Imperial College Healthcare NHS Trust

Trust Board – Public

Wednesday, 30th September 2020, 11am to 1.30pm (10.45am to 11am join Microsoft Teams)
Virtual meeting via Microsoft Teams

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

Members of the public are welcome to join this meeting via Microsoft Teams (joining instructions are on the Trust's website: https://www.imperial.nhs.uk/about-us/events/board-meeting-september) or forward questions to the Trust Secretariat via imperial.trustcommittees@nhs.net. Questions will be addressed at the end of the meeting and included in the minutes.

AGENDA

Time	Item no.	Item description	Presenter	Paper / Oral
1100	**1.**	**Opening remarks**	Paula Vennells	Oral
	2.	**Apologies:** Jeremy Butler	Paula Vennells	Oral
	3.	**Declarations of interests** *If any member of the Board has an interest in any item on the agenda, they must declare it at the meeting, and if necessary withdraw from the meeting*	Paula Vennells	Oral
1105	**4.**	**Minutes of the meeting held on 29th July 2020** *To approve the minutes from the last meeting*	Paula Vennells	01
	5.	**Record of items discussed in Part II of Board meeting held on 29th July 2020** *To note the report*	Paula Vennells	02
	6.	**Matters arising and review of action log** *To note updates on actions arising from previous meetings*	Paula Vennells	03
1115	**7.**	**Chief Executive Officer's report** *To note the report*	Tim Orchard	04
Strategic				
1130	**8.**	**Organisational strategy review and refocus - metrics and priorities** *To approve the metrics, priorities and the prioritisation approach*	Tim Orchard, Bob Klaber	05
1140	**9.**	**Update on recovery and reset (including 'phase 3' Covid-19 response)** *To note the update*	Tim Orchard, Peter Jenkinson	06
1150	**10.**	**Learning and Insights report** *To discuss and endorse the recommendations*	Bob Klaber	07
Operations / Performance				
1200	**11.**	**Integrated quality and performance report** *To discuss and note the IMIS performance scorecard for month 4 and performance updates*	Claire Hook	08
1210	**12.**	**Finance report** *To note the position up to 31st August 2020*	Jazz Thind	09

1220	**13.**	**Patient Story** *To note the update and patient story*	Janice Sigsworth	10
1230	**14.**	**Workforce Annual Equality, Diversity and Inclusion Report** *To approve the content of report for publication*	Kevin Croft	11
1240	**15.**	**Responsible Officer's report** *To note and confirm the report*	Julian Redhead	12
For noting / information				
1245	**16.**	**Infection Prevention and Control and Antimicrobial Stewardship Quarterly Report** *To note the quarter 1 2020/21 report*	Julian Redhead	13
1250	**17.**	**Cost Improvement Programme Quality Impact Assessment report** *To note the learning* from post implementation evaluations	Janice Sigsworth, Julian Redhead	14
1255	**18.**	**NWL Pathology annual report** *To note the annual report*	Saghar Missaghian-Cully	15
1300	**19.**	**National cancer patient experience survey 2019** *To note the results and next steps*	Katie Urch	16
1305	**20.**	**Clinical Negligence Scheme for Trusts - maternity incentive scheme Year 3** *To note the report*	TG Teoh	17
1310	**21.**	**Midwifery Safe Staffing Levels – Bi-Annual Midwifery Staffing Oversight Report** *To note the report*	Janice Sigsworth	18
1315	**22.**	**Trust Board Committees – summary reports** *To note the summary reports from the Trust Board Committees*		
	22.1.	Quality Committee, 23rd September 2020	Andy Bush	19a
	22.2.	Finance, Investment and Operations Committee, 23rd September 2020	Andreas Raffel	19b
	22.3.	Redevelopment Board Committee, 9th September 2020	Paula Vennells	19c
1320	**23.**	**Any other business**	Paula Vennells	Oral
	24.	**Questions from the public**	Paula Vennells	Oral
1330 Close	**25.**	**Date of next meeting** 25th November 2020		

Updated: 28 September 2020

Reading Room items:

- BRC report (relates to Item 7, CEO report)
- Covid-19 (relates to Item 7, CEO report)
- Learning and Insights working group reports (relates to Item 10)
  - Research & Evidence
  - Community Networks & Partners
  - Patient, citizen and community insights
  - Quality, safety and operational
  - Staff experience
- NHS Providers One Day Briefing (relates to Item 12, Finance Report)

Imperial College Healthcare NHS Trust

Public Trust Board
Draft Minutes of the meeting held on 29th July 2020, 11am
Virtual meeting held via Microsoft Teams and video-recorded.

Members present

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

In attendance

Dr Ben Maruthappu	Associate Non-executive Director
Mr Peter Jenkinson	Director of Corporate Governance
Prof. Jonathan Weber	Dean of the Faculty of Medicine, Imperial College London
Mrs Claire Hook	Director of Operational Performance
Mr Hugh Gostling	Director of Estates and Facilities
Mr Jeremy Butler	Director of Transformation
Ms Michelle Dixon	Director of Communications
Dr Bob Klaber	Director of Strategy, Research & Innovation
Mr Kevin Jarrold	Chief Information Officer
Mr Kevin Croft	Director of People and Organisational Development
Mr TG Teoh	Divisional Director, Women, Children and Clinical Support
Ms Katie Urch	Divisional Director, Surgery, Cancer and Cardiovascular
Ms Winsome Thomas	Matron for Quality Improvement (shadowing Prof. Orchard)
Ms Trish Longdon	Chair, Strategic Lay Forum
Ms Tanya Hughes	Deputy Chair, Strategic Lay Forum
Mr Paul Craven	Head of Clinical Research Operations, Imperial College (tem 11)
Mrs Ginder Nisar	Deputy Trust Secretary (minutes)

Apologies

Mr Nick Ross	Non-executive Director
Ms Frances Bowen	Divisional Director, Medicine and Integrated Care
Dr Matt Tulley	Director of Redevelopment

Item	Discussion
1.	**Opening remarks**
1.1.	Ms Vennells welcomed everyone to the meeting which was held virtually and where in person was in keeping with social distancing guidelines. The Board meeting would be video-recorded and uploaded onto the Trust's website and members of the public had been invited to submit questions ahead of the meeting which would be taken at the end of the meeting. Members of the public were welcome to submit questions to the Trust Secretary at any time.
1.2.	Ms Vennells welcomed Ms Winsome Thomas, Matron for Quality Improvement, who was shadowing Prof. Orchard as his reverse mentor.
1.3.	Ms Vennells thanked colleagues and staff across the Trust for their dedication and commitment over the past few months with the Covid-19 pandemic and their response.

2.	**Apologies** Apologies were noted from those listed above.
3.	**Declarations of interests** None other than those disclosed previously.
4.	**Minutes of the meeting held on 20th May 2020** The minutes of the previous meeting were agreed.
5. 5.1. 5.2.	**Record of items discussed in part II of the Board meeting held on 20th May 2020 and 24th June Board Seminar** The Board noted the summary of confidential items discussed at the confidential Board meeting held on 20th May and 24th June 2020 Board Seminar. In response to the public question regarding why the Trust discussed the Covid-19 update in the private part of the meeting instead of in public, Mr Jenkinson advised that it was not because there was any sensitivity around what was discussed but the nature of the conversation meant that the Chief Executive provided a thorough and comprehensive update on the Trust's response to the pandemic. It was agreed that the relevant extract of the private Board minutes would be made available to the public as part of the response to questions. Noted that an update on Covid-19 was provided at both parts of the meeting in May 2020. **Action: Mr Jenkinson**
6. 6.1. 6.2. 6.2.1.	**Matters arising and actions from previous meetings** Updates against the actions arising from previous meetings were noted on the action log. Oral updates were provided as follows: **Diagnostic pathways** – the Trust consistently met the statutory <1% DM01 position until lockdown which was now 56%. Various measures had been used which included involving the Independent Sector which was being negotiated as the Trust had been quoted £100 above tariff. There may also not be enough slots as the Integrated Care Systems (ICS) was catering for the whole sector. Weekly meetings were being held with managers of the various diagnostic modalities so as to help them address their challenges and to have oversight of the operational challenges. The directorate was also addressing the use of community diagnostic hubs with the recently approved funding of four MRI and two CT machines to be housed in the community. This work was being overseen by the Strategic Imaging Asset Management (SIAM) Programme Board which was now encompassing all the acute Trusts in the ICS. **Patient story review** – the patient stories had been well received by the Board and Prof. Sigsworth's team were exploring the logistics around how to share patient stories with the Board in light of the Covid-19 pandemic. Sir Gerry suggested it would be useful to review the patient stories received so far and assess how the Trust's behaviour had changed as a result and whether that behaviour had been sustained – as the benefit must be changed behaviour. Ms Vennells added that one of the recommendations from the Board effectiveness review was around greater visibility of metrics relating to patient experience as well as stories and Ms Boycott had some helpful input which would be discussed with Prof. Sigsworth. This would be discussed further with Board members and the Strategic Lay Forum and a proposal would be provided to the September or November Board. **Action: Prof. Sigsworth** Sir Gerry noted the lessons learned from the experience of a patient who was profoundly deaf who could not lip read through the face mask of the clinician, and was pleased to note that masks were now being manufactured with a transparent section of the mask to assist people who were deaf – ICHT would be piloting these masks. The Board noted it was a good example of how the patient story had changed the way in which things are done for patients and the long term benefits. Prof. Sigsworth advised that her team were also exploring other mechanisms to help patients such as a dictation machine which could be passed between the patient and the clinician/nurse, and also for staff members who were hard of hearing.
7. 7.1.	**Chief Executive Officer's briefing** Prof. Orchard presented his report, highlighting key updates on strategy, performance, leadership over the month, and the focus of Trust business in response to Covid-19.

7.2.	**Covid-19**
7.2.1.	The level of Covid-19 cases were reducing and it was likely that this was the lowest it would reach in the immediate future. The number of cases at the Trust had continued to drop, and as at 29th July there were no patients on ventilators in relation to Covid-19. As at 21st July, the Trust was caring for 29 inpatients who had tested positive for Covid-19 on their current admission to hospital. None of these patients required ventilation or intensive care, noting that at the height of the pandemic the Trust had 132 patients on ventilation and with approx. 400 people with the condition. As at 21st July, the Trust had treated 1,792 patients with Covid-19 of which 1,355 patients has been helped to recover from Covid-19 and be discharged. The Trust reported 427 deaths of patients positive for Covid-19 via NHS England which placed the Trust's mortality rate at the better end of overall performance which was encouraging, noting that NWL had a high number of cases. The Trust had not reported any deaths for over two weeks as at 29th July.
7.3.	**Recovery and reset**
7.3.1.	The recovery and reset portfolio was launched on 1st June to ensure positive changes from the pandemic could be built upon and embedded for pathways, models of care, ways of working and staff and patient support. It was essential that the Trust was able to resume its planned care as quickly as possible, provide urgent and emergency care for everyone who needed it and be prepared for any future peaks in infection as well as usual increased demand in winter, all while ensuring the safety and wellbeing of Trust staff, patients and visitors. The recovery and reset programme would ensure lessons were learned from the initial response, using insights to drive future developments.
7.3.2.	Prof. Orchard referred to a WHO article in which it stated that it was not helpful to refer to potential increases as a second wave, instead the mind-set should be living with intermittent outbreaks - key to this would be how those intermittent outbreaks were controlled, locally and nationally.
7.3.3.	There were a number of concerns such as the increased 52 week waits and people on diagnostic pathways – in particular, people who may be awaiting a significant diagnosis and had not had the tests and received the right treatment, were of more concern as the level of risk was unknown. People waiting for treatment had been assessed and prioritised including an assessment of harm. Prof. Orchard stressed it was important that the Trust does not forget that those people waiting to have treatment were suffering, and the Trust was mindful of this and was doing all it could to address the backlog and were encouraging people to attend appointments. The Trust along with sector colleagues, were thinking carefully about how such pathways were restarted. Prof. Orchard was leading the endoscopy service recovery workstream across London.
7.3.4.	Ms Vennells enquired whether the dispute in diagnostics tariffs mentioned earlier in the meeting, was causing delays in addressing the diagnostic pathways and backlogs. Prof. Orchard advised that the tariff was not the key factor but one of a number of issues such as scheduling, level of acuity in the independent sector and other reasons. For treatments, the Trust had done well in high utilisation of theatre lists by using the independent sector. Endoscopy was using the private sector but key to getting patients through was to 'sweat' the NHS assets instead of buying additional capacity which often relied on NHS workforce. He reiterated that the Trust's most valuable asset is its workforce who were tired and important to factor this in and not make unreasonable demands of people.
7.3.5.	London as a whole was undertaking approx. 50% elective work than it should as a result of Infection Prevention Controls (IPC) and also due to patients choosing not to attend, making scheduling difficult. Significant education needed to be done to encourage people to come to the hospital as a safe place to be in. Focus continues to improve this position.
7.3.6.	In the event of another outbreak, London was ensuring it has the appropriate level of critical care beds; for certain operations, ensuring a 'systemised way' could be established quickly and effectively across the sector and London; and trying to consolidate specialist work.

7.4.	**Keeping our staff and patients safe**
7.4.1.	The Trust had implemented a programme of individual risk assessments for its staff, to assess their safety at work. As at 29th July, the Trust completed risk assessments for 94.1% of all staff and 90.36% of Black, Asian and Minority Ethnic (BAME) staff, and appropriate provisions made for those staff who were at risk. The Trust also implemented a programme of action and review of staff work spaces to determine whether they could be categorised as Covid-19 secure areas which included a final check by Executive Directors of all work spaces across the Trust. In all other staff and public areas, all staff and public were required to wear face coverings and the Trust provides appropriate hand sanitiser. Ms Vennells thanked Executive colleagues for their work and effort in getting the risk assessments done, particularly the hotel services staff. The Board noted that the Trust was the best performing acute Trust in London in this regard.
7.4.2.	Prof. Bush enquired what had happened as a result of the risk assessments and what positive actions had been taken referring to the greater risk to BAME people. Prof. Orchard advised that the outcome of the assessments were more important than the risk assessment itself and he referred to Sir David Sloman's (NHS Improvement London Regional Director) catchphrase '*this can't be an exercise in reaching the target and missing the point'*. He advised that staff were worried if they had a negative assessment outcome, it would impact their future in the organisation therefore the action must be at a local level. Conversations were taking place around the Trust and guidance in place about what actions managers should take including identifying who should be shielding and where adjustments needed to be made - local action was felt to be the right approach instead of collecting actions centrally. He agreed that the BAME workforce was integral to the Trust. Ms Thomas was pleased to see how well the Trust had turned this around so quickly and commented that it would be useful to see the shared learning at the end of July and what further adjustments needed to be made, including changes to the risk assessment as needed. **Action: Mr Croft**
7.5.	**Testing -** A programme of staff and patient testing had been implemented. As well as on-site symptomatic testing for staff and routine testing for all A&E and inpatients, the Trust established a regular testing regime for staff working in Covid-19 protected areas and areas where the Trust has particularly vulnerable patients.
7.6.	**Critical care –** The Trust had undertaken modelling to understand the requirements for a permanent increase in critical care beds and surge capacity across its sites. The Trust was developing plans to enable increased, safe and equitable access to critical care across all three pathway types (Covid-19 risk-managed, Covid-19 protected and Covid-19 positive) for both elective and emergency patients. The relaxation of IPC may unlock difficult areas.
7.7.	**Urgent and emergency care**
7.7.1.	The Trust had submitted a bid to NHS England for capital to support social distancing in its emergency departments and same day emergency care. In general, emergency departments were small with small waiting rooms, therefore work was underway to identify mechanisms for time slots for people who do not need to be seen immediately. Chelsea and Westminster Hospital were running a pilot on timed slots.
7.7.2.	The NHS 111 service was being boosted to have access to all pathways of care.
7.7.3.	The Board noted that the experience with Covid-19 pandemic would most likely result in an even greater emphasis on the flu campaign, including flu vaccinations being mandated by NHS England for all NHS staff.
7.8.	**Elective recovery -** A number of elective surgical pathways had resumed and Cerner surgical forms were now live for referral to treatment processes and planned patients and theatre availability was on track. There were a number of key challenges, especially to ensure the Trust was fully aligned across the NWL ICS on capacity planning, performance and financial forecasting.

7.9.	**Staff support and wellbeing Covid-19 legacy programme**
7.9.1.	At an early stage in the pandemic, in partnership with Imperial Health Charity, the Trust had been able to establish an enhanced programme of staff support. It increased the emotional and wellbeing support on offer in response to the vast workloads and very challenging situations that many staff experienced. Overall, the Charity raised over £2.7m with its Covid-19 relief fund and NHS Charities Together raised £130m nationally.
7.9.2.	In May 2020, the Trust asked for staff views and ideas on changes and what the Trust should take forward. One of the most common responses was that the Trust should continue to have a focus on staff support - on the facilities and resources that make staff feel valued and that enable them to do their best in looking after patients and colleagues. The Trust was pleased to announce a new £1.7m Covid-19 legacy staff support programme, allowing for further input from staff and partners. In partnership with Imperial Health Charity, the programme would deliver improvements in three key areas: staff spaces, food and shops and emotional wellbeing, described further in the report.
7.10.	**Strategic development -** The Board noted that Dr Klaber and colleagues had done significant work on strategy, including consideration of how Covid-19 would affect the Trust's strategy and priorities. It was felt that the Trust should have a leaner structure with fewer layers with priorities feeding into the goals with clear metrics – this work would be completed by September 2020. The Board noted that there was one clear objective within the NHS which was to get the services back up and running whilst living by the Trust's values and behaviours, recognising the challenge in terms of stress, tiredness, transformation and moving to a new way of working across the entire range of activities. This year the Trust would need to identify whether there are any particular priorities that need to be pulled or added from its previous framing of the strategy and then ensuring, when next year's planning is discussed the Trust has the right set of ambitions and priorities. Therefore in September the Trust would have a revised set of priorities for 2020/21 which would place the Trust in good stead for getting its strategic goals right for 2021/22. **Action: Dr Klaber**
7.11.	**Redevelopment**
7.11.1.	The Trust had completed the Strategic Outline Case (SOC) for the St. Mary's redevelopment which was ready for formal submission to NHS Improvement. The Trust had worked with the developer design team and received a feasibility study looking at how the Trust's requirements could be delivered on the Paddington site. At the beginning of July 2020, the Trust met with Westminster City Council to provide an update on progress which was received positively.
7.11.2.	The Trust was also progressing the plans for Charing Cross and Hammersmith Hospitals currently focussing on documenting the clinical plans for these sites ahead of developing the site-wide masterplans.
7.11.3.	The Trust launched the first phase of its patient and public insight and engagement programme in July 2020 working with the specialist agency Kaleidoscope, to gather views and ideas through online groups, a survey and community group outreach.
7.12.	**CQC update: assessment of the Trust's Infection Prevention and Control Board Assurance Framework**
7.12.1.	The CQC introduced a temporary approach to inspection during the pandemic period which involved Emergency Support Frameworks (ESF) that focuses on key aspects of safety and leadership. Assessment using ESFs would be in the form of a telephone call, after which organisations would be scored as either managing on their own or requiring support. For organisations identified as needing support, the next steps would vary depending on the support the CQC considers is required.
7.12.2.	The Trust's ESF phone call took place on 20th and 23rd July 2020, and the Trust had received the report from this review. The report confirmed that the Trust had undertaken a thorough assessment of IPC, across all services, since the pandemic of Covid-19 was declared and maintained appropriate systems and processes of controls and assurances. The report highlighted two areas of outstanding practice regarding how the Trust addressed the concerns of local BAME population groups regarding rumours and misinformation that were being spread on social media about the Covid-19 pandemic and how it affected patients in hospital; and the

	PPE Helper Programme. The Trust's GP practice undertook its own assessment against the CQC's ESF for primary care and considers that it was fully compliant.
7.13.	**CQC Provider Collaboration Reviews -** On 8th July the CQC announced a programme of local area reviews called Provider Collaboration Reviews (PCRs), aimed at helping organisations rapidly learn lessons from responding to the first wave of the Covid-19 pandemic. Phase 1 includes the North West London STP and review findings would be published in the CQC's Covid Insight Report in September 2020. They would also be included in the CQC's next annual State of Care report, due for publication in October 2020.
7.14.	**Hotel services direct employment -** As reported previously, the transition of over 1,000 cleaning, catering, and portering staff from employment by the Trust's previous service provider Sodexo, to be employed by the Trust on 1 April had gone smoothly. The Trust would run Hotel Services on a direct management basis for a year in order to establish the long-term viability of the model. An evaluation would then be taken to decide whether to continue to employ hotel services staff directly, and bring all staff up to full NHS (Agenda for Change) terms and conditions, or retender the contract with a significantly amended specification.
7.15.	**Financial performance**
7.15.1.	Under the current NHS financial regime, the Trust had been moved to a block contract arrangement for the first four months with an expectation that a 'top-up' payment would be received to achieve a break even position, now extended to end of October 2020. The block contract was based on the previous year's month 8-10 run rate. It did not include additional new costs incurred in-year such as Covid-19 costs or the cost of bringing the facilities management contract in house.
7.15.2.	Year to date (April 20 - June 20), the Trust had requested an additional £16.6m of top up funding, otherwise the position would be deficit. The deficit was mainly due to additional costs to support the response to Covid-19 of £20.3m.
7.16.	**Research and innovation**
7.16.1.	The Board noted the substantive item on the agenda outlining how the research and development teams within the Trust responded to the Covid-19 pandemic and some of the key research studies the Trust was involved in. The Trust recruited more than 1,900 patients and volunteers to date into 13 nationally prioritised Covid-19 research studies. 17 national studies and approximately 60 others were opened to date, with the average time to set up and open a national Covid-19 research study of 6 days, enabling more patients to benefit from inclusion. The Board noted that the Trust's research delivery workforce (research nurses, clinical research practitioners) had been key during the intense period of activity, which continues to evolve as new research questions emerge while the Trust tries to restart its previous research activity in a safe way.
7.16.2.	In partnership with Imperial Health Charity, the Trust launched the first round of the 'Innovate at Imperial', with 11 teams from across the Trust successful in being awarded small grants to support putting their innovative ideas into practice. 48 teams submitted an expression of interest for the second round of the funding programme.
7.17.	**Stakeholder engagement -** A list of meetings held with stakeholders was provided in the report. Prof. Orchard commented that he had a helpful meeting with the Strategic Lay Partners who continue to do an outstanding job on holding the Trust to account to ensure the Trust takes into account the patient voice. Ms Vennells echoed Prof. Orchard's comments and particularly thanked Ms Longdon for her contribution at the Clinical Reference Group during Covid-19.
7.18.	**Annual general meeting 2020 -** Over 200 viewers joined the Trust's live-streamed 'virtual' Trust AGM on 15th July. The Trust covered a range of topics including its response to Covid-19.
7.19.	Comments from the Non-executive Directors:
7.19.1.	Dr Raffel commented that a number of times colleagues had mentioned the workforce and how tired they were and making sure they take time off. He asked whether there was a way of

	monitoring that staff were taking time off. Prof. Orchard and Mr Croft advised that staff were being asked to take a proportion of their annual leave at intervals noting that leave was also carried over from the previous year due to Covid-19. Through the e-roster system, annual leave was being monitored and the Executive Team would receive regular reports to gain assurance.
7.19.2.	On behalf of Mr Ross, Ms Vennells enquired, for different cohorts of staff particularly those in vulnerable categories such as obesity, what further help could be provided. Mr Croft advised that the charity award money covered aspects of health and wellbeing which included the physical element as well as the psychological aspect, both would be pulled together to ensure a coherent approach. It was agreed to discuss further as a theme at the Quality Committee as part of the safe staffing report. The Board noted that the executive were considering the appointment of a senior role to bring all of this agenda together. **Action: Mr Croft**
7.19.3.	Responding to Mr Goldsbrough, Ms Hook confirmed that the Board would have the opportunity to review the new scorecard before it was finalised and the metrics would be aligned with the Trust's objectives. **The Board noted the report from the Chief Executive.**
8.	No items for decision.
9.	**Trust Board Governance**
9.1.	Following the Board and Committee effectiveness review, learning from changes made during the Covid-19 pandemic, and resuming the previously agreed changes to Executive routines to support the programmes, projects and priorities of the Imperial Way Programme, it was timely to review the overall governance arrangements at Executive and Board levels.
9.2.	The effectiveness review of each of the Committees had been discussed at the respective Committee and the detailed report in relation to the Trust Board itself and the overarching review was provided in the Reading Room. Overall the review provided a good level of insight due to the number of comments received, therefore the quantitative and qualitative data allowed key themes to be drawn out which would be the areas of focus, summarised in the report. Overall the outcome was positive in terms of Board level governance with some areas of continued focus to be taken forward by each of the Committees and the Board itself.
9.3.	Mr Jenkinson explained that the purpose of the Imperial Management and Improvement System (IMIS) programme (part of The Imperial Way) was to establish the way in which the Trust manages the development and delivery of its priorities from Board to ward, including cascaded strategic objectives and bottom-up identified local initiatives, in a consistent and transparent manner. It was therefore a key component in establishing the systems and processes to support the delivery of the strategic goals. As part of this, the Trust looked at executive routines and lessons learnt from Covid-19 and the resultant changes described in the report.
9.4.	The report described the move to a six week reporting cycle and the proposal to move the scheduling of the Board and its Committees to enable them to receive more current information. This would allow a flow of information from operations to Executive and then Board. A key component of the changes was to ensure that the organisation has the appropriate governance routines to support the delivery of the strategic goals.
9.5.	Mr Goldsbrough and Sir Gerry enquired about the six week reporting cycle and whether this could be shortened mindful of the modern age and IT solutions. Mr Jenkinson explained from the end of month 1, to completing the review and reporting of performance of month 1 (and the assurance mechanisms) would take six weeks therefore by the second week of month 3 the Board would have completed the review of all reporting. In terms of whether that was the quickest time, Mr Jenkinson advised that was the best that could be done noting that teams were driving effectiveness and efficiency. Prof. Orchard added that with the new approach, the figures would be one month out of date opposed to two and although it was easier to bring forth reporting of finance due to internal reporting mechanisms, performance was somewhat dictated by NHS England (NHSE) and NHS Improvement (NHSI) submissions. The Executive Team would

	continue to review and bring forward reporting where possible to provide a fully integrated view of performance, however he advised that if there was anything of concern it would be reported to the Board outside of usual reporting. The Board noted the increased data quality – 'getting it right first time' approach to data quality would in time assist with the reporting cycle notwithstanding NHSI submission timelines.
9.6.	**The Board noted the Board and Committee effectiveness review and the arising actions and agreed the next steps in exploring dates for Board and Committees.**
10.	**Patient and public involvement 2019/20 annual review**
10.1.	The Board welcomed Ms Longdon and Ms Hughes from the Strategic Lay Forum who presented a progress update on the forum's priorities and work programme for 2019/20; how the forum influenced the Trust's 2020/21 business plan; involvement in the Trust's response to Covid-19 and in the estate redevelopment, in particular.
10.2.	The Board received an update on the Strategic Lay Forum's priorities for 2019/20 covering: increasing the influence and reach of the Strategic Lay Forum; expand the lay partner programme and strengthen lay partner involvement; demonstrate lay partner impact through evaluation; support reduction in health inequalities; learn and act on feedback and complaints; embed patient-centred care in all staff objectives.
10.3.	In particular, Ms Longdon drew the Board's attention to the lay partner impact through evaluation under which an impact evaluation and methodology and plan was co-designed with staff, quality improvement coaches, lay partners and colleagues from Imperial College London and Imperial Health Charity. It would be delivered by quarter 4 to provide qualitative data and case studies on the positive impact of lay partner collaboration. This would be linked with the 'learning and insights' programme.
10.4.	Ms Longdon commented it was helpful to be involved in the Trust's business planning process. She referred to the patient appointments system which was a key and ongoing complaint and suggested consideration be given to this as a priority transformational project for the Trust – in this context she raised the importance of patient records and championed integrated care.
10.5.	Ms Longdon commented that Covid-19 demonstrated how embedded in the Trust the Lay Forum was and she was pleased to be involved in the Clinical Reference Group where the patient voice was important to be heard – she was confident decisions were mindful of safety and were fair and she was able to convey this to patients during the pandemic to allay fears and misconceptions. She continued to be involved in the new pathways and was able to air concerns. The Lay Forum were pleased to be involved early on in recovery and reset.
10.6.	The involvement in the redevelopment programme was welcomed by the Strategic Lay Forum who had the opportunity to input into hospital design, vision and to co-design an Involvement Charter which had been included in the way the Strategic Lay Forum does things at the Trust.
10.7.	The Board noted the Strategic Lay Forum's priorities for 2020/21.
10.8.	The Board heard a video from Ms Nafsika Thalassis, Director of Hammersmith and Fulham BME Health Forum and member of the Strategic Lay Forum, in which she relayed concerns and fears circulating amongst local black, Asian and minority ethnic communities about hospital care and Covid-19. The video was made to address some of the rumours and fears which had been helpful however need to address the use of interpretation services which should be used more widely. The Board noted that the Lay Forum had invited members of the Trust to the next forum to explain the interpretation service with a view to making it more effective, this would also be discussed at the Quality Committee. **Action: Prof. Teoh**
10.9.	Linking with Sir Gerry's comments at item 6.2.1, the Board watched a video from Ms Jane Wilmot, member of the Strategic Lay Forum and accessibility advocate, who was deaf and was helping to raise issues and develop solutions to ensure all patients have equal access to care. The forum had been focusing on how it responds to digital poverty with the move to much more

	digital care. Ms Wilmot had been helping the Trust consider how face masks and coverings were inhibiting lip reading and how to respond. The Lay Forum was pleased that the government had approved the clear face masks and that ICHT were piloting these for deaf people.
10.10.	Comments from the Board:
10.10.1.	The Board was pleased to note the valuable input by the Strategic Lay Forum and asked that their thanks are passed to Ms Thalassis and Ms Wilmot for sharing their thoughts.
10.10.2.	Ms Boycott acknowledged the work that had gone on in providing assurance about the Lay Forum's involvement with Covid-19 from the start noting that the work was visible. She noted the comments in relation to the patient appointments system which was a fair challenge as was the issue of digital poverty. In terms of the latter, technology and associated ethics were going to be key to patient trust going forward and she requested that the Strategic Lay Forum helps to contribute and make sure the patient voice comes through, stressing that the forum's role in getting it right would be key. In the same token she advised in order to enable the forum to contribute effectively around new ways of working, it was important to ensure the Trust provides adequate support such as training.
10.10.3.	Dr Maruthappu was delighted to receive the update with valuable insights. Looking forward he asked whether any further support could be provided by the Trust with some of the Strategic Lay Forum's priorities, and how it could assist further to increase and improve lay partner diversity. Prof. Orchard had offered support to increase lay partner diversity and work was in train with BAME and lay partners with targeted recruitment and encouraging people to apply for this role. Ms Longdon advised it was helpful at times to work with divisions using their own resources therefore less dependent on additional lay forum resource – she stressed that the more the lay forum was embedded, the more support from the Trust would be needed, noting that the forum has good internal links with the Trust to move things forward.
10.10.4.	Mrs Thind echoed colleagues' comments. In terms of technology she enquired about plans for those people who could not easily access technology and therefore possibly left behind, and the support for them. Ms Longdon advised that the issues were often around broadband, equipment, space and such issues would be picked up as part of recovery and reset. She felt the voice was being heard and it was important that no part of the community was disenfranchised by making things virtual and particular arrangements would be made for specialist areas to make the service accessible to everyone.
10.10.5.	Ms Vennells and Prof. Orchard had discussed the patient appointments system and the patient records system with Ms Longdon and agreed that both were important. Consideration in terms of transformational projects would need to be discussed as part of the Imperial Way programmes and priorities, taking into account management capacity. **Action: Mr Butler**
10.10.6.	Prof. Bush referred to the Patterson report which included recommendations including hospitals writing to the patient in lay language that could be understood with a copy to the GP, instead of consultants writing to GPs with a copy to the patient/family. Ms Longdon commented that this would be welcome as writing directly to the patient would enable patients to get back to the hospital on any issues directly therefore supporting the notion of self-care. This would not require additional resource but a different way of working and she looked forward to further communication on this when available.
10.11.	**The Board thanked the Strategic Lay Forum for their contribution and for their objective challenge.**
11. 11.1.	**Covid-19 research – the imperial experience and response** The Board noted a paper outlining research conducted by the Trust during the pandemic. The report detailed the Imperial response to the Covid-19 pandemic since mid-March 2020 in terms of clinical research within the Trust, in partnership with Imperial College London and the wider Imperial Academic Health Science Centre (AHSC). It also considered what insights have been gained to inform research, and its translation into excellent clinical care going forward. The report

	described how the research and development teams within the Trust responded to the crisis, some of the key research studies it was involved in, and the outputs and outcomes to date. The Board thanked Dr Klaber, Mr Craven and colleagues for a good report and content, noting that it was good to see the Trust at the forefront of research.
11.2.	Dr Klaber commented that the work around research in partnership with colleagues across Imperial college was all about 'health and wellbeing' and 'health and inequalities' some of which was mentioned by the Strategic Lay Forum and agreed that it was crucial to tackle some of the issues mentioned by Ms Longdon.
11.3.	Multi-disciplinary and collaborative approaches were essential to respond to the crisis and all those involved were thanked.
11.4.	Ms Vennells had read through some of the studies noting that Imperial College was strong throughout. She also commented it was helpful to receive regular briefings and updates on research.
11.5.	Mr Goldsbrough commented that the report was a fantastic reflection of the work that had been done over the past few months and thanked all those involved. Responding to his question about lessons learnt, Dr Klaber informed him of the learning and insights programme which had been established, one of the strands being about research and evidence thereby looking at lessons learnt and benefits such as the speed of research during Covid-19. Prof. Bush echoed Mr Goldsbrough's comments and stated that it was indeed possible to do research quicker noting the bureaucracy pre-Covid, and it was possible to achieve results outside of a crisis situation.
11.6.	Ms Boycott commented on the excellent report and stressed it was important to continue to harness the energy and momentum of participating with research and recruitment to studies. She suggested it would be helpful to assess the risks as the portfolio rebalances 'with Covid' and 'without Covid' and identify any hidden costs as important to get early warning. Dr Klaber advised that his team were working on this with clinical teams and although research was deeply integrated, lateral thinking is important.
11.7.	Mr Craven added that the key community of people who should be thanked and whose importance had come to the forefront were research nurses, clinical research practitioner and research deliverers. Important to think about how this integral community is supported and developed and as we balance demands and priorities. The Board expressed their gratitude to them too and supported these community of people.
11.8.	**The Board noted the report.**
12.	**Integrated Quality and Performance report (IQPR)**
12.1.	The report covered performance during May 2020 and any variances could entirely be explained by the impact of Covid-19. The report described the Trust's performance and provided an update on the overall approach to arrangements underpinning reporting as described by Mr Jenkinson at item 9. The scorecard would continue to be developed.
12.2.	The important next step was to set the performance trajectory now that there was some clarity around national expectations of Trusts. This work would be concluded by the next report to Board in September, therefore the Trust would be in exception reporting mode.
12.3.	The report was taken as read which had been discussed at the Quality Committee.
12.4.	**The Board noted the report.**
13.	**Finance report**
13.1.	The report was taken as read which had been discussed in detail at the Finance, Investment and Operations Committee, and also mentioned in the Chief Executive's Report at item 6.
13.2.	**The Board noted the report.**

14.	**Integrated risk management and assurance report**
14.1.	The Trust Board reviewed the corporate risk register and the Board Assurance Framework at its meeting in November 2019. Since then, a review of the Board Assurance Framework had been undertaken and its outcome, with a new assurance process was agreed at the Audi, Risk and Governance Committee in July 2020.
14.2.	**The Board noted the report.**
15.	**Annual report of the end of life steering group 2019/20**
15.1.	The report was taken as read which had been discussed at the Quality Committee.
15.2.	Prof. Urch welcomed the work the Strategic Lay Forum had done on end of life requests and the documentation piece around that, and also the work around managing the behavioural aspects of caring for patients at the end of life and ensuring that staff feel confident to care for the person themselves and those important to them. She advised that this work would continue and 'the big room' was helpful with good engagement and the Lay forum had contributed significantly in developing a better conversation with how to record and also discussions around end of life.
15.3.	In terms of documentation, this had been revised and was on Cerner as a key metric as to what was exactly documented. Another metric was complaints and PALS enquiries around the care of the dying. 'The big room' would resume and take up work as soon as the reset work was completed, noting that the recovery work was not complete and reaches wider than the hospital into the community.
15.4.	Mr Goldsbrough commented that the report reflected good progress in this area but enquired about what were the key indicators in terms of assessing progress. Dr Urch advised that these were set by the CQC around the five priorities: completion of DNA CPR; and discharge and rapid discharge for patients who do not wish to have their last time at the hospital which are quantitative. More importantly which the CQC look at in detail and the discussion of big rooms thereby qualitative, was around how communication is undertaken; what is documented; and how handovers between care services are undertaken.
15.5.	Prof. Orchard added that end of life care was a key target and adding qualitative data to quantitative was important.
15.6.	**The Board noted the report.**
16.	**Mortality update – including learning from deaths quarterly report: Q3 and 4 2019/20**
16.1.	The report was taken as read which had been discussed at the Quality Committee.
16.2.	The Board thanked Prof. Redhead and everyone working in this area - the results were encouraging. Prof. Redhead commented that as the Trust obtains more comparative death rates, these would be added and learn from the experience of Covid-19.
16.3.	**The Board noted the report.**
17.	**Trust complaints service annual report**
17.1.	The report was taken as read which had been discussed at the Quality Committee.
17.2.	Ms Boycott commented that complaints was the tip of the iceberg in terms of feedback and it was important to have a wider view, taking into account PALS, raising concerns and legal cases - all contributing to the wider patient experience.
17.3.	Referring to the qualitative and quantitative data comments at item 15, Mr Goldsbrough was surprised that the Trust has a target for the number of complaints - if there are complaints to be heard, the Trust should hear them. The fact that there were a number of them upheld, suggested there was more there to be found therefore tied in with Ms Boycott's point to consider more active market research, surveys and focus groups in order to get more granular insight into patient and population perspective.

17.4.	Prof. Sigsworth advised that the Trust receives feedback from patients and families in many different ways. A small group involving herself, Ms Boycott and the Strategic Lay Forum would discuss and structure what key elements should be collated in terms of narrative and data around what the Trust's patients and families are saying and then shape priorities. Prof. Orchard confirmed that the Trust would pull something together and how it feeds into overall user experience to be discussed at the Quality Committee. **Action: Prof. Sigsworth**
17.5.	**The Board noted the report.**
18.	**Trust Board Committees – summary reports** The reports were noted and questions to be handled via email which would be published with the recording of the video. *Post meeting note: There were no comments via email or the Microsoft Teams chat room.*
18.1.	**Audit Risk and Governance Committee** The Board noted the summary points from the meeting held on 8th July 2020.
18.2.	**Quality Committee** The Board noted the summary points from the meeting held on 8th July 2020.
18.3.	**Remuneration and Appointments Committee** The Board noted the summary points from the meeting held on 14th July 2020.
18.4.	**Finance, Investment and Operations Committee** The Board noted the summary points from the meeting held on 22nd July 2020.
18.5.	**Board Redevelopment Committee** The Board noted the summary points from the meeting held on 22nd July 2020.
19. 19.1.	**Any other business** Ms Vennells thanked the Executive Team for their work who have worked tirelessly for the past few months and she encouraged people to take annual leave and to enjoy their holidays and thanked families for their support.
20. 20.1.	**Questions from the public** A number of questions were received from members of the public ahead of the meeting. A written response to each of the questions would be added to the Trust's website.
21.	**Date of next meeting** 30th September 2020, 11am, Virtual meeting

Updated: 18 September 2020

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Record of items discussed at the confidential Trust board meeting held on 29 July 2020	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 30 September 2020	**Item 5, report no. 02**
Responsible Executive Director: Professor Tim Orchard, chief executive officer	**Author:** Peter Jenkinson, Director of corporate governance

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

Chief Executive's report
As part of the Chief Executive's oral update, the Board received an update on the NWL Integrated Care Systems plan and the Trust's recovery and reset programme.

Trust wide estates maintenance contract extension
The Board considered the proposed contract extension, noting that it had been discussed at the Finance, Investment and Operations Committee. The Board approved the extension of the contract.

St Mary's Hospital Redevelopment Strategic Outline Case
The Board considered the Strategic Outline Case (SOC) for the redevelopment of St. Mary's Hospital ahead of the submission to NHS England and NHS Improvement. The Board was supportive of progressing to the next stage, agreed the submission of the SOC following further amendments, and to start external stakeholder engagement regarding the SOC.

PET CT Scanner Full Business Case
The Board considered the Full Business Case, noting that the case had been discussed at the Finance, Investment and Operations Committee. The Board approved the full business case.

Development of a Fleming Centre
The Board received and noted the paper setting out initial proposals for the development of a centre at St. Mary's Hospital to study infectious diseases and innovative treatments, serving as a clinical arm of Imperial College's Institute of Infection. The Board noted the proposed concept and agreed that further work would be progressed to develop the proposal.

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

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC) - ACTION POINTS REGISTER, Date of last meeting 29 July 2020

Updated: 24 September 2020

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	20 May 2020 13.5	Infection data by site (arising from IPC report)	Dr Maruthappu requested to see data by site for infection in subsequent reports or outside of the meeting. Prof. Redhead confirmed this was possible and he would arrange. July 2020 update: This is part of the work being undertaken by the Director of Operational Performance looking at splitting metrics by site. The IMIS scorecard showed the metrics that can be split by site. We agreed to review which would be useful to see at this level as part of the overall development of the scorecard. September 2020 update: The Trust, Division and Directorate scorecards are being reviewed as part of the IMIS programme with a plan to include site level detail where appropriate going forward, this is being led by the DOP. In the meantime site level IPC data has been reviewed and a description of it is included in the IPC Board report with a plan to include the data in the next quarterly report. There is no variance in IPC data at site level in the current report. Close	Julian Redhead	September 2020
2.	20 May 2020 12.3	Hotel services transition	The Board agreed to receive a progress update on the service in September 2020, noting that the Trust would only consider outsourcing if the service was not performing or due to increased costs, mindful of the significant effort to bring the service in-house and staff morale. September 2020 update: Included in the CEO's public Board report.	Hugh Gostling	September 2020
3.	29 July 2020 5.2	Public question: Why Covid item was discussed in private	In response to the public question regarding why the Trust discussed the Covid-19 update in the private part of the meeting instead of in public, Mr Jenkinson advised that it was not because there was any sensitivity around what was discussed but the nature of the conversation meant that the Chief Executive provided a thorough and comprehensive update on the Trust's response to the pandemic. It was agreed that the relevant extract of the private Board minutes would be made available to the public as part of the response to questions. Noted that an update on Covid-19 was provided at both parts of the meeting in May 2020. September 2020 update: Included as part of the response to the list of questions. Close.	Peter Jenkinson	September 2020
4.	29 July 2020 7.10	Strategic development	This year the Trust would need to identify whether there are any particular priorities that need to be pulled or added from its previous framing of the strategy and then ensuring, when next year's planning is discussed, the Trust has the right set of ambitions and priorities. Therefore in September the Trust would have a revised set of priorities for 2020/21 which would place the Trust in good stead for getting its strategic goals right for 2021/22. September 2020 update: Main agenda item	Bob Klaber	September 2020

5.	29 July 2020 7.4.2	Keeping our patients and staff safe / risk assessments (arising from CEO report)	Ms Thomas was pleased to see how well the Trust had turned this around so quickly and commented that it would be useful to see the shared learning at the end of July and what further adjustments need to be made, including changes to the risk assessment as needed. September 2020 update: Oral update	Kevin Croft	September 2020
6.	29 January 2020 7.3 29 July 2020 6.2	Patient story review	January 2020: Prof. Sigsworth welcomed the comments and would discuss a plan with the Strategic Lay Forum, Executive Quality Committee and Quality Board Committee with a next steps plan to Board in summer. July 2020 update: The patient stories had been well received by the Board and Prof. Sigsworth's team were exploring the logistics around how to share patient stories with the Board in light of the Covid-19 pandemic. Sir Gerry suggested it would be useful to review the patient stories received so far and assess how the Trust's behaviour had changed as a result and whether that behaviour had been sustained – as the benefit must be changed behaviour. Ms Vennells added that one of the recommendations from the Board effectiveness review was around greater visibility of metrics relating to patient experience as well as stories and Ms Boycott had some helpful input which would be discussed with Prof. Sigsworth. This would be discussed further with Board members and the Strategic Lay Forum and a proposal would be provided to the September or November Board. September 2020 update: Main agenda item.	Janice Sigsworth	September 2020
7.	29 July 2020 17.4	Patient experience (arising from annual complaints report)	Prof. Sigsworth advised that the Trust receives feedback from patients and families in many different ways. A small group involving herself, Ms Boycott and the Strategic Lay Forum would discuss and structure what key elements should be collated in terms of narrative and data around what the Trust's patients and families are saying and then shape priorities. Prof. Orchard confirmed that the Trust would pull something together and how it feeds into overall user experience to be discussed at the Quality Committee. September 2020 update: Included in the Learning and Insights work. Close	Janice Sigsworth	September 2020
8.	29 July 2020 10.10.5	Patient appointment system (arising from Strategic Lay Forum discussion)	Ms Vennells and Prof. Orchard had discussed the patient appointments system and the patient records system with Ms Longdon and agreed that both were important. Consideration in terms of transformational projects would need to be discussed as part of the Imperial Way programmes and priorities, taking into account management capacity. September 2020 update: The input of our patients and the wider population is key to 'co-producing' changes to the ways services are delivered. We are involving patients at different levels of the work we are undertaking to redesign models of care. For example, 2 members of the Strategic Lay Forum are members of the Steering Group that oversees changes to models of care. Similarly, specific patient groups are being engaged in the work the Trust is talking forward jointly with London Northwest Healthcare NHS Trust to consolidate vascular services across NW London.	Jeremy Butler	September 2020

9.	29 July 2020 10.8	Interpretation service (arising from Strategic Lay Forum discussion)	Use of interpretation services should be used more widely. The Board noted that the Lay Forum had invited members of the Trust to the next forum to explain the interpretation service with a view to making it more effective, this would also be discussed at the Quality Committee. September 2020 update: Linda Watts and Patricia Reyes attended the Lay forum on behalf of the Division and provided a short briefing on the interpretation service which was well received. There was an awareness that clear two-way communication is crucial for excellent patient care and experience and a summary of the input from the strategic lay forum provided to the Trust Secretariat.	TG Teoh	Added to Quality Committee forward planner
10.	29 July 2020 7.19.2	Staff wellbeing (arising from CEO Report)	On behalf of Mr Ross, Ms Vennells enquired, for different cohorts of staff particularly those in vulnerable categories such as obesity, what further help could be provided. Mr Croft advised that the charity award money covered aspects of health and wellbeing which included the physical element as well as the psychological aspect, both would be pulled together to ensure a coherent approach. It was agreed to discuss further as a theme at the Quality Committee as part of the safe staffing report. The Board noted that the executive were considering the appointment of a senior role to bring all of this agenda together. September 2020 update: Added to the Quality Committee forward planner	Kevin Croft	Added to Quality Committee forward planner
11.	29 January 2020 14.6	Employee metrics matrix (arising from FTSU item)	Ms Boycott suggested a joined up matrix capturing employee experience such as concerns arising from staff survey, and concerns raised via other sources including FTSU. Other Non-executive Directors agreed and suggested including excellence awards and staff stories to Board in the employee experience piece. Mr Croft would give some thought to this. July 2020 update: The People and OD team are currently working on setting back up the culture programme and the people metrics that will be used in the Imperial Management and Improvement System. This will include directorate level dashboards relevant to this item. It is proposed this is considered in September once this work has progressed through the executive and the relevant Board Committee. September 2020 update: Deferred to next meeting.	Kevin Croft	November 2020
12.	25 March 2020 9.4	Sustainable development management plan	The Board endorsed the plan and the ambition, and asked the Executive Team to review and include more granularity around key aspects and then submit to the Board Redevelopment Committee when ready. The report to also include it would need a rolling plan as it would evolve over time. May 2020 update: Planned for December 2020 Redevelopment Board Committee	Hugh Gostling	November 2020

Items closed at the July 2020 meeting

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
13.	27 November 2019 9 25 March 2020 8	Strategic development – Implementation of a management system (The Imperial Way)	November 2019: Claire Hook highlighted that the proposed approach to delivering the Trusts strategy in a standardised way, linking in with the Trusts values and behaviours. Board members discussed the programme and agreed whilst they all supported the proposal, that there needed to be a clear and practical way of delivering it, with it being collectively owned by the executive team. The Board approved the Imperial management system (working title 'the Imperial Way') and noted the process for agreeing priorities for 2020/21 and the process for delivery of the 2019/20 objectives. An update outlining the delivery process and risks would be presented to a future board meeting. March 2020 update: The Board received a summary of the proposed priorities for the Trust for 2020/21 as discussed in the February 2020 Board strategy seminar and taking into consideration the evolution of priorities in response to Covid-19. The Board would be kept updated on changes. July 2020 update: An updated was provided within the IMIS report.	Tim Orchard/Claire Hook, Bob Klaber, Peter Jenkinson	Closed
14.	20 May 2020 10.2.12-13	Performance score card metrics	a) The refresh of the programmes and projects would set out the metrics and Mrs Hook would make clear which were regulatory. b) In response to Ms Vennells' query about site led KPIs and whether there were two or three that could be combined to give an overall performance of each site, the Executive would give some thought to the request, as the current metrics could easily be split by site. July 2020 update: a) Included in score card. Closed b) The IMIS scorecard showed the metrics that can be split by site. We agreed to review which would be useful to see at this level as part of the overall development of the scorecard. Action closed.	Claire Hook	Closed
15.	20 May 2020 13.2	Infection risk (arising from IPC report)	Given that the norms would change Ms Boycott suggested the Quality Committee look at the way in which infection is seen going forward and from a risk point of view, a conversation needed around how risk would be managed going forward. Prof. Redhead agreed that a discussion at Quality Committee would be helpful and Prof. Bush would lead on this. July 2020 update: This will be discussed at the Quality Committee.	Prof. Redhead	Transferred to Quality Committee Forward Planner
16.	29 January 2020 17.3 20 May 2020 6	Pathway to excellence	Sir Gerald Acher also congratulated the directorate and suggested this is brought to the attention of North West London colleagues and included in a communications exercise/bulletin. May 2020 update: Prof. Sigsworth advised that this was currently on hold but would take stock in the coming weeks with the Executive team. July 2020 update: The programme is being restarted and we will be using the framework to support our post-Covid learning and to drive initiatives such as the Winter flu campaign.	Janice Sigsworth	Closed

17.	29 January 2020 9.5 29 July 6.1	Integrated Quality and Performance Report – Diagnostics	Prof. Teoh informed the Board that in November and December 2019, the diagnostic target had not been met with a 175% increase in ultrasounds as the seasonable variation had increased. He was working with the CCGs to address this and he would report back to Board on discussions. March 2020 update: Contact made with the CCG but focus currently on Covid-19. July 2020 update: the Trust used to meet the statutory <1% DM01 position until lockdown and it is now 56%. Various measures have been used which include involving the Independent Sector which was being negotiated as the Trust had been quoted £100 above tariff. There may also not be enough slots as the ICS was catering for the whole sector. Weekly meetings were being held with managers of the various diagnostic modalities so as to help them address their challenges and to have oversight of the operational challenges. The directorate was also addressing the use of community diagnostic hubs with the recently approved funding of four MRI and two CT machines to be housed in the community. This work was being overseen by the SIAM Project Board which is now encompassing all the acute Trusts in the ICS.	TG Teoh	Closed
18.	20 May 2020 9.2.4	Capital regime for 2020/21 (arising from Finance report)	A point would be reached requiring Board decision around the residual gap and what the Trust could afford to do within that limit. As the next Board was not until July, it was agreed, if needed, an Extraordinary Finance, Investment and Operations Committee (FIOC) would be convened with delegated authority to make decisions around the capital plan. All Board members would be invited to the Committee July 2020 update: The NWL sector undertook a review of all capital schemes which resulted in the ICS remaining within its CRL of £290m. The Trust's CRL remained as per plan thereby negating the need to convene an extra ordinary meeting of FIOC.	Jazz Thind	Closed

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

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TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Chief Executive Officer's Report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 30 September 2020	**Item 7, report no. 04**
Responsible Executive Director: Prof Tim Orchard, Chief Executive Officer	**Author:** Prof Tim Orchard, Chief Executive Officer

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

1) Hotel Services progress update
2) Thank you week
3) CQC update
4) Financial performance
5) Operational performance
6) Redevelopment
7) Research and innovation
8) Stakeholder engagement

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

This report has been discussed at: N/A

Quality impact: N/A

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

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

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

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

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

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

Trust strategic goals supported by this paper:

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

Chief Executive's Report to Trust Board

1. Hotel Services progress update

Following the successful and smooth transition of over 1,000 cleaning, catering, and portering staff to direct employment with the Trust on 1 April 2020, the stabilisation plan (which ran from 1 April to the end of July) has been successfully completed, with service performance remaining on a par with the previous provider, and starting to show improvement in some areas such as cleaning. Recruitment campaigns have been undertaken to fill a large number of vacancies in front line staffing. In addition, plans to deliver training to staff quality auditing plans have been developed and implemented and this is linked to the overall agreed governance structure which has been implemented as part of stabilisation.

The transition project has now moved into the service improvement phase, where services and resources are being evaluated for service performance delivery against the specifications previously developed for tendering, and plans will be developed to implement changes where deemed appropriate. There will also be a strong focus on staff engagement and development in this third phase of the project, which has been hampered by Covid-19, restricting face to face meetings; however this is key to embedding the Trust values and behaviours into the culture of the Hotel Services staff.

2. Thank you week: 14 – 18 September 2020

Thank you week began on Monday 14 September. It was a special week of (mostly virtual) activities, supported by Imperial Health Charity, to recognise, remember and reflect on our response to Covid-19 so far and celebrate our 2019/20 Make a Difference and Long Service awards. The event included activities throughout the week, as well as evening broadcasts each day. We had good uptake of the daytime activities and growing engagement with daily broadcasts and social media activity via our event hashtags.

The daily broadcasts were streamed live each evening for staff, and included a different theme each evening – Collaboration, the Impact of Covid-19 on black and minority ethnic communities, Research and innovation, Supporting our staff, and the Future – with recognition of our Make a Difference annual award finalists, Long Service award recipients and our volunteers.

We'll undertake a full evaluation but the data so far is encouraging. We've had thousands of views of the daily broadcasts through a range of different channels – we'll be consolidating the data to properly understand the reach while continuing to share and repurpose the content. On social, our Tweets have had over 105k impressions, with just under 5,000 likes and 1,800 retweets. Followers on all our social channels grew significantly during the week.

3. CQC update

3.1 Assessment of the Trust's Infection Prevention and Control (IPC) Board Assurance Framework (BAF)

The CQC implemented revised regulatory approaches for all of its sectors during the first wave of the pandemic; for NHS trusts the initial focus was on infection prevention and control (IPC) as measured against NHS England's infection prevention and control guidance and board assurance framework.

- The Trust's assessment took place on 20 and 23 July 2020 and the CQC provided a brief report to the Trust on 24 July 2020.
- No concerns were identified. The CQC assigns a score to each Trust based on its assessment; the score does not appear in the report as it is for use only by the CQC's national panel, however the Trust was advised that it received the highest possible score.

3.2 CQC Provider Collaboration Reviews (PCRs)

From 2018, the CQC began undertaking local area reviews; London is one region with each borough being a local area. The latest local area profiles for the Trust (Hammersmith & Fulham and Westminster) were published in March 2020.

On 8 July 2020 the CQC announced a programme of local area reviews called Provider Collaboration Reviews (PCRs), aimed at helping organisations rapidly learn lessons from responding to the first wave of the Covid-19 pandemic. These reviews will:

- Focus on older people, defined as persons over 65 years of age, both with and without coronavirus.
- Be organised based on current integrated care systems (ICSs) and sustainability and transformation programmes (STPs).
- Begin to be carried out during July and August 2020; this Phase 1 includes the North West London STP.

These are not inspections; no inspection report will be produced and organisations will not be rated. Review findings will be published in the CQC's Covid Insight Report for September 2020. A copy of the report can be found in the reading room. They will also be included in the CQC's next annual State of Care report, due for publication in October 2020.

4. Financial performance

Under the current NHS financial regime, the Trust has been moved to a block contract arrangement for the first six months with a 'top-up' payment being received to achieve a break even position. The block contract is based on the previous year's month 8-10 run rate. It does not include additional new costs incurred in year, such as Covid-19 costs or the cost of bringing the facilities management contract in house.

Year to date (April 20 – August 20), the Trust has requested an additional £30.8m of top up funding, i.e. the Trust would have a £30.8m deficit without central support. The Trust has incurred additional costs for Covid-19 of £31.2m year to date. There has also been a drop in the income received from private patients and research as this activity was reduced to focus on the pandemic response. This has been offset by reductions in costs in the Trust where elective activity was reduced during the pandemic.

NHS England / Improvement (NHSI/E) has published the revised contracts and payments guidance for month 7 to 12 of 2020/21 which explains the changes relating to system funding envelopes, and how block contracts and top-ups will operate until the end of the financial year. The executive are considering the impact of this on financial planning for the remainder of the year.

Further details on financial performance are outlined in the finance report.

5. Operational performance

Operational performance will be covered in more detail in the IMIS Integrated Quality and Performance report. Performance against a number of the responsiveness metrics remains significantly impacted by Covid-19, but plans are well advanced to return our planned care activity to pre Covid-19 levels as quickly as possible. There is a separate Reset and Recovery paper that covers progress with these plans in detail and also sets out how we are preparing for any future peaks in infection, as well as general increased demand in the winter. Field testing of the proposed new urgent and emergency care standards continues and we await further information from NHSI/E about the outcome of the pilot.

6. Redevelopment

The Strategic Outline Case for the redevelopment of St Mary's was submitted to the regional NHSI/E team on 7 August 2020. The Trust has responded to requests for further information and clarification. We are expecting a joint letter from DHSC and HM Treasury on next steps.

The Trust is working up a proposition for the development of a life sciences cluster at Paddington to support and compliment the St Mary's redevelopment. This is at an early stage but in concept the conditions to create a successful cluster exist. Early informal engagement with stakeholders has been promising and we are working this up in further detail.

The patient and public insight and engagement work undertaken by Kaleidoscope has been completed. The work was framed around our values; Kind, Expert, Collaborative and Aspirational. Using this framework the participants discussed what this meant for them in terms of redevelopment. The outputs are now being incorporated into the Trust's brief for redevelopment.

The work to document the clinical plans for the Charing Cross and Hammersmith hospital sites is largely complete. The Divisional Directorate and Executive Teams are providing final comments and clarifications. The work to identify the redevelopment plans for the sites will then commence.

7. Research and innovation

With the low prevalence of Covid-19 over the summer, recruitment of patients and volunteers into interventional and observational studies has slowed, but our research teams are well prepared to increase recruitment should the numbers of patients with Covid-19 increase in the weeks and months ahead. Recent focus has been on recruitment to vaccine trials and exploration of the possibility of undertaking human challenge studies in which there is expertise within our infectious diseases teams.

We have also been continuing to work hard to re-establish many of our non-Covid-19 related trials after they were paused in March. We have submitted our 2019-20 BRC annual report (available in the reading room) which demonstrates a wide breadth and depth of outstanding research outputs and, along with all of the work we have done on Covid-19, should help strengthen our bid as we gear up for the start of the BRC reaccreditation process early next year.

