Imperial College Healthcare NHS Trust

Trust Board – Public

Wednesday 20 July 2022 at 11:00 - 13:30 (10:45 – 11:00 to join Microsoft Teams)
Virtual meeting via Microsoft Teams

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

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

AGENDA

Time	No.	Item	Presenter	Format
11:00	**1.**	**Opening remarks**	Matthew Swindells	Oral
	2.	**Apologies: Representatives in brackets:** Frances Bowen (Jo Sutcliffe) Beverley Ejimofo Andreas Raffel Sim Scavazza Janice Sigsworth (Sue Burgis) Jazz Thind (Des Irving Brown)	Matthew Swindells	Oral
	3.	**Declarations of interests** If any member of the Board has an interest in any item on the agenda, they must declare it at the meeting, and if necessary withdraw from the meeting.	Matthew Swindells	Oral
11:05	**4.**	**Minutes of the meeting held on 25 May 2022** To approve the minutes from the last meeting	Matthew Swindells	Report
	5.	**Record of items discussed in Part II of Board meetings held on 25 May 2022 and the Trust Board Seminar held on 14 June 2022** To note the report	Matthew Swindells	Report
	6.	**Matters arising and review of action log** To note updates on actions arising from previous meetings	Matthew Swindells	Report

Time	No.	Item	Presenter	Format
	7.	**Chair's report - North West London Acute Trusts** To note the report	Matthew Swindells	Report
11:10	**8.**	**Establishing the north west London acute provider collaborative – governance model**	Matthew Swindells / Peter Jenkinson	Report
11:40	**9.**	**Chief Executive Officer's Report** To receive an update on a range of activities and events since the last Trust Board	Tim Orchard	Report
11:50	**10.**	**Patient and Public Involvement Annual Report** To note the report	Michelle Dixon	Report
Operations / Performance				
12:00	**11.**	**Integrated Quality and Performance Report** To note the report	Claire Hook / Julian Redhead	Report
Quality				
12:10	**12.**	**Infection Prevention and Control Quarterly report** To note the report	Julian Redhead	Report
	13.	**Hospital Mortality Associated with Covid-19** To discuss the report	Julian Redhead	Report
	14.	**Improving Equity in our Service Delivery** To discuss the report	Bob Klaber / Tim Orchard	Report
	15.	**National Audit of Care at End of Life Summary** To note the report	Katie Urch	Report
	16.	**Complaints & PALS Annual Report** To discuss the report	Michelle Dixon	Report
	17.	**Board Summary Report: Quality Committee, 7 July 2022** To note the summary report	Andy Bush	Report
Finance				
12:30	**18.**	**Finance Report** To note the report	Jazz Thind	Report
12:45	**19.**	**Board Summary Report: Finance, Investment and Operations Committee, 6 July 2022** To note the summary report	Andreas Raffel	Report

Time	No.	Item	Presenter	Format
People				
12:50	**20.**	**People Performance Scorecard Report -** to include Health and Safety report To note the report	Kevin Croft	Report
13:00	**21.**	**Board Summary Report: People Committee, 5 July 2022** To note the summary report	Sim Scavazza	Report
Governance				
13:05	**22.**	**Board Summary Report: Audit, Risk and Governance Committee, 13 July 2022** To note the summary report	Kay Boycott	Report
Any Other Business				
13:10	**23.**	**Board Summary Report: Redevelopment Committee, 12 July 2022** To note the summary report	Bob Alexander	Report
13:15	**24.**	**Any Other Business**	Matthew Swindells	Oral
	25.	**Questions from the public**	Matthew Swindells	Oral
13:30 Close	**26.**	**Date of next meeting:** Wednesday 21 September 2022 at 11:00 – 13:30.		

Updated: 13 July 2022 / SH

Reading Room:

Imperial College Healthcare NHS Trust

Public Trust Board
Minutes of the meeting held on Wednesday 25 May 2022 at 11:00
Virtual meeting held via Microsoft Teams and video-recorded.

Members present

Mr Matthew Swindells	Chair in Common - North West London
Mr Bob Alexander	Acting Chair
Ms Kay Boycott	Non-Executive Director
Mr Peter Goldsbrough	Non-Executive Director
Ms Claire Hook	Chief Operating Officer
Prof. Tim Orchard	Chief Executive
Dr Andreas Raffel	Non-Executive Director
Ms Sim Scavazza	Non-Executive Director
Ms Jazz Thind	Chief Financial Officer

In attendance

Mr Raymond Anakwe	Medical Director
Ms Cara Barrett	Media Manager
Prof. Frances Bowen	Divisional Director, Medicine and Integrated Care
Mr Jeremy Butler	Director of Transformation
Mr Kevin Croft	Chief People Officer
Ms Michelle Dixon	Director of Communications
Mr Philip Edmunds	Business Manager
Mr Nick Fox	Director IPH
Mr Hugh Gostling	Director of Estates and Facilities
Ms Sara Harris	Interim Head of Trust Secretariat (Minutes)
Ms Layla Hawkins	Head of Strategic Communications
Mr Kevin Jarrold	Chief Information Officer
Mr Peter Jenkinson	Director of Corporate Governance
Dr Bob Klaber	Director of Strategy, Research & Innovation
Dr Ben Maruthappu	Associate Non-Executive Director
Ms Shona Maxwell	Chief of Staff
Ms Saghar Missaghian-Cully	NWL Pathology Managing Director
Mr James Price	Director of Infection Prevention and Control
Prof. Julian Redhead	Medical Director
Prof. Janice Sigsworth	Director of Nursing
Prof. Tg Teoh	Divisional Director, Women, Children and Clinical Support
Dr Matthew Tulley	Director of Redevelopment
Prof. Katie Urch	Divisional Director, Surgery, Cancer and Cardiovascular
Prof. Jonathan Weber	Dean of the Faculty of Medicine, Imperial College London
Ms Raakee Nagar - Item 8	Senior Occupational Therapist
Ms Anna Bokobza – Item 10	Integrated Care Programme Director

Apologies

Prof. Andrew Bush	Non-Executive Director (partial attendance)
Ms Beverley Ejimofo	Associate Non-Executive Director
Mr Nick Ross	Non-Executive Director

Item	Discussion
1.	**Opening remarks**
1.1.1.	Matthew Swindells, Chair in Common of the London North West welcomed to everyone participating in this virtual meeting.
1.1.2.	Acknowledging the Covid situation, the public meeting was being held virtually and was video-recorded. The Board observed social distancing guidance and therefore limited people participating via Microsoft Teams from different locations.
1.1.3.	The Board continued to hold the Board meetings virtually, to protect staff, patients and public. National Covid restrictions remain in place in NHS premises, including social distancing and Covid-secure protocols while they remain, Trust Board meetings would continue to be held virtually, however, this would be kept under review.
1.1.4.	The Chair reminded members of the public that this was a meeting of the Trust Board held in public, but that they would be given an opportunity to ask questions at the end of the meeting. The video of the meeting would be published on the Trust website following the meeting.
2.	**Apologies**
2.1.1.	Apologies were noted from those listed above.
3.	**Declarations of interests**
3.1.1.	There were no additional declarations to those disclosed on the Trust's register of interests.
4.	**Minutes of the meeting held on 16 March 2022**
4.1.1.	The minutes of the previous meeting were approved.
5.	**Record of items discussed in part II of the Board meetings held on 16 March 2022 and the Trust Board Seminar held on 20 April 2022.**
5.1.1.	The Board noted the summary of confidential items discussed at the confidential Board meeting held on 16 March 2022 and the Trust Board Seminar held on 20 April 2022.
6.	**Matters arising and actions from previous meetings**
6.1.1.	Updates against the actions arising from previous meetings were noted on the action register.
7.	**Chair's report – North West London Acute Trusts**
7.1.1.	Matthew Swindells commenced his role as Chair in Common of the Acute Collaborative on the 1 April 2022. The Chair had said that since his report was written there had been further developments.
7.1.2.	The Board was informed about his series of meetings with the non-executive directors, Integrated Care System (ICS), regional and national NHS England teams and with the local stakeholders to develop joint working to meet a series of recognised challenges, which included to reduce waiting lists and times for surgery, improve emergency access, recover the quality of patient experience and put in place a financial plan to revert to pre-pandemic levels of activity.
7.1.3.	The aim of the north west London acute provider collaborative would be to deliver the best healthcare services in North West London; address issues of inequalities of access by geography and population and create the best place to work in the

	NHS. The Chair thanked all those who have supported him in his role.
8.	**Staff Story – Rakhee Nagar**
8.1.1.	The Board welcomed Rakhee Nagar, an Allied Health Professional employee of the Trust, to the meeting.
8.1.2.	Kevin Croft introduced Rakhee Nagar to present her story to the Board and noted this was the first story to be presented by staff. . The Board would hear at alternate meetings patient or staff stories that were relevant to the strategic people objectives, those of protected characteristics and relevant to the equality and diversity (EDI) programme, and also those stories that have come via the Staff Network.
8.1.3.	Rakhee Naghar began by informing the Board that she had been at the Trust for over four years. She shared her EDI and cultural experiences in the workplace both in a patient and staff interaction front. Early on in her career she was passionate about EDI and joined the BAME Network and the Allied Health Professionals Race Equity Group, where she was able to share her experiences and ideas for improvement. The groups were inclusive regardless of banding. In the past year, she confirmed she had witnessed two cases of racial abuse by staff to staff. In one incident, she had intervened, and the other incident was investigated by an anonymous reporting system.
8.1.4.	In terms of patient racial abuse towards staff, the Datix reports 1-2 incidents per month. It was noted that many staff do not have the courage to speak out and take action, which results in them not wishing to come to work given how they were feeling with the interactions they were receiving. Rakhee Nagar's approach has been to promote good practice in a kind setting, by empowering staff and to know is it not acceptable and not part of their job to accept racial abuse, and that there is a boundary.
8.1.5.	Rakhee Nagar recently held a workshop and obtained relevant information from Datix to feed into the session about real experiences, this was followed by an engagement session whereby staff were asked to make pledges on how they could make changes to create an environment of inclusion. A review would be taken around the pledges to understand the barriers and why things were not advancing. The vision is to roll out the training and educate staff and Rakhee Nagar expressed her keen interest and gratitude to the Trust for the support for allowing her to undertake the Masters Apprenticeship programme which had given her the confidence to lead change and transform the service. She acknowledged that much of this work was around racial equity which was managed in their own time and suggested to have protected time as well as looking at diversity in senior leadership posts would be a positive step forward.
8.1.6.	Kevin Croft thanked Rakhee Nagar for her successful story and noted that there was much work to do following on from the staff survey.
8.1.7.	The Chair wanted to understand whether staff who reported incidents of racial abuse know that they have the support of the senior management team. Rakhee Nagar confirmed that she did not know how it operated Trust wide, however, in therapies the issue was tackled by the Leadership team. The Therapies Leadership team had attended training sessions, and had been incredibly supportive and wanted to make changes for the better. It had set a good example and could only have a waterfall effect.

8.1.8.	Bob Alexander articulated that it would be insightful for the Board to see the measured outputs from the review and urged the People Committee to be very active in this arena. Kay Boycott noted that there was a disproportionate number of people of colour to take on the challenges and how others help given this is an area that affects all people. Rakhee added that engagement was key and from a senior leadership perspective for them to attend the meetings, hear the stories, experiences and understand the impact on the individual. Sim Scavazza concurred with Rakhee Nagar that by having these conversations and bringing these issues to the forefront, metrics and impact could be measured to improve staff of ethnic minority backgrounds experience and in turn encourage the completion of the pulse surveys.
8.1.9.	Andreas Raffel stated that it would be good for the non-executive directors to sign up for the training sessions as it would show they are taking EDI seriously and highlighted their commitment in addition to finding it invaluable. **Action: Kevin Croft / Rakhee Nagar**
8.1.10.	Tim Orchard confirmed that the EDI agenda was large and complex and one category that was depicted was the staff survey around staff experience, with the Trust very much committed to improving staff experience. EDI covered a range of issues and the need to spend time on race was significant. Other areas had been focussed on such as the disability and getting reasonable adjustments in place and centralising the funding. He reflected on the comment made by Sim Scavazza about getting people engaged in this arena and added that by making people realise senior management are taking this issue seriously and absolutely committed to making improvements both in respect of staff and patient abuse. If clear and firm action was taken that would send a clear signal and encourage more engagement with staff and set a challenge of six months.
8.1.11.	Matthew Swindells concluded that if the members of staff were found not to be demonstrating Trust values and expected levels of behaviours then that would need to be dealt with, and those who speak up would be listened to and supported.
8.1.12.	The Board thanked Rakhee Nagar for her story, the work and dedication shown around educating and training staff to promote a better place to work.
9.	**Chief Executive Officer's report**
9.1.	Prof Orchard presented his report, highlighting key updates on strategy, performance and leadership over the month and the focus of Trust business in response to Covid-19.
9.1.1.	**Operational Performance** – The number of patients with Covid had reduced however, consideration was applied when managing all the other operational challenges in conjunction when dealing with the Covid patients. The NHS had reduced its national alert level 4 to a level 3, and the focus was now on the operational performance to reduce the backlog. The number of patients waiting for more than two-years had been eliminated, and the endoscopy team had achieved huge success with completion of 99% of investigations within 6 weeks of referral. Imaging too had made good progress. The elective performance particularly in day cases and operations had increased to 100% as in the year of 2019/20, and this was due to the small incremental measures put in place. There had been changes in the national guidance around testing with polymerase chain reaction (PCR) tests on the day to lateral flow tests (LFT0, which would help with the elective procedures and changes around the visiting policy, to ensure it was more liberal and the Trust noted it was important to have friends and family visit patients to aid their recovery,

	however, this would not be permissible in the emergency department given the physical space and the busy flow of work.
9.1.2.	In terms of ambulance handover, Charing Cross Hospital had achieved the best rating followed by St Mary's, given it is the busiest major trauma centre in London.
9.1.3.	Flu vaccination campaign went well with 90% of staff receiving the booster.
9.1.4.	Prof Orchard summarised financial performance, noting that the Trust had achieved a draft surplus of £83,000 against the break-even plan and delivered against both its external finance and capital resource limits Given the amount of capital that had become available in the second half of the year this was a good result. The final results remain subject to audit.
9.1.5.	The operational plan for this year had been submitted, which was challenging both operationally and financially. Funding streams for this year mirrored that of 2021/22 with the Trust receiving its core income via block contract arrangements. A plan had been reached with the NWL ICS, the Trust's assessment of the estimated unfunded inflationary cost pressure was cited as an unmitigated risk, and the outcome of this resulted in the Trust submitting a £10m deficit plan.
9.1.6.	**Ockenden report and maternity** – Prof Orchard reported that a review of the final report and recommendations had been completed, including the benchmarking exercise around the 15 immediate and essential actions. The Quality Committee had considered the Trust response and progress being made to date, and woud continue to maintain oversight.
9.1.7.	**Monkeypox** – Prof Orchard updated the Board on the current situation, advising that this was not a particularly infectious virus and was transmitted only by close contact. It caused mild symptoms and in many cases did not need treatment. The emergency department and sexual health clinics had done much work to ensure staff were clear how to handle those patients. There is national guidance what staff and patients should do. The management of patients with the virus was, however, impacting on the availability of isolation facilities, due to the infection control measures required when treating patients with the virus.
9.1.8.	**Redevelopment** – Work continued with the master plan for all sites and the Trust was awaiting the National Hospital programme to make a decision around the business case. There was a plan in place to restore the full range of services with an extra operating theatre at the Western Eye Hospital. For the interim, an additional operating theatre had been put in at the Charing Cross Hospital in order to help with backlog. Ventilation issues in gynae day surgery meant that theatres had to be closed, though were re-opened on the 10 May 2022.
9.1.9.	Prof Orchard also reported that the Trust had been interviewed, alongside Imperial College London colleagues, in relation to the application for Biomedical Research Centre funding, and the outcome would be published in June 2022. Despite the challenges of Covid and related pressures, the Trust continued to deliver a wide portfolio of clinical research.
9.1.10.	**Staff Survey** – The Trust scored higher than average amongst other acute trusts in the category of staff morale, but the figure had dipped in comparison to last year. As part of the improvement programme, the line management training would be launched, geared for those who manage staff.

9.1.11.	Refurbishment work continued in over 80 staff areas to promote staff wellbeing areas.
9.1.12.	Prof Orchard also highlighted the achievements of individual members of staff and teams, including national recognition and awards.
	Questions from the Non-Executive Directors
9.1.13.	Peter Goldsbrough mentioned that pre-Covid the flu vaccination uptake was 60% and the vaccination programme had achieved 90%. He enquired about whether lessons had been learnt from the Covid vaccination programme to increase the update. Prof. Orchard responded that it was a perception of risk. People were wearing masks and as a result the amount of flu was considerably less compared to previous years, and there were lessons that could be reflected on.
9.1.14.	Dr Raffel noticed that the reduced availability of the Covid booster vaccination currently and enquired whether the Trust should wait for the onset of autumn when it would actually be needed? Prof Orchard replied that the Trust would wait for the Joint Committee on Vaccination and Immunisation's (JCVI) advice on this area. Prof Redhead, the National Lead, stated when there is a start of an increase in the community acquired infections, then it may be the time to start the booster campaign. The Trust was waiting for further advice from the JCVI and staff were still encouraged to take up the booster vaccinations.
9.1.15.	**The Board noted the update.**
10.	**Integrated quality and performance report**
10.1.	The Board received the integrated quality and performance report for month 12, summarising performance against the key performance indicators for March 2022.
10.1.1.	Claire Hook presented key headlines:
10.1.2.	**Operating Plan -** Overall elective activity continued to recover in March 2022. A total of 9,487 elective spells (day cases and overnight admissions) was completed which was the highest volume since November 2021, and peak following the 2nd wave of Covid and that upward trend was continuing. There were issues around how activity was profiled, however, for 2022/23 the activity would be weighted over the year to avoid the peaks and troughs. Work was underway to ensure capacity around elective and day cases going forward. Processes were being implemented around infection control that were in place prior to Covid-19. These were around managing activity, scheduling, forward view and more importantly delivering in waiting times over the course of the year.
10.1.3.	**Outpatients and Diagnostics** – The Trust had achieved activity levels above baseline. There was overachievement in the last financial year in terms of the RTT clock stops, one of the measures that was introduced in the second half of the year. Waiting lists had been increasing due to demand. A forward forecast of demand capacity analysis was underway to ensure there was enough capacity in the system to be able to achieve our waiting time trajectories.
10.1.4.	**Long Waits** – There were two patients waiting over 104 weeks at the end of March 2022. One was treated and the other one waiting. In terms of 52 weeks waits, there would be more patients at the end of March 2022 due to winter pressures, with the aim being to be back on track in May 2022.

10.1.5.	**Diagnostic Performance** – The number of patients waiting over 6 weeks had increased. The two areas that delivered significant improvement was endoscopy and neurophysiology. It was noted that for April 2022 the performance had improved yet again and was the best it had been for over 12 months.
10.1.6.	**Cancer** – There had been slow improvements in cancer performance. Trajectories had been developed so the focus was clear on achieving the required standards and trajectories.
10.1.7.	**Ambulance Services** – St Marys and Charring Cross had been supporting more of the challenged emergency departments and this area was being continually reviewed to understand the impact on waiting times and emergency departments.
10.1.8.	**Discharge** – In April 2022, there was an average of 202 patients with a length of stay of 21 days or more against the target of 167. The main factors were increasing patient need, managing infection control measures, adult social care, market dynamics, local policy changes and staffing challenges across the system. For comparison, the pre-pandemic average for the same period was 220.
10.1.9.	Trust-wide performance and improvement plans were overseen by the Urgent and Emergency Care (UEC) Programme Board and informed by the Long Length of Stay Taskforce.
10.1.10.	In partnership with Central London Community Healthcare NHS Trust, a joint role was created in 2021 to lead on integrated discharge hubs which were now operating on our three main hospital sites.
	Questions from the Non-Executive Directors
10.1.11.	Kay Boycott enquired about the cancer inequalities and whether the long waiters were from the deprived postcodes or from certain communities and was the gap widening. Katie Urch responded that work had begun with the Royal Marsden Partners (RMP) to look at inequalities in the areas of Hillingdon and Brent who do have very poor cancer equality targets that was driven by their local cancer services and their diagnostic services. There was support through their one stop shop and their diagnostic hubs in the community. A review of the long waiters on the Patient Tracking List (PTL) revealed no difference at all between age and sex. There had been a rise in patients with protected characteristics inequalities in late transfers from Hillingdon and Northwick Park, as a result there had been close liaison to speed up their diagnostic pathways to decrease inbuilt inequalities. Katie Urch stressed that once patients are on a pathway they do not see a difference in terms in of patients with protected characteristics.
10.1.12.	Andreas Raffel raised an enquiry about the performance metrics to which Claire Hook responded that there was an issue about the demand that was driving the PTL size, and some were legacy issues but expected those performance issues to be addressed going forward. Urgent and emergency care is work in progress with months February and March being particularly very difficult. The performance for April looked better. For discharge process the focus was to ensure all the performance review mechanisms were in place prior to the pandemic.
10.1.13.	Prof Redhead presented the quality section of the report, highlighting that harm levels remained low. A never event had occurred relating to the use an insulin pen then using it as a normal syringe, which meant a dose calculation. The actions had been reviewed with further education and training around diabetic management

	across the whole Trust. There was another bloodstream infection from Magnetic Resonance Imaging (MRI), however, there were no further events after the actions were taken in that area. There was work ongoing around helping to train staff around management of lines both at insertion and ongoing management to prevent bloodstream infections.
10.1.14.	Peter Goldsbrough was interested to hear more on the repeated never event which was around human error and whether that was in terms of knowledge base and had the actions been followed through. There was a much wider review and the ICS understood that the Trust had that never event, and would ensure that they were reviewing their practices.
10.1.15.	**The Board noted the report.**
11.	**Infection Prevention & Control Board Assurance Framework**
11.1.1.	The Board received the report noting that the Board Assurance Framework had been re-issued in December 2021, included revised key lines of enquiry. The Board noted the report contained 125 key lines of enquiry over 10 domains, of which 42 remained unchanged from the previous board assurance framework, and 83 were new or significantly revised and cover aspects of Infection Prevention & Control practice beyond specifically Covid-19 as previously the case. The Board was pleased to note that there were no red areas reported in the Board Assurance Framework.
11.1.2.	The Board noted that there was 16 ambers in place and since the last report 3 had turned into green. It was highlighted to the Board that progress had been made in all the important areas.
11.1.3.	The Board noted the Infection Prevention & Control Board Assurance Framework self-assessment noting that the Quality Committee had endorsed the Infection Prevention & Control Board Assurance Framework self-assessments.
11.1.4.	Andreas Raffel enquired about the recent publicity around monkeypox. Prof Redhead explained that it has been classified as a high consequence infectious disease and there was a small mortality rate associated with it. The issue was trying to make sure it did not become an endemic in this country. It was not as infectious as Covid, but required infection control measures such as isolation facilities.
11.1.5.	**The Board noted the report.**
12.	**Ockenden Report**
12.1.1.	The Board received the report noting that the final Ockenden report was published in March 2022 with a number of recommendations and immediate actions for Trusts to take forward. The Board was aware of the recommendations within the report and was provided with an update on progress with the actions required to achieve those recommendations.
12.1.2.	Prof Teoh explained to the Board that the review was of 1592 clinical incidents and interviewed 1406 families which occurred in the Trust from the 2000-2019 where it showed failings and sadly resulted in maternal and foetal morbidity and mortality. The report was first published in December 2020 and the second part published in March 2022. There were 7 immediate actions from Ockenden 1 and 15 actions from Ockenden 2, totalling 92 individual action points. These had been grouped into four pillars of safe staffing levels: 1. well trained, 2. workforce learning, 3. learning from

	incidents and 4. Listening to families. The report had been shared with the maternity staff at various engagement events.
12.1.3.	The report addressed the gap analysis of the immediate and essential actions from the previous Morecambe Bay report, and the maternity self-assessment tool from Ockendon 1 and 2. The report highlighted areas of compliance in relation to the four pillars and outstanding actions. The report also addressed the continuity of care model. It was noted the model was challenged by workforce constraints around midwifery. Prof Teoh acknowledged his Head of Midwifery had used the care model group to help serve women in the most deprived areas of the patch.
12.1.4.	Kay Boycott stated that it was important that the Board understood that the Trust had provided excellent services and improvement to the maternity care services prior to the publication of the Ockenden report. The Trust had received a rating as outstanding from the CQC due to demonstration of it being a learning service. Kay Boycott confirmed she had seen a huge amount of improvement and activity since 2020. There had been really active discussions, challenges and continuous improvement activities and not just about Ockenden, including issues such poorer outcomes for those of minority ethnic backgrounds.
12.1.5.	Kay Boycott explained the reasons why she became a NHS board member and champion for maternity services. It was due to her own poor experience in maternity services and she felt very passionately about the service. There was real commitment and even more deep dives with reviews when things have gone wrong.
12.1.6.	Andreas Raffel enquired about the poorer outcomes, how we can make sure that in other pockets of the Trust we potentially did not encounter similar behaviour patterns or belief systems. Prof Orchard responded that some of the related issues that happened at Shrewsbury and Telford were connected to the speciality itself. The Regional Midwife for London made the observation that midwifery and maternity was a very complex dynamic. The importance of the woman's view should be taken into account, so they had the right experience and guidance. What may be right for one woman may not be right for another woman. Relationships with midwifery staff and obstetric staff in the maternity unit can only work if there was good connection. It was not appropriate to have a target as every woman is unique, however, they do need clearer outcomes and an outlier from national practice. As an organisation, the home births was around 1.5% and there was still much work to do around home births, making sure people understood about how people were interacting in a more qualitative way; also ensuring good processes were in place for alerts when there were problems with performance metrics.
12.1.7.	Matthew Swindells mentioned to the Board that in other Trusts there were 2-3 incidents per month with no benchmarking and it was hard to understand the context. Under the Acute Collaborative this type of data would be visible and would facilitate the sharing of that learning. When there is an incident, and you have multiples, we should be able to view that on a dashboard and nationally.
12.1.8.	Prof Redhead confirmed that data audits such as Get it Right First Time (GIRFT), National Audits, CQC Insights, Peer data and now the ICS data which allowed comparisons and in terms of quality insight around data specialities understanding those issues recurring. Another issue that had come out of Ockenden was how we related to complaints and how we responded to families, supported families around incidents. A complex complaint was raised at the Quality Committee and the learning from that complaint was being applied in the Trust's overall response and management of complaints.

12.1.9.	Peter Goldsbrough stated that avoiding deaths was unavoidable and probed about the unit's approach to excellence in this area. Prof Teoh confirmed to have better or comprehensive feedback from patients, and use of outcomes data. Delivering best outcomes and build that into the culture which was important and a future priority.
12.1.10.	Prof Orchard responded that this year the Trust had created a user insight function which would collate feedback from 'friends and families' feedback, stakeholders and staff to triangulate the information about the services for improvement.
12.1.11.	Prof Teoh added that the Trust could improve its existing learning culture if it was applied in two specific areas: 1. Care and feedback from patients, friends and family test, and in addition complaints that are received and how they are responded to. 2. Staff group that they enjoy coming to work and delivering care.
12.1.12.	**The Board noted the report.**
13.	**Learning from Deaths Quarterly Report**
13.1.1.	The Board received the report noting the findings from the Trust's Mortality Surveillance Programme quarter 4. The findings would be submitted to NHS England.
13.1.2.	Prof Redhead briefed the Board there was a robust process around Structured Judgement Reviews (SJRs), how that information was reviewed and used around Trust priorities on quality for improvement. As a result of that work, dysphasia was identified through this process of learning from deaths and a focus improvement programme was underway.
13.1.3.	Peter Goldsbrough referred to a specific case reported and asked what had been learnt from the incident. Prof Redhead explained dysphasia is when a person has difficulty swallowing, how that was identified and how care was provided for those patients. A focussed piece of work from the entire Trust was underway about how those patients were assessed, treated and when they go out into the community.
13.1.4.	Peter Goldsbrough enquired further was it a case of where the right care was delivered and the outcome was not achieved, or was the care delivered and was not as expected. Prof Redhead confirmed it was the latter and it was important that the focus was on to educate, learn and make sure robust processes were in place.
13.1.5.	**The Board noted the report.**
14.	**Board Summary Report Quality Committee, 5 May 2022** The Board received the Quality Committee Board Summary report.
14.1.1.	Bob Alexander drew the Board's attention to the provision of care for patients with mental health needs in the emergency department. Colleagues had been concerned about the number of mental health patients waiting for assessment and treatment in the emergency department (ED). A good conversation was held and the ED team were doing the best they could for those mental health patients. Action was required on a system level with the Commissions and other Mental Health Providers to provide improved access to mental health services. In the meantime the Committee welcomed the measures put into place by the Trust to mitigate the risks of patients with mental health waiting in emergency department for assessment and transfer to an appropriate place of safety.

14.1.2.	The Quality Committee would also be reviewing other areas of concern as a deep dive, and one was the ambulance handover which had been identified.
14.1.3.	Matthew Swindells explained that he had discussed the issues of the number of mental health patients in the ED with the London Regional Director. It was high on their agenda as well as ensuring the right and timely support was available for mental health patients who turned up in an acute A&E and that they received the appropriate care from the right professionals in the right place as quickly as possible.
14.1.4.	**The Board noted the report.**
15.	**Finance Report**
15.1.1.	The Board received and noted the financial performance report for month 12.
15.1.2.	Ms Thind updated the Board that the Trust had achieved a draft surplus of £83,000 and thanked all those involved in achieving this position. The final outturn against the Capital Resource Limit (CRL) of £79.4m was £78.8m, with total capital expenditure increasing to £94.9m once schemes funded by grants and donations are included. The cash position remained resilient at the end of the year but noted this was partly driven by timing and will reduce once the payments, where income had been received in advance, are settled in early 22/23. The better payment practice code performance remained above the threshold of 95% with creditors being paid in a timely manner to prevent any detrimental impact on the delivery of services/care. The transfer of the Chelsea and Westminster NHS Foundation Trust payroll service was successfully transitioned on the 1st April 2022 and successful weekly and monthly pay runs had been delivered to date.
15.1.3.	**The Board noted the report.**
16.	**Board Summary Report: Finance, Investment & Operations Committee 4 May 2022**
16.1.1.	The Board received and noted the Finance, Investment & Operations Committee Board Summary Report.
16.2.	**Annual Accounts and Annual Report** Peter Jenkinson briefed the Board that the Annual Accounts would need to be submitted by the 22 June 2022. The Board approved the delegation of authority to the Audit, Risk and Governance Committee to scrutinise the accounts, annual report, the auditors' comments and to approve the submission of the annual accounts and report.
16.2.1.	**The Board approved delegation to the Audit, Risk and Governance Committee to submit the annual accounts on behalf of the Board.**
17.	**Board Summary Finance, Investment and Operations Committee, 4 May 2022**
17.1.1	The Board received and noted the Finance, Investment and Operations Committee report.
17.1.2	**The Board noted the report.**
18.	**People Assurance Report**
18.1.1	Kevin Croft presented key highlights of the report around the inclusion of the SPC charts with timelines, vacancies, established posts and turnover had been growing. Metrics around EDI and particularly for Band 7 and above had been included.

	Changes were being applied around recruitment and selection processes, and talent management following on from a workshop with Roger Klein.
18.1.2.	Bob Alexander referred to the reported spend on temporary staffing,. He enquired about the new national restriction on levels of temporary staff usage and the implications of that, and the additional controls that would need to be in place to ensure adherence. Kevin Croft replied that real time data was being sought to bridge the pay cap. The acute HR directors in NW London were looking at medical workforce to ensure those controls were in place. Recruiting into the vacancies and those with high volumes was hard to recruit to. It was noted the difficulty was trying to manage the market and due to patient safety, the need on occasions for an escalated pay rate. AHPs and Scientists were areas that were identified in terms of difficult recruitment. There was a good staffing programme across the NW London Acute Collaborative.
18.1.3.	Matthew Swindells enquired about delivering staff inductions and the plan to reach the target of 95% was the figure pre-pandemic. Kevin Croft replied that the data had been compiled and there was a focussed approach to those divisions to reach the target. It was noted that staff who previously had not received an induction were making a request to register their interest.
18.1.4.	Prof Orchard explained that the local induction was about having an induction in their area of work, how things were run and managed. The Trust wide corporate induction was well attended with near 100% attendance levels.
18.1.5.	**The Board noted the report.**
19.	**National Staff Survey Results**
19.1.1.	Kevin Croft presented to the Board the high-level staff survey results for the 2021 NHS Staff Survey (NSS) and summarised the actions planned in response to the survey. The NHS Staff Survey was one of the largest workforce surveys in the world and had been conducted every year since 2003. It asked NHS staff in England about their experiences of working for their respective NHS organisations. The survey provided essential information to employers and national stakeholders about staff experience across the NHS in England. The National Staff survey 2021 was completed in all NHS Trusts in October – December 2021. The national and local results was fully published on 30 March 2022.
19.1.2.	As a Trust, the response rate was 42% (5523 responses) which compares with the median response rate for Acute Trusts of 46% but it was the same as our 2020 response which was 42% (5431 responses). In comparison London North West had a response rate of 61%.
19.1.3.	Kevin Croft added that actions had been taken on the relevant areas as identified in the report and timelines was discussed both at the Board Seminar and regularly reviewed by the People Committee and the People Priorities had been mapped to the Staff Survey questions.
19.1.4.	Sim Scavazza articulated to the Board that extensive conversations had been held at the People Committee to seek innovative ways for staff to talk and give feedback. There was the Freedom to Speak up Guardian for staff to speak with, and as Execs they try and triangulate the feedback from the ward visits and feedback via the poll surveys. One of the key objectives was listening to staff, engaging and putting in activity which focusses on improving their staff experience was vital.

19.1.5.	Matthew Swindells added that it would be good to have staff satisfaction working for the organisation and knowing the Trust is investing with its staff.
19.1.6.	Prof Orchard added that in 2018 the Trust was 7th in the rankings with engagement and now joint 3rd in the Shelford Group. There was much work around culture taking place, to ensure the organisation was a fair place to work and doing that visibly was very important. Upskilling staff through the people management programme to the needs of the organisation if you are responsible for another person.
19.1.7.	**The Board noted the report.**
20.	**Board Summary Report: People Committee 3 May 2022**
20.1.1.	The Board received and noted the People Committee report.
20.1.2.	Sim Scavazza reminded the Board that the Committee also received the health and safety updates and there was a good framework in place. If there were areas of quality those issues were passed on to the Quality Committee and then reverted to the Audit, Risk and Governance Committee.
20.1.3.	**The Board noted the report.**
21.	**Annual Provider Licence Compliance**
21.1.1.	Peter Jenkinson briefed the Board that NHS Improvement required that NHS Trusts, and Foundation Trusts (FT) had always been required to self-certify compliance against a number of specific declarations. Providers must publish their self-certification by 30 June 2022.
21.1.2.	Peter Jenkinson referred to appendix one that had the summary of compliance statements of the provider conditions, risks to the delivery of those standards and have robust governance processes. The Audit, Risk and Governance Committee had scrutinised the statements and recommended a declaration of full compliance to the Board.
21.1.3.	**The Board approved the assurance statements and the proposed compliance declarations.**
22.	**Board Summary Report: Audit, Risk and Governance Committee, 10 May 2022**
22.1.1.	The Board received and noted the Audit, Risk and Governance Committee report.
22.1.2.	Kay Boycott added that the Committee was busy closing off the audit and starting the new year with a change in the audit provider.
22.1.3.	**The Board noted the report.**
23.	**Board & Committee Effectiveness Report, and Board Committee Terms of Reference 10 May 2022**
23.1.1.	Peter Jenkinson presented to the Board the annual committee effectiveness report which had been received at the relevant Committees and asked the Board to approve the terms of references for each of the Committees.

23.1.2.	**The Board noted the report and approved the Terms of References for each Committee.**
24.	**Redevelopment Committee: Summary Report**
24.1.1.	The Board received and noted the Redevelopment Committee report.
24.1.2.	Bob Alexander explained there was on-going work to quantifiably baseline the green plan proposition, a report was due in the autumn with metrics to the November Board. **Action: Bob Klaber**
24.1.3.	Dr Bob Klaber confirmed that much work had been invested. The report will detail about the initiatives of the work, decarbonisation and many people led items such as initiatives the local community were driving forward on.
24.1.4.	**The Board noted the report.**
25.	**Any other business**
25.1.1.	Noted that Des Irving Brown would be attending the next meeting on behalf of Ms Thind.
26.	**Questions from the public**
26.1.	A member of the public commented on the ideas on discharge management and echoed the suggestions made by Kay Boycott. He gave his views that there was misalignment between admission and discharge, access and emergency. In addition, there were also problems around culture and not just around flow of patients, and asked how the Trust would manage all those issues.
26.1.1.	Prof Orchard replied that there was approximately 6 million people in the NHS who were waiting for treatment and there was always a need to look ahead. The key focus was to record data and investigating early warning signs. There had been a shift to using SPC charts to have a better idea of when things were being moved out of the statistical range. The need for external comparison such as the Shelford Group, which comprises the largest teaching hospitals across the country and gave an indication of how well the Trust was performing. He highlighted that the MD, Chief Nurse, Chief Finance Officers and the Chief Operating Officers all had their own groups to set their own benchmarking across the Acute Collaborative and gather that intelligence, triangulate and make those predictions to enable the strategic overview.
26.1.2.	A member of the public asked whether there a mismatch between attitude and culture and how the Trust would balance these two.
26.1.3.	Prof Orchard responded that the organisation was spread across a number of different sites. One of the initiatives to address this was to set up a number of programmes such as the people management programme to make sure these were embedded and also instilled in the induction programmes.
26.1.4.	A member of the public enquired about sending patients to the private sector for cancer diagnostics and treatments and asked whether the Trust had a mechanism to track those patients and the costs.

26.1.5.	Prof Orchard responded that the Trust did not send a large number of people with cancer for treatment externally. There were some patients for elective work as part of the long waiters who were offered this option. There was an arrangement with the NHS that they can use the private sector if needed to. The Trust would ensure there was a minor uplift on the NHS tariff so not to waste NHS money on the private sector unless it was absolutely essential. Ultimately, the Trust would like to deliver the entire service from its own NHS resources.
26.1.6.	A question was raised regarding the role of the Trust in managing its own elective recovery whilst also helping the region as a whole to meet that target, noting challenges faced in other Trusts.
26.1.7.	Prof Orchard responded that the Trust turnoverwas almost half of the total in the NW London Acute Collaborative. It was important for the Trust to meet its own internal operational plan and performance on this was good so far. The Trust had received during the pandemic complex work from other parts of the sector, and this would help the partner organisations going forward. Regular prioritisation meetings were held across the sector by the medial directors to make sure all P2 surgeries were completed.
26.1.8.	**Matthew Swindells thanked all for their contributions and closed the meeting.**
27.	**Date of next meeting** Wednesday 20 July 2022 at 11:00.

Updated: 29 June 2022

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC

Paper title: Record of items discussed at the confidential Trust board meeting held on 25 May 2022 and the Board Seminar held on 14 June 2022

Agenda item: 5

Executive Director: Professor Tim Orchard, Chief Executive
Author: Sara Harris, Interim Head of Trust Secretariat

Purpose: For information

Meeting: Wednesday 20 July 2022

Executive summary

1. Introduction

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

1.2. The Trust Board had met in private on two occasions since the last meeting, on 25 May 2022 and the Trust Board Seminar on 14 June 2022.

Private Trust Board – 25 May 2022

2. Chair's briefing

2.1 The Chair briefed the Board on various stakeholder engagement sessions held with the National Provider Collaborative teams led by Miranda Carter. Discussions had also taken place with the Chief Executives and Governance Leads in devising a model which focussed on keeping local board committee structures in each organisation, as well as adopting a collaborative approach. The Board noted progress in the development of cross-organisation work streams being led by Chief Executives. There was concern that the NHS had not returned to pre-pandemic levels of productivity nationally and would not be able to deliver this year's plan in terms of getting the waiting lists under control. The Committee noted that there were elements of culture that the Acute Collaborative would need to consider, in terms of standardisation, ways of working, quality and efficiency and how all those elements were cascaded.

3. Chief Executive's update

3.1 The Chief Executive provided an oral update on operational issues, including the number of patients with Covid-19 being treated in our hospitals. An update was also provided on the Trust's planned care capacity which had been at 85-95% of pre-pandemic levels, relating primarily to IPC restrictions. The Board noted the success of the endoscopy team, who achieved 99% of investigations within 6 weeks of referral.

4. Community diagnostic centres

4.1. The Board approved business cases for three community diagnostic centres, though they are still subject to NHSE approval. Next steps include widening engagement now with patients, local communities, staff and partners to raise awareness and understanding of the centres and inform more detailed implementation plans

5. Business plan

5.1 The business plan submission was 'approved in principle' and allowed the Trust to make the submission on 28 April 2022.

Board Seminar – 14 June 2022

6. Board Seminar Update

6.1 The Board seminar focused mainly on the development of an acute provider collaborative for north west London, particularly on evolving proposals for new governance arrangements. The Board also considered the development of a north west London data strategy and the Trust's life sciences strategy.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC) - ACTION POINTS REGISTER

Updated: 14 July 2022 / SH

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	25 May 2022 8.1.8	Staff Story	Non-executive directors to sign up for the EDI training sessions as it would show they are taking EDI seriously and highlighted their commitment in addition to finding it invaluable. **July 2022 update:** 1. NEDs expressed an interest in engaging with the staff networks and learning more about allyship. Update: a) Communication is taking place with staff networks about engaging with NEDs. b) the white allies programme is being evaluated and advice will be produced regarding the way forward, including opportunities for NEDs 2. AF expressed an interest in attending the Active Bystander programme. Update: NEDs have been invited to attend the Active Bystander programme.	**Kevin Croft**	July 2022
2.	16 March 2022 24.2.2	Question from the Public: Palliative and End of Life care	Prof Urch agreed to provide a report of the results from the Palliative & End of Life Survey when they are published. **July 2022 update:** Prof Urch presented the results from the Palliative & End of Life Survey at the July Board meeting. **Propose to close.**	**Prof Urch**	July 2022

Items closed at the March 2022 meeting

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

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

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC

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

Agenda item 7

Author: Matthew Swindells, Chair in Common

Purpose: For noting

Meeting date: Wednesday 20 July 2022

1. Meeting Staff

1.1 In my report back in May I said that top of my priorities would be to get out around our hospitals and meet the staff who are doing such a brilliant job for local people. I am pleased to say that I now have a programme in place which enables me to get out into the service and do just that. Over the past few weeks, I have made a number of visits and met hundreds of staff, and I intend to continue to do this every month going forwards. My thanks to the people who organised my visits and to the people who were so generous with their time in showing me their services.

1.2 At **St Mary's** I had a full tour of the estate to see the desperate need for major capital investment and met ward managers and their teams who were delivering great care in Victorian conditions.

1.3 At **Charing Cross** I visited the physiology departments where we talked about the accreditation programmes that they have been going through, the challenge of recovering waiting times post COVID with high levels of sickness and vacancies and the difficulty in getting needed equipment (with the global shortage of microchips) and the need to finish the roll-out of the Cerner system and connect up other IT to give a full end-to-end view of the patient pathway.

1.4 At **Hillingdon** I visited teams from catering, security, maternity, the respiratory unit and care of the elderly to discuss their experience of working in the hospital and their pride in working in a hospital that is a real part of its local community.

1.5 At **Northwick Park** I was delighted to be part of the opening of new Clinical Research Facility and walk around it with Christiana Dinah, Director of Research, and Dame Kate Bingham.

1.6 At **Central Middlesex**, Pippa Nightingale, Chief Executive of London North West University Healthcare NHS Trust, took me for a walk around which included meeting staff that have been part of the transfer of St Mark's Hospital and see the great job they are doing to settle their patients into the new surroundings.

1.7 At **Chelsea and Westminster** I had a guided tour of the hospital from end to end by Lesley Watts, Chief Executive, seeing the exceptional facilities and care delivered to local people.

1.8 I have not visited every site yet, including my local hospital at Ealing, and I am a long way from getting to know every department - which will take me years. So, please, if you would like me

to visit your department and tell me what works and what could be better, please contact my office.

2. Meeting Stakeholders

2.1 I have met with a range of our critical stakeholders including Sean Harris - the outgoing CEO of Harrow Council, Cllr Ketan Sheth - the Chair of Community & Wellbeing Scrutiny Committee at Brent Council, and Cllrs Cowan and Coleman - the Leader and Chair of Health & Wellbeing respectively at Hammersmith and Fulham Council.

2.2 I also chaired the Hillingdon Redevelopment Partnership Board which expressed its whole-hearted support for the Outline Business Case for the new Hillingdon Hospital, developed by the hospital team. We wait anxiously now for the decision of the Department of Health and Ministers before moving on to the next phase of planning.

2.3 I have worked closely with our two Councils of Governors, chairing four meetings for Hillingdon Hospitals – Nominations and Remuneration, a redevelopment briefing, a briefing on the acute collaborative and the full Council of Governors; and two for Chelsea and Westminster – Nominations and Remuneration and the away day as well as a number of meetings with individual governors. I also met with Trish Longdon, the lead lay partner for Imperial's Lay Strategy Forum. I look forward to further developing our governor and lay member engagement in the coming months.

2.4 Lastly, I spoke at the Australia – British Health Catalyst Event at the Royal College of Physicians on "Adopting change for effective and efficient healthcare" and chaired a panel session on "Putting data to work; tackling the elective care backlog" at the NHS Confederation conference in Liverpool which our own Kate Wilson from Hillingdon and Bruno Botelho from Chelsea and Westminster were excellent contributors.

3. The Acute Collaborative

3.1 During the past month we have been developing the forward vision and structures for the acute collaborative. You will remember that the acute collaborative is driven out of the experience of COVID when the four acute hospitals in North West London demonstrated how working in partnership delivered a fantastic response for the benefit of our local population. The acute collaborative aims to continue that tightly integrated working as we recover our services after COVID and focus on improving the health of the population and reducing health inequalities, and avoid drifting back into sterile competition between our institutions.

3.2 As the first steps towards that joint working we have been moving forward on four fronts in the past few weeks.

3.3 Firstly, with the support of the two Foundation Trusts' Councils of Governors, I have confirmed Vice Chairs into post with enhanced roles to reflect their new responsibilities in tying together the work of the Boards across the Acute Collaborative. Thank you to: Steve Gill (Chelsea and Westminster), Catherine Jervis (Hillingdon), Bob Alexander (Imperial) and Janet Rubin (London North West).

3.4 Secondly, each of the four Trust Chief Executives has taken cross-system leadership for a major strategic area and is now working with the appropriate senior leadership in each of the four Trusts to implement improvements in: i) Operational performance (Lesley Watts, Chelsea and Westminster); ii) Clinical Quality and Care (Tim Orchard, Imperial); iii) People management (Pippa Nightingale, London North West); and iv) Information and data (Patricia Wright, Hillingdon).

3.5 Thirdly, we have launched a programme to bring our information across the acute collaborative onto a common data platform and to align the way we count and measure things, so that we

identify excellence and risks across the four Trusts and align around best practice so that everyone in North West London receives an equally high quality of services.

3.6 Fourthly, we have been consulting widely to design the governance structures that will enable ourselves to come together around a single Board in Common for the four Trusts in the autumn whilst, at the same time, enhancing engagement with local communities.

4. Recovering Our Services

4.1 The Chief Executives will talk more about this, but perhaps the most important thing that we have done in the last couple of months is agree and start to implement our plans for the coming year.

4.2 All of our hospitals have signed up to challenging plans for the coming year that will show us returning to levels of activity higher than they were pre-COVID whilst maintaining financial control. If we can achieve this, we will see reductions in A&E waiting time, reductions in the number of patients waiting a very long time for outpatients and surgery and a reduction in the total number of people on the waiting lists.

4.3 This will be tremendously challenging for all of our staff, and we know that even if we achieve what we have set out to do, we will still be a long way short of what any of us would consider to be our ambition for waiting time. The journey back from the impact of COVID on our services will be a long one.

5. Our Staff

5.1 By the time you read this we may know the recommendations of the pay review bodies and the government response to them. Staff will know whether the gratitude of the public expressed by people clapping on their doorsteps is being turned into a pay offer that reflects the cost of living increases our people face and supports the hospitals in recruiting and retaining staff. Whatever happens, the Board and I remain hugely grateful to all our staff, clinical and non-clinical, for the tremendous work they do every day to care for our patients.

