NHS
Imperial College Healthcare
NHS Trust

Trust Board – Public

Wednesday, 10th November 2021, 11.15am to 1.30pm (11am 11.15am join Microsoft Teams)
Virtual meeting via Microsoft Teams

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

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

AGENDA

Time	Item no.	Item description	Presenter	Paper / Oral
1115	**1.**	**Opening remarks**	Bob Alexander	Oral
	2.	**Apologies:**	Bob Alexander	Oral
	3.	**Declarations of interests** If any member of the Board has an interest in any item on the agenda, they must declare it at the meeting, and if necessary withdraw from the meeting.	Bob Alexander	Oral
1120	**4.**	**Minutes of the meeting held on 15th September 2021** To approve the minutes from the last meeting	Bob Alexander	01
	5.	**Record of items discussed in Part II of Board meetings held on 15th September 2021 and the Board Seminar held on 20th October 2021** To note the report	Bob Alexander	02
	6.	**Matters arising and review of action log** To note updates on actions arising from previous meetings	Bob Alexander	03
1125	**7.**	**Patient story** To note the patient story	Janice Sigsworth, Guy Young	04
1140	**8.**	**Chief Executive Officer's report** To receive an update on a range of activities and events since the last Trust Board	Tim Orchard	05
Operations / Performance				
1155	**9.**	**Integrated quality and performance report** To note the month 6 report	Claire Hook Julian Redhead	06

1205	**10.**	**Finance report** To note the month 6 report	Jazz Thind	07
Quality				
1215	**11.**	**Maternity quality assurance oversight report** To note the oversight report	TG Teoh	08
1225	**12.**	**Infection prevention and control quarterly report** To note the quarter 2 report	Julian Redhead/ James Price	09
1235	**13.**	**Learning from Deaths quarterly Report** To note the quarter 2 report and approve the data submission	Julian Redhead	10
1245	**14.**	**North West London Pathology Annual Report** To note the annual report	Saghar Missaghian-Cully	11
Governance				
1255	**15.**	**Annual review of Trust Board Committees and Governance Update** To note and approval of deletegated authority to the Board Committees	Peter Jenkinson	13
1300	**16.**	**Trust Board Committees – summary reports** To note the summary reports from the Trust Board Committees		
	16.1.	Audit, Risk and Governance Committee, 4th November 2021	Kay Boycott	14a
	16.2.	Quality Committee, 3rd November 2021	Andy Bush	14b
	16.3.	Finance, Investment and Operations Committee, 3rd November 2021	Andreas Raffel	14c
	16.4.	Redevelopment Board Committee, 2nd November 2021	Bob Alexander	14d
	16.5.	People Committee, 2nd November 2021	Sim Scavazza	14e
	16.6.	Remuneration and Appointments Committee, 20th October 2021	Peter Goldsbrough	14f
1310	**17.**	**Any other business**	Bob Alexander	Oral
1315	**18.**	**Questions from the public**	Bob Alexander	Oral
1330 Close	**19.**	**Date of next meeting** 19th January 2022, 11am		

Updated: 4 November 2021

Reading Room

- Research Report (refers to item 16.2)
- Board Committee Terms of Reference (refers to item 15)

Imperial College Healthcare NHS Trust

Public Trust Board
Minutes of the meeting held on 15th September 2021, 11am
Virtual meeting held via Microsoft Teams and video-recorded.

Members present

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

In attendance

Dr Ben Maruthappu	Associate Non-Executive Director
Ms Beverley Ejimofo	NExT Director
Mr Peter Jenkinson	Director of Corporate Governance
Mr Kevin Croft	Chief People Officer
Dr Matthew Tulley	Director of Redevelopment
Dr Bob Klaber	Director of Strategy, Research & Innovation
Mr Jeremy Butler	Director of Transformation
Mr Kevin Jarrold	Chief Information Officer
Mr Hugh Gostling	Director of Estates and Facilities
Ms Michelle Dixon	Director of Communications
Prof. TG Teoh	Divisional Director, Women, Children and Clinical Support
Prof. Frances Bowen	Divisional Director, Medicine and Integrated Care
Prof. Katie Urch	Divisional Director, Surgery, Cancer and Cardiovascular
Mr Guy Young	Deputy Director, Patient Experience (item 7)
Mr James Price	Director of Infection Prevention and Control
Mrs Ginder Nisar	Deputy Trust Secretary (minutes)

Apologies

Mr Peter Goldsbrough	Non-Executive Director
Prof. Jonathan Weber	Dean of the Faculty of Medicine, Imperial College London

Item	Discussion
1.	**Opening remarks**
1.1.	Mr Alexander welcomed everyone to the meeting which was held virtually and where in person, was in keeping with social distancing guidelines for the NHS. The Board meeting would be video-recorded and the recording uploaded onto the Trust's website. Members of the public had been invited to submit questions ahead of the meeting or ask questions at the end of the meeting via Microsoft Teams meeting. Members of the public were welcome to submit questions to the Trust Secretary at any time. Mr Jenkinson outlined the etiquette for the meeting.
1.2.	Subject to the circumstances nearer the time and any changes in national guidance, the Trust would consider returning to limited face to face meetings in November, possibly

	using a hybrid model of face to face for Board members, with members of the public still able to join by video link.
2.	**Apologies** Apologies were noted from those listed above.
3.	**Declarations of interests** There were no other declarations other than those disclosed previously to the Trust Secretariat.
4.	**Minutes of the meeting held on 14th July 2021** The minutes of the previous meeting were agreed.
5.	**Record of items discussed in part II of the Board meeting held on 14th July and the Extraordinary Trust Board held on 29th July 2021** The Board noted the summary of confidential items discussed at the confidential Board meeting held on 14th July and the Extraordinary Trust Board held on 29th July 2021**.**
6.	**Matters arising and actions from previous meetings** Updates against the actions arising from previous meetings were noted on the action register.
7.	**Patient story**
7.1.	The Board heard the patient story told by the Deputy Director of Patient Experience. The patient was complimentary about the care she received in the Trust, but the overall experience was marred by a question that she was asked as part of the Friends and Family Test (FFT) survey in the demographic section in relation to gender identity. The complainant argued that this question, structured as it was, meant that she was in effect being forced to identify with a particular gender rather than being defined by her biological sex.
7.2.	Being mindful that there are users of Trust services who identify with a gender that is different to their biological sex, a two stage option to address this issue was settled on. Part one of the question asks about sex with the options: man/boy, woman/girl, prefer not to say, and part two about gender identity can be answered not applicable or provides a more options choice which includes: male, female, trans man/woman, non-binary. In this way people who wish to answer based solely on their biological sex can do so and those who wish to record their gender preference can do so too. This approach was discussed with users of the Trust gender reassignment services who supported it.
7.3.	The patient experience team was also contacted by a researcher at Imperial College who raised a question about how gender identity was recorded in the Trust electronic patient record (EPR) - to which the Trust's response was based on the above experience and resolution.
7.4.	This also prompted a programme of work to review the current demographic data in the EPR to ensure that it was consistent with what was being recorded elsewhere and would be reported to the Equality, Diversity and Inclusion (EDI) Committee. This would be aligned with the ongoing work around recording demographic data of complainants as referred to in the 2020/21 annual complaints report.
7.5.	Mrs Boycott and Ms Scavazza reiterated that it was critical for the Trust to ensure its data collection in respect of EDI was correct and referred to the ongoing work and monitoring by the People Committee. One of the key focuses in this area by the People Committee was on how the Trust looks at data sets and differential experiences with the aim of improving the data collection to enable richer insights – therefore important to engage with people at the point of collection demonstrated well by this story. They were pleased that this was already an area of focus by the People Committee noting that it was an area of continuous improvement.

7.6.	Mr Alexander thanked Mr Young and his team for the story and their efforts to improve the patient experience. He commented that learning was important for the Trust and this story and the Trust's response was a good example of a learning organisation. He enquired about sharing the outcome with partner organisations. Mr Young advised that the story had been shared with the London and National Patient Experience Group, and that although obliged to ask the FFT question in all organisations, Trusts have the scope to ask the question in a different way.
7.7.	**The Board noted the patient story.**
8.	**Chief Executive Officer's report** Prof. Orchard presented his report, highlighting key updates on strategy, performance, leadership over the month and the focus of Trust business in response to Covid-19.
8.1.	**Operational environment –** The operational environment continued to be challenging and Prof. Orchard commended the continued extraordinary efforts and resilience demonstrated by the staff during the pandemic and over the past few months in keeping the Trust going whilst responding to issues such as staff shortages over the summer. The Trust had a number of mechanisms to support staff as part of the health and wellbeing programme.
8.1.1.	In terms of elective recovery work, over the past 2-3 months the Trust had reduced the number of patients waiting for more than 52 weeks for treatment in the Trust by 44% down to 1,464 patients at the end of July – for context purposes, before the pandemic the Trust had less than 10 patients waiting for this length of time, which demonstrated the extent of the issue.
8.1.2.	There was concern across London in terms of the significant increase in the use of the urgent and emergency departments (ED) leading to pressures usually experienced later in winter. Some cases were Covid related: on average the Trust was caring for 85 patients who had Covid at any time point during their admission and 50 patients who had Covid and 17-22 patients on critical care units with Covid. When compared to wave 2 the Trust had 496 patients in the hospital with Covid and 130 in ICU which showed that the Trust was in a better place but was trying to manage the increased urgent and ED demand whilst trying to focus on the back log work. The Trust continues to ensure Covid safe pathways were in place for patients coming into the Trust hospitals and ensuring basics of infection prevention and control were in place to keep people safe with some restrictions anticipated over winter, as needed.
8.2.	**Covid-19 and flu vaccination programme -** As of the end of August 2021, the Trust's in-house vaccination programme delivered more than 24,500 first doses of the Covid-19 vaccine and over 22,600 second doses to Trust staff, health and social care colleagues across the sector and patients. Considering eligible staff designated as frontline, 92.3% had their first dose, of these, 93% had their second dose and work continues to support the remainder to complete their course as soon as possible.
8.2.1.	In August 2021, the Trust Executive endorsed high-level plans, including indicative funding, for a phase 3 joint flu and Covid-19 booster programme in autumn/winter 2022. An implementation plan had been developed for the anticipated delivery of a programme commencing in late September. Guidance from the JCVI was expected imminently on the delivery of this programme which may further shape Trust plans.
8.3.	**Acute care programme update -** In early 2021, the four acute NHS Trusts in north west London came together to establish a joint acute care board and programme to guide and coordinate developments across all key operational areas. The effectiveness of the response to the pandemic demonstrated that Trusts could and should do more to harness

	collective resources, join-up care and reduce unwarranted variations in access and outcomes. The immediate focus was on recovery from the peak of the pandemic, reducing waiting times for planned care while continuing to prioritise by clinical need and minimising the ongoing risk of Covid-19 infection. The aim was to build on new ways of working catalysed by the pandemic, drawing on evidenced best-practice and deeper collaboration, to make longer term, sustainable improvements in quality, fairness and efficiency. The latest programme briefing was provided as an appendix to the report which provided an overview of key developments, challenges and opportunities as well as an update on progress.
8.4.	**Financial performance –** Prof. Orchard acknowledged the recent announcement by the government confirming that the NHS would receive an extra £5.4 billion over the next six months to support its response to Covid and help tackle waiting lists. Further detail on the allocated was expected in due course.
8.5.	**CQC update -** During the Trust's engagement meetings with the CQC in June and July 2021, the CQC indicated the Trust was considered low risk and therefore a routine regulatory assessment or inspection by the CQC was not anticipated during 2021/22.
8.5.1.	The Trust's Improving Care Programme Group (ICPG), which oversees regulatory activity at the Trust and centrally oversees CQC related preparations and actions, reconvened in May 2021. One of the key focuses of the group was to build in quality improvement drawing on the expertise from the Trust's outstanding quality improvement team into business as usual - looking at quality at a ward and department level.
8.5.2.	Other key points were: prior to the previous CQC inspections of the Trust in February 2019, four common areas for focused improvement were identified across all services – following which a revised set of focused improvements for 2021/22 were agreed at the Executive Huddle on 1 September 2021. ICPG activities were being aligned with the Trust's ward accreditation programme and Pathway to Excellence accreditation preparation activities.
8.6.	**Redevelopment -** The Trust formally submitted its strategic outline case (SOC) for the redevelopment of St Mary's Hospital (SMH). It represented the first stage of the approval process for NHS England and the Department for Health and Social Care. St Mary's hospital, together with the Trust's Charing Cross and Hammersmith hospitals, were included in the 40 new hospitals programme the government has committed to build by 2030 as part of the government's wider Health Infrastructure Plan. Phase 1 of the Charing Cross and Hammersmith hospitals development outlined that planning was complete and phase 2 would commence as soon as funding from new hospitals programme was confirmed. A summary of the detail of the SOC submission would be published on the Trust's website on 16th September 2021.
8.7.	**Research and innovation -** Following submission for stage 1 of the NIHR Biomedical Research Centre (BRC) re-application at the end of May, the Trust received notification from NIHR that the Trust would continue to stage 2 of the process with its proposed 15 themes and £100m budget. The Trust was working with theme leads to craft the stage 2 submission by mid-October, together with a financial plan to deliver Trust research objectives. The NIHR Imperial Clinical Research Facility was also in the process of re-applying for five years further funding.
8.7.1.	Patient recruitment to Covid-19 urgent public health clinical research studies continues. The world's first human challenge study with the SARS-COV-2 virus (led by Imperial) was nearing the initial stages of analysis and publication, and new studies were being initiated to study 'long Covid'.

8.7.2.	The Trust had been successful in attracting funding from NHS Digital for a number of high-profile digital projects to improve care and care pathways. These were moving towards detailed agreements.
8.8.	**Stakeholder engagement -** The report outlined the meetings and communications with key stakeholders since the last Trust Board meeting.
8.9. 8.9.1.	**Recognition and celebrating success -** The Board congratulated Prof. Julian Redhead who had been appointed as National Clinical Director for urgent and emergency care. He would continue with the Trust as Medical Director but the Trust would recruit another Medical Director to ensure the full portfolio was covered.
8.9.2.	The Board was pleased to note and congratulated the following members of staff and teams: ▪ Saghar Missaghian-Cully, Managing Director of North West London Pathology (NWLP), who was recognised in this year's Pathologist Power List for her work in NWLP's response to the Covid-19 pandemic and transformation programme; ▪ Dr Ros Bacon, Consultant Anaesthetist, who was awarded the RCoA President's Commendation for her contribution to work allowing anaesthetists in training to continue sitting exams during the pandemic. ▪ The Thrombectomy service was shortlisted for the British Medical Journal's stroke and cardiovascular team award for 2021; ▪ Imperial College was shortlisted for its work on the REMAP-CAP study in the critical care category; ▪ Sabrina Das, consultant obstetrician and gynaecologist based at Queen Charlotte's and Chelsea Hospital, was shortlisted for the HSJ Clinical Leader of the Year award. ▪ Lauren Hutton, Trust bereavement midwife, was nominated for Best Midwife in the Sun's Who Cares Wins awards. ▪ Nonhlanhla Nyathi was nominated in Nursing Times award for 'Diversity & Inclusion Champion of the Year' for her work in developing innovative hair caps for Black, Asian and minority ethnic staff. This work has also been recognised in the 'Best Diversity and Inclusion Practice' award shortlist. The remote patient monitoring project has also been recognised with a nomination in the 'Best Use of Technology to Improve the Working Environment' category.
8.9.3.	14 members of staff who have clinical roles across the Trust, including radiologists, gynaecologists, infectious disease experts and surgeons, had been promoted as part of the latest round of academic promotions at Imperial College London. The promotion of Trust staff who hold both academic and clinical positions further highlights research excellence at Imperial College Healthcare, with many senior clinicians actively researching in their field to improve care and provide cutting edge treatments for patients. The list of staff is provided on the Trust's website.
8.10.	Comments and questions from the Non-Executive Directors:
8.10.1.	Mr Ross congratulated Prof. Redhead and all the members of staff who had received awards, nominations and promotions. In respect of CQC, he commented that ICHT has some of the best outcomes in the country and it was disappointing that the CQC had rated the Trust poorly in the past and that although he recognised that the Trust was low risk, it would not have the opportunity of changing its overall rating despite the positive outcomes. He asked how close the Trust was to getting to good or outstanding. Prof. Orchard advised that the CQC drives improvement and they have in the past recognised improvements in areas such as well led and maternity and the rating changed. He advised that in 2014 the Trust was not delivering on some basic tasks but focusing on other key

	areas which led to the rating at the time. Since then a lot had been done on driving improvement with clear improvements in medical devices, medicines management and statutory mandatory training. He advised that due to the pandemic, the CQC was rightly focusing their attention on high risk organisations and that monthly engagement meetings continue to be held between the Trust and the CQC and they were aware of the good work being done by the Trust – the aim was to get to good but the aspiration of the organisation was to get to outstanding with quality improvement embedded in all that is done. Mr Jenkinson added that the CQC had also published its new methodology for inspections with a dynamic rating model which would provide an opportunity for the Trust to demonstrate improvement and to amend ratings outside of a formal inspection – this was being piloted and when published, Mr Alexander suggested the Trust puts itself forward to be an earlier adopter. Dr Klaber added that the Board member visit programme was also being linked to the quality improvement work and it would be a good opportunity for Board members to get close to this work, at ward level.
8.10.2.	Mrs Boycott was pleased to note the positive outcomes in operational performance and the focus on staff, both of which were demonstrated and discussed in more detail at the Board Committees. She commented that although the executive response in relation to operational difficulties and challenges was that they and their teams would continue to be resilient and supportive, the coming months were forecast to be difficult impacting further on staff, and asked what more could be done for staff. Prof. Orchard welcomed the comments and advised that the number of patients being treated were higher than usual for this time of the year which was a concern and coupled with the anticipated increase in the number of patients presenting with Covid, flu and the back log of patients, would require reprioritising the Trust's focus, and if needed, and to help staff cope, decisions would need to be taken such as pausing on the elective recovery programme if needed.
8.10.3.	Dr Maruthappu congratulated staff and the range of accolades was a good reflection of the talent the Trust has. He asked about the percentage of staff who were not double vaccinated and what more could be done to encourage staff given Covid cases were increasing across the capital. Prof. Orchard advised that across the capital and NHS, the vaccination rates were high and that ICHT Medical Director's office had and continue to drive the uptake of the vaccinations including individual conversations with hesitant staff. The teams were assessing patient areas that may be at particular risk through a range of mechanisms to assess the risk where unvaccinated staff usually work. He also advised that a consultation around possibly making the vaccination mandatory, had also commenced at a national level.
8.10.4.	Ms Scavazza was encouraged that the acute care collaborative were concerned and would focus on tackling health inequalities in the system but enquired whether they had enough robust data to be able to analyse and manage the inequalities that were long standing in the system and gave the example of being able to provide a number from the 180,000 waiting list of patients who had a physical disability or had learning disabilities - if not, she asked about plans to improve this situation. Prof. Orchard advised that the Trust records these particular areas and were able to extract them from the Cerner system and the electronic patient record system. In terms of the other Trusts within the collaborative, one other Trust was also recording data using the same system and the other two would migrate over the next two years. He advised that data quality in the NHS was continually improving and recording data in real time was an area of focus - across the Trusts until further progression of unified systems, they would need to understand the size of the waiting list and identify any obvious factors associated with people waiting longer. He advised that a sector Patient Tracking List (PTL) was updated and discussed weekly at sector meetings who were also working on a system across NWL to allow a real time view of the waiting list.

8.10.5.	Prof. Bush enquired about the uptake of lateral flow tests and compliance rates at the Trust. Prof. Orchard and Prof. Redhead advised that across the NHS, organisations were experiencing similar problems with the requirement of staff carrying out the twice weekly lateral flow tests and uploading the result which was a little tedious. Work continues on exploring options to encourage staff to carry out the test and to upload their results – specific focused work in some areas had seen a 30% increase therefore it was possible to increase the rates using different methodologies. For high risk areas, the Trust was insisting on ensuring the tests were done by staff.
8.10.6.	Mr Alexander welcomed the acute care programme report and commented that as the Board of the organisation it would be important and interesting to see some analysis of the resources ICHT were committing into the programme and enquired about any indications of non-collaborative services which might be challenged as result of that. Prof. Orchard advised that the acute care programme report was agreed by the programme, however he would give some consideration to producing an ICHT specific report to include the resource commitments and rationale. **Action: Prof. Orchard, Mr Jenkinson**
8.11.	**The Board noted the report.**
9.	**Integrated quality and performance report**
9.1.	The Board received the integrated quality and performance report for month 4, summarising performance against the key performance indicators for data published at July 2021.
9.2.	Overall, the Trust had achieved the Elective Recovery Funding (ERF) requirement for July year to date. The trajectory targets were met for total waits over 52 weeks, total waits over 78 weeks and total waits over 104 weeks.
9.3.	A summary of the performance headlines were provided in the main report along with the counter measure summaries for: Cancer waiting times – the percentage of patients who start their first treatment within 62 days of a GP urgent referral; Patients spending more than 12 hours in the emergency department from time of arrival; and Improving long length of stay
9.4.	The HSMR rates remain low and the Trust remains to be the third lowest acute Trust in the country.
9.5.	Prof. Redhead commented that it was important that the Trust compares well amongst its peers on the relative risk to viral infections, which showed that the Trust was doing well in terms of Covid deaths.
9.6.	The incident reporting rate had continued to increase and harm levels remained within the threshold level.
9.7.	Prof. Orchard referred to a report presented at the Quality Committee which showed that in wave one of the Covid pandemic, the mortality rate in the Trust's critical care units was lower at 33% than the national average of 37%. In the second wave the mortality in critical care units dropped by 27% therefore there was a 27% improvement from one wave to another which set the Trust at lower than the national average. This demonstrated learning from the first wave into the second wave.
9.8.	Prof. Redhead advised that the Quality Committee received a report on how the Trust compared with the national objectives on patient safety and the improvements that could be made by the Trust. This was well received by the Quality Committee.

9.9.	Comments and questions from the Non-Executive Directors:
9.9.1.	Mr Ross commended the progress made by the Trust.
9.9.2.	Mrs Boycott enquired why social workers were not yet on site and sought to understand the barriers inhibiting discharge. Prof. Bowen advised that the Trust was working closely with Directors of Adult Social Care and contributing factors had been numbers, staff sickness, safety and vaccinations. Productive meetings including the A&E Delivery Board were expected to improve the situation including escalation processes and supporting other members of the team.
9.9.3.	Mrs Boycott acknowledged the discussions around the operational pressures including people presenting at the Trust. She enquired about the people who do not present or present late whose outcomes were likely to be poor and whether the Trust would have the data to assess the profile of these groups particularly identifying people whose first language was not English, racial characteristics or deprivation to help understand and focus actions as a Trust and/or system at a point where equity of access was not working. Prof. Bowen commented that from her observations on presentations, there did not appear to be a socio-economic or background theme but a variety of conditions. The Trust was linking in with GPs and trying to learn by doing single point morbidity case reports for all those involved.
9.9.4.	Dr Raffel enquired about ambulance waiting times which had deteriorated. Prof. Bowen advised that when it was busy at St Mary's Hospital, the team were unable to offload quickly due to a combination of reasons around capacity. Charing Cross Hospital was more efficient in terms of triaging but the team could not offload quickly at times when capacity was stretched.
9.9.5.	Mr Alexander enquired about the number of patients who were waiting for more than 12 hours for access to the mental health pathway, particularly the extent to which the system was working to improve that link. Prof. Bowen advised that the system was working together at a variety of levels and were looking at ways to be able to make sure that patients were suitably cared for with the appropriate nursing care. The teams were working together and met regularly – although some improvements had been seen, there was more to be done in this area. Prof. Redhead added that this was also discussed at the daily gold meetings at which the Chief Operating Officers of Mental Health Trusts were present therefore able to effectively work together on solutions.
9.9.6.	Mr Alexander commented that in the event the Trust finds its waiting list growing due to circumstances beyond its control, when reported it would be important for the Board to have sight of the granularity in respect of the segmentation of that growth and mitigations. Prof. Orchard agreed and advised that the waiting lists work had been done on the separation of patients into P1s – P4s, and he would share the rational of this along with future plans. **Action: Prof. Orchard, Mrs Hook**
9.10.	**The Board noted the report.**
10.	**Finance report** The Board received the finance report which set out the reported financial position of the Trust for the four months from April to July 2021.
10.1.	Financial performance - Year to date the Trust delivered a break even position against a £1m deficit plan and was forecasting a break even position for the first six months of the year (H1). This was net of the under delivery of the Trust cost improvement programme (CIP) and additional costs of Covid (over and above that funded in the cash envelope)

	being offset by the contribution generated from the non-recurrent elective recovery funding (ERF).
10.1.1.	The activity targets to allow organisations to access ERF were revised during July from 85% of 2019/20 activity for the first two quarters of the year to 85% for quarter 1 and 95% for quarter 2. Year to date the Trust had recognised £23m of ERF income.
10.1.2.	Although the Trust awaited planning guidance for the second half of the year (H2) all things being equal to H1, the Trust aimed to deliver a break-even position for the year with any residual unmitigated CIP gap; under delivery of efficiency schemes already identified and the net impact of additional expenditure over and above plan being mitigated by on-going ERF/other non-recurrent actions. This forecast continues to be updated to reflect operational circumstances, but a review of the current assumptions versus those that were set out in the publication of the financial regime for H2, would be a key aspect requiring a detailed re-assessment.
10.1.3.	The Trust welcomed the announcement of the £5.4bn and was awaiting on how that would be allocated to systems and to NWL – the Trust would then plan how the money would be utilised.
10.2.	Capital – the full year capital plan equated to £84.7m of which only £56.9m scored against the Trust Capital Resource Limit (CRL), with the balance funded by donations or other sources. Year to date the Trust spent £11.0m (57%) of its total capital plan and expects to deliver to plan over the year.
10.3.	Cash – at 31st July, cash was £148m. The future cash outlook remained resilient in the short to medium term but this was dependent on the funding regime for the second half of the financial year (which is yet unknown) and the delivery of CIPs.
10.4.	Comments and questions from the Non-Executive Directors:
10.4.1.	Mrs Boycott commented that recurrent CIPs had been difficult to secure in the Trust for a number of years, and more so in view of the stretched workforce and continued operational pressures. Although it was helpful that the ERF was going to be a mitigation it did not address the issue. She asked how the radical approaches would deliver sustainability in the medium to long term. Prof. Orchard advised that the Trust would need to be more circumspective about the reliance on ERF in the second year as it would be dependent on pressures that the Trust may face in the second year. In respect of recurrent CIPs, he commented that it was important to note the steady progress over the years improving the Trust's position from £50m deficit to £30m deficit – he agreed that it was important to go back to basics and in this respect. Mrs Thind and a lead from the Transformation team were working closely with a view to ensuring a realistic run rate at the start of 2022-23. A Waste and Efficiency Group was being established which would be chaired by Mrs Thind.
10.4.2.	In terms of contingency planning, Mrs Ejimofo enquired whether it was possible to forecast for future events and pressures. Mrs Thind advised that when forecasting expenditure the finance team account for fluctuations and work with the directorates and departments. She assured the Board that the process was thorough and positions discussed at the monthly Divisional Oversight Meetings to capture issues on the horizon.
10.4.3.	Responding to Ms Scavazza's question regarding the timing of the allocation of the £5.4m, Mrs Thind advised that this had not yet been communicated to Trust, however the H2 planning guidance was expected at the end of September which may include this allocation.

10.4.4.	Mr Alexander urged Prof. Orchard and Mrs Thind to try and get clarity and agreement within the sector (ICS) of some underlying assumptions that would be used across the ICS which organisations can agree - in advance of knowing the sector guidance. Mrs Thind advised that this was done for H1 and the same approach would be taken for H2 i.e. reviewing the principles, assumptions and building in nuisances.
10.5.	**The Board noted the report**.
11.	**Maternity quality assurance oversight report**
11.1.	The Board received the assurance report on the progress on achieving compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). The report also included the quarterly Perinatal Mortality Review Tool (PMRT) Trust Board report. The report had been discussed and accepted by the Quality Committee.
11.2.	The Board noted that the maternity service continues to provide a high quality service alongside meeting increasing external assurance requests. The CNST MIS Declaration form was submitted to NHS Resolution on 19 July 2021, approved by the Board in May 2021. The July 2021 quarterly PMRT Trust Board report demonstrated compliance with the CNST MIS. There were no care issues identified which impacted on the outcome of the cases included within the report. The CNST MIS Year four launched on 8 August 2021 with a deadline for declaration by 30 June 2022.
11.3.	**The Board noted the report.**
12.	**Infection prevention and control report**
12.1.	The Board received the Infection prevention and control report covering quarter 1 2021/22, key highlights were: ▪ The Trust remained on track to meet its annual targets for C. difficile and E. Coli blood stream infection (BSI) reduction, and continued to see a reduction in overall consumption of antimicrobials despite the impact of the pandemic. ▪ There had been an increase in hospital-associated MRSA BSI, with 3 reported in Q1 2021/22 and 5 reported in 2020/21, compared to 3 in total during each of the two previous financial years. An action plan was being monitored through EMB Quality Group (EMBQG). Since writing the report there had not been any further hospital acquired MRSA cases. ▪ Water management continued to be an area of concern, particularly with increases in pseudomonas in neonatal units, and legionella contamination identified. Estates and facilities were leading on an action plan with IPC support, with regular updates to EMBQG. ▪ Catheter line-associated BSI rates in the adult and paediatric intensive care units increased in Q1, and an increase seen in blood culture contaminants and MRSA BSIs in critical care. A working group was in place to support improvements using quality improvement methodology. Actions to strengthen routine IPC practices had been implemented, with subsequent reductions in infection. ▪ Using learning from these successful interventions, and from what other organisations have in place, IPC were developing a new approach to training, assessment and support for staff for core IPC competencies, including aseptic non-touch technique, hand hygiene and personal protective equipment (PPE) use). Over the next month, the new techniques would be tested in selected clinical areas and assess their impact. Recommendations for the Trust wide approach would be presented to EMBQG in September. ▪ The PPE/Hand hygiene helper programme was continuing as one of the Trust's key safety improvement workstreams for the next 12 months. The next step was a Trust wide audit of hand hygiene which would commence in September.

12.2.	Comments and questions from the Non-Executive Directors:
12.2.1.	Prof. Bush commended teams for effective antibiotic stewardship, despite the pressures of the pandemic. Prof. Redhead added that the Quality Committee discussed the issue of using gloves and cross contamination. Following further discussions, the Trust had changed its guidance and recommendations to encourage hand washing instead of using gloves which would reduce some infection rates and cross contamination. This learning had been discussed with the sector who endorsed this approach.
12.2.2.	Mr Ross enquired about Trust actions in relation to the Trust not meeting its target for sepsis diagnosis. Prof. Redhead advised that this had been discussed at the Quality Committee at which he had informed the Committee that there were some data issues and improvement plans had been requested from the divisions which would be closely monitored. He assured the Board that the Trust was not seeing a lot of instances and incidents relating to sepsis issues.
12.2.3.	Responding to Mrs Ejimofo's question regarding increased numbers in blood cultures and MRSA cases and the associated learning, Mr Price advised that the IPC teams aim to identify the source and potential cross transmission in respect of blood cultures and skin organisms. Although challenges included PPE, hand hygiene, these were being addressed through educating people and revamping IPC practices.
12.2.4.	Responding to Mrs Ejimofo's question around future actions in relation to water contamination, Prof. Redhead advised that Prof. Sigworth and her team have a working group which monitors water hygiene and undertaken regular testing. He and Mr Gostling advised that all water sources have a level of contamination, not helped by the age of the estate. Water sources were tested and monitored to keep at a safe levels and the estates and IPC teams work together on specific types of water related infections and noted that treatments could take some time for them to act - other national recommended changes had been implemented. The teams were looking into how pseudomonas had entered the neonatal ward as the link was not directly related to the water source.
12.3.	The report was discussed and accepted by the Quality Committee.
12.4.	**The Board noted the report.**
13.	**Learning from deaths report**
13.1.	The Board received an update on Learning from Deaths programme outlining activity undertaken as part of the programme in quarter one 2021/2022 for approval ahead of submission to NHS England. The key highlights were: ▪ Deaths which occurred in Q1 2021/2022 had been identified as 'avoidable' through the processes outlined in the report. There was one death for which the team were comparing the associated SI and structured judgement reviews (SJR) reports to review the learning, avoidability and harm. ▪ SJRs had been completed for the 53 Hospital-onset Covid-19 infection deaths which occurred during the second wave of the pandemic. Following agreement of a standardised process across North West London, actions had been agreed and the outputs would be reported to the September EMBQG. ▪ A new learning from deaths process had been implemented, which once embedded would improve how the Trust investigates and learns from deaths in our care and ensure mortality reviews and processes align appropriately with the Medical Examiner service.
13.2.	The report was discussed and accepted by the Quality Committee. Prof. Bush commented on the Trust demonstrating well on learning from incidents and cases.

13.3.	**The Board noted the findings and supported the submission to NHS England.**
14.	**Annual report from the Trust Safeguarding Committee** The Board received an update on the systems and processes in place to ensure that the Trust safeguards users of its services and noted the summary of safeguarding activity and the impact that the Covid-19 pandemic had during the year. The report had been discussed and accepted by the Quality Committee.
14.1.	The Board noted that the pandemic had an effect on the volume and type of safeguarding concerns the Trust dealt with and less people were seen during the lockdowns, but there was increased complexity in safeguarding cases with mental health issues and domestic abuse being seen more commonly.
14.2.	Although training levels were mostly maintained throughout the year, compliance with level 3 children's safeguarding fell, in part due to the requirement for a face-to-face component. A plan was in place to increase this and compliance was increasing.
14.3.	For the year ahead a close eye would be kept on activity and how the change in referral pattern might move as the pandemic moves into a different phase.
14.4.	The Board noted that in an effort to ensure processes and practices were up to date, Prof. Sigsworth had commissioned a review of the service model of safeguarding drawing on best practice.
14.5.	Responding to Mr Alexander's question regarding which agencies the report was shared with, Prof. Sigsworth advised that it was shared with Borough based safeguarding organisations and the CQC also refers to the report.
14.6.	**The Board noted the report.**
15.	**End of Life annual report**
15.1.	The Board received an overview of activity related to end of life care noting the improvements made during the year. This report has been discussed and accepted by the Quality Committee.
15.2.	Specifically, Prof. Urch commended the work done by Katherine Proxton and Guy Young on continuing their work during the pandemic in ensuring the Cerner offering of being able to document end of life care and also their work via the BIG room and engaging with community teams on developing and Trust-wide implementation of MAAR chart and EOL discharge power plan for prescribing end of life medications.
15.3.	She commented on the importance of developing staff communication skills in respect of caring for end of life patients and teams were working with the Strategy Lay Forum in this respect – this was a key strand of work.
15.4.	**The Board noted the report.**
16.	**Workforce equality, diversity and inclusion annual report**
16.1.	The Board received the annual report which included the combined data and plans for the Workforce Race Equality Standard (WRES), the Workforce Disability Equality Standard (WDES) and Gender Pay Gap Report – this would be published on the Trust's website by 31 October 2021.
16.2.	In summary, there had been no significant changes in the workforce composition in regard to age since 2010; no significant change in ethnicity in recent years; the workforce split in terms of gender also remained unchanged in the last 5 years.

16.3.	The Board received an update on WRES which highlighted the deteriorating performance in respect of the likelihood of staff from a black, asian and minority ethnic background being subject to disciplinary action, and noted the actions that would be taken to improve the performance in this area. The relative likelihood of white applicants being appointed from shortlisting compared to black, asian and minority ethnic applicants had improved from last year. The Trust recognised it needs to further improve on its people practices, including recruitment and people practices impacting on staff experience.
16.4.	The Board noted the improvement in performance in respect of staff who say the Trust made adequate reasonable adjustments and the improvement in performance required in engagement for disabled staff and staff who have not stated to have a disability. Both had slightly decreased compared to last year. The Trust did not have any disabled staff who were performance managed in the year and the relative likelihood of applicants with no disability being appointed from shortlisting compared to applicants with a declared disability had increased.
16.5.	The Board noted the gender pay gap position for March 2021.
16.6.	Equality Delivery System (EDS2) was reported in full within the 2020 annual report and published on the Trust's website. The five EDS2 priorities cover the period 2020-2023 and there was no change during the reporting period.
16.7.	The workplan for 2021 remained focused on race equality, disability equality and the development of staff networks.
16.8.	The report set out the Trust's strategic plan. Looking ahead, in the main, the objectives from 2020/2021 would be retained with the remit of objective 1 and objective 5 expanded. The objectives are: ▪ Objective 1: (measurement for improvement) To create a suite of divisional and directorate-level diversity data 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 black, asian and minority ethnic staff being appointed from shortlisting ▪ Objective 5: (education and leadership) To design a range of equality education tools and intervention for all staff. ▪ Objective 6: (WDES) To create a flexible work environment where disabled staff are treated equitably supported and feel safe to disclose where needed.
16.9.	Mr Croft and Ms Scavazza summarised that the People Committee had discussed this report and had also had a deep dive into EDI. The particular focus of the Committee was on the increase in numbers of disciplinary hearings involving BAME staff significantly affected by the transfer of Hotel Services staff into the Trust. The Committee asked for more assurance and clarity around priorities and how and when the Trust would see impact on staff experience as well as the metrics.
16.10.	Mr Alexander requested that the wider Board receives an update on the prioritisation of work. Ms Scavazza concurred and advised that once progress had been discussed and agreed at the People Committee, a summary on priorities and metrics, including risks of not achieving some metrics and timings would be shared with Trust Board. **Action: Mr Croft, Ms Scavazz**a

16.11.	**The Board supported compliance against Public Sector Equality duties under the Equality Act 2010 and approved the report for publication.**
17.	**Safe, sustainable and productive nursing and midwifery staffing report**
17.1.	The Board received a summary of the mid-year nursing and midwifery establishment review, and progress against initiatives that the Trust was undertaking to support safe staffing, address nursing and midwifery shortages and ensure a sustainable workforce.
17.2.	The last annual nursing and midwifery establishment review was completed in autumn 2020 and presented to the Trust Board in March 2021. This took into consideration needs for additional bed capacity, stretch staffing requirements, and national guidance relating to the pandemic response. The mid-year review was conducted in June 2021 and provided an update on the staffing position and progress against workforce plans.
17.3.	The report highlighted a small decrease of 6.7 WTE in the nursing and midwifery workforce when compared with the annual establishment review. This was caused by a reduction in activity in private healthcare and is not anticipated to be a permanent change to their establishment in the future. The Trust was continuing to deliver against a range of recruitment and retention initiatives to support evidence-based reviews of our establishment and skill-mix as part of our strategic workforce plan for nursing and midwifery.
17.4.	The report had been discussed by the People Committee, at which the Red flag system of reporting was discussed and agreed to look at the systems in more detail to ensure staff were able to raise staffing concerns in a timely manner and that what they say was taken into consideration. In terms of the operational pressures, it was important to ensure staff were supported and to help them to be supportive of each other whilst managing patient needs. The Committee noted the challenges of the macro environment and the difficulties in recruiting and retaining staff, and the mitigating actions to ensure the Trust has the right levels of staff.
17.5.	**The Board approved the mid-year establishment compliance against the Developing Workforce Standards; and noted the ongoing work of the Trust to deliver safe, effective, and sustainable nursing and midwifery care.**
18.	**Pathway to excellence**
18.1.	The Board received an update on the Trust's participation in the American Nurse Credentialing Centre (ANCC) Pathway to Excellence® (PtE®) programme, which was recognised as aligning with the vision of collective leadership, and supported by NHS England. The report had been discussed and accepted by the People Committee.
18.2.	The Board noted that in addition to participating in a globally renowned accreditation programme, the Trust would also benefit from progressive nursing and midwifery leadership, advanced evidence-based care, better outcomes for patients and a more positive workplace. The Ward Accreditation Programme would underpin this programme.
18.3.	Mr Alexander referred to a comment about financial implications. Prof. Sigsworth confirmed that the programme was jointly funded by the Trust and NHSE.
18.4.	**The Board was supportive of this programme and the proposals set out to take the work forward.**
19.	**Responsible Officer's annual report**
19.1.	The Board received the annual report on the revalidation of medical staff and the activities undertaken by the Responsible Officer over the previous year which provided both Board-level and external assurance on medical governance procedures. The report had been discussed and accepted by the People Committee.

