

## BARTS HEALTH NHS TRUST

### TRUST BOARD MEETING (PART 1)

There will be a meeting of the Trust Board in public on  
 Wednesday 5 May 2021 at 11.00am via Webex videoconferencing  
*Scheduled to end by 13.45*

### AGENDA

Please note that this is a Trust Board meeting held in public. In accordance with the Trust's Standing Orders, no filming or recording of the meeting is permitted. There will be an opportunity for questions and comments from members of the public at the end of the meeting.

		Paper TB	Lead	Time
1.	<b>WELCOME</b>		Mr I Peters	11.00
2.	<b>APOLOGIES FOR ABSENCE:</b>			
3.	<b>DECLARATION OF INTERESTS</b> To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting including gifts and hospitality (accepted or refused)			
4.	<b>MINUTES</b> To approve the Minutes of the meeting held on 3 March 2021 and review the appended action log	10/21	Mr I Peters	11.00
5.	<b>MATTERS ARISING</b> To consider any matters arising from the Minutes not covered elsewhere on the agenda			
6.	<b>TRUST BOARD MEMBERSHIP</b>	11/21	Mr I Peters	11.05
7.	<b>PATIENT STORY</b> To hear a patient story		Ms C Alexander	11.10
8.	<b>CHAIR'S REPORT</b> To receive a report from the Chairman		Mr I Peters	11.25
9.	<b>CHIEF EXECUTIVE'S REPORT</b> To receive a report from the Chief Executive		Ms A Williams	11.30

<b>QUALITY, SAFETY AND PERFORMANCE</b>				
		<b>Paper TB</b>	<b>Lead</b>	<b>Time</b>
<b>10.</b>	<b>IMPLEMENTATION OF NEXT PHASE PLAN</b> <ul style="list-style-type: none"> <li>• Elective restoration</li> <li>• Urgent and emergency care</li> <li>• Vaccination update</li> </ul>	12/21	Mr R Coulbeck, Mr S DeGaris and Mr A Hines	11.35
<b>11.</b>	<b>INTEGRATED PERFORMANCE REPORT – 2020/21 M12</b> To receive the report and discuss performance on: Covid-19; Access; Quality and Safety; People; and Finance	13/21	Executive leads	12.00
<b>12.</b>	<b>REPORTS FROM BOARD COMMITTEES</b> <ul style="list-style-type: none"> <li>12.1 Finance and Investment Committee (oral)</li> <li>12.2 Quality Assurance Committee</li> <li>12.3 Nominations and Remuneration Committee</li> </ul>	14/21 15/21	Mr A Camp Dr K McLean Mr I Peters	12.20
<b>13.</b>	<b>INCLUSION</b> <ul style="list-style-type: none"> <li>13.1 To receive a WeBelong progress report</li> <li>13.2 To receive the Inclusion Matters yearly equalities information report</li> </ul>	16/21	Ms R Bhamber and Mr A Abraham	12.30
<b>14.</b>	<b>EQUITY OF ACCESS</b> To receive and discuss the report	17/21	Mr R Coulbeck and Dr I Basnett	12.40
<b>GOVERNANCE</b>				
<b>15.</b>	<b>WHIPPS CROSS REDEVELOPMENT</b> To receive a programme update report	18/21	Mr R Coulbeck	12.50
<b>16.</b>	<b>RESPONDING TO DEATHS</b> To receive the yearly report	19/21	Prof A Chesser	13.00
<b>17.</b>	<b>GUARDIAN OF SAFE WORKING</b> To receive the yearly report	20/21	Prof A Chesser / Dr R Serafino Wani	13.10
<b>18.</b>	<b>USE OF THE SEAL</b> To ratify use of the Trust Seal	21/21	Mr S Collins	13.20

ANY OTHER BUSINESS/ITEMS FOR INFORMATION (UNLESS OTHERWISE STATED)				
19.	ANY OTHER BUSINESS			
20.	QUESTIONS FROM MEMBERS OF THE PUBLIC	22/21		13.25
21.	<b>DATE OF THE NEXT MEETING</b> The next meeting of the Trust Board in public will be held on Wednesday 7 July 2021 at 11.00am (venue tbc)			
22.	<b>RESOLUTION</b> That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section (2) Public Bodies (Admissions to Meetings) Act 1960).			

**Sean Collins**  
**Trust Secretary**  
**Barts Health NHS Trust**  
**020 3246 0637**

## BARTS HEALTH NHS TRUST

### TRUST BOARD MEETING (PART 1)

Minutes of the Trust Board meeting in public on  
Wednesday 3 March 2021 at 11.00am held via Webex Videoconferencing

**Present:**

- Mr I Peters (Chairman)
- Ms A Williams (Group Chief Executive)
- Ms C Alexander (Chief Nurse)
- Mr A Camp (Non Executive Director)
- Professor A Chesser (Chief Medical Officer)
- Mr R Coulbeck (Director of Strategy)\*
- Mr G Dalal (Vice Chairman)
- Mr S DeGaris (Deputy Chief Executive)
- Ms M Exley (Non Executive Director)
- Mr A Hines (Director of Corporate Development)\*
- Ms K Kinnaird (Non Executive Director)
- Ms K McLean (Non Executive Director)
- Mr M Pantlin (Director of People)\*
- Ms T Rehal (NExT Director)\*
- Mr H Virdee (Chief Finance Officer)
- Mr C Williams (Associate Non Executive Director)

**In attendance:**

- Mr S Collins (Trust Secretary)
- Mr R Khan (Women's Clinical Board Chair)
- Ms A Herron (Divisional Director of Midwifery)
- Mr Y Dudhwala (Head of Chaplaincy)

**Apologies:**

- Ms N Howard (Non Executive Director)
- Professor S Thornton (Non Executive Director)

*\* Non-voting member*

#### 22/21 WELCOME

The Chairman welcomed everyone to the meeting and invited the Trust's Head of Chaplaincy, Yunus Dudhwala, to open the meeting.

The Head of Chaplaincy provided the setting ahead of holding a minute's silence for remembrance and reflection. He reflected on the experiences of staff, patients and the public during the pandemic and the reminders of the human impact provided in the statistics and media coverage in recent

months. He celebrated the fact that so many in the Trust had grown as leaders by virtue of serving the call placed on the hospital's services by their example on the front line or in other similar ways outside their 'business as usual' roles. He predicted that the local population would in future reflect on the value of being to be able to access NHS services and he noted examples of how the nation had united to respond swiftly in reacting to the crisis. He introduced a minute's silence as a mark of respect for all those who had lost their lives, including those staff members confirmed as Covid-19 fatalities.

The Chairman thanked the Head of Chaplaincy following the observation of a minute's silence.

### **23/21      DECLARATION OF INTERESTS**

Attendees were reminded of the need to declare any interests they may have in connection with the agenda or interests acquired since the previous meeting, including gifts and hospitality (accepted or refused). There were no new declarations.

### **24/21      MINUTES**

The Minutes of the meeting of the Trust Board held in public on 4 November 2020 were received and approved.

### **25/21      STAFF STORY**

The Chief Nurse introduced Safia Jama, the founder of the Women's Inclusive Team, which operated in Tower Hamlets to support representation and awareness of black and minority ethnic women's issues. The Chief Nurse noted Safia's prominent role in supporting the Somali community in particular.

Ms Jama highlighted the continued issues of inequalities in East London and opportunities for stakeholders to support change in the context of the pandemic and Black Lives Matter movement. She outlined the role of the Women's Inclusive Team over a number of years and highlighted the importance of a voice for the local community. As the second largest ethnic group in Tower Hamlets and its biggest black ethnic population there were issues with visibility in institutions and representative groups. Safia also recognised risks associated with the Somali community's needs in terms of language and health advocacy being obscured by others included in the BAME category. She highlighted the importance of some simple things, such as supporting patients and relatives receiving food and access to chaplaincy support and noted the work with Abbas Mirza and the Head of Chaplaincy to encourage feedback and act on this to develop trust. The potential to expand the pool of Somali volunteers could prove a key element of improving these dynamics and embedding links to the community.

The following observations were made by Board members:

- The Chief Nurse highlighted ongoing work to review advocacy services to improve Somali representation and language support, with a workshop planned in March to explore this further.
- Ms Exley welcomed the collaborative approach taken in Tower Hamlets with the Trust and sought ideas on how the Trust Board could assist with this work. Ms Jama noted that a BAME Inequalities Commission in Tower Hamlets had recently concluded; and anticipated that there could be lessons arising from the resulting report that the Trust could help work through. She felt it would be helpful for Board members to challenge itself to support the needs of particular communities as well as the more generic BAME interests.
- Dr McLean recognised that the pandemic had led to a number of changes in how services were developed and that some positive aspects would need to be retained. Ms Jama agreed that there was a need to keep up momentum on initiatives such as food banks and tackling vaccine hesitancy would be important in the next phase.

The Chairman noted how impressed Board members were with the honesty and the commitment of Ms Jama and the Women's Inclusive Team. A number of learning opportunities had been identified including the importance of representation, food and language. He recognised that some early steps had been taken and that Barts Health would need to do more to sustain that trust.

## 26/21

### CHAIR'S REPORT

The Chairman outlined the challenges faced by the Trust since November, noting that the Trust had been treating 5% of the country's critical care patients. While recognising that every death was a tragedy, over 10,000 patients with Covid-19 had been discharged and survival rates had improved. local health economy including the impact of a coronavirus second wave. He recognised that there was a particular spotlight on health inequalities in East London from a patient and staffing perspective which emphasised the need to widen access to healthcare. He took the opportunity to thank the extensive range of stakeholders and staff for their contributions and their resilience. He also highlighted the Trust's contribution to the vaccination campaign and with QMUL to support research initiatives including the Janssen vaccine trials. He took the opportunity to congratulate five members of staff receiving national honours including Alwen Williams being awarded a DBE damehood for services to healthcare. He also thanked Michael Pantlin, attending his last Trust Board meeting prior to joining Sussex Heartlands ICS,

for his service over the last eight years at Barts Health including for his leadership and championing of staff welfare and wellbeing.

## 27/21 **GROUP CHIEF EXECUTIVE'S REPORT**

The Group Chief Executive firstly endorsed the comments made by the Chairman and Head of Chaplaincy about the achievements of the Trust's people. She added that conversations with staff and partners had consistently emphasised the need to create an enduring legacy of improvement in the aftermath of the pandemic. As the Trust started to fully restore elective services, there was a renewed determination and commitment to embed equity and the Trust's values in its plans. The publication of HM Government's White Paper on health services signalled an increasing direction towards integrated services across organisational boundaries and the Trust's plans would be more sector-based with the Integrated Care System (ICS) having a key role. Finally, she noted her thanks to the executive team during the challenging months.

## 28/21 **COVID-19 REPORT AND NEXT PHASE PLANS**

### *Hospital experience*

The Deputy Chief Executive outlined the report, detailing the Trust's second peak pandemic response, entitled 'a winter like no other'. He confirmed that the Trust had received double the number of patients as seen in the first peak and that the peak itself had lasted for a longer period resulting in significant pressure on all of the Trust's hospitals. He set out the planning that had taken place leading up to the building of operational pressures and the key role of partners, such as the London Ambulance Service working with the Trust to support the most effective possible deployment of critical care resource. The peak had seen challenges such as constraints on piped oxygen availability, requiring careful transfer of patients within and outside the Trust where necessary. The Chief Medical Officer confirmed the challenges faced during the Christmas and January period, with staff not knowing how long this peak would last, but showing unwavering commitment nonetheless. Despite a gradually declining caseload, the Trust still had double the number of ITU patients compared with the normal range and critical care remained the slowest clinical speciality to return towards normal activity. It was too early for data-supported evidence, but the Trust had been better prepared than in the first peak in terms of understanding of the disease, at-risk groups affected and management using new medicines and ventilation protocols. He was grateful to emergency departments for their responsiveness, critical care teams for flexibility and operating teams to prioritise workloads effectively. The challenge of the next stage would be equally formidable given the size of waiting lists.

Each hospital chief executive provided an account of their experience of the pandemic response in terms of challenges and highlights including:

- The commitment of staff redeploying to different locations, roles and conditions.
- The scale and scope of critical care expansion, while maintaining essential services alongside this.
- The new challenges faced in managing oxygen supplies optimally.
- The important role of the clinical physics team in supporting provision, maintenance and procurement of essential medical equipment.
- An emphasis on staff wellbeing recognising the life-changing impact of the pandemic response work; and the key role of partners such as Elixir and the Barts Charity supporting staff in this respect.
- The rapid implementation of vaccination arrangements.
- Infrastructure changes required to meet the pandemic response and the role of the infection prevention and control team during this.
- Rapid changes to ways of working including virtual clinic implementation, establishing family contact arrangements and multidisciplinary working.

Ms Exley felt that it would be helpful for leaders to challenge themselves to minimise layers of governance and sense check the value added by traditional structures as next phase plans were developed. She felt that, with some of the fundamental changes that had been made and the lack of contingency capacity identified throughout the pandemic, the Trust should revisit and 'right size' the capacity of its hospitals, assessing the population demand.

Dr McLean recognised the innovation that had accompanied the response and the opportunity to apply this to restoration of services. The Group Chief Executive agreed the need to embed Quality Improvement methodology and to embed the patient's voice. The pace of transformation during the pandemic had been rapid and this underlined the need to be ambitious and less tolerant of slow change when planning service restoration.

#### *Staff recovery and wellbeing*

The Chief Nurse and Director of People provided an update on staff wellbeing and plans for restoring services. There had been some changes during the pandemic and it was widely felt that there would be no way of returning to the same ways of working in place prior to this. The Chief Nurse noted the extensive learning from the first wave that had been applied to managing care pathways in the second wave. A workforce hub had been established for each hospital helping to co-ordinate the staffing response. A key area of focus had been the stretching of staffing ratios and the mitigation put in place to enable this to be done safely. The Director of People looked ahead to the next phase and noted that one practical consideration would be absences due to the significant annual leave not taken during the peak. The psychological impact for staff had been recognised and support introduced at each hospital site. In restoring services, he noted that the experience of high volumes of



redeployment suggested that barriers to this should not be allowed to return. Ultimately there would be some tension initially between restoring services for patients having waited very long times and safely enabling staff to recover. The role of team leaders would be key to this as the conversations involved would need personal attention and could not be done centrally. He outlined some of the tools, such as leadership webinars, to support communication in the wider organisation.

Ms Kinnaird recognised the importance of team leaders in developing the staffing response to restoring services. She felt that it would be important to identify where supportive interventions were self-selected or centrally directed. The Director of People confirmed that selected areas had been targeted for support already. He noted the need to recognise that there were some 'hard to reach' groups that would need focus.

Mr Camp asked whether there was support in place to help identify staff struggling with the impact of the pandemic. The Director of People noted that, as well as the clinical psychology support, staff mental health first aiders had been identified to help ensure a sympathetic voice was available and able to direct affected staff towards the most appropriate source of help.

Mr Dalal noted the importance of recruitment and retention during this period, noting some increased attractiveness of working in the NHS and relatively low turnover. The Director of People felt that a targeted approach was required. He also anticipated some correction to the current low levels of leavers as the economy returned to normality.

#### *Vaccination update*

The Director of Corporate Development provided an update on the vaccination activity being led on hospital sites and the ExCel Centre. He noted progress in establishing robust vaccination arrangements and recognised the need to address vaccine hesitancy, particularly among the BAME staff and patient population. The work at the ExCel centre was supporting vaccination of health and care staff across London as well as the initial older cohort of patients identified as priority in line with the national JCVI guidance. There had been a need to be relatively agile in response to vaccine supply and the approach had been a team effort with contributions from military advisors and volunteers among others.

Around 87% of staff had now received their initial dose of the vaccination with a second dose due within 12 weeks. Around 54% of the Trust's workforce was BAME. 47% of those that had received the vaccine had identified as BAME.

The next phase of vaccines would extend offers to younger age groups and those with underlying conditions and further national guidance was anticipated on implementing the full roll out of vaccinations.

Dr McLean indicated that she had found the staffing breakdowns opaque and felt that it would be helpful to assess confidence on how close the Trust was to achieving a satisfactory level of vaccination completion. The Director of Corporate Development indicated that the Trust benchmarked well in terms of comparison with peers on overall staff and BAME vaccination rates, while recognising the need to develop more granular information. He outlined some outreach activity, such as providing vaccinations at faith centres, to support take-up. This would be balanced with an approach to maintaining high volume rates through hospital hubs.

## **29/21 INTEGRATED PERFORMANCE REPORT**

The Chairman noted that the Quality Assurance Committee and Finance and Investment Committee had recently reviewed key quality and financial metrics and would feed back by exception during that agenda item. Although the Integrated Performance Report item was typically a key focus of the Board's discussions at each meeting, he had felt that, on this occasion, the majority of time should instead be set aside to discuss the Covid-19 report and hospital perspectives. As such the report would be considered as read, with discussion limited to inviting any questions on performance questions from members.

The Trust Board noted the report.

## **30/21 OCKENDON REVIEW**

The Chief Nurse introduced TB 04/21, a paper detailing the Trust's response to the 7 Immediate and Essential Actions (IEAs) from the Emerging Findings and Recommendations from the Ockendon Independent Review of Maternity Services. The Ockendon review had looked at failures in maternity services at Shrewsbury and Telford Hospitals NHS Trust, with the emerging report highlighting some immediate actions in addition to a wider theme of the need for cultural improvements in services. Only through this cultural change could women-centred and baby-centred care be consistently provided in a way that was compassionate, inclusive and safe; respecting women and families as equal partners in maternity service delivery.

The Chief Nurse noted that the report reflected discussions at executive level and at the Quality Assurance Committee. As the executive lead, she had felt that this work would require dedicated oversight arrangements and a maternity board had been established alongside a dashboard to track progress. She thanked Ms Herron and Mr Khan who were in attendance and had led on this work to date.

Dr McLean welcomed the opportunity to refocus boards on the important maternity services provided in hospitals and felt that this provided an opportunity to develop consistency across the group.

Mr Camp suggested that the recognition of only partial assurance in some areas reflected an open culture and recognised also the high risk nature of maternity services, particularly among the local population in East London.

Mr Dalal noted that CQC reviews of the Trust's maternity services had proved increasingly favourable in recent years, although progress appeared to have been slower at Newham. The Chief Nurse agreed that the maternity department at Newham had been on an improvement journey and felt that progress had been made more recently. She felt that, as with at all of the Trust's hospitals, there was work required to understand and improve the culture of the maternity service. She noted good engagement with local women and felt confident that the CQC would recognise improvements in future reviews. Mr Sewell-Jones agreed, noting that there had been a need to strengthen some 'basics' such as governance arrangements and challenging the team further on cultural understanding and awareness.

Ms Kinnaird noted the importance of reflecting local demographic changes in planning service provision. Ms Herron recognised the growth in Newham maternity services demand and outlined processes to involve local women in Trust initiatives such as home birthing and midwifery-led centres. She recognised that there was more to be done to ensure the voice of different ethnicities was represented in planning services.

The Trust Board approved the self-assessment and proposed next steps. A timeline for reporting back to the Board on progress would be confirmed in due course.

**ACTION: Chief Nurse**

## 31/21      **REPORTS FROM BOARD COMMITTEES**

Reports from Board committees on recent activity and items for escalation were received and the following points noted:

- Mr Camp confirmed that the Month 10 financial position remained broadly on track. The Finance and Investment Committee had spent time on Whipps Cross redevelopment business case development and a Pathology Partnership financial update report, ahead of a more detailed Trust Board paper due next month expanding on the associated governance arrangements.
- Dr McLean confirmed the range of topics covered, as detailed in the Quality Assurance Committee exception report, highlighting revisions to the terms of reference appended and taking the opportunity to praise the work of the infection control team.

- Mr Dalal noted a streamlined Audit and Risk Committee meeting agenda with the focus on the evolution of the Internal Audit function and discussion of the BAF and risk appetite.

The Trust Board noted the reports from Board committees and approved the Quality Assurance Committee terms of reference.

### **32/21 BOARD ASSURANCE FRAMEWORK**

The Director of Corporate Development introduced the Board Assurance Framework (BAF). He suggested that the version being presented reflected some significant progress on evolving the Trust's risk management approach, detailing a number of refinements including the inclusion of a risk appetite dimension.

He reminded members that there had been some pandemic-related delay this year to approving the objectives this year, with a refresh of the BAF risks to these confirmed by the Board in November. He highlighted some changes to risk scores and wording since the last meeting. The risk appetite dimension, previously used in shadow form during 2020, had been included following further development and provided the opportunity to move beyond analysis of current risks towards a view of where these need to get to. He highlighted a helpful and open discussion of this at the Audit and Risk Committee and plans to develop the thinking further to align this with business planning for 2021/22.

Mr Dalal felt that this version of the BAF represented good progress and thanked the Trust Secretary and Director of Corporate Development in particular on making strides with the Trust's risk management maturity. He recognised the need for further work to refine the approach to applying risk appetite but felt that the Trust now had the potential to become an exemplar in this respect.

The Trust Board approved the BAF.

### **33/21 WHIPPS CROSS REDEVELOPMENT**

The Director of Strategy and Director of Redevelopment introduced the progress report. The Director of Strategy highlighted the significant impact of Covid-19 on the thinking and planning for the new hospital. He highlighted the theme of messages from Whipps Cross staff that the new hospital represented a beacon of hope and opportunity for the local community and the hospital workforce.