6. 74th Birthday of the NHS

6.1 The NHS Celebrated its 74th birthday on Tuesday 5 July and a number of events took place across the four Trusts to mark the celebration.

6.2 Chelsea and Westminster NHS Foundation Trust received a visit from Professor Jacqueline Dunkley-Bent, Chief Midwifery Officer for England, who met with our staff and served up tea and cake to many of our staff and patients. Also on the day, MP Seema Maholtra visited West Middlesex University Hospital to pay a special tribute to staff from the Kew Ward.

6.3 Imperial College Healthcare NHS Trust received a visit from Amanda Pritchard, Chief Executive of NHS England, to Charing Cross hospital where she met hospital staff at the Marjory Warren acute medical unit and visited the new staff 'rest nest' break area, before stopping at the renal dialysis unit to see patients take part in one of our regular arts engagement activities. The visit ended with an NHS Big Tea party in our new staff lounge, funded by Imperial Health Charity as part of our staff spaces improvement programme.

6.4 A number of colleagues from Hillingdon Hospitals NHS foundation Trust attended a special reception at 10 Downing Street on the evening of Monday 4 July and met the prime minister.

6.5 At London North West University Healthcare NHS Trust, a number of events were held across the three sites and teams came together for tea and cake, posed for photos, watched the new HEART values video and received gifts.

7. London Bridges Walk 2022

7.1 And lastly, I would like to thank Ian Tate and the collective efforts of the Griffin Institute, Hillingdon Hospitals Charity, London North West Healthcare Charity, The Red Lion Group and the St Mark's Hospital Foundation in organising the London Bridges Walk to raise funds for their important causes. My wife and I had a great time meeting the other walkers on our way through central London and are now proud owners of the official t-shirt. Well done and thankyou to the other walkers.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC

Paper title: Establishing the north west London acute provider collaborative – governance model

Agenda item: 8

Lead Executive Director(s): Matthew Swindells, chair
Author(s): Dawn Clift, programme director; David Searle, director of corporate affairs (LNWT, THHFT); Peter Jenkinson, director of corporate governance (ICHT, CWFT)

Purpose: For approval

Meeting date: Wednesday 20 July 2022

1. Purpose of this report

1.1 The purpose of this paper is to seek approval from the four trust boards in north west London (Chelsea & Westminster NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust, London North West University Healthcare NHS Trust) for the establishment of the north west London acute provider collaborative ('the collaborative').

1.2 The paper sets out to;

- summarise the key considerations in the operation of a collaborative governance arrangement;
- outline the high level principles and assumptions which will underpin the formation and development of the collaborative;
- propose a meeting structure for the collaborative, based on agreed principles;
- propose the principles and the process for establishing an initial non-executive director (NED) complement for the collaborative, based on agreed principles, and a process to then manage recruitment / retention of NEDs (subject to the approval of councils of governors);
- propose required amendments to the NHS foundation trust constitutions to support the implementation of the collaborative (subject to the approval of councils of governors).

1.3 The paper also sets out next steps for the implementation of the proposed arrangements, if approved.

1.4 Trust boards are asked to:

- note the draft principles and vision for the collaborative, to be included in the statement of intent that will be presented for approval by the board in common (section 7)
- approve the delegation of authority to create a committee in common, to operate collaboratively with the other trust committees in common as the collaborative board in common (section 10)
- approve the proposed meeting structure for the collaborative (section 10);
- approve the process for the initial NED appointments (section 12)
- approve the proposed amendments to the NHS foundation trust constitutions and NHS trust establishment orders (section 14)
- note next steps (section 15)

2. Executive Summary

2.1 This paper provides the background and rationale for the governance changes required in order to give effect to the north west London acute provider collaborative, whose purpose is indicated in a statement of intent agreed by all four trust boards.

2.2 These proposed arrangements are a product of an appraisal of various options, considered against the principles set out in the draft statement of intent shared with boards in December 2021:

- Collaborative decision-making
- Holding each other to account
- Ensuring compliance with statutory and regulatory requirements

2.3 The Collaborative will adopt the London Leadership Values:

- Core values
  - Courage, passion and decisiveness
  - Compassion
  - Integrity
- Aspirational values
  - Consistently hard on problems but generous with people
  - Effortlessly inclusive
- Eradicate our accidental values
  - Putting institutions and staff ahead of patients and citizens
  - Using power to obstruct or for gaming, point scoring, personal attacks and bullying
  - Using information and knowledge as a “bargaining chip”
  - Failing to be open and honest
  - Learned helplessness and “playing safe”
- Alongside honesty and integrity, we expect our leaders to
  - Work collaboratively and
  - Take accountability

2.4 The paper has been developed with input from the respective vice chairs and chief executives and chair-led discussions with trust boards and, for the two

foundation trusts, councils of governors during June 2022, as well as input from key regulators, Care Quality Commission and NHS England (London).

2.5 If approved, the aim is to hold the inaugural meetings of the board in common in October 2022.

2.6 The proposed collaborative arrangements must ensure the continuation of public accountability and stakeholder involvement at trust level as well as at the level of the whole collaborative. There are also wider aspects of patient, public and staff involvement that need to be assured at all levels of the collaborative. We have sought to ensure these important issues are central to our proposed governance arrangements and ways of working and will be seeking further input from our local and sector level stakeholders to consider how we best maintain local accountability and stakeholder involvement.

2.7 We also want to support and expand other ways of building effective two-way stakeholder relationships at a local and collaborative level to help ensure openness, scrutiny and further collaboration. We will develop a shared involvement and collaboration charter, including best practice for local and collaborative transparency and wider collaboration with all stakeholders. For example, we will continue to publish trust level data on quality, finances, workforce and performance as part of the board in common meetings. Reports from the board in common and trust level committees and the board in common cabinet meetings will also be noted at the public board in common meetings. We will also expect individual trust senior teams to have regular meetings with governors (in NHS foundation trusts), elected representatives, staff side, HealthWatch and other key stakeholders.

2.8 The proposed governance arrangements have been developed based on core principles of corporate governance in a collaborative system, including adhering to the principle of subsidiarity while ensuring collaborative decision-making and holding each other to account. The proposals have also been developed to ensure the continuation of public accountability and stakeholder involvement and engagement at trust level as well as at the level of the collaborative.

2.9 The approach is consistent with the recently published (22 May 2022) NHS England draft guidance on governance and collaboration, and supports the NHS London values – working together for patients; respect and dignity; commitment to quality of care; compassion; improving lives; everyone counts.

2.10 The proposed governance arrangements have been developed to ensure continued trust level oversight of quality of care, and effective and efficient use of resources, and to provide collaborative decision-making on strategy in the interests of the population of north west London.

2.11 The central proposal is to create a board in common comprising four committees in common, each with delegated authority from its respective trust board. The board in common will meet in public and will be responsible for setting the strategy for the collaborative. It will be comprised of all voting members of the four trust boards and will normally meet four times per year. To ensure agility in decision making and to maintain oversight, the board in

common will delegate some specific responsibilities to a board in common cabinet, comprising the chair, vice chairs and chief executives, meeting in the months when the board in common is not meeting.

2.12 Five collaborative level committees which report into the board in common will be established (finance and performance, quality, people, nominations and remuneration, capital and digital), each chaired by a trust vice chair or chair and to include the lead chief executive (or nominee) and the NED who chairs their respective trust board committee. Each trust will have five standing board level committees (audit and risk management, finance and performance, quality, people, nominations and remuneration), each chaired by a vice chair or NED. This covers the statutory obligation to have committees covering audit and remuneration. Other trust and collaborative level board committees can be created by the board in common as required.

2.13 Each trust will meet at least once per year to deal with matters reserved only for that respective trust board, including approval of the annual accounts and report. Each trust will also hold its own annual general meeting / annual members meeting.

2.14 While the board in common and collaborative committees' remit will be to develop and agree collaborative level strategy, standardised approaches and common policies, the board level committees will be responsible for oversight of local implementation of these policies and discharging the responsibilities of the statutory organisations.

2.15 While ensuring that NED voting members at both trust board and board in common levels remain in the majority, the overall number of NEDs will be reduced. The NED composition of each trust will comprise the chair, vice chair, six NEDs and a university appointed NED. NEDs will be appointed as shared roles across two trusts, chairing one board committee, serving on the trust board committees of two trusts, one collaborative committee and the board in common. Vice chairs will also be a member of one other trust and sit on one of the other trust's committees.

2.16 Subject to approval by councils of governors and NHS England, NEDs will be appointed against selection criteria to ensure the collaborative has the skills and experience required, using the following process:

- Where eligible NEDs demonstrate that they have the capacity and competency to fill positions, the NEDs will be 'slotted in';
- Where there are more eligible and interested NEDs than there are positions at a trust, there will be an internal competition;
- Once these two processes are complete, any remaining vacancies will be opened up to eligible NEDs within the collaborative;
- Any vacancies that are still unfilled at the end of this process will be advertised through external competition.

2.17 In the NHS foundation trusts, the duties of governors remain the same but the scope of their remit is enhanced. This is in terms of not being restricted to representing the interests of a narrow section of the public served by 'their' NHS foundation trust but to take account of the interests of the 'public at large', including the population of the local system of which their trust is a part.

2.18 Some additional amendments are required to other governance documents to support these proposals, including the amendment of NHS trust establishment orders and NHS foundation trust constitutions.

3. Approval process

3.1. This paper has previously been discussed by the four trust boards (including vice chairs, chief executives, audit chairs), councils of governors (NHS foundation trusts), NHS England, and Care Quality Commission.

4. Recommendation(s)

4.1 Trust boards are asked to:

- note the draft principles and vision for the collaborative, to be included in the statement of intent that will be presented for approval by the board in common (section 3)
- approve the delegation of authority to create a committee in common, to operate collaboratively with the other trust committees in common as the collaborative board in common (section 6)
- approve the proposed meeting structure for the collaborative (section 6);
- approve the process for the initial NED appointments (section 8)
- approve the proposed amendments to the NHS foundation trust constitutions and NHS trust establishment orders (section 10)
- note next steps (section 11)

1.5 It is recognised that this is an innovative model and the intention is that we will review and adjust the structure as we learn over time and that the effectiveness of this structure is reviewed 12 months after implementation.

5. Next steps

5.1. Next steps are set out in section 11 of the main paper.

6. Impact assessment

6.1 Quality / workforce / equality impact: Our aim is that through the partnership work we will:

- achieve recovery of our elective care, emergency care and diagnostic capacity, not just to pre-pandemic levels but to deliver sustainable reductions in waiting and treatment times that are significantly better than before the pandemic;
- support the ICS's mission to address the health inequalities that exist in our population and eliminate inequity in access to - and experience - of our services;
- create an excellent environment that attracts, retains and develops the best staff in the NHS, recognising and supporting the exceptional effort

and dedication of our people, and provide resilience to workforce pressures across north west London;
- achieve continuous improvement in quality, efficiency and outcomes including proactively addressing unwarranted variation in clinical services and improving effectiveness and efficiency of corporate and clinical support services; and
- achieve a more rapid spread of innovation, research and transformation

6.2 Financial impact: While there has been financial target attached to these proposals, the proposed governance model outlined in this paper will provide overall savings across the four acute trusts in the cost of governance at board level.

6.3 Risk impact: a risk assessment and risk register for the collaborative will be developed and presented to the inaugural meeting of the board in common.

Main paper

7. Introduction – vision / ambition

7.1 On 1 April 2022, the first chair in common for the four acute trusts north west London was appointed. This was based upon an agreement between NHS England (London region), the provisional North West London Integrated Care System (ICS), the four trust boards and the governors of the two foundation trusts that the trusts needed to formalise their co-working for the benefit of the population of north west London.

7.2 The trusts' united response to Covid-19, where they demonstrated the value that was to be gained from working together as an acute collaborative, had made clear that as the NHS faces up to the post Covid-19 challenges of reducing long waits, tackling population health inequalities and preparing for future challenges to the health of the population, the best way forward is through working together, not working in competition.

7.3 This vision is being brought together into a statement of intent that describes our goal to broaden and deepen collaborative working across the trusts and their leadership, working in partnership with our dedicated and diverse workforce and engaging closely with non-executives as well as governors of the two foundation trusts.

7.4 We want to be demonstrably best in class in partnership working across health and care within the ICS with other parts of the NHS, Local Authorities, and the voluntary and private sectors; realising the benefits of mutual aid and working at scale for our populations and staff to deliver the highest quality of care efficiently, and supporting excellence in research and education.

7.5 Through this partnership work we will:

- achieve **recovery** of our elective care, emergency care and diagnostic capacity, not just to pre-pandemic levels but to deliver sustainable reductions in waiting and treatment times that are significantly better than before the pandemic;
- support the ICS's mission to address the **health inequalities** that exist in our population and eliminate inequity in access to - and experience - of our services;
- create an excellent environment that attracts, retains and develops the best **staff** in the NHS, recognising and supporting the exceptional effort and dedication of our people, and provide resilience to workforce pressures across north west London;
- achieve **continuous improvement** in quality, efficiency and outcomes including proactively addressing unwarranted variation in clinical services and improving effectiveness and efficiency of corporate and clinical support services; and
- achieve a more rapid spread of **innovation, research and transformation**.

7.6 Through partnership working we will demonstrate the NHS London values:

- **Working together for patients** – The value of 'working together for patients' is a central tenet guiding service provision in the NHS and other organisations providing health services. Patients must come first in everything the NHS does. All parts of the NHS system should act and collaborate in the interests of patients, always putting patient interest before institutional interest, even when that involves admitting mistakes. As well as working with each other, health service organisations and providers should also involve staff, patients, carers, local communities to ensure they are providing services tailored to local needs.
- **Respect and dignity** – Every individual who comes into contact with the NHS and organisations providing health services should always be treated with respect and dignity, regardless of whether they are a patient, carer or member of staff.
- **Commitment to quality of care –** The NHS aspires to the highest standards of excellence and professionalism in the provision of high quality care that is safe, effective and focused on patient experience.
- **Compassion –** Compassionate care ties closely with respect and dignity in that individual patients, carers and relatives must be treated with sensitivity and kindness.
- **Improving lives –** The core function of the NHS is emphasised in this value – the NHS seeks to improve the health and wellbeing of patients, communities and its staff through professionalism, innovation and excellence in care. This value also recognises that to really improve lives the NHS needs to be helping people and their communities take responsibility for living healthier lives.
- **Everyone counts –** We have a responsibility to maximise the benefits we obtain from NHS resources, ensuring they are distributed fairly to those most in need. Nobody should be discriminated or disadvantaged and everyone should be treated with equal respect and importance.

7.7 The Collaborative will adopt the London Leadership Values:

- Core values
  - Courage, passion and decisiveness
  - Compassion
  - Integrity
- Aspirational values
  - Consistently hard on problems but generous with people
  - Effortlessly inclusive
- Eradicate our accidental values
  - Putting institutions and staff ahead of patients and citizens
  - Using power to obstruct or for gaming, point scoring, personal attacks and bullying
  - Using information and knowledge as a "bargaining chip"
  - Failing to be open and honest
  - Learned helplessness and "playing safe"
- Alongside honesty and integrity, we expect our leaders to
  - Work collaboratively and
  - Take accountability

7.8 We have developed a consensus amongst existing trust boards that the establishment of a board in common, the consequent collaborative committees and board level committees, and the sharing of NEDs between trusts in the collaborative is the necessary next step to make a reality of opportunities described above for the acute collaborative.

8. Background

8.1 The north west London acute provider collaborative is in the process of forming. A draft statement of intent expresses the aim to build on the existing collaborative arrangements, including the north west London acute care programme, to establish governance arrangements that enable providers efficiently to reach joint decisions, which each organisation is committed to upholding, while recognising the statutory roles of trust boards and, for foundation trusts, councils of governors. These arrangements will also provide strong mechanisms for acute provider partners to hold each other to account.

8.2 Through these arrangements, the collaborative will ensure that decisions are reached and implemented, and benefits of scale are realised at pace, so that the resources across the four acute trusts are harnessed to support improvements in the health and life outcomes of the population we serve as a key player in the North West London Integrated Care System (ICS).

8.3 The governance mechanism used to deliver the envisaged arrangements will be the establishment of a board in common. This model is familiar to the NHS and is already in operation in some systems.

8.4 The proposed arrangements have also been based on recently published NHS England / Improvement guidance on good governance and collaboration. The documents reflect the passing of the Health and Care Act 2022 and include provisions related to system working.

9. Key principles / assumptions

9.1 For the collaborative to form as envisaged, each trust will need to establish a committee in common (CiC). Each trust board will delegate an agreed scope of decision making, via the scheme of delegated authority, to a (new) committee of its board. In the case of our collaborative, the CiC for each trust will comprise all voting members of the board. These four committees meeting in common form the collaborative board in common.

9.2 Formal voting tends to be rare for NHS boards but is a governance concept applicable to all boards. ‘Voting’ in this paper therefore refers to the decision-making process employed by the north west London acute provider collaborative. Where the collaborative board in common votes on resolutions, under current regulations there is no delegation of powers between the statutory trust boards and therefore no trust could be bound by a decision taken by another trust in the board in common.

9.3 For those members of the board in common who hold a shared role across one or more trust boards, that individual must consider the respective trust's best interests in relation to each matter and vote separately on each relevant CiC of which he/she is a member. That means when voting for resolutions for the board in common, each trust board will form as its own CiC to vote as a statutory body and so board members with shared roles will need to vote at each of the trust boards they serve.

9.4 The board in common will meet in public but will reserve the right to meet in private session to discuss confidential items, reflecting the current practice for trust boards.

9.5 In developing these proposals, governance mechanisms required under regulations or statute have been adhered to (eg the maintenance of audit and nomination and remuneration committee at trust level) and latest best practice in corporate governance applied.

10. Governance / meeting structure

10.1 This section of the paper sets out the proposed outline terms of reference for these meetings, including purpose, frequency and membership. The proposed governance structure is based on some core principles:

- The north west London acute provider collaborative will establish a board in common
- The board in common will be comprised of four committees in common, with delegated authority from the trust boards of Chelsea & Westminster NHS Foundation Trust, The Hillingdon Hospitals NHS Foundation Trust, Imperial College Healthcare NHS Trust, London North West University Healthcare NHS Trust.
- The board in common will have membership from all four trusts.
- The board in common will meet in public.
- Collaborative committees will be established for functional areas of governance in common to all four trusts (eg quality, finance and operations, people), and nominations and remuneration.
- Each trust will maintain at least one trust board meeting to deal with matters reserved only for that respective board, including approval of the annual accounts and report. Each trust will also hold its own annual general meeting / annual members meeting.
- Each trust will need a sub-committee structure, to include statutory duties (ie audit, remuneration) and other committees to ensure local oversight of performance (eg quality, finance, performance, people).

10.2 The collaborative will establish a board in common, by each trust delegating authority to a committee in common (CiC) and the board in common having a membership made up of the four CiCs.

10.3 The board in common will be responsible for setting the strategy for the collaborative and will provide oversight of performance in areas such as

quality, finance, workforce at collaborative level, receiving assurance from the collaborative committees.

10.4 Each trust will delegate an agreed scope of decision making to a committee of its board, and maintain a trust board meeting to deal with matters reserved only for that respective board, including:

- Approval of scheme of delegated authority (annual)
- Approval of standing orders (annual)
- Approval of annual accounts and report (annual)
- Charitable funds – annual accounts and report (annual) (where applicable)
- Receive annual management letter from external auditor (annual)
- Receive the annual Head of internal audit opinion (annual)
- Approval of annual financial and operational plan (annual)

10.5 As now, each trust will establish a board level committee structure, to include statutory duties (i.e audit, remuneration) and the trust board will delegate some powers to these committees to give time to detailed scrutiny and oversight, and to make decisions within agreed levels of authority.

10.6 The key component parts of the governance structure are:

(i) Board level committees
(ii) Collaborative committees
(iii) Board-in-common

(i) Board level committees

10.7 ***Subsidiarity*** is an important principle in the governance of a collaborative - that holds that issues should be dealt with at the most immediate (or local) level that is consistent with their resolution. Local trust-level oversight and decision-making is an important feature of the proposed governance arrangements.

10.8 We propose to establish five standing board level committees at each Trust, each of which will be chaired by a NED or the vice chair.

- Audit and risk
- Finance and performance
- Quality
- Workforce
- Nominations & remuneration

10.9 There are two statutory committees that trusts must have – audit and nominations and Remuneration committee (both have NED only membership). Trusts may also establish specific committees to meet local need, such as charity funds committee, estate redevelopment.

10.10 The normal frequency of these meetings will be:

- Audit and risk (quarterly)
- Finance and performance (bi-monthly)
- Quality (bi-monthly)
- Workforce (bi-monthly)
- Nominations and remuneration (quarterly)

10.11 This frequency can be amended at local level to accommodate local (e.g. regulatory) needs. Committees may at times need to convene extra-ordinary meetings to manage specific needs.

10.12 The purpose of these meetings will be:

- Oversight of trust level performance (assurance)
- Trust level decision-making (within the authorities set out in the scheme of delegated authority)
- Overseeing development and implementation of trust level strategy, within the strategic framework agreed at collaborative level (eg local quality priorities within the overall quality strategy for the collaborative).

10.13 With the exception of audit and the nominations and remuneration committees (NED only membership), membership will include:

- Vice chair / NED chair
- Two NED members
- Executive lead(s)
- Chief executive / nominated representative (as standing attendees)

10.14 The draft terms of reference for these committees will be considered by the respective committees and recommended to the board in common for approval.

10.15 With the exception of the audit and risk committees, the board level committees will report into the collaborative committees, to provide a trust level view of delivery against collaborative priorities; all board committees will also provide a summary of assurance to the trust board via the board in common.

(ii) <u>Collaborative level committees</u>

10.16 We propose to establish five collaborative committees, each chaired by one of the vice chairs or the chair, and including the relevant 'lead' chief executive (each chief executive has been assigned to lead a specific workstream, aligned with the collaborative committees) and the NED chairs of respective trust board committees in the membership.

- Finance and performance (Vice chair, F&P board committee chairs, lead chief executive, plus chief financial officers (CFOs)
- Quality (Vice chair, quality board committee chairs, lead chief executive)
- People (Vice chair, workforce board committee chairs, lead chief executive)

- Estates and digital (vice chair, relevant NEDs, chief executive nominations, lead chief executive)
- Nominations and Remuneration (Chair, Vice chairs)

In addition to the voting membership above, the individual terms of reference for each committee will define any regular attendees, to provide subject matter expertise.

10.17 These collaborative committees will meet quarterly.

10.18 The purpose of these meetings will be to:

- Consider a collaborative view of performance (assurance)
- Develop relevant strategy and policy at collaborative level (strategy)
- Oversee alignment / standardisation of approach (including reporting etc) (alignment)

10.19 Membership will include:

- Vice chair
- NED chairs of respective board level committees
- Lead chief executive
- Chief executive or their nominees appropriate for each committee

10.20 Additional attendees will be agreed by the appropriate Vice chair and the lead chief executive.

10.21 The relevant chief executives (or in the case of the finance committee the chief financial officers) will coordinate and provide secretariat support for these meetings.

10.22 Collaborative committees will report into the board in common to provide assurance at collaborative level.

(iii) <u>'Board in common'</u>

10.23 The core concept of the collaborative is the four statutory boards working together in the interests of their patients and the population of north west London. Therefore, a key component of the collaborative governance framework is how the four statutory boards of the trusts work together to make collective decisions and hold each other to account.

10.24 The governance model for the collaborative is focused around the role of the board in common as the primary decision-making body for the collaborative, being fully representative of the four trusts.

<u>Key principles / statutory guidance</u>

10.25 This is achieved by creating a board in common' which is made up of four committees in common (CiC), with delegated authority from each of the four trusts. Each trust therefore remains a statutory organisation but delegates an

agreed scope of decision making to a committee of its board. These four CiCs meet at the same time and at the same place and discuss a common agenda, but decisions are taken by each individual CiC on behalf of their trust board. Each CiC has duties to the organisation from which it is constituted. The general structure is indicated in figure 1.

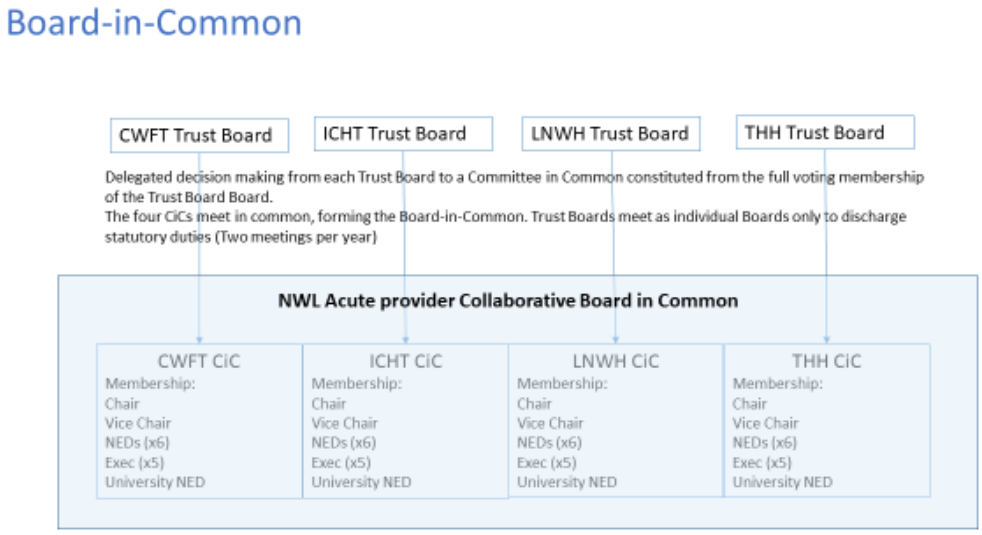


Figure 1

10.26 The members of each CiC will vote on resolutions put forward at the board in common, as a CiC – there would be no delegation of powers between trusts, therefore no trust could be bound by a decision taken by another trust's CiC.

10.27 Where an individual board member has a shared role across more than one trust, that individual must consider the respective trust's best interests in relation to each matter and vote separately on each CiC. Policies in relation to managing conflicts of interest will be included in the standing orders of the board in common.

10.28 The board in common will consist of a CiC with delegated authority from each trust board. Each CiC will be composed of the whole voting membership of each Trust board; the board in common therefore comprises the voting members of all four trust Boards.

10.29 All four Trust Boards will therefore be 'in the room' at all meetings of the board in common. The board in common will discuss common agenda items for the collaborative but would then vote on resolutions on behalf of their own trust board.

10.30 The board in common will normally meet four times per year. Each meeting will consist of three parts:

- board in common meeting in public
- board in common meeting in private – strategy / development session

- Individual trust board meetings for matters reserved for the trust board, when required.

10.31 This arrangement means that all board members are present at board in common meetings and therefore all board members get a 'vote' when it comes to decision-making. Although the actual number of NED members would be less than the number of executive directors present given the proposed model of shared NEDs, the voting rights held by the NEDs means that each CiC will have a majority of NED votes. Individual trust boards will only need to meet separately to the board in common when necessary to conduct matters reserved to individual trust boards, and may be held in public or private as the agenda dictates.

10.32 While it is important for all members of the four boards to be present at board in common, given that this will be the prime decision-making body for the collaborative, the number of members in the meeting increases the risk of ineffectiveness of the meeting by restricting individual board members' ability to contribute. To mitigate this risk, a detailed 'managing meetings' protocol has been developed, including how decisions are made and 'dispute resolution' arrangements.

10.33 There is also a risk of this arrangement being insufficiently agile should more urgent decisions be required. To mitigate this risk, the board in common will delegate authority to a board in common 'cabinet' to meet in the months when the full board in common is not meeting to make any urgent decisions required, acting within a scheme of delegated authority agreed by the full board in common. Any decisions made by the cabinet will be reported to and ratified by the full board in common.

10.34 This Board in Common Cabinet will have a membership consisting of:

- Chair
- Vice chairs of each trust
- Chief executives of each trust

10.35 Others will be invited as appropriate, as attendees.

10.36 Figure 2 below shows how this board in common will operate and the scheme of delegated authority.

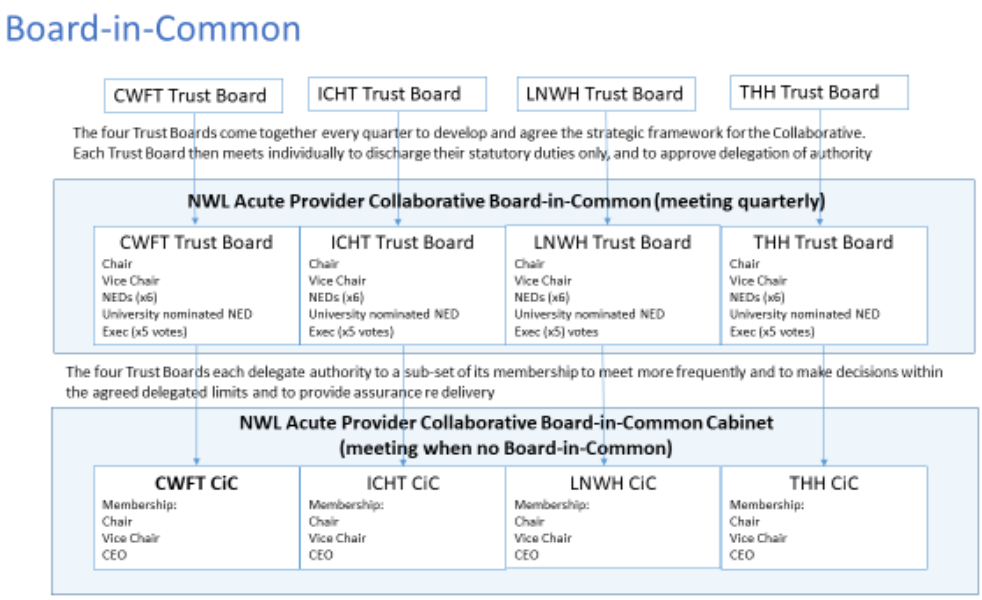


Figure 2

11. Audit and risk management

11.1 As statutorily independent organisations, each trust will establish an audit and risk management committee with delegated authority from each trust board. The role of the audit committee is to ensure, on behalf of the board, that the systems of internal control are effective and financial reporting is accurate.

11.2 The main role and responsibilities of the audit and risk committee will be set out in written terms of reference and will include:

- to monitor the integrity of the financial statements and any formal announcements relating to financial performance, reviewing significant financial reporting judgements contained in them;
- to review internal financial controls and internal control and risk management systems;
- to make recommendations to the board, in relation to the appointment and terms of engagement of the external auditor;
- to review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process;
- to develop and implement policy on the engagement of the external auditor to supply non-audit services, and to report to the board; and
- to report to the board on how it has discharged its responsibilities.

11.3 Other responsibilities of the audit and risk committee include:

- **Whistleblowing** – to ensure appropriate arrangements are in place by which staff can, in confidence, raise concerns about possible improprieties in matters of financial reporting, patient safety, or other matters, and to ensure that arrangements are in place for the proportionate and

independent investigation of such matters and for appropriate follow-up action.

- **Internal controls and risk management systems** – the committee will be responsible for oversight of the trust's risk management systems and to provide assurance to the trust board that such systems are effective (management is responsible for the identification, assessment, management and monitoring of risk, for developing, operating and monitoring the system of internal control and for providing assurance to the board that it has done so). The committee will therefore act on behalf of the trust board to ensure that risks are identified and managed appropriately, and that other board level committees have appropriate oversight mechanisms for relevant risks. The committee will also review specific risks within its own remit, as specified in the terms of reference.
- **Internal audit –** the committee will ensure that there is an effective internal audit function and a plan of activities being performed by the internal audit function appropriate to the trust's risk universe.
- **Counter fraud** – The committee will receive regular updates on counter fraud activities at the trust, including initiatives to raise aware and ongoing cases under investigation.

11.4 Within the north west London acute provider collaborative, each trust remains a statutory organisation, subject to its own regulatory requirements. However, while under the subsidiarity principles the audit function will operate at individual trust level and will provide assurance to each trust board, there is a need for common issues and risks to be reported at collaborative level so that the benefits of the joint resources of the collaborative can be brought to bear to manage common issues / risks.

11.5 The board in common will ensure that there is adequate cooperation within the collaborative (and with internal and external auditors of individual trusts within the collaborative) to enable common risks to the achievement of the strategic objectives of the collaborative to be identified and managed appropriately.

11.6 Initially, there will not be a collaborative level audit and risk management committee and each audit and risk committee will report to the board in common, but this will be reviewed over time. As the collaborative develops and more common areas of risk are identified through the individual trusts' audit and risk management committees and internal / external audit functions, the opportunities of a more collaborative approach to audit and risk will be considered. While there is no case for a standing audit and risk management committee at collaborative level in the first instance, a regular audit chairs' coordination meeting will be established to allow cross-organisational learning and alignment of audit planning.

Risk and assurance management – processes and structures

11.7 Each trust must have a systematic framework for internal control, ensuring effective reporting and escalation mechanisms from 'ward to board'. This includes divisional and directorate level management and quality groups, as well as specialist committees (for example health and safety and infection

prevention and control), where quality, safety and performance reports are reviewed and issues or risks escalated, as appropriate.

11.8 Each trust's framework will consist of:

- risk appetite statement which sets the amount of risk that the Trust is prepared to accept or tolerate for each area of risk
- risk management policy which describe the approach that the Trust takes to identifying, assessing and managing risk, including: the different levels of risk registers (e.g. directorate / divisional level risk registers); how to assess and evaluate risks using a standardised matrix; and how risks are escalated through the risk management structure, ultimately to the corporate risk register if they have a significant impact on the whole organisation or on the achievement of corporate objectives
- risk registers which document risks at each level of the Trust, including actions to control, mitigate or resolve
- board assurance framework, identifying the key strategic risks to achievement of the Trust's aims and objectives, and assurance processes to ensure that these strategic risks are being managed.

11.9 The effectiveness of the risk management framework, and the management of risks, will be monitored by the trust's executive management team. The audit and risk management committee oversees the effectiveness of the risk management process, on behalf of the trust board. The corporate risk register is also reviewed regularly, together with themes from key divisional risk registers and the key divisional risks profile. These give the committee visibility of the overall trust risk exposure and how effectively risks are managed at the trust.

11.10 At collaborative level, there will be a collaborative level board assurance framework and risk register, including key strategic risks to achievement of the vision and objectives of the collaborative. This will be reviewed by the board in common and appropriate actions delegated to mitigate any risks.

11.11 Prior to the first meeting of the board in common, the collaborative level board assurance framework will be populated with strategic risks to the achievement of the collaborative aims and objectives.

12. Board composition

Non-executive directors (NEDs)

12.1 Currently, in accordance with trust constitutions and establishment orders, the four acute trusts have, in total, a voting board membership of 51 people consisting of 29 voting NEDs and 22 voting executives. In addition to this, trust boards also employ non-voting associate NEDs to provide some resilience in succession planning.

12.2 The proposal is to amend the composition of each trust board, creating shared NED posts across trusts. The creation of shared NED roles will ensure cross-organisational learning and collaborative working.

12.3 The NED complement for each Trust Board, consisting of:

- Chair
- Vice chair
- Vice chair from one other trust
- Six NEDs (shared across trusts)
- University appointed NED

12.4 In the case of the two NHS Trusts (Imperial College Healthcare NHS Trust and London North West University Healthcare NHS Trust), this will mean increasing the maximum number of NEDs in the trusts' establishment order. The proposal is to appoint NEDs to shared roles on a 'designate' basis, pending the successful outcome of a process required to amend the establishment order as a statutory instrument.

12.5 In considering the NED composition across the four trust boards, and proposing an initial establishment, some key principles have been applied:

- The NED relationship with the foundation trust council of governors, and the duties of councils of governors in respect of NEDs, is unchanged.
- Each of the four trusts will have a composition of six NEDs, each NED role being a shared post across two trusts within the collaborative;
- In addition, each trust will have a chair (the chair in common), plus a vice chair.
- The two NHS trusts are required to have a university appointed NED as part of their NED establishment in addition to the six indicated above; we will seek the nomination from Imperial College London of two university appointed NEDs across the four trusts.
- There will be standardisation across the four trusts in the terms of office for NEDs. Applying the foundation trust constitution rules, and therefore compliance with the foundation trust code of governance, NEDs will be able to serve two terms of three years, plus additional years with annual approval (to a maximum of 9 years).
- NEDs will be appointed as a shared post across two of the four trusts, with shared posts across the NHS trusts and the NHS foundation trusts.
- Vice chairs will also be appointed as member of one other trust, in order to sit on one of the other trust's committees.
- No employee of the four acute trusts can be appointed as a NED due to potential conflict of interest in view of the new collaborative arrangements.
- NEDs' time commitment across both of their Trusts should not be significantly greater than currently but it is acknowledged that these roles will be more complex and require more time during the transition period.

- The NED voting composition of each trust board, including the Chair, must be in majority over the executive composition – each trust will have up to five voting executive directors.
- There will be a provision for vice chairs to appoint associate NEDs to local trust board committees, where appropriate. These will be remunerated roles, at a rate agreed by the collaborative.

12.6 In developing the governance arrangements a guiding principle has been that NEDs' time commitment should not be significantly greater than the current commitment.

12.7 It is recognised that there are several elements of a NED role that add to the time commitments, including conducting board member visits to parts of the Trust, engaging with the Governors and stakeholder groups, and participating in consultant appointment panels when appropriate.

12.8 In terms of meetings, the normally expected commitment from NEDs will include:

- chair one board-level committee (bi-monthly) and be a member of two additional board-level committees (bi-monthly);
- attend one collaborative committee in their capacity as chair of one of the Board committees feeding into the collaborative committee (quarterly);
- attend the Board-in-Common (quarterly);
- attend the Trusts' Annual General Meeting / Annual Members' Meeting (annually x2)
- take on Board Champion roles as requested
- support local committees set up by agreement with the Chair and the appropriate Vice Chairs to meet local needs when requested, such as the Charity Committee in some Trusts and the Redevelopment Committee in others

12.9 Vice chairs will chair one board committee, attend one other board committee, and chair one collaborative committee. They will also chair the trust level nominations and remuneration committee as well as the trust board meeting when convened to discharge matters reserved for their trust board.

12.10 We propose that NED champion roles will be appointed as shared roles across two trusts, with a standardised approach each champion role, unless there is a need for increased commitment at any given time (for example current requirements for maternity champions.)

12.11 It is acknowledged that these roles will be more complex and require more time during the transition period, as NEDs getting to know a second hospital and the collaborative as a whole will place additional demands. As the new structure comes into place we will undertake a thorough review of how NED time is used to ensure that it is used efficiently and effectively and that the roles are doable.

12.12 We also recognise that the new roles will be more complex and therefore, subject to approval by NHSI/E and councils of governors, we propose to recognise that by adding a 'complexity supplement' to NEDs' remuneration.

12.13 Applying these principles to consideration of an initial establishment means the following rules will be applied:

- NEDs in post with a term of office that ends in the next six months which is equivalent to, or more than six years, will not be able to continue in their current roles. They will, however, be able to apply for roles in different trusts within the collaborative, should vacancies arise.
- NEDs with a term of office below six years will have the opportunity to be appointed for a minimum period of one year; in cases where this results in a total term of office exceeding six years, any further extension will require additional approval.

12.14 For the initial NED establishment, where possible while maintaining accordance with the rules above, existing NEDs will be considered first for the new roles. Thereafter, when vacancies then arise, they will be filled by normal recruitment process as per NHS England / FT constitution requirements.

12.15 When appointing NEDs, we need to ensure everyone has the basic skillset of a NED, including competency and capability to:

- be a member of the board in common
- be a member of two trust boards for their statutory meeting
- chair a board level committee and sit on the related committee in common
- sit on two other committees in a second Trust
- sit on or chair other committees as required
- take on lead NED champion roles as allocated by vice chair, such as FTSU and Maternity Champion
- Maintain an engagement with the trust beyond board and committee meetings

NEDs will also need to demonstrate that they provide specific skills that Boards require, including, for example: financial experience, quality, workforce, strategy.

12.16 We will be seeking:

- The right skills for the roles
- Diversity that reflects the populations we serve
- A relationship with the north west London area or the hospitals within the collaborative

12.17 The proposed process for appointing NEDs will be:

- Where NEDs demonstrate that they have the capacity and capability as outlined above, and we have the right number of eligible NEDs for the

vacant positions, those existing NEDs will be 'slotted in' to the vacant NED positions by agreement with the individuals.

- Where there are more eligible and interested NEDs than there are positions at a trust, there will be an internal competition for the roles.
- Once these two processes are complete, any remaining vacancies will be opened up to NEDs who are still looking for a role in the new structure and to current associate NEDs
- Any vacancies that are still unfilled at the end of this process will be opened up to external applicants.

12.18 Through this process, we will establish an initial NED establishment of 12 NEDs, with the appropriate mix of skillset and characteristics. In addition, Imperial College London will be invited to nominate two university appointed NEDs, who would hold shared roles across two trusts each and would perform a specific NED portfolio in quality / education. **Appendix 1** shows how these NEDs may be allocated to trust board committees.

12.19 This approach helps to preserve corporate memory amongst NEDs within the trusts and collaborative, and avoids immediate disruption to the entirety of NED members. It, however, allows for an appropriate assessment of NEDs' skills against the required skillset, and ensures we select the best candidates while also ensuring diversity of characteristics.

12.20 Once we have an initial NED complement established, we will subsequently use the normal process of recruitment to vacant NED roles, using the same principles / rules as above, but with a particular focus on the skills and characteristics we want to achieve to ensure balanced and diverse trust boards and therefore board in common.

Next steps

12.21 Those individuals directly affected have been involved in the development of this process and will now be asked to confirm their intention to be appointed in to these revised roles and, therefore, to take part in an assessment process to be undertaken by the chair and vice chairs.

12.22 This process and the appointment of individuals is subject to approval by NHS England and NHS London in the case of appointments to NHS trusts, and the councils of governors in the case of appointments to the NHS foundation trusts.

12.23 The NHS trusts will follow the process to seek parliamentary assent to vary their respective establishment orders.

Executive directors

12.24 The proposal is for the executive director complement of each trust board to remain as is.

12.25 There is some variation in the number of voting executive directors across the four trusts. However, all trusts (FT and NHS trusts) must have:

- Chief executive
- Finance director
- Medical director
- Nurse director

12.26 In the event of the board in common electing to go to a vote on a specific resolution, each trust board will vote separately and therefore the majority between NEDs and executive director votes will apply for each trust. In normal practice at the board in common in decision making, each trust will have five executive director 'votes'.

13. Maintaining public accountability and stakeholder involvement

13.1 The proposed collaborative arrangements must ensure the continuation of public accountability and stakeholder involvement at trust level as well as at the level of the whole collaborative. There are also wider aspects of patient, public and staff involvement that need to be assured at all levels of the collaborative. We have sought to ensure these important issues are central to our proposed governance arrangements and ways of working and will be seeking further input from our local and sector level stakeholders to consider how we best maintain local accountability and stakeholder involvement.

13.2 Within the collaborative, we have NHS trusts (Imperial College Healthcare and London North West) and NHS foundation trusts (Chelsea and Westminster and Hillingdon) which have differing statutory and regulatory requirements. We will build on both existing statutory stakeholder representation via the FT councils of governors and non-statutory lay partnership input across all trusts.

13.3 The purpose of this section is to set out the role of FT councils of governors in the proposed governance arrangements for the north west London acute provider collaborative, and to outline how we will continue to ensure public accountability and effective patient and public involvement at local and collaborative levels.

Role and responsibilities of governors

13.4 For foundation trusts, governors play an integral part in the trust governance. Much of the role of governors won't change from the original statutory duties as set out in the 2006 Act. However, recent guidance published by NHS England ('System working and collaboration: The role of foundation trust councils of governors' May 2022) explains how the duties of NHS foundation trust councils of governors are enhanced in collaborative systems:

"Within those duties, councils of governors are legally responsible for representing the interests of the members of the NHS foundation trust and the public. While the meaning of 'the public' is not specified in legislation, councils of governors are not restricted to representing the interests of a narrow section of the public served by the NHS foundation trust – that is, patients and the public within the vicinity of the trust or those who form governors' own electorates.

To support collaboration between organisations and the delivery of better, joined up care, councils of governors are required to form a rounded view of the interests of the 'public at large'. This includes the population of the local system of which the NHS foundation trust is part. No organisation can operate in isolation, and each is dependent on the efforts of others."
['System working and collaboration: The role of foundation trust councils of governors' May 2022]

13.5 While staff governors and patient, carer and service user governors represent specific constituencies, they are also expected to represent the interests of the members of the trust as a whole and the public. Therefore, they are required to seek and form a view of the interests of the 'public at large'.

13.6 The proposed governance arrangements for the collaborative will not change the role that councils of governors have within their individual trusts but they will affect what governors need to consider when performing their statutory duties.

13.7 The governors hold various statutory duties. Those that will be most affected by the proposed transition to system-working within the collaborative:

- Holding the non-executive directors individually and collectively to account for the performance of the board of directors.
- Representing the interests of the members of the NHS foundation trust and the public.
- Approving 'significant transactions', mergers, acquisitions, separations or dissolutions.
- Approval of the appointment and remuneration of chair and non-executive directors.

Holding the non-executive directors individually and collectively to account for the performance of the board of directors.

13.8 To hold the non-executive directors to account, the governors already have a number of approaches in place, including:

- observing the contributions of the non-executive directors at board meetings and during meetings with governors;
- gathering information on the performance of the board against its strategy and plans;
- receiving the trust's quality report and accounts and questioning the non-executive directors on their content.

13.9 There are also local arrangements, as agreed between board and council of governors, that will remain as is.

13.10 These allow the council of governors to determine its key areas of concern and provide appropriate challenge at local trust level. These will remain under the proposed arrangement, with governors invited to attend the board-in-common meetings (quarterly) and the individual trust board meetings (twice per year).

13.11 However, governors will also now need to form a view about their trust's contribution to system performance and development, shared planning and

contribution towards the achievement of ICS strategy, and receiving assurance that the board's decisions have regard to the 'triple aim' duty – better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. Observing the board-in-common meetings will help governors to gain this assurance. We will work with the two Councils of Governors to explore new ways in which they can work together to have wider visibility of the health improvement opportunities across north west London and engagement with the Board in Common.

Representing the interests of the members of the NHS foundation trust and the public.

13.12 Councils of governors have a duty to represent the interests of the members of 'their' NHS foundation trust and the public.

13.13 However, councils of governors are not restricted to representing the interests of a narrow section of the public served by the NHS foundation trust – that is, patients and the public within the vicinity of the trust or those who form governors' own electorates. To discharge this statutory duty, councils of governors are required to take account of the interests of the 'public at large'. This includes the population of the local system of which the trust is part.

13.14 The governors already have existing mechanisms to represent the interests of the members of the foundation trust, including:

- governor drop-in events where members and the public can meet governors
- a dedicated page on the foundation trust's website to share information and surveys to gather members' and the public's views
- Council of governor sub-committees, including quality, planning and membership

13.15 Governors will be invited to attend and observe the board in common meetings and will be able to input into the development of the collaborative strategy and to seek assurance that the strategy is in the interests of the public and patients of north west London (including helping to ensure equality of access, experience and outcomes to acute care and to tackle health inequalities across the population of north west London).

Approving 'significant transactions', mergers, acquisitions, separations or dissolutions

13.16 Councils of governors are responsible for assuring themselves that their board of directors has been thorough and comprehensive in reaching its decision to undertake a 'significant transaction' and that it has appropriately considered the interests of members and the public as part of the decision-making process.

13.17 This duty to consider the interests of the wider public means that there may be examples where councils of governors approve a significant transaction that may not immediately benefit 'their' individual trust but overall does benefit the population of the wider Integrated Care System (ICS).

13.18 Councils of governors will need to be assured their foundation trust board has considered the consequences of decisions on other partners within their system, and the impact on the public at large.

Appointment and deciding on the remuneration of chair and non-executive directors.

13.19 The Council of Governors duty to appoint the chair and non-executive directors of their foundation trust will not change.

13.20 More details on the proposed non-executive director composition for each trust is contained in the governance proposals. Non-executive directors of the two foundation trusts will also be appointed as non-executive directors of one other trust within the collaborative, and non-executive directors appointed by NHS trusts will also serve as non-executive directors of one of the foundation trusts. As such, there will need to be dual approval of such posts, and remuneration, by NHS England and the council of governors, with final approval for non-executives appointed by foundation trusts resting with the council of governors.