19.2.	The Board noted how the Covid-19 pandemic affected the revalidation and appraisal process. In April 2020, the RO authorised a Trust wide deferral action of four months for all doctors. The process was restarted fully in September 2020 and further extensions granted where necessary on a case by case basis. The process was suspended between January-February 2021 in response to the second surge and restarted in March 2021.
19.3.	The key action over the last year was the re-tendering of the electronic revalidation and appraisal system. The new system (L2P) was implemented in June 2021 and encompasses both appraisal and job planning. Due to the migration to the new system, the Trust was not currently reporting data on its appraisal rate. Once the transition period is complete, reporting would recommence with performance expected to return to pre-pandemic levels (over 95%) over the course of the year.
19.4.	Other priority focuses for the year ahead include a review of how data is reported and outcomes relating to the professional development of doctors now that new committee structures for P&OD related issues and processes have been implemented. This would include an improved process for reporting on concerns about doctors to the People Committee, including the progress and outcomes of any investigations, and information on protected characteristics.
19.5.	**The Board approved compliance with the Responsible Officer regulations and recommended approval by the Trust Board ahead of submission to NHS England.**
20.	**Trust Board Committees – summary reports**
20.1.	**Audit, Risk and Governance Committee** The Board noted the summary points from the meetings held on 9th September 2021
20.2.	**Quality Committee** The Board noted the summary points from the meeting held on 9th September 2021
20.3.	**Finance, Investment and Operations Committee** The Board noted the summary points from the meeting held on 1st September 2021
20.4.	**Redevelopment Committee** The Board noted the summary points from the meeting held on 8th September 2021
20.5.	**People Committee** The Board noted the summary points from the meeting held on 7th September 2021 The Committee endorsed the use of a staff story, the Board will receive a staff story in the future.
21.	**Any other business** No other business reported.
22.	**Questions from the public**
22.1.	Two questions were raised ahead of the Board related to patients which would be addressed separately.
22.2.	One other question had been submitted about increased Ambulances and noise from the sirens which had been re-directed to the London Ambulance Service.
22.3.	A member of the public was concerned with media news that the Boroughs immediately served by Imperial's hospitals remain amongst the lowest Covid-vaccinated areas in the country and asked to what extent is this likely to impact on Imperial's ability to cope with autumn and then winter pressures. Is Imperial engaging proactively with NW London CCG to improve both Covid and flu vaccination rates, particularly in Westminster, Kensington and Chelsea, Hammersmith and Fulham and Brent? What more could/should be done to increase vaccine rates?
22.3.1.	Prof. Orchard referred to the work the Trust has done to increase the vaccination uptake

	and commented that the two mass vaccination centres that the Trust was running, vaccinated approx. 200,000 people. He agreed that the number was lower than the average and London as a whole was lower than the national average which was of concern. He acknowledged there would be an inevitable impact of the some of the population in the Boroughs served by ICHT not being vaccinated, compared to other Boroughs whose rates were higher, however he advised that there were a number of unknown factors such as people being exposed to Covid-19 and their immunity levels – pragmatically, he advised that the Trust would need to continue with its efforts and plan for the worst. In terms of optimising vaccinations across the sector, he informed the Board of the 'hyper local' approach which would identify pockets of groups and with local Boroughs to work with them to raise awareness and increase the uptake within key groups. Prof. Redhead added that it was important that everyone continues to encourage colleagues, friends, families and citizens. He advised that planning was afoot to deliver the third booster for the vulnerable population and commencing the vaccination programme for children. He commented that there was an issue with the denominator which was being worked through. He offered to work with any community leaders to increase the vaccination uptake. The member of public welcomed the update which she would feedback to other organisations she was involved in.
22.4.	A member of the public made a number of suggestions and comments to assist the Trust in several areas of work. The Board welcomed the suggestions and asked that he send an email to so that the list of suggestions could be given due consideration then engage with him regarding his ideas.
22.5.	The same member of public enquired why disabled patients and Muslim employees were not represented on the Trust Board. Prof. Orchard welcomed his comment and he agreed that the Board does not currently have the spectrum of the population it serves represented on the Board. He advised that even with the intent to address this, limited number of job opportunities at Board level and the range of protected characteristics would not enable the Board to have full representation – however, over the course of 18 months the Board has improved in gender balance and there was wider representation of colleagues across different groups in the population. He stated that the Trust was determined that for every job vacancy, the Trust was making efforts to ensure that all groups of people were given an equal opportunity to apply for those jobs and considered in a fair way. He acknowledged that the Trust needed to do more.
22.6.	The same member of public referred to material in which he had read about the Trust's ambition to compete in the private care global market and although attractive he stated that the ambition does not support the Trust's core business and cannot be sustained financially. Prof. Orchard advised that the Trust had considered a collaboration opportunity in the middle east some years ago but decided against it. Recently the Trust had joined a scheme which enabled healthcare conversations and the exchanging of expertise with the aim of improving healthcare in other parts of the world, but not about setting up in other parts of the world. He confirmed that it was not a priority or an area of focus for the Trust.
23.	**Date of next meeting** 10th November 2021, 11am

Updated: 18 October 2021 / GN

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Record of items discussed at the confidential Trust board meeting held on 15 September 2021 and the Board Seminar held on 20 October 2021

Agenda item 5 and paper number 02

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

Purpose: For information

Meeting: 10 November 2021

Executive summary

1. Introduction

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

1.2. The Trust Board has met in private on two occasions since the last meeting on 15 September 2021 and the Trust Board Seminar on 20 October 2021.

15 September 2021 Private Trust Board

2. Chair's briefing

2.1. As part of the Chairman's oral update, the Board received an update on the national guidance on Integrated Care Systems (ICS) which was published in August 2021. This guidance contains an explicit requirement for providers to be part of a collaborative from April 2022 but partner provider organisations are to agree on what their model would look like. The NW London acute trust chairs had been discussing the approach to developing a proposed model for the NW London acute trusts. The London region had also asked that all developing collaboratives produce a high level statement of principles as a basis for their collaborative arrangements. Some additional part-time resource from NHS England had been advising on how to take this work forward.

3. Chief executive's update

3.1. The Chief Executive provided an oral update on the business planning process for the second part of the financial year (H2), the current operational pressures and the contingency plans that would be put in place as the Trust heads into winter.

4. Redevelopment update

4.1. The Board received an update on the current position of the St Mary's Hospital (SMH) redevelopment. The Strategic Outline Case (SOC) for the redevelopment of St Mary's Hospital had been submitted on 9 September 2021 and feedback was awaited. A summary would be published on the Trust's website. The Trust was now considering

options for the design and implementation plans in collaboration with the national Hospital Improvement Programme (HIP) team.

5. Managed maintenance service contract review post project evaluation

5.1. The Board received an update on the managed maintenance service contract which was tendered in August 2015, for 5 years, to provide assurance to the Trust that there would be a centralised system in place to meet its responsibility to minimise the risks associated with the safe and effective use of medical devices. The contract was extended in August 2020, for 3 + 2 years, as the managed maintenance contract had proved cost effective for managing medical devices.

20 October 2021 Board Seminar

6. The Board noted the submission of the Trust's application for Biomedical Research Centre (BRC) and received an update on strategic planning items, including the development of the ICS and acute collaborative, H2 2021/22 planning and winter planning. The Board considered some key programmes of work that support the delivery of the Trust's strategic aims, including strengthening our operating model and empowering clinical directorates, and the immediate managers' programme.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC) - ACTION POINTS REGISTER, Date of last meeting 15 September 2021

Updated: 2 November 2021/GN

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	12 May 2021 9.8.4	Board Member Visits (arising from Integrated Business Plan 2021-22 discussion)	As government restrictions ease, Prof. Orchard and Mr Jenkinson would revisit the Board member visit programme. July 2021 update: Work was progressing to update the Board member schedule to be launched at the end of July. September 2021 update: The programme was being finalised and would be launched in September. The Non-Executive Directors were reminded to complete their training. **November 2021 update:** The Board member visit programme had been launched in October. Close	Mr Jenkinson	November 2021
2.	15 Sept 2021 8.10.6	CEO Report	Prof. Orchard advised that the acute care programme report was agreed by the programme, however he would give some consideration to producing an ICHT specific report to include the resource commitments and rationale. **November 2021 update:** Oral update	Prof. Orchard, Mr Jenkinson	November 2021

3.	15 Sept 2021 9.9.5	IQPR Report	Mr Alexander commented that in the event the Trust finds its waiting list growing due to circumstances beyond its control, when reported it would be important for the Board to have sight of the granularity in respect of the segmentation of that growth and mitigations. Prof. Orchard agreed and advised that the waiting lists work had been done on the separation of patients into P1s – P4s, and he would share the rational of this along with future plans. **November 2021 update:** The Trust has a clinical prioritisation and harm review SOP for elective care. At the end of October 2021, 93% of patients waiting on a surgical RTT pathway had a clinical prioritisation code attached on their patient record. This meets the minimum requirement set out by NHS England and Improvement. The Trust reviews the number of P2 patients on the inpatient waiting list a weekly basis (includes RTT and non-RTT patients waiting on a planned pathway). The P2 waiting list size started to reduce in July and now remains stable.	Prof. Orchard, Mrs Hook	November 2021
4.	15 Sept 2021 16.10	EDI Annual Report	Mr Alexander requested that the wider Board receives an update on the prioritisation of work. Ms Scavazza concurred and advised that once progress had been discussed and agreed at the People Committee, a summary on priorities and metrics, including risks of not achieving some metrics and timings would be shared with Trust Board.	Mr Croft, Ms Scavazza	January 2022

Items closed at the September 2021 meeting

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)

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

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Patient Story

Agenda item 7 and paper number 04

Executive Director lead: Janice Sigsworth
Authors: Steph Harrison-White & Guy Young

Purpose: For information

Meeting date: 10 November 2021

1. Purpose

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

1.2. The perceived benefits of patient stories are:

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

2. Executive summary

2.1. The story on this occasion will be told by the Deputy Divisional Director of Nursing and Midwifery for the Women's & Children's Services at the request of the patient. The patient is autistic and finds public speaking stressful. She has provided a full 'script' and photograph for the Board meeting.

2.2. The patient, referred to as Ms D, contacted the Trust this summer following the birth of her third child. Ms D was very complimentary about the care she received from her community midwife, enabling her to have a home birth.

2.3. This story highlights the difference that good communication, consistency and kindness makes when supporting a person with autism to have a home birth.

2.4. Staff education and patient information are also crucial in ensuring that all staff understand how to support women with autism during child-birth and for women with autism to have the information they need to make informed choices about child birth.

3. Next steps

3.1 Further work and education is required to ensure that the experience that Ms D had is the experience of all women with autism.

Imperial College Healthcare NHS Trust

4. Recommendation(s)

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

5. Impact assessment

5.1. There is no impact of this paper in itself. It is hoped that the understanding and changes generated as a result of the story will lead to a better standard of data collection and make survey completion easier for users of our services.

Main paper

6. Patient story

6.1. In May 2021, Ms D gave birth to her third child under the care of the home birthing team at the Trust. Ms D felt compelled to contact the Trust following her experience, to thank the midwife who had had such a positive impact on her care.

6.2. Ms D describes herself as a 'late diagnosed autistic woman' who had wrongly been diagnosed with various mental health conditions in the past. She explains how her disability is largely 'invisible' and that she like many other women in her position, can mask their autistic traits by 'withdrawing from normal activities.'

6.3. Ms D explains that she has been left with anxieties about health care due to her own life experiences and being autistic can mean that in certain situations, such as being put under too much pressure or given too many demands or questions, can lead to changes in her behaviour, panicking, becoming emotional or confrontational. In her everyday life, Ms D is supported by her family and friends thus allowing her to enjoy her life and being a mum.

6.4. Ms D's previous experiences of child birth had left her feeling anxious about facing child birth and uncertain as to which birth plan would best suit her and her baby at this time. She decided to explore the feasibility of having a home birth to avoid the need for a hospital stay. Initially, Ms D felt that this may not be a viable option as she didn't think she would cope with potential sudden change of plans if needed and describes feeling 'trapped and helpless' about going through the pregnancy.

6.5. Home births are supported by the community midwife teams. Marta …. was the community midwife allocated to lead on Ms D's care and birth plan. Ms D describes how in spite of her own anxieties, Marta was able to 'dismantle Ms D's anxieties' through the care, kindness and excellent communication skills she showed. Ms D felt listened to, she trusted her midwife and did have her baby safely at home.

6.6. Whilst Ms D acknowledges the impact that excellent midwifery care can have in enabling a person with autism, to have their baby at home, she comments that 'people with complex developmental conditions, like her, or mental health problems, are so frequently unsupported or offered inappropriate or insufficient healthcare'.

6.7. Ms D's hopes that by sharing her experience more widely, other women with similar needs will feel enabled to explore the possibility of having a home birth, supported by staff who are trained to understand and care for them.

6.8. As mentioned earlier, Ms D find certain situations difficult to manage. Although Ms D met with the patient experience team in person, her preference was for her story to be shared verbatim and she has kindly provided a 'script'. Her story will be shared by the deputy divisional director of midwifery.

7. Conclusion and next steps

7.1. This story exemplifies the type of care that would be expected of a maternity service rated outstanding by the CQC.

7.2. The National Autistic Society (2021) conducted a study to look at the differences for non-autistic women and those with autism. This small study highlighted the challenges faced by those with autism due to the sensory aspects of childbirth.

7.3. The study stressed the importance of clear, direct communication from professionals and the need for greater autism-related training for professionals involved in childbirth and postnatal care. Continuity of care and one to one support were considered to be important factors, alongside individualised care, adapted to meet the diverse needs of those with autism.

7.4. There are increased risks for first-time mothers who chose a home birth. However this risk is negligible for second and subsequent births if the woman is healthy and the pregnancy straightforward.

7.5. There are many advantages associated with home births for example you are less likely to have medical interventions such as an episiotomy, a caesarean or instrumental birth. This is especially relevant for Ms D as it reduced her chance of requiring hospitalisation.

7.6. This patient story illustrates the impact of good communication, kind and attentive care with the outcome that a person with a disability is supported to experience the same opportunities to have the birth plan of their choice.

7.7. Further work and education is required to ensure that the experience that Ms D had is the experience of all women with autism. This must include information for women, so they are aware of their choices and the care and support they will receive.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Chief executive's report

Agenda item 8 and paper number 05

Lead Executive Director: Prof Tim Orchard, Chief executive

Purpose: For noting

Meeting date: 10 November 2021

Chief executive's report to Trust Board

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

- Operational update
- Covid-19 and flu vaccination programme
- Covid-19 and infection prevention and control
- Financial performance
- CQC update
- Redevelopment
- Research
- Equality, diversity and inclusion update
- Stakeholder engagement
- Review of visiting policies and how we are considering new infection prevention and control recommendations
- Celebrating Black History Month 2021
- NHS staff survey 2021
- Second Medical Director appointment
- Recognition and celebrating success

1. Operational update

Since the end of the summer we have experienced increasing operational pressure on our services. We are already seeing higher demand for our A&E departments than usual. In September 2021, we treated 20 percent more patients in our emergency department and urgent treatment centres than during the same period in 2019, before the pandemic. While ambulance attendances are at a similar level compared with 2019, we have seen an increase in walk-in patients. The situation is made more challenging because we continue to care for patients who have tested positive for Covid-19, with the number of admissions increasingly slightly over the last month. At present we are able to manage this increased demand within existing capacity and continue to explore further improvements to help us through our busiest time.

A number of key investments and improvements are in place already, including expanding our ambulatory emergency care facilities, increasing staffing across our urgent and emergency care services, improving our specialty pathways and moving to a model where we directly triage all patients needing urgent and emergency care at St Mary's Hospital rather

than going via our urgent treatment centre provider. We have also worked closely with our partners across north-west London to try to make sure patients only come into hospital when they really need to and are able to leave as soon as they are medically fit to do so.

Further details about our operational performance are included in the integrated quality and performance report.

2. Covid-19 and flu vaccination programme

Phase 3 of the Trust's programme to administer Covid-19 booster and flu vaccinations to staff and patients began on 30 September 2021. All Trust staff have been given a vaccination clinic appointment to discuss their personal circumstances and, if they wish, to have one or both vaccinations. Appointments have been scheduled over a seven-week period up to 18 November 2021.

Good progress has been made at this half way point. Over half of eligible staff have been vaccinated with their Covid booster, which compares with national data showing an uptake of between 40-50 per cent. Thirty per cent of our frontline staff have received their flu vaccine which is 7 per cent above NHS England's trajectory of 23 per cent for this point. We had also booked in early appointments for staff who had not previously come forward for a Covid-19 or flu vaccine so that we could provide additional support as early as possible in this phase.

Further work is needed now to encourage and support remaining staff to come for their appointments and have their vaccines wherever possible. All staff who did not attend their vaccine clinic appointment are being actively followed up, including via their line managers. At this stage, very few members of staff have formally declined their vaccinations.

We have an active and targeted communications programme, focusing particularly now on reaching staff groups with low uptake. Tailored Q&A sessions are planned for staff in professional groups and from ethnic backgrounds with particularly low uptake and for a number of staff who have concerns about the vaccines and pregnancy. Expert clinical support is being incorporated into these discussions, as we have done previously with good effect.

We will continue to report vaccination uptake internally and externally and to do all that we can to encourage as many staff and patients as possible to take up their vaccinations.

3. Covid-19 and infection prevention and control

With high prevalence of Covid-19 and other respiratory viruses in the community, we are continuing with enhanced infection and prevention controls across our hospitals alongside the other hospitals in our ICS. This includes key restrictions on the number of visitors and how visiting is managed as well as a wide range of measures for staff and care pathways. We have recently provided updated guidance for all staff in relation to Christmas plans and we are currently working through new national infection prevention and control recommendations for healthcare settings to help determine next steps.

4. Financial performance

At the end of first six months of the financial year (H1) the Trust delivered a break even position which is in line with the plan agreed with the North West London Integrated Care System (NWL ICS) for this planning period. This position includes the delivery of an efficiency target of £15.8m and £28m of elective recovery funding (ERF) where the Trust was able to draw down additional non-recurrent income for the elective recovery activity it delivered over and above the national target thresholds. The contribution from the ERF has been helpful in offsetting the underperformance on our cost improvement programme for the first six months of the year. Nationally agreed pay awards, backdated to April 2021, were paid to staff in September with the cost offset by additional central income.

The operational planning guidance for H2 was issued on 30 September. The Trust will remain on a block contract with the majority of our income flowing through this route with the ability to access additional ERF now dependent on ICS performance in reducing the number of incomplete referral to treatment (RTT) pathways. Changes in the way ERF is calculated, with introduction of revised thresholds, will result in a significantly lower amount of ERF in H2. The Trust is required to agree its H2 plan with the NWL ICS prior to submission in mid-November.

The Trust has set a capital plan of £86.8m for the year (including grants and donations). Year to date against planned expenditure of £28.9m, the Trust has spent £18.3m (63%) and remains, all things being equal, on track to spend all of its capital resource limit. At 30 September, cash was £178m and, based on the current regime, the Trust expects to maintain a healthy cash balance in the medium term and will continue to track its performance against the Department of Health and Social Care target of ensuring 95% of undisputed supplier invoices are paid within 30 days (current performance above threshold).

5. CQC update

The Trust had its regular quarterly engagement meeting with the CQC on 30 September. Normally these meetings have two parts, one with Trust service leads and a Trust level session. However, the CQC did not consider that there was a need to meet with any particular services at this time, and only the Trust level meeting took place. The outcomes from the meeting were very positive and the CQC continues to indicate that it considers the Trust to be low risk for regulatory non-compliance.

The new Health and Care Bill, which gives statutory footing to integrated care systems (ICSs) from April 2022, has been amended to reflect that the CQC will be the regulatory body for ICSs. Although this had been anticipated, its confirmation means the CQC will now move forward to develop a regulatory framework for ICSs, along with accompanying methodology. It is not yet clear whether this will be in place from 1 April 2022 or developed after ICSs are established.

The CQC published the results of the 2020 Adult Inpatient survey on 19 October, capturing the views of patients aged 16 years and older who had spent at least one night in hospital. The sampling period for the survey was the month of November 2020, which means the outcomes will reflect the experiences of adult inpatients who were inpatients at the Trust during the second wave of Covid. The survey does not include maternity services, psychiatric units, or Imperial Private Healthcare.

The survey involved 137 acute and specialist NHS Trusts and had an overall response rate of 46%; the Trust's response rate was 40%. Of the 47 survey questions, the Trust performed about the same as other Trusts for most questions.

Overall, compared to its performance in the previous survey in 2019, the Trust improved on all questions except for only one, which related to long waits for admission. The Trust performed well in three questions:

- Beforehand, how well did hospital staff explain how you might feel after you had the operations or procedures?
- During your hospital stay, were you ever asked to give your views on the quality of your care?
- Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?

However we performed worse than other Trusts for the question:

- There were restrictions on visitors in hospital during the coronavirus (COVID-19) pandemic. Were you able to keep in touch with your family and friends during your stay?

It is of note that 98.6% of respondents said they were treated with dignity and respect, a measure the Trust has consistently performed well on; and 88.8% of respondents rated their overall experience as 7/10 or greater, an improvement over the previous survey.

We are now reviewing the survey results to consider areas for further improvement, looking particularly at how patients keep in touch with family and friends as visiting restrictions related to the Covid-19 pandemic continue.

6. Redevelopment

St Mary's, Charing Cross and Hammersmith hospitals are all included in the 40 new hospitals the government has committed to build by 2030 as part of the government's wider Health Infrastructure Plan.

The strategic outline case (SOC) for the redevelopment of St Mary's Hospital was submitted in September 2021. The SOC represents the first stage of the approval process for NHS England and the Department for Health and Social Care. The Trust is awaiting feedback from the New Hospital Programme (NHP).

Initial work exploring the high level options for developments at Charing Cross and Hammersmith hospitals has been completed and we are awaiting feedback NHP on funding to support further work.

7. Research

Our key research update since the last Board relates to the re-application for our National Institute for Health Research (NIHR) Imperial Biomedical Research Centre (BRC), where the Stage 2 bid was submitted on 19 October. BRCs focus on early-stage clinical research – experimental medicine – where new treatments, techniques or diagnostics are trialled in humans for the first time. Our current 5-year BRC programme is worth £91m over the period 2017-22. The new application is for £100m from December 2022 to November 2027 – the maximum that can be applied for.

The bid was co-ordinated by Professor Mark Thursz (the Trust's Director of Research and BRC Director) with support from the BRC Office and College Research Strategy team. Wide engagement on the shape and content of the application took place at regular intervals over the previous few months, including with our Trust Board. The application proposes at least £5m to be invested in research capacity development and training, at all stages of the clinical academic career pathway, and for medics as well as nurses, midwives, allied health professionals, healthcare scientists, pharmacy staff and psychologists. It also includes other non-medical disciplines such as chemical biology and AI for healthcare. This £5m leverages the same amount from other partners, including Imperial Health Charity and industry.

Our application was developed collaboratively with the BRC's Public and Patient Advisory Panel, who have reviewed several sections of the text (plain English summary, case studies) and in accordance with our new equality, diversity and inclusion (EDI) framework. This framework, which builds on the work of the Trust's People and EDI Committees, will be important both in ensuring that all populations in our diverse community have the opportunity to participate in research, but also that internal career development and funding opportunities are provided in an equitable and inclusive manner.

8. Equality, diversity and inclusion update

As part of our ongoing commitment to build an inclusive workforce, we have re-launched an inclusive recruitment approach for all band 7 and above Agenda for Change roles, with executive oversight of the process to help us improve workforce representation of Black, Asian and minority ethnic staff at senior levels.

We published externally our Workforce Annual EDI Report 2020/2021 and we also launched an internal video animation for staff to encourage updating of personal electronic staff records to improve the collection of our diversity data. Having this information helps us to understand the makeup of our workforce, so that we can identify and address barriers that prevent us from attracting, retaining and promoting staff from all backgrounds.

Six of our senior leaders started their journey on the White Allies development programme and participants in our disability leadership programme Calibre are now working on their final projects before their graduation in November.

9. Stakeholder engagement

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

- Cllr Tim Mitchell, Westminster City Council: 16 September 2021
- Karen Buck MP for Westminster North and Andy Slaughter MP for Hammersmith: 30 September 2021
- Cllr Stephen Cowan, London Borough of Hammersmith & Fulham: 13 October 2021
- Hammersmith & Fulham Save our NHS, Brent Patient Voice and Ealing Save our NHS: 18 October 2021
- Amanda Pritchard, NHS England, visit to St Mary's Hospital: 18 October 2021
- Healthwatch Central West London: 8 November 2021

10. Celebrating Black History Month 2021

A range of activities were held to mark Black History month. This provided an opportunity to celebrate the achievements and contributions of our black colleagues and black people across the UK. Activities included panel discussions and expert talks, on-site Caribbean food trucks, virtual cooking demonstrations and a fascinating discussion around Sickle Cell Disease.

11. NHS staff survey 2021

This year's NHS national staff survey launched on 4 October 2021 and is one of the most important ways for our staff to tell us what it's like working at the Trust.

12. Second Medical Director appointment

I am delighted to report that Raymond Anakwe, Associate Medical Director and Consultant Orthopaedic Surgeon, has been appointed as a second Medical Director for the Trust and took up his new role, alongside his clinical commitments, on 1 November.

This second, part-time post was created to allow our existing Medial Director, Professor Julian Redhead, to dedicate part of his time to his additional new role as national Clinical Director for Urgent and Emergency Care. Julian will continue as Medical Director with voting rights on the Trust Board and as the responsible officer for our doctors.

13. Recognition and celebrating success

Doctors at Queen Charlotte's and Chelsea hospital have completed a world first procedure to safely treat a pair of twins in the womb with a rare condition caused by shared blood vessels, without the need for an invasive procedure. Twin to twin transfusion syndrome (TTTS) has been estimated to affect 10-15 per cent of identical twins, or approximately 300-400 pregnancies each year in the UK. The condition occurs in identical twins who share a placenta where, in some cases, the sharing of blood flow between the babies is unbalanced. This is the first step in a long-term clinical trial which will require many more people who are pregnant with twins suffering from TTTS to volunteer to take part. Researchers are currently focusing on ensuring that the procedure can be undertaken safely but, once they have completed this phase, they will then be able to continue the research,

gather and analyse evidence to understand whether this procedure does have a positive clinical impact for mothers and their unborn babies.

I am pleased to report Rose Amadi, Midwife at the Lindo Wing, has won the 'Archie Award' at the 2021 Mariposa Awards. The Mariposa Awards were launched by the Mariposa Trust in 2018 to recognise medical professionals and others making a real difference in the lives of people who have experienced baby loss. Rose was nominated by a couple she supported following the death of their unborn baby, and was commended for her compassion, empathy and professionalism.

I am also delighted to report that Noni Nyathia, Ward Manager, was also highly commended at the enei Inclusivity Excellence Awards for 'Driving Social Inclusion in the Workplace' for her innovative headwear idea to help BAME staff who have to wear PPE. Noni has also been shortlisted for this year's European Diversity Awards, Hero of the Year.

Dr Dominique Allwood**,** Associate Medical Director and Consultant in public health medicine has been nominated 'Mentor of the Year' at this year's Women of the Future award and the English National Opera's ENO Breathe programme for COVID-19 patients has been shortlisted for the Royal Philharmonic Society's 2021 Impact Award. The programme was developed in partnership with Imperial College Healthcare, an integrated social prescribing programme of singing, breathing and wellbeing which brings together musical and medical expertise to combat the increasing need for support for those experiencing long-Covid symptoms.

Professor Tim Orchard
Chief executive
3 November 2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Integrated quality and performance report scorecard for month 6 (September 2021 data)

Agenda item 9 and paper number 06

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

Purpose: For discussion

Meeting date: 10 November 2021

1. Purpose of this report

1.1. This report provides an update to the Board on the performance against our key performance indicators (KPIs) for data published at month 6 (September 2021).

2. Executive Summary

2.1. The enclosed scorecard presents KPIs covering the Trust's strategic goals, priority programmes and focussed improvements.

2.2. On 30 September 2021, NHS England and Improvement published the priorities and operational planning guidance covering October 2021 to March 2022 (referred to as H2). The Trust's activity and performance trajectories for H2 are being finalised with the Integrated Care System (ICS) team ahead of the final submission on 16 November.

2.3. The Trust is on track to meet the minimum Elective Recovery Funding (ERF) target for September year to date. Although elective activity levels against baseline are flagging on the scorecard as non-compliant (combined number of day cases and overnight spells), achievement is measured in financial value rather than volume alone. A greater number of higher priority and more complex cases have been completed and this impacts on the final ERF achievement. The Trust continued to exceed planned activity levels for outpatient attendances.

2.4. The RTT waiting list increased to a level that was slightly over the plan. The trajectory will be reset for H2 with the ambition to stabilise the elective waiting list at the same level to March 2022. The 52 week wait trajectory continues to be met, however, unfortunately 25 patients were waiting over 104 weeks against a plan of 11. The Trust's trajectory for H2 will ensure compliance with the national commitment to eliminate very long waits by March 2022.

2.5. Overall 12 hours waits within the emergency department increased, reflective of increasing pressures on urgent and emergency care pathways over recent months.

2.6. The Trust's incident reporting rate (per 1,000 bed days) for September is 58.65 which is below our target to be within the top quartile compared to other acute non-specialist trusts.

2.7. Since April 2020 we have declared nine never events. Six of these occurred in 2020/21 and three so far in 2021/22. Work streams are being established to address recurrent issues identified.

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

3. Approval process

3.1. This report has been discussed and approved at the meeting of the Executive Management Board.

4. Recommendation(s)

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

5. Next steps

5.1. The enclosed countermeasure summaries set out next steps for those areas where performance is below the trajectory.

6. Impact assessment

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

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

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

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

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

<u>Main report</u>

7. Month 6 performance

Operating plan 2021/22 – performance and activity update

7.1. On 30 September 2021, NHS England and Improvement published the priorities and operational planning guidance covering October 2021 to March 2022 (referred to as

H2). The Trust's activity and performance trajectories are being finalised with the Integrated Care System (ICS) team ahead of the final submission on 16 November.

7.2. The Trust is flagging on the enclosed scorecard as not meeting the minimum requirement of 95% of baseline activity for total elective spells under the Elective Recovery Fund (ERF) scheme. However, overall the Trust achieved the elective recovery requirement year to date for September.

7.3. As previously highlighted in this report, ERF achievement is measured in financial value rather than volume alone. Whilst the total number elective day cases has been lower than the plan during H1, operationally, a greater number of planned higher priority cases (with greater complexity) have been completed and this has impacted on the values and calculation of our overall ERF achievement. The Trust continued to exceed the planned elective recovery levels for outpatient attendances.

7.4. The trajectory continued to be met for patients waiting over 52 weeks to receive consultant-led treatment and the target for patients waiting over 78 weeks was met. The trajectory for 104 week waits was not met.

7.5. Changes to the integrated scorecards in light of H2 operating plan requirements (covering October 2021 – March 2022) will be made from next month.

Referral to Treatment

7.6. At end September 2021, the overall size of the RTT waiting list closed at 76,585 patient pathways (+1.4% on the previous month) which was slightly outside of the Trust's trajectory of 76,211 or less for the month. As part of H2 operating plan submission, the waiting list trajectory will be reset to meet the national ambition to stabilise at the current level for the remainder of 2021/22.

7.7. The 52 week wait trajectory target was met, with 1,515 patients waiting over 52 weeks against the plan of 2,539. The 78 week wait trajectory target was met, with 314 patients waiting against the plan of 320. Unfortunately, the 104 week wait trajectory target was not met, with 25 patients waiting over 2 years against a plan of 11. Our trajectory for the remainder of the financial year (H2) is compliant with the national ambition to eliminate very long waits by March 2022.

7.8. The prioritisation of the surgical waiting list continues to meet the national standards.

Diagnostics

7.9. The Trust continued to improve performance of diagnostics waiting times, with 27% of patients waiting more than 6 weeks for their diagnostic test at end of September 2021 (from 30% the previous month). In Imaging services, the national standard of no more than 1% of patients waiting more than 6 weeks for their diagnostic test was achieved in September for the first time since March 2020.

7.10. An internal trajectory has been developed in line with the national expectation to return overall Trust performance to the 1% national standard by March 2022.

Cancer waiting times

7.11. The 62-day GP referral to first treatment performance was 81.0% against the 85% target (up from performance of 73.8% in the previous month). Due to the lag in cancer

reporting and the date of the Board meeting, the action plan in the enclosed Countermeasure summary is aligned to August performance. The action plan associated with September performance will be reported through the divisional oversight meeting and executive management board

Urgent and Emergency care

7.12. The Trust's Ambulance handover performance (within 30 minutes) decreased by 1.6% to 89.0%, below the overall improvement trajectory.

7.13. Overall waits within the emergency department increased. A total of 642 patients spent more than 12 hours in the emergency department from time of arrival. Based on the underlying statistical process control (SPC) charts, this is indicated as special cause variation.

7.14. The increase in waiting times is reflective of increasing pressures on our urgent and emergency care pathways over recent months. In September 2021, 20 per cent more patients were treated in our emergency department and urgent treatment centres than during the same period in 2019, before the pandemic. Plans are in place to prepare for anticipated greater pressures during the winter period, including investments for additional staffing and improved space for urgent and emergency care and sector wide initiatives.

7.15. The overall length of stay across the trust has remained stable over the last three months.

Quality – safe and effective

7.16. The Trust's incident reporting rate (per 1,000 bed days) for September is 58.65 which is below our target to be within the top quartile compared to other acute non-specialist trusts. This target has been refreshed based on recent publication of the National Reporting and Learning System (NRLS) annual report for financial year 2020/21. Based on this revised data, we have not achieved our top quartile target over the last 12 months and our reporting rate for 2020/21 is below national average. Our rate continues to be variable in line with pre-pandemic performance, showing the ongoing challenge with delivering sustainable improvement. A trustwide programme is underway to improve how we report, investigate and learn from incidents, however these actions are longer-term (e.g. the re-tendering of Datix, our incident reporting system) and will take time to embed. Divisional plans are focusing on more short term actions including local huddles focusing on incident reporting and learning.

7.17. Since April 2020 we have declared nine never events. Six of these occurred in 2020/21 and three so far in 2021/22. While the incidents were varied in nature, however we are seeing some recurrent issues related to line insertion, stop before you block and general safety checking. A weekly task and finish group in in place focusing on line safety in the first instance. A trust wide campaign to improve safety of line insertions, followed by a staged review, relaunch and audit of all LocSSIPs (local safety standards for invasive procedures). An agreed set of actions are in place which will be expanded as the work progresses. In addition to the trust wide group, a workstream has been established in response to the increase in incidents in theatres/anaesthetics. Actions have been agreed focusing on the re-launch of stop before you block, implementation of an electronic process for checking prior to blood transfusion and a review of safety measures around administration of medication.

7.18. Our mortality rates and harm profile remain low. Our current rolling 12 month percentage of incidents causing moderate and above harm is 1.40%, which is below our threshold of 2.67% (refreshed target based on publication of the latest annual report from the NRLS).

7.19. No CPE blood stream infections (BSIs) or C. difficile lapses in care were reported in September 2021, however there was one MRSA BSI case reported. We have an observed increase in MRSA BSIs, with four so far in 2021/22. Following clinical review, two have been confirmed as not healthcare associated. The remaining two cases are clinically confirmed healthcare-associated MRSA BSI, so we are above the national threshold of zero cases. Review of the two remaining healthcare associated cases has not identified any lapses in care. Actions being taken include focused work with the divisions to improve our MRSA screening rates which are currently below our 90% target, and the implementation of a monthly review of all healthcare-associated BSIs, including MRSA, to identify learning and other areas for improvement.