The Director of Redevelopment reflected the challenges of translating the hopes of staff and patients into realistic expectations for the hospital redevelopment. He noted that the report identified the creation of a new national New Hospitals Team, looking to maximise the benefits of economies

of scale nationally; the appointment of a technical team; and a focus on healthcare planning, strategy, design and costings methodology. He felt that the timing of the creation of a national team was helpful as this should inform the development of the Trust's Outline Business Case and testing assumptions set out in the SOC. He recognised that a key consideration was the size of the hospital, with plans for this to be of similar size although consolidated over reduced space. The footprint of this would change to produce a higher proportion of clinical service occupancy of the built estate. Costings would be informed by the work of quantity surveyors and national team feedback. He noted that there would be two planning applications due to be submitted in Spring; with the first related to a multi-storey car park and the second relating to the wider site. The programme was now entering a new phase, with the appointment of demolition partners due to start work in April.

The Director of Redevelopment outlined the consultation and engagement work in recent months, including a virtual meeting with over 100 attendees. A number of helpful recommendations, observations and concerns were flagged and would be followed up. He emphasised that there would be opportunities for stakeholders and the public to input throughout the life of the programme and suggested that communications would need to increasingly cover aspects such as regeneration and economic benefits for the local population.

Mr Williams reported that he had participated in the recent public engagement event, which he had found very helpful. He noted one technical drawback (relating to the ability to see other public participants contributing to the discussions) and suggested that the presentations had appeared to lack sufficient articulation of the potential health benefits of this significant investment in health services. He felt that communications for the redevelopment should ensure that these remained a focal point (ahead of other considerations such as specific estates considerations). The Director of Redevelopment noted that the team would check on the specific technical issue raised. He agreed that communications should return to the core health benefits regularly and promoted a two-way dialogue. He recognised the risks of communications being drawn too heavily into addressing specific issues of concern to interested parties, rather than the wider headlines.

Professor Thornton noted that QMUL's five year strategy included a focus on digital healthcare and long-term conditions management, suggesting that there would be good opportunities to develop joined-up thinking for the redevelopment.

Ms Exley recognised the significant changes to pathways and challenges to maintain flexibility of the hospital's design to anticipate future changes to clinical needs. She recognised also the importance of engaging a wider audience than those self-selecting to participate in more specific aspects of design consultation. The Director of Redevelopment noted that he was increasingly confident in the ability to flex services and respond to significant

changes to clinical assumptions, with the flexibility of staff and partner organisations evidenced during the pandemic. He recognised that a key limitation of the current estate was the ability to flexibly adapt to winter challenges; the selection of design and construction of partners that were able to build in flexibility and adaptability to the design would be key. He noted also the establishment of a community engagement group which sought to look more widely at representation, with a specific strand of the communications plan focusing on engaging harder-to-reach target audiences. He noted that one aspect of the pandemic had been an increasing move towards virtual conferencing which he hoped would improve access for some groups to be able to provide their voice.

The Trust Board noted the progress report.

**34/21 USE OF THE SEAL**

The Trust Board approved the use of the Trust seal as outlined in the paper.

**35/21 ANY OTHER BUSINESS**

There was no other business.

**36/21 QUESTIONS FROM MEMBERS OF THE PUBLIC**

The Chairman introduced the section of the meeting inviting questions from the public, with no questions submitted in advance on this occasion. There were no questions submitted.

**37/21 DATE OF THE NEXT MEETING**

The next meeting of the Trust Board in public would be held on Wednesday 5 May 2021 at 11.00am via videoconferencing, with joining details to be published on the website.

**38/21 RESOLUTION**

The Board resolved that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section (2) Public Bodies (Admissions to Meetings) Act 1960).

**Sean Collins**  
**Trust Secretary**  
**Barts Health NHS Trust**  
**020 3246 0637**

**Action log**

<b>Trust Board Part 1: 3 March 2021</b>			
Page No.	Action	Lead	By
	Ockendon review – A timeline for reporting back to the Board on progress would be confirmed in due course	Chief Nurse	5 May 2021

<b>Report to the Trust Board: 5 May 2021</b>	<b>TB 11/21</b>
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<b>Title</b>	Trust Board membership
<b>Sponsoring Director</b>	Chairman
<b>Author(s)</b>	Trust Secretary
<b>Purpose</b>	To note changes to Board membership
<b>Previously considered by</b>	n/a

**Chairman**

The Trust Chairman, Ian Peters, has been appointed to the position of Chairman of the new UK Health Security Agency with effect from 1 April 2021. He has confirmed that he will continue to serve as Barts Health NHS Trust in the interim during the search for a successor, which will be led by NHS England/Improvement.

**Non Executive Director membership**

Ms Natalie Howard, whose term of office was due to complete in November 2021, has announced her decision to step down following this meeting (5 May 2021) in light of the time demands of her new executive post at an investment bank.

**Executive Director**

Ms Raj Bhamber was engaged on secondment as Interim Director of People and non-voting Trust Board member with effect from 1 April 2021 (following the departure of Michael Pantlin). An appointment process for the substantive post is under way and it is anticipated that a formal announcement will be made shortly.

<b>Related Trust objectives</b>	n/a
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<b>Risk and Assurance</b>	n/a
<b>Related Assurance Framework entries</b>	n/a

<b>Legal implications/regulatory requirements</b>	No direct legal implications identified.
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**Action required by the Board**

The Trust Board is asked to note the above changes to Trust Board membership



<b>Report to the Trust Board: 5 May 2021</b>	<b>TB 12/21</b>
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<b>Title</b>	Next Phase plan implementation
<b>Sponsoring Director</b>	Director of Strategy, Deputy Chief Executive and Director of Corporate Development
<b>Author(s)</b>	Director of Strategy Director of Emergency Care Improvement Head of Group Development
<b>Purpose</b>	To update the Board on the Next Phase plan including the vaccination programme
<b>Previously considered by</b>	-

**Executive summary**

This paper updates the Board on delivery of the Trust Board approved Next Phase plan including details on: Ongoing Covid demand and resilience; Urgent and emergency care; Elective recovery and restoration; and the vaccination programme.

**Related Trust objectives**

This paper relates to our second objective for 2020/21, 'To restart and transform clinical services to provide equitable access, high quality outcomes and a focus on population health'.

<b>Risk and Assurance</b>	The Group Executive Board oversees the programme and associated risks.
<b>Related Assurance Framework entries</b>	5. Failure to restore planned care to restated capacity requirements (through elective activity plans, implementation of surgical hubs and outpatients transformation) at a pace consistent with staff recovery impacts on quality of care [DCEO/DS]
	6. Failure to restore non elective care to restated capacity requirements (through transforming urgent and emergency care pathways, critical care expansion and managing winter pressures) at a pace consistent with staff recovery impacts on quality of care [DCEO]

<b>Legal implications/ regulatory requirements</b>	NHS England / NHS Improvement requirements
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**Action required by the Board**

The Board is requested to note this update.



# Next phase plan: overview of progress

Trust board update

May 2021



## Summary

- In March, the trust board agreed plans for the next stage of the pandemic, focusing on staff rest and recovery, restoration of elective services, ongoing clinical transformation, and continued preparation for further peaks of Covid activity.
- Delivery of this plan is underway and this paper provides updates on:
  - Ongoing Covid demand and resilience,
  - urgent and emergency care,
  - elective recovery and restoration and
  - the trust's vaccination programme.
- Following the issuing of national planning guidance in April, plans for the remainder of 2021/22 are now in development and will be submitted by the Northeast London ICS in June.
- The board is asked to **note** the content of this overview report.

## Our over-arching priorities for the next phase

Our priorities for the next phase include:

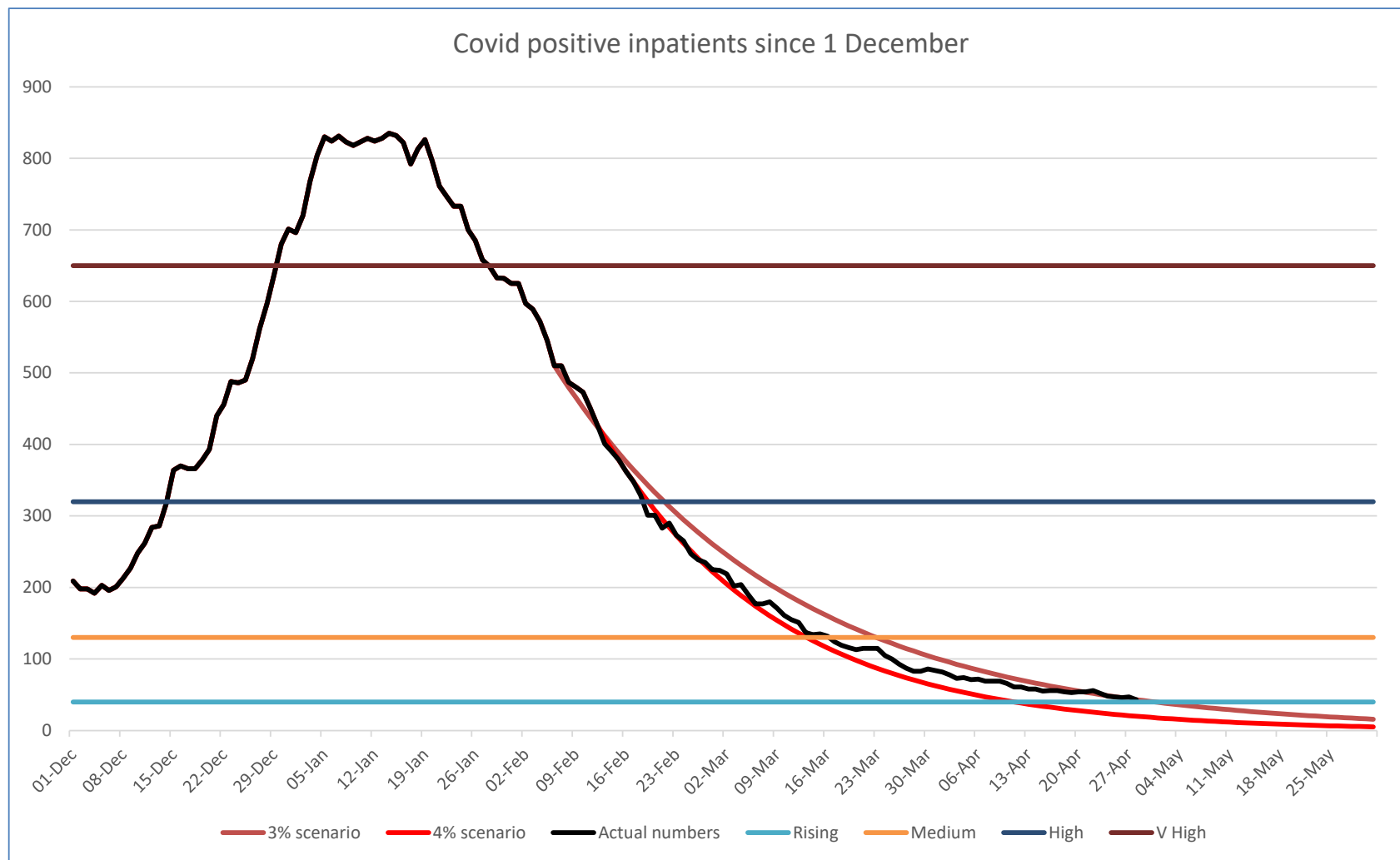
1. Creating time and space for **staff rest and recovery**.
2. Continuing to **provide high quality care for Covid-19** patients as numbers steadily reduce and in response to any future increases in Covid demand.
3. Ensuring that alongside Covid care we **sustain other emergency and urgent services**, including for cancer, trauma, cardiac and stroke and for emergency and urgent surgery and diagnostics.
4. Planning and delivering the **phased restoration of routine services**, including elective surgery, outpatients and diagnostics.
5. Transforming care by **building on the many innovations we have put in place** during the pandemic in medicine, emergency care, critical care, surgery and women's and children's services.
6. Playing out part in **delivering Covid vaccinations** to staff, patients and the public and addressing vaccine hesitancy.

# Ongoing action to support staff rest and recovery



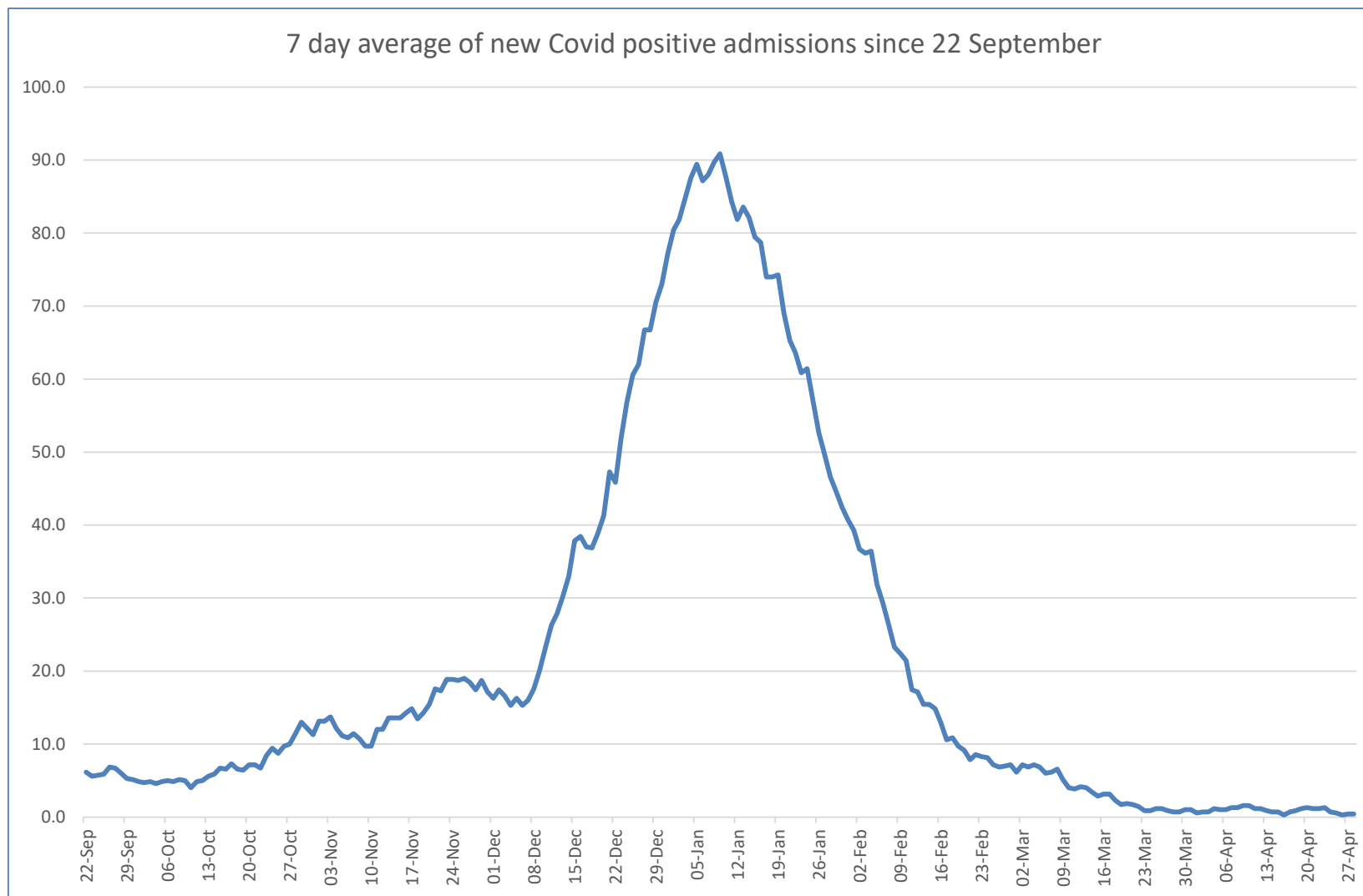
# 1. Covid resilience

# Trends in Covid inpatient numbers

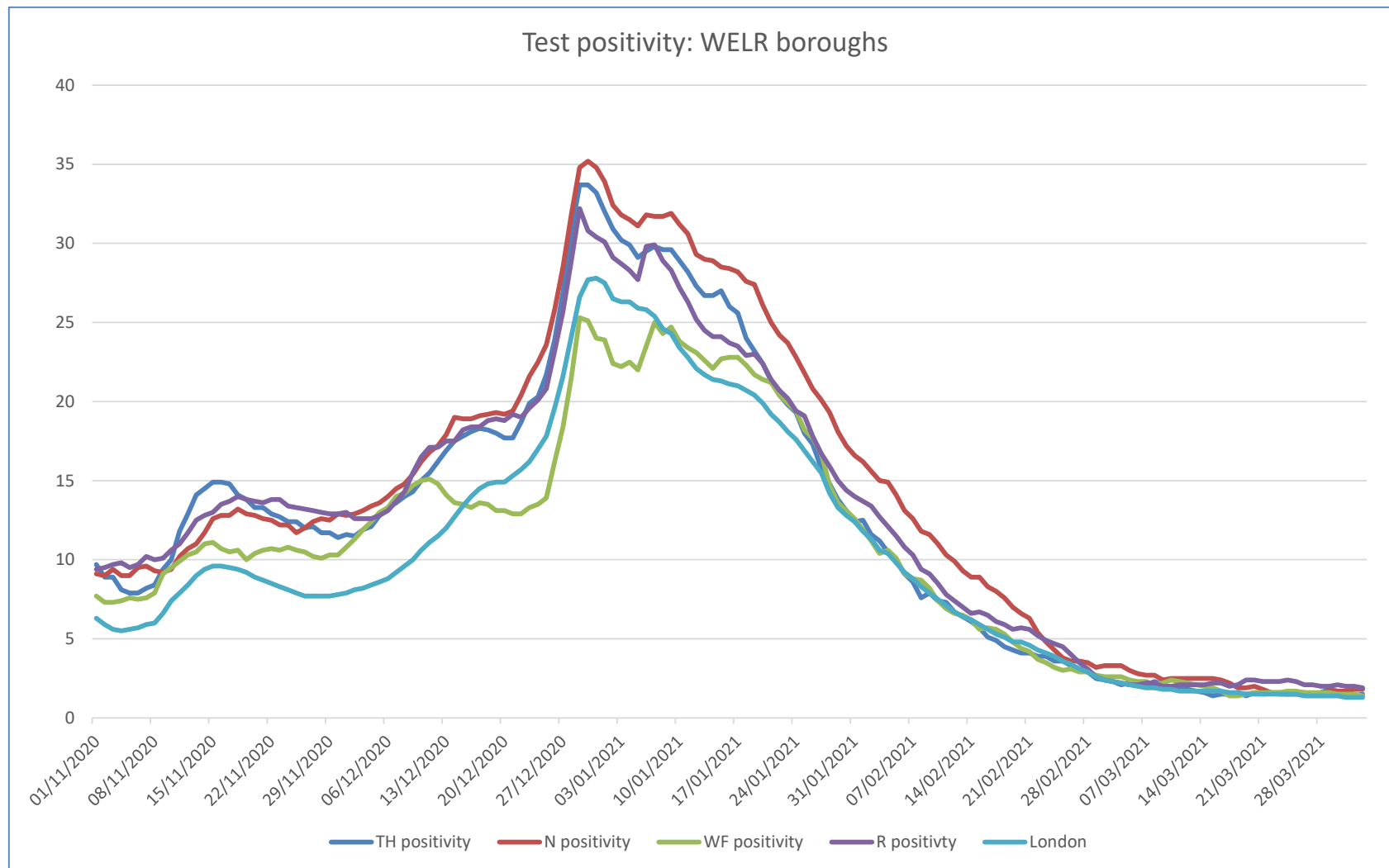




# Trends in new Covid positive admissions



# Trends in test positivity



## Ongoing Covid resilience

- Current trends for Covid admissions and community positivity remain low and stable while Covid inpatient numbers continue to fall slowly
- However, with the steady unlocking of society, further waves of Covid activity are likely to occur with academic modelling suggesting the potential for increased hospital Covid hospital activity over the Summer or Autumn period
- There is significant uncertainty in modelling future Covid activity due to unknown impact of vaccination, changes to lockdown measures and regional and local variation. All models suggest any future wave is likely to be significantly smaller than the first and second waves of activity due to the impact of the vaccination programme.
- In order to ensure ongoing Covid resilience the trust is:
  1. Maintaining additional critical care capacity at the Royal London hospital to respond to increases in activity and investing in critical care staffing,
  2. Ensuring continuing compliance with infection prevention and control guidelines in emergency, inpatient and outpatient care to maintain patient and public safety,
  3. Separating elective activity into 'green' zones with clear infection protocols,
  4. Maintaining our staff vaccination and staff and patient testing programmes, and
  5. Tracking key data on Covid trends and maintaining resilience plans so that the trust can escalate through the agreed pressure levels in the event of a further wave of activity.

## 2. Urgent and emergency care

## Urgent and emergency care: governance

To create a clear focus on the challenges of maintaining emergency flow in the context of ongoing Covid and infection control challenges, COVEG (Covid emergency flow group) was set up in response to the first wave of COVID and its initial remit was to reduce volumes within ED waiting rooms to prevent nosocomial spread of COVID 19.

