Imperial College Healthcare NHS Trust

Trust Board – Public

Wednesday 25 May 2022, 11:00 to 13:30 (10:45 – 11:00 to 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
11:00	**1.**	**Opening remarks**	Matthew Swindells	Oral
	2.	**Apologies:** Nick Ross	Matthew Swindells	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.	Matthew Swindells	Oral
11:05	**4.**	**Minutes of the meeting held on 16 March 2022** To approve the minutes from the last meeting	Matthew Swindells	A.
	5.	**Record of items discussed in Part II of Board meetings held on 16 March 2022 and the Trust Board Seminar held on 20 April 2022** To note the report	Matthew Swindells	B.
	6.	**Matters arising and review of action log** To note updates on actions arising from previous meetings	Matthew Swindells	C.
	7.	**Chair's report - North West London Acute Trusts** To note the report	Matthew Swindells	D.
11:10	**8.**	**Staff Story** To note the staff story	Kevin Croft	E.

11:25	**9.**	**Chief Executive Officer's Report** To receive an update on a range of activities and events since the last Trust Board	Tim Orchard	F.
Operations / Performance				
11:40	**10.**	**Integrated Quality and Performance Report** To note month 12 performance	Claire Hook Julian Redhead	G.
Quality				
11:50	**11.**	**Infection Prevention and Control Board Assurance Framework** To note the report	Julian Redhead	H.
12:00	**12.**	**Ockendon Report** (including gap analysis and plan for Midwifery Continuity of Carer) To discuss the report	Tg Teoh	I.
12:20	**13.**	**Learning from Deaths** To note the quarter 4 report	Julian Redhead	J.
12:30	**14.**	**Board Summary Report: Quality Committee, 5 May 2022** To note the summary report	Andy Bush	K.
Finance				
12:35	**15.**	**Finance Report** To note the month 12 report **Annual Accounts and Annual Report** To approve the delegation of authority to the Audit, Risk and Governance Committee to approve the annual accounts and annual report for 2021-22 on behalf of the Board	Jazz Thind	L.
12:45	**16.**	**Board Summary Report: Finance, Investment and Operations Committee, 4 May 2022** To note the summary report	Andreas Raffel	M.
People				
12:55	**17.**	**People Performance Scorecard Report** To note the month 12 workforce report	Kevin Croft	N.
13:00	**18.**	**Staff Survey Results 2021** To note the results of the survey	Kevin Croft	O.
13.05	**19.**	**Board Summary Report: People Committee, 3 May 2022** To note the summary report	Sim Scavazza	P.

Governance				
13:10	**20.**	**Annual Provider Licence Compliance Report** To agree the annual statement of compliance against provider licence conditions	Peter Jenkinson	Q.
13:15	**21.**	**Board Summary Report: Audit, Risk and Governance Committee, 10 May 2022** To note the summary report	Kay Boycott	R.
13:20	**22.**	**Board & Committee Effectiveness Report, and Board Committee Terms of Reference** To note the annual effectiveness report and approve the terms of references	Peter Jenkinson	S.
13:25	**23.**	**Redevelopment Committee: summary report** To note the summary report	Bob Alexander	T.
	24.	**Any other business** Des Irving Brown to attend July Board on behalf of Jazz Thind, CFO	Matthew Swindells	Oral
	25.	**Questions from the public**	Matthew Swindells	Oral
13:30 Close	**26.**	**Date of next meeting** Wednesday 20 July 2022 at 11:00 – 13:30.		

Updated: 19 May 2022

Reading Room:

18: **Staff Survey Results 2021**

- Staff Survey 2021 National Benchmark Report
- Staff Survey 2021 National Briefing Results

22: **Board & Committee Effectiveness Report, and Board Committee Terms of Reference**

Terms of References:

- Audit, Risk & Governance Committee
- Finance, Operations & Governance Committee
- People Committee
- Quality Committee
- Redevelopment Committee
- Remuneration Committee

Imperial College Healthcare NHS Trust

Public Trust Board
Minutes of the meeting held on 16 March 2022 at 11:15
Virtual meeting held via Microsoft Teams and video-recorded.

Members present

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

In attendance

Matthew Swindells	Designate North West London Chair in Common (Observer)
Dr Ben Maruthappu	Associate Non-Executive Director
Ms Beverley Ejimofo	Associate Non-Executive Director
Mr Peter Jenkinson	Director of Corporate Governance
Mr Kevin Croft	Chief People Officer
Dr Matthew Tulley	Director of Redevelopment
Dr Bob Klaber	Director of Strategy, Research & Innovation
Mr Jeremy Butler	Director of Transformation
Mr Kevin Jarrold	Chief Information Officer
Mr Hugh Gostling	Director of Estates and Facilities
Ms Michelle Dixon	Director of Communications
Mr Raymond Anakwe	Medical Director
Prof. TG Teoh	Divisional Director, Women, Children and Clinical Support
Prof. Frances Bowen	Divisional Director, Medicine and Integrated Care
Prof. Katie Urch	Divisional Director, Surgery, Cancer and Cardiovascular
Prof. Jonathan Weber	Dean of the Faculty of Medicine, Imperial College London
Mr James Price	Director of Infection Prevention and Control
Ms Saghar Missaghian-Cully	NWL Pathology Managing Director
Guy Young	Deputy Director of Patient Experience (item 7)
Amrit Panesar	Trust Secretariat Officer (Minutes)

Apologies

Mr Peter Goldsbrough	Non-Executive Director
Mrs Ginder Nisar	Head of Trust Secretariat

Item	Discussion
1.	**Opening remarks**
1.1.	Mr Alexander welcomed everyone to the meeting which was held virtually and where in person, was in keeping with social distancing guidelines for the NHS. The Board meeting would be video-recorded and the recording uploaded onto the Trust's website. Members of the public had been invited to submit questions ahead of the meeting or ask questions at the end of the meeting via Microsoft Teams meeting. Members of the public were welcome to submit questions to the Trust Secretary at any time. Mr Jenkinson outlined the etiquette for the meeting.
1.2.	Mr Alexander explained that while the current national Covid restrictions remain in place in NHS premises, including social distancing and Covid-secure protocols, the Trust would not be holding face to face Board meetings in order to keep patients, visitors and staff safe. Therefore the Trust Board meetings will continue to be held virtually until April 2022, however, this will be kept under review.
1.3.	Mr Alexander welcomed Matthew Swindells to the meeting. Mr Swindells will be joining the Trust in April 2022 as the Joint Chair of North West London Acute Trusts and will be observing the meeting today.
2.	**Apologies**
2.1.	Apologies were noted from those listed above.
3.	**Declarations of interests**
3.1.	There were no additional declarations to those disclosed on the Trust's register of interests.
4.	**Minutes of the meeting held on 19th January 2022**
4.1.	The minutes of the previous meeting were agreed.
5.	**Record of items discussed in part II of the Board meetings held on 19th January 2022 and the Trust Board Seminar held on 23rd February 2022.**
5.1.	The Board noted the summary of confidential items discussed at the confidential Board meeting held on 19th January and the Trust Board Seminar held on 23rd February.
6.	**Matters arising and actions from previous meetings**
6.1.	Updates against the actions arising from previous meetings were noted on the action register.
7.	**Patient Story**
7.1.	The Board welcomed Mr Guy Young, who presented a patient story on behalf of a patient who attended the Trust's emergency department in November 2021 with an acute problem and his means of communication was sign language. The patient attended with his son who also used the British sign language. The staff in the emergency department recognised that the patient required interpreting services and asked for an interpreter to attend the emergency department to support the patient. Staff in the emergency department were advised that an interpreter was not available for 48 hours which the staff felt was unacceptable. This was then

	escalated, and an interpreter communicated with the patient via a virtual consultation.
7.1.1.	Mr Young highlighted the actions undertaken by the Trust, including sourcing interpreters in the Trust by engaging with stakeholders and communities. Staff at the Trust have undertaken basic sign language and deaf awareness training which was delivered in December 2021 and positively received. Another 250 members of staff would be trained. The Board noted that it was sign language week that week, and the Trust was promoting this through screen savers across the Trust. The Board noted that staff working with the community, outpatients and emergency departments would be encouraged to attend the training and noted that the Trust would be extending the use of hearing loops in imaging and outpatients.
7.1.2.	The Board noted that previously a patient had presented a story regarding their experience with the sign language and issues they had experienced when they came into the Trust. Since then the patient had worked closely with the Trust to implement the use of a wrist band which identifies that the person requires support with communicating. The patient had since died however the initiative developed is supporting patients and visitors attending the Trust.
7.1.3.	Prof. Redhead commented that the work undertaken during the Covid-19 pandemic engaging with communities highlighted translation services as a major issue within all communities and welcomed the work undertaken by the Trust**.**
7.1.4.	The Board welcomed the story and thanked Prof. Sigsworth and Mr Young for their work and dedication in undertaking the positive actions from patients' experience at the Trust.
8.	**Chief Executive Officer's report**
8.1.	Prof Orchard presented his report, highlighting key updates on strategy, performance and leadership over the month and the focus of Trust business in response to Covid-19.
8.1.1.	Prof Orchard highlighted that the number of Covid-19 infections had increased slightly and currently 15.7% of trust beds were occupied by patients who had tested positive for Covid; this was an increase from 12% the previous week. The number of patients who had tested positive on this admission had increased from 116 to 149 patients and the number of patients who had tested positive at their latest test had increased from 74 to 92. This increase in Covid positive patients being treated resulted in increased operational pressures within the Trust. Prof Orchard reported that the teams working in the emergency department had done a fantastic job in maintaining ambulance handovers and noted that Charing Cross Hospital was the best performer in London in terms of ambulance handover times. The Board noted that the Trust had achieved 90% of its 'business as usual' levels of activity in elective care and just over 100% for diagnostics and outpatients. The ongoing estates issues at the Western Eye Hospital had also had an impact on the Trust's ability to deliver the whole of the elective programme.
8.1.2.	**Visiting Restrictions** At the end of January 2022, in light of the relaxation of the Government's Plan B Covid-19 restrictions and reduction of infections, the North West London sector had reverted to pre-January visiting restrictions in hospitals. This meant that all patients could have one visitor, for one hour, once a day. It would not be necessary for the visitor to be the same individual throughout the duration of the patient's stay.

8.1.3.	**Covid-19 and Flu Vaccination Programme** The Trust was continuing to provide a comprehensive vaccination programme for staff and wider community. To date 61.12 per cent of staff had received their flu vaccine, 91.72 per cent had received doses one and two of the Covid-19 vaccine, and 88.37 per cent of those eligible had received their Covid-19 booster.
8.1.4.	**Vaccination as a condition of deployment** On 21st January 2022, the government announced its intention to revoke the regulations making Covid-19 vaccination a condition of deployment in health and social care, subject to consultation and parliamentary process.
8.1.5.	**Acute care programme update** The Trust's collaborative approach to working across our 12 acute and specialist hospitals in North West London was becoming increasingly embedded. It had enabled the Trust to maintain more planned (elective) care during the third wave of Covid-19 infections than in the second wave when, in turn, we had seen an improvement on the first wave.
8.1.6.	**Financial performance** At the end of the first ten months of the financial year, the Trust had achieved a break-even position against a break-even plan and the Trust continued to forecast a year-end break-even position.
8.1.7.	**CQC update** Following a government mandate, non-essential working was suspended from mid-December 2021 through January 2022. As a result, the CQC's quarterly engagement meeting with the Trust scheduled in January 2022 had been cancelled. The next quarterly engagement meeting was scheduled to take place in June 2022.
8.1.8.	**Maternity assurance report** The Trust provided oversight of quality assurance within the maternity service via a report to each Quality Committee meeting. This included assurance on the progress on achieving compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) as well as key issues relating to the quality and safety of the maternity service.
8.1.9.	**Redevelopment** With the support of the New Hospital Programme, the Trust has begun the next phase of redevelopment planning work for its three main hospital sites, all of which are included in the 40 new hospitals the government has committed to build by 2030. While the Trust awaits a decision on its strategic outline case for St Mary's, it was continuing to work up options for phasing the redevelopment to explore whether it could accelerate key aspects of delivery and benefit realisation and spread the costs. The Trust was also now looking to create a high-level masterplan for the whole St Mary's site, exploring the scale of the total development opportunity including on land that will no longer be required due to more efficient use of the space. There would be more opportunities for staff, patients and local communities and others to get involved in the planning and preparation work over the coming weeks and months.
8.1.10.	**Western Eye Hospital** In November 2021, a review of the vacant Samaritan Hospital, which is adjacent to the Western Eye Hospital, raised fire safety concerns. The Trust took the immediate precaution of closing some areas of the Western Eye while more detailed investigations took place.

8.1.11.	**Research** As part of the selection process in the competitive re-application for our National Institute for Health Research (NIHR) Biomedical Research Centre (BRC), the Trust would be attending an interview at the beginning of April along with Imperial College London. It was confirmed last month that the NIHR Imperial Clinical Research Facility (CRF) would receive a further 5 years of funding, after undergoing a similar application process. The CRF would receive an increase in budget on the previous 5 years. Another NIHR research infrastructure programme – the NIHR Imperial Patient Safety Research Centre (PSTRC) – had also been submitted for re-application, and the outcome of this is awaited.
8.1.12.	**Equality, diversity and inclusion update** The Trust staff networks had continued to focus on raising awareness, including celebrating International Women's Day, designing the I-Can buddy scheme and preparations for Disability History Month. Our LGBTQ+ network had progressed with the second stage application for NHS Rainbow Badge Scheme, which includes a self-assessment by general managers, patient and staff surveys.
8.1.13.	**Joint Chair appointment** Prof Orchard said that he was delighted to announce the appointment of Matthew Swindells as the new Chair-in-common for Chelsea and Westminster Hospital NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust. Matthew has over 30 years' experience in healthcare and is the former Deputy Chief Executive and Chief Operating Officer for NHS England. He would take up his position on 1 April 2022. Prof Orchard thanked Mr Alexander for his support as interim chair over the last year. Questions from the Non-Executive Directors
8.1.14.	Dr Raffel welcomed the report and asked whether the Trust would provide visitors with lateral flow tests as the government were not providing free lateral flow tests from April. Prof Orchard explained that the Trust would continue to encourage visitors to undertake lateral flow tests; however this would not be compulsory. He added that lateral flow tests were available across the ward areas. Prof Sigsworth commented that the Trust would be anticipating further relaxation of the national guidance; however, the Trust would be asking visitors not to come into the hospitals if they were symptomatic. The Board were supportive of this approach.
8.1.15.	**The Board noted the update.**
9. 9.1.	**Integrated quality and performance report** The Board received the integrated quality and performance report for month 10, summarising performance against the key performance indicators for January 2022.
9.1.1.	**Operating plan 2021/22 – elective recovery position for January 2022** The volume of outpatient attendances had increased during January and stood at 105% of the trajectory target for the month as a whole. The volume of elective spells (day cases and overnight elective admissions) stood at 84% of the trajectory target f January as a whole. The overall size of the RTT waiting list had decreased and the trajectory for completed RTT activity pathways (clock stops) continued to be met. Th reduction targets for patients waiting 52 weeks and 104 weeks were not met, althou the overall 52 week wait backlog reduced by 10%.

9.1.2.	**Referral to Treatment** The Trust had reported 79,218 patient pathways at January month end, a reduction of 1,449 pathways (1.8%) on the previous month, although behind trajectory to achieve 78,728 or less. There were 1,605 patients waiting over 52 weeks for treatment, a reduction of 176 (10%) on the previous month although behind the planned trajectory of 1,538 for January. Unfortunately, 26 patients remained waiting over two years against the planned trajectory of 9.
9.1.3.	**Diagnostics** In January 2022, 18.6% of patients were reported as waiting more than 6 weeks for their diagnostic test, which was above the Trust internal trajectory of 9% for the month. However, the overall improvement in diagnostic waiting times continued and January 2022 was the best performance since beginning of the pandemic. The Endoscopy and Neurophysiology services both continued to report significant improvement in the waits over 6-weeks.
9.1.4.	**Cancer waiting times** A significant decline in cancer 2-week wait performance was highlighted and the Board advised that it was expected to remain non-compliant with the 93% target for the remainder of 2021/22. This was due to sustained increases in 2-week wait referral demand across specialties, prostate and breast diagnostic pathway capacity. The 62-day GP referral to first treatment performance was 62.6% against the 85%, also a significant decline.
9.1.5.	**Urgent and Emergency care** The number of patients waiting over 12 hours within the emergency department from time of arrival remained very high with 905 such patients in January 2022, the equivalent of 4% of attendances. Significant increases had been seen across both the CXH and SMH sites. The national requirement during 2022/23 was to reduce 12-hour waits to no more than 2% (NHS operating plan). The overall length of stay remained high with an average of 205 patients with a stay of 21 days or more. Questions and Comments from Non-Executive Directors
9.1.6.	Mrs Boycott raised a question relating to effective discharges and asked what assurances the Trust has in place to ensure patients do not have re-attendances and re-admissions and asked if the Trust is assured on the effectiveness and safety of the discharge pathway. Mrs Hook reported that a lot of work the Trust had been undertaken regarding discharges; however agreed to review feedback regarding effectiveness of discharges and attendances. The Board noted that re-admissions had been reviewed as a sector and the re-admission rates had reduced significantly over the last 12 months and re-attendance rates are stable. Mrs Hook explained that further work would be undertaken to improve the discharge process and the quality of discharges. Mr Alexander commented that this could be an opportunity to learn from the other trusts in the North West London acute provider collaborative. **Action: Mrs Hook**
9.1.7.	Prof Redhead commented that there were a number of patients who were expected to be re-admitted which is monitored separately. Prof Orchard commented that there is a substantial focus nationally on discharges and highlighted the importance of socialising the process of discharges for patients and families which the transformation team have been establishing.
9.1.8.	**The Board noted the report.**

10.	**Infection Prevention & Control Quarterly Report**
10.1.1.	The Board received the quarterly infection prevention & control report noting that the Trust's current trajectory of healthcare-associated C. difficile infection and healthcare associated E. Coli and P. aeruginosa bloodstream infections indicates that the Trust will not exceed the annual thresholds, and therefore do not flag as a cause of concern. Klebsiella infections were highlighted as a concern, especially intravascular line care to prevent sepsis. The Board noted that the Trust has implemented a monthly review of all healthcare-associated BSIs, including MRSA, and through this will include internal post infection reviews. The Board were pleased to note that the Trust continues to see an increase in the narrow spectrum antimicrobial metrics.
10.1.2.	**The Board noted the report.**
11.	**Infection Prevention & Control Board Assurance Framework**
11.1.1.	The Board received the report noting that the Board Assurance Framework had been re-issued in December 2021, included revised key lines of enquiry. The Board noted the report contained 125 key lines of enquiry over 10 domains, of which 42 remained unchanged from the previous board assurance framework, and 83 were new or significantly revised and cover aspects of Infection Prevention & Control practice beyond specifically Covid-19 as previously the case. The Board were pleased to note that there were no red areas reported in the Board Assurance Framework.
11.1.2.	The Board noted the Infection Prevention & Control Board Assurance Framework self-assessment noting that the Quality Committee had endorsed the Infection Prevention & Control Board Assurance Framework self-assessments.
11.1.3.	**The Board noted the report.**
12.	**Learning from Deaths Quarterly Report**
12.1.1.	The Board received the report noting the findings from the Trust's Mortality Surveillance Programme quarter 3. The findings would be submitted to NHS England.
12.1.2.	The Board noted that the Trust's new Structured Judgement Reviews had had a positive impact on performance, with significant improvement in the percentage of SJRs completed within seven days.
12.1.3.	There had been 35 Healthcare Onset Covid-19 Infections (HOCI) deaths in the recent surge. The HOCI deaths would be reviewed within the same process as deaths occurring in the previous Covid-19 surges.
12.1.4.	Prof Redhead reported that there had been a small deterioration in the Trust HSMR ranking earlier this year; however, the position had improved, and no areas had been identified of concern. The Board noted that the Trust's harm profile had not declined due to this; however other healthcare providers had improved their reporting.
12.1.5.	**The Board noted the report.**
13.	**National Patient Safety Strategy Implementation update**
13.1.1.	Prof Redhead presented the report summarising the Trust response to the recently published National Patient Safety Strategy. The NHS Patient Safety Strategy focused on how the NHS can continuously improve safety by building on two

	foundations: a patient safety culture and a patient safety system - setting out three strategic aims for the NHS as a whole such as insight, involvement and Improvement.
13.1.2.	The Board noted that the Trust had been working with the Trust's Strategic Lay Forum to ensure there is good patient involvement in the development of the patient safety strategy. The Medical Directors Office were working with the Divisions to ensure that there is a patient safety specialist in all areas across the Trust. Questions and Comments from the Non-executive directors
13.1.3.	Mrs Boycott reflected on an incident panel meeting that she had observed, which highlighted the JUST culture behaviours, and encouraged the Board to attend meetings as a good example of Board to Ward assurance.
13.1.4.	The Board agreed that the Quality Committee will continue to monitor the implementation of the National Patient Safety Strategy.
13.1.5.	**The Board noted the report.**
14.	**Board Summary Report Quality Committee, 9th March 2022** The Board received the Quality Committee Board Summary report.
14.1.1.	Prof Bush was pleased to note that the Trust provided substantial support for a critical incident following a case of Lassa fever which resulted in critical care capacity being compromised. Prof Bush congratulated all who were involved.
14.1.2.	**The Board noted the report.**
15.	**Finance Report**
15.1.1.	The Board received and noted the financial performance report for month 10. Year to date the Trust had achieved a break even position (on plan) and is forecasting to maintain this position to year-end. An increased focus on elective recovery had resulted in additional elective recovery income offsetting any in year pressures.
15.1.2.	The current full year capital plan equates to £104.3m of which only £80.2m scores against the Trust Capital Resource Limit (CRL). The Trust expects to meet its capital resource limit (with the final value to be confirmed) and is closely managing the programme internally and in dialogue with the NWL sector to achieve this position.
15.1.3.	The cash outlook remains resilient for the remainder of the financial year, assuming achievement of a break even position for the full year.
15.1.4.	Mr Alexander asked if Mrs Thind is assured that a break-even position will be delivered at 31st March 2022. Mrs Thind confirmed that all things being equal, the Trust is on track to achieve this position.
15.1.5.	**The Board noted the report.**
16.	**Board Summary Report: Finance, Investment & Operations Committee 9th March 2022**
16.1.1.	The Board received and noted the Finance, Investment & Operations committee Board Summary Report.

17.	**Annual Nursing and Midwifery Establishment Report**
17.1.1.	The Board received the annual report which provided a summary of findings from the annual nursing and midwifery establishment review and reports on whole time equivalent (WTE) changes to the nursing and midwifery establishment since the last review. The report also highlighted workforce plans, recruitment, and retention initiatives, to support safe and sustainable staffing, and address nursing and midwifery shortages.
17.1.2.	An annual nursing and midwifery establishment review took place in autumn 2021. In line with national guidelines, this included the collection of acuity and dependency data for ICHT in-patient and acute assessment areas, using the Safer Nursing Care Tool. The review also took into consideration, where appropriate, planned changes to service delivery, needs for additional bed capacity and stretch staffing requirements, to support the delivery of safe, effective, and sustainable nursing and midwifery care.
17.1.3.	The annual establishment review highlighted an increase of 37.2 WTE in the nursing and midwifery workforce when compared with the mid-year establishment review. This increase reflects the correct establishment requirements as of September 2021.
17.1.4.	Some services were subject to ongoing review, with establishment requirements still emerging. These would be reflected in the next mid- year review.
17.1.5.	The Trust was continuing to deliver against comprehensive strategic workforce plans for nursing and midwifery, which supported evidence-based establishment and skill-mix reviews.
	Questions and comments from the Non-Executive Directors
17.1.6.	Ms Scavazza highlighted that a deep dive into Nursing and Midwifery staffing had been undertaken by the People Committee and reported that the Committee were confident that the initiatives which were shared were innovative and will be effective in mitigating the Trust's position. The People Committee were assured that the activity in place in the Trust will support the Trust to secure the nurses and midwives the Trust requires to deliver safe care for patients. Ms Scavazza thanked the People & Organisational Development team and Prof Sigsworth for their ongoing work in this area.
17.1.7.	Mr Alexander commented that the actions resulting in the deep dive will be continued to be monitored through the People Committee work plan. Ms Scavazza confirmed the Committee will be focusing on this area throughout the year.
17.1.8.	**The Board noted the report.**
18.	**Board Summary Report People Committee, 8th March 2022**
18.1.	The Board received and noted the People Committee report.
19.	**Approach to Board effectiveness and Planning for Committee annual reports**
19.1.1.	Mr Jenkinson presented the report highlighting that the Trust will be launching the year end process of Board and committee effectiveness, and annual reporting through Committees. The Board noted that the effectiveness questionnaire will be circulated to Board members this week and results will be compared to responses received last year. The Committee annual reports will be presented to the Committees in May which will then be included in the Trust annual report.
19.1.2.	Mrs Boycott asked a question in regard to external Board effectiveness and asked if the Trust will be undertaking an external Board effectiveness exercise this year. Mr Jenkinson explained that foundation trusts are required to undertake external

	Board Effectiveness reviews every three years; however NHS Trusts do not have this requirement. Trusts will also undertake well led reviews through the CQC inspection process. Due to the Covid-19 pandemic and change of leadership, the Executive felt that this year was not the appropriate year to undertake an external review; however the Trust would receive assurance around some of the key controls and governance processes via the Trust's internal auditors.
19.1.3.	Mr Alexander agreed with this approach and added that external effectiveness review may be incorporated with all four Trusts in the Acute Provider Collaborative next year.
19.1.4.	**The Board noted the report.**
20.	**Board Summary Report: Audit Risk and Governance Committee, 10th March 2022**
20.1.1.	The Board received and noted the Audit Risk and Governance Committee report.
20.1.2.	Mrs Boycott highlighted that the Corporate Governance team had undertaken a large amount of work planning for next year considering the changes of leadership and different working across the acute provider collaborative; however highlighted that it will be an agile process in terms of reviewing and agreeing the Trusts assurance activities for next year.
20.1.3.	The Board noted that the Audit, Risk & Governance Committee had undertaken a deep dive into the Trust's technology assurance, working with internal audit services, with a particular focus on cyber security in the context of global security risks. Prof Orchard confirmed that the Trust has undertaken an in-depth analysis into cyber security of where they may be gaps and committed substantial amount of resource to ensure these gaps are mitigated. Mr Jarrold added that cyber security is a priority for the Trust and that the Executive have approved several investments which the Trust was moving at pace to implement.
20.1.4.	Mrs Boycott reported that the Committee noted the receipt of a fire safety improvement notice in respect of Western Eye Hospital and had considered the action plan in response. Progress on implementation of the plan would be reported to the Committee in July 2022.
20.1.5.	**The Board noted the report.**
21.	**Board Summary Report: Audit Risk & Governance; Finance, Investment & Operations, Redevelopment Board Governance "Lite" Committee 2 February 2022**
21.1.1.	The Board received and noted the report.
21.1.2.	Mr Alexander informed the Board that the summary reports and actions undertaken at the governance lite Committees have been reverted to the relevant Committees and will be considered within the Committee circle in March or 2022/23.
22.	**Board Summary Report: Redevelopment Board Committee, 8th March 2022**
22.1.	The Board received and noted the report.

23.	**Any other business**
23.1.1.	Mr Alexander informed the Board that this was the last Trust Board he will be undertaking as interim chair and thanked the Board for their effort and dedication leading the organisation over the past year.
23.1.2.	Mr Swindells introduced himself to the Trust Board and thanked Mr Alexander for his contribution to the Trust as Acting Chair. Mr Swindells was warmly welcomed.
24.	**Questions from the public**
24.1.	**Learning from Deaths**
24.1.1.	A member of the public raised a question in relation to the Learning from Deaths report and asked what procedures and processes are in place when a patient is discharged from hospital and dies outside of the hospital environment.
24.1.2.	Prof Redhead responded to the question and explained that the next stage in the learning from deaths process and journey will be that all deaths in both community and hospital go through the same process of reporting. The staff employed to complete the reports will be responsible to the trusts and directly reporting to the coroner.
24.1.3.	The member of the public followed up their question and asked whether there is a timescale for the reporting to be put in place. Prof Redhead confirmed that the timeline for the collaborative system will be the end of the year, subject to the publication of national guidance.
24.2.	**Palliative and End of Life care**
24.2.1	The member of the public acknowledged that there is a survey on end of life and palliative care published in North West London. The member of the public asked the Trust to explain the difference between palliative care and end of life care, and how much the Trust was involved in this survey which has been published.
24.2.2.	Prof Urch explained the difference between the palliative and end of life care. She also explained that the Trust was actively involved with the palliative care & end of life survey, and the Trust engaged with North West London colleagues in the community and hospital based systems. Prof Urch agreed to provide a report of the results when they are published. **Action: Prof Urch**
24.3.	**Discharge to Assessment**
24.3.1.	A member of the public raised a question in regard to discharge to assessment and asked what the Trust's view is on this matter.
24.3.2.	Prof Orchard explained that the Trust had undertaken the discharge to assessment process particularly during the pandemic and agreed that this was the right process for patients, providing that the patient is stable. Prof Orchard highlighted that the reason to undertake this process is to understand how the patient can function in their own normal environment and commented that when the process works well there is excellent communication with the hospital and community teams. He highlighted, however, that one of the challenges for the Trust now is to make sure that the Trust can continue to do it as well as it has been doing it as the Trust moves out of the Covid-19 emergency and make it business as usual.
25.	**Date of next meeting** Wednesday 25 May 2022 at 11:00.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Record of items discussed at the confidential Trust board meeting held on 16th March 2022 and the Board Seminar held on 20th April 2022

Agenda item 5 and paper B

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

Purpose: For information

Meeting: 25th May 2022

Executive summary

1. Introduction

1.1. Decisions taken, and key briefings, during the confidential sessions of a Trust Board are reported (where appropriate) at the next Trust Board meeting held in public. Some items may be excluded on the grounds of commercially sensitive or confidentiality.

1.2. The Trust Board has met in private on two occasions since the last meeting on 16 March 2022 and the Trust Board Seminar on 20 April 2022.

Private Trust Board – 16th March 2022

2. Chair's briefing

2.1 The Board approved the use of Chair's action outside of the normal meeting cycle to approve an urgent contract for the continued supply of gas for 2022/23.

2.2 Then Board welcomed Matthew Swindells as the new Chair across the four acute trusts in North West London, and received some introductory remarks regarding the vision for the Acute Provider Collaborative.

3. Chief Executive's update

3.1 The Chief Executive provided an oral update on operational issues, including the number of patients with Covid-19 being treated in our hospitals. An update was also provided on the Trust's preparation of its application, in conjunction with Imperial College London, for continued Biomedical Research Centre funding, ongoing engagement with the CQC, and the Trust redevelopment programme.

4. West London Children's Healthcare

4.1 The Board considered the proposed operating model for the collaborative provision of children's services with Chelsea & Westminster NHS Foundation Trust.

Board Seminar – 20th April 2022

5. The Board seminar focused on the strategic priorities and draft business plan for 2022/23, the development of proposed governance arrangements for the Acute Provider Collaborative, and an update on the Trust's plans and work to date in playing our part in reducing health inequalities and improving population health.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC) - ACTION POINTS REGISTER

Updated: 25 May 2022

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	16 March 2022 9	Integrated Quality & Performance Report	Mrs Hook agreed she would provide an update on the work being undertaken to improve the discharge process and what assurance the Trust has about how well it works. This update will be covered within the IQPR on the main agenda.	Mrs Hook	May 2022
2.	16 March 2022 24	Question from the Public	Prof Urch agreed to provide a report of the results from the Palliative & End of Life Survey when they are published.	Prof Urch	tbc

Items closed at the March 2022 meeting

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

3.	15 Sept 2021 16.10	EDI Annual Report	Mr Alexander requested that the wider Board receives an update on the prioritisation of work. Ms Scavazza concurred and advised that once progress had been discussed and agreed at the People Committee, a summary on priorities and metrics, including risks of not achieving some metrics and timings would be shared with Trust Board. January 2022 update: A workshop to review the Trust's EDI strategies with external experts, People Committee members and internal stakeholders had been posted from January to February. The 2022/23 EDI programme would be presented to the March People Committee. **March 2022 update:** The Workshop was delayed due to Covid-19 and VCOD. The Workshop has been rescheduled for 27th April and will feed into the Annual People and OD plan to be presented to May People Committee.	Mr Croft, Ms Scavazza	March 2022
4.					

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

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Chair's report - North West London Acute Trusts

Agenda item 7 and paper number D

Author: Matthew Swindells, Chair in Common

Purpose: For noting

Meeting date: 25 May 2022

North West London Acute Trusts – Chair's Report to the Trust Board

1. Firstly, Thanks

1.1. Before I do anything else, let me express my thanks to Bob Alexander who has done a fabulous job as interim Chair of Imperial College Healthcare NHS Trust. I am delighted that Bob will take on the role of Vice Chair, providing wise counsel to me.

2. Introduction to the Chair of the Acute Collaboration for the four trusts in North West London

2.1. Background

The Joint Chair / Chair in Common position was created to facilitate closer working between the four North West London (NWL) Acute trusts: Imperial College Healthcare NHS Trust; Chelsea and Westminster Hospital NHS Foundation Trust; The Hillingdon Hospitals NHS Foundation Trust; and London North West University Healthcare NHS Trust, building on the increased collaboration over the past two years that has helped the NHS in NWL respond to the pandemic. At the heart of our objective is the ambition to improve the health and care for individuals and communities by making the best that is available in NWL available to everyone in NWL, working with our partners in other parts of the NHS, in local government and the voluntary sector to help people stay well and improve their experience of care, and sweep aside the bureaucratic blockages to good decision making that occur when institutions are placed before patients.

I formally started as Chair in Common for the four Acute trusts in NWL on 1 April, although I attended three of the four Trusts' Board meetings (including Imperial) as a member of the public in March and also joined the weekly calls of the four trust Chairs during March to start to get up to speed.

2.2 A Bit About Me

I have had a long career in healthcare, as hospital Chief Executive, as Deputy Chief Executive and Chief Operating Officer for the NHS in England, in the Cabinet Office and as a Senior Vice President for the world's largest dedicated healthcare IT company, Cerner Corporation, where I ran their global business across 21 countries, whilst living in the US. Through these roles, I have had the opportunity to see some of the best healthcare delivery in England and the rest of the world. We have an exciting opportunity to turn NWL into the best health system in England and a place that is admired around the world, I hope to bring my experience to bear in helping that to happen.

2.3 First Steps

Over the next couple of months I shall be taking the opportunity to speak to as many people as possible and get to know our organisations in more depth. I am not walking into the chair role with a manifesto. I want to find out what really matters to communities, staff and patients. I am looking forward to working with the excellent leadership teams at each trust to understand how I can best support them and their goals. I plan to be a very visible chair and to get out and about, though I will most definitely not be getting involved in any day-to-day management!

If you step back and take the perspective of our population, there are some obvious priorities. We have to reduce waiting lists and waiting times for surgery, we need to speed the flow through our A&E department, we need to recover the quality of patient experience in all departments to its pre-COVID levels, we need to support our staff coming out of the pressures of COVID and we need to enhance our efforts to ensure access to care is fair to everyone in our population. Working ever closer with other NHS and care partners will be key to this - if care can be better provided at home or by a GP, social worker or community nurse, then we must support that. And, finally, we have some big sustainability issues to get to grips with, not least improving much of our estate and getting on top of our finances for the long term.

3. Our Staff

As everyone will be aware, the NHS has a major workforce challenge. As we emerge from the extraordinary experience of the pandemic and into the pressures it has compounded, we have to create working environments that are so much better than what we accepted before. It's vital that we are organisations which represent the communities we serve, where people feel passionately about their work and are truly valued and included, whatever their background, role or place of work. It is our staff who will make or break collaboration - they will need the right space and support to work with our partners, patients and communities to change the way healthcare is provided.

Significant investment has been made in Health and Well-being (H&WB) programmes to support staff through this unprecedented period.

On behalf of the Trust Board, we would like to express our gratitude to the Trust staff and Executive Team for their hard work and resilience throughout the pandemic to maintain a high standard of care.

The entire organisation has now been operating at or above capacity for two and a half years since the start of the winter pressures in October 2019 and is continuing to face major ongoing challenges dealing with the current Covid wave.

4. NWL Acute Collaborative / NWL Integrated Care System (ICS)

The NWL ICS and the NWL Acute Collaborative cannot individually succeed without both succeeding.

ICSs have a huge agenda across multiple settings and will be key in helping us all to navigate the massive complexity of health and care. They have great potential to transform health and reduce health inequalities but it will require all partners to work together to ensure that potential is delivered. Although the legislation that formally brings ICSs into being has only just been passed by Parliament, the NWL ICS has already made a great start in defining its priorities.

All four Acute Trust Boards across NWL have had a chance to meet with the new ICS Chair, Penny Dash, and the new ICS Chief Executive, Rob Hurd, to discuss these priorities:

- Improving outcomes in population health and health care
- Preventing ill health and tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money

- Supporting broader economic and social development

As part of delivering this agenda the ICS will be working closely with, and relying on, the Acute Collaborative to play our part, which we are wholly committed to doing.

5. Update

As I said in my interview for the hospital websites, which can be seen here: my first few weeks have been mostly about getting to know people. I have spent time at all four Trusts, met the NEDs and am starting to get to know the executive leadership. I hope that in the next few weeks I will be able to spend more time walking about the hospitals talking to staff on the front-line.

Bob Alexander has done a fantastic job as the interim Chair of the Trust participating in meetings with the Chief Executive and the other Trust Chairs that addressed: COVID-19 Omicron variant; the ongoing Elective Recovery programme; the NWL ICS Development plan and 'road map'; NHS England/Improvement (NHSE/I) guidance on Provider collaboratives; Urgent & Emergency Care, with a focus on Ambulance response and handover times plus hospital discharge pathways.

Since I joined in April, there has been a particular focus agreeing our operational and financial plans for the coming year to address the challenge of reducing waiting times, whilst dealing with the ongoing pressures of emergency demand and the impact of COVID.

During February and March as part of the work on the NWL Acute Provider Collaborative, the NWL Acute Trust Chairs continued to have weekly meetings, from mid-February I joined these meetings as the NWL Acute Joint Chair designate. From April onwards these meetings have continued with myself and the 4 NWL Acute Vice Chairs.

I am starting the process of speaking to the governors / patient voice representatives across our four Trusts to ensure that we have a strong patient and public engagement across all of North West London.

