendance at the respective Committees and feedback to Mr Jenkinson – this would feed into the effectiveness review noting the need to balance Executive and Non-Executive Director attendance at Committees. In parallel Mr Alexander would like to better understand the pull on individuals in terms of the ICS work. **Action: Committee Chairs, Mr Jenkinson**
16.6.	**The Board approved the Committee Terms of Reference which had been reviewed and recommended for approval by the respective Committee. The Board agreed with the proposed approach to the Committee annual reports and effectiveness review timelines.**
17.	**Trust Seal Annual Report** The Board **noted** the annual report of the use of the Trust Seal.
18.	**Trust Board Committees – summary reports**
18.1.	**Audit, Risk and Governance Committee** The Board noted the summary points from the meeting held on 26th April 2021.

18.1.1.	Mrs Boycott added that the Committee was in year-end and annual report mode and was progressing well.
18.2. 18.2.1. 18.2.2.	**Quality Committee** The Board noted the summary points from the meeting held on 6th May 2021. Mrs Boycott added that the conversations around the quality account were interesting with helpful focus for the coming year. The Committee had a risk deep dive into estates maintenance and redevelopment through the quality lens which was helpful with good debate on how the Board understands the current and future impact on quality on the Trust estate. There was clear assurance that the estates team were doing a good job in mitigating the risks given the challenges, however the quality risk continued and there was a need to think about how that was being articulated and quantified.
18.3. 18.3.1. 18.3.2.	**Finance, Investment and Operations Committee** The Board noted the summary points from the meeting held on 5th May 2021. Dr Raffel added that the high degree of uncertainty on planning was known. The continuation of the ICS discussions was important, particularly the impact on Trust financial and operational performance which would flow into Trust planning.
18.4. 18.4.1. 18.4.2.	**Redevelopment Committee** The Board noted the summary points from the meeting held on 6th April 2021. Mr Alexander pointed out that the Redevelopment Committee would meet less regularly (every two months rather than monthly) to enable teams to focus on project work and produce definitive reports. Also the Redevelopment Committee would lead on sustainability going forward.
18.5. 18.5.1. 18.5.2.	**People Committee** The Board noted the summary points from the meeting held on 4th May 2021. Ms Scavazza referred to the three Trust priorities as highlighted in the report which were the right priorities. She commented that this was the right time for the Trust to focus on workforce. She pointed out that WRES and Equality, Diversity and Inclusion (EDI) were challenging referring to the EDI Committee and other positive initiatives. She commented that racism was systemic and the journey was long – recognising that the establishment of the People Committee was a good first step, all individuals must change their behaviour to increase the impact of the EDI work.
19.	**Any other business** No other business.
20.	**Questions from the public** There were no questions from the public.
21.	**Date of next meeting** 14th July 2021, 11am

Updated: 18 May 2021

TRUST BOARD (PUBLIC)

Paper title: Record of items discussed at the confidential Trust board meeting held on 12th May 2021 and Board Seminar, 30th June 2021

Agenda item 5 and paper number 02

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

Purpose: For information

Meeting: 14 July 2021

Executive summary

1. Introduction

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

1.2. The Trust Board has met in private on two occasions since the last meeting on 12 May and 30 June 2021.

12 May 2021 Private Trust Board

2. Chair's briefing

2.1. As part of the Chairman's oral update, the Board received an update on discussions between north west London provider trust chairs' about greater collaboration and working together to identify risks, mitigations and possible joint governance arrangements. The Board also acknowledged the importance of collaborating on work relating to approaches led by Professor Briggs (Chair of Getting it right first time (GIRFT) programme) on productivity gains from elective recovery work.

3. Chief executive's update

3.1. As part of an oral update, the Chief Executive confirmed that the whole executive team were fully engaged with the sector acute programme. In respect of GIRFT, he advised that the executive team would review our own progress to understand where we need to apply more focus. The Board noted an update on the Royal Brompton merger. The Board noted that the CQC was consulting on its strategy and inspection methodology and the Trust would engage with them in an effort to have our quality improvements fully recognised with an improved CQC rating overall - the Improving Care Steering Group had been reinstated to support this. The Board received an update on the Health and Safety Executive (HSE) visit to NWL Pathology (NWLP) and the action plan in place.

4. Provision of a Managed Service Contract for Molecular Testing for North West London Pathology Network

4.1. The Board noted that NWLP was seeking a managed service partner(s) in the design and implementation of a laboratory molecular diagnostics service within Infection and Immunity Sciences at its hub at Charing Cross Hospital with further small scale rapid molecular diagnostic testing in five 'spoke' laboratories located in North West London hospitals (Hammersmith Hospital, St Mary's Hospital, Chelsea and Westminster Hospital, West Middlesex Hospital, Hillingdon Hospital). The Board considered the options appraisal and the recommendation from the Finance, Investment and Operations Committee, and approved the award to the preferred supplier.

5. West London Children's Healthcare Memorandum of Understanding

5.1. The Board noted that in November 2018, Imperial College Healthcare NHS Trust Chelsea & Westminster Hospital NHS Foundation Trust and Imperial College London set out, as part of 'Healthier Hearts and Lungs', their joint commitment to developing an integrated children's hospital network for North West London and a new academic centre for child health. Subsequently, plans to coordinate the two trusts' paediatric services under a single governance structure and to establish strategic partnership with other north west London providers of health and wellbeing services for children and young people have been developed. The Board received a memorandum of understanding (MOU) which set out the proposed bilateral arrangements between Chelsea and Westminster and Imperial College Healthcare, and the approach to integrating paediatric services. This approach is being developed to align with the evolving ICS structures. The Board noted the changes impacting paediatric service delivery across London; noted the progress made; and approved the bilateral MOU.

6. Redevelopment update

6.1. The Board received an update on the redevelopment programme and noted the key areas of work, The New Hospital Programme (NHP) Round Table took place on 5th March 2021. Following feedback, the Board discussed next steps including progress on re-submitting the Strategic Outline Case (SOC) for St Mary's. Relevant sections have been reviewed by the Quality Committee and Finance, Investment and Operations Committee. Phase 1 of the Charing Cross and Hammersmith Hospital development planning was complete. Phase 2 would commence when funding for the NHP was confirmed. The Board noted the key risks around decisions and funding to support the continued redevelopment programme as well as the continuing significant failure of the existing estate.

7. Acute Programme update

7.1. The Board received an update on the NWL Acute Programme established with the aim of developing and delivering a strategic recovery and reset plan for the next 12 months, and establishing a shared view of collective aims. The aims set out in the papers would be delivered through an agreed set of workstreams, including: Elective care; Critical care; Urgent & emergency care; Outpatients; and diagnostics and imaging. The Programme Board was chaired by Prof. Orchard. The Board received a summary of each Programme Board meeting held to date.

30th June 2021 Board Seminar

8. The Board received an update on the Trust's strategic priorities in the context of the development of the ICS and acute collaborative; an update on Redevelopment activities; and an update on the development of commercial and innovation initiatives. The Board also took part in a facilitated Equality, Diversity and Inclusion Board Development session.

TRUST BOARD (PUBLIC) - ACTION POINTS REGISTER, Date of last meeting 12 May 2021

Updated: 7 July 2021

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	12 May 2021 9.8.4	Board Member Visits (arising from Integrated Business Plan 2021-22 discussion)	As government restrictions ease, Prof. Orchard and Mr Jenkinson would revisit the Board member visit programme. July 2021 update: Work was progressing to update the Board member schedule to be launched at the end of July.	Mr Jenkinson	July 2021
2.	12 May 2021 16.5	Attendance at meetings (arising from Annual Review of Board Committee Terms of Reference and Board Governance Update item)	Mr Alexander asked Committee Chairs in their first cycle of 2021-22, consider attendance at the respective Committees and feedback to Mr Jenkinson – this would feed into the effectiveness review noting the need to balance Executive and Non-Executive Director attendance at Committees. July 2021 update: As part of the effectiveness review (commencing in July), Board members will be invited to comment in respect of attendance at Committees.	Committee Chairs, Mr Jenkinson	September 2021

Items closed at the May 2021 meeting

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	25 Nov 2020 8.7.7	New ways of accessing healthcare and information (arising from CEO report)	Mrs Boycott enquired whether the Trust was making sure every channel was being used to communicate the messages to educate people around the new ways of accessing healthcare and information. Ms Dixon would provide an update to the Board (via email) around the new ways of accessing healthcare and information. May 2021 update: We are leading on communications and engagement for the Acute care programme. Our communications plan for the programme is evolving and includes a range of activities across all audiences to build awareness and understanding of changes that have taken place and to embed involvement in the development of further changes. Immediate priorities for patients and the public include: making changes to patient letters and updating patient information about how we have been prioritising waiting list backlogs and ensuring safety and to let anyone waiting for care know about relevant changes, such as the introduction of 'fast-track surgical hub'; a 'mini' public campaign to promote NHS 111 First; working with outpatient transformation teams to review patient information and 'user journey' for virtual consultations. The latest communications plan is available to provide more detail.	Ms Dixon	Closed
2.	31 Mar 2021 8.12	Covid-19 vaccinations (arising from CEO report)	Mr Goldsbrough enquired about the 80% of staff vaccinated figure and asked whether what the figure would be if the 'not eligible staff' were discounted from that figure. Prof. Orchard advised that the approach taken by the Trust was to vaccinate all members of staff and he would check the proportion of staff compared with front line staff which was thought to be approximately identical in percentage. May 2021 update: Staff who are not eligible are included in the compliance data, therefore already in the percentage. Through our hesitancy calls we have been able to improve data quality with regards to non-eligible colleagues, therefore there is more confidence that the figure is accurate.	Tim Orchard, Julian Redhead	Closed

3.	31 Mar 2021 9.5	Organisational strategy review and refocus – priorities for the year ahead	The Non-Executive Directors noted the important link between developments and finances and the way in which the priorities were proposed to be managed. In the future it was important to ensure resources were deployed appropriately and the extent the work could itself drive benefits. The next iteration to be more explicit and also include new models of care and be realistic about what can and cannot be achieved or may take a longer period of time. May 2021 update: The integrated business plan is an agenda item and the paper within this meeting.	Dr Klaber	Closed
4.	25 Nov 2020 8.7.9 12 May 2021 6.1	Outpatient discussion (arising from CEO report)	The Board suggested discussing outpatients in detail at a future Board or Board Seminar. May 2021 update: In regard to a deeper Board discussion regarding outpatients, Mr Jenkinson explained that there was a deep dive into outpatients at the Quality Committee, the highlights of which would be included in a future Board Seminar. This item would be closed from the Board action log.	Prof. Teoh, Mr Jenkinson	Added to Board Seminar Forward Planner

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

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

TRUST BOARD (PUBLIC)

Paper title: Patient Story

Agenda item 7, paper number 04

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

Purpose: For information

Meeting date: 14 July 2021

Executive summary

1. Purpose

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

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

2. Introduction and background

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

2.2. This paper will be presented by a senior nurse who works at the Trust and experienced first-hand the impact of COVID-19. She will describe the journey she made as she became increasingly unwell, frightened for her own life, to sharing her experience to encourage colleagues to have the vaccination.

2.3. The story will focus on the patient perspective through the lens of a healthcare practitioner. She will describe her experiences and how she has used this to reach out to others in similar situations.

3. Key findings

3.1. It is well reported that there are a number of factors that increase the risk of developing COVID-19, including age, pre-existing co-morbidities and ethnicity. There is a disproportionate number of mortality and morbidity amongst black, Asian and minority ethnic (BAME) groups who contracted COVID-19 (PHE 2020). This is reflected in the

significant number of those from a BAME background who were admitted to intensive care units (ICNARC 2020).

3.2. Health care professionals were also at increased risk of contracting COVID-19 and a further study published in the BMJ (2020) reinforced the disparity in ethnicity amongst healthcare professionals, with 63 percent of the sample being from a BAME background.

3.3. Vaccination rates for the first dose of a coronavirus (COVID-10) vaccine were lower among all ethnic groups compared with the White British population (ONS May 2021).

3.4. This story will describe the lived experience of a senior nurse. She is young and does not have any pre-existing comorbidities. She is from a BAME background. Her story will highlight how debilitating COVID-19 is and how important it is for all staff reflect upon this when considering the need for the COVID-19 vaccination.

4. Future plans

4.1. The Board has been receiving patient stories in a variety of forms since 2014. These have provided the Board with an insight into the experience of patients being treated and cared for within the organisation. Excellent clinical practice has been highlighted as have areas for improvement.

4.2. Following recent discussion at the Executive People Committee and the importance of staff wellbeing and engagement, it is felt that there would be benefit in the Board hearing stories from Trust staff as well as patients. The focus being how the trust learns from the experience of what it is like to work here as well as what is it like to be cared for and treated here.

4.3. At the next board meeting, a member of staff will present their experiences of working in the organisation. In the future there will be a mix of patient and staff stories.

5. Recommendation(s)

5.1. The Board is asked to note the patient story.

5.2. The Board is asked to note the future plan for staff stories to be shared with the Board.

6. Next steps

6.1. This important story will continue to be shared and the trust will continue its programme of staff vaccination.

7. Impact assessment

7.1. There is no impact arising from the paper, but it is hoped that in sharing the story there will be greater awareness of what it is like to suffer from COVID-19 and how it affects the individual.

<u>Main report</u>

8. Patient story

8.1. Roxanne works as a senior nurse in the Trust. In January 2021, she became very unwell and was confirmed as being positive for COVID-19. Roxanne has a child at home with chronic health problems and as such had access to a pulse oximeter machine, which measures your oxygen levels in your blood. She was very breathless at home and so used this machine. Her oxygen levels were reading at 74 percent (normal range >95 percent in air for an adult). She initially assumed this was a machine issue and changed the batteries, her reading did not change.

8.2. Roxanne called an ambulance and required urgent admission to the high dependency unit at her local hospital. During this time she describes how she felt scared for her family and was especially worried that her daughter may also become unwell.

8.3. Roxanne explains how uncomfortable the treatment was, making it difficult to tolerate, so she required sedation. She recalls having hallucinations whilst in the unit, where she felt she could walk, yet her body was unable to move. She lost her ability to communicate, to think clearly and describes feeling totally debilitated.

8.4. After a week, she was discharged home to continue her treatment and recovery. She was still receiving oxygen and couldn't walk or barely speak. She describes the impact on the whole family and how scared they all were. At her lowest point, Roxanne decided to write a note for her family in case she died.

8.5. During this time, she remained in close contact with her local hospital and the Trust. After a few days at home it was evident she was not recovering and required further hospitalisation. At this point, the clinicians at Charing Cross Hospital communicated with her local hospital and arranged for her to be cared for in the Trust.

8.6. Roxanne describes how initially it felt daunting being cared for in her own hospital, but that the support she received from colleagues made all the difference. Her own family could not visit during this time due to visiting restrictions; however her colleagues or 'Imperial family' as she describes them, looked after her, bringing in food and magazines and offering comfort and support.

8.7. Roxanne reflects on the physical and emotional impact of COVID-19. She describes a level of exhaustion were everything was an effort, talking, thinking, every movement. She explains that although she knew about COVID-19 and the risk factors, she had not considered how badly it could affect her as she is young and healthy, her main risk factor was her ethnic background.

8.8. Roxanne's experience highlighted how vulnerable we all can be. As she says, she 'wouldn't wish it on anyone' and is determined to be an advocate for the importance of the vaccine by sharing her experience with staff who may not have seen or lived with COVID-19.

9. Conclusion and next steps

9.1. Vaccination rates amongst people from a BAME background have been lower than White British people both in the community and within the healthcare sector. There are many contributing factors to this including historical concerns and socio-economic reasons for example.

9.2. A recent government report (May 2021) indicates that whilst vaccine confidence has steadily increased, 30 percent of Black or Black British adults reported vaccine hesitancy, the highest compared with all ethnic groups.

9.3. This story highlights the crippling effects of COVID-19 on a previously healthy person from a BAME background. Roxanne has implored her colleagues to learn from her experience and to take positive steps in looking after their own health and well-being by having the vaccination.

9.4. To date she has shared her experience at the Trust BAME network with a positive impact, resulting in a number of staff immediately arranging to be vaccinated.

9.5. The trust has been proactive in encouraging staff hesitant to get the vaccine through extensive information on the intranet, webinars and videos which address the concerns and myths surrounding the vaccination programme. There are also a number of vaccine advocates who can support particular groups in their decision making.

TRUST BOARD (PUBLIC)

Paper title: Chief executive's report

Agenda item 8 and paper number 05

Executive Director: Prof Tim Orchard, Chief executive

Purpose: For noting

Meeting date: 14 July 2021

Chief executive's report to Trust Board
This report outlines the key strategic priorities and issues for Imperial College Healthcare NHS Trust. It will cover:

- Operating plan, Covid-19 recovery and wave three planning
- Covid-19 vaccination programme
- Financial performance
- CQC update
- Redevelopment
- Research
- EDI update, including 'white allies' programme
- Stakeholder engagement
- Celebrating success

1. COVID wave three planning

Information regarding operational performance and recovery is included in the integrated quality and performance report.

There are concerns now about a potential third wave of Covid-19 infections as we have now seen the Delta variant becoming the dominant strain in the UK. This has meant that the ending of remaining lockdown restrictions is delayed, currently until 19 July.

The current prevalence of the variant does not mean that there will necessarily be a third wave of previous magnitudes, or that we will have numbers of patients similar to previous waves. As the vaccination programme has been very successful, the increased number of cases has not yet translated into a large increase in hospitalisations. But we must future proof ourselves for any potential surges and so a team of our staff, with partners across our wider sector, have been working together to ensure we have robust plans in place to manage any future waves.

Our staff plan, which will be completed shortly, looks at what we would like to keep and what we would like to improve on from previous waves, based on feedback. The plan focuses on:

- Emotional and psychological support
- Practical support such as food, parking and hotel accommodation

- Health and safety including occupational health and our staff helpline, infection prevention and control guidance, test and trace, Covid-secure workspaces and vaccination
- Having good access to PPE and ensuring relevant staff are fit tested
- Redeployment and de-deployment, with wellbeing being key to our approach
- Support for staff who live alone or who are shielding
- Our decision making arrangements, should we need to revert back to a Gold command structure.

We have also been looking at how we can rapidly expand our acute respiratory and critical care units again to manage any significant increase in demand, working alongside NHS and local authority partners.

The number of critical care beds required across the sector – which we are finalising currently – is intended to allow us to care for patients with Covid-19 while also continuing to provide elective care to those who need it, safely.

2. Covid-19 vaccination programme

As of the end of June 2021, our in-house vaccination programme has delivered more than 24,500 first doses and over 21,800 second doses to our staff, health and social care colleagues across the sector and patients. Considering eligible staff designated as frontline, over 8,953 (91%) have had their first dose, this includes staff who have advised us that they have been vaccinated outside of the Trust. Of these, 7,889 (93%) have had their second dose and we are supporting the remainder to complete their course as soon as possible. Our operational model has changed as the number of unvaccinated staff continues to reduce; we are now running clinics two days a week on two sites, while supporting sector-wide initiatives to increase accessibility of the vaccine within the community, including running community clinics on weekends in June and July as part of the ‘Grab a jab’ scheme.

We are now starting to plan how we will deliver booster vaccinations for staff in line with national guidance as it becomes available.

3. Financial performance

The Trust has set a plan for the first six months of the financial year (‘H1’ which runs from April 2021 to September 2021) in line with national guidance. The North West London Integrated Care System (NWL ICS) agreed that all organisations would set a breakeven plan, with funding to be made available by the ICS to cover lost non-NHS income, contingent on the Trust ensuring it has exhausted all other avenues to achieve a breakeven plan. Within our H1 plan, there is a requirement to deliver a cost improvement programme (CIP) of £15.8m of which £4.1m had been identified at the end of May.

In line with national guidance, the Trust has a block income contract but will be funded for elective work above trajectories through the elective recovery fund (ERF). This income is non-recurrent and any contribution may be used to mitigate the shortfall in CIP.

For the 2 months to the end of May 2021, the Trust delivered an underlying deficit position of £4.6m (before ERF). This is £2.4m behind the year-to-date (YTD) planned deficit of £2.2m and has been fully offset by non-recurrent ERF (£8.7m).

The Trust has set a capital plan of £52.7m for the year. Year-to-date the Trust has spent £3.4m (38%) of its agreed capital plan, however this underspend is largely due to timing, and it is expected that the full plan will be achieved within the financial year. At 30 May, cash was £150.4m. The future cash outlook is robust in the medium term but the full-year forecast is

highly dependent on the funding regime for the second half of the year which has yet to be published.

4. CQC update

The CQC's new strategy for 2021-26 was published on 27 May. Their methodology for implementing the strategy has not yet been published, so there is limited information about the practical impact the strategy will have on how the Trust will be assessed by the CQC going forward. The CQC announced, on 14 June, the launch of a pilot programme to test some of its proposed new methodology (originally scheduled to take place in early 2021 but suspended due to the second wave of Covid). The pilot began on 14 June with GPs and will be rolled out from 13 July 2021 for all other sectors, except NHS trusts and dentists. The CQC has indicated that it is currently only scheduling inspections in the pilot for independent (private) trusts / services that are considered higher risk i.e. where there are concerns. However it has not indicated when new methodology may be piloted and/or ready to use for NHS trusts.

The Improving Care Programme Group (ICPG) was reconvened on 24 May 2021, after being stood down during the pandemic. We have revised our approach and methodology for quality improvement and preparations for CQC engagement / inspection, to embed our quality improvement (QI) and transformation in the approach. To further embed continuous improvement, ICPG is shifting to a quality-based approach. The CQC standards have been mapped to six quality questions:

1. What is the service trying to achieve?
2. How well is the service currently performing?
3. How does service performance compare to others?
4. Does the service provide equitable care across its populations?
5. Where is there unwarranted variation in the service?
6. How is the service improving over time?

Three levels of quality assurance and improvement have been identified:

- Trust level (including Trust-wide focused improvements such as hand hygiene, mandatory and statutory training, medicines management). Presentations of performance against CQC standards to ICPG began on 5 July
- Service / directorate level. Presentations of self-assessment against CQC standards to ICPG began on 21 June
- Ward level (the 'unit of change' in delivery of the 'basics of care'). Presentations to ICPG are being developed in alignment with Pathway to Excellence work and begin on 13 September.

In August 2021, we will start developing a combination of desktop review (the Trust's version of virtual assessments) and peer review (with site visits).

The Trust's chief pharmacist had their annual engagement meeting with the CQC on 16 June, to review key lines of enquiry regarding medicines management. The Trust's medication safety officer also attended the meeting. Feedback was very positive.

The Trust had its regular quarterly engagement meeting with the CQC on 23 June, which was in two parts: the first session was with the renal service, followed by the Trust level 'well led' session. Feedback from both sessions was very positive. The CQC indicated that it does not have any current concerns about either the renal service or Trust leadership and have not flagged any other areas of concern.

5. Redevelopment

Having worked very closely with the national New Hospitals Programme team over a number of months, we have submitted, in draft, a revised business case for the redevelopment of St Mary's. The case looks in detail at the size and location of the proposed redevelopment and demonstrates that the proposal is affordable, value for money and delivers significant benefits. We are working with the national team to look at ways in which the redevelopment could be phased to deliver early benefits to the programme.

The next stage of the Charing Cross and Hammersmith hospitals redevelopment planning is getting underway. It will start with a detailed review of stakeholder requirements including engagement with staff and patients.

6. Research

Patient recruitment to Covid-19 urgent public health clinical research studies continues (more than 6,300 to date) although is decreasing with declining patient admissions. We also continue to recruit and follow up healthy volunteers into vaccine studies, and have begun the world's first human challenge study with the SARS-COV-2 virus. Analysis and interpretation of data is also a priority and new research reports have been published recently by Imperial authors, including on the number of people likely living with 'long COVID', treatment options for the Covid-related multi-inflammatory syndrome seen in children, and how artificial intelligence tools can help to predict and manage the care needs of Covid patients in intensive care.

We recently submitted stage 1 of the re-application for our NIHR Biomedical Research Centre (BRC). This is a competitive bid for up to £100m over the period 2022-2027, to continue cutting-edge, proof-of-concept experimental medicine and to translate new scientific discoveries into patient benefits. We expect to hear the outcome of our initial proposal at the beginning of August. We carried out an equitable and inclusive process to recruit new theme leads for the BRC, which has resulted in more diverse demographic of leaders.

A number of annual reports have been submitted to NIHR in recent months, highlighting the science carried out in the 2020/21 year across all our NIHR infrastructure awards – the Clinical Research Facility, Patient Safety Translational Research Centre, In Vitro Diagnostics Co-operative, Experimental Cancer Medicine Centre and Biomedical Research Centre. We have seen a number of grant applications submitted, and awards received, for the career development of nurses, midwives, allied health professionals and psychologists, in line with our strategy to increase the number of research-active staff in these important 'non-medical' careers. Imperial has also been successful in attracting funding from NHSX for a number of high-profile projects involving artificial intelligence (AI).

The North West London Clinical Research Network (CRN) has also submitted its annual report to NIHR. Hosted by the Trust, the NWL CRN provides support and funding for research delivery staff 'on the front line' – the research nurses, practitioners and midwives who invite, consent and care for patients throughout their participation in clinical trials. The CRN hosting contract has been extended to 2024 and a national consultation is now open to inform the future of the CRNs nationally. As of 31 March 2021, North West London NHS Trusts had recruited 30,091 participants to urgent public health studies (excluding REACT 2), and are ninth highest nationally when recruitment is measured per 100,000 population. Over 80% of non-Covid research studies (which were paused during the pandemic) have now re-opened. We are aiming to promote more research studies to under-served populations, with the aim of increasing participation from these communities, in order to ensure the validity of findings for the whole population.

7. EDI update

There have been many notable achievements and milestones completed in the last few months which include launching recruitment for our participation in a new national disability leadership programme, Calibre. Eight Trusts across the ICS will take part in the programme with us.

We have improved our ethnicity data by updating 1,100 staff records and also shared design plans for a new diversity dashboard. Business Disability Forum and Employers Network for Equality and Inclusion membership have commenced. A board development seminar was held in June and we have concluded our reverse mentoring programme, with programme evaluation due to commence in July. We have procured a training provider for our race equity training programme and been successful in securing a place on the White Allies, NHS London development programme for six of our senior leaders.

8. Stakeholder engagement

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

- Cllr Tim Mitchell, Westminster City Council: 13 May 2021
- Cllr Ben Coleman, London Borough of Hammersmith & Fulham: 14 May 2021
- Nickie Aiken MP: 18 May 2021
- Cllr Rachael Robathan, Westminster City Council: 25 May 2021
- Karen Buck MP and Andy Slaughter MP: 8 June 2021
- Healthwatch Hammersmith & Fulham: 22 June 2021
- Hammersmith & Fulham Save our NHS: 12 July 2021

9. AGM and annual report

We are holding our virtual AGM this evening (Wednesday 14 July) when we also share our 2020/21 annual report

10. Recognition and celebrating success

Gratitude Festival

Gratitude Festival took place between 5 - 9 July, a week of activities and entertainment, supported by Imperial Health Charity, to say thank you to our staff for all they have done – and continue to do – through the pandemic. With as much of a festival feel as possible given infection prevention and control requirements, we have provided thousands of meals from food trucks on site; had attendances in the hundreds for each of our classes (virtual spa, Persian cookery and making cocktails), art and dance workshops and discussion events (research and sustainability); launched a brochure detailing special discounts for staff at local businesses, shops, activities and major attractions; and offered everyone a commemorative badge featuring exclusive artwork by acclaimed artist Julian Opie. We also ran three virtual ‘headliner’ events - virtual long-service awards, all-staff quiz with celebrity-hosted rounds, and our grand finale, Imperial’s Got Talent!

Queen’s Honours

I am delighted to report that four Imperial people are amongst those awarded honours in the Queen’s Birthday Honours list.

- Nick Ross, Non-Executive Director, has been awarded a CBE for his services to broadcasting, charity and crime prevention.

- Professor Alison Holmes, Infection Disease Consultant has been awarded an OBE for services to medicine and infectious diseases. Professor Holmes recently stepped down as Director of Infection Prevention and Control at the Trust after being in post for over 15 years to focus on her academic roles and in supporting applied research within the Trust.
- Professor Paul Elliott, Chair in Epidemiology and Public Health Medicine at Imperial College London and Honorary Consultant in Public Health Medicine at the Trust, was awarded a CBE for services to scientific research in public health.
- Professor Azra Ghani, Chair in Infectious Disease Epidemiology in the School of Public Health at Imperial College London has been awarded an MBE for services to infectious disease control and epidemiological research.

Awards
I would also like to congratulate Catherine Rennie, one of our consultant ear, nose and throat surgeons at Charing Cross Hospital, for making the ‘Women’s Engineering Society’s 2021 Top 50 Women in Engineering’ list.

Chief operating officer
I am delighted to report that Claire Hook has been appointed as chief operating officer. Claire will lead and co-ordinate operations functions across our clinical divisions and sites to ensure we continue to deliver the highest standards of treatment and care effectively and safely, meeting or exceeding national and local quality standards.

The Board felt it was now the right time to reintroduce the chief operating officer role to take up the oversight and co-ordination of our sites and clinical divisions as we move towards more integrated healthcare working at sector and regional levels. Claire joined the Trust in 2012 as divisional director of operations for medicine and integrated care. In 2018 she was appointed as director of operational performance, responsible for co-ordinating care pathways across the Trust and ensuring key operational and performance targets were met consistently. This post has now been superseded by the chief operating officer role. Claire began her new position on 1 July.

Director of Infection Prevention and Control
I am also pleased to report that Dr James Price has been appointed Director of Infection Prevention and Control. James is a consultant in infection prevention and control and antimicrobial stewardship. He joined the Trust in 2019. James takes over from Professor Alison Holmes, who stepped down after being in post for over 15 years. She will now focus more on her other academic roles and in supporting applied research within the Trust. Many thanks to Professor Holmes for all of her hard work and commitment.

Professor Tim Orchard
Chief executive
8 July 2021

Item 8, Appendix 1

North west London acute care programme update – July 2021

As part of the north west London integrated care system, the sector’s four acute NHS trusts established a joint acute care board and programme in March 2021. Building on the collaboration that has enabled us to respond so effectively to the Covid-19 pandemic, we want to do more to make the most of our collective resources and opportunities, join-up our care and reduce unwarranted variations in access and outcomes.

This approach recognises that, while we remain separate organisations, we are all now facing additional, shared challenges of long waiting times, worsened health inequalities and staff who have been working continuously under extreme pressure.

Our initial focus is on making sure we restore planned care and reduce our long waits as quickly as possible, while also continuing to prioritise by clinical need (including meeting urgent and emergency demand and preparing for a potential third wave of Covid-19 admissions), minimising the risk of Covid-19 infections, supporting staff health and wellbeing, reducing health inequalities and contributing to a financially sustainable sector.

We also want to work with patients and local communities, as well as our partners and stakeholders, in the development of longer term proposals so that we don’t simply return to ‘normal’ but draw on the expertise and energy of everyone involved to make real and lasting improvements that will serve us well for the future. This is especially important as we can expect more people to join our waiting lists as we emerge from the pandemic and we will continue to see growing health and care demand generally, as a factor of population changes and new diagnostics and treatments.

Key points

Planned care

- The acute programme has developed a single view of waiting across all of the sector hospitals to help provide more opportunities for patients to have surgery or other treatment more quickly, safely and efficiently. Currently, these opportunities include:
    - hospitals with more capacity providing care for patients waiting at other hospitals in the sector with long waits and less capacity
    - ‘fast track surgical hubs’ – 14 surgical facilities across the sector’s hospitals that have been dedicated to specific routine operations where evidence shows carrying out high volumes, systematically, improves quality and efficiency. The current focus is on six specialties which have the most ‘high volume, low complexity’ procedures – gynaecology; ophthalmology; ear, nose and throat; trauma orthopaedics; urology; and general surgery
    - increasing capacity - organising extra operating lists and clinics, including at the weekends and evenings in some cases, plus looking to external organisations to help us provide some of this additional capacity, primarily using our own facilities (also known as ‘insourcing’).
- The acute programme is also benchmarking the sector’s ‘high volume’ specialties against national GIRFT (getting it right first time) metrics to help focus improvements.

- As of May 2021, the sector's planned inpatient activity (including day and longer stay surgery) is at 76 per cent of pre-pandemic levels, above the national target of 75 per cent.
- The overall sector waiting list for planned care was 171,279 as of May 2021. Our clinicians continue to prioritise all patients according to clinical need, in categories established by the Royal College of Surgeons, and to regularly review for potential clinical harm.
- Over recent weeks, we have succeeded in making a significant reduction in overall 52 week waits, from a peak of 6,802 in February 2021 to 4,652 as of May 2021, though some very long waits remain – 1,280 over 78 weeks and 90 over 104 weeks. All of these very long wait patients now have a plan in place to receive their treatment as soon as possible.

Outpatient care

- The acute programme is overseeing the introduction of common approaches to providing GPs with advice and guidance from hospital clinicians to bring specialist care into consultations earlier and reduce unnecessary outpatient referrals. A new online system has been procured to support the provision of advice and guidance and will be rolled out gradually in partnership with GPs and our clinical teams.
- We are also beginning to pilot approaches to giving patients who have regular outpatient checks the ability to initiate follow up consultations as and when they feel they need them, rather than at specific intervals that we set in advance.
- We continue to offer virtual (video or telephone) consultations where possible and we will be exploring further engagement to understand how we can ensure the process and experience is as effective as possible for all of our patients.
- As of May 2021, the sector has increased its outpatient activity to 90 per cent of pre-pandemic levels, above the national target of 75 per cent.

Diagnostics

- As of May 2021, the sector has increased its diagnostic activity to 78 per cent of pre-pandemic levels, above the national target of 75 per cent.
- As of May 2021, 20 per cent of patients across the sector were waiting more than six weeks for a diagnostic test, against the usual national standard of 1 per cent.
- The sector has a particular challenge with echocardiography and neurophysiology waits and the programme is working through the best approach to bringing them down as soon as possible.

Urgent and emergency care

- Urgent and emergency care demand is currently above pre-pandemic levels for this time of year, with a similar picture across the sector.
- Imperial College Healthcare and Chelsea and Westminster are continuing to measure urgent and emergency waiting times as part of a national pilot of new metrics and so we are currently unable to publish this data in full for the sector.
- There is a review of urgent care pathways across the sector and a focus on expanding and maximising the effectiveness of 'same day emergency care'.

Critical care

- The current focus is on ensuring we are fully prepared for a potential third wave of Covid-19 hospital admissions, with the ambition to maintain as much planned care as possible if we do see a significant increase in urgent and emergency critical care demand.

Governance

- The acute care programme board reports into the North West London Integrated Care System chief executives meeting and partnership committee. There are sector boards for urgent and emergency care, critical care and elective care (incorporating additional diagnostics, cancer and outpatient transformation boards as well as the lead provider (elective) steering group).

Communications and engagement

- Long wait communications/engagement with patients and GPs – we are piloting a suite of letters and information explaining – and apologising for - long waits and providing background on prioritisation and initiatives to tackle long waits and ensure fair access, to help patients understand what is happening and what they can do.
- With input from patients and the public, we are finalising materials and communications to help raise awareness and understanding of the NHS 111 First approach – especially the ability of the service to book appointments in an A&E or urgent treatment centre for those who need one, to avoid waiting in busy areas.
- We have (or are) appointing lay partners to programme-related boards and have a workshop planned to support a more joined up approach to patient and public involvement across the sector.

TRUST BOARD (PUBLIC)

Paper title: Integrated quality and performance report - month 2 (May 2021 data) **Agenda item 10, paper number 07** **Executive Director: Claire Hook (Director of Operational Performance)** **Author: Submitted by Performance Support Team** **Purpose: For discussion** **Meeting date: Wednesday 14 July 2021**

Executive summary

1. Purpose of this report

1.1. This paper presents the integrated quality and performance report for month 2, summarising performance against the key performance indicators (KPIs).

2. Background

2.1. The enclosed scorecard presents the Board KPIs covering the Trust's strategic goals, priority programmes and focussed improvements. The scorecard is for data published at month 2 (May 2021).

2.2. Three countermeasure summaries are enclosed:

- CMS 1: Cancer waiting times – the percentage of patients who start their first treatment within 62 days of a GP urgent referral
- CMS 2: Patients spending more than 12 hours in the emergency department from time of arrival
- CMS 3: Improving long length of stay

3. Key findings

3.1. The Trust exceeded national minimum elective activity levels for April and May and also achieved the augmented operating plan trajectories for the majority of metrics. With the return of normal activity, our incident reporting rate has also increased and our harm levels remain below average.

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

4. Recommendation(s)

4.1. The Board is asked to note this report.

5. Impact assessment

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

the Board committees. Effective monitoring and oversight of KPIs through this report and the integrated performance scorecards will have a positive impact across all CQC domains.

5.2. Financial impact: Integrated Care Systems (ICSs) are responsible for delivering plans for elective activity, through a combination of core funding and extended funding that has been made available via the national Elective Recovery Fund (ERF). The ERF will be payable at a system level for achieving activity levels above the nationally set thresholds, as compared to 2019/20 baseline levels.

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

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

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

Main report

6. Updates made to the month 2 scorecard

6.1. Four new KPIs have been added to help monitor progress against the operational requirements of the NHS operating plan 2021/22. These are:

- Elective activity levels - % against trajectory {overnight and day cases}
- Outpatient attendance levels - % against trajectory
- Clinical prioritisation of the surgical waiting list -% prioritised
- Patients spending more than 12 hours in the emergency department

6.2. Finalised operating plan trajectories have also been embedded for two existing KPIs:

- Overall size of the elective waiting list
- Patients waiting more than 52 weeks to start consultant-led treatment

6.3. Further KPIs may be added in-year, including those arising from the internal review of priority programmes and projects.

7. Month 2 performance

Operating plan 2021/22 – performance and activity update

7.1. The Trust exceeded the national minimum activity levels for April and May. We have also achieved the augmented operating plan trajectories for the majority of metrics,

with the exception of a shortfall in day case activity in May and an increase the number of patients waiting over 63 days on a cancer pathway.

7.2. Day case activity is expected to return to the target level for June. The cancer waiting list is forecast to return to the trajectory level during July.

Referral to Treatment

7.3. In May 2021, the overall size of the Referral to Treatment (RTT) waiting list closed at 68,242 patient pathways (+4% increase on the previous month). This continued increase has brought the overall size of the waiting list above pre-Covid levels which is consistent with forecasted growth within the North West London sector.

7.4. The forecast is for the overall size of the Trust's elective waiting list to continue to increase to circa 77,000 patient pathways in September 2021. The forecast is that the level will then start to reduce before stabilising at the April 2021 level (circa 66,000 patient pathways) from January 2022.

7.5. The Trust is ahead of plan for reducing the number of patients waiting more than 52 weeks to start consultant-led treatment. At the end of May 2021, 1,837 patients were waiting over 52 weeks which met the Trust's recovery target of 2,134 patients for the month of May.

7.6. Although the total 52 week wait trajectory was met in May 2021, the trajectory targets for 78 week waits and 104 week waits were not met and we were slightly behind plan. The delays for very long waits are predominantly associated with patient choice.

Diagnostics

7.7. The Trust reported a minor variation in diagnostics waiting times, with 36.6% of patients waiting more than 6 weeks for their diagnostic test at end of May 2021 (compared to 36.4% the previous month). In Neurophysiology the waiting list reduced by 4% compared to the previous month. Improvements were also reported in Respiratory Physiology, with this modality reporting under the 1% target for the first time since February 2020. Imaging services reported their lowest breach rate since the start of the pandemic.

Cancer waiting times

7.8. Due to the lag in the national reporting timelines for cancer waiting times, data for April 2021 are reported in June 2021. The Trust delivered 7 of the 8 national standards in February. The 62-day GP referral to first treatment performance was 80.6% against the 85% standard.

7.9. The 104+ day totals plateaued during the second wave but have started to reduce again and significant improvements in the colorectal backlog are expected during May 202. 63+ day totals are and patient choice delays are expected to reduce in line with increased patient confidence resulting from the vaccine programme and reduction of social restrictions.

Urgent and Emergency care

7.10. The Trust's Ambulance handover performance (within 30 minutes) increased by 1.1% in May to 96.9% which met the Trust improvement trajectory.

7.11. 147 patients spent more than 12 hours in the emergency department from time of arrival. Mental health delays accounted for 37% of the total 12 hour waits.

7.12. The performance of long length of stay continued to improve. In May 2021 there was an average of 140 patients with a long length of stay of 21 days or more (from 158 in April 2021).

Quality – safe and effective

7.13. There was an increase in the number of incidents reported in May 2021, which reflects the return to normal activity following the second surge, and for this month we met our patient safety incident reporting rate target to be in the top quartile of comparable NHS trusts (per 1,000 bed days). Our trust-wide improvement programme, which is designed to support sustained improvement, is progressing and divisional action plans are in place which are being managed through the EMB quality group.

7.14. There were no CPE BSIs reported in May 2021 and we are on track to meet our annual targets for C. difficile and E. Coli BSI reduction.

7.15. There was one MRSA BSI reported in May 2021. A patient with spinal infection had positive blood cultures over 14 days into their inpatient stay. The case is currently undergoing post infection review.

Appendices:

Appendix 1 Integrated quality and performance scorecard (Board version) month 2
Appendix 2 Countermeasure summaries

Imperial College Healthcare NHS
NHS Trust

Integrated Quality and Performance Scorecard - Board Version

Imperial Management and Improvement System (IMIS)

FI = Focussed improvement

M2 - May 2021

	FI	Metric	Watch or Driver	Target / threshold	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Reporting rules	SPC variation
To develop a sustainable portfolio of outstanding services																			
Quality safety improvement	FI	Patient safety incident reporting rate per 1,000 bed days	Driver	>=54.9	50.52	52.86	58.55	51.75	54.35	50.59	56.17	56.74	53.98	50.61	53.39	50.74	59.66	Share Success	-
		Trust-attributed MRSA BSI	Watch	0	0	0	1	0	0	0	0	1	2	1	0	0	1	Note performance / SVU if statutory	-
		Trust-attributed C. difficile	Watch	7	6	3	1	2	11	4	5	0	4	8	7	3	7	-	-
		E. coli BSI	Watch	54	5	5	6	4	3	8	3	6	7	5	6	6	3	-	-
		CPE BSI	Watch	0	-	-	-	-	-	-	-	-	1	0	0	0	0	-	-
		% of incidents causing moderate and above harm (rolling 12 months)	Driver	<2.13%	1.50%	1.56%	1.57%	1.57%	1.50%	1.49%	1.50%	1.48%	1.46%	1.50%	1.61%	1.57%	1.48%	Share Success	-
		Hospital Standardised Mortality Ratio (HSMR) (rolling 12 months)	Watch	<100	67	68	68	69	71	71	72	71	72	72	73	76	76	-	-
		Formal complaints	Watch	<=100	53	56	60	51	71	76	68	55	66	74	95	77	53	-	-
Response and Recovery		Total elective spells (overnight and daycases) as % of trajectory target	Watch	100%	-	-	-	-	-	-	-	-	-	-	-	103.2%	96.3%	Note performance / SVU if statutory	-
		Total outpatient attendances as % of trajectory target	Watch	100%	-	-	-	-	-	-	-	-	-	-	-	105.9%	100.5%	-	-
		RTT waiting list size	Watch	70,902	50,570	50,550	52,270	54,924	55,225	55,790	57,226	57,699	57,334	57,991	62,763	65,753	68,242	-	SC
		RTT 52 week wait breaches	Driver	2,134	258	533	834	1,072	1,259	1,160	990	1,050	1,667	2,278	2,374	2,157	1,837	Share Success	CC
		% clinical prioritisation (RTT inpatient waiting list – surgical)	Watch	>=85%	-	-	-	-	-	-	-	-	88.7%	90.0%	89.4%	89.4%	89.2%	-	-
		Diagnostics waiting times	Watch	<=1%	65.7%	67.4%	56.3%	50.7%	40.5%	32.9%	29.6%	26.8%	50.5%	47.7%	38.8%	36.4%	36.6%	Note performance / SVU if statutory	CC
		Cancer 2 week wait	Watch	>=93%	96.4%	93.6%	86.8%	85.1%	83.5%	94.3%	88.8%	95.8%	94.1%	95.3%	94.9%	93.4%	-	-	CC
		Cancer 62 day wait	Driver	>=85%	75.9%	69.9%	72.1%	76.4%	72.3%	71.4%	73.4%	76.8%	77.3%	73.0%	79.1%	80.6%	-	CMS	CC

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard - Board Version

Imperial Management and Improvement System (IMIS)

FI = Focussed improvement

M2 - May 2021

	FI	Metric	Watch or Driver	Target / threshold	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Reporting rules	SPC variation
continued		Ambulance handovers - % within 30 minutes	Driver	98%	92.6%	92.9%	95.6%	94.3%	95.7%	95.6%	97.1%	88.8%	89.5%	95.1%	96.0%	95.7%	96.8%	Share Success	CC
continued		Number of patients spending more than 12 hours in the emergency department from time of arrival	Watch	0	139	140	154	156	173	219	175	480	632	199	156	165	147	CMS	CC
continued	FI	Long length of stay - 21 days or more	Driver	<=126	143	127	131	129	145	154	165	166	165	210	180	158	140	CMS	CC
Safe and Sustainable Staffing		Vacancy rate	Watch	<10%	7.1%	7.1%	8.2%	8.5%	9.5%	9.7%	9.8%	10.0%	9.8%	9.8%	9.9%	10.6%	11.0%	Note performance / SVU if statutory	-
Safe and Sustainable Staffing	FI	Agency expenditure as % of pay	Driver	tbc	1.2%	1.1%	1.3%	1.1%	1.4%	1.6%	1.6%	2.3%	1.8%	2.7%	2.4%	3.1%	2.4%	-	-
Safe and Sustainable Staffing		Staff Sickness (rolling 12 month)	Driver	<=3%	4.30%	4.32%	4.33%	4.36%	4.39%	4.39%	4.39%	4.43%	4.50%	4.54%	4.18%	3.79%	3.74%	CMS	-
Safe and Sustainable Staffing		Staff turnover (rolling 12 months)	Watch	<12%	11.8%	11.1%	11.1%	11.1%	11.0%	10.9%	10.8%	10.7%	10.1%	9.9%	9.8%	9.9%	10.6%	-	-
Finance		Year to date position (variance to plan) £m	Watch	£0	5.97	7.60	11.10	14.32	17.56	-0.42	-0.53	-0.65	-0.66	10.48	5.07	-3.31	0.34	-	-
Finance		Forecast variance to plan	Watch	£0	0.00	-0.87	-2.88	-32.02	17.02	-8.06	-1.39	-15.39	-13.85	1.91	5.07	0.00	11.79	-	-
Finance		CIP variance to plan	Watch		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
To build learning, improvement and innovation into everything we do																			
		Core skills training	Watch	>=90%	94.5%	94.6%	89.8%	91.8%	92.4%	92.0%	91.6%	91.8%	91.6%	91.5%	92.2%	93.0%	93.8%	-	-

Abbreviations

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

Reporting rules
CMS - Countermeasure summary
SVU - Structured verbal update

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Appendix 2

Integrated quality and performance report:

Countermeasure summaries at month 2 (May 2021 data)

Contents

Three countermeasure summaries are enclosed:

CMS 1: Cancer waiting times – the percentage of patients who start their first treatment within 62 days of a GP urgent referral

CMS 2: Patients spending more than 12 hours in the emergency department from time of arrival

CMS 3: Long length of stay

Imperial College Healthcare NHS Trust

CMS 1

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

Countermeasure Summary: 62-day GP referral to first treatment

Problem Statement: Performance against the standard has been non-complaint for 12 consecutive months. April was reported at 80.6% against the 85% standard, an improvement from March (79.1%). The impact is longer waiting times to access diagnostics and treatment for cancer.