The aim of CoVEG was to provide leadership and direction to the Redesign of Emergency and Urgent Care Pathways producing a Transformed Emergency Provision of Care using a QI approach. The membership of CoVEG is multidisciplinary and includes external stakeholders, clinical support systems as well as clinicians.

### **The key changes made before the second peak:**

- MEADOW (medical examination and disposition of walk-ins)
- BEACH (Barts Emergency Access Coordination Hub): 111 and ambulance (BEACH ambulance operates across NEL with the aim of decreasing ambulance conveyances to all hospitals across the ICS)
- Pathways for the mandated SDEC (Same Day Emergency Care) models were finalised

During the second peak the change work paused to allow services to concentrate on the influx of critically patients.

### **February 2021**

CoVEG re grouped in February and set out its priorities moving forward which included embedding the changes already started and to agree future innovations and pathways of work.

# Emergency care transformation: BEACH model

## BEACH

This model Provides clinically-led support and assessment of all patients being considered for ED attendance via 999 and 111

The BEACH model has two arms to it:

- BEACH ambulance
- BEACH 111

The BEACH Ambulance pathway is operational covering all BH sites:

- Beach Ambulance went live on 07.10.20 at RLH, extended to WX on 09.11.20 and NUH on 07.12.20.
- As of 29.12.20 BH extended the service to cover all of NEL trusts.
- It is run via a centralised model from RLH.

The BEACH 111 pathway is operational and covering all BH sites:

- 111 BEACH went live on 24.09.20 at RLH, 09.11.2020 at NUH and 16.11.2020 at WX.
- RLH are covering Newham area 111 calls (started during the 2<sup>nd</sup> peak of covid).
- The plan is to run BEACH 111 via a centralised model from RLH (as per BEACH ambulance)

## DATA

4416 calls have been taken via the BEACH (combined 111 and Ambulance) from Sept 20 to March 21  
BEACH Ambulance received 1689 calls between Sept and March with 46% of the outcome being immediate conveyance to ED.

Further work is needed with LAS to improve the use of BEACH ambulance by the crews (they are not consistently calling with all suitable patients) and refine the process of BEACH 111

## Emergency care transformation: other innovations

### MEADOW

This is the agreed preferred model of front door clinician assessment.

Following medical assessment which includes examinations and investigations, the clinicians will establish how urgently the patient needs to be seen and book them an appointment within a certain time frame. This allows further investigations to be booked for when the patient returns allowing the patient to be diagnosed and treated in a timely manner.

Currently it has not been deployed consistently across all sites and there is further work needed to embed the model across the organisation. Over the next 8 weeks there is work on going to establish the model across all the sites and embed with the intention of having a consistent MEADOW model being fully embedded by the end of July.

### SDEC

SDEC pathways designed for 10 of the mandated pathways which includes Deep Vein Thrombosis (DVT), Falls in the Over 65's, Low Risk Chest Pain and Pyelonephritis.

An IT solution being built to enable electronic referral information and data capture.

Next steps:

- Work with primary care to ensure SDEC pathways are end to end
- Comms plan for the launch of the SDEC pathways planned

# Emergency care transformation: performance impact

## Impact of Transformation Projects on Performance

A suite of operational performance measures which align to the outputs of the CoVEG work have been developed. This data will measure points within patient journey through the ED and will demonstrate if the movement of patients away from ED is being optimised by the changes implemented. This will be linked to performance against the 4 hour standard: if more patients are appropriately streamed away from ED due to the changes implemented then the 4 hour standard should improve as there are less patients being seen in ED.

This CoVEG data will be tracked in run rate charts to plot the progress over time and enable trends to be identified more easily.

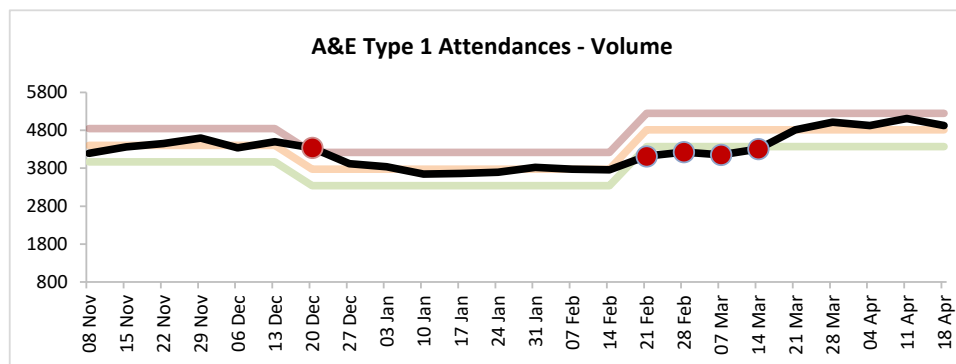
## Agreement on COVEG priorities:

- Embed BEACH and the centralised service
- Work with LAS to increase appropriate utilisation of BEACH ambulance
- Track the CoVEG data run rate to demonstrate impact of the changes made
- First Net standardisation (electronic documentation in ED)
- Achievement of the revised UEC standards including the inclusion of the 3 mandated standards in the Operating Plan from April 21
- Mapping of ED Flow and operating plans to maintain flow and safety with COVID principles determining workflows.



## Emergency care: trends in patient volumes

Emerging from the second COVID peak, the number of patients presenting at the front door has increased:



A cohort of COVID patients have an increased period of hospitalisation due to the complexity of their condition. There is a reported increase in acuity presenting at the front door and trauma levels are back to numbers seen pre pandemic.

Due to these factors bed occupancy has increased causing congestion and poor flow in ED. Increased volumes of ED attendances cannot be accommodated in a timely way due to the poor flow and this has corresponded with a decrease in performance against the 4 hour standard.

Week commencing	Performance	London Ranking
29 <sup>th</sup> March	87.23%	11/16
19 <sup>th</sup> April	84.14%	13/16

In addition to the priorities in CoVEG which includes tracking the measures of the impact of the transformation and QI work, additional programmes are in place to improve performance whilst the transformation works fully embed and become BAU.

This includes: Data Driven Performance Meetings and associated improvement plans

# Emergency care: data-driven performance improvement



- Data driven performance improvement is required for change to be targeted in the right area, to measure improvement and use these measures for the changes to become embedded.
- ED data dashboards provide a suite of measures which describe data points through the emergency flow across the hospitals.
- A trajectory has been set for each site to achieve 90%. Schemes to reduce both admitted and non admitted breaches are in place to move performance towards 90%. These schemes include:
  - Review of processes associated with UTC to maximise numbers and minimise type 3 breaches.
  - Strengthen the AAU/MAU models to decrease the time taken to move acute medical patients from ED.
  - Successful discharge initiatives: streamline processes and increase earlier discharge profile.
- ED performance meetings are in place with each of the ED hospitals and the reduction in breaches will be tracked against the progress of the schemes.
- The CoVEG run rate data will be used alongside the performance and trajectory measures to ensure QI work is incorporated into the sites improvement work.
- Work to further improve hospital flow and streamline the discharge process builds on work started during the COVID peaks and closer working with our system partners. These initiatives will help build resilience going into the Winter /3<sup>rd</sup> peak by having robust practice and policies in place.

### **3. Transformation and restoration of elective services**

## Elective recovery and transformation: overview

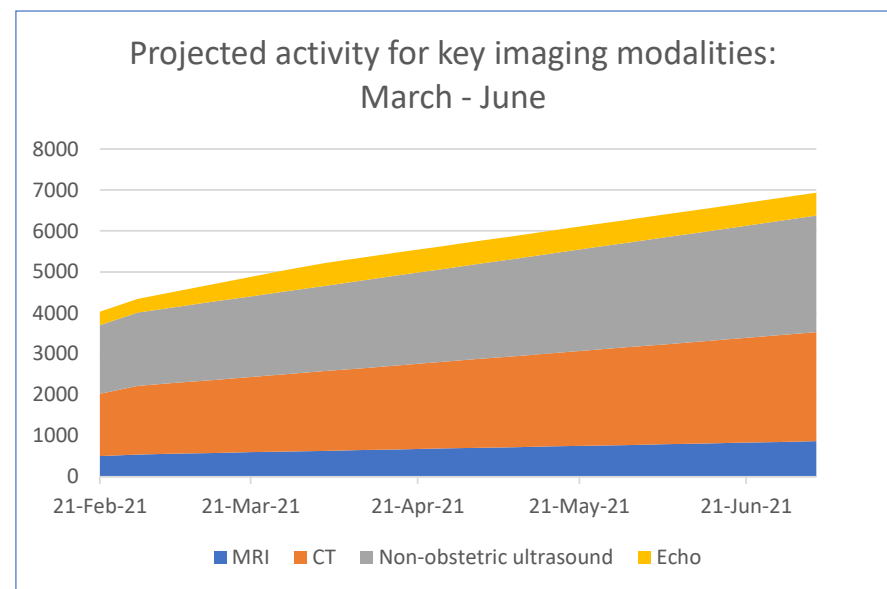
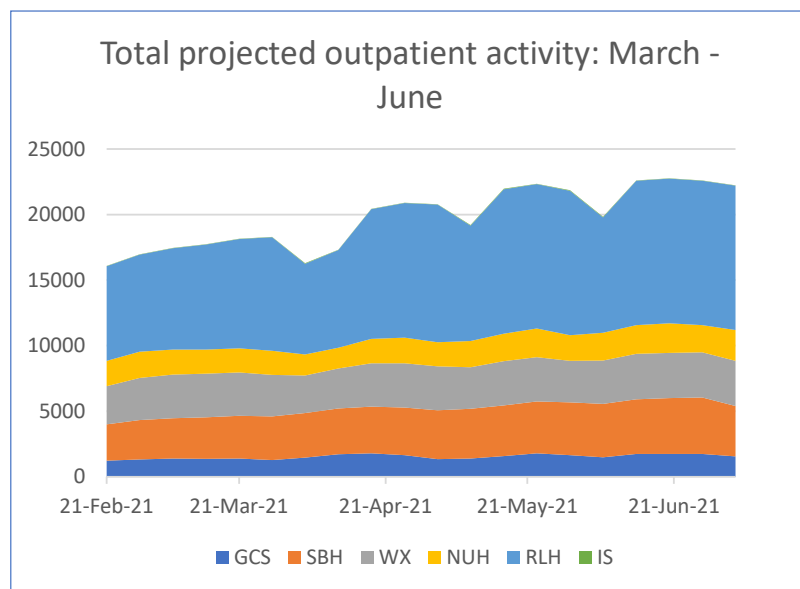
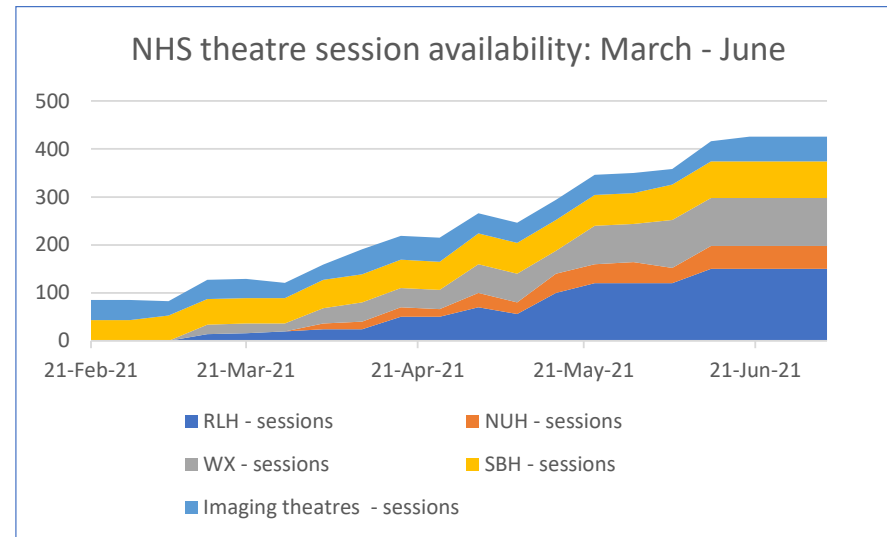
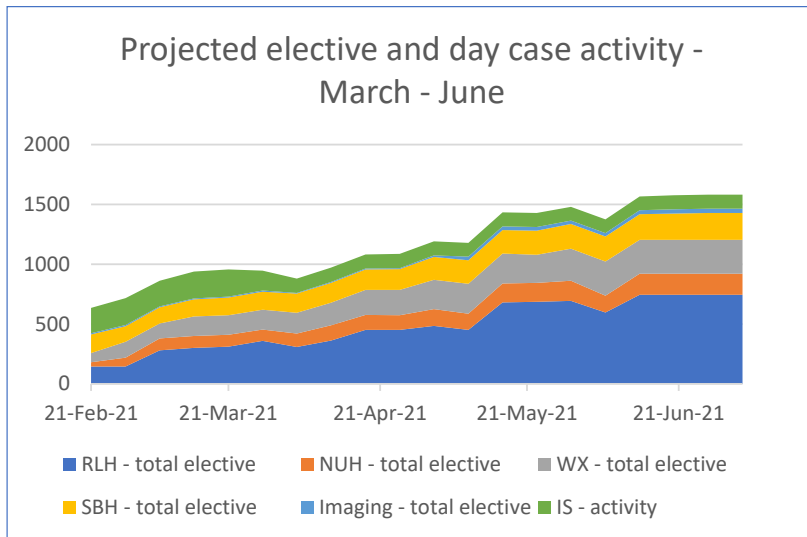
Restoration of elective activity (outpatients, surgery, procedures and diagnostics) is a key priority within the next phase plan. Key priorities are:

- Phased restoration of NHS capacity, balancing the need for staff rest and recovery,
- Use of independent sector capacity to support restoration of NHS services and address long waiting times,
- Transformation of outpatient and admitted care to improve quality, efficiency and personalisation of care,
- Reduction of waiting times for urgent surgery and phased reduction in long waiters.

The national planning guidance creates new incentives to increase elective activity through a new Elective Recovery Fund. Elective activity above a specific % of BAU will be funded at 120% of tariff subject to meeting 5 conditions covering clinical validation, equity and inequalities, outpatient transformation, system oversight of waiting times and staff recovery.

The trust is working with NEL partners to ensure compliance with ERF conditions and increase activity in order to address the elective backlog. There is a particular focus on understanding the equity dimension of our elective position to inform future planning.

# Elective recovery: planned restoration of NHS capacity



## Elective recovery: growth in long waiters

At the end of March 2021, the trust had 15,849 patients waiting for more than 52 weeks for elective care. This compared with February 2020 when the trust recorded 23 52-week breaches – the significant growth in long waits results almost entirely from the impact of the pandemic on elective services.

This position is reflected regionally and nationally but there are a number of reasons why the trust has particular challenges overall with long waiters and relative to other trusts:

- The pandemic result in **two lengthy periods where routine elective activity was suspended**, between March and June 2020 and between December 2020 and April 2021.
- The restart of elective activity in Summer and Autumn 2020 was impacted significantly by requirements for maintaining infection prevention and control and by patient hesitancy, **significantly limiting overall productivity**. The trust had a longer and higher second wave than most other organisations, leading to a longer suspension of elective services.
- The trust has a relatively **very high proportion of complex, specialised surgical services** which have rightly been prioritised for sustaining and re-starting. Waiting times for P2 (urgent) surgery remain extended and this work must be prioritised ahead of long waiters. Performance against national cancer standards remains strong, particularly relative to other teaching hospitals.
- The trust has a **relatively high proportion of dental services** at the Royal London which have been particularly affected by IPC restrictions and represent a disproportionate proportion of long waiters. Appendix 1 provides a specialty level breakdown of projected long waits.

## Elective recovery: managing long waiting times

The scale of the elective waiting list represents a new and significant strategic challenge for the trust, requiring concerted action on a number of fronts. Key elements of the strategy for addressing the growing challenge will include:

- **High quality operational management** of inpatient and outpatient waiting lists at hospital and specialty level in order to maintain high data quality, maximise operational productivity and focus capacity on areas with longer waiting times. This is supported by weekly activity tracking focusing on activity volumes, long wait numbers and the distribution of activity by patient priority groups.
- Transformation of surgical services in line with the trust's surgical strategy and with a particular focus on **establishing and optimising high-volume low-complexity hubs** for routine elective surgery. Around 70% of projected admitted waits are in the eight specialty areas where the trust is working to create high volume centres (Orthopaedics; Urology; Ophthalmology; ENT; General Surgery Gynaecology; Paediatric Dentistry and Pain Management).
- Transformation of outpatient pathways to **sustainably reduce non-admitted demand and improve referral, clinic and follow-up systems through digitisation**. These are amongst the key goals of the trust's outpatient & pathways transformation programme.
- Working with the wider sector, to **secure independent sector capacity in the short term** to supplement NHS capacity during the re-start process, and to explore options for mutual aid in specialties with particular capacity challenge (e.g. ENT, gynaecology and general surgery). In the medium term, the sector will focus on options to **increase NHS elective capacity**.

## Elective recovery: clinical oversight of waiting lists

A range of actions are required to ensure effective clinical and operational oversight of waiting lists, in particular in light of the increase in long waiters caused by the pandemic. These include:

- Oversight of the non-admitted waiting list, including clinical triage on referral, re-triage and review of long waiters and timely booking of appointments for long waiters and higher risk patients,
- Oversight of the admitted waiting list including clinical prioritisation against nationally defined categories, clinical validation of long waiters against the NHSE criteria and recording of prioritisation and validation decisions on the electronic record. As part of the clinical validation process, long waiting patients should be contacted for a clinical discussion about their care and future options, and
- An ongoing clinical harm review process which needs to be applied consistent across the waiting list.

A single trust policy and process is being put in place to ensure consistency in these areas and record progress.

This will also support and inform the review of the Trust's Access Policy, which has commenced to ensure there is consistency across the ICS.



# Elective transformation: non-admitted pathways

## Current State

Highest volume A&G referrals in London

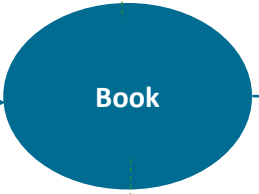
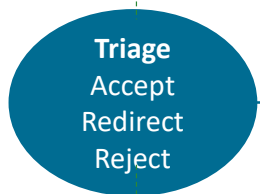
- A&G services in place across most specialties
- 3,004 A&G requests in March-21
- SPAs/GP referral hubs in place in ENT, Ophthalmology, MSK Dermatology, Gastro

- Approach for clinical re-triage in place across NEL via a combination of technical DQ and patient contact via text/phone

- BH non-admitted >52ww 8,717 below spring plan of 10,071
- 19 non-admitted pathways >104ww, 78.95% have next event booked

- 96% BAU for total outpatient attendances (w/e/ 25 April)
- 24.8% outpatient activity delivered virtually (last 3 months)

- Personalised stratified FUP for cancer (prostate, colorectal and breast open access)
- PIFU in place for Rheumatology and pilots in Cardiology, Gastro Gynae and MSK underway



## Transformation Objectives

- Increase A&G and roll out of consistent reporting incl. impact / conversion
- Increase and maximise community pathways / GP Referral Hubs / SPAs

- Clinical triage at point of referral
- Clinical validation and re-triage of long waits (DQ / patient contact / clinical review)

- Mutual aid
- Shared capacity

- Virtual by default where clinically appropriate
- Clinic re-profiling
- Accurate systematic reporting of virtual activity

- Personalised stratified FUP for Cancer
- Further roll out of PIFU, (incl. Barts Cardiology pilot)
- IT solution to enable digital tracking of patients discharged to PIFU

## Elective transformation: surgery and diagnostics

### *High Volume Low Complexity surgical hubs*



- The trust is working with partners in Northeast London on the development of HVLC hubs to increase activity in specialties with significant waiting list challenges: orthopaedics, ENT, urology, ophthalmology, gynaecology and generally surgery.
- HVLC hubs are now in place at Newham (orthopaedics) and in development at Whipps Cross (ENT, urology, ophthalmology) and at Mile End for pain services

### *Project Tooth Fairy*



- The trust is hosting a new regional service at the Royal London hospital to increase capacity for children's dentistry, an area with long waiting times
- 3 additional procedure rooms are being developed from Autumn 2021 as part of a £6.4m investment