I also have had my first meetings with the leaders of our local authorities and look forward to meeting with them all over the next few weeks. And, I have met with Rt Hon Jacqui Smith, the Chair of the North East London Acute Collaborative, incorporating Barts and the London Trust and Barking, Havering and Redbridge Trust, to ensure that we learn from each other's experiences of developing an Acute Collaborative.

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TRUST BOARD (PUBLIC)

Paper title: Staff Story

Agenda item: 8 and paper E

Executive Director: Kevin Croft, Director of People and OD

Author: Sue Grange, Deputy Director of People and OD

Purpose: For noting

Meeting date: 25 May 2022

Executive summary

1. Purpose of this report

1.1. The purpose of this paper is to provide a summary of the first staff story to be presented at the Trust Board and note the recommended next steps.

2. Introduction and background

2.1. In September 2021, the People Committee agreed to trial the use of Staff Stories initially at People Committee and to be extended to Trust Board in 2022/23. The agreed aims would be:

- To triangulate staff experience from a staff story with the quantitative data that is usually presented at Board level
- To raise awareness of the staff experience to inform Board decision making
- To support improvements in the staff experience
- To provide assurance in relation to the staff experience at the Trust (assuming stories will feature positive as well as negative experiences) and that the organisation is learning from poor experiences.

2.2. Three staff stories have been taken to People Committee as part of this trial. This is the first Staff Story that has come to Trust Board.

3. Key Findings

3.1. The story presented will be told by Raakhee Nagar, a senior occupational therapist in the Major Trauma and Neuro-outliers team. Raakhee has worked here for four years and her story gives insight into her experiences of equality diversity and inclusion incidents in her day to day clinical role, and what she has tried to do as a frontline member of staff to address this locally and to take action in her team to create a culture of inclusion in the workplace.

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3.2. Raakhee joined the Trust four years ago and was keen to get involved in the BAME network and also joined an Allied Health Professionals Race Equity group, where she was able to share experiences and ideas for improvement.

3.3. Throughout her time here, she and her colleagues have experienced racist comments and poor behaviours from both patients and colleagues on a frequent basis. She cites seeing at least 1-2 datix incidents logged per month relating to racist comments. These are upsetting for all staff involved and notes that many staff are reluctant to take action when these occur. Raakhee has made a personal commitment to take action, and she aims to role model to others. This will typically take the form of calling out the action in an appropriate and kind way but making it clear when behaviours are not acceptable.

3.4. In addition, Raakhee has developed and delivered her own training session for her team and colleagues on "Creating a culture of inclusion" in her team. In this she has worked with her colleagues to all create pledges and commitments to action such as

- To be more active in EDI discussions regarding racism in the workplace by educating more people about the harmful effects of racism
- To do the active bystander training and to have more confidence in standing up when I see something inappropriate
- To be more aware of boundaries and speaking up when something is unacceptable
- To have the confidence to step in/intervene if I see/hear challenging behaviour between staff members
- To ask for feedback from all members of the team regarding observed practise
- To ensure there are professional boundaries maintained in the office and to ensure that everyone is comfortable with the topics being discussed
- To create a better rapport with colleagues
- To be mindful and respectful of differences and put yourself in someone else's shoes before speaking
- To try to be an active bystander and address situations professionally and to complete the course
- To be more comfortable with challenging my own unconscious bias when recruiting
- To be more open and honest to raise issues when I am uncomfortable and encourage others to do the same
- To think about how to phrase questions to establish information about others i.e. culture and language for interpreters.

Raakhee plans to follow this up with a review session and to also deliver bite sized sessions in team meetings on "unconscious bias" and "equality versus equity".

3.5. This is an example of exemplar action from a local team to promote a culture of inclusion in a frontline team, and the type of action that we would like to see in all teams in order to achieve our stated ambitions in our Equality Diversity and Inclusion goals.

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3.6. There are a number of Trust initiatives which have helped Raakhee achieve success which include the support of the staff networks where she gains support and an opportunity to share experiences, as well as the Active Bystander training.
The Therapy leadership team have also provided support; they were the first to undertake the team EDI training and also actively support the Trust inclusive recruitment training. Senior Colleagues support junior colleagues from a BAME background through coaching and career development support.

3.7. Equally there are many things which she would like to change which she feels she cannot influence in her position such as the lack of diversity in senior levels of the organisation, to increase the number of people who support the white ally programme and to have support for how we improve our response to staff who are verbally abusive to staff.

4. Key Learning and action

4.1. It is important that the Trust central work programmes do encourage and support local managers and team leaders to lead work like this example. There are number of Trust actions already planned which aim to support this such as:

(i) Continued roll out of the active Bystander training (265 attended in 2021/22).
(ii) Local and trust wide EDI groups for staff to network and discuss and implement changes.
(iii) Local champions for EDI and BAME Ambassadors to discuss any issues or for advice.
(iv) Development of training in handling verbal aggression from patients (as part of the violence and aggression action plan).
(v) Continued roll out of the new toolkits on Micro-aggressions, Talking about Race and Being an Ally.
(vi) Review the follow up processes for Datix incidents which relate to equality, diversity and inclusion incidents, in terms of follow up to staff and action.
(vii) Review how we respond to incidents of verbal abuse to our staff.

5. Next Steps

5.1. Work on this will continue through the Equality Diversity and Inclusion Committee during 2022/2023.

6. Recommendations

6.1. The Board is asked to:
(i) NOTE the findings of this story and the recommended next steps.

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7. Impact Assessment

7.1. Quality impact: The engagement of staff, and provision of good staff experience will impact on the quality of care received by our patients at ICHT crossing all CQC domains.

7.2. Financial impact: Staff engagement will have a link to turnover, retention and financial impact of vacancy rates, bank and agency spend.

7.3. Workforce impact: The paper highlights the importance of our work in equality, diversity and inclusion in maximising retention, recruitment and engagement of staff with disabilities.

7.4. Equality impact: The aims of the proposal are to listen and ensure improvements are being made to workforce and staff engagement and also to the experience of staff in relation to equality diversity and inclusion.

7.5. Risk impact: The engagement of staff will link directly to risks of retention and turnover.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Chief executive's report

Agenda item 9 and paper F

Lead executive director: Prof Tim Orchard, Chief executive

Purpose: For noting

Meeting date: 25 May 2022

Chief executive's report to Trust Board

This report includes key updates on:

- Operational performance and issues
- Covid-19 and flu vaccination programme
- Financial performance
- Maternity assurance report
- Monkeypox
- Redevelopment
- Estates issues
- Research
- Staff survey
- Stakeholder engagement
- Recognition and celebrating success

1. Operational performance and issues

1.1. The number of patients we are caring for with Covid-19 has slowly decreased over the last month but Covid-19 remains a significant presence in our hospitals – about 12% of our available beds are currently occupied by patients with Covid-19.

1.2. This position, combined with high numbers of attendances to our emergency departments, increased levels of staff sickness and the challenges of returning to pre-pandemic levels of elective activity mean our services remain under pressure. I am hugely grateful to all our staff for their dedicated work and flexibility during this busy time; it has made a big difference for patients and staff in the areas experiencing the immediate impacts.

1.3. Notwithstanding the operational challenges we currently face, the whole NHS must maintain its renewed focus on tackling the backlog of elective care. As of March 2022, the Trust was back to 90% of its pre-pandemic planned care activity overall, up to 120% of pre-pandemic outpatient activity, and 97% of total pre-pandemic diagnostic testing. We continue to increase our non-urgent planned care activity and are committed to providing over 100% of pre-pandemic planned care capacity throughout 2022/23 to help us achieve a sustainable reduction in overall waiting times.

1.4. One of the most significant operational pressures facing the NHS as a whole in recent months has been lengthy ambulance handover times. Our hospitals have worked to minimise these and the impact on patients wherever possible, and have consistently

achieved some of the shortest handover times in London. We will continue to work with our partners across north west London to ensure a sustained improvement for our patients and populations.

Incremental changes to Covid-19 measures

1.5. Reflecting changes to national guidance, the Trust began implementing new approaches to self-isolation and Covid-19 testing for patients from Monday 26 March. We no longer require all patients having a planned procedure or surgery to self-isolate in advance. We are also phasing in a move from universal PCR testing for planned surgery patients to instead asking most to take only a lateral flow test on the day of their procedure. We are giving particular consideration to patients most vulnerable to severe disease from Covid-19 who may need to continue to have a PCR alongside a lateral flow test. Other patients admitted to hospital will continue to need to have a PCR test daily during their first seven days but will no longer require a weekly PCR test after that seven-day period.

1.6. We have updated our visiting guidance to be broadly in line with the latest national guidance, now allowing two visitors for at least an hour in most situations. We are encouraging outpatients to attend without anyone else wherever possible while limiting emergency department attendance to patients only unless there are exceptional circumstances.

1.7. These changes to Covid-19 infection prevention and control measures build on other recent changes and more changes will follow as our clinical reference group and operational teams work through all of the implications of updated national guidance. We are working to keep everyone as safe as possible while putting in place new ways of working that enable greater operational flexibility as quickly as possible.

2. Covid-19 and flu vaccination programme

2.1. The Trust is continuing to provide a comprehensive vaccination programme for our staff and wider community. Uptake of vaccinations in our frontline staff on 10 May is as follows:

- 61.15 per cent have received their flu vaccination
- 92.15 per cent have received doses one and two of the Covid-19 vaccination
- 87.35 per cent of those eligible have received their Covid-19 booster.

2.2. The Trust has worked with the north west London vaccination programme team to implement NHS England guidance for the delivery of the Covid-19 Spring booster campaign which was recommended by the Joint Committee on Vaccination and Immunisation (JCVI) for over 75 year olds and any clinically extremely vulnerable person over the age of 12. Surge contingency planning is included in this sector activity.

2.3. We have completed an outreach programme to administer Covid-19 Spring booster vaccinations to our renal dialysis patients as they attend their appointments in renal dialysis satellite units. This has improved vaccination accessibility for hundreds of our most vulnerable patients. Other clinically extremely vulnerable patients continue to receive their vaccinations in our on-site hospital vaccination centres.

2.4. The St Mary's Hospital site continues to offer a vaccination clinic for 5-11 year olds who are most at risk of Covid-19 when it is clinically safer for the patient to receive this vaccination in a hospital setting. A referral process has been established with NWL primary care networks to ensure children are able to receive their vaccinations where it may not be suitable to have this at school or local vaccination centres due to allergies or being extremely clinically vulnerable.

2.5. NHS England are expected to provide planning guidance for the autumn/winter booster campaign of the national vaccination programme. We will work with the north west London vaccination programme team to plan how the Trust can best support the ongoing needs of our staff and local communities.

3. Financial performance

3.1. At the end of the 2021/22 financial year, the Trust has reported a £83k surplus against a breakeven plan, driven by additional income received for delivering increased levels of elective activity via the elective recovery fund.

3.2. The updated gross capital plan for the financial year equated to £99.1m of which £19.7m was funded through grants and donations. Against a revised Capital Resource Limit of £79.4m, the Trust spent £78.8m (99%) which was marginally (£0.6m) below plan but a great achievement given the level of national funding announced and secured in the latter part of the financial year.

3.3. The cash balance at 31 March 2022 was £238m. Draft accounts have been submitted and are subject to audit, which is now in train.

2022/23 plan

3.4. For the 2022/23 financial year, the Trust has submitted an operational, workforce and financial plan that meets the national requirements in relation to elective recovery and continues to form part of the overarching North West London Integrated Care System (NWL ICS) consolidated submission.

3.5. Our operational plan confirms the Trust will deliver 10% additional activity over and above the 2019/20 baseline position and provide clinically appropriate follow-ups in the right setting so we see more patients as first appointments and reduce waiting times for those waiting for care.

3.6. Our financial plan takes account of national guidance and reflects the agreed set of North West London Integrated Care System (NWL ICS) wide principles and assumptions, allowing for the level of resource required to deliver the operational requirements.

3.7. The funding regime mirrors that of 2021/22 with the Trust receiving its core income via block contract arrangements, with the ability to secure additional funding for performance above the 2019/20 baseline activity levels through the Elective Recovery Fund and includes a 3% efficiency target.

3.8. In line with the agreement reached across the NWL ICS, the Trust's assessment of the estimated unfunded inflationary cost pressure is cited as an unmitigated risk, the outcome of this results in the Trust approving and submitting a £10m deficit plan.

3.9. Our workforce plan represents the Trust's known and agreed investments, agreed cost pressures, recovery and activity plans, service changes and developments and efficiency opportunities for the period April 2022 to March 2023. This has been a collaborative and partnership approach between finance, activity teams and divisional colleagues to ensure consistency and planning triangulation.

4. Maternity assurance report

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

4.2. The Quality Committee reviewed the detailed maternity assurance documentation in May with assurance gained about the management of risks, incidents and key metrics.

4.3. The final Ockenden report was published on 30 March 2022 following the independent review into maternity services at The Shrewsbury and Telford Hospital NHS Trust. We completed a benchmarking exercise of the 15 immediate and essential actions and have developed an action plan to address required service developments and improvements. This is included as a separate agenda item in the public board meeting.

4.4. The report included a summary of our performance in the CQC maternity survey 2021. We performed well compared to other trusts, and our performance is similar in most areas to our 2019 results, despite the impact of the pandemic (the survey was completed during the second surge in January-February 2021). One question scored somewhat worse than other trusts which was related to taking personal circumstances into account. Care has since returned to pre Covid-19 pathways and there are actions in place to improve performance.

4.5. The refurbishment of our theatre suite at Queen Charlotte's and Chelsea Hospital is progressing well and is expected to be completed by 30 May. This is the outstanding action in response to the Morecombe Bay benchmarking exercise and the key maternity directorate risk; both will be able to be closed once the work has finished.

5. Monkeypox

5.1. As of 18 May, our specialist teams are treating a patient diagnosed with monkeypox in our high consequence infectious diseases unit at St Mary's Hospital. The unit is specifically designed so we can treat patients with infectious diseases in isolation while keeping the rest of our ward and hospital site safe.

5.2. There are now several cases of confirmed monkeypox in London and in Portugal. It is a viral infection usually causing a mild, self-limiting illness. It is spread by very close contact with an infected person and most people recover within a few weeks. The virus does not spread easily between people and the risk to the UK population is low.

5.3. We are following national guidance and robust infection control procedures to keep our staff and patients safe. NHS advice is to contact your GP or call 111 if you have a rash with blisters and either you've returned from west or central Africa in the last three weeks or you've been in contact with someone who has monkeypox in the last three weeks.

6. Redevelopment

6.1. The Trust is working with master planning architects to develop phased options for the delivery of the new hospital and potential development opportunities on the remainder of the St Mary's Hospital site. This work is due to be completed in summer 2022. As part of this process we have had early engagement with Westminster City Council to discuss some principles to shape the planned developments.

6.2. The St Mary's Hospital Strategic Outline Case submitted in September 2021 has been reviewed by the regional NHS England/Improvement team. A date for the formal review with the national New Hospital Programme team is being discussed.

6.3. Work continues developing plans for our Charing Cross and Hammersmith Hospital sites. Options are being reviewed and preferred plans will be identified towards the end of this calendar year.

7. Estates issues

Western Eye Hospital

7.1. We are progressing building works at the Western Eye Hospital to allow us to restore our full range of services there later this year. We had to temporary relocate some services in November 2021 due to fire safety concerns relating to the adjacent, vacant Samaritan Hospital.

7.2. We have developed a short business case for the costs of the fire safety remediation work as well as the creation of an additional ophthalmology theatre suite to help tackle the long waiting lists that have built up during the pandemic. We anticipate these works will be funded through NHS England's 'targeted investment fund'.

7.3. In the meantime, we continue to provide eye surgery displaced from the Western Eye at Charing Cross Hospital, including in an additional mobile operating theatre.

Gynaecology day surgery unit, St Mary's Hospital

7.4 A fault in the ventilation system in the gynaecology day surgery unit meant we had to close both theatres within the unit on 24 April. Following emergency repairs, both theatres were re-opened on 10 May.

8. Research

8.1. As part of the selection process in the competitive re-application for our National Institute for Health Research (NIHR) Biomedical Research Centre (BRC), a senior panel of Trust and College representatives attended an interview on 8 April, with an international selection panel and the DHSC/NIHR. The outcome of the competition will be announced in June 2022.

8.2. Despite the challenges of Covid-19 and related pressures, we continue to deliver a wide portfolio of clinical research. In 2021/22, the Trust recruited 14,084 patients and healthy volunteers into 442 separate studies in total (12,309 of these patients were recruited into 426 NIHR portfolio studies). More than 850 studies were open at some point during the year.

8.3. We had more portfolio commercial studies open in 2021/22 (318) than in any previous year. We have increased revenue (£8.15m) and overhead income (£1.49m) from commercially sponsored clinical trials.

8.4. We have launched an initiative to significantly improve our study set-up times, with the aim of being the most competitive in the country.

8.5. Trust research and innovation has featured in a number of high profile media stories over the last quarter, including:

- The 'ENO Breathe' programme developed by the English National Opera (ENO) and respiratory clinicians at the Trust, which uses singing techniques to improve wellbeing for patients with persistent breathlessness due to Covid-19.
- The psychological impact of miscarriage.
- The use of ultrasound to detect prostate cancers.
- The recycling of face masks with the aim of turning them into bed-pans, prosthetics and other products that can be used in healthcare delivery

9. Staff survey

9.1. Results of the 2021 national staff survey, published on 31 March 2022, have been widely disseminated across the Trust and organisational and local action planning is now underway.

9.2. The results showed we continue to have higher than average engagement and morale amongst our workforce compared with other acute trusts. We perform especially well for staff saying that the care of patients is our number one priority and for recommending our organisation as a place to work and to be treated. Our trust scores better than average on questions under the 'NHS people promise', 'we are always learning'.

9.3. However, scores for staff engagement and morale have dropped by 0.2 points and 0.3 points, respectively, across both our own organisation and all acute trusts from the 2020 survey. And, while no other themes can be compared over time due to changes in how the survey questions are now structured, we scored below average for 'promises' where we are already committed to major improvement – 'we are compassionate and inclusive', 'we are recognised and rewarded', and 'we are a team'. In particular, the latest survey results show that we have much to do to improve fairness and to tackle discrimination.

9.4. We are developing a quarterly map of key areas of focus to ensure that there is a clear and manageable phasing of the action and to maximize the visibility of the actions to frontline staff. Progress will be monitored through the divisional oversight meetings. Full details are included in a separate paper to the public board meeting.

10. Stakeholder engagement

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

- North West London Joint Health Overview & Scrutiny Committee: 9 March 2022
- London Borough of Hammersmith & Fulham Health, Inclusion and Social Care Policy and Accountability Committee: 23 March 2022
- Karen Buck MP for Westminster North and Andy Slaughter MP for Hammersmith: 6 April 2022

11. Recognition and celebrating success

11.1. Juliet Albert, a specialist midwife at the Trust, has been awarded £261,000 from Higher Education England / NIHR for a Career Development Research Fellowship to improve specialist services for women who have experienced female genital mutilation.

11.2. Four of the Trust's clinicians and researchers have been elected to the Fellowship of the Academy of Medical Sciences for their work in biomedical and health research. The researchers are among 60 outstanding biomedical and health scientists to be elected Fellows of the Academy of Medical Sciences (AMS) this year. The new Fellows are Professor George Hanna, Professor Iain McNeish, Professor Shiranee Sriskandan, and Professor Anthony Gordon. They will be formally admitted to the Academy on 27 June 2022. This is an incredible achievement and well deserved recognition for their vital research.

11.3. Imperial College London has ranked first in the UK for research in the Research Excellence Framework assessment this year. This is an outstanding achievement and reflects the College's commitment to both discovery-led research and the translation of that work into tangible benefits for society.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Integrated quality and performance report scorecard month 12

Agenda item 10 and paper G

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

Purpose: For discussion

Meeting date: 25 May 2022

1. Purpose of this report

1.1. This enclosed scorecard summarises performance against the key performance indicators (KPIs) for data published at March 2022. A summary of the performance headlines is provided in the main section below. April figures are included where available

1.2. Countermeasure summaries are also provided with actions linked to the March 2022 performance. The actions associated with April performance are being updated and will be reported through the executive management board meeting late May 2022.

2. Executive Summary

2.1. Overall elective activity continued to recover in March 2022. A total of 9,487 elective spells (day cases and overnight admissions) were completed which was at the highest level since November 2021. The final NHS operating plan trajectories for 2022/23 were submitted by the ICS on 28 April 2022. All KPIs will now be aligned to these trajectories.

2.2. In March 2022, the elective waiting list increased as did the number of patients waiting over 52 weeks for treatment. Good progress was made against the cancer 62-day waiting times standard and 28-day faster diagnoses continued to improve.

2.3. There was a significant reduction in Ambulance handover breaches over 30 minutes at the St. Mary's site in April 2022, and performance has returned within statistical control limits. For April, 1,077 patients waited over 12-hours waits in the emergency department from time of arrival, from a peak of 1,320 in the previous month.

2.4. Our incident reporting rates increased, with performance at its highest since before the pandemic which is positive. Our mortality rates remain low, although an in-depth review into a slight regression in our HSMR ranking is in progress. Unfortunately, a fifth never event occurred in March 2022 (declared in April 2022). Local immediate actions have been implemented.

3. Approval process

3.1. Elements of this integrated quality and performance report are discussed at Divisional oversight and EMB quality subgroup meetings in advance of EMB and the Board.

4. Recommendation(s)

4.1. The Board committee members are asked to discuss the contents of this report.

5. Next steps

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

6. Impact assessment

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

6.2. Financial impact: Integrated Care Systems (ICSs) are responsible for delivering plans for elective activity. The funding mechanisms for 2022/23 are still being clarified but it is expected that funding will be available via the national elective recovery framework for achieving minimum activity levels above 2019/20 baseline levels.

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

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

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

Main report

7. Operating plan – elective recovery position

7.1. Overall elective activity continued to recover in March 2022. A total of 9,487 elective spells (day cases and overnight admissions) were completed which was the highest volume since November 2021. The H2 trajectory was to increase elective activity to 11,824 spells in March 2022, accounting for the drop to 80.2% achievement in the March scorecard. The table below provides the actual activity figures for H2.[1]

Metric	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Number of elective spells - actual	9,020	9,877	7,940	7,962	8,728	9,487
H2 trajectory	9,555	10,780	9,276	9,366	9,751	11,824
% against trajectory	94.4%	91.6%	85.6%	85.0%	89.5%	80.2%

[1] Figures may be subject to minor changes as a result of retrospective changes and data completeness

8. Month 12 (March 2022) performance

Referral to Treatment

8.1. The overall size of the RTT waiting list increased which follows the overall upwards trend over the last year. 82,657 patient pathways were reported for March month end (+2,119 pathways on the previous month). Further analysis into contributing factors is ongoing. 1,662 patients were waiting over 52 weeks which did not achieve the trajectory of 908 by end March 2022. Unfortunately, there were 2 patients waiting over two years for treatment against the trajectory of 0. Both patients were since treated.

Diagnostics

8.2. In March 2022, 12.9% of patients were reported as waiting more than 6 weeks for their diagnostic test against the 1% target. The Endoscopy and Neurophysiology services both continued to report significant improvement.

Cancer waiting times

8.3. In March 2022, the 62-day GP referral to first treatment performance was 69.6% against the 85% standard, bringing the level of performance back up to within statistical control limits following a run of special cause decline since the autumn last year. Good progress continues to be made against the 28-day cancer faster diagnosis standard, formally launched October 2021, with performance of 73.4% (FDS 2ww).

Urgent and Emergency care

8.4. In April 2022, the Trust's Ambulance handover performance (within 30 minutes) was 89.4%, bringing performance back within statistical control limits. This was driven by a significant reduction in 30 minute handover breaches at the SMH site. The number of patients waiting over 12 hours within the emergency department from time of arrival remains high, across both the SMH and CXH sites. In April 2022 there were 1,077 such patients, from a peak of 1,320 in the previous month.

Update on discharge process - following discussion at March 2022 Board meeting

8.5. In April 2022, there was an average of 202 patients with a length of stay of 21 days or more against a target of 167. The main factors are increasing patient need, infection control measures, adult social care market dynamics, local policy changes and staffing challenges across the system. For comparison, the pre-pandemic average for the same period was 220.

8.6. Trust-wide performance and improvement plans are overseen by the UEC Programme Board and informed by the Long Length of Stay Taskforce. This framework brings together tri-borough system partners to (i) review effectiveness of discharge systems and processes (ii) hold each other to account and (iii) report into the NWL ICS Urgent Care Board. Some local place-based Integrated Care Partnerships (ICPs) are now adopting hospital discharge as a key priority, particularly the bi-borough ICP covering Westminster and Kensington & Chelsea, and this provides further opportunity for high level collaboration.

8.7. In partnership with Central London Community Healthcare NHS Trust, a joint role was created in 2021 to lead on integrated discharge hubs which are now operating on our three main hospital sites. The hubs themselves are staffed by ICHT specialist discharge nurses, co-ordinators and hospital social workers employed by Local Authority partners. This multi-agency approach allows decisions to be made in partnership with teams across health and social care. This is particularly important where there is a need for some form of ongoing care following admission to hospital.

Focus for the year ahead

8.8. A key area is on improving daily routines for board rounds, through a Trust-wide 'focussed-improvement' effort. There is evidence of improvements already for some early ward adopters, with plans for full scale rollout for the summer / early autumn 2022.

8.9. Although reducing the number of medically optimised patients is not fully within the Trust's direct influence, the focus of partnership work for the year ahead is to:

- *Maximise the impact of the virtual ward and remote monitoring systems*
- *Embed joint screening of discharge referrals with hospital social work leads*
- *Digitisation of the Discharge to Assess referral process (September 2022)*
- *Make the case for an adapted model of commissioned step down and neuro rehabilitation beds, where demand locally outstrips the current supply*
- *Strengthen materials offered to admitted patients to manage expectations*
- *Test the effect of Criteria Led Discharge to improve weekend discharge*

8.10. Up until this point, the emphasis has been on embedding new models and coordinating policies with partners. A key priority for 2002/23 will be to gain feedback from patients and their families or carers into experiences of hospital discharge, provide quality assurance and inform ongoing improvements.

Quality – safe and effective

8.11. Our harm profile remains good despite the ongoing impact of the pandemic, with a lower than average 12-month percentage of incidents causing moderate and above harm. In March, our incident reporting rates increased, with performance at its highest since before the pandemic which is positive. This is being partly driven by a change in the way we report admission delays in the emergency departments; previously we used to only report 12-hour trolley breaches for patients who were waiting for a mental health bed to become available, however from February 2022 we have begun reporting all 12-hour trolley breaches and 1-hour ambulance handover delays as incidents to ensure that these are captured appropriately and investigated through our normal processes in line with other patient safety incidents. Even without this change in practice, our reporting rates would have improved in March. Trustwide actions and focused improvement work are progressing following a pause during the recent surge.

8.12. Our mortality rates also remain low, however we are progressing an in-depth review into a slight regression in our HSMR ranking, as although our rolling 12 month HSMR has improved from 72.0 (December 2019 to November 2020) when we had the lowest HSMR in the NHS, to 69.20 (December 2020 to November 2021), our HSMR is now 7th lowest. Investigation so far shows that Covid death coding is likely to be one of the drivers. This will report to the Quality Committee in July 2022.

8.13. We are continuing to see blood stream infections related to sub-optimal line care practices, with one MRSA BSI and one CPE BSI reported in March 2022. Targeted local intervention is occurring in response when cases are reported, and since the cluster in paediatric haematology in 2021 there have been no areas with repeat issues. The trustwide action plan in response, and the development of the two programmes to provide improved long-term education, training and support for staff for central line management and insertion, and for IPC practice more widely, are progressing.

8.14. A fifth never event occurred in March 2022 (declared in April 2022). Insulin was drawn up from a pen device and an incorrect dose administered to a patient in our paediatric emergency department. This is the same as a previous never event which occurred in 2020 in critical care. A trustwide safety alert was issued in April the medical director met with the service, following which assurance was provided that local immediate actions have been implemented to prevent recurrence. A full review of diabetes management and education is planned to identify further trustwide improvements.

Appendices:

1. Trust Board integrated performance scorecard – month 12
2. Countermeasure summaries – month 12

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard - Board Version

Imperial Management and Improvement System (IMIS)

FI = Focussed improvement

M12 - March 2022

Section	FI	Metric	Watch or Driver	Target / threshold	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Reporting rules	SPC variation
To develop a sustainable portfolio of outstanding services																			
Quality safety improvement	FI	Patient safety incident reporting rate per 1,000 bed days	Driver	**>=65.6**	52.90	47.50	54.58	58.73	57.96	53.97	53.94	52.57	58.30	55.26	49.22	52.54	62.83	CMS	-
		Healthcare-associated (HOHA + COHA) Trust-attributed MRSA BSI	Watch	**0**	0	0	1	2	0	0	1	3	0	1	1	1	1	Note performance / SVU if statutory	-
		Healthcare-associated (HOHA + COHA) Trust-attributed C. difficile	Watch	**8**	7	3	7	6	6	10	4	7	4	2	8	8	6	-	-
		Healthcare-associated (HOHA + COHA) E. coli BSI	Watch	**12**	6	7	4	6	12	6	15	11	8	12	11	5	8	-	-
		CPE BSI	Watch	**0**	1	0	0	0	0	0	0	0	0	0	0	0	1	Note performance / SVU if statutory	-
		% of incidents causing moderate and above harm (rolling 12 months)	Driver	**<2.67%**	1.55%	1.53%	1.39%	1.32%	1.29%	1.30%	1.31%	1.27%	1.19%	1.18%	1.23%	1.28%	1.31%	Promote to Watch	-
		Hospital Standardised Mortality Ratio (HSMR) (rolling 12 months)	Watch	**<=100**	73	76	76	76	76	71	71	70	67	68	67	69	70	-	-
		Formal complaints	Watch	**<=100**	95	77	53	77	83	75	83	96	73	67	66	92	82	-	-
Response and Recovery		Elective spells (overnight and daycases) as % of trajectory target	Watch	**100%**	-	103.3%	97.6%	115.0%	88.2%	88.4%	91.6%	94.4%	91.6%	85.6%	85.0%	89.5%	80.2%	Switch to Driver	-
		Outpatient attendances (all) as % of trajectory target	Watch	**100%**	-	106.9%	101.9%	117.8%	100.2%	105.6%	101.0%	103.4%	109.2%	93.7%	106.7%	105.2%	102.1%	-	-
		Completed RTT Pathways (Total clock stops)	Watch	**16,506**	-	14,872	14,929	17,315	16,820	14,360	15,081	17,331	18,250	16,225	18,258	17,787	21,385	-	-
		RTT waiting list size	Watch	**76,585**	62,763	65,753	68,242	72,362	74,437	75,500	76,585	78,533	80,050	80,667	79,218	80,538	82,657	Switch to Driver	SC
		RTT 52 week wait breaches	Driver	**908**	2,374	2,157	1,837	1,467	1,464	1,516	1,515	1,605	1,650	1,781	1,605	1,559	1,662	CMS	CC
		% clinical prioritisation (RTT inpatient waiting list – surgical)	Watch	**>=85%**	89.4%	89.4%	89.2%	91.3%	91.6%	91.7%	92.0%	94.7%	93.9%	86.4%	88.7%	93.7%	93.9%	-	-
		Diagnostics waiting times	Driver	**1.0%**	38.8%	36.4%	36.6%	36.9%	33.2%	29.8%	27.0%	22.9%	20.6%	22.1%	18.6%	11.7%	12.9%	CMS	SC

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard - Board Version

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M12 - March 2022

Section	FI	Metric	Watch or Driver	Target / threshold	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Reporting rules	SPC variation
continued		Cancer 2 week wait	Watch	>=93%	94.9%	93.4%	95.0%	93.4%	93.1%	94.2%	91.5%	86.8%	80.4%	71.7%	71.6%	73.7%	74.4%	Switch to Driver	SC
		Cancer 62 day wait	Driver	>=85%	79.1%	80.6%	78.7%	74.7%	73.8%	81.0%	73.9%	76.3%	66.7%	62.6%	52.0%	57.9%	69.6%	CMS	SC
		Cancer 28-day Faster Diagnosis Standard (2ww)	Driver	75%	-	65.0%	64.0%	66.2%	65.5%	60.6%	62.5%	67.9%	66.7%	64.0%	60.7%	71.4%	73.4%	CMS	-
		Ambulance handovers - % within 30 minutes	Driver	99.0%	96.0%	95.8%	96.9%	96.1%	92.5%	90.6%	89.0%	87.0%	85.1%	84.7%	87.9%	84.8%	82.6%	CMS	SC
		Number of patients spending more than 12 hours in ED from time of arrival	Driver	230	156	165	147	180	356	541	642	785	966	1,074	905	954	1,320	CMS	SC
		Long length of stay - 21 days or more	Driver	<=150	180	158	140	145	172	169	170	180	180	187	205	177	202	CMS	SC
Safe and Sustainable Staffing		Vacancy rate	Watch	<=10%	9.9%	10.6%	11.0%	11.5%	12.0%	12.4%	12.3%	12.7%	12.6%	13.0%	12.9%	13.5%	13.4%	Switch to Driver	-
		Agency expenditure as % of pay	Driver	tbc	2.4%	3.1%	2.4%	2.0%	1.9%	1.5%	2.2%	2.0%	2.37%	2.7%	2.9%	3.3%	4.0%	-	-
		BAME % of workforce Band 7 and above	Driver	tbc	39.8%	41.9%	40.2%	39.94%	40.1%	40.4%	40.4%	41.1%	41.45%	41.7%	40.9%	41.2%	41.7%	-	-
		Staff Sickness (rolling 12 month)	Driver	<=3%	4.18%	3.79%	3.74%	3.67%	3.70%	3.79%	3.87%	3.96%	4.05%	4.21%	4.26%	4.36%	4.55%	CMS	-
		Staff turnover (rolling 12 months)	Watch	<=12%	9.8%	9.9%	10.6%	10.4%	10.4%	11.1%	11.1%	11.4%	11.6%	12.1%	11.9%	12.0%	12.2%	-	-
Finance		Year to date position (variance to plan) £m	Watch	£0	5.07	-3.18	0.50	0.75	1.00	1.25	0.00	0.00	0.00	0.00	0.00	0.00	0.09	-	-
		Forecast variance to plan	Watch	£0	5.07	0.00	18.51	1.51	0.00	0.00	-14.50	0.00	0.00	7.00	0.00	0.00	0.09	-	-
		CIP variance to plan YTD	Watch	£0	-	-	-	-6.15	-6.09	-5.73	-4.08	-4.68	-4.76	-3.65	-5.30	-5.42	-6.88	Switch to Driver	-
To build learning, improvement and innovation into everything we do																			
	FI	Core skills training	Watch	>=90%	92.2%	93.0%	93.8%	94.5%	94.0%	92.7%	92.2%	91.7%	90.3%	90.9%	92.2%	90.5%	91.1%	-	-

Abbreviations

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

Reporting rules
CMS - Countermeasure summary
SVU - Structured verbal update

SPC - CC - Common Cause; SC - Special Cause

Imperial College Healthcare NHS Trust

Appendix 2

Integrated quality and performance report:

Countermeasure summaries at month 12 (March 2022 data)

Imperial College Healthcare NHS Trust

Contents

The enclosed Countermeasure summaries are linked to the March 2022 performance (Cancer waiting times actions are associated with February datat due to the lag in national reporting).

The plans associated with April 2022 performance are being updated and will be reported through the executive management board meeting late May 2022.

Imperial College Healthcare NHS Trust

SPC charts

Some of the summaries use statistical process control (SPC) charts to plot data over time, an approach we intend to keep developing. SPC is a way to understand variation in the underlying data and can help guide the most appropriate actions to be taken.

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

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

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

Imperial College Healthcare NHS Trust

CMS

Improving our incident reporting rate

Countermeasure summary: Improving our incident reporting rate

Imperial College Healthcare NHS Trust

Problem statement: **Aim:** to improve how we report, investigate and learn from incidents using behavioural change strategies, education and coaching resulting in a sustainable increase in incident reporting and improving our patient safety culture. **Impact on patient care:** Incident reporting is one of the most important sources of patient safety information, helping us to identify risks to patients and staff. High rates of incident reporting enable us to identify with more accuracy actual or potential harm; analysing this data alongside other sources of intelligence helps us to learn and continuously improve.

Owner: Shona Maxwell, chief of staff

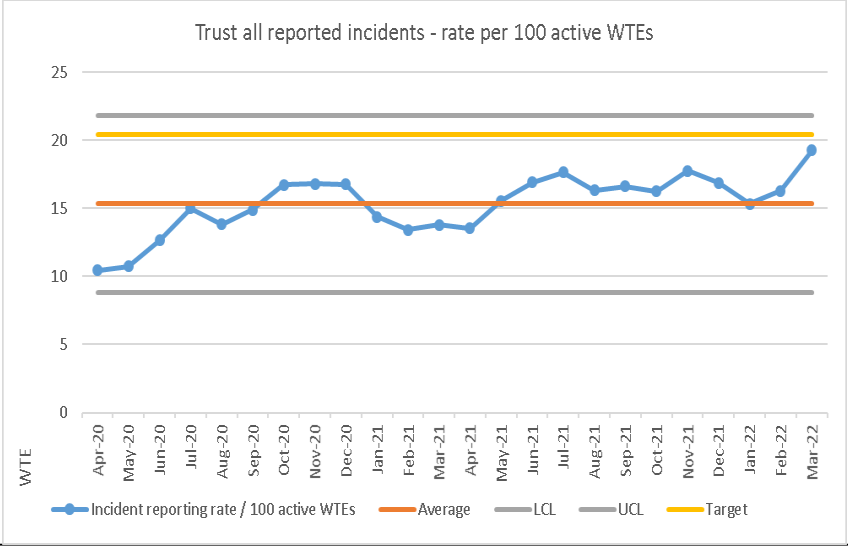
Metric: Incident reporting rate

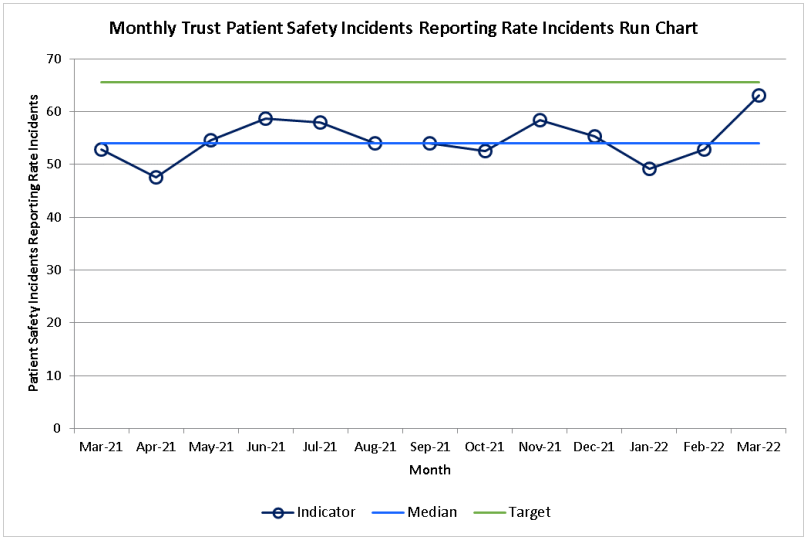
Target:
Patient safety incident reporting rate per 1,000 bed days >= 65.6
Patient safety incident reporting rate per 100 active WTEs >=20.4

Desired trend: ↑

Historical performance:

- **Data analysis**: Internally, we measure our incident reporting rate per 100 whole time equivalent (WTE) to allow us to compare locally across different areas. At trust level, we use the National Reporting and Learning System's (NRLS) measure of incident reporting rate per 1,000 bed days so we can compare ourselves nationally. Since May 2021 at WTE level there have been 11 consecutive data points above the mean indicating a sustained change albeit rates remain below the target ambition.
- **In March 2022,** our incident reporting rates increased, with performance at its highest since before the pandemic. This is being partly driven by a change in the way we report admission delays in the emergency departments; previously we used to only report 12-hour trolley breaches for patients who were waiting for a mental health bed to become available, however from February 2022 we have begun reporting all 12-hour trolley breaches and 1-hour ambulance handover delays as incidents to ensure that these are captured appropriately and investigated through our normal processes in line with other patient safety incidents.
- Even without this change in practice, our reporting rates would have improved and there have been increases across most directorates.