8. Stakeholder engagement

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

- Karen Buck MP and Andy Slaughter MP: 23 July 2020
- Cllr Tim Mitchell, Westminster City Council: 6 August 2020
- Healthwatch Central West London: 10 August 2020
- London Borough of Brent Community and Wellbeing Scrutiny Committee: 15 September 2020
- Cllr Harbi Farah, London Borough of Brent: 16 September 2020

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TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Organisational strategy review & refocus - metrics and priorities	☒ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 30 September 2020	**Item 8, report. No. 05**
Responsible executive director: Dr Bob Klaber, director of strategy research and innovation	**Authors:** Hannah Fontana Sophie Massie Bob Klaber **Contributors:** Dominique Allwood; Claire Hook; Jeremy Butler; Peter Jenkinson; Michelle Dixon

Summary
Following the organisational strategy review paper which was brought to the board in July, we have continued work in this area to:

- Review any need for changes of focus and emphasis in our priority programmes, projects and focused improvements, in light of the themes that have come from this review, to ensure that we are prioritising the work that will most directly drive us towards our strategic goals
- Define three key measures that will directly help us to track progress against our strategic goals and our ambition to be the most user-centred organisation in the NHS
- Prepare to support each of the clinical directorates and corporate teams as they begin to prepare their business plans in the autumn.

Proposed strategic metrics
Our ambition was to devise and introduce metrics to our executive scorecard, for which we would target year on year improvements. These metrics directly relate to tracking our progress against our strategic goals, the emergent themes highlighted through the COVID-19 pandemic and our ambition to become the most user-centred organisation within the NHS.

For each of the three strategic goals, we have proposed an **aspirational metric.** This is an overarching metric that excites and engages our staff and allows people to feel connected to our goals – it is purposefully aligning to our value of 'aspirational'. Under the aspirational measure sits our **core delivery metrics**. These are metrics which are already used and where the data is routinely collected. These have been aligned to each of our three strategic goals and will make up the executive scorecard.

Prioritisation and business planning
This paper outlines two approaches to better addressing cross-cutting themes which have emerged as priorities during the strategy review process.

(a) Build in metrics & focus on these themes within existing priorities, both at Trust and directorate level
(b) New programmes and task & finish projects

Work has been done to assess how our existing priorities, as well as directorate-led work and new programmes and task & finish projects, would map against our cross-cutting themes. By undertaking

this process, we have been able to clearly define our Trust priorities for the next 6 months at a programme, task & finish project and focussed improvement level:

Programmes	Reset & recovery (inc. command centre); Imperial Management & Improvement System (IMIS); Redevelopment (inc. decant)
Task & finish projects	Flu vaccination programme
Focussed improvements	Reduced number of patients that have been in hospital for 21 days or more; Improved incident reporting rates

We have also been able to develop an updated prioritisation process for the identification of new programmes and task & finish projects as we enter the autumn business planning cycle. This paper marks the end of this summer's organisational strategy review process. Following approval from the Board on the content of this paper, the next steps will be:

- Update the board, executive, divisional and directorate scorecards to include the new and approved aspirational and core delivery metrics.
- Support the transformation team to roll out the updated approach to business planning and communicate the outputs of this work during the business planning cycle for 2020/2021.
- Develop a programme of communication and engagement with all staff, as well as patients and members of our local community, around our vision, values and behaviours and strategic goals. The focus of this work will be on listening to staff and patients about how the work they are doing and care they are receiving is connecting to and driving our strategy, and then sharing their stories on this.
- Capture learning from this year's organisational review process to feed into the 2021 review which will start in June 2021.

Recommendations:
The Trust board is asked to approve the proposed metrics, priorities for 2020/2021 and the updated prioritisation approach to be used going forward in business planning.

This report has been discussed at:
The content of this work has come from a breadth of discussions with key stakeholders as well as at IMIS programme board, Executive Transformation and Executive Management Board.

Quality impact: N/A

Financial impact: N/A

Risk impact and Board Assurance Framework (BAF) reference: Well-led

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

What impact will this have on the wider health economy, patients and the public?
Ensuring that we have a strategy that is clear, bold and genuinely meets the health and well-being needs of our patients, staff and local communities is integral to making the sorts of improvements to healthcare that we want to achieve.

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

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

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

Organisational strategy review & refocus – metrics and priorities

Purpose and process of phase 2 of the organisational strategy review

In July 2020, we brought a paper to the board which was the output of our first phase of the organisational strategy review. The aims of this first phase of work were to:

a) Use a wide range of insights, data and learning to review the changing context in which our organisational strategy sits
b) Review and, where needed, refocus our vision, goals and objectives such that they meet this new strategic context, and can be understood by everyone in the organisation
c) Use this process, and the communication and engagement plans that will follow it, to widen involvement of staff and patients in this strategy development work.

Following discussions at July Board, it was agreed that the next steps would be to:

- Review any need for changes of focus and emphasis in our priority programmes, projects and focused improvements, in light of the themes that have come from this review, to ensure that we are prioritising the work that will most directly drive us towards our strategic goals
- Define three key measures that will directly help us to track progress against our strategic goals and our ambition to be the most user-centred organisation in the NHS
- Support each of the clinical directorates and corporate teams as they begin to prepare their business plans in the autumn. Within this work, which will be led by the transformation team, each directorate will be asked to demonstrate how their contribution to the priority programmes, projects and focused improvements, and their wider service delivery work, will drive our vision and strategic goals in a measurable way.

This phase of the strategy review process has been led by the strategy and transformation teams and has involved consultation with Executive colleagues and discussions at Executive Transformation, IMIS Programme Board and Executive Management Board.

Proposed strategic metrics

Our ambition was to devise and introduce metrics to our executive scorecard, for which we would target year on year improvements. These metrics directly relate to tracking our progress against our strategic goals, the emergent themes highlighted through the COVID-19 pandemic and our ambition to become the most user-centred organisation within the NHS.

Using the IHI Model for Improvement[1], we are able to describe the clear link between our strategy, our metrics and our delivery framework.

What are we trying to achieve? *Our strategic goals*
How will we know that a change is an improvement? *Using our aspirational metrics*
What change can we make that will result in improvement? *Our programmes, task & finish projects and focussed improvements*

Our proposal is that these are measures that:

- really mean something to the majority of staff and help create a sense of mission and purpose in everyone's work
- are aspirational and connect right into the heart of each of the three strategic goals
- directly address the changing strategic context described above
- can be measured and improved at many layers of the organisation; which the ongoing development of the Imperial management and improvement system (IMIS) will facilitate

[1] Institute for Healthcare Improvement - http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Since July, this work has been progressed through a diverse range of conversations with key stakeholders, as well as conversations with many teams who are developing scorecards and are owners of the collection and recording of proposed strategic metrics including patient experience, estates, and diversity and inclusion. Early engagement with teams who will be using the strategic metrics and the updated scorecards has been a valuable experience both for receiving feedback on the process and validating the proposed approach. Integration of a range of metrics in one scorecard has been appreciated as it supports us taking a 'big picture' view when considering the impact of our work and greater inclusion of different strategic priorities within each work stream.

The proposed metrics can be found in Appendix 1. For each of the three strategic goals, we have proposed an **aspirational metric.** This is an overarching metric that excites and engages our staff and allows people to feel connected to our goals – it is purposefully aligning to our value of 'aspirational'. Under the aspirational measure sits our **core delivery metrics**. These are metrics which are already used and where the data is routinely collected. These have been aligned to each of our three strategic goals and will make up the executive scorecard.

In addition to the measurement approach above, we have also proposed a range of **growth metrics** (Appendix 2)**.** We are keen to ensure that our strategic metrics are continually assessed to ensure they are the most effective and appropriate metrics to be using. By identifying growth metrics, metrics we hope to use but aren't able to currently, we will focus on improving and adapting our approach to measurement over time and identify opportunities to use new and improved metrics in the future. There are specific areas we will prioritise in terms of growth metrics for example around integrated care, quality of the PDR and population health. There are also additional metrics for education which will be used within division level scorecard.

Prioritisation and business planning

Our ambition is that there is strong strategic alignment between our goals and our delivery framework. This needs to be both top down, and answering the question: *What portfolio of programmes, projects and focussed improvements will together help us deliver our strategic goals?* As well as bottom up: *What are each of our programmes, projects and focussed improvements trying to achieve and how do their outcomes drive our goals?*

This process, reviewed in light of COVID-19, has surfaced some cross-cutting themes in our current which we should be prioritising. These include:

- Tackling health inequalities and improving population health (including staff as a population) - fulfilling our role as an anchor institution
- Integrated care
- Building our portfolio of research and innovation
- Becoming the most user-focused organisation in the NHS (for patients, staff, citizens and local communities)
- Building on our digital transformation journey
- Developing our green plan and becoming a more sustainable organisation

Through discussions at Executive level, we have agreed on two approaches to addressing these themes.

(a) Build in metrics & focus on these themes within existing priorities, both at Trust and directorate level

The work to develop appropriate metrics for our strategic goals has involved cross-directorate collaboration. The updated metrics will form a part of each board, executive, directorate and divisional

scorecard going forward. This integration into the scorecards will strengthen the links between the work we are undertaking as well as our service delivery work, and the strategic direction of the Trust. It will help us better understand the extent to which the work going on is contributing towards achieving our goals and allow our workforce to feel more connected to them.

These metrics cover a breadth of areas including some which have been highlighted as cross-cutting themes - for example population health metrics around equity and environmental sustainability through measuring our carbon emissions. We will use the updated scorecard, and our current programmes, task & finish projects and focussed improvements to drive and demonstrate progress against key metrics which measure against these themes. This will encourage existing work to refocus and reprioritise against these priorities to allow us to address some of these key areas.

We will also use the business planning and reporting process, for directorates to show how their directorate level work will contribute towards these metrics (e.g. equity of access, research outputs, user-focus).

During this strategy review process, we have clarified the purpose and definition of our delivery mechanisms. The updated detail of which can be found below:

Delivery mechanism	**Definition**
Programme	*Strategic initiatives which align strongly to our goals to be delivered over a year or more and comprised of specific projects and/or work streams.*
Task & Finish projects (previously Project)	*Short-term, time-bounded work which is specific in its aim whilst contributing to the overall goals. Delivered in a 'task & finish' approach. Some link to programmes whilst others are mandatory.*
Focussed Improvement	*Trust-wide metrics chosen to be the focus of widespread improvement activities across the breadth of the organisation.*

We also assessed the alignment of our current programmes, task & finish work and focussed improvements to our strategic goals and corresponding metrics and reprioritised and refocussed our work going forward. The prioritisation of programmes, task & finish projects and focussed improvements can be found below:

Figure 2: Priority areas

Delivery mechanism	**October 2020 – March 2021** ***Priorities over the next 6 mths***	**October 2020 – March 2022** ***Longer term priorities***
Programme	• Reset & recovery *(inc. command centre)* • Imperial Management & Improvement System (IMIS) • Redevelopment *(inc. decant)*	• Culture • Imperial Private Healthcare Growth • Quality & safety improvement programme *(inc. HOTT safety programme)* • Safe, sustainable staffing *(inc. redeployment)*
Task & Finish projects	• Flu vaccination programme	

Focussed Improvement	• Reduced number of patients that have been in hospital for 21 days or more • Improved incident reporting rates	• Reduced agency expenditure • Improved WRES 2 standards

This shows that our clear priorities for the next six months are the *reset & recovery* programme alongside *IMIS*, to enable us to deliver on our priorities, and the *redevelopment* programme, including decant. Some of programmes, projects and focussed improvements have been removed from the IMIS framework following discussions around alignment. This has been a result of the work no longer being deemed a Trust-specific piece of work or where the work can take place at a more local level. This exercise has allowed us to be clear and intentional with our priorities for the next six months and beyond and refocus our energy around this work.

(b) New programmes and task & finish projects

Other thematic areas would need to be addressed by agreeing new priorities through the business planning process, and would clearly need to be balanced with everything else that is going on. This could include new programmes, task & finish projects (to include scoping work) and new focussed improvements and/or new directorate-level work. Any new work would need to demonstrate how it contributes to improving the metrics on our scorecard which we will know will help address these themes.

This new strategic approach to business planning will be rolled out in October by the transformation team. In order to support people's understanding of the new process, a webinar will be hosted to explain how the process will work and what people will need to do and ongoing support will be available.

Early thinking has been done to assess how our existing priorities, as well as directorate-led work and new programmes and task & finish projects, would map against our cross-cutting themes (full details can be found in Appendix 3).

Next steps

This paper marks the end of the formal organisational strategy review process. Following approval from the Board on the content of this paper, the next steps will be:

- Update the board, executive, divisional and directorate scorecards to include the new and approved aspirational and core delivery metrics.
- Support the transformation team to roll out the updated approach to business planning and communicate the outputs of this work during the business planning cycle for 2020/2021.
- Develop a programme of communication and engagement with all staff, as well as patients and members of our local community, around our vision, values and behaviours and strategic goals. The focus of this work will be on listening to staff and patients about how the work they are doing and care they are receiving is connecting to and driving our strategy, and then sharing their stories on this.
- Capture learning from this year's organisational review process to feed into the 2021 review which will start in June 2021.

Imperial College Healthcare NHS Trust

Organisational strategy review & refocus - metrics and priorities

September Board – Appendices

September 2020

Appendix 1

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Proposed metrics

Strategic Goal:	to help create a high quality integrated care system with the population of north west London	to develop a sustainable portfolio of outstanding services	to build learning, improvement and innovation into everything we do
Aspirational metric: *An overarching measure that excites and engages our staff and allows people to feel connected to our goals – aligning to our value of 'aspirational'. All 3 of these support the 'user-focus' drive*	User insights: ask every inpatient 'What matters to you?' *Staff to ask every inpatient the question at the beginning of their episode of care and log the response on Cerner as a 'goal'.* *Then use patient experience measures (inc NLP) to track progress against this goal.*	Service level insights: how do our services benchmark against others? *Using external assessments and rating of the Trust, divisions and services*	Staff insights: ask all staff 'Do you feel that your work environment is one in which you can learn, innovate and make improvements?' *Apps available through which staff can answer the question on a rolling monthly basis with the answer on a Likert scale – all of the time to not at all*
Core delivery metrics:	**Patient Experience** · Overall rating of care · Net sentiment score · Patient experience of care · Number of complaints (formal and PALS) **Population health and reducing inequalities** · <u>Staff</u> ○ Improved performance on Workforce Race Equality Standard (WRES): BAME % of workforce Band 7 and above; vacancies at Band 7 and above and BAME recruitment % Band 7 and above. ○ Workforce Disability Equality Standard (WDES) – likelihood of those with disabilities being recruited · <u>Access</u> ○ Equity of access against key demographic data	**Sustainable** · <u>Green plan</u> ○ Reduction in carbon emissions · <u>Workforce</u> ○ Staff engagement survey ○ Agency spend · <u>Finance</u> ○ Contribution **Outstanding** · <u>Quality & safety</u> ○ Patient safety incident reporting rate ○ % of incidents causing moderate and above harm ○ HSMR (rolling 12 months) ○ National Audits ○ GIRFT and/or other peer review · <u>Access & experience</u> ○ RTT waiting list size ○ RTT 52 week wait breaches ○ Diagnostics waiting times ○ Wait to first OP appointment (routine) ○ Patients waiting >12 hours from decision to admit to admission ○ Long length of stay - 21 days or more ○ Cancer 2 week wait ○ Cancer 62 day wait	**Learning** · Improved appraisal rates · Improved compliance with Statutory and Mandatory Training **Improvement** · Measures of staff and patient involvement in improvement and transformation work **Innovation** · Value of grants awarded across the Trust · Measures of research outputs and impact · Numbers of patients enrolled and actively using CIE

Appendix 2

Imperial College Healthcare NHS Trust

Growth Metrics

Strategic Goal	to help create a high quality integrated care system with the population of north west London	to develop a sustainable portfolio of outstanding services	to build learning, improvement and innovation into everything we do
Aspirational metric ***An overarching measure that excites and engages our staff and allows people to feel connected to our goals – aligning to our value of 'aspirational'*** ***These would continue***	User insights: ask every patient 'What matters to you?' *Staff to ask patients the question at the beginning of their episode of care and log the response on Cerner as a 'goal'.* *Then use patient experience measures to track progress against this goal.*	Service level insights: how do our services benchmark against others? *Using external assessments and rating of the Trust, divisions and services*	Staff insights: ask all staff 'Do you feel that your work environment is one in which you can learn, innovate and make improvements?' *Apps available through which staff can answer the question on a rolling monthly basis with the answer on a Likert scale – all of the time to not at all*
Core delivery metrics	**Measures of integration** • Data Sharing Agreements • Working with PCNs/ICS **Population health and reducing inequalities** • <u>Staff</u> ○ Gender Pay Gap ○ Workforce Disability Equality Standard (WDES) – likelihood of those with disabilities being recruited • <u>Outcomes</u> ○ Equity of outcomes against key demographic data	**Access & Experience** • PROMS	**Innovation** • Real impact factor **Learning** • Quality of PDR

Appendix 3

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Mapping against the cross-cutting themes

Gaps:	Tackling health inequalities and improving population health (including staff as a population) - fulfilling our role as an anchor institution	New models of care / integrated care	Building our portfolio of research and innovation	Becoming the most user-focused organisation in the NHS (for patients, staff, citizens and local communities)	Building on our digital transformation journey	Developing our green plan and becoming a more sustainable organisation
Current programmes, task & finish projects and focused improvements	• Culture (staff health and wellbeing) • Reset & recovery (Phase 3 letter) • Redevelopment • WRES (via EDI committee)	• New models of care within reset & recovery	• BRC reapplication – to be run as a task & finish project	• Implementation of the new metrics & scorecard • Reset & recovery (Learning & Insights)	• Reset & recovery (virtual consultations; staff testing and CIE) • Redevelopment (Inc. decant)	• Redevelopment (net zero carbon) • Culture (active transport) • Safe and sustainable staffing (local employment, remote working)
Directorate business planning	• Each directorate asked to measure equity of access to key service lines	• Each directorate asked to describe its existing integrated care work	• Each directorate asked to describe research outputs (as per the SRP spreadsheet)	• Implementation of the new user-focused metrics at directorate scorecard level		
New work that we will need to consider in the months ahead	• Population health programme (including our Anchors mission)	• Consider re-establishing PCN test beds with adapted financial model	• Establish virtual commercial & innovation team to provide strategic leadership for this	• Repurpose existing resource to establish a ‘User Focus’ function	• Potential strategic partnership (e.g. with Google Health)	• Trust Green Plan with ‘foundation year 1’

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Update on recovery and reset (including our 'phase 3' Covid-19 response)	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 30 September 2020	**Item 9, report no. 06**
Responsible Executive Director: Tim Orchard, Chief executive officer	**Author:** Peter Jenkinson, Director of corporate governance Claire Hook, Director of operational performance

Summary:

This report provides an update on our recovery and reset programme established in June 2020 to ensure positive changes prompted by our initial response to the pandemic are embedded and strengthened.

It incorporates progress on priorities set out by NHS England in July that form the third phase of the NHS response to Covid-19:

- accelerating the return to near-normal levels of non-Covid health services
- preparing for winter demand pressures as well as potential further spikes in Covid-19 locally and nationally
- taking account of lessons learned during the first Covid-19 peak to lock in beneficial changes, specifically to tackle inequalities and to support staff.

Our recovery and reset programme now has five work streams as set out below. The progress of each is detailed in the report:

- Operations – putting in place plans and additional infection and prevention measures to enable us safely to restore all of our urgent, emergency and planned services, reduce waiting lists with a focus on minimising clinical harm, and to be fully prepared for potential further spikes on Covid-19 as well as additional winter demand.
- Learning and insights - developing an overarching framework to gather insights, learn and improve following our response to the first wave to inform our response to potential further waves.
- Models of care – maximising the impact of innovative clinical approaches and transformation work that has been recently introduced
- Ways of working - accelerating the roll out and enhancement of digital approaches to support remote patient interactions
- Staff support - working in partnership with Imperial Health Charity to establish a Covid-19 legacy programme for wellbeing and practical support for staff.

Recommendations: The Board is asked to note the report.
This report has been discussed at: Executive Huddle
Quality impact: Quality impacts are outlined in the paper.
Financial impact: The impact of the pandemic on our finances is picked up in the financial update to the Board.
Risk impact and Board Assurance Framework (BAF) reference: Corporate risk register.
Workforce impact (including training and education implications): As outlined in the report.
Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☒ No ☒ Not applicable If yes, are further actions required? ☐ Yes ☐ No The disproportionate impact of COVID on BAME has been recognised as part of the Trust response to the pandemic.
What impact will this have on the wider health economy, patients and the public? Significant.
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: All ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No

Imperial College Healthcare NHS Trust

Update on recovery and reset (including our 'phase 3' Covid-19 response)

1. Introduction

This paper provides an update on our recovery and reset programme established in June 2020 to ensure positive changes prompted by our initial response to the pandemic are embedded and strengthened.

It incorporates progress on priorities set out by NHS England in July that form the third phase of the NHS response to Covid-19:

- accelerating the return to near-normal levels of non-Covid health services
- preparing for winter demand pressures as well as potential further spikes in Covid-19 locally and nationally
- taking account of lessons learned during the first Covid-19 peak to lock in beneficial changes, specifically to tackle inequalities and to support staff.

Our recovery and reset programme now has five work streams:

- Operations – putting in place plans and additional infection and prevention measures to enable us safely to restore all of our urgent, emergency and planned services, reduce waiting lists with a focus on minimising clinical harm, and to be fully prepared for potential further spikes on Covid-19 as well as additional winter demand.
- Learning and insights - developing an overarching framework to gather insights, learn and improve following our response to the first wave to inform our response to potential further waves.
- Models of care – maximising the impact of innovative clinical approaches and transformation work that has been recently introduced
- Ways of working - accelerating the roll out and enhancement of digital approaches to support remote patient interactions
- Staff support - working in partnership with Imperial Health Charity to establish a Covid-19 legacy programme for wellbeing and practical support for staff.

2 Operations

2.1 Implementing new low, medium and high risk care pathways

All patients attending our hospitals are now assigned to a low, medium or high risk care pathway – in line with national guidance issued in August by Public Health England and NHS England, *Covid-19 guidance for the remobilisation of services within health and care settings*.

These risk-based pathways replace the previous 'Covid risk-managed' and 'Covid protected' clinical areas. The pathway for each patient is determined through a combination of triage and testing for Covid-19, before and/or on arrival. The risk relates to the likelihood of the patient being infected with Covid-19.

Directorate and divisional leads are working with site teams to establish pathways suitable for our services and facilities. As before, we are aiming to maintain planned surgery (low risk pathways) primarily at Hammersmith and Charing Cross, while St Mary's and Charing Cross will provide most of the urgent and emergency care (high and medium risk pathways). As specialist hospitals, Queen Charlotte's and Chelsea and the Western Eye will provide primarily low and medium risk pathways, while outpatient services and diagnostics will be provided through primarily medium risk pathways on all sites.

Communications are underway to ensure all staff, patients and visitors understand the changes and what the pathways mean for them. We are developing a simple flowchart for managers to use to clarify the risk status of pathways in operation on their ward or unit at any given time. Related to this,

we are also preparing clear and easily replaceable signage that managers can use to highlight the risk status of pathways to everyone in their area.

Guidance on the use of personal protective equipment (PPE) has been amended slightly to correspond to the new pathways. We have a strong focus on ensuring a good supply of required PPE – both into the organisation and onto the wards, with a daily in-ward order and distribution service. We have a growing pool of PPE helpers to provide staff with additional training and support to use PPE effectively and we are ensuring that PPE is properly fitted.

We have expanded testing for staff and members of their household with symptoms to include children under five and, where necessary, more than one household contact. With implementation of the new risk-based care pathways, we are now testing only the small number of staff working in areas with extremely medically vulnerable patients, such as those undergoing bone marrow transplants. Staff working in low-risk pathways -previously Covid-protected areas - no longer need to be routinely tested. There are no changes for staff in medium and high-risk pathways who have never been required to be tested routinely.

In line with the new care pathways, all patients attending hospital or being admitted to hospital will be triaged either before they arrive or as soon as possible on arrival to determine their likelihood of having Covid-19. With most planned procedures, patients will be tested up to 72 hours beforehand and asked to self-isolate after their test until they come into hospital. If they self- isolate, they don't need to be tested again on admission, provided they don't have Covid-19 symptoms. For urgent and emergency admissions, patients will be tested and, if asymptomatic, placed on a medium risk pathway

2.2 Infection prevention and control in workspaces and public areas

We have a range of measures in place to keep staff safe in their own workspaces and everyone safe in our public areas:

- All staff have to wear a surgical mask in all of our buildings at all times, unless in a designated 'Covid secure' workspace.
- Workspaces – including rest areas, kitchens and regular meeting rooms – can be designated as Covid secure by following a checklist that includes ensuring staff are working at least 2m apart and that there is a supply of surgical masks and cleaning materials. Some workspaces may require other measures in order to be made Covid secure. Once a workspace has been made Covid secure, tailored posters and stickers are used to display the maximum number of people who can be in the space at any one time as well as the ways of working that everyone in the space needs to follow.
- We are continuing to refine measures in our public areas to ensure 2m physical distancing and that staff wear surgical masks and patients wear face coverings. This includes lifts, stairwells, restaurants, cafes and waiting areas. We are reviewing the number of general access entrances to our buildings, embedding hygiene stations and support at all general entrances, installing more signage to encourage one way flows and support physical distancing and exploring bleeper systems for waiting.
- Staff have been asked to continue to minimise face-to-face meetings and avoid any large scale meetings.
- All places where people congregate, such as restaurants, pubs and bars, now have to display a QR code to enable users of the new NHS Covid-19 app to check in. This supports automated contact tracing if someone using these areas is found to have been infected with Covid-19. Hospitals do not need to display QR codes in areas where we can trace patients, such as wards and booked clinics. We are installing notices with QR codes in public areas such as our restaurants and coffee shops. We will also display notices with QR codes in other areas with high general public footfall.

2.3 Resuming planned care

We continue to work through our own plans and trajectories for returning to 2019/20

planned activity levels. The position as of mid-September was:

- Planned surgery is at 75 per cent capacity, increasing from 62 per cent at the end of August, towards the national target of 80 per cent for September.
- Imaging capacity ranges from 70 – 90 per cent capacity, depending on modality, with a national target of 100 per cent for October.
- Endoscopy is at 71 per cent capacity with a target of 100 per cent for October.
- Outpatient services (face to face, telephone and video) are at 87 per cent capacity with a target of 100 per cent.

Our clinical teams have developed a harm prioritisation process whereby our consultant-led teams review every patient awaiting a procedure to ensure we are continuously focusing available clinical capacity on those patients with greatest need and to minimise harm. This process has subsequently been adopted by the north west London integrated care system.

2.4 Planning for a potential second wave of Covid-19

Detailed 'surge plans' – to be deployed in the event of significant rising demand – are continuing to be developed by clinical and site teams for each of our hospitals, drawing on all of the learning from the first wave of Covid-19. The plans set out where – in what circumstances, over which timescales – we would expand intensive care and general acute capacity and how we would adapt care pathways. Importantly, the plans are being developed to protect as much planned care as possible, for as long as possible.

We have worked very closely with other providers in north west London so that our plans are part of a co-ordinated sector surge plan. We could see an expansion in intensive care at all of our sites, up to a maximum of 191 beds. This includes acute respiratory beds at Charing Cross and St Mary's hospitals. There are centrally funded estates works underway at Hammersmith and St Mary's to support the expansion as well as detailed plans for ensuring we have all the necessary equipment.

Surge plans will be triggered by rising admissions of patients with Covid-19 and/or rising demand for intensive care or ventilation. They will also take into account any significant operational impact caused by seasonal conditions like flu and norovirus.

We are also finalising detailed staffing plans to support the site surge plans. Drawing on feedback from the first wave and working with our partnership committee, we have developed a temporary redeployment policy to establish clear expectations and processes for staff and managers. A range of developments have been put in place to support staff who may be redeployed, such as new training plans and training passports and access to emotional and psychological support.

2.5 Getting ready for winter

Our usual winter demand challenge will be compounded this year by Covid-19, both in terms of the potential increase in patients with Covid-19 as well as the additional infection prevention and control measures in place, especially physical distancing. This will mean there can be no overcrowding in our emergency departments and no additional beds on our wards. Now, more than ever, it is essential that everyone helps to keep care flowing at every stage of the care pathway.

We have committed to treat and discharge all 'non-admitted' patients within three hours or admit 'admitted' patients within four hours to help support safe occupancy levels in the department. This means that specialty doctors need to review patients in A&E within 30 minutes of referral to avoid delays to admission or discharge. Clinicians are also encouraged to triage patients to one of 12 'same-day emergency care' pathways to help avoid unnecessary hospital admissions.

We are using funds awarded by NHS England to expand our same day emergency care space at Charing Cross and St Mary's hospitals and we are organising online briefing sessions for staff and external stakeholders to explain how to get the most from these services. We are also further

developing our 'command centre' which co-ordinates a range of data automatically to help staff make best use of our beds and ensure patients are admitted or moved to the right ward or unit at the right time.

For ward staff, best practice in ensuring 'patient flow' will be essential. This includes carrying out daily board rounds, prioritising discharges as early as possible each day and logging patients' green or red status. Delays to discharge will be avoided by following criteria-led discharge, discharging to nursing/care home and escalating long stays.

Our staff flu vaccination campaign will be particularly important this year and is already underway.

3 Models of care and new ways of working

Efforts to improve our ways of working and develop better models of care have been accelerated by our response to the Covid-19 pandemic. Examples of recent progress include:

- We are now running the majority of our outpatient consultations remotely, either over the phone or using video technology, with good feedback from patients and clinicians and more to do to prevent potential inequalities arising from digital access or knowledge.
- We have established enhanced support to our primary care colleagues through the introduction of regular online webinars and immediate access to paediatric and respiratory expertise via hotlines.
- We are working in partnership with other hospitals in north west London to improve equity of access and outcomes for specialist services with an initial focus on vascular and complex gastrointestinal surgery.
- We are working on the development of high volume, low dependency fast track surgical centres, specifically acting as the lead provider for urology and ophthalmology and with active involvement in gynaecology, general surgery, ear, nose and throat and trauma and orthopaedics.

4 Learning and insights (see separate board paper also)

We have produced our initial report, drawing on the conclusions and recommendations of five workstreams covering:

- staff insights
- patient, citizen and community insights
- quality, safety and operational insights
- research and evidence insights
- community partners and network insights

5 Staff support Covid-19 legacy programme

This £1.7m programme, funded through Imperial Health Charity's Covid-19 emergency relief fund, includes:

- Staff spaces: bringing all of our staff rest rooms, changing areas, shower rooms and kitchens up to a consistent and high quality standard and meeting any significant gaps by July 2021. Also exploring free basic provisions for our staff restrooms and possible 'flagship' staff areas on each of our main sites. An audit of all staff areas has been completed and the divisions have been asked to indicate their priorities for their area. Some immediate 'quick-wins' will start in October while the project plan is developed.
- Food and shops: a comprehensive review of our food and shops offer for staff – and visitors to better meet needs. A tender is being developed for consultancy support to explore options and approaches.
- Emotional wellbeing – doubling our counselling resource and expanding our wellbeing offer for at least the 12 months to July 2021, responding to the increased need for support and training.

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TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Learning & Insights Work Stream Update	☐ Approval ☒ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 30 September 2020	**Item 10, report no. 07**

Responsible Executive Director:
Bob Klaber, Director of Strategy, Research and Innovation

Authors:
- Bob Klaber, work stream SRO
- Kara Firth, Head of Regulation and work stream Programme Manager
- Dominique Allwood, Deputy Director of Strategy & Improvement
- Sue Grange, Lara Ritchie and Fran Cleugh, Staff Insights
- Hannah Fontana, Dominique Allwood, Tanya Hughes, Linda Burridge and Trish Longdon, Patient, Citizen & Community Insights
- Will Gage and Shona Maxwell, Quality, Safety & Operational Insights
- Paul Craven and Bob Klaber, Research & Evidence Insights
- Anna Bokobza, Toby Hyde and Hari Grewal, Community Networks & Partners Insights

Summary:

Purpose
This is the first update from the Learning & Insights work stream and covers the work stream's first two objectives (see Background).

Background
The Learning & Insights work stream was established in July 2020 under the Trust's Recovery and Reset programme to enable the Trust to:
- Learn lessons from its management of the first wave of the Covid-19 pandemic to inform preparations for a possible second wave.
- Assess regulatory compliance during the first wave of the pandemic, for the Trust's own assurance and in preparation for queries from regulators / in the event of a public inquiry.
- Support the Trust's strategic objective "*To building learning, improvement and innovation into everything we do"* and use the above work to help drive forward the Trust as a learning organisation.

Methodology
The five working groups (see Outcomes) all asked the same three questions:
- What learning has already been undertaken and what insights were identified from learning carried out within and external to the Trust?
- Where are gaps in learning activities? This included taking action to close gaps, i.e. to gather further insights.
- What are the recommendations for the Trust to be best prepared for a possible second wave of Covid-19, and to improve how the Trust gathers intelligence and learns lessons going forward?

Outcomes
Highlight summaries of each working group's findings are presented below, followed by some overall analysis and recommendations. Core data and detailed outcomes and analysis from each working group are available in the reading room and will be shared with Trust teams and the SROs of all of our priority programmes in order to offer reflection, analysis and to take proposed recommendations forward. The detailed reports also map key recommendations to existing work already taking / which will take these forward.

- Staff insights working group report
  - This working group evaluated learning about communications, support and safe working among substantive (including sub-contracted), temporary and redeployed staff, and volunteers. Insights were gathered from surveys, forums such as after action reviews and other local engagement activities, structured interviews, staff helplines and service evaluations.
- Patient, Citizen & Community Insights working group report
  - This working group evaluated learning about communications, support and access to care / treatment among patients, their carers, their families and friends, local communities and public. Sources included Trust patient experience activities, Trust strategic lay form, Trust BAME Forum, Healthwatch, Community Voices, National Voices, and Connecting Children for Care.
- Quality, Safety & Operational working group report
  - This working group evaluated learning about clinical decision-making, implementation of clinical guidelines, incident reporting, operational performance and regulatory compliance. More than 50 qualitative and quantitative sources were drawn on.
- Research & Evidence working group report
  - This group evaluated evidence-based decision-making using research and available evidence, and implementation of innovations.
- Community Networks & Partners working group report
  - This working group evaluated involvement of and learning from others, including primary care, other trusts, community groups / organisations (e.g. care homes, hospices), local authorities, royal colleges, NHS England / Improvement, government, clinical networks (e.g. paediatric, critical care, end of life care), quality networks (e.g. Shelford group) and the Imperial Trust charity.

Recommendations: To discuss and endorse the recommendations.

This report has been discussed at: Executive Huddle on 18/09/2020
If this is a business case for investment, has it been reviewed by the Decision Support Panel? X N/A

Quality impact: This paper impacts all five CQC domains and aims to improve patient care by proposing recommendations relating to lessons learned from the first wave of the Covid-19 pandemic.

Financial impact: This paper has no financial impact.

Risk impact and Board Assurance Framework (BAF) reference:
Risk 2472 on the corporate risk register: *Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC.*
Risk 3296 on the corporate risk register: *There is a risk of a second wave of COVID-19 infections in London, or another pandemic occurring, which could result in increased critical care demand, reduced staffing levels and delay to patients treatments.*

Workforce impact (including training and education implications): Not applicable

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

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

What impact will this have on the wider health economy, patients and the public? As declared in the Trust's strategic goals below.

The report content respects the rights, values and commitments in the NHS Constitution X Yes

Trust strategic goals supported by this paper:

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

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared with senior managers? X No – Senior Managers are aware of this work and that action will be required to implement the recommendations.
Should senior managers share this information with their own teams? X Yes – Action taken as a result of recommendations in this paper will require support from across the Trust.

Learning & Insights Work Stream Key Findings and Recommendations

2. Staff Insights

Key findings	Key recommendations	
	Keep	**Improve**
Clear purpose on fewer priorities, a flattened hierarchy and rapid, evidence-based decision making enabled much better progress and patient care than prior to the pandemic	• Site based leadership presence • Visibility of leaders across the Trust • Proning team as a specialist team • New communication routes and processes	• Silo working where it still exists • Timeliness of support from private providers • Timeliness of engagement with other trusts
Remote and virtual working was embraced and generally worked very well	• Remote working opportunities • Virtual meetings; with ways to vary them • Virtual outpatient appointments	• Proactive support for staff working at home, shielding, BAME staff • Support around remote working fatigue
Redeployment had very mixed reviews	• Many of the new roles that were created (bed buddies, ward helpers, PPE helpers, hand hygiene helpers team)	• Disjointedness of the redeployment and health clearance processes • Notice period ahead of and training for redeployed roles • Utilisation of medical staffing • Coordination of ICU medical rotas
Staff generally did not feel they were as involved in designing the Trust's response first time around; planning / preparations for a second wave must be co-designed	• The various staff helplines • CRG and clinical support groups	• Equipment access, e.g. PPE, scrubs, ventilators • Fit testing • Earlier engagement with / support from private providers and other trusts

3. Patients, Citizen and Community Insights

Key findings	Key recommendations	
	Keep	**Improve**
There was a huge amount of volunteer support but some people said they wouldn't do it again	We need to understand why this is the case to identify what worked well and what needs to improve.	
Visiting restrictions had a significant impact, especially for families whose loved one died	• Tablets for inpatients • Enhanced wi-fi / internet	• Visiting policies, especially for people receiving end of life care • Explore the wider use of family liaison staff
Virtual appointments were welcomed but often didn't work well, e.g. multiple and inconsistent instructions received, doctors late or missed the appointment	• Virtual outpatient appointment options (an important part of patient choice)	• Management of virtual outpatient appointments to ensure consistent quality • Virtual outpatient support, e.g. community phlebotomy, collecting medicines in the community (so don't need to go to hospital)
Poor access to mental health services and support		• Access to mental health support across our integrated care system

Communications were not always clear or had an adverse impact. Fear among patients, citizens and local communities is a very significant issue	• Recognition that there are many groups and organisations within our local communities who can help us to gain insights on an ongoing basis • Some of the communication strategies including the videos made by community groups for their community	• Management of patients' fears about keeping their appointment / having their treatment, particularly among BAME groups • Lack of information available for patients with disabilities • Patient / loved one access to & education to use digital tools; the digital inclusion agenda • Need a single point of contact for families • Clearer, safety focused information

4. Quality, Safety and Operational Insights

Key findings	Key recommendations	
	Keep	**Improve**
CRG and clinical support group improved evidence-based decision making	• CRG and clinical support groups in an evolved form to meet ongoing need for clinical decision making • Evidence-based rapid translation of research / evidence into practice	• Evaluation of use of guidance and research to ensure it is appropriately applied to each area • Clinical harm review processes • Continue to widen involvement
Operational pressures exacerbated existing issues (poor record keeping, silo working) and allowed some well managed risks (pre-pandemic) to become issues	• Cross team working • PPE and hand hygiene helpers	• Contingency planning for centralised upscaling of access to medical devices (e.g. ventilators) and supplies (e.g. PPE) • Data collection / monitoring / reporting for key aspects to ensure emerging risks are identified and have suitable oversight, e.g. incident reporting, regulatory requirements
Cross working, redeployed staff and working differently was largely positive	• Skills maintenance outside of staff normal areas of working • High number of senior decision makers present in clinical areas, including out of hours	• Requirements for rapid standing up need to be included in our new staffing models • Support for staff who feel highly pressured, isolated, etc. when they were working outside their normal area • Variation among sites and divisional practice

5. Research and Evidence Insights

Key findings	Key recommendations	
	Keep	**Improve**
The governance structures and processes set up by the Trust's research leadership team, in partnership with Imperial College, enabled the rapid set up and delivery of a wide range of Covid19 related research.	• Processes that underpin agile and supportive approvals around research quality, governance, ethics, and access to/sharing of data. • Processes that comply with regulatory requirements.	• Evolve these into a more sustainable approach that builds on the partnership working that has been established.
The research & innovation delivered by the Trust was wide in content with immediate and far-reaching impact.	• Collaborative and multi-disciplinary approaches involving engineers, chemists, data scientists and other non-medical	• Link this widening involvement into strategic planning around the next BRC reapplication – a 'unique selling point' for Imperial

	researchers in addressing the key Trust research questions	
The establishment of a group to rapidly look at the best-evidence available to clinical and operational questions was innovative and supported senior clinical & Exec decision making.	• The availability of synthesised best evidence to support senior clinical (e.g. in CRG) and Executive decision making	• How this temporary function is sustained in the long term (? Opportunity for junior doctors / clinical academics to contribute)
Our research delivery staff are crucial to the quantity and quality of clinical research that is carried out in the Trust; how they are managed and supported should be reviewed.	• Dedicated teams working across specialties where possible and providing 'pools' of expertise to be called upon, rather than numerous isolated individuals and small groups.	• Opportunity to review the management and support of research delivery staff. • Develop the academic and research career pathways of research delivery staff. • Recruit and retain non-medical health professionals who demonstrate potential for academic careers
The Trust was able to form new relationships around research and innovation, to involve staff and patients widely in research, and to communicate and engage on this agenda more widely.	• The widening involvement of staff and patients across the Trust in research. • The strong focus on communication & engagement around research and innovation.	• Develop further communication channels and opportunities for increasing patient awareness of clinical research and its impact / benefits • Expand the breadth and depth of clinical research across ICHT specialties

6. Community Partners and Networks Insights

Key findings	Key recommendations	
	Keep	**Improve**
NWL worked well as an acute network in terms of management, establishing provider collaboration at ICS level. Some variation in practice were present. The Trust contributed actively to the Nightingale hospital	• Recognition and use of experts within and external to the Trust • Sector / system wide approach with boundaries overcome • Use of / working with community services (support for GPs, hot hubs & care homes)	• Standardisation of key practices to reduce unwarranted variation as our integrated care system continues to emerge • Guidance that is aligned for the Trust as well as community / primary care colleagues (ie at a pathway / population level)
Reduced bureaucracy and ability to make local decisions / take action quickly was very positive	• Respiratory input into the hot hubs • Covid training sessions jointly run by Imperial consultants and local GPs	• Widen the involvement in these activities to the full range of Imperial specialties
The Charity had excellent volunteer support and donations; supporting staff in such stressful times was challenging	• Staff support for, and team-working with volunteers	• Management of donations • Running of staff shops (access, safety) • HR management for charity activities
Although some best practice networks were established the Trust does not always make the most of working with and learning from others	• Active involvement in Shelford group, specialty society, improvement networks to share ideas and learning	• Leadership hierarchy in parts of the Trust could do with more flattening • The Trust can sometimes lack an organisational curiosity to learn from others

7. Analysis and Overarching Themes

7.1. This work has demonstrated the extraordinary impact the last six months has had on individuals and teams within the Trust, our patients and their families, local partners and communities. We knew almost nothing about this disease in March 2020 and had to learn extremely quickly; some existing issues were exacerbated, mistakes were made and things were missed, however, there was also innovation, good practice and a significant amount was achieved. The rapid cycles of learning,

strong application of rigorous change methodologies and leadership underpinned by a desire to learn, make evidence-based decisions and improve showed how we as a Trust can be a true learning organisation. Examples of key themes that have emerged from this work and will enable us to continue to develop as a learning organisation include the importance of:

- Collaborative leadership: huddles and other facilitated meetings with flat hierarchies enabled people to come together to work through issues.
- Genuine co-design in our work (this has come through all of the working groups).
- Multi-professional approaches to delivery of care, underpinned by work to understand need and then match skills and capacity to it
- Rapid learning, without being labelled as PDSA cycles, teams undertook rapid learning and improvement in so much of their work.
- Evidence-based decision-making: getting the right balance of local versus site versus trust, and strategic versus pragmatic.
- Reduced bureaucracy: people found this very liberating and more energy was directed to delivering outcomes that really matter.
- Standardisation and reducing unwarranted variation: teams valued using clear guidelines and protocols to ensure consistent high quality care. This needs to be enabled by high quality real-time data and informatics.
- Staff health and well-being: this needs to stay as an organisational priority and needs to include work to ensure staff feel safe in their work (e.g. through access to PPE, PPE helpers, access to symptomatic testing, safe work-places, etc.).
- Mission and purpose: Covid-19 showed that being clear about what we wanted to achieve led to extraordinary team work and positive outcomes; we need to use our strategy work and the story telling around it to replicate this for the organisational goals.
- Communication and engagement became front and central to everything we did through the pandemic and needs to stay as a key tool for mobilising staff, patients and our local communities around our mission and purpose.

8. Key Overarching Recommendations and Next Steps

8.1. The committee is asked to note the following as key recommendations from individual working groups and the over-arching work stream:

a) Ensure that all key operational issues presented in these reports (e.g. on PPE, fit testing, redeployment, access to training) are systematically picked up and addressed by the trust-wide operational steering group who are responsible for the planning for our response to a second surge of Covid-19. A full mapping of this will need to be presented to assure the executive team that each and every item has been actioned.

b) Ensure that all senior responsible officers (SROs) of each of the Trust's priority programmes and projects are leading and role modelling how the insights gained from this work are being actively addressed within their areas of work.

c) Co-design surge plans with staff to ensure that they feel real ownership over the issues and potential improvements, and that things that worked well are maintained and/or put in place again.

d) Across all of our work ensure a focus on reducing inequalities, including prioritising proactive support for groups of staff (e.g. shielding staff), patients and local citizens (e.g. those from BAME backgrounds) who are feeling particularly anxious, fearful and/or isolated.

e) Use our priority programme on culture to scale up our work on values, behaviours and improving culture such that this remains a key focus at all levels of the organisation even at times of considerable pressure and uncertainty

f) Actively build external relationships at all levels of our work. This needs to include developing understanding and influence at a national and regional level, growing trust and relationships with local communities and partners (including GPs, community providers, local authorities, local charities, local community groups).

g) Build on this work to formally develop and prioritise a director-led, user-insights function (staff, patients and local communities) that brings together existing expertise within the Trust to underpin be the most user-focused organisation in the NHS.

h) Define the mechanisms by which on-going learning and insights are able to continuously feed into our Imperial Management and Improvement System (IMIS) in order to meet our strategic goal of becoming a learning organisation.

8.2. Once recommendations (g) and (h) are in place, the Learning & Insights task and finish project can be stood down.

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TRUST BOARD -PUBLIC REPORT SUMMARY	
Title of report: Integrated quality and performance report (month 4 – July)	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 30 September 2020	**Item 11, report no. 08**
Responsible Executive Director: Julian Redhead (Medical Director) Janice Sigsworth (Director of Nursing) Catherine Urch (Divisional Director) Tg Teoh (Divisional Director) Frances Bowen (Divisional Director) Kevin Croft (Director of People and Organisational Development) Claire Hook (Director of Operational Performance)	**Author:** Submitted by Performance Support Team

Summary:

The Board are asked to consider the integrated quality and performance report for month 4 which is presented in the new Imperial Management and Improvement System (IMIS) format.

As part of the transition into the new Executive and Board routines, IMIS 'reporting rules' have been introduced to help structure the performance reporting process.

Contents:

1. Summary report, including IMIS update and performance summary
2. Month 4 integrated performance scorecard
3. Countermeasure summary reports

Recommendations:

The Board is asked to note the contents of the IMIS performance scorecard for month 4 and performance updates.

The performance sections have been discussed at:

Board Quality Committee.

Quality impact:
The delivery of the full integrated quality and performance report will support the Trust to more effectively monitor delivery against internal and external targets and service deliverables. All CQC domains are impacted by the paper.

Financial impact:
No financial impact.

Risk impact and Board Assurance Framework (BAF) reference:

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

Workforce impact (including training and education implications): None

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

☐ Yes ☐ No ☒ Not applicable

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

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

Comprehensive performance and quality reporting is essential to ensure standards are met which benefits patients. The report is aligned with CQC domains to ensure the Trust has visibility of its compliance with NHS wide standards.

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

Trust strategic goals supported by this paper:

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

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

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

☐ Yes ☒ No

If yes, why?.....

Imperial College Healthcare NHS Trust

Integrated quality and performance report

1. Introduction

1.1. The Board are asked to consider the integrated quality and performance report for month 4 which is presented in the Imperial Management and Improvement System (IMIS) format.

2. IMIS update

2.1. The format of the enclosed performance scorecard presents the metrics within the Trust's strategic goals, priority programmes and focussed improvements.

2.2. In light of the recent strategy refresh, the Board scorecard is still to be noted as a work in progress. Further changes will incorporate the core delivery metrics in line with the revision to the Trust's strategy.

Reporting process

2.3. As part of the transition into the new Executive and Board routines, IMIS 'reporting rules' have been introduced to help structure the performance reporting process.

2.4. The reporting rules inform the type of update required for a particular scorecard metric or project milestone, dependent on trend and recent performance against target or trajectory. The rules are driven by 'by exception' principles and statistical process control to prompt the type of further investigation needed.

2.5. Updates may include (i) sharing successes from sustained performance against target or improvement against trajectory, (ii) providing a structured verbal update or (iii) driven by exception, presenting a full written countermeasure summary with trend analysis and improvement actions. The rules are detailed further in appendix 1.

2.6. The scorecard metrics have also been differentiated between 'Driver metrics' and 'Watch metrics'. This helps to prioritise resources for key improvement projects where it is needed and acknowledges business as usual activities to maintain performance in other areas.

2.7. In summary:

- **Driver** metrics include metrics that are consistently not performing against target / trajectory and where we want to align resources via a specific improvement project in order to drive improvement.

- **Watch** metrics include metrics that are consistently performing and this is expected to be reliably maintained through business as usual activities, for example, Core skills training is currently a watch metric as shown in the enclosed scorecard.

  The watch category may also include metrics that are important to track but where we are not currently able to directly influence performance. For example, the overall size of the RTT waiting list and the 6 week diagnostic standard have been moved to the watch category. These will revert to drivers once the Reset and Recovery phase is completed and all of our services are reinstated.

Imperial College Healthcare NHS Trust

3. Performance summary at month 4

3.1. Five Countermeasure summary reports are provided for the month 4 scorecard as follows:

1) Incident reporting rates

2) RTT 52 week waits

3) Cancer waiting times – 62-day performance

Reports are provided for the 2 metrics below, though since producing the reports these metrics have been moved to the watch category.

4) Diagnostics waiting times (6 week waits) will be managed through the Trust operational scorecard and will remain as a watch metric within the IMIS scorecard until completion of reset and recovery work.

5) Patients waiting over 12 hours from decision to admit will remain within the watch category because performance overall is not directly within our control and sits with the mental health trust however we will continue to pursue the actions with our partners.

3.2. Additional narrative on the points of note for the month 4 scorecard are provided below.

3.3. The size of the Referral to Treatment waiting list fell between March 2020 and June 2020 but in July we saw a slight upturn which is reflective of the increased trend in referrals. The prioritisation work continues with clinical teams to ensure all patients on the patient tracking list (PTL) have a documented and timely assessment of their priority and risk.

3.4. The number of patients waiting over 52 weeks for treatment continued to increase as a result of reduced elective capacity. A total of 834 patients had been waiting for more than 52 weeks at the end of July. Patients are being managed according to clinical priority. The Trust has submitted a 52 week trajectory as part of the NW London Phase 3 submission.

3.5. The 62-day GP referral to first treatment performance was 72.1% against the 85% standard. Activity has continued to increase across August and the Trust is working to develop an improvement trajectory that is in line with Phase 3 requirements.

3.6. The Trust is working as part of the wider NW London elective recovery programme to increase and maximise outpatient, surgical and diagnostics productivity. The Phase 3 recovery expectations published by NHSE/I on 31 July are provided below. *See the Board Phase 3 recovery paper for full detail.*

- In September at least 80% of last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October;

- Return to at least 90% of last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October; &

- 100% of last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year.

3.7. The number of Long stay inpatients rapidly reduced during the Covid-19 period. At the end of July there were 131 patients with a stay of 21 days or more. This metric has not flagged as a Countermeasure summary and the performance is within the trajectory. Long length of stay is

being managed as a *focused improvement* as part of IMIS and continued improved working with external partners.

3.8. The performance of Ambulance handovers delays (30 minutes) improved in July but remains below target. As one of our scorecard Driver metrics a full Countermeasure summary and analysis is being prepared.

3.9. The Trust incident reporting rate for July is 46.6, below our target of 55.09 (the national top quartile). All three clinical divisions reported more incidents in July. Improving incident reporting is a focused improvement for the Trust, with weekly progress updates provided to the executive huddle.

3.10. A never event was declared in July, where a transfusion was commenced on a patient using the incorrect blood. The transfusion was immediately stopped and the patient did not come to harm. The investigation has been completed using after action review (AAR) and the report is due to be presented to panel in September. Immediate actions include a trust-wide safety alert, and a training refresh for local nursing staff. The divisional director of nursing for the Surgery and Cancer Division is leading a full review of transfusion governance.

3.11. Another never event was declared in August, where insulin was drawn up from a pen device and an incorrect dose administered to a patient in ICU. The patient did not come to harm. The investigation is on-going with an AAR being arranged. Immediate actions include a trust-wide safety alert, identification of a process with pharmacy to ensure reliable access of insulin pens and needles, and review of the escalation processes within the unit.

3.12. There was one Trust-attributable MRSA BSI in July 2020, when a patient who was known to be colonised with MRSA developed a bloodstream infection whilst on the ICU at Charing Cross Hospital. This is the first case reported in 13 months, and is being investigated as a serious incident.

4. Recommendation

4.1. The Board is asked to (i) note the development of the IMIS scorecard and (ii) note the five Countermeasure summaries provide for month 4 performance updates.

Imperial College Healthcare NHS Trust

Appendix 1 IMIS Reporting rules

-	Metric / project	Reporting expectation	Reporting rule – shown on scorecard
Driver	Driver is green for current reporting period	No action required	Share success
	Driver is red for current reporting period	Standard structured verbal update	SVU
	Driver is red for 2+ reporting periods	Present full written countermeasure summary	CMS
	Driver is green for 6 reporting periods	Standard structured verbal update, and promote metric to watch status	Promote to Watch
Watch	Watch is green for current reporting period	No action required	-
	Watch is red for current reporting period	If constitutional / statutory standard share structured verbal update	Note performance / SVU if statutory standard
	Watch is red for 4 reporting periods	Switch and replace to driver metric	Switch to Driver

Imperial College Healthcare NHS Trust

IMIS performance scorecard - Board version

FI = Focussed improvement

M4 - July 2020

Section	FI	Site	Metric	Watch Or Driver	Target	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Reporting rules	SPC variation
To help create a high quality integrated care system with the population of North West London																				
	FI		Workforce Race Equality Standard (WRES)		tbc	-	-	-	-	-	-	-	-	-	-	-	-	-		-
To develop a sustainable portfolio of outstanding services																				
Quality safety improvement	FI		Patient safety incident reporting rate	Driver	>=55.09	57.04	47.70	51.01	54.99	56.10	49.35	59.99	56.57	47.45	30.63	31.55	37.45	46.46	CMS	-
			Trust-attributed MRSA BSI	Watch	0	0	0	0	0	0	0	0	0	0	0	0	0	1	Note Performance / SVU if Statutory	-
			Trust-attributed C. difficile	Watch	6	12	10	6	10	7	10	12	3	6	8	6	3	1	-	-
			E. coli BSI	Watch	7	8	3	5	10	9	7	6	3	3	2	5	5	6	-	-
			CPE BSI	Watch	0	1	3	0	0	0	0	1	1	0	0	1	0	0	-	-
			% of incidents causing moderate and above harm (rolling 12 months)	Driver	<=2.10%	1.29%	1.27%	1.33%	1.34%	1.40%	1.45%	1.49%	1.44%	1.38%	1.40%	1.56%	1.64%	1.67%	Promote To Watch	-
			HSMR (rolling 12 months)	Watch	<=100	72	56	60	55	72	79	60	60	65	66	63	73	-	-	-
			Formal complaints	Watch	<100	136	87	98	100	83	87	80	80	67	32	53	56	60	-	-
Reset and recovery			RTT waiting list size	Watch	-	63,098	62,918	62,664	60,992	63,036	62,608	62,583	62,932	59,324	53,774	50,570	50,550	52,270	-	SC
			RTT 52 week wait breaches	Driver	0	0	2	3	2	4	8	2	1	10	90	258	533	834	CMS	SC
			Diagnostics waiting times	Watch	1.0%	0.90%	1.00%	0.50%	0.69%	1.15%	1.67%	0.79%	0.51%	8.50%	87.0%	65.7%	67.4%	56.3%	-	SC
			Cancer 2 week wait	Watch	>=93%	85.8%	82.9%	84.5%	89.1%	91.7%	89.6%	86.2%	93.5%	89.1%	92.9%	96.4%	93.6%	86.8%	Note Performance / SVU if Statutory	CC
			Cancer 62 day wait	Driver	>=85%	87.3%	86.9%	86.3%	83.7%	87.4%	89.1%	80.8%	78.4%	86.1%	85.0%	75.9%	69.9%	72.1%	CMS	CC
			Ambulance handover delays	Driver	100%	90.6%	90.6%	91.4%	92.7%	92.7%	89.3%	89.5%	88.3%	84.4%	87.7%	92.6%	92.9%	95.6%	CMS	CC
			Patients waiting >12 hours from decision to admit to admission	Watch	0	17	8	7	8	5	11	16	21	135	39	5	7	13	-	CC
	FI		Long length of stay - 21 days or more	Driver	<=142	218	212	212	208	206	233	224	229	191	131	143	127	131	Share Success	SC
			Bed occupancy	Watch	90%	84.8%	83.1%	84.3%	89.2%	90.3%	83.9%	85.7%	85.3%	68.6%	51.5%	49.6%	58.3%	62.3%	-	SC
Safe and sustainable staffing			Vacancy rate	Watch	<10%	12.0%	11.7%	11.1%	10.3%	9.7%	10.0%	9.7%	9.1%	8.9%	8.4%	7.1%	7.1%	8.2%	-	-
	FI		Agency expenditure	Driver	tbc	3.2%	3.1%	2.9%	2.8%	2.8%	2.7%	2.6%	2.5%	2.5%	0.8%	0.5%	0.5%	0.6%	-	-
			Staff Sickness (rolling 12 month)	Driver	<=3%	3.20%	3.18%	3.18%	3.24%	3.26%	3.29%	3.29%	3.29%	3.70%	4.00%	4.05%	4.09%	2.95%	Share Success	-
			Staff turnover (rolling 12 months)	Watch	<12%	11.8%	11.7%	11.8%	11.8%	11.8%	11.8%	12.0%	11.7%	12.1%	11.0%	11.8%	11.1%	11.1%	-	-
Finance			YTD position £m	Watch	£0	0.97	1.09	1.03	4.80	3.19	1.01	1.01	0.97	-1.47	0.00	0.00	0.00	0.00	-	-
			Forecast variance to plan	Watch	£0	-18.11	-11.34	-9.14	-5.02	-6.51	-3.52	-2.62	-3.43	-	-	-	-	-	-	-
			CIP variance to plan	Watch	0%	64.6%	66.0%	74.1%	73.5%	74.8%	75.0%	74.4%	75.7%	75.7%	-	-	-	-	-	-
To build learning, improvement and innovation into everything we do																				
			Core skills training	Watch	>=90%	92.5%	93.5%	93.8%	93.8%	94.3%	94.3%	93.4%	93.2%	94.0%	94.4%	95.2%	94.6%	91.8%	-	-

Countermeasure Summary: Incident reporting rate

Imperial College Healthcare NHS Trust

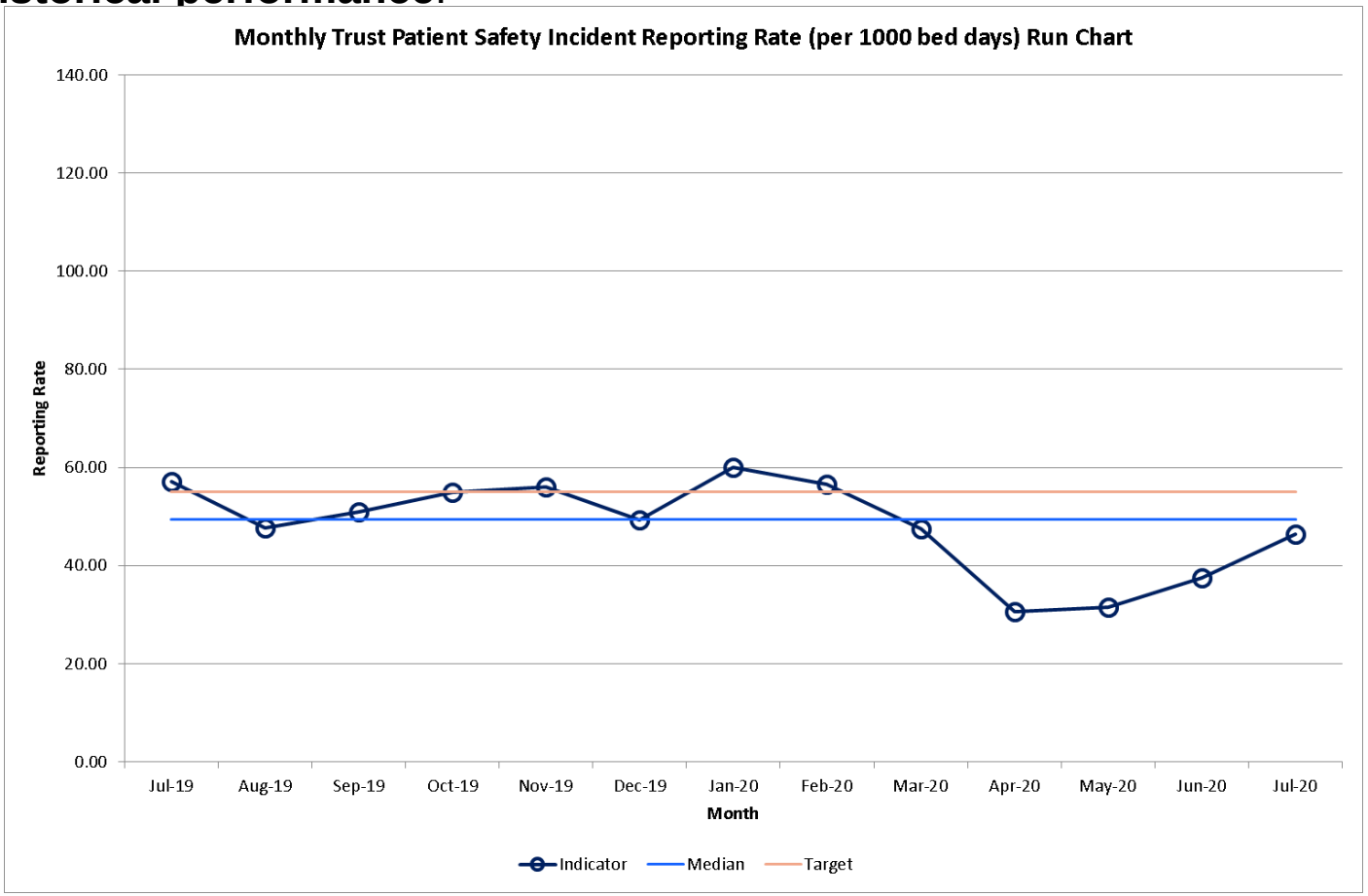
Problem Statement:

- Our incident reporting rate for July is 46.6, below our target of 55.09 (the national top quartile). We have been below target for 5 months, since March 2020.
- Pre-pandemic, our incident reporting rates were variable and although historically we had been in the top quartile overall, this had reduced over the preceding 12 months. During the pandemic reporting rates dropped across all divisions.
- We know that the safest healthcare organisations have the highest reporting rates, and this is a good measure of staff engagement as well as patient safety. We believe this is an important measure of how we are embedding our values & behaviours, supporting staff to report and be open and as such this is currently a focused improvement for the Trust.

