Imperial College Healthcare NHS Trust

Public Trust Board
Draft Minutes of the meeting held on 20th May 2020, 11am
Virtual meeting held via Microsoft Teams and video-recorded.

Members present

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

In attendance

Mr Nick Ross	Designate Non-executive Director
Dr Ben Maruthappu	Associate Non-executive Director
Mr Peter Jenkinson	Director of Corporate Governance
Prof. Jonathan Weber	Dean of the Faculty of Medicine, Imperial College London
Mrs Claire Hook	Director of Operational Performance
Mr Hugh Gostling	Director of Estates and Facilities
Mrs Ginder Nisar	Deputy Trust Secretary (minutes)

Apologies

Mr Jeremy Butler	Director of Transformation
Ms Michelle Dixon	Director of Communications
Dr Bob Klaber	Director of Strategy, Research & Innovation
Mr Kevin Jarrold	Chief Information Officer
Mr Kevin Croft	Director of People and Organisational Development
Mr TG Teoh	Divisional Director, Women, Children and Clinical Support
Ms Katie Urch	Divisional Director, Surgery, Cancer and Cardiovascular
Ms Frances Bowen	Divisional Director, Medicine and Integrated Care

Item	Discussion
1.	**Opening remarks**
1.1.	Ms Vennells welcomed everyone to the meeting which was held virtually and in keeping with social distancing guidelines. Divisional Directors and other Directors were not present in order to allow them to respond to operational needs. The Board meeting would be video-recorded and uploaded onto the Trust's website.
1.2.	Ms Vennells thanked the Clinical Directors, Executive team and staff for their extraordinary contribution during the past weeks in response to the pandemic and to Mrs Hook and Prof. Redhead for covering whilst Prof. Orchard was recovering from Covid-19.
1.3.	Sadly four members of Trust staff lost their lives to Coronavirus: Professor Mohammed Sami Shousha, Donald Suelto, Melujean Ballesteros and Jermaine Wright and the Board observed a minute's silence in recognition of their contribution to the Trust, and also for all those across the NHS who lost their lives during the pandemic. Prof. Orchard echoed Ms Vennells sentiments and commented on the funeral of Melujean Ballesteros whose funeral cortege stopped at St Mary's hospital for an emotionally moving ceremony.
2.	**Apologies** Apologies were noted from those listed above.

3.	**Declarations of interests** None other than those disclosed previously.
4. 4.1.	**Minutes of the meeting held on 25th March 2020** The minutes of the previous meeting were agreed subject one amendment: 9.4 The Board endorsed the ambition and direction for the Sustainable development management plan**.**
5.	**Record of items discussed in part II of the Board meeting held on 25th March 2020** The Board noted the summary of confidential items discussed at the confidential Board meeting held on 25th March 2020.
6.	**Matters arising and actions from previous meetings** Pathway to excellence – Prof. Sigsworth advised that this was currently on hold but would take stock in the coming weeks with the Executive team.
7. 7.1. 7.2. 7.2.1. 7.2.2. 7.2.3. 7.2.4. 7.2.5. 7.2.6.	**Chief Executive Officer's briefing** Prof. Orchard presented his report, highlighting key updates on strategy, performance, leadership over the month, and latterly the focus of Trust business in response to Covid-19. <u>Covid-19</u> Since the last Board meeting, the Trust had to more than double its intensive care capacity, redeploy hundreds of staff into new roles and put in place a raft of initiatives and new ways of working to respond to the pandemic. At the same time, the Trust did all it could to continue to care for patients, including transferring planned surgery and treatment to other NHS providers and private hospitals who were less impacted by Covid-19. The Trust also transformed its outpatient appointments into primarily telephone and video consultations. The scale of the effort could be seen in some of the operational data provided within the report. Prof. Orchard was pleased to report that the numbers were decreasing following the peak on 8th April. Just before Easter, the Trust had 346 inpatient Covid-19 cases and as at 20th May 2020, the Trust had 130 Covid-19 inpatients of which 27 were on ventilation which had significantly decreased compared to 132 at the time of the peak. The Trust was beginning to step down much of its surge intensive care capacity, although additional capacity would be maintained for the longer term as part of wider London plans. The Trust was able to respond well to the pandemic due to the commitment and expertise of its staff and closer working relationship with partners, and with the support and goodwill of individuals, businesses, partners, Imperial Health Charity and Imperial College, to all of whom Prof. Orchard was grateful to. He was particularly grateful to clinical and non-clinical staff throughout the organisation and their commitment and effort, especially those who were personally affected. The Trust was concerned with the disproportionate impact of Covid-19 on the Black, Asian and Minority Ethnic (BAME) groups within the population and NHS workforce. The numbers being admitted to intensive care were exceptionally higher, reflective of the local population. Additional measures were in place to support and protect the Trust's BAME staff. In response to Mr Ross' question about protecting staff in proportion to their risk, Prof. Orchard confirmed that risk assessments, taking into account particular factors, were taking place for the BAME staff. Given the Trust has a large BAME diverse group of staff, Mr Goldsbrough enquired whether more insight was available around the dramatically different observed outcomes and incident levels for this group of people. Prof. Orchard advised that continued analysis would provide more insight and currently for the Trust's local population, it appeared that the South Asian community numbers were high, and generally there appeared to be a strong link with diabetic patients. Prof. Redhead advised that the national inquiry would assist with delving into the detail and the compounding factors. Prof. Orchard outlined some of the changes and developments in response to the pandemic which included the establishment of a daily Clinical Reference Group chaired by Prof. Redhead; temporary services changes; procurement and use of Personal Protective Equipment (PPE); patient and staff testing noting that NWL Pathology's contribution had been exceptional; a dedicated HR guidance line; staff and wellbeing programme; new staff, patient and public

	communications; and roll out of Microsoft Teams. Work was underway to support redeployed staff back to their origin of work.
7.2.7.	Given the peak had passed, a programme of work had commenced to learn lessons from the response to the pandemic and ascertain what changes generated benefits for patients and staff that the Trust could build upon, which also included collaboration with London-wide providers. The Trust was working through the implications for patient waiting times and how best it resumes planned care and other elements of overall organisational work, mindful of ongoing risks from Coronavirus and the likelihood of further peaks in the months ahead, thereby being better prepared for future waves.
7.2.8.	The Trust was also analysing some of the unintended consequences of Covid-19 on the wider health and care including a decline in patients attending A&Es, stroke units and heart attack centres for care unrelated to Covid-19. Of concern was that the Trust had seen an excess in overall all-cause mortality. The Trust was supporting a national campaign to raise awareness that it remained open to provide safe care for anyone with urgent and emergency health needs. Prof. Orchard stressed that anyone needing to come to A&E would be seen via a non-Covid pathway which was completely separate to Covid pathways therefore anyone concerned about their health should seek the appropriate healthcare. Although the Western Eye Hospital had to be closed due to redeployment of staff, it would re-open soon.
7.3.	<u>Hotel services</u>
7.3.1.	The transition of over 1,000 cleaning, catering and portering staff from Sodexo to the Trust on 1st April 2020 had gone smoothly. Prof. Orchard acknowledged the commitment from both the management team and staff to making the transition a success. The Board expressed their gratitude to Mr Gostling and his team for the phenomenal work done to on-board the hotel services staff during an exceptionally difficult time as the Trust responded to the Coronavirus pandemic. The Trust would run Hotel services for one year in order to establish the long term viability of the model.
7.3.2.	Sir Gerry acknowledged that at November's Board meeting, the Board made a commitment to a group of Sodexo staff and Union members to review the contractual issues and subsequently made a decision to bringing hotel services in-house for a period of one year. Given the long standing issues, if the decision had not been taken to bring the service in-house, this could have adversely impacted the response to the pandemic - it was clearly a good decision. Prof. Orchard concurred and commented that the positive response was a testament to the facilities team and hotel services staff.
7.3.3.	Given the Trust was going through a significant change management process, Ms Boycott commented that it would be useful to draw out the success factors that could be learnt from and how they were different this time and possibly retained. Prof. Orchard commented that the determination by the management team involved sourcing the right level of external expertise and building a strong coalition across the Trust in order to make the change - these were the success factors. Fundamentally, the management team and staff who were in transition were committed to making it work.
7.4.	<u>Redevelopment</u>
7.4.1.	The Trust continued to work with Sellar during the exclusivity period to develop the proposals for the new St. Mary's hospital. A design team was appointed who were working on the response to the Trust's outline brief which highlighted a number of expected issues which the design team and the Trust team were working through. The Trust continues to advance the Business Case and has regular dialogue with colleagues at NHS Improvement (NHSI). The Trust remained on-track to submit the Strategic Outline Case during the summer with the Outline Business Case programme for early 2021. An engagement and involvement strategy was also being developed to reflect new requirements around social distancing and avoiding contact. The Board noted that although progress was being made, the project was challenging both from a cost and project management view.
7.5.	<u>Research and innovation</u>
7.5.1.	Prof. Orchard was pleased to announce that the Trust was successful in renewing its

	membership with Academic Health Science Centre from 1st April 2020 for another five years.
7.5.2.	Led by NIHR Imperial Biomedical Research Centre and Academic Health Science Centre (AHSC), the Trust continued to be active in research directed towards the diagnosis and treatment of Covid-19. The aim was for every patient with Covid-19, admitted to ICHT hospitals, to be offered the opportunity to be part of one of the research trials or studies that were running at Imperial. The Trust also commenced work at the Hammersmith Clinical Research Facility to support the Oxford Vaccine Centre's Covid-19 vaccine trial, which was being run by the Jenner Institute and Oxford Vaccine Group. An Imperial led clinical trial on a second vaccine, led by Prof Robin Shattock, was due to commence in June. The Trust was also engaged in the rapid uptake of innovative approaches to care across many of its clinical teams and support services.
7.6. 7.6.1.	<u>Stakeholder engagement</u> The Trust's programme of contact meetings with key stakeholders had been suspended due to the Covid-19 response, however the Trust had been keeping its stakeholders up to date on developments. **The Board noted the report from the Chief Executive.**
8. 8.1.	**Response to the Coronavirus pandemic and plans for reset and recovery** Building on the update provided in the CEO's report and a detailed discussion at the private Board meeting, the report was taken as read. The report set out the actions the Trust had taken in response to the coronavirus pandemic, including governance arrangements, issues and risks that would need to be managed; and next steps for planning reset and recovery taking into consideration learning, changes and how risks were managed.
8.2.	The recovery and reset programme and approach would need to sit within the strategic context of the organisation and the external environment. The strategic direction would need to build on the work done at the February Board Seminar around the Imperial Way, strategy, programmes, priorities and projects, which would be revisited at a future Board Seminar. The assumption was that the strategic goals of the Trust would remain the same, however the programmes and priorities likely to change as a result of Covid-19.
8.3.	Mr Goldsbrough enquired whether the Trust had settled on an optimal testing strategy for Trust staff. Prof. Orchard advised this would be agreed across the sector to ensure consistency; also important to work out what the difference was in testing regimes for Covid protected pathways and Covid risk managed pathways; and antibody testing. Dr Klaber was working with NWL Pathology and Kathy Kale, Hillingdon Hospital, to work this through as it was important and urgent. Prof. Redhead advised that the antibody test was likely to commence week commencing 25th May 2020 but waiting for details from the national team. **The Board noted the report.**
9. 9.1. 9.1.1.	**Finance** **Approval of annual accounts, annual report and quality account** The Board noted the process for the approval of the annual accounts, annual report and quality account and **approved** the delegation of authority to the Audit, Risk and Governance Committee to approve the submission of these documents on behalf of the Board. Sir Gerry thanked Ms Thind, Mr Doyin Ogunbiyi and the accounting team for their tremendous contribution and effort working on the accounts during an unprecedented crisis and also thanked the auditors who had been supportive of the process during this time.
9.2. 9.2.1.	**Finance report** The Trust ended the 2019/20 financial year £0.1m better than the control total, not including Provider Sustainability Funding (PSF) and allowed adjustments. The Trust therefore received PSF in year of £16.8m with an additional £01.m relating to 2018/19. The Trust spent £51.7m on capital against a CRL of £51.8m and it ended the year with £44.9m of cash in the bank and met the External Financing Limit. The Trust received central funding in March for additional costs incurred to manage the Covid-19 response. This excluded £2.6m estimated cost relating to annual leave carried forward due to Covid-19 and had not been funded centrally but agreed that it would not count towards the delivery of the control total.

9.2.2.	The Trust had previously been working on a business planning process for 2020/21 which had been paused due to Covid-19 and now subject to a new national financial regime until 31st October 2020. As a result the Trust was moved to a block contract for the first seven months of 2020/21 and expected top up payment to achieve a break even position. The Trust would need to continue to maintain financial control and demonstrate its decision making, linked to operationally critical expenditure during this time.
9.2.3.	Mr Ross commented that whilst ICHT had achieved its control total, other Trusts had possibly not and given fiscal restrains had been cancelled, did that mean ICHT had been more responsible but would not gain any recognition for it. Ms Thind was not aware of control total positions across the sector, however the focus was on completing 2019/20 and she had not heard anything untoward. Trusts were asked to submit the level of resources required to meet their control total and were asked to set out the additional costs and income lost due to Covid-19, and those requests were made good in most instances. Prof. Orchard commented that the expectation for 2019/20 was for Trusts to meet their control total and for 2020/21 the financial arrangements would be different with increased scrutiny of Covid-19 related costs. By meeting the control total and demonstrating that the Trust took it seriously, places the Trust in good stead.
9.2.4.	Ms Thind outlined the capital regime for 2020/21. Previously organisations had their own delegated capital limits and under the new financial regime this would be issued at STP level. The ask of the centre was that Trusts think about capital resource in the system and the decisions Trusts make must support the system needs and changes to pathways, and other changes post Covid-19. For the NW London sector, there was a gap between the allocation and the draft plan submitted in March and teams were going through a ratification and reconciliation process across the sector to understand whether that gap could be mitigated. A point would be reached requiring Board decision around the residual gap and what the Trust could afford to do within that limit. Therefore Ms Thind alerted the Board to the process by which the ICS would be asked to report its capital plan within its limit and the decisions needed to achieve the plan. However as the next Board was not until July, it was agreed, if needed, an Extraordinary Finance, Investment and Operations Committee (FIOC) would be convened with delegated authority to make decisions around the capital plan. All Board members would be invited to the Committee. **Action: Ms Thind**
9.2.5.	Dr Raffel stressed the need to maintain discipline on costs and efficiencies. Ms Thind welcomed the comment. In terms of revenue, she advised that until the end of October or end of the year, the Trust would be on a block contract and top-up system resulting in thorough scrutiny of returns. Therefore maintaining discipline was essential and examples included the Trust not approving any new resource unless business critical thereby making efficient use of current resource. Ms Thind stressed the need to concentrate on 2021/22 planning during 2020/21, however until post Covid-19 changes could be articulated, the Trust could not articulate the figures and therefore levelling up resource was a key area. Once the financial model becomes available, there would be more clarity for Trusts and the ICS.
9.2.6.	Ms Thind informed the Board that the Finance Report would be revamped with a rounded view around money, given the changes. This would be regularly discussed at FIOC. **The Board noted the report.**
10.	**Integrated Quality and Performance report (IQPR)** The Board noted the key headlines relating to performance for month 12. Exception slides provided within the report covered other scorecard metrics.
10.1. 10.1.1.	**Imperial Management and Improvement System** (**IMIS) scorecard** At the last meeting of the Trust Board the Board received an update on the implementation plan for the IMIS and agreed that performance data for March 2020 would be presented in both the existing IQPR format and in the proposed new IMIS format. The new proposed IMIS format was provided and the scorecard would be further developed during 2020/21 to include monitoring of the Trust-level focussed improvements and metrics associated with the delivery of priority programmes and projects. A near final draft of the IMIS report would be available for the next Board.

10.2.	**Performance summary at month 12**
10.2.1.	As anticipated, performance against a number of the access standards had been negatively impacted as a result of Covid-19.
10.2.2.	The overall Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) scores were positive and the Trust remained in the top five hospitals in terms of their safety profiles.
10.2.3.	The reporting of Referral to Treatment (RTT) performance data continued nationally in order to maintain continuity and support recovery of the waiting list position. In March 2020, the overall size of the Trust RTT waiting list reduced by 6%. This reduction was driven by multiple factors linked to the Covid-19 response, including a reduction in referrals, optimised use of advice and guidance to GPs and operational delays with checking patients in and out. In March 2020, 10 patients were waiting for more than 52 weeks for treatment and the Trust expected long waiter breaches to increase in the immediate term.
10.2.4.	The size of the cancer waiting list reduced by approximately 37% and the number of cancer two week wait referrals reduced by 78%, compared with the position at the end of February 2020. Similar reductions in demand had been seen at all of the Trusts in the Royal Marsden Provider Alliance.
10.2.5.	The diagnostics waiting times performance reduced to 8% of patients waiting for their diagnostic test. There was also a reduction in referrals and a number of imaging cases put on hold.
10.2.6.	The Trust was reviewing all waiting list information to ensure that during the recent extraordinary changes to elective care management, there was consistency in RTT recording and reporting, where patients have had their appointment cancelled or delayed. The processes to manage potential risk to patient care were set out and monitored through Trust clinical policy in relation to the coronavirus response. Mrs Hook assured the Board that the Trust has robust mechanisms in place which were being audited, to ensure that the Trust knows where every patient is on their pathway so that when the Trust is ready to reinstate its elective work, it could do so according to priority, with confidence.
10.2.7.	The Trust was also collating and reviewing all elective waiting lists to understand service level demand. This information was being reviewed as part of a sector-wide approach to recovery. Although continuing to improve elective performance would remain important, booking would be done according to latest assessment of risk and clinical priority and not necessarily in order of length of wait.
10.2.8.	The number of patients waiting for over 12 hours in the Trust's emergency departments from the decision to admit to admission, increased significantly in March 2020. 122 of the 135 breaches occurred at St Mary's Hospital and were related to the need to isolate patients on admission.
10.2.9.	One of the new metrics within the IMIS scorecard was bed occupancy. The average bed occupancy was 82% for March 2020 and 73% for April 2020. This level of occupancy reflected a reduction in elective activity and in non-elective activity that was not Covid-19 related.
10.2.10.	Incident reporting rates were not provided for March 2020 but would be included in the next report to Board. Given changes in the Trust's bed base due to Covid-19, the March incident reporting rate would be erroneously affected. The crude number of incidents reported reduced in March 2020. The reduction was linked to a reduction in activity across a number of Trust specialties. Additional corporate support was in place to encourage and support staff to report incidents.
10.2.11.	The Trust's harm profile remained good and the proportion of moderate and above incidents this year was below the target threshold.
10.2.12.	Mr Goldsbrough enquired over the next quarter, what particular KPIs the Board should focus on, noting that waiting time in A&E would be one to monitor; and also requested to understand the

	rationale for including and excluding metrics on the scorecard. Prof. Redhead advised that the safety and quality metrics were essential metrics, and going forward he suggested metrics would be needed around reset and recovery including innovations such as virtual appointments. Mrs Hook advised that the KPI to keep closely monitored would be the waiting times in the emergency department (ED) which would provide a good indication of whether the Trust has the balance right of its pathways in terms Covid positive and Covid risk managed patients and the level of capacity to accommodate those, as it would be important not to have patients waiting in EDs if it could be avoided. She advised that the refresh of the programmes and projects would set out the metrics and she would make clear which were regulatory. **Action: Mrs Hook**
10.2.13.	In response to Ms Vennells' query about site led KPIs and whether there were two or three that could be combined to give an overall performance of each site, the Executive would give some thought to the request, as the current metrics could easily be split by site. **Action: Mrs Hook**
10.2.14.	Dr Raffel enquired how the Board would receive assurance that the Trust was getting back to a normal state. Prof. Redhead advised that this would be dependent on the size of the backlog of the Patient Treatment List (PTL) and in order to care for those patients across the sector, Trusts need to look at prioritising those patients across London in a standardised way. The Royal College of Surgeons published a methodology for prioritisation identifying five/six categories in which patients could be placed in order of urgency of their need. This methodology had been taken further to look at potential harm and how that affected prioritisation. These factors would place patients into a PTL based on need for treatment and that PTL would be repeated across the sector using up all of the estate and facilities to help treat patients across the sector. **The Board noted the update.**
11.	**Annual self-certification for NHS Trusts**
11.1.	In response to the Covid pandemic, NHSI relaxed the requirement for Trusts to submit their declarations centrally, but the requirement for self-certification remained. The Executive team reviewed the assurance statements and the proposed compliance declarations and recommended the proposed declarations for the two conditions contained within Appendix 1 to the Trust Board for approval.
11.2.	The Board **approved** the recommendation that the Trust confirms 'compliance' with Condition G6. In terms of Condition FT4 (4a), despite the progress made by the Trust in performance, recognised by NHSI/E through removal of the Trust undertakings and improvement of the Trust segmentation, there are continuing risks to the Trust ensuring compliance with the Trust's duty to operate efficiently, economically and effectively. Although the recommendation in the report was for the Trust to declare 'not confirmed', following further discussion at the Executive meeting on 19th May 2020, the recommendation was to declare 'partial-compliance' as positive improvements had been made and the text in the submission would be updated. The Board **approved** partial-compliance submission for FT4 (4a).
12.	**Hotel services transition update**
12.1.	Following on from Item 7, Mr Gostling thanked the Board for their support to the transition and to colleagues and all who were involved to make the transition a success. Ms Vennells acknowledged Mr Gostling's and Prof. Orchard's leadership in driving this project given the Covid-19 pandemic circumstances.
12.2.	Mr Gostling advised that the Trust was now in phase two 'stabilisation' of the project and advised that the areas of focus included ensuring pay was correct for hotel services staff as well as training and Disclosure and Barring Service (DBS) records.
12.3.	The Board agreed to receive a progress update on the service in September 2020, noting that the Trust would only consider outsourcing if the service was not performing or due to increased costs, mindful of the significant effort to bring the service in-house and staff morale. **Action: Mr Gostling**
12.4.	Sir Gerry enquired whether the Trust should enter the public debate on the government's visa

	proposals for overseas workers for its workforce in this category. Mr Gostling advised that the checks conducted for hotel services staff ensured the overseas workers have a right to work permit.
12.5.	Dr Raffel asked whether all that Sodexo were contractually obliged to do during the transition, had been done. Mr Gostling confirmed they had.
12.6.	Mr Goldsbrough suggested that the factors that made this transition a success should be used to test every change initiative i.e. the Trust had the right people and resources; built a coalition of the willing; and there was an absolute leadership commitment to make it work. Prof. Orchard agreed and added that everyone had the commitment not just the management and the Trust had the support of the Union. Prof. Orchard agreed that this would be picked up as part of the lessons learnt. **The Board noted the update.**
13.	**Infection Prevention and Control (IPC) report**
13.1.	The report was taken as read and the Board noted the quarter 4 2019/20 update. Prof. Redhead drew the Board's attention to the hard work by the IPC team in response to Covid-19 and the impressive work they had done to help keep staff and patients safe through a difficult landscape. He commented that the research and innovation that had gone on around infection control with Imperial college and AHSC had been an important factor in infection control.
13.2.	Ms Boycott observed that it was obvious through discussions how difficult the landscape was to navigate through, and recognised the extraordinary work to date acknowledging as the Trust goes into recovery with different pathways and different groups of patients, complexity would further increase. She commented that 12 weeks ago everyone knew how to wash hands yet there had been very little attention on this over the recent weeks. Given that the norms would change she suggested the Quality Committee look at the way in which infection is seen going forward and from a risk point of view, a conversion needed around how risk would be managed going forward. Prof. Redhead agreed that a discussion at Quality Committee would be helpful and Prof. Bush would lead on this. He assured the Board that the Trust had been talking a lot about handwashing and appropriate use of PPE but the challenge was the interpretation of all the different recommendations coming through from a large number of different bodies, and putting those into practice within the Trust had been a challenge. Prof. Orchard stressed the point about hand washing as focus in media had recently been around face coverings but the single most important thing is to wash hands throughout the day. **Action: Prof. Redhead, Prof. Bush**
13.3.	Mr Goldsbrough enquired, whether a year from now, would the way infection control is managed be different? Prof. Redhead advised that there would be continued focus on the fundamentals of infection control in a whole heath service approach with the need to be more rigorous in controlling infection. The focus on infection in health and social care would increase.
13.4.	Mr Goldsbrough asked whether the number of patients in hospitals would need to reduce in the interests of infection control. Prof. Redhead advised that the Trust would need to await guidance from the centre. Likely that pathways would change and the ability to move patients through those pathways would be limited and precautions taken in procedures. New hospital builds would take into account high consequence infections.
13.5.	Dr Maruthappu requested to see data by site for infection in subsequent reports or outside of the meeting. Prof. Redhead confirmed this was possible and he would arrange. **Action: Prof. Redhead / Alison Holmes**
14.	**Annual Trust seal report** The Board noted the use of the Trust seal over 2019/20.
15.	**Annual Declarations of interest report** The Board noted the interests of the Board which would be published on the Trust's website.
16.	**Trust Board Committees – summary reports**
16.1. 16.1.1.	**Audit Risk and Governance Committee** The Board noted the summary points from the meeting held on 29th April 2020.

16.2. 16.2.1.	**Quality Committee** The Board noted the summary points from the meeting held on 29th April 2020.
16.3.	**Finance, Investment and Operations Committee** The Board noted the summary points from the meeting held on 13th May 2020.
16.4.	**Board Redevelopment Committee** The Board noted the summary points from the meeting held on 15th April 2020.
17. 17.1.	**Any other business** Ms Vennells expressed her gratitude to technical teams for all their support and making it possible for meetings to be held virtually. Prof. Orchard would relay the Board's gratitude. **Action: Prof. Orchard**
18. 18.1.	**Questions from the public** A number of questions were received from members of the public ahead of the meeting which were themed as below. A written response to each of the questions would be provided to the individual and added to the Trust's website. a) Covid - relating to online appointments, testing, staff support and wellbeing, deferred treatment, informed consent for trials and vaccinations, and gratitude expressed to Trust staff and the NHS. b) Redevelopment programme and particularly the Trust's public engagement process. c) Saving money strategies and improving services for the disabled and other patients. Mr Croft, Director of People and OD was in touch with Abdifatah Dhuhulow.
18.2.	In terms of the question relating to the Trust Chair, Prof. Orchard advised that as previously discussed at public Board meetings, Ms Vennells was appointed by NHS Improvement who conducted a fit and proper persons regulation test at the time. The Trust had since reviewed the application of this test based on information available currently and remains satisfied. Ms Vennells continues to be committed and engaged in supporting the Executive team to develop and deliver the organisation's strategy in line with its values. Ms Vennells had been fully engaged in the Trust's response to the pandemic and had held daily calls with the Chief Executive, as well as overseeing other Board level governance, including weekly virtual meetings held with Non-executive Directors.
18.3.	Prof. Orchard outlined key points covering the Covid related questions, some of which were covered in his report at item 7. The Trust would not want to lose benefits and was looking at technical possibilities of online appointments and other innovations. Focus was on pathways and deferred treatment. If all goes to plan, in a year's time, patients with long term conditions would be managed more effectively. Deferred patients would be assessed via a clinical harm review by the Medical Director's Office to get prioritisation right. This Trust and other Trusts were making sure as much urgent work gets done as soon as possible including cancer and surgery, however some treatments would need to be balanced against the risk of Covid. Regarding recovery, there was a substantial amount to cover and a sector wide response required using every facility at its disposal to work through the backlog and in doing so also provide a level of confidence to elective patients that mechanisms are in place to protect them from Covid.
18.4.	In terms of care homes, Prof. Orchard responded that North West London as a sector was doing a lot to support care homes with daily interventions and each care home had been buddied up with a Trust. Strong relationships in place with local authorities to get the discharge right.
18.5.	Prof. Orchard reassured members of the public that the Trust takes informed consent for all trials and vaccinations. The Trust's Research Committee meets fortnightly, scrutinising each proposal whilst adhering to high ethical standards.
18.6.	In terms of Redevelopment, Prof. Orchard stated that the Trust was at an early stage of redevelopment and clearly important it builds the right hospital to serve local communities as effectively as possible. Key stakeholders were engaged and as the programme progresses, wider engagement with local communities would be arranged.
19.	**Date of next meeting** 29th July 2020, 11am, Virtual meeting

Updated: 10 July 2020

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TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Record of items discussed at the confidential Trust board meeting held on 20 May and 24 June 2020	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 29th July 2020	**Item 5, report no. 02**
Responsible Executive Director: Professor Tim Orchard, chief executive officer	**Author:** Peter Jenkinson, Director of corporate governance

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

May 2020

Covid-19
The Board thanked the Clinical Directors and Executive Team for their work and contribution during the past weeks in response to the pandemic, and to Mrs Hook and Prof. Redhead for covering whilst Prof. Orchard was recovering from Covid-19.

The Board received an update on the Covid-19 pandemic reflecting on the Trust's response, current activity including status of ICU beds, plans to returning to business as usual where possible including focus on elective work and prioritisation of deferred treatment, standing down staff from deployment, activities around staff health and wellbeing, pairing arrangements with care homes, testing and considering lasting benefits at Trust level and across the sector.

SMH Redevelopment programme
The Board received an update on the Strategic Outline Case which was being developed for submission in July. The Board received an update on the commercial aspects, design, decant discussions, planning and capital costs.

Annual accounts
The Board noted the points for the Trust to consider, following a meeting between the Audit Committee Chair and the Auditors.

Imperial College London
The Board noted the oral update provided by the Dean of the Faculty of Medicine, Imperial College London, regarding the impact of Covid-19 on the College and Universities in general.

June 2020

The Board met in seminar mode in June 2020 and discussed the impact of Covid-19 on the local population health, changes in the needs of the local population and the health inequalities within our communities and population in NWL. The Board considered and agreed the importance of

prioritising major focus on equality and diversity of our workforce, with a specific focus on NHS Workforce Race Equality Standard (WRES). The Board also discussed the development of an integrated care system (ICS) in NW London and the role of the Trust, and the Trust Board in this development, considering how the Trust's internal governance processes, including our Board committees, relate to this development.
Recommendations: The Trust board is asked to note this report.