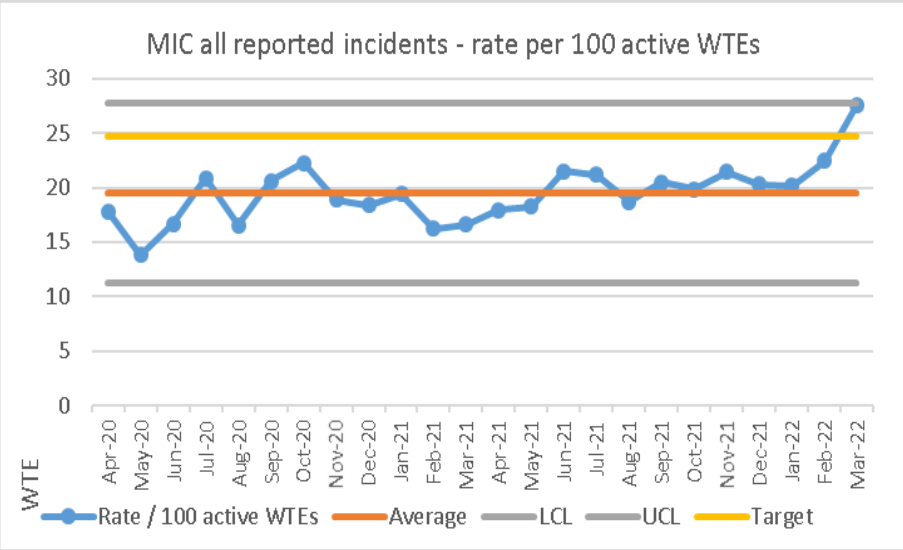


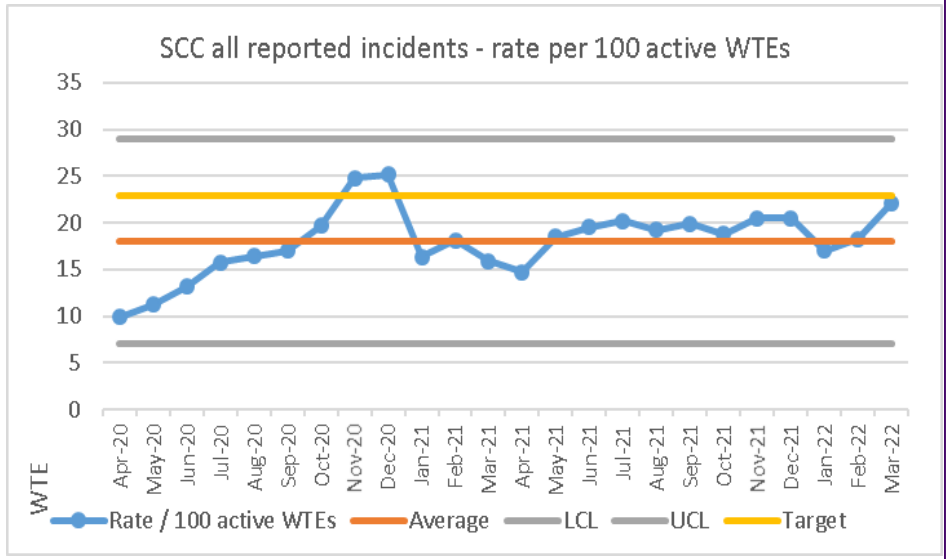


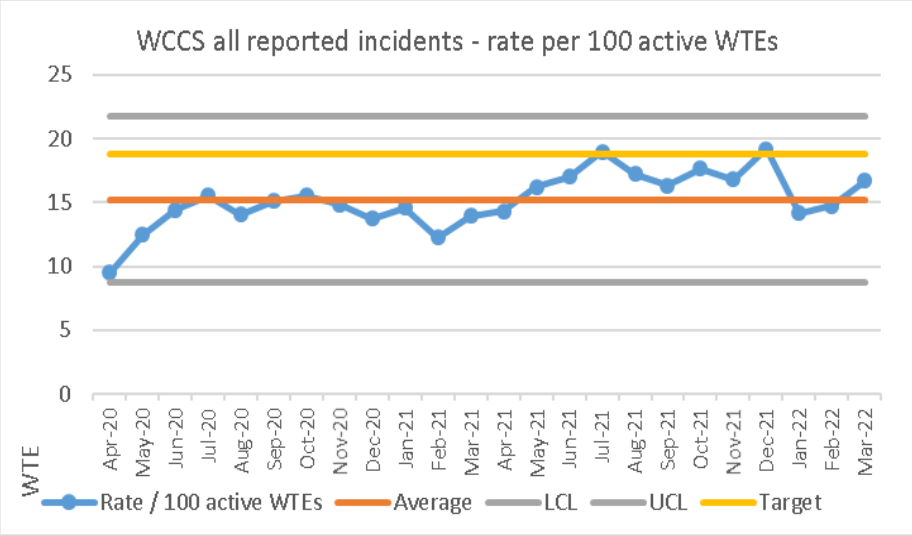
Countermeasure summary: Improving our incident reporting rate

Imperial College Healthcare NHS Trust

Stratified Data:





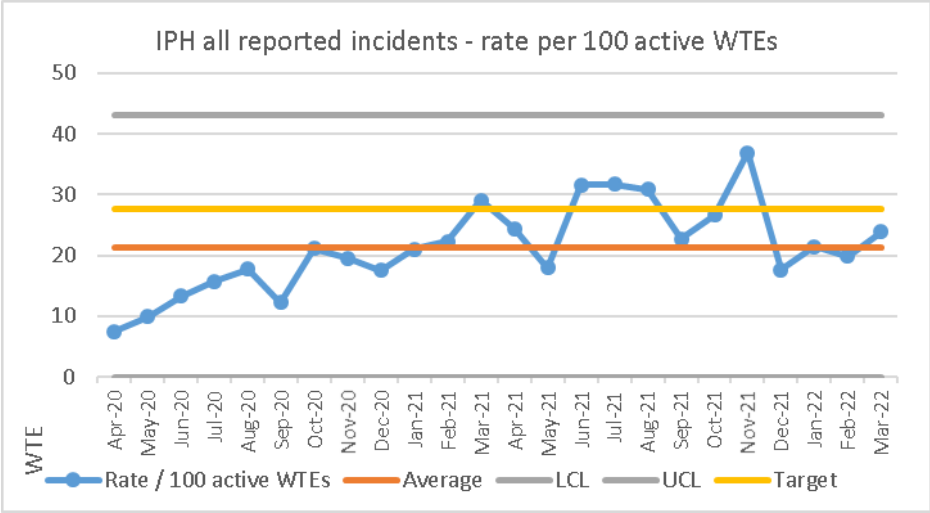


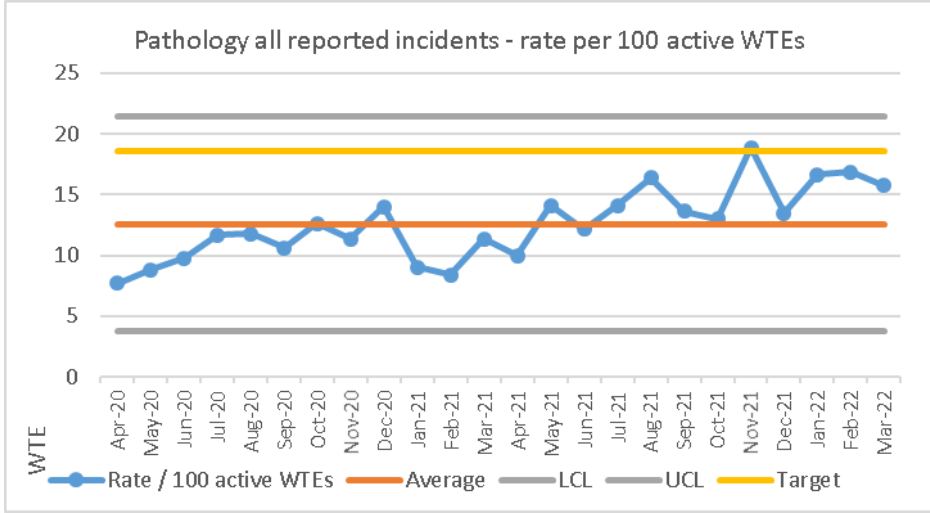
- The graphs show the incident reporting rate per 100 WTE for each of the main clinical divisions.
- MIC: there have been 7 consecutive data points above the mean, with no significant dip in performance during the most recent surge. The recent increase is being influenced partly by the decision to report all 12 hour trolley breaches and ambulance delays as incidents from February 2022 onwards.
- SCC: before January 2022, there were 8 consecutive data points above the mean indicating a sustained change. In February and March 2022 the rates were above the mean again following the dip in January indicating that this reduction is likely to have been due to the impact of surge activity.
- WCCS: the reporting rate is more variable compared to the other divisions, however since February 2021 there appears to have been a general increase in reporting, with a more significant dip than other divisions during the most recent surge.

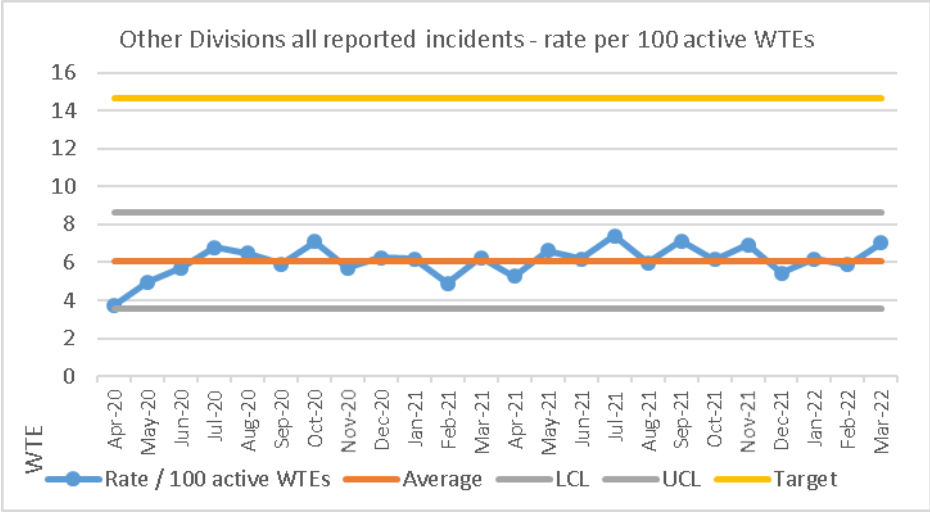
Countermeasure summary: Improving our incident reporting rate

Imperial College Healthcare NHS Trust

Stratified Data:





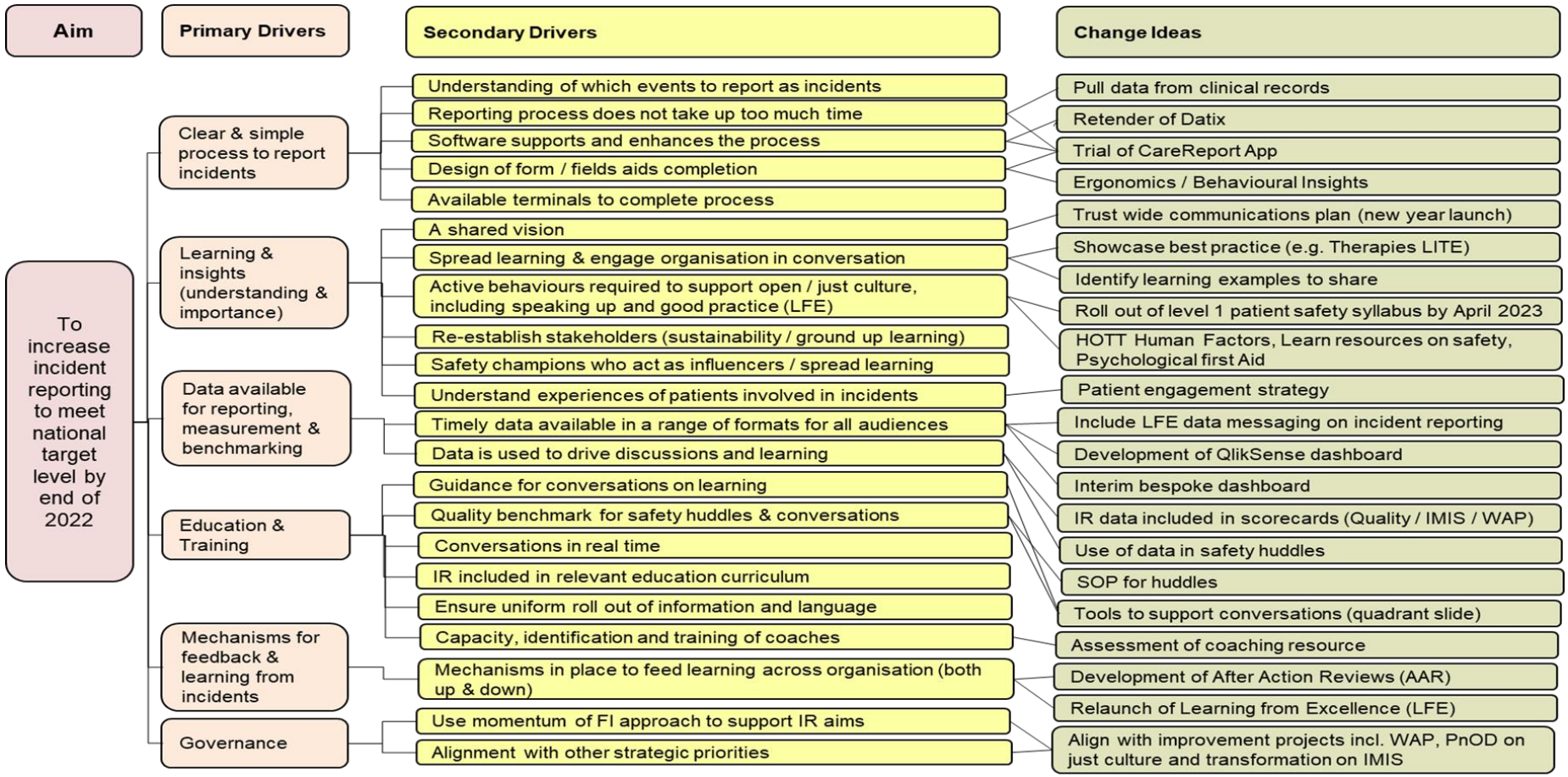


- The graphs show the incident reporting rate per 100 WTE for IPH, NWLP and 'other divisions' which is made up of the corporate areas within the trust.
- For IPH, reporting rates remain variable, which is primarily driven by drops in activity during pandemic surges. Over the last 12 months they have achieved their target 5 times.
- For NWLP, reporting rates are also variable and dipped in March 2022.
- The reporting rate for corporate areas (other divisions) is low and has remained mostly static, although there has been an increase in March 2022 following a dip in February.

Countermeasure summary: Improving our incident reporting rate

Imperial College Healthcare NHS Trust

Top Contributors:



Countermeasure summary: Improving our incident reporting rate

Imperial College Healthcare NHS Trust

30 DAY ACTION PLAN

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Data visualisation – data is not easy to access from Datix in a visually meaningful way to support local use e.g. in huddles	• Information from Datix can be accessed in multiple ways and does not support visual data usage.	• QlikView enhancement ideas will be an output of phase 1 improvement projects. QlikSense server migration complete, views and tables being developed by the data warehouse team. Potential Qlik developer resource implications to be addressed. • Visual prompt to be tested as part of PDSA cycle, currently delayed due to operational pressures with a plan to refocus early May 2022.	PM D&I Hub & Safety Improvement Team Safety Improvement Team	Q1 22/23 June 2022
Divisional/directorate engagement	• Incident reporting is a focused improvement as part of the management system. This is a new way of working and plans to take this forward are still in development within the divisions.	• Divisional action plans recommenced. These are being monitored through EMB quality group.	DDNs/DGDs	Ongoing
Negative perception of incident reporting – staff have reported a number of barriers and that they do not see Datix as a tool for improvement.	• Messaging regarding the importance of incident reporting not reaching frontline staff • Blame culture around incident reporting	• Communication plan developed, with messaging agreed and content drafted. The communications team ran a focus group to gather feedback on the key messages from the campaign. As an outcome further supporting resources are going to be developed to launch alongside the campaign. The programme is also to be presented at Back to the Floor in early May.	Chief of Staff & Safety Improvement Team	May 2022

Countermeasure summary: Improving our incident reporting rate

Imperial College Healthcare NHS Trust

30 DAY ACTION PLAN

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Local clinical engagement – both the research literature and our pilot to improve incident reporting show that the majority of barriers and enablers to incident reporting are local. In order to be successful, improvement plans need to be developed and progressed locally.	• Identification of local areas to focus on improving incident reporting not yet complete for all divisions • Variable attitudes to incident reporting amongst different staff groups – nurses are the main reporters of incidents	Phase 1 improvement projects: Focus on learning from incidents through the use of huddles & visual prompt to encourage discussion and sharing of learning in divisional pilot areas: • Projects in specialist surgery have been hindered by staffing issues • Clinical haematology areas are working through improvement ideas including a type of see one do one training for staff's first time reporting through Datix. Scoping work has begun with the pilot areas for MIC division (SMH acute & specialist medicine and stroke & neurosciences). • The project to improve the experience of being involved with incidents for junior doctors has developed ideas around sharing learning, and types of support, next steps are around channels of communication.	Safety Improvement Team/DDNs/Local teams Safety improvement team/ MIC junior doctor reps	On-going
Potential under-reporting of near miss/low harm incidents – Anecdotal evidence suggests that staff feel too busy to report, which was exacerbated by COVID-19, and therefore de-prioritise reporting of near miss/low harm incidents.	• Perceived amount of time taken to complete incident reports	• Datix: system: an assessment has been completed of the input forms leading to a number of initial changes that have been enacted, further recommendations require resourcing to be able to take forward, this is being explored through the Quality, Compliance and Assurance team. A change to the content and language of the confirmation of submission email reporters receive when they submit a Datix is also in progress. • Trial incident reporting App CareReport - App build being finalised with original developers. The team from Helix Centre will be providing future support. Trial needs to be taken to the new system/apps committee for progression. • Plan to develop automatic reporting from CERNER. Pilot to run for two types of incident, patients diagnosed with sepsis who did not receive antibiotics within 1 hour and falls assessments not completed. Falls data being analysed to understand scale.	Deputy GM - MDO Safety improvement team Chief of staff and CNIO	2022/23 (TBC) – for full system delivery TBC (once code transferred) May 2022

Imperial College Healthcare NHS Trust

CMS

Referral to Treatment (RTT) – Patients waiting over 52 weeks for treatment

Countermeasure summary: Referral to treatment – Patients waiting over 52 weeks

Imperial College Healthcare NHS Trust

Problem statement: Many patients continue to wait too long for their treatment. The impact on individuals (and families / carers) is wide ranging. Waiting longer can mean an existing condition worsens with the potential of complicated surgeries or increased use of medications.

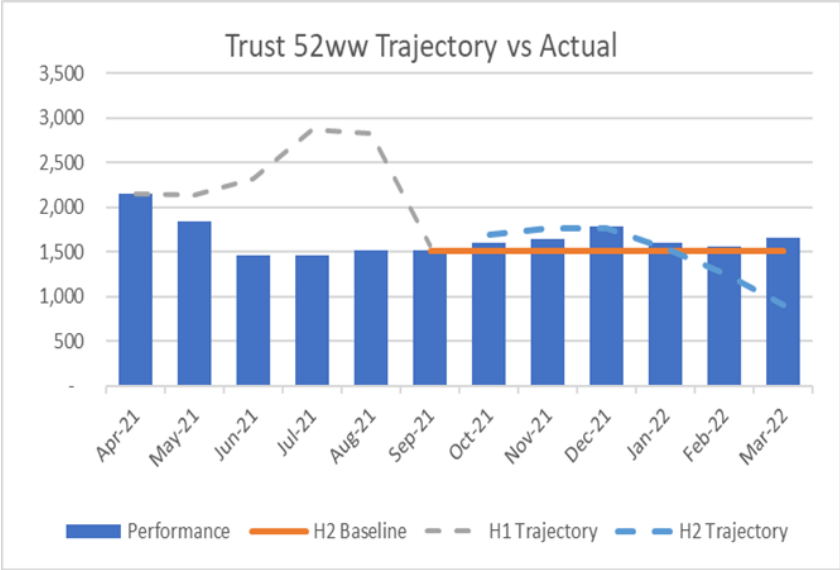
Owner: Professor Katie Urch

Metric: RTT 52 week wait breaches

Target:
- 2021/22 - 908 breaches or less by March 2022
- 2022/23 - 708 breaches or less by March 2023

Desired trend: ⇩

Historical performance: The Trust reported 1,662 patients waiting over 52 weeks for treatment at end March 2002 which did not meet the trajectory. Recovery in February and March 2022 was not at the level expected, resulting in a higher number of tip overs each month and this is expected to continue into April 2022.



Key updates

- CEO deep dive into longest waiters completed In-depth review of contributory factors, challenges and risks to performance has translated into a clearer understanding of priorities and required collaboration across multiple directorates.
- Theatres Elective Recovery High Level Action Plan is progressing across key areas: (i) list planning & scheduling, (ii) access to ICU capacity, (iii) productivity initiatives across HVLC areas, and (iv) oversight of weekly activity levels vs plan and coordination with cancer, P2 and long-waiter trajectories.
- Independent Sector (IS) capacity Cardiology and Cardiac Surgery are currently making use of additional IS capacity. Subject to final contract agreement, Ophthalmology is due to start in May. General Surgery and ENT are also exploring the use of IS capacity.
- Service specific action plans agreed Progress monitored through the Weekly Elective Activity Recovery meetings (chaired by Divisional Director of Operations for Surgery & cancer).

Countermeasure summary: Referral to treatment – Patients waiting over 52 weeks

Imperial College Healthcare NHS Trust

30 DAY ACTION PLAN

Top contributor	Potential root cause	Countermeasure	Owner	Due date
General Surgery	• Theatre capacity for routine patients awaiting surgery, particularly for those requiring an overnight bed • Volume of cancer cases • Wait for first outpatient appointment	• Ongoing use of Saturday lists and outsourced lists at WMH • Explore options for procedure room to be used for certain procedures • IS negotiations regarding use of outsourced lists with bed capacity ongoing • Additional outpatient capacity	Louise Toler, General Manager	31/05/2022 31/05/2022 – room now identified 31/05/2022 31/05/2022
Neurosurgery	• High proportion of more urgent cases (P2)	• Additional weekend scheduling resource approved to schedule long waiters and improve theatre utilisation in May	Heena Asher, General Manager	31/05/2022
Ophthalmology	• Closure of Western Eye Hospital theatres • Increased administrative burden on scheduling teams • One stop cataract capacity	• Vanguard theatre at CXH site in use by ophthalmology from mid March 2022. • High Volume Low Cost (HVLC) lists will be re-implemented at Healthshare Clinic West London from 3rd May 2022. This will greatly assist with the 52 ww position given that >50% of the waitlist is Phacoemulsification procedures • Short term increase in scheduling staff to extend the booking horizon of elective routine lists • Additional Optom-led one stop cataract clinics to start from mid May – doubling the current cataract capacity	Rochelle Scott, General Manager Ophthalmology	Complete 31/05/2022 – on track 31/05/2022 Ongoing –currently booked until June 22

The above actions are for the top three services with the highest percentage of tip overs driving variance against trajectory in March - Ophthalmology, Neurosurgery and General Surgery.

Localised plans in place for all areas contributing to 52 week waits.

Imperial College Healthcare NHS Trust

CMS

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

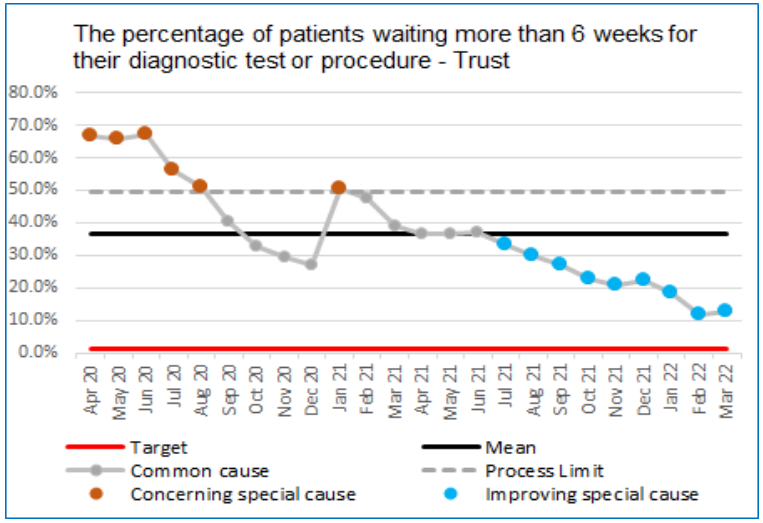
Countermeasure summary: Diagnostic waiting times

Imperial College Healthcare NHS Trust

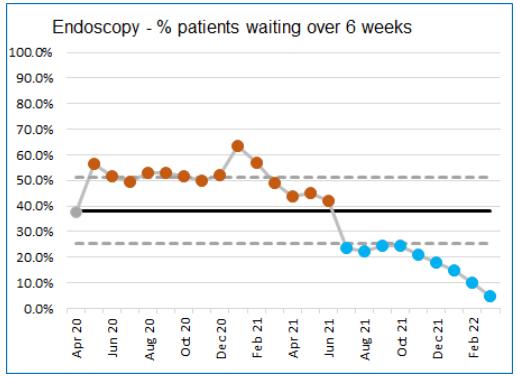
Problem statement: Performance against the diagnostic 6 week standard deteriorated for all modalities at the start of the pandemic, with significant backlogs accumulated due to the cancellation and reduction of services. Many patients continue to wait too long (over 6 weeks) for their diagnostic test. Failure to meet the diagnostic target adversely impacts patient experience and can delay treatment.	**Owner:** Prof Tg Teoh **Metric:** % of patients waiting six weeks or more for a diagnostic test **Target:** The national standard is no more than 1% of patients needing a diagnostic test should be waiting over six weeks **Desired trend:** ⇩

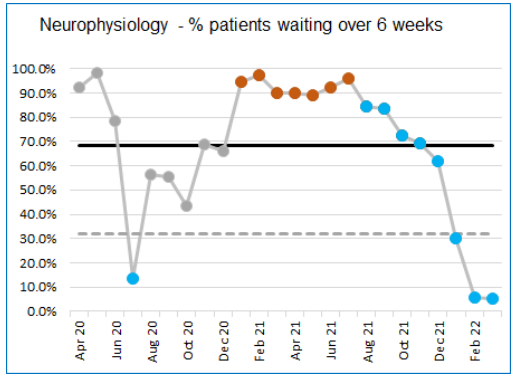
Historical performance:

The overall proportion of patients waiting six weeks or more at the end of March 2022 was 12.9%



The Endoscopy and Neurophysiology services both continued to report significant improvement in the waits over 6 weeks

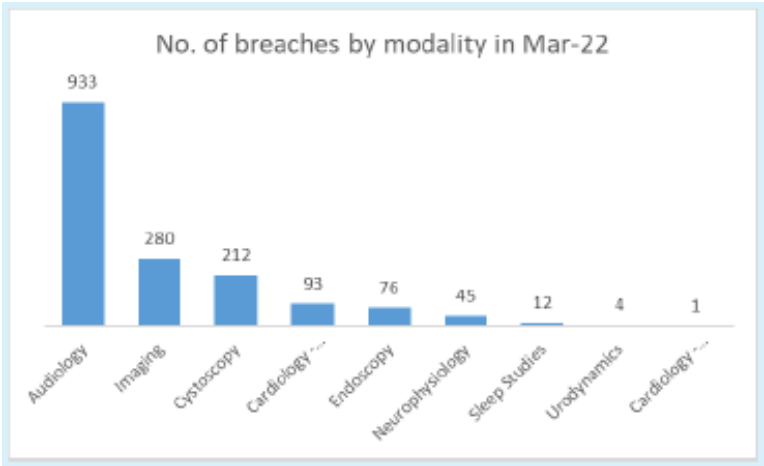




Countermeasure summary: Diagnostic waiting times

Imperial College Healthcare NHS Trust

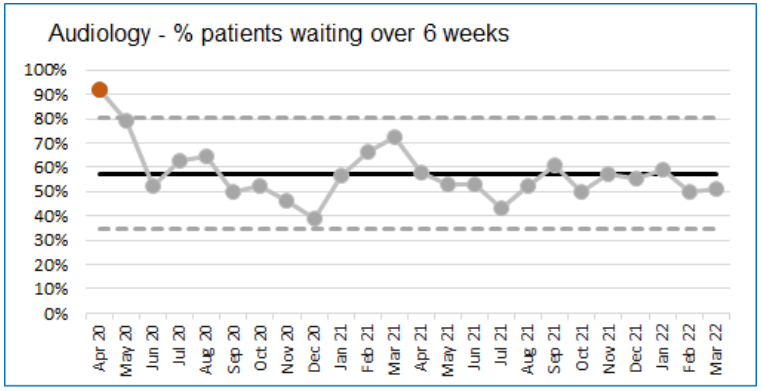
Stratified data / top contributors:

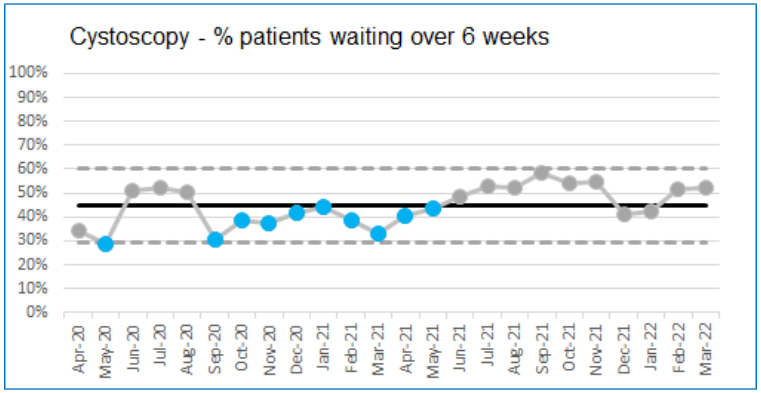


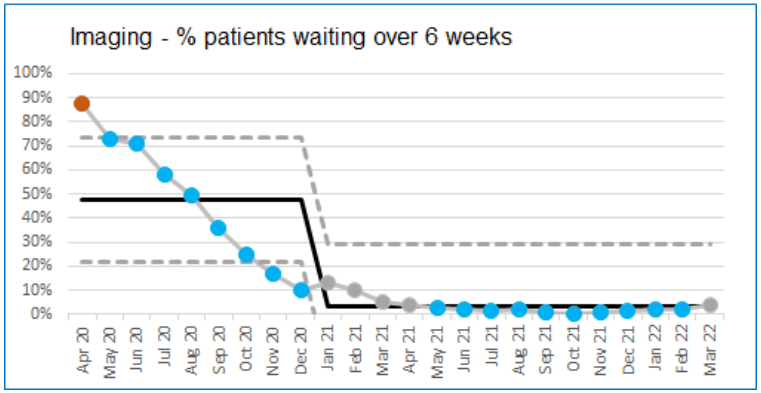
Of the total number of 6 week diagnostic wait breaches in Mar 22 (1656), 86% are concentrated in three services:

- Audiology
- Imaging
- Cystoscopy - urology

SPC charts for these services are provided on the right, showing % patients waiting over 6 weeks







Countermeasure summary: Diagnostic waiting times

Imperial College Healthcare NHS Trust

30 DAY ACTION PLAN

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Audiology	• Loss of capacity • Increased demand	• Scope and plan requirements to return to ENT one-stop appointments • Continued use of locum staff to mitigate against loss in capacity • Stringent review of vetting process to allow non-complex referrals to be relocated to community providers • Validation / audit of waiting list.	Harry Monaghan Laurence Turner (actions points 1&3)	End May 22 Ongoing Audit of accepted referrals to be completed June 22 April 2022
Imaging	• Aged equipment resulting in downtime and loss of slots • Staff vacancies	• Additional long weekend sessions at HH continuing through April and May • Mutual aid from Harefield Hospital Cardiac CT continues (this is being shared with LNWUH who also have Cardiac CT breaches. • Additional lists in MRI being run as and when staff are available.	Rex Rehamati	Ongoing as older machines are replaced
Cystoscopy - urology	• Increased requests and insufficient prospective bookings, impacting upon utilisation	• Additional scoping room, workforce and equipment • Validation of current waiting list. Validation of uncontactable patients to be completed by 27.04. • Additional Weekend all day Flexible cystoscopy.	Laurence Turner	End April Completed Ongoing – currently booked until June 22

Imperial College Healthcare NHS Trust

CMS

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

Countermeasure summary: Cancer Waiting Times 62-day Performance

Imperial College Healthcare NHS Trust

Problem statement: Compliant performance is required by March 2023 – included in Trust trajectories. The patient impact is longer waiting times to access diagnostics and treatment for cancer. The performance impact is reputational and increased pressure on clinical and supporting admin teams.

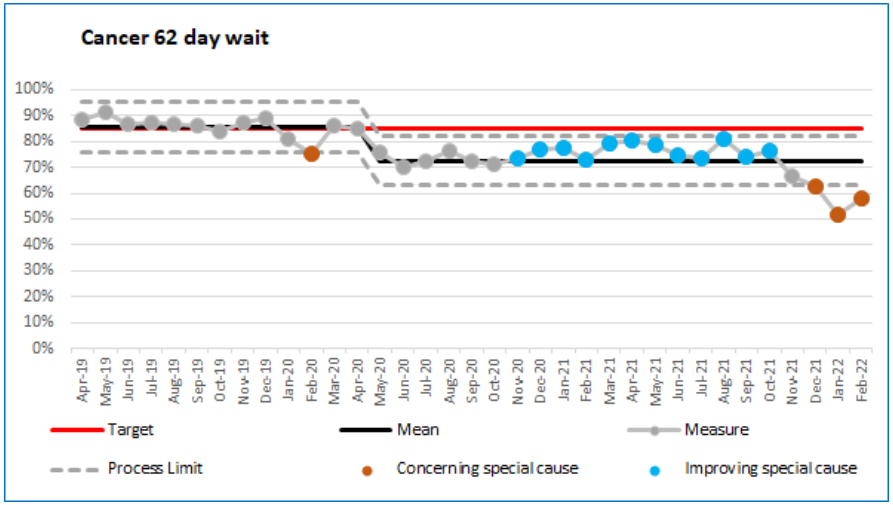
Owner: Prof Katie Urch

Metric: CWT 62-day GP referral to first treatment

Target: National operating standard 85%

Desired trend: ⇧

Historical performance: Performance against the standard has been non-complaint for 21 consecutive months. February was reported at 57.9% against the 85% standard.