Metric Owner: Prof Katie Urch
Metric: Cancer Waiting Times: 62-day GP referral to first treatment – operating standard 85%

Desired Trend: ↑

Historical performance:

Standards	Oct	Nov	Dec	2021 Jan	Feb	Mar	Apr
3.1 - Cancer Plan 62 Day Standard	**71.4%**	**73.4%**	**76.8%**	**77.3%**	**73.0%**	**79.1%**	**80.6%**
Acute leukaemia					100.0%		100.0%
Brain/Central Nervous System	100.0%			100.0%			100.0%
Breast	69.6%	86.7%	81.8%	84.6%	64.3%	65.0%	77.1%
Gynaecological	65.4%	67.9%	91.3%	58.3%	61.5%	79.2%	83.3%
Haematological (Excluding Acute Leukaemia)	66.7%	85.7%	60.0%	100.0%	100.0%	100.0%	100.0%
Head and Neck	92.9%	33.3%	100.0%	100.0%	100.0%	100.0%	100.0%
Head and Neck - Thyroid	50.0%	50.0%	100.0%		75.0%	100.0%	50.0%
Lower Gastrointestinal	21.1%	37.5%	33.3%	33.3%	50.0%	55.6%	46.2%
Lung	75.0%	55.6%	62.5%	58.3%	72.7%	100.0%	60.0%
Other	100.0%	100.0%	100.0%		33.3%		100.0%
Paediatric							
Sarcoma							100.0%
Skin	66.7%	66.7%	89.5%	60.0%	71.4%	100.0%	90.9%
Testicular	100.0%	100.0%				100.0%	
Upper Gastrointestinal			100.0%				
Upper GI - HpB	100.0%	40.0%	60.0%	72.7%	71.4%	50.0%	100.0%
Upper GI - OG	100.0%		33.3%	100.0%	60.0%	81.8%	66.7%
Urology - Prostate	83.7%	92.3%	91.7%	94.4%	93.3%	66.7%	91.7%
Urology - Renal	100.0%	50.0%	70.0%	100.0%	90.0%	66.7%	100.0%
Urology - Urothelial	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Key associated metrics to watch against trajectory	
2WW	April performance 93.4%% against 93% target. Performance expected to be pressured in April due to 2WW referral demand increases across specialties
104+ day backlog	76 patients at 16/06/2021. Continued improvement expected as endoscopy booking times improve
63+ day tip over drivers	GI diagnostic pathway capacity and process, late referrals from other North West London trusts and patient choice delays

Countermeasure Summary: 62-day GP referral to first treatment

30-day action plan

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Late inter-trust referrals	• Elective capacity reductions at partner trusts in North West London have resulted in delayed diagnosis and later transfer of care to ICHT for treatment.	• Local elective capacity improvement plans.	NWL Trusts / Integrated Care System	On-going
Breast	• Priority 3 breast cases had surgery delayed during the second Covid-19 wave, managed on hormones instead. Scheduling the surgery dates for these patients increased the number of reported breast 62-day breaches.	• The backlog of cases has now been resolved. • Additional surgical capacity has been agreed on an on-going basis to manage Priority 3 cases. • A named consultant will review the breast patient tracking list with the corporate cancer team each week to improve surgical access times. • Standard Operating Procedure to be drafted to stratify management of low risk cases.	Breast Breast	16/07/2021 Aug 2021
Colorectal	• Endoscopy waiting times improved but still reporting median waits of 14 days for direct booking from straight to test clinics, and 21 days for requests from other sources.	• Agree capacity improvement trajectory – target of maximum 14 day wait for scope from request for all suspected cancer patients. • This action will support delivery of the Faster Diagnostic Standard on Gastrointestinal (GI) pathways.	Endoscopy	30/07/2021
Pathology	• > 7 day waits for cancer diagnostic sample analysis – affecting most tumour groups.	• Tumour level performance review with pathology operational team to assess current waiting times and agree improvement plans. • Pathology to submit a case for increased working hours following end of temporary funding from Royal Marsden Partners (RMP) (West London cancer alliance).	Pathology/ corporate cancer Pathology	16/07/2021 Not confirmed

Imperial College Healthcare NHS Trust

CMS 2

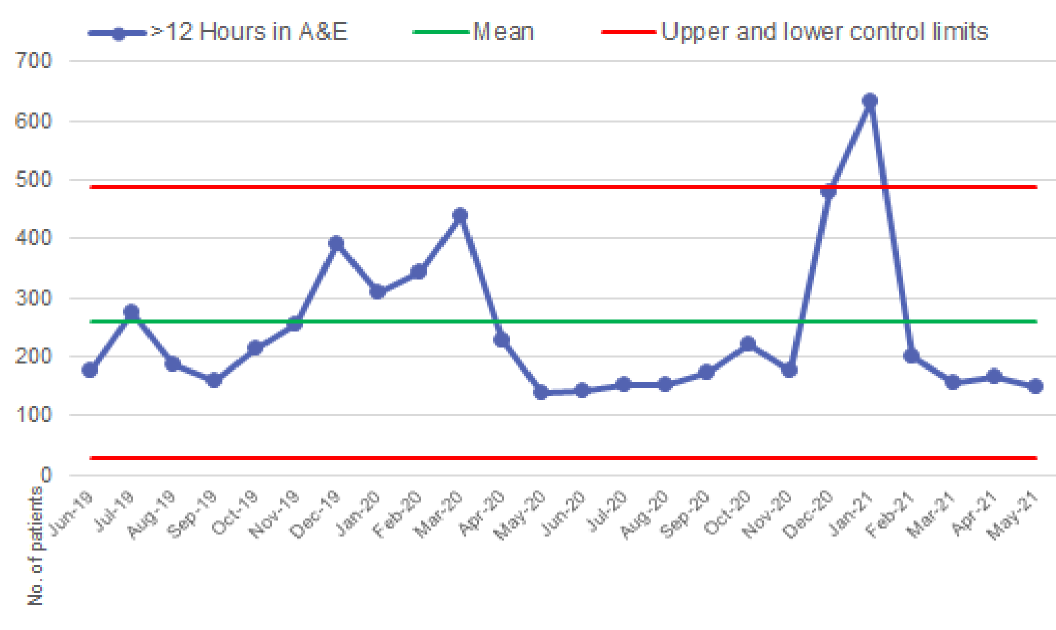
The number of patients spending more than 12 hours in the emergency department from time of arrival

Countermeasure Summary: Patients spending more than 12 hours in the emergency department from time of arrival

Problem Statement: It can be detrimental for patients to spend extended lengths of time in an emergency department environment. The impact is on patient experience, quality and extended waits can also impact on staffing resource.	**Metric Owner**: Ben Pritchard-Jones **Metric**: The number of patients spending more than 12 hours in the emergency department (ED) from time of arrival **Desired Trend**:

Historical performance:

The number of patients waiting over 12 hours within the emergency department increased during the second surge in January 2021. The level has reduced with 147 patients spending more than 12 hours in the department in May 2021. Mental health delays accounted for 37% of the total 12 hour waits. 27% of total waits occurred in general medicine.



Countermeasure Summary: Patients spending more than 12 hours in the emergency department from time of arrival

30-day action plan

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Mental Health Pathway Delays	• Lack of section 136 facilities (place of safety) • Approved Mental Health Practitioner (AHMP) Provision • Lack of bed capacity • Inappropriate internal Registered Mental Health Nurse (RMN) resource	• Daily huddle escalation calls with Central and North West London • Escalation to NWL Lead for mental health for support with local authorities on AHMP provision • Mental health staffing review paper • Transformation team support on ICHT Trust strategy for RMN provision • Escalation to ED delivery board for further support	Jo Sutcliffe	June 21
Acute Medicine Admissions	• Lack of beds • Patient flow challenges • Long length of stay	• Medical Pathway Improvement plan at SMH • Weekly review of themes for patients spending >12 hours in ED • ED and Acute Medicine leadership teams to review 12 hour themes (plan to keep meeting monthly) • Faster moves work streams on each site developing awareness and solutions • Junior doctor reps to be involved in flow projects	Ganan Sritharan / Adam Hughes / Jo Edwards / George Tharakan	June 21
Not referred – Urgent & Emergency pathway	• Clinical Decision Unit (CDU) closure • Complex multi specialty pathways • SDEC capacity	• Ongoing CDU closure agreed for coming months to support pathway separation in ED • Review of patient pathways in these cohorts for wider learning • Implement actions from business case for extension of SDEC service at SMH	Ben Pritchard-Jones MIC	August 21

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CMS 3

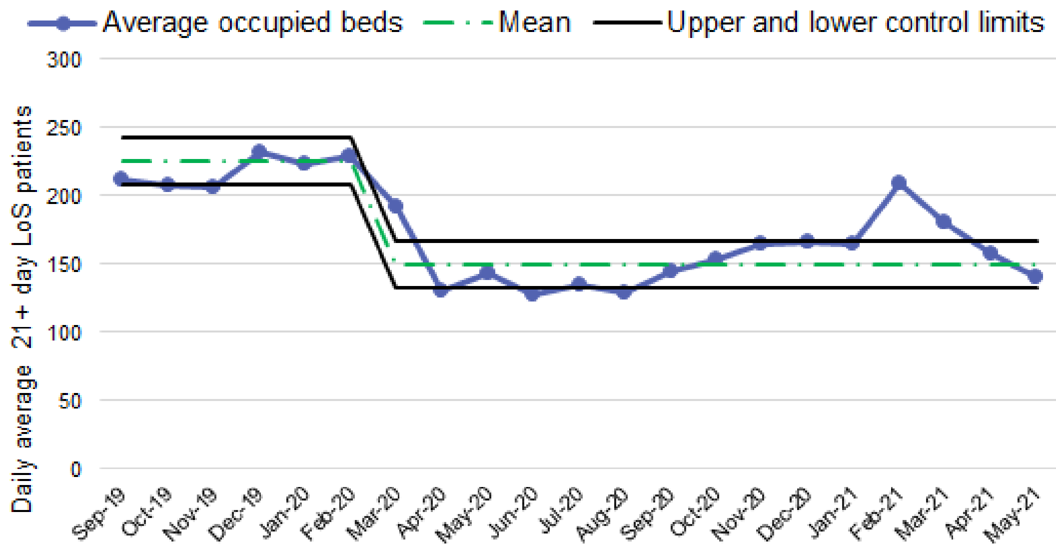
Improving long length of stay (LLOS)

Countermeasure Summary: Improving Long Length of Stay (LLOS)

Problem Statement: High numbers of patients with a Long Length of Stay (LLOS) is an indicator of poor patient flow and sub-optimal use of resource.	**Metric Owner**: Anna Bokobza **Metric**: Number of patients with a Length of Stay (LOS) of 21 days or more **Desired Trend**: ⬇

Historical performance:

The performance of long length of stay continued to improve. In May 2021 there was an average of 140 patients with a length of stay of 21 days or more.



Countermeasure Summary: Improving Long Length of Stay

30-day action plan

Top contributor	Potential root cause	Countermeasure	Owner	Due date
All internal drivers of exit flow and LOS	• Pursuit of best in class ward processes to facilitate flow not possible during pandemic • Long term variation in practice	• Participation in NHS Alliance 16 improvement programme; ward scope and design methodology agreed, quality improvement cycles commencing by end June • Phase 1 SMH flow improvement projects complete; 3 month implementation plan agreed	Anna Bokobza & Shuli Levy Anne Kinderlerer	30 July 31 August
All external drivers of exit flow and LOS	• Risk of loss of talent/experience and improved relationships, processes and systems reverting to pre-Covid models if hubs dissolve due to lack of funding	• Development & approval of business case for substantiation of integrated discharge hubs from Quarter 2 • Development of business continuity plan for Quarter 2 as back up	Anna Bokobza (in partnership with sector Senior Responsible Officer)	30 June
Accuracy of data and reporting	• Differential recording practice between acute Trusts invalidates benchmark comparisons • Ward and directorate teams spending considerable time on manual processing of discharge referrals and reporting	• Implement plan to migrate weekly reporting to pull direct from Cerner replacing manual returns • Implement plans to embed Discharge to Assess form in Cerner (delayed by sector changes to form)	Monica Sobhan Anna Bokobza & James Bird	30 June (extended to end July) 16 July
Homeless/no right of recourse to public funds/no place to discharge to	• High prevalence of tri-morbidity and need for multi-agency approach to case management • Staff not always clear on Duty to Refer and how to support service navigation	• Build specialist homeless discharge team as 12 month proof of concept using 2nd wave central government funding (awaiting formal funding confirmation, informal feedback very positive)	Anna Bokobza (in partnership sector Senior Responsible Officer)	October 21

TRUST BOARD (PUBLIC)

Paper title: Annual Emergency Preparedness, Resilience and Response update

Agenda item 11 and paper number 08

Executive Director: Claire Hook, Director of Operational Performance
Authors: Niina Bell, EPRR Manager and Merlyn Marsden, Hospital Director, Charing Cross Hospital

Purpose: Information

Date of meeting: 14 July 2021

Executive summary

1. Purpose

1.1. The purpose of this paper is to provide an update and assurance in relation to the Trust's Emergency Preparedness, Resilience and Response (EPRR) arrangements and plans.

2. Introduction

2.1. Annually, the EPRR team is required to provide an update to the Trust Board to adhere to its duties under the Civil Contingencies Act and the NHS England EPRR Core Standards.

2.2. The Civil Contingencies Act (2004) requires NHS acute providers to demonstrate that they can respond to incidents whilst maintaining appropriate patient services.

2.3. NHS organisations are also required to adhere to NHS England's EPRR Core Standards (2015) setting out the minimum criteria which NHS organisations and providers of NHS funded care are required to meet.

3. Key points

3.1. To support our ongoing work required to meet the NHS EPRR Core Standards and to fulfil our duties under the Civil Contingencies Act the Trust Board is required to be updated on the EPRR achievements annually.

3.2. The paper contains the following updates:

1. Threat Level
2. EPRR and covid-19
3. EPRR Activity and Incidents January 2020 – February 2021
4. EPRR Incident Action tracker update
5. EPRR Exercises and Training
6. NHS England EPRR Assurance 2020/21

4. Next steps

4.1. To remain fully compliant when assessed against the NHS EPRR Core Standards the annual EPRR programme will continue embedding lessons learnt from the EPRR plan activations to our existing practice and addressing areas for improvement.

4.2. The focus will be on business continuity ensuring the successes from the pandemic so far are translated to the plans.

5. Recommendation(s)

5.1. The Board is asked to note the report.

6. Impact assessment

6.1. Quality impact: In addition to our statutory requirement through the Civil Contingencies Act, EPRR forms part of the patient safety and quality agenda of Care Quality Commission regulation.

6.2. Financial impact: No financial impact

6.3. Workforce impact: EPRR has an allocated workforce. Training and exercising is resourced through existing EPRR programmes.

6.4. Equality impact: EPRR adheres to all existing relevant policies and is working with the Equality, Diversity and Inclusion team to add or update the equality impact assessments as necessary. The EPRR Steering group, which has responsibility for decision making and emergency plan review and approval, includes members from every clinical division and corporate group.

6.5. Risk impact: EPRR risks derive from the national risk register, local risk registers and as identified through EPRR Steering group. Risks are managed through the EPRR Steering group. No new risks are associated with the paper.

<u>Main report</u>

The following is to provide an annual update to the Board of the current EPRR work within our Trust as required by the Core Standards.

7. Threat level

7.1. The terrorism threat level system reflects the threat posed by all forms of terrorism, irrespective of ideology. There is a single national threat level describing the threat to the UK.

7.2. The current threat level is substantial, indicating an attack is likely.

8. EPRR and covid-19

8.1. The EPRR team suspended the majority of its business as usual activities to support the Trust response to the covid-19 pandemic e.g. from arranging exercises prior to the first wave to managing the mask fit testing programme.

8.2. The EPRR team delivered a Trustwide exercise in March 2020 to test and identify gaps in its existing Command and control, Business continuity and Pandemic Influenza plans.

8.3. The Trust Command and control plan was activated on 13th March 2020 providing the structure to the response with set membership, work streams and meeting regimens.

8.4. The use of Gold, Silver and Bronze decision making levels are now well-embedded to the organisational culture.

8.5. Many of the emergency plans had to be reviewed to ensure social distancing and other covid-19 related restrictions were considered e.g. the treatment of contaminated people as per the Chemical, Biological, Radiological, Nuclear, explosion and Hazardous material CBRN(e) and HAZMAT plan had to be amended to ensure casualty safe distancing.

8.6. Tightly fitted filtering face piece (FFP) 3 mask fit testing is led by the EPRR team, who provide central fit testing co-ordination, troubleshooting when none of the available masks fit and expertise on both disposable and reusable mask fit testing.

8.7. The existing fit testing arrangements have been reviewed and a business case prepared to enable a more robust and sustainable centralised testing process to be in place in the event of further surges or other emergency situations.

8.8. Following the first two covid-19 waves a debrief questionnaire has been circulated to directors and senior managers to collect emergency planning related learning and to build on our resilience.

8.9. Review of all the service business continuity plans have commenced to ensure valuable lessons from the pandemic are captured, analysed and documented.

8.10. NHS England in London has collated a lessons learnt document from the first pandemic wave with 16 recommendations which the Trust has been addressing as part of its response to the second wave and preparations made for any subsequent waves.

9. EPRR Activity and Incidents January 2020 – March 2021

9.1. Below outlines the business continuity incidents across the organisation in addition to the externally declared national major incident due to the pandemic.

9.2. November 2020 – Basement flood and water disruption:

- Following a main water tank connection failure several litres of water escaped to the basement areas on 27th November at Charing Cross Hospital resulting in water pump failure and subsequent loss of water the following day.
- North West London Pathology activated their business continuity plans and transferred some of its operations temporarily to St Mary's.
- The attendance by London Fire Brigade highlighted issues with fire hydrant maintenance which were promptly addressed.

9.3. December 2020 – Medical vacuum pump system failure:

- Following a power disruption on 1st December, the central vacuum system failed at Charing Cross including the medical vacuum and scavenger systems. As both the main and back-up system pumps failed the replacement using portable equipment was required.
- The pumps were repaired and further leaks which were identified in the system will be addressed to increase the system resilience further.

- There was a good response especially from the senior nursing and clinical engineering teams supporting the distribution of the portable equipment.

10. EPRR Incident Action tracker update

10.1. There have few business continuity incidents during the current pandemic.

10.2. Incident debrief sessions have been held and action plans have been created, circulated to stakeholders and added to the EPRR action tracker for monitoring. The majority of the actions have been completed or are in process of being completed. All remaining actions are monitored and reviewed through the EPRR & Fire Safety steering group.

11. EPRR and EU exit

11.1. EPRR forms the link between national NHS EU exit planning and the Trust.

11.2. Planning for the EU exit continued alongside the pandemic response, ensuring plans were in place and tested prior the end of transition period.

11.3. Key stakeholders continue to meet at regular intervals and monitor any arising issues, providing information to other teams or externally as required.

11.4. The EU risk is monitored through the key stakeholder meetings and with EPRR assistance the business continuity plans are kept up-to-date to address majority of potential issues.

12. EPRR Exercises and Training

12.1. As per the Civil Contingencies Act 2004, the Trust is required to run statutory EPRR training involving an annual table top exercise, a live exercise every three years and a communications exercise every 6 months.

12.2. A live lockdown exercise was held at St Mary's in February 2020 to test the recently updated lockdown arrangements using staff members as intruders. Robust security arrangements were observed but also issues with tailgating clinical staff were noticed which have been addressed through ongoing training and education.

12.3. Alerts of increased fire risk caused by high concentrations of oxygen were received from NHS England following intensive care unit evacuations due to fires in Scotland and in Romania and an evacuation table-top exercise was arranged in Trust areas performing AGPs to test our resilience. The exercise confirmed robust arrangements are in place despite the additional areas being utilised for patients receiving AGPs and high flow oxygen.

12.4. The Trust's 6-monthly internal communication exercise was held in April 2021, which successfully demonstrated that the Trust key staff are contactable should an incident occur.

12.5. A cyber-incident and major incident table-top exercises are scheduled to test recently updated emergency plans.

12.6. Annual training for the Emergency Department and selected staff for the Chemical, Biological, Radiological and Nuclear (CBRN) incidents continued over the summer adhering to social distancing guidance.

12.7. The Trust is due to receive further 10 NHS funded power respirator suits (PRPS) from the DHSC to ensure the full NHS compliment of 48 suits. The suits are required for the protection of staff during a CBRN incident.

12.8. The ongoing service over the 10-year lifetime of the new suits will be included, the existing 38 suits' service is met by the Trust.

12.9. Gold, Silver, Defensible Decision Making and Loggist training to on call teams continue to ensure incident response preparedness at all times.

13. NHS England Assurance 2020/21

13.1. NHS Trusts are legislatively mandated to participate in the annual EPRR assurance process which comprises of an annual self-assessment every autumn followed by a formal review with the NHS England before December to confirm the overall level of EPRR compliance.

13.2. The purpose of this process is to assess the preparedness of the NHS, both commissioners and providers, against the NHS Core Standards for EPRR.

13.3. In 2020, NHS England revised its assurance process following the NHS response to the pandemic and focussed only on the three areas:

- Progress made by those organisations identified as partially or non-compliant in the 2019/20 process.
- The process of capturing and embedding the learning from the first wave of the COVID-19 pandemic.
- Inclusion of progress and learning into winter planning preparations.

13.4. The Trust was fully compliant against the 10 NHS England EPRR Core Standards and 69 evidential measures last year. Therefore the progress made against 2019/20 submission was not required to be submitted.

13.5. The lessons learnt and winter preparedness were addressed by relevant work streams.

13.6. Based on the submission the NHS England agreed that the Trust remains fully compliant.

Author(s)

Niina Bell EPRR Manager
Merlyn Marsden Hospital Director Charing Cross Hospital

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TRUST BOARD (PUBLIC)

Paper title: Finance report for May 2021

Agenda item 12, paper number 09a

Executive Director: Jazz Thind, Chief Financial Officer
Author: Michelle Openibo, Associate Director Finance Business Partnering; Des Irving-Brown, Deputy Chief Financial Officer

Purpose: For Information

Meeting: 14 July 2021

Executive summary

1. Purpose

1.1. The finance report for May 2021 sets out the month two reported financial position of the Trust.

2. Key findings

2.1. The Trust had an initial agreed plan resulting in a £6.6m deficit for the first 6 months of 21/22 based on block income from CCGs and NHSE. Since that point sector level discussions and the financial opportunities afforded by the Elective Recovery Fund has allowed the Trust to move to a break even plan.

2.2. As at Month 2 the Trust achieved a breakeven position.

2.3. Capital – the Trust has spent £3.4m (38%) of its agreed capital plan year to date. Spend is forecast to deliver to plan over the year. Around £5m of the plan remains to be allocated to schemes in-year.

2.4. Cash – at 30th May, cash was £150.4m. The future cash outlook is robust in the short to medium term but the full-year forecast is highly dependent on the funding regime for the second half which remains to be fully clarified and the delivery of ongoing CIPs.

3. Recommendation

3.1. The Board is asked to note this report.

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Public Board 14th July 2021

Finance Report May 2021

Financial overview – Scorecard	2
Statement of Comprehensive Income	3
Statement of Financial Position (Balance Sheet)	4
Capital	5

Scorecard

	Year to Date		
	Budget	Actual	Var
	£m	£m	£m
Trust position before ERF income and CIP	(7.5)	(5.7)	1.8
Other CIP achievement	5.3	1.0	(4.2)
	(2.2)	**(4.6)**	**(2.4)**
ERF net of cost	-	4.6	4.6
Indicative ICS funding to break-even	1.7	-	(1.7)
Reported position	**(0.5)**	**0.0**	**0.5**

Income and expenditure

- The Trust had an initial agreed plan resulting in a £6.6m deficit for the first 6 months of 21/22 based on block income from CCGs and NHSE. Since that point sector level discussions and the financial opportunities afforded by the Elective Recovery Fund has allowed the Trust to move to a break even plan.
- As at Month 2 the Trust achieved a breakeven position.

Capital – the Trust has spent £3.4m (38%) of its agreed capital plan year to date. Spend is forecast to deliver to plan over the year. Around £5m of the plan remains to be allocated to schemes in-year.

Cash – at 30th May, cash was £150.4m. The future cash outlook is robust in the short to medium term but the full-year forecast is highly dependent on the funding regime for the second half which remains to be fully clarified and the delivery of ongoing CIPs

Statement of Comprehensive Income

	Year to Date Plan £m	Year to Date Actual £m	Year to Date Variance £m	H1 Budget £m
Income	211.6	223.5	11.9	633.3
Pay	(123.1)	(126.8)	(3.7)	(369.6)
Non Pay	(80.2)	(86.2)	(6.0)	(238.9)
EBITDA	**8.2**	**10.5**	**2.2**	**24.8**
Financing cost & donated asset treatment	(10.4)	(10.5)	(0.0)	(31.4)
Impairment of assets	0.0	0.0	-	0.0
Surplus/deficit Internal	**(2.2)**	**(0.0)**	**2.2**	**(6.6)**
Indicative ICS funding to break-even	1.7	0.0	(1.7)	6.6
Surplus/deficit Internal	**(0.5)**	**(0.0)**	**0.5**	**(0.0)**

- **Income** – the Trust is £11.9m favourable to plan year to date, driven mainly by the ERF benefit and additional private patient activity above planned levels.
- **Pay** – pay costs are £0.6m adverse to plan in month (£3.7m adverse YTD). Pay spend has continued at elevated levels in ICU due to increased occupancy and acuity, although costs have reduced from the month 1 levels.
- **Non Pay** – non-pay costs are £2.2m adverse to plan in month (£6.0m adverse YTD) due mainly to CIP targets currently held within this category offset by lower spend in Trauma, private patients and ICT.
- **Financing Costs** – financing costs are broadly in line with plan YTD.

Statement of Financial Position (Balance Sheet)

	31-Mar-20 £'000	31-May-21 £'000	Movement £'000
Intangible assets	14.1	13.4	(4.7)
Property, plant and equipment	553.8	549.1	(0.7)
Total non-current assets	**567.9**	**562.4**	**(5.4)**
Inventories	17.1	17.1	(0.0)
Trade and other receivables	86.2	93.1	6.9
Cash and cash equivalents	149.1	150.4	1.3
Total current assets	**252.3**	**260.5**	**8.1**
Trade and other payables (<1 year)	(277.1)	(270.1)	7.0
Total current liabilities	**(277.1)**	**(270.1)**	**7.0**
Non current Liabilities	(21.2)	(21.0)	0.2
Total Non current Liabilities	**(21.2)**	**(21.0)**	**0.2**
Net Assets employed	**521.9**	**531.8**	**9.9**
Public Dividend Capital	773.9	777.3	3.5
Revaluation Reserve	3.0	3.0	0.0
Income and expenditure reserve	(254.9)	(248.5)	6.5
Total tax payers' and other equity	**521.9**	**531.8**	**9.9**

Non-Current Assets
Non-current assets have decreased by £5.4m year-to-date, comprised of depreciation of £8.8m offset by capital expenditure of £3.4m.

Current Assets
Receivable balances have increased by £6.9m year-to-date mostly due to accruals. Inventory balances are stable to date.

Cash
Cash balances were £150.4m at Month 2, which is an increase of £1.3m from Month 1. The current level of cash is beneficial to the Trust, however, the position is driven by both timing of cash flows and the effects of the emergency funding regime for 2020/21 Funding for the second half of the year remains subject to the planning process and cash forecasting is subject to this uncertainty.

Current Liabilities
Trade and other payables balances have reduced by £7m year-to-date at Month 2 mostly due to the settlement of payables invoices. The Trust maintains a focus on effective payment of suppliers and pays 98% of invoices within the Better Payment Practice Code guidelines.

Taxpayers' and Other Equity
Equity balances are stable at Month 2. The level of Public Dividend Capital currently expected to support the capital programme is currently £0.7m – much less than 2020-21.

Capital – Month 2

Sources of Funds	£m
Internal Financing	51.7
Charitable Funds	0.3
PDC funding (TBC)	0.7
Total	**52.7**

Applications	Annual Plan £m	Plan £m	Actual £m	Variance £m
Backlog Maintenance	16.4	2.7	1.6	(1.1)
ICT	7.0	1.2	0.2	(0.9)
Medical Equipment Replacement	6.7	1.3	0.4	(0.9)
Other Capital Projects	20.7	3.2	0.9	(2.3)
Redevelopment	1.9	0.3	0.2	(0.1)
Total Expenditure	**52.7**	**8.7**	**3.4**	**(5.4)**
Income and Donation	**(0.3)**	**(0.1)**	**0.0**	**0.1**
Capital Resource Limit	**52.4**	**8.6**	**3.4**	**(5.2)**

Summary

The Trust has commenced delivery of the agreed 2021-22 capital programme. Year-to-date expenditure to £3.4m, 38% of the plan figure of £8.6m. Given the planning process to confirm the available capital resources for the year was only confirmed in mid-April 2021 it is expected that the rate of spend will increase and align with the planned level over the balance of the year.

Capital planning this year has been co-ordinated at a NWL sector level. The programme is consistent with the Trust's ability to finance its own capital expenditure with the exception of £0.7m for radiology – confirmation of the funding is being sought from the sector.

The agreed capital plan includes standing allocations for investment in backlog maintenance, ICT and medical equipment. Other significant projects within the plan include:

- Works on the improvement of critical care at A-Block, Hammersmith Hospital;
- Imaging equipment including PET CT;
- Completion of new Multi-Disciplinary Team (MDT) rooms to enable improved cross-team working;
- Divisional works budgets.

TRUST BOARD (PUBLIC)

Paper title: Estates Capital Projects 2020 - 2021

Agenda item 12.1, paper number 09b

Lead Executive Director(s): Janice Sigsworth, Director of Nursing
Author(s): Hugh Gostling, Director of Estates and Facilities

Purpose: For information

Meeting date: 14 July 2021

Executive summary

1. Purpose of this report

1.1. To provide the Board with an overview of the capital projects completed in the previous financial year.

2. Background

2.1. This is an annual report of the capital projects completed in the previous financial year.

3. **Key findings**

3.1. The report (Appendix 1) recognises the efforts made to deliver projects which assisted clinical service in responding to the Covid pandemic and in delivery of major capital projects during 2020-21 financial year with overall budget circa £19M. The projects were:

- Brain FUS MRI- SMH
- Cambridge Wing MRI- SMH
- Imaging Programme MDR- SMH
- Foetal Medicine Unit- SMH
- Renal Dialysis Expansion- CXH
- PET CT Scanner- CXH
- 4 South ARU- CXH
- Gary Weston Phlebotomy- HH
- Renal OPD Phlebotomy- HH
- Surge: Patterson Centre, 11 South, GICU-CICU- All Sites
- Various UEC Schemes- SMH & HH

3.2. The report also highlights the key objectives being delivered by the Capital Estates Projects team and highlights some of the Risk that are being managed.

4. Conclusion and Next steps

4.1 Future annual Capital reports will include Capital works carried out by Estates Backlog Maintenance, Information Communication and Technology and Medical Equipment.

5. Recommendation(s)

5.1. The report was noted at the Finance, Investment and Operations Committee and presented to Board for noting.

6. **Impact assessment**

6.1. Quality impact: Many of the projects had a direct impact on the quality of patient care.

6.2. Financial impact: All works were part of the agreed capital plan for 2020/21, recognising that the plane increased significantly during the year.

6.3. Workforce impact: Many of the projects improved the working conditions for staff.

6.4. Equality impact: N/A

The contents of this report demonstrates the improvements to patients and staff.

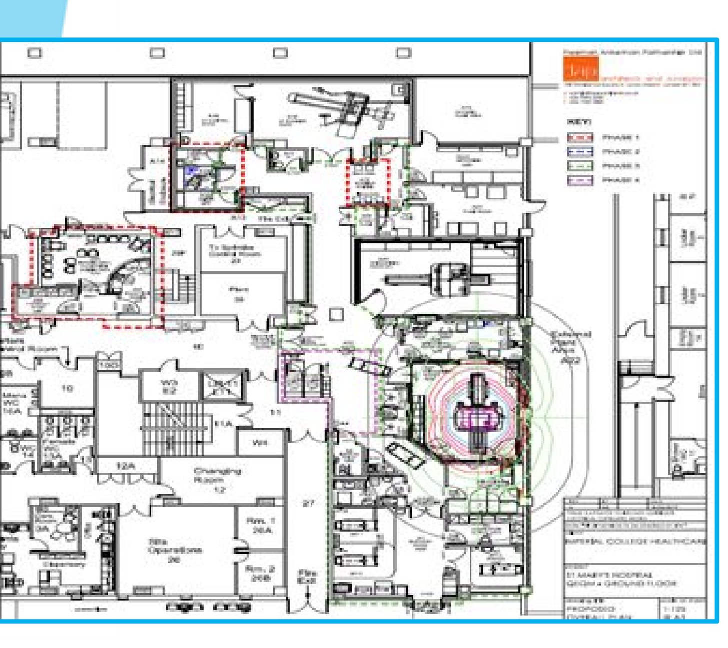
6.5. Risk impact: The works directly mitigated the risk that the Trust could not respond to the Covid pandemic.

Appendices

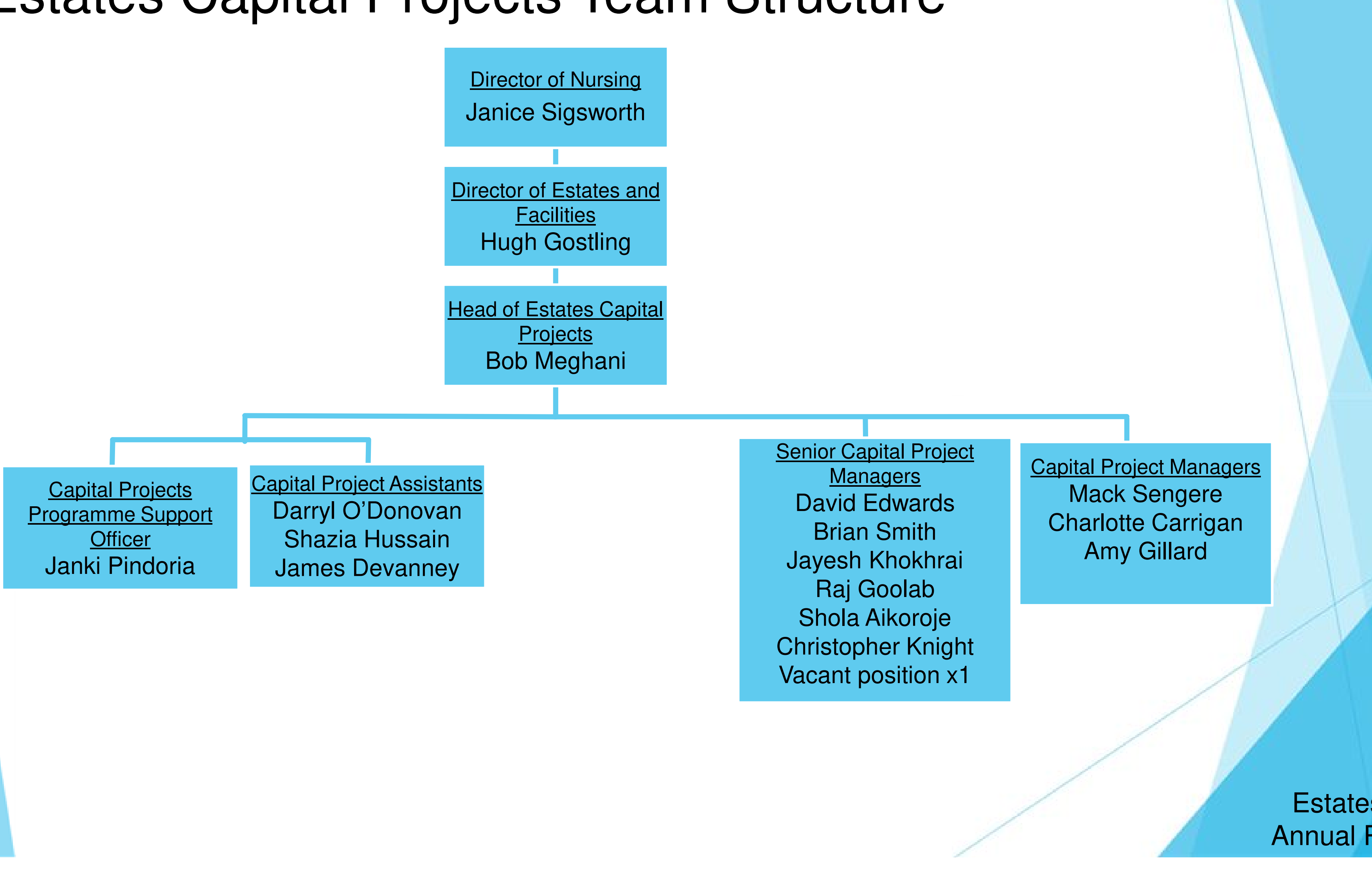
Appendix 1 Capital Projects Annual report

Author: Hugh Gostling Director of Estates and Facilities

Estates Capital Projects 2020-2021



Estates Capital Projects Team Structure



Estates Capital Projects Annual Report 2020/2021

2020-21 Key Objectives

Estates Capital Projects Objectives

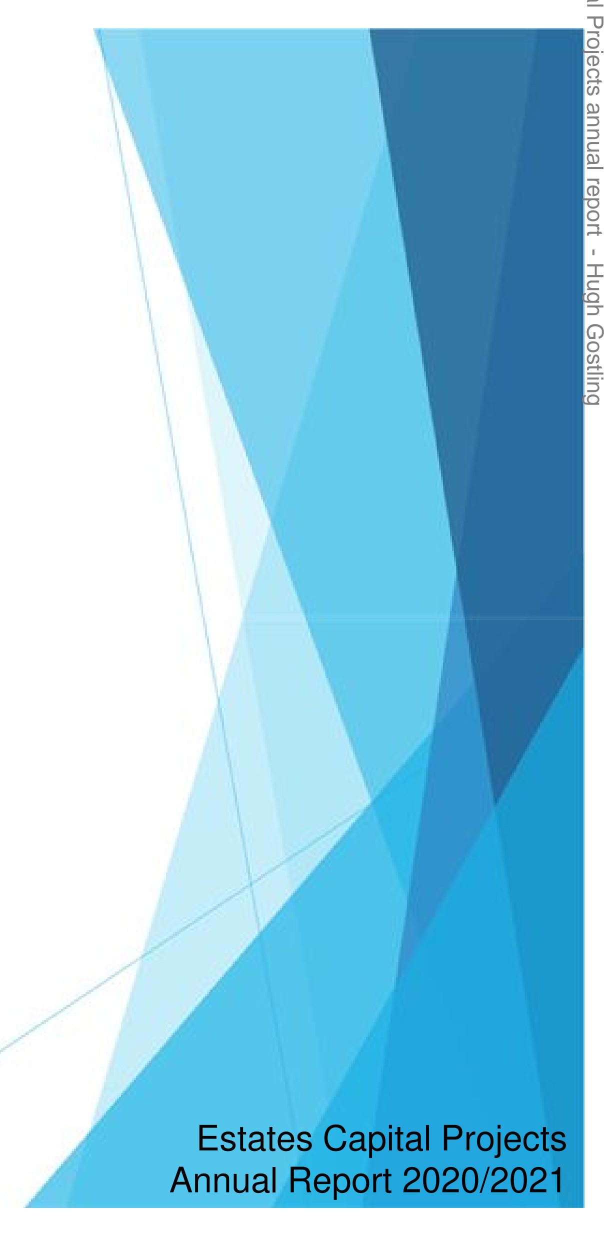
- Manage and deliver the 2020/2021 capital programme within timescale and budget
- Deliver capital projects in an environmentally sustainable way
- Priority assess all projects in alignment with the Trust Investment Criteria
- To deliver capital projects to a high quality and compliant standard
- Deliver each capital project to approved timescales and budgets
- Value Engineer projects where possible to drive down cost
- To embrace the Trusts strategic objectives in our day to day working and decision making processes
- Streamline the capital project systems and procedures to allow delivery of capital projects more efficiently
- Streamline E-Mandate process and project management tool
- Aim to promote Trust wide use of the E-Mandate system and FX Space Property register to allow efficient information management
- Improvement in Stakeholder engagement and management
- Strengthen knowledge on Department of Health procurement routes and contracts
- Provide strategic input and support in planning decants for the Trust redevelopment plans
- Provide CPD & training courses via in-house and external resources for estates teams

2020-21 Trust Capital Programme

- 20/21 Estates Capital Project schemes :
  - Brain FUS MRI- SMH
  - Cambridge Wing MRI- SMH
  - Imaging Programme MDR- SMH
  - Fetal Medicine Unit- SMH
  - Renal Dialysis Expansion- CXH
  - PET CT Scanner- CXH
  - 4 South ARU- CXH
  - Gary Weston Phlebotomy- HH
  - Renal OPD Phlebotomy- HH
  - Surge: Patterson Centre, 11 South, GICU-CICU- All Sites
  - Various UEC Schemes- SMH & HH

- Estates Capital Project schemes currently in feasibility or design:
  - HH A Block Theatre Expansion and Extension
  - CXH Breast Surgery Clinic
  - CXH Endoscopy Upgrade

- Various back log maintenance projects being supported

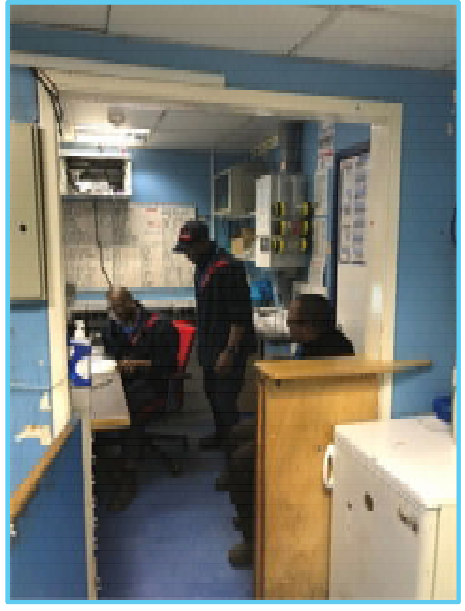


Estates Capital Projects
Annual Report 2020/2021

Brain Focused Ultrasound MRI

St Mary's Hospital
Commenced December 2019 and completed February 2021

Project consisted of new scanner installations requiring new RF cage, power source from QEQM substation, new external plant and deck to serve new MRI. Work involved decanting existing Reception and forming a new patient flow and waiting area, plus associated ancillary rooms.



Before

After

Total Cost £3M

Cambridge Wing MRI

St Mary's Hospital
Commenced March 2020 and completed January 2021

Project consisted of rebuilding existing scanner with new hardware components and systems, enabling works entailed removal of non-mechanical plant and BMS panel with new plant compliant with new Covid-19 guidelines. There were also aesthetic works to existing MRI area.

Before

After

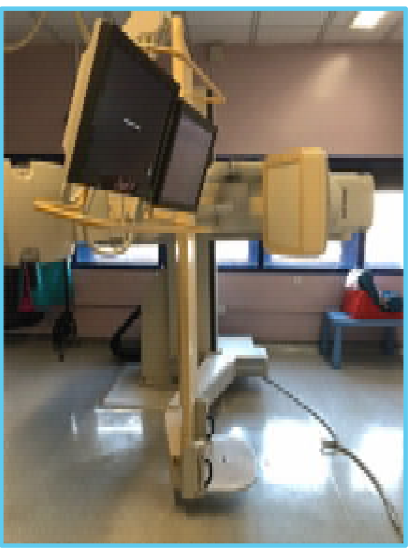
Total Cost £2.6M

Estates Capital Projects
Annual Report 2020/2021

MDR

St Mary's Hospital
Commenced February 2020 and completed December 2020

Project consisted of replacement of the existing scanning equipment, due to the out of date service contract and reliability of equipment was a high risk. The area was also refurbished which entailed a stand alone new ventilation plant, new electrical works and an upgrade to finished.



Before

After

Total Cost £1.157M

Fetal Medicine Unit

St Mary's Hospital
Commenced August 2020 and completed November 2020

The project involved providing two new ultrasound rooms and increasing the size of the waiting area and extra office space. Security was also enhanced by building a wall along the corridor with programed mag locked doors to only open during clinic times. The HOD office was changed to a staff restroom; the old reception was reduced in size and became the new office also increasing the size of the waiting area in addition. A new reception was created with an office with capacity for 8 to the side. Two new Sonography rooms where created on from the Occupational therapy (OT) kitchen and one from the OT laundry.