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC) - ACTION POINTS REGISTER, Date of last meeting 20 May 2020

Updated: 24 July 2020

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	29 January 2020 17.3 20 May 2020 6	Pathway to excellence	Sir Gerald Acher also congratulated the directorate and suggested this is brought to the attention of North West London colleagues and included in a communications exercise/bulletin. May 2020 update: Prof. Sigsworth advised that this was currently on hold but would take stock in the coming weeks with the Executive team. July 2020 update: Oral update	Janice Sigsworth	July 2020
2.	29 January 2020 9.5	Integrated Quality and Performance Report – Diagnostics	Prof. Teoh informed the Board that in November and December 2019, the diagnostic target had not been met with a 175% increase in ultrasounds as the seasonable variation had increased. He was working with the CCGs to address this and he would report back to Board on discussions. March 2020 update: Contact made with the CCG but focus currently on Covid-19. July 2020 update: Oral update	TG Teoh	July 2020
3.	27 November 2019 9 25 March 2020 8	Strategic development – Implementation of a management system (The Imperial Way	November 2019: Claire Hook highlighted that the proposed approach to delivering the Trusts strategy in a standardised way, linking in with the Trusts values and behaviours. Board members discussed the programme and agreed whilst they all supported the proposal, that there needed to be a clear and practical way of delivering it, with it being collectively owned by the executive team. The Board approved the Imperial management system (working title 'the Imperial Way') and noted the process for agreeing priorities for 2020/21 and the process for delivery of the 2019/20 objectives. An update outlining the delivery process and risks would be presented to a future board meeting. March 2020 update: The Board received a summary of the proposed priorities for the Trust for 2020/21 as discussed in the February 2020 Board strategy seminar and taking into consideration the evolution of priorities in response to Covid-19. The Board would be kept updated on changes. July 2020 update: Covered on main agenda item.	Tim Orchard/Claire Hook, Bob Klaber, Peter Jenkinson	July 2020

4.	29 January 2020 14.6	Employee metrics matrix (arising from FTSU item)	Ms Boycott suggested a joined up matrix capturing employee experience such as concerns arising from staff survey, and concerns raised via other sources including FTSU. Other Non-executive Directors agreed and suggested including excellence awards and staff stories to Board in the employee experience piece. Mr Croft would give some thought to this. July 2020 update: The People and OD team are currently working on setting back up the culture programme and the people metrics that will be used in the Imperial Management and Improvement System. This will include directorate level dashboards relevant to this item. It is proposed this is considered in September once this work has progressed through the executive and the relevant Board Committee.	Kevin Croft	July 2020
5.	29 January 2020 7.3	Patient story review	January 2020: Prof. Sigsworth welcomed the comments and would discuss a plan with the Strategic Lay Forum, Executive Quality Committee and Quality Board Committee with a next steps plan to Board in summer. July 2020 update: Deferred to September.	Janice Sigsworth	July 2020
6.	20 May 2020 9.2.4	Capital regime for 2020/21 (arising from Finance report)	A point would be reached requiring Board decision around the residual gap and what the Trust could afford to do within that limit. As the next Board was not until July, it was agreed, if needed, an Extraordinary Finance, Investment and Operations Committee (FIOC) would be convened with delegated authority to make decisions around the capital plan. All Board members would be invited to the Committee July 2020 update: The NWL sector undertook a review of all capital schemes which resulted in the ICS remaining within its CRL of £290m. The Trust's CRL remained as per plan thereby negating the need to convene an extra ordinary meeting of FIOC.	Jazz Thind	July 2020
7.	20 May 2020 10.2.12-13	Performance score card metrics	a) The refresh of the programmes and projects would set out the metrics and Mrs Hook would make clear which were regulatory. b) In response to Ms Vennells' query about site led KPIs and whether there were two or three that could be combined to give an overall performance of each site, the Executive would give some thought to the request, as the current metrics could easily be split by site. July 2020 update: a) Covered on main agenda item. b) Covered on main agenda item.	Claire Hook	July 2020
8.	20 May 2020 13.2	Infection risk (arising from IPC report)	Given that the norms would change Ms Boycott suggested the Quality Committee look at the way in which infection is seen going forward and from a risk point of view, a conversion needed around how risk would be managed going forward. Prof. Redhead agreed that a discussion at Quality Committee would be helpful and Prof. Bush would lead on this. July 2020 update: Oral update	Prof. Redhead	July 2020
9.	20 May 2020 13.5	Infection data by site (arising from IPC report)	Dr Maruthappu requested to see data by site for infection in subsequent reports or outside of the meeting. Prof. Redhead confirmed this was possible and he would arrange. July 2020 update: Oral update	Prof. Redhead	July 2020
10.	20 May 2020 12.3	Hotel services transition	The Board agreed to receive a progress update on the service in September 2020, noting that the Trust would only consider outsourcing if the service was not performing or due to increased costs, mindful of the significant effort to bring the service in-house and staff morale.	Hugh Gostling	September 2020

11.	25 March 2020 9.4	Sustainable development management plan	The Board endorsed the plan and the ambition, and asked the Executive Team to review and include more granularity around key aspects and then submit to the Board Redevelopment Committee when ready. The report to also include it would need a rolling plan as it would evolve over time. May 2020 update: Planned for December 2020 Redevelopment Board Committee	Hugh Gostling	December 2020

Items closed at the May 2020 meeting

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.					

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

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Chief Executive Officer's Report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 29 July 2020	**Item 7, report no. 04**
Responsible Executive Director: Prof Tim Orchard, Chief Executive Officer	**Author:** Prof Tim Orchard, Chief Executive Officer

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

1) COVID-19 and reset / recovery
2) CQC Update
3) Hotel Services direct employment
4) Financial performance
5) Operational performance
6) Strategic development
7) Research and innovation
8) Stakeholder engagement

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

This report has been discussed at: N/A

Quality impact: N/A

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

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

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

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

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

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

Trust strategic goals supported by this paper:

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

Chief Executive's Report to Trust Board

1. Covid-19

1.1 Overview

As of Tuesday 21 July, we were caring for 29 inpatients who have tested positive for Covid-19 on their current admission to hospital. None of these patients needed to be on a ventilator in intensive care. As of 21 July treated 1,792 patients with COVID-19: 1,355 patients have been helped to recover from Covid-19 and be discharged and we have reported 427 deaths of patients positive for Covid-19 via NHS England. Really encouragingly, we have not reported any deaths for over two weeks.

1.2 Recovery and reset

The recovery and reset portfolio was launched on 1 June 2020 to ensure positive changes from the pandemic could be built upon and embedded for pathways, models of care, ways of working and staff and patient support. It is also essential that we are able to resume our planned care as quickly as possible, provide urgent and emergency care for everyone who needs us and are prepared for any future peaks in infection as well as general increased demand in the winter, all while ensuring the safety and wellbeing of our staff, patients and visitors. The recovery and reset programme will also ensure lessons are learned from our initial response, using insights to drive future developments.

There are a number of projects and programmes delivering on these priorities, underpinned by the operations workstream which includes: site restoration; elective recovery; urgent and emergency care; and diagnostics recovery. Like the rest of the NHS, our recovery will take some time as we have to ensure we maximise infection prevention and control.

Progress to date includes:

Site restoration: there is a major programme of work underway to establish the right service provision for each of our sites as part of our longer term response to Covid-19. In particular, we have to identify and separate out: 'Covid-protected' and 'Covid-risk-managed pathways. Protected pathways are for as much of our planned care as possible, ensuring that patients and staff do not have - and are not exposed to - Covid-19. While for risk-managed pathways – for our urgent and emergency care and most outpatient care, we have to assume initially that patients may have been exposed to Covid-19.

We're looking to:

- to make the majority of Hammersmith Hospital Covid-protected, providing planned specialist care (so far, part of A block has been established as Covid-protected)
- to create a mixture of protected and-risk managed areas at Charing Cross and the Western Eye, enabling some planned surgery and procedures as well as urgent and emergency care (so far, Riverside theatres at Charing Cross and part of the Western Eye have been established as Covid-protected)
- for Queen Charlotte's and Chelsea to continue as a primarily Covid-risk-managed facility
- run most of St Mary's services as Covid-risk-managed, reflecting its position as a major trauma centre.

This means exploring potential service moves, building adaptations and new ways of working and we will be engaging with wider staff, patients and stakeholders over the coming weeks to help determine the best approach. As well as protecting patients, staff and visitors right now, we need to make sure we are prepared for possible further peaks of Covid-19 infections and the certain increase in urgent and emergency care demand over the winter. We also want to make sure that any changes help us deliver our wider organisational strategy, wherever possible.

Keeping our staff and patients safe: we have implemented a programme of individual risk assessments for our staff, to assess their safety at work. As of 24 July, we have completed risk assessments for 90% of our staff. We have also implemented a programme of action and review of staff work spaces to determine whether they can be categorised as COVID-secure areas. In all other

staff and public areas, all staff and public are required to wear face coverings and we provide appropriate hand sanitiser.

Testing: A programme of staff and patient testing has been implemented. As well as on-site symptomatic testing for staff and routine testing for all A&E and inpatients, we have established a regular testing regime for staff working in Covid-protected areas and areas where we have particularly vulnerable patients.

Critical care: We've undertaken modelling to understand the requirements for a permanent increase in critical care beds and surge capacity across our sites. We are developing plans to enable increased, safe and equitable access to critical care across all three pathway types (Covid-risk-managed, Covid-protected and Covid-positive) for both elective and emergency patients.

Diagnostic recovery: To enable diagnostic recovery, performance for national reporting has been baselined and the position on testing availability for pre/post Covid has been identified. A prioritisation process for scheduling work going forward has been agreed and there has also been a focus on identifying services who are using the independent sector capacity for diagnostics.

Urgent and emergency care: We have submitted a bid to NHS England for capital to support social distancing in our emergency departments and same day emergency care.

Elective recovery: a number of elective surgical pathways have resumed and Cerner surgical forms are now live for referral to treatment processes and planned patients and theatre availability is on track.

There are a number of key challenges, especially to ensure we are fully aligned across the North West London integrated care system on capacity planning, performance and financial forecasting.

1.3 Staff support and wellbeing Covid-19 legacy programme

At an early stage in the pandemic, in partnership with Imperial Health Charity, we were able to establish an enhanced programme of staff support. This included delivering 170,000 meals and 7,000 wellbeing gifts and providing over 3,500 nights of hotel accommodation in the three months to the end of June. We also increased the emotional and wellbeing support on offer in response to the big workloads and very challenging situations that many of you experienced.

Overall, the Charity raised over £2.7m with its Covid-19 relief fund and NHS Charities Together raised £130m nationally, not least through the amazing efforts of centenarian Captain – now Sir – Tom Moore. Our Charity also adapted its volunteer service, with 358 volunteers providing over 11,000 hours of support on site.

As we came to the end of our initial Covid-19 response in May, we asked for staff views and ideas on the changes and what we should take forward. One of the most common responses was that we should continue to have a focus on staff support - on the facilities and resources that make staff feel valued and that enable them to do their best in looking after patients and colleagues.

Even before Covid-19, we had recognised the need to do much better on valuing and supporting our staff, especially those from black, Asian and minority ethnic backgrounds who are disproportionately represented in our lower banded roles. It came through in some of our otherwise rapidly improving staff survey results and in feedback about the key barriers to living our values. We also looked at the evidence for how best to help our people deal with the longer term impacts and how we could be best prepared for any future peaks in infections.

We're therefore very pleased to be able to announce a new £1.7m Covid-19 legacy staff support programme to be launched formally in September, allowing for further input from staff and partners. In partnership with Imperial Health Charity, the programme will deliver improvements in three key areas:

- Staff spaces: we have over £1.2 million to bring all of our staff rest rooms, changing areas, shower rooms and kitchens up to a consistent and high quality standard and to meet any

significant gaps. We're also exploring free basic provisions for our staff restrooms and possible 'flagship' staff areas on each of our main sites.
- Food and shops: we're undertaking a comprehensive review of our food and shops offer for staff – and visitors. With the support of Help NHS Heroes, we've been able to continue with an improved offer through the summer, to give us time to get our permanent offer right.
- Emotional wellbeing – we're doubling our counselling resource and expanding our wellbeing offer for at least the next 12 months, responding to the increased need for support and training.

We are planning for a week of virtual activities 14-18 September to recognise, reflect on and remember what has happened and what has been achieved since the beginning of the pandemic as well as the challenges and opportunities ahead. We particularly want to thank all of our staff, volunteers and donors for the extraordinary response. The week will also incorporate our delayed Make a difference and longs service awards.

2. Strategic development

In March 2019 Board approved our organisational vision and strategic goals, and in the 12 months that followed we worked to develop greater prioritisation around the key programmes, projects and focused improvements that we believe will take us towards our long-term goals. We introduced a new business planning process and began the implementation of the Imperial management and improvement system (IMIS) as a mechanism for greater measurement, rigour and continuous improvement across every level of the organisation.

From early March 2020 almost all of our focus as an organisation moved to the emergency operational and clinical response to the COVID-19 pandemic. This period of intense work, great uncertainty and rapid learning has had a profound impact on our organisation, on our wider healthcare system and on our country as whole. The focus of our efforts remains on managing the COVID pandemic and in particular now recovering the Trust services as outlined above.

As we began to move out of the acute response to this first wave of COVID-19, alongside the introduction of new executive team routines, we established a 6-week programme to review the new context in which our organisational strategy sits, and to make some recommendations about how we might need to refocus aspects of our strategy in light of this. The aims of the initial phase of this work were to:

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

Through this process we have identified how COVID-19 is shining a strong light on the inequalities within our communities, the recognition of the need to invest in the health and well-being of staff, the profound digital transformation that occurred within days and has impacted on every NHS worker and patient in the last few months, and the impact of the research and rapid learning that we were able to undertake.

Having undertaken this first phase to better understand the context in which we are now operating, we are in a strong position to complete the second phase of this work over the next 2 months. This will include work to:

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

each directorate will be asked to demonstrate how their contribution to the priority programmes, projects and focused improvements, and their wider service delivery work, will drive our vision and strategic goals in a measurable way.

Develop a programme of communication and engagement with all staff, as well as patients and members of our local community, to make sure that the work is well understood and that everyone can see how their work, or the care they receive, contributes to the wider organisational vision and goals.

2.1 Redevelopment

The redevelopment programme has continued to progress at pace. The Trust has completed the Strategic Outline Case (SOC) for the St. Mary's redevelopment. This is ready for formal submission to NHS Improvement.

We have worked with the developer design team and have received a feasibility study looking at how our requirements can be delivered on the Paddington site. At the beginning of July we met with Westminster City Council to provide an update on progress. This was received positively. We are also progressing the plans for Charing Cross and Hammersmith Hospitals currently focussing on documenting the clinical plans for these sites ahead of developing the site wide masterplans. We launched the first phase of our patient and public insight and engagement programme in July, working with specialist agency Kaleidoscope to gather views and ideas through online groups, a survey and community group outreach.

3. CQC update

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

The CQC introduced a temporary approach to inspection during the pandemic period which involved what it called Emergency Support Frameworks (ESF) that focus on key aspects of safety and leadership. Assessment using ESFs will be in the form of a telephone call, after which organisations will be scored as either managing on their own or requiring support. For organisations identified as needing support, the next steps will vary depending on the support the CQC considers is required.

The CQC wrote to all NHS trusts on 19 June 2020 to advise that it would begin implementing an ESF for acute trusts from 22 June. Initially this will be an assessment of how trusts assured themselves that infection prevention and control (IPC) was effectively managed during the first wave of the pandemic. The CQC expects that trusts will either use NHS England's infection prevention and control guidance and board assurance framework or otherwise be able to demonstrate assurance relating to the aspects of IPC it identifies. The Trust's ESF phone call took place on 20 and 23 July 2020, and the Trust has received the report from this review. The report confirms that the Trust has undertaken a thorough assessment of infection prevention and control, across all services, since the pandemic of Covid-19 was declared and maintained appropriate systems and processes of controls and assurances. The report highlights two areas of outstanding practice:

- The trust addressed the concerns of local BAME population groups regarding rumours and misinformation that were being spread on social media about the Covid-19 pandemic and how it affected patients in hospital. The trust chief executive officer addressed these concerns in an informative and clear video that was uploaded to the trust website and circulated on social media.
- The PPE Helper Programme which established a specially trained cohort of redeployed staff that visited wards to promote best practice around the use of PPE in a face-to-face and timely manner.

The CQC also introduced an ESF for GP practices, which was implemented from 26 May 2020. The CQC has not yet contacted the Trust's GP practice about the GP ESF however the Trust's GP practice undertook its own assessment against the CQC's ESF for primary care and considers that it was fully compliant.

2.2 CQC Provider Collaboration Reviews (PCRs)
On 8 July 2020 the CQC announced a programme of local area reviews called Provider Collaboration Reviews (PCRs), aimed at helping organisations rapidly learn lessons from responding to the first wave of the Covid-19 pandemic. These reviews are a continuation of the CQC's existing local area review programme, which began in 2017 and:

- Are based on data held by the CQC, discussions with organisations, and views of patients and the public.
- Focus on older people, defined as persons over 65 years of age, both with and without coronavirus.
- Are not inspections – no inspection report will be produced and organisations will not be rated.

PCRs will be organised based on current Integrated Care Systems (ICSs) and Sustainability and Transformation Programmes (STPs) and Phase 1 of the PCR programme for Covid-19 will be carried out during July and August 2020. Phase 1 includes the North West London STP and review findings will be published in the CQC's Covid Insight Report for September 2020. They will also be included in the CQC's next annual State of Care report, due for publication in October 2020.

4. Hotel services direct employment
The transition of over 1,000 cleaning, catering, and portering staff from employment by our previous service provider Sodexo, to be employed by the Trust on 1 April has gone smoothly. The move to directly employ hotel services staff follows a review last autumn and a decision to bring staff in house by the Trust board in January, and was delivered on time by a dedicated team of Trust staff. The aim of the move was to make the Trust's cleaners, porters and catering staff feel properly valued as part of the wider Trust team, whilst delivering improvements in the quality of the service. All staff now have NHS basic pay rates and sick leave and access to the NHS pension scheme.

The Trust will run Hotel Services on a direct management basis for a year in order to establish the long-term viability of the model. An evaluation will then be taken to decide whether to continue to employ hotel services staff directly, and bring all staff up to full NHS (Agenda for Change) terms and conditions, or retender the contract with a significantly amended specification.

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

Year to date (April 20 - June 20), the Trust has requested an additional £16.6m of top up funding, ie the Trust would have a £16.6 deficit without central support. The deficit is mainly due to additional costs to support the response to Covid-19 of £20.3m.

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

6. Operational performance
Operational performance will be covered in the Imperial Management and Improvement System (IMIS) report. As anticipated, performance against a number of the responsiveness metrics has been significantly impacted by Covid-19. Field testing of the proposed new urgent and emergency care standards continues.

7. Research and innovation
Within the main public Board papers we have published a report that describes how the research & development teams within the Trust responded to the Covid-19 pandemic, some of the key research studies we are involved in, and the outputs and outcomes to date. The Trust has recruited more than 1,900 patients and volunteers to date, into 13 nationally prioritised Covid-19 research studies. 17 national studies and approximately 60 others have been opened to date, with the average time to set up and open a national Covid-19 research study of 6 days, enabling more patients to benefit from inclusion. Our research delivery workforce (research nurses, clinical research practitioners) have been

key to supporting this intense period of activity, which continues to evolve as new research questions emerge while we also try to restart our previous research activity in a safe way.

In partnership with Imperial Health Charity, we have launched the first round of the 'Innovate at Imperial', with 11 teams from across the Trust successful in being awarded small grants to support putting their innovative ideas into practice. 48 teams have since submitted an expression of interest for the second round of the funding programme, which closed last week.

8. Stakeholder engagement

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

- Cllr Tim Mitchell, Westminster City Council: 21 May 2020
- Cllr Stephen Cowan and Cllr Ben Coleman, London Borough of Hammersmith & Fulham: 28 May 2020
- H&F Save Our NHS: 1 June 2020
- Strategic Lay Forum: 10 June 2020
- Prime Minister video call with Charing Cross Hospital staff: 15 June 2020
- Nickie Aiken MP: 25 June 2020
- Karen Buck MP and Andy Slaughter MP: 26 June 2020
- Cllr Marwan Elnaghi, Royal Borough of Kensington and Chelsea: 3 July 2020
- Healthwatch Central West London: 3 July 2020
- London Borough of Hammersmith and Fulham Health, Inclusion and Social Care Policy and Accountability Committee: 8 July 2020

8.1 Annual general meeting 2020

Over 200 viewers joined our live-streamed 'virtual' Trust AGM last Wednesday, 15 July. We covered a range of topics including our response to Covid-19. You can now watch the event and see the full slide presentation via the intranet. We will be following up with publication of responses to the questions that we didn't have time to answer in the next week or so. You can also now download our Annual Report 2019/20 which this year incorporates our annual quality account.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Proposed changes to Board governance arrangements/model	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 29 July 2020	**Item 9, report no. 05**
Responsible Executive Director: Prof. Tim Orchard, Chief Executive	**Author:** Peter Jenkinson, Director of Corporate Governance and Trust Secretary

Summary:
Following the Board and Committee effectiveness review, learning from changes made during the Covid-19 pandemic, and resuming the previously agreed changes to executive routines to support the programmes, projects and priorities of the Imperial Way Programme, it is timely to review the overall governance arrangements at executive and board levels. The proposed changes in this paper aim to continually strengthen the delivery of Trust Strategy.

The purpose of the Imperial Management and Improvement System (IMIS) programme is to establish the way in which we manage the development and delivery of our priorities from board to ward, including cascaded strategic objectives and bottom-up identified local initiatives, in a consistent and transparent manner. It is therefore a key component in establishing the systems and processes to support the delivery of the strategic goals.

A key component of this is to ensure that the organisation has the appropriate governance routines to support the delivery of the strategic goals. The purpose of this report is therefore to outline proposed changes in executive and board level governance arrangements.

This report summarises the findings and recommendations arising from the Board effectiveness survey carried out earlier in 2020, and sets out proposed changes in Board governance arrangements for Trust Board to discuss and approve. It also outlines the changes being made to executive level routines for Trust Board to note.

Recommendations:
The Board is asked to:

- To note the Board and Committee effectiveness review and the arising actions (appendix 1)
- To note the new executive routines;
- To agree in principle moving Board Committees to week 1 of month 2; and
- To agree in principle moving the Trust Board meeting to week 2 of month 2.

This report has been discussed at: Executive Huddle

Quality impact: Well-led

Financial impact: N/A

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

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

Has an Equality Impact Assessment been carried out or have protected groups been considered? N/A
How have patients, the public and/or the community been involved in this project and what changes were made as a result? N/A
What impact will this have on the wider health economy, patients and the public? N/A
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? No

Imperial College Healthcare NHS Trust

Proposed changes to Board governance arrangements/model

1. Purpose

The purpose of this report is to consider the findings and recommendations arising from the Board effectiveness survey carried out earlier in 2020, to outline proposed changes in Board governance arrangements, for Trust Board to discuss and approve, and to note changes being made to executive level routines.

2. Introduction

One of the priority Trust programmes for this year is the Imperial Management and Improvement System (IMIS) programme. The purpose of the IMIS programme is to establish the way in which we manage, monitor and problem solve the delivery of our priorities from board to ward, including cascaded strategic objectives and bottom-up identified local initiatives, in a consistent and transparent manner. It is therefore a key component in establishing the systems and processes to support the delivery of the strategic goals.

As part of that programme, the executive team have reviewed, pre-COVID and post-COVID, the executive level routines to adopt and embed the successful transformational changes made during the pandemic, and to ensure a focus on operational effectiveness, recovery and reset, and delivery of the strategic goals and priority programmes, projects and focused improvements. The changes that have been made and will be made are summarised below.

The Board and Board Committee level effectiveness review was completed earlier in 2020, and findings and recommendations have been shared with each Board committee. A summary of the findings and recommended actions are included below. These actions are aligned with and support the previous discussions the Board have had, starting in February this year, regarding the continual improvement in effectiveness of the Board Committees.

3. Key drivers for change

The drivers for change behind the proposed changes to Board level governance routines derive from these various initiatives and reviews:

- Performance management systems and timeliness of data – the aim of the changes being proposed is to introduce a six week performance cycle, to improve the timeliness of data being provided at all assurance levels, including divisional performance reviews, Executive Management Board, Board Committees and Trust Board.
- Streamlined assurance reporting – there is a need to focus on the assurances that the executive, Board Committees and Board require, to improve effective use of Board Committees.
- Focus on development and delivery of strategy – Board Committees need to closer align with the strategic goals and priorities, in both oversight and steering.
- Systems and processes – one of the priorities for the Trust is to ensure that the systems and processes are in place to support focus on operational effectiveness.
- Management capacity and bandwidth – by reducing overall time spent in meetings and focus on effective use of time spent in meetings, the executive team will have more bandwidth to deliver the Trust priorities.

4. Board governance

4.1. Board and Committee effectiveness

In line with good practice and with the aim of continually strengthening Board governance, the Board and Committee effectiveness review was carried out in quarter 1 of 2020/21 reflecting

on 2019/20. The outcome and actions following the effectiveness reviews has been discussed with each of the Committee Chairs and at the respective Committees. The review of the Trust Board itself, and the overarching effectiveness report for the Board and its Committees is available. The overarching actions are provided at appendix 1 of this report. The generic actions captures the actions that were common across the Board and Committees. The actions for each will be taken forward by the respective Board/Committee (including the generic actions).

The feedback on the Board effectiveness was generally very positive, with average scores of over 80% of responses strongly agreeing or agreeing with the statements in each of the categories:

- Board structure and composition
- The role of the Board
- Board dynamics and relationships
- The role of the chair
- Corporate strategy
- Internal control, risk management and the regulatory environment

To maximise the impact of the overall Board effectiveness review, and to ensure best practice across all Committees, the following actions are proposed for the Board to consider as key areas of action (detail provided at appendix 1):

1. Review composition and diversity of the Board and its Committees, and introduce a regular process to review.
2. Review all terms of reference with a particular focus on ensuring that they include the committee role in regard to strategic development and oversight.
3. Review format of agendas and forward planners to ensure a focus of content in meetings and alignment with strategic priorities.
4. Executive action to improve the timeliness and quality of papers such as the level of detail provided to Board and making papers more concise.
5. Review templates to assist with improving the quality of papers and increasing focus.
6. Introduce strategy and risk / assurance 'deep dives' across all Committees, to ensure Committee ownership of key strategic risks and alignment with strategic goals.

Learning from the COVID pandemic has acknowledged the effectiveness of the 'governance lite' arrangements during COVID with shorter and focused meetings. This paper recognises this feedback and takes into account maintaining some of the governance lite arrangements.

The Board is asked to note the current arrangements for Board and Committees to take place virtually as per NHSE guidance. When the arrangements are relaxed the Trust Secretariat will review the mechanisms for holding future meetings.

4.2. Proposed changes to Board and Board Committees

The move to a six week reporting cycle, as outlined above, would be possible if Board Committee meetings took place in the same week, the week after Executive Management Board (see 'Executive routines' below) – week 1 of month 2 – and the Board the week after that, in week 2 of month 2. This cycle of meetings would allow the Board to receive reports which are current and validated appropriately, providing clear and timely reporting from the Executive Management Board to the Board. This approach would increase the quality of papers and streamlined reporting aligned with strategic goals and key risks to achieving those

goals. This approach supports the emerging themes from the Board and Committee effectiveness review.

This report seeks agreement in principle to this approach. If agreed, the Trust Secretariat will liaise with the Board of Directors in terms of the practical arrangements with a view to implementing from November.

4.3. Board Seminars

The effectiveness review feedback was generally complimentary of the focus of Board Seminars, namely Trust strategy as part of the Trust's approach to achieving its objectives, including tracking and evaluating progress towards them, the continual development of the Trust strategy, the focus, format and content of the Board seminars. There was mixed views regarding the attendance at Board seminars and time spent in seminars, which will be considered as we continue to evaluate the effectiveness of the new approach to seminars started earlier this year.

5. Executive routines

Before the COVID pandemic, the executive team had discussed possible changes to executive level governance arrangements, including moving from a weekly excutive committee focusing on individual areas of performance (finance, quality, people and operations) to a monthly executive management board supported by a range of sub-groups that allow executive directors to engage with operational teams to manage their respective portfolios. The benefit of the executive management board model is the integration of performance across different domains and therefore manage the interdependencies between finance, people, operations and quality. This change will be effected from September 2020. September 2020 will also see the introduction of monthly divisional oversight meetings, the outcome of which will be reported into the executive management board.

During Covid-19, the Executive Team met daily in gold command mode, and have agreed that meeting daily was effective in terms of both team development and timely identification of operational issues and agile decision-making. Therefore instead of weekly, the Executive Team continue to meet daily as Executive huddles with specific focus on specific days, including delivery of the programmes, projects and focused improvements. These daily huddles are supported by fortnightly executive transformation 'deep dive' sessions that enable the executive to discuss topics in more detail.

The changes in executive routines outlined above is the first phase of this work. There is also a need to consider the effectiveness of our routines at divisional and directorate level to ensure that they are consistent and robust. The directorate level governance reviews have therefore been restarted, the outcome of which will be a gap analysis against a standard operating model and recommendations regarding any changes in systems and processes at that level and any developmental requirements to address capacity and skill set gaps. The aim is to conclude the first phase of this work, the benchmark reviews, in September. The workplan and timescales to strengthen existing arrangements can then be developed.

6. Conclusion and recommendations

The Board has reviewed some of its Board level governance arrangements, as outlined above, in line with good corporate governance practice.

The Board is asked to:

- To note the Board and Committee effectiveness review and the arising actions (appendix 1)
- To note the new executive routines;
- To agree in principle moving Board Committees to week 1 of month 2; and
- To agree in principle moving the Trust Board meeting to week 2 of month 2.

Trust Secretariat, July 2020

Appendix 1

Actions from the Annual review of Board and Committee effectiveness, across Trust Board and its Committees

The feedback on the Board effectiveness was generally very positive, with average scores of over 80% of responses strongly agreeing or agreeing with the statements in each of the categories:

- Board structure and composition
- The role of the Board
- Board dynamics and relationships
- The role of the chair
- Corporate strategy
- Internal control, risk management and the regulatory environment

To maximise the impact of the overall Board effectiveness review, and to ensure best practice across all Committees, the following actions are proposed for the Board to consider as key areas of action, detailed in the tables below. Table 1 'generic actions', captures the actions that were common across the Board and Committees. The actions for each will be taken forward by the respective Board/Committee, including the generic actions.

1. Review composition and diversity of the Board and its Committees, and introduce a regular process to review.
2. Review all terms of reference with a particular focus on ensuring that they include the committee role in regard to strategic development and oversight.
3. Review format of agendas and forward planners to ensure a focus of content in meetings and alignment with strategic priorities.
4. Executive action to improve the timeliness and quality of papers such as the level of detail provided to Board and making papers more concise.
5. Review templates to assist with improving the quality of papers and increasing focus.
6. Introduce strategy and risk / assurance 'deep dives' across all Committees, to ensure Committee ownership of key strategic risks and alignment with strategic goals.

Table 1: GENERIC ACTIONS

Specific suggested action
Board structure and composition
Across all a) Increase diversity [consider under 'Membership and diversity of the Board and its Committees]
The role of the Board/Committee
Across all a) Shorter duration of meetings b) Format of agendas/forward planners: - consider Covid impact - more time for discussion - sufficient time for strategy - check point/agenda section to agree what is being reported/escalated to Board from Committees - focus and time on items - avoid duplication across Committees - review standing items - move away from 'tick-box' approach for some items c) Quality of papers: - shorter, focused, less information/detail, options appraisal for decision items - no later papers (caveats for those due to data positions)

Specific suggested action
- build in time to critically review reports before circulation - review level of detail provided to NEDs - Move away from 'tick-box' approach for some items d) Templates: Cover sheet – include how does this support delivery of strategy e) Review ToRs alignment with strategic goals (and therefore forward planners); f) Clarify how items flow from one Committee to another g) Introduce 6-12 month review of agendas (time spent on items). h) Embed some of the routines of governance lite during Covid. i) Review effectiveness of Committee Chairs attending other Committees (to bring risk management to the forefront) j) Consider whether a Workforce Committee should be established
Board dynamics and relationships (behaviours)
No specific actions
The role of the Chair
No specific actions
Corporate Strategy
Across all Include in strategy discussions: – Golden thread from strategy to operations to be more defined. – Review progress against goals. – Simplified strategy maps would be helpful when assessing assurance
Internal control, risk management and the regulatory environment
Across all a) Review how risks are reported and simplify - suggestion that ARG should oversee risks held by Committees and review these through a cyclical presentation by the NED and exec lead of each Committee.

Table 2: TRUST BOARD ACTIONS

Specific suggested action
Board structure and composition
Board – see comment about heading under 'generic actions' table a) Review membership/size of Board b) Review voting rights balance c) Increase NEDs with experience in nursing/allied health, community/social care for NED **Also see 'generic actions' section**
The role of the Board/Committee
Board a) Consider frequency of meetings b) Shorter Board Seminars with fewer attendees c) Tick-box view d) MD Office and Perf Team currently refreshing the IQPR and to give consideration comments regarding detail and length e) DoN to consider reporting of patient feedback to Board (Board and Quality) f) Agendas to allow more time for public questions; and balance between private and public sections **Also see 'generic actions' section**
Board dynamics and relationships (behaviours)

Specific suggested action
Board a) Balance of discussion across NEDs and Executives b) Board development sessions: session on external landscape; and understanding of Board roles and responsibilities
The role of the Chair
No specific actions
Corporate Strategy
Also see 'generic actions' section
Internal control, risk management and the regulatory environment
Also see 'generic actions' section

Table 3: ARG ACTIONS

Specific suggested action
Board structure and composition
Nothing specific for ARG
The role of the Board/Committee
ARG a) TORs review how major developments and formal legal arrangements are handled b) Review TORs and forward plans to avoid duplication between ARG & Quality Committees c) Focus on realising opportunities/ensuring opportunities not missed. (including Technology) d) Clearer delineation with quality committee clinical risks e) Focus on non-clinical risks f) Consider the frequency of some standing items g) Consider deep dives h) Raising concerns: consider external service for independence/more trust. i) Financial risk - formal review of procurement (ARG or FIOC agenda) **Also see 'generic actions' section**
Board dynamics and relationships (behaviours)
a) Increase focus of aspirational value
The role of the Chair
No specific actions
Corporate Strategy
Also see 'generic actions' section
Internal control, risk management and the regulatory environment
a) Review of BAF b) Look into risk assessing opportunities, research, teaching and technology c) Confirm how the annual review is conducted by ARG d) Review process for execs reviewing Internal Audit reports and management responses e) Consider Counter Fraud not attending each meeting and review frequency of other standing items **Included in generic actions table** a) Review how risks are reported and simplify - suggestion that ARG should oversee risks held by Committees and review these through a cyclical presentation by the NED and exec lead of each Committee.