Key dependencies for performance recovery:

- Recovery of RAPID prostate diagnostic pathway
- Reduction and stabilisation of endoscopy waiting times
- Recovery of breast triple assessment pathway
- Reduction of diagnostic-only biopsies for suspected skin cancers
- Consistent delivery of 7 day turnaround times (TAT) for cancer diagnostic pathology samples
- Consistent delivery of 10 day TAT for key diagnostic modalities

Performance is not expected to be compliant with the standard before March 2023

Key associated metrics to watch against trajectory:

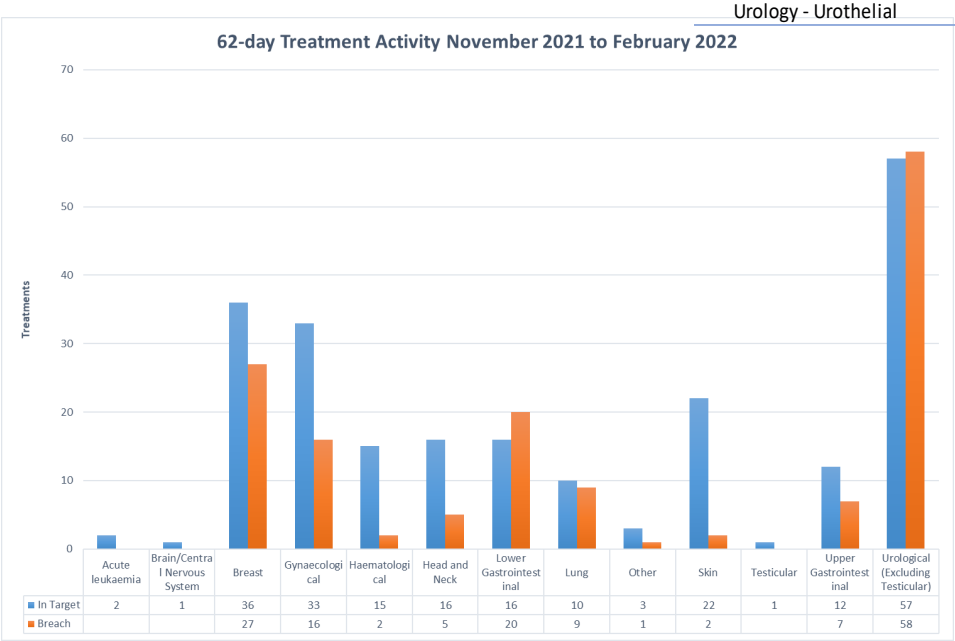
- 2WW performance – February performance was 73.7% against the 93% target – increase from 71.6% in January. Performance expected to remain non-compliant until June due to sustained 2WW referral demand increases across specialties, prostate and breast diagnostic pathway capacity;
- 104+ day Patient Tracking List (PTL) backlog – 82 patients at 14/04/2022 – increase from 79 in mid-February. Pressure in breast, GI, gynae and prostate;
- PTL 63+ day tip over rate increasing following previous improvement in March. Drivers – GI diagnostic pathway capacity, pathology reporting time delays, prostate RAPID diagnostic pathway compliance, skin biopsy capacity, breast triple assessment capacity, surgical waits in GI, gynae and urology

Countermeasure summary: Cancer Waiting Times 62-day Performance

Imperial College Healthcare NHS Trust

Stratified data / top contributors:

Standards	Sep	Oct	Nov	Dec	Jan	Feb
3.1 - Cancer Plan 62 Day Standard (Tumour)	**73.9%**	**76.3%**	**66.7%**	**62.6%**	**52.0%**	**57.9%**
Acute leukaemia	100.0%		100.0%		100.0%	
Brain/Central Nervous System	100.0%					100.0%
Breast	90.5%	84.8%	75.0%	64.9%	37.9%	58.8%
Gynaecological	68.2%	83.3%	87.1%	56.3%	57.1%	62.5%
Haematological (Excluding Acute Leukaemia)	90.0%	100.0%	100.0%	100.0%	75.0%	81.8%
Head and Neck	75.0%	100.0%	100.0%	71.4%	0.0%	100.0%
Head and Neck - Thyroid		100.0%	66.7%		100.0%	100.0%
Lower Gastrointestinal	44.4%	25.0%	43.5%	50.0%	28.6%	57.1%
Lung	75.0%	75.0%	25.0%	50.0%	66.7%	71.4%
Other			100.0%	0.0%	100.0%	100.0%
Sarcoma		100.0%				
Skin	100.0%	75.0%	100.0%	100.0%	75.0%	88.2%
Testicular	100.0%	100.0%		100.0%		
Upper GI - HpB	50.0%	60.0%		75.0%	57.1%	100.0%
Upper GI - OG	33.3%	37.5%	0.0%	77.8%	66.7%	50.0%
Urology - Prostate	70.6%	57.1%	45.8%	50.0%	39.2%	28.6%
Urology - Renal	66.7%	0.0%	75.0%	75.0%	85.7%	80.0%
Urology - Urothelial	100.0%	100.0%		100.0%	100.0%	50.0%



Countermeasure summary: Cancer Waiting Times 62-day Performance

Imperial College Healthcare NHS Trust

30 DAY ACTION PLAN

Top contributor	Potential root cause	Countermeasure	Owner	Due date
RAPID prostate pathway	• Triage waiting times preventing 2WW performance recovery • MRI waits at 5 days in March • Biopsy capacity insufficient to deliver diagnostic pathway within FDS 28 days.	• Capacity across the full pathway audited – triage and DTT clinic capacity to increase.	Urology	Completed (13/05)
Pathology	• > 7 day waits for cancer diagnostic sample analysis – affecting most tumour groups • Service has no prioritisation system or visibility of patient waiting times • Significant impact on patient experience through delayed communication of diagnosis and MDT discussion deferral • Particular impact in gynae, urology, GI and skin pathways	• Business case pending agreement to increase staffing resource. Service has gone at risk with recruitment plans agreed to June 2022 • NWL-wide working group established, agreed maximum TAT by tumour group, escalation and ordering processes and improve reporting visibility.	Path RMP/ NWL trusts	June 2022 Monitoring until April 2022
GI diagnostic pathways	• Endoscopy waiting times 14 days for UGI, 13 days for colorectal STT and 16 days for non-STT in March 2022 – target 10 • CTC waits 14 days in March	• Joint FDS improvement meetings with endoscopy, imaging and GI surgery to begin to review existing improvement plans • Imaging TAT improvement plan	Cancer Imaging	April 2022 On-going
Breast diagnostic pathway	• Sustained high referrals during Covid recovery • A reduction in the number of clinics we have been able to provide	• Additional sessional rates agreed • Recruit additional MDTC and tracker resource agreed to manage inflated PTL • Agree and implement IS capacity plan • Recruitment started for new triage pathway to reduce TAC demand – start dates expected May 2022	Spec. Surg. Cancer Spec. Surg. Spec. Surg.	March-June 2022 May 2022 May 2022 May 2022

Imperial College Healthcare NHS Trust

CMS

Cancer waiting times - 28-day Faster Diagnosis Standard

Countermeasure summary: Cancer Waiting Times – 28-day Faster Diagnosis Standard

Imperial College Healthcare NHS Trust

Problem statement: Compliant performance is expected by October 2022 – included in performance trajectories. The patient impact is longer waiting times to access diagnostics and confirmation of their diagnosis for suspected cancer. The performance impact is reputational and increased pressure on clinical and supporting admin teams.

Owner: Prof Katie Urch

Metric: CWT 28-day GP faster diagnosis standard (FDS)

Target: National operating standard 75%

Desired trend: ⇧

Historical performance: Performance against the standard began formal reporting in October 2021. In February, the Trust delivered 73.8% performance against the 75% standard (improvement from 62.5% in January).

	Feb				Mar			
Cancer Site	Total Seen	Breach	Performance	Variance (+/-)	Total Seen	Breach	Performance	Variance (+/-)
⊞ Brain	26	11	57.7%	-4	43	13	69.8%	-2
⊞ Breast	812	109	86.6%	94	759	105	86.2%	85
⊞ CRC	320	198	38.1%	-118	306	192	37.3%	-115
⊞ Gynae	214	73	65.9%	-19	250	100	60.0%	-37
⊞ H&N	252	42	83.3%	21	268	55	79.5%	12
⊞ Haem	27	2	92.6%	5	32	4	87.5%	4
⊞ Lung	45	2	95.6%	9	59	5	91.5%	10
⊞ Paeds	33	3	90.9%	5	27	4	85.2%	3
⊞ Skin	289	49	83.0%	23	261	46	82.4%	19
⊞ UGI	125	41	67.2%	-10	141	58	58.9%	-23
⊞ Urol	179	69	61.5%	-24	187	72	61.5%	-25
Grand Total	2322	599	74.2%	-18	2333	654	72.0%	-71

Key dependencies for performance recovery:

- Restoration of additional breast triple assessment clinics - Tender being prepared for IS capacity, no mutual aid support available within NWL
- Recovery of RAPID prostate diagnostic pathway – consistent delivery of additional MRI and triage clinic capacity
- Reduction and stabilisation of endoscopy waiting times
- Consistent delivery of 7 day TAT for cancer diagnostic pathology samples
- Increased skin telederm and biopsy capacity and reduced TAT
- Breast 2WW recovery is essential to FDS recovery. The standard will not be met until October 2022 based on current capacity planning across services.

Countermeasure summary: Cancer Waiting Times – 28-day Faster Diagnosis Standard

Imperial College Healthcare NHS Trust

30 DAY ACTION PLAN

Top contributor	Potential root cause	Countermeasure	Owner	Due date
GI Diagnostic pathways	• Insufficient endoscopy capacity and scheduling delays contributing to waits over 14 days for new UGI 2WW referrals • Endoscopy waiting times 14 days for UGI, 13 days for colorectal STT and 16 days for non-STT in March 2022 – target 10 • Discharge information not consistently included in endoscopy reports	• Sector-wide procurement initiated for new reporting system • Corporate cancer to support with building capacity/scheduling reporting	Endo Cancer/ Endo	October 2022 April 2022
RAPID prostate diagnostic pathway	• Triage waiting times preventing 2WW performance recovery • MRI waits at 5 days in March • Biopsy capacity insufficient to deliver diagnostic pathway within FDS 28 days. • 31-day High Intensity focused ultrasound HIFU) and prostatectomy capacity	• Capacity across the full pathway audited – triage and DTT clinic capacity to increase.	Urology	Prostate pathway review completed
Pathology delays	• > 7 day waits for cancer diagnostic sample analysis • Service has no prioritisation system or visibility of patient waiting times • Significant impact on patient experience through delayed communication of diagnosis and MDT discussion deferral • Particular impact in gynae, urology, GI and skin pathways	• Business case pending agreement to increase staffing resource. Service has gone at risk with recruitment plans agreed to June 2022 • NWL-wide working group established, agreed maximum TAT by tumour group, escalation and ordering processes and improve reporting visibility.	Path RMP/ NWL trusts	June 2022 Monitoring until April 2022
Breast diagnostic pathway	• Sustained high referrals during Covid recovery • LNWH offer of increased rates for radiologists significantly reduced capacity for triple assessment clinics	• Additional sessional rates agreed • Recruit additional MDTC and tracker resource agreed to manage inflated PTL • Agree and implement IS capacity plan • Recruitment started for new triage pathway to reduce TAC demand – start dates expected May 2022	Spec. Surg. Cancer Spec. Surg. Spec. Surg.	March-June 2022 May 2022 May 2022 May 2022

Imperial College Healthcare NHS Trust

CMS

Ambulance handover times (within 30 minutes)

Countermeasure summary: Ambulance handovers

Imperial College Healthcare NHS Trust

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

Owner: Ben Pritchard-Jones

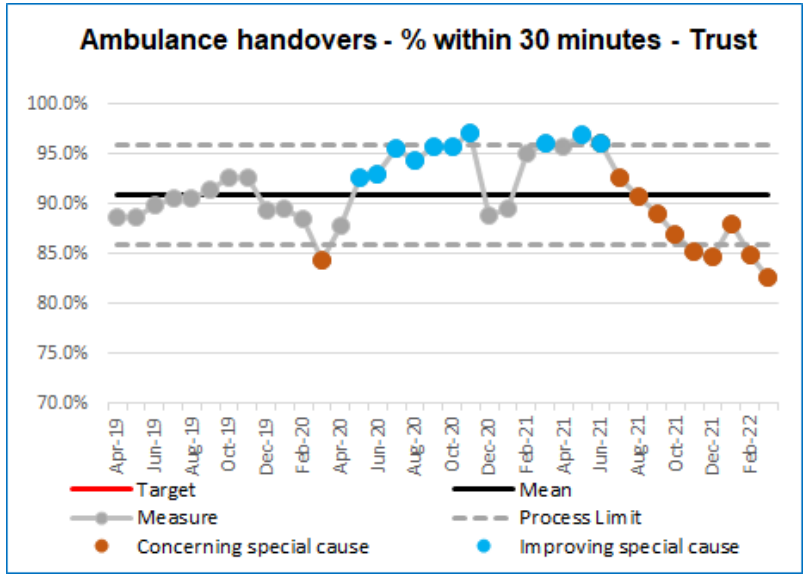
Metric: % of ambulance arrivals with a handover time of less than 30 minutes

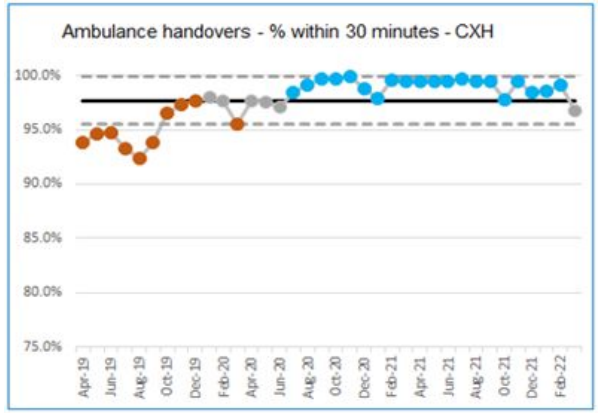
Target: National operating standard is 100% (2021/22) (95% for 2022/23)

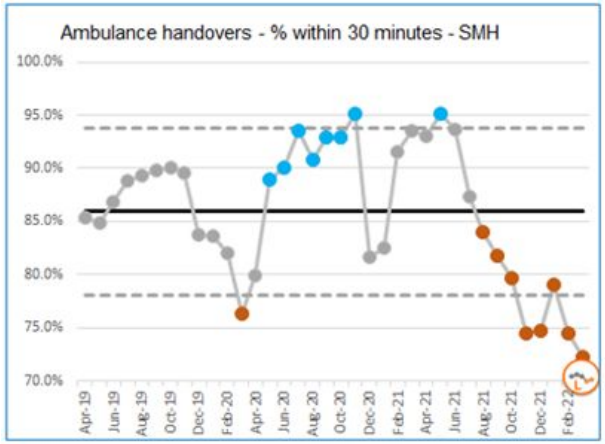
Desired trend: ⇧

Historical performance: The overall handover performance (within 30 minutes) continues to be highlighted as special cause variation with performance of 82.6% for March 2022.

Our internal trajectory was 95.6% for the month.







Countermeasure summary: Ambulance handovers

Imperial College Healthcare NHS Trust

Top contributors:

Clusters of arrivals contribute to the 30 and 60 minute breaches, however physical space was the overarching reason for the 60 minute breaches.

St. Mary's Hospital

- Continued higher levels of activity, especially walk-ins, has had an impact on the assessment capacity within ED; this in turn affects the handover / triage response times for ambulance arrivals.
- Wider flow issues across the pathways having an effect on front door flow (e.g. increase in LLOS and wider staffing issues)
- Lack of space to offload ambulances whilst social distancing
- Unplanned early closure of Same Day Emergency Care (SDEC) due to staff limitations meaning patients cannot be moved out of the ED or are being directed back to the ED
- Numbers of long waiting psychiatric patients who require cubicles for an extended period of time, making offloading more challenging

Countermeasure summary: Ambulance handovers

Imperial College Healthcare NHS Trust

30 DAY ACTION PLAN

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Ambulance Handover Delays	• Number of ambulances arriving to department that is already full	• London Ambulance Service (LAS) / Emergency Department (ED) Escalation plans re-shared with Site and ED teams and Silver on-call teams • Review impact of NWL / LAS Level 3 redirection pilot process to redistribute cross sector • Reset of expectations and targets in line with operating plan • Update plus one policy to include rapid plus one if ambulance alert levels increase to level 4 or if 60 minute breach imminent • Review ambulance arrival times as clusters appear to impact performance at SMH and CXH sites	Ben Pritchard-Jones Iain Taylor Hospital Directors/Ben Pritchard-Jones Jo Sutcliffe/ Frances Bowen Iain Taylor Ben Pritchard-Jones / Bec Dubock	April 22 April 22 May 22
Lack of space to offload ambulances whilst social distancing	• Slow flow out of the ED • Estate too small prior to pandemic now even more constrained	• E-mandate submitted for feasibility of reconfiguration of triage facility at front door to create 2 additional spaces. Costs above Divisional Minor Works budget are being reworked to go through DSP and CSG as part of 2022/23 plan • Front door pathways estate challenges scoped with estates, comms team and division • Regular update of CMS from ED and Site to support Intelligent Conveyancing • NWL ED Leads forum requesting LAS feedback on IC actions from sector review	Ben Pritchard-Jones/ Andy Angwin Hugh Gostling/Michelle Dixon/Jo Sutcliffe/Frances Bowen Iain Taylor/Ben Pritchard-Jones Ben Pritchard-Jones	April 22 April 22 Ongoing
Urgent & Emergency pathways	• CDU closure Same day Emergency Care (SDEC) expansion, Staffing levels	• Recruitment pipeline prioritising key areas of greatest need – target of <3 down on any shift • Forecast 40% reduction in vacancies across UEM by May 22 • Consider whether to treat 12 hour DTAs as a never event for site, wards and ED. Implement plus ones to avoid a 12 hour DTA • Complete analysis of T1 and T3 moves at SMH once Vocare data available	Ben Pritchard-Jones Iain Taylor/Ben Pritchard-Jones	April 22 April 22

Imperial College Healthcare NHS Trust

CMS

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

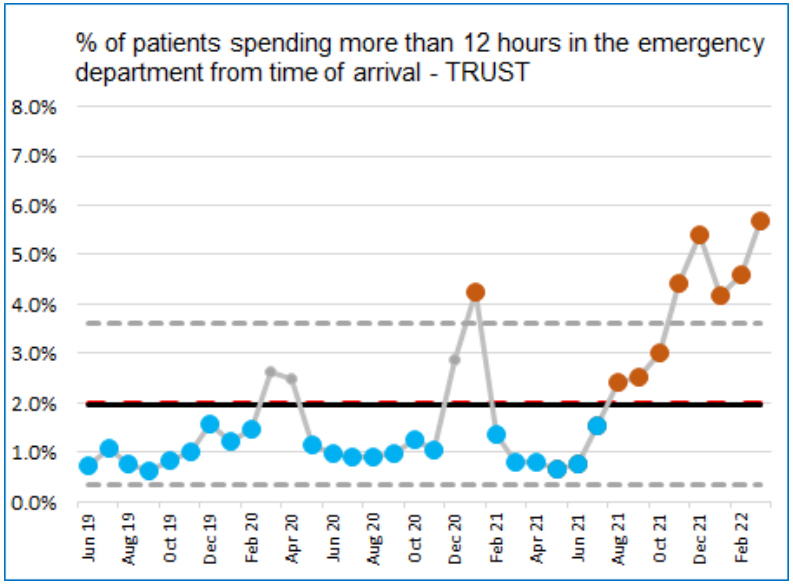
Countermeasure summary: Patients spending more than 12 hours in the emergency department

Imperial College Healthcare NHS Trust

Problem statement: Extended length of time patients are in an emergency department environment is detrimental for patient experience and quality and also impacts on staffing resource (ED staff, RMNs and security), cubicle capacity and the ability to manage flow through the department.	**Owner:** Frances Bowen **Metric:** % of patients spending more than 12 hours in the emergency department from time of arrival **Target:** National operating standard is no more than 2% during 22/23 **Desired trend:** ⇩

Historical performance: The number 12 hours waits from time of arrival remained high with 1,320 such patients in March 2022, the equivalent of 5.7% of attendances.

Significant increases in extended waits over recent months are seen across both sites. Of the total 12 hour waits, 88 were mental health patients (6.7% of total 12 hour attendances). 12 hour wait data shows 50% of waits occurred in general medicine with 90% on admitted pathways, 16% occurred on Surgical pathways, 7% on mental health pathways and 13% remained in ED.



Countermeasure summary: Patients spending more than 12 hours in the emergency department

Imperial College Healthcare NHS Trust

Stratified data / top contributors:

Overall context

- Total attendances - the average per day increased by 1% from an average of 745 in February 2022 to 751 in Mar-22. Type 1 daily averages were 4% lower (407/day) than Feb 2022 and type 2 increased by 1% (122/day). Type 3 increased by 10% compared to February (222/day)
- In comparison with March 2019, overall activity was 9.7 higher and T1 activity through ED was 20% higher, with T1 walk ins accounting for 71% of attendances in March 2022

Cross team themes

- Vacancy rates in ED, increased levels of annual leave due to year end, and fluctuating levels of short notice sickness absence or self isolation due community prevalence
- Inpatient bed and care home bed closures due to IPC
- Stable levels of MO and good recording of MO/R2R

Acute Medicine and Surgical Admissions

- Demand for beds outstripping capacity made worse by beds being closed for IPC reasons
- Occupancy and bed capacity not available at the right time of day, or with right combination of covid pathway and gender bed availability;
- Consistently higher numbers of LLOS patients (specifically D2A pathways, neurorehab, homeless, repats to other hosptials and out of area delays)
- Delays with discharges through internal and external delays and lack of resource impacted by absence of nursing and medical staff
- Delays due to incorrect or delayed completion of paperwork due to staffing numbers stretching teams

Not referred – Urgent & Emergency pathway

- Pathways that would previously have been admitted for short period have become non-admitted long stay pathways
- Unplanned SDEC closures and lack of resource to clerk patients fast enough at the front door meant that SDEC were not always able to take appropriate patients from ED
- Lack of physical space to see patients

Mental Health pathway delays

- In March , MH delays accounted for 7% of the total 12 hour waits, and 25 % of MH attendances waited over 12 hours.

Countermeasure summary: Patients spending more than 12 hours in the emergency department

Imperial College Healthcare NHS Trust

30 DAY ACTION PLAN

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Admitted pathway bed availability	Delayed discharges downstream/lack of beds earlier in the day	• Update boarding / plus 1 policy with feedback from wards and LAS escalation	Iain Taylor	April 22
		• Continue to use and adjust plus 1 policy and 'fit to sit' approach to support flow	Adam Hughes/ Jo Edwards	
		• Acute locum consultant being interviewed SMH March 2022	Jo Sutcliffe/ Frances Bowen	
		• Analysis of trend of 12 hrs admitted patients by speciality and if possible by theme	Ben PJ/ Ali Sanders	
		• Cross site transfers and delays for IPC to be reviewed for understanding of impact more broadly	Jo Edwards / Adam Hughes / Anne Hall	
		• Reinvigorate specific actions per directorate on time of discharge and usage of lounge through performance meetings and UEC board	MDO Transformation team	May 22
		• Discharge lounge for bedded patients at CXH due to open in April	Jo Sutcliffe	
		• Support focussed improvement on board rounds on 6 first wards, support increased training and release of coaches to do more, support clarity of message for all on board round expectations	Frances Bowen/Jo Sutcliffe	April 22
		• Transformation team focus on Albert ward to look at routine leading up to discharge day and work on improving	Jo Sutcliffe	June 22
		• Regular engagement and shared data from transport and pharmacy teams on actions taken the day before - wards areas needing greatest support in pipeline for transformation or FI coaching.		May 22
		• Engage in/drive and promote any site based scheme which helps create bed, CDU or ED capacity on site at SMH – review formally whether to continue without CDUs	Anne Hall/David Kovar Jo Sutcliffe/Frances Bowen	
		• Continue to support new specialties to SMH to ensure that impact of the move is neutral on beds		
		• Instigate ED invitations to twice daily site/bed meetings to ensure focus on long waiters in ED and shared understanding of pressures		
		• SCC to pilot reg allocated to ED to assess benefit of increased resource		
		• Task and finish group to be set up with Medicine and ED plus site to focus on faster moves		

Countermeasure summary: Patients spending more than 12 hours in the emergency department

Imperial College Healthcare NHS Trust

30 DAY ACTION PLAN

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Mental Health Pathway Delays	• AMHP Provision • Lack of bed capacity • Lack of urgency • Specific CAMHS pressures	• Mental health pathways - work with ICS on shifting focus and performance metrics for MH trusts to reduce stays in ED • Advertise lead MH Nurse and drive bank RMN recruitment • Focus on medical clearance speed, earlier escalation between CNWL and WLMHT and AMHP delays • Developing joint proposal for Emergency Assessment MH Lounge at SMH, in discussions with Estates teams on options scoping • Lead a task and finish group along with CNWL to eradicate 12 hour DTAs by end of September 2022	Jo Sutcliffe Barbara Cleaver Jo Sutcliffe Jo Sutcliffe/CNWL lead	 April 22 Sept 22
Urgent & Emergency pathways	• CDU closure SDEC expansion, Staffing levels	• Recruitment pipeline prioritising key areas of greatest need – target of <3 down on any shift • Forecast 40% reduction in vacancies across UEM by May 22 • Implement plus ones to avoid a 12 hour DTA • Complete analysis of T1 and T3 moves at SMH once vocare data available	Ben Pritchard-Jones Ben Pritchard-Jones Iain Taylor/Ben Pritchard-Jones	April 22 March 22 April 22

Imperial College Healthcare NHS Trust

CMS

Improving long length of stay (LLOS)

Countermeasure summary: Long length of stay

Imperial College Healthcare NHS Trust

Problem statement: High numbers of patients with a Long Length of Stay (LLOS) is an indicator of poor patient flow and sub-optimal use of resource.

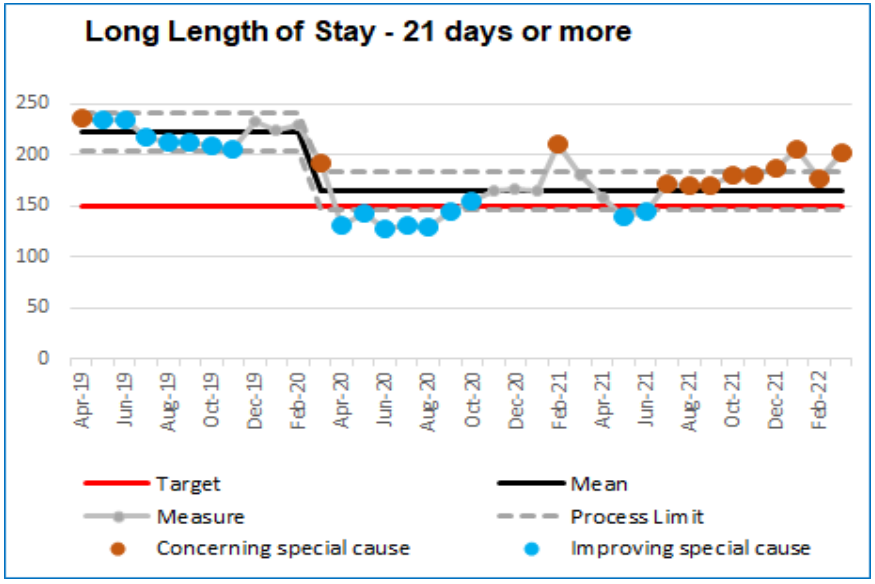
Owner: Anna Bokobza

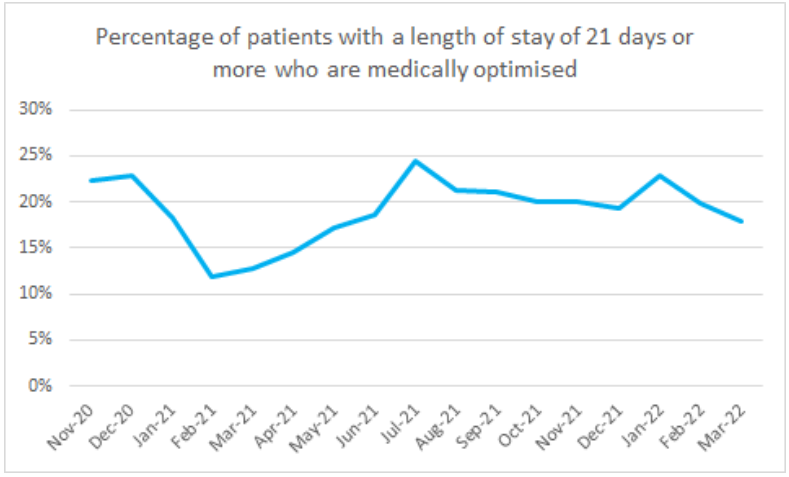
Metric: Number of patients with >20 days Length of Stay (LOS)

Target: A new improvement trajectory has been submitted with the sector as part of the 2022/23 NHS operating planning process

Desired trend: ⇩

Historical performance: The overall average length of stay in March 2022 was 202 patients with a stay of 21 days or more.





The percentage of all long length of stay patients (21 days or more) who were Medically Optimised was at 18% in March 2022.

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

Countermeasure summary: Long length of stay

Imperial College Healthcare NHS Trust

Stratified data / top contributors:

The trend in MO delays is primarily driven by:

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

Countermeasure summary: Long length of stay

Imperial College Healthcare NHS Trust

30 DAY ACTION PLAN

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

Countermeasure summary: Long length of stay

Imperial College Healthcare NHS Trust

30 DAY ACTION PLAN

Top contributor	Potential root cause	Countermeasure	Owner	Due date
High number of Medically Optimised LLOS patients	• Constrained senior capacity in historical discharge structure to support complex discharges • Variable relationships with system partners in different boroughs • Hospital social work teams do not always get early sight of complex post discharge needs • Growing numbers of homeless patients who have longer LoS on average • Demand for specialist neuro rehab beds in NWL outstrips supply • Care home market dynamics make behaviourally complex patients hard to place • Demand for community health and social care P1 support sometimes outstrips supply • Insufficient upstream management of patient/family expectations around discharge and choice	• Implement NWL integrated discharge structure – all in post except one 8b starting in April. Full skill mix review planned for completion by July • Iterate improvements to daily discharge hub routines; hub lead sign off of all D2As implemented in December, QI programme for 22/23 to be agreed end April • Level up medequip ordering rights across acute sites and boroughs; delayed by SMH ward leadership capacity; Jo M to demo to SMH matrons • Implement joint screening process (SMH + CXH) and separate pathway 1 workflow (CXH) with 3B ASC to improve P1 and P3 speed; success during Better Together Week so now embedding. Delayed due to Easter leave and ASC staffing levels. • Implement NWL D2A form in Cerner with auto-notifications to LA teams (delayed by need for further changes to Power Form following testing phase in November); risk that NWL may move away from common D2A form • Deliver 12 month Inclusion Health proof of concept; went live 29 Nov, Q1 impact report shared, generating further evidence for mid year review • Hold system partners to account for delivery of sector plan to source additional neuro rehabilitation beds • Review and adapt commissioned step down model • Commission Homelink extension for SCC 22/23 and run two month for Acute & Specialist Medicine at SMH • Review and strengthen patient letters and train MDTs in confident usage • Trial Personal health Budgets (P0+1)	Anna Bokobza Annabel Rule Liz Wordsworth Annabel Rule James Bird Anna Bokobza Jo Sutcliffe & Anna Bokobza Linda Jackson (LBHF) Anne Hall & Adam Hughes Annabel Rule Annabel Rule (and NWL CCG)	Complete July End April End May September May April November End April End May June

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

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Infection prevention and control board assurance framework

Agenda item 11 and paper H

Executive Director: Professor Julian Redhead, Medical Director

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

Purpose: For Information

Meeting date: 25 May 2022

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 infection prevention and control (IPC) board assurance framework (BAF). This is a live document including the self-assessment from April 2022.

2. Key findings

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

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

2.3. Considering the revised IPC BAF, we took the opportunity to re-review all previous KLOEs to ensure that our level of assurance remains appropriate, and to identify any additional actions that were required.

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

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

2.6. There are no red rated KLOEs. Sixteen KLOE are RAG rated as amber with actions in progress and designated leads for each area. These are predominately related to the transition to symptom-based pathways in line with recently updated national guidance and to the work to move to using hierarchy of controls to support IPC risk assessments, both of which are progressing.

2.7. Since the last report to Quality Committee in March, three KLOEs have been moved from amber to green following review and agreement at CRG:
- KLOE 1.9: the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases
- KLOE 8.4: pathology test turnaround times
- KLOE 10.16: that where fit testing fails, suitable alternative equipment is provided.

2.8. There have been some occasions where we have had to derogate from national IPC guidance due to operational pressures and in order to maintain our services. This is always risk assessed and reviewed at CRG to ensure no significant adverse impact. There has been no harm found to date.

3. Approval process

3.1. This self-assessment against the revised IPC BAF has been reviewed at CRG where the RAG ratings for each KLOE were agreed. It was presented to EMB-Q and EMB in April, and Quality Committee in May who noted the update and approved it for submission to Trust Board.

4. Recommendation(s)

4.1. The committee is asked to note the IPC BAF self-assessment for April 2022.

5. Next steps

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

6. Impact assessment

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

6.2. Financial impact
N/A

6.3. Workforce impact
N/A

6.4. Equality impact
N/A

6.5. Risk impact: this report is a self-assessment based on the NHSE IPC BAF. Gaps in assurance and mitigating actions against each KLOE are outlined in the full document (appendix 1).

Main paper

7. Discussion/key points

7.1. The updated BAF action plan for April 2022 is attached as Appendix 1.

7.2. There are no KLOE currently rated as red. 108 KLOE have been rated as green on the revised BAF.

7.3. The following KLOEs are rated as amber and work is progressing to ensure compliance.

- Hierarchy of controls (KLOE 1.3, 1.6, 2.12, 2.13, 2.14, 2.15, and 2.16): The hierarchy of control is a structured risk assessment for controlling exposure to occupational hazards using different risk avoidance or mitigation strategies in decreasing order of effectiveness. A number of these relate to actions around optimising ventilation, Estates continue to lead a trust wide review but risk mitigations (including enhanced respiratory protection) remain in place.
- Asymptomatic staff testing (KLOE 6.10): relates to the monitoring of staff-based compliance on asymptomatic testing. Whilst we receive some reporting metrics from the national reporting system this is not at a granular level, and so does not provide us with actionable information. This is a national challenge experienced by all providers and is outside the direct control of the organisation. Extensive discussions are on-going nationally regarding possible reporting metrics. We continue to promote the use of lateral flow testing but we have not asked staff to double report which is the only way currently for us to monitor actual use. Staff do report positive lateral flows when they are entering isolation.
- Staff break areas and changing facilities (KLOE 9.3): there is an extensive trust wide development programme underway to address issues related to the provision of some of these facilities. The first fully upgraded staff rooms have been completed. Year 2 of the development programme is now underway.

7.4. The following KLOEs are rated as amber and will be subject to review under the work to transition to symptom-based pathways:

- Signage and information (KLOE 4.6 and 5.1): relate to trust wide signage, providing sufficient information to visitors, staff and other patients about recognition and management of respiratory symptoms. Information is available to external visitors via the trust website, and work is underway to optimise displayed signage across the trust in in-patient and out-patient areas.
- Screening (KLOE 5.3): relates to staff knowledge of appropriate screening questions to ask patients and visitors as they attend appointments. Staff in relevant departments have local measures in place to coordinate screening attendees. To support this, we will publish a standardised screening template on the intranet for all staff. The template is currently being reviewed to incorporate recent national changes to guidance as well as new testing recommendations. We will publish this in the coming weeks.
- Patient testing (KLOE 5.7): relates to compliance with routine patient testing for Covid-19. Several interventions have been introduced to meet internal targets of 90% set for each screening metric. These continued to be monitored by Divisional leads and compliance is reported at the weekly HCAI sit-rep.
- Compliance with mask wearing (KLOE 5.8. and 7.1): relates to inpatient compliance with wearing surgical masks. Following an audit revealing limited compliance the medical director's office is undertaking a review with divisional directors of nursing to

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

- Enhanced respiratory protective equipment (KLOE 10.13): specifically relates to those staff required to wear FFP-3 respirators being fit tested for at least 2 different masks. 40% of staff require fitting for a second mask, and the emergency preparedness team have an action plan to address this, which remains unchanged from previous reports.

7.5. Since the February update was presented to Quality Committee in March, the following KLOE have moved to green:

- Reporting (KLOE 1.9): relates to reporting to the executive leadership on a regular basis, via a daily sitrep, on Covid-19, other seasonal respiratory infections, and hospital onset cases.
- Pathology test turnaround times (KLOE 8.4): relates to reporting sample turnaround times (TAT). The reporting processes were presented to CRG, and the group were satisfied that we have sufficient monitoring arrangements in place and have established mitigations that can be implemented rapidly in the event we experience increased in-lab TAT. We have activated these mitigations on several occasions to prioritise in-patient care. The group were satisfied that we were working within the intended principle of the KLOE.
- Enhanced respiratory protective equipment (KLOE 10.16): relates to the provision of reusable respiratory hoods for those staff that fail fit testing. Significant work has been undertaken to identify a product that can be appropriately decontaminated to maintain patient safety. Implementation is in progress.

8. Conclusion

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

8.2. Although there have been some occasions where we have had to derogate from national IPC guidance due to operational pressures and in order to maintain our services, there has been no harm found to date. This will continue to be monitored.

