Imperial College Healthcare NHS Trust

Trust Board – Public

Wednesday, 15th September 2021, 11am to 1.30pm (10.45am to 11am join Microsoft Teams)
Virtual meeting via Microsoft Teams

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

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

AGENDA

Time	Item no.	Item description	Presenter	Paper / Oral
1100	**1.**	**Opening remarks** Observing as part of the Trust's Frontier Leadership course: Mr Hamid Abboudi, Consultant Urological Surgeon	Bob Alexander	Oral
	2.	**Apologies:** Peter Goldsbrough, Prof. Weber	Bob Alexander	Oral
	3.	**Declarations of interests** If any member of the Board has an interest in any item on the agenda, they must declare it at the meeting, and if necessary withdraw from the meeting.	Bob Alexander	Oral
1105	**4.**	**Minutes of the meeting held on 14th July 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 14th July 2021 and Extraordinary Trust Board held on 29th July 2021** To note the report	Bob Alexander	02
	6.	**Matters arising and review of action log** To note updates on actions arising from previous meetings	Bob Alexander	03
1110	**7.**	**Patient Story** To note the patient story	Janice Sigsworth, Guy Young	04
1125	**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				
1140	**9.**	**Integrated quality and performance report** To note the month 4 report	Claire Hook Julian Redhead	06
1150	**10.**	**Finance report** To note the month 4 report	Jazz Thind	07
Quality				
1155	**11.**	**Maternity quality assurance oversight report** To note the oversight report	TG Teoh	08
1200	**12.** 12.1.	**Infection prevention and control** **Infection prevention and control quarterly report** To note the quarter 1 report	Julian Redhead/ James Price	09
1210	**13.**	**Learning from Deaths quarterly Report** To note the quarter 1 report and approve the data submission	Julian Redhead	10
1215	**14.**	**2020/21 Annual report from the Trust Safeguarding Committee** To note the annual report	Janice Sigsworth	11
1220	**15.**	**End of life Annual Report** To note the annual report	Katie Urch	12
People				
1225	**16.**	**Workforce Equality, Diversity and Inclusion Annual Report 2020-21** To approve the report for publication	Kevin Croft	13
1235	**17.**	**Safe, sustainable and productive Nursing and Midwifery staffing Report** To approve the mid-year establishment findings	Janice Sigsworth	14
1245	**18.**	**Pathway to Excellence** To support the proposals	Janice Sigsworth	15
1255	**19.**	**Responsible Officer's Annual Report** To approve the annual report	Julian Redhead	16
Governance				
1300	**20.**	**Trust Board Committees – summary reports** To note the summary reports from the Trust Board Committees		
	20.1.	Audit, Risk and Governance Committee, 9th September 2021	Kay Boycott	17a
	20.2.	Quality Committee, 9th September 2021	Andy Bush	17b

	20.3.	Finance, Investment and Operations Committee, 1st September 2021	Andreas Raffel	17c
	20.4.	Redevelopment Board Committee, 8th September 2021	Bob Alexander	17d
	20.5.	People Committee, 7th September 2021	Sim Scavazza	17e
1310	**21.**	**Any other business**	Bob Alexander	Oral
1315	**22.**	**Questions from the public**	Bob Alexander	Oral
1330 Close	**23.**	**Date of next meeting** 10th November 2021, 11am		

Updated: 10 September 2021

Imperial College Healthcare NHS Trust

Public Trust Board
Draft Minutes of the meeting held on 14th July 2021, 11am
Virtual meeting held via Microsoft Teams and video-recorded.

Members present

Mr Bob Alexander	Acting Chair
Mr Peter Goldsbrough	Non-Executive Director
Dr Andreas Raffel	Non-Executive Director
Mr Nick Ross	Non-Executive Director
Prof. Andrew Bush	Non-Executive Director (in part)
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
Prof. Jonathan Weber	Dean of the Faculty of Medicine, Imperial College London
Mr Kevin Croft	Director of People and Organisational Development
Dr Matthew Tulley	Director of Redevelopment
Dr Bob Klaber	Director of Strategy, Research & Innovation
Mr Jeremy Butler	Director of Transformation
Mr Hugh Gostling	Director of Estates and Facilities
Ms Michelle Dixon	Director of Communications
Prof. TG Teoh	Divisional Director, Women, Children and Clinical Support
Prof. Katie Urch	Divisional Director, Surgery, Cancer and Cardiovascular
Mr James Price	Director of Infection Prevention and Control
Ms Jo Sutcliffe	Divisional Director of Operations MIC (representing Frances Bowen)
Mr Matthew Kybert	Deputy Chief Information Officer (representing Kevin Jarrold)
Ms Trish Longdon	Chair, Strategic Lay Forum (for item 13)
Ms Nafsika Thalassis	Deputy Chair, Strategic Lay Forum (for item 13)
Ms Linda Burridge	Head of Patient and Public Partnerships (for item 13)
Ms Roxanne Barrington-Stoute	Matron, Charing Cross Hospital (for item 7)
Mr Andy Worthington	Deputy Director of Nursing, Strategy and Regulation (shadowing Janice Sigsworth)
Mrs Ginder Nisar	Deputy Trust Secretary (minutes)

Apologies

Mr Kevin Jarrold	Chief Information Officer
Prof. Frances Bowen	Divisional Director, Medicine and Integrated Care

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. The Board meeting would be video-recorded and the recording uploaded onto the Trust's website. The Trust would keep under review the guidance from the Government in terms of when it would be safe to hold meetings in person. 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.	The Board welcomed Mr James Price, new Director of Infection Prevention and Control and congratulated Mrs Claire Hook who was appointed Chief Operating Officer of the Trust.
2.	**Apologies** Apologies were noted from those listed above.
3.	**Declarations of interests** There were no other declarations other than those disclosed previously.
4.	**Minutes of the meeting held on 12th May 2021** The minutes of the previous meeting were agreed.
5.	**Record of items discussed in part II of the Board meeting held on 12th May 2021 and 30th June 2021** The Board noted the summary of confidential items discussed at the confidential Board meeting held on 12th May and the Board Seminar on 30th June 2021.
6.	**Matters arising and actions from previous meetings**
6.1.	Updates against the actions arising from previous meetings were noted on the action register.
6.2.	Board members visit programme - The programme was being prepared with the aim of circulating to Board members in July with a view to starting the actual visits in September. This programme would be in line with Government guidance when published.
7.	**Patient Story**
7.1.	The story was presented by Ms Roxanne Barrington-Stoute, a senior nurse who works at the Trust and experienced first-hand the impact of Covid-19. She described her journey as she became increasingly unwell. She is young and does not have any pre-existing comorbidities and is from a BAME background. She continues to share her experience widely within the Trust to encourage colleagues to have the vaccination.
7.2.	Responding to a question from Mr Goldsbrough regarding learning for the Trust from her experience as an inpatient, Roxanne provided some insight into how, as a healthcare professional, more could be done by listening more intently to the symptoms as described by the patient, as only the patient knows what he/she was going through. Prof. Orchard agreed and thanked Roxanne for her helpful and useful insight and stated that reflections from patients was an important mechanism for healthcare professionals to understand the positive and the negative impact they could have on patients they are treating.

7.3.	Responding to Mr Ross, Prof. Sigsworth advised that Roxanne would be asked to share her story more widely and to larger groups and she would ensure the actions from her lived experience were taken forward through the Trust's Improvement Programmes including work around communications and behaviours.
7.4.	The Board thanked and commended Roxanne for her courage in sharing her powerful and moving experience as a Covid-19 patient and were pleased that she was recovering well. The Board thanked Roxanne for sharing her experience more widely so as to educate people of the severity of the virus and the importance of being vaccinated.
7.5.	**Future plans -** The Board noted the future plans for sharing stories with the Board which would include staff stories as well as patient stories, given the importance of staff wellbeing and engagement. The focus therefore would be on how the Trust learns from the experience of what it is like to work at the Trust as well as what is it like to be cared for and treated at the Trust.
7.6.	**The Board noted the report.**
8.	**Chief Executive Officer's briefing** Prof. Orchard presented his report, highlighting key updates on strategy, performance, leadership over the month and the focus of Trust business in response to Covid-19.
8.1.	**Covid-19 wave three planning -** There were concerns about a potential third wave of Covid-19 infections as the Delta variant was becoming the dominant strain in the UK. This meant that the ending of remaining lockdown restrictions was delayed, currently until 19 July 2021. Based on current numbers, a peak was expected in August which could last several weeks – the Trust has contingency plans to increase capacity for ICU provision across London and within the sector. No impact on the elective recovery programme was anticipated but the situation would be closely monitored. The current prevalence of the variant did not necessarily mean there would be a third wave of similar magnitude to previous variants – this was primarily due to the successful vaccination programme and the increased number of cases had not yet translated into a large increase in hospitalisations. However, the Trust must future proof itself for any potential surges, therefore staff were working in collaboration with partners across the wider sector to ensure robust plans are in place to manage any future waves. Staff health and wellbeing was a key part of planning which incorporates learning from previous waves. ICU Mortality in the second wave had reduced by 25% compared to the first wave which indicated successful learning from the first wave.
8.2.	**Covid-19 vaccination programme -** As at end of June 2021, the Trust's in-house vaccination programme had delivered more than 24,500 first doses and over 21,800 second doses to its staff, health and social care colleagues across the sector and patients. Considering eligible staff designated as frontline, over 8,953 (91%) had received their first dose, this included staff who had been vaccinated outside of the Trust. Of these, 7,889 (93%) had received their second dose and the Trust was supporting the remainder to complete their course as soon as possible and encouraging hesitant staff. The Trust's operational model had changed as the number of unvaccinated staff continued to reduce and running clinics two days a week on two sites, while supporting sector-wide initiatives to increase accessibility of the vaccine within the community, including running community clinics as part of the 'Grab a jab' scheme. The Trust was beginning to plan how it would deliver booster vaccinations for staff in line with national guidance as it becomes available.

8.3.	**Financial performance -** Summarised at item 12. Prof Orchard advised that the financial environment that the Trust was operating in was currently uncertain for the current year, so the Trust was adopting a prudent approach as it planned for the second half of the year.
8.4.	**CQC update -** The CQC's new strategy for 2021-26 had been published on 27th May 2021. Their revised methodology for implementing the strategy had not yet been published, therefore there was limited information about the practical impact the strategy would have on how the Trust would be assessed by the CQC going forward. However, the CQC announced on 14th June, the launch of a pilot programme to test some of its proposed new methodology. The pilot began on 14th June 2021 with GPs and from 13th July 2021 for all other sectors, except NHS Trusts and dentists. The CQC had indicated that it was currently only scheduling inspections in the pilot for independent (private) Trusts / services which were considered higher risk. It was not yet clear when the new methodology may be piloted and/or ready to use for NHS Trusts. In August 2021, the Trust would start developing a combination of internal desktop reviews and peer reviews.
8.4.1.	The Improving Care Programme Group (ICPG) had reconvened on 24th May 2021, after being stood down during the pandemic. The Trust had revised its approach and methodology for quality improvement and preparations for CQC engagement / inspection, to embed quality improvement and transformation in the approach. To further embed continuous improvement, ICPG was shifting to a quality-based approach. The CQC standards had been mapped to six quality questions and three levels of quality assurance and improvement identified.
8.4.2.	The Trust's Chief Pharmacist attended the annual engagement meeting with the CQC on 16th June 2021 to review key lines of enquiry regarding medicines management. The feedback was positive.
8.4.3.	The Trust had its regular quarterly engagement meeting with the CQC on 23rd June 2021, which was in two parts: the first session was with the renal service, followed by the Trust level 'well led' session. Feedback from both sessions was positive. The CQC indicated that it did not have any current concerns about either the renal service or Trust leadership and had not flagged any other areas of concern.
8.5.	**Redevelopment -** The Trust had submitted, in draft, a revised business case for the redevelopment of St Mary's. The case looks in detail at the size and location of the proposed redevelopment and demonstrates that the proposal was affordable, value for money and delivers significant benefits. The Trust continues to work with the national team to look at ways in which the redevelopment could be phased to deliver early benefits to the programme. The next stage of the Charing Cross and Hammersmith Hospitals redevelopment planning was underway commencing with a detailed review of stakeholder requirements, including engagement with staff and patients.
8.6.	**Research -** Patient recruitment to Covid-19 urgent public health clinical research studies continued, but noting that numbers were decreasing with declining patient admissions. The Trust continues to recruit and follow up healthy volunteers into vaccine studies, and had begun the world's first human challenge study with the SARS-COV-2 virus. Analysis and interpretation of data was also a priority and new research reports published recently by Imperial authors.
8.6.1.	The Trust recently submitted stage 1 of the re-application for its National Institute for Health Research (NIHR) Biomedical Research Centre (BRC). This was a competitive bid

	for up to £100m over the period 2022-2027, to continue cutting-edge, proof-of-concept experimental medicine and to translate new scientific discoveries into patient benefits. The outcome of the initial proposal was expected at the beginning of August.
8.6.2.	A number of annual reports had been submitted to NIHR in recent months, highlighting the science carried out in the 2020/21 year across the NIHR infrastructure awards.
8.6.3.	The North West London Clinical Research Network (CRN) had also submitted its annual report to NIHR. The CRN hosting contract had been extended to 2024 and a national consultation was open to inform the future of the CRNs nationally.
8.7.	**Equality, Diversity and Inclusion (EDI) -** EDI continued to be a key area of work for the Trust, particularly as over 50% of its workforce is from a BAME background, and is committed to getting to a position of being exemplars using a range of measures to achieve this. Amongst a number of work programmes, recording ethnicity data was important to monitor Trust performance; and the focus on how immediate managers deal with their teams in respect of EDI. As well as race, work continues with other staff networks such as Disability, LGBT and Women. The Trust would be participating in a new national disability leadership programme, Calibre, along with seven other Trusts across the Integrated Care System (ICS). Business Disability Forum and Employers Network for Equality and Inclusion membership had commenced. The Trust had improved its ethnicity data by updating 1,100 staff records and also shared design plans for a new diversity dashboard. A Board development seminar was held in June and the Trust had concluded its reverse mentoring programme, with programme evaluation due to commence in July. The Trust had procured a training provider for its race equity training programme and been successful in securing a place on the White Allies, NHS London development programme for six Trust senior leaders.
8.8.	**Stakeholder engagement -** The report outlined the meetings and communications with key stakeholders since the last Trust Board meeting.
8.9.	**Recognition and celebrating success**
8.9.1.	The Gratitude Festival which took place between 5th and 9th July 2021 was received well. The week consisted of activities and entertainment, supported by Imperial Health Charity, to say thank you to staff for all they had done and continue to do through the pandemic.
8.9.2.	The Board congratulated four Imperial staff who were awarded honours in the Queen's Birthday Honours list: ▪ Nick Ross, Non-Executive Director, awarded a CBE for his services to broadcasting, charity and crime prevention. ▪ Professor Alison Holmes, Infection Disease Consultant, awarded an OBE for services to medicine and infectious diseases. Professor Holmes recently stepped down as Director of Infection Prevention and Control at the Trust after being in post for over 15 years to focus on her academic roles and in supporting applied research within the Trust. ▪ Professor Paul Elliott, Chair in Epidemiology and Public Health Medicine at Imperial College London and Honorary Consultant in Public Health Medicine at the Trust, awarded a CBE for services to scientific research in public health. ▪ Professor Azra Ghani, Chair in Infectious Disease Epidemiology in the School of Public Health at Imperial College London, awarded an MBE for services to infectious disease control and epidemiological research.

8.9.3.	Congratulations were also extended to Catherine Rennie, Consultant Ear, Nose and Throat Surgeon at Charing Cross Hospital, for making the 'Women's Engineering Society's 2021 Top 50 Women in Engineering' list.
8.10.	**Acute Programme update** Prof Orchard provided an update on the NW London acute care programme, noting that the Acute Programme Board met monthly, consisting of acute Trust CEOs and senior members of their Executive teams. The Elective Recovery Fund which was based on sector performance, not individual Trusts, was an example of the importance of having a good understanding of activity across the sector and working together effectively to achieve common goals. One of the key purposes of the programme was to work together in respect of increasing standards, equity of access and equality of outcomes for patients. The aim was to provide an update paper to Board at each of its meetings which was evolving in terms of its format and content. The appendix to the Chief Executive's report outlined the span of work and progress against: Planned care; Outpatient care; Diagnostics; Urgent and emergency care; Critical care; Governance; and Communications and engagement.
8.11.	Comments from the Non-Executive Directors:
8.11.1.	Mr Goldsbrough noted there was a lot of focus on vaccinating frontline staff and enquired about the remaining staff as more face-to-face working would occur over the coming months. Prof. Orchard advised that all Trust staff had been offered the Covid-19 vaccination including ensuring those currently working from home have access to the vaccine, either at work or locally, and work continues to encourage 'hesitant' staff to have the vaccine. However he advised there was a judgement to be made as the vaccination was not mandatory and the need to be mindful of 'harassment' when staff have declined the vaccine. Those staff who decline the vaccine would be risk assessed in terms of the risk to themselves and patients. Prof. Redhead added that all 'hesitant' staff had been contacted and provided with the right information and efforts also continue within communities.
8.11.2.	Prof. Bush commended the Executive and teams for their efforts to increase the uptake of the Covid-19 vaccination and stressed the need to also think about the annual influenza vaccine, and enquired about any possibility of a joint vaccine. Prof. Redhead advised that current thinking was that both vaccines would be given on the same day to vulnerable groups, but not a joint vaccine – communications around this would be important. The influenza vaccine campaign would be launched in the second week of September.
8.12.	**The Board noted the report from the Chief Executive.**
9.	**Acute Programme Update** This was covered within the CEO's report, item 8.
10. 10.1.	**Integrated quality and performance report** The Board received an update on the Board metrics covering the Trust's strategic goals, priority programmes and focused improvements. The scorecard was for data published at month 2 (May 2021). Four new KPIs had been added to help monitor progress against the operational requirements of the NHS operating plan 2021/22. These were: Elective activity levels - % against trajectory (overnight and day cases); Outpatient attendance levels - % against trajectory; Clinical prioritisation of the surgical waiting list -% prioritised; and Patients spending more than 12 hours in the emergency department. Finalised

	operating plan trajectories had also been embedded for two existing KPIs: Overall size of the elective waiting list; and Patients waiting more than 52 weeks to start consultant-led treatment. Further KPIs may be added in-year, including those arising from the internal review of priority programmes and projects.
10.2.	Performance summary - The Trust exceeded national minimum elective activity levels for April and May 2021 and also achieved the augmented operating plan trajectories for the majority of metrics. With the return to normal activity, the Trust incident reporting rate had also increased and harm levels remained below average. A summary of performance headlines was provided in the main report along with countermeasure 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.
10.3.	Quality (safe and effective) - There was an increase in the number of incidents reported in May 2021, which reflected the return to normal activity following the second surge, and for this month, the Trust met its patient safety incident reporting rate target which was in the top quartile of comparable NHS trusts (per 1,000 bed days). The Trust-wide improvement programme, was progressing and divisional action plans in place.
10.4.	Hospital Standardised Mortality Ratios (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) Scores remain low. There were no Carbapenemase-producing Enterobacteriaceae (CPE) blood-stream infections (BSIs) reported in May 2021. The Trust was on track to meet its annual targets for C. difficile and E. Coli BSI reduction. There was one MRSA BSI reported in May 2021. A patient with spinal infection had positive blood cultures over 14 days into their inpatient stay and the case was currently undergoing post infection review.
10.5.	Comments from the Non-Executive Directors:
10.5.1.	Mr Ross commented that it was important to get 100% incident reporting but there were pockets of people reluctant to report. Prof. Redhead advised that it was for this reason that the incident reporting featured as one of the Trust's areas of focused improvements as well as working with and supporting teams to learn from incidents. Prof. Redhead was confident that staff had veered away from a blaming culture and were embracing learning, this was supported by the positive outcome from the staff survey in respect of quality.
10.5.2.	Mrs Boycott noted the improvements in the two week cancer waits and 62 day waits. Although the counter measure summary covered some of the improvements, she enquired about improvement processes and what would be done to keep improving to get back on track. Prof. Urch advised that the Trust was up to normal (pre-Covid) projected cancer referrals from GPs for all areas for 2 week waits and targeted recovery work had been done to get back to this level. In respect of 62 days waits, all areas had improved except for GI where further focused improvement work would be done. The 62 days wait position would take some months to recover. Focus remains on ensuring that the 28 day target is met.
10.5.3.	Mr Alexander enquired whether the national changes to some thresholds from July would put some of the Trust's services under pressure. Mrs Hook advised that the Trust would set itself internal targets to exceed those thresholds and would continue to treat as many patients as it could, however advised that finances would be challenging.

10.5.4.	Mr Goldsbrough commended the scorecard. Given there were a number of red areas on the scorecard, and the Trust and the system was entering a period of pressure, he enquired about bottle necks which may be of concern and equally the opportunities that could be realised. Mrs Hook advised that the bottle necks would be the physical capacity in Emergency Department (ED) and the ability to maintain social distancing and managing the different pathways; winter planning; staffing which would be further impacted in the event of a wave 3 which would also impact the Trust's plan. In terms of opportunities, working across the sector, mutual aid and particularly Patient Treatment List (PTL) management across the system allows for the most urgent patients to get treated first across NWL.
10.5.5.	Ms Scavazza enquired about additional support for staff in ED knowing that numbers and pressures were likely to increase. Mrs Hook and Ms Sutcliffe advised that although efforts were always made to relieve the pressure, ED teams were generally used to working in a highly pressurised setting and looking after themselves with a lot of health and wellbeing support, however staffing was a key area of impact due to staff self-isolating and therefore they were looking to replicate the ITU staff support model. St Mary's recently had approval to expand the same day emergency care which would reduce the number of patients going to ED, thereby releasing some pressure.
10.5.6.	**The Board noted the report.**
11.	**Annual Emergency Preparedness, Resilience and Response update**
11.1.	The Board received the Trust's Emergency Preparedness, Resilience and Response (EPRR) annual report which provided an update on its duties under the Civil Contingencies Act and the NHS England EPRR Core Standards. The report provided an update and assurance in relation to EPRR arrangements and plans. To remain fully compliant when assessed against the NHS EPRR Core Standards the annual EPRR programme would continue to embed lessons learnt from the EPRR plan activations to existing practice and addressing areas for improvement. The focus would be on business continuity ensuring the successes from the pandemic so far were translated to the plans.
11.2.	Mr Ross enquired of the process and plan in the event that something out of the ordinary should occur with mass casualties. Mrs Hook assured the Board that the Trust has a plan for mass casualty incident which was refreshed regularly. Planning at London level also takes place in the form of a whole system response which was tested on an annual basis. The plans were resilient and had been tested in real life incidents.
11.3.	**The Board noted the annual report.**
12.	**Finance report**
12.1.	The Board received an update on the month 2 position. The Trust had set a plan for the first six months of the financial year ('H1' which runs from April 2021 to September 2021) in line with national guidance. The NWL ICS agreed that all organisations would set a breakeven plan, with funding to be made available by the ICS to cover lost non-NHS income, contingent on the Trust ensuring it had exhausted all other avenues to achieve a breakeven plan. Within the Trust's H1 plan, there is a requirement to deliver a cost improvement programme (CIP) of £15.8m of which £4.1m had been identified at the end of May 2021. It was imperative that the Trust was in a resilient position as it could be, as it enters the second half of the year particularly as it was likely the funding and resources would be tightened compared to H1.

12.1.1.	In line with national guidance, the Trust has a block income contract but would be funded for elective work above trajectories through the Elective Recovery Fund (ERF). This income was non-recurrent and any contribution may be used to mitigate the shortfall in CIP.
12.1.2.	Sector level discussions and the financial opportunities afforded by the ERF had allowed the Trust to move to a break even plan. As at Month 2 the Trust achieved a breakeven position.
12.1.3.	For the two months to the end of May 2021, the Trust delivered an underlying deficit position of £4.6m (before ERF). This was £2.4m behind the year-to-date planned deficit of £2.2m and had been fully offset by non-recurrent ERF (£8.7m).
12.1.4.	The Trust had set a capital plan of £52.7m for the year. Year-to-date the Trust had spent £3.4m (38%) of its agreed capital plan, however this underspend was largely due to timing and it was expected that the full plan would be achieved within the financial year.
12.1.5.	At 30 May, cash was £150.4m. The future cash outlook was robust in the medium term but the full-year forecast was highly dependent on the funding regime for the second half of the year which was yet to be published.
12.1.6.	Mr Alexander enquired how long it would take for Mrs Thind to feel comfortable with the reset position for the first part of the year and how confident she was that the divisions were embracing the challenge for cost reduction opportunities. Mrs Thind was confident that the divisions had embraced the challenge and were actively identifying efficiencies and a programme of CIP deep dives planned in July ahead of discussion at the Executive meeting and the Finance, Investment and Operations Committee. She would take a view on this at the end of July.
12.1.7.	**The Board noted the report.**
12.2.	**Estates Capital Projects 2020-21 Annual Report** The Board received the annual report of capital projects completed in the previous financial year. The report recognised the efforts made to deliver projects which assisted clinical service in responding to the Covid-19 pandemic and in delivery of major capital projects during 2020-21 financial year with overall budget circa £19m. Mr Gostling acknowledged the difficult year and commended his team for delivering to the surge response. Future annual capital reports would include capital works carried out by Estates Backlog Maintenance, Information Communication and Technology and Medical Equipment.
12.2.1.	The risks relating to projects were: Unable to recruit suitably qualified and experienced permanent candidates on current band level; very short timeframe given to carryout feasibility resulting in inadequate client brief, budgets not completed with due diligence and signoffs on scheme proposals from all; shortage of capital funds impacting on project deliverables with regards to compliance and stakeholder CIP requirements; and increased costs projects due to unforeseen infrastructure capacity issues due to age of building services and increase demand on supplies.
12.2.2.	Mrs Boycott congratulated Mr Gostling and his team for their achievements during the response to the pandemic. In terms of the risks, she enquired about the context in relation to the short timeframe to carry out a feasibility study. Mr Gostling outlined the process and tight timeframes dictated by external deadlines and having to weigh the risk

	– this was done so through the appropriate governance processes – he outlined some examples. Mrs Boycott queried how often the risk may materialise into something inadequate. In response, Mr Gostling advised that there was now greater awareness of risks associated with capital schemes and where a risk was material it would be raised and assessed appropriately. Prof. Orchard added that at times the Trust was restrained when bidding for money and no time to do a full feasibility assessment but advised that no undue risk was taken.
12.2.3.	Mr Ross commended the achievement and asked about smaller jobs such as replacing toilet seats and shortening the timescale from reporting to action. Mr Gostling advised that a regular estates meeting takes place to discuss staff feedback, action and prioritisation of smaller works and that his team were in regular discussions with CBRE in respect of the backlog of works.
12.2.4.	**The Board noted the report.**
13.	**Patient and Public Involvement: Strategic Lay Forum 2020-21 Annual Review and 2021-22 Priorities**
13.1.	The Board welcomed Ms Longdon, Strategic Lay Forum Chair and Ms Thalassis, Deputy Chair, and received the annual update from the Trust's strategic lay forum covering progress against 2020/21 priorities, input into Trust business planning and priorities for 2021/22. Highlights of progress against strategic lay forum priorities for 2020/21 included: closer collaboration between lay partners and clinicians; engaging communities and building trust through relationships; and greater strategic input by lay partners.
13.2.	Ms Longdon referenced the delay to their usual work due to the pandemic but instead presenting some fresh opportunities to work in key areas with the Trust and building/developing relationships across key groups of senior teams. In particular having a voice at the Clinical Reference Group (CRG) to bring a patient perspective and to feedback to the Strategic Lay Forum – this was felt to be a key development for the Forum.
13.3.	The Board watched a short video recording from the Chair of the CRG, Prof. Redhead, who outlined the purpose of the CRG and the Strategic Lay Forum contributions which had added to changing the culture of the Trust to be more patient focused.
13.4.	Another key area of work was engaging communities. The BAME forum which Ms Thalassis chairs, commenced during the pandemic and involves community leaders who continue to have regular meetings with clinicians to raise issues for experts to answer as well as receiving Covid-19 updates and education around the Covid-19 vaccination. This had been useful for learning and sharing further within community groups. The Board watched a short video of Mr Kalantari from the Iranian Association who shared his experience of this group. These meetings would in future feedback from communities to the Trust.
13.5.	The third area was involvement at senior levels within the Trust which enabled the Lay Forum to raise key issues from a patient's perspective such as the meaning of Do Not Resuscitate (DNR), end of life care, and interpreting services which all became more important during the pandemic.
13.6.	A patient user focus measure was being established, the focus was on asking what matters to patients and listening to them, instead of asking people what is the matter with

	them. The Lay Forum was working with the Trust to develop this measure across the whole Trust.
13.7.	Ms Longdon outlined the Strategic lay forum priorities for 2021/22 and work continues with the Trust to include within their business planning. ▪ Maintain emphasis on supporting the Trust to become the most user-focused NHS organisation. ▪ Support the Trust, local ICPs and the ICS to embed the patient voice in providing more integrated services for patients in north west London. ▪ Enable deeper involvement in research and strengthened collaboration between the Trust and Imperial College. ▪ Continue to develop the lay partner community.
13.8.	Lastly, the Lay Forum had received funding to submit a much bigger funding application to reduce health inequalities in NWL and hope the Trust would be a partner in this.
13.9.	Comments from the Board:
13.9.1.	Prof. Orchard was grateful for the Lay Forum's input and stated the key significance of the forum to the Trust which was invaluable, particularly their voice at CRG which the clinicians found extremely useful. He also thanked the Lay Forum for their helpful input into the Acute Programme Board at sector level. Prof. Orchard commended their work and efforts to represent the communities.
13.9.2.	Dr Klaber commended the presentation and the extraordinary work of the Lay Forum. He referenced the Trust's strategic goal around learning, which was demonstrated well through the work with the Lay Forum and partners and he thanked the Forum for their constructive challenge and the ambition to continue to develop and learn. He welcomed the specifics of the priorities for 2021-22 and would continue to work with the Lay Forum to achieve these.
13.9.3.	Mrs Boycott welcomed the presentation and commended the work and the ambition. She enquired about the Care Information Exchange (CIE) challenge in terms of the development and use of it – what should the Trust be thinking about in this respect; and it was clear how important the maternity voice is as the Trust looks at national maternity care; and what support may be needed for these groups. Ms Longdon advised that she had asked for monthly updates regarding CIE and it was felt that the project lacked leadership. Mr Kybert and Mr Butler provided an update on the work of the CIE and the launch of the new process and a user group had been set up. Remote care was a work stream and CIE was part of this. In respect of Maternity voices, it was a good forum and going forward the Lay Forum would act as an enabler for other patient voice groups.
13.9.4.	Ms Scavazza commended the proactive work of the Lay Forum. She encouraged the Forum to continue their work with increasing lay partner diversity, opining that it was imperative to have good representation of the population and the body of staff. In terms of building trust in the communities, as well as communication, she stated it was important to demonstrate the actions and the influence the Lay Forum was able to have on the Trust. Ms Thalassis agreed and referred to the positive actions such as DNR and interpreting services.
13.10.	**The Board noted the update and supported the strategic lay forum priorities for 2021-22.**
14.	**Maternity Quality Assurance Oversight Report**

14.1.	The Board received the assurance report on the maternity quality assurance report and progress on achieving compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) year three. The Local Maternity and Neonatal System (LMNS) had signed-off the CNST MIS compliance on 7th July 2021.
14.2.	The report also outlined to the Board of the evidence submission progress with the seven Ockenden Immediate and Essential Actions (IEA). The evidence in relation to the Ockenden recommendations had been submitted to NHS England.
14.3.	The Board noted that there were seven requirements rated as 'not met' within the active Board Declaration action form and that mitigations were in place and accepted by CNST as compliant with the scheme. Prof. Teoh outlined the 'not met' actions and mitigations.
14.4.	The Quality Committee had received a draft report and declaration at its meeting on 8th July 2021 and authority was delegated to the Committee Chair to review the final version before recommending sign-off by the Trust Board. Mr Jenkinson confirmed that he had received written confirmation of the Committee Chair's sign-off, who was content for the Board to sign the Declaration.
14.5.	Comments from the Non-Executive Directors:
14.5.1.	In respect of the serious incidents, Mr Goldsbrough enquired about the reference to 'reduced staff and reduced seniority of staff available at the time'. Prof. Teoh advised that this was dependent on how busy the labour wards are at the time of an incident occurring and that assurance is provided via one-to-one care in labour and supernumerary labour ward co-ordinator being present for 99% of the time but cannot provide a guarantee that this arrangement would be available 24/7, 356 days over the year. He advised that there were a few occasions when the appropriate staffing cannot be arranged. He assured the Board that reflecting over a six month period of activity and staffing levels, the number of incidents had reduced significantly. In terms of lack of availability of experienced staff, Prof. Teoh advised that this would require 24/7 consultant cover, predominately anaesthetic staff, and most maternity units do not have this arrangement at the current time. Mindful of the constraints, Dr Raffel enquired whether larger maternity units would alleviate staffing constraints. Prof. Teoh advised that if maternity units were combined onto one site, it would enable better provision of cover but obstetrics and anaesthetist consultants would likely continue to be a challenge.
14.5.2.	In terms of further assurance, Prof. Orchard added the Trust would be reviewing all the maternity serious incidents which occurred over the last year – although he was confident that the Trust has a good and safe service, he wanted to make sure that the Trust had learned lessons and addressed any gaps or areas, and assess whether the actions taken were right and the Trust did everything it could have done. As part of this review, a view would also be taken around the staffing issues – local maternity systems were a key component of assurance around maternity, however, the LMNS may need to take a view across the sector in regard to staffing.
14.6.	**The Board noted the assurance report and approved the CNST Declaration.**
15.	**Infection, Prevention and Control (IPC)**
15.1.	**IPC and Antimicrobial Stewardship Annual Report 2020-21**
15.1.1.	The Board received the annual report which highlighted the key activities throughout 2020-2021. The Covid-19 pandemic had continued to demand fundamental changes to the healthcare services provided by the Trust, the NHS, and all healthcare providers

	globally. The annual report provided a summary of the Trust's response to the pandemic, progress with improvement plans and data related to the reduction of HCAIs and the antimicrobial stewardship programme. The Board noted and applauded the IPC team who played a central role in the Trust's response to the Covid-19 pandemic. The report had been discussed and accepted by the Quality Committee.
15.1.2.	Mr Price highlighted that the Trust has had positive feedback from public health colleagues on its management, particularly the management of healthcare onset Covid-19 infections. He added that the Trust was a high reporter and was reporting smaller situations than other Trusts which was an indicator of good management and learning. The Trust's antimicrobial stewardship programme had been strong throughout the pandemic and the team had kept the broad spectrum antibiotics use in line with the quality performance indicators. The Trust was able to undertake and apply its research during the Covid-19 pandemic which had also been incorporated into the national and international response to Covid-19.
15.1.3.	In the context of Covid-19 becoming endemic, Mr Goldsbrough sought views on how the Trust should target the number of hospital acquired infections in the same way as for other diseases; what would good like compared to what was currently being done; and were there other things that needed to be considered as part of living with endemic Covid-19. Mr Price advised that the pandemic had also presented an opportunity and heightened learning and engagement across the Trust, partners and communities and enabled different approaches. He advised there was a wide spectrum of germs which cause HCAIs transmitted via different routes and therefore the focus going forward would be around balancing that engagement recognising that processes were not the same for all germs therefore the education around PPE use, risk assessments for different germs would be key. Prof. Redhead added that the approach to infection control would be integral to hospital rebuilds including research and staff engagement.
15.1.4.	**The Board noted the report.**
15.2.	**IPC Board Assurance Framework (BAF) Report**
15.2.1.	The Board received an update on progress with completion of the actions required to provide assurance with all elements of the BAF. This was a live document including the self-assessment from June 2021. The report had been discussed and accepted by the Quality Committee.
15.2.2.	An action plan was in place to undertake the necessary work that would improve Board assurance related to IPC management of Covid-19 infection. This was being monitored weekly at the CRG reporting to the Executive management Board. Good progress was being made in general. One area remained "red" rated (provision and recording of training for staff issued with FFP3 respirators). A plan for FFP3 respirator management was being led by the Chief Operating Officer, which would address this Key Line of Enquiry.
15.2.3.	**The Board noted the report.**
16.	**Complaints and PALS Annual Report**
16.1.	The Board received the annual report for 2020-21. Key highlights included the impact of Covid-19 on activity as formal complaints fell as services were reduced, this was particularly noticeable during the two peaks of the pandemic in April 2020 and January 2021. PALS activity overall remained the same but identified new areas of concern for patients, such as issues arising from the shift to virtual appointments. The Trust sees complaints as learning opportunities and actively supports people to raise concerns

	about their care. It also links with the Trust's improvement work as noted during the Public and Patient Involvement discussion at item 13.
16.2.	In the year 768 formal complaints were received (down from 1074 in 2019/20) which represented less than 0.1% of total patient contacts. There were 3401 PALS concerns during the year (3375 in 2019/20) around 0.3% of total contacts. Overall performance in complaints handling was good throughout the year and for the first time no cases were upheld by the Parliamentary Health Service Ombudsman (PHSO).
16.3.	The complaints team worked closely with Imperial College on the development of Healthcare Complaints Analysis Tool (HCAT), which provides a way of categorising complaints as an alternative to the NHS Digital categories that organisations report on. It was expected that during the current year benchmark data would be available and more detailed review would start to identify areas for improvement work.
16.4.	Key issues arising from complaints and PALS concerns during the year were related to appointments, communication and maternity, which were explained in more detail in the report. Another key area of work was recording protected characteristics to ensure equity of access and quality of outcomes.
16.5.	The report had been discussed in detail at the Quality Committee as one of its deep dive topics and Mr Alexander suggested for those who were not members of the Quality Committee to read the deep dive report, available from the Trust Secretariat.
16.6.	Mr Ross enquired about the size of the complaints team and the process for complaints which were not upheld by the Trust. Prof. Sigsworth outlined the structure and process of the complaints and PALS team and the arrangements during the pandemic. If a complainant was unhappy with the Trust's response, the Parliamentary Ombudsman could be contacted who would review and advise whether the decision by the Trust was upheld or not. Prof. Sigsworth stressed that the Trust tries hard to resolve complaints with families and patients.
16.7.	Ms Scavazza asked whether the Trust makes the complaints process clear for all users and families, particularly for those whose first language was not English. Prof. Sigsworth advised that in the national inpatient survey this question was asked and although the Trust fairs well in this area, the Covid-19 restrictions had made it difficult. Once the team improve on recording the protected characteristics of complainants, the data would enable the team to focus on groups who may be disproportionately represented in respect of complaints and PALS and would enable focus to drive improvement in liaison with Lay partners and families.
16.8.	**The Board noted the annual report.**
17.	**Integrated Risk and Assurance Report**
17.1.	Mr Jenkinson reminded the Board that the Audit, Risk and Governance (ARG) Committee was the Board level Committee with responsibility for oversight of risk and assurance mechanisms. The report had been discussed in detail at the ARG Committee. He commented that at the beginning of the year although the Trust had moved to governance lite arrangements where some Board Committees were stood down, the Trust continued with its risk management processes including a specific Non-Executive Directors session on risk management.
17.2.	The Board received an update on risk management and assurance activities at the Trust over the past six months. In particular, the report focused on: The updated Trust risk

	appetite; Board Assurance Framework (BAF) with focus on the risk and assurance deep dives; key changes to the corporate risk register over the past six months; and Risk themes to focus on in 2021-22.
17.3.	The risk appetite would be further reviewed by the Chairs of the Board Committees for their related statements and the KPIs would be aligned to the Committee level scorecards to be introduced via the Imperial Management and Improvement System (IMIS) programme. Next steps in terms of embedding the risk appetite would be discussed at each committee in September.
17.4.	The corporate risk register would continue to be monitored by the Executive Management Board monthly and by the ARG Committee at each meeting.
17.5.	Risk and assurance deep-dives would continue to occur at all Board Committees as agreed by the Committees' chairs and would be overseen by the ARG Committee.
17.6.	Risk themes for focus in 2021/22 would be further reviewed and any current gaps on the risk registers addressed as appropriate.
17.7.	Mr Alexander confirmed that the work set out in the report builds on the risk conversation between the Executive Team and the Non-Executive Directors. Mr Goldsbrough enquired whether the themes from the discussion were now fully reflected within the Risk Register. Mr Jenkinson advised that work was progressing to translate those into risks or capture within the governance framework. The updated Risk Register which would be presented to the September ARG Committee.
17.8.	**The Board noted the report.**
18.	**Trust Board Committees – summary reports**
18.1.	**Audit, Risk and Governance Committee** The Board noted the summary points from the meetings held on 17th, 25th June and 7th July 2021.
18.2.	**Quality Committee** The Board noted the summary points from the meeting held on 8th July 2021.
18.3.	**Finance, Investment and Operations Committee** The Board noted the summary points from the meeting held on 7th July 2021.
18.4.	**Redevelopment Committee** The Board noted the summary points from the meeting held on 9th June and 8th July 2021.
18.5.	**People Committee** The Board noted the summary points from the meeting held on 6th July 2021.
19.	**Any other business** The Trust would be holding its Annual General Meeting in the evening (Wednesday 14 July) at which the Trust's 2020/21 annual report would be shared.
20.	**Questions from the public** One question was received in advance of the meeting. The member of public shared his and his partner's experience on exiting from Charing Cross Hospital following a late night discharge. The Site Director had reviewed the pathway that would have been followed as a patient and found that the signage was not helpful to patients and would work with the communications team to improve the signage. A written response would be sent to the member of public.
21.	**Date of next meeting** 15th September 2021, 11am

Updated: 8 September 2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Record of items discussed at the confidential Trust board meeting held on 14th July 2021 and Extraordinary Trust Board held on 29th July 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: 15 September 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 14th July 2021 and Extraordinary Trust Board held on 29th July 2021.

14 July 2021 Private Trust Board

2. Chair's briefing

2.1. As part of the Chairman's oral update, the Board received an update on discussions between north west London acute provider Trust chairs on collaborative working across providers and the development of collaborative governance arrangements. This included a joint workshop for NWL Audit Committee Chairs to meet to discuss risk and governance. An update was provided regarding the approach to the appointment process of the joint chair for the four acute trusts in NW London.

3. Chief executive's update

3.1. The Chief Executive provided an oral update on Covid-19 and the Trust's response; changes to the Elective Recovery Fund requiring the Trust to review its elective plans and financial impact; and Imperial Charity engagement in respect of the Redevelopment project. An update was also provided regarding Employment Tribunal cases.

4. Redevelopment update

4.1. The Board received an update on the current position of the St Mary's Hospital (SMH) redevelopment. The Board approved the strategic outline case for the redevelopment, and agreed to hold an extraordinary Board meeting to consider further the available options for next steps.

5. Centre for clinical infection update

5.1. The Board received an update on the development of a centre for clinical infection as part of the redevelopment of the St Mary's. Work had been progressing through clinical academic engagement and working group meetings led through a steering group chaired by Prof. Orchard. The Board noted the updates and supported the next steps following the feasibility study.

29th July 2021 Extraordinary Board Meeting

6. Redevelopment Programme

6.1. An Extraordinary Board meeting was held to consider further the available options for next steps on St Mary's redevelopment.

6.2. Alongside submission of the strategic outline case, work is to be progressed urgently on options for phasing the redevelopment to accelerate key aspects of delivery and benefits realisation and to spread costs.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC) - ACTION POINTS REGISTER, Date of last meeting 14 July 2021

Updated: 31 August 2021

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	12 May 2021 9.8.4	Board Member Visits (arising from Integrated Business Plan 2021-22 discussion)	As government restrictions ease, Prof. Orchard and Mr Jenkinson would revisit the Board member visit programme. July 2021 update: Work was progressing to update the Board member schedule to be launched at the end of July. **September 2021 update: The programme would be emailed to the Board mid-September.**	Mr Jenkinson	September 2021

Items closed at the July 2021 meeting

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	12 May 2021 16.5	Attendance at meetings (arising from Annual Review of Board Committee Terms of Reference and Board Governance Update item)	Mr Alexander asked Committee Chairs in their first cycle of 2021-22, consider attendance at the respective Committees and feedback to Mr Jenkinson – this would feed into the effectiveness review noting the need to balance Executive and Non-Executive Director attendance at Committees. July 2021 update: As part of the effectiveness review (commencing in July), Board members will be invited to comment in respect of attendance at Committees.	Committee Chairs, Mr Jenkinson	Closed

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

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Patient Story

Agenda item 7 and paper number 04

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

Purpose: For information

Meeting date: 15 September 2021

Executive summary

1. Purpose

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

1.2. The perceived benefits of patient stories are:

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

2. Introduction

2.1. The pandemic continues to hamper the ability to have patients tell their stories in person. The story on this occasion will therefore be told by the Deputy Director of Patient Experience, based on a complaint received by the Patient Advice and Liaison Service in June 2021. The patient experience team is aiming to have a patient tell their story at the November Board meeting.

3. Findings

3.1. The patient in this case was very 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

3.2. The story describes the issue and how the patient experience team learned from it and changed the way the question is asked.

3.3. Patient feedback from the FFT is a very important source of information about how people experience our services. Anything that might impact whether people complete the survey therefore needs to be addressed.

3.4. The pandemic has had an impact on the number of people completing the FFT although this now appears to be improving again. In August a total of 10,500 responses were received across all surveys.

4. Next steps

4.1. Work to review the collection of demographic data, including gender identity, across all trust platforms is underway.

5. Recommendation(s)

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

6. Impact assessment

6.1. 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

7. Patient story

7.1. In June 2021 a complaint was received through the Patient Advice & Liaison Service (PALS) about the demographic section of the trust online Friends and Family Test (FFT) survey. The complaint related to a question asked as part of the FFT survey, specifically in relation to gender identity.

7.2. This was the only issue complained about. The patient was otherwise very complimentary about her experience of care at Queen Charlotte's and Chelsea Hospital.

7.3. All users of trust services are given the opportunity to complete the FFT to comment on their experience. The FFT question is "*Overall, how was your experience of our service?"* This question is consistent throughout all NHS organisations.

7.4. Since the introduction of the FFT, the Trust has asked a series of demographic questions and these have been subject to amendment over time based on factors such as changes to response rates, feedback from patients and issues that may have been identified from the survey results.

7.5. At the time the complaint was received the demographic questions in the survey asked about age, gender identity, ethnicity, disability, religion and sexual orientation.

7.6. The gender identity question gave four response options; male, female, trans man/woman, non-binary. This was based on NHS guidance and consultation with users of the trust gender reassignment services.

7.7. 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.

7.8. Initially the patient experience team proposed adding a “prefer not to answer” question, but the complainant felt that this still failed to recognise their biological sex as the defining characteristic.

7.9. Being mindful that there are users of our services who identify with a gender that is different to their biological sex a two stage option to address this issue was settled on.

7.10. Part one of the question asks about sex with the options: man/boy, woman/girl, prefer not to say.

7.11. 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.

7.12. In this way people who wish to answer based solely on their biological sex can do so and those who wish record their gender preference can do so too.

7.13. Again this approach was discussed with users of the Trust gender reassignment services who supported it.

8. Conclusion and next steps

8.1. Issues related to the recording of gender identity are relatively new territory; indeed the Equality Act still refers to gender reassignment rather than identity.

8.2. Asking about sex and gender is important to help analyse people’s experiences but has the potential to present difficulties and so ensuring it is done consistently and appropriately is of benefit to both patients and staff.

8.3. At around the same time as the PALS complaint was received the patient experience team was contacted by a researcher at Imperial College who raised a question about how gender identity was recorded in the Trust electronic patient record (EPR). The answer was in a fairly rudimentary way.

8.4. This has prompted a programme of work to review the current demographic data in the EPR to ensure that it is consistent with what is being recorded elsewhere. This work is at an early stage and progress will be reported to the Equality, Diversity & Inclusion Committee.

8.5. The Board will also recall that in the 2020/21 annual complaints report the issue of recording demographic data of complainants has been identified as a priority. Again, it will be important to align this with the wider work.

8.6. This story demonstrates how, even with the best intentions and preparation, crafting demographic questions can have negative consequences for the people being asked to complete them and that there is always room for improvement.

Imperial College Healthcare NHS Trust

8.7. This was a valuable learning experience for the patient experience function and shows how complaints to the trust can result in positive change.

8.8. More details about the Friends and Family Test can be found on the patient experience page of the Trust website.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Chief executive's report

Agenda item 8 and paper number 05

Executive Director: Prof Tim Orchard, Chief executive

Purpose: For noting

Meeting date: 15 September 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 performance, including Covid-19 update
- Covid-19 and flu vaccination programme
- Acute care programme update
- Financial performance
- CQC update
- Redevelopment
- Research and innovation
- Stakeholder engagement
- Celebrating success

1. Operational performance, including Covid-19 update

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

Although we have not seen the number of Covid-19 patients during this wave that we had earlier this year, the number of admissions has added extra pressures for our hospitals and the region. We have also seen significant pressure on the urgent and emergency care pathway for the last month or so and have responded to this using our existing escalation processes.

2. Covid-19 and flu vaccination programme

As of the end of August 2021, our in-house vaccination programme has delivered more than 24,500 first doses of the Covid-19 vaccine and over 22,600 second doses to our staff, health and social care colleagues across the sector and patients. Considering eligible staff designated as frontline, 92.3% have had their first dose, this includes staff who have advised us that they have been vaccinated outside of the Trust. Of these, 93% have had their second dose and we are supporting the remainder to complete their course as soon as possible.

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 has been developed for the anticipated delivery of a programme

commencing in late September. Guidance from the JCVI is expected imminently on the delivery of this programme which may further shape our plans.

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 of our key operational areas. The effectiveness of our response to the pandemic has demonstrated that we can – and should - do more to harness our collective resources, join-up our care and reduce unwarranted variations in access and outcomes.

Our immediate focus is on recovery from the peak of the pandemic, reducing our waiting times for planned care while continuing to prioritise by clinical need and minimising the ongoing risk of Covid-19 infection. We also want 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.

Attached as an appendix is the latest programme briefing, providing an overview of our key developments, challenges and opportunities as well as an update on progress.

4. Financial performance

The Trust continues to work to a breakeven plan for the first six months of the financial year ('H1' which runs from April 2021 to September 2021) as agreed with North West London Integrated Care System (NWL ICS). This includes funding made available by the ICS to cover lost non-NHS income, contingent on the Trust ensuring it has exhausted all other avenues to achieve breakeven. Within our H1 plan, there is a requirement to deliver a cost improvement programme (CIP) of £15.8m. The Trust will be funded for elective work above trajectories through the elective recovery fund (ERF). This income is non-recurrent.

For the 4 months to the end of July 2021, the Trust has achieved a break-even position with the year to date under delivery of CIPs offset by non-recurrent ERF funding. To address the shortfall in CIPs and ensure the Trust continues to focus on its underlying financial position; the Executive will be launching a revised approach to CIP planning that not only maximises current opportunities but develops a more resilient plan for the future. All things being equal and given the uncertainty around funding arrangements for the second half of the year the Trust is forecasting to meet a break even position in H1.

The Trust has set a capital plan of £84.7m for the year and has spent £11.0m (57%) of its agreed capital plan year to date. This underspend is largely due to timing, and it is expected that the full plan will be achieved within the financial year. At 31 July, cash was £148m. The cash outlook is robust in the medium term but the full-year forecast is highly dependent on the funding regime for the second half of the year which has yet to be published.

5. CQC update

During the Trust's engagement meetings with the CQC in June and July 2021, the CQC indicated the Trust is considered low risk and therefore a routine regulatory assessment or inspection by the CQC is not anticipated during 2021/22.

The Board will recall that 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. The previous methodology around CQC compliance and ICPG has been enhanced by a continuous quality improvement approach with three levels of quality monitored:

- Trust level (corporate functions and Trust wide matters, called 'focused improvements')
- Service / directorate level
- Ward level (the 'unit of change' in delivery of the basics of care).