Table 4: QUALITY COMMITTEE ACTIONS

Specific suggested action
Board structure and composition
a) Review membership/size of Quality Committee b) Assistant MD Safety should be in attendance c) Increase professional roles across on the Quality Committee

Specific suggested action
Also see 'generic actions' section
The role of the Board/Committee
a) Tick-box view b) MD Office and Perf Team currently refreshing the IQPR and to give consideration comments regarding detail and length (Board & Quality) c) Review TORs and forward plans d) To avoid duplication between ARG & Quality Committees e) Include Quality aspects of major initiatives i.e. new builds, strategy and future planning, risk; clarify the Committees role in shaping/influencing quality strategy (shape it rather than oversight) f) Clarify oversight of strategic matters and time for shaping the quality strategy and priorities, mindful of balance between steering and supervision role of Committee g) Quality & FIOC -look into how are financial cases at FIOC tested for quality implications and when these should be escalated to Quality – consider for ToR h) Consider deep dives i) Does the Chair feel he has sufficient links with FIOC and Redevelopment? **Also see 'generic actions' section**
Board dynamics and relationships (behaviours)
a) Increase focus of aspirational value
The role of the Chair
No specific action.
Corporate Strategy
Also see 'generic actions' section
Internal control, risk management and the regulatory environment
Also see 'generic actions' section

Table 5: FIOC ACTIONS

Specific suggested action
Board structure and composition
a) Review DDO attendance **Also see 'generic actions' section**
The role of the Board/Committee
a) Review FIOC forward planner to include (for greater focus) on VFM, CIP, Covid finances, Redevelopment costs and funding (and ROI from the Redevelopment Committee/Director) b) Review/monitor FIOC in terms of additional responsibilities on operations and transformation, plus a new CFO, which may need bedding in. c) Quality & FIOC - look into how are financial cases at FIOC tested for quality implications and when these should be escalated to Quality – consider for ToR d) Financial risk - formal review of procurement (ARG or FIOC agenda) **Also see 'generic actions' section**
Board dynamics and relationships (behaviours)
No specific actions for FIOC
The role of the Chair
No specific actions
Corporate Strategy
Also see 'generic actions' section
Internal control, risk management and the regulatory environment
Also see 'generic actions' section

Table 6: REMCO ACTIONS

Specific suggested action
Board structure and composition
Also see 'generic actions' section
The role of the Board/Committee
a) Improve rigor of papers to include and clarify Trust comms handling at times of high emotion, when dependent on central policy i.e NHS Pensions issue.
Board dynamics and relationships (behaviours)
No specific action
The role of the Chair
No specific actions
Corporate Strategy
Also see 'generic actions' section
Internal control, risk management and the regulatory environment
Also see 'generic actions' section

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TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Patient and public involvement: 2019/20 annual review	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 29 July 2020	**Item 10, report no. 06**
Responsible Executive Director: Michelle Dixon, director of communications	**Authors:** Linda Burridge, head of patient and public partnerships / Trish Longdon, chair of the strategic lay forum / Tanya Hughes, deputy chair of the strategic lay forum

Summary:
This is the fourth annual update from the Trust's strategic lay forum. The forum was established in late 2015 to ensure we put patients at the centre of everything we do and to oversee our patient and public involvement strategy. The forum meets every two months, when 13 volunteer lay partners and key staff from around the Trust come together to review and develop plans to make sure care is patient-centred, integrated and based on patients' wants, needs and preferences. Meeting agendas are agreed with both the lay forum chair and the executive sponsor for this area of work, Director of communications Michelle Dixon. Lay partners on the forum and a wider group of lay partners are also involved in a wide range programmes, projects and discussions outside of the formal strategic lay forum meetings.

The attached presentation covers progress against the forum's priorities and work programme for 2019/20, how the forum influenced the Trust's 2020/21 business plan and was able to have significant involvement in the Trust's response to Covid-19 and in estate redevelopment, in particular, and concludes with the forum's own priorities for 2020/21.

Update on strategic lay forum priorities for 2019/20

1. To increase the influence and reach of the strategic lay forum

The forum continues to expand its role in shaping Trust strategy and priorities. It had significant early input into 2020/21 business planning. Each year the forum has an 'away day' to set priorities and is invited to input into the Trust's developing business plan with the executive team. This year, the forum brought attention to the importance of staff wellbeing and morale and how this is necessary for kind, compassionate and effective patient care. It also challenged the Trust to improve the appointment booking system, which is the main complaint from patients. It also promoted use of an online patient record system to improve patient experience. This yearly event is now an established step in annual business planning and enables the forum to align priorities with the Trust and bring a patient focus to yearly objectives.

2. To expand the lay partner programme and strengthen lay partner involvement

The lay partner programme was further expanded throughout the year. The Trust currently has 85 lay partners who volunteer their time on strategic projects and. Lay partners have positively impacted projects such as 'end of life' care, the new invasive procedures committee, redevelopment and various improvement meeting 'big rooms'. Four lay partner community events were held during the year to provide networking opportunities and share relevant training and upcoming involvement opportunities. Since the start of the programme, 126 lay partners have been engaged.

3. Demonstrate lay partner impact through evaluation

An impact evaluation and methodology and plan was co-designed with staff, quality improvement coaches, lay partners and colleagues from Imperial College London and Imperial Health Charity. It will

be delivered by Q4 to provide qualitative data and case studies on the positive impact of lay partner collaboration.

4. Support reduction in health inequalities
The forum reviewed the equality delivery system, the NHS tool to review equality performance with staff, patients and public and advised the Trust how to engage with community groups as there was limited previous engagement. The forum also raised the rumours and fears felt amongst BAME communities about coming to hospital during the pandemic, and helped ensure there was a good response. In the immediate term, this included producing two tailored videos, translated into other languages, as well as our medical director attending a local BME forum to answer questions directly. There is a short video (link: https://vimeo.com/438813536/543f0b9c6c) of Nafsika Thalassis, director of Hammersmith and Fulham BME Health Forum and a member of the strategic lay forum, where she shares her views and the impact of this work.

5. Learn and act on feedback and complaints
Through collaboration with Guy Young, deputy director of patient experience, the forum helped review patient feedback and complaint data which led to the conclusion that the Trust has to prioritise improvements to appointment booking which fed into 2020/21 business planning.

6. Embed patient-centred care in all staff objectives
The strategic lay forum and lay partners provided input into the 'values and behaviours' programme and training and will continue to be involved as this work progresses. There is more to do on this area of work.

This attached presentation covers a few areas in a bit more detail, to demonstrate how our approach to patient and public involvement, and our lay partner programme in particular, is contributing to the Trust's goals and especially to help us become more user focused. This includes a spotlight on lay input to the Trust's initial Covid-19 response and the recovery and reset programme that has followed; how we have responded to the concerns of BAME communities; how we are working to ensure equal access to our services, specifically in terms of the impact of face masks on patients with hearing problems (video link: https://vimeo.com/438812828/e32ba27b4d); and ensuring redevelopment is shaped by the views and needs of our patients and local communities, as well as staff.

Strategic lay forum priorities for 2020/21
The strategic lay forum has committed to the following priorities for 2020/21, refreshed to take account of the current environment:

- To retain focus on patient-centredness and 'what matters most to patients', including staff morale and ensuring the Trust is a 'great place to work'
- To champion integrated care
- To continue to maximise the patient-voice and user insight in redevelopment
- To bring clear patient focus to 'recovery and reset' projects, especially: insight and data gathering through relationship building, particularly with seldom-heard groups; inclusive access to information and care, such as interpreters, sign language and non-digital access
- To increase lay partner diversity through proactive recruitment and involvement, exploring remuneration in line with national policies
- To continue to challenge the Trust to improve the appointment booking system – a longstanding issue and difficult to resolve
- To contribute to the development and use of the online patient record system, the Care Information Exchange

Recommendations:
The Trust board is asked to note this report and support the strategic lay forum priorities for 2020/21. Discussion and reflection on these priorities are welcomed. The forum will take up the priorities with respective Trust colleagues following the presentation.

This report has been discussed at: N/A

Quality impact: Patient and public involvement and the work of the strategic lay forum will impact all patient care and experience and supports the Trust's overall goal to be the most user-focused NHS organisation. It aims to improve all CQC domains.

Financial impact: Work is underway to explore potential resource requirements for our 2020/21 work programme.

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

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

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

How have patients, the public and/or the community been involved in this project and what changes were made as a result? This report has been authored jointly with strategic lay forum chair and deputy chair.

What impact will this have on the wider health economy, patients and the public?
This area of work aims to positively impact on and support the wider heath economy, patients and the public by encouraging and challenging the Trust to become more user-focused and develop patient care based on patients' wants, needs and preferences. It supports the Trust's overall goal to be the most user-focused NHS organisation.

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

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

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

If the details can be shared, please provide the following in one to two line bullet points:
- The strategic lay forum meet every two months to co-design Trust programmes and developments to ensure they're patient-centred and based on patients' wants, needs and preferences.
- Information on the forum and how Trust staff can influence their own work to be more patient-centred is available on the Trust intranet: https://intranet.imperial.nhs.uk/Interact/Pages/Content/Document.aspx?id=3878
- For more information contact: Linda Burridge, linda.burridge@nhs.net
- Should senior managers share this information with their own teams? ☒ Yes ☐ No
  If yes, why? To inform staff how the Trust is working to become more patient-centred and what resources are available to them

Imperial College Healthcare NHS Trust

Patient and public involvement: 2019/20 annual review and priorities

Trish Longdon

Chair, Strategic lay forum

What we'll cover

Imperial College Healthcare NHS Trust

- Progress against our priorities for 2019/20
- Feeding into the Trust's 2020/21 business plan
- Our involvement in the Trust's Covid-19 response
  - Spotlight on responding to BAME community fears
  - Spotlight on 'recovery and reset'
  - Spotlight on ensuring equal access to our care
- Our involvement in redevelopment
  - Spotlight on creating a shared vision
- Our updated priorities – refreshed following Covid-19

Our 2019/20 priorities and progress

1 To increase the influence and reach of the strategic lay forum

- Invited to contribute to the Trust's 2020/21 business plan and had significant, early input. We were able to check alignment of priorities with Trust chair and chief executive:
  - promoted the importance of staff wellbeing and morale as necessary for kind, compassionate and effective patient care
  - challenged the Trust to focus on and improve the appointment booking system (the number one complaint) and promote use of online patient record systems, such as the Care Information Exchange
- Major input to the 'recovery and reset' programme following Covid-19 and redevelopment programme:
  - Trust now has more focus on digital poverty, and fears and concerns of seldom-heard groups

Our 2019/20 priorities and progress

Imperial College Healthcare NHS Trust

2 To expand the lay partner programme and strengthen lay partner involvement

- Currently have 85 lay partners across 25 projects, improved induction and regularly reviewed collaboration and impact
- Examples of lay partner impact:
  - advocating the role of carers and families and how they can support patients when considering ‘end of life’ care
  - promoting the importance of clear patient information, 'bedside manner' and accessible language when using new medical devices or treatments
  - highlighting adolescents' communication and pastime preferences and advocating for a separate play space from young children
- Held four lay partner community events, included Trust ‘values and behaviours’ training, co-designed the redevelopment involvement charter
- To date, have collaborated with 126 lay partners since the start of the programme

Our 2019/20 priorities and progress

Imperial College Healthcare NHS Trust

3 To demonstrate lay partner impact through evaluation

- Co-designed and agreed an impact evaluation methodology and plan with lay partners, staff, quality improvement colleagues, Imperial Health Charity and Imperial College London
- To be linked with 'learning and insights' and will be delivered in Q3 or Q4

4 To support a reduction in health inequalities

- Reviewed the equality delivery system, the NHS tool to review equality performance with staff, patients and public. Advised and supported the Trust on engaging community groups representative of those with protected characteristics
- Raised rumours and fears amongst BAME communities about coming to hospital during the pandemic – supported the Trust in responding, in the short term through two tailored videos (with translations) and meetings with local BME forum and now exploring longer term responses

5 To learn and act on feedback and complaints

- Reviewed data which led to conclusion that improving appointment bookings should be a key focus for the Trust and fed into business planning

6 To embed patient-centred care in all staff objectives

- Involved in shaping the Trust's values and behaviours programme and training. More to do

Input to Trust 2020/21 business planning

Imperial College Healthcare NHS Trust

The strategic lay forum asked the Trust to:

- Enable kind compassionate care that reflects ‘what matters most to patients’
- Continue to work on improving the appointment system and wider use of an online patient record system
- Promote preventative and self care
- Improve and co-design care pathways so they are genuinely user-centred and patients can easily navigate their care
- Adopt innovation and learn from other organisations
- Develop pathways so they are integrated around patients
- Take a leading role across the sector to achieve true integrated care, centred around patients
- Ensure site redevelopments are suitable for change and future models of care
- Introduce measurement systems to value things that matter to patients and measure care outcomes

Our involvement in Covid-19

Imperial College Healthcare NHS Trust

- Strong existing relationships enabled rapid collaboration:
  - strategic lay forum chair attended the daily clinical reference group as soon as it was established
  - this enabled the patient voice to be heard throughout, resulting in more patient-centred pathways, the development of clear patient and visitor information and issues of equity and inclusivity to be raised at an early stage
  - the patient reference group continued to input into patient communication, improved discharge information and a new inpatient booklet
- The strategic lay forum continued, meeting online in May, to input into key projects
- The strategic lay forum highlighted the disconnect and fear with seldom-heard groups, BAME communities and vulnerable groups and emphasised the need for inclusivity – communication challenges and digital poverty
- Lay partners are being appointed to all major recovery and reset programmes

Spotlight on responding to BAME fears

Imperial College Healthcare NHS Trust

Nafsika Thalassis, director of Hammersmith and Fulham BME Health Forum and member of our strategic lay forum, raised concerns and fears circulating amongst local black, Asian and minority ethnic communities about hospital care and Covid-19.

She talks briefly in a video here about what happened and the impact.

Spotlight on ‘recovery and reset'

Imperial College Healthcare NHS Trust

- Input includes:
  - ensuring the operational programmes were focused more around patients and there was more opportunity for lay input, review and feedback
  - promoting the role of online patient record system (Care Information Exchange) and how that can enable self-care and greater levels of patient ownership and control
  - encouraging the Trust to collaborate and integrate care with partner organisations
- Eight lay partners already appointed to four new key programmes:
  - operational ‘subject matter expert’ group
  - models of care
  - remote care ‘ways of working’
  - staff support programme
- Six lay partners involved in organisational strategy refresh big rooms, including:
  - bringing a focus to ‘what matters most for patients’ and designing care around individuals' needs, wants and preferences
  - ensuring developments are integrated with the community where possible
  - focusing on seldom-heard groups and encouraging more active engagement

Spotlight on ensuring equal access to our care

Imperial College Healthcare NHS Trust

Jane Wilmot, member of our strategic lay forum and accessibility advocate, is helping to raise issues and develop solutions to ensure all patients have equal access to our care.

The forum has been focusing on how we respond to digital poverty with the move to much more digital care. Jane has also been helping the Trust consider how face masks and coverings are inhibiting lip reading and how we can best respond. She talks briefly in a video here about this work.

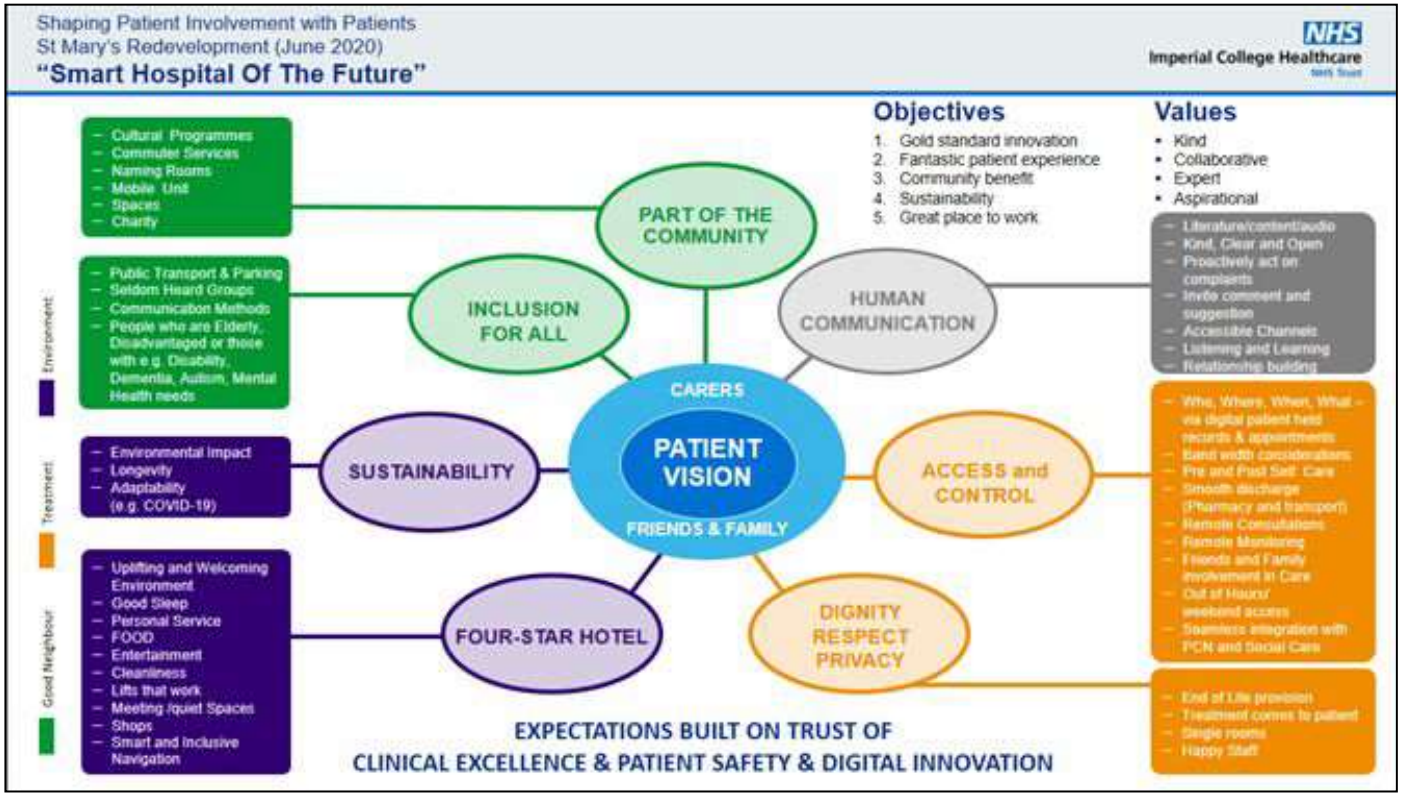
Our involvement in redevelopment

- Strategic lay forum and lay partner involvement from the start
- Co-designed an ‘involvement charter’ with staff and patients. This sets out the expectation for involvement throughout the project, now included in the communication plan and shared with redevelopment partners for consistent collaboration
- Lay and patient/public input at all levels:
  - strategic lay forum chair on stakeholder steering group
  - lay partner on redevelopment communications group
  - lay partners involved in ‘clinical thinking group’
  - first phase of patient and public insight and engagement launched in July – discussion groups, survey and community group outreach sessions

Spotlight on creating a shared vision

Imperial College Healthcare NHS Trust

Developed a patient vision ‘mind map’, co-designed first phase of insight/engagement and led work to generate 'pen portraits' from lay partners and volunteers.



Our priorities for 2020/21

Imperial College Healthcare NHS Trust

- To retain focus on patient-centredness and ‘what matters most to patients’, including staff morale and ensuring the Trust is a ‘great place to work’
- To champion integrated care
- To continue to maximise the patient-voice and user insight in redevelopment
- To bring clear patient focus to ‘recovery and reset’ projects, especially:
  - insight and data gathering through relationship building, particularly with seldom-heard groups
  - inclusive access to information and care, such as interpreters, sign language and non-digital access
- To increase lay partner diversity through proactive recruitment and involvement, exploring remuneration in line with national policies
- To continue to challenge the Trust to improve the appointment booking system – a longstanding issue and difficult to resolve
- To contribute to the development and use of the online patient record system, the Care Information Exchange

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TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: COVID-19 Research: the Imperial experience & response	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 29th July 2020	**Item 11, report no. 07**
Responsible Executive Director: Bob Klaber, Director of Strategy, Research & Innovation	**Authors:** Paul Craven (Head of Research Operations) Bob Klaber (Director of Strategy, Research & Innovation) Mark Thursz (Director of Research) Graham Cooke (Professor of Infectious Disease)

Summary:
Research into SARS-CoV-2 and COVID-19 has been driven at pace and at scale within the academic and healthcare sectors since the pandemic came to the fore in early January 2020. The national R&D infrastructure quickly responded, as did regional university and NHS Trust partnerships, including Imperial. Additional funding was announced, new governance structures arose to guide decision-making and prioritisation, clinical research workforce personnel were re-deployed, and discoveries about this new disease were quickly published and implemented into practice; all at a time when many were working remotely from home, and during massive service reconfiguration within the NHS.

This paper details the Imperial response to the COVID-19 pandemic since mid-March 2020 in terms of clinical research within Imperial College Healthcare NHS Trust (ICHT), in partnership with Imperial College London and the wider Imperial Academic Health Science Centre (AHSC). It also considers what insights have been gained to inform our research – and its translation into excellent clinical care – going forward. We describe how the research & development teams within the Trust responded to the crisis, some of the key research studies it is involved in, and the outputs and outcomes to date. Of note:

- The Trust has recruited more than 1,900 patients and volunteers to date, into 13 nationally prioritised COVID-19 research studies;
- The average time to set up and open a national COVID-19 research study was 6 days, enabling more patients to benefit from inclusion (17 national studies have been opened to date and approximately 60 others);
- Our research delivery workforce (research nurses, clinical research practitioners) has been invaluable in supporting this intense period of activity, and will benefit from further development as a workforce community in its own right;
- Multi-disciplinary and collaborative approaches have been essential to respond to the crisis;
- The Imperial NIHR infrastructure (including the Biomedical Research Centre and Clinical Research Facility) have been at the heart of our response to COVID-19 and this will inform our re-application for these major funding programmes in 1-2 years' time;
- The Imperial Academic Health Science Centre (AHSC) has supported close working and alignment of priorities across the partnership in North West London;

The Board is asked to note the response and achievements over the last 4 months.

Recommendations:
The Committee is asked to note the attached paper regarding the research undertaken at and by the Trust during the recent public health crisis, and consider potential future impact, insights and learning.

This report has been discussed at: Executive team meeting, 24 July 2020
Quality impact: The benefits of an active clinical research environment for NHS Trusts are well documented. The Trust currently benefits from a number of important NIHR infrastructure awards which form the basis of our joint clinical research strategy with Imperial College London. The quality and scale of biomedical and clinical research carried out across the Imperial Academic Health Sciences Centre (AHSC) will impact patient care in the future in terms of innovative treatments, diagnostics and devices. The effective domain of the CQC will be impacted mainly by this paper.
Financial impact: This paper has no direct financial impact. Overall research income at the Trust is valued at ~£45m per annum. Delivery of high-quality clinical research (experimental and applied) for the benefit of patients is essential to future revenue streams, to the reputation of the AHSC, and to the continuation of a culture of innovation and continuous improvement.
Risk impact and Board Assurance Framework (BAF) reference: There are no specific risks attached to this report. The general risks associated with research are financial and reputational. Competition for research funds is extremely high and Imperial must continue to demonstrate a high level of high-quality research outputs and activity, as well as value for money.
Workforce impact (including training and education implications): The public health emergency has had, and will continue to have, an impact at many stages of the clinical academic pathway, as well as on the non-medical, associated healthcare professionals and nursing staff. In addition, there are implications for another, often over-looked workforce community – the research nurses and clinical research practitioners who deliver clinical studies to our patients.
Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☐ No ☒ Not applicable
How have patients, the public and/or the community been involved in this project and what changes were made as a result? Patient and public involvement in research is enabled through the Imperial Patient Experience Research Centre (PERC) and through the NIHR Imperial BRC and other infrastructure awards.
What impact will this have on the wider health economy, patients and the public? Clinical and biomedical research, when validated, is adopted and embedded into the healthcare system, enabling better diagnostics and treatments, as well as informing preventative measures and taking advantage of 'big data' to develop improved service pathways.
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do

COVID-19 Research: the Imperial experience & response

1) Clinical Research Governance

Towards the end of March 2020, we created new structures to respond to the challenge of the disease. The Imperial AHSC formed a COVID-19 Research Committee, chaired by Professor Mark Thursz (ICHT Director of Research and Director of the NIHR Imperial Biomedical Research Centre (BRC)). The Committee brought together senior clinical academics from across Imperial College, ICHT and the Royal Brompton, meeting weekly online and supported by the Faculty of Medicine.

All new COVID-19 research projects were (and are being) channelled through this Research Committee with the aim of considering the scientific value and likely impact of each, whether they were deliverable, and what resources may be needed. The Committee coordinated the COVID-19 research effort across the bilateral AHSC in particular, approved specific clinical research protocols, distributed resources and coordinated funding where required. The Committee worked in parallel with the new national process whereby Urgent Public Health (UPH) research projects were prioritised for support by an expert panel chaired by the Chief Medical Officer (CMO). More than 140 individual COVID-19 research projects have been approved through this process (Annex A).

An Imperial COVID-19 Research Network was also created – a broader forum bringing together stakeholders from many different scientific and operational disciplines, including therapeutics, diagnostics, vaccines, virology, data/informatics, new devices and technologies, and public health. Representatives from other Faculties of Imperial College were also part of this forum – computing, AI, engineering and chemistry, which was an exciting development that picks up a key area of feedback from the previous BRC application review. The aim of this forum being to generate cross-disciplinary approaches and collaborations to the challenges presented.

As the need to analyse and respond to the wealth of new data arising in real-time materialised, a dedicated COVID-19 Research Data Committee was created (chaired by Professor Paul Aylin) to consider the very specific needs of data-driven work. This works in tandem with a new Research Data Prioritisation Group established by Professor Erik Mayer (Clinical Senior Lecturer at Imperial College & ICHT Consultant Urological Surgeon) and Dr Sanjay Gautama (ICHT Consultant Anaesthetist, Chief Clinical Information Officer and Caldicott Guardian).

This Group controls access to the wealth of valuable structured data within the new iCARE secure high performance data environment, another initiative which was given added impetus and momentum driven by the immediate needs of clinicians at the front-line. This group picks up the balance between ensuring the confidentiality and privacy of identifiable (or potentially identifiable) clinical data and use of those data in near 'real-time' to improve care, particularly at a system level. We continue to work on streamlining these systems.

These new structures, illustrated in Annex B, worked in close partnership with existing clinical research infrastructures at Imperial, including the NIHR Imperial Biomedical Research Centre (BRC), the NIHR Imperial Clinical Research Facility (CRF) and the NIHR NWL Clinical Research Network (CRN).

2) Clinical Research Activity Suspension

In March, there were more than 600 individual clinical research studies underway across the Trust, spanning multiple specialties. In anticipation of the clinical pressures and changes to come, all these studies were temporarily suspended. A case-by-case exemption process was established and managed through the Joint Research Office to ensure that certain studies could continue – those involving patient procedures which were critical for their ongoing treatment, or studies which could be delivered remotely from hospital. Key considerations in this process, with decisions taken by the Trust's Divisional Directors of Research, focused on any additional risk to patients or the availability of resources to deliver the study. Over 200 studies were exempted via a new shared online application form, with the majority of decisions being taken within the first 3-4 weeks.

3) Research Delivery Workforce

Most of our research nurses and clinical research practitioners were able to be re-deployed from their existing work to support either new research studies or the direct care of patients with COVID-19. Some research nurses with the relevant experience were deployed directly into intensive care support, others were re-trained quickly in infection-related disciplines to support the wards or other areas of the hospital.

We have identified some potential improvements to be made in terms of the management structure of our research nurse and practitioner community and are taking this forward with the Lead Research Nurse (Prof Mary Wells). This will be important as we plan to manage future waves of infection.

In addition, over 200 clinical academic staff from the College Faculty of Medicine volunteered to support clinical care of COVID-19 patients in the Trust. The Imperial AHSC, and in particular the close bilateral partnership between the College and the Trust, has been critical to close working over the previous 4 months.

Many of the new COVID-19 research studies were both intensive (from a procedural perspective) and intense (in terms of the personal and emotional impact on the staff), and we are looking at ways to recognise and reward those staff members who went 'above and beyond' during the most critical times. We have collated feedback from research delivery staff which has also identified areas which could be improved in the event of a 'second wave' or future pandemic, and which would provide further support to this important group of staff.

4) Support for National Urgent Public Health (UPH) Studies

As of the time of writing, 50 research projects have been badged as Urgent Public Health (UPH) studies by the Chief Medical Officer – these projects have been fast-tracked and given national priority in terms of regulatory and ethical approvals. In addition to having a potentially high impact on public health within 12 months, the UPH group considers the science underpinning each proposal, the feasibility of delivering in the current environment, the level of funding, and whether there is duplication of effort of potential interference with other studies. These studies cover a wide range of disciplines and approaches, from observational to interventional to data-only, looking at how to diagnose and treat COVID-19 in individuals and in populations.

Our Trust has recruited 1,987 participants into COVID UPH studies since March (the 6th highest among NHS Trusts in England) and has recruited to 14 different UPH studies overall – the highest in the country. See Annex C for more details.

The median set-up time for these studies (from receipt of study documentation to opening the study) was 6 days, an impressive response from those teams responsible for the local review of study feasibility, sponsorship, contracts and costings. This is often an 'unseen' activity, but rapid study set-up enables more patients to be recruited into studies by maximising the 'recruitment window'.

We recruited 83 patients to date to the RECOVERY trial (led by Oxford University) which recently highlighted the first proven effective treatment of COVID-19 (dexamethasone). 10 patients were recruited to the Gilead-sponsored studies which demonstrated the positive effect of remdesivir.

1,286 Trust patients have contributed to the International Severe Acute Respiratory & Emerging Infection Consortium (ISARIC) Clinical Characterisation Protocol (co-led nationally by Professor Peter Openshaw) which collects and analyses a wide variety of data from hospitalised patients in the UK. ISARIC CCP first identified the main demographic risk factors of the disease.

Through the NIHR Imperial Clinical Research Facility (CRF) at Hammersmith Hospital, we have recruited more than 250 volunteers for the Oxford vaccine study, and 15 to the successful initial phase of the Imperial vaccine study led by Professor Robin Shattock. In the current dose optimisation phase of the trial, 105 participants aged 18-75 are being randomised to receive their first shot of one of three doses of the vaccine, followed by a booster four weeks later.

5) Imperial-Led Research

Imperial is leading on 4 of the national UPH studies:

- A major UK government supported self-amplifying RNA (saRNA) vaccine study (Prof Robin Shattock; CoVAC01) has recruited 15 volunteers in the initial safety study. CoVAC02 – the next phase efficacy study to begin in October 2020 – will recruit ~6,000 participants and has secured £22.5m of funding from the NIHR. A social enterprise and commercialisation structure has also been founded, with the input of venture capital, to scale up the technology to population level next year if the vaccine is successful;
- Professor Mike Levin is leading a re-purposed European Commission-funded study (DIAMONDS-Search) which aims to design new diagnostic tests that can tell quickly and accurately what illness a patient has (including children) when they come to hospital with common symptoms such as fever. The same team (E Whitaker, H Lyall, M Levin) authored a paper in the Journal of the American Medical Association, which first characterised the new COVID-related syndrome in children now known as PIMS-TS (Paediatric Inflammatory Multisystem Syndrome – Temporally Associated with SARS-CoV-2);
- Pregnancy & Neonatal Outcomes in COVID-19, funded by UKRI/NIHR, is led by Ed Mullins and Christoph Lees. It is a global registry of women with suspected COVID-19 or confirmed SARS-CoV-2 infection in pregnancy and their neonates, aiming to evaluate the association of suspected infection in women in pregnancy with birth complications including miscarriage, foetal growth restriction and stillbirth, and pre-term delivery;
- The REMAP-CAP trial (led in the UK by Tony Gordon, Professor in Anaesthesia & Critical Care and ICHT Consultant in Intensive Care Medicine) is a platform trial for severely ill patients with COVID-19. It aims to generate evidence that can be applied during the pandemic to reduce mortality, reduce ICU use, and reduce morbidity in severely ill patients with COVID-19 infection.