Before

After

Total Cost £146K

Estates Capital Projects
Annual Report 2020/2021

Trust Board (Public), 14 July 2021, 11am (virtual meeting)-14/07/21

Renal Dialysis Expansion

Charing Cross Hospital
Commenced February 2020 and completed September 2020

Refurbishment of a fire-damaged area in Renal Dialysis at Charing Cross Hospital to provide 10 new dialysis stations for inpatients and outpatients and a nurse base area. The project also included improvements to the patient waiting area, a new patient accessible toilet, improvements to staff changing and rest areas and new technical workshops. Art strategy developed and implemented by the Imperial Charity.

Before

After

Total Cost £2.15M

PET CT Scanner

Charing Cross Hospital

Commenced December 2020 and due to complete September 2021

The works is the refurbishment of the current Nuclear Medicine area (PET CT) on the first floor of New North block of CXH. It involves the removal and replacement of existing scanner with a state of the Art digital scanner, conversion of a former Gamma room to four uptake rooms, extension of the hot lab into a former toilet area, conversion of one of the existing uptake rooms to level access shower/DDA compliant toilet, conversion of former Injection room to Control room and former control room to uptake room 1, refurbishment of the existing consulting room and uptake room. All rooms to have new washing facilities, new light fittings, flooring and ceilings and the decoration of the walls.

Before

Proposed

Total Budget £5.3M

Estates Capital Projects
Annual Report 2020/2021

4 South ARU

Charing Cross Hospital
Commenced October 2020 and completed January 2021

The existing ARU was non-compliant and required to increase the level of care to patients. The project consisted of converting a 4-bed bay and side room to create the new ARU.

Before

After

Total Cost £350k

Gary Weston Phlebotomy

Hammersmith Hospital

Commenced June 2019 and completed November 2020

To create five phlebotomy blood taking areas within a new area to replace an existing unit that was non-compliant. The original phlebotomy room in a different area consisted of only one phlebotomy chair which was increased to five.

Before

After

Total Cost £134k

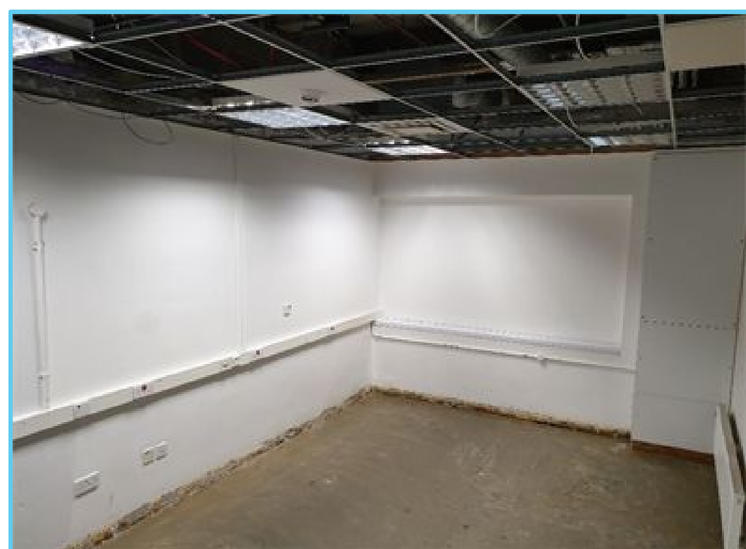
Estates Capital Projects
Annual Report 2020/2021

Renal OPD New Phlebotomy Suite

Hammersmith Hospital

Commenced 18 November 2020 and completed 12 January 2021

To convert the existing Medical Records Storeroom into a 4 Bay Phlebotomy Suite and refurbishment of adjacent/ connected office. Project consisted of removing a medical records file system; strip flooring and fitted new non-slip flooring; installation of clinical IPS wash hand basin; renewal of ventilation systems; installation of PC wall mounted brackets; installation of new ceiling grid system; white rock on all surfaces; termination of access door to adjacent office; redecoration works in office; installation of new lighting, lighting circuit, data and power to both rooms and equipping room to work as a Phlebotomy area.



Before

After

Total Cost £65K

Surge

Cross-site

Commenced June 2020 and completed March 2021

St Mary's Hospital:

- Patterson Centre:

  Project consisted of converting the current Theatre & Recovery into a surge ward environment to accommodate for additional HDU 12 beds. Works entailed, works to ventilation, install of additional medical gas outlets & UPS/IPS power outlets to all new bed locations.

Charing Cross Hospital:

- 11 South Neurology:

  Works were undertaken on our 11 South Neurology ward at Charing Cross Hospital to upgrade the mechanical and electrical services to suit the requirements of ICU surge patients due to the pressures of COVID-19. This involved providing additional power sockets with UPS/IPS back-up, additional medical gas outlets, improved oxygen gas supply resilience and an upgrade of the supply ventilation to ICU performance standards. In addition a new fire compartment wall with corridor doors and hand basins was installed to allow the rear part of the ward to be sectioned off for safely treating COVID-19 patients and managing staff donning/doffing PPE. Some new ceilings and redecoration was also provided to enable these works and enhance the patient areas.

Hammersmith Hospital:

- GICU-CICU:

  Project consisted of upgrading existing ITU areas to support surge capacity for more ITU beds. Works entailed the installation of additional medical gas, air and Vacuum outlets, new electrical IPS socket outlets, upgrade of IT infrastructure to install of additional Data ports, temporary negative pressure units and upgrade and redecoration of staff facilities.

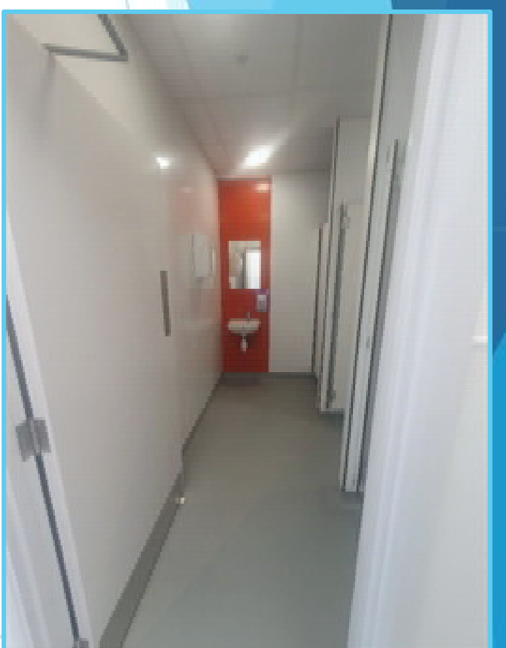
Surge

Cross-site

Cont…

St Mary's Hospital: Patterson Centre

Hammersmith Hospital: GICU-CICU



Charing Cross Hospital: 11 South Neurology

UEC

SMH & HH

Commenced November 2020 and completed March 2021

St Mary's Hospital

- Paediatric ED nursing office conversion: November – December 2020 Cost £77K
  To increase the clinical capacity to the current Paediatric department. The scheme converted an office into a clinical side room with the installation of a new IPS unit as well as improvements to the medical gases, flooring and walls. The scheme also included storage upgrades to two Paediatric resuscitation rooms and the installation of new flooring and a Kwickscreen to the Rapid Nurse Assessment within the emergency department, to comply with current Covid-19 regulations.

- 2-bay assessment: November – December 2020 Cost £108K
  To create additional capacity to 1st floor A&E department by converting office space into two assessment cubicles.

- SDEC: November 2020 – February 2021 £529K
  Involved expanding the AEC footprint into ground floor Paterson by moving the AEC from second floor QEQM.

Hammersmith Hospital

- GP/UTC building: November 2020 – March 2021 £406K
  Phase 1 - Added additional storage to existing clean utility/store room which comprised of new Stirling cabinets and enclosure of existing reception to the first floor.

  Phase 2 - Reconfiguration of the GF area to accommodate a Triage room and move reception.

  Phase 3 - Creating 3 new GP consulting rooms and separation of the existing Renal Dept.

Estates Capital Projects
Annual Report 2020/2021

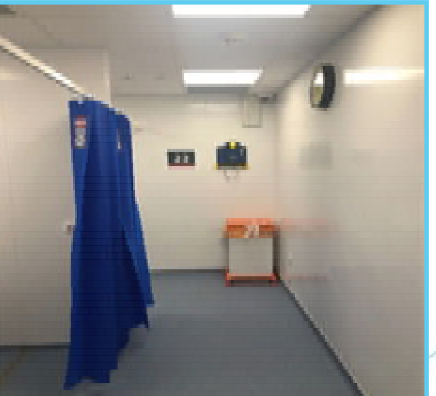
UEC

Cross-site
Cont…

Paediatric ED nursing office conversion – before and after

SDEC – before and after

2 bay assessment – before and after



Estates Capital Projects
Annual Report 2020/2021

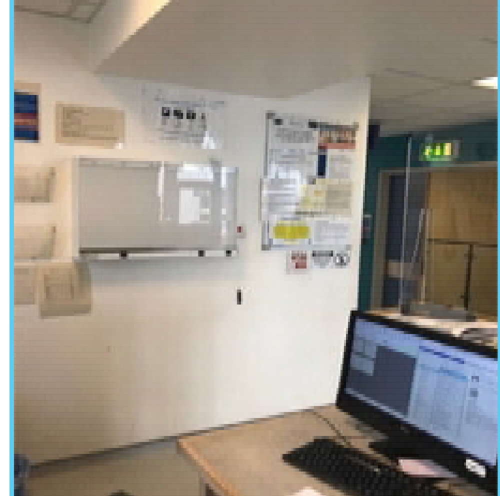
UEC

SMH & HH
Cont…

GP/UTC building – before and after

Phase 1

Phase 2



Estates Capital Projects
Annual Report 2020/2021

Bike Enclosures

SMH

Commenced and completed in March 2021

Works to the Acrow enclosure included the installation of two tier bike racks to increase the bike storage capacity from 28 bikes to 52 bikes. Within the enclosure a bike repair station has been installed and a flood light externally, for additional security.

Before

After

Total Cost £18K

Bike Enclosures

QCCH

Commenced and completed in March 2021

This project included the installation of two tier bike racks and the relocation of existing rails to increase the bike storage capacity from 42 bikes to 76 bikes. Improvements have been made to the security with the installation of new flood lighting, tougher fencing to the enclosure perimeter and gate, additional magnetic lock and modifications to enable swipe in/ swipe out access.

Before

After

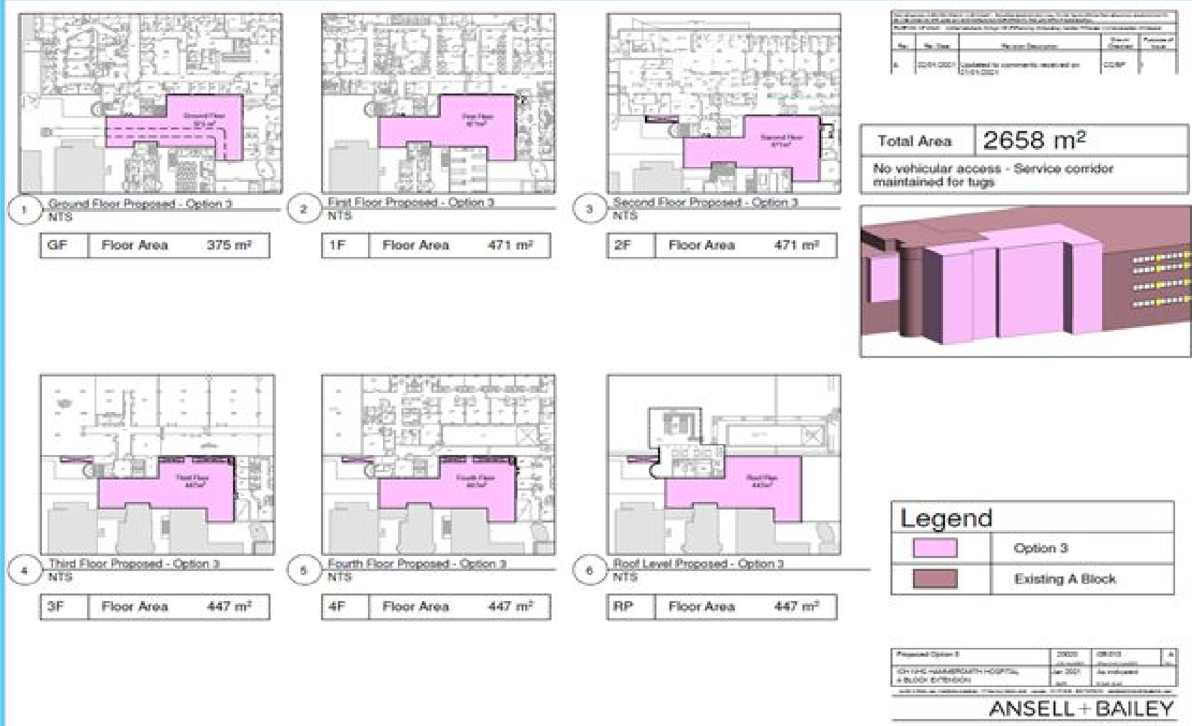
Total Cost £31K

A Block extension

Hammersmith Hospital

Feasibility project commenced September 2020

An extension of A block to create 3 new theatres to include additional clinical & non-clinical support accommodation and possibly a new critical care ward to support new theatres. There is also a proposal of the expansion of the theatre recovery to accommodate the 3 new theatres.



Existing and Proposed

Budget Estimate £25M

Breast Surgery Clinic

Charing Cross Hospital

Feasibility

Refurbishment of the Breast surgery clinic with a view to making the clinical rooms HTM compliant and the offices compliant with The Health, Safety and Welfare Regulations. This includes the relocation of the reception desk, creating of more friendly waiting area with new glass wall and Artwork on the glass wall, IPS panels in the clinical rooms and creation of Lucy's room which is vital to the project.

Existing

Proposed

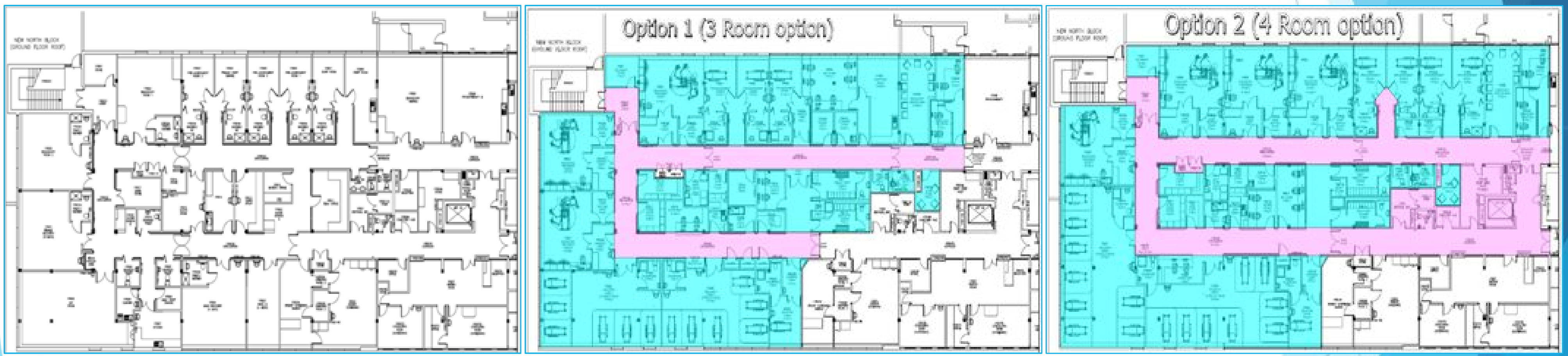
Budget Estimate £476K including £326k Charity Funding

Endoscopy Upgrade

Charing Cross Hospital

Feasibility project commenced June 2020

The Endoscopy unit at CXH occupies an old ward area on the 1st floor of the Pilot block. The department was moved there some years ago as a temporary move, and has remained there since. The unit was not refurbished at the time and does not comply with the levels of ventilation required. The initial brief was to look at providing the correct levels of ventilation and also look at expanding the unit to increase capacity, from their current two endoscopy room layout. There are now two options being worked up, one for a three room and one for a four room Endoscopy department. This will include the ventilation upgrades and expansion to the pre- and post-endoscopy facilities. The current high level budget costs sit at £5.37m for the 3 room option and £6.57m for the 4 room option.



Existing

Proposed

Budget Estimate £5.37M for the 3 room option and £6.57M for the 4 room option.

Current Risks

- Unable to recruit suitably qualified and experienced permanent candidates on current band level
- Very short timeframe given to carryout feasibility resulting in inadequate client brief, budgets not completed with due diligence and signoffs on scheme proposals from all.
- Shortage of Capital funds impacting on project deliverables with regards to compliance and stakeholder CIP requirements
- Increased costs to projects due to unforeseen infrastructure capacity issues due to age of building services and increase demand on supplies.

Estates Capital Projects
Annual Report 2020/2021

TRUST BOARD (PUBLIC)

Paper title: Patient and public involvement: Strategic lay forum 2020/21 annual review and 2021/22 priorities

Agenda item 13, paper number 10

Lead Executive Director(s): Michelle Dixon, director of communications
Author(s): Trish Longdon, chair of the strategic lay forum
Linda Burridge, head of patient and public partnerships

Purpose: For discussion

Meeting date: 14 July 2021

Executive summary

1. Purpose of this report

1.1. The Board is asked to note this annual review of progress on patient and public involvement and to support/feedback on the strategic lay forum priorities for the coming year.

2. Background

2.1. This is the annual update from the Trust's strategic lay forum covering progress against 2020/21 priorities, input into Trust business planning and priorities for 2021/22.

2.2. The forum was established over five years ago to help ensure we put patients at the centre of everything we do and to oversee patient and public involvement at the Trust. The forum – made up of 12 volunteer lay partners and key staff from around the Trust meets every two months to review and initiate plans to make sure care is patient-centred, integrated and based on patients' wants, needs and preferences.

3. **Key findings**

3.1. **Highlights of progress against strategic lay forum priorities for 2020/21:**

3.1.1. Closer collaboration between lay partners and clinicians

- Lay partners are now more directly involved with clinicians and inputting into clinical issues, including through key roles on the clinical reference group and reset and recovery projects.

3.1.2. Engaging communities and building trust through relationships

- Consistent and regular meetings with community leaders from black, Asian and minority ethnic groups, with shared agenda setting, direct Q&A and responding to issues raised by them.

- This created a sense of trust so that messages – for example, on vaccine hesitancy, safety and the importance of face masks – reached further and were considered reliable.

3.1.3. Greater strategic input by lay partners

- Through closer working relationships with senior leaders, lay partners have been able to input earlier and more effectively into strategic developments.
- Lay partners are increasingly raising issues proactively to improve user/patient focus, rather than just responding to developments that the Trust chooses to share.

3.2. **Strategic lay forum priorities for 2021/22**

- Maintain our emphasis on supporting the Trust to become the most user-focused NHS organisation.
- Support the Trust, local ICPs and the ICS to embed the patient voice in providing more integrated services for patients in north west London.
- Enable deeper involvement in research and strengthened collaboration between the Trust and Imperial College.
- Continue to develop the lay partner community.

4. Next steps

4.1. The report was discussed at the executive huddle on 7 July who were supportive. Drawing on feedback from the Trust Board, the forum will continue to progress its priorities with relevant Trust colleagues.

5. Recommendation(s)

5.1. The Trust Board is asked to note this report and support the strategic lay forum priorities for 2021/22. Discussion and feedback on priorities is also welcome.

6. **Impact assessment**

6.1. Quality impact: Patient and public involvement and the work of the strategic lay forum will impact all patient care and experience and supports the Trust's ambition to be the most user-focused NHS organisation. It aims to improve all CQC domains.

6.2. Financial impact: Work is underway to explore potential resource requirements for the future work programme.

6.3. Workforce impact: NA

6.4. Equality impact: NA.

6.5. Risk impact: This work mitigates risk around one of our key organisational enablers : to ensure a strong user (patients, staff and local communities) focus in change and developments

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Patient and public involvement

Strategic lay forum 2020/21 annual review and 2021/22 priorities

Trish Longdon
Chair, strategic lay forum

What we'll cover

Short presentation

- Highlights from 2020/21, including two videos
- Our priorities for 2021/22
- Q&A

Strategic lay forum 2020/21 annual review and priorities report

- Progress against 2020/21 priorities
- 2020/21 highlights:
    - Closer collaboration between lay partners and clinicians
    - Engaging communities and building trust through relationships
    - Greater strategic input by lay partners
- Input into Trust business planning
- Our priorities for 2021/22

Highlights from 2020/21

1. Closer collaboration between lay partners and clinicians

- Lay partners are now more directly involved with clinicians and inputting into clinical issues, including through key roles on the clinical reference group and reset and recovery projects.
- Medical director, Prof Julian Redhead, explains the impact of lay partner collaboration on clinical work in this short video.

2. Engaging communities and building trust through relationships

- Consistent and regular meetings with community leaders from black, Asian and minority ethnic groups, with shared agenda setting, direct Q&A and responding to issues raised by them.
- It created a sense of trust so that messages – for example, on vaccine hesitancy, safety and the importance of face masks – reached further and were considered reliable.
- Nafsika Thalassis and Kaveh Kalantari from the Iranian Association discuss how and why the Q&A sessions were so valuable in this short video.

3. Greater strategic input by lay partners

- Through closer working relationships with senior leaders, lay partners have been able to input earlier and more effectively into strategic developments.
- Lay partners are increasingly raising issues proactively to improve user/patient focus, rather than just responding to developments that the Trust chooses to share.
- Examples include the development of a patient reported measure plus organisational prioritisation of improvements to ‘end of life’ care and interpreting services, both issues identified by the strategic lay forum.

Our priorities for 2021/22

1. Maintain our emphasis on supporting the Trust to become the most user-focused NHS organisation:

- Development of a patient reported measure.
- Support the two user-focused projects originally identified by the strategic lay forum and cited in the Trust organisational strategy – 'end of life' care and patient interpreting.
- Support the establishment of a user-insight function at the Trust.
- Continue to challenge the Trust to improve the appointment booking system.
- Continue to advocate for the development and use of the online patient record system, the Care Information Exchange.

2. Support the Trust, local ICPs and the ICS to embed the patient voice in providing more integrated services for patients in north west London:

- Support the development of more efficient and effective services to address the waiting list backlog, for example through centralising high volume, low complexity procedures.
- It is a huge challenge for different providers across a large geographical area to adopt a consistent user-focused approach but one the strategic lay forum is dedicated to addressing.

3. Enable deeper involvement in research and strengthened collaboration between the Trust and Imperial College:

- As a key part of healthcare innovation, we actively support efforts to encourage and enable less silo-working.
- We want to enable deeper involvement, particularly from black, Asian and minority ethnic groups, to influence research priorities and design.
- Develop an organisational culture of research, focusing especially on education and training, that is understood by all Trust staff.

4. Continue to develop the lay partner community:

- Complete the lay partner evaluation and implement any recommendations.
- Continue to increase the diversity of our lay partner community through proactive recruitment.
- We currently have 39 lay partners working across 64 lay partner roles on 27 projects. To date, we've collaborated with 140 lay partners on 79 Trust projects.

Patient and public involvement 2020/21 annual review and priorities

Report from the strategic lay forum

July 2021

1. Progress against 2020/21 priorities

1. To retain focus on patient-centredness and 'what matters most to patients', including staff morale and ensuring the Trust is a 'great place to work'

- Covid-19 brought health inequalities and staff health and wellbeing strongly into focus. We advocated and supported many projects that sought improvement in these areas along as well as promoting patient-centredness more generally. E.g. Efforts to address digital poverty given the increase in online appointments and ensuring tailored care for those with hearing or learning disabilities.
- We had consistent lay partner input to the clinical reference group that has influenced many key projects and developments to be more patient-focused. This enabled a strong patient lens to be applied to everything that was discussed. For example, supporting patient visiting where possible and other ways to keep patients in touch with family and friends, improving patient information and beginning to establish the concept that patients' care journeys start at home, not when they arrive at hospital (leading to planned care patients having Covid-19 tests closer to home to avoid unnecessary travel and delay).
- The strategic lay forum has driven the development of a patient reported measure to provide an indication on how user-focused the Trust is. An approach that asks patients 'what matters to you?' (as opposed to the usual question: 'what's the matter with you?') aims to understand patient preferences and enables shared decision making. It is currently being piloted in the Trust. Responses and staff actions will be recorded on patients' electronic records and reviewed along with other patient feedback. Learning from the pilot will inform future work to establish a robust Trust-wide measure on how user-focused the organisation is.
- The forum highlighted and advocated for patients on issues such as interpreting and improved communication, particularly around the use of 'do not attempt resuscitation' protocols and coordination of 'end of life' care. 'End of life' care and interpreting improvements are now included in refreshed organisational priorities.
- Lay partner input into the Charity-funded Trust programme to improve staff spaces and on-site retail food and shops.

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2. To champion integrated care

- Lay partners have continued to be involved in developments in integrated care. We raised the issue that consistent benefits for all patients must be available across the boroughs, not just in some specific GP practices.
- Lay partners have also been involved in initial discussions on overall engagement for primary care networks. They have inputted into other integrated care initiatives such as the discharge transformation programme, a project looking at discharge processes and experience across the sector. As part of this, lay partners brokered links with key patient carer representatives who, in turn, have provided useful insight into their experiences which we are using to inform improvements.
- Promoted integrated care through the north west London acute care programme board. Two lay partners are part of this senior forum.

3. To continue to maximise the patient-voice and user insight in redevelopment

- Lay partners were involved in the technical bid process that appointed the architects for the St Mary's hospital redevelopment. This included highlighting the importance of seamless patient led care, accessibility and a good night's sleep. They also inputted into the development and speaker list of the Trust's 'better hospitals' thought leadership events to engage all stakeholders, including patients, communities and partner organisations.
- Lay partners inputted into the initial 'terms of reference' on a St Mary's hospital community forum and will continue to input into this project and the development of a wider engagement plan for St Mary's and other redevelopments.
- The chair of the strategic lay forum will be a member of the redevelopment partnership committee when it is established.
- 362 lay partners, staff and members of the public took part in the user research for the redevelopment of St Mary's. Three lay partners sat on the steering group to design the research.

Imperial College Healthcare NHS Trust

4. To bring clear patient focus to 'reset and recovery' projects, especially a) insight and data gathering through relationship building, particularly with seldom-heard groups and b) inclusive access to information and care, such as through interpreters, sign language and non-digital access

- This is an area to expand. A series of successful Q&A events were held with community leaders to share information on the Covid-19 vaccine and allay concerns. Improving interpreting is an organisational priority for 2021/22.
- The strategic lay forum fed into the development and initial thinking around the establishment of a user-insight function. We fully support a coordinated cross-Trust system of learning from and responding to patient feedback, complaints and insights. This is now with Trust management to set up and realise.

5. To increase lay partner diversity through proactive recruitment, training and remuneration

- An ongoing area of work. We are currently delivering 'equality, diversity and inclusion' training for lay partners and now routinely capture diversity information inline with national standards to monitor our diversity.
- We remunerate lay partners more often as one way to remove a barrier to involvement and enable more diversity. We will also proactively promote the role to black, Asian and minority ethnic communities. The next step is to formalise remuneration processes.

6. To continue to challenge the Trust to improve the appointment booking system

- This remains a key issue for the Trust which needs to be addressed. The pandemic further highlighted how this needs improvement with more appointments moving online and different systems of text messages and letters to advise of appointments, needing to be co-ordinated.

7. To contribute to the development and use of the online patient record system, the Care Information Exchange

- We have continued to request updates on this project, contributed to its development and feel it is a crucial area to empower patients to take ownership of their own health. If we want patients to enjoy these benefits, the Trust must take a strategic step to develop and integrate a consistent role for the Care Information Exchange within care pathways.

8. To demonstrate lay partner impact through evaluation

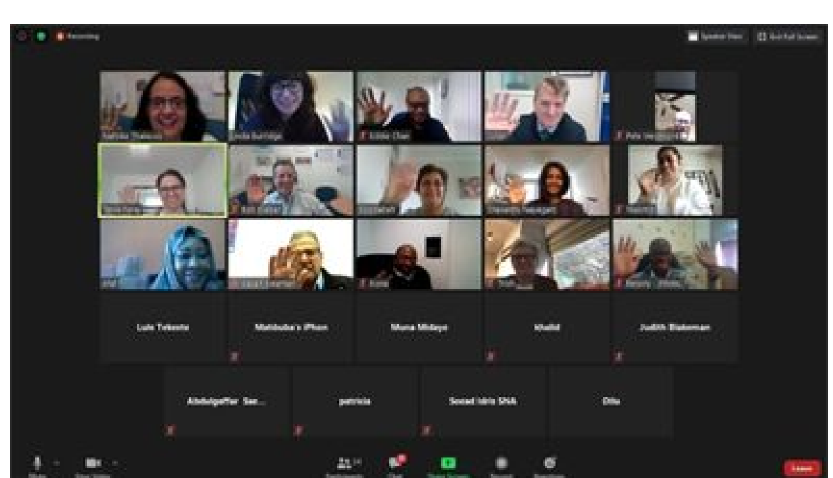
- A robust evaluation plan lead by public health consultant, Dr Esther Wong, is now underway and set for completion in autumn 2021.
- This was co-designed and agreed with lay partners, staff, quality improvement colleagues, Imperial Health Charity and Imperial College London and will be the first time we have formally looked at the impact lay partners make.
- We look forward to growing and improving the lay partner community with these insights.

2. 2020/21 highlights

1. Closer collaboration between lay partners and clinicians

- Lay partners are now more directly involved with clinicians and input into to clinical issues, including through key roles on the clinical reference group and reset and recovery projects.
- This has enabled external patient-focused perspectives on care and treatment approaches that directly affect the quality of care and patient experience.
- Examples include ensuring the restarting of services following Covid-19 was equitable, with prioritisation based on clinical need.
- Medical director, Prof Julian Redhead, explains the impact of lay partner collaboration on clinical work in this short video.

2. Engaging communities and building trust through relationships



- In 2020, Nafsika Thalassis, director of the BME Health Forum and deputy chair of our strategic lay forum, raised concerns and fears circulating amongst local black, Asian and minority ethnic communities about hospital care and Covid-19. This led to the Trust creating some targeted communications for our diverse communities.
- We set up quarterly Q&A events with community leaders and medical director, Prof Julian Redhead.
- Consistent and regular meetings with community leaders from black, Asian and minority ethnic groups, with shared agenda setting, direct Q&A and responding to issues raised by them.
- This created a sense of trust so that messages – for example, on vaccine hesitancy, safety and the importance of face masks – reached further and were considered reliable.
- This has shown the value of engaging our communities in this way and that relationships need to be consistently maintained over time.
- Nafsika Thalassis and Kaveh Kalantari from the Iranian Association discuss how and why the Q&A sessions were so valuable in this short video.

3 Greater strategic input by lay partners

- Through closer working relationships with senior leaders, lay partners have been able to input earlier and more effectively into strategic developments.
- Lay partners are increasingly raising issues proactively to improve user/patient focus, rather than just responding to developments that the Trust chooses to share.
- There are various examples, including :
  - A strong relationship between the forum and Dr Bob Klaber has enabled the Trust to respond to the call to develop a patient reported measure on being user-focused. This approach asks patients ‘what matters to you?’ as opposed to the usual question: ‘what’s the matter with you?’. It aims to elicit patient preferences and enable shared decision making. Through consistent follow up, a project group was established, and the pilot is now underway. This will inform future work to establish a robust Trust-wide measure.
  - Our deputy chair, Nafsika Thalassis, has strong links with black, Asian and minority ethnic and seldom-heard groups. Through this and the strengthened relationship between the forum and senior leadership, two key issues (patient interpreting and ‘end of life’ care) have been included as organisational priorities for 2021/22.
- Lay partners are on key strategic groups, such as the acute care programme board.
- We want to enable deeper involvement in research and better collaboration between the Trust and Imperial College and proactively raised this issue at our last forum meeting in June.

3. Input to Trust 2021/22 business planning

Key priorities the strategic lay forum identified for 2021/22 business planning:

- When developing this input, we took into account the pressures and challenges created by Covid-19. We think many of them will support work to respond better to future challenges posed by the pandemic.
- We maintain our focus on patient-centeredness and that it must be reflected in all of the Trust's strategic plans, programmes and projects in order to achieve the Trust's aim of becoming the most user-focused NHS organisation. For us, this means that all care and support for patients, families, carers and communities – including seldom-heard groups – is shaped by actively asking and understanding what matters to them, and measuring outcomes against agreed goals.
- We continue to strongly support the integration of care and treatment centred around each individual, both across the Trust and in collaboration with all north west London health and care partners, including local government, community and mental health services, GPs, care homes and the voluntary sector.
- We strongly support the need for redevelopment of the St Mary's site – as well as the Charing Cross and Hammersmith sites (and incorporation of the Western Eye, as most appropriate). It is positive that early lay input into this work was sought.

Our priorities for 2021/22

1. Maintain our emphasis on supporting the Trust to become the most user-focused NHS organisation:

- Development of a patient reported measure.
- Support the two user-focused projects originally identified by the strategic lay forum and cited in the Trust organisational strategy – ‘end of life’ care and patient interpreting.
- Support the establishment of a user-insight function at the Trust.
- Continue to challenge the Trust to improve the appointment booking system.
- Continue to advocate for the development and use of the online patient record system, the Care Information Exchange.

2. Support the Trust, local ICPs and the ICS to embed the patient voice in providing more integrated services for patients in north west London:

- Support the development of more efficient and effective services to address the waiting list backlog, for example through centralising high volume, low complexity procedures.
- It is a huge challenge for different providers across a large geographical area to adopt a consistent user-focused approach but one the strategic lay forum is dedicated to addressing.

3. Enable deeper involvement in research and strengthened collaboration between the Trust and Imperial College:

- As a key part of healthcare innovation, we actively support efforts to encourage and enable less silo-working.
- We want to enable deeper involvement, particularly from black, Asian and minority ethnic groups, to influence research priorities and design.
- Develop an organisational culture of research, focusing especially on education and training, that is understood by all Trust staff.

4. Continue to develop the lay partner community:

- Complete the lay partner evaluation and implement any recommendations.
- Continue to increase the diversity of our lay partner community through proactive recruitment.
- We currently have 39 lay partners working across 64 lay partner roles on 27 projects. To date, we’ve collaborated with 140 lay partners on 79 Trust projects.

TRUST BOARD (PUBLIC)

Paper title: Maternity Quality Assurance Oversight Report

Agenda item: 14 and paper number 11

Executive Director: Tg Teoh, Divisional Director
Author: Louise Frost - Lead Midwife - Quality Assurance, Governance and Compliance

Purpose: For discussion and approval

Meeting date: 14 July 2021

Executive summary

1. Purpose of this report

1.1. This report is presented to the Trust Board for oversight on the maternity quality assurance report and to inform the Board of progress on achieving compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) year three. The report also informs the Board of the evidence submission progress with the seven Ockenden Immediate and Essential Actions (IEA).

2. Background

2.1. The CNST MIS Year three re-launched on 1 October 2020. Trusts who can demonstrate achievement of all ten safety actions will recover the additional 10% of their contribution. Guidance has since been updated in March 2021.

2.2. The Ockenden report was published in 2020. Each Trust participated in a peer review and subsequently evidence has been submitted to NHS England.

2.3. A single quality assurance oversight report has been developed including all relevant information and actions in place to address performance of the maternity service.

3. **Key findings**

3.1. The maternity service continues to provide a high quality service alongside meeting increasing external assurance requests.

3.2. A robust risk management process continues in regard to oversight and update of the risk register, incident review and appropriate level of investigations to meet national recommendations. Due to the external panel requirements for serious incidents there have been agreed extensions to serious incident investigations. Learning is shared with staff which includes feedback from issues raised to the safety champions.

3.3. The Local Maternity and Neonatal System (LMNS) signed off the CNST MIS compliance on 7 July 2021.

3.4. There are seven requirements rated as not met within the active Board Declaration form however, mitigations are in place and accepted by CNST as compliant with the scheme.

3.5. The evidence in relation to the Ockenden recommendations has been submitted to NHS England.

3.6. The Quality Committee received a draft report and declaration at its meeting on 8 July 2021 and authority was delegated to the Committee Chair to review the final version before recommending sign-off by the Trust Board.

4. Next steps

4.1. Divisional commitment continues to work towards improving quality and safety.
4.2. The Board Declaration to be approved for submission by Trust Board on 14 July 2021 and submitted to NHS Resolution by 22 July 2021.
4.3. Await response and next steps from NHS England following Ockenden evidence submission.

5. Recommendation(s)

5.1. The Board is asked to **note** the findings and ongoing progress with the required actions.
5.2. **To discuss and approve** the CNST MIS year three active Board Declaration Form.

6. Impact assessment

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

Main report

1. Quality Assurance report

1.1. Maternity Dashboard/ Score card (appendix 1).

Perinatal mortality rate – the smallest babies in the region are delivered at Queen Charlotte Hospital (QCCH) due to the hospital having the medical neonatal intensive care unit for the sector. For this reason, it is expected there will be a higher perinatal mortality rate to our peers because their cases are referred to Imperial. The LMNS are currently developing a process of collating this data including a review of ethnicity in relation to stillbirths. The review of stillbirths at Imperial in 2020, shows the stillbirth rate was highest for women of Pakistani and Indian origin. A large proportion of post mortems were unable to determine the cause of death. Learning and actions are shared within the report and on-going monthly PMRT updates. The deviation in stillbirth rates occurs between 24 weeks to 32 weeks where it is higher at QCCH. The rate after this gestation is similar at both sites. More comparisons are being made to similar level 3 units to make the data contextual.

1.2. Risk register: There are currently 24 risks on the directorate's risk register with risk levels of 1 extreme, 16 high and 6 moderate. Effectiveness of the mitigations are reviewed at local Quality and Safety (Q&S) meetings and feed in to the divisional Q&S committee. All risks have been reviewed and are within the review date.

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

- 3462 Risk of compliance with Continuity of care models offered to vulnerable adults booked for maternity care (score 9).
- 2019 State of Labour ward theatres at QCCH (score 20). This risk was increased last month due to an incident.
- 2504 Failure of the lockable automatic doors on Operating Theatres on QCCH Labour Ward (score 16). Risk static, no date for repair.
- 1195 Delay in transfer of maternity patients in an emergency due to lift failure in Cambridge wing at SMH. This risk was reduced from a score of 8 to 4 as new lifts are now in place. Plan for the risk to be closed if no issues in the next three months.

- 2162 Poor environment in some of the USS areas related to estates (score 12).
- 2663 Financial risks associated with the risk of fall in birth-rates in NWL (score 12).
- 2338 Failure in call bell system on Edith Dare Ward (score 8). This was reduced as a new system in now in place on Labour Ward, however the risk remains on the 1st floor of QCCH.

1.3. Incidents: Reported incidents in April 2021: St Mary's Hospital (SMH) 72, QCCH 92. May 2021: SMH 91, QCCH 109. There is an increase in reported incidents at both sites compared to March 2021 – majority of the incidents reported are from labour wards. Highest incident reporting category continues to be labour/delivery followed by admission, diagnostic investigation, clerical/appointments and implementation of care. The highest incident reporting sub categories are unexpected term admission to neonatal unit, post-partum haemorrhage, un-expected readmission, third/fourth degree tears and follow-up appointment not booked. On 1 July 2021 there were 57 datix reported overdue for review. Email communication has been sent to the relevant managers and these are under review. On 5 July 2021 there are a total of 21 on-going Serious Incidents (SI) investigations. 14 are closed and awaiting Clinical Commissioning Group (CCG) approval. 5 are on-going and currently being investigated by Health Safety Investigation Branch (HSIB). Two SI investigations are overdue with agreed extensions due to the Local Maternity and Neonatal System (LMNS) requirement for external panel review as part of the investigation process. The Trust will request further clarification on the LMNS external panel requirement as this has been beyond the guidance of the Ockenden recommendations.

Table 1 Severity of incidents:

May 2021	Near miss	No harm	Low harm	Moderate harm	No severity recorded	Total
Affecting patient	17	52	109	1	6	185
Affecting staff	1	5	1	0	1	8
Affecting organisation	0	9	0	0	0	9
Total	18	66	110	1	7	202

Table 2 Serious incidents – All incidents reported to HSIB are reported as SI's from January 2021

	19/20 total	20/21 total	2020/21				
			Jan	Feb	Mar	Apr	May
HSIB	8	10	1	2	2	1	1
SI total	12	24	1	2	3	3	1

*SI total includes HSIB cases reported as SI's

1.4. Serious incidents declared in April and May 2021:

- HSIB – Multiparous woman delivered on Birth Centre. Hypoxic ischaemic encephalopathy grade 2 diagnosed.
- SI – Primiparous woman, 31 weeks gestation admitted over weekend with possible pneumonia. Echo examination on the Monday diagnosed aortic dissection. Moved to Kings Hospital for surgery.
- SI (HSIB rejected as the woman was not in labour) – Primiparous woman, routine growth scan abnormal. Referred to Maternity Day Assessment Unit. Pathological CTG. Transferred to labour ward. Baby born poor condition. Therapeutic cooling.
- SI - Primiparous woman. Induction of labour for reduced fetal movements and prolonged rupture of membranes. Delay in transfer to labour ward to continue induction process. When the Cardiotocograph (CTG) was commenced there was a bradycardia and the woman was moved to the labour ward for an emergency caesarean section. Baby born in poor condition and required therapeutic cooling.

1.4.1. Four serious incident reports have been finalised and shared with the women involved. Summary and learning is included in appendix 2.

1.5. Audits: One ongoing in date national audit relating to maternity care for women with a Body Mass Index of 30 Kg/m2 or above.

1.6. Guidelines: One guideline overdue (1 June 2021) and currently under review (6 July 2021).

1.7. Complaints & Compliments

1.7.1. The following table details the complaints and compliments received by the maternity service.

Table 3: Complaints and compliments

	Mar 21		Apr 21		May 21	
	SMH	QCCH	SMH	QCCH	SMH	QCCH
Formal complaints	4	6	3	2	2	4
Total number of breaches	0	0	0	0	0	0
% responded to within timeframe	100	100	100	100	100	100
PALS issues & complaints	9		7		12	
Formal compliments	6		3		3	

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

1.9. Core skills compliance: (reported 23 June 2021) 24 out of 26 Core 10 and Core Clinical achieved above 90% threshold across all relevant staff groups. Those staff not meeting compliance continue being targeted. Resuscitation level 2 and safeguarding level 3 training remains below the threshold, however each staff member has been informed and booked the relevant training.

1.10. Care Quality Commission (CQC) Ward Accreditation Programme: The CQC rating for all maternity services across sites and Lindo Wing is Outstanding. A benchmarking exercise was performed following the Nottingham Hospital maternity service CQC findings and recommendations. Actions are on going but there appears to be overall reassurance of the Imperial maternity service pathways and performance.

1.11. Workforce metrics

- Vacancy and turnover - Band 6 Midwives currently 18 WTE vacancies (8%). Band 2 and 3 Support Workers 10 WTE vacancies (11%).
- Recruitment - Retention of our student midwives upon qualification remains good with the majority of our students choosing to stay with us. Rolling adverts in place for experienced midwives as well as newly qualified midwives. Recent new Maternity Support Worker recruits have made a noticeable improvement in fill rates in specific areas. Maternity have been further engaged with the new Deputy Director People & Organisation Development - HR Operations & Resourcing to further strengthen our recruitment and retention plans.
- Sickness 4.8% (March 2021) a slight rise on the previous month.

1.12. Staff escalation concerns to maternity safety champions have included issues around workload and acuity at QCCH. The concerns were responded to acknowledging the volume of planned activity in the unit specifically the numbers of induction of labour. The plans for this pathway have been shared with staff and they are involved in the developments to improve this area of the service. There has also been a recruitment drive with the MSW's which have improved the staffing of all areas of the service.
Staff have also been informed of security cover at weekends and overnight at QCCH ground floor due to concerns raised about the safety for women and babies out of hours.

2. CNST MIS safety action update report

The information below details completed actions to demonstrate compliance with the ten safety actions included in the maternity incentive scheme. The active declaration form for sign-off by the Trust Board is in appendix 3.

2.1. **National Perinatal Mortality Review Tool (PMRT)** Next quarterly report for Trust Board review is due for collation in July 2021. The monthly update report submitted to the Quality Committee demonstrates compliance with CNST MIS requirements.

2.2. **Maternity Services Data Set (MSDS)** Compliant and on-going data submitted to NHS Digital.

2.3. **Transitional Care (TC) and Avoiding Term Admissions into Neonatal (ATAIN) units programmes** Weekly ATAIN review meetings continue. Action plan reviewed and signed-off monthly by safety champions and submitted to the Quality Committee for oversight.

2.4. **Clinical Workforce planning (obstetric, anaesthetic, neonatal & neonatal nursing)** Neonatal nursing workforce review - Action plan emailed to the Royal College of Nursing and submitted to the Operational Delivery Network. ICHT has agreed to use a local safe staffing SOP recognising that the Neonatal Critical Care service specifications workforce skill mix is unachievable due to a lack of skilled staff nationally. Our staffing is safe as evidenced in the action plan submitted to Trust Board in May 2021.

2.5. **Midwifery Workforce planning** Six monthly reports demonstrating safe staffing have been submitted to the trust board with required action plans where 100% has not been achieved. March 2021 report detailed 99% compliance rate for one to one midwifery care in labour and supernumerary labour ward coordinator status for the previous 6 months.

2.6. **Saving Babies Lives Care Bundle Version 2**

2.6.1. April 2021 Quarterly care bundle survey completed and submitted to NHS England. Audits have been completed demonstrating compliance with CNST MIS requirements for elements 1, 2, 3 and 5. These were submitted to the Quality Committee for oversight. Single action plan developed to address further improvements for each element. Maternity Services Data Set (MSDS) requirements under review to enable data reporting to NHS Digital. Guidelines updated to provide assurance to the Trust Board of standards implementation, such as women with BMI>35 Kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards and uterine artery Doppler flow velocimetry is performed by 24 weeks gestation in high risk pregnancies. Assurance that women at high risk of preterm birth have access to a specialist preterm birth clinic. There is commitment to facilitate local, in-person, fetal monitoring training when this is permitted. MDT fetal monitoring training session reinstated 08/03/21. 90% compliance target has been removed from CNST MIS guidance, however the service aims to meet 90% by the end of July 2021.