13.21 Non-executive directors will be responsible for oversight of the delivery of the regulatory requirements of their individual trusts, but will also be responsible for the delivery of the strategic objectives of the collaborative. Governors will have the appropriate mechanisms to hold those non-executive directors to account for both these areas of responsibility.

Engagement and involvement of governors

13.22 The proposed arrangements for governors will ensure that the council of governors is provided with appropriate information, and that the governors are given opportunities to meet their board to raise questions about their trust's role within the system, or systems, of which it is part.

13.23 Governors can expect to attend and observe a variety of meetings organised by the trust, which intend to help inform their decision-making, and to support governors in fulfilling their duties. Formally, this will include the existing council of governor meetings and annual members meetings. Governors will also be invited to attend and observe board in common meetings held in public, and their respective trust board meetings held in public as current.

13.24 Other existing mechanisms of engagement will continue as they are, including, for example:

- informal meetings such as Q&As with the chief executive or chair, and workshops with the non-executive directors or board
- regular briefings to members and governors from the chief executive or chair
- ad-hoc briefings or dissemination of information as an issue arises
- non-executive director committee chair reports to council of governor meetings.

Patient and public involvement strategies, including the role of lay partners

13.25 NHS Trusts do not have councils of governors and do not have the same statutory responsibilities relating to governors. However, they can and do draw on other means of helping to ensure the trust understands the needs and views of its stakeholders (including patients, local communities, carers and staff) and responds to them effectively. At Imperial College Healthcare, there is a comprehensive patient and public involvement strategy and framework that is overseen by its strategic lay forum – made up of lay partners drawn from local and patient populations. The strategic lay forum helps to ensure that the trust's strategy, priorities and major projects and programmes take into full consideration the needs and views of patients, local communities and other stakeholders.

13.26 Lay partners are also beginning to be involved in collaborative level projects and programmes, including on key project groups and programme boards, to help ensure effective patient and public involvement and user-focus. We will seek to build on and expand this approach as the collaborative develops, exploring how this can also complement the role of governors in this new environment.

Public accountability

13.27 Meetings of the board in common will be in two parts, as per current practice. While the board in common will reserve the right to deal with specific matters in private, due to confidential or commercial sensitivity, the board in common meetings will be held in public. As per current practice, members of the public, and governors, will be able to ask questions of the board as part of that meeting.

13.28 Each individual trust, as individual statutory organisations, will also hold individual trust board meetings at least once per year, to transact matters reserved for the trust board and will hold separate annual general/ annual members' meetings, where the individual trusts' annual report and accounts will be presented and members of the public/members will be invited to ask questions of the board.

Place based engagement

13.29 We are very aware that developments in the Acute Collaborative's ability to think and act strategically for the benefit of the whole population of north west London needs to be matched by an enhanced engagement at a local or "place" level with care providers, patient groups and the Local Authorities. We want to support and expand other ways of building effective two-way stakeholder relationships at a local and collaborative level to help ensure openness, scrutiny and further collaboration.

13.30 Each of our Trusts already has strong relationship with its Local Authorities and patient groups and the dynamic of those Chief Executive and Executive level engagements will not change. In addition, we will work with stakeholder groups to discuss how they want to further improve their engagement with their local Trusts and explore how they want to engage with the Acute Collaborative. We will also work with the Local Authorities to ensure that we are national

exemplars in the two-way sharing of information and data and align our plans with their aspirations, within the context of the wider ICS strategy.

13.31 We will develop a shared involvement and collaboration charter, including best practice for local and collaborative transparency and wider collaboration with all stakeholders. For example, we will continue to publish trust level data on quality, finances and performance as part of the boards in common meetings. Reports from the board in common and trust subcommittees and the board in common cabinet meetings will also be noted at the public board in common meetings. We will also expect individual trust senior teams to have a regular meetings with elected representatives, staff side, HealthWatch and other key stakeholders.

13.32 The trusts and the collaborative will also be held accountable via the ICS, quarterly system oversight meetings, local council overview and scrutiny committees and the integrated care board.

14. Amendments to constitutional documents

14.1 To enable these governance arrangements to work, and to ensure that the four trusts maintain compliance with their respective constitutions (NHS Foundation Trusts) or establishment orders (NHS Trusts), we propose some amendments to these governance instruments.

14.2 These amendments will allow provision across all four trusts for up to 10 NED posts, including the Chair, Vice Chair, and a University nominated NED.

Foundation trust constitutions

14.3 The Constitution for Chelsea and Westminster Hospitals NHS Foundation Trust states within Annex 8 clause 1.9 that:

‘The following may not become, or continue as a member of the Board of Directors: In the case of a Non-executive Director, a person who is no longer a member of the public or patients’ constituency’.
The Constitution currently determines the following as public constituencies:-

- Royal Borough of Kensington and Chelsea
- City of Westminster
- London Borough of Hammersmith and Fulham
- London Borough of Wandsworth
- London Borough of Hounslow
- London Borough of Richmond upon Thames
- London Borough of Ealing

14.4 In order to implement the proposed model of NEDs posts being shared across two Trusts, the Constitution will require an amendment to create an additional public constituency that represents ‘the Rest of North West London’ to ensure that any NEDs appointments are compliant with Annex 8 clause 1.9.

14.5 If approved by the CWFT Trust Board (more than half of members), approval will be sought from the Council of Governors to enact this change with immediate effect.

14.6 The proposed amendment to the CWFT constitution is therefore:

1. Annex 1 – Add an additional public constituency to represent 'The Rest of North West London' – minimum number of members to be confirmed
2. Annex 4 – Add an additional public constituency to represent 'The Rest of North West London' and create one Governor seat to represent this constituency
3. Annex 9 – Clause 3.2 – Amend to state that the Board of Directors will meet in public as part of the North West London Acute Provider Collaborative no less than four times a year and will hold an Annual Members Meeting in public once a year.

14.7 The Constitution for Hillingdon Hospitals NHS Foundation Trust states its board composition as:

- The Chair
- A maximum of 7 NEDs
- A maximum of 7 Execs

14.8 In order to enable a NED complement as proposed in this paper, we propose to amend the constitution to:

- The Chair
- A maximum of **9** NEDs
- A maximum of 7 Execs

NHS establishment orders

14.9 The Establishment Orders for both ICHT and LNWT state the NED complement of the Board to be "The Chair plus 7 NEDs, one of whom is the Imperial College nominated representative".

14.10 We are proposing the new NED complement to be

- Chair
- Vice chair
- Vice chair from one other trust
- six NEDs
- plus a university nominated NED.

14.11 We therefore propose to amend the Establishment Orders for both trust to be "The Chair, plus **9** NEDs, one of whom is the Imperial College nominated representative". This would provide us with one spare NED post in the establishment order, in case of future need.

15. Next steps

15.1 The aim is to enable the Board in Common to hold its inaugural meeting in early autumn. Subject to approval of the proposed governance arrangements in this

paper, an implementation plan has been developed to establish the Collaborative. These include:

- Complete the appointment process for the NED complement
- Seek approval from the Councils of Governors and NHS England for the appointment of the NEDs
- Seek approval of the Councils of Governors for the amendment of respective constitutions
- Seek approval, via the DHSC, for the amendment of the NHS Trusts' establishment orders.
- Develop more detailed governance documents for approval at the inaugural Board in Common meeting, including:
    - Terms of reference for the Collaborative level committees
    - Terms of reference for the Trust Board level committees
    - Scheme of delegated authority, including scheme of delegated financial authorities
    - Standing Orders, including standard operating procedure for the Board in Common and associated meetings
- Publication of meeting dates for Board committees, Collaborative committees and Board-in-Common, and venues
- Agreement of board / committee cycles with committee chairs and executive leads, including agendas and forward planners, including essential assurance items for each committee and draft scorecards and key performance indicators.

Dawn Clift, Peter Jenkinson, David Searle

13 July 2022

Appendix 1 – NED allocation to Trust Board committees (subject to periodic change)

Imperial	Trust 1 - Chairing	Trust 2 - Attending
VC	**F&P / NomRem**	**Audit (LNW)**
NED 1	Audit	Audit / People (H)
NED 2	People	F&P / Quality (LNW)
NED 3	Quality	F&P / People (CW)
Academic NED		Quality (I / CW)
ChelWest		
VC	**Quality / NomsRems**	**F&P (H)**
NED 1	Audit	F&P / Quality (I)
NED 2	People	Audit / Quality (H)
NED 3	F&P	Audit / People (LNW)
Academic NED		Quality (I / CW)
LNW		
VC	**People / NomsRems**	**F&P (I)**
NED 1	Audit	F&P / People (H)
NED 2	Quality	Audit / People (CW)
NED 3	F&P	Audit / People (I)
Academic NED		Quality (LNW / H)
Hillingdon		
VC	**F&P / NomsRems**	**Audit (CW)**
NED 1	Quality	Audit / People (I)
NED 2	Audit	F&P / Quality (CW)
NED 3	People	F&P / People (LNW)
Academic NED		Quality (LNW / H)

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC

Paper title: Chief executive's report

Agenda item: 9

Lead executive director: Prof Tim Orchard, Chief executive

Purpose: For noting

Meeting date: Wednesday 20 July 2022

Chief executive's report to Trust Board

This report includes key updates on:

1. Operational performance
2. Monkeypox update
3. Covid-19 and flu vaccination programme
4. Financial performance
5. Maternity assurance
6. CQC update
7. Redevelopment update
8. Research update
9. Health and Care Act 2022
10. EDI update
11. Stakeholder engagement
12. Acute care programme update
13. Trust annual general meeting/annual report
14. Recognition and celebrating success

1. Operational performance

1.1. Covid-19 continues to be a significant factor within our hospitals. Over the past four weeks, Covid-19 admissions have noticeably increased; on Friday 10 June, we were caring for 71 positive patients, rising to 148 on Friday 8 July. Based on this increase, and the prevalence of Covid-19 in our communities, we have strengthened some of our infection prevention and control measures again after easing them in early June in line with national guidance. All staff and visitors now need to wear a surgical mask upon entry to, and for the duration of their time, in any inpatient area or clinical treatment room though they are still optional in public areas. It is important to note, however, that despite the increase in Covid-19 positive patients, we have not seen a similar increase in the number of patients requiring treatment in our intensive care units or requiring a ventilator. On Monday 27June, we reached the milestone of having cared for over 10,000 Covid-19 positive patients in our hospitals.

1.2. Higher levels of staff sickness, coupled with the challenges of returning to pre-pandemic levels of elective activity, mean our services remain under pressure across all sites. I am grateful to all our staff for their dedicated work and flexibility during this sustained period of pressure and demand; it continues to make all the difference to our patients and colleagues particularly in areas experiencing the immediate impacts.

1.3. The NHS as a whole must continue to maintain its focus on tackling the backlog of elective care. We have had a sustained focus on reducing very long waits, driven by a series of 'deep dives' with individual directorates. I am very pleased that, as of July, we no longer have anyone waiting more than 104 weeks. The focus is now very much on ending waits of over 78 weeks at the same time as continuing to provide time critical care for everyone who needs it. As of May 2022, we were back to 91 per cent of our overall pre-pandemic planned care activity, up to 129 per cent of our pre-pandemic outpatient activity and 99 per cent of our total pre-pandemic diagnostic testing. We are committed to delivering over 100 per cent of overall pre-pandemic planned care capacity throughout 2022/23 to help us achieve a sustainable reduction in waiting times.

2. Monkeypox update

2.1. Since our first confirmed case in mid May 2022, we have diagnosed over 90 patients with monkeypox. Nationally over 1,000 positive cases have now been identified across all four nations, the majority of which are in London. Within the capital, north west London has the highest diagnosis rate but the lowest case rate for patients living within the area.

2.2. Post-exposure vaccination is being offered to our staff who meet the criteria. Plans are being developed nationally to introduce occupational pre-exposure vaccination for healthcare staff at the highest risk of infection, which our occupational health team is supporting. We have also begun providing pre-exposure vaccination for the most at-risk patient groups.

3. Covid-19 and flu vaccination programme

3.1. The Trust is continuing to provide a comprehensive vaccination programme for our staff and wider community.

3.2. The Joint Committee of Vaccinations and Immunisations (JCVI) issued an interim position statement in May 2022 regarding a vaccination booster programme in autumn. Acknowledging the uncertainty regarding the likelihood, timing and severity of any potential future wave of Covid-19 in the UK, the JCVI current view is that in autumn 2022, a Covid-19 vaccine should be offered to:

- residents in a care home for older adults and staff
- frontline health and social care workers
- all those 65 years of age and over
- adults aged 16 to 64 years who are in a clinical risk group.

3.3. NHSE/I have provided planning guidance based on JCVI interim advice and our vaccination programme team has started to plan the delivery of this next phase of the vaccination programme with the north west London vaccination programme team. At this stage, our planning is focusing on providing a joint Covid-19 and flu programme to improve 'at work' access for staff, with additional capacity made available to support other groups, including patients. Surge contingency planning is included in this sector activity.

4. Financial performance

4.1. For the first two months of the financial year (April - May 2022), the Trust has reported a £10m deficit. This includes an assumption for elective recovery (ERF) income which is calculated quarterly. Our ERF assumption is very prudent and we may well see higher income from this source for the first quarter than we have anticipated in our financial report for May 2022. The other cause of the reported deficit position is a shortfall in delivery of efficiencies which we expect to recover through the balance of the year. The gross capital plan for the first two months of the year is £7.0m against which the Trust has spent £9.6m. The cash balance at 31 May 2022 was £203m.

4.2 We have a break even plan for the financial year 2022/23. The plan is underpinned by: a level of additional ERF funding for achieving the national target of 104 per cent of cost weighted 2019/20 activity; a level of income to offset the estimated cost of higher than usual inflationary pressure and the delivery of a 3 per cent efficiency programme.

5. Maternity assurance

5.1. The Trust provides oversight of quality assurance within the maternity service via a maternity quality oversight assurance report to each Quality Committee meeting. Highlights from the most recent report include that Professor Janice Sigsworth, Chief nurse, will become the Executive director champion for maternity from July 2022. A new maternity oversight group is also being established which will include representation from the Medical directors' office, the Non-executive director champion for maternity and divisional and directorate leads. This will give additional support and scrutiny of the metrics for maternity care.

5.2 The refurbishment of the maternity theatre suite at Queen Charlotte's and Chelsea Hospital is now complete. The only outstanding action in response to the Morecombe Bay benchmarking exercise and one of the key maternity directorate risks; both have now been closed.

5.3. Infection control measures in place during the Covid pandemic have been relaxed allowing a second birth partner during labour, and partners to stay overnight on the postnatal ward. It is hoped that this will improve the experience of our patients receiving postnatal care.

5.4. We continue to have midwifery staffing challenges due to vacancies and sickness which is being exacerbated by the current rise in community rates of Covid-19 infection. Staffing is being reviewed and managed daily to ensure all areas remain safe which has resulted in staff being relocated to support areas where acuity is highest.

6. CQC update

6.1. On 21 June 2022, the CQC held an engagement meeting with the leads for Trust cancer services; the submission following this meeting is due on 22 July 2022. The CQC was positive about the meeting and did not raise any concerns at the time.

6.2. The CQC continues to indicate that overall the Trust continues to be considered low risk compared to other trusts. Following the resumption of routine inspections of NHS trusts from April 2022, the Trust is not expected to be prioritised for inspection in the current financial year (though urgent inspections can be carried out should concerns emerge).

6.3. Our 'improving care' peer review programme is underway, with three now completed (A&E, diagnostic imaging and cancer services). Outcomes are shared with the improving care group to agree actions in response.

6.4. The CQC's transformational restructure and new regulatory approach for NHS trusts are both on track to be in place from October 2022, with full implementation from April 2023.

6.5. On 29 June 2022, the Chair and Corporate governance leads for the four acute trusts in north west London met with key leads for developing the CQC's new approach to regulating ICSs and acute NHS providers. The aim of the meeting was to share the proposed approach for our acute provider collaborative governance structure. The CQC indicated that the proposed structure covers all technical components that it will look for and, therefore, feels the structure is sound; what they will need to assess is how well it is implemented, both collectively and by the individual partner trusts.

7. Redevelopment update

7.1. The Trust has been developing phasing options for the redevelopment of St Mary's Hospital as well as exploring potential development opportunities for land that will then be surplus to requirements. This work is now being reviewed in order to determine next steps.

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

7.3. Work continues on the development plans for Charing Cross and Hammersmith Hospitals. Options are being reviewed and preferred plans will be identified towards the end of this calendar year.

8. Research update

8.1. We are awaiting the formal announcement of the outcome of our reapplication for our National Institute for Health Research (NIHR) Biomedical Research Centre (BRC) for the period 2022-27.

8.2. We believe that our application demonstrated:

- a very strong strategic plan with effective leadership across the team
- excellent quality and breadth of experimental medicine research with a strong collaboration between the NHS Trust and the university
- robust and proportionate governance structures, and strategic alignment across the partnership
- our commitment to the 'levelling up' agenda, including through our partnership with a new medical school in Cumbria
- strong public and patient involvement and a commitment to making improvements to the research culture to support equality, diversity and inclusion
- that research was following patient need and that we are offering good value for money.

9. Health and Care Act 2022

9.1. The Act introduced legislative measures that aim to make it easier for health and care organisations to deliver joined-up care for people who rely on multiple different services. The Act establishes integrated care systems (ICSs) as statutory bodies. Imperial College Healthcare NHS Trust is a member of the North West London Integrated Care System and will, as part of this place based partnership, help bring together providers and commissioners of NHS services with local authorities and other local partners to plan, co-ordinate and commission health and care services.

10. EDI update

10.1. We launched our internal equality, diversity and inclusion quarterly newsletter to support communications and networking and continue to promote our increasingly influential staff networks.

10.2. We proudly celebrated Pride with a mixture of local and national events. We raised rainbow flags across our sites and 40 of our staff marched to Celebrate 50 Years of Pride.

10.3. We opened applications for our second internal cohort of the Calibre Disability Leadership Programme. The Calibre Programme is designed to transform how disabled staff think about themselves and their disabilities and boost their confidence and self-worth through understanding that disability is an asset and not a liability. The programme is designed and delivered by international disability consultant Dr Ossie Stuart. The course consists of four core modules and a personal project and will commence in September.

10.4. Working with our women's network and Solace Women's Aid we delivered workshops on safety and gender equality. We covered domestic abuse and safer society, with seminars open to all staff.

11. Stakeholder engagement

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

- Cllr Stephen Cowan and Cllr Ben Coleman, London Borough of Hammersmith: 30 May 2022
- Hammersmith & Fulham Save our NHS, Brent Patient Voice and Ealing Save our NHS: 6 June 2022
- Healthwatch Hammersmith & Fulham: 15 June 2022
- Amanda Pritchard, NHS England, visit to Charing Cross Hospital: 5 July 2022
- Cllr Nafsika Butler-Thalassis, Westminster City Council: 11 July 2022
- Karen Buck MP for Westminster North and Andy Slaughter MP for Hammersmith: 12 July 2022
- Cllr Adam Hug, Westminster City Council: 18 July 2022

12. Acute care programme update

12.1 The four acute trusts in north west London continue to build increasingly effective partnership working arrangements as we emerge from the pandemic with the urgent need to restore planned care capacity and reduce waits and delays. This is supporting immediate priorities – for example, we have collectively eliminated all over two year waits from a peak of 127 this time last year – as well as longer term, more strategic improvements.

12.2 We have reached milestones in the first strategic collaborations for us as acute partners:

- **Proposed development of a north west London elective orthopaedic centre** Following a significant amount of exploratory and feasibility work involving a wide range of teams, and drawing on feedback from patient and public events, focus groups and interviews in June, we have worked up a formal proposal to develop an elective orthopaedic centre at Central Middlesex Hospital. Bringing together more 'high volume, low complexity' surgery, separated as far as possible from urgent and emergency care, is one of the key ways in which we can increase planned care capacity to help us tackle long waits. Evidence also shows that when teams have more experience of the same, routine operation, there is an improvement in both quality and efficiency. The four acute trusts are asking the July meeting of the North West London Joint Health Overview and Scrutiny Committee for its agreement for us to progress the proposal by undertaking a formal three-month public consultation later this autumn. We will also be developing our plans further, including establishing detailed approaches to staffing, patient pathways, travel and accessibility. We will be looking to involve many more staff, patients and member of the public in this work over the next few months, aiming to have a full business case ready by late autumn.

- **Establishing community diagnostic centres in north west London -** Community diagnostic centres are a national initiative with dedicated national funding to help increase diagnostic capacity to support planned care. Located in the community and separated from urgent and emergency pathways, they are intended to offer a 'one stop' approach for checks, scans and tests. Using central funding, anticipated to be £44.3m over three years from 2022/23, we plan to establish three new community diagnostic centres using existing NHS estate. They are due to be located in two areas of north west London where there are significant clusters of deprivation. Our plans reflect the findings of an initial programme of public, patient and staff involvement in the development of community diagnostic centres programme that was led by NHS

London as well as detailed analysis of access to diagnostic services and deprivation across our sector. We are updating the July JHOSC meeting on this work and asking them to support our plans to widen engagement and involvement locally to help shape more detailed designs and our implementation approach.

13. Trust annual general meeting/annual report

13.1. This year's AGM will be held online via Microsoft Teams on Wednesday 20 July 2022, from 18.00 until 19.30. We will be sharing our annual accounts and the highlights and challenges of 2021/22, as well as looking forward to the year ahead. There will be a live Q&A session via the Teams chat function. We are promoting the event to our staff and externally through our Trust social media channels as well as email invitations to a range of stakeholders. More information, including the agenda and the Microsoft Teams link to join the meeting are available via the events section on the Trust website. Our 2021/22 annual report is due to be published by Tuesday 19 July.

14. Recognition and celebrating success

14.1. I would like to thank all our staff for their hard work, dedication and commitment in ensuring we continued to provide high quality care, particularly throughout the recent rail and tube strikes.

14.2 We are delighted that we have gained bronze accreditation following a recent evaluation of our LGBTQ+ inclusion work with staff and patients. The rainbow badge accreditation programme, funded by NHS England, evaluates how well NHS organisations support and recognise LGBTQ+ patients and staff. The evaluation identified areas where we are doing well, as well as others that need improvement, which is all being used to shape our improvement plans priorities.

14.3 As noted by the Chair in his report, I was delighted to welcome Amanda Pritchard, Chief Executive of NHS England, along with the Imperial Health Charity CEO, Ian Lush on a special visit to Charing Cross Hospital on 5 July to mark the anniversary of the NHS. Amanda had the opportunity to meet with our staff at the Marjory Warren acute medical unit and to see improvements that we have been making to staff areas, supported by Imperial Health Charity. These included the unit's new staff 'rest nest' break area, and one of our new staff lounges, where our NHS Big Tea party was hosted. She also saw patients taking part in one of our regular arts engagement activities supported by the charity in the renal dialysis unit.

14.4 I am also delighted that Professor Dame Lesley Regan, Consultant at St Mary's Hospital, has been appointed as the Government's first ever Women's Health Ambassador for England. Through the ambassador role, Professor Regan will support the implementation of the government's upcoming Women's Health Strategy, which aims to tackle the gender health gap and ensure services meet the needs of women throughout their life.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC

Paper title: Strategic Lay Forum 2021/22 annual review and 2022/23 priorities

Agenda item: 10

Lead executive director: Michelle Dixon, Director of Communications
Authors: Trish Longdon, Chair of the Strategic Lay Forum, Linda Burridge, Head of patient and public partnerships

Purpose: For discussion/noting

Meeting date: Wednesday 20 July 2022

1. Purpose of this report

1.1. The Trust Board are asked to note this report and feedback on - and support - the Strategic Lay Forum's priorities for patient and public involvement for the coming year.

2. Executive summary

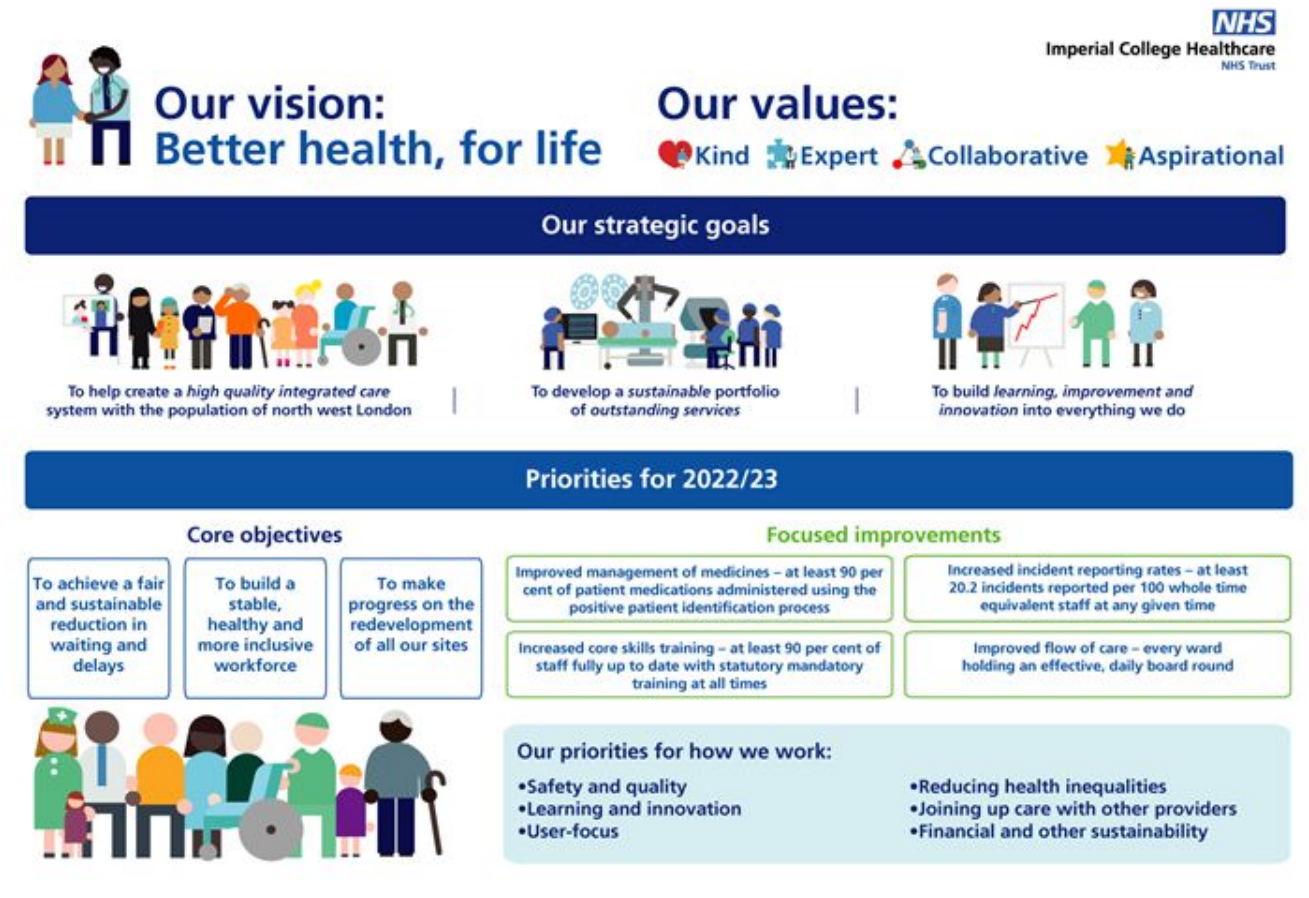
2.1. This is the annual update from the Trust's strategic lay forum that covers progress against 2021/22 priorities and priorities for 2022/23 which reflect aspirations for the Trust and for the forum itself.

2.2. Our strategic lay forum was established in November 2015 to help set a clear vision for effective patient and public involvement across the Trust. It has members from a wide range of backgrounds and experience. Its role is to oversee the Trust's involvement strategy, provide advice and feedback and ensure the Trust's plans and major initiatives are appropriately shaped by the needs and preferences of patients and local communities.

2.3. The forum – and our wider lay partner programme – has built increasingly strong relationships with staff across the Trust as well as with stakeholders externally. Its influence in helping us to become a more user-focused organisation has also grown and lay partners have been at the heart of our Covid-19 response and the early development of collaborative approaches to tackling long waits and delays as we emerge from the pandemic.

2.4. We are now moving towards a new phase of involvement with the development of an integrated 'user' insight and experience function (bringing together relevant teams previously within the core communications function (patient and public involvement, user experience design, patient information and front of house) with the existing patient experience teams (PALS, complaints and patient experience). A key objective of this move is to help ensure we bring together different types of information (data, qualitative research, case studies) about and from our 'users' (patients, carers, local communities, staff, GP and other partners) to share and build understanding of how we can shape all aspects of the way we work to respond to the needs and preferences of our users. This will only have the impact intended, though, if we create an organisational culture where all staff are motivated, empowered and skilled to gather, understand and respond to user insights.

2.5. The Strategic Lay Forum has been instrumental in the development of our plans to create an integrated user insight and experience function. Their focus has been consistent and has its roots in the co-design of our organisational strategy in 2016/17 and subsequent updates, including the most recent update to include annual priorities for impact for 2022/23 (see below).



2.6. The main part of this item is a presentation by the Chair of the Strategic Lay Forum (attached), covering:

- Our public and patient involvement framework
- Highlights and progress in 2021/22
- Priorities for 2022/23

3. Approval process

3.1. NA

4. Recommendation

4.1. The Trust board is asked to note this report and support the strategic lay forum priorities for 2022/23. Discussion and reflection on these priorities would also be welcomed.

5. Next steps

5.1. NA

6. Impact assessment

6.1. Quality impact: Patient and public involvement and the work of the Strategic Lay Forum will positively impact all patient care and experience and supports the Trust's ambition to be more user focused. It aims to improve all CQC domains.

6.2. Financial impact: We are expanding resource for PPI within the existing financial envelope of the combined engagement and experience division. There will be a cost associated with reimbursing and remunerating lay partners in line with NHS England policy which is currently being analysed.

6.3. Workforce impact: Lay partner development plans will include training and support. This will both enhance the experience and effectiveness of lay partners and the staff collaborating with them.

6.4. Equality impact: PPI and Strategic Lay Forum priorities include projects that are intended to have a significant positive impact on improving equality, diversity and inclusion.

6.5. Risk impact: The paper includes reflections on barriers to PPI as well as how they can be mitigated.

NHS
Imperial College Healthcare
NHS Trust

Strategic Lay Forum 2021/22 annual review and 2022/23 priorities

Trish Longdon
Chair, Strategic Lay Forum

About this presentation

Imperial College Healthcare NHS Trust

What we will cover

- Recap on the Trust's patient and public involvement framework
- Highlights and progress in 2021/22
- Our priorities for 2022/23
- Discussion and questions

Patient and public involvement framework

Imperial College Healthcare NHS Trust

The Strategic Lay Forum and Trust work together to deliver our vision for patient and public involvement and the commitment to be a user-focused organisation. The below diagram explains the spectrum of involvement in every aspect – and at every level – of our work.

2021/22 highlights and progress

NHS
Imperial College Healthcare
NHS Trust

Greater input to strategic developments and acting as a 'critical friend'

- The Strategic Lay Forum fed its priorities into Trust business planning, including improving user-focus, proactive patient and community engagement, improving inclusion and tackling health inequalities
- Lay partners were invited to be involved in an increasingly wide range of strategic roles, from local place-based partnerships to the sector-wide acute care programme, e.g. helping to ensure a strong patient and inequalities focus to the development of community diagnostic centres
- We continued our involvement in the Trust's Clinical Reference Group – for example, highlighting the need to minimise Covid-19 restrictions on visiting because of the benefits and improved outcomes for patients and reassurance for carers and families
- However, many lay partners have reflected that it is becoming challenging to ensure that co-design, user-focus and reducing health inequalities are given proper consideration in key developments because the focus is on delivering immediate and demanding targets, such as to a reduction in the waiting list backlog

Supporting the Trust to become more user-focused

- We supported the decision to use 'What matters to you?' as a metric to measure patient-centredness, and are pleased to report that this is being adopted by the Trust
- We review the Trust's approach to reducing health inequalities at every Strategic Lay Forum meeting. We support the Trust's new framework and have encouraged an initial focus on improving data accuracy and completeness
- We continued to encourage the Trust to engage with the communities we serve and have specifically facilitated the creation of trusting relationships with the local BME Health Forum and involvement in the redevelopment of St Mary's Hospital
- We are pleased to have contributed to the development of the Trust's new user-insight function to make sure we know and share what our patients and communities think and need, and have continued to support the Trust to develop care, systems and ways of communicating that are patient-centred

2021/22 Highlights and progress

Imperial College Healthcare NHS Trust

Listening and responding to the views and needs of patients and local communities

- Drawing on feedback from our local communities over the past two years, the provision of a fit for purpose patient interpreting service was advocated by the forum as an essential step towards reducing health inequalities. We have now embarked on the first step of a major project to transform our approach to interpreting – scoping analysis and engagement is underway with internal and external stakeholders
- We emphasised the vital importance of 'end of life' care being every staff member's responsibility - a key learning from the pandemic - and the need for improved patient communication around 'do not attempt resuscitation'. We welcome the renewed emphasis being given to this and the staff training which has been rolled out. We would also like to encourage a continued focus on improvement in this area
- Lay partners are involved in the programme to develop an elective orthopaedic centre for the sector, helping to ensure it includes comprehensive patient and public involvement. A first phase of involvement activities has been completed, with insights already feeding into formal proposals

Developing our lay partner programme

- Quality improvement colleagues completed an independent evaluation of lay partner involvement and impact. Findings show lay partner involvement is valued and valuable and results in changes and improvements to those projects in which we are involved. The report recommends that lay partners should receive more training, support and feedback on their involvement
- We currently have 62 lay partner roles fulfilled by 35 people across 33 projects. To date, the Trust has collaborated with 152 lay partners
- A remuneration scheme, in line with Imperial College London and NHS England recommendations, is in place to ensure that all members of our community can participate as a lay partner, irrespective of their income or circumstances. Many lay partners choose not to use the scheme but it is always offered to ensure lay partnership and patient involvement is accessible and inclusive
- We are actively expanding our own diversity, as we start to recruit again after the pandemic; staff pressures during the pandemic meant we had to focus resource on supporting existing partners

Reflections from Nafsika Thalassis

Imperial College Healthcare NHS Trust

Nafsika Thalassis, former Deputy Chair of the Strategic Lay Forum and Director of the local BME Health Forum, reflects in this video on the importance of working with lay partners and listening to what local communities have to say about their needs and preferences. She focuses especially on how local views have led to the creation of a new project at the Trust to transform our patient interpreting approach.

Reflections from Dr Roger Chinn

Imperial College Healthcare NHS Trust

Dr Roger Chinn, Medical Director for Chelsea and Westminster Hospital NHS Foundation Trust and medical director lead for the sector's acute care programme, reflects in this video on how the involvement of lay partners in the acute care board and in major initiatives within the acute care programme – such as the development of an elective orthopaedic centre and community diagnostic centres – is making a difference.

Reflections from Dr Anne Kinderlerer

Imperial College Healthcare NHS Trust

Dr Anne Kinderlerer, Associate Medical Director for St Mary's and Western Eye hospitals and consultant rheumatologist, reflects in this video on why we need to embed co-design and involvement further at every level of the Trust, in particular highlighting the benefits of having the chair of the Strategic Lay Forum as a member of the Trust's Clinical Reference Group throughout the pandemic as well as adopting 'what matters to you' into clinicians' day to day practice and evaluation.

Strategic Lay Forum priorities for 2022/23

Imperial College Healthcare NHS Trust

The following priorities were developed at the forum's annual planning day in January 2022 and fed in to the Trust's wider business planning process.

1. User-focus and patient-centredness

We are helping to champion and embed 'what matters to you' as a tool to help ensure patient focus across the Trust and a measure of patient-centredness in all our care and treatment.

We are supporting the development of a Trust wide user-insight and experience function as a key way to better understand the needs and preferences of all users and to ensure they shape all aspects of the Trust's work and actions.

We are also encouraging the continued reduction in silo working and the development of Trust-wide leadership approaches and processes which embed patient-centred themes consistently throughout the organisation. Examples of these include:

- end of life care
- integrated care
- development of a patient-own electronic patient record
- open, consistent, transparent, two-way communication with communities on issues that are important to them, such as redevelopment plans, health inequalities and patient interpreting
- ensuring ways of communicating with patients, including digital and virtual approaches, do not exclude any patients.

2022/23 priorities

Imperial College Healthcare NHS Trust

2. Integrated care

This is one of the Trust's three strategic aims and integrating services around patients has been a longstanding focus of the Strategic Lay Forum. We have worked with Trust staff to understand barriers to making faster progress. Our reflection is that there are dedicated people working in this area but they do not yet have the strategic framework to move the work from a series of projects to 'the way we work'. We would like to see more visible Trust leadership and accountably for the vision and delivery of integrated care.

Specifically on sector developments and collaborations, where we have lay partners, we have found that there are inconsistencies in how patient and public involvement and insight work is understood and carried out across providers. We are committed to helping to find effective ways to maximise the patient voice within these new, collaborative ways of working. While acknowledging that the integrated care system itself is at an early stage of strategy development, we are clear that acute hospitals must have a key role in ensuring care is organised around the needs of patients, holistically.

We see real synergy between the Trust’s work on improving population health and reducing health inequalities and the practical development of integrated care in specific locations. We encourage the Trust to explore whether these approaches might usefully be brought together to create the needed strategic framework and a place-based focus for piloting vertically integrated care.

2022/23 priorities

Imperial College Healthcare NHS Trust

3. Health inequalities

The pandemic highlighted the extent of health inequalities and we are very positive of the Trust's work to address them. The Strategic Lay Forum will encourage and support work to develop and better coordinate this work. There has recently been a focus on the scope and accuracy of the patient data collected as a basis for targeted action to address the worst inequalities.

We would like to see Trust's goals for reducing health inequalities being measured and monitored at Board level, and for specific projects to be embedded across the organisation. We also see value in increasing staff awareness of the cultural and other needs diverse communities have to enable staff to be confident in communicating and providing equitable care.

We have a dedicated slot on the agenda of every strategic lay forum meeting to follow up on, understand and support progress in this critical area.

2022/23 priorities

Imperial College Healthcare NHS Trust

4. Redevelopment

It is crucial that the plans are co-designed so that they reflect the genuine needs and preferences of our diverse local communities. This will help ensure our hospitals are seen as a key part of the community, valued and supported, contributing to the overall wellbeing, health and wealth of the area. This process of co-design will deepen existing relationships with local communities and develop a sense of trust.

5. Working with Imperial College London and other research bodies to ensure research is inclusive and based on our communities' needs and priorities

The Biomedical Research Centre provides infrastructure funding to enable high quality biomedical research across Imperial College London and the Trust. Lay partners are involved in this work as well as that of other organisations such as the Royal Society of Medicine. The Strategic Lay Forum has reflected on this network with colleagues from the Trust and College. It supports the development of research that is responsive to our communities' needs, inclusive and has user/public involvement throughout its life cycle – from setting priorities, research design, the research itself and its review and publication. Inclusivity in research will help address health inequalities, including key aspects such as vaccine hesitancy. In 2021, we met with Trust and other colleagues to discuss how we can better co-ordinate research involvement and engagement so that there is a diversity of participants and research priorities in areas that our communities feel are the right ones. We agreed to set some joint goals and activities for 2022 and are putting together a paper setting this out. Sandra Jayacoti, chair of the Biomedical Research Centre public panel, has joined the strategic lay forum to promote networking and synergy.

2022/23 priorities

Imperial College Healthcare NHS Trust

6. Continued support for improving patient appointment bookings system

Each year we highlight that the appointments system is the source of the most complaints from patients and has consistently not been addressed. This year is no exception, indeed the numbers of cancelled and delayed procedures, the move to virtual consultations and the sheer pressure on all our staff meant that the confusion for patients was even worse. We have always recognised that our Trust cannot resolve this issue on its own and with the creation of the integrated care system and increased collaboration between acute hospitals in the sector, we will continue to raise this issue at every opportunity. However, we continue to expect the Trust to resolve the failings which are specific to itself and the Strategic Lay Forum will continue to input into related areas, such as outpatients transformation and improvements to the patient service centre.

7. Improving our lay partner contribution

We will reenergise the development of our lay partner community. This has been largely on hold as the resources supporting the forum and lay partners were stretched during the pandemic. Further support to enable us to develop our lay partner community is now being recruited. We have more demands for lay partner involvement from staff at the Trust than we can meet and we are committed to increasing the number and significantly the diversity of lay partners. The lay partner impact evaluation is now complete and we have an opportunity to improve the impact of what we do by implementing the recommendations.

Discussion and questions

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC

Paper title: Integrated quality and performance report scorecard - month 2

Agenda item: 11

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

Purpose: For discussion

Meeting date: Wednesday 20 July 2022

1. Purpose of this report

1.1. This enclosed scorecard summarises performance against the key performance indicators (KPIs) for data published at May 2022. A summary of the performance headlines is provided in the main section below.

1.2. Countermeasure summaries are also provided with actions linked to the May 2022 performance (April for cancer waiting times). The actions associated with June performance are being updated and will be reported through the executive management board.

2. Executive Summary

2.1. A total of 9,483 elective spells (day cases and overnight admissions) were completed in May 2022 which was the highest level of activity level so far during 2022 and the underlying performance has continued across June. A general uptick in our commitments to NHS operating plan trajectories will be evident from September onwards, particularly within the outpatient setting and reducing outpatient follow-up appointments. The Executive team is assessing activity trajectories on a weekly basis to understand drivers.

2.2. The Trust does not anticipate any 104 week wait breaches for June, with the next operating plan milestones being to ensure no patients are waiting over 90 weeks by November 2022 and no patients waiting more than 78 weeks by March 2023.

2.3. No significant changes in performance were reported across the main urgent and emergency care indicators for May 2022, reflecting continuing pressures across the system as a whole, although our ambulance handover times continue to benchmark well across the London sector.

2.4. Our harm profile remains good, with a lower than average 12-month percentage of incidents causing moderate and above harm. The most recent monthly HSMR data (for January 2022) ranks us as the second lowest in the country.

2.5. Our patient safety incident reporting rate per 1,000 bed days is above our top quartile target, which is good. Unfortunately, a never event occurred in April 2022 (declared in May 2022). Local immediate actions have been implemented.

3. Approval process

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

4. Recommendation(s)

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

5. Next steps

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

6. Impact assessment

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

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

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

6.4. Equality impact: ICSs are required to demonstrate the impact of plans for elective recovery in addressing disparities in waiting lists and focus on health equity when designing care pathways.

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

Main report

7. Operating plan – elective recovery position

7.1. A total of 9,483 elective spells (day cases and overnight admissions) were completed in May 2022. This was the highest elective activity level so far during 2022 and the underlying performance has continued throughout June. Over the coming months we will see our commitments increase around our operating plan trajectories across all areas of delivery. This will be particularly apparent within the outpatient setting as the 2022/23 plan aims for a 25% reduction in follow up appointments alongside increases in elective activity. The Executive team is assessing activity trajectories on a weekly basis to understand drivers and support an integrated approach.

8. Month 2 (May 2022) performance

Referral to Treatment

8.1. The increase seen in elective referrals in April 2022 has continued into May 2022. The overall size of the RTT waiting list closed at 87,459 patient pathways at month end (+2,457 pathways on the previous month).

8.2. Unfortunately, one patient was waiting over two years for treatment at the end of May 2022 against the trajectory of zero. The breach was due to an incorrect clock stop being applied earlier in the pathway. The Trust does not anticipate any further breaches for June with focus on achievement of the next long waiter milestones: reducing patients waiting over 90 weeks to zero by November 2022 and ensuring no patients are waiting more than 78 weeks by March 2023.

Diagnostics

8.3. The overall improvement trend in our diagnostic waiting times has continued, albeit at modest incremental steps. In May 2022, 10.5% of patients were reported as waiting more than 6 weeks for their diagnostic test against the 1% target.

Cancer waiting times

8.4. The 62-day GP referral to first treatment performance was 47.2% in May 2022 against the 85% standard, from 65.7% the previous month. The main contributing factor is a significant increase in late referrals from other trusts with some referrals being made without full work up, requiring us to complete investigations. Other factors include increases in pathology delays; RMP-led improvement meetings are continuing.

8.5. The 28-day cancer faster diagnosis standard (FDS) was 71% in May 2022 which met the trajectory target and is on track to meet national standard of 75% by October 2022.

Urgent and Emergency care

8.6. Overall, no significant changes are highlighted within the UEC performance data for May 2022, with levels mostly remaining at or above the upper statistical process control limits and reflecting continuing pressures across the system as a whole. Whilst this is not where we would want to be our hospital ambulance handover times continue to benchmark well across the London sector.

9. Quality – safe and effective

9.1. Our harm profile remains good, with a lower than average 12-month percentage of incidents causing moderate and above harm. Our mortality rates also remain low; our 12-month rolling HSMR is 7th lowest in the country, with our most recent monthly data (for January 2022) being the second lowest. The review of the slight regression in our rolling 12 month HSMR ranking was reported to Quality Committee in July. This confirmed that despite a change in rank our actual HSMR is reducing, the likely cause is changing clinical coding practices in other trusts for recording palliative care as well as coding differences for Covid-19. The only diagnostic groupings with an increasing HSMR that we could not fully explain were in maternity and neonatology. National audit data and local mortality numbers do not correlate with the HSMR data and so we have agreed to undertake an additional review of the data with support from Imperial College. We are also commencing a review of the processes and function of the mortality and morbidity meetings across the trust to include the data being used. We will report progress with this work through the quarterly learning from deaths report.

9.2. Our patient safety incident reporting rate per 1,000 bed days is above our top quartile target. The recent increase is being partly driven by a change in the way we report admission delays in the emergency departments. Even without this reporting change, rates would have improved in May with increases across most directorates. Trustwide actions and focused improvement work continue to progress.

9.3. Although we reported no MRSA BSIs in May 2022, there were two in April and a total of 11 reported in 2021/22 giving us the highest rate in the Shelford Group. The trustwide action plan in response, and the implementation of the two programmes to

provide improved long-term education, training and support for staff for central line management and insertion, and for IPC practice more widely, are progressing.

9.4. A never event occurred in April 2022 (declared in May 2022). The patient had consented for a contraceptive device insertion following caesarean section, however the wrong type was used. The patient had no complications and opted not to return to theatre to have the correct device inserted. Immediate local action has been taken and the incident is being investigated. This is the second similar event in less than two years (the last was in September 2020). We have seen recurrence of a number of never events and so a review of the assurance of the use of the recommended safety processes for all never events is being scoped. The resultant audit plan will commence in August the outcomes of which will report to quality committee.