A number of other important (non-UPH) studies have also been initiated from the Imperial AHSC in recent months, some of which are listed below. In total, nearly 100 individual research projects (including data-driven) have been approved by the Imperial AHSC COVID-19 Research Committee.

- Preventing Cardiac Complications of COVID-19 Disease with Early Acute Coronary Syndrome Therapy (C19-ACS) is a randomised controlled trial led by Dr Prapa Kanagaratnam which aims to determine whether acute coronary syndromes are occurring during COVID-19 disease and not being adequately diagnosed and treated;
- The Real-time Assessment of Community Transmission (REACT) 1 and 2 studies, led by Ara Darzi, Helen Ward, Graham Cooke, Wendy Barclay and Paul Elliott, are seeking to improve understanding of how the COVID-19 pandemic is progressing across England. Two major projects are looking at the possibility of using home sampling and testing to track the infection. REACT1 rolled out antigen (swab) tests to 120,000 randomly selected people across England in May. Initial findings have revealed that infection rates significantly fell, dropping by half every 8 to 9 days. During this period, on average around 1 in 1,000 people tested positive for the virus. Rates were found to be highest in care home workers (7 positive cases per thousand). The study was also able to estimate the reproduction (R) number – the number of people that an infected individual will pass the virus onto – as 0.57 (lower than previously reported). REACT2, will assess a number of different antibody tests to see how accurate they are and how easily people can use them at home. Critical development work for these studies was possible by close collaboration with the Trust where staff evaluated new tests before national roll-out.
- More than 20 data-driven projects have been reviewed and approved, analysing multiple sources of clinical data in a secure environment. These include the impact of COVID-19 on renal and immunosuppressed patients, analytics informing treatments in ICU, and improving currently-used early warning tools for predicting deterioration in patients with the virus.
- A cross-disciplinary team from Imperial (including Wendy Barclay, Alison Holmes, James Kinross, Jon Otter and Frankie Bolt) recently published a paper evaluating the role of surface and air contamination in SARS-CoV-2 transmission. This was based on a study which took place within

various Trust clinical areas. It found extensive viral RNA contamination of surfaces and air across a range of acute settings and will help to inform risk management in relation to various surgical and clinical procedures.

- The SPARTAN trial (Graham Cooke, Chris Toumazou) was a cross-disciplinary study (with the College's Faculty of Engineering) which validated an accurate point-of-care virus test, using a sample-to-result COVID-19 diagnostic test based on 'NudgeBox' and 'DnaCartridge' technology, capable of providing a result in less than 90 minutes. The study assessed the performance of this novel device for the diagnosis of COVID-19 from nasal swabs at the point of care, compared with the current standard of lab-based testing. The system is now implemented in ICHT and has been procured for national roll-out within the NHS.
- The Imperial Health Knowledge Bank (IHKB) is an ongoing research database and biobank of our patients who are interested in taking part in research studies. They provide consent to store biological samples for research, in order to increase our understanding of health conditions, detect diseases earlier, and develop new tests and treatments. IHKB has recently been amended to include recruitment of patients with COVID-19.
- BIOAID (Bioresource for Adult Infectious Diseases, part of the ISARIC consortium), is an NIHR Imperial BRC-supported collaborative project that aims to collect biological samples and clinical information from 10,000 episodes in which patients present to hospital with a suspected infectious disease. This initiative has been extended to include COVID-19 and identified novel signatures that will help to diagnose COVID.
- The School of Public Health has published a number of studies in collaboration with the Trust, to inform policy and practice at national level – in April, report 17 summarised the clinical characteristics and predictors of outcomes of patients hospitalised with COVID-19 at the Trust, and report 29 analysed the impact of COVID-19 on attendances to our emergency departments.

6) Communications

The NIHR Imperial BRC developed a new suite of webpages to highlight the ongoing COVID-19 research at Imperial, including details of key studies and their recruitment, and how to access the new secure data environment. The press offices in the Trust and College have issued daily highlights and newsletters, bringing COVID-19 research stories to the fore, internally and externally.

7) Re-starting Clinical Research, Learning & Insight

Taking into consideration new clinical pathways and infection controls, we have begun to re-start suspended clinical research studies and open new non-COVID-19 research. This has progressed cautiously (case-by-case basis), balancing potential risks and benefits to participants in those studies, modifying study procedures where possible, and bearing in mind available delivery staff resources and support services. Over 100 studies have now been re-started, including those which involve patients who are already in hospital or who need to come into hospital for treatment, and those trials which demonstrate a therapeutic benefit (e.g. cancer drug trials). We are continuing to explore how we extend our capacity to return to 'normal' in delivering clinical research across all specialties in a changed clinical environment.

Recent experience has demonstrated the benefits of close interaction between clinical practice and research, and this has happened almost in 'real time', particularly for those projects which can analyse and interpret large amounts of clinical data. Learning from research and evidence is a workstream in the new learning & insights programme within the Trust, which aims to provide regulatory assurance to our work during the first 'wave', inform planning for a potential second wave, and in the longer term to drive the Trust's broader approach to developing as a learning, research-driven organisation.

Annex A

Currently active COVID-19 research projects approved by the Imperial AHSC Research Committee:

Imperial-Sponsored Studies

1) 'Investigating the relationship between infectivity, PCR and Antibody testing at the time of tracheostomy', Mr Neil Tolley, Imperial College Healthcare NHS Trust
2) 'COV-CML UK National Retrospective Data Collection For COVID-19 Disease / SARS-CoV-2 Infection in CML Patients', Dr Dragana Milojkovic, Imperial College Healthcare NHS Trust
3) 'Functional trajectory of older patients admitted to hospital with COVID-19', Dr Melanie Dani, Imperial College Healthcare NHS Trust
4) 'Mortality rate associated with hospital acquired COVID-19', Mr Brian Drumm, Imperial College Healthcare NHS Trust
5) 'Evaluation of cell-mediated and humoral immunity following COVID-19 in pregnancy (ImmunoCOVID)', Dr Nishel Shah, Imperial College London
6) 'The representation of Black, Asian, and minority ethnic patients in COVID-19 drug trials at Imperial College Healthcare NHS Trust', Dr Graham Cooke, Imperial College London
7) 'Best Available Treatment Study for Paediatric Inflammatory Syndromes temporally associated with SARS-CoV-2', Professor Michael Levin, Imperial College London
8) 'The epidemiology, severity and outcomes of children presenting to emergency department across Europe during the Sars-Cov-2 pandemic', Dr Ruud Nijman, Imperial College London
9) 'REal-time Assessment of Community Transmission 2 (REACT 2): Usability and feasibility study of widespread home self-testing for SARS-CoV-2 antibodies', Dr Graham Cooke, Imperial College London
10) 'Coagulopathy associated with Covid 19 (CA-COVID-19) A Multi-Centre observational study', Dr Deepa Arachchillage, Imperial College London
11) 'Diagnosis and Management of Febrile Illness using RNA Personalised Molecular Signature Diagnosis', Dr Jethro Herberg, Imperial College London
12) 'Rapid and sensitive detection of SARS-CoV-2 using a nucleic acid based lab-on-a-chip diagnostic platform', Professor Alison Holmes, Imperial College London
13) 'Pregnancy and Neonatal Outcomes in COVID-19: A global registry of women affected by COVID-19 in pregnancy and their neonates, understanding natural history to guide treatment and prevention', Dr Edward Mullins, Imperial College London
14) 'The PanSurg-PREDICT Study', Dr James Kinross, Imperial College London
15) 'Investigating the relationship between the renin angiotensin system and the coagulopathy associated with COVID-19', Dr David Owen, Imperial College London
16) 'A first-in-human clinical trial to assess the safety and immunogenicity of a self-amplifying ribonucleic acid (saRNA) vaccine encoding the S glycoprotein of SARS-CoV-2, the causative agent of COVID-19 - COVAC1', Dr Katrina Pollock, Imperial College London
17) 'Determining the reproductive health of men post-COVID-19 infection', Dr Channa Jayasena, Imperial College London
18) 'Multi-organ failure in SARS-CoV2: identifying mechanisms and potential therapeutic targets', Dr Sanooj Soni, Imperial College London
19) 'Transmission of SARS-CoV-2 in Healthcare Settings', Professor Alison Holmes, Imperial College London
20) 'Artificial intelligence-assisted diagnosis and prognostication in COVID-19 using electrocardiograms and imaging (AICOV-19)', Dr Fu Siong Ng, Imperial College London
21) 'A study to assess the safety and efficacy of Clazakizumab in patients with COVID-19 and kidney disease.', Dr Michelle Willicombe, Imperial College London
22) 'ONCOVID: natural history and outcomes of cancer patients during the COVID19 epidemic', Dr David Pinato, Imperial College London

23) 'Preventing Cardiac Complications of COVID-19 Disease with Early Acute Coronary Syndrome Therapy: A Randomised Controlled Trial.', Professor Prapa Kanagaratnam, Imperial College London
24) 'Personalised Risk assessment in Febrile illness to Optimise Real-life Management across the European Union (PERFORM)', Dr Jethro Herberg, Imperial College London
25) 'An Epidemiological Study of Host and Microbial Risk Factors Leading to Acquisition of Hospital Infections', Professor Shiranee Sriskandan, Imperial College London
26) 'Identifying incidence and nature of fatigue in individuals infected with SARS-Cov-2 in the United Kingdom', Ms Adine Adonis, Imperial College London
27) 'Co-CO-19: Night-time Cough Surveillance for Disease Monitoring and Classification in COVID-19', Professor Nicholas Peters, Imperial College London
28) 'Imperial Health Knowledge Bank', Professor Paul Elliott, Imperial College London
29) 'Phase 2/3, Randomised, Open-Label, Single-Site, Multi-Arm Trial of Ruxolitinib Plus Best Available Treatment (BAT) versus Fostamatinib Plus BAT versus BAT for COVID-19 pneumonia', Dr Nichola Cooper, Imperial College London
30) 'The Impact of COVID19 on Renal Patients and Immunosuppressed patients', Dr Candice Clarke, Imperial College London
31) 'DISCOVER-consortium "Digital and non-invasive Screening for COVID19 with AI-ECG Repository"', Professor Nicholas Peters, Imperial College London

Commercially-Sponsored Studies

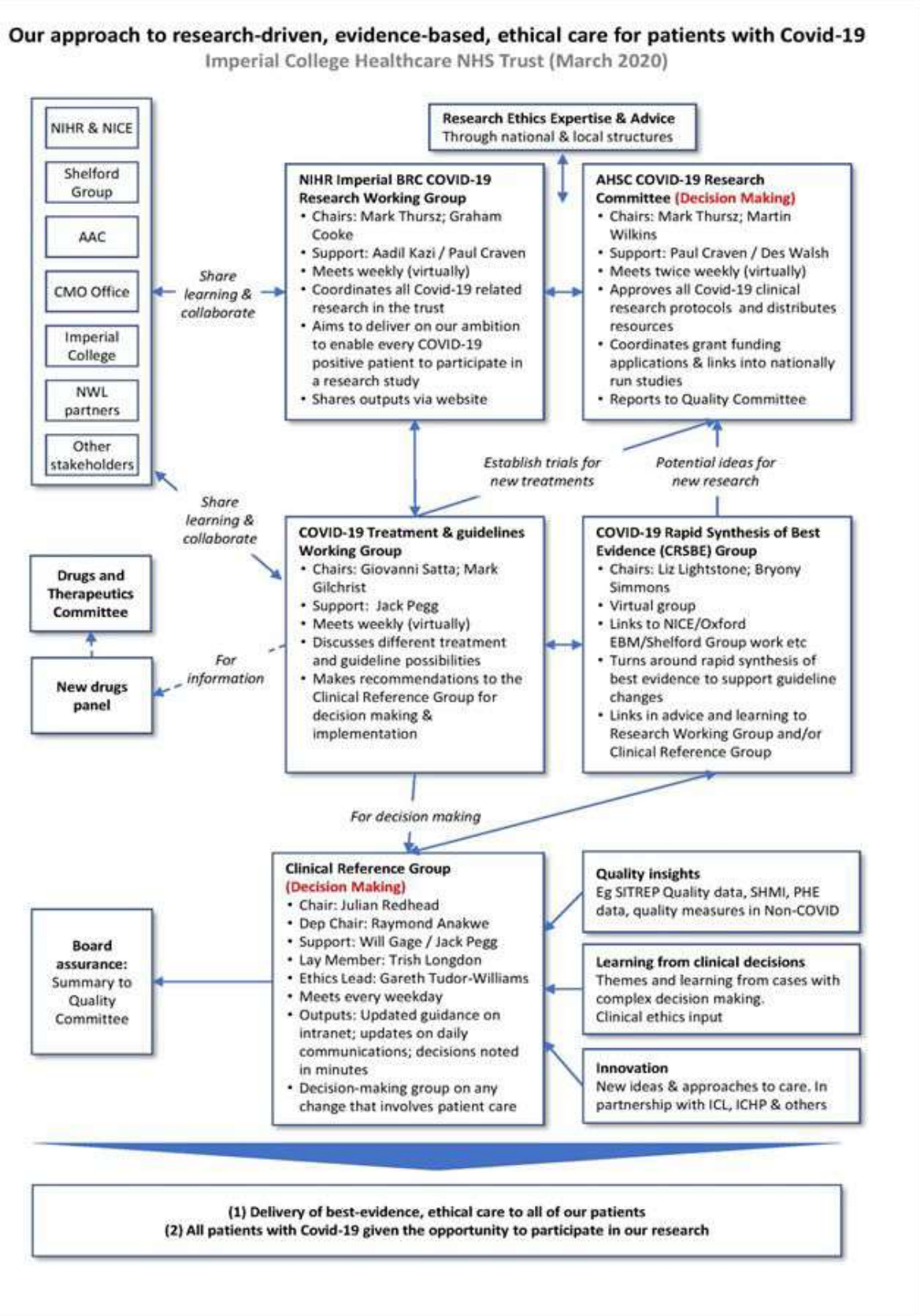
1) NOCoV2 - An open-label, adaptive randomized, controlled multicenter study to evaluate the efficacy and safety of RESP301 plus standard of care (SOC) compared to SOC alone in hospitalized participants with COVID-19 requiring supplemental oxygen', Dr Onn Min Kon, 30 Technology
2) 'A Phase 3 Open-label, Randomized, Controlled Study to Evaluate the Efficacy and Safety of Intravenously Administered Ravulizumab Compared with Best Supportive Care in Patients with COVID-19 Severe Pneumonia, Acute Lung Injury, or Acute Respiratory Distress Syndrome', Dr Michelle Willicombe, Alexion Pharmaceuticals
3) 'A randomized, double-blind, placebo-controlled, multi-centre study to evaluate the safety and efficacy of tocilizumab in patients with severe COVID-19 pneumonia', Dr Nichola Cooper, F.Hoffman-La Roche Ltd.
4) 'A Phase 3 Randomized Study to Evaluate the Safety and Antiviral Activity of Remdesivir (GS-5734) in Participants with Moderate COVID-19 Compared to Standard of Care Treatment', Dr Graham Cooke, Gilead Sciences, Inc.
5) 'A Phase 3 Randomized Study to Evaluate the Safety and Antiviral Activity of Remdesivir (GS-5734) in Participants with Severe COVID-19', Dr Sarah Fidler, Gilead Sciences, Inc.

Non-Commercially-Sponsored Studies

1) 'PROphylaxis for paTiEnts at risk of COVID-19 infecTion', Dr Megan Griffith, Cambridge University Hospitals NHS FT
2) 'Objective assessment of olfactory dysfunction and impact on quality of life in SARS CoV-2 (COVID-19) infection using the UPSIT, eQOD and SNOT-22 questionnaires: A prospective observational cohort study.', Ms Catherine Rennie, Cambridge University Hospitals NHS FT
3) 'A prospective non interventional study to evaluate the role of immune and inflammatory response in recipients of allogeneic haematopoietic stem cell transplantation (SCT) affected by severe COVID19 infection (COVID19_BMT)', Dr Josu de la Fuente, Great Ormond Street Hospital NHS FT

4) 'Studying the impact of COVID-19 on the NHS workforce to guide trauma-informed and psychologically-informed support provisio', Dr Sarah Finlay, Greater Manchester Mental Health NHS FT
5) 'Management protocol for the National COVID-19 Chest Imaging Database', Dr Susan Copley, NHS England
6) 'SIREN- Impact of detectable anti-SARS-COV2 on the subsequent incidence of COVID-19 in healthcare workers', Dr Frances Sanderson, Public Health England
7) 'SeroIncidence for COVID-19 Antibodies among frontline NHS Staff', Dr Frances Sanderson, Public Health England
8) 'COVID 19 in haemodialysis patients; clinical characteristics, risk factors and outcomes', Dr Damien Ashby, St Georges Healthcare NHS Trust
9) 'A phase III prospective, interventional, cohort, superiority study to evaluate the benefit of rapid COVID-19 genomic sequencing (the COVID-19 GENOMICS UK project) on infection control in preventing the spread of the virus in United Kingdom NHS hospitals', Professor Alison Holmes, University College London
10) 'NIHR BioResourceAdult Infectious Disease', Professor Shiranee Sriskandan, University College London
11) 'The impact of COVID-19 pandemic on the provision, practice and outcomes of vascular surgery', Mr Joseph Shalhoub, University Hospital Coventry & Warwickshire NHS Trust
12) 'Coronavirus infection in primary or secondary immunosuppressed children', Dr Elizabeth Whittaker, University Hospital Southampton NHS FT
13) 'Randomized, Embedded, Multifactorial, Adaptive Platform trial for Community-Acquired Pneumonia', Dr Anthony Gordon, University Medical Centre Utrecht
14) 'A randomised phase II proof of principle multi-arm multi-stage trial designed to guide the selection of interventions for phase III trials in hospitalised patients with COVID-19 infection', Dr Graham Cooke, University of Birmingham
15) 'Genetics Of Mortality In Critical Care', Dr David Antcliffe, University of Edinburgh
16) 'Post-hospitalisation COVID-19 study: a national consortium to understand and improve long-term health outcomes (PHOSP-COVID Study)', Dr Luke Howard, University of Leicester
17) 'Viral tropism of COVID-19 and the human immune system', Dr Michael Osborn, University of Leicester
18) 'Neonatal Complications of Coronavirus Disease (COVID-19) Study', Dr Chris Gale, University of Oxford
19) 'Chloroquine/ hydroxychloroquine prevention of coronavirus disease (COVID-19) in the healthcare setting; a randomised, placebo-controlled prophylaxis study (COPCOV)', Professor Alan Winston-O'Keefe, University of Oxford
20) 'Randomised Evaluation of COVID-19 Therapy', Dr Graham Cooke, University of Oxford
21) 'Maternal and perinatal outcomes of pandemic influenza or novel coronavirus in pregnancy', Dr Tom Prior, University of Oxford
22) 'A phase 2/3 study to determine the efficacy, safety and immunogenicity of the candidate Coronavirus Disease (COVID-19) vaccine ChAdOx1 nCoV-19', Dr Katrina Pollock, University of Oxford
23) 'A phase I/II trial of a candidate COVID-19 vaccine (COV001)', Dr Katrina Pollock, University of Oxford
24) 'Multicentre EuRopean study of MAjor Infectious Disease Syndromes (MERMAIDS): Acute Respiratory Infections in Adults', Professor Peter Openshaw, University of Oxford
25) 'Novel Coronavirus Observational Study: ISARIC/WHO Clinical Characterisation Protocol (CCP) for Severe Emerging Infections', Dr Graham Cooke, University of Oxford
26) 'RECOVERY-Supportive Care', Ms Clare Ross, University of Warwick

Annex B


Our approach to research-driven, evidence-based, ethical care for patients with Covid-19
Imperial College Healthcare NHS Trust (March 2020)
NIHR & NICE
Shelford Group
AAC
CMO Office
Imperial College
NWL partners
Other stakeholders
Share learning & collaborate
Research Ethics Expertise & Advice
Through national & local structures
NIHR Imperial BRC COVID-19 Research Working Group
• Chairs: Mark Thursz; Graham Cooke
• Support: Aadil Kazi / Paul Craven
• Meets weekly (virtually)
• Coordinates all Covid-19 related research in the trust
• Aims to deliver on our ambition to enable every COVID-19 positive patient to participate in a research study
• Shares outputs via website
AHSC COVID-19 Research Committee (Decision Making)
• Chairs: Mark Thursz; Martin Wilkins
• Support: Paul Craven / Des Walsh
• Meets twice weekly (virtually)
• Approves all Covid-19 clinical research protocols and distributes resources
• Coordinates grant funding applications & links into nationally run studies
• Reports to Quality Committee
Establish trials for new treatments
Potential ideas for new research
Share learning & collaborate
Drugs and Therapeutics Committee
New drugs panel
For information
COVID-19 Treatment & guidelines Working Group
• Chairs: Giovanni Satta; Mark Gilchrist
• Support: Jack Pegg
• Meets weekly (virtually)
• Discusses different treatment and guideline possibilities
• Makes recommendations to the Clinical Reference Group for decision making & implementation
COVID-19 Rapid Synthesis of Best Evidence (CRSBE) Group
• Chairs: Liz Lightstone; Bryony Simmons
• Virtual group
• Links to NICE/Oxford EBM/Shelford Group work etc
• Turns around rapid synthesis of best evidence to support guideline changes
• Links in advice and learning to Research Working Group and/or Clinical Reference Group
For decision making
Clinical Reference Group
(Decision Making)
• Chair: Julian Redhead
• Dep Chair: Raymond Anakwe
• Support: Will Gage / Jack Pegg
• Lay Member: Trish Longdon
• Ethics Lead: Gareth Tudor-Williams
• Meets every weekday
• Outputs: Updated guidance on intranet; updates on daily communications; decisions noted in minutes
• Decision-making group on any change that involves patient care
Board assurance: Summary to Quality Committee
Quality insights
Eg SITREP Quality data, SHMI, PHE data, quality measures in Non-COVID
Learning from clinical decisions
Themes and learning from cases with complex decision making.
Clinical ethics input
Innovation
New ideas & approaches to care. In partnership with ICL, ICHP & others
(1) Delivery of best-evidence, ethical care to all of our patients
(2) All patients with Covid-19 given the opportunity to participate in our research

Annex C Latest Trust-based Urgent Public Health (UPH) Study Data

The following data are extracted from the national NIHR Open Data Platform and relate to the CMO-badged UPH studies only (date of extract: 23 July 2020).

NHS Trust	LCRN	No. Studies	No. Studies Recruited	No. Participants
Imperial College Healthcare NHS Trust	NWL	17	14	1,987
University Hospital Southampton NHS Foundation Trust	W essex	16	13	2,674
Manchester University NHS Foundation Trust	GM	19	13	1,917
King's College Hospital NHS Foundation Trust	SL	16	13	779
Pennine Acute Hospitals NHS Trust	GM	15	12	1,977
Guy's and St Thomas' NHS Foundation Trust	SL	18	12	1,890
St George's University Hospitals NHS Foundation Trust	SL	19	12	1,639
Oxford University Hospitals NHS Foundation Trust	TVSM	14	12	1,390
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	NENC	17	12	1,273
Leeds Teaching Hospitals NHS Trust	YH	16	11	1,266
University Hospitals Plymouth NHS Trust	SW P	12	11	972
Royal Free London NHS Foundation Trust	NT	14	11	248
University Hospitals Birmingham NHS Foundation Trust	WM	13	10	2,875
Hull University Teaching Hospitals NHS Trust	YH	13	10	838
University Hospitals of Leicester NHS Trust	E Mids	10	9	2,078
NHS Lothian	Scotland	12	9	2,062
Liverpool University Hospitals NHS Foundation Trust	NWC	14	9	1,808
Sheffield Teaching Hospitals NHS Foundation Trust	YH	12	9	1,687
Aneurin Bevan University LHB	W ales	9	9	1,551
University Hospitals Bristol And W eston NHS Foundation Trust	WE	13	9	1,265

Table 1. Imperial College Healthcare has recruited patients/volunteers into the highest number of unique COVID-19 UPH studies nationally (n=14).

NHS Trust	LCRN	No. Studies	No. Studies Recruited	No. Participants
Manchester University NHS Foundation Trust	GM	19	13	1,917
St George's University Hospitals NHS Foundation Trust	SL	19	12	1,639
Guy's and St Thomas' NHS Foundation Trust	SL	18	12	1,890
Imperial College Healthcare NHS Trust	NWL	17	14	1,987
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	NENC	17	12	1,273
University Hospital Southampton NHS Foundation Trust	W essex	16	13	2,674
King's College Hospital NHS Foundation Trust	SL	16	13	779
Leeds Teaching Hospitals NHS Trust	YH	16	11	1,266
Pennine Acute Hospitals NHS Trust	GM	15	12	1,977
Bradford Teaching Hospitals NHS Foundation Trust	YH	15	8	697
Oxford University Hospitals NHS Foundation Trust	TVSM	14	12	1,390
Royal Free London NHS Foundation Trust	NT	14	11	248
Liverpool University Hospitals NHS Foundation Trust	NWC	14	9	1,808
University College London Hospitals NHS Foundation Trust	NT	14	9	806
University Hospitals Birmingham NHS Foundation Trust	WM	13	10	2,875
Hull University Teaching Hospitals NHS Trust	YH	13	10	838
University Hospitals Bristol And W eston NHS Foundation Trust	WE	13	9	1,265
University Hospitals Plymouth NHS Trust	SW P	12	11	972
NHS Lothian	Scotland	12	9	2,062

Table 2. Imperial College Healthcare has opened the third highest number of COVID-19 UPH studies nationally (n=17; NB. Opening a study does not necessarily mean that patients have been recruited into it yet).

NHS Trust	LCRN	No. Studies	No. Studies Recruited	No. Participants
Non-NHS Activity in North Thames	NT	2	2	3,784
University Hospitals Birmingham NHS Foundation Trust	WM	13	10	2,875
University Hospital Southampton NHS Foundation Trust	W essex	16	13	2,674
University Hospitals of Leicester NHS Trust	E Mids	10	9	2,078
NHS Lothian	Scotland	12	9	2,062
Imperial College Healthcare NHS Trust	NWL	17	14	1,987
Nottingham University Hospitals NHS Trust	E Mids	12	7	1,979
Pennine Acute Hospitals NHS Trust	GM	15	12	1,977
Manchester University NHS Foundation Trust	GM	19	13	1,917
Guy's and St Thomas' NHS Foundation Trust	SL	18	12	1,890
University Hospitals of North Midlands NHS Trust	WM	10	7	1,814
Liverpool University Hospitals NHS Foundation Trust	NWC	14	9	1,808
Gloucestershire Hospitals NHS Foundation Trust	WE	7	3	1,793
Non-NHS Activity in Thames Valley and South Midlands	TVSM	4	4	1,792
Sheffield Teaching Hospitals NHS Foundation Trust	YH	12	9	1,687
St George's University Hospitals NHS Foundation Trust	SL	19	12	1,639
Aneurin Bevan University LHB	W ales	9	9	1,551
Royal Berkshire NHS Foundation Trust	TVSM	7	7	1,550
University Hospitals of Derby and Burton NHS Foundation Trust	E Mids	8	5	1,510
Epsom and St Helier University Hospitals NHS Trust	SL	7	3	1,475

Table 3. As of 23 July 2020, ICHT had recruited the 6th highest number of participants nationally into COVID-19 UPH studies (n=1,987). NB: The "Non-NHS Activity in North Thames" figure reflects the high numbers of volunteers being screened into the Oxford vaccine study.

Trust Name	Estimated COVID admissions 20/03/2020 - 20/07/2020	Recruitment from 20/03/2020 - 20/07/20	Recruitment per 1,000 estimated COVID-19 admissions
Sheffield Teaching Hospitals NHS Foundation Trust	1,411	795	563
University Hospital Southampton NHS Foundation Trust	1,367	665	486
University Hospitals of Leicester NHS Trust	1,538	660	429
Guy's and St Thomas' NHS Foundation Trust	1,459	432	296
St George's University Hospitals NHS Foundation Trust	2,093	556	266
Pennine Acute Hospitals NHS Trust	1,309	328	251
North West Anglia NHS Foundation Trust	1,015	212	209
Oxford University Hospitals NHS Foundation Trust	1,072	206	192
Imperial College Healthcare NHS Trust	2,326	446	192
South Tees Hospitals NHS Foundation Trust	1,526	251	164
University Hospitals Birmingham NHS Foundation Trust	4,103	620	151
Frimley Health NHS Foundation Trust	1,020	147	144
Bedfordshire Hospitals NHS Foundation Trust	1,472	182	124
Nottingham University Hospitals NHS Trust	2,046	244	119
North Middlesex University Hospital NHS Trust	1,188	131	110
York Teaching Hospital NHS Foundation Trust	1,004	107	107
London North West University Healthcare NHS Trust	2,680	281	105

Table 4a. Of those NHS Trusts which have seen more than 1,000 COVID-19 patient admissions, we are 8th nationally in terms of the relative number of patients recruited to interventional studies (n=192 patients per 1,000 COVID-19 admissions).

Trust Name	Estimated COVID admissions 20/03/2020 - 20/07/2020	Recruitment from 20/03/2020 - 20/07/20	Recruitment per 1,000 estimated COVID-19 admissions
St George's University Hospitals NHS Foundation Trust	2,093	556	266
Imperial College Healthcare NHS Trust	2,326	446	192
University Hospitals Birmingham NHS Foundation Trust	4,103	620	151
Nottingham University Hospitals NHS Trust	2,046	244	119
London North West University Healthcare NHS Trust	2,680	281	105
King's College Hospital NHS Foundation Trust	2,947	190	64
Barts Health NHS Trust	2,633	147	56
Manchester University NHS Foundation Trust	4,124	225	55
Southend University Hospital NHS Foundation Trust	2,065	86	42

Table 4b. Of those NHS Trusts with more than 2,000 COVID-19 admissions, we are 2nd nationally in terms of the relative number of patients recruited to interventional studies.

Study Title	Speciality	Study Design	Sponsor	Recruitment to Date
Clinical Characterisation Protocol for Severe Emerging Infection	Infection	Observational	University of Oxford	1,324
Investigating a Vaccine Against COVID-19 (COV002)	Infection	Interventional	University of Oxford	151
A phase I/II trial of a candidate COVID-19 vaccine (COV001)	Infection	Interventional	University of Oxford	104
DIAMONDS Search	Infection	Observational	Imperial College London	99
Pregnancy and Neonatal Outcomes in COVID-19	Reproductive Health and Childbirth	Observational	Imperial College London	95
RECOVERY trial	Infection	Interventional	University of Oxford	83
Clinical trial of a SARS-CoV-2 vaccine in healthy men and women	Infection	Interventional	Imperial College London	60
GenOMICC	Critical Care	Observational	NHS Lothian	23
REMAP-CAP	Critical Care	Interventional	University Medical Centre Utrecht (Netherlands) / Imperial College London (UK lead)	21
A study to evaluate TCZ in patients with severe COVID-19 Pneumonia	Infection	Interventional	F. Hoffmann-La Roche Ltd	12
5773 Safety and Antiviral Activity of Remdesivir for severe COVID-19	Infection	Interventional	Gilead Sciences Inc	6
5774 Safety & Antiviral Activity of Remdesivir for moderate COVID-19	Infection	Interventional	Gilead Sciences Inc	4
COPCOV trial	Infection	Interventional	University of Oxford	4
RECOVERY - Respiratory Support	Respiratory Disorders	Interventional	University of Warwick	1
Coronavirus infection in immunosuppressed children	Children	Observational	University Hospital Southampton NHS Foundation Trust	questionnaire study
SARS-COV2 immunity and reinfection evaluation (SIREN)	Infection	Observational	Public Health England	0
UKOSS: Pandemic Influenza in Pregnancy	Reproductive Health and Childbirth	Observational	University of Oxford	registry
			TOTAL	1,987

Table 5. Imperial College Healthcare NHS Trust patient recruitment into COVID-19 UPH studies (to date).