Table 4: June 2021 compliance figures:

Staff group	K2 assessments	Training session
Midwives	↑ 82%	↑ 65.4%
Obstetric consultants	↑ 31% (12)	↑ 15%
Obstetric doctors	↑ 45% (27)	↑ 18%

2.7. **Maternity Voices Partnership (MVP)** Terms of Reference approved by Chair of MVP and Head of Midwifery. Further evidence produced to demonstrate CNST compliance including co-production reports and a presentation following prioritising hearing voices of women from Black Asian and minority ethnic backgrounds and areas of deprivation listening event. Evidence has been submitted to the Quality Committee for oversight.

2.8. **Multi-professional maternity emergency training** - Virtual Practical Obstetric Multi-Professional Training (PROMPT) and neonatal resuscitation training reinstated 8 March 2021. There is a commitment to facilitate local, in-person, multi-disciplinary team training when this is permitted. Covid-19 specific e-learning has been made available to the multi-professional team within the PROMPT session meeting CNST compliance. Plan in progress to ensure PROMPT and neonatal resuscitation training target 90% of each staff group. 90% compliance target has been removed from CNST MIS guidance.

Staff group	PROMPT	Neonatal resuscitation
Midwives	↑ 303 (73%)	↑ 303 (73%)
Obstetric consultants	↑ 32 (80%)	N/A
Obstetric doctors	↑ 62 (71%)	N/A

Obstetric anaesthetic consultants	↑ 31 (73%)	N/A
Obstetric anaesthetic doctors	↑ 33 (89%)	N/A
Critical care staff (ODP's)	23 (44%)	N/A
Maternity support workers	↑ 100 (83%)	N/A
Neonatal consultants	N/A	100%
Neonatal junior doctors	N/A	100%
Neonatal nurses	N/A	100%

Table 5: Training compliance figures for PROMPT and neonatal resuscitation

2.9. **Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?** Quality and safety strategy document finalised and emailed to all maternity staff. Score culture survey results have been addressed within the maternity clinical, quality and safety strategy. Areas of improvement were teamwork, communication and burn out climate. The presentation was submitted to the Quality Committee for oversight. Continuity of Care (CoC) action plan monthly reviews continue with development of data capture to review ability to prioritise women from Black and Asian backgrounds and areas of high deprivation. The Trust is working to meet the 35% target of women being placed onto a CoC pathway and ensure that the current teams meet the national definition of CoC. Data reported for women placed onto a CoC pathway from April 2020 to March 2021 was 27%.

2.10. **NHS Resolution Early Notification Scheme (NHSR EN) -** Trust Board will continue to receive oversight of EN incidents and numbers reported to NHSR EN scheme and HSIB.

3. Ockenden Immediate and Essential Actions (IEA)

3.1. Evidence submitted to NHS England.

3.2. On-going actions to address recommendations are listed below for each IEA:

- IEA1 (Enhanced Safety) – SI learning presented to Trust Board and LMNS Maternity Serious Incident Oversight Group meetings. Agreed pathway to ensure external panel member present for required cases.
- IEA2 (Listening to women and families) – continued involvement with Maternity Voices Partnership (MVP) and Non-Executive Director maternity safety champion.
- IEA3 (Staff training and working together) – Audit completed of consultant led MDT ward rounds. Refer to CNST safety action 8.
- IEA4 (Managing complex pregnancy) – Continued involvement in development of tertiary maternal medicine service. Audit completed of complex pregnancy pathway.
- IEA5 (Risk assessment throughout pregnancy) – Cerner changes completed. Staff training to record risk assessment and intended place of birth correctly.
- IEA6 (Monitoring fetal wellbeing) – substantive recruitment to midwifery post in progress.
- IEA7 (Informed consent) – MVP completed a website review and developed an action plan. Audit completed demonstrating women involved in decision making and views respected.
- Workforce planning benchmarking exercise completed against RCM Strengthening midwifery leadership manifesto. Birthrate + assessment planned in 2021.

4. Conclusion

4.1. The maternity service continue to strive to improve quality and safety in line with national requirements.

Glossary (attached)

Appendices:

Appendix 1: LMS Scorecard April 2021
Appendix 2: SI summary of learning
Appendix 3: Imperial MIS Safety Action 2021 (Declaration Form)

LMS Scorecard - April 2021

Imperial College Healthcare NHS Trust

Category	KPI Description	Target (Green)	Target (Red)	Imperial College Healthcare NHS Trust					
				Queen Charlotte's		St Mary's Hospital		Trust Wide	
				2021/04	YTD	2021/04	YTD	2021/04	YTD
Choice & Personalisation	Number of women offered a personal care plan (%)			100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Number of women who have a personalised care plan			461	461	374	374	835	835
	Number of women who have a personalised care plan (%)	50.00%	19.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Number of women offered choice of all three birth settings			461	461	374	374	835	835
	Number of women offered choice of all three birth settings (%)	100%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Number of women giving birth in midwifery settings (home births + Midwifery Led Birth Units)			57	57	36	36	93	93
	Number of women giving birth in midwifery settings (% of total maternities) - NHSE definition	21.50%	16.00%	12.56%	12.56%	17.56%	17.56%	14.11%	14.11%
	Number of women giving birth in midwifery settings (% total maternities excluding elective cs, still births, and pre-term)			16.38%	16.38%	25.35%	25.35%	18.98%	18.98%
Safety	Number of still births			1	1	2	2	3	3
	Crude still birth rate	3.12		2.14	2.14	9.35	9.35	4.40	4.40
	Number of neonatal deaths			0	0	0	0	0	0
	Crude neonatal death rate	0.94		0.00	0.00	0.00	0.00	0.00	0.00
	Number of intrapartum brain injuries (to NHS resolution)			1	1	0	0	1	1
Screening	All bookings			461	461	374	374	835	835
	Booking by 10+0 (%) Exclusions: Late referrals (women referred after 10 weeks of pregnancy)	60.00%	49.00%	76.42%	76.42%	82.35%	82.35%	78.98%	78.98%
	Booking by 10+6 (%) Exclusions: Late referrals (women referred after 10 weeks and 6 days of pregnancy)	90.00%	39.00%	90.71%	90.71%	93.53%	93.53%	91.93%	91.93%
Clinical Outcomes - Births	Total births			468	468	214	214	682	682
	Live Births			466	466	213	213	679	679
	Non-Viable Births (<24 weeks) and medical TOPs of any gestation looked after on labour ward			3	3	0	0	3	3
	Total maternities (number of women (any birth ≥ 24/40 + live births <24/40))			454	454	205	205	659	659
	Number of women giving birth in Midwifery Led Birth Units			52	52	30	30	82	82
	Women birthing in Midwifery Led Birth Units (%)- NHSE definition	20.00%	15.00%	11.45%	11.45%	14.63%	14.63%	12.44%	12.44%
	Women birthing in Midwifery Led Birth Units (of all maternities exc elective cs and pre term births) (%)	20.00%	15.00%	14.94%	14.94%	21.13%	21.13%	16.73%	16.73%
	Actual home births			5	5	6	6	11	11
	Actual home births (of all maternities) (%) NHSE definition	1.50%	1.00%	1.10%	1.10%	2.93%	2.93%	1.67%	1.67%
	Actual home births (of all maternities exc elective cs and pre term births) (%)			1.44%	1.44%	4.23%	4.23%	2.24%	2.24%
	Babies born before arrival (BBAs)			2	2	1	1	3	3
	Babies born before arrival (BBAs)(%)	0.50%	1.00%	0.43%	0.43%	0.47%	0.47%	0.44%	0.44%
	Induction of labour including PROM ((%) of all who do not have a planned CS)			43.47%	43.47%	29.07%	29.07%	38.94%	38.94%
	Spontaneous unassisted vaginal births (of all maternities) (%)			48.68%	48.68%	46.34%	46.34%	47.95%	47.95%
	Normal vaginal births including spontanous & induced labour (of all maternities) (%)	55.00%	50.00%	84.58%	84.58%	70.73%	70.73%	80.27%	80.27%
	Instrumental deliveries (of all maternities) (%)	16.90%	20.00%	15.64%	15.64%	8.78%	8.78%	13.51%	13.51%
	Instrumental deliveries (of all who do not have CS) (%) - Pan london def	16.90%	20.00%	24.23%	24.23%	15.65%	15.65%	21.81%	21.81%
	Unsuccessful instrumental births (of all instrumentals) (%)	4.90%	7.00%	7.04%	7.04%	5.56%	5.56%	6.74%	6.74%
	Full dilatation LSCS (of all CS in labour-emergency) (%)	5.90%	8.00%	8.54%	8.54%	5.26%	5.26%	7.19%	7.19%
	Number of regional analgesia in labour (Combined Spinal Epidural or Epidural) (excluding all caesareans sections)			120	120	40	40	160	160
	Number of epidurals (excluding spinal only)			271	271	115	115	386	386
	Prelabour caesarean sections (ELCS + pre labour) (of all maternities) (%)	16.00%	18.00%	17.40%	17.40%	16.10%	16.10%	17.00%	17.00%
	Caesarean sections in labour (emergency) (of all maternities) (%)	13.00%	15.00%	18.06%	18.06%	27.80%	27.80%	21.09%	21.09%
	Total number of caesarean sections (of all maternities) (%)	29.00%	33.00%	35.46%	35.46%	43.90%	43.90%	38.09%	38.09%
	NNAP Magnesium sulphate eligible			8	8	3	3	11	11
	NNAP Magnesium sulphate given (%)	85.00%	80.00%	87.50%	87.50%	100.00%	100.00%	90.91%	90.91%
Public Health	Women smoking at booking			9	9	12	12	21	21
	Women smoking status at birth (%)			2.20%	2.20%	1.95%	1.95%	2.12%	2.12%
	Women offered smoking cessation treatment (of all smokers at booking)	95.00%	90.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Breastfeeding initiation rate			82.83%	82.83%	87.79%	87.79%	84.39%	84.39%
Clinical Outcomes - Maternal	Number of episiotomies (% vaginal births)			23.18%	23.18%	13.79%	13.79%	20.60%	20.60%
	Women experiencing 3rd or 4th degree tear (% vaginal births)	4.00%	8.00%	0.26%	0.26%	6.21%	6.21%	1.89%	1.89%
	Post partum haemorrhage of ≥1500 ml (%)	3.60%	7.20%	3.30%	3.30%	2.44%	2.44%	3.03%	3.03%
	Puerperal Sepsis (ICD 10 code 085) (%)	1.50%	3.00%	0.44%	0.44%	0.00%	0.00%	0.30%	0.30%
	Maternal readmissions			9	9	6	6	15	15
	Preterm births (Total Number of live Births before 37 weeks)			26	26	28	28	54	54
	Preterm birth rate (%)	6.00%	8.00%	5.56%	5.56%	13.08%	13.08%	7.92%	7.92%
Workforce	1:1 care in labour			344	344	145	145	489	489
	1:1 care in labour (%)			99.14%	99.14%	98.64%	98.64%	98.99%	98.99%
	Midwife:Birth ratio (only direct clinical care)	1.30	1.33	1:26	1:26	1:24	1:24	0	0
	Obstetric (consultant) cover in hours per week (24 hour time frame)			98	98	84	84	182	182
	Does the obstetric unit provide 7 day/week dedicated consultant presence 12 hours per day.	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Operational Support	Number of Formal complaints per month	Local Targets		2	2	3	3	5	5
	Closure of maternity unit	Local Targets		1	1	0	0	1	1
	Closure of maternity unit- total duration (hours)	Local Targets		5	5	0	0	5	5

Appendix 2 - Maternity Serious Incident (SI) summary of learning

Incident 2020/20846

A woman attended the maternity day assessment unit at 37 weeks pregnant with a history of reduced fetal movements and upper abdominal pain. She had 3 caesarean sections in previous pregnancies and a premature vaginal delivery at 26 weeks gestation.
The woman was admitted to the antenatal ward with a plan for a category 3 caesarean section when labour ward acuity allowed. The labour ward remained busy throughout the night through to the following day.
The following night, the woman was taken to theatre where a combined spinal epidural (CSE) was sited and a urinary catheter inserted. Shortly afterwards the woman became unresponsive and went into cardiac arrest. Cardio-pulmonary resuscitation begun and the trachea was intubated. Four minutes later as the baby was delivered, there was return of spontaneous circulation. The woman was transferred to the Intensive Care Unit for on-going care.

Findings:

- Good practice identified with immediate recognition of cardiac arrest and prompt response in line with recommended Resuscitation Council guidelines.
- Delayed caesarean section due to acuity of labour ward workload.
- The woman displayed symptoms of dehydration and complained of feeling dizzy.
- The spinal dose uses, whilst within the range normally used for caesarean sections, was higher than commonly used as part of a CSE technique.
- The woman was laid supine for urinary catheterisation. Even with left lateral tilt, there would have been some degree of aortocaval compression.
- The caesarean section occurred out of normal working hours when the availability of staff numbers and seniority is reduced.

Root cause:

The loss of cardiac output was likely to have been due to a combination of dehydration and aortocaval compression in the presence of spinal anaesthesia.

Recommendations and learning:

- To raise awareness of the formal process for review and escalation of multi-disciplinary workload.
- Fasting guideline to be readily available on Lewis Suite and Labour ward. Staff should be familiar with contents.
- Continue on-going training for anaesthetic staff in CSE.
- To update bladder management in labour guideline to include urinary catheterisation for spinal anaesthesia should be performed, whenever possible, when the woman is in lateral position.
- To raise awareness of the guidelines for reduced fetal movements.

Incident 2019/26632 – HSIB investigation

A woman having her first baby, booked for high risk maternity care at 12+0 weeks. She had an emergency caesarean section following an induction of labour at 41+3 weeks. The mother was discharged home on day two with an iron supplement, oral antibiotics and low molecular weight heparin. The mother's postnatal care was overseen by a different Trust and she was reviewed on day three and day five by community staff. The mother reported that her ankles were swollen and that she was short of breath on mobilising on day three. The mother had a sudden, unexpected collapse on day seven at 12:42 hours and on the arrival of the emergency services to the mother's home at 12:50 hours, she was unconscious. She was transferred to a different Trust's emergency department (ED) where she arrived at 13:50 hours. During the transfer the mother had a cardiac arrest. Advanced life support was started at 13:32 hours and continued in the ED for 100 minutes. The mother died at 15:50 hours.

Findings:

- The mother's antenatal, intrapartum and postnatal care was in line with trust and national guidance. In view of a history of ulcerative colitis, the mother received multidisciplinary care in pregnancy.
- The mother's pre-hospital and hospital care following her collapse and cardiac arrest were in line with local and national guidance.

Root cause:

A post-mortem (PM) documented the mother's cause of death as **'cardiorespiratory failure, postnatal hypertension and pregnancy'**.

Recommendations and learning:
The Trust to ensure that local guidance supports full discharge information being given to other Trusts when the mother's care is transferred.

Incident 2020/23482

A woman who booked for maternity care in her first ongoing pregnancy and was low risk at booking. Her antenatal care was uneventful and in view of prolonged membrane rupture her labour was augmented with oxytocin at 39+6 weeks gestation. This was successful and she subsequently had a spontaneous vaginal delivery of a live female infant. She sustained a second degree tear which was sutured by a senior midwife. Post-delivery she was unable to pass urine and therefore she had an indwelling catheter inserted by the midwife caring for her; this was removed as per protocol. Later that evening, the woman reported pain at her perineum and on examination the midwife noted a cotton gauze swab inside the woman's vagina which she removed immediately. This cotton gauze swab was later identified as being part of a vaginal examination pack that was used for the urinary catheterisation. Later that night the woman developed mild pyrexia and was prescribed intravenous antibiotics and fluids. A speculum examination by a consultant obstetrician revealed no further retained materials

Findings:

- An unknown number of swab gauze balls were used for cleaning the woman's urethra and vulva prior to catheterisation which led to one being retained inside the vagina.
- Aseptic non touch technique (ANTT) not performed during catheterisation.

Root cause:
Aseptic Non Touch Technique was not correctly adhered to during catheterisation.

Recommendations and Learning:

- Highlight with maternity staff, the importance of correct ANTT when catheterising women.
- Reflective session with the staff involved regarding ANTT and appropriate use of gauze balls in the vaginal examination packs.
- To include ANTT reminder at midwifery annual statutory/mandatory training at Bladder management session.
- Remove the vaginal examination packs that contain the gauze balls from the ward areas.

Incident 2020/23974

Due to a supply error, 17 women who attended antenatal clinic for vaccination were mistakenly given REVAXIS which protects against polio, diphtheria and tetanus. They should have been given REPEVAX which protects against polio, diphtheria, tetanus and pertussis (whooping cough).

The 17 women who received the incorrect vaccine were contacted and informed of the error. Following a discussion with pharmacy, where the value of revaccinating the women was discussed: 13 women who were before 34 weeks gestation were recalled; 12 were given the Repevax vaccine; and 1 woman declined. 4 postnatal women were offered rapid access to the infant vaccination programme by their GP of which 2 mothers declined and as such were advised that if their baby became unwell they were to let their GP or the Paediatric team know that they hadn't been vaccinated for pertussis in pregnancy.

Findings:

- Revaxis vaccination incorrectly supplied from pharmacy to antenatal clinic (ANC)
- The return of the incorrect vaccine was not logged by pharmacy staff as an incident neither or Datix nor on the pharmacy near miss forms
- Incorrect vaccination not identified in ANC on receipt from pharmacy
- Wrong vaccination administered

Root Cause:
The picking process in pharmacy was not adhered to. The checking-in process in the antenatal clinic to ensure that the correct vaccines were received was not adhered to.

Recommendations:

- Mark the vaccine locations with a high risk note to warn staff of similar sounding/looking drugs.

- Ensure that new stores staff are aware that drugs delivered in the same bag may need to be stored in different locations.
- The Picking SOP to be redistributed to all staff to reread and sign.
- Report the incident to MHRA.
- Share the learning from this incident with pharmacy staff at the Pharmacy Dispensary Meeting.
- Delivery notes need to be signed and dated by a registered midwife to state that correct stock has been received.
- Ensure that Midwifery staff returning to work in the Antenatal clinic and giving vaccinations after extended time off receive a refresher update.
- Update the Maternity PGD care set on Cerner to include access to the whooping cough vaccine ordering page.
- Ensure midwives are made aware that the PGD line for Boostrix within the Maternity care set is now available to use.
- PGD to be printed out and put in a prominent position within the vaccination clinic for midwives to use as a check against the vaccine removed from the fridge.

Maternity incentive scheme - Guidance

Trust Name	**Imperial College Healthcare NHS Trust**
Trust Code	**T670**

This document must be used to complete your trust self-certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. **Your trust name will populate each tab. If the trust name box is coloured pink please update**

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.**

The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested.

There are multiple additional tabs within this document:

Tab A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed within the condition of the scheme with each maternity incentive scheme safety action. Note, 'N/A' (not applicable) is available only for set questions. The information which has been populated in this tab, will automatically populate onto tab D which is the board declaration form.

Tab B - action plan summary sheet - This will provide you information on your Trust's progress in completing the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet - This sheet will enable your Trust to insert action plan details for any safety actions not achieved.

Tab D - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution.

Upon completion of the following processes please add an electronic signature into the three allocated spaces within this document: one signature to declare compliance stated in the board declaration form with the safety actions and their sub-requirements, one signature to confirm that the maternity incentive scheme evidence have been discussed with commissioners and a third signature to declare that there are no external or internal reports covering either 2020/21 financial year or the previous financial year (2019/20) that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 22 July 2021.
Any queries regarding the maternity incentive scheme and or action plans should be directed to **MIS@resolution.nhs.uk**
Technical guidance and frequently asked questions can be accessed here:
https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

Submissions for the maternity incentive scheme must be received no later than 12 noon on **Thursday 22 July 2021** to MIS@resolution.nhs.uk
You are required to submit this document signed and dated. Please do not send evidence to NHS Resolution.

Version Name: MIS_SafetyAction_2021_Revised_V3

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Were all perinatal deaths eligible notified to MBRRACE-UK from the 11 January 2021 onwards to MBRRACE-UK within 7 working days and the surveillance information where required completed within four months of each death?	Yes
2	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 20 December 2019 to 15 March 2021 been started before 15 July 2021?	Yes
3	Were at least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 20 December 2019 to 15 March 2021 reviewed using the PMRT, by a multidisciplinary review team? Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15 July 2021.	Yes
4	For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, were parents told that a review of their baby's death will take place? This includes any home births where care was provided by your Trust staff and the baby died.	Yes
5	For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, were parents' perspectives, questions and any concerns they have about their care and that of their baby sought? This includes any home births where care was provided by your Trust staff and the baby died.	Yes
6	If delays in completing reviews were anticipated, were parents advised of this and were they given a timetable for likely completion?	N/A
7	Have you submitted quarterly reports to the Trust Board from 1 October 2020 onwards? This must include details of all deaths reviewed and consequent action plans.	Yes
8	Were the quarterly reports discussed with the Trust maternity safety champion from 1 October 2020 onwards?	Yes

Safety action No. 2
Are you submitting data to the Maternity Services Data Set to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Were your Trust compliant with all 12 criteria in either the December 2020 or the January 2021's submission?	Yes
2	Has the Trust Board confirmed that they have fully conformed with the MSDSv2 Information Standards Notice, DCB1513 And 10/2018, which was expected for April 2019 data, or that a locally funded plan is in place to do this, and agreed with the maternity safety champion and the LMS. This should include submission of the relevant clinical coding in MSDSv2 in SNOMED-CT.	Yes

Safety action No. 3
Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Please note standard a), b) and c) of safety action 3 have now been removed.		
Standard D) Commissioner returns on request for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC.		
1	Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 have been shared, on request, with the Operational Delivery Network (ODN) and commissioner to inform a future regional approach to developing TC. Is this in place?	Yes
Standard E) A review of term admissions to the neonatal unit and to TC during the Covid-19 period (Sunday 1 March 2020 – Monday 31 August 2020) is undertaken to identify the impact of: • closures or reduced capacity of TC • changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding.		
2	Has a review of term admissions to the neonatal unit and to TC during the COVID period (Sunday 1 March 2020 – Monday 31 August 2020) been undertaken and completed by 26 February 2021 to identify the impact of: • closures or reduced capacity of TC • changes to parental access • staff redeployment • changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding	Yes
An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion.		
3	Do you have evidence of the following • An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from ATAIN reviews. • Evidence of an action plan to address identified and modifiable factors for admission to transitional care. • Evidence that the action plan has been revised in the light of learning from term admissions during Covid-19. Where no changes have been made, the rationale should be clearly stated. • Evidence that the action plan has been shared and agreed with the neonatal, maternity safety champion and Board level champion.	Yes
Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.		
4	Has the ATAIN action plan been revised in the light of learning from term admissions during Covid-19 and has it been shared and agreed with the neonatal, maternity and Board level champions, with progress on Covid-19 related requirements monitored monthly by the neonatal and board safety champions from January 2021?	Yes
5	Has the progress with the Covid-19 related requirements been shared and monitored monthly with the neonatal and maternity safety champion ?	Yes
6	Has the progress on Covid-19 related requirements been monitored monthly by the board safety champions from January 2021?	Yes

Safety action No. 4
Can you demonstrate an effective system of clinical workforce planning to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Please note that the standards related to the obstetric workforce have been removed.		
1	**Anaesthetic medical workforce** Have your Trust Board minuted formally the proportion of ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 that are met?	Yes
2	If your Trust did not meet these standards, has an action plan been produced (ratified by the Board) stating how the Trust is working to meet the standards?	N/A
3	**Neonatal medical workforce** Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing?	Yes
4	If your Trust did not meet the standards outlined in requirement no.3, has an action plan been produced (signed off by the Board) stating how the Trust is working to meet the standards?	N/A
5	**Neonatal nursing workforce** Does the neonatal unit meet the service specification for neonatal nursing standards?	No
6	If your Trust did not meet the standards outlined in requirement no.5, has an action plan been produced (signed off by the Board) and shared with the RCN, stating how the Trust is working to meet the standards?	Yes

Safety action No. 5
Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed?	Yes
2	Has your review included the percentage of specialist midwives employed and mitigation to cover any inconsistencies?	Yes
3	Has an action plan been completed to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent been completed, where deficits in staffing levels have been identified?	Yes
4	Do you have evidence that the Maternity Services detailed progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls?	Yes
5	Do you have evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with **supernumerary labour ward co-ordinator** status in the scheme reporting period? This must include mitigations to cover shortfalls.	No
6	If trust did not meet this standard, has an action plan been produced detailing how the maternity service intends to achieve 100% supernumerary status for the **labour ward coordinator** which has been signed off by the Trust Board, and includes a timeline for when this will be achieved?"	Yes
7	Do you have evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with **1:1 care in labour** in the scheme reporting period? This must include mitigations to cover shortfalls.	No
8	If trust did not meet this standard, has an action plan been produced detailing how the maternity service intends to achieve 100% compliance with **1:1 care in labour** has been signed off by the Trust Board, and includes a timeline for when this will be achieved?"	Yes
9	Do you have evidence that a review has been undertaken regarding COVID-19 and possible impact on staffing levels to include: - Was the staffing level affected by the changes to the organisation to deal with COVID? - How has the organisation prepared for sudden staff shortages in terms of demand, capacity and capability during the pandemic and for any future waves?	Yes
10	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board at least once every 12 months within the scheme reporting period?	Yes

Safety action No. 6
Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have evidence of Trust Board level consideration of how the Trust is complying with the Saving Babies' Lives Care Bundle Version 2 (SBLCBv2), published in April 2019?	Yes
2	Has each element of the SBLCBv2 been implemented? Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by the Clinical Network.	Yes
3	The quarterly care bundle survey must be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net. Have you completed and submitted this?	Yes
ELEMENT 1 - Reducing smoking in pregnancy		
Standard a) Recording of carbon monoxide reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' Maternity Services Data Set (MSDS) submission to NHS Digital. If CO monitoring remains paused due to Covid-19, the audit described above needs to be based on the percentage of women asked whether they smoke at booking and at 36 weeks.		
4	Has **standard a)** been successfully implemented (80% compliance or more)?	Yes
5	If the process metric scores are less than 95% for Element 1 **standard A**, has an action plan for achieving >95% been completed?	Yes
Standard b) Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.		
6	Has **standard b)** been successfully implemented (80% compliance or more)?	Yes
7	If the process metric scores are less than 95% for element 1 **standard b)**, has an action plan for achieving >95% been completed?	Yes
Standard c) Percentage of women where CO measurement at 36 weeks is recorded.		
8	Has **standard c)** been successfully implemented (80% compliance or more)?	Yes
9	If the process metric scores are less than 95% for element 1 **standard c)**, has an action plan for achieving >95% been completed?	Yes
ELEMENT 2 - Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction		
Standard a) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking.		
10	Has **standard a)** been successfully implemented (80% compliance or more)?	Yes
11	If the process metric scores are less than 95% for element 2 **standard a)**, has an action plan for achieving >95% been completed?	Yes
Do you have evidence that the Trust Board has specifically confirm that all the following 3 standards are in place within their organisation:		
12	1) women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards (or an alternative intervention that has been agreed with the CCG and that the trust's Clinical Network)	Yes
13	2) in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation (or an alternative intervention that has been agreed with the CCG and that the trust's Clinical Network)	Yes
14	3) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation	Yes
15	If your Trust have elected to follow Appendix G due to staff shortages related to the COVID pandemic, has Trust Board evidenced that they have followed the escalation guidance for the short term management of staff?	N/A
16	If the above is not the case, has your Trust Board described the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice?	N/A
17	If your Trust have elected to follow Appendix G due to staff shortages related to the COVID pandemic, has Trust Board confirmed that the Maternity Services are following the modified pathway for women with a BMI>35 kg/m2?	N/A
18	If Trusts have elected to follow Appendix G due to staff shortages related to the Covid-19 pandemic Trust Boards should evidence they have followed the escalation guidance for the short term management of staff (https://www.england.nhs.uk/publication/saving-babies-lives-care-bundle-version-2-Covid-19-information/). They should also specifically confirm that they are following the modified pathway for women with a BMI>35 kg/m2. If this is not the case, has your Trust Board described the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice?	N/A
ELEMENT 3 Raising awareness of reduced fetal movement		
Standard a) Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy.		
19	Has **standard a)** been successfully implemented (80% compliance or more)?	Yes
20	If the process metric scores are less than 95% for element 3 **standard a)**, has an action plan for achieving >95% been completed?	N/A
Standard b) Percentage of women who attend with RFM who have a computerised CTG		
21	has **standard b)** been successfully implemented (80% compliance or more)?	Yes
22	If the process metric scores are less than 95% for element 3 **standard b)**, has an action plan for achieving >95% been completed?	N/A
ELEMENT 4 Effective fetal monitoring during labour		

Standard a) Percentage of staff who have received training on fetal monitoring in labour in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness.		
23	Has the Trust Board minuted in their meeting records a written commitment to facilitate local, in-person, fetal monitoring training when this is permitted?	Yes
24	Can you evidence that 90% of all staff groups have complete the fetal monitoring competency assessment as outlined in the technical guidance?	No
25	If the process metric scores are less than 90% for Element 4 standard a), has the trust identify shortfall in reaching the 90% and commit to addressing those?	Yes
Standard b) Percentage of staff who have successfully completed mandatory annual competency assessment.		
26	Have training resources been made available to the multi-professional team members?	Yes
27	Can you evidence that 90% of all staff groups have complete the fetal monitoring competency assessment as outlined in the technical guidance?	No
28	If the process metric scores are less than 90% for **Element 4 standard b)**, has the trust board identify shortfall in reaching the 90% and commit to addressing those when this is permitted?	Yes
ELEMENT 5 Reducing preterm births		
Standard a) Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth		
29	Has **standard a)** been audited? Completion of the audit for element 5 standards A should be used to confirm successful implementation.	Yes
30	If the process metric scores are less than 85% for Element 5 **standard a)**, has an action plan for achieving >85% been completed?	N/A
Standard b) Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.		
31	Has **standard b)** been audited? Completion of the audits for element 5 standards B should be used to confirm successful implementation.	Yes
32	If the process metric scores are less than 85% for Element 5 **standard b)**, has an action plan for achieving >85% been completed?	N/A
Standard c) Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).		
33	Has **standard c)** been audited? Completion of the audits for element 5 standards C should be used to confirm successful implementation.	Yes
34	If the process metric scores are less than 85% for Element 5 **standard c)**, has an action plan for achieving >85% been completed?	Yes
35	Do you have evidence that the Trust Board has specifically confirmed that: • women at high risk of pre-term birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • an audit has been completed to measure the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.	Yes

Safety action No. 7

Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have Terms of Reference for your Maternity Voices Partnership group meeting?	Yes
2	Are minutes of Maternity Voices Partnership meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback?	Yes
3	Do you have evidence of service developments resulting from coproduction with service users?	Yes
4	Do you have a written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses?	Yes
5	Do you have evidence that the MVP is prioritising the voice of woman from Black Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation as a result of UKOSS 2020 coronavirus data?	Yes

Safety action No. 8

Can you evidence that the maternity unit staff groups have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS year three in December 2019?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
MULTI-PROFESSIONAL MATERNITY EMERGENCY TRAINING, including Covid-19 specific training, including maternal critical care training and mental health & safeguarding concerns training In the current year we have removed the threshold of 90% for this year. This applies to all safety action 8 requirements. We recommend that trusts identify any shortfall in reaching the 90% threshold and commit to addressing this as soon as possible.		
Can you confirm that: Covid-19 specific e-learning training has been made available to the multi-professional team members listed below:		
1	Obstetric consultants	Yes
2	All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota	Yes
3	Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	Yes
4	Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)	Yes
5	Obstetric anaesthetic consultants	Yes
6	All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota	Yes
7	Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit)	Yes
8	Can you evidence that 90% of all staff groups in line 1-7 above have attended the the multi-professional training outlined in the technical guidance?	No
9	If the trust has identify any shortfall in reaching the 90% threshold described above in requirement no.8, can you evidence that there is a commitment by the trust board to facilitate multi-professional training sessions when this is permitted?	Yes
NEONATAL RESUSCITATION TRAINING Can you evidence that the following staff groups involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended your in-house neonatal resuscitation training or Newborn Life Support (NLS) course since launch of MIS year three in December 2019:		
10	Neonatal Consultants or Paediatric consultants covering neonatal units	Yes
11	Neonatal junior doctors (who attend any deliveries)	Yes
12	Neonatal nurses (Band 5 and above)	Yes
13	Advanced Neonatal Nurse Practitioner (ANNP)	Yes
14	Midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) Maternity theatre midwives who also work outside of theatres	Yes
15	Can you evidence that 90% of all staff groups in line 10-14 above have attended the the neonatal resuscitation training as outlined in the technical guidance?	No
16	If the trust has identify any shortfall in reaching the 90% threshold described above in requirement no.15, can you evidence that there is a commitment by the trust board to facilitate multi-professional training sessions once when this is permitted?	Yes

Safety action No. 9

Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a pathway been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions, share safety intelligence between each other, the Trust Board, the LMS and MatNeoSIP Patient Safety Networks?	Yes
2	Do you have evidence that the written pathway is in place, visible to staff and meeting the requirements detailed in part a) and b) of the action is in place by Friday 28 February 2020?	Yes
3	Do you have evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff?	Yes
4	Were monthly feedback sessions for staff undertaken by the Board Level safety champions in January 2020 and February 2020?	Yes
5	Were feedback sessions for staff undertaken by the Board Level safety champions every other month from 30 November 2020 going forward?	Yes
6	Do you have a safety dashboard or equivalent, visible to both maternity and neonatal staff which reflects action and progress made on identified concerns raised by staff and service users? This must include concerns relating to the Covid-19 pandemic.	Yes
7	Is the progress with actioning named concerns from staff workarounds visible from no later than 26 February 2021?	Yes
8	Has the CoC action plan been agreed by 26/02/2021 and progress in meeting the revised CoC action plan is overseen by the Trust Board on a minimum of a quarterly basis commencing January 2021?	Yes
9	Has the Board level safety champion reviewed the continuity of carer action plan in the light of Covid-19, taking into account the increased risk facing women from Black, Asian and minority ethnic backgrounds and the most deprived areas? The revised action plan must describe how the maternity service will resume or continue working towards a minimum of 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups they serve.	Yes
Together with their frontline safety champions, has the Board safety champion has reviewed local mortality and morbidity cases has been undertaken and an action plan, drawing on insights from the two named reports and the letter has been agreed		
10	I) Maternal and neonatal morbidity and mortality rates including a focus on women who delayed or did not access healthcare in the light of COVID-19, drawing on resources and guidance to understand and address factors which led to these outcomes by Monday 30 November 2020?	Yes
11	II) The UKOSS report on Characteristics and outcomes of pregnant women admitted to hospital with confirmed SARS-CoV-2 infection in UK.	Yes
12	III) The MBRRACE-UK SARS-COVID19 report	Yes
13	IV) The letter regarding targeted perinatal support for Black, Asian and Minority Ethnic groups	Yes
14	Together with their frontline safety champions, has the Board safety champion considered the recommendations and requirements of II, III and IV on I by Monday 30 November 2020?	Yes
Do you have evidence that the Board Level Safety Champions actively supporting capacity (and capability), building for all staff to be actively involved in the following areas:		
15	• work with Patient Safety Networks, local maternity systems, clinical networks, commissioners and others on Covid-19 and non Covid-19 related challenges and safety concerns, ensuring learning and intelligence is actively shared across systems	Yes
16	• utilise SCORE safety culture survey results to inform the Trust quality improvement plan	Yes
17	Attendance or representation at a minimum of two engagement events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event held in March 2020 by 30 June 2021	Yes

Safety action No. 10

Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all outstanding qualifying cases for 2019/2020 been reported to NHS Resolution EN scheme?	Yes
2	Have all qualifying cases for 2020/21 been reported to Healthcare Safety Investigation Branch (HSIB)?	Yes
3	For cases which have occurred from 1 October 2020 to 31 March 2021 the Trust Board are assured that: 1. the family have received information on the role of HSIB and EN scheme: and 2. there has been compliance with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	Yes
4	Have the Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team?	Yes

Section A : Maternity safety actions - Imperial College Healthcare NHS Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives V2 ?	Yes
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes
8	Can you evidence that the maternity unit staff groups have attended as a minimum an half day 'in-house' multi-professional maternity emergencies training session, which can be provided digitally or remotely, since the launch of MIS year three in December 2019?	Yes
9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Yes
10	Have you reported 100% of qualifying incidents under NHS Resolution's Early Notification scheme? a) Reporting of all outstanding qualifying cases to NHS Resolution EN scheme for 2019/2020 b) Reporting of all qualifying cases to Healthcare Safety Investigation Branch (HSIB) for 2020/21	Yes

Section B : Action plan details for Imperial College Healthcare NHS Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action | **To be met by**

Work to meet action — *Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off | **Action plan agreed by head of midwifery/clinical director?**

Action plan owner — *Who is responsible for delivering the action plan?*

Lead executive director — *Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required

Reason for not meeting action — *Please explain why the trust did not meet this safety action*

Rationale — *Please explain why this action plan will ensure the trust meets the safety action.*

Benefits — *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*

Risk assessment — *What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 2

Safety action | **To be met by**

Work to meet action — *Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off | **Action plan agreed by head of midwifery/clinical director?**

Action plan owner — *Who is responsible for delivering the action plan?*

Lead executive director — *Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required

Reason for not meeting action — *Please explain why the trust did not meet this safety action*

Rationale — *Please explain why this action plan will ensure the trust meets the safety action.*

Benefits — *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*

Risk assessment — *What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 3

Safety action | **To be met by**

Work to meet action — *Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off | **Action plan agreed by head of midwifery/clinical director?**

Action plan owner — *Who is responsible for delivering the action plan?*

Lead executive director — *Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required

Reason for not meeting action — *Please explain why the trust did not meet this safety action*

Rationale — *Please explain why this action plan will ensure the trust meets the safety action.*

Benefits — *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*

Risk assessment — *What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 4

Safety action | **To be met by**

Work to meet action — *Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off | **Action plan agreed by head of midwifery/clinical director?**

Action plan owner — *Who is responsible for delivering the action plan?*

Lead executive director — *Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required

Reason for not meeting action — *Please explain why the trust did not meet this safety action*

Rationale — *Please explain why this action plan will ensure the trust meets the safety action.*

Benefits — *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*

Risk assessment — *What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 5

Safety action | **To be met by**

Work to meet action — *Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off | **Action plan agreed by head of midwifery/clinical director?**

Action plan owner — *Who is responsible for delivering the action plan?*

Lead executive director — *Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required

Reason for not meeting action — *Please explain why the trust did not meet this safety action*

Rationale — *Please explain why this action plan will ensure the trust meets the safety action.*

Benefits — *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*

Risk assessment — *What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 6

Safety action | **To be met by**

Work to meet action — *Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off | **Action plan agreed by head of midwifery/clinical director?**

Action plan owner — *Who is responsible for delivering the action plan?*

Lead executive director — *Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required

Reason for not meeting action — *Please explain why the trust did not meet this safety action*

Rationale — *Please explain why this action plan will ensure the trust meets the safety action.*

Benefits — *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*

Risk assessment — *What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 7

Safety action | **To be met by**

Work to meet action — *Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off | **Action plan agreed by head of midwifery/clinical director?**

Action plan owner — *Who is responsible for delivering the action plan?*

Lead executive director — *Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required

Reason for not meeting action — *Please explain why the trust did not meet this safety action*

Rationale — *Please explain why this action plan will ensure the trust meets the safety action.*

Benefits — *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*

Risk assessment — *What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 8

Safety action | **To be met by**

Work to meet action — *Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off | **Action plan agreed by head of midwifery/clinical director?**

Action plan owner — *Who is responsible for delivering the action plan?*

Lead executive director — *Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required

Reason for not meeting action — *Please explain why the trust did not meet this safety action*

Rationale — *Please explain why this action plan will ensure the trust meets the safety action.*

Benefits — *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*

Risk assessment — *What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 9

Safety action | **To be met by**

Work to meet action — *Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off | **Action plan agreed by head of midwifery/clinical director?**

Action plan owner — *Who is responsible for delivering the action plan?*

Lead executive director — *Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required

Reason for not meeting action — *Please explain why the trust did not meet this safety action*

Rationale — *Please explain why this action plan will ensure the trust meets the safety action.*

Benefits — *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*

Risk assessment — *What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Action plan 10

Safety action | **To be met by**

Work to meet action — *Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off | **Action plan agreed by head of midwifery/clinical director?**

Action plan owner — *Who is responsible for delivering the action plan?*

Lead executive director — *Does the action plan have executive sponsorship?*

Amount requested from the incentive fund, if required

Reason for not meeting action — *Please explain why the trust did not meet this safety action*

Rationale — *Please explain why this action plan will ensure the trust meets the safety action.*

Benefits — *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*

Risk assessment — *What are the risks of not meeting the safety action?*

	How?	Who?	When?
Monitoring			

Maternity incentive scheme - Board declaration Form

Trust name Imperial College Healthcare NHS Trust
Trust code T670

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process:

Electronic signature

For and on behalf of the board of Imperial College Healthcare NHS Trust

Confirming that:
The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

Electronic signature

For and on behalf of the board of Imperial College Healthcare NHS Trust

Confirming that:
The content of this form has been discussed with the commissioner(s) of the trust's maternity services

Electronic signature

For and on behalf of the board of Imperial College Healthcare NHS Trust

Confirming that:
There are no reports covering either **this year (2020/21) or the previous financial year (2019/20)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.

Electronic signature

For and on behalf of the board of Imperial College Healthcare NHS Trust

Confirming that:
If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the

Name:
Position:
Date:

TRUST BOARD (PUBLIC)

Paper title: Infection prevention and control (IPC), and antimicrobial stewardship annual report 2020/21

Agenda item 15.1 and paper number 12a

Lead Executive Director: Professor Julian Redhead, Medical director
Author(s): Jon Otter, General Manager, IPC and Dr James Price, Director, IPC

Purpose: For information

Meeting date: 14 July 2021

Executive summary

1. Purpose of this report

1.1. The attached report (appendix 1) is the Trust's Infection prevention and control (IPC) and antimicrobial stewardship annual report for 2020/21. It is being presented to Trust Board for information ahead of publishing on the Trust's website in July.

2. Background

2.1. The Trust has a statutory responsibility to be compliant with Health and Social Care Act 2008 (Regulated Activities) regulations 2014. A requirement of this Act is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control. This report details our infection prevention and control activity from 1 April 2020 to 31 March 2021, detailing our key achievements and performance against national healthcare associated infection objectives for the year.

3. Key points

3.1. Preventing the spread of organisms that cause healthcare-associated infections (HCAI) and ensuring optimal antimicrobial use is fundamentally important for all healthcare facilities. At Imperial College Healthcare NHS Trust the prevention and control of infection remains a top priority and is central to all areas of the organisation. The Infection Prevention and Control and antimicrobial stewardship (IPC) service is responsible for ensuring that policies and procedures for appropriate antimicrobial use and reducing the risk of HCAI are in place, and that expert advice is available continuously.

3.2. Throughout 2020/21, the Covid-19 pandemic continued to demand fundamental changes to the healthcare services provided by Imperial College Healthcare, the NHS, and all healthcare providers globally. The IPC team have played a central role in the Trust's response to the Covid-19 pandemic.

3.3. The annual report provides a summary of our response to the pandemic, progress with our improvement plans and data related to the reduction of HCAIs and our antimicrobial stewardship programme.

4. Next steps

4.1. The annual report will be published on the trust website in July.

5. Recommendation(s)

5.1. The report has been discussed at the Quality Committee and presented to Trust Board for noting.

6. Impact assessment

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

6.2. Financial impact: No direct financial impact.

6.3. Workforce impact: No workforce impact.

6.4. Equality impact: N/A

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

<u>Main report</u>

7. Key IPC activity for 2020/21

7.1. This section of the report provides a short summary of the key points in the annual report. The full report can be found in appendix 1.

7.2. Throughout 2020/21, the Covid-19 pandemic continued to demand fundamental changes to the healthcare services provided by Imperial College Healthcare, the NHS, and all healthcare providers globally. The IPC team have played a central role in the Trust's response to the Covid-19 pandemic. This includes a monthly review of the IPC Covid-19 Board Assurance Framework.

7.3. Despite a range of new approaches aimed at preventing the spread of the SARS-CoV-2 virus that causes Covid-19 in our hospitals, a total of 61 Covid-19 transmission incidents / outbreaks have been identified and managed since July 2020, when formal national reporting of Covid-19 outbreaks commenced.

7.4. 24 of these 61 incidents affected only staff and 37 affected patients or both patients and staff. 18 of these 61 incidents affected only two individuals.

7.5. In 2020/21, of 4494 C. difficile tests performed, there were 59 cases of Trust-attributed C. difficile, against a ceiling of 77. There have been two lapses in care during 2020/21 (in June 2020 and February 2021), compared with two lapses in care during 2019/20.

7.6. Imperial College Healthcare has seen an increase in the number of Trust-attributed MRSA bloodstream infections (BSI) in 2020/21; of the 31,125 blood cultures processed in 2020/21 five Trust-attributed MRSA BSI were identified compared with three in 2019/20. A review of these cases has resulted in the development of an action plan, which is being reviewed monthly at EMB Quality.

7.7. Imperial College Healthcare has developed ambitious Gram-negative BSI reduction plans and achieved an 18 per cent year-on-year reduction in Trust-attributed E. coli BSIs.

7.8. Central line-associated BSI (CLABSI) rates are an important preventable cause of HCAI and are an indicator of patient safety. In 2020/21 the CLABSI rates in paediatric and neonatal intensive care units, and renal services were below benchmark levels. Reporting of CLABSI rates in adult ICUs was interrupted by the pandemic, and have now restarted.

7.9. Imperial College Healthcare's leading antimicrobial stewardship programme continues to drive improvement. In 2020/21, we saw an increase in prescribing associated with the first and second waves of Covid-19. Focused antimicrobial stewardship activities resulted in a

rapid return to the baseline prescribing levels. We continue to have an average compliance for all antimicrobial quality indicators of >90 per cent (an internal performance target).