### *Early Diagnosis Centre and Community diagnostic hubs*



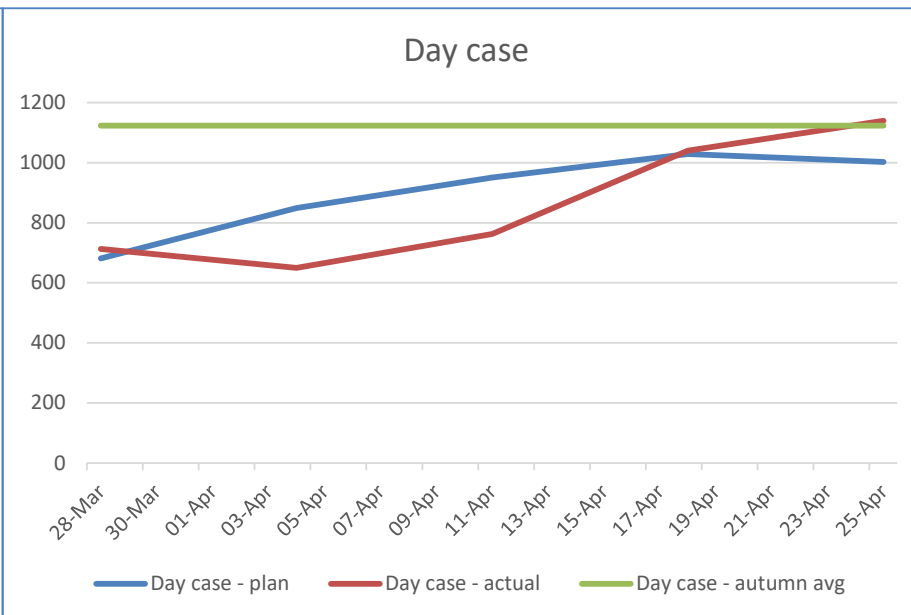
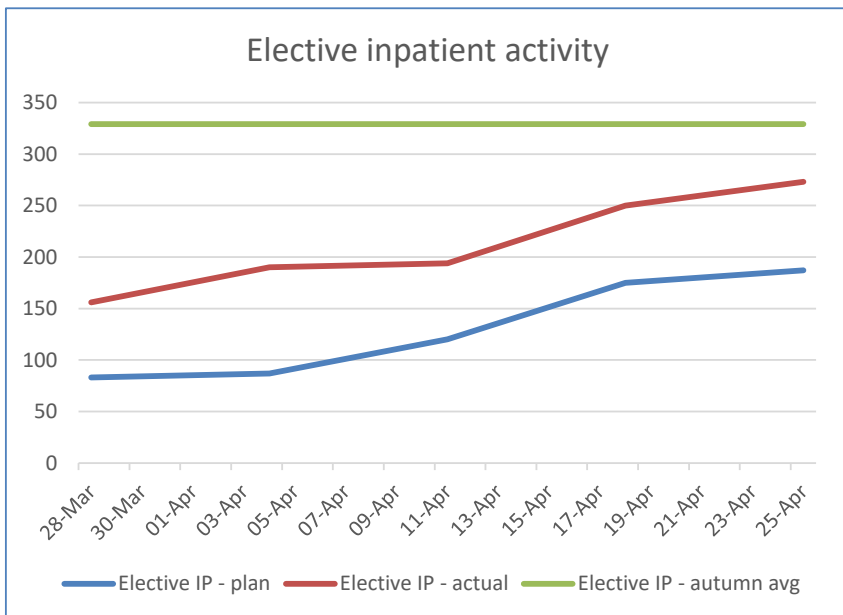
- The Mile End Early Diagnosis Centre is now operational, providing welcome additional capacity for endoscopy and ultrasound
- The trust is working with NEL partners to develop plans for investment in additional diagnostic capacity as part of the national CDH programme, focusing on CT, MRI and ultrasound

### *Additional capacity expansion*

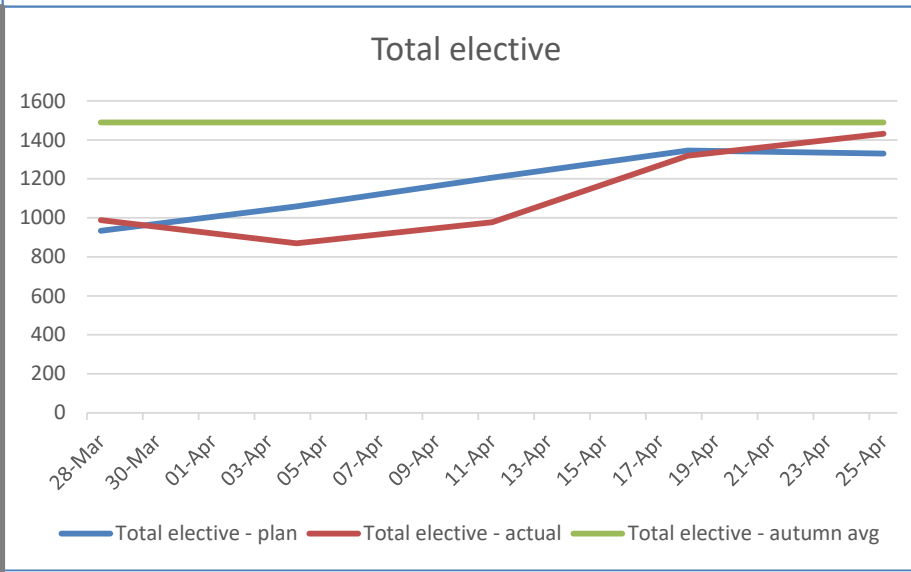


- Further capacity options are being developed at all hospitals in light of the Elective Recovery Fund incentives. There are particular opportunities to expand day case capacity at Newham hospital.

# Elective recovery: surgical activity against plan

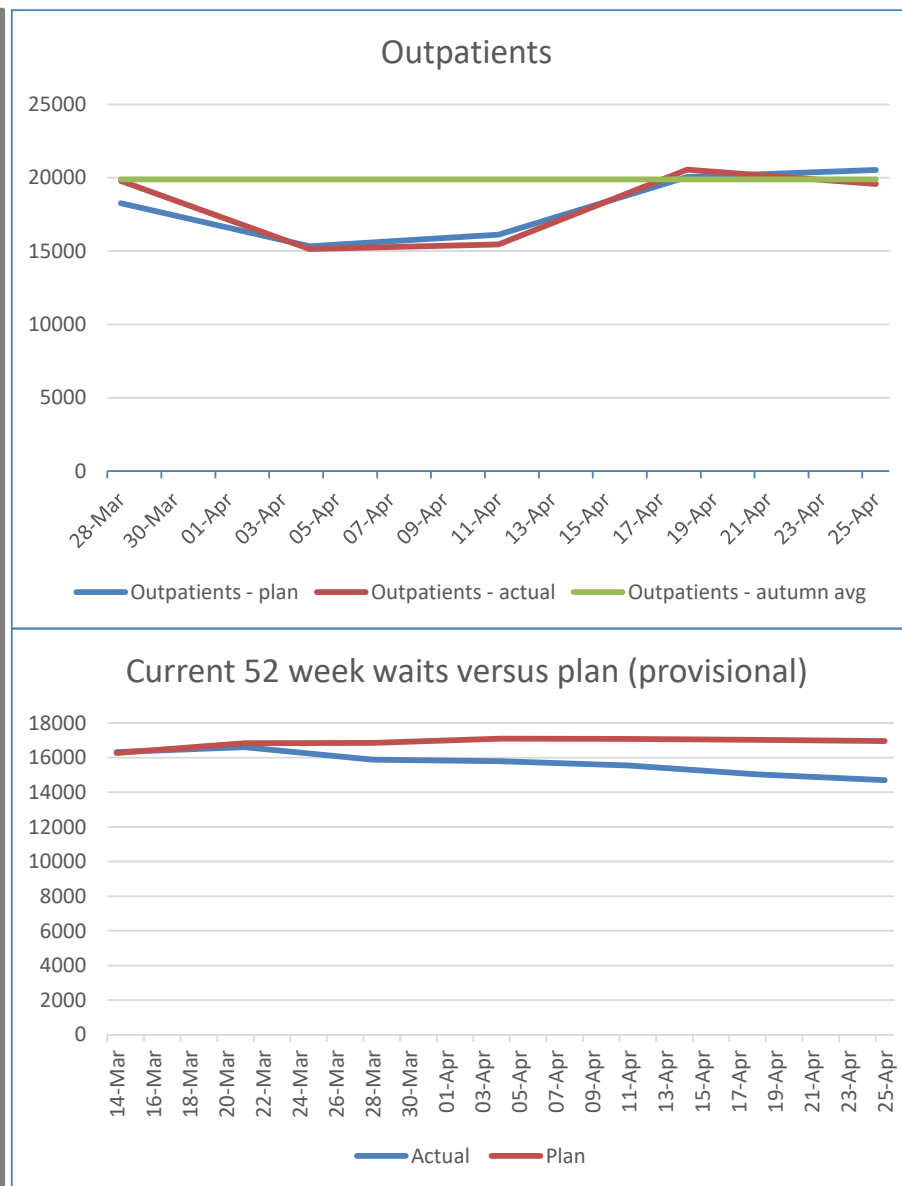


- The restoration of surgical activity is currently on track with planned activity levels exceeded in the most recent week. Total activity levels are now approaching the Autumn average and crude activity is above the ERF target of 70% of BAU for the most recent week.
- Clearance times for urgent (P2) surgery have also reduced significantly during April.



## Elective recovery: outpatient activity and long waiters

- Restoration of outpatient services is proceeding well with activity at or above plan in most recent weeks and overall activity close to the Autumn average level. Activity levels significantly exceed the ERF target of 70% of BAU for April. Levels of virtual activity and Advice & Guidance utilisation are also at or above national thresholds and high compared with other trusts.
- Tracking of provisional data on 52-week waits for March and April shows that actual numbers during April are lower than the planned trajectory and the number of long waiters is beginning to decrease. However, this is in part due to the impact of the pandemic on referral rates. Longer-term modelling of clearance times for long waiters is being undertaken as part of the wider planning process.
- Diagnostic and endoscopy activity is also above planned levels for April.



## 4. Delivery of the vaccination programme

## Introduction

- The Trust operates the Covid-19 Newham vaccination centre at the ExCeL conference centre, and vaccination hubs at the four main Barts Health hospitals.
- The vaccination centre is offering the Astra Zeneca vaccination to the population cohorts prioritised nationally. Since January the centre has delivered 73,817 vaccinations. The lease for space in the ExCeL has been extended to the end of June, with the service planned to relocate prior to this date to the Westfield shopping centre. It will operate until the expected completion of second doses at the end of September.
- In March the hospital hubs commenced administration of Pfizer second doses for health and care staff across North East London. This process will be completed on 30 April, when the hubs will no longer be required and staff will revert to their substantive roles. 53,323 vaccine doses have been administered to date in the hubs. The hospitals staffed the hubs in parallel with responding to the second Covid peak.
- The Trust is working with North East London partners to continue to work to increase take-up across all groups of health and care staff and particularly those of black African, black Caribbean and south Asian heritage; and to ensure alternatives to the Astra Zeneca vaccine for staff under the age of 30 in line with national guidance.
- This paper focuses on the drivers of vaccine hesitancy and the actions the Trust is taking to maximise take-up, consistent with our 'WeBelong' inclusion strategy.

# Staff uptake



It is estimated that 14,215 (87%) of Barts Health permanent staff have been vaccinated out of a total of 16,404, at Barts Health hospital hubs, the vaccination centre and other locations. With the addition of bank, agency and contracted staff, a total of 19,456 (86%) have been vaccinated out of 22,646.

10,959 permanent staff (67%) are confirmed as having been vaccinated at Trust locations. In addition it is estimated that 3,250 have been vaccinated in primary care and other locations. In common with many other providers, we are continuing to seek to match Trust HR data with primary care records. Detailed analysis is only possible in relation to the 67% of staff who have been vaccinated directly by the Trust.

	Site	Total Staff	Vaccinations Overall			% Vaccinated	Doses Administered	
			Yes	No - Unknown	No - Decline		Dose 1	Dose 2
			<b>Barts Health Perm-Fixed Term Employees</b>					
	Royal London	5,566	3,724	1,837	5	67%	3,683	3,542
	Whipps Cross	2,604	1,659	944	1	64%	1,633	1,581
	Newham	1,897	1,172	725	0	62%	1,167	1,069
	St Barts	2,333	1,768	565	0	76%	1,752	1,686
	Central Income & Expenditure	188	132	56	0	70%	131	123
	CSS	2,044	1,417	627	0	69%	1,409	1,344
	GSS	1,694	1,054	635	5	62%	1,049	946
	Other	78	33	45	0	42%	31	20
	<b>Grand Total</b>	<b>16,404</b>	<b>10,959</b>	<b>5,434</b>	<b>11</b>	<b>67%</b>	<b>10,855</b>	<b>10,311</b>
<b>Barts Health Temporary and Contract Employees</b>								
	Other Barts Health Employees - Bank, Students, ESR Leaver		4,248				3,537	3,094
	Serco/Skanska/Linit/Elior Employees	2,084	993			48%	993	837
	<b>Grand Total</b>		<b>5,241</b>				<b>4,530</b>	<b>3,931</b>

# Ethnicity

The table below shows a vaccination rate 19% higher for white staff than those identifying as BAME. Of the BAME staff cohort there are 3,707 people that have not been recorded as having been vaccinated as opposed to 1,256 white staff without a positive vaccination status.

Consistent with experience in the wider population, there has been progress in reducing the gap in take-up between ethnicities over the last three months.

Barts Health Employees	BAME Group	Total Staff	% Staff In Each Ethnic Category	Vaccinations			% Vaccinated
				Yes	No - Unknown	No - Decline	
	BAME	9,303	57%	5,589	3,707	7	60%
	White	5,875	36%	4,615	1,256	4	79%
	Not Stated/Undefined	1,226	7%	755	471	0	62%
	<b>Grand Total</b>	<b>16,404</b>	<b>100%</b>	<b>10,959</b>	<b>5,434</b>	<b>11</b>	<b>67%</b>

\*The table above shows a subset of the total people vaccinated that have been identified in the Barts Health HR system (ESR) as being a permanent or fixed term contract “active” employee.



# Intersectionality



The table below shows vaccine uptake by ethnicity and banding. Vaccination take-up rates are strongly correlated with both ethnicity and seniority. The less senior roles have a younger age profile and many younger staff are likely to take a different view of personal risk from Covid, affecting take-up rates.

Ethnic Group	Ethnicity	Doctor in Training	Consultant	VSM	Band 8A+	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Other
White	White	77%	78%	85%	87%	86%	78%	75%	74%	70%	65%	50%
BAME	Asian or Asian British	78%	72%	60%	73%	78%	67%	62%	54%	49%	55%	
	Black or Black British	63%	85%	100%	60%	52%	49%	38%	38%	39%	41%	
	Mixed	75%	81%		74%	63%	55%	61%	30%	50%	46%	
	Other Ethnic Groups	75%	77%		78%	84%	83%	78%	75%	66%	70%	
Not Stated/Undefined	Z - Not stated	74%	82%	100%	79%	72%	61%	56%	49%	43%	45%	
<b>Grand Total</b>		<b>76%</b>	<b>77%</b>	<b>84%</b>	<b>81%</b>	<b>77%</b>	<b>68%</b>	<b>61%</b>	<b>57%</b>	<b>53%</b>	<b>52%</b>	<b>33%</b>

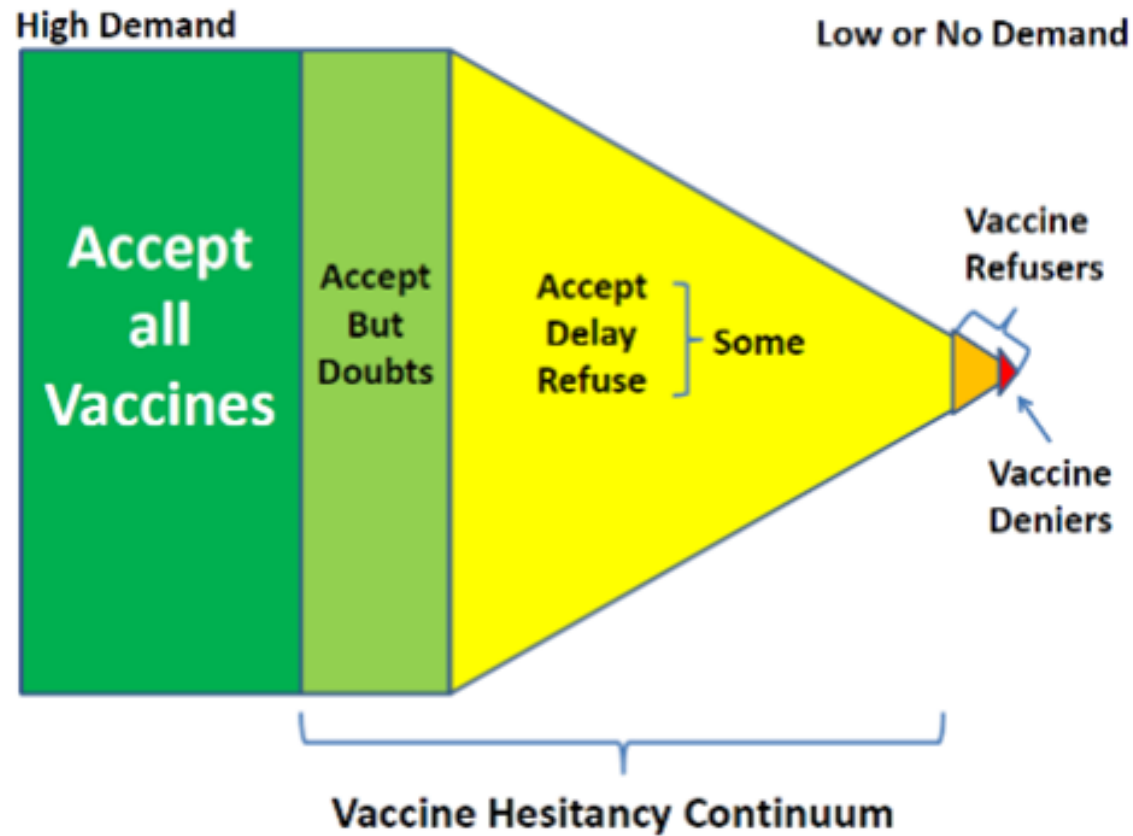
\*The table above shows a subset of the total people vaccinated that have been identified in the Barts Health HR system (ESR) as being a permanent or fixed term contract “active” employee.

## Black, Asian and Minority Ethnic Staff uptake of the COVID-19 Vaccine: "A journey not a sprint"

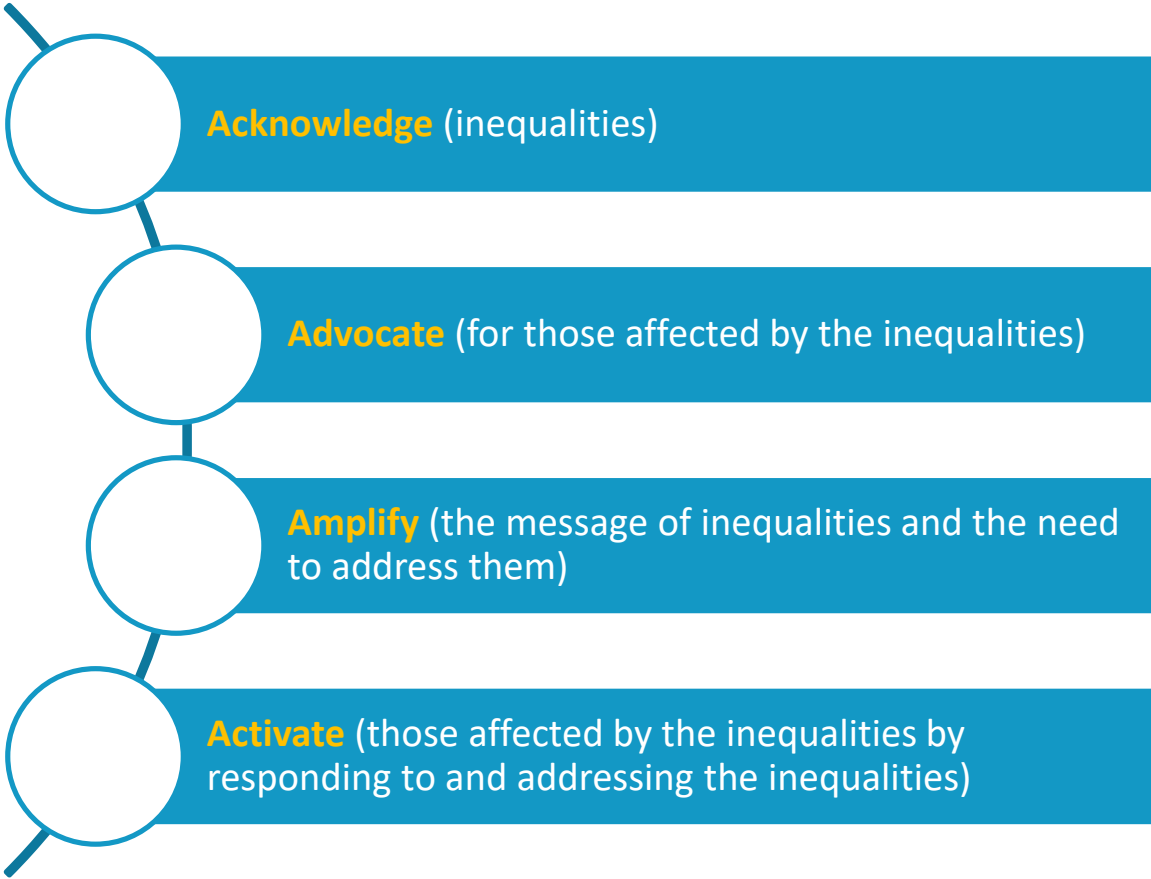
Barts Health's work to encourage ethnic minority staff to take up the COVID vaccine has focused on a number of key initiatives:

- Webinars for staff
- Focused staff information sessions for staff groups particularly where there was low take up, including "BME" Staff Network, Patient Transport Services
- Videos featuring key staff on answering key FAQs and dispelling some of the myths
- Vaccine Influencers' forum
- Up to date information on Weshare for staff on the latest information on the vaccines