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Month 02 integrated quality and performance report	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: Wednesday 29 July 2020	**Item 12, report no. 10**
Responsible Executive Director: Julian Redhead (Medical Director) Janice Sigsworth (Director of Nursing) Catherine Urch (Divisional Director) Tg Teoh (Divisional Director) Frances Bowen (Divisional Director) Kevin Croft (Director of People and Organisational Development) Claire Hook (Director of Operational Performance)	**Author:** Submitted by Performance Support Team

Summary:
The Board are asked to consider the integrated quality and performance report for month 2 which is presented in the new Imperial Management and Improvement System (IMIS) format.

Contents:
1. Summary report, including IMIS update and performance summary
2. M02 scorecard
3. Appendix 1 – Indicative summary of how metrics link to the prioritised objectives

Recommendations:

The Board is asked to (i) note the next steps with the development of the IMIS scorecard and (ii) note contents of the IMIS performance scorecard for month 2 and performance updates.

The performance sections have been discussed at:

Executive Finance Committee
Executive Operational Performance Committee
Executive Quality Committee
Board Quality Committee
Executive POD Committee

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

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

Risk impact and Board Assurance Framework (BAF) reference:

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

Workforce impact (including training and education implications):
none

Has an Equality Impact Assessment been carried out or have protected groups been considered?
☐ Yes ☐ No ☒ Not applicable

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

What impact will this have on the wider health economy, patients and the public?
Comprehensive performance and quality reporting is essential to ensure standards are met which benefits patients. The report is aligned with CQC domains to ensure the Trust has visibility of its compliance with NHS wide standards.

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

Trust strategic goals supported by this paper:

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

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

Imperial College Healthcare NHS Trust

Integrated quality and performance report

1. Introduction

1.1. The Board are asked to consider the integrated quality and performance report for month 2 which is presented in the new Imperial Management and Improvement System (IMIS) format.

2. IMIS update

2.1. At the meeting of the Trust Board on 25 March 2020 the Board received an update on the implementation plan for IMIS and agreed that performance data for March 2020 would be presented in both the existing IQPR format and in the proposed new IMIS format. In addition, the Board discussed the benefits of providing a reduced performance scorecard as part of the overall efforts to reduce reporting burden during the response to the Covid-19 pandemic.

2.2. At the meeting of the Trust Board on 20 May 2020, the IMIS scorecard was progressed and presented showing a reduced format. Feedback from the Board was that metrics should be aligned to the Trust's prioritised strategic annual objectives, categorised in the delivery framework as Focused Improvements, Trust Programmes and Trust Projects, as opposed to by domains of User Experience, People, Quality, Finance and Access.

2.3. The format of the enclosed performance scorecard has therefore been amended to present the performance metrics within the prioritised programmes.

2.4. In light of the strategy refresh that has taken place between June and July 2020, the Board scorecard is still to be noted as a work in progress as the Board may request further changes to be in line with any revision to the Trust's strategy.

3. Future reporting process and templates

3.1. At the next Board meeting in September, the reporting process will be governed by a set of 'business rules'. These business rules will determine the type of update required dependent on trend and recent performance. The business rules can be applied to performance metrics or milestone plans and reporting requirements are driven by 'by exception' principles and statistical process control rules. These updates may include sharing successes from sustained performance against target or statistically significant improvement against trajectory, providing a structured verbal update or presenting a full written countermeasure summary with trend analysis and improvement actions.

3.2. Where a metric requires a full written countermeasure summary, the format required consists of 4 sections:

- Section 1: a written problem statement and visual graphic depiction of historical performance, including the target, demonstrating when the issues started occurring
- Section 2: stratification of data to demonstrate a deeper level of understanding of where the issues are occurring
- Section 3: root cause analysis to demonstrate a deeper level of understanding of why and/or how the issues are occurring
- Section 4: action plan detailing the countermeasures and/or actions to address the root cause of the issues related to performance, i.e. what we are doing.

3.3. For programmes or projects that have deliverables that are dependent on milestone achievement, as opposed to metrics, the reporting template will be focused on detailing milestones achieved in the last month, milestones due in the next period and risks/issues and mitigation plans. Four of the eight Trust priority programmes are currently not represented in the enclosed scorecard but will be covered through the milestone reporting template.

4. Next steps

4.1. Further detail on the proposed forward plan of changes in the routines and reporting for Board and Board committees is detailed in the "Proposed changes to Executive and Board routines – Transition to a 'new norm'" paper.

4.2. In regard to the next steps on scorecard development, the plan is as follows:

4.2.1. **Board IMIS scorecard.** To be approved. Reporting of countermeasure summaries and reporting of milestone achievement to be in place by the next Board meeting in September.

4.2.2. **Executive IMIS scorecard.** To be developed in July.

4.2.3. **Programme scorecards.** To be developed in July / August.

4.2.4. **Division IMIS scorecards.** To be developed in September/October/November in line with the business planning process.

4.3. Due to the impact of Covid-19 on performance as a whole we are not yet utilising the aforementioned approach and countermeasure summaries are not provided at present. The performance summary below provides a narrative on the points of note.

5. Performance summary at month 2

5.1. The size of the Referral to Treatment waiting list reduced by 6% compared to April 2020 and was 20% lower than the pre-Covid level. The reduction, which occurred during March, April and May, has been driven by a drop in referrals we well as optimised use of clinical advice and guidance through the NHS e-Referral service. We are predicting no further reduction in the RTT waiting list for June as referrals have started to rise.

5.2. As anticipated the number of patients waiting over 52 weeks for treatment has increased as a result of patients continuing to be on hold for treatment. A total of 258 patients had been waiting for more than 52 weeks at the end of May and the final figure June is expected to be over 500 patients.

5.3. As part of the wider elective recovery response, the Trust is implementing a system to ensure that all patients on our waiting lists have a documented and timely assessment of risk and priority. A prioritisation project has been established and the prioritisation clinical harm matrix has been agreed. We are working with clinical teams to put this in place and training for clinicians will continue throughout July.

5.4. Patients who are waiting for elective surgery are being managed according to clinically agreed priority levels and risk assessment. Some patients who cannot be booked at ICHT (including urgent and cancer) are being offered treatment in the independent sector.

5.5. The volume of cancer 2 week wait activity has continued to increase and is predicted to recover to pre-Covid volumes by the end of July. The 2 week wait performance was 96.4% against the 93% target. The Corporate Cancer team is working with services to prepare for more significant increases in referrals resulting from delayed patient presentation to primary care.

5.6. 62-day GP referral to first treatment performance was 75.9% against the 85% standard. Treatment activity has reduced significantly, from 104 treatments in April to 54 in May, reducing our breach tolerance. Imaging waiting times have remained good throughout the pandemic, but endoscopy and biopsy waiting times have increased. FIT testing (faecal immunochemical test) in primary care for suspected colorectal cancer was implemented in May and has mitigated demand on endoscopy services. Biopsy capacity is improving as surgical pathways are re-established on site and through partnership with Independent Sector providers and the Cancer Hub.

5.7. All cancer MDTs are following the NHS England surgical prioritisation guidelines, recorded in MDT meeting outcomes. This work has supported surgical scheduling through the Cancer Hub and with Independent Sector providers. As priority 3 patients (requiring surgery within 12 weeks) begin to be scheduled from June onwards, it is expected that longer waiting times will be reported against the 62-day standard. This will result in additional breaches, and consequently performance against the standard is expected to remain below 85% in June and July.

5.8. 66% of patients were waiting more than 6 weeks for their diagnostic test at the end of May. Prioritisation work continues, including identifying patients for completion of their diagnostic test within the independent sector. Imaging services are working as part of a NWL sector wide approach to assess capacity and ensure each Trust has access to additional capacity through the independent sector providers.

5.9. There was a significant spike in the number of patients waiting for over 12 hours in our emergency departments from the decision to admit to admission in March 2020. These breaches were related to the need to isolate patients on admission. This has now recovered to 5 in May, with 3 of the 5 were mental health waits. No acute breaches were recorded for June.

5.10. Improving waiting times for mental health patients in the emergency department is a key area of focus for the coming winter. The ICHT QI Team will facilitate a virtual event in mid-July to share learning from recent months and plan next steps with representatives from West London Mental Health Trust and Central and North West London NHS Foundation Trust.

5.11. The number of Long stay inpatients rapidly reduced during the Covid-19 period. At the end of May there were 143 patients with a stay of 21 days or more, latest figures show a further reduction in June to 127 occupied beds. Long length of stay is being managed as a *focused improvement* as part of IMIS and there will be continued improved working with external partners.

5.12. The overall incident reporting rate has dropped and this is related to a reduction in overall patient activity to a certain extent. Incident reporting is a *focussed improvement* for 2020/21 and will be reviewed as part of this workstream.

There were 45 Moderate incidents recorded for May and one major harm incident which is under the category ‘Failure to Rescue’, and is currently under investigation. There were no extreme harm incidents in May 2020.

Moderate and above incidents accounted for 5.09% of all incidents in May. This figure is high compared to our normal harm profile for one month, however our 12-month rolling average for moderate and above incidents remains low at 1.6% of all incidents reported in the previous 12-months. Of the 45 moderate harm incidents, nine relate to pressure ulcer incidents, associated with pressure damage from proning and respiratory support for patients with COVID-19 in critical care. The tissue viability team are undertaking further analysis and a full report will be presented to the executive quality committee in August. There were also six moderate harm incidents related to infection prevention and control practice. This compares to 13 for the whole of 2019/20. These relate to three (non COVID) outbreaks and three COVID related incidents

5.13. The Trust's vacancy rate at the end of May 2020 was 7.1%; this figure includes those staff employed to support the Trusts Covid-19 response and without these the overall vacancy rate is 10.1%.

5.14. For the months of April and May 2020, sickness absence was 9.2% and 4.5% respectively, reflective of the peak of staff absence due to Covid-19 during April and the declining rate during May. Over a 12-month rolling period, the sickness absence rate currently stands at 4.0%.

5.15. NHS Digital has suspended the collection of Friends and Family Test performance data and therefore figures are not included.

6. Recommendation

6.1. The Board is asked to (i) note the next steps with the development of the IMIS scorecard and (ii) note contents of the IMIS performance scorecard for month 2 and performance updates.

Imperial College Healthcare NHS Trust

IMIS performance scorecard - Board version

FI = Focussed improvement

M2 May 2020

Section	FI	Site	Metric	Target	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Business rules	SPC variation
Quality safety improvement	FI	Y	**Patient safety incident reporting rate**	>=50.38	48.36	56.43	57.04	47.70	51.01	54.99	56.10	49.38	59.99	56.57	47.41	30.70	31.90		-
	FI	Y	**Hand hygiene compliance - TBC**	tbc	-	-	-	-	-	-	-	-	-	-	-	-	-		-
		Y	Trust-attributed MRSA BSI	0	2	1	0	0	0	0	0	0	0	0	0	0	0		-
		Y	Trust-attributed C. difficile	tbc	9	11	12	10	6	10	7	10	12	3	6	8	7		-
		Y	E. coli BSI	tbc	6	5	8	3	5	10	9	7	6	3	3	2	5		-
		Y	CPE BSI	0	0	2	1	3	0	0	0	0	1	1	0	0	1		-
		Y	% of incidents causing moderate and above harm	<1.68%	1.48%	1.35%	1.30%	1.25%	1.36%	1.44%	1.46%	1.47%	1.49%	1.43%	1.37%	2.65%	3.89%		-
			HSMR (rolling 12 months)	<100	57	64	72	56	60	55	72	79	60	60	65	66	63		-
Safe and Sustainable Staffing			Vacancy rate	<10%	11.7%	11.7%	12.0%	11.7%	11.1%	10.3%	9.7%	10.0%	9.7%	9.1%	8.9%	8.4%	7.1%		-
	FI	Y	**Agency expenditure**	tbc	3.4%	3.1%	3.2%	3.1%	2.9%	2.8%	2.8%	2.7%	2.6%	2.5%	2.5%	0.8%	0.5%		-
			Staff Sickness (rolling 12 month)	<=3%	3.17%	3.19%	3.20%	3.18%	3.18%	3.24%	3.26%	3.29%	3.29%	3.29%	3.70%	4.00%	4.05%		-
			Staff turnover (rolling 12 months)	<12%	11.6%	11.3%	11.8%	11.7%	11.8%	11.8%	11.8%	11.8%	12.0%	11.7%	12.1%	11.0%	11.8%		-
			Core skills training	>=90%	91.8%	91.9%	92.5%	93.5%	93.8%	93.8%	94.3%	94.3%	93.4%	93.2%	94.0%	94.4%	95.2%		-
Culture	FI	Y	**User experience - TBC**		-	-	-	-	-	-	-	-	-	-	-	-	-		-
			Placeholder TBC		-	-	-	-	-	-	-	-	-	-	-	-	-		-
Recovery and			RTT waiting list size	tbc	63,097	63,088	63,098	62,918	62,664	60,992	63,036	62,608	62,583	62,932	59,324	53,774	50,570		SC
			RTT 52 week wait breaches	0	0	1	0	2	3	2	4	8	2	1	10	90	258		SC
			Diagnostics waiting times	1.0%	0.90%	0.75%	0.90%	1.00%	0.50%	0.69%	1.15%	1.67%	0.79%	0.51%	8.50%	87.0%	65.7%		SC
			Cancer 2 week wait	>=93%	92.5%	91.0%	85.8%	82.9%	84.5%	89.1%	91.7%	89.6%	86.2%	93.5%	89.1%	92.9%	96.4%		CC
			Cancer 62 day wait	>=85%	91.5%	86.7%	87.3%	86.9%	86.3%	83.7%	87.4%	89.1%	80.8%	78.4%	86.1%	85.0%	75.9%		CC

Imperial College Healthcare NHS Trust

IMIS performance scorecard - Board version

FI = Focussed improvement

M2 May 2020

Section	FI	Site	Metric	Target	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Business rules	SPC variation
Recovery and Reset (contd.)	FI	Y	Ambulance handover delays	tbc	89.0%	90.0%	90.6%	90.6%	91.4%	92.7%	92.7%	89.3%	89.5%	88.3%	84.4%	87.7%	92.6%		CC
		Y	Patients waiting >12 hours from decision to admit to admission	0	7	22	17	8	7	8	5	11	16	21	135	39	5		CC
		Y	**Long length of stay - 21 days or more**	tbc	235	234	218	212	212	208	206	233	224	229	191	131	143		SC
		Y	Bed occupancy	tbc	84.8%	83.7%	84.8%	83.1%	84.3%	89.2%	90.3%	83.9%	85.7%	85.3%	68.6%	51.5%	49.6%		SC
		Y	Formal complaints	<100	104	96	136	87	98	100	83	87	80	80	67	32	53		-
Finance			YTD position £m		0.05	0.97	0.97	1.09	1.03	4.80	3.19	1.01	1.01	0.97	-1.47	2.66	6.14		-
			Forecast variance to plan		-	-12.58	-18.11	-11.34	-9.14	-5.02	-6.51	-3.52	-2.62	-3.43	-	-	-		-
			CIP variance to plan		66.5%	65.7%	64.6%	66.0%	74.1%	73.5%	74.8%	75.0%	74.4%	75.7%	75.7%	-	-		-

1) Four priority programmes are currently not included in the above and will be covered by the milestone reporting template (redevelopment, IMIS implementation, IPH growth, West London Children's).

2) Figures are highlighted Red / Green according to whether performance is above/below target.

3) Due to Covid-19 NHSE/I paused operational planning for 2020/21 and a number of the nationally reported metrics do not yet have trajectory targets. These are marked as 'tbc'. However, it is expected that internal targets will be set through the Trust's recovery programme.

4) SPC (statistical process control) is applied to selected metrics. CC - denotes common cause variation and no significant change. SC - denotes special cause variation. *Currently all special cause highlighted above is as a result of Covid-19 impact on performance.*

5) A metric on Emergency Department waiting times will be added once the outcomes of the national UEC field testing are made clear. Publication of the Clinical Review of NHS Access Standards has been deferred to later this year.

6) Due to the reporting lag the HSMR is only available up until February 2020.

Appendix 1: Alignment of IMIS scorecard metrics (Board version) with prioritised programmes and objectives

Prioritised programmes / scorecard metric	High quality integrated care system	Sustainable portfolio of services	Learning, improvement, innovative organisation	National regulatory / reporting requirement
Quality, safety improvement				
• Patient safety incident reporting rate [focussed improvement]		✓	✓	✓
• Hand hygiene compliance [focussed improvement]		✓	✓	
• Trust-attributed MRSA BSI		✓		✓
• Trust-attributed C. difficile		✓		✓
• E. coli BSI		✓		✓
• CPE BSI		✓		✓
• % of incidents causing moderate and above harm		✓		✓
• HSMR		✓		✓
Safe and sustainable staffing				
• Vacancy rate		✓	✓	✓
• Agency expenditure [focussed improvement]		✓		✓
• Staff Sickness		✓		✓
• Staff turnover		✓	✓	✓
• Core skills training		✓		✓
Culture programme				
• User experience [focussed improvement]	✓	✓	✓	
Recovery and reset				

Prioritised programmes / scorecard metric	High quality integrated care system	Sustainable portfolio of services	Learning, improvement, innovative organisation	National regulatory / reporting requirement
• RTT waiting list size	✓	✓		✓
• RTT 52 week wait breaches	✓	✓		✓
• Diagnostics waiting times	✓	✓		✓
• Cancer 2 week wait	✓	✓		✓
• Cancer 62 day wait	✓	✓		✓
• Ambulance handover delays	✓	✓		✓
• Patients waiting >12 hours from decision to admit to admission	✓	✓		✓
• Long length of stay - 21 days or more [focussed improvement]	✓	✓		✓
• Bed occupancy	✓	✓		✓
• Formal complaints		✓	✓	✓
Finance				
• YTD position £m		✓		✓
• Forecast variance to plan		✓		✓
• CIP variance to plan		✓		
Redevelopment		✓		
Imperial Way Management & Improvement System			✓	
IPH Growth		✓	✓	
West London Children's	✓	✓	✓	

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Finance Report for June 2020	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 29th July 2020	**Item 13, report no. 09**
Responsible Executive Director: Jazz Thind, Chief Financial Officer	**Author:** Des Irving-Brown, Deputy Chief Finance Officer Michelle Openibo, Associate Director: Business Partnering

Summary:
This paper provides the Board with an update on the financial position for the Trust for the three months to the 30th June 2020.

Key highlights:

- For the first 4 months of the year the Trust has been given block funding for clinical activity for the year with an agreement to fund a break even position. The Trust is on a block contract for NHS clinical activity, there has been a 57% reduction in this activity compared to the same period of the last financial year
- The Trust requires £16.6m of additional funding from NHS I/E to achieve this break even
- £20.3m of costs have been spent in response to the Covid-19 pandemic
- £16.2m of income has been lost due to Covid-19 due to reductions in private patients, overseas visitors and R&D where resources have been used to support NHS activity
- The Trust has spent £14m capital year to date against a £17.4m plan, this assumes all Covid-19 capital is funded centrally
- Cash was £137m at the end of June, balances are higher as the block payment have been made in advance

Recommendations:
The Committee is asked to note this report.

This report has been discussed at: N/A

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

Financial impact:
Has no financial impact

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

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

Has an Equality Impact Assessment been carried out or have protected groups been considered?
☐ Yes ☐ No ☒ Not applicable

If yes, are further actions required? ☐ Yes ☒ No
What impact will this have on the wider health economy, patients and the public? ☐ Yes ☐ No ☒ Not applicable
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To develop a sustainable portfolio of outstanding services
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No ▪ *Should senior managers share this information with their own teams? Yes*

Imperial College Healthcare NHS Trust

Trust Board 29th July 2020

Finance Report June 2020

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Scorecard

Imperial College Healthcare NHS Trust

	Plan £m	Actuals £m	Variance £m
Year to Date Position before Covid-19 specific costs and Top up	(18.80)	8.98	27.78
Advanced Top Up	10.86	10.86	-
Income lost due to Covid-19		(16.20)	(16.20)
Covid-19 expenditure		(20.26)	(20.26)
Reported Position before true up	**(7.94)**	**(16.62)**	**(8.69)**
Retrospective true up		16.62	16.62
Reported Position	**(7.94)**	**0.00**	**7.94**

Risks

Covid costs – the Trust has not received guidance on the revised financial regime post July. It is expected that further revenue funding for Covid-19 costs will attract additional scrutiny and it is therefore essential that we continue to track closely COVID-19 spend and ensure we have a robust narrative on the drivers to be able to future secure reimbursement. Should this not be forthcoming, this may need to be funded by efficiencies.

True-up payments - these are not guaranteed however the Trust has received confirmation of month 1 (£6.4m) & month 2 (£3.4m).

Soft FM – given the change in service provision during Covid-19 it is currently difficult to confirm the cost associated with BAU requirements. An initial view is expected at the end of July but this is likely to be subject to change as the Trust's activity changes.

Activity – the block funding means there has been no reduction in income from loss of activity. Cost reductions are likely to be on a marginal basis. The removal of the block contract will result in a large deficit position for the Trust.

Capital - We have approved a number of capital investments linked to changes needed or learnings from the pandemic. COVID capital reimbursements to the value of £5.2m have been submitted for funding with confirmation awaited. This expenditure is not assumed to score against the national sector CRL allocation. Should funding not be forthcoming then this is likely to result in a breach of the Trust's (and ultimately the sector) CRL.

Commentary

- Under the current financial regime the Trust is expected to show a break even position in month. This financial regime is confirmed to be in place until the end of July and is expected to continue to the end of October.
- At the end of June 2020, before the additional true up funding, the Trust delivered a net deficit position of £16.6m. This is driven by :-
  - Covid-19 related costs and income losses of £36.5m (£20.3m and £16.2m respectively), with the latter linked to reductions in private patients, overseas visitors and R&D.
  - the additional cost pressure associated with the in-housing of hotel services of £3.4m, of which £3.2m was expected by the Trust but not funded in the block
  - offset by expenditure reductions in other clinical and non clinical areas
- Activity – total Trust activity year to date is 57% down compared to this time last year.
- Capital – YTD the Trust has incurred 80% of plan (FOT on plan)
- Cash at 30th June was £137m, driven by the payment on account
- NHSE/I Use of Resources Financial risk rating – 3 (1 being the best). Although not utilised at present this is the rating the regulator used to measure overall financial performance

Strategy and Forecast

- Ongoing work to understand the block arrangements
- MUST maintain financial control on cost run rate
- Sector wide working to ensure the cost of resuming patient care is understood including impact of enhanced IPC measures; use of independent sector etc.

Statement of Comprehensive Income

Imperial College Healthcare NHS Trust

	Year to date		
	Plan £m	Actual £m	Variance £m
Income	311.70	296.78	(14.91)
Pay	(176.67)	(184.22)	(7.54)
Non Pay	(129.63)	(115.79)	13.85
EBITDA	**5.39**	**(3.22)**	**(8.61)**
Financing cost and donated asset treatment	(13.33)	(13.40)	(0.08)
Impairment of assets	0.00	0.00	-
Surplus/deficit before retrospective "true up"	**(7.94)**	**(16.62)**	**(8.69)**
Retrospective "true up"	(0.00)	16.62	16.62
Surplus/deficit	**(7.94)**	**0.00**	**7.94**

In month before the retrospective top up payment, the Trust delivered a deficit of £6.8m against an NHSE/I expected position of break even (£16.6m YTD).

Key highlights are:-

- £9.1m loss of private patient income
- £4.5m deferral of research income
- £20.3m additional covid-19 costs
- £1.8m of overseas income loss
- £3.4m of soft FM cost pressure
- £26.4m non recurrent expenditure reductions

- **Income** – the Trust is adverse to plan due to a loss of income from changes due to Covid pandemic, driven mainly by reductions associated with private patient (PP) activity and agreements associated with how research funding is to be accounted for. PP income is £4.2m YTD (£12.8m for the same period in 19/20). PP activity is not expected to return to previous levels in this financial year due to overseas travel restriction and the need to use private facilities for NHS activity.

- **Pay** – the pay overspend includes £11.0m of COVID-19 related costs driven by sickness cover, additional time worked by staff; Imperial college staff seconded into the NHS during the pandemic and nursing students brought onto the payroll early. Removing this expenditure results in the Trust being underspent on pay due to a reduction in activity.

- **Non Pay** – overall non pay in underspent however this includes £8.8m in non pay costs for Covid-19 spend including the provision of additional PPE, hotel accommodation and related costs and other costs to support Covid activity. In month non pay costs have also increased within clinical divisions linked to activity increases.

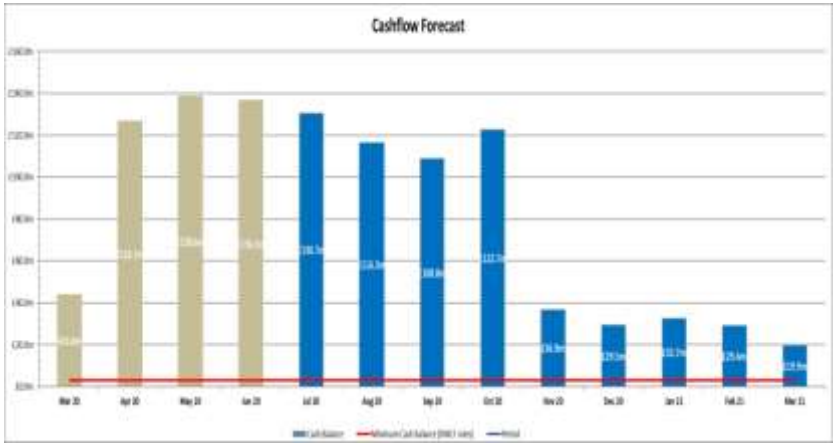
- **Financing costs -** there is a small overspend on financing costs due to Public Dividend Capital(PDC) being over plan.

Statement of Financial Position (Balance Sheet)

Imperial College Healthcare NHS Trust

	31-Mar-20	30-Jun-20	Movement
Property plant and equipment	538.1	542.0	3.9
Intangible assets	4.3	3.9	(0.4)
Total Non-current assets	**542.4**	**545.9**	**3.5**
Inventories	15.3	15.3	0.0
Trade and other receivables	125.5	98.1	(27.4)
Cash and cash equivalents	43.9	136.5	92.6
Total current assets	**184.7**	**250.0**	**65.3**
Trade and other payables (<1 year)	(229.6)	(298.4)	(68.8)
Total current liabilities	**(229.6)**	**(298.4)**	**(68.8)**
Non Current Liabilities	(18.1)	(18.4)	(0.3)
Total non current liabilities	**(18.1)**	**(18.4)**	**(0.3)**
Net Assets employed	**479.4**	**479.1**	**(0.3)**

Public Divided Capital	720.8	720.8	0.0
Revaluation Reserve	2.5	2.5	0.0
Income and expenditure reserve	(243.9)	(244.2)	(0.3)
Total tax payers' and other equity	**479.4**	**479.1**	**(0.3)**



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

Current Assets
Trade receivable balances have reduced by £27.4m in the year, in particular relating to other NHS bodies as the current funding arrangements have stabilised payment patterns and older debts have been settled. Inventory balances are broadly stable.

Cash
Cash balances are unusually high due to the temporary funding arrangements in place as part of the response to Covid-19. The main drivers of increased cash are the bringing forward of SLA and contract payments from NHS England and Commissioners, and the move to a block payment model.

The favourable cash position is expected to unwind during the year and there remains considerable uncertainty around the cash position later in the year pending further clarity on future funding arrangements (in respect of both cash flow financing and the underlying cash generation from ongoing activities).

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

Taxpayers' and Other Equity
Public Dividend Capital balances are unchanged but are expected to increase significantly over the year as funding is received for capital projects and a current working capital loan is converted to equity in line with recent government announcements.

Retained earnings are currently stable, in line with the guidance to report a break-even position, but are subject to uncertainty around the future funding environment and cost base as the current situation evolves.

Capital

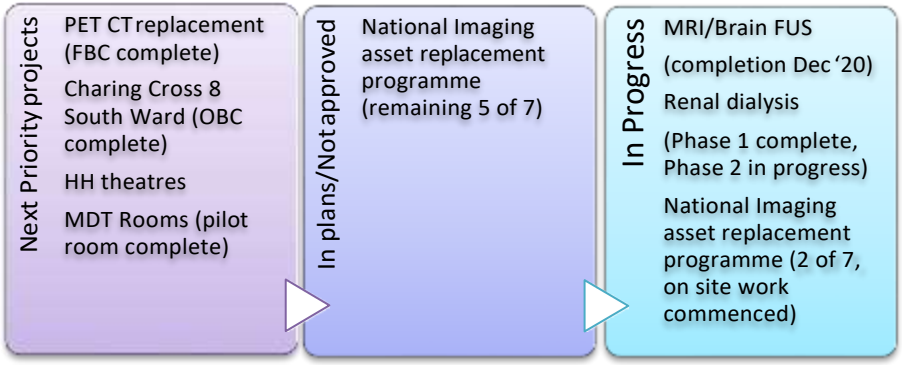
Imperial College Healthcare NHS Trust

Sources of Funds	£m
Internally Financed (Depr'n & Cash)	42.3
Public Dividend Capital - agreed	13.3
Public Dividend Capital - not agreed	4.2
Charitable Funds	1.3
Total	**61.1**

Applications	Annual Plan	YTD @ Month 3 Plan £m	YTD @ Month 3 Actual £m	YTD @ Month 3 Var £m	
Backlog Maintenance	17.4	7.1	7.0	0.1	
ICT	7.0	1.4	0.4	1.1	
Replacement of Med Equip.	6.2	1.5	0.3	1.2	
Other Capital Projects	21.3	2.5	1.7	0.8	
Redevelopment	5.0	0.9	0.6	0.3	
Covid-19*	4.2	4.0	4.0	0.0	
Total	**61.1**	**17.5**	**14.0**	**3.4**	
Actual spend as a % of plan			*80%*		

On plan <10% off plan >10% off plan

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



Summary

The Trust has continued to make good progress on delivering its capital programme at Month 3 with spend of £3.2m in month bringing the year-to-date total spent to £14.0m against a plan of £17.5m.

The main areas behind against year-to-date plan are the Brain FUS MRI project (£0.9m behind) and the ICT programme (£1.1m behind), both of which are due to Covid-19 related delays earlier in the year. Both schemes and indeed the overall programme are expected to spend to plan in the year.

To-date the Trust has managed its capital expenditure within the context of four major uncertainties:

- **Agreement of capital plan with NHSI and North-West London Sector -** The Trust has submitted its capital plans in conjunction with the North-West London sector and accounts for 15% of the NWL sector's £290m envelope (excluding nationally-allocated programmes). Plan levels presented are based on the draft plan submitted to NHSI/E, but formal confirmation of these is awaited.
- **Covd-19 capital expenditure -** The Trust is planning on the basis that expenditure of £4.2m on Covid-related projects requested to date will be financed by the DHSC through PDC to be awarded in-year, but confirmation has not been formally received and if PDC is not forthcoming this would create a budget pressure. A further £0.9m of Covid 19-related expenditure has been approved which may be an additional pressure if funding is not agreed.
- **Post-Covid-19 Recovery & Re-set** - to date, there is uncertainty around the sources and level of funding available for capital works required as part of the recovery of services following the initial peak of the Covid-19 pandemic. Prioritisation exercises are being carried out across the sector but it remains possible that recovery works may need to be financed from existing resources.
- **Level of cash resources available** - The Trust is currently holding unusually large cash balances due to covid financing arrangements that are expected to unwind later in the year. As the post Covid-19 cash regime is understood more clearly, there will need to be a corresponding assessment of the impact of this on the availability of cash towards the capital programme.