The Board will also recall that, prior to the previous CQC inspections of the Trust in February 2019, four common areas for focused improvement were identified across all services. We have established a revised set of focused improvements for 2021/22, agreed at the Executive Huddle on 1 September 2021:

- Medicines management (continuing priority)
- Statutory / mandatory training (continuing priority)
- Incident reporting (new priority)
- Daily board rounds (new priority)

ICPG activities are being aligned with the Trust's ward accreditation programme and Pathway to Excellence accreditation preparation activities.

6. Redevelopment

We have formally submitted our strategic outline case for the redevelopment of St Mary's Hospital. It represents the first stage of the approval process for NHS England and the Department for Health and Social Care. St Mary's – together with the Trust's Charing Cross and Hammersmith hospitals – are included in the 40 new hospitals 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 outline planning is complete. Phase 2 will commence as soon as funding from new hospitals programme is confirmed.

7. Research and innovation

Following submission for stage 1 of our NIHR Biomedical Research Centre (BRC) re-application at the end of May, we received notification from NIHR that we can continue to stage 2 of the process with our proposed 15 themes and £100m budget. Feedback has been minimal, but we have been asked to consider more how we might further integrate themes. We are currently working with theme leads to craft the stage 2 submission by mid-October, together with a financial plan to deliver our research objectives. The NIHR Imperial Clinical Research Facility (CRF) is also in the process of re-applying for five years further funding.

Patient recruitment to Covid-19 urgent public health clinical research studies continues (7,789 to date across 34 studies). The world's first human challenge study with the SARS-COV-2 virus (led by Imperial) is nearing the initial stages of analysis and publication, and new studies are being initiated to study 'long Covid'.

We have been successful in attracting funding from NHS Digital for a number of high-profile digital projects to improve care and care pathways. These are moving towards detailed agreements.

8. Stakeholder engagement

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

- Annual General Meeting: 14 July 2021
- Nickie Aiken MP visit to St Mary's Hospital: 21 July 2021
- Karen Buck MP and Andy Slaughter MP: 7 September 2021

- Jo Churchill MP visit to Charing Cross Hospital (North West London Pathology): 8 September 2021
- Jo Churchill MP visit to Hammersmith Hospital (Cardiology service): September 2021

9. Recognition and celebrating success

National clinical director for urgent and emergency care
Trust medical director, Professor Julian Redhead, has been appointed as national clinical director for urgent and emergency care.

Awards
I am delighted to report that Saghar Missaghian-Cully, Managing Director of North West London Pathology (NWLP), has been recognised in this year's Pathologist Power List for her work in NWLP's response to the Covid-19 pandemic and transformation programme; and Dr Ros Bacon, Consultant Anaesthetist, has been awarded the RCoA President's Commendation for her contribution to work allowing anaesthetists in training to continue sitting exams during the pandemic.

I am also pleased to report the Thrombectomy service has been shortlisted for the British Medical Journal's stroke and cardiovascular team award for 2021; Imperial College has been shortlisted for its work on the REMAP-CAP study in the critical care category; and Sabrina Das, consultant obstetrician and gynaecologist based at Queen Charlotte's and Chelsea Hospital, has been shortlisted for the HSJ Clinical Leader of the Year award.

Lauren Hutton, Trust bereavement midwife, has been nominated for Best Midwife in the Sun's Who Cares Wins awards. Lauren has been nominated by Carly and Roo Hogson, a couple she supported following the death of their unborn daughter Poppy. The family founded Poppy's Fund in her memory.

Nursing Times award nominations: Nonhlanhla Nyathi 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.

Trust staff members have been promoted as part of the latest round of academic promotions at Imperial College London.
Of more than 130 academic staff promoted at Imperial College for this year, 14 also have clinical roles across the Trust, including radiologists, gynaecologists, infectious disease experts and surgeons. The promotion of Trust staff who hold both academic and clinical positions further highlights research excellence at Imperial College Healthcare, with many of our senior clinicians actively researching in their field to improve care and provide cutting edge treatments for patients.

Imperial College Healthcare staff promoted at Imperial College London in 2021:
- **Dr Caroline Alexander** - Lead clinical academic for therapies and Professor of practice (Musculoskeletal Physiotherapy)
- **Dr Tara Barwick** - Consultant radiologist and Professor of practice (cancer imaging)
- **Dr Christopher Chiu** - Honorary consultant in infectious disease and Professor of infectious diseases
- **Dr Susan Copley** - Consultant radiologist and Professor of ractice (radiology)
- **Dr Elizabeth Dick** – Consultant radiologist and Professor of practice (neurosurgery)
- **Dr Andrew Hartle** - Consultant in anaesthesia and intensive care and Professor of practice (anaesthesia)

- **Dr Luke Howard** - Consultant respiratory physician and Professor of practice (Cardiopulmonary Medicine)
- **Dr Maria Kyrgiou** - Consultant gynaecologist, gynaecologic oncologist and Clinical professor of gynaecological oncology
- **Dr Hermione Lyall** - Clinical director, children's services and Professor of practice in paediatric infectious diseases
- **Mr Erik Mayer** - Clinical senior lecturer, consultant urological surgeon and Clinical reader in urology
- **Dr Michael Osborn** - Consultant histopathologist and Professor of practice
- **Mr Nick Panay** - Consultant gynaecologist and Professor of practice
- **Mr Guri Sandhu** - Consultant ENT surgeon and Professor of practice (laryngology)

The Trust is part of the Imperial College Academic Health Science Centre, a partnership between Imperial College London, Imperial College Healthcare NHS Trust and two other London NHS trusts, which brings together multi-disciplinary research and education with NHS resources and clinical experience to advance discovery and innovation in healthcare. The Trust also hosts the (National Institute for Health Research (NIHR) Imperial Biomedical Research Centre, a translational research partnership with Imperial College that provides infrastructure to conduct early-stage experimental medicine and exploits the scientific power of Imperial College to provide breakthroughs in the clinical setting.

Congratulations to all of our Imperial People.

Professor Tim Orchard
Chief executive
9 September 2021

Appendix 1 – Acute Care Programme briefing

Appendix 1 Acute Care Programme Briefing

September 2021- Briefing 2
Ensuring high quality acute care as we emerge from the Covid-19 pandemic

Chelsea and Westminster Hospital, The Hillingdon Hospitals, Imperial College Healthcare and London North West University Healthcare

1 Introduction

In early 2021, we came together to establish a joint acute care board and programme to guide and coordinate developments across all of our key operational areas, including: planned surgery, cancer care, outpatients, intensive care, urgent and emergency care and diagnostics and imaging. The effectiveness of our response to the pandemic has demonstrated that we can – and should - do more to harness our collective resources, join-up our care and reduce unwarranted variations in access and outcomes.

Our immediate focus is on recovery from the peak of the pandemic, reducing our waiting times for planned care while continuing to prioritise by clinical need and minimising the ongoing risk of Covid-19 infection. We also want 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.

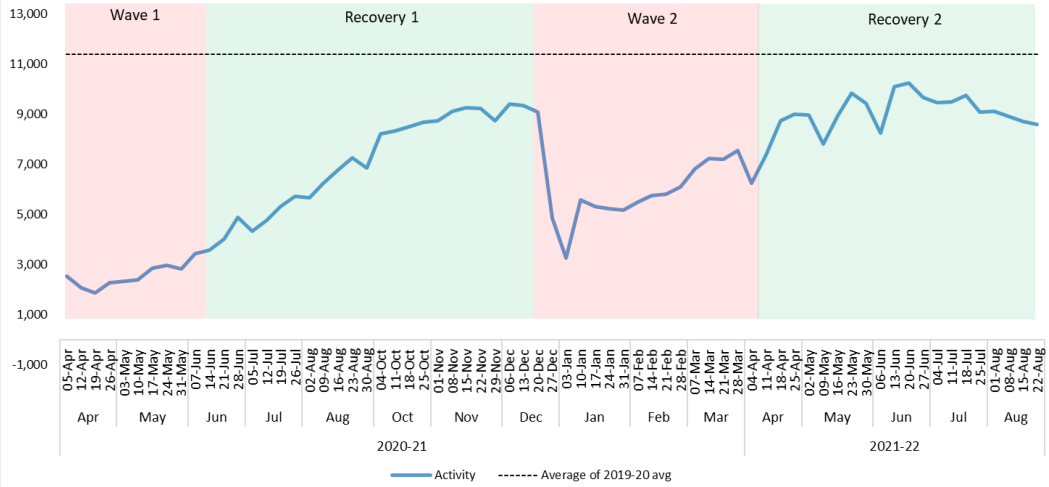
This briefing provides an overview of our key developments, challenges and opportunities as well as an update on progress.

2 Returning to pre-pandemic capacity and improving care pathways

2.1 Planned surgery

We are learning much during the pandemic and working hard to apply that learning rapidly. While we treated more patients with Covid-19 in the second wave of infections, we also managed safely to maintain more planned care. In wave one, planned surgery activity dropped to as low as 15 per cent of pre-pandemic levels while we maintained 50 – 60 per cent of our pre-pandemic activity levels throughout the vast majority of the second wave.

Table 1: Surgery activity for north west London acute trusts (patient episodes per week during the pandemic and compared with pre-pandemic)



In August 2021, we averaged 83 per cent of pre-pandemic planned care activity levels. We achieved 87 per cent in June and took the decision to reduce activity slightly through July and

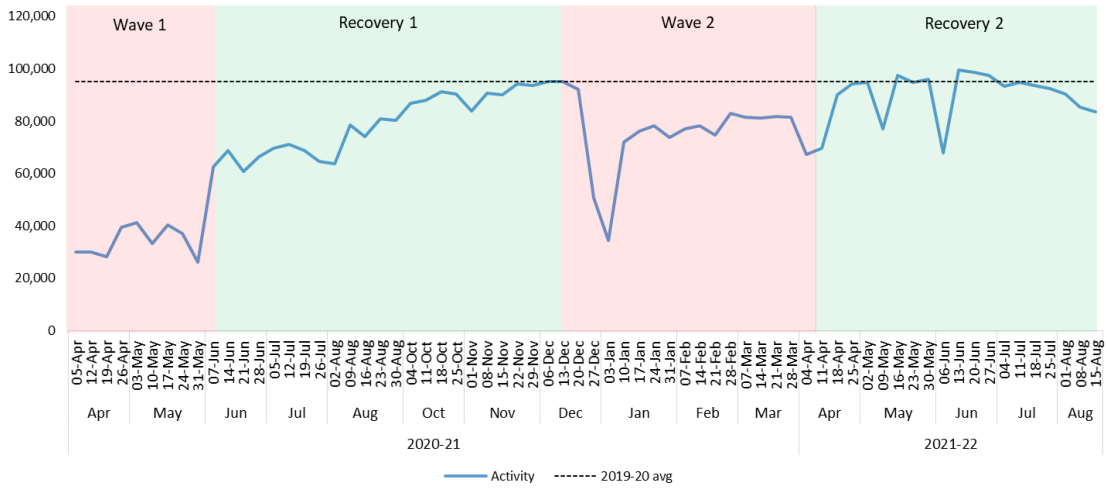
August in order to help ensure our staff had an opportunity to rest and recuperate. In addition, our hospitals are under pressure from unplanned admissions. This includes continuing admissions due to Covid-19, albeit at a much lower and steadier level than during the second wave of infections. A national target has been set for planned care recovery which, if we meet, gives us access to additional central income through the elective recovery fund (ERF). The national target was up to 85 per cent for the first quarter of 2021/22, which we met. The target was increased to 95 per cent from July and we are working to meet that level from September. To help us boost capacity, we are maximising the use of our existing facilities, using national benchmarks and best practice (supported by the national Getting It Right First Time (GIRFT) programme) to help us understand where we should focus our improvements. Our clinical and operational leaders meet regularly through joint 'speciality huddles' and sector wide clinical reference groups to review data visualisations to aid analysis and agree actions.

The GIRFT approach also underpins the further development of our fast track surgical hubs - 14 surgical facilities across our hospitals dedicated to one or more types of routine operation where evidence has demonstrated improved quality and efficiency if a surgical team undertakes high numbers of that procedure systematically. The hubs focus on six clinical specialties characterised by 'high volume, low complexity' procedures.

For a small number of services with particular capacity challenges, we have brought in an external specialist organisation to provide additional capacity within our own facilities or contracted with an independent sector hospital to provide surgery or treatment for our patients.

2.2 Outpatient care

Table 2: Outpatient care activity for north west London acute trusts (appointments per week during the pandemic and compared with pre-pandemic)



During the second wave of Covid-19 infections, we managed to maintain outpatient activity at around 80 per cent of pre-pandemic levels. In August, we averaged 97 per cent of previous levels, continuing to exceed the national target which was 85 per cent for the first quarter of 2020/21, increased to 95 per cent from July.

We are continuing to provide around 25 per cent of our outpatient consultations via telephone or video. We had to move quickly to virtual appointments at the start of the pandemic and, while we need to continue to improve the user experience and our own processes, the vast majority of patients and clinicians welcome the new approach and want it to continue.

A further significant development for outpatient services will be the implementation of a common and consistent approach to how our hospital clinicians work with GPs to provide

specialist advice and guidance earlier in a patient's care pathway. This will help determine whether and how a patient should be referred for hospital care or whether their condition is better managed in the community or at home. The approach is being supported by investment in a sector-wide digital platform for GPs and hospital clinicians, to be integrated with core patient administration and referral systems so that a referral can be progressed automatically if required. The system is already being used by The Hillingdon Hospitals and London North West University Healthcare and will be rolled out to Chelsea and Westminster and Imperial College Healthcare this autumn.

2.3 Cancer care

Urgent cancer referrals (on the 'two-week' pathway) have increased since March 2021 and are now above the average for 2019/20. We have still managed to improve performance against the national 'faster diagnosis' standard, with 73 per cent of patients being informed whether they have cancer or not within 28 days of urgent referral as of July 2021, equivalent to an additional 400 patients month.

The significant increase in referrals is having an impact throughout the cancer care pathway. Overall, as of July 2021, cancer first treatments are up 8 per cent against of the baseline of 2019/20. Total cancer surgical treatments (excluding skin and breast) are up 16 per cent against the 2019/20 baseline, with an additional 139 surgeries compared with the 2019/20 average. This increase in demand is creating capacity and operational pressures and longer waits for cancer care than planned. Performance against the 62-day wait (between an urgent referral and the start of treatment) standard is stable at 78 per cent. Together with RMP Cancer Alliance and wider partners across the integrated care system, we are working through how we can best achieve greater, sustainable improvement.

The increase in referrals is a positive development following a fall-off in patients presenting with cancer concerns during the pandemic. There continues to be a major sector-wide focus to help increase awareness amongst local communities, GPs and other partners of the importance of investigating cancer symptoms as soon as possible. The overall 'gap' (between actual and expected cancer diagnoses and 'first treatments') for patients resident in north west London has significantly reduced since March 2021 - from a starting deficit of 471 patients to a deficit of 233 patients in July 2021.

2.4 Diagnostics and imaging

Activity for all but one imaging modalities is now above 2019/20 levels. The exception is non-obstetric ultrasound which is running at 60 per cent of 2019/20 activity levels though referrals have also reduced due to the introduction of more detailed referral guidance. We are addressing some specific capacity challenges in the same way as for planned surgery, by offering care in our hospitals where there is more capacity and making use of independent sector capacity.

Greater collaboration and coordination is enabling a major upgrade and expansion of imaging equipment, funded by a national programme, to deliver greater benefits to our local population. Following replacement of two MRI scanners at St Mary's Hospital in February 2021, a further two new scanners are now being installed at Ealing and West Middlesex hospitals. A wider transformation programme is in development.

3 Minimising clinical harm and engaging with patients

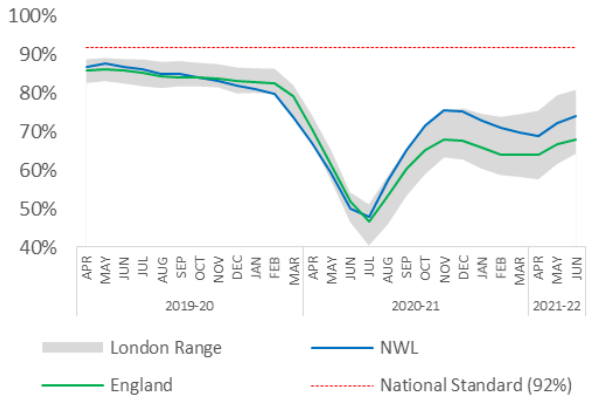
Our clinicians continue to prioritise all patients according to clinical need and regularly review patients waiting for treatment for potential clinical harm. They aim to understand whether anyone waiting for care is likely to be suffering – or has suffered - any harm as a result of the delay to their treatment and to identify appropriate remedial action. We are following principles established by the medical royal colleges which have been adapted for local use by the clinical

leaders across north west London who make up the clinical reference groups for the different specialties.

We are beginning to roll out a pilot to improve communications and engagement for patients who have been waiting a long time for outpatient care and planned surgery, beginning in ear, nose and throat services at Imperial College Healthcare. It includes a letter and materials apologising to patients for the delay, providing information and advice about their care and asking them to confirm their details and whether they still need their appointment. Initial results have been positive, with the vast majority of patients who respond saying they feel more reassured and some letting us know that they no longer need care or rearranging their appointment or changing their details, helping us to make best use of our resources.

4 Tackling long waits and making waiting fairer

Table 3 Percentage of patients who have been waiting 18 weeks or less from referral to treatment



In line with expectations, our combined waiting list increased during the first quarter of 2021/22 though our sector has the lowest per capita list in London. As of June 2021, an overall total of 179,753 patients were waiting for planned care, equivalent to 85 patients per 1,000 population. As of June 2021, 74 per cent of patients had waited 18 weeks or less from referral to treatment, still under the pre-pandemic national standard of 92 per cent but significantly up on a low of less than 50 per cent in July 2020. As a sector, we are also above the average for England.

Like the rest of the NHS, though, a significant number of patients on our list have been waiting for a long time. Alongside ensuring we treat patients with urgent clinical needs within the safest timescales, we have also put a special focus on treating those with the longest waits.

We have reduced the number of patients waiting 52 weeks or more from a peak of 6,802 in February 2021 to 3,883 as of June 2021. Currently, 2 per cent of patients on our list are waiting more than 52 weeks, compared to 4 per cent for the whole of London and 6 per cent across England. We have reduced the number of patients waiting more than 104 weeks from a peak of 126 on 17July 2021 to 112 patients at the end of August. Almost all of these patients now either have a booked date for their treatment or have chosen to postpone their treatment further for personal reasons. We are committed to having no one waiting over 104 weeks by the end of 2021/22.

Closer collaboration has been one of the key ways in which we have been able to tackle our longer waits and it is also driving a strategic development to make waiting times fairer overall. We have been creating a single view of waits across our hospitals to understand where a service in a hospital that has good capacity might be able to support the same service in

another hospital that has long waits. In recent months, we have been able to offer faster care for patients waiting for gynaecological surgery, cataract surgery and endoscopy.

Longer term, we want to create a common and consistent approach to managing waiting lists across specialties and hospitals as effectively as possible. We're working towards common definitions and processes and beginning to explore digital systems to help provide up to date information and booking support to hospital clinicians and GPs, as well as to patients.

5 Urgent and emergency care

Urgent and emergency attendances continue to be significantly higher than expected for this point in the year. We have a major focus on Trust and sector-wide plans and improvements to help manage demand as we head into the winter. This includes: an expansion of 'same day emergency care'; optimising our 'front door' pathways, including encouraging the use of NHS111 First, to avoid waits in A&E and urgent treatment centres; and closer working to reduce delays in discharging patient who are medically fit to leave hospital.

6 Specialist care

While not formally part of the acute care programme, the four acute providers are also working collaboratively, along with NHS England, to improve the quality of specialist care services. So far, the vascular care teams from Imperial College Healthcare and London North West University Healthcare have come together to provide complex surgery for abdominal aortic aneurysms in one centre at St Mary's Hospital in line with research demonstrating best practice and outcomes. This service change was completed in July 2021, with engagement and input from our local authorities and wider stakeholders. The two clinical teams are continuing to work together in order to explore further improvements.

Clinical leaders for a number of other specialist services in the four acute providers, including complex colorectal cancer, pouch surgery, head and neck cancer and clinical haematology, are also coming together to explore opportunities to improve quality through greater collaboration and, potentially, some service consolidation.

For more information, please contact:

Imperial College Healthcare - mick.fisher@nhs.net
London North West University Healthcare - Tracey.Beck@nhs.net
Chelsea and Westminster Hospital - stephen.cox15@nhs.net
The Hillingdon Hospitals - justine.mcguinness@nhs.net

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Integrated quality and performance report - month 4 (July 2021 data)

Agenda item 9 and paper number 06

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

Purpose: For discussion

Meeting date: Wednesday 15 September 2021

Executive summary

1. Purpose of this report

1.1. This paper presents the integrated quality and performance report for month 4, summarising performance against the key performance indicators (KPIs) for data published at month 4 (July 2021).

2. Background

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

2.2. Three countermeasure summaries are enclosed:

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

3. Key findings

3.1. Overall, the Trust has 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.

3.2. Our incident reporting rate has continued to increase and our harm levels remain within the threshold level.

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

4. Recommendation(s)

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

5. Impact assessment

5.1. Quality impact: This report highlights areas where there may be a risk or potential issues to the delivery of quality of care and operational performance. Improvement plans are monitored through the Executive Management Board (EMB), its subgroups and the Board committees. Effective monitoring and oversight of KPIs through this report and the integrated performance scorecards will have a positive impact across all CQC domains.

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

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

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

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

Main report

6. Month 4 performance

Operating plan 2021/22 – performance and activity update

6.1. The Trust is flagging on the enclosed scorecard as not meeting the minimum requirement of 95% of baseline activity for elective spells under the Elective Recovery Fund (ERF) scheme.[1] However overall the Trust achieved the recovery requirement overall for July year to date. This is because ERF target is measured in financial value rather than volume alone. Although the total number day cases was lower than the plan, operationally, a greater number of higher priority cases (with greater complexity) have been completed which has an impact on values and overall ERF achievement.

6.2. Although activity plans did make assumptions around impact of annual leave, sickness and isolation absence, these factors have impacted delivery in July.

6.3. The trajectory targets were met for total waits over 52 weeks, total waits over 78 weeks and total waits over 104 weeks.

[1] The minimum threshold for trusts to access the ERF was adjusted from 85% of 2019/20 activity levels to 95%, with effect from 1 July 2021.

Referral to Treatment

6.4. In July 2021, the overall size of the RTT waiting list closed at 74,437 patient pathways (+2.9% on the previous month). This continued increase is consistent with forecasted growth within the North West London sector and is within the Trust's trajectory of 77,159 or less for the month.

6.5. The Trust remained ahead of plan for reducing the number of patients waiting more than 52 weeks to start consultant-led treatment. At the end of July 2021, 1,464 patients were waiting over 52 weeks against the target of 2,873.

6.6. The 78 week wait target was met overall, although performance for 78 week non-admitted pathways was behind plan (114 non-admitted patients were waiting over 78 weeks against target of 70). The delays for very long waits are predominantly associated with patient choice. Patients in this cohort have experienced significant disruption to their elective care during the course of the pandemic and some are choosing to defer their treatment whilst remaining active on the waiting under regular review (categorised as P5s and P6s according to national elective care guidance).

6.7. The target for 104 week waits was also met.

Diagnostics

6.8. The Trust diagnostics waiting times reduced, with 33.2% of patients waiting more than 6 weeks for their diagnostic test at end of July 2021 (compared to 36.9% the previous month).

6.9. In Neurophysiology, the total number of patients waiting for a diagnostic has reduced but performance of the 6 week standard has not yet improved. An action plan has been developed by the Division of Medicine and Integrated Care to address the underlying issues and updates are being provided at the divisional oversight meetings.

6.10. Endoscopy reported an improvement in their performance and Imaging reported further reductions in their breach rate.

6.11. From August 2021, NHS Acute Trusts are being asked to report on prioritisation for patients waiting for a diagnostic test or procedure. The first submission was 18 August and currently over 99% of patients on a diagnostics waiting list are prioritised according to the new prioritisation codes.

Cancer waiting times

6.12. The Trust continued to meet the cancer 2 week wait standard in July. The 62-day GP referral to first treatment performance was not met, with performance of 73.8% against the 85% standard. 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 June performance. The action plan associated with July performance will be reported through the divisional oversight meeting and executive management board

6.13. The cancer 62-day waiting list backlog increased. At the end of July, 252 patients were waiting more than 62 days against a trajectory target of 212. The main causes were related to temporary staff absence within the corporate cancer team (now resolved) and general surgery which increased colorectal virtual clinic waiting times. Pathology reporting delays also resulted in increased tip over rates in some areas.

Urgent and Emergency care

6.14. The Trust's Ambulance handover performance (within 30 minutes) decreased by 3.5% to 92.5% and fell below the overall improvement trajectory.

6.15. 356 patients spent more than 12 hours in the emergency department from time of arrival (up from 180 the previous month). 60 of these were patients waiting on a mental health pathway.

6.16. Two acute 12 hour trolley wait breaches (waits from decision to admit) occurred in July 2021. These have had investigations completed via the sector proforma with learning and actions being taken to support staff and prevent reoccurrence. Non-clinical contributing factors included adherence to escalation policy, documentation issues, delayed confirmation of Covid status and transport delays.

6.17. The overall length of stay across the Trust increased in July. There was an average of 172 patients with a long length of stay of 21 days or more (up from 145 in the previous month).

Quality – safe and effective

6.18. We met our top quartile target for our patient safety incident reporting rate per 1,000 bed days for the third consecutive month. Our Trust-wide improvement programme, which is designed to support sustained improvement, is progressing and divisional action plans are in place which are being managed through the EMB quality group.

6.19. Our mortality rates and harm profile remain low. Our current rolling 12 month percentage of incidents causing moderate and above harm is 1.36%, which is below our threshold of 2.13%.

6.20. There were no MRSA BSIs, CPE BSIs or C. difficile lapses in care reported in July 2021, and we remain on track to meet our annual targets for C. difficile and E. Coli BSI reduction.

Appendices:

Appendix 1 Integrated quality and performance scorecard (Board version) month 4
Appendix 2 Countermeasure summaries

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard - Board Version

Imperial Management and Improvement System (IMIS)

FI = Focussed improvement

M4 - July 2021

Section	FI	Metric	Watch or Driver	Target / threshold	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Reporting rules	SPC variation
To develop a sustainable portfolio of outstanding services																			
Quality safety improvement	FI	Patient safety incident reporting rate per 1,000 bed days	Driver	>=54.9	58.55	51.75	54.35	50.59	56.14	56.74	53.98	50.65	53.39	50.65	58.58	62.90	67.55	Share Success	-
		Trust-attributed MRSA BSI	Watch	0	1	0	0	0	0	1	2	1	0	0	1	2	0	-	-
		Trust-attributed C. difficile	Watch	6	1	2	11	4	5	0	4	8	7	3	7	6	6	-	-
		E. coli BSI	Watch	54	6	4	3	8	3	6	7	5	6	6	3	5	8	-	-
		CPE BSI	Watch	0	0	0	0	1	0	0	1	1	1	0	0	0	0	-	-
		% of incidents causing moderate and above harm (rolling 12 months)	Driver	<2.13%	1.57%	1.57%	1.50%	1.49%	1.50%	1.46%	1.44%	1.48%	1.57%	1.53%	1.41%	1.34%	1.36%	Share Success	-
		Hospital Standardised Mortality Ratio (HSMR) (rolling 12 months)	Watch	<100	68	69	71	71	72	71	72	72	73	76	76	76	76	-	-
		Formal complaints	Watch	<=100	60	51	71	76	68	55	66	74	95	77	53	77	83	-	-
Response and Recovery		Elective spells (overnight and daycases) as % of trajectory target	Watch	100%	-	-	-	-	-	-	-	-	-	103.2%	97.4%	114.6%	87.7%	Note Performance/SVU if Statutory	-
		Outpatient attendances as % of trajectory target	Watch	100%	-	-	-	-	-	-	-	-	-	106.5%	101.5%	117.2%	99.1%	Note Performance/SVU if Statutory	-
		RTT waiting list size	Watch	77,159	52,270	54,924	55,225	55,790	57,226	57,699	57,334	57,991	62,763	65,753	68,242	72,362	74,437	-	SC
		RTT 52 week wait breaches	Driver	2,873	834	1,072	1,259	1,160	990	1,050	1,667	2,278	2,374	2,157	1,837	1,467	1,464	Share Success	CC
		% clinical prioritisation (RTT inpatient waiting list – surgical)	Watch	>=85%	-	-	-	-	-	-	88.7%	90.0%	89.4%	89.4%	89.2%	91.3%	91.6%	-	-
		Diagnostics waiting times	Watch	<=1%	56.3%	50.7%	40.5%	32.9%	29.6%	26.8%	50.5%	47.7%	38.8%	36.4%	36.6%	36.9%	33.2%	Switch to Driver	CC
		Cancer 2 week wait	Watch	>=93%	86.8%	85.1%	83.5%	94.3%	88.8%	95.8%	94.1%	95.3%	94.9%	93.4%	95.0%	93.4%	93.1%	-	CC
		Cancer 62 day wait	Driver	>=85%	72.1%	76.4%	72.3%	71.4%	73.4%	76.8%	77.3%	73.0%	79.1%	80.6%	78.7%	74.7%	73.8%	CMS	CC
		Ambulance handovers - % within 30 minutes	Driver	95%	95.6%	94.3%	95.7%	95.6%	97.1%	88.8%	89.5%	95.1%	96.0%	95.7%	96.8%	96.2%	92.5%	SVU	CC
		Number of patients spending more than 12 hours in the emergency department from time of arrival	Driver	0	154	156	173	219	175	480	632	199	156	165	147	180	356	CMS	CC
	FI	Long length of stay - 21 days or more	Driver	<=126	131	129	145	154	165	166	165	210	180	158	140	145	172	CMS	CC

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard - Board Version

Imperial Management and Improvement System (IMIS)

FI = Focussed improvement

M4 - July 2021

Section	FI	Metric	Watch or Driver	Target / threshold	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Reporting rules	SPC variation
Safe and Sustainable Staffing	FI	Vacancy rate	Watch	<10%	8.2%	8.5%	9.5%	9.7%	9.8%	10.0%	9.8%	9.8%	9.9%	10.6%	11.0%	11.5%	12.0%	Switch to Driver	-
		Agency expenditure as % of pay	Driver	tbc	1.3%	1.1%	1.4%	1.6%	1.6%	2.3%	1.8%	2.7%	2.4%	3.1%	2.4%	2.0%	1.9%	-	-
		Staff Sickness (rolling 12 months)	Driver	<=3%	4.33%	4.36%	4.39%	4.39%	4.39%	4.43%	4.50%	4.54%	4.18%	3.79%	3.74%	3.67%	3.70%	CMS	-
		Staff turnover (rolling 12 months)	Watch	<12%	11.1%	11.1%	11.0%	10.9%	10.8%	10.7%	10.1%	9.9%	9.8%	9.9%	10.6%	10.4%	10.4%	-	-
Finance		Year to date position (variance to plan) £m	Watch	£0	11.10	14.32	17.56	-0.42	-0.53	-0.65	-0.66	10.48	5.07	-3.31	0.34	0.95	2.44	-	-
		Forecast variance to plan	Watch	£0	-2.88	-32.02	17.02	-8.06	-1.39	-15.39	-13.85	1.91	5.07	0.00	11.79	13.20	-36.01	Note Performance/SVU if Statutory	-
		CIP variance to plan	Watch	15.77	-	-	-	-	-	-	-	-	-	-	-	3.77	-6.09	Note Performance/SVU if Statutory	-
To build learning, improvement and innovation into everything we do																			
		Core skills training	Watch	>=90%	89.8%	91.8%	92.4%	92.0%	91.6%	91.8%	91.6%	91.5%	92.2%	93.0%	93.8%	94.5%	94.0%	-	-

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)
RTT - Referral to Treatment

Reporting rules
CMS - Countermeasure summary
SVU - Structured verbal update

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Appendix 2

Integrated quality and performance report:

Countermeasure summaries at month 4 (July 2021 data)

Imperial College Healthcare NHS Trust

Contents

Three countermeasure summaries are enclosed:

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

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

CMS 3: Long length of stay

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CMS 1

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

Countermeasure Summary: Cancer Waiting Times 62-day Performance

Imperial College Healthcare NHS Trust

Problem Statement: Performance against the standard has been non-complaint for 14 consecutive months. May was reported at 74.7% against the 85% standard, an deterioration from May (78.7%)

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

Desired Trend: ⬆

Historical performance:

Standards	2021 Jan	Feb	Mar	Apr	May	Jun
3.1 - Cancer Plan 62 Day Standard (Tumour)	**77.3%**	**73.0%**	**79.1%**	**80.6%**	**78.7%**	**74.7%**
Acute leukaemia		100.0%		100.0%	100.0%	
Brain/Central Nervous System	100.0%			100.0%	100.0%	
Breast	84.6%	64.3%	65.0%	77.1%	73.2%	73.0%
Gynaecological	58.3%	61.5%	79.2%	83.3%	85.2%	82.6%
Haematological (Excluding Acute Leukaemia)	100.0%	100.0%	100.0%	100.0%	80.0%	66.7%
Head and Neck	100.0%	100.0%	100.0%	100.0%	100.0%	84.6%
Head and Neck - Thyroid		75.0%	100.0%	50.0%		100.0%
Lower Gastrointestinal	33.3%	50.0%	55.6%	46.2%	35.3%	15.8%
Lung	58.3%	72.7%	100.0%	60.0%	100.0%	66.7%
Other		33.3%		100.0%	0.0%	100.0%
Paediatric						
Sarcoma				100.0%		
Skin	60.0%	71.4%	100.0%	90.9%	100.0%	50.0%
Testicular			100.0%		100.0%	100.0%
Upper Gastrointestinal						
Upper GI - HpB	72.7%	71.4%	50.0%	100.0%	33.3%	80.0%
Upper GI - OG	100.0%	60.0%	81.8%	66.7%	100.0%	100.0%
Urology - Prostate	94.4%	93.3%	66.7%	91.7%	100.0%	93.8%
Urology - Renal	100.0%	90.0%	66.7%	100.0%	100.0%	87.5%
Urology - Urothelial	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Key associated metrics to watch against trajectory	
2 Week Waits (2WW)	June performance 93.4% against 93% target. Performance expected to be pressured in July and August due to 2WW referral demand increases across specialties and increased patient choice delays through summer.
104+ day backlog	59 patients at 12/08/2021. Continued improvement expected as Gastrointestinal (GI) service discharge times improve.
63+ day tip over drivers	GI diagnostic pathway capacity and process, late referrals from other North West London (NWL) trusts and pathology reporting time delays.

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 improved but still reporting median waits of 16 days from request for direct booking from Straight to Test (STT) clinics, and 21 days for requests from other sources. • CTC waiting times increase to 16 days from request • Avoidable delays in discharge times through virtual clinic processes in general surgery and gastro	• Weekly Faster Diagnosis Standard (FDS) performance improvement meetings to continue and performance improvement trajectory to be agreed • Imaging waiting times dashboard launched to support waiting times improvement. Resourcing to deliver target waits to be agreed • Discharge information to be included in endoscopy reports • Template letters to be used in gastro and general surgery virtual clinics to reduce discharge times from average 9 days to 1 day	Endoscopy Imaging Endoscopy Gastro/ general surgery	September 2021 September 2021 September 2021 September 2021
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 – impact affecting Imperial, The Hillingdon Hospitals and Chelsea and Westminster Hospital	Pathology	In process
Complex pathways	• Expected increase in cases with more complex diagnostic and care requirements following delays in presentation to primary care now materialising	• For agreement		

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CMS 2

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

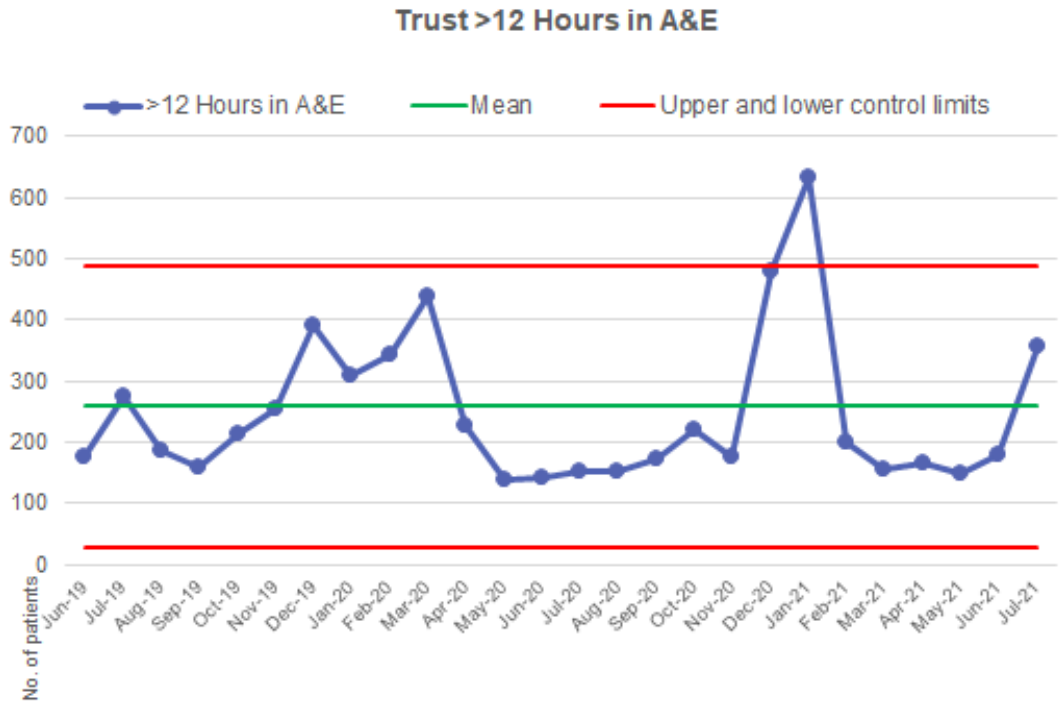
Countermeasure Summary: Patients spending more than 12 hours in the emergency department from time of arrival

Imperial College Healthcare NHS Trust

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

Historical performance:

The overall number of patients waiting over 12 hours within the emergency department from their time of arrival increased in July, driven by increased waits on the SMH site. 356 patients spent more than 12 hours in the emergency department from time of arrival (up from 180 the previous month). Of the total 12 hour waits across the trust, 60 were mental health patients.



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

Imperial College Healthcare NHS Trust

30-day action plan

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Mental Health (MH) Pathway Delays	• Lack of section 136 facilities (section 136 Mental Health Act – place of safety) • Approved Mental Health Professional (AMHP) provision • Lack of bed capacity • Lack of internal mental health nurse (RMN) resource	• Daily huddle escalation calls with Central and North West London NHS Trust, started. • Audit underway to understand causality of delays with MH patients; will feed into wider sector discussion on AMHP provision • Transformation team support for trust strategy for RMN provision • Push for winter pressures plans to incorporate offsite MH assessment unit options • Escalation to A&E delivery board for further support • Focus on increasing capacity at weekends in MH trusts	Barbara Cleaver Jo Sutcliffe	Sep-21 Sep-21
Acute Medicine Admissions	• Lack of beds • Patient flow challenges • Long length of stay	• Medical Pathway Improvement plan at SMH • Weekly review of patients spending >12 hours in ED for themes • Monthly ED and Acute Medicine leadership teams meeting to review 12 hour themes & identify improvements • CXH focused programme on 7 workstreams led by local clinical leads started in June • Faster moves work streams on each site developing awareness and solutions • Junior doctor reps to be involved in flow projects	Ganan Sritharan / Adam Hughes / Jo Edwards / George Tharakan	Sep 21
Urgent & Emergency pathways	• Clinical Decision Unit (CDU) closure • Complex multi specialty pathways • Same Day Emergency Care (SDEC) capacity	• Working with site team to review the re-opening of CDU or change in use of space; change dependant on risk management with covid pathways reducing • Front door: transfer of all initial assessments to ICHT from October to improve redirection & Getting it Right First Time (GIRFT) in ED • Introduction of telephone handovers to reduce nursing escort from ED to Ward • Recruitment underway for expanded SDEC team	Ben Pritchard-Jones Specialty Teams	Sept- 21 Oct-21 Sept-21 Sept-21

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CMS 3

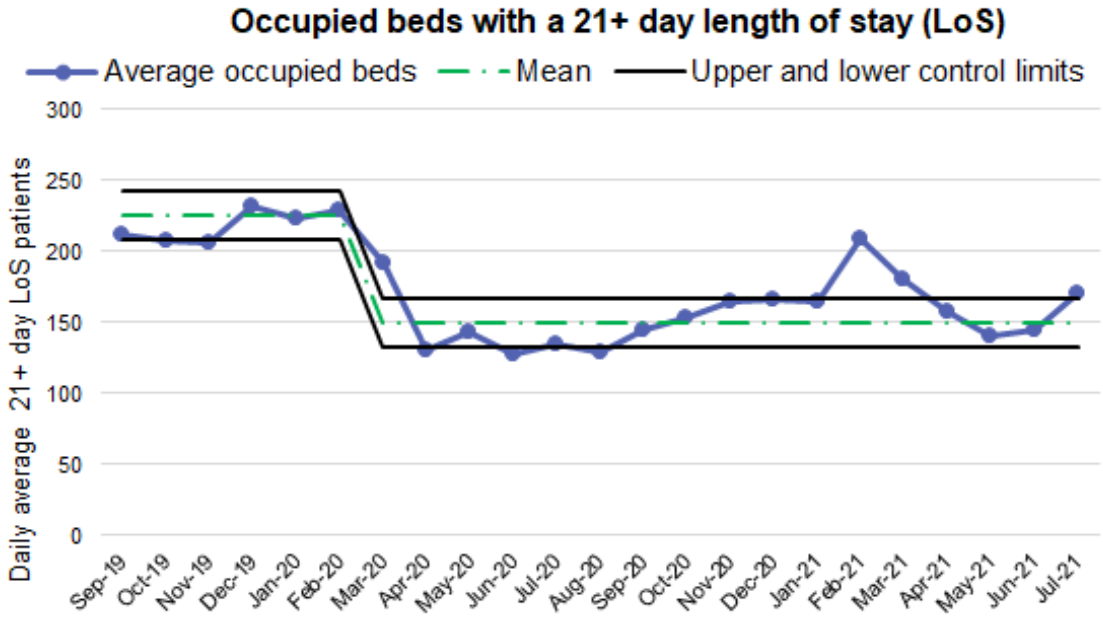
Improving long length of stay (LLOS)

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 a Length of Stay (LOS) of 21 days or more **Desired Trend**: ⬇

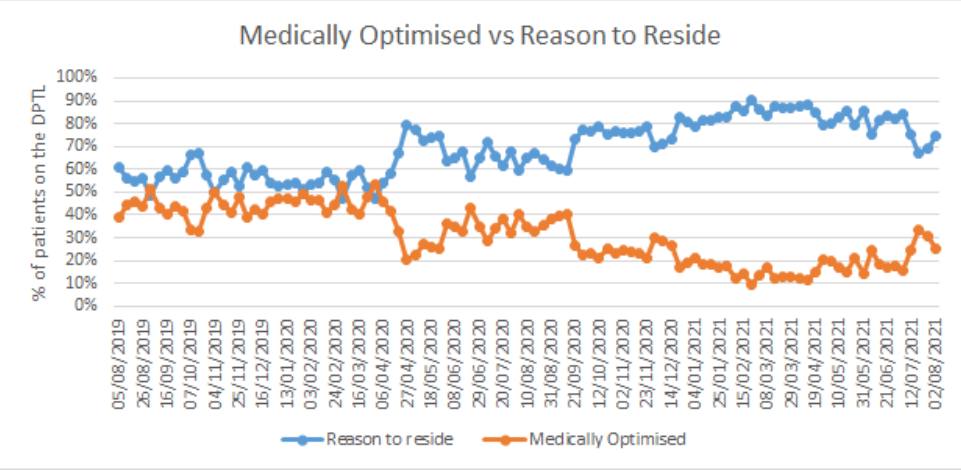
Historical performance: The performance of long length of stay increased across the trust in July. There was an average of 172 patients with a long length of stay of 21 days or more (up from 145 in the previous month).

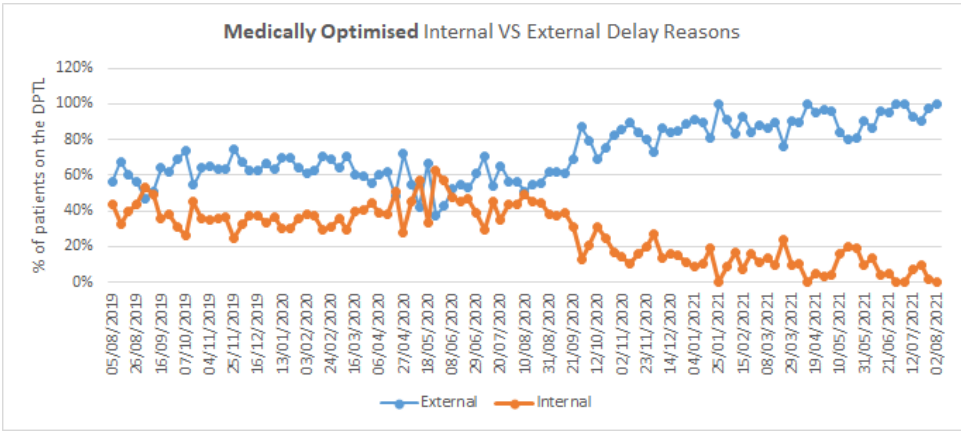


Countermeasure Summary: Improving Long Length of Stay (LLOS)

Imperial College Healthcare NHS Trust

Stratified Data





- The first chart shows that the proportion of all patients with a reason to reside decreased during July 2021 compared to prior months whilst medically optimised patient numbers increased.
- The second chart shows that the delay reasons for medically optimised patients are now predominantly external in nature.
- In September 2020, new Emergency Care Improvement Support Team (ECIST) codes were introduced in line with revised national requirements issued by NHS England and Improvement. This has contributed to the noticeable shifts in the proportion of ‘fit/not fit’ and ‘external/internal’ delays since then.
- Further changes to daily reporting requirements were implemented in mid-May 2021 as per national guidance, which will lead to some changes in reported trends.
- Finally, 16 neuro-rehabilitation beds were excluded from the reporting LLOS position from 20 May 2021.

30-day action plan

Top contributor	Potential root cause	Countermeasure	Owner	Due date
All internal drivers of exit flow and Length of Stay	• Pursuit of best in class ward processes to facilitate flow not possible during pandemic • Long term variation in practice • Inaccurate/incomplete Discharge to Assess (D2A) referrals	• Participation in Alliance 16 programme; ward scope and design methodology agreed, baseline process mapping completed, 2/4 wards progressing with first cycle tests of change; MDT capacity on other wards impacted by staff absence and/or impact of 3rd surge. Scope and end date to be formalised with the Emergency Care Improvement Support Team. • Board Round audit to inform improvement plan via the Urgent and Emergency Care Programme Board – audit complete and recommendations circulated, improvement support TBC • Regular feedback to ward DMTs on how to complete D2A referrals • Flow guidance materials for junior doctors	Anna Bokobza & Shuli Levy Anna Bokobza & Anne Kinderlerer Directorate triumvirates Rupert Bright	24 Sept 15 Sept Complete
All external drivers of exit flow and Length of Stay	• Demand for specialist neuro-rehabilitation beds in NWL outstrips supply • Hospital social workers not yet back to on-site working	• Fortnightly MADE events Aug-March • Escalate to sector gold for action and confirmed timescales for review • Escalate to sector gold for Directors of Adult Social Care to address	Anna Bokobza Frances Bowen Frances Bowen	Complete
Accuracy of data and reporting	• Differential recording practice between acute Trusts invalidates benchmark comparisons • Ward and directorate teams spending considerable time on manual processing of discharge referrals and reporting	• Implement plan to migrate weekly reporting to pull from Cerner replacing manual returns – delayed due to ongoing coding gaps in Gen & Vasc Surgery and Stroke & Neurosciences • Implement plans to embed Discharge to Assess form in Cerner (delayed by sector changes to form + C&W pilot)	Monica Sobhan Anna Bokobza & James Bird	30 July - delayed Delayed to early Sept
Homeless/no right of recourse to public funds/no place to discharge to	• High prevalence of tri-morbidity and need for multi-agency approach to case management • Staff not always clear on Duty to Refer and how to support service navigation	• Build specialist homeless discharge team as 12 month proof of concept using 2nd wave central government funding (formal funding confirmed, implementation on track)	Anna Bokobza (in partnership with Joe Ngyuyen, sector SRO)	October

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Finance report for July 2021 (Month 4)

Agenda item 10 and paper number 07

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

Purpose: For Information

Meeting: 15 September 2021

Executive summary

1. Purpose

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

2. Key highlights

- Year to date the Trust has delivered a break even position against a £1m deficit plan and is forecasting a break even position for the first 6 months of the year (H1). This is 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).

- The activity targets to allow organisations to access ERF were revised during July from 85% of 19/20 activity for the first two quarters of the year to 85% for quarter 1 and 95% for quarter 2. Year to date the Trust has recognised £23m of ERF income.

- Although the Trust awaits planning guidance for the 2nd half of the year (H2) all things being equal to H1 the Trust aims 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 are set out in the publication of the financial regime for H2, will be a key aspect requiring a detailed re-assessment.

- Capital – the full year capital plan equates to £84.7m of which only £56.9m scores against the Trust Capital Resource Limit (CRL), with the balance funded by donations or other sources. Year to date the Trust has spent £11.0m (57%) of its total capital plan and expects to deliver to plan over the year.

- Cash – at 31st July, cash was £148m. The future cash outlook remains resilient in the short to medium term but this is highly dependent on the funding regime for the second half of the financial year (which is yet unknown) and the delivery of CIPs.

3. Recommendation

3.1. The Board is asked to note this report.

Public Board 15th September 2021

Finance Report July 2021

Scorecard

Imperial College Healthcare NHS Trust

	Year to Date			First 6 months (H1)		
	Budget £m	**Actual £m**	**Var £m**	**Plan £m**	**Forecast £m**	**Var £m**
Trust position before Elective Recovery Fund (ERF) income and Cost Improvement Programme (CIP)	(14.9)	(16.2)	(1.3)	(22.4)	(22.5)	(0.1)
CIP achievement	10.5	4.4	(6.1)	15.8	8.3	(7.5)
	(4.4)	**(11.8)**	**(7.4)**	**(6.6)**	**(14.2)**	**(7.6)**
ERF net of cost	0.0	11.8	11.8	0.0	14.2	14.2
Indicative sector funding to break even	3.4		(3.4)	6.6	0.0	(6.6)
Reported Position	**(1.0)**	**0.0**	**1.0**	**0.0**	**0.0**	**0.0**

Income and Expenditure

- For the year to date the Trust has achieved a break even position against a £1m deficit plan and is forecasting a break even position for the first 6 months of the year. Against the £15.8m cost improvement programme (CIP) target for the first six months of the year, £8.3m of opportunities have been identified to date with the positive contribution from non-recurrent ERF income offsetting: the current unmitigated CIP gap; under delivery of schemes identified to date and the net impact of additional expenditure over and above plan.

Capital

- The full year capital plan equates to £84.7m of which only £56.9m scores against the Trust CRL, with the balance funded by donations or other sources. Year to date the Trust has spent £11.0m (57%) of its total capital plan and expects to deliver fully by year plan.

Cash

- At 31st July, cash was £148m. The future cash outlook remains resilient in the short to medium term but this is highly dependent on the funding regime for H2 (which is yet unknown).