Author Dr James Price, Director of IPC

Date: 13th May 2022

Contributing Authors

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

Appendix 1. IPC BAF April 2022

Domain	No.	Key Line of Enquiry	New or updated	RAG	Evidence	Gaps in assurance	Mitigating actions	Lead	Due	Outstanding actions	Progress update
1. Systems to manage and monitor the prevention and control of infection	Systems and processes are in place to ensure that:										
	1.1	a respiratory season/winter plan is in place: o that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services o to enable appropriate segregation of cases depending on the pathogen. o plan for and manage increasing case numbers where they occur. o a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.	Yes	Green	Thrice weekly executive huddles to discuss operations. Daily sit ops meetings ICHT winter plan. Multiplex testing in place		Laboratory multiplex PCR testing with TAT for 13.5hours after receipt in lab.	Site Operations / ED / Virology	Complete		
	1.2	health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	Yes	Green	COVID secure dashboard of workspaces have been assessed for 'covid security' is regularly reviewed; and 81% of workspaces have been assessed as being covid-secure. In particular, the clinical divisions have assessed over 99% of their workspaces. 99.3% of Estates and Facilities workspaces have now been assessed.	Timeframe for completion of 0.7% workspace remain unassesed. Mitigations in place for the 19% workspaces are not covid secure	Information to staff provided via Comms have been diseminated on covid-secure areas Information available on intranet. Updates given at all staff briefings	Occupational Health and Safety / Estates	Complete	No firm timeframe for assessment of those outstanding non-clinical workspaces Those non-clinical workspaces which have been identified as not covid-secure (should) have local mitigation plans and action plans drawn up to make them, in due course, covid secure. H&S is contacting the managers of those workspaces to check on any	
	1.3	Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: o based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. o applied in order and include elimination; substitution, engineering, administration and PPE/RPE. o communicated to staff.	Yes	Amber	COVID-19 patient assessment pathways agreed at the CRG and widely communicated. •Risk assessment of patients for COVID-19 during emergency admission pathways is embedded in the organisation. •Pathway breaches are reported on Datix and trigger incident investigation. •An audit of patient notes was completed (in December 2020) and	Evaluation of ventilation in clinical areas Retrospective risk assessment is not possible at present due to capacity. Commincation of processes pending crib sheet for HoC	An exercise is taking place to clarify the extent to which HoC assessments need to be carried out, including whether this needs to be done for every clinical area. It should be noted that if there is a requirement to roll the HoC process out widely this will have resource implications. New guidance is due to be released with likely updates on HoC. Decision to review these guidelines prior to implementation. Risk assessments in plan as mitigation.	Occupational Health and Safety / HR	30/06/2022	Remain amber whilst HoC integreated	
	1.4	safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	Yes	Green	Risk assessments reviewed at CRG and ICS			H&S	Complete		
	1.5	if the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	Yes	Green	All proposals for deviation from nationally recommended practices are reviewed and agreed through CRG. Current deviations include: (i) Staff with household contacts return to work with negative LFD test but prior to PCR result. (iii) LFT instead of PCR in outbreak testing (iv) mixing different risk level pathways (v) not adopting newest national IPC guidance		Regular review at CRG	MDO	Complete		

	1.6	risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.	Yes	Amber	Clinical areas have been reviewed by IPC and site teams Non-clinical areas, as per 1.2 / 1.3	As per 1.2 /1.3	As per 1.2/1.3	Occupational Health and Safety	30/06/2022	No firm timeframe for assessment of those outstanding non-clinical workspaces Those non-clinical workspaces which have been identified as not covid-secure (should) have local mitigation plans and action plans drawn up to make them, in due course, covid secure. H&S is contacting the managers of those workspaces to check on any
	1.7	if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	Yes	Green	RPE in place in clinical areas where AGPs may occur, ventilation is not assessed, or when managing suspected or confirmed Covid-19 cases	Ventiltion assessment in clinical areas outstanding	FF3 use optional for those caring for patients with confirmed or suspected seasonal respiratory virus where ventilation is unknown	Estates / Communications	Complete	
	1.8	ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	Yes	Green	Audit of internal transfer documentation completed in Dec 2020 to provide this assurance	Re-audit required - up to date		Site Operations	Complete	Need to repeat audit
	1.9	the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	No	Green	"""Daily sit rep of COVID-19 cases provided Pathology (NWLP), provide daily COVID-19 list but does not segregate hospital onset cases as this information sits with the Trust. This includes a daily list for all rapid COVID-19 tests performed in ED together with follow-up PCR performed. Seasonal Respiratory infections - Currently there is no daily list shared with Trust. A daily list	Confirm HOCI and other seasonal respiratory infection are provided on a daily basis		IPC - Epidemiology / NWLP	Complete	05.01.22: Confirm with MD they receive daily updates of all three metrics Epi/BI/NWLP to provide data on seasonal respiratory infections SM/IB - conversation with BI to add figures to daily operational sitrep - actioned and reporting is live 15.03.22
	1.10.0	there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	No	Green	The methodology for the daily COVID-19 sitrep has been agreed with IPC, and the Director of Operations Performance signs off the returns.	Execs and senior leadship teams undertake regular rounds in clinical and non-clinical areas providing opportunities to check and challenge		Exec Board	Complete	
	1.11	resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	Yes	Green	Annual PPE and hand hygiene audit Reviews at incident meetings • Trust PPE guidance updated in line with PHE guidance regularly, approved at the CRG and communicated on the Intranet and via all-staff emails. • There is a bi-weekly Strategic PPE Planning group chaired by the Director of Nursing and including the Director of Finance.		Re-developing IPC practices education and competency assessments	Clinical Divisions	Complete	
	1.12	the application of IPC practices within this guidance is monitored, eg: o hand hygiene. o PPE donning and doffing training. o cleaning and decontamination.	Yes	Green	IPC practice education and assessment	Further action is required to obtain assurance on staff adherence to hand hygiene, staff physical distancing across the workplace, and staff adherence to wearing fluid resistant surgical facemasks (FRSM) in non-clinical settings.		Clinical Divisions	Complete	

	1.13	the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	No	Green	The Board Assurance Framework is RAG rated, updated monthly, and reviewed by the Executive Team at EMB Quality and the Trust Board. In addition, an associated action plan is reviewed weekly at CRG			IPC - DIPC	Complete		
	1.14	the Trust Board has oversight of ongoing outbreaks and action plans.	No	Green	The Board Assurance Framework is RAG rated, updated monthly, and reviewed by the Executive Team at EMB Quality and the Trust Board. In addition, an associated action plan is reviewed weekly at CRG			IPC - DIPC	Complete		
	1.15	the Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Made FFP3 masks are available to users as required.	Yes	Green	Daily SitReps include details on the supply of required PPE and consistently report sufficent stock levels. The PPE strategic planning group has responsibility for ensuring that we have a secured supply of PPE as needed and for responding to changes in PPE from a supply line perspective. PPE can be ordered by all teams as needed.	Of the six types of disposable FFP3 masks that the Trust provides, five are UK manufactured and one brand is not.		Procurement	Complete		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	Systems and processes are in place to ensure that:											
	2.1	the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.	Yes	Green	Trust has fully implemented the new cleaning standards, and has a full audit schedule and new audit team structure to comply with these guidelines			Facilities - Stuart Walmsley	Complete		
	2.2	the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	Yes	Green	There are standard notification processes in place			Facilities	Complete		
	2.3	cleaning standards and frequencies are monitored in clinical and non- clinical areas with actions in place to resolve issues in maintaining a clean environment.	Yes	Green	•Clear guidance for cleaning and disinfection in non-clinical areas has been issued, and posters are in place to remind staff of the new for frequent environmental hygiene. •The frequency of monitoring cleaning in non-clinical areas has been increased from 6 monthly to quarterly.		Non-clinical environments	Facilities	Complete		
	2.4	increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.	Yes	Green	Trust guidance, which is based on national guidance, has been produced and published on the Intranet.			Facilities	Complete		
	2.5	Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.	Yes	Green	2.6 •In all medium and high risk pathways, cleaning and disinfection is undertaken using Actichlor plus (a chlorine-based detergent disinfectant). •Disinfection of some items is undertaken using Clinell Green detergent/disinfectant wipes, which are effective against non-enveloped viruses including SARS-CoV-2.			Facilities / IPC - Decontamination	Complete		
	2.6	if an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	Yes	Green	Manufacturers' guidance and recommended product 'contact time' are followed for all cleaning/disinfectant solutions/products.			IPC - Decontamination / Facilities	Complete		
	2.7	manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	Yes	Green	Manufacturers' guidance and recommended product 'contact time' are followed for all cleaning/disinfectant solutions/products.			Facilities / IPC - Decontamination	Complete		
	2.8	a minimum of twice daily cleaning of: o patient isolation rooms. o cohort areas. o Donning & doffing areas o 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails. o where there may be higher environmental contamination rates, including toilets/commodes particularly if patients have diarrhoea.	Yes	Green	This applies to medium and high risk pathways. Trust guidance, including the need for increased cleaning in some areas, has been produced and published on the Intranet. Each site maintains a record of which ward areas are undergoing enhanced cleaning.			Facilities / IPC - Decontamination	Complete		
	2.9	A terminal/deep clean of inpatient rooms is carried out: o following resolutions of symptoms and removal of precautions. o when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens); o following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	Yes	Green	Trust guidance, which is based on national guidance, has been produced and published on the Intranet.			Facilities / IPC - Decontamination	Complete		

	2.10.0	reusable non-invasive care equipment is decontaminated: o between each use. o after blood and/or body fluid contamination o at regular predefined intervals as part of an equipment cleaning protocol	Yes	Green	Trust guidance for the use of single use items is included in the Trust Decontamination Policy. All PPE items are either decontaminated using manufacturer instructions or single use. Appropriate items are sent to equipment library, items which remain on the wards are cleaned per protocol. Equipment inspections form part of teh IP&C environmental reviews and are a particular			Clinical Divisions	Complete		
	2.11	Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	Yes	Green	Trust guidance for the use of single use items is included in the Trust Decontamination Policy. All PPE items are either decontaminated using manufacturer instructions or single use. Cleaning scores are monitored through the quality scorecard to EMBQ. We get countermeasure summaries when we're below target from the E&F team.			Clinical Divisions / Facilities	Complete		
	2.12	As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities.	Yes	Amber			Gap analysis against 04-01 Patient Care Health Building Note	Estates / Health & Safety	30/06/2022	amber whilst HoC are incorporated. Clarity provided that all areas require assessment but starting with all inpatient areas	
	2.13	the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.	Yes	Amber				Estates / Health & Safety	30/06/2022	amber whilst HoC are incorporated. Clarity provided	
	2.14	a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	Yes	Amber	Review of windows and doors has taken place As per	Formal ventilation assessments required.	RPE according to HoC	Estates / Health & Safety	30/06/2022	amber whilst HoC are incorporated. Clarity provided that all areas	
	2.15	where possible air is diluted by natural ventilation by opening windows and doors where appropriate	Yes	Amber	The importance of ventilation has been communicated to staff. A review enhanced ventilation in admission and waiting areas is now required	The review is complete in all clinical and non-clinical areas	Need to see evidence of review	Estates / Divisions	30/06/2022	amber whilst HoC are incorporated. Clarity provided that all areas require assessment but starting with all inpatient areas	
	2.16	where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	Yes	Amber				Estates	30/06/2022	amber whilst HoC are incorporated. Clarity provided	
	2.17	when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	Yes	Green	•Screens are used in some non-clinical areas to improve segregation of staff. •Staff working in clinical areas continue to wear surgical masks, even if they are behind a screen.			Estates	Complete		

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	Systems and process are in place to ensure that:										
	3.1	arrangements for antimicrobial stewardship are maintained	No	Green	Arrangements for AMS are maintained - Regular Antimicrobial Review Group & TIPCC meetings & documented minutes and action plans - NICE AMS Compliance audit – completed in 2021 - Antibiotic App in operation to aid prudent selection at the point of prescribing - Cerner prescribing care			IPC / AMS	Complete		
	3.2	previous antimicrobial history is considered	Yes	Green	Previous Antimicrobial History is considered - Electronic patient records enable previous therapeutic history to be reviewed at any time point. - Electronic patient records enable link to primary care GP records through NHS spine - Antimicrobial stewardship ward rounds in operation to highlight antimicrobial			IPC / AMS	Complete		
	3.3	the use of antimicrobials is managed and monitored: o to reduce inappropriate prescribing. o to ensure patients with infections are treated promptly with correct antibiotic.	Yes	Green	Use of antimicrobials is managed/ monitored at individual patient level , but not at trust level, which woudl provide great levels of assurance against NICE guidelines - Monthly review of antimicrobial consumption (bacterial and fungal) to ensure within NHSE/ PHE / WHO criteria for prudent antimicrobial use - Point Prevalence		lack of regular antimicrobial resistance data (trust level) leading to potentially excessive or sub-optimal empirical therapies.	IPC / AMS	Complete		
	3.4	mandatory reporting requirements are adhered to, and boards continue to maintain oversight.	No	Green	Mandatory reporting requirements are adhered to and boards continue to maintain oversight - Quarterly reporting of AMS within IPC &AMS EMB quality report. - GAP – Previous used to report quarterly to CCG to share best practice. This needs to be re-energised			IPC/AMS/EPi	Complete		

	3.5	risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	Yes	Green	Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens – on the basis of resistance data which is a clinical risk - Standing agenda for unintended consequences within ARG for changes in policies - Quarterly DATIX report from Medication Safety with any antimicrobial prescribing		lack of regular antimicrobial resistance data leading to potentially excessive or sub-optimal empirical therapies.	IPC/AMS/EPI	Complete		

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	Systems and processes are in place to ensure that:											
	4.1	visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors	Yes	Green	Trust policy & guidance reflects this and is under regular review			Corporate Nursing	Complete			
	4.2	national guidance on visiting patients in a care setting is implemented.	No	Green	Trust policy & guidance reflects this			Corporate Nursing	Complete			
	4.3	restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	Yes	Green	All visiting restrictions considered and where appropriate recommended suspended non-essential visitors in active outbreak situations. Does not apply to designated essential carers EOL etc		Comms to patients and visitors Use of virtual visits	Corporate Nursing	Complete			
	4.4	there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing.	Yes	Green	•The communications team have produced signage to designate areas used to care for patients with confirmed or suspected COVID-19, and for designated COVID-protected pathways. •Clear signage has also been designed to designate COVID-secure non-clinical workspaces.		Discrepencies in face mask / face covering	Corporate Nursing	Complete			
	4.5	if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	Yes	Green	•Each hospital entrance has a welcome station with signage to encourage 'hands, face, space.' Ward areas have entrance signage. Guidance for visitors is aloso published on our trust website and is regularly reviewed		Gaps in comms for relatives at ward level	Corporate Nursing / C	Complete			
	4.6	visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	Yes	Amber	Covered in policy, guidance and patient information		policy in place but recent evidence shows gaps in application - challenges on exemptoin etc	Corporate Nursing / C	30/06/2022	signage does not cover this - but internet does state that you should not come to hospital if you are symptomatic - remain amvber whilst signage is updated		
	4.7	visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian.	Yes	Green	These restrictions are in place. clinical areas where AGPs take place are aware of IPC requirements included visitors not present. Only occurs when essential such as parents of young children			Corporate Nursing	Complete			
	4.8	Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	No	Green	Review of each of the resources noted in the toolkit is taking place. Decision on whether the implementation of these on ICHT or alternatives in place.			IPC - DIPC	Complete			
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	Systems and processes are in place to ensure that:											
	5.1	signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Yes	Amber	5.2 •COVID-19 patient assessment pathways approved at CRG and widely communicated for the Emergency Department and Admission wards. These included physical segregation of patients with confirmed COVID-19 or symptoms from those without.		need evidence	Communications	30/06/2022	amber whilst signage is updated		

	5.2	infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.	Yes	Green	•Patients are tested 48 hours prior to discharge. •COVID-19 status is automatically included in patient discharge summaries. •Compliance with discharge testing is monitored electronically		Internal comms	Clinical Divisions	Complete	need to re-audit	
	5.3	staff are aware of agreed template for screening questions to ask.	No	Amber	•Staff are aware of agreed template for triage questions to ask. Compliance was audited in late 2020."	Sample screen tool for use in Covid-19 in healthcare settings	New up to date audit required	Clinical Divisions / Communications	30/06/2022	Screening template and questions are in place, however are not available on intranet. ** to be checked and then reviewed and updated pending UKHSA guidance re: removal of governemnt restrictions	
	5.4	screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.	Yes	Green	Triaging and testing processes are in place and embedded in all care pathways.	Compliance with admission testing is <100%.	Compliance with routine patient testing is monitored weekly (Divisional leads). Patients who have tested negative on/before admission and are not COVID-recovered have been tested daily for the first 7 days of their admission. Weekly discussion at HCAI sit rep. Divisions actioned with understanding reason why some metrics remain below 90% to support targeted interventions.	Clinical Divisions	Complete		
	5.5	front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.	Yes	Green	COVID-19 patient assessment pathways approved at CRG and widely communicated for the Emergency Department and Admission wards. These included physical segregation of patients with confirmed COVID-19 or symptoms from those without.			Clinical Divisions / Site Operations	Complete		
	5.6	triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	Yes	Green	COVID-19 patient assessment pathways including the triggers for patient testing approved at CRG and widely communicated. Processes in place about allocation to appropriate pathways			Clinical Divisions	Complete		
	5.7	there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	Yes	Amber	•Compliance with patient testing pre-admission, on admission, on day 3, day 7, weekly, and prior to discharge (if required) is monitored automatically.	Compliance remains <100%.	Patients who have tested negative on/before admission and are not COVID-recovered have been tested daily for the first 7 days of their admission Weekly discussion at HCAI sit rep. Divisions actioned with understanding reason why some metrics remain below 90% to support targeted interventions.	Clinical Divisions	30/06/2022	appropriate testing protocols in place but need aligning to HoC	
	5.8	patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.	Yes	Amber	5.7 •Clear advice is provided to all patients to encourage the use of surgical facemasks unless they are eating, drinking, or sleeping. •If a patient is unable to wear a surgical mask, this is documented in Cerner.		re-audit or not doing ?	Clinical Divisions	30/06/2022	Discussion at CRG re: proportinate review and ?audit with focus on offer of mask rather than wearing one. Not currently happening in all areas. This will form part of changing to symptom based pathways	

	5.9	patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result.	Yes	Green	Rapid identification and testing of patients along with contact tracing is in place.			Site Operations / Clinical Divisions / ED	Complete		
	5.10.0	patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.	Yes	Green	Discussion on-going with site operations and clinical divisional colleagues to obtain evidence			Site Operations / Clinical Divisions / ED	Complete		
	5.11	patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their	Yes	Green	Face masks are available for patients with respiratory symptoms. Patients are advised to wear surgical masks unless they are eating, drinking, or sleeping. If a patient is not able to wear a surgical mask, this is documented in Cerner.		At the point of admission and throughout their stay in hospital all patients are managed against our bed base on the basis of their clinical presentation, risk factors and comorbidities/vulnerabilities. This took place prior to Covid 19 are remains standard clinical practice.	Site Operations / Clinical Divisions / ED	Complete		
	5.12	families and carers accompanying them for treatments/procedures must be considered.	Yes	Green	Face coverings are required by all outpatients and visitors and this is reinforced by welcome station staff. •PPE Helpers have spent some time in welcome stations to review practice.			Site Operations / Clinical Divisions / ED	Complete	to develop guidance for visitors as part of new visiting criteria	
	5.13	where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	Yes	Green	•Patients attending for routine appointments are triaged to make sure they don't have symptoms consistent with COVID-19. •Patients that are not tested prior to their admission are managed on medium risk pathways. •Recovery plans are scrutinised to ensure face-to-face is the exception not the rule. •All recovery plans are approved by the site IPC lead before approval			Site Operations / Clinical Divisions / ED	Complete		
	5.14	face masks/coverings are worn by staff and patients in all health and care facilities.	Yes	Green	•Clear advice is provided to all patients to encourage the use of surgical facemasks unless they are eating, drinking, or sleeping. •If a patient is not able to wear a surgical mask, this is documented in Cerner.	There are systems and processes in place. Staff adherance os regularly monitored by ward based leadership, and PPE helpers as well as IPC colleagues. Patient compliance with face mask wearing has not been audited.	Monitoring compliance with patient mask wearing (clinical audit team). An audit of patient compliance with face mask wearing has been completed and results shared with divisions. This exercise will be re-assessed in light of new guidance	Clinical Divisions / Corporate Nursing	Complete		
	5.15	where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.	Yes	Green	•Clear guidance has been given to staff about the need to maintain physical distancing of at least 2m wherever possible. •Beds and patient chairs should be spaced >2m apart when possible (bed centre to bed centre). •"Chair, bed, locker" arrangement of furniture is in place. Review of entire trust took place and 2m distanced confirmed. Process in place	Some bed / trolley spaces are not >2m apart.	Bed spacing across the Trust has been reviewed. The areas where bed spacing is <2m are the neonatal units at QCCH and SMH, parts of labour recovery at HH, and parts of AB2 (maternity) at SMH. A risk assessment has been undertaken (approved at CRG) in these areas to document the mitigations in place. The mitigation measures for these areas are now in place.	Site Operations / Clinical Divisions / ED	Complete	Need to align boarding policy	
	5.16	patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff.	Yes	Green	•Screens are used in some non-clinical areas to improve segregation of staff. •Staff working in clinical areas continue to wear surgical masks, even if they are behind a screen.			Site Operations / Clinical Divisions / ED	Complete		

	5.17	patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly.	No	Green	•COVID-19 patient assessment pathways widely communicated. •Pathway breaches are reported on Datix and trigger incident investigation.	Pre-emptive isolation of patients who develop symptoms following a negative test are not always available due to lack of single room availability.	Situations are managed on a case-by-case basis with input from the IPC team, usually be establishing cohorts of confirmed or suspected patients. There is a risk on the IPC risk register related to limited isolation facilities in the Trust.	Site Operations / Clinical Divisions / ED	Complete		
	5.18	isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative.	No	Green	Rapid identification and testing of patients along with contact tracing is in place.			Site Operations / Clinical Divisions / ED	Complete		
	5.19	patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	No	Green	•Patients attending for routine appointments are triaged to make sure they don't have symptoms consistent with COVID-19. •Patients that are not tested prior to their admission are managed on medium risk pathways. •Recovery plans are scrutinised to ensure face-to-face is the exception not the rule. •All recovery plans are approved by the site IPC lead before approval			Clinical Divisions / OPD	Complete		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	Systems and processes are in place to ensure that:										
	6.1	appropriate infection prevention education is provided for staff, patients, and visitors.	Yes	Green	Staff have been trained to follow PHE guidance on PPE usage and have had donning and doffing training, there are posters in all clinical areas, and advice readily available on the Trust intranet. All staff are asked to complete Infection Prevention Training at Induction – Level 1 for Non-Clinical – Level 2 for Clinical. Clinical Staff Complete Refresh this Annually			IPC - DIPC	Complete		
	6.2	training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	Yes	Green	•All staff undergo electronic IPC training (IPC Level 1), with clinical staff receiving a more detailed session (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.	IPC - DIPC	Complete		
	6.3	all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	Yes	Green	•All staff receive training on appropriate use of PPE.	Ward-based training records are not routinely stored electronically.	The content of mandatory training for clinical staff has been reviewed and it covers the selection of appropriate use of PPE and how to safely don and doff. Compliance with this training ("IPC Level 2") is reviewed at the Executive People and Organisational Development Committee. An updated electronic resource for training staff related to PPE has been produced and will be launched in the coming weeks.	IPC - DIPC	Complete		
	6.4	adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	Yes	Green	•PPE helper programme provide ward-level support for staff to use the correct PPE, and to use it safely. •The PPE helper programme provides an assessment of adherence to national guidance around PPE in clinical areas. •The safe and effective use of PPE is a strategic objective of the Hand Hygiene and PPE Improvement Group, which meets monthly.		PPE helpers are visiting clinical areas daily to observe PPE use and support best practice.	IPC - DIPC - Divisions	Complete		
	6.5	gloves are worn when exposure to blood and/or other body fluids, non- intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	Yes	Green	reviewing IPC practice and training, discussion with clinical divisions		need audit data - check with tracey HH audit	IPC - DIPC - Divisions	Complete		
	6.6	the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance.	No	Green	•Hand driers are not used in clinical areas. •Hands are dried using disposable paper towels in clinical areas.		Some public toilet spaces withi main outpatient areas have handdryer, but there are not considered clinical spaces	Estates / IPC - Decontamination	Complete		
	6.7	staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	Yes	Green	Clear guidance has been given to staff about the need to maintain physical distancing of at least 2m wherever possible.			Clinical Divisions	Complete		
	6.8	staff understand the requirements for uniform laundering where this is not provided for onsite.	No	Green	•The Trust Uniform Policy provides specific information about laundering uniforms. Scrubs were used in more areas during the peak of the pandemic and increased laundry facilities provided to ensure safe laundering.			Clinical Divisions	Complete		

	6.9	all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance.	Yes	Green	Test and Trace service work and existence, including contact tracing Staff response to being contacted Covid Helpline Intranet info Work of Trust contract managers (e.g. with CBRE) to raise awareness Whoever has been liaising with the Trust Charity re volunteers			Occupational Health	Complete		s Note that OH/ Test & Trace is responsible mainly for reactively dealing with this agenda e.g. in contact-tracing and outbreak management Test & Trace working collectively with other departments (e.g. Medical Directors Office, IP&C and Comms) is responsible for proactive mangaement of this area e.g. for ward-based outbreaks and PCR testing
	6.10.0	to monitor compliance and reporting for asymptomatic staff testing	Yes	Amber	•Routine testing using lateral flow testing has been implemented and is available to all patient-facing staff. •For staff who participate, positive and negative results are recorded using an electronic system, with automated reminders in place if results are not logged twice weekly. •Staff who report a positive lateral flow test are contacted to arrange a PCR confirmatory test.		National reporting issues	MDO	30/06/2022	Amber - we are able to monitor and report based on the data we receive from the governmental reporting system, but this does not provide granular information. This is a national challenge.	
	6.11	there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	Yes	Green	•IPC review each new case of COVID-19 to identify possible cross transmission. •The rate of hospital-onset COVID-19 infection at ICHT and across London is reviewed weekly at CRG. •Occupational Health review each new case of COVID-19 in staff to identify possible cross-transmission.			IPC - DIPC	Complete		
	6.12	positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	Yes	Green	•Robust procedures are in place for the identification and management of COVID-19 outbreaks in patients and/or in staff. •Learning is captured from local and regional COVID-19 outbreaks.			IPC - DIPC	Complete		

7. Provide or secure adequate isolation facilities	Systems and processes are in place to ensure:										
	7.1	that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs	Yes	Amber	•Clear advice is provided to all patients to encourage the use of surgical facemasks	Patient compliance with face mask wearing has not been audited.	Monitoring compliance with patient mask wearing (clinical audit team). An audit of patient	Clinical Divisions	30/06/2022	As above to be fed into new symptomatic pathway - partially adopted	
	7.2	separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.	Yes	Green	The Trust has adopted a risk pathway system for all areas, designating the area based on patient status and PPE requirements to safely manage that cohort. Includes use of symptom checker			Outpatients / Clinical Divisions	Complete		
	7.3	patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	Yes	Green	•COVID-19 patient assessment pathways approved at CRG and widely communicated, including the preferable use of single rooms for patients with confirmed or suspected COVID-19.	There are limited single rooms in our Trust, so patients with confirmed COVID-19 have been cohorted together in clearly designated areas according to the guideline approved at CRG	IPC have advised on when it is appropriate to cohort patients together. There is a risk on the IPC risk register related to limited isolation facilities in the Trust.	Site Operations / Clinical Divisions	Complete		
	7.4	patients are appropriately placed ie, infectious patients in isolation or cohorts.	Yes	Green	•IPC review each new proposed cohort area to ensure compliance with PHE national guidance			Site Operations / Clinical Divisions	Complete		
	7.5	ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	Yes	Green	•Clear guidance has been given to staff about the need to maintain physical distancing of at least 2m wherever possible. We undertake assessment of areas and have processes in place to discuss any derogation.	Some bed / trolley spaces are not >2m apart.	Bed spacing across the Trust has been reviewed. The areas where bed spacing is <2m are the neonatal units at QCCH and SMH, parts of labour recovery at HH, and parts of AB2 (maternity) at SMH. A risk assessment has been undertaken (approved at CRG) in these areas to document the mitigations in place. The mitigation measures for these areas are now in place.	Site Operations / Clinical Divisions / Estates	Complete		
	7.6	standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	Yes	Green	reviewing IPC practice and training, discussion with clinical divisions			Clinical Divisions	Complete		
	7.7	the principles of SICPs and TBPs continued to be applied when caring for the deceased	Yes	Green	Mortuary staff follow UK Health Security Agency & HSE guidance on care of the deceased			Corporate Nursing	Complete	Corporate Nursing	
8. Secure adequate access to laboratory support as appropriate	There are systems and processes in place to ensure:										
	8.1	testing is undertaken by competent and trained individuals.	No	Green	•Testing is performed in accredited laboratories.			MDO	Complete		
	8.2	patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance;	No	Green	Pathways for testing symptomatic patient and staff have been established and outlined on the Trust Intranet. Trust Test and Trace processes are in place. We comply with national guidance on covid As the national guidance on other respiratory viruses in interpreted locally we do this. we offer testing for all viruses all year round and step up when we need to based on		promptly	NWLP	Complete		
	8.3	staff testing protocols are in place	No	Green	•Pathways for testing symptomatic patient and staff have been established and outlined on the Trust Intranet. Trust Test and Trace processes are in place.			MDO	Complete		

	8.4	there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available.	No	Green	Pathology TATs are monitored from sample receipt in the pathology specimen reception. Monitoring can extend to the when the order was placed (referred in our system as collection date) but this has been shown to be unreliable since physical sample collection is often different from the time the electronic test order was raised.		lab based not pt based	NWLP	Complete	Discussed at CRG - agree we are working within the principle of the KLOE and have mitigations we can activate where necessary to ensure in-pt care is not affected when in lab TAT is increased. CRG agree that green is a reasonable position.		
	8.5	there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data).	No	Green	• The laboratory have clear SOPs and quality assurance systems in place. Results are reported through Cerner.			NWLP	Complete			
	8.6	screening for other potential infections takes place.	No	Green	• The laboratory have clear SOPs and quality assurance systems in place. Results are reported through Cerner.	Compliance with MRSA admission screening was on target at 90% for Q4: 5813 of the 6488 patients identified as requiring MRSA screening were screened. Overall compliance with CPE admission screening was 83%, and >90% in the four specialties performing universal admission screening.	Screen for COVID MRSA CPR Gram negatives in neonates	NWLP	Complete			
	8.7	that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	No	Green	Requesting of these tests is down to the Clinical teams. NWLP offers rapid screening in each hospital for COVID-19 as well as Influenza-A, Influenza-B and RSV during the seasonal periods for these viruses. Testing for a more extending respiratory viruses panel takes place in the main pathology Hub at Charing Cross.	Compliance with testing is monitored electronically and is <100%.	Patients who have tested negative on/before admission and are not COVID-recovered have been tested daily for the first 7 days of their admission. Weekly discussion at HCAI sit rep. Divisions actioned with understanding reason why some metrics remain below 90% to support targeted interventions.	NWLP	Complete			
	8.8	that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise.	No	Green	Requesting of these tests is down to the Clinical teams. NWLP offers rapid screening in each hospital for COVID-19 as well as Influenza-A, Influenza-B and RSV during the seasonal periods for these viruses. Testing for a more extending respiratory viruses panel takes place in the main pathology Hub at Charing Cross. Staff are encouraged to re-test when ever symptoms emerge or clinical suspicioun	Compliance with testing is monitored electronically and is <100%.	Patients who have tested negative on/before admission and are not COVID-recovered have been tested daily for the first 7 days of their admission. Weekly discussion at HCAI sit rep. Divisions actioned with understanding reason why some metrics remain below 90% to support targeted interventions. Need to audit time from symptom onset to test collection	NWLP	Complete			
	8.9	that all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission.	No	Green	Requesting of these tests is down to the Clinical teams. NWLP offers rapid screening in each hospital for COVID-19 as well as Influenza-A, Influenza-B and RSV during the seasonal periods for these viruses. Testing for a more extending respiratory viruses panel takes place in the main pathology Hub at Charing Cross.	Compliance with testing is monitored electronically and is <100%.	Patients who have tested negative on/before admission and are not COVID-recovered have been tested daily for the first 7 days of their admission. Weekly discussion at HCAI sit rep. Divisions actioned with understanding reason why some metrics remain below 90% to support targeted interventions.	Clinical Divisions	Complete			

	8.10.0	that sites with high nosocomial rates should consider testing COVID-19 negative patients daily.	No	Green	•Contacts of a known positive case are testing daily through their 14 day isolation period. •Patients who have tested negative on/before admission and are not COVID-recovered are tested daily for the first 7 days of their admission.		currently restricted to Live outbreak areas only	IPC - DIPC	Complete		
	8.11	that those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge.	No	Green	Homes request up to date swabs before admitting. These requests are processed through the discharge hub emails. Wards have access to rapid swabs when a bed has been confirmed and their existing swab is out of date. We keep a record of most up to date swab result in the Complex discharge tracker. Discharge teams ensure prompts are done to wards on weekends when discharges to	No programme of regular audits yet in place - done on ad hoc basis	Complete small sample audit	MIC - Discharge Team	Complete	Complete small sample audit	
	8.12	those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	No	Green	Discharge to Assess forms have specific request for isolation dates. These dates are monitored on the complex discharge tracker. All patients requiring rehab bed or care home bed are referred to Designated Units via the discharge hub inbox. They remain on those waiting lists for the duration of their isolation period.	No programme of regular audits yet in place - done on ad hoc basis	Complete small sample audit	MIC - Discharge Team	Complete	Complete small sample audit	
	8.13	there is an assessment of the need for a negative PCR and 3 days self- isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	Yes	Green	Discussed with appropriate clincial teams and decision made not to implement LFTon day of admisison across the trust at that time			Clinical Divisions	Complete		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections	Systems and processes are in place to ensure that											
	9.1	the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	Yes	Green	The IPC Team perform regular Quality Ward Walks on all wards in the Trust. If a ward has been identified as an outbreak ward, then an enhanced Quality Ward walk will be completed. This observes adherence to Hand Hygiene, social distancing and adherence to wearing surgical facemasks in both clinical and non- clinical settings.			IPC - DIPC	Complete		
	9.2	staff are supported in adhering to all IPC policies, including those for other alert organisms.	Yes	Green	•IPC policies are published on the Trust Intranet and promoted via various channels. IPC support staff in implementing			IPC - DIPC	Complete		
	9.3	safe spaces for staff break areas/changing facilities are provided.	Yes	Amber	we do not universally provide appropriate staff break ares/changing facilities.			HR / Estates / H&S / Divisions	30/06/2022	On-going trust wide improvement plan to address this	03/03/22 - the trust programme to improve staff restspaces is underway; the first fully upgraded staff rooms have been completed and launched and year 2 of roll out is
	9.4	robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	No	Green	•Robust procedures are in place for the identification and management of COVID-19 outbreaks in patients and/or in staff. •Learning is captured from local and regional COVID-19 outbreaks.			IPC - DIPC	Complete		
	9.5	all clinical waste and linen/laundry related to confirmed or suspected COVID- 19 cases is handled, stored and managed in accordance with current national guidance.	No	Green	•A guideline for managing clinical waste related to COVID-19 has been created and published on the Trust Intranet. Our waste management procedures are audited regularly as part of contract arrangements and KPIs indicate no issues.			Facilities	Complete		
	9.6	PPE stock is appropriately stored and accessible to staff who require it.	No	Green	Some PPE stock is held centrally in the Stores area of each main site. Additonal stock held in warehouse in Milton Keynes.Staff order Mon-Fri via Eleanor Helpdesk.If ordered by 12midday, the area will receive their order by 4pm on the same day.If PPE is required out of hours, a small quantity is held in the Site Manager's office.			Procurement	Complete		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	Systems and processes are in place to ensure that:											
	10.1	staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	Yes	Green	Occupational Health service/ HR intranet webpages Recruitment policy Absence management policy		Staff are directed to OH for personal queries, IPC support OH colleagues where required	Occupational Health	Complete			
	10.2	bank, agency, and locum staff follow the same deployment advice as permanent staff.	Yes	Green	Recrutiment policy Staff Bank			Occupational Health	Complete			
	10.3	staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)	Yes	Green	Test and trace service work.			HR / OH	Complete			
	10.4	staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	Yes	Green	•Trust PPE guidance updated in line with PHE guidance regularly, approved at the CRG and communicated on the Intranet and via all-staff emails. •There is a bi-weekly Strategic PPE Planning group chaired by the Director of Nursing and including the Director of Finance. •The monthly Hand Hygiene Improvement Group has become the Hand Hygiene			IPC - DIPC	Complete			
	10.5	a fit testing programme is in place for those who may need to wear respiratory protection.	Yes	Green	Fit testing programme is in place			Emergency Prepardness	Complete			
	10.6	where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: - lead on the implementation of systems to monitor for illness and absence. - facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce - lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 - encourage staff vaccine uptake.	Yes	Green	IP&C policy Immunisation policy OH service procedures Medical Director's office work re covid and flu vaccine programme 2021/22 People Planning service work (re monitoring illness etc)			Occupational Health	Complete			
	10.7	staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	Yes	Green	*Trust PPE guidance updated in line with PHE guidance regularly, approved at the CRG and communicated on the Intranet and via all-staff emails.*			HR / OH	Complete			
	10.8	a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. • A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups; • that advice is available to all health and social care staff, including specific advice to those at risk from complications. • Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff . • A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	Yes	Green	Trust covid individual risk assessment arrangements (see intranet)			Occupational Health	Complete			

	10.9	vaccination and testing policies are in place as advised by occupational health/public health.	Yes	Green	Immunisation policy (Covid vaccination and any testing in relation to covid is overseen by MDO)			HR	Complete			
	10.10.0	staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records.	No	Green	•Reusable FFP3 masks are issued through procurement to staff. Over 1000 masks have so far been issued and a record of each issue is available. Mask maintenance information is available on Intranet and issued with the reusable mask. Application development is in progress and lead by Health & Safety to capture mask maintenance, filter expiry and fit testing in one location. Emergency	Training records (aside from fit testing) are not maintained.	New EPRR member to start later this month to support training. Records held on cerner.To remain amber until EPRR started and confirmation that all staff requiring FFP reusable respirators have undergone training. Records of staff been fit tested are held on Health roster (rather than Cerner). Staff who have a record been tested on a reusable mask means have received the relevant training too. Regardless of the new EPRR staff starting this action	Emergency Prepardness	Complete		
	10.11	staff who carry out fit test training are trained and competent to do so.	No	Green	•Staff who carry out fit test training are trained and competent to do so.. Training programme is in place and conforms to HSE requirements.			Emergency Prepardness	Complete			
	10.12	all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	No	Green	•All staff required to wear an FFP respirator have been fit tested for the model being used and this is repeated each time a different model is used.			Emergency Prepardness	Complete			
	10.13	all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	No	Amber	Fit testing for a second mask is in progress. Pending the recruitment of the fit testing team to roll out in all areas.	40% of fit tested staff need to be tested for a second mask.	Recruitment of the fit testing team in progress. Engagement & provision for the high risk areas already in place. DHSC fit testing continues to mitigate the gap in recruitment.	Emergency Prepardness	30/06/2022	There are processes in place but complaince metrics are low	2/3/22 - The recruitment of the team is still in progress, appointed but working their notice period. Due to the Western Eye relocation we are required to relocate some of our services pending refurbishment completion. We are on track in the app development. Currently 50% of staff in AGP areas are already fit tested for two masks. DHSC fit testing provision continues until
	10.14	a record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	No	Green	•A record of the fit test and result is given to and kept by the trainee and held centrally within the organisation.			Emergency Prepardness	Complete			
	10.15	those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	No	Green	•For those who fail a fit test, there is a record given to and held by the trainee and centrally within the organisation of repeated testing on alternative respirators.			Emergency Prepardness	Complete			
	10.16	that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	Yes	Green	Several different masks are available and staff are fit tested as many times as required to find a mask which fits. Alternative equipment does not include hoods as these are not available in the Trust at the moment. This means that staff with facial hair or specific headwear are not fitted with a RPE.	Staff with beards or headwear for religious reasons are not fitted for a RPE	IPC to approve a hood. IPC to provide cleaning instructions for the hood. Procurement to source tubing covers.	Emergency Prepardness	Complete	single person use hood identified. Decon lead working with EP team on SOP and procurement	

	10.17	members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	No	Green	For members of staff who fail to be adequately fit tested, a discussion is had regarding redeployment opportunities and options commensurate with the staff members' skills and experience and in line with nationally agreed algorithm. This fits with standrad OH processes			HR	Complete		
	10.18	a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	No	Green	For members of staff who fail to be adequately fit tested, a discussion is had regarding redeployment opportunities and options commensurate with the staff members' skills and experience and in line with nationally agreed algorithm. This fiots with standard OH processes			HR	Complete		
	10.19	boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	No	Green	Weekly report is available to board on the fit testing compliance.			Emergency Prepardness	Complete		
	10.20.0	consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance.	No	Green	Staff are allocated to a particular care pathways to the extent possible. It continues whereever possible and is practicable. Staffing cover is considered in situations of pathway mixing			Divisions / HR / IPC	Complete	CRG	
	10.21	health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	No	Green	Local self assessments is the H& S approved process and has executive level approval			Occupational Health and Safety	Complete	CRG - self nomination, HS independent	
	10.22	staff absence and well-being are monitored and staff who are self -isolating are supported and able to access testing.	No	Green	Staff absence and their wellbeing monitored by People and Planning and the line manager In relation to covid, Test and Trace do some (limited) follow-up monitoring of well being for those who are self-isolating See intranet re their ability to access testing			HR	Complete		
	10.23	staff who test positive have adequate information and support to aid their recovery and return to work.	No	Green	OH/ Test and Trace service/ covid intranet page Test and Trace email content to affected staff Covid Helpline Contact Service referencing			Occupational Health	Complete		

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Ockenden Report (including gap analysis and plan for Midwifery Continuity of Carer)

Agenda item 12 and paper I

Executive Director: Professor Tg Teoh, Divisional Director – Women's, children's and clinical support

Author(s): Susan Barry, Interim Head of Midwifery, Cathy Hughes, Divisional Director of Nursing & Midwifery

Purpose: For discussion

Meeting date: 25 May 2022

1 Purpose of this report

1.1 The final Ockenden report was published in March 2022 with a number of recommendations and immediate actions for Trusts to take forward. The purpose of this paper is to ensure the Trust Board is aware of the recommendations within the report and to provide an update on progress with the actions required to achieve those recommendations.