Divisional Overview

Imperial College Healthcare NHS Trust

		Year to Date Plan £m	Year to Date Actual £m	Year to Date Variance £m
Medicine and Integrated Care	Income	81.91	81.64	(0.26)
	Expenditure	(62.08)	(57.10)	4.98
	Internal Recharges	(3.02)	(3.02)	0.00
	Total	**16.81**	**21.53**	**4.72**
Surgery, Cancer and Cardiovascular	Income	92.66	92.53	(0.13)
	Expenditure	(79.06)	(69.08)	9.98
	Internal Recharges	4.48	4.48	(0.00)
	Total	**18.07**	**27.93**	**9.86**
Women, Children & Clinical Support	Income	42.21	41.64	(0.57)
	Expenditure	(43.80)	(39.23)	4.56
	Internal Recharges	5.52	5.52	0.00
	Total	**3.94**	**7.93**	**3.99**
Imperial Private Healthcare	Income & Expenditure	6.63	(0.31)	(6.94)
	Internal Recharges	(6.98)	(6.99)	(0.00)
	Total	**(0.35)**	**(7.30)**	**(6.95)**
Total Clinical Division		**38.47**	**50.09**	**11.62**
Non- Clinical Division	Medical Directorate	(2.68)	(2.30)	0.38
	Education	10.41	10.48	0.07
	R&D	0.29	(4.09)	(4.39)
	Nursing	(1.18)	(1.14)	0.04
	Estates	(21.80)	(22.39)	(0.59)
	Finance	(3.59)	(3.39)	0.20
	People & Org. Devel.	(1.96)	(2.15)	(0.19)
	Information & Technology	(6.30)	(6.37)	(0.08)
	Communication	(0.48)	(0.59)	(0.11)
	Office of the CEO	(2.80)	(2.45)	0.35
Total Non- Clinical Division		**(30.08)**	**(34.41)**	**(4.32)**
NHS Income	Clinical Commissioning	35.45	35.66	0.20
	Drugs & Devices (Cost)	(27.90)	(22.41)	5.49
Other Income	Central Income	12.64	10.67	(1.97)
Central Costs	CNST & Other Central Costs	(11.12)	(11.08)	0.04
	Pathology Residual	(9.04)	(8.45)	0.59
	Hosted Services	0.00	0.00	0.00
	Reserves	(3.03)	(3.03)	(0.00)
	Covid 19	0.00	(20.26)	(20.26)
Total Central Income and Costs		**(3.00)**	**(18.91)**	**(15.91)**
Financing Donated Asset + Impairment Adj		(13.33)	(13.40)	(0.08)
Surplus/deficit before retrospective "true up"		**(7.94)**	**(16.62)**	**(8.69)**
Retrospective "true up"		(0.00)	16.62	16.62
SURPLUS / (DEFICIT)		**(7.94)**	**0.00**	**7.94**

- The in-month divisional positions have been adjusted with the cost associated with the additional bank holiday payments for April and May (£1m) now accounted for centrally.
- **MIC** £4.7m net favourable to plan - the division has underspent on variable costs, in month there has been an increase in clinical supplies and drugs costs where activity has increased.
- **SCC** £9.86 net favourable to plan - due to underspends in services where elective activity has reduced.
- **WCCS** £4.0m net favourable to plan – there has been an increase in non pay costs in-month in line with increasing activity and underperformance on income due to reductions in local SLAs, however this is offset by reduced costs linked to underperformance in elective areas.
- **IPH** £6.9m adverse to plan - due to loss of income with some offset in variable costs.
- **R&D** £4.4m adverse to plan - linked to the deferral of research income reflecting the transfer of research staff to support Covid-19 activity.
- **Estates** £0.6m adverse to plan - due to the loss of car parking income and overspends on equipment maintenance contracts. The latter is being reviewed.
- **Covid-19** - there has been £20.3m of additional Covid-19 costs year to date. Costs have increased in month due to the receipt of additional PPE and catch up of other expenditure not previously recorded in the month to which it related. The Trust anticipates that all things being equal the level of Covid costs post June will be lower.

Appendix 1 – Finance and Use of Resources Score

Imperial College Healthcare NHS Trust

- The 'Single Oversight Framework' scoring system went live on 1st October 2016.
- NHSI Segmentation - Providers are assigned a overall 'segment' taking into account scores attained across 5 core themes, with 'Finance and the use of resources' being one of these. Segment 1 means complete autonomy and a segment rating of 4 would lead to special measure being instigated.
- 'Finance and use of resources' theme is made up of the metrics detailed in the table below. Each metric has been assigned an equal weighting. A score of 1 is the 'best' and 4 the 'worst'.
- Scoring a '4' on any metric caps the overall score to at most a '3', triggering a concern.
- The SOF was updated and the Finance and Use of Resources theme will be disaggregated into 2 scores. The 'Finance' score will be based on the metrics already in place below. The 'Use of Resources Assessment' will be used to improve understanding of how effectively and efficiently trusts are using their resources (including finances, workforce, estates and facilities, technology and procurement) to provide high quality, efficient and sustainable care for patients. Work to evaluate our position against the 'Use of Resources Assessment 'metrics continues.

Area	Finance and use of Resources metric	YTD	Score	Weight	Score 1	Score 2	Score 3	Score 4
Financial Sustainability	Capital Servicing Capacity Rating (times	3.9	1	20%	>2.5x	1.75 - 2.5X	1.25-1.75x	<1.25x
	Liquidity Rating (days)	(18.9)	4	20%	>0	(7) - 0	(14) - (7)	<(-14)
Financial Efficiency	I&E margin (%)	0.0%	2	20%	>1%	0% - 1%	(1%) - 0%	<(1%)
	Distance from Financial Plan (%) - plan assumes break even	0.0%	2	20%	>0%	(1%) - 0%	(2%)-(1%)	<(2%)
Financial controls	Agency Spend against cap (%) - assumed at previous years cap	(70.0%)	1	20%	<0%	0% - 25%	25% - 50%	>50%
Total Rating			2					

Override if any metric 4 highest achievement is 3	3

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Integrated risk management and assurance paper	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 29th July 2020	**Item 14, report no. 10**
Responsible Executive Director: Peter Jenkinson, Director of Corporate Governance	**Authors:** Valentina Cappo, Corporate Risk/ Project Manager and Stephanie Goddard, Corporate Governance Manager

Summary:
The Trust Board reviewed the corporate risk register and the Board Assurance Framework at its meeting in November 2019. Since then, a review of the Board Assurance Framework has been undertaken and its outcome, with a new assurance process that was agreed at the Audi, risk and governance committee earlier in July 2020, is reflected in this report.

In March 2020, COVID-19 was declared a pandemic from the World Health Organisation and it has had the utmost impact on the Trust's ability to deliver care and overall business as usual. A thorough approach has been established at the Trust to ensure appropriate oversights of the main risks that emerged from the pandemic and details are reflected in this paper.

There are 23 risks within the corporate risk register; these include 3 risks that are commercial in confidence or have other confidential information and are therefore not included in this report. The highest risks are scored as 20 and the lowest is scored as 8.
Key themes include:

- COVID-19
- Operational performance
- Financial sustainability
- Estates critical equipment and facilities
- Workforce
- Delivery of care (including regulation and compliance, medicines management and safety)
- ICT infrastructure (including cyber security, data quality, infrastructure, Information Governance and security).

Next steps

- The corporate risk register and Board Assurance Framework will be presented to the Audit, Risk and Governance Committee on 7 October 2020.
- The Corporate Risk Register will be presented to the Executive Committee on 18 August 2020 and monthly thereafter.

Recommendations:
The Committee is asked to note changes to corporate risk register and the Board Assurance Framework.

This report has been discussed at:
The Executive Finance Committee (Executive risk committee) and Audit, Risk and Governance Committee meetings between December 2019 and July 2020.

NHS
Imperial College Healthcare
NHS Trust

Quality impact:
The corporate risks are reviewed by the Executive Committee regularly to consider any impact on quality and associated mitigation.
The report applies to all CQC domains: Safe, Caring, Responsive, Effective and Well-Led.

Financial impact:
Where relevant, the financial impact of the risks presented is captured within the detail of each risk within the corporate risk register.

Risk impact and Board Assurance Framework (BAF) reference:
Evidence of assurance to the effectiveness of controls for risks included onto the Corporate Risk Register is reflected on the Board Assurance Framework.

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

What impact will this have on the wider health economy, patients and the public?
Individual risks have different impact on the above topics, as reflected within each risk description.

Has an Equality Impact Assessment been carried out?
☐ Yes ☐ No ☒ Not applicable

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

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

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Please use the detail outlined in the Executive Summary.

Imperial College Healthcare NHS Trust

PART 1: Corporate Risk Register

1. Background

The Trust Board last reviewed the Corporate Risk Register at its meeting on 27 November 2019. The Audit, Risk and Governance Committee reviews the CRR at each meeting and provides assurance to the Board that the risk management processes are robust and maintained.

In March 2020, COVID-19 was declared a pandemic from the World Health Organisation and it has had the utmost impact on the Trust's ability to deliver care and overall business as usual. A thorough approach has been established at the Trust to ensure appropriate oversights of the main risks that emerged from the pandemic and details are reflected in this paper.

2. Ward to Board Risk Management

In order to allow robust ward-to-board risk management, the following risk management governance process is in place within the Trust:

- **Directorate risk registers** are in place for all clinical directorates and are discussed and approved at directorate Quality and Safety Committee meetings or equivalent; risks that cannot be managed locally are escalated to the divisional risk register.
- The top risks from each directorate are circulated to the relevant Divisional Quality and Safety Committee every month.
- **Divisional risk registers** are discussed and approved at the designated forums with responsibility for risk within all clinical and corporate divisions. In the clinical divisions these are the divisional Quality and Safety Committees.
- Key quality divisional risks are escalated to the Executive Quality Committee each month.
- All key divisional risks are presented to the Executive Finance Committee monthly and relevant themes are escalated to the Audit, Risk and Governance Committee at each meeting.
- **Corporate risk register:** This is discussed and approved monthly at the Executive Finance Committee, and to the Trust Board every six months. The Audit, Risk and Governance Committee receive the corporate risk profile at each meeting.

2.1 Risk and assurance 'deep dives'

- The Audit, risk and governance committee has discussed the development of the Board Assurance Framework (BAF) over the past year, and how such a framework can ensure that the Board and its committees receive assurance that risks to the achievement of key performance indicators and strategic objectives are being effectively managed.
- The recently published findings from the Board effectiveness survey showed a generic theme across all Committees regarding the need for more focus on risk and assurance. These results, and the lessons learned from the approach to 'governance-lite' during the COVID-19 pandemic, confirmed the work already underway for the

development of this process, and the particular need to focus the discussions at Board committee.

- On 4 July 2020, the Audit, risk and governance committee agreed a proposal for a framework for risk and assurance deep dives by Board committees which serves as the Trust's board assurance framework. Through implementation of this framework, the aim is to ensure that Board level committees have a focus on key risks and that they receive the appropriate assurances in relation to the management of those risks.
- The framework is based around a series of deep dive reviews of existing and emerging risks as part of committee agendas. To establish such deep dives, committees will be asked to agree a prioritised list of risks to review. The actual risks to be covered in each committee meeting will be agreed at the preceding meeting. These risks may be existing risks already codified in the Corporate Risk Register, or may be emerging risks identified by the Committee.
- The output from these deep dive reviews will be an appropriate statement from the respective committee chair as to action to be taken in respect of the risk, in the context of the agreed risk appetite, and additional actions being taken to address any gaps in controls or assurances.
- The Audit, risk and governance committee will oversee the implementation of the framework on behalf of the Board.

3. Oversight of risks that emerged from COVID-19

- COVID-19 has affected all areas of care and business in the organisation and the Trust has implemented a thorough approach to maintain adequate oversight of its top risks on the corporate risk register. This is described in table 1.

Table 1: Oversight of top COVID-19 risks on the Corporate Risk Register

Area of risk	Actions undertaken/ planned to ensure it is reflected on the CRR
Preparedness	A new risk was escalated onto the CRR in June 2020: Risk 3296 *Risk of a second wave of COVID-19 or another pandemic.*
Patient safety	• A new risk focussing on the potential harm to non-Covid patients as a result of the pandemic is being drafted by Office of the Medical Director for escalation in August 2020. • A new risk of failure to implement staff and patient testing in a consistent and sustainable manner, that may result in harm to staff and patients through either transmission of COVID-19 in the hospital setting or prior to admission/ in the community is being drafted by Office of the Medical Director for escalation in August 2020. • Risk 2946 *Failure to provide timely access to critical care services* has been reviewed to reflect the impact of the pandemic on critical care services.

Area of risk	Actions undertaken/ planned to ensure it is reflected on the CRR
Staff wellbeing	A new risk was escalated onto the CRR in June 2020: Risk 3258 *Failure to protect staff who are in groups where there is increased susceptibility to COVID-19.*
Staffing	Risk 2944 *Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas* is currently being reviewed to include new issues that emerged from the pandemic and actions agreed in response to those.
Financial performance	Risk 3014 *Failure to deliver financial recovery* has been reviewed to include COVID-19 amongst its causes.
Operational performance	Risks 2937 (RTT) and 2938 (Diagnostics) have been reviewed to include COVID-19 in their causes. Risk 2943 (non-elective flow) is being reviewed to include new issues that emerged from the pandemic and actions agreed in response to those.

- In addition to the risks on the corporate risk register, a number of other risks have been identified that are managed via the usual governance structure at the Trust. Those risks are overseen by the Executive Committee via the following collective reports:
  - COVID-19 Acute Phase Risk Register –includes those risks that have been treated as part of crisis management. This register includes 23 risks.
  - COVID-19 Recovery Phase Risk Register – includes those risks that are expected to have an impact on the recovery phase and will be mitigated as part of recovery planning. This register includes 26 risks.

4. Other changes to the Corporate Risk Register

The following changes have been made to the corporate risk register and approved by the Executive Committee since it was last presented to the board in November 2019. These changes were also presented to the Audit, risk and governance Committee in March and July 2019.

- The following two risks have been closed:
  - **Risk 3196** - *Impact of COVID-19 on Trust's ability to deliver business as usual*.
  - **Risk 3057** – *Restrictions and Limited availability of capital funding negatively impact Trust's ability to mitigate significant risks.*

- The following risk has been de-escalated:
  - **Risk 2922** - *Risk of delay to patient care caused by un-monitored shared mailboxes leading to patient harm*.
  - **Risk** – *Risk that was confidential*

- The following two risks have been merged:
  - **Risk 3015** – *Failure to meet control total* is merged into **Risk 3014** – *Failure to deliver financial recovery* and the risk title be changed as follows:
    - **Risk 3014** - Failure to deliver financial improvement trajectory.

- The score of following three risks has increased:
  - **Risk 2938** – *Risk of delayed diagnosis and treatment and failure to maintain diagnostic operational performance standards*
  - The score has increased from 12 (C4 x L3) to 16(C4 x L4).
  - **Risk 2937** – *Failure to consistently achieve timely elective (RTT) care*
  - The score has increased from 16 (C4 x L4) to 20 (C4 x L5).
  - **Risk 1660** – *Risk of poor waiting list data quality*
  - The score has increased from 12 (C3 x L4) to 15 (C3 x L5).

- The score of the following three risks has reduced:
  - **Risk 2976** – *Effect of knives and rising violence at the Trust*
  - The score has reduced from 15 (C5 x L3) to 10 (C5 x L2).
  - **Risk 3038** – *Failure to provide timely transportation for non-emergency patients;*
  - The score has reduced from 15 (C3 x L5) to 12 (C3 x L4).
  - **Risk 2911** – *Condition of Sub Structure to Mint Wing and Interface with Paddington Station*
  - The score has reduced from 16 (C4 x L4) to 12 (C4 x L3).

- The target risk score date for a number of risks has been revised.

4. Recommendations

The Board is asked to note changes to the Board Assurance Framework and the corporate risk register that were agreed by the Executive Committee and Audit, Risk and Governance Committee.

Next steps

- The corporate risk register and Board Assurance Framework will be presented to the Audit, Risk and Governance Committee on 7 October 2020.
- The Corporate Risk Register will be presented to the Executive Committee on 18 August 2020 and monthly thereafter.

APPENDIX 1

Corporate Risk Profile
Trust Board
July 2020

Scoring Matrix

To calculate the risk score it is necessary to consider both how severe would be the consequences and the likelihood of these occurring, as described below:

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Key:

Initial Score: The score of the risk when first identified

Current Score: The current risk score including key controls to mitigate this risk

Target Score: Target of the risk once all future and current actions have been completed and implemented

Corporate Risk Profile

Risks scored 15:

1. 2976 Effect of knives and rising violence on the Trust (3 x 5)
2. 2613 Risk of failure to Uphold Rights and Freedoms of Data Subjects (3 x 5)
3. 2938 Risk of delayed diagnosis and treatment and failure to maintain key diagnostic operational performance standards (5 x 3)

Risks scored 20:

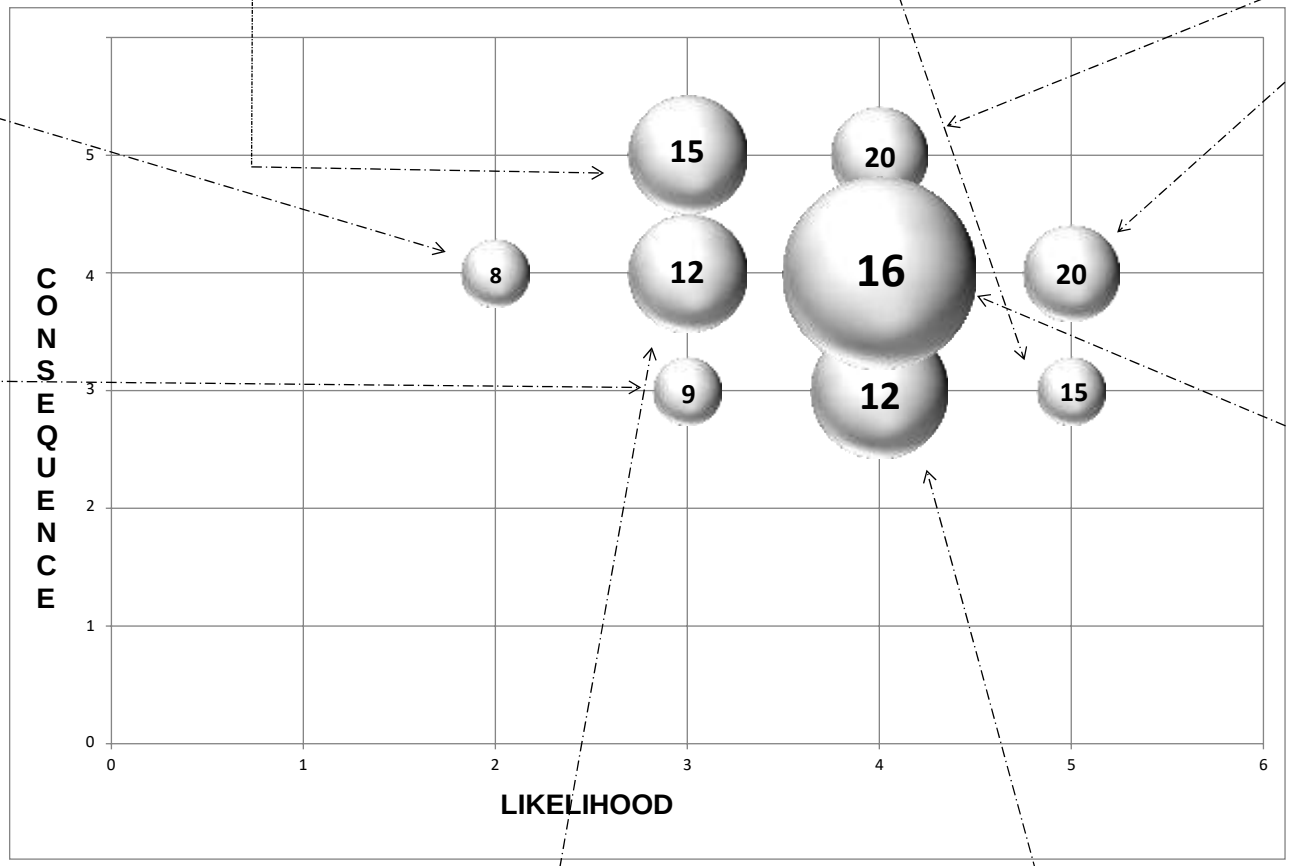
1. 2485 Failure of estates critical equipment and facilities (4 x 5)
2. 3014 Failure to deliver financial recovery (4 x 5)
3. 2477 Risk to patient experience and quality of care in the ED caused by the significant delays experienced by patients presenting with mental health issues (5 x 4)
4. 2937 Failure to consistently achieve timely elective (RTT) care (5 x 4)

Risk scored 8:

1. 2383 Failure to identify poor compliance with legislative and regulatory requirements, including required accreditations (2 x 4)

Risk scored 9:

1. 2538 Risk of medication safety being adversely affected by poor adherence to medication safety policies (3 x 3)



Risks scored 16:

1. 2482 Risk of Cyber Security threats (4x4)
2. 2946 Failure to provide timely access to critical care services (4x4)
3. 2498 Failure to gain funding and approvals from key stakeholders for the redevelopment programme (4x4)
4. 2942 Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines (4x4)
5. 2943 Failure to manage non-elective flow (4x4)
6. 1660 Risk poor waiting list data quality (4 x 4)
7. 3296 Risk of a second wave of COVID-19 or another pandemic (4x4)
8. 3258 Failure to protect staff who are in groups where there is increased susceptibility to COVID-19 (4x4)

Risks scored 12:

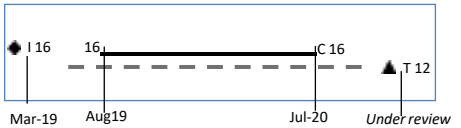
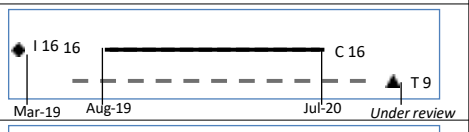
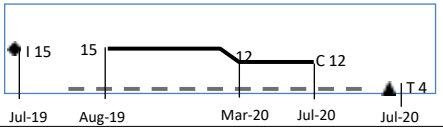
1. 2472 Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards(3 x 4)
2. *Risk that is confidential* (3 x 4)
3. 2480 Patient safety risk due to inconsistent provision of cleaning services across the Trust (4 x 3)
4. 2944 Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas (4 x 3)
5. 2487 Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae) (4 x 3)
6. 3038 Failure to provide timely transportation for non-emergency patients (4 x 3)

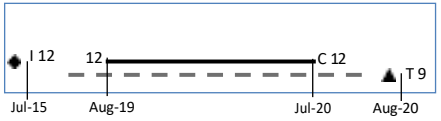
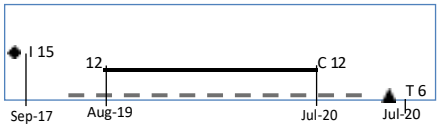
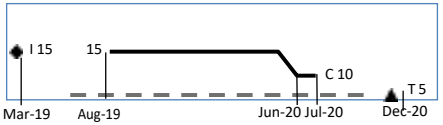
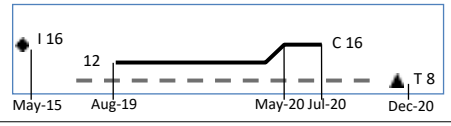
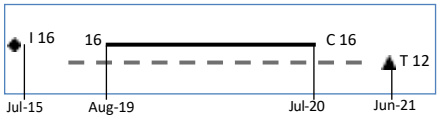
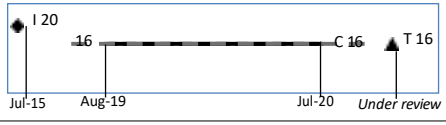
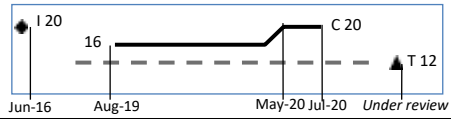
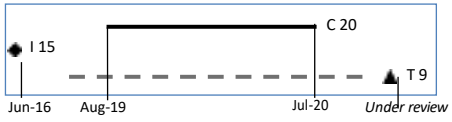
Corporate Risk Register Dash Board

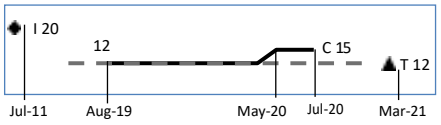
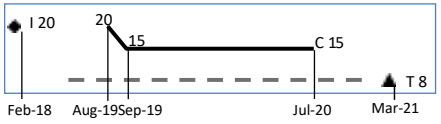
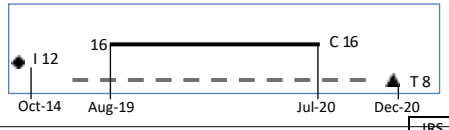
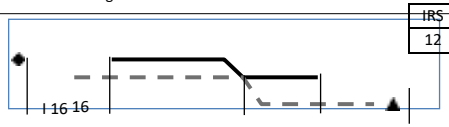
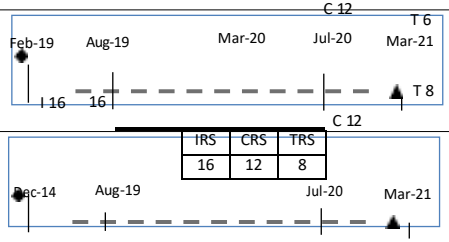
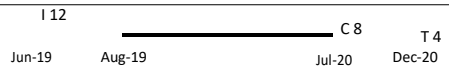
Key:	
♦	Initial Risk Score
▲	Target Risk Score
-------	Benchmark target risk score
IRS	Initial Risk Score
CRS	Current Risk Score
TRS	Target Risk Score

Risk appetite		
Avoid/ Minimal (ALARP - As little as reasonably possible)	**Low**	Strives to avoid risk and uncertainty and works to minimize unavoidable risk. Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
Cautious	**Medium**	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
Open		Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
Seek/ Mature	**High**	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). Confident in accepting or setting high levels of risk because controls, forward scanning and responsiveness systems are robust.

Risk Response:	
Treat	The risk is being managed and the mitigation plan is being implemented
Tolerate	Accept that all possible mitigations have been implemented from the Trust and the risk has to be tolerated until further mitigations that are dependent on external stakeholders are implemented
Transfer	The risk can be transferred to a third party (e.g. insurance)
Terminate	The risk is too severe and the Executive has decided to terminate the activity that is causing it

Page	Risk ID	CQC Domain	Risk Description	Lead Director	Risk movement in the last 12 months, Initial and Target risk scores and dates	Original Target Risk Score date	Risk Appetite	Risk Response
Page 5	3296	Safe Effective Responsive Well Led	Risk of a second wave of COVID-19 or another pandemic	Director of Operational Performance		IRS 20 / CRS 16 / TRS 12 TRSD initially agreed: Dec-20	Low	Treat
Page 5	2485	Safe	Failure of estates critical equipment and facilities that prejudices trust operations and increases clinical and safety risks	Director of Nursing		IRS 20 / CRS 20 / TRS 15 TRSD initially agreed: Oct-17	Medium	Tolerate
Page 6	2946	Safe Effective	Failure to provide timely access to critical care services	Divisional Director of SCC		IRS 16 / CRS 16 / TRS 12 TRSD initially agreed: Mar-20	Low	Treat
Page 7	2942	Safe	Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines	Medical Director		IRS 16 / CRS 16 / TRS 9 TRSD initially agreed: Mar-20	Low	Treat
Page 9	3258	Safe Well Led	Failure to protect staff who are in groups where there is increased susceptibility to COVID-19.	Director of P&OD		IRS 16 / CRS 16 / TRS 8 TRSD initially agreed: Jul-20	Low	Treat
Page 8	3038	Safe	Failure to provide timely transportation for non-emergency patients	Director of Nursing		IRS 15 / CRS 12 / TRS 4 TRSD initially agreed: Jul-19	Low	Treat

Page	Risk ID	CQC Domain	Risk Description	Lead Director	Risk movement in the last 12 months, Initial and Target risk scores and dates	Original Target Risk Score date	Risk Appetite	Risk Response
Page 9	2487	Safe	Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae)	Medical Director		IRS 12 / CRS 12 / TRS 9 TRSD initially agreed: Apr-18	Low	Treat
Page 10	2480	Safe Responsive	There is a risk to patient safety and reputation caused by the inconsistent provision of cleaning services across the Trust	Director of Nursing		IRS 15 / CRS 12 / TRS 6 TRSD initially agreed: Dec-17	Low	Treat
Page 11	2976	Safe	Effect of knives and rising violence at the Trust	Director of Operational Performance		IRS 15 / CRS 15 / TRS 5 TRSD initially agreed: Aug-19	Low	Treat
Page 12	2944	Safe	Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas	Director of People & OD		IRS 12 / CRS 12 / TRS 9 TRSD initially agreed: Mar-18	Low	Treat
Page 13	2938	Responsive	Risk of delayed diagnosis and treatment and failure to maintain key diagnostic operational performance standards	Divisional Director of WCCS		IRS 16 / CRS 16 / TRS 8 TRSD initially agreed: Dec-20	Low	Treat
Page 14	2538	Safe	Risk of medication safety being adversely affected by poor adherence to medication safety policies	Divisional Director of MIC Divisional Director of SCC Divisional Director of WCCS		IRS 16 / CRS 9 / TRS 6 TRSD initially agreed: May-18	Low	Treat
Page 15	2482	Caring Well Led	Risk of cyber security threats to Trust data and infrastructure	Chief Information Officer		IRS 16 / CRS 16 / TRS 12 TRSD initially agreed: Mar-18	Low	Treat
Page 17	2943	Responsive	Failure to manage non elective flow	Divisional Director of MIC		IRS 20 / CRS 16 / TRS 16 TRSD initially agreed: Mar-20	Medium	Treat
Page 18	2937	Responsive	Failure to consistently achieve timely elective (RTT) care	Divisional Director of SCC		IRS 20 / CRS 20 / TRS 12 TRSD initially agreed: Mar-20	Medium	Treat
Page 19	2477	Responsive	Risk to patient experience and quality of care in the Emergency Departments caused by the significant delays experienced by patients presenting with mental health issues	Divisional Director of MIC		IRS 15 / CRS 20 / TRS 9 TRSD initially agreed: Dec-17	Low	Treat

Page	Risk ID	CQC Domain	Risk Description	Lead Director	Risk movement in the last 12 months, Initial and Target risk scores and dates *Under review*	Original Target Risk Score date	Risk Appetite	Risk Response
Page 21	3014	Well Led	Failure to deliver financial recovery	Chief Financial Officer		IRS 20 / CRS 20 / TRS 12 TRSD initially agreed: Mar-22	Medium	Treat
Page 24	1660	Well Led	Risk of poor waiting list data quality	Director of Operational Performance		IRS 20 / CRS 15 / TRS 6 TRSD initially agreed: Mar-18	Medium	Treat
Page 25	2613	Well Led	Risk of failure to Uphold Rights and Freedoms of Data Subjects	Chief Information Officer		IRS 20 / CRS 15 / TRS 8 TRSD initially agreed: Mar-21	Low	Treat
Page 26	2498	Well Led	Failure to gain funding approval from key stakeholders for the redevelopment programme resulting in continuing to deliver services from sub-optimal estates and clinical configuration	Chief Executive Officer		TRSD initially agreed: Dec-20	Medium	Treat
Page 27	2911	Well Led	*Risk that is confidential*	Chief Executive Officer		IRS 12 / CRS 16 / TRS 8 IRS 16 / CRS 12 / TRS 6 TRSD initially agreed: Jan-20	Low	Treat
Page 29	2472	Well Led	Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC	Director of Corporate Governance		TRSD initially agreed: Apr-18	Medium	Treat
Page 30	2383	Well Led	Failure to identify poor compliance with legislative and regulatory requirements	Director of Corporate Governance		IRS 12 / CRS 8 / TRS 4 TRSD initially agreed: Apri-20	Low	Treat

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Annual report of the end of life steering group 2019/20	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 29th July 2020	**Item 15, report no. 11**
Responsible Executive Director: Prof C Urch	**Author:** Dr Katherine Buxton & Guy Young

Summary:
This is the second annual report of the end of life steering group for the Trust.
The end of life steering group accepts that this is a true reflection of achievements over the past year.