Statement of Comprehensive Income

Imperial College Healthcare NHS Trust

	Year to Date			H1 Position		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	422.9	449.2	26.3	634.4	677.0	42.6
Pay	(249.0)	(253.0)	(4.0)	(373.6)	(380.1)	(6.5)
Non Pay	(157.4)	(175.2)	(17.8)	(235.9)	(265.3)	(29.4)
EBITDA	**16.5**	**21.0**	**4.4**	**24.9**	**31.6**	**6.6**
Financing cost and donated asset treatment	(20.9)	(21.0)	(0.0)	(31.5)	(31.6)	(0.0)
Impairment of assets	0.0	0.0	-	0.0	0.0	-
Surplus/deficit Internal	**(4.4)**	**0.0**	**4.4**	**(6.6)**	**(0.0)**	**6.6**
Sector Planning Assumption	3.4	0.0	(3.4)	6.6		(6.6)
Surplus/deficit Internal	**(1.0)**	**0.0**	**1.0**	**(0.0)**	**(0.0)**	**0.0**

- **Income** – the Trust is favourable to plan year to date, driven mainly by ERF benefit of £23m 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, and in theatres where additional staff are in place to meet increased activity.
- **Non Pay** – non-pay costs are above plan in month and year to date due mainly to the fact that CIP targets are sitting within this category (£10.5m). There has also been spend on drugs within divisions to meet 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	31-Jul-21 £'000	Movement £'000
Property, plant and equipment	550.6	545.3	(5.2)
Other Non Current Assets	17.3	15.8	(1.4)
Total non-current assets	**567.9**	**561.2**	**(6.7)**
Inventories	17.1	17.7	0.7
Trade and other receivables	90.6	109.3	18.7
Cash and cash equivalents	149.1	147.6	(1.5)
Total current assets	**256.7**	**274.6**	**17.9**
Trade and other payables (<1 year)	(281.5)	(290.1)	(8.6)
Total current liabilities	**(281.5)**	**(290.1)**	**(8.6)**
Non current Liabilities	(21.2)	(20.9)	0.3
Total Non current Liabilities	**(21.2)**	**(20.9)**	**0.3**
Net Assets employed	**521.9**	**524.8**	**2.9**
Public Dividend Capital	773.9	773.9	0.0
Revaluation Reserve	2.4	2.4	0.0
Income and expenditure reserve	(254.4)	(251.5)	2.9
Total tax payers' and other equity	**521.9**	**524.8**	**2.9**

Non-Current Assets
Non-current assets have decreased by £6.7m year-to-date, due to depreciation of £17.7m offset by capital expenditure of £11.0m.

Current Assets
Receivable balances have increased by £18.7m year-to-date as provider income is accrued in advance of consolidated billing and central funding is accrued prior to receipt. Inventory balances have increased by £0.7m, primarily around pharmacy stock.

Cash
Cash balances were £147.6m at Month 4,. The current level of cash is beneficial to the Trust but is driven by both timing of cash flows and the effects 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 reduced by £8.6m year-to-date. The Trust focuses on effective payment of suppliers and pays 98% of invoices within Better Payment Practice Code guidelines.

Taxpayers' and Other Equity
Equity balances are stable at Month 4. The level of Public Dividend Capital currently expected to support the capital programme is £0.7m – significantly lower than 2020-21.

Capital – Month 4

Imperial College Healthcare NHS Trust

Sources of Funds	Annual £m
Internal Financing (NWL allocation)	51.7
Confirmed external funding inc. PDC	26.9
Charitable Funds	0.9
Unconfirmed external funding inc. PDC	5.3
Total	**84.7**

Applications	Annual £m	YTD Plan £m	YTD Actual £m	YTD Variance £m
Backlog Maintenance	15.6	5.5	4.2	(1.2)
ICT	7.2	2.5	1.3	(1.2)
Replacement of Med Equip.	6.0	2.4	0.7	(1.7)
Decarbonisation	27.7	1.2	1.3	0.1
Other Capital Projects	26.3	7.1	2.4	(4.7)
Redevelopment	1.9	0.6	1.1	0.5
Total Expenditure	**84.7**	**19.3**	**11.0**	**(8.3)**
Income and Donation	**(27.8)**	**(1.2)**	**(1.8)**	**(0.6)**
Capital Resource Limit	**56.9**	**18.1**	**9.2**	**(8.8)**

£2.3m of 2021-22 capital programme expenditure has been incurred in Month 4, bringing year-to-date expenditure to £11.0m (57% against plan).

The level of spend at this stage of the year is consistent with previous years and the Trust remains confident that it will fully utilise its Capital Resource Limit (CRL).

Notwithstanding this, the Capital Expenditure Assurance Group (CEAG) is reviewing the plan in detail to identify issues affecting the delivery of spend. External factors around delays to imports and availability of supplies are a factor in some areas of the programme and these will be monitored closely.

Further funding to support the work on the Trust site redevelopment programme iis yet to be confirmed with discussions continuing with NHSEI.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Maternity Quality Assurance Oversight Report

Agenda item 11 and Paper number 08

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

Purpose: For noting

Meeting date: 15 September 2021

Executive summary

1. Purpose of this report

1.1. This report informs the Trust Board of progress on achieving compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). This includes presentation of the quarterly Perinatal Mortality Review Tool (PMRT) Trust Board report. The report has been discussed and accepted by the Quality Committee.

2. Background

2.1. The CNST MIS Year three declaration was approved at the Trust Board in May 2021.
2.2. The CNST MIS Year four launched on 8 August 2021 with a deadline for declaration by 30 June 2022.

3. Key findings

3.1. The maternity service continues to provide a high quality service alongside meeting increasing external assurance requests.
3.2. The CNST MIS Declaration form was submitted to NHS Resolution on 19 July 2021.
3.3. The July 2021 quarterly PMRT Trust Board report demonstrates compliance with the CNST MIS. There were no care issues identified which impacted on the outcome of the cases included within the report.

4. Next steps

4.1. Commitment to continue working towards improving quality and safety.
4.2. Await response from NHS Resolution following CNST MIS year three declaration submission.
4.3. Review of CNST MIS year four requirements and actions required to meet compliance.

5. Recommendation(s)

5.1. The Trust Board is asked to note the findings and ongoing progress with the PMRT.

6. Impact assessment

6.1. Quality impact - The maternity service have developed a quality and safety strategy which aims at improving the quality of the service for women and their families. The CNST MIS supports the delivery of safer maternity care and contributes towards meeting 7 IEA's recommended from the Ockenden report.

6.2. Financial impact - Robust oversight of the maternity quality and safety strategy will improve outcomes and experience. This aims to reduce litigation claims for the Trust. The CNST MIS is an incentive scheme.

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 report.

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

7. CNST MIS safety action update report

7.1. The active board declaration form was submitted to NHS resolution on 19 July 2021.

7.2. The Trust are awaiting feedback following submission of the declaration form which demonstrated compliance with the ten safety actions in year three of the MIS.

7.3. CNST MIS Year four launched on 8 August 2021. The safety actions are currently under review and plans are being implemented to achieve compliance with all safety actions included within the scheme.

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

8. National Perinatal Mortality Review Tool (PMRT)

8.1. Each quarterly PMRT Trust Board report (appendix 1) must be submitted to the Trust Board to meet compliance with the CNST MIS.

8.2. The PMRT tool allows Trusts a period of four months to investigate and close all reviews reported, therefore the Trust board report is dated to the review this timeframe of four months previous.

8.3. The Trust is meeting all the requirements for PMRT reviews however there is one stillbirth and five neonatal deaths still under review as these are either under investigation by external agencies (Healthcare Safety Investigation Branch) or awaiting coroner's court outcomes. For these cases PMRT allows the reviews to be temporarily closed in order to facilitate the completion of investigations.

8.4. There are internal meetings every two weeks to discuss all cases reported to PMRT from the maternity and neonatal services. This meeting is attended by Consultant Neonatologists, Consultant Obstetricians from St. Mary's Hospital and Queen Charlotte and Chelsea Hospital, the perinatal mortality midwives, bereavement midwives, risk midwives, a member of the Northwest London neonatal death panel and external representation from other Trusts in the Northwest London region. This meeting is open to any member of staff who wishes to attend. There was 100% representation from an external member at the multi-disciplinary meetings included within this report.

8.5. All babies had their placenta examined but only 4 of the 14 cases agreed to a post-mortem. The Trust is currently auditing reasons for declining post mortem in stillbirths to gain an understanding on how we could improve this for the future.

8.6. There were 8 cases where grading B was allocated following the review of the maternity care. Grade B is where the review group identified care issues which they considered would have made no difference to the outcome for the baby. There were no cases graded C or D where care issues may have or were likely to have made a difference to the care. The remaining cases were all graded A where there were no issues with care provided.

8.7. There were no issues with the care provided for the cases involving neonatal deaths.

8.8. The Trust board report details the learning and action plans for each of the reviews. There were some actions plans which were unable to be completed partly due to the Sars Covid-19 pandemic and others are in relation to Trust policy. This included the requirement for placenta analysis to be completed by perinatal pathologists. This is not possible as the laboratory the placentas are sent to do not have one employed. All the other actions are in progress and are allocated to individual leads.

9. Conclusion

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

Appendices

Appendix 1: PMRT quarterly Trust Board report

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:

1/11/2020 to 28/2/2021

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *23*

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
21	6	1	14	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
8	0	5	3	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: 01/07/2021 13:50

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 = 17)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	2	--	--	--	--	2
Stillbirths total (24+ weeks)	0	0	3	2	3	4	12
Antepartum stillbirths	*0*	*2*	*2*	*2*	*3*	*4*	*13*
Intrapartum stillbirths	*0*	*0*	*1*	*0*	*0*	*0*	*1*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	0	0	1	0	2	3
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	2	3	3	3	6	17
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	1	0	1	2
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	2	0	2
Not Applicable	0	2	3	2	1	5	13
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	1	3	3	3	6	16
No	0	1	0	0	0	0	1
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	2	3	3	3	6	17
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	0	0	1	0	2	3
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	0	0	0	0	1	1
Neonatal care re-orientated	0	0	0	0	0	1	1

*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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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 = 17)

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	2	3	2	3	4	14
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	2	3	2	3	4	14
Hospital post-mortem declined	0	1	3	2	2	2	10
Hospital post-mortem carried out:							
Full post-mortem	0	1	0	0	1	1	3
Limited and targeted post-mortem	0	0	0	0	0	1	1
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	0	0	1	0	0	1
No	0	0	0	0	0	2	2
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	1	1
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	1	0	1	2
Hospital post-mortem declined	0	0	0	1	0	1	2
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	1	0	0	1	2	4
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	1	0	0	1	2	4
No	0	1	3	2	2	2	10

*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	14	100% (14)
Vice Chair	14	100% (14)
Admin/Clerical	0	0%
Bereavement Team	24	78% (11)
External	11	78% (11)
Management Team	23	92% (13)
Midwife	67	100% (14)
Neonatal Nurse	8	50% (7)
Neonatologist	31	71% (10)
Obstetrician	27	100% (14)
Other	1	7% (1)
Risk Manager or Governance Team	41	100% (14)
Safety Champion	13	92% (13)

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	3	100% (3)
Vice Chair	3	100% (3)
Admin/Clerical	0	0%
Bereavement Team	3	33% (1)
External	4	100% (3)
Management Team	4	66% (2)
Midwife	13	100% (3)
Neonatal Nurse	4	100% (3)
Neonatologist	8	100% (3)
Obstetrician	4	100% (3)
Other	0	0%
Risk Manager or Governance Team	9	100% (3)
Safety Champion	2	66% (2)

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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 = 17)

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	2	1	1	0	6
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	1	1	2	4	8
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	2	3	2	3	4	14
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	0	0	1	0	2	3
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	0	0	1	0	2	3
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	0	0	1	0	2	3
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 = 17)

Timing of death	Cause of death
Late fetal losses	**2 causes of death out of 2 reviews**
	Placental insufficiency
	Hydrops secondary to fetal anaemia
Stillbirths	**12 causes of death out of 12 reviews**
	The cause of death was undetermined
	The exact cause of the pregnancy loss is likely to be related to placental dysfunction however there is a small possibility of intrahepatic cholestasis of pregnancy however not supported by PM findings.
	Chorioamnionitis
	Intrapartum stillbirth secondary to severe early onset PET and early onset growth restriction
	The cause of death was undetermined
	Placental dysfunction
	Fetal vascular malperfusion
	Miller Dieker syndrome
	Placental dysfunction
	Placental abruption
	Suspected placental dysfunction
	Acute placental abruption
Neonatal deaths	**3 causes of death out of 3 reviews**
	1a) Severe hypoxic encephalopathy 1b) Left sided congenital diaphragmatic hernia leading to postnatal collapse 2) Multi organ failure
	- Pulmonary Hypoplasia - Bilateral Renal Agenesis, Cardiomyopathy - Anhydramnios
	1a Pulmonary hypoplasia due to hydrops fetalis (RASA1 gene mutation) 1b prematurity
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	16	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		CM testing on hold due to Covid-19. There is a plan in place to reintroduce this safely . Women are asked at booking about their smoking status
		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	11	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
The baby had to be transferred elsewhere for the post-mortem	4	No action entered
		No action entered
		No action entered
		No action entered

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This mother missed some of her antenatal appointments but was not followed-up according to the local DNA policy	3	Remind staff to follow-up missed antenatal appointment as per local DNA policy
		The trust put an action plan in place to address this issue and reminded staff of the DNA policy
		Implement system to chase up DNAs when women are referred to triage/maternity day assessment unit
It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	2	Inform Bereavement team
		Remind staff that it is hospital policy to offer parents the opportunity to take their baby home and this needs to be clearly documented in the notes.
It is not possible to tell from the notes whether during the early bereavement period use of a cold cot was offered/available	2	Inform Bereavement team
		The use of the Cold cot is being added to the electronic checklist to make it easier to tell if it has been offered or used in future.
There is no evidence in the notes that this mother was asked about domestic abuse at booking	2	No action entered
		Remind staff to ask sensitive questions at first opportunity. If not possible antenatally due to some appointments happening over the phone, to ask whilst inpatient.
This mother had poor/no English and family members were used as interpreters during her labour and birth	2	Staff have been reminded about the importance of using interpreters and made aware how to contact language line
		Remind staff that the need of an interpreter needs to be acknowledged and documented at each appointment. If declined, practitioners should make sure that the patients understand the information given and document it in the notes.
This mother had poor/no English and family members were used as interpreters on occasions during her antenatal care	2	Staff have been reminded about the importance of using interpreters and made aware how to contact language line
		Action has been undertaken to ensure that clinicians are aware of interpreting services and have access to contact numbers for interpreting. This has been shared with staff through email communications, teaching sessions and the Risk newsletter. This continues to be disseminated through the relevant platforms
This mother was assessed as high risk and in need of aspirin but aspirin was not prescribed	2	This has been discussed with the Doctor who reviewed the patient in the antenatal clinic
		Remind staff to appropriately assess the need of aspirin and make sure women who are high risk are prescribed the medication

*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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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 (IPC) and Antimicrobial Stewardship Quarterly Report: quarter 1 2021/22

Agenda item 12.1 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: 15 September 2021

Executive summary

1. Purpose of this report

1.1. This paper provides an update for information on Infection prevention and control practice and activity during quarter 1 (Q1) 2021/22; it summarises our infection rates and actions being taken in response to areas of risk. This report was discussed and accepted by the Quality Committee.

2. Background

2.1. The Health and Social Care Act 2008 Code of Practice in the Prevention and Control of Infection (updated 2015) requires that regular presentations are made to the Trust Board on IPC practice.

2.2. This quarterly report encompasses all aspects of infection prevention and control, in line with the requirements, including infection rates, management systems, environment, cleaning, training and policies to protect patients and staff.

3. Key findings

3.1. We remain on track to meet our annual targets for *C. difficile* and *E. Coli* blood stream infection (BSI) reduction, and continue to see a reduction in overall consumption of antimicrobials despite the impact of the pandemic.

3.2. There has been a recent 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 is being monitored through EMB Quality Group (EMBQG). Ward level MRSA screening data is regularly reviewed by the divisions and actions implemented in areas with lower compliance. A solution to the lack of data related to MRSA suppression therapy has been found and data will be presented to September EMBQG with plans for any areas requiring improvement.

3.3. Water management continues to be an area of concern, particularly with increases in pseudomonas in neonatal units, and legionella contamination identified. Estates and facilities are leading on an action plan with IPC support, with regular updates to EMBQG.

3.4. Catheter line-associated BSI rates in the adult and paediatric intensive care units (ICU) increased in Q1. We have also seen an increase in blood culture contaminants and MRSA BSIs in critical care. A working group is in place to support improvements using quality improvement methodology. Actions to strengthen routine IPC practices have been implemented, with subsequent reductions in infection.

3.5. Using learning from these successful interventions, and from what other organisations have in place, IPC are developing a new approach to training, assessment and support for staff for

core IPC competencies, including aseptic non-touch technique (ANTT), hand hygiene and personal protective equipment (PPE) use). Over the next month, we will test new techniques in selected clinical areas and assess their impact. Recommendations for the trustwide approach will be presented to EMBQG in September for approval.

4. Next steps

4.1. The PPE/Hand hygiene helper programme is continuing as one of our key safety improvement workstreams for the next 12 months. The next step is a trustwide audit of hand hygiene which will commence in September. Focused work will continue to tackle ongoing water hygiene issues in augmented care areas. A new IPC core competency assessment process will be rolled out in quarter three.

4.2. A new report format is being developed to improve how we report on IPC issues and activity. This will be trialled for the quarter two report.

5. Recommendation: The Trust Board is asked to note the report.

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: N/A

6.5. Risk impact: There have been no new IPC risks identified in Q1. All risks in the IPC risk register have been updated to reflect the challenges related to COVID-19.

Main Paper

7. Response to the COVID-19 pandemic

7.1. Infection Prevention and Control (IPC) expertise continues to be integral to the Trust management of COVID-19 through provision of expert advice, interpretation of national recommendations and evidence-base, development of local guidelines, and supporting Trust operations.

7.2. IPC continue to play a key role in supporting occupational health (OH) through developing and implementing the Trust-wide strategy for patient and staff testing.

7.3. A focus on antimicrobial stewardship (AMS) and treatment of both COVID-19 and other infections continues to be maintained during the pandemic.

7.4. Experts from IPC continue to work with (i) the Integrated Care System and the Pan-London COVID-19 reference group to develop regional approaches to guidance interpretation and recommendations and (ii) national hospital-onset COVID-19 infection expert advisory group.

7.5. We continue to undertake applied research to support decision making and patient care in the Trust including collaborating with the COVID-19 Genomics UK Consortium (COG-UK) to investigate the role of whole-genome sequencing in understanding the transmission of COVID-19. We continue collaborations with the World Health Organization (WHO) and National Institute for Health Research (NIHR) on projects related to COVID-19.

8. Key actions to prevent healthcare-associated COVID-19

8.1. The NHS England (NHSE) COVID-19 board assurance framework continues to be updated monthly and an action plan related to the framework is reviewed weekly at the Clinical Reference Group (CRG) with good progress.

8.2. We continue to utilise our locally established surveillance system for hospital-onset COVID-19 infections (HOCI) within the Trust (Appendix 15.1, Figure 1).

8.3. Daily testing for COVID-19 during the first 7 days of admission was previously introduced to support robust surveillance of HOCI. IPC have continued to monitor and feedback screening metrics at weekly sit-rep meetings, and work with Divisions to optimise serial screening. Trust-

wide compliance with day 3 and day 7 testing improved during Q1, ending the quarter at 85% and 77% respectively.

8.4. IPC, in partnership with OH, continue to utilise and strengthen previously developed systems to identify and manage outbreaks of COVID-19 amongst staff.

8.5. IPC, in partnership with our internal colleagues at virology and external colleagues at Public Health England (PHE), continue to closely monitor the epidemiology of strains, including novel variants, causing infection at our Trust.

8.6. The Trust's clinical incident management systems are used to investigate and learn from COVID-19 outbreaks and related incidents.

8.7. Post-infection reviews are undertaken for each case of hospital-onset COVID-19 infection identified >7 days after their day of admission.

8.8. PHE updated their national guidelines for the prevention and management of COVID-19 in June 2021. No changes in COVID-prevention measures were required. Hierarchy of control have been incorporated into risk assessments.

8.9. The 'PPE/Hand hygiene helper programme', launched during the first wave of COVID-19 to provide ward-level support for staff, continues to support clinical areas across the trust. The programme has been nominated for a Health Service Journal (HSJ) award.

9. Healthcare-associated infection surveillance and mandatory reporting

9.1. There have been 16 hospital-associated Clostridioides difficile cases during Q1 (15 hospital-onset, healthcare-associated (HOHA) and 1 community-onset, healthcare-associated (COHA)) against a ceiling of 21 HOHA and COHA cases combined (Appendix 15.2, Table 1, Figure 2). Hospital-associated C. difficile cases were detected in 1.5% of 1061 stool specimens tested during Q1. There was one lapse in care identified in Q1 relating to cross-transmission, which is being investigated as a SI. Our rate of healthcare-associated C. difficile cases was the second lowest in the Shelford group based on figures from April 2021 to May 2021.

9.2. There have been 3 healthcare-attributable methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections (BSI) during Q1 (Appendix 15.2, Table 1). Compliance with MRSA admission screening was 90% for Q1, a rise from 85% during Q4 2020/21. The rate of healthcare-associated MRSA BSI cases was the fourth highest in the Shelford group based on figures from April 2021 to May 2021. An action plan is being monitored through EMBQG; a key element of this is a wider review of IPC core competencies (see section 11). Ward level MRSA screening data is regularly reviewed by the divisions and actions implemented in areas with lower compliance. A solution to the lack of data related to MRSA suppression therapy has been found and data will be presented to September EMBQG with plans for any areas requiring improvement.

9.3. There have been 9 cases of trust-attributed methicillin-susceptible S. aureus (MSSA) BSI during Q1, with no evidence of patient-to-patient transmission.

9.4. The number of Gram-negative Escherichia coli, Pseudomonas aeruginosa, and Klebsiella spp. BSI have returned to levels comparable with those observed prior to the pandemic (following a dramatic reduction during Q4 2020/21). These changes follow increasing elective and emergency patient admissions following the 2nd COVID-19 surge. These trends have been observed elsewhere; our E. coli BSI rate rank third lowest in the Shelford group based on figures from April to May 2021.

9.5. The activities to support the Government's ambition to halve healthcare-associated Gram-negative BSI by 2021 have been interrupted by the management of COVID-19. These will restart in Q2 2021/22.

9.6. Contaminants[1] accounted for 3.9% of 6767 blood cultures taken during Q1, which is above our local benchmark of 3%.[2] This increase in blood culture contaminants, particularly in the adult intensive care units (ICUs) during the 1st and 2nd COVID-19 surges, likely relates with suboptimal practices in hand hygiene, ANTT and personal protective equipment (PPE) use. An ICU working group is in place to support improvements using quality improvement

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

methodology. Actions to strengthen routine IPC practices have been implemented, with subsequent reductions in infection.

9.7. Catheter line-associated BSI (CLABSI):

- Adult-ICUs: 16 CLABSI occurred in Q1 equating to a quarterly rate of 4.3 per 1000 line days, higher than our ECDC (European Centre for Disease Prevention and Control) benchmark figure of 3.6 per 1000 line days. Based on data from the last 12-month period (Jul 2020 – Jun 2021) our annual rate is 3.0 per 1000 line days.
- PICU: 4 CLABSI occurred in Q1, giving a quarterly rate of 10.3 per 1000 line days. Over the last 12-month period (Jul 2020 – Jun 2021) a total of 5 CLABSI cases were reported, giving a rate of 6.0 per 1000 line days. Both rates are above the ECDC benchmark of 3.6 per 1000 line days.
- Neonatology ICUs: During Q1 there was 1 CLABSI episode (identified in a very low birth weight (VLBW) baby) reported across the Neonatology ICUs, a rate of 2.6 per 1000 line days, and a cross-site 12-month rolling rate of 3.6 per 1000 line days. Both rates are below the National Neonatal Audit Programme benchmark of 4.4 per 1000 line days. Furthermore, our 12-month rolling CLABSI rate for VLBW babies is 4.0 per 1000 line days, lower than the Nosocomial Infection Surveillance Project benchmark figure of 8.6 per 1000 line days.
- We continue surveillance with feedback at weekly situation reports (sit-reps), weekly clinical ward rounds with the wider infection team, and discussions with clinicians across critical care areas on management and prevention measures.

9.8. The latest finalised surgical site infection (SSI) surveillance data available (Jan – Mar 2021) reveal an SSI incidence of 7.1% following coronary artery bypass graft (CABG) which is above the national average (3.8%), although lower than our pre-pandemic (c. 12%). A SSI prevention improvement project is underway, led by the directorate. The numbers are small, with 4 cases in total in Q1. Two of these were identified in the community over 30 days post-discharge. Actions being taken include implementation of a wound care letter for patients and a review of the use of antibiotic-coated sutures. SSI rates following non-CABG procedures was 0% for the same period, below the national average (1.3%). All SSIs were superficial infections, as per National Institute for Health and Care Excellence (NICE) criteria. Further details are provided in Appendix Section 15.3. The rate is decreasing in Q2 with no cases reported so far.

9.9. We continue to make progress in supporting our Divisions to embed prospective SSI surveillance in specialities identified as priority areas, including Caesarean section, neurosurgery, cardiothoracic, and vascular (Appendix Section 15.3).

9.10. The average number of new patients identified with carbapenemase-producing Enterobacterales (CPE) per month in Q1 was 40, remaining below pre-pandemic levels. This reflects an overall decreasing trend in CPE carriage rates observed between August 2019 and June 2021 (Appendix 15.4, Figure 3). Trust-wide compliance with CPE screening during Q1 was 88%, comparable with pre-pandemic rates. CPE admission screening was maintained throughout the COVID-19 pandemic.

10. Antimicrobial stewardship

10.1. During Q1 the Trust continued to see a reduction in overall consumption of antimicrobials despite the pressures of the COVID-19 pandemic (Appendix 15.5, Figure 4). Key antimicrobial stewardship (AMS) initiatives that have supported the reduction during Q1 include:

- AMS rounds continue to operate on all sites using the AMS dashboard to identify carbapenem use and prolonged antibiotic durations. Preliminary data indicates that interventions have been made for approximately 56% of all antibiotics prescriptions reviewed, with a 77% acceptance rate of intervention made.
- Critical care microbiology ward rounds continue to be supported by the infection pharmacy team on all sites to optimise prescribing. During Q1, initial discussions between critical care and the infection team have instigated a collaborative approach to improve antimicrobial prescribing practices. Antimicrobial consumption will continue to be monitored and fed back to critical care teams in Q2 2021/22.

- Work is underway to launch a new antimicrobial prescribing mobile app in Q2. The new mobile app will to replace the current version and will allow for rapid updates, greater accessibility and navigation of the antimicrobial guidelines.
- The infection pharmacy team continue to report antimicrobial consumption on a monthly basis by site and antimicrobial class.

10.2. The Trust continues to promote the "Access" group as recommended by PHE and WHO to curb the threat of resistance.

10.3. The biannual antibiotic point prevalence survey due in January 2021 was postponed in light of the COVID-19 pandemic. It will take place in Q2 2021/22.

10.4. The infection pharmacy team, together with infection colleagues, are managing the impact of national antimicrobial shortages for a number of agents. There is no evidence of patient harm as a result of these shortages.

10.5. We continue to participate in the NHSE Anti-fungal CQUIN (Commissioning for Quality and Innovation) which is part of the wider Medicines Optimisation CQUIN and await further information on how this will continue into 2021/22.

11. Hand hygiene and aseptic non-touch technique (ANTT) competency assessment

11.1. ANTT competency assessment compliance rate is 86.9% (7497/8628 clinical staff), an increase from the previous quarter, but below our 90% target. The competency assessment was suspended during the COVID-19 peak and replaced with an ANTT training video. Clinical areas have restarted ANTT competency assessments with existing staff.

11.2. As a result of on-going issues with compliance, a review of our ANTT competency assessment process began in Q1. Following a review of our IPC data and what other organisations have in place, IPC are developing a new approach to training, assessment and support for staff for core IPC competencies (including ANTT, hand hygiene and PPE use). Over the next month, we will test new techniques in selected clinical areas and assess their impact. Recommendations for the trustwide approach will be presented to EMBQG in September for approval.

11.3. The PPE and Hand Hygiene helper programme will continue as a priority of our safety improvement programme for 2021/22. The helpers carried out visits throughout the second pandemic surge, and continue to conduct around 100 visits per week. A trustwide observational hand hygiene audit is planned to commence in September.

12. Clinical activity, incidents, and lookback investigations

12.1. Much of the capacity of the IPC service has been directed towards the response to the COVID-19 pandemic. In Q1 the following key incidents were identified:

12.2. Water hygiene continues to be a concern. Testing has identified P. aeruginosa in some samples in a number of designated augmented care areas (ICU at SMH, Winnicott Baby Unit at SMH, PICU at SMH, Paediatric haematology at SMH, Dacie ward at HH), and there have been 16 neonates colonised with P. aeruginosa since March 2021 (no cases of infection). Task and finish groups are in place for each area reporting to the water hygiene group. These are primarily looking at engineering solutions, however other issues identified include hand hygiene practices for visitors and inappropriate disposal of both organic waste matter and non-biodegradable waste e.g. wipes. Actions being taken include implementation of a hand hygiene leaflet for parents and an awareness campaign is being planned for staff around the issue of safe disposal of waste. A progress update will be provided to EMBQG in September.

12.3. In response to a PHE briefing in Q4 2020/21 highlighting an excess of neonatal infections caused by Staphylococcus capitis (a skin organism) across London over the last 18 months enhanced surveillance commenced. 4 babies managed on a neonatal unit have yielded S. capitis from blood cultures since March this year; 1 in Q4 2020/21 and 3 in Q1. Typing results reveal 2 of 4 babies (sharing the same nursery at different times) have highly-related isolates suggesting cross-transmission via an intermediate vector.

12.4. Two separate incidents involving Klebseilla pneumoniae OXA-48 (CPE) were identified in Q1: (i) 3 patients sharing time and space on a medical ward were identified as colonised with K. pneumoniae OXA-48 of the same type and (ii) 4 patients sharing time and space on a renal

ward yielded K. pneumoniae OXA-48 of the same type; 1 blood stream infection and 3 colonisation.

12.5. 2 patients who developed C. difficile infection sharing time and space on a haematology ward. Both are the same ribotype reflecting a lapse in care. This is being investigated as a SI.

12.6. 6 cases of Enterobacter cloacae-IMP (CPE) were identified across 2 surgical wards. Due to infrequent detection of this resistance mechanism and the close surgical pathway links these are being managed as a single incident. Typing is pending.

12.7. An immunosuppressed patient being managed on a medical ward had Legionella spp. cultured from their respiratory sample 1 month into their admission. An investigation took place and healthcare-acquired infection could not be ruled out. Water sampling has revealed Legionella contamination of some water outlets. IPC are working with Estates and public health to understand any potential link to healthcare-acquisition and mitigate risk of contaminated water.

12.8. Following an excess of the skin organism Corynebacterium striatum identified from clinical samples from various clinical across all sites (particularly related to patients being managed in critical care areas during surge 1 and 2), the rates of detection have returned to baseline during Q1. We continue to monitor and work with PHE.

12.9. In Q1, a total of 25 communicable disease 'look back' investigations were undertaken related to potential exposures to shingles, tuberculosis, measles, chickenpox, shigella, scarlet fever, pertussis, salmonella and meningitis. No contacts or onward transmission were identified as a result of these look backs and no action in the form of prophylaxis or additional treatment was required.

13. Other

13.1. Members of the IPC team have produced 3 peer-reviewed publications relating to applied research in HCAI and AMR during Q1 (Appendix 15.6).

13.2. Members of the IPC team are also supporting a range of COVID-19 related national and international expert groups and committees.

13.3. The Trust responded to a field safety notice for a complete product recall of BD venflon pro-safety cannulae (all sizes) due to irregularities in sterilisation. This has been reviewed through the line safety committee and no patient harm was identified. All products have now been replaced with alternatives that have assured sterilisation procedures.

14. Conclusion

14.1. This report summarises IPC activity in Q1 2021/22. Action plans are in place and progressing in response to IPC related issues, including on-going water hygiene concerns and increasing numbers of MRSA BSIs, CLABSI and blood culture contaminants in ICU and SSIs in Cardiothoracic surgery. 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, Carol Hernandez, Siddharth Mookerjee, Jan Hitchcock
Date: 16th August 2021

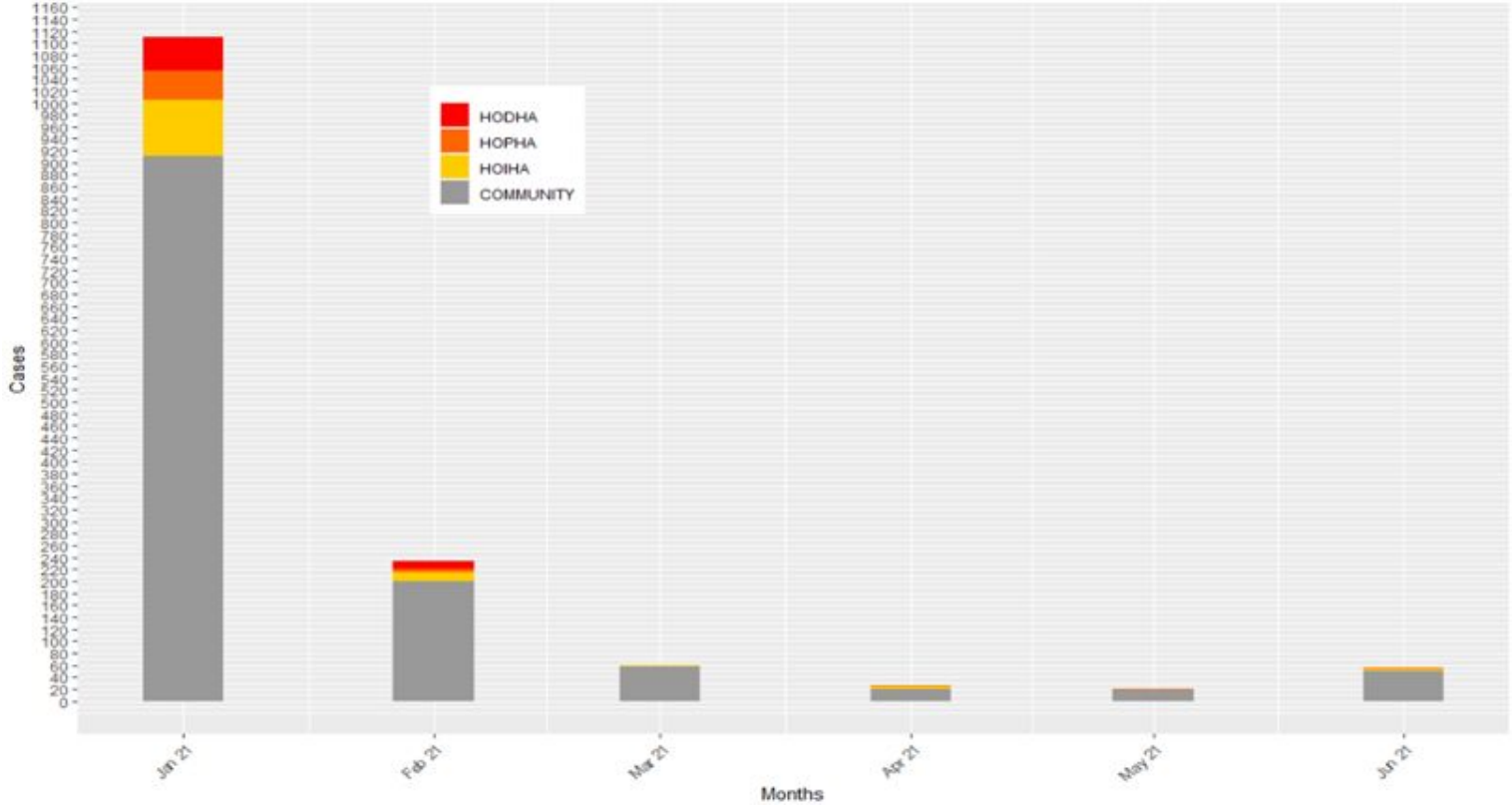
Appendices

Appendix 1 Hospital-onset COVID-19 infection
Appendix 2 Healthcare-associated infection surveillance and mandatory reporting
Appendix 3 Surgical site infection
Appendix 4 Carbapenemase-producing Enterobacterales (CPE) trends
Appendix 5 Antimicrobial stewardship

15. Appendices

15.1 Appendix 1 Hospital-onset COVID-19 infection

Figure 1: Cumulative summary of all COVID-19 identified in inpatients (6-month view) according to NHS England (NHSE) categories: (i) community-onset (Community, positive sample ≤ 2 days), (ii) hospital-onset indeterminate healthcare-associated (HOIHA, positive sample 3-7 days), (iii), hospital-onset probable healthcare-associated (HOPHA, positive sample 8-14 days), (iv) hospital-onset definite healthcare-associated (HODHA, positive sample ≥15 days).



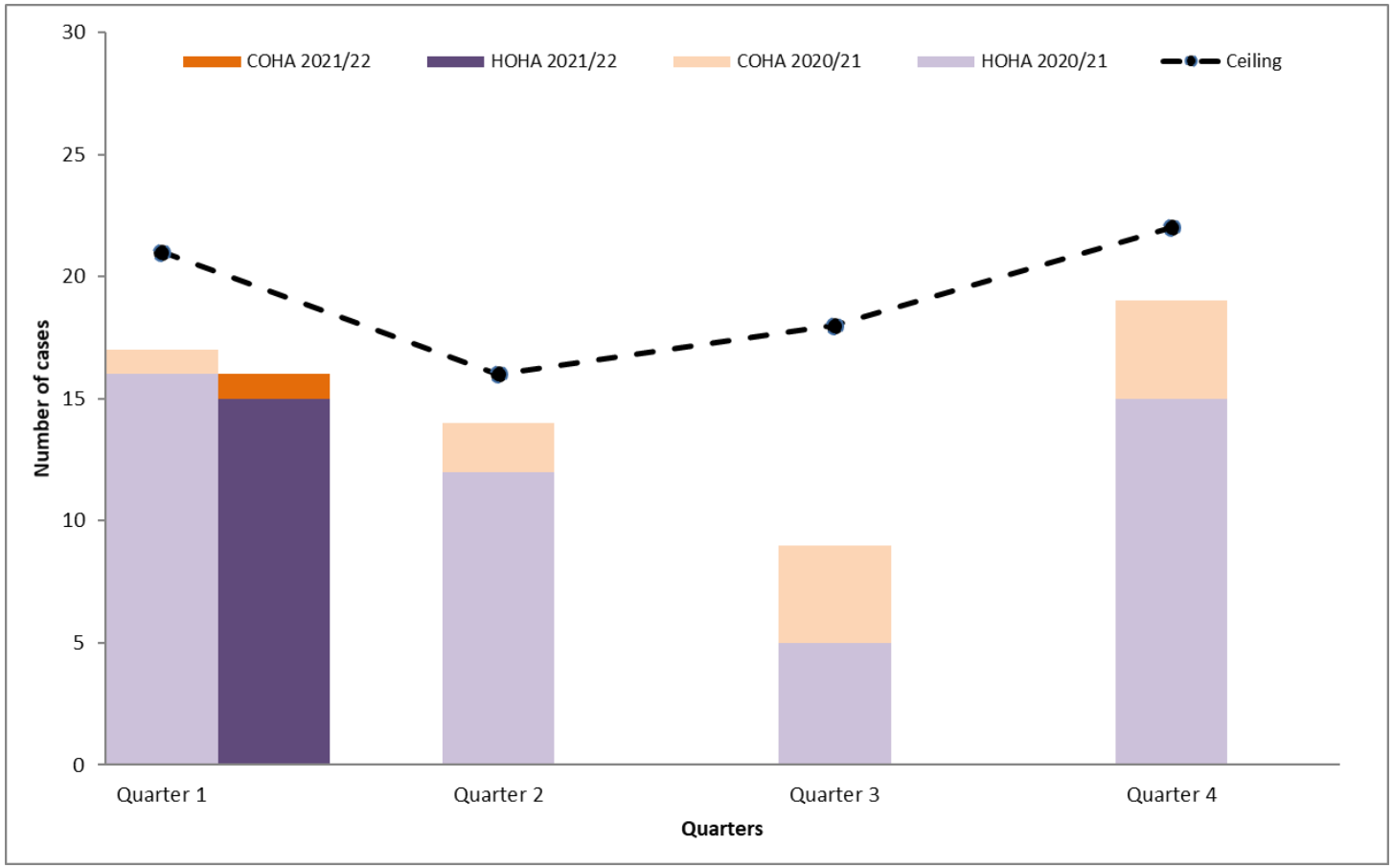
15.2 Appendix 2 Healthcare-associated infection surveillance and mandatory reporting

Table 1: A cumulative summary of healthcare-associated infection reported to PHE

	Apr-21		May-21		Jun-21		Jul-21		Aug-21		Sep-21		Oct-21		Nov-21		Dec-21		Jan-22		Feb-22		Mar-22		YTD	
	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	**No. cases**	**YTD (ceiling)**
Trust MRSA BSI	0	0	1	0	2	0																			**3**	**0**
Hospital onset-Healthcare associated (HOHA)	3	-	7	-	5	-																			**15**	**-**
Community onset-Healthcare associated (COHA)	0	-	0	-	1	-																			**1**	**-**
Total Healthcare associated *C.difficile* cases (HOHA + COHA)	3	8	7	7	6	6																			**16**	**21**
Trust *Escherichia coli* BSI	6	-	3	-	5	-																			**14**	**-**
Trust MSSA BSI	2	-	3	-	4	-																			**9**	**-**
Trust CPE BSI	0	-	0	-	0	-																			**0**	**-**
Trust *Pseudomonas aeruginosa* BSI	1	-	2	-	6	-																			**9**	**-**
Trust *Klebsiella* spp. BSI	1	-	6	-	13	-																			**20**	**-**

'Trust' refers to cases that are identified after two days of hospitalisation and so are defined epidemiologically as "healthcare-associated". A further delineation is made for *C. difficile* whereby non-Trust toxin (EIA)-positive cases where the patient has had a previous hospitalisation within 4 weeks are classified as 'community-onset healthcare-associated (COHA), distinguishing it from 'healthcare-onset healthcare-associated' (HOHA) cases. National thresholds are set for MRSA BSI and *C. difficile* infection. Key: Year to date (YTD)

Figure 2: Healthcare-associated *C. difficile* cases by FY and quarter (2020/21 to 2021/22). Key: community-onset healthcare-acquired (COHA), hospital-onset, healthcare acquired (HOHA)



15.3 Appendix 3 Surgical site infection

We report SSI in selected orthopaedic procedures in line with the national mandatory reporting scheme, and selected cardiothoracic procedures in a national voluntary reporting scheme. Elective orthopaedic surgery was suspended and the number of cardiothoracic procedures has reduced due to COVID-19 management. Number of procedures undertaken still remain below pre-pandemic levels across both cardiothoracic and orthopaedic specialities.

15.3.1 Cardiothoracic

The latest quarter for which finalised surveillance data is January - March 2021, and has seen:

- CABG: 4 SSIs (7.1%) in 56 procedures; 12-month average is 3.7% (9 SSI of 244 procedures); national average is 3.8%.
- Non-CABG: 0 SSIs (0%) in 37 procedures; 12-month average is 1.4% (2 SSI of 140 procedures); national average is 1.3%.

We observe the SSI rate in CABG to lie above the national average rate for the January - March 2021 quarter. The non-CABG SSI rate for the January – March 2021 is below the national average rate.

15.3.2 Orthopaedic

The latest quarter for which finalised surveillance data is January - March 2021, and has seen:

- Knee replacement: 0 SSI in 0 procedures; 12-month average is 0.0% (0 SSIs in 123 procedures); national average is 0.6%.
- Hip replacement: 0 SSIs in 10 procedures; 12-month average is 0.0% (0 SSI in 117 procedures); national average is 0.6%.

15.3.3 Expanded SSI surveillance and prevention

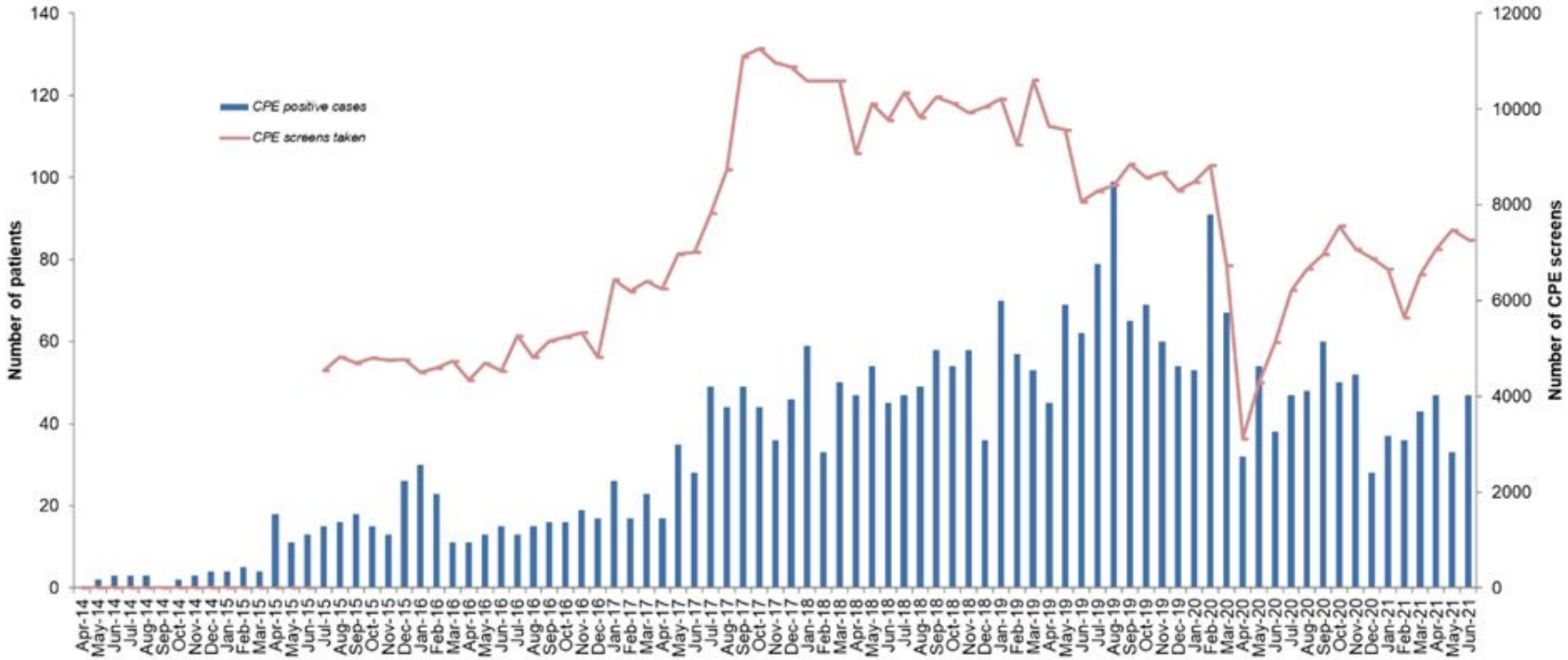
We continue to make progress in supporting the Divisions to embed prospective surveillance in the specialities identified as priority areas (Caesarean section, vascular, neurosurgery, and cardiothoracic). Following completion of the SSI audit in Caesarean section patients, we have worked with neurosurgery to undertake a joint audit aiming to:

- Determine baseline SSI rates following all elective and emergency neurosurgery through a pilot surveillance scheme.
- Establish a sustainable platform for neurosurgery SSI surveillance, including post-discharge surveillance.
- Provide actionable audit data on compliance with evidence-based SSI prevention measures.

In Q2 2021/22 we aim to pilot a post-discharge follow-up platform in general surgery, evaluate the impact of an updated wound care leaflet for patients recruited as part of the SSIS audit work, and gaining assurance on key NICE guideline recommendations.

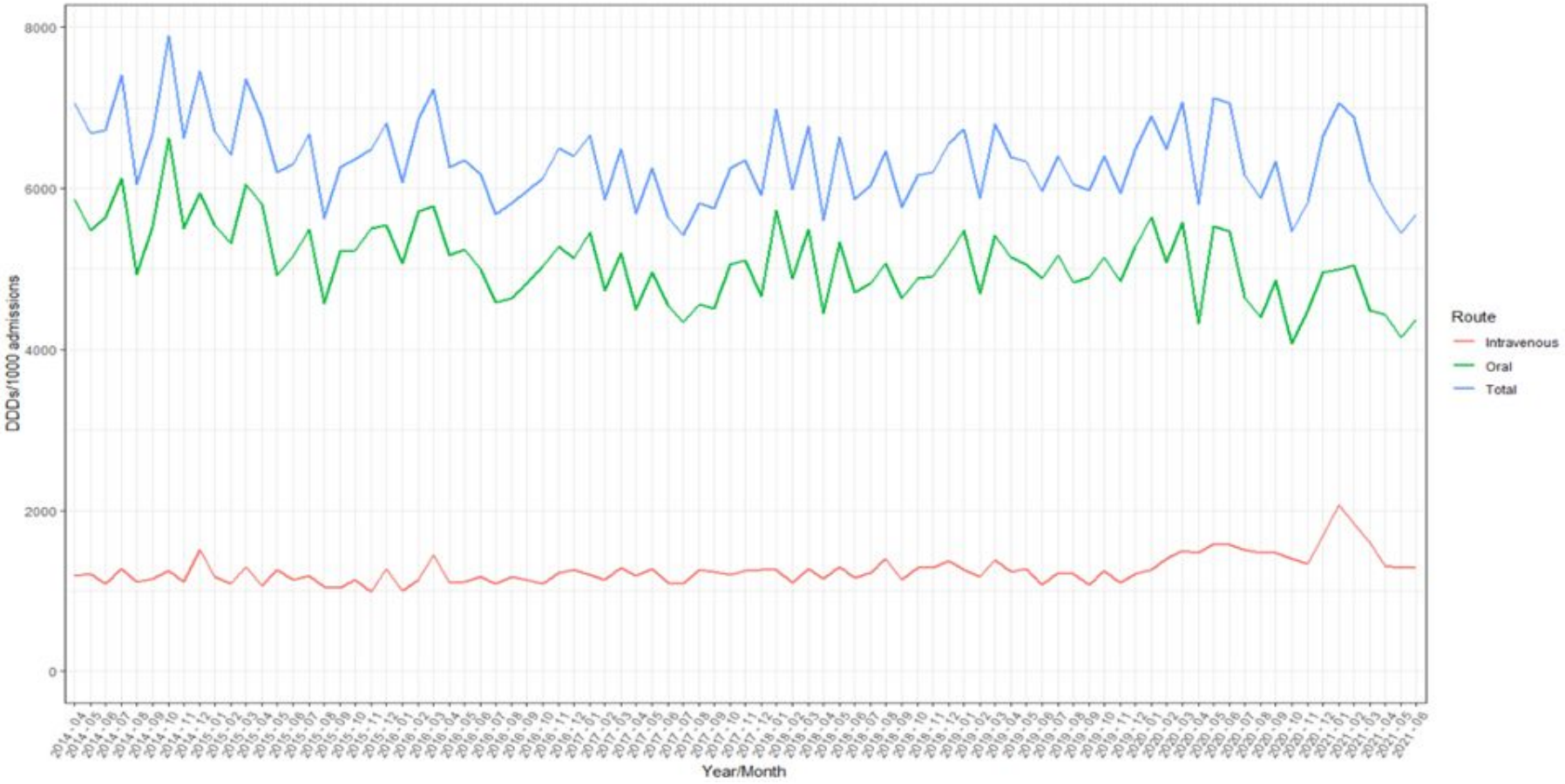
15.4 Appendix 4 Carbapenemase-producing Enterobacterales (CPE) trends

Figure 3: CPE positive cases detected at the Trust, de-duplicated by patient (meaning that each patient appears only once). The line represents the total number of screens taken each month. 78% of positive cases in the past six months are from screening specimens.