Appendices:

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

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard - Board Version

Imperial Management and Improvement System (IMIS)

FI = Focussed improvement

M02 - May 2022

Section	FI	Metric	Watch or Driver	Target / threshold	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Reporting rules	SPC variation
To develop a sustainable portfolio of outstanding services																			
Quality safety improvement	FI	Patient safety incident reporting rate per 1,000 bed days	Driver	**>=65.6**	54.50	57.79	58.14	54.08	54.59	52.64	58.82	55.50	53.56	57.20	68.15	56.10	67.24	Share Success	-
		Healthcare-associated (HOHA + COHA) Trust-attributed MRSA BSI	Watch	**0**	1	2	0	0	1	3	0	1	1	1	1	2	0	-	-
		Healthcare-associated (HOHA + COHA) Trust-attributed C. difficile	Watch	**8**	7	6	6	10	4	7	4	2	8	8	6	6	7	-	-
		Healthcare-associated (HOHA + COHA) E. coli BSI	Watch	**12**	4	6	12	6	15	11	8	12	11	5	8	7	9	-	-
		CPE BSI	Watch	**0**	0	0	0	0	0	0	0	0	0	0	1	0	0	-	-
		% of incidents causing moderate and above harm (rolling 12 months)	Driver	**<2.67%**	1.39%	1.31%	1.29%	1.29%	1.31%	1.27%	1.18%	1.18%	1.22%	1.26%	1.29%	1.26%	1.28%	Promote to Watch	-
		Hospital Standardised Mortality Ratio (HSMR) (rolling 12 months)	Watch	**<=100**	76	76	76	71	71	70	67	68	67	69	70	68	68	-	-
		Formal complaints	Watch	**<=100**	53	77	83	75	83	96	73	67	66	92	82	98	76	-	-
Response and Recovery		Elective spells (overnight and daycases) as % of trajectory target	Watch	**100%**	97.6%	115.0%	88.2%	88.4%	91.6%	94.3%	91.0%	85.6%	84.5%	88.6%	79.7%	83.0%	84.5%	Switch to Driver	-
		Outpatient - New - % of trajectory	Watch	**100%**	-	-	-	-	-	-	-	-	-	-	-	113.1%	112.3%	-	
		Outpatient - Follow-up - % of trajectory	Watch	**100%**	-	-	-	-	-	-	-	-	-	-	-	113.1%	123.1%	Note performance / SVU if statutory standard	
		Completed RTT Pathways (Total clock stops)	Watch	**17,305**	14,929	17,315	16,820	14,360	15,081	17,331	18,250	16,225	18,258	17,787	20,019	17,199	19,723	-	-
		RTT waiting list size	Watch	**87,578**	68,242	72,362	74,437	75,500	76,585	78,533	80,050	80,667	79,218	80,538	82,657	85,002	87,459	-	SC
		RTT 52 week wait breaches	Driver	**2,077**	1,837	1,467	1,464	1,516	1,515	1,605	1,650	1,781	1,605	1,559	1,662	1,863	1,976	-	-
		% clinical prioritisation (RTT inpatient waiting list – surgical)	Watch	**>=85%**	89.2%	91.3%	91.6%	91.7%	92.0%	94.7%	93.9%	86.4%	88.7%	93.7%	93.9%	93.8%	93.9%	-	-
		Diagnostics waiting times	Driver	**1.0%**	36.6%	36.9%	33.2%	29.8%	27.0%	22.9%	20.6%	22.1%	18.6%	11.7%	12.9%	11.1%	10.5%	CMS	SC

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard - Board Version

Imperial Management and Improvement System (IMIS)

FI = Focussed improvement

M02 - May 2022

Section	FI	Metric	Watch or Driver	Target / threshold	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Reporting rules	SPC variation
continued		Cancer 2 week wait	Watch	>=93%	95.0%	93.4%	93.1%	94.2%	91.5%	86.8%	80.4%	71.7%	71.6%	73.7%	74.4%	71.0%	79.9%	Switch to Driver	SC
		Cancer 62 day wait	Driver	>=85%	78.7%	74.7%	73.8%	81.0%	73.9%	76.3%	66.7%	62.6%	52.0%	57.9%	69.6%	65.7%	47.2%	CMS	SC
		Cancer 28-day Faster Diagnosis Standard (2ww)	Driver	62%	-	-	-	-	-	67.9%	66.7%	64.0%	60.7%	71.4%	73.4%	71.9%	71.2%	-	-
		Ambulance handovers - % within 30 minutes	Driver	95.6%	96.9%	96.1%	92.5%	90.6%	89.0%	87.0%	85.1%	84.7%	87.9%	84.8%	82.6%	89.4%	87.9%	CMS	CC
		Number of patients spending more than 12 hours in ED from time of arrival	Driver	230	147	180	356	541	642	785	966	1,074	905	954	1,320	1,077	1,197	CMS	SC
		Long length of stay - 21 days or more	Driver	162	140	145	172	169	170	180	180	187	205	177	202	207	220	CMS	SC
Safe and Sustainable Staffing		Vacancy rate	Watch	<=10%	11.0%	11.5%	12.0%	12.4%	12.3%	12.7%	12.6%	13.0%	12.9%	13.5%	13.4%	13.4%	13.8%	Switch to Driver	-
		Agency expenditure as % of pay	Driver	tbc	2.4%	2.0%	1.9%	1.5%	2.2%	2.0%	2.37%	2.7%	2.9%	3.3%	4.0%	2.6%	3.2%	-	-
		BAME % of workforce Band 7 and above	Driver	59%	40.2%	39.94%	40.1%	40.4%	40.4%	41.1%	41.45%	41.7%	40.9%	41.2%	41.7%	38.9%	39.4%	CMS	-
		Staff Sickness (rolling 12 month)	Driver	<=3%	3.74%	3.67%	3.70%	3.79%	3.87%	3.96%	4.05%	4.21%	4.26%	4.36%	4.55%	4.71%	4.78%	CMS	-
		Staff turnover (rolling 12 months)	Watch	<=12%	10.6%	10.4%	10.4%	11.1%	11.1%	11.4%	11.6%	12.1%	11.9%	12.0%	12.2%	12.6%	12.9%	Note performance / SVU if statutory standard	-
Finance		Year to date position (variance to plan) £m	Watch	£0	0.50	0.75	1.00	1.25	0.00	0.00	0.00	0.00	0.00	0.00	0.09	-2.53	-8.38	Note performance / SVU if statutory standard	-
		Forecast variance to plan	Watch	£0	18.51	1.51	0.00	0.00	-14.50	0.00	0.00	7.00	0.00	0.00	0.09	0.00	0.00	-	-
		CIP variance to plan YTD	Watch	£0	-	-6.15	-6.09	-5.73	-4.08	-4.68	-4.76	-3.65	-5.30	-5.42	-6.88	-2.94	-5.73	Switch to Driver	-
To build learning, improvement and innovation into everything we do																			
	FI	Core skills training	Watch	>=90%	93.8%	94.5%	94.0%	92.7%	92.2%	91.7%	90.3%	90.9%	92.2%	90.5%	91.1%	92.2%	92.9%	-	-

Abbreviations

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

Reporting rules

CMS - Countermeasure summary
SVU - Structured verbal update

Imperial College Healthcare NHS Trust

Appendix 2

Integrated quality and performance report:

Countermeasure summaries at month 2 (May 2022 data)

Condensed version for Board

Imperial College Healthcare NHS Trust

Contents

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SPC charts

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

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

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

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

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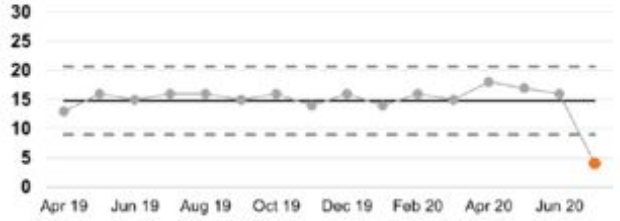
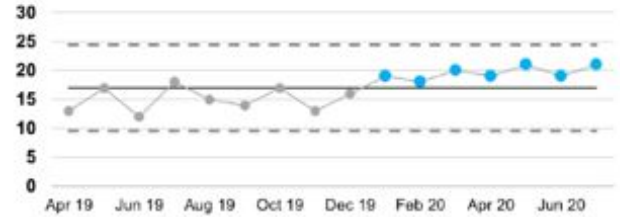
SPC rules : special cause variation

A single point outside the process limits



Two out of three points close to a process limit

A shift of points above / below the mean



A run of points in consecutive ascending or decending order

Making Data Count (NHS Improvement & NHS England)

Imperial College Healthcare NHS Trust

CMS

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

Countermeasure summary: Diagnostic waiting times

Imperial College Healthcare NHS Trust

Problem statement:

- Performance against the diagnostic 6 week standard deteriorated for all modalities at the start of the pandemic, with significant backlogs accumulated due to the cancellation and reduction of services.
- In May-22, 1,538 patients wait over 6 weeks for their diagnostic test. Failure to meet the diagnostic target adversely impacts patient experience and can delay treatment.

Owner: Prof Tg Teoh

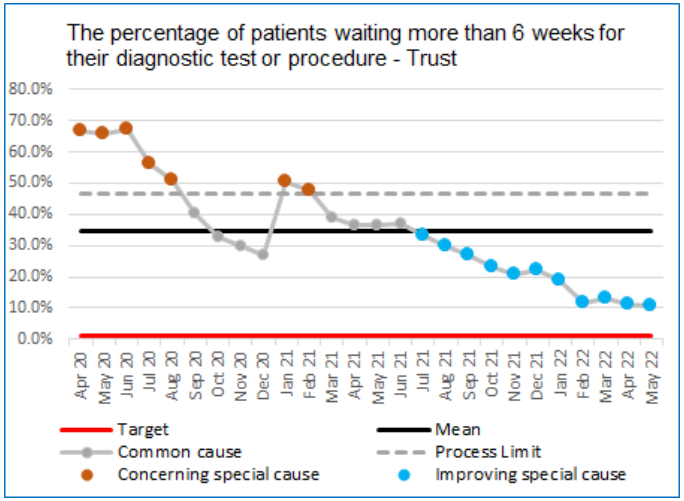
Metric: % of patients waiting six weeks or more for a diagnostic test

Target: The national standard is no more than 1% of patients needing a diagnostic test should be waiting over six weeks

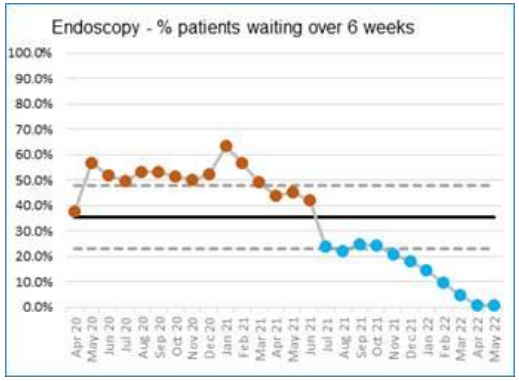
Desired trend: ⇩

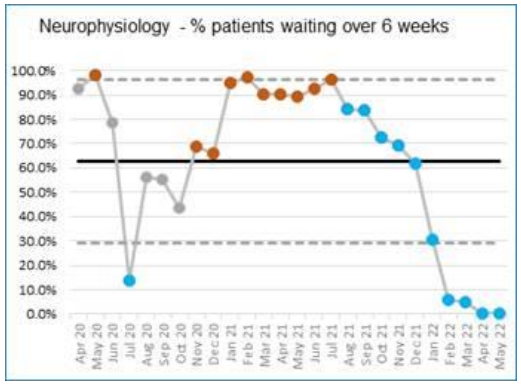
Historical performance:

The overall proportion of patients waiting six weeks or more at the end of May-22 was 10.5%



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

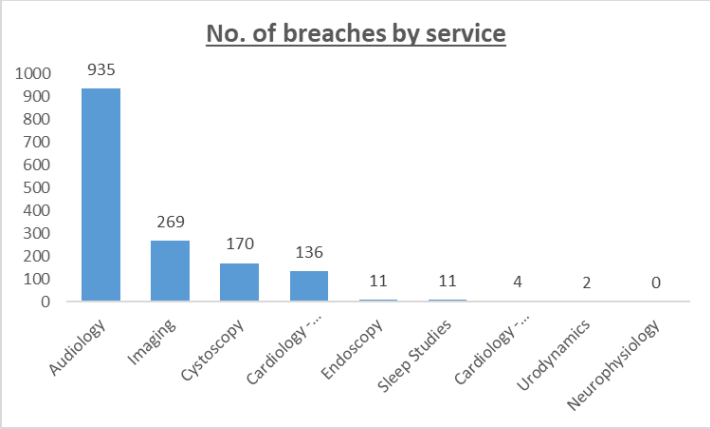


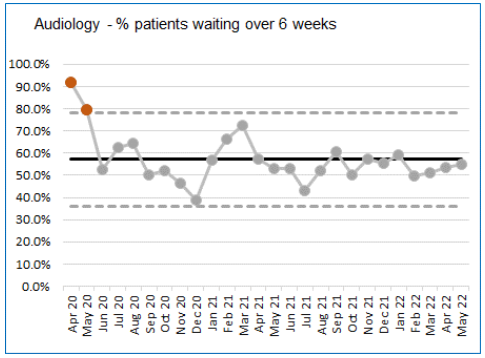


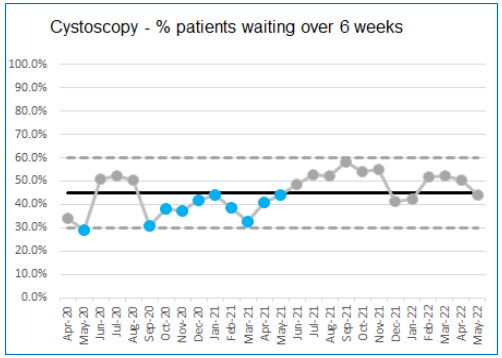
Countermeasure summary: Diagnostic waiting times

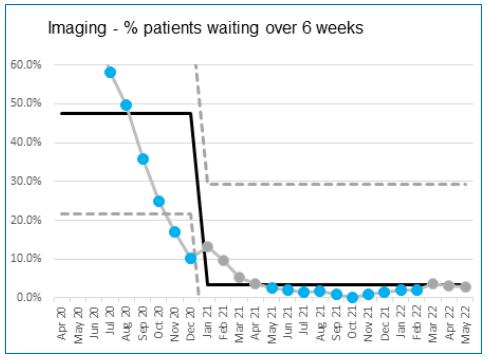
Imperial College Healthcare NHS Trust

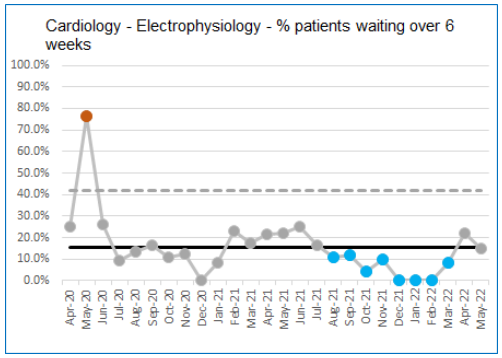
Stratified data / top contributors:











Of the total number of 6 week diagnostic wait breaches in May-22 (1538 breaches), nearly 98% (1510) are confined to the following services:

- Audiology (935)
- Cystoscopy (170)
- Imaging (269)
- Cardiology-Echocardiography (136)

Performance charts for these services are provided below, showing % patients waiting over 6 weeks

Countermeasure summary: Diagnostic waiting times

Imperial College Healthcare NHS Trust

30 DAY ACTION PLAN

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Audiology	• Increased demand • Requests from ENT increasing due to inability for one stops (awaiting guidance on removal of social distancing) • Challenges on-going with closure of community paediatric service @ Parkview increasing demand above booth capacity	• Sector Community paediatric audiology review plan for backlog recovery • Increased validation now moved 1 WTE B4 & 0.4 B3 from Spec Surg moved in. GM weekly review of top 100 patients waiting with team to provide senior assurance of delivery. • Stringent review of vetting process with withdrawal from AQP contract • Return to ENT one-stop appointments (needing end of social distancing or outpatients estate modifications)	Harry Monaghan	TBC June-22 Completed IPC walkaround completed – wider space identification meeting TBC
Imaging	• Aged equipment resulting in downtime and loss of slots • Agency continues to be challenging • Staff vacancies (sonographers)	• Additional sessions– more lists planned in June / July • Teams continue to work as part of contractual rota. Voluntary overtime used to cover lists when there are staffing challenges. • Training sonographers internally as part of “grow our own” scheme continues. Plan to train sonographers to undertake US MSK examinations. Exploring international recruitment	Rex Rehamati Sharan Narang Rona Buxton	Ongoing as older machines are replaced
Cystoscopy - urology	• Increased requests and insufficient prospective bookings, impacting upon utilisation	• Additional scoping room, workforce and equipment. • Validation of current waiting list. Clinical review on-going. • Additional Saturday and Sunday all day Flexible cystoscopy clinics every weekend.	Harry Monaghan	Ongoing Ongoing
Cardiology – Electrocardiography	• National chronic workforce shortage of Physiologists • Lack of capacity due to physiologist vacancy rate	• Restructure of the physiologists with a focus on increasing the number of B6 physiologists in training, as well as increasing the senior physiologist management and training support by creating additional roles • Insourcing contract that has been in place since September 2021 • Company provides staff to use our facilities both in hours and at weekends to increase capacity	Lead Physiologist. Chris Robbins	Training programme – 12 months Ongoing

Imperial College Healthcare NHS Trust

CMS

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

Countermeasure summary: Cancer Waiting Times 62-day Performance

Imperial College Healthcare NHS Trust

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

Owner: Prof Katie Urch

Metric: CWT 62-day GP referral to first treatment

Target: National operating standard 85%

Desired trend: ⇧

Historical performance: Performance against the standard has been non-complaint for 23 consecutive months. April was reported at 65.7% against the 85% standard.

Standards	2022 Nov	Dec	Jan	Feb	Mar	Apr
3.1 - Cancer Plan 62 Day Standard (Tumour)	66.7%	62.6%	52.0%	57.9%	69.6%	65.7%
Acute leukaemia	100.0%		100.0%			
Brain/Central Nervous System				100.0%		100.0%
Breast	75.0%	64.9%	37.9%	58.8%	59.5%	57.1%
Gynaecological	87.1%	56.3%	57.1%	62.5%	71.0%	76.0%
Haematological (Excluding Acute Leukaemia)	100.0%	100.0%	75.0%	81.8%	100.0%	77.8%
Head and Neck	100.0%	71.4%	0.0%	100.0%	81.8%	100.0%
Head and Neck - Thyroid	66.7%		100.0%	100.0%	100.0%	0.0%
Lower Gastrointestinal	43.5%	50.0%	28.6%	57.1%	75.0%	57.1%
Lung	25.0%	50.0%	66.7%	71.4%	44.4%	81.8%
Other	100.0%	0.0%	100.0%	100.0%		33.3%
Sarcoma						100.0%
Skin	100.0%	100.0%	75.0%	88.2%	81.8%	80.0%
Testicular		100.0%				100.0%
Upper GI - HpB		75.0%	57.1%	100.0%	50.0%	62.5%
Upper GI - OG	0.0%	77.8%	66.7%	50.0%	42.9%	40.0%
Urology - Prostate	45.8%	50.0%	39.2%	28.6%	67.8%	28.6%
Urology - Renal	75.0%	75.0%	85.7%	80.0%	33.3%	72.7%
Urology - Urothelial		100.0%	100.0%	50.0%	100.0%	100.0%

Key dependencies for performance recovery:

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

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

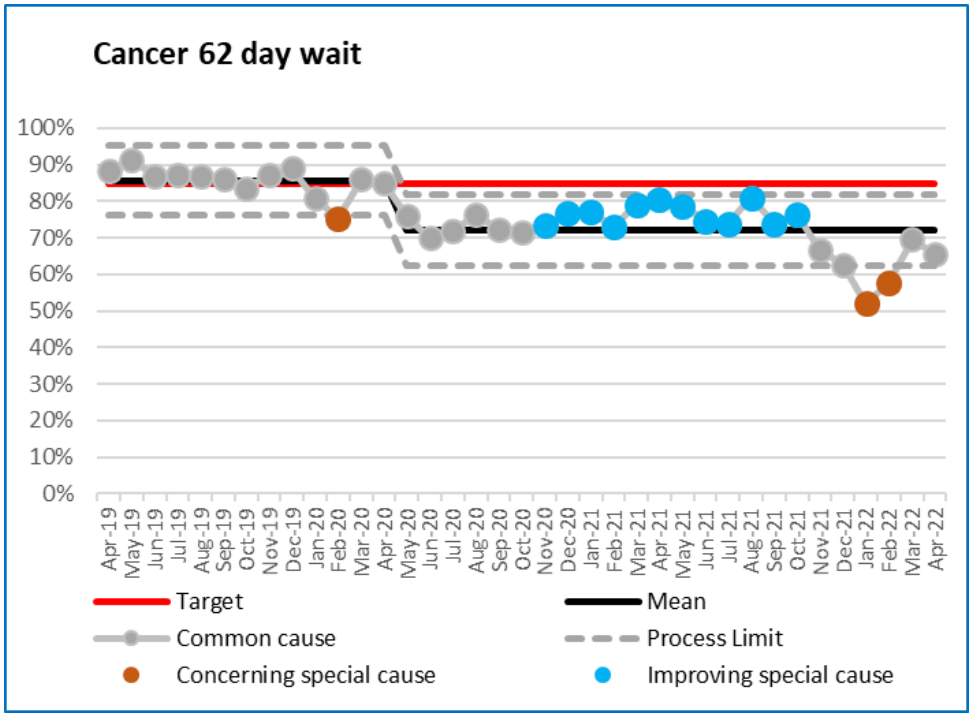
Key associated metrics to watch against trajectory:

- 2WW performance – April performance was 71.0% against the 93% target – decrease from 74.4% in March. Performance expected to remain non-compliant until July due to sustained 2WW referral demand increases across specialties, and breast diagnostic pathway capacity;
- 104+ day PTL backlog – 110 patients at 10/05/2022 – increase from 87 in mid-April. Pressure in breast, GI, gynae and prostate, tracking capacity
- PTL 63+ day tip over rate increasing following previous improvement in March. Drivers – GI diagnostic pathway capacity, pathology reporting time delays, prostate RAPID diagnostic pathway compliance, skin biopsy capacity, breast TAC capacity, gynae and urology surgery waits, tracking capacity

Countermeasure summary: Cancer Waiting Times 62-day Performance

Imperial College Healthcare NHS Trust

SPC



Countermeasure summary: Cancer Waiting Times 62-day Performance

Imperial College Healthcare NHS Trust

30 DAY ACTION PLAN

Top contributor	Potential root cause	Countermeasure	Owner	Due date
RAPID prostate pathway	• MRI waits at 5 days in May, triage improvement implemented • Biopsy capacity insufficient to deliver diagnostic pathway within FDS 28 days.	• Trust to bid for RMP funding for additional ANP post	Urology	July 2022
Pathology	• > 7 day waits for cancer diagnostic sample analysis • Recruitment delays impacting pace of recovery • Significant impact on patient experience through delayed communication of diagnosis and MDT discussion deferral • Particular impact in gynae, urology, and colorectal pathways where waits are increasing	• NWL-wide working group established, agreed maximum TAT by tumour group, escalation and ordering processes and improve reporting visibility.	RMP/ NWL trusts	Monitoring until June 2022
GI diagnostic pathways	• Endoscopy waiting times stable at 14 days for UGI, 13 days for colorectal STT (increased from 11) and 15 days for non-STT in May 2022 – target 10 • CTC waits 15 days in May • Increase in clinic letter TAT delaying patient discharge	• Joint FDS improvement meetings with endoscopy, imaging and GI surgery to begin to review existing improvement plans • Imaging TAT improvement plan • Review options for use of dictation software and template letters with service	Cancer Imaging Gen. Surg.	June 2022 On-going 22/06/2022
Breast diagnostic pathway	• Sustained high referrals during Covid recovery • Heavy reliance on additional capacity for breast clinics has meant we have struggled to cover some of the sessions	• Draft IS capacity business case • Recruit additional MDTC and tracker resource agreed to manage inflated PTL • Recruitment started for new triage pathway to reduce TAC demand	Spec. Surg. Cancer Spec. Surg.	July 2022 June 2022 June 2022

Imperial College Healthcare NHS Trust

CMS

Ambulance handover times (within 30 minutes)

Countermeasure summary: Ambulance handovers

Imperial College Healthcare NHS Trust

Problem statement: The national operating standard for 2022/23 is 95% handovers within 30 minutes in order to reduce the time ambulance crews spend in emergency departments and therefore freeing them up to respond to other calls. Delays have a knock on effect to overcrowding in the emergency departments.

Owner: Ben Pritchard-Jones

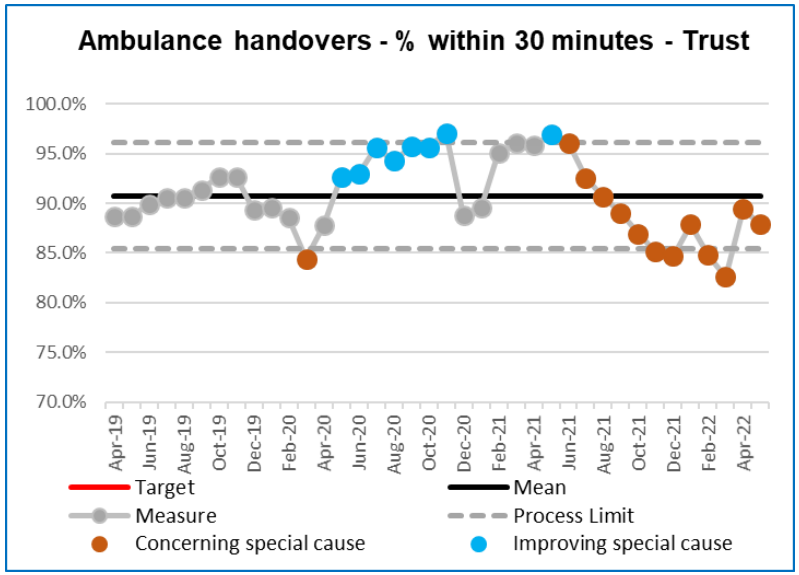
Metric: % of ambulance arrivals with a handover time of less than 30 minutes

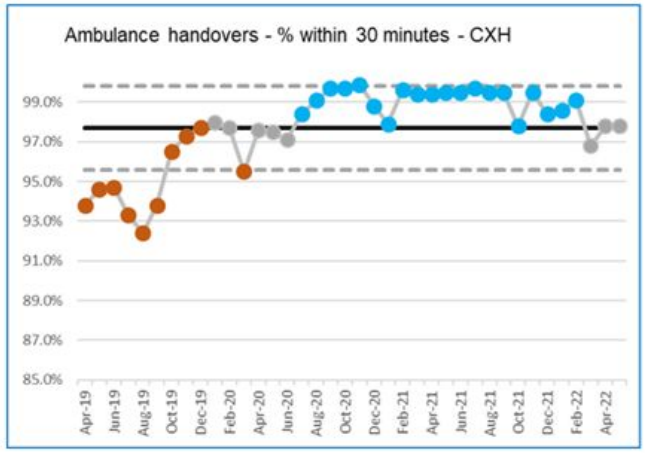
Target: National operating standard is 95% for 2022/23

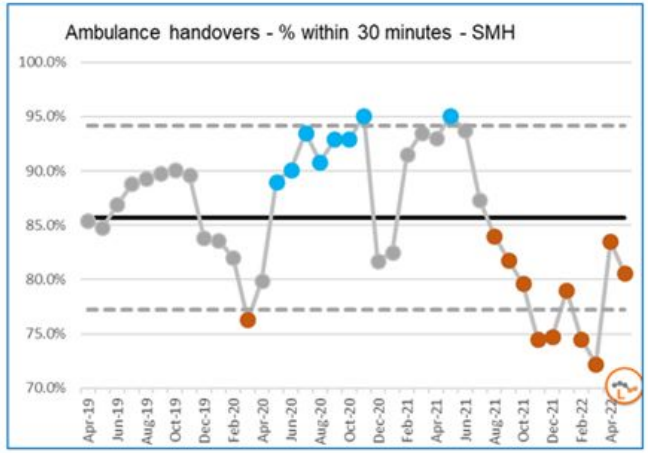
Desired trend: ⇧

Historical performance: The overall handover performance (within 30 minutes) continues to be highlighted as special cause variation with performance of 87.9% for May 2022 (a shift of points below the mean).

Our internal trajectory was 95.6% for the month.







Due to unavailability of validated month-end data, the current month's figures are a cumulative forecast from weekly London Ambulance Service (LAS) data.

Countermeasure summary: Ambulance handovers

Imperial College Healthcare NHS Trust

30 DAY ACTION PLAN

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Ambulance Handover Delays	• Number of ambulances arriving to department that is already full	• LAS / ED Escalation plans shared with Site and ED teams and Silver on-call teams • Review impact of NWL/LAS Level 3 redirection pilot process to redistribute cross sector • increase to level 4 or if 60 minute breach imminent • Escalation process for ambulance handovers between site and ED to be reviewed and clarified consistently applied in and out of hours • Acute take consultants to have a plan prior to leaving each day to allow out of hours plans	Ben Pritchard-Jones Iain Taylor Hospital Directors/Ben Pritchard-Jones Site directors Merlyn Marsden Frances Bowen	complete June 22 June 22
Lack of space to offload ambulances whilst social distancing	• Slow flow out of the ED • Estate too small prior to pandemic now even more constrained	• Reconfiguration of triage facility at front door to create 2 additional spaces. Costs above Divisional Minor Works to go through DSP and CSG as part of 2022/23 plan • Front door pathways estate challenges scoped with estates, comms team and division now moving to feasibility stage • Temporary reconfiguration of trolley space RNA area at SMH in line with RAT trial (increase of trolley space, reduction in seated space)	Ben Pritchard-Jones/ Andy Angwin Hugh Gostling/Michelle Dixon/Jo Sutcliffe/Frances Bowen Ben Pritchard-Jones	June 22 June 22 June 22
Urgent & Emergency pathways	• CDU closure SDEC expansion, Staffing levels	• Recruitment pipeline prioritising key areas of greatest need – target of <3 down on any shift • 15% reduction in vacancies across UEM delivered by end May 22. Further engagement with recruitment and retention schemes for further improvement. Current UEM rate at 17% across directorate • Implement plus ones to avoid a 12 hour DTA • Rapid assessment & treatment (RAT) senior decision maker at front door pilot • In discussion with NWL ICS team to direct 111 UTC direct to SMH UTC (Totally)	Ben Pritchard-Jones Karen Powell, Jo Sutcliffe Ben Pritchard-Jones Ben Pritchard-Jones	May 22 complete June 22 June 22

NHS
Imperial College Healthcare
NHS Trust

CMS

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

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

Imperial College Healthcare NHS Trust

Problem statement: Extended length of time patients are in an emergency department environment is detrimental for patient experience and quality and also impacts on staffing resource (ED staff, RMNs and security), cubicle capacity and the ability to manage flow through the department.

Owner: Frances Bowen

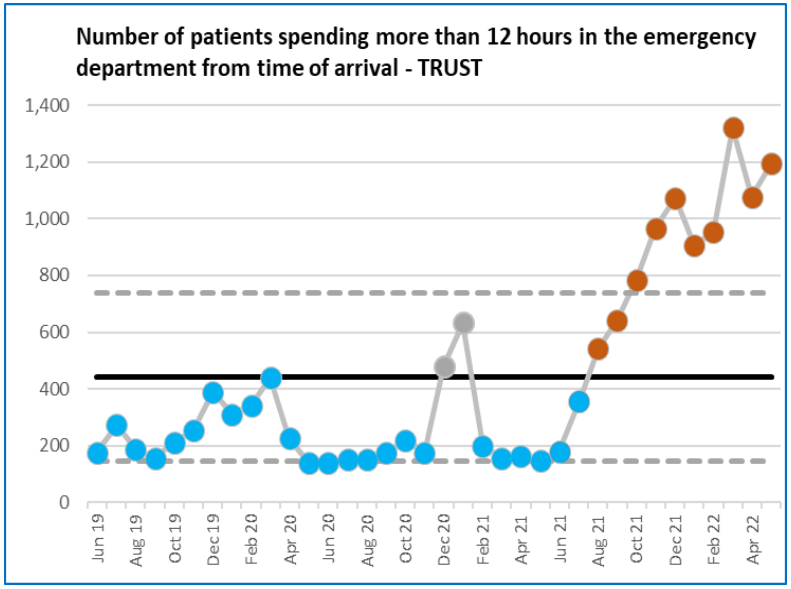
Metric: % of patients spending more than 12 hours in the emergency department from time of arrival

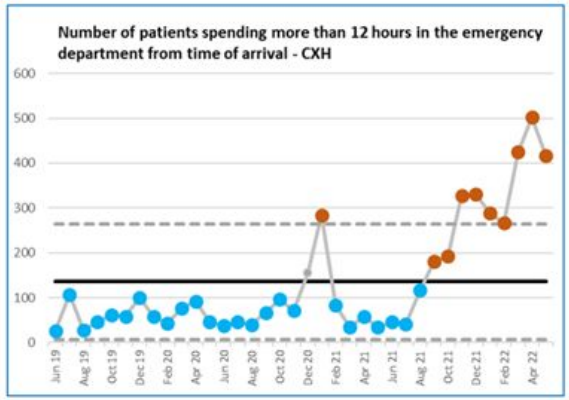
Target: National operating standard is no more than 2% during 22/23

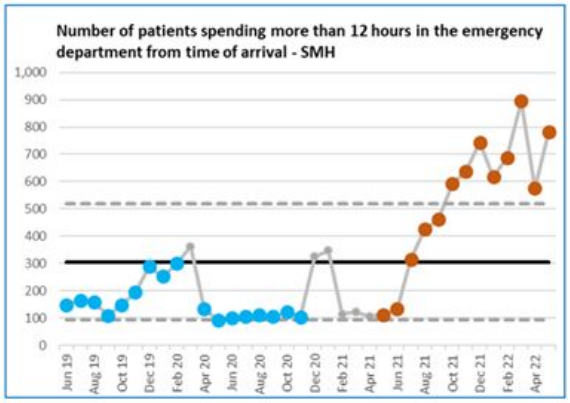
Desired trend: ⇩

Historical performance: The number 12 hours waits from time of arrival remained high with 1,197 such patients in May 2022, the equivalent of 5.05% of attendances. Significant increases in extended waits over recent months are seen across both sites.

Of the total 12 hour waits, 101 were mental health patients (8.4% of total 12 hour attendances). 12 hour wait data shows 43% of waits occurred in general medicine with 88% on admitted pathways, 22% occurred on Surgical pathways, 9% on mental health pathways and 15% remained in ED.







Countermeasure summary: Patients spending more than 12 hours in the emergency department – actions for 12 hr waits and admitted and non-admitted mean time

Imperial College Healthcare NHS Trust

30 DAY ACTION PLAN

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Admitted pathway bed availability	Delayed discharges downstream/lack of beds earlier in the day	• Review go live on bed requests to speed up moves from ED to ward and admitting ward to specialist ward • Acute Consultant for SMH commencing July 2022 • Homelink pilot proposal, revamp of long stay meeting, faster moves first floor, ED bed managers meeting, crit led d/c, FI, bleep replacement • Task and finish group to be set up with Medicine and ED plus site to focus on faster moves • Trial and review Acute med SDEC pathways at CXH and SMH • Reinvigorate specific actions per directorate on time of discharge and usage of lounge through performance meetings and UEC board • Discharge lounge for bedded patients at CXH due to open in June 2022 • Support focussed improvement on board rounds on 6 first wards, support increased training and release of coaches to do more • Transformation team focus on Albert ward and Douglas Ward to look at routine leading up to discharge day and work on improving • Regular engagement and shared data from transport and pharmacy teams on actions taken the day before - wards areas needing greatest support in pipeline for transformation or FI coaching. • Review formally whether to continue without CDUs • Continue to support new specialties to SMH to ensure that impact of the move is neutral on beds • Instigate teams comms between acute and downstream wards • Explore possibility of site based manager of the day leading on flow • SCC to pilot reg allocated to ED to assess benefit of increased resource • Surgical board rounds, matrons and wards to get capacity updates each morning, LLOS meeting, use weekend discharge proforma • Focussed workshop on weekend discharges and criteria led discharges • Monthly cross site and cross divisional engagement with transformation projects through UECPB • Bed meeting template to identify consultant led ward round and review of MO each week, following on from LLOS meeting. Plus 1's at CXH	Site directors, Transformation team Adam Hughes George Tharakan, Katie Groom Jo Edwards / Adam Hughes / Anne Hall MDO Transformation team Jo Sutcliffe Frances Bowen/Jo Sutcliffe Jo Sutcliffe Jo S/ Jo E / Adam Hughes Anne Hall/David Kovar Jo Sutcliffe/Frances Bowen Jo Edwards	June 22

Countermeasure summary: Patients spending more than 12 hours in the emergency department – actions for 12 hr waits and admitted and non-admitted mean time

Imperial College Healthcare NHS Trust

30 DAY ACTION PLAN

Top contributor	Potential root cause	Countermeasure	Owner	Due date
Mental Health Pathway Delays	• AMHP Provision • Lack of bed capacity • Specific CAMHS pressures	• Mental health pathways - work with ICS on shifting focus and performance metrics for MH trusts to reduce stays in ED • Lead MH Nurse appointed to start in August 22, advertise Matron roles and • Drive bank RMN recruitment, lines of work, off framework discussions • Focus on medical clearance speed, earlier escalation between CNWL and WLMHT and AMHP delays • Developing joint proposal for Emergency Assessment MH Lounge at SMH, in discussions with Estates teams on options scoping • Lead a task and finish group along with CNWL to eradicate 12 hour DTAs by end of September 2022	Jo Sutcliffe Jo Sutcliffe Sarah Haines / Jo Sutclife Barbara Cleaver Jo Sutcliffe/CNWL lead	June 22 June 22 Sept 22
Urgent & Emergency pathways	• CDU closure SDEC expansion, Staffing levels	• Recruitment pipeline prioritising key areas of greatest need – target of <3 down on any shift • 15% reduction in vacancies across UEM delivered by end May 22. Further engagement with recruitment and retention schemes for further improvement. Current UEM rate at 17% across directorate • Implement plus ones to avoid a 12 hour DTA • Rapid assessment & treatment (RAT) senior decision maker at front door pilot • In discussion with NWL ICS team to direct 111 UTC direct to SMH UTC (Totally)	Ben Pritchard-Jones Karen Powell, Jo Sutcliffe Ben Pritchard-Jones Ben Pritchard-Jones	May 22 complete June 22 June 22

NHS
Imperial College Healthcare
NHS Trust

CMS

Improving long length of stay (LLOS)

Countermeasure summary: Long length of stay

Imperial College Healthcare NHS Trust

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

Owner: Anna Bokobza

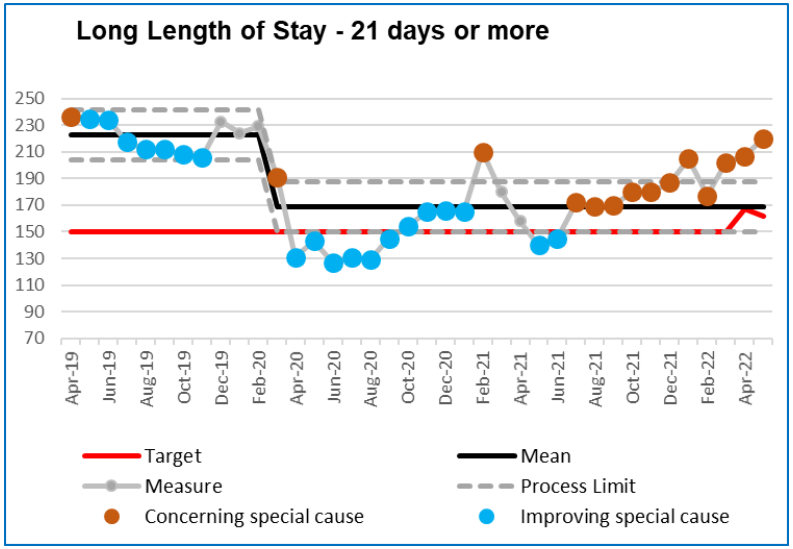
Metric: Number of patients with >20 days Length of Stay (LOS)

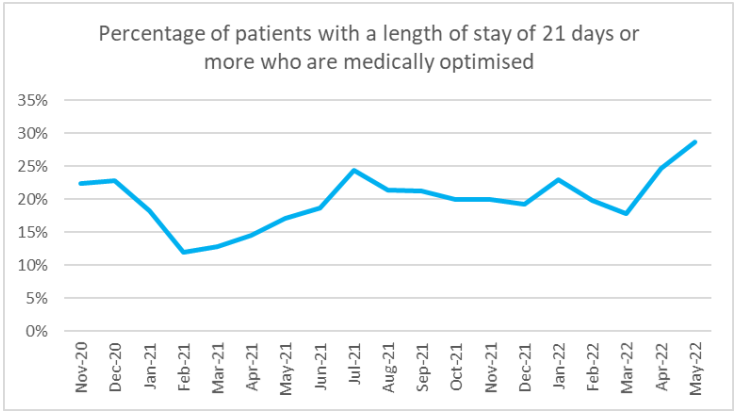
Target: A new improvement trajectory has been submitted with the sector as part of the 2022/23 NHS operating planning process

Desired trend: ⇩

Historical performance: The overall average length of stay in May 2022 was above the process control limits with an average of 220 patients with a stay of 21 days or more.

A new improvement trajectory is to be agreed with the sector as part of the 2022/23 NHS operational planning process. Regional trended benchmark data is being finalised and will be included in this report from next month





The percentage of all long length of stay patients (21 days or more) who were Medically Optimised was at 29% in May 2022.

At the end of M2, we reported a total of 57 Medically Optimised discharge delays (not all with >21 days LoS) of which:

- 0 Pathway 0
- 19 Pathway 1 (home with package of care)
- 13 Pathway 2 (bedded rehabilitation)
- 25 Pathway 3 (care home placement) – this was an increase on the prior month and one mirrored across the region.

Challenged performance in last two months has continued partially due to effect on staff capacity of planned and unplanned leave requirements across ward staff, discharge team, therapies, community and hospital social work teams. Social Work staffing challenges are reported in Brent and Ealing teams which have been escalated to relevant borough directors.

Countermeasure summary: Long length of stay

Imperial College Healthcare NHS Trust

30 DAY ACTION PLAN

Top contributor	Potential root cause	Countermeasure	Owner	Due date
High number of patients with Reason to Reside	• Variable practice in daily ward routines to optimise patient flow and discharge planning • Quality and completeness of coding in Cerner • Variable process for managing repatriations to other acute Trusts • Insufficient range of alternative options for safe management of LTCs in the community	• Improve daily ward routines through Board Rounds focussed improvement; baselining complete, improvement actions started with 6 wards and scoping & diagnostic work on a further 6. SPC shift (8 points below mean) seen on 9S showing reduction in average time of discharge and similar signs on Peters. Improvement team capacity has limited ability to scale coaching interventions. Trust Wide Flow programme now links Board round project with On the Day of Discharge project incl. Current cohort of improvement coaches will be paired with wards in June achieving support to further 9 areas.	Lauren Harding & Raymond Anakwe	Update to ICPG end June
		• Improve completeness and accuracy of ADD/R2R/MO; stably >90% complete for G&A patients >7 days LoS through some decline in April; now focussing on c.100 patients <7 days LoS on downstream wards	Anna Bokobza	End July
		• Develop and expand early supported discharge model with virtual ward and remote monitoring for suitable specialties; COPD and frailty went live mid April and now monitoring impact on NEL demand for winter 22/23; developing Lucii app functionality for pneumonia and asthma. Delayed by lack of project support for overarching steering group – raised with CCIO	Sarah Elkin & James Bird	End May - delayed

Countermeasure summary: Long length of stay

Imperial College Healthcare NHS Trust

30 DAY ACTION PLAN

Top contributor	Potential root cause	Countermeasure	Owner	Due date
High number of Medically Optimised LLOS patients	• Constrained senior capacity in historical discharge structure to support complex discharges • Variable relationships with system partners in different boroughs • Sub-optimal quality of Discharge to Assess referrals from ICHT to system partners • Hospital social work teams do not always get early sight of complex post discharge needs • Growing numbers of homeless patients who have longer LoS on average • Demand for specialist neuro rehab beds in NWL outstrips supply • Care home market dynamics make behaviourally complex patients hard to place • Demand for community health and social care P1 support sometimes outstrips supply • Insufficient upstream management of patient/family expectations around discharge and choice • Process inefficiencies with equipment, blitz cleaning/key safes	• Implement NWL integrated discharge structure – last 8b post filled in April. Phase 1 of skill mix review in implementation stage • Trial bi-borough overnight care (P1) to reduce number of fast track P3 referrals and delays. Funding secured for 1 year. Next step to identify providers, aiming to be in place by winter • Implement new P1 co-ordinator post at CXH and twice daily huddles with P1 partners; pending recruitment to associated posts • Improving quality of D2A referrals; in planning stage with Therapies leads • Level up medequip ordering rights across acute sites and boroughs; delayed by SMH ward leadership capacity; session to transfer learning from CXH to CXH matrons held end April; paperwork to be completed to have logins by July • Trial joint screening meetings 3 x daily with 3B ASC to improve P1 and P3 speed; tested during Better Together Week. P3 now BAU. P1 almost BAU at CXH. Trial completed at SMH but space constraining so seeking alternative space or grant for changes to Acrow • Implement NWL D2A form in Cerner with auto-notifications to LA teams (delayed by need for further changes to Power Form following testing phase in November); final changes and format agreed by NWL stakeholders 9 May, now for changes to implemented in Cerner and tested • Deliver 12 month Inclusion Health proof of concept; went live 29 Nov, Q1 impact report shared, generating further evidence for mid year review and ICB business case. RSI bid for 2nd year was unsuccessful due to constraints on the fund • Hold system partners to account for delivery of sector plan to source additional neuro rehabilitation beds (known London issue)	Anna Bokobza Donna Barry (ASC) Annabel Rule Annabel Rule Liz Wordsworth Annabel Rule James Bird Anna Bokobza NHSE/I	Complete September October July July July September Exec huddle briefing end June Updated expected mid-July

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC

Paper title: Infection Prevention and Control and Antimicrobial Stewardship Quarte 4 2021/22 report

Agenda item: 12

Lead Executive Director: Professor Julian Redhead, Medical Director

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

Purpose: For Information

Meeting date: Wednesday 20 July 2022

1. Purpose of this report

1.1. This paper provides a quarterly update of key indicators and infection rates, indicative of effective infection prevention and control (IPC) practice. The indicators and activity noted in the paper relates to quarter 4 2021/22 (Q4).

1.2. This report is designed to provide assurance to the board across all infection indicators, with a focus on those areas where concerns have been identified during the preceding quarter, and to note areas of concern or risk and associated plans and mitigations.

2. Executive summary

2.1. The focus of the IPC team in Q4 has been on the continuing response to the latest pandemic surge. We observed and responded to an increased incidence of hospital-onset Covid-19 infection (HOCI), as well as outbreaks and incidents associated, a trend paralleled nationally as the Omicron strain continued to result in high infection prevelance nationally. NHSE data on HOCI rates showed that our rate of HOCI per 100,000 bed days was lower than the London average rate (NHSE data, Mar 2022).

2.2. We continued to navigate, interpret and help implement frequent changes in National respiratory virus (including Covid-19) guidance, and support the Trust in balancing infection and operational risks.

2.3. We have continued to monitor and respond to all healthcare-associated infections (HCAI), including outbreaks of emerging pathogens such as *Candida auris* and *Corynebacterium striatum*

2.4. End of financial year (FY) figures for 2021/22 indicate that healthcare-associated *C. difficile* infection (including those flagged as lapses in care) and healthcare-associated *E. coli* and *P. aeruginosa* bloodstream infections (BSI) did not exceed annual thresholds set by UKHSA, and therefore do not flag as a cause for concern.

2.5. Our observed incidence of healthcare-associated *Klebsiella spp*. BSI is in line with our anticipated incidence for Q4, and similar to our position in Q3. However, due to an increased incidence in Q1 and Q2 the end of year figures have narrowly surpassed the annual threshold set. Increased incidence of healthcare-associated *Klebsiella spp*. BSI have been noted nationally - further detail on this is included in this paper.

2.6. In Q4 three healthcare-associated MRSA BSI were identified, totalling eleven cases for 2021/22 (end of FY figure), compared to a total of five reported in FY 2020/21. A detailed review of all MRSA BSI cases and actions is included in this paper.

2.7. In Q4 all metrics associated with Covid-19 screening remained comparable to figures in Q3. Overall our compliance against pre-admission patient testing remains below 90%, this islargely a facet of how tertiary screening takes place in the community and does not link to Cerner. An audit of compliance in Q4 has identified methodological changes needed to ensure that this is appropriately captured. We have placed this development on hold as a result of revised testing requirements for elective patients coming in to hospital – further detail is contained in this paper.

2.8. Carbapenemase-producing Enterobacterales (CPE) and MRSA screening compliance has fallen below the threshold for some divisions. This is monitored through the HCAI sitrep with divisional actions in place to improve.

2.9. The Director of Infection Prevention & Control is leaving the Trust in July. We would like to formally thank him for his outstanding contribution and wish him well in his new role. While we recruit the Medical Director will assume the DIPC responsibilities with support from our Infectious Diseases consultants. A consultation is underway with the wider IP&C team to implement a new structure which will provide enhanced support to sites and divisions. An implementation plan is in place and the risks associated with both are being managed on the risk register of the Medical Director's Office.

3. **Approvals process:** The contents of the report have been discussed at TIPCC and at EMBQ, EMB and Quality Committee where it was approved for onward submission to Trust Board.

4. **Recommendation:** The committee is asked to note the report.

5. **Next steps:** These are detailed in the body of 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:** no specific equality impact.