Appendices:

1. Trust Board integrated performance scorecard – month 6
2. Countermeasure summaries – month 6

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard - Board Version

Imperial Management and Improvement System (IMIS)

FI = Focussed improvement

M6 - September 2021

Section	FI	Metric	Watch or Driver	Target / threshold	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Reporting rules	SPC variation
To develop a sustainable portfolio of outstanding services																			
Quality safety improvement	FI	Patient safety incident reporting rate per 1,000 bed days	Driver	**>=65.6**	54.35	50.56	55.99	56.71	53.89	50.45	52.90	47.54	54.58	58.77	62.72	58.61	58.65	CMS	-
		Healthcare-associated (HOHA + COHA) Trust-attributed MRSA BSI	Watch	**0**	0	0	0	1	2	1	0	0	1	2	0	0	1	Note performance / SVU if statutory standard	-
		Healthcare-associated (HOHA + COHA) Trust-attributed C. difficile	Watch	**8**	11	4	5	0	4	8	7	3	7	6	6	10	4	-	-
		Healthcare-associated (HOHA + COHA) E. coli BSI	Watch	**14**	3	8	3	6	7	5	6	6	3	5	8	5	15	Note performance / SVU if statutory standard	-
		CPE BSI	Watch	**0**	0	1	0	0	1	1	1	0	0	0	0	0	0	-	-
		% of incidents causing moderate and above harm (rolling 12 months)	Driver	**<2.67%**	1.50%	1.49%	1.49%	1.46%	1.43%	1.46%	1.54%	1.50%	1.38%	1.34%	1.36%	1.34%	1.40%	Promote to Watch	-
		Hospital Standardised Mortality Ratio (HSMR) (rolling 12 months)	Watch	**<=100**	71	71	72	71	72	72	73	76	76	76	76	66	53	-	-
		Formal complaints	Watch	**<=100**	71	76	68	55	66	74	95	77	53	77	83	75	83	-	-
Response and Recovery		Elective spells (overnight and daycases) as % of trajectory target	Watch	**100%**	-	-	-	-	-	-	-	103.3%	97.6%	114.9%	88.1%	88.4%	90.7%	Note performance / SVU if statutory standard	-
		Outpatient attendances as % of trajectory target	Watch	**100%**	-	-	-	-	-	-	-	106.8%	101.8%	117.6%	100.0%	105.1%	100.2%	-	-
		RTT waiting list size	Watch	**76,211**	55,225	55,790	57,226	57,699	57,334	57,991	62,763	65,753	68,242	72,362	74,437	75,500	76,585	Note performance / SVU if statutory standard	CC
		RTT 52 week wait breaches	Driver	**2,539**	1,259	1,160	990	1,050	1,667	2,278	2,374	2,157	1,837	1,467	1,464	1,516	1,515	Promote to Watch	CC
		% clinical prioritisation (RTT inpatient waiting list – surgical)	Watch	**>=85%**	-	-	-	-	88.7%	90.0%	89.4%	89.4%	89.2%	91.3%	91.6%	91.7%	92.0%	-	-
		Diagnostics waiting times	Driver	**<=1%**	40.5%	32.9%	29.6%	26.8%	50.5%	47.7%	38.8%	36.4%	36.6%	36.9%	33.2%	29.8%	27.0%	CMS	CC
		Cancer 2 week wait	Watch	**>=93%**	83.5%	94.3%	88.8%	95.8%	94.1%	95.3%	94.9%	93.4%	95.0%	93.4%	93.1%	94.2%	-	-	CC
		Cancer 62 day wait	Driver	**>=85%**	72.3%	71.4%	73.4%	76.8%	77.3%	73.0%	79.1%	80.6%	78.7%	74.7%	73.8%	81.0%	-	CMS	CC

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M6 - September 2021

Section	FI	Metric	Watch or Driver	Target / threshold	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Reporting rules	SPC variation
continued		Ambulance handovers - % within 30 minutes	Driver	**96%**	95.7%	95.6%	97.1%	88.8%	89.5%	95.1%	96.0%	95.7%	96.8%	96.2%	92.5%	90.6%	89.0%	CMS	CC
		Number of patients spending more than 12 hours in the emergency department from time of arrival	Driver	**0**	173	219	175	480	632	199	156	165	147	180	356	541	642	CMS	SC
	FI	Long length of stay - 21 days or more	Driver	**<=126**	145	154	165	166	165	210	180	158	140	145	172	169	170	CMS	CC
Safe and Sustainable Staffing		Vacancy rate	Watch	**<=10%**	9.5%	9.7%	9.8%	10.0%	9.8%	9.8%	9.9%	10.6%	11.0%	11.5%	12.0%	12.4%	12.3%	Switch to Driver	-
	FI	Agency expenditure as % of pay	Driver	**tbc**	1.4%	1.6%	1.6%	2.3%	1.8%	2.7%	2.4%	3.1%	2.4%	2.0%	1.9%	1.5%	2.7%	-	-
		Staff Sickness (rolling 12 month)	Driver	**<=3%**	4.39%	4.39%	4.39%	4.43%	4.50%	4.54%	4.18%	3.79%	3.74%	3.67%	3.70%	3.79%	3.87%	CMS	-
		Staff turnover (rolling 12 months)	Watch	**<=12%**	11.0%	10.9%	10.8%	10.7%	10.1%	9.9%	9.8%	9.9%	10.6%	10.4%	10.4%	11.1%	11.1%	-	-
Finance		Year to date position (variance to plan) £m	Watch	**£0**	18.30	0.00	0.00	0.00	0.00	10.30	15.80	-3.18	0.50	0.75	1.00	1.25	0.00	-	-
		Forecast variance to plan	Watch	**£0**	19.10	-8.40	-1.50	-15.60	-14.00	1.80	15.80	0.00	18.51	1.51	0.00	0.00	-14.50	Note Performance / SVU if Statutory	-
		CIP variance to plan YTD	Watch	**£0**	-	-	-	-	-	-	-	-	-	-6.15	-6.09	-5.73	-4.08	Note Performance / SVU if Statutory	-
To build learning, improvement and innovation into everything we do																			
		Core skills training	Watch	**>=90%**	92.4%	92.0%	91.6%	91.8%	91.6%	91.5%	92.2%	93.0%	93.8%	94.5%	94.0%	92.7%	92.2%	-	-

Abbreviations

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

Reporting rules
CMS - Countermeasure summary
SVU - Structured verbal update

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Appendix 2

Integrated quality and performance report:

Countermeasure summaries at month 6 (September 2021 data)

Imperial College Healthcare NHS Trust

Contents

Fice countermeasure summaries are enclosed:

CMS: Incident reporting rates

CMS: Cancer waiting times 62-day performance

CMS: Ambulance handovers (within 30 minutes)

CMS: Patients spending more than 12 hours in the emergency department

CMS: Long length of stay

Imperial College Healthcare NHS Trust

CMS

Incident reporting rates

Countermeasure summary: Improving our incident reporting rate

Problem Statement:

- Incident reporting is one of the most important sources of patient safety information, helping us to identify risks to patients and staff. High rates of incident reporting enable us to identify with more accuracy actual or potential harm; analysing this data alongside other sources of intelligence helps us to learn and continuously improve. Internally, we measure our incident reporting rate per 100 whole time equivalent (WTE) to allow us to compare locally across different areas. At trust level, we use the National Reporting and Learning System's (NRLS) measure of incident reporting rate per 1,000 bed days so we can compare ourselves nationally.
- Pre-pandemic, the numbers of incidents we reported were variable and during the first surge in spring 2020 reporting dropped across all divisions. We also saw a decrease during the most recent surge, however the numbers overall remained higher than the first surge. This was partly due to an increase in incidents reported in critical care; the result of increased activity, but also measures put in place by the division to support incident reporting during the surge.
- Since we came out of surge, our incident reporting rates have been improving due to the return to 'normal' activity and some targeted interventions by the divisions, and July saw our highest incident reporting rate per 100 WTE (17.83) since we began reporting this metric. The subsequent drop to 16.39 in August appears to be normal variation in line with previous fluctuations. In September 2021, our incident reporting rate increased slightly to 16.64. We remain below our target of 20.4.
- On 29th September 2021, the NRLS published their latest annual report for 2020/21. Incident reporting rates have increased nationally, although the number of incidents reported actually decreased, and the top quartile target is now 65.6. Based on this revised data, we have not achieved our target over the last 12 months.

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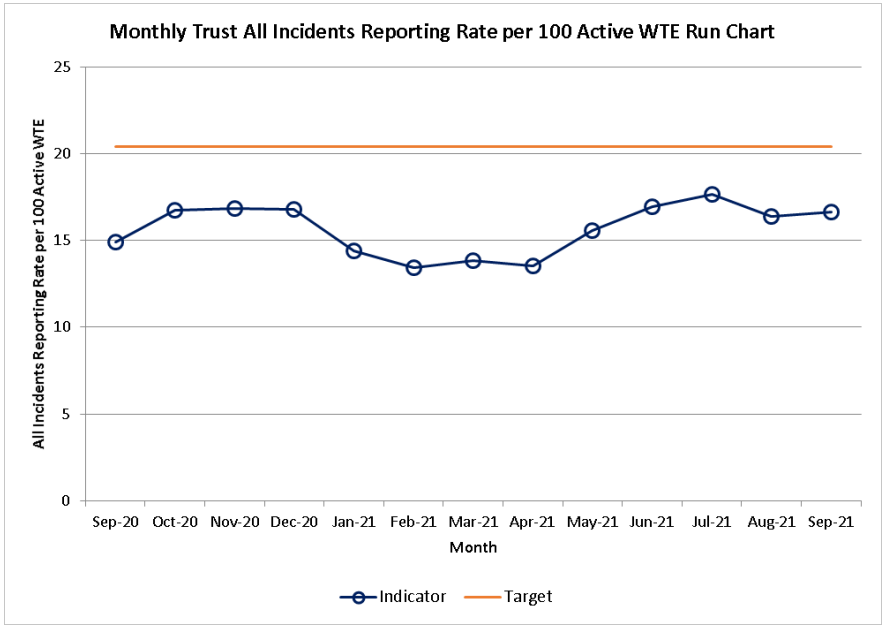
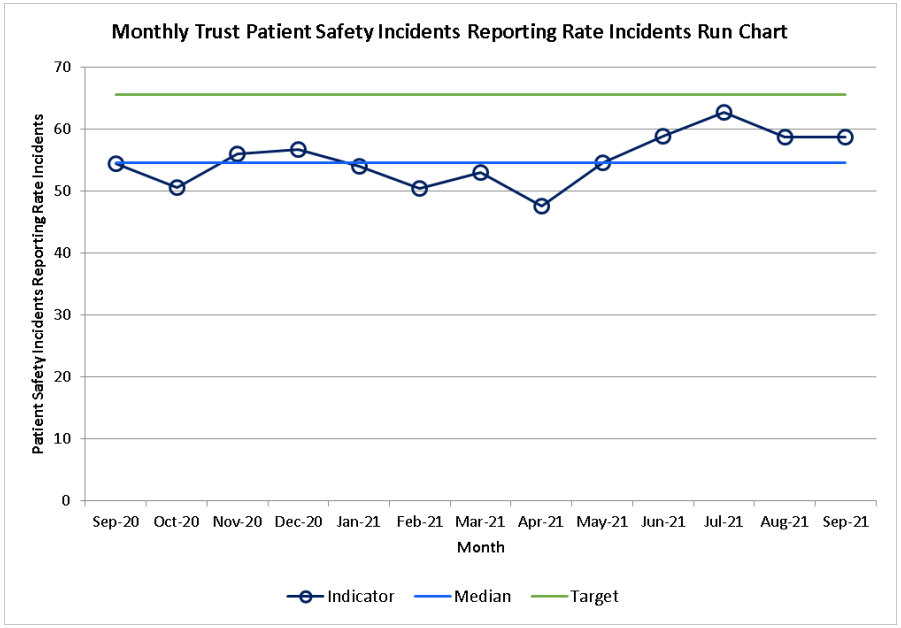
Metric Owner: Shona Maxwell, chief of staff
Metric: Incident reporting rate

Desired Trend: ↑

Historical performance:

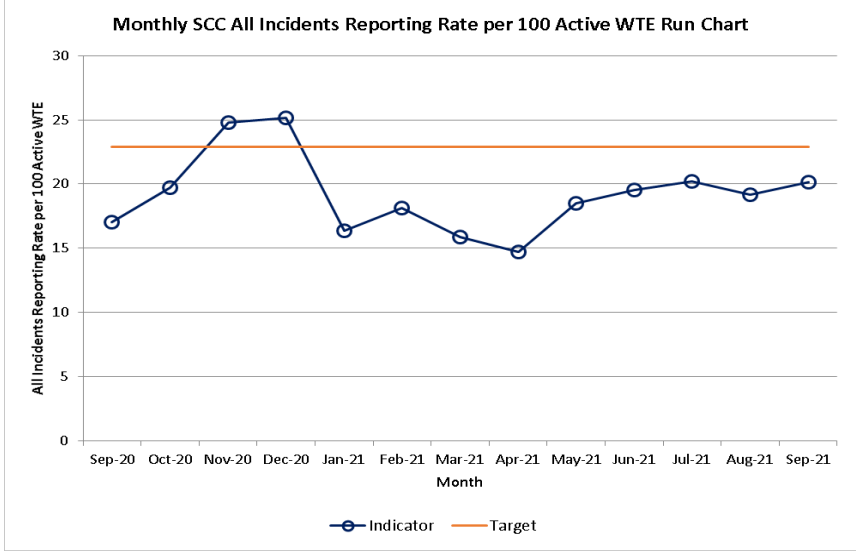


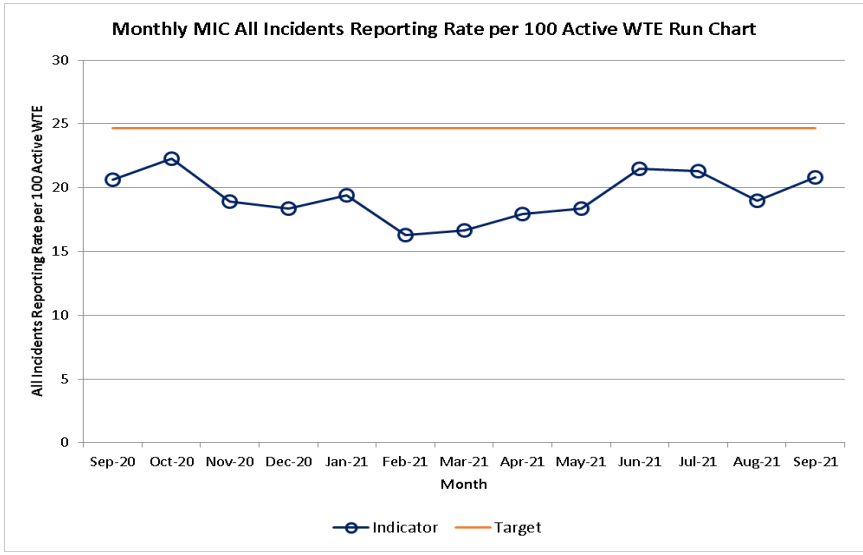


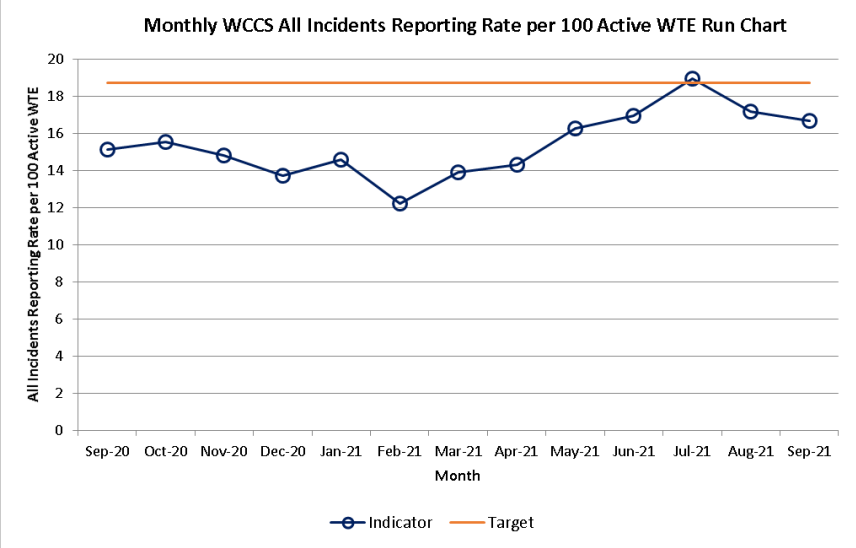
Countermeasure summary: Improving our incident reporting rate

Imperial College Healthcare NHS Trust

Stratified Data:







- The graphs show the incident reporting rate per 100 WTE for each of the main clinical divisions.
- During Q3 2020/21, there was a temporary change in practice in the division when general surgery and vascular began reporting all bed and staffing shortages as incidents. This resulted in a higher reporting rate for the division of Surgery, Cancer & Cardiovascular (SCC) , which was reflected at trust level.
- Following an increase in reporting rates over the last few months with the return of ‘normal’ activity after the second surge, all three clinical divisions saw a decrease in August 2021, with a subsequent slight increase in September 2021 in the division of Medicine and Integrated Care (MIC) and SCC.
- This appears to be normal variation, with sustainable improvement remaining challenging.
- Directorate level data is provided on the following slide.

Countermeasure summary: Improving our incident reporting rate

Imperial College Healthcare NHS Trust

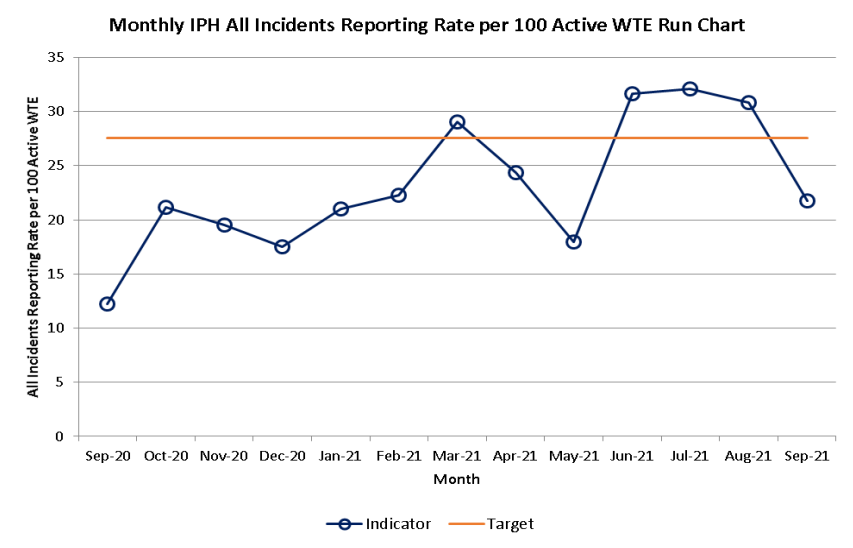
Stratified Data:

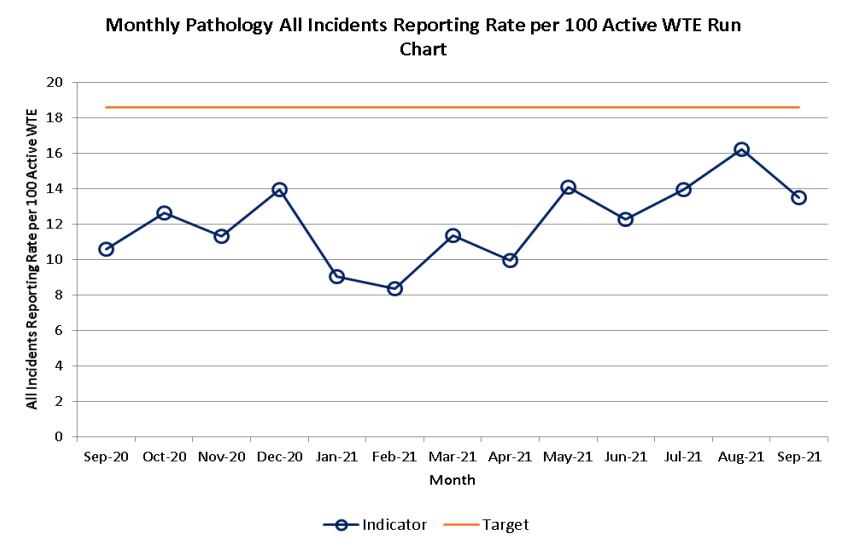
Division	Metric	Directorate	TARGET	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
TRUST	All incidents reporting rate per 100 active WTEs	TRUST	20.40	14.89	16.74	16.82	16.77	14.40	13.45	13.81	13.54	15.56	16.93	17.67	16.39	16.64
SCCS	All incidents reporting rate per 100 active WTEs	SCC Total	22.91	17.01	19.70	24.80	25.14	16.36	18.15	15.88	14.70	18.49	19.47	20.26	19.61	20.17
SCCS	All incidents reporting rate per 100 active WTEs	Cardiac	23.82	15.93	16.24	15.10	16.08	9.50	12.11	14.49	17.70	28.71	23.80	21.64	30.55	26.61
SCCS	All incidents reporting rate per 100 active WTEs	Clinical Haematology	19.67	17.10	13.41	8.87	9.32	4.96	9.66	8.26	8.65	6.80	5.09	13.24	5.98	6.86
SCCS	All incidents reporting rate per 100 active WTEs	Corporate Cancer	2.21	3.04	1.00	1.01	1.01	0.00	0.00	0.00	0.99	1.99	0.00	2.06	1.03	0.00
SCCS	All incidents reporting rate per 100 active WTEs	Oncology & Pallative Care	30.51	16.28	20.80	18.82	15.13	11.86	13.96	17.49	12.69	18.85	26.38	19.50	16.76	23.98
SCCS	All incidents reporting rate per 100 active WTEs	Specialist Surgery (Urology, ENT, Breast, Riverside)	16.22	8.32	11.53	8.63	10.48	7.57	8.11	8.01	9.81	9.43	12.83	10.45	8.84	11.57
SCCS	All incidents reporting rate per 100 active WTEs	Trauma (Major Trauma, Orthopaedics & Plastics)	25.97	17.57	23.61	16.99	26.22	17.87	15.14	17.91	12.14	20.48	16.62	15.43	21.40	20.88
SCCS	All incidents reporting rate per 100 active WTEs	General Surgery & Vascular	35.64	22.83	28.39	106.23	86.15	41.07	14.31	23.87	22.07	23.90	25.15	26.65	23.65	35.51
SCCS	All incidents reporting rate per 100 active WTEs	Opthalmology	17.66	11.38	9.63	12.92	18.98	11.65	4.88	10.31	11.59	11.02	19.61	14.22	11.13	17.31
SCCS	All incidents reporting rate per 100 active WTEs	Critical Care	37.04	34.99	38.75	39.27	45.11	38.99	59.41	34.31	25.50	31.70	32.14	37.12	31.45	28.67
SCCS	All incidents reporting rate per 100 active WTEs	Theatres, Anaesthetics & Pain	13.04	8.86	10.60	9.88	9.42	4.45	8.15	5.68	8.65	8.53	10.03	13.71	16.10	10.93
MIC	All incidents reporting rate per 100 active WTEs	MIC Total	24.68	20.60	22.24	18.92	18.36	19.41	16.25	16.65	17.93	18.37	21.47	21.22	19.19	20.79
MIC	All incidents reporting rate per 100 active WTEs	Integrated Care	7.94	3.37	4.72	6.01	2.19	3.03	3.30	3.58	3.37	4.20	5.96	5.71	5.43	4.02
MIC	All incidents reporting rate per 100 active WTEs	Renal	16.06	11.15	16.06	12.85	11.83	10.96	8.83	13.91	11.72	13.70	16.11	19.66	13.29	18.36
MIC	All incidents reporting rate per 100 active WTEs	HH Specialist Medicine	11.71	5.98	5.14	7.09	5.91	11.43	4.41	3.64	5.00	5.02	7.47	7.84	6.06	11.89
MIC	All incidents reporting rate per 100 active WTEs	Stroke & Neurosciences	25.15	18.07	17.15	17.41	19.55	15.67	15.60	13.90	17.72	20.43	17.53	21.64	16.30	22.20
MIC	All incidents reporting rate per 100 active WTEs	CXH Acute & Specialist Medicine	28.07	21.69	20.60	20.15	21.43	20.88	21.43	14.13	16.84	18.39	18.59	21.02	22.48	21.42
MIC	All incidents reporting rate per 100 active WTEs	Urgent & Emergency Care	51.89	51.38	50.24	36.58	33.41	35.18	28.91	31.28	41.33	37.38	51.94	37.58	35.70	39.14
MIC	All incidents reporting rate per 100 active WTEs	SMH Acute & Specialist Medicine	30.17	25.57	34.01	26.83	27.09	33.45	24.47	28.76	23.85	23.28	25.14	28.19	27.30	22.83
WCCS	All incidents reporting rate per 100 active WTEs	WCCS Total	18.74	15.11	15.60	14.83	13.73	14.55	12.24	13.89	14.30	16.25	17.08	18.86	17.43	16.68
WCCS	All incidents reporting rate per 100 active WTEs	Outpatients	9.18	2.34	1.86	3.69	5.42	3.13	1.77	5.90	1.82	8.68	7.66	4.13	4.59	7.44
WCCS	All incidents reporting rate per 100 active WTEs	Imaging	9.13	7.95	9.04	7.34	5.67	6.17	6.14	6.98	6.57	6.16	7.97	6.71	8.89	7.45
WCCS	All incidents reporting rate per 100 active WTEs	Pharmacy	8.19	7.81	3.50	4.32	2.58	2.91	2.52	5.21	7.63	3.15	4.02	7.04	4.97	5.54
WCCS	All incidents reporting rate per 100 active WTEs	Gynaecology & Reproductive Medicine	20.22	16.61	17.41	14.70	10.41	8.56	6.28	13.02	17.40	19.43	14.46	19.39	16.62	18.48
WCCS	All incidents reporting rate per 100 active WTEs	Maternity	33.00	32.86	34.05	33.38	31.48	34.89	33.16	31.14	31.84	34.98	36.78	37.86	34.91	31.39
WCCS	All incidents reporting rate per 100 active WTEs	Children's, Young People & Neonatal	22.49	12.85	13.93	13.10	13.74	15.22	8.91	11.55	11.55	15.34	17.52	23.89	20.26	19.97

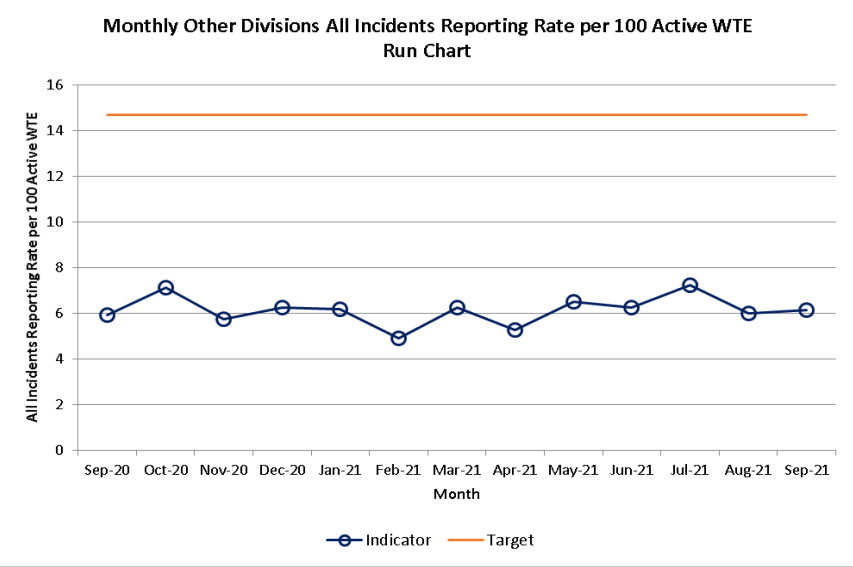
Countermeasure summary: Improving our incident reporting rate

Imperial College Healthcare NHS Trust

Stratified Data:







- The graphs show the incident reporting rate per 100 WTE for Imperial Private Health (IPH), North West London Pathology (NWLP) and 'other divisions' which is made up of the corporate areas within the trust.
- For IPH, reporting rates have historically been variable, however between June and August 2021 they met their target following focused work within the division including discussions in internal meetings led by the divisional director or nursing and encouragement of hotel services staff, to report. There was a dip in September 2021, and additional actions have been implemented by the division with performance expected to be back on track in October.
- For NWLP, reporting rates have also been variable. On 17th May, Hillingdon & Ealing CCG GP work transitioned from the Hillingdon lab to Charing Cross, leading to an overall increase in incidents reported over the last few months.
- The reporting rate for corporate areas (other divisions) is low and has remained mostly static. Corporate areas are being supported to develop their own improvement plans.

Countermeasure summary: Improving our incident reporting rate

Imperial College Healthcare NHS Trust

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.

The programme was on hold during the pandemic surge, but has now restarted with an updated project plan and revised driver diagram in place.

Countermeasure summary: Improving our 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.	• Strategic outline case to retender for a Digital Incident and Risk Management system will be finalised and submitted to execs for approval in Nov	Head of quality compliance and assurance	Nov 2021
		• Launch dashboards in Qliksense to help make data more available to frontline teams (currently under development). This has been delayed due to the pandemic and requires additional support from BI. • Ward level reporting rate per 100 WTE will be included in the WAP data packs.	DiHub/BI	Nov 2021
		• Project to trial incident reporting App Care Report will launch in A&E at SMH in collaboration with PSTRC (date TBC by PSTRC)	PSTRC/ Improvement Team	TBC (by PSTRC)
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.	• Development of dashboards of key incident reporting data for use by frontline staff in safety huddles (these were piloted at the end of 2020, but put on hold during the second wave of the pandemic)	Improvement team / DiHub	Nov 2021
Divisional/directorate engagement	• Incident reporting is a focused improvement as part of the management system. This is a new way of working and plans to take this forward are still in development within the divisions.	• Divisional action plans recommenced. These are being monitored through EMB quality group. Divisions are reviewing the actions in their action plans as reporting rates remain variable despite most of these being implemented.	DDNs/DGDs	Ongoing
		• Development of action plans for corporate areas.	Corporate leads	Nov 2021
		• Presentation of focused improvement work at ICPG.	MDO	Complete

Countermeasure summary: Improving our incident reporting rate

Imperial College Healthcare NHS Trust

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Local clinical engagement – both the research literature and our pilot to improve incident reporting show that the majority of barriers and enablers to incident reporting are local. In order to be successful, improvement plans need to be developed and progressed locally	• Identification of local areas to focus on improving incident reporting not yet complete for all divisions • Variable attitudes to incident reporting amongst different staff groups – nurses are the main reporters of incidents	• Focused improvement work begun with Haematology and Specialist Surgery with an action plan drawn up. This will now commence with Stroke and Neurosciences and Specialist Surgery. Nominations are required from WCCS. • Development of a plan to support improved incident reporting amongst doctors	DDNs/DGDs MDO/DGDs	Nov 2021 Nov 2021
Negative perception of incident reporting – staff have reported a number of barriers and that they do not see Datix as a tool for improvement.	• Messaging regarding the importance of incident reporting not reaching frontline staff • Blame culture around incident reporting	• Development of communications and awareness campaign • After action review (AAR) continues to be implemented for all newly declared SIs where appropriate • Meeting being arranged to agree plan to relaunch positive reporting.	Communications Head of quality compliance and assurance Head of quality compliance and assurance / DDNs	On-going On-going Nov 2021
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 (this will be part of the re-tendering process) • Project to trial incident reporting App CareReport will launch in A&E at SMH in collaboration with PSTRC. • Plan to develop automatic reporting from CERNER alongside implementation of a new incident reporting system (following re-tendering). This will be developed throughout 2021/22. Key themes where this would be possible include pressure ulcers, PPID, PPH and falls.	Head of quality compliance and assurance PSTRC / Improvement team Office of the medical director with chief clinical information officer	March 2022 TBC (by PSTRC) On-going

Imperial College Healthcare NHS Trust

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

Countermeasure Summary: Cancer Waiting Times 62-day Performance

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Problem Statement: Performance against the standard has been non-complaint for 16 consecutive months. August was reported at 81.0% against the 85% standard, an improvement from July (73.8%)

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	Aug
3.1 - Cancer Plan 62 Day Standard (Tumour)	79.1%	80.6%	78.7%	74.7%	74.1%	81.0%
Acute leukaemia		100.0%	100.0%		100.0%	
Brain/Central Nervous System		100.0%	100.0%			
Breast	65.0%	77.1%	73.2%	73.0%	65.8%	86.5%
Gynaecological	79.2%	83.3%	85.2%	82.6%	81.0%	84.2%
Haematological (Excluding Acute Leukaemia)	100.0%	100.0%	80.0%	66.7%	81.8%	75.0%
Head and Neck	100.0%	100.0%	100.0%	84.6%	100.0%	100.0%
Head and Neck - Thyroid	100.0%	50.0%		100.0%	60.0%	100.0%
Lower Gastrointestinal	55.6%	46.2%	35.3%	15.8%	58.8%	33.3%
Lung	100.0%	60.0%	100.0%	66.7%	40.0%	100.0%
Other		100.0%	0.0%	100.0%	100.0%	100.0%
Sarcoma		100.0%				
Skin	100.0%	90.9%	100.0%	50.0%	88.9%	84.6%
Testicular	100.0%		100.0%	100.0%	100.0%	
Upper GI - HpB	50.0%	100.0%	33.3%	80.0%	33.3%	85.7%
Upper GI - OG	81.8%	66.7%	100.0%	100.0%	50.0%	0.0%
Urology - Prostate	66.7%	91.7%	100.0%	93.8%	100.0%	89.5%
Urology - Renal	66.7%	100.0%	100.0%	87.5%	71.4%	0.0%
Urology - Urothelial	100.0%	100.0%	100.0%	100.0%	100.0%	

Key associated metrics to watch against trajectory	
2 Week Waits (2WW)	August performance 94.2% against 93% target. Performance expected to be pressured in September due to sustained 2WW referral demand increases across specialties and increased patient choice delays through summer.
104+ day backlog	78 patients at 14/10/2021 – decrease from 86 in July. Improvement expected as GI discharge times improve;
63+ day tip over drivers	GI diagnostic pathway capacity and discharge times, late referrals from other NWL trusts and pathology reporting time delays, prostate diagnostic pathway compliance, skin biopsy capacity and telederm pathway management

Countermeasure Summary: Cancer Waiting Times 62-day Performance

Imperial College Healthcare NHS Trust

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Late inter-trust referrals	• Elective capacity reductions at partner trusts in NWL have resulted in delayed diagnosis and later transfer of care to ICHT for treatment.	• Local elective capacity improvement plans.	NWL Trusts / Integrated Care System	On-going
GI Diagnostic pathways	• Endoscopy waiting times increasing for 2 consecutive months – mean average waits over 21 days in September. • Avoidable delays in discharge times through virtual clinic processes in general surgery and gastro	• Weekly escalation process to identify endoscopy scheduling delays from cancer PTL to be implemented. • Discharge information to be included in endoscopy reports. • Template letters to reduce discharge times from average 9 days to 1 day	Endoscopy Endoscopy Gastro/ general surgery	Agreed and implemented October 2021 Agreed October 2021 – completeness to be audited November 2021 w/c 11/10/2021 - implemented
Pathology	• > 7 day waits for cancer diagnostic sample analysis – affecting most tumour groups. • Significant impact on patient experience through delayed communication of diagnosis • Particular impact in gynae, urology, GI and skin pathways	• Pathology to submit a case for increased working hours following end of temporary funding from Royal Marsden Partners (RMP) (West London cancer alliance) • Performance issues escalated to NWL COO and CEO groups for resolution	Pathology	Not confirmed
Complex pathways	• Expected increase in cases with more complex diagnostic and care requirements following delays in presentation to primary care now materialising	• Alignment with RMP strategic objectives for recovery of ‘unmet need’ population within NWL	Corporate cancer/ Trust-wide	On-going (strategy approval 30/09/2021)
Patient choice delays	• Increase in patient choice delays during August	• Review of outpatient booking scripts to align with Faster Diagnosis Standard (FDS) pathways and encourage patient attendance	Corporate cancer/ Patient Services Centre	November 2021

Imperial College Healthcare NHS Trust

CMS

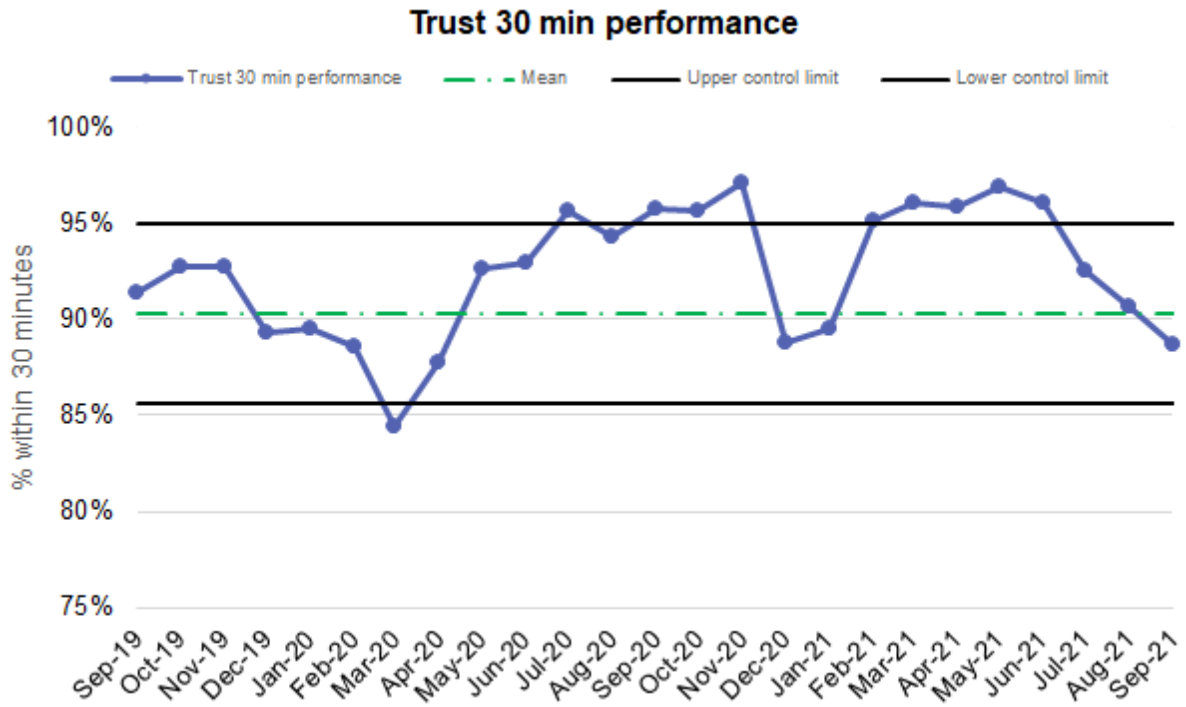
Ambulance handover times (within 30 minutes)

Countermeasure Summary: Ambulance handovers

Imperial College Healthcare NHS Trust

Problem Statement: The national target is 100% in order to reduce the time London Ambulance Service (LAS) crews spend in Emergency Departments (ED) and therefore freeing them up to respond to other calls. Delays have a knock on effect to overcrowding in the Emergency Departments.	**Metric Owner**: Ben Pritchard-Jones **Metric**: % of ambulance arrivals with a handover time < 30 minutes - target 100% **Desired Trend**: ↑

Historical performance: The overall performance declined by 1.6% in September 2021 to 89.0% for 30 minute ambulance handovers, below the internal target of 95.6%. This has been driven by a decline in performance at the SMH site.