15.5 Appendix 5 Antimicrobial stewardship

Figure 4: Trust-wide antimicrobial consumption (defined daily doses, DDD per 1000 admissions) 2019/20 to present, including the split between intravenous and oral administration.



15.6 Publications

Ledwoch K, Dancer SJ, **Otter JA**, Kerr K, Roposte D, Maillard JY. How dirty is your QWERTY? The risk of healthcare pathogen transmission from computer keyboards. *J Hosp Infect.* 2021;112:31-36.

Denny S, Rawson TM, Hart P, Satta G, Abdulaal A, Hughes S, **Gilchrist M**, Mughal N, Moore LSP. Bacteraemia variation during the COVID-19 pandemic; a multi-centre UK secondary care ecological analysis. *BMC Infect Dis. 2021* 11;21(1):556.

Abbas M, Zhu NJ, **Mookerjee S**, Bolt F, **Otter JA, Holmes AH, Price JR**. Hospital-onset COVID-19 infection surveillance systems: A systematic review. *J Hosp Infect.* 2021:S0195-6701(21)00220-6.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Learning from deaths quarterly report – quarter 1 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 approval

Meeting date: 15 September 2021

Executive summary

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 one (Q1) 2021/2022 for approval ahead of submission to NHS England. The report was discussed and accepted by the Quality Committee.

2. Background

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.

2.2. 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.

3. Key findings

3.1. So far, none of the deaths which occurred in Q1 2021/2022 have been identified as 'avoidable' through the processes outlined in this report.

3.2. Structured judgement reviews (SJRs) have been completed for the 53 Hospital-onset Covid-19 infection (HOCI) deaths which occurred during the second wave of the pandemic. Following agreement of a standardised process across North West London, and completion of the SJRs, Serious incident investigations and post-infection reviews, a weekly slot at the Clinical Reference Group will be dedicated to reviewing these from 6th September to confirm harm levels and whether any of the deaths were avoidable. The outputs will report to the September EMBQG.

3.3. A new learning from deaths process has been implemented, which once embedded will improve how we investigate and learn from deaths in our care and ensure that our mortality reviews and processes align appropriately with the Medical Examiner service. Where care is deemed to be "poor" the specific issues are being managed through our incident management process which is beginning to support improved learning and triangulation of outcomes from these processes.

Imperial College Healthcare NHS Trust

4. Next steps

4.1. The findings from our mortality surveillance programme from Q1 2021/22 will be submitted to NHS England following approval by the executive and sign off by the Quality Committee on behalf of Trust Board.

5. Recommendation(s)

5.1. The Trust Board is asked to note the findings from our mortality surveillance programme in Q1 2021/2022 and sign off the data for submission to NHS England.

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 third lowest HSMR (Hospital Standardised Mortality Ratio) across the last year of data (Mar 2020 – Feb 2021), and the third lowest SHMI (Summary Hospital-level Mortality Indicator) (Jan 2020 – Dec 2020). For the latest available month of data (Feb 2021) our HSMR is 73 and the sixth lowest. This is a return to a low relative risk mortality following Jan 2021, when our HSMR was 'within expected range' and over 100 for the first time since before 2009, as a result of the latest Covid-19 surge.
7.2. Benchmarking data for February 2021 shows a reduction in our relative risk for the viral infection mortality alert (where Covid deaths are coded) compared to January, and we continue to perform well compared to our peers, remaining below London and national average.

8. Summary of learning from deaths data – Q1 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 359 deaths in the reporting period, in contrast to 688 in Q4 2020/2021 during the peak of the second wave of the pandemic.
8.3. Of the total 359 deaths in the last quarter, 13 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 357 out of the 688 deaths in Q4 2020/2021.
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 June 2021. We have reported 907 COVID-19 deaths. Current data does not suggest that our mortality rate is being disproportionately affected by any other factor.

8.5. There were no deaths in Q1 2021/2022 where the patient's infection met the Public Health England definition of Hospital Onset COVID Infection (HOCI) because they tested negative for COVID-19 on admission and subsequently tested positive more than 7 days after their admission to hospital.

8.6. Structured judgement reviews (SJRs) have been completed for the 53 Hospital-onset Covid-19 infection (HOCI) deaths which occurred during the second wave of the pandemic. Following agreement of a standardised process across North West London, and completion of the SJRs, Serious incident investigations and post-infection reviews, a weekly slot at the Clinical Reference Group will be dedicated to reviewing these from 6th September to confirm harm levels and whether any of the deaths were avoidable. The outputs will report to the September EMBQG.

8.7. A SJR has been requested for 59 (16%) of the deaths that occurred in the reporting period. The triggers for SJR can be found in appendix A.

8.8. 50 SJRs were completed in Q1 2021/2022. (Note: these SJRs do not all relate to deaths within Q1 2021/2022 because of our "backlog" of cases).

8.9. Of the 50 SJRs completed rating of global care were as follows:-

Number of case	Rating of Global Care
2	2- Poor care
14	3 - Adequate care
30	4 - Good care
4	5 - Excellent care

8.10. 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).

8.11. In Q1 2021/2022, six SJRs were reviewed at MD panel. The outcomes are summarised in the table below. One of these was investigated as a SI. The root cause was found to be 'the patient was downgraded from 'Urgent' to 'Routine' on Vocare's patient record system and was directed to Vocare triage rather than being escorted directly to the Emergency Department for an ECG. There was then a delay in conducting an ECG as there was not a robust system of prioritising ECGs for patients with cardiac risk factors**.'** Although the incident resulted in major harm, this has not been confirmed as an avoidable death. This case is being reviewed by the division. If the outcome remains as major harm this case may be classified as being potentially avoidable. This will be updated in the next report.

Global care rating	Issue	MD panel review	Outcome
4	Possible indication that a bronchoscopy was carried out after the patient's death	Further review confirmed that a bronchoscopy had been done just prior to death to try and establish	Local investigation completed. Confirmed as no harm.

		cause of bleeding and airway obstruction.	
3	Delay in triage and incorrect “routine” triage in UCC, late referral to ED of patient with chest pain	Confirmed delay in referral and ECG in ED	Serious Incident completed. Confirmed as major harm. Under review by the division to confirm if this is an avoidable death
3	• Premature discharge • Management of complex specialist surgical patient remote to site of original surgery	Premature discharge has been reported as in incident and following presentation of the 72 hour report at MD Panel is being locally investigated	Local investigation ongoing
3	HOCI death	Awaiting completion of the PIR and SJR triangulation process	Awaiting outcome
2	Possible delay in escalation of deterioration in patient with severe abdominal pain and history of ischaemic bowel	Deterioration and delay in escalation to be reported as an incident and a 72 hour report will be reviewed at panel	Level of investigation to be agreed at MD panel following review of 72 hour report
2	Choking was not considered early as a cause for the arrest. No input of airway “expert”. Hypoxia was not reversed. CPR abandoned after four rounds despite no record of ceiling of care.	Management of hypoxia, choking and cardiac arrest to be reported as an incident and 72 hour report will be reviewed at panel.	Level of investigation to be agreed at MD panel following review of 72 hour report

9. Themes and learning

9.1. 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).

9.2. Themes for learning identified from SJRs in Q1 2021/2022 are set out below.

9.3. **Ceilings of care**: Although some of the SJRs show evidence of good provision of end of life care with full records of decision making on ceilings of care and communication with the patient and family, there are a number of cases where the following issues were identified:

- Importance of discussing and agreeing ceilings of care in a suitable time frame to avoid possible inappropriate escalations and distress to the patient and family;

- Decisions about ceilings of care and DNACPR (do not attempt cardiopulmonary resuscitation) are not always comprehensively documented;
- Community DNACPR not always reviewed and reinstated on admission.

Improving how we agree and document appropriate treatment escalation plans is one of the priority workstreams for the next 12 months of our safety improvement programme. The workstream is currently being scoped, with metrics and a driver diagram being confirmed. The learning from these SJRs has fed into the planning process. The proposed project plan will be presented to EMB quality group in September.

9.4. **Handovers:** issues include the need for inter ward/intensive care transfer handovers to comprehensively cover all aspects of care. This has also been a theme in a number of recent incidents. A transfer improvement group was previously set up in response to issues raised at an inquest, but has since been disbanded, as the workstream was completed. The transfer policy is being reviewed by corporate nursing and these themes will be highlighted to the deputy chief nurse overseeing the review.

9.5. **Documentation:** as well as issues with documenting ceilings of care noted above, the SJRs also show:

- Documentation by specialist teams when reviewing their patients in critical care is not always optimal.
- Patients with multiple hospital numbers increasing the risk of missed information or delays in obtaining information from the records.

We propose that a documentation audit is considered for inclusion in the trust priority audit plan to identify areas for improvement.

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

10.1. 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.

10.2. The latest data available is for the period November 2020 to February 2021. The total number of perinatal deaths reported to MBRRACE-UK in this period was 23. There were 17 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:

- Reintroduction of carbon monoxide testing for all patients at booking (paused due to Covid-19)
- Reminder to staff to follow-up missed appointments according to the DNA (did not attend) policy and implementation of a system to chase up DNAs when women are referred to triage/maternity day assessment unit
- Remind staff that it is hospital policy to offer parents the opportunity to take their baby home and this needs to be clearly documented in the notes
- Remind staff to appropriately assess the need of aspirin and make sure women who are high risk are prescribed the medication

- Action has been undertaken to ensure that clinicians are aware of interpreting services and have access to contact numbers for interpreting.
- The use of the Cold cot is being added to the electronic checklist to make it easier to tell if it has been offered or used in future.

11. Changes to our current learning from deaths process

11.1. We are working to improve 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. The new process was implemented in June 2021 and is now embedding.

11.2. 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. Once embedded, this will help ensure more consistency and timely completion of SJRs, the target timescales of which will be reduced from 30 to 7 days from the beginning of August.

11.3. A new learning from deaths dashboard has been implemented and is attached as appendix A. This will be updated to include the new target timescale of 7 days from request date for completion of SJRs in September.

11.4. There were 46 overdue SJRs from before June 2021; these have been reassigned to the new reviewers. The latest data shows that 23 of these have now been reviewed; the outstanding cases are expected to be completed within the next month.

11.5. 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. A new monthly learning from deaths forum commenced in August. The purpose of this meeting is to review and identify themes for learning and draw on identified best practice. This committee will also monitor performance with the new dashboard.

11.6. The committee will report to the EMB quality group and will also oversee the reporting of data at speciality level.

11.7. Communication pathways have been developed to support the governance of outputs from SJRs and the dissemination of themes and learning across the organisation. This will also include teaching and learning events for clinical staff.

11.8. The revised policy will be published in September 2021 following ratification.

12. Conclusion

12.1. There have been no ‘avoidable’ deaths identified in Q1 2021/2022 by the processes outlined in this report. However the review of HOCI deaths in the second wave of the pandemic is ongoing and a SI has confirmed a case to have caused major harm so this may change when reviewed. An update will be provided in the next report.

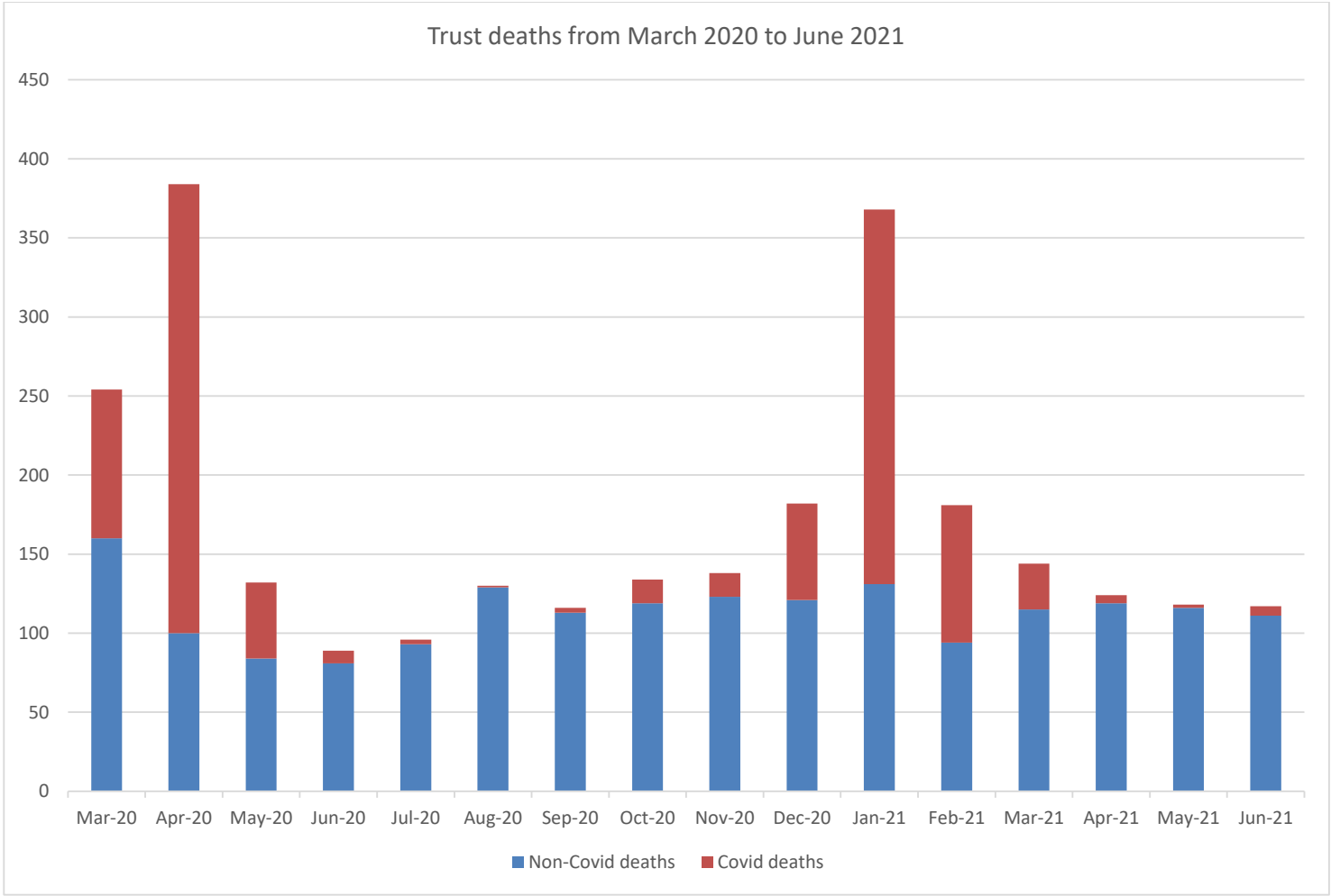
12.2. The review of the learning from deaths process has been completed, with the SJR reviewers now in post and the policy due to be approved by the end of in July. The new processes for coordination and cascading of learning will be implemented over the coming months.

Author: Darren Nelson, head of quality compliance and assurance
Date: 31st August 2021

List of appendices
Appendix A - Learning from Deaths Dashboard
Appendix B – Number of trust deaths from March 2020 to June 2021
Appendix C – Quarterly PMRT report

Imperial College Healthcare NHS Trust

Appendix B – Number of trust deaths from March 2020 to June 2021



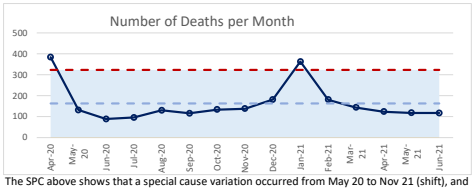
Reported in Scorecard: **Jun-21**
Data up to: **Jun-21**

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

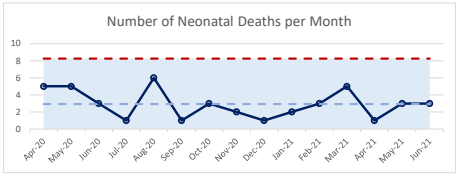
Learning from Deaths Dashboard 05-07-2021

Latest reported month:

Deaths	Rolling 12m	Neonatal Deaths	Rolling 12m	Very Poor/Poor Overall Quality of Care	Rolling 12m
117	1843	3	31	3	8



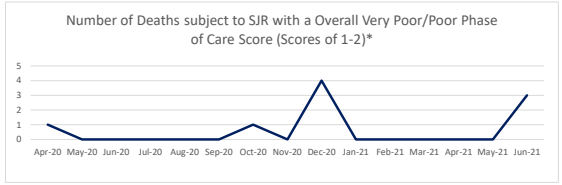
The SPC above shows that a special cause variation occurred from May 20 to Nov 21 (shift), and at January 21 (outlier).



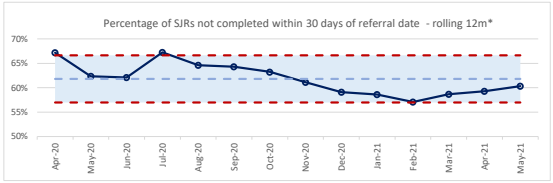
The SPC above shows no special cause variations.

Latest reported month:

SJRs Requested	SJRs Requested r12m	SJRs completed	SJRs completed Rolling 12m	Not complete <30 days (%) r12m*	Not complete <10 days (%) r12m*	Overdue SJRs
26	243	22	234	60.31%	reported in July onwards	36



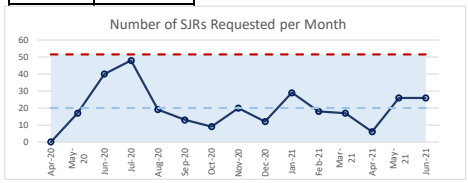
*requires 7 or more points of data to be converted into an SPC (action)



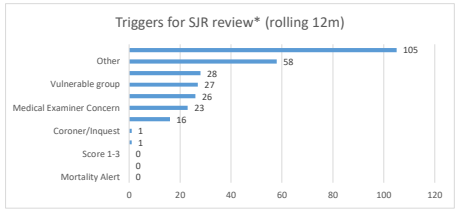
The SPC above currently shows that a special cause variation occurred from July 20 to February 21 (trend).
* This data is reported 1 month in arrears

Latest reported month:

PMRTs requested	PMRT requested Rolling 12m
4	52



The SPC above shows no special cause variations.



*please note that there can be more than 1 trigger for each SJR.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: 2020/21 Annual Report from the Trust Safeguarding Committee

Agenda item 14 paper number 11

Lead Executive Director(s): Janice Sigsworth, Director of Nursing
Author(s): Nicci Wotton, Guy Young

Purpose: For noting

Meeting date: 15 September 2021

Executive summary

1. Purpose of this report

1.1. The attached report provides a summary of the systems and processes in place to ensure that the Trust safeguards users of its services.

1.2. It also provides a high-level summary of safeguarding activity and the impact that the COVID-19 pandemic had during the year.

1.3. The report has been discussed and accepted by the Quality Committee.

2. Background

2.1. The Trust has a responsibility to safeguard children, young people and adults in its care.

2.2. The Trust Safeguarding Committee oversees the provision of safeguarding services in the organisation and seeks assurance that these services are in place and effective.

3. Key findings

3.1. The Committee was satisfied that these systems were in place and effective during the year.

3.2. The pandemic had an effect on the volume and type of safeguarding concerns the Trust dealt with. 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.

3.3. 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. There is a plan to increase this and compliance appears to be increasing.

4. Next steps

4.1. The team will continue to provide the current service with a focus on supporting divisions in relation to level 3 training compliance.

5. Recommendation(s)

5.1. The Board is asked to note the report.

6. Impact assessment

6.1. Quality impact: The trust has a responsibility to protect people in its care from abuse and neglect. It is therefore vital that the right systems and processes are in place to do this.

6.2. Financial impact: There is no financial impact as a result of this annual report.

6.3. Workforce impact: There is no direct workforce impact in relation to this annual report, but there needs to be a focus on staff completing their level 3 children's safeguarding training

6.4. Equality impact: This is an annual report so there is no direct impact on equality. It is noted by definition that age is a protected characteristic in terms of children's safeguarding. Older people are also more likely to be victims of abuse and neglect, as are people with disabilities. There are particular safeguarding issues related to pregnancy and maternity.

6.5. Risk impact: There are no risk associates with this annual report.

Appendices:

1. 2020/21 Annual report from the Trust Safeguarding Committee

Authors: Nicci Wotton & Guy Young
Date: 01.09.2021

Imperial College Healthcare NHS Trust

2020/21 Annual report from the Trust Safeguarding Committee

1. Introduction

The Trust has a responsibility to safeguard children, young people (C&YP) and adults in its care. This requirement is laid out in legislation including; The Children Act (1989), the Children Act 2 (2004) and The Care Act (2014).

This responsibility is also made clear in CQC Regulation 13: Safeguarding service users from abuse and improper treatment.

This report outlines the systems and processes in place at Imperial College Healthcare NHS Trust (ICHT) to ensure that it fulfils its responsibilities.

2. Trust infrastructure and governance arrangements for safeguarding

2.1 Executive leadership

The Intercollegiate Guidance (Royal College of Paediatrics and Child Health, 2018) continues to define roles and responsibilities of named doctors, nurses and midwives. The document also specifies that named individuals and the nominated Trust Board representatives have a duty to monitor safeguarding throughout the organisation.

In accordance with this, the Director of Nursing is the Trust Executive Lead for Safeguarding. The Deputy Director – Patient Experience is the managerial lead and chairs the ICHT Safeguarding Committee.

2.2 The safeguarding team

The role of the safeguarding team is primarily to provide expert advice and support to the trust to ensure that at risk children or adults are kept safe. This is done through ensuring that the appropriate safeguarding processes are applied. The team provides liaison between the Trust, social services, schools, the police and other agencies. The team sits within the corporate nursing division and consists of:

- a consultant nurse
- a named doctor for children (4 programmed activities)
- a named midwife
- a named nurse children
- a named nurse adults
- four C&YP clinical nurse specialists (CNS)
- two safeguarding midwives and one supporting safeguarding midwife
- a safeguarding adult band 5 nurse with a domestic abuse remit
- an identified doctor for adult safeguarding (1 programmed activity)
- two administrators

The two named children's professionals and the named midwife are mandated posts within NHS organisations and all had people in position during 2020/2021.

2.3 The ICHT Safeguarding Committee

The committee oversees the provision of safeguarding services across the Trust and seeks assurance that these services are in place and effective. The committee is chaired by the Deputy Director of Patient Experience and membership includes all Trust named professionals, designated professionals from the CCG, local authority safeguarding representatives and senior nurses from the clinical divisions. The committee focuses on assurance and key decision-making.

The committee met three times in the year; the meeting scheduled in April 2020 was cancelled due to the COVID-19 pandemic and January 2021 was postponed for the same reason. On each occasion the committee was quorate with good attendance from the named professionals. All meetings were held virtually on Teams.

2.4 Policy framework

Practice during the year was supported by a comprehensive framework of policies and guidance that support the safeguarding agenda. During the year, the following were reviewed and updated:

- Prevent policy
- Female genital mutilation policy
- Restraint procedural guidance
- Patients detained under the Mental Health Act policy

2.5 Training and safeguarding supervision.

ICHT has a requirement to provide training at different levels for safeguarding children and adults depending on their role in the organisation; for example all staff are required to do level 1 training, whereas only safeguarding professionals are required to do level 4. This has been done in line with national intercollegiate guidance, ensuring that staff get the level of training most appropriate to their role. Training is delivered through a combination of e-learning and face-to-face sessions. There are planned and bespoke training sessions. Domestic abuse, child sexual exploitation and modern slavery are included in the training. All members of the safeguarding team have additional training and safeguarding supervision commensurate with their role. Level 3 safeguarding children training has moved from the classroom to Teams and this has been positively evaluated.

As at 31 March 2021, trust compliance levels were as follows;

Type	Compliance level
Safeguarding adults level 1	90%
Safeguarding adults level 2	88%
Safeguarding children level 1	91%
Safeguarding children level 2	87%
Safeguarding children level 3	65%
Safeguarding children level 4	100%

Level 3 children training was negatively affected by COVID-19 as it is more involved than the other training, consisting of a number of online modules plus a final classroom/online Teams session. The trust has a remedial plan to get this back on track and compliance increased in quarter one of 2021/22.

Staff working with children who require level 3 training also need to undertake periodic formal supervision: an opportunity to discuss cases and issues with a safeguarding professional. This was also difficult to maintain during the pandemic, but it is anticipated that opportunities will increase in 2021-22.

2.6 Safer recruitment

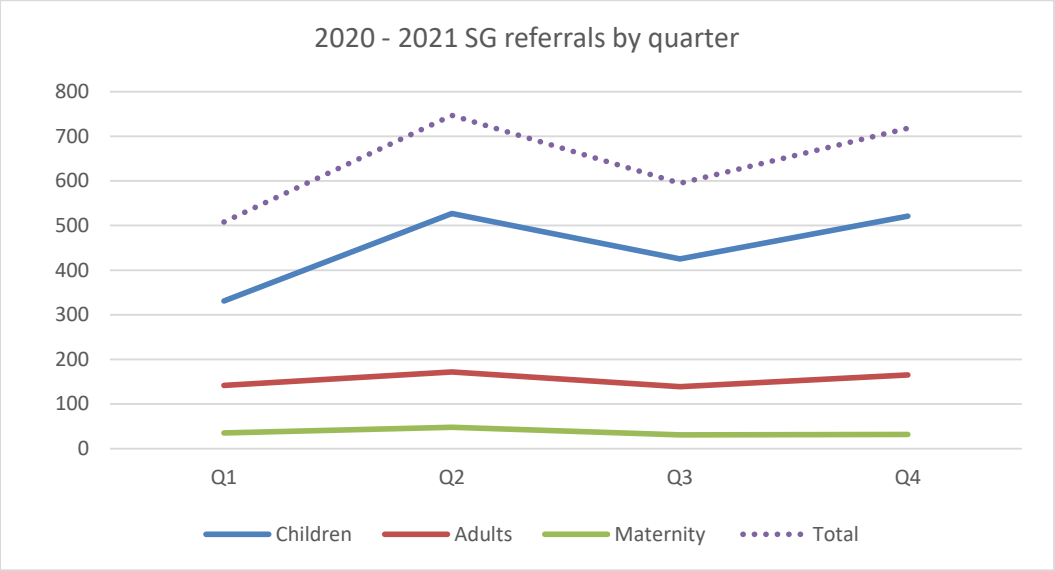
NHS Trusts are required to ensure that staff are recruited using *safer recruitment practice* in accordance with NHS Employers' guidance. ICHT complies with this by carrying out either enhanced or standard DBS (Disclosure & Barring Service) checks on new employees as well as rigorous checking of identity and referencing. Compliance with this standard is monitored by the people & organisational development division.

2.7 Child Protection – Information Sharing project (CP-IS)

CP-IS, introduced by NHS Digital, helps health professionals and social care to work together to share information when children or pregnant women attend an unscheduled healthcare setting. At the time of writing CP-IS has not been fully rolled out across health and social care and progress has been delayed by the pandemic. However, CP-IS is now an integrated system within Cerner and therefore the Trust is fully prepared to take advantage of it as its use extends more widely.

3. Safeguarding activity

The chart below shows the number of cases (c.2500) that resulted in a referral to children's or adult social care. This represents around a third of the total number of cases the team reviewed during the year. The dips in Q1 and Q3 coincide with national lockdowns.



Although there were fewer contacts with the safeguarding team during the lockdowns as there were less attendances at the trust, the level of complexity increased. More detail including types of abuse is shown in the COVID-19 section below.

4. Impact of COVID-19 on safeguarding activity and team

The year saw two waves of COVID-19 and two national lockdowns. Because safeguarding concerns are identified during attendances at the hospital, there was a fall in contacts and referrals during these periods. However, the pandemic brought its own safeguarding related issues.

The impact of lockdown on people's mental health, the increased risk of domestic abuse and children's absence from schools all had an impact. There was an increase in the number of parents and children attending with substance or alcohol abuse both of which raise the risk to children and of domestic abuse in the home. Attempted and actual suicides were more prevalent and the methods increasingly violent such as hanging or jumping from a height.

An increased number of referrals were made to a Multi-Agency Risk Assessment Conference (MARAC) by the trust. MARAC is for the high risk domestic abuse cases where there is a significant risk of harm to adults or children. The reasons for this were twofold, firstly the lockdown confined families in abusive situations to their homes for long periods and secondly the absence of perpetrators in the hospital because of the visiting restrictions led to people asking for help or disclosing domestic abuse who might otherwise not have done; a positive unanticipated consequence of the pandemic.

Serious youth violence and gang related activity fell due to school closures and the lockdown, but this has increased again as restrictions have been lifted.

A Home Office strategy to use empty hotel space in central London to temporarily house asylum seekers led to a significant increase in maternity related safeguarding concerns as they were presented with many women late in pregnancy who had had little or no antenatal care. Unaccompanied under 18s and families with young children also attended unscheduled care because no GP facilities were provided for them. This was raised local authorities and the Home Office.

There is evidence nationally that people with learning disabilities were more likely to be adversely affected by the pandemic. During the year the safeguarding team worked closely with the Trust learning disability team to ensure that patients with learning disabilities using Trust services were properly protected.

Cases of self-neglect in at risk adults increased as a result of lockdown when friends and family were not able to visit people in their homes. Financial abuse also increased related to scams, such as getting people to pay for COVID-19 tests.

The pandemic had affected the team as it affected many others. Some team members got ill as a result of COVID-19, others deemed clinically vulnerable had to shield and two members of the team were redeployed to critical care. As previously mentioned, level 3 training and supervision suffered as a result, but a 7-day service safeguarding service was maintained.

5. Feedback from external agencies

Despite the challenges throughout the year ICHT safeguarding team has received positive feedback from external agencies, such as children's and adult social care, about its performance. The Trust's focus on hearing the child's voice and "making safeguarding personal" are cited as positives. Offering a 7 day service is also considered to be valuable and quite unusual. The partnership with Redhread, an agency that supports victims of serious youth violence, has also been commended in a serious case review (yet to be published). The approach to supporting victims of serious youth violence which includes first aid conversations with the young people and gaining their views on their life experience is recognised as being innovative.

6. The year ahead

- The primary aim of will be to maintain the existing level of service and to try and to reset following the pandemic.
- The team will work with divisions to help drive up compliance with level 3 training.

- Building on work started in the year, the team will continue to develop resources on the Trust Intranet.

7. Conclusion

- The COVID-19 pandemic had an impact on the type and volume of safeguarding cases.
- The Trust Safeguarding Committee, based on evidence and reports received during 2020/21, is assured that the Trust had the infrastructure and appropriate systems in order to provide a safe and effective safeguarding service.
- The Committee has no significant areas of concern that it wishes to advise the Trust about, but will continue to monitor the volume and type of safeguarding cases and escalate them if necessary.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Annual report of the End of Life Steering Group 2020-2021

Agenda item 15 and paper number 12

Lead Executive Director(s): Catherine Urch – Divisional Director SCC
Author(s): Katherine Buxton, Guy Young

Purpose: For noting

Meeting date: 15 September 2021

Executive summary

1. Purpose of this report

1.1. To provide an overview of activity related to end of life care as reviewed by the End of Life Care (EOLC) Steering Group. This report has been discussed and accepted by the Quality Committee.

2. Background

2.1. The EOLC steering group provides oversight and direction to the end of life work programme. The group meets every 2 months and is attended by a broad range of stakeholders. Issues of concern raised at the steering group meetings will go to the Executive Management Board Quality Group by exception.

2.2. EOLC is a CQC core service and was last assessed in 2014, when it was given a good rating.

3. Key findings

3.1. During the year a number of key improvement were made:

- launch of updates to the cardiopulmonary resuscitation (CPR) & treatment escalation plan on Cerner
- development of CPR decisions dashboard
- launch of the care agreement and the nursing care plan for the last hours & days of life and on Cerner
- development & trust-wide implementation of MAAR chart and EOL discharge power plan for prescribing EOL medications
- significant progress with work on advance care planning & integration of CMC trust-wide
- launch of trust-wide bereavement survey

4. Next steps

4.1. The EOLC steering group will continue to retain a focus on CQC preparedness by delivering against the key priorities (as shown below).

4.2. All priorities require trust-wide engagement and senior engagement for the effective implementation and on-going monitoring of performance.

4.3. To consider what actions need to be taken to raise awareness of EOLC and the continued improvements that need to be made.

5. Recommendation

5.1. The Trust Board is asked to note the report.

6. Impact assessment

6.1. Quality impact: The provision of good EOLC is a fundamental part of patient care. Failing to deliver high quality EOLC is distressing for patients and families and can result in complaints and incidents. EOLC is a CQC core service and will be subject to an inspection at some point. The aim is to improve on the 2014 good rating.

6.2. Financial impact: There is no financial impact associated with this annual report although it is acknowledged that EOLC resource is very limited in relation to delivering ongoing improvements

6.3. Workforce impact: Effective delivery of a trust wide education programme for EOLC is still an aim, but opportunities are limited by a lack of people to deliver this. Options are continually being explored and a range of online resources have been made available.

6.4. Equality impact: This is an annual report. No decisions need to be made that are likely to have an impact on any protected groups.

6.5. Risk impact: There is no risk associated with this annual report.

Main report

7. Key items for noting

7.1. The end of life care team is a strategic team leading on the planning and implementation of innovative service improvements and the co-ordination and delivery of education. There is a close relationship with the specialist palliative care team who are the providers of direct clinical care for those with complex needs and support the ward teams with the non-complex care where they feel they need additional support.

7.2. This is the third annual report of the End of Life Steering Group. We aim to provide a summary of the achievements over the past year (1st April 2020 to 31st March 2021).

8. Key achievements in 2020/21:

- launch of updates to the cardiopulmonary resuscitation (CPR) & treatment escalation plan on Cerner
- development of CPR decisions dashboard
- launch of the care agreement and the nursing care plan for the last hours & days of life and on Cerner
- development & trust-wide implementation of MAAR chart and EOL discharge power plan for prescribing EOL medications
- significant progress with work on advance care planning & integration of CMC trust-wide
- launch of trust-wide bereavement survey.

9. Background

9.1. The end of life team is a strategic team leading on the planning and implementation of innovative service improvements and the co-ordination and delivery of education across Imperial College Healthcare NHS Trust, to allow everyone to be able and

confident to deliver good end of life care. The end of life care team does not deliver direct patient care but has a close relationship with the specialist palliative care team.

9.2. The EOLC steering group provides oversight and direction to the end of life work programme. The group meets every 2 months and is attended by a broad range of stakeholders. Issues of concern raised at the steering group meetings will go to the Executive Management Board Quality Group by exception.

9.3. The EOLC team consists of:

- Dr Katherine Buxton – Clinical Lead for End of Life Care
- Guy Young – Nursing Lead for End of Life Care
- Judy Naidoo – End of Life Administrator

10. Update against priorities for 2020/21

10.1. **Improving the quality and consistency of decision making and recording of CPR & treatment escalation plans:**

- launch of updates to the cardiopulmonary resuscitation (CPR) & treatment escalation plan on Cerner
- completion of audits of CPR & treatment escalation decisions during the first wave of covid to ensure consistency of decision-making in line with policy
- development of CPR decisions dashboard to allow monitoring of performance.
- update to patient written information on CPR & treatment escalation decisions
- progress with e-module development on CPR & treatment escalation decisions.

10.2 **Developing a robust means of delivering and evaluating end of life education across the organisation:**

Further funding for the end of life educator post was not secured to date. During the past year we have completed a scoping exercise to determine the end of life education & training requirements trust-wide, and we continue to work on agreeing the resource to appropriately support this.

10.3 **Improving and embedding the rapid discharge process for people who wish to die outside of hospital**

- collaboration on the development of discharge processes trust-wide and incorporation of the rapid discharge checklist for those who wish to die outside of hospital within this.
- development & trust-wide implementation of MAAR chart and EOL discharge power plan for prescribing EOL medications.
- significant progress with work on advance care planning & integration of CMC trust-wide for sharing care plans across the settings including:
  - continued progress within the big room to integrate advance care planning and CMC usage into key teams across the organisation
  - development of training package for advance care planning and use of CMC
  - development of centralised processes for managing education & training delivery, the CMC login application and the management of data/reporting
  - development of the federated access model

10.4 **Managing the behavioural aspects of caring for patients at the end of life and ensuring that staff feel confident to care for the person themselves and those important to them:**

Plan developed for a trust-wide communications campaign to highlight key cultural priorities for end of life care including:

- ensuring clarity of language so we all have a shared understanding
- end of life care is everybody's business including how this may be achieved by spotlighting different organisational roles
- the importance of shared decision-making and prioritisation of patient wishes and how we may accomplish this
- the importance of caring and compassionate communication

11 Additional key achievements for 2020/21

11.1 Response to Covid 19 pandemic:

During the past year the Trust has faced an unprecedented number of deaths due to the Covid 19 pandemic. All staff involved in delivering face to face clinical care have responded remarkably and worked above and beyond to care for patients and those close to them. To support the delivery of excellent care the end of life team in conjunction with the specialist palliative care team developed several supportive tools:

- prescribing guidance in covid 19 for the last hours and days of life, including in the event of drug shortages
- supportive guides for key aspects of Cerner such as how to prescribe a syringe driver, how to use the anticipatory medication care set and how to complete the CPR & treatment escalation form thoroughly
- bite size education modules available on the intranet page
- improvements in processes to support the bereaved enabled by changes to registration of deaths under the Coronavirus act

11.2 Launch of trust-wide bereavement survey:

- development and launch of trust-wide bereavement survey to seek views on the care received, in particular in the last hours and days of life

11.3 Patient written information:

- development of the initial three, in a series, of patient written information leaflets to support difficult conversations with patients and those close to them on end of life issues. These include 1) CPR & treatment escalation decisions, 2) Care in the last hours & days of life, 3) Specialist palliative care team leaflet.

11.4 End of life care intranet page:

- redevelopment of the end of life intranet page as a central repository for key documents and education packages related to the delivery of end of life care

11.5 Relationships:

- cohesive working with allied teams including specialist palliative care, medical examiner's office & bereavement services, mortuary services and chaplaincy

12 Priorities for 2021/22 remain largely unchanged from the previous year:

- improving the quality and consistency of decision making and recording of CPR & treatment escalation plans
- developing a robust means of delivering and evaluating end of life education across the organisation

- improving and embedding the rapid discharge process for people who wish to die outside of hospital
- Managing the behavioural aspects of caring for patients at the end of life and ensuring that staff feel confident to care for the person themselves and those important to them.
- consolidate changes to bereavement processes

13 Options appraisal including financial appraisal (not relevant)

14 Conclusion

14.1 The EOLC steering group will continue to retain a focus on CQC preparedness by delivering against the key priorities (as shown below).

14.2 All priorities require trust-wide engagement and senior engagement for the effective implementation and on-going monitoring of performance.

14.3 To consider what actions need to be taken to raise awareness of EOLC and the continued improvements that need to be made.

Author Dr Katherine Buxton & Guy Young
Date: June 2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Workforce Equality, Diversity and Inclusion Annual Report 2020/2021

Agenda item 16 and paper number 13

Executive Director: Kevin Croft, Director of People and Organisational Development
Author: Gemma Glanville, Divisional Director of People (EDI Lead)

Purpose: For approval

Meeting date: 15 September 2021

Executive Summary

1. Purpose

1.1. The Trust are required to publish its Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) action plans (part of our Workforce EDI Work Programme) on its external website by 31 October 2021. We are required to submit data using the online systems for both standards by 31 August 2021. The report has been discussed and accepted by the People Committee and presented to Trust Board for approval.

2. Introduction and background

2.1. Workforce Equality, Diversity and Inclusion Annual Report 2020/21 is to be published on the Trust's website and sets out how we are meeting the Public Sector Equality duties under the Equality Act 2010. This is the third year that in our annual report we have combined our data and plans for the WRES, the WDES and our Gender Pay Gap Report. The report is being discussed, and then approved at the following meetings:

- Workforce Race Equality Standard (WRES) Implementation Steering Group (14 July 2021)
- Equality, Diversity and Inclusion Committee (including chair of staff-side and all staff network leads) (20 July 2021)
- Executive Management Board People (21 July 2021)
- Partnership Committee circulated (3 August 2021)
- Executive Management Board (24 August 2021)
- Trust People Committee (7 September 2021)
- **Trust Board (15 September 2021)**

3. Report overview:

3.1. Executive summary (pg.4) & Our Progress (pg.6) – an executive summary provides an overview of the report structure, the key findings of our equality analysis and an overview of our work programmes.

3.2. Workforce profile commentary (pg.12, Appendix 1, pg.19) - there have been no significant changes in the workforce composition in regards to age since 2010. There has been no significant change in regards to ethnicity in recent years either with the Trust continuing to have a higher percentage of staff employed from black, asian and minority ethnic backgrounds than the local (London) population. The workforce split in regards to gender has also remained unchanged in the last 5 years.

3.3. Workforce, EDI work programme overview 21/22 (pg.13 & Appendix 2, pg.22) The EDI Committee is chaired by the Chief Executive, in 2020 the membership was expanded to include Network Executive sponsors. For 2021 the Trust continues to prioritise work on race equality, remains focussed on disability equality and re-commits to the development of staff networks. Our work programme objectives for 2021/22 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.

3.4. WRES (pg.14 & Appendix 3, pg.25) We disciplined more black, asian and minority ethnic staff compared to white in the last year, this has increased our likelihood (two year average) from 1.27 to **2.69**. WRES have changed the way the indicator is recorded this year, from a two year average, to an end of year position. The relative likelihood of white applicants being appointed from shortlisting compared to black, asian and minority ethnic applicants was **1.39** times greater a small improvement from last year, 1.43. We recognise we need to further improve on our people practices, including recruitment and people practices impacting on staff experience.

3.5. We have introduced a number of changes to our disciplinary practices, and a dedicated senior employee relations specialist was appointed in March to conduct a full review of our practices, and help us to manage individual and team conflict more promptly and constructively. We have introduced external panel members for dismissals. We have taken on recommendations from an external review by a specialist race consultancy and our employee relations and investigation team received bespoke training on race. Ways of working in the central investigations team have been overhauled to encourage informal resolution to issues wherever possible. From September 2021, all allegations of bullying, harassment related to discrimination will be investigated centrally with a peer review system in place. Our immediate manager programme will focus on developing managers that are able and skilled to manage diverse teams and recognise bias earlier.

3.6. WDES (pg.14 and Appendix 4, pg.31) We continued to make improvements in the percentage of staffing say we made adequate reasonable adjustments from 67.7% to, **70.1%,** compared to a national average of 75.6%. We aim to improve further next year. The engagement score for disabled staff is **6.6** compared to **7.2** for staff who have not stated to have a disability. Both have **decreased** by 0.1 each compared to last year. We did not have any disabled staff who were performance managed this year and the relative likelihood of applicants with no disability being appointed from shortlisting compared to applicants with a declared disability is **1.25** times greater (1.12 last year).

3.7. Gender pay report (pg.15 and Appendix 6, pg.39) the Trust gender pay gap position for March 2021. It is also noted that the CEA awards bonus data does not include any newly issued awards in 2020/2021, due to a pause in this process due to covid-19. Therefore year by year comparisons are not recommended.

3.8. EDS2 (pg.16) we reported on EDS2 in full in the 2020 annual report and this has been published on our external website in March 2020. The five EDS2 priorities cover the period 2020-2023 and there is no change this year.

4. Recommendation(s)

4.1. This Board is asked to agree this report for publication.

4.2. The Trust are required to publish our WRES and WDES action plans (part of our Workforce EDI Work Programme) on our external website by 31 October 2021. We have already submitted data using the online systems for both standards.

5. Impact assessment

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

5.2. Financial impact: None.

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

5.4. Equality impact: A full Equality Impact Assessment was completed for the EDI Work Programme, identifying positive impact for all protected characteristics and was approved by the EDI Committee in May 2021.

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

NHS
Imperial College Healthcare
NHS Trust

Workforce Equality, Diversity and Inclusion Annual Report

2020/2021

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

Directorate of People and Organisational Development

Authors: Olayinka Iwu, Gemma Glanville, Sebastiano Rossitto

disability confident COMMITTED

Contents

1. Welcome

The last year has been particularly challenging with a global pandemic. Our staff have been responding to covid-19 at a pace that has never been seen. We understand that the pandemic has brought inequalities to the forefront and our commitment to improving inequalities for our staff has not wavered.

As Chief Executive and Chair of the Equality, Diversity and Inclusion Committee, I am very proud of the commitment of our staff networks and the contributions that they have made. We are actively working on improving inclusiveness through contributions of our staff network groups.

We made a financial investment in our EDI agenda, to fund training for 200 managers on race relations, we also expanded our team from one part time person to four full time people, and we became members of professional EDI organisations, and now have a budget for financial support for our networks.

We will continue to develop opportunities for staff to engage on equality, diversity and inclusion, including through our reverse mentoring programme, which is giving our senior leaders more exposure to the insights of Black, Asian and Minority Ethnic staff with different lived experiences.

I am very proud of our diversity at Imperial College Healthcare – it is a huge strength. We have to ensure that everyone has an equal chance to succeed so that we can harness that potential for everyone's benefit. I have made a commitment to achieve real and meaningful progress in challenging inequality and prejudice – both through formal means, such as chairing our Equality, Diversity and Inclusion Committee, and through my own personal development and learning. I would like this to be a commitment shared by everyone in our organisation, whatever their background.

(To be Signed)

Professor Tim Orchard, Chief Executive Officer

1.1 Use of data and information

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

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

We use data and information in relation to a range of national standards relating to workforce equality that we are required to meet annually as outlined in this report. Staff can update their personal data via employee self-service at any time.

1.2 Terminology

Throughout this report, we use the term “black, asian and minority ethnic”, expressed as the acronym BAME, to refer to those members of the NHS workforce who are not white. As set out in the WRES technical guidance, the definitions of “black, asian and minority ethnic” and “white” used in the WRES have followed the national reporting requirements of ethnic category in the NHS data model and dictionary and are as used in NHS digital data. We are aware that terminology is being reviewed and we will follow NHS guidance as it is produced.

1.3 Purpose and Scope

In line with the Equality Act 2010, the Trust is required to publish equality information annually (1 April 2020 - 31 March 2021) to show how it has complied with the public sector equality duty. This annual report focuses on workforce and provides the Trust with valuable insights into our workforce equality performance. It identifies priority areas for improvement. In addition, this report has incorporated information required by the Workforce Race Equality Standard (WRES) and Workforce Equality Disability Standard (WDES) that is mandated in the NHS standard contract. It also includes the Gender Pay Gap report. We report separately on other internal NHS requirements, such as the Model Employer Goals and Equality Delivery System 2.

This data was captured during the unprecedented pandemic of coronavirus (covid-19). During covid-19, many factors affected our equality data, including changes to our workforce, streamlined recruitment practices, changes to on-boarding new staff, training opportunities were reduced or paused in many areas, many of our employee relations cases were postponed and elements of our Equality, Diversity and Inclusion (EDI) Work Programme were placed on hold as individuals were redeployed.

1.4 About us

We are an NHS Trust of 13,000 people, providing care for around a million people every year, in our five hospitals and a growing number of community services. We have a rich heritage and an ambitious vision for the future of our patients, staff and local communities. We want you to know all about who we are, what we do and where we are heading.

2. Executive Summary

This report marks the third year of the new format in which the Trust publishes all its equality data together. This report comprises of the Trust’s updated 2021/2022 Workforce EDI programme which sets out our strategic plan which has been co-designed with our EDI committee members. Our Workforce EDI programme is accompanied by a detailed project plan.

There are six key objectives for 2021/2022. We have kept the main objectives from 2020/2021 and expanded the remit of objective 1 and objective 5 to broaden our data collection and our educational interventions. Our 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.

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

Equality profile of our workforce (Appendix 1)
Workforce Equality, Diversity and Inclusion Programme 21/22 (Appendix 2)
Workforce Race Equality Standard 20/21 (Appendix 3)
Workforce Disability Equality Standard 20/21 (Appendix 4)
Gender Pay Gap Report 20/21 (Appendix 5)

The WRES and WDES action plans required under the NHS contract are incorporated in the Workforce EDI Programme 21/22 and are highlighted.

3. Our approach

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

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

We recognise that to support the NHS to deliver its ambition to reduce health inequalities across ethnic minority communities we must look at delivering equality internally for the people we employ. We want to understand the communities we serve, understand their lived experience and how this in turn affects their health outcomes. We acknowledge we must create an organisation where diversity is welcomed, the benefits understood and there is strong evidence of equality, belonging and psychological safety.

3.1 Our governance

- The Workforce EDI programme comprises of six key objectives with a strong focus on race
- We have a monthly WRES Implementation Steering group with a specific focus on race equality actions
- The bi-monthly EDI Committee is chaired by the Trust Chief Executive Officer. The EDI Committee includes representatives from divisions, staff networks and staff side. It also reviews progress on the Workforce EDI Programme.
- In 2021, we introduced a new board committee, focused on People. The People Delivery Board oversees the EDI Committee on the overall work programme and is accountable for the Trust workforce EDI performance.
- The Trust People Committee and Board receive reports, presentations and verbal feedback on the Workforce EDI Programme and other statutory reports as well as playing a pivotal role in shaping the strategy and vision for the long-term EDI agenda.
- We have executive sponsors for all our networks and four trained WRES experts.
- Externally we have EDI lead representatives on the pan-London EDI network and the North West London EDI network.

3.2 Our progress 20/21

Developing our staff

We expanded our internal EDI team to add three full time members of staff, to support the delivery of our work programme.

We have four nationally trained WRES experts at the Trust (including the Director of People and Organisational Development). They take part in a monthly WRES steering group and connect with other networks in other organisations to share best practice.

We completed the NHS Employers, Diversity and Inclusion Partners programme for 2020/21. The programme is designed to support and develop equality performance. The programme offered a number of benefits including advice, guidance and an opportunity to discuss, network and test our new concepts and approaches.

Our Capital Nurses' Programme was paused during the covid-19 pandemic and the programme restarted in May 2021. We are supporting nine nurses on the programme to complete their improvement project, expecting the programme to conclude at the end of 2021.

HR Policies

We reviewed many of our policies this year, with active involvement from our network chairs, line managers and trade union partners. We reviewed and updated our Supporting Staff Transitioning guidance.

We also combined our former Equal Opportunities Policy, with our former Equality and Diversity Policy in a new single policy, Equality, Diversity and Inclusion. This policy clearly sets out how the Trust will achieve its aim of protecting the rights of people

under the law and ensuring that the Trust is compliant with its statutory and regulatory obligations.

The Trust formally launched new guidance on making reasonable adjustments, including an optional reasonable adjustment passport. This was accompanied by new training for managers and a dedicated intranet page and links to Access to Work. We also improved our Performance Management Policy to state that reasonable adjustments should be implemented before commencing formal performance management, and to allow a set time to see if the adjustments result in an improvement.

Diversity Data

We have agreed three metrics that will drive improvements for our WRES indicator 2. Two of these metrics are now included on our Trust management dashboards. We will also be working to deliver EDI workforce composition data for both directorate and division in 2021.

We had approximately 1300 records for our staff with an unknown category for ethnicity on ESR. The People and Organisational Development directorate reviewed staff personal files to improve the quality of data. This project resulted in confirming the ethnicity of 1200 staff. Not all of these were entered into ESR by 31 March 2021, so are not reflected in our 2021 data. Approximately 100 records therefore remain where the organisation does not hold data on ethnicity. These staff will be directly invited to update their records as part of our wider plan to improve ESR declaration.

We produced mid-year Model Employer Goals as part of a pilot to help support our three largest clinical divisions to enable them to consider local divisional actions to employing a more representative workforce at senior levels.

Reverse Mentoring

Our Reverse Mentoring programme helped support our response to the covid–19 pandemic. The executive mentees had a session during the pandemic in response to the disproportionate effect of covid–19 on Black Asian and Minority Ethnic communities. The programme has clearly affected attitudes of our executive directors and concludes in 2021.