7.10. Imperial College Healthcare is committed to reducing surgical site infections (SSIs) and participates in national surveillance programmes for orthopaedic and cardiothoracic surgical procedures. SSI for the orthopaedic and cardiothoracic procedures monitored were below the national average. A new programme to expand SSI surveillance has been launched, and begun working in obstetrics and neurosurgery.

7.11. The strategic work to improve hand hygiene practice and promoted best practice for the use of Personal Protective Equipment (PPE) has continued, with the PPE Helper Programme demonstrating impact in improving PPE practice.

7.12. Longstanding priority risks relating to the Trust's estate, cleaning standards and water quality issues and new risks related to Covid-19 continue to be identified in the IPC risk register, along with mitigating actions.

7.13. Several outbreaks have been identified and managed, including Covid-19, CPE, *Pseudomonas aeruginosa*, *Stenotrophomonas maltophilia*, MRSA, and *C. difficile*.

7.14. As NHS leads within Imperial College's NIHR funded Health Protection Research Unit (HPRU) in HCAI and AMR, and the Centre for Antimicrobial Optimisation (CAMO) research programme, the IPC department are contributing to broad multi-disciplinary research programmes.

8. Conclusion

8.1. This report summarises the activities of the IPC team, in line with the requirements of the Health and Social Care Act.

Appendices:

1. IPC annual report 2020/21

Author **Jon Otter, General Manager, IPC and James Price, Director, IPC**
Date 29th June 2021

Infection prevention and control and antimicrobial stewardship Annual Report 2020/21

1.1. Introduction

Preventing the spread of organisms that cause healthcare-associated infections (HCAI) and ensuring optimal antimicrobial use is fundamentally important for all healthcare facilities. At Imperial College Healthcare NHS Trust the prevention and control of infection remains a top priority and is central to all areas of the organisation. The Infection Prevention and Control and antimicrobial stewardship (IPC) service is responsible for ensuring that policies and procedures for appropriate antimicrobial use and reducing the risk of HCAI are in place, and that expert advice is available continuously.

Patients requiring healthcare are increasingly complex with ageing populations and increasing co-morbidities. This means that patients are increasingly at risk of HCAI. Nonetheless, strides have been taken on a local and national level in reducing MRSA bloodstream infection and *Clostridioides difficile* infection. However, there are still improvements to be made. Furthermore, new challenges continue to emerge nationally and locally. Throughout 2020/21, the Covid-19 pandemic continued to demand fundamental changes to the healthcare services provided by Imperial College Healthcare, the NHS, and all healthcare providers globally. The IPC team have played a central role in the Trust's response to the Covid-19 pandemic.

One of the key drivers for antimicrobial resistance in HCAI and *C. difficile* infection is antimicrobial exposure and suboptimal antimicrobial therapy. Imperial College Healthcare continues to introduce new strategies to monitor antimicrobial use and ensure that all antimicrobials are used appropriately. Another key risk is the use of indwelling devices and intravenous lines, which can become infected if not managed appropriately. Intravenous lines are therefore another important area of focus, led by a dedicated vascular access team, with a Trust-wide aseptic non-touch technique (ANTT) training and assessment programme in place. The correct management and decontamination of high-risk medical devices (such as endoscopes) is a crucial function of the service. IPC is closely involved in decisions around the hospital estate, ensuring that it is fit for purpose in order to minimise the risk of transmission.

1.2. Responding to Covid-19

The IPC team have played a central role in the Trust's response to the Covid-19 pandemic, including:

- The processes for IPC-supported decision making changed during Covid-19, with new assurance structures implemented.
- IPC expertise continues to be integral to decision making during the Trust management of Covid-19 including in the provision of advice, guidelines, clinical pathway development and patient safety.
- IPC played a key role in developing and implementing the Trust-wide strategy for patient and staff testing.
- IPC have supported the occupational health and safety team to develop a range of new approaches and protocols to support staff safety.
- A focus on antimicrobial stewardship (AMS) and treatment of both Covid-19 and other infections was maintained during the pandemic.
- Systems were developed and implemented for the identification and management of hospital-onset Covid-19 infections.
- A daily Covid-19 "sitrep" and forecasting to support decision making about surge capacity and related staffing was developed and implemented.
- Several existing and some new models were used to provide training and education to staff.

- IPC led improvement work around Personal Protective Equipment (PPE) and hand hygiene use, including the design, implementation, development, and evaluation of a PPE Helper programme to promote best practice in the use of PPE.
- IPC worked closely with estates and facilities, providing advice around changes to the use of clinical and non-clinical areas, developed mitigating plans for water hygiene management, and provided advice and support for specialist ventilation / modification. IPC also issued recommendations around enhanced environmental cleaning in clinical areas used to manage patients with Covid-19 in line with national guidelines.
- IPC also worked closely with the Trust communications team to develop a series of "IPC/AMS messages of the day", participate in various staff briefings, and supported the development and accuracy of the Trust Intranet Covid-19 pages and other communications materials (e.g. infographics / posters).
- Experts from IPC joined a range of expert advisory groups and undertook applied research to support decision making in the Trust.
- A number of IPC-related work streams 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), Trust-wide audits of antimicrobial prescribing indicators, Antimicrobial Resistance CQUIN, changes to the way that water hygiene management is conducted, surveillance for central line-associated BSIs in adult ICUs, and plans to improve the identification and management of surgical site infection. These changes were reflected on the IPC risk register.

1.3. Governance and Organisation

During 2020/21, the Trust maintained compliance with the criteria set out in the Hygiene Code of Practice (2008). The annual plan for IPC for 2019/20 set out the proposed activities for IPC at the Trust. This plan ensures that the Trust continued to meet the requirements of the Hygiene Code, Department of Health and Social Care and the CQC. The plan also accounted for locally agreed actions as well as internal programmes of work that IPC would deliver throughout the financial year. The Trust has on-going action plans focusing on preventing and managing HCAIs across our hospitals, and these 'live' documents underpin the programmes of work referenced in this plan. The plan is reviewed annually, with progress and evidence of completing actions documented. Actions are examined at the Trust Infection Prevention and Control Committee (TIPCC). Progress on actions is also followed up by weekly operational meetings. While the Trust has many examples of excellent work and high-quality care, it recognises that there is more to do to achieve its goals and ambitions. The IPC annual plan and associated action plans support the Trust to deliver its strategic objectives.

1.3.1. Trust Infection Prevention Committee (TIPCC)

The role of the TIPCC is to oversee the delivery of IPC across the organisation. TIPCC reports to the Executive Quality Committee, Trust board, and Chief Executive Office through quarterly reports (Figure 1). Meetings are held quarterly, and attended by external stakeholders representing Public Health England and the CCG. The committee receives reports from the clinical divisions and subsidiary committees and groups including:

- Divisional IPC / quality committees
- Decontamination steering group
- Line safety management group
- Surgical infection group
- Water hygiene group
- Antimicrobial review group
- Occupational health

- Health & safety
- Hand hygiene and PPE Improvement Group
- Trust Estates and facilities (including the Ventilation committee, by exception)
- PHE CCDC
- CCG IPC Lead

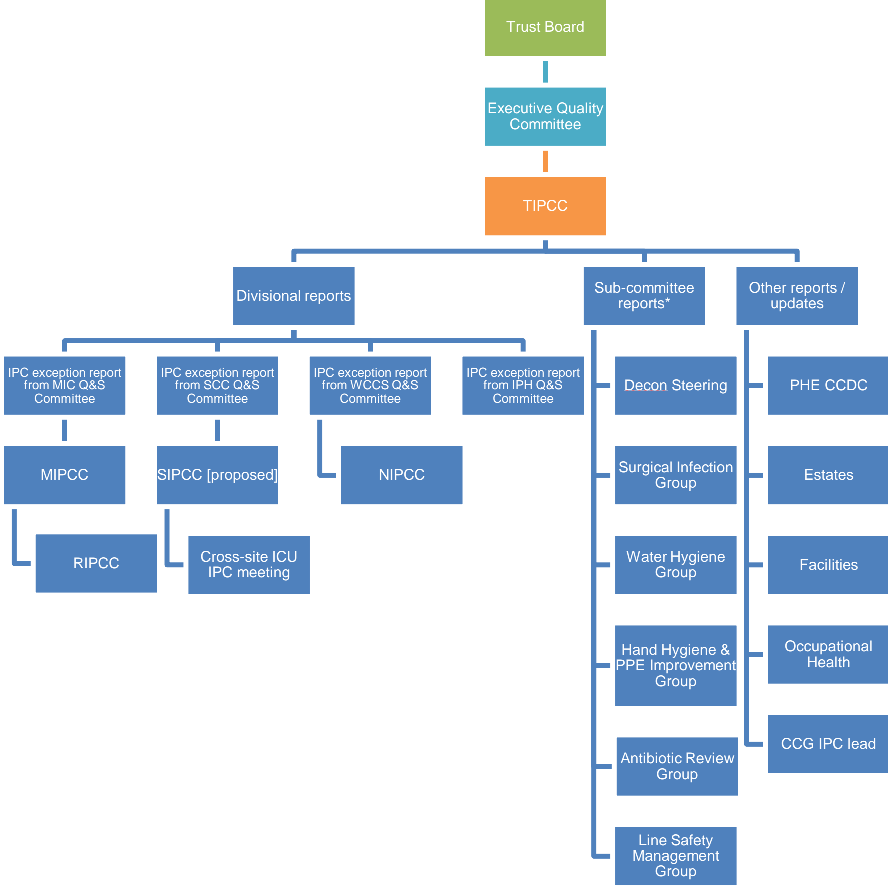


Figure 1: *IPC Organisational chart*

1.3.2. **Organisation of the service**

The IPC service is a corporate directorate situated in the office of the Medical Director. The multidisciplinary service is led by the director of IPC, who is responsible for overseeing all IPC and antimicrobial stewardship activity in the Trust. The service includes doctors, nurses, pharmacists, data scientists and other technical and operational experts who create structures working collaboratively across the organisations with the Divisions to ensure patient safety through effective infection control practices and optimal use of antimicrobials. The service also works closely with key external regulatory and public health agencies and experts and provides clinical and operational expertise throughout the Trust.

1.3.3. **HCAI Sitrep**

A weekly meeting is held to support the operational delivery of IPC throughout the organisation. The Taskforce ensures weekly engagement with senior leaders in the Trust, including a lead from each of the clinical divisions. Live clinical front-line issues, real time surveillance information, and actions from investigations are reviewed across all sites. This meeting has a critical function in the management of patient flow and inpatient capacity related to IPC.

1.3.4. Risk Register

The IPC service maintains a risk register to record, identify and manage all risks that affect patient safety and clinical services. There are 13 live risks on the risk register including three longstanding priority risks (estates, water quality and poor cleaning standards). Each risk has been updated to reflect the challenges related to Covid-19.

- Patients exposed to microbiologically unsafe water
- Poor cleaning standards
- Low level of hand hygiene and inappropriate use of PPE (Divisional Risk)
- Risk of spread of CPE (Corporate Risk)
- Fragile supply chain of anti-infectives
- Limited surveillance of HCAI (especially SSI)
- Inflexible IT infrastructure
- Limited negative pressure single rooms
- Estates work affecting Infection Prevention & Control practices
- Poor practice related to vascular access
- Occupational health provision
- Limited microbiology laboratory support
- Prolonged high capacity

These risks are reviewed and updated regularly and a summary of new and updated risks is included in the IPC quarterly report to ensure risks are identified and addressed.

1.4. HCAI for the Trust

Table 1 shows the number of Trust cases reported to PHE as part of their mandatory reporting scheme.

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

Table 1: *Summary of the number of cases reported to PHE in their mandatory reporting scheme. For MRSA, MSSA, and E. coli BSI Trust cases are those that are identified after 2 days of hospitalisation; for C. difficile, Trust cases are those that are identified after 3 days of hospitalisation. 'Trust' refers to cases defined epidemiologically as having most likely been acquired in hospital.*

1.4.1. ***Clostridioides difficile*** **infection**

C. difficile infections are a major cause of antibiotic-associated diarrhoea; significant increases were noted in the 1990s and in response extended mandatory reporting was implemented in 2007. More recently NHS England implemented organisational *C. difficile* infection objectives and financial penalties, where lapses in care were identified. In 2020/21, there were 59 cases of Trust-attributed *C. difficile*, against a ceiling of 77. There have been two lapses in care during 2020/21 (June 2020 and February 2021), both lapses in care were due to cross transmission. Similarly, there were two lapses in care during 2019/20.

We adhere to a comprehensive set of measures to prevent cross-transmission and optimise antibiotic usage thereby minimising the risk of *C. difficile* infections. This includes a multidisciplinary clinical review of all cases, rapid feedback of lapses in care to prompt ward-level learning, and *C. difficile* prevention ward rounds. These actions have supported a reduction from 101 *C. difficile* cases during 2019/20, although changes in patient mix due to the pandemic may have contributed too.

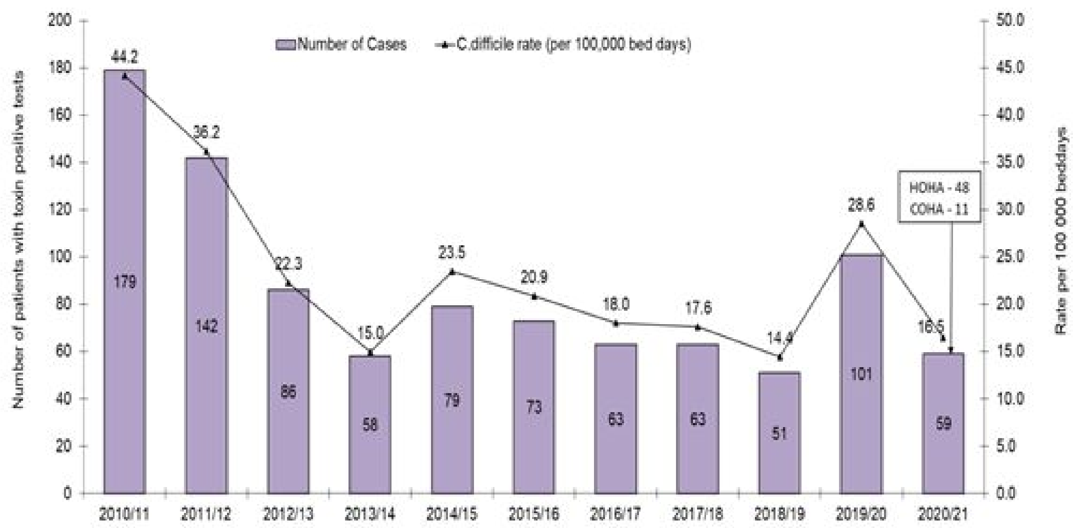


Figure 1: *Imperial College Healthcare C. difficile infection rates from 2010/11. HOHA = Healthcare Onset Healthcare Associated, COHA = Community Onset Healthcare Associated.*

1.4.2. **MRSA bloodstream infection**

Imperial College Healthcare has reduced the number of Trust attributed MRSA BSI significantly since 2014 (Figure 3). There have been five Trust-attributed MRSA BSIs during 2020/21, an increase from three cases in the previous four financial years. Post-infection reviews are routinely performed for all MRSA BSI cases to ensure patient care is improved and lessons learnt are captured. Key actions in response to these cases have included reinforcing the need for the safe management and documentation related to vascular access devices, and promoting MRSA screening and the prescription and administration of MRSA suppression therapy.

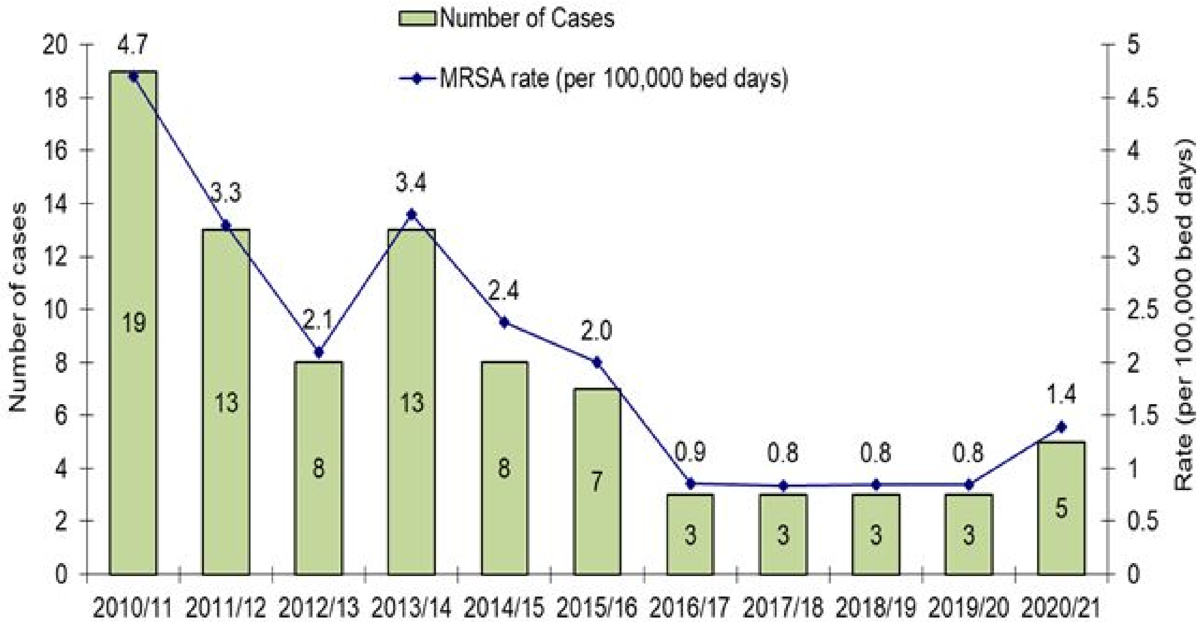


Figure 2: *MRSA BSI cases rate since 2010/11*

1.4.2.1. ***MRSA admission screening***

On average, 1,287 admissions were screened for MRSA each month in 2020/21, with an average compliance of 88 per cent

1.4.2.2. ***MSSA BSI***

There were 31 Trust attributable methicillin-susceptible *S. aureus* (MSSA) BSI in 2020/21, compared to 32 cases in 2019/20. Whilst there is no national threshold for MSSA BSI, each case is reviewed by a multidisciplinary group and those related to a vascular access device are reviewed by vascular access specialists, in order to identify and implement learning from these cases. Specific actions include 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.

1.4.3. **Gram-negative BSIs (*Escherichia coli, Pseudomonas aeruginosa*, and *Klebsiella pneumoniae***

Imperial College Healthcare has developed a reduction plan and implemented an annual 10 per cent reduction target for *E. coli* BSIs to address national rises in Gram-negative BSI rates and support Government objectives aiming to reduce Gram-negative BSI. The Trust has met its 10 per cent 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 College Healthcare's *E. coli* BSI rate ranks lowest in the Shelford group.

A multidisciplinary group was established before the pandemic to reduce Gram-negative BSI with a focus on minimising *E. coli* BSIs, particularly those originating from urinary and surgical sources. Imperial College Healthcare, in collaboration with the CCG, have developed a Gram-negative BSI reduction plans which include:

- Enhanced reporting of Gram-negative BSI cases to PHE, including *E. coli*, *K. pneumoniae* and *P. aeruginosa* to identify, monitor and track local Gram-negative BSI.

- Amending GNBSI case review procedures, with a focus on improving the identification and designation of infection sources.
- Supporting and facilitating CCGs investigating non-Trust attributable Gram-negative BSIs by identifying cases and sharing the tools used to review cases.
- Performing regular reviews of antimicrobial susceptibility rates for Gram-negative organisms to ensure antimicrobial prescribing for non-susceptible isolates is appropriate.
- Implemented bi-annual point prevalence surveys of antibiotic prescribing to monitor prescribing patterns.
- Supporting the identification and management of sepsis to improve clinical outcomes.

The graph below shows the number of *E. coli* cases and rate per 100,000 bed days by year since PHE mandatory surveillance started in 2011/12.

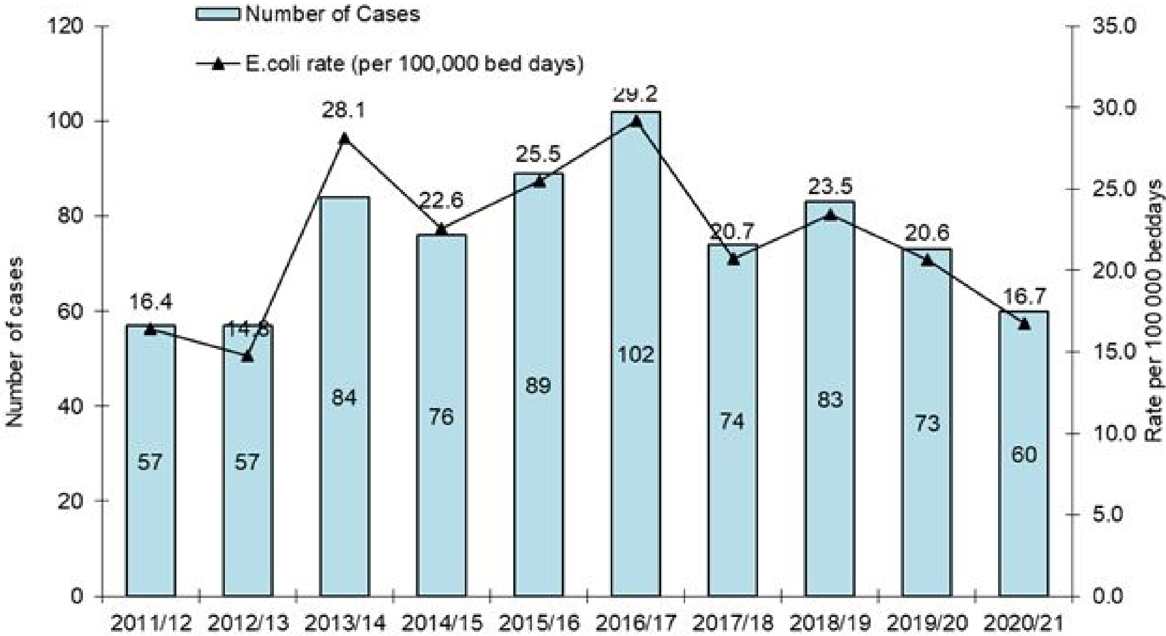


Figure 3: *E. coli BSI cases from 2011/12 – 2020/21*

1.4.4. Bloodstream infections surveillance

1.4.4.1. ***Quality of blood culture collection***

Contaminants accounted for 3.2 per cent of the 31,125 blood cultures taken during 2020/21 which is above our benchmark of 3 per cent. The rate of contaminated blood cultures was 2.3 per cent in 2019/20. The increase above the benchmark during 2020/21 is associated with an increase in blood culture contaminants observed across the ICUs (including additional surge ICUs) during the Covid-19 peaks, likely related to challenges with hand hygiene and ANTT whilst wearing additional PPE. In response to these findings, the need for careful aseptic technique during blood culture collection has been reinforced, and the rate of contaminated blood cultures has returned to below the benchmark of 3 per cent.

*1.4.4.2. **Adult ICUs***

The six month period spanning April – September 2020 (Q1 and Q2 2020/21) saw 27 CLABSI episodes of 9518 catheter line-days, a rate of 2.8 per 1000 catheter line-days; this is below the benchmark rate of 3.6 per 1000 catheter-line days (ECDC benchmark). The similar period in FY 2019/20 (April – September 2019) saw 13 CLABSI episodes of 6686 catheter line-days, rate of 1.9 per 1000 catheter line-days. The increase in the absolute number of CLABSI episodes reported during the peak of the pandemic was off-set by the rapid expansion of the level 3 ICU capacity and the resulting increase in critical care activity. Data for Q3 and Q4 is not available.

*1.4.4.3. **Paediatric ICU (PICU)***

In the 12 month period (April 2020 – March 2021) there has been one CLABSI episode reported in the PICU, as compared to five CLABSI episodes reported during the similar period in FY 2019/20. Due to Covid-19 level 3 expansions, where the PICU facilities were used to care for adult patients over the first and second Covid-19 surges, the activity data for the PICU is uninterpretable as it is a mixture of adult and paediatric patients; therefore a 12 month rate is unavailable.

*1.4.4.4. **Neonatal ICU (NICU)***

For the period April 2020 – March 2021 the CLABSI rate on the neonatal ICU at St Mary's Hospital (SMH) and Queen Charlotte & Chelsea Hospital (QCCH) combined was 4.1 per 1000 catheter line-days, as compared to a rate of 5.2 per 1000 catheter line over the similar period in 2019/20. The benchmark figure from the National Neonatal Audit Programme (NNAP) is 4.5 per 1000 line-days. The CLABSI rate in Very Low Birth Weight (VLBW) babies was 4.1 per 1000 line-days, below the NEO-KISS nosocomial infections surveillance project benchmark figure of 8.6 per 1000 catheter line days.

1.4.5. **Carbapenemase-producing Enterobacterales (CPE) surveillance**

Enhanced CPE surveillance began in 2014 to ensure all patients colonised or infected with CPE are recorded in a comprehensive centralised database which includes information on the strain type, molecular mechanisms and culture collection details. The number of patients with CPE identified each month has plateaued at between 50 and 80 each month. More than 95 per cent of these samples are from screening specimens rather than from clinical specimens.

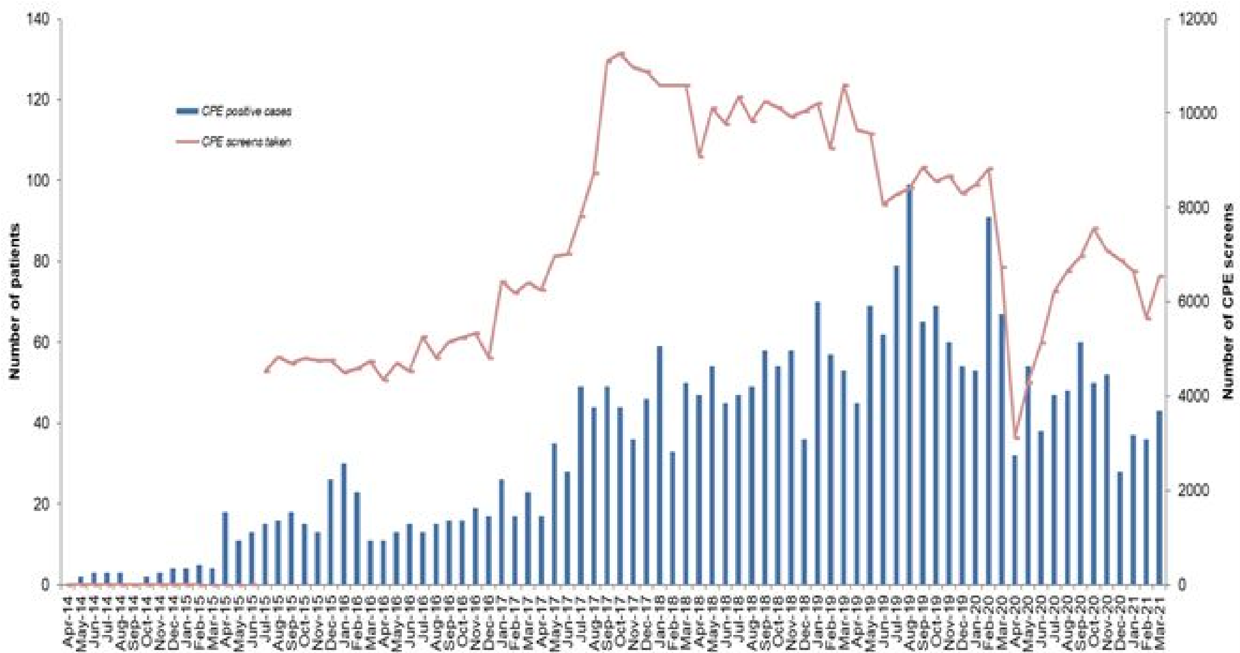


Figure 4: *CPE detected at the Trust, de-duplicated by patient since April 2014. The line represents the total number of screens taken each month.*

1.4.6. **Surgical Site Infections (SSI)**

SSI are a significant cause of HCAI and are associated with poor clinical outcomes. Co-ordinated surveillance and IPC programmes where clinical feedback is provided, has been shown to significantly reduce the rate of SSI. Imperial College Healthcare currently performs both mandatory and voluntary surveillance for the following categories;

- Orthopaedic:
  - Knee procedures: 12-month average is 0.5 per cent (1 SSI in 204 operations); national average is 0.6 per cent.
  - Hip procedures: 12-month average is 0 per cent (zero SSI in 159 operations); national average is 0.6 per cent.
- Cardiothoracic:
  - CABG: 12-month average is 5.1 per cent (15 SSI in 271 procedures); national average is 3.8 per cent. The rate of 5.1 per cent reflects the observed rise in CABG SSI rates over the period April 2020 to March 2021. However, SSI rates have since returned to below national-average levels over the first three quarters of 2020/21 (the latest available data). This reduction is in response to a comprehensive set of measures implemented to reduce the risk of SSI pre-operatively, peri-operatively, and post-operatives. These measures were introduced by a multi-disciplinary group led by a cardiothoracic surgeon.
  - Non-CABG: 12-month average is 1.2 per cent (2 SSI in 166 procedures); national average is 1.3 per cent.

1.4.6.1. **Expanded Surgical Site Infection Surveillance (SSIS) and prevention**

The Trust's Surgical Site Infection Surveillance (SSIS) and improvement programme was launched during 2020/21 at a challenging time for the Trust, owing to the Covid-19 pandemic. Despite the challenges faced owing to the disruption of clinical pathways and reduction in elective and emergency surgical procedures, the SSIS team made significant progress in

supporting the Divisions to embed prospective surveillance in the specialities identified as priority areas (Caesarean section, vascular, neurosurgery, and cardiothoracic).

A joint audit between the speciality of maternity and IPC was undertaken in the latter half of 2020 to determine baseline SSI rates following elective and emergency Caesarean section (C-section) procedures at the Trust. The pilot surveillance scheme took place over 12 weeks and included all patients who had an elective or emergency Caesarean section. A patient information leaflet was developed and given to eligible patients to inform them of this audit and provide SSI prevention information. Detailed risk factor information collected as part of the pilot is currently being analysed alongside a confirmation of the rate of SSI in the speciality, as per Public Health England guidance. Intelligence gleaned from the audit is being used to establish a sustainable platform for Caesarean section SSI surveillance, including post-discharge surveillance and provide actionable audit data on compliance with evidence-based SSI prevention measures.

The beginning of 2021 saw us commence a joint audit with the speciality of neurosurgery. All elective and emergency neurosurgical procedures are being included, with detailed risk factor information collected alongside an assessment of the rate of SSI in the speciality. Intelligence and learning from these audits will be used to develop a robust model to extend SSI surveillance in other specialities across the Trust in 2021/22.

1.5. Antimicrobial Stewardship

1.5.1. Prescribing surveillance: point prevalence survey

Antibiotic stewardship (AMS) encompasses all activities intended to improve patient outcomes through optimised antimicrobial use while minimising negative consequences such as HCAI and limiting development of resistance.

An audit of antimicrobial prescribing indicators in adult medical patients was undertaken in August 2020. Of the 548 inpatients reviewed across the Trust, 43 per cent were scheduled to receive an antimicrobial. All indicators remained above the 90 per cent target in this audit including antimicrobials being prescribed in line with policy or under guidance from our infection service, antimicrobials being reviewed at 72 hours and if the duration of our antimicrobial prescriptions is appropriate.

1.5.2. Antimicrobial consumption and reduction

Imperial College Healthcare is committed to reducing total antimicrobial consumption and broad-spectrum antimicrobial use in line with World Health Organisation (WHO) and Department of Health and Social Care initiatives. As part of this, antimicrobial consumption data continued to be analysed in 2020/21. During 2020/21, the Trust experienced an increase in antimicrobial use, notably in Q1 and Q3 (Figure 6). This is in keeping with historical trends over the winter months but also linked to the unprecedented pressure placed by Covid-19 pandemic. The initial presentations of Covid-19, often as an undifferentiated respiratory infection was a contributory factor towards increased use during both waves (Q1 and Q3). In response, the Trust deployed various antimicrobial stewardship (AMS) initiatives (see 5.1.3) to counteract this shift, which successfully led to an overall reduction in antimicrobial usage during Q2 and Q4 2020/21.

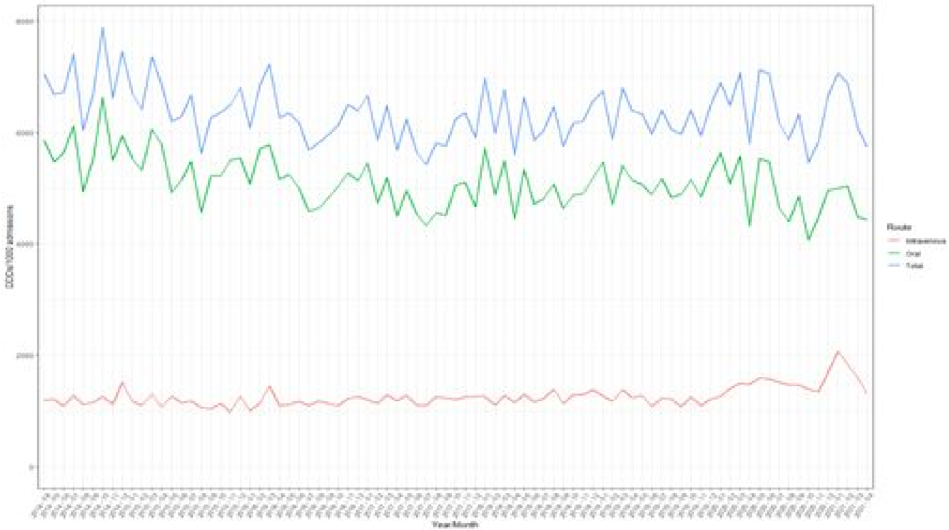


Figure 5: *Trust-wide antimicrobial consumption (Defined Daily Doses / 1000 admissions) 2014/15 – present, including the split between intravenous and oral administration*

1.5.3. **AMS activity during Covid-19**

AMS initiatives that have assisted in curbing antimicrobial use secondary to Covid-19 pressures during 2020/21 included:

- AMS rounds have been initiated on all sites using the AMS dashboard to identify carbapenem use and prolonged antibiotic durations. To date, interventions have been made for approximately 56 per cent of all antibiotics prescriptions reviewed, with a 77 per cent acceptance rate of intervention made.
- ICU microbiology ward rounds are now also attended by the infection pharmacy team on all sites to optimise prescribing in critical care.
- The infection pharmacy team have shifted reporting of antimicrobial consumption from quarterly to monthly to allow site based AMS teams to develop a more focused stewardship strategy targeted at high use areas.

1.5.4. **Sepsis reduction**

The deteriorating patient big room, which leads on improvement work associated with sepsis, was suspended during the pandemic but has now resumed with a focus on improving compliance and reporting as part of a wider programme of work associated with the deteriorating patient. Further research work is ongoing to refine the management of suspected sepsis using artificial intelligence.

1.6. **AMR CQUIN**

The Antifungal Stewardship CQUIN continued with reduced reporting requirements and a short break in activity during the first wave of Covid-19. Antifungal stewardship ward rounds continued twice weekly alongside the monthly antifungal MDT from the end of April 2020. Additionally, guidelines were developed for - Covid-19 associated pulmonary aspergillosis to curb increases in liposomal amphotericin (AmBisome) use and to support effective antifungal usage during echinocandin supply shortages.

1.6.1. Antimicrobial review group

The Antimicrobial Review Group, in conjunction with TIPCC, is responsible for antimicrobial use to ensure their safe, appropriate and economic use in line with good antimicrobial stewardship. During 2020/21 the group met on six occasions and reviewed 12 guidelines including a full review of the Trust surgical prophylaxis guideline. The group also met towards the end of 2020/21 with a meeting dedicated to the stewardship agenda, focusing on antimicrobial usage across the Trust and strategies to curb inappropriate use.

1.6.2. Antimicrobial shortages

Antimicrobial shortages in a number of key agents has presented a significant clinical challenge, specifically shortages of anti-fungal agents. Currently the long-standing supply issues are with IV Flucytosine and ceftolozone/tazobactam. In response, the infection pharmacy team and microbiology team are ensuring stock is only released where appropriate. These shortages have not resulted in patient harm.

1.7. Hand hygiene, PPE, and Aseptic Non-Touch Technique (ANTT) competency assessment

1.7.1. Competency assessment for PPE, Hand Hygiene, and ANTT

We have a requirement that all clinical staff perform a documented competency assessment for hand hygiene, PPE, and ANTT. Currently the compliance rate is 82.6 per cent (7154/8664 clinical staff), below our 90 per cent target. Of the 1510 non-compliant staff, 69.7 per cent (1052) have never had an assessment for ANTT, and 30.3 per cent (458) have had an assessment in the past, but have gone beyond the three-year deadline for re-assessment. The competency assessment was suspended during the Covid-19 peak and replaced with an ANTT training video. During 2021/22, plans are in place to review the processes for competency assessments for PPE, Hand Hygiene and ANTT.

1.7.2. PPE and Hand Hygiene Improvement

A multidisciplinary PPE and Hand Hygiene Improvement Group meets monthly to lead the hand hygiene improvement work. This group was suspended during both ways of the pandemic.

The remit of the group is to:

- Oversee and monitor the progress of the Trust's PPE and hand hygiene programme
- Provide 'check and challenge' to programme pace and direction
- Lead on initiatives to promote effective PPE and hand hygiene practice
- Commission and review audits and intelligence gathering on PPE and hand hygiene
- Review PPE and hand hygiene audit data and intelligence
- Identify specific applied research opportunities related to PPE hand hygiene
- Celebrate success of the programme

1.7.2.1. PPE helper programme

The careful use of personal protective equipment (PPE) is vital to ensure staff and patient safety. During the initial phases of the pandemic in March 2020 and early April 2020, it because clear from observations in Covid-19 cohort wards that the use of PPE was not optimal. A multidisciplinary group led the development and implementation of a PPE Helper

Programme, establishing a trained cohort of 'PPE Helpers' that visited wards to promote best practice around the use of PPE in a face-to-face and timely manner. The key aims of the PPE Helper Programme were to support staff to: don and doff safely; be provided with or signposted to key PPE information; and feel reassured and supported. The PPE Helper Programme ran from mid-April to the end of May 2020 initially and then from July 2020 to date.

At the conclusion of the first wave of the programme, a survey was circulated to all staff to evaluate perceptions towards PPE. The survey was stratified by whether or not the respondent had been in contact with a PPE Helper. Of the 261 staff members who responded to the survey, 177 (68 per cent) reported having been in contact with a PPE Helper. The findings showed that being in contact with a PPE Helper significantly improved perceptions related to PPE availability, knowledge about PPE, anxiety related to PPE, and confidence to challenge peers on poor PPE practice. The programme was commended as an area of outstanding clinical practice by an inspection of the Trust's IPC response by the CQC in July 2020.

There are currently 5 full time PPE helpers undertaking daily visits to clinical areas, including as part of outbreak investigations. In the period between September 2020 and May 2021, the PPE Helpers have conducted more than 2500 visits to clinical areas across all hospital sites: in-patient and out-patient areas, public spaces and renal satellite units every weekday (approximately 100 visits per week). Over 600 staff have been trained by the PPE Helpers via intensive staff training sessions. Data collected by the programme indicates a sustained decrease in the level of anxiety reported by staff. Data also shows a sustained reduction in variation in practice with donning and doffing, and increased levels of good practice across the Trust.

1.8. Vascular Access

1.8.1. Intravascular device insertions

The Trust wide vascular access service is provided by IPC. During 2020/21, the vascular access service received a total of 1035 referrals, a decrease of 79 (7 per cent) compared to 2019/20. The decrease in referrals reflected the cessation of chemotherapy in all but exceptional circumstances during April and May 2020 due the first surge of the Covid-19 pandemic. The complexity of patients referred this past year has increased and the complexity of insertions has also increased particularly in the Covid-19 positive patient cohort.

Referrals included requests for the insertion of vascular access devices, for expert advice, support and management of existing vascular access devices. There is an increased number of patients we are seeing in our weekly outpatients clinic, ranging from accessing implantable ports for blood tests and radiological procedures to complex medical adhesive related skin injuries in patients with peripherally inserted catheters in situ.

Of the vascular access devices inserted, 641 were peripherally inserted central catheters (PICC), and 133 were midline catheters and 36 power injectable long peripheral cannula to assist in CT imaging. Requests for ultrasound-guided cannulation are increasing, which we support as capacity allows. The median dwell of all our catheters was 20 days with a range from 1 – 112 days. We introduced a disinfecting cap to use in a specific cohort of patients, namely those patients who have a PICC, require parenteral nutrition and have a stoma to prevent infection; this has proved very successful. Results demonstrated with compliance of the Curos cap we had zero PICC infections in this patient cohort, two patients who acquired a CRBSI in this cohort on investigation it was found the Curos cap had been removed showing the benefits of the disinfecting cap. We are moving to implement this in other areas. We

continue to monitor complications in vascular access devices inserted by the service; overall these are very low and unrelated to the insertion process.

1.8.2. Line safety management group

The Line Safety Management Group (LSMG) is the Trust-wide committee where all matters relating to the safe insertion, dwell, use, and removal of intravascular devices are scrutinised. The clinical divisions are represented on this group by senior clinicians and nurses. The multidisciplinary group reviews all MRSA and MSSA bacteraemias; trends are noted and acted upon to provide safe practice for our patients. One key challenge this past year has been the very fragile supply chain (as result of the pandemic and product failures and recalls) with a number of products being unavailable and having to rapidly review new product or indeed managing with alternative products. North West London procurement collaborative to standardise vascular access packs remains a challenging situation with our peripheral cannula pack so to be replaced with a lesser product. The committee are now reviewing sharps injuries reports and we hope to review trends to ensure best practise in this critical area. There have been a number of Datix related to vascular access devices and intravenous therapy which the committee review regularly to ensure adherence to best practise, making recommendations where appropriate. All guidelines related to intravascular devices are reviewed within LSMG to ensure they adhere to recognised national and international guidance and best practice.

1.9. Decontamination and Estates

1.9.1. Sterile services

Sterile services are outsourced to a third-party provider, IHSS Ltd. IPC advice on the development, monitoring, and audit of Key Performance Indicators (KPIs) which are managed by Trust facilities.

1.9.2. Reprocessing units

The demand on reprocessing units has dropped during the two waves of Covid-19. Internal and external audits continue as part of the quality system. Imperial continues to retain external accreditation against ISO 13485 (Medical Devices Quality Management).

1.9.3. Medical Devices

We continue to monitor medical devices being brought into the Trust including new, loaned, consignment and research items.

1.9.4. Other decontamination

All other local areas of decontamination, which includes bedpan washers and laboratory sterilisers, continue to be compliant with the relevant regulations.

1.9.5. CJD and NICE 666 risk management

One patient was identified as having Creutzfeldt-Jakob disease (CJD) following surgery and five other patients were potentially exposed to CJD via surgical instruments. Another patient was identified as being at high risk of CJD and was managed correctly by the endoscopy department for two separate procedures. Changes to Trust guidance have been implemented to reflect the changes in NICE 666 (which supersedes NICE 196) to reduce the risk of transmitting prions have been implemented.

1.9.6. **Projects and estates**

Project and estate developments in 2020/21 include:

- Refurbishment of environment of C8 and A8 at Hammersmith Hospital (HH) (complete).
- Urgent care centre at HH (complete).
- Works on A7 at HH have been put on hold due to Covid-19, and will be restarted.
- Western eye injection rooms (in progress).
- Brain FUS and MRI as SMH (complete).
- Relocation of Same Day Emergency Care (SDEC) at SMH (complete).
- Hybrid theatre project at SMH (complete).
- Riverside theatre and ward refurbishment at Charing Cross Hospital (CXH) (complete).
- Limb fitting at CXH (complete).
- Renal dialysis unit at CXH (complete).
- 4S ward to include a respiratory HDU at CXH (complete).
- The management of surge ICU capacity on all three sites (complete).
- Lung function at SMH and CXH (complete) and HH (in progress).

1.9.7. **Water hygiene and ventilation**

The procedures around the delivery of a safe supply of water continue to be monitored. The ventilation group continues to meet quarterly and oversee the Trust's specialist ventilation systems.

1.10. **Serious incident investigations**

There were 45 infection related incidents that required serious incident investigations. Each serious incident results in a specific set of actions to ensure that learning is captured and to reduce the risk of issues reoccurring. 32/45 of these serious incidents were related to Covid-19 outbreaks. Key learning from these investigations included ensuing that the correct PPE is worn during patient care and in non-clinical areas, improving compliance with regular patient testing, ensuring that staff do not come to work with Covid-19 symptoms and that all staff are participating in twice weekly lateral flow testing, ensuring that visiting is managed safely, improving the provision of clinical rest areas, improving processes for managing patients who are difficult to isolate due to cognitive impairment, ensuring that patient beds are appropriately spaced, ensure that contacts from separate exposures are not mixed together, and ensuring that staffing levels are adequate.

1.11. **Freedom of Information (FOI) requests**

During 2020/21, the IPC service received one requests for data and information under the Freedom of Information Act (2000). This was completed within the legislated timeframe.

1.12. **Review of infection prevention and control policies and audit of compliance**

There is a well-established, comprehensive guideline review programme to ensure all policies are up to date and reflect the latest evidence-based practice. In 2020/21, the following policies and guidelines were reviewed/ratified:

- Infection Prevention and Control Management of Covid-19 Policy
- CJD (and other Prion disease) Policy

- Decontamination Policy
- Skin tunnelled catheter Guidelines
- Peripherally inserted central catheter (PICC) continuing care Guidelines
- Implantable port Guidelines
- Midline continuing care Guidelines
- Peripheral venous cannula Guidelines

1.13. Responding to external issues and directives

In 2020/21 the Trust responded to external directives received related to the management of the Covid-19 pandemic were actioned. The Trust responded to two external directives in Q4, one related to promoting best-practice use of ultrasound gel, the other a national alert related to Becton-Dickenson (BD) intravenous administration sets

1.14. Responding to local issues and events

1.14.1. Covid-19 outbreaks and investigations

A total of 61 Covid-19 transmission incidents / outbreaks have been identified and managed since July 2020, when formal Trust reporting commenced. Twenty-four of these 61 incidents affected only staff and 37 affected patients or both patients and staff. Eighteen of these 61 incidents affected only two individuals. Each outbreak has been reviewed in order to identify recurring themes and possible root causes.