Countermeasure Summary: Ambulance handovers

Imperial College Healthcare NHS Trust

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Ambulance Handover Delays	• Number of ambulances arriving to department that is already full	• Escalation process signed off and agreed with London Ambulance Service (LAS) and Imperial site team, support requested of more staff when possible from across site.	Ben Pritchard-Jones	Oct-21
Long waiting psychiatric patients	• Unavailability of psychiatric beds leading to long waits in the department	• MH Trusts – Central and North West London NHS Foundation Trust (CNWL) - reviewing occupancy levels to increase capacity across weekends to support admissions & introducing new discharge targets for wards to increase flow. • Focus on medical clearance speed, earlier escalation between CNWL and West London Mental Health Trust (WLMHT) and Approved Mental Health Professional (AMHP) provision delays • Developing joint proposal for Emergency Assessment MH Lounge at SMH, in discussions with Estates teams on options scoping	Jo Sutcliffe Ben Pritchard-Jones	Oct-21 Oct-21
Lack of space to offload ambulances whilst social distancing	• Slow flow out of the ED • Estate too small prior to pandemic now even more constrained	• E-mandate submitted for feasibility of reconfiguration of triage facility at front door to create 2 additional spaces • Project team reviewed September 2021. Costs above Divisional Minor Works budget are being reworked to go through DSP and CSG	Ben Pritchard-Jones	Nov-21
Same Day Emergency Care (SDEC) capacity due to staffing constraints	• Previous staffing resource does not account for expanded footprint and increased patient numbers	• Recruitment underway for additional staffing in SDEC (current service specification) with first appointees starting in late October, increased capacity already helping	Paul Smith	Oct -21

Imperial College Healthcare NHS Trust

CMS

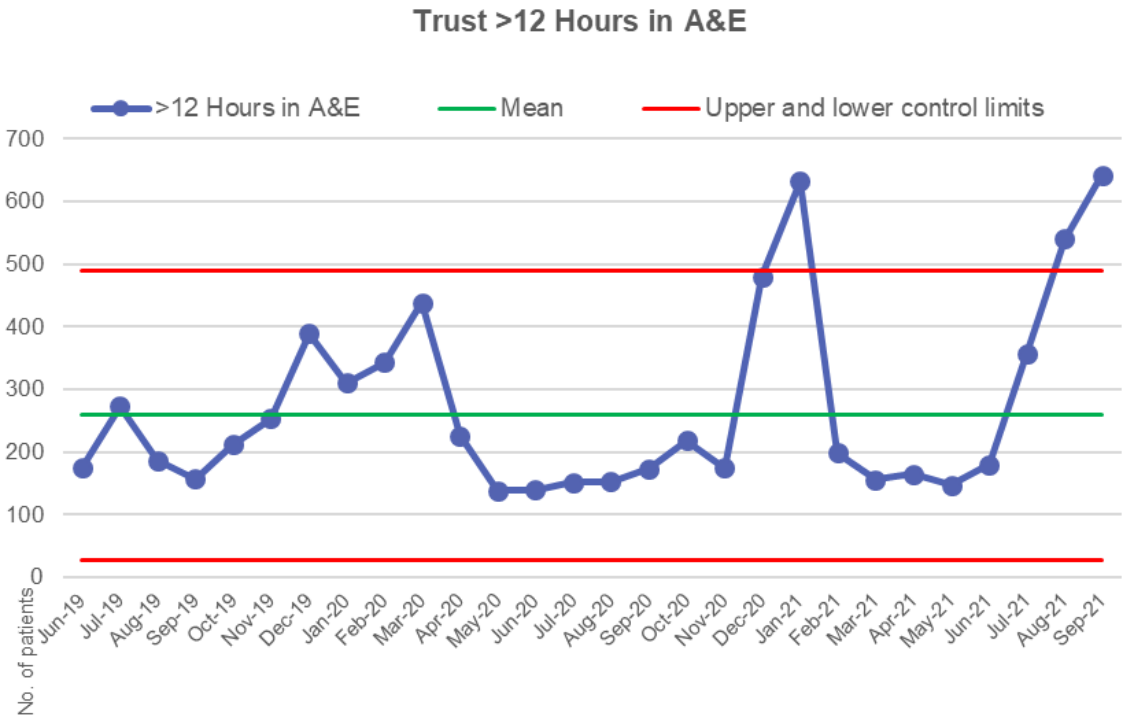
The number of patients spending more than 12 hours in the emergency department from time of arrival

Countermeasure Summary: >12 Hour waits in Department

Imperial College Healthcare NHS Trust

Problem Statement: Extended length of time patients are in an emergency department environment is detrimental for patient experience and quality and also impacts on staffing resource (ED staff, RMNs and security), cubicle capacity and the ability to manage flow through the department.	**Metric Owner**: **Frances Bowen** **Metric**: # of patients waiting > 12 hours in department **Desired Trend**: ↓

Historical performance: The number of patients waiting over 12 hours within the department increased to 642 patients from the previous month, with increases seen at both sites. 52% of waits occurred in general medicine (predominantly on admitted pathways), 18% occurred on surgical pathways, 9% on mental health pathways and 12% remained in ED



Countermeasure Summary: >12 Hour waits in Department

Imperial College Healthcare NHS Trust

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Bed availability	• Delayed discharges downstream	• Work with transport team to identify areas of improvement to reduce delays between booking/pick up to support timely discharges/release beds • Discharge by time, use of discharge lounge and MO recording being pushed as key drivers and added to weekly governance pack for UEC Board and site meetings • Winter consultant x 3 each day from 1/11, increase acute SDEC pathways at CXH • ARU/ITU pathways developed on both sites • Senior team oversight and support with lack of lead nurse and acute HOS soon • Benefits of onsite ID from mid October for SDEC and Inpatient pathways • Review boarding policy and bed spaces closed due to spacing requirements • Review and reshare full capacity protocol actions for downstream wards • Focus on booking transport the day before discharge improved form 23% to 43% in September • On the day ops on rota for SMH Med starting from mid October • Acute locum consultant being advertised • Criteria led discharge and gold patient focused improvement for SMH • review phlebotomy resource allocation	Jo Sutcliffe/ Iain Taylor Jo Sutcliffe/ Frances Bowen Jo Edwards / George Tharakan Iain Taylor Adam Hughes	Oct-21 Oct-21 Oct-21 Oct-21 Oct-21
Mental Health Pathway Delays	• AMHP Provision • Lack of bed capacity • Inappropriate internal RMN resource • Lack of urgency	• Daily huddle escalation calls with Central and North West London NHS Foundation Trust (CNWL) • Audit shared in Oct highlighted 3 areas of focus 1) expediting medical clearance, 2) escalating sooner across MH units when capacity is going to be an issues, 3) garnering support from Chelsea & Westminster to share Approved Mental Health Professional (AMHP) data to shine a light on delays due to out of hours AMHPs • Transformation team support on ICHT Trust strategy for MH/RMN provision • ED site strategy to include offsite MHAU options, commenced engagement with estates on scoping options	Barbara Cleaver Jo Sutcliffe	Oct-21 Oct-21
Urgent & Emergency pathways	• CDU closure • Complex multi specialty pathways	• Front door: transfer of all initial assessments to ICHT from November to improve redirection times • Introduction of telephone handovers to reduce nursing escort from ED to Ward • Active recruitment to expand SDEC SMH due to improve capacity from November • Recruitment pipeline prioritising key areas of greatest need	Ben Pritchard-Jones Rob Nicholls/ Paul Smith	Oct- 21 Oct-21

Imperial College Healthcare NHS Trust

CMS 4

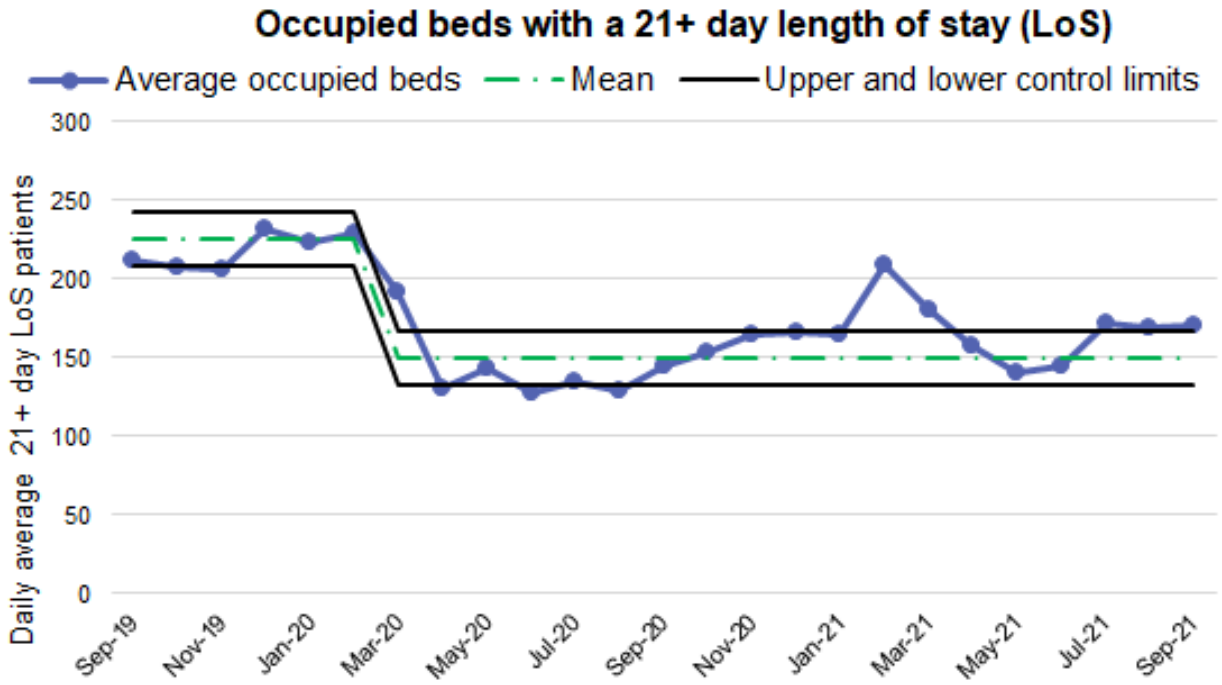
Improving long length of stay (LLOS)

Countermeasure Summary: Improving Long Length of Stay (LLOS)

Imperial College Healthcare NHS Trust

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

Historical performance: The performance of long length of stay remained stable since July 2021. In September there was an average of 170 patients with a long length of stay of 21 days or more.



Countermeasure Summary: Improving Long Length of Stay

Imperial College Healthcare NHS Trust

30-Day Action Plan:

Top contributor	Potential root cause	Countermeasure	Owner	Due date
High number of patients with Reason to Reside	• Sub-optimal speed of clinical decision making • Sub-optimal speed of MDT decision making • Sub-optimal coding accuracy and completeness in Cerner • Variable process for managing repatriations to other acute Trusts	• Improve daily ward routines through Board Rounds focussed improvement • Improve completeness and accuracy of ADD/R2R/MO coding (prioritise through SMH flow 2.0 then scale across other sites) • Implement plan to automate repatriation process in Cerner	Fran Cleugh & Raymond Anakwe Anne Kinderlerer & directorate triumvirates Iain Taylor & James Bird	Plan to Integrated Care Board - completed End Dec End Oct
High number of Medically Optimised LLOS patients	• Constrained senior capacity in historical discharge structure to support complex discharges • Variable relationships with system partners in different boroughs • Sub-optimal quality of Discharge to Assess (D2A) referrals from ICHT to system partners • Hospital social work teams do not always get early sight of complex post discharge needs • Growing numbers of homeless patients who have longer LoS on average • Demand for specialist rehab beds in NWL outstrips supply • Care home market dynamics make behaviourally complex patients hard to place	• Implement NWL integrated discharge structure • Iterate improvements to daily discharge hub routines • Continue relationship development through place based partnerships/ICPs • Level up medequip ordering rights across acute sites and boroughs • Run fortnightly MADE events throughout winter • Pathway 1 Homefirst standardisation Quality Improvement project • Run rolling programme of bitesize learning for ward MDTs • Implement NWL D2A form in Cerner with auto-notifications to Local Authority teams • Deliver 12 month Inclusion Health proof of concept • Hold system partners to account for delivery of sector plan	Anna Bokobza 3 x discharge hub leads once in post Anna Bokobza Liz Wordsworth Anna Bokobza Annabel Rule Liz Wordsworth James Bird Anna Bokobza Anna Bokobza	End Dec End Feb Ongoing End Nov Ongoing End Oct Ongoing End Nov Kick off by end Nov Extra P2 beds go live early Nov

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Finance report for September 2021 (Month 6)

Agenda item 10 and paper number 07

Lead Executive Director: Jazz Thind, CFO
Author: Des Irving-Brown, Deputy CFO, Michelle Openibo, Associate Director of Finance

Purpose: For Information

Meeting: 10 November 2021

1. Purpose of this report

1.1. The finance report for September sets out the reported financial position of the Trust for the six months from April to September 2021

2. Executive Summary

2.1. For the year to date the Trust has achieved a break even position against a break even plan. Against the £15.8m cost improvement programme (CIP) target for the first six months of the year, £11.8m (75%) has been delivered with the shortfall in achievement offset by the positive contribution from ERF income as the Trust has been able to deliver the activity at a marginal cost.

2.2. The full year capital plan equates to £85.8m of which only £58.8m scores against the Trust Capital Resource Limit (CRL), with the balance funded by donations or other sources. Year to date the Trust has spent £18.3m (63%) of its total capital plan and continues to forecast to meet its CRL.

2.3. At 30th September, cash was £178m. The future cash outlook remains resilient for the remainder of the financial year, assuming achievement of a break even position for the full year.

2.4. Year to date, 98% of invoices by volume and 96% by value have been paid within BPPC guidelines. This performance is consistent with previous performance and better than the threshold set by the DHSC (95%).

2.5. The Trust has received planning guidance for the 2nd half of the year (H2) which confirms NHS income will continue on a block contract basis with the ability to earn additional Elective Recovery Funding (ERF) remaining intact. The calculation of ERF has however been revised and will be based on completed Referral to Treatment (RTT) pathways. The Trust is in negotiations with the sector commissioners to agree an appropriate funding envelope with the current draft plan underpinned by a £31.5m efficiency requirement for the full year.

3. Recommendation

3.1. The Board is asked to note this report.

Des Irving-Brown, Deputy CFO, Michelle Openibo, Associate Director of Finance
3rd November 2021

Public Board 10th November 2021

Finance Report September 2021

Scorecard

Imperial College Healthcare NHS Trust

	Year to Date April-Sept 21		
	Plan £m	Actual £m	Variance £m
Trust position before Elective Recovery Fund (ERF) and Cost improvement programme (CIP)	(22.4)	(28.1)	(5.7)
CIP achievement	15.8	11.8	(4.0)
ERF net of costs	0	15.0	15.0
	(6.6)	**1.3**	**(5.3)**
Indicative sector funding	6.6	1.3	(5.3)
Reported Position	**0.0**	**0.0**	**0.0**

Income and Expenditure

- For the year to date the Trust has achieved a break even position against a break even plan. Against the £15.8m cost improvement programme (CIP) target for the first six months of the year, £11.8m (75%) has been delivered with the shortfall in achievement offset by the positive contribution from ERF income as the Trust has been able to deliver the activity at a marginal cost.

Capital

- The full year capital plan equates to £85.8m of which only £58.8m scores against the Trust Capital Resource Limit (CRL), with the balance funded by donations or other sources. Year to date the Trust has spent £18.3m (63%) of its total capital plan and continues to forecast to meet its CRL.

Cash

- At 30th September, cash was £178m. The future cash outlook remains resilient for the remainder of the financial year, assuming achievement of a break even position for the full year.

Better Payment Practice Code

- Year to date, 98% of invoices by volume and 96% by value have been paid within BPPC guidelines. This performance is consistent with previous performance and better than the threshold set by the DHSC (95%).

Statement of Comprehensive Income

Imperial College Healthcare NHS Trust

	Year to Date April-Sept 21		
	Plan £m	Actual £m	Variance £m
Income	639.2	666.5	27.3
Pay	(385.2)	(386.7)	(1.5)
Non Pay	(229.1	(249.4)	(20.4)
EBITDA (Earnings before Interest Depreciation and Amortisation)	24.9	30.3	5.4
Financing costs and donated asset treatment	(31.5)	(31.6)	(0.1)
Surplus/(deficit) internal	**(6.6)**	**1.3**	**(5.3)**
Sector Planning Assumption	6.6	1.3	(5.3)
Surplus/(deficit) External	**0.0**	**0.0**	**0.0**

- **Income** – the Trust is favourable to plan year to date, driven mainly by ERF benefit of £28m and private patient income.
- **Pay** – pay costs are adverse to plan year to date, driven mainly by additional staffing in the Intensive Care Units due to increased occupancy and acuity, in theatres where additional staff are in place to meet increased activity and imaging to meet recovery targets.
- **Non Pay** – non-pay costs are above plan in month and year to date due mainly to, CIP targets sitting within this category (£15m) and additional expenditure on drugs to meet increased activity.
- **Financing Costs** – financing costs are in line with plan YTD and forecast.

Statement of Financial Position (Balance Sheet)

Imperial College Healthcare NHS Trust

	31-Mar-21 £'000	30-Sep-21 £'000	Movement £'000
Property, plant and equipment	550.6	544.3	(6.3)
Other Non Current Assets	17.3	15.3	(2.0)
Total non-current assets	**567.9**	**559.6**	**(8.3)**
Inventories	17.1	18.2	1.1
Trade and other receivables	90.6	101.2	10.6
Cash and cash equivalents	149.1	177.5	28.4
Total current assets	**256.7**	**296.9**	**40.1**
Trade and other payables (<1 year)	(281.5)	(312.5)	(31.0)
Total current liabilities	**(281.5)**	**(312.5)**	**(31.0)**
Non current Liabilities	(21.2)	(20.2)	1.0
Total Non current Liabilities	**(21.2)**	**(20.2)**	**1.0**
Net Assets employed	**521.9**	**523.8**	**1.8**
Public Dividend Capital	773.9	773.9	0.0
Revaluation Reserve	2.4	2.4	0.0
Income and expenditure reserve	(254.4)	(252.5)	1.8
Total tax payers' and other equity	**521.9**	**523.8**	**1.8**

Non-Current Assets
The decrease of £8.3m year-to-date is driven by depreciation of £26.5m offset by capital expenditure of £18.3m.

Current Assets
Receivable balances have increased by £10.6m year-to-date due to NHS accruals in relation to funding and consolidated billing with balances reducing with effect from Month 5. The increase in inventory balances of £1.1m are primarily due to pharmacy stock.

Cash
Cash balances were £177.5m at Month 6, driven by both timing of cash flows and the positive effect of the funding regime. It remains the case that under 'normal' arrangements the Trust is running an underlying deficit, therefore the current cash position is dependent on managing working capital balances and long-term liabilities.

Current Liabilities
Trade and other payables balances have increased by £31.0m year-to-date but the Trust's focus on effective payment of suppliers results in 96% of invoices (by value being settled within the Better Payment Practice Code guidelines year to date.

Taxpayers' and Other Equity
Equity balances are stable at Month 6. Public Dividend Capital is expected to be received for additional approved capital projects in the second half of the year.

Capital – Month 6

Imperial College Healthcare NHS Trust

Sources of Funds	Annual £m
Internal Financing	51.7
Confirmed external funding	2.6
Charitable Funds & Grants	28.0
Unconfirmed external funding	4.5
Total	**86.8**

Applications	Annual £m	YTD Plan £m	YTD Actual £m	YTD Variance £m
Backlog Maintenance	15.6	8.2	6.8	(1.4)
ICT	7.2	3.5	3.5	0.0
Replacement of Med Equip.	6.0	4.0	1.5	(2.5)
Decarbonisation	24.9	2.1	2.1	0.0
Other Capital Projects	31.7	10.4	3.0	(7.4)
Redevelopment	1.4	0.7	1.4	0.7
Total Expenditure	**86.8**	**28.9**	**18.3**	**(10.6)**
Income and Donation	**(28.0)**	**(2.9)**	**(2.8)**	**(0.1)**
Capital Resource Limit	**58.8**	**26.0**	**15.5**	**(10.5)**

£5.0m of 2021-22 capital programme expenditure has been incurred in Month 6, bringing year-to-date expenditure to £18.3m (63% against plan).

The Trust continues to plan to fully utilise its Capital Resource Limit (CRL) in the year with the Capital Expenditure Assurance Group (CEAG) reviewing the detailed project delivery. The outcome of the latest review indicates an increase in the rate of expenditure over Q3 and Q4 of this year. Inherent delivery risks, particularly given the wider economic situation, are being managed through the capital governance process.

Public Dividend Capital funding to support the replacement of radiotherapy and other equipment has now been confirmed and is reflected in the current plan.

The Trust is still in discussions with the DHSC regarding further funding for work on its site redevelopment project.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Maternity Quality Assurance Oversight Report

Agenda item: 11, paper number 08

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

Purpose: For discussion

Meeting date: 10 November 2021

1. Purpose of this report

1.1. This report is presented for oversight of quality assurance within the maternity service and to inform the Committee of progress on achieving compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) year four.

2. Executive Summary

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

2.2. The CNST MIS year 4 launched on 8 August 2021 with a submission deadline of the declaration form by 30 June 2022. Further amendments to the scheme were announced on the 13 October 2021. A scorecard (appendix 4) has been developed to demonstrate on-going compliance with the ten safety actions. There are on-going actions in place to ensure compliance is achieved by June 2022.

2.3. A maternity improving care group weekly meeting has been implemented to address improvements required following the CQC benchmarking exercise completed in September and actions identified after the internal peer review visits to areas of the maternity service.

2.4. The Perinatal Mortality Review Tool reports require Trust Board oversight to meet CNST MIS compliance. There were no concerns identified from the cases reviewed within the report (appendix 5 and 6).

2.5. There are plans to reinstate face to face multi-professional emergency training however due to the planning required to meet social distancing requirements it is expected this will be in place in January 2022.

2.6. Escalations of concern from staff have been regarding midwifery staffing levels (see 1.8). A report (appendix 3) is provided detailing assurance that safe staffing has been maintained and the recruitment plans will mitigate the risk to the service. This has been included in the directorate risk register.

3. Approval process

3.1 The maternity quality assurance oversight report has been presented to the Executive Management Board and updated after the Quality Committee and signed off by the Committee Chair.

4. Recommendation

4.1 For Board oversight of the submitted monthly update reports.

5. Next steps

5.1. Continue to await response from NHS Resolution following CNST MIS year three declaration submission.
5.2. On-going actions in place to achieve CNST Maternity Incentive Scheme year four.
5.3. Monitor improvements required to maintain our CQC outstanding accreditation.

6. Impact assessment

6.1. Quality impact - The maternity service have developed a quality and safety strategy which aims for continuous sustained improvement in the quality of the service for women and their families. The CNST MIS supports the delivery of safer maternity care and contributes towards meeting seven immediate and essential action's (IEA) recommended from the Ockenden report.
6.2. Financial impact – This is associated with the reduction in litigation claims against the trust by ensuring that there is a robust process to maintain an oversight of all aspects of quality and safety in maternity as stated in the strategy. The primary aim of this is to improve outcomes and experience of maternity care for service users.
6.3. Workforce impact - A proposal was presented to the division to support the recruitment of permanent staffing to meet compliance with the CNST MIS and Ockenden recommendations. Workforce reviews are included in the MIS and Ockenden.
6.4. Equality impact - To ensure an equitable service is provided to anyone who either access maternity services or is part of the workforce.
6.5. Risk impact - Compliance with all ten CNST safety actions will optimise the delivery of safe maternity service provision that is sustainable.

Main report

1. Quality Assurance report

1.1. Maternity Dashboard/ Score card August 2021 (appendix 1). The service continues to monitor performance and areas that require improvement are addressed with data validation and audits to explore service development. The scorecard RAG rating is currently under review with the LMNS.

1.2. Risk register: Of the 23 risks on the directorate's risk register, 3 score 16 rated as extreme. These risks continue to be in relation to the QCCH labour ward theatres where a business case is progressing for refurbishment. The third relates to midwifery staffing concerns resulting from vacancies, sickness and isolation requirements. Safe staffing has been maintained. (See 2.8)

1.3. Incidents: A similar number of incidents (174) were reported in September 2021 compared to August with similar categories and sub-categories. The highest incident reporting category continues to be labour/delivery with staff shortages included within the top 5 this month (see 2.8).

Table 1 Severity of incidents (11 had no severity recorded):

September 2021	Near miss	No harm	Low harm	Moderate harm	Total
Affecting patient	7	96	22	2	127
Affecting staff	0	7	1	0	8
Affecting organisation	0	27	1	0	28
Total	7	130	24	2	163

There has been a decrease in the number of incidents awaiting investigation on the Datix system including those overdue for review.
On 04/10/2021 there were a total of 10 on-going SI investigations all within date (one of which is being led by surgery). Eight of these are HSIB cases. Three on-going level 1 investigations within date. Reported figures in table 2 and this includes confirmation that the families receive information on the scheme and the Trust complies with the statutory Duty of Candour

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

	19/20 total	20/21 total	2020/21								
			Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
HSIB	8	10	1	2	2	1	1	2	2	1	1
SI total	12	24	1	2	3	3	1	2	4	2	1

*SI total includes HSIB cases reported as SI's

1.4. Serious incident declared in September 2021:

- Datix ID 171574 – Unexpected admission to neonatal unit with neonatal cooling. Induction of labour for reduced fetal movements. The CTG was pathological and the baby was delivered by ventouse. Referred to HSIB.

1.4.1. There were two serious incident reports finalised in September. Both have been shared with the women involved. A summary of the incident and learning is included in appendix 2. The top 5 recommendations identified from serious incidents and HSIB investigations relate to review and updating guidance, clinical oversight, communication, escalation and fetal monitoring.

1.5. Patient experience: There has been feedback from women about the high standard of care they received, thanking staff for the care and positive experience of the maternity service. Feedback has also shared on the maternity Instagram page.

1.6. Core skills compliance: (reported 01/10/21) 22 out of 26 Core 10 and Core Clinical achieved above 90% threshold across all relevant staff groups. Fire safety (87.1%), resuscitation level 2 (89.5%) and safeguarding level 3 (72.8%) training are below the threshold however have increased compliance figures since the previous month. Blood transfusion compliance is 89.7%. Monthly compliance data continues to be reviewed with a targeted approach for those staff who need to complete training.
There are plans to reinstate face to face multi-professional emergency training however due to the planning required to meet social distancing requirements it is expected this will be in place in January 2022.

Table 3 Multi-professional emergency training compliance September 2021

Staff group	**PROMPT**
Midwives	↑ 378 (90%)
Obstetric consultants	↑ 27 (79%)
Obstetric doctors	↑ 68 (82%)
Obstetric anaesthetic consultants	↑ 31 (79%)
Obstetric anaesthetic doctors	↑ 36 (87%)
Maternity support workers	↑ 123 (96%)

1.7. Care Quality Commission (CQC): Internal supportive peer reviews continue on both sites of the maternity service. Action plans have been developed to address areas of improvement.

The maternity service also completed a CQC benchmarking exercise and presented the findings to the Improving Care Programme Group in September. Areas identified for improvement were midwifery staffing (see 2.8), equipment checking, resuscitaire and emergency resuscitation trolley checking. The senior team are completing ad hoc checks in all clinical areas and a maternity improving care group weekly meeting has been implemented. Other improvements are further development of continuity of care teams, and funding for additional caesarean section lists due to increasing demand.

Table 4 CQC ratings July 2019

Overall	Safe	Effective	Caring	Well-Led	Responsive
Outstanding	Good	Good	Outstanding	Good	Outstanding

1.8. Escalation of concerns from staff to maternity managers have been mainly due to staffing issues in all areas of the maternity services. Actions include, twice daily staffing huddles, redistribution of staff and workload, specialist midwives and managers have been supporting clinically to ensure safety has been maintained across all areas of the maternity service. This has included senior midwifery present on the weekends and bank holidays. There are current 33 band 6 midwifery vacancies with 23 newly qualified midwives due to start in the next 4 months. The Maternity directorate are working closely with recruitment colleagues and have started a Task and Finish group to boost midwifery recruitment and retention. In the medium and longer term the service has joined the NHSE led international recruitment program and have increased the numbers of student midwives at Imperial. Appendix 3 includes a midwifery staffing recruitment update report.
There were also concerns raised about availability of equipment on both labour wards. The matrons and lead midwives have reviewed supplies and have ordered relevant equipment.

2. CNST MIS safety action update report

2.1. The Trust continue to await feedback following submission of the declaration form which demonstrated compliance with the ten safety actions in year three of the MIS.

2.2. CNST MIS Year four scorecard developed in appendix 4. This demonstrates compliance with deadlines that have passed and on-going actions in place to ensure compliance for all safety actions.

2.3. The deadline for submission of the declaration form for year four is 30 June 2022.

2.4. Communication was received from NHS Resolution on 13.10.2021 detailing amendments and extensions to certain aspects of the scheme following feedback from Trusts.

2.5. **Safety action 1** - **National Perinatal Mortality Review Tool (PMRT) -** Quarterly Trust Board report produced for October 2021 (appendix 5) showing no concerns with care. There were 11 stillbirth/ late fetal loss cases for review during the 1/3/2021 to 31/5/2021. Of those 5 are in progress and 6 have been completed. There were 9 neonatal deaths and one review has been completed. This is due to awaiting information from other Trusts to complete and close the remaining PMRT records. Of all the completed cases there were no identified care issues which may have/ likely to have made a difference to the outcome for the baby. Relevant actions have been identified and shared for learning within the maternity Risky Business newsletter and wider team communication.
Monthly compliance update report for September 2021 demonstrates compliance with the updated year four standards of the CNST MIS (appendix 6).

3. Conclusion

3.1. The maternity service continue to strive to improve quality and safety in line with national requirements and progress is being made with the CNST MIS year four.

Appendices

- Appendix 1: LMS scorecard August 2021
- Appendix 2: Summary of incidents
- Appendix 3: Midwifery staffing recruitment update report
- Appendix 4: CNST scorecard 2021-2022
- Appendix 5: Quarterly Trust Board PMRT report
- Appendix 6: Monthly PMRT update report September 2021

Author Louise Frost – Quality Assurance, Governance and Compliance Lead Midwife
Date 21 October 2021

Appendix 1 - LMS Scorecard - August 2021

Imperial College Healthcare NHS Trust

Category	KPI Description	Target (Green)	Target (Red)	Imperial College Healthcare NHS Trust					
				Queen Charlotte's		St Mary's Hospital		Trust Wide	
				2021/08	YTD	2021/08	YTD	2021/08	YTD
Choice & Personalisation	Number of women offered a personal care plan (%)	100%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Number of women who have a personalised care plan			454	2291	331	1775	785	4066
	Number of women who have a personalised care plan (%)	50.00%	19.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Number of women offered choice of all three birth settings			454	2291	331	1775	785	4066
	Number of women offered choice of all three birth settings (%)	100%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Number of women giving birth in midwifery settings (home births + Midwifery Led Birth Units)			67	285	33	197	100	482
	Number of women giving birth in midwifery settings (% of total maternities) - NHSE definition	21.50%	16.00%	14.92%	12.62%	12.45%	15.19%	14.01%	13.56%
	Number of women giving birth in midwifery settings (% total maternities excluding elective cs, still births, and pre-term)			19.42%	17.31%	16.10%	21.39%	18.18%	18.78%
Safety	Number of still births			1	10	1	5	2	15
	Crude still birth rate	3.12		2.20	4.35	3.70	3.75	2.76	4.13
	Number of neonatal deaths			2	12	0	1	2	13
	Crude neonatal death rate	0.94		4.41	5.25	0.00	0.75	2.77	3.60
	Number of intrapartum brain injuries (to NHS resolution)			1	8	0	1	1	9
	Number of maternity related SIs (excluding de-escalated SIs)			2	7	0	3	2	10
Screening	All bookings	486/343/829		454	2291	331	1775	785	4066
	Booking by 10+0 (%) Exclusions: Late referrals (women referred after 10 weeks of pregnancy)	60.00%	49.00%	80.91%	81.91%	79.34%	83.03%	80.27%	82.39%
	Booking by 10+6 (%) Exclusions: Late referrals (women referred after 10 weeks and 6 days of pregnancy)	90.00%	39.00%	92.17%	91.95%	92.34%	92.60%	92.24%	92.23%
Clinical Outcomes - Births	Total births			455	2294	270	1333	725	3627
	Live Births			454	2284	269	1328	723	3612
	Total maternities (number of women (any birth ≥ 24/40 + live births <24/40))	427/236/663		449	2258	265	1297	714	3555
	Number of women giving birth in Midwifery Led Birth Units			60	259	29	187	89	446
	Women birthing in Midwifery Led Birth Units (%)- NHSE definition	20.00%	15.00%	13.36%	11.47%	10.94%	14.42%	12.46%	12.55%
	Women birthing in Midwifery Led Birth Units (of all maternities exc elective cs and pre term births) (%)	20.00%	15.00%	17.39%	15.74%	14.15%	20.30%	16.18%	17.37%
	Planned home births			6	22	2	8	8	30
	Actual home births			7	26	4	10	11	36
	Actual home births (of all maternities) (%) NHSE definition	1.50%	1.00%	1.56%	1.15%	1.51%	0.77%	1.54%	1.01%
	Actual home births (of all maternities exc elective cs and pre term births) (%)			2.03%	1.58%	1.95%	1.09%	2.00%	1.40%
	Intrapartum transfers to Labour ward from MLU (labouring on MLU) (%)	Local Targets		0.23333333	15.44%	0.4137931	16.04%	0.29213483	15.70%
	Babies born before arrival (BBAs)			2	11	1	13	3	24
	Babies born before arrival (BBAs)(%)	0.50%	1.00%	0.44%	0.48%	0.37%	0.98%	0.41%	0.66%
	Induction of labour including PROM ((%) of all who do not have a planned CS)			40.22%	40.56%	28.63%	29.91%	35.80%	36.64%
	Spontaneous unassisted vaginal births (of all maternities) (%)			52.56%	50.00%	47.92%	46.95%	50.84%	48.89%
	Normal vaginal births including spontanous & induced labour (of all maternities) (%)	55.00%	50.00%	51.45%	48.98%	47.17%	45.41%	49.86%	47.68%
	Instrumental deliveries (of all maternities) (%)	16.90%	20.00%	13.14%	13.82%	12.83%	10.79%	13.03%	12.71%
	Instrumental deliveries (of all who do not have CS) (%) - Pan london definition			20.34%	22.00%	21.38%	19.20%	20.71%	21.05%
	Unsuccessful instrumental births (of all instrumentals) (%)	4.90%	7.00%	3.39%	4.17%	0.00%	5.00%	2.15%	4.42%
	Full dilatation LSCS (of all CS in labour-emergency) (%)	5.90%	8.00%	3.85%	6.21%	0.00%	4.99%	2.05%	5.66%
	Number of regional analgesia in labour (Combined Spinal Epidural or Epidural) (excluding all caesareans sections)			102	531	93	332	195	863
	Number of epidurals (excluding spinal only)			236	1266	190	814	426	2080
	Prelabour caesarean sections (ELCS + pre labour) (of all maternities) (%)			18.04%	18.64%	14.34%	17.50%	16.67%	18.23%
	Caesarean sections in labour (emergency) (of all maternities) (%)			17.37%	18.56%	25.66%	26.29%	20.45%	21.38%
	Total number of caesarean sections (of all maternities) (%)			35.41%	37.20%	40.00%	43.79%	37.11%	39.61%
	NNAP Magnesium sulphate eligible			5	37	3	13	8	50
	NNAP Magnesium sulphate given (%)	85.00%	80.00%	100.00%	97.30%	100.00%	100.00%	100.00%	98.00%
Public Health	Women smoking at booking			18	85	17	66	35	151
	Women smoking status at birth (%)			2.00%	2.21%	1.51%	2.70%	1.82%	2.39%
	Women offered smoking cessation treatment (of all smokers at booking)	95.00%	90.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Breastfeeding initiation rate			87.89%	84.94%	80.30%	80.05%	85.06%	83.14%
Clinical Outcomes -	Number of episiotomies (% vaginal births)			21.09%	21.93%	18.23%	16.25%	20.14%	20.05%
	Women experiencing 3rd or 4th degree tear (% vaginal births)	4.00%	8.00%	2.60%	1.65%	4.17%	4.09%	3.13%	2.46%
	Post partum haemorrhage of ≥1500 ml (%)	3.60%	7.20%	4.23%	3.68%	4.53%	3.16%	4.34%	3.49%
	Puerperal Sepsis (ICD 10 code 085) (%)	1.50%	3.00%	0.22%	0.58%	0.00%	0.23%	0.14%	0.45%
	Post partum Hysterectomies (%)	0.08%	0.12%	0.00%	0.09%	0.00%	0.08%	0.00%	0.08%
	Maternal admission to ITU	1/Month	3/Month	0	4	1	1	1	5

Maternal	Maternal readmissions			13	50	2	24	15	74
	Maternal Mortality	0/Year	2/Year	100.00%	1	0.00%	0	100.00%	1
	Preterm births (Total Number of live Births before 37 weeks)			22	181	21	144	43	325
	Preterm birth rate (%)	6.00%	8.00%	4.84%	7.88%	7.78%	10.81%	5.93%	8.95%
Workforce	1:1 care in labour			342	1698	206	960	548	2658
	1:1 care in labour (%)	95.00%		97.44%	98.55%	98.56%	98.26%	97.86%	98.44%
	Midwife:Birth ratio (only direct clinical care)	1.30	1.33	0	1:26	24	1:24	0	
	Obstetric (consultant) cover in hours per week (24 hour time frame)	84 (S); 98 (Q)	<84 (S); <98 (Q)	98	98	84	84	182	
	Does the obstetric unit provide 7 day/week dedicated consultant presence 12 hours per day.	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Operational	Number of Formal complaints per month	Local Targets		3	14	0	9	3	23

Appendix 2

ID 161527 Aortic dissection at 31/40 (SI investigation)

A 38 year old woman presented to SMH on 9th April 2021 at 30+1weeks of gestation with a history of shortness of breath. Prior to this she had presented to the Royal Free Hospital on 5th April 2021 with sudden onset chest pain and shortness of breath, had a negative V/Q scan (scan to check for a clot in the lungs) and was discharged home. During the first three days of her admission at SMH she was seen by Obstetricians, Physicians and Anaesthetists.