2 Executive Summary

2.1 The Ockenden review of the failings of the maternity services at Shrewsbury and Telford Hospital NHS Trust was one of the largest inquiries relating to a single NHS service. The review was published in two parts, in December 2020 and the final report in March 2022.The final report is available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064302/Final-Ockenden-Report-web-accessible.pdf.

2.2 The final report consists of 15 Immediate and Essential Actions (IEAs) grouped into four pillars; safe staffing levels, a well trained workforce, learning from incidents and listening to families. In total there are 92 individual action points.

2.3 A full review of these has been undertaken and an action plan prepared, which was reviewed at the Quality Committee in May 2022. There are a number of areas where we have excellent processes in place, many of which were assessed by the Care Quality Commission (CQC) when they inspected us most recently. There are a number of areas where we have work to do to ensure continued improvement and learning, and we are committed to do this. A date for submission of evidence has not yet been confirmed and will be overseen by the Trust Quality Committee.

2.4 The Trust submitted evidence to NHSE/I for the seven Immediate and Essential Actions (IEAs) from the first Ockenden report with 100% compliance.

2.5 One of the actions requiring Board oversight relates to the provision of maternity continuity of carers (MCoC). The Trust has reviewed staffing levels and have agreed to prioritise the most vulnerable. A phased roll out plan is in place and further detail will be shared at the Board meeting in July 2022.

2.6 Three engagement events have been held, with over 50 staff, to share the report and support staff following the publication. This is also an opportunity for staff to contribute and share ideas.

2.7 All maternity services will receive an assurance visit from their Regional Chief Midwife. For the Trust this will take place in September 2022.

2.8 The NHS announced investment of £127m over the next two years, on top of the £95m annual increase that was started last year.

3 Approval process

The seven IEAs from the first Ockenden report were discussed at the Quality Committee on 5 May 2022. This report has been signed off by the Maternity Triumvirate and the Divisional Director of Nursing and Midwifery. It has also been reviewed by the Medical Director's Office.

4 Recommendation(s)

The Board is asked to acknowledge the findings of the Ockenden report and the Trust response.

5 Next steps

These are detailed in the body of the report.
The Trust Board Quality Committee will continue to oversee the implementation of the action plan.

6 Impact Assessment

6.1 Quality impact: The IEAs detailed within Ockenden 1 and 2 will support the continuous sustained improvement for the maternity service as part of the quality and safety strategy.

6.2 Financial impact: The primary aim of this is to improve outcomes and experience of maternity care. Robust oversight of the maternity quality and safety strategy will improve outcomes and experience, which aims to reduce litigation claims for the Trust.

6.3 Workforce impact: Recruitment to new roles once investment is secured.

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: Securing investment to achieve compliance with the 15 IEAs of the final publication.

7 Main report

7.1 The final report (2 of 2) of the Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust was published 30 March 2022. This was one of the largest inquiries relating to a single service in NHS history, reviewing 1,592 clinical incidents involving 1,486 families between 2000 and 2019. The final report consists of 15 Immediate and Essential Actions (IEAs), this is in addition to the 7 IEAs in the first Ockenden report 2020. The 15 IEAs include 92 individual action points. The final report is available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064302/Final-Ockenden-Report-web-accessible.pdf.

7.2 In line with a letter received from Amanda Pritchard, Chief Executive of NHS England, on 1 April 2022, the Trust was asked to develop robust plans against areas where services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

7.3 We have undertaken a gap analysis to assess our position against the 15 IEAs in collaboration with the midwifery, obstetric, neonatal and anaesthetic teams. An overall action plan for the maternity service has been developed to address service developments and improvements required. This includes actions identified from the Morecambe Bay report benchmarking exercise and maternity self-assessment tool.

7.4 Using the four key pillars against the IEA action points, we have identified areas where progress has already been made, work that is underway and where action has yet to be taken to achieve compliance. A more detailed action plan is in place and will be overseen by the executive quality group and the Trust Quality Committee, but the key areas are summarised below, including timescales for achievement. All 'outstanding' actions will be completed by end of June 2022:

1. Safe staffing levels

Completed	In progress	Outstanding
Business Continuity plan and risk assessment -VCOD	Birthrate Plus® assessment – due to be completed **Expected by end June 2022**	Review of maternity escalation policy **Reviewed by 30th June 2022**
Continuation of Twice daily staffing huddles	Redesign MCoC teams to provide access to care for those from the most vulnerable areas -**Q2 2022**	Fund anaesthetic elective lists at SMH **Reviewed by 30th June 2022**
Continue daily senior midwifery staffing huddles	Complete RCM midwifery leadership manifesto action plan– **Q4 2022**	
Band 7 Midwifery bleep holder 24 hours based at QCCH	Review current services changes – birth centres, group practice, homebirth **-Q3 2022**	
Senior midwife on-call out of hours – onsite presence as required	Amend labour ward co-ordinator Job Description in line with national guidance - **June 2022**	
Six monthly midwifery staffing Trust Board report (CNST SA6)	Review the establishment and working arrangements of the bereavement midwives to offer daily cover -**June 2022**	
Yearly operational risk assessment completed for the birth centres	Midwifery recruitment and retention task force - O**ngoing**	
Ensure competency assessment to provide assurance that middle grade and trainee obstetricians are able to manage the maternity service without direct consultant presence		
To ensure prospective Consultant antenatal ward round cover is funded at SMH and QCCH		

2. A well-trained workforce

Completed	In progress	Outstanding
Appointment of two additional supernumerary clinical skills facilitators to provide preceptor support	Review preceptorship programme – supernumerary status for one month (currently 3 or 4 weeks) and hospital only setting for initial 12 months **-June 2022**	Allocate a leadership mentor for newly appointed Band 7 and 8 midwives **Reviewed by 30th June 2022**
Continue PG forums and monitor attendance	Develop Labour Ward coordinator orientation programme and training package – **August 2022**	
Ensure sustainable training for maternal medicine	Audit labour ward coordinator supernumerary status – **June 2022**	
	Ensure at least one HDU trained midwife available on every shift – **June 2022**	
	Develop a strategy around succession planning opportunities– **Sept 2022**	
	Monitor compliance of Active Bystander training – **August 2022**	
	Ensure human factor training is included in annual education, including psychological safety – **July 2022**	
	Reinstate regular MDT skills drills in clinical areas -**June 2022**	
	Set trajectory and compliance with PROMPT and fetal monitoring training – **Sept 2022**	

Ensure relevant staff attend the HOTT training programme – **August 2022**
Review and maintain a record of staff trained in post-mortem consent – **June 2022**
Review structure and oversight of education of maternity service staff groups – **August 2022**

3. Learning from incidents

Completed	In progress	Outstanding
Developing the maternity QA oversight report to ensure progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.	Review and develop an action plan from the completed maternity self-assessment tool using appreciative inquiry– **June 2022**	Identify a named patient safety specialist for the maternity service (pending clarification on the role) **Reviewed by 30th June 2022**
	Clinicians with responsibility for maternity governance given sufficient time to be able to engage effectively with their management responsibilities – **August 2022**	Develop a conflict of opinion policy to support staff members escalating concerns in collaboration with the Medical Director office **Reviewed by 30th June 2022**
	Train individuals leading maternity governance teams in human factors, causal analysis and family engagement –-**July 2022**	Audit the review of postnatal readmissions and ensure consultant review within 14 hours or sooner - **Reviewed by 30th June 2022**
	Provide incident investigation training for risk midwives -**June 2022**	
	Ensure a 6 month deadline on actions arising from SIs -**August 2022**	
	Identify a midwifery co-lead for guideline development – **June 202**2	
	Review capacity for Induction of Labour - updated national guidance– **June 2022**	
	Share with trust board remedial plans following a self-assessment, including governance structure – **June 2022**	

4. Listening to families

Completed	In progress	Outstanding
Continue offering birth choices and listening clinic appointments	Continue monthly complaints reports to the maternity Q&S which includes themes and trends - **ongoing**	Liaise with the MVP regarding complaint responses - **Reviewed by 30th June 2022**
Review the provision of psychological support and counselling for service users and their families before May 2022	Ensure the language used in investigation reports is easy to understand for families **- ongoing**	
Continue Preparation Inspiration and Support for Motherhood (PRISM) Imperial bespoke Antenatal Education	Continue MVP co-production and NED involvement -**ongoing**	
	Continue monitoring FFT and improve response rates – Action plan **June 2022**	
	Review the information provided to service users and local guideline regarding transfer time to hospital for out of hospital births - **June 2022**	
	Review the Trust website and ensure information is accurate and up-to-date -**June 2022**	

8. Ockenden One

8.1 The Trust submitted evidence to NHSE/I for the seven IEAs from the first Ockenden report. Confirmation was received from the Regional Chief Midwife, on 2 December 2021, that the Trust was 100% compliant.

8.2 Following an NHS England request in February 2022, the Trust submitted an update to the regional team regarding actions identified to meet the recommendations of both the Morecambe Bay and Ockenden One reports, along with the findings of the maternity self-assessment assurance tool. This was approved by the Executive Management Board.

8.3 In addition to providing assurance to the Trust Board and regional maternity teams, the Chief Executive received email communication from the NWL CEO and Senior Responsible Officer for Maternity for the Sector, following publication of the final Ockenden report, proposing nine actions (including actions relating to Ockenden one). This request was completed and actions have been shared with the CEO and Chief Nurse.

8.4 The Trust continues to complete actions against the initial seven IEAs.

IEA	Action
1 Enhance safety	Compliant. The audit midwife has started spotlight monthly audits to review compliance.
2 Listening to women and families	Compliant. Plans to further increase birth choice clinic and launching a listening clinic in June.
3 Staff training and working together	Initial audit of MDT consultant lead ward rounds identified the anaesthetic team were not always present for all ward rounds. Communication has been circulated and this area is now compliant cross-site.
4 Managing complex pregnancy	• A recent audit found that midwives are correctly allocating appropriate consultant on the booking documentation, however known IT/admin issues with the booking team are causing a discrepancy between named consultant and lead clinician. This has been addressed. • The care of complex pregnancies in March showed 75% compliance with evidence of early specialist involvement with no obvious themes for non-compliance.
5 Risk assessment throughout pregnancy	• Risk assessment and intended place of birth discussion at every appointment shows poor compliance with appropriate documentation on Cerner in the observation and assessment tab. Discussion with team leaders/Matrons will take place during May/June to discuss barriers to address this as a priority. Free text notes will also be audited as a further measure of compliance. • Personal Care Plans have now been implemented onto Cerner but not currently rolled out as we are completing the pilot in conjunction with the Mum & Baby app before going live. • April scorecard audit themes are: correct pathway for women who DNA and more robust care plans were evident during the labour process rather than in the antenatal period.
6 Monitoring Fetal Wellbeing	Fetal monitoring training falls below the 90% target (78% QCCH and 82% SMH) due to the temporary suspension of training during Covid. There has been a significance increase in staff compliance and we plan to achieve 90% by the end of August 2022.
7 Informed consent	• Website redevelopment continues, in collaboration with the communications team and Maternity Voice Partnership. • Improvements in the use of translation services remains a priority for the department. 100% of women have translation services at booking and there is evidence of compliance during the antenatal period. The department have consulted with other London Trusts about their translation services and we are now exploring the possibility of a new system to improve compliance.

9. Maternity Continuity of Carer

9.1 Midwifery Continuity of Carer (MCoC) has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for MCoC to be the default model of care for maternity services, and available to all pregnant women in England. Where safe staffing allows, and the building blocks (detailed implementation plan / communication and engagement with staff / education programme for new teams including team building / estate and equipment) are in place this should be achieved by March 2023 – with rollout prioritised to those most likely to experience poorer outcomes first.

9.2 In line with Better Births and the NHS Long Term Plan, all women should be offered the opportunity to receive MCoC across antenatal, intrapartum, and postnatal care. Not all women will be in a position to receive MCoC, as some will have chosen to receive some of their care at another maternity service and, in a small number of cases, women will be offered a transfer of care to a specialist service for maternal / fetal medicine reasons.

9.3 Ockenden Two includes a specific action on MCoC: 'All trusts must review and suspend if necessary, the existing provision and further roll out of MCoC unless they can demonstrate staffing meets safe minimum requirements on all shifts'.

9.4 The Trust's current MCoC positon is as follows:

- The Trust currently has four continuity teams.
- The maternity service has completed the required review and taken the following position in line with option 1 in the communication from Amanda Pritchard: *Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.*
- For the Trust this means that roll out of MCoC will be in four waves. The proposed plan is to achieve 56% MCoC for women and pregnant people living within our geographical boundaries by the end of Quarter 4, 2024. Wave 1 implementation (Q2 – 2022) will incorporate reconfiguring three of the existing teams into the three areas of highest deprivation.
- Expansion of MCoC is subject to ongoing review of minimum staffing requirements.
- The Birthrate Plus (BR+) workforce analysis is currently in process and due to be reported in June and will be utilised to complete the NHSE/I workforce toolkit for MCoC.

10. Engagement Events

10.1 Three engagement events have been held, with over 50 staff, to share the report and to offer an opportunity for staff to contribute and share ideas. Further events are planned in May/June 2022. Staff are also signposted to CONTACT the Trust counselling service and the Professional Midwifery Advocate team for additional health and well-being support.

11. Assurance visits

11.1 All maternity services will receive an assurance visit from their Regional Chief Midwife together with the Senior Responsible Officers from their local and buddy Local Maternity System (LMS) by September 2022. The Trust will undergo an assurance visit on either 19 or 28 September, subject to confirmation.

12. Investment

12.1 Following the final Ockenden publication, the NHS announced significant investment to kick-start transformation of maternity services with investment of £127m over the next two years, on top of £95m annual increase that was started last year. This will fund further workforce expansion, leadership development, and capital to increase neonatal cot capacity, additional

support to Local Maternity and Neonatal Systems and retention support. We are awaiting further information regarding the bidding process for this funding.

13. Next Steps

- Complete outstanding actions.
- The service is awaiting notification from the national midwifery team on the submission date and evidence requirements for compliance with Ockenden Two.
- Continue Ockenden staff engagement events during May and June.
- Prepare for Ockenden assurance visit – 19 or 28 September.
- Await completion of BR + assessment to plan safe staffing and next steps for MCoC teams.
- Awaiting an investigation report into maternity services in East Kent – anticipate a refreshed delivery plan in the Autumn bringing together existing work and learning from Ockenden and East Kent.
- The Trust Quality Committee will continue to oversee implementation of the overall Trust response.

14. Conclusion

14.1 The maternity service has shared the final Ockenden report and its proposed actions with the Trust Board. The service was 100% compliant with the evidence submission for Ockenden One and there is a robust action plan in place for meeting the requirements of Ockenden Two. A Trust plan is in place for MCoC.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

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

Agenda item 13 and paper J

Lead Executive Director(s): Julian Redhead, medical director

Author(s): Darren Nelson, head of quality compliance and assurance

Purpose: For information

Meeting date: 25th May 2022

Executive summary

1. Purpose of this report

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

2. Executive summary

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

2.2. To bring us in line with how this is reported nationally, we now report on the number of deaths where care and service delivery issues may have contributed, rather than on deaths deemed 'avoidable'.

2.3. Although our mortality rates remain statistically significantly low, we are reviewing why our HSMR ranking has fallen outside the top 5, with a detailed report due to be provided to Quality Committee in July. Investigation so far points to Covid as a cause of death as one of the likely root causes in conjunction with a reduction in the percentage of deaths with palliative care coded in comparison to the NHS in general where this has increased. There are also specific specialties where the HSMR has increased; divisions are currently reviewing this data.

2.4. All cases of 'poor care' and any other SJRs where there are additional concerns are reviewed at the Medical director's weekly incident panel (MD panel). Five SJRs were reviewed at MD panel in Q4 2021/2022. In four of the cases, care was deemed appropriate with no further investigation required. One of the 'poor care' cases is being investigated as a level 1 as there was a failure to recognise that the patient was deteriorating.

2.5. In addition to review at MD panel, we have reintroduced a regular review meeting, chaired by the medical director to consider any complex cases and triangulate all associated investigations. Recently, this meeting has been predominately used to review HOCI deaths however we are now re-starting review of other cases. Of the non-HOCI deaths reviewed in quarter, there was one in which care and service delivery issues were identified that may have contributed to a patient's death (confirmed as moderate harm) and another where it was confirmed that they did contribute to the

death (extreme harm). In response to this, and another similar incident, a new safety improvement priority has been agreed for 2022/23 to improve the identification and management of adult patients with dysphagia.

2.6. Learning from the SJRs completed in Q4 is summarised in the report. While most of the themes are consistent with previous quarters, the reviews completed this quarter show the impact of the recent surge and on-going capacity issues.

3. Approval process

3.1. This report was presented to EMBQ and EMB in April 2022, and Quality Committee in May 2022 which noted the report and approved it for onward submission to the Board and NHS England.

4. Recommendation(s)

4.1. The committee is asked to note the findings from our mortality surveillance programme in Q4 2021/2022.

5. Next steps

5.1. The findings from Q4 2021/22 will be submitted to NHS England following review at the Board.

6. Impact assessment

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

Main paper

7. Mortality rates

7.1. Our mortality rates remain statistically significantly low. Our rolling 12-month HSMR has improved; against an expected relative risk of 100 our HSMR is 69.2 (for the period December 2020 to November 2021), compared to a relative risk of 72.0 (for December 2019 to November 2020). However, when previously we were the acute non-specialist trust with the lowest HSMR in the NHS, we are now seventh.

7.2. We are reviewing why our HSMR ranking has fallen outside the top 5, with a detailed report due to be provided to Quality Committee in July. Investigation so far points to Covid as a cause of death as one of the likely root causes in conjunction with a reduction in the percentage of deaths with palliative care coded in comparison to the NHS in general where this has increased. There are also specific specialties where the HSMR has increased; divisions are currently reviewing this data.

7.3. We receive mortality alerts via the Dr Foster analytics services. These alerts do not infer clinical issues but indicate that the data for the diagnosis group is significantly different at Imperial to similar diagnosis groups in the NHS. The alert triggers may change over time with modification of the overall data resulting from coding audits and corrections by Imperial and/or changes in the overall NHS data set. Where a coding issue is identified this is corrected. However if the coding is correct, the individual cases

are reviewed to identify if there are any clinical themes or trends that should undergo further investigation or action.

7.4. There were five diagnosis groups which alerted between July and October 2021:
- Transurethral resection of bladder tumour
- Surgical arrest of bleeding of nose
- Retinal detachments, defects, vascular occlusion, and retinopathy
- Crushing injury or internal injury
- Other perinatal conditions

7.5. Review of the 12 individual cases involved have not identified any particular concerns with the care provided by the Trust, however a full review of perinatal mortality is underway which will report in July as part of the wider HSMR review described above.

8. Summary of learning from deaths data – Q4 2021/2020

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

8.2. There were a total of 440 deaths in Q4, compared to 524 in Q3 2021/2022.

8.3. Of the total 440 deaths in the last quarter, 88 died with a positive COVID-19 swab within 28 days of death or had COVD-19 on the medical certificate of cause of death, compared to 89 out of the 524 deaths in Q3 2021/2022. This is reflective of the ongoing prevalence of Covid in the community.

8.4. There were 28 deaths in Q4 2021/2022 where the patient's infection met the Public Health England definition of Hospital Onset COVID Infection (HOCI) because they tested negative for COVID-19 on admission and subsequently tested positive. These deaths are currently being reviewed through our HOCI death review process (see section 9).

8.5. Appendix B shows the total number of deaths and ratio between COVID and non-COVID deaths from March 2020 (start of pandemic) to the end of March 2022. We have reported 1145 COVID-19 deaths.

8.6. 58 SJRs have been allocated so far for deaths which occurred during Q4. The triggers for these can be seen in Table 2 below.

Table 2 – Triggers for SJR by quarter

Triggers by Quarter	**Q2 20-21**	**Q3 20-21**	**Q4 20-21**	**Q1 21-22**	**Q2 21-22**	**Q3 21-22**	**Q4 21-22**
Medical Examiner Concern	5	7	3	3	16	11	16
Clinical Concern	3	6	3	1	5	2	2
Family Concern	4	5	3	6	13	6	3
Score 1-3	0	0	0	0	0	0	0
Coroner/Inquest	0	1	0	0	0	0	0
SI / Incident	1	0	0	0	0	0	0
Vulnerable group	4	6	9	4	9	3	8
Age Range	16	5	3	1	6	1	0
Specialty /Condition	6	13	36	38	34	11	25

Other	35	9	4	5	16	17	4

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

8.7. The automatic trigger following a coronial referral was removed in December 2020 and the PMRT process commenced at the end of 2020 which has reduced the number of cases triggered under the age category.

8.8. The increase in deaths triggering under 'specialty/condition' is primarily due to HOCI deaths.

8.9. A review into the reasons for the increase in cases referred due to 'medical examiner concerns' over the last three quarters is being undertaken to determine the reason.

8.10. 57 SJRs were completed in Q4 2021/2022. (Note: these SJRs do not all relate to deaths within Q4 2021/2022).

8.11. Of the 57 SJRs completed rating of global care scores were as follows:-

Number of cases	Rating of Global Care
4	2 - Poor care
14	3 - Adequate care
32	4 - Good care
7	5 - Excellent care

8.12. There were four SJRs completed with an overall score of 'poor' care in Q4 2021/22, which is a slight increase compared to last quarter when two were reported.

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

8.14. In Q4 2021/2022, five SJRs were reviewed at MD panel, four because they had an overall score of 'poor care' and one because the SJR reviewer requested that it be presented at the panel for confirmation as to whether further investigation was needed. In four of the cases, care was deemed appropriate with no further investigation required. One of the 'poor care' cases is being investigated as a level 1 as there was a failure to recognise that the patient was deteriorating.

8.15. In addition to review at MD panel, we have a regular meeting, chaired by the medical director to review any complex cases and triangulate all associated reviews and investigations. This meeting will also determine whether the death was more likely than not due to problems in the care provided to the patient and confirm the final harm level. Recently, this meeting has been predominately used to review HOCI deaths (see section 9) however we are now re-starting review of other cases. Two non-HOCI deaths were reviewed in Q4, the outcomes of the discussions were:

- One case was changed from major to extreme harm – this involved inappropriate management of a patient with dysphagia, which contributed to the death of the patient. A comprehensive local action plan is in place and a new safety improvement priority has been agreed for 2022/23 to improve the identification and management of adult patients with dysphagia. This work will focus on development of an education and training plan and improvements to our trustwide processes and systems, as well as locally led improvements at ward level.

- One case was confirmed as moderate harm – care and service delivery issues were identified that may have contributed to the patient's death, however there were other complications and co-morbidities. This case involved a recognised complication after an invasive procedure (endoscopic feeding tube) that led then to further complications. The learning from this to prevent this happening again has included amending the Trust guideline to include how assessments should be carried out and that care plans are available on Cerner for documenting these.

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

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

9.2. There were 32 HOCI deaths identified for review in the first surge, 58 in the second, and 48 identified so far in the third surge (28 of which occurred in Q4 2021/22).

9.3. The 90 cases from the first two surges have been fully reviewed and nine cases (2 from wave 1 and 7 from wave 2) were confirmed as not HOCI deaths, leaving 81 cases in total. With regards to the third surge, four cases have so far been reviewed and one is confirmed as not a HOCI death.

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

9.5. Of the 48 HOCI deaths which have occurred so far during the current surge, 32 have had SJRs completed. These are being reviewed at a weekly panel chaired by the MD, through the same process as the deaths which occurred during the other surges, with 13 completed so far. A full report will be provided to EMBQ when the process is complete.

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

9.7. Following review, harm levels are agreed for each case, however these have not been updated on Datix as we are waiting for confirmation of a sector-level approach to ensure consistency. This is nearing completion. Following discussions at a sector-wide meeting in April, it looks likely that we will report very few cases as being definitely avoidable. An update will be provided next month with a plan across the sector for all trusts to provide a detailed report to their Boards in July.

10. Themes and Learning

10.1. Learning from Deaths continues to be a standard monthly agenda item on all the Divisional QS meetings where developments in the LFD agenda and learning is shared which is then disseminated to the all the directorates and throughout the division. In addition, a bi-monthly newsletter is now being produced, with the first being published in February 2022.

10.2. The key learning themes from SJRs in this quarter have included early referrals to specialist teams, and, the importance and impact of contemporaneous record keeping as much as is practicable to enhance clinical care. The impact of long stays in ED due to capacity issues is a new theme for SJRs completed in this quarter, reflecting the operational pressures during the recent surge.

10.3. SJRs continue to show issues with timely referral to palliative care and early confirmation of ceilings of care. Improving end of life care is one of our safety improvement programme priorities for 2022/23. A business case, focused on improving education and training is being developed and will then taken through the appropriate approvals process.

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

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

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

11.3. For the last quarter NHSR suspended many of the maternity safety standards due to the pandemic, advising to continue to report on the MBRRACE system any baby deaths and if there is capacity within the maternity units to undertake reviews using the perinatal mortality tool.

11.4. During this time the team completed 23 reviews. The key learning themes were the importance of clear and concise handovers when care is transferred from another unit, including PMH history and operation notes. Two cases with key learning include:

- The identification of risk factors and appropriate referral at booking and at every consultation as indicated. Uterine artery Doppler's were not completed as it was not highlighted as high risk for SGA. Static growth on SFH at 31/40 gestation and the woman should have been seen by Obstetric Medical team in view of previous IUGR. Categorised as low risk obstetric and social. However, there were risk factors of previous IUGR and premature birth.
- The importance of completing the telephone pro-forma when a woman called the unit with brown PV loss. No questions were asked regarding fetal wellbeing. The proforma would have prompted these questions and other important clinical ones to have asked.

11.5. Many of the reviews involved ex utero transfers from other maternity units. The learning from these units was also shared to improve clinical practice.

12. Conclusion

12.1. Our harm profile remains good, however through the processes outlined in this report, there was one death in which care and service delivery issues were identified that may have contributed to a patient's death and another where it was confirmed that they did contribute to the death. In response to this, and another similar incident, a new safety improvement priority has been agreed for 2022/23 to improve the identification and management of adult patients with dysphagia.

12.2. While most of the learning themes are consistent with previous quarters, the reviews completed this quarter show the impact of the recent surge and on-going capacity issues.

Author: Darren Nelson, head of quality compliance and assurance
Date: 13th May 2022

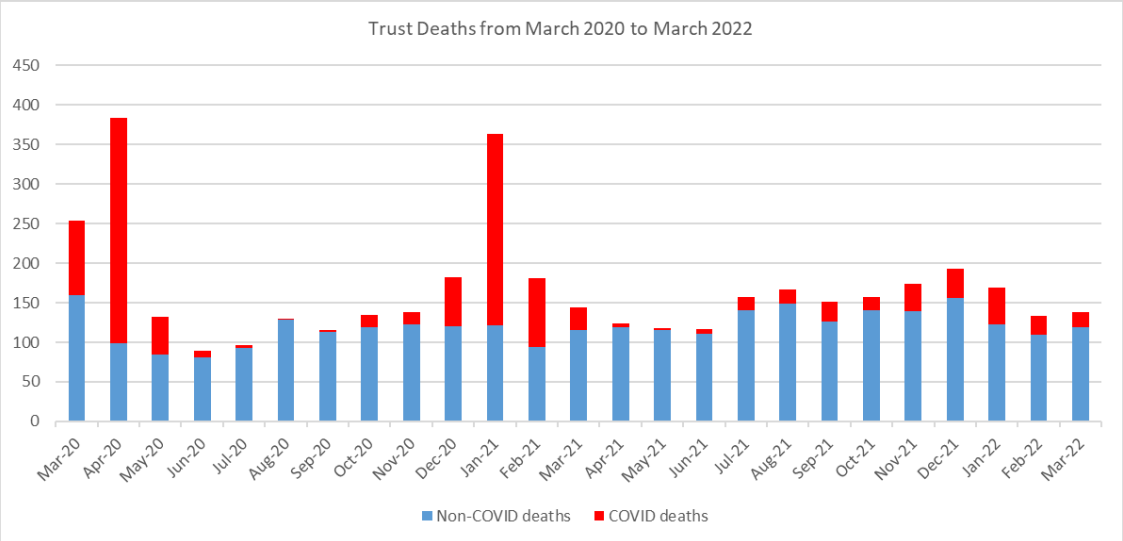
Imperial College Healthcare NHS Trust

List of appendices

Appendix A - Learning from Deaths Dashboard

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

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



Learning from Deaths Dashboard Quarter 4 2021-22

Up to: **Quarter 4**

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

Latest Quarter

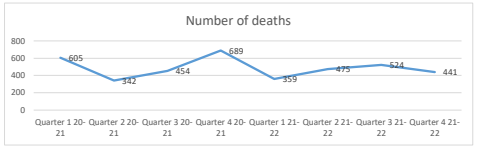
Deaths	Last Quarter	Neonatal Deaths	Last Quarter	Very Poor/Poor Overall Quality of Care	Last Quarter
441	524	Suspended	Suspended	4	2

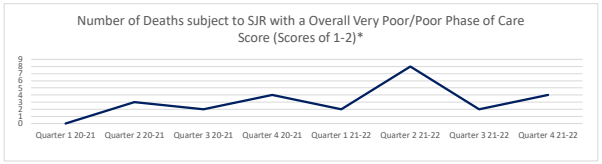
Latest Quarter

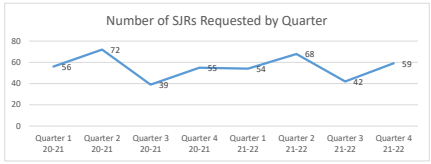
SJRs Requested	Last Quarter	SJRs completed	Last Quarter	Not complete <30 days (%)	Last Quarter
59	42	57	52	6.78%	16.67%

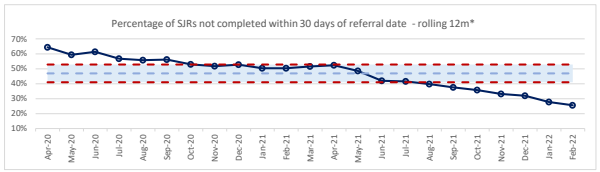
Latest Quarter

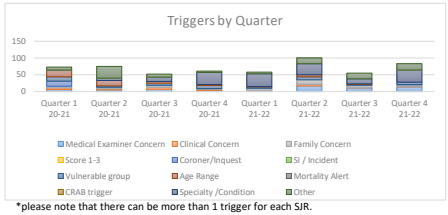
PMRTs requested	Last Quarter
12	14











Suspended neonatal reporting

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

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

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Quality Committee Report

Agenda item 14 and paper K

Committee Chair: Professor Andy Bush, Non-Executive Director
Executive Director: Julian Redhead / Janice Sigsworth
Author: Sara Harris, Interim Head of Trust Secretariat

Purpose: Information

Date of meeting: 25 May 2022

1. Purpose of this report

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

2. Introduction

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

3. Key points

3.1. The key items to note from the Quality Committee meeting held on 5 May 2022 (National Midwives Day) include:

4. Quality Committee Annual Report and Review of Terms of Reference

4.1 The Committee was provided a summary of the work of the Quality Committee for the year 2021-22 and, in doing so, was provided with assurance that it operates effectively in delivering its Terms of Reference (TOR). The Committee also noted the outcome of the annual committee effectiveness review.

4.2 The Committee approved the annual report for inclusion in the Trust's Annual Report 2021-22 and approved the Terms of Reference, for approval by the Board.

5. Update on Covid-19 including Covid-19 vaccination and Flu update

5.1 The Committee received a presentation on the Trust's response to Covid-19 and the sector position across North West London.

5.2 The Committee noted that the management of Covid-19 across the world had improved but was also reflective of the rate of spread of the virus. There was a decrease in numbers of patients in UK hospitals, with confirmation that all UK regions had seen an improved picture. There was also reduced numbers of staff on sick leave with Covid-19 and also with other illnesses. The data for the NW London ICS showed a reduction in beds with a steadier decline. Variances in the number of vaccine administered showed no evidence of waning immunity in the OS data. In April 2022, 13,300 beds were occupied with a prediction of 5000 beds being occupied in June 2022.

5.3 The Committee discussed the Covid and flu vaccination, noting that it was anticipated that the Joint Committee of Immunisation and Vaccination (JCVI) may plan a combined approach with Covid-19 immunity and the flu vaccine programme. The Committee noted the update and requested more analysis of the data around ethnicity recording and ethnicity differences in the reduction of Covid-19 cases.

6. Risk and Assurance Deep Dive – Caring for Patients with Mental Health in ED

6.1 The Committee conducted a deep dive review of the provision of care to patients with mental health needs attending the Trust's emergency departments at St Mary's and Charing Cross hospitals. The Committee noted the concerns reported over some time regarding the increased number of attendances to Trust emergency departments at both sites by patients with mental health needs, and the challenges in providing adequate care for those patients while waiting for assessment by Mental Health providers and the transfer of patients to an appropriate place of safety.

6.2 The Committee noted the measures that the Trust had put in place to minimise the risk to such patients, noting that ensuring that patient safety was paramount but acknowledging that an ED was not an appropriate place of safety for this cohort of patients but was the best option in an acute hospital. The Committee also noted the estates constraints, especially at St Mary's that had fewer cubicles in the emergency department in comparison to the West Middlesex or Chelsea hospitals but is the busiest Trauma centre in London.

6.3 The Committee agreed that the executive and clinical teams had done as much as possible to mitigate the risk and welcomed the continued escalation of the issue to local mental health providers and the ICS.

6.4 The Committee noted with pleasure the recent appointment of a new Mental Health Lead Nurse to oversee wider Mental Health issues within the Trust, including in-patients admitted with physical illnesses who also had mental health issues, and would like to have a more broadly based deep dive when she has been in post a little longer, probably in about six months' time.

7. Maternity Quality Assurance Oversight Report and Approach to Ockenden Report

7.1 The Committee received the Maternity Quality Assurance Oversight report noting the QCCH maternity theatre refurbishment had progressed well. The Committee noted the perinatal mortality assurance report had been completed and the deep dive found a decline in stillbirths from 2019 to 2021 with no care delivery issues impacting the outcome for the babies concerned.

7.2 The CQC maternity survey 2021 results showed the Trust had performed well against other Trust's in almost all areas and actions were in place to address improving experience for our service users.

7.3 The Committee noted the update and that CNST MIS year 4 was currently paused and the Trust awaits further guidance.

7.4 Midwifery staffing levels due to vacancies continued to be a concern despite the on-going recruitment and retention task group. The senior team agreed actions to ensure the service remains safe across both sites and would monitor this daily.

7.5 The Committee noted that the Ockenden final report had been published on 30 March 2022 and had recommended 15 immediate and essential actions for all trusts. A benchmarking exercise had been completed in collaboration with midwifery, obstetric, neonatal and anaesthetic leads and an action plan was in its developmental stages. The Committee will monitor progress in the development and implementation of the Trust response to the recommendations.

8. Quality Assurance report

8.1 The Committee noted the Quality performance report, noting exceptions against quality key performance indicators and measures being taken to address areas of variance against target. The Committee were notified of a fifth 'never event'.

8.2 The Committee noted continued strong performance in HSMR, and will consider this in more detail at the next meeting, in light of the fact that although our HSMR had not dropped, we had fallen out of the top five performing Trusts.

9. Draft Quality Account 2021/22

9.1 The Committee considered the draft Quality Account for 2021/22, including the quality priorities for 2022/23. This year's quality account outlined progress against the six safety improvement programme priorities agreed for 2021/22, and confirmed the priorities for delivery in 2022/23.

9.2 Recognising that owing to the impact of the pandemic there was more work to do to achieve the aims from last year, the Trust would continue to focus on the six improvement areas prioritised in 2021/22, with two new additional priorities which have been identified as risks through our incident reporting processes. The priorities for 2022/23 are:

- Improve incident reporting rates across the Trust
- Improve hand hygiene practice, and the safe use of PPE in our clinical areas
- Improve how we agree and document appropriate treatment escalation plans, for our patients in an individualised, compassionate, and inclusive manner
- Improve how we document that our patients have provided informed consent prior to relevant procedures
- Reduce avoidable harm and improve performance and outcomes associated with invasive procedures
- Reduce the number of patient falls and associated harm levels
- Improve the checking of blood products prior to transfusion (new)
- Improve the identification and management of adult patients with dysphagia (new).

9.2 The Committee noted that work continues to set appropriate targets for all of these priorities, this will be reflected in the next draft. The Committee were concerned that the excellent achievements of the Trust should be highlighted in a way accessible to lay people rather than risk being lost in a welter of detail.