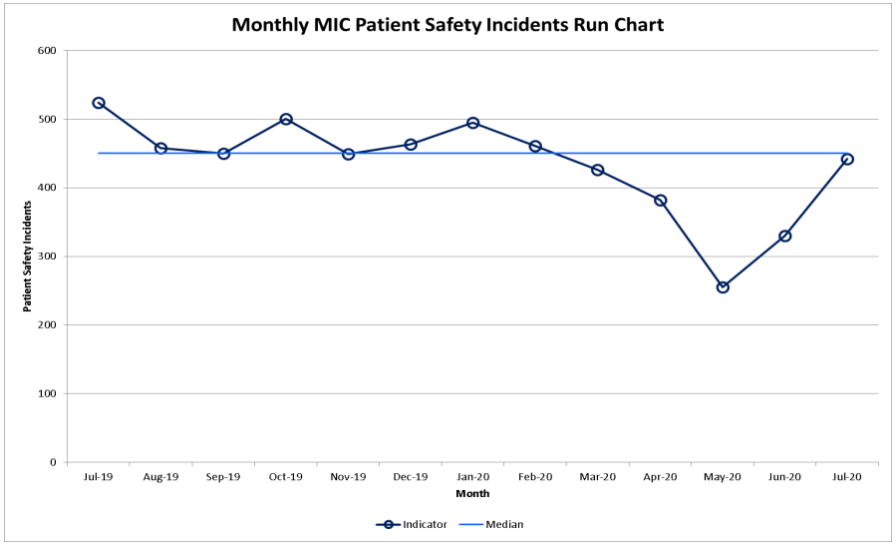
Metric Owner: Darren Nelson, head of quality compliance and assurance
Metric: Incident reporting rate

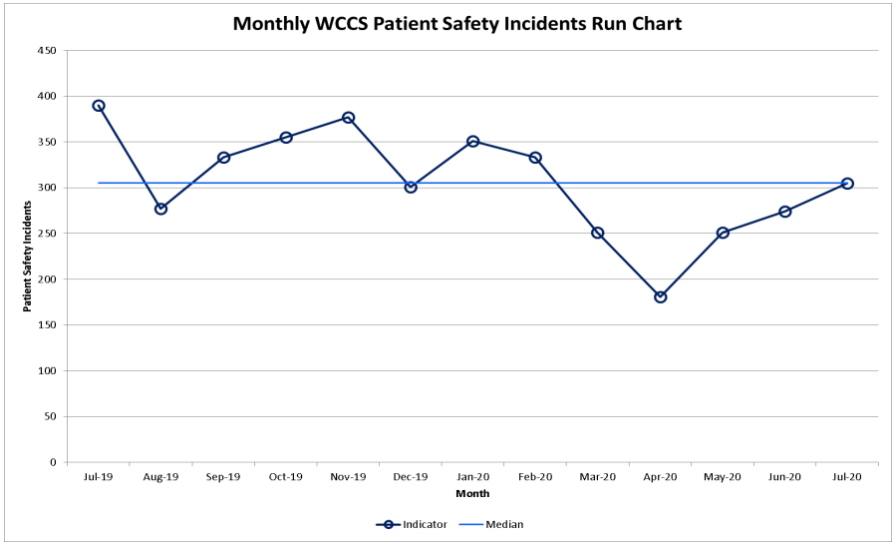
Desired Trend: ↑

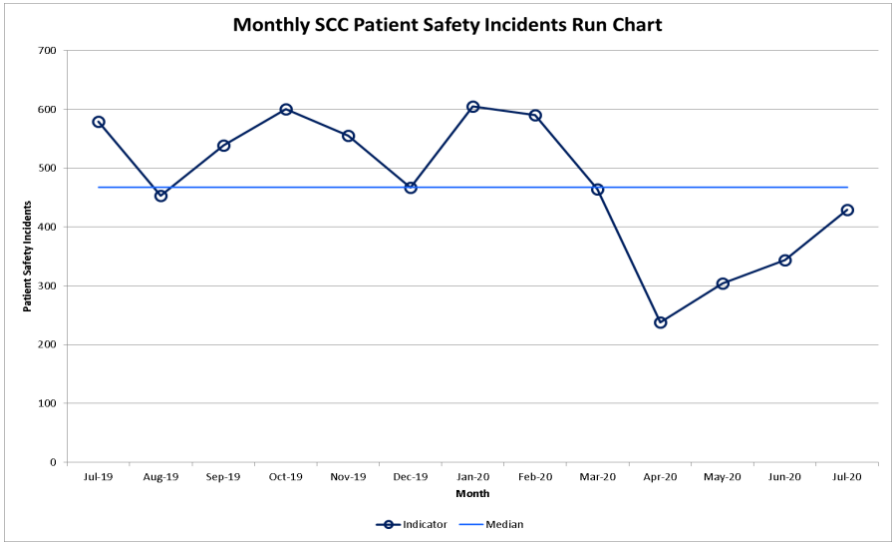
Historical performance:



Stratified Data:







The graphs show the number of patient safety incidents reported per division showing historic variance and dips that coincide with the pandemic. Reporting is improving but below the median. Data at directorate level shows the same pattern. It is important to note that these are run charts of divisional reported incidents rather than comparison to the target using bed days. Bed day data is complicated to calculate at specialty and ward unit level where it would be most useful to drive improvement. This is currently being progressed (see action plan).

Countermeasure Summary: Incident reporting rate

NHS
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Top Contributors:

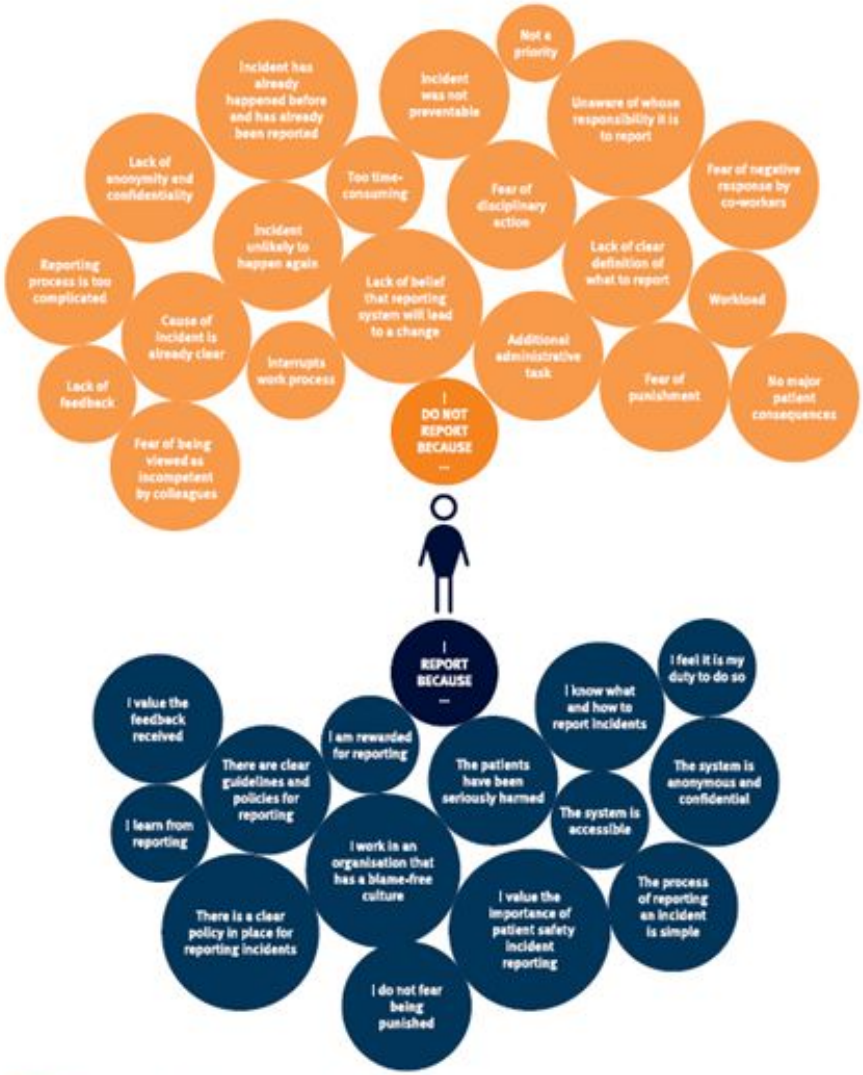


EXHIBIT 1: Barriers and facilitators to incident reporting[1] https://www.imperial.ac.uk/media/imperial-college/institute-of-global-health-innovation/IMPJ4219-NRLS-report_010316-INTS-WEB.pdf

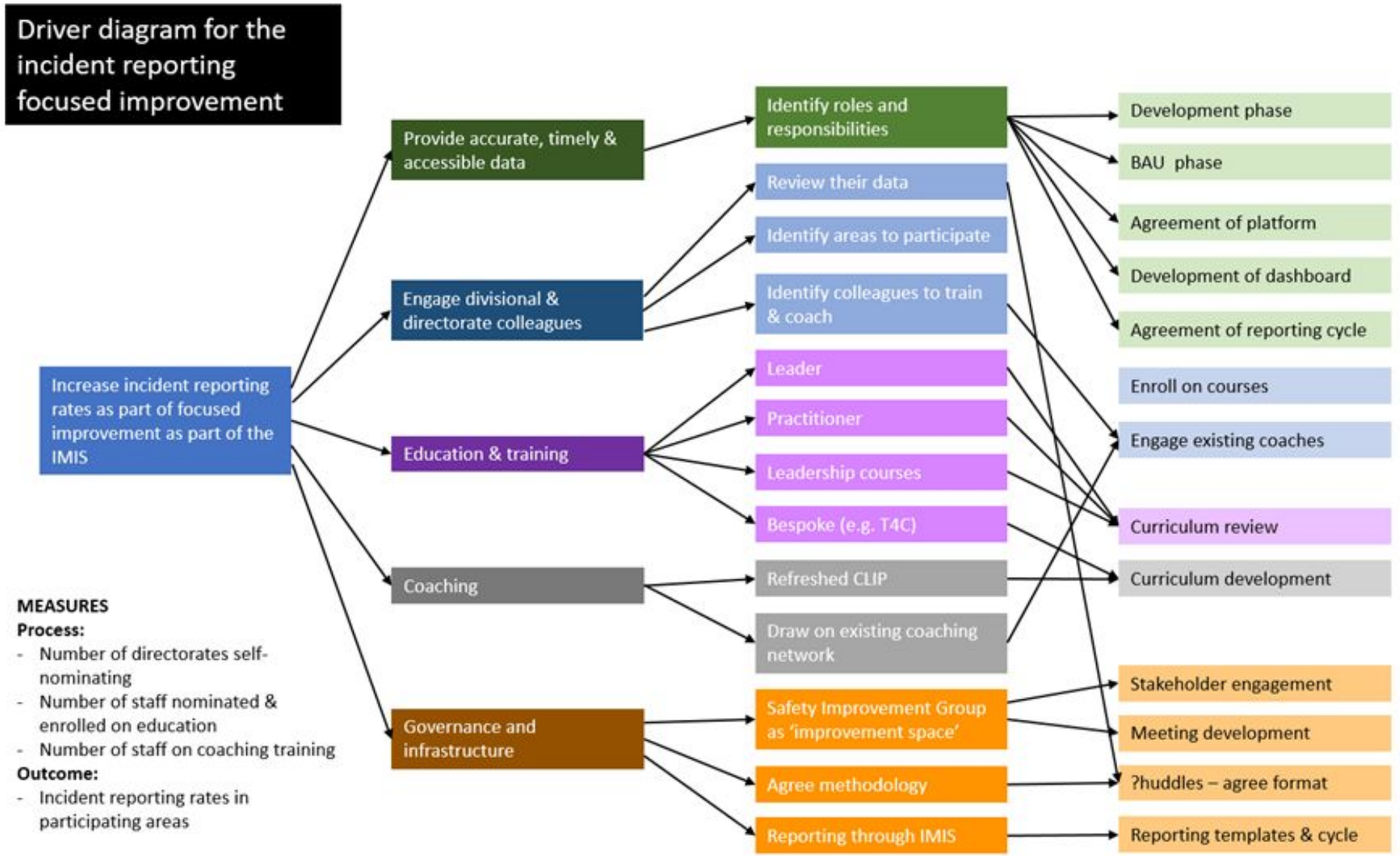
In 2019, a pilot of incident reporting improvement projects commenced in 3 wards in surgery, cancer and cardiovascular sciences identified as some of the lowest reporting (ranked by total number of incidents by ward by month). Ward teams were asked to review their barriers and enablers to incident reporting using those set out in the research literature. This then formed the basis of local improvement plans.

In the pilot wards, these included frontline staff 'owning' their data, reporting cultures amongst professional groups, leadership for reporting, education & training, locally held beliefs around the utility of incident reporting, feedback and genuine commitment to learn from incidents. The key findings of the pilot were the importance of local ownership and the culture within teams.

This pilot reported to quality and safety sub-group in November 2019. There were small but significant increases in incident reporting in the three pilot wards. If this was replicated at scale, it may have the potential to impact on overall reporting rates Trust wide, with most impact in those areas that currently under-report.

The findings of the pilot helped develop the programme and driver diagram for the trust's focused improvement, with the focus on locally developed actions in response to locally identified barriers to incident reporting. Trust wide actions focus on common issues reported by staff, such as availability of data, usability of Datix (our incident reporting system), and the need for improvement support for frontline staff to enable them to develop and deliver their own improvement plans.

Overall programme driver diagram:



Countermeasure Summary: Incident reporting rate

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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	• Datix functionality does not support visual data usage.	• Tender specification for reporting system in final draft. Due to be completed by end of November. • Development of prototype dashboards in Qliksense to help make data more available to frontline teams – timelines for this work being developed with Business Intelligence	Head of quality compliance and assurance Improvement team / BI	Nov 2020 Oct 2020
Local data comparisons – comparison data uses bed days which is not widely applied at local level making comparison difficult.	• Bed day data at local level has not historically been applied to incident data in a meaningful way.	• Bed day data review completed and data shared with divisions for consideration 01/09/19. Further work is being undertaken with BI to ensure accuracy of the data. Once complete, this data will be incorporated into the quality scorecard reviewed at EMB quality group, and into directorate and ward level scorecards.	DiHub / BI	Oct 2020
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.	• Paper presented to quality and safety sub-group in August 2020 with divisional actions agreed. Update at September meeting: Divisions have discussed the programme within their quality and safety committees and are identifying areas requiring focused improvement support which they will share with the improvement team. • Plan for local huddles to review data and the barriers/enablers will be developed once focus areas confirmed.	Divisional Directors of Nursing and Divisional Directors of Governance	Oct 2020

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	• Divisions to identify wards/areas reporting low incident numbers to implement local huddles for incident reporting, supported by the improvement team • Divisions to identify clinical and professional leads to lead work locally within directorates (this may include individuals with existing improvement and/or coaching expertise) • Divisions to nominate names of individuals requiring education and/or coaching support	Divisional Directors of Nursing and Divisional Directors of Governance	Oct 2020
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	• Future awareness campaigns to be planned and developed • Education for local managers to be developed – focusing on psychological safety to support incident reporting • Human factors training in place as part of HOTT programme with plans to offer to all staff • Implementation of new model to manage SIs, moving away from current investigation process towards using after action review (AAR) following a successful pilot - approved at executive committee in August	Improvement team / Communications Improvement team HOTT programme lead Head of quality compliance and assurance	Oct 2020 Oct 2020 Oct 2020 Nov 2020
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	• Review of alternatives to Datix system including possible incident reporting app • Develop automatic reporting from CERNER for regularly occurring incidents	Head of quality compliance and assurance Office of the medical director with chief clinical information officer	Oct 2020 Oct 2020

Countermeasure Summary: RTT 52 week wait breaches

Imperial College Healthcare NHS Trust

Problem Statement: 52 week waits are increasing due to the impact of Covid and reduced elective activity. Prior to Covid the Trust was reporting single figures. The impact is increased operational and clinical pressures and extended waiting times and poor experience for patients.

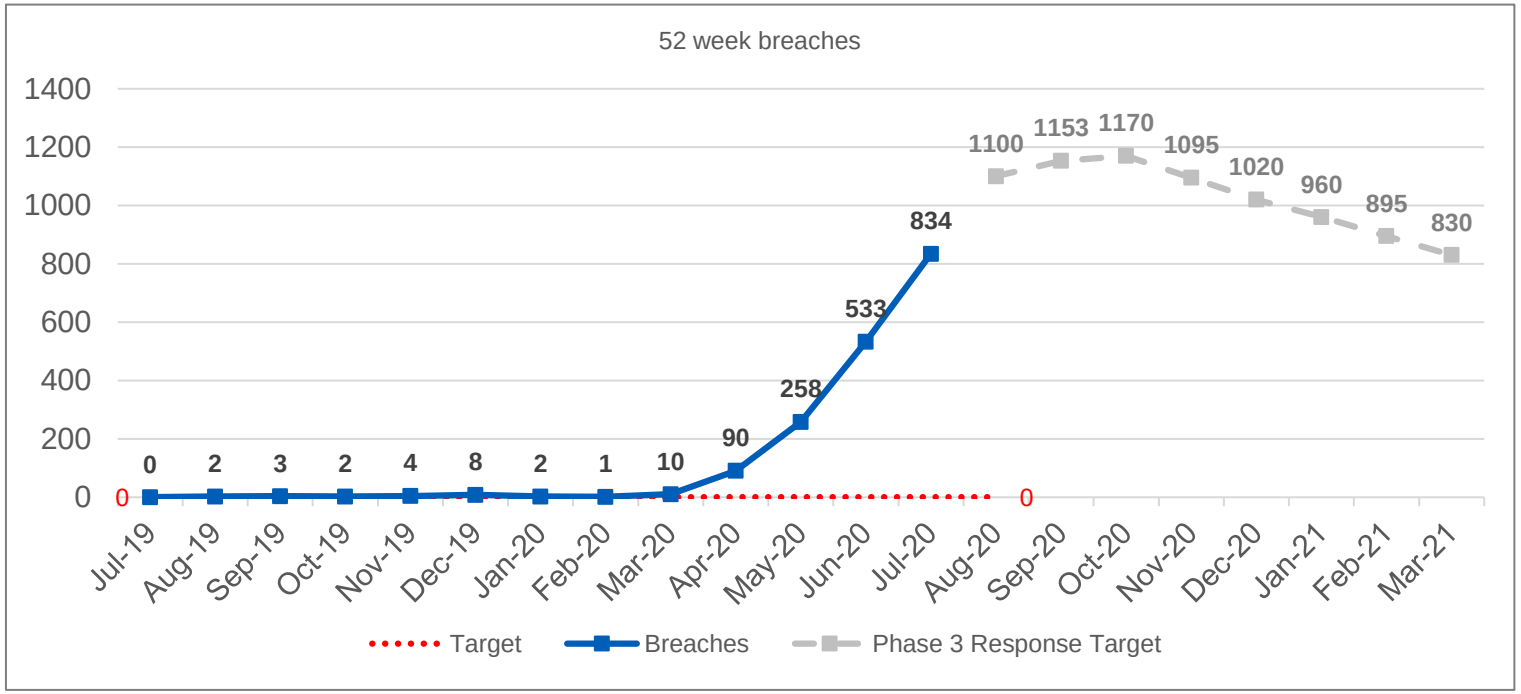
Metric Owner: Professor Katie Urch
Metric: RTT 52 week wait breaches
Desired Trend: ↓

Historical performance:

The last peak in 52 week wait reported breaches was in September 2017 at 440 and it took 14 months to reduce this backlog to within a threshold of no more than 10 in November 2018. In February 2021 the trust reported just 1 patient that had waited longer than 52 weeks and was on track to report zero in March 2020 but due to the suspension of elective surgery in response to the Covid-19 pandemic reported 10 and this number has increased month on month to a high of 834 in July 2020.

In September 2017 the number of pathways 40-52 weeks was 1088 and now this has increased by over 3 times and is currently at 3435.

In response to Phase 3 recovery plans the Trust has submitted a trajectory based on the anticipated length of time to treat the backlog of long waiting patients whilst managing the number of pathways tipping over into 52 weeks each month (average of 440 per month)



Stratified Data:

The tables below demonstrate that the problem is predominantly in the incomplete admitted pathway and included the breakdown by division and by TFC

Division	Admitted	Non-Admitted	Grand Total
Medicine and Integrated Care	94	61	155
Surgery, Cancer and Cardiovascular	469	151	620
Womens, Childrens and Clinical Support	49	10	59
Grand Total	**612**	**222**	**834**

MIC	Admitted	Non-Admitted	Grand Total
341 - Respiratory Physiology	44	8	52
301 - Gastroenterology	22	28	50
302 - Endocrinology	10	12	22
317 - Allergy	14	3	17
410 - Rheumatology		9	9
340 - Respiratory Medicine	3		3
150 - Neurosurgery	1		1
307 - Diabetic Medicine		1	1
Grand Total	**94**	**61**	**155**

WCCS	Admitted	Non-Admitted	Grand Total
502 - Gynaecology	35	9	44
215 - Paediatric Ear Nose And Throat	13	1	14
258 - Paediatric Respiratory Medicine	1		1
Grand Total	**49**	**10**	**59**

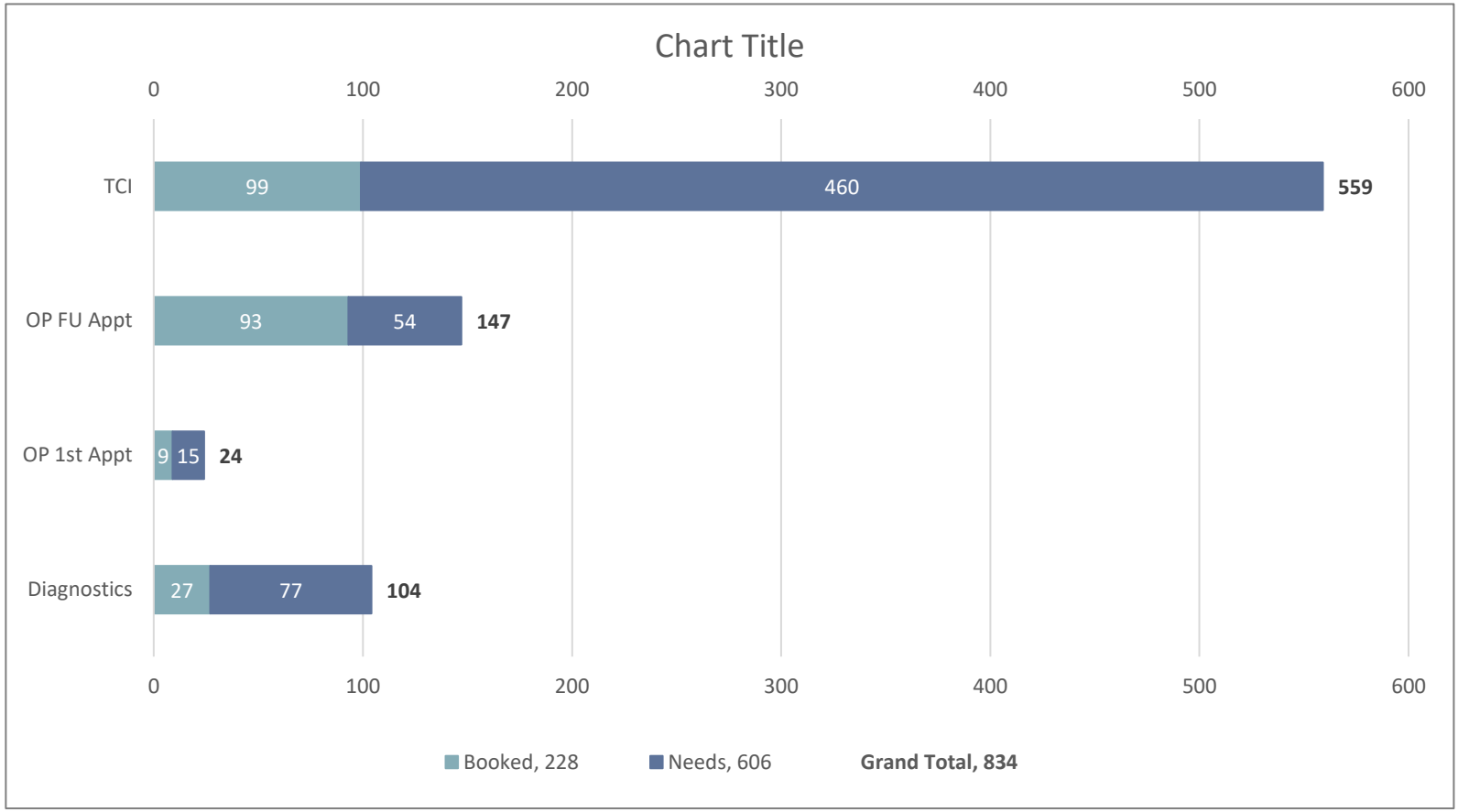
SCC	Admitted	Non-Admitted	Grand Total
101 - Urology	60	49	109
320 - Cardiology	97	6	103
100 - General Surgery	72	18	90
110 - T&O	66	14	80
130 - Ophthalmology	45	12	57
120 - ENT	34	16	50
105 – HpB Surgery	37	5	42
104 - Colorectal Surgery	22	11	33
107 - Vascular Surgery	17	15	32
160 - Plastic Surgery	11	4	15
103 - Breast Surgery	4	1	5
214 - Paediatric T&O	2		2
170 - Cardiothoracic Surgery	1		1
140 - Oral Surgery	1		1
Grand Total	**469**	**151**	**620**

Countermeasure Summary: RTT 52 week wait breaches

Imperial College Healthcare NHS Trust

Top Contributors:

Of the 834 reported breaches July 606 are still waiting for the next step to be booked. The largest contributor to the problem is insufficient theatre capacity followed by insufficient diagnostic capacity to book priority 4 long wait patients



Countermeasure Summary: RTT 52 week wait breaches

Imperial College Healthcare NHS Trust

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Theatre capacity is insufficient to manage demand and treat backlog of patients waiting over 52 weeks alongside patients at risk of tipping over into 52 weeks each month	• Clinical priority 1, 2 and 3 numbers exceed the current theatre capacity available and impacts on the treatment of priority 4 long waiters • "COVID 19 low prevalence protocols" to deliver the activity trajectories will have to adjust upward of 30% if they have to be maintained in current form	• Specific focus on order of booking TCIs in line with clinical priorities as agreed by Clinical Senior Responsible Officer (SRO) and Medical Directors Office • Capacity and demand analysis review of theatre requirements with each specialty to allow Directorates and Divisions to plan the activity levels required to meet and sustain the 52 week trajectory alongside treating clinically urgent and emergency patients • Individual services to ensure that access of additional capacity Independent Sector continues if required to treat priority 3 and 4 long waiters • Focused structured weekly oversight arrangements for managing long waiting patients over 44 weeks, including identifying and managing clinical risk with the focus on treating patients; led by Elective Care Delivery Manager (ECDM) with support from Clinical Senior Responsible Officer (SRO) and Performance Support Lead • Confirm weekly internal local service PTL meetings, led by general manager or deputy, are in place to provide a focal point for the review and management of long waiters; with expertise from the ECDM and/or Performance team supporting, coaching, mentoring and acting as a critical friend added as required for services with high numbers that may require intensive support	Jan Palmer, Elective Care Delivery Manager (ECDM)	01/10/2020
Diagnostic capacity is insufficient to manage demand and treat backlog of patients waiting over 52 weeks alongside patients at risk of tipping over into 52 weeks each month	• Majority of patients over 52 weeks and waiting for diagnostics are priority 4 and as diagnostics are booked in order of priority this is causing further delay on long waiters • Although 73% of long waiters are expected to require a TCI many of the current long waiters next step required is reported as a diagnostic which highlights a key dependency on diagnostic capacity for long waiting patients	• Review of booking priorities for diagnostics in line with requirements to meet the reduction in 52 week waiting patients and confirm trust direction Clinical Senior Responsible Officer (SRO) and Medical Directors Office • Confirm diagnostics such as MRI, CT and Endoscopy plan to return to BAU levels of activity as per Phase 3 guidance and have sufficient capacity and are responsive to booking needs of patients in priority order and for patients in the backlog of over 52 weeks	Jan Palmer, Elective Care Delivery Manager (ECDM)	01/10/2020

Countermeasure Summary: Diagnostics waiting times

Imperial College Healthcare NHS Trust

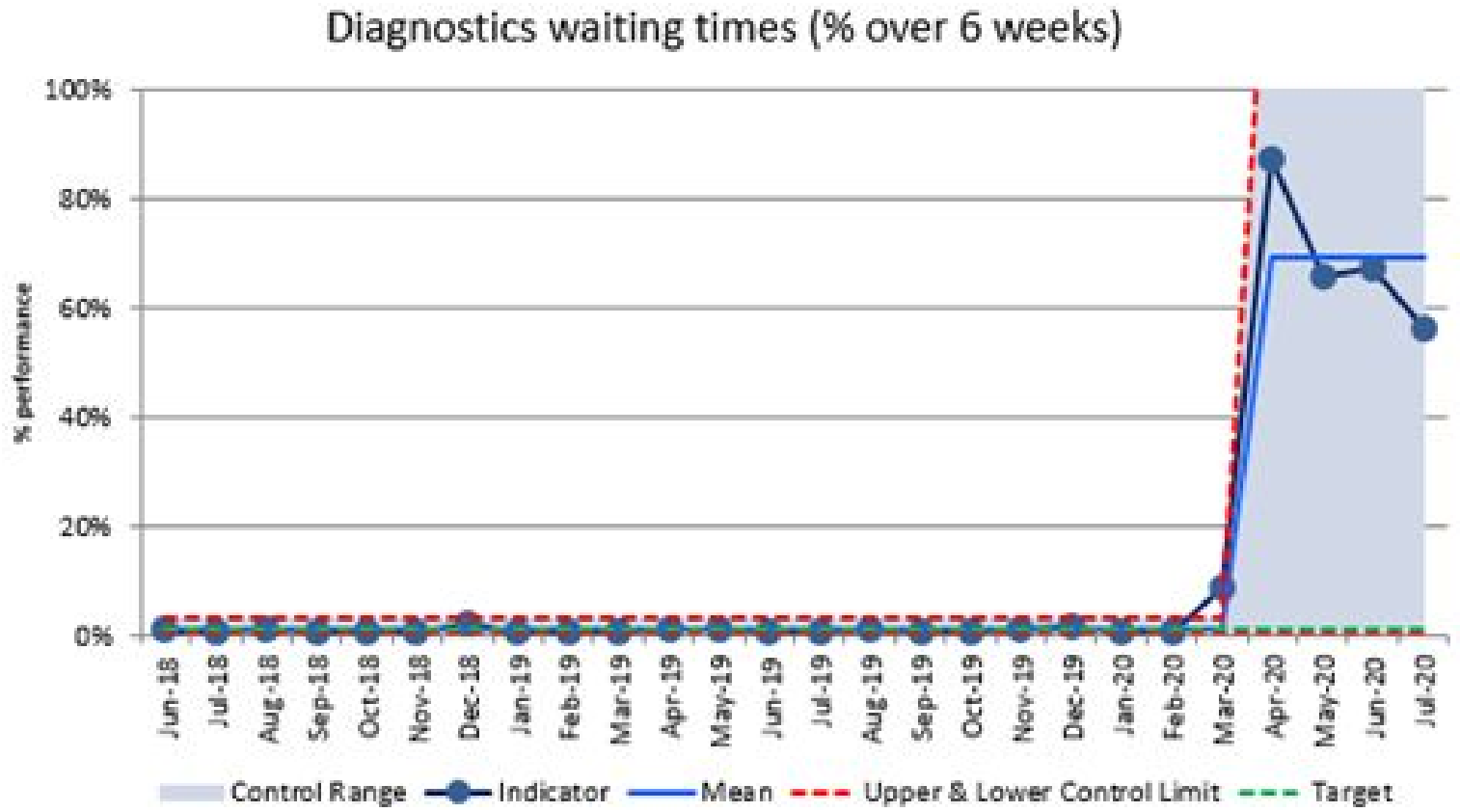
Problem Statement:

- As at the end of July 2020, 56.3% of patients are waiting 6 weeks or longer for a diagnostic test, against a target of less than 1%
- This is the fifth consecutive month that this target has not been met, although this represents an improvement from June 2020, for which 67.4% of patients were waiting longer than six weeks
- Failure to meet this target adversely impacts patient experience by extending waiting times and has the potential of delayed diagnosis and treatment

Metric Owner: Professor Tg Teoh
Metric: less than 1% of patients should wait 6 weeks or more for a diagnostic test

Desired Trend: ↓

Historical performance:



Countermeasure Summary: Diagnostics waiting times

NHS
Imperial College Healthcare
NHS Trust

Stratified Data:

Modality		Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Imaging	WL	10300	9760	9920	9455	9485	10307	10374	3449	6366	10810	15400	12781
	Breaches	85	36	69	128	195	81	45	23	5594	7841	10899	7414
	%	0.8%	0.4%	0.7%	1.4%	2.1%	0.8%	0.4%	0.7%	87.9%	72.5%	70.8%	58.0%
Endoscopy	WL	2261	2471	2381	2420	2465	2204	1977	2027	2752	3134	2684	2937
	Breaches	38	18	24	17	21	12	10	369	1041	1777	1389	1451
	%	1.7%	0.7%	1.01%	0.7%	0.9%	0.5%	0.5%	18.2%	37.8%	56.7%	51.8%	49.4%
Cystoscopy	WL	253	250	244	306	252	227	277	180	135	229	294	321
	Breaches	10	3	0	1	3	1	1	13	46	66	149	168
	%	4.0%	1.2%	0.0%	0.3%	1.2%	0.4%	0.4%	7.2%	34.1%	28.8%	50.7%	52.3%
Urodynamics	WL	33	21	32	52	33	30	60	49	19	71	128	83
	Breaches	5	0	0	0	0	1	0	22	12	57	95	64
	%	15.2%	0.0%	0.0%	0.0%	0.0%	3.3%	0.0%	44.9%	63.2%	80.3%	74.2%	77.1%
Cardiology - Echocardiography	WL	868	1063	1065	854	737	665	744	522	2085	829	526	752
	Breaches	9	13	8	12	16	14	10	54	801	145	331	506
	%	1.04%	1.2%	0.8%	1.4%	2.2%	2.1%	1.3%	10.3%	38.4%	17.5%	62.9%	67.3%
Cardiology - Electrophysiology	WL	24	27	24	19	18	15	23	21	8	17	23	21
	Breaches	4	0	1	1	1	0	3	3	2	13	6	2
	%	16.7%	0.0%	4.2%	5.3%	5.6%	0.0%	13.0%	14.3%	25.0%	76.5%	26.1%	9.5%
Neurophysiology	WL	400	348	644	427	525	436	440	194	159	151	56	81
	Breaches	1	0	0	0		1	0	29	147	148	44	11
	%	0.3%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	14.9%	92.5%	98.0%	78.6%	13.6%
Audiology	WL	424	416	427	400	440	400	402	381	126	97	227	497
	Breaches	1	2	1	3	0	4	2	61	116	77	119	311
	%	0.2%	0.5%	0.2%	0.8%	0.0%	1.0%	0.5%	16.0%	92.1%	79.4%	52.4%	62.6%
Sleep Studies	WL	131	139	115	102	141	90	184	145	253	312	104	306
	Breaches	0	0	0	0	0	0	0	19	174	156	67	83
	%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	13.1%	68.8%	50.0%	64.4%	27.1%
Trust Total	WL	14694	14495	14852	14035	14096	14374	14481	6968	11903	15650	19442	17779
	Breaches	153	72	103	162	236	114	71	593	7933	10280	13099	10010
	%	**1.0%**	**0.5%**	**0.7%**	**1.2%**	**1.7%**	**0.8%**	**0.5%**	**8.5%**	**66.6%**	**65.7%**	**67.4%**	**56.3%**

Countermeasure Summary: Diagnostics waiting times

NHS
Imperial College Healthcare
NHS Trust

Top Contributors:

- Since March 2020, the Trusts diagnostic performance has been below the 1% National target due to patients waiting longer for their examinations. This is the effect of cancellations & postponements on patient pathways as the Trust managed the impact of Covid-19. The potential impact is delay in diagnosis and treatment of our patients.
- Prior to March the Trust had been achieving the standard (with the exception of Aug-19 and Nov-Dec 2019 due to an increase in ultrasound referrals).
- For July 2020, 10010 of the 17779 patients on the waiting list have waited six weeks or longer for their diagnostic. Imaging services account for 74.1% of these breaches with 7414 patients, followed by Endoscopy at 14.5% with 1451 patients.
- The overall trust position has improved in July 2020 compared to the previous 3 months.
- This improvement is predominantly driven by a reduction in the backlog of imaging patients (comprising of MRI, CT, US, PET-CT, plain film, DEXA, Fluoro, Interventional Radiology and Nuclear Medicine) from 10899 in June 2020 to 7414 in July 2020. Significant reductions have been seen in CT (36%), MRI (14%) and U/S (22%).
- The Endoscopy backlog has increased marginally in July 2020 to 1451 patients, an increase of 62 patients from June 2020. Internal capacity is reduced due to two CXH rooms being closed, however activity it forecasted to increase through utilising all available internal suites, continued independent sector usage and weekend working. Work is underway to improve booking process and incorporate clinical prioritisation and harm reviews. NWL sector have agreed to outsource some of the waiting list to a private provider starting with patients on cancer pathways >104 days.

Countermeasure Summary: Diagnostics waiting times

Imperial College Healthcare NHS Trust

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
1. Ultrasound accounts for 45% of Imaging service waiting list	This is the effect of cancellations & postponements on patient pathways as the Trust managed the impact of Covid-19	• Remove the cleaning times in ultrasound and revert to the average 20 minute appointment slots (from existing 25 minute slots) • Pending approval: Recruit additional Band 2 IA to support US return to normal examination timings.	Catriona Todd	07/10/20
2. 74.1% of Trust backlog is within Imaging Services	This is the effect of cancellations & postponements on patient pathways as the Trust managed the impact of Covid-19	• Capacity increases: Continue running additional sessions (US, MR, CT- including extended days)	Catriona Todd	14/10/20
3. 14.5% of Trust backlog is within Endoscopy	This is the effect of cancellations & postponements on patient pathways as the Trust managed the impact of Covid-19	• Work with patient testing team to introduce testing for all patients which will enable increased capacity with new IPC guidance	Andy Angwin	07/10/20
4. 14.5% of Trust backlog is within Endoscopy	This is the effect of cancellations & postponements on patient pathways as the Trust managed the impact of Covid-19	• Expand weekend working using insourcing to enable SMH to run lists on Saturday and Sunday in addition to HH	Andy Angwin	07/10/20
5. 14.5% of Trust backlog is within Endoscopy	This is the effect of cancellations & postponements on patient pathways as the Trust managed the impact of Covid-19	• Whole waiting list validation to take place by end of September	Andy Angwin	30/09/20
6. Significant backlog for both Imaging services and Endoscopy	This is the effect of cancellations & postponements on patient pathways as the Trust managed the impact of Covid-19	• Optimisation of in-house and IS capacity with ongoing monitoring • Minimisation of DNAs • Gap analysis re capacity with mitigation and resource assessment • Completion of prioritisation of patients to minimise risk	Catriona Todd / Andy Angwin	14/10/20

Countermeasure Summary: Cancer Waiting Times 62-day Performance

Imperial College Healthcare NHS Trust

Problem Statement:

- *Performance against the standard has been non-complaint for 3 consecutive months. July was reported at 72.1% against the 85% standard*
- *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*
- *Performance has improved slightly in July, but is expected to remain non-compliant during clinical pathway, activity and PTL recovery*

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

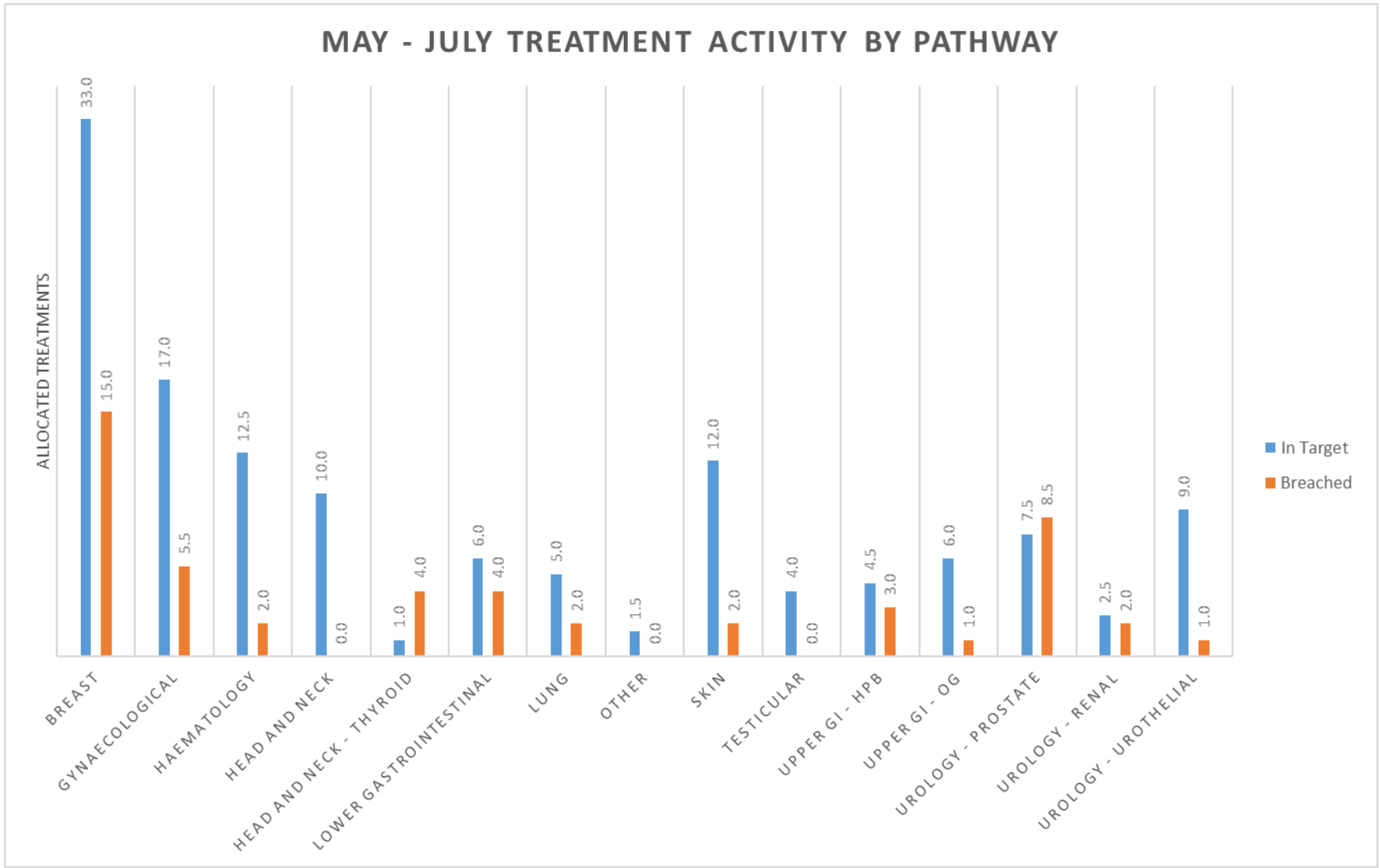
Historical performance:

Standards	Mar	Apr	May	Jun	Jul
3.1 - Cancer Plan 62 Day Standard (Tumour)	**86.1%**	**85.0%**	**75.9%**	**69.9%**	**72.1%**
Breast	90.2%	85.7%	100.0%	61.1%	55.6%
Gynaecological	81.3%	85.7%	70.0%	73.3%	90.0%
Haematological (Excluding Acute Leukaemia)	100.0%	100.0%	100.0%	84.6%	71.4%
Head and Neck	90.0%	84.6%	100.0%	100.0%	100.0%
Head and Neck - Thyroid	100.0%		0.0%	100.0%	0.0%
Lower Gastrointestinal	75.0%	57.1%	66.7%	60.0%	50.0%
Lung	60.0%	100.0%	80.0%	0.0%	100.0%
Other				100.0%	
Skin	100.0%	100.0%	100.0%	75.0%	87.5%
Testicular	100.0%	100.0%		100.0%	100.0%
Upper GI - HpB	50.0%	100.0%	50.0%	71.4%	50.0%
Upper GI - OG	20.0%	33.3%	75.0%	100.0%	87.5%
Urology - Prostate	90.7%	94.7%	33.3%	30.8%	69.2%
Urology - Renal	50.0%	85.7%	40.0%	50.0%	100.0%
Urology - Urothelial	100.0%		75.0%	100.0%	100.0%

Countermeasure Summary: Cancer Waiting Times 62-day Performance

Imperial College Healthcare NHS Trust

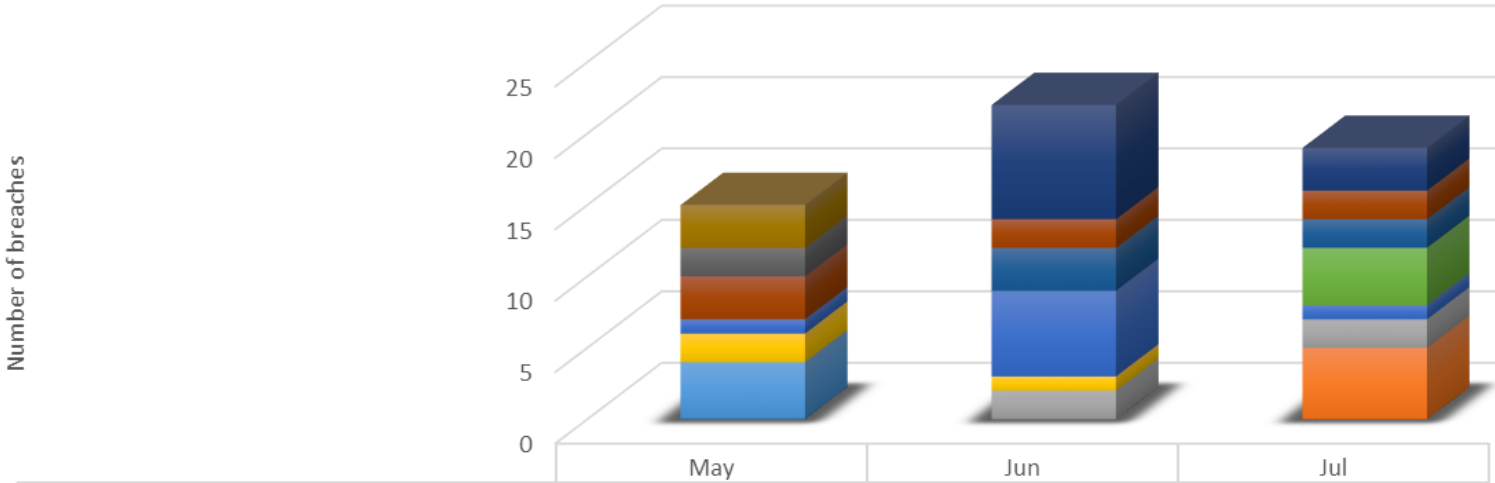
Stratified Data:



Countermeasure Summary: Cancer Waiting Times 62-day Performance

NHS
Imperial College Healthcare
NHS Trust

Top Contributors:



	May	Jun	Jul
Temporising hormones prior to surgery		8	3
Patient Covid positive	3		
Patient comorbidity	2		
Patient choice - no Covid impact	3	2	2
Late ITR		3	2
Diagnostics delayed by patient Covid risk			4
Diagnostics delayed by Covid capacity reduction	1	6	1
Complex diagnostic pathway	2	1	
Admission delayed by patient Covid risk		2	2
Admission delayed by isolation period			5
Admission delayed by Covid capacity reduction	4		

Countermeasure Summary: Cancer Waiting Times 62-day Performance

NHS
Imperial College Healthcare
NHS Trust

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Elective diagnostic and treatment capacity reduction	• Reduction in capacity for key diagnostics and loss of internal theatre capacity increased waits to diagnosis and treatment; • Scheduling has been based on clinical priority rather than performance standard breach dates; • 14 day isolation period requirement resulted in patients breaching when there was available capacity to admit within target	• All key internal surgical pathways have been re-established; • Local agreement reached with KE7 to continue using additional elective theatre capacity with them; • Additional IS endoscopy capacity has been agreed with HealthShare and RMP; • RMP funding has been provided to increase CTC capacity, consultant sessions for clinical pathway reviews and admin capacity for GI pathway recovery (impacting PTL recovery more than 62-day recovery)	Elective care directorates IPH Corporate Cancer	Complete Patients scheduled from 14/09/2020 Complete Recruitment to posts by 21/09/2020
Late inter-trust referral from NWL trusts	• Elective capacity reductions at partner trusts in NWL are resulting in delayed diagnosis and later transfer of care to ICHT for treatment	• Local elective capacity improvement plans	NWL trusts ICS	
National policy on clock stops for patients placed on hormone therapy prior to surgery	• NHSE issued an instruction in April 2020 that the 62-day clocks for patients placed on hormone or endocrine therapy prior to surgery in response to the pandemic had to be the date of surgery, even where the hormone therapy stopped tumour growth or shrank tumour size; • Breast, gynae and prostate patients are most affected, with patients having been on active treatment since March/April but being reported as breaches in June onwards when surgery could be scheduled.	• Corporate Cancer have escalated the issue to NHSE directly and through RMP. RMP are lobbying for a change in policy	Corporate Cancer	TBC – awaiting confirmation of outcome from RMP escalation

Countermeasure Summary: >12 hours from decision to admit (DTA)

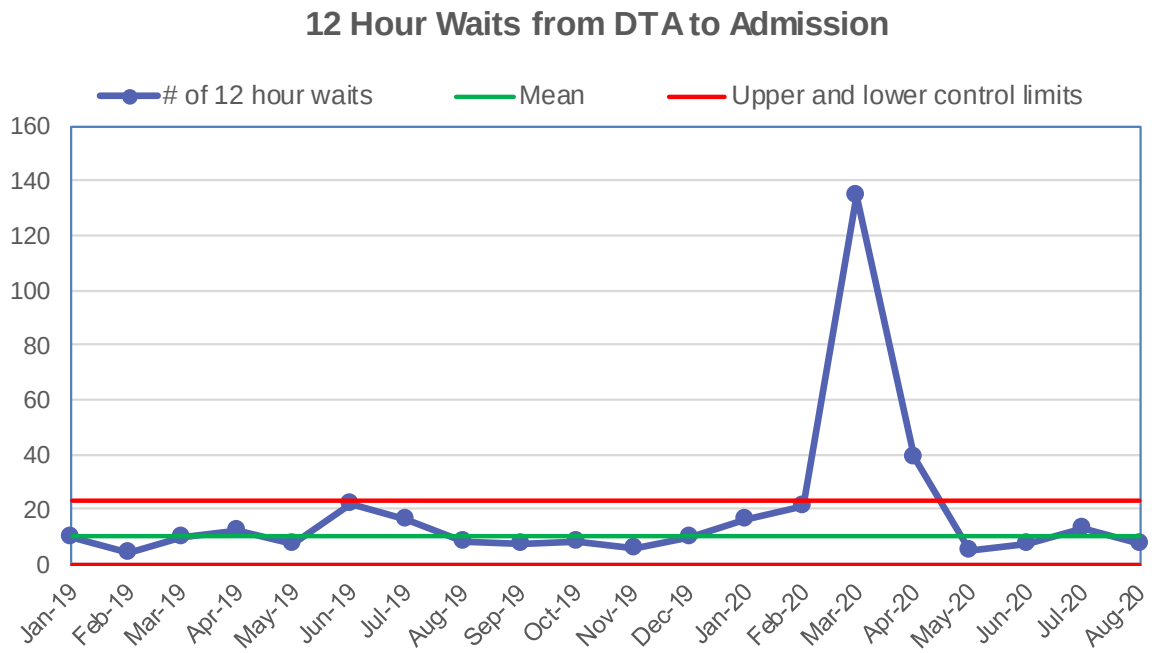
Imperial College Healthcare NHS Trust

Problem Statement: *There is an average of 9 patients per month (Jun-Aug) waiting over 12 hours from DTA to admission in our type 1 Emergency Departments against a target of 0. The average wait from DTA to admission for this cohort of patients is 20 hours and average total time in department is 30 hours. This length of time in an emergency department environment is detrimental for patient experience and quality and also impacts on staffing resource (ED staff, RMNs and security), cubicle capacity and the ability to manage flow through the department.*

Metric Owner: Ben Pritchard-Jones
Metric: # of patients waiting > 12 hours from DTA to admission
Desired Trend: ↓

Historical performance:

After the significant spike in patients waiting over 12 hours from DTA to admission during the first wave of covid-19 there were very few patients reported in May (5), the number rose in June (7) and July (13), and reduced again in August (7); however there have already been 5 reported in the first week of September. These breaches are solely related to patients admitted under Mental Health pathways to services outside of ICHT

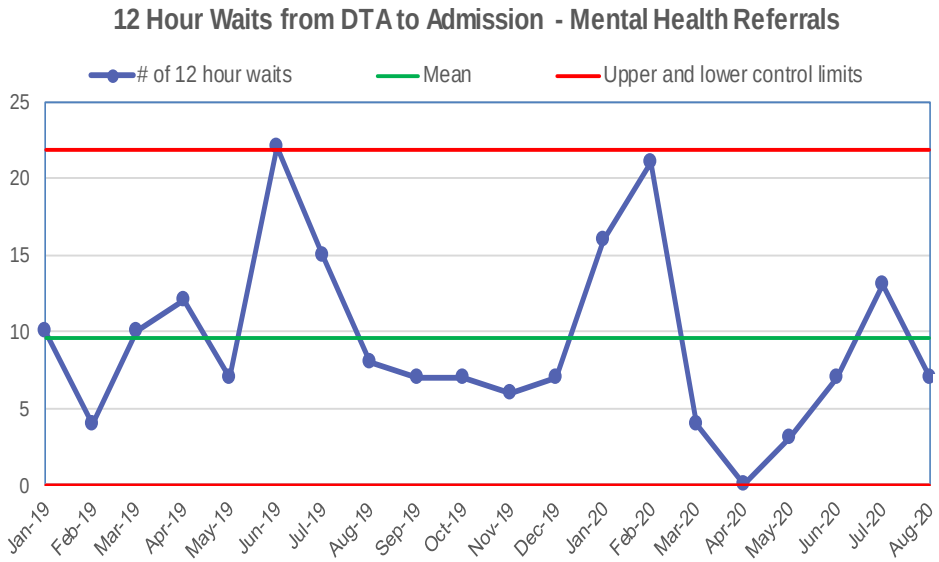


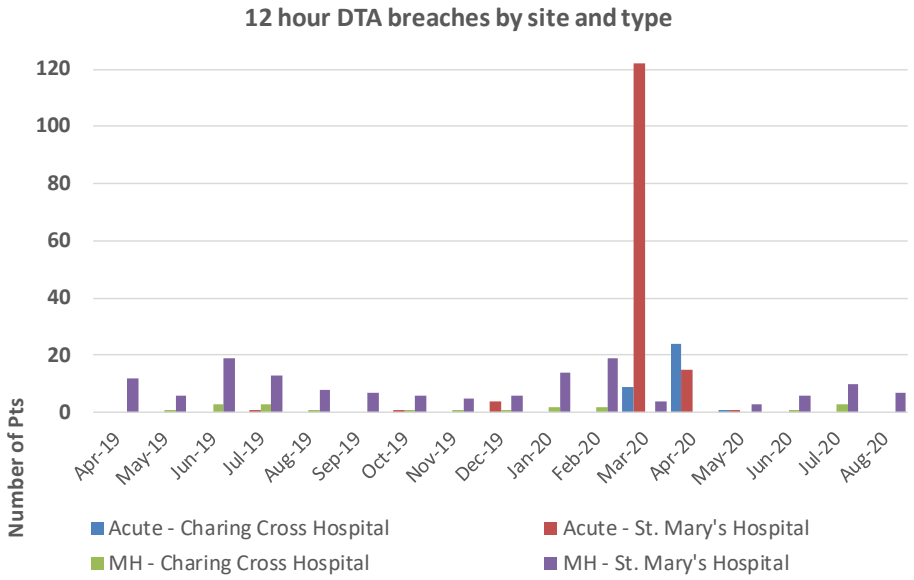
Countermeasure Summary: >12 hours from decision to admit (DTA)

Imperial College Healthcare NHS Trust

Stratified Data:

Looking at the last 3 months all patients waiting over 12 hours from DTA to admission have been on a mental health pathway. The split between sites is 15% CXH and 85% SMH.