The initial working diagnosis was of pneumonia, with pulmonary embolism and cardiomyopathy considered as possible causes of her symptoms.

She was seen by a Cardiologist on the fourth day of her admission. The Cardiologist performed a bedside echocardiogram which raised suspicion of a Type A aortic dissection (a tear in the inner layer of the major artery branching off the heart). This was confirmed on CT scan, and she was transferred on the same day to Kings College Hospital where she underwent repair of the dissection and an emergency caesarean section.

Findings:

- Maternity helpline- 25 minute waiting time, call not answered
- Maternity helpline- failure to recognise severity of symptoms and urgency for medical review
- No face-to-face cardiology review over the weekend
- No care pathway for Aortic dissection in pregnancy
- Lack of joint multi-disciplinary reviews
- Lack of consultant obstetrician input over the weekend
- Delay in cardiology review and echocardiogram
- Lack of preparation by obstetric team for potential early delivery prior to diagnosis being made

Identifiable good practice:
The woman had an Obstetric review at consultant level within 24 hours of admission in keeping with the 2012 guidance from the Academy of Medical Royal Colleges. Once the diagnosis of aortic dissection became most likely, rapid multi-disciplinary review at consultant level and escalation for transfer to a centre of excellence was performed in a timely manner.

Root cause: Atypical presentation of aortic dissection.

Recommendations:

- Undertake audit of the Maternity helpline wait times
- Consider developing a method for call diversion to labour ward other clinical areas when calls are not answered
- Develop a tool to triage a list of acute symptoms that warrant 999 call and urgent A&E attendance (refer to NHS website advice)
- Remote review of Cerner notes as a minimum requirement when cardiology are asked for opinion

- Cardiothoracics to confirm current and future cover/ rota for Aortic dissections (both in and outside of pregnancy)
- SOP on the treatment pathway for patients suffering an aortic dissection to be written and placed on the intranet
- Ensure Obstetric consultant led ward multi-disciplinary round twice a day on labour ward, and daily for medical outliers
- Audit on compliance of carrying out multi-disciplinary, consultant-led, ward rounds on Labour Ward
- Create a SOP for care of pregnant women with acute medical conditions and to include named consultant leads (for non-obstetric specialities) with a special interest in pregnancy
- To share this case for learning
- Personal reflection of all staff involved
- Formalise the escalation policy for medically unwell pregnant women to an Obstetrician with maternal medicine expertise.
- Formalise support network from a named Obstetric Physician for pregnant women who are medically unwell and consider on a case by case basis if transfer to QCCH for Medical care on an obstetric ward would be more appropriate than transfer to a medical ward at SMH
- Cardiology escalation policy for pregnant women to be reviewed.
- Radiology to comment on the standard of care provided by radiology, with attention to why CT was not performed and why delay in date offered initially for V/Q

D 159043 Term IUD (HSIB investigation)

A 30 year old mother was booked for maternity care at 11 weeks' and 1 day gestation (11+1 weeks), in her second pregnancy. Her medical, obstetric, and social history was obtained. At booking it was noted that the Mother had sustained a third degree tear and had a postpartum haemorrhage (PPH) following the birth of her first baby. The mother's pregnancy was assessed to be high obstetric risk. The mother's blood group was B rhesus negative, and routine antenatal blood tests revealed that she had anti-D and anti-C antibodies. A plan was made for her to have a blood test for antibodies every two weeks until the baby's birth. Due to the mother's previous birth experience, she requested a caesarean section which was scheduled at 39 weeks. At 38+1 weeks, the mother began to experience contractions and had SROM, which she noted to be blood-stained. She attended the maternity triage, and the midwife was unable to hear the FHR. An USS confirmed that the Baby had died. The mother's labour progressed, and she had a vaginal birth. The baby weighed 2,750g (12th centile on a customised growth chart). An external post-mortem examination of the baby was performed, the findings reported a 'baby with growth parameters average for the stated gestation. There were no dysmorphic features or external congenital abnormalities to suggest an underlying chromosomal anomaly or malformation syndrome. There were also no features to support hydrops, anaemia, or infection. The placenta showed a hypercoiled umbilical cord and areas of avascular villi – in keeping with fetal vascular malperfusion'.

Findings:

- The mother's antenatal care was planned in line with national guidance.
- The mother requested a caesarean section as she found her previous birth traumatic. The risks and benefits, and options for birth were discussed and the mother chose to have a CS which was planned for 39 weeks.
- The mother's routine blood tests at 28 weeks revealed that she had red cell antibodies. A plan was made for regular blood tests to be carried out, and for the baby to be observed following the birth, in accordance with national guidance.
- The mother's symphysis-fundal height (SFH) was not measured and plotted at each of her antenatal appointments. Retrospective plotting by HSIB of the SFH measurements on the customised growth chart found the measurements to be within the expected range, and there would have been no indication to change the management of the mother's care.
- The mother telephoned the triage for advice as she was having contractions and had a CS planned. Her contractions were considered to be infrequent and she was asked to stay at home, which led to her not having a face to face assessment and a plan made for her ongoing care at that time.
- The contractions increased and the mother attended the triage. There was a delay in her assessment as the activity on the triage was increased. This meant that she was not seen and assessed within the 30 minute time-frame set out by NICE (2015).
- The triage is staffed by one midwife who is responsible for answering telephone calls, and providing clinical care to mothers presenting to the delivery suite or having induction of labour. HSIB considers that the current system in triage does not support staff to provide holistic and safe care, in a timely manner.
- When the mother was assessed in triage it was identified that the baby's movements were reduced and the midwife was unable to auscultate the Baby's heartbeat. There was escalation to the obstetrician which led to a prompt USS being performed and it was confirmed that the Baby had died.
- The mother's labour progressed rapidly which meant that there was not enough time to site an epidural for pain relief. The mother had intravenous (IV) pain relief. The Baby was born shortly afterwards.
- The mother and father consented to the bby having an external post-mortem examination and placental histology being carried out. The post-mortem showed no obvious abnormalities. The placental examination showed features suggestive of malperfusion.
- The mother's care was during the COVID-19 pandemic period. The COVID-19 pandemic did not have an impact on the outcome for the Baby. The father was unable to attend triage due to changes in birth partner attendance which led to the mother being informed of the baby's death alone.

Recommendations:

The Trust to ensure that staff are supported to fully assess and provide robust advice to mothers telephoning the maternity unit. This is to be recorded on the electronic maternity system.

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Divisional Q&S Meeting Oct 2021

Paper title: Midwifery staffing recruitment update

Author: Scott Johnston, Head of Midwifery

Executive Director: TG Teoh

Purpose: discussion/ information

Meeting date: 11/10/21

1. Introduction and background

1.1. Safe Midwifery staffing levels are vital to the provision of safe Maternity Services. The maternity service at Imperial College Healthcare NHS Trust use the nationally recommended tools and guidance to maintain safe staffing locally and guide recruitment, local escalation and day to day monitoring.

1.2. Recently we have had significant challenges around maintaining safe midwifery staffing due to

- Increased activity and acuity of women and babies
- Increasing background vacancy rate
- Sickness- COVID and other
- Self-isolation

1.3. The maternity team have been working to maintain safe staffing levels and have plans in the short, medium and long term to tackle the challenge.

2. Purpose

The purpose of the report is to-

- Provide an update on Safe Midwifery staffing. A full report will be provided next month.
- Update the committee on key midwifery recruitment metrics
- Highlight key progress and ongoing work regarding midwifery recruitment and retention.
- Propose actions for discussion

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Main paper

3. Discussion/key points

Update on progress with maintaining safe Midwifery Staffing

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 c10% turnover of staff.

The historic main source of recruitment of newly qualified midwives onto our preceptorship programme are King's and University of West London students that have been on placement with us. The first tranche of Imperial students qualifying from the University of West London started employment with us in March 21 and are progressing well with their preceptorship year. 23 King's Student will be starting over the next few months.

Appendix 1 provides an update on the current Midwifery Vacancy position as reported to NHSE.

Maternity continue to care for women with COVID 19. Some of these have been unwell and requiring HDU care within the maternity service or transfer to ITU.

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 18 months work has been undertaken to further improve the resilience of the service to cope with these peaks and troughs in activity. These have included;

- Twice daily Maternity Staffing Huddles continue, with additional huddles if needed.
- The new maternity bleep holder team at QCCH site will be complete by the end of November.
- Communication and collaboration with the Trust Site Teams and on call managers
- Senior Midwife on Call rota remains in place with on-site presence at weekends when needed.
- Improved planning of elective activity with cross site consideration to manage workload
- Using RNs and additional support staff to mitigate midwifery gaps
- Cross site working and collaboration of day to day staffing and activity shifts where possible
- Redeployment of specialist midwives and the senior team into clinical shifts.
- Daily/weekly sitrep reporting to NHSE regarding safe staffing

Despite these measures-

- There have been occasions- 2 to 3 per week when activity has been diverted from one site to the other due to increased activity of reduced midwifery staffing. For July QCCH diverted to SMH for a total of 36 hours.
- There have been delays to some clinical care, namely Induction of labour and Elective CS.

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Midwifery Vacancies/Recruitment

Appendix 1 provides the latest vacancy position as reported to NHSE. The data can be summarised as follows.

Current overall vacancies = 52 wte (Bands 6-8)

Current Band 6 Midwifery vacancies

Current band 6 vacancies= 39.64 wte (including 5.5 additional posts from Ockenden external funding)

- Anticipated Band 6 recruitment by March 22= 26 wte
- Anticipated Band 6 Turnover by March 22= 17 wte (including those promoted to band 7 internally)
- Expected overall Band 6 vacancies by March 22= 30 wte

In April 22, 7 UWL students and c10wte external students are anticipated to start are preceptors so the vacancies will fall at this point.

In response to this the Team have a plan to address this issue-

Short term

- Ensuring swift onboarding of midwives in the current pipeline
- Improvements to our advert wording
- Close monitoring of recruitment numbers.

Medium term

- The service have been given £100k from NHSE to improve preceptorship support (2wte Band 7 Midwives for one year). This will allow us to significantly increase the number of preceptor midwives (external) that we recruit.
- The Trust are fully engaged with the NHSE led International midwifery recruitment programme. We anticipate 10-15 midwives to join the service from June 22, gaining their NMC registration and commencing the preceptorship programme around November 22.

Long term

- Continue with International recruitment
- In the past two years we have increased the overall number of student midwives per year by 7, we will continue to increase these numbers.
- HEE have funded a NWL project lead to scope and lead a further increase in the number of students in each service.

Midwifery Recruitment Task and Finish Group

The Maternity Team have collaborated with the Trust Recruitment Team to start a Recruitment Task and finish group. The work of the group will include-

- Improving the wording and placement of adverts
- Exploring new sources of recruitment
- Analysis of exit interview and auctioning any themes
- Reviewing recruitment processes and touchpoints for recruits
- Implementing the Short, Medium and Long term plans as above.

6 Conclusion

1. In line with most services in England, maternity continue to have significant midwifery staffing challenges
2. Mechanisms are in place to monitor and act upon shortfalls in midwifery staffing.
3. Proactive monitoring and metrics remain in place to ensure that midwifery staffing remains safe
4. The Maternity team are working closely with recruitment colleagues to improve local recruitment numbers and processes.
5. The current vacancy numbers are concerning but the Maternity team are engaged with sector and London programs to increase recruitment in the medium and long term.

Author
Scott Johnston – Head of Midwifery

11/10/21

Imperial College Healthcare NHS Trust

Appendix 1

Actuals (in month)	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total year end
Registered Midwives FTE (substantive) staff in post (total)	314.70								315
of which are band 5	0.00								0
of which are band 6	206.20								206
of which are band 7	92.70								93
of which are band 8	15.80								16

Registered Midwives Vacancy (FTE) (total)	52.07							
of which are band 5	0.00							
of which are band 6	39.64							
of which are band 7	10.43							
of which are band 8	2.00							

Recruitment forecast (in month appointments)	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total year end
Registered Midwives FTE (substantive) to be recruited (total)									0
of which are band 5		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0
of which are band 6			5.00	9.00	4.00	3.00	2.00	3.00	26
of which are band 7				4.00	4.00				8
of which are band 8					1.00	1.00			2

Of your Midwifery vacancies how many will be recruited (FTE appointments) via	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total year end
International recruitment		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0
Return to practice								1.00	1
Bank to perm									0
Newly qualified			5.00	7.00	4.00	3.00			19
Local recruitment				2.00			2.00	2.00	6
Increase in hours									0
Other									0
Please specify other									0

Recruitment forecast (in month)	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total year end
Obstetricians FTE (substantive) to be recruited (total)		0.60	0.30	0.20	0.20	0.20	0.20	0.20	2
of which are new posts (FTE)		0.20	0.20	0.20	0.20	0.20	0.20	0.20	1
of which are increases in FTE		0.40	0.10	0.00	0.00	0.00	0.00	0.00	1

Temporary staffing forecast	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Registered Midwives FTE (bank)		14.00	14.00	14.00	12.00	12.00	10.00	10.00
Registered Midwives FTE (agency)		3.00	3.00	3.00	3.00	3.00	2.00	2.00
Obstetricians FTE (bank)		0.60	0.30	0.20	0.20	0.20	0.20	0.20
Obstetricians FTE (agency)								

Retention	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total year end
Number of Midwife leavers (FTE) expected (in month)		5.86	3.86	3.86	4.86	3.86	4.86	3.86	31
of which are band 5		1.00	0.00	0.00	0.00	0.00	0.00	0.00	1
of which are band 6		2.42	2.42	2.42	2.42	2.42	2.42	2.42	17
of which are band 7		1.44	1.44	1.44	1.44	1.44	1.44	1.44	10
of which are band 8		1.00	0.00	0.00	1.00	0.00	1.00	0.00	3

MDT training for all staff working in maternity services	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
% of staff who have participated in MDT training (actuals)	89%							
% of staff who will have participated in MDT training (forecast)		89%	89%	91%	91%	92%	92%	92%

Appendix 4 - ICHT CNST Maternity Incentive Scheme Year 4 Scorecard

Safety Action	Required standard	Deadline	RAG
1 - PMRT	a) i. All perinatal deaths eligible to be notified to MBRRACE-UK from 1 September 2021 onwards must be notified to MBRRACE-UK within two working da	30.06.2021	
	a) ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 August 2021 w	30.06.2021	
	b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 8 August 2	30.06.2021	
	c) For at least 95% of all deaths of babies who died in your Trust from 8 August 2021, the parents will have been told that a review of their baby's death v	30.06.2021	
	d) Quarterly reports will have been submitted to the Trust Board from 8 August 2021 onwards that include details of all deaths reviewed and consequen	30.06.2021	
2 - MSDS	1) Trust Boards to confirm that they have either: already procured a Maternity Information System complying with the forthcoming commercial frame	30.06.2021	
	2) Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality crite	01.01.2022	
	3) January 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded at the first antenatal booking appointment for	01.01.2022	
	4) January 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month.	01.01.2022	
	5) Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria on the national Maternity Services Dashboard for	01.01.2022	
3 - ATAIN	a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers	30.09.2021	
	b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety cha	On-going	
	c) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward,	30.09.2021	
	d) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are	On-going	
	e) Reviews of term admissions to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion	On-going	
	f) An action plan to address local findings from the audit of the pathway (point b) and ATAIN reviews (point e) has been agreed with the maternity and n	30.11.2021	
	g) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality su	30.06.2021	
4 - Workforce	1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the	1. By January 2022	
a) Obstetric medical workforce	2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to atte	2. By January 2022	
b) Anaesthetic medical workforce	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaest	30.06.2021	
c) Neonatal medical workforce	The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not b	30.06.2021	
d) Neonatal nursing workforce	The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS,	30.06.2021	
5 - Midwifery workforce	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.		
	b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) t	30.06.2021	
	c) All women in active labour receive one-to-one midwifery care d) Submit a midwifery staffing oversight report that covers staffing/safety issues to the b		
	d) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme ye		
6 - Saving Babies Lives Care bundle	1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in Apri	30.06.2022	
	2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bund	30.06.2022	
	Element one - Reducing smoking in pregnancy	30.06.2022	
	Element two - fetal growth restriction (FGR)	30.06.2022	
	Element three - Reduced fetal movements	30.06.2022	
	Element four - Fetal monitoring	30.06.2022	
	Element five - Reducing preterm birth	30.06.2022	
	3. The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requi	30.06.2022	
7 - Maternity Voices Partnership	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voic	30.06.2022	
8 - Multi-professional training	a) A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programm	30.06.2022	
	b) 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day, to include maternity emergencies	30.06.2022	
	c) 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day, to include antenatal and intrapar	30.06.2022	
	d) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating new	30.06.2022	
9 - Safety champions	a) The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (	30.09.2021	
	b) Board level safety champions present a locally agreed dashboard to the Board on a quarterly basis. To include, as a minimum, the measures set out in	31.10.2021/ 31.12.2021	
	c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the mate	31.03.2022	
	d) Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neon	30.04.2022	
10 - HSIB/ EN Scheme	1. A) Reporting of all qualifying cases to HSIB for 2021/22.	30.06.2022	
	2. B) For qualifying cases which have occurred during the period 1 April 2021 to 31 March 2022 the Trust Board are assured that: 3. 1. the family have re	30.06.2022	

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

Imperial College Healthcare NHS Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/3/2021 to 31/5/2021

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *19*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
15	4	5	6	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
10	1	8	1	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Deaths following termination of pregnancy are excluded.

** Post-neonatal deaths can also be reviewed using the PMRT

*** Reviews completed and have report published

Report Generated by: Sophie Hopkins
Date report generated: 05/10/2021 15:30

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 7)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	3	--	--	--	--	3
Stillbirths total (24+ weeks)	0	0	1	1	1	0	3
Antepartum stillbirths	*0*	*3*	*1*	*1*	*1*	*0*	*6*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	1	0	0	0	0	1
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	4	1	1	1	0	7
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	1	0	1
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	0	0	0
Not Applicable	0	4	1	1	0	0	6
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	4	1	1	1	0	7
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	4	1	1	1	0	7
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	1	0	0	0	0	1
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	1	0	0	0	0	1
Neonatal care re-orientated	0	0	0	0	0	0	0

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

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Date report generated: 05/10/2021 15:30

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 7)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	1	1	1	0	0	3
No	0	2	0	0	1	0	3
Hospital post-mortem offered	0	3	1	1	1	0	6
Hospital post-mortem declined	0	3	0	1	1	0	5
Hospital post-mortem carried out:							
Full post-mortem	0	0	1	0	0	0	1
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	1	0	0	0	0	1
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	0	0
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	1	0	0	0	0	1
Hospital post-mortem declined	0	1	0	0	0	0	1
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	1	0	0	0	1
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	1	0	0	0	1
No	0	1	0	1	0	0	2

*Includes coronial/procurator fiscal post-mortems

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Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation

Role	Total Review sessions	Reviews with at least one
Chair	7	100% (6)
Vice Chair	7	100% (6)
Admin/Clerical	0	0%
Bereavement Team	15	100% (6)
External	11	100% (6)
Management Team	9	100% (6)
Midwife	47	100% (6)
Neonatal Nurse	3	50% (3)
Neonatologist	15	66% (4)
Obstetrician	8	100% (6)
Other	0	0%
Risk Manager or Governance Team	17	100% (6)
Safety Champion	7	100% (6)

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths

Role	Total Review sessions	Reviews with at least one
Chair	1	100% (1)
Vice Chair	1	100% (1)
Admin/Clerical	0	0%
Bereavement Team	5	100% (1)
External	2	100% (1)
Management Team	2	100% (1)
Midwife	8	100% (1)
Neonatal Nurse	0	0%
Neonatologist	3	100% (1)
Obstetrician	3	100% (1)
Other	0	0%
Risk Manager or Governance Team	4	100% (1)
Safety Champion	1	100% (1)

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Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 7)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	2	0	1	1	0	4
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	1	1	0	0	0	2
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	3	1	1	1	0	6
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	1	0	0	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	1	0	0	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	1	0	0	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

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Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 7)

Timing of death	Cause of death
Late fetal losses	**3 causes of death out of 3 reviews**
	Selective growth restriction
	Selective growth restriction
	Placental insufficiency
Stillbirths	**3 causes of death out of 3 reviews**
	The cause of death was undetermined
	The cause of death was undetermined
	Trisom 18
Neonatal deaths	**1 causes of death out of 1 reviews**
	Extreme prematurity Chorioamnionitis
Post-neonatal deaths	**0 causes of death out of 0 reviews**

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Table 7:Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

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Table 8: Issues raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened because carbon monoxide testing was paused due to COVID-19	7	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
Placental histology was performed but was not carried out by a perinatal/paediatric pathologist	3	No action entered
		No action entered
		No action entered
During the early bereavement period the baby was not able to be cared for in a cold cot because we do not have a cold cot	2	Cold cot not functioning at the time. It's now working.
		Cold cot not functioning at the time. It's now working.
The COVID-19 pandemic situation adversely affected how this woman accessed care	2	No action entered
		No action entered
The baby had to be transferred elsewhere for the post-mortem	1	No action entered
The opportunity to take their baby home was not offered to the parents as there is no local policy for this	1	No action entered
The opportunity to take their baby home was not offered to the parents as this was logistically too complicated to organise	1	No action entered
The risk allocation of this mother based on her history at booking was incorrect	1	No action entered
There were no specific contraindications to organ donation but this was not discussed with the parents as part of end of life care for their baby	1	No action entered
These parents have a first degree relative with a genetic condition and an urgent referral to genetic services was not offered	1	Remind staff to appropriately refer women to genetic counselling in the presence of family history (or partner's family history) of genetic conditions.

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

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Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors

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Appendix 6

Monthly Report on the Perinatal Mortality review tool September 2021.

Purpose

The purpose of this report is to provide assurances that the Trust is meeting all the 10 standards of year 4 of the CNST Maternity Incentive Scheme related to the MBRRACE tool and provide actions of learning from the PMRT reviews. The monthly report supports the quarterly PMRT report that is presented to the Trust Board. It ensures that trends and themes from the PMRT are reviewed and addressed in a timely manner.

Background

Imperial college Healthcare NHS trust, SMH and QCCH, started reporting on the PMRT tool from 23.12.2018

This report includes:

- Late fetal losses where the baby is born between 22^{+0} and 23^{+6} weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g.
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life.
- All neonatal deaths where the baby is born alive from 22^{+0} but dies up to 28 days after birth.
- Post-neonatal deaths where the baby is born alive from 22^{+0} but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

The PMRT is not designed to support the review of the following perinatal deaths:

- Termination of pregnancy at any gestation.
- Babies who die in the community 28 days after birth or later who have not received neonatal care.
- Babies with brain injury who survive.

(https://www.npeu.ox.ac.uk/pmrt/faqs#governance)

In total, 211 babies have fallen into these categories across site since reporting began on the 20th December 2018. The graph below shows all late miscarriages, stillbirths and neonatal deaths per month since reporting started.

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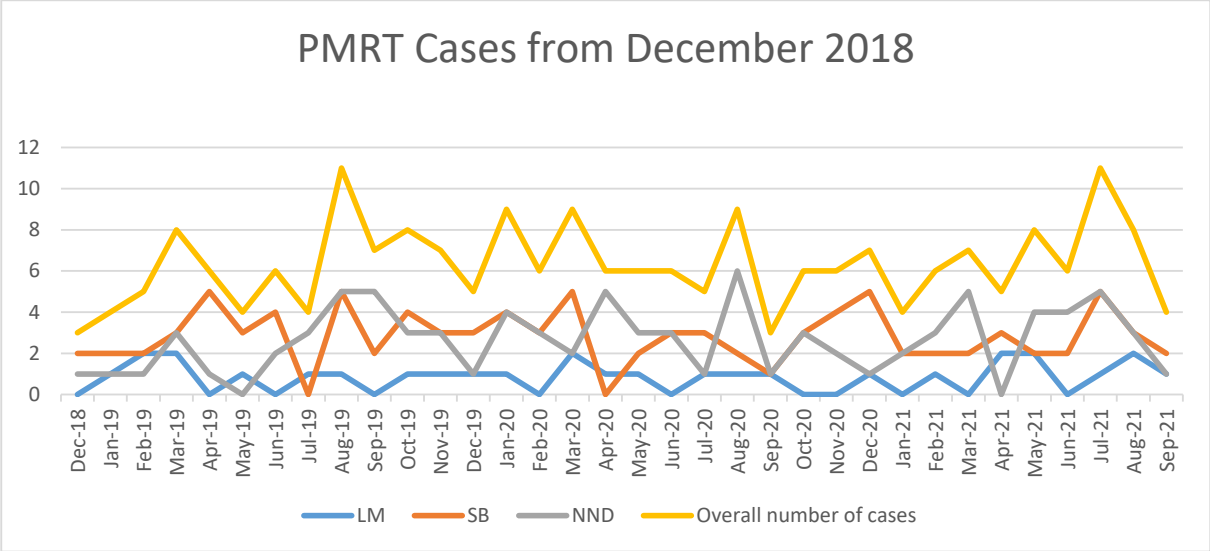
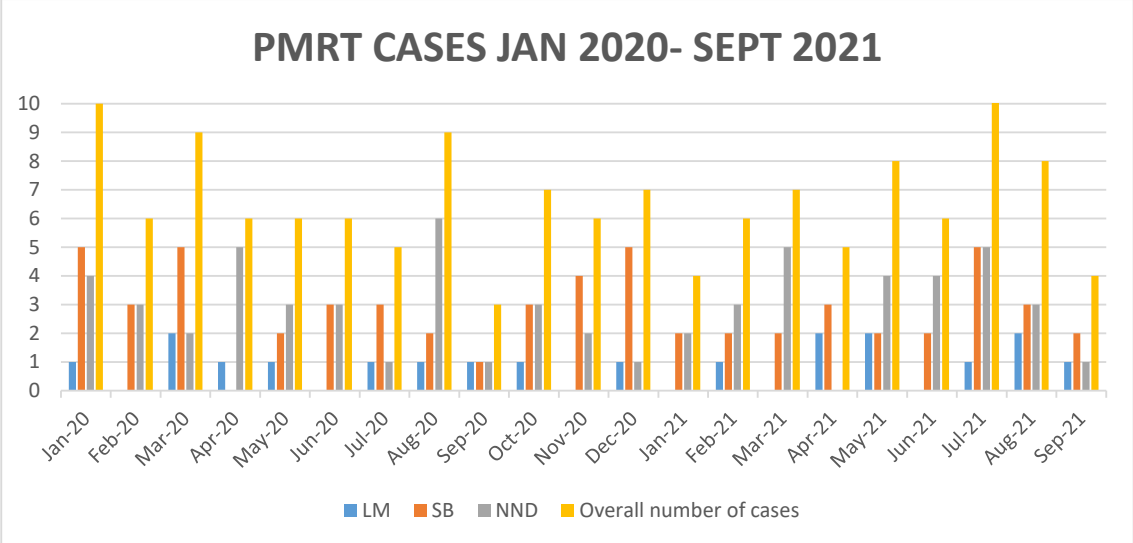


Audit period

The Trust complies will all standards for the CNST Maternity Incentive Scheme Year 4.



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Audit of standards from 8th August 2021.

Standards	Compliance
All perinatal deaths eligible to be notified to MBRRACE UK from 1 September 2021 onwards must be notified to MBRRACE-UK within two working days	Compliant to date.
Surveillance information where required must be completed within one month of the death.	Compliant to date.
A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 August 2021 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust.	Compliant to date.
At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 8 August 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.	Compliant to date. To meet the new standards we have introduced a small MDT on a Tuesday morning to review new cases
For at least 95% of all deaths of babies who died in your Trust from 8 August 2021, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of	Compliant to date. Leaflets given to parents in bereavement pack. The bereavement team keep in contact with the families and feedback any concerns.

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whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.	
Before they are discharged home all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of neonatal deaths parents should also be told that a review will be undertaken by the local Child Death Overview Panel (CDOP). Verbal information can be supplemented by written information.	Compliant to date.
Quarterly reports will have been submitted to the Trust Board from 8 August 2021 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions	Compliant to date. PMRT reported to Quality and Safety meetings and Quarterly reports pulled off the database for Trust Board.
External member present for review Ideally the team should include a member from a relevant professional group who is external to the unit who can provide peer review as part of the PMRT review team	CDOP and Chelsea and Westminster continue to support the team, and where there are two sites involved in the PMRT case a member of that Trust is invited to the meeting. Compliant to date
General Update on cases from 8th August 2021 (new standards commenced)	Of the 9 cases eligible for PMRT review, 1 case was a nenonatal transfer from another unit that is being investigated jointly by Imperial and the other trusts involved. 5 cases were babies born at Imperial, of those 4 are intrauterine transfers which we aim to complete jointly with other hospitals involved in care.

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We aim to have a full multi-disciplinary review every two weeks to review all PMRT cases.

Although the PMRT standards do not specifically mention external members we hope to continue to invite colleagues from other Trusts to support our reviews

Following the most recent PMRT meeting, please see findings below:

Learning	Action	Action owner	Date completed
It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	Remind staff to document that the parents are offered the opportunity to take their baby home and that they decline or accept. This must be documented in the bereavement checklist or in the free text notes Added to checklist	Neonatal team	October 2021
This mother missed some of her antenatal appointments but was not followed-up according to the local DNA policy	Remind staff to follow the local DNA policy Risky Business Presented at Postgrad forum	Risk team maternity	October 2021
This mother had poor/no English and an interpreter was not used on every occasion when she was seen for her antenatal care	Remind staff to use interpreters when required and clearly document that the patient understands the information given if a translator is declined. Presented at Postgrad forum Risky Business	Risk team maternity	October 2021
These parents have a first degree relative with a genetic condition and an urgent	Remind staff to appropriately refer women to genetic counselling in the presence of family	Risk team maternity	October 2021

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referral to genetic services was not offered.	history (or partner's family history) of genetic conditions. Risky Business		

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Maternity Quality Assurance Oversight Report Glossary

Anaesthesia Clinical Services Accreditation (ACSA) scheme - is based on a relevant and robust set of standards set by the profession, for the profession. Domains one to four aim to cover all aspects of general anaesthetic care provided in all hospitals in the UK.

Apgar scores - is a test given to newborns soon after birth. This test checks a baby's heart rate, muscle tone, and other signs to see if extra medical care or emergency care is needed. The test is usually given twice: once at 1 minute after birth, and again at 5 minutes after birth.

Auscultation - is a method of periodically listening to the fetal heartbeat.

Avoiding Term Admissions into Neonatal (ATAIN) units - is a programme of work to reduce harm leading to avoidable admission to a neonatal unit (NNU) for infants born at term, i.e. ≥ 37 +0 weeks gestation. A central aim of the work is to prevent harm leading to separation of mother and baby.

Birth centre - are maternity units that are usually staffed by midwives. They aim to offer a homely, rather than clinical, environment. Birth centres are especially good at supporting women who want a birth without medical interventions.

British Association of Perinatal Medicine (BAPM) framework for practice - provides guidance on optimal activity levels and additional guidance on medical staffing for Local Neonatal Units (LNUs) and Special Care Units (SCUs) in the UK. It is aimed at individuals, organisations and government bodies involved in the provision, planning and commissioning of neonatal care.

CNST Maternity Incentive Scheme (MIS) - supports the delivery of safer maternity care. The scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in year two, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Continuity of care (CoC) - describes consistency in the midwife or clinical team that provides care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour and the postnatal period. Women who receive midwifery-led continuity of carer are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth and report significantly improved experience of care across a range of measures. Pre-term birth is a key risk factor for neonatal mortality.

Cardiotocograph (CTG) - is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy. The machine used to perform the monitoring is called a cardiotocograph, more commonly known as an electronic fetal monitor (EFM).

Cooling treatment - or mild hypothermia may be offered to a baby if they are suspected of having moderate or severe HIE to help with the healing process. The treatment needs to be started within the first 6 hours after birth. A special cooling mattress is used to lower the baby's temperature to between 33 and 34 degrees centigrade for 72 hours. The mattress is filled with fluid that can be cooled or warmed according to your baby's needs.

Cord blood gas - analysis is an objective measure of the fetal metabolic condition at the time of delivery. By determining fetal acid-base status, it helps identify infants at risk for neonatal encephalopathy.

Early Notification (EN) Scheme - investigates serious brain injuries that happen to children at birth. Its aim is to speed up the investigation of these incidents and give families answers as soon as possible after serious injuries. The scheme requires trusts to report all maternity incidents that have led to severe brain injury.

Evacuation of retained products - is a small operation to remove any remaining products of conception that are still inside the uterus (womb).

Grade 1 caesarean section (CS) - is one that is done if there is an immediate threat to the baby's or mother's life.

Health Safety Investigation Branch (HSIB) - conduct independent investigations of patient safety concerns in NHS-funded care across England.

Hypoxic ischaemic encephalopathy (HIE) - is a type of brain dysfunction that occurs when the brain doesn't receive enough oxygen or blood flow for a period of time. Hypoxic means not enough oxygen; ischemic means not enough blood flow; and encephalopathy means brain disorder.

Induction of labour (IOL) - In an induced labour, or induction, labour processes are started artificially. It might involve mechanically opening the cervix, breaking the waters, or using medicine to start off contractions.

K2 training package - is an interactive, online, e-learning tool, offering certification for fetal monitoring and maternity crisis management, with a CTG training simulator, Competency Assessments and Learning Pathways, enabling tailored learning to improve core knowledge and test skills.

Local Maternity and Neonatal System (LMNS) - is the mechanism through which it is expected that a sector will collaboratively transform maternity services, with a focus on delivering high quality, safe and sustainable maternity services and improved outcomes and experience for woman and their families. This includes a group of people who are involved with either providing, receiving or commissioning maternity care.

Major Obstetric Haemorrhage (MOH) - refers to any kind of excessive bleeding inclusive or above 1500ml during pregnancy, child birth, or in the postpartum period.

Maternal and Neonatal Health Safety Improvement Programme (MatNeoSIP) - A programme to support improvement in the quality and safety of maternity and neonatal

units across England – formerly known as the Maternal and Neonatal Health Safety Collaborative.

Maternity Services Data Set (MSDS) - is a patient-level data set that captures information about activity carried out by Maternity Services relating to a mother and baby(s), from the point of the first booking appointment until mother and baby(s) are discharged from maternity services.

Maternity Voices Partnership (MVP) - is a NHS working group: a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care.

Midwifery education – two full day training for midwives which includes all training needs identified for the 12 month period.

Multiparous woman (multip) – has given birth more than once. A grand multipara is a woman who has already delivered five or more infants who have achieved a gestational age of 24 weeks or more, and such women are traditionally considered to be at higher risk than the average in subsequent pregnancies.

National Perinatal Mortality Review Tool (PMRT) - The aim of the PMRT programme is introduce the PMRT to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales. The PMRT has been designed with user and parent involvement to support high quality standardised perinatal reviews on the principle of 'review once, review well'.

Ockenden report Immediate and Essential Actions (IEA) - After reviewing 250 cases and listening to many more families, this first report published in 2020 identifies themes and recommendations for immediate action and change, at The Shrewsbury and Telford Hospital NHS Trust and across every maternity service in England.

Oxytocin - is a natural hormone that causes the uterus to contract used to induce labour, strengthen labour contractions during childbirth, control bleeding after childbirth.

Pathological Cardiotocograph (CTG) - The purpose of CTG recordings is to identify when there is concern about the baby. The focus is on identifying baby's heart rate (FHR) patterns associated with inadequate oxygen supply to the baby. When a CTG is pathological it requires urgent review by a doctor to exclude acute events and can lead to consider expediting birth.