10. Learning from deaths quarterly report quarter 4 2021/22

10.1 The Committee received the report noting the findings from the Trust's Mortality Surveillance Programme. The Trust now reports on the number of deaths where care and service delivery issues may have contributed, rather than on deaths deemed 'avoidable'. The findings from Q4 2021/22 will be submitted to NHS England following review at the Quality Committee on behalf of the Board.

11. Infection Prevention and Control Board Assurance Framework for Covid-19 Self-Assessment

11.1 Committee members received the Board Assurance Framework (BAF), updated following a review in December 2021. The BAF now contains 125 KLOE over 10 domains; 42 KLOE remain unchanged from the previous BAF and 83 are either new or significantly revised and cover aspects of IPC practice beyond specifically Covid-19 as was previously the case. The Committee noted that a re-review of all previous KLOEs had taken place to ensure the level of assurance remains appropriate and noted the following points:

- To undertake a self-assessment against the ten domains in the framework.
- An action plan was in place to undertake the necessary work that will improve board assurance related to IPC management.
- No red rated KLOEs. Sixteen KLOE are RAG rated as amber with actions in progress and designated leads for each area.

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

12. Paediatric Asthma Discharges

12.1 The Committee members received an excellent presentation on paediatric asthmas discharges. The Committee noted that the key achievements made in the last 7 months which included:

- The NACAP data provides reasonable assurance
- Improvement in all areas observed over the 7 month period
- Ongoing quality improvement (QI) work locally and regionally
- Recruitment to a substantive post as Local Asthma Lead
- Joint recruitment with the Royal Brompton Hospital (RBH) ongoing of regional Asthma Specialist
- Reviewing the Asthma CNS job plans
- Reviewed clinic provision

12.2 The Committee congratulated the Team on the excellent presentation and successes made and requested the presentation be included as part of the Board report.

13. Safeguarding Situation Report

13.1 The Committee received a summary of the current situation and the Trust safeguarding processes, including compliance with mandatory training. The report was a one-off situation report to provide context and oversight. The Committee noted the 7 day a week safeguarding service. A comprehensive suite of policy and guidance available through the Trust Intranet. Safeguarding training has been delivered through a combination of e-learning and group sessions via Teams. Level 3 children's training has been more problematic and this issue has been escalated to the ICS.

13.2 A key focus has been paediatric consultants who need to be compliant with level 3 in order to practise. There is a plan in place to achieve full compliance by July 2022.

13.3 The Committee was very concerned that the Lead Doctor post had remained vacant for more than a year. We noted this is not a Trust appointment, and urged that our concerns be escalated upwards. The Committee also noted the tremendous work achieved by Guy Young, Deputy Director, Patient Experience who announced his retirement. His knowledge around mental health, mental capacity and the safeguarding agenda was exemplary. This would be his last Quality Committee meeting attendance and the Committee noted his fantastic work and thanked him for his dedication.

14. Regulatory Compliance Update

14.1 The Committee received the update regulatory compliance, noting an update on engagement activity with the CQC.

14.2 The Committee noted the update on the Management Review launched by the CQC to investigate a concern relating to the management of patients with mental health needs attending the emergency department (ED) at St Mary's Hospital.

15. Recommendation(s)

15.1 The Board is asked to note this summary.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Financial update - Month 12

Agenda item: 15 and paper L

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

Purpose: For noting

Meeting date: 25th May 2022

1. Purpose of this report

1.1. This report provides a summary of the key finance items being presented to the Trust Board.

2. Executive Summary

2.1. **Income and Expenditure** - at the end of the year the Trust achieved a £83k surplus position against a breakeven plan.

2.2. **Capital** – the final outturn against the Capital Resource Limit (CRL) of £79.4m was £78.8m, with total capital expenditure increasing to £94.9m once schemes funded by grants and donations are included.

2.3. **Cash** – The closing cash position was £237.5m which was higher than forecast due to the timing of receipt of funding and payments to suppliers. Cash is expected to decrease in 2022-23 as liabilities are settled, but balances are forecast to remain higher than historic levels.

2.4. **Better Payment Practice Code** – the year-end performance was higher than the 95% target with 95.4% of invoices by value paid settled within the threshold.

2.5. The transition of the Chelsea and Westminster NHS Foundation Trust payroll and pension service to the Trust was successfully concluded and went live on 1st April 2022.

3. Recommendation(s)

3.1. The Board is asked to note the report.

Appendix 1: 2021/22 Month 12 Finance Report

Imperial College Healthcare NHS Trust

Trust Board 25th May 2022

Finance Report March 2022

Statement of Comprehensive Income

Imperial College Healthcare NHS Trust

	Full Year		
	Plan £m	Actual £m	Variance £m
Income	1,300.3	1,408.0	107.7
Pay	(771.7)	(812.5)	(40.8)
Non Pay	(466.3)	(533.3)	(67.1)
EBITDA	**62.3**	**62.2**	**(0.1)**
Financing cost and donated asset treatment	(62.2)	(41.9)	20.4
Impairment of assets	0.0	(21.2)	(21.2)
National PPE Adjustments	0.0	1.1	1.1
Draft Surplus/(Deficit)	**0.0**	**0.1**	**0.1**

At the end of the year the Trust has achieved a £83k surplus position against a breakeven plan. The Trust continued to receive the majority of it's core funding via block contract arrangements throughout 2021/22 but through the delivery of increased levels of elective work, secured additional income via the elective recovery fund offsetting other in-year pressures.

The current position reflects the draft accounts as submitted on the 26th April with final audited accounts due to be concluded by the 22nd June.

Statement of Financial Position (Balance Sheet)

Imperial College Healthcare NHS Trust

	31-Mar-21	31-Mar-22	Movement
Property plant and equipment	550.6	591.6	41.1
Intangible assets	14.1	14.1	0.1
Other Non Current Assets	3.2	3.2	0.0
Total Non-current assets	**567.9**	**609.0**	**41.1**
Inventories	17.1	17.4	0.3
Trade and other receivables	90.6	57.3	(33.2)
Cash and cash equivalents	149.1	237.5	88.4
Total current assets	**256.7**	**312.2**	**55.5**
Trade and other payables (<1 year)	(281.5)	(335.3)	(53.9)
Total current liabilities	**(281.5)**	**(335.3)**	**(53.9)**
Non Current Liabilities	(21.2)	(27.2)	(6.1)
Total non current liabilities	**(21.2)**	**(27.2)**	**(6.1)**
Net Assets employed	**521.9**	**558.6**	**36.7**
Public Dividend Capital	773.9	797.1	23.2
Revaluation Reserve	2.4	2.4	0.0
Income and expenditure reserve	(254.4)	(240.9)	13.5
Total tax payers' and other equity	**521.9**	**558.6**	**36.7**

Non-Current Assets
Non-current assets have increased by £41.1m since March 2021 following capital expenditure of £94.9m offset by capital charges of £53.7m.

Current Assets
Receivable balances have decreased by £33.2m following the ongoing settlement of out-standing balances.

Cash
Cash balances were £237.5m at year end, an increase of £88.4m from the start of the year. Although this position is expected to reduce over 2022/23, it is expected that cash levels will remain at historically high levels in the medium term.

Current & Non-Current Liabilities
Trade and other payables balances have increased by £53.9m in the year, representing increases in both deferred income and accrued costs for capital expenditure and other liabilities.

The Trust ended the year paying 98% of invoices within Better Payment Practice Code timelines, representing 95.4% by value. Movements on non-current liabilities reflect the repayment of capital investment loans and finance lease liabilities.

Taxpayers' Equity
PDC equity funding of £23.3m was received in March 2022.

Capital Expenditure

Imperial College Healthcare NHS Trust

Sources of Funds	£m
Internal Financing	51.7
External funding inc. PDC	27.8
Charitable Funds & Grants	19.7
Total	**99.1**

Applications	Annual Plan £m	Full Year Actual £m	Var £m
Backlog Maintenance	17.2	18.3	1.1
ICT	10.5	10.2	-0.3
Replacement of Med Equipment	12.5	14.0	1.5
DecarbonisationPproject	19.5	13.1	-6.4
Other Capital Projects	36.9	36.8	0.0
Redevelopment	2.5	2.4	0.0
Total Expenditure	**99.1**	**94.9**	**-4.2**
Income & Donation	**-19.7**	**-16.0**	**3.7**
Capital Resource Limit	**79.4**	**78.8**	**-0.5**
Actual spend as a % of total plan		**96%**	

£38.6m of 2021-22 capital programme expenditure has been incurred in Month 12, bringing full year expenditure to £94.9m, 96% of the planned figure of £99.1m.

Against the Capital Resource Limit (CRL) target of £79.4m, the Trust achieved expenditure of £78.8m (99% of plan), an underspend of £0.6m.

In the context of the delivery challenges posed by both the late award of £22.5m of PDC funding (in December 2021) and the wider economic and public health environment in the second half of the year, the outturn position represents a considerable achievement.

The Trust makes every effort to maximise resources but elected not to draw down the full allocation against available external PDC awards where either the schemes could not be accommodated within accounting rules for capital expenditure or could not be delivered by the year end (a condition of funding).

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Finance, Investment & Operations Committee report

Agenda item 15 and paper L

Committee Chair: Andreas Raffel, Non-Executive Director
Executive Director: Jazz Thind, Chief Finance Officer
Author: Sara Harris, Interim Head of Trust Secretariat

Purpose: For information

Meeting date: 25 May 2022

1. Purpose

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

2. Introduction

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

3. Key points

The key items to note from the Finance, Investment and Operations Committee held on 4 May 2022 include:

3.1 Operations

The Committee noted no items for escalation at this meeting and noted that the new integrated finance and operations report would be presented at the next meeting.

3.2 Finance report

The Committee received and reviewed the finance report for month 12 noting that the Trust had achieved a £83k surplus position against the breakeven plan.

3.3 Business Planning 2022-23

The Committee received a report on the Trust's operational plan concerning operations and finance, updating on the presentation at the Trust Board Seminar on 20 April 2022. The key change related to the income calculation associated with elective recovery.

The Committee noted that there needed to be a focus on longer term planning, and that this would feature over time in the newly formed Integrated Finance and Operations Report.

3.4 **Productivity & Efficiency Programme update**

3.5 The Committee received an update on the Trust's Productivity & Efficiency Programme, established to develop the framework through which the organisation is building its plans to reduce waste and improve efficiency.

3.6 The Committee supported the timeline for the maturity of the plan: 75% of the organisational efficiency target for 2022/23 to be identified and planned by 26 May 2022 with the remaining 25% to be closed down by June 2022. The Committee noted also that identification of the efficiencies was well behind plan and needed an extra push to get back to the proposed timeline.

3.7 It was agreed that Divisional and Corporate teams should continue building the 'long listing' of ideas and schemes throughout the year in the interests of building a longer term multi-year plan that enables the Trust to develop a continuous approach to financial improvement.

3.8 The Committee noted there was a risk of non-delivery of 100% of the efficiency target and that this may require additional actions to be put in place. It was, however, noted the need to continue to develop and write plans over the course of the next 4 months was of paramount importance, to build up plans that are credible and deliverable in 2022/23 and beyond.

4. Business cases

4.1. The Committee discussed business cases for the North West London Procurement Shared Service and for the North West London Community Diagnostic Centres programme.

5. IPH International Affiliation Network report

5.1 The Committee received an update on the IPH International Affiliate Network programme and wider international activities and noted the launch of the first affiliation with the Aman Hospital in Qatar in August 2021.

5.2 The Committee welcomed the progress made in the affiliation programme, and noted the Affiliate network is being promoted by Healthcare UK as an innovative example of NHS internationalisation, and championed through the NHS Export Collaborative. The Committee noted other future opportunities and agreed that each one should be considered on their own merits.

6. Summary of business cases approved by the Executive

6.1 The Committee received and noted the summary of business cases considered and approved by the Executive since the last meeting of the Finance, Investment and Operations Committee.

7. FIOC Committee annual report and review of its Terms of Reference

7.1 The Committee noted a summary of the work of the Finance, Investment and Operations Committee for the year 2021-22 and, in doing so, was provided with assurance that it operates effectively in delivering its Terms of Reference. The Committee also noted the outcome of the annual committee effectiveness review.

7.2 The Committee approved the annual report for inclusion in the Trust's Annual Report 2021-22 and approved the Terms of Reference, for approval by Trust Board.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: People Performance Scorecard - Month 12

Agenda item: 17 and paper N

Lead Executive Director: Kevin Croft, Chief of People Officer
Author: Lou Clark, Director of workforce

Purpose: For discussion and noting

Meeting date: 25 May 2022

1. Purpose of this report

1.1. This report covers a high level summary of people performance metrics as detailed on the monthly people performance scorecard (appendix one).

1.2. The People Committee review a more detailed and consolidated update on the core people priorities, performance, risk and mitigation is taken to the People Committee – this includes workforce performance not included on the monthly scorecard e.g. employee relations.

1.3. The Board are asked to note increased use of statistical process control (SPC) charts to view trends and highlight any significant changes in the variation. This approach will continue to be developed in future reports.

2. Executive Summary

The report provides a clear view of performance against the Trust's workforce performance indicators, identifying areas requiring focus and improvement as well as the actions being taken to enable that improvement.

There are several items to highlight:

- A people scorecard (appendix 1) provides performance trends
- Current staff in post is 12,839 WTE at the end of March 2022, an increase of 36 WTE
- The current Trust vacancy rate is 13.4% and is a small decrease from the month 11 position of 13.5%
- Nursing & Midwifery vacancies (all bands) have steadily reduced from 14% in September 2021 to 12.0% at the end of March
- Band 5 nursing and midwifery vacancies continue to reduce, now at 14.8% compared to the 20.2% in September 2021, a reduction of 27%
- Midwife vacancies were at 14.4% at the end of March (58.1 WTE)
- Voluntary turnover is 12.2%, above the Trust's 12% target. The NWL Trusts have a collective voluntary turnover rate of 13.5%
- Temporary staff spend during 2021/22 was £89.08; £63.75m on bank and £25.33m on agency

- Sickness Absence for March 2022 was 5.50%; higher than in February (5.0%) and driven by increased episodes of short-term illness linked to Covid-19
- The percentage of ethnic minority leaders (band 7+) has seen no significant change in profile over the last 12 months and is currently 41% of all leaders.

3. Approval process

3.1. The content of this report has been discussed at the April 2022 Executive Management Board (EMB), the EMB People Group meetings and the May People Committee.

4. Recommendation(s)

4.1. The Trust Board is asked to discuss and note the key updates.

Appendix 1: Month 12 People Scorecard

Main report

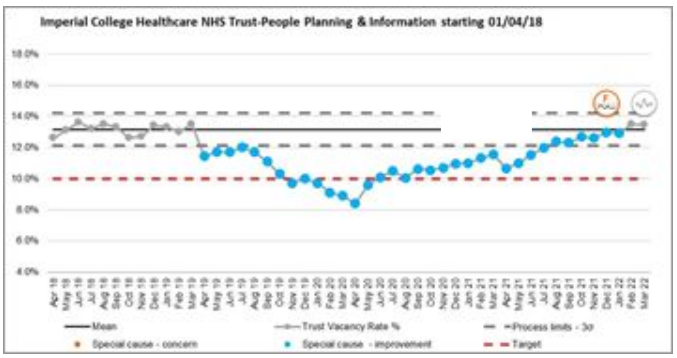
1.0 This report provides an overview of the Trust's workforce at the end of month 12, March 2022, reporting on workforce performance and providing context against the pressures and drivers, risks, and mitigations, which contribute to that performance. In support of this report is, Appendix 1, the People Performance Scorecard.

2.0 Workforce size, strength and stability

2.1 Staff in Post - the number of staff directly employed was 12,839 WTE at the end of March 2022; higher by 36 WTE from the end of February 2022. In terms of headcount, we employ just over 14,500 staff on substantive and fixed-term contract across all Trust services. Since April 2021, the number of staff employed on substantive and fixed-term contracts has increased, overall, by 119 WTE.

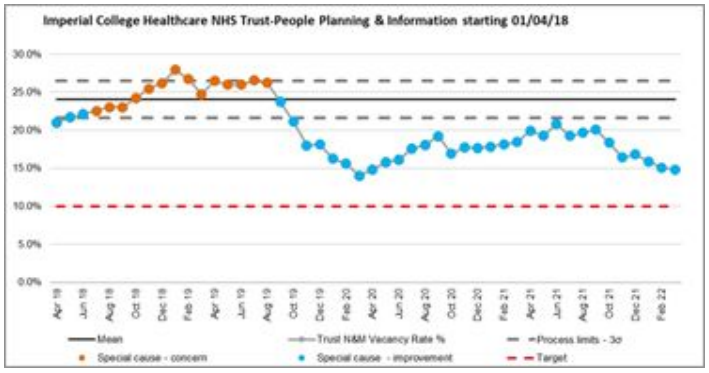
2.2 Establishment - at the end of March 2022 was 14,832 Whole Time Equivalents (WTE); an overall increase of 33 WTE from the end of February 2022.

2.3 Vacancy Rate & Recruitment - the Trust's vacancy rate at the end of March 2022 was 13.4%, (1,993 WTE). The Statistical Process Control Chart (SPC) shows the Trusts vacancy rate over the four years. Whilst not technically special cause variation, the graph shows the progress in reducing vacancies pre-Covid but since the first wave we have struggled to maintain enough recruitment activity to keep pace with leavers and the growing establishment.



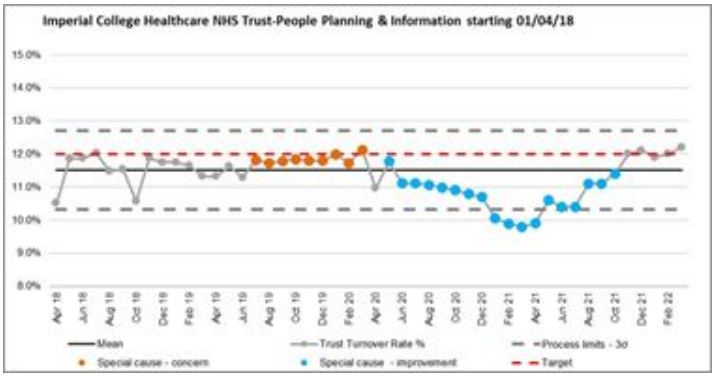
2.2.1 Nursing & Midwifery vacancies (all bands) have reduced from 14% in September 2021, to 12.0% in March 2022 and recovered to pre-covid levels. This represents a significant reduction of 14.3% for vacancies within this staffing group. Band 5 nursing vacancies also

continue to reduce, now at 14.8% compared to the 20.2% reported in September 2021; a 26.7% reduction. The SPC chart shows the Trusts band 5 nursing and midwifery vacancy rate over the four years which clearly shows that since August 2019 there have been no special cause points of concern.



2.2.2 Midwife vacancies (including those created by maternity leave) were at 14.4% at the end of March, 58.1 WTE. Vacancies are reducing with successful recruitment from overseas and through the preceptorship programme. The recommendations from the Ockenden inquiry relating to maternity resourcing and other workforce factors such as culture, leadership and training are being reviewed to identify where improvements and changes may be needed.

2.3 Turnover – the Trust's rolling 12-month voluntary turnover is 12.2%, marginally above the Trust's 12% target. The NWL Trusts have a collective voluntary turnover rate of 13.5%. The SPC chart shows the Trusts voluntary turnover over four years. There have been no special cause points of concern since March 2020, when we saw a drop in staff movement due to the pandemic response. Similarly to other industries, turnover has been rising steadily post wave two and is now above our Trust target of 12%. Noting the rising turnover of staff and the need for increased focus on retention, it is one of the Trust's 22/23 people priority programmes. A multi-disciplinary task force has been launched to design and lead the focused initiatives to reduce turnover.

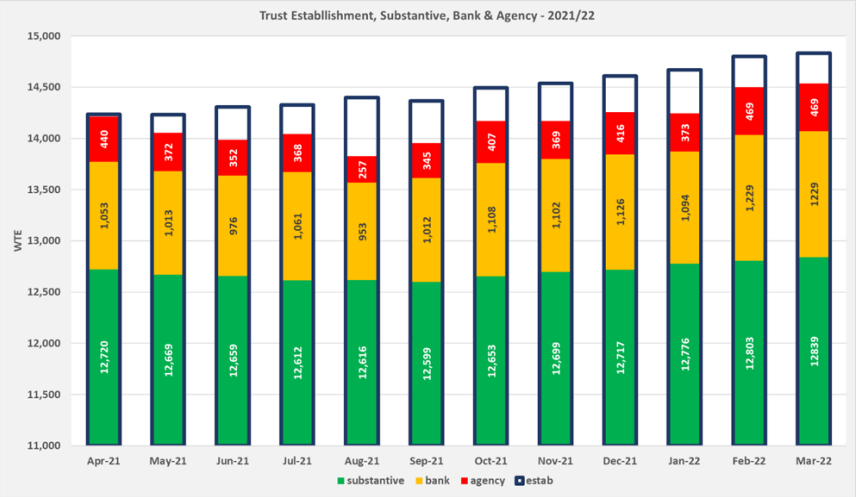


3.0 Workforce productivity

Temporary staff spend - during 2021/22, a total of £89.08m was spent on temporary resource; with £63.75m on bank and a further £25.33m on agency.

The combined bank and agency spend is 10.6% of the total pay bill. The Trust agency spend is 4.3% of total pay spend in month 12 and remains above the target of <2%. This rise in month 12 is due to year-end invoicing and payments and is a usual trend. In addition a movement in M12 substantive pay position, driven by unspent provisions for Annual Leave (-£ 4.8m) and Reset and Recovery days (-£1.7m) impacted the total pay bill causing agency percentage to be shown as higher.

The majority of vacancies are covered through bank and agency and the chart below shows the overall staffing profile against the establishment.



4.0 Performance and skills

4.1 Doctors in training core skills – there has been a marginal improvement in month 12 to 87.3% compliant but remains short of the 90% target.

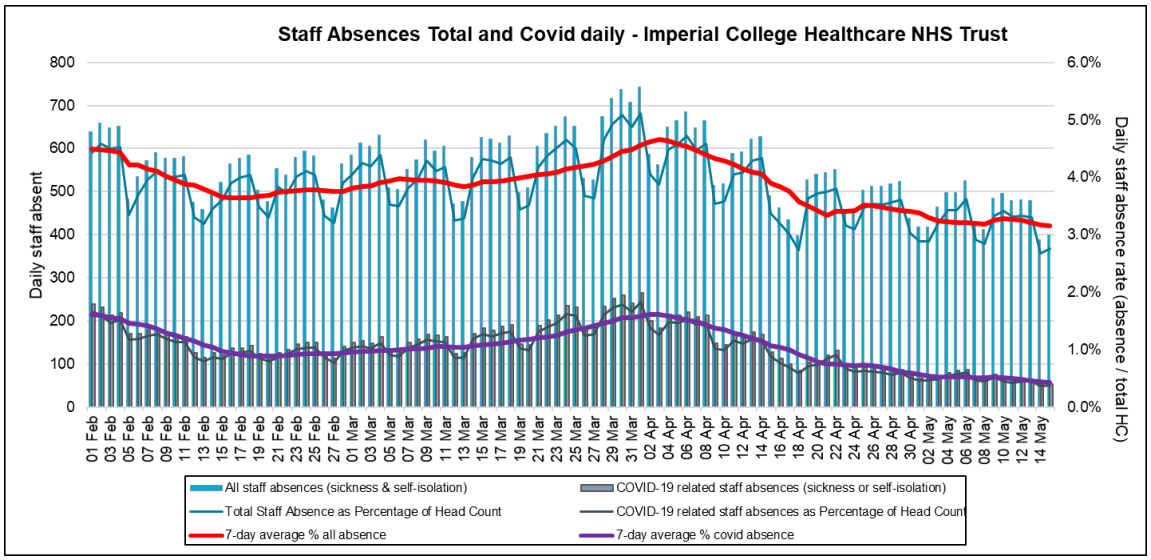
4.2 Local induction – remains below target at 66%. The learning and development team are actively supporting managers through regular reminders and education to ensure that our new starters are welcomed and inducted.

4.3 Medical appraisal – the month 12 compliance rate continues to improve and is now 92.4% against a target of 95%. This is the highest it has been since pre-pandemic and the aspiration is to achieve the NHS England benchmark, 95% compliance, by the end of the 22/23.

5.0 Health and wellbeing

5.1 Sickness absence

Given the changing nature of absence due to Covid, the table below gives the most recent position on overall and Covid-related absence. It can be seen that absence has steadily been declining since the end of March. Over the past year, the Trust's rolling 12-month sickness absence rate has increased from 4.2% to 4.6%.



During month 12, the top three sickness absence reasons, accounting for 52.1% of all recorded absence, were as follows.

February 2022 - Reason as % of Total Sickness	%
S15 Chest & respiratory problems*	34.3 %
S10 Anxiety/stress/depression/other psychiatric illnesses	10.4 %
S98 Other known causes - not elsewhere classified	7.4%

**Note that Covid-19 illness is captured within Chest & Respiratory category*

5.2 **Staff psychology referrals** – new referrals to the CONTACT service remain high at 60 per month and above pre-covid levels. During 22/22, there have been a total of 889 new referrals made to CONTACT. Themes remain consistent with high levels of grief, trauma and past bereavement.

5.3 Annual Leave – 84% of all leave entitlement for 2021/22 was booked/taken which equates to approved levels of carryover leave.

6.0 Equality, diversity and inclusion

6.1 **Ethnic minority leaders** – the percentage of ethnic minority leaders (band 7+) has seen no significant change over the last 12 months and is currently 41%. Vacancies at this level have grown over the last 12 months due to a combination of establishment growth and turnover.

6.2 In September 2021, the Trust launched a new inclusive recruitment approach to be implemented for all appointments at a band 7 and above. The approach required line managers to do two things; to ensure they have a diverse panel (gender and ethnicity) and to write an outcome letter to the Chief Executive, providing details of their shortlisted candidates, outlining their selection process and providing rationale for the hiring decision made.

Between September 21 and March 22, 412 campaigns for new band 7 or above leaders have been advertised, shortlisted and a hiring decision made. There have been 375 offers of employment with 65% of applicants, 52% of shortlisted applicants and 44% of the successful candidates are leaders from a black, asian or minority ethnic background. Work will continue to embe this process and track progress for impact and outcome.

7.0. **Conclusion**

The Trust Board is asked to note this report and scorecard to gain a broad understanding of the key people performance across the core workforce indicators.

The content of this report has been discussed at the April 2022 Executive Management Board (EMB), the EMB People Group and the May 2022 People Committee.

Appendices:
Appendix 1, People Performance Scorecard – March 2022

Imperial College Healthcare NHS Trust

IMIS performance scorecard - People

Section	FI	Metric	Watch or Driver*	Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Workforce Size, Strength & Stability		Trust Post Establishment (WTE)	Watch		14,293	14,236	14,231	14,308	14,325	14,397	14,367	14,492	14,536	14,610	14,670	14,799	14,832
		Trust Staff Inpost (WTE)	Watch		12,643	12,720	12,669	12,659	12,612	12,616	12,599	12,653	12,699	12,717	12,776	12,803	12,839
		Vacancies (WTE)	Watch		1,650	1,516	1,562	1,649	1,713	1,781	1,768	1,839	1,837	1,893	1,894	1,996	1,993
		Vacancy Rate (%)	**Driver**	**<=10%**	**11.5%**	**10.6%**	**11.0%**	**11.5%**	**12.0%**	**12.4%**	**12.3%**	**12.7%**	**12.6%**	**13.0%**	**12.9%**	**13.5%**	**13.4%**
		Voluntary Turnover (%)	**Driver**	**<=12%**	**9.8%**	**9.9%**	**10.6%**	**10.4%**	**10.4%**	**11.1%**	**11.1%**	**11.4%**	**12.0%**	**12.1%**	**11.9%**	**12.0%**	**12.2%**
Workforce Productivity		Temporary Staffing Spend (£'000s) per month	Watch		£10,644	£7,556	£6,837	£5,684	£6,584	£6,605	£6,742	£8,323	£6,236	£7,995	£8,518	£8,867	£9,132
		of which Agency Spend (£'000's)	Watch		£3,622	£2,292	£1,887	£1,646	£1,760	£1,408	£1,974	£1,936	£2,022	£2,467	£2,389	£2,675	£2,876
		of which Bank Spend (£'000s)	Watch		£7,022	£5,264	£4,950	£4,038	£4,824	£5,197	£4,768	£6,387	£4,214	£5,528	£6,129	£6,192	£6,256
		Agency Spend as % of Total Paybill	**Watch**	<=2%	**2.8%**	**3.4%**	**2.8%**	**2.4%**	**2.6%**	**2.1%**	**2.6%**	**2.7%**	**2.9%**	**3.4%**	**3.3%**	**3.0%**	**4.3%**
Performance & Skills		**Core Skills Compliance Rate (%) excl. Doctors in Training**	**Driver**	**>=90%**	**89.6%**	**90.7%**	**92.2%**	**92.9%**	**92.7%**	**92.8%**	**91.7%**	**91.0%**	**90.7%**	**90.9%**	**89.4%**	**90.5%**	**90.4%**
		Core Clinical Skills Compliance Rate (%) excl. Doctors in Training	**Driver**	**>=90%**	**90.7%**	**91.5%**	**92.7%**	**93.2%**	**94.0%**	**92.2%**	**92.6%**	**92.1%**	**91.6%**	**92.6%**	**90.6%**	**91.9%**	**91.0%**
		Doctors in Training Core & Core Clinical Skills Compliance Rate (%)	**Driver**	**>=90%**	**80.4%**	**80.0%**	**83.5%**	**84.5%**	**74.7%**	**83.3%**	**85.1%**	**85.2%**	**86.7%**	**87.3%**	**75.4%**	**87.2%**	**87.3%**
		Personal Development Reviews Completion Rate (%)	Watch	>=95%	Deferred due to Covid-19 and Recovery, health & well-being conversations due				**62.2%**	**68.7%**	n/a	n/a	n/a	n/a	n/a	n/a	n/a
		Local induction Completion Rate (%)	**Driver**	**>=95%**	**60.8%**	**57.7%**	**62.1%**	**71.0%**	**72.5%**	**70.8%**	**72.3%**	**72.1%**	**72.1%**	**71.3%**	**71.4%**	**69.0%**	**66.1%**
		Doctors Appraisal Completion Rate (%)	Watch	>=95%	aisals paused due to Covid-19 and re-started in July					**88.6%**	**85.9%**	**90.7%**	**88.1%**	**85.8%**	**88.4%**	**91.2%**	**92.4%**
Health, Well-being & Safety		**In-Month Sickness Absence Rate (%)**	**Driver**	**<=3.7%**	**3.2%**	**3.1%**	**3.2%**	**3.5%**	**4.0%**	**4.3%**	**4.4%**	**4.7%**	**4.5%**	**6.1%**	**6.4%**	**5.0%**	**5.5%**
		Rolling 12-Month Sickness Absence Rate (%)	Watch	<=4.4%	**4.2%**	**3.8%**	**3.7%**	**3.7%**	**3.7%**	**3.8%**	**3.9%**	**4.0%**	**4.1%**	**4.2%**	**4.3%**	**4.4%**	**4.6%**
		New Referrals to Contact (per month)	Watch		79	74	70	100	75	71	82	82	69	66	86	64	60
		Annual Leave Booked as a % of Expected Annual Leave to be Booked	**Driver**		t monitor						**84.0%**						
Equality, Diversity & Inclusion		BAME % of workforce band 7 and above	Driver	tbc	39.8%	41.9%	40.1%	39.9%	40.1%	40.4%	40.4%	41.1%	41.4%	41.7%	40.4%	41.0%	41.0%
		Vacancies WTE at band 7 and above	Watch	tbc	245	266	279	287	337	319	328	328	331	326	322	338	345
		Likelihood to recruit (white staff compared to BAME staff from shortlisting)	Watch	tbc							1.13						

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Staff Survey Results 2021

Agenda item 18 and paper O

Lead Executive Director(s): Kevin Croft, Chief People Officer
Author(s): Sue Grange, Director of OD Health and wellbeing

Purpose: For approval

Meeting date: 25 May 2022

1. Purpose of this report

1.1. This report outlines the high level staff survey results for the 2021 NHS Staff Survey (NSS) and summarises the actions planned in response to the survey.

2. Executive Summary

2.1. The NHS Staff Survey is one of the largest workforce surveys in the world and has been conducted every year since 2003. It asks NHS staff in England about their experiences of working for their respective NHS organisations. The survey provides essential information to employers and national stakeholders about staff experience across the NHS in England.

2.2. The National Staff survey 2021 was completed in all NHS Trusts in October– December 2021. The national and local results were fully published on 30 March 2022.

2.3. As a Trust, our response rate was 42% (5523 responses) which compares with the median response rate for Acute Trusts[1] of 46% but it is the same as our 2020 response which was 42% (5431 responses). In comparison London North West had a response rate of 61%.

2.4. The format of the survey, and the results has changed significantly since 2020 and has been now aligned around the 7 NHS People Promise themes. Some themes and sub-themes therefore have no trend data this year. Two original themes of “Engagement” and “Morale” have been retained and have trend data across five years (the staff 2021 benchmarking report is available in the reading room).

2.5. The overall results across all participating Trusts show a decline in the themes where trend data is available.

- Overall Engagement across all Trusts has declined
- Staff who would recommend their Trust as a place to work which has declined having improved steadily between 2017 and 2020
- Recommend as a place if a friend or relative needed treatment Declined
- The overall national results for Morale declined having improved steadily between 2017 2020

[1] Our comparator group is all Acute and Acute & Community Trusts; for ease this will be referred to as “Acute Trusts”

2.6. A comparison has been done against our peers in the Shelford group and the Acute Trusts in North West London. This shows that the Trust has improved its relative position compared to Shelford Trusts over time since 2015, and has the highest or joint highest score on engagement and morale against the acute Trusts in NW London.

2.7. The detailed results, including free text answers, have been analysed, and widely communicated across the Trust. The action planning has been undertaken at Trust level and local level (Directorate and department) as well as including staff-side and staff network colleagues.

2.10 At Trust level, a review has been undertaken of the theme results and a mapping completed against the current live areas of work that are already underway. This has helped to identify where we already have actions and improvements planned or underway which respond to the themes contained within the survey.

2.8. This highlights that there are planned improvements and actions underway in all areas of the survey. These are set out in a number of different action plans and programmes of work including

(i) Proposed 7 People priority programmes 2022-23
(ii) Equality Diversity and Inclusion action plan 2022-23
(iii) Pathways to Excellence programme
(iv) Ward Accreditation programme
(v) Improvement programme
(vi) HOTT programme
(vii) Staff Spaces programme
(viii) Food, Retail and shops programme

It is therefore proposed that a separate action plan for the staff survey is not created, and that the tracking of improvements and actions at organisational level is managed through the pre-existing work programmes. Each of these programmes has an executive lead and pre-existing governance arrangement (the mapping of current actions is available in the reading room).

2.11 Detailed action plans are also being developed at Directorate level and will be managed through Divisional/Directorate oversight meetings.

2.12 Following discussion at the People Committee in May 2022, it was noted that whilst the response rate was not an outlier compared with other Acute Trusts, it does indicate that 58% of staff did not respond and that a clear plan would be required to ensure we hear from all staff in the coming year. It was also noted that access to training and professional development is an important driver in staff experience and staff engagement.

3. Approval process

3.1. This paper has been discussed at EMB People group in March 2022 (results) and April 2022 (actions and recommendations). It was further discussed at the People Committee in May 2022.

4. Recommendation(s)

4.1. The Board is asked to:

(i) NOTE the high level summary results
(ii) AGREE the proposed plans set out Appendix 2 in response to the survey results

5. Next steps

The next steps will be to commence all actions as set out in Appendix 2 and to report on progress through our existing governance arrangements. A quarterly map of key areas of focus will be developed to ensure that there is a clear and manageable phasing of the action, to maximise the visibility of the actions to frontline staff. Divisional progress will be monitored through the Divisional Oversight Meetings.

6. Impact assessment

6.1. **Quality impact**: The engagement of staff, and provision of good staff experience will impact on the quality of care received by our patients at ICHT crossing all CQC domains.

6.2. **Financial impact:** Staff engagement will have a link to turnover, retention and financial impact of vacancy rates, bank and agency spend

6.3. **Workforce impact:** The paper sets out a range of improvements to workforce experience and staff engagement

6.4. **Equality impact:** The aims of the proposal are to listen and ensure improvements are being made to workforce and staff engagement and also to the experience of staff in relation to equality diversity and inclusion

6.5. **Risk impact:** The engagement of staff will link directly to risks of retention and turnover

Main paper

1. Background

1.1. The NHS Staff Survey is one of the largest workforce surveys in the world and has been conducted every year since 2003. It asks NHS staff in England about their experiences of working for their respective NHS organisations. The survey provides essential information to employers and national stakeholders about staff experience across the NHS in England. Participation is mandatory for trusts and voluntary for non-trust organisations (CCGs, CSUs, social enterprises).

1.2 The National Staff survey 2021 was completed in all NHS Trusts in October– December 2021. The national and local results were fully published on 30 March 2022

2. Response rate

2.1. As a Trust, our response rate was 42% (5523 responses) which compares with the median response rate for Acute Trusts[2] of 46% but it is the same as our 2020 response which was 42% (5431 responses). In comparison London North West had a response rate of 61%. Following discussion at the May People Committee, a clear action was agreed to set and increase a target or an improved response rate in 2022.

3. National results

3.1. The overall results across all UK Trusts show a decline in the themes where trend data is available.

(i) Overall Engagement across all Trusts has declined from 7.0 to 6.8 and within this theme

- 59.4% staff would recommend their Trust as a place to work which has declined by more than 7% this year, having improved steadily between 2017 (59.7%) and 2020 (66.8%).