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

Main Paper

7. Covid-19 related incidents and outbreaks

7.1. In Q4 we observed 53 incidents and 28 outbreaks related to Covid-19, with a median of 5 patients involved in each outbreak (range 2 – 20). This compared to 34 incidents and 23 outbreaks in Q3, with the rise in Q4 representative of the continued high prevelance of community Covid-19 infection and the increased transmissibility of the Omicron variant.

7.2. This increase in Covid-19 activity is also reflected in the rise in cases of 'new' Covid-19 laboratory confirmed infection cases seen across the Trust in Q4: 1156 in Q4 compared to 798 in Q3, of which 297 and 143 HOCI cases in Q4 and Q3 respectively (Table 1). NHSE data on HOCI rates showed that our rate of HOCI per 100,000 bed days was lower than the London average rate (NHSE data, Mar 2022).

7.3. The focus of the IPC team in Q4 has been on the continued response to the latest pandemic surge, most notably:

7.3.1. Navigating and interpreting frequent changes in national guidance pertaining to management of seasonal respiratory viruses including Covid-19

7.3.2. Supporting divisions and site teams to balance infection and operational risks, and providing expertise on safe derogations where needed in response to operational pressures

7.3.3. Managing patient-led Covid-19 incidents and outbreaks, and supporting staff-only incidents, across the Trust through regular outbreak meetings held and weekly updates submitted to CRG and the sector.

7.3.4. Managing outbreaks of emerging pathogens including *Candida auris* and *Corynebacterium striatum*.

7.4. The IPC board assurance framework continues to be updated monthly, and an action plan related to the framework is reviewed regularly at the Clinical Reference Group (CRG). Progress is reported bi-monthly to the Quality Committee. It is anticipated that there will be further revisions to the national BAF template following changes in guidance on living with Covid-19. The majority of the Key Lines of Enquiry (KLOE) are complete, with sixteen which remain RAG rated as amber with designated leads for each area and plans to progress each .

8. Healthcare-associated infection surveillance and mandatory reporting

8.1. ***C. difficile* infections:** The annual ceiling set by UKHSA is 99 for the FY 2021/22. Our year end position was 71 *C.difficile* cases, therefore below the ceiling set. We reported a lapse in care in Q4 – a patient testing positive for *C.difficile* in Feb-22 was confirmed as having overlapped with a previous *C.difficile* positive patients on the ward, and therefore a lapse in care owing to transmission. The case was discussed in detail at the monthly MDT, and subsequently with the Division and ward in question, with key learnings including raising awareness around cleaning / hand hygiene practices at board and ward rounds (clinical staff) and huddles (non clinical staff).

8.2. ***E. coli* BSI*:*** The annual ceiling set by UKHSA is 152 for the FY 2021/22, with our year end position of 105 cases, and therefore below the ceiling set.

8.3. ***P. aeruginosa* BSI:** The annual ceiling set by UKHSA is 51 for the FY 2021/22, with our year end position of 36 cases, and therefore below the ceiling set.

8.4. ***Klebsiella spp*. BSI**: Q4 saw a decline in healthcare-associated cases, with eight cases compared to 18 in Q3, both below quarterly thresholds set. Albeit due to higher than expected cases in Q1 and Q2, our year end position of 70 cases narrowly exceeds the annual threshold set of 68 (Table 1, Figure 1a).

8.4.1. *Klebseilla spp.* BSI have increased nationally. We have the second lowest rate amongst 10 Shelford Trust hospitals, based on Apr 2021 - Feb 2022 data (Figure 1b).

8.4.2. Local investigation of *Klebseilla spp.* BSI indicate 12% of healthcare-associated cases in Q4 were attributable to vascular access devices, a drop from 26% in Q3. In addition, a further 12% were attributable to urinary sources (including urinary catheter devices) in Q4 compared, at level with the 12% seen in Q3.

8.4.3. An action plan has been developed and comprises: (i) a Trustwide point-prevalence survey (completed in Feb 2022), ii) monthly MDT to review all healthcare-associated BSIs to understand commonalities in sources of infection, areas of high incidence, lapses in care, and (iii) gap analysis of national BSI reduction recommendations. Due to ongoing pressures, we aim to

formally commence the monthly MDT in May of 2022, and aim to provide an update on key themes in the next iteration of the quarterly report.

8.4.4. Key headlines from the Trustwide point-prevelance survery (PPS) of central venous access devices (CVAD) in adults are as follows:

8.4.4.1. 14% of patients reviewed (172 of 1150) on the day of the PPS had a central vascular access device *in-situ*, with an slightly higher proportion in intentive care units (59%, 102 of 172) than in non-intensive care unit ward areas. The number of central vascular access devices is slightly less than 2017 which was 16% (204 in 1261 patients).

8.4.4.2. Documentation of CVAD insertion across the Trust was found to be inconsistent, in part this is because we have many places this can be documented. Where the insertion record is not in the vascular access tab in Cerner there is subsequent lack of ongoing care documentation. A wider piece of work within the organisation regarding CVAD documentation is required which will be taken forward via the Trust-wide line safety work in response to recent never events – it is of note that the ongoing care record in ICCA (ICU documentation) was very good.

8.4.4.3. One of the key findings of the survey was dressings associated with CVAD were not according to Trust guidelines - 38% (66 of 172) of patients had a correct semi-permeable transparent dressing intact with chlorhexidine impregnated sponge (biopatch) and dated as per trust guidelines. The action to improve this has already commenced, a review of product has been undertaken to ensure we have the correct dressing in clinical areas.

8.4.5. This plan builds on the current robust surveillance and clinical investigation process which accompanies the reporting of each BSI.

8.5. **MRSA BSI:** In Q4 there has been three MRSA BSI meeting UKHSA criteria of healthcare-associated (Table 1, Figure 2a), which brings the year end total to eleven healthcare-associated MRSA BSI against an annual set ceiling of zero.

8.5.1. Based on UKHSA data we rank highest amongst the 10 Shelford Trust (Shelford group) (Figure 2b). Seven out of ten Shelford Trusts report an MRSA rate higher than the national mean, suggesting a higher burden of healthcare-associated MRSA BSI across larger Acute Trusts.

8.5.2. Table 2 (see Appendix) details each case, source of bacteraemia and key outcomes and related learnings from each post-infection review.

8.5.3. Alongside the actions relating to vascular-access device associated *Klebsiella sp.* BSI, we are taking the following actions:

8.5.3.1. Ongoing observation and targeted education and assessment of aseptic non-touch techniques including vascular access device management, decontamination of needle free connectors and appropriate use of passive disinfecting caps.

8.5.3.2. Regular review of line infection surveillance data at the Trust's weekly HCAI meeting.

8.5.3.3. Implementation of the updated IPC practice eduction and training programme (see next section).

8.5.3.4. Review MRSA screening compliance (see section 10).

8.5.3.5. Audit timing of suppression therapy to identify targeted actions in response to potential delays in prescriptions.

9. IPC education, training and competency assessment

9.1. In October 2021 the IPC team undertook a Trust-wide hand hygiene and PPE audit, which was conducted in October 2022. Results of this were shared with divisional colleagues as well as plans to review our overall approach to IPC education and training – including the IPC competency assessment currently in place (commonly known as ANTT (aseptic non-touch technique) assessment.

9.2. In light of new learning as a result of the most recent Covid-19 surge, and observed increase in central line associated blood stream infections (CLABSIs), we have seen the positive impact of (i) front-loading education and training, and (ii) hands on support to clinical teams to when challenges with standard IPC practices are observed through infection-related incidents. We have reviewed the education and training undertaken by other Shelford Group Trusts (two other Trusts undertake an 'ANTT competency assessment') and across North West London and the proposals outlined here are in line with the practice of our contemporaries.

9.3. We are implementing the following:

9.3.1. Cease delivery of our current IPC training and competency assessment process, including ANTT training and competency assessment in April 2022.

9.3.2. An enhanced level two IPC e-learning in line with Skills for Health Framework, including additional training around the principles of asepsis and central/peripheral intra-venous line care launched on 1st June 2022. All clinical staff will undertake this training within the first three months of launch as a baseline and then yearly moving forward.

9.3.3. As part of the trust wide plan to continue 'better together week', it has been agreed with the Chief Nurse that there will be a quarterly focus on IPC practices with associated observation of practice, education, and training. The first event is due to take place in July 2022.

9.3.4. Good progress is being made on this programme and engaging with Divisional colleagues on both the programme and outcomes of the October 2021 audit. Ongoing progress will be monitored through EMB-Q.

9.3.5. We plan to use behavioural insights to support practical changes to improve IPC practice.

9.3.6. In implementing this new approach we will continue to regularly monitor our rate of HCAI as well as maintain surveillance of other key indicators such as CLABSI, contaminated blood cultures and screening to ensure that we identify any consequence, positive or negative, of this change.

10. Screening

10.1. Compliance with infection screening metrics and progress with divisional actions to improve are reviewed weekly at the HCAI sit rep.

10.2. Covid-19 screening compliance remains good with minimal fluctuations on three of five metrics, namely, emergency admission, seven and three day screening in Q4, compared to Q3. Two metrics, namely, elective screening and prior to discharge screening fell below the 90% internal target (Table 1). In anticipation of a change in National Covid-19 mitigation measures, we foresee a change in Covid-19 screening strategy and compliance from Q1 in FY22/23.

10.2.1. Covid-19 elective admissions compliance was 75% (average over the quarter), which is lower than expected. Contributing factors include re-opening of patient pathways, and patients screened at community/tertiary centres prior to admission not being recorded on Cerner automatically. An audit of compliance in Q4 has identified a methodological changes needed to ensure that this is

appropriately captured. We have placed this development on hold as a result of revised testing requirements for elective patients coming in to hospital.

10.3. CPE screening compliance remains good with minimal fluctuations below our internal threshold of 90%. Following targeted action, compliance in WCCS continues to improve with 82% compliance in Q4 compared to 59% compliance in Q1, albeit this remains below our internal compliance level of 90%. SCCS compliance was below internal threshold in Q4 at 83%, in part owing to continued Covid-19 linked pressures. (Table 1). We continue to monitor SCCS' compliance and work with the Division in improving compliance.

10.4. Compliance with MRSA admission screening was 90% (overall Trust average) for Q4, at par with Q3, and in line with the internal target of 90% (Table 1). We continue to review the cases where MRSA screening did not occur in order to identify any specific themes or learning to support improvement alongside Divisional colleagues.

11. Antimicrobial stewardship (AMS)

11.1. AMS objectives for 2022/23 have been set and endorsed by EMB Quality, and are in line with local and national antimicrobial resistance priorities. For 2022/23 one of the major focuces will be to promote a reduction in the use of intravenous antimicrobials and associated durations. We will continue to develop ways to reduce our broad spectrum antimicrobial prescribing, particualy those within the WHO AwARe index "Watch" and "Restrict" categories, this includes carbapenems and piperacillin/ tazobactam.

11.2. In Q4 we continued to see a reduction in our overall use of antimicrobials following the winter months of November and December. We are on target to meet our NHSE/I 2021/22 antimicrobial metrics of 2% reduction.

11.3. The January 2022 antimicrobial point prevalence survey showed an overall Trust compliance of > 90% for our prescribing and safety indicators. 37% of patients were on antimicrobials (similar to previous years). Results have been disseminated to divisional colleagues for discussion at local quality and safety meetings.

11.4. Paediatrics is currently reviewing their local antimicrobial stewardship service – we are involved in that review and helping to align themes to the objectives for the broader Trust-wide AMS prorgamme.

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

12.1. Surgical site infections (SSI) are reviewed quarterly with surgical specialities submitting information on SSI rates to UKHSA's national surveillance platform. SSI rates following orthopaedic surgery (knee, hip) remain below the UKHSA national benchmark figure of 0.6%, with zero SSIs flagged over the previous seven quarters (Jul-20 to Mar-22). Similarly, SSI rates following CABG (coronary artery bypass graft) procedures and non-CABG procedures have remained below UKHSA's national benchmark figure of 1.3% for the past three quarters, with zero SSIs flagged thus far in Q4 (figures finalised in May-22).

12.2. Our SSI programme and priorities for the coming year were reviewed and approved at EMBQ in June 2022.

13. Conclusion

13.1. This report summarises IPC activity in Q4 2021/22, plans in place and progressing in response to IPC-related issues.

13.2. In addition to this, the report outlines our continued emphasis on working closely with speciality and divisional colleagues in managing incidents and outbreaks, ultimately helping deliver a high quality of patient care.

13.3. Q4 continued to flag the importance of AMS initiatives to tackle multi-drug resistant infections, line-associated infection surveillance, and understanding ways in which to tackle healthcare-associated, particularly MRSA and GNR BSIs.

13.4. IPC continues to develop new approaches to training, assessment and support for staff for core IPC competencies and the paper outlines our plans to change our current apporach.

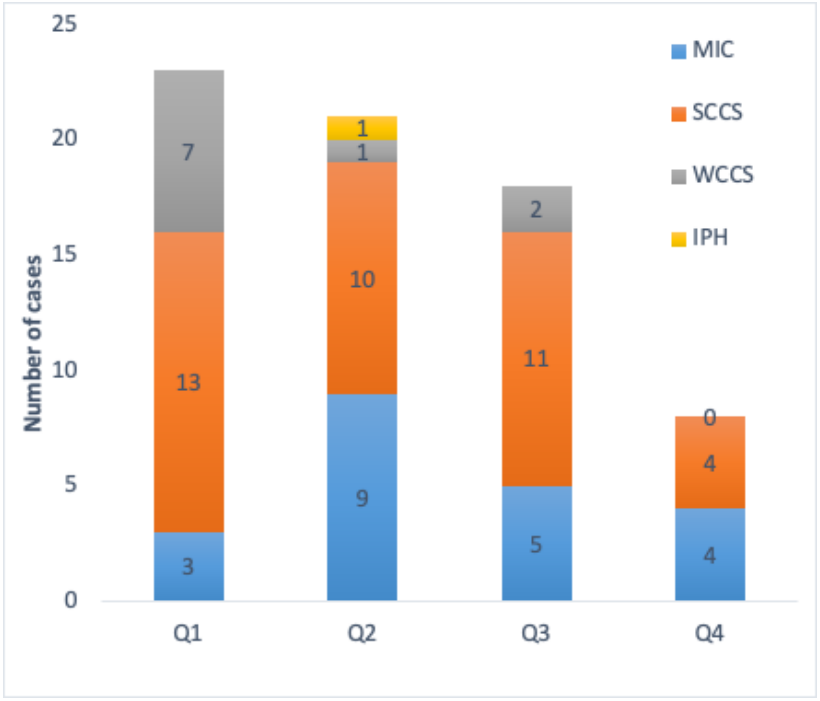
Author: James Price, Director of Infection Prevention and Control
Contributors: Tracey Galletly, Mark Gilchrist, Ian Bateman, Trisha Bourke and Sid Mookerjee
Date: 11 July 2022

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

Section		Indicators	Q1	Q1 ceiling	Q2	Q2 ceiling	Q3	Q3 ceiling	Q4	Q4 ceiling	Year end ceiling 21/22
Infections	Mandatory reportable infections	Methicillin-resistant *Staphyloccocus aureus* (all healthcare-associated cases, HOHA +	3	0	1	0	4	0	3	0	0
		Methicillin-sensitive *Staphyloccocus aureus* (all healthcare-associated cases, HOHA +	9	-	8	-	13	-	6	-	-
		E.coli (all healthcare-associated cases, HOHA + COHA)	17	38	33	42	31	36	23	36	152
		Klebsiella spp. (all healthcare-associated cases, HOHA + COHA)	23	16	21	18	18	18	8	16	68
		P. aeruginosa (all healthcare-associated cases, HOHA + COHA)	9	13	16	14	10	12	1	12	51
		C.difficile (all hospital-associated cases, HOHA + COHA)	16	25	20	26	13	24	22	24	99
	COVID-19	Hospital-Onset Indeterminate Healthcare Associated	7	-	17	-	49	-	112	-	-
		Hospital-Onset Probable Healthcare-Associated	3	-	5	-	38	-	76	-	-
		Hospital-Onset Definite Healthcare-Associated	0	-	6	-	56	-	109	-	-
		Incidents	8	-	36	-	34	-	53	-	-
		Outbreaks	0	-	11	-	23	-	28	-	-
	Surgical site infection	Knee Replacement	0.0%	0.6%	0.0%	0.6%	0.0%	0.6%	0.0%	0.6%	-
		Hip Replacement	0.0%	0.6%	0.0%	0.6%	0.0%	0.6%	0.0%	0.6%	-
		CABG	3.2%	3.8%	0.0%	3.8%	1.4%	3.8%	0.0%	3.8%	-
		Other Cardiac	1.9%	1.3%	0.0%	1.3%	2.9%	1.3%	0.0%	1.3%	-
	CLABSI	ICU CLABSI rate per 1000 line days	2.4%	3.6%	3.4%	3.6%	2.9%	3.6%	2.6%	3.6%	
		PICU CLABSI rate per 1000 line days	6.6%	3.6%	0.0%	3.6%	3.6%	3.6%	0.0%	3.6%	
		NICU CLABSI rate per 1000 line days	2.4%	4.4%	2.7%	4.4%	1.8%	4.4%	2.6%	4.4%	

Section		Metrics/Division	Q1	Q1 target	Q2	Q2 target	Q3	Q3 target	Q4	Q4 target
Screening metrics	COVID-19 Screening	Metric 1: NonElec 12 hr testing	89%	90%	87%	90%	90%	90%	89%	90%
		Metric 2: 5 day preadmission testing - inpatient electives only	75%	90%	71%	90%	76%	90%	75%	90%
		Metric 3: 72 hr pre discharge testing	96%	90%	82%	90%	98%	90%	90%	90%
		Metric 4: Inpatient 7 day testing	91%	90%	92%	90%	90%	90%	90%	90%
		Metric 5: Inpatient 3 day testing	89%	90%	88%	90%	90%	90%	91%	90%
	MRSA Screening	Medicine and Integrated Care	90%	90%	88%	90%	86%	90%	86%	90%
		Surgery, Cancer and Cardiovascular	90%	90%	90%	90%	87%	90%	88%	90%
		Womens, Childrens and Clinical Support	88%	90%	88%	90%	89%	90%	89%	90%
		Imperial Private Healthcare	98%	90%	99%	90%	97%	90%	97%	90%
	CPE Screening	Medicine and Integrated Care	96%	90%	96%	90%	92%	90%	92%	90%
		Surgery, Cancer and Cardiovascular	90%	90%	89%	90%	82%	90%	83%	90%
		Womens, Childrens and Clinical Support	59%	90%	49%	90%	73%	90%	82%	90%
		Imperial Private Healthcare	100%	90%	97%	90%	94%	90%	93%	90%

Figure 1a and 1b (left and right respectively): (Left) Healthcare-associated *Klebsiella spp* BSI by quarter, FY 2021/22, split by Division, (Right) Healthcare-associated *Klebsiella spp* BSI rate per 100,000 bed days, comparison across Shelford trusts (UKHSA)



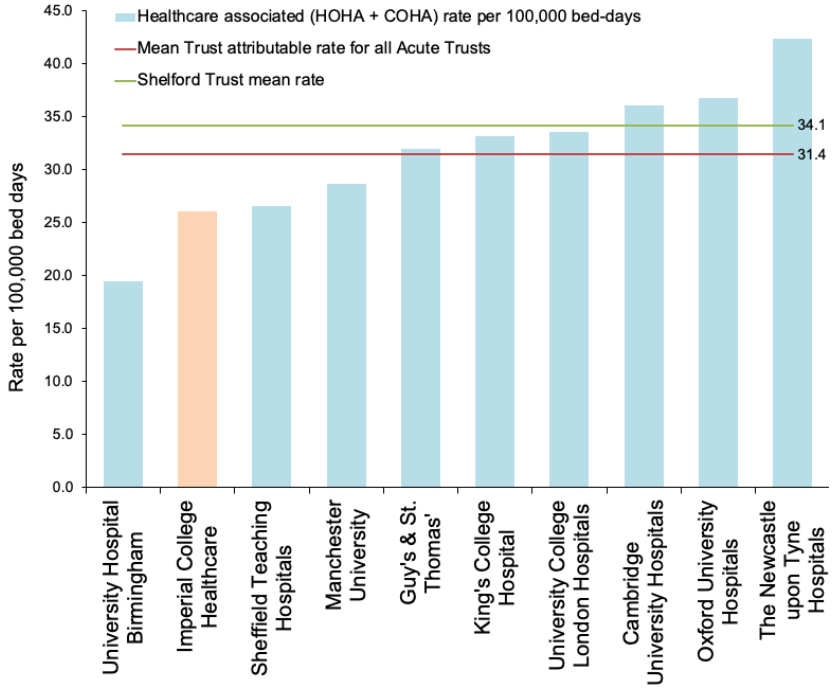
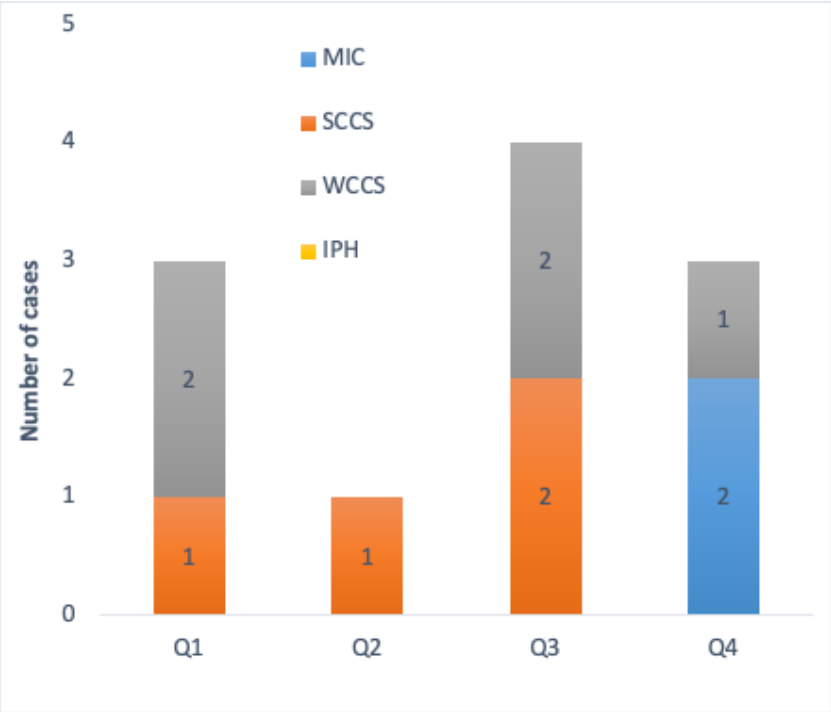


Figure 2a and 2b (left and right respectively): (Left) Healthcare-associated MRSA BSI by quarter, FY 2021/22, split by Division, (Right) Healthcare-associated MRSA BSI rate per 100,000 bed days, comparison across Shelford trusts (UKHSA)



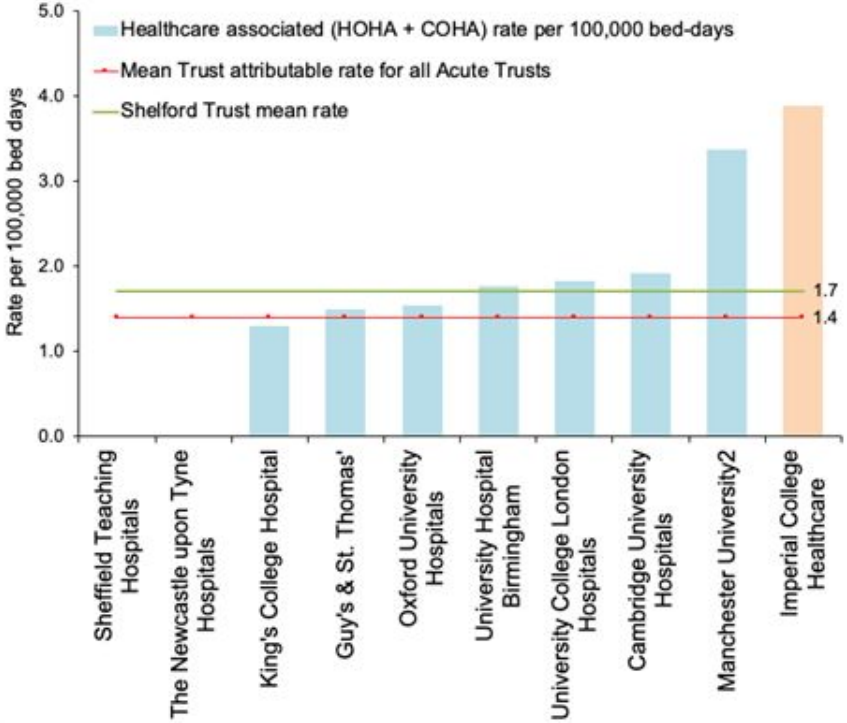


Table 2: Healthcare-associated MRSA BSI summarise compliance against 'investigation themes', source of infection and key learnings.

Key: BC = blood culture

Date	Division	HA category	MRSA colonisation known prior to this BC	MRSA screening issues	MRSA suppression issues	Were invasive devices managed appropiately	Were antimicrobials managed appropiately pre BC	Were any skin/soft tissue issues managed appropiately	Was the BC taken appropiately	Source	Key learnings
May-21	Surgery, Cancer, & Cardiovascular	HOHA	Y	N	N	Y	Y	Y	Y	Persistent bacteraemia owing to community onset spinal abscess	None identified
Jun-21	Women's and Children's	HOHA	Y	Y	Y	Y	Y	N/A	Y	Pneumonia and vascular access device associated	Delays in reporting the positive BC and initiation of suppression therapy
Jun-21	Women's and Children's	HOHA	Y	Y	Y	Y	Y	N/A	Y	Persisent bacteraemia owing to Pneumonia and vascular access device associated	As above
Sep-21	Surgery, Cancer, & Cardiovascular	HOHA	N	N	N	Y	Y	N/A	Y	Community acquired Covid pneumonitis with co-bacteraemia	None identified
Oct-21	Women's and Children's	HOHA	Y	N	Y	N	Y	N/A	Y	Vascular access device associated	Education regarding the correct management of needle free connectors used for vascular access devices
Oct-21	Women's and Children's	HOHA	N	N	N	N	Y	N/A	Y	Vascular access device associated	Education regarding the correct management of needle free connectors used for vascular access devices
Oct-21	Surgery, Cancer, & Cardiovascular	HOHA	Y	N	Y	N	Y	N/A	Y	Endocarditis/Chest	Education regarding 1) the importance of completing full course of suppression therapy and 2) Consistent documentation of VA devices
Dec-21	Surgery, Cancer, & Cardiovascular	HOHA	Y	N	Y	N	Y	Y	Y	Vascular access device associated	Education regarding 1) the importance of completing full course of suppression therapy and 2) Consistent documentation of VA devices
Jan-22	Women's and Children's	COHA	Y	Y	N	N	Y	Y	Y	Skin colonisation	None identified
Feb-22	Medicine	HOHA	N	N	Y	N	Y	N/A	Y	Vascular access device related & infective endocarditis	Education regarding 1) the importance of promptly prescribing suppression therapy and 2) Consistent documentation of VA devices
Mar-22	Women's and Children's	HOHA	N	N	N	Y	Y	N/A	Y	Maternal colonisation and wound infection	None identified

North West London Integrated Care System
Working together for better health and care

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD - PUBLIC

Paper title: Hospital Mortality associated with COVID-19

Agenda item: 13

Lead Executive Director(s): Julian Redhead, Medical Director
Raymond Anakwe, Medical director
Author(s): Clemmie Burbidge, Improvement lead – compliance and assurance,
Shona Maxwell, Chief of staff, Office of the medical director

Purpose: For information

Meeting date: Wednesday 20 July 2022

1. Purpose of this report

1.1. Covid-19 has been recognised as the greatest public health emergency since the foundation of the National Health Service which resulted in a large number of lives lost in patients who were admitted to NHS care establishments during this period.

1.2. The Trusts within NWL Integrated Care System (ICS) have worked together to undertake a retrospective review of the care given to patients who died in hospital of Covid 19 during the first two waves of the pandemic. Although this was not nationally mandated we wanted to make sure that we learnt as much as we possibly could from each death to improve the future care of our patients. This is important given the huge impact these losses have had on bereaved relatives as well as our frontline teams who cared for the people who died.

1.3. The reviews have been carried out in keeping with each organisation's guidance on learning from deaths (1) so although they follow key principles there are some differences in approach.

1.4. This report is written using a template agreed across the ICS but only includes information from the multidisciplinary reviews that have been undertaken within Imperial College Healthcare NHS Trust. The outcomes are presented for information.

2. Executive Summary (key messages)

2.1. We would like to start by offering our condolences to the families of the patients who lost their lives as a consequence of Covid-19 whilst being cared for within our hospitals. We hope that our reviews will provide some comfort that although they could not always be with their loved ones when they died that our staff were doing all they could to keep them safe and to care for them.

2.2. From 11th March 2020 (first death) to 31st March 2021, Imperial College Healthcare NHS Trust reported 897 COVID-19 related deaths. Of these, 80 have been confirmed as being the result of hospital acquired Covid-19 infection.

2.3. The care of these 80 patients has been individually scrutinised by the medical examiners, undergone structured judgement review by a team of consultants and then reviewed at our mortality review panel chaired by the Medical Director. A sample of the cases were then presented for peer review at the ICS mortality group, and then all cases had further scrutiny at the mortality review panel before finalising the outcomes.

This process has been complicated as we have been careful to scrutinise each death using the lens of knowledge and guidance available at the time of the infection as well as considering realistic prevention strategies.

2.4. From these reviews we have confirmed that there were no significant lapses in care in relation to the acquisition of Covid-19 from the standards which would have been expected at the time and nothing more that we could have reasonably done to prevent infection at the time it was acquired. This is a testament to the hard work of our teams to rapidly implement guidance as we released it and their efforts to keep people as safe as possible as we responded to the pandemic.

2.5. There are six cases where care was assessed to have fallen below the standards we expect, classified as “poor”. This was not related to Covid-19 acquisition and so have not been described in detail in this report. These cases are all being managed through our serious incident framework and will be included in our learning from deaths reports to Quality Committee in the coming months.

2.6. Learning from these cases has influenced our evolving response to the Covid-19 pandemic and is now embedded in our policies. Examples of this includes changes to inpatient testing regimes, the implementation of our Hand hygiene/Personal protective equipment (PPE) supporter programme to help with the changing national guidance, work to reduce patient ward moves and to improve physical distancing in non-clinical areas e.g. staff changing areas and break rooms as well as our new approach to infection prevention and control education, training, and audit to support staff with routine IPC practices.

2.7. The next of kin, where there was one, for all patients who died had a discussion with a medical examiner at the time of death. In line with our learning from deaths guidance we are now planning to contact them to follow up on that discussion and provide feedback.

3. Approval process

3.1. The template and pre-populated sections of this report were agreed at the NWL ICS Clinical and Quality Leadership Group. This report was discussed at EMB Quality Group (EMBQ) and Executive Management Board in June, and Quality Committee in July where it was approved for onward submission to Trust Board.

4. Recommendation(s)

4.1. The committee is asked to note the outcomes of the mortality reviews for deaths attributed to Covid-19 from the first and second waves of the pandemic.

5. Next steps

5.1. Review of the care for people who have died from Covid-19 is now fully embedded in our learning from deaths process. The outcome from these reviews will report regularly to Quality Committee.

6. Impact assessment

6.1. Quality impact: improving how we learn from HOCI 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: N/A

Main report

7. National context

7.1. The first cases of Covid-19 in the UK were confirmed on 31 January 2020 and the first death reported on 5 February 2020. By 7 March 2020, there were 316 confirmed cases of Covid-19 in the UK and a further four people had died.

7.2. On 11 March 2020, the World Health Organization (WHO) declared a pandemic. The pandemic continued to progress rapidly and on 23 March 2020 the Prime Minister announced full lockdown across England (2).

7.3. Initially, London was the most severely affected, where the confirmed number of cases accounted for almost one-third of the total in England by 31 March 2020. The death toll increased along with the number of cases, resulting in the UK overtaking Italy as the country with the highest death toll in Europe and the second highest in the world on 5 May 2020. As of 24 June 2020, there had been over 306,000 confirmed cases of Covid-19 and almost 43,000 deaths in the UK. (4)

7.4. The overall death toll from Covid-19 from the start of the pandemic in March 2020 to 9 April 2021 was 137,000, one in five of all deaths in England and Wales during this period. The first wave from about March to August 2020 resulted in 52,000 Covid-19 deaths and the second wave from September 2020 to 9 April 2021 caused an additional 85,000 Covid-19 deaths. (2)

7.5. A summary report published by HSIB highlighted a number of challenges faced by hospital trusts at the height of the pandemic (4):

- There had been a need to constantly develop national guidance to respond to the emerging risks of Covid-19 infection. This posed a significant challenge in how guidance was developed and disseminated. It was noted that there were 21 separate updates to the Covid-19 infection prevention and control guidance between 1st January and 7th May 2020 (6). Local teams had challenges in interpreting guidance and identifying resources to implement this rapidly evolving guidance.
- Community testing was introduced in early April 2020 which meant that hospital trusts had no way of confirming whether an individual was infected with Covid-19 unless they were unwell enough to be admitted to hospital
- The timeliness of test results being returned impacted on a hospitals ability to respond effectively to the pandemic. When rapid testing was introduced, these were in limited supply and supplies had reduced further during the course of the pandemic. Patients awaiting a test result were sometimes required to be moved into the hospital system prior to test results being returned, either due to the demand on Covid-19 related admission areas or based on the clinical needs of the patient. This provided a further challenge should any patient subsequently return a positive Covid-19 test following admission to a non-Covid-19 area.
- Transmission of Covid-19 by asymptomatic individuals was not well understood. There was limited evidence on the rate of asymptomatic transmission; estimates suggested the rate could be as low as 16% or as high as 41% (5).
- Trusts reported frequent problems in receiving a consistent supply of FFP3 respirator masks. With each change in supplier, the regulatory requirement to 'fit test' staff with masks arose which had an impact on the numbers of staff who could undertake duties with patients.
- Estates- In some old builds there were a small number of side rooms which further complicated by the fact that there are no ensuite facilities so patients would have to share facilities. In addition, ventilation systems of some trusts could not be easily repurposed as they were not designed to be filtered to capture a high proportion of airborne particulates.

- Concerns about patients becoming infected with Covid-19 during hospital admission began to emerge into the public domain in mid-May 2020. A report which collated clinical data from hospital admissions suggested that approximately 20% of patients were reporting symptoms of Covid-19 seven days following admission indicating possible nosocomial transmission.
- Trusts had to make rapid adaptations to enable them to respond to the pandemic. This had seen a trade-off in levels of consultation, assurance and governance systems usually in place to embed systems.

8. ICS GOLD decisions

8.1. All Trusts within NWL ICS were involved in key decision making during the height of the pandemic so that the approach was sector wide. Below is a summary of these decisions taken to support the sector at the height of the first wave of the pandemic.

March 2020

- Noted NHSE letter to free up critical care beds
- Mutual aid agreed to decant pressurised sites
- Surge protocol agreed by CEO's- to ensure that blue light patients and Covid-19 patients could be diverted rapidly at high pressure sites.

April 2020

- Covid patient ambulance distribution-distributing ambulance conveyances of Covid patients to different A&Es, concentrating them to potentially 3 areas to reduce pressures.
- Working with London Ambulances on divert arrangements to give a better distribution of patients to inner NWL acute Trusts
- Patients transferred between Trusts to support with capacity issues and some to the Nightingale Hospital
- Pembridge unit opened with 20 bed capacity(CLCH)
- Reinforce message about appropriate use of PPE by staff to ensure no under use to ensure staff safety
- CNWL - Mental health patients to be re-directed to St Charles, Northwick Park Hospital and Hillingdon hospital from emergency departments when attending with mental health issues only to special units.
- Principle that urgent patients to Independent Sector should go ahead with retrospective approval
- Endorsed proposal, including prioritisation equipment to support ECMO patients.

9. Definitions used for Hospital acquired COVID-19

9.1. In line with the NHSE guidance (3) the following definitions have been used in completing the investigations into COVID related deaths.

9.2. **COVID-19 hospital death**: The NHS defines a COVID-19 hospital death as the death of a patient in hospital who has a positive specimen result where the swab was taken within 28 days of death and/or COVID-19 is cited on either Part 1 or Part 2 of the death certificate (i.e., the death resulted from a COVID-19 clinically compatible illness with no period of complete recovery between the illness and death).

9.3. **A Hospital-Onset Probable Healthcare-Associated infection** is defined as an infection where the first positive specimen was taken 8-14 days after hospital admission with day of admission counted as day 1.

9.4. **A Hospital-Onset Definite Healthcare-Associated infection** is defined as an infection where the first positive specimen was taken 15 or more days after hospital admission with day of admission counted as day 1.

10. Challenges associated with community acquired COVID-19 infections

10.1. The focus for the NWL ICS group was in investigating definite or probable inpatient COVID deaths attributed to the relevant Trust. For patients who died in the community, it is noted that it would be very difficult to accurately ascertain how the individual contracted the infection.

11. ICS approach to Mortality and Nosocomial infections including assigning harm ratings.

11.1. The ICS approach has been agreed by all the mortality leads across Acute, Mental Health and Community Trusts in NWL and is aligned to the guidance set out by NHSE (3)

- Trusts to use existing processes in place to review mortality.
- Building on the statutory reporting requirements for COVID deaths, each Trust is to ensure that robust processes exist to report probable and definite COVID related deaths.
- The approach is designed to support system wide learning. There must be an agreement that if patients have been transferred between sectors, there should not be any hindrance in obtaining relevant information to complete the review from the organisations involved in the patient's care.
- The system has agreed that although a retrospective review was not mandated nationally, this will be the NWL ICS approach of all cases involving "probable" and "definite "COVID related mortality from April 2020 to March 2021. Any new or emerging themes that are arising from the new infections are analysed as appropriate.
- Those that meet the definitions of a serious incident should be recorded and managed as such.
- Thematic analysis of learning to be shared with the system including any rapid learning identified for new cases of COVID related mortality.
- Sector wide agreement on assigning harm ratings. If the individual Trust, via its internal MDT panel have not identified any lapses in care, taking into consideration guidance in place at the time of the infection, the final harm rating will be recorded as low /no harm.

12. Trust review process

12.1. Our approach to investigating hospital onset Covid infection, potential outbreaks and then the care of patients who died has evolved during the pandemic.

12.2. During both waves, all deaths were individually scrutinised by the medical examiners and underwent structured judgement review (SJR) by a team of consultants as part of our learning from deaths process. When reviewing deaths via SJR we use a grading system developed by the Royal College of Physicians which rates care using a five-point Likert scale (1: Very Poor Care – 5: Excellent Care). This grading system enables us to identify deaths where there were care and service delivery issues so that we can take forward the learning. The SJRs carried out for these deaths were focused on all aspects of the patients' care, rather than just the acquisition of Covid-19.

12.3. We also recorded all HOCI deaths on our incident reporting system and have followed the ICS guidance on recording final harm levels.

12.4. The deaths were then all reviewed at our mortality review panel chaired by the Medical Director. At this meeting a decision was made regarding whether there were any avoidable care or service delivery issues that may have contributed to the patient's infection.

12.5. A sample of these cases was presented for peer review at the ICS mortality group, and then all cases had further scrutiny at the mortality review panel before finalising the outcomes.

12.6. This process has been complicated as we have been careful to scrutinise each using the lens of knowledge and guidance at the time of the infection as well as considering realistic prevention strategies.

13. Trust data

13.1. From 11th March 2020 (first death) to 31st March 2021, Imperial College Healthcare NHS Trust reported 897 COVID-19 related deaths.

13.2. Appendix 1 shows our rates of Covid mortality as a percentage of bed days and admissions, demonstrating that there was a higher proportion of Covid-related deaths in the first wave than in the second. This is due to the initial uncertainty about the virus at the beginning of the pandemic, with lack of testing, known treatments, and knowledge around how the virus was transmitted all playing a part. In addition, our normal activity was significantly reduced as the country went into lockdown and resource was diverted to deal with Covid cases.

13.3. During the second wave, we maintained a greater proportion of our elective activity, and saw an increase in non-Covid related emergency activity as well as an increase in Covid cases due to higher rates of community transmission. While our collective knowledge of the virus had increased considerably, and we had stronger systems in place to detect the virus and prevent transmission, the higher volume of patients provided an additional risk to in-hospital transmission.

13.4. Of the 897 Covid-19 related deaths, 80 have been confirmed as hospital-onset Covid infections (HOCIs), 30 in the first wave (approx. March 2020 to May 2020) and 50 in the second wave (approx. October 2020 to March 2021). These deaths have been confirmed as being caused by Covid, with Covid on part one of the death certificate in 54 cases and on part two in 27 cases.

13.5. Data showing the breakdown of these confirmed cases by month, division and specialty and site can be found in appendix 2. Data on ethnicity is provided in appendix 3; the largest group of the patients (n=37) has their ethnicity recorded as white on Cerner.

13.6. Of the 80 cases, 85% were over the age of 65, with the youngest patient being 46. The majority of the patients had significant comorbidities.

14. Outcome of our review process

14.1. All 80 cases were reviewed through the process outlined in section 12.

14.2. Of these deaths, the SJRs identified the following overall care scores:

- Excellent care (score 5) – 5 cases
- Good care (score 4) – 41 cases
- Adequate care (score 3) – 28 cases
- Poor care (score 2) – 6 cases
- Very poor care (score 1) – 0 cases

14.3. There are six cases where care was assessed to have fallen below the standards we expect, classified as “poor”. This was not related to Covid-19 acquisition and so has not been described in detail in this report. These cases are all being managed through our serious incident framework and will be included in our learning from deaths reports to Quality Committee in the coming months.

14.4. From these reviews we have confirmed that there were no significant lapses in care in relation to the acquisition of Covid-19 from the standards which would have been expected at the time and nothing more that we could have reasonably done to prevent infection at the time it was acquired. This is a testament to the hard work of our teams to rapidly implement guidance as we released it and their efforts to keep people as safe as possible as we responded to the pandemic.

14.5. The next of kin, where there was one, for all patients who died had a discussion with a medical examiner at the time of death. In line with our learning from deaths guidance we are now planning to contact them to follow up on that discussion and provide feedback.

15. Key learning and action points

15.1. Our review process identified that while care was in line with the knowledge and guidance in place at the time, there was learning which could improve patient care going forward.

15.2. Key themes and learning from our reviews of these deaths are set out below. Learning from these cases has influenced our evolving response to the Covid-19 pandemic and is now embedded in our policies. It has also informed our action plan in response to the infection prevention and control board assurance framework (IPC BAF). This was first published In June 2020 by NHSE to support the provision of assurance to Trust boards that their approach to the management of Covid-19 is in line with national IPC guidance that risks have been identified and are mitigated.

15.3. This learning has also been triangulated with other insights, including complaints, to inform our ongoing response to the Covid-19 pandemic, which is led by our Clinical Reference Group. It has also been shared through our learning from deaths processes, including through our quarterly learning from deaths report to the board, bi-monthly newsletter, and through our divisional and directorate quality and safety committees.

15.4. **Patient testing**: As well as the challenges noted in section 7 above, the testing in place during the first wave meant that in some cases there was late identification that patients had become Covid positive, which increased the risk of cross-transmission. This resulted in changes in our testing programmes for inpatients to include swabbing on admission, when symptomatic, daily for 7 days and then weekly after that. This allowed us to better identify and manage Covid positive patients to prevent cross-transmission, supporting the introduction of pathways for positive, negative and unknown status patients during the second wave and the designation of wards as high, medium or low risk.

15.5. **Movement of patients:** the reviews of cases during the first wave identified that some patients had multiple bed and ward moves – in some cases this was without knowing their Covid status due to the testing issues outlined above, increasing the risk of cross-transmission. We undertook an audit in December 2020 which provided reasonable assurance that while most patient moves during wave one had been undertaken for their clinical needs, there were some cases where the moves had not been clinically necessary e.g. for operational reasons. Improved guidance was issued ahead of the second wave and a follow-up audit completed in May 2021 showed that unnecessary bed moves for patients with Covid-19 were rare.

15.6. **PPE:** Regularly changing national guidance meant that there was initial confusion regarding the correct use of PPE amongst staff, including the appropriate processes for hand hygiene when donning and doffing, as well as supply chain issues noted in section 7. As a result of the learning from our HOCI deaths, and other insights as the pandemic evolved, we introduced the “PPE/Hand hygiene helper programme” to provide ward-level support for staff to use the correct PPE, and to use it safely. Our PPE helpers visit clinical areas daily to observe PPE use and support best practice, delivering over 2,200 visits to clinical areas in 2020/21 and over 3,580 in 2021/22. During 2020/21 we tracked staff anxiety in relation to PPE usage and found that this decreased as a result, with overall compliance improving.

15.7. **Estates issues:** reviews from cases during the second wave identified issues relating to the age and configuration of our estate, making adequate social distancing in some areas difficult, including:

- Bed-spacing: we undertook an audit of spacing between beds and ensured that wherever possible beds where at least 2 metres apart. In areas where this is not possible e.g. our neonatal units and some parts of our labour units, risk assessments were undertaken and mitigating actions implemented which were approved out our clinical reference group.
- Covid-secure non-clinical areas: requirements for 2 metre physical distancing for staff were challenging, particularly in non-clinical areas such as staff break rooms, and changing rooms which are often small. Following the second wave, we undertook a full assessment of all non-clinical areas across the trust and identified that 19% were not ‘Covid-secure’, these areas had local mitigation plans implemented to reduce the risk of cross-transmission between staff.

15.8. **Staffing issues**: During the second wave in particular there was significant redeployment of trust staff to critical care and higher risk areas and reliance on bank and agency staff to backfill on the wards. This increased the likelihood of errors occurring, including PPE breaches, due to the number of staff who were not fully familiar with all protocols and the areas in which they were working. The reviews highlighted the importance of identifying and mobilising additional staff earlier and ensuring support and training is in place. As a result, we introduced additional substantive healthcare support workers to improve care in BAU but also increase resilience in surge, and we worked with the agency provider to strengthen the competency assessment processes for temporary staff.

16. Processes in place to reduce the risk of Nosocomial infections

16.1. The Trust's Infection Prevention and Control and antimicrobial stewardship (IPC) service is responsible for ensuring that policies and procedures are in place, and that expert advice is available. This includes our outbreak management policy, screening, antimicrobial resistance, and our PPE/Hand hygiene helper programmes. Quarterly updates from our infection prevention and control team are provided to our Trust Board for assurance.

16.2. Actions are taken locally in response to infections, with trustwide plans put in place where required, including an action plan developed in 2021/22 in response to an increase in MRSA BSIs and central line associated BSIs.

16.3. In December 2021 the IPC BAF was re-issued, revising previous key lines of enquiry with a broader focus to account for all seasonal respiratory viruses. An action plan is in place to do the necessary work that will improve board assurance related to IPC management. This is being monitored through the Clinical Reference Group (CRG) and is reported monthly to EMB quality group and EMB, and bi-monthly to Quality Committee and Trust Board.

16.4. Following review of our infection related data and feedback from our staff, we have developed a new approach to infection prevention and control education, training and competency assessment, which launched in June 2022. This approach has been informed by learning through our responses to Covid-19 waves, and by what similar organisations have in place. This new approach involves an improved online training package, and quarterly observational practice audit and training as part of the new 'Better Together Thursday' initiative. This will be enhanced by a rolling programme of structured education and training visits across every area of the trust by members of our IPC team with divisional colleagues. We will also continue to offer targeted support for areas with IPC-related issues.

17. Conclusion

17.1. Of the 897 deaths from Covid-19 which occurred within Imperial College Healthcare NHS Trust between March 2020 and April 2021, 80 have been confirmed as being the result of hospital acquired Covid-19 infection. While review of these cases has shown that in the context of the knowledge and guidance in place at the time there was nothing more that we could reasonably done to have prevented the acquisition of Covid-19, we acknowledge the huge impact that these losses have had on bereaved relatives and families.

17.2. Our retrospective review of these cases has provided us with key learning which has influenced our evolving approach to the pandemic. We are committed to continuing to learn from all deaths which occur in our hospitals to improve the future care of our patients.