Perinatal Clinical Quality Surveillance Model (PCQSM) – includes five principles for improving oversight for effective perinatal clinical quality to ensure a positive experience for women and their families. They integrate perinatal clinical quality into developing integrated care system (ICS) structures and provide clear lines for responsibility and accountability for addressing quality concerns at each level of the system.

Perinatal Mortality Review Tool (PMRT) – the tool standardises perinatal mortality reviews across NHS maternity and neonatal units. It supports active communication with parents, and systematic, multidisciplinary, high quality reviews of the

circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care. A report is produced for the parents.

Personalised Care and Support Plan (PCSP) - people have proactive, personalised conversations which focus on what matters to them, paying attention to their clinical needs as well as their wider health and wellbeing.

Pertussis vaccination - Pregnant women can help protect their babies from developing whooping cough by getting the pertussis vaccination – ideally from 16 weeks up to 32 weeks pregnant.

PRactical Obstetric Multi-Professional Training (PROMPT) - is a multi-professional obstetric emergencies training package that has been developed for use in local maternity units with the aim of reducing preventable harm to mothers and their babies.

Primiparous woman (primip) - a medical term used to refer to a condition or state in which a woman is bearing a child for the first time.

Prolonged prelabour rupture of membranes (PROM) – when a woman's waters have broken for more than 24 hours and they are not in labour.

Reduced fetal movements (RFM) – if a baby is not as active as usual this can be a sign of infection or another problem. Any change in patterns of movements should be reviewed by a doctor.

Saving Babies Lives Care Bundle - The bundle aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice.

SCORE culture survey - is a way of measuring and understanding culture that exists within organisations and teams. It is an anonymous, online tool that teams can use to assess their culture. It provides an overview but also detail in specific focus areas such as communication and staff burn out.

Second degree tear - is a tear in the skin and muscle of the perineum, which is the area between the vagina and anus.

Stillbirth (SB) - is when a baby is born dead after 24 completed weeks of pregnancy. It happens in around 1 in every 200 births in England.

Term gestation - at 37 weeks, pregnancy is considered full-term.

Tertiary maternal medicine service - receives referrals from GPs and hospitals across the UK and internationally. The service provides outpatient and inpatient care for women affected with any medical disease in pregnancy, as well as pre-pregnancy counselling. Obstetric medicine is the specialist care of pregnant women who either have pre-existing medical diseases, or have specific pregnancy-related diseases that can affect any organ in the body.

Transitional Care (TC)- means 'in between care' and is for babies who need a little more nursing care and monitoring than the routine care that all babies receive on the maternity ward. It supports babies to stay with their mother rather than going to the Special Care Baby Unit.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Infection Prevention and Control and Antimicrobial Stewardship Quarterly Report: quarter 2 2021/22

Agenda item 12 and paper number 09

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

Purpose: Information

Meeting date: 10 November 2021

1. Purpose of this report

1.1. This paper provides an update of key indicators and infection rates, indicative of effective infection prevention and control (IPC) practice. The indicators and activity noted in the paper relates to quarter 2 2021/22 (Q2).

1.2. This report employs a refreshed layout, targeted at providing assurance to the Trust Board across all infection indicators, with a focus on those areas where concerns have been identified during the preceding quarter.

2. Executive summary

2.1. The Health and Social Care Act 2008 Code of Practice in the Prevention and Control of Infection requires the Trust Board are regularly briefed on IPC practice.

2.2. This report encompasses all aspects of mandatory IPC reporting, as well as other relevant information relating to IPC, environmental hazards, cleaning, training, and policies.

2.3. In Q2 NHS England updated definitions and thresholds for reportable healthcare-associated infections as part of their review of the NHS standard contract. Definitions have been harmonised across all reportable infections, thresholds for healthcare-acquired *C. difficile* infection have been increased, and new thresholds for healthcare-associated Gram-negative bloodstream infection (BSI) have been published. Our current trajectory indicates that we will not exceed our annual threshold for healthcare-associated *C. difficile* infection and *E. coli* BSI. However the observed incidence of Klebsiella spp., and *P. aeruginosa* BSI are above our anticipated threshold in this quarter. We are developing a new approach to reviewing the healthcare-associated BSIs to ensure that learning from post infection reviews is identified, acted upon and shared across the Trust.

2.1. In Q2 one healthcare-associated MRSA BSI has been identified, totalling four cases for 2021/22 compared to a total of five reported in 2020/21. The observed increase has raised several questions regarding our rate of MRSA BSI and corresponding actions are outlined in this paper.

2.2. The number of incidents and outbreaks related to Covid-19 has increased in Q2 compared to Q1 alongside a concomitant rise in the incidence of Hospital-Onset COVID-19 (HOCI) cases. Key themes from these incidents include patient screening not been undertaken in line with IPC requirements, reduction in staff asymptomatic testing compliance, and the extent to which patients wear masks while in hospital. We continue to work to increase staff asymptomatic testing but face challenges which are representative of the regional and national uptake of staff asymptomatic testing. Our PPE helper programme have been working with ward based

teams to increase their understanding of when patients need to be screened for Covid-19, and to provide additional education and training around core IPC competencies such as hand hygiene and the correct use of PPE.

2.3. In Q2, four out of five of the Covid-19 screening metrics were below the 90% target threshold, carbapenemase-producing Enterobacterales (CPE) screening compliance for one division stands at 49% with another marginally below the 90% threshold, and MRSA screening compliance for two divisions fell below the 90% threshold.

2.4. We have commenced a Trust-wide audit of hand hygiene and use of personal protective equipment (PPE). We will present the findings to EMB quality group (EMB-Q) in November. The findings of the audit will be utilised to identify areas to pilot new approaches to IPC competency assessment and training.

3. Approval process

3.1. This report has been signed off at the Trust Infection Prevention and Control Committee, and discussed at the Executive Management Board. The report was discussed and accepted by the Quality Committee.

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

5. Next steps

5.1. We will review MRSA BSI reporting with UKHSA and provide an update on this to EMB-Q.

5.2. We are developing our GNR BSI reduction action plan and will provide regular updates on this to EMB-Q.

5.3. We will be present the outcome from our HH/PPE audit to EMB-Q and will utilise the results to inform piloting new approaches to IPC competency assessment and training.

5.4. In addition we will present a work plan for surgical site infection and AMS to EMB-Q.

6. Impact assessment

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

6.2. Financial impact: no direct financial impact.

6.3. Workforce impact: no workforce impact.

6.4. Equality impact: no specific equality impact.

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

Main Paper

7. Key actions to prevent HOCI, Covid-19 related incidents and outbreaks

7.1. In Q2 we observed 36 incidents and 11 outbreaks related to Covid-19. Whilst these reflect a slight increase compared to the previous quarter, our reporting rate remains high and incident sizes remain small (Table 1).

7.2. There has been an observed increase in the number of patients identified with Covid-19 through routine screening across our renal satellite units in Q2. No outbreaks have been declared but these incidents have been investigated and managed internally under the outbreak management process.

7.3. All incidents are internally reviewed and reported weekly to CRG.

8. Healthcare-associated infection surveillance and mandatory reporting

8.1. In Q2 NHS England updated definitions and annual thresholds for reportable healthcare-associated infections as part of their review of the NHS standard contract. For the purpose of monitoring, annual thresholds have been divided to provide a monthly threshold.

8.2. ***C. difficile*:** the annual threshold for healthcare-acquired *C. difficile* infection has been increased and we remain on target not to exceed this.

8.3. **Gram-negative BSI:** new thresholds have been published for healthcare-associated Gram-negative BSI including *E. coli, Klebsiella spp., and P. aeruginosa*.

8.3.1. ***E.coli:*** to date trends in *E.coli* BSI remain below the threshold.

8.3.2. **Klebsiella sp. and *P. aeruginosa* BSI**: are higher than internal thresholds for Q2. (Table 1, Figure 2 and 3). Respectively we are rank 5th and 4th highest in the Shelford group (Figure 2 and 3). Intra-abdominal and vascular access devices are predominant sources of these infection. Review of cases has identified the need for further details on sources of infection and management to support effective interventions. In response an action plan is being developed comprising: (i) monthly MDT to review healthcare-acquired BSIs to understand commonalities in sources of infection, areas of high incidence, lapses in care, to identify targeted interventions and (ii) gap analysis of national BSI reduction recommendations.

9. MRSA BSI

9.1. In Q2 there has been one MRSA BSI meeting UKHSA criteria of healthcare-associated, against a quarterly threshold of zero (Table 1, Figure 1). Post-infection review of the case reveals this infection was community-acquired.

9.1.1. In 2021/22 to date we have identified 4 cases of MRSA BSI which have met the UKHSA surveillance definition of healthcare-associated.

9.1.2. Of the four cases, one has been clinically deemed community-acquired (symptoms on admission) and one represents detection of persisting infection 14-days after first positive sample (meeting UKHSA criteria for new infection episode).

9.1.3. It is important to note that the remaining two cases are clinically confirmed healthcare-associated MRSA BSI, placing the Trust above the national threshold of zero cases.

9.1.4. We have challenged UKHSA's surveillance methodology and have raised our clinical and epidemiological concerns regarding classification of infection onset based solely on the timing of the blood culture being collected for inpatients.

9.1.5. UKHSA have acknowledged the limitations of their surveillance definitions but have stated that they have no plans to change their current approach.

9.1.6. From discussions with colleagues at local Trusts and the Shelford group there is very broad recognition of encountering similar classification challenges and recourse for reclassification.

9.2. We are implementing a monthly review of all healthcare-associated BSIs, including MRSA, and through this will interrogate internal post infection reviews. We will continue to engage with UKHSA regarding the classification of healthcare-associated BSIs – and while we do this, we will ensure that any reported cases are accompanied by clear clinical narrative regarding the extent to which their onset are associated with care and treatment in our hospitals.

10. Screening

10.1. Screening patients for SARS-CoV-2 (the virus which causes Covid-19), CPE and MRSA during their admission remains an important IPC measure (Table 1).

10.2. Covid-19 screening metrics are reviewed weekly at the healthcare-associated infection sit rep. Compliance remains below the 90% internal target and the divisions are assessing

reasons behind this, particularly the impact of tertiary elective patient screening which does not get recorded automatically on Cerner.

10.3. CPE screening compliance remains good overall with minimal fluctuations below our internal threshold of 90% in all divisions apart from WCCS. This has been raised through the WCCS quality and safety governance structures and the division are reviewing their performance to understand the root cause.

10.4. Compliance with MRSA admission screening was 89% for Q2, a marginal drop from Q1 (90%). We rank the 10th in the Shelford group for compliance with MRSA screening based on figures from April to July 2021 (Figure 4).

10.5. We are exploring how screening can be added to the Trust's command centre, or how a separate patient screening app on Qlik could be developed in our efforts to support clinical teams to ensure screening is undertaken as required.

11. Antimicrobial stewardship

11.1. During Q2 we observed an overall reduction in antimicrobial consumption.

11.2. The AMS team have launched a monthly meeting dedicated to AMS to focus on data driven reduction strategies, while continuing dedicated AMS rounds on all sites to identify carbapenem use and prolonged antibiotic durations. In addition to this we have launched a new antimicrobial prescribing mobile app to support improved access to information to guide decision making around antimicrobials.

11.3. National antimicrobial shortages which directly affect our AMS programme are managed by the infection pharmacy team, and reported/monitored within the pharmacy governance structures. There is no evidence of patient harm as a result of these shortages.

11.4. The biannual antibiotic point prevalence survey which examines prescribing and safety quality indicators was due in January 2021. This was postponed due to the pandemic and is scheduled to take place in Q3 2021/22.

12. IPC practices education and assessment

12.1. A Trust-wide audit is taking place during October 2021 which focusses on hand hygiene compliance and the correct use of PPE in all inpatient areas. This audit will be used to identify areas to subsequently pilot different approaches to IPC competency education and training between November and February 2022.

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

13.1. Water hygiene continues to be an area of concern, particularly within the context of ongoing environmental contamination of pseudomonas and Legionella. Estates and facilities, supported by IPC, are leading on an action plan with regular updates to EMB-Q.

13.2. Surgical site infections (SSI) are reviewed quarterly in liaison with surgical specialities submitting information on SSI rates to PHE's national surveillance platform. SSI rate information is reported a quarter in arrears, and Q2 information will be provided in the next quarterly IPC report. Currently presented at the surgical infection group, IPC are working with the key stakeholders to support optimising engagement.

13.3. We are currently reviewing our SSI work plan and will present this to EMB-Q in November, along with an updated work plan for AMS.

14. Conclusion

14.1. This report summarises IPC activity in Q2 2021/22, action plans in place and progressing in response to IPC-related issues, including increasing incidence of CLABSIs and healthcare-associated MRSA and GNR BSIs. IPC are developing a new approach to training,

assessment and support for staff for core IPC competencies. Regular updates on progress are being provided to EMB quality group.

Author: James Price, Director of Infection Prevention and Control

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

Date: 26th October 2021

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

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

RAG rating key: GREEN - below Q threshold, AMBER - at par with Q threshold, RED - above Q threshold

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

RAG rating key: GREEN - above 90% target, AMBER - between 80 and < 90%, RED - < 80%

Section	PPS (August 2020)	Number of patients on antimicrobial(s)/total patients seen (%)	INDICATOR A % antimicrobialS in line with policy or approved by Microbiology/ID	INDICATOR B % review within 72 hours of initial prescribing	INDICATOR C % duration in line with policy or approved by Microbiology/ID	Trust Target 2020/21
Antimicrobial stewardship	Medicine and Integrated Care	156/402 (39%)	93%	93%	91%	90%
	Surgery, Cancer and Cardiovascular	74/138 (54%)	93%	100%	93%	90%
	Womens, Childrens and Clinical Support	5/8 (63%)	89%	67%	22%	90%
	Imperial Private Healthcare	-	-	-	-	90%

* In PPS Aug 2020, all surgical patients and wards, private healthcare, women's and children's wards (except for gynaecology) were excluded.

RAG rating key: GREEN - above 90% target, AMBER - between 80 and < 90%, RED - < 80%

Figure 1: (Left) Healthcare-associated MRSA BSI by quarter, FY 2021/22, split by Division, (Right) Healthcare-associated MRSA BSI rate per 100,000 bed days, comparison across Shelford trusts (PHE data, Apr – Jul 2021).

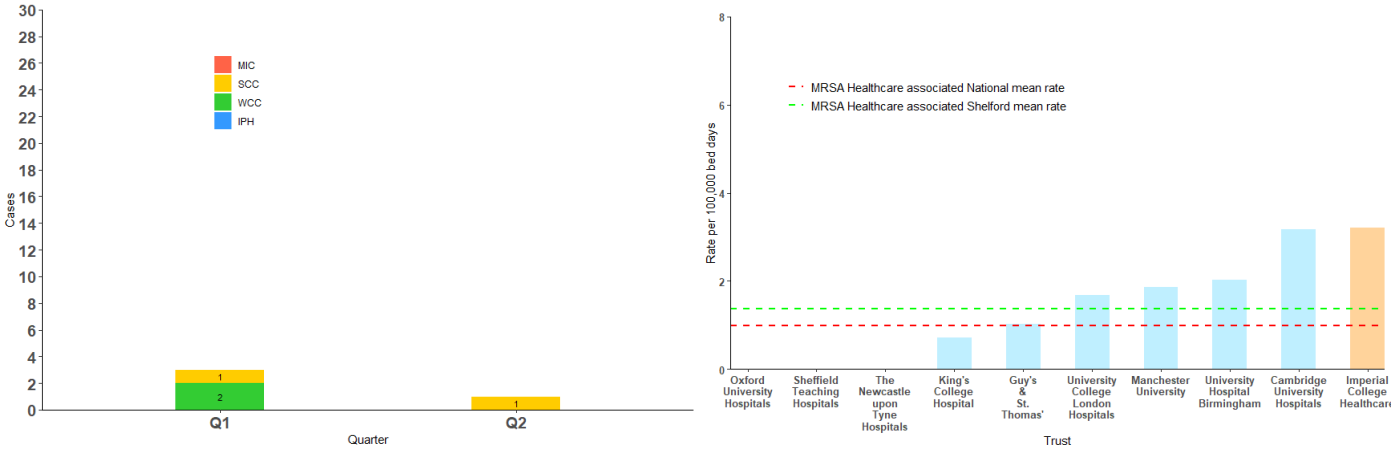


Figure 2: (Left) Healthcare-associated *Klebsiella spp* BSI by quarter, FY 2021/22, split by Division, (Right) Healthcare-associated *Klebsiella spp* BSI rate per 100,000 bed days, comparison across Shelford trusts (PHE data, Apr – Jul 2021).

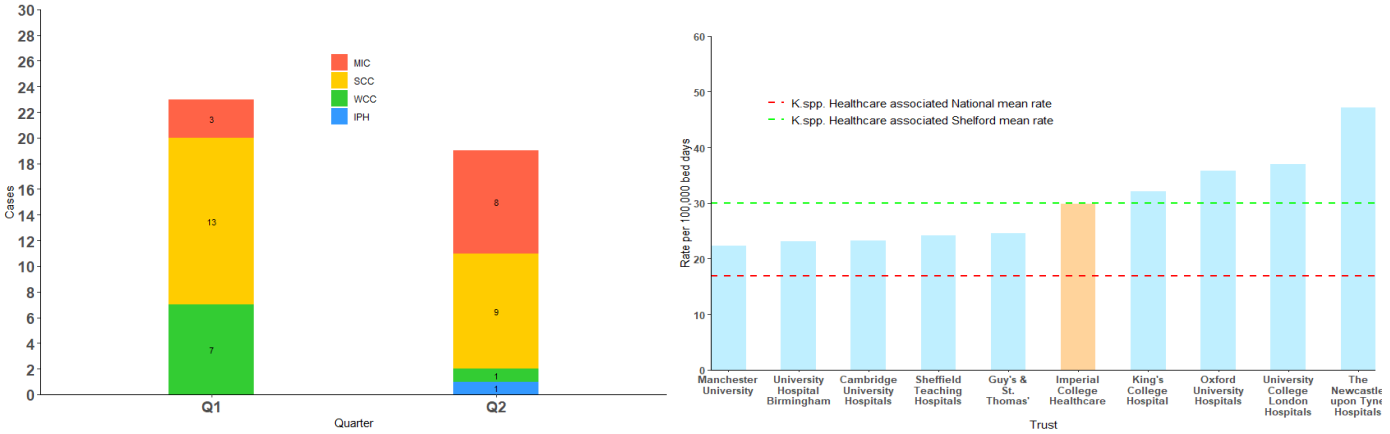
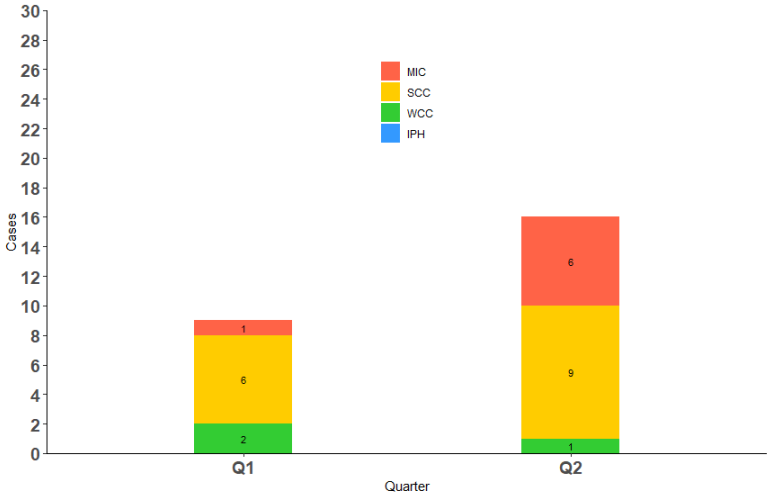


Figure 3: (Left) Healthcare-associated *P. aeruginosa* BSI by quarter, FY 2021/22, split by Division, (Right) Healthcare-associated *P. aeruginosa* BSI rate per 100,000 bed days, comparison across Shelford trusts (PHE data, Apr – Jul 2021).



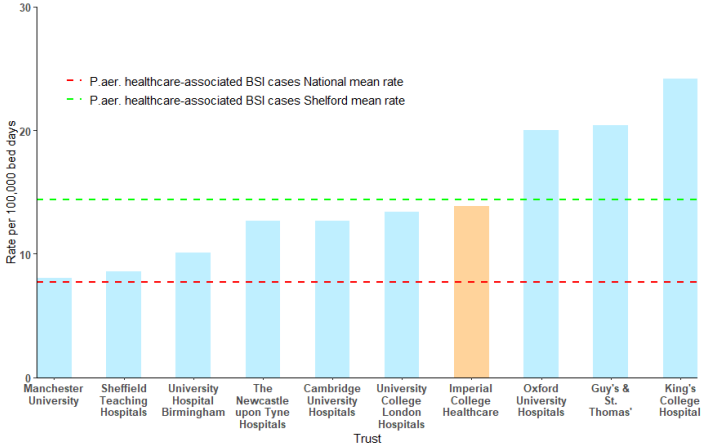
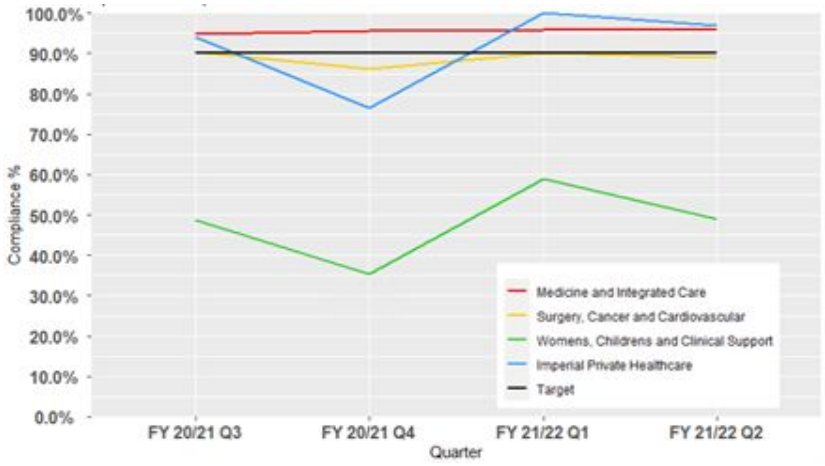
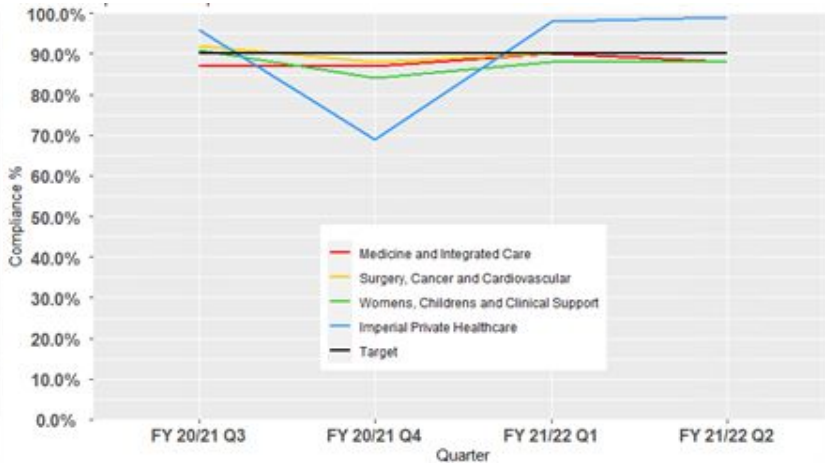
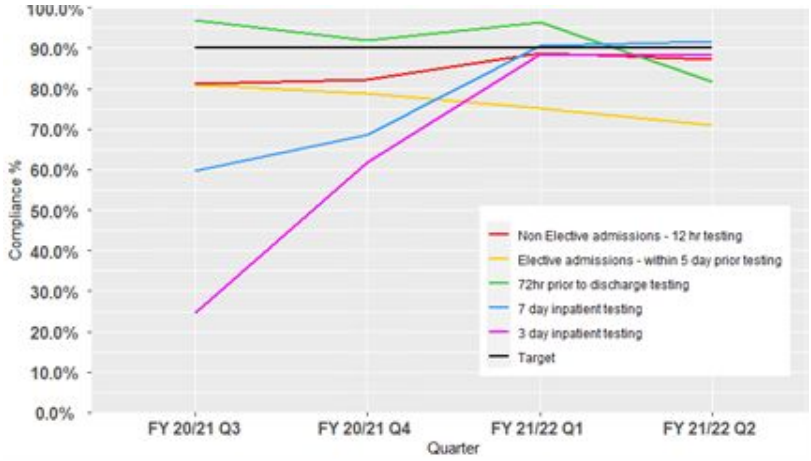


Figure 4: (Left to Right Clockwise) CPE admissions screening compliance by Division, MRSA admission screening compliance by Division, COVID-19 screening compliance by metric. Data range: Q3 FY 2020/21 – Q2 FY 2021/22







Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

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

Agenda item 13 and paper number 10

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

Purpose: For discussion

Meeting date: 10 November 2021

1. Purpose of this report

1.1. This paper provides an update to the executive on our Learning from Deaths (LfD) programme. It includes an updated dashboard outlining activity undertaken as part of the programme in quarter two (Q2) 2021/2022 for approval ahead of submission to NHS England.

2. Executive summary

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

2.2. Our mortality rates remain low, and so far, none of the deaths which occurred in Q2 2021/2022 have been identified as 'avoidable' through the processes outlined in this report. Our Hospital Onset COVID Infection (HOCI) death review process is ongoing, with 29 out of the 53 cases in wave 2 reviewed at a weekly panel chaired by the medical director. A provisional harm level has been attributed to these cases, pending a sector-wide decision to ensure consistency. This decision is likely to result in an increase in incidents reported as extreme harm which will have an impact on our harm profile, and is likely to result in some deaths being confirmed as 'avoidable'. Once the process has been completed for deaths in wave 2, we will undertake the same review for deaths during the first wave.

2.3. The impact of our new SJR process is starting to be seen, with an increase in SJRs completed on time and a subsequent increase in the number of SJRs completed in quarter. This has also led to a rise in the number of SJRs with an overall score of poor care compared to previous quarters.

2.4. All cases of 'poor care' and any other SJRs where there are additional concerns are reviewed at the Medical director's weekly incident panel (MD panel). Of the 6 cases that have been this quarter, two cases have required no further investigation with care deemed appropriate, one has been investigated as a SI and confirmed as moderate harm where the incident contributed to but did not cause the death, one was a fall which did not contribute directly to the death however is reported as major harm in line with national guidance, and one is being investigated as a level 1 as there was a possible delay in administration of antibiotics following a sepsis diagnosis. The details of these cases were reviewed at quality committee and the learning is being taken forward.

2.5. Learning from the SJRs completed in Q2 is summarised in the report. A recurring theme is around treatment escalation plans and end of life care, which is one of the safety

improvement programme priorities for the trust. A new communications plan for learning from deaths is being developed, with the first quarterly LfD newsletter and intranet story planned to launch in November. Learning will also be fed into the winter communications about safety standards where appropriate.

3. Approvals process

This report has been reviewed at the Learning from Deaths Forum, EMB quality group and EMB. The report was discussed and accepted by the Quality Committee.

4. Recommendation(s)

4.1. The Board is asked to note the findings from our mortality surveillance programme in Q2 2021/2022 and to note that the data was approved by the Quality Committee for submission to NHS England on behalf of the Trust Board.

5. Next steps

5.1. The findings from our mortality surveillance programme from Q2 2021/22 will be submitted to NHS England following sign off by the quality committee on behalf of trust board.

6. Impact assessment

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

Main paper

7. Mortality rates

7.1. Compared to other non-specialist acute providers we have the fifth lowest HSMR (Hospital Standardised Mortality Ratio) across the last year of data (July 2020 – June 2021), and the fourth lowest SHMI (Summary Hospital-level Mortality Indicator) (April 2020 – Mar 2021).
7.2. We receive mortality alerts via the Dr Foster analytics services. These alerts relate to cases where death(s) have occurred that require further investigation, either because there is a possible trend/pattern, or the death(s) is an outlier compared to other organisations.
7.3. We received the following alerts in October 2021 for the period between April and June 2021: cancer of pancreas (4 patients), endoscopic resection of outlet of male bladder (1 patient), poisoning by nonmedicinal substances (1 patient), respiratory distress syndrome (4 patients). These are being reviewed and any findings will be summarised in the next report.
7.4. As reported in last month's report, in January, February and March we received 'viral infection' mortality alerts (where Covid deaths are coded) along with most trusts in the country. This alert has not continued as deaths from COVID have reduced. Details of the review process we are undertaking for HOCI deaths can be found in section 9.

8. Summary of learning from deaths data – Q2 2021/2020

8.1. We are required to submit data on learning from deaths to the Trust Board, for onward submission to NHS England (NHSE). The data in Appendix A will be the basis of our submission to NHSE.
8.2. There were a total of 474 deaths in Q2, compared to 359 in Q1 2021/2022.
8.3. Of the total 474 deaths in the last quarter, 60 died with a positive COVID-19 swab within 28 days of death or had COVD-19 on the medical certificate of cause of death, compared

to 13 out of the 359 deaths in Q1 2021/2022. We believe the increase is reflective of increasing background rates in the community with no issues raised. There were 2 deaths in Q2 2021/2022, both in September, where the patient's infection met the Public Health England definition of Hospital Onset COVID Infection (HOCI) because they tested negative for COVID-19 on admission and subsequently tested positive. These deaths are currently being reviewed through our HOCI death review process (see section 9).

8.4. Appendix B shows the total number of deaths and ratio between COVID and non-COVID deaths from March 2020 (start of pandemic) to the end of September 2021. We have reported 963 COVID-19 deaths.

8.5. While the current data does not suggest that our mortality rate is being disproportionately affected by any other factor, there was an increase in the number of deaths in oncology and palliative care in Q2 2021/2022 compared to previous quarters in this directorate. Number of deaths by quarter are shown in Table 1 below.

Table 1. Number of deaths by quarter in oncology and palliative care directorate

	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22
Deaths	11	14	23	16	19	33

8.6. All of these deaths have been reviewed and three cases were referred for SJR, one due family concerns, one due to sepsis and one was because the patient was under 25.

8.7. A SJR has been requested by the medical examiners for 71 (15%) of the deaths that occurred in the reporting period. The triggers for SJRs can be seen in Table 2 below.

Table 2 – Triggers for SJR by quarter

Triggers by Quarter	Quarter 1 20-21	Quarter 2 20-21	Quarter 3 20-21	Quarter 4 20-21	Quarter 1 21-22	Quarter 2 21-22
Medical Examiner Concern	6	8	7	5	4	7
Clinical Concern	5	6	4	3	3	8
Family Concern	5	7	5	4	4	6
Coroner/Inquest	15	15	8	0	0	0
SI / Incident	0	0	1	1	1	0
Vulnerable group	13	14	7	4	5	7
Age Range	20	24	33	16	13	3
Specialty /Condition	0	3	4	7	6	9
Other	9	41	40	35	5	8

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

8.8. The automatic trigger following a coronial referral was removed in December 2020 and the PMRT process commenced at the end of 2020 which has reduced the number cases triggered under the age category. The majority of cases that have triggered under 'other' are HOCI deaths.

8.9. 82 SJRs were completed in Q2 2021/2022. (Note: these SJRs do not all relate to deaths within Q2 2021/2022).

8.10. Of the 82 SJRs completed rating of global care were as follows:-

Number of cases	**Rating of Global Care**
8	2- Poor care
10	3 - Adequate care
50	4 - Good care
14	5 - Excellent care

8.11. There were 8 SJRs completed with an overall score of 'poor' care in Q2 2021/22, which is an increase compared to last quarter when 2 were reported. This has been attributed to the increase in SJRs completed during this quarter (82 compared to 50 in Q1) as a result of the new reviewers being in post.

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

8.13. In Q2 2021/2022, six SJRs were reviewed at MD panel. Of these 6, two cases have required no further investigation with care deemed appropriate, one has been investigated as a SI and confirmed as moderate harm where the incident contributed to but did not cause the death, one was a fall which did not contribute directly to the death however is reported as major harm in line with national guidance, and one is being investigated as a level 1 as there was a possible delay in administration of antibiotics following a sepsis diagnosis. The details of these cases were reviewed at quality committee and the learning is being taken forward.

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

9.1. All deaths of patients who have died after a HOCI with a negative swab on admission and first positive swab more than 8 days after admission are subject to enhanced mortality review. There were 53 cases identified in the second wave of the pandemic.

9.2. Panels chaired by the Trust Medical Director or nominated deputy and attended by MIC, SCCS and WCCS Divisional Management teams and IPC are taking place weekly. Information reviewed includes, Medical Examiner review, SJR, MCCD and investigation reports (post infection review (PIR) for single cases and Serious Incidents (SI) for outbreaks).

9.3. Using a standardised pro forma, the reviews seek to answer the following questions:

- Was the Covid infection hospital acquired?
- Was Covid the primary/main cause of death?
- Were any avoidable care/service delivery issues identified that contributed to this infection?
- What is the agreed level of harm?

9.4. The panel has met weekly since 10th September 2021 and 29 cases have been reviewed so far. The level of harm suggested is in the table below.

Harm level	Number of cases
Extreme (Death)	12
Major	2
Moderate	0
Low Harm	13
No Harm	2

9.5. These harm levels are not currently recorded on Datix. We are working with the rest of the sector to reach a sector-wide agreement of a final level of harm for cases where it is felt that Covid was contracted in the hospital and contributed to the death of the patient to ensure consistency.

9.6. This decision is likely to result in an increase in incidents reported as extreme and major harm which will have an impact on our harm profile. If the harm levels are agreed as they currently stand, then the percentage of incidents causing extreme harm over the last 12 months would increase from 0.01% to 0.08%. This is still below national average (0.2%) and our target, however the review process has not yet been completed for all HOCI deaths so additional cases of harm are likely to be identified.

9.7. Once the process has been completed for deaths in wave 2, we will undertake the same review for deaths during the first wave.

10. Themes and learning

10.1. The completed SJRs are provided to the directorates with the expectation that the learning is shared locally. The new process, when fully implemented, will ensure that learning is shared more effectively across the Trust (see section 11).

10.2. There were some themes and examples of good practice noted in SJRs including:

- Regular, effective multi-disciplinary team review and input into treatment plans.
- Good communication with families.
- Collaborative decision making on ceilings of care and end of life with patients and their families.

10.3. Themes for learning identified from SJRs in Q2 2021/2022 are set out below. All of the findings will be highlighted in a quarterly LfD newsletter and intranet story, which describe scenarios where these issues have occurred. Learning will also be fed into the winter communications about safety standards where appropriate.

- Although there were a number of SJRs which highlight good, timely collaborative decision making on ceilings of care, there were a small number which identified that recording of some decision making was not comprehensive.
- The need for medicines reconciliation to take place as early as possible after admission to avoid any confusion with prescribing.
- There have also been reviews that have highlighted unnecessary diagnostic tests for patients that are coming to the end of their life.
- Response to the deteriorating patient and the need for timely escalation.

10.4. Improving how we agree and document appropriate treatment escalation plans is one of the priority work streams for the next 12 months of our safety improvement programme. The scoping exercise undertaken has highlighted that this is a significant programme of work. A plan is being worked up and will be presented to EMBQG next month. There are likely to be resource and budget implications which will be reviewed through the appropriate processes.

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

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

11.2. The latest data available is for the period March to May 2021. The total number of perinatal deaths reported to MBRRACE-UK in this period was 19. There were 7 PMRTs completed in this timeframe. There were no issues identified as ‘relevant to the deaths reviewed’, however there were several which are ‘of concern but not directly relevant to the deaths reviewed’, meaning that care issues were identified but it was considered that they would have made no difference to the outcome for the baby. Actions being taken in response to these issues are:

- Reminder to staff to appropriately refer women to genetic counselling in the presence of family history (or partner's family history) of genetic conditions.
- Ensure availability of a cold cot for the early bereavement period.

12. Changes to our current learning from deaths process

12.1. In summer 2021, we changed our processes so that we can ensure we are reviewing deaths more quickly, and better identifying, and sharing learning and implementing actions to improve as a result.

12.2. The amended process includes a new structure for SJR reviews. Six consultants from various specialties have been in post since June 2021 and are undertaking reviews. We have seen improvements in timely completion of SJRs within 30 days as a result.
12.3. The reviewers have also been focusing on completing a backlog of overdue cases caused by the availability of reviewers during the pandemic. This is now nearing completion.
12.4. A weekly learning from deaths meeting has been in place since May 2021; this is attended by all 6 SJR reviewers to allow for sharing of learning and triangulation of cases.
12.5. A new learning from deaths forum chaired by an Associate Medical Director commenced in August 2021. The committee reports to the EMB quality group and will also oversee the reporting of data at division and speciality level.
12.6. Communication pathways have been developed to support the governance of outputs from SJRs and the dissemination of themes and learning across the organisation. This also includes teaching and learning events for clinical staff. The first learning from deaths newsletter and intranet story will be published at the beginning of November 2021.
12.7. The learning from deaths policy has been approved and published.