Countermeasure Summary: >12 hours from decision to admit (DTA)

Imperial College Healthcare NHS Trust

Top Contributors:

Majority of delays are seen in pathways at the SMH site. This is a longstanding situation and has been raised and reviewed regularly via the A&E Delivery Board.

The initial response pathway is performing well on reported metrics of initial assessment and liaison psychiatry support :

- *Mean waiting times from arrival in ED to initial clinical/medical assessment – 1hr 25 mins*
- *Mean time from arrival in ED to referral made to liaison psychiatry - 1hr 18 mins*
- *Mean time from arrival to ED to commencement of face to face assessment by liaison psychiatry - 1hr 50 mins*
- *Mean waiting time from referral received by liaison psychiatry to commencement of face to face assessment – 33mins*
- *Number of referrals to liaison psychiatry which are assessed in 1 hour – 92%*
- *Mean time taken from start to completion of liaison psychiatry assessment – 2hrs 11mins*

The key issues are;

- *Delays for admissions – lack of available admitting capacity to mental health beds*
- *Complexity of out of area admissions – patients who are not 'local' are admitted to capacity in their area not by services covering ICHT sites*
- *Gatekeeping assessment and Home Treatment Team capacity – currently no 24 hour HTT service covering SMH site*
- *AMPH provision for completion of section paperwork*

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Delays to available Mental Health inpatient capacity	• Insufficient capacity to meet emergency demand • Length of stay • Limited crisis alternatives	• LOS reduction programme for 30 day plus – weekly review group • TIA tailored plans in boroughs for full roll out underway	CNWL Transformation Programme	October 2020
Insufficient gatekeeping / HTT service in support of SMH site	• No current 24/7 provision • Reduced ability to assess admission requirements earlier in pathways	• Increased capacity, 24/7 coverage, meeting fidelity incl. intensive home treatment and in reach to wards to facilitate early discharge • Face to face gatekeeping, standardising threshold for admission	CNWL Transformation Programme	October – December 2020
Increased AMPH provision	• Variable service across boroughs	• Increase AMPH provision to reduce waiting times for patients, with a particular focus on those in A&E	CNWL Transformation Programme	TBA
Impact of RMN support within ED	• Whilst not impacting outcome of performance the ED is not supported with adequate RMN provision and is reliant on temporary staffing, often at short notice, leading to	• Request for a review of the RMN provision across Trust and a site based approach to supporting all patients and services where required	Janice Sigsworth, SRO TBC, supported by transformation team	Ongoing
Delays less likely to be resolved out of hours	• Reduced services operating out of hours	• Review of out of hours escalation with MH partners	Jo Sutcliffe (working with Site Directors)	Sept/Oct
Ensuring safety and efficiency of internal aspects of patient pathway	• Space and facilities for patients within the ED setting • Rapid assessment and documentation of physical health	• Site based forums to discuss and improve pathways	Trish Ward and Barbara Cleaver	Ongoing
Delays to available Mental Health inpatient capacity and Insufficient gatekeeping / HTT service in support of SMH site	• As noted in first two lines of plan	• Escalate to NWL UEC board issues around OOH HTT and MH bed requirements	Julian Redhead	Sept/Oct

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Finance Report for August 2020	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 30th September 2020	**Item 12, report no. 09**
Responsible Executive Director: Jazz Thind, Chief Financial Officer	**Author:** Des Irving-Brown, Deputy Chief Finance Officer Michelle Openibo, Associate Director: Business Partnering

Summary:

This paper provides the Board with an update on the financial position for the Trust for the five months to the 31st August 2020.

For the first 6 months of the year the Trust has been given block funding for clinical activity with an agreement to provide retrospective top-up funding (should it be required) to achieve a break even position.

Key highlights YTD:

- £30.8m of additional funding has been required to achieve a breakeven position
- £31.2m of costs have been incurred in response to the Covid-19 pandemic
- £28.7m of income was not achieved due to Covid-19; key drivers relate to significantly lower than planned private patient and overseas visitor activity where capacity has been diverted to support NHS patients and R&D activity
- £22m of capital investment has been expended year to date against a plan of £28m. Capital planning assumes all Covid-19 related spend will be cash backed by NHSI/E
- Cash was £153m at the end of August. This is materially higher than usual and relates to block contact payments being received in advance; this positon will unwind in due course.

Trust Finance Regime:

NHSI/E published the 'Contracts and payment guidance October 2020 - March 2021' on the 16th September. The purpose of this guidance is to outline the financial regime for the NHS for the balance of the 20/21 financial year superseding all previous arrangements.

- Provider 'top ups' will cease at the end of September
- NHSI/E has calculated a financial envelope for all providers and CCGs in the STP. This allocation assumes the sector has sufficient resources to respond to the recovery and reset required by the Phase 3 letter with the expectation that STPs as a whole achieve break even
- The STP allocation includes funding for growth (cost increase) and expected Covid-19 spend
- The provider position assumes all non NHS income is recovered back to 19/20 levels
- An incentive scheme will apply to elective activity performance, with further guidance expected
- STPs will need to consolidate a sector wide position to ascertain the potential gap between funding received and cost/income changes and agree proposals to close any sector level gap

- Next steps for NWL STP include:-
    - detailed review of guidance and application of this to financial positions;
    - compilation and agreement of financial/business principles within which the sector will operate;
    - work through governance and sign off processes at both organisation and sector level –
        - Trust plan (October- March) to the STP by 5th October
        - Organisational plan to NHSE/I 22nd October

Recommendations:
The Board is asked to note this paper.

This report has been discussed at: N/A

Quality impact: This paper relates the CQC domain well-led.

Financial impact:
The financial impact of this proposal as presented in the paper enclosed:
1) Has no financial impact

Risk impact and Board Assurance Framework (BAF) reference:
This report relates to risk ID:2473 on the trust risk register - Failure to maintain financial sustainability.

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

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

What impact will this have on the wider health economy, patients and the public?
☐ Yes ☐ No ☒ Not applicable

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

Trust strategic goals supported by this paper:
- To develop a sustainable portfolio of outstanding services
- To help create a high quality integrated care system with the population of north west London

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

- Should senior managers share this information with their own teams? Yes

Imperial College Healthcare NHS Trust

Trust Board 30th September 2020

Finance Report August 2020

Scorecard

Imperial College Healthcare NHS Trust

	Plan £m	Actual £m	Variance £m
Year to date Position before Covid-19 expenditure and True Up	(33.1)	11.0	44.1
Top up	18.1	18.1	0.0
Income loss due to Covid-19		(28.7)	(28.7)
Covid-19 incremental expenditure		(31.2)	(31.2)
Reported position before true up	**(15.0)**	**(30.8)**	**(15.8)**
True Up		30.8	30.8
Reported Position	**(15.0)**	**0.0**	**15.0**

Risks

- **Financial regime** – The Trust remains on the current financial regime until the end of September. A *'Contracts and payment guidance document October 20 – March 21'* was published 15th September, and the detail of this will be worked through in due course. ICS level funding envelopes were expected to be shared on the14th September but this did not happen as envisaged.
- **True-up payments** – the Trust has received confirmation of payment for months 1-4 and will continue to seek reimbursement to the end of September. Confirmation of arrangements post this period to be confirmed via new guidance.
- **Activity** – block payments remain intact to the end of September, our understanding at present is that after October funding will be on a variable rate based on the phase 3 trajectories, tbc.
- **Cash** – based on the current forecast revenue and capital commitments results in a negative cash positon by the end of the financial year with a need for central cash support if this is not addressed by system measures. Maintaining a BAU cash buffer, the level of which needs to be determined, is important as falling below this could also have a negative impact on the settlement of creditor invoices.
- **Capital –** the national expectation is capital commitments are absorbed within the notified system allocations. There is therefore an emerging risk that if this is not manageable decisions regarding 'trade offs' will need to be considered.

Commentary

- Under the current financial regime the Trust is expected to show a break even position in month. This financial regime is confirmed to be in place until the end of September.
- At the end of August 2020, before the additional true up funding, the Trust delivered a net deficit position of £30.8m. This is driven by:
  - Covid-19 related costs and income losses of £59.9m (£31.2m and £28.7m respectively), with the latter linked to reductions in private patients, overseas visitors and R&D.
  - the additional cost pressure associated with the in-housing of hotel services of £4.8m, which is £0.5m less than expected by the Trust. This costs is not funded in the block, the service is forecasting a £0.8m underspend against the budget for the full year
  - The additional spend is offset by expenditure reductions in other clinical and non clinical areas
- Forecast – an initial forecast model has been developed using a agreed set of sector wide principles. Assuming no retrospective top up wef October and taking no account of any further Covid surge costs, the Trust ends the year with a £67m deficit position.
- Activity – year to date the Trust is now delivering 39% of the activity of the same period last financial year reflecting a month on month improvement.
- Capital – YTD the Trust has incurred 79% of plan and continues to forecast meeting its annual plan as per guidance. The narrative that sits alongside the financial return submission to NHSE/I sets out the risk of breaching this position.
- Cash at 31st August was £153.0m driven by the upfront payment from commissioners
- NHSE/I Use of Resources Financial risk rating would be a 3 (see appendix 6)

Strategy and Forecast

- Further work to be undertaken to triangulate the current activity plan and the costs of delivery
- A detailed review of capital plan has been undertaken but further work will be required across the sector to set out the impact on the CRL and cash, given the lack of funding approvals and the need to proceed at risk.

Statement of Comprehensive Income

Imperial College Healthcare NHS Trust

	Year to date			Full Year		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	518.9	492.3	(26.6)	1,243.3	1,189.9	(53.4)
Pay	(302.2)	(305.6)	(3.4)	(725.7)	(738.5)	(12.8)
Non Pay	(209.4)	(195.7)	13.7	(487.7)	(487.5)	0.2
EBITDA	**7.3**	**(8.9)**	**(16.3)**	**18.7**	**(50.5)**	**(69.2)**
Financing cost and donated asset treatment	(22.3)	(21.8)	0.5	(53.5)	(53.7)	(0.2)
Impairment of assets	0.0	0.0	-	0.0	0.0	-
Surplus/deficit before retrospective "true up"	**(15.0)**	**(30.8)**	**(15.8)**	**(34.8)**	**(104.2)**	**(69.4)**
Retrospective "true up"	(0.0)	30.8	30.8	(0.0)	37.2	37.2
Surplus/deficit	**(15.0)**	**0.0**	**15.0**	**(34.8)**	**(67.0)**	**(32.2)**

Before the retrospective top up payment, the Trust delivered a deficit of £30.8m against an NHSE/I expected position of break even.

Key highlights are:

- £14.7m loss of private income
- £8.3m deferral of research income
- £31.2m additional covid-19 costs
- £2.8m of overseas income loss
- £3.1m of other income loss
- £4.8m of soft FM cost pressure
- £9.7m other pressures not funded in the block
- £43.8m non recurrent expenditure reductions

- **Income** –Income in the Trust is adverse to plan due to changes in services during the Covid-19 pandemic, driven mainly by losses of private, overseas and research income with reductions in car parking (patients and staff) also having an impact. The Trust is not specifically reimbursed for this loss of income however any loss is included in the retrospective top up.
- The Trust is forecasting a small increase in private income but expects to remain significantly lower than last year as private capacity continues to support NHS activity.
- The Trust has forecasted the loss of research income to September, with this no longer being the case for future months.

- **Pay –** there is £14.8m in pay costs relating to Covid-19. This covers additional sickness costs as well as pay for additional work completed.
- Covid pay costs are forecast to decrease over the remainder of the year whilst costs in clinical areas are forecast to increase in line with increased activity.

- **Non Pay** – overall non pay is underspent however this includes:-
  - £16.4m for Covid-19 spend
  - a material underspend against drugs and devices as this has been funded on the basis of previous pass through cost level
  - a reduction in the costs rechargeable back by North West London Pathology (NWLP) against plan. There has been a reduction in test volumes at NWLP but, in line with Trust funding, owners have agreed to pay at last year's outturn thereby decreasing the deficit position for NWLP.
- The forecast shows an increase in activity based costs.

Divisional Overview

Imperial College Healthcare NHS Trust

		Year to Date			Full Year		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Medicine and Integrated Care	Income	136.50	136.18	(0.33)	327.60	326.79	(0.82)
	Expenditure	(103.49)	(95.74)	7.75	(248.36)	(238.12)	10.24
	Internal Recharges	(5.15)	(5.14)	0.00	(12.38)	(12.38)	0.00
	Total	**27.87**	**35.29**	**7.43**	**66.86**	**76.29**	**9.43**
Surgery, Cancer and Cardiovascular	Income	154.43	154.36	(0.07)	370.63	370.57	(0.05)
	Expenditure	(131.76)	(117.54)	14.22	(316.21)	(296.66)	19.55
	Internal Recharges	7.64	7.64	(0.00)	18.36	18.36	0.00
	Total	**30.30**	**44.46**	**14.16**	**72.78**	**92.28**	**19.50**
Women, Children & Clinical Support	Income	70.36	69.60	(0.76)	168.87	167.28	(1.59)
	Expenditure	(72.98)	(66.76)	6.22	(173.83)	(170.18)	3.66
	Internal Recharges	9.42	9.42	0.00	22.64	22.64	(0.00)
	Total	**6.80**	**12.26**	**5.46**	**17.68**	**19.74**	**2.07**
Imperial Private Healthcare	Income	22.65	7.98	(14.67)	54.36	22.39	(31.97)
	Expenditure	(11.22)	(7.98)	3.24	(27.32)	(20.84)	6.48
	Internal Recharges	(11.94)	(11.94)	0.00	(28.70)	(28.70)	0.00
	Total	**(0.51)**	**(11.94)**	**(11.43)**	**(1.67)**	**(27.16)**	**(25.50)**
Total Clinical Division		**64.49**	**80.10**	**15.60**	**155.74**	**161.23**	**5.49**
Non- Clinical Division	Medical Directorate	(4.44)	(3.99)	0.45	(10.54)	(10.32)	0.21
	Education	16.15	16.17	0.03	36.27	36.05	(0.21)
	R&D	1.00	(7.28)	(8.28)	5.86	(3.12)	(8.98)
	Nursing	(1.97)	(1.80)	0.17	(4.69)	(4.52)	0.17
	Estates	(36.93)	(35.81)	1.12	(87.95)	(85.46)	2.49
	Finance	(5.88)	(5.56)	0.32	(13.96)	(13.66)	0.30
	People & Org. Devel.	(3.37)	(3.68)	(0.30)	(8.14)	(8.75)	(0.61)
	Information & Technology	(10.53)	(10.63)	(0.10)	(25.27)	(25.41)	(0.13)
	Communication	(0.85)	(0.89)	(0.04)	(2.11)	(2.13)	(0.02)
	Office of the CEO	(4.58)	(4.69)	(0.10)	(10.80)	(10.79)	0.01
Total Non- Clinical Division		**(51.41)**	**(58.15)**	**(6.74)**	**(121.35)**	**(128.11)**	**(6.76)**
NHS Income	Clinical Commissioning	59.09	59.45	0.36	141.82	141.82	0.00
	Drugs & Devices (Cost)	(48.01)	(40.14)	7.86	(116.09)	(104.33)	11.77
Other Income	Central Income	21.07	17.99	(3.07)	50.56	44.09	(6.47)
Central Costs	CNST & Other Central Costs	(18.54)	(19.94)	(1.40)	(44.49)	(49.99)	(5.50)
	Pathology Residual	(15.06)	(12.79)	2.27	(36.15)	(45.58)	(9.42)
	Hosted Services	0.00	0.00	0.00	0.00	0.00	0.00
	Reserves	(4.28)	(4.28)	0.00	(11.36)	(14.48)	(3.12)
	Other Activity Growth	0.00	0.00	0.00	0.00	(11.90)	(11.90)
	Covid 19	0.00	(31.16)	(31.16)	0.00	(43.27)	(43.27)
Total Central Income and Costs		**(5.74)**	**(30.89)**	**(25.15)**	**(15.73)**	**(83.64)**	**(67.91)**
Financing Donated Asset + Impairment Adj		(22.29)	(21.84)	0.45	(53.49)	(53.66)	(0.17)
Surplus/deficit before retrospective "true up"		**(14.95)**	**(30.78)**	**(15.83)**	**(34.84)**	**(104.19)**	**(69.36)**
Retrospective "true up"		(0.00)	30.79	30.79	(0.00)	37.19	37.19
SURPLUS / (DEFICIT)		**(14.95)**	**0.01**	**14.95**	**(34.84)**	**(67.00)**	**(32.17)**

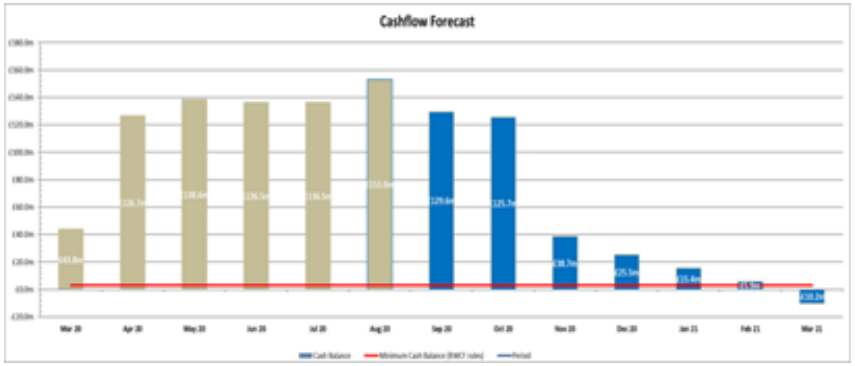
- **MIC** is favourable to plan year to date due to underspends from lower activity. The division has seen increased costs in month to cover for sickness, maternity leave and specialling. There have also been additional junior doctors costs with the implementation of the new A&E rota. The division has some additional costs for insourcing endoscopy activity.
- The forecast for MIC remains underspent but costs increase in line with increase activity. There is further work being undertaken in the division to review costs based on expected delivery of phase 3 activity. The full additional costs for endoscopy are not in the MIC forecast at this time but will be updated in future months.
- **SCC** remains favourable against plan due to activity underspends. There has been an increase in costs in month in theatres with additional activity, further work is to be done in this area to ensure forecast spend is in line with the new theatre schedule.
- The forecast for SCC shows an increase in costs, though the division remains underspent at the end of the year. The position for the division does not include ICU base bed increase, further work is being done to agree the trajectory of this spend.
- **WCCS** is favourable to plan with underperformance in elective areas.
- The forecast for the division shows an increase in costs, with additional costs for winter pressures and additional costs for phase 3 activity. This includes the additional imaging activity. Due to this the divisional run rate will be overspent by the end of the financial year.
- **IPH** is adverse to plan due to loss of income with offsetting variable costs.
- **R&D** is adverse to plan, the Trust has deferred research income. There is further work to be undertaken with Imperial college to understand the effect for both organisations on the research activity for the rest of the year.
- **Estates** is underspent. The soft FM service is underspent on the budget and is forecasting a £0.8m underspend. Given that this is a new service to the Trust, and there are lily t be changes to the requirements due to Covid-19, there is likely to be some variability in the forecast. The directorate is underspent on utilities and forecasting to continue this underspend.
- **Drugs and Devices** the Trust moves drugs and devices excluded from tariff centrally. These are part of the block contract in this year.
- **Other Activity Growth** – the forecast position includes the ICU bed base expansion and endoscopy recovery whilst these numbers are finalised.
- **Pathology** is underspent year to date, there has been a reduction in BAU pathology costs in line with activity. All costs of Covid testing completed by North West London Pathology are included in the Trust top up

Statement of Financial Position (Balance Sheet)

Imperial College Healthcare NHS Trust

	31-Mar-20	31-Aug-20	Movement YTD
Property plant and equipment	538.2	539.3	1.1
Intangible assets	4.3	8.2	3.9
Total Non-current assets	**542.5**	**547.5**	**5.0**
Inventories	15.3	14.9	(0.4)
Trade and other receivables	125.5	97.7	(27.8)
Cash and cash equivalents	43.9	153.0	109.1
Total current assets	**184.7**	**265.6**	**80.9**
Trade and other payables (<1 year)	(229.6)	(314.9)	(85.3)
Total current liabilities	**(229.6)**	**(314.9)**	**(85.3)**
Non Current Liabilities	(18.1)	(18.3)	(0.2)
Total non current liabilities	**(18.1)**	**(18.3)**	**(0.2)**
Net Assets employed	**479.5**	**480.0**	**0.5**

Public Divided Capital	720.8	722.0	1.2
Revaluation Reserve	2.5	2.5	0.0
Income and expenditure reserve	(243.8)	(244.6)	(0.8)
Total tax payers' and other equity	**479.5**	**480.0**	**0.5**



Non-Current Assets
Non-current assets have increased in line with movements on capital expenditure and depreciation – capital expenditure is a little behind the expected level but forecast to reach planned levels during the year.

Current Assets
Trade receivable balances have reduced by £27.8m in the year, in particular relating to other NHS bodies as the current funding arrangements have stabilised payment patterns and older debts have been settled.

Cash
Cash balances are unusually high (at £153.0m) due to the temporary funding arrangements in place as part of the response to Covid-19. The main drivers of increased cash are the bringing forward of SLA and contract payments from NHS England and Commissioners, and the move to a block payment model. This favourable cash position is expected to unwind during the remainder of the year.

The emerging forecast in relation to the revenue and capital budget for the remainder of the year is likely to result in a cash negative position before year-end unless there are further favourable developments in the post-Covid funding regime. This is a fluid situation and further clarity is expected in the next few weeks, but the cash position – and the potential requirement for mitigating actions – is being monitored closely.

Current Liabilities
Trade payables are £130.3m and have decreased by around £9.4m year to date, as outstanding balances with suppliers are settled. Progress has been made with major suppliers such as NHS Supply Chain but the Trust has ensured that payment levels have been maintained to suppliers of all sizes. Payables overall have increased due to the deferral of SLA & contract income for which cash is received in advance.

Taxpayers' and Other Equity
Public Dividend Capital balances have increased by £1.2m upon receipt of capital funding for Covid-19 & Redevelopment (with further drawdowns to follow, subject to risks outlined in the Capital section of this report). PDC levels are expected to increase significantly during the year driven by further planned and new capital funding, and conversion of the Trust's working capital loan to PDC equity. Retained earnings are currently stable, but are likely to reduce in line with the expected revenue outturn.

Capital – overview

Imperial College Healthcare NHS Trust

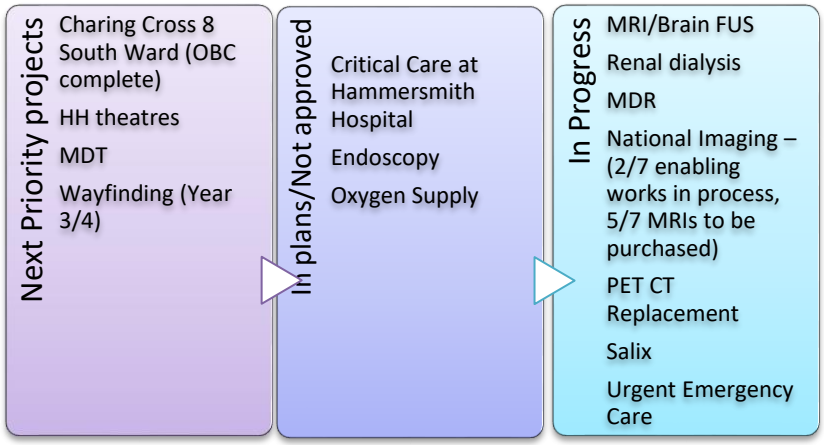
Sources of Funds	£m
Depreciation (NWL sector allocation)	29.4
Public dividend capital - confirmed	14.3
Charitable Funds	1.5
Other funding sources - not confirmed	18.4
Total	**63.6**

Applications	Annual Plan	YTD @ Month 5 Plan £m	YTD @ Month 5 Actual £m	YTD @ Month 5 Var £m	
Backlog Maintenance	16.4	9.4	11.1	1.7	
ICT	7.0	2.5	1.1	-1.4	
Replacement of Med Equip.	5.1	2.3	0.8	-1.5	
Other Capital Projects	25.9	8.0	4.2	-3.7	
Redevelopment	5.0	1.8	1.6	-0.2	
Covid-19	4.2	4.2	3.5	-0.7	
Total	**63.6**	**28.1**	**22.3**	**-5.9**	
		Actual spend as a % of plan		79%	

Additional Covid-19 schemes committed	2.6
Potential further schemes	80.2
Potential further schemes	**82.8**

up to 10% off plan | 10-20% off plan | >20% off plan

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



Summary

The Trust has continued to make good progress on delivering its current £63.6m capital programme. At Month 5 capital spend was £3.9m in-month bringing the year-to-date total spent to £22.3m against a plan of £28.1m (79%). Where schemes are behind, this is largely due to delays caused by Covid-19, but both individual schemes and the overall programme are expected to fully spend during the year.

The level of uncertainty and risk around the capital programme has increased significantly in Month 5 as the system-wide response to the Covid pandemic and re-set gathers pace.

The Trust has not received confirmation from NHS Improvement around funding for Covid-19 related costs (incurred or committed) totalling £6.8m. This represents a risk to the achievement of the CRL target if funding is not forthcoming. The current CRL forecast assumes the £4.2m Covid capital is funded but the £2.6m additional Covid capital is not leading to a CRL breach. The monthly return to NHSE/I mandates that we do not show a CRL breach.

In addition, there are a number of schemes emerging from the North West London STP which address recognised investment needs but for which there is considerable uncertainty around the funding and revenue implications. There are proposed schemes totalling £80.2m being considered by the Trust and the North West London sector. These schemes cover Urgent Emergency Care, Critical Care, Endoscopy and others, and are set out in more detail on the next page of this report.

The Trust needs to manage the risk of progressing with these projects in terms of the extent to which they are backed by additional cash funding. As with Covid-19 projects, funding shortfalls would require the Trust to breach statutory limits or make changes to existing capital projects and priorities.

Appendix 1: NHSI Finance and Use of Resources Score

Imperial College Healthcare NHS Trust

- The 'Single Oversight Framework' scoring system went live on 1st October 2016.
- Providers are assigned a overall 'segment' taking into account scores attained across 5 core themes, with 'Finance and the use of resources' being one of these. Segment 1 means complete autonomy and a segment rating of 4 would lead to special measure being instigated.
- 'Finance and use of resources' theme is made up of the metrics detailed in the table below. Each metric has been assigned an equal weighting. A score of 1 is the 'best' and 4 the 'worst'.
- Scoring a '4' on any metric caps the overall score to at most a '3', triggering a concern.
- The ratings are not being used under the current regime.
- Due to the Trust's low liquidity the trust cannot score higher than a 4. To raise this rating to a 3 would require an improvement of £16m in the Trusts working capital balance.

Area	Finance and use of Resources metric	YTD	Score	Weight	Score 1	Score 2	Score 3	Score 4
Financial Sustainability	Capital Servicing Capacity Rating (times)	2.5	1	20%	>2.5x	1.75 - 2.5X	1.25-1.75x	<1.25x
	Liquidity Rating (days)	(18.7)	4	20%	>0	(7) - 0	(14) - (7)	<(-14)
Financial Efficiency	I&E margin (%)	0.0%	2	20%	>1%	0% - 1%	(1%) - 0%	<(1%)
	Distance from Financial Plan (%) - plan assumes break even	0.0%	2	20%	>0%	(1%) - 0%	(2%)-(1%)	<(2%)
Financial controls	Agency Spend against cap (%) - assumed at previous years cap	(82.0%)	1	20%	<0%	0% - 25%	25% - 50%	>50%
Total Rating			2					

Override if any metric 4 highest achievement is 3	3

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Patient Story	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 30 September 2020	**Item 13, report no. 10**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Author:** Steph Harrison-White, Head of Patient Experience and Improvement Guy Young, Deputy Director - Patient Experience

Summary:

Patient stories were suspended during the first wave of the pandemic COVID-19. The on-going restrictions to public access and contact make the previous format of face to face patient stories more difficult.

This patient story will therefore be shared by a staff member as an example of many families' journeys over the past few months. This is based on a real patient story and direct interactions with our support services teams during the COVID- 19 pandemic.

Mrs A sadly died in our Trust in April 2020, during the peak of the pandemic. Restrictions in place, through the Coronavirus Bill, meant that families were not visiting relatives nor were they be permitted to view deceased relatives.

Mrs A's daughter was struggling to accept it was her mother who had died and it was only when two important items of her property were located, that she could believe it was her mother.

This story will highlight the importance of managing patient property and the changes we are making to this process as a result of this story and the unique challenges the pandemic has raised.

Recommendations:
The Board is asked to note the issues raised.

This report has been discussed at:
Quality Committee – 23 September 2020

Quality impact:
Understanding the experience of patients supports the business of the Board. There is no detrimental impact on quality as a result of this paper.

Financial impact:
The financial impact of this proposal as presented in the paper enclosed:
- Has no financial impact

Risk impact and Board Assurance Framework (BAF) reference:
There are no risks associated with this paper.

Workforce impact (including training and education implications):
There is no workforce impact associate with this paper

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

☐ Yes ☐ No ☒ Not applicable

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

What impact will this have on the wider health economy, patients and the public?
Better understanding of the experience of patients should lead to improvements in the quality of care.

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

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

- To build learning, improvement and innovation into everything we do

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers?

☐ Yes ☒ No

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

- What should senior managers know?
  - Patient property must be collected and stored in accordance with the Trust Policy.
- What (if anything) do you want senior managers to do?
  - To share this report and patient story within their divisions.
- Contact details or email address of lead and/or web links for further information
  - stephanie.harrison-white@nhs.net
- Should senior managers share this information with their own teams? ☒ Yes ☐ No

Imperial College Healthcare NHS Trust

Patient story

1. Executive Summary

1.1. The Board received a patient story review paper in January 2020. It was agreed that the Board valued the use of patient stories, particularly those delivered in person, and agreed that they should continue to receive them. However, the subsequent restrictions related to COVID-19 have prevented the presentation of in-person stories and have also complicated the provision of stories in alternative ways. As a result the Board has not received a patient story since the beginning of the pandemic.

1.2. The Trust is exploring ways to get the patient story programme back on track, particularly in relation to patients communicating directly with the board although it is recognised that a second wave of COVID-19 will complicate this.

1.3. That said, this month a story will be told by a staff member who will describe how seemingly trivial things, such as looking after an old hat, can take on great significance for a grieving family.

1.4. This story is very much a COVID-19 story and it highlights the importance of looking after people's possessions. The lessons learned however apply at all times and in all cases where we are the custodians of patients' belongings.

2. Purpose

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

The perceived benefits of patient stories are:

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

3. Background

3.1. The Patient Story review paper presented at the January Board (2020) summarised our approach to patient stories and highlighted learning and actions arising as a result.

3.2. These approaches included:

- Patients attending the Board in person to tell their story
- Video or audio presentations of patients telling their stories

- Divisional, clinical or patient experience staff telling a story on the patient's behalf
- An executive director, usually the Director of Nursing, telling the story about a patient's experience

3.3. Since the onset of the ongoing COVID-19 pandemic, patient stories have been temporarily suspended due to overriding health and safety priorities and protective measures put in place through government guidance and legislation.

3.4. The Trust remains committed to listening to and learning from our patients and so, during this uncertain period, we will use other ways to capture and share patient stories whilst ensuring we are compliant with national and local infection control measures. The potential second wave of COVID-19 may complicate this, but the aim is to reinstate the regular presentation of stories at the board.

3.5. This month's story will be shared by the patient support team as an example of many families' journeys over the past few months. This is based on a real patient story and direct interactions with our support services teams during the COVID- 19 pandemic.

3.6. This story occurred during the height of the pandemic when all services were acutely affected and many staff had been redeployed. The Coronavirus Bill (2020) had been passed to put additional and special measures in place to respond to COVID-19. This included changes to how we managed those who had died. Mrs A died from COVID-19.

3.7. COVID-19 meant that restrictions were placed on funerals, viewing of the deceased in our mortuaries, registration of deaths and the ability of relatives to be able to come to the hospital to collect death certificates and property. Subsequently, during the height of the pandemic, the management of property of those who had died became very challenging. Under normal circumstances relatives would normally collect patient property or property would be stored in accordance with the Trust Policy. We found a lot of property was not handled in line with policy.

3.8. This story will highlight the importance and significance of appropriately managing patient belongings especially when a person dies

4. Summary/ key points

4.1. Mrs A, an 86 year old woman, sadly died in our Trust in April following a short illness and admission. Mrs A's family were contacted following her death by our patient affairs team. The patient affairs team deal with all bereaved families within the Trust.

4.2. Mrs A's daughter was the main point of contact and her next of kin. Her daughter had also been present when the ambulance was called and had held discussions with the clinical staff when her mother had arrived in hospital.

4.3. Following her mother's death, her daughter struggled to accept that it was indeed was her mother who had died and not someone else. She had several conversations with staff in the patient affairs team. One of our medical examiners also spoke with

her about how we identify deceased people to try and reassure her that it was indeed her mother who had died.

4.4. These conversations provided the daughter with some assurance but she was still reluctant to organise a funeral because she was finding it hard to accept that it was her mother. Because of COVID-19 restrictions she was unable to physically identify her mother in the trust mortuary or at a funeral director.

4.5. Mrs A had had some personal items with her at the time she came to hospital (a distinctive hat and a pair of slippers) but these were not with her in the mortuary or in patient affairs and had not been recorded in the property book on the ward on which she had died. This added to Mrs A's daughter's distress and difficulty in accepting this was her mother.

4.6. The PALS team retraced Mrs A's journey. They found her belongings in a bag, stored in a cupboard in the emergency department. They were able to describe the hat and slippers to Mrs A's daughter over the phone which provided the confirmation that she needed. She said 'now I know my mum has died'. We were subsequently able to reunite Mrs A's belongings with her daughter and the family were able arrange funeral.

5. Conclusion and Next Steps

5.1. Patient property can symbolise a great deal to a family especially at a time of bereavement. When you have lost everything, having a reminder, a treasured memory that represented that person to you (an old battered hat they always wore and a pair of fluffy slippers) can help a family to have a precious connection with their loved one and, in this case, to accept they had died and to begin the grieving process.

5.2. COVID-19 highlighted that our existing Patient Property Policy needs to be reviewed to incorporate these exceptional times of larger numbers of deceased with potentially infectious property and limited family access.

5.3. This review is currently underway. We have already changed the bags in which we store property to enable closer tracking of it. We have also completed a property amnesty in the Trust to collect all lost/unclaimed property and have been able to reunite many families with personal items of loved ones.

5.4. We are using Mrs A's story to share with clinical teams to stress how important it is to deal effectively and carefully with patient's property, particularly during events such as pandemics. We are highlighting the emotional connection with seemingly insignificant items and the difference it can make to families to have these items returned.

Author : Steph Harrison-White
Guy Young
Sept 2020

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Workforce Annual Equality, Diversity and Inclusion Report 2019/2020 (WRES, WDES, Gender Pay Gap)	☒ Approval ☐ Endorsement/Decision ☐ Discussion ☐ Information
Date of Meeting: 30th September 2020	**Item 14, report no. 11**
Responsible Executive Director: Kevin Croft, Divisional Director of People	**Author:** Gemma Glanville Divisional Director of People, Equality Diversity Inclusion Lead

Summary:

1. Background

The Workforce Equality, Diversity and Inclusion Annual Report 2020/21 is to be published on the Trust's website and sets out how we are meeting the Public Sector Equality duties under the Equality Act 2010. This is the second year that in our annual report we have combined our data and plans for the Workforce Race Equality Standard (WRES), the Workforce Disability Equality Standard (WDES) and our Gender Pay Gap Report.

2. Report Overview:

Executive summary (pg. 2) & Our Progress (pg.5-6) – an executive summary provides an overview of the report structure, the key findings of our equality analysis and an overview of our work programmes.

Workforce profile commentary (*pg. 8-9, Appendix 1, pg. 15-17)* - there have been no significant changes in the workforce composition in regards to age since 2010. There has been no significant change in regards to ethnicity in recent years either with the Trust continuing to have a higher percentage of staff employed from Black, Asian and Minority Ethnic (BAME) backgrounds than the local (London) population. The workforce split in regards to gender has also remained unchanged in the last 5 years.

Workforce, EDI work programme overview 20/21 (pg. 9 & Appendix 2, pg. 18-20) Since 2019 the EDI Committee has been chaired by the Chief Executive. In 2020 it has also increased to bi-monthly and the membership expanded to improve the accountability and profile of the work programme. For 2020 the Trust continues to prioritise work on race equality, and expands the focus on disability equality and re-commits to the development of staff networks. Our work programme objectives for 2020/21 are:

- **Objective 1: (measurement for improvement)** To create a divisional and directorate-level diversity dashboard to guide areas for improvement
- **Objective 2: (people practices)** To re-design people management processes, practice and policy to create a fairer and more inclusive place to work
- **Objective 3: (engagement and empowerment)** To continue the growth and empowerment of our staff networks
- **Objective 4: (focused improvement and cultural change)** To deliver the WRES 2 focused improvement on improving the likelihood of BME staff being appointed from shortlisting
- **Objective 5: (education and leadership)** To design and deliver a 3-level workforce race equality education programme
- **Objective 6: (WDES)** to create a flexible work environment where disabled staff are treated equitably, supported and feel safe to disclose where needed.

WRES (pg. 10-11 & Appendix 4, pg. 21-26) We made several improvements in our BAME staff experience scores compared to last year, however we acknowledged that our EDI themed score had not changed over five years and is significantly worse compared to the average. We disciplined less BAME staff compared to white in the last year, this has reduced our likelihood (two year average) from 1.51 to 0.73 The relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants was 1.41 times greater (1.63 last year). This improvement in data is associated with a review of our end to recruitment process and implementation of initiatives which focus on inclusive recruitment practices. We recognise we need to further improve on our people practices, including recruitment (our focused improvement metric for EDI) and people practices impacting on staff experience.

WDES (11 and Appendix 5, pg.27-34) We have made improvements in several key areas in the staff survey, including a significant rise from 48% to 67.8% of staff saying we made adequate adjustments. The engagement scores for both disabled (and non-disabled staff) are above the national averages of 6.6 and 7.1, and both have increased compared to last year. We did not have any disabled staff who were performance managed this year and the relative likelihood of applicants with no disability being appointed from shortlisting compared to applicants with a declared disability is 1.12 times greater (1.08 last year).

Gender pay report (12 and Appendix 6, pg. 35-41) the Trust gender pay gap position for March 2020. To note, due to covid-19 no long service awards were held and the data does not include any first time CEA awards that have been issued – therefore year by year comparisons are not recommended
EDS2 (pg. 12 & Appendix 7, pg. 42-43) – this information was already agreed by the executive in March 2020 and has been published externally, it is included again here for completeness in the annual report.

Quality Committee Feedback
The final report for publication reflects feedback at the committees listed above. Most recently at the Trust Quality Committee, there was a concern identified about the number of staff who experience bullying and harassment and the committee asked what interventions the Trust had put in place to address this. The Trust has expanded the Freedom to Speak up service, revised the active bystander training and will be introducing a new role of BAME ambassadors. The committee that the Board diversity had improved since the official March 2020 data and recommended that this was highlighted in the annual report. This has been added. In addition, there was a challenge for the Trust to focus improve representation at all senior levels in the organisation. It was noted that additional work was required in the 2020/2021 equalities programme. The Quality Committee also made recommendations regarding the report's format and style and therefore the communications directorate have been asked to support making the report more visually in line with our brand and other annual report publications, with photographs and graphics ready for the 31 October 2020 deadline.

Recommendations: The Trust Board are asked to approve the content of report for publication. The Trust are required to publish our WRES and WDES action plans (part of our Workforce EDI Work Programme) on our external website by 31 October 2020.

This report has been discussed at:

- Equality, Diversity and Inclusion Committee (including chair of staff-side and all staff network leads) (22 July & 8 September)
- Workforce Race Equality Standard (WRES) Steering Group (12 & 25 August)
- Workforce Delivery Board (8 September)
- Executive Management Huddle (14 September)
- Trust Quality Committee (23 September)

Quality impact: Equality, diversity and inclusion is now an integral part of CQC inspections because of its association with quality and patient care as well as staff experience. The analysis and actions outlined in this paper enable the Trust to provide evidence under the CQC domain for Well Led.

Financial impact: The report has no financial impact. A request for further resource will follow to executive as a business case.

Risk impact and Board Assurance Framework (BAF) reference: The lack of equality, diversity and inclusion can have a detrimental effect on patient care, recruitment and retention. The actions and work programmes outlined in the report mitigate the risks of these issues have a major impact.

Workforce impact (including training and education implications): The workforce impacts are outlined in the report and a number of the improvement objectives are linked to training and education both to raise awareness of equality issues and support the inclusion and progression of staff with protected characteristics.

Has an Equality Impact Assessment been carried out or have protected groups been considered?
☒ Yes ☐ No ☐ Not applicable Yes, the report is dedicated to the actions to reduce the equality impact.
If yes, are further actions required? ☐ Yes ☒ No

What impact will this have on the wider health economy, patients and the public? Greater equality, diversity and inclusion will enable improved access to services and, with Imperial being a major local employer, is an economic generator for the local population

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

Trust strategic goals supported by this paper:

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

NHS
Imperial College Healthcare
NHS Trust

Workforce Equality, Diversity and Inclusion Annual Report

2019/2020

(Incorporating - Workforce Race Equality Standard, Workforce Disability Equality Standard and Gender Pay Gap Report)

Directorate of People and Organisational Development

Authors: Olayinka Iwu, Mia Oliver, Gemma Glanville, Sebastiano Rossitto

disability confident COMMITTED

Contents

1. Welcome

"We want everyone to feel able to bring their whole selves to their employment with us. We want to enable our people to be open about their individual characteristics and feel safe to do so. We believe that diversity is one of our greatest strengths.

At Imperial College Healthcare NHS Trust 53% of our workforce are from a black asian and minority background. That diversity gives us a unique perspective on the challenges facing the world, and enables us to build bridges across cultures and communities. As a Trust we understand that equality, diversity and inclusion are the cornerstone of the culture which we wish to ensure exists in our Trust. We want all our people to be able to fully participate and achieve their potential and our Trust to be a place where difference is celebrated.

As a Trust we acknowledge the representation of our Board historically has not been as diverse. Since April 2020 we have a new associate non-executive director and we have appointed a new non-executive who will join us in October and both appointments have improved the diversity of our board. We are also supporting the succession planning of non-executives through the NExT Director scheme, a scheme developed to help find and support the next generation of talented people from black, Asian and minority ethnic (BAME) communities to become non-executive directors in the NHS, with a placement starting in October. These appointments continue to show our Trust commitment on diverse boards.

Improving equality, diversity and inclusion culture is a priority for us at Imperial College Healthcare NHS Trust. We want to become an exemplar of best practice across the sector and to see equality, diversity and inclusion placed at the very heart of our workforce."

(To be Signed)

Professor Tim Orchard, Chief Executive Officer

1.1 Use of data and information

Throughout this report, we refer to important equality monitoring information about our workforce. When you join our organisation, for employment, we ask you questions about personal details, including protected characteristics such as your age and sexual orientation. This is known as equality monitoring information. Sometimes people are concerned or confused as to why we ask for this type of information and are not sure why we would need to know.

Any information you provide is held securely and confidentially on our electronic staff record systems. The data when extracted for analysis in reports such as this one, is anonymous. We have to comply with strict rules in managing and using people's personal information. We analyse the anonymised information to identify and respond to any issues affecting groups which share certain protected characteristics, or identify as part of certain groups.

We use data and information in relation to a range of national standards relating to workforce equality that we are required to meet annually as outlined in this report.

1.2 Purpose and Scope

In line with the Equality Act 2010 the Trust is required to publish equality information annually (1 April 2019 - 31 March 2020) to show how it has complied with the public sector equality duty. This annual report focuses on workforce and provides the Trust with valuable insights into our workforce equality performance. It identifies priority areas for improvement. In addition, this report has incorporated information required by the Workforce Race Equality Standard (WRES), Workforce Equality Disability Standard (WDES) that is mandated in the NHS standard contract. It also includes the Gender Pay Gap report.

At the time in which this report was compiled the unprecedented pandemic of the coronavirus (covid-19) impacted the NHS. Therefore there are some references to covid-19 and in particular where it has impacted on data collection.

1.3 About us

Imperial College Healthcare NHS Trust provides acute and specialist health care in North West London for around a million and a half people every year. Formed in 2007, we are one of the largest NHS trusts in the country, with almost 13,000 staff. Our five hospitals – Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and the Western Eye – have a long track record in research and education, influencing clinical practice nationally and worldwide.

2. Executive Summary

The 2019/2020 Workforce Equality, Diversity and Inclusion (EDI) annual report marks the second year of the new format in which the Trust publishes all its equality data at the same time of the year in one report. This report comprises of the Trust updated 2020/2021 Workforce EDI Work programme which sets out our strategic plan which has been co-designed with our EDI committee members. Our Workforce EDI Work Programme is accompanied by a detailed project plan. The six key objectives of the 2020/2021 plan are:

- **Objective 1: (measurement for improvement)** To create a divisional and directorate-level diversity dashboard to guide areas for improvement
- **Objective 2: (people practices)** To re-design people management processes, practice and policy to create a fairer and more inclusive place to work
- **Objective 3: (engagement and empowerment)** To continue the growth and empowerment of our staff networks
- **Objective 4: (focussed improvement and cultural change)** To deliver the WRES 2 focused improvement on improving the likelihood of BME staff being appointed from shortlisting
- **Objective 5: (education and leadership)** To design and deliver a 3-level workforce race equality education programme
- **Objective 6: (WDES)** to create a flexible work environment where disabled staff are treated equitably, supported and feel safe to disclose where needed.

For completeness and statutory reporting, full data is provided in the appendices of the annual report:

Equality profile of our workforce (Appendix 1)
Workforce Equality, Diversity and Inclusion Work Programme 20/21 (Appendix 2)
Workforce Race Equality Standard 19/20 (Appendix 3)
Workforce Disability Equality Standard 19/20 (Appendix 4)
Gender Pay Gap Report 19/20 (Appendix 5)
Equality Delivery System 2 19/20 (Appendix 6)

The WRES and WDES action plans required under the NHS contract are incorporated in the Workforce EDI Work Programme 20/21 and are highlighted.

3. Our approach

The work of Imperial College Healthcare NHS Trust touches almost a million and a half people every year who rely on our care. We make many judgements every day so it's vital that our people reflect the society that we serve and we bring diverse attitudes and opinions to our work.

During the year we have continued to raise awareness of diversity and improve the way we recognise and value difference in our people. We need to continue to promote and embed inclusive behaviours in order to develop an inclusive and collaborative culture.

3.1 Our governance

- The Workforce EDI work programme comprises of six key objectives with a strong focus on race
- Fortnightly we have a WRES Implementation Steering group with a specific focus on race equality actions
- This is overseen by the bi-monthly EDI Committee which is chaired by the Trust Chief Executive Officer. The EDI Committee includes representatives from divisions, staff networks and staff side. It also reviews the work carried out within the Workforce EDI Work Programme.
- The Workforce Delivery Board (formally the People and Organisation Development committee) oversees the EDI Committee on the overall work programme and is accountable for the Trust workforce EDI performance.
- The Trust Board receives reports, presentations and verbal feedback on the Workforce EDI work programme and other statutory reports as well as playing a pivotal role in shaping the strategy and vision for the long term EDI agenda.
- We have executive sponsors for all our networks and three trained WRES experts.
- Externally we have EDI lead representatives on the pan-London EDI network and the North West London EDI network.

3.2 Our progress 19/20

We introduced a reverse mentoring programme for our executive team and are halfway through the implementation. Reverse mentoring launched in July 2019, supported by expert training and support, the programme paired fifteen nurses and midwives from a black Asian and minority ethnic (BAME) background with fifteen Trust executives. All initial meetings between mentors and mentees have taken place.

We plan to analyse the impact of this mentoring programme as part of our Workforce EDI Work Programme for 2020/2021 and listen to participant feedback to understand if this is an intervention that is effective. We will then make informed decisions about expanding and adjusting the programme for future cohorts.

We also introduced the concept of diverse recruitment panels in December 2019 with a pilot training session for interview panel members on fair recruitment and interview processes. Alongside the one day training workshop, participants have access to a webinar and workbook to support them. This training was quickly re-designed to be delivered online due to covid-19. Further work will be carried out to embed this inclusion training in the Trust. The roll out of our new applicant tracking system in phased stages throughout 2020 will give the Trust the ability to better track and monitor the composition of interview panels and design interventions at different recruitment stages.

We also ran two pilot training sessions on unconscious bias in November 2019. The training centred on how unconscious bias can impact on formal and informal people practices within teams. We have started the process of engaging with suppliers to deliver a race training for us and will roll out a comprehensive race education programme in 2020/21 once funding is confirmed.

We continue to have three WRES experts at the Trust who are nationally trained. They take part in a fortnightly WRES steering group and connect with other networks in other organisations to share best practice.

We have made changes to our disciplinary procedures and policy this year, to ensure there is greater oversight of every investigation and hearings, so biases do not influence decision-making. At hearings that may lead to dismissals, we make sure panels have two senior trained managers involved in the decision-making. We have also created a central investigations team with trained investigators to support managers with extensive and complex investigations, so they are rigorous and there are no delays.

In December 2019, we secured £20, 000 funding from a pan-London fund, to review our disciplinary cases and help review the effectiveness of our revised procedures. This project with focus specifically at how to reduce the likelihood of people from a BAME background entering the disciplinary procedure and provide specialist race training for our employee relations teams. We have chosen a supplier to work with and are re-starting this project as the launch was delayed due to covid-19. This will be completed by March 2020.

Following a successful application in February 2019, we are delighted that we have been selected to become part of the NHS Employers, Diversity and Inclusion Partners programme for 2020/21. By becoming a partner organisation, we undertake to work with other NHS Employers, partner organisations and alumni in our region to improve how we measure EDI activities, across the health and social care system. The programme will support the personal development of an executive director and our EDI lead developing them to become EDI ambassadors for our region.

4. Our staff networks

Our networks play a pivotal role in supporting the Trust equality, diversity and inclusion commitments. We now have five established staff networks that play an important role in providing support to staff while identifying and sharing concerns and issues with our leadership teams. Four of our networks have their own staff led elected chair and our women's network is reviewing its membership and arrangements to provide more structure.

All our networks have recently appointment executive sponsors to support networks with board-level visibility. Members of our BAME network recently presented to the board directly. We have a further commitment to develop and strengthen our networks as a key objective in our Workforce EDI Work Programme for 2020/21. Our networks include:

The **BAME nurses and midwives network** is sponsored by director of nursing professor Janice Sigsworth. The network's projects include the reverse mentoring programme, and in 2019 they were invited to present this work to the NHS chief nursing officer's black and minority ethnic strategy advisory group, London region. Network members have also been central in ensuring voices and concerns specific to BAME staff have been addressed during covid-19.

The Trust-wide **BAME network** is working in partnership with the BAME network for nurses and midwives to help the Trust meet its race equality objectives. Professor Julian Redhead, medical director, is the network's executive sponsor.

The **LGBTQ+ network** is working to connect LGBTQ+ staff, reduce health inequalities and improve experience for LGBTQ+ patients and staff. The network is sponsored by professor Frances Bowen, divisional director for medicine and integrated care, and Jeremy Butler, director of transformation. In June 2019, the LGBTQ+ network brought the NHS Rainbow Badge scheme to Imperial, making rainbow NHS badges available to staff who wished to show their support to LGBTQ+ staff and patients.

'I-Can', the network for people with disabilities, is working to raise awareness of disability issues, the government's access to work scheme and the importance of disability data reporting. The network's executive sponsors are Peter Jenkinson, director of corporate governance and Trust secretary, and professor Catherine Urch, divisional director for surgery, cancer and cardiovascular.

The **women's network** is working to help improve career opportunities for women by supporting the promotion and development of leadership skills. The network helped develop national NHS toolkits for parental leave that launched in September 2019. The network's executive sponsors are director of communications Michelle Dixon and interim chief financial officer Jazz Thind.

5. Project search

Project Search is a supported internship programme that gives young adults with a learning disability the opportunity to learn the skills to do a job in a real working environment. The programmes main aim is to give a transition from school/college is to help young people with special educational needs and disabilities to gain the

experience and skills needed to get paid employment. The Trust offers 12 interns a placement in which they undertake 10 to 12 week placements around our hospitals.

Since the programme started in 2016, more than 40 young people have taken part in the programme. Eleven former interns are employed by the Trust, with two more employed by Imperial College London. Other interns have gone on to find paid employment in areas such as coffee shops, care homes, restaurants, clothes shops. The Trust regularly achieves 92% success rate for interns securing sustainable paid employment, all of which support the Trust in its ambition to be an anchor institution within our local community.

The programme is run in partnership with local organisations Brent Council, the College of North West London, Action on Disability, Kaleidoscope Sabre and Project Search. This year Project Search was recognised at Hammersmith and Fulham Brilliant Business Awards. The annual awards, now in its eighth year, recognises business success across Hammersmith and Fulham. Imperial was nominated for and won 'highly commended' in the Most Inclusive Employer Award for Project Search.

6. Our wellbeing

There has been an increased focus on wellbeing during 2019-20 and in particular on mental health. In recognition of the increasing need to support staff who may be in mental health distress at work, the Trust developed an in house programme for managers on Mental Health Awareness which started in January 2019.

Facilitated by our in house counselling team and Occupational Health this training supports managers to appreciate the importance of workplace mental health and aims to equip managers with the basic skills and knowledge essential in supporting a member of staff who may be in mental health distress in the workplace. We recognize that managers are in a unique position to promote good mental health at work and support staff who experience poor mental health temporarily, intermittently or have enduring mental health issues

7. Our accreditations

The Trust is a Disability Confident Committed employer and we have committed to the following:

- Ensure our recruitment process is inclusive and accessible
- Communicate and promote vacancies
- Offer an interview to disabled people
- Anticipate and provide reasonable adjustments as required
- Support any existing employee who acquires a disability or long-term health conditions, enabling them to stay in work
- At least one activity that will make a difference for disabled people (Project Search)

8. Commentary: Our Workforce Profile 19/20

The first appendix of this report provides data and analysis for the overall Trust workforce in the same standard format as previous years, reviewing age, ethnicity, disability and gender composition. This varies little from year to year.

There have been no significant changes in the workforce composition in regards to age since 2010/11. The workforce split in regards to gender has also remained unchanged in the last five years. The Trust continue to seek to increase its attractiveness to people of all age groups through a range of measures including the widespread provision of work experience opportunities and apprenticeships and the promotion of flexible working.

There has been no significant change in the workforce composition regarding ethnicity either. The trust continue to have a higher percentage of staff employed from BAME backgrounds than the London population.

We know as a trust that when we examine our ethnicity data in more detail that the majority of people in bands 7 and above are from white backgrounds. The trust has committed to a Workforce Equality, Diversity, and Inclusion Work Programme with a strong focus on race equality in order to improve the representation of BAME staff at Band 7 and above. The aim is that these interventions will support the trust to deliver change over time will have an impact on that progression and ethnic distribution within bands that is more representative of our overall workforce. This is aligned with the NHS England Aspirational Goals, Model Employer, Increasing black and minority ethnic representation at senior levels.

The workforce profile section also reviews the trust recorded information for disability, sexual orientation and religion. This is presented in two sets of data, one data set shows the recorded information for all staff, and one data set shows the recorded data set for only new staff.

This split of this workforce profile data demonstrates that for 2019/2020 we have seen an increase in the overall recorded data for all staff of 3% for all areas (sexual orientation, religion and disability). However, for data collection has declined for new staff only in the disability category. For new starters whose applications are recorded via the Trac recruitment system this data is accurate, however, there are staff groups where this facility is not yet available resulting in an incomplete overall capture of data on new starters.

We are rolling out a new applicant tracking system for recruitment and this will have enhanced management information and reporting functionality and help improve accuracy of demographic information and the recording. This new applicant tracking system is to be rolled out starting in the autumn of 2020.

We only report on protected characteristics that we currently hold data for on our electronic staff record system. We are aware we do not currently capture data for gender reassignment or marriage/civil partnership and are unable to report on this for the purpose of this report.

8. 1 Commentary: Workforce Equality, Diversity and Inclusion Work Programme 20/21

The Workforce EDI work programme is aligned to support delivery of trust's overarching strategy and vision of better health for life and the trust people strategy.

It builds upon the programme approved by the trust board in 2019 and provides a more structured and specific action plan, with short and medium term progress tracked. This programme is to address inequity identified across the largest groups of protected characteristics that is - race, gender and disability equality as well as addressing inclusion across all protected characteristics.

- Objective 1: **(measurement for improvement)** To create a divisional and directorate-level diversity dashboard to guide areas for improvement
- Objective 2: **(people practices)** To re-design people management processes, practice and policy to create a fairer and more inclusive place to work
- Objective 3: **(engagement and empowerment)** To continue the growth and empowerment of our staff networks
- Objective 4: **(focussed improvement and culture change)** To deliver the WRES 2 focused improvement on improving the likelihood of BME staff being appointed from shortlisting
- Objective 5: **(education and leadership)** To design and deliver a 3-level workforce race equality education programme
- Objective 6: **(WDES)** to create a flexible work environment where disabled staff are treated equitably, supported and feel safe to disclose where needed.

The Workforce EDI Work Programme has been revised and updated in order to support the continued delivery of work for 2020/2021 across all protected characteristics (Appendix 2). Presenting and reviewing the programme alongside WRES, WDES and Gender Pay data allows us to ensure it is fit for purpose and actions are relevant. The trust under the governance of the EDI Committee will continue to review equality data separately for attendance on our leadership and development programmes, our performance management ratings, and our employee relations cases throughout the year to allow actions and interventions to be more agile and responsive.

The programme of work aims to ensure that the trust can continue to drive culture change and understanding around race. This year we have also expanded on the deliverables for WDES actions following feedback and learning from the staff network 'I-Can'.

8.2 Commentary: Race Equality 19/20

We know that the trust continues to have a higher percentage of staff employed from BAME backgrounds than the London population therefore race equality will continue to be a key focus for the trust. In addition, the WRES data demonstrates that the majority of people in Band 7 above are from white backgrounds.

The full analysis and data for WRES Report is presented in Appendix 3. In summary for 2020, for the non- clinical workforce, the percentage of BME workforce increased

in Band 2, 4-6, 7,8a, 8b, 8d and 9. Increases have also been seen in both spot salary and VSM compared to 18/19. The percentage of the BME workforce has decreased for Band 8c compared to 18/19.