Improving our WRES 3 Indicator

We continue to focus on how we can improve our disciplinary processes and the experiences of staff involved in this. We adapted and reviewed our checklists and ways of working to ensure our decision making around potential disciplinary cases is robust and considered. We have trained over 100 senior managers and executive team members to chair disciplinary panels in accordance with ACAS best practice. We introduced the use of external panel members at disciplinary hearings that may result in dismissal to ensure the process is as impartial and fair as it can be.

In addition, we commissioned an external organisation to review some of our disciplinary cases involving black, asian and minority ethnic colleagues to identify key themes and issues. The review found that there has been an improvement in the quality of investigation reports since the Central Investigations team was formed, and

that we are probing issues around race more deeply. This was accompanied by training for 37 managers on Managing Diverse teams and two days of bespoke training for 16 employee relations professionals on how race impacts in the management of employee relations.

Following this, peer review mechanisms have been put in place around our employee relations internal processes, to build a culture of continuous improvement and encourage us to reflect on and challenge our own potential biases and assumptions. We also will take forward the recommendations to implement a new employee relations tone of voice to make our communications more concise, accessible, straightforward and kind.

Hair caps and hijabs
Our WRES frontline expert worked with procurement to ensure that appropriate hair caps were ordered for black, asian and minority ethnic staff who wear uniforms. We have distributed over 300 hair caps to staff across all of our sites. We also now have hijabs easily available to order for muslim staff in any clinical role and for hotel services staff who are based in clinical areas.

Accessibility
Following feedback and engagement with the I-Can disability staff network, we took a range of steps to make our online all-staff briefing lead by our CEO more accessible. We have also created a new page on the intranet explaining more about the accessibility tools that Windows and MS teams offers, and we will build on this over the coming year. The promotion of accessibility features addressing vision, hearing, mobility, neurodiversity and colour/contrast.

4. Our staff networks

Our networks play a pivotal role in supporting the Trust's equality, diversity and inclusion commitments. This year we placed a strong focus on developing our networks to develop governance, membership and organisational support available for them. We recognise the CIPD advice that if staff networks are to be effective tools in improving inclusivity and tackling discrimination at work, networks need to function as real vehicles for employee voice at an individual and collective level. They need to be able to support organisations in delivering real change, not just existing as a tokenistic nod towards inclusion.[1]

We now have five established staff networks. All our networks have two or three chairs, terms of reference, a membership list and regular meetings.

The **black, asian and minority ethnic nursing and midwifery network** is sponsored by the Director of Nursing, Professor Janice Sigsworth. The network's projects in 2020/2021 include:

[1] CIPD, A guide to establishing staff networks, March 2020

- guiding the response to covid-19, including vaccination strategy and approach, risk assessments, broadening our health and well-being offer to look at spiritual support.
- the procurement of hair caps for our Black Asian Minority Ethnic staff with afro hair. This initiative has been adopted across the NHS.
- supporting the review of the Trust's disciplinary process.

The **multidisciplinary black, asian and minority ethnic network** is working in partnership with the Nursing and Midwifery Network to help the Trust meet its race equality objectives. Professor Julian Redhead, Medical Director, is the network's executive sponsor. The network's projects in 2020/2021 include:

- the development and training of 21 Black, Asian and Minority Ethnic Ambassadors. Our ambassadors went through a structured training programme, which consisted of development and received a certificate of completion from our CEO. The ambassadors are vital to ensuring staff can speak up and raise concerns. Imperial Charity funded this programme.

Both the networks have collaborated on:

- providing input into the Trust's approach and development of inclusive recruitment and diverse panels.
- celebrating Black History Month, the network alongside the EDI team invited Lord Simon Woolley to lead a conversation on race and the NHS.
- Supporting the design of individual risk assessment and identified concerns around personal protective equipment (PPE).

The **LGBTQ+ network** is working to connect LGBTQ+ staff, reduce health inequalities and improve experience for LGBTQ+ patients and staff. The network is sponsored by Professor Frances Bowen, Divisional Director for Medicine and Integrated Care, and Jeremy Butler, Director of transformation. The network's projects in 2020/2021 included:

- distributing rainbow badges, asking each member of staff to make a pledge to support the community before receiving their badge.
- celebrating LGBTQ+ History Month, the network published a blog that reflected on the inequalities that persist for LGBTQ+ people and on the important role healthcare providers have in improving the experiences of LGBTQ+ staff, patients and communities
- raising awareness as the subject of a photo story in the Pride edition of *Attitude* magazine, and in December were the first recipients of the Society Award (on behalf of the NHS) in the Attitude Awards.

'I-Can', the network for people with disabilities, is working to raise awareness of disability issues, the Government's Access to Work scheme and the importance of disability data reporting. The network's executive sponsors are Peter Jenkinson, Director of Corporate Governance and Trust Secretary, and Professor Catherine Urch, Divisional Director for Surgery, Cancer and Cardiovascular. The network's projects in 2020/2021 included:

- providing advice to introduce more accessible communication, resulting in improvements in the accessibility of All Staff Briefings, an example of this was providing captions on recordings and written transcripts. This focus on accessibility has carried over to other Trust activities such as the Trust's well-being podcast producing transcripts of episodes.
- providing advocacy and support to people shielding during the covid-19 pandemic through virtual coffee mornings.
- co-designing the new guidance for the reasonable adjustment's passport, designed to provide a documented record of an individual's needs, which will allow our staff to function in a supportive and encouraging environment. They have also worked on new policies to ensure they are accessible, use the correct terminology for disabilities, and are relevant to disabled staff.
- working with the internal transport (Hopper bus) service to ensure bus drivers were aware that disabled staff with mobility aids (such as frames) were permitted to bring these onto the site-to-site bus, as well as consulting on various projects including the redevelopment programme and the staff spaces programme.
- representing the Trust at the National Disabled Staff Networks meetings by NHS England's Workforce Disability Equality Standard Team.

The **women's network** is working to help promote equality and diversity at all levels across the Trust, supporting skills development, improve women's experience at work at Imperial and focusing on women's health such as menopause. The network's executive sponsors are director of communications Michelle Dixon and chief financial officer Jazz Thind. The network's projects in 2020/2021 include:

- re-electing new chairs and surveying membership
- developing their web page and raising their profile
- held a conversation to celebrate International Women's Day, including a blog from their executive sponsor. This year's theme was #ChooseToChallenge, so our panel of women from across the Trust discussed the challenges they have faced in their roles and the impact Covid-19 has had on them.
- held a series of events for International Women's Month including a development event "finding your voice and developing personal impact workshop," a cut-up poetry workshop to explore gender identity, an 80's dancercise class
- designing and facilitating listening sessions for women and all staff to improve safety in and around the workplace
- contributing to the design of the Trust's wellbeing strategy

5. Project SEARCH

Project SEARCH is a supported internship programme that gives young adults with a learning disability the opportunity to learn skills to do a job in a real working environment. The programme's main aim is to give a transition from education and is to help young people with special educational needs and disabilities to gain the experience and skills needed to get paid employment. The Trust offers 12 interns a placement in which they undertake 10 to 12 week placements around our hospitals.

Due to the covid-19 pandemic the internship programme was adapted and we had interns on site at Imperial College from September – December returning to our hospitals in January. Due to the lockdown we had to take a more blended approach using online learning for development sessions. Some of the adaptions to the programme included the development of physical tasks around interns' homes. All participants have either taken up employment or are in an apprenticeship. We have five interns in employment with the Trust, with a further intern finishing the apprenticeship and other interns employed with Hammersmith and Fulham Council.

6. Our wellbeing with an EDI Focus

The Trust's initial response to covid-19 was informed by a steering group of 30 staff that represented both professional groups and our diversity networks. This representative group informed the design of the wellbeing interventions we put in place, provided feedback on further improvements and acted as outreach support to communicate the offers across the organisation.

The wellbeing response included physical, emotional and psychological, spiritual as well as vocational wellbeing interventions including but not limited to; accommodation support, groceries and food supplies, free parking, staff rest spaces, supportive resources including "before you go home" checklists, remote working guidance, a Filipino staff support champion network to support our Filipino staff community during the latest surge of the pandemic and a shielding staff network that included bi-weekly information briefings, a Christmas day social and emotional wellbeing groups.

Our emotional and psychological wellbeing response was led by the Trust's CONTACT counselling service who have provided a wide-ranging, holistic support offer throughout the pandemic. This included a bespoke psychological support offer for the Trust's critical care teams, expanded counselling service with online and telephone provision to support accessibility and client choice, and a delivery of psychological first aid and mental health awareness training. We were grateful to receive additional funding from Imperial Health Charity to support our wellbeing response.

We have also promoted the Keeping Well North West London (NWL) psychological support services and the national Our NHS People that includes the nationally curated wellbeing resources and mental health apps. The Trust is part of the NWL London ICS Keeping Well programme board.

7. Our accreditations

The Trust is a Disability Confident Committed (level 2) employer and we have committed to the following:

- Ensure our recruitment process is inclusive and accessible
- Communicate and promote vacancies
- Offer an interview to disabled people
- Anticipate and provide reasonable adjustments as required
- Support any existing employee who acquires a disability or long-term health conditions, enabling them to stay in work

- At least one activity that will make a difference for disabled people (Project SEARCH)

In 2021, the Trust will become professional members of Employers Network for Equality Inclusion, Stonewall and Business Disability Forum. We will use membership of these organisations to share good practice, upskill our network chairs and expand our understanding of EDI.

8. Commentary: Our Workforce Profile 20/21

The first appendix of this report provides data and analysis for the overall Trust workforce in the same standard format as previous years, reviewing age, ethnicity, disability and gender composition. This varies little from year to year. To note, on 1 April 2020 hotel services transferred approximately 1000 staff into the hospital, therefore this is the first year that these staff members appear in our workforce composition metrics. This new department has a large percentage of black, Asian and minority ethnic staff.

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

There has been no significant change in the workforce composition regarding ethnicity either. The Trust continues to have a higher percentage of staff employed from black, asian and minority ethnic backgrounds than the London population.

We know as a Trust that when we examine our ethnicity data in more detail that the majority of people in band 7 and above are from white backgrounds. The Trust has committed to a Workforce EDI Programme with a strong focus on race equality in order to improve the representation of black, asian and minority ethnic staff at band 7 and above.

The workforce profile section also reviews the Trust's ESR information for disability, sexual orientation and religion. This split of workforce profile data demonstrates that for 2020/2021 we have seen a very small 1% increase in the overall recorded data for all staff for all areas (sexual orientation, religion and disability).

We started to roll out a new applicant tracking system for recruitment in 2020, this was delayed due to covid-19 and then withdrawn later in the year, so we were not able to realise the benefits for improvements in our ESR recruitment data that we anticipated.

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

8.1 Commentary: Workforce Equality, Diversity and Inclusion Programme 21/22

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

This programme is to address inequity identified across the largest groups of protected characteristics that is - race, gender and disability equality as well as addressing inclusion across all protected characteristics.

- Objective 1: **(measurement for improvement)** To create a divisional and directorate-level diversity dashboard to guide areas for improvement
- Objective 2: **(people practices)** To re-design people management processes, practice and policy to create a fairer and more inclusive place to work
- Objective 3: **(engagement and empowerment)** To continue the growth and empowerment of our staff networks
- Objective 4: **(focussed improvement and culture change)** To deliver the WRES 2 focused improvement on improving the likelihood of 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.

The Workforce EDI Programme has been revised and updated in order to support the continued delivery of work for 2021/2022 across all protected characteristics (Appendix 2). Presenting and reviewing the programme alongside WRES, WDES and Gender Pay data allows us to ensure it is fit for purpose and the actions are relevant. The Trust under the governance of the EDI Committee will continue to review equality data separately for attendance on our leadership and development programmes and our employee relations cases to allow actions and interventions to be more agile and responsive.

In 2020 the NHS launched the People Plan that outlines actions for leaders across the NHS. It includes specific commitments around:

- **Looking after our people** – with quality health and wellbeing support for everyone
- **Belonging in the NHS** – with a particular focus on tackling the discrimination that some staff face
- **New ways of working and delivering care** – making effective use of the full range of our people's skills and experience
- **Growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return

Our Workforce EDI Programme addresses all of the equality, diversity and inclusion actions required in the People Plan. Including 1) recruitment and promotion practices 2) leadership diversity, 3) tackling the disciplinary gap, 4) staff governance, 5) information and education 6), accountability, 7) regulation and oversight, and 8) building confidence to speak up.

8.2 Commentary: Race Equality 20/21

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

The full analysis and data for the WRES Report is presented in Appendix 3. In summary for 2021, for the non- clinical workforce, the percentage of black, asian and minority ethnic Workforce increased in band 6, 8b, 8c and 9. Increase have also been seen in VSM compared to 19/20. The percentage decreased for band 2 –3, band 8d and spot salary.

For the clinical workforce the percentage of black, asian and minority ethnic workforce increase in band 5, 7, 8a, 8c and 8d. Doctors (career grade) and doctors (training grade) also show an increase compared to 19/20. The percentage of the black, Asian and minority ethnic workforce has decrease for band 2-4, band 6, 8b, 9 and consultants. Spot salary decreased by 2%.

The WRES data shows that the relative likelihood of white applicants being appointed from shortlisting compared to applicants from black, asian and minority ethnic groups is roughly 1.39 times greater. This is an decrease of 0.02 from last year when the relative likelihood was 1.43 times greater. In the last three reporting period this has shown a successive improvement in this metric. We will focus in 2021 on fully embedding diverse recruitment panels and we are introducing metrics to help monitor our improvements in this area.

Our disciplinary data (WRES 3) shows that in the year we disciplined 46 individuals, with 33 from a black, asian and minority ethnic background. The relative likelihood of black, asian and minority ethnic staff being disciplined compared to white staff is 2.69 this is an increase from last year when the relative likelihood for the former two year average indicator was 1.27.

We have introduced a number of changes to our disciplinary practices, and a dedicated senior employee relations specialist was appointed in March to conduct a full review of our practices, and help us to manage individual and team conflict more promptly and constructively. We have introduced external panel members for dismissals. We have taken on recommendations from an external review by a specialist race consultancy and our employee relations and investigation team received bespoke training on race. Ways of working in the central investigations team have been overhauled to encourage informal resolution to issues wherever possible. From September 2021, all allegations of bullying, harassment related to discrimination will be investigated centrally with a peer review system in place. Our immediate manager programme will focus on developing managers that are able and skilled to manage diverse teams and recognise bias earlier.

We recognise that there is significant work to be done which include the delivery of a new conflict management approach. The delivery of our race equity training programme for managers. The delivery of a number of toolkits to support understanding of microaggressions and race within the workplace. We recognise that

the impact of these programmes of work may not take effect until 2022. We also recognise that other work with our programmes will not commence until late 2021 and these interventions will then need to be implemented, embedded and monitored and evaluated for progress.

8.3 Commentary: Disability Equality 20/21

The reporting period of 20/21 is the third year of reporting on WDES for NHS organisations. Only 2% of our staff have declared a disability on ESR. We already know from our annual review of workforce composition data that recording for disability status on ESR is 78% (Table 1). However, we also know that the staff survey disability declaration data at 13%, is considerably higher than ESR.

We have a promotional campaign designed for 2021 to encourage updating of personal information onto ESR. In addition, the actions outlined in the Workforce EDI Programme will create a flexible work environment where disabled staff are treated equitably, supported and feel safe to disclose where needed.

We were pleased to see a continued improvement from 67.7% to 70.1% of staff who said that we had made adequate reasonable adjustments. Since the staff survey we have updated Supporting Staff with Disabilities Guidance, introduced an optional reasonable adjustment passport and new training for managers including a dedicated intranet and guidance from Access to Work.

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

- training for managers and individuals on accessibility e.g. MS teams
- implementation of our Business Disability Forum membership and relevant resources
- commission and a roll out of a Calibre Leadership Programme, for disabled staff, across five Integrated Care Systems in London.
- implementation of our ICT Strategy to provide assistive technology
- implementation of reasonable adjustments passports

The complete WDES Report is in Appendix 4.

8.4 Commentary: Gender Equality 20/21

In summary, for 2021, when considering ordinary pay, the mean hourly rate of male employees is 9.7% higher than that of female employees. When median calculations are used, the hourly rate of male employees' ordinary pay is 1.2% lower than that of female employees. There have been decreases in both mean (7.1% decrease) and median gender pay gaps (12.6% decrease), which are both the lowest figures recorded since the introduction of gender pay gap reporting.

For 2021, relevant bonus pay includes Clinical Excellence Awards (CEA) for consultants, long service awards and one-off incentive payments relating to the Trust's covid-19 response. Long service awards of £150, awarded to those who completed their twentieth year of service in 2019/2020, were issued in September 2020 and are

therefore included in this analysis. Long service awards for 2020/2021 will be paid in 2021/2022 and will be reported on in next year's gender pay gap report.

During covid-19, our substantive pay for Agenda for Change staff was impacted by a one-off incentive scheme, where we paid ICU surge rota enhancements for a period of 10 weeks. This incentive was paid to nursing staff over the period of 21 January 2021 to 31 March 2021. As this incentive was paid in arrears, the period reported on will be 21 January 2021 to 28 February 2021, with the remaining payments to be reported on in next year's gender pay gap report.

It is also noted that the CEA awards bonus data does not include any newly issued awards in 2020/2021, due to a pause in this process due to covid-19. The tripartite negotiating group (NHS Employers, the British Medical Association and HCSA) advised Trusts to equally distribute the year's Local CEA funds (and any remaining from previous years) among all eligible consultants. This was a one-off, non-consolidated payment in place of a normal Local CEA round and was not transacted into payroll until after March 2021.

Considering overall the Trust population, 4.2% of male employees received a bonus payment compared to 2.6% of female employees. Of the 464 employees who received a bonus, 61% were men and 39% were women.

When considering all types of bonus pay, there is a 33.3% mean gender pay gap and a 52.5% median gender pay gap between men and women. It is difficult to compare these figures to previous years' results, due not only to the halt in issuing new CEAs but also the inclusion of the covid-19 incentive, which has not appeared in any previous reports.

There is a 29.4% mean pay gap between male and female consultants' CEA pay and a 27.1% median pay gap. There has been a 0.3% decrease in the mean gender pay gap for bonus pay (CEA only), compared to previous year's data. There has been a 16.7% decrease in the median gender pay gap for bonus pay (CEA only), compared to previous year's data.

The complete Gender Pay Gap Report is in Appendix 5.

9. Equality Delivery System 2

We reported on our Equality Delivery System (EDS) in 2019/2020 and these were published on our external website in March 2020. The five EDS2 priorities agreed for the Trust for the period of 2020-2023 remain as:

- Ensuring that black, asian and minority ethnic patients who do not speak English are able to access appropriate support so that they have a clear understanding of their treatments and options
- Transitions from one service to another for people on care pathways, are made smoothly with everyone informed - protected characteristics being considered

- Patients and carers report positive experiences of the NHS, where they are listened to and respected and their privacy and dignity is prioritised
- Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
- When at work, staff are free from abuse, harassment, bullying and violence from any source.

10. Conclusion

We are committed to making positive progress in resolving inequalities within our workforce to ensure that our workforce is representative of the communities we serve at all levels. Creating an inclusive culture allows our workforce to speak up and bring their whole selves to work. The NHS Planning Guidance provides a clear focus on belonging in the NHS and addressing inequalities. Our plan for 2021/2022 is designed to continue with the improvement plans based on our WRES metrics, including improving diversity through recruitment and promotion practices.

London has one of the most diverse workforces and we have welcomed the development and implementation of London's Workforce Race Equality Strategy that outlines the challenges and complexity involved in addressing race equality. We will be working to address the 15 recommendations within our Workforce EDI Programme 2021/2022.

Model Employers outlines the ambitions set by NHS England and NHS Improvement and for each NHS organisation to set its own target for black, asian and minority ethnic representation across its leadership team and broader workforce by 2025. We continue to work towards this commitment and our EDI Work Porgramme is intended to help us accelerate towards this goal. We continue to produce annual, bi-annual and divisional clinical model employer goals data to help to develop local interventions and drive accelerated progress..

As part of our commitment to making significant progress and in the coming year we will be working to progress in the following areas:

- A continued focus on workforce race equality, this is a major priority for the Trust
- We will be rolling out our race training to 200 managers starting in October 2021. This training is designed to enhance the understanding of the issue of race and inclusive leadership to support personal change and action to support race equity. We will be evaluating this programme using a number of techniques including the Kirkpatrick Longitudinal Evaluation Tool Methodology.
- We will continue to review incidents of discrimination and abuse in our people processes relating to protected characteristics and develop responsive, innovative approaches to reduce incidents.
- We will continue to empower our five staff networks to ensure they remain a critical friend to the Trust.
- We will continue to work with our North West and Pan-London sector searching and learning from best practices and approaches to workforce inclusion.

Appendices

Appendix 1: Equality profile of our workforce 20/21

Below shows the percentage of staff employed by the Trust by age, disability, ethnicity and gender at 31 March 2021.

Workforce composition: Age

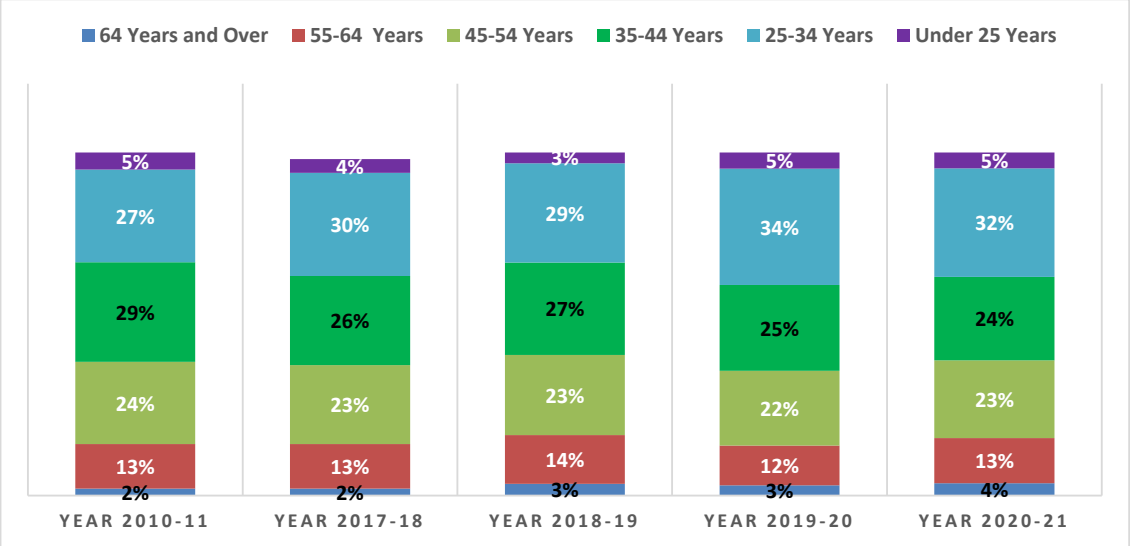
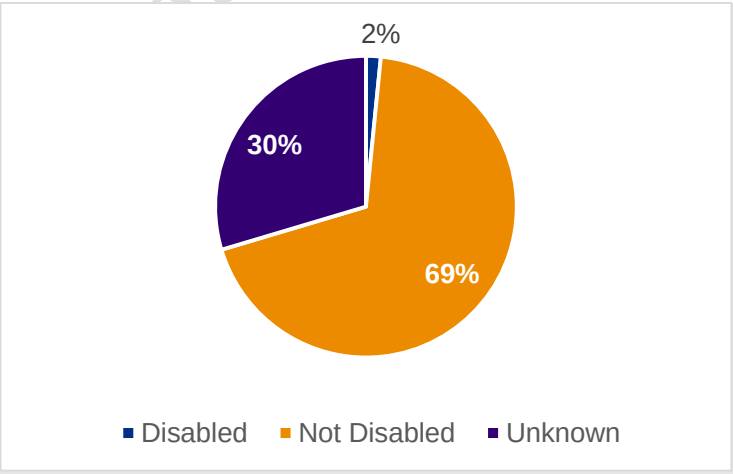


Diagram 1: Trust age composition over four years

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

Workforce composition: Disability

Diagram 2: Disability disclosure



Workforce composition: Disability, Sexual orientation and Religion

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

Protected Characteristic	Recorded demographic for all staff in 2016/17	Recorded demographic for all staff in 2017/18	Recorded demographic for all staff in 2018/19	Recorded demographic for all staff in 2019/20	Recorded demographic for all staff in 2020/21
Disability	62%	66%	68%	71%	73%
Sexual Orientation	67%	70%	70%	73%	74%
Religion	67%	70%	70%	73%	74%

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

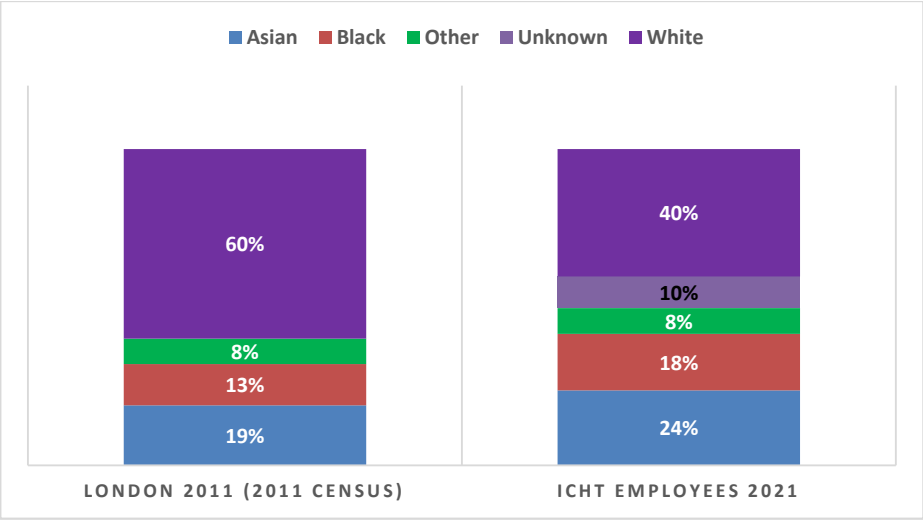
Table 2 below illustrates that the Trust has seen a decline in the information recorded for new staff in 2020/2021 for disability since last year, whilst sexual orientation and religion data collection remains consistent.

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

Protected Characteristic	Recorded demographic for NEW staff in 2016/17	Recorded demographic for NEW staff in 2017/18	Recorded demographic for NEW staff in 2018/19	Recorded demographic for NEW staff in 2019/20	Recorded demographic for NEW staff in 2020/21
Disability	87%	88%	82%	78%	78%
Sexual Orientation	88%	88%	82%	82%	76%
Religion	88%	88%	82%	82%	76%

Workforce composition: Ethnicity

The percentage of staff employed by the Trust from BAME backgrounds is higher than the local population. White people make up 40% of the workforce compared to 60% of the London population based on the census information taken in 2011. At the time of this report the census data for 2021 had not been released.



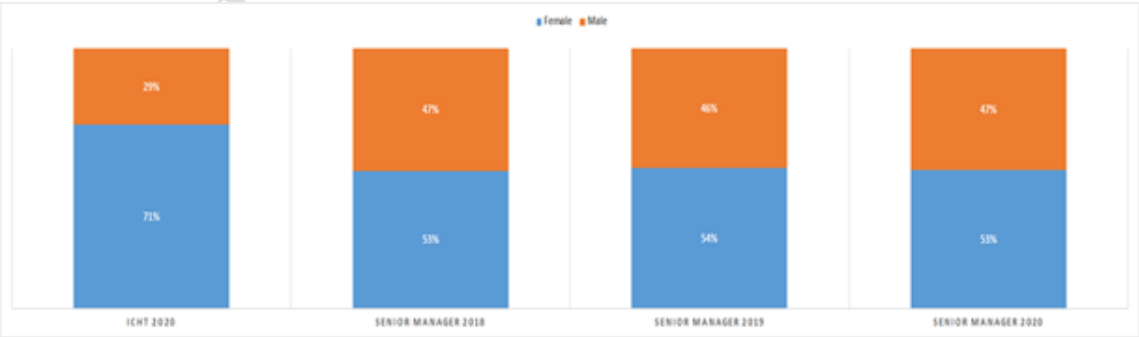
We know when we examine our ethnicity data in more detail the majority of people in roles Band 7 and above are from white backgrounds. Our Workforce EDI Programme has actions designed to address this imbalance.

Workforce Composition: Gender

The workforce split in regard to gender has remained unchanged in the last 6 years: 71% of our staff are female and 29% are male. The high proportion of female workers is typical of NHS organisations, reflecting the gender split of people entering healthcare professions.

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

Senior manager is defined as Agenda for Change, band 7 and above, excluding doctors.



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

Overview

The Workforce EDI Programme focuses on the delivery of six objectives. Objectives 4 and Objective 5 focusing directly on improvement in our WRES performance and Objective 6 focuses directly on improvement in our WDES performance.

Objectives	WRES	WDES	Gender
Objective 1: (**measurement for improvement**) To create a 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: (**focused improvement and culture 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			

Further Detail

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

Workstreams: jointly lead by Head of Workforce Equality, Diversity and Inclusion, & People Planning Lead, by March 2022

- Complete first ethnicity pay gap report (September 2021)
- Raise awareness and deliver action plan for medical WRES report
- Design, develop and implement different diversity dashboards for directorate, Trust level
- Improve the quality of our protected characteristics data in ESR
- Produce Model Employer goals and action plan (June 2021)

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

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

Workstreams: jointly lead by Head of Workforce Equality, Diversity and Inclusion, Divisional Director of People (Employee Relations) by March 2022

- Improve people practices – disciplinary process
- Implement new conflict strategy for employee relations
- Support recruitment into EDI development programmes (White Allies, Capital Nurses)
- Review diversity and decision making in Emergency Preparedness, Resilience and Response (Site Director, October 2021)
- Train wider organisation how to complete robust and effective equality impact assessments for major decision-making
- Development of a menopause and andropause guidance and supporting communications for staff
- Review and improve access to support returning mothers (breastfeeding, return to work)

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

The Trust has five employee networks. Our networks are essential to enhancing our culture of inclusivity and ensuring people feel able to bring their whole selves to work.

Workstreams: lead by Head of Workforce Equality, Diversity and Inclusion, by March 2022

- Continue to develop network leads and develop transparent network infrastructure
- Plan for promotion of pronouns on email
- Delivery of structured calendar of EDI communications to support change
- Implementation of LGBTQ+ action plan, self-assessment of rainbow badge scheme
- Develop Trust capacity to deliver the Stonewall Workplace Equality Index
- Develop resources to support staff understanding on LGBTQ+ inclusion for patients
- Set up and embed the professional memberships to share good practice and upskill our network chairs
- Work with the I-CAN Network to use Business Disability Forum self-assessment

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

Workstreams: lead by Deputy Director People and Organisational Development (Resourcing) and Divisional Director of People (EDI Lead) by March 2022

- Setting specific KPIs and targets link to recruitment
- Roll out inclusive panels (including training, monitoring and data reviews)
- Design and delivery race training to 200 managers
- Support recruitment into EDI development programmes (White Allies, Capital Nurses)
- Conduct a review of Band 9 recruitment practices
- Train wider organisation how to complete robust and effective equality impact assessments for major decision-making
- Introduce talent pools for under-represented groups

Objective 5: (**education and leadership**) To design a range of equality education tools and intervention for all staff.

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

Workstreams: lead by Head of Workforce Equality, Diversity and Inclusion, by March 2022

- Design and delivery race training to 200 managers
- Implicit association development and diagnostic assessors training
- Develop resources to support staff understanding on LGBTQ+ inclusion for patients
- Deliver executive/board development on equality, diversity and inclusion
- Co-design anti-racist statement
- Design range of toolkits to support EDI behavioural change
- Review and evaluate reverse mentoring pilot
- Implement robust and effective equality impact assessments for major decision-making

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

Workstreams: lead by Head of Equality, Diversity and Inclusion, by March 2022

- Training for managers and individuals on accessibility e.g. MS teams
- Implementation of our Business Disability Forum membership and relevant resources
- Commission and a roll out of a Calibre Leadership Programme, for disabled staff, across five Integrated Care Systems in London.
- Implementation of our ICT Strategy to provide assistive technology
- Implementation of reasonable adjustments passports & access to work guidance

Appendix 3: Workforce Race Equality Standard 20/21

Introduction

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

Why is WRES important?

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

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

The WRES indicators:

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

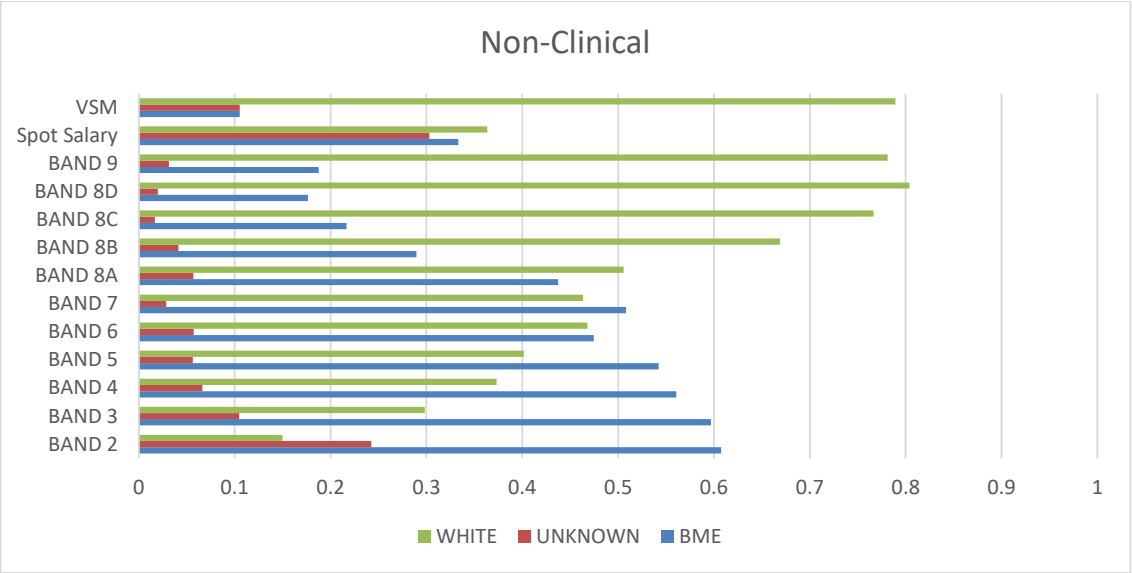
A small number of revisions were made to the WRES reporting requirements for 2021.

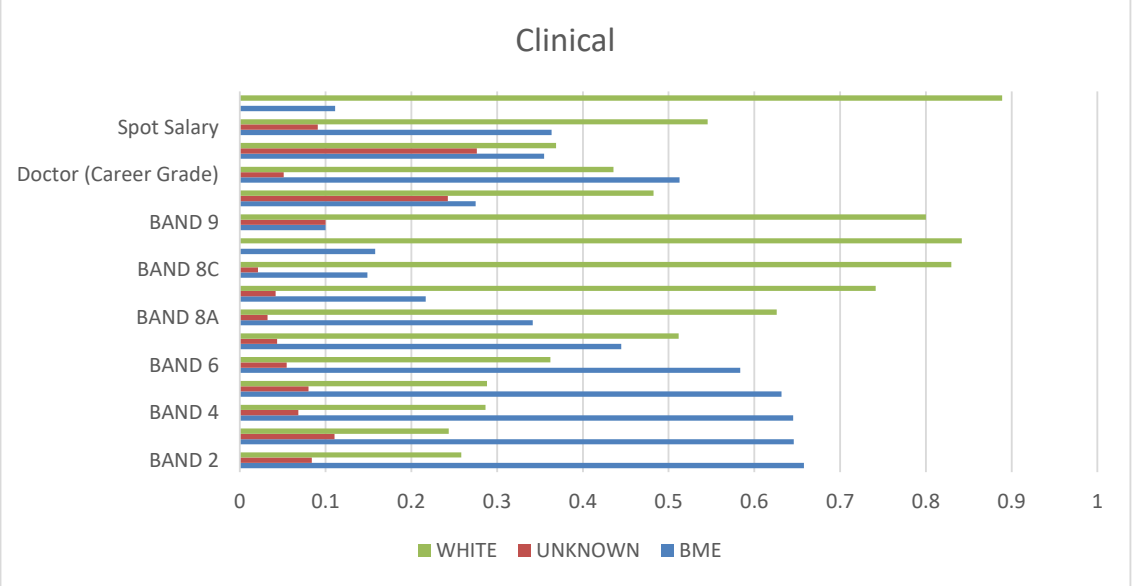
- WRES Indicator 1 now has a clearer definition of “senior medical manager” and “very senior manager”.
- WRES Indicator 2 and 3 have been simplified. The calculation has been changed from using a two-year rolling average to using the year end figure
- WRES Indicator 9 now requires submission of data that disaggregate: (i) the voting and non-voting members of boards, and (ii) the executive and non-executive members of boards. Trusts are encouraged to try and ensure that there are no board members with an unknown ethnicity.

Indicator 1

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

Graph 1 Ethnicity profile – percentage of staff in each of the AfC bands, medical grades and Very Senior Managers (VSM) – March 2021





For the non- clinical workforce, the percentage of Black Minority Ethnic Workforce increased in Band 6, 8b, 8c and 9. Increase have also been seen in VSM compared to 19/20. The percentage of the Black Minority Ethnic workforce has decreased for Band 2 –3, Band 8d and spot salary compared to 19/20.

For the clinical workforce the percentage of Black Minority Ethnic workforce increase in Band 5, 7, 8a, 8c and 8d. Doctors (career Grade) and Doctors (training grade) also show an increase compared to 19/20. The percentage of the Black Minority Ethnic workforce has decrease for Band 2-4, Band 6, 8b, 9 and Consultants. Spot salary decreased by 2% for Black Minority Ethic staff compared to 19/20.

Indicator 2

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

Descriptor	Number of shortlisted applicants	Number appointed	Likelihood of being appointed from shortlisting
White	3483	713	20.47%
Black, Minority Ethnic	5965	877	14.70%
Unknown	307	33	10.75%

The relative likelihood of white applicants being appointed from shortlisting compared to applicants from black, asian and minority ethnic groups is **1.39;** this is an decrease from last year when the relative likelihood was 1.41 times greater. We will continue to work to embed the actions outlined in Appendix 2.

Note: Data is drawn from a both Trac and the new recruitment system which we partially operated on during 2020/2021. The total headcount varies year to year, depending on when posts were advertised, when people applied and when the appointment was made.

Indicator 3

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

Note: This year this indicator has been changed from a a two year rolling average to the data at year end.

We report on the formal disciplinary hearings, excluding doctors who are managed in accordance with Maintaining High Professional Standards. In 20/21 the Trust held 46 disciplinary hearings.

Descriptor	Number of staff in workforce	Year end number of formal disciplinary meeting	Likelihood of entering formal disciplinary meetings
White	5341	9	0.17%
Black, Minority Ethnic	7280	33	0.45%
Unknown	1728	4	0.23%

The relative likelihood of black, asian and minority ethnic staff being disciplined compared to white staff is **2.69**; this is an increase from last year when the relative likelihood was 1.27. To note the indicator methodology has changed from a two year average to a year end for 2021.

Indicator 4

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

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

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

Descriptor	Number of staff in workforce	Staff accessing non mandatory training (data held by leadership team)	Likelihood of accessing non mandatory training
White	5341	465	8.70%
Black, Minority Ethnic	7280	515	7.07%
Unknown	1728	36	2.08%

Indicators 5-8

Indicators 5 -8 relate to the 2020/2021 national staff survey results, comparing the responses of Black Minority Ethnic and white staff.

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

Indicator 5

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

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

	White	Black, Minority Ethnic
2020	33.0%	27.9%
2019	35.5.%	31.8%

Indicator 6

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

For indicator 6 a lower score is better. There has been an increase for our Black Minority Ethnic staff experiencing harassment, bullying or abuse from staff since 2019. While there has been a decrease for our white staff. Our Black Minority Ethnic staff experience is worse than our white staff experience.

	White	Black, Minority Ethnic
2020	28.6%	30.1%
2019	29.6%	28.1%

Indicator 7

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

For indicator 7 a higher score is better. Both our white and Black Minority Ethnic staff experience has worsened since 2019. Our Black Minority Ethnic staff experience has decreased significantly since 2019, whereas white is a small decrease. Our Black Minority Ethnic staff experience is worse than our white staff experience.

	White	Black, Minority Ethnic
2020	81.9%	65.5%

2019	85.5%	70.8%

Indicator 8

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

For indicator 8 a lower score is better. Our white staff experience has got slightly worse since 2019 and our black, asian and minority ethnic staff experience has worsened considerably. Our black, asian and minority ethnic staff experience is slightly worse than our white staff experience.

	White	Black, Minority Ethnic
2020	9.5%	16.7%
2019	7.0%	9.0%

Indicator 9

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

	White	Black, Minority Ethnic	Unknown
Overall Trust Workforce	5341	7280	1728
Overall Trust Board Members	81.8%	18.2%	0.0%
Voting Board Members	75.0%	25.0%	0.0%
Executive Board Members	75.0%	25.0%	0.0.%
Non – Executive Board Members	85.7%	14.3%	0.0%

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

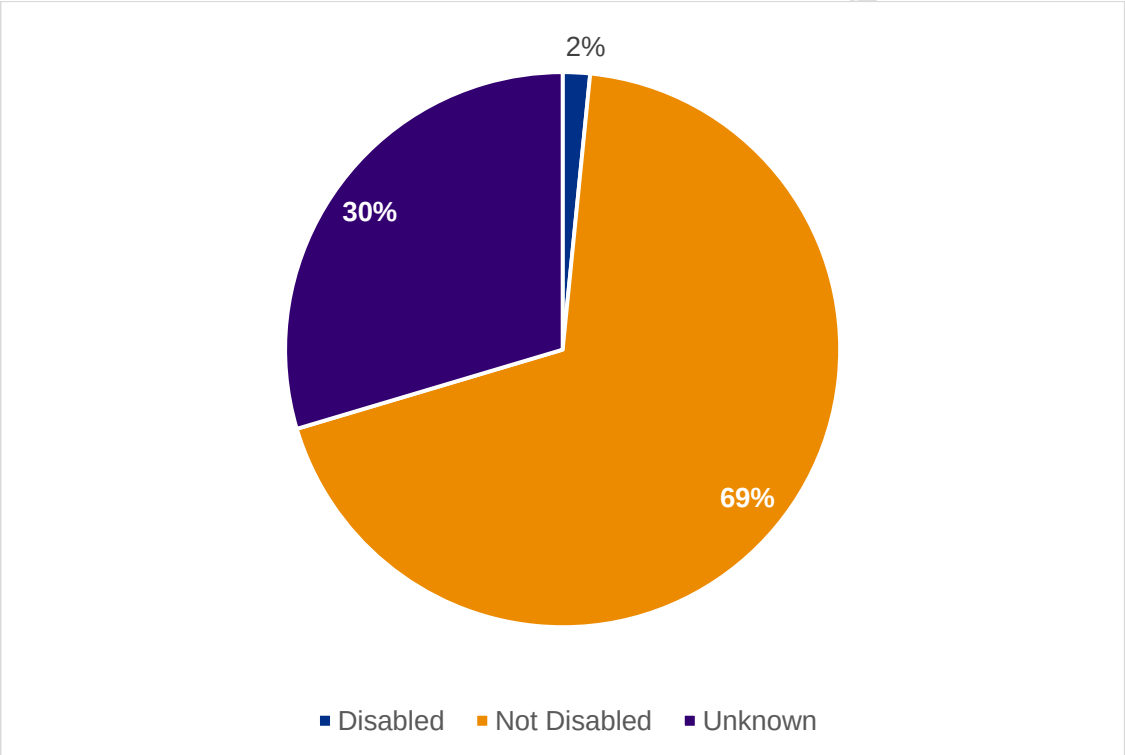
Appendix 4: Workforce Disability Equality Standard Report 20/21

1. Background

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

2. Organisational Breakdown by Disability

Below details the overall breakdown of employees who have and have not declared a disability, and where this is unknown, based on data from electronic staff record. This data excludes bank and locum staff, students on placement and staff employed by contractors. The data is correct as of 31 March 2021.



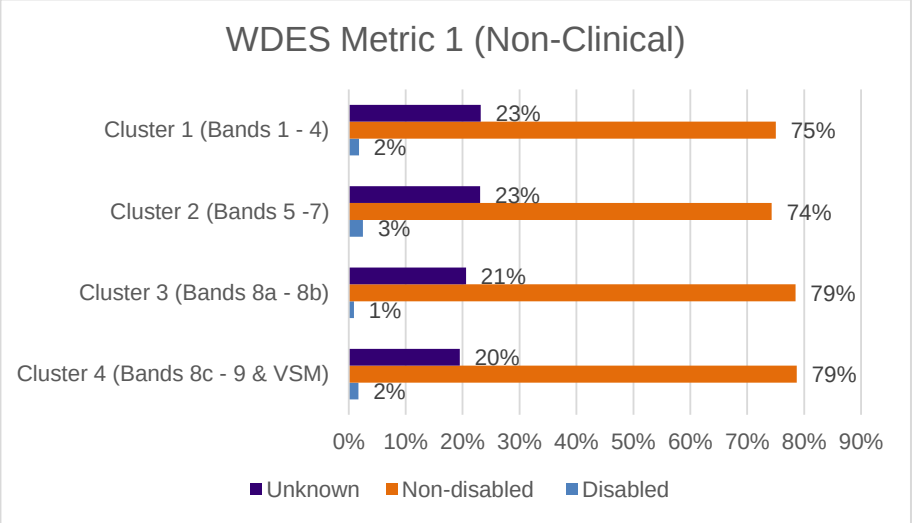
Out of 14,382 employees, 2% (228 people) have disclosed a disability and 69% (9896) are recorded not to have a disability. Out of the 31% (4258 people) where the disability status is unknown, 27% are coded as 'unspecified', less than 1% prefer not to answer and 2% are listed as 'not declared'.

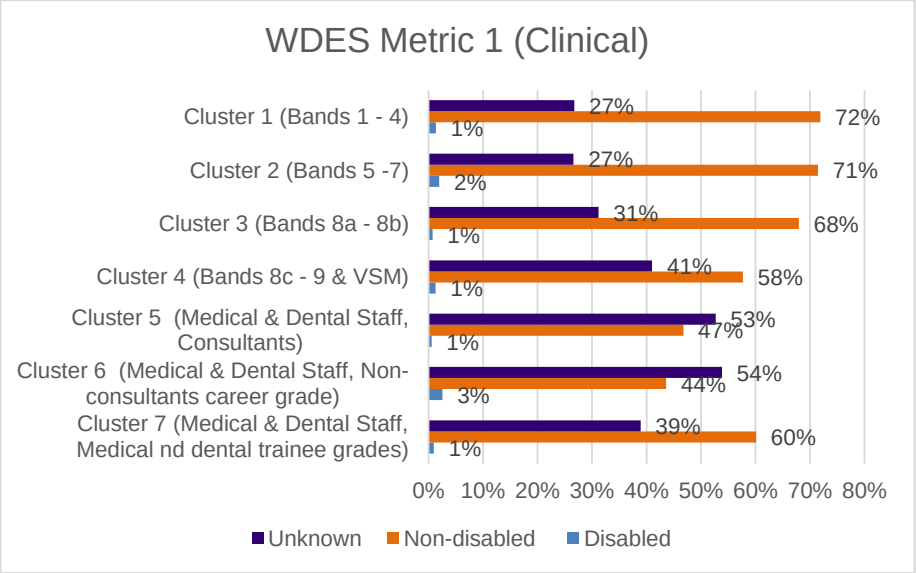
Compared to 2019/2020, the proportion of people reporting a disability has remains unchanged at 2**%** and the proportion of people reporting to have no disability has increased by 2%. The unknown group has reduced by 1%, and within the breakdown codes of the unknown group, Prefer Not To Answer has remained the same at 1**%,** Not

declared has increased by 2**%** from 5 to 7 percent, and unspecified has decreased by 2**%** from 94 to 92 percent**.**

3. WDES Metrics

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





While the proportion of disabled staff is low across all clusters, it is evident that with non-clinical roles there is a higher proportion of disabled staff in clusters 1 and 2, whereas in medical, the higher proportion of disabled staff are in clusters 2 and 6. This pattern slightly differs from the previous year where the higher proportion of disabled staff were in clusters 1 and 2 within both clinical and non-clinical areas.

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

Data from this metric is taken from two of our online recruiting systems. Candidates are given a yes or no option regarding whether they wish to declare a disability. This includes medical and non-medical staff. We run a guaranteed interview scheme for disabled candidates who meet essential criteria. The total headcount varies year to year, depending on when posts were advertised, when people applied and when the appointment was made.

The likelihood of applicants with no disability being appointed from shortlisting is 16% and the likelihood from those declaring a disability is 13%.

The relative likelihood of applicants with no disability being appointed from shortlisting compared to applicants with a declared disability is 1.25 times greater. This is a small increase from the previous year's figure of 1.12.

Descriptor	Number of shortlisted applicants	Number appointed	Likelihood of being appointed from shortlisting
Disability	398	51	0.13
No disability	9096	1456	0.16
Unknown	167	24	0.14

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

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

The relative likelihood of staff with a disability entering the formal capability procedure, compared to staff without a disability was zero.

It is important to note the very small amount of performance management cases that this metric is based on, as outlined below, which means the likelihood of any of the below groups entering the formal capability process is less than 0.00. There were no new performance cases for staff with a disability in 2020/21.

Descriptor	Number of staff in workforce	Annual average of number of formal performance meeting	Likelihood of entering formal performance meetings
Disability	228	0	0
No Disability	9896	12	0.001
Unknown	4258	0	0

Metrics 4 to 9: National Staff Survey Responses

Metrics 4 to 9 relate to the 2020/2021 national staff survey results, comparing the responses of disabled and non-disabled staff. This is based on a sample of 5370 staff who responded to the survey, which represents a 42% completion rate across the Trust.

Within the demographic section of the staff survey, respondents are asked if they have any physical, mental health conditions, disabilities or illness that have lasted or are expected to last for 12 months or more. There are only 'yes' or 'no' responses to this question. 5370 staff chose to answer this question, Out of these staff, 13% answered yes to having a disability.

However, the staff survey disability declaration percentage of 13% is considerably higher than electronic staff record, where 2% of staff are recorded to have a disability. This is a similar contrast to the last two years.

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

Metric 4

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

	Disabled respondents	Non-disabled respondents
2020	38.2%	29.3%
2019	39.5.%	33.0%

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

	Disabled respondents	Non-disabled respondents
2020	24.3%	14.0%
2019	21.1%	13.2%

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

	Disabled respondents	Non-disabled respondents
2020	33.8%	21.9%
2019	34.7%	22.5%

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

	Disabled respondents	Non-disabled respondents
2020	43.4%	42.8%
2019	47.8%	46.7%

Metric 5

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

	Disabled respondents	Non-disabled respondents
2020	64.3%	74.5%
2019	72.1%	78.8%

Metric 6

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

	Disabled respondents	Non-disabled respondents
2020	36.2%	28.1%
2019	33.0%	23.3%

Metric 7

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

	Disabled respondents	Non-disabled respondents
2020	38.7%	52.7%
2019	40.1%	51.9%

The below table summarises these metrics outlining the differences between disabled and non-disabled staff responses.