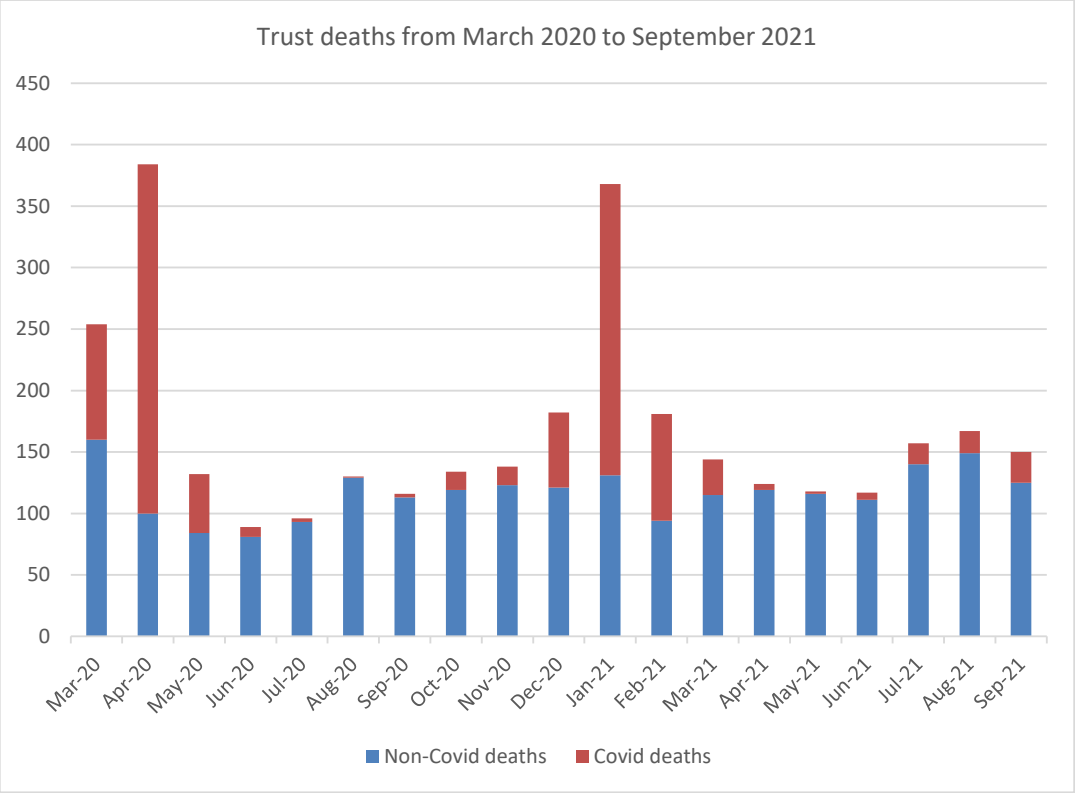
13. Conclusion

13.1. There have been no 'avoidable' deaths identified in Q2 2021/2022 by the processes outlined in this report. However the review of HOCI deaths in the second wave of the pandemic is ongoing. An update will be provided in the next report.
13.2. The review of the learning from deaths process has been completed, with the SJR reviewers now in post and the revised policy approved and published. The new processes for coordination and cascading of learning are currently being implemented.

Author: Darren Nelson, head of quality compliance and assurance
Date: 26th October 2021

List of appendices
Appendix A - Learning from Deaths Dashboard (provided separately)
Appendix B – Number of trust deaths from March 2020 to September 2021
Appendix C – Quarterly PMRT report (provided separately)

Appendix B Number of trust deaths from March 20201 to September 2021



Learning from Deaths Dashboard Quarter 2 2021-22

Up to: **Quarter 2**

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

Latest Quarter

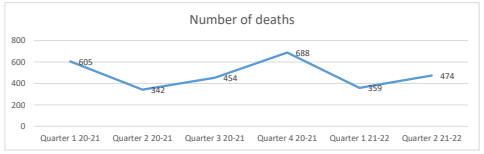
Deaths	Last Quarter	Neonatal Deaths	Last Quarter	Very Poor/Poor Overall Quality of Care	Last Quarter
474	359	Suspended	Suspended	8	2

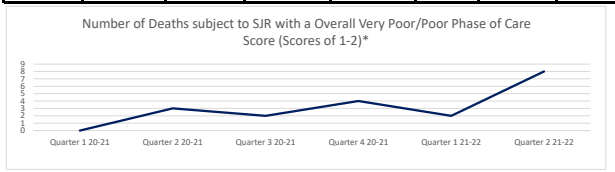
Latest Quarter

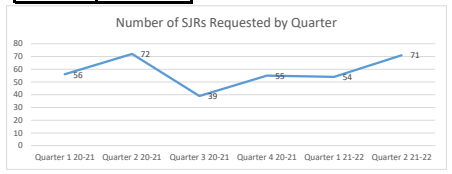
SJRs Requested	Last Quarter	SJRs completed	Last Quarter	Not complete <30 days (%)	Last Quarter	Overdue SJRs	Last Quarter
71	54	82	51	22.54%	29.63%	81	104

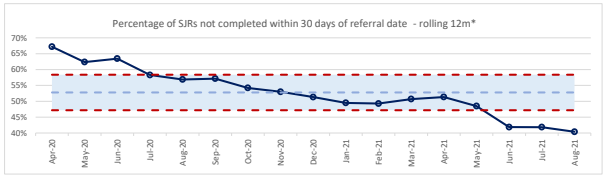
Latest Quarter

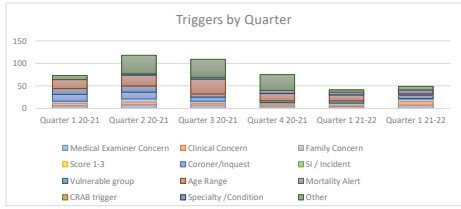
PMRTs requested	Last Quarter
18	12











Suspended neonatal reporting

The SPC above currently shows that a special cause variation occurred from July 20 to February 21 (trend).
* This data is reported 1 month in arrears

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

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: NWL Pathology Annual Report 2020-2021

Agenda item 14 and paper number 11

Lead Executive Director: Saghar Missaghian-Cully, Managing Director NWLP
Author: Angela Jean-Francois, Director of Operations

Purpose: For information/Noting

Meeting date: 10 November 2021

1. Purpose of this report

1.1. The 2020-21 Annual Report for North West London Pathology is presented to the Trust Board for noting.

2. Executive Summary

2.1. The report outlines our year at a glance and the achievements of our organisation.

2.2. The report details the NWLP response to the Pandemic and how Pathology has stepped up to delivering services for Covid-19 PCR, Variant of Concern testing, Covid antibody screening, provision of postal testing and access to Fit to Fly testing.

2.3. The transformation programme that has continued through 2020/2021 is detailed in the report and how this delivers against the strategy for NWLP.

2.4. Pathology is delivering 30 million tests across the organisation per annum.

2.5. Performance, accreditation and risks are outlined for 2020-2021.

2.6. There are over 800 WTE working across NWLP services, across 7 Hospital sites. The Division of Infection Immunity brought in 50WTE to deliver the Covid-19 services across the 7 sites.

2.7. NWLP continues to invest in the training and development of our workforce.

2.8. The Pathology IT department have delivered projects as part of the transformation programme, and supported a number of ICT projects across each of the Trusts. The team has also responded rapidly to changes needed to support COVID-19 and North West London sector requirements.

2.9. NWLP research has a number of goals. Perhaps foremost is fostering new experimentalists who can combine science with an everyday pathology post. Although funds are limited, they can allow pathologists to garner the data to apply for greater funding from NIHR and the Medical Research Council.

3. Approval Process

3.1. The annual report was noted by the Executive Management Board. The Quality Committee discussed and accepted the report.

4. Recommendations

4.1. The Board is asked to note this report.

5. Next steps

5.1. The service will continue to prepare for upcoming accreditation body inspections and focus on improvements to the service.

6. Impact assessment

6.1. Diagnostic Pathology is relied upon for over 70% of clinical decisions made. The service routinely offers hundreds of different tests and investigations daily to requesting clinicians. The service is highly regulated by UKAS, MHRA and HTA.

6.2. Financial impact: NWLP recorded a surplus for the year ended 31 March 2021 of £0.2m compared to a prior year deficit of £7.8m.

6.3. Workforce impact: There are over 800 staff working across NWLP

6.4. Equality impact: Over 60% of our staff are from a Black, Asian and Ethnic minority groups however, there are some areas we can improve on such as staff at Band 8B and above and we will be monitoring our future recruitment in this area. 62% of our staff are within the age groups of 21 – 46 years of age.

6.5. Risk impact: Risk management is an integral part of pathology service provision.

7. Conclusion

7.1. The Annual Report details our development over the past year and highlights the significantly impactful and supportive response we have provided across the healthcare ecosystem in response to the COVID pandemic; all of it while maintaining our high quality pathology service offer. It demonstrates our collaborative working with our Partners and reflects our strong relationship with service users.

Authors:
Saghar Missaghian-Cully, Managing Director
Angela Jean-Francois, Director of Operations
Date: 27 October 2021

NHS
North West
London Pathology

North West London Patho

Annual Report 2020/21

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Message from our Managing Director

"The pandemic has encouraged us to consider new ways of working and has sparked innovation throughout the sector with the introduction of new laboratories and the launch of the diagnostic postal services."

It is my pleasure to present the Annual Report for the year 2020-2021. The pandemic made it an astonishing and challenging year across the NHS , at the same time it brought great opportunity to highlight our strengths as an organisation and we have achieved much for which we can be proud.

We have fought for the best possible outcomes in an uncertain environment and continued to use our expertise to connect and collaborate. The pandemic encouraged us to consider new ways of working and sparked innovation throughout the sector with the introduction of new laboratories and the launch of diagnostic postal services.

This report details our development over the past year and highlights the significantly impactful and supportive response we have provided across the healthcare ecosystem in response to the COVID pandemic; all of it while maintaining our high quality pathology service offer. It demonstrates our collaborative working with our Partners and reflects our strong relationship with service users.

As I reflect on NWLP's vision it feels a privilege to know that our laboratories, coupled with our relentless determination to deliver for the hospitals and communities we serve, have helped in ensuring access to timely testing in the most challenging of times.

This year has truly allowed me to see first-hand the tremendous dedication and commitment from our staff in a time of crisis and has shown how they truly live our core values. I remain proud of the teams and thankful for all that has been achieved.

Saghar Missaghian-Cully, DBMS, CSci, FIBMS, MSc

An overview

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 seven hospital sites across London. We process nearly 30 million tests annually, providing a wide range of diagnostic and clinical support services in North West 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.

Imperial College Healthcare NHS Trust sites:

Charing Cross Hub - Multi-Disciplinary Automated Laboratory, Chemistry (including Specialist Services), Haematology (including Specialist Services), Cellular Pathology, Infection & Immunity (including Microbiology, Virology, Immunology & Serology), Blood Transfusion

St Mary's - Chemistry, Special Haematology, Blood Transfusion

Hammersmith - Chemistry, Special Haematology, Blood Transfusion

Chelsea & Westminster NHS Foundation Trust sites:

Chelsea & Westminster - Chemistry, Haematology, Blood Transfusion

West Middlesex - Chemistry, Haematology, Blood Transfusion

The Hillingdon Hospitals NHS Foundation Trust sites:

Hillingdon & Mount Vernon - Chemistry, Haematology, Blood Transfusion

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:

Clinical Biochemistry

Clinical Biochemistry measures a wide range of substances in bodily fluids, predominantly blood (serum or plasma), urine and cerebrospinal fluid. A 24 hour, 7 day acute core clinical biochemistry service is provided on all Imperial College, Chelsea and Westminster and the Hillingdon Hospitals trust sites with dedicated urgent pathways, monitored by a dashboard.

Haematology and Blood Transfusion

Haematology performs full blood counts and secondary testing to assist in the diagnosis and treatment of various disorders. Our Haematology laboratories also offer additional tests to identify specific conditions, e.g. malaria screening, infectious mononucleosis, and reviewing blood film morphology. Blood Transfusion services are 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 requirements.

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 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.

Molecular Pathology

The Specialist Integrated Haematological Malignancy Diagnostic Service (SIHMDS), is a diagnostic service that includes immunophenotyping (flow cytometry), cytogenetics, and molecular genetics. The molecular genetics laboratory offers a variety of tests to study a range of haematological malignancies which are essential for the diagnosis, prognosis and monitoring of disease. The tests provided are either for molecular diagnostics or minimal residual disease monitoring.

Infection and Immunity Sciences

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.

Point of Care Testing

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.

Clinically Led Services

Consultant Leads are supported by Consultants teams, Clinical Scientists and Specialist Registrars covering all disciplines. 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.

Dr Corrina Wright, Clinical Director

The pathology clinical service is led by Dr Corrina Wright as Clinical Director with Consultant Leads in each pathology service. Corrina is a Professional Clinical Advisor to Public Health England, London, for the cervical screening programme, and has led cervical cytology services for Imperial NHS Trust.

Professor Tricia Tan, Clinical Lead for Clinical Biochemistry

The Clinical Biochemistry service is led by Professor Tricia Tan. Tricia is a Consultant in Diabetes, Endocrinology and Metabolic Medicine at Imperial College London and NHS Trust.

Dr Abdul Shlebak, Clinical Lead for Haematology

Dr Abdul Shlebak is the service lead for Haematology. He has been the lead for Imperial College Healthcare NHS Trust's Haematology diagnostic service since its inception in 2008.

Professor Peter Kelleher, Clinical Lead for Infection and Immunity

The Infection & Immunity service is led by Professor Peter Kelleher. He holds honorary consultant positions with the HIV & Sexual Directorate at the Chelsea & Westminster Trust, the Department of Respiratory Medicine and the Royal Brompton & Harefield Trust.

Professor Mike Osborn, Clinical Lead for Cellular Pathology

Professor Mike Osborn currently works as a consultant histopathologist for at Imperial College Healthcare NHS Trust, London were he is clinical lead for the Cellular Pathology service as well as being the President of the Royal College of Pathologists.

Our Vision and Values

DELIVERING SCIENCE
SUPPORTING HEALTHCARE

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.

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:

Expert

Collaborative

Caring

Patient -focused

2020-2021
Our year at a glance

April

- Saghar Missaghian-Cully takes on Pathology Incident Director role for the Network.
- Saghar and Angela Jean-Francois, Director of Operations take on regional and national roles in response to Covid pandemic management response for pathology.
- Infection and Immunity's new test method for Covid-19 gets national recognition and is selected to be rolled out nationally.
- NWLP supports the implementation of the Covid -19 PCR staff testing programme.
- Dr Corrina Wright and Dr Frances Davies working with Imperial our host Trust establish and lead the Covid -19 staff testing clinic at the Hammersmith site.
- Histopathologists redeployed to support Covid staff testing clinic at Hammersmith.

May

- Dr Mike Osborn elected as president elect of the Royal College of Pathologists.
- Dr Luke Moore and colleagues, has an article published in The British Society for Antimicrobial Chemotherapy and in Nature magazine.
- NWLP reach the milestone of processing over 25k PCR tests for Covid-19.
- NWLP begins processing Covid-19 antibody tests.
- NWLP support on implementation of the Covid -19 Antibody staff testing programme.

June

- Dr Corrina Wright is appointed as Clinical Director for NWLP
- The pathology postal service trial begins.
- Dr Nick Martin, head of trace elements laboratory, appears in BBC Four documentary - Ocean Autopsy: The Secret Story of Our Seas.
- Manfred Almeida, Microbiology Laboratory Manager, wins the Queen's Award for Voluntary Service - the MBE for volunteer groups.
- Two members of staff win prizes from the Institute of Biomedical Sciences.

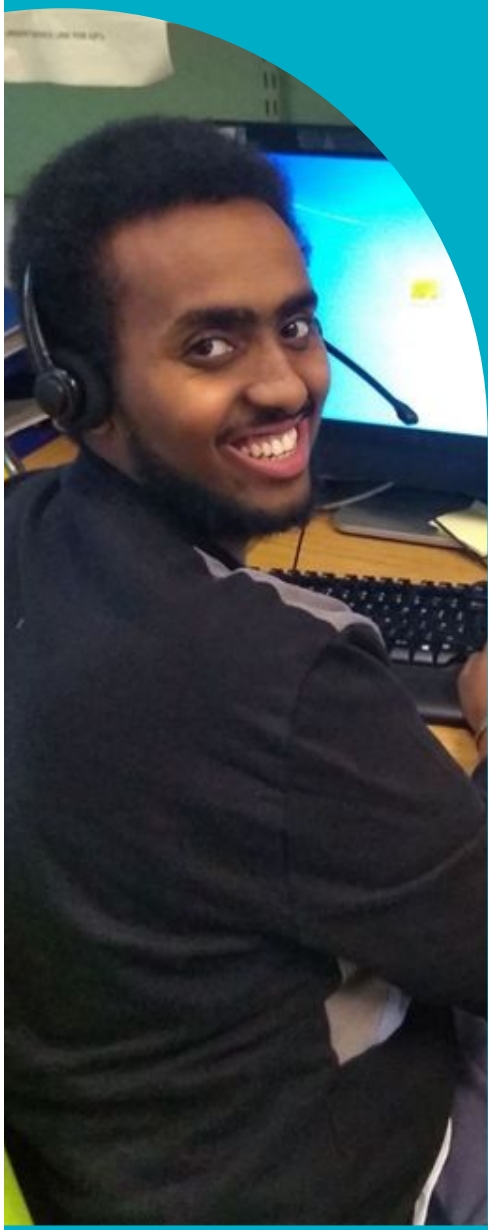
July

- Clinical Biochemistry laboratory at the hub site support the REACT-2 study (Real-time Assessment of Community Transmission) to track how COVID-19 is spreading across England.
- Dr Panos Pantelidis, Infection & Immunity Divisional Manager and Dr Alison Cox, Specialist Biomedical Scientist, receive recognition for work on Covid-19 from Advancing Healthcare Esteem Awards.
- Webinar for GPs led by Dr Paul Randell on: Covid testing, changes in service, lab trends and remote monitoring.

August

- Phase 2a of Multi-Disciplinary Automated Laboratory (MDAL) goes live with HbA1c samples being processed on the automated track at the Charing Cross hub becoming the first site in the UK to connect the TOSOH G11 analysers onto an automated track.
- NWLP Cellular Pathology Clinical Lead, Prof Mike Osborn, co-authors with Dr Brian Hanley a Covid-19 article in The Lancet: Largest study of Covid-19 post-mortems could help clinicians treat severe disease.

2020-2021
Our year at a glance



September

- NWLP's education and research board announces winners of the research co-ordination grants.
- Jill Callard, Medical Secretary in Cellular Pathology, is presented with the Unsung Hero Award from Imperial Trust.

October

- The new Felix laboratory for high-throughput PCR Covid-19 testing goes live.

November

- NWLP celebrates receiving two awards from Royal College of Pathologists for the work associated with Covid-19.
- NWLP is awarded a Certificate of Excellence from Univants for their work during the pandemic.
- Prof Mike Osborn, Cellular Pathology Clinical Lead, begins his role as president of the Royal College of Pathologists.
- As part of National Pathology Week NWLP staff are celebrated for working above and beyond since the start of the pandemic and given specially designed NWLP Covid-19 badges

December

- NWLP successfully bids to for funding to support Covid-19 recovery of cancer services, extending histopathology laboratory hours.

January

- NWLP reaches the milestone of processing over 400,000 PCR tests for Covid-19.
- Luke Moore and colleagues, has article published in The Lancet Infectious Diseases: Structured serology testing is an essential component to investigating SARSCoV2 Covid-19 reinfection

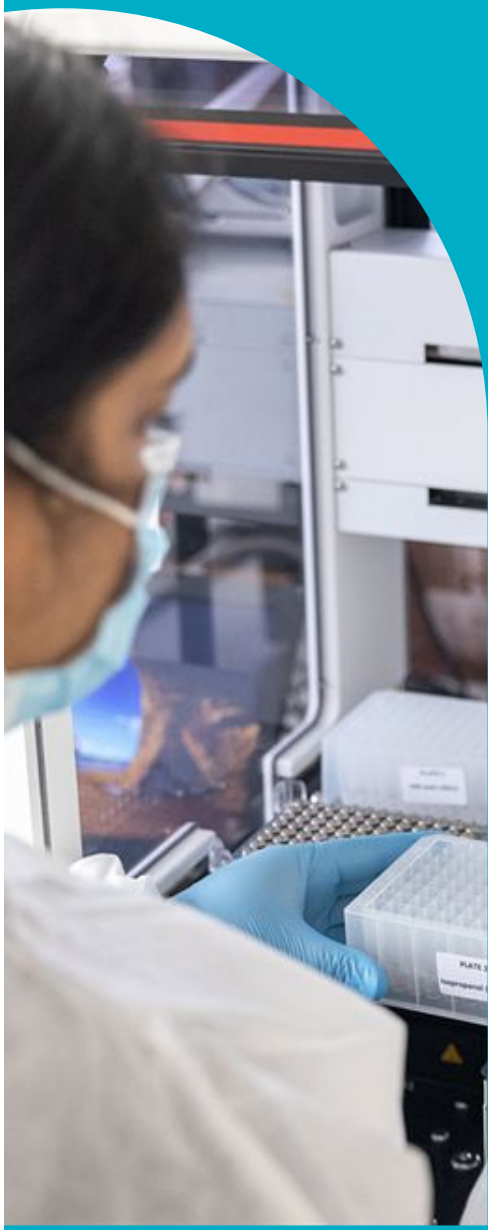
February

- Multi-disciplinary Automated Laboratory (MDAL) phase 2b successfully goes live. Haematology services at the hub site transfer onto the automated track system within the MDAL at Charing Cross.
- The Virology team are presented with their Make A Difference Award Team Excellence Award.
- NWLP celebrates International Day of Women In Science on social media channels.

March

- Interview with Prof Mike Osborn, Cellular Pathology Clinical Lead, is published in Health Europa on pathology and cancer diagnostic services.
- Histopathologists redeployed to support vaccination clinics.

Stepping up to Covid-19



Our laboratory and testing strategy

The requirement to deliver testing for Covid-19 (SARS-Co-V-2) was initiated rapidly within NWLP, with the Infection and Immunity 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.

Molecular testing

In April 2020 NWLP began using a robotic testing platform which led to an increase in testing capacity to 2,500 samples per day. Unlike the vast majority of testing equipment worldwide, the new platform was not reliant on specific reagent suppliers making it more resilient, as different test kits can be used on the same platform.

Community Testing

In March NWLP began processing samples from care homes and GPs to test key workers and patients. In May community testing was increased and community GP hubs are established.

Rapid Laboratories

To support the growing requirement to provide rapid results for COVID-19 diagnosis, NWLP took a strategic approach to deliver a suite of rapid COVID-19 instruments which aimed to future proof services to support the clinical requirements of rapid molecular diagnostics.

Based on this, NWLP implemented bespoke rapid COVID laboratories across all Trusts which utilised a range of devices including DnaNudge, Cepheid Gene Expert, Biomerieux Biofire and the Mobidiag Novodiag. This diversification allowed COVID-19 results to be delivered within 1 hour.

Antibody Testing

In May NWLP processes the first batch of tests for patients and staff with 900 samples processed on the first day.

PCR Testing

By July the Infection and Immunity team are processing 2,000 PCR tests per day – equivalent to the entire workload of the Immunology service pre-pandemic.

New Covid-19 PCR lab

A new COVID-19 PCR lab called the Felix laboratory goes live in October. This increased our molecular testing capacity for COVID-19 samples in preparation for the coming months. NWLP ends the year with a capacity of 4500 tests per day able to be performed.

Variants of Concern and Genotyping

Testing for Variants of Concern and Genotyping are introduced towards the end of the year.

Stepping up to Covid-19

Responding to Covid-19

National Reporting

During the COVID-19 pandemic there was a national requirement for reporting on many elements of COVID-19 testing. NWLP was responsible for reporting on behalf of the entire London 1 Network. The reporting requirements involved building a bespoke daily SGSS data extract to PHE, building daily and within day Covid-19 report summaries to the Infection control team at Hillingdon Hospital and completing the daily testing volumes.

Covid-19 Dashboard

During the COVID pandemic it was critical to understand the service status at any given time. Using innovative methods, NWLP designed and built a bespoke daily and near real-time management dashboard which included changes in activity, KPI status, COVID testing capacity vs usage and staffing levels. This allowed the service to be more flexible in response to acute changes and provided a direct near real-time data feed to NHS North West London COVID Gold command.

Staff Testing

Working with the Medical Director's office at Imperial, NWLP were a key part of the set up of the staff testing programme across the sector. As well as advising on workflow and laboratory practices, the scope included producing multiple, within-day clinical reporting for a range of staff and patient categories as well as a data feed to provide SMS text results to staff. All of this included segregation of staff/patient and symptomatic/asymptomatic detail.

The support from NWLP involved building a near real-time COVID-19 report to the Imperial Track & Trace team for any staff positive with a COVID-19 result, thus allowing for the staff member to be isolated as quickly as possible, especially so for asymptomatic testing.

Academic Contributions

Throughout the pandemic, NWLP staff continued to contribute to the academic community by publishing a number of papers .

Pathology Postal Service

In response to the need to continue patient monitoring during the pandemic, NWLP developed a postal pathology service which allowed patients to collect their own blood from their own homes using a finger prick collection method. The service has been validated for use with tests such as HbA1c, Liver Function Test (LFTs), Lipids, Creatinine and Tacrolimus. It is being used to help support virtual clinics such as renal transplant, diabetes and TB services and is especially helpful for our most vulnerable patients.

2020-2021 Our transformation programme

Due to the COVID pandemic, all non-essential activity including the transformation project was paused in March 2020. This allowed members of the transformation team to be redeployed to the laboratory and support pathology's response to the the ongoing need of the pandemic.

In July 2020 the transformation programme was reviewed to assess the capacity of the organisation to begin delivery. From August 2020 programme activity slowly resumed and was able to pick up pace by October 2020. By March 2021 the transformation team had made tremendous progress and enabled the go-live of the significant milestone of the Laboratory Information Management System (LIMS) deployment at the Hillingdon and Mount Vernon sites.

This meant LIMS was harmonised across all NWLP sites, and delivery of the first replacement for aging Blood Transfusion LIMS allowing the service to move to a true hub and spoke operating model.

The following milestones were delivered August 2020-March 2021:

August

- Blood Sciences MDAL phase 2a successfully went live with 4 x G11 Tosoh instruments for HbA1c analysis connected to a Total Laboratory Automation (TLA) track solution. NWLP were the first laboratory in the UK to achieve this and only the second in Europe.
- Infection & Immunity MALDI-ToF instrument went live.

September

- Cellular Pathology consultants from the Hillingdon began to re-locate to the Charing Cross hub.
- Infection & Immunity MAST Uri System went live.
- A second Infection & Immunity MALDI-ToF was taken live.
- Cellular Pathology SMART AP phase 2 went live.

October

- The Andrology service transferred from Hillingdon to Hammersmith resulting in a fully centralised service.

November

- The remaining Cellular Pathology laboratory service transferred from the Hillingdon to the hub at Charing Cross completing the centralisation of the Cellular Pathology services across the network.
- Both the Infection & Immunity and Clinical Biochemistry Optilite instruments were taken live.
- The MDAL phase 2b project comprising the connection of the Haematology and Coagulation instrument to the TLA re-started.

2020-2021 Our transformation programme

January 2021

- In response to challenges with incumbent Haematology instruments at the Hillingdon site there was a requirement to expedite the equipment replacement project. In January 2021, plans were re-evaluated to provide a solution to this in the timescales required to protect the service.
- The Hillingdon LIMS cut over planning began.

February

- The MDAL Phase 2b moved to live resulting in the successful connection of the Haematology and Coagulation instrument to the laboratory integrated solution.
- The Hillingdon LIMS user acceptance testing completed.

March

- Centralisation of the Hammersmith and Chelsea and Westminster haemoglobinopathies screening activity to the St Mary's site completed.
- The Hillingdon and Mount Vernon LIMS project passed though both the gateway to exit user acceptance testing and to move into the go-live phase.

In addition to the above, further equipment installations across the network have been undertaken as part of the plans for future equipment replacement and roll out projects.

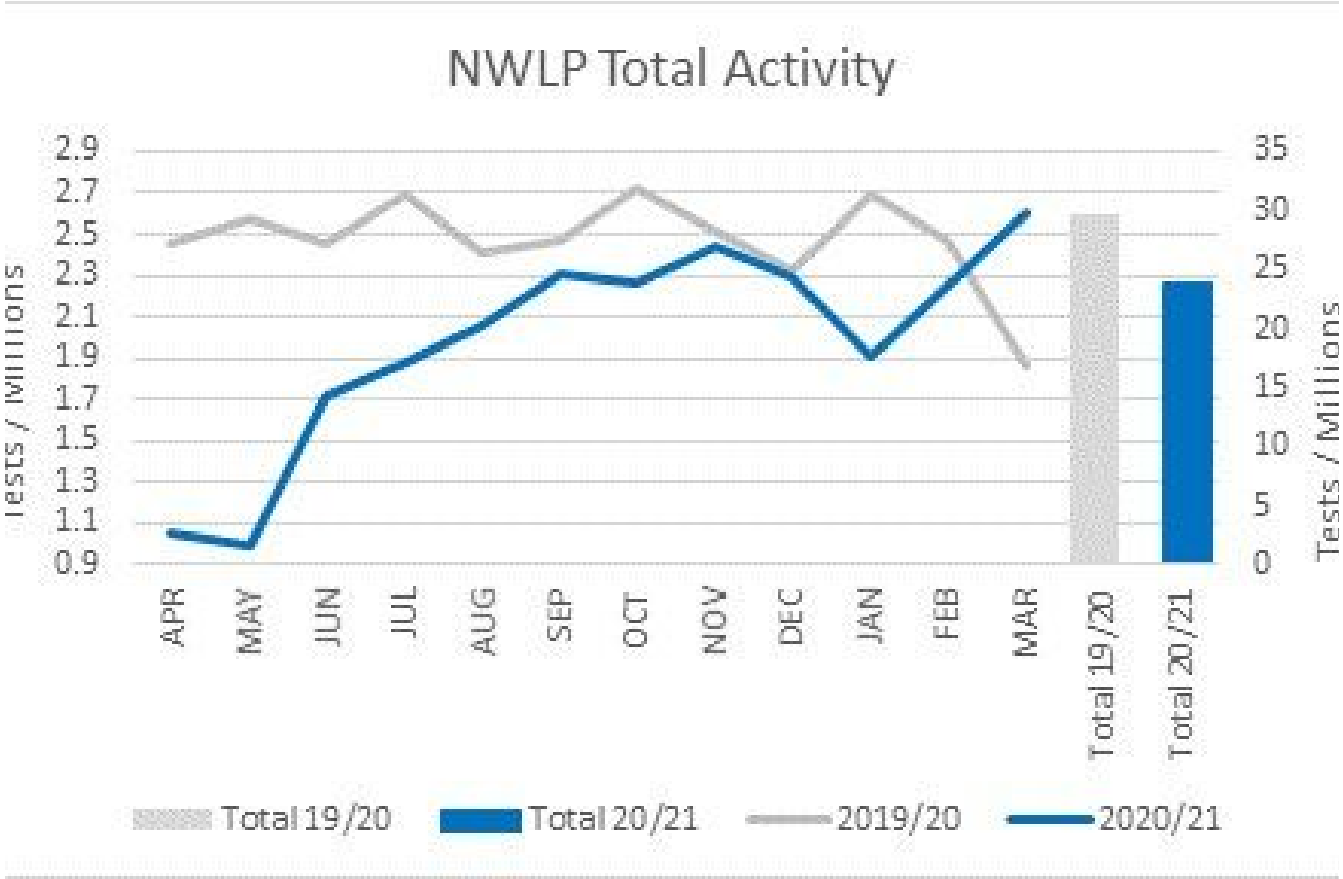
The next months will be critical for the transition as the final NWLP site moves go live with the LIMS deployment and the programme completes major element of the service transfer.

TOTAL ACTIVITY

March 2020 - April 2021

The service experienced a decrease in activity due to the impact of the pandemic and government guidelines associated with lockdown measures. This affected both internal acute Trust activity as well as primary care.

Activity across the financial year was variable relating to the tightening and relaxing of government COVID restrictions. An example of this can be seen in January 2021 where a drop in activity aligns with the UK entering a third national lockdown.



Our Key Performance Indicators

There are four key performance indicators (KPIs) used to monitor NWLP's performance. Like many NHS services, 2020/21 has been a challenging year for NWLP as the organisation contended with the difficulties and change in requirements due to the COVID pandemic.

1

A&E blood sciences turn-around-times. Target 90%.

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. The overall KPI average performance for the year was 94%, a 4% overall improvement on 2019-20 figures.

2

Histopathology diagnostic biopsy turnaround times. Target 80%.

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 KPI is not restricted to cancer pathway cases. Over the past 12 months the average performance was 67%

3

Overall Histopathology reporting turnaround times. Target 90%.

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. Over the past 12 months the average performance was 82%.

4

Routine antenatal screening tests for Hepatitis B, HIV, Syphilis, and Rubella susceptibility. Target 90%.

Percentage of routine antenatal screening tests for Hepatitis B, HIV, Syphilis, and Rubella susceptibility reported, confirmed, authorised and electronically available to requestor within 5 calendar days from sample being taken. Over the past 12 months an average performance of 100% well above target.

Incidents, Compliments and Complaints

A brief summary of incidents, complaints and compliments over the past year. Recording and monitoring these provides us with critical insight about how we are managing incidents. The aim is to continuously improve our incident management, incident response solutions and breach notifications.

23m

Tests

In 2020/21 our annual activity was 23,788,523 tests.

0.01%

Errors Reported

There were 3026 errors reported in 2020/21 against an annual activity of 23,788,523 tests. This results in the service having a 0.01% errors reported rate which is comparable to 2019/20.

23

Serious Incidents

There were 14 externally reportable and 9 internal serious incidents reported. Incident themes were identified as result delays, wrong results, missing specimens and failure in the communication of results. Actions were taken to prevent recurrence of incidents across all themes.

159

Compliments and Complaints

There were 41 compli
The most frequent th
result delays (from a
not performed. Delay
delayed histopatholog
reported complaints. Us
further information to redu
expectations for Covid-19 test
times. Service improvement action pl
been formulated to address issues identified in histopathology. Feedback has been given to requesting GPs to ensure sample acceptance requirements are understood and requests are not rejected.

72

Health and Safety Incidents

There were a total of 72 health and safety incidents reported on across NWLP. Of these, 23 were RIDDORS; 22 were linked to ‘cases of disease’ due to a COVID outbreak and one related to a fall sustained within the hospital, but outside of Pathology.

Accreditation Status

All our laboratories at the Imperial sites, Chelsea and Westminster site and West Middx site site are accredited by UKAS against ISO15189:2012. 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)

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 (www.nwlpathology.nhs.uk) 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.

Risk Register

At the end of March 2021, there were 37 open risks, 29 of which were scored high risk (12) or above and eight were scored medium. In April 2020 the top **five** risks on the NWLP risk register (with associated resolutions) were:

1. **A risk to patient safety due to delays in processing and reporting of histopathology specimens at Charing Cross**

   Consolidation of all cellular pathology laboratories at the hub s[illegible] March 2020 which improved workflow with all samples being processed on one site. In May 2020, due to the impact of the national shortage of pathologists we had a 20% vacancy shortage of consultants within the service. Our posts were filled with temporary staffing until substantive appointments could be made.

   The service undertook a detailed workflow review to further optimise Histopathology, the outcome was an improvement plan for the laboratory. The service was able to secure funding through the Royal Marsden Partners in order to extend the working hours in the laboratory for four months.

2. **Histocompatability and Immunogenetics laboratory**

   The Histocompatibility & Immunogenetics laboratory's deceased donor tissue typing service was closed in November 2020. Following recruitment of additional staff to support the service it was resumed in October 2021.

3. **Containment Level 3 safety cabinet failure**

   There was a risk of failure of equipment (safety cabinets) in the containment level 3 facility in Microbiology. Phase one of the work was completed in July 2020 with phase two in October 2020. The work was delayed initially due to funding and then the Covid-19 pandemic. The risk was associated with staff safety and continuity of service.

4. **Access to supplies for Covid 19 molecular PCR testing**

   Access to supplies for Covid-19 testing and the provision of a pathology service as a whole during the pandemic was assessed and added to the NWLP risk register. These risks were being managed as part of the national response to the pandemic. There was no significant impact to the pathology service regarding access to supplies, NWLP executives worked closely with NHSEI to manage supply issues should they arise.

5. **Ageing equipment in the pathology laboratories**

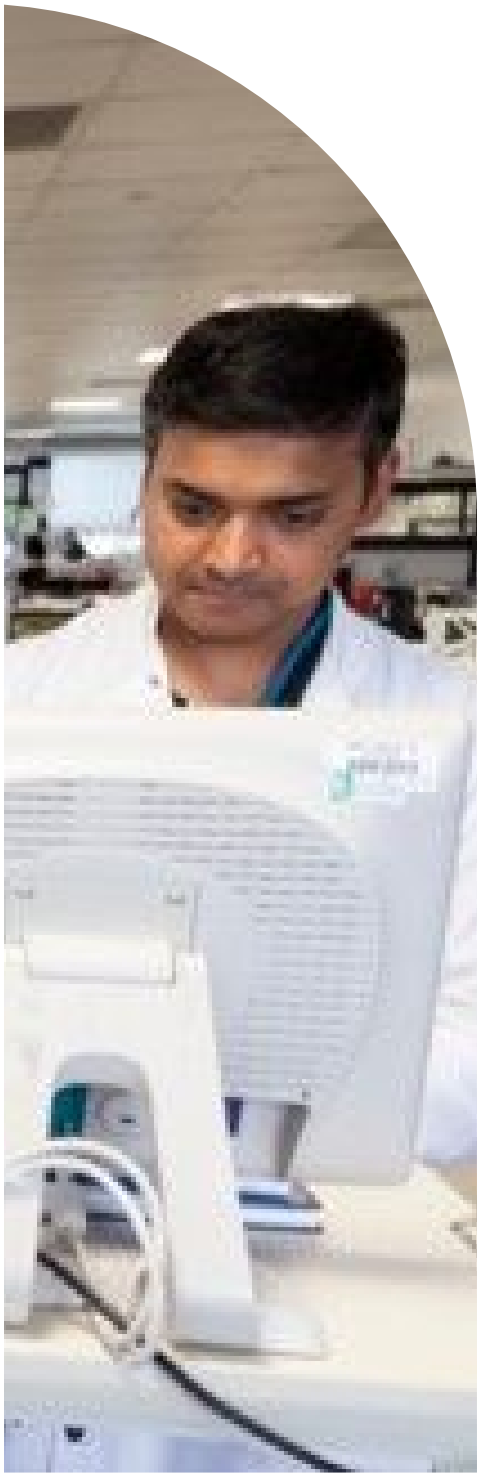
   A significant investment has been made in many areas of pathology as part of the extensive transformation programme. There remain a proportion of equipment that were outside of this process, this aging technology will be managed through asset replacement management.