In 2020 for the clinical workforce, the percentage of BME workforce increased in Bands 4-6, 7, 8d and 9. Doctor (training grade) also showed an increase compared to 18/19. The percentage of the BME workforce has decreased for Bands 2, 8c, consultant and doctors (career grade). Spot salary also decreased compared to 18/19.

The WRES data shows that the relative likelihood of white applicants being appointed from shortlisting compared to applicants from BAME groups is roughly 1.41 times greater. This is a decrease from last year when the relative likelihood was 1.63 times greater. This improvement in our figure has been achieved by a number of key actions such as reviewing our end to end recruitment process and use of our standarised recruitment packs.

In addition to the WRES staff survey metrics we also looked at staff survey data by theme. Within the EDI theme we made improvement compared to last year, however we also noted that we had not made significant improvement over last five years and are below national average. Our executive recognised that our scoring in the EDI theme that was top of four significantly worse compared to the sector and EDI remains a key priority for us this year.

We commissioned an additional thematic analysis of staff survey comments this year, which helped us identify that the main comments relating to equality and diversity were regarding fair career progression; discrimination from staff/public; and adequate workplace adjustments. Our Workforce EDI Work Programme (Appendix 2) contains objectives to assist with improving the experience for our staff in this area.

Our disciplinary data (WRES 3) shows that in year we disciplined 20 individuals, with 9 from a BAME background. The relative likelihood of BAME staff being disciplined compared to white staff is **1.27** this is a decrease from last year when the relative likelihood was **1.51**.

We recognise that there is still significant work to be done including embedding diverse recruitment panels and the delivery of a suite of training with more specific cultural awareness on race equality following training pilots and learning from other trusts in 2019. Some of these large programmes of work will not take effect until the later part of 2020 and we recognise that to deliver sustained change, these interventions will need to be piloted, implemented, embedded and then monitored and evaluated for progress.

We are prioritising the WRES 2 metric - the relative likelihood of staff being appointed from shortlisting across all posts - for a focused quality improvement. This focus aligns with our trust EDS2 priority of improving fair NHS recruitment and selection processes lead to a more representative workforce at all levels.

We will continue with reverse mentoring, introduce diverse recruitment panels, design a suite of educational material, review our disciplinary procedures and provide specialist training to our employee relations teams. These actions will specifically focus on race and are detailed in the Workforce, EDI Work Programme (Appendix 2).

8.3 Commentary: Disability Equality 19/20

The reporting period of 2019/20 is the second year of reporting on WDES for NHS organisations. Only 2% of our staff have declared a disability on ESR. We already know from our annual review of workforce composition data that recording for disability status on ESR is 71% (Table 1). However, we also know that the staff survey disability declaration data at 10%, is considerably higher than ESR. The roll out of the applicant tracking system will improve data quality capture. In addition the actions outlined in the Workforce EDI work programme will create a flexible work environment where disabled staff are treated equitably, supported and feel safe to disclose where needed.

Following the actions set out in the WDES action plan 2018/19, our disability network was established in late 2019 and mental health first aider training has been introduced for managers. There has also been increased communications sharing positive stories about our disabled staff. Project search - a supported internship programme that gives young adults with a learning disability opportunities in work has continued.

We recognise more action is required to support staff with disabilities. We have committed to the following areas of work as part of the Workforce EDI Work Programme (Appendix 2)

- creation of reasonable adjustments passports & training for managers
- training for managers and individuals on accessibility e.g. MS teams
- develop better relationship with Access to Work
- working towards submission for Disability Level 2 standard

The complete WDES Report is in Appendix 4.

8.4 Commentary: Gender Equality 19/20

For 2020, we will publish the Gender Pay Gap report in September 2020 using the snapshot data of 31 March 2020. This is published in advance of the government deadline as we did last year.

In summary, for 2020, when considering ordinary pay, the mean hourly rate of male employees is **16.8%** higher than that of female employees. When median calculations are used, the hourly rate of male employees' ordinary pay is **11.4%** higher than that of female employees. There have been decreases in both mean (1.3% decrease) and median gender pay gaps (2.3% decrease), which are both the lowest figures recorded since the introduction of gender pay gap reporting

For 2020, relevant bonus pay only includes Clinical Excellence Awards (CEA) for Consultants. Long service awards have been included for the last 2 reporting periods, however this scheme was paused due to covid-19, so there is currently no relevant data to capture for this time period. It is also noted that the CEA awards bonus data does not include any newly issued awards in 2019/2020, due to a pause in this process due to covid-19. This will impact on our data and comparative analysis drawn.

Considering overall the Trust population, **3.9%** of male employees received a bonus payment compared to **1.0%** of female employees.

There is a **29.1%** mean pay gap between male and female consultants' CEA pay and a **43.8%** median pay gap. There has been a 0.1% increases in the mean gender pay gap for bonus pay (CEA only), compared to previous year's data. There has been a 1% decrease in the median gender pay gap for bonus pay (CEA only, compared to previous year's data.

The complete Gender Pay Gap Report is in Appendix 5.

9. Equality Delivery System 2 (EDS2)

The original Equality Delivery System (EDS) was designed to help NHS organisations review and improve performance in equality approaches to support people with characteristics protected by the Equality Act 2010. EDS was launched in 2011 and refreshed as the EDS version 2 in 2015. EDS2 is a systematic way of meeting the public sector equality duty under the Equality Act 2010

EDS2 is a mandatory assessment tool that requires NHS organisations to analyse and grade their equality performance across a number of indicators. It is a generic tool designed for NHS commissioners and providers alike. At the heart of EDS2 are 18 outcomes, against which NHS organisations assess and grade themselves. They are grouped under four goals:
1) Better health outcomes
2) Improved patient access and experience
3) A representative and supported workforce
4) Inclusive leadership.

The goals and outcomes relate to the issues that matter to people using services, the public and the workforce. Engagement and understanding of people's perceptions of services enables us to understand what our priorities should be. EDS2 is a transparent and standard measure of progress, so people can see what we are doing and how well we are doing it. It also enables us to benchmark our performance.

Following a review of our evidence base, engagement with key stakeholders and approval from the EDI committee, between January- March 2020, new self-assessment grading's were agreed under the EDS2 framework. (Appendix 6). These were published on our external website in March 2020.

The five EDS2 priorities agreed for the Trust for the period of 2020-2023 are:

- Ensuring that BAME patients who do not speak English are able to access appropriate support so that they have a clear understanding of their treatments and options
- Transitions from one service to another for people on care pathways, are made smoothly with everyone informed- Protected characteristic being considered
- Patients and carers report positive experiences of the NHS, were they are listened to and respected and their privacy and dignity is prioritised
- Fair NHS recruitment and selection processes lead to a more representative workforce at all levels

- When at work, staff are free from abuse, harassment, bullying and violence from any source

The final two priorities which are workforce specific priorities are strongly aligned with the goals in our Workforce EDI Work programme 2020/2021.

10. Conclusion:

We are committed to making significant progress and in the coming year we will be working to progress in the following areas

- A renewed focus on workforce race equality, this is a major priority or the Trust
- We will be actively implementing our reasonable adjustments passport and reviewing our existing polices for staff with disabilities and ensuring the adjustment are made in a timely way to support our people to get the most from their employment with the Trust.
- We will continue to review incidents of discrimination and abuse in our people processes relating to protected characteristics and develop responsive, innovative approaches to reduce incidents.
- We will continue to empower our five staff networks to ensure they remain a critical friend to the Trust.
- We will continue to work with our North West and pan-London sector searching and learning from best practices approaches to workforce inclusion.

As a Trust we looking forward to reporting next year to ensuring an open and transparent dialogue with our staff, patient and stakeholder to deliver a truly inclusive workforce at all levels.

Appendices

Appendix 1: Equality profile of our workforce 19/20

Appendix 2: Workforce Equality, Diversity and Inclusion Work Programme 20/21

Appendix 3: Workforce Race Equality Standard 19/20

Appendix 4: Workforce Disability Equality Standard 19/20

Appendix 5: Gender Pay Gap Report 19/20

Appendix 6: Equality Delivery System 2

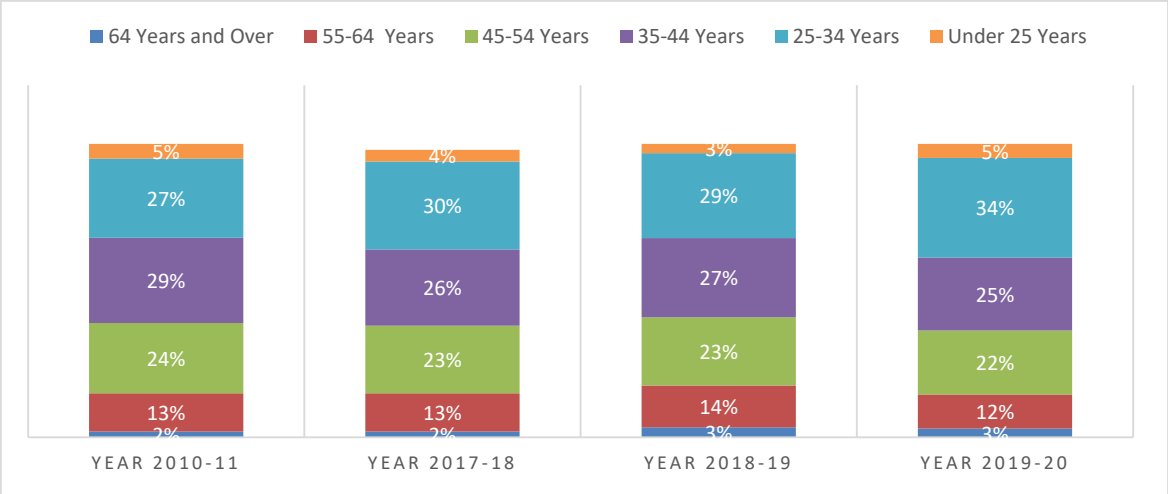
Appendix 7: Glossary of Terms

Appendix 1: Equality profile of our workforce 19/20

Below shows the percentage of staff employed by the Trust by age, disability, ethnicity and gender as at 31 March 2020.

Workforce composition: Age

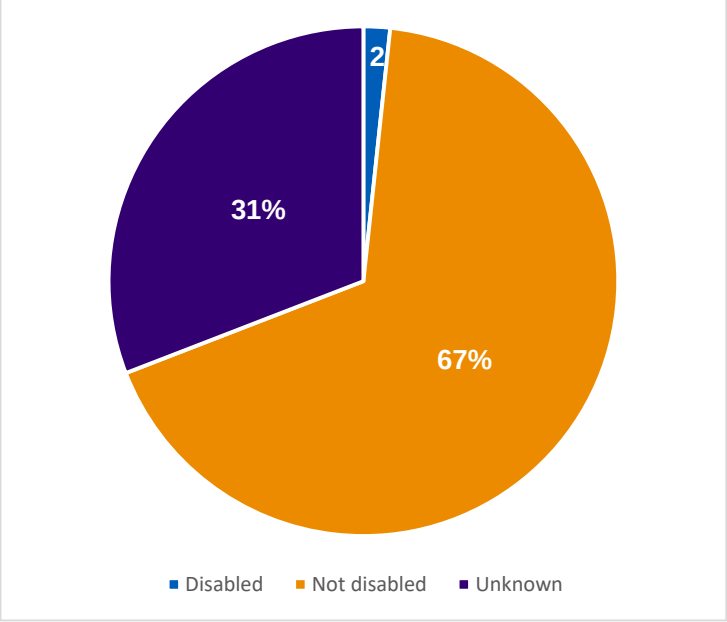
Diagram 1: Trust age composition over three years



There has been no significant change in the workforce composition in regards to age since 2010/11. While there has been a small increase in the number of our people aged 25-34, the majority of our staff are aged 25-54.

Workforce composition: Disability

Diagram 2: Disability disclosure



Workforce composition: Disability, Sexual orientation and Religion

Table 1: Disability, sexual orientation and religion records for all staff (including new staff)

Protected Characteristic	Recorded demographic for all staff in 2013/14	Recorded demographic for all staff in 2014/15	Recorded demographic for all staff in 2015/16	Recorded demographic for all staff in 2016/17	Recorded demographic for all staff in 2017/18	Recorded demographic for all staff in 2018/19	Recorded demographic for all staff in 2019/20
Disability	40%	47%	56%	62%	66%	68%	71%
Sexual Orientation	46%	54%	60%	67%	70%	70%	73%
Religion	46%	54%	60%	67%	70%	70%	73%

Table 1 above illustrates that the Trust has seen a 3% percentage increase in all areas for the information recorded on workforce disability, sexual orientation and religion since last year.

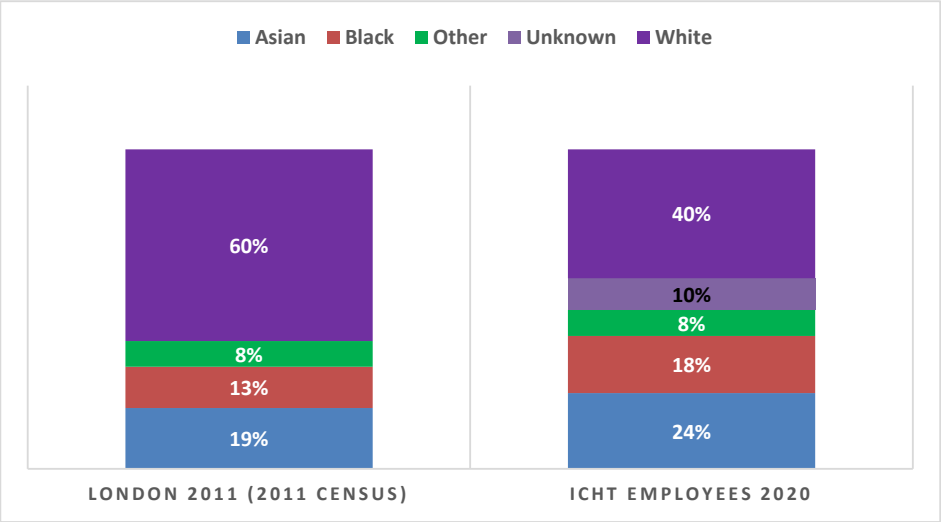
Table 2 below illustrates that the Trust has seen a decline in the information recorded for new staff in 2019/2020 for disability since last year, whilst sexual orientation and religion data collection remains consistent.

Table 2: Disability, sexual orientation and religion records for new staff

Protected Characteristic	Recorded demographic for NEW staff in 2013/14	Recorded demographic for NEW staff in 2014/15	Recorded demographic for NEW staff in 2015/16	Recorded demographic for NEW staff in 2016/17	Recorded demographic for NEW staff in 2017/18	Recorded demographic for NEW staff in 2018/19	Recorded demographic for NEW staff in 2019/20
Disability	95%	89%	92%	87%	88%	82%	78%
Sexual Orientation	96%	88%	90%	88%	88%	82%	82%
Religion	96%	88%	90%	88%	88%	82%	82%

Workforce composition: Ethnicity

The percentage of staff employed by the Trust from BAME backgrounds is higher than the local population. White people make up 40% of the workforce compared to 60% of the London population.

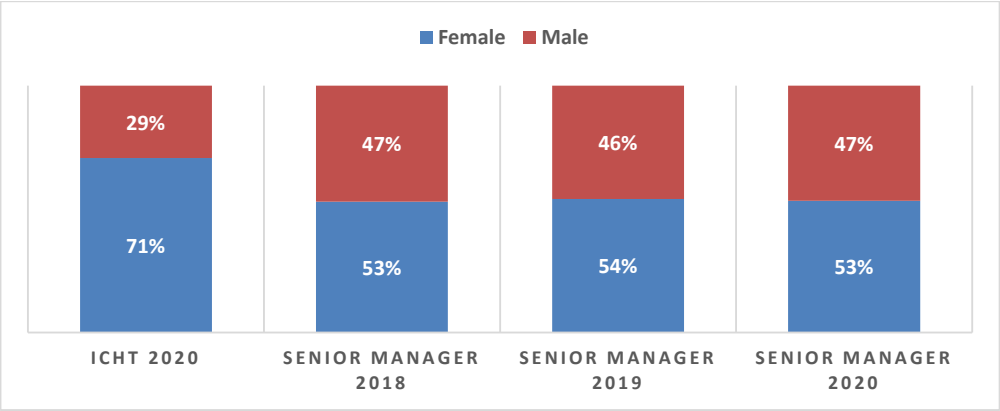


We know when we examine our ethnicity data in more detail the majority of people in roles Band 7 and above are from white backgrounds. Our Workforce EDI Work Programme has actions designed to address this imbalance.

Workforce Composition: Gender

The workforce split in regards to gender has remained unchanged in the last 5 years: 71% of our staff are female and 29% are male. The high proportion of female workers is typical of NHS organisations, reflecting the gender split of people entering healthcare professions.

The proportion of male employees increased in senior roles. The figures below shows that 47% of people employed as senior managers are men and 53% are women. This is a small increase in female representation of 1% compared to last year.



Appendix 2: Workforce Equality, Diversity and Inclusion Work Programme 20/21

Overview

The Workforce EDI work programme focuses on the delivery of six objectives which address WRES, WDES, Gender and LGBTQ+. Objectives 4 and Objective 5 focusing directly on improvement in our WRES performance and Objective 6 focuses directly on improvement in our WDES performance.

Objectives	WRES	WDES	Gender	LGBTQ+
Objective 1: (**measurement for improvement**) To create a divisional and directorate-level diversity dashboard to guide areas for improvement				
Objective 2: (**people practices**) To re-design people management processes, practice and policy to create a fairer and more inclusive place to work				
Objective 3: (**engagement and empowerment**) To continue the growth and empowerment of our staff networks				
Objective 4: (**focused improvement and culture change**) To deliver the WRES 2 focused improvement on improving the likelihood of BME staff being appointed from shortlisting				
Objective 5: (**education and leadership**) To design and deliver a 3-level workforce race equality education programme				
Objective 6: (WDES) to create a flexible work environment where disabled staff are treated equitably, supported and feel safe to disclose where needed				

Further Detail

Objective 1: **(measurement for improvement)** To create a divisional and directorate-level diversity dashboard to guide areas for improvement

Areas of work: - jointly lead by Head of Workforce Equality, Diversity and Inclusion, & People Planning Lead, by March 2021

- Produce targets for 2020 on model employer aspirational senior level workforce
- design, develop and implement different diversity dashboards for directorate, Trust level
- Improve the quality of our protected characteristics data

Objective 2: **(people practices)** To re-design people management processes, practice and policy to create a fairer and more inclusive place to work

We want to continue to ensure that the decisions and practices of our managers are underpinned by proactive policies.

Areas of work: -jointly lead by Head of Workforce Equality, Diversity and Inclusion, both Deputy Directors of People and Organsiational Development, by March 2021

- A review of our disciplinary processes including specialist training for our employee relations teams and managers
- Roll out of diverse recruitment panels
- review and improve guidance for managers on staff transitioning gender
- review and improve guidance on supporting staff with disabilities
- review of application processes for MBA/MSC & leadership programmes

Objective 3: **(engagement and empowerment)** To continue the growth and empowerment of our staff networks

The Trust has five employee network who are continuing to evolve. We value the critical friend as the networks provide a safe space for employees to have real, honest conversations on work-life experience, highlighting both areas for improvement and areas of success. Our networks are essential to enhancing our culture of inclusivity and ensuring people feel able to bring their whole selves to work.

Areas of work: lead by Head of Workforce Equality, Diversity and Inclusion, by March 2021

- support the LGBTQ+ network to establish their terms of reference
- support the women's network to establish their membership and terms of reference and permanent chair
- continue to provide support our BAME networks on the delivery of our BAME ambassadors programme
- support the growth of the disability network (I-Can)
- identify and appoint a Non-Executive Director for EDI
- identify CPD funding to support network events

Objective 4: **(focused improvement and culture change)** To deliver the WRES 2 focused improvement on improving the likelihood of BME staff being appointed from shortlisting

We have identified this as our EDI area for focused improvement in 2020/2021. Focused improvements are a subset of metrics that have a direct impact on the trust strategic goals and will be the focus of improvement for the year.

Areas of work: - lead by Deputy Director People and Organisational Development, by March 2021

- Roll out of diverse recruitment panels (including training, monitoring and data reviews)

Objective 5: (**education and leadership**) To design and deliver a 3-level workforce race equality education programme

We want to increase our cultural and EDI knowledge within our organisation to increase the inclusion of different identity groups.

Areas of work: -lead by Head of Workforce Equality, Diversity and Inclusion, by March 2021

- to design and deliver a 3-level workforce race equality programme
- creating training materials for Equality Impact Assessments

Objective 6: **(WDES Action Plan)** to create a flexible work environment where disabled staff are treated equitably, supported and feel safe to disclose where needed

Areas of work: lead by Divisional Director for People, EDI Lead, by March 2021

- creation of reasonable adjustments passports & training for managers
- training for managers and individuals on accessibility e.g. MS teams
- develop better relationship with Access to Work
- working towards submission for Disability Level 2 standard

Metric	Objective		

Appendix 3: Workforce Race Equality Standard 19/20

Introduction

There are nine WRES indicators. Four of the indicators focus on workforce data, four are data from the national NHS Staff Survey, and one indicator focuses upon BME representation on boards

Why is WRES important?

The WRES is a tool for identifying a number of key gaps, referred to as Indicators, between White and BME staff experience of the workplace - gaps which we want to close. Closing these gaps will achieve tangible progress in tackling discrimination, promoting a positive culture and valuing all staff for their contributions to their work.

This will in turn positively impact on patients, as it is known that a decrease in discrimination against BME staff is associated with higher levels of patient satisfaction. An environment that values and supports the entirety of its diverse workforce will result in high quality patient care and improved health outcomes for all.

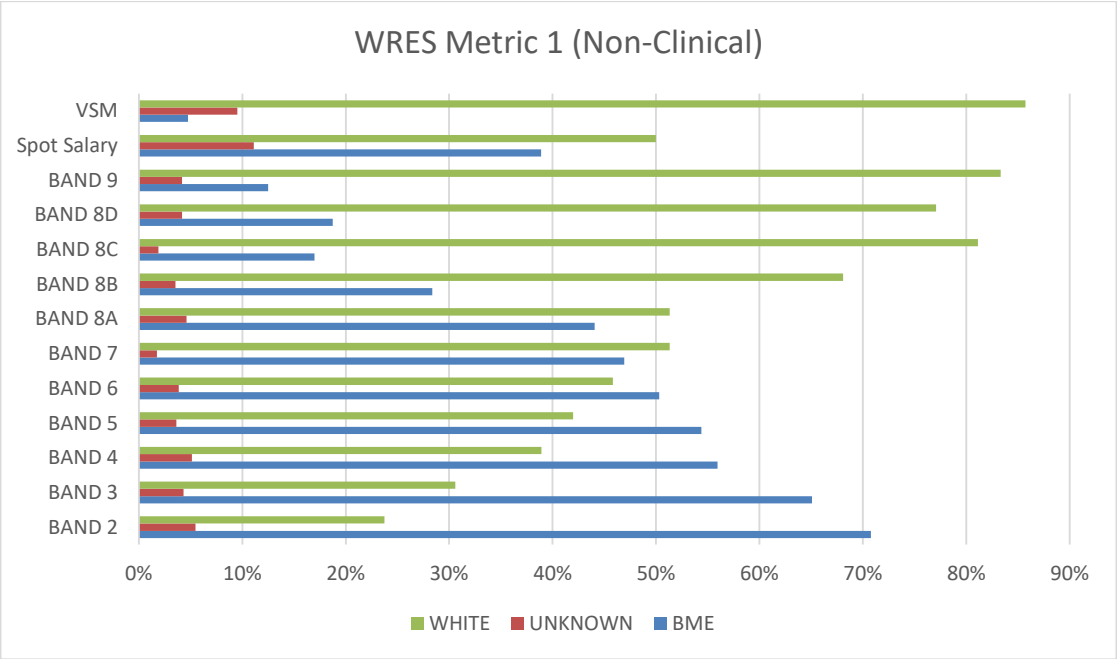
The WRES indicators:

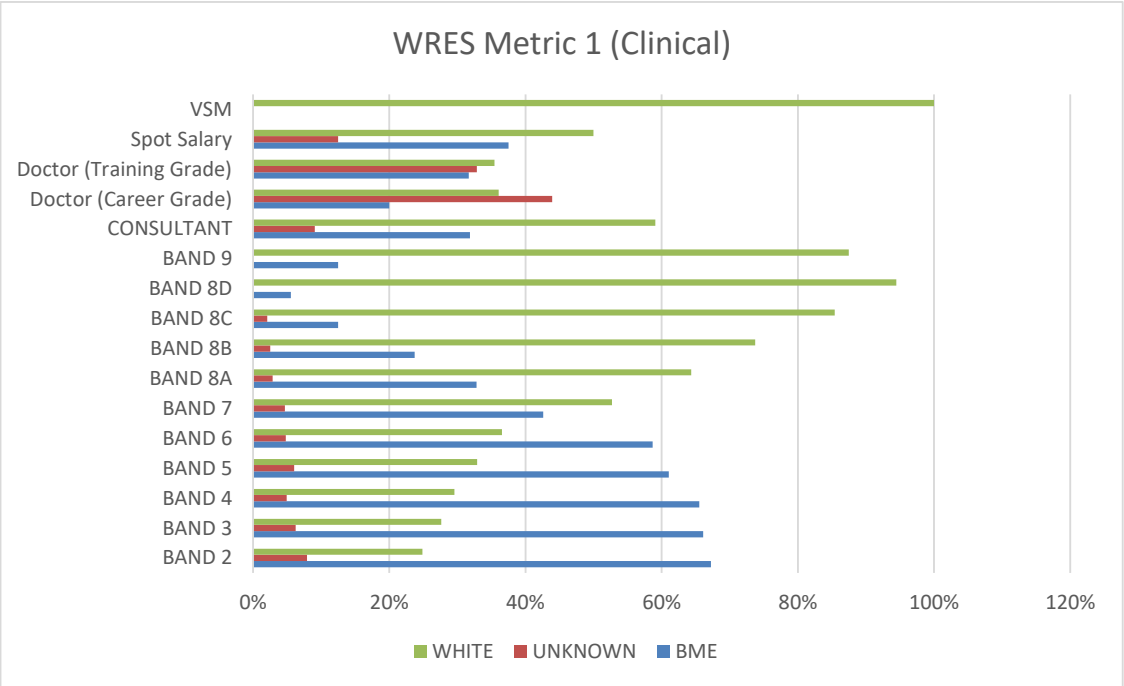
- Four of the indicators focus on workforce data (1 -4)
- Four are based on data from the national NHS Staff Survey questions (5-8)
- One indicator focuses upon black and minority ethnic (BME) representation on boards (9)

Indicator 1

Percentage of staff in each of the AFC Band 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by clinical and non-clinical staff

Graph 1 Ethnicity profile – percentage of staff in each of the AfC bands, medical grades and Very Senior Managers (VSM) – March 2020





For the non- clinical workforce, the percentage of BME workforce increased in Band 2, Band 4- 6, Band 7,8a, 8b, 8d and 9. Increase have also been seen in both spot salary and VSM compared to 18/19. The percentage of the BME workforce has decreased for Band 8c compared to 18/19.

For the clinical workforce, the percentage of BME workforce increased in Bands 4, -6, 7, 8d and 9. Doctor (training grade) also showed an increase compared to 18/19. The percentage of the BME workforce has decrease for Bands 2, 8c, Consultant and Doctors (career grade). Spot salary decreased by 1% for BME staff compared to 18/19.

Indicator 2

Examines the relative likelihood of staff being appointed from shortlisting across all posts

Descriptor	Number of shortlisted applicants	Number appointed	Likelihood of being appointed from shortlisting
White	5751	1152	0.20
BME	11272	1606	0.14
Unknown	502	56	0.11

The relative likelihood of white applicants being appointed from shortlisting compared to applicants from BME groups is roughly **1.41 times greater;** this is a decrease from last year when the relative likelihood was 1.63 time greater. This improvement in data is associated with a review of our end to recruitment process and implementation of initiatives which focus on inclusive recruitment practices. We will continue to work to embed the actions outlined in Appendix 2.

Note: Data is drawn from Trac the Trust recruitment system. The total headcount varies year to year, depending on when posts were advertised, when people applied and when the appointment was made.

Indicator 3

Examines the relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

Note: This indicator is based on data from a two year rolling average of the current year (19/20) and the previous year (18/19).

We report on the formal disciplinary hearings, excluding doctors who are managed in accordance with Maintaining High Professional Standards. In 18/19 the Trust held 59 disciplinary hearings, in 19/20 the Trust held 20 disciplinary hearings. The figures below are the average across two years.

Descriptor	Number of staff in workforce	Annual average of number of formal disciplinary meeting	Likelihood of entering formal disciplinary meetings
White	5142	14	0.27

BAME	6338	22	0.35
Unknown	1267	2	0.08

The relative likelihood of BME staff being disciplined compared to white staff is **1.27;** this is a decrease from last year when the relative likelihood was **1.51**.

Indicator 4

Examines the relative likelihood of staff accessing non-mandatory training and CPD

Note: The data collected only includes leadership development and skills training held by the learning and development team. This is the only data which is centrally available for equality analysis. It does not include locally delivered training, professional and clinical education or any externally provided training which is a significant proportion of the training offered and accessed.

Therefore results are not seen as a reliable indication of all training activity available within the Trust. However, all Trusts are expected to maintain internal consistency of approach from year to year, so that changes in uptake trends can be compared over time.

Descriptor	Number of staff in workforce	Staff accessing non mandatory training (data held by leadership team)	Likelihood of accessing non mandatory training
White	5142	1480	0.28
BME	6338	3453	0.54
Unknown	1267	225	0.17

Indicators 5-8

Indicators 5 -8 relate to the 2019/2020 national staff survey results, comparing the responses of BME and white staff. The 2018/2019 national staff survey was based on a sample of 522 staff who responded to the survey. The 2019/2020 results are based on a sample of 5,659 staff who responded to the survey, which represents a 52% completion rate across the Trust. This is a much larger sample than the previous year's staff survey (based on 522 respondents), which should be taken into account when comparing the previous year's metrics.

The wording of these four indicator is taken directly from the national NHS Staff Survey. For indicators 5, and 8 a low score is better. For indicator 7, a high score is better.

Indicator 5

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last

There has been a decrease for both our white and BME staff experiencing harassment, bullying or abuse from patients, relatives or the public since 2018/2019. Our BME staff experience is slight better than our white staff.

	White	BME
2019	35.5%	31.8%
2018	37.6%	37.3%

Indicator 6

Examines the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

For indicator 6 a lower score is better. There has been a decrease for both our white and BME staff experiencing harassment, bullying or abuse from staff since 2018. Our BME staff experience is now slightly better than our BME staff experience.

	White	BME
2019	29.6%	28.1%
2018	32.7%	34%

Indicator 7

Examines the percentage of staff believing that the trust provides equal opportunities for career progression or promotion

For indicator 7 a higher score is better. Both our white and BME staff experience has improved since 2018. Our BME staff experience has increased significantly since 2018, whereas white is a very small increase. Our BME staff experience is worse than our white staff experience.

	White	BME
2019	85.5%	70.8%

2018	82.7%	65.2%

Indicator 8

Examines percentage staff personally experience discrimination at work from manage/team leader or other colleague

For indicator 8 a lower score is better. Our white staff experience has got slightly worse since 2018 by 0.5% and our BME staff experience has improved. Our BME staff experience remains slightly worse than our white staff experience.

	White	BME
2019	7.0%	9.0%
2018	7.5%	14.7%

Indicator 9

Examines percentage difference between the organisations board voting membership and its overall workforce (Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce)

	White	BME	Unknown
Overall Trust Workforce	40.3%	49.8%	10.0%
Overall Trust Board Members	80.0%	0.0%	20.0%
Voting Board Members	80.0%	0.0%	20.0%
Executive Board Members	75.0%	0.0%	25.0%
Non – Executive Board Members	83.3%	0.0%	16.7%

Note: only voting members of the board should be included when considering the indicator

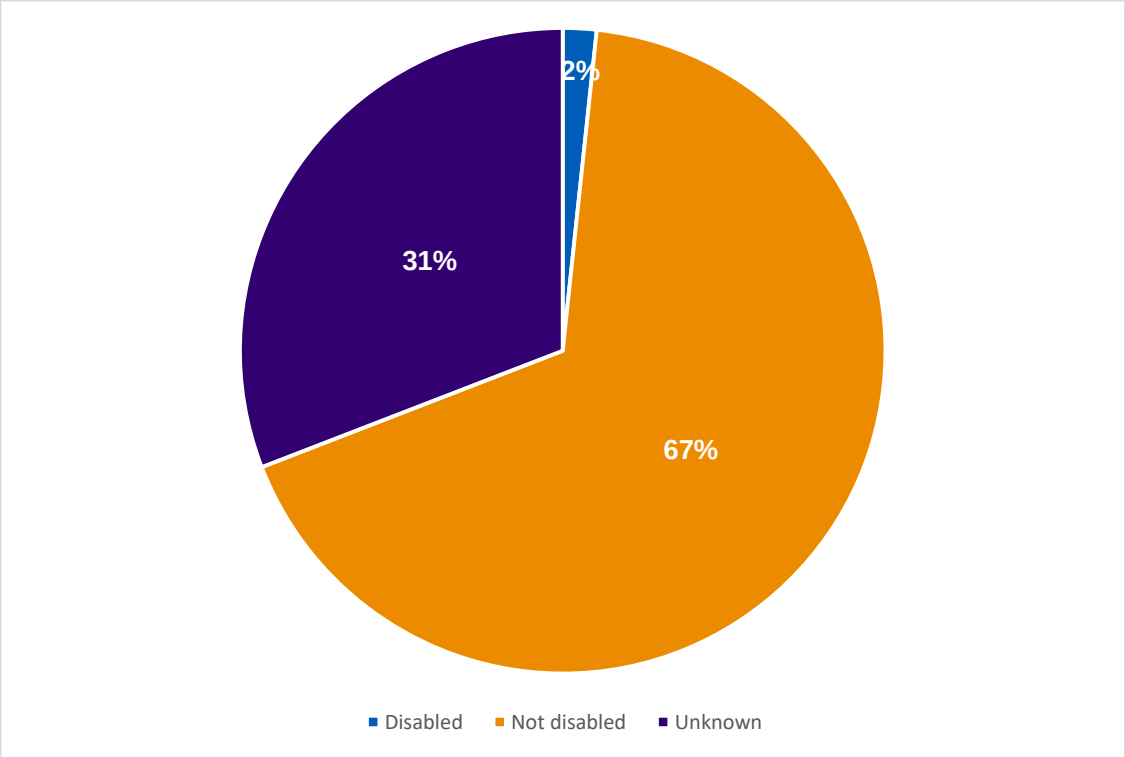
Appendix 4: Workforce Disability Equality Standard Report 19/20

1. Background

The Workforce Disability Equality Standard is a set of ten specific metrics to enable NHS organisations to compare the career and workplace experiences of disabled and non-disabled staff. This is the second year of reporting WDES. WDES is an important step for the NHS and is a clear commitment in support of the government's aims of increasing the number of disabled people in employment.

2. Organisational Breakdown by Disability

Below details the overall breakdown of employees who have and have not declared a disability, and where this is unknown, based on data from electronic staff record. This data excludes bank and locum staff, students on placement and staff employed by contractors. The data is correct as of 31 March 2020.

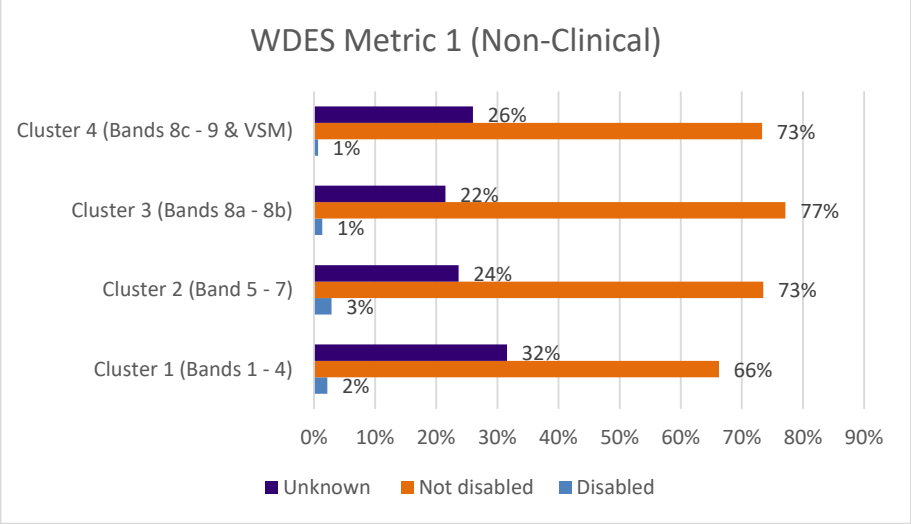


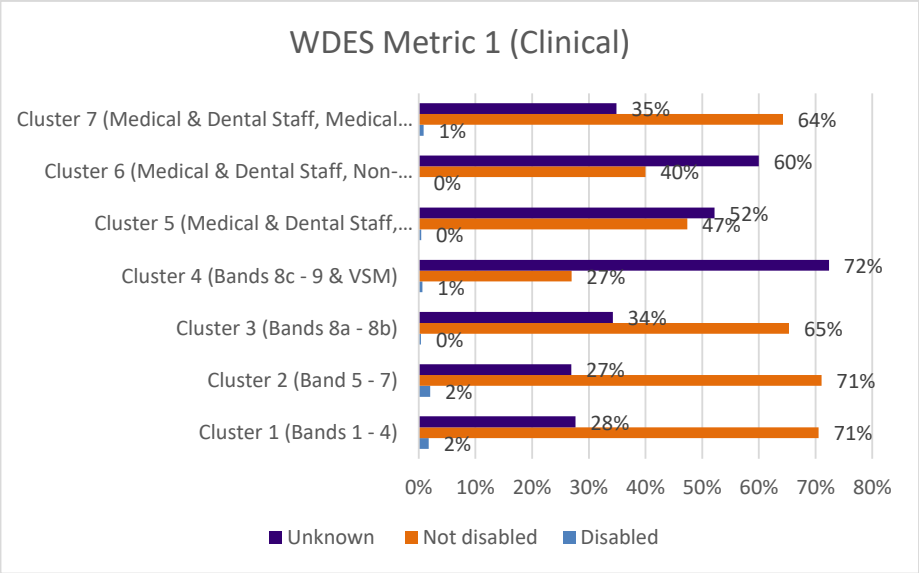
Out of 12756 employees, 2% (215 people) have disclosed a disability and 67% (8603) are recorded not to have a disability. Out of the 31% (3938 people) where the disability status is unknown, 94% are coded as 'unspecified', 1% prefer not to answer and 5% are listed as 'not declared'.

Compared to 2018/2019, the proportion of people reporting a disability has increased from 1% to 2% and the proportion of people reporting to have no disability has increased by 2%. The unknown group has reduced by 3%, and the breakdown of codes within the unknown group has remained the same.

3. WDES Metrics

Metric 1: Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce (based on data from electronic staff record)





While the proportion of disabled staff is low across all clusters, it is evident within both clinical and non-clinical areas; there are higher proportions of disabled staff in clusters 1 and 2, which represent the junior levels of the organisation. This is a similar pattern to the previous year.

Metric 2: Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.

Data from this metric is taken from the online Trac recruitment system. Candidates are given a yes or no option regarding whether they wish to declare a disability. This includes medical and non-medical staff. We run a guaranteed interview scheme for

disabled candidates who meet essential criteria. The total headcount varies year to year, depending on when posts were advertised, when people applied and when the appointment was made.

The likelihood of applicants with no disability being appointed from shortlisting is 15% and the likelihood from those declaring a disability is 13%.

The relative likelihood of applicants with no disability being appointed from shortlisting compared to applicants with a declared disability is **1.12 times greater**. This is a small increase from the previous year's figure of 1.08. However, the relative likelihood is still very close to 1, which means that disabled and non-disabled candidates are near equally likely to be shortlisted.

	Disability	No disability	Unknown
Shortlisted	652	17560	502
Appointed	88	2660	49
Likelihood	0.13	0.15	0.10

Metric 3: Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure

This metric relates to capability on the grounds of performance (not ill-health). Staff whose disability is unknown are excluded for the purpose of this metric. The data is based on a 2 year rolling average of the annual average number of formal performance meetings recorded on the employee relations tracker system for non-medical staff.

The relative likelihood of staff with a disability entering the formal capability procedure, compared to staff without a disability was **2.5 times greater**, which has decreased from the figure of 5.92 times greater from the previous year.

It is important to note the very small amount of performance management cases that this metric is based on, as outlined below, which means the likelihood of any of the below groups entering the formal capability process is less than 0.00. There were no new performance cases for staff with a disability in 2019/20.

Year	Disability	No disability	Unknown
2018/19	1	9	3
2019/20	0	7	5

Metrics 4 to 9: National Staff Survey Responses

Metrics 4 to 9 relate to the 2019/2020 national staff survey results, comparing the responses of disabled and non-disabled staff. This is based on a sample of 5,659 staff who responded to the survey, which represents a 52% completion rate across the Trust. This is a much larger sample than the previous year's staff survey (based on 522 respondents), which should be taken into account when comparing the previous year's metrics.

Within the demographic section of the staff survey, respondents are asked if they have any physical, mental health conditions, disabilities or illness that have lasted or are expected to last for 12 months or more. There are only 'yes' or 'no' responses to this question. 5,457 staff chose to answer this question, Out of these staff, 10.3% answered yes to having a disability. This is lower than the national average of other acute Trusts (17.8% of staff saying yes to this question).

However, the staff survey disability declaration percentage of 10.3% is considerably higher than electronic staff record, where 2% of staff are recorded to have a disability. This is a similar contrast to last year.

It is noted that staff survey questions are not compulsory, so the number of responses fluctuates per question. Where a metric is marked with a *, this means a higher percentage indicates a positive response. For all other metrics, a lower percentage is positive.

Metric 4

1. Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months

Year	Disabled respondents	Non-disabled respondents
2019	39.5%	33.0%
2018	49.1%	36.4%

2. Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months

Year	Disabled respondents	Non-disabled respondents
2019	21.1%	13.2%
2018	42.9%	15.5%

3. Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months

Year	Disabled respondents	Non-disabled respondents
2019	34.7%	22.5%
2018	35.1%	24.8%

4. Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months*

Year	Disabled respondents	Non-disabled respondents
2019	47.8%	46.7%
2018	28.9%	43.9%

Metric 5

Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion*

Year	Disabled respondents	Non-disabled respondents
2019	72.1%	78.8%
2018	65.7%	75.5%

Metric 6

Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Year	Disabled respondents	Non-disabled respondents
2019	33.0%	23.2%
2018	45.7%	23.5%

Metric 7

Percentage of staff saying that they are satisfied with the extent to which their organisation values their work*

Year	Disabled respondents	Non-disabled respondents
2019	40.1%	51.9%
2018	23.2%	46.3%

The below table summarises these metrics outlining the differences between disabled and non-disabled staff responses. Bearing in mind the significant differences in sample size from the previous year, it should be noted that while disabled respondents still report higher instances of negative experiences in the workplace overall, the differences between disabled and non-disabled respondents have reduced in all

metrics, with the exception of staff reporting harassment and bullying from other colleagues which has increased by 2%.

Summary of Metrics 4-7 by percentage of responses to staff survey questions 2019

Staff survey question	% of disabled respondents	% of non-disabled respondents	difference
% of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months	39.5%	33.0%	6.5%
% of staff experiencing harassment, bullying or abuse from managers in the last 12 months	21.1%	13.2%	7.9%
% of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	34.7%	22.5%	12.2%
% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months*	47.8%	46.7%	1.1%
% of staff believing that the Trust provides equal opportunities for career progression or promotion*	72.1%	78.8%	-6.7%
% of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	33.0%	23.2%	9.8%
% of staff saying that they are satisfied with the extent to which their organisation values their work*	40.1%	51.9%	-11.8%

Metric 8: Adequate Adjustments

This metric relates to the percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. This is only answered by those who have declared a disability within the staff survey. **329** staff who declared a disability chose to answer this question. **67.8%** of staff said employer has made adequate adjustments, compared to a national average of 73.3%. This is a

significant improvement from 2018, where only 48.4% responded positively to this question.

Metric 9a: Engagement Score

The staff engagement score is calculated based on nine questions in the staff survey relating to motivation, ability to contribute to improvements and recommendation of the organisation as a place to work/receive treatment. The engagement score for disabled staff is **6.7** compared to **7.3** for staff who have not stated to have a disability. The engagement scores for both disabled and non-disabled staff are above the national averages of 6.6 and 7.1, and both have increased compared to last year.

This metric has changed from the previous year as there is no longer the requirement to compare the NHS Staff Survey staff engagement score between Disabled staff and the overall workforce.

Metric 9b: Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)

The questions refers to action specifically related to disabled staff, rather than all staff engagement exercises The Trust answered 'no' to Metric 9b in 2019 and set a number of actions as part of the WDES action plan to improve performance. This year we answered yes due to:

- Establishing the Trust disability network
- Holding coffee mornings with contact and training with Microsoft teams
- Commissioning and offering mental health first aider training
- A communications campaign to share positive stories of disabled staff across the Trust

Metric 10: Board Representation Metric

This metric looks at the percentage difference between the organisation's board voting membership and its organisation's overall workforce, disaggregated by voting membership of the board and by executive membership of the board. The below data is based on board membership as of 31 March 2020 and disability declaration data from the electronic staff record. No members of the board have declared a disability.

	Disabled	Not disabled	Unknown
Total Board members - % by Disability	0%	50%	50%
Voting Board Member - % by Disability	0%	50%	50%
Non-Voting Board Member - % by Disability	0%	0%	0%
Executive Board Member - % by Disability	0%	0%	100%
Non-Executive Board Member - % by Disability	0%	83%	17%
Overall workforce - % by Disability	2%	67%	31%
Difference (Total Board - Overall workforce)	-2%	-17%	19%
Difference (Voting membership - Overall Workforce)	-2%	-17%	19%

Difference (Executive membership - Overall Workforce)	-2%	-67%	69%

Appendix 5: Gender Pay Gap Report 19/20

Summary

In line with gender pay gap reporting requirements, this report provides the six mandatory calculations, with additional analysis and commentary:

1. Proportion of males and females in each pay quartile
2. Mean gender pay gap for ordinary pay
3. Median gender pay gap for ordinary pay
4. Proportion of males and females receiving a bonus payment
5. Mean gender pay gap for bonus pay
6. Median gender pay gap for bonus pay

There are a higher proportion of male employees in the upper pay quartile of the Trust compared to proportions of male and female employees in the lower quartiles.

When considering ordinary pay, the mean hourly rate of male employees is **16.8%** higher than that of female employees. When median calculations are used, the hourly rate of male employees' ordinary pay is **11.4%** higher than that of female employees. There have been decreases in both mean and median gender pay gaps, which are both the lowest figures recorded since the introduction of gender pay gap reporting.

Considering overall the Trust population, **3.9%** of male employees received a bonus payment compared to **1.0%** of female employees. Relevant bonus pay relates to Clinical Excellence Awards (CEA) for Consultants only for this year's calculations.

There is a **29.1%** mean pay gap between male and female consultants' CEA pay and a **43.8%** median pay gap. There has been a 0.1% increases in the mean gender pay gap for bonus pay (CEA only), compared to previous year's data. There has been a 1% decrease in the median gender pay gap for bonus pay (CEA only), compared to previous year's data.

Gender Pay Action plan

Refer to Workforce, EDI Work Programme (Appendix 2).

Background

This report is published in line with gender pay gap reporting requirements for organisations with more than 250 staff. All calculations relate to the pay period in which the snapshot day falls, which is 31 March 2020. This report is in line with the Equality Act 2010 regulations. 11,8831, employees' were categorised as "relevant employees"2 for the purposes of the gender pay calculations. Please see definitions at end for further details.

[1] Excluding the Trust unpaid honorary consultants and junior Doctors
[2] Relevant employee refers to those employee who are paid by the Trust and does not included the Trust's Honorary consultants

A gender pay gap is the difference between the average earnings of men and women across an organisation, expressed relative to men's earnings.

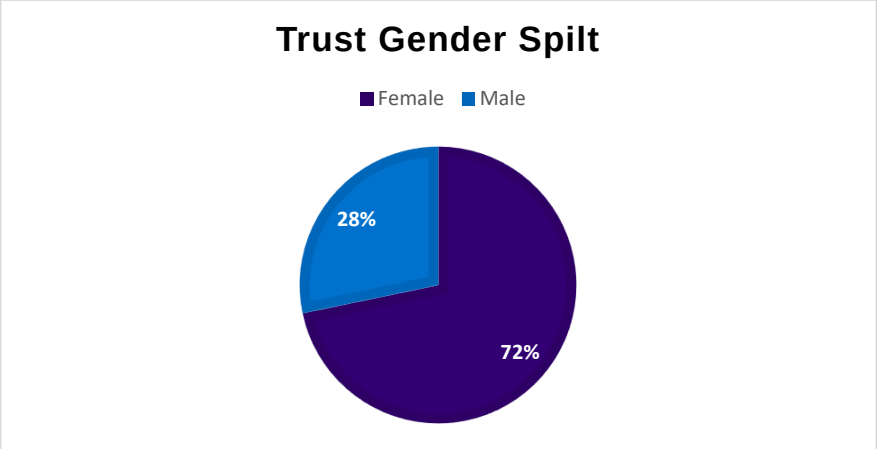
The mean pay gap is the difference between the pay of all male and all female employees when added up separately and divided respectively by the total number of males, and the total number of females in the workforce.

The median pay gap is the difference between the pay of the middle male and the middle female, when all male employees and then all female employees are listed from the highest to the lowest paid.

The gender pay gap is different to equal pay for equal value work. The Trust operates within a national pay structure and job evaluation system for staff on agenda for change terms and conditions and those on medical and dental terms and conditions.

Trust Gender Mix

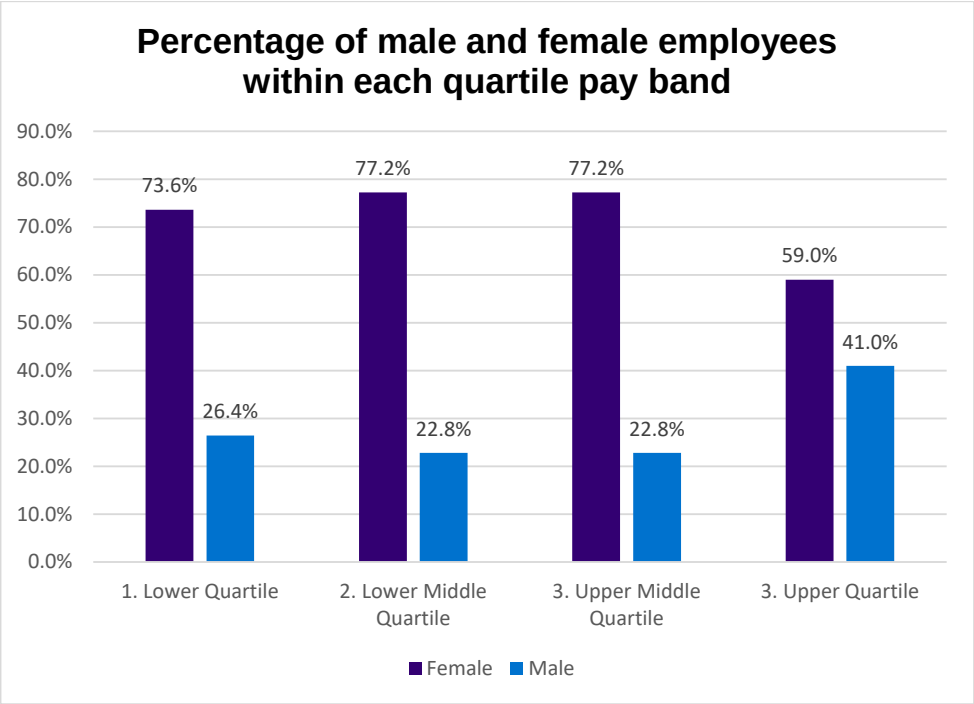
Overall, 72% (8,523) of Trust employees are female, while 28% (3,360) are male. These percentages relate to the 11,8833 staff included for the purposes of this calculation.



Quartile pay band gender representation

The data below ranks our full-pay employees from lowest to highest paid, divides this into four equal parts (quartiles) to establish the percentage of men and women in each quartile. Quartile 1 contains the lowest pay groups, while Quartile 4 contains the highest pay groups.

[3] 11,883 refers to those employees who are paid by the Trust and does not included the Trusts Honorary consultants and Honorary junior Doctors



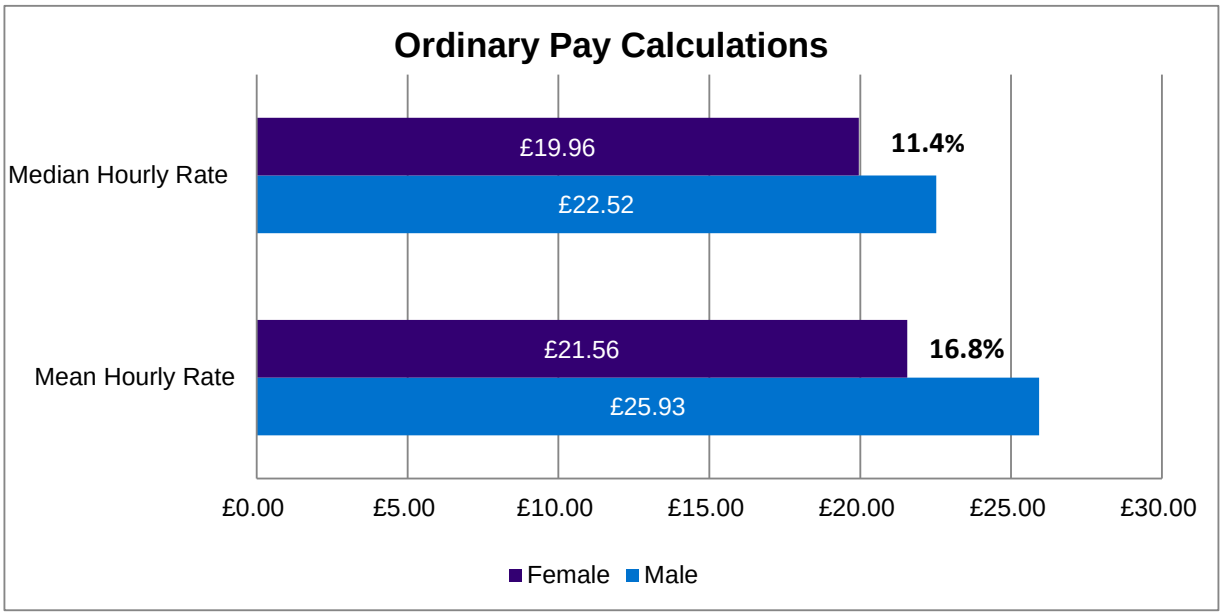
There is a higher proportion of women than men in Quartile 2 and Quartile 3 compared to overall Trust population proportions. The Trust has a higher proportion of male employees in the upper pay quartile of the Trust compared to proportions of male and female employees in the lower quartiles, which partly explains the gender gap in ordinary pay.

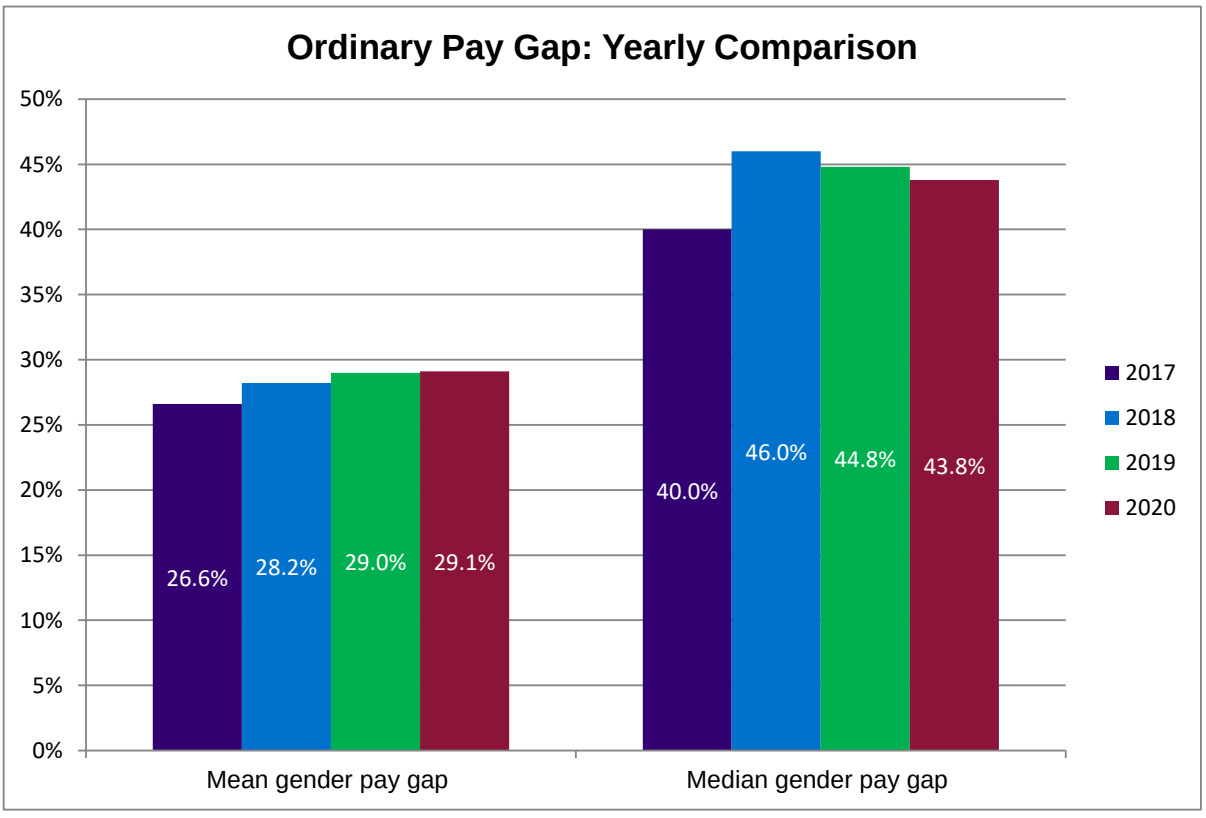
The proportions of male and female employees in each quartile are very similar to the previous year's figures:
Quartile 1: The proportion of female employees has increased by 0.1%
Quartile 2: The proportion of female employees has increased by 1.3%
Quartile 3: The proportion of female employees has increased by 0.5%
Quartile 4: The proportion of female employees has decreased by 0.4%

Ordinary Pay

This section establishes the mean and median differences in hourly rates of ordinary pay between male and female employees.

During the defined pay period that includes the snapshot date of 31 March 2019, the mean hourly rate of male employees was **16.8%** higher than that of female employees and the median hourly rate of male employees was **11.4%** higher than that of female employees. Both pay gaps have decreased since last year, and are the lowest figures reported by the Trust, compared to all previous years, as outlined below.


Ordinary Pay Calculations
Median Hourly Rate
£19.96
£22.52
11.4%
Mean Hourly Rate
£21.56
£25.93
16.8%
£0.00
£5.00
£10.00
£15.00
£20.00
£25.00
£30.00
Female
Male


Ordinary Pay Gap: Yearly Comparison
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
26.6%
28.2%
29.0%
29.1%
40.0%
46.0%
44.8%
43.8%
Mean gender pay gap
Median gender pay gap
2017
2018
2019
2020

39

Bonus Pay

Guidance was issued by NHS Employers in February 2019 to ensure consistency amongst Trusts regarding what should be included within bonus pay gap calculations. Following this guidance, Clinical Excellence Awards (CEA) and Long Service Awards (LSA) were identified as the relevant bonus payments made within the 12-month period ending on the snapshot date for the previous two years. However, due to covid-19, the long service award ceremony was delayed, and there is no relevant data to capture for long service award payments. Therefore, this year's bonus section will only focus on existing CEAs.