Summary of Metrics 4-7 by percentage of responses to staff survey questions 2020

Staff survey question	% of disabled respondents	% of non-disabled respondents	Difference
% of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months	38.2%	29.3%	8.9%
% of staff experiencing harassment, bullying or abuse from managers in the last 12 months	24.3%	14.0%	10.3%
% of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	33.8%	21.9%	11.9%
% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a	43.4%	42.8%	0.6%

colleague reported it in the last 12 months*			
% of staff believing that the Trust provides equal opportunities for career progression or promotion*	64.3%	74.5%	10.2%
% of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	36.2%	28.1%	8.1%
% of staff saying that they are satisfied with the extent to which their organisation values their work*	38.7%	52.7%	14.0%

Metric 8: Adequate Adjustments

This metric relates to the percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. This is only answered by those who have declared a disability within the staff survey. 404 of disabled staff who required workplace adjustments chose to answer this question. 70.1% of staff said employer has made adequate adjustments, compared to a national average of 75.6%. This is up from 2019, where 67.7% responded positively to this question.

Metric 9a: Engagement Score

The staff engagement score is calculated based on nine questions in the staff survey relating to motivation, ability to contribute to improvements and recommendation of the organisation as a place to work/receive treatment. The engagement score for disabled staff is 6.6 compared to 7.2 for staff who have not stated to have a disability. The engagement score for disabled staff is lower than the national average (6.7), while the engagement score for non-disabled staff is above the national average (7.1). Both engagement scores for staff who stated a disability and for staff that have not, have decreased by 0.1 each compared to last year.

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

The questions refers to action specifically related to disabled staff, rather than all staff engagement exercises. We answered yes due to:

- Supporting the ongoing development of our disability network.
- Re-designing our Equality Impact Assessment process to encourage engagement with disabled staff and disability considerations within decision-making.

- Stakeholders on our redevelopment projects for the sites, including foods and access

- Shielding feedback and support groups throughout the pandemic

Metric 10: Board Representation Metric

This metric looks at the percentage difference between the organisation's board voting membership and its organisation's overall workforce, disaggregated by voting membership of the board and by executive membership of the board. The below data is based on board membership as of 31 March 2021 and disability declaration data from the electronic staff record. No members of the board have declared a disability.

	Disabled	Not disabled	Unknown
Total Board members - % by Disability	0%	100%	0%
Voting Board Member - % by Disability	0%	100%	0%
Non-Voting Board Member - % by Disability	0%	100%	0%
Executive Board Member - % by Disability	0%	100%	0%
Non-Executive Board Member - % by Disability	0%	100%	0%
Overall workforce - % by Disability	2%	69%	30%
Difference (Total Board - Overall workforce)	-2%	31%	-30%
Difference (Voting membership - Overall Workforce)	-2%	31%	-30%
Difference (Executive membership - Overall Workforce)	-2%	31%	-30%

Appendix 5: Gender Pay Gap Report 20/21

Summary

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

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

There are a higher proportion of male employees in the upper pay quartile of the Trust compared to proportions of male employees in the lower quartiles, although the difference is most pronounced in the second and third quartile.

When considering ordinary pay, the mean hourly rate of male employees is 9.7% higher than that of female employees, which has decreased by 7.1% from last year's difference. When median calculations are used, the hourly rate of male employees' ordinary pay is 1.2% lower than that of female employees. There have been decreases in both mean and median gender pay gaps, which are both the lowest figures recorded since the introduction of gender pay gap reporting.

Considering overall the Trust population, 4.2% of male employees received a bonus payment compared to 2.6% of female employees. Relevant bonus pay relates to Clinical Excellence Awards (CEA) for Consultants, Long Service Awards, and a bonus payment paid to nurses for shifts worked on ICU for a ten week period.

There is a 29.4**%** mean pay gap between male and female consultants' CEA pay and a 27.1**%** median pay gap. There has been a 0.3% increase in the mean gender pay gap for bonus pay (CEA only), compared to previous year's data. There has been a 16.7% decrease in the median gender pay gap for bonus pay (CEA only), compared to previous year's data.

Gender Pay Action plan

Refer to Workforce, EDI Programme (Appendix 2).

Background

This report is published in line with gender pay gap reporting requirements for organisations with more than 250 staff. All calculations relate to the pay period in which the snapshot day falls, which is 31 March 2021. This report is in line with the Equality Act 2010 regulations. 15,092 employees were categorised as "relevant employees"[1] for the purposes of the gender pay calculations. Please see definitions at end for further details.

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

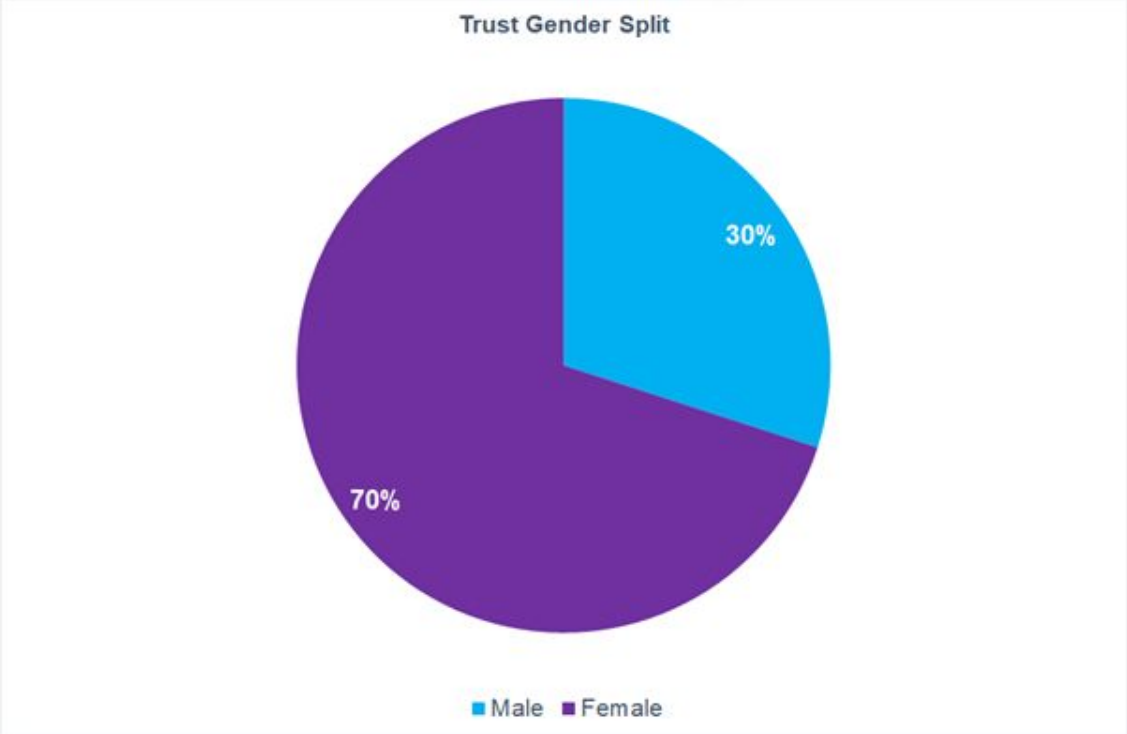
The mean pay gap is the difference between the pay of all male and all female employees when added up separately and divided respectively by the total number of males, and the total number of females in the workforce.

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

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

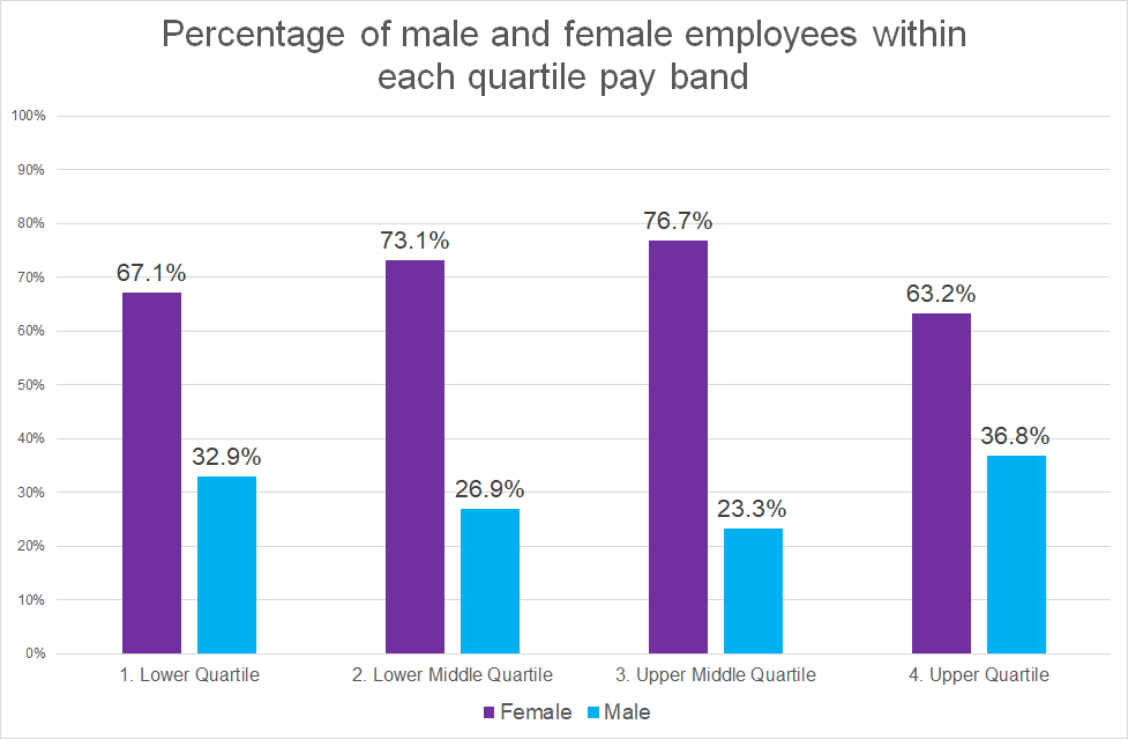
Trust Gender Mix

Overall, 70% (10,569) of Trust employees are female, while 30% (4,523) are male. These percentages relate to the 15,092 staff[2] included for the purposes of this calculation.



Quartile pay band gender representation

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



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

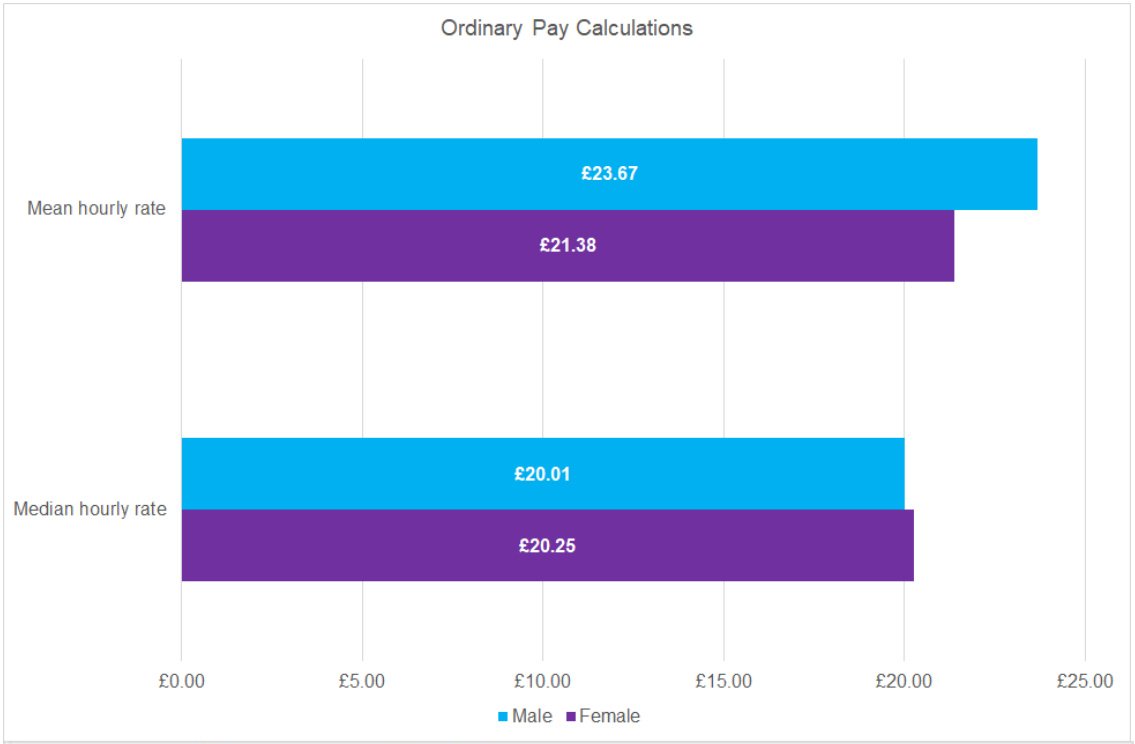
There has been a change to the proportions of male and female employees in each quartile, with the proportion of female employees decreasing in all but the highest-paid quartile:

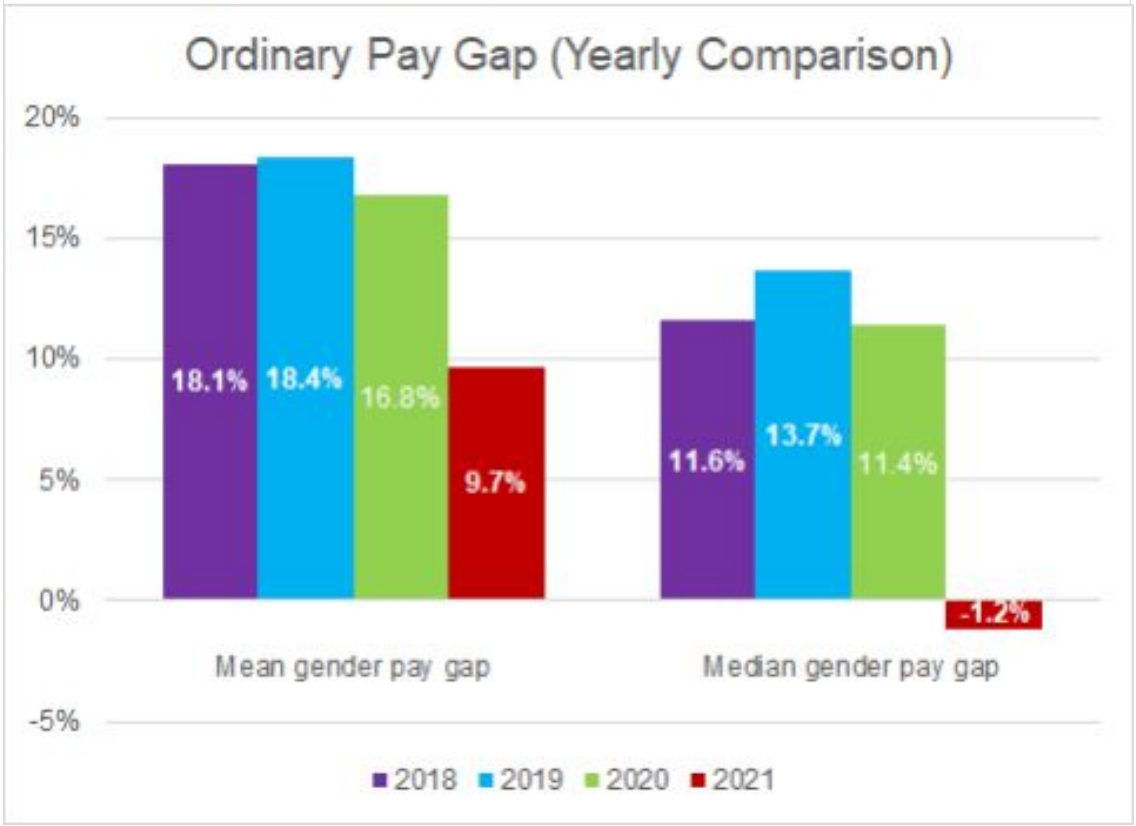
Quartile 1: The proportion of female employees has decreased by 6.5%
Quartile 2: The proportion of female employees has decreased by 4.1%
Quartile 3: The proportion of female employees has decreased by 0.5%
Quartile 4: The proportion of female employees has increased by 4.2%

Ordinary Pay

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

During the defined pay period that includes the snapshot date of 31 March 2021, the mean hourly rate of male employees was 9.7% higher than that of female employees and the median hourly rate of male employees was 1.2% lower than that of female employees. Both pay gaps have decreased since last year, and are the lowest figures reported by the Trust, compared to all previous years, as outlined below.





Bonus Pay

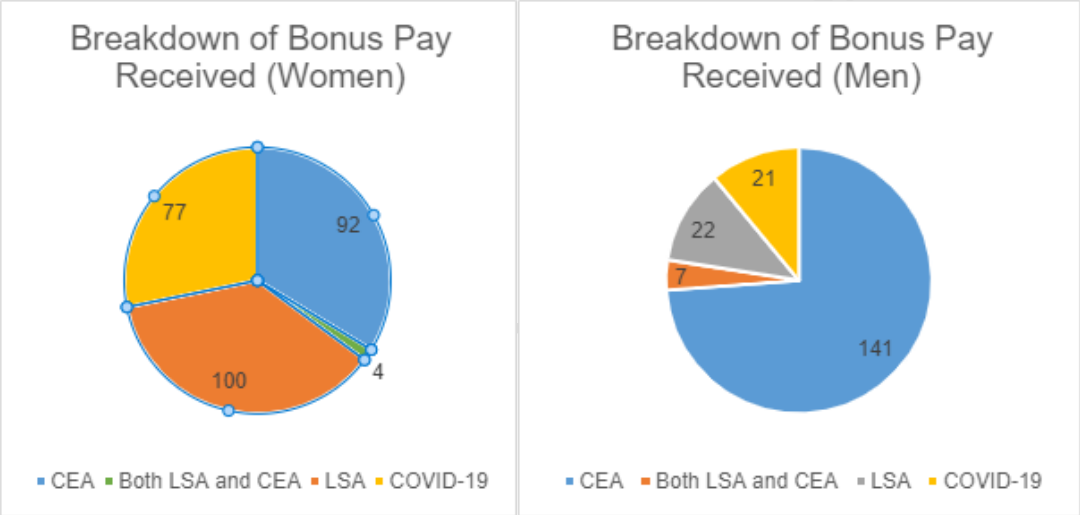
Clinical Excellence Awards (CEA), Long Service Awards (LSA) and an incentive payment for nursing staff working within ICU are identified as the relevant bonus payments made within the 12-month period ending on the snapshot date. The CEA awards bonus data does not include any newly issued awards in 2020/2021, due to a

pause in this process due to covid-19. The Long Service Awards included in this report were issued in September 2020 for the financial year 2019/20. The analysis also includes a bonus never previously included in the Gender Pay Gap report. This will impact on our data and comparative analysis drawn.

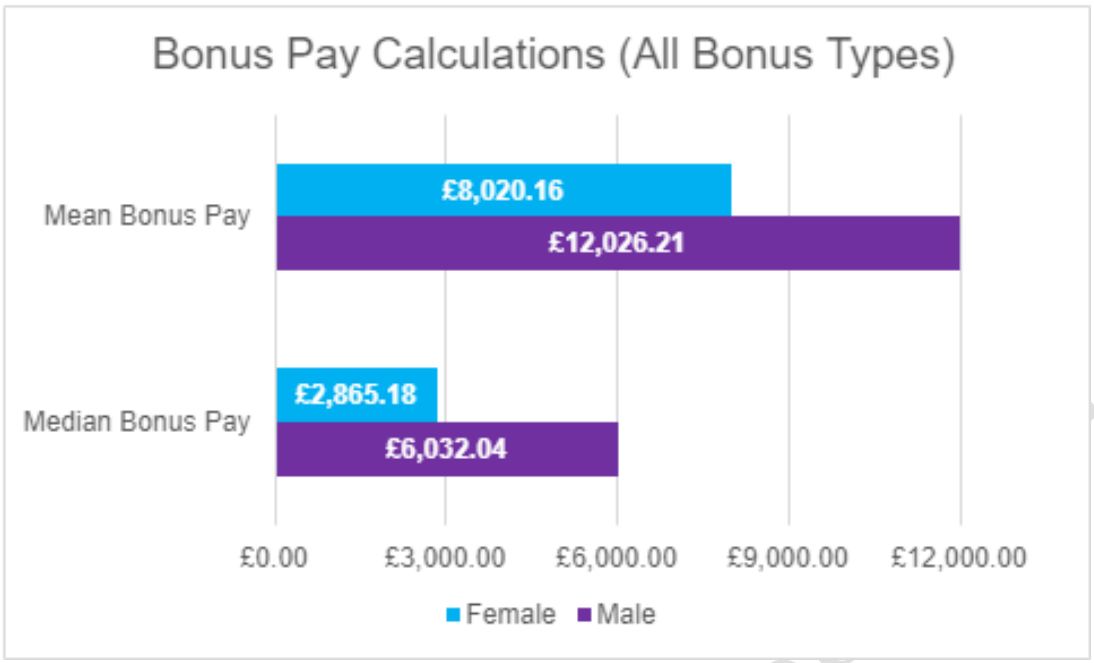
Overall calculations

When considering the overall Trust gender populations, 4.2% of male employees receive a bonus payment, while 2.6% of female employees do. Therefore**,** 1.6% more men receive bonus payments compared to women across the Trust. Only specific groups of employees are eligible for all three types of payments.

Overall, there were 273 male and 191 female employees who received a form of bonus pay for the relevant period. While no employee received both a Long Service Award and covid -19 incentive payment, 11 consultants received both a CEA and Long Service Award. For the purposes of the overall bonus calculations, both types of bonus payment made to these individuals were combined, so the individuals were not counted twice; multiple payments of covid-19 incentive payments were combined. The charts below detail the breakdown of the types of bonus pay received for each gender.



When considering all bonus pay data together, the figure below indicates that men receive significantly more bonus pay than women. It should be considered that the LSA is a flat rate of £150 and the average covid -19 incentive payment was £861.65, and it was women who received the majority of these payments. Men received the majority of CEAs (59.5%), of which the average value was £18,519.67. However, it should also be considered that the value of the CEA is an annual value, and the covid -19 incentive payment was given over a period of weeks, which makes a direct comparison difficult.



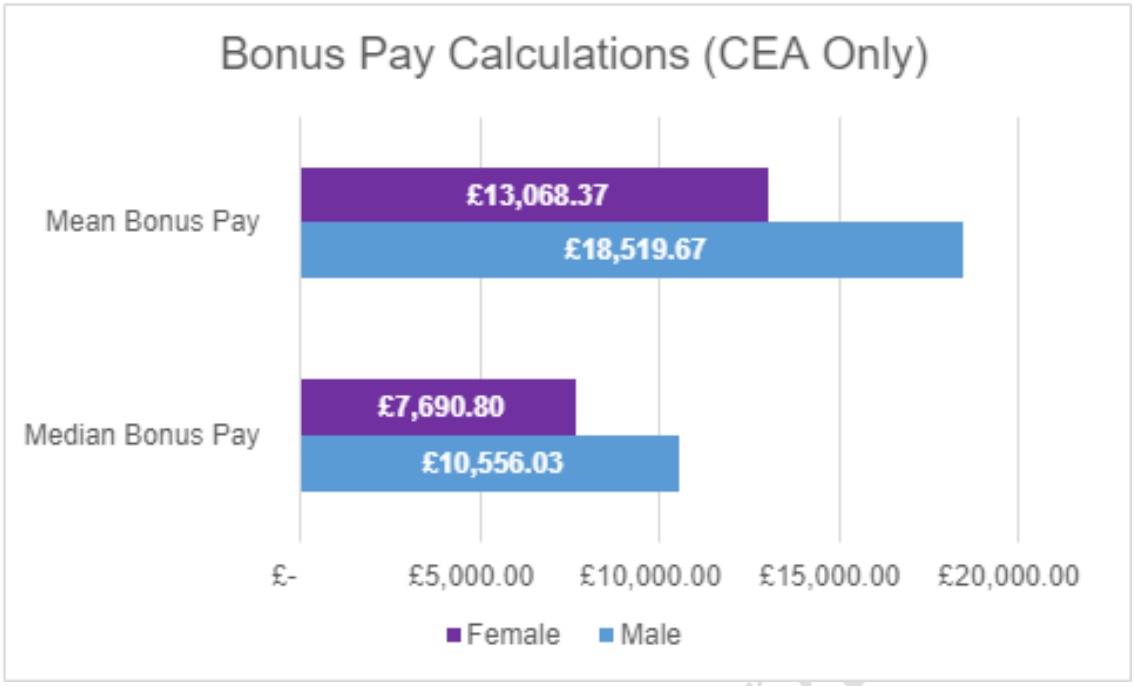
Clinical Excellence Awards (CEAs)

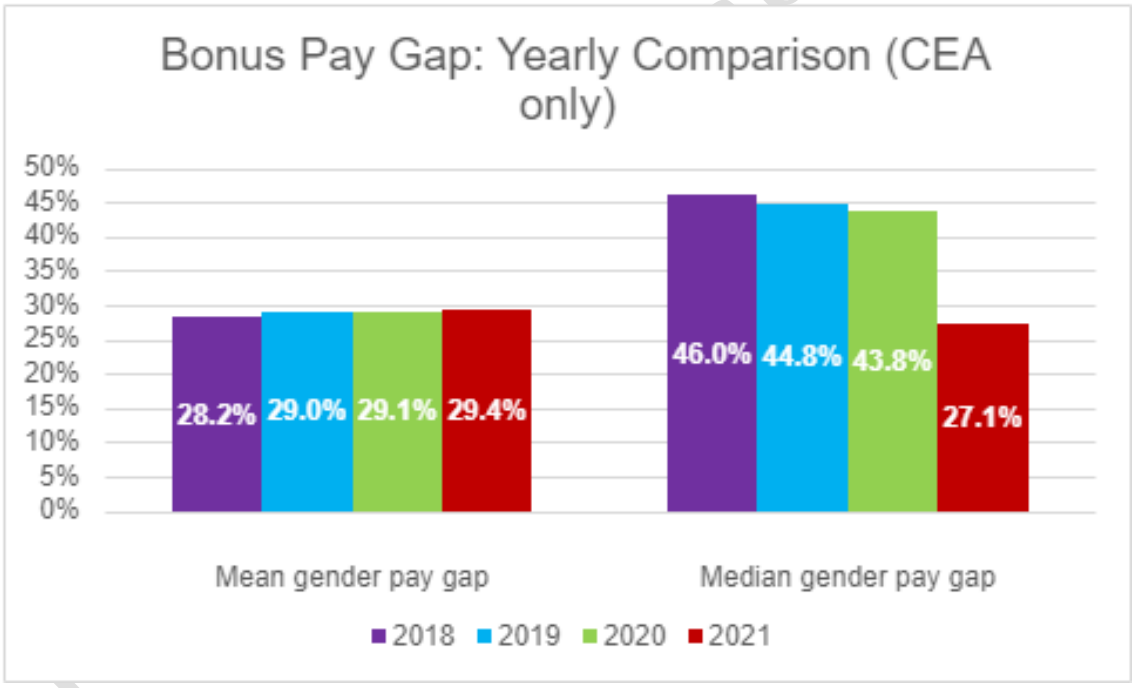
The CEA scheme is intended to recognise and reward those Consultants who contribute most towards the delivery of safe and high-quality care to patients and to the continuous improvement of NHS services. Eligible consultants are those in substantive posts with more than one year's Trust service at the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

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

The diagram below demonstrates that there is a 29.4% mean pay gap between male and female consultants' CEA pay. When looking at the median difference, the difference is lower yet still substantial, with male consultants receiving 27.1% more bonus pay than female consultants.

The below yearly comparison demonstrates a largely similar picture to the previous year relating to the mean bonus pay, and a significant decrease relating to the median bonus pay.





Long Service Awards

LSAs are awarded to staff who have completed 20 years' of service at the Trust. Recipients are awarded a monetary voucher of the value of £150.00. Therefore, there is no difference in the mean or median values of this type of bonus payment awarded to male and female employees.

Out of the 134 recipients of a LSA, 22% were male and 78% recipients were female, which is largely representative of the overall organisational gender mix.

Covid -19 Incentive Payment

From 21 January 2021 to 31 March 2021, people carrying out registered nurse duties at night were offered an incentive payment of £13.60 an hour, to be added to their contractual pay for the shift.

98 individuals received this payment in 2020/21; 79% were women and 21% were men. While the overall average payment was £861.65, women received an average payment of £855.82 and men received a slightly higher average payment of £883.03.

Definitions

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

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

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

Bonus pay: 'Bonus pay' is defined as any remuneration that is in the form of money, vouchers, securities or options and relates to profit sharing, productivity, performance, incentive or commission. For the purposes of this report, the relevant bonus pay relates to Consultant Clinical Excellence Awards (CEA) and Long Service awards, in line with guidance from NHS Employers.

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

Appendix 6: Glossary of Terms

Protected characteristic	The Equality Act 2010 introduced the term 'protected characteristics' to refer to groups that are protected under the Act. The Act refers to 9 protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex (gender) and sexual orientation.
Black, Asian and Minority Ethnic (BAME)	Term currently used to describe a range of minority ethnic communities and groups in the UK – can be used to mean the main Black, Asian and Mixed racial minority communities (also referred to as BME) or it can be used to include all minority communities, including white minority communities. The term ethnic minorities is also used interchangeably with this acronym.
Disability	The Equality Act 2010 define disability as a mental or physical impairment that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.
Discrimination	Unfair treatment based on prejudice. In health and social care, discrimination may relate to a conscious decision to treat a person or group differently and to deny them access to relevant treatment or care.
Diversity	Valuing and celebrating difference and recognising that everyone through their unique mixture of skills, experience and talent has their own valuable contribution to make.
EDS2	Equality Delivery System 2 is a mandatory assessment tool that requires NHS Trusts to analyse and grade their equality performance across 18 outcomes.
Equality	Equality is about making sure people are treated fairly and given fair chances. Equality is not about treating everyone in the same way, but it recognises that their needs are met in different ways. Equality can be defined 'as the state of being equal, especially in status, rights, or opportunities.'
Ethnicity	A sense of cultural and historical identity based on belonging by birth to a distinctive cultural group.
Gender	This describes characteristics such as appearance, presentation and behaviour to identify gender (not sex). Characteristics could be masculine, feminine or androgynous.
Gender reassignment	Gender reassignment refers to individuals who either have undergone, intend to undergo or are currently undergoing

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

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

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Mid-Year Review on Safe, Sustainable and Productive Nursing and Midwifery Staffing

Agenda item 17 and paper number 14

Lead Executive Director: Janice Sigsworth, Director of Nursing
Authors: Jenny Ekstrom, Lead Nurse Safe Staffing, Professional Regulation and Revalidation; Andrew Worthington, Deputy Chief Nurse

Purpose: For approval

Meeting date: 15 September 2021

Executive summary

1. Purpose

1.1. The paper provides a summary of the mid-year nursing & midwifery establishment review (Part A), and Part B summarises progress against initiatives which support safe staffing, address nursing and midwifery shortages and ensure a sustainable workforce. The report has been discussed and accepted by the People Committee and presented to Trust Board for approval.

2. Introduction and background

2.1. In accordance with Developing Workforce Standards (NHSEI, 2018), the Trust undertakes nursing and midwifery establishment reviews twice a year: a thorough full year review which forms the basis for any permanent changes in establishment and/or skill mix, and a mid-year desktop review to provide assurance that ward staffing remains safe and is utilised as planned.

2.2. 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 provides an update on our staffing position and progress against workforce plans which support the delivery of safe, effective, and sustainable nursing and midwifery care.

3. Key findings

3.1 The mid-year nursing and midwifery establishment highlighted a small decrease of 6.7 WTE in the nursing and midwifery workforce when compared with the annual establishment review. This is caused by a reduction in activity in private healthcare and is not anticipated to be a permanent change to their establishment in the future.

3.2 The Trust is 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.

4. Recommendations

4.1. The Board is asked to approve the mid-year establishment findings and note the ongoing work of the Trust to deliver safe, effective, and sustainable nursing and midwifery care.

5. Impact assessment

5.1 Quality impact: No impact. This work supports the safe domain and demonstrates compliance with national guidance.
5.2 Financial impact: There is no financial impact.
5.3 Workforce impact: there is no impact on workforce associated with this paper.
5.4 Equality impact: There is no impact associated with this paper.
5.5 Risk impact: There are no risks associated with this paper.

Main paper

PART A: MID-YEAR NURSING AND MIDWIFERY ESTABLISHMENT REVIEW

6. Process

In accordance with Developing Workforce Standards (NHSEI, 2018), the Trust uses evidence-based tools such as the Safer Nursing Care Tool (SNCT) and Birth Rate Plus, to accurately match patient acuity and dependency in nursing and midwifery ratios. In conjunction with professional judgement and quality indicators, this enables a systematic and triangulated approach to informing safe establishment requirements. The SNCT has been implemented across our adult and children inpatient ward areas.

Nursing and midwifery staffing levels and skill mix are reviewed daily at site/capacity meetings and retrospectively reviewed monthly by the Executive Director of Nursing, who also chairs the established safe staffing group. An escalation process remains in place if staffing levels fall below the level required to maintain safe patient care, as set out in the Trust policy for the provision of safe nurse staffing and skill mix establishments.

7. Red Flag Reporting

We are required to ensure a clear and structured escalation process to raise red flags relating to staffing shortages. The current E-rostering system enables a simple and transparent process to raise red flags, with evidence of actions taken to support optimal staffing and effective real time deployment. This process has recently been piloted in the division of medicine and Integrated care and is supported by a standard operating procedure. We will continue to embed this process and monitor red flag reporting through the safe staffing steering group.

8. Mid-Year Establishment Review

Mid-year establishment reviews were led by the Executive Director of Nursing with each Divisional Director of Nursing and the Lead Nurse for Safe Staffing, Professional Regulation and Revalidation. All clinical areas have been included. Each division reviewed.

- Roster templates
- ESR data
- Allocated budgets
- Workforce metrics i.e., sickness, vacancy, turnover, study leave
- Bank and agency spend
- Quality indicators
- Geographical layout and specifics of the area

To be fully compliant with national guidelines, acuity and dependency data collection using the SNCT, should be collected twice a year. This usually takes place in February and June, in-line with the business planning cycle, however timescales have been revised due to demands of the pandemic. The 2021 SNCT data collection was delayed and commenced in September. This will form the basis of the full annual establishment review during autumn.

9. Mid-Year Establishment Review Findings

Overall, there has been a small decrease of 6.7 WTE reported in the nursing and midwifery establishment when compared with the data from the annual establishment review carried out in autumn 2020. This is solely contributed to a reduction in activity in private healthcare due to the pandemic and is not a permanent change in the establishment in that area.
A summary of each division is outlined below with a break down at ward level in appendix 1.

9.1. Division of Women's, Children's, and Clinical Support Services

There has been no change in WTE when compared to the establishment data reported for September 2020. As services are beginning to return to pre-surge activity, the division's establishment reviews are in progress. A review of midwifery staffing will include a comprehensive Birth Rate Plus assessment and implementation of recommendations made in the 'Ockenden Report' (DHSC, 2020).

TABLE 1: DIVISION OF WOMEN, CHILDREN, AND CLINICAL SUPPORT						
Establishment in September 2020 (WTE)	Establishment in March 2021 (WTE)	Change to establishment (WTE)	Registered nurse and unregistered care staff breakdown (WTE)		Registered nurse to unregistered care staff ratio	
			RN	CS	RN	CS
911.78	911.78	0.00	719.30	192.48	79%	21%

9.2. Division of Surgery, Cancer and Cardiovascular Sciences

Overall, there has been a reported **increase** of **0.62** WTE when compared to the establishment data reported for September 2020. This comprises of -3.77 WTE registered nurses and 4.39 WTE care staff.

TABLE 2: DIVISION OF SURGERY, CANCER AND CARIOVASCULAR SERVICES						
Establishment in September 2020 (WTE)	Establishment in March 2021 (WTE)	Change to establishment (WTE)	Registered nurse and unregistered care staff breakdown (WTE)		Registered nurse to unregistered care staff ratio	
			RN	CS	RN	CS
1545.95	1546.57	0.62	1265.01	281.56	82%	18%

Key Reasons for Change:

- Accommodation of Nursing Associate roles and change to skill mix.
- Additional senior critical care nursing post.

This excludes any temporary staffing agreed as part of surge resilience planning. Critical care is subject to ongoing review against the need for increased surge capacity.

9.3 Division of Medicine and Integrated Care

Overall, there has been a decrease in 0.10 WTE when compared to the establishment data reported for September 2020.

TABLE 3: DIVISION OF MEDICINE AND INTEGRATED CARE						
Establishment in September 2020 (WTE)	Establishment in March 2021 (WTE)	Change to establishment (WTE)	Registered nurse and unregistered care staff breakdown (WTE)		Registered nurse to unregistered care staff ratio	
			RN	CS	RN	CS
1721.43	1721.33	-0.10	1267.37	453.96	74%	26%

Key Reasons for Change:

- Change to skill mix

In addition to the substantive establishment, there are currently several temporarily funded posts, specifically in the emergency departments and endoscopy services, which are subject to review in line with the planned review of services.

9.4 Imperial Private Healthcare

Overall, there has been a reported **decrease of 7.22 WTE** when compared to the establishment data reported for September 2020. This comprises of 3.22 WTE registered nurses and 4.00 WTE unregistered care staff.

TABLE 4: IMPERIAL PRIVATE HEALTHCARE						
Establishment in September 2020 (WTE)	Establishment in March 2021 (WTE)	Change to establishment (WTE)	Registered nurse and unregistered care staff breakdown (WTE)		Registered nurse to unregistered care staff ratio	
			RN	CS	RN	CS
199.50	192.28	-7.22	153.15	39.13	80%	20%

Key Reasons for Change:

- Reduced service activity due to the Covid-19 pandemic.

10. Financial Impact

All substantive increases to nursing and midwifery establishment are funded within agreed business planning or business cases.

11. Next steps

11.1. Acuity and Dependency Data Collection

Collection of acuity and dependency data by designated staff, using the Safer Nursing Care Tool (SNCT), commenced in all adult and paediatric in-patient wards on 1st September 2021. In line with national safe staffing guidance and our SNCT Standard Operating Procedure, this will involve daily scoring of acuity and dependency for patients over a minimum of 20 days (Monday to Fridays), and weekly validation by a senior nurse.

We are rapidly progressing work to develop the ability to automatically generate acuity and dependency data directly from the electronic patient record. We will test the accuracy of automated data with the manual recorded and validated SNCT data during the September data collection period. If successful, we will have the ability to access live acuity and dependency data and reduce the need for labour-intense data collection in the future. This development will also enable an agile approach to ward establishment reviews.

11.2. Red Flag Reporting

Following piloting of our e-rostering system as a mechanism for raising staffing related red flags; further analysis of findings by site, department, staffing grade and comparison with datex reporting will take place, prior to being launched across the Trust. Use of e-rostering for this purpose will make it easier for front line staff to raise and act on safe staffing concerns in real-time, and forms part of a systematic and structured escalation process.

PART B: KEY NURSING AND MIDWIFERY WORKFORCE INITIATIVES

12. National and Local Context

The committee will be aware of the local and national shortages and challenges within the nursing and midwifery workforce, and there will be further discussions of the actions we are taking across the Trust to address this.
Our overall vacancy rate for nursing and midwifery staff has increased from 12.2% to 13.5%. The highest number of vacancies is amongst band 5 staff nurses, which equates to 376 WTE (19.5%) out of a planned establishment of 1,930 WTE band 5 nurses.

In view of our increasing nursing vacancies, we are focussing on our nursing and midwifery recruitment and retention plans, as part of a sustainable staffing priority programme and 90-day recovery plan.

Progress against existing schemes is outlined below.

13. International Recruitment

This year, 98 Internationally Educated Nurses (IENs) have been recruited by the Trust, primarily from the Philippines and India. We have received a total of £1,563,050 from NHSE/I to support increased recruitment of IENs and aim to recruit an additional 170 by March 2022. ICHT is leading a Health Care Support Workers (HCSW) campaign across the NWL ICS, to

identify and support individuals with overseas nursing qualifications to achieve nurse registration in the UK. So far, 206 individuals have been identified across the ICS.

14. New Roles - Nursing Associates

Nursing Associates are a registered role, educated to diploma level and regulated by the Nursing and Midwifery Council (NMC). 21 qualified Nursing Associates are currently employed within the Trust and a further 19 are undertaking the apprenticeship trainee programme. A target of 100 trainee Nursing Associates per year from 2021/22 (80 UCAS entry and 20 apprenticeships) has been agreed, and we are working with four university partners to achieve this.

15. Registered Nurse Degree Apprenticeships (RNDA)

The Trust is currently training 44 RNDAs, who will qualify as registered nurses in the next three years. The aim is to continue to recruit 30 registered nurses annually through this route. Apprentice numbers are small in the context of overall trainee nursing and midwifery numbers, and we will continue to focus on ways to improve the number of apprenticeships in the organisation.

16. Automatic Offer

Student nurses and midwives who undertake their clinical placements with the Trust are provided with an automatic offer of employment when they complete their studies, which has proved to be a successful approach. As a result, we have increased our automatic offer uptake target from 80% to 90%.

17. Placement Capacity Expansion

Following a Health Education England (HEE) award of £50,000 to support clinical placement expansion, we have developed a comprehensive programme aimed at doubling placement capacity, numbers of nursing students and trainee Nursing Associates over the next four years.

18. Personalised Training Budgets

Confirmation of 2021/22 personalised training budget allocations has been received from HEE, from their three-year plan. This replaces the previous Continuing Professional Development (CPD) system and provides each nurse, midwife, and allied health professional with access to £1000 over a three-year period, to support their professional development. A system is in place for individuals to apply for and access their budget, and a range of in-house training is being developed.

Workforce Development Funding for 2021/22 has been allocated to individual Trusts but will be managed at an ICS level. We are currently awaiting confirmation of key priorities for this funding.

19. Retention

We are continuing to focus on the retention of our staff and a significant amount of work has been carried out before and during the pandemic which has focussed on improving wellbeing. We are relaunching the Pathway to Excellence programme, which aims to create a positive practice environment for nurses and midwives and supports retention.

Appendix 1**:** Breakdown of staffing establishments by division (See section 8).

Jenny Ekstrom, Lead Nurse for Safe Staffing, Professional Regulation and Revalidation
Andrew Worthington, Deputy Chief Nurse, Strategy and Regulation.
7th September 2021

Appendix 1 - Mid year establishment review by division

Clincial Division	Total registered nurse and unregistered care staff WTE September 2020	Total registered nurse and unregistered care staff WTE March 2021	WTE Change to establishment September 2020 to March 2021	September 2020 Registered nurse and unregistered care staff breakdown WTE		March 2021 Registered nurse to unregistered care staff ratio	
				RN	CS	RN	CS
Women's children's and clincial support	912	912	0.00	79%	21%	79%	21%
Surgery, Cancer and Cardiovascular sciences	1,546	1,547	0.62	82%	18%	82%	18%
Medicine and Integrated care	1,721	1,721	-0.10	74%	26%	74%	26%
Imperial Private Healthcare	200	192	-7.22	78%	22%	80%	20%
GRAND TOTAL	4,379	4,372	-6.70	78%	22%	79%	21%

DIVISION OF MEDICINE AND INTEGRATED CARE- ESTABLISHMENT DATA SEPTEMBER 2020							DIVISION OF MEDICINE AND INTEGRATED CARE- ESTABLISHMENT DATA MARCH 2021							Differences September 2020 to March 2021				
Clinical area	Number of beds	Total registered nurse and unregistered care staff WTE	Registered nurse and unregistered care staff breakdown WTE		Registered nurse to unregistered care staff ratio		Clinical area	Number of beds	Total registered nurse and unregistered care staff WTE	Registered nurse and unregistered care staff breakdown WTE		Registered nurse to unregistered care staff ratio		Difference in overall Totals (WTE)	Difference (WTE) Staff Type and Banding		Difference in ratio	
			RN	CS	RN	CS				RN	CS	RN	CS		RN	CS	RN	CS
OVERALL TOTAL		1721.43	1268.47	452.96	74%	26%	OVERALL TOTAL		1721.33	1267.37	453.96	74%	26%	-0.10	-1.10	1.00	0.00	0.00
Cxh Acute &		321.34	215.32	106.02	67%	33%	Cxh Acute &		321.34	215.32	106.02	67%	33%	0.00	0.00	0.00	0.00	0.00
21000 - Lady Skinner Ward	15	21.21	13.75	7.46	65%	35%	21000 - Lady Skinner Ward	15	21.21	13.75	7.46	65%	35%	0.00	0.00	0.00	0.00	0.00
band 2		7.46					band 2		7.46					0.00				
band 5		10.79					band 5		10.79					0.00				
band 6		1.96					band 6		1.96					0.00				
band 7		1.00					band 7		1.00					0.00				
ACASU - Acute Assessment Unit	24	42.29	29.36	12.93	69%	31%	ACASU - Acute Assessment Unit	24	42.29	29.36	12.93	69%	31%	0.00	0.00	0.00	0.00	0.00
band 2		12.93					band 2		12.93					0.00				
band 4		0.00		includes 1 x TNA			band 4		0.00					0.00				
band 5		20.61					band 5		20.61					0.00				
band 6		7.75					band 6		7.75					0.00				
band 7		1.00					band 7		1.00					0.00				
EL130 - 8 West Ward	22	34.39	21.69	12.70	63%	37%	EL130 - 8 West Ward	22	34.39	21.69	12.70	63%	37%	0.00	0.00	0.00	0.00	0.00
band 2		12.70					band 2		12.70					0.00				
band 5		15.52					band 5		15.52					0.00				
band 6		5.17					band 6		5.17					0.00				
band 7		1.00					band 7		1.00					0.00				
EL150 - 8 North Ward	22	34.78	22.28	12.50	64%	36%	EL150 - 8 North Ward	22	34.78	22.28	12.50	64%	36%	0.00	0.00	0.00	0.00	0.00
band 2		12.50					band 2		12.50					0.00				
band 5		16.11					band 5		16.11					0.00				
band 6		5.17					band 6		5.17					0.00				
band 8a		1.00					band 8a		1.00					0.00				
GM120 - Marjory Warren Amu	32	85.55	63.55	22.00	74%	26%	GM120 - Marjory Warren Amu	32	79.94	57.94	22.00	72%	28%	-5.61	-5.61	0.00	-0.02	0.02
band 2		22.00					band 2		22.00					0.00				
band 5		42.34					band 5		37.73					-4.61				
band 6		17.21					band 6		16.21					-1.00				
band 7		3.00					band 7		3.00					0.00				
band 8b		1.00					band 8b		1.00					0.00				
RN380 - Ward 8 South	25	37.21	21.69	15.52	58%	42%	RN380 - Ward 8 South	25	37.21	21.69	15.52	58%	42%	0.00	0.00	0.00	0%	0%
band 2		15.52					band 2		15.52					0.00				
band 5		15.69					band 5		15.69					0.00				
band 6		5.00					band 6		5.00					0.00				
band 8a		1.00					band 8a		1.00					0.00				
RS110 - 7 West	26	34.93	22.00	12.93	63%	37%	RS110 - 7 West	26	34.93	22.00	12.93	63%	37%	0.00	0.00	0.00	0%	0%
band 2		12.93					band 2		12.93					0.00				
band 5		18.00					band 5		18.00					0.00				
band 6		3.00					band 6		3.00					0.00				
band 7		1.00					band 7		1.00					0.00				
WWC01 - 4 South	21	30.98	21.00	9.98	68%	32%	WWC01 - 4 South	21	36.59	26.61	9.98	73%	27%	5.61	5.61	0.00	5%	-5%
band 2		9.98					band 2		9.98					0.00				
band 5		15.00					band 5		19.61					4.61				
band 6		5.00					band 6		6.00					1.00				
band 7		1.00					band 7		1.00					0.00				
Hh Specialist Medicine		115.15	88.98	26.17	77%	23%	Hh Specialist Medicine		115.15	88.98	26.17	77%	23%	0.00	0.00	0.00	0%	0%
63200 - Hh Endoscopy		16.56	14.56	2.00	88%	12%	63200 - Hh Endoscopy		16.56	14.56	2.00	88%	12%	0.00	0.00	0.00	0%	0%
band 2		1.00					band 2		1.00					0.00				
band 3		1.00					band 3		1.00					0.00				
band 5		8.00					band 5		8.00					0.00				
band 6		4.76					band 6		4.76					0.00				
band 7		1.80					band 7		1.80					0.00				
GM130 - John Humphrey Ward	21	30.05	20.66	9.39	69%	31%	GM130 - John Humphrey Ward	21	30.05	20.66	9.39	69%	31%	0.00	0.00	0.00	0%	0%
band 2		9.39					band 2		9.39					0.00				
band 5		15.72					band 5		15.72					0.00				
band 6		3.94					band 6		3.94					0.00				
band 7		1.00					band 7		1.00					0.00				
GM160 - Christopher Booth Ward	28 (16 PIU & 12 inpatient gastro beds	33.35	22.53	10.82	68%	32%	GM160 - Christopher Booth Ward	28 (16 PIU & 12 inpatient gastro beds	33.35	22.53	10.82	68%	32%	0.00	0.00	0.00	0%	0%
band 2		10.82					band 2		10.82					0.00				
band 5		16.63					band 5		16.63					0.00				
band 6		4.90					band 6		4.90					0.00				
band 7		1.00					band 7		1.00					0.00				
band 8a		0.00					band 8a		0.00					0.00				
MED05 - Smh Endoscopy Unit		20.88	18.88	2.00	90%	10%	MED05 - Smh Endoscopy Unit		20.88	18.88	2.00	90%	10%	0.00	0.00	0.00	0%	0%
band 2		2.00					band 2		2.00					0.00				
band 5		14.00					band 5		14.00					0.00				
band 6		2.88					band 6		2.88					0.00				
band 7		2.00					band 7		2.00					0.00				
RA050 - Cxh Endoscopy		14.31	12.35	1.96	86%	14%	RA050 - Cxh Endoscopy		14.31	12.35	1.96	86%	14%	0.00	0.00	0.00	0%	0%
band 3		1.96					band 3		1.96					0.00				
band 5		7.61					band 5		7.61					0.00				
band 6		2.74					band 6		2.74					0.00				
band 7		1.00					band 7		1.00					0.00				
band 8b		1.00					band 8b		1.00					0.00				
Integrated Care		25.00	21.00	4.00	84%	16%	Integrated Care		25.00	21.00	4.00	84%	16%	0.00	0.00	0.00	0%	0%
MED44 - Discharge Services		25.00	21.00	4.00	84%	16%	MED44 - Discharge Services		25.00	21.00	4.00	84%	16%	0.00	0.00	0.00	0%	0%
band 2		4.00					band 2		4.00					0.00				
band 5		3.00					band 5		3.00					0.00				
band 6		15.00					band 6		15.00					0.00				
band 7		3.00					band 7		3.00					0.00				
band 8a		0.00					band 8a		0.00					0.00				
Neurosciences & Stroke		218.89	160.52	58.37	73%	27%	Neurosciences & Stroke		218.89	160.52	58.37	73%	27%	0.00	0.00	0.00	0%	0%
HAS01 - 9 North Hasu	21 - 23	47.85	39.03	8.82	82%	18%	HAS01 - 9 North Hasu	21 - 23	47.85	39.03	8.82	82%	18%	0.00	0.00	0.00	0%	0%
band 2		8.82					band 2		8.82					0.00				
band 3		0.00					band 3		0.00					0.00				
band 5		27.42					band 5		27.42					0.00				
band 6		10.61					band 6		10.61					0.00				
band 7		1.00					band 7		1.00					0.00				
NE010 - 10 North Ward Neurology	21	33.61	26.63	6.98	79%	21%	NE010 - 10 North Ward Neurology	21	33.61	26.63	6.98	79%	21%	0.00	0.00	0.00	0%	0%
band 2		6.98					band 2		6.98					0.00				
band 5		18.75					band 5		18.75					0.00				
band 6		4.88					band 6		4.88					0.00				
band 7		1.00					band 7		1.00					0.00				
band 8a		1.00					band 8a		1.00					0.00				
band 8b		1.00					band 8b		1.00					0.00				
NE020 - 11 South Neurosurgery	25	47.77	34.47	13.30	72%	28%	NE020 - 11 South Neurosurgery	25	47.77	34.47	13.30	72%	28%	0.00	0.00	0.00	0%	0%
band 2		13.30					band 2		13.30					0.00				
band 5		27.47					band 5		27.47					0.00				
band 6		6.00					band 6		6.00					0.00				
band 8a		1.00					band 8a		1.00					0.00				
NE180 - 5 South NTU		20.00	20.00	0.00	100%	0%	NE180 - 5 South NTU		20.00	20.00	0.00	100%	0%	0.00	0.00	0.00	0%	0%
band 5		7.00					band 5		7.00					0.00				
band 6		5.00					band 6		5.00					0.00				
band 7		5.00					band 7		5.00					0.00				
band8a		3.00					band8a		3.00					0.00				