As part of a national investigation of a novel Covid-19 'Variant Under Investigation' (VUI), IPC collaborated with PHE to investigate two VUI isolates at our Trust in Feb 2021.This concluded that the Trust had undertaken all appropriate infection prevention and control measures and no further action was required. No additional cases were identified.

1.14.2. CPE clusters

Three clusters of CPE were identified and managed during 2020/21, one of NDM-producing *Enterobacter cloacae* affecting three patients on a medical ward, one of NDM-producing *Escherichia coli* affecting eight patients on a separate medical ward, and one of VIM-producing *Klebsiella pneumoniae* affecting three patients on a surgical ward. Following the investigation improvements were made with regard to hand hygiene and IPC practices such as decontamination of equipment and documentation of cleaning. There was also a focus on reducing patient movement between bays and to other wards.

1.14.3. *Corynebacterium striatum* in the ICU

During the first wave of Covid-19, 30 patients were affected during an outbreak of *Corynebacterium striatum* in the ICUs at SMH, HH, and CXH. There were no deep infections and no attributable deaths. As a result of the investigation actions focused on hand hygiene, PPE use and management of vascular access devices.

1.14.4. *Pseudomonas aeruginosa* clusters

Three clusters of *Pseudomonas aeruginosa* were identified and managed:

- In Winnicott Baby Unit, 6 babies have been identified with *P. aeruginosa* colonisation between March and May 2021.
- In the adult ICU at SMH, 12 patients were affected with *P. aeruginosa* between February and March 2021.

- In Dacie ward, six patients were affected by bloodstream infections between August and September 2020.
- In all of these clusters, contaminated water outbreaks have been identified that are linked in time and space with patients who have become colonised or infected with *P. aeruginosa*. In response to these issues, separate Estates-led task and finish groups have been used to develop and implemented strategic engineering solutions to improve water hygiene.

1.14.5. **CJD**

An SI was declared following a confirmed case of CJD at CXH. A total of 5 patients have been defined as at risk following exposed to potentially contaminated instrument sets according to PHE guidance. As a result of the investigation improvements have been made regarding assessing risk for CJD and the systems used to track surgical instruments used in theatre.

1.14.6. ***Candida auris***

A patient on critical care was identified with *Candida auris* in their urine in November 2020. The patient had neurological surgery in Kuwait prior to arrival in the UK and additional surgery whilst an inpatient. An investigation including contract tracing was undertaken and no other patients were identified with this organism.

1.14.7. **ICU possible cross-transmission during the second wave**

There have been a number of incidents involving likely cross-transmission of different organisms in the ICUs across the Trust. These include MDR-*Pseudomonas aeruginosa*, MRSA, *Corynebacterium striatum, Stenotrophomonas maltophilia, Klebsiella pneumoniae* OXA-48 (CPE), VRE and *C. difficile*. The investigation has identified some shared underpinning themes and risks across the ICUs and actions are focused on hand hygiene, PPE use and management of vascular access devices. These are being addressed through a weekly cross-site ICU meeting co-led by IPC and the ICU team.

1.14.8. ***Staphylococcus capitis***

A PHE briefing in February 2021 highlighted an excess of invasive *Staphylococcus capitis* infections impacting neonates across London over the last 18 months (n=80). We have identified a neonate in the NICU at HH meets the PHE case definition; PHE have been informed.

1.14.9. **Communicable disease "look back" investigations**

A total of 50 communicable disease 'look back' investigations were undertaken related to potential exposures to probable CJD, measles, shingles, tuberculosis, chickenpox, mumps, hepatitis A and E, Campylobacter, Parvovirus, Rubella, PVL *Staphylococcus aureus*, *E. coli* 0157, norovirus, and invasive group A Streptococcus.

1.15. **Applied Research**

IPC lead and support applied research to improve patient care and inform local and national practice. As NHS leads within Imperial College's NIHR funded Health Protection Research Unit (HPRU) in HCAI and AMR, and the Centre for Antimicrobial Optimisation (CAMO) research programme, the IPC department are contributing to broad multi-disciplinary research programmes. IPC are working with Imperial College and PHE to address the local and national challenges associated with carbapenemase-producing organisms.

Experts in the IPC team have continued to shape national and international Covid-19 guidelines through roles in:

- WHO Covid-19 related panels and groups including the WHO Health Emergencies Program (WHE) Ad-Hoc Advisory Panel of Infection Prevention and Control Experts for Preparedness, Readiness and Response to Covid-19 (WHE-IPC-AP).
- UK Scientific Advisory Group for Emergencies (SAGE) Coronavirus Response working group on nosocomial transmission.
- Covid-19 Genomics (COG)-UK Hospital Onset Covid-19 Infection Study Group.

Since the start of the Covid-19 pandemic, IPC have led and supported applied Covid-19 research:

- In collaboration with the NIHR HPRU in AMR and HCAI, and Professor Wendy Barclay, IPC have evaluated air and hospital surface SARS-CoV-2 levels to better understand its role in disease spread (Zhou Clin Inf Dis 2020).
- Developed and implemented a hospital-onset Covid-19 infection (HOCI) surveillance system, incorporating analysis of patient pathways and networks to better understand local epidemiology and guide IPC interventions (Price Clin Inf Dis 2020).
- Two review articles have considered the impact of Covid-19 on antimicrobial stewardship activities (Rawson, Nature Review Microbiol 2020 & Rawson JAC 2020).
- Investigated the impact of Covid-19 on antibiotic prescribing in the community (Zhu Antibiotics 2020).
- Evaluated the impact of the PPE Helper Programme (Castro-Sanchez J Hosp Infect 2020).

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TRUST BOARD (PUBLIC)

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

Agenda item 15.2 and paper number: 12b

Executive Director: Professor Julian Redhead, Medical Director
Author: Jon Otter, General Manager, IPC and Dr James Price, Director, IPC

Purpose: For discussion

Meeting date: 14 July 2021

Executive summary

1. Purpose of this report

1.1. This document provides an update on progress with completion of the actions required to provide assurance with all elements of the Board Assurance Framework (BAF). This is a live document including the self-assessment from June 2021.

2. Background

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

2.2. The recommended approach is to undertake a self-assessment against the 10 domains in the framework. This paper sets this out for Imperial College Healthcare NHS Trust with “RAG” ratings for each line.

3. Key findings

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

3.2. Good progress is being made in general and one area remains “red” rated (provision and recording of training for staff issued with FFP3 respirators). A plan for FFP3 respirator management is being led by the Director of Operational Performance, which will address this KLOE.

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

4. Next steps

4.1. The IPC BAF self-assessment will be undertaken monthly and shared with CRG until further notice.

4.2. The BAF will continue to be reported monthly to the Executive Management Board (EMB) Quality group and EMB, and bi-monthly to Quality Committee and the Trust Board.

5. Recommendation(s)

5.1. The IPC BAF self-assessment for June 2021 has been discussed at the Quality Committee and presented to Trust Board for discussion.

6. Impact assessment

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

6.2. Financial impact - N/A

6.3. Workforce impact - N/A

6.4. Equality impact - N/A

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

Main report

7. Discussion/key points

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

- The following KLOE is rated as red:
  - 10.3. Training records for reusable FFP3 respirators (Director of Operational Performance). A plan for FFP3 respirator management is being led by the Director of Operational Performance, which will address this KLOE.
- The following KLOE has moved from red to amber:
  - 1.4 and 10.13. Monitoring IPC practices in non-clinical areas (Occupational Health and Health and Safety). A Trust-wide review of non-clinical workspaces is being undertaken to determine the extent to which they meet our criteria for being "COVID-secure". The process should be completed by 23/07/2021. Weekly progress updates are being given to the Executive team by Occupational Health and Health and Safety.
- The following KLOEs are amber:
  - 1.8. IPC training for contractors (IPC / Communications). A new training video has been filmed and is being added to the induction for contractors.
  - 2.9. Cleaning of electronic equipment (Communications / DDNs). A message has been sent out in the all staff email about the importance of cleaning electronic equipment including mobile phones. The need for cleaning electronic equipment will be reinforced in the new COVID-secure monitoring exercise (outlined in 1.4 and 10.13).
  - 2.15. Measures to ensure good ventilation in admission and waiting areas are being reviewed (Estates/IPC). Admission and waiting areas have been reviewed across the Trust to ensure that ventilation is maximised. The operational logistics of ensuring admission areas are maximally ventilated are being developed.
  - 5.1, 5.13, 8.7. Compliance with routine patient testing is monitored weekly (Divisional leads). Patients who have tested negative on/before admission and are not COVID-recovered have been tested daily for the first 7 days of their admission. Compliance with Day 3 testing has risen to 90% and with 7 day testing to 70%. The denominator data is being reviewed to ensure accuracy.

  - 5.8. Monitoring compliance with patient mask wearing (clinical audit team). An audit of patient compliance with face mask wearing is planned to be completed by the end of June 2021.
  - 5.10. Bed spacing across the Trust has been reviewed. The areas where bed spacing is <2m are the neonatal units at QCCH and SMH, parts of labour recovery at HH, and parts of AB2 (maternity) at SMH. A risk assessment has been undertaken (approved at CRG) in these areas to document the mitigations in place. Further mitigating actions are being reviewed in these areas, outlined in the risk assessment.
- The following KLOEs are now green:
  - 1.2. Reducing unnecessary patient moves (clinical audit team). A further audit of bed moves for patients with COVID-19 concluded that unnecessary bed moves were rare.
  - 2.14. Monitoring cleaning standards in non-clinical areas (Facilities). The frequency of monitoring cleaning in non-clinical areas has been increased from 6 monthly to quarterly. The latest audit results (for April 2021) show high compliance in non-clinical areas (96.1%).
  - 6.9. New signage to encourage best-practice hand hygiene in public toilets has been designed and implemented (Communications/facilities).

8. Conclusion

8.1. The IPC BAF has been completed for June 2021. The CRG will continue to devote part of its agenda to the BAF to ensure implementation of the actions required to provide full assurance.

Author Jon Otter, General Manager, IPC and Dr James Price, Director, IPC

Appendix 1 – IPC BAF June 2021

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

Key lines of enquiry; systems and processes are in place to ensure:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Status**	**RAG rating**
1.1. Infection risk is assessed at the front door and this is documented in patient notes	• COVID-19 patient assessment pathways agreed at the CRG[1] and widely communicated. • Risk assessment of patients for COVID-19 during emergency admission pathways is embedded in the organisation. • Pathway breaches are reported on Datix and trigger incident investigation. • An audit of patient notes was completed (in December 2020) and returned substantial assurance that infection risk is assessed and documented in patient notes. • An electronic system for reviewing compliance with patient admission testing for COVID has been implemented, and shows good compliance with COVID admission testing.	-	-	Ongoing	Green
1.2 There are pathways in place which support minimal or avoid patient bed/ward transfers for	• An audit of internal transfer documentation (in December 2020) has been completed and provides reasonable assurance that patient moves are justified.	-	•	Completed	Green

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

duration of admission unless clinically imperative	• When contacts from separate exposures are cohorted together, this is investigated via Datix. • Limiting the movement of patients with pathogens associated with HCAI is included in various IPC policies, and is reinforced in COVID-19 specific guidance. • The need to limit the movement of patients was reinforced during pathway remobilisation in the summer of 2020. • Specific guidance for moving patients between low, medium, and high risk pathways has been agreed at CRG. • A further audit of bed moves for patients with COVID-19 concluded that unnecessary bed moves were rare.				
1.3 That on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	• Cohorting patients with COVID-19 in routine practice. • Cohort areas are disinfected using chlorine as per the Infection Prevention and Control Management of COVID-19 Policy. • IPC advise when COVID-19 cohort bays are established and discontinued.			Completed	Green
1.4 Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice: ○ staff adherence to hand hygiene	• Each Division has structures in place to monitor IPC practice and identify areas of concern for escalation. • IPC visit clinical areas regularly to review practice. • IPC visit clinical areas where possible cross-transmission has	Limited assurance around COVID-prevention measures in non-clinical settings.	A Trust-wide review of the Trusts non-clinical workspaces is being undertaken to determine the extent to which they meet our criteria for being "COVID-secure".	In progress	Amber

○ staff social distancing across the workplace ○ staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: • a) clinical • b) non-clinical setting	been identified to reinforce best-practice. • PPE Helpers visit clinical areas regularly to review and support best practice. • Hand hygiene auditing is undertaken regularly across the Trust in clinical areas. • PPE Helpers visit some non-clinical areas including public areas and staff restaurants. • Staff in non-clinical areas have been provided <u>information</u> and access to surgical face masks, hand gel, and cleaning wipes to enable the management of COVID-secure offices.		The process should be completed by 23/07/2021. Weekly progress updates are being given to the Executive team by Occupational Health and Health and Safety.		
1.5 Monitoring of compliance with PPE, within the clinical setting consider implementing the role of PPE guardians/safety champions to embed and encourage best practice.	• A PPE Helper programme was developed during the first wave of COVID-19, and PPE Helpers have been active in clinical areas since the summer of 2020.			Completed	Green
1.6 Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor results and staff test and trace.	• Routine testing using lateral flow testing has been implemented and is available to all patient-facing staff. • For staff who participate, positive and negative results are recorded using an electronic system, with automated reminders in place if results are not logged twice weekly. • Staff who report a positive lateral flow test are contacted to arrange a PCR confirmatory test. • Staff with COVID-19 symptoms undergo PCR testing which feeds into trace and isolate •			Completed	Green

1.7 Additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team.	• Targeted testing of all staff in areas where outbreaks are identified			Completed	Green
1.8 Training in IPC standard infection control and transmission-based precautions are provided to all staff	• All clinical staff undergo a competency assessment for ANTT[2], hand hygiene, and PPE when they join the Trust and every three years. • All staff undertake mandatory IPC training, which covers transmission-based precautions every three years. • Contractors receive IPC training as part of their contract.	Compliance with IPC training for contractors staff is not managed electronically.	A new training video has been filmed and being added to the induction for contractors.	In progress	Amber
1.9 IPC measures in relation to COVID-19 should be included in all staff induction and mandatory training	• IPC measures in relation to COVID-19 are included in mandatory IPC training for all staff.			Completed	Green
1.10 All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	• Trust PPE guidance updated in line with PHE guidance regularly, approved at the CRG and communicated on the Intranet and via all-staff emails. • There is a bi-weekly Strategic PPE Planning group chaired by the Director of Nursing and including the Director of Finance. • The monthly Hand Hygiene Improvement Group has become the Hand Hygiene and PPE Improvement Group. • PPE donning and doffing is included in mandatory training.	•	•	Completed	Green

[2] ANTT = aseptic non-touch technique.

	• All clinical staff undergo a competency assessment for ANTT, hand hygiene, and PPE when they join the Trust and every three years. • Contractors receive IPC training as part of their contract. • Guidance updated regularly and communicated to staff. • A review of each clinical area completed to review pathways and PPE usage. • PPE Helpers are now actively reviewing clinical practice related to PPE.				
1.11 There are visual reminders displayed communicating the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	• Messages about COVID-19 prevention measures are reinforced through posters, intranet pages, regular all-staff communications, and in relation to specific issues.			Completed	Green
1.12 National IPC PHE guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• Trust IPC guidance is updated in line with changes to PHE guidance. This process includes review and scrutiny at the CRG, and communication of changes through the all-staff email and through Divisional networks. • Pathway remobilisation checklists were completed and reviewed by CRG. Low risk pathways are operating as medium risk due to the high level of community prevalence.	-		Completed	Green
1.13 Changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• Changes to guidance are discussed at CRG and the BAF updated accordingly which reports ultimately to the Board.			Completed	Green

1.14 Risks are reflected in risk registers and the Board Assurance Framework where appropriate.	The appropriate risks on the IPC risk register have been updated to reflect the COVID-19 situation. A COVID risk is on the corporate risk register as well as at divisional levels. These are reported to the executive committees and the board quality committee. This board assurance framework highlighting any gaps in assurance will be shared with the Executive Team following each update and then Trust Board through the Quality Committee and quarterly DIPC report. Risk registers have been updated to better reflect the emerging risks associated with COVID-19.	-		Completed.	Green
1.15 Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens.	• The Trust Infection Prevention and Control Committee (TIPCC) continues to meet quarterly. • TIPCC receives updates from IPC-related groups and committees. • There is also a weekly HCAI sitrep call, which includes representatives from IPC, clinical Divisions, and relevant support services to discuss current and strategic IPC and antimicrobial stewardship priorities. • The Trust will publish the IPC annual report. • The IPC service will continue to provide real-time data for all alert organisms and HCAI rates. • Regular input from our PHE CCDC. • The Trust receives quarterly reports which monitor progress against national targets for MRSA bacteraemia and C. difficile infection and the mandatory reporting of			Completed.	Green

	MSSA and E.coli BSI and any significant IPC issues. • IPC activity and data is reported to the Trust Board and CCG in the monthly Quality and Safety report, and quarterly in the IPC and Antimicrobial Stewardship report. • The Trust's divisional and corporate risk register will continue to identify and monitor any Trust wide risks in relation to IPC.				
1.16 The Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	• The methodology for the daily COVID-19 sitrep has been agreed with IPC, and the Director of Operations Performance signs off the returns.			Completed	Green
1.17 This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	• The Board Assurance Framework is RAG rated, updated monthly, and reviewed by the Executive Team at EMB Quality and the Trust Board. In addition, an associated action plan is reviewed weekly at CRG.			Completed	Green
1.18 Ensure Trust Board has oversight of ongoing outbreaks and action plans.	• A summary of COVID-19 outbreaks is included in IPC reports to the board. • Each new outbreak is discussed at CRG prior to external reporting. • Action plans related to areas of concern around COVID-19 outbreaks are discussed at CRG.			Completed	Green

1.19 There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas.	• The senior leadership and executive teams regularly visit clinical and non-clinical areas to speak to staff and allow them to raise concerns.			Completed	Green

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

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

2.8. 'Frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids	In medium and high risk pathways, each area receives at least one full clean (including frequently touched surfaces) and two touch-point cleans each day.	-	-	Completed	Green
2.9. Electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards should be cleaned a minimum of twice daily	In medium and high risk pathways, each area receives at least one full clean (including frequently touched surfaces) and two touch-point cleans each day including electronic equipment.	Limited assurance that electronic frequently touched items are cleaned at least twice daily.	A message has been sent out in the all staff email to remind staff about the importance of cleaning electronic equipment including mobile phones. The need for cleaning electronic equipment will be reinforced in the new COVID-secure monitoring exercise.	In progress	Amber
2.10. Rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	In medium and high risk pathways, each area receives at least one full clean (including frequently touched surfaces) and two touch-point cleans each day.	-	-	Completed	Green
2.11. Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Trust guidance for the management of linen from possible and confirmed COVID-19 patients has been produced and published on the Intranet. The process for managing infectious linen is monitored through an external contract with KPIs in place to manage the contract.	-	-	Completed	Green

2.12. Single use items are used where possible and according to Single Use Policy	Trust guidance for the use of single use items is included in the Trust Decontamination Policy. Disposable cloths and mops are used as routine practice in areas managing suspected or confirmed COVID-19 patients.	-	-	Completed	Green
2.13. Reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	Trust guidance for the use of single use items is included in the Trust Decontamination Policy. All PPE items are either decontaminated using manufacturer instructions or single use.	-	-	Completed	Green
2.14. Ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	• Clear guidance for cleaning and disinfection in non-clinical areas has been issued, and posters are in place to remind staff of the new for frequent environmental hygiene. • The frequency of monitoring cleaning in non-clinical areas has been increased from 6 monthly to quarterly. The latest audit results (for April 2021) show high compliance in non-clinical areas (96.1%).	-	-	Completed	Green
2.15. Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	The importance of ventilation has been communicated to staff.	Enhanced ventilation has not been specifically reviewed in admission and waiting areas.	Admission and waiting areas have been reviewed across the Trust to ensure that ventilation is maximised. The operational logistics of ensuring admission areas are maximally ventilated are being developed.	In progress	Amber
2.16. Monitor adherence to environmental decontamination with actions in place to mitigate any identified risk.	• Cleaning audits are undertaken in clinical areas across the Trust, with actions put in place by Facilities Quality Managers to address any issues or risks identified.	-	-	-	Green

2.17. Monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk.	• Clear guidance for staff have been issued on the decontamination of shared equipment. • Decontamination of shared equipment is routinely audited as part of the national cleaning standards audits.	-	-	Completed.	Green

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance					
Key lines of enquiry; systems and processes are in place to ensure:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Status**	**RAG rating**
3.1. Arrangements around antimicrobial stewardship are maintained	• The bi-annual point prevalence study of antimicrobial prescribing was conducted in January 2020, and showed good compliance with prescribing indicators. • Interim guidance for initial antimicrobial management of adult patients with suspected or confirmed COVID-19 being admitted to ICHNT and changes to the management of HAP have been produced, approved through the CRG, and published on the Trust Intranet. • The Antibiotic Stewardship Cerner Dashboard has been used to target antimicrobial stewardship activities. • Working across HCID centres nationally to determine AMS strategies being deployed + manage fragile supply chains • Introduction of COVID trails in line with CMO requests.	-	-	Completed	Green
3.2. Mandatory reporting requirements are adhered to and boards continue to maintain oversight	Mandatory reporting requirements related to antimicrobial consumption and CQUINs have been maintained in the IPC quarterly report to the Trust board.	-	-	Completed	Green

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

Key lines of enquiry; systems and processes are in place to ensure:	Evidence	Gaps in Assurance	Mitigating Actions	Status	RAG rating
4.1 Implementation of national guidance on visiting patients in a care setting	Trust visiting guidance has been updated and is in line with national guidance in June 2021.			Completed.	Green
4.2 Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas marked with appropriate signage and where appropriate with restricted access	• The communications team have produced signage to designate areas used to care for patients with confirmed or suspected COVID-19, and for designated COVID-protected pathways. • Clear signage has also been designed to designate COVID-secure non-clinical workspaces.	-	-	Completed.	Green
4.3 Information and guidance on COVID-19 is available on all Trust websites with easy read versions	• The Trust website has dedicated COVID-19 management pages on the homepage of the site.A booklet for patients admitted during the COVID-19 pandemic has been produced. • Easy Read versions have been produced and published.	-	-	Completed.	Green
4.4. Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• Discharge guidance for patients with COVID-19, including the need to communicate COVID-19 status, has been produced and published on the Trust Intranet.	Documentation of compliance with protocol for internal transfers has not been audited.	The results of tests for COVID-19 are in Cerner (electronic patient record) and should be routinely reviewed by receiving clinical teams during internal transfers.	Completed.	Green

	• COVID-19 status is routinely included in patient discharge summaries. • An audit of internal transfer documentation has returned substantial assurance that infection status is communicated during internal patient transfers of patients with COVID-19.				
4.5. There is clearly displayed and written information available to prompt patients, visitors and staff to comply with hands, face and space advice	• Each hospital entrance has a welcome station with signage to encourage 'hands, face, space.'	-	-	Completed.	Green

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people					
Key lines of enquiry; systems and processes are in place to ensure:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Status**	**RAG rating**
5.1 Screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.	Triaging and testing processes are in place and embedded in all care pathways.	Compliance with admission testing is <100%.	Compliance with routine patient testing is monitored weekly (Divisional leads). Patients who have tested negative on/before admission and are not COVID-recovered have been tested daily for the first 7 days of their admission. Compliance with Day 3 testing has risen to 90% and with 7 day testing to 70%. The denominator data is being reviewed to ensure accuracy.	In progress	Amber

5.2 Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from non-COVID-19 cases to minimise the risk of cross-infection as per national guidance	COVID-19 patient assessment pathways approved at CRG and widely communicated for the Emergency Department and Admission wards. These included physical segregation of patients with confirmed COVID-19 or symptoms from those without.	-	-	Completed	Green
5.3 Staff are aware of agreed template for triage questions to ask	Staff are aware of agreed template for triage questions to ask. Compliance was audited in late 2020.	-	-	Completed	Green
5.4 Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	• COVID-19 patient assessment pathways including the triggers for patient testing approved at CRG and widely communicated.	-	-	Completed	Green
5.5 Face coverings are used by all outpatients and visitors	• Face coverings are required by all outpatients and visitors and this is reinforced by welcome station staff. • PPE Helpers have spent some time in welcome stations to review practice.	-	-	Completed	Green
5.6 Face masks are available for all patients and they are always advised to wear them.	Face masks are available for patients with respiratory symptoms. Patients are advised to wear surgical masks unless they are eating, drinking, or sleeping. If a patient is not able to wear a surgical mask, this is documented in Cerner.	-	-	Completed	Green

5.7 Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	• Clear advice is provided to all patients to encourage the use of surgical facemasks unless they are eating, drinking, or sleeping. • If a patient is unable to wear a surgical mask, this is documented in Cerner.	-	-	Completed	Green
5.8 Monitoring of inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so).	• Clear advice is provided to all patients to encourage the use of surgical facemasks unless they are eating, drinking, or sleeping. • If a patient is not able to wear a surgical mask, this is documented in Cerner.	Patient compliance with face mask wearing has not been audited.	Monitoring compliance with patient mask wearing (clinical audit team). An audit of patient compliance with face mask wearing is being planned to be completed by the end of June 2021.	In progress	Amber
5.9 Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	• Screens are used in some non-clinical areas to improve segregation of staff. • Staff working in clinical areas continue to wear surgical masks, even if they are behind a screen.	-	-	Completed	Green
5.10 To ensure 2 metre social & physical distancing in all patient care areas.	• Clear guidance has been given to staff about the need to maintain physical distancing of at least 2m wherever possible. • Beds and patient chairs should be spaced >2m apart when possible (bed centre to bed centre). • "Chair, bed, locker" arrangement of furniture is in place.	Some bed / trolley spaces are not >2m apart.	Bed spacing across the Trust has been reviewed. The areas where bed spacing is <2m are the neonatal units at QCCH and SMH, parts of labour recovery at HH, and parts of AB2 (maternity) at SMH. A risk assessment has been undertaken (approved at CRG) in these areas to document the mitigations in place. Further mitigating actions are being reviewed in these areas, outlined in the risk assessment.	In progress	Amber
5.11 For patients with new-onset symptoms, isolation, testing and instigation of	Rapid identification and testing of patients along with contact tracing is in place.	-	-	Completed	Green

contact tracing is achieved until proven negative					
5.12 Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly.	• COVID-19 patient assessment pathways widely communicated. • Pathway breaches are reported on Datix and trigger incident investigation.	Pre-emptive isolation of patients who develop symptoms following a negative test are not always available due to lack of single room availability.	Situations are managed on a case-by-case basis with input from the IPC team, usually be establishing cohorts of confirmed or suspected patients. There is a risk on the IPC risk register related to limited isolation facilities in the Trust.	Completed	Green
5.13 There is evidence of compliance with routine patient testing protocols in line with 'Key actions: infection prevention and control and testing document.'	• Compliance with patient testing pre-admission, on admission, on day 3, day 7, weekly, and prior to discharge (if required) is monitored automatically.	Compliance remains <100%.	Patients who have tested negative on/before admission and are not COVID-recovered have been tested daily for the first 7 days of their admission from 22/03/2021. Compliance with Day 3 testing has risen to 90% and with 7 day testing to 70%.	In progress.	Amber
5.14 Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• Patients attending for routine appointments are triaged to make sure they don't have symptoms consistent with COVID-19. • Patients that are not tested prior to their admission are managed on medium risk pathways. • Recovery plans are scrutinised to ensure face-to-face is the exception not the rule. • All recovery plans are approved by the site IPC lead before approval at CRG and then the Trust executive team.	-	-	Completed.	Green

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection					
Key lines of enquiry; systems and processes are in place to ensure:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Status**	**RAG**
6.1 Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	Each pathways was reviewed at CRG to optimise the separation of patients, staff, and visitors in the summer of 2020.	-	-	Completed	Green
6.2 All staff (clinical and non-clinical) have appropriate training, in line with latest PHE guidance, to ensure their personal safety and working environment is safe	All staff undergo electronic IPC training (IPC Level 1), with clinical staff receiving a more detailed session (IPC Level 2).	Compliance is >90% for Level 1 and Level 2.	The need for high compliance with this (and other) mandatory training is a Trust priority.	Ongoing/sustain via HR with IPC support.	Green
6.3 All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it.	All staff receive training on appropriate use of PPE.	Ward-based training records are not routinely stored electronically.	The content of mandatory training for clinical staff has been reviewed and it covers the selection of appropriate use of PPE and how to safely don and doff. Compliance with this training ("IPC Level 2") is reviewed at the Executive People and Organisational Development Committee. An updated electronic resource for training staff related to PPE has been produced and will be launched in the coming weeks.	Completed.	Green
6.4 A record of staff training is maintained.	Electronic records are kept for the Level 1 and Level 2 training modules.	-	-	Completed	Green

6.5 Adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	• PPE helper programme provide ward-level support for staff to use the correct PPE, and to use it safely. • The PPE helper programme provides an assessment of adherence to national guidance around PPE in clinical areas. • The safe and effective use of PPE is a strategic objective of the Hand Hygiene and PPE Improvement Group, which meets monthly.	-	PPE helpers are visiting clinical areas daily to observe PPE use and support best practice.	Ongoing/sustain via Hand Hygiene and PPE Improvement Group	Green
6.6 Hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: • hand hygiene facilities including instructional posters • good respiratory hygiene measures • staff maintain physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care • staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace • frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear visually displayed advice on use of face	• Each hospital entrance has a welcome station with signage to encourage 'hands, face, space.' • Specific guidance has been produced for managing COVID-secure non-clinical areas, including specific signage to promote physical distancing, and hand, respiratory (including the use of masks), and surface hygiene. • Separate signage has been produced for clinical areas to promote physical distancing, and hand, respiratory (including the use of masks), and surface hygiene. • Staff are clear that car sharing should be avoided (but June be the safest route to travel). • Reminders to reinforce these key prevention messages are sent regularly to all staff. • The Trust Intranet has key information on COVID-19 prevention measures.				Green

coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas					
6.7 Staff regularly undertake hand hygiene and observe standard infection control precautions	The bi-annual hand hygiene audits were planned for June but postposed given the pandemic and the need to minimise non-COVID related activity on wards.	Limited surveillance on current standards of hand hygiene practice.	Hand hygiene audit data undertaken since the last Trust-wide audit has been collated and review, and a Trust-wide hand hygiene audits will be scheduled for Q1 2021/22.	Completed	Green
6.8 The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	• Hand driers are not used in clinical areas. • Hands are dried using disposable paper towels in clinical areas.	-	-	Completed	Green
6.9 Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	Guidance on hand hygiene is displayed in staff areas. New signage to encourage best-practice hand hygiene in public toilets has been designed and implemented.	-	-	Completed	Green
6.10 Staff understand the requirements for uniform laundering where this is not provided for on site	The Trust Uniform Policy provides specific information about laundering uniforms. Scrubs were used in more areas during the peak of the pandemic and increased laundry facilities provided to ensure safe laundering.	-	-	Completed	Green
6.11 All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms	The Trust Intranet COVID-19 pages provide information for staff about actions to take when they or a family member display symptoms.	-	-	Completed	Green

6.12 A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	• IPC review each new case of COVID-19 to identify possible cross transmission. • The rate of hospital-onset COVID-19 infection at ICHT and across London is reviewed weekly at CRG. • Occupational Health review each new case of COVID-19 in staff to identify possible cross-transmission.				Green
6.13 Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	• Two or more cases of COVID-19 in patients linked in time or space trigger an investigation by IPC. • Two or more cases of COVID-19 in staff linked in time or space trigger an investigation by IPC. • A daily review meeting occurs including IPC and Occupational Health. • Outbreaks are reported using the IIJUNE system. • Each new IIJUNE form is reviewed at CRG prior to submission.				Green
6.14 Robust policies and procedures are in place for the identification of and management of outbreaks of infection	• Robust procedures are in place for the identification and management of COVID-19 outbreaks in patients and/or in staff. • Learning is captured from local and regional COVID-19 outbreaks.				Green

7. Provide or secure adequate isolation facilities					
Key lines of enquiry; systems and processes are in place to ensure:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Status**	**RAG rating**
7.1 Restricted access between pathways if possible (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	Restricted access between pathways is in place where possible.	-	-	Completed	Green
7.2 Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	Areas/wards are clearly signposted to ensure that patients/visitors and staff understand the different risk areas.	-	-	Completed	Green
7.3 Patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate.	COVID-19 patient assessment pathways approved at CRG and widely communicated, including the preferable use of single rooms for patients with confirmed or suspected COVID-19.	There are limited single rooms in our Trust, so patients with confirmed COVID-19 have been cohorted together in clearly designated areas according to the guideline approved at CRG	IPC have advised on when it is appropriate to cohort patients together. There is a risk on the IPC risk register related to limited isolation facilities in the Trust.	Completed	Green
7.4 Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance.	IPC review each new proposed cohort area to ensure compliance with PHE national guidance.	-	-	Completed	Green
7.5 Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.	Usual guidance has been followed unless it has not been feasible to do so. The routine isolation of patients colonised with CPE has been reinstated. Compliance with MRSA and	-	-	Completed	Green

	CPE screening is monitored monthly.				

8. Secure adequate access to laboratory support as appropriate					
Key lines of enquiry; systems and processes are in place to ensure:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Status**	**RAG rating**
8.1 Ensure screens taken on admission given priority and reported within 24hrs	Laboratory turnaround times for all specimens remain <24 hours.	-	-	Completed	Green
8.2 Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	Laboratory turnaround times are monitored and reported.			Completed	Green
8.3 Testing is undertaken by competent and trained individuals	Testing is performed in accredited laboratories.	-	-	Completed	Green
8.4 Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Pathways for testing symptomatic patient and staff have been established and outlined on the Trust Intranet. Trust Test and Trace processes are in place.	-	-	Completed	Green
8.5 Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	The laboratory have clear SOPs and quality assurance systems in place. Results are reported through Cerner.			Completed	Green

8.6 Screening for other potential infections takes place	Screening for other potential infections (such as CPE and MRSA) has continued. Weekly screening for key organisms continues in the ICUs.	Compliance with MRSA admission screening was on target at 90% for Q4: 5813 of the 6488 patients identified as requiring MRSA screening were screened. Overall compliance with CPE admission screening was 83%, and >90% in the four specialties performing universal admission screening.	Ward level results from MRSA and CPE screening programmes are fed-back to wards to prompt local investigation and improvement planning.	Completed	Green
8.7 • That all emergency patients are tested for COVID-19 on admission. • That those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise. • That those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission. • That all elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	• Emergency admissions are tested on day 0, 3, 7, and weekly thereafter. • Inpatients are tested 48 hours prior to discharge to another care facility. • Elective admissions are tested 3 days prior to their admission and self-isolate from the time of the test. A pre-admission test for an elective admission taken within 5 days of admission is acceptable, provided self-isolation has been adhered to. • Patients are tested whenever symptoms	Compliance with testing is monitored electronically and is <100%.	Patients who have tested negative on/before admission and are not COVID-recovered have been tested daily for the first 7 days of their admission from 22/03/2021. Compliance with Day 3 testing has risen to 90% and with 7 day testing to 70%.	In progress.	Amber

	consistent with COVID-19 develop.				
8.8 That sites with high nosocomial rates should consider testing COVID negative patients daily.	• Contacts of a known positive case are testing daily through their 14 day isolation period. • Patients who have tested negative on/before admission and are not COVID-recovered are tested daily for the first 7 days of their admission.	-	-	In progress	Green
8.9 That those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge.	• Patients are tested 48 hours prior to discharge. • COVID-19 status is automatically included in patient discharge summaries. • Compliance with discharge testing is monitored electronically	-	-	-	Green
8.10 That those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation.	• Patients who are identified as contacts are transferred to designated care settings.				Green

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections					
Key lines of enquiry; systems and processes are in place to ensure:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Status**	**RAG rating**
9.1 Staff are supported in adhering to all IPC policies, including those for other alert organisms	IPC policies are published on the Trust Intranet and promoted via various channels. IPC support staff in implementing them.	-	-	Completed	Green
9.2 Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Trust PPE guidance is updates in line with changes to PHE guidance.	-	-	Completed	Green
9.3 All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	A guideline for managing clinical waste related to COVID-19 has been created and published on the Trust Intranet. Our waste management procedures are audited regularly as part of contract arrangements and KPIs indicate no issues.	-	-	Completed	Green
9.4 PPE stock is appropriately stored and accessible to staff who require it	The supply and storage of PPE management during COVID-19 is done by site-based command centres. PPE stock levels are shared on a daily dashboard to identify upcoming potential shortages.	-	-	Completed	Green

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection					
Key lines of enquiry; systems and processes are in place to ensure:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Status**	**RAG rating**
10.1 Staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and psychological wellbeing is supported	• All staff who are identified as being "at risk" are now beginning to return to work. • Also, the Trust has developed and widely shared wellbeing advice and resources. This has included group videoconferences and redeployment to tasks that can be accomplished for staff shielding at home.		A Trust-wide COVID-19 risk self-assessment for all staff has been undertaken.	Completed.	Green
10.2 That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	Risk assessments have been completed for all staff.			Completed	Green
10.3 Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally	Reusable FFP3 masks are issued through procurement to staff. Over 1000 masks have so far been issued and a record of each issue is available. Mask maintenance information is available on Intranet and issued with the reusable mask. Application development is in progress and lead by Health & Safety to capture mask maintenance, filter expiry and fit testing in one location. Emergency planning provides mask fit testing, training on individual fit check and provides information on how to don the	Training records (aside from fit testing) are not maintained.	A plan for FFP3 mask management is being led by the director of operational performance.	In progress	Red

	mask. Fit testing records are held centrally.				
10.4 Staff who carry out fit test training are trained and competent to do so	Staff who carry out fit test training are trained and competent to do so.	-	-	Completed	Green
10.5 All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	All staff required to wear an FFP respirator have been fit tested for the model being used and this is repeated each time a different model is used.			Completed	Green
10.6 A record of the fit test and result is given to and kept by the trainee and centrally within the organisation	A record of the fit test and result is given to and kept by the trainee and held centrally within the organisation.	-	-	Completed	Green
10.7 For those who fail a fit test, there is a record given to and held by the trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	For those who fail a fit test, there is a record given to and held by the trainee and centrally within the organisation of repeated testing on alternative respirators.	-	-	Completed	Green
10.8 For members of staff who fail to be adequately fit tested, a discussion should be had regarding redeployment opportunities and options commensurate with the staff members' skills and experience and in line with nationally agreed algorithm	For members of staff who fail to be adequately fit tested, a discussion is had regarding redeployment opportunities and options commensurate with the staff members' skills and experience and in line with nationally agreed algorithm.	-	-	Completed	Green
10.9 A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational Health	A documented record of this discussion is available for the staff member and held centrally within the organisation, as part of employment record including Occupational Health.	-	-	Completed	Green
10.10 Following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are	Following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are	-	-	Completed	Green

unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational Health service record.	unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational Health service record.				
10.11 Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	The board regularly reviews fit testing records.	-	-	Completed	Green
10.12 Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance	Staff are allocated to a particular care pathways to the extent possible.	-	-	Completed	Green
10.13 All staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas	The use of surgical masks by staff is now embedded practice, except when they are working alone in an office or physically distanced from others in their COVID-secure office.	Physical distancing is challenged in some non-clinical areas.	A Trust-wide review of the Trusts non-clinical workspaces is being undertaken to determine the extent to which they meet our criteria for being “COVID-secure”. The process should be completed by 23/07/2021. Weekly progress updates are being given to the Executive team by Occupational Health and Health and Safety.	In progress	Amber
10.14 Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace	COVID-secure offices have been established, with detailed guidance on the intranet and a documented risk assessment for each COVID-secure office.	-	-	Completed	Green

risk(s) are mitigated maximally for everyone					
10.15 Staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	Surgical masks are worn when staff are unable to maintain physical distancing in their COVID-19 secure office.	-	-	Completed	Green
10.16 Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	A process has been established to ensure that line managers communicate daily with staff who are self-isolating.	-	-	Completed	Green
10.17 Staff that test positive have adequate information and support to aid their recovery and return to work	There is good quality information on the Internet.	-	-	Completed	Green

TRUST BOARD (PUBLIC)

Paper title: 2020/2021 PALS and complaints service annual report

Agenda item 16, paper number 13

Executive Director: Janice Sigsworth
Author: Daniel Marshall, Complaints & Service Improvement Manager & Guy Young, Deputy Director – Patient Experience

Purpose: For discussion

Meeting date: 14 July 2021

Executive summary

1. Purpose of this report

1.1. The 2020/21 annual report of the patient advice and liaison (PALS) and complaints service is presented for discussion by the Trust Board. The report outlines the PALS and complaints activity during the year and sets out the themes and trends that emerged.

2. Introduction and background

2.1. The complaints service and PALS sit within the corporate nursing division and work closely together to deal with concerns raised by our patients and their relatives.

2.2. The report (appendix 1) covers the period April 2020 to March 2021 and provides detail of formal complaints and PALS concerns received during the year.

2.3. For the first time the report includes analysis using the Healthcare Complaints Analysis Tool (HCAT) which has been developed in conjunction with the Patient Safety Translational Research Centre at Imperial College.

2.4. The report was discussed in detail at the Quality Committee on 08 July 2021. The committee were assured that there are good systems in place for managing complaints. The importance of effective administration processes was noted and that this is an area in which further work will be undertaken. A deep dive on the outpatient transformation programme will be brought to a future meeting. It was agreed that work needs to be undertaken by the complaints team to better collect protected characteristics related to complaints.

3. Key findings

3.1. COVID-19 has affected the activity during the year. Formal complaints fell as services were reduced, this was particularly noticeable during the two peaks of the pandemic in April 2020 and January 2021. PALS activity overall remained the same but identified new areas of concern for patients, such as issues arising from the shift to virtual appointments.

3.2. In the year 768 formal complaints were received (down from 1074 in 2019/20) which represents less than 0.1% of total patient contacts. There were 3401 PALS concerns during the year (3375 in 2019/20) around 0.3% of total contacts.

3.3. Whilst there is a nominal annual threshold for complaints (5400 combined formal and PALS) which was not exceeded, the trust sees complaints as learning opportunities and actively supports people to raise concerns about their care.

3.4. Overall performance in complaints handling was good throughout the year and for the first time no cases were upheld by the Parliamentary Health Service Ombudsman (PHSO).

3.5. The complaints team worked closely with Imperial College on the development of HCAT, which provides a way of categorising complaints as an alternative to the NHS Digital categories that organisations report on. It is early days for HCAT and COVID-19 interrupted the work on it in 2020/21. It is expected that during this year benchmark data will be available and more detailed review will start to identify areas for improvement work. For example, a higher proportion of complaints occur during the ward stage of a patient's journey which would help to focus the improvement activity. A section on HCAT is included in the report to demonstrate some of the emerging work and thinking around complaints analysis.

3.6. Key issues arising from complaints and PALS concerns during the year were related to appointments, communication and maternity, which are explained in more detail below:

3.7. **Appointments**

3.7.1. This category covers outpatient appointments and elective surgery. The main concerns raised relate to delays in getting appointments, cancellation of appointments (late or repeated cancellations are generally what lead people to complain) and waiting, either in clinic of for telephone calls where there appointment is virtual. The increase in delays and cancellations of elective surgery as a result of COVID-19 had an impact during the year.

3.7.2. Telephone and video appointments were introduced rapidly during the early stages of the pandemic. We know from Friends & Family Test data that the quality of these appointments is highly rated and patients value not having to travel into the hospital. The complaints about these result from the call not coming at the allotted time.

3.7.3. The outpatient transformation programme continues to address these issues. This includes a strategic clinic build in Cerner, implementing an *Advice & Guidance* platform (which ensures that patients are on the right pathway from the outset avoiding unnecessary appointments) and automating manual processes.

3.7.4. The complaints and outpatient teams will work together to explore the issues in more detail. Not all clinics are overseen by the central complaints team and so further breakdown by service will be undertaken so that issues can be addressed collaboratively, working across both central outpatients and service led clinics.

3.8. **Communication & behaviours**

3.8.1. There is no doubt that the pandemic contributed to complaints about communication. Relatives in particular found it difficult to always get the information they were looking for and the difficulties associated with talking to loved ones are well known. The committee will be aware that much was learned from the first wave and the introduction of virtual visiting and communications via tablets and phones, though not without issues, helped people to connect.

3.8.2. Communication complaints are often associated with attitudes and behaviours of staff and this has been very much a focus of the 2021 performance development review cycle. Staff and managers are asked to review the application of the staff values and 'love to see' behaviours in the trust behaviours framework. This framework is shared at the corporate welcome sessions so that expectations are made clear right from the start of someone's employment.

3.8.3. A number of training programmes available in the Trust support application of the values and skills required to communicate effectively; for example Springboard for band 5 & 6 nurses and midwives, *Giving, receiving and asking for feedback*, Active Bystander training and a series of bite-size 'digital skill pill' communication skills packages.

3.8.4. Managing violence and aggression towards staff has been highlighted recently as a result of a small number of serious incidents against staff. Underlying this is an increasing sense of low level abuse experienced by staff. A violence and aggression task and finish group has been set up to address this. Initial plans include an engagement plan with the development of a 'compact' between staff and patients/visitors, training for staff, an increase in use of body worn cameras and a review of existing policies.

3.9. **Maternity**

3.9.1. The appearance of maternity an issue is new and seems to be related to COVID-19 and the restrictions applied to birth partners and family associated. Although this has been noted across the whole maternity pathway, the post-natal wards have generated the most concerns. Pandemic restrictions meant that the number of visitors and the length of time that partners could stay was restricted.

3.9.2. Following revised guidance from NHS England, visiting has been largely reintroduced in maternity and it is expected that this will have an impact on the volume of complaints. No additional actions are felt to be required at this time.

3.10. **Equity and monitoring protected characteristics**

3.10.1. A summary of protected characteristics data is presented at the end of the report. It can be seen that this is limited in scope and will therefore be a priority for the complaints team to address over the coming year.

3.10.2. The trust collects a broad range of protected characteristics in its Friends & Family Test surveys, but the same system is not available for complaints. The complaints team will explore ways of collecting and recording these data that doesn't add to the upset that complainants may already be experiencing.