Overall calculations

When considering the overall Trust gender populations, **3.9%** of male employees receive a bonus payment, while **1.0%** of female employees do. Therefore**, 2.9%** more men receive bonus payments compared to women across the Trust. Only specific groups of employees are eligible for CEA and LSA payments. Proportions for both men and women have decreased compared to last year.

Clinical Excellence Awards (CEAs)

The CEA scheme is intended to recognise and reward those Consultants who contribute most towards the delivery of safe and high quality care to patients and to the continuous improvement of NHS services. Eligible consultants are those in substantive posts with more than one year's Trust service at the time of the application.

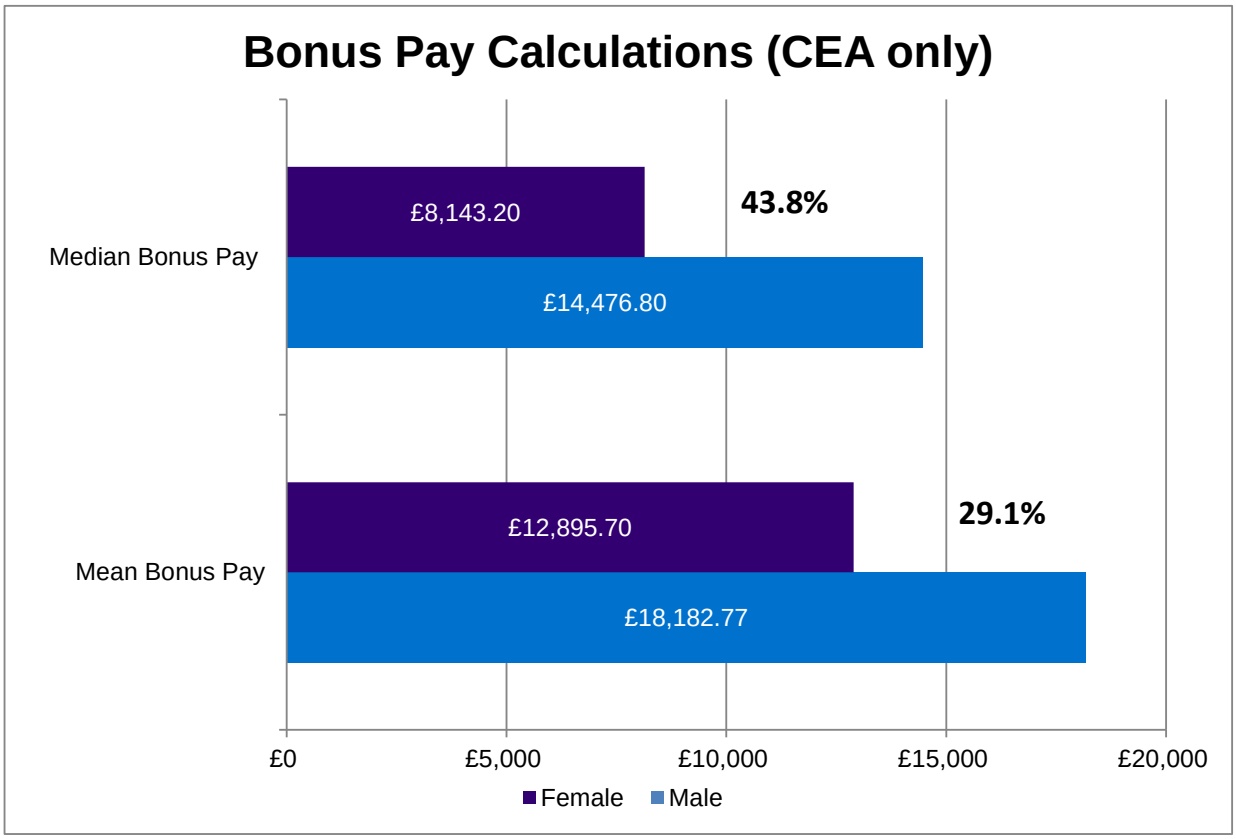
For the purpose of the bonus pay gap calculations, all CEA payments made to relevant employees in the 12 months to the snapshot date are included. This includes local awards, which are awarded by the Trust and national awards which are awarded by the Department of Health and Social Care paid via the Trust payroll.

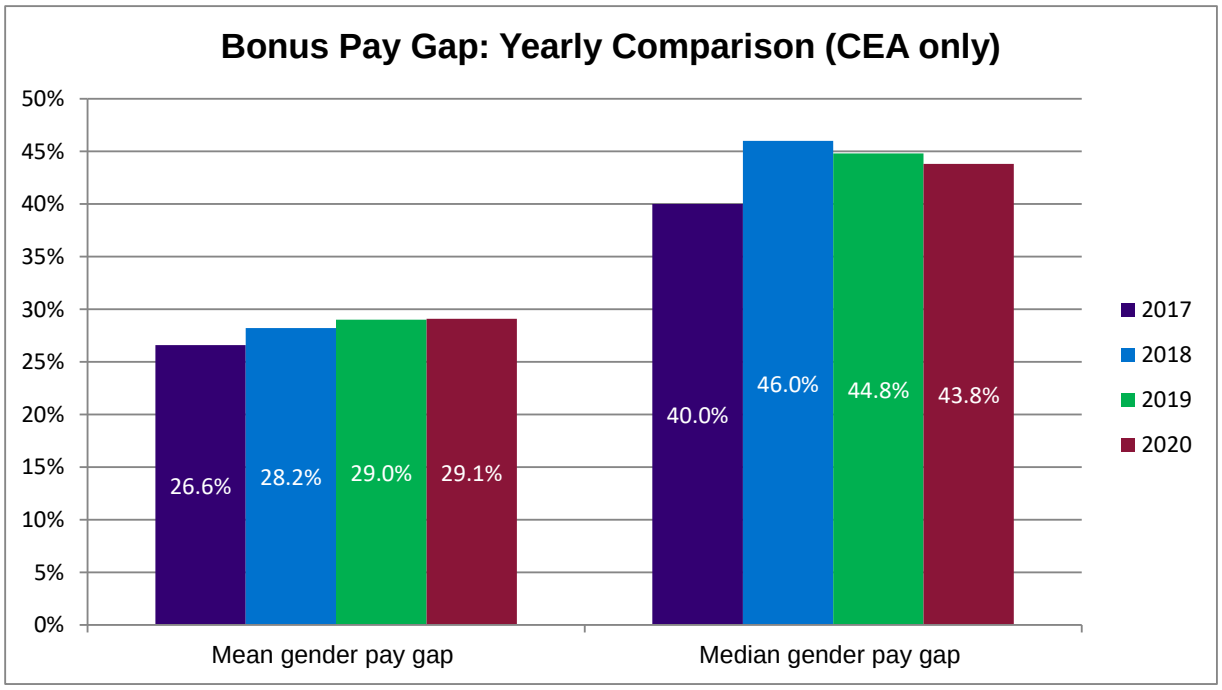
Due to covid-19, the Trust's award round for 2019/20 was delayed and suspended indefinitely while discussions take place between Trusts, NHS Employers and the British Medical Association regarding ongoing arrangements for CEAs during the pandemic. As such, this data does not include any first time CEA awards that have been issued.

It is also noted that changes to the local CEA process and previous analysis on those who have achieved a local CEA for the first time in 2018/19 suggest positive changes in addressing the bonus pay gap for future years

The diagram below demonstrates that there is a **29.0%** mean pay gap between male and female consultants' CEA pay. When looking at the median difference, this is higher, with male consultants receiving **44.8%** more bonus pay than female consultants.

The below yearly comparison demonstrates a very similar picture to the previous year.


Bonus Pay Calculations (CEA only)
Median Bonus Pay
£8,143.20
43.8%
£14,476.80
Mean Bonus Pay
£12,895.70
29.1%
£18,182.77
£0
£5,000
£10,000
£15,000
£20,000
Female
Male


Bonus Pay Gap: Yearly Comparison (CEA only)
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
26.6%
28.2%
29.0%
29.1%
40.0%
46.0%
44.8%
43.8%
Mean gender pay gap
Median gender pay gap
2017
2018
2019
2020

41

Definitions

Gender pay gap: The difference between the average earnings of men and women, expressed relative to men's earnings. This is a broad measure of the difference in the average earnings of men and women, regardless of the nature of their work.

Equal pay: A legal requirement that within an organisation, male and female staff members who are engaged in equal or similar work or work of equal value must receive equal pay and other workplace benefits. This definition is included for clarification purposes as this report relates to the gender pay gap, and not equal pay.

Ordinary pay: Basic pay, paid leave, including annual, sick, maternity, paternity, adoption or parental leave (except where an employee is paid less than usual or nothing because of being on leave), high cost area and other allowances, shift premium pay, and pay for piecework. This would include on call framework and banding supplement in Doctor's pay, for example.

Bonus pay: 'Bonus pay' is defined as any remuneration that is in the form of money, vouchers, securities or options and relates to profit sharing, productivity, performance, incentive or commission. For the purposes of this report, the relevant bonus pay relates to Consultant Clinical Excellence Awards (CEA) and Long Service awards, in line with guidance from NHS Employers. While under this guidance, monetary vouchers awarded as part of the 'Make a Difference' staff recognition scheme could also be included. However, due to data quality issues for 2018/19, this has been excluded, with a view to review this for future years.

Inclusion Criteria: A wider definition of who counts as an employee is used for gender pay gap reporting. This means staff who are employed under a contract of employment, a contract of apprenticeship or a contract personally to do work. This includes those under Agenda for Change terms and conditions, medical staff, very senior managers and Trust bank workers. Agency workers and people employed by another employer to provide services to the Trust e.g. Sodexo staff, are excluded from the Trust's calculations, but counted directly by the agency/employer. Apprentices at the Trust are employed by an apprentice training agency, therefore the contract of apprenticeship is with the agency. Doctors under honorary contracts are also excluded from calculations, but counted by their academic institution. Self-employed workers and contractors of the Trust are also excluded as it is not reasonably practicable to obtain the data to include within the calculations. This is in line with Regulation 2(3) of the Gender Pay Gap Information Regulations 2017.

Appendix 6: Equality Delivery System 2

Scoring Criteria

Each outcome is graded based on how well people from the nine protected characteristic groups fare compared with people overall. The below table outlines the scoring criteria. In response to the question, how well do people from protected groups fare compared with people overall, the Trust have scored as follows:

Grade	Criteria
Undeveloped	If there is no evidence one way or another for any protected group of how people fare or if evidence shows that the majority of people in only two or less protected groups fare well
Developing	If evidence shows that the majority of people in three to five protected groups fare well
Achieving	If evidence shows that the majority of people in six to eight protected groups fare well
Excelling	If evidence shows that the majority of people in all nine protected groups fare well

Trust assessment

EDS2 Criteria	Outcome	Grade
1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities	Achieving
1.2	Individual people's health needs are assessed and met in appropriate and effective ways	Achieving
1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	Developing
1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	Achieving
1.5	Screening, vaccination and other health promotion services reach and benefit all local communities	Developing
2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Achieving
2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	Achieving
2.3	People report positive experiences of the NHS	Achieving
2.4	People's complaints about services are handled respectfully and efficiently	Achieving

3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Undeveloped
3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Achieving
3.3	Training and development opportunities are taken up and positively evaluated by all staff	Developing
3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	Undeveloped
3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Developing
3.6	Staff report positive experiences of their membership of the workforce	Developing
4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Developing
4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	Undeveloped
4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.	Developing

Appendix 7: Glossary of Terms

Protected characteristic	The Equality Act 2010 introduced the term 'protected characteristics' to refer to groups that are protected under the Act. The Act refers to 9 protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex (gender) and sexual orientation.
Black, Asian and Minority Ethnic (BAME)	Term currently used to describe a range of minority ethnic communities and groups in the UK – can be used to mean the main Black, Asian and Mixed racial minority communities (also referred to as BME) or it can be used to include all minority communities, including white minority communities. The term ethnic minorities is also used interchangeably with this acronym.
Disability	The Equality Act 2010 define disability as a mental or physical impairment that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.
Discrimination	Unfair treatment based on prejudice. In health and social care, discrimination may relate to a conscious decision to treat a person or group differently and to deny them access to relevant treatment or care.
Diversity	Valuing and celebrating difference and recognising that everyone through their unique mixture of skills, experience and talent has their own valuable contribution to make.
EDS2	EDS2 is a mandatory assessment tool that requires NHS Trusts to analyse and grade their equality performance across 18 outcomes.
Equality	Equality is about making sure people are treated fairly and given fair chances. Equality is not about treating everyone in the same way, but it recognises that their needs are met in different ways. Equality can be defined 'as the state of being equal, especially in status, rights, or opportunities.'
Ethnicity	A sense of cultural and historical identity based on belonging by birth to a distinctive cultural group.
Gender	This describes characteristics such as appearance, presentation and behaviour to identify gender (not sex). Characteristics could be masculine, feminine or androgynous.
Gender reassignment	Gender reassignment refers to individuals who either have undergone, intend to undergo or are currently undergoing

	gender reassignment (medical and surgical treatment to alter the body).
Inclusion	Inclusion means that all people, regardless of their abilities or health care needs, have the right to be respected, appreciated and included as valuable members of their communities.
LGBTQ+	It may refer to anyone who is non-heterosexual or non-cisgender, instead of exclusively to people who are lesbian, gay, bisexual, or transgender. To recognize this inclusion, a popular variant adds the letter Q for those who identify as queer or are questioning their sexual identity; LGBTQ has been recorded since 1996.

This document can be requested in alternative formats via the Trust Communications Department.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Responsible Officer Annual Report	☒ Approval ☐ Endorsement/Decision ☐ Discussion ☐ Information
Date of Meeting: 30 September 2020	**Item 15, report no. 12**
Responsible Executive Director: Julian Redhead, Medical Director	**Author:** Andrew Worthington, General Manager

Summary:

The Responsible Officer is mandated to produce an annual report for submission to the Trust Board. The purpose of this report is to detail the activity, policies and procedures in place to manage the process of doctor's appraisals and revalidation. The Chief Executive Officer will then sign a statement of compliance to confirm that the core standards as mandated by NHS England are being met by the organisation to be submitted by 30 September 2020 to NHS England.

This report is being presented for review at Trust Board, following approval at executive huddle on 14 September 2020 and board quality committee on 23 September 2020. In response to questions at quality committee an additional note has been added to the report to explain that the annual data return (annual organisational audit) was not required for this year hence is not included. Regular data has historically been reported to Quality Committee and board through the scorecard however given changes to reporting with the new IMIS this is being reviewed. Plans are in place to report the dataset that supports the RO report to Quality Committee going forward.

The board is asked to note this report and confirm they are satisfied that "the organisation, as a designated body, is in compliance with the framework of quality assurance (FQA) regulations" to enable sign off and submission to the higher-level responsible officer by 30 September 2020 to NHS England. The full report which includes the statement of compliance is included as an appendix.

Recommendations:

The board are asked to note this report and confirm that they are satisfied that "the organisation, as a designated body, is in compliance with the FQA regulations" to enable sign off and submission to the higher-level responsible officer by 30 September 2020.

This report has been discussed at:

☒ Executive huddle
☒ Board quality committee

Quality impact:

There is a statutory requirement for the RO to produce an annual report. Medical revalidation aims to improve standards, safety and promote trust in the medical profession. The CQC domains that will be improved from this paper are safe, effective and well-led.

Financial impact:

The financial impact of this proposal as presented in the paper enclosed:
There is no financial impact associated with this report

Risk impact and Board Assurance Framework (BAF) reference:

There are no risks attached to this paper

Workforce impact (including training and education implications):

N/A

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

None

Has an Equality Impact Assessment been carried out?

☒ Not applicable
Paper respects the rights, values and commitments within the NHS Constitution. ☒ Yes
Trust strategic objectives supported by this paper: ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do

Imperial College Healthcare NHS Trust

Responsible Officer's Annual Report 2020

1. Executive Summary

1.1. The responsible officer is mandated to produce an annual report for submission to the Trust board. The purpose of this report is to detail the activity, policies and procedures in place to manage the process of doctor's appraisals and revalidation.

1.2. The report provides assurance of the Trust's compliance with the framework of quality assurance standards as set out by NHS England's responsible officer regulations. The Trust is required to submit an annual report on the activities of the responsible officer, and a statement of compliance signed by the CEO.

2. Purpose

The purpose of this report is to:

2.1. provide the board with an annual report on compliance with the framework of quality assurance (FQA) standards.

2.2. provide assurance of the Trust's compliance with the FQA standards. This will allow the board to approve the statement of compliance (appendix A) required to be submitted to NHS England by the end of September 2020.

3. Background

3.1. The background to the requirement of this report is described in detail within **appendix 1**.

3.2. NHS England monitors compliance with responsible officer regulations via quality assurance audit. As part of this, designated bodies are to adhere to a set of core standards. The Trust is required to submit the following as evidence of performance against these standards:

- An annual report to the Trust board on compliance with these standards (see appendix 1);
- the annual statement of compliance made by the Trust board to NHS England, due by 30 September 2020 (included in appendix 1);
- the annual organisational audit (AOA) end of year questionnaire return to NHS England.

3.3. Due to the global pandemic, NHS England have removed the requirement for trusts to complete the AOA for 2019/20 (This is the report that would contain data to outline performance). Although the requirement to submit an annual report and statement of compliance is optional for this year, we have completed this to provide both board-level and external assurance on medical governance procedures.

4. Summary/Key points

4.1. The full RO annual report is included as **appendix 1**. The report demonstrates that the Trust meets the requirements for compliance with the FQA and that it meets its statutory duty to support the RO to discharge their duties. The report describes how the

standards are met by the organisation and this should provide the assurance required for the Trust board to sign the statement of compliance.

4.2. The annual report was approved at the executive huddle on 14 September, with no amendments required.

4.3. As a designated body, the Trust is reporting an improvement in the number of appraisals completed within the timeframe covered by the AOA (last financial year). The Trust is also stating compliance with the standards required of a designated body.

5. Conclusion and next steps

5.1. This report provides a detailed response to the Framework of Quality Assurance standards as determined by the Responsible Officer regulations and NHS England.

5.2. Once approved by the board, the statement of compliance will be signed by the CEO and submitted to NHS England.

6. Recommendations

6.1. The board is asked to note this report and confirm that they are satisfied that "the organisation, as a designated body, is in compliance with the FQA regulations". This will enable sign off and submission to the higher-level responsible officer by the end of September 2020.

Author **Andrew Worthington, General Manager**
Date 23 September 2020

Draft Responsible Officer's Annual Report – Revalidation & Appraisal

Purpose of the report:

- To provide the Board with an Annual Report on compliance with the Framework of Quality Assurance (FQA) standards;
- To provide the Board with assurance of the Trust's compliance with the FQA standards to allow them to approve the Statement of Compliance (Appendix A) required to be submitted to NHS England.

1. Background

Revalidation is the process by which all doctors with a license to practice are required to provide evidence they are up to date, fit to practice in their chosen field, and able to provide a good level of care.

Revalidation strengthens the way doctors are regulated, improves patient safety and the quality of care provided to patients, and increases public trust and confidence in the medical system. Licensed doctors revalidate by having an annual appraisal (based on the GMC core guidance for doctors, *Good medical practice*), and a five-yearly recommendation from their Responsible Officer.

All designated bodies must have an appointed Responsible Officer (RO) who submits revalidation recommendations to the GMC for all doctors with a prescribed connection to the organisation, based on the output of their annual appraisal. The Trust's primary RO is the Medical Director.

Provider organisations have a statutory duty to support the RO in discharging their duties under the Responsible Officer Regulations. Revalidation recommendations for doctors in training are dealt with by Health Education England.

NHS England monitors compliance with RO regulations via a quality assurance audit. As part of this, designated bodies are to adhere to a set of core standards. The Trust is required to submit the following as evidence of performance against these standards:

- Annual Organisational Audit (AOA) End of Year Questionnaire return to NHS England
- An Annual Report to the Trust Board on compliance with these standards (this report).
- Annual Statement of Compliance made by the Trust Board to NHS England.

Due to the global pandemic, NHS England have removed the requirement for trusts to complete the AOA for 2019/20. Although the requirement to submit an annual report and statement of compliance is optional for this year, we have completed both in order to provide both board-level and external assurance on medical governance procedures. The format for the annual report has remained the same as last year, allowing organisations to assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance, while providing the opportunity to reflect on the Coronavirus pandemic.

1.1. Statement of Compliance

Each core standard is outlined below with the Trust assurance response and the Chief Executive is asked to sign a Statement of compliance with these standards which can be found at the end of this report.

Section 1 - General

***Statement 1* – The Annual Organisational Audit (AOA) for this year has been submitted**.

NHS England suspended the requirement to complete the AOA for 2019/20. However, regular reporting of the Trust's appraisal compliance data shows that during the last financial year, we achieved the target of more than 95% compliance with appraisals for five consecutive months.

Statement 2 **- An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.**

Professor Julian Redhead is the Trust's Responsible Officer. Dr Roseanne Meacher, Associate Medical Director for Professional Development, was appointed as the delegate RO in December 2019 dealing with daily revalidation and operational issues. Dr Ruth Brown, Associate Medical Director, Medical Education, was appointed as the de facto RO for doctors in training. Dr Meacher's original training date was cancelled in the pandemic and virtual RO training is scheduled in September. Dr Brown completed the training before the start of the pandemic. Professor Redhead, Dr Meacher and Dr Brown have all participated in RO network events over the last year.

Statement 3 **- The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.**

There were no funding or resourcing issues to report in the last year and none anticipated in the current year. We are committed to ensuring the RO carries out the responsibilities of the role effectively.

Statement 4 **- An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained.**

The Professional Development (PD) team is part of the Medical Director's Office and reports to the General Manager. The PD team maintains and verifies an accurate electronic record of all doctors with a prescribed connection to the Trust using the GMC Connect database.

Statement 5 **- All policies in place to support medical revalidation are actively monitored and regularly reviewed.**

The Trust Appraisal/Revalidation policies have been widely disseminated and are located on the intranet. The Appraisal and Revalidation policy was ratified in 2018 and is set for review in February 2021. The policy will be subject to consultation with clinical divisions, HR and the Trust's Local Negotiating Committee before it is approved and ratified.

Statement 6 **- A peer review has been undertaken of this organisation's appraisal and revalidation processes.**

It is a requirement for the NHS England Higher Level RO (HLRO) to review services once in every five year appraisal cycle. The HLRO Quality Review Visit was completed in 2018. The key actions were to appoint a number of appraisal leads, ensuring they are supported in their roles; and to develop a strategy to tackle overdue appraisals.

The Trust currently has five appraisal leads, with quarterly meetings established with the RO. We have a focussed plan to reduce the number of overdue appraisals, and performance is reported monthly. This has led to a sustained improvement in performance and enabled the organisation to achieve 95% compliance with appraisals.

Not all appraisals are completed in a timely way, and the RO and PD team have made significant improvements in reducing the number of appraisals overdue by more than six months. This will remain a priority for this financial year.

The appraisal and revalidation processes were suspended in March with the onset of the pandemic. Additional time to complete revalidation portfolios have been granted, and new appraisal dates set. The Trust is now encouraging individual doctors to complete revalidation if they are ready, and to actively engage in the appraisal process.

***Statement 7* – A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.**

The Trust takes a pro-active approach to the professional development of all doctors, regardless of the nature of their employment or prescribed connection. All employed doctors have access to study leave and support from the PD team for appraisal and revalidation and job planning if required, regardless of the length of their employment. The PD team provide both 1:1 advice and regularly facilitate virtual support sessions (via MS Teams).

There is regular communication and a focussed set of actions for those within the group who are overdue.

Section 2 – Effective Appraisal

***Statement 1* – All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.**

We use the PREP revalidation e-system which offers doctors a platform encompassing the GMC domains and requirements for revalidation. This includes the doctor's full scope of work, fitness to practise, complaints, significant events and outlying clinical outcomes. Datix reports are also used to strengthen the portfolio of evidence for revalidation. As part of the assurance process for revalidation, the PD team ensures that appraisals are robust and meet the GMC requirements.

We are in the process of procuring a new software platform for appraisal and revalidation, which will help to support and improve our current processes and procedures.

During the height of the Covid-19 pandemic, the appraisal and revalidation process was suspended. Resources from the RO network were disseminated to all consultants, which provided details of how to access support and help as required. Appraisers were encouraged to 'check-in' with their appraisee and to signpost them to the appropriate support.

The RO recognised that for those doctors who wished to continue with their revalidation, it would be more difficult to gather patient feedback. The amount and source of feedback has been assessed on a case by case basis during the recovery phase of the pandemic. During the coming financial year, we will be exploring more innovative ways to collect patient feedback.

***Statement 2* - Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.**

Since its inception in 2012, revalidation/appraisal has evolved and through national and Trust promotion and support, doctors have become more knowledgeable and familiar about the processes and more proficient at completing a robust appraisal on schedule. In the event that an appraisal lacks the requirements to meet the GMC standards, the PD team would alert the RO who would review and make a recommendation to the individual doctor.

The PD team maintains a list of overdue appraisals, and suitable action is taken if the RO deems that the individual is not engaging. The electronic system records special circumstances which is used to provide mitigation for late or overdue appraisals and includes long-term leave such as maternity or sick leave.

Statement 3 **- There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).**

The Appraisal and Revalidation policy is compliant and was ratified and published in 2018 and is set for review in February 2021. The current policy received excellent feedback during the HLRO visit in 2018.

Statement 4 **- The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.**

In 2019/2020 the Trust had 227 active appraisers which met the recommended ratio of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners (1:5/6). The PD team are working closely with clinical divisions to ensure there are enough appraisers within each directorate.

The Trust supports appraisers to fully undertake their role through the provision of accredited training courses. In 2019, the Trust commissioned four one-day courses on 'Appraisal for Revalidation' from the Royal College of Physicians and offered to 100 existing and aspiring appraisers. A total of 88 individual doctors went through this training, which was evaluated very positively.

Statement 5 **- Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).**

Following the HLRO visit, the Trust has appointed five appraisal leads, which provides additional scope for peer review and support of appraisers. The RO is working closely with the appraisal leads on programmes supporting the development of appraisers, raising the profile of professional development and establishing focus groups for key pieces of work, such as the procurement of r a single electronic system for appraisal and job planning. The appraiser's appraisal is also a forum through which there can be reflective discussion on performance. As previously noted, the Trust offers training/refresher courses to consultants, the most recent delivered by the RCP.

Statement 6 **– The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.**

In 2018, NHS England conducted their Higher Level R.O. Quality Review Visit. The outcome and actions were reported in that year's annual report. The annual report for 2018/19 was approved by the Trust board in September 2019 and the statement of compliance was signed by the CEO in October 2019.

Section 3 – Recommendations to the GMC

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Statement 1 - **Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.**

Since last year's AOA the Trust has made 329 GMC revalidation recommendations and 34 deferrals. Completed appraisal rates are reported bi-monthly to the Trust board.

Revalidation notices are sent via internal email six months ahead of the doctor's revalidation date and at this stage the doctor becomes 'under notice'. There is focussed communication from the PD team to support the doctor in gathering their evidence and preparing for their final appraisal before revalidation. By targeting doctors individually, the PD team effectively manage the revalidation process and can highlight any potential deferrals in advance. All deferrals are made in exceptional circumstances and are all sanctioned by the RO. In the last financial year, The RO did not make any late recommendations.

Statement 2 - **Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.**

Submitted recommendations are confirmed via email or phone conversation, and the consultant will receive a notification from the GMC. If deferral is indicated, it is discussed in advance of any action between the individual doctor and RO, and the doctor is made aware of the requirements for a positive recommendation. Although there is a policy in place for doctors who do not engage with the revalidation process, the RO did not need to make any referrals for non-engagement in the last financial year.

Section 4 – Medical governance

Statement 1 **- This organisation creates an environment which delivers effective clinical governance for doctors.**

There are systems in place in the organisation that support and promote the protection of patients. This includes clinical incident reporting, a serious incident investigation framework, clinical audit and NICE guidance, regulation, complaints, and concerns raised via other bodies, such as the GMC. Doctors are encouraged to reflect on all aspects of their practice, including complaints, concerns and clinical incidents, at any time, but specifically as part of their annual appraisal.

When responding to any GMC queries, or ahead of a revalidation recommendation, all Trust information systems (e.g. Datix) are consulted. The Medical Director's Office maintains a database of outcomes from GMC enquires and investigations and shares this information with the relevant doctor to ensure they undertake the required reflection.

Statement 2 **- Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.**

The Trust mandates the use of complaints and incidents in annual appraisal, this data is provided for doctors to use and a process for auditing that this is in place. We also have access to several data sources which are used to monitor performance locally, nationally and against peer groups including surgical outcome data e.g. in cardiac surgery. The Getting It Right First Time (GIRFT) programme can be used to highlight individual clinical issues, while CRAB and Dr Foster intelligence look at both individual and specialty performance and outcomes and have been used

during the time covered by this report. Data is also reviewed in a number of local forums e.g. the Surgical Outcomes Group and the Mortality Review Group.

Statement 3 - **There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.**

The Trust has a policy for responding to concerns about a doctor's practice, 'Handling Concerns About Doctors and Dentists' Conduct, Performance and Health' which is based on the Maintaining High Professional Standards (MHPS) framework. This policy was ratified in 2018 and provides details, including flow charts, on every stage of the process. The policy also describes the key personnel required in the membership of panels for hearings, the appeals procedure and the role of external or independent panel members. This policy is due for review and consultation in the next few months.

Statement 4 **- The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].**

There are several processes in place to ensure that concerns about a doctor are handled appropriately. The first point of call is with the GMC Employer Liaison Service (ELS) and the RO has a regular review meeting with the named individual for the organisation. There are routine discussions with Practitioner Performance Advice (PPA) about all excluded or restricted doctors, and the RO seeks advice from PPA even if the case does not warrant exclusion. There is a designated non-executive director who has a direct link to the RO to provide advice and support. The RO convenes decision making panels, including lay representation as required, to decide on case management on an ad hoc basis.

Internally, there is a monthly case review meeting with the HR Consultant, HR Director, RO, GM and AMD PD to review all active cases, and to ensure progress is being made against timelines.

Statement 5 **- There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].**

The organisation is fully committed to working in partnership with other organisations, and to cooperate with investigating any concerns raised about doctors. There are systems in place to share information with external organisations when required, ensuring principles for data protection are adhered to. MPIT forms are used routinely to share information between organisations.

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[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

The records of local investigations and management of concerns are stored electronically. All appraisal and revalidation information is stored in the PREP electronic database.

Direct RO to (external) RO discussions between organisations are by initial email or telephone contact, with a scheduled telephone discussion followed by email follow-up. Key decisions are communicated by letter to support telephone conversations. The RO and deputy RO arrange cover for leave to ensure a named person is always available.

***Statement 6* - Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).**

The organisation utilises both the GMC ELS and PPA to discuss concerns, and there is a full-time HR consultant within the Medical Director's Office to support the MHPS, grievance and disciplinary processes.

Decision making panels with lay representation and NED involvement for recommendations on how to proceed with cases and to confirm or scrutinise investigation findings. In 2019 the Trust increased the number of trained case investigators to approximately thirty by hosting a bespoke two-day training programme delivered by PPA.

The Trust has access to a number of Freedom to Speak Up guardians.

As detailed in response to statement 4, there is a monthly case review meeting with the HR Consultant, HR Director, RO, GM and AMD PD to review all active cases.

Section 5 – Employment Checks

***Statement 1* - A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties**.

There are systems in place within the organisation to ensure pre-employment checks are undertaken for all doctors, including locums and doctors in short-term employment, which is managed by the Medical Staffing department of HR.

The PD team undertake further verification of the correct contract, licence to practice and revalidation details when the doctor connects to the Trust.

Local departments review CVs for locums to ensure they have the required skills and undertake local inductions prior to taking up their role.

Overseas doctors are supported to pass English language tests before taking up employment and encouraged to participate in GMC-run courses which provide a welcome and overview to practicing in the UK.

Section 6 – Summary of comments and overall conclusion

This report provides a detailed response to the Framework of Quality Assurance standards as determined by the Responsible Officer regulations and NHS England. The Annual Organisation Audit is attached as appendix 1.

As a designated body, the Trust is reporting an improvement in the number of appraisals completed within the last financial year. We are also stating compliance with the standards required of a designated body.

Last year, we made significant progress with reducing the number of overdue appraisals. This year there will be a continued focus on improving the quality of appraisals, with both improved software and internal audit against the core appraisal requirements. There are some key successes to note, such as not having made any late recommendations during the last financial year and achieving 95% compliance with appraisal completion. We are also strengthening our commitment to the training and development of clinicians by commissioning courses specifically to enhance the appraisal and revalidation process and increasing the number of independently trained case investigators.

Overall conclusion:

The board is asked to note this report and confirm that they are satisfied that "the organisation, as a designated body, is in compliance with the FQA regulations" to enable sign off and submission to NHS England by 30 September.

Section 7 – Statement of Compliance

The Board of Imperial College Healthcare NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).
Signed on behalf of the designated body

(Chief executive or chairman)

Official name of designated body: Imperial College Healthcare NHS Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _
Role: _ _ _ _ _ _ _ _ _ _ _ _
Date: _ _ _ _ _ _ _ _ _ _

APPENDIX A

Designated Body Statement of Compliance

The executive management team of Imperial College Healthcare NHS Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments: Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: Yes

4. Medical appraisers participate in on-going performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments: Yes

5. All licensed medical practitioners[4] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners, which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments: Yes

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments: Yes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer

[4] Doctors with a prescribed connection to the designated body on the date of reporting.

and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments: Yes

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[5] have qualifications and experience appropriate to the work performed; and

Comments: Yes

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: Yes

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Signed: _

[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

[5] Doctors with a prescribed connection to the designated body on the date of reporting.

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Infection Prevention and Control (IPC), and Antimicrobial Stewardship Quarterly Report: Q1 2020/21	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 30 September 2020	**Item 16, report no. 13**
Responsible Executive Director: Professor Julian Redhead, Medical Director	**Author:** Jon Otter, General Manager, IPC Professor Alison Holmes, Director, IPC

Summary:

- This report includes a summary of IPC activity related to the COVID-19 pandemic.
- There have been 17 hospital-associated *C. difficile* cases during Q1, which is below the Q1 ceiling of 21 cases. There has been one lapse in care related to cross-transmission.
- It has been >12 months since the last Trust-attributed MRSA BSI.
- We are on target to meet our 10% year-on-year reduction in Trust-attributed *E. coli* BSIs (an internal performance metric).
- In Q1 2020/21 we saw a drop in oral antibiotic use with a corresponding rise in intravenous agents. This change was a direct result of the COVID-19 pandemic and patients presenting to our organisation with undifferentiated respiratory infections. The drop in oral antibiotic use was recognised and counteracted. Work is ongoing to reverse the upward trend in the use of intravenous agents.
- The strategic hand hygiene improvement programme has been extended to include encouraging best practice around the use of personal protective equipment (PPE).
- During Q1, several clusters and outbreaks were identified and managed, including two clusters of CPE, three clusters of hospital-onset COVID-19 infection, and an outbreak of *Corynebacterium striatum* across the three sites. There were also six communicable disease 'look back' investigations.
- IPC data is reviewed by site as well as division/directorate. There is no clear variance at site level.
- The IPC risk register has been reviewed and updated to reflect the risks associated with the management of COVID-19.

Recommendations: The board is asked to note the report.

This report has been discussed at:
Executive quality committee – August 2020
Board quality committee – September 2020

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

Financial impact: No direct financial impact.

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

Workforce impact (including training and education implications): None.

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

Trust strategic goals supported by this paper:

- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do

1 Response to the pandemic of COVID-19

- The processes for IPC-supported decision making changed during COVID-19, with new assurance structures implemented.
- IPC were integral in the provision of advice, guidelines, and clinical pathway development.
- A patient and staff testing strategy was developed and iterated in the context of changing national guidelines and with reference to local laboratory capacity.
- A focus on antimicrobial stewardship (AMS) and treatment of both COVID-19 and other infections was maintained during the pandemic.
- Systems were developed and implemented for the identification and management of hospital-onset COVID-19 infections.
- A daily COVID-19 "sitrep" and forecasting to support decision making about surge capacity and related staffing was developed and implemented.
- Several existing and some new models were used to provide training and education to staff.
- IPC led improvement work around Personal Protective Equipment (PPE) and hand hygiene use, including the design, implementation, development, and evaluation of a PPE Helper programme to promote best practice in the use of PPE.
- IPC worked closely with estates & facilities, providing advice around changes to the use of clinical and non-clinical areas, developed mitigating plans for water hygiene management, and provided advice and support for specialist ventilation / modification. IPC also issued recommendations around enhanced environmental cleaning in clinical areas used to manage patients with COVID-19 in line with national guidelines.
- IPC also worked closely with the Trust communications team to develop a series of "IPC/AMS messages of the day", participate in various staff briefings, and supported the development and accuracy of the Trust Intranet COVID-19 pages and other communications materials (e.g. infographics / posters).
- Experts from IPC joined a range of expert advisory groups and undertook applied research to support decision making in the Trust.

2 Healthcare-associated infection surveillance and mandatory reporting

- There have been 17 hospital-associated ***Clostridioides difficile*** cases during Q1 (16 Hospital Onset, Healthcare-Associated (HOHA) and 1 Community-Onset, Healthcare-Associated (COHA) against a ceiling of 21 HOHA and COHA cases combined (Appendix, Figure 1). Hospital-associated *C. difficile* cases were detected in 1.3% of 1277 stool specimens tested during Q1. One *C. difficile* case was identified as having a lapse in care in Q1, the first since October 2019.
- There have been no **MRSA BSI** during Q1. It has been >12 months since the last Trust-attributed MRSA BSI. Compliance with MRSA admission screening was above the 90% for May and June 2020. Compliance dipped in March (87%) and April (76%), probably related to our peak in COVID-19. Clinical areas that consistently have lower compliance with MRSA admission screening have been identified and flagged via the weekly HCAI sitrep to prompt local investigation and improvement.
- There have been four cases of Trust-attributed **MSSA BSI** during Q1, with no evidence of patient-to-patient transmission.
- The number of Gram-negative ***Escherichia. coli*****,** ***Pseudomonas aeruginosa*****,** and ***Klebsiella pneumoniae*** **BSI** cases during Q4 2019/20 is summarised in Appendix Table 1. There has been a decrease in the number of *E.coli* BSIs during Q1, which is most likely associated with a reduction in activity over this period. Our *E. coli* BSI rate ranks third lowest in the Shelford group.
- The activities to support the Government's ambition to halve healthcare-associated Gram-negative BSI by 2021 have been largely on hold during COVID-19. However, plans for Q2 include:

  - Continue to support NWL CCGs in developing plans to reduce Gram-negative BSI through the newly established NWL IPC ICS sector meeting.
  - We aim to develop a refreshed pre-COVID-19 plan with a particular emphasis on reducing urinary catheter related BSIs.
  - Developing a series of interventions to improve urinary catheter management in order to prevent *E. coli* BSIs secondary to urinary catheter-associated UTI.
  - Planning of interventions aimed at preventing *E. coli* BSIs in patients with cancer following the findings of the national audit.
- **Contaminants**[1] accounted for 3.2% of 7713 blood cultures taken during Q1, which is slightly above our local benchmark of 3%.[2] This is associated with an increase in blood culture contaminants observed across ICU during the COVID-19 peak, likely related to challenges with hand hygiene and ANTT whilst wearing additional PPE. IPC and vascular access continue to support ICU in addressing these issues. The peak in contaminants occurred in April 2020 and has since returned to below benchmark levels.
- There is no available data on **catheter line-associated BSI (CLABSI)** in the adult ICUs due to operational challenges during COVID-19 not allowing for routine surveillance of BSI at detailed case reviews. Data covering the Q1 period will be reported in the Q2 report. CLABSI rates in the paediatric and neonatal ICUs remain below benchmark rates.
- Rates of **surgical site infection (SSI)** remain below national benchmark rates following the selected elective orthopaedic procedures included in the mandatory national surveillance scheme (Appendix Section 8.2). The SSI rate following CABG and non-CABG procedures remains consistently above the national average over the past 12 months. Regular task-and-finish group meetings chaired by a cardiothoracic surgeon have recommenced.
- We continue to make progress in supporting our Divisions to embed prospective surveillance in the specialities identified as priority areas, starting with Caesarean section, neurosurgery, cardiothoracic, and vascular.
- The number of patients with **carbapenemase-producing Enterobacterales (CPE)** detected each month fell to the lowest level since 2017 (around 30 new patients per month), probably due to changes in activity and patient mix during the COVID-19 pandemic. CPE admission screening was maintained throughout the COVID-19 pandemic. Although Trust-wide compliance dipped during COVID-19, it has now returned to pre-COVID-19 levels.

3 Antimicrobial stewardship

- The next biannual antibiotic point prevalence study (PPS) will be conducted in August 2020. This PPS will adopt a modified approach to take into account existing COVID-19 pathways – for the gradual reintroduction of routine surgery.
- There was an expected rise in oral antimicrobial consumption during Q3 and Q4 2019/20 (Appendix Figure 2) in keeping with changes seen during the winter months and as the Trust continued to promote the “Access” group as recommended by PHE and WHO to curb the threat of resistance. However in Q1 2020/21 we saw a drop in oral use with a corresponding rise in intravenous agents. This change was a direct result of the COVID-19 pandemic and patients presenting to our organisation with undifferentiated respiratory infections. The drop in oral antibiotic use was recognised and counteracted.
- We continue to participate in the *NHSE Anti-fungal CQUIN* which is part of the wider *Medicines Optimisation CQUIN.*
- During Q1, a semi-automated tool was developed in Cerner to assist clinicians in distinguishing viral and bacterial infection.

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

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

- We have a requirement that **ANTT competency assessment** is undertaken and documented for all clinical staff. Currently the compliance rate is 87.5% (7484/8558 clinical staff), below our 90% target. The competency assessment was suspended during the COVID-19 peak and replaced with an ANTT training video. From Q2, plans are in place to restart the ANTT competency assessment process. Clinical areas have restarted ANTT competency assessments with existing staff. New doctors starting in August 2020 will have a virtual induction which will include the training video and face to face competency in clinical practice done by the Divisional colleagues.
- A new group was established in Q1 to oversee strategic work around **hand hygiene and PPE improvement**, building on the success of the hand hygiene improvement programme (established in 2018) and the PPE Helper programme (established during the COVID-19 peak). A "Look, Listen, Learn" audit of PPE and hand hygiene practice is planned across the Trust during Q2. This will be a supportive approach to intelligence gathering that includes a focus on staff and patient experience. The programme will also provide and on-the-spot education to address poor practice.

5 Clinical activity, incidents, and lookback investigations during Q4

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

- Two clusters of CPE were identified and managed, one of NDM-producing *Enterobacter cloacae* affecting three patients on a medical ward, and one of NDM-producing *Escherichia coli* affecting eight patients on a separate medical ward.
- Three clusters of hospital-onset COVID-19 that developed symptoms of COVID-19 14 days after their admission were identified and managed, one affecting six patients on a surgical ward, one affecting five patients on a medical ward, and one affecting four patients on a haematology ward.
- 30 patients were affected during an outbreak of *Corynebacterium striatum* in the ICUs at SMH, HH, and CXH. There were no deep infections and no attributable deaths.
- In Q1, six communicable disease 'look back' investigations were undertaken related to potential exposures to probable Creutzfeldt-Jakob Disease (CJD) (1), measles (1), and shingles (4). This is considerably fewer lookbacks than is usual, and probably relates to changes in patient demographics due to COVID-19.

6 Compliance, policies, and risks

- The quarterly *Trust Infection Prevention and Control Committee* was held in May 2020, and approved nine policies and guidelines.
- Issues with **cleaning** and **estates** standards continue to be identified. These have proved challenging during the COVID-19 pandemic, when cleaning demands have increased. IPC have supported the transition to the new in-house cleaning service.
- There have been no new **IPC risks** identified. All risks in the IPC risk register have been updated to reflect the challenges related to COVID-19.

7 Other

- Members of the IPC team have produced 14 peer-reviewed **publications** relating to applied research in HCAI and AMR during Q1.
- Members of the IPC/AMS team are also supporting a range of COVID-19 related national and international expert groups and committees.
- External directives received related to the management of the COVID-19 pandemic were actioned.

8 Appendix

8.1 *Healthcare-associated infection surveillance and mandatory reporting*

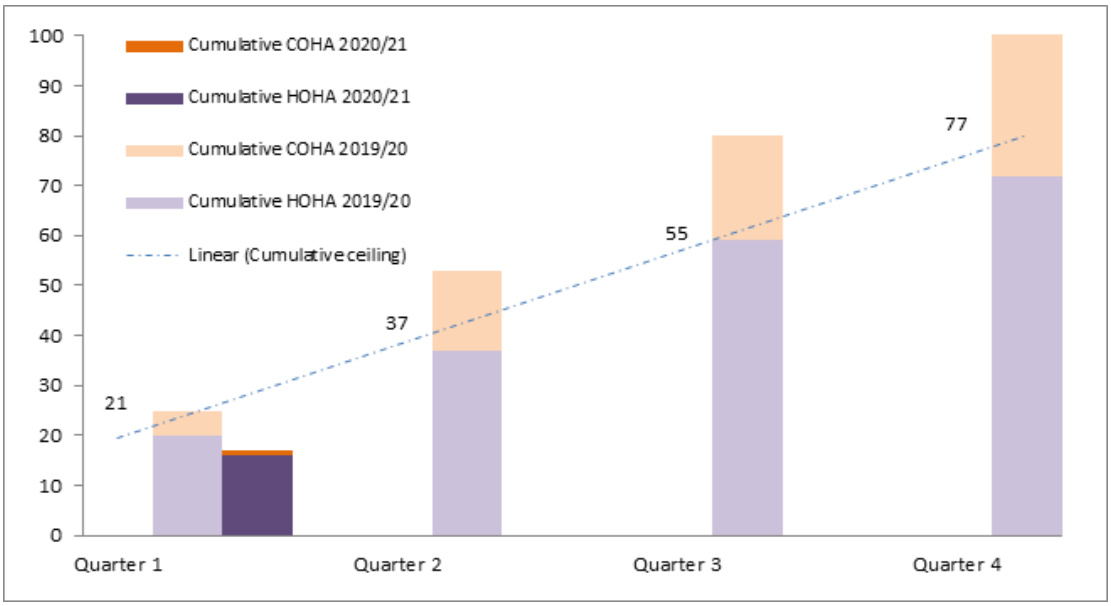
A summary of healthcare-associated infection (HCAI) that is reported to Public Health England is shown in Table 1.

Table 1: HCAI mandatory reporting summary.

	Apr-20		May-20		Jun-20		Jul-20		Aug-20		Sep-20		Oct-20		Nov-20		Dec-20		Jan-21		Feb-21		Mar-21		YTD	
	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	**No. cases**	YTD (ceiling)
Trust MRSA BSI	0	0	0	0	0	0																			**0**	0
Hospital onset- Hospital associated (HOHA)	8	-	6	-	2	-																			**16**	-
Community onset-Hospital associated (COHA)	0	-	0	-	1	-																			**1**	-
Total Hospital associated C.difficile cases (HOHA + COHA)	8	8	6	7	3	6																			**17**	21
Trust *Escherichia coli* BSI	2	-	5	-	5	-																			**12**	-
Trust MSSA BSI	4	-	0	-	0	-																			**4**	-
Trust CPE BSI	0	-	1	-	0	-																			**1**	-
Trust *Pseudomonas aeruginosa* BSI	4	-	3	-	2	-																			**9**	-
Trust *Klebsiella* BSI	5	-	0	-	4	-																			**9**	-

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

Figure 1: Hospital-associated C. difficile cases by Financial Year (2010/11 to 2018/19), 2019/20 incorporating COHA cases, and finally Q1 2020/21 C.difficile cases YTD.



8.2 *Surgical site infection*

We report SSI in selected orthopaedic procedures in line with the national mandatory reporting scheme, and selected cardiothoracic procedures in a national voluntary reporting scheme.

8.2.1 Orthopaedics

The latest quarter of finalised data, Jan-Mar 2020 saw:

- Knee procedures: 1 SSI in 81 procedures; 12-month average is 0.3% (1 SSI in 374 operations); national average is 0.6%.
- Hip procedures: 0 SSI in 51 procedures; 12-month average is 0.4% (1 SSI in 255 operations), national average is 0.6%.

8.2.2 Cardiothoracic

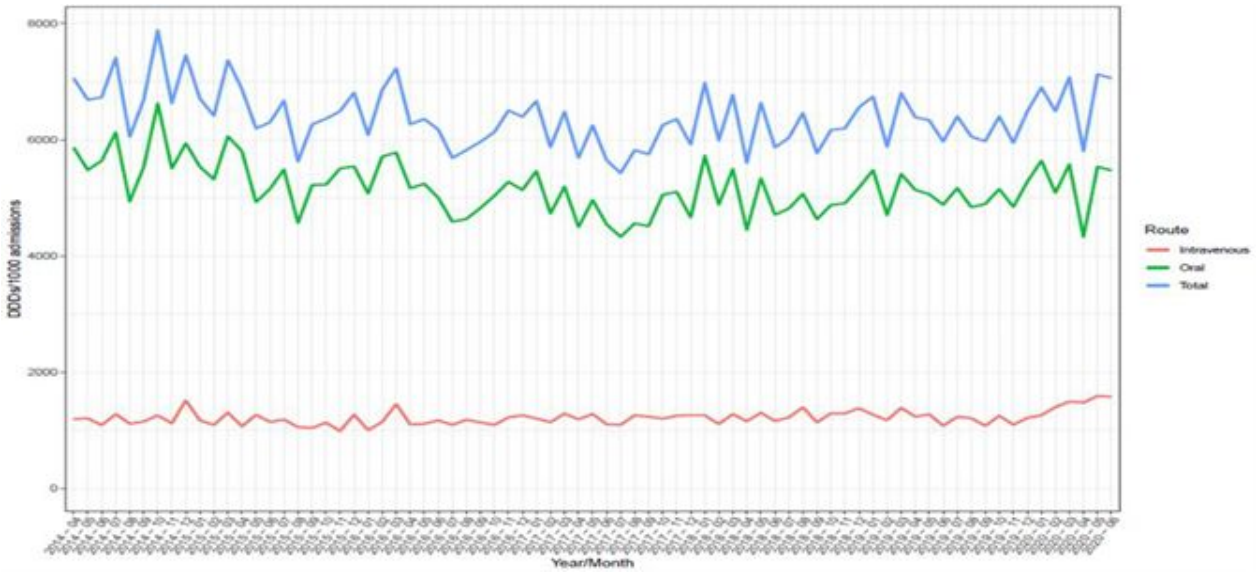
The latest quarter with finalised submitted data (Jan-Mar 2020 finalised data) has seen:

- CABG: 10 SSI (12.2%) of 82 procedures; 12-month average is 9.8% (31 SSI in 317 procedures); national average is 3.8%. Eight were superficial incisional SSIs, one was a deep incisional SSI and one undeterminable.
- Non-CABG: 0 SSI (0.0%) of 63 procedures; 12-month average is 2.3% (5 SSI in 219 procedures); national average is 1.3%.

8.3 *Antimicrobial stewardship*

8.3.1 Antimicrobial consumption

Figure 2: Trust-wide antimicrobial consumption (DDD / 1000 admissions) 2014/15 present, including the split between intravenous and oral administration.



Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: CIP QIA - Update on the outcomes of the post-implementation reviews of Quality Impact Assessments for Cost Improvement Programmes (2019/20)	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 30 September	**Item 17, report no. 15**
Responsible Executive Director: Janice Sigsworth, Director of Nursing Julian Redhead, Medical Director	**Author:** Cheryl Crespo, Head of PMO

Summary:
The Trust has a comprehensive Cost Improvement Programme (CIP) Quality Impact Assessment (QIA) process in place to help understand the risk/s to quality (aligned to the five CQC domains) that may result when implementing a CIP scheme.

The proactive and on-going assessment on quality is an important part of CIP governance cycle. This process should include an annual post implementation evaluation (PIE) to ensure that lessons learned are incorporated into future plans. This process normally takes place in May however due to the pandemic, the review was delayed to late summer.

Clinical divisions have reviewed a number of CIPs QIA and a sample has been discussed at meetings held with the Medical Director and Director of Nursing.

In general, of the schemes evaluated, it was considered that implementation of the scheme had improved or maintained quality as the original QIA risk score had either stayed the same or reduced once the scheme was implemented. Only one CIP scheme was highlighted as having had unintended consequences however; this was not directly linked to quality of services but related to staff wellbeing.

2020/21 CIPs are on paused due to the changes to NHS providers financial regime as result of the COVID-19 pandemic.

Recommendations:
The Board is asked to note the learning made from the post implementation evaluations.

This report has been discussed with:
- QIA responsible Directors
- September Quality Committee

Quality impact:
The CIP QIA and PIE process ensures that any adverse impact on quality and patients (taking into account all five CQC domains) is mitigated.

Financial impact:
The financial impact of this proposal as presented in the paper enclosed:
Has no financial impact

Risk impact and Board Assurance Framework (BAF) reference:
This paper relates to the following corporate risks**:**

3014: Failure to deliver financial recovery 2072: Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards
Workforce impact (including training and education implications): No direct impact
Has an Equality Impact Assessment been carried out or have protected groups been considered? ☒ Yes ☐ No ☐ Not applicable If yes, are further actions required? ☐ Yes ☒ No
What impact will this have on the wider health economy, patients and the public? As outlined above under 'quality impact'.
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No If yes, why?..... If the details can be shared, please provide the following in one to two line bullet points: ▪ What should senior managers know? o PIEs for CIPs are to be carried out periodically throughout the year ▪ What (if anything) do you want senior managers to do? o Undertake the PIEs and share the learning from past reviews ▪ Contact details or email address of lead and/or web links for further o C.crespo@nhs.net ▪ Should senior managers share this information with their own teams? ☒ Yes ☐ No If yes, why? o Teams should be completing the PIEs for the schemes they are responsible for

1. Purpose

The following report provides a summary of the findings from the Post-Implementation Evaluations undertaken on Quality Impact Assessments for 2019/20 Cost Improvement Programmes and provides assurance to the Board around the approach. This information should be shared widely throughout the organisation to embed the learning.

2. Background FY1920

The Quality Impact Assessment (QIA) is an essential process in the Trust's approach to managing Cost Improvement Programmes (CIPs) to ensure schemes consider risks and benefits aligned to the CQC domains so that where necessary, risks can be mitigated to support excellent quality of patient care and opportunities can be maximised. All QIAs rated medium impact (score 6) or higher are reviewed by the QIA Panel that is led by the Trust's Executive Nurse and Medical Directors and all low rated QIAs are reviewed and held by the Divisional Clinical leadership team.

An impact assessment on quality and safety will be completed in the CIP planning stage and which should be signed off, the monitoring of the quality impact is an iterative process that has been embedded as part of the assurance and general governance arrangements of CIPs. This process also involves an annual Post Implementation Evaluation (PIE) to ensure that lessons learned are incorporated into on-going work and future plans.

In 2019/20, The Trust had a total of 267 recurrent CIP schemes across the three clinical divisions, 257 required formal QIAs risk assessment of the CIPs and were approved.

Final 19/20 CIPs and QIAs		
Clinical Division	CIP Schemes #	QIA Approved
SCC	140	140
MIC	93	86
WCCs	34	31

3. Post Evaluation Impact Outcomes

As a fundamental part of the year end process, a review of a number of schemes took place. Divisions were asked to extract at a minimum of six CIP schemes from last year, prioritised based on the approved QIA score apportioned to each in relation to quality impacts rather than overall risk scoring which should also cover a cross section of Specialties / Directorates. A sample from those was taken for discussion by the QIA panel based on the ability to learn lessons from the review.

The evaluation was undertaken in line with the process set out in the Trust's CIP QIA policy.

A summary of the learning outcomes has been outlined on the table below:

Subject of PIE	QIA Score (before and after implementation)	Learning Outcome

Decommissioning Community Ophthalmology	6/6	Working in a changing Commissioner / Provider landscape, with moves from a community model to new ways of working to minimise attendances to hospital including: Use of virtual clinics, One stop clinics and Monitoring services
ENT Outsourcing	6/6	Review outcome showed an increased focus on trying to streamline patient pathways, primarily in Otology and impact of driving efficiency. Only patients likely to progress to surgery would have their consultation with a surgeon, therefore increasing the scope of AHP and CNS practice taking forwards into new working relationships with Independent Sector
Medical Rota Staffing Costs (Trauma)	6/6	Options to realise savings through improved job planning and how to mitigate risks, with learning to be taken into other similar programmes across Directorates
Reduce outpatient prescribing for non-red listed drugs.	6/2	Found no evidence of : • An adverse impact on patient experience due to sourcing prescriptions through their GPs. • An adverse impact on clinical efficacy through an increase in reported Datix showing delays to medication. Have considered that stakeholder engagement and communications on changes to clinical practice prior to launch could have been enhanced. It was recommended that the practice be re-implemented once the measure in place to support patients through the COVID-19 pandemic are fully lifted
Combining MS and PIU services	4/2	Seen a reduction on bank and agency spend, an improvement on coding and a reduction on waiting lists through the use of a single booking system. Patients were seen within required timeframe. Lessons learned include: • Implementation of new processes/SOPs • Shared training matrix/gaps and clear KPIs • Need for electronic systems for real time booking* *Being taken forward as an implementation project
Interpreting service	6/6	Traditional mechanisms of face to face interpreting changed to telephone interpreting in 19/20. Phase 1 was to introduce telephone interpreting (19/20). Phase 2 is to introduce video interpreting (20/21). British Sign Language and safeguarding interpreting was to remain as face to face. Currently working with the providers to address concerns around connection time to interpreters and reviewing interpreter training and on-boarding process to support with their medical terminology gaps. A revised pathway and governance process may be required to deliver the planned second phase.

Reduction in pay expenditure in WCCS	6/12	4 x vacant posts from the WCCS divisional management business support cost centre were disestablished. The changes have resulted in additional pressures to current staff who lacked capacity or consistent level of expertise to provide the quantity and quality of information required which affected staff morale. Has impacted on the Division's ability to quickly respond to changing demands. The service will bring a revised Business Support structure to the 2021/22 business planning process for approval.

Capturing lessons learned from the implementation of CIP schemes has been an important process to provide solutions to safeguard quality whilst delivering significant changes to service delivery and to assist with the transition from current state to improved practices.

It was noted that the risk scoring was in some instances higher than reasonably expected based on the description and therefore where appropriate, there should be some group reflection to moderate the Divisional risk rating based on the wider Trust impact.

Based on the evaluations undertaken, it was largely demonstrated that the implementation of the schemes had either improved or maintained quality as the original QIA risk score had either stayed the same or reduced once the scheme had begun. There was one exception that had been highlighted to the panel. This was as a result of removing several vacant business support posts of a Division which resulted in a recommendation for future QIAs to assess schemes against performance, quality, and impact on patient and *staff* experience as well as financial benefits. Further work with divisions to revise the post scores if quality is the same or improved to assess consequences.