# The journey was expected



# Rooted in a journey to health equity



# Key Insights



- Historical context – unethical medical research – “guinea pigs”
- Recent care and research
- Lack of long term data – side effects/fertility concerns
- Myths and conspiracy
- Mistrust of societal structures

### Never to be forgotten



19th-century doctor  
"Grandfather of gynaecology to some, torturer to others"  
Performed experimental surgeries on enslaved black women throughout his career, & chose not to use anaesthesia



Tuskegee Study of the Negro Male - 1932-1972  
U.S. Public Health Service  
Natural history of untreated syphilis  
African-American men were unaware - Only told they were receiving free health care

### The “Whatsapp” Effect



Intentionally vs unintentionally false (misleading)



## Challenges and key actions encouraging staff to vaccinate

### Challenges

- Penetrating staff who are vaccine hesitant (particularly Black & Black British staff)
- Data reporting and the ability to accurately reflect BAME uptake
- Not all staff/people identifying their ethnicity
- External media and anti-vax social media
- Vaccine supply inconsistency
- Workforce support to site vaccination hubs intermittent issue

### Actions – Listening/Trusted Voices Campaign

- Direct team and network listening
- Vaccination Support group
- Opportunity for individual questions via Covid Inform mailbox – connecting people where necessary with specific clinical advice
- 1:1 conversation with team leaders
- Vaccination influencers/Posters
- Short video clips in multiple languages and from diverse staff groups
- BAME network sessions
- Faith and community leader engagement and shared messaging
- Opportunity to link with TV networks – BBC, BBC Asian network to build trust
- Webinars and MS teams sessions
- Schwartz Round – “This thing called vaccine” rolling programme giving a chance to share feelings and perspectives
- Ask a virologist
- Workforce: cross site working/BankPartners

# Keeping up the momentum



Tailored engagement - Taking issues around vaccine hesitancy to ethnic minority staff groups in particular those in bands 2,3,4

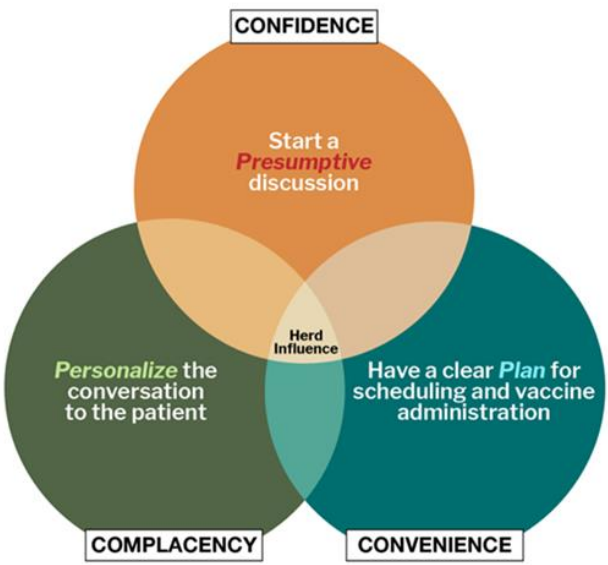
Continue to support and provide information so staff can make an informed choice on the vaccine

Using the “BME” staff network and its members to support and provide ongoing information to network members

Directly and pro-actively address Astra Zeneca concerns as these are leading to cancellations of vax appointments

Continued learning from our local communities

**Success should be seen not solely in statistics but how we support ethnic minority staff on their vaccine journey**



## Actions underway and next steps

<i>Equity</i>	<i>Build cultural intelligence for all</i>	<i>Timely response to concerns</i>	<i>Trust</i>
<i>Honesty and transparency</i>	<i>Offer choice and ease of access</i>	<i>Build a future with freedom</i>	<i>Representation</i>

### What we need to review

- Guidance on having a conversation sensitively with staff regarding vaccine, information links and how to book 1<sup>st</sup> dose to all frontline team leaders and managers accessible
- Team leader conversations with frontline staff – keep local records
- Additional support and option to discuss with independent person from the Vaccine team (champions/influencers) on-site made more easily available
- If still hesitant – team leader & staff member revised risk assessment discussion
- Staff self identify – eform sent to EWS to include decline, may take the vaccine later, had the vaccine elsewhere (already have had the vaccine elsewhere so would just be an expansion)
- Opportunity for 1:1 Occ Health discussion
- Continue engagement activity and promote 1<sup>st</sup> dose clinics through Excel and schedule of rolling site based clinics
- Decline numbers and uptake of additional 1<sup>st</sup> doses
- With IPC regarding evidence based approach to practical frontline impact: framework AGP areas, clinical risks

### What we need to do better – learning from others

- **Understand** Importance of intersectionality - people fit into multiple groups reasons for not getting vaccinated are not always consistent across groups (e.g. young men and women concerned re fertility – not necessarily because of ethnicity)
- **Communication and language** - Addressing staff's concerns about safety and side
- **Delayed cohorts** - Acknowledge Some staff require a “wait and see” approach – not a no, just a not yet, Important staff do not feel singled out in the approach taken
- **Access** - Ability to choose between Pfizer and AZ vaccine was/is significant for many
- **Decision making** is a journey pay attention to how we communicate with different staff groups ensure transparency and clarity of data
- **What do people think and feel?** (Historic, political and socio-cultural context, Interpersonal factors)- continue holding listening events
- **Peer support / buddy systems** creating a safe space for people to have open discussions (e.g. buddy system at Kingston Hospital NHS Foundation Trust)



## Actions underway and next steps

<i>Equity</i>	<i>Build cultural intelligence for all</i>	<i>Timely response to concerns</i>	<i>Trust</i>
<i>Honesty and transparency</i>	<i>Offer choice and ease of access</i>	<i>Build a future with freedom</i>	<i>Representation</i>

### Immediate actions for cohort penetration

- **NIMs system support team** to assist the Trust with data reconciliation using the workforce reporting tool, work underway aiming to complete by 30<sup>th</sup> April
- **Explore the data** to identify opportunities for further improvement e.g. between age/gender uptake etc.,
- BAME Network at Barts Health to support focus groups/1:1 conversations and survey monkey to **understand why staff are hesitant**
- Continue **working in partnership** with colleagues regionally and nationally

### Further actions for cohort penetration

- Set up **telephone hotline** for staff
- Schedule more leaders webinar events to **understand the support needed by leaders**
- Develop workforce **training programmes** for leaders in partnership with the Education Academy
- Test vaccinating **multi-generational households** at the same time in AZ outreach clinics
- Buddy with a high performing Trust with **top quartile BAME vaccine uptake**
- Continue to **promote and support local community initiatives** e.g. vaccine helplines, roadshows and events for local residents
- Develop vaccine uptake plans in partnership with the engagement agenda to **target key groups of staff**

# Case Study

## Newham outreach vaccination service Improving uptake in a familiar, more comfortable environment

### Introduction: Vaccine hesitancy

Over 90% of adults in the UK have or would be prepared to be vaccinated against COVID-19. However, certain groups are much more wary, especially people of black, Bangladeshi and Pakistani origin (up to 12 times less likely to get vaccinated) and particularly older people in these groups [1]. Even more regrettably, these groups are also more likely to develop COVID-19 and be disproportionately affected by the disease [2].

There are many reasons why certain groups are less likely to be vaccinated. These include concerns about side-effects, perceived long-term effects on health and previous unethical vaccine research studies involving black people. A key factor for ethnic minority groups is trust in healthcare professionals whilst for the homeless and rough-sleepers, access to healthcare settings (many are not registered with primary care) and perceptions of how healthcare staff will treat them are significant deterrents to attending for vaccination [3].

### Background

The London Borough of Newham is the most ethnically diverse district in England and Wales. Its local population includes about 17% White, 14% Indian, 12% African, 12% Bangladeshi and 10% Pakistani people. More than 30% of the population is Muslim and the Borough has a 37% poverty rate, the second highest in London.

Acute healthcare services are provided by Barts Health NHS Trust from five local hospitals: St Bartholomew's, The Royal London, Mile End, Whipps Cross and Newham. Since January 2021, it has also operated the large-scale NHS COVID-19 Vaccination Centre Newham at ExCel London.

### Programme aims

The aim of the outreach programme is to increase numbers being vaccinated, the rate of vaccine completion (2nd dose) and to encourage those vaccinated to act as 'Vaccine Ambassadors' within their communities. In particular, staff at the NHS Vaccination Centre, Newham wanted to explore whether outreach clinics in local and more familiar environments could improve vaccine uptake amongst eligible groups across north east London (NEL). The



specific aims were to (1) increase the numbers vaccinated and (2) promote high levels of trust in the NHS as a health care provider.

## Approach

They adopted a quality improvement approach, running 'Plan-Do-Study-Act' cycles to test the feasibility of the idea and ensure sessions could be run safely. Initially, they ran five pilot vaccine outreach sessions at Barts Health renal dialysis centres, testing transport and set-up protocols. Once demonstrated to be successful, the East London Health and Care Partnership agreed that they could run similar clinics in other settings.

Before each outreach service went live, the proposed location was vetted and assessed against a strict check-list, before permission was given to go ahead. In the first two weeks, they ran sessions in an independent clinical setting (Mildmay Mission Hospital) and a faith-based homeless advice centre. The initial plan was to make vaccines available to anyone who wanted it in an eligible group on a "walk-in" basis. They quickly discovered that this model risked wasting large amounts of vaccine with staff having to recover unused vials at short notice. They therefore changed to an appointment based system.

In weeks three to five, they onboarded 9 new centres, but kept the numbers at each centre relatively low. This allowed them to develop safe working patterns with community partners, whilst the core outreach staff could familiarise themselves with the settings and liaison volunteers. With this foundation in place, the plan was to now increase numbers vaccinated at each centre.

Outreach clinics now take place every day – from half a day to full day - using trained staff from ExCel. The Team consists of a Health Care Practitioner, Vaccinator and Pharmacist. The size of the team depends on the number of vaccinations planned to take place (range 33-200 per clinic).

To date, the outreach team has run clinics in settings such as:

- Places of worship (churches, mosques, temples, synagogues etc.) with high numbers of attendees from Black, Asian and other Minority Ethnic groups
- Homeless centres, hostels and hotels commissioned by the council as part of their homeless COVID-19 response
- Hotels and community centres focused on the refugee population
- Local hospitals

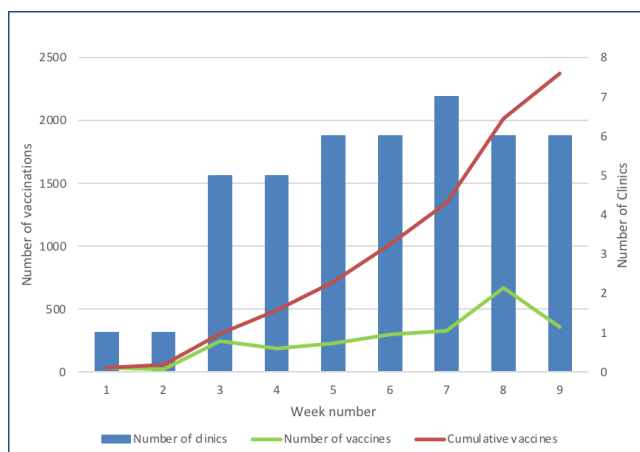
## Results

The services have proved highly popular and have managed to vaccinate large numbers of people who otherwise might not have attended more traditional settings.

By week nine of the programme, they were running up to seven sessions each week and had organised over 40 outreach clinics in 14 community settings, vaccinating over 2,300 eligible members of the public.

The number of people coming has steadily increased, showing that there is plenty of scope to increase uptake in these communities. On average they are now vaccinating over 400 people each week, and up to 200 in each of the three Places of Worship.

Figure: Vaccination activity per week



77% of people attending are from ethnic minorities (Black, Asian, Mixed or Other ethnic groups) of whom only 3.5% are over 60 years (1% of the white population attending). This may reflect the fact that older people fall into higher risk vaccination cohorts that were vaccinated before this programme began.

Since week six, we have been conducting routine surveys of people attending for vaccination. 94% of respondents (95% ethnic minority, 86% white) responded “definitely” (92%) or “somewhat” when asked whether they had confidence and Trust in the healthcare professional that they saw. 95% (96%, ethnic minority, 86% white) stated that their experience was “very good” (91%) or “good”.

Other findings have included:

- People attending the centres feel safe receiving a vaccine in a local, familiar environment
- They are reassured by having staff available who can speak to them in their native language and answer any concerns
- They would recommend the service to their friends and families.

Providing these services has also had benefits for vaccination centre staff, Newham Council colleagues and local partners. They have felt valued and have taken great pride and joy in running and supporting the clinics.

### Key success factors

As well as the more obvious requirements needed to set-up and run a safe vaccination service (logistics, cold chains, tech, social distancing etc), there are some specific features that particularly helped build trust with the local community, ensuring high levels of vaccine take up:

1. **Working with local public health and commissioning groups:** A specific challenge was to identify suitable locations across NEL where vaccine uptake was / is low. They worked with local Council and Clinical Commissioning Group colleagues to select these, primarily in locations linked to places of worship and the community. This was crucial in engaging with members of the public and reassuring them that the venues were safe and culturally familiar.

2. **Flexible hours:** they arranged booking slots to reflect demand and when venues were busiest. For example, at mosques this tended to be from 3-7pm.
3. **Trained and engaged vaccination staff:** They staff the clinics with volunteers from the main service at Excel. This means everyone working on-site is highly motivated with a clear interest in what they are trying to achieve. They generally used more experienced staff, including pharmacists at times, and provided additional training so that anyone with last minute doubts or questions could receive informed and meaningful answers.
4. **Sharing responsibilities:** Staff and volunteers share responsibility for running each clinic as efficiently as possible. Volunteers and non-clinical staff book people into appointment slots whilst the clinical team check eligibility and liaise with the lead pharmacist the day before the session to confirm numbers and formulate local contingency plans to address non-attendance. This allows the small vaccination team to focus on patient care and safety, reduces vaccine wastage from unfilled slots or non-attendance, and is key to the smooth running of each session.
5. **Local knowledge & language:** They recruited many local volunteers who speak additional languages such as Punjabi, Gujarati and Somali to support delivery. Having individuals on site who can speak to people in their own language provided another layer of comfort and reassurance.

### Next steps

They are exploring how they can expand the reach of the outreach services, including how they might need to be modified to deliver second doses when the time comes. They are also using a combination of surveys and focus groups to understand what concerns people have about vaccination and how best to respond. In addition, they are creating an on-line training tool to enable vaccination staff to explore and respond to vaccine nervousness and hesitancy amongst members of the public who attend the Centre or Outreach Clinics.

For more information, please contact:

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NHS Vaccination Centre, Newham at the ExCel Centre

### References

1. COVID-19 vaccine hesitancy among ethnic minority groups. BMJ 2021; 372 doi: <https://doi.org/10.1136/bmj.n513> (Published 26 February 2021)
2. Beyond the data: Understanding the impact of COVID-19 on BAME groups. PHE June 2020
3. Delivering health and care for people who sleep rough: going above and beyond. Kings Fund. <https://www.kingsfund.org.uk/publications/delivering-health-care-people-sleep-rough>

END

19 April 2021

<b>Report to the Trust Board: 5 May 2021</b>	<b>TB 13/21</b>
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<b>Title</b>	Integrated Performance Report (Month 12)
<b>Accountable Director</b>	Director of Strategy
<b>Author(s)</b>	Director of Performance
<b>Purpose</b>	This report provides a performance update

<p><b>Executive summary</b></p> <p>The Integrated Performance Report provides detail in relation to performance drivers at Trust and Hospital level in relation to the NHSI single oversight framework indicators as well as the Trust’s own improvement plan, Safe and Compassionate. The report also identifies exceptions, including positive exceptions, where performance has outperformed usual tolerances, or where a target has been failed. The report will be presented by the respective lead directors for Covid-19, access, quality and safety, finance and people sections.</p>
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<b>Related Trust objectives</b>
All trust objectives

<b>Risk and Assurance</b>	This report provides assurance in relation to all trust objectives - including 1, 2, 4 and 9.
<b>Related Assurance Framework entries</b>	All BAF entries

<b>Legal implications/ regulatory requirements</b>	N/A
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<p><b>Action required by the Board</b></p> <p>The Trust Board is asked to note the Trust’s position against all standards detailed, including those indicators where sustained improvement has been made due to the actions taken, exceptions to target achievement, reasons for variation and remedial actions.</p>
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# Barts Health Integrated Performance Report

May-21

Performance for: **Mar-21**



- **Overall Report:**

- Some national reporting for which metrics are usually presented in the report has been temporarily suspended during the Covid-19 pandemic crisis. For most, the performance from the last national submission before the suspension is the latest included in the report, as indicated below:
  - Mixed sex accommodation breaches: Feb-20 performance.
  - Complaints: national reporting was previously suspended but the Trust is now following the NHS Digital timetable for the catch-up of national submissions. Throughout the pandemic, performance has continued to be monitored internally (and included in this report).
  - Dementia screening: Feb-20 performance.
  - Venous Thromboembolism (VTE) Risk Assessment: performance continues to be monitored internally.
  - Staff Friends and Family Test (FFT): 2019/20 Q4 performance.
- The above suspended metrics have been temporarily greyed out in the report.
- Serious Incidents Closed in Time: a clock stop has been applied by commissioners until the end of Mar-21; this metric has also been temporarily greyed out in the report.
- **Metrics from Mar-20 will include the period of the Covid-19 pandemic, which has seen significant changes to patient demand and service delivery. All metrics need to be considered in this context.**

- **Targets:**

- Targets for most metrics have been rolled forward from 2019/20 or Mar-20 (for metrics where the target changed over the course of 2019/20 to reach a set target by Mar-20). Targets have not been rolled forward for most Responsive metrics (e.g. A&E 4 Hours Waiting Time).



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May-21

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May-21



# Executive Summary



### **Covid-19 Monitoring and Recovery**

#### **Covid-19 Inpatient Activity Levels**

- The number of Covid-19 positive inpatients rose from 8 on 31/08/2020 to a highest point of 835 on 14/01/2021. This level of activity was 38% greater than that experienced by the Trust at the first peak of the pandemic in early Apr-20. The second Covid-19 peak has now passed; since then, Covid-19 positive bed occupancy has been reducing across both General & Acute and intensive care unit (ITU) beds.
- In order to manage the flow of Covid-19 positive patients, the Trust significantly expanded intensive care capacity. Over recent weeks the Trust has been deescalating this capacity and also repatriating staff to usual work locations to support the elective restart programme.
- On the day of finalising this report (28/04/2021), the number of Covid-19 positive inpatients across the Trust has decreased to 43 (5% of the second wave peak recorded in mid Jan-21), of whom 8 are in intensive care. This represents 7% of the Trust's current overall ITU capacity and is 4% of the volume experienced at the height of the second peak of the pandemic.
- Sadly there have been 11 further patient deaths during Apr-21 (to 28/04/2021) within 28 days of a positive Covid-19 diagnosis; however, for the same period, 870 inpatients with confirmed Covid-19 recovered and were discharged.

#### **Covid-19 Community Cases**

- Comparing the week to 09/04/2021 to the week to 16/04/2021 shows the following movements in the 7-day case rate per 100,000 population:
  - For Hackney and City of London, a decrease from 25.4 to 19.3 (-24%).
  - For Tower Hamlets, a decrease from 25.8 to 24.2 (-6%).
  - For Newham, an increase from 34.9 to 36.4 (+4%).
  - For Waltham Forest, no change from 18.8.
- As a comparator the London case rate has effectively stayed the same at 22.9 (from 22.8) and the England case rate has decreased from 30.8 to 26.0 (-14%).

#### **Staffing**

- For staff there was a decrease in absence due to all Covid-19 related reasons, with 532 absent staff recorded at the end of Mar-21 decreasing to 96 as at 22/04/2021, a decrease of 436 (-82%). The reduction reflects the return to work of many of the Trust's shielding staff; shielding absences reduced from 436 at the end of Mar-21 to 50 for the week reported, a decrease of 386 (-89%).

#### **Vaccinations**

- The Trust has been delivering the Pfizer vaccine in "hubs" at its four acute hospital sites since the end of Dec-20, and the Astra Zeneca vaccine at the Newham Covid-19 vaccination centre at the ExCeL conference centre since mid Jan-21. From mid Mar-21, second doses started to be given. 28,995 first dose vaccinations have been given in the hospital hubs to staff and the public and 24,328 second doses (as at 23/04/2021). A further 73,817 vaccinations have been given at the ExCeL. 67% of substantive staff are known to have received a first dose vaccination at Trust hospital sites. In addition, the Trust is continuing to match staff on its electronic staff record against vaccinations given in primary care and other locations, in common with other providers. The vaccination team estimates that this increases the substantive staff vaccination rate above 80%. In addition 5,241 Bank, temporary and contract staff have received the vaccine through the hospital site vaccination centres. The Trust continues to work very actively to respond to vaccine hesitancy in staff and the local community, working with partners.

**Covid-19 Monitoring and Recovery (Continued)****Elective Activity Recovery Trajectories**

- The Trust, in common with all providers, paused its elective activity recovery in favour of concentrating resources on managing the second phase of the pandemic. The Trust has submitted activity recovery trajectories to NHS England until the end of Jun-21 and will now be submitting trajectories until the end of Sep-21; activity will be focussed on clinically prioritised and long-waiting patients.