[2] Our comparator group is all Acute and Acute & Community Trusts; for ease this will be referred to as "Acute Trusts"

- 67.8% said that if a friend or relative needed treatment they would be happy with the standard of care provided by the organisation, which represents a decrease of 6% from 2020 (74.2%)

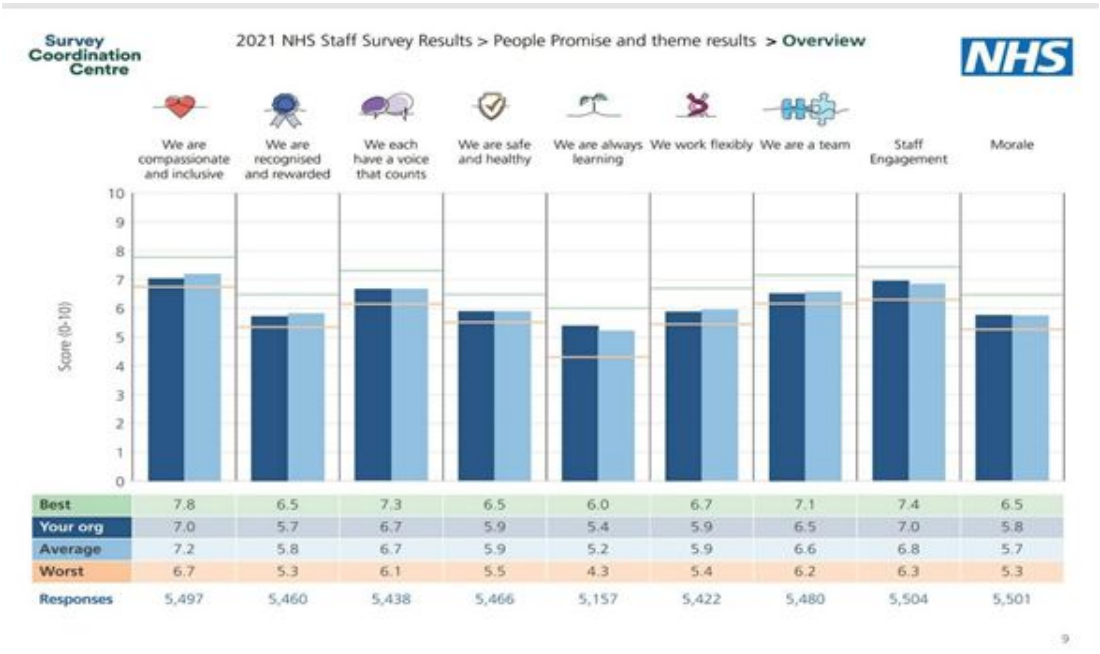
(ii) The overall national results for Morale declined to 5.8, below the 2017 level having improved steadily between 2017 (5.9) and 2020 (6.1).

4. Trust results

4.1. As a Trust, our overall ***Staff Engagement score*** has fallen from 7.2 in 2020 to 7.0 in 2021 but remains "above average" of acute Trusts (This theme encompasses Motivation, advocacy and involvement). (See Table 1)

4.2. The overall ***Morale score*** has fallen from 6.1 in 2020 to 5.8 in 2021 but again remains "above average" of acute Trusts (This theme encompasses work pressures, stressors and thoughts about leaving).(See Table 1)

Table 1 Themes against acute Trust average 2021



4.3. At theme level, the results show that there are three themes where we are above the acute Trust average, three the same as the average and three where we are below average

(i) Above Acute Trust average: Engagement, Morale, We are always learning

(ii) The same as the Acute Trust average: We have a voice that counts, We are safe and healthy, We work flexibly

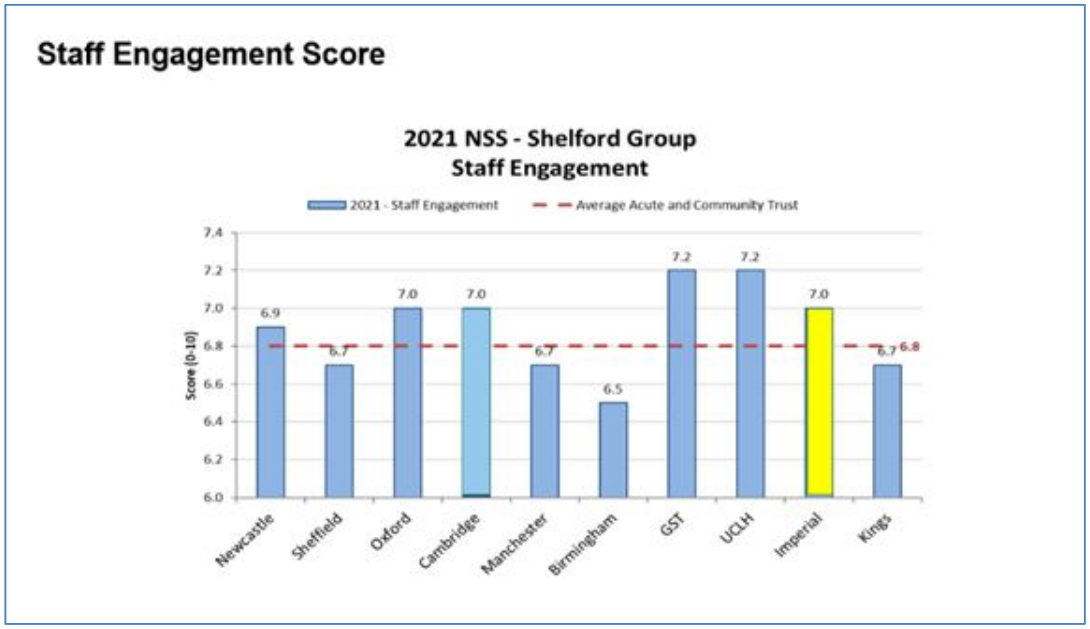
(iii) Below the acute Trust average: -We are compassionate and inclusive, We are recognised and rewarded, We are a team

5. Comparison with NWL and Shelford peers

5.1. A comparison has been undertaken of our scores compared to our peers in the Shelford Group. In the theme of "Engagement" our results are shown in Table 4. In this theme

we were joint second place compared at 7.0 compared to two Trust (Guys and St Thomas' Hospital (GSST) and University Hospital London (UCL)) who scored 7.0.

Table 4: Shelford Acute Trusts Staff Survey scores 2021



5.2. The comparison of engagement scores against our Shelford Trusts over time is shown in Table 5

Table 5: Shelford Comparison on Engagement score over time

Shelford Group – Staff Engagement Scores

Pos	Trust	2014
1	GST	3.96
2	Newcastle	3.90
3	Birmingham	3.87
4	UCLH	3.87
5	Oxford	3.82
6	Sheffield	3.81
7	Kings	3.79
8	Imperial	3.77
9	Manchester	3.76
10	**CUH**	**3.70**

Pos	Trust	2015
1	GST	4.04
2	Birmingham	3.90
3	Newcastle	3.89
4	Manchester	3.88
5	UCLH	3.85
6	**CUH**	**3.83**
7	Kings	3.81
8	Oxford	3.76
9	Sheffield	3.74
10	Imperial	3.74

Pos	Trust	2016
1	GST	4.03
2	Newcastle	3.97
3	Birmingham	3.90
4	UCLH	3.89
5	**CUH**	**3.88**
6	Oxford	3.87
7	Manchester	3.84
8	Sheffield	3.82
9	Imperial	3.80
10	Kings	3.74

Pos	Trust	2017
1	GST	3.99
2	Newcastle	3.91
3	Birmingham	3.88
4	UCLH	3.88
5	**CUH**	**3.84**
6	Imperial	3.84
7	Sheffield	3.83
8	Manchester	3.78
9	Oxford	3.78
10	Kings	3.72

Pos	Trust	2018
1	GST	7.4
2	Newcastle	7.3
3	**CUH**	**7.2**
4	UCLH	7.2
5	Manchester	7.1
6	Birmingham	7.0
7	Imperial	7.0
8	Sheffield	7.0
9	Oxford	6.9
10	Kings	6.8

Pos	Trust	2019
1	GST	7.5
2	Newcastle	7.3
3	**CUH**	**7.2**
4	Imperial	7.2
5	UCLH	7.2
6	Oxford	7.1
7	Manchester	7.1
8	Sheffield	7.1
9	Birmingham	6.9
10	Kings	6.8

Pos	Trust	2020
1	GST	7.5
2	UCLH	7.4
3	Newcastle	7.3
4	**CUH**	**7.2**
5	Imperial	7.2
6	Oxford	7.2
7	Manchester	7.0
8	Sheffield	7.0
9	Birmingham	6.8
10	Kings	6.8

Pos	Trust	2021
1	UCLH	7.2
2	GST	7.2
3	**Cambridge**	**7.0**
4	Oxford	7.0
5	Imperial	7.0
6	Newcastle	6.9
7	Sheffield	6.7
8	Manchester	6.7
9	Kings	6.7
10	Birmingham	6.5

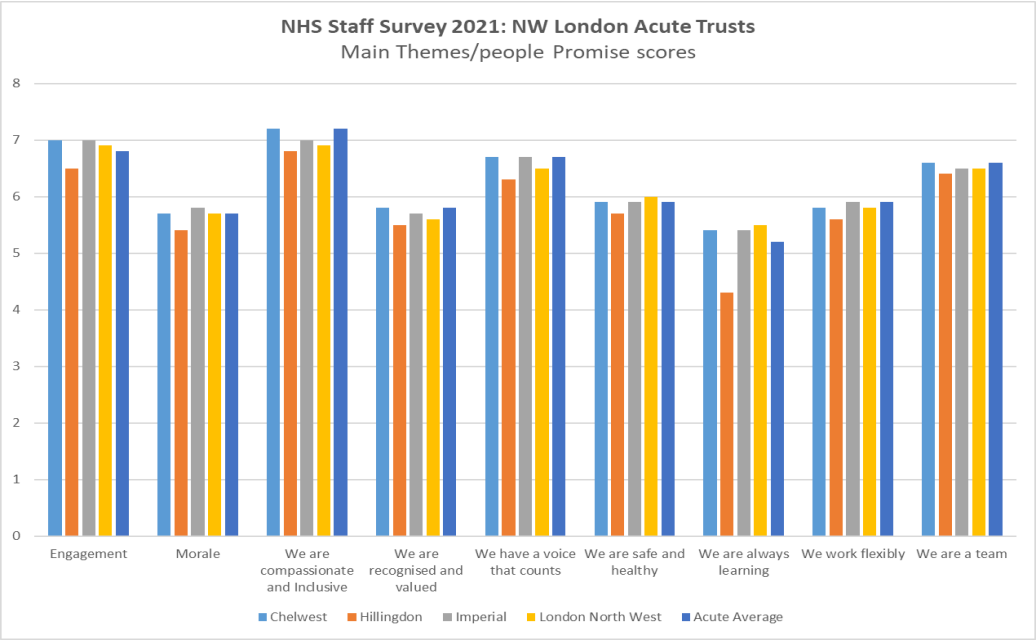
This shows that our position has improved since 2014 and been consistently in the upper half of the scores in the last 3 years, with GSST, Newcastle and UCL most consistently in the highest scoring position.

(NB (i) data prepared by Cambridge and so CUH is highlighted (ii) where scores are the same, Trusts are shown in alphabetical order and our position in the table can be lower than the scores would suggest.)

6. North West London

6.1. In comparing with NW London, we have used the Acute Trust as our peers to benchmark due to the fact that all national benchmarking is split into Acute Trusts, Mental health and community Trusts and Specialist Hospitals because of the different trends in their results. Table 6 shows our results at theme level compared to the Acute Trusts in NW London and the national average for acute Trusts (i.e. the 'Acute Average' below is not the NWL acute average). It can be seen that performance is broadly similar in many themes.

Table 6: Staff Survey results for Acute Trusts in NW London 2021



7. Way Forward / next steps

The next steps will be to commence all actions as set out and to report on progress through our existing governance arrangements. A quarterly map of key areas of focus will be developed to ensure that there is a clear and manageable phasing of the action, to maximise the visibility of the actions to frontline staff. Divisional progress will be monitored through the Divisional Oversight Meetings.

Appendices

Appendix 1: Summary of the Trust wide programme to deliver change in response to the staff Survey and survey question measures

Reading Room

2021: NHS Staff Survey Benchmark report

2021 NHS Staff Survey results – National Briefing

Appendix 1: Summary of the Trust wide programmes to deliver change in response to the staff Survey and survey question measures

This table maps the specific Staff Survey questions which map to each of our Trust programmes of work to improving the experience of staff

Lead	Programme	Key Staff Survey Question focus*
Priority POD programmes	**Improvement through people management programme**	***Q9*** *-My immediate manager…* *a…encourages me at work* *b…gives me clear feedback on my work* *c…asks for my opinion before making decisions that affect my work* *d …takes a positive interest in my health and well-being* *e My immediate manger values my work* ***Q19a****-In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?* *If yes:* *b-It helped me to improve how I do my job* *c-It helped me agree clear objectives for my work* *d-It left me feeling that my work is valued by my organisation*
	Health and wellbeing, and workplace safety	***Q11a****-Myorganisation takes positive action on health and well-being* **Q11b***-Experience of musculoskeletal problems as a result of work activities* **Q11c***-Whether felt unwell as a result of work-related stress* **Q13a-c***-Experience of physical violence*
	Equality Diversity and Inclusion	**Q15***-Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age* **Q16a/b -***Experience of discrimination at work* **Q16c***-I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas)*
	Sustainable recruitment	***Q3i****-Thereare enough staff at this organisation for me to do my job properly*
	Retention programme	**Q21c***-I would recommend my organisation as a place to work* **Q20b***-There are opportunities for me to develop my career in this organisation** **Q20c***-I have opportunities to improve my knowledge and skills** **Q20d***-I feel supported to develop my potential** **Q20e***-I am able to access the right learning and development opportunities when I need to** **Q6c***-I achieve a good balance between my work life and my home life** **Q6d***-I can approach my immediate manager to talk openly about flexible working** *Q22a I often think about leaving this organisation* *Q22b-I will probably look for a job at a new organisation in the next 12 months*

		Q22c – As soon as I can find another job I will leave this organisation
	Values and behaviours	**Q7h**-*I feel valued by my team* **Q7i**-*I feel a strong personal attachment to my team* **Q8b**-*The people I work with are understanding and kind to one another* **Q8c**-*The people I work with are polite and treat each other with respect** **Q14a-c**-*Experience of harassment, bullying or abuse* ***Q7e***-*I enjoy working with the colleagues in my team** ***Q8a***-*Teams within this organisation work well together to achieve their objectives**
Nurse Directorate	**Ward Accreditation programme**	**Q21d**-*If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation*
Medical Directors office	**Helping Our Teams Transform programme (HOTT)**	Q17a-*I would feel secure raising concerns about unsafe clinical practice* Q17b-*I am confident that my organisation would address my concern* ***Q8a***-*Teams within this organisation work well together to achieve their objectives**
	Pathways to Excellence	***Q11a***-*Myorganisation takes positive action on health and well-being* **Q3d**-*I am able to make suggestions to improve the work of my team / department* **Q3e**-*I am involved in deciding on changes introduced that affect my work area / team / department* **Q3f**-*I am able to make improvements happen in my area of work* **Q20b**-*There are opportunities for me to develop my career in this organisation** *Q4: Satisfaction with a the recognition I get for good work*
	Improvement programme	**Q3d**-*I am able to make suggestions to improve the work of my team / department* **Q3e**-*I am involved in deciding on changes introduced that affect my work area / team / department* **Q3f**-*I am able to make improvements happen in my area of work*
	Staff Spaces programme	**Q21c**-*I would recommend my organisation as a place to work*
	Food Transformation and Retail programme	**Q21c**-*I would recommend my organisation as a place to work*

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Board Summary Report from the People Committee

Agenda item 19 and paper P

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

Purpose: For noting

Meeting date: 25 May 2022

Executive Summary

1. Purpose

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

2. Introduction

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

3. Key points

3.1. The key items to note from the People Committee held on 3 May 2022:

4. Equality, Diversity and Inclusion in Focus: Race

4.1. The Committee heard a staff story, told by a nurse. She shared the story of her career with the Trust, highlighting some of the barriers to progression she had encountered. She started her career in 2000 when she came to this country. After two years, was invited to take up the specialised neonatal course which she declined due to feeling she would not be at par with her senior nurses and colleagues as she was adjusting to a new environment, new country and starting a family. After 5 years, with the lack of progression she took up the neonatal course which took about 18 months, followed by another course. In 2009, she was diagnosed with breast cancer and was treated. She felt lucky to have been treated and cared for by the Trust and her unit, and her treatment was flawless.

4.2. She then wanted to give back to the Trust because of the care she had received. She returned to her team and was invited to join the education team, which gave her a different perspective of nursing.

4.3. She looked after the pre-Registered students and also started her degree pathway and applied for a position at Band 7, but was unsuccessful. In 2017, she enrolled on a Foundation for Management course provided by the Trust and which she realised was the development that needed.

4.4. After a year, there was a follow-up course, which was the Springboard. The post was at band 7, having been successful in her appointment meant progressing from a level 3 to level 2, which in St. Mary's is a smaller team. There were challenges along the way and one was her talking in her native language and that was brought to the immediate attention of her senior managers without having any prior conversations with her.

4.5. She highlighted another petty incident involving an email sent, which was very upsetting after working for 19 years at Level 3 in which she had not received any complaints. It's just the last two years since she was promoted these issues had arisen. After which point she sought help from the Trust Contact service and the support was amazing. It opened her eyes that having the support even if it's a short conversation, was very helpful. Despite all the challenges she was still happy to return to work the next day because the support was there from her unit.

4.6. She now has different set of challenges to help her with people management in her band 7 role.

4.7. She also reflected on the Trust's approach to panel interview, which was a difficult process. She suggested that coaching and feedback would be helpful for preparing colleagues for interview. This notion was based on her last two interviews whereby no feedback, coaching or guidance was provided. She did attempt, however, to obtain feedback though it was never provided.

4.8. On reflection, she felt the last course she attended had better equipped her to be in her current role.

4.9. The Committee welcomed this insightful story and noted the ongoing work regarding training around interview preparation, by trialling workshops at the Trust including assistance to improve CVs, a new digital platform which provides tools and resources to help staff prepare for their career progression. On reflection, it was noted that the Trust was giving more support for the interview process rather than looking at the process itself. An action for the Trust from this story had been to review the selection process and see if there is a better way going forward.

5. Race Equality Network

5.1. The Committee heard from the chair of the Multi-disciplinary Race Equality Network (formerly known as the BAME Network) who provided background to the Network launched in March 2020, currently has 276 members from the Black, Asian and Minority Ethnic groups. 36 Allies and friends and is all inclusive membership group. Eight committee meetings had been held. £50,000 had been awarded by the Imperial Charity for external courses which were being worked through. Various events had been held e.g. Black History Month with Levi Roots, Sickle Cell Society, held panel discussions etc. A training and development package for Ambassadors had been developed. The EDI Racial Incidents Reporting Project was underway and an update to be provided at a subsequent meeting. The Committee commended the work of the Network and recognised the tremendous work that had been achieved with the formation of the network and the impact it has already made on the Trust.

6. People Priorities, Performance and Risk Report

6.1. The Committee discussed and noted the detailed consolidated report on the core people priorities, performance, risk and mitigation for Month 12, March 2022. The report provided a summary of performance against the Trust's seven people priorities and the associated performance metrics, identifying areas requiring focus and improvement as well as the actions being taken to enable that improvement. The report also provided detail of the corporate and divisional People & OD risks, linked to the seven people priorities, and actions being taken to mitigate these risks. The Committee noted the report.

7. People and OD Risk Deep Dive: Staff Survey

7.1. The Committee received the staff survey results from 2021 and approved the actions proposed in response. The National Staff survey 2021 was completed in all NHS Trusts in October– December 2021. The national and local results were fully published on 30 March 2022.

7.2. The Trust response rate was 42% (5523 responses) which compares with the median response rate for Acute Trusts of 46% but it was the same as the 2020 response which was 42% (5431 responses). In comparison London North West had a response rate of 61%. The committee sought assurance that the Trust would continue to drill down and find ways of engaging staff (the 58%) that had not responded to the national survey.

7.3. The results by theme indicated key areas which should be prioritised for action in 2022/23. The Committee noted the direct link with the outcomes of the survey with the People Strategy priorities.

8. 2022-23 Trust People Priorities

8.1. The Trust People Strategy 2019-23 sets out a clear vision for our Imperial people and detailed six people themes. Each year, the Trust draws on this strategy and with the national, regional and local drivers confirms the annual people priorities. The strategy is due to be reviewed and refreshed during 2022.

8.2. In 2021/22, the Trust agreed to seven core people priorities. In 2022/23, there will again be seven core people priorities, albeit with some changes that reflect the current organisational, regional and national priorities. The proposed new themes for 2022/23 are:

1) Sustainable workforce
2) Retention and engagement
3) Equality, diversity and inclusion
4) Immediate managers
5) Health, wellbeing and safety
6) Values and behaviours
7) New ways of working, productivity and efficiency

8.3. The People Committee agreed the proposed set of new People Priorities for 2022/23 and acknowledged the work that was underway.

9. Health and Safety Framework

9.1 The Committee reviewed the latest draft of the Health and Safety assurance framework, recognising that the purpose of the framework is to set out the management controls and assurance mechanisms relating to the management of this area of risk. The process of developing the framework had aided the continual improvement of the governance processes for health & safety, including the definition of the audit universe for health & safety and the reporting arrangements.

9.2 The Committee welcomed the progress made in developing this framework, noting that it would also be reviewed by the Audit, Risk and Governance (ARG) Committee. It was agreed that the People Committee would be the Board committee with oversight over health & safety, including occupational health & safety, with specific quality issues reported to Quality Committee and statutory compliance issues reported to ARG.

9.3 The Committee noted that the framework would be strengthened with the inclusion of 3rd line (external) assurances.

10. People Assurance Report

10.1. The assurance report for the People Committee and is in addition to the People Priorities, Performance and Risk Report. It summarised the assurance items and key updates received by the Executive Management Board (EMB) since the last report to the Committee in March 2022.

10.2. The Committee noted the report and acknowledged that further work was required around career progression for our ethnic minority staff.

10.3. An update to the Pathway to Excellence programme was presented which is a positive framework for nurses with 6 dimensions and was being rolled out the Charing Cross site. The Committee noted the programme was a robust credentialing programme and would make a meaningful change across the site.

11. Health & Safety Report

11.1. The report updated the committee on aspects of the Trust occupational health and safety arrangements, including the performance of the Occupational Health (OH) service. The Committee noted the Health and Safety report.

12. Recommendation(s)

12.1. The Board is asked to note this report.

13. Impact assessment

13.1. Quality impact: N/A for this report
13.2. Financial impact: N/A for this report
13.3. Workforce impact: N/A for this report
13.4. Equality impact: N/A for this report
13.5. Risk impact: N/A for this report

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Annual Provider Licence Self-Certification for NHS Trusts

Agenda item 20 and paper Q

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

Purpose: For approval

Meeting date: 25th May 2022

Executive summary

1. Purpose

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

3. **Background**

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

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

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

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

4. Key findings

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

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

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

4.3. The executive team, Audit, Risk and Governance Committee have reviewed these assurance statements and the proposed compliance declarations and have agreed to recommend full compliance to the Trust Board for approval.

5. Next steps

5.1. Subject to Board approval the declaration will be published.

6. Recommendation(s)

6.1. The Board is asked to approve the proposed declaration of compliance as included in Appendix 1.

7. Impact assessment

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

Appendices:
Appendix 1 Trust self-certification statements

Appendix 1

Trust self-certification statements – May 2022

FT4 declaration for Imperial College healthcare NHS Trust

Corporate governance statement (FTs and NHS Trusts)		
The Trust board is required to respond 'confirmed' or 'not confirmed' to the following statements, settings out any risks and mitigating actions for each one where it is 'not confirmed'		
Corporate governance statement	**Response**	**Risks and mitigating actions**
1 The Trust board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS	Confirmed	The Board confirms compliance with this statement with objective measures detailed through the Annual Governance Statement.
2 The Trust board has regard to such guidance on good corporate governance as may be issued by NHS England/Improvement from time to time	Confirmed	
3 The Trust board is satisfied that the Licensee has established and implements: (a) effective board and committee structures (b) clear responsibilities for its Trust board, for committees reporting to the Trust board and for staff reporting to the Trust board and those committees and (c) clear reporting lines and accountabilities throughout its organisation	Confirmed	The Trust is committed to implementing and maintaining the standards of good governance to support the Trust Board and its Committees. The Trust has implemented its corporate governance framework for meetings which sets out: • Board and Executive level structure of meetings and a uniform approach to support effective decision making • Reporting lines and escalation of risks and issues • Information flow and reporting • Values and behaviours
4 The Trust board is satisfied that the Licensee has established and effectively implements systems and/ or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively (b) For timely and effective scrutiny and oversight by the Trust board of the Licensee's operations (c) To ensure compliance with healthcare standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England/Improvement and statutory regulators of healthcare professions (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/ or processes to ensure the Licensee's ability to continue as a going concern) (e) To obtain and disseminate accurate, comprehensive, timely and up-to-date information for the Trust board and committee decision-making (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence (g) To ensure compliance with all legal requirements	Confirmed	The Trust continues to strengthen its systems and processes to ensure it operates efficiently, economically and effectively. The Trust's rating within the NHS England and NHS Improvement system oversight framework remained as segment two across the year, monitored via the System Oversight Meetings (SOMs). The CQC has indicated that overall the Trust continues to be considered low risk in relation to regulatory compliance compared to other trusts. The Trust continues to make progress in elective recovery but challenges remain in meeting national constitutional standards. This is reflective of sustained referral demand and continued pressures on urgent and emergency care pathways and the system as a whole. The trust continues to build collaboration with system partners to address these areas of challenge for 2022/23, in line with national recovery efforts. The integrated scorecard reports received by the Board and its committees are aligned with national planning requirements and the organisation priorities which are approved by the

		Board for the year. The Imperial Management and Improvement System (IMIS) programme provides a mechanism to embed effective practices in delivery of priorities from Board to ward. The Board committees use risk and assurance deep dives for the corporate risk register to understand emerging risks or seek assurance regarding the management of existing risks. The Trust achieved its financial targets for 2021/22 in terms of delivering against the financial plan agreed with the North West London Integrated Care System; remaining within its external financing limit and achieving its capital resource limit. However, the Trust does still need to continue to focus on improving its underlying financial sustainability and a Productivity and Efficiency Board has been put in place to strengthen governance in this area.
5 The Trust board is satisfied that the systems and/ or processes referred to in paragraph 4 should include but not be restricted to systems and/ or processes to ensure: (a) That there is sufficient capability at Trust board level to provide effective organisational leadership on the quality of care provided (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Board routinely receives reports on quality of care. The cycle of integrated performance reporting ensures there is a strong focus on quality metrics and exception reporting. A comprehensive Quality assurance report is presented via the Board Quality Committee. The Board receive additional quarterly or annual standing reports relating to quality (examples learning from deaths, infection prevention control, cancer patient experience). Patient stories are presented and discussed at the Board
6 The Trust board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Trust board, reporting to the Trust board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence	Confirmed	
Signed on behalf of the Trust board Signature . . . . . Signature		

Name	Name . . . . .

G6 declaration for Imperial College Healthcare NHS Trust

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

Signed	Signed . . . . .
Name	Name . . . . .
Capacity	Capacity . . . . .
Date	Date . . . . .

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Audit, Risk & Governance Committee report

Agenda item 21 paper R

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

Purpose: For information

Meeting date: 25 May 2022

1. Purpose of this report

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

2. Introduction

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

3. Key points

3.1. The key items to note from the Audit, Risk and Governance Committee held on 11 May 2022:

4. External Audit

4.1 The Committee received an oral update on the year-end audit from Deloitte. The Committee noted the audit work is now underway and received assurances that improvements were being seen over the past year. The final accounts and audit opinion would be approved by the Committee at the next meeting, subject to delegation of authority by the Trust Board.

5. Internal audit Progress Report 2021/22

5.1 The Committee noted a report from PWC confirming the progress against the internal audit plan 2021/22 since the last meeting in March 2022, noting conclusion of the additional audit / advisory work agreed by the Committee. The Committee noted that audit work was on track to enable the Head of Internal Audit to provide their opinion on time. The Committee also noted good progress in completing follow up actions.

5.2 **Draft Internal Audit Annual Report 2021/2022**

The Committee reviewed the draft annual report from PwC and received assurance that sufficient internal audit work has been undertaken to allow an opinion to be given as to the adequacy and effectiveness of governance, risk management and control. The committee noted that there was only one high risk outcome this year, in relation

to the management of subject access requests, and no major improvements needed. All risks are low or medium and all impacts on the Trust should be low to moderate.

5.3 **Draft Counter Fraud annual report 2021/2022**
The Committee received the Counter Fraud annual report, noting that all work against the work plan had been completed and PwC are able to give full compliance against the Counter Fraud Functional Standard Return (CFFSR).
The Committee noted the self-review toolkit ratings and actions agreed to address any areas for improvement. The Committee also noted the outcome of the staff survey conducted and the low return rate. The Committee acknowledged the circumstances that explained the low return, the operational pressures arising from the Covid pandemic, and welcomed the planned staff communications campaign themed around 'speaking up' which would include awareness of counter fraud measures.

5.4 The Committee thanked the PwC team, and previous members of the team who had worked with the Trust, for the service provided over the past three years.

6. Internal Audit – Draft 2022/23 Plan

6.1 The Committee welcomed the KPMG team as the new internal auditors and considered the proposed schedule for the internal audit plan 2022/2023 noting the rationale and scope for each review, and assurances to be provided from these. The draft plan was approved, subject to amendments.

7. Counter fraud plan 2022/23

7.1 The Committee noted a report outlining the strategic counter fraud plan 2022/2023.
7.2 The committee were happy with the proposed schedule for delivering the plan, and approved commencement of the work.

8. Data Security and Protection (DSP) Toolkit Audit – KPMG

8.1 The Committee received a report outlining the findings of the independent audit assessment of the Trust's DSP Toolkit carried out by KPMG. This is a mandatory requirement from NHS England consisting of 10 domains to be met by the Trust.

8.2 The findings of audit assessment showed that the Risk Assurance provided by the Trust is high, the confidence of the Independent Assessor in the veracity of the self-assessment is Substantial, and the overall Risk Assurance Rating for the Trust is Significant Assurance. This is subject to one 'low risk' finding in respect to the Trust's latest ICT backup test. KPMG reported a high degree of confidence that the DSP Toolkit return would be delivered by the Trust in full by the deadline of 30 June 2022.

9. ICS & Acute Programme governance – risk register

9.1 The committee received a verbal update on the development of the risk register and development of governance arrangements noting that the exercise to refresh the strategic objectives of the acute programme is ongoing, and the programme risk register will then be revised accordingly.

10. Risk and Assurance report including summary of Risk Management Strategy

10.1 The Committee received an update on risk management and assurance at the Trust providing updates on the corporate risk register, the corporate risk profile and board assurance framework process.

The development of the risk and assurance strategy, including consultation with the Board committee chairs, had identified the risk and assurance management priorities for 2022/23. The priorities within the strategy include:

- to embed the existing risk management processes across the organisation, in particular using the newly established directorate oversight meetings and the governance toolkit to embed risk management at directorate level
- to continue the work with Board committees and chairs to embed the approach to risk and assurance management at that level, including the use of the Trust's risk appetite, risk and assurance deep dives and the development of assurance frameworks for areas of strategic risks.

11. Reports from Board sub-committee's re: risk and assurance deep dives and key risks

11.1 The Committee received and noted the summary findings from the other Board committee meetings held in this cycle, including the risks and assurances discussed in their 'deep dives'.

12. Provider licence self-assessment

12.1 The Committee received the annual self-assessment of compliance against provider licence provisions, noting that the assurance statements and the proposed compliance declarations are to be presented to Trust board for approval.

12.2 The committee were assured that the executive team had reviewed the assurance statements, and the proposed compliance declarations, and agreed to recommend full compliance to the Trust Board for approval.

13. ARG Committee annual report and review of its Terms of Reference

13.1 The Committee reviewed the Committee annual report, which outlined the work of the Committee for the year 2021-22 and provided assurance that it operates effectively in delivering its Terms of Reference (TOR).
The committee approved the annual report and Terms of Reference as accurate references.

The Committee approved the annual report for inclusion in the Trust's Annual Report 2021-22 and approved the Terms of Reference, for approval by the Board

14. Summary of Board Committees annual reports and Terms of Reference

14.1 The Committee noted the annual reports from the other Board sub-committees and approved these as accurate references.

14.2 The Committee approved the annual reports for inclusion in the Trust's Annual Report 2021-22 and approved the Terms of Reference, for approval by the Board.

15. Health and safety assurance framework

15.1 The Committee reviewed the latest draft of the Health and Safety assurance framework, recognising that the purpose of the framework is to set out the management controls and assurance mechanisms relating to the management of this area of risk. The process of developing the framework had aided the continual improvement of the governance processes for health & safety, including the definition of the audit universe for health & safety and the reporting arrangements.

Imperial College Healthcare NHS Trust

15.2 The Committee welcomed the progress made in developing this framework. It was agreed that the People Committee oversee health & safety, including occupational health & safety, with specific quality issues reported to Quality Committee and statutory compliance issues reported to ARG.

15.3 The Committee noted that the framework would be strengthened with the inclusion of 3rd line (external) assurances.

16. Losses and special payments / Tender waivers

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

17. Committee Forward Planner 2022-23

17.1 The Committee reviewed the forward planner 2022/23, noting a number of gaps however assurance was provided that these would be completed as we move forward with agenda planning

18. Review of meeting effectiveness – values & behaviours

The Committee reviewed the effectiveness of the meeting and were pleased to note that the meeting was well chaired and overall consistent with the Trust values and behaviours.

19. Recommendations:

19.1 The Trust Board are requested to note this report.

20. Impact assessment

20.1 Quality impact: N/A for this report
20.2 Financial impact: N/A for this report
20.3 Workforce impact: N/A for this report
20.4 Equality impact: N/A for this report
20.5 Risk impact: N/A for this report

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

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

Agenda item: 22 and paper S

Executive Director: Peter Jenkinson, Director of Corporate Governance
Author: Ginder Nisar, Head of Trust Secretariat

Purpose: For approval

Meeting date: 25th May 2022

1. Purpose

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

2. Executive summary

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

2.2. In April 2022, Board members and regular attendees of the Board and its Committees engaged with the effectiveness review of the Board and Board Committees. The outcome of these reviews were included in a Committee annual report produced for each Board Committee fulfilling the requirement of their Terms of Reference. The Board Committee annual reports included an overview of performance against their Terms of Reference, membership, attendance and meetings, and a high level summary of the business conducted during the year and the outcome of the effectiveness review. Each Committee considered its annual report and outcome of the effectiveness reviews at the May cycle of Committees. A summary of the outcome was provided in an overarching report to the Audit, Risk and Governance Committee in May who will oversee the key actions arising from this exercise.

2.3. The outcome of the 2021-22 effectiveness survey drew out similar themes to the previous year regarding the quality of papers, duplication of information across Committees and Trust Board, timeliness of papers with little time for Non-Executive Directors to read and digest late papers, length of agendas compromising discussion time and the quality of discussions regarding strategic items. These are areas which improvement work has been done over the past three years and further work still required. In terms of areas of success, there was recognition of a good culture of reflection, learning and improvement across all Board committees, with a genuine commitment to continuously improving how they run; there has been improvement since last year in agenda setting and quality and flow of information with room for further improvement; and a better structure with monthly rhythm and reporting.

2.4. Each committee has subsequently reviewed and agreed their Terms of Reference, in accordance with Trust annual practice. The terms of reference for each committee were agreed at the following meetings (a copy is available from the Trust Secretariat or the Reading Room for this meeting).

- Audit, Risk and Governance Committee, 11 May 2022
- Finance, Investment and Operational Committee, 4 May 2022
- Quality Committee, 5 May 2022
- Redevelopment Committee, 10 May 2022
- People Committee, 3 May 2022
- Remuneration and Appointments Committee, 10 May 2022

2.4.1. The People Committee discussed its Committee annual report at its meeting on 3 May. The members welcomed the progress made in the first year of the Committee and reflected that the decision to establish the People Committee in May 2021 had been justified. The Committee had created more space and time to discuss important people issues than previously available via the Quality Committee, and provided appropriate oversight of the work being done across People priorities. It was felt that the People Committee fulfilled an important gap in terms of Board assurance in respect of the detail of the people function within the Trust and agreed to recommend its continuation.

2.5. While retaining the principle of a condensed performance cycle, but also taking into account feedback and the enhanced remit of the Audit, Risk and Governance Committee in oversight of the assurance mechanisms across the other Board committees, it has been agreed that the schedule of meetings will be amended for 2022-23 to a three week cycle rather than the current two week cycle with the Trust Board taking place in week three.

3. Recommendation

3.1. The Trust Board is asked to note this update and to approve the continued delegated authorities to the Board Committees as set out in the respective Terms of Reference and agreed by each Committee.

4. Impact assessment

4.1. Quality: Regular review of terms of references and effectiveness reviews support good assurance and oversight arrangements.
4.2. Financial: N/A
4.3. Workforce impact: N/A
4.4. Equality impact: N/A
4.5. Risk impact: Good governance supports the reduction of risk to the Trust overall.

Reading Room
Terms of reference for:

- Audit, Risk and Governance Committee
- Finance, Investment and Operational Committee
- Quality Committee
- Redevelopment Committee
- People Committee
- Remuneration and Appointments Committee

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Report from the Redevelopment Committee

Agenda item 23 and paper number T

Lead Executive Director(s): Bob Alexander, Vice Chair
Author(s): Philippa Healy, Business Manager

Purpose: For noting

Meeting date: 25 May 2022

1. Purpose of this report

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

2. Introduction

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

3. Key points

3.1. The key items to note from the Redevelopment Committee meeting held on 10 May 2022 include:

3.1.1. The Redevelopment Committee Annual Report for 2021-22, provided a summary of the work of the Committee and assurance that it operates effectively in delivering its Terms of Reference. The Committee approved the Committee annual report for inclusion in the Trust's annual report and approved the Terms of Reference but noting that may be subject to change as the governance arrangements for the acute provider collaborative are developed.

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

3.1.3. As part of this update the Committee received a presentation about master planning for the redevelopment of the St Mary's site.

3.1.4. The focus of the Committee meeting was on the development of life sciences. The Committee agreed the importance of developing a co-located life sciences campus in Paddington as a key driver to achieving the Trust ambition to build a new research-focused teaching hospital at St Mary's. The Committee noted that initial work on the redevelopment of the Hammersmith site has also highlighted the opportunity of strengthening the links between the Hammersmith Hospital, Imperial College London White City campus and health care research focused partners based in the area.

3.1.5. The Committee received an update on the Trust's Green Plan, including an update around decarbonisation. The next update would be brought to the Committee in November and it was recommended the paper also be included for the public Trust Board agenda.

3.2. **Recommendation**

3.2.1. The Board is asked to note this report.