NE220 - Neuro Rehab	16	31.70	18.70	13.00	59%	41%	NE220 - Neuro Rehab	16	31.70	18.70	13.00	59%	41%	0.00	0.00	0.00	0%	0%
band 2		13.00					band 2		13.00					0.00				
band 5		11.20					band 5		11.20					0.00				
band 6		5.50					band 6		5.50					0.00				
band 7		1.00					band 7		1.00					0.00				
band 8a		1.00					band 8a		1.00					0.00				
STK01 - Stroke Unit/ New 9 West	22	37.96	21.69	16.27	57%	43%	STK01 - Stroke Unit/ New 9 West	22	37.96	21.69	16.27	57%	43%	0.00	0.00	0.00	0%	0%
band 2		16.27					band 2		16.27					0.00				
band 5		14.73					band 5		14.73					0.00				
band 6		5.96					band 6		5.96					0.00				
band 7		1.00					band 7		1.00					0.00				
Renal		416.74	304.25	112.49	73%	27%	Renal		416.64	304.15	112.49	73%	27%	-0.10	-0.10	0.00	0%	0%
70200 - Peritoneal Dialysis		10.67	10.00	0.67	94%	6%	70200 - Peritoneal Dialysis		10.67	10.00	0.67	94%	6%	0.00	0.00	0.00	0%	0%
band 3		0.67					band 3		0.67					0.00				
band 5		0.00					band 5		0.00					0.00				
band 6		4.00					band 6		4.00					0.00				
band 7		5.00					band 7		5.00					0.00				
band 8a		1.00					band 8a		1.00					0.00				
82400 - Hdc St Charles		27.08	19.54	7.54	72%	28%	82400 - Hdc St Charles		27.08	19.54	7.54	72%	28%	0.00	0.00	0.00	0%	0%
band 2		7.54					band 2		7.54					0.00				
band 3		0.00					band 3		0.00					0.00				
band 5		11.74					band 5		11.74					0.00				
band 6		6.80					band 6		6.80					0.00				
band 7		1.00					band 7		1.00					0.00				
RN130 - 1 South Renal		24.88	18.88	6.00	76%	24%	RN130 - 1 South Renal		24.88	18.88	6.00	76%	24%	0.00	0.00	0.00	0%	0%
band 2		6.00					band 2		6.00					0.00				
band 5		11.00					band 5		11.00					0.00				
band 6		5.88					band 6		5.88					0.00				
band 7		1.00					band 7		1.00					0.00				
band 8a		1.00					band 8a		1.00					0.00				
RN330 - West Middlesex Renal Unit		11.34	10.36	0.98	91%	9%	RN330 - West Middlesex Renal Unit		11.34	10.36	0.98	91%	9%	0.00	0.00	0.00	0%	0%
band 2		0.98					band 2		0.98					0.00				
band 5		6.40					band 5		6.40					0.00				
band 6		2.96					band 6		2.96					0.00				
band 8a		1.00					band 8a		1.00					0.00				
RN360 - Ealing Satellite		23.98	17.44	6.54	73%	27%	RN360 - Ealing Satellite		23.98	17.44	6.54	73%	27%	0.00	0.00	0.00	0%	0%
band 2		6.54					band 2		6.54					0.00				
band 5		10.53					band 5		10.53					0.00				
band 6		4.91					band 6		4.91					0.00				
band 7		1.00					band 7		1.00					0.00				
band 8a		1.00					band 8a		1.00					0.00				
RN370 - Hayes Renal Unit		28.78	20.90	7.88	73%	27%	RN370 - Hayes Renal Unit		28.78	20.90	7.88	73%	27%	0.00	0.00	0.00	0%	0%
band 2		7.88					band 2		7.88					0.00				
band 3		0.00					band 3		0.00					0.00				
band 5		13.00					band 5		13.00					0.00				
band 6		5.90					band 6		5.90					0.00				
band 7		1.00					band 7		1.00					0.00				
band 8a		1.00					band 8a		1.00					0.00				
RN390 - Handfield Jones Ward	21	26.63	18.63	8.00	70%	30%	RN390 - Handfield Jones Ward	21	26.63	18.63	8.00	70%	30%	0.00	0.00	0.00	0%	0%
band 2		8.00					band 2		8.00					0.00				
band 5		13.71					band 5		13.71					0.00				
band 6		3.92					band 6		3.92					0.00				
band 8a		1.00					band 8a		1.00					0.00				
RN400 - Peters Ward	20	29.47	18.64	10.83	63%	37%	RN400 - Peters Ward	20	29.47	18.64	10.83	63%	37%	0.00	0.00	0.00	0%	0%
band 2		10.83					band 2		10.83					0.00				
band 5		13.72					band 5		13.72					0.00				
band 6		3.92					band 6		3.92					0.00				
band 8a		1.00					band 8a		1.00					0.00				
RN410 - De Wardener Ward	12 - level 2 x 6	25.97	20.57	5.40	79%	21%	RN410 - De Wardener Ward	12 - level 2 x 6	25.97	20.57	5.40	79%	21%	0.00	0.00	0.00	0%	0%
band 2		5.40					band 2		5.40					0.00				
band 5		9.79					band 5		9.79					0.00				
band 6		9.80					band 6		9.80					0.00				
band 7		0.98					band 7		0.98					0.00				
RN420 - Kerr Ward	22	21.47	13.63	7.84	63%	37%	RN420 - Kerr Ward	22	21.37	13.53	7.84	63%	37%	-0.10	-0.10	0.00	0%	0%
band 2		7.84					band 2		7.84					0.00				
band 5		8.71					band 5		8.53					-0.18				
band 6		3.92					band 6		4.00					0.08				
band 7		1.00					band 7		1.00					0.00				
RN430 - Renal Acute Dx		46.00	37.00	9.00	80%	20%	RN430 - Renal Acute Dx		46.00	37.00	9.00	80%	20%	0.00	0.00	0.00	0%	0%
band 2		9.00					band 2		9.00					0.00				
band 3		0.00					band 3		0.00					0.00				
band 5		20.00					band 5		20.00					0.00				
band 6		13.00					band 6		13.00					0.00				
band 7		3.00					band 7		3.00					0.00				
band 8a		1.00					band 8a		1.00					0.00				
RN440 - Northwick Park Satellite Renal		58.02	41.02	17.00	71%	29%	RN440 - Northwick Park Satellite Renal		58.02	41.02	17.00	71%	29%	0.00	0.00	0.00	0%	0%
band 2		17.00					band 2		17.00					0.00				
band 5		23.18					band 5		23.18					0.00				
band 6		12.96					band 6		12.96					0.00				
band 7		3.00					band 7		3.00					0.00				
band 8a		1.00					band 8a		1.00					0.00				
band 8b		0.88					band 8b		0.88					0.00				
RN450 - St Charles Satellite		30.00	22.00	8.00	73%	27%	RN450 - St Charles Satellite		30.00	22.00	8.00	73%	27%	0.00	0.00	0.00	0%	0%
band 2		8.00					band 2		8.00					0.00				
band 5		14.00					band 5		14.00					0.00				
band 6		6.00					band 6		6.00					0.00				
band 7		1.00					band 7		1.00					0.00				
band 8a		1.00					band 8a		1.00					0.00				
RN460 - Watford Satellite		20.61	13.80	6.81	67%	33%	RN460 - Watford Satellite		20.61	13.80	6.81	67%	33%	0.00	0.00	0.00	0%	0%
band 2		6.81					band 2		6.81					0.00				
band 5		8.00					band 5		8.00					0.00				
band 6		4.00					band 6		4.00					0.00				
band 7		1.00					band 7		1.00					0.00				
band 8a		0.80					band 8a		0.80					0.00				
band 8c		0.00					band 8c		0.00					0.00				
RN470 - Central Middlesex Unit		23.68	16.68	7.00	70%	30%	RN470 - Central Middlesex Unit		23.68	16.68	7.00	70%	30%	0.00	0.00	0.00	0%	0%
band 2		7.00					band 2		7.00					0.00				
band 5		9.78					band 5		9.78					0.00				
band 6		4.90					band 6		4.90					0.00				
band 7		1.00					band 7		1.00					0.00				
band 8a		1.00					band 8a		1.00					0.00				
RN580 - Piu (Planned Inv. Unit)		8.16	5.16	3.00	63%	37%	RN580 - Piu (Planned Inv. Unit)		8.16	5.16	3.00	63%	37%	0.00	0.00	0.00	0%	0%
band 2		1.00					band 2		1.00					0.00				
band 3		1.00					band 3		1.00					0.00				
band 4		1.00					band 4		1.00					0.00				
band 5		1.16					band 5		1.16					0.00				
band 6		3.00					band 6		3.00					0.00				
band 7		1.00					band 7		1.00					0.00				
Smh Acute & Specialist		325.33	227.96	97.37	70%	30%	Smh Acute & Specialist		325.33	226.96	98.37	70%	30%	0.00	-1.00	1.00	0%	0%
HIV25 - Gu Nursing		33.40	24.40	9.00	73%	27%	HIV25 - Gu Nursing		33.40	24.40	9.00	73%	27%	0.00	0.00	0.00	0%	0%

band 3		6.00					band 3		6.00					0.00					
band 4		3.00					band 4		3.00					0.00					
band 5		6.00					band 5		6.00					0.00					
band 6		4.60					band 6		4.60					0.00					
band 7		10.80					band 7		10.80					0.00					
band 8a		1.00					band 8a		1.00					0.00					
band 8b		1.00					band 8b		1.00					0.00					
band 8d		1.00					band 8d		1.00					0.00					
HIV26 - Hiv Nursing		11.20	8.20	3.00	73%	27%	HIV26 - Hiv Nursing		11.20	8.20	3.00	73%	27%	0.00	0.00	0.00	0%	0%	
band 3		3.00					band 3		3.00					0.00					
band 5		1.00					band 5		1.00					0.00					
band 6		3.00					band 6		3.00					0.00					
band 7		3.20					band 7		3.20					0.00					
band 8a		1.00					band 8a		1.00					0.00					
MED28 - Opat		5.00	5.00	0.00	100%	0%	MED28 - Opat		5.00	5.00	0.00	100%	0%	0.00	0.00	0.00	0%	0%	
band 5		0.40					band 5		0.40					0.00					
band 6		2.00					band 6		2.00					0.00					
band 7		2.60					band 7		2.60					0.00					
CAS01 - EMSS	18	33.04	22.69	10.35	69%	31%	CAS01 - EMSS	18	33.04	22.69	10.35	69%	31%	0.00	0.00	0.00	0%	0%	
band 2		10.35					band 2		10.35					0.00					
band 5		15.52					band 5		15.52					0.00					
band 6		5.17					band 6		5.17					0.00					
band 7		1.00					band 7		1.00					0.00					
band 8b		1.00					band 8b		1.00					0.00					
CAS32 - EMA	17	31.31	26.14	5.17	83%	17%	CAS32 - EMA	17	31.31	26.14	5.17	83%	17%	0.00	0.00	0.00	0%	0%	
band 2		5.17					band 2		5.17					0.00					
band 5		19.97					band 5		19.97					0.00					
band 6		5.17					band 6		5.17					0.00					
band 7		1.00					band 7		1.00					0.00					
HIV02 - Almroth Wright-Rodney Porter	15+8 (23)	37.21	24.28	12.93	65%	35%	HIV02 - Almroth Wright-Rodney Porter	15+8 (23)	37.21	23.28	13.93	63%	37%	0.00	-1.00	1.00	-3%	3%	
band 2		12.93					band 2		12.93					0.00					
band 4		0.00		includes 1 x TNA			band 4		1.00		includes 1 x TNA			1.00					
band 5		17.28					band 5		16.28					-1.00					
band 6		6.00					band 6		6.00					0.00					
band 8a		1.00					band 8a		1.00					0.00					
MED10 - Lewis Ward	15	24.29	13.94	10.35	57%	43%	MED10 - Lewis Ward	15	24.29	13.94	10.35	57%	43%	0.00	0.00	0.00	0%	0%	
band 2		10.35					band 2		10.35					0.00					
band 5		9.94					band 5		9.94					0.00					
band 6		3.00					band 6		3.00					0.00					
band 7		1.00					band 7		1.00					0.00					
MED11 - Manvers/ARU	17 +8 ARU +8 Short stay (33)	61.50	51.15	10.35	83%	17%	MED11 - Manvers/ARU	17 +8 ARU +8 Short stay (33)	61.50	51.15	10.35	83%	17%	0	0.00	0.00	0%	0%	
band 2		10.35					band 2		10.35					0.00					
band 5		38.80					band 5		38.80					0.00					
band 6		10.35					band 6		10.35					0.00					
band 7		1.00					band 7		1.00					0.00					
band 8a		1.00					band 8a		1.00					0.00					
MED15 - Douglas (Med)	16	29.46	19.11	10.35	65%	35%	MED15 - Douglas (Med)	16	29.46	19.11	10.35	65%	35%	0.00	0.00	0.00	0%	0%	
band 2		10.35					band 2		10.35					0.00					
band 5		13.11		includes 1 x TNA			band 5		13.11		includes 1 x TNA			0.00					
band 6		5.00					band 6		5.00					0.00					
band 7		1.00					band 7		1.00					0.00					
WIT01 - Witherow Ward	12	24.29	13.94	10.35	57%	43%	WIT01 - Witherow Ward	12	24.29	13.94	10.35	57%	43%	0.00	0.00	0.00	0%	0%	
band 2		10.35					band 2		10.35					0.00					
band 5		9.94					band 5		9.94					0.00					
band 6		3.00					band 6		3.00					0.00					
band 8a		1.00					band 8a		1.00					0.00					
WWS01 - Thistlethwaite (Med)	20	34.63	19.11	15.52	55%	45%	WWS01 - Thistlethwaite (Med)	20	34.63	19.11	15.52	55%	45%	0.00	0.00	0.00	0%	0%	
band 2		15.52					band 2		15.52					0.00					
band 4		0.00		includes 1 x TNA			band 4		0.00		includes 1 x TNA			0.00					
band 5		15.11					band 5		15.11					0.00					
band 6		3.00					band 6		3.00					0.00					
band 7		1.00					band 7		1.00					0.00					
Urgent Care, Emergency		298.98	250.44	48.54	84%	16%	Urgent Care, Emergency		298.98	250.44	48.54	84%	16%	0.00	0.00	0.00	0%	0%	
AE110 - Cxh Cdu		27.76	18.92	8.84	68%	32%	AE110 - Cxh Cdu		27.76	18.92	8.84	68%	32%	0.00	0.00	0.00	0%	0%	
band 2		8.84					band 2		8.84					0.00					
band 5		14.92					band 5		14.92					0.00					
band 6		3.00					band 6		3.00					0.00					
band 7		1.00					band 7		1.00					0.00					
AE120 - Cxh Ed Nursing		78.85	70.84	8.01	90%	10%	AE120 - Cxh Ed Nursing		78.85	70.84	8.01	90%	10%	0.00	0.00	0.00	0%	0%	
band 2		0.00					band 2		0.00					0.00					
band 3		8.01					band 3		8.01					0.00					
band 5		41.38					band 5		41.38					0.00					
band 6		20.05					band 6		20.05					0.00					
band 7		8.41					band 7		8.41					0.00					
band 8a		1.00					band 8a		1.00					0.00					
CAS04 - Smh Ed Nursing		88.76	79.96	8.80	90%	10%	CAS04 - Smh Ed Nursing		88.76	79.96	8.80	90%	10%	0.00	0.00	0.00	0%	0%	
band 2		0.00					band 2		0.00					0.00					
band 3		8.80					band 3		8.80					0.00					
band 5		41.38					band 5		41.38					0.00					
band 6		24.47					band 6		24.47					0.00					
band 7		11.11					band 7		11.11					0.00					
band 8a		1.00					band 8a		1.00					0.00					
band 8c		1.00					band 8c		1.00					0.00					
band 8d		1.00					band 8d		1.00					0.00					
CAS07 - Paediatric Ed & Cdu		35.89	30.50	5.39	85%	15%	CAS07 - Paediatric Ed & Cdu		35.89	30.50	5.39	85%	15%	0.00	0.00	0.00	0%	0%	
band 2		0.00					band 2		0.00					0.00					
band 3		5.39					band 3		5.39					0.00					
band 5		15.50					band 5		15.50					0.00					
band 6		12.00					band 6		12.00					0.00					
band 7		2.00					band 7		2.00					0.00					
band 8a		1.00					band 8a		1.00					0.00					
PFH02 - Pfh Unplanned Care		23.21	19.21	4.00	83%	17%	PFH02 - Pfh Unplanned Care		23.21	19.21	4.00	83%	17%	0.00	0.00	0.00	0%	0%	
band 3		4.00					band 3		4.00					0.00					
band 7		18.21					band 7		18.21					0.00					
band 8a		1.00					band 8a		1.00					0.00					
AECCX - Ambulatory Emergency Care Cx		11.62	9.00	2.62	77%	23%	AECCX - Ambulatory Emergency Care Cx		11.62	9.00	2.62	77%	23%	0.00	0.00	0.00	0%	0%	
band 3		2.62					band 3		2.62					0.00					
band 5		2.00					band 5		2.00					0.00					
band 6		5.00					band 6		5.00					0.00					
band 7		1.00					band 7		1.00					0.00					
band 8a		1.00					band 8a		1.00					0.00					
OL001 - Ambulatory Emergency Care Smh		13.28	10.66	2.62	80%	20%	OL001 - Ambulatory Emergency Care Smh		13.28	10.66	2.62	80%	20%	0.00	0.00	0.00	0%	0%	
band 3		2.62					band 3		2.62					0.00					
band 5		3.66					band 5		3.66					0.00					
band 6		4.00					band 6		4.00					0.00					
band 7		1.00					band 7		1.00					0.00					
band 8a		2.00					band 8a		2.00					0.00					
CAS31 - Cdu	12 trolleys/beds	19.61	11.35	8.26	58%	42%	CAS31 - Cdu	12 trolleys/beds	19.61	11.35	8.26	58%	42%	0.00	0.00	0.00	0%	0%	
band 2		8.26					band 2		8.26					0.00					
band 5		7.35					band 5		7.35					0.00					
band 6		3.00					band 6		3.00					0.00					
band 7		1.00					band 7		1.00					0.00					

DIVISION OF SURGERY, CANCER AND CARDIOVASCULAR SCIENCES ESTABLISHMENT DATA SEPTEMBER 2020							DIVISION OF SURGERY, CANCER AND CARDIOVASCULAR SCIENCES ESTABLISHMENT DATA MARCH 2021							Differences SEPTEMBER 2020 to MARCH 2021				
Clinical area	Number of beds	Total registered nurse and unregistered	Registered nurse and unregistered care staff breakdown		Registered nurse to unregistered care staff ratio		Clinical area	Number of beds	Total registered nurse and unregister	Registered nurse and unregistered care staff breakdown		Registered nurse to unregistered care staff ratio		Difference in overall Totals (WTE)	Difference (WTE) Staff Type and Banding		Difference in ratio	
			RN	CS	RN	CS				RN	CS	RN	CS		RN	CS	RN	CS
OVERALL TOTAL		1545.95	1268.78	277.17	82%	18%	OVERALL TOTAL		1546.57	1265.01	281.56	82%	18%	0.62	-3.77	4.39	0.00	0.00
Cardiac		137.67	116.24	21.43	84%	16%	Cardiac		138.67	116.24	22.43	84%	16%	1.00	0.00	1.00	-1%	1%
58300 - HH Ward A9		23.22	18.61	4.61	80%	20%	58300 - HH Ward A9		24.22	18.61	5.61	77%	23%	1.00	0.00	1.00	-3%	3%
band 2	20			3.61			band 2	20			3.61				0.00	0.00		
band 3				1.00			band 3				2.00				0.00	1.00		
band 5			12.61				band 5			12.61					0.00	0.00		
band 6			5.00				band 6			5.00					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
58400 - HH Cardiology Ward A7		40.08	35.08	5.00	88%	12%	58400 - HH Cardiology Ward A7		40.08	35.08	5.00	88%	12%	0.00	0.00	0.00	0%	0%
band 2	27			3.00			band 2	27			3.00				0.00	0.00		
band 3				2.00			band 3				2.00				0.00	0.00		
band 5			26.41				band 5			26.41					0.00	0.00		
band 6			6.67				band 6			6.67					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
band 8a			1.00				band 8a			1.00					0.00	0.00		
58500 - HH Citu (A6)		0.00	0.00	0.00	#DIV/0!	#DIV/0!	58500 - HH Citu (A6)		0.00	0.00	0.00	#DIV/0!	#DIV/0!	0.00	0.00	0.00	#DIV/0!	#DIV/0!
band 2	16		0	0.00			band 2	16		0	0.00				0.00	0.00		
band 5			0	0			band 5			0	0				0.00	0.00		
band 6			0.00	0			band 6			0.00	0				0.00	0.00		
band 7			0.00	0			band 7			0.00	0				0.00	0.00		
band 8a			0.00	0			band 8a			0.00	0				0.00	0.00		
58600 - HH Ccl & Day-Ward Nurse Staff		50.15	43.33	6.82	86%	14%	58600 - HH Ccl & Day-Ward Nurse Staff		50.15	43.33	6.82	86%	14%	0.00	0.00	0.00	0%	0%
band 2				1.82			band 2				1.82				0.00	0.00		
band 3				5.00			band 3				5.00				0.00	0.00		
band 5			21.53				band 5			21.53					0.00	0.00		
band 6			17.80				band 6			17.80					0.00	0.00		
band 7			3.00				band 7			3.00					0.00	0.00		
band 8a			1.00				band 8a			1.00					0.00	0.00		
65500 - Ward C8		24.22	19.22	5.00	79%	21%	65500 - Ward C8		24.22	19.22	5.00	79%	21%	0.00	0.00	0.00	0%	0%
band 2	20			5.00			band 2	20			5.00				0.00	0.00		
band 5			12.22				band 5			12.22					0.00	0.00		
band 6			6.00				band 6			6.00					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
Clinical Haematology		100.29	90.29	10.00	90%	10%	Clinical Haematology		100.29	89.29	11.00	89%	11%	0.00	-1.00	1.00	-1%	1%
67800 - Weston Ward		22.80	20.80	2.00	91%	9%	67800 - Weston Ward		22.80	20.80	2.00	91%	9%	0.00	0.00	0.00	0%	0%
band 2	15			2.00			band 2	15			2.00				0.00	0.00		
band 5			11.00				band 5			11.00					0.00	0.00		
band 6			9.00				band 6			9.00					0.00	0.00		
band 7			0.80				band 7			0.80					0.00	0.00		
71400 - Fraser Gamble		39.08	33.08	6.00	85%	15%	71400 - Fraser Gamble		39.08	32.08	7.00	82%	18%	0.00	-1.00	1.00	-3%	3%
band 2	21			6.00			band 2	21			6.00				0.00	0.00		
band 4			0				band 4				1.00				0.00	1.00		
band 5			25.08			cludes 1 x TN	band 5			24.08			cludes 1 x TN		-1.00	0.00		
band 6			7.00				band 6			7.00					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
71500 - Dacie Ward		23.85	21.85	2.00	92%	8%	71500 - Dacie Ward		23.85	21.85	2.00	92%	8%	0.00	0.00	0.00	0%	0%
band 2	14			2.00			band 2	14			2.00				0.00	0.00		
band 3				0.00			band 3				0.00				0.00	0.00		
band 5			12.15				band 5			12.15					0.00	0.00		
band 6			8.70				band 6			8.70					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
71700 - Renal Haem Triage		14.56	14.56	0.00	100%	0%	71700 - Renal Haem Triage		14.56	14.56	0.00	100%	0%	0.00	0.00	0.00	0%	0%
band 5	8		6.56				band 5	8		6.56					0.00	0.00		
band 6			6.00				band 6			6.00					0.00	0.00		
band 7			2.00				band 7			2.00					0.00	0.00		
Critical Care		409.56	395.62	13.94	97%	3%	Critical Care		409.60	395.66	13.94	97%	3%	0.04	0.04	0.00	0%	0%
72300 - ICU - HH		135.49	131.49	4.00	97%	3%	72300 - ICU - HH		135.06	131.06	4.00	97%	3%	-0.43	-0.43	0.00	0%	0%
band 2	12			3.00			band 2	12			3.00				0.00	0.00		
band 3				1.00			band 3				1.00				0.00	0.00		
band 5			72.93				band 5			72.93					0.00	0.00		
band 6			45.56				band 6			45.13					-0.43	0.00		
band 7			11.00				band 7			11.00					0.00	0.00		
band 8a			2.00				band 8a			2.00					0.00	0.00		
ANA01 - ICU - SMH		158.31	153.37	4.94	97%	3%	ANA01 - ICU - SMH		158.23	153.29	4.94	97%	3%	-0.08	-0.08	0.00	0%	0%
band 2	16			4.94			band 2	16			4.94				0.00	0.00		
band 5			78.61				band 5			78.61					0.00	0.00		
band 6			62.96				band 6			62.88					-0.08	0.00		
band 7			10.00				band 7			10.00					0.00	0.00		
band 8a			1.80				band 8a			1.80					0.00	0.00		
IT010 - Level 2 & 3 CXH		115.76	110.76	5.00	96%	4%	IT010 - Level 2 & 3 CXH		116.31	111.31	5.00	96%	4%	0.55	0.55	0.00	0%	0%
band 2	24			2.00			band 2	24			2.00				0.00	0.00		
band 3				3.00			band 3				3.00				0.00	0.00		
band 5			60.42				band 5			60.42					0.00	0.00		
band 6			41.34				band 6			40.89					-0.45	0.00		
band 7			8.00				band 7			8.00					0.00	0.00		
band 8a			1.00				band 8a			2.00					1.00	0.00		
eneral & Vascular Surge		161.49	119.03	42.46	74%	26%	eneral & Vascular Surge		161.49	119.03	42.46	74%	26%	0.00	0.00	0.00	0%	0%

66200 - Ward A8 HH		36.13	29.00	7.13	80%	20%	66200 - Ward A8 HH		36.13	29.00	7.13	80%	20%	0.00	0.00	0.00	0%	0%
band 2				4.25			band 2				4.25				0.00	0.00		
band 3	20			1.88			band 3	20			1.88				0.00	0.00		
band 4				1.00			band 4				1.00				0.00	0.00		
band 5			21.00				band 5			21.00					0.00	0.00		
band 6			7.00				band 6			7.00					0.00	0.00		
band 8a			1.00				band 8a			1.00					0.00	0.00		
CIR13 - Zachary Cope Ward		43.28	32.87	10.41	76%	24%	CIR13 - Zachary Cope Ward		43.28	32.87	10.41	76%	24%	0.00	0.00	0.00	0%	0%
band 2	22 (incl. 5 Level 2)			8.88			band 2	22 (incl. 5 Level 2)			8.88				0.00	0.00		
band 3				1.53			band 3				1.53				0.00	0.00		
band 5			20.22				band 5			20.22					0.00	0.00		
band 6			10.65				band 6			10.65					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
band 8a			1.00				band 8a			1.00					0.00	0.00		
ical Assessme		15.00	11.00	4.00	73%	27%	SIC02 - Surgical Assessment Unit (Sau)		15.00	11.00	4.00	73%	27%	0.00	0.00	0.00	0%	0%
band 3	12 Trolleys			4.00			band 3	12 Trolleys			4.00				0.00	0.00		
band 5			5.00				band 5			5.00					0.00	0.00		
band 6			5.00				band 6			5.00					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
SUR16 - New Charles Pannett		41.08	30.16	10.92	73%	27%	SUR16 - New Charles Pannett		41.08	30.16	10.92	73%	27%	0.00	0.00	0.00	0%	0%
band 2	25			6.92			band 2	25			6.92				0.00	0.00		
band 3				3.00			band 3				3.00				0.00	0.00		
band 4				1.00			band 4				1.00				0.00	0.00		
band 5			22.55				band 5			22.55					0.00	0.00		
band 6			6.61				band 6			6.61					0.00	0.00		
band 8a			1.00				band 8a			1.00					0.00	0.00		
SUR22 - Paterson Ward		26.00	16.00	10.00	62%	38%	SUR22 - Paterson Ward		26.00	16.00	10.00	62%	38%	0.00	0.00	0.00	0%	0%
band 2	18			9.00			band 2	18			9.00				0.00	0.00		
band 3				1.00	includes x1 TNA		band 3				1.00	includes x1 TNA			0.00	0.00		
band 5			13.00				band 5			13.00					0.00	0.00		
band 6			3.00				band 6			3.00					0.00	0.00		
band 7			0.00				band 7			0.00					0.00	0.00		
Oncology & Palliative Car		64.51	44.39	20.12	69%	31%	Oncology & Palliative Car		64.99	43.87	21.12	68%	32%	0.48	-0.52	1.00	-1%	1%
CA210 - 6 South Ward		28.78	19.76	9.02	69%	31%	CA210 - 6 South Ward		29.02	20.00	9.02	69%	31%	0.24	0.24	0.00	0%	0%
band 2	25			6.08			band 2	25			6.08				0.00	0.00		
band 3				2.94			band 3				2.94				0.00	0.00		
band 5			10.00				band 5			10.00					0.00	0.00		
band 6			8.76				band 6			9.00					0.24	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
CA230 - 6 North Ward		35.73	24.63	11.10	69%	31%	CA230 - 6 North Ward		35.97	23.87	12.10	66%	34%	0.24	-0.76	1.00	-3%	3%
band 2				9.14			band 2				9.14				0.00	0.00		
band 3	26			1.96			band 3	26			1.96				0.00	0.00		
band 4						includes 1 x TNA	band 4				1.00		includes 1 x TNA		0.00	1.00		
band 5			18.63				band 5			17.87					-0.76	0.00		
band 6			5.00				band 6			5.00					0.00	0.00		
band 8a			1.00				band 8a			1.00					0.00	0.00		
Ophthalmology		18.86	12.36	6.50	66%	34%	Ophthalmology		18.86	12.36	6.50	66%	34%	0.00	0.00	0.00	0%	0%
EYE02 - Alex Cross Eye Ward		18.86	12.36	6.50	66%	34%	EYE02 - Alex Cross Eye Ward		18.86	12.36	6.50	66%	34%	0.00	0.00	0.00	0%	0%
band 2	4			6.50			band 2	4			6.50				0.00	0.00		
band 5			11.36				band 5			11.36					0.00	0.00		
band 6			1.00				band 6			1.00					0.00	0.00		
Specialist Surgery		112.89	84.28	28.61	75%	25%	Specialist Surgery		111.99	82.99	29.00	74%	26%	-0.90	-1.29	0.39	-1%	1%
SM260 - Ward Riverside		39.11	29.50	9.61	75%	25%	SM260 - Ward Riverside		37.21	28.21	9.00	76%	24%	-1.90	-1.29	-0.61	0%	0%
band 2	26 beds/ 18 trolleys			8.61			band 2	26 beds/ 18 trolleys			8.00				0.00	-0.61		
band 3				1.00			band 3				1.00				0.00	0.00		
band 5			21.50				band 5			21.21					-0.29	0.00		
band 6			5.00				band 6			5.00					0.00	0.00		
band 7			1.00				band 7			0.00					-1.00	0.00		
band 8a			2.00				band 8a			2.00					0.00	0.00		
SU030 - 7 North Urology		39.37	28.37	11.00	72%	28%	SU030 - 7 North Urology		39.37	27.37	12.00	70%	30%	0.00	-1.00	1.00	-3%	3%
band 2	26			10.00			band 2	26			10.00				0.00	0.00		
band 3				0.00			band 3				0.00				0.00	0.00		
band 4				1.00			band 4				2.00				0.00	1.00		
band 5			22.37				band 5			21.37					-1.00	0.00		
band 6			5.00				band 6			5.00					0.00	0.00		
band 8a			1.00				band 8a			1.00					0.00	0.00		
TN110 - Ward 10 Sth - Hnb & Plastics		34.41	26.41	8.00	77%	23%	TN110 - Ward 10 Sth - Hnb & Plastics		35.41	27.41	8.00	77%	23%	1.00	1.00	0.00	1%	-1%
band 2	23			4.00			band 2	23			4.00				0.00	0.00		
band 3				4.00			band 3				4.00				0.00	0.00		
band 5			17.41			includes 1 x TNA	band 5			17.41			includes 1 x TNA		0.00	0.00		
band 6			8.00				band 6			8.00					0.00	0.00		
band 7							band 7			1.00					1.00	0.00		
band 8a			1.00				band 8a			1.00					0.00	0.00		
eatres, Anaesthetics & P		400.55	311.00	89.55	78%	22%	eatres, Anaesthetics & P		400.55	310.00	90.55	77%	23%	0.00	-1.00	1.00	0%	0%
71800 - Theatres Main HH		80.83	61.43	19.40	76%	24%	71800 - Theatres Main HH		80.83	61.43	19.40	76%	24%	0.00	0.00	0.00	0%	0%
band 2				17.40			band 2				17.40				0.00	0.00		
band 3				1.00			band 3				1.00				0.00	0.00		
band 4				1.00			band 4				1.00				0.00	0.00		
band 5			25.46				band 5			24.46					-1.00	0.00		
band 6			26.97				band 6			27.97					1.00	0.00		
band 7			8.00				band 7			8.00					0.00	0.00		

band 8a			1.00				band 8a			1.00					0.00	0.00		
TH110 - Theatres Main CXH		155.24	119.60	35.64	77%	23%	TH110 - Theatres Main CXH		156.24	119.60	36.64	77%	23%	1.00	0.00	1.00	0%	0%
band 2				30.43			band 2				30.43				0.00	0.00		
band 3				4.21			band 3				4.21				0.00	0.00		
band 4				1.00	excludes ODPs (now AHPs)	includes 1 x TNA	band 4				2.00	excludes ODPs (now AHPs)	includes 1 x TNA		0.00	1.00		
band 5			64.82				band 5			63.82					-1.00	0.00		
band 6			43.78				band 6			43.78					0.00	0.00		
band 7			10.00				band 7			11.00					1.00	0.00		
band 8a			1.00				band 8a			1.00					0.00	0.00		
THE01 - Main Theatre SMH		164.48	129.97	34.51	79%	21%	THE01 - Main Theatre SMH		163.48	128.97	34.51	79%	21%	-1.00	-1.00	0.00	0%	0%
band 2				27.48			band 2				27.48				0.00	0.00		
band 3				5.03			band 3				5.03				0.00	0.00		
band 4				2.00	excludes ODPs (now AHPs)		band 4				2.00	excludes ODPs (now AHPs)			0.00	0.00		
band 5			56.80				band 5			55.80					-1.00	0.00		
band 6			61.17				band 6			62.17					1.00	0.00		
band 7			10.00				band 7			9.00					-1.00	0.00		
band 8a			1.00				band 8a			1.00					0.00	0.00		
band 8b			1.00				band 8b			1.00					0.00	0.00		
Trauma		140.13	95.57	44.56	68%	32%	Trauma		140.13	95.57	44.56	68%	32%	0.00	0.00	0.00	0%	0%
LHD01 - Albert Ward		43.58	24.84	18.74	57%	43%	LHD01 - Albert Ward		43.58	24.84	18.74	57%	43%	0.00	0.00	0.00	0%	0%
band 2				14.78			band 2				14.78				0.00	0.00		
band 3	30			2.96			band 3	30			2.96				0.00	0.00		
band 4				1.00		includes 1 x TNA	band 4				1.00		includes 1 x TNA		0.00	0.00		
band 5			18.92				band 5			18.92					0.00	0.00		
band 6			4.92				band 6			4.92					0.00	0.00		
band 7			0.00				band 7			0.00					0.00	0.00		
band 8a			1.00				band 8a			1.00					0.00	0.00		
MJT03 - Major Trauma Ward		36.55	22.61	13.94	62%	38%	MJT03 - Major Trauma Ward		36.55	22.61	13.94	62%	38%	0.00	0.00	0.00	0%	0%
band 2	16			10.61			band 2	16			10.61				0.00	0.00		
band 3				3.33			band 3				3.33				0.00	0.00		
band 5			15.61				band 5			15.61					0.00	0.00		
band 6			6.00				band 6			6.00					0.00	0.00		
band 8a			1.00				band 8a			1.00					0.00	0.00		
SUR14 - Valentine Ellis		34.87	27.87	7.00	80%	20%	SUR14 - Valentine Ellis		34.87	27.87	7.00	80%	20%	0.00	0.00	0.00	0%	0%
band 2				5.00			band 2				5.00				0.00	0.00		
band 3	24			2.00			band 3	24			2.00				0.00	0.00		
band 5			18.87				band 5			18.87					0.00	0.00		
band 6			6.00				band 6			6.00					0.00	0.00		
band 7			2.00				band 7			2.00					0.00	0.00		
band 8a			1.00				band 8a			1.00					0.00	0.00		
TN120 - Ward 7 South - T&O		25.13	20.25	4.88	81%	19%	TN120 - Ward 7 South - T&O		25.13	20.25	4.88	81%	19%	0.00	0.00	0.00	0%	0%
band 2	25			4.88			band 2	25			4.88				0.00	0.00		
band 5			15.25				band 5			15.25					0.00	0.00		
band 6			4.00				band 6			4.00					0.00	0.00		
band 8a			1.00				band 8a			1.00					0.00	0.00		

DIVISION OF WOMENS CHILDRENS AND CLINICAL SUPPORT - ESTABLISHMENT DATA SEPTEMBER 2020							DIVISION OF WOMENS CHILDRENS AND CLINICAL SUPPORT - ESTABLISHMENT DATA MARCH 2021							Differences SEPTEMBER 2020 to MARCH 2021				
Clinical area	Number of beds	Total registered nurse and unregistered care staff WTE	Registered nurse and unregistered care staff breakdown WTE		Registered nurse to unregistered care staff ratio		Clinical area	Number of beds	Total registered nurse and unregistered care staff WTE	Registered nurse and unregistered care staff breakdown WTE		Registered nurse to unregistered care staff ratio		Difference in overall Totals (WTE)	Difference (WTE) Staff Type and Banding		Difference in ratio	
			RN	CS	RN	CS				RN	CS	RN	CS		RN	CS	RN	CS
OVERALL TOTAL		911.78	719.30	192.48	79%	21%	OVERALL TOTAL		911.78	719.30	192.48	79%	21%	0.00	0.00	0.00	0.00	0.00
Childrens Services		288.51	268.46	20.05	93%	7%	Childrens Services		288.51	268.46	20.05	93%	7%	0.00	0.00	0.00	0%	0%
46500 - Qcch Neonatal Unit	24	65.31	60.71	4.60	93%	7%	46500 - Qcch Neonatal Unit	24	65.31	60.71	4.60	93%	7%	0.00	0.00	0.00	0%	0%
band 4				4.60			band 4				4.60				0.00	0.00		
band 5			5.71				band 5			5.71					0.00	0.00		
band 6			47.00				band 6			47.00					0.00	0.00		
band 7			8.00				band 7			8.00					0.00	0.00		
62200 - David Harvey Unit	0 (Ambulatory 8am - 6pm)	6.40	5.40	1.00	84%	16%	62200 - David Harvey Unit	0 (Ambulatory 8am - 6pm)	6.40	5.40	1.00	84%	16%	0.00	0.00	0.00	0%	0%
band 3				1.00			band 3				1.00				0.00	0.00		
band 5			1.00				band 5			1.00					0.00	0.00		
band 6			3.40				band 6			3.40					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
NEO09 - Winnicott Baby Unit	22	47.17	42.72	4.45	91%	9%	NEO09 - Winnicott Baby Unit	22	47.17	42.72	4.45	91%	9%	0.00	0.00	0.00	0%	0%
band 4				4.45			band 4				4.45				0.00	0.00		
band 5			17.47				band 5			17.47					0.00	0.00		
band 6			20.25				band 6			20.25					0.00	0.00		
band 7			5.00				band 7			5.00					0.00	0.00		
band 8a			0.00				band 8a			0.00					0.00	0.00		
PAE01 - Westway	4 + Ambulatory	0.00	0.00	0.00	#DIV/0!	#DIV/0!	PAE01 - Westway	4 + Ambulatory	0.00	0.00	0.00	#DIV/0!	#DIV/0!	0.00	0.00	0.00	0%	0%
band 3				0.00			band 3				0.00				0.00	0.00		
band 5			0.00				band 5			0.00					0.00	0.00		
band 6			0.00				band 6			0.00					0.00	0.00		
band 7			0.00				band 7			0.00					0.00	0.00		
PAE02 - Grand Union	14	31.73	31.73	0.00	100%	0%	PAE02 - Grand Union	14	31.73	31.73	0.00	100%	0%	0.00	0.00	0.00	0%	0%
band 3				0.00			band 3				0.00				0.00	0.00		
band 5			23.77				band 5			23.77					0.00	0.00		
band 6			6.96				band 6			6.96					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
PAE03 - Great Western/Pssu Staff	20 + 4	48.17	43.17	5.00	90%	10%	PAE03 - Great Western/Pssu Staff	20 + 4	48.17	43.17	5.00	90%	10%	0.00	0.00	0.00	0%	0%
band 3				5.00			band 3				5.00				0.00	0.00		
band 5			29.37			includes 1 x TNA	band 5			29.37			includes 1 x TNA		0.00	0.00		
band 6			12.80				band 6			12.80					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
band 8a			0.00				band 8a			0.00					0.00	0.00		
PAE07 - Paediatrics Icu	7 + 3	78.33	78.33	0.00	100%	0%	PAE07 - Paediatrics Icu	7 + 3	78.33	78.33	0.00	100%	0%	0.00	0.00	0.00	0%	0%
band 3							band 3								0.00	0.00		
band 5			49.77				band 5			49.77					0.00	0.00		
band 6			19.34				band 6			19.34					0.00	0.00		
band 7			9.22				band 7			9.22					0.00	0.00		
band 8a			0.00				band 8a			0.00					0.00	0.00		
PAE08 - Paediatric Outpatients	OPD	6.00	2.00	4.00	33%	67%	PAE08 - Paediatric Outpatients	OPD	6.00	2.00	4.00	33%	67%	0.00	0.00	0.00	0%	0%
band 3				4.00			band 3				4.00				0.00	0.00		
band 5			0.00				band 5			0.00					0.00	0.00		
band 6			1.00				band 6			1.00					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
PAE12 - Clinical Haematology / Phdu	5 + 5 + Ambulatory	5.40	4.40	1.00	81%	19%	PAE12 - Clinical Haematology/ Phdu	5 + 5 + Ambulatory	5.40	4.40	1.00	81%	19%	0.00	0.00	0.00	0%	0%
band 3				1.00			band 3				1.00				0.00	0.00		
band 4				0.00			band 4				0.00				0.00	0.00		
band 5			0.00				band 5			0.00					0.00	0.00		
band 6			3.40				band 6			3.40					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
band 8b			0.00				band 8b			0.00					0.00	0.00		
Gynaecology &		76.20	52.22	23.98	69%	31%	Gynaecology & Reproductive		76.20	52.22	23.98	69%	31%	0.00	0.00	0.00	0%	0%
58900 - Victor Bonney Ward	20 + 4 + DU (6 trolleys)	27.98	20.61	7.37	74%	26%	58900 - Victor Bonney Ward	20 + 4 + DU (6 trolleys)	27.98	20.61	7.37	74%	26%	0.00	0.00	0.00	0%	0%
band 2				7.37			band 2				7.37				0.00	0.00		
band 3				0.00			band 3				0.00				0.00	0.00		
band 5			16.61				band 5			16.61					0.00	0.00		
band 6			3.00				band 6			3.00					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
59000 - Gynaecology Outpatients	OPD	8.00	5.00	3.00	63%	38%	59000 - Gynaecology Outpatients	OPD	8.00	5.00	3.00	63%	38%	0.00	0.00	0.00	0%	0%
band 2				2.00			band 2				2.00				0.00	0.00		
band 3				1.00			band 3				1.00				0.00	0.00		
band 4				0.00			band 4				0.00				0.00	0.00		
band 5			4.00				band 5			4.00					0.00	0.00		
band 6			0.00				band 6			0.00					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
band 8a			0.00				band 8a			0.00					0.00	0.00		
64500 - Ivf Clinic	Ambulatory and Recovery	11.00	8.00	3.00	73%	27%	64500 - Ivf Clinic	Ambulatory and Recovery	11.00	8.00	3.00	73%	27%	0.00	0.00	0.00	0%	0%
band 2				1.00			band 2				1.00				0.00	0.00		
band 3				2.00			band 3				2.00				0.00	0.00		
band 5			2.00				band 5			2.00					0.00	0.00		
band 6			4.00				band 6			4.00					0.00	0.00		
band 7			2.00				band 7			2.00					0.00	0.00		
band 8a			0.00				band 8a			0.00					0.00	0.00		

GYN02 - Lillian Holland Ward	13 + Paintin	21.22	14.61	6.61	69%	31%	GYN02 - Lillian Holland Ward	13 + Paintin	21.22	14.61	6.61	69%	31%	0.00	0.00	0.00	0%	0%
band 2				5.61			band 2				5.61				0.00	0.00		
band 3				1.00			band 3				1.00				0.00	0.00		
band 5			9.61				band 5			9.61					0.00	0.00		
band 6			4.00				band 6			4.00					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
GYN06 - Gynae - Opd	OPD	8.00	4.00	4.00	50%	50%	GYN06 - Gynae - Opd	OPD	8.00	4.00	4.00	50%	50%	0.00	0.00	0.00	0%	0%
band 2				3.00			band 2				3.00				0.00	0.00		
band 3				1.00			band 3				1.00				0.00	0.00		
band 5			3.00				band 5			3.00					0.00	0.00		
band 6			0.00				band 6			0.00					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
Imaging		44.82	38.25	6.57	85%	15%	Imaging		44.82	38.25	6.57	85%	15%	0.00	0.00	0.00	0%	0%
63000 - Radiology Nursing	3 suites	44.82	38.25	6.57	85%	15%	63000 - Radiology Nursing	3 suites	44.82	38.25	6.57	85%	15%	0.00	0.00	0.00	0%	0%
band 2				6.57			band 2				6.57				0.00	0.00		
band 3				0.00			band 3				0.00				0.00	0.00		
band 5			17.25				band 5			17.25					0.00	0.00		
band 6			18.00				band 6			18.00					0.00	0.00		
band 7			3.00				band 7			3.00					0.00	0.00		
band 8a			0.00				band 8a			0.00					0.00	0.00		
band 8b			0.00				band 8b			0.00					0.00	0.00		
Maternity		416.82	322.94	93.88	77%	23%	Maternity		416.82	322.94	93.88	77%	23%	0.00	0.00	0.00	0%	0%
47100 - Caseload Midwives Smh/Qcch	0	19.00	18.00	1.00	95%	5%	47100 - Caseload Midwives Smh/Qcch	0	19.00	18.00	1.00	95%	5%	0.00	0.00	0.00	0%	0%
band 2				1.00			band 2				1.00				0.00	0.00		
band 3				0.00			band 3				0.00				0.00	0.00		
band 6			6.00				band 6			6.00					0.00	0.00		
band 7			12.00				band 7			12.00					0.00	0.00		
48700 - Fetal Medicine (4e)	0	8.84	5.22	3.62	59%	41%	48700 - Fetal Medicine (4e)	0	8.84	5.22	3.62	59%	41%	0.00	0.00	0.00	0%	0%
band 2							band 2								0.00	0.00		
band 3				3.62			band 3				3.62				0.00	0.00		
band 6			4.22				band 6			4.22					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
band 8a							band 8a								0.00	0.00		
50200 - Mdau & Triage	0	0.00	0.00	0.00	0%	0%	50200 - Mdau & Triage	0	0.00	0.00	0.00	0%	0%	0.00	0.00	0.00	0%	0%
band 3				0.00			band 3				0.00				0.00	0.00		
band 6			0.00				band 6			0.00					0.00	0.00		
band 7			0.00				band 7			0.00					0.00	0.00		
50300 - Specialist Midwives	0	0.00	0.00	0.00	#DIV/0!	#DIV/0!	50300 - Specialist Midwives	0	0.00	0.00	0.00	#DIV/0!	#DIV/0!	0.00	0.00	0.00	#DIV/0!	#DIV/0!
band 6			0.00				band 6			0.00					0.00	0.00		
band 7			0.00				band 7			0.00					0.00	0.00		
band 8a			0.00				band 8a			0.00					0.00	0.00		
band 8c			0.00				band 8c			0.00					0.00	0.00		
54700 - Qcch Labour Ward	19	86.59	72.45	14.14	84%	16%	54700 - Qcch Labour Ward	19	86.59	72.45	14.14	84%	16%	0.00	0.00	0.00	0%	0%
band 2				10.14			band 2				10.14				0.00	0.00		
band 3				4.00			band 3				4.00				0.00	0.00		
band 5			6.83				band 5			6.83					0.00	0.00		
band 6			47.46				band 6			47.46					0.00	0.00		
band 7			18.16				band 7			18.16					0.00	0.00		
band 8a				0.00			band 8a				0.00				0.00	0.00		
55500 - Smh Outpatients	OPD	6.23	2.61	3.62	42%	58%	55500 - Smh Outpatients	OPD	6.23	2.61	3.62	42%	58%	0.00	0.00	0.00	0%	0%
band 2				2.62			band 2				2.62				0.00	0.00		
band 3				1.00			band 3				1.00				0.00	0.00		
band 6			1.61				band 6			1.61					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
56100 - Edith Dare Ward	34	43.66	30.16	13.50	69%	31%	56100 - Edith Dare Ward	34	43.66	30.16	13.50	69%	31%	0.00	0.00	0.00	0%	0%
band 2				5.89			band 2				5.89				0.00	0.00		
band 3				7.61			band 3				7.61				0.00	0.00		
band 4				0.00			band 4				0.00				0.00	0.00		
band 6			27.16				band 6			27.16					0.00	0.00		
band 7			3.00				band 7			3.00					0.00	0.00		
56200 - Lewis Suite	14	21.09	15.92	5.17	75%	25%	56200 - Lewis Suite	14	21.09	15.92	5.17	75%	25%	0.00	0.00	0.00	0%	0%
band 2				3.17			band 2				3.17				0.00	0.00		
band 3				2.00			band 3				2.00				0.00	0.00		
band 6			9.92				band 6			9.92					0.00	0.00		
band 7			6.00				band 7			6.00					0.00	0.00		
56300 - Stanley Clayton Ward Priv Pats	8	13.44	8.27	5.17	62%	38%	56300 - Stanley Clayton Ward Priv Pats	8	13.44	8.27	5.17	62%	38%	0.00	0.00	0.00	0%	0%
band 2				0.00			band 2				0.00				0.00	0.00		
band 3				5.17			band 3				5.17				0.00	0.00		
band 6			5.27				band 6			5.27					0.00	0.00		
band 7			3.00				band 7			3.00					0.00	0.00		
band 8b			0.00				band 8b			0.00					0.00	0.00		
58800 - Birth Centre Qcch	7	22.35	17.18	5.17	77%	23%	58800 - Birth Centre Qcch	7	22.35	17.18	5.17	77%	23%	0.00	0.00	0.00	0%	0%
band 2				0.00			band 2				0.00				0.00	0.00		
band 3				5.17			band 3				5.17				0.00	0.00		
band 6			13.57				band 6			13.57					0.00	0.00		
band 7			3.61				band 7			3.61					0.00	0.00		
MAT01 - Smh Maternity Inpatients Ab2	34	0.00	0.00	0.00	#DIV/0!	#DIV/0!	MAT01 - Smh Maternity Inpatients Ab2	34	0.00	0.00	0.00	#DIV/0!	#DIV/0!	0.00	0.00	0.00	#DIV/0!	#DIV/0!
band 2				0.00			band 2				0.00				0.00	0.00		
band 3				0.00			band 3				0.00				0.00	0.00		
band 6			0.00				band 6			0.00					0.00	0.00		
band 7			0.00				band 7			0.00					0.00	0.00		
band 8a							band 8a								0.00	0.00		