**Contextual note: metrics from Mar-20 will include the period of the Covid-19 pandemic, which has seen significant changes to patient demand and service delivery. All metrics need to be considered in this context.**

## **Quality & Performance**

### **Responsive**

#### **A&E 4 Hour Performance**

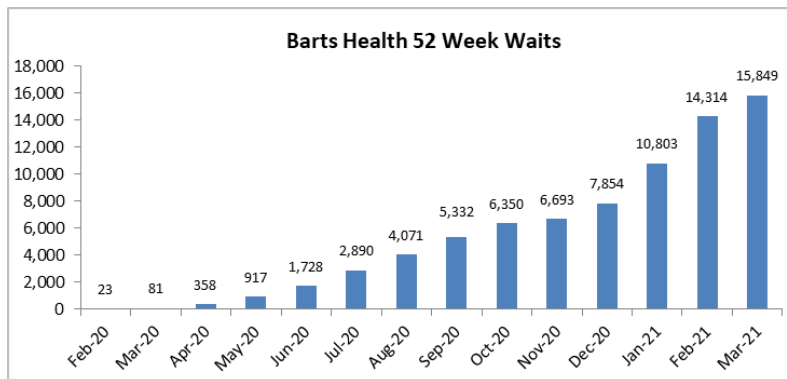
- Due to reductions in demand resulting from the public's response to the Covid-19 pandemic, attendances at the Trust's A&E departments decreased by nearly half between Mar-20 and Apr-20. Attendances increased again each month between May-20 and Sep-20, with Sep-20 attendances increasing to 80% of the volume recorded in Sep-19. However, from Oct-20 attendances started to reduce again as the impact of the second wave of the Covid-19 pandemic started to be felt and the government introduced escalating social distancing measures. Between Sep-20 and Feb-21, attendances reduced by nearly a quarter from 33,281 to 25,484. However, for Mar-21 attendances increased by 34% to 34,223, the highest volume of attendances recorded since the start of the pandemic. Of these 34,223 total attendances, 60% (20,504) were Type 1 (higher acuity) and 40% (13,719) were Type 2/3 (lower acuity); proportionally this is slightly fewer Type 1 attendances (-3%) and slightly more Type 2/3 attendances (+3%) compared to the preceding 14 months.
- During the first wave of the pandemic, as attendances fell so performance against the 4 hour standard improved with performance levels exceeding 90% between May-20 and Aug-20. However, such was the severity of the second wave impact, particularly in relation to Covid-19 patient bed occupancy, that even though attendances reduced, performance could not be maintained, with reductions in 4 hour compliance recorded each month between Sep-20 and Jan-21. However, in Feb-21 performance increased to 83.9%, with 86.4% recorded in Mar-21, despite a significant increase in attendances during the month. This represents a 10.6% performance improvement since Jan-21.
- For Mar-21, the Trust was ranked 12<sup>th</sup> best performing of the 16 London Acute Trusts reporting data and the third best performing of the top 9 largest (by volume of attendances) Trusts in England reporting data.

## Quality & Performance (Continued)

### Responsive (Continued)

#### Referral to Treatment (RTT)

- During the course of the Covid-19 pandemic, the NHS has been required to suspend elective services, firstly between Mar-20 and Jun-20 and then between Dec-20 and Mar-21. This has had a significant impact on waiting lists across England, including growth in 52 week wait pathways. This growth is driven by the compound effect of existing 52 week wait breach volumes being inflated each month by additional pathways moving from under to over 52 weeks. For Mar-21, the Trust is reporting 15,849 52 week pathways.
- The Trust is now engaged in re-starting its elective programme which focuses on clinically prioritised patients as well as reductions in the number of long waiting pathways, including 52 week wait breaches. Initial elective activity and 52 week wait recovery and improvement trajectories have been submitted to NHS England with further trajectories currently being developed for the period to the end of Sep-21.
- The growth in 52 week pathways has affected all trusts. However, given that Barts Health has the third largest waiting list in England, due to the scale of its operations, the volume of 52 week pathways will inevitably be greater than most other Trusts. It is therefore helpful to look instead at the proportion of 52 week breaches against the total waiting list. Looking at London, of the 17 Trusts reporting 52 week breaches for Feb-21, Barts Health ranks 17<sup>th</sup> with 15.9% of the waiting list waiting 52 weeks or longer against a total London performance of 6.9%. Turning to the top 10 largest provider Trusts (by size of waiting list) reveals that Barts Health has the third largest waiting list and the ninth highest proportion of 52 week pathways.



**Quality & Performance (Continued)****Responsive (Continued)****Diagnostic 6 Week Wait Standard**

- As with the RTT waiting list, the impact of the Covid-19 pandemic on the diagnostic waiting list has been significant, resulting in increased waiting times.
- Placing this in context, between Feb-20 and May-20 the number of patients waiting for a diagnostic test reduced by 50%. However, the number of 6 week breaches increased from 288 to 5,609. From Jun-20 to Sep-20, recovery in relation to referrals and waiting list volumes continued as did performance improvement in relation to the 6 week waiting time standard. At the end of Sep-20, the waiting list had recovered to pre-pandemic levels with performance improving from the Apr-20 low of 35.5% to 81.3%.
- However, as the second wave pandemic approached, referrals started to reduce, with the waiting list declining from 30,954 at the end of Sep-20 to 26,633 at the end of Jan-21, a reduction of 4,321 (14%). Due to capacity constraints and the pull of clinical staff to Covid-19 facing duties, performance reduced from 81.3% at the end of Sep-20 to 60.1% at the end of Jan-21.
- During Feb-21 the waiting list started to recover as more referrals were received; at the end of that month there were 29,887 patients waiting, close to Sep-20 levels. Performance stabilised with 61.3% of patients seen within six weeks, a slight improvement against Jan-21. Waiting list and performance recovery continued in Mar-21 with 36,399 patients waiting and a six week wait performance of 67.4%, a 6.1% improvement on Feb-21.
- During Mar-21, the greatest challenge was in the imaging modalities, particularly non-obstetric ultrasound and MRI; imaging breaches accounted for over 77% of all breaches.
- Turning to London benchmarking, Barts Health was ranked 16<sup>th</sup> best performing out of 18 Trusts for Feb-21, the most recent month for which national data are available.

**Cancer 62 Days from GP and Screening Service Referral**

- For Feb-21, performance for the 62 day GP standard was 87.9% against the 85% target. Barts Health has therefore continued to deliver the national standard for each month of this year, Apr-20 to Feb-21 and also in Mar-20, thereby ensuring that essential cancer treatment has been provided to patients throughout the course of the pandemic to date. During the first phase of the Covid-19 pandemic, cancer treatment was supported by independent sector outsourcing; this continued through the second wave and will also continue until the Trust fully restarts its elective programme.
- In relation to the 62 day screening standard, the Trust failed the standard, recording a performance of 84.0% against the 90% target with 12.5 screening pathways and a 2 breaches. Of the breaches, 1.5 were recorded in the Lower Gastrointestinal pathway and 0.5 in the Breast pathway. Locally and nationally, the NHS is investing in multi-media awareness programmes designed to return screening programmes to pre-pandemic service levels.

**Quality & Performance (Continued)****Caring, Safe and Effective**

- It is positive to note the continued strong performance on replying to complaints in the agreed time.
- Duty of candour performance deteriorated after both the first and second waves of the pandemic. Performance improved in Feb-21 and it is anticipated that this recovery will continue. The metric in this report measures compliance with the Trust's internal target of 14 calendar days. Even when this target is missed, the legal Duty is complied with in most cases as the specified time-frame is "as soon as reasonably practicable".
- Friends and Family Test (FFT): response rates and patient satisfaction have been impacted by the pandemic. The Trust is keen to ensure inclusion and share meaningful insights from FFT and a range of patient experience measures through its new Inclusion Observatory, starting with understanding the experiences of diverse patient populations and a decision to pilot the FFT in Bengali (see detailed FFT slide for more detail).
- It is positive to note that the rates of hospital-acquired pressure ulcers and falls continue to improve following the second wave of the pandemic.
- One Never Event was reported in Mar-21. A guide wire was left in the patient following insertion of a central venous catheter. The event was classified as "No Harm". Learning from this incident was shared with the other hospital sites regarding the need to use Local Safety Standard for Invasive Procedures (LocSSIPs) and undertake verbal checks to confirm any wires inserted have been removed.
- Infection Prevention and Control (IPC): for 2020/21 the Trust saw decreases overall in C.difficile and E.coli bloodstream infections against the previous year. The national Covid-19 bundle contributed to an increase in antimicrobial prescribing; however, the post infection review (PIR) process for C.difficile agreed that antimicrobial use was appropriate in all cases. Learning from PIRs has been shared via multiple routes and will be cascaded in the Trust's IPC campaign over the next 6 months. Investigations for E.coli also identified prescribing changes as a potential cause of an increase in infection rates for cancer patients. A review of the benefits of the Trust's agreed prophylactic antibiotic policy for haematology-oncology patients will be carried out.



**Finance**

- The current draft year end position for 2020/21 is break-even, which is £6.8m favourable against the Phase 3 plan submitted to NHS England/Improvement (NHSE/I), which commenced from Oct-20 (Month 7). The position includes £11.5m of additional top-up income recently notified by NHSE to support the Oct-20 to Mar-21 (Months 7-12) finance regime.
- Income is £24.4m favourable year to date against the Phase 3 plan. This includes the £11.5m of additional income for the Oct-20 to Mar-21 (Months 7-12) finance regime and a further £9.6m income for re-imburement of the costs of activity against NHSE co-ordinated Independent Sector contracts. Additional income for Independent Sector contracts is fully offset by the associated additional expenditure.
- Expenditure is (£17.6m) adverse year to date against the Phase 3 plan. The adverse variance is driven by hospital sites and services pay costs overspend (£6.4m year to date) primarily due to increased staffing associated with additional critical care capacity within the Queen Elizabeth Unit and additional central expenditure notified by NHSE for Independent Sector contracts (£9.6m).
- The final funding from exchequer sources was £122.3m and the Trust's capital programme was £121.6m (excluding schemes funded by donated sources), which gives an underspend against the Capital Resourcing Limit of £0.7m. The Trust secured £6.2m of donated funds against the planned programme of £7.0m, and also incurred £6.2m of costs. For the year to date, expenditure relating to the Covid-19 response was £42.3m.
- Cash balances are £51.2m higher than the plan of £3m, as a result of the movements in working capital. The Trust's capital and revenue loans (£593m) were converted to public dividend capital (PDC) in Aug-20 and the balance of £0.4m capital loan was repaid in Sep-20. Following the debt conversion, dividends are now due to the Department of Health and Social Care (DHSC) and £10.2m (based on the Trust's original plan) has been paid in year, with an expected refund due back to the Trust in 2021/22 of £4.8m.

## People

### Looking After the Trust's People – Staff Vaccination (COVID-19), Sickness Absence Rates and Appraisal Rates

- **Staff vaccination rates for Covid-19** are now amongst the highest in London and the Trust is “buddying” with another Hospital Trust to share learning.
- **Sickness absence rates** have increased slightly from 4.77% in Jan-21 to 4.81% in Feb-21 (annualised); however, COVID-19 related sickness absence has reduced from 3.03% at the peak to 0.41% at the end of Mar-21.
- **Appraisal rates** across medical and non-medical staff groups remain very challenged at 35% and 74% respectively. For non-medical appraisals there has been a small increase in month, covered in more detail later. For medical appraisals, the process was relaunched in Mar-21, and this is reflected in an increase from 69% reported for Feb-21.

### We Belong

- At present 35.3% of the Trust's Band 8A+ staff are from a Black, Asian and Minority Ethnic (BAME) background. The senior recruitment process put in place to ensure candidates from all backgrounds have an opportunity to apply for these roles is currently being reviewed now that 6 months have passed, to understand what lessons can be learnt to enhance this process further.

### New Ways of Working – Rostering

- Roster approval compliance (rosters approved six weeks in advance) reduced to 31% from 39%, with all hospital sites at 40% or below. 42% of rosters were approved at least five weeks in advance and 61% four weeks in advance.

### Growing the Workforce – Recruitment, Temporary Staffing and Turnover

- **Recruitment** – in Mar-21, 361 Whole Time Equivalent (WTE) unconditional offers were made in comparison to 297 in Feb-21. Across the last 12 months, 3,993 unconditional offers have been made which represents over 99% of planned recruitment.
- The Trust's substantive staff fill rate in Mar-21 was at 93.8% with all hospital sites above a 91% fill rate. There has been an increase of 20 WTE. This position is above plan by 120 WTE, in part due to student nurses, but also fixed term contracts supporting the vaccination centre at the ExCeL.
- **Temporary Staffing** – temporary staffing usage increased by 320 WTE compared to Feb-21, with the proportion of temporary staff as part of the workforce increasing from 13.1% to 14.6%. This is largely a reflection of 3 additional days in Mar-21 compared to Feb-21.
- **Turnover** – Annualised Voluntary Turnover is at a record low at 8.9% and is likely to be significantly impacted by the pandemic, both due to the reduced recruitment market (many organisations reduced their overall level of recruitment) and increased loyalty whilst supporting colleagues across the Trust. There is a recognition across Chief Nurses in London that these rates may be suppressed and it could be expected to see these rates increase, both as the labour market continues to improve but also with the risk of burnt-out colleagues leaving the NHS.

May-21



# Covid-19 Monitoring and Recovery Report



Summary of Vaccinations Given to Barts Health Staff as at 28/04/2021

	Site	Total Staff	Vaccinations Overall			% Vaccinated	Doses Administered	
			Yes	No - Unknown	No - Decline		Dose 1	Dose 2
<b>Barts Health Perm-Fixed Term Employees</b>	Royal London	5,566	3,724	1,837	5	67%	3,683	3,542
	Whipps Cross	2,604	1,659	944	1	64%	1,633	1,581
	Newham	1,897	1,172	725	0	62%	1,167	1,069
	St Bart's	2,333	1,768	565	0	76%	1,752	1,686
	Central Income & Expenditure	188	132	56	0	70%	131	123
	Group Clinical Services	2,044	1,417	627	0	69%	1,409	1,344
	Group Support Services	1,694	1,054	635	5	62%	1,049	946
	Other	78	33	45	0	42%	31	20
	<b>Grand Total</b>	<b>16,404</b>	<b>10,959</b>	<b>5,434</b>	<b>11</b>	<b>67%</b>	<b>10,855</b>	<b>10,311</b>
<b>Barts Health Temporary and Contract Employees</b>	<b>Grand Total</b>		<b>5,241</b>				<b>4,530</b>	<b>3,931</b>

Note: the 67% vaccination rate for substantive staff relates to staff vaccinated in the Barts Health hospital hubs and excludes staff vaccinated in primary care, vaccination centres and hospital hubs at other Trusts

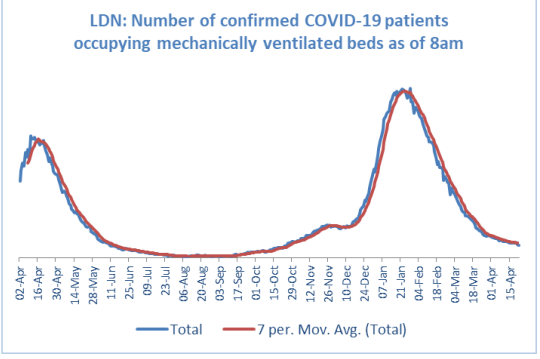
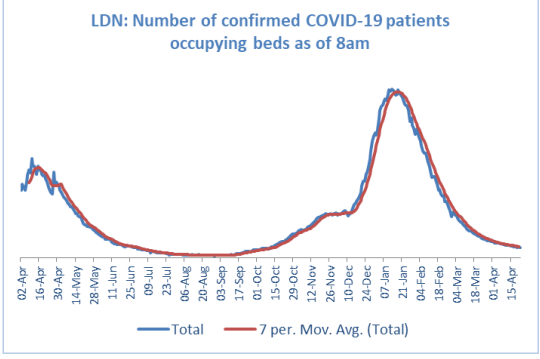
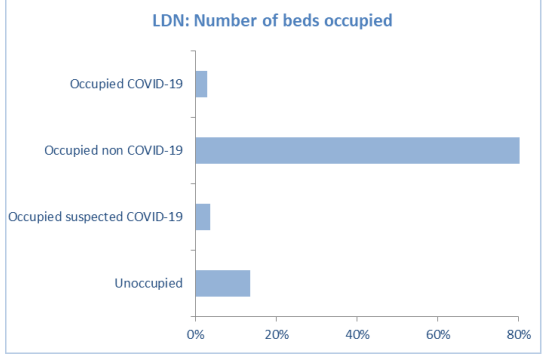
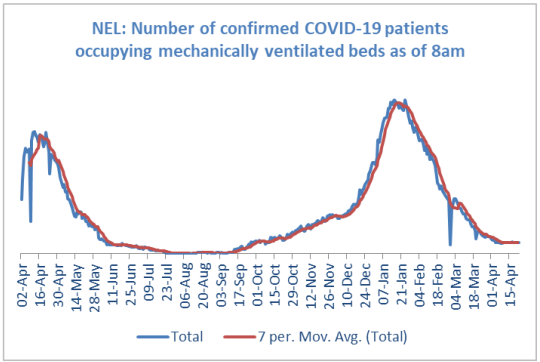
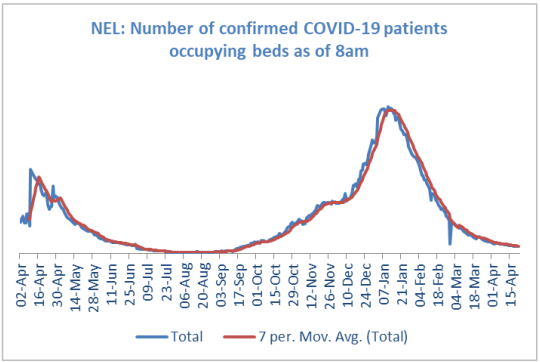
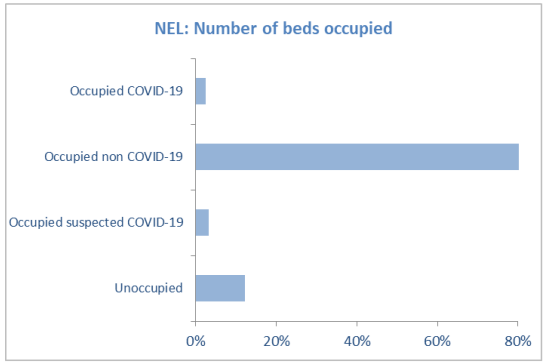
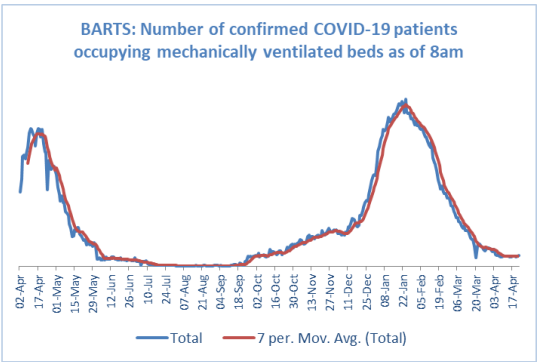
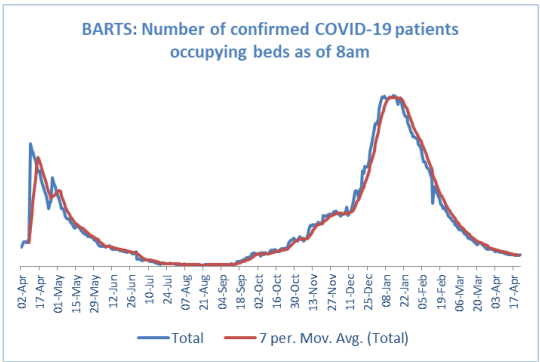
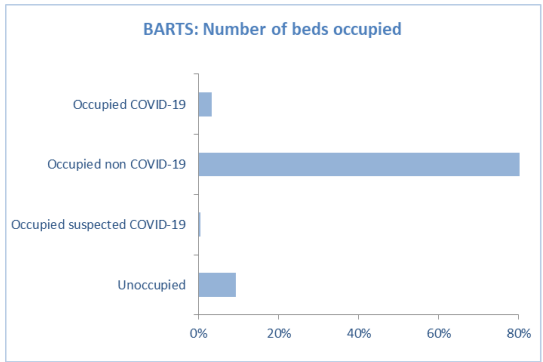
Summary of Vaccinations Given to Barts Health Staff (Permanent/Fixed Term) by Ethnic Category as at 28/04/2021

<b>Barts Health Employees</b>	BAME Group	Total Staff	% Staff In Each Ethnic Category	Vaccinations			% Vaccinated
				Yes	No - Unknown	No - Decline	
	BAME	9,303	57%	5,589	3,707	7	60%
	White	5,875	36%	4,615	1,256	4	79%
	Not Stated/Undefined	1,226	7%	755	471	0	62%
	<b>Grand Total</b>	<b>16,404</b>	<b>100%</b>	<b>10,959</b>	<b>5,434</b>	<b>11</b>	<b>67%</b>