Recommendations:
The Board is asked to note the Annual Report for End of Life Care 2019/20

This report has been discussed at:
End of life steering group
Quality Committee
Executive Quality Committee

Quality impact:
The end of life care programme is focused on improving care for patients and those important to them towards the end of their life. At present there is minimal patient engagement with our program.
This paper improves aspects of all 5 CQC domains.

Financial impact: Has no financial impact

Risk impact and Board Assurance Framework (BAF) reference:
Risk 2848 - Risk of non-compliance with NICE Guidance/meeting CQC required standards regarding CPR & Escalation due to lack of timely recognition of those appropriate for CPR & Escalation conversations coupled with poor documentation of conversations around CPR & escalation on the Cerner forms by junior team members. Current score 9. Cerner end of life builds due to go live June/July which will mitigate this risk.

Workforce impact (including training and education implications):
There will be education and training programmes associated with many aspects of the service improvements proposed. The majority will be delivered via e-learning modules.

Has an Equality Impact Assessment been carried out or have protected groups been considered?
☐ Yes ☐ No ☒ Not applicable

How have patients, the public and/or the community been involved in this project and what changes were made as a result?
Through the end of life big room there has been key engagement with our community services across North West London in the development of key strategic plans and their implementation.

What impact will this have on the wider health economy, patients and the public?
Improved integration of care for people at the end of their life across north west London

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

Trust strategic goals supported by this paper:

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

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

Is there a reason the key details of this paper cannot be shared more widely with senior managers?
☐ Yes ☒ No

Senior managers should know:

1. Development of Cerner builds to support the documentation of care in the last hours and days of life will go live July 2020
2. Updates to the CPR & treatment escalation build will go live in July 2020 Senior managers should:

1. Share these key messages with all team members and ensure they have completed the associated training

For further information please contact Dr Katherine Buxton, clinical lead for end of life care at imperial.eolc@nhs.net or see the end of life care pages on the intranet

Imperial College Healthcare NHS Trust

Annual Report of the End of Life Steering Group 2019-20

1 Executive Summary

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

1.2. Key achievements in 2019/20 included:

- agreement of updates to the cardiopulmonary resuscitation (CPR) & escalation plan on Cerner and for a mandatory education programme for all staff
- delivery of a ward based programme of education to key wards who frequently support patients in the last days and weeks of life and integration of syringe pump training to Learn
- successful pilot of the rapid discharge checklist to support people who wish to die outside of hospital & work within the big room to develop this trust-wide
- collaborative development of Cerner builds to support the documentation of care in the last hours and days of life
- weekly big room for end of life care
- planned developments to improve the use of CMC across the organisation
- completion of NACEL 2019

2 Purpose

2.1. This is the second annual report of the End of Life Steering Group for the Trust. We aim to provide a summary of the achievements over the past year (1st April 2019 to 31st March 2020).

3 Background

3.1. The end of life team is a strategic team leading on the planning and implementation of innovative service improvements and the co-ordination and delivery of education across Imperial College Healthcare NHS Trust, to allow everyone to be able and confident to deliver good end of life care. The end of life care team does not deliver direct patient care but has a close relationship with the specialist palliative care team.

3.2. The EOLC team consists of:

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

3.3. The EOLC steering group provides oversight and direction to the end of life work programme. The group meets every 2 months and is attended by a broad range of stakeholders. Minutes of the meetings go to the Quality & Safety Subgroup and by exception to the Executive Quality Committee.

Imperial College Healthcare NHS Trust

4 Key achievements against priorities for 2019/20

4.1. Improving the quality and consistency of decision making and recording of CPR & Escalation plans:

- Update to CPR & treatment escalation plan on Cerner agreed with Chelsea & Westminster and due to go live June 2020
- Executive agreement December 2019 for a mandatory training programme on CPR & treatment escalation planning. Due for launch April 2020, delayed due to covid.

4.2. Delivering a ward based programme of education:

Our end of life educator, Cynthia Lever, completed her 12 month HENWL funded post in December 2019. During her year in post Cynthia achieved several key priorities including:

- development of a well evaluated ward based programme for end of life including:
  - care in the last hours and days of life (based on the 5 priorities of care)
  - CPR & treatment escalation decisions
  - communication skills
- development of competencies for end of life care matched to role and grade
- integration with clinical practice educator network to ensure standardisation of teaching packages delivered across the organisation
- development of training package for McKinley T34 syringe pumps embedded within Learn

Unfortunately recurrent funding for this post was not agreed.

4.3. Improving and embedding the rapid discharge process for people who wish to die outside of hospital:

- pilot of a newly developed rapid discharge checklist at the St Mary's site demonstrated that 86% of patients were successful in achieving their preferred place of death. This has been presented to the end of life steering group.
- developmental work to role this out trust-wide has begun within the end of life big room in collaboration with Chelsea & Westminster and community stakeholders

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

- addressed within the ward education programme
- Cerner builds to support the documentation of care in the last hours and days of life have been agreed in collaboration with Chelsea & Westminster. These are hoped to go live summer 2020. A training programme is to be developed regarding use.

5 Additional key achievements for 2019/20

5.1. Flow Coaching:

The end of life big room began in June 2019 and ran weekly until March 2020 when covid caused it to temporarily cease. The big room focused primarily on co-ordinate my care, which is method sharing of care plans electronically across care settings within London. Using CMC supports the achievement of patient's wishes such as preferred place of death and carries key information such as CPR status and symptom control plans to help achieve this. Key outputs from the big room include:

- Increased awareness of Co-ordinate My Care (CMC) as a means of sharing care plans across the settings

- Development of education programme delivering clinical knowledge & training on use of CMC with access to passwords
- Delivering developments in collaboration with community colleagues, third sector colleagues and lay members

5.2. Co-ordinate my care (CMC):
To support the work of the big room and move the use of CMC trust-wide more easily, agreement has been made to pilot federated access, i.e. directly via smartcard, from summer 2020. This will be supported by a formal e-learning package.

5.3. National audit for care at the end of life (NACEL):
- progress against actions from NACEL 2018
- completion of data analysis from NACEL 2019. This has been incorporated into priorities for 2020/21 and presented to the end of life steering group
- NACEL 2020 on hold due to covid

5.4. Additional achievements:
- development of online survey for bereaved relatives
- CQC preparation including core service leaflet
- cohesive working with allied teams including palliative care, medical examiner's office & bereavement services, mortuary services and chaplaincy
- development of risk register for end of life

6 Priorities for 2020/21 remain largely unchanged from the previous year:
- improving the quality and consistency of decision making and recording of CPR & treatment escalation plans
- developing a robust means of delivering and evaluating end of life education across the organisation
- improving and embedding the rapid discharge process for people who wish to die outside of hospital
- managing the behavioural aspects of caring for patients at the end of life and ensuring that staff feel confident to care for the person themselves and those important to them.

7 Options appraisal including financial appraisal (not relevant)

8 Conclusion and Next Steps
8.1. Endorsement of the Annual Report for End of Life Care 2019/20 by the executive committee.

9 Recommendations
9.1. The Board is asked to note the Annual Report for End of Life Care 2019/20.

Author Dr Katherine Buxton & Guy Young
Date June 2020

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Mortality update – including learning from deaths quarterly report: Q3 and 4 2019/20	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 29th July 2020	**Item 16, report no. 12**
Responsible Executive Director: Professor Julian Redhead, Medical Director	**Author:** Ian Bateman Deputy Chief of Staff, Office of the Medical Director

Summary:
This paper was reviewed at Trust Quality Committee on 8th July 2020 and provides an update to the Trust Board on the Trust's Learning from Deaths (LfD) programme. It includes an updated dashboard outlining activity undertaken as part of the programme in Q3 and 4 2019/20.

The paper also provides an update on mortality, the medical examiner service and mortality associated with COVID-19.

The Trust is required to report avoidable deaths on a regular basis to the Trust Board and NHS England and this paper outlines the findings that will be reported to NHS England in relation to Q3 and 4 2019/20.

The Trust has now fully implemented the Medical Examiner service, and the service was implemented prior to the 1 April 2020 deadline despite the current challenges associated with COVID-19. The demand that has been placed on the ME service, patient affairs and the mortuary teams since the start of the COVID-19 pandemic has been very significant, however the rate of mortality has now reduced to below our normal expected levels. We are developing plans to maintain a state of readiness should there be an increase in mortality.

Detailed analysis has been undertaken of the mortality rate since January 2020, the findings of which are detailed in this paper. We have concluded that our mortality rate was not being adversely affected by any other factor other than COVID-19. Our mortality rate has now reduced, and COVID-19 is having a minimal impact on our overall mortality rate. Other causes of death have remained consistent throughout the first phase of COVID-19 and our mortality rate is lower than we would expect usually.

Recommendations:
The Trust Board is asked to

- note the progress in implementing the medical examiner service, and in implementing the actions and recommendations to improve our learning from deaths processes
- note the findings from our mortality surveillance programme in relation to Q3 and 4 2019/20 ahead of submission to NHS England. Furthermore, to note the detail provided in the paper with regard to our mortality rate, and COVID-19

This report has been discussed at:
Trust Quality Committee (July 2020)
Executive Quality Committee (July 2020)

Quality impact:
This paper and the processes within supports the improved learning from deaths that occur in the Trust, therefore supporting the safe, effective and well-led quality domains.

Financial impact: Has no financial impact
Risk impact and Board Assurance Framework (BAF) reference: There is potential for reputational risk associated with the ability to deliver reviews within the specified time periods, thus impacting on national reporting. Learning from Deaths is on the divisional risk register (no. 2439).
Workforce impact (including training and education implications): NA
Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☐ No ☒ Not applicable
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: • To develop a sustainable portfolio of outstanding services • To build learning, improvement and innovation into everything we do
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No

Imperial College Healthcare NHS
NHS Trust

Mortality update – including learning from deaths quarterly report Q3/4 2019-20

1. Executive Summary

1.1. This paper provides an update to the Trust Board on the Learning from Deaths (LfD) programme. It includes an updated dashboard outlining activity undertaken as part of the programme in Q3 and 4 2019/20.

1.2. The paper also provides an update on mortality, the medical examiner service and mortality associated with COVID-19.

1.3. The paper outlines activity undertaken as part of the mandated programme, it further provides information regarding our mortality rate and mortality surveillance activity as a Trust.

1.4. The time periods in this paper differ by section due to varying reporting periods – the subtitle of each section details the time period covered.

2. Background

2.1. The Trust's established mortality review process and associated policy was reviewed in line with the new national requirements set out in the National Quality Board framework published in March 2017. This included using Structured Judgment Review (SJR) for selected deaths.

2.2. Every NHS Trust in England and Wales was required to implement a Medical Examiner (ME) service by April 2020. Initially a non-statutory service, this function will in time be subject to primary legislation via changes to the Coroners and Justice Act (2009). MEs are responsible for reviewing every inpatient death prior to the issuance of the Medical Certificate of Cause of Death (MCCD).

2.3. This service has been successfully implemented in our Trust in a four-phased programme in the required timeframes despite the significant challenges of the Covid-19 pandemic. We are fully compliant with the Guidance on ME services published by the National Medical Examiner (NME).

2.4. Our mortality rate increased during the COVID-19 pandemic, analysis of this is included in this paper.

3. Mortality data – *most recent reporting period*

3.1. From the latest data available, the Trust has had a significantly low relative mortality risk at monthly level when assessed via the Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Index (SHMI). Appendix A includes detail on both of these measures and shows our rate of mortality to be significantly, and consistently, lower than that which is expected for a Trust of our size.

3.2. The Trust receives mortality alerts via the Dr Foster analytics services. These alerts relate to cases where death(s) have occurred that require further investigation, either because there is a possible trend/pattern, or the death(s) is an outlier compared to other organisations. Our Trust did not receive any alerts of this nature in the latest reporting period.

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4. Summary of learning from deaths data (see Appendix B) – *Q3 and Q4 2019/20*

4.1. There have been a total of 1034 deaths in Q3 and Q4 2019/20.

4.2. Of these 94 had died with a positive COVID-19 swab, the first on 11 March 2020, and these have been reported to NHS England in line with national reporting requirements. There were a further eight deaths in Q3/4 2019 where the patient did not have a positive COVID-19 test result, but did have COVID-19 recorded as the cause or contributing cause of death on the death certificate. These cases did not meet the case definition for NHSE reporting at that stage so were not been reported (criteria extended on 24 April).

4.3. An SJR has been requested for 116 (11%) of the deaths that occurred in Q3 and 4 2019/20; of which 86 have been completed. COVID-19 impacted on the resource available for requesting and completing SJRs which adversely affected performance in February and March 2020. Progress has been made addressing the backlog and is ongoing.

4.4. In Q3 and Q4 2019/20 no deaths were identified as being avoidable, or having a global care score of poor or very poor via the SJR process. However it is possible that there may be some in the SJRs which have not yet been completed for the reporting period. These will be reported appropriately if identified.

4.5. We are required to submit data on learning from deaths to the Trust Board, for onward submission to NHSE. The dashboard at Appendix B will be the basis of our Q3 & 4 submission to NHSE.

Triggers for SJR review

4.6. The graphs in Appendix C show the triggers for an SJR by type, and the percentage of triggers based on the overall number.

4.7. The highest number of triggers are from cases that relate to coroner/inquest where the referral for an SJR was automatic until changes were made at the end of February 2020. This was a trigger in 35% of SJRs. We no longer automatically refer cases for an SJR on the basis of a coroner's investigation or inquest because we have successfully implemented the ME service.

5. Medical Examiner Service Update – *16 March - 28 June 2020*

5.1. The ME service is now fully implemented across our hospitals providing a week day service. The service was challenged during the pandemic due to the increased number of deaths requiring review however the team worked hard to meet demand with additional support provided. Between 16 March *(the date the ME service was fully implemented)* – 28 June 2020 the service has scrutinised the deaths of 784 patients, this is higher than would usually be expected during this time-period (circa 490).

5.2. Plans are in progress to move the service to a 7-day model on a permanent basis. We are aiming to have this in place by September 2020.

5.3. We are putting plans in place to increase the number of MEs available to the ME service should there be a second surge in mortality. This includes training so that we can access additional support from trained individuals if required.

5.4. We have sought clarity from NHSE/I on the timelines associated with the roll out of the ME service to cover deaths that have occurred in the community. We have been advised that the timelines associated with this are currently unclear as many Trusts paused the implementation of, or suspended the delivery of, their ME service during the first phase of COVID-19.

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6. COVID-19 mortality – *11 March – 28 June*

6.1. The first recorded death of a patient who had a positive test for COVID-19 at our Trust occurred on 11 March 2020.

6.2. Between 11 March *(the date of the first COVID-19 death at the Trust*) - 28 June 2020 there has been 807 deaths, of which 430 or 53% relate to patients who have a Medical Certificate of Cause of Death (MCCD) that records COVID-19 as a cause or contributing factor in their death.

6.3. The remaining 377 deaths are not COVID-19 deaths. This represents an average weekly non-COVID-19 death rate, between 11 March - 28 June, of circa 24 deaths per week. This is lower than our normal average rate of death, which is 30-35 deaths per week.

6.4. We continue to undertake detailed analysis of our mortality rate in response to COVID-19, we provided details of our analysis of mortality in early 2020 to May Quality Committee. Since this point, we have focussed on analysing the nature and rate of mortality across our hospitals. Graphs relating to this is included at Appendix D to this paper. The key findings from this analysis is as follows:

- 6.4.1. Our mortality rate increased significantly from mid-March and peaked in mid-April. This increase was attributed to deaths associated with COVID-19.
- 6.4.2. Since the end of May 2020 our mortality rate has reduced to a rate below that which we would usually expect (circa 35 deaths per week). This is representative of a significant decrease in the number of COVID-19 associated deaths, and also our continued reduced activity.
- 6.4.3. The number of deaths associated with COVID-19 has reduced substantially in recent weeks from a peak in mid-April. Between 1-28 June there were three deaths associated with COVID-19, compared to 39 over the same time period in May. This reduction is in line with the overall reduction in COVID-19 mortality seen in figures published by the DHSC.
- 6.4.4. Deaths associated with other respiratory illness continues to be lower than earlier in the year, and there has not been a significant increase in other causes of death.
- 6.4.5. Our rate of death is no longer adversely affected by COVID-19, and our overall rate of mortality has reduced to below our normal rate.

6.5. There are 32 patients that the Trust have identified to have had Hospital Onset of COVID-19 (HOCI), who have subsequently died.

There are 20 cases where the patient meets the Public Health England definition of HOCI because they tested positive for COVID-19 more than 14-days after their admission to hospital. There are a further 12 patients who tested positive between days 7-14 of their admission.

In the interest of maximising our opportunity to learn from these cases we are undertaking an SJR on all 32 cases. The SJRs will be undertaken by one SJR reviewer in order to ensure that we have consistency in this process. We will present the findings from these reviews to the September 2020 Board Quality Committee.

7. Conclusion and Next Steps

7.1. The Trust has a comprehensive learning from deaths process in place. We continually strive to improve our processes and our ability to learn from deaths that occur at our hospitals.

7.2. We have not identified any deaths in Q3 or 4 2019/20 where the overall quality of care was poor or very poor. We will focus more moving forward on theming and learning from the findings of SJRs, irrespective of the overall quality or care score noted following review.

7.3. We continue to have a lower than expected rate of mortality when compared with other NHS organisations via the HSMR and SHMI data sets.

7.4. The Trust is required to report avoidable deaths on a regular basis to the Trust Board and NHS England and this paper outlines the findings that will be reported to NHS England in relation to Q3 and 4 2019/20.

7.5. The Trust has now fully implemented the Medical Examiner service, and the service was implemented prior to the 1 April 2020 deadline despite the challenges associated with COVID-19. The demand that has been placed on the ME service, patient affairs and the mortuary teams since the start of the COVID-19 pandemic has been very significant, however the rate of mortality has now reduced to below our normal expected levels. We are developing plans to maintain a state of readiness should there be an increase in mortality.

7.6. We have undertaken detailed analysis of our mortality rate since January 2020, the findings of which are detailed in this paper. We have concluded that our mortality rate was not being adversely affected by any other factor other than COVID-19. Our mortality rate has now reduced, and COVID-19 is having a minimal impact on our overall mortality rate. Other causes of death have remained consistent throughout the first phase of COVID-19 and our mortality rate is lower than we would expect usually.

8. Recommendations

The Trust Board is asked to:

8.1. note progress with implementing the actions and recommendations to improve our learning from deaths processes

8.2. note the findings from our mortality surveillance programme in relation to Q3 and 4 2019/20 ahead of submission to NHS England

8.3. note the progress made with implementing the medical examiner service

8.4. note the detail provided in the paper with regard to our mortality rate, and COVID-19

Ian Bateman
Deputy Chief of Staff, Office of the Medical Director
21 July 2020

Appendices:
Appendix A – Dr Foster Mortality Data – HSMR and SHMI
Appendix B – Learning from Deaths Data and NHSE Dashboard – Q3 and Q4 2019/20
Appendix C – Triggers for SJR – Q3 and Q4 2019/20
Appendix D – COVID 19 Mortality Analysis

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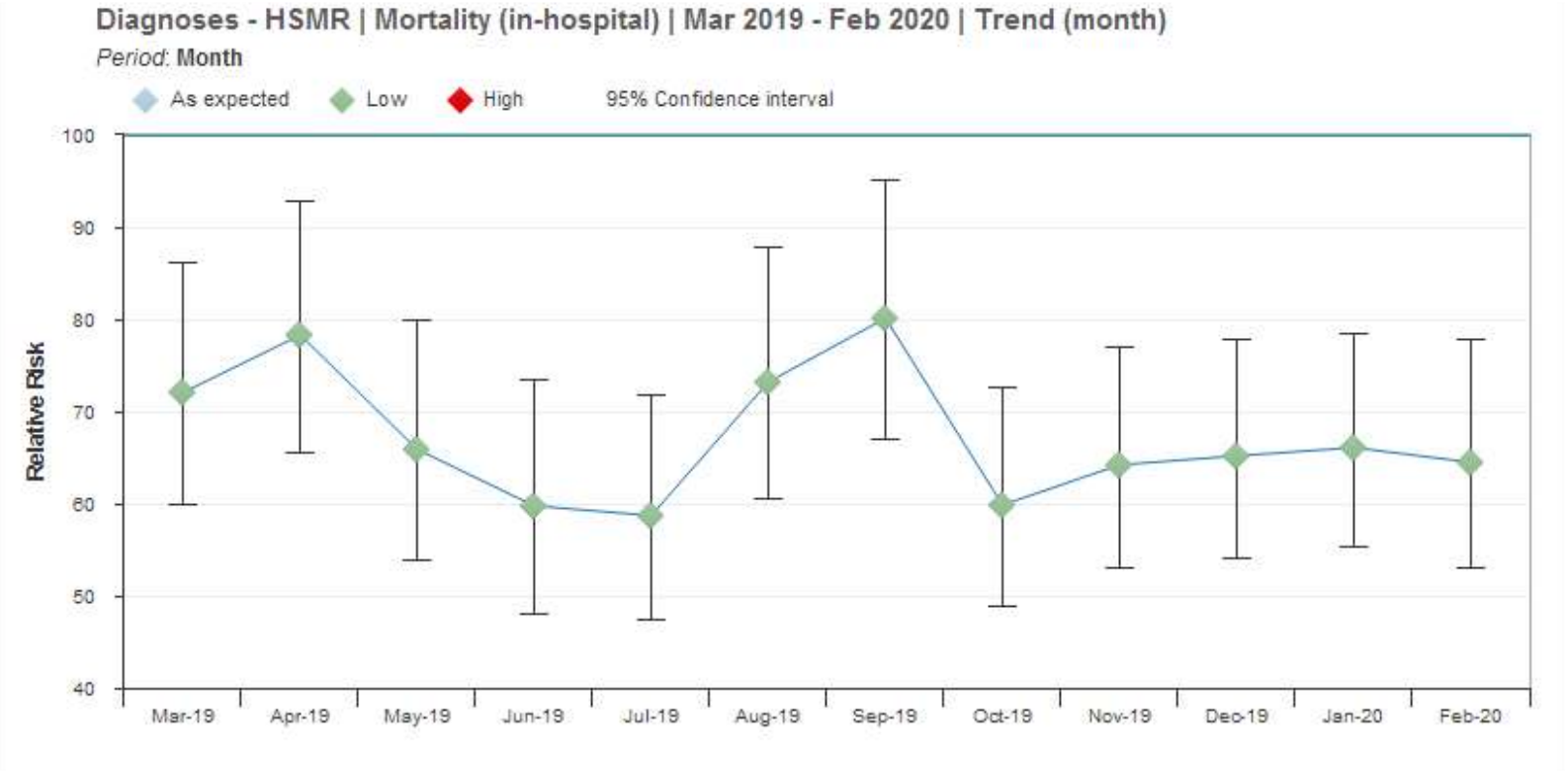
APPENDIX A – DR FOSTER MORTALITY DATA – HSMR AND SHMI



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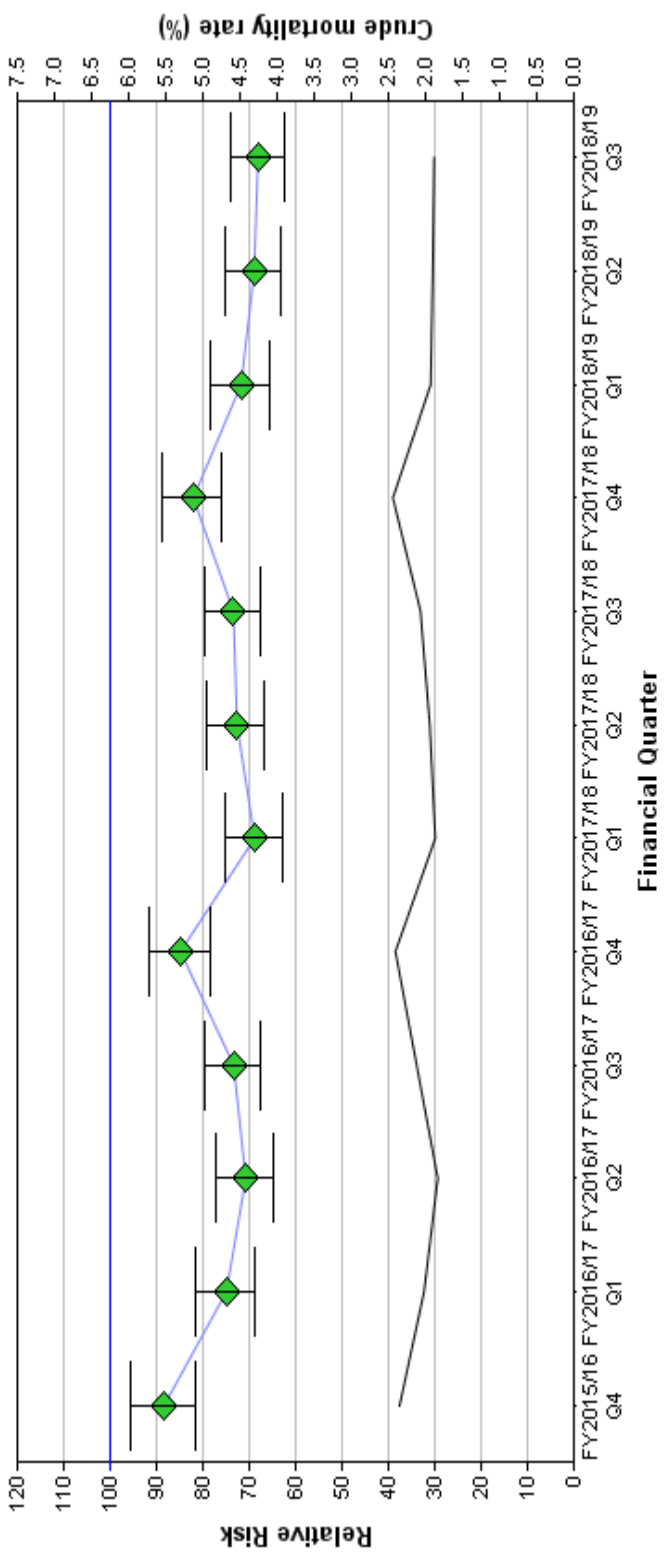
SHMI –Trend from Q4 2015/16 to Q3 2018/19 (Financial Years)



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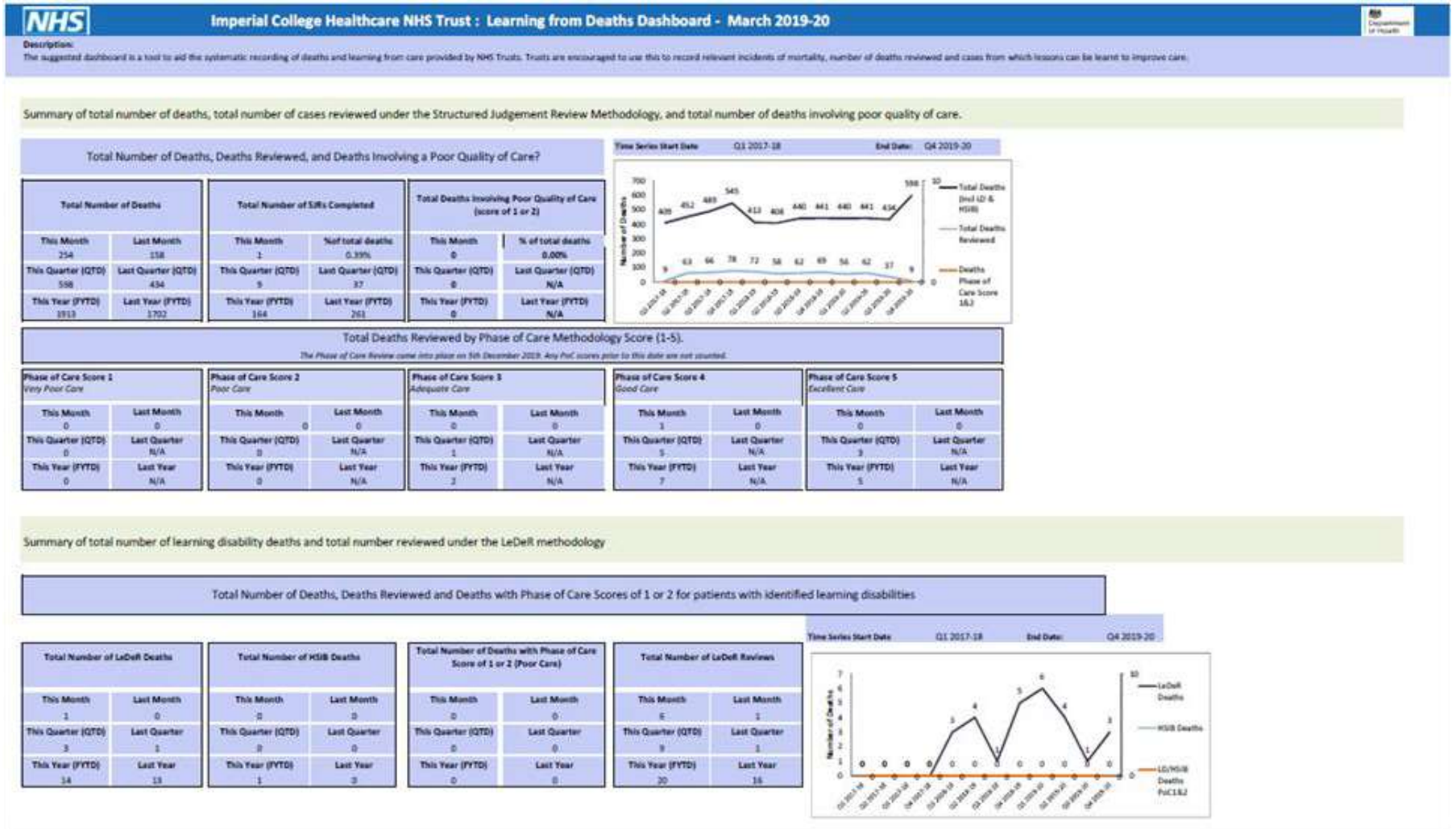
APPENDIX B – LEARNING FROM DEATHS DATA 2019/2020 – Q3/4

Trust Total	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Total Deaths	138	147	151	186	158	254
No. Level 1 Reviews Completed	121	124	123	141	105	89
% Level 1 Reviews Completed	87.7%	84.4%	81.5%	75.8%	66.5%	35.0%
No. of SJRs Requested	29	25	9	1	18	20
No. of SJRs Completed	21	14	4	1	18	19
% SJRs Completed	72.4%	56.0%	44.4%	100.0%	100.0%	95.0%
No. of avoidable deaths reported via SJR or deaths with poor or very poor global care score	0	0	0	0	0	0
No. of Avoidable Deaths confirmed via senior decision maker review	**0**	**0**	**0**	**0**	**0**	**0**

NHSE Learning from Deaths Dashboard



NHS | Imperial College Healthcare NHS Trust : Learning from Deaths Dashboard - March 2019-20

Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths, total number of cases reviewed under the Structured Judgement Review Methodology, and total number of deaths involving poor quality of care.

Total Number of Deaths, Deaths Reviewed, and Deaths Involving a Poor Quality of Care?

Total Number of Deaths		Total Number of SJRs Completed		Total Deaths Involving Poor Quality of Care (score of 1 or 2)	
This Month: 254	Last Month: 158	This Month: 1	%of total deaths: 0.39%	This Month: 0	% of total deaths: 0.00%
This Quarter (QTD): 598	Last Quarter (QTD): 434	This Quarter (QTD): 9	Last Quarter (QTD): 37	This Quarter (QTD): 0	Last Quarter (QTD): N/A
This Year (FYTD): 1913	Last Year (FYTD): 1702	This Year (FYTD): 164	Last Year (FYTD): 261	This Year (FYTD): 0	Last Year (FYTD): N/A

Time Series Start Date: Q1 2017-18 End Date: Q4 2019-20

Total Deaths Reviewed by Phase of Care Methodology Score (1-5).

The Phase of Care Review came into place on 5th December 2019. Any PoC scores prior to this date are not counted.