DELIVERING SCIENCE SUPPORTING HEALTHCARE

Workforce

This year we are even more proud of all our staff and recognise the important role they played within the service. Our performance has depended on staff working on site in laboratories across the network.

There was a significant impact on how we work and keep safe and all staff adapted to working practices to keep safe in the workplace and to work remotely where possible. The pandemic delayed our progress on implementing our target operating model, however, we were still able to complete many of the planned consultations and changes to the service.



Our Workforce

The workforce establishment fluctuated during the year due to the movement of staff between the sites.

There were 800 WTE in post

There were 134 WTE bank and agency staff members working in the service each month.

The Infection and Immunity Division brought in 50.0 WTE posts that were essential for the delivery of the service for Covid testing in the newly set up laboratories. These posts were filled either by bank and agency or fixed term.

As part of the transformation programme and to minimise the potential for redundancies, posts were not filled on a substantive basis. This has led to high vacancy rates during the year, ranging from 15.2% to 23.19%.

Staff Turnover

Turnover through 2020/21 remained at similar levels to the previous years between 13.5% and 15.3%. There were 112 leavers during the year. Our Blood Sciences Division had the highest number of leavers due to the end of fixed term contracts as well as the uncertainty associated with the upcoming staff consultations across all our sites. The most common reason for leavers was promotional opportunites elsewhere, followed by staff relocating and the end of fixed term contracts.

Change Management – Staff Consultations

In January 2021, Blood Sciences commenced their consultation, which affected some 400 staff. Due to the complexity of this process, it was further extended to 3rd March 2021 in agreement with our staff side colleagues.

This was a large scale consultation including changes to skill mix for each site, rota changes, out of hours arrangements and consolidation of all staff onto Agenda for Change terms and conditions.

Staff Engagement

All Staff Briefings

Due to being unable visit each site for regular meetings with staff, online monthly meetings were held ensuring staff were kept up to date and enabling feedback.

Staff Engagement Group meetings

We continued our monthly staff engagement group remotely which proved to be more successful as it enabled staff from all sites to participate. This group includes NWLP Directors as well as representatives from each site (grade 7 and below) to share views and questions raised by their colleagues.

Staff Events

In December an NWLP on-line Christmas quiz was organised. There were 7 teams with team names ranging from “The Unlikely Crew, Spartans of Blood Sciences to the Ding Don DNAs”. This proved very successful and we will be looking to run further staff engagement events such as this in the future.

NHS Staff Survey

The national response rate was lower than the previous year and this was echoed in our response rate, which was to be expected as the survey was run during the pandemic.

- A total of 410 staff responded to the survey.
- Our response rate was 49.5%, compared to 53% in 2019 and 29% in 2018.
- Overall our engagement score was 6.8 which was similar to the previous year.

The results were shared with our staff, at our staff briefings, staff engagement group, partnership committee and discussed at our workforce committee. Managers were then asked to discuss the outcomes and develop appropriate action plans. Key areas to concentrate on and develop actions plans were around: Immediate Managers; Morale; Staff Engagement; Quality of Care and Team Working.

We also undertook a comparison to three other pathology providers and our scores were very similar. This was against a period of uncertainty for staff due to the pending staff consultants which were carried out some months later.

Staff Development

Although all non-mandatory training was suspended during the pandemic, as an organisation we continued to support and develop our workforce.

Training for Band 8a line managers
ACAS were commissioned to provide training for Band 8a line managers to support them through the change process.

Induction booklet
As face to face corporate inductions were suspended, we developed a welcome pack for new starters designed to give an introduction to NWLP as part of our continued improvement to on-boarding, engaging and retaining staff.

Workforce Committee

The Workforce Committee was created in 2020 to support the NWLP workforce strategy and to ensure that NWLP meets its obligations in relation to the people agenda and forthcoming workforce challenges. The main focus of the group is to:

- Review monthly workforce KPI reports and engagement surveys
- Develop appropriate action plans to improve performance and retention of staff
- Ensure we have a diverse workforce at all levels
- Review monthly training reports to ensure that we are utilising training funds appropriately

Equality / Diversity

Working with our host organisation we are continuing to create a more inclusive workforce to ensure that we recognise each person's unique perspectives when we work together.

We are pleased that two members of NWLP have become BAME ambassadors and we are well represented on Imperial's Equality, Diversity and Inclusion Committee and Workforce Race Equality Standard Steering Group.

Over 60% of our staff are from a Black, Asian and Ethnic minority groups however, there are some areas we can improve on such as staff at Band 8B and above and we will be monitoring our future recruitment in this area. 62% of our staff are within the age groups of 21 – 46 years of age.

Pathology IT

The Pathology IT department has had an extremely busy year providing an excellent service to operations as well as those using our pathology services from GPs to hospital trust staff. The team has delivered projects as part of the transformation programme, and supported a number of ICT projects across each of the Trusts. The team has also responded rapidly to changes needed to support COVID-19 and North West London sector requirements.

IT Project Activity

Sunquest (v8.3) LIMS roll out at Hillingdon

The LIMS system is a key enabling project to enable the full harmonisation of IT across all NWLP sites. This will replace the legacy LIMS system and enable the transfer of activity into the hub and spoke model for pathology services. The implementation also includes the deployment of the Sunquest Blood Bank system that will eventually replace the legacy transfusion systems across all NWLP sites. The project will include a number of analyser replacements which will be integrated to the LIMS with full ordercomms connectivity. The project has been underway since 2019 and received sign off to move to the deployment phase on 31st March 2021.

Cerner CIE Integration

Pathology information was integrated into the Cerner CIE record, enabling results to be accessed throughout this network. This also can be used to support data informatics for discrete data.

Multi-disciplinary Automated Laboratory (MDAL)

One of the most significant and complex projects within the transformation programme has been the implementation of the MDAL, a project heavily reliant on pathology IT and integration. Phase 2 of the MDAL went live in February enabling the service to operate as a hub site for all GP activity. This deployment of a large automated track physically connected to a number of analysers and additional supportive pre/post analytical systems to it, along with integrated IT with the LIMS system to facilitate orders and results to flow seamlessly between systems. This highly automated development allows for high throughput processing expanding on the benefits of large scale consolidation and standardisation.

SMART AP

The second stage of SMART AP - a sample tracking and audit software specifically for Histopathology samples - went live providing further 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.

Microsoft Windows 10 Upgrades

A large, complex project to upgrade over 800 PCs as well as servers used by NWLP was undertaken to ensure the organisation is operating using Windows 10. Working closely with Imperial Trust ICT department, these upgrades have enabled a smooth transition into new applications used within NWLP such as the Dragon Voice dictation system.

Covid-19

The Pathology IT department responded quickly to any requests to support changes and new implementations around Covid testing and patient pathways. The team worked at accelerated pace to support the setup 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 as well as Point Of Care Testing (POCT) based devices.

Business Intelligence

The Business Intelligence team has completed a wide variety of projects and introduced a number of new reports providing detailed current data on all aspects of our business for NWLP staff, NWLP Partners and our clients.

During 2020/2021 there was also a significant workload due to the transformation programme. Many of the initiatives were due to the COVID-19 pandemic. Due to a rapidly changing environment timescales for design and implementation were short with considerable flexibility needed to keep pace with requirements.

Between April 2020 – March 2021, the team completed 357 ad-hoc requests for data (reasons include: service evaluations, clinical audits, research, and additional data in support of third party income invoices).

Research

NWLP research has a number of goals. Perhaps foremost is fostering new experimentalists who can combine science with an everyday pathology post. Although funds are limited, they can allow pathologists to garner the data to apply for greater funding from NIHR and the Medical Research Council.

NWLP research funding helps establish new diagnostics. Pathology data and single exemplars can be exploited to establish new pathological mechanisms, test and monitor new drugs to demonstrate clinical effectiveness, and help understand side effects. We aim to integrate new measurement techniques and science breakthroughs into everyday pathology for patient benefit.

We have also 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 and inculcating the scientific approach in everyday diagnostics.

Haematology Research

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

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 and immunity Research

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 Research

Cellular pathology has received NWLP grants in renal, gynaecological, gestational trophoblastic, hepatic, gastrointestinal, lung disease, neuropathology and haematopathology research. They have published 41 articles 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 play key roles in several journals and research committees.

FINANCE

1 Summary Ope

The following table summarises the operating financial position of NWLP for the Year to March 2021:

OPERATING I&E	Year to 31/3/2021	Year to 31/3/2021 (Excluding Covid)	Underlying Movement (Excluding Covid)	Year to 31/3/2021 (Covid)	Year to 31/3/2021 (Including Covid)
	£'000	£'000	£'000	£'000	£'000
Income	81,792	85,438	3,646	7,025	92,463
Non Medical Pay Costs	(41,287)	(40,303)	984	(1,813)	(42,116)
Medical Consultant Pay	(9,053)	(9,162)	(110)		(9,162)
Non Pay Costs	(37,540)	(35,203)	2,337	(5,212)	(40,415)
Direct Costs	**(87,880)**	**(84,668)**	**3,211**	**(7,025)**	**(91,693)**
Transition Costs	(1,663)	(591)	1,072		(591)
Operating Deficit after Transition	**(7,751)**	**178**	**7,929**	-	**178**

NWLP recorded a surplus for the year ended 31 March 2021 of £0.2m compared to a prior year deficit of £7.8m. The improved position for NWLP is largely due to the treatment of income under the Covid block arrangements. Income for Partner and CCG activity were fixed during the year, to mirror the NHSEI block funding arrangements with Partners. Covid income and expenditure were directly offset through the specific covid funding mechanism. Costs for the core services were however lower than prior year due to the reduced activity across the rest of the service. As activity and services return to pre Covid levels we expect the income and costs to return to pre Covid levels.

Underlying Non Medical employee costs, excluding Covid staff, reduced year on year by £1.0m.The organisation absorbed inflationary pressures and achieved a cost reduction on this line by managing temporary staffing costs where reduced activity in the service allowed.

Medical staff costs have increased slightly year on year, largely due to inflationary pressures. Underlying Non Pay costs reduced by £2.3m compared to the previous year, largely due to the reduced activity across the service.

Transformation costs were significantly lower than plan as the transformation programme was paused for much of the year to allow the service to focus on responding to the Covid Pandemic.

PATHOLOGY SERVICES INCOME	ICHT	THH	CWH	TOTAL
	£'000	£'000	£'000	£'000
2019/20				
Trust Pathology Services	32,269	2,829	22,676	57,774
GP Income				19,445
Other Third Party				4,573
BUDGET TOTAL	32,269	2,829	22,676	81,792
2020/21				
Trust Pathology Services	33,221	2,896	23,593	59,711
Covid Income				7,025
GP Income				20,431
Other Third Party				5,297
ACTUAL TOTAL	33,221	2,896	23,593	92,463
Movement				
Trust Pathology Services	952	67	918	1,937
Covid Income				7,025
GP Income				986
Other Third Party				723
VARIANCE TOTAL	952	67	918	10,671

The year end overall contribution required from partners was £59.5m, £6.0m lower than 2019/20. Partner contributions to the NWLP total costs are comprised of two key elements:

- Pathology Services Charges, which includes Partner Acute services but excludes GPDA and Other Third Party Income; and
- Share of NWLP Deficit, which includes a contribution to transition costs.

Partner Pathology Services charges were £1.9m which reflects mainly inflationary pressures that were encompassed in the block funding arrangements.

The £6.0m reduction in service was driven primarly by cost reductions in the service and transition costs.

TOTAL PARTNER CONTRIBUTIONS	ICHT	THH	CWH	TOTAL
	£'000	£'000	£'000	£'000
2019/20				
Trust Pathology Services	32,269	2,829	22,676	**57,774**
Share of Deficit (including transition	4,743	1,463	1,544	**7,750**
Total Income	**37,012**	**4,292**	**24,219**	**65,523**
2021/21				
Trust Pathology Services	33,221	2,896	23,593	**59,711**
Share of Deficit (including transition	(109)	(34)	(36)	**(178)**
Total Income	**33,112**	**2,862**	**23,558**	**59,532**
Movement				
Trust Pathology Services	(952)	(67)	(918)	**(1,937)**
Share of Deficit	4,852	1,497	1,579	**7,928**
Total Income	**3,900**	**1,430**	**662**	**5,991**

cts

During March 2021, the decision was taken to close the transformation programme, in light of the COVID-19 Pandemic. The programme was reconfigured during the year in order to re-start the remaining aspects of the transition. Transformation costs for the full year 2020/21 were therefore £0.6m which is considerably lower than prior year or planned for the current year.

As the programme picked up pace during 2020/21, we have estimated the costs of completing the programme to be a further £2.2m during the year to 31 March 2022.

	Project to March 2021			
£'000	Spend B/F at 31/03/20	Spend for year to 31/3/21	Forecast Costs to end of Project	Forecast Project Outturn
Central PMO	738	139	101	978
Estates	1,324	58	95	1,477
IT	3,320	242	577	4,139
Pathology Services Transition	1,090	64	244	1,398
Transition Project Cost	**6,472**	**504**	**1,015**	**7,991**
Workforce	676	87	1,216	1,979
Total Transition Cost	**7,148**	**590**	**2,232**	**9,970**
Total Revenue Transition	**3,224**	**592**	**1,928**	**5,743**
Net Balance Sheet Transition Cost	**3,924**	**(1)**	**304**	**4,227**

DELIVERING SCIENCE SUPPORTING HEALTHCARE

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Published October 2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Annual review of Trust Board Committees and Board governance update

Agenda item 15 and paper number 13

Executive Director: Peter Jenkinson, Director of Corporate Governance
Author: Ginder Nisar, Deputy Trust Secretary

Purpose: For decision

Meeting date: 10 November 2021

1. Purpose

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

2. Executive summary

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

2.2. Over the summer, Board members and regular attendees of the Board and its Committees engaged with the annual effectiveness review of the Board and Board Committees. The outcome of these effectiveness reviews were included in a Committee annual report produced for each Board Committee, which also included an assessment of how each committee had fulfilled the requirement of their respective terms of reference. Each committee considered its annual report and outcome of the effectiveness reviews during the September/October cycle of meetings. A summary of the outcome was provided in an overarching report to the Audit, Risk and Governance Committee who will oversee the key actions arising from this exercise.

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

- Audit, Risk and Governance Committee, 4 November 2021
- Finance, Investment and Operational Committee, 3 November 2021
- Quality Committee, 3 November 2021
- Redevelopment Committee, 2 November
- People Committee, 4th May 2021 (not reviewed as this is a new Committee)
- Remuneration and Appointments Committee, 20 October 2021

2.4. As part of the effectiveness review, specific feedback was provided by the non-executive directors on the current meeting schedule. Feedback showed that while there are benefits of convening Board Committees within one week, including the timeliness of performance data and cross-committee working, the schedule is currently onerous.

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

3. Recommendation

3.1. The Trust Board is asked to note this update and to approve the continued delegated authorities to the Board committees as set out in the respective terms of reference and agreed by each committee.

4. Impact assessment

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

Authors
Ginder Nisar, Deputy Trust Secretary
3 November 2021

Reading Room
Terms of reference for:

- Audit, Risk and Governance Committee, 4 November 2021
- Finance, Investment and Operational Committee, 3 November 2021
- Quality Committee, 3 November 2021
- Redevelopment Committee, 2 November
- People Committee, 4th May 2021 (not reviewed as this is a new Committee)
- Remuneration and Appointments Committee, 20 October 2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Audit, Risk & Governance Committee report

Agenda item 16.1 and paper number 14a

Committee Chair: Kay Boycott, Non-Executive Director
Author: Jessica Hargreaves, Deputy Trust Secretary

Purpose: For information

Meeting date: 10 November 2021

1. Purpose of this report

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

2. Introduction

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

3. Key points

3.1. The key items to note from the Audit, Risk and Governance Committee meeting held on 4 November 2021 include:

3.1.1. External Audit

The Committee received an update, including some forward looking into potential audit requirements for NHS trusts such as climate response. The Committee noted that the launch of the Trust's Green Plan would support the Trust in meeting such requirements.

3.1.2. Internal audit

The Committee received the internal audit progress report noting the progress against the internal audit plan as well as progress with actions. Committee members also noted and discussed the thought leadership around medical device connectivity and cyber security and the importance of data going into an integrated care system. The Committee noted areas of strategic risk highlighted in the internal auditor view of the wider risk universe – these would be considered by the executive against current risks captured.

The Committee received an update from the counter fraud team and were pleased to note that all work was on track and on target against the work plan. In relation to an ongoing criminal case the committee asked for further information on the lessons learned.

Committee members noted that the national fraud initiative exercise that had been completed for 2020/21 had identified 686 high priority matches which were now being investigated; the process would be completed by the end of the year and the Committee was assured that no fraud matches had been identified so far.

3.1.3. **Risk and assurance update**

The Committee received an update on the development of governance arrangements for the North West London acute provider collaborative and reviewed and discussed the acute programme risk register. Committee members noted that the next steps would include collation of existing collaborative relationships and consideration of what they are already delivering, developing the principles of collaboration for approval by Trust boards, framing the ambition of the group and agreeing the resource required to support the programme. The next board seminar in December 2021 would include further discussion regarding the development of a collaborative and the role of a Trust board in such a collaborative.

The Committee reviewed the Trust risk and assurance report and noted that the new risk rating matrix had been implemented in the Trust and the risk management policy and strategy would be reviewed and updated in January 2022. Two new risks had been added to the corporate risk register since the previous meeting; ICS and acute provider collaborative governance arrangements and leadership capacity. Committee members reviewed these new risks and the mitigating actions in place.

The Committee received a summary of the risks and assurances that had been discussed at the other board committees.

3.1.4. **Tech assurance deep dive**

The Committee had a 'deep dive' discussion about technology assurance in the Trust and reviewed and discussed the technology assurance framework which had been developed by the ICT senior leadership team with support and guidance from PwC. The framework focused on three elements; understanding existing sources of technology assurance through discussions with management and review of system and process documentation, mapping the sources of assurance to the 'three lines of defence' model to the Trust's audit universe and supporting the development of the updated framework. Committee members welcomed the new process and felt that the data gathered to demonstrate assurance was particularly helpful; it was noted however, that further work would be helpful to identify gaps in third line assurance, as well as more work on how assurance was provided at board level. It was recognised that there would need to be continual updating of the links between the Trust and system assurance, given the changes in system working. It was recognised that the IT audit domains were currently not tailored to healthcare and were to be reviewed taking, into account digital clinical safety.

It was also requested that a series of further deep dives be presented to the Committee starting with IT disaster recovery.

3.1.5. **Health and safety assurance framework update**

The Committee noted the updated health and safety assurance framework, and progress made since the last meeting. Members were pleased to note the recommendations and actions that had been identified in order to strengthen existing

governance processes and address gaps in assurance; Committee members particularly welcomed the proposed integrated annual report on health and safety which would be presented annually to this Committee and Trust board.

3.1.6. **Terms of reference – annual review**
The Committee approved the terms of reference and noted that work to review and ensure the Committee work plan maps to the terms of reference would be undertaken.

3.1.7. **Annual review of Trust Board Committees**
The Committee noted the annual report of Board committees, including a summary of the findings and recommendations arising from each committee's review of their annual report.

3.1.8. **Medical devices strategy**
Committee members noted the medical devices strategy as evidence of closure of a recommendation from an internal audit, and agreed that the strategy would be shared with, and monitored by, Quality Committee.

3.1.9. **Tender waiver report**
The Committee noted the tender waiver report for quarter 2 of 2021/22 of which there were 29. This is an increase from the previous quarter but a decrease when compared to the previous year.

3.1.10. **Losses and special payments**
The Committee noted the losses and special payments approved in the second quarter of 2021/22 which saw an increase from quarter 1. Material items in the quarter include the write offs of both unrecoverable income related to overseas visitors and drugs and supplies.

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

Jessica Hargreaves, Deputy Trust Secretary
4 November 2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Quality Committee Report

Agenda item 16.2 and paper number 14b

Committee Chair: Professor Andy Bush, Non-Executive Director
Author: Amrit Panesar – Corporate Governance Assistant

Purpose: Information

Date of meeting: 10 November 2021

1. Purpose of this report

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

2. Introduction

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

3. Key points

3.1. The key items to note from the Quality Committee meeting held on 3rd November 2021 include:

3.1.1. **Committee Terms of Reference**

The Committee reviewed the Committee terms of reference including membership. The terms of reference were noted and approved.

3.1.2. **Risk and Assurance Deep Dive – Outpatient Transformation Programme deep dive**

The Committee reviewed the Outpatient Transformation Programme deep dive noting that the outpatient department was impacted by the Covid-19 pandemic as the Trust moved to a virtual clinic setting at fast pace. Committee members noted that the Patient Service Centre had implemented a two way text messaging service to support patient and staff communication which is being monitored to understand the impact on patients who did not attend their appointments. The Committee noted that currently approximately 30% of outpatient activity is carried out virtually. Committee members were reassured that the outpatient department was making good progress to support specialities and were focused on the key areas of risk, as well as focussing on learning during CoVID to inform future practice.

3.1.3. **Quality Performance Report**

The Committee noted the Quality performance report, noting exceptions against quality key performance indicators and measures being taken to address areas of variance against target.

Imperial College Healthcare NHS Trust

3.1.4. **Never events – response and actions**

The Committee reviewed the actions taken in response to a recent increase in never events. There have been six never events reported over the past 12 months. Local actions have been taken where needed and, thankfully, in most cases, there has been minimal patient harm. Committee members noted that two Trust-wide workstreams had been established which included a campaign focusing on the importance of basic safety checks, led by a weekly task and finish group, and an action plan in response to the two most recent never events being related to central line insertion, being led by each Division. The Committee reviewed the actions taken in response to a recent increase in never events. There have been six never events reported over the past 12 months. Local actions have been taken where needed and, thankfully, in most cases, there has been minimal patient harm. Committee members noted that two Trust-wide workstreams had been established which included a campaign focusing on the importance of basic safety checks, led by a weekly task and finish group, with the initial focus on improving the safety of central line insertion, and a workstream specific to theatres/anaesthetics focusing on the re-launch of stop before you block, implementation of an electronic process for checking prior to blood transfusion and a review of safety measures around administration of medication, which is being led by the division.

3.1.5. **Infection Prevention and Control (IPC) and Antimicrobial Stewardship Quarterly report Quarter 2**

Committee members received the quarterly infection prevention and control report noting that the Trust was on track to meet its annual targets for C. difficile and E. Coli blood stream infection (BSI) reduction, and continues to see a reduction in overall consumption of antimicrobials despite the impact of the pandemic. The Committee noted that the Trust has implemented a monthly review of all healthcare-associated BSIs, including MRSA, and through this will interrogate internal post infection reviews.

3.1.6. **Infection Prevention & Control Board Assurance Framework for COVID-19 self-assessment October 2021.**

The Committee received the report noting that good progress is being made in general and no areas were noted as “red” rated.

3.1.7. **Learning from Deaths Quarterly report**

The Committee received the report noting the findings from the Trust’s Mortality Surveillance Programme quarter 1. The findings would be presented to the Trust Board and NHS England.

3.1.8. **COVID-19 & Vaccination update**

The Committee received a presentation on the Trust’s response to COVID-19 and the sector position across North West London which included an update on the Flu Campaign and the third covid-19 vaccine vaccination programme. The Committee noted the operational pressures being faced by the Trust currently, arising from the increase in Covid-19, patients being treated as well as reduced ability to discharge patients and the increase in patients attending through the urgent and emergency care

pathway. Committee members noted the significant operational risk through the winter and emphasised that patient safety should remain paramount.
The Committee were assured that the executive team were managing the risks associated with the covid-19 pandemic and winter pressures. The Non-executive directors thanked the executive team for their dedication and hard work throughout each stage of the pandemic.

3.1.9. **Key Divisional Risks**
The Committee noted the key divisional and corporate risks which were largely focused on the planning for winter and elective activity during the winter period. A future deep dive will focus on the management of the inevitable delays to non-Covid work due to the pandemic. Committee members noted that there was a common theme of people related risk, including recruitment and retention.

3.1.10. **Maternity Quality Assurance Oversight Report**
The Committee reviewed and accepted the Maternity Quality Assurance Oversight report.

3.1.11. **Research Report Quarter 2 2021/22**
The Committee received the report and welcomed the contribution made by research to the Trust and the national response during the pandemic. The Committee thanked the Research team for their hard work in finalising the submission for the BRC application.

3.1.12. **Learning, Improvement & Innovation: Improvement Team update**
The Committee noted the work of the Improvement Team on Learning, Improvement and Innovation. Committee members noted that there had been a pause in reporting due to the pandemic, and the full redeployment of the team went into supporting covid-19 related work.

3.1.13. **Transformation Team Quality Committee update**
The Committee noted the breadth of the transformation team's portfolio and progress to date. The Committee were reassured that the resource implications, especially human resource, in this and the previous item was being carefully managed

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

4. Recommendation(s)
Trust Board is asked to note this summary.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Finance, Investment & Operations Committee report

Agenda item 16.3 and paper number 14c

Committee Chair: Andreas Raffel, Non-executive Director
Author: Jessica Hargreaves, Deputy Trust Secretary

Purpose: For information

Meeting date: 10 November 2021

1. Purpose

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

2. Introduction

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

3. Key points

The key items to note from the Finance, Investment and Operations Committee held on 3 November 2021 include:

3.1 Winter plan

The Committee received and discussed an update on progress against the Trust's winter plan, noting that a bed capacity analysis had been undertaken to understand the capacity gap as well as predicting peak weeks in terms of operational pressures. The outcome of the modelling predicts a shortfall in beds and a sustained high occupancy; Committee members reviewed and discussed the mitigations in place against these.

3.2 Finance report and Deep dive into H2 / business planning

The Committee received and reviewed the finance report for month 6 noting that the Trust had delivered a breakeven position (on plan) for the first 6 months of the financial year as agreed by the North West London Integrated Care System (NWL ICS).

The Committee had a deep dive discussion regarding the Trust's business plan for the second half of the financial year (H2), covering operational, financial and workforce. The Committee heard that this will continue to be a iterative process with regards to the finances with the key areas of focus being the agreement of the funding envelope (recurrent and non-recurrent) and the development and delivery of recurrent cost improvement schemes to ensure the Trust is best placed to mitigate the current gap and have in place a programme of opportunities for 2022/23 and

beyond. The Trust would also undertake further due diligence of the divisional forecasts with the aim of improving these where possible to do so.

Committee members also received and noted the outputs of the 2019/20 National Cost Collection, which is a nationally mandated collection of cost and activity data from secondary and tertiary care providers and is used for benchmarking nationally. It was noted that the NWL ICS had confirmed it would be using the 2019/20 data to assess excess cost across providers to inform opportunities for efficiencies and improved value for money, with the ICS financial recovery board overseeing this work.

3.3 **Revised capital budget**

The Committee noted the month 6 capital budget position and the plans in place to assure the Trust continues to remain on track in not undershooting its capital resource limit 2021/22. An update on capital allocations for 2022/23 is awaited.

3.4 **Productivity and Efficiency Programme Board update**

Committee members noted the establishment and launch of the Productivity and Efficiency Programme Board (12th October 2021). Next steps are to develop key objectives for the work-streams, commence high level and early project identification, and support divisions to complete their self-assessments, meet with finance business partners and divisional cost improvement leads and agree the Trust wide communications strategy. The Committee welcomed this programme of work and requested regular updates at future meetings.

3.5 **Transformation update**

The Committee received and reviewed an update on the transformation programme and welcomed the detail around benefits realised and progress made against current projects. It was acknowledged that although the majority of transformation projects did not stem from the basis of improving financial efficiency it was important to assess this and ensure that wherever possible improvement targets (quantitative or qualitative) are established and progress tracked. Committee members noted that the transformation team was now working closely with the finance team to quantify both potential financial benefits and the cost of implementation.

3.6 **Outsourced service contracts**

Committee members received a report on the review of outsourced service contracts and the rationale behind these and thanked colleagues for the update.

3.7 **Imperial Private Healthcare performance and strategy review**

The Committee discussed the performance and strategy report for Imperial Private Healthcare and whilst acknowledging the difficult year the private sector had faced during the pandemic, activity in the first half of the year had been positive and the Committee was pleased to note that the activity generated had been above plan. However, it was noted that the activity estimated during quarter 4 had been reduced to reflect the anticipated winter pressures and the need to maximise capacity for NHS care. Committee members discussed recovery strategies including branding, growth and progress with the international affiliate network.

Imperial College Healthcare NHS Trust

3.8 **Terms of reference**
The Committee approved the updated terms of reference with the agreement the wording for one change to be updated to add further clarity.

3.9 **Summary of business cases approved by the Executive**
The Committee noted both the business cases approved by the Executive and the annual review of the financial benefits of business cases signed off in the previous financial before. It was highlighted that undertaking the review for the latter had led to some key learnings that the Executive will be taking forward including better articulation of SMART benefits at the outset of the case, reflections on which approaches ensure success etc.

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

Jessica Hargreaves, Deputy Trust Secretary
4 November 2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Report from the Redevelopment Committee on 2 November 2021

Agenda item 16.4 and paper number 14d

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

Purpose: For noting

Meeting date: 10 November 2021

1. Purpose of this report

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

2. Introduction

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

3. Key points

3.1. The key items to note from the Redevelopment Committee meeting held on 2 November 2021 include:

3.1.1. The Committee discussed contingency planning for the St Mary's site and the Western Eye / Samaritan Hospitals. The Committee agreed that it would focus its next meeting on understanding the potential impact on services arising from major failure of any of the hospital buildings and the associated contingency planning required.

3.1.2. The Terms of Reference for the Committee were reviewed as part of the annual review, to reinforce the Committee's role as a sub-Committee of the Board and to strengthen its relationship with the Audit, Risk and Governance Committee. The Committee would receive updates on the Trust's sustainability (green plan) programme. As a result of the extended Terms of Reference, the development of the assurance framework and the Committee's focus on the need to receive assurances regarding redevelopment contingency planning and the implications that may have for strategic estate and risk management mitigations, consideration will be given to reflecting this in the Committee's formal name. The Committee noted the updated membership and, subject to minor amendments, approved the Terms of Reference.

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

3.1.4. The Committee received a report on the redevelopment assurance framework, which outlines the governance arrangements for this area of strategic risk, including an assessment of the robustness of the risk management processes and levels of assurance available to the Board.

3.1.5. The Committee also received an update and noted progress on the Trust's green plan, noting progress made since the Board approved the Trust's Green Plan in March 2021. A small project team is now in place who have been establishing baseline data and scoping Trust-wide workstreams as well as supporting local initiatives that align with NHS net-zero goals.

3.2. **Recommendation**

3.2.1. The Board is asked to note this report.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Summary report from the People Committee

Agenda item 16.5 and paper number 14e

Committee Chair: Sim Scavazza, Non-Executive Director
Author: Ginder Nisar, Deputy Trust Secretary

Purpose: For noting

Meeting date: 10 November 2021

1. Purpose

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

2. Introduction

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

3. Key points

3.1. The key items to note from the People Committee held on 2nd November 2021 include:

4. Freedom to Speak Update

4.1. The Committee received a summary and annual report of the work of the Freedom to Speak Up (FTSU) service for 2020-21 and discussed the short-term and long-term priorities for the FTSU service. The key actions included understanding the increased number of referrals managed by the Guardians over the past 18 months and to ascertain whether this increase in activity was sustained as a normalised level of activity, through increased awareness of the service amongst staff and increased confidence in using the service. Further work was in train regarding the reasons for the referrals which were predominately HR related (rather than patient safety related) and the work underway by the HR team to improve their interaction with staff in an effort to reduce the number of HR related referrals. Short-term priorities include recruiting to vacancies in the team, developing the network of FTSU ambassadors, and ensuring the guardians have the right protected time, support and development. In order to develop the longer-term strategy and service model, there is a need to engage with a range of stakeholders across the organisation to inform a view of the type of service required. The Committee noted the annual report and endorsed the direction of travel. The longer-term strategy will be presented to the Committee once developed.

5. Staff story

5.1. The Committee heard the story told by a medical secretary when she contracted Covid-19 at an early stage in March 2020. She was due to have an interview for a permanent position in March but the interview was moved to accommodate her sickness. Shirley was appointed to role, but subsequently had a number of serious medical

complications over the following months. When Shirley was ready to return, her line manager was able to arrange for her all the equipment she needed to work from home, and she was able to do her role of medical secretary remotely. Shirley's story highlighted a mix of challenges and positive management action. Lessons were identified from Shirley's story which inform the recommendations that would be taken forward by the people and organisational development division. The Committee welcomed the first staff story.

6. People Strategy and Priority Objectives – Progress report

6.1. The Committee received an update against the seven Priority People programmes for 2021/22. Work was underway and progressing well in all programmes. The Committee in particular discussed net gain/loss in respect of joiners and leavers, vacancy rates, and the data– further analytical work was underway for these areas. The Committee received an update on the staff health and wellbeing projects, namely staff spaces and retail food and shops.

7. Workforce performance report

7.1. The Committee received an update on the core workforce performance and indicators for month 6, September 2021. The report summarised the areas of good performance and the areas for improvement with action plans. The actions and performance challenges were consistent with the priority programme areas and the statement of people-related risks. The Committee discussed the increasing sickness and absence rates due to varying reasons. The team were deep diving into the reasons and looking at interventions to drive improvement. Future performance reports would also include (annually) the cost of Employment Tribunals. The Committee agreed that how the Trust manages its junior doctors and learning from their experiences was important – this would be the topic of a future deep dive topic and staff story.

8. People and Organisational Development (P&OD) Risk Register and Risk Appetite Methodology

8.1. The Committee received an update on the People related risks on the P&OD Risk Register which has 18 risks, 7 risks scored at 12, 6 risks are scored at 9, and 5 risks scored between 4 and 8. Two of these risks also appear on the corporate risk register. All risks which score 12 or above were being managed through one of the Trust People Priority programmes and/or a with clear action plan. The Committee noted the approach by the P&OD team to adopt the new risk appetite methodology to the P&OD risks.

9. Assessing Impact of Race Equality Interventions

9.1. The Committee discussed and agreed with the approach to assessing the impact of race equality interventions to provide assurance to the People Committee and Trust Board on the Trust's short and medium-term progress on some of its longer-term goals. The business planning process would be used to review the vision, objectives and interventions which would inform a more advanced method for judging impact and progress. External expertise would be sought to ensure the Trust was focusing on the right things and measure against other Trusts – the approach would be evidence based and inform a strategy.

10. Staff networks

10.1. The Committee received an update on staff networks which were considered to be a core part of staff engagement and EDI workforce strategy as they provide an important mechanism for listening to and engaging with staff with protected characteristics. They are also a vehicle to support the development and progression of staff with protected characteristics that were under-represented in Trust senior leadership management

structures. The Committee discussed feedback from the staff networks following meetings with the People Committee Chair and NED member and further thought would be given to how best to support the networks to balance their independence against ensuring they are properly supported.

11. Occupational Health and Safety Report

11.1. The Committee received an update on aspects of the Trust occupational health and safety arrangements, including 'Covid-19 secure' workplace, the Trust's statutory duty to investigate certain Covid-19 related incidents and the performance of the Occupational Health service. Effective action continues to be taken to control health and safety risks in the workplace, including those risks arising from covid-related matters. The Committee noted that anticipated updated guidance on covid measures from public health england had been delayed. The Trust would review its covid measures once this guidance was published. The Committee discussed a return to business as usual reporting once the Trust had fully implemented processes to ensure covid risk assessments were included in the recruitment process and ensuring staff were vaccinated.

12. Recommendation(s)

12.1. The Board is asked to note this report.

13. Impact assessment

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

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Summary report from the Remuneration and Appointments Committee

Agenda item 16.6 and paper number 14f

Committee Chair: Peter Goldsbrough, Non-Executive Director
Author: Ginder Nisar, Deputy Trust Secretary

Purpose: For noting

Meeting date: 10 November 2021

1. Purpose

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

2. Introduction

2.1. In line with the Remuneration and Appointments Committee's reporting responsibilities as detailed in its terms of reference, a summary of the items discussed since the last meeting is provided in this report.

3. Key points

The key items to note from the Remuneration and Appointments Committee held on 20th October 2021 include:

3.1. **Annual Executive appraisal process and timetable -** The Committee received a briefing setting out the various processes and timetable relating to executive appraisals and agreed the annual process and timetable.

3.2. **Chief Executive remuneration** - The Committee noted an oral update provided regarding the process to agree the Chief executive remuneration.

3.3. **Executive and Very Senior Managers pay -** The Committee received an oral update on the process to establish a remuneration framework for executive directors and Very Senior Managers (VSMs), including pay ranges, benchmarking, and discretionary payments and bonuses. The Committee noted the update and agreed next steps.

3.4. **Executive and Very Senior Manager pay award 2021/22 -** The Committee considered options and recommendations for the pay award for executive directors and VSMs, noting recently published national guidance. The Committee considered the options, and agreed an approach. A revised recommendation would be circulated for approval.

3.5. **Executive level continuity and succession planning -** The Committee received an update on executive succession planning, including continuity planning for executive team members. The Committee noted action being taken. The Committee noted the update and agreed that the output of this work – short-term and long-term succession

plans – would be presented to the next meeting of the Committee.

3.6. **Committee annual report -** The Committee noted and approved the annual committee report for 2020/21, including the recommendations from the annual committee effectiveness review. The Committee approved the annual report.

3.7. **Committee Terms of Reference** - The Committee agreed the revised terms of reference.

4. Recommendation(s)

4.1. The Board is asked to note this report.

5. Impact assessment

5.1. Quality impact: N/A
5.2. Financial impact: N/A
5.3. Workforce impact: N/A
5.4. Equality impact: N/A
5.5. Risk impact: N/A