COVID-19

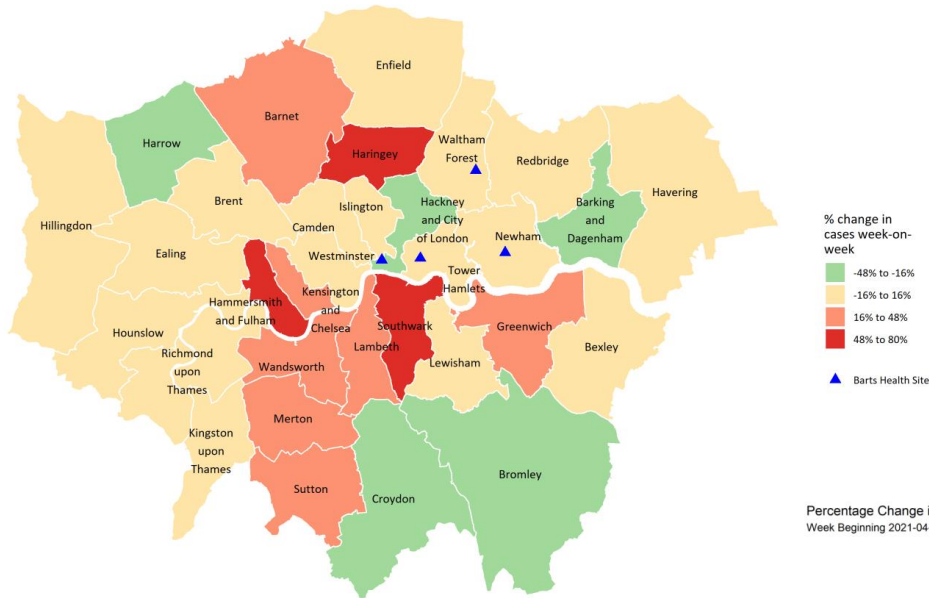
# COVID-19 – Barts Health

May-21



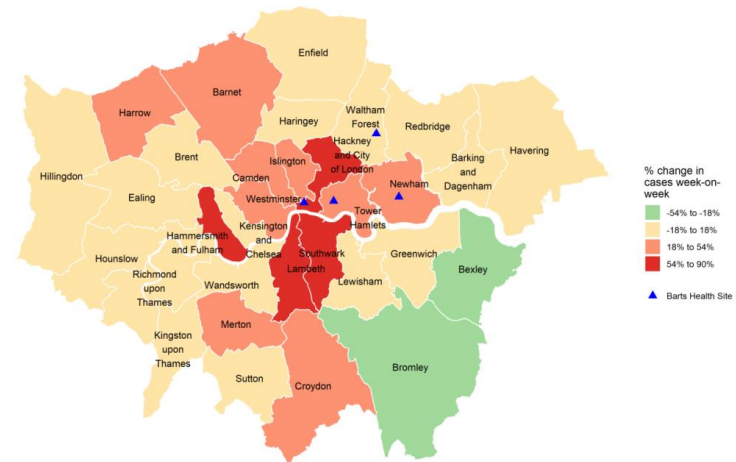
Data as at 22/04/2021

Percentage Change in New Lab-confirmed Covid-19 Cases Week-on-Week  
Week Beginning 2021-04-10



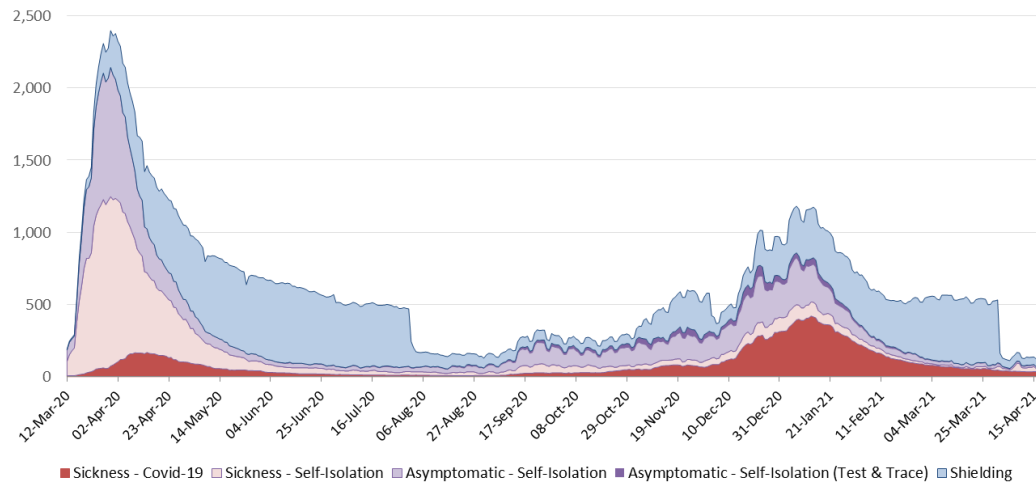
	Cases Week to Week to Apr 09	Cases Week to Week to Apr 16	Rate /100,000 Week to Week to Apr 09	Rate /100,000 Week to Week to Apr 16	% change in cases Week on Week
Hackney and City of London	71	54	25.4	19.3	-24%
Barking and Dagenham	65	51	30.7	24.1	-22%
Tower Hamlets	82	77	25.8	24.2	-6%
Redbridge	105	99	34.6	32.6	-6%
Havering	37	35	14.4	13.6	-5%
Waltham Forest	52	52	18.8	18.8	0%
Newham	123	128	34.9	36.4	4%
London	2,025	2,032	22.8	22.9	0%
England	16,007	13,772	30.8	26.0	-14%

Percentage Change in New Lab-confirmed Covid-19 Cases Week-on-Week  
Week Beginning 2021-04-07



		Thu 22/04
<b>Trust</b>	Shielding against Covid-19	50
	Isolating due to Covid-19 (asymptomatic)	10
	Self-Isolating due to Covid-19 (sickness absence)	36
<b>Royal London</b>	Shielding against Covid-19	26
	Isolating due to Covid-19 (asymptomatic)	4
	Self-Isolating due to Covid-19 (sickness absence)	10
<b>Whipps Cross</b>	Shielding against Covid-19	6
	Isolating due to Covid-19 (asymptomatic)	1
	Self-Isolating due to Covid-19 (sickness absence)	7
<b>Newham</b>	Shielding against Covid-19	6
	Isolating due to Covid-19 (asymptomatic)	1
	Self-Isolating due to Covid-19 (sickness absence)	5
<b>St Bart's</b>	Shielding against Covid-19	9
	Isolating due to Covid-19 (asymptomatic)	2
	Self-Isolating due to Covid-19 (sickness absence)	3

Trustwide Staff Sickness

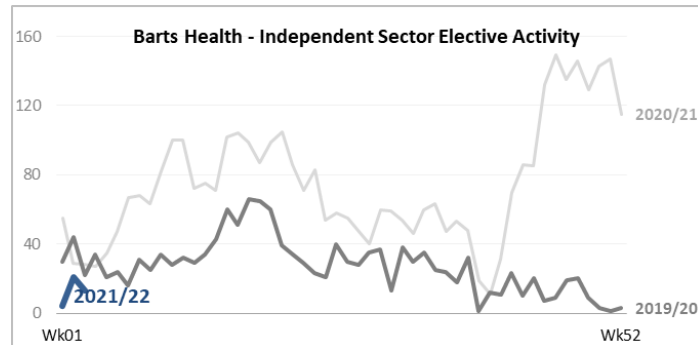
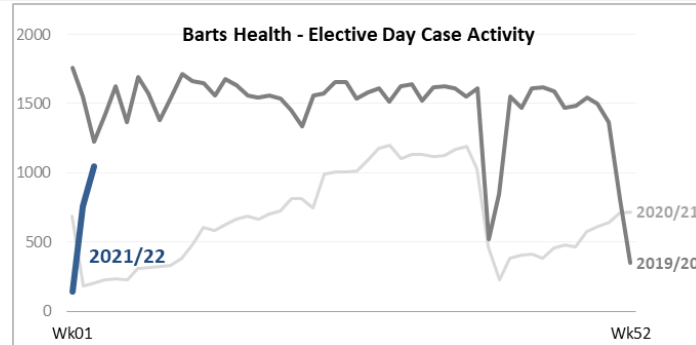
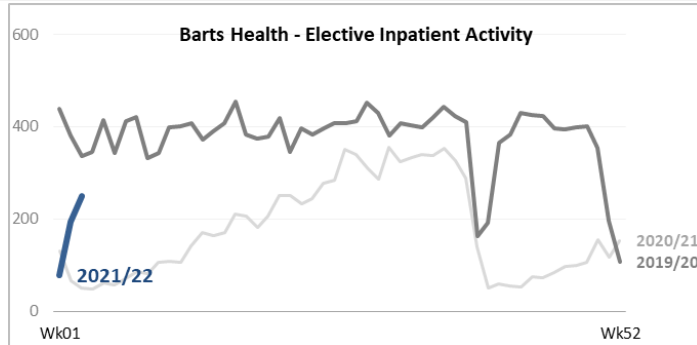


COVID-19

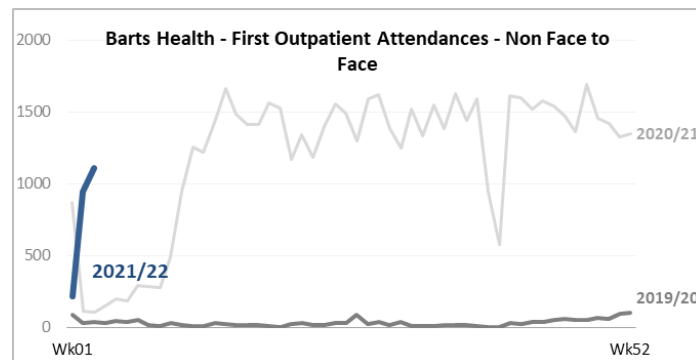
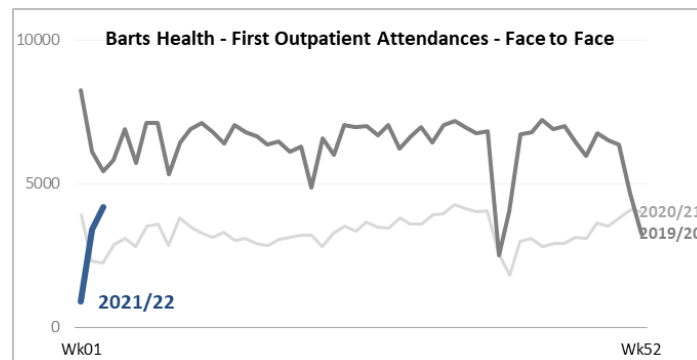
# Elective Activity

May-21

## Elective Activity



## Outpatient Activity



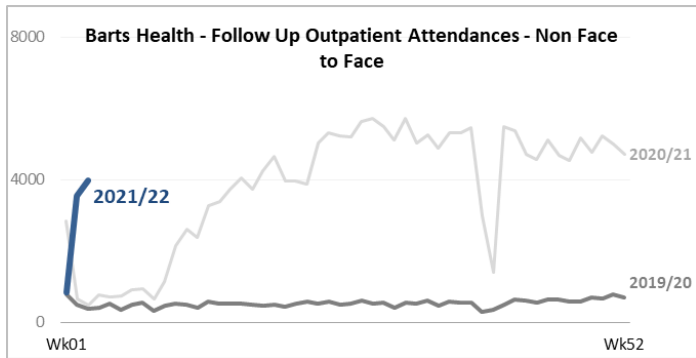
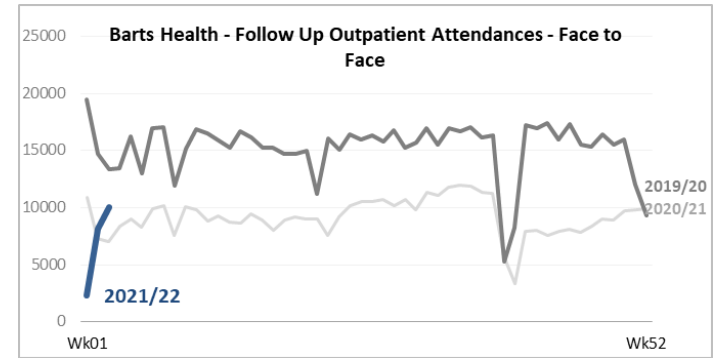
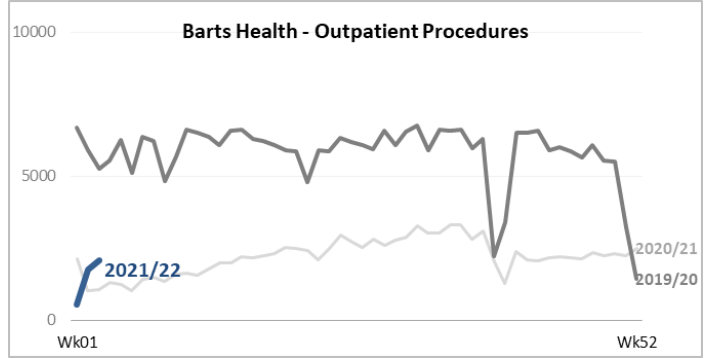


COVID-19

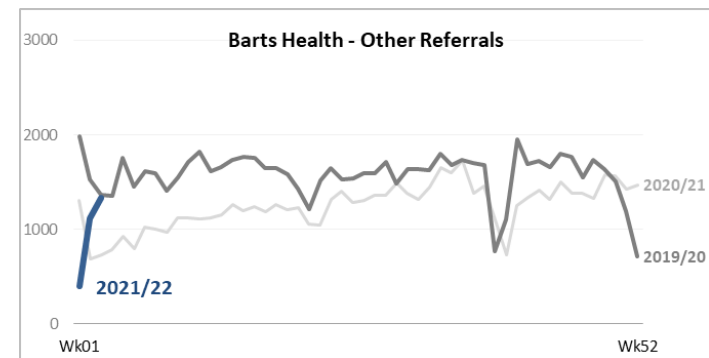
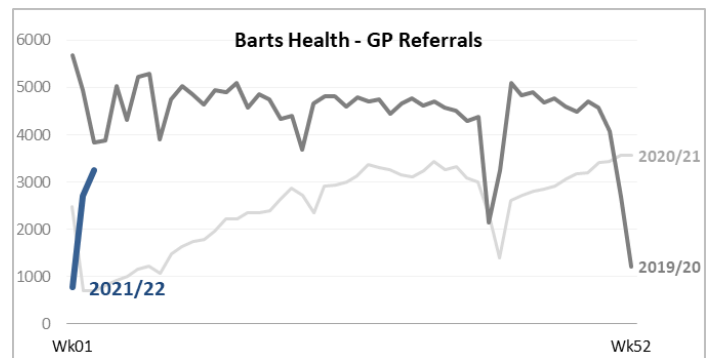
# Elective Activity

May-21

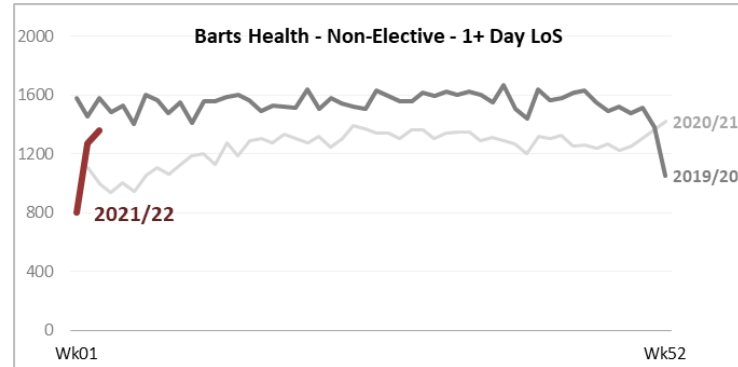
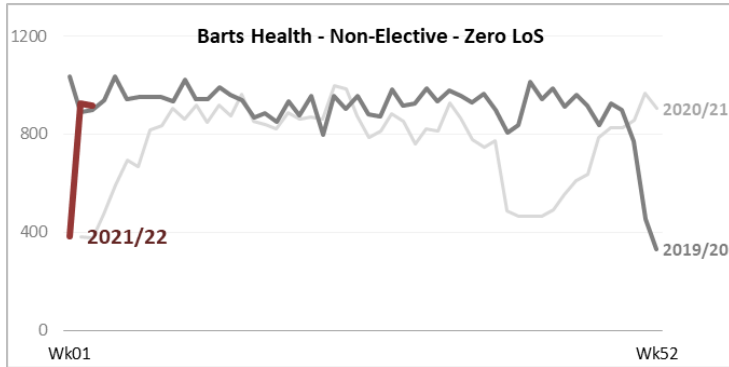
## Outpatient Activity



## Referrals Activity



## Non-Elective Activity

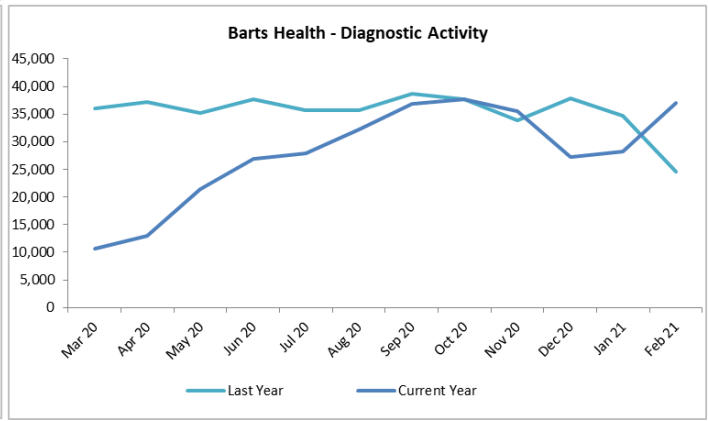
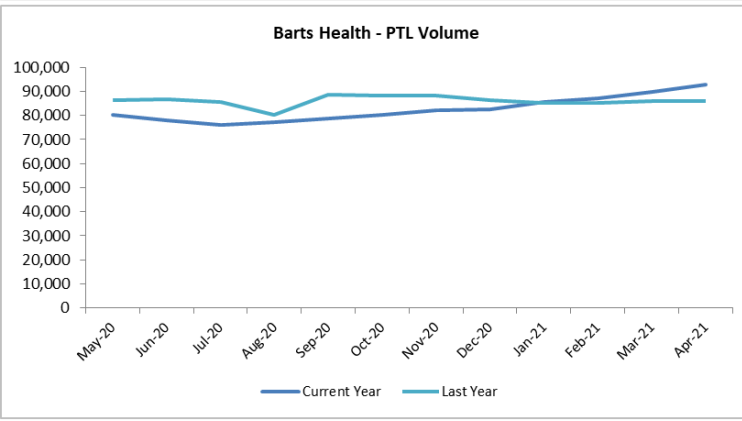
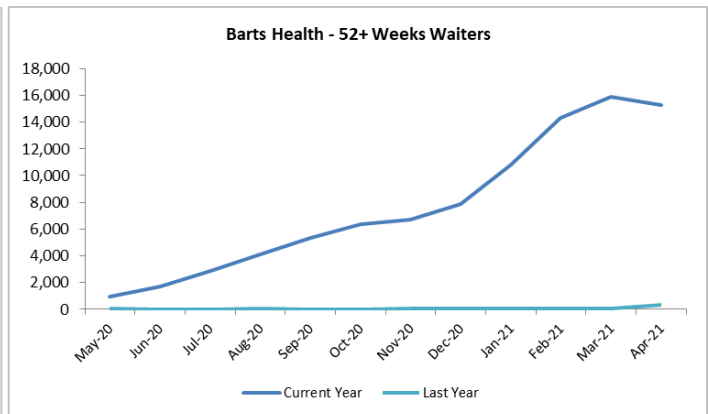
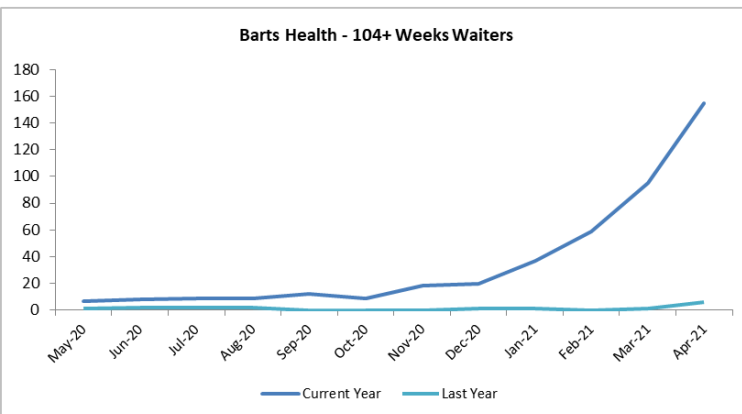


COVID-19

# Referral to Treatment (RTT) and Diagnostic (DM01) Activity

May-21

Barts Health							Latest Month's Site Position					
Setting	Ref	Reporting Period	Dec-20	Jan-21	Feb-21	Mar-21	Royal London	Whipps Cross	Newham	St Bart's	CSS	Other
PTL Activity	0481	52+ Weeks Waiters	7,854	10,803	14,314	15,849	8,702	3,339	2,111	149	10	3
		104+ Weeks Waiters	20	37	59	95	75	7	13	0	0	0
	0482	PTL Volume	85,463	87,011	89,897	92,888	42,046	28,438	11,477	10,146	728	53
DM01	0487	Diagnostic Activity	35,550	27,310	28,170	37,042	2,554	770	348	7,754	25,616	-
		<i>Equivalent Month Position Last Year</i>	33,912	37,823	34,688	24,618	1,646	774	266	4,293	17,639	-