3.10.3. Understanding whether certain groups are under or over represented when raising complaints will help to identify any changes to the complaints process and to address specific concerns. In order to do this the protected characteristics of complainants will need to be compared to patient and general population demographics. Further work will also be undertaken to try to understand if complaints themes are more prevalent in certain groups.

4. Recommendation(s)

4.1. The Board is asked to discuss and note the report.

5. Conclusion and next steps

5.1. The COVID-19 pandemic continues to create a great deal of uncertainty for the complaints and PALS team and this is likely to continue into the next year. However, it has also provided opportunities to develop new ways of working, such as home/office hybrid working (for complaints) and a move to email/telephone support for PALS. We expect a steady increase in PALS and Complaints activity during the year as delayed demand for elective procedures continues to put pressure on services. Additionally, the return of visitors to our hospitals is likely to lead to an increase in the reporting of PALS and complaints concerns. Any winter wave of COVID-19 2021/22 is also likely to present similar challenges to the previous year.

5.2. The complaints team will focus in 2021/22 on maintaining the high quality of its responses and reducing the “re-open” rate further. We are aiming to ensure that few cases are upheld upon review by the PHSO.

5.3. Although this has been more challenging during the pandemic, complaints and PALS feedback will be fed back the Divisions to ensure that it continues to drive learning and improvement, particular as we aim to start to return to ‘business as usual’.

5.4. The complaints team will continue to explore how it can do more to follow up with patients to provide assurance that agreed actions have taken place.

5.5. PALS will continue to provide support to clinical teams and patients, as well as working on longer term service improvements, such as those related to patient property.

6. Impact assessment

6.1. Quality impact: Complaints provide a valuable insight into how patients and their families experience our services. Learning from complaints and introducing improvements will lead to better quality care.

6.2. Financial impact: None

6.3. Workforce impact: None

6.4. Equality impact: There is no direct impact of this report. However, the service recognises the potential to expand the collection of the protected characteristics of people who complain. This will be explored over the coming year.

6.5. Risk impact: There are no direct risks associated with this annual report, but not acting on learning from complaints would be highlighted in any future CQC reviews.

Appendices

Appendix 1 - 2020/21 Trust PALS and complaints service annual report

Appendix 1 - 2020/21 Trust PALS and complaints service annual report

1.0 Introduction

The Patient Advice & Liaison Service (PALS) and Complaints Teams have, as with the rest of the Trust, faced a challenging year as a result of the COVID-19 pandemic. However, we have continued to maintain a high standard of service and met key targets for timeliness and responsiveness of responses to patients. For the first time on record, no complaints investigated by the Parliamentary & Health Service Ombudsman (PHSO) were upheld.

During the COVID-19 pandemic, all 'walk-in' PALS offices have been closed. The PALS team have however maintained their telephone and email service supporting families/carers in the past year. PALS worked with the Patient Experience Team to deliver personal messages and photographs to patients on the wards. PALS also facilitate a 'Drop Off' service in which families and friends can drop off parcels to the PALS offices on each site for the Officers to deliver to wards.

The headline performance figures for 2020/21 are:

- 768 formal complaints received and 3401 PALS cases logged.
- 395 compliments were logged by the PALS team.
- 97.0% of complaints were responded to within their agreed deadlines
- 97% of acknowledgment letters were sent within 3 working days.
- 759 complaints were closed during the year with an average response time of 33 days (target < 40). This was the same as last year.
- 4 complaints that were referred to the PHSO proceeded to a full investigation, the lowest to date.
- 2 outcomes from the PHSO were reported to the trust of which neither were upheld. We set a maximum target of just one upheld/partly upheld cases for 20/21 and achieved this.
- 4% of complaints were re-opened, meaning we needed to provide a follow up written response. This was higher than last year and above the 2% target we set ourselves.
- Members of the complaints and PALS team continue to offer expert support and training to colleagues around the Trust.

The Central Complaints Team and PALS continue to have a strong and collaborative working relationship and they support colleagues to resolve complaints as swiftly as possible. The Central Complaints Team and PALS have continued to develop links with colleagues in the wider team, such as Patient Affairs, Mortuary and Safeguarding and have assisted each other during periods of pressure caused by COVID-19, via redeployment.

Complaints are reviewed at divisional monthly and quarterly governance meetings, as well as some of the specialty meetings where trends are identified that need to be brought to their attention and there is a complaints presence at these meetings when required. This is supported by quarterly reports provided by the Complaints & Service Improvement Manager. A monthly tracker is sent out to key staff. This shows a summary of complaints performance across the Trust and allows queries and delays to be identified and dealt with promptly. The report continues to highlight the great work being done around the Trust by including compliments. This helps balance feedback, ensures colleagues get recognition for the excellent work they do, and improves general engagement with the complaints team. In the interest of openness and to demonstrate our commitment to learning

and improvement, starting this year the quarterly reports have been made available to the public via the Trust website.

The Central Complaints Team supports the Chief Executive’s office by managing and preparing responses to “high profile” complaints such as those received from MPs and those that have been raised via social media.

The Complaints & Service Improvement Manager added to the Intranet a guide for staff on how to handle complaints. This contains some useful tips and guidance on how to seek support.

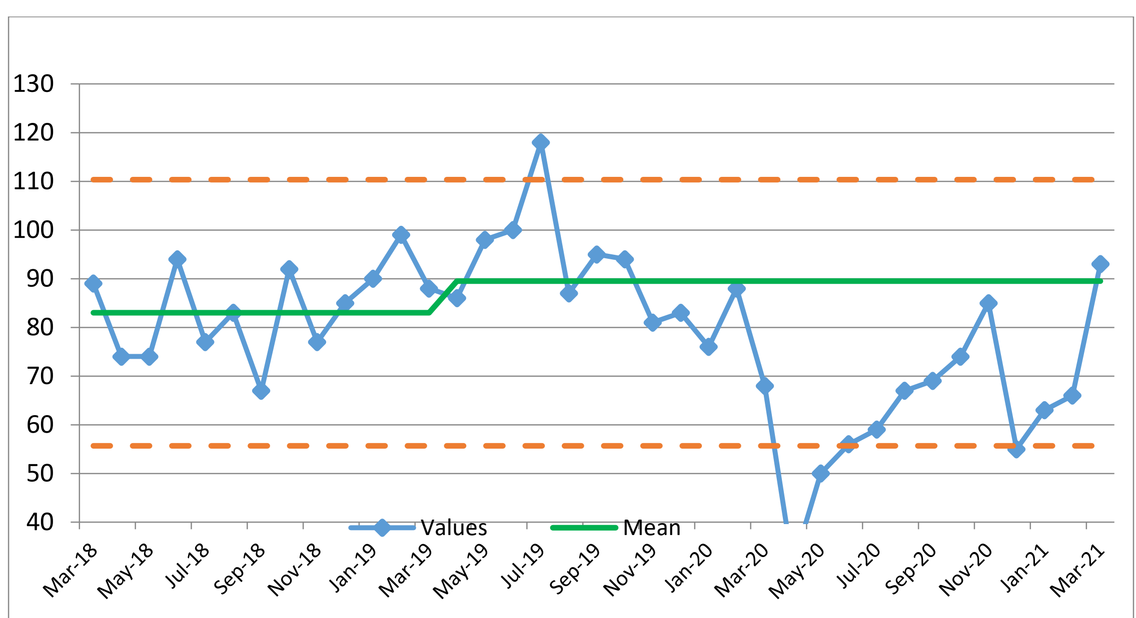
The Central Complaints Team keeps track of all actions and learning arising from complaints investigations to make sure they are delivered and evidence is collected to ensure they take place. Due to the pandemic the Complaints & Service Improvement Manager has not been able to deliver as many training sessions to colleagues as in previous year, but at the time of writing (June 2021) he has re-started virtual training for Preceptorship Nurses.

2.0 Numbers of Formal Complaints Received

Last year the Trust received 768 formal complaints. This was a 28.5% decrease on the 1074 received in the previous year. This decrease comes after prior year-on-year increases and is most likely as a result of the COVID-19 pandemic. The number of complaints received fell significantly from March 2020 as the COVID-19 ‘first wave’ started to affect services. There was then a steady increase in summer and early autumn 2020, before another ‘dip’ during the winter COVID-19 second wave. At the end of the financial year, monthly figures were almost back to pre-COVID-19 levels. The effect of the pandemic has made it harder to analyse year on year trends in overall complaints numbers.

The graph below shows the trend in the number of formal complaints raised over the last three financial years.

Graph 1: Numbers of formal complaints received for the last three years



3.0 Complaints cases

We report the subject of complaints using standardised categories, set by NHS Digital, which allow for benchmarking across NHS Trusts. Table 1 highlights the top 5 categories of formal complaints received in the year in comparison with the previous year (for reporting purposes Clinical Treatment and Patient Care have been combined as they are similar).

Table 1: Formal complaints by category

Category	2020/21	% of total	2019/20	% of total
Clinical treatment/patient care	217	**29%**	301	**28%**
Values and Behaviours (Staff)	111	**15%**	165	**15%**
Appointments	94	**12%**	159	**15%**
Communications	81	**11%**	118	**11%**
Trust admin/policies/procedures including patient record management	59	**8%**	58	**5%**
TOTAL	**562**	**74%**	**801**	**75%**

It is interesting to note how the proportion of formal complaints across the service areas has remained similar in 2020/21 compared with the previous years. However, there are a few changes to note. Firstly, the proportion of formal complaints about *Appointments* has decreased. However, the management of outpatient appointments remains an area of concern for our patients and it is noted later in the report that the fall in formal cases is due to an increasing proportion of these issues being dealt with informally by PALS before they escalate to the formal stage. Patients have complained about delays to elective appointments and procedures, and short notice, and sometimes repeated cancellations. Additionally, there have been a number of complaints made about the move towards remote appointments and a lack of clarity in communication about this, including staff not calling patients at the expected times or patients not being clear if they should attend in person.

Transport was a key theme in the previous quarter when there were issues with the service being provided by Falck to our patients. This has fallen in 20/21, likely due to the reduction in demand due to COVID-19 and lockdowns, fewer traffic delays and efforts by our transport team and Falck to improve the standard of service being provided.

It is reassuring to note that despite the unprecedented pressures colleagues have been under during the last year the proportion of complaints about *clinical treatment/patient* care has remained unchanged. This demonstrates that on the whole, patients are satisfied with the overall standard of care they are receiving when in our hospitals.

Table 2 provides a breakdown by service area. During 2019/20 there were more complaints received concerning outpatients than inpatients. This is likely due to the aforementioned capacity issues which have resulted in complaints about delays and cancellations to elective outpatient appointments and procedures.

Table 2: Complaints by service area

Service area	2020/21	% of total	2019/20	% of total
Outpatients	316	41%	501	47%
Inpatients	320	41%	432	40%
A&E	66	9%	85	8%

Maternity	66	9%	56	5%
Total	**768**	**100%**	**1074**	**100%**

Table 3 shows the number of complaints received by Division compared with the previous year. Table 4 shows the directorates that have attracted the most complaints.

Table 3: Complaints by division

Division	2020/21	% of total	2019/20	% of total
Medicine & Integrated Care	260	34%	311	29%
Surgery, Cancer & Cardiovascular	264	34.5%	398	37%
Women's, Children's & Clinical Support	150	19.5%	180	17%
Corporate (including IPH and Transport)	91	12%	184	17%
NWL Pathology	3	<1	1	<1
Total	**768**	**100%**	**1074**	**100%**

Table 4: Complaints by Directorate with the largest overall numbers of complaints

Directorate	2020/21	**% of total**	**2019/20**	**% of total**	**% change year on year**
Maternity	66	9%	56	5%	+4%
Urgent Care & Emergency Medicine	62	8%	84	8%	No change
General Surgery & Vascular	52	7%	76	7%	No change
Acute and Specialist Medicine (CXH)	51	7%	44	4%	+3%
Stroke and Neurosciences	47	6%	82	8%	-2%
Ophthalmology	46	6%	81	8%	-2%

The largest increase in complaints during the year were for the directorates of Maternity and Acute and Specialist Medicine at Charing Cross Hospital. The main theme for Maternity complaints was Values and Behaviours of midwives (i.e. staff attitude) followed by Clinical Treatment in Obstetrics & Gynaecology.

For Acute and Specialist Medicine, the main theme in complaints was Loss and Damage to personal property, followed by concerns about clinical care.

Maternity was one of the few areas that continued to provide care right throughout the pandemic so we should be mindful they had the same number of patient interactions from which to generate complaints, unlike areas that reduced their activity.

In some cases, telephone midwifery appointments instead of face to face caused a feeling of not being well looked after, especially for first timers. (This feedback was not confined to maternity and was also a theme in other areas that had moved to telephone consultations).

Many couples were unhappy at partners being excluded from coming into the hospital, and there were some complaints about the way requests for exceptions to be made. In some cases partners were from the birth, due to COVID-19 test results being pending.

We also stopped partners from spending much time on the postnatal wards, which led to some women saying they felt uncared for.

The Complaints & Service Improvement Manager and the Complaints Investigator allocated to the above areas will explore with the services the key challenges to support a reduction the number of complaints they are receiving.

All complaints are risk assessed upon receipt by the Complaints & Service Improvement Manager. They are assigned a risk grade which informs the timescale for completing the investigation as well as who approves and signs off the final response. Table 5 shows the number of complaints per division by risk grade. Although there were only two complaints investigated under the complaints procedure, the complaints team flagged a number of issues with the Clinical Governance Teams which were declared SIs (Serious Incidents) and went on to be investigated and responded to via the Duty of Candour process.

Table 5: Risk grade by division

Division	LOW	MEDIUM	HIGH
Medicine & Integrated Care	218	52	0
Surgery, Cancer & Cardiovascular	241	32	1
Women, Children & Clinical Support	144	6	0
Corporate (including) IPH	69	1	1
NWL Pathology	2	1	0
Total	**674**	**92**	**2**

The outcome of trust complaint investigations is that the complaint can be “not upheld”, “partly upheld” or “upheld”. For those cases that are partly upheld or upheld, actions and learning are extracted and recorded on the complaints action tracker for follow-up. Table 6 shows the outcomes of the 713 complaints investigations completed in 2020/21. This number is lower than the cases received because some of the cases received towards the end of the financial year were carried over into 2021/22.

A slightly higher proportion of complaints were upheld/partly upheld than not upheld during the year, which is a small change compared to previous years when the proportions have been more evenly split.

Table 6: Outcome by division

	Upheld	Partly upheld	Not upheld	Total

Medicine and Integrated Care	24	84	116	224
Surgery, Cancer and Cardiovascular	46	81	134	261
Women's, Children's and Clinical Support	32	49	56	137
NWL Pathology	1	0	1	2
Corporate (Inc. IPH)	36	27	26	89
Total	**139**	**241**	**333**	**713**
Percentage	**19%**	**34%**	**47%**	

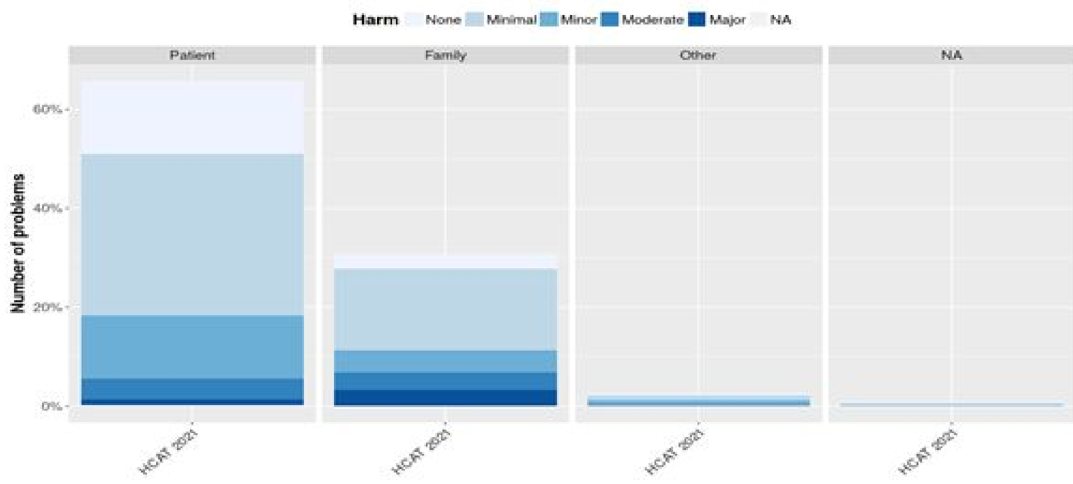
4.0 Healthcare Complaints Analysis Tool (HCAT)

From 1 April 2020, all new complaints are being logged using the Healthcare Complaints Analysis Tool (HCAT), which has been developed in conjunction with the Patient Safety Translational Research Centre at Imperial College. HCAT is a method for systematically analysing complaints, and grouping key insights. The tool allows staff to reliably determine the problems reported in complaints at three-levels of specificity; to grade their severity, the harm reported by our patients, and where in the hospital system problems occurred. We have now gathered a full year of data using HCAT. Next year we will be able to conduct year on year comparisons, but for now we are able to share the following analysis:

Who complained?

The table below tells us who has brought the complaints to us and shows that the majority are submitted by the patient themselves, with a large significant number being brought by family members. Interestingly, complaints made by family members are often graded as high-harm, which would appear to reflect that these incorporate complaints made on behalf of patients who have died.

Table 6: Cases by Complainant

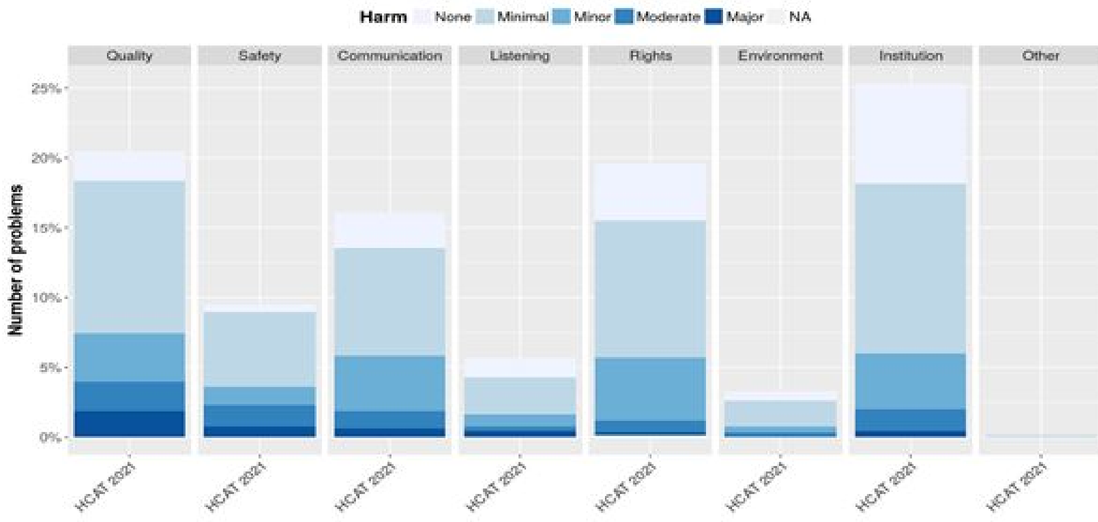


What problems did complainants report?

The following table illustrates problems reported in complaints by type and subsequent level of alleged harm. Please note that this alleged harm is based on what is reported by the complainant when the complaint is received and does not always reflect the findings of the investigation. Complaints reporting issues with the ‘quality of care’ and ‘safety’ have been a major theme, some of which were graded with moderate or major harm. These cases relate to complaints receive that raise concerns about shortcomings in clinical and nursing care. The category “Rights” reflect

concerns raised about Values and Behaviours are well as issues regarding fairness and equality of access to services. The "Institution" category relates to concerns about institutional processes, including bureaucracy, delays and waiting times, and records management.

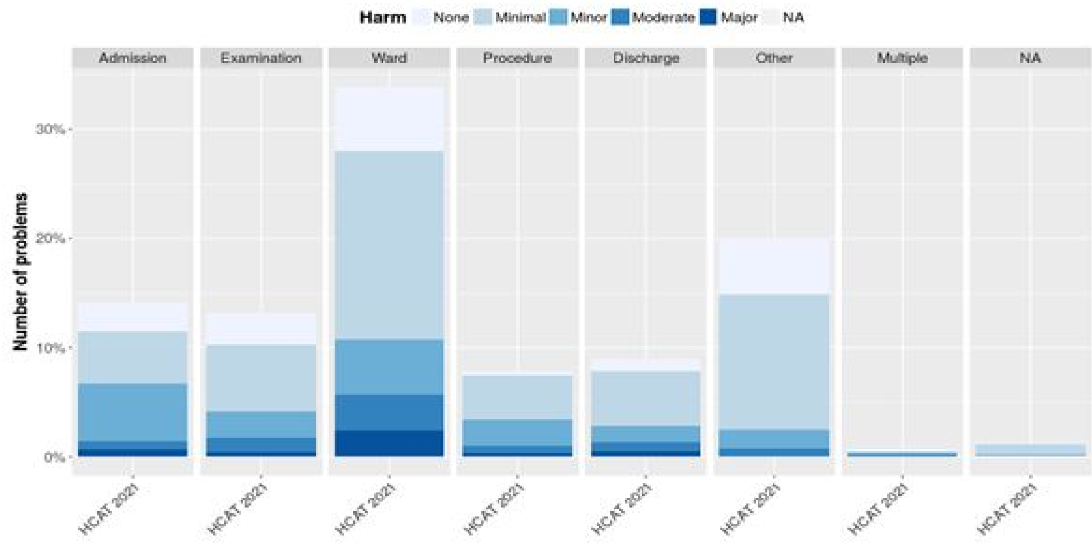
Table 7: Cases by type



<u>During which stages in the patient journey did problems occur?</u>

The next table illustrates problems reported in complaints by type and the stage at which they occurred. The majority of problems occurred during care on the ward, although the level of harm alleged was generally low. This is to be expected given that non-elective procedures were suspended for a significant portion of the year, and visiting on the wards was extremely restricted. Problems during care on the ward were often about a lack of communication from staff, disrespect, and feeling neglected. Problems during admissions appear to have increased, and are a reflection of issues relating to delays in outpatient appointments. During the next year, the Complaints & Service Improvement Manager will carry out more analysis into the 'other' category to see if more insights can be gained from this.

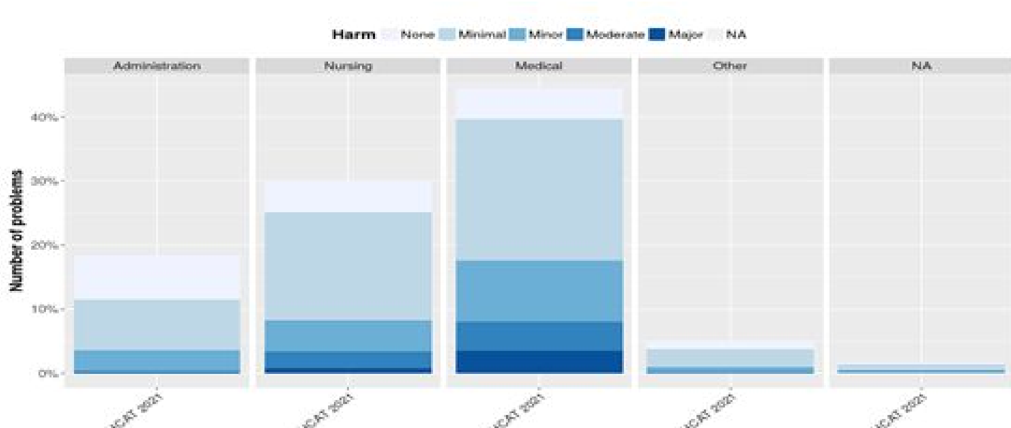
Table 8: Cases by the stage at which they occurred.



Which staff groups were involved?

The next table shows cases by the type of staff group involved and shows that the majority of complaints raised concerns involving medical staff, with nursing care also a significant proportion. Complaints raised about medical care often involved higher harm than those against nursing, and often described problems relating to a lack of communication, diagnostic errors, making and following care plans, and poor outcomes or side effects from procedures (the latter being particularly high-harm). to the relative high-harm of issues concerning medical staff is expected given the nature of the work clinicians do and the fact that complaints relating to end of life care often focus on clinical decision making. Problems regarding nursing staff were mostly about disrespectful treatment and feelings of neglect. Another proportion of the cases relate to administration, primarily around appointments and we would hope to see a reduction in these over the next year as outpatient improvement work takes effect.

Table 9: Cases by the staff group involved



5.0 Parliamentary & Health Service Ombudsman (PHSO) Cases

Table 10 provides a breakdown of all the PHSO decisions last year. The PHSO shared the outcome of two cases, one for Emergency Medicine and one for Maternity Service. Neither were upheld.

Table 10: Decisions the PHSO made last year by division

Division	Upheld	Partly Upheld	Not Upheld
Medicine & Integrated Care	0	0	1
Surgery, Cancer & Cardiovascular	0	0	0
Women's, Children's & Clinical Support	0	0	1
TOTAL	**0**	**0**	**2**

In cases where there has been a financial loss, we are required to put a complainant back to the same financial position they would have been in had the problem not occurred.

The Trust made monetary payments totaling £5039 last year to help remedy complaints where a service failure occurred. £1188 came from the complaints team budget and the remainder £3851 came from the relevant services' budgets.

The complaints team arranged some payments for valuables that were lost while patients were in the hospital, and the hospital was found to be at fault. Property loss was a theme for PALS and Complaints over the year partly, particularly as staff and patients were displaced and services were disrupted as a result of COVID-19. However, a large proportion of the losses were avoidable and sometimes caused additional distress to bereaved families. PALS is working to support improvements in the management of patient property and this is explained later in the report.

6.0 Learning and Service Improvements following a formal complaint investigation

The Complaints & Service Improvement Manager works with the wider complaints team to ensure that learning and actions are recorded when complaints are closed. The list is reviewed on a monthly basis and any outstanding actions are reviewed and flagged with the Divisional Governance Lead on a quarterly basis, at their Divisional Quality and Safety Committee meeting, until they are completed. There was a pause to this process during the last year while services were dealing with the immediate pressures of the pandemic and staff were redeployed. However, the complaints team continued to gather information on actions agreed as a result of complaints investigations and the Complaints & Service Improvement Manager will restart the systematic checking of compliance with these during 2021/22.

On a quarterly basis, the Complaints & Service Improvement Manager produces the Complaint & PALS Service Improvement report. This provides a regular update on numbers, themes and learning from formal complaints and PALS feedback. Learning and actions are also presented in a "You Said, We Did" section as well as a list of actions already undertaken. This is presented at the Divisional Quality & Safety Committee meetings so that staff are able to see how we have learned and improved because of a complaint investigation. It is also shared with Healthwatch and the Trust Executive and made available to the public via the Trust's website.

As well as immediate improvements, the Complaints & Service Improvement Manager uses complaints data to identify and make significant service improvements. Below are some examples where changes and improvements have been made as a direct result of complaints:

- After feedback from a family, the Critical Care team now discuss all patients receiving end of life care at safety briefings to ensure families are well informed. A system was put in place to ensure consistent and informative updates are given via phone and video calls by both the medical and nursing teams were set up for families unable to visit.
- We identified that a nursing team had failed to inform a patient's spouse of the 'Carer's Passport' which would have allowed them to visit every day and avoided the patient reporting feeling 'abandoned' during the first five days of their stay. We shared information surrounding the carer's passport and supporting family members with the managers of the wards the patient visited during their admission. We apologised to the patient's spouse for the distress caused.
- A patient observed non clinical staff as well as visitors and patients not following social distancing or wearing masks correctly. During a departmental staff meeting all staff were reminded about the policy on wearing PPE in the correct manner at all times, on and off duty, when inside the hospital. Staff were reminded of their responsibility to challenge anybody they saw not adhering to the rules on wearing masks. The specific staff members that we were able to identify were spoken to individually.
- Following a complaint about a staff member refusing to give their name, we reminded staff that they are required to wear their ID badges at all times and that they give their names and show ID on request.

- We upheld a complaint that a patient's fall was not communicated to a relative in a more timely fashion, in line with our policy on 'being open'. The Matron discussed this at length with the nurses concerned and made it explicitly clear that contact should have been made with the patient's closes relative. They will work with these nurses to ensure they have the confidence to undertake difficult conversations in the future, or ensure the correct escalation is sought to prevent this from happening again.
- Following a complaint about noise on a post-natal ward, we have reminded the night staff to be aware of the needs of mothers who are trying to get their much-needed rest.

7.0 The year ahead for the Central Complaints Team

As with every part of the Trust, the work of the complaints team has been significantly affected by the COVID-19 pandemic. Although there was a decline in overall numbers of cases during 2020/21, these increased towards the end of the period and this continued in 2021/22. During the focus on managing patients with COVID-19, there has been an increase in the backlog of patients waiting for elective procedures, and we anticipate that the number of complaints about delays and cancellations will increase and this will be an emerging theme.

Additionally, *Appointments* will continue to be of concern to our patients in the year ahead. This has already presented challenges, in terms of how we communicate with patients about the arrangements for their appointment, ensuring they are supported to participate in remote consultations, continuing to see people face to face when appropriate and making sure that patients are called at the agreed times. The Complaints & Service Improvement Manager will be working closely with the Outpatient team on their transformation work to ensure that feedback received via complaints leads to long term improvements to the service.

We also anticipate that *Communication* will remain a key theme in complaints, particularly whilst visiting on wards is restricted. It is a vital part of clinicians' and nurses' duties to provide regular updates to patients' loved-ones. These updates have been particularly important whilst visiting on the wards has been restricted, but they have also sometimes been challenging for staff to achieve due to the unprecedented pressure caused by COVID-19-19. We will continue to support efforts around the Trust to improve communication between patients and their loved-ones during the ongoing pandemic.

Members of the complaints team will continue to run the complaints service whilst supporting colleagues in the wider teams, such as PALS and Patient Affairs when they are under particular pressure as a result of COVID-19.

We will maintain the current high standard of our complaints handling, both in terms of timeliness, and most importantly, on providing high quality responses that reflect the Trust's values whilst being mindful of the pressures that our staff currently face. We will continue to work hard to 'get it right' the first time, leading to fewer complaints being reopened, and ensuring that those that are escalated by patients to the PHSO are not upheld. We have carried over the previous year's target of one upheld/partly upheld cases for the year ahead.

Last year we set a target of reopening just 2% of cases in 2020/21 which unfortunately, we did not achieve; we reopened 4% of cases. In 2020/21 we will set a target of 2% and the Complaints & Service Manager will support the Complaints Investigators to reduce their reopened case rates. We will continue to respond to all complaints received in less than 40 working days.

We will ensure that all complaints that are closed as ‘partly upheld’ or ‘upheld’ contain learning and, when appropriate, clear actions to ensure that services are improved. We keep a log of actions from complaints and once we return to ‘business as usual’ we will follow them up systematically with the Divisions to ensure they provide confirmation and evidence that agreed actions have happened.

During 2018/2019 we introduced a new key performance measure of “overall satisfaction” with the handling of patients’ complaints, for which we have set ourselves a target of 70%. This is measured via an online feedback questionnaire that we are sending to complainants six weeks after conclusion of their complaint. During 2020/21 the score for overall satisfaction in the handling of complaints was 72%. Feedback gained via the questionnaire is given by the Complaints and Service Improvement Manager during regular 1:1 meetings with the Patient Complaints Investigators and this has led to improvements in complaints handling, for example by ensuring that investigators introduce themselves personally to complainants at the outset so that they know who is handling their case. Additionally, we have improved our signposting to the Ombudsman in our response letters.

Finally, the Complaints & Service Improvement Manager will continue to offer expert advice to colleagues across the Trust and will be resuming scheduled training sessions, such as supporting the nursing Preceptorship programme.

8.0 PALS cases

The PALS team resolved 3401 informal concerns and enquiries during 2020/21. Table 11 displays a breakdown of the cases received by Division.

Table 11: PALS cases by Division

Division	2020/21	% of total	2019/20	% of total
Medicine & Integrated Care	1161	34%	996	29%
Surgery, Cancer & Cardiovascular	1451	43%	1510	45%
Women’s, Children’s & Clinical Support	590	17%	493	15%
NWL Pathology	11	<1%	6	<1%
Corporate (including Transport)	188	6%	370	11%
Total	**3401**	**100%**	**3375**	**100%**

This year has seen a PALS deal with a very similar number of informal complaints as in the previous year. PALS continue to offer a pro-active service, supported by PALS Volunteers, which aims to resolve issues before they have the chance to escalate unnecessarily. Looking at the breakdown by Division, it is evident that PALS are dealing with a greater proportion of cases relating to Medicine & Integrated care then in the previous year, in particular with the Stoke & Neuro and Acute & Specialist Medicine Directorates.

The proportion of PALS cases about transport have significantly increased over the past year. This is for the same reasons mentioned in section 3.0

Table 12 shows the breakdown of PALS cases by specialty (for those specialties receiving more than 150 concerns in the year).

Table 12: PALS cases by specialty

Speciality	Number of cases	% of all PALS
Orthopaedics	198	6%
Ophthalmology	197	6%
Neurology	189	6%
Urology	183	5%
Ear, Nose & Throat	166	5%
Neurosurgery	164	5%
Gynaecology	151	4%

Table 13 shows a breakdown of PALS cases by category (top 5 categories only)

Table 13: PALS cases by category

Subject	2021/21	% of total	2019/20	% of total
Appointments	1208	36%	944	28%
Communications	584	17%	392	12%
Clinical Treatment	247	7%	119	4%
Transport	170	5%	298	9%
Trust admin/policies/procedures including patient record management	167	5%	93	3%
TOTAL	**2367**	**70%**	**1932**	**56%**

The above table reflects the pressures the Trust is under in terms of demand for appointments and the impact of COVID-19 in terms of delays and short notice cancellations. Additionally, Transport complaints have increased significantly as mentioned previously. The increase in concerns being raised about communication and clinical treatment is likely to be a reflection of the difficulties caused by the restrictions on visiting in place for most of the year, as well as the pressure that colleagues have been under which has sometimes made it harder to provide regular family updates. This has made it harder for loved-ones to get a sense of what patients' treatment plans are and how they are progressing.

PALS continue to support the complaints team in ensuring that issues such as appointment concerns, that lend themselves to swift resolution, are dealt with quickly without needing to be escalated.

Table 10: Compliments

Table 10 shows a breakdown of compliments received by Specialty during the year for those areas that recorded 10 or more compliments:

Specialty	Number received
Emergency Medicine	63
Maternity	39
Ophthalmology	30
Ambulatory Emergency Medicine	21
Patient Advice and Liaison Service	17
Gynaecology	16
Cardiology	11

Orthopaedics	11
Acute Medicine	10

9.0 The year ahead for PALS

It has been over a year since the PALS new telephone call service was introduced. This service has negated the need for an answer machine system, so people using the system are able to talk to a PALS officer when they call. The system enables the PALS service manager to monitor the time taken to answer calls and any calls that are 'abandoned' by the caller due to long response times. To date over 96.6% of calls have been answered within one and a half minutes.

In April 2021, the call system will be upgraded. This involves a major change across all services that use the system including outpatients and major incident calls. Once this has been completed and the new system embedded, the second phase of the PALS new communication project will commence. This will involve the introduction of the web chat function. It is anticipated that the time frame for this will be 3-6 months post implementation of the upgraded call system.

The web chat functionality will enable patients to access instant feedback to minor questions. It will be used to supplement the email and telephone functions.

The new system has been well received by patients and their families. It has enabled the PALS function to continue throughout the COVID-19-19 pandemic. The team have been able to work in different ways, visiting patients on wards if needed as well as attend clinic consultations and Local Resolution Meetings. Over the next few months we will continue to build the new service with a continued focus on telephone, email, web chat and ward visits. Our activity and feedback has demonstrated that patients and families are happy with the service model we are currently providing.

PALS continue to work with the Patient Experience Team to deliver personal messages and photographs to patients on the wards. PALS also facilitate a 'Drop Off' service in which families and friends can drop off parcels to the PALS offices on each site for the Officers to deliver to wards. This will continue until visiting restrictions are lifted.

The continuing work on patient property was suspended during Q4 due to the impact of COVID-19-19. This work will recommence next year in partnership with Chelsea and Westminster Hospital NHS Foundation Trust.

Finally, over the next year, PALS officers will attend the Big Rooms to provide a valuable patient/ family/carer perspective.

10.0 Conclusion

The COVID-19 pandemic continues to create a great deal of uncertainty for the complaints and PALS team and this is likely to continue into the next year. However, it has also provided opportunities to develop new ways of working, such as home/office hybrid working (for complaints) and a move to email/telephone support for PALS. We expect a steady increase in PALS and Complaints activity during the year as delayed demand for elective procedures continues to put pressure on services. Additionally, the return of visitors to our hospitals is likely to lead to an increase in the reporting of PALS and complaints concerns. Any winter wave of COVID-19 2021/22 is also likely to present similar challenges to the previous year.

The complaints team will focus in 2021/22 on maintaining the high quality of its responses and reducing the “re-open” rate further. We are aiming to ensure that few cases are upheld upon review by the PHSO.

Although this has been more challenging during the pandemic, complaints and PALS feedback will be fed back the Divisions to ensure that it continues to drive learning and improvement, particular as we aim to start to return to ‘business as usual’.

The complaints team will continue to explore how it can do more to follow up with patients to provide assurance that agreed actions have taken place.

PALS will continue to provide support to clinical teams and patients, as well as working on longer term service improvements, such as those related to patient property.

Protected characteristics

The following provides a breakdown of PALS/Complaints cases over the last year by certain protected characteristics. NB The information below relates to the patients, not the people who raised the complaint.

Sex

Female – 533

Male – 331

Ethnicity

White - British	33
White - Irish	2
White - other white	17
Mixed white and Asian	1
Other mixed	4
Indian	4
Pakistani	1
Bangladeshi	1
Other Asian	6
Black Carribean	2
Black African	2
Other Black	5
Other ethnic category / Not stated	47
Totals:	124

Age band

Age 0 to 5	16
Age 18 to 25	64
Age 26 to 55	399

Age 56 to 64	104
Age 65 to 74	123
Age 6 to 17	11
Totals:	717

The Complaints and PALS Managers recognise that there is currently underreporting of information related to protected characteristics, and the increased collection of this data will be an area of focus in the year ahead.

TRUST BOARD (PUBLIC)

Paper title: Integrated risk and assurance report

Agenda item 17, paper number 14

Lead Executive Director: Peter Jenkinson, Director of Corporate Governance
Author: Valentina Cappo, Corporate Risk Manager

Purpose: For discussion

Meeting date: 14 July 2021

Executive summary

1. Purpose of this report

1.1. This report presents an update on risk management and assurance activities at the Trust over the past six months.

1.2. In particular, the report focuses on:
- The Trust risk appetite, which was updated in June 2021 and is attached as Appendix 1.
- Board Assurance Framework (BAF), with focus on the risk and assurance deep dives
- Key changes to the corporate risk register over the past six months; the corporate risk profile is attached as Appendix 2.
- Risk themes to focus on in 2021/22.

2. Background

2.1 The Trust Board receives an integrated risk and assurance report twice a year, in January and July, which includes a summary of changes to the corporate risk register over the previous six months, and updates with regard to the risk management process and assurance mechanisms that are in place at the Trust.

2.2 Due to the pandemic, the Trust implemented governance 'lite' arrangements between January and April 2021 and the January Board meeting was cancelled. However, risk management activities were maintained and the Non-Executive directors received an ad hoc assurance report in January to maintain oversight of risk management activities.

2.3 Through the various sub-committees, the Board has continued receiving regular risk management updates, including changes to the corporate risk register that are presented to the Audit, Risk and Governance Committee at each meeting.

2.4 The Board Assurance Framework (BAF) was initially reviewed in September 2020, with the introduction of risk and assurance deep dives. Following a pause due to the winter wave of COVID-19, the BAF was further reviewed and risk and assurance deep-dives were reintroduced.

2.1 In response to the amount of change that occurred as a consequence of the pandemic and the White paper published by the government in February 2021, on 24 May 2021 the executive team held a risk 'reset' workshop to review the Trust approach to risk appetite, including how risk appetite should be used to support the management of risks on the risk registers. The executives

also considered the Trust risk profile in the context of the strategic priorities for 2021/22 and the changing external environment.

2.2 The non-executive directors had a separate session on 9 June 2021, focusing on identifying areas of risk and concern for in depth assurance focus throughout the remainder of 2021/22.

2.3 The output of these sessions informed a wider Board conversation regarding the delivery of the Trust's priorities in the context of a changing external environment at the Board Seminar on 30 June 2021, and was the focus of discussion at the Audit, Risk and Governance Committee meeting on 7 July.

2.5 The corporate risk register was reviewed at the Executive Management Board every month.

3. Key findings

3.1 In the context of the transformation of services through and beyond the pandemic, and the changing risk universe for the Trust including changes in the external environment, the Trust Executive Management Board and the Non-executive directors took time to reflect on new priorities and how to best assure themselves that the key risks to the Trust are being effectively managed.

3.2 The risk appetite has been reviewed and now forms a more comprehensive document that aligns with the Trust strategic priorities for 2021/22 and provides managers with practical guidance on when risks should be considered and which level of risk is acceptable for each risk area.

3.3 The Corporate Risk Register has seen a number risks being de-escalated and a new risk escalated. More changes were made which can be seen in the corporate risk profile.

3.4 The Board Assurance Framework has developed into a more comprehensive approach that has moved away from it being a single document and now entails the following processes:

- Corporate risk register
- Risk & Assurance deep dives
- Board committees and annual reporting
- Governance frameworks for key risk areas.

3.5 Risk and assurance 'deep dives' were introduced in September 2020 and later suspended during governance 'lite'. Details of deep-dives undertaken since May 2021 are included in the paper.

3.6 The main risk areas for focus in 2021/22 are also included in this paper.

4. Next steps

4.1. The risk appetite will be further reviewed by the Chairs of the Board committees for their related statements and the KPIs will be aligned to the committee level scorecards to be introduced via the IMIS programme. The final version will be cascaded to the Trust divisions and directorates

4.2. The corporate risk register will continue being monitored by the Executive Management Board monthly and by the Audit, Risk and Governance Committee at each meeting.

4.3. Risk and assurance deep-dives will occur at all Board Committees as agreed by the Committees' chairs and will be overseen by the Audit, Risk and Governance Committee.

4.4. Risk themes for focus in 2021/22 will be further reviewed and any current gaps on the risk registers addressed as appropriate.

5. Recommendation

5.1. Note the Contents of this report.

6. Impact assessment

6.1 Quality - The report applies to all CQC domains: Safe, Caring, Responsive, Effective and Well-Led.

6.2 Financial - The financial impact of the risks presented is captured within the detail of each applicable risk within the corporate risk register.

6.3 Workforce impact - The financial impact of the risks presented is captured within the detail of each applicable risk within the corporate risk register.

6.4 Equality impact - The equality impact of the risks presented is captured within the detail of each applicable risk within the corporate risk register.
6.5 Risk impact - The impact of the risks presented is captured within each risk on the corporate risk register.

Main report

7. Risk appetite

7.1 After an initial update in November 2020, a revised version of the Trust risk appetite was reviewed at an Executive risk management ‘reset’ (transformation) session on 24 May 2021 and it was later approved at the Executive Management Board on 29 June 2021.
7.2 The Audit, Risk and Governance Committee also oversaw the development of the new risk appetite and provided useful comments at every stage.
7.3 A new approach to defining the risk appetite has been introduced this year, with the aim of making it a more practical guidance for managers. To this end, the risk appetite document now aligns the following information:

- Strategic priorities
- Areas of risk
- Risk appetite statements
- Key performance indicators (KPI*s*)/ Acceptable risk exposure
- Risk appetite levels
- Target risk scores
- Risk responses.

7.4 The purpose of introducing KPI*s* is to provide a threshold for managers to understand when action is needed. Agreed targets reflect an exposure to risk that is acceptable to the Trust; however, failing to meet those targets could be a signal that existing processes are no longer sufficient to prevent risk and further action is needed.
7.5 Target risk scores reflect the level of risk that can be tolerated, in line with the agreed risk appetite; if a risk is higher, a mitigation plan should be implemented to bring the risk back to the agreed score.
7.6 Most KPI*s* that have been included in the document are the same that are already monitored via Trust scorecards; other KPI*s* have been developed with key Trust stakeholders.
7.7 The risk appetite will be further reviewed by the Chairs of the Board committees for their related statements and the KPIs will be aligned to the committee level scorecards to be introduced via the IMIS programme.
7.8 The full risk appetite is attached as Appendix 1.

8. Changes to the Corporate Risk Register

8.1 Since the last risk and assurance update was provided in January 2021, several changes were made to the Corporate Risk Register, which were approved by the Executive Management Board and reported to the Audit, Risk and Governance Committee in March, April and July 2021. In particular:
8.2 Three risks were de-escalated from the corporate risk register:

- Risk 3392 - Risk of inability to effectively manage both a second wave of Covid-19 admissions and Winter pressure.
- Risk 2487 - Risk of spread of CPE (Carbapenemase-Producing Enterobacteriaceae)
- Risk 3388 - Unsustainable cash position due to both operational and capital commitments.

- Risk 2480 - There is a risk to patient safety and reputation caused by the inconsistent provision of cleaning services across the Trust.

8.3 One risk was escalated onto the corporate risk register:

- Risk 3428 Failure to effectively manage supplier contracts leads to financial loss or operational issue.

8.4 A number of risks have changed their scores. Details of this changes can be seen in the corporate risk profile that is attached as Appendix 2.

9. Board Assurance Framework

9.1 The Board will recall that in July 2020 it was informed of how the Board Assurance Framework (BAF) had developed in response to the outcome of Board effectiveness survey, which had highlighted the need for more focus on risk and assurance.

9.2 In September 2020, the Trust introduced risk and assurance 'deep dives' by Board committees, to serve as the Trust's BAF.

9.3 Over time, the assurance framework has further developed to an even more comprehensive approach for ensuring that boards get the right information, which is accurate and relevant, at the right time and with a level of assurance attributed to each source of data. In June 2021 the Executive Management Board approved a final version of the BAF, which was also circulated to the Audit, Risk and Governance Committee earlier this month.