Phase of Care Score 1 *Very Poor Care*		Phase of Care Score 2 *Poor Care*		Phase of Care Score 3 *Adequate Care*		Phase of Care Score 4 *Good Care*		Phase of Care Score 5 *Excellent Care*	
This Month: 0	Last Month: 0	This Month: 0	Last Month: 0	This Month: 0	Last Month: 0	This Month: 1	Last Month: 0	This Month: 0	Last Month: 0
This Quarter (QTD): 0	Last Quarter: N/A	This Quarter (QTD): 0	Last Quarter: N/A	This Quarter (QTD): 1	Last Quarter: N/A	This Quarter (QTD): 5	Last Quarter: N/A	This Quarter (QTD): 3	Last Quarter: N/A
This Year (FYTD): 0	Last Year: N/A	This Year (FYTD): 0	Last Year: N/A	This Year (FYTD): 2	Last Year: N/A	This Year (FYTD): 7	Last Year: N/A	This Year (FYTD): 5	Last Year: N/A

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths with Phase of Care Scores of 1 or 2 for patients with identified learning disabilities

Total Number of LeDeR Deaths		Total Number of HSIB Deaths		Total Number of Deaths with Phase of Care Score of 1 or 2 (Poor Care)		Total Number of LeDeR Reviews	
This Month: 1	Last Month: 0	This Month: 0	Last Month: 0	This Month: 0	Last Month: 0	This Month: 6	Last Month: 1
This Quarter (QTD): 3	Last Quarter: 1	This Quarter (QTD): 0	Last Quarter: 0	This Quarter (QTD): 0	Last Quarter: 0	This Quarter (QTD): 9	Last Quarter: 1
This Year (FYTD): 14	Last Year: 13	This Year (FYTD): 1	Last Year: 3	This Year (FYTD): 0	Last Year: 0	This Year (FYTD): 20	Last Year: 16

Time Series Start Date: Q1 2017-18 End Date: Q4 2019-20

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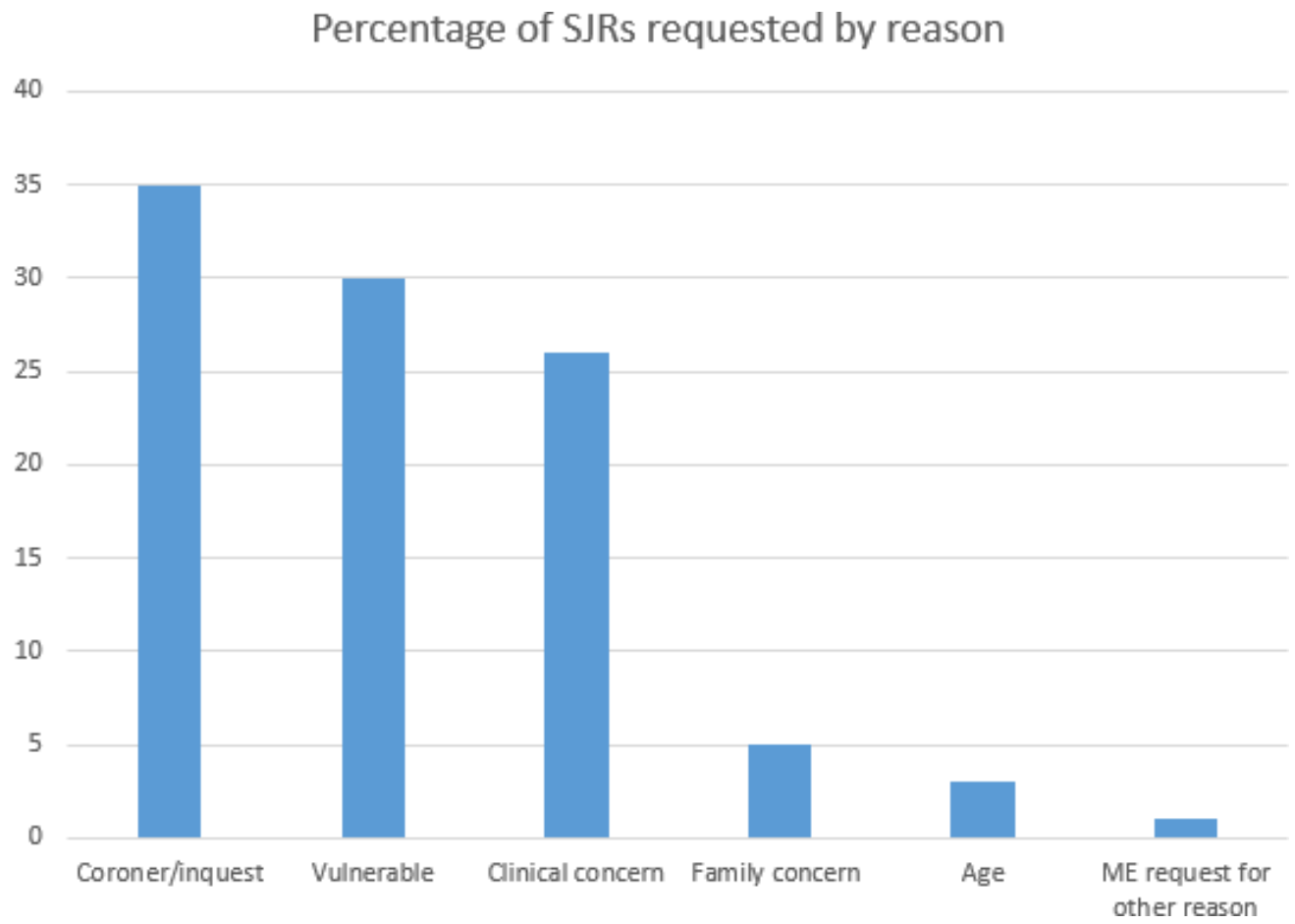
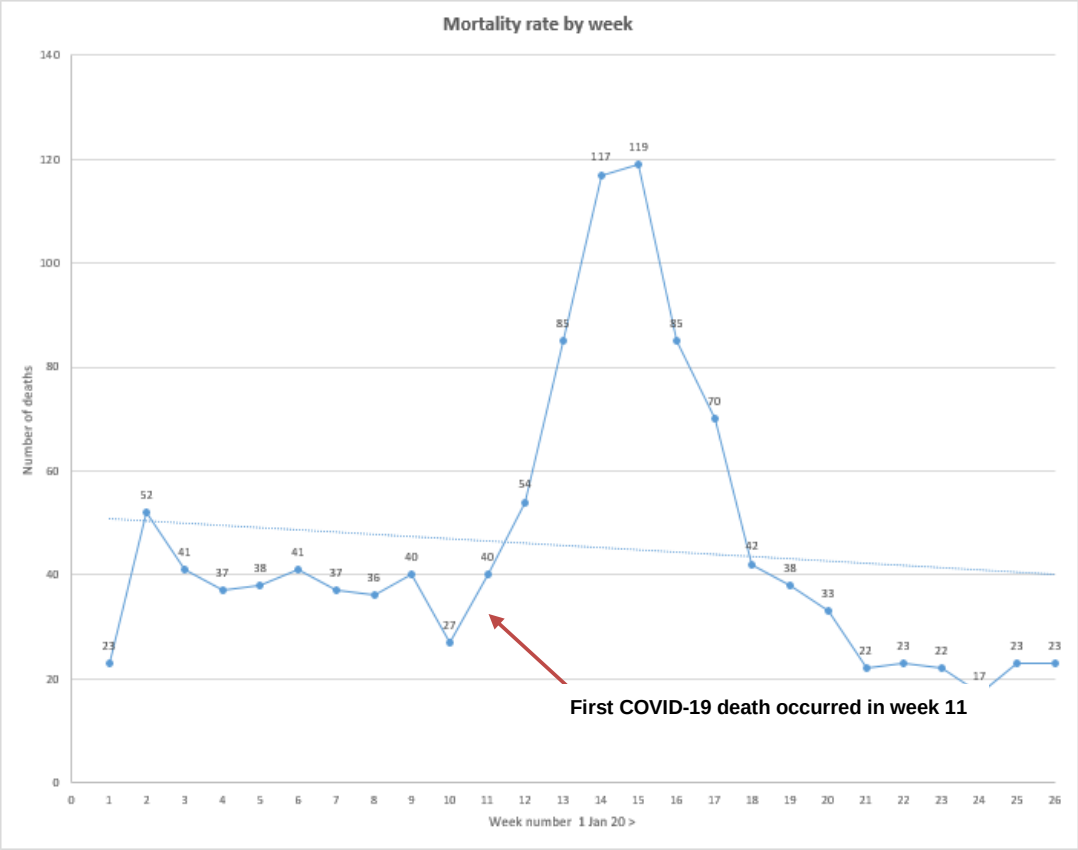
APPENDIX C – TRIGGERS FOR SJR – Q3 AND Q4 2019/20



APPENDIX D – COVID 19 MORTALITY ANALYSIS

Comparative mortality rate: the graphs below show our overall crude mortality rate by month and by week from 1 January – 28 June 2020:



The graph above clearly shows a substantial increase in our mortality rate from week 11, with a peak in week 15 of 119 deaths in one week.

From week 21 our mortality has reduced to a rate below that which we would usually expect (circa 35 deaths per week). This is representative of a significant decrease in the number of COVID-19 associated deaths, and also our continued reduced activity.

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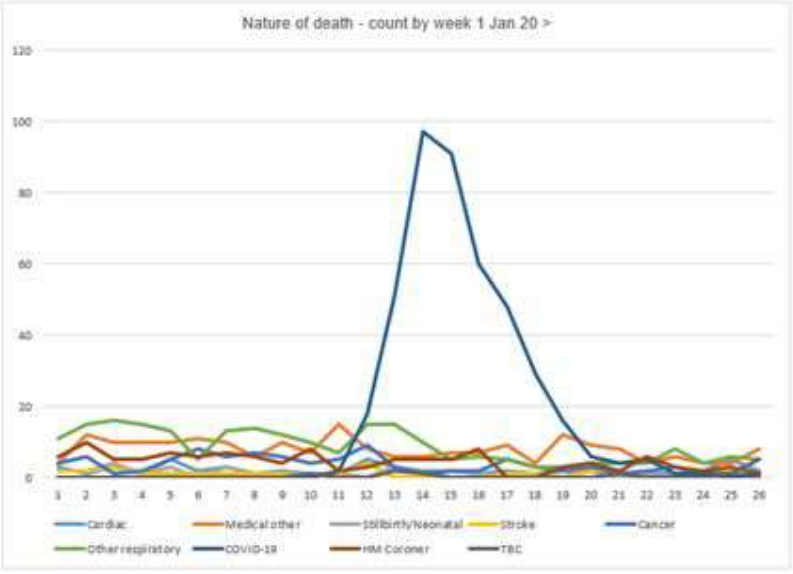
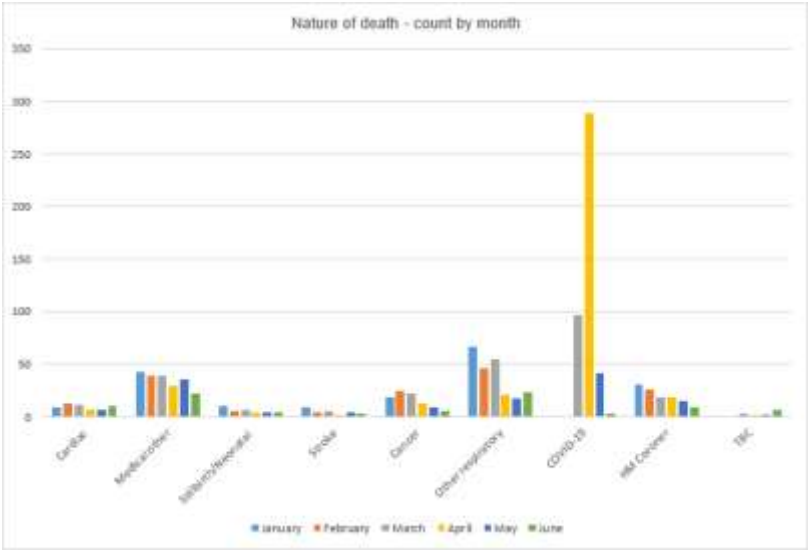
Nature of death: we have analysed the nature of deaths that have occurred between 1 January – 28 June 2020 in order to understand our mortality rate further.

Each death has been manually coded based on cause of death recorded on the Medical Certificate of Cause of Death (MCCD). Where COVID-19 is recorded in any part of the MCCD the death is noted here as a COVID-19 death. The charts below show the nature of mortality since 1 January 2020:





The number of deaths associated with COVID-19 has reduced in recent weeks from a peak at week 14-16. Between 1-28 June there have been three deaths associated with COVID-19, compared to 39 over the same time period in May.

Deaths associated with other respiratory illness continues to be lower than earlier in the year, and there has not been a significant increase in other causes of death.

Our rate of death is no longer adversely affected by COVID-19, and our overall rate of mortality has reduced to below our normal rate.

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TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: 2019/20 Trust complaints service annual report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 29 July 2020	**Item 178, report no. 13**
Responsible Executive Director: Janice Sigsworth	**Author:** Daniel Marshall Guy Young

Summary:
The attached report summarises complaints activity during the period April 2019 to March 2020.

The performance against complaints KPIs remains strong and the vast majority of complaints were resolved effectively.

Overall numbers of complaints were up by around 10% over the previous year, mainly due to a large number of complaints related to the transfer of patient transport services.

Complaint reviews undertaken by the Parliamentary and Health Service Ombudsman were the lowest to date accounting for less than 1% of the total number of complaints.

This report looks at the complaint activity, themes and outcomes during the year.

Recommendations:
The Board is asked to note the report.

This report has been discussed at:
Executive Quality Committee and Quality Committee

Quality impact:
An effective complaints management function is important to maintain a quality service and the reputation of the trust? Complaints management is covered by the CQC responsive domain.

Financial impact:
Has no financial impact

Risk impact and Board Assurance Framework (BAF) reference:
There are no specific risks related to this report

Workforce impact (including training and education implications):
None

Has an Equality Impact Assessment been carried out or have protected groups been considered?
☐ Yes ☐ No ☒ Not applicable

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

What impact will this have on the wider health economy, patients and the public? Refer to report.
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No If the details can be shared, please provide the following in one to two line bullet points: ▪ What should senior managers know? o The trust maintains an effective high quality complaints service ▪ Contact details or email address of lead and/or web links for further information o Daniel Marshall – daniel.marshall@nhs.net ▪ Should senior managers share this information with their own teams? X Yes ☐ No If yes, why? It is good for all staff to have an understanding of how complaints are managed and the issues that people complain about.

2019/20 Trust complaints service annual report

1. Introduction

The Complaints service maintained the required standards and met all key targets for timeliness and responsiveness to patients during 2019/20. There were a low number of complaints reopened and only two complaints investigated by the Parliamentary & Health Service Ombudsman (PHSO) were upheld.

The headline performance figures for 2019/20 are:

- 1074 formal complaints received.
- 99.0% of complaints were responded to within their agreed deadlines
- 99.5% of acknowledgment letters were sent within 3 working days
- 1079 complaints were closed during the year with an average response time of 33 days
- 9 complaints were referred to the PHSO
- 5 outcomes from the PHSO were reported to the trust of which one was upheld and one was partially upheld
- Only 2.5% of complaints were re-opened
- The overall satisfaction rate of complainants with the handling of their complaint was 76% (online survey 6 weeks after complaint closed)

2. Number of Formal Complaints Received

Last year the Trust received 1074 formal complaints, which was just within the target of 1080 set for the year. This was a 9% increase on the previous year (985). The increase was primarily a result of two factors: a change of patient transport provider which resulted in a large increase in transport related complaint and an increase in delays and cancellations to elective patients as a result of capacity issues across a number of specialties.

3. Complaint details

We monitor the type of complaint using standardised categories, set by NHS Digital, which allow for benchmarking across NHS Trusts. Table 1 shows the top 5 categories of formal complaints received in the year in comparison with the previous year.

Table 1: Formal complaints by category

Category	2019/20	% of total	2018/19	% of total
Clinical treatment/patient care	301	**28%**	355	**36%**
Appointments	159	**15%**	123	**12%**
Values and Behaviours (Staff)	165	**15%**	150	**15%**
Communications	118	**11%**	134	**14%**
Transport	70	**7%**	21	**2%**
TOTAL	**813**	**76%**	**783**	**79%**

There has been an increase in complaints relating to appointments as patients have experienced delays to elective appointments and procedures, and short notice (and sometimes repeated) cancellations. However, there has also been a reduction in complaints about *clinical treatment/patient care* as a percentage of overall complaints, which is positive.

Complaints related to transport have appeared in the top 5 for the first time and this is clearly related to the difficulties faced immediately after the transfer of transport services to a new provider. The volume of these complaints reduced over the year.

Table 2 provides a breakdown by service area.

Table 2: Complaints by service area

Service area	2019/20	% of total	2018/19	% of total
Outpatients	501	47%	431	44%
Inpatients	432	40%	404	41%
A&E	85	8%	86	9%
Maternity	56	5%	64	6%
Total	**1074**	**100%**	**985**	100%

Table 3 shows the number of complaints received by division compared with the previous year.

Table 3: Complaints by division

Division	2019/20	% of total	2018/19	% of total
Medicine & Integrated Care	311	29%	288	29%
Surgery, Cancer & Cardiovascular	398	37%	392	40%
Women's, Children's & Clinical Support	180	17%	200	20%
Corporate (including IPH and Transport)	184	17%	102	10%
NWL Pathology	1	<1	3	<1
Total	**1074**	**100%**	**985**	**100%**

The outcome of a trust complaint investigation will be one of three; the complaint can be upheld, partly upheld or not upheld. The table below shows the outcomes for complaint investigations completed in 2019/20. It shows that just over half were found to have been partly or fully substantiated. Where this was the case the complainant would have received a formal apology, an explanation as to what the trust has learned and will do differently as a result of the complaint and possibly some sort of remedy.

Table 4: Outcome by division

	Upheld	Partly upheld	Not upheld	Total
Medicine and Integrated Care	77	66	175	318
Surgery, Cancer and Cardiovascular	102	95	197	394
Women's, Children's and Clinical Support	54	51	94	199
NWL Pathology	0	0	1	1
Corporate (Inc. IPH)	86	36	45	167
Total	**319**	**248**	**512**	**1079**
Percentage	**30%**	**23%**	**47%**	

4. Parliamentary & Health Service Ombudsman (PHSO) Cases

The PHSO accepted 9 cases for review during the year, which amounts to less than 1% of the Trust's annual caseload.

We continued to follow a structured approached to managing PHSO cases. This ensures we report and share learning with our divisional triumvirates and that we involve them in devising any necessary service improvements.

In cases where there has been a financial loss, we are required to put a complainant back to the same financial position they would have been in had the problem not occurred. The Trust made monetary payments totaling £15660.85 last year to help remedy complaints where a service failure occurred.

The complaints team arranged some significant payments for valuables that were lost while patients were in the hospital, and the hospital was found to be at fault. Property loss has become an increasing theme of both PALS and Complaints cases over the year and will be a focus of attention in 2020/21.

5 Future developments

From 1 April 2020, all new complaints are being logged using the Healthcare Analysis Tool (HCAT), which has been developed in conjunction with the Patient Safety Translational Research Centre at Imperial College. HCAT is a method for systematically analysing complaints, and grouping key insights. The tool allows staff to reliably determine the problems reported in complaints at three-levels of specificity; to grade their severity, the harm caused to patients, and where in the hospital system problems occurred. The aim of this is to provide a much deeper layer of insight into the complaints we received than is possible using the current (KO41) system and it will change the way we report during 2020/21.

6 Conclusion

The effects of the Covid-19 pandemic make it difficult to predict what will happen with complaints during 2020/21. There has been a reduction in the volume of complaints during the first quarter of 2020/21, but this is now appears to be increasing as services start to be reintroduced.

The complaints team will focus in 2020/21 on maintaining the high quality of its responses, which will maintain the low *re-open* rate and our strong performance in terms of PHSO outcomes. The findings from complaints will continue to drive improvements and learning. To provide additional assurance, we aim to do more to follow up with patients to let them know when agreed actions have taken place.

The Trust continues to provide a high quality complaints service that performs well against targets, but more importantly provides an accessible and supportive service for people who have cause to raise concerns.

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TRUST BOARD - PUBLIC SUMMARY REPORT	
Title of report: Audit, Risk & Governance Committee **–** report from meeting on 8 July 2020	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 29 July 2020	**Item 18.1, report no. 14a**
Responsible Non-Executive Director: Sir Gerald Acher, Deputy Chair	**Author:** Jessica Hargreaves, Deputy Trust Secretary

Summary:

The Audit, Risk and Governance Committee was held on 8 July 2020. Key items to note from that meeting include:

External Audit
The Committee received an update from external audit and noted the annual audit letter in relation to the 2019/20 audit which would be published on the Trust website.

Internal audit
Committee members received an update on progress against the internal audit plan for 2020/21 noting that scoping meetings were being held with executive leads over the coming weeks. The Committee noted that the impact of COVID-19 on the delivery of the plan was minimal and not likely to impede on the ability to fulfil the plan. Committee members reviewed management progress reports and action plans against audit reports relating to IR35 and key financial services.

Committee effectiveness, risk management and development of the Board Assurance Framework
The Committee discussed the development of the Board Assurance Framework noting that such a framework can ensure that the Board and its committees receives assurance that risks to the achievement of key performance indicators and strategic objectives are being effectively managed. The Committee discussed the proposal to increase the focus on risk and assurance which had been identified as part of the board effectiveness survey, and implement a revised framework which would be based around a series of deep dive reviews of existing and emerging risks as part of the board committee portfolios; it was agreed that the Audit, Risk and Governance Committee would oversee the implementation of the framework on behalf of the Board.

Raising concerns (whistleblowing)
The Committee received an update of the review undertaken of the Trust's 'Raising Concerns (whistleblowing) policy and the procedures currently followed for managing, recording, monitoring and reporting whistleblowing disclosures and were pleased to note the key changes that were being taken to improve the current processes; these aimed to encourage staff to raise concerns internally and detailed how these concerns would be handled and would provide consistency in the quality and timeliness of handling whistleblowing disclosures and concerns. The revised policy was due to be consulted on by the Trust's Partnership Committee and Executive Committee with the aim to have the new policy and procedures in place by 1 September 2020.

The Committee will next meet on 7 October 2020

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

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TRUST BOARD - PUBLIC BOARD SUMMARY	
Title of report: Report from The Quality Committee meeting held on 2020 8 July 2020	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 29 July 2020	**Item 18.2, report no. 14b**
Responsible Non-Executive Director: Professor Andy Bush, Non-Executive Director (Committee Chair)	**Author:** Amrit Panesar, Corporate Governance Assistant

Summary:

The Quality Committee met on 8 July 2020. Key items to note from that meeting include:

Update on COVID-19, Recovery & Reset
The Committee received a presentation on the Trust's response to COVID-19 and its reset & recovery plan. The Committee discussed and acknowledged the key risks and issues being faced by the Trust as it moves into the reset & recovery phase. The Committee were reassured that the executive team were managing the risks associated with the recovery phase and the Non-executive directors thanked the executive team for their dedication and hard work throughout each stage of the pandemic.

Strategic case for redevelopment of St. Mary's hospital – quality aspects
The Committee noted that the establishment of the Learning & Insights workstream within the Trust's recovery & reset programme would ensure that the Trust was continuing to bring in learning and insights into the redevelopment work in an adaptive and future looking way, noting that post-pandemic, there would be many changes in practice, and changes in models of care to meet changing population needs.

Integrated Quality and Performance Report
The Committee noted the quality aspects of the performance report.

Incident Monitoring report
The Committee noted that 903 Patient Safety Incidents were reported in May 2020. The bed day data for Quarter 4, 2019/20 aligned to a reduced bed base in February and March. The rate was now accurate and it demonstrates a large reduction in reporting across the Trust. There had been reductions in all divisions compared to their average reporting rates.

Implementation of the Medical Examiner Service
The Committee were pleased to note that the implementation of the Medical Examiner Service had made very good and significant progress and noted that there had been a transition into a new process with Medical Examiners completing the immediate review of all deaths in liaison with the responsible clinicians and the patient's families.

Learning from deaths Quarterly report Quarter 3&4 2019/20
The Committee received an update on the progress since the last report to the Committee and noted the progress with implementing actions to improve the learning from deaths process.

Key Divisional Quality Risks
The Committee noted that Divisional and Corporate key risks were largely focusing on the reset & recovery planning.

NHSI/E letter – assurance of risk assessments of at risk staff groups

The Trust had been asked by NHSI/E to undertake individual risk assessments relating to COVID 19 for all members of staff. The Trust noted that a video had been produced to educate staff about the risks and the actions that can be taken to minimise risks. Staff were then asked to complete a risk assessment to recognise at risk staff groups.

Committee effectiveness review
The Committee effectiveness review was reviewed and the Committee agreed the implementation of the risk and assurance deep dives which would be implemented in September 2020.

National Cancer Patient Experience Survey Results 2018
The Committee noted the National Cancer Patient Experience Survey Results 2018. The 2019 results would be presented to the Committee in September.

Annual report of the end of life steering group 2019/20
The Committee noted the annual report of the end of life steering group 2019/20.

North West London Pathology Operational Performance and Governance Report
The Committee noted that in May 2020, two new pathology related serious incidents (SI's) had been reported; these were currently being investigated in line with the Trusts SI process. The Committee noted that there had been a significant reduction in activity across pathology services in May 2020 due to the pandemic.

Recommendations:
Trust Board is asked to note this summary.

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TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Summary from Remuneration and Appointments Committee	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 29th July 2020	**Item 18.3, report no. 14c**
Responsible Non-Executive Director: Peter Goldsbrough	**Author:** Ginder Nisar, Deputy Trust Secretary

Summary:

The Remuneration and Appointments Committee met on 14th July 2020. Key points to note include:

Pensions update
The committee noted recent changes to the taxation of pensions. The Trust would publish guidance in the autumn to reinforce these changes and raise awareness in advance of any HMRC communication of the deadline for self-assessment tax returns.

Chief Executive's appraisal and objectives
The Committee noted the oral summary of the CEO's appraisal, provided by the Trust Chair. The Committee agreed the rating to be submitted to NHS Improvement, and the bonus commensurate with this rating. The Committee thanked Prof Orchard for his outstanding leadership.

The Committee noted that the objectives would be further developed in light of Covid-19, the reset and recovery programme and the impact on the sector. These would also include personal development objectives.

Executive appraisals 2019/20 and objectives 2020/21
The Committee received a summary of individual 2020/21 objectives for the Executive Team members and received an oral summary of the outcome of appraisal discussions regarding 2019/20 objectives. The Committee noted the exceptional performance of the Executive Team during the Covid-19 pandemic, furthermore so, when the team covered the CEO whilst he was recovering from Covid-19.

Executive remuneration
The Committee considered national pay quartiles from NHS Improvement/England and benchmarking data with comparators to enable decisions to be taken with regard to Executive Director level remuneration for 2020/21, and agreed actions for individual Directors to bring into line with comparators.

Continuity and Succession Planning
The Committee noted the overview of the succession planning timetable, noting that much of this had been paused whilst the Trust was responding to Covid-19. A further detailed discussion was planned for October.

Committee effectiveness review
The Committee noted the feedback and actions arising from the Committee effectiveness review.

Recommendations:
The Committee is asked to note this report.

This report has been discussed at:

Remuneration and Appointments Committee, 14th July 2020
Quality impact: Well-led
Financial impact: N/A
Risk impact and Board Assurance Framework (BAF) reference: N/A
Workforce impact (including training and education implications): Personal Development Plans.
Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☐ No ☒ Not applicable
How have patients, the public and/or the community been involved in this project and what changes were made as a result? N/A
What impact will this have on the wider health economy, patients and the public? N/A
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No

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TRUST BOARD – PUBLIC BOARD SUMMARY	
Title of report: Report from the Finance, Investment and Operations Committee meeting held on 22 July 2020	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 29 July 2020	**Item 18.4, report no. 14d**
Responsible Non-Executive Director: Dr Andreas Raffel, Non-executive Director (Committee Chair)	**Author:** Jessica Hargreaves, Deputy Trust Secretary

Summary:
The Finance Investment & Operations Committee met on 22 July 2020. Key items to note from the meeting include:

Financial performance
Committee members received the finance report for month 3, noting that the Trust was reporting a breakeven position year to date and had accrued a further £6.8m of retrospective 'top-up' funding for month 3. There continues to be significant uncertainty regarding the future funding model by the Centre. Committee members also received and noted the finance report from North West London Pathology and discussed the strategy plan for Imperial Private Healthcare, noting the plan to ensure patients continued to receive the best experience and outcomes, and to be fully aligned to the governance processes within the Trust.

Committee members noted the budgetary framework guidance which provided a set of principles for budget management and control during the financial year and sought to provide clarity and transparency on the approach to budget setting and financial management across the Trust.

Business cases approved by the Executive
The Committee noted the business cases that had been approved by the executive from 1 May 2020 and received an annual review of the financial benefits of business cases that had been approved by the executive in the previous financial year; it was noted that the impact of COVID-19 had affected the delivery and timeframe of many projects and the Trust was still awaiting capital expenditure approval from the sector. The committee will also review the result of multi-year business cases that were approved in earlier years and concluded in 19/20

PET CT business case
The Committee approved and agreed to recommend to the Trust board for final approval, the capital investment to replace the PET CT scanner within nuclear medicine at Charing Cross Hospital.

Strategic Imaging Asset Management (SIAM) programme update
The Committee received an update on the status of the overall SIAM project following approval of the strategic outline case (SOC) at the Trust Board in November 2019 noting the new national strategy for imaging networks which had been released by NHS England and NHS Improvement; this strategy sets out a proposal for implementing collaborative imaging networks on a national basis across England, delivering better quality care, better value services for patients and providing NHS staff opportunities to develop their career and increase their productivity. The Trust was currently in the process of submitting a revised SOC to NHS Improvement, aligning to this recent guidance.

Transformation plan, speciality review programme and Project Management Office update
The Committee received an update on progress against the Trust's transformation plan, noting that the current focus included the recovery and reset programme and specialist services reconfiguration at sector level.

Redevelopment
The Committee reviewed the financial aspects of the Strategic Outline Case for the redevelopment of St. Mary's Hospital.

Preparing for winter 2020/21
Committee members noted the planning principles that the Trust was working on in preparation for winter, recognising that this would be more challenging than in previous years as the impact of COVID-19 had created a new operating context that means some of the Trust's established escalation arrangements would no longer be appropriate. This was further complicated by the need to prepare for a potential second peak that could coincide with winter and in view of the fact that the pandemic has had such a fundamental impact on non-elective activity that future demand would be more difficult to predict.

Committee effectiveness
Committee members discussed the findings from the annual effectiveness review of the Committee and noted the proposed introduction of risk and assurance 'deep dives' for each board Committee that would be used to ensure a greater alignment with strategic goals.

Recommendations:
To note this summary.

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TRUST BOARD – PUBLIC BOARD SUMMARY	
Title of report: Report from the Board Redevelopment Committee 22 July 2020	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 29th July 2020	**Item 18.5, report no. 14e**
Responsible Non-Executive Director: Paula Vennells, Committee Chair	**Author:** Philippa Beaumont, EA to the Chair

Summary:

The Strategic Outline Case for redevelopment at St. Mary's was presented to the Committee for final review, prior to formal approval by the Trust Board before onward submission to NHS Improvement. The Strategic Outline Case sets out the case for the re-provision of a major new acute teaching hospital on the St. Marys site. It presents the opportunity to do this whilst contributing to the redevelopment and regeneration of the Paddington Basin. The Committee discussed the opportunities for redevelopment in the context of the post COVID world, noting the update on the clinical design work being led by the Patients Pathways and Population workstream

The Committee received an update on benchmarked capital costs and the upcoming design team procurement process. The Committee also briefly discussed alternative procurement options, included in the Strategic Outline Case, as comparators to ensure best value for money and commercial transaction principles.

Committee Terms of Reference update:
Last year the Board approved the change from Redevelopment Committee to Redevelopment Programme Board to provide the opportunity for stakeholder engagement. Whilst for a period of six months that was appropriate and useful, now that the programme has moved into the Strategic Outline Case phase, it was deemed necessary to revert back to a Redevelopment Board Committee and establish a Steering Group to engage stakeholders with the detail of the business case. The Board is asked to note this and the updated Terms of Reference (TORs) will be presented along with other TORs in September.

Recommendations:
To note this summary.