May-21



# Quality & Performance Report



RESPONSIVE

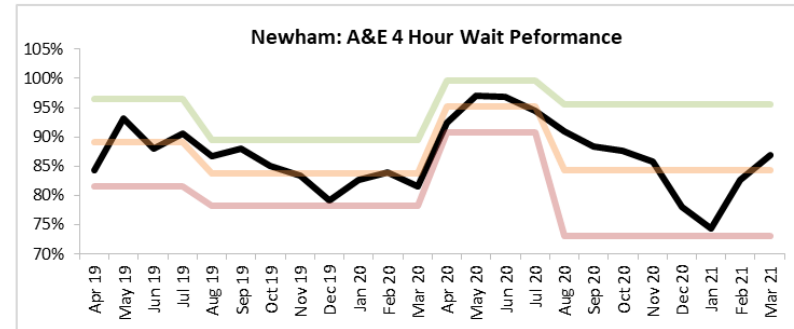
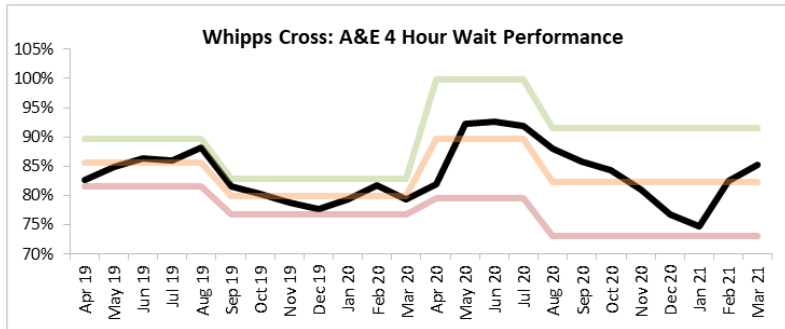
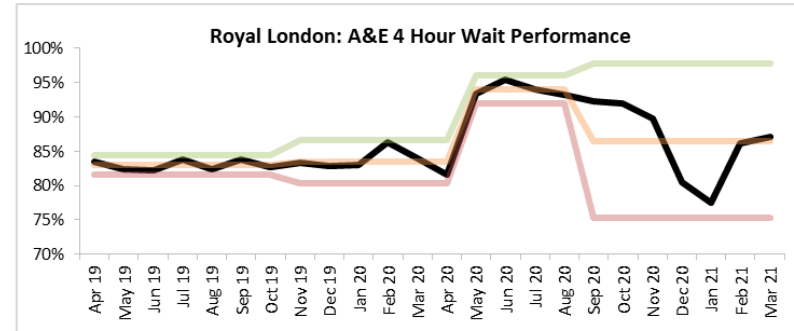
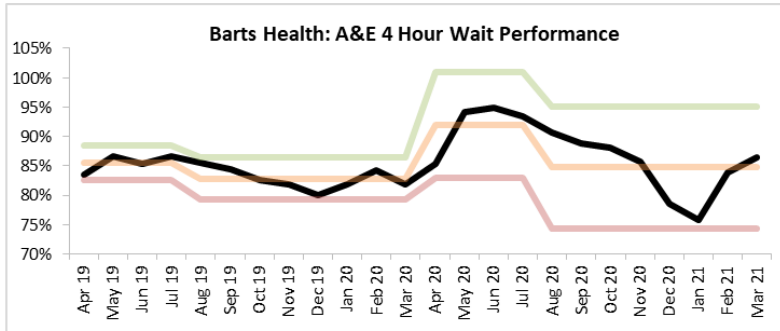
# Domain Scorecard

May-21

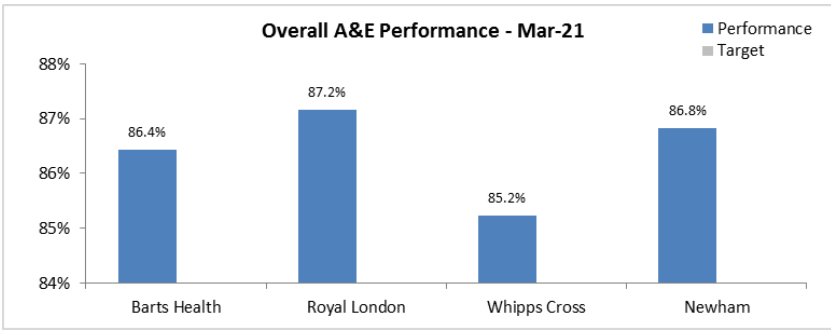
**Contextual note: metrics from Mar-20 will include the period of the Covid-19 pandemic, which has seen significant changes to patient demand and service delivery. All metrics need to be considered in this context.**

	Ref	Indicator	Exception Triggers			This Period	This Period Target	Performance			Site Comparison						Excep.
			Month Target	Step Change	Contl. Limit			Last Period	This Period	YTD	Royal London	Whipps Cross	Newham	St Bart's	CSS	Other	
Waiting Times	R1	A&E 4 Hours Waiting Time				Mar-21 (m)	-	83.9%	86.4%	87.2%	87.2%	85.2%	86.8%	-	-	-	●
	R35	Cancer 62 Days From Urgent GP Referral	●			Feb-21 (m)	>=85%	85.8%	87.9%	86.8%	85.1%	85.4%	82.4%	94.3%	-	-	●
	R36	Cancer 62 Days From Screening Programme	●			Feb-21 (m)	>=90%	92.0%	84.0%	87.0%	100.0%	50.0%	100.0%	83.3%	-	-	●
	R6	Diagnostic Waits Over 6 Weeks				Mar-21 (m)	-	61.3%	67.4%	70.3%	53.2%	50.2%	38.2%	98.5%	66.7%	-	●
	R5	52+ Week RTT Breaches		●		Mar-21 (m)	-	14,314	15,849	77,159	9,341	4,065	2,288	144	8	3	●

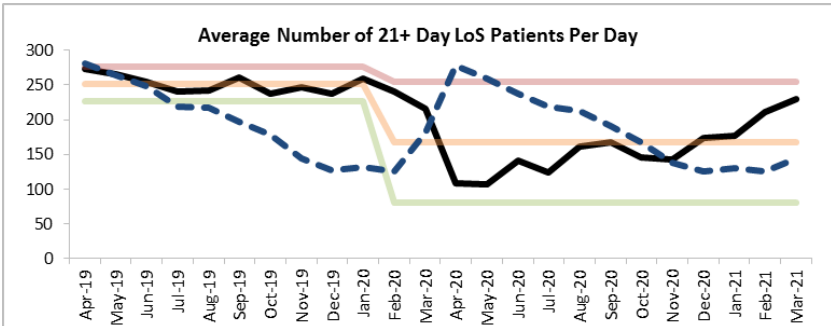
Note: the 18 Week RTT Compliance (Incomplete) metric is no longer being reported while the Trust takes part in the NHS England pilot project to assess the new RTT metric looking at average waiting time instead



**RESPONSIVE** **A&E 4 Hours Waiting Time** **May-21**



Site	Mar-20	Mar-21	Variance
Barts Health	30,388	34,223	12.6%
Royal London	10,992	12,821	16.6%
Whipps Cross	9,393	11,062	17.8%
Newham	10,003	10,340	3.4%



**Performance Overview**

- For Mar-21 attendances increased by 34% to 34,223, the highest volume of attendances recorded since the start of the pandemic. Of these 34,223 total attendances, 60% (20,504) were Type 1 (higher acuity) and 40% (13,719) were Type 2/3 (lower acuity); proportionally this is slightly fewer Type 1 attendances (-3%) and slightly more Type 2/3 attendances (+3%) compared to the preceding 14 months.
- During the first wave of the pandemic, as attendances fell so performance against the 4 hour standard improved with performance levels exceeding 90% between May-20 and Aug-20. However, such was the severity of the second wave impact, particularly in relation to Covid-19 patient bed occupancy, that even though attendances reduced, performance could not be maintained, with reductions in 4 hour compliance recorded each month between Sep-20 and Jan-21. However, in Feb-21 performance increased to 83.9%, with 86.4% recorded in Mar-21, despite a significant increase in attendances during the month. This represents a 10.6% performance improvement since Jan-21.

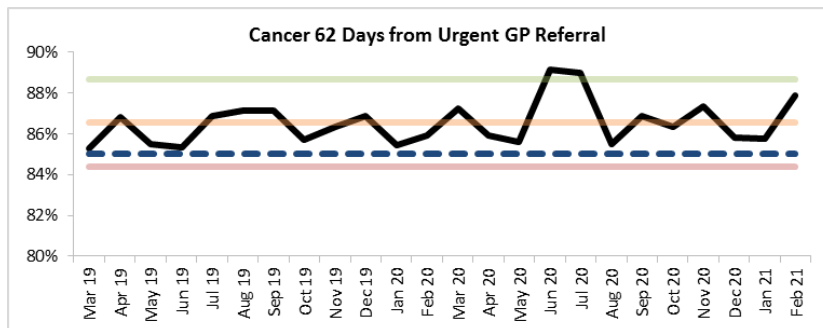
**Responsible Director Update**

- Barts Health was ranked 12<sup>th</sup> best performing out of 16 providers in Mar-21 against the 4 hour standard, with the 7 best performing Trusts all recording a performance greater than 90%. Barts Health is therefore implementing a 90% common performance standard across all its Type 1 provider sites, Royal London, Newham and Whipps Cross.
- Performance improvement trajectories have recently been constructed to be delivered over a 4 week timeline. It is expected that performance will be improved primarily through a reduction in non-admitted breaches, with a greater tolerance applied to admitted breaches while the Trust reorganises its bed base following the second wave of the pandemic.

RESPONSIVE

# Cancer 62 Days From Urgent GP Referral

May-21



Tumour Site	Seen	Breaches	Performance
<b>All Tumour Sites</b>	<b>82.5</b>	<b>10</b>	<b>87.9%</b>
Other	2	1	50.0%
Lung	6	2.5	58.3%
Gynaecological	7.5	2.5	66.7%
Urological	8.5	2.5	70.6%
Upper Gastrointestinal	8.5	1.5	82.4%

Metric	Jan-21			Feb-21			Variance
	Seen	Breaches	%	Seen	Breaches	%	
28 Day FDS Two Week Wait	2,036	635	68.8%	2,169	516	76.2%	7.4%
28 Day FDS Breast Symptomatic	140	7	95.0%	152	8	94.7%	-0.3%
28 Day FDS Screening Referral	72	9	87.5%	58	9	84.5%	-3.0%

Internal / External	Start Site	End Site	Seen	Breaches	Performance	
Internal	Royal London	Royal London	14	0	100.0%	
		St Bart's	5	0	100.0%	
	Whipps Cross	Royal London	2	0	100.0%	
		Whipps Cross	18	2	88.9%	
		St Bart's	9	2	77.8%	
		Newham	Royal London	1	1	0.0%
		Newham	Newham	7	1	85.7%
		St Bart's	St Bart's	2	0	100.0%
	Transfer In	St Bart's	St Bart's	11	0	100.0%
		Basildon	Royal London	1	1	0.0%
Colchester		St Bart's	0.5	0	100.0%	
Homerton		Royal London	2.5	2	20.0%	
		St Bart's	6	0	100.0%	
Transfer Out	King George	St Bart's	0.5	0	100.0%	
	Queen's	Royal London	1	0	100.0%	
		St Bart's	0.5	0.5	0.0%	
	Southend	Royal London	1	0	100.0%	
	Whipps Cross	UCLH	0.5	0.5	0.0%	
<b>Grand Total</b>			<b>82.5</b>	<b>10</b>	<b>87.9%</b>	

### Commentary

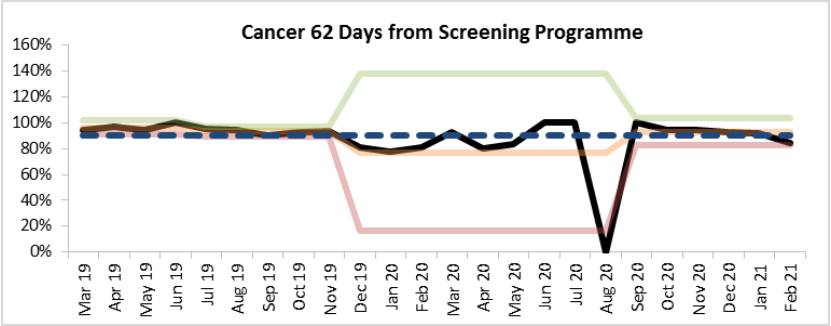
- The Trust has maintained compliance against the 62 Days from Urgent GP Referral standard throughout the course of the Covid-19 pandemic to date, Mar-20 to Feb-21. During the period of reduced activity caused by the first and second wave pandemic, patient treatments and delivery of the standard have been supported by Independent Sector outsourcing; this will continue as the Trust's elective programme restarts.
- A breakdown of those tumour sites not achieving the target in Feb-21 is presented in the table to the left. Upper Gastrointestinal and Urology performance is being influenced by Endoscopy diagnostic test availability and timeliness; recovering Endoscopy activity levels is a Trust priority.
- The Trust returned to compliance against the 28 Day Faster Diagnosis (FDS) Two Week Wait standard in Feb-21 having failed the standard in Jan-21; compliance was also achieved for Breast Symptomatic and Screening Referral pathways.



RESPONSIVE

## Cancer 62 Days From Screening Programme

May-21



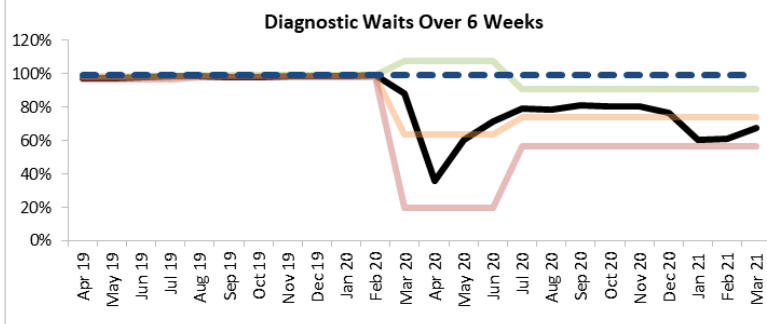
Breakdown by Tumour Sites Failing Standard - Feb-21			
Tumour Site	Seen	Breaches	Performance
All Tumour Sites	12.5	2	84.0%
Lower Gastrointestinal	3.5	1.5	57.1%

Performance Overview	Responsible Director Update
<ul style="list-style-type: none"> <li>The Trust failed the 62 day screening standard, recording a performance of 84.0% against the 90% target with 12.5 screening pathways and 2 breaches. Of the breaches 1.5 were recorded in the Lower Gastrointestinal pathway and 0.5 in the Breast pathway.</li> </ul>	<ul style="list-style-type: none"> <li>Breaches this month were due to complexity of patients, high risk of COVID-19 and late referral into Barts Health from other North East London providers. The corporate team is monitoring this closely.</li> <li>Draft data show that this standard will be compliant for Mar-21.</li> <li>The Trust is closely working with the Central and East London Breast Screening Service to ensure that enough capacity is made available within Barts Health. This aim is to have the backlog cleared by summer 2021 (rest of London 2022).</li> <li>Locally and nationally, the NHS is investing in multi-media awareness programmes designed to return screening programmes to pre-pandemic service levels.</li> </ul>

RESPONSIVE

# Diagnostic Waits Over 6 Weeks

May-21



DM01 Breakdown by Test							
Test Name	Feb-21			Mar-21			Variance in Performance
	Waiting	Breaches	Performance	Waiting	Breaches	Performance	
Urodynamics - pressures & flows	47	45	4.3%	66	39	40.9%	36.7%
Gastroscopy	1,760	1,114	36.7%	1,909	1,167	38.9%	2.2%
Flexi sigmoidoscopy	403	259	35.7%	451	249	44.8%	9.1%
Neurophysiology - peripheral neurophysiology	371	209	43.7%	532	272	48.9%	5.2%
Audiology - Audiology Assessments	472	241	48.9%	553	269	51.4%	2.4%
Colonoscopy	1,194	573	52.0%	1,369	614	55.1%	3.1%
Non-obstetric ultrasound	15,444	6,563	57.5%	18,927	6,486	65.7%	8.2%
Magnetic Resonance Imaging	4,859	1,898	60.9%	5,954	2,128	64.3%	3.3%
Respiratory physiology - sleep studies	108	29	73.1%	93	21	77.4%	4.3%
Cystoscopy	121	26	78.5%	114	29	74.6%	-4.0%
DEXA Scan	633	131	79.3%	677	79	88.3%	9.0%
Computed Tomography	2,655	449	83.1%	3,197	470	85.3%	2.2%
Cardiology - echocardiography	1,820	28	98.5%	2,557	36	98.6%	0.1%
Barium Enema	0	0	100.0%	0	0	100.0%	0.0%
Cardiology - Electrophysiology	0	0	100.0%	0	0	100.0%	0.0%
<b>Grand Total</b>	<b>29,887</b>	<b>11,565</b>	<b>61.3%</b>	<b>36,399</b>	<b>11,859</b>	<b>67.4%</b>	<b>6.1%</b>

### Performance Overview

- As the second wave of the pandemic approached, referrals started to reduce, with the waiting list declining from 30,954 at the end of Sep-20 to 26,633 at the end of Jan-21, a reduction of 4,321 (14%). Due to capacity constraints and the pull of clinical staff to Covid-19 facing duties, performance reduced from 81.3% at the end of Sep-20 to 60.1% at the end of Jan-21.
- During Feb-21 the waiting list started to recover as more referrals were received; at the end of that month there were 29,887 patients waiting, close to Sep-20 levels. Performance stabilised with 61.3% of patients seen within six weeks, a slight improvement against Jan-21. Waiting list and performance recovery continued in Mar-21 with 36,399 patients waiting and a six week wait performance of 67.4%, a 6.1% improvement on Feb-21.
- During Mar-21, the greatest challenge was in the imaging modalities, particularly non-obstetric ultrasound and MRI; imaging breaches accounted for over 77% of all breaches.

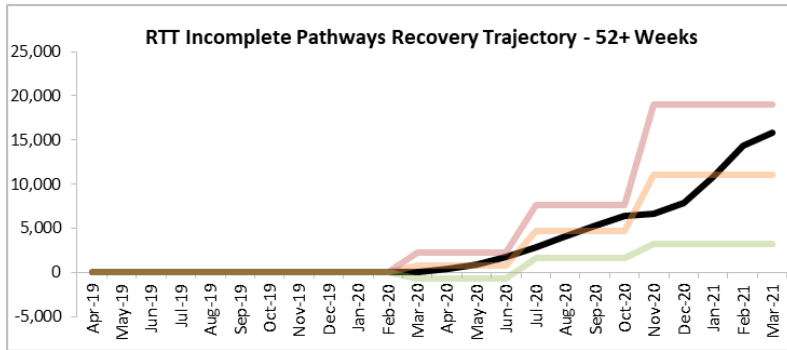
### Responsible Director Update

- Following the second wave peak of the Covid-19 pandemic, an elective recovery plan is being developed with improvement trajectories through to Sep-21. The diagnostic element of the recovery plan will focus on Endoscopy and Imaging diagnostic recovery in the first instance, including the following modalities:
  - Magnetic Resonance Imaging
  - Computed Tomography
  - Non-Obstetric Ultrasound
  - Colonoscopy
  - Flexi Sigmoidoscopy
  - Gastroscopy
  - Echocardiography

RESPONSIVE

# 52+ Week RTT Breaches

May-21



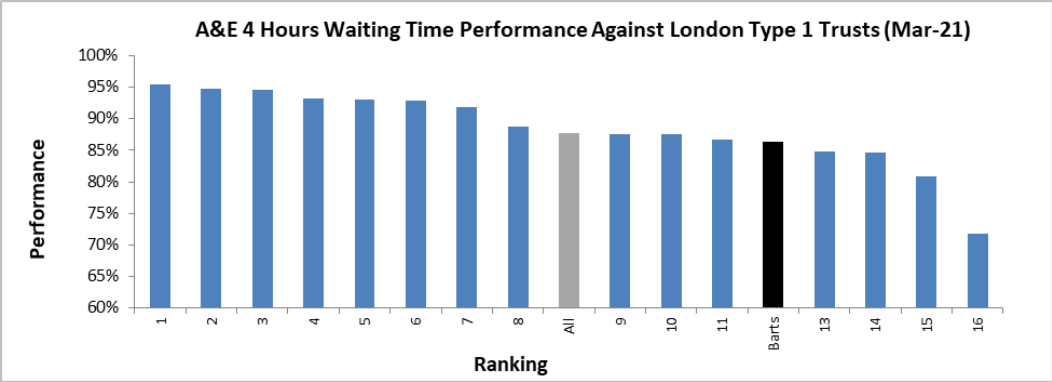
Specialty Name	52-104 Weeks	>104 Weeks	Grand Total
ENT	2,470	19	2,489
Trauma & Orthopaedics	2,131	9	2,140
Paediatric Dentistry	1,066	8	1,074
Paediatric Ear Nose And Throat	959	1	960
Oral Surgery	947	10	957
Ophthalmology	955		955