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5. Transmission dynamics of the COVID-19 epidemic in England. Yang Liu, Julian W. Tang, Tommy T.Y. Lam
   Int J Infect Dis. 2021 Mar; 104: 132–138.
6. https://www.hcsa.com/media/154216/HCSA-Report-Covid19-Learning-from-the-First-Wave.pdf

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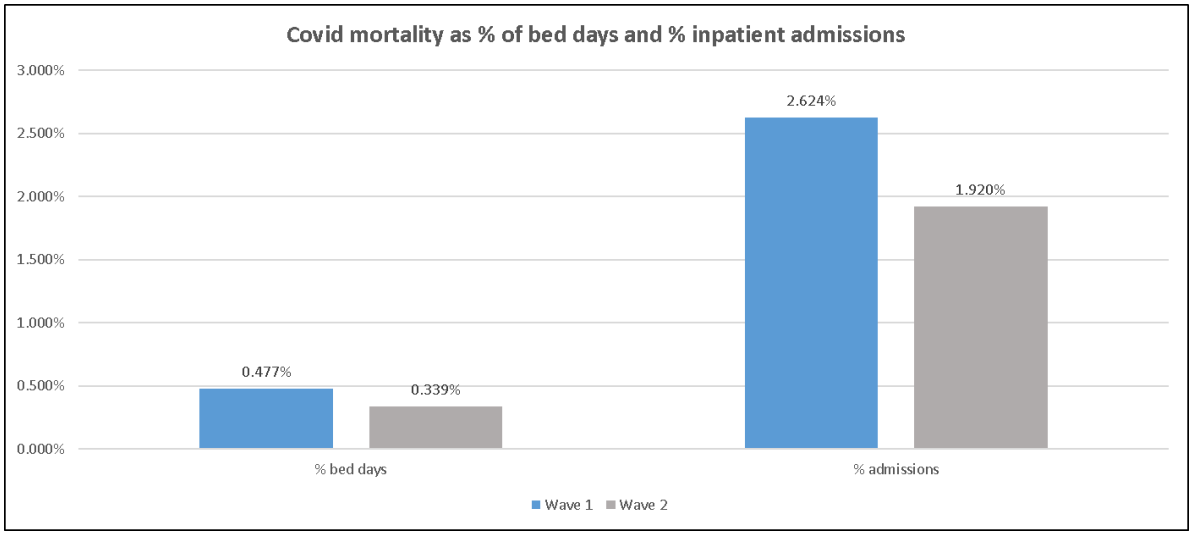
Date 14th July 2022

Appendix 1



Appendix 2

Fig 1 All Covid deaths

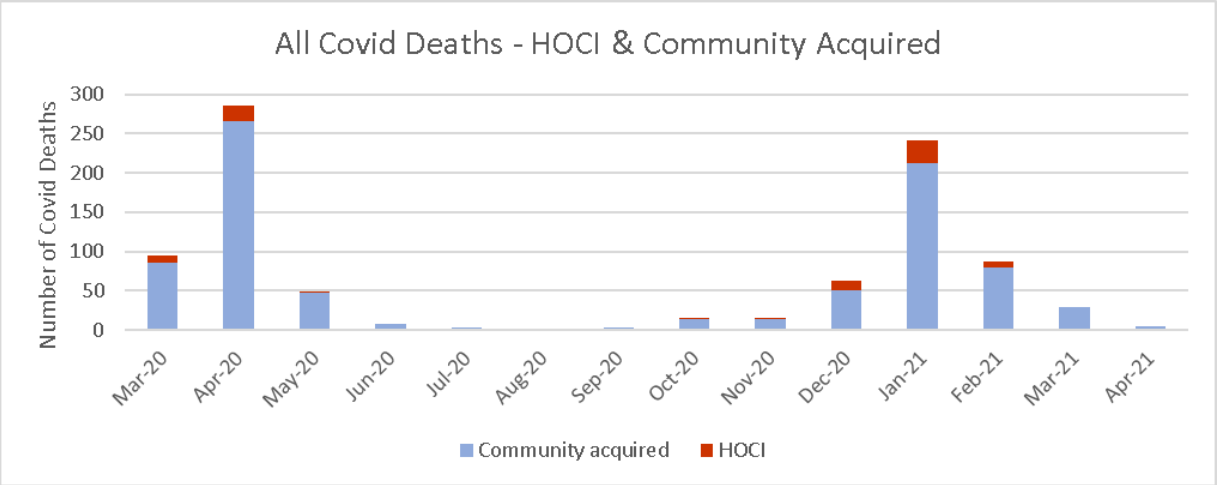


Fig 2 Covid-19 related deaths

Month	Community acquired	HOCI	Total Covid
Mar-20	85	9	**94**
Apr-20	265	20	**285**
May-20	47	1	**48**
Jun-20	8	0	**8**
Jul-20	3	0	**3**
Aug-20	1	0	**1**
Sep-20	3	0	**3**
Oct-20	14	1	**15**
Nov-20	14	1	**15**
Dec-20	50	12	**62**
Jan-21	213	29	**242**
Feb-21	80	7	**87**
Mar-21	29	0	**29**
Apr-21	5	0	**5**
Totals	**817**	**80**	**897**

Fig 3 – HOCI deaths by month

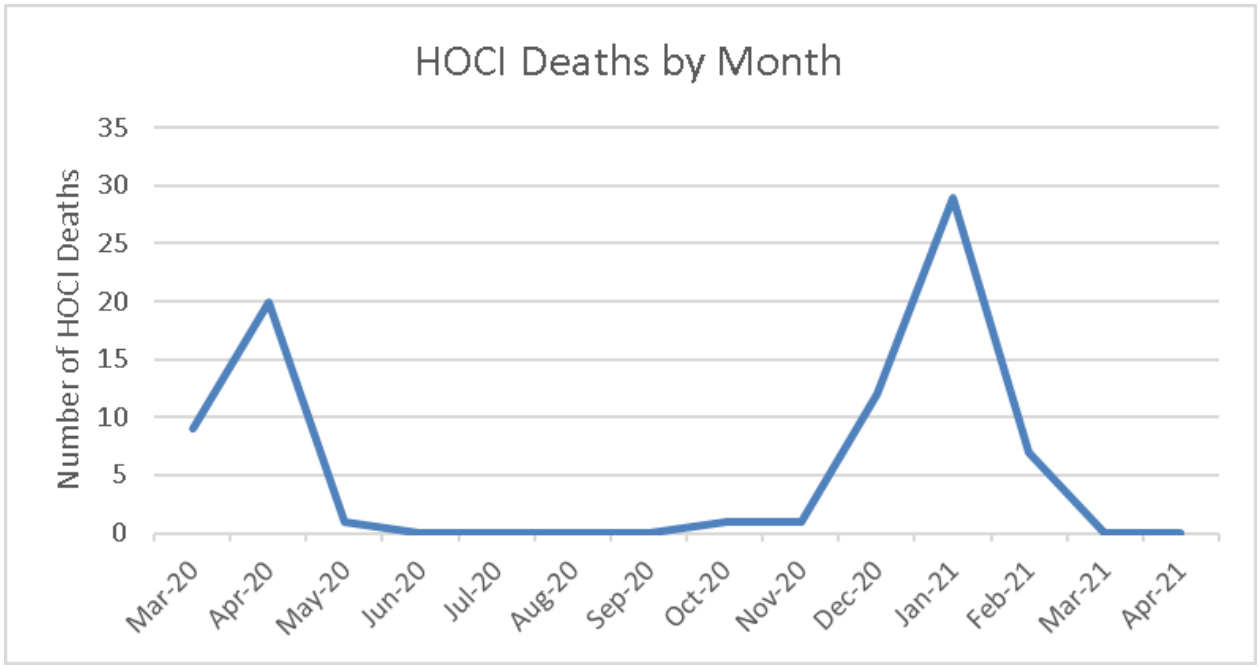


Fig 4 HOCI deaths by Division

Wave	MIC	SCCS	Total
Wave 1	20	10	**30**
Wave 2	43	7	**50**
Total	**63**	**17**	**80**

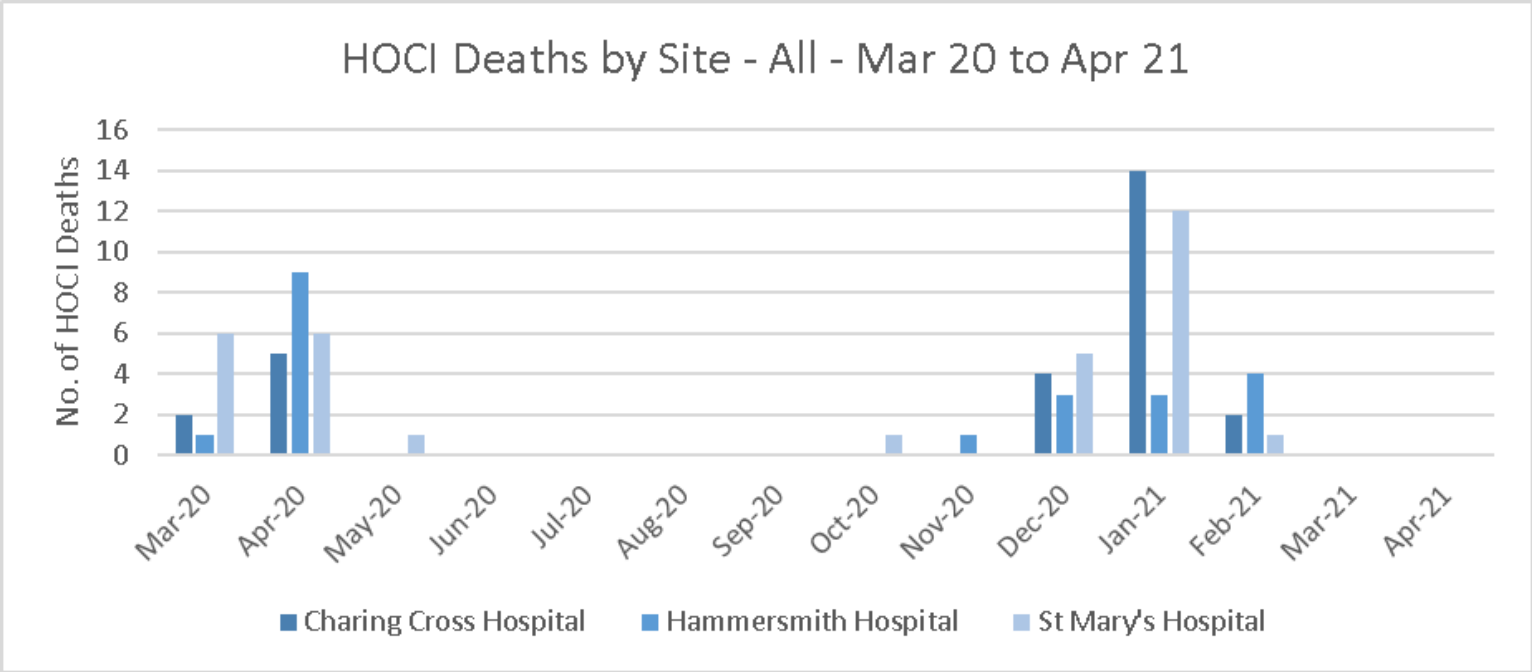
Fig 5 HOCI deaths by Specialty – Medicine and Integrated Care (MIC)

Wave	Acute Med SMH	Acute Med CXH	Care of the Elderly	Gastroenterology	Neurology	Renal	Respiratory	Total MIC
Wave 1	2	1	3	2	2	9	1	**20**
Wave 2	9	5	10	3	5	8	3	**43**
Total	**11**	**6**	**13**	**5**	**7**	**17**	**4**	**63**

Fig 6 HOCI deaths by Specialty – Surgery, Cancer and Cardiovascular (SCC)

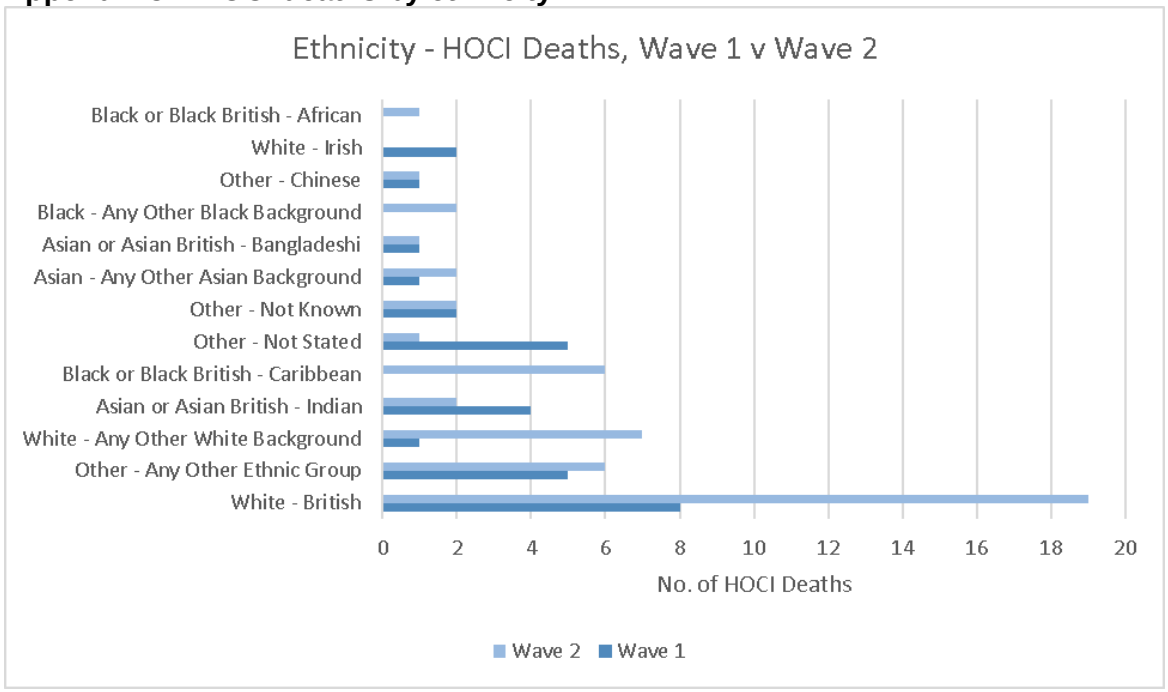
Wave	Clinical Haematology	ENT	General Surgery	ICU	Major trauma	Orhopaedics	Urology	Vascular	Total SCCS
Wave 1	1	1		1	3		1	3	**10**
Wave 2			2		4	1			**7**
Grand Total	**1**	**1**	**2**	**1**	**7**	**1**	**1**	**3**	**17**

Fig 7 HOCI deaths by site



Month	Charing Cross Hospital	Hammersmith Hospital	St Mary's Hospital	Total
Wave 1	7	10	13	**30**
Wave 2	20	11	19	**50**
Total	**27**	**21**	**32**	**80**

Appendix 3 – HOCI deaths by ethnicity



Ethnicity	Wave 1	Wave 2	Total HOCI
White - Any	11	26	37
Other - Any	6	7	13
Asian - Any	6	5	11
Not stated	7	3	10
Black - Any	0	9	9
Totals	**30**	**50**	**80**

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC

Paper title: Improving equity in our service delivery

Agenda item: 14

Lead Executive Director(s): Dr Bob Klaber (Director of Strategy, Research and Innovation)
Author(s): Dr Dominique Allwood (Consultant in Public Health), Hannah Franklin (Interim Strategy, Research and Innovation Programme Manager)

Purpose: For discussion & approval

Meeting date: Wednesday 20 July 2022

1. Purpose of this report

1.1. The purpose of this paper is to set out and agree the ambition required to identify and address inequity in services we provide across the Trust.

1.2. Quality Committee are asked to endorse the approach and approve plans to continue developing a detailed two year programme of work based on this, including submission of a business case for a Health Equity Lead to coordinate the Trust-wide initiatives.

2. Executive Summary (key messages)

2.1. Pre-existing health inequalities have been laid bare by the direct and indirect impacts of the COVID pandemic. Within our North West London (NWL) Integrated Care System (ICS) population, there are significant avoidable disparities in health outcomes including a life expectancy gap as great as 17 years between different communities. Inequalities in terms of access, outcomes and experience of healthcare also exacerbate these health inequalities, compounding the health, social and economic disadvantage faced by certain patient groups. Inequity of access in our service provision has already begun to be evidenced at the Trust (Appendix 1) with further analysis and improvement work underway.

2.2. As an NHS provider we have a moral, statutory, strategic and operational requirement to improve the health of our local population and reduce the inequalities they face, which includes changing the way we provide our services to be more equitable. Failure to act on this agenda is not only unjust, it will compromise the Trust's priority of providing timely, safe and equitable care, lessening the impact of concurrent efforts to manage the elective backlog, reduce A&E volumes and support issues with flow through a one size fits all approach. The Covid vaccine equity work for example successfully evidenced this.

2.3. To accelerate efforts to bring us in line with peer Trusts and meet national mandatory requirements, a coordinated 2 year programme of work (workstreams, activities, timing and resources) is proposed to be scoped and delivered. This will prioritise and implement corporate and clinic level changes to address inequity in care for our patients. The high-level plan is detailed in this paper. This work will form part of a longer term piece of continuous improvement work to change organisational culture and systematically embed equity as a domain of quality at the Trust - we cannot see ourselves as a high-quality Trust until we are an equitable Trust, demonstrated at ward through to board level.

2.4. A focus on improving equity is also a key tenet of our Population Health Framework and Anchors work (Figure 1, Appendix 2), addressing the wider determinants of health and health inequalities and building healthier communities around our hospitals.

3. Engagement & approval process

3.1. In response to the 22/23 operating guidance and understanding implications for the Trust, the CEO, COO and CIO helped input into an initial draft of our approach. The work was then presented at a Trust Board Seminar in April 2022 where its focus as a Trust priority and the need to embed equity into existing quality work was outlined. This paper pulls together the next steps from that discussion.

3.2. We have had strong patient and public involvement in this work from the outset - Health Inequalities is a standing agenda item on the Strategic Lay Forum with regular updates and input received by the members who endorse this paper and its approach.

3.3. The Equity work was recently shared at a Trust Race and Health Inequalities conference hosted by the multidisciplinary and nursing and midwifery race equality staff networks. The Chief People Officer is Joint SRO for the health inequalities contractual requirements related to the Workforce Race Equality Standards (see Appendix 2).

3.4. Engagement has begun with the Medical Directors Office (MDO) to scope how to bring the work within the existing quality management processes at the Trust. This paper went to EMB on 28th June 2022, and is being discussed here before going to the Public Trust Board.

4. Recommendation(s)

4.1. Accept and adopt the level of Trust-wide ambition and focus required to assess and improve equity in our service delivery.

4.2. Accept the recommended workstreams and high-level activities so these can be formalised within a detailed 2-year programme of work.

4.3. Endorse the move to view equity as a domain of quality and support scoping of a roadmap which looks to integrate equity into the existing Trust quality infrastructure.

5. Next steps

5.1. Progress understanding of our current context and baseline through richer data analysis and qualitative sense making. This includes applying a deprivation and ethnicity lens to existing access, experience and outcome indicators at the Trust.

5.2. Use this analysis to identify 2-3 priority areas to take forward into specialty level improvement projects.

5.3. Continue to collaborate on the acute provider DNAs Task and Finish Group; next step being to meet with patient groups across July and August to understand barriers to attendance and co-produce some solutions to test and evaluate from September to October.

5.4. Advance discussions with Trust and Divisional quality leads on bringing equity into existing focus areas (quality and operational) and identify key actions to take this forward.

5.5. Progress work underway to incorporate consideration of equity into corporate processes including the Trust Investment Appraisal process and Quality Impact Assessments.

5.6. Develop an internal and external communications plan - which situates equity as a Trust improvement priority, in the context of our wider population health work - with the communications team, including increasing presence of this work with staff and working with academic colleagues to set up and run an 'Equity Summit'.

5.7. Finalise the detailed plan of work and outputs through to 2023/24 including resource requirements for further approval by EMB in September 2022.

6. Impact assessment

6.1. *Quality impact*: CQC has tackling inequalities in health and care as a 'core ambition' running through the four themes of their new strategy. This work presents an opportunity to deliver more patient-centred and inclusive care through availability of new data analysis and increased co-production with patients and community. When viewed as a domain of quality, addressing equity will also support improvement across other quality areas such as patient safety and patient experience.

6.2. *Financial impact:* We are finding examples of waste driven by inequity i.e. DNAs which if addressed have a productivity and effectiveness impact, and thus potential to support an

improved financial position, i.e. through being in receipt of more elective recovery funding. Reducing inequity and associated efficiency of resources has already been included in the benefits framework of the new Trust Investment Appraisal process, but the programme of work outlined in this paper will be required to help staff identify and realise these tangible benefits. Without doing this work we may put some ERF opportunities at risk. Prioritisation and management of Trust waiting lists with an equity lens could lead to better outcomes for patients, avoid future health service usage and associated financial burden.

6.2.1. *Workforce impact:* Through our population health approach we consider our staff as a population whose health and wellbeing we need to be concerned about. 7,000 Trust staff live in NWLs 8 boroughs and there is potential to improve their access, outcomes and experience of Trust care through this work. Additionally many staff are passionate about the health inequalities agenda and want to use their skills to make a change, but are unsure how; this programme provides a way to engage. We have evidence that involvement in equity related projects improves staff experience[1].

6.3. *Equality impact*: Unlike other potential changes, those who are typically least likely to benefit or have their needs met are the main benefactors of this work. Age, sex and race (through ethnicity) are protected characteristics purposefully considered for analysis with regards to equity under this initial phase of the programme (further characteristics to follow). Those living in deprived areas and other groups at greater risk of inequalities i.e. disabled homeless, carers are also actively included.

6.4. *Risk impact:* Failing to act quickly and intentionally will worsen health inequalities. Reputational and financial risk (via ERF and contractual mechanisms) through failing to meet mandatory requirements or negative benchmarking against peers.

Main report

7. Introduction and background - the problem statement

7.1. As a healthcare organisation who is determined to deliver high quality services, the impact of our work will always remain diluted, and inequitable, unless we take steps to understand and mitigate disparities in access, outcomes and experience of care for our patients.

7.2. Whilst ‘health’ is primarily driven by social determinants such as employment, literacy levels and structural racism, inequalities in healthcare experienced by disadvantaged groups also have a contributing factor and reflect an issue within the immediate sphere of our control as a healthcare provider to address. Examples of healthcare inequalities include certain patients experiencing disproportionate levels of harm, discriminatory treatment and bias by providers, or failure to understand care plans provided only in English.

7.3. There is also a clear mandate from both NHSE (Appendix 2) and the CQC, for Trusts to actively understand inequality in their services and rectifying inequalities which are identified.

7.4. Further still, there are potential financial implications to the mandate of ‘restoring services inclusively’. When applying an equity ‘lens’ to the elective backlog for example, through proactively managing variations such as access to appointments or impact of waiting for care on health outcomes by relevant characteristics such as deprivation, there is an opportunity to make additional productivity gains and increase the effectiveness of recovery efforts. In turn, some other Trusts have intentionally situated their health inequalities work within their elective recovery delivery and governance structures (i.e. Barts, Royal Free).

8. Our proposal to focus on EQUITY

8.1. Whilst the NHS is universal it is not necessarily equal, nor equitable. Whilst ‘equality’ means ensuring everyone receives the same resources or opportunities, the term ‘equity’ goes further still, to acknowledge not everyone has the same circumstances to begin with. Under ‘ensuring equity’ resources and opportunities are allocated based on need to achieve an equal outcome (Figure 2, Appendix 2).

[1] NHSE 2019 unpublished survey of 432 maternity staff

8.2. As a Trust we want to take a step on from NHSE language and focus on "reducing inequalities" to promote an asset-based approach towards improving and achieving ***equity***. This aligns with our Trust vision of 'better health, for life', our values and behaviours and also the Trust 22/23 priority of providing timely, safe and equitable care and goal of being more 'user-centred'. It also aligns with work on equity within our newly awarded NIHR Imperial Biomedical Research Centre (BRC) award.

8.3. It is important to note that while connected to and complimentary with, this work is distinct from the Equality, Diversity and Inclusion priority led by our People and OD team which have a set of objectives aimed at achieving equity for our workforce. Both the Strategy, Research and Innovation and P&OD teams are working closely together to understand and improve disparities in staff health and wellbeing (pillar 3 of the population health framework) as a potential driver of differences in care and inequity in outcomes and experience for our patients.

9. National and system context

9.1. There are statutory, strategic and operational requirements on ICSs (& ICBs) to discharge their duties with regards to Population Health Management and Health Inequalities (PHMHI).

9.2. The Trust has provided senior clinical leadership to the development of the NWL ICS PHMHI programme which as a result aligns closely with own Trust aims and approach, including our existing quality improvement (QI) methodology.

9.3. A national NHSE Framework 'Core20+5' (Figure 3, Appendix 2) has been developed to support ICSs understand priorities when it comes to health inequalities. We too have adopted the framework at Trust level to drive targeted action in our Trust equity work, ensuring we focus on the 20% most deprived (the 'Core' – which reflects ~12.5% of the total NWL resident population) and minority ethnic groups under the 'plus' category given these communities represent over 50% of the population in some local boroughs.

9.4. At acute provider collaborative level, the elective recovery programme have actively applied the QI methodology to identify and address inequalities, with Imperial a lead collaborator on a DNA focused task and finish group across the providers to continue this important work.

9.5. Several major trusts now have dedicated equity programmes in place (Bart's, Royal Free, Leicester, ELFT, Royal Berkshire are good examples) recognising the need to bring greater organisational focus to equity issues. These programmes and their associated leadership teams and working groups focus on ensuring planning guidance is met, proving structure, understanding and action with regards to equity in access, outcomes and experience, sharing best practice and leveraging required resources across the Trusts, particularly from key enablers such as analytics.

10. Internal context: Evidence of inequity in access, outcomes and experience for our Trust patients

10.1. Whilst the fact healthcare inequalities exist in the work of NHS is well evidenced, we need to understand at Trust level (using quantitative data and qualitative insights) if and where this manifests for our patients, so that we can start to coproduce and test interventions. There is much we still don't know about our patients however i.e. under reporting of protected characteristics if we are to adequately identify and address equity related issues. The Trust will be sharing learning in this space with other acute providers in the NWL collaborative.

10.2. Analysis has already started with access data in response to the mandatory guidance. When examining outpatient DNA rates for the 20% most deprived and those from minority ethnic backgrounds there is a direct correlation with DNA rates (see Appendix 1). Similar trends were found across the NWL acute provider collaborative and are being actioned through a joint DNA task and finish group which the Trust is collaborating on.

10.3. We have taken steps to understand and improve our Cerner ethnicity data quality gaps from ~30% ethnicity 'not known' or 'not stated' down to just 5% through developing a solution using a WSIC supplement and adding this to our data warehouse and production cycle, along with deprivation code mapping. This will allow us to move to deeper, speciality level

analysis and identification of specific problems with specific patient cohorts to take forward into improvement projects.

10.4. The recent 'Annual patient equality and diversity' report for 21/22 found respondents of the friends and family test who selected 'prefer not to say' in terms of their ethnicity, sexuality and disability all scored lower on their experience of care which needs further investigation. Understanding our patient experience data, along with a deeper analysis of our DNA and waitlist data is an ongoing process for 22/23 and with plans to triangulate with user insights to provide a more complete picture.

11. Trust population health framework

11.1. This drive to achieve equity in our service delivery and our research work is not happening in isolation. We already have a strategic Trust population health framework (Figure 1, Appendix 2) that we are using to plan, prioritise and evaluate activities which contribute to addressing the wider determinants of health and health inequalities.

11.2. The framework was developed through engagement with stakeholders from across the Trust, the NWL ICS and other local organisations, and is guiding broader work including delivering more integrated care, supporting trust staff as a key population and growing our role as an anchor institution. Embedding equity, prevention and health improvement across our clinical, research and education work forms pillar 1 of the four-pillar framework. This work has been widely recognised and adopted by other Trusts within the Shelford Group.

12. Systematically embedding a focus on equity, as a domain of quality, across the Trust

12.1. Achieving equity is complex, multi-layered and will require us to learn how to work in a different way. We have to recognise that if we continue to do what we have always done, we will get the same results – meaning inequities will widen, and outcomes will worsen.

12.2. As part of making significant and sustained improvements we are proposing to make a clear and deliberate shift to viewing ***equity as a domain of quality***. The Institute of Medicine (IOM) defined 6 dimensions of quality (Figure 4, Appendix 2), including equity, yet equity perspectives are still rarely considered in healthcare quality improvement programmes, clinical audits, service evaluation or adverse events investigations[2].

12.3. We will make this change through building equity into the existing quality structures at the Trust and build a culture of continuous equity improvement, leveraging our current quality governance mechanisms within each clinical service and our QI approach and resources.

12.4. We will co-design a roadmap of how to build a focus on equity into quality and performance meetings with each division and how to bring equity into the into the control, assurance and improvement approaches at directorate and divisional level.

12.5. Through bringing the focus to teams already concentrating on quality (be it patient-centeredness, safety, efficiency) we believe this positioning will help put improving equity as part of the solution, not an additional priority to manage. This reduces potential resource implications and means improving equity is something everybody can contribute to at all levels of their work.

13. Trust action to accelerate efforts to address inequity

13.1. The goal of achieving equity of access, outcomes and experience for all patients regardless of who they are will not be achieved overnight. However, a concentrated programme of work to put foundational elements in place and elevate the status of equity within the Trust, will start to move us in the right direction. This includes filling our current knowledge gap, inspiring a desire to change with staff and providing skills to identify and address inequity through use of data and applying a QI approach. Meeting the national requirements with regards to reducing inequalities will also be met through our intended approach.

13.2. Six interconnected workstreams are proposed (Appendix 3) intended to build our organisational capability and drive tangible outputs in the near term whilst making the

[2] Transforming health systems to reduce health inequalities | RCP Journals

required culture change in the long term to ensure achieving equity is everybody's business, catalysing staff and achieving spread.

13.3. Work has already started to obtain the data required to help us understand our current position and identify key areas of focus specific to the Trust and our patients (Appendix 3).

13.4. Early progress has also been made to build our capability across the Trust to engage with that data. Deprivation and ethnicity filters have been added to the outpatient flow clinical analysis dashboard to allow speciality level analysis. Further relevant and high-usage Qlik sense apps will also have this ability added, along with a training package for staff. A knowledge and training gap analysis for staff with regards to population health and reducing health inequalities is also underway and will guide an education offer to accompany this.

13.5. To strengthen our understanding we will triangulate this data with qualitative insights and co-production, feeding heavily into the development and utilisation of the Trust user insights function to ensure the equity lens is considered and solutions we test are designed directly with those patient impacted. The need to improve the Trust's interpreting services for example was identified through discussions with community organisations and the strategic lay forum and reflects an active example of listening and acting on community insights to improve equity.

13.6. Existing corporate processes are already being reviewed for equity impact, including adapting the existing quality impact assessment and business case framework. More work is required however under this programme to develop tools and templates to help Trust colleagues understand and quantify equity within all decision making purposes.

13.7. A balance of top down and bottom up will be achieved by the programme through the anticipated changes at corporate level alongside enabling staff-led clinic/specialty level QI projects focussed on equity.

13.8. The six interconnected workstreams identified are at various stages of development and delivery as per the GANTT chart (Appendix 3). High level activities - where possible - have been mapped out accordingly, with further detail to be worked through with key colleagues.

14. Measurement and outcomes

14.1. Through this programme of work we intend to make measured year-on-year improvements across several key access, experience and outcome indicators with regards to equity, with a particular focus on patients from the most deprived communities in line with the Core20+5 measurement framework. This will done through completing the data analysis of our current position, assessing where we have the greatest gaps for improvement and can make the most impact, then applying quality improvement methods to close these gaps through levelling up those at the bottom. This may have an important impact on ERF and other contractual funding we are able to realise through making these improvements.

14.2. In 22/23 we expect this to initially focus on 1-2 access indicators (disparities in DNA rates have already been identified) given the availability of data and importance of elective recovery, before moving to include wider experience and outcome related improvements.

14.3. With leadership support we hope to include these access equity related improvements on the Trust's integrated performance score card, as a priority programme of work for the Trust.

14.4. Through working with the medical director's office we will also undertake a review of existing quality metrics and improvement areas to identify those which have relevance for equity and track them accordingly. 'Enabling' metrics which measure the successful culture change and integration of equity into health will also be identified.

14.5. By April 2023 we aim for all specialities to have identified and be implementing an equity related area for improvement, with regular monitoring and discussion of key markers of equity included in quality and performance meetings.

15. Mitigating resource implications

15.1. The plan to frame improving equity as a key domain of quality will enable us to leverage significant existing expertise, resource and infrastructure that sits within our well-established quality infrastructure at the Trust. The work will require additional support from other directorates to help build our internal capacity e.g. communications, quality improvement,

business intelligence (BI). The practicalities of this are being fully scoped collaboratively with team leads over the coming weeks – the aim is for this work to be aligned to existing resource. BI/analytics support is already committed, given the reliance on data as a foundational element of this programme, with reporting on health inequalities a department priority for 22/23.

15.2. To provide coordination and leadership we are proposing establishing a single dedicated Health Equity Lead role – to start before the end of 2022. This person will be responsible for the delivery of the 2 year plan; directly accountable for the activities which sit under Dr Bob Klaber as SRO for the work. They will provide input from an equity perspective into other relevant Trust initiatives and be an enabler to others teams as part of readying the organisation to 'embed equity'. They will mobilise key stakeholders within the Trust to design, deliver and report on the programme of activities, providing subject matter expertise, direction and coaching. They will also be responsible for receiving and assuring ongoing requirements with regards to health inequalities i.e. from NHSEI, ICS, CQC are met. The Health Equity Lead will be supported by Dr Dominique Allwood (Consultant in Public Health) in her part-time role leading our population health work.

15.3. Resourcing a Health Equity Lead would mean parity with other trust priority programmes who are all expected to have a dedicated lead responsible for operationally driving the work forward. Examples of similar roles at other Trusts have been identified and we are in communication with them to share job descriptions, person specifications and adverts.

16. Governance and reporting

16.1. The Health Equity Lead will establish and convene a regular multi-disciplinary working group of wider Trust colleagues delivering activities under the programme i.e. BI/Analytics, communications. The lead will also establish a bi-monthly open invite forum for discussion and facilitate cross-learning and dissemination

16.2. As part of embedding quality as a domain of equity, this working group will feed into EMB Quality and EMB, as well as the new acute provider quality committee as it forms.

16.3. As per the national 22/23 operating guidance, Trust reporting in this area will also commence quarterly from July 2022 (Appendix 1).

17. Conclusion

17.1. If we are committed to playing our part in the local and national agenda to address health inequalities and improve population health we must make the shift to viewing equity as a domain of quality and endorse a Trust programme of work which aims to scale our understanding of inequities in our service delivery and move more rapidly into action.

17.2. Recognising the need to prioritise, achieve some 'quick-wins' for our patients alongside sustained culture change as an organisation, the proposed programme sets out a high-level approach to achieving this with a view to move to more detailed planning with executive approval.

Appendices:

1. DRAFT Inequalities in Access, Outcomes and Experience at the Trust July 2022 report
2. Supporting Information:
    a. Mandatory guidance detail (Operational plan, elective recovery, Core20+5)
    b. Health inequalities action plan from CCG contract
    c. Population health framework
3. High Level Equity Programme Plan

Author(s) (name and position)

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Dr Dominique Allwood - Consultant in Public Health
Hannah Franklin - Interim Strategy, Research and Innovation Programme Manager
Date 29/06/22

Appendix 1 – Inequalities in Access, Outcomes and Experience at the Trust Report (July 2022)

Referrals: Deprivation

NHS
Imperial College Healthcare
NHS Trust

Higher referral rates received from the most deprived communities

Why is this important for understanding population health and inequity in our service delivery?

- Tells us about the demand for care from our communities and how we can better work with GPs to understand and meet that demand

Deprivation measured by the national Index of Multiple Deprivation (IMD) where 1 represents the most deprived and 5 the least deprived

*Referrals from 18 referral sources, primarily general practitioners (~41%) and consultants (~47%)

What does the graph tell us?

- That there is a higher demand for care amongst our patients from the most deprived communities

What doesn't it tell us?

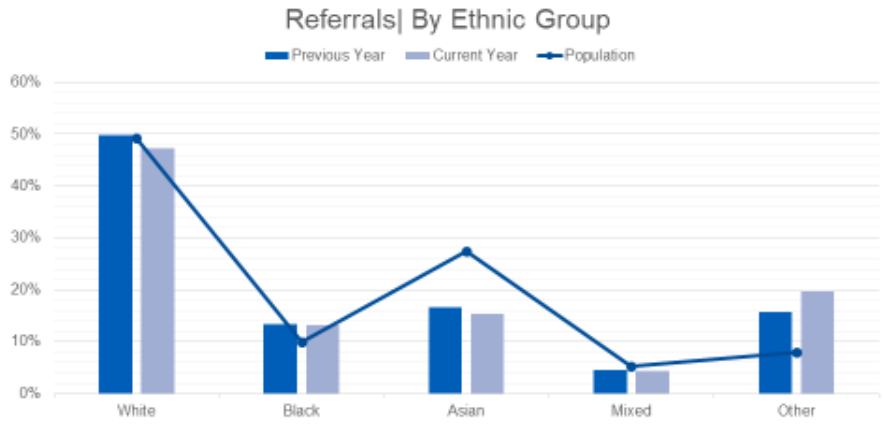
- Is this demand for care high enough based on population need?
- Are the patients who need the care most being referred to us?
- Patterns of health-seeking behaviour which feed into this

What is our next step?

- Map this against the relevant disease burden
- Look at pathways from referrals into attendances/consultations and the role of Advice and Guidance
- Compare to emergency attendances to identify other patterns of healthcare use

Referrals: Ethnicity
Potential under representation by certain ethnic groups

Imperial College Healthcare NHS Trust



**Resident population 'other' category does not include ethnicity 'not stated' or 'not-known whilst our WSIC patient information does*

What does the graph tell us?
- We are receiving more referrals from Black and Other ethnic minority backgrounds versus the relative NWL population, indicating their demand for care is higher
- Asian backgrounds are potentially under represented in our current referrals

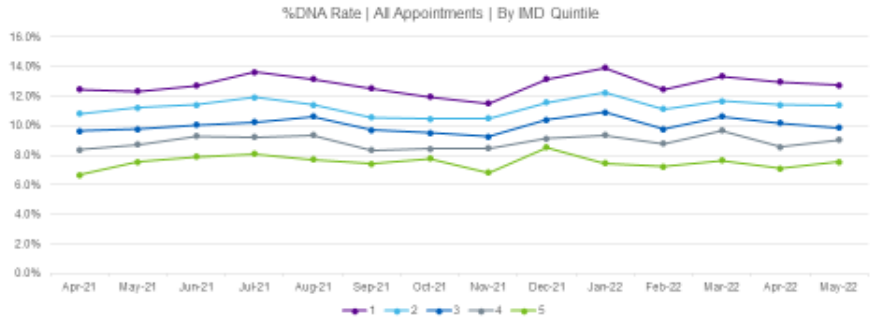
What doesn't it tell us?
- Where the NWL Asian population might be going for care and why – is there a perceived barrier to Imperial specifically?

What is our next step?
- Do borough/GP level analysis of referrals for the Asian population

DNA Rates (all appointments): Deprivation
Higher rates of DNAs from more deprived communities

Imperial College Healthcare NHS Trust

Why is this important for understanding population health and inequity in our service delivery?
- An individual's non-attendance at appointments delays further care and treatment which can impact health outcomes
- As the entry point on our waitlists, appointment wastage might cause further delays to managing the current elective backlog for patients, impacting health outcomes



What does the graph tell us?
- Patients from most deprived communities are twice as likely to DNA compared to patients from the least deprived communities. This is the same whether it is a new or follow-up appointment.

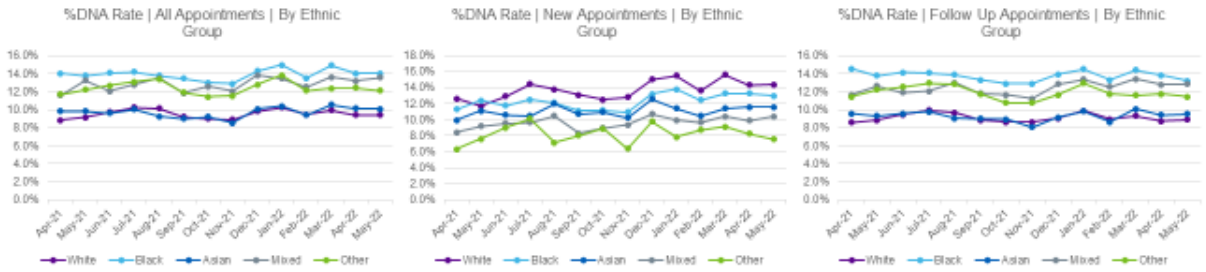
What doesn't it tell us?
- The reasons for non-attendance / lack of healthcare engagement

What is our next step?
- Understand intersectionality with ethnicity, age, sex and specialty for the 20% most deprived
- Engage with community to understand potential drivers to non-attendance

DNA Rates (all appointments): Ethnicity

Higher rates of DNAs from minority ethnic communities which vary between new and follow up appointments

Imperial College Healthcare NHS Trust



What does the graph tell us?

- Patients from Black, Mixed and Other ethnic backgrounds DNA more than the our White or Asian patients.
- This pattern changes when the appointment is an initial appointment, which needs further investigation.

What doesn't it tell us?

- Difficulties (real/perceived) patients have with attending appointments
- Why these might change based on whether the appointment is a new or a follow up appointment

What is our next step?

- Look at Patient Initiated Cancellations (PICs) and attendances to see if they follow similar trends
- Deeper analysis into appointment type (timing, speciality, new versus follow-up, remote) to understand potential barriers to access
- Triangulate this with qualitative insights from patients

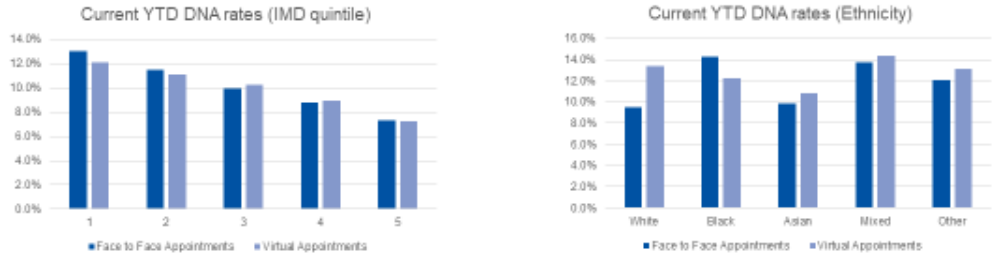
DNA: Face-to-face versus virtual appointments

DNA rates vary based on ethnicity

Imperial College Healthcare NHS Trust

Why is this important for understanding population health and inequalities in our service delivery?

- Might tell us if digital exclusion is contributing to lack of access for some patient groups



What does this graph tell us?

- DNA rates follow a similar trend and are largely consistent whether the appointment was held face-to face or virtually based on deprivation (patients from the most deprived communities are marginally more likely to non-attend a face-to-face appointment)
- Patients from different ethnic backgrounds however vary in their non-attendance

What doesn't it tell us?

- Deprivation alone might be masking other factors which are more important for remote consultations i.e. age and in work versus retired
- Anything about patient preference and what choice the patient was offered initially

What is our next step?

- Stratified analysis to include age
- Breakdown by speciality and explore mapping to patient choice

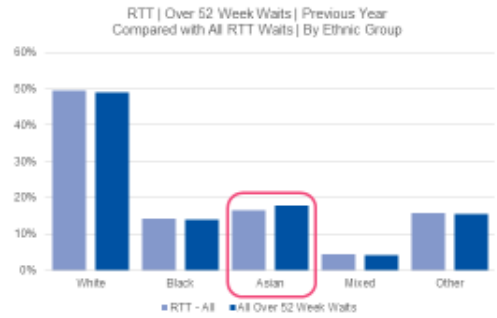
Waitlists: Over 52 week waiters (RTT)

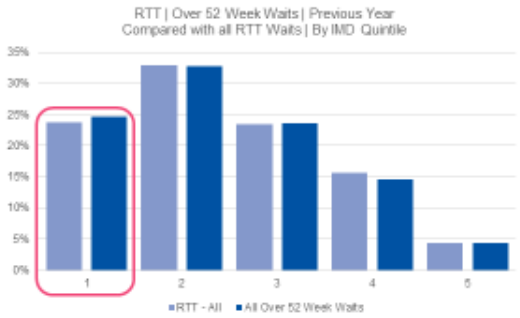
Some patient groups are at risk of waiting longer to access their elective care

Imperial College Healthcare NHS Trust

Why is this important for understanding population health and inequalities in our service delivery?

- The impact of waiting for elective care might worsen health outcomes and general wellbeing for some patient groups versus others i.e. time out of work





What does the graph tell us?

- Based on current trends the percentage of waiters in the 52 week+ banding is in line with the total percentage on the RTT waitlist with regards to ethnic background or deprivation level
- Marginal increases in the percentage of Asian and IMD1 patients on our 52 week+ waitlist compared to their relative percentage of RTT waiters as a whole

What doesn't it tell us?

- Any prioritisation steps already taken to mitigate at risk patients waiting longer than necessary
- The experience of patients waiting longest and impact on their health outcomes and wellbeing

What is our next step?

- Analyse by P-codes to understand if patients from certain groups present as a greater clinical priority initially
- Start analysing this by specialty to see if there are any outliers with regards to ethnicity, deprivation, age and gender
- Look at mean and median wait length in days / weeks and whether ethnicity or deprivation level impacts on this

Patient experience: Friends and Family test (FFT)

Some patient groups have a less positive experience of our care

Imperial College Healthcare NHS Trust

Why is this important for understanding population health and inequity in our service delivery?

- Patient groups may be receiving care differently as a result of their protected characteristics

	NWL Resident population Ethnicity (2019 projections)	Ethnicity of Trust referrals (20/21)	Count of Friends and Family Test responders (20/21)	% of total Friends and Family test responders (20/21)	Friends and Family % recommended score (20/21)
White	49.3%	49.8%	72,527	63%	93%
Black, African Caribbean, Black British	10%	13.4%	16,801	15%	92%
Asian, Asian British	27.5%	16.6%	11,385	10%	92%
Mixed	5.2%	4.5%	4,921	4%	85%
Other ethnicity	8%	15.7%	8,909	8%	89%

What does the data tell us?

- Asian and other ethnic minority patients are under-presented compared to the relative Trust patient population when providing feedback through the Friends and Family Test (FFT)
- Mixed and Other ethnic minority patients have a lower overall experience of our service

What doesn't it tell us?

- Who isn't providing us feedback and why (only 114,543 responses of the survey in 20/21 provided their ethnicity for analysis). Therefore also fails to include patients who are choosing not to declare their ethnicity and reasons for this
- Whether experience varies based on patient deprivation (since responses are anonymous and a post-code identifier is required for this analysis)

What is our next step?

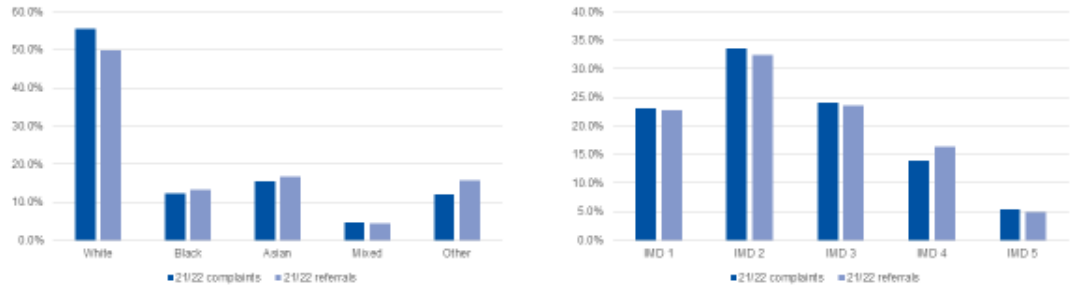
- Better understand ethnicity data completeness and quality issues
- Analyse other protected characteristics i.e. sexuality and disability which had varying scores for experience of care on the FFT
- Supplement with other patient and community insights (from FFT and elsewhere), with an initial focus on Asian, Mixed and Other minority ethnic groups

Patient experience: Complaints
Under representation by some ethnic groups

Imperial College Healthcare NHS Trust

Why is this important for understanding population health and inequalities in our service delivery?

- Some patient groups might not feel empowered to complain or believe there might be bias or different treatment in the management of their complaint
- This is the first time we have been able to analyse 100% of NWL complaints by patient ethnicity and deprivation using a data supplement from the Whole Systems Integrated Care Dashboard*



What does the graph tell us?