MAT04 - Community	0	63.78	52.38	11.40	82%	18%	MAT04 - Community	0	63.78	52.38	11.40	82%	18%	0.00	0.00	0.00	0%	0%
band 3				11.40			band 3				11.40				0.00	0.00		
band 6			45.32				band 6			45.32					0.00	0.00		
band 7			7.06				band 7			7.06					0.00	0.00		
band 8a			0.00				band 8a			0.00					0.00	0.00		
MAT10 - Smh Maternity Inpatients Ab1/MDAU/Triage	13	90.14	70.89	19.25	79%	21%	MAT10 - Smh Maternity Inpatients Ab1/MDAU/Triage	13	90.14	70.89	19.25	79%	21%	0.00	0.00	0.00	0%	0%
band 2				5.80			band 2				5.80				0.00	0.00		
band 3				13.45			band 3				13.45				0.00	0.00		
band 6			52.89				band 6			52.89					0.00	0.00		
band 7			18.00				band 7			18.00					0.00	0.00		
MAT11 - Birth Centre Smh	5	16.92	11.75	5.17	69%	31%	MAT11 - Birth Centre Smh	5	16.92	11.75	5.17	69%	31%	0.00	0.00	0.00	0%	0%
band 3				5.17			band 3				5.17				0.00	0.00		
band 6			8.75				band 6			8.75					0.00	0.00		
band 7			3.00				band 7			3.00					0.00	0.00		
58700 - QCCH Outpatients	0	24.78	18.11	6.67	73%	27%	58700 - QCCH Outpatients	0	24.78	18.11	6.67	73%	27%	0.00	0.00	0.00	0%	0%
band 2				0.00			band 2				0.00				0.00	0.00		
band 3				6.67			band 3				6.67				0.00	0.00		
band 6			15.51				band 6			15.51					0.00	0.00		
band 7			2.60				band 7			2.60					0.00	0.00		
															0.00	0.00		
Outpatients		85.43	37.43	48.00	44%	56%	Outpatients		85.43	37.43	48.00	44%	56%	0.00	0.00	0.00	0%	0%
NE040 - Hh & Cxh Outpatients (CXH OPD)	OPD	37.83	18.83	19.00	50%	50%	NE040 - Hh & Cxh Outpatients (CXH OPD)	OPD	37.83	18.83	19.00	50%	50%	0.00	0.00	0.00	0%	0%
band 2				0.00			band 2				0.00				0.00	0.00		
band 3				16.00			band 3				16.00				0.00	0.00		
band 4				3.00			band 4				3.00				0.00	0.00		
band 5			13.43				band 5			13.43					0.00	0.00		
band 6			4.40				band 6			4.40					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
OPD01 - Smh & Sch Outpatients (SMH OPD)	OPD	24.80	10.80	14.00	44%	56%	OPD01 - Smh & Sch Outpatients (SMH OPD)	OPD	24.80	10.80	14.00	44%	56%	0.00	0.00	0.00	0%	0%
band 2				0.00			band 2				0.00				0.00	0.00		
band 3				12.00			band 3				12.00				0.00	0.00		
band 4				2.00			band 4				2.00							
band 5			7.80				band 5			7.80					0.00	0.00		
band 6			2.00				band 6			2.00					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
GM 140 - Medicine General Outpatients (HH OPD)	0	22.80	7.80	15.00	34%	66%	GM 140 - Medicine General Outpatients (HH OPD)	0	22.80	7.80	15.00	34%	66%	0.00	0.00	0.00	0%	0%
band 2				0.00			band 2				0.00				0.00	0.00		
band 3				13.00			band 3				13.00				0.00	0.00		
band 4				2.00			band 4				2.00				0.00	0.00		
band 5			4.80				band 5			4.80					0.00	0.00		
band 6			2.00				band 6			2.00					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		

IMPERIAL PRIVATE HEALTHCARE - ESTABLISHMENT DATA SEPTEMBER 2020							IMPERIAL PRIVATE HEALTHCARE - ESTABLISHMENT DATA MARCH 2021							Differences SEPTEMBER 2020 to MARCH 2021				
Clinical area	Number of beds	Total registered nurse and unregistered care staff	Registered nurse and unregistered care staff breakdown		Registered nurse to unregistered care staff ratio		Clinical area	Number of beds	Total registered nurse and unregistered care staff	Registered nurse and unregistered care staff breakdown		Registered nurse to unregistered care staff ratio		Difference in overall Totals (WTE)	Difference (WTE) Staff Type and Banding		Difference in ratio	
			RN	CS	RN	CS				RN	CS	RN	CS		RN	CS	RN	CS
OVERALL TOTAL		199.50	156.37	43.13	78%	22%	OVERALL TOTAL		192.28	153.15	39.13	80%	20%	-7.22	-3.22	-4.00	0.01	-0.01
Charing Cross Private Patients		46.62	39.01	7.61	84%	16%	Charing Cross Private Patients		44.62	39.01	5.61	87%	13%	-2.00	0.00	-2.00	4%	-4%
PR010 - Pp Cx - Thames View	19 + 10 (currently closed)	46.62	39.01	7.61	84%	16%	PR010 - Pp Cx - Thames View	19 + 10 (currently closed)	44.62	39.01	5.61	87%	13%	-2.00	0.00	-2.00	4%	-4%
band 3				7.61			band 3				5.61				0.00	-2.00		
band 5			19.40				band 5			19.40					0.00	0.00		
band 6			14.61				band 6			14.61					0.00	0.00		
band 7			5.00				band 7			5.00					0.00	0.00		
band 8A							band 8A								0.00	0.00		
band 8b							band 8b								0.00	0.00		
Hammersmith Private Patients		44.22	37.22	7.00	84%	16%	Hammersmith Private Patients		41.00	34.00	7.00	83%	17%	-3.22	-3.22	0.00	-1%	1%
84100 - Pp Hh Lisa Sainsbury Wing	26	44.22	37.22	7.00	84%	16%	84100 - Pp Hh Lisa Sainsbury Wing	26	41.00	34.00	7.00	83%	17%	-3.22	-3.22	0.00	-1%	1%
band 3				7.00			band 3				6.00				0.00	-1.00		
band 4				0.00			band 4				1.00				0.00	1.00		
band 5			19.00				band 5			15.00					-4.00	0.00		
band 6			14.22				band 6			15.00					0.78	0.00		
band 7			4.00				band 7			4.00					0.00	0.00		
band 8A							band 8A								0.00	0.00		
Lindo Wing St. Marys		108.66	80.14	28.52	74%	26%	Lindo Wing St. Marys		106.66	80.14	26.52	75%	25%	-2.00	0.00	-2.00	1%	-1%
LIN04 - Lindo Maternity	11 + 5 labour beds	52.28	32.76	19.52	63%	37%	LIN04 - Lindo Maternity	11 + 5 labour beds	52.28	32.76	19.52	63%	37%	0.00	0.00	0.00	0%	0%
band 3				12.61			band 3				12.61				0.00	0.00		
band 4				6.91			band 4				6.91				0.00	0.00		
band 6			19.23				band 6			20.23					1.00	0.00		
band 7			12.53				band 7			11.53					-1.00	0.00		
band 8a			1.00				band 8a			1.00					0.00	0.00		
LIN05 - Lindo Nursing	13 + 5 day case + 5 escalation	36.38	29.38	7.00	81%	19%	LIN05 - Lindo Nursing	13 + 5 day case + 5 escalation	34.38	29.38	5.00	85%	15%	-2.00	0.00	-2.00	5%	-5%
band 3				6.00			band 3				4.00				0.00	-2.00		
band 4				1.00			band 4				1.00				0.00	0.00		
band 5			20.38				band 5			20.38					0.00	0.00		
band 6			8.00				band 6			8.00					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		
band 8a							band 8a								0.00	0.00		
band 8b							band 8b								0.00	0.00		
LIN08 - Lindo Theatres		20.00	18.00	2.00	90%	10%	LIN08 - Lindo Theatres		20.00	18.00	2.00	90%	10%	0.00	0.00	0.00	0%	0%
band 3				2.00			band 3				2.00				0.00	0.00		
band 5			4.00				band 5			4.00					0.00	0.00		
band 6			13.00				band 6			13.00					0.00	0.00		
band 7			1.00				band 7			1.00					0.00	0.00		

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Pathway to Excellence

Agenda item 18 and paper number 15

Lead Executive Director: Janice Sigsworth, Director of Nursing
Authors: Andrew Worthington, Michael Underwood

Purpose: For discussion and support

Meeting date: 15 September 2021

Executive Summary

1. Purpose of this Report

1.1. This paper provides an overview of the Pathway to Excellence, PtE® programme, which is being relaunched following a delay due to the Covid-19 pandemic. The report was discussed and supported by the People Committee.

2. Introduction and background

2.1 The Chief Nursing Officer for England's national vision is to establish an England-wide collective leadership model with a focus on transformational leadership, research and innovation. Supported by NHS England and NHS Improvement (NHSE/I), Imperial College Healthcare Trust (ICHT) is one of 14 Trusts in England selected to participate in the American Nurse Credentialing Centre (ANCC) Pathway to Excellence® (PtE®) programme, which is recognised as aligning with this vision of collective leadership.

2.2 Recognising the benefits of collective leadership in supporting and enhancing practice and improving staff wellbeing, NHSE/I approached organisations to express an interest in joining the first cohort to apply for PtE® accreditation. In addition to participating in a globally renowned accreditation programme, the Trust will also benefit from progressive nursing and midwifery leadership, advanced evidence-based care, better outcomes for patients and a more positive workplace.

2.3 The programme provides a framework for organisations to create a positive, healthy work environment for nurses and midwives and to promote nursing and midwifery excellence. Utilising a model of collective ownership, and involving nurses and midwives at all levels in decision making processes, clinical practice is developed and improved. NHS England state the programme delivers impressive results, and organisations that have achieved accreditation have seen a reduction in nursing vacancies, pressure ulcer rates, nursing complaints and improvements in national inpatient survey results.

2.4 Implementation was paused during the first two waves of the Covid-19 pandemic. The programme has now been relaunched to underpin the reset and recovery work, the Ward Accreditation Programme (WAP+), to build on our many successes, and to support our

ambition to achieve excellence at ICHT. The Executive Management Board has been briefed and approved establishment of a steering group to oversee the programme.

2.5 PtE® is a global Nursing and Midwifery (N&M) programme that requires sustained commitment from the whole organisation. To achieve accreditation, the Trust must provide a portfolio of evidence showing we have met the following six standards:

- Shared Decision Making
- Leadership
- Safety
- Quality
- Well-being
- Professional Development

Each standard is comprised of a set of examples that the Trust will need to provide evidence (Elements of Performance/EOP) to demonstrate how we are meeting them.

A comprehensive description and examples of how these standards can be met is included in the Pathway Standards manual, which is available from Melanie Woodfield-Bailey, Executive Assistant, melanie.woodfield-bailey@nhs.net or Andrew Worthington, Deputy Chief Nurse, Andrew.worthington2@nhs.net

2.6 The ANCC set specific PtE® application and submission cycles, for example, final submission of evidence is required 12 months post application. The PtE® steering group will make recommendations on application timeframes.

3. Progress and next steps

3.1 To date, progress with implementing the programme include:

- Recruitment to a lead facilitator post, a shared governance facilitator, and a project manager. This team have all been redeployed during the pandemic response.
- Established a steering group to provide leadership and oversight for the whole programme. The first steering group meeting is scheduled for 26 August and includes stakeholders from the clinical divisions, P&OD, communications, and the strategic lay forum.
- The principles of PtE® have been socialised and promoted at relevant meetings
- The PtE® standards have informed the revised WAP+

4. Recommendations

4.1 The Board is asked to note the update and support the proposals set out in this paper.

Main Paper

5. Key points

5.1 PtE® is founded on six core standards as described below:

5.2 Shared Decision Making – PtE® organisations have an established shared governance structure that involves N&M of all levels in decision making. This approach positively influences decisions about care, recruitment, and nursing practice. Inter-professional collaboration is a key enabler to workforce engagement, promotion of new technology and

has a positive impact on population health. It reflects NHS England's strategy to establish a shared leadership model.

5.3 Leadership – successful organisations foster a culture of collaboration and N&M leaders actively engage frontline staff in decisions about resources, quality and cost improvement. Leaders should be accessible to the frontline workforce and have a bespoke programme of development that has been tailored to their needs.

5.4 Safety – accredited organisations will protect the safety and wellbeing of N&M, staff and patients through effective safety policies and processes. N&M will work collaboratively with other professional groups to address fluctuations in patient acuity and transfers of care. The organisation will develop a culture that is free from incivility, bullying and violence in the workplace.

5.5 Quality – through inter-professional collaboration and benchmarking, the organisation will develop initiatives that are evidence-based and focussed on making improvements in patient and population health outcomes. Creating a culture of personal and family centred care is driven by a strong mission, vision, goals and values.

5.6 Well-being – staff well-being is an essential component of any successful PtE® application. All levels of N&M staff should be involved in the selection, planning and evaluation of staff wellbeing initiatives. Nurse leaders foster a culture of day-to-day recognition, and measures to combat both physical and compassion fatigue are implemented. Supporting staff through adverse incidents is prioritised. This approach has been shown to benefit recruitment and retention rates, and more involved, motivated and confident staff.

5.7 Professional development - PtE® organisations recognise the value of lifelong learning, ongoing education and professional development. A commitment to comprehensive and bespoke orientation, mentorship, preceptors and access to N&M experts, combined with leadership development and succession planning all contribute to delivering safe and effective care.

6. Key milestones and next steps

6.1 **Organisational self-assessment and gap analysis** – review current PtE® manual and assess readiness to proceed. Based on the gap analysis, decide on key areas for focussed improvement, and make a decision about which site we will implement PtE®.

6.2 **Organisational Demographic form (ODF)** – is a data collection exercise which is required prior to applying to be on the programme. It involves recording the number of registered nurses (budgeted vs employed), educational qualifications, and data on vacancy, turnover and skill mix. The PtE® team will need support from People Planning and Healthroster teams to collect and validate this data.

6.3 **Communication Plan** – A robust communication plan will be developed and implemented to market the value, impact and opportunity attached to the PtE® programme. Support will be needed from the Communications team throughout all stages of the programme to promote the programme, maintain awareness, support with surveys, and proof reading of portfolio submissions.

6.4 **Ward Accreditation** – The six PtE® standards will be embedded into the WAP process, creating an enabler for the sustainability of excellence in N&M. The WAP process will be a valuable repository of evidence demonstrating compliance with the six standards.

6.5 **Shared Decision Councils**

6.5.1 Shared Decision Councils (SDCs) provide the opportunity for nurses and midwives who provide direct care to participate in the decision-making process that influences care delivery, workflow, recruitment, wellbeing, and product evaluation**.** This supports the fundamental PtE® culture of shared governance which is integral to achieving accreditation**.**

6.5.2 The PtE® corporate team will support divisions in establishing 'pilot' shared decision councils, advising on implementation and ensuring good governance. Guidance on structure and role descriptions will be provided. Training on chairing and minute taking will be made available.

6.5.3 Following the pilot phase a full evaluation will take place through Back to the Floor and other forums. Any improvements will be implemented prior to a full roll out planned for January 2022.

6.5.4 Examples of councils include**:**

- Unit Practice Council – (one ward/clinical area only) A unit council will meet monthly and tend to have an average of 4-6 members of staff across Bands 2-6, and will use measurable outcomes to achieve and evaluate improvements that are meaningful to patients and staff within their clinical areas.
- Speciality Council – (wards/clinical areas that are within the same speciality or multi-site speciality e.g. children's services or Trauma pathway). The council will sit monthly and have 2-3 members of staff per ward / unit representing their area.
- Themed Council – (Trust-wide representing a group of staff or particular topic/theme such as wellbeing, evidence-based practice, research, care planning or equality and diversity e.g. BAME, LGBT) They will use Shared Governance principles to formulate discussions and actions
- Leadership Council – exists to support the frontline staff councils described above, to develop and push forward their agendas. This is normally chaired by the Chief Nurse (or Deputy). The shared decision facilitator employed within the PtE® team will liaise between the unit practice, speciality and themed councils, attending the Leadership Council to report on their work and to take part in strategic discussion and decision making for the Trust. Completed initiatives will be celebrated at leadership council.

6.5.5 It is proposed that the Nursing & Midwifery Professional Practice Committee (N&M PPC) provides oversight and replicates the leadership council model. N&M PPC will need to dedicate one hour every four to six weeks to receive feedback from the unit, themed and speciality councils.

6.6 Nursing and Midwifery Recognition scheme

6.6.1 A dedicated N&M reward scheme is required as part of the PtE® accreditation. An options appraisal to consider how this will be delivered will be presented to the steering group in August 2021. This could be through further development of the current Trust 'Making a Difference' scheme or through the implementation of a bespoke N&M scheme in collaboration with P&OD.

6.7 Nursing and Midwifery Strategy

6.7.1 The development of an N&M strategy is a requirement of the programme. Shared decision councils and focus groups will act as enablers to the development of the new strategy which will include a vision and mission statement. These focus groups will also support the completion of the gap analysis. Support from the communications team in design and circulation will be needed.

6.8 Nursing and midwifery survey

6.8.1 At the end of the programme, an independent survey of all N&M is administered to demonstrate a positive culture, and to support the evidence submitted by the organisation.

6.8.2 The survey will be undertaken approximately three months after final document submission. It is vital throughout the survey period that staff are encouraged to complete it to achieve the required 60% response rate. Divisions will be supported in collaboration with communications team, to participate in engaging activities to encourage completion.

6.8.3 Learning from other UK accredited organisations is that Information Technology (IT) support is fundamental, e.g. IPad's for survey completion and access to computers available at key locations.

6.8.4 The ANCC recommends that at the start of the Pathway programme, a pre–survey is administered to assess staff views of the practice environment in relation to each of the six standards. The results of the survey will enable the formulation of an action plan to address areas for development that will support a successful survey at the end of the programme.

7.0 Programme Governance

7.1 The steering group will be the main group overseeing the delivery of the programme. It will report to the N&M Professional Practice Committee and to the Executive Management Board and Trust Board at regular intervals**.**

8.0 Risks

8.1 The prolonged impact of the Covid-19 response and seasonal operational pressures within the Trust, may result in disruption to the effective implementation of the programme.

9. Conclusion

9.1 The implementation of this programme at the Trust, and being awarded with accreditation, supports our ambition to achieve excellence and quality, and to provide a safe and positive work environments for nurses and midwives and the wider organisation.

9.2 The People Committee are asked to note the update and approve the next steps.

10. Impact assessment

- Quality impact: As described in the body of this paper, the overall aim of the programme is to improve the quality of care to patients and their families, by recognising and celebrating nursing and midwifery excellence and involving direct-care nurses and midwives in decision making.
- Financial impact: There is no financial impact associated with this report. Successful accreditation in the programme will improve recruitment and retention.
- Workforce impact: There are no requirements for additional workforce as part of the programme currently. There are recognised benefits from achieving accreditation, such as improvements in wellbeing and retention.
- Equality impact: Not applicable
- Risk impact: The risk of the programme being suspended or disrupted due to Covid-19 has been described in the body of the paper.

Andrew Worthington, Deputy Chief Nurse
Michael Underwood, Pathway to Excellence® Facilitator
26 August 2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

3

Paper title: 2020-21 Annual Responsible Officer Report

Agenda item 19 and paper number 16

Lead Executive Director(s): Julian Redhead (Medical Director, Responsible Officer)
Author(s): Teena Ferguson (Deputy Chief of Staff), Roseanne Meacher (Delegated Responsible Officer)

Purpose: For approval

Meeting date: 15 September 2021

Executive summary

1. Purpose of this report

1.1. As a designated body, the Trust is required to provide NHS England with an annual report on the revalidation of medical staff and the activities undertaken by the Responsible Officer (RO) over the previous year. This is to provide both board-level and external assurance on medical governance procedures. The report has been discussed and accepted by the People Committee and presented to Trust Board for approval.

2. Background

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

2.2. Licensed doctors revalidate by having an annual appraisal (based on the GMC core guidance for doctors, Good medical practice), and a five-yearly recommendation from their Responsible Officer.

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

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

- Annual Organisational Audit (AOA) End of Year Questionnaire return to NHS England (suspended in 2019/20 and 2020/21 by NHSE in response to the Covid-19 pandemic)
- An Annual Report to the Trust Board on compliance with these standards (appendix 1).
- Annual Statement of Compliance made by the Trust Board to NHS England.

3. Key findings

3.1. Appendix 1 is the annual report and statement of compliance against the FQA standards. The report demonstrates that the Trust meets the requirements for compliance with the FQA standards and that it meets its statutory duty to support the RO to discharge their duties. The report describes how the standards are met by the organisation and this should provide the assurance required for the Trust board to sign the statement of compliance.

3.2. Over the last year, the Covid-19 pandemic has affected how we run our 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.

3.3. The key action over the last year has been 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. Over the next 12 months we will focus on implementing the new system and maximising its benefits, and ensuring that appraisal and revalidation returns to business as usual. Due to the migration to the new system, we are not currently reporting data on our appraisal rate. Once the transition period is complete we will begin reporting again and we expect performance to return to pre-pandemic levels (over 95%) over the course of the year.

3.4. Other priority focuses for the year ahead include a review of how we report data and outcomes relating to the professional development of doctors now that our new committee structures for P&OD related issues and processes have been implemented. This will include an improved process for reporting on concerns about doctors to the People Committee (sub-committee of the trust board), including the progress and outcomes of any investigations, and information on protected characteristics.

4. Next steps

4.1. Approval by the Trust Board will enable sign off and submission to NHSE by the end of September 2021.

5. Recommendation(s)

5.1. The Trust Board is asked to approve this report and confirm they are satisfied that we are compliant with the Responsible Officer regulations.

6. Impact assessment

6.1. Quality impact: There is a statutory requirement for the RO to produce an annual report. Medical revalidation aims to improve standards, safety and promote trust in the medical profession. The CQC domains that will be improved by this paper are safe, effective and well-led.
6.2. Financial impact: A recurrent budget is in place to support annual appraisal and revalidation.
6.3. Workforce impact: N/A
6.4. Equality impact: N/A. No decision is being requested in this paper.
6.5. Risk impact: There are no risks identified in this report.

Appendices: Responsible Officer Annual Board Report 2020-21

Author: Teena Ferguson (Deputy Chief of Staff), Roseanne Meacher (Delegated RO)
Date 2nd August 2021

Appendix 1

Designated Body Annual Board Report

Section 1 – General:

The board of Imperial College Healthcare NHS Trust can confirm that:

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

Date of AOA submission: NA. For 2019/20 and 2020/21, NHSE removed the requirements for trusts to complete the AOA due to the Covid-19 pandemic.

Action from last year: In June 2021, we implemented a new electronic appraisal and revalidation system, L2P, following a tendering process which took place throughout 2020/21. The new system combines appraisal and job planning and is more user-friendly. Training is being provided to doctors on the new system, which should improve the quality and experience of the appraisal process and ensure our data reporting is more robust.

Comments: Pre-pandemic, we were reporting over 95% compliance with annual appraisal completion. In April 2020, the RO authorised an automatic extension of four months for all appraisals, to allow doctors to focus on clinical work in response to the pandemic. The process was restarted in September 2020 and cases were assessed individually and further extensions granted where necessary. The process was suspended between January-February 2021 in response to the second surge and restarted in March 2021. Due to the migration to the new system, we are not currently reporting data on our appraisal rate. Once the transition period is complete we will begin reporting again and we expect performance to return to pre-pandemic levels (over 95%) over the course of the year.

Action for next year: Over the next 12 months we will focus on embedding the new system and on ensuring that appraisal and revalidation returns to business as usual. We will submit the AOA in line with requirements.

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

Action from last year: NA

Comments: Yes. Professor Julian Redhead is the Trust's Responsible Officer. Dr Roseanne Meacher, Associate Medical Director for Professional Development, was appointed as the delegate RO in December 2019 dealing with daily revalidation and operational issues. Dr Ruth Brown, Associate Medical Director, Medical Education, was appointed as the delegate RO for doctors in training. All three have completed the required training.

Action for next year: NA

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

Action from last year: NA

Comments: There were no funding or resourcing issues to report in the last year and none anticipated in the current year. The Trust has provided sufficient funds to cover the cost of 4 PAs of consultant time for the delegated RO role and SPA time for Trust Appraisers. There is recurrent funding for the appropriate job planning, appraisal and revalidation system and a small budget to cover the costs for the professional development team and to provide quarterly appraiser refresher training.

Action for next year: N/A

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

Action from last year: NA

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

Action for next year: N/A

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

Action from last year: NA

Comments: Yes. The Trust appraisal and revalidation policy has been widely disseminated and is located on the intranet. It is currently undergoing review and will be subject to consultation with clinical divisions, HR and the Local Negotiating Committee (LNC) before it is approved and ratified.

Action for next year: We will complete the review process and ensure the updated policy is ratified, published on the intranet, and communicated across the organisation.

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

Action from last year: NA

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

The Trust now has six appraisal leads, with quarterly meetings arranged with the RO. As the Trust emerges from the pandemic the whole team will develop a focussed plan to support doctors to complete appraisals on schedule, whilst acknowledging the growing elective lists and so being flexible by offering deferrals when required.

Action for next year: N/A.

7. **A process is in place to ensure locum or short-term placement doctors working**

in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: NA

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

Doctors who are employed for less than 6 months are required to compete their appraisal using the GMC MAG form and this is uploaded into the Trust's L2P system for compliance reporting. Doctors who are employed for over 6 months are required to complete a Trust appraisal using the L2P system as per the Appraisal Policy. Ad hoc MPIT forms are done at the request of other organisations.

Action for next year: To collaborate with Health Education England to maximise the support we offer to doctors, including those in training who take a specific period of time out of programme.

Section 2 – Effective Appraisal

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

Action from last year: N/A

Comments: Yes. The Trust uses an electronic revalidation management system (L2P) which offers doctors a platform to complete annual appraisals for revalidation. This includes the doctor's full scope of work, fitness to practise, complaints, significant events and outlying clinical outcomes. Datix reports are also used to strengthen the portfolio of evidence for revalidation. As part of the assurance process for revalidation, the PD team ensures that appraisals are robust and meet the GMC requirements.

At the height of the pandemic the appraisal and revalidation process was suspended and the Medical Director also authorised a "Professional Development curtailment period" from 25 January 2021 until the end of February to allow doctors to focus on clinical activity during the second surge. Resources from the RO network were disseminated to all consultants, which provided details of how to access support and help as required. Appraisers were encouraged to 'check-in' with their appraisee and to signpost them to the appropriate support.

The RO recognised that for those doctors who wished to continue with their revalidation, it would be more difficult to gather patient feedback and agreed that the required number of patient submissions for a revalidation recommendation should

reduce from 34 to 15. SARD, our previous multisource feedback provider, which has a patient feedback report mechanism was used to generate reports and additionally a coversheet option, designed by the RO and aggregating all data, could also be utilised.

Action for next year: In June 2021 we launched a new system, called L2P, for appraisal and revalidation, which as we emerge from the pandemic will support and improve our current processes and procedures. The system includes a patient feedback mechanism with the option of providing a response via an online link or via paper, which should make the process easier and more robust for both doctors and patients who complete the feedback.

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

Action from last year: NA

Comments: Yes. In the event that an appraisal lacks the requirements to meet the GMC standards, the professional development team would alert the RO who would review and make a recommendation to the individual doctor.

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

Action for next year: An audit will be completed to make sure that all required information is being captured in an appropriate way.

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

Action from last year: NA

Comments: Yes. The Appraisal and Revalidation policy is compliant with national policy and was ratified and published in 2018. It is currently undergoing review and will be subject to consultation with clinical divisions, HR and the Local Negotiating Committee (LNC) before it is approved and ratified.

Action for next year: We will complete the review process and ensure the updated policy is ratified, published on the intranet, and communicated across the organisation.

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

Action from last year: NA

Comments: Yes. The Trust has 300 accredited appraisers and so is compliant with the NHS England recommended ratio of trained appraisers to carry out timely annual medical appraisals for all our licensed medical practitioners (1:5). Each appraiser commits to delivering at least 5 appraisals per annum and SPA time is ring-fenced in job plans.

The Trust supports appraisers to fully undertake their role through the provision of accredited training courses. In 2020/21, we commissioned the Royal College of Physicians to deliver three appraiser training sessions, which were attended by 61 doctors.

Action for next year: N/A.

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

Action from last year: NA

Comments: Yes. Following the recommendations from the HLRO visit, the Trust now has six appraisal leads in post, which provides additional scope for peer review and support of appraisers. The RO continues to work closely with the appraisal leads on programmes supporting the development of appraisers, raising the profile of professional development. This included establishing focus groups for the procurement of the new electronic appraisal system (L2P). The appraiser's appraisal is also a forum through which there can be reflective discussion on performance. As previously noted, the Trust offers training/refresher courses to consultants, the most recent was delivered by the RCP in March 2021.

Action for next year: Our training programme is currently being reviewed and refreshed for 2021/22.

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

Action from last year: NA

Comments: Yes.

In 2018, NHS England conducted their Higher Level RO Quality Review Visit. The outcome and actions were reported in the 2018/19 annual report to the Board.

Under normal conditions, the Trust participates in the AOA, which is then reported to the Trust Board as an appendix to the RO report, but due to the pandemic this was not required in 2019/20 or 2020/21.

Following agreed changes to our executive routines and board governance through the Imperial management and improvement system (IMIS), monthly appraisal compliance data is included in the people scorecard, which reports to EMB people group, and to the People Committee (sub-committee of the Trust Board) as part of the workforce report. There are also monthly appraisal performance meetings with the RO and Medical Director at which key compliance metrics are reviewed.

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

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

Action for next year: We will review and improve how we report data and outcomes relating to the professional development of doctors now that our new committee structures for P&OD related issues and processes have been implemented.

Section 3 – Recommendations to the GMC

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

Action from last year: NA

Comments: Yes**.** The pandemic had a significant impact on the number recommendations as doctors focussed on the clinical response to Covid-19. 148 Trust revalidations and 28 deferrals have been approved by the GMC since 1st March 2020.

As we emerge from the pandemic, revalidation notices will be sent via internal email six months to one year ahead of the doctor's revalidation date, in advance of the 'under notice' period. There will be focussed communication from the PD team to support the doctor in gathering their evidence and preparing for their final appraisal before revalidation. By focussing on doctors individually, the PD team effectively manages the revalidation process and can highlight any potential deferrals in advance. All deferrals are made in exceptional circumstances and are all sanctioned by the RO.

Action for next year: NA

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

Action from last year: NA

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

Action for next year: NA

Section 4 – Medical governance

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

Action from last year: NA

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

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

Action for next year: NA

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

Action from last year: NA

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

Action for next year: NA

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

Action from last year: NA

Comments: Yes.

The Trust has a policy for responding to concerns about a doctor's practice, 'Handling Concerns About Doctors and Dentists' Conduct, Performance and Health' which is based on the Maintaining High Professional Standards (MHPS) framework. This policy was ratified in 2018 and provides details, including flow charts, on every stage of the process. The policy also describes the key personnel required in the membership of panels for hearings, the appeals procedure and the role of external or independent panel members. It is currently undergoing review and will be subject to consultation with clinical divisions, HR and the Local Negotiating Committee (LNC) before it is approved and ratified

In addition, cases are discussed with Practitioner Performance Advice (PPA) where appropriate.

Action for next year: NA

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

Action from last year: NA

Comments: Yes.

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

Internally, there is a fortnightly case review meeting which is attended by the medical director and P&OD director to review all active cases, and to ensure progress is being made against timelines.

We have an internal tracker which we use to record any concerns raised about a doctor, the type and status of each investigation. Through links with the L2P system, we can also monitor other aspects, such as protected characteristics.

Action for next year: Now that our committee structures have been reviewed and a new set of meetings implemented for P&OD related processes and issues, we will develop an improved process for reporting on concerns about doctors to the People Committee (sub-committee of the trust board), including the progress and outcomes of any investigations, and information on protected characteristics.

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

Action from last year: NA

Comments: Yes. The organisation is fully committed to working in partnership with other organisations, and to cooperate with investigating any concerns raised about doctors. There are systems in place to share information with external organisations

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

when required, ensuring principles for data protection are adhered to. MPIT forms are used routinely to share information between organisations.

The records of local investigations and management of concerns are stored electronically. All appraisal and revalidation information is stored in the L2P electronic database.

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

Action for next year: NA

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

Action from last year: NA

Comments: Yes. All cases are assessed on an individual basis with consideration given to the nature of the concerns raised before a decision is made as to whether to proceed informally or formally.

Decision making group meetings are used to support the process in cases which are borderline/complex or contentious whilst panels encompassing lay representation/NED involvement are assembled to inform on how to proceed with the cases and scrutinise investigation findings.

The organisation utilises both the GMC ELO and PPA to discuss concerns, and there is a full-time HR Consultant within the Medical Director's Office to support the MHPS process, and twenty trained investigators in place.

Active cases are reviewed at fortnightly meetings which the Medical Director and P&OD Director attend.

Finally all staff in the Trust have access to Freedom to Speak Up guardians.

Action for next year: NA

Section 5 – Employment Checks

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

Action from last year: NA

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

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

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

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

Action for next year: We are in the process of reviewing the consultant induction programme and the consultant on-boarding process.

Section 6 – Summary of comments, and overall conclusion

1. **Please use the Comments Box to detail the following:**

Due to the pandemic, over the last year we have largely focused on maintaining our current processes. The key action from last year was to implement a new electronic revalidation management and job planning system. This was launched in June 2021 following a retendering process. The main benefit of the new system is that it encompasses both appraisal and job planning which maximises efficiency for its users. The system should also improve the quality of appraisals and ensure our data reporting is more robust. The roll-out has been supported by a communications campaign and a series of webinars. Our current focus is on embedding the new system and ensuring that appraisal and revalidation returns to business as usual over the next 12 months.

Overall conclusion:

This report provides a detailed response to the Framework of Quality Assurance standards as determined by the Responsible Officer regulations and NHS England. We are stating compliance with the standards required of a designated body.

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

Section 7 – Statement of Compliance:

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

Signed on behalf of the designated body

Official name of designated body:

Imperial College Healthcare NHS Trust

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

Role: Chief executive

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

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Audit, Risk & Governance Committee report

Agenda item 20.1 and paper number 17a

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

Purpose: For information

Meeting date: 15 September 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 9 September 2021 include:

3.1.1. External Audit

The Committee received a post audit review following the 2020/21 annual report and accounts process and were pleased to note the lessons learned and planned improvements to ensure a smoother process the following year, taking into account the many challenges that the audit and finance teams had faced following an extraordinary year due to Covid. The Committee also reviewed and approved the External Audit Annual Report for 2020/21 which included the new National Audit Office requirements. Committee members were pleased to note that there were no significant weaknesses identified by the auditors under the Value for Money assessment.

3.1.2. Internal audit

The Committee noted the internal audit progress report noting a proposed change to the plan which deferred the directorate governance audit to allow for some focused advisory work around technology assurance including cyber security. An output of this work would also include an agreed template that could be used for assurance frameworks for other key areas of risk across the Trust; Committee members supported the proposed change to the plan and noted the terms of reference for the technology assurance review.

The Committee also 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.

3.1.3. **Risk and assurance update**

The Committee reviewed and discussed the Acute Programme risk register, noting that this was still a work in progress as the programme was in its embryonic stages; Committee members agreed that it would be useful to seek feedback from Audit Committees across the other acute providers. It was agreed that updates on the Integrated Care System and the Acute Collaborative would be presented to the Committee as a standing item at each meeting.

The Committee reviewed the Trust risk and assurance report and noted the work in progress to develop the strategic risks. Discussions with Committee Chair's regarding the implementation of risk appetite at board committee level continued. Committee members reviewed the deep dive discussions that had taken place in the other Board committee's and noted that there had been additional Board briefing sessions regarding redevelopment that had provided additional assurance. The Committee discussed the development of emerging and strategic risks previously identified and noted that these would be presented at the next meeting.

3.1.4. **Health and safety deep dive**

The Committee had a 'deep dive' discussion about health and safety across the Trust. The draft health and safety governance framework set out the current processes and assurances in place; it was agreed that there were some gaps to address including improved integrated reporting to relevant Board committees. Further work to agree the audit and risk universe around health and safety and to finalise the governance framework would take place and be presented back to the Committee in November. The variation in action updates and mitigations relating to health and safety risks would be addressed through the directorate and divisional governance work to standardise governance processes including risk management, however the Committee were assured that current processes for reviewing health and safety risks were robust and ensured the safety of patients, staff and members of the public.

The Committee received and discussed the annual fire safety report and were pleased to note the assurances around fire safety and welcomed the continuing work to maintain compliance with the Fire Code throughout the pandemic.

3.1.5. **Committee annual report 202/21**

Committee members reviewed the Committee annual report for 2020/21 noting that despite the challenges of the Covid pandemic over the past year, as well as changes in Non-Executive membership and all meetings taking place virtually, that the Committee had continued to be effective in delivering its duties. Committee members noted the outcome of the effectiveness review and the areas of improvement including ongoing work to improve the quality and timeliness of papers and agenda planning. Noting that the Audit, Risk and Governance Committee is the overarching governance Committee of the Board, a report along with a thematic action plan would be presented for discussion at the November meeting.

3.1.6. **Losses and special payments**

The Committee noted the losses and special payments approved in the first quarter of 2021/22 and were pleased to note a decrease since quarter 4 of the previous year.

Imperial College Healthcare NHS Trust

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

Jessica Hargreaves, Deputy Trust Secretary
9 September 2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Quality Committee Report

Agenda item 20.2 and paper number: 17b

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

Purpose: Information

Date of meeting: Wednesday 15 September 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 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 09 September 2021 include:

3.1.1. **Risk and Assurance Deep Dive – National Patient Safety Strategy and Gap analysis deep dive**

The Committee reviewed the National Patient Safety Strategy and Gap analysis deep dive noting despite the pandemic, much of the work the Trust had commenced in 2019 in response to the national strategy has either been implemented, or was now in progress. The Committee noted that the Trust had completed a lessons learnt exercise which highlighted that the Trust's compliance in line Infection Prevention and Control had improved significantly. Committee members were reassured that the Trust's safety improvement plans were progressing and were focused on the key areas of risk.

3.1.2. **Intensive Care Unit (ITU) Outcomes deep dive**

The Committee reviewed the ITU outcomes deep dive noting the Trust's response to the COVID-19 pandemic and the lessons learnt through each stage. The Committee expressed their gratitude to all staff working in the Intensive Care Units noting the ongoing difficulties faced during the pandemic.

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. **Infection Prevention and Control (IPC) and Antimicrobial Stewardship Quarterly report Quarter 1**
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 there had been a recent increase in hospital associated MRSA BSI, with 3 cases reported in this quarter.

3.1.5. **Infection Prevention & Control Board Assurance Framework for COVID-19 self-assessment June 2021.**
The Committee received the report noting that good progress is being made in general and no areas were noted as "red" rated.

3.1.6. **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.

3.1.7. **Serious Incident Monitoring and assurance report**
The Committee received the report noting that the Trust's harm profile continues to be low, however the type of incidents reported had changed as a result of COVID-19. Committee members noted that emerging themes and issues highlighted from incidents are reviewed by the Medical Director and actions are implemented locally or included in the Trust wide improvement work.

3.1.8. **2020/21 Annual report from the Trust Safeguarding Committee**
The Committee noted the annual report of the 2020/21 Trust Safeguarding Committee. Committee members noted that the impact of COVID-19 had an effect on the volume and type of safeguarding concerns the Trust dealt with. It was noted that fewer people were seen during the lockdowns, but there had been an increased complexity in safeguarding cases with mental health issues and domestic abuse being seen more commonly.

3.1.9. **Annual report of the End of Life Steering Group 2020/21**
The Committee noted the activity related to the end of life care as reviewed by the End of Life Care Steering Group.

3.1.10. **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 discussed and acknowledged the key risks and mitigations; noted the planning for a busy winter period. The Committee were assured that the executive team were managing the risks associated with the covid-19 pandemic. The Non-executive directors thanked the executive team for their dedication and hard work throughout each stage of the pandemic.

Imperial College Healthcare NHS Trust

3.1.11. **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

3.1.12. **Maternity Quality Assurance Oversight Report**
The Committee reviewed the Maternity Quality Assurance Oversight report.

3.1.13. **North West London Pathology Quarterly Report**
The Committee members received the report noting the high level activities of North West London Pathology in line with the requirements of the joint venture requirements for the pathology services. Committee members noted that the service would continue to prepare for upcoming accreditation body inspections and focus on improvements to the service. 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 20.3, paper number 17c

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

Purpose: For information

Meeting date: 15 September 2021

Executive summary

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 1 September 2021 include:

3.1 **Preparing for winter 2021/22**

The Committee received and discussed an update on the Trust's winter plan which had been based on previous winter and Covid-19 learning, along with North West London partner engagement via our A&E Delivery Board membership. It was noted that preparations were in place for potential further waves of Covid-19 which, combined with seasonal demand, may make the winter period even more challenging than usual. Committee members noted that the Trust was seeing unusual pressure for August and while there had not been the number of Covid-19 patients that were seen earlier in the year, the stable increase in cases did add extra pressure for the Trust's hospitals. The ICS had requested that each acute trust leads their local planning process to ensure there is the correct support in place to help keep patients moving through the healthcare pathways and to minimise delays to discharges. Local plans would be reviewed through the ICS Urgent and Emergency Care Board at the end of September.

3.2 **Finance report and CIP deep dive**

The Committee received and reviewed the finance report for month 4 noting that for the year to date the Trust delivered a break even position against a £1m deficit plan

and is forecasting a breakeven for the first 6 months of the year without the need to draw down top-up funding from the sector. The latest detailed bottom up forecast for the balance of the year indicates that, all things being equal to H1, the Trust should achieve breakeven at 31st March 2022. This position continued to be reviewed and would need to be re-assessed post the publication of planning guidance for H2.

The Committee had a 'deep dive' review of the Cost Improvement Programme (CIP) and the visibility of the delivery pipeline for the balance of 2021/22 and beyond. It was noted that given the focus on operational delivery and work to stand up services to meet the elective trajectories the Trust was behind the development of its CIP plan but had re-focused attention to this since July with all divisions evaluating and quantifying opportunities as well developing a pipeline of other potential plans. The aim was to establish a rolling CIP programme whereby there is a continual focus on waste reduction / cost efficiency opportunities which are crystallised as appropriate on an on-going basis throughout the year. The Executive was resetting the way CIPs are approached and delivered across the Trust, such as inclusion of financial sustainability in the IMIS priorities, staff engagement in waste reduction, strengthening of governance and accountability in respect of the efficiency agenda, as well as re-pointing resources from across the Trust to this agenda. The Transformation team was supporting this work and were focusing on developing a formal governance structure as well as supporting the identification and formulation of new schemes across the Trust.

3.3 **Transformation update**

The Committee received an update on the programmes of work the transformation team were supporting. These included the speciality review programme, the St Marys flow programme, outpatients transformation and corporate workflow. Work to quantify operational, qualitative and financial benefits of each programme was ongoing and would be presented to the Committee in November.

3.4 **Managed maintenance post project evaluation**

Committee members received and reviewed a post project evaluation of the managed maintenance service contract and were pleased to note that medical devices were well managed and continued to be cost effective. The Trust's clinical engineering team and the service provider have regular meetings to review key performance indicators and to address any potential areas that require improvement and this process worked well.

3.5 **Redevelopment Financials**

The Committee received and reviewed an update on the financial position of the Trust's redevelopment projects.

3.6 **Committee annual report**

Committee members reviewed the Committee annual report for 2020/21 noting that despite the challenges of the Covid pandemic over the year, as well as changes in Non-Executive membership and all meetings taking place virtually, that the Committee had continued to be effective in delivering its duties. Committee members noted the outcome of the effectiveness review and the areas of improvement including ongoing work to improve the timeliness of papers and agenda planning.

Imperial College Healthcare NHS Trust

3.7 **Summary of business cases approved by the Executive**
The Committee reviewed the summary of business cases that had been approved by the Executive and noted the update on the annual review of business cases that had been approved the previous year. The Committee requested a more detailed deep dive on how the anticipated outcomes when the case was approved (quantitative, qualitative) had/had not been realised where cases had progressed sufficiently to allow this to be set up comprehensively.

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

Jessica Hargreaves, Deputy Trust Secretary
7 September 2021

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Report from the Redevelopment Committee on 8th July 2021

Agenda item 20.4 and paper number 17d

Committee Chair: Bob Alexander, Acting Trust Chair
Author: Philippa Beaumont, EA to the Chair

Purpose: For noting

Meeting date: 15th September 2021

1. Purpose of this report

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

2. Introduction

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

3. Key points

3.1. The key items to note from the Redevelopment Committee meeting held on 8th September 2021 include:

3.1.1. 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, communication and stakeholder engagement, patients pathway and populations, life sciences and finance.

3.1.2. Work on phase 1 of the Charing Cross and Hammersmith Hospitals development control plan had been completed and the first part of phase 2 had commenced.

3.1.3. The Committee also discussed contingency planning for the St Mary's site and an update on the Western Eye campus was given.

3.1.4. The Committee received an annual report of Committee business against its Terms of Reference and feedback from the committee effectiveness review.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Summary report from the People Committee

Agenda item 20.5 and paper number 17e

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

Purpose: For noting

Meeting date: 15 September 2021

Executive summary

1. Purpose

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

2. Introduction

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

3. Key points

3.1. The key items to note from the People Committee held on 7th September 2021 include:

4. Mid-year Review on Safe, Sustainable and Productive Nursing & Midwifery Staffing

4.1. The Committee received a summary of the mid-year nursing and midwifery establishment review, and progress against initiatives that the Trust is undertaking to support safe staffing, address nursing and midwifery shortages and ensure a sustainable workforce. The Committee supported the mid-year establishment compliance against the Developing Workforce Standards and recommended approval by the Trust Board; and noted the ongoing work of the Trust to deliver safe, effective, and sustainable nursing and midwifery care.

5. Responsible Officer's Annual Report

5.1. The Committee 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 Committee supported compliance with the Responsible Officer regulations and recommended approval by the Trust Board ahead of submission to NHS England.

6. Proposal for the use of Staff Stories at ICHT Board

6.1. The Committee discussed and supported the proposal to use staff stories at the Board, to mirror the process of using patient stories. The People and OD department would work closely with the Nursing Directorate to interchange with patient stories to Trust

Board. The exact timing of taking to Trust Board would be confirmed following the November People Committee.

7. People Strategy and Priority Objectives – Progress report

7.1. The Committee received an update against the seven Priority People programmes for 2021/22, which would assist with the delivery of the Trust strategic objectives. These had been discussed and agreed in principle at the May 2021 People Committee. Work was underway and progressing well in all programmes and the 'Developing a Sustainable workforce' and 'Equality, Diversity and Inclusion' priorities were the subject of deep dive discussions at this meeting. The Health and Wellbeing section included an update on Covid-19 vaccinations as well as the Flu Campaign.

(i) Developing a Sustainable workforce
(ii) Equality, Diversity and Inclusion*
(iii) Health and wellbeing*
(iv) Improvement through our People Management*
(v) Values and behaviours, team working and conflict
(vi) Remote, Agile an Flexible working
(vii) NW London System working
*Trust wide priority programmes

8. Workforce Performance Report

8.1. The Committee received an update on the core workforce performance and indicators for month 4, July 2021. The report summarised the areas of good performance and the areas for improvement with action plans in place.

9. Deep dive topic: Risk 2944 - Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas

9.1. The Committee received a summary of the context of the risk which had seen an increase in the vacancy rate during Covid-19 for a number of reasons including reduced international recruitment, reduced available candidates for hard to fill posts, and delayed/frozen recruitment processes as a result of changes to teams and workloads caused by Covid-19. The Committee noted the range of controls and actions in place which were overseen by the "Strategic Supply of Nursing and Midwifery Group, in addition, in August the Director of People and OD established a 90 day action plan with weekly meetings to drive short term improvement. These and the establishment of the sustainable staffing priority programme provided reasonable assurance to support the reduction of this risk. The Committee discussed this risk in detail and supported the risk score of 12 based on the evidence and the controls and assurances in place.

10. Pathway to Excellence

10.1. The Committee noted 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 Committee 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 Committee was supportive of this programme and the proposals set out to take the work forward.

11. Priority Objective Review: Equality, Diversity and Inclusion (Work Programme 2021/2022) Deep Dive

11.1. The Committee received an update on one of the Priority People Programmes, Equality Diversity and Inclusion and discussed in detail as a subject of deep dive. The report set out the six objectives and progress against them. The Committee members discussed the report in detail agreeing that the impact of actions was a key area to keep under review and to regularly check the impact of any improvements on the staff by way of assurance. The Committee noted the EDI Work Programme for 2021/2022.

12. Workforce Equality, Diversity and Inclusion Annual Report 2020-21

12.1. The Committee 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. The Committee supported compliance against Public Sector Equality duties under the Equality Act 2010 and recommended approval by the Trust Board.

12.2. The Committee had a detailed discussion on the deteriorating performance on Workforce Race Equality Standard number three - the likelihood of staff from a Black, Asian and Minority Ethnic background being subject to disciplinary action. It was outlined that the position had been significantly affected by the transfer of Hotel Services staff into the Trust but it was also an area of priority to reduce the number of formal disciplinary cases, both generally as well as ensuring there was no bias against staff from a Black, Asian and Minority Ethnic background. The Committee received an update of this work, which was being undertaken in close liaison with the Trust's Race Equality staff networks. It was agreed to add a paragraph to the report to explain the context of any year on year comparison in this area.

13. People Committee Effectiveness Review

13.1. The Committee received an oral update on early feedback of the effectiveness review of two cycles of this Committee, since it was established in May 2021. The feedback was not too different from other Committee effectiveness reviews and the Committee recognised it was in a learning and development phase, and the effectiveness review next year would provide more granular feedback.

14. GMC Junior Doctors National Training Survey Report

14.1. The Committee noted the preliminary results of the 2021 General Medical Council (GMC) National Training Survey (NTS) and the actions arising from the results, focusing in particularly around the areas that were flagged red/pink.

15. Occupational Health and Safety Report

15.1. The Committee received an update on aspects of the Trust occupational health and safety arrangements, including 'Covid-19 secure', the Trust's statutory duty to investigate certain Covid-19 related incidents and the performance of the Occupational Health service. The Committee noted the outcome of the pending discussion at the September Audit, Risk and Governance Committee which would discuss the Health and Safety governance framework and determine which Committee should monitor this aspect in its entirety.

16. People Induction for Non-Executive Directors

16.1. The People Committee Non-Executive Directors participated in a session after the main Committee, which provided them with some background detail into key aspects of the People and OD Directorate. This included: Strategic context: National NHS People Plan; NW London ICS People Priorities; Trust People Strategy 2019-22 and Trust Priority People Programmes 2021-22; Performance Management: External and Internal; NHS Pay; Benefits and Offer; and Equality Diversity and Inclusion.

17. Recommendation(s)

17.1. The Board is asked to note this report.

18. Impact assessment

18.1. Quality impact: N/A
18.2. Financial impact: N/A
18.3. Workforce impact: N/A
18.4. Equality impact: N/A
18.5. Risk impact: N/A