9.4 The BAF now includes a number of component parts, each of which provides assurance that the principal risks to the Trust's achievement of its strategic objectives are managed appropriately.

9.5 To this end, the assurance framework includes processes for:

- Corporate risk register; this is the repository for the principal risks facing the Trust. Escalation of risks and regular review of the corporate risk register ensure that the main risks to the Trust are managed in the context of the agreed risk appetite.
- Risk & Assurance deep dives; the purpose of these 'deep dives' is to enable committees to consider identified or emerging risks in more details, and the assurances available that demonstrates that risks are being managed effectively.
- Board committees and annual reporting; a key part of the BAF is the oversight role played by committees and the internal / external reporting mechanisms. Each committee produces an annual report, including a summary of the business conducted during the year, and the outcome of the committee effectiveness review, as well as a gap analysis to ensure that they are fulfilling their duties as per their terms of reference, and providing appropriate assurance
- Governance frameworks for key risk areas; the purpose of these frameworks is to provide the Board with assurance that there are robust governance mechanisms in place to manage risk in these areas, in line with the risk appetite agreed by the Board, and to provide the Board with appropriate levels of assurance.

9.6 In line with the Trust culture of continuous improvement, the BAF will continue to be developed as assurance mechanisms are evaluated and improved.

10. Risk and assurance 'deep dives'

10.1 Seven deep dives were completed between September and November 2020; however, the process was suspended during the winter COVID-19 surge, when the Trust implemented governance 'lite' arrangements.

10.2 When governance arrangements went back to normal, in May 2021, a new Board committee was also established to focus on workforce matters; this is the People Committee.

10.3 While each committee reviews risks that fall within their remit, the Audit, Risk and Governance Committee oversees the outcome of all risk and assurance 'deep dives', as well as focusing on certain areas of risk that do not naturally fall within the remit of any other committee.

10.4 Table 1 reflects the risk and assurance 'deep dives' that have occurred since May 2021.

Committee	Deep dive focus
Audit, Risk and Governance Committee	• Tech Assurance Governance Framework • Redevelopment Governance Framework
Finance, Investment and Operations Committee	• Business planning, including in-year and long term risks and assurances • Debt management
People Committee	• Risk of staff developing COVID-19 infection as a result of exposure at work and the subsequent impact on their health • Risk of staff experiencing poor mental / psychological health as a result of the Covid-19 pandemic
Quality Committee	• Estates & Facilities risk management • Complaints and PALS management

11. Risk themes to focus on in 2021/22

11.1 On 30 June 2021, the Board seminar discussed the delivery of the Trust's priorities in the context of the changing external environment.

11.2 The conversation touched on the areas of risk management and assurance focus for the Board and its Committees for the remainder of 2021/22, as previously identified at a risk management session attended by the non-executive directors (NEDs) on 9 June 2021.

11.3 The main themes identified by the NEDs include:

- Recovery
- Finance
- Quality assurance
- Estates and Redevelopment
- Technology and digital
- Integrated Care System (ICS) governance
- Capacity of change
- Workforce
- Service reconfiguration and public engagement.

11.4 Some of these themes are already captured and monitored through the corporate risk register, and some further work will be undertaken to ensure all areas of focus are adequately covered.

11.5 The executive team will be working with the Audit, Risk and Governance Committee to establish appropriate risk management and assurance mechanisms around each of these areas of risk where not already established.

12. Conclusion

12.1 The Trust has undertaken important work to ensure its risk management processes continue to evolve and being robust, in the context of the pandemic and the changing external environment.

12.2 The BAF has developed into a comprehensive process of assurance and will continue to be developed as assurance mechanisms are evaluated and improved.

12.3 The executive team will be working with the Audit, Risk and Governance Committee to establish appropriate risk management and assurance mechanisms around areas of risk to focus on in 2021/22.

Appendices:
1. Risk Appetite
2. Corporate Risk Profile.

Valentina Cappo, Corporate Risk Manager
5 July 2021

Appendix 1

Proposed Trust Risk Appetite

Introduction

Describing the Trust risk appetite helps our staff and stakeholders understand the level of risk that we are prepared to accept in any given area and reduces the likelihood of erratic or inopportune risk taking, which could expose the organisation to a risk that it cannot tolerate, or prevent it from exploiting opportunities it should take. It also helps with prioritising resource allocation when there are competing priorities.

1. How to read the risk appetite

In the context of working towards the achievement of the Trust strategic priorities, the risk appetite should help leaders understand the amount of risk that the Board has agreed can be carried in any given area. To achieve this, the format of the risk appetite has been changed from previous versions, where only the statement was included. The new document consists of:

- Strategic priority
- Area of risk
- Risk appetite statement
- KPI/ Acceptable risk exposure
- Risk appetite level
- Target risk score
- Risk response.

1.1 Strategic priority

Risk management is the process to methodically address the risks attaching to Trust activities. Good risk management "increases the probability of success, and reduces both the probability of failure and the uncertainty of achieving the organisation's overall objectives"[1]. To this end, when setting the risk appetite it is important that we put it in the context of the Trust organisational objectives. Since the risk appetite should be reviewed every year, the strategic priorities for 2021/22 are being used in this document.

1.2 Area of risk

This descriptor indicates the main risk areas at the Trust, including threat/ hazard and opportunistic risk.

1.3 Risk appetite statement

This part of the document indicates the overarching statement to advise the level of risk that the Trust is prepared to carry in a given area.

1.4 KPI/ Acceptable risk exposure

[1] The Institute of Risk Management, 2002

This is the true measure for managers to understand when action is needed. Key performance indicators' (KPI) targets reflect an exposure to risk that is acceptable to the Trust; however, failing to meet those targets could be a signal that existing process are no longer sufficient to prevent risk and further action is needed. Most KPIs are the same that are already monitored via Trust scorecards; other KPIs have been developed with key Trust stakeholders and should be considered and approved by the Executive team. KPIs will be used to both identify when action is needed and/ or a risk should be captured, and also to monitor whether the risk is being managed effectively.

1.5 Risk appetite level

The Trust uses three main levels to describe its risk appetite: low, medium and high.
These levels correspond to the definitions used in the matrix for Risk Appetite for NHS Organisations that was developed by the Good Governance Institute, in a simplified version that was approved by the Trust board in March 2018.
Details of each level of risk appetite are described in the table below.

Risk appetite level*		Description
Avoid/ Minimal	**Low**	Strives to avoid risk and uncertainty. Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
ALARP (As little as reasonably possible)		Works to minimize unavoidable risk.
Cautious	**Medium**	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
Open		Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
Seek/ Mature	**High**	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). Confident in accepting or setting high levels of risk because controls, forward scanning and responsiveness systems are robust.

**Adapted from Risk Appetite for NHS Organisations, the Good Governance Institute*

1.6 Target risk score

After a risk is captured and being managed, this is the target score that risk owners should aim for in the context of the risk appetite for the relevant area of risk. Bringing Targets are presented as ranges and where each risk's target falls should be agreed based on the relevant risk's details.

1.7 Risk response

If a risk falls outside the agreed appetite levels, this part of the report advises what type of action should be implemented to mitigate the risk.

The four T*s* of risk management response have been associated to more specific actions, as described by ISO 31000:2018 Risk management Guidelines.
Risk treatment options are not necessarily mutually exclusive or appropriate in all circumstances; one or more of these options can be involved when responding to a risk:

Risk response	**ISO 31000:2018**
Threat/ Hazard risk	
Treat	Removing the risk source
	Changing the likelihood
	Changing the consequences
Tolerate	Retaining the risk by informed decision
Transfer	Sharing the risk (e.g. through contracts, buying insurance)
Terminate	Avoiding the risk by deciding not to start or continue with the activity that gives rise to the risk
Opportunistic risk	
Take the opportunity	

2. Proposed Risk Appetite

The Trust risk appetite statement is described below:

The Trust recognises that its long term sustainability depends upon its ability to deliver its strategic objectives while recovering from the COVID-19 outbreak. It will continue focusing on providing the safest possible level of care to its patients and ensure its staff wellbeing, while implementing complex work programmes aimed to minimise threats and exploit opportunities.

The statements below are a reflection of the Trust's current position in relation to its primary risks.

Strategic priority	Area of risk (Threat and opportunistic risks)	Risk appetite statement	KPI/ Acceptable risk exposure	Risk appetite	Target risk score	Risk response
Ensure all our patients who are waiting for specialist care get the advice, guidance and/or treatments/operations they need as quickly as possible	**Patient Safety**	The Trust will not take any unnecessary risk that has a direct impact on patient safety. Where patients have been exposed to a higher clinical risk in response to the pandemic, every effort will be made to ensure the safest clinical response has been implemented and no unnecessary harm has occurred.	The Trust will want 0 never events per year.	**Low (Avoid/ Minimal)**	**4-6**	**Treat** – Changing the likelihood.
			The Trust will want <2.13% of incidents causing moderate or above harm. In particular: <1.83% causing moderate harm <0.22% causing serious harm <0.08% causing extreme harm			**Treat** – Changing the likelihood.
	Operational Performance	The Trust will tolerate a higher than usual risk in the delivery of its operational performance targets, while priority is given to maintaining	**Driver** is **red** for 2+ reporting periods (against target, or improvement trajectory) for any of the following metrics:	**Medium (Cautious)**	**8-12**	**Treat** – Changing the likelihood.

Strategic priority	Area of risk (Threat and opportunistic risks)	Risk appetite statement	KPI/ Acceptable risk exposure	Risk appetite	Target risk score	Risk response
		patients safety and outcomes at all times and prioritising patients with more time sensitive conditions.	• RTT 52 week wait breaches (2,398) • % of inpatient waiting list (RTT) with clinical prioritisation (≥ 85%) • Compliance to DM01 Diagnostics waiting times (≤ 1%) • Compliance to Cancer 2 week wait (≥ 93%) • Compliance to Cancer 62 day wait (≥ 85%) • Average time in ED for admitted patients (≥ 200)			**Treat** - Changing the consequence
	Data Quality	Recognising the challenging environment, the Trust will be cautious when responding to any risk that could compromise data quality, which also carries performance and reputational risks. The Trust will commit to continual improvement in data quality.	• No more than 3 indicators can worsen for 3 consistent months • Data quality error rate must not go above 10% for any high risk (PT risk) audit	**Low (ALARP)**	**6-9**	**Treat** – Changing the likelihood.
	Innovation	The Trust is open to the risk arising from the implementation of new ways of working and technologies; however, it will continue minimising exposure to cyber risk.		**Medium (Open)**	**8-12**	**Taking** - or increasing the risk in order to pursue an opportunity

Strategic priority	Area of risk (Threat and opportunistic risks)	Risk appetite statement	KPI/ Acceptable risk exposure	Risk appetite	Target risk score	Risk response
	Research	The Trust has a significant appetite to exploit opportunistic risks where positive gains can be anticipated, particularly in relation to promoting and delivering excellent research and education.		**High (Mature)**	**8-12**	**Taking** - or increasing the risk in order to pursue an opportunity
Maintain a sustainable workforce – through a deep focus on improving the health & wellbeing of staff, as well as making improvements to recruitment, equality, diversity & inclusion, career pathways & support, retention etc.	**Workforce safety and wellbeing**	The Trust will minimise any risk posed to patients or staff as a result of staff competence, conduct, health and behaviour. The Trust will work to minimise the risk to staff physical and mental wellbeing.	Maintain staff sickness below 3%	**Low (Avoid/ Minimal)**	**6-9**	**Treat** – Changing the likelihood.
			Occupational Health referrals for stress below (TBC)			**Treat** – Changing the likelihood.
			Mandatory training compliance cannot go below 90%			**Treat** - Changing the consequence
	Sustainable workforce	Recognising the challenging recruitment environment, the Trust will be open to taking opportunistic risk in improving staff recruitment and retention, and to ensure the appropriate skill mix is available in all clinical areas. In doing this, the Trust will put focus into increasing inclusion and reducing inequality.	Staff vacancy rate cannot go above 10%	**Medium (Open)**	**6-9**	**Treat** – Changing the likelihood.
			Staff turnover cannot go above 12%			**Treat** – Changing the likelihood.
			Time to hire			**Treat** – Changing the likelihood.

Strategic priority	Area of risk (Threat and opportunistic risks)	Risk appetite statement	KPI/ Acceptable risk exposure	Risk appetite	Target risk score	Risk response
			• Manager leaver process completed within first week for 90% of resignations • Advert to replacement start date average of 35 days (TBC)			**Treat** - Changing the consequence
Advance our plans to redevelop our estates across each of our sites	**Estates**	It is recognised that the condition of Trust estates, and the volume and complexity of backlog maintenance, expose the Trust to a significant risk in this category. The extent of the capital budget only allows to address the highest and most pressing estate risks and for this reason the Trust will accept some other minor risks, while focus is put on the redevelopment programme.	>70% of reactive maintenance jobs for category 1 and 2 must be completed within timeframes: • Category 1 – attend within 1 hour • Category 2 – attend within 2-4 hours. Urgent jobs related to Infrastructure or where clinical disruption is likely are responded to as appropriate.	**Low (ALARP)**	**12-15**	**Treat** – Change the likelihood **Treat** - Changing the consequence
	Redevelopment	The Trust will tolerate a higher reputational risk associated with ensuring the implementation of its redevelopment programme. This will ensure sustainable mitigation to the estates risk.		**High (Mature)**	TBC	**Taking** - or increasing the risk in order to pursue an opportunity
Play our part in collaboratively developing our	**New patient pathways**	A higher level of risk will be accepted while developing intra and inter-provider pathways which do		**Medium (Open)**	TBC	**Taking** the risk in order to pursue an opportunity

Strategic priority	Area of risk (Threat and opportunistic risks)	Risk appetite statement	KPI/ Acceptable risk exposure	Risk appetite	Target risk score	Risk response
integrated care system		not impact on any individual patient negatively.				
Continue to place quality as the defining outcome of our work (Quality meaning: safe, effective, caring, responsive, well-led, good use of resources, equitable)	**Regulatory compliance and compliance with other standards set by regulators**	The Trust will minimise the risk of non-compliance to CQC and other regulations. The Trust will continue developing robust control processes and assurance to oversee the delivery of regulatory requirements and maintain non-statutory accreditations.	The Trust will want 0 civil or criminal enforcement action in any form and whatever it's called, whether or not it related to an inspection	**Low (Avoid/ Minimal)**	**4-8**	**Treat** – Changing the likelihood.
			The Trust would find it unacceptable to have any core service rated as inadequate by the CQC, whether it is a single domain or overall			**Treat** – Changing the likelihood.
			None of the Core services can see a deterioration in their safe, well-led or overall rating from the CQC.			**Treat** – Changing the likelihood.
	Data Security and protection (confidentiality, integrity and availability)	The Trust will continue minimising exposure to any risk that could compromise data security and protection, which also includes cyber risk.	Trust's data and systems cannot be compromised by a cyber attack	**Low (ALARP)**	**8-12**	**Treat** – Changing the consequence.
						Treat - Removing the risk source (e.g. unsupported systems)

Strategic priority	Area of risk (Threat and opportunistic risks)	Risk appetite statement	KPI/ Acceptable risk exposure	Risk appetite	Target risk score	Risk response
			Trust data must not be exposed to any unauthorised individual			**Treat** – Changing the likelihood.
			The Trust must meet the DSP toolkit			**Treat** – Changing the likelihood.
	Finance	The Trust will be cautious in the management of risks that can affect its financial sustainability, while it is recognised that the organisation continues being exposed to a high level of financial risks and challenges in this area.	The Trust cannot be in a position that doesn't meet annual plan	**Medium (Cautious)**	**8-12**	**Treat** – Change the likelihood
Ensuring a strong user (patients, staff and local communities) focus in change and developments	**Legal compliance and operational impact**	The Trust will be aspirational in its approach to change and improvement – and will not shy away from complex and potentially controversial proposals where required – but we must develop such proposals in collaboration with stakeholders and partners, they must be in the best interests of our patients and local communities and they must comply with legislation.	The Trust must comply with legislation around service change Service change governance should always include consideration of how far user needs, experience and views have shaped proposals, including those of more vulnerable or disadvantaged user groups	**Low (ALARP)**	**6-9**	**Treat** – Change the likelihood
	Reputational	The Trust will minimise all risk that prevents achievements of these collaborations.	The Trust must do all it can to maintain constructive relationships with its local authorities, MPs,			

Strategic priority	Area of risk (Threat and opportunistic risks)	Risk appetite statement	KPI/ Acceptable risk exposure	Risk appetite	Target risk score	Risk response
			patient groups and other key stakeholders All major Trust programmes and projects should have at least one lay partner involved			

APPENDIX 2

Corporate Risk Profile
Trust Board
July 2021

Scoring Matrix
To calculate the risk score it is necessary to consider both how severe would be the consequences and the likelihood of these occurring, as described below:

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Key:

Initial Score: The score of the risk when first identified

Current Score: The current risk score including key controls to mitigate this risk

Target Score: Target of the risk once all future and current actions have been completed and implemented

Corporate Risk Profile

Risk scored 15:

1. 2613 Risk of failure to Uphold Rights and Freedoms of Data Subjects (3 x 5)

Risks scored 20:

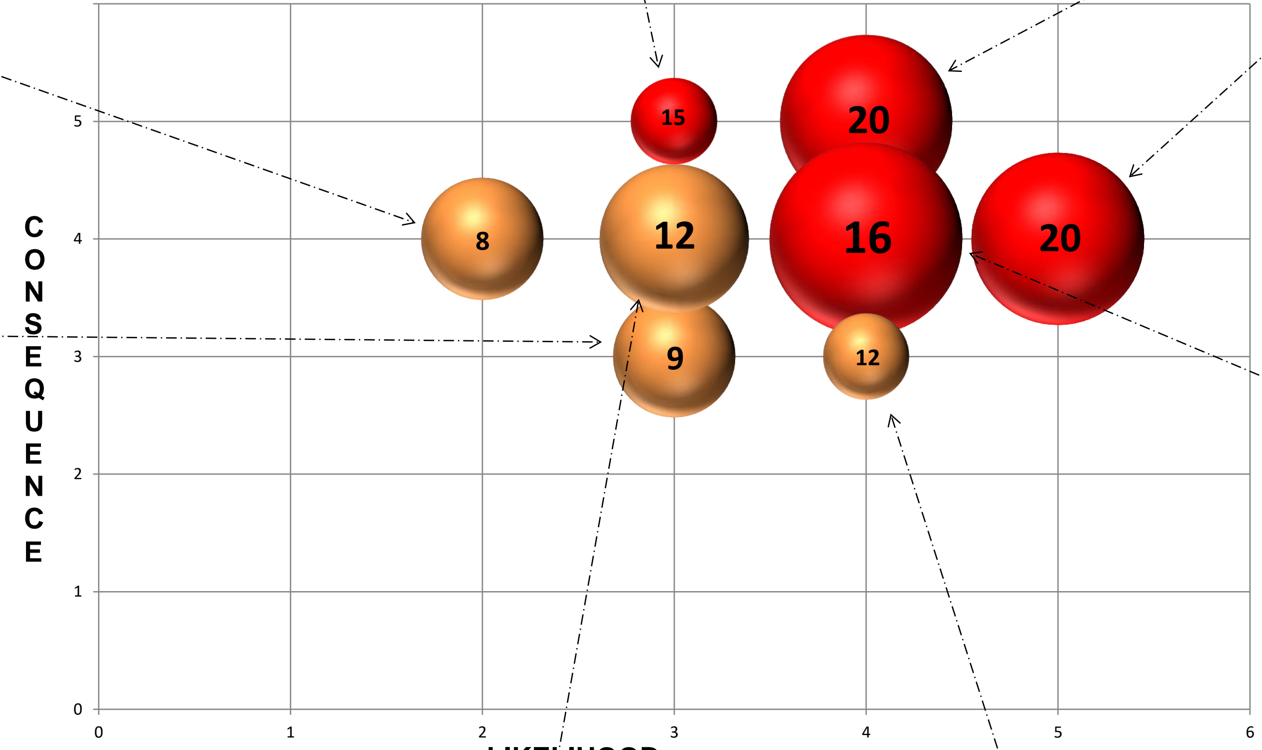
1. 2485 Failure of estates critical equipment and facilities (4 x 5)
2. 3014 Failure to deliver financial recovery (4 x 5)
3. 2482 Risk of Cyber Security threats (4 x 5)
4. Risk that is commercial in confidence (4 x 5)
5. 2477 Risk to patient experience and quality of care in the ED caused by the significant delays experienced by patients presenting with mental health issues (5 x 4)
6. 2937 Failure to consistently achieve timely elective (RTT) care (5 x 4)
7. 3326 Risk of deterioration in condition of patients requiring planned interventions (5 x 4)
8. 1660 Risk poor waiting list data quality (5 x 4)

Risks scored 8:

1. 2383 Failure to identify poor compliance with legislative and regulatory requirements, including required accreditations (2 x 4)
2. 2896 Risk of disruption to the continued provision of service due to changes introduced by the EU-UK trade and co-operation deal (2 x 4)

Risks scored 9:

1. 2538 Risk of medication safety being adversely affected by poor adherence to medication safety policies (3 x 3)
2. 2944 Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas (3 x 3)



Risks scored 16:

1. 2498 Failure to gain funding and approvals from key stakeholders for the redevelopment programme (4x4)
2. 2942 Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines (4x4)
3. 2943 Failure to manage non-elective flow (4x4)
4. 3258 Failure to protect staff, particularly who are in groups where there is increased susceptibility to COVID-19 (4x4)
5. 2938 Risk of delayed diagnosis and treatment and failure to maintain key diagnostic operational performance standards (4x4)

Risks scored 12:

1. 2472 Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards(3 x 4)
2. 2946 Failure to provide timely access to critical care services (3 x 4)
3. Risk of inability to identify gaps with fit testing compliance due to failure to record fit testing on healthroster (3 x 4)
4. 3428 Failure to effectively manage supplier contracts lead top financial loss or operational issues (4 x 3)

Corporate Risk Register Dash Board

Key:	
♦	Initial Risk Score
▲	Target Risk Score
-------	Benchmark target risk score
IRS	Initial Risk Score
CRS	Current Risk Score
TRS	Target Risk Score

Risk appetite		
Avoid/ Minimal (ALARP - As little as reasonably possible)	**Low**	Strives to avoid risk and uncertainty and works to minimize unavoidable risk. Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
Cautious	**Medium**	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
Open		Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
Seek/ Mature	**High**	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). Confident in accepting or setting high levels of risk because controls, forward scanning and responsiveness systems are robust.

Risk Response:	
Treat	The risk is being managed and the mitigation plan is being implemented
Tolerate	Accept that all possible mitigations have been implemented from the Trust and the risk has to be tolerated until further mitigations that are dependent on external stakeholders are implemented
Transfer	The risk can be transferred to a third party (e.g. insurance)
Terminate	The risk is too severe and the Executive has decided to terminate the activity that is causing it

Risk ID	CQC Domain	Risk Description	Lead Director	Risk movement in the last 12 months, Initial and Target risk scores and dates	Original Target Risk Score date	Consequence impact on	Risk Appetite	Risk Response	Last reviewed
3326	Safe Responsive Well Led	Risk of deterioration in condition of patients requiring planned interventions	Medical Director	I 20, T 12 Jun-20, Aug-20, Apr-21, Jun-21, Jul-21	IRS 20, CRS 16, TRS 12 TRSD initially agreed: Jul-21	Safety of patients	Low *(Avoid/ minimal)*	Change the likelihood	Jun-21
3356	Safe Well Led	Risk of inability to identify gaps with fit testing compliance due to failure to record fit testing on healthroster	Director of Operational Performance	I 15, 15, 16, 12, C 12, T 3 Sep-20, Sep-20, Oct-20, Mar-21, Jun-21 *Under review*	IRS 15, CRS 12, TRS 3 TRSD initially agreed: Oct-20	Safety of staff	Low *(Avoid/ minimal)*	Change the likelihood Change the consequence	May-21
2485	Safe	Failure of estates critical equipment and facilities that prejudices trust operations and increases clinical and safety risks	Director of Nursing	I 20, C 20, T 15 Mar-11, Jul-20, Jun-21, Jul-21	IRS 20, CRS 20, TRS 15 TRSD initially agreed: Oct-17	*TBC*	Low *(ALARP)*	Change the likelihood	May-21
2946	Safe Effective	Failure to provide timely access to critical care services	Divisional Director of SCC	I 16, 16, C 12, T 12 Mar-19, Jul-20, Sep-20, Jun-21, Jun-21	IRS 16, CRS 12, TRS 12 TRSD initially agreed: Mar-20	Safety of patients	Low *(Avoid/ minimal)*	Change the likelihood Change the consequence	Jun-21
2942	Safe	Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines	Medical Director	I 16, 16, C 16, T 9 Mar-19, Jul-20, Jun-21, Apr-22	IRS 16, CRS 16, TRS 9 TRSD initially agreed: Mar-20	Safety of patients	Low *(Avoid/ minimal)*	Change the likelihood Change the consequence	Jun-21
3258	Safe Well Led	Risk of staff developing COVID-19 infection as a result of exposure at work and the subsequent impact	Director of P&OD	I 16, 16, C 12, T 8 May-20, Jul-20, Apr-21, Jun-21, Mar-21	IRS 16, CRS 12, TRS 8 TRSD initially agreed: Jul-20	Safety of staff	Low *(Avoid/ minimal)*	Change the likelihood	May-21

Risk ID	CQC Domain	Risk Description	Lead Director	Risk movement in the last 12 months, Initial and Target risk scores and dates	Original Target Risk Score date	Consequence impact on	Risk Appetite	Risk Response	Last reviewed
2944	Safe	Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas	Director of People & OD	I 12, 12, C 9, T 6; Mar-19, Jul-20, Dec-20, Jun-21, *Under review*	IRS 12, CRS 9, TRS 6; TRSD initially agreed: Mar-20	*TBC*	Low *(ALARP)*	Change the likelihood	Apr-21
2938	Responsive	Risk of delayed diagnosis and treatment and failure to maintain key diagnostic operational performance standards	Divisional Director of WCCS	I 16, 16, C 16, T 8; May-15, Jul-20, Jun-21, Jul-21	IRS 16, CRS 16, TRS 8; TRSD initially agreed: Dec-20	*TBC*	Low *(Avoid/ minimal)*	Change the likelihood	Mar-21
2538	Safe	Risk of medication safety being adversely affected by poor adherence to medication safety policies	Divisional Directors (MIC, SCC and WCCS)	I 16, 9, C 9, T 6; Nov-17, Jul-20, Jun-21, Apr-21	IRS 16, CRS 9, TRS 6; TRSD initially agreed: May-18	*TBC*	Low *(Avoid/ minimal)*	Change the likelihood	Jun-21
2482	Caring Well Led	Risk of cyber security threats to Trust data and infrastructure	Chief Information Officer	I 16, 16, C 20, T 12; Jul-15, Jul-20, Nov-20, May-21, Jun-21	IRS 16, CRS 20, TRS 12; TRSD initially agreed: Mar-18	*TBC*	Low *(ALARP)*	Change the likelihood Change the consequence	Jun-21
2943	Responsive	Failure to manage non elective flow	Divisional Director of MIC	I 20, 16, C 16, T 12; Jul-15, Jul-20, Jun-21, *Under review*	IRS 20, CRS 16, TRS 12; TRSD initially agreed: Mar-20	*TBC*	Low *(Avoid/ minimal)*	Change the likelihood	May-21
2937	Responsive	Failure to consistently achieve timely elective (RTT) care	Divisional Director of SCC	I 20, 20, C 12, T 6; Jun-16, Jul-20, Jun-21, Mar-21	IRS 20, CRS 12, TRS 6; TRSD initially agreed: Mar-20	Safety of patients	Low *(ALARP)*	Change the likelihood Change the consequence	Jun-21
2896	Well Led	Risk of disruption to the continued provision of service due to changes introduced by the EU-UK trade and co-operation deal	Director of Operational Performance	I 12, 12, 12, C 8, T 4; Nov-20, Nov-20, May-21, Jun-21, *Under review*	IRS 12, CRS 8, TRS 4; TRSD initially agreed: Dec-20	*TBC*	Medium *(Cautious)*	Change the likelihood	May-21
2477	Responsive	Risk to patient experience and quality of care in the Emergency Departments caused by the significant delays experienced by patients presenting with mental health issues	Divisional Director of MIC	I 15, C 20, T 9; Jun-16, Jul-20, Jun-21, Jan-21	IRS 15, CRS 20, TRS 12; TRSD initially agreed: Dec-17	*TBC*	Low *(ALARP)*	Change the likelihood	May-21
3014	Well Led	Failure to achieve financial sustainability	Chief Financial Officer	I 20, 20, C 20, T 12; Mar-12, Jul-20, Jun-21, Mar-22	IRS 20, CRS 20, TRS 12; TRSD initially agreed: Mar-22	*TBC*	Medium *(Cautious)*	Change the likelihood Change the consequence	Jun-21
3428	Well Led	Failure to effectively manage supplier contracts lead top financial loss or operational issues	Chief Financial Officer	I 12, 12, 12, T 6; Feb-21, Feb-21, Jun-21, Dec-21	IRS 12, CRS 12, TRS 6; TRSD initially agreed: Dec-21	*TBC*	Medium *(Cautious)*	Change the likelihood	May-21

Risk ID	CQC Domain	Risk Description	Lead Director	Risk movement in the last 12 months, Initial and Target risk scores and dates	Original Target Risk Score date	Consequence impact on	Risk Appetite	Risk Response	Last reviewed
1660	Well Led	Risk of poor waiting list data quality	Director of Operational Performance	I 20, 12, C 20, T 6; Jul-11, Jul-20, Nov-20, Jun-21, *Under review*	IRS 20, CRS 20, TRS 6; TRSD initially agreed: Mar-18	Safety of patients	Low *(ALARP)*	Change the likelihood Change the consequence	Jun-21
2613	Well Led	Risk of failure to Uphold Rights and Freedoms of Data Subjects	Chief Information Officer	I 25, 15, C 15, T 10; Feb-18, Jul-20, Jun-21, Mar-21	IRS 25, CRS 15, TRS 10; TRSD initially agreed: Mar-21	*TBC*	Low *(Avoid/ minimal)*	Change the likelihood	Jun-21
2498	Well Led	Failure to gain funding approval from key stakeholders for the redevelopment programme resulting in continuing to deliver services from sub-optimal estates and clinical configuration	Chief Executive Officer	I 12, 16, C 16, T 8; Oct-14, Jul-20, Jun-21, Dec-22	IRS 12, CRS 16, TRS 8; TRSD initially agreed: Dec-20	*TBC*	Medium *(Cautious)*	Change the likelihood	Jun-21
2472	Well Led	Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC	Director of Corporate Governance	I 16, 12, C 12, T 8; Dec-14, Jul-20, Jun-21, Dec-21	IRS 16, CRS 12, TRS 8; TRSD initially agreed: Apr-18	Statutory duty/ Inspections	Low *(Avoid/ minimal)*	Change the likelihood	Jun-21
2383	Well Led	Failure to identify poor compliance with legislative and regulatory requirements	Director of Corporate Governance	I 12, C 8, T 4; Jun-19, Jul-20, Jun-21, Dec-21	IRS 12, CRS 8, TRS 4; TRSD initially agreed: Apri-20	Statutory duty/ Inspections	Low *(Avoid/ minimal)*	Change the likelihood	Apr-21

TRUST BOARD (PUBLIC)

Paper title: Audit, Risk & Governance Committee report

Agenda item 18.1, paper number 15a

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

Purpose: For information

Meeting date: 14 July 2021

1. Purpose of this report

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

2. Introduction

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

3. Key points

3.1. The key items to note from the Extraordinary Audit Committee's held on 17 and 25 June and the Audit, Risk and Governance Committee meeting held on 7 July 2021 include:

3.1.1. **External Audit:** The Committee noted that, following an extraordinary meeting of the Committee held on 25 June to approve the annual accounts and report, they had been submitted to NHSI, within the deadline. Committee members extended thanks to all involved in completing these after an extraordinary year. A debrief on this year's audit would be presented to the Committee in September 2021.

3.1.2. **Internal audit**

The Committee received an internal audit progress update and were pleased to note that all audits had been completed for the 2020/21 year and that there had been good engagement with executive leads regarding the audits planned for the year ahead.

An update on contract management was reviewed and Committee members were pleased to note progress against all of the actions, particularly around the development of the contract management policy and the introduction of a procurement management system.

Committee members also received a counter fraud progress report noting that there had been three new cases this financial year, all were on track in terms of investigations.

3.1.3. **Risk management update**

The Committee had an extensive discussion on risk management, including consideration of the revised risk appetite framework which had been approved by the executive. There is a recognition that the pandemic had changed the risk profile of the organisation, and new collaborative working requires consideration of how risk management and assurance needs to evolve. Committee members welcomed the way risks had clearly been set out and linked to the future development of committee-level scorecards as part of the Imperial management improvement system (IMIS) programme. Next steps will be to finalise the framework and work with committee chairs to embed in the routines of each committee.

Committee members reviewed the corporate risk register and the first draft of the acute programme risk register.

Committee members also reviewed and welcomed the updated Trust assurance framework which outlined the Trust's Board assurance framework (BAF) approach and associated systems and processes – the mechanisms by which assurance is provided to the Trust Board and its committees.

Examples of new individual governance frameworks, which sought to outline the Trust governance processes and assurance mechanisms for particular areas, were reviewed. They were technology including cyber security and redevelopment.; These were found to be helpful; work to standardise them further would be completed and reviewed with PwC to establish a standardised approach and assure the technology governance framework in particular. Further frameworks will then be developed for other areas of risk, including health and safety.

3.1.4. **Risks associated with EU exit**

The Committee noted the update against risks associated with EU exit and were pleased to note that there had been no significant issues, and the risk rating had reduced. Committee members noted that NHS England had recently recommended that organisations maintain their current level of EU exit preparedness in case of potential further impacts on service delivery in the coming months. Organisations had also been asked to continue to keep appropriate EU exit contingency measures in place as part of overall incident response capability.

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

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

Jessica Hargreaves, Deputy Trust Secretary
8 July 2021

TRUST BOARD (PUBLIC)

Paper title: Quality Committee Report

Agenda item 18.2, paper number 15b

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

Purpose: Information

Date of meeting: 14 July 2021

1. Purpose of this report

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

2. Introduction

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

3. Key points

3.1. The key items to note from the Quality Committee meeting held on 08 July 2021 include:

3.1.1. **Risk and Assurance Deep Dive – Complaints and PALS annual report**
The Committee reviewed the Complaints and PALS annual report noting that due to the Covid-19 pandemic, formal complaints had been affected due to the Trust reducing its services in waves 1 and 2. Committee members were pleased to note that complaints were regarded as a learning opportunity, and that the virtual appointments and the introduction of the PALS call centre was welcomed by patients noting that the majority of PALS interaction had become virtual. Committee members noted that due to national guidance during the pandemic, patients attending the Trust for maternity care could not attend with a partner or family member which resulted in a high number of complaints. However, following further changes in guidance allowing a partner or family member to accompany the patient, the number of complaints had reduced. The Committee agreed that the overall performance in complaints handling was good throughout the year and noted that for the first time no cases were upheld by the Parliamentary Health Service Ombudsman. The Committee thanked the Director of Nursing for the report and the efforts of herself and her team.

3.1.2. **Quality Report**
The Committee noted the Quality performance report, noting exceptions against quality key performance indicators and measures being taken to address areas of variance against target.

3.1.3. **Infection Prevention & Control (IPC) Annual Report**
Committee members received the annual report noting that throughout 2020/21, the Covid-19 pandemic continued to demand fundamental changes to the healthcare services provided by the Trust. The Committee noted that the IPC team have played a central role in the Trust's response to the pandemic which consisted of the introduction of the Infection Prevention and Control Board Assurance Framework. Committee members noted that despite a range of new approaches aimed at preventing the spread of the Covid-19 virus, a total of 61 Covid-19 transmission outbreaks had been identified and managed since July 2020. The Committee noted that the Trust had seen an increase in the number of Trust-attributed MRSA BSI bloodstream infections in 2020/21 and acknowledged this was similar across all Trusts in London. The Committee was particularly pleased to note that antibiotic stewardship had continued despite so many ill patients in ICU.

3.1.4. **Infection Prevention & Control Board Assurance Framework for COVID-19 self-assessment June 2021.**
The Committee received the report noting that good progress is being made in general and one area remaining "red" rated (provision and recording of training for staff issued with FFP3 respirators). A plan for FFP3 respirator management is being led by the Chief Operating Officer, which will address this Key Line of Enquiry (KLOE). The Committee noted that this framework was a dynamic review of the Trust's infection prevention and control assurance mechanisms and further work was ongoing to improve ratings in the area rated red.

3.1.5. **COVID-19 and Vaccination update**
The Committee received a presentation on the Trust's response to Covid-19 and the sector position across North West London which included an update on the Trust staff vaccination programme. The Committee discussed and acknowledged the key risks and mitigations; noted the planning for a potential wave 3; and lifting of restrictions on 19 July 2021. The Committee were assured that the executive team were managing the risks associated with the Covid-19 pandemic. The Non-executive Directors thanked the executive team for their dedication and hard work throughout each stage of the pandemic.

3.1.6. **Regulatory Compliance Report**
The Committee received the regulatory compliance report noting that the CQC had published its next five year regulatory strategy for 2021-2026 which sets out the changes that would impact the areas the Trust would be assessed against and how they would be assessed by the CQC. Committee members noted that the Improving Care Programme Group (ICPG) had been suspended during the pandemic but had re-commenced in May 2021.The focus of ICPG would be to align the CQC standards with the Trust Quality Improvement team priorities to support clinical services in ensuring continual improvement in quality. The Committee was pleased to note that a recent CQC engagement meeting with the renal services was a success and positive feedback was received from staff.

3.1.7. **Key Divisional Risks**
The Committee noted the key divisional and corporate risks which were largely focused on the reset and recovery programme, and restarting of services following the second surge of Covid-19. Planning for a potential third wave was well underway.

3.1.8. **Maternity Quality Assurance Oversight Report & CNST Declaration**
The Committee reviewed the Maternity Quality Assurance Oversight report. The Committee noted that there were still changes being made, and therefore delegated authority to the Committee Chair for subsequent signing off of the CNST Declaration for final approval by the Trust Board.

3.1.9. **North West London Pathology Quarterly Report**
The Committee members received the report noting the high level activities of North West London Pathology in line with the requirements of the joint venture requirements for the pathology services. Committee members noted that the service would continue to prepare for upcoming accreditation body inspections and focus on improvements to the service.

3.1.10. **Research Report**
The Committee received the report and welcomed the contribution made by research to the Trust and the national response during the pandemic. The Committee agreed that it would also be useful to consider some research governance metrics in the report to provide assurance that the research governance processes were efficient and effective. The Executive Team would consider how to reflect this in future reports.

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

Imperial College Healthcare
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TRUST BOARD (PUBLIC)

Paper title: Finance, Investment & Operations Committee report

Agenda item 18.3, paper number 15c

Committee Chair: Peter Goldsbrough, Non-executive Director
Author: Jessica Hargreaves, Deputy Trust Secretary

Purpose: For information

Meeting date: 14 July 2021

Executive summary

1. Purpose

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

2. Introduction

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

3. Key points

3.1. The key items to note from the Finance, Investment and Operational Committee held on 7 July 2021 include:

3.2. **Delivering the operating plan**
The Committee received and discussed the Trust's performance against the operating plan trajectories, noting that the majority of metrics had been achieved during April and May. The priority for the coming month would be to finalise plans to achieve the increased capacity required to continue to deliver the activity trajectories whilst also ensuring the health and wellbeing of staff.

3.3. **Finance report and risk and assurance 'deep dive' into debt management**
The Committee received the finance report for month 2 noting that the Trust had reported a breakeven position at the end of May once the anticipated level of Elective Recovery Funding had been taken into account. The Committee noted that there had still not been any further guidance received regarding the funding regime for the second half of the year but agreed it was important that the Trust continue the work to develop its business plan (H2 plus 2022/23) taking into account the need to do as much activity as possible whilst being as efficient as possible. Divisional planning meetings have commenced with financial sustainability a key area of focus.

Committee members received a risk and assurance 'deep dive' review of the Trust's management controls to minimise the risk of debt 'write-off', particularly focusing on

Imperial College Healthcare
NHS Trust

the 'over one year' category and areas of concern. Committee members were pleased to note the key actions being taken to reduce specific categories of debt and improvements to current processes to mitigate further future deterioration, whilst acknowledging some areas such as overseas debt are likely to remain a perennial issue.

The Committee also noted the finance report for North West London Pathology (NWLP).

3.4. **Intra-system financial framework**
The Committee noted the proposed financial framework to align financial incentives as an enabler to allow all partners within the Integrated Care System (ICS) to work in the best interest of the system, and a system governance process to enable a consistent and agreed approach to the way we collaboratively make decisions. Committee members extended thanks for the team for developing the framework which had been welcomed across the sector.

3.5. **North West London (NWL) payroll consolidation update**
The Committee received the update on the NWL payroll consolidation project and noted that both parties had accepted that the level of work required for Chelsea and Westminster NHS FT to sufficiently reduce the data quality and payroll feeder system issues within the original timeline was substantial and as a result had required the go-live date to be deferred by at least a further six months.

3.6. **Costing updates**
The Committee noted the requirements and approach to the annual National Cost Collection (NCC) and were made aware that NCC superseded the previous Reference Cost Submission and that the collection had evolved as part of the Costing Transformation Programme (CTP) to transition to patient level costing. Patient level NCC costs had been mandated in acute, mental health and ambulatory service trusts and community services would transition to patient level costs in 2021/22.

The Trust had been allocated a slot to submit the NCC on 5 October 2021 and Committee members noted that for the 2020/21 submission, the sign-off process had been changed due to Covid-19 and that the Trust's Chief Finance Officer was required to sign off the submission on behalf of the Board, rather than requiring Board approval.

The Committee also received an update on the re-launch of the Patient Level Information Costing System programme.

3.7. **St Mary's Hospital redevelopment business case**
The Committee received an update on the progress of the St Mary's Hospital redevelopment business case focusing on the financial and economic aspects. The Committee were supportive of the business case and recommended it proceed to Trust board for approval.

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

3.9 **Capital projects update**
The Committee received and discussed the annual report of the capital projects completed in the previous financial year.

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

Jessica Hargreaves
Deputy Trust Secretary
8 July 2021

TRUST BOARD (PUBLIC)

Paper title: Report from the Redevelopment Committee on 8th July 2021

Agenda item 18.4 and paper number 15d

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

Purpose: For noting

Meeting date: 14th July 2021

1. Purpose of this report

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

2. Introduction

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

3. Key points

3.1. The key items to note from the Redevelopment Committee meeting held on 8th July 2021 include:

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

3.1.2. Work on phase 1 of the Charing Cross and Hammersmith Hospitals development control plan was now complete.

3.1.3. The Committee discussed potential options for phase 1 of St Mary's Hospital redevelopment.

TRUST BOARD (PUBLIC)

Paper title: Summary report from the People Committee

Agenda item 18.5 and paper number 15e

Acting Committee Chair: Ben Maruthappu, Associate Non-Executive Director
Author: Ginder Nisar, Deputy Trust Secretary

Purpose: For noting

Meeting date: 14 July 2021

Executive summary

1. Purpose

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

2. Introduction

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

3. Key points

3.1. The key items to note from the People Committee held on 6th July 2021 include:

3.1.1. **Priority People Programmes -** The Committee received the updated seven Priority People programmes for 2021/22, which would assist with the delivery of the Trust strategic objectives. These had been discussed and agreed in principle at the May 2021 People Committee. The Committee discussed some of these areas in detail.

- Developing a Sustainable Workforce
- Equality, Diversity and Inclusion*
- Remote, Agile and Flexible working
- Health, wellbeing and workplace safety*
- Improvement through People Management*
- Values, Behaviours and Conflict Management
- NW London System working

*Trust wide priority programmes

3.1.2. **Workforce Performance Report -** The Committee received an update on the core workforce performance and indicators for month 2, May 2021. The report summarised the areas of good performance and the areas for improvement with action plans in place. The workforce report format and the scorecard would continue to be developed as the priority areas were worked through.

3.1.3. **People Risk Register -** The Committee received the People and Organisational Development (POD) risk register which had been refreshed to ensure that the Trust

was focusing on the most appropriate risks in light of the last year. The exercise concluded that the POD Risk Register had 18 risks. The risks would be kept under regular review to ensure that actions were effective in reducing the risk noting that there were some risks that should be further refined, including the risks associated with recruitment, retention and vacancies, to align with the work of the Developing a Sustainable workforce programme. The identified risks would be reviewed to establish what level they should be managed at, either the corporate risk register for strategic risks or the POD directorate risk register.

3.1.4. **Risk Register Deep Dive -** The report set out the risk and assurance deep dive ensuring there was a focus on the CRR Risk 3269: Risk of staff experiencing poor mental /psychological health as a result of the Covid 19 pandemic. The risk score was 12. The Committee acknowledged that the pandemic had brought about unprecedented challenge to healthcare staff who have been at the frontline of the Trust's overall response, both clinical and non-clinical. Evidence of previous or similar events would suggest that staff were at more risk of developing mental health or psychological impact as a result, and the experience at the Trust suggested that staff have been affected by the events of the last year. The report summarised a range of control measures in place and a range of data which had been included to provide assurance in support of this risk.

3.1.5. **Priority Objective Review: Improvement through People Management Priority People Programme and Managing our Values, Behaviours and Conflict Resolution Priority People Management Programme -** The Committee received a deep dive into two Priority People Programmes: Improvement through People Management; and Managing Values, Behaviours and Conflict Resolution. The programmes build on the previous value and behaviour work, and focus on both the role and importance of people management, how the Trust improves the way it manages conflict and how it continues to embed the values and behaviours. Both programmes had established a programme charter and milestone plan with stakeholders. They have also identified measures, KPIs and identified risks to the delivery of the programme.

3.1.6. **Occupational Health and Safety Report -** The Committee received an update on aspects of the Trust occupational health and safety arrangements, including 'Covid secure', the Trust's statutory duty to investigate certain Covid 19-related incidents and the performance of the Occupational Health service.

4. Recommendation(s)

4.1. The Board is asked to note this report.

5. Impact assessment

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