- 21/22 complaints by White patients were over-represented compared to the relative percentage of referrals received that year, whilst Black, Asian and Other ethnic minorities are under-represented.
- 21/22 complaints based on deprivation quintile follow a similar trend to the referrals received, including for those patients from our most deprived communities

What doesn't it tell us?

- Who is having a negative experience of our service but is choosing not to or is unable to complain
- Themes of complaints and whether these vary between different patient groups

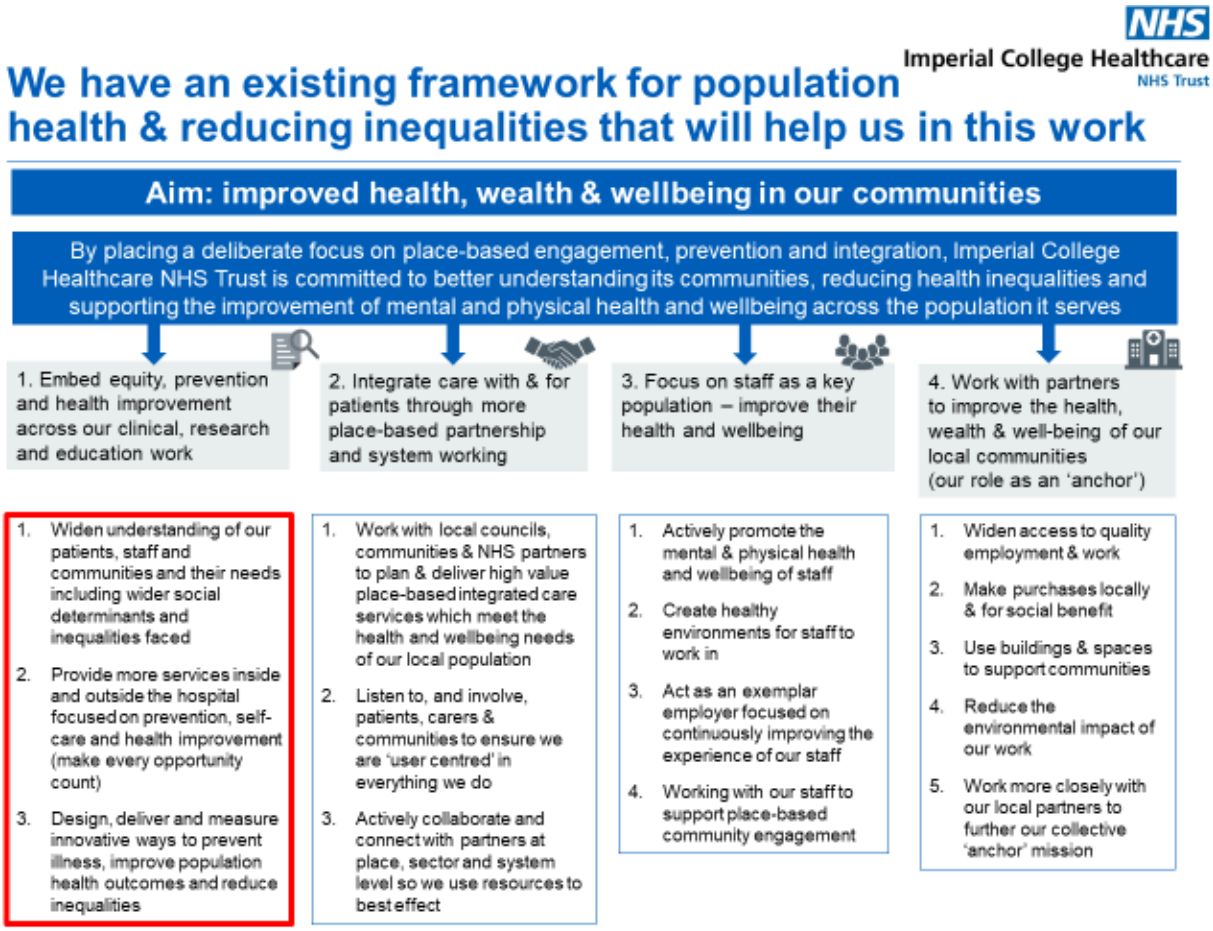
What is our next step?

- Themes analysis and stratification by age, sex, service area and division
- Triangulate with other qualitative user insights and patient feedback mechanisms

**Record that is contributed to by all sections of the health service in a local area i.e GPs*

Appendix 2 – Supporting Information

Figure 1: Imperial College Healthcare NHS Trust Population Health Framework (improving equity work highlighted in red)



National Mandatory Guidance

- NHSEI 2022/23 Priorities and Operational Planning guidance: [NHS England » 2022/23 priorities and operational planning guidance]

    - **Priority 1: Restoring NHS services inclusively**: where performance reports will be broken down by patient ethnicity and IMD quintile, focusing on unwarranted variation in referral rates and waiting lists for assessment diagnostic and treatment pathways, immunisation, screening and late cancer presentations.

    - **Priority 2: Mitigating against 'digital exclusion'** – ensuring providers offer face to face care to patients who cannot use remote services; and ensure more complete data collection, to identify who is accessing face to face/telephone/video consultations is broken down by patient age, ethnicity, IMD, disability status etc.

    - **Priority 3: Ensuring datasets are complete and timely** – to continue to improve data collection on ethnicity, across primary care/outpatients/A&E/mental health/community services, specialised commissioning and secondary care Waiting List Minimum Dataset (WLMDS).

- **Priority 4: Accelerating preventative programmes**; covering flu and Covid-19 vaccinations; annual health checks for people with severe mental illness (SMI) and learning disabilities; supporting the continuity of maternity carers and targeting long-term condition diagnosis and management.
- **Priority 5: Strengthening leadership and accountability** –Supporting PCN, ICS and Provider health inequalities SROs to access training and wider support offer, including utilising the Health Inequalities Leadership Framework, developed by the NHS Confederation.
- "We are also asking that all NHS Board performance reports include reporting by deprivation and ethnicity"

- NHSEI Elective recovery plan (February 2022): C1466-delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care.pdf (england.nhs.uk)
  - "Systems will be expected to analyse their waiting list data by relevant characteristics, including age, deprivation and ethnicity, and by specialty"

22/23 CCG contractual requirements:

SCHEDULE 2 – THE SERVICES

A. Health Inequalities Action Plan

The indicators below reflect the recognised National Framework and associated programmes set up to reduce Health Inequalities (see references)
All parties to this agreement must understand that this schedule will grow in compulsion and significance. Therefore, it is expected that the Provider makes it their ambition internally to record and collate information aligned to the principles outlined in the indicators.
It is also the Commissioner's assumption that Providers will have already established access and record keeping of such data on protected characteristics as part of their internal policies and endeavours to reduce health inequalities for both patients and workforce.

Please refer to these References for additional guidance:

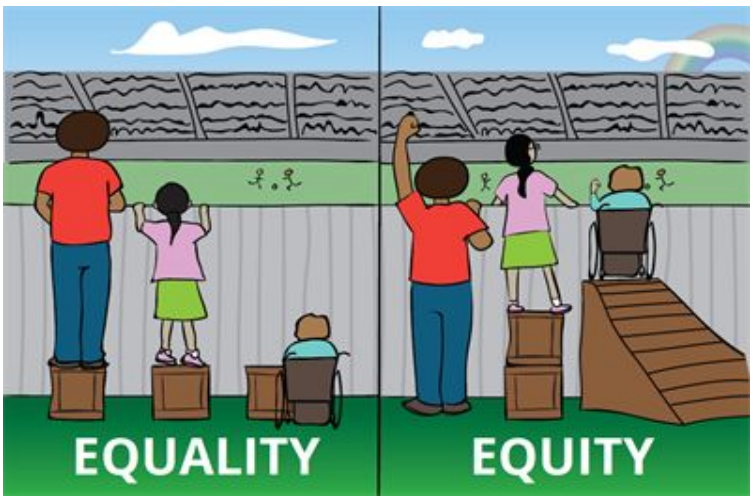
- A Framework for Healthcare Providers (nhsproviders.org)
- Technical Guidance for the NHS Workforce Race Equality Standard (WRES) May 2019 WRES (england.nhs.uk)
- Report template - NHSI website (england.nhs.uk)
- NHS England » 2021/22 priorities and operational planning guidance
- Cultural Competence - e-Learning for Healthcare (e-lfh.org.uk)

Item	Indicators [Assumption that age and sex data is routinely collected; ideally analyses should be done by all protected characteristics but from a pragmatic perspective age, sex, ethnicity and IMD decile at a minimum. Depending on client/patient group: analysis by learning disability]	Status	Actions & Comments [Frequency depends on size of service and resources to monitor so needs to be proportionate]
1	Access: **referral rates** and **consultation (or admission) rates** by age, sex, ethnicity and IMD decile E.g., does conversion rate from a referral to a consultation vary by ethnicity and IMD?	Applicable	Mitigation-action plan to address unwarranted variation by age, sex, ethnicity and IMD decile Quarterly The Commissioner reserves the right to request this dataset from the Provider at any time, if reasonable notice is given. Both parties will work together to address any issues arising from the request.

2	Access: **waiting lists** by age, sex, ethnicity and IMD decile	Applicable	Mitigation-action plan to address unwarranted variation by age, sex, ethnicity and IMD decile Quarterly The Commissioner reserves the right to request this dataset from the Provider at any time, if reasonable notice is given. Both parties will work together to address any issues arising from the request.
3	Access- remote consultations– if intend to deliver more virtual services **Remote consultation rates by age, sex, ethnicity and IMD decile**	Applicable	Mitigation- action plan to reduce digital exclusion; quarterly analysis by age, sex, ethnicity and IMD decile Quarterly The Commissioner reserves the right to request this dataset from the Provider at any time, if reasonable notice is given. Both parties will work together to address any issues arising from the request.
4	Access- **DNAs** by ethnicity and IMD decile (for outpatient services)	Applicable	Mitigation-action plan to address unwarranted variation by ethnicity and IMD decile Quarterly The Commissioner reserves the right to request this dataset from the Provider at any time, if reasonable notice is given. Both parties will work together to address any issues arising from the request.
5	Experience: **patient survey** on experience within the service by age, sex, ethnicity and IMD decile; learning disability	Applicable	Mitigation- action plan to address unwarranted variation by ethnicity and IMD decile 6 monthly or annual depending on volume of patients. The Commissioner reserves the right to request this dataset from the Provider at any time, if reasonable notice is given. Both parties will work together to address any issues arising from the request.
6	Experience: complaints by ethnicity	Applicable	No. of complaints by ethnicity, IMD decile Mitigation- action plan Quarterly The Commissioner reserves the right to request this dataset from the Provider at any time, if reasonable notice is given. Both parties will work together to address any issues arising from the request.
7	Outcomes- **28-day readmissions** by ethnicity and IMD decile [Success criteria by ethnicity and IMD decile]	Not applicable	Readmissions by ethnicity and IMD decile Quarterly The Commissioner reserves the right to request this dataset from the Provider at any time, if reasonable notice is given. Both parties will work together to address any issues arising from the request.
8	Workforce **WRES indicator 8** In the last 12 months have you personally experienced discrimination at work from a manager, team leader or other colleagues?	Applicable	Mitigation-action plan See Technical Guidance for the NHS Workforce Race Equality Standard (WRES) May 2019 WRES (england.nhs.uk) The Commissioner reserves the right to request this dataset from the Provider at any time, if reasonable notice is given. Both parties will work together to address any issues arising from the request.
9	Workforce **Workforce risk assessment (COVID-19)** by demographic characteristics and staff groupings	Applicable	Action plan to address any gaps/unwarranted variation Quarterly The Commissioner reserves the right to request this dataset from the Provider at any time, if reasonable notice is given. Both parties will work together to address any issues arising from the request.

10	Leadership: **executive lead for health inequalities**	Applicable	There is an appointed lead at Board level; included in JD and objectives Annually reviewed	

Figure 2: Equality versus Equity



Equality means each individual or group of people is given the same resources or opportunities.

Equity recognizes that each person has different circumstances and allocates the exact resources and opportunities needed to reach an **equal** outcome

https://www.diffen.com/difference/Equality-vs-Equity

Figure 3: Core20PLUS5 NHS England » Core20PLUS5 – An approach to reducing health inequalities

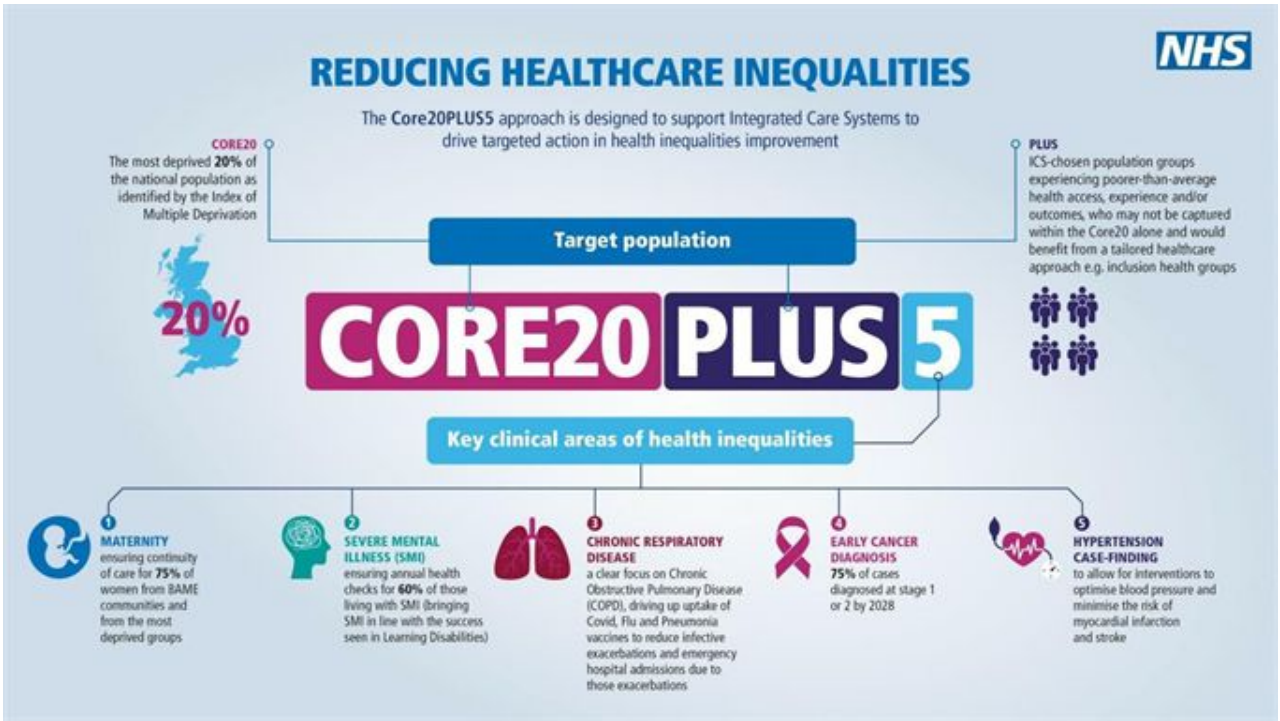


Figure 4: Institute of Medicine - Equity as a domain of quality

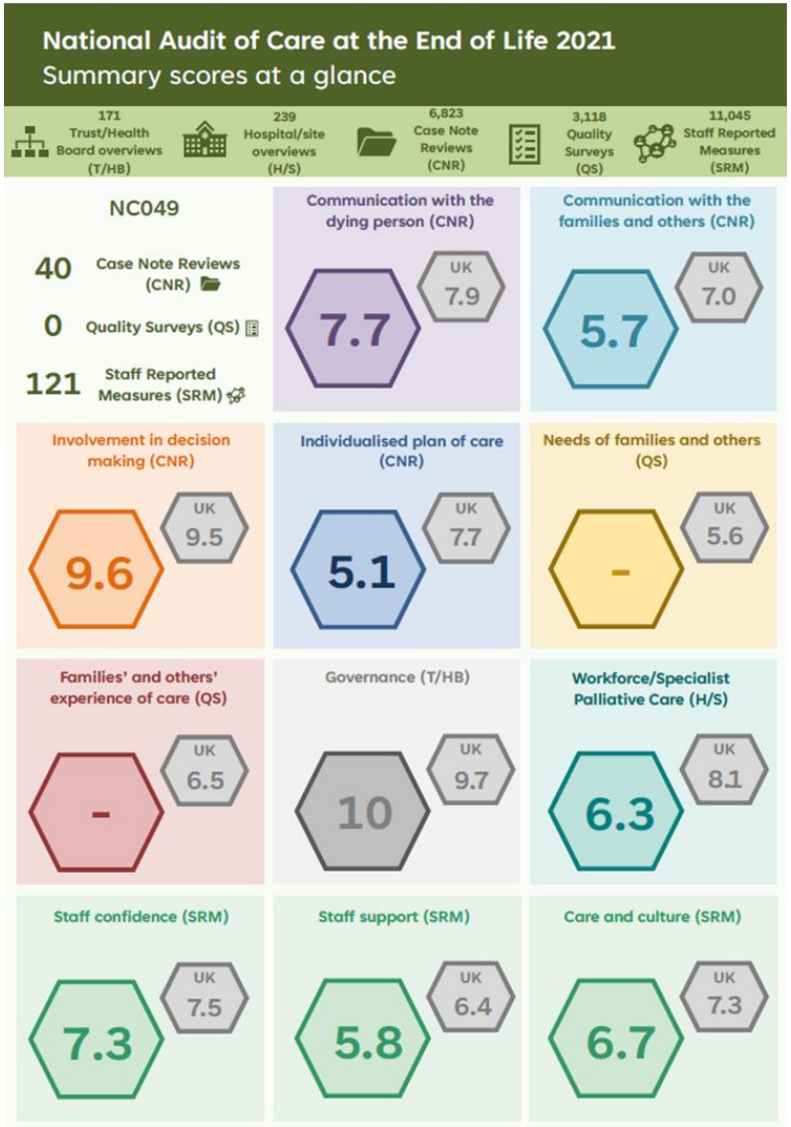
https://draminu.com/six-domains-of-care-quality/

Appendix 3 – High Level Equity Programme Plan (GANTT chart)

				22/23												23/24 to be scoped
				April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April onwards
Mandatory requirements	**Programme Workstreams (Primary drivers)**	**High-level activities**	**Responsibility**													
Ensure datasets are complete and timely	**Improve equity data quality and access**	Develop methodology to supplement Cerner ethnicity data gaps with WSIC	BI/Analytics													
		Build ethnicity and deprivation data sets into trust data warehouse and production cycle	BI/Analytics													
		Deliver an accurate ethnicity data recording campaign with staff	BI / SRI / Comms													
Analyse waiting list data by relevant characteristics, including age, deprivation and ethnicity, and by specialty		Adapt existing published waitlists (RTT/Cancer/Diagnostics) to show breakdown by age, gender, deprivation and ethnicity	BI/Analytics													
NHS Board performance reports include reporting by deprivation and ethnicity		Initiate trust board reporting on equity (access, outcomes and experience indicators by age, sex, ethnicity and deprivation)	BI/Analytics & SRI													
		Continue to refine trust reporting as methodology and analysis matures and more guidance released	BI/Analytics & SRI													
		Add ethnicity / deprivation to identified Qliksense apps and provide staff training package	BI/Analytics & SRI													
Restore NHS services inclusively	**Use user insights, patient engagement and co-production to understand drivers of equity**	Establish a community 'big room' to co-design improvements with local stakeholders	SRI													
		Gather insights on reasons for DNA and co-produce solutions for testing														
		Ensure contribution to insights function from those facing inequity / seldom heard voices i. those with LDA	Comms & SRI													
		Adapt existing patient experience functions (FFT, complaints) to provide further insights on equity														
	Engage and upskill trust staff around the equity agenda	Develop and deliver a comms plan which situates equity as a trust improvement priority	Comms & SRI													
		Build equity and understanding our local community into trust corporate induction and other trust leadership programmes	SRI													
		Assess trust staff gaps in knowledge and skills with regards to population health and health inequalities	SRI													
		Develop and launch a Pop Health and health inequalities education offer for staff based on gaps	SRI													
		Provide equity training 'bolt on' for Trust QI team and improvement coaches	SRI													
		Develop and launch health equity 'toolkit' for staff	SRI													
	Implement identified changes to trust services and processes	Development and early implementation of the road map to embed equity into existing quality infrastructure and governance	SRI / MDO													
		Review corporate decision making processes for equity inclusion and impact	Governance / SRI													
		Roll out identified changes to corporate processes i.e. ERAF, Business Case, QIA framework, Trak it, update EHIA	Multiple													
		Test and evaluate DNA interventions as identified by co-production	TBD													
		Support staff to deliver specialty level Equity improvement projects as identified	Multiple													
		Implementation of Interpreting improvement project	Comms													
Mitigate against digital exclusion		Undertake a review of digital transformation initiatives at the trust for equity inclusion and make recommended changes	TBD													
		Bring focus on equity into digital accessibility improvements project	Comms / IT													
Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes		Scope 'waiting well' proposal	Comms													
		Pilot a healthy lifestyle programme for trust patients in collaboration with Chelsea Football Club Foundation (CFCF)	SRI													
		Implement trust commitments for smoking cessation 22/23	TBD													
	Aligning existing research and trust public health work	Identify 3 key equity research priorities to take forward	PH / SRI													
		Establish a joint programme of work and regular forum for Trust and College collaboration	PH / SRI													
Strengthen leadership and accountability	**Build networks and learn from others**	Establish a platform / Community of Practice for engaged staff to contribute and share best practice	SRI													
		Hold an 'Equity summit'	SRI / Comms													
		Share trust learnings with ICS PHMHI programme	SRI													

National Audit of Care at End of Life 2021

- The audit focuses on the quality and outcomes of care experienced by those in their last admission in acute or community hospitals.
- Builds on previous audits, review of case notes, organisational audit, development of carer reported measures (including bereavement survey), staff reported measure, topics for spotlights
- NACEL did not run in 2020 due to covid
- 2021- period of excess deaths, important to understand care received.
- Audit run and supported by Dr Buxton (Palliative Medicine consultant and Trust End of Life lead)
- Results discussed at IPCG as part of Trust response to care at end of life.



How do we compare nationally

- Poor / late recognition of dying
- Missing opportunity to involve dying person in decisions about their care including CPR & treatment escalation, balance of symptom control medications & alertness, preferred place of care & death
- Frequently involve those important to the dying person in decisions when cannot involve person themselves
- Meet NICE guidance <25% of the time as not reviewing plan for nutrition & hydration every 24 hours once the possibility of dying is recognised
- Once dying is recognised, we still fall below the national average for creation of individualised care plan for the dying person based on 5 priorities of care
- Deficient in our holistic assessment of patient's symptoms in the last hours and days of life, in documenting the benefit of starting, continuing or stopping certain interventions and in recording preferred place of death.
- 30% of patients who were expected to die did not have SC anticipatory medications prescribed to allow prompt treatment of any symptoms.

All of the above points could be met with robust trust-wide implementation of the care agreement bundle on Cerner

- Workforce: we have very limited education & training for staff across the organisation in end of life care which is demonstrated in not only what we tangibly deliver but also in our staff confidence and staff support data.
- We have a highly valued and supportive specialist palliative care team, who are resourced to provide a face to face service Monday to Friday, 9am to 5pm. 60% of acute organisations now have a face to face 7 days specialist palliative care service
- From the staff survey we can see across many domains that a large proportion of staff feel confident in recognising and managing a dying person and their family, although this is not necessarily demonstrated by the results from the case note review. This may be due to the self-selecting group who chose to respond to the survey when circulated.
- Staff do lack confidence in responding to requests to die outside of hospital.

What our service users say and how we involve them

Chair of lay members recommendations:

1) Development of a strong cultural focus regarding end of life care is required, as it relies heavily on communication, empathy, behaviours and patient-centred care.
2) Improved links between end of life care and other trust initiatives such as ‘what matters to you?’
3) Stronger alignment between the Trust values and end of life. End of life relies on Trust colleagues being able to have difficult conversations and an openness, which could be highlighted in the Trust’s values and culture work, and used to support reinvigorate of the programme.
4) Incorporation of end of life within the refreshed Ward Accreditation Programme is another way to adopt consistent standards of care around end of life and share/influence communication and cultural issues.
5) Improved across-trust collaboration could allow development of a suite of measures to drive and monitor high quality end of life care, to support it becoming Trust-wide business as usual.
6) Development of a clear strategy to ensure patient and public views, experience and outcomes are influencing action plans going forward

Feedback from bereaved relatives:

- “grandmother's care in hospital had been first class”
- "The nurses were wonderful, they were so kind, they did all they could"
- “The care on the ward was outstanding“
- “Appreciates all the care given at CXH. Really bent over backwards to support her and allow her to be with him overnight and in the hours before he died. Very kind to her when unable to get a taxi at 2:30 and kept her safe until trains started running again”
- “Lack of information, the ward direct line was hardly ever answered, caused additional stress for the family. Would have preferred if they could be called proactively with updates rather than having to chase”
- “Father was in pain for several hours at a time in the last 2 days of his life in spite of assurances by the palliative care team that he would be kept comfortable. Delays in administering analgesics at regular frequent intervals, and in setting up a syringe driver”

Compliments received End of Life Team

Feedback from lay partner:

“I am one of the two lay partners who sit on the steering group. I have also been able to attend the majority of the big room meetings. In the latter, I aim to provide the perspective of the patient or carer who knows little about the detail of end of life care.

I have been really impressed by the degree of team working exhibited in the big room – whether across Trust disciplines, with the CCG, with hospice providers or other partners across the health sector. It is crystal clear that the wellbeing of the patient – and the carer – is the focus of this work, whether we are considering process, practical or more subjective and emotional issues.

As a lay partner, I think that I speak for both of us when I say that in the context of both the steering group and the big room, we feel that we are treated as an integral part of the team and that our views are taken fully into account.”

Feedback from staff member:

“I wanted to say thank you for your help and support, particularly when I first joined and for the inclusivity and voice that you extend to everyone who comes to the meetings. I've learnt so much”

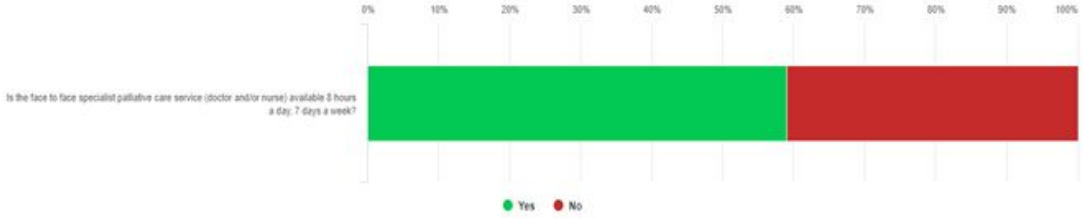
Feedback from external service lead:

“I Just wanted to let you know that I finally managed to join you for your EOLC Big room today – the wonders of MS teams made it doable!

I felt the need to congratulate you on the creation of a really appreciative and enabling culture in the meeting and was impressed how many different departments and professionals you have engaged successfully with. I was so impressed how many people are “excited” by the work you are leading. … and finally the connections which formed between people”

How do we compare nationally – SPCT workforce NACEL 2021

SPCT face to face availability (8hours a day, 7 days a week):



Sample Information

Metric	Number of Responses
Is the face to face specialist palliative care service (doctor and/or nurse) available 8 hours a day, 7 days a week?	193

Your Response

Submission	Metric	Response
Imperial College Healthcare NHS Trust	Is the face to face specialist palliative care service (doctor and/or nurse) available 8 hours a day, 7 days a week?	No

If the SPCT does not provide (Doctor and/or Nurse) face to face advice 8hours a day, 7 days a week, reason why:

Sample Information

Metric / Response	Value (%)
Recruitment issues	3.85
Local service model will not support this/not commisioned	67.95
Operational issues	2.56
Business case in development	20.51
Other	5.13

SPCT skill mix by discipline:

Metric	National Position (%)	Your Position (%)
Medical (WTE)	17.26	6.84
Nursing (WTE)	68.71	93.16
AHP (WTE)	7.31	-
Other (WTE)	6.72	-

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC

Paper title: Annual Complaints & PALs Report 2021/22

Agenda item: 16

Executive Director: Michelle Dixon, Director of Engagement and Experience
Authors: D Marshall, J Parker

Purpose: For information

Date: Wednesday 20 July 2022

1. Purpose

1.1. The NHS complaints regulations require trusts to produce an annual complaints report focusing primarily around activity. This report also explores categories and themes identified during the year and improvement initiatives that have developed as a result of learning from complaints.

2. Introduction and background

2.1. The annual complaints report is presented for information.

2.2. The report covers complaints and Patient Advice & Liaison Service (PALS) activity during the year. The report was presented to EMB Quality on 21 June 2022 and the Executive Management Board on 28 June 2022.

3. Executive Summary

3.1. The volume of complaints fell during the first half of the pandemic but during 2021/22 numbers rose again to around pre-pandemic levels.

3.2. The general themes during the year remained consistent although there was an increase in complaints related to the attitude and behaviour of staff. This is possibly a reflection of the pressure that staff have been under, but it has also been noted that there has been an increase in the hostility of some complainants from the outset of their complaint. The complexity of complaints has also increased.

3.3. Responsiveness was generally good with the trust meeting complaints based targets. The vast majority of complaints were resolved by the first response and very few cases were taken up for further review by the Parliamentary & Health Service Ombudsman (PHSO). Two thirds of complainants surveyed were satisfied with the way their complaint had been handled by the trust.

3.4. PALS saw a significant increase in activity over the year across all categories. This may be in part due to the introduction of a call centre model that made it easier for

people to get through to them. PALS volunteers and walk-in services were negatively affected by the pandemic but were beginning to be reintroduced by the end of the report period.

4. Recommendation

4.1. The Quality Committee is asked to note the paper.

5. Impact assessment

5.1. Quality impact: This report provides assurance that the Trust has a robust system in place for handling complaints and concerns and that it is reporting annually on formal complaints in line with the requirements of the NHS The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

5.2. Financial impact: No financial impact

5.3. Workforce impact: The actions arising from PALS and Complaints cases contribute to individual and organisational learning.

5.4. Equality impact: There is a neutral impact from this report. However, the Complaints & Service Improvement Manager is working with the Strategy, Research and Innovation Programme Team to establish if those raising concerns and complaints are representative of the communities we serve and where there are gaps, to take steps to address these.

5.5. Risk impact: No risk impact

6. Main paper

Introduction

The Patient Advice & Liaison Service (PALS) and Complaints Teams have, as with the rest of the Trust, begun emerging from the COVID-19 pandemic over the last year with new challenges and pressures. However, we have continued to maintain a high standard of service and met key targets for timeliness and responsiveness of responses to patients. This was reflected in the low number of cases which were upheld or not upheld by the Parliamentary & Health Service Ombudsman (PHSO)

The headline performance figures for 2021/22 are:

- 885 formal complaints received, and 4521 PALS cases logged.
- 463 compliments were logged by the PALS team.
- 94% of complaints were responded to within their agreed deadlines. (The target set by NW London integrated care system quality schedule is 90%)
- 93% of acknowledgment letters were sent within 3 working days. (The target set by NW London integrated care system quality schedule is 90%)
- 808 complaints were closed during the year with an average response time of 40 days (this met the local target of <= 40).
- Three complaints that were referred to the PHSO proceeded to a full investigation, the lowest to date.

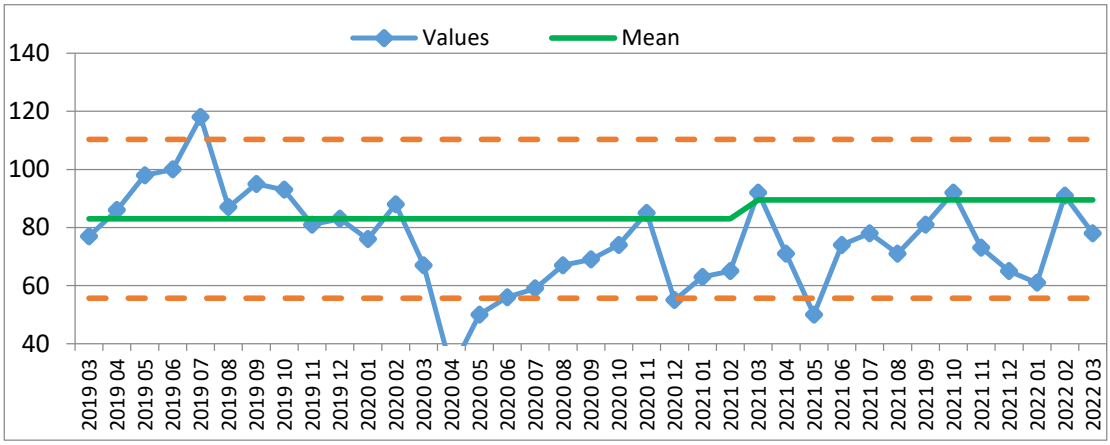
- 4 outcomes from the PHSO were reported to the Trust of which were all partly upheld. Further details about these are provided later in the report.
- 3% of complaints were re-opened, meaning we needed to provide a follow up written response. This was lower than the 4% rate achieved in 2020/21
- Members of the complaints and PALS team continue to offer expert support and training to colleagues around the Trust.

7. Numbers of Formal Complaints Received

7.1. Last year the Trust received 885 formal complaints. This was a 13% increase on the 768 received in the previous year. However, this increase was to be expected when compared against the drop in complaints observed across the NHS in 2020/21 when the COVID-19 pandemic and lockdowns led to a drop in people raising complaints.

7.2. The effect of the pandemic has made it harder to analyse year on year trends in overall complaints numbers but as the pandemic recedes, a clearer picture will emerge. The graph below shows the trend in the number of formal complaints raised over the last three financial years. We can observe that the numbers have fluctuated more in the last two years, as a result of COVID-19. There appears to be some correlation between a reduction in complaints being received and COVID-19 “waves”. However, it seems likely that numbers will increase significantly as the effect of COVID-19 wanes and concerns which people have previously been hesitant to raise are brought to us.

Graph 1: Numbers of formal complaints received for the last three years



8. Complaints cases

8.1. We report the subject of complaints using standardised categories, set by NHS Digital, which allow for benchmarking across NHS Trusts. Table 1 highlights the top 5 categories of formal complaints received in the year in comparison with the previous year (for reporting purposes Clinical Treatment and Patient Care have been combined as they are similar).

Table 1: Formal complaints by category

Category	2021/22	% of total	2020/21	% of total
Clinical treatment/patient care	219	**25%**	217	**29%**
Values and Behaviours (Staff)	164	**19%**	111	**15%**
Appointments	102	**12%**	94	**12%**
Communications	114	**13%**	81	**11%**
Trust admin/policies/procedures including patient record management	55	**6%**	59	**8%**
TOTAL	**654**	**74%**	**562**	**74%**

Table 2: Complaints by service area

Service area	2021/22	% of total	2020/21	% of total
Outpatients	390	44%	316	41%
Inpatients	312	40%	320	41%
A&E	124	14%	66	9%
Maternity	59	6%	66	9%
Total	**885**	**100%**	**768**	**100%**

Table 3: Complaints by division

Division	2021/22	% of total	2020/21	% of total
Medicine & Integrated Care	330	37%	260	34%
Surgery, Cancer & Cardiovascular	296	33%	264	34.5%
Women's, Children's & Clinical Support	149	17%	150	19.5%
Corporate (including IPH and Transport)	106	12%	91	12%
NWL Pathology	4	1%	3	<1
Total	**885**	**100**	**768**	**100%**

9. Parliamentary & Health Service Ombudsman (PHSO) Cases

9.1. Table 4 provides a breakdown of all the PHSO decisions last year. The PHSO shared the outcome of four cases. All were partly upheld, and the outcomes were as follows:

Table 4: Decisions the PHSO made last year by division

Division	Upheld	Partly Upheld	Not Upheld
Medicine & Integrated Care	0	1	0
Surgery, Cancer & Cardiovascular	0	2	0
Women's, Children's & Clinical Support	0	0	0
Corporate	0	1	0
TOTAL	**0**	**4**	**0**

10. PALS cases

10.1. The PALS team resolved 4521 informal concerns and enquiries during 2020/21. The tables below show how they breakdown of the cases received by Division and Category.

Table 5: PALS cases by Division

Division	2021/22	% of total	2020/21	% of total
Medicine & Integrated Care	1548	34%	1161	34%
Surgery, Cancer & Cardiovascular	1909	42%	1451	43%
Women's, Children's & Clinical Support	685	15%	590	17%
NWL Pathology	11	<1%	11	<1%
Corporate (including Transport)	267	6%	188	6%
No Division Recorded/NA	101	3%	N/A	N/A
Total	**4521**	**100%**	**3401**	**100%**

Table 6: PALS cases by category

Subject	2021/22	% of total	2021/21	% of total
Appointments	1709	38%	1208	36%
Communications	925	21%	584	17%
Clinical Treatment	352	7%	247	7%
Transport	224	5%	170	5%
Values & Behaviours (Staff)	206	5%	162	5%
TOTAL	**3416**	**76%**	**2371**	**70%**

11. The year ahead for PALS

11.1. The PALS Service Manager will continue to work closely with The Deputy Divisional Director of Nursing for Outpatients & Patient Access, to improve the effectiveness of the process of handling Trust wide PALS concerns raised within the Outpatient Service, leading to improved concern resolution and better implementation of learnings to drive service improvement.

11.2. The PALS Service Manager will continue to expand and develop the PALS Volunteer services over the next year. The aim is to increase the number of PALS Volunteers and expand the remit of the volunteers as well as relaunching the library trolley service.

11.3. PALS officers will continue to attend Big Rooms and also each PALS Officer has assigned themselves to work in collaboration with a specific speciality where feedback received indicates that patient experience needs improvement. The purpose of PALS Officer's role is to support staff and provide guidance on best practices so that all concerns are resolved in a timely manner.

11.4. Additionally, the PALS Service Manager will establish and maintain the management of lost property across the Trust. This will involve visiting each ward across the trust and working with staff to ensure all patient property is managed effectively.

11.5. PALS will continue to maintain the one day a week walk-in frontline service for across all sites as well as PALS Officers continuing to attend clinical areas to support patients/relatives/carers/staff etc. as required.

12. Conclusion

12.1. The COVID-19 pandemic continued to impact on the complaints and PALS teams during 2021/22, which required them to be flexible in their ways of working, such as home/office hybrid working (for complaints) and email/telephone support for PALS. We experienced a steady increase in PALS and Complaints activity during the year as delayed demand for elective procedures continued to put pressure on services. An increase in complaints about values & behaviours has been observed and the reasons for this appear to be multi-faceted; however, they primarily appear to be a reflection of the pressures on staff as well as the frustrations that the impact of delays to treatment are causing to our patients.

12.2. The complaints team continue maintaining the high quality of its responses and have reduced the “re-open” rate further. We will also aim to bring down our average response times by increasing the complaints presence at Divisional and Directorate meetings now that COVID-19 appears to be receding. This will ensure that delays and potential breaches to deadlines are managed pro-actively.

12.3. The complaints team will focus on ensuring that actions and learning from complaints are implemented and follow up with patients to provide assurance that agreed actions have taken place.

12.4. PALS will continue to provide support to clinical teams and patients, develop the volunteer service and ensure that the new patient property policy is implemented and is effective.

13. Appendices in the Reading Room:

16.1 Q4 PALS & Complaints Report
16.2 Equality and Diversity Annual Report

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC

Paper title: Quality Committee Report

Agenda item: 17

Committee Chair: Professor Andy Bush, Non-Executive Director
Executive Director: Julian Redhead / Janice Sigsworth
Author: Debbie Arney, Corporate Governance officer

Purpose: Information

Date of meeting: Wednesday 20 July 2022

1. Purpose of this report

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

2. Introduction

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

3. Key points

3.1. The key items to note from the Quality Committee meeting held on 7 July 2022 include:

4 Improving equity in our service delivery at Imperial College Healthcare NHS Trust

4.1 The Committee was provided with a report to set out and agree the ambition required to identify and address inequity in services we provide across the Trust.

4.2 The Committee noted that inequity of access in our service provision has already begun to be evidenced at the Trust with further analysis and improvement work underway. To accelerate efforts to bring us in line with peer Trusts and meet national mandatory requirements, a coordinated 2 year programme of work (workstreams, activities, timing and resources) is proposed to be scoped and delivered. This will prioritise and implement corporate and clinic level changes to address inequity in care for our patients. This work will form part of a longer term piece of continuous improvement work to change organisational culture and systematically embed equity as a domain of quality at the Trust.

Through this programme of work it is the intention to make measured year-on-year improvements across several key access, experience and outcome indicators with regards to equity, with a particular focus on patients from the most deprived communities in line with the Core20+5 measurement framework. This will done through completing the data analysis of our current position, assessing where we have the greatest gaps for improvement and can make the most impact, then applying quality improvement methods to close these gaps through levelling up those at the bottom.

4.3 The Committee were asked to endorse the approach and approve plans to continue developing a detailed two year programme of work based on this, including submission of a business case for a Health Equity Lead to coordinate the Trust-wide initiatives.

4.4 The Committee approved the report, now referred for approval by Trust Board.

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

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

5.2 The Committee noted that there had been a recent increase in Covid-19 infections, and data for the NW London ICS had shown a rising number of Covid-19 related staff sickness across all hospitals.

The data showed that in London there had been a rise in beds with older age groups driving up these admissions.

National statistics showed that we are not, however seeing a huge rise in ITU admissions (likely indicating that the vaccine programme is effective in preventing serious illness, but could also be related to reduced virulence of currently circulating strains).

National predictions indicated that we should peak in 1-2 weeks, however operational issues may continue over the next few months.

5.3 The Committee noted the update.

6. Hospital Mortality associated with COVID-19

6.1 The Committee received a report encompassing information from all of the multidisciplinary reviews that had been undertaken within Imperial College Healthcare NHS Trust for deaths from hospital-acquired Covid-19 during the first two waves of the pandemic, using a template developed by the ICS.

6.2 The Committee approved the report for onward submission and approval to Trust Board.

7. Risk and assurance 'deep dive'

7.1 **Introduction to ambulance handover deep dive**

7.1.2 The Committee noted the report on London Ambulance Service LAS handover and delays to patient care.

7.1.3 The report demonstrates the ICHT LAS performance on each acute site and compares ICHT performance across NWL and all London trusts.

7.1.4 The Committee noted that ICHT performs well when benchmarked against other NWL trusts and very well against national peers. The Committee felt that, as a result of the clarity and excellence of the report, a further deep dive on this subject was not necessary

There have been no Datix or SIs as a result of ambulance handover delays reported this year.

7.2 **Mortality Rate review**

7.2.1 The Committee noted the report summarising a review undertaken of the Trust's mortality rates following a slight regression in our HSMR ranking.
Rolling 12 month data showed that although HSMR has improved from 72.0 (to November 2020) when it was ranked lowest, to 68.71 for the period (to January 2022), we are now ranked 7th lowest. We had previously maintained a position within the top 5 best performing trusts.
The review confirmed that despite a change in rank our actual HSMR is reducing, the likely cause is changing clinical coding practices in other trusts for recording palliative care as well as coding differences for Covid-19. The only diagnostic groupings with an increasing HSMR that we could not fully explain were in maternity and neonatology. National audit data and local mortality numbers do not correlate with the HSMR data. The committee supported the recommendations approved by the executive for an additional review of the data to be undertaken with support from Imperial College and a review of the processes and function of the mortality and morbidity meetings across the trust to include the data being used. Progress will be reported through the learning from deaths report.

7.2.2 The Committee were assured that despite the slight regression in ranking, our mortality rates remain significantly low..

8. Agree next deep dives

8.2 The committee agreed that there would be a deep dive into care for patients with mental health in December 2022.

9. Quality Assurance Report

9.1.1 The Committee noted the report summarising the key exceptions and risks discussed at EMB Quality Group (EMBQ) and Executive Management Board (EMB) in May and June 2022 for assurance, with key messages highlighted as below:

9.1.2 One Never Event occurred in April 2022 (declared in May 2022). Immediate local action had been taken and the incident was being investigated. No harm to the patient was recorded.
The committee noted that the Trust had seen recurrence of a number of never event categories therefore a review of the assurance of safety processes for all never events was being scoped. This would involve increased audit (including observational) which would have resource implications for divisions as well as corporate areas.

9.1.3 The committee noted that the Trust had remained below the 95% target for VTE assessment for the second month, however issues had been identified with the data caused by ward and specialty profile changes which had been corrected bringing us back above target.

9.1.4 Following two recent SIs at Charing Cross, a quality review meeting is being set up to review the care of patients who have mental health needs in our in-patient wards. There are concerns about the use of the enhanced observation policy, awareness

of DOLS and rapid tranquilisation standards and care for patients when they are withdrawing from alcohol and have other health needs. This will be chaired by the Chief Nurse and will include all divisions.

9.2 Quality Impact Assessments and Efficiency Schemes

9.2.1 The committee noted the report on the Quality Impact Assessments carried out for efficiency plans being deployed in 2022/23.

9.2.2 As of 9th June 2022, 190 schemes (excluding SCC) are planned for implementation in 2022/23. SCC are excluded as at the time of the report the QIA review has been scheduled for 16th June 2022 which is after the deadline for papers to be submitted for EMB Quality Group.

9.2.3 The Quality Impact Assessment was currently focused on assessing the potential impact of a scheme across the 5 domains of quality; Caring, Well Led, Responsive, Effective and Safe. As our understanding around the need to address health inequalities had developed, there is a requirement to evolve our approach to the assessment of the impact of changes may have on our patient groups. Working with the Directorate of Strategy, Research and Innovation, guidance had been sent to divisional teams to support them with thinking about the impact of schemes in terms of equity for our patients, including national guidance around Core20+5.

9.2.4 It is recognised that there will be a need to make sure we refresh our approach to how we assess schemes for their potential impact on quality, equity and equality beyond the awareness raising and guidance that has been issued to date. Through existing collaboration with the acute Trusts in our sector there is an opportunity jointly refresh our processes together. Work to move this forward is planned over the summer where we will be looking to bring key stakeholders together to agree the common approach. We will then work to embed the agreed approach into our systems and processes, including updating our existing QIA policy.

9.3 Pressure Damage 2021-22 Report

9.3.1 The committee noted the report outlining the number of Trust acquired (TA) moderate or above harm pressure ulcers over the last financial year.

9.3.2 The committee noted that the trust had seen a 70% reduction in the number of moderate or above harms in 2021/22 compared to 2020/21. This was the result of sustained education, training and advice provided by the tissue viability team (TVN) as well as a reduction in seriously ill susceptible patients in intensive care as a result of the pandemic.

9.3.3 Over the last two years, we can consistently show that the number of community acquired pressure damage is much higher than the number of incidents sustained whilst in our care. We will work with our community colleagues to understand how we can work collaboratively to improve this.

9.3.4 New reporting mechanisms via the model hospital platform are scheduled to be implemented later this year.

9.4 Infection Prevention and Control and Antimicrobial Stewardship Quarterly Report: Quarter 4 2021/22

9.4.1 The committee noted the paper providing a quarterly update of key indicators and infection rates, indicative of effective infection prevention and control (IPC) practice, plans in place and progressing in response to IPC-related issues. The indicators and activity noted in the paper relates to quarter 4 2021/22 (Q4).

9.4.2 It was highlighted that Q4 continued to flag the importance of AMS initiatives to tackle multi-drug resistant infections, line-associated infection surveillance, and understanding ways in which to tackle healthcare-associated infections, particularly MRSA and GNR BSIs.

9.4.3. The committee were assured that IPC continue to develop new approaches to training, assessment and support for staff for core IPC competencies and plans to change our current approach were detailed in the report. The Committee were sad to note that Dr James Price was leaving the Trust, and he was warmly thanked in his absence for his hard work and the excellent results therefrom. The importance of recruiting a high calibre replacement to this important post was stressed by the Committee

9.5 Infection prevention and control board assurance framework for COVID-19 – self-assessment.

9.5.1 The committee received an update on progress with completion of the actions required to provide assurance with all elements of the infection prevention and control (IPC) board assurance framework (BAF).

9.5.2 The committee noted that an action plan was in place to undertake the necessary work that would improve board assurance related to IPC management. This was being monitored at the Clinical Reference Group (CRG) reporting to the Executive management board quality group (EMB-Q).