4. Next steps

Prior to COVID-19 pandemic, the Trust was fully engaged in development of the business plan which included a comprehensive Cost Improvement Programme as a key driver to delivering a sustainable financial position. The focus has shifted to supporting the organisation through the COVID-19 response. Recently work has continued to develop the PID pipeline and progress to fully developed CIPs based on current viability. The next routine quarterly CIP/QIA meetings with divisions are scheduled to take place in January.

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: NWLP Annual Report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 30 September 2020	**Item 18, report no. 15**
Responsible Executive Director: Saghar Missaghian-Cully NWLP Managing Director	**Author:** Saghar Missaghian-Cully – Managing Director NWLP

Summary:
North West London Pathology (NWLP) is an NHS partnership between Imperial College Healthcare NHS Trust, Chelsea & Westminster Hospital NHS Foundation Trust and The Hillingdon Hospitals NHS Foundation Trust. It is hosted by Imperial College Healthcare NHS Trust but is jointly owned by the three Trusts.

The partnership represents a new model for delivering pathology and has created a modern, efficient, innovative and sustainable service that delivers outstanding quality. Our innovative approach allows the service to better manage demand, standardise operations, improve value for money and make use of new technology. We are also one of the largest pathology providers in the UK.

Our structure is based on a hub and spoke model providing pathology services at six hospital sites across London. We are processing nearly 30 million tests annually, providing a wide range of diagnostic and clinical support services in NW London, serving around 250 GP practices, across six CCGs, and a population of over two million people. The majority of routine, specialist and non-urgent activity is completed at our state of the art hub laboratory based at Charing Cross Hospital. Urgent tests required for immediate patient management and treatment are performed at our spoke site laboratories which operate 24/7.

Since 2018 substantial investment has been made in new state-of-the-art equipment, our Laboratory Information Management Systems (LIMS) and estates as part of the transformation programme. The transformation of our pathology services also provides a great opportunity to drive translational research and innovation in all aspects of pathology, as well as supporting training for medical and scientific staff.

Recommendations:
For noting the NWLP Annual Management report

This report has been discussed at:
Quality Committee
Executive Team Huddle

Quality impact:
The Annual Report provides a summary of the performance of North West London Pathology over 2019/20. The report covers all areas of the CQC domains – safe, caring, responsive, effective and well-led.

Financial impact:
The financial impact of this proposal as presented in the paper enclosed: (delete/complete as appropriate)
- Has no financial impact

Risk impact and Board Assurance Framework (BAF) reference: Not applicable

Workforce impact (including training and education implications): Not applicable
Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☐ No ☒ Not applicable If yes, are further actions required? ☐ Yes ☒ No
How have patients, the public and/or the community been involved in this project and what changes were made as a result? Not applicable
What impact will this have on the wider health economy, patients and the public? Not applicable
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No

NHS
North West
London Pathology

NORTH WEST LONDON PATHOLOGY

Annual Report 2019- 2020


Patient-focused


Collaborative


Expert


Caring

NORTH WEST LONDON PATHOLOGY

NORTH WEST LONDON PATHOLOGY

Annual Report 2019-2020

FORWARD

I am proud to present the Annual Report for the year 2019-2020. It has been a year of many challenges but equally of many achievements.

The report sets out our progress in delivering the highest quality pathology services. Quality assurance is central in all we do and we aim to reflect it in our processes, professional practice and of course our culture.

Looking back over the last year, we took significant steps within our large scale transformation programme with key projects being delivered successfully.

We are transforming our services not just for today but with sustainability, future proofing and continuous quality improvement as our focus. We are already seeing some of the benefits provided as we have strengthened collaborative ways of working and alignment internally and externally with service users.

Our core values are patient focused, collaborative, expert and caring. These drive the purpose of our laboratories and enable better outcomes for patients.

I would like to thank everyone at NWLP for their professionalism, passion and dedication, without whom this would not be possible.

Saghar Missaghian-Cully

NWLP Managing Director

Highlights

- The NWLP Rapid Flu Testing Team won the 2019 annual Chair Make a Difference award.
- Implemented the new Sunquest Laboratory Information Management System, at West Middlesex Hospital
- Launched a new state of the art Multi-Disciplinary Automated Laboratory at the Charing Cross hub site.
- Implemented a new central state of the art Cellular Pathology Laboratory at the Charing Cross hub site
- Centralised and integrated the histopathology and cytopathology services from St Mary's, Hammersmith and Charing Cross laboratories at the hub site, incorporating samples from Imperial and Chelsea and Westminster Trusts.

DELIVERING SCIENCE SUPPORTING HEALTHCARE

NORTH WEST LONDON PATHOLOGY

Table of Contents

1. Overview

1.1 About us

North West London Pathology (NWLP) is an NHS partnership between Imperial College Healthcare NHS Trust, Chelsea & Westminster Hospital NHS Foundation Trust and The Hillingdon Hospitals NHS Foundation Trust. It is hosted by Imperial College Healthcare NHS Trust but is jointly owned by the three Trusts.

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The hospitals included within the NWLP partnership are:

Imperial College Healthcare NHS Trust

- St Mary's Hospital (Paddington)
- Charing Cross Hospital (Hammersmith)
- Hammersmith Hospital (East Acton)
- Queen Charlotte and Chelsea Hospital (East Acton)
- Western Eye Hospital (Marylebone)

Chelsea and Westminster Hospital NHS Foundation Trust

- Chelsea and Westminster Hospital (Chelsea)
- West Middlesex University Hospital (Isleworth)

The Hillingdon Hospitals NHS Foundation Trust

- Hillingdon Hospital (Uxbridge)
- Mount Vernon Hospital (Northwood)

1.2 Our vision

Our vision is to be a state of the art integrated pathology network, delivering diagnostics to users and patients alike across primary, secondary and tertiary care. To be at the forefront of diagnostic innovation, translating research into routine pathology.

1.3 Our values

Our values were developed through extensive staff engagement and consultation. They are fundamental to everything we do at NWLP and form the basis of our staff culture and behaviours. These values are:

1.4 Our services

NWLP offers a comprehensive testing repertoire which includes internationally recognised specialist services affiliated with clinical expertise from within our partner Trusts and collaboration and innovation with Imperial College London. These include:

Core Services		Specialist Services
Haematology **Blood Transfusion**	→	Specialised coagulation service
Clinical Biochemistry	→	Clinical Biochemistry specialist testing Andrology
Cytology	→	Non-Gynae cytology
Histopathology	→	Electron Microscopy, Immunocytochemistry
Molecular Pathology	→	Molecular diagnostics, Cytogenetics and immunophenotyping
Immunology	→	Histocompatibility and Immunogenetics
Microbiology **Virology and Serology**	→	Molecular diagnostics

➢ Blood sciences (Clinical Chemistry, Haematology and Blood Transfusion)

All NWLP sites offer tests requiring a turnaround time of less than 4 hours to support acute care services including emergency, urgent care centres, intensive care units, pre-op and post op testing. Each spoke site offers Chemistry, Haematology, Blood Transfusion and specimen reception with dedicated urgent pathways, monitored by a dashboard.

The Blood Sciences department is also responsible for the Point Of Care Testing governance within NWLP to facilitate safe use of near patient testing devices.

Blood Transfusion services are networked where possible with harmonised and standardised IT, governance and protocols. Each blood transfusion laboratory has been optimised to suit the specific requirements of the hospital services it is on the site of, for example, A&E, maternity, Trauma and transplantation. All laboratories comply with MHRA and UKAS requirements.

➢ Infection and Immunity

Infection and Immunity Sciences (I&I) is comprised of Microbiology, Immunology, Virology and Histocompatability and Immunogenetics (H&I).

All I&I services, apart from H&I which is based at Hammersmith, are located at the hub site at Charing Cross. I&I services are integrated with state of the art technology managed across shared platforms, which include total laboratory automation in Microbiology and comprehensive services for serological and molecular diagnostics. Serological services are integrated into the state of the art Multi-Disciplinary Automated Laboratory (MDAL) facility which offers 24/7 diagnostics.

➢ Cellular Pathology

Cellular pathology services, made up of Histopathology, Cytopathology and electron microscopy are available at our hub site at Charing Cross hospital. Specialist Integrated Haematological Malignancy Diagnostics (SIHMDS) including Molecular Pathology are currently situated at Hammersmith Hospital with plans to centralise services at the hub.

The specialities include Gastrointestinal, Liver, Pancreas, Skin, Breast, ENT/head & neck, Gynaecological, Renal, Haematological, Musculoskeletal, Urological, Lung, Endocrine and Cardiovascular Pathology, molecular and HMDS. The Department offers a comprehensive and expert service including diagnostic testing, reporting and interpretation of results as well as clinical advice on further investigation and treatment of patients.

Collectively the Cellular pathology service handles approximately 100,000 cases per year.

➢ Consultant led service

The pathology clinical service is led by Dr Corrina Wright as Clinical Director with Consultant Leads in each of the pathology divisions:

• **Blood Sciences**	
Clinical Biochemistry	Professor Tricia Tan
Haematology	Dr Abdul Shlebak
• **Infection and Immunity**	Professor Peter Kelleher
• **Cellular Pathology**	Dr Mike Osborn

Consultant Leads are supported by Consultants teams, Clinical Scientists and Specialist Registrars covering all disciples. This team provides 24/7 support to the routine and specialist services including diagnostic testing, reporting and interpretation of results as well as clinical advice on further investigation and treatment of patients. The service is dedicated to ensuring that the pathology service delivers in supporting better clinical decisions, leading to better outcomes for patients.

1.5 Our year at a glance

Pathology has had a year of many challenges in 2019/20, especially in the final month. Nationally, while pathology workforce issues continued as a dominant theme, there were unprecedented changes to the National Cervical Screening Programme with primary HPV testing and with the Covid-19 pandemic.

In NWLP we worked on providing a high quality service, achieving significant transformation milestones along with significant service developments, improvements and achieving recognition for our staff.

Some of the highlights of our year:

April 2019

- Cellular Pathology and Mortuary Team wins Imperial's annual Corporate Team Excellence Award for their involvement in the 2018 Human Tissue Authority (HTA) Mortuary inspection at Imperial. They are also finalists for Imperial Trust's Corporate and Divisional Team of the Year.
- Hosted the 15th internationally recognised 'Diagnostic Histopathology of Breast Disease' course.
- NHS England approved funding for histopathology National Gestational Trophoblastic Disease Service.
- Consultant Genomic Lead appointed for the host Trust.
- At Charing Cross the new Blood culture room for Microbiology was completed.
- At St Mary's the Chemistry Alinity CI analysers went live.
- Implemented Sunquest Laboratory Information Management System, at West Middlesex Hospital.

May 2019

- The Rapid Flu Team- a multi-disciplinary team from Blood Sciences, Infection and Immunity Sciences and Pathology IT- receives a special commendation from the Royal College Of Pathologists Excellence Awards in the 'Innovation in pathology practice' category for their rapid flu service.

June 2019

- Hosted 2nd NWLP Cellular Pathology Academic Day.
- Clinical Lead appointed by Public Health England-London as Professional Clinical Advisor to Cervical Screening Programme.

July 2019

- The Rapid Flu Team wins Imperial Chair's award for 'Driving Improvement Through Data' for the implementation of the rapid flu test.

- The Cellular Pathology and Mortuary team were nominated for “Team of the year” in the Imperial College Healthcare NHS Trust Make a Difference awards.
- The West Middlesex Hospital cellular pathology service centralised to the Charing Cross hub.
- Prof Robert Goldin and Dr Mike Osborne nominated for the 2019 Imperial College Students Academic Choice Awards.

August 2019

- Prof Mona El-Bahrawy conferred the title of Professor of Practice (Histopathology), Imperial College London.
- At West Middlesex site the new ESR Alifax analyser went live.
- Some significant Pathology IT transition related projects were completed including the AMS Upgrade, Sunquest Lab 8.2 upgrade and the Sunquest Copath 7.0.
- The new automated track installation completed thus creating the Multi-Disciplinary Automated Laboratory (MDAL) at Charing Cross site.

October 2019

- Rapid flu service began across all of the NWLP sites. This is the first year that services were being offered on the Hillingdon site.
- Dr Peter Kelleher, Clinical Lead for Infection and Immunity, appointed as the Laboratory Medicine External Examiner for Oxford University.
- NWLP launches the first NWLP Staff Recognition Awards.

November 2019

- NWLP is shortlisted for UK Diagnostics Award for Lab of the Year and NWLP's I&I service receives highly commended award at awards event.
- Integration of West Herts Upper GIT services with ICHT is achieved, consolidating at Hammersmith site.
- New logistics contract with DHL went live providing a sophisticated and highly reliable solution across the network and included 250 GP practices.
- At Hammersmith and St Mary’s sites the new Sebia Capillary analysers went live.
- The West Middlesex site Haemoglobinopathy service transferred to St Mary’s site.

December 2019

- Following the outcome of the National Tender for Primary HPV Testing, the Cervical Cytology Screening Service was closed at the St Mary’s site with successful redeployment and TUPE transfer of all staff to HSL.

January 2020

- Commenced a huge project to upgrade all the NWLP PC hardware and software to operate in Microsoft Windows 10.

- A significant Sunquest Lab 8.3 Upgrade went live seamlessly in Jan 2020 with new developments for the Blood Bank module.

February 2020

- Awarded £36 k from HEE, following a successful bid for digital equipment to innovatively enhance cellular pathology training.
- The brand new state of the art MDAL at the Charing Cross went live with the Chemistry and Immunoassay analysers marking a significance milestone for the transformation.
- Our new central state of the art cellular pathology laboratory along with brand new dissection facilities completed
- The Hillingdon cellular pathology service partially transferred to the hub site.
- Cytogenetics was granted UKAS accreditation.
- Large scale redevelopment project to create new consultant histopathologist offices at the Charing Cross hub was to enable the consultant centralisation as part of the Cellular Pathology service consolidation.

March 2020

- Completion of centralisation and integration of the histopathology and cytopathology services from St Mary, Hammersmith, and Charing Cross laboratories at the Charing Cross hub, incorporating samples from Imperial and Chelsea & Westminster Trusts.
- The first phase of the tracking software SMART AP for cellular pathology went live.
- Transformation programme paused due to the pandemic.
- The I&I team rapidly responded to the Covid-19 pandemic by introducing PCR testing as one of the first laboratories outside of PHE, building capacity rapidly to meet the increasing demand. Antibody testing also introduced rapidly once testing became available.
- Supported staff redeployment to clinical areas and the Nightingale Hospital.
- Worked closely with the three Partner Trusts to ensure an active staff testing programme for Covid-19 PCR screening
- Evaluated and supported new ways of working in response to the pandemic.

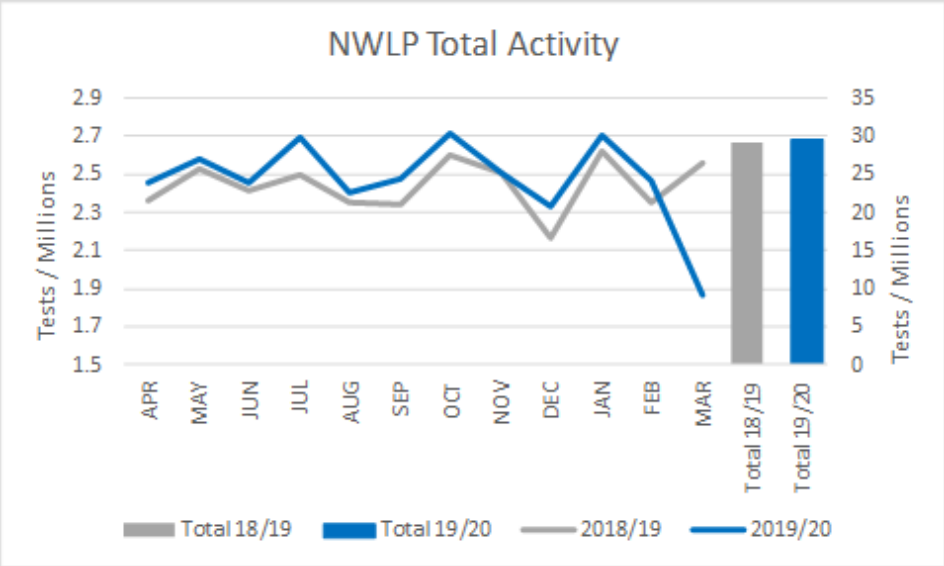
2. Operational Performance Report

2.1 Activity

NWLP processed a total of 29,637,824 tests - an increase of 1.20% in activity compared to the previous year.

Activity across this financial year has been relatively stable across NWLP sites, in line with expected seasonal variation.

The impact of the pandemic can start to be seen from February 2020, as activity rapidly declined to 40% of baseline activity during lockdown.



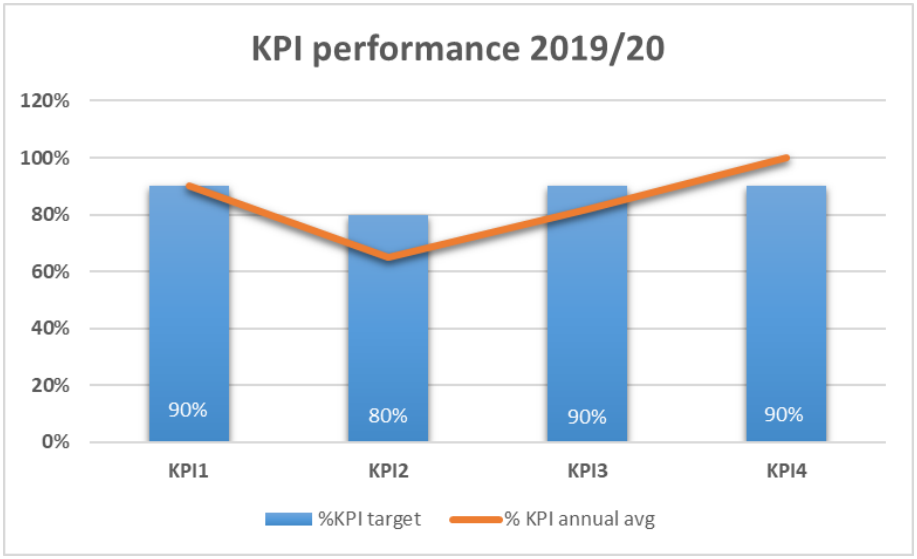
2.2 Key Performance Indicators (KPIs)

Performance is measured against a suite of KPIs as outlined in the table below:

KPI	Baseline	Target
1 -A&E blood sciences turn-around-times	Percentage of core investigations, i.e. renal function, liver function tests and full blood counts from A&E completed within 1 hour of receipt, including out of hours	90%
2 -Histopathology diagnostic biopsy turnaround times	Percentage of diagnostic biopsies reported, confirmed, and authorised within 7 days of biopsy Percentage of all biopsy cases (excluding those requiring decalcification) reported, confirmed, electronically authorised and electronically available to the requestor within 7 calendar days of biopsy being taken. This Key Performance Indicator is not restricted to cancer pathway cases	80%

3 -Overall Histopathology reporting turnaround times	Percentage of all histopathology and diagnostic cytology final reports available within 10 calendar days of procedure. Reflex molecular tests are excluded from this Key Performance Indicator but should have documented and agreed pathways with specified and monitored turnaround times.	90%
4 -Routine antenatal screening tests for Hepatitis B, HIV, Syphilis, and Rubella susceptibility	Percentage of routine antenatal screening tests for Hepatitis B, HIV, Syphilis, and Rubella susceptibility reported, confirmed, authorised and electronically available to requestor within 6 calendar days from sample being taken.	90%

2019/20 has been a challenging year for NWLP as the organisation underwent major changes as part of the transformation programme that despite planning and mitigation actions impacted aspects of KPI performance. Implementation of new analysers, transition of services, consolidation of laboratories, staff consultations, major building works are just some of the factors that contributed to variations in performance throughout the year. In addition, the early months of the Covid-19 pandemic added to these existing challenges.



KPI 1

KPI 1 performance for the year has been variable due to the impact of performance issues of the new analysers that were implemented in Chemistry and Haematology. Overall NWLP met the KPI target as the average performance for the year was 90.3% in target.

New Chemistry analysers were implemented to the St Mary's and Charing Cross sites as part of our transformation programme. The new chemistry analysers experienced hardware issues when first introduced which impacted on the service performance. In response, the manufacturer completed an extensive hardware upgrade programme that significantly improved the uptime of analysers and stability of their performance.

New Haematology analysers were implemented to the Imperial and Chelsea & Westminster sites. Similar issues were experienced with hardware and software from the roll out. The manufacturer implemented extensive upgrade programmes and improvements in the turnaround times were seen from September 2019 onwards following implementation of this mitigation.

The MDAL on the Charing Cross site went live at the end of February 2020. The service maintained the A&E performance for Charing Cross during the transition period.

KPI 2 & KPI 3

The performance against KPI2 and KPI3 for the Cellular Pathology service has been a challenge in 2019/20 as the service went through major changes under the transformation programme. Throughout March 2020, the Cellular Pathology laboratories moved from St Mary's and Hammersmith sites to the centralised Charing Cross hub. During the transition into the new location there were planned decreases in turnaround time performance. Following the consolidation of the service, the department carried out service reviews and implemented new improved ways of working.

A service improvement action plan was implemented with strong focus on service integration, performance and quality improvement.

A new post for NWLP Cancer Services Manager was introduced to specifically focus on management of the cancer services pathway.

Other service improvements include:

- centralisation of Histopathologists at the Charing Cross hub
- roll out of voice recognition software
- implementation of digital scanning of frozen section slides to facilitate Pathologist centralisation in the hub
- integrated, efficient new ways of working
- improved workflow
- reduced variation

Improvements have also been seen in individual specialities, particularly GI and Gynae-pathology where additional consultants came into post, ceasing outsourcing of work.

KPI 4

KPI4 remained in target over the past 12 months with an average performance of 100% well above target.

Serological Virology testing has now been integrated into the MDAL, moving from a five day service to being offered 24/7.

2.3 Histocompatibility and Immunogenetics (H&I) service

During 2019/20, H&I Laboratory Director's role was appointed. The inherited service was experiencing workforce related issues due to poor workforce planning, staff exceeding European Working Directive regulations and an emergency outsourcing of deceased donor typing. A critical service review outlined the requirements for safe clinical service delivery and investment made in staffing. Stabilisation of

services has resulted in the planned re-introduction of deceased donor typing once services re-establish post-covid.

2.4 The Hillingdon Laboratory Referral Process

The year saw an increase of incidents and complaints reported regarding results for tests referred off site.

A team of senior biomedical scientists representing all departments within Pathology carried out a review of the referral process at the Hillingdon site to identify improvements. A review of the IT processes for the use of the LIMS is also being undertaken to ensure the optimal processes are in place prior to the change in LIMS.

Focussed improvement at the Hillingdon labs over the year included:

- A change in leadership implemented to support the services, providing improved escalation pathways for on-site staff in the laboratories and effective oversight of action plans.
- New documented standard operating procedures written in line with the rest of NWLP sites to ensure shared learning is implemented.
- Re-training and competence assessment programmes introduced to ensure staff on all NWLP spoke sites have the same quality training with documented evidence.
- Improvements and monitoring of clinical support offered to the Blood Sciences labs.
- Improvements made to the referral process and improved documented procedures and training documentation at the Hillingdon site laboratory.

2.5 Risk Register

At the start of the year in April 2019 the NWLP risk register held 28 open risks out of which 22 risks were graded 12 (High risk) or above.

The highest risk at the time was the discrepant results generated on the new Haematology analysers. NWLP worked with the manufacturer and in March 2020 the outcome of a study carried out by the Haematology clinical team at Hammersmith Hospital was reported. Based on the conclusion of the study this risk was later closed as no further discrepancies were noted.

A number of IT related risks were mitigated and closed during the year. The appointment to the position of Associate Director of IT for NWLP has led to more robust processes for Pathology IT and the identification and mitigation of related risks. Successful launch of Sunquest LIMS on the West Middlesex site in April 2019 and supporting the go live of Cerner at Chelsea & Westminster Hospital site in November 2019 has provided evidence of the effectiveness of the mitigation.

In total 11 risks were closed in 2019-2020.

At the end of March 2020, the NWLP risk register held 37 open risks, 18 of which were graded 12 (High risk) or above.

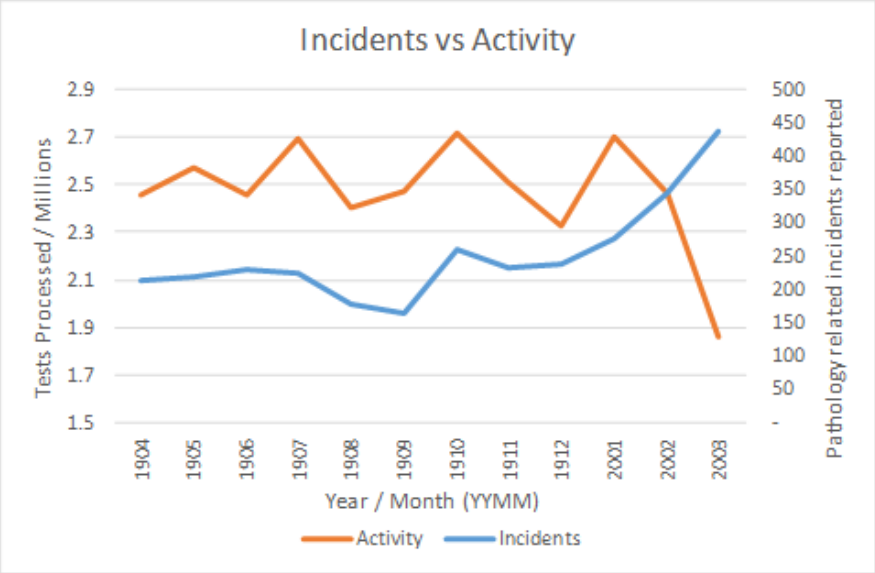
The highest rated risk at the end of March 2020 relates to reporting of Histopathology specimens at the Charing Cross Site. Since the centralisation of the service at the hub site, improvements in performance have been made.

Risks regarding the provision of COVID-19 testing due to limited access of supplies for the provision of the NWLP service as a whole during the pandemic have also been assessed and added to the NWLP risk register. These risks are being managed as part of the national response to the pandemic.

2.6 Pathology serious incidents - Annual review

2.6.1 Incidents vs activity

The service has a 0.010% incident rate. The number of incidents reported was 3016 against an annual activity of 29,637,824 tests. The monthly breakdown of activity versus number of incidents reported is presented below. This is reported as all pathology related incidents within month and those incidents pathology is required to investigate.

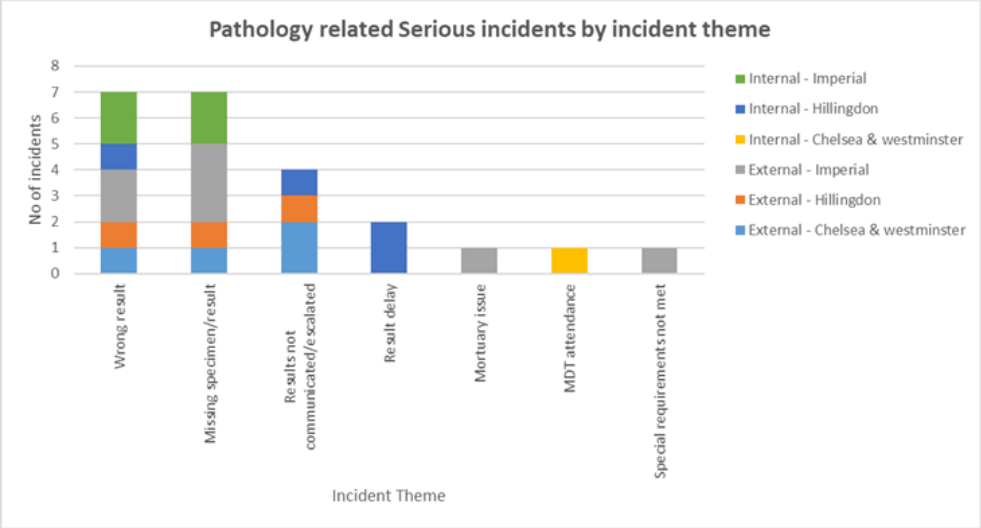


	1904	1905	1906	1907	1908	1909	1910	1911	1912	2001	2002	2003	TOTAL
Incidents	212	220	229	224	177	164	261	231	238	277	345	438	3,016
All pathology related incidents	0.009%	0.009%	0.009%	0.008%	0.007%	0.007%	0.010%	0.009%	0.010%	0.010%	0.014%	0.024%	0.010%
Activity	2,456,153	2,574,322	2,456,960	2,690,149	2,405,939	2,475,029	2,717,357	2,509,213	2,328,371	2,698,426	2,464,229	1,861,676	29,637,824

2.6.2 Serious Incidents report

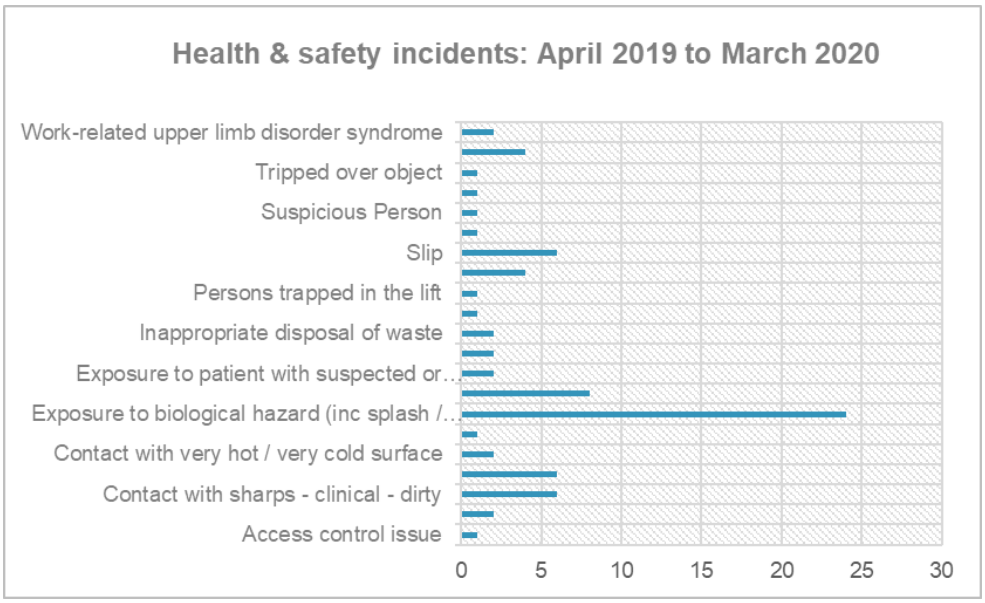
There were fourteen externally reportable and nine internal serious incidents reported.

Incident themes were identified as result delays, wrong results, missing specimens and failure in the communication of results. Actions have been taken to prevent recurrence of incidents across all themes.



2.6.3 NWLP Health and Safety report

For the period April 2019 to March 2020 a total of 78 health and safety incidents were reported. Six of which were recorded as RIDDORs. The table below provides details of the sub category of incidents.



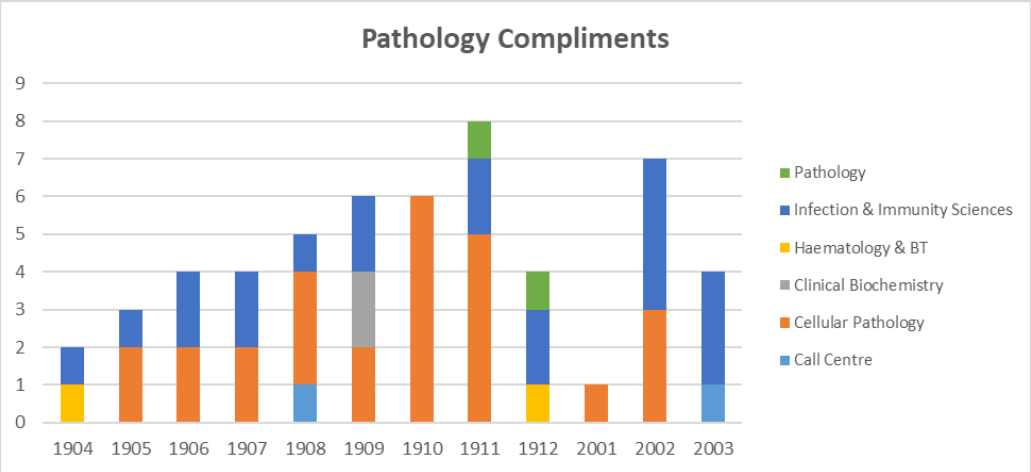
2.7 Pathology User Feedback

2.7.1 Pathology User satisfaction

A pathology user survey was carried out between February and April 2019. In total 64 GPs and 124 Trust users responded.

When asked how satisfied the users were with the pathology service on a scale of 1-10, 94% of GPs and 59% of Trust users answered positively (>5) with 90% of GPs and 47% of Trust users answering 7 or above.

A number of 54 Compliments were received during 2019-20.



Thanks received ranged from support in contingency plans for external hospital labs, expedited cases in Cellular pathology including molecular pathology, maintaining the Blood Transfusion service following a power cut and recognition of Andrology staff for their 'professional and adult, kind and empathetic manner'.

Compliments were also received for the NWLP call centre staff who were always willing and ready to help resolve queries quickly and in a professional manner.

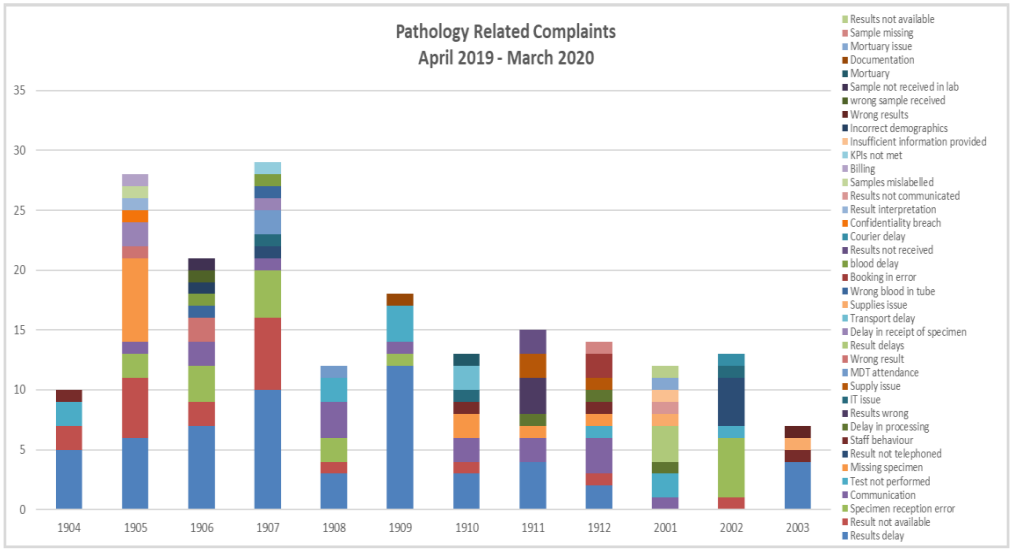
2.7.2 Pathology complaints

Since the beginning of 2019 NWLP had a further drive to ensure that all complaints, in particular informal complaints, are recorded appropriately. This has seen an increase in complaints being recorded.

In total we received a total of 192 complaints in the period between April 2019 and March 2020.

The top five themes were:

- Results delay
- Result not available
- Specimen reception error
- Communication
- Test not performed



The management of complaints, led to a number of improvements, changes and additional measures to ensure issues are efficiently addressed and lessons learnt.

2.8 Accreditation & Regulatory status of laboratories

The Pathology Quality department is responsible for ensuring that quality management systems are fully implemented, and regulatory and accreditation requirements are met. All laboratories at the Imperial sites within NWLP are accredited by UKAS against ISO15189:2012, and the relevant laboratories also comply with the regulations and requirements of the following bodies:

- The Medicines and Healthcare Products Regulatory Agency (MHRA);
- The European Federation for Immunogenetics (EFI);
- The Human Fertilisation & Embryology Authority (HFEA);
- The National Health Service Cervical Screening Program (NHSCSP);
- The Health & Safety Executive (HSE).
- The Human Tissue Authority (HTA)

The table below present the current accreditation status of our laboratories.

UKAS accreditation

Department	Site	CPA/UKAS Ref	Date of last assessment	Outcome	Date of next assessment
Clinical Biochemistry	St Mary's, Charing Cross, Hammersmith, Chelsea & Westminster	8673	September 2019	Accredited	September 2020
Clinical Biochemistry	The Hillingdon	0124	N/A	Working towards accreditation	TBC
Clinical Biochemistry	West Middlesex	N/A	N/A	Working towards accreditation	TBC
Haematology & BT	St Mary's, Charing Cross, Hammersmith, Chelsea & Westminster	8674	February 2020	Accredited	February 2021
Haematology & BT	The Hillingdon	0554	N/A	Working towards accreditation	TBC
Haematology & BT	West Middlesex	N/A	N/A	Working towards accreditation	TBC
Microbiology	The Hillingdon	1073	N/A	Working towards accreditation	TBC
Infection & Immunity Sciences	Charing Cross	8756	February 2020	Accredited	March 2021
Cellular Pathology	St Mary's, Charing Cross, Hammersmith, Chelsea & Westminster, West Middlesex Hospital	9615	January 2020	Accredited	March 2021
Cellular Pathology	The Hillingdon	1072	N/A	Working towards accreditation	TBC

As part of the transformation programme there have been numerous changes in the laboratories. Due to the change from being an accredited laboratory (CPA) to being accredited for a particular repertoire/scope (ISO15189), any changes or additions to repertoire require assessment by UKAS (extension to scope).

There are some assays performed by NWLP that must be reported as not accredited for one of the following reasons:

1. The material tested does not come under the scope of the ISO standard 15189:2012 which pertains to the testing of material of human origin.
2. The reagent manufacturer and laboratory may be able to validate the performance of a particular test for some sample types but it is not feasible to validate the test for others because of insufficient data.
3. There may be insufficient mechanisms available for some less commonly performed tests in the form of external quality assurance schemes or independent quality control material to provide evidence to UKAS that the test performance meets the requirements of the ISO Standard.
4. A new assay/test has been introduced and is awaiting assessment by UKAS (as described above).

5. A change in equipment/methodology requires the laboratory to apply for an extension to scope to accreditation and the tests performed are awaiting assessment by UKAS (as described above).

The NWLP website is kept up to date with the latest accreditation information. Where an assay cannot be accredited, a relevant statement appears on the website in the notes section of the test information in the Test Directory.

MHRA Blood Safety & Quality Regulations

The transfusion laboratories at St Mary's, Charing Cross, Chelsea & Westminster, Hammersmith and West Middlesex have at their last MHRA visits found to be in general compliance with the requirements of Blood Safety & Quality Regulations (BSQR) and associated best practice guidelines.

In March 2020, the Blood Transfusion laboratory at Hillingdon underwent an inspection by the MHRA against the BSQR and associated best practice guidelines.

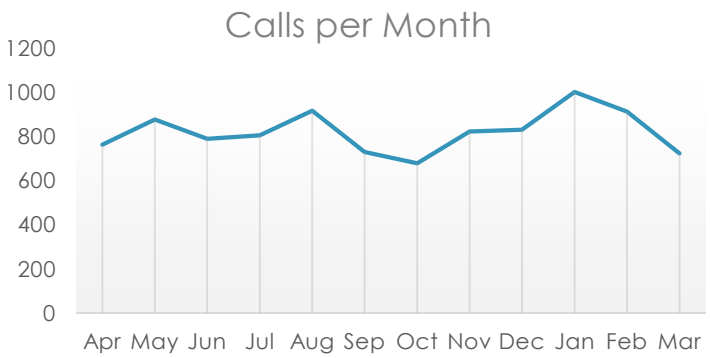
An action plan was put in place to address the findings, lessons learned from the inspection have been shared across all NWLP sites. The MHRA confirmed that the Blood Bank operations are in general compliance with the requirements of the Blood Safety and Quality Regulations, 2005/50, as amended in June 2020.

2.9 Pathology IT

The Pathology IT department has had an extremely busy year providing an excellent service to operations and service users, delivering projects as part of the transformation programme, and support a number of ICT projects across the Trusts.

2.9.1 Helpdesk

The graph below presents the number calls dealt with by the helpdesk between the period April – March 2020. The helpdesk deals with a large number of users from within the Pathology service and from service users from primary and secondary care.



2.9.2 Project activity

- **Implementation of Sunquest LIMS at West Middlesex site**

The successful roll-out of the Sunquest system on the West Middlesex site in April 2019 was an exemplar transition project to a new Laboratory Information Management system. This project was part of our

transformation programme and NWLP have been commended for the professionalism and handling of this project and preparation clinically and operationally for the go-live.

- **Sunquest V8.3 Upgrade**

The LIMS system was upgraded in January to enable functionality that would support the testing and eventual deployment of the Blood Bank LIMS system at a later date.

- **Multi-Disciplinary Automated Laboratory (MDAL)**

One of the most significant and complex projects under the transformation programme has been the implementation of MDAL, a project heavily reliant on Pathology IT and integration. Phase 1 of the MDAL went live in February with the Biochemistry equipment. This deployment of a large automated track connecting physically a number of chemistry and other analysers to it, along with integrated IT with the LIMS system to facilitate orders and results to flow seamlessly between systems, provides the foundation for the continued incorporation of more analytical equipment from Haematology and I&I areas expanding on the benefits of large scale consolidation and standardisation.

- **Smart AP**

The first stage of SMART AP went live providing enhancements for Cellular Pathology. This can now be built upon to record more detailed workflow of samples through the lab and enable additional functionality to be utilised as later stages are deployed.

- **Dragon Voice Dictation**

This software was installed across Cellular Pathology to support the voice dictation for both Consultants and lab staff. This will result to efficiencies through being able to interact with the microscopes and specimens while conducting reporting of the specimen at the same time.

- **Microsoft Windows 10 and Server 2008 support**

A large project to upgrade the PCs and servers used by NWLP is underway to ensure the organisation is operating is Windows 10. Working closely with the Trust ICT department, these upgrades have enabled a smooth transition into new applications such as the Dragon Voice dictation system.

- **Cerner Ordercomms at Chelsea**

NWLP worked closely with the Chelsea Cerner project team to ensure the successful implementation of Cerner order comms at Chelsea to replace the legacy Lastword system. This brings both Chelsea and Imperial much closer in sharing the same systems and processes, while reducing the number of legacy systems in use for clinical staff. This was a large scale change for Chelsea as the hospital migrated on to a new EPR system and Pathology IT provided close support during this successful transition.

- **Millcare Results Feed**

NWLP has supported the implementation of a results feed for the St Mary's GUM system which reduces the risk of transcription error and speeds up the accessibility of the results within the Millcare system for Clinical staff.

- **West Middlesex Results feed to Cerner**

NWLP has established a Pathology results feed to the Cerner system, prior to the system being used by staff for most day to day clinical purposes. This connectivity sets out some of the groundwork needed for the migration of pathology order comms from the ICE system when the organisation is ready to move completely onto Cerner.

- **Covid-19**

The Pathology IT department responded quickly and worked in accelerated pace to support the set up of new analysers and systems required for the Covid-19 testing and integrate these with the LIMS system. These were scaled rapidly and included the generation of various reports to inform Trusts and NHSEI of the output and capacity of the testing capabilities.

2.10 Covid-19 testing

The requirement to deliver testing for Covid-19 (SARS-Co-V-2) was initiated rapidly within NWLP, with the I&I team acting as one of the first in London to introduce PCR testing in March 2020.

By the end of March, the laboratory was offering a 24/7 service for molecular PCR testing. The service ramped up and diversified use of technologies and collaborated with Molecular Diagnostics Unit (Imperial College) at St Mary's site.

Novel techniques developed in-house using heat inactivation to remove the dependency on extraction and use of inactivation viral transport media received national recognition.

The laboratory is now supporting patient, staff and community testing in response to service demand with capacity increasing to three thousand tests per day.

2.11 EU Exit Preparedness

NWLP have completed risk assessments to identify any potential risk and planned mitigations in relation to the EU Exit.

NWLP will work closely with the three Partner trusts emergency preparedness teams to ensure that plans are fed into the Trust high level planning.

3. Service Development

North West London Pathology (NWLP) is committed to delivering first class diagnostic laboratory services, including research, development and training. We fully understand the needs of all our users, whether clinicians, patients or commissioners, and continually work towards improving our service as these needs change.

Service development is high on our agenda as we are driven to excel in quality outcomes and we aspire to strengthen our position as a leader in pathology services provision.

3.1 Service Development & Innovation

Haematology & Blood Transfusion

There has been a robust programme of change within Haematology. Through the clinically led operating model meetings, services across Haematology have been harmonised. As the new technologies were rolled out, harmonised reference ranges have been implemented. Services across the three Imperial sites and Chelsea Westminster are all now using the same analysers. Progress is being made for the implementation of the equipment into West Middlesex and Hillingdon sites. New tests have been introduced which include; anti-factor 10 assay to monitor heparin, replacing clotting time measurements, as well as implementing new assays to measure novel oral anticoagulant drugs. In March 2020, the pandemic required rapid upscaling of D dimer measurement and monitoring of heparin concentrations.

The NWLP Blood Transfusion service in collaboration with the three partner Trusts have completed significant quality improvement to reduce the wastage of blood components. Through close collaboration across the network, a strategy to reduce the wastage of blood products was delivered resulting in an annual savings of over £150K. This included a stock sharing initiative for all sites to manage shelf-life of platelets and red cell products across the network and ensure usage within the Hammersmith site, where the requirements for these products was higher. Additional schemes are being explored to continue these service improvements.

The Blood Transfusion service is now providing extended red cell phenotyping across the NWLP network.

Point of Care (POC)

Currently NWLP are working with all three Partners, bringing forward a business case for a sustainable POC strategy. This is required to support a rapidly increasing demand on the current POC services. The main contracts for blood gas analysers and glucose meters are due for re-procurement and NWLP are resource planning to enable support for a multi-Trust procurement exercise.

Service improvements this year include implementation of the Sysmex FBC analyser which was interfaced to Sunquest LIMS within the A&E at St Mary's. The team has also supported the new glucose meter implementation at Chelsea & Westminster.

Biochemistry

Colorectal Cancer is one of the most common cancers in England. Patients with an earlier diagnosis at stage 1 have a survival rate of five years or more. The rate is less than 1 in 10 of people diagnosed at a

late stage. Over half of all cases in England and almost 60% of cases in London are diagnosed at stages 3 and 4.

NWLP rolled out Quantitative Faecal Immunochemical Test (FIT) to GPs and hospital Trusts in June 2019. FIT is a stool test that is highly sensitive for identifying bleeding in the gastrointestinal tract, a sign of colorectal cancer and is an improved test for identifying patients to be referred for investigation.

Significant service developments were undertaken in Biochemistry, together with Virology and Immunology with the go-live of the Multidisciplinary Automated laboratory within the hub. The state of the art laboratory service provides a high throughput testing facility supporting all Chemistry and Immunoassay automated analysis in a 24/7 operation. Service improvements in IT connectivity provide complex calculations and autovalidation, removing the requirement for manual intervention in reflex testing and result validation.

Specialist Clinical Biochemistry are now offering a renal stones service.

Infection & Immunity (I&I)

Winter 2019 gave the I&I service an opportunity to showcase their innovative working models in delivering a rapid diagnostic flu service across the six hospital sites. Rapid flu testing was rolled out across all of the sites, enabling respiratory PCR testing for FluA, FluB and RSV within 2 hours turnaround time. The impact on clinical services and clinical flow, led to the Infection and Immunity team winning awards for their innovative operating models and ability to utilise complex data to support the Trust winter planning.

Following the implementation of the successful diagnostic service for respiratory viruses, the advent of the Covid-19 pandemic produced a huge demand to which the laboratory services were able to respond much more quickly than other pathology networks.

The major clinical focus for Infection and Immunity in the last year has been antimicrobial resistance.

There has been major ongoing clinical support in the treatment of respiratory infections, immune deficiency syndromes and renal and bone marrow transplant programmes.

Cellular Pathology

In cellular pathology the focus was integration and centralisation of the six separate laboratory services to the hub site. This incorporated structural modification and expansion of the existing histopathology laboratory at the Charing Cross site, while services continued to operate there.

National external regulatory bodies, UKAS, have commended the service, for maintaining delivery while building work was ongoing. During this period staff consultation was launched, with completion of the target operating staffing model in readiness for the centralised service. UKAS accreditation was achieved during this time, following an enormous amount of work and collaboration of our staff across all sites. After months of work the safe consolidation of the service was completed by March 2020.

The first stage of SMART AP - a sample tracking and auditable software specifically for Histopathology samples - went live providing enhancements for Cellular Pathology. This can now be built upon to record more detailed workflow of samples through the lab and enable additional functionality to be utilised as later stages are deployed.

Digital scanners were installed at Hammersmith and St Mary's sites to enable digital scanning of frozen sections. This aided the facilitation of Pathologists centralisation at the hub, as the frozen section services can be delivered from a wider pool of pathologists located at the hub. Demonstrating an increased service resilience and removing the requirements for Pathologists to travel across multiple sites. Dragon Voice

Dictation – a new software to support the voice dictation for both Consultants and lab staff was installed across Cellular Pathology. This enables efficiencies through being able to interact with the microscopes and specimens while conducting reporting of the specimen at the same time. This has revolutionised the service, removing the requirement for manual transcription and allowed a reduction in the requirement for administrative support in this area.

Stock Management

Implementation of STOK UK - a delivery plan for stock management – is in progress across the services, reducing the burden for the management of reagent supply to the laboratories., providing access to 'just in time' stock management and a centralised inventory management system.

3.2 Research

NWLP research has a number of goals, establishing new diagnostics, using pathology data and single exemplars to establish new pathological mechanisms, testing new drugs to demonstrate clinical effectiveness, as well as understand side effects and integrating new measurement techniques and science breakthroughs into everyday pathology for patient benefit. We have been very successful at using our exciting new ideas to raise support funding and have an excellent publication record. NWLP prides itself on high academic standards having an impact in the real world

Haematology research has been active in practical fields. Particular focus has been the explanation of out of range coagulation results, especially in relation to anticoagulation therapy. Field testing of a novel coagulation assessment device was a major focus. Specific studies have monitored the outcomes of anticoagulation therapy in intensive care and cardiopulmonary bypass.

Chemistry research continued the major exploration of lipid metabolism and the effect of standard and novel lipid lowering agents. Basic laboratory work looked at biased agonists and how they might improve the function profile of new drugs. The anti-diabetic and obesity research continued apace with successful identification of novel therapeutic agents, the successful role out of novel applications of existing agents and identification of methods to personalise gastric bypass surgery. Our successful research fellowship programme ensured laboratory research remained very active with a number of grants and publications.

Infection & Immunity research has been very productive with several publications on unusual infections with interesting or novel scientific explanations and insights. Considerable support has been provided to ongoing clinical trials in both the immunological and microbiological fields (and more recently to virology in the Covid-19 infection).

Cellular pathology has been productive in renal, gynaecological, gestational trophoblastic, hepatic, gastrointestinal, lung disease, neuropathology and haematopathology research. They have achieved 41 publications in peer-reviewed journals, 6 national guidelines, 2 book chapters, 15 abstract publications in journals with abstracts related to conference presentation, investigators or co-investigators in projects with over £900K new grant funding, support for PhD (6), MD (1), MSc (2) and BSc (2) students, and Academic Clinical Fellows (3) and 34 invited lectures in international and national meetings. They also provide support to many journals (editorial support) and research committees.

3.3 Teaching

All subspecialist pathology disciplines continued to deliver and support undergraduate, postgraduate teaching and training to all staff groups.

NWLP continued to support the delivery of exciting credible career pathways for our scientific workforce. This will help build resilience in our workforce, especially in areas with national staffing shortage, notably cellular pathology.

We continued to support clinical attachments, fellows and observers. There were successful examination outcomes with IBMS, RCPath and joint IBMS/RCPath qualifications. With Covid-19, we adapted teaching methods to ensure staff maintained a safe teaching environment and digital technologies were utilised in innovative ways.

4. Workforce

Our people are fundamental to our success in delivering a high quality service. We are proud of all our colleagues and recognise the important role they play in our service.

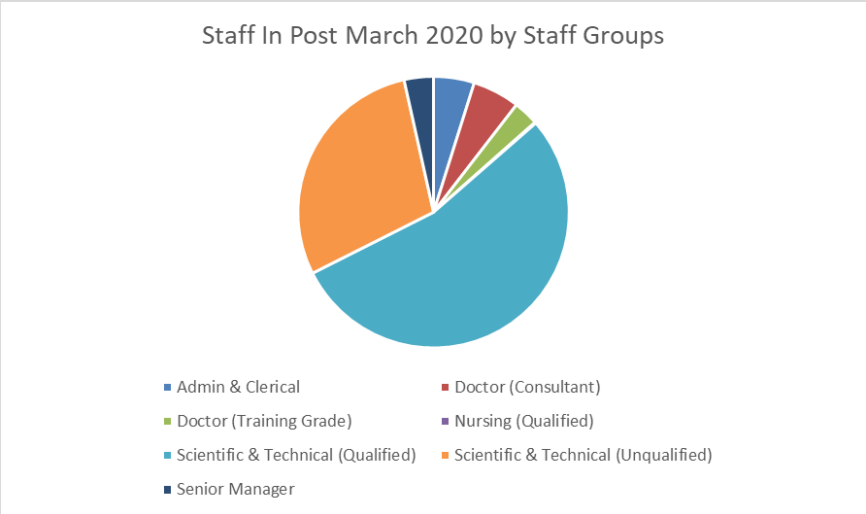
During the year we have continued to undergo significant changes to our IT, equipment and the transfer of services to the hub and the workforce has worked hard to maintain our services and lessen the impact on our service users during this period.

This section provides an overview of our activities on workforce planning and engagement for our staff in NWLP over the last financial year.

4.1 Workforce composition

By the end of the financial year, 827 WTE staff were in post. The workforce establishment has fluctuated during the year due to the movement of staff between the sites and a number of staff consultations which have taken place. Once we have completed the transition to the hub and spoke model all the changes required to remove posts which are not part of the target operating model (TOM) will take place. This has commenced and is due to be completed by the end of 20/21 financial year. As a consequence of this we have maintained a high vacancy rate of between 11.9% and 14.8% during the year. Turnover through this period of change remained high between 14% and 16%. This is expected to reduce once the final staff consultations take place.

Below is a breakdown of staff in post, excluding bank and agency, by staff groups.



4.2 Change Management

4.2.1 Consultations

NWLP was formed with the expectation that with large investment in IT, laboratory technology and moving to a hub and spoke model there would be significant changes in the workforce. As we progressed with the transformation a number of consultations were undertaken to move towards the end state. These included:

- Centralisation of Cellular Pathology on the Charing Cross Site which involved a reduction in the workforce numbers
- Divisional management consultation for Band 8A managerial roles and the establishment of Deputy Divisional Manager roles to support the Divisional Managers in Cellular Pathology, Blood Sciences and Infection and Immunity.
- Corporate Management Consultation – disestablishing the corporate support services and moving functions into other corporate areas and aligning the call centre with specimen reception within the Blood Sciences Division. This change resulted in the redundancy of the role of Corporate Service Divisional Manager
- Two new roles were established – Performance Improvement Manager and Contract Manager.

4.2.2 Cervical screening

Nationally it was a year of unprecedented change, with implementation of Primary HPV testing into the National Cervical Screening Programme (CSP). In England over 40 national laboratories were centralised into eight hubs, with redundancy of up to 70% of the workforce, as HPV technology replaced scientific staff.

In June 2019, following a competitive tendering process, Health Services Laboratories (HSL) was formally awarded the HPV screening contract for London by NHSE. In view of this we TUPE transferred all the gynae cytology screening staff to HSL in December 2019. Staff who provided non-gynae work were transferred to the Charing Cross site as part of the centralisation of Cellular Pathology.

Throughout the year we supported all our cervical cytology staff through the uncertainty of their future, employment, location, job security and redundancy. We had regular staff engagement forums and worked collaboratively with HSL on our staff consultation, TUPE transfer and transfer of services. During the year we maintained performance to National standards, while most other Trusts failed.

4.2.3 Covid-19

In March 2020 as the pandemic took hold, we redeployed staff to various areas, including clinical roles, staff testing at Hammersmith site, setting up the mortuary at the Nightingale Excel Hospital and post mortems on Covid patients. All staff were supported with new ways of working, adapting our services and workforce to accommodate safe practices and keeping our staff safe.

4.2.4 Redundancies and Mutually Approved Resignation Scheme (MARS)

A mutually agreed resignation scheme (MARS) was approved and launched in April 2019 for a period of three months in anticipation of the large scale changes which were to come once the transformation of the services had been completed. Ten applications were approved with staff leaving between August and

September. The application of MARS resulted in no redundancies following the Cellular Pathology consultation and the Band 8 management consultation.

4.2.5 Review of NWLP governance

During 2019/20 the Owner Trusts commissioned an independent review of NWLP. Following the outcome of the review the Trusts made temporary changes to the governance of the organisation by aligning NWLP with the host Imperial College Health NHS Trust's governance and reporting structures. The NWLP Board was dis-established and the role of a Chair of NWLP became redundant. The Board was replaced with the Owners Committee.

4.2.6 Productivity Improvement Project

Meridian Productivity were invited to undertake a study within NWLP and based on their findings to assist in improving productivity across the service.

As part of the improvement project a series of management workshops for managers and team leaders across all divisions have taken place. The technical aspects of the workshops prepared managers for the implementation of a new management control system. The tactical learning ensured managers fully utilise the system, focusing on how to manage their teams in order to accomplish the objectives smoothly and efficiently, and to make the project an ongoing success.

Parts of these workshops will be built into a management development programme we are developing for 2020/21.

4.3 Staff Engagement

4.3.1 Values

NWLP brings together staff from three different organisations requiring focus on the creation and development of a sense of belonging as part of one organisation. Building on the vision, over a period of months through numerous workshops with staff from all sites a set of values were established.

The values developed and agreed for NWLP are:

Further work is ongoing to develop our behaviours linked to these values and branding of the organisation.

4.3.2 Staff Engagement Group

A number of other initiatives set up include a staff engagement group chaired by NWLP Managing Director with representatives from all sites who are band 7 or below. The role for the representatives is to bring issues they have not been able to progress within their departments and to take back to their departments any updates shared with them at the meetings. This is designed to be a two way process.

We have held a regular roadshows and walk-abouts on each site, to ensure that all staff have an opportunity to be briefed directly by NWLP executives and to be able to ask questions about the service.

4.3.3 NWLP Staff Recognition Awards

We were pleased to be able to launch the NWLP Staff Recognition Awards in 2019.

This was the first year of the awards intended to become an annual event. These awards will provide our staff an opportunity to thank those colleagues that have gone the extra mile in carrying out their work and have been nominated to receive the award.

4.3.4 NHS Staff Survey

Overall there was an increase in the number of people who responded to the NHS Staff Survey this year. It must be highlighted that this is the highest response we have received within pathology for some years.

Year	Type of Survey	% Response	No. of Responses
2018	Sample of staff	29%	8
2019	All staff	53%	469

In five of the themes NWLP scored at the national average or above.

- Quality of Care
- Safe Environment – Bullying and Harassment (national best score)
- Safe Environment – Violence (above the national best score)
- Safety culture
- Quality of appraisals

We scored just below the national average for Equality, diversity & Inclusion - 8.9 compared to the average of 9.

It is worth noting that the survey was conducted during a period of significant transition for the service and during staff consultations.

Areas for Improvement

The following are areas for improvement under the specific themes and the specific questions where NWLP have scored lower:

- Health & Wellbeing
- Immediate Managers
- Morale
- Staff Engagement
- Team Working

Our managers are committed to working through the developed action plans with staff.