9.5.3 The committee were informed that there were no red rated KLOEs. Sixteen KLOEs remained RAG rated as amber;, focused meetings would take place with the leads for the outstanding KLOEs to review the action plans to progress these.

9.6 Maternity Quality Assurance Oversight Report including Ockenden report

9.6.1 The committee received the report to provide assurance within the maternity service and to highlight key issues relating to the quality and safety of the maternity service.

9.6.2 Key highlights were noted as:

9.6.3 The QCCH maternity theatre refurbishment was now complete, addressing the risks associated with the outdated estates and the final action from the Morecombe Bay investigation report recommendations.

9.6.4 A case for relocation of the Maternity Day Assessment Unit (MDAU) is being worked up, with the aim of moving prior to the Ockenden assurance visit September 2022.

9.6.5 Infection control measures have been relaxed allowing a second birth partner and overnight stay on the postnatal ward. It is hoped this this will improve the overall rating of postnatal care.

9.6.6 There were no incidents causing severe/major harm or extreme harm and maternity meets the target for incidents causing moderate and above harm.

9.6.7 Safe staffing had been maintained throughout May and both birth centres remained open. A decision was made June 30 to consolidate both MLUs to QCCH site to support the staffing pressures at QCCH labour ward. The homebirth team and complex caseload teams have also amalgamated to support safe staffing.
The committee were assured that this was a temporary measure, and a meeting with the division had been scheduled for a full review to understand the pressure points and find a resolution to this.

10. Quarterly Safeguarding Report Q4 2021-22

10.1 The committee noted the Quarterly Safeguarding report.

10.2 It was noted that the Trust safeguarding committee was held once in the quarter on 22nd February 2022. At this time one named professional post (adult) was vacant, so bank nurse cover was increased and the trust safeguarding leads supported the adult safeguarding work. This post was recruited to in the quarter with the post holder due to start in Q1 2022-23.
Since this report was presented to EMBQ and EMB a replacement named doctor for children's safeguarding has been appointed and safeguarding children's level 3 training compliance has started to increase. At the time of writing 70%, up from 62% at the end of Q4. It was stressed that a condition for working with children was completion of training

10.3 The committee were assured that an effective safeguarding service was provided during this quarter.
The current priorities are to increase the level of compliance with safeguarding training, particularly children's level 3 and to ensure the Trust is preparing for the introduction of the Liberty Protection Safeguards.

11. Ward Accreditation Programme (WAP+) Progress Report

11.1 The committee received the report outlining progress and next steps in implementation and report on thematic findings from pilot three.

11.2 The committee noted that the 22/23 WAP+ would be implemented across general and acute wards using the methodology developed during the three pilots and incorporating new metrics as these become available.
The WAP+ will be implemented in specialist areas, prioritising Emergency and Paediatrics and options would be explored for multi- professional engagement.

11.3 The committee noted the report and approved the next steps for delivery. In particular, the need for incorporating the patient voice in the process was stressed

12. National Audit of Care at End of Life

12.1 The committee received the report presenting the results of the National Audit for Care at the End of Life (NACEL) 2021 and associated action plan**.**

12.2 It was noted that we continue to demonstrate poor / late recognition of dying. This is seen across several domains within the case note survey.
For patients in whom dying is recognised early enough there was no formal capacity assessments made of their ability to take part in their end of life care planning.
When we consider discussions with those important to the dying person, we routinely discuss CPR & treatment escalation decisions, recognition of dying and the individualised plan of care, but we still do not routinely discuss nutrition & hydration and potential side effects from anticipatory medications at the end of life.

12.3 Where dying is recognised, we still fall below the national average in regard to the development of an individualised end of life care plan for the last hours and days of life based upon the 5 priorities of care for the dying person. We are also consistently lacking in meeting the NICE guidance around hydration and nutrition which asks us to review these statuses at least once in every 24 hour period once a person is acknowledged to be in the last hours and days of life. We are also deficient in our holistic assessment of patient's symptoms in the last hours and days of life, in documenting the benefit of starting, continuing or stopping certain interventions and in recording preferred place of death. 30% of patients who were expected to die did not have SC anticipatory medications prescribed to allow prompt treatment of any symptoms.

12.4 It is important to note that we do have an individualised care plan bundle available on Cerner based on the 5 priorities to support the care of the dying person which would address the majority of concerns raised above if it was implemented and embedded robustly across the organisation.

12.5 The committee noted the report and associated action plan outlining areas of learning and improvements.

13. Patient experience report Q4 2021/22

13.1 The committee noted the report for quarter 4 of 2021/2022, with key highlights being:

13.2 Patient experience related activity largely returned to pre Covid-19 levels during Q3.

13.3 Performance against scorecard metrics were generally good.

During this quarter the Trust had seen the volume of FFT surveys returning to closer to pre- COVID-19 pandemic numbers, with the exception of maternity services. The positive rating of care, the new FFT measurement, remains lower than the previous FFT likely to recommend question both locally and nationally.

14. 2021/22 Annual Complaints Report

14.1 The committee noted that key issues from formal complaints were related to treatment and care and in this quarter we had seen complaints related to care that was delivered during the first wave of Covid-19. The focus of PALS concerns remains appointments although new issues related to virtual appointments have appeared.

14.2 The number of informal complaints through PALS had continued to rise over the past year, reflective of the ongoing impact of the pandemic on our services.

15. Transformation team report

15.1 The committee noted the report outlining the breadth of the Transformation team's portfolio and to report progress.

16. Recommendation(s)

16.1 The Board is asked to note this summary

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC

Paper title: Financial update - Month 2

Agenda item: 18

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

Purpose: For noting

Meeting date: Wednesday 20 July 2022

1. Purpose of this report

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

2. Executive Summary

2.1. **Plan** – the Trust has recently received notification of additional funding for inflation which has offset the previously planned deficit giving a break even plan for the year.

2.2. **Income and Expenditure** – year to date month 2 (April – May 2022) the Trust had a £10m deficit. This was due to underachievement of the efficiency programme and underachievement of elective income.

2.3. **Capital** – the Trust has a gross capital programme of £95.6m with a Capital Resource Limit (CRL) of £71.7m. Year to date the Trust has spent £7.1m against a CRL of £6.8m. This is due to timing, and the forecast is to achieve the CRL for the year

2.4. **Cash** – The closing cash position was £203.4m at the 31st May 2022, this is a decrease since the start of the year due to settlement of items incurred late in 21/22 mainly capital. Balances are forecast to decrease in year but to remain higher than historic levels.

2.5. **Better Payment Practice Code** – the year to date performance was higher than the 95% target with 95.5% of invoices by value paid settled within the threshold and 98.3% by volume.

3. Recommendation(s)

3.1. The Board is asked to note the report.

Appendix 1: 2022/23 Month 2 Finance Report

Imperial College Healthcare NHS Trust

Trust Board 20th July 2022

Finance and Activity Report May 2022

Statement of Comprehensive Income

Imperial College Healthcare NHS Trust

	Year to Date			Full Year
	Plan £m	Actual £m	Variance £m	Plan £m
Income	227.7	226.7	(1.0)	1,362.5
Pay	(130.1)	(135.7)	(5.6)	(783.5)
Non Pay	(88.3)	(90.6)	(2.3)	(523.4)
EBITDA	**9.3**	**0.4**	**(8.8)**	**55.6**
Financing cost and donated asset treatment	(10.9)	(10.5)	0.5	(65.6)
Surplus/deficit Internal	**(1.7)**	**(10.0)**	**(8.4)**	**(10.0)**

- **Income** – the Trust is currently reporting an underperformance against the operating plan target to achieve 104% Cost Weighted Activity (CWA) compared to 19/20, although the Trust is awaiting final guidance from NHSE/I as to how achievement against the 104% baseline will be determined.
- Over performance on research income (which tends to vary with activity) is offset by additional expenditure.
- Additional inflationary funding has been accrued and will be reflected in the plan figures from M3 following the 20th June revised plan submission.
- **Pay** – pay costs are £5.6m adverse to plan YTD due to under-delivery of the efficiency target.
- **Non Pay** – non-pay costs are £2.3m adverse to plan driven by under-delivery of the efficiency target and increased drug costs, particularly high cost drugs offset in income

Capital Expenditure

Imperial College Healthcare NHS Trust

Sources of Funds	£m
Internal Financing (NWL allocation)	70.6
PDC Funding	1.1
Charitable Funds & Grants	23.9
Total	**95.6**

Applications	Annual Plan £m	Year To Date Plan £m	Actual £m	Var £m
Backlog Maintenance	23.3	2.5	2.1	-0.4
ICT	7.2	0.6	0.2	-0.4
Replacement of Med Equip.	4.1	0.2	0.5	0.3
Decarbonisation	23.0	0.0	2.5	2.5
Other Capital Projects	35.0	2.5	3.2	0.7
Redevelopment	3.1	1.2	1.2	0.0
Total Expenditure	**95.6**	**7.0**	**9.6**	**2.6**
Income & Donation	**-23.9**	**-0.2**	**-2.5**	**-2.3**
Capital Resource Limit	**71.7**	**6.8**	**7.1**	**0.4**
Actual spend as a % of YTD plan			**137.7%**	

At month 2 the capital programme, following the recognition of the decarbonisation grant income of £23m, now equates to £96.6m of which £71.7m counts towards the Trust capital resource limit.

YTD the Trust remains ahead of planned levels which is indicative of the level of success in the Trust's efforts to smooth the annual cycle of capital expenditure by giving project managers greater certainty around budgets so expenditure can be incurred earlier in the year.

Public Dividend Capital funding of £1.06m has been received to support the redevelopment agenda; as well as a small contribution (£82k) for cyber security costs there is the likelihood that further awards could be added to the overall programme as the year progresses.

The outcome of bids submitted against the Targeted Investment Fund remains unknown at the time of writing this report and are now expected early August 22.

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD - PUBLIC

Paper title: Finance, Investment & Operations Committee report

Agenda item: 19

Committee Chair: Bob Alexander, Vice Chair
Executive Director: Jazz Thind, Chief Finance Officer
Author: Sara Harris, Interim Head of Trust Secretariat

Purpose: For information

Meeting date: Wednesday 20 July 2022

1. Purpose

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

2. Introduction

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

3. Key points

The key items to note from the Finance, Investment and Operations Committee held on 6 July 2022 include:

3.1 Annual National Cost Collection (NCC) Exercise

The paper highlighted that NHSE /I had published the NCC guidance. This required that the Board of each NHS Trust is provided with a report ahead of the 2021/22 NCC submission to satisfy itself that the Trust has adequate resources and appropriate processes in place to deliver the NCC submission on time, in line with national guidance, and to sufficient standard of quality. On behalf of the Board, the Committee with its delegated authority noted that the appropriate systems, processes and resources were in place and approved the recommendation to delegate the final submission approval to the Chief Finance Officer.

3.2 Integrated Activity and Finance Report

The Committee received the new integrated activity and finance report allowing it to better translate the operational performance with financial position. In April the Trust set a £10m deficit plan for the year reflecting the additional unfunded inflationary costs. In June all NHS organisations were required to submit a revised plan and the key update reflected in the revised submission was the inclusion of £10m of additional national funding for estimated inflationary costs moving the Trust to a break even financial plan.

At month 2, the Trust has reported a £10m deficit position, due primarily to both: lower than planned - elective recovery funding against current activity levels and

efficiency improvements. These remain key areas of focus and it is anticipated that both aspects will be further recovered throughout the year.

Elective activity performance improved during month 2 with a 9% increase to 8,600 procedures over a four week, 28 day period compared to similar period in April. This improvement is expected to continue given the changes that have now been implemented in relation to covid patient pathways across all sites.

It was noted however that the calculation of cost weighted activity and therefore ERF receivable is based purely on the Trust interpretation of the limited guidance that has been available to date and this may be a very prudent assessment, with the necessary detailed guidance still awaited. In the meantime the Trust is aware that national reporting indicates a materially higher level of performance than the internal view and should this be the finalised validated the Trust would as a minimum, recover all planned year to date ERF (if not more).

At month 2, the capital programme following the recognition of the decarbonisation grant income of £23m totalled £96.6m of which £71.7m counts towards the Trust capital resource limit (CRL). YTD the Trust remains ahead of planned levels with a total gross spend of £9.6m against plan of £7.0m (£7.1m and £6.8m respectively when comparing performance against the CRL). This is indicative of the level of success in the Trust's efforts to smooth the annual cycle of capital expenditure by giving project managers greater certainty around budgets so expenditure can be incurred earlier in the year.

The Trust's cash position at 31 May 2022 was £203.4m.

3.3 Financial Recovery Framework

The Committee noted and welcomed the financial performance management framework the Executive Management Board had approved and adopted with immediate effect. The framework aims to ensure there is a structured supportive process in place to achieve financial targets with a clear and transparent financial management approach where financial performance is not in line with plan

The Committee welcomed the introduction of this additional control and escalation process to support the achievement of financial delivery.

3.4 Productivity & Efficiency Programme Update

The Committee received an update on the Trust's Productivity & Efficiency Programme, established to develop the framework through which the organisation is building its plans to reduce waste and improve efficiency. In line with the initial financial planning assumptions for 2022/23, the Trust efficiency requirement is 3%; initiatives to the value of £19.9m have been identified to date but further work remained in train to bridge the gap to target. This includes stretching cross cutting schemes across identified themes, opportunities for collaboration across the ICS and pursuing six priority areas.

The Committee noted the update and welcomed formulating a multi-year programme of delivery.

3.5 Capital Programme Report

The Committee received the detailed deep dive Trust capital report. The purpose of which report was to: present the governance processes underpinning the capital programme; set out the construct of the capital plan (schemes and financial values); provide an update on current funding applications; give assurance on delivery of

the Capital Resource Limit (CRL) for 2022/23; and summarise investments approved thus far and their impact on the capital programme.

It was noted that Public Dividend Capital funding of £1m had been received to support the redevelopment programme as well as a small contribution (£82k) for cyber security costs and that there is the likelihood that further awards could be added to the overall programme as the year progresses.

The outcome of bids submitted against the Targeted Investment Fund remains unknown at the time of writing this report and are now expected early August 22.

3.6 Roadmap for Integrated Specialised Services within ICSs

The Committee received an update on NHSE/I's future plans as described in the "Roadmap for Integrating Specialised Services within Integrated Care Systems".

Since 2013/14, the commissioning of NHS clinical services has been split between CCGs (commissioning standard care), NHSE (commissioning specialised care) and Local Authorities (commissioning Sexual Health/Public Health). With the creation of Integrated Care Boards (ICBs), NHSE/I is now of the view that synergies can be gained by delegating Specialised Services Commissioning to ICBs. This transfer in commissioning responsibility is currently scheduled to start from 1 April 2023 for a cohort of services. The Committee noted the services which NHSE/I has determined are:

- suitable and ready for delegation to ICBs from April 23 (subject to system readiness); and
- suitable but not ready for delegation in April 23 (where delegation should be deferred until a point at which they are considered ready)
- Identified as not suitable for delegation (remaining directly commissioned by NHSE/I).

3.7 IPH Performance and strategy review

The Committee received an update on the IPH performance and strategy review in light of the pandemic and NHS pressures. Private activity made a slow recovery in 2021/22 as the pandemic continued to impact on short term plans. However, services performed better than budget and generated £37.7m in 2021/22 7% favourable to plan and £9.9m (35%) up on prior year. Working closely with the Divisions, IPH has agreed a plan to make the most of opportunities to increase activity while, as ever, ensuring there are no adverse impacts on NHS care. IPH is also currently undertaking a review of its branding.

3.8 Annual Review of the Financial Benefits of Business Cases Approved by the Executive – PICU

The Committee considered a post project evaluation of the upgrade and development of the PICU at St Mary's Hospital.

3.9 Summary of Business Cases approved by the Executive

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

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC

Paper title: People Performance & Scorecard - Month 2

Agenda item: 20

Lead Executive Director: Kevin Croft, Chief of People Officer
Author: Pen Parker, Associate Director – People Planning & Information

Purpose: For discussion and noting

Meeting date: Wednesday 20 July 2022

1. Purpose of this report

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

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

2. Executive Summary

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

There are several items to highlight:

- A people scorecard (appendix 1) provides performance trends
- Current staff in post is 12,736 WTE at the end of May 2022
- The current Trust vacancy rate is 13.8% and is a small increase from the month 1 position of 13.4%
- Nursing & Midwifery vacancies (all bands) has marginally increased in month from 12.5% to 12.6% but remains lower than 14% in September 2021. Band 5 nursing and midwifery vacancies has worsened from 14.7% in April 22 to 16.1% in May. This is due to an increased number of leavers and challenges with international pipeline
- Midwife vacancies were at 12.1% at the end of May 2022 (48 WTE) , an improvement from the April 2022 position of 14.5% (58 WTE)
- Voluntary turnover has marginally increase from 12.6% 12.9% in May 2022, above the Trust's 12% target. The North West London Trusts have a collective voluntary turnover rate of 14.2%
- Temporary staff spend for 2022/23 to end of May 2022 was £16.59m; £11.65m on bank and £4.94 on agency. Higher than for the same period in 2021/22 at £10.21m and £4.18m respectively
- Sickness Absence for May 2022 was 4%; lower than in April (5.1%) and driven by reduced episodes of COVID related short-term illness and reduction in long-term sickness episodes

- The percentage of ethnic minority leaders (band 7+) has changed from 42.8% to 41.9% over the past month

3. Approval process

3.1. The content of this report has been reviewed and discussed at the People Executive Management Board and the People Committee.

4. Recommendation(s)

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

Appendix 1: People Performance Scorecard

MAIN REPORT

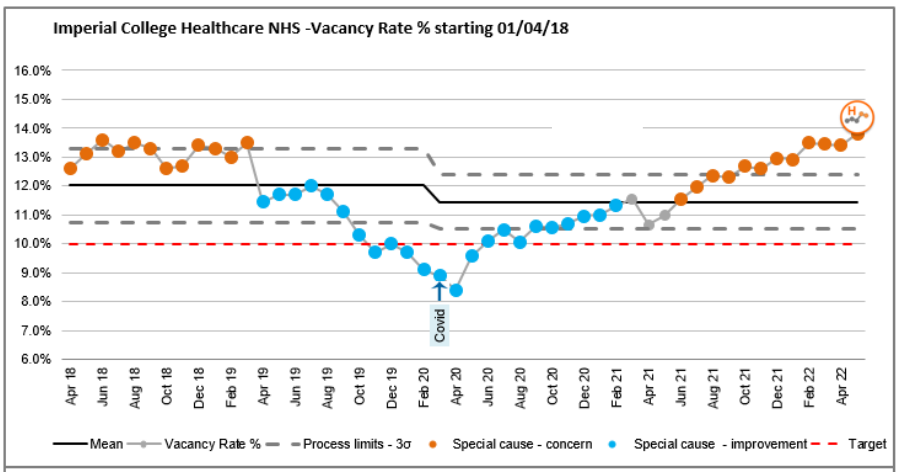
1.0 This report provides an overview of the Trust's workforce at the end of month 2, May 2022, reporting on workforce performance detailed on the scorecard and providing context against the pressures and drivers, risks, and mitigations, which contribute to that performance. In support of this report is, Appendix 1, the People Performance Scorecard.

2.0 Workforce size, strength and stability

2.1 Staff in Post - the number of substantive staff in post was 12,736 WTE at the end of May 2022 and in terms of headcount, we employ just over 14,500 staff on substantive and fixed-term contract across all Trust services.

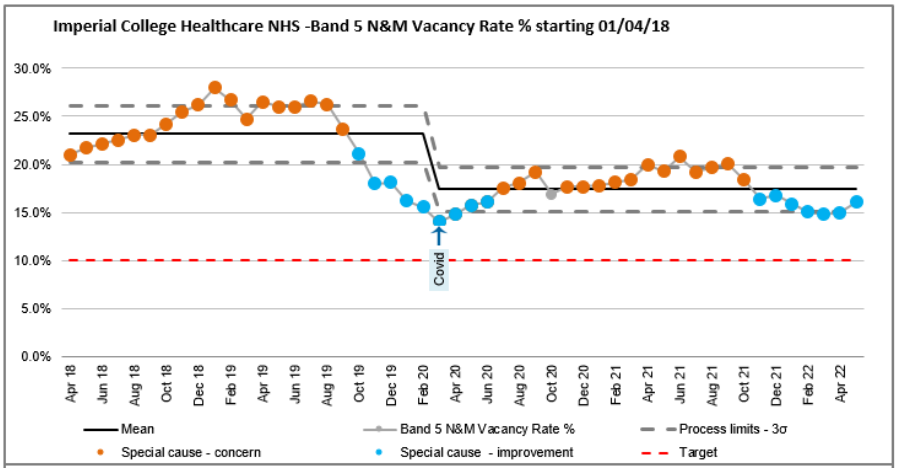
2.2 Establishment - at the end of May 2022 was 14,781 Whole Time Equivalents (WTE); an overall decrease of 9 WTE from the end of April 2022.

2.3 Vacancy Rate & Recruitment - the Trust's vacancy rate at the end of May 2022 was 13.8%, (2,045 WTE) and is a small increase from the month 1 position of 13.4%. The Statistical Process Control Chart (SPC) shows the Trusts vacancy rate over the past four years. Clearly showing the progress in reducing vacancies pre-Covid but, since April 2021, we have struggled to maintain enough recruitment activity to keep pace with leavers and the growing establishment.



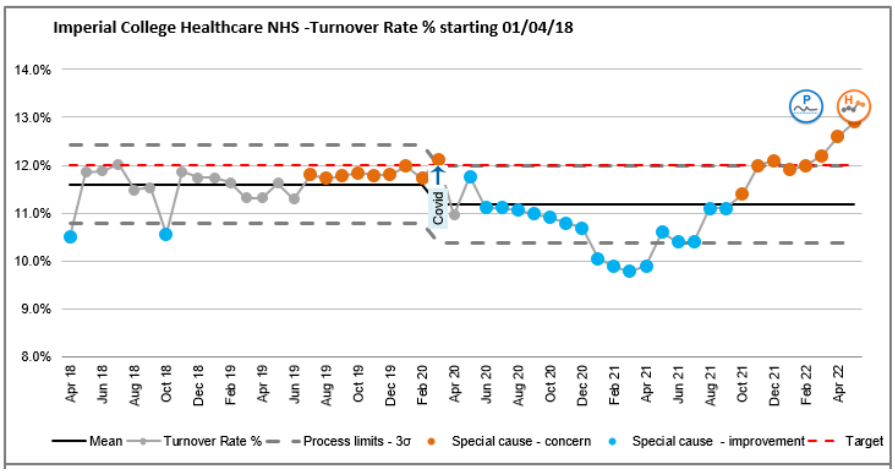
2.2.1 Nursing & Midwifery vacancies (all bands) have marginally increased in month from 12.5% to 12.6% but remains lower than the 14% in September 2021; representing an overall reduction of 10.0% for vacancies within this staffing group. Band 5 nursing and midwifery vacancies has worsened from 14.7% in April 22 to 16.1% in May. This is due to an increased number of leavers and nationally recognised challenges with the international pipeline. The SPC chart below shows the Trusts band 5 nursing and midwifery vacancy rate over the past four years which shows that currently, and since October 2021, there have been no special cause points of concern.

2.2.2 There are a number of actions being taken to improve our vacancy rate position. These include, bespoke campaigns for hotspot or hard to recruit areas e.g. theatres and maternity, regular recruitment events, student conversions, international resourcing campaigns for nursing, maternity and AHP, wide social media campaigns and marketing.



2.2.2 Midwife vacancies were at 12.1% at the end of May 2022 (48 WTE), an improvement from the April 2022 position of 14.5% (58 WTE). Vacancies are reducing with successful recruitment from overseas and through the preceptorship programme. The recommendations from the Ockenden inquiry, relating to maternity resourcing and other workforce factors such as culture, leadership and training, are being reviewed to identify where improvements and changes may be needed.

2.3 Turnover – voluntary turnover has marginally increased from 12.6% 12.9% in May 22, above the Trust's 12% target. The North West London Trusts have a collective voluntary turnover rate of 14.2%. The SPC chart below shows the Trusts voluntary turnover over the past four years. There were no special cause points of concern between March 2020 and August 2021, when we saw a drop in staff movement due to the pandemic response. But, similarly to other industries, turnover has been rising steadily post wave two of Covid and is now above our Trust target of 12%. Noting the rising turnover of staff and the need for increased focus on retention, it is one of the Trust's 22/23 people priority programmes. A multi-disciplinary task force is leading the focused initiatives to improve retention.

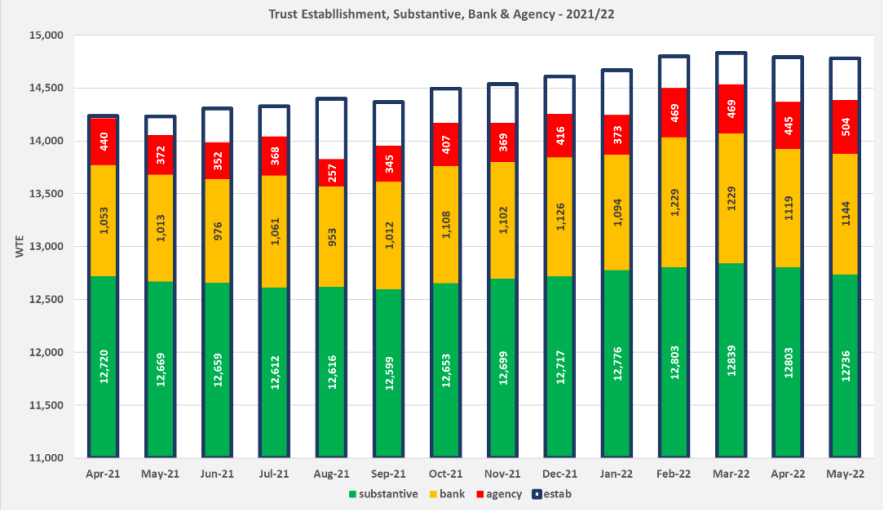


3.0 Workforce productivity

Temporary staff spend – the total temporary staffing resourcing spend for 2022/23 YTD is £16.59m (£14.39m 2021/22); with £11.65m on bank and a further £4.94m on agency.

The 2022/23 combined bank and agency spend is 11.1% of the total YTD pay bill. The YTD Trust agency spend is 3.3% of total pay spend and above the Trust target of <=2%. This is higher than the 3.1% reported at the same time last year; £4.18m agency spend

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



4.0 Performance and skills

4.1 Doctors in training core skills – there has been an improvement over the past two months with compliance now above target at 90.8%

4.2 Local induction – remains below target at 80.4% but significantly improved from the March 2022 position of 66.1%. There has been a steady increase over the past two months as a result of new actions.

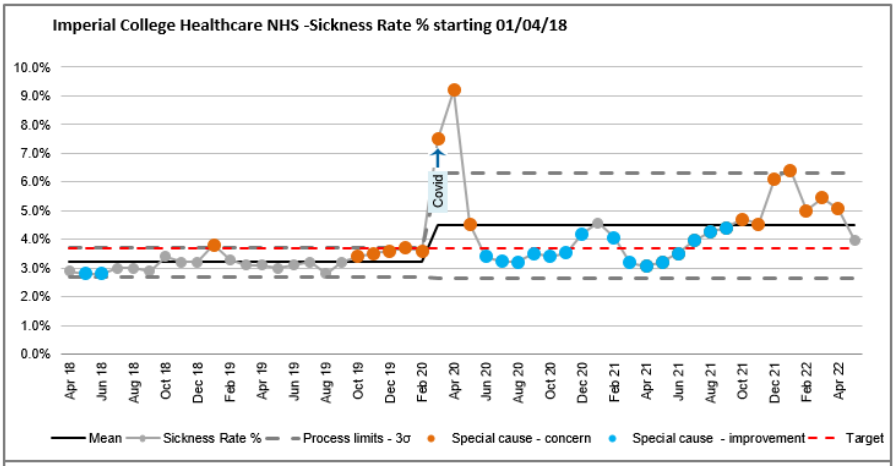
4.3 Performance & Development Review – we are mid-cycle and will review performance at the end of cycle; 31 July 2022

4.4 Medical appraisal – the compliance rate continues to improve and is now 94.1% against a target of 95%. This is the highest it has been since pre-pandemic and the aspiration is to achieve the NHS England benchmark, 95% compliance, in the coming months.

5.0 Health and wellbeing

5.1 Sickness absence

The Trusts current rolling 12-month sickness absence level is 4.8% compared to 3.3% pre- pandemic. The SPC chart below shows the Trusts monthly sickness absence profile over the past four years. Since December 2021 we see the impact of the most recent two waves of Covid (Dec/Jan and Mar/Apr) with the most recent run of seven special cause concern points. Whilst sickness returned to a more seasonal level in May 2022, we are monitoring sickness absence daily for alert changes in levels of Covid absence.



During May 2022, the top three sickness absence reasons, and accounting for 46.2% of all recorded absence, were as follows.

May 2022 – Absence Reason as % of Total Sickness	%
Chest & respiratory problems*	17.2 %
Anxiety/stress/depression/other psychiatric illnesses	15.7 %
Musculoskeletal illness/injury	13.3 %

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

5.2 **Staff psychology referrals** – new referrals to the CONTACT service remain high at 59 per month and above pre-Covid levels. During 2021/2022, there were a total of 889 new referrals made to CONTACT. Themes remain consistent with high levels of grief, trauma and past bereavement.

5.3 Annual Leave – to date, 84% of all expected leave entitlement has been booked for quarter 1 of 2022/23.

6.0 Equality, diversity and inclusion

6.1 **Ethnic minority leaders** – the percentage of ethnic minority leaders (band 7+) has changed from 42.8% to 41.9% over the past month. Vacancies at this level have grown over the last 12 months due to a combination of establishment growth and turnover.

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

Between September 2021 and March 2022, 412 campaigns for new band 7 or above leaders have been advertised, shortlisted and a hiring decision made. There have been 375 offers of employment with 65% of applicants, 52% of shortlisted applicants and 44% of the successful candidates are leaders from a black, Asian or minority ethnic background. Work will continue to embed this process and track progress for impact and outcome. The monthly data will be added to the directorate and divisional scorecards to support embedding the inclusive recruitment programme across the Trust.

In addition, the People Performance Scorecard will be enhanced to include additional metrics in support of inclusive recruitment, including reporting the percentage of black, Asian and minority ethnic staff at bands 5 and 6.

5 Conclusion

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

Appendix:

Appendix 1, People Performance Scorecard – May 2022

IMIS performance scorecard - People

Section	Metric	Watch or Driver*	Target	YTD Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Workforce Size, Strength & Stability	Trust Post Establishment (WTE)	Watch			14,231	14,308	14,325	14,397	14,367	14,492	14,536	14,610	14,670	14,799	14,832	14,790	14,781
	Trust Staff Inpost (WTE)	Watch			12,669	12,659	12,612	12,616	12,599	12,653	12,699	12,717	12,776	12,803	12,839	12,803	12,736
	Vacancies (WTE)	Watch			1,562	1,649	1,713	1,781	1,768	1,839	1,837	1,893	1,894	1,996	1,993	1,987	2,045
	Vacancy Rate (%)	**Driver**	**<=10%**		**11.0%**	**11.5%**	**12.0%**	**12.4%**	**12.3%**	**12.7%**	**12.6%**	**13.0%**	**12.9%**	**13.5%**	**13.4%**	**13.4%**	**13.8%**
	Voluntary Turnover (%)	**Driver**	**<=12%**		**10.6%**	**10.4%**	**10.4%**	**11.1%**	**11.1%**	**11.4%**	**12.0%**	**12.1%**	**11.9%**	**12.0%**	**12.2%**	**12.6%**	**12.9%**
Workforce Productivity	Temporary Staffing Spend (£'000s) per month	Watch			£6,837	£5,684	£6,584	£6,605	£6,742	£8,323	£6,236	£7,995	£8,518	£8,867	£9,132	£7,736	£8,858
	of which Agency Spend (£'000's)	Watch			£1,887	£1,646	£1,760	£1,408	£1,974	£1,936	£2,022	£2,467	£2,389	£2,675	£2,876	£2,195	£2,748
	of which Bank Spend (£'000s)	Watch			£4,950	£4,038	£4,824	£5,197	£4,768	£6,387	£4,214	£5,528	£6,129	£6,192	£6,256	£5,541	£6,110
	Agency Spend as % of Total Paybill	**Watch**	<=2%		**2.8%**	**2.4%**	**2.6%**	**2.1%**	**2.6%**	**2.7%**	**2.9%**	**3.4%**	**3.3%**	**3.0%**	**4.3%**	**3.0%**	**3.6%**
Performance & Skills	**Core Skills Compliance Rate (%) excl. Doctors in Training**	**Driver**	**>=90%**		**92.2%**	**92.9%**	**92.7%**	**92.8%**	**91.7%**	**91.0%**	**90.7%**	**90.9%**	**89.4%**	**90.5%**	**90.4%**	**92.2%**	**92.3%**
	Core Clinical Skills Compliance Rate (%) excl. Doctors in Training	**Driver**	**>=90%**		**92.7%**	**93.2%**	**94.0%**	**92.2%**	**92.6%**	**92.1%**	**91.6%**	**92.6%**	**90.6%**	**91.9%**	**91.0%**	**92.9%**	**92.6%**
	Doctors in Training Core & Core Clinical Skills Compliance Rate (%)	**Driver**	**>=90%**		**83.5%**	**84.5%**	**74.7%**	**83.3%**	**85.1%**	**85.2%**	**86.7%**	**87.3%**	**75.4%**	**87.2%**	**87.3%**	**87.8%**	**90.8%**
	Personal Development Reviews Completion Rate (%)	Watch	>=95%		Paused for Covid		**62.2%**	**68.7%**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**4.1%**	**13.3%**
	Local induction Completion Rate (%)	**Driver**	**>=95%**		**62.1%**	**71.0%**	**72.5%**	**70.8%**	**72.3%**	**72.1%**	**72.1%**	**71.3%**	**71.4%**	**69.0%**	**66.1%**	**76.4%**	**80.4%**
	Doctors Appraisal Completion Rate (%)	Watch	>=95%		Paused for Covid			**88.6%**	**85.9%**	**90.7%**	**88.1%**	**85.8%**	**88.4%**	**91.2%**	**92.4%**	**93.1%**	**94.1%**
Health, Well-being & Safety	**In-Month Sickness Absence Rate (%)**	**Driver**	**<=3.7%**		**3.2%**	**3.5%**	**4.0%**	**4.3%**	**4.4%**	**4.7%**	**4.5%**	**6.1%**	**6.4%**	**5.0%**	**5.5%**	**5.1%**	**4.0%**
	Rolling 12-Month Sickness Absence Rate (%)	Watch	<=4.4%		**3.7%**	**3.7%**	**3.7%**	**3.8%**	**3.9%**	**4.0%**	**4.1%**	**4.2%**	**4.3%**	**4.4%**	**4.6%**	**4.7%**	**4.8%**
	New Referrals to Contact (per month)	Watch			70	100	75	71	82	82	69	66	86	64	60	61	59
	Annual Leave Booked as a % of Expected Annual Leave to be Booked	**Driver**								**84.0%**						**84.0%**	
Equality, Diversity & Inclusion	BAME % of workforce band 7 and above	Driver	tbc		40.1%	39.9%	40.1%	40.4%	40.4%	41.1%	41.4%	41.7%	40.4%	41.0%	41.0%	42.8%	41.9%
	Vacancies WTE at band 7 and above	Watch	tbc		279	287	337	319	328	328	331	326	322	338	345	352	340
	Likelihood to recruit (white staff compared to BAME staff from shortlisting)	Watch	tbc						1.13								

This scorecard will continue to evolve and mature

Driver metrics include metrics that are consistently not performing against target / trajectory and where we want to align resources via a specific project to drive improvement. This helps to prioritise resources for key improvement projects where they are needed.

Watch metrics acknowledges business as usual activities to maintain performance in other areas. Watch metrics include metrics that are consistently performing and this is expected to be reliably maintained through business as usual activities or where we are not currently able to directly influence performance

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC

Paper title: The People Committee report

Agenda item: 21

Committee Chair: Sim Scavazza, Non-Executive Director
Executive Director: Kevin Croft, Chief People Officer
Author: Amrit Panesar, Trust Secretariat Officer

Purpose: For noting

Meeting date: Wednesday 20 July 2022

Executive summary

1. Purpose

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

2. Introduction

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

3. Key points

3.1. The key items to note from the People Committee held on 5th July 2022:

4. Equality Diversity and Inclusion in Focus: LGBTQ+

4.1. The Committee heard from Andrew Hartle - LGBTQ+ network chair - who provided an update on the ongoing work within the network. He highlighted the Trust's participation in the first Pride parade in London since the beginning of the pandemic which was a success, with staff representing from the Trust. The Committee were pleased to note that the Trust had received a bronze award for the Rainbow Badge Accreditation programme which evaluates how the Trust supports and recognises LGBTQ+ patients and staff. The Committee recognised that while there were some areas where the Trust was doing well in reducing barriers for LGBTQ+ people in employment or in the Trust's care, there was still a lot of work to be done to support staff joining the network and as part of the accreditation. The Trust has received comprehensive feedback through the accreditation scheme and a Trust wide action plan will be developed. The Committee welcomed the suggestion of an Anti-Homophobia statement as part of the Trust's commitment to eradicating homophobia, similar to the work being undertaken on an anti-racist statement and recognised the importance of staff attending network meetings confidentially.

4.2. The Committee thanked Andrew and the network for their hard work and dedication for the network.

5. People Performance and Scorecard month 2

5.1. The Committee received the People Performance Report and Scorecard. The report provided a summary of people performance and metrics against the Trust's workforce performance indicators identifying areas requiring focus and improvement as well as the actions being taken to enable that improvement. The Committee noted the report and acknowledged that there was recently an increase in sickness absences due to a rise in Covid-19 infections which has started to impact the workforce availability across the Trust.

5.2. The Committee agreed that the scorecard will be closely monitored noting that staff were being encouraged to book their annual leave during the summer whilst preparing for a potentially busy winter.

6. Priority People Programmes and Risk Mitigation

6.1. The Committee received the report which provided an update on progress against the 2022/23 People Priorities, noting the performance against key millstones and associated metrics, updates on future activities and links to corporate and local risks. The Committee noted that the programme was on track but highlighted a number of workforce pressures (e.g. Covid absence, maintaining high take up of annual leave, non-NHS industrial action, NHS staff industrial action, flu, elective recovery and winter emergency pressures. The Committee noted that plans were in development now within the Trust, acute collaborative and across the ICS to mitigate the risks associated with the emerging workforce pressures.

7. People and OD Risk Deep Dive: Retention

7.1. The Committee received an update on the people retention priority noting that the Trust had commenced an analysis into the people retention priority to collate evidence which could support to deliver sustainable change. The analysis provided evidence of a number of trends. Over 12 months there have been 1806 leavers and the Trust has a voluntary turnover rate of 12.2% of a target of 12%. The Committee noted that 56% of the 1806 leavers have left within two years of joining the Trust. The Committee noted that this review had enabled a set of retention priorities to be created, that are based on the data and evidence available. The Committee were supportive of the priorities for 2022/23.

7.2. The retention priorities for 22/23 are:

- Flexible working
- Career progression
- Pay and progression
- Nursing and Midwifery new starters / early careers
- Entry level roles and development pathways
- Intensive support to high turnover areas

8. Employee Relations Report

8.1. The Committee received an update on the employee relations casework numbers and performance for 2021/22. The Committee noted that the Trust closed 79 misconduct cases, 26 grievance cases and 19 performance management cases compared to 80 misconduct cases, 26 grievance cases and 19 performance management cases in 2020/21. There were 27 colleagues subject to formal disciplinary processes in

2021/22, of which 70.4% were BAME. This compares to 65% BAME representation across the workforce for the pay bands that were subject to formal proceedings.

8.2. The report included the actions the Trust had taken in response to the requirements of the 2019 letter from Baroness Harding which had been triggered by the death of Amin Abdullah, a member of staff at Imperial. The Committee were satisfied that the Trust were complying with the requirements and, in certain areas, going further than set out in the national directive. The compliance with the national requirements would be noted at the Board in line with the request by Baroness Harding for Board oversight of these procedures and safeguards.

8.3. The Committee noted that the Trust had significantly reduced the number of formal cases as well as the overall time it takes to conclude cases that do go to a formal hearing – 14.5 weeks in 2021/22, compared with 21 weeks in the year before. The Committee noted and commended the progress reflected in the report.

9. People Assurance Report

9.1. The Committee received the assurance report for the People Committee which included an update on the Continuing Professional Development (CPD) Funding for Nurses, Midwives and Allied Health Professionals (NMAHPs), Establishment Review Briefing, Financial Wellbeing, Violence and Aggression, Equality, Diversity and Inclusion Work Programme 2022/2023, NWL Acute Care Collaborative Workforce Programme, the Professional Nurse Advocate and the Pathways to Excellence programme

10. Pathway to Excellence

10.1. The Committee received the report noting that the Pathway to Excellence programme at the Trust has been relaunched as part of the organisation's reset and recovery work in late 2021 and early 2022 and supports the Trust's desire to become an outstanding organisation. The Committee noted that the Trust has agreed to launch the pathway to excellence programme as a pilot at Charing Cross Hospital and a self-assessment against where the Trust was against the standard has been completed. The Committee noted that the next step in the programme was to enrol on the ANCC Pre-Intent Programme (PIP), which provides structured guidance to organisations as they start their pathway to excellence journey and support organisations through the application process, and helps to understand the requirements of the Elements of Performance and the completion of our evidence portfolio. The Committee were pleased to note the progress of the programme.

11. Health and Safety Report

11.1. The Committee received the routine Health and Safety report noting that work was underway to operationalise the new integrated Health and Safety Governance Framework. Future reports would be based on the new framework to provide a wider oversight of all Health and Safety items. The Committee noted that the Trust is continuing to ensure workspaces have adequate ventilation. Over 250 non-clinical workspaces had been identified as having inadequate ventilation on the back of assessments relating to Covid working environments. Those non-clinical workspaces plus all inpatient (clinical) workspaces have been prioritised for an assessment of the adequacy of their ventilation and the formulation of a corrective action plan. The

Committee noted that for clinical workspaces, the Trust is prioritising ventilation adequacy assessments for those clinical workspaces in which inpatients receive care.

12. Recommendation(s)

12.1. The Board is asked to note this report.

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD (PUBLIC)

Paper title: Board Summary report: Audit, Risk & Governance Committee

Agenda item: 22

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

Purpose: For information

Meeting date: Wednesday 20 July 2022

1. Purpose of this report

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

2. Introduction

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

3. Key points

3.1. The key items to note from the Audit, Risk and Governance Committee held on 13 July 2022:

4. External Audit

4.1 The Committee received an oral update on the year-end audit from Deloitte. The Committee noted that the final report had been approved on 11 July 2022, subject to a few minor amendments. The audit team assured the committee that these amendments would be finalised today and the audit would be signed off by close of business.

4.2 The committee noted that the Letter of Management Representation will reflect that the report was approved on 11 July 2022.

4.3 The committee requested that a paper outlining lessons learned through this audit process, with an action plan, be presented at the next committee in September

Action: Jazz Thind

5. Internal audit update

5.1 Internal audit progress report

5.1.1 The committee received the report and noted that work for 2022/2023 has commenced, with scoping completed of the first six reviews. These reviews will be presented to the committee between September and November 2022.
Field work for the risk management, data quality and the capital projects reviews will commence next week.

The committee also noted that the audit team are currently scoping a review around financial sustainability, which internal auditors are required to do across all NHS Trusts and this will be shared once complete.

5.2 **Counter fraud progress report**

5.2.1 The Committee received the report outlining the progress of the plan and work being scoped.

5.2.2 The committee also noted the appendices detailing reactive status which compares the referrals received compared to last year.

5.2.3 The committee were also alerted to a recently published fraud prevention notice, and assurance was provided that work on promoting fraud awareness across the organisation was on-going, and are scoping a communications plan.

6. Contract/procurement management report / update

6.1 The Committee received the report setting out the progress to date against the outstanding actions as highlighted in the follow-up review undertaken by PWC as part of the internal audit programme in 2021/22, in which Contract Management was classified as 'High Risk', with three high and one low risk findings.

6.2 The committee were assured that of the five outstanding actions, one had been completed, two are scheduled to complete within 4 weeks of the date of this meeting, one is in progress with the anticipation it will be completed by the completion date of September 2022; with one action now overdue to follow up.

7. Subject Access Request Audit (High Risk)

7.1 The committee noted the paper providing an update to the action plan and wider progress report that was presented to the committee in March 2022, following the recommendations from the internal audit & external reviews that were commissioned in respect to an identified risk in respect to the Trust's capacity to provide Data Subject Access Requests under the UK-GDPR 'Right of Access'

7.2 The committee were assured that the Trust had developed a clear strategy to fulfil the auditor's recommendations. Updates on progress will be fed back at future meetings.

8. Risk and Assurance Report

8.1 The committee received the report on risk management and assurance at the Trust providing updates on the corporate risk register, the corporate risk profile and board assurance framework process.

8.2 The committee noted two changes the Corporate Risk Register, with the score for the risk around Failure to Effectively Manage Supplier Contracts being de-escalated to the Finance risk register for monitoring, and the score for the risk around Inability to Identify Gaps with Fit Testing Compliance Due to Failure to Record Fit Testing on Healthroster being reduced as we had now reached our target on staff testing.

8.3 The committee discussed the risk scoring around Failure to secure funding and approval from Key Stakeholders for the redevelopment programme. It was agreed to increase impact score.

8.4 An update on the progress being made on collaborative governance was given.

8.5 The committee were informed that the Corporate Governance Team would be meeting with Directors regularly to review their relevant risks in detail, focussing mainly on the current and target risk scores in line with the risk appetite, and

ensuring the actions are being completed and closed within the listed timeframes. This will also be an opportunity for the Executives to raise any emerging risks that may be considered for escalation to the Corporate Risk Register.

8.6 The committee noted recent risk and assurance deep dives surrounding current corporate risk register risks or on emerging risks that had been completed. Future deep dives for the September meetings are to be agreed with each committee chair as part of the committee forward planner

9. Reports from Board sub-committees re risk and assurance deep dives and key risks

9.1 The committee received updates from the Board sub-committees with key highlights noted

10. Estates risks – Mint Wing

10.1 The committee received an update on the works related to the Mint Wing Beam Risk, noting progress to date and planned next steps.

10.2 Subject to the Specified Enabling Works and Basic Implementation Agreements being signed by all parties in the coming months; Network Rail and Westminster Council will mobilise to undertake all alteration work to make South Wharf Road a cul-de-sac and open up Norfolk Place for use by ambulances.
Once this work is completed to the satisfaction of all parties, Tanner Lane will be closed to allow the remediation works to the overbridge and Mint Wing to commence.

10.3 The committee commented it may be prudent to ensure key stakeholders were sufficiently sighted on the works and potential risks at the appropriate stage.

11. Technology governance framework – local deployment of clinical systems

11.1 The committee received a report providing an update on the clinical safety components of the Technology Assurance Framework which was developed in collaboration with the Internal Audit function.

11.2 The committee were assured that the Trust has an established approach to digital clinical safety, which continues to be evolved in line with new guidance.

12. Tender Waiver Report

12.1 The committee noted the Tender waiver report

13. Recommendations:

13.1 The Trust Board are requested to note this report.

Imperial College Healthcare NHS Trust

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TRUST BOARD – PUBLIC

Paper title: Report from the Redevelopment Committee

Agenda item: 23

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

Purpose: For noting

Meeting date: Wednesday 20 July 2022

1. Purpose of this report

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

2. Introduction

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

3. Key points

3.1. The key items to note from the Redevelopment Committee meeting held on 12 July 2022 include:

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

3.1.2. The Programme Director's report to the Committee provided updates on a number of activities relating to the redevelopment of St. Mary's, Charing Cross and Hammersmith Hospitals, including possible phasing options for the St Mary's site, communication and stakeholder engagement, life sciences development, finance and risks.

3.1.3. The Committee also received an update on management of estate risks, with next steps including raising awareness amongst key stakeholders of the potential impact on services arising from a major failure of any of our hospital buildings and the associated contingency planning required.

3.1.4. The Committee received an update and noted progress on the public sector decarbonisation programme.

3.1.5. The Committee discussed the future frequency of the Redevelopment Committee in light of the planned establishment of the northwest London acute provider collaborative.

3.2. **Recommendation**

3.2.1. The Board is asked to note this report.