4.4 Staff development

We continued to innovatively plan our workforce, supporting scientists in undertaking IBMS/RCPath qualifications for independent reporting, advanced dissection, utilising overseas attachments, visiting fellows and implement digital solutions to effectively use our staff resource.

We adapted and supported our consultant staff in taking on new roles, some outside NWLP, to advance patient care. Roles included senior medical examiner, genomics lead, professional clinical advisor to Public Health England.

Development of our staff is important and as well as attending external training events a number of our staff attended leadership courses run by Imperial Healthcare NHS Trust.

Our managers, senior clinical scientists and consultants attended an NWLP Leadership forum. The theme of the session was Change and Resilience to support managers on the significant changes taking place within NWLP.

A Healthcare Science Senior Leaders Forum was organised by our Chief Healthcare Scientist in October 2019.

4.5 Statutory & Mandatory Training

The majority of core and mandatory skills training are delivered through Imperial College Healthcare NHS Trust's online training software. Compliance to the targets are monitored on a monthly basis. Core skills training and core clinical skills has remained above the target (85%) at a monthly average of 94.3%

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4.6 Equality/ Diversity

Our workforce is very diverse (54% of our staff are from BAME groups) and we are involved in the Trust's initiatives and programmes to ensure that this diversity is reflected fairly in all aspects of NWLP. It is important that we ensure that all our staff feel included and fairly treated. We have representation on the Trust's EDI Committee and the WRES (workforce race equality standard) Steering Group.

4.7 Staff Health & Wellbeing

Improving staff health & wellbeing is of great importance to NWLP. In May 2019 we worked with CNWL's Recovery and Wellbeing College and ran a workshop entitled "Understanding Mental Health" for our managers which was well received. Our host Trust has since developed an in house Mental Health Awareness training programme, our managers are encouraged to attend.

5. NWLP Transformation Programme

The NWLP transformation programme is a complex service transformation initiative with major cross-cutting changes across multiple sites, all pathology disciplines and across many different levels such as clinical governance, operational structures, workforce, new analyser platforms, estates reconfiguration works, new logistics solution and IT integration across the network with a unique new LIMS.

The transformation programme was formally launched in 2018 and encompasses:

- Workforce transformation, including staff remodelling
- IT transformation - new single LIMS deployment across all sites
- Equipment standardisation - common analytical platforms across all sites
- Significant redesign and reconfiguration across all laboratories to accommodate the new equipment and a new model of service delivery
- Creation of a state of the art multidisciplinary automated laboratory at the hub
- New state of the art cellular pathology laboratory at the hub
- Harmonisation of laboratory and clinical processes across all sites
- Centralisation of services at the hub site including cellular pathology, infection and immunity and core blood sciences, with more to follow
- Transformation of all the spoke sites to operate as Essential Services Laboratories
- Optimisation of transport and logistics to support the hub and spoke model.

Achievements

Due to the pandemic, all transformation projects paused in March 2020. Between April 2019 and March 2020 some key programme milestones have been achieved:

- Charing Cross new Blood culture room was completed in Mar 2019
- St Mary's Chemistry Alinity CIs went live in Apr 2019
- West Middlesex new Sunquest LIMS went live successfully in Apr 2019
- The West Middlesex Cellular Pathology service transferred to the Charing Cross hub in Jul 2019
- West Middlesex new ESR Alifax analyser went live in Aug 2019
- The AMS Upgrade project completed successfully in Aug 2019
- The Sunquest Lab 8.2 and Sunquest Copath 7.0 upgrade projects completed successfully in Aug 2019
- The new automated Track installation completed at the Multi-Disciplinary Automated Laboratory (MDAL) at Charring Cross in Aug 2019
- The West Mid special chemistry service (protein electrophoresis) transferred to the Charing Cross hub in Sep 2019

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- The West Middlesex HbA1C transferred to St Mary's in Sep 2019
- At Hammersmith and St Mary's sites the new Sebia Capillary analysers went live in Nov 2019
- The West Middlesex Haemoglobinopathy service transferred to St Mary's in Nov 2019
- A significant Sunquest Lab 8.3 Upgrade went live seamlessly in Jan 2020 with new developments for the Blood Bank module.
- Completion of the new state of the art Central Cellular Pathology Laboratory including new dissection facilities in Feb 2020.
- The Multi-Disciplinary Automated Laboratory (MDAL) at Charring Cross went live in Feb 2020 with the Biochemistry analysers.
- The 1st phase of the Hillingdon Cellular Pathology service transfer to the hub completed in Feb 2020. Andrology transferred at Hammersmith in June 2020.
- A large scale redevelopment project to create new consultant histopathologist offices at the Charing Cross hub was completed In Feb 2020 to enable the consultant centralisation as part of the Cellular Pathology service consolidation.
- The St Mary's Cellular Pathology service transferred to the Charing Cross hub in its totality in Mar 2020
- The Hammersmith Cellular Pathology service transferred to the Charing Cross hub in its totality in Mar 2020.
- Phase 1 of the Sunquest Copath SMART AP tracking software for cellular pathology went live Mar 2020.

The programme is now starting to resume activity and a number of projects are progressing to ensure that the visionary large-scale transformation of our organisation is fully completed.

6. Finance

6.1 Summary Operating Results to March 2020

The operating financial position of NWLP for the Year to March 2020 is summarised in the table below:

	OUTTURN RESULTS / £'000		
	18/19	19/20	MOVEMENT
TOTAL			
Income	80,422	81,792	1,370
Non Medical Pay Costs	(41,370)	(41,287)	83
Medical Consultant Pay	(8,138)	(9,053)	(914)
Non Pay Costs	(35,036)	(37,540)	(2,504)
Direct Costs	**(84,544)**	**(87,880)**	**(3,336)**
Transition Costs	(1,245)	(1,663)	(418)
Operating Deficit after Transition	**(5,367)**	**(7,751)**	**(2,384)**

2019/20 posted a £7.7m deficit after Transformation costs, £2.4m worse than the 2018/19 deficit of £5.4m. There are many contributing elements to the deficit position but the broad highlights are:

- Dilution in GP Direct Access (GPDA) position due to the loss of the Hounslow contract during 18/19 (£1.6m), Rate reduction for Triborough CCG contracts (£2.0m) and general dilution due to lack of inflationary uplifts on Hillingdon CCG contracts (£1.4m).
- Transition costs incremental to baseline partner charges (£1.7m).
- Investment in Corporate Management overhead structure, not included in the baseline partner charges (£1.7m).
- Net service changes identified including part year impact of investment in Cancer Turnaround Time improvements (£0.6m) offset by other net cost improvements (£1.3m).

The deficit position has worsened since the previous year due primarily to the diluting impact of the GPDA pricing adjustments for the Triborough CCGs (£2.0m), the full year impact of the full transformation programme during 2019/20 (£0.4m).

Income increased year on year by £1.4m (1.7%). The growth in income is comprised primarily of an inflationary increase (£1.2m), growth in overall partner activity (£1.2m) offset by the net reduction in GPDA income due to the impact of reduced Triborough CCG prices (£2.0m) offset by generic growth (£0.8m).

Non Medical employee costs reduced year on year by £0.1m, despite £1.6m inflationary pressures and 1.2% activity growth during the year. The Cervical screening service ceased during December resulting in a £0.3m reduction in non medical staff, the remaining difference was due to a focus on reducing overtime and agency costs during the year.

Medical staff costs have increased year on year by £0.9m (11%). The key factors are increased costs for Consultants at the Hillingdon site due to the use of locums in advance of the service transfer; and the investment in improving cancer turnaround times during the year.

Non Pay costs have increased by £2.5m (7%). After inflationary pressures the key variances were: activity growth (£1.5m) which is disproportionately high compared to the overall activity growth due to the change in test mix, and in particular due to the higher volumes of rapid flu testing and initial investigations into Covid-19 testing response. There were also a number of identified non recurring items, including the investment in the Operational Management System improvements, and costs associated with a high number of employment tribunal cases experienced during the year

PATHOLOGY SERVICES INCOME

£'000	ICHT	THH	CWH	Third Party	TOTAL
2018/19					
Trust Pathology Services	30,995	2,591	21,728		**55,314**
GP Income				20,665	**20,665**
Other Third Party				4,443	**4,443**
BUDGET TOTAL	**30,995**	**2,591**	**21,728**	**25,108**	**80,422**
2019/20					
Trust Pathology Services	32,269	2,829	22,676		**57,774**
GP Income				19,445	**19,445**
Other Third Party				4,573	**4,573**
ACTUAL TOTAL	**32,269**	**2,829**	**22,676**	**24,018**	**81,792**
Movement					
Trust Pathology Services	1,274	238	948		**2,460**
GP Income				(1,220)	**(1,220)**
Other Third Party				130	**130**
VARIANCE TOTAL	**1,274**	**238**	**948**	**(1,090)**	**1,370**

6.2 Partner Contributions

The year end overall contribution required from partners is £65.5m, £4.8m higher than 2018/19.

Partner contributions to the NWLP total costs are comprised of three key elements:

- Pathology Services Charges, which includes the pass through of GP Direct Access and Other Third Party Income
- Share of NWLP Deficit
- Share of NWLP Revenue Transformation Costs

A summary of these key elements compared to the business plan is provided below.

Partner Pathology Services charges were £2.5m higher than prior year and is explained in the narrative above.

The operational deficit and transformation costs were £2.4m higher.

TOTAL PARTNER CONTRIBUTIONS				
£'000	ICHT	THH	CWH	TOTAL
2018/19				
Trust Pathology Services	30,995	2,591	21,728	**55,314**
Share of Deficit	2,522	778	821	**4,122**
Contribution to Transformation Costs	762	235	248	**1,245**
Total Income	**34,279**	**3,604**	**22,797**	60,681
2019/20				
Trust Pathology Services	32,269	2,829	22,676	**57,774**
Share of Deficit	3,725	1,149	1,213	**6,087**
Contribution to Transformation Costs	1,018	314	331	**1,663**
Total Income	**37,012**	**4,292**	**24,219**	65,524
Movement				
Trust Pathology Services	(1,274)	(238)	(948)	**(2,460)**
Share of Deficit	(1,203)	(371)	(392)	**(1,966)**
Contribution to Transformation Costs	(256)	(79)	(83)	**(418)**
Total Income	**(2,733)**	**(688)**	**(1,422)**	(4,844)

6.3 Transformation Costs

Transformation costs for the full year 2019/20 are £2.8m, This is £0.4m higher than prior year but £4.1m favourable compared to plan. The in-year favourable variance primarily reflects delays in the project during 2019/20.

During March, the decision was taken to pause the transformation programme, in light of the pandemic. There were a number of key elements of the transformation which are left incomplete and which must be completed to realise the benefits anticipated from the programme. It is our intention to complete the outstanding workstreams when operational challenges imposed due to the Covid-19 pandemic have stabilised.

The key in year variances remain:

- Slower than planned implementation of capital Estate costs.
- Release of a prior year over accrual in LIMS implementation.
- Delays to the LIMS implementation plan.
- Phasing of redundancy costs (Workforce).
- Sharing of planned expenditure with our strategic partner, Abbott in the delivery of the MES solution (Pathology Service Transition).

NORTH WEST LONDON PATHOLOGY

£'000	CURRENT MONTH BUDGET	CURRENT MONTH ACTUAL	CURRENT MONTH VARIANCE	FULL YEAR BUDGET	FULL YEAR ACTUAL	FULL YEAR VARIANCE	PROJECT OUTTURN Spend B/F at 31/03/19	PROJECT OUTTURN FY ACTUAL 19/20	PROJECT OUTTURN Project Cost to Date
Central PMO	42	3	39	509	381	127	356	381	738
Estates	14	279	(265)	1,854	1,156	698	168	1,156	1,324
IT	47	53	(6)	920	265	655	3,055	265	3,320
Pathology Service Transition	194	(38)	232	1,119	319	800	771	319	1,090
Transition Project Cost	**296**	**297**	**(0)**	**4,401**	**2,122**	**2,280**	**4,351**	**2,122**	**6,472**
Workforce	365	159	206	2,533	676	1,857	-	676	676
Total Transition Cost	**661**	**456**	**206**	**6,934**	**2,798**	**4,137**	**4,351**	**2,798**	**7,148**
Total Revenue Transition	**540**	**158**	**382**	**4,397**	**1,663**	**2,733**	**1,560**	**1,663**	**3,224**
Net Balance Sheet Transition Cost	**121**	**298**	**(177)**	**2,537**	**1,134**	**1,403**	**2,790**	**1,134**	**3,924**

7. Looking ahead

The organisation will continue to mobilise and deliver the final key components of the transformation programme. Our focus will as ever remain on the delivery of high-quality services and best outcomes for the service users and patients. Working with the Partner Trusts we will continuously evolve, adapt and improve our offering.

The expansion of the laboratory services in areas of molecular diagnostics, new technologies and innovative use of digital platforms will continue and the introduction of new tests alongside the provision of clinical decisions support will further enhance the role we play.

We look forward to completing the creation of a single, fully integrated organisation across the Partner Trusts and moving closer to expanding the NWLP partnership, formalising the intended configuration of London 1 network for pathology.

NORTH WEST LONDON PATHOLOGY

DELIVERING SCIENCE SUPPORTING HEALTHCARE

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Published Sep 2020

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: National Cancer Patient Experience Survey Results 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 30 September 2020	**Item 19, report no. 16**
Responsible Executive Director: Dr Katie Urch – Divisional Director SCC	**Author:** Di Dunn

Summary:
The ninth National Cancer Patient Survey (NCPES) was conducted last year and the results were published on 25 June 2020. The results indicate significant improvements to 12 of the questions as reported by Royal Marsden Partners (RMP) and an increase in the overall rating of care from 8.6/10 to 8.8/10 (equal to the national average).

This paper highlights key results and shows comparisons with the national context and with previous years.

Whilst we have seen some improvements compared with the previous survey of 2018, as evidenced by an increase of three places in the Royal Marsden Partners (RMP) calculated league table, it is disappointing that we are 136th out of 145 trusts (139/145 in 2018). 2018 results were presented at Executive Quality Committee in June 2020.

The paper will summarise our next steps planned for 2020, focusing on those areas we need to improve upon. Close collaborative working across the services will be needed to support this work. The Cancer Performance Team will monitor progress.

Recommendations: The Board is asked to note paper.

This report has been discussed at:
Quality Committee

Quality impact: Understanding the experience of patients supports the business of the Trust. There is no detrimental impact on quality as a result of this paper.

Financial impact Has no financial impact

Risk impact and Board Assurance Framework (BAF) reference: There are no risks associated with this paper.

Workforce impact (including training and education implications): There is no workforce impact associate with this paper

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

What impact will this have on the wider health economy, patients and the public?
Better understanding of the experience of patients should lead to improvements in the quality of care.

The report content respects the rights, values and commitments within the NHS Constitution. Yes
Trust strategic goals supported by this paper: Retain as appropriate: ▪ To build learning, improvement and innovation into everything we do

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers?
No
 	
If the details can be shared, please provide the following in one to two line bullet points:
▪ What should senior managers know?
  ▪ The current Trust position and key areas for improvement.
▪ What (if anything) do you want senior managers to do?
  ▪ Share the report with their teams for discussion.
▪ Contact details or email address of lead and/or web links for further information
  ▪ diane.dunn1@nhs.net
 	
▪ Should senior managers share this information with their own teams? ☒ Yes No
If yes, why? The report relates to patient experience and is relevant to most adult inpatient areas.

Imperial College Healthcare NHS Trust

National Cancer Patient Experience Survey results 2019

1. Executive Summary

The National Cancer Patient Survey (NCPES), the ninth in succession, was conducted last year and the 2019 results were published on 25th June 2020. Whilst Imperial College Healthcare NHS Trust (ICHT) showed some improvements in comparison to the previous survey of 2018 and an increase of three places in the Royal Marsden Partners (RMP) calculated league table, it is disappointing that we are 136th out of 145 trusts.
This paper highlights key results and shows comparisons with other organisations and with previous years. The full report is available here.

2. Background

The survey includes all adult patients (aged 16 and over) with a primary diagnosis of cancer, who have been admitted to hospital as *inpatients for cancer related treatments*, or who were seen as *day case patients for cancer related treatments* and were discharged between 01 April 2018 and 30 June 2019.
1,578 patients who were treated at ICHT were sent questionnaires and 747 responded to the survey; a response rate of 47% (national response rate= 61%).

3. NCPES Reporting and performance

The survey consists of 52 questions the scores of which are reported as a percentage: the higher the percentage the more favourable the responses. These scores are then presented in two ways:

- *Unadjusted* percentage scores are provided for each trust so that organisational year-on-year comparisons can be made
- *Case mix adjusted* scores are provided to enable comparing against the national results. These scores allow for the impact of differing patient populations and take into account factors such as age, gender, ethnicity, deprivation and tumour group. These scores are presented as expected ranges, and each organisation can see whether it lies within the expected range or above or below it.

4. NCPES 2019 Results

Based on the crude (unadjusted data), the results indicate statistically significant improvements in 12 questions as reported by RMP since 2018 and an overall small increase in performance.
When analysing the Cancer Alliances by improvement since 2018, North West and South West London ranked the highest for having the most number of questions that had significantly improved. ICHT was the second highest contributor to this change.

The adjusted data indicates ICHT were;

- 'about the same' as expected for 66 percent of the questions compared with 46 percent in 2018
- 'better than' expected for 2 percent (unchanged from 2018)
- 'worse than' expected for 32 percent of the question, compared with 52 percent in 2018

The overall rating of care is now the same at the national average - 8.8/10, compared with 8.6/10 in 2018.
To note, almost half of the questions that were lower than expected were less than 1 percent outside of the normal range.

The RM Partners Cancer Alliance uses a methodology to create a league table of trusts' results across the country. This involves the creation of a net rating of questions where trusts performed better than expected minus those where they performed worse. Using this measure ICHT has improved from 139/145 to 136/145.

Patients also had the opportunity to leave free text comments. The majority of comments about what was good related to our people, their professionalism and kindness and the quality of care.

Based on further analysis of the patient free text comments and the survey questions, the key areas for improvements included:

- Communication and information, specifically:
  - patient involvement in decision making
  - understanding diagnosis/type of cancer, treatment and side effects of treatments/post treatment
  - information on free prescriptions &/or financial help
  - information relating to operations
  - understandable answers to questions
  - pre-chemo/radiotherapy treatment information
  - Offering care plans to patients
  - discussing worries & fears in OPD

- Wait times
  - for tests to be undertaken
  - attending clinics & appointments
  - to be seen by GP

- Home care & support
  - Not enough support during treatment
  - Lack of information to/from GP

5. Key contributing factors

Since 2016, we have seen a year on year growth in the number of referrals we have received. On average 72% of all the referrals are from GPs, 8% from Inter-Trust referrals and remainder from Urgent/Routine care.

Our cancer services are located across sites, and throughout all surgical pathways, necessitating patients to travel between sites at times for different parts of their cancer pathway treatment. This has its inherent challenges for both our patients and our clinicians.

Historically, the Trust Cancer Lead Nurse (TLCN), who directly manages the cancer clinical nurse specialists (CNS), has coordinated the NCPES. Whilst the CNS' are pivotal to a positive patient experience, the survey results highlight the impact on patients from across all cancer services of Oncology, Haematology and including radiology, chemotherapy and outpatients. It is imperative that in order to improve our patients' experience these services must work in closer collaboration and across operational services.

6. Next steps

A new collaborative project between the Trust, Hammersmith & Fulham CCG and Macmillan Cancer Support has been established and a project manager appointed. This project 'Right by You' stalled due to COVID 19 and will now start in August 2020. The project, focuses on supporting people affected by cancer, and is designed to address care integration across complex patient pathways.

Integral to the projects will be enhanced links with primary and community services, living with and beyond cancer and personalised care interventions, so improving communication and seamless care provision and addressing key areas of deficits reported in the survey including information giving and care-planning with patients

Working with charity sector Macmillan Cancer support and Maggie's West London at CXH, Summer & Autumn 2020 programmes are being developed to enable virtual support groups and courses for cancer patients within the remits of living with and beyond cancer.

An in-house patient survey has been developed and delivered focusing on specific aspects of our patients' experience. A patient focus group will be held on 28th July 2020 to explore key themes arising from this survey.

Finally, a Trust working group will be established to include representation from the oncology, haematology, chemotherapy, radiotherapy, and outpatient services and cancer CNS Community of Practice, to ensure a coordinated approach to addressing the key themes from this survey. The actions arising from this group will be reported and monitored through the Cancer Performance Management Team

7. **Summary**

Overall, the ICHT results have improved since last year however, we need to sustain this improvement and see this translated into an improvement in our national league standing.

Author: Di Dunn (TLCN)
Date: 21 July 2020

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TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: CNST Year 3 compliance update	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 30 September 2020	**Item 20, report no. 17**
Responsible Executive Director: Tg Teoh	**Author:** Louise Frost, Interim Lead Midwife

Summary:
It had been agreed that ICHT would endeavour to meet full compliance for the Clinical Negligence Scheme for Trusts - maternity incentive scheme Year 3 to continue to support the delivery of safer maternity care. There are 10 Safety Standards to meet.

An announcement from NHS Resolution on 15th April 2020 detailed that the majority of the CNST Maternity Incentive Scheme reporting requirements would be paused until 31st August 2020 due to the pressures on the maternity services in response to the Covid-19 pandemic. Trusts were asked to continue to apply the principles of the 10 safety actions, given that the aim of the maternity incentive scheme is to support the delivery of safer maternity care.

An update on 26th August 2020 detailed the following:

The current plan is to relaunch the scheme on **Thursday 1 October 2020.**
The MIS safety actions, the timeframe for submission and revised board declaration form are currently being reviewed by members of the Collaborative Advisory Group and will be shared with trusts in the forthcoming weeks.
The review/submission dates for the year three maternity safety actions initially planned from **March 2020** onwards are being revised and will be updated.

- The timeline for the MIS will also be revised and the submission date for the board declaration form will be deferred to 2021 (submission date TBC).
- The trust declarations will be required to be submitted six months after the launch date of the scheme.

There will be additional elements within some safety actions to ensure that learning from important, emerging Covid-19 themes is rapidly implemented by maternity services. In particular, safety action eight has been affected by Covid-19.

Finance
We plan to operate the financial arrangements on the same basis as before, i.e. to uplift the maternity element of contributions by 10% with a view to returning all of those funds to the trusts that meet all of

the ten maternity safety actions. Trusts that have not achieved all ten safety actions may be eligible for a small amount of funding to support progress. The maternity contribution will collected in the financial year starting in April 2021.

This report serves to provide assurance to the board that CNST safety actions are being met as far as practically possible thus far this year.

Recommendations:
The Board is asked to note that CNST Maternity Incentive Scheme safety standards detailed in the Year 3 document are continuing to be implemented whilst awaiting further updated guidance.

This report has been discussed at (delete/tick as relevant):
Executive Huddle

Quality impact:
Safe, effective, responsive.
Meeting the Maternity Incentive Scheme 10 safety actions will ensure the trust demonstrates a high level of safety required by NHS Resolution.

Financial impact:
In year 3 it was anticipated that a 10% uplift of the insurance premium of £1.7 million would be paid with anticipation of being reimbursed on compliance of all 10 safety actions. However in light of the Covid-19 pandemic CNST reporting requirements were suspended and NHS Resolution also confirmed at that time trusts were not required to pay the additional 10% contribution. Awaiting further updates.

Risk impact and Board Assurance Framework (BAF) reference:
Risks attached to this project and how they will be managed. Reference to risk register and BAF where appropriate, and clear reference to key risks and mitigations.
Compliance of the 10 safety actions will reduce risk for the trust.

Workforce impact (including training and education implications):
Mandatory training requirements are detailed in this paper and mandated by the CNST Maternity Incentive Scheme.

What impact will this have on the wider health economy, patients and the public?
Compliance with CNST 10 safety actions demonstrates the Trust ability to support the delivery of safer maternity care to women and their families.

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

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

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

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers? Y/N (And if yes – why?) No

If the details can be shared, please provide the following in one to two line bullet points:
- What should senior managers know? (maximum three bullet points)
- The Trust is committed to achieving full compliance of CNST Maternity incentive Scheme Year 3
- What (if anything) do you want senior managers to do? (maximum two bullet points)
- For information and noting
- Contact details or email address of lead and/or web links for further information (maximum one bullet point)
- https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/
- Should senior managers share this information with their own teams? Y/N (And if not – why?) Yes

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CNST Maternity Incentive Scheme Year 3 update

1. Executive Summary

It had been agreed that ICHT would endeavour to meet full compliance for the Clinical Negligence Scheme for Trusts - maternity incentive scheme Year 3 to continue to support the delivery of safer maternity care. There are 10 Safety Standards to meet.
An announcement from NHS Resolution on 15th April 2020 detailed that the majority of the CNST Maternity Incentive Scheme reporting requirements would be paused until 31st August 2020 due to the pressures on the maternity services in response to the Covid-19 pandemic. Trusts were asked to continue to apply the principles of the 10 safety actions, given that the aim of the maternity incentive scheme is to support the delivery of safer maternity care.

An update on 26th August 2020 detailed the following:

The current plan is to relaunch the scheme on ***Thursday 1 October 2020.*** *The MIS safety actions, the timeframe for submission and revised* board declaration form *are currently being reviewed by members of the Collaborative Advisory Group and will be shared with trusts in the forthcoming weeks.*

The review/submission dates for the year three maternity safety actions initially planned from ***March 2020*** *onwards are being revised and will be updated.*

- *The timeline for the MIS will also be revised and the submission date for the board declaration form will be deferred to 2021 (submission date TBC).*
- *The trust declarations will be required to be submitted six months after the launch date of the scheme.*

There will be additional elements within some safety actions to ensure that learning from important, emerging Covid-19 themes is rapidly implemented by maternity services. In particular, safety action eight has been affected by Covid-19.

Finance

We plan to operate the financial arrangements on the same basis as before, i.e. to uplift the maternity element of contributions by 10% with a view to returning all of those funds to the trusts that meet all of the ten maternity safety actions. Trusts that have not achieved all ten safety actions may be eligible for a small amount of funding to support progress. The maternity contribution will collected in the financial year starting in April 2021.

This report serves to provide assurance to the board that CNST safety actions are being met as far as practically possible thus far this year.

Imperial College Healthcare NHS Trust

2. Purpose

2.1. The report below provides an update of the Maternity Incentive Scheme Year 3 safety actions to meet compliance, whilst awaiting updated guidance on timeframes and amendments to reflect changes during the Covid-19 pandemic.

3. Background

3.1. In 2018, NHS Resolution introduced the CNST Maternity Incentive Scheme to support the delivery of safer maternity care. Trusts that evidenced their compliance against the safety standards are eligible to receive a rebate of 10% of their CNST maternity premium.

3.2. In 2018 and 2019 the trust was successful in meeting all safety standards and a rebate of £1.3 million was received by the trust last year.

4. Summary/Key points

4.1 Safety Action 1 – National Perinatal Mortality Review Tool (PMRT)

Quarterly report submitted.

Compliant with all required standards since 20th December 2019 including:

- use of PMRT for 95% of all deaths and review started within 4 months of death.
- at least 50% of all deaths reviewed by MDT using PMRT. Each review completed to draft report generation within 4 months of death.
- for 95% of all deaths, the parents were told that a review would take place, and that the parent's perspectives and any concerns they have about their care and that of their baby have been sought.

4.2 Safety Action 2 - Maternity Services Data Set (MSDS)

13 categories – all compliant. Actions in place to ensure category 10, valid ethnicity at booking, meets compliance of 80% each month.

4.3 Safety Action 3 – Avoiding Term Admission Into Neonatal units (ATAIN)

Meeting planned with named CNST neonatal consultant lead – Emma Porter.

Midwifery support in place for Transitional Care (TC) audits and ATAIN reviews.

Action plan in development to address findings from monthly TC audit and weekly ATAIN review MDT meetings.

4.4 Safety Action 4 - Medical Workforce planning

Anaesthetic Clinical Workforce - action plan in progress to ensure cover for ELCS.

Neonatal medical workforce – compliant with BAPM national standards of junior staffing.

Neonatal nursing workforce – update received from neonatal leads. Service does not meet service specification standards however mitigations in place.

4.5 Safety Action 5 – Midwifery Workforce planning

Midwifery staffing report presented June 2020 to Maternity Q&S.

Bi-Annual midwifery staffing oversight report awaiting approval.

4.6 Safety Action 6 – Saving Babies Lives Care Bundle

Audits are being set-up to enable automatic monthly generation available on Qliksense.

Action plans to be developed when performance does not meet the required thresholds.

MSDS submission not yet required – specification not yet enabled for various elements.

<u>Element 1 - Reducing smoking in pregnancy</u>

Carbon Monoxide (CO) monitoring paused during Covid-19 pandemic. NWL QI project improved access to CO monitors and training of staff. Cerner updated to include CO testing at 36/40.

New guidance - Staff informed to ensure documentation of smoking status at booking & 36/40 appointments. Monthly audit of data started in August 2020 and action plan to follow.

Element 2 – Risk assessment, prevention and surveillance of pregnancies at risk of Fetal Growth restriction (FGR)

Compliant with CNST criteria for growth scans as funding for 1.0 WTE sonographer to enable additional/ amended criteria. Handheld notes updated with growth scan pathway. This will move to a Cerner Powerform at 16/40 – currently on hold due to Cerner freeze.

Aspirin prophylaxis changes live on Cerner.

Requirements for birth centile audit directly from Cerner – currently in development.

Element 3 – Raising awareness of Reduced Fetal Movements (RFM)

All women receive RFM leaflet in hand held notes provided at booking – compliant.

Audit started August 2020 for percentage of women who attend with RFM who have a computerized CTG. Training in progress since June 2020 by IT midwives to ensure correct documentation on Cerner to enable this audit.

Computerised antenatal CTG compliance - Oxford CTG's in use at SMH and QCCH.

Element 4 – Effective fetal monitoring during labour

Maternity plan for 1 day fetal monitoring training compliance in the following format:

- Completion of K2 training package. Interface with LEARN system under investigation.
- Completion of K2 assessment. Paper assessment available if K2 not completed and plans for this to be available on LEARN.
- Multi-disciplinary training 3 hours delivered by midwife and obstetric consultant. This will be part of midwifery mandatory education sessions and obstetricians attend.

Face to face training paused during Covid-19. Paper for CRG to be finalised to reinstate face to face training.

Fresh ears changes on Cerner live. Manual audits continue and current development of automatic data generation is in progress by IT support.

Element 5 – Reducing preterm births

Data collation from Cerner started August 2020 to enable the following monthly audits:

- Percentage of singleton live births (less than 34+0 weeks) receiving full course of antenatal steroids within 7 days of birth.
- Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.
- MSU completed at booking and follow-up of positive culture results.

4.7 Safety Action 7 – Maternity Voices Partnership

Terms of Reference in draft – currently being ratified.

Action plan developed in August 2020 incorporating the CQC National Maternity Survey results.

4.8 Safety Action 8 – Multi-professional maternity emergency training

Face to face training paused due to Covid-19. Paper being finalised to be presented at CRG requesting to reinstate face to face PROMPT training with hands-on skill drills in October 2020 with smaller groups of staff who work together. Awaiting IPC sign off for locations.

Action plan developed including requirements to meet B) ad-hoc multi-professional training and C) neonatal resuscitation training requirements included on the skills drills sessions.

4.9 Safety Action 9 – Safety Champions

Continuity of care data template updated including new team plans and compliance for both SMH and QCCH sites. Action plan in development to ensure each team meets all AN/ IP/ PN requirements to achieve 35% by March 2021 and 51% by March 2022 (previous date to achieve 51% March 2021).

Pathway to be developed to demonstrate the process for sharing safety intelligence from frontline staff to board safety champions.

Imperial College Healthcare NHS Trust

Risk leads will present lessons learnt, recommendations from reports including HSIB and current concerns on the PROMPT training day to ensure MDT informed and feedback completed.
Safety lead poster in development for staff information areas/ boards.

4.10 Safety Action 10 – NHS Resolution Early notification Scheme

From 1st April 2020 reporting via the early notification scheme was paused due to Covid-19. The decision will be reviewed in September 2020. All cases meeting criteria continue to be reported to HSIB, who triage and prioritise cases with harm (brain injury). These are shared directly with NHS Resolution. Risk team continue to notify trust legal department.

5. Options appraisal including financial appraisal (as relevant)

5.1. In year 3 it was anticipated that a 10% uplift of the insurance premium of £1.7 million would be paid with the anticipation of being reimbursed on compliance of all 10 safety actions. However in light of the Covid-19 pandemic CNST reporting requirements were suspended and NHS Resolution also confirmed at that time trusts were not required to pay the additional 10% contribution. Awaiting further updates.

6. Conclusion and Next Steps

6.1. The Board is asked to note this report for information.

6.2. The trust awaits further communication from NHS Resolution with timeframes and updated guidance for the Maternity Incentive Scheme 10 safety actions.

7. Recommendations

7.1 To continue with implementation of the 10 safety actions to meet compliance of Year 3 until further guidance is released.

Author Louise Frost, Interim Lead Midwife
Date 01/09/2020

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TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Midwifery Safe Staffing Levels – Bi-Annual Midwifery Staffing Oversight Report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 30 September 2020	**Item 21, report no. 18**
Responsible Executive Director: Professor Janice Sigsworth.	**Author:** Scott Johnston – Head of Midwifery Karen Powell – DDN WCCS

Summary:

The purpose of the report is to-

- Provide an update on Safe Midwifery staffing including maintaining safe midwifery staffing during the COVID peak
- Update the committee on key midwifery staffing metrics
- Update the committee on the progress with Midwifery Staffing Ratios as per Birthrate Plus recommendations
- Highlight key plans and work underway regarding safe midwifery staffing.
- Propose actions for discussion

Currently the Maternity Service at Imperial College Healthcare NHS Trust is staffed to the recommended safe midwifery staffing level. The correct skill mix is in place within the midwife to birth ratio and the specialist and leadership establishment meets the recommended criteria. ICHT is committed to meeting full compliance for Year 3 CNST. The scheme is currently paused however the service continue to strive to meet the team safety actions and are expecting to have full compliance once the scheme restarts.

The paper give assurance that the funded midwifery staffing establishment fully meets the recommend standards set by Birthrate Plus and mechanisms are in place to monitor and act upon shortfalls in midwifery staffing.

Recommendations:
The Board is asked to note the contents of the paper.

This report has been discussed at:
Executive Huddle

Quality impact:
The paper supports the Safe, Effective and Well-led CQC domains and gives assurance of the ongoing commitment of the Maternity Directorate to their 'Outstanding' CQC rating.

Financial impact:
The safe staffing levels described are within the agreed and funded midwifery establishment.

Workforce impact (including training and education implications):
The paper supports ongoing safe midwifery workforce and leadership planning

Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☐ No ☒ Not applicable
How have patients, the public and/or the community been involved in this project and what changes were made as a result? N/A
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No

Imperial College Healthcare NHS Trust

Midwifery Safe Staffing Levels – Bi-Annual Midwifery Staffing Oversight Report

1. Executive Summary

1.1 The purpose of the report is to-

- Provide an update on Safe Midwifery staffing including maintaining safe midwifery staffing during the COVID peak
- Update the committee on key midwifery staffing metrics
- Update the committee on the progress with Midwifery Staffing Ratios as per Birthrate Plus recommendations
- Highlight key plans and work underway regarding safe midwifery staffing.
- Propose actions for discussion

1.2 Currently the Maternity Service at Imperial College Healthcare NHS Trust is staffed to the recommended safe midwifery staffing level. The correct skill mix is in place within the midwife to birth ratio and the specialist and leadership establishment meets the recommended criteria.

1.3 Regular six monthly reviews of safe staffing are undertaken as well as monitoring of actual versus planned staffing reviews in line with the Trust Safe Nursing and Midwifery Staffing Policy. Twice daily staffing huddles occur, out of hours support and communication pathways are in place in line with the Maternity Staffing escalation policy.

1.4 ICHT is committed to meeting full compliance for Year 3 CNST. The scheme is currently paused however the service continue to strive to meet the team safety actions and are expecting to have full compliance once the scheme restarts.

2. Background

2.1 Midwifery staffing across the UK is a challenge in terms of recruitment and retention. ICHT, along with other London Trusts, have faced the challenge of vacancies, a lack of experienced midwives leading to skill mix challenges and a 10% turnover of staff.

2.2 The historic main source of recruitment of newly qualified midwives onto our preceptorshisp programme are King's students that have been on placement with us. This continues but will be complimented by the first tranche of Imperial students qualifying from the University of West London in Spring 2021.

2.3 Since July 2019 ICHT have been meeting the recommended BirthRate Plus ratios on both sites. There have been Birthrate plus assessments in 2018 (full assessment) and 2019 (tabletop assessment)

2.4 Workload in maternity fluctuates due to the unpredictability of the activity leading to peaks and troughs in activity and acuity. The two labour wards can be similar to emergency departments with little control over levels of activity. In the past work has been undertaken to improve the resilience of the service to cope with these peaks and troughs in activity. These have included;

- Embedding of a revised Maternity Staffing Escalation policy
- Twice daily Maternity Staffing Huddles
- Daily maternity bleep holder on the QCCH site
- Improved communication and collaboration with the Trust Site Teams and on call managers
- Senior Midwife on Call rota
- Improved planning of elective activity with cross site consideration to manage workload
- Cross site working and collaboration of day to day staffing and activity shifts where possible
    - Reconfiguration and education of our community midwifery services to allow for bringing in community staff to assist in inpatient areas when needed and vice versa.

3. BR+ Safe Midwifery Staffing Ratio

Birth Rate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in use in UK maternity units for a significant number of years.

The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings, and have been endorsed by the RCM and RCOG. The interim NHS People Plan and the NHS Long Term Plans recommend services to be using evidence-based approaches to staffing by 2023

The most recent assessment of the recommended safe staffing ratios for the maternity service are-
SMH 1:24
QCCH 1:25

The increased recommended ratio at SMH is due to in caesarean section rate at SMH and the high volume of postnatal activity for women that have birthed elsewhere that are cared for by SMH community midwives

Please see appendix 1 for the detailed calculations.

In conclusion-

- the current midwifery staffing funded establishment is in line with the recommended site specific safe midwifery staffing ratios
- the correct number of specialist and support worker roles are included in the ratio
- the Midwifery management and clinical leadership staffing is in line with the recommended numbers.

4. Actual Versus Planned Midwifery Staffing

All maternity In-Patient (Including Intrapartum) areas report the actual v's planned midwifery and care staffing for day and night shifts alongside the other wards in the Trust

https://www.imperial.nhs.uk/about-us/who-we-are/publications/safe-nurse-and-midwife-staffing

For January, Feb and July 2020 all the reported metrics for safe staffing in all maternity areas were met. Actual vs Planned reporting was paused from Mar to June 2020 due to the COVID pandemic. For July 2020 (appendix 2) all parameters were met for maternity.

5. One to One care midwifery care in labour and Supernumerary Labour Ward Coordinator Status

One to One midwifery care in labour is a key safety metric that is reported via Cerner and monitored on Maternity dashboard monthly at the Directorate meeting and at the NWL Local Maternity System Meeting. For the past 6 months the compliance rate reported via Cerner has been 98 to 99 %. This safety metric is also reported on the Intrapartum acuity tool that is completed every 4 hours on our Labour Wards and Birth Centres. For the period 25 May 2020 - 10 August 2020 no instances of inability to provide one to one care was identified on the intrapartum acuity on either of our Birth Centres or on SMH Labour Ward. During this period there were 5 occasions identified when one to one care was not being provided on the QCCH Labour Ward, however reassuringly each time this was reported as being resolved by redeployment of staff. The reasons behind the inability to provide one to one care without redeployment from other areas was due to peaks in activity or acuity.
The rosters for the Labour Wards and planned to allow one supernumerary Labour Ward Coordinator at all times. There have been 3 reported occasions via datix (one at SMH and two at QCCH) in the 3 month period May to July 2020 when this did not occur. Again the reasons behind the inability to have a supernumerary coordinator without redeployment from other areas was due to peaks in activity or acuity.
The acuity tool also records actions taken to mitigate any red flag issues (including inability to provide one to one care midwifery care in labour). The most common solution to the red flag issue was 'redeployment of staff within the site', there were no suspensions of our maternity service and no risk investigations where midwifery staffing was identified as a contributory factor.
Overall we are reassured by these metrics but continue to strive for 100% compliance

Actions

1. During the six monthly establishment review in June 2020 an opportunity was identified to reshape some of the midwifery establishment to provide a 24/7 maternity bleep holder. Their role will include

- Leading and recording the twice daily huddles
- Joining the Trust site calls to represent maternity
- Attending and supporting at all emergency calls
- Coordinating the maternity response in event of a major incident
- Keeping shift by shift oversight of overall maternity staffing to ensure safe staffing, reduce bank usage and minimise agency usage
- Keep over sight of bed capacity and flow on both sites.
- Coordinate IUT requests and ensure that declining IUT are minimised
- Support junior staff with clinical skills where needed ad hoc (suturing, cannulation for example)
- Maximise flow or women through the service by anticipating demand supporting clinically when needed (e.g. transferring women, NIPE)

The role will be implemented in October/November 2020 and the impact will be monitored.
2. The Maternity Staffing Escalation Policy is currently under review. The review will include an emphasis on reacting early to these situations and a clear course of action to reduce occurrences.

6. Midwifery Recruitment and Diversity of Midwifery Staffing

Midwifery Turnover remains in line with other London Trusts at around 8-10%. Oversight of exit interviews has highlighted that the most common reasons for midwives leaving the organisation were retirement and moving to posts out with London. We have been successful in retaining a number of retirees as part of the 'retire and return' option.
Currently there are 26 w.t.e. vacant band 6 midwife posts equating to 9% of the establishment.
Our main sources of recruitment are ongoing-

- Automatic offer of a post to our own King's and UWL student midwives. Our retention of students remains good with 19 students (80%) of the current 3rd year accepting posts with us.
- International recruitment of theatre nurses for QCCH theatres.
- External recruitment for experienced band 6 midwives. Currently 6 midwives are in the pipeline to start
- Internal and external recruitment for band 7 and specialist midwives has been successful with a number of band 6 midwives being promoted internally and 3 band 7 midwives being recruited externally.

The diversity data in relation to midwifery workforce reveals that 40% of qualified midwives and 67% of maternity support workers are from BAME backgrounds. The multidisciplinary leadership team in the Maternity Directorate have ensured that the diversity of the maternity workforce is supported and involved in the trust wide diversity agenda. This includes-

- Maternity Black History Week events
- Supporting BAME staff to become Inclusive recruitment panellists
- Active involvement in Trust BAME network
- Updated Job Descriptions to include specifying our Directorate does not tolerate any discrimination.

7. Maternity Transformation Programme- Progress with Midwifery Continuity of Care

The NHSE led Maternity Transformation programme has been underway for over two years. ICHT have been fully engaged with NWL partners as an Early Adopter of Continuity of Midwifery Care then as part of the fully launched programme. We were delighted to achieve the NHSE expectation of 35 % of women being booked onto a midwifery continuity of carer pathway in February 2020. At ICHT went achieved this expectation through expansion of our existing Caseloading Midwifery Teams and the introduction of a number of new hospital based teams.
The programme was paused from March 2020 due to the COVID pandemic. However as part of the establishment reviews was have been able to being two new teams recently, a home birth team and a team that will focus on caring for women with safeguarding issues, mental health problems and those who have had a previous pregnancy bereavement.

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8. Maintaining Safe Midwifery Staffing during COVID

The nature of maternity services meant that all the core parts of the service continued to run throughout the pandemic. The antenatal services, labour wards, birth centres, in-patient wards and the community midwifery service all continued to run with modifications. Severe pressure on the London Ambulance Service meant that our Home Birth Service was suspended for several weeks. This suspension was not due to staffing pressures within the Trust. The service has fully resumed.

At the peak sickness in maternity rose to 8.5% and around 24 staff were shielding. This was mitigated and safe midwifery staffing was maintained by-

- The return of midwives who had been seconded external to the organisation
- The voluntary return of midwives from maternity leave
- Voluntary cancellation of annual leave
- Cancellation of study leave
- Use of bank midwives and agency when required
- Specialist midwives undertaking rostered clinical shifts
- One recently retired senior midwife returned on a fixed term contract
- Shielding midwives undertaking remote video consultations with women and postnatal contact calls
- A total of 50 2nd and 3rd year student midwives return to employed roles in the service as part of the government's scheme

On top of the routine monitoring of safe staffing levels additional actions were taken-

- On site Senior Midwifery presence at weekends and bank holidays for two months
- Active participation in site safety huddles
- Reporting and sharing of actions and staffing challenges and solutions via NHSE and London wide networks.
- Close monitoring of risk reporting and clinical metrics. No adverse events related to midwifery staff occurred during the period.

In addition to maintaining safe midwife staffing levels in maternity, several appropriately skilled midwives undertook clinical shifts in the COVID ITU areas.
In conclusion, safe midwifery staffing was maintained during the COVID pandemic.

9. Conclusion

1. The funded midwifery staffing establishment fully meets the recommend standards set by Birthrate Plus.
2. Mechanisms are in place to monitor and act upon shortfalls in midwifery staffing.

Author **Scott Johnston – Head of Midwifery**
Karen Powell – DDN WCCS

Date 21/08/20

Appendix 1

Current Midwifery Staffing ratios 20/21
The midwife to Birth Ratio is calculated using consistent and nationally recognised methodology.
Calculation of the Midwife to Birth Ratio (including Specialist Midwives)

Staff included the Midwife to Birth Ratio			
	QCCH	**SMH**	
Band 7 Midwives	43.31	29.02	All funded Band 7 Clinical midwives are included
Band 6 Midwives	142	87.8	All funded band 6 Midwives are included
Specialist midwives & Consultant Midwife	3.15	2.45	See table below
Band 3 MSWs*	18.37	11.3	
Total	**206.83**	**130.57**	

*The B+ methodology allows for up to 10% of staff included in the ratio to come from the band 3 Maternity Support Worker Workforce. Therefore band 3 MSWs from our Inpatient Wards and Community have been included. For the ICHT service this equates to 9% of the overall numbers included in the ratio.
Birthrate Plus methodology expects the face to face clinical component of specialist roles to be included within the ratio. The funded posts and calculation that was approved by the Birthrate Plus assessors in 2019 have been reviewed and included as follows.

Specialist Midwives included in the Ratio			Notes
Role	**Funded w.t.e (cross site)**	**Actual w.t.e. included in the ratio**	
IT	1	0	Non-clinical role
Risk Support Midwives	2.8	0	Non-clinical role
Bereavement Midwives	2	1	50% of their role is providing clinical care.
Midwifery Education Team	4	1	Overall around 1 wte of this team is involved in providing direct clinical care
Perinatal Mental Health	1	0.5	50% of their role is providing clinical care.
Inf Diseases and Antenatal Screening	3	1	Overall around 1 wte of this team is involved in providing direct clinical care
Inf feeding	1.6	0.4	25% of their role is providing clinical care
FGM	0.5	0.2	50% of their role is providing clinical care.
Maternal Med/ Diabetes	2	1	50% of their role is providing clinical care.
Band 8 Cons MW	1	0.5	50% of their role is providing clinical care.
Total		**5.6 w.t.e**	

Overall site specific Midwife to Birth ratio		
	QCCH	**SMH**
Recommended safe staffing Ratio	1 to 25	1 to 24
Planned Births for 20/21	5179	3114
Therefore Recommended Safe Staffing numbers	**207.16wte**	**129.75wte**
Actual Funded Staffing (for B+ purposes)	206.83 wte	130.57 wte
Difference	**-0.33 wte**	**0.82 wte**

In addition Birthrate plus expects around 8-10% of the midwifery establishment to not be included in the clinical numbers, this include management role and a proportion of specialist midwife roles. This ensure dedicated time for safe management and leadership of the service.

Safe ratio of Management/Leadership roles	
Funded Specialist Midwives that are not included in the ratio	13.3wte
Midwifery Leadership team (Band 8a to 8d)	16wte
Overall Funded establishment (Band 2-8)	356 wte
As a percentage of overall funded establishment	**8.2%**

Appendix 2

		Day							Night					
		Registered Nurses/Midwives			Care Staff			Day	Registered Nurses/Midwives			Care Staff			Night
Roster Name	Hospital Site Name	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Overall % Fill Rate	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Overall % Fill Rate
Edith Dare	Queen Charlotte's Hospital - RYJ04	2,389.50	2,339.50	97.91%	1,231.80	1,155.30	93.79%	96.51%	1,782.50	1,782.50	100.00%	747.50	736.00	98.46%	99.55%
QCCH Birth Centre	Queen Charlotte's Hospital - RYJ04	1,227.00	1,227.00	100.00%	324.00	311.50	96.14%	99.19%	1,023.50	1,023.50	100.00%	322.00	310.50	96.43%	99.15%
QCCH Labour Ward & Triage	Queen Charlotte's Hospital - RYJ04	4,867.00	4,795.00	98.52%	874.00	829.00	94.85%	97.96%	4,623.00	4,532.00	98.03%	1,059.00	921.00	86.97%	95.97%
Alek Bourne 1&2	St Mary's Hospital (HQ) - RYJ01	4,682.50	4,381.98	93.58%	1,443.00	1,388.00	96.19%	94.20%	4,278.00	4,266.50	99.73%	1,414.50	1,414.50	100.00%	99.80%
QCCH Lewis Suite	Queen Charlotte's Hospital - RYJ04	713.00	713.00	100.00%	356.50	356.50	100.00%	100.00%	715.00	715.00	100.00%	356.50	356.50	100.00%	100.00%
Sir Stanley Clayton	Queen Charlotte's Hospital - RYJ04	356.50	356.50	100.00%	353.00	353.00	100.00%	100.00%	356.50	356.50	100.00%	356.50	345.00	96.77%	98.39%
SMH Birth Centre	St Mary's Hospital (HQ) - RYJ01	759.00	759.00	100.00%	356.50	345.00	96.77%	98.97%	713.00	713.00	100.00%	356.50	356.50	100.00%	100.00%

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC BOARD SUMMARY	
Title of report: Report from The Quality Committee meeting held on 2020 23 September 2020	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 30 September 2020	**Item 22.1, report no. 19a**
Responsible Non-Executive Director: Professor Andy Bush, Non-Executive Director (Committee Chair)	**Author:** Amrit Panesar, Corporate Governance Assistant

Summary:

The Quality Committee met on 23 September 2020. Key items to note from that meeting include:

Risk & assurance "deep dive"

COVID-19 Recovery and Reset
The Committee received a presentation on the Trust's response to COVID-19 and its reset & recovery phase. The Committee discussed and acknowledged the key risks and issues being faced by the Trust recovery phase and noted the planning currently in place for a second surge. The Committee were aware of the rapidly changing situation with regard to COVID, and therefore some perfectly reasonable plans rapidly became out of date. The Committee were reassured that the executive team were managing the risks associated with the recovery phase and surge planning as far as is possible given the rapid changes in the situation. The Non-executive directors thanked the executive team for their dedication and hard work throughout each stage of the pandemic.

Learning and Insights workstreams
The Committee received a presentation noting that the learning and insights workstream which was established under the reset and recovery programme, has achieved its planned objectives to date. The Committee were pleased to note the work undertaken by the five working groups and thanked Dr Bob Klaber and the teams involved for all their hard work and efforts into the worksteam. It was agreed that the learning and insights steering group will now commence implementing the lessons learnt with Trust teams for the second wave. The Committee were keen to receive an update in 6 months to note the actions implemented by the workstream.

Key Divisional Quality Risks
The Committee noted that Divisional and Corporate key risks were largely focusing on the reset & recovery and future surge planning.

Discharge to Care Homes During COVID-19
The Committee received an update on the processes implemented by the Trust for patients being discharged back into care homes from the Trust and noted that a pilot had commenced in April to support staff and patients in care homes relating to PPE and aftercare following discharge.

Staff Safety including staff risk assessment
The Committee received the staff safety report noting the progress on seven key areas of staff safety which have been combined together into an integrated dashboard to monitor progress. The Committee were pleased to note that the Trust had achieved 97.8% of staff risk assessments for the total workforce. The Non-Executive directors congratulated the teams for their hard work to achieve 97.8%

- Staff Risk Assessments
- COVID Sickness, Self-isolation and Shielding
- Workplace Risk Assessments
- Face Masks Fit Testing
- COVID 19 Staff Testing
- Staff Redeployment
- Flu Vaccination.

Annual flu vaccination campaign
Committee members received the annual flu vaccination campaign report noting that this year's campaign will commence on 21 September and an online form for staff to register will be available for staff to sign and register for their vaccines. The Trust is continuing to support peer vaccinators to ensure they are trained and ready for the campaign to commence. The Committee were pleased to note that all new contracts, including internal promotions, mandated receiving the immunisation, and also that others who did not accept the immunisation would have a discussion with their line manager

Month 4 Performance scorecard (Quality)
The Committee noted the quality aspects of the performance report.

Infection Prevention and Control (IPC), and Antimicrobial Stewardship Quarterly Report Q1
Committee members received the quarterly infection prevention and control report and noted that 17 of Trust attributed C. difficile cases had been reported in quarter 1; this was a decrease on previous quarters. The Committee noted that the strategic hand hygiene improvement programme had been extended to include encouraging best practice around the use of person protective equipment. The Trust saw a drop in oral antibiotic use with a corresponding rise in intravenous agents. This change was a direct result of the COVID-19 pandemic and patients presenting with undifferentiated respiratory infections.

CIP QIA update on the outcome of the post implementation reviews of Quality Impact Assessments for Cost Improvement Programmes 2019/20
The Committee reviewed and noted the summary of the findings from the post implementation evaluations undertaken on Quality Impact Assessments for 2019/20 Cost Improvement Programmes. The Trust had a total of 267 recurrent CIP schemes across the three clinical divisions 257 required formal QIAs risk assessment of the CIP and were approved.

CQC Update
The CQC suspended all of its routine activity between March and September 2020. It is now starting some routine activity again, though for NHS trusts this is very limited and inspections of NHS acute trusts are not expected to start again until possibly Q4. The Trust has an engagement meeting with the CQC in October, it's first since January 2020, which will be with the leads for the Western Eye Hospital.

Responsible Officer's Annual Report
The Committee reviewed the Responsible Officer's annual report which would be presented to the Trust board for sign off of the statement of compliance. Prof Julian Redhead highlighted that the outstanding challenges relating to reducing the number of overdue appraisals continued to be of focus; work to address this was being overseen by the Medical Director's Office.

Workforce Annual Equality, Diversity and Inclusion Report 2019/20
The Committee received the report prior to submission to the Trust Board and publishing onto the Trust website noting that the Trust continues to prioritise work on race and equality, and expands the focus on disability equality and re-commits to the development of staff networks. The Trust was complimented on their employers equality and diversity award.

National Cancer Patient Experience Survey Results 2019
The Committee noted the National Cancer Patient Experience Survey Results 2019 noting that the results are an improvement on the results published in 2018, although still below where we would wish to be.

2019/20 Annual Report from the Trust Safeguarding Committee
The Committee noted the annual report of the 2019/20 Trust Safeguarding Committee. The impact of COVID-19 on late presentations at least in children of safeguarding issues was highlighted by the Chair, and it was requested that in the future there would be consideration of this, both in terms of children under our care, and how we interact with the Community to help protect new-presenting children not previously known to us.

North West London Pathology Annual Report
The Committee received the Annual Report noting that North West London Pathology underwent changes as part of the transformation programme achieving significant transformation millstones along with significant service developments, improvements in achieving recognition for staff.

Patient Story
The Committee received the patient story prior to presentation at the Trust Board noting that the patient story focuses on a family's journey over the past few months during the COVID-19 pandemic. The Committee welcomed the story and noted that this will highlight the importance of recognising challenges the pandemic has raised.

Recommendations:
Trust Board is asked to note this summary.

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TRUST BOARD – PUBLIC BOARD SUMMARY	
Title of report: Report from the Finance, Investment and Operations Committee meeting held on 23 September 2020	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 30 September 2020	**Item 22.2, report no. 19b**
Responsible Non-Executive Director: Dr Andreas Raffel, Non-executive Director (Committee Chair)	**Author:** Jessica Hargreaves, Deputy Trust Secretary

Summary:
The Finance Investment & Operations Committee met on 23 September 2020. Key items to note from the meeting include:

Financial performance
Committee members received the finance report for month 5, noting that the Trust was reporting a breakeven position for the year as required by NHSI/E. In order to achieve a year to date break even position the Trust required £30.8m of retrospective top up funding of which £24.4m (applicable to month 1-4) has been approved in full. The Committee noted that the Trust was working though the detail of the newly published financial arrangements for the second half of the financial year to better understand the financial impact. Committee members also received and noted the finance report from North West London Pathology.

Risk and assurance 'deep dive' - capital and availability of funding
The Committee considered the current capital programme and the availability of funding, noting that there were significant risks in the latest 2020/21 plan, on both the Trust's ability to stay within the Trust capital resource limit and the impact on the Trust cash position, should the cash not be forthcoming for those schemes over and above the original capital plan. The Committee agreed that maintaining working capital to manage the day to day operations of the Trust was key and that the Trust should proceed as and when funding becomes available, noting however that this did present a risk to operational recovery and surge planning. The Committee agreed the governance arrangements for additional requests for capital and acknowledged that funding is flowing through the system albeit not at the pace it needs to. The Trust is in regular dialogue with the Sector /London Region to highlight concerns.

Business cases approved by the Executive
The Committee noted the business cases that had been approved by the executive from 1 July 2020, including the contract extensions agreed within the delegated authority of the Executive.

Managed service contract extension
The Committee agreed to the extension of the cardiac services' catheterisation laboratory managed service for a further three years, in line with the initial contract.

Transformation plan and speciality review programme update
The Committee received an update on progress against the Trust's transformation plan highlighting progress against the specialty review programme, with the Trust now working at pace with North West London as a sector. The project management office had provided the recovery and reset programme with a set of standards and processes for managing projects within the portfolio and was currently

tracking progress with a particular focus on seeking assurance with regards to phase 3 delivery. The Committee was updated on the upcoming Business Planning round and how the approach will be enhanced on the back of the learning and feedback from last year.

Hotel services
The Committee received a progress update against with regards to the in-housing of hotel services on 1st April 2020, noting that the focus of the stabilisation period (stage 2, April – July) had been to both ensure previous service standards were maintained and supporting infrastructure was in place. The programme has now progressed to stage 3 which is to focus on achieving standards and service performance to the required level. The committee also discussed the outline for the planned evaluation paper.

Redevelopment
The Committee received an update on the financial position against the £5m seed funding received as part of the Health Infrastructure Programme and the work in progress looking at the demand and capacity modelling and associated bed numbers which was currently being worked through with the clinical directorates and executive.

Preparing for winter 2020/21
The Committee received an update on the Trusts winter planning, and noted that the overall approach has been to build on the learning from winter 2019/20 and to incorporate what we understand about the impact of Covid-19 and our response to it.

Recommendations:
To note this summary.

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TRUST BOARD – PUBLIC BOARD SUMMARY	
Title of report: Report from the Board Redevelopment Committee 9th September 2020	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 30th September 2020	**Item 22.3, report no. 19c**
Responsible Non-Executive Director: Paula Vennells, Committee Chair	**Author:** Ginder Nisar, Deputy Trust Secretary

Summary:

The Redevelopment Board Committee met on 9th September 2020.

The Committee reflected on discussions at the Programme Board covering the Programme Director's report on key activities which included the submission of the Strategic Outline Case to NHS England and NHS Improvement on 7th August 2020. The report included updates on commercial activities, communication and engagement, project planning, capital cost, programme, risk, decant and clinical design. The Committee also received an update on the workstreams associated with this programme.

Recommendations:
To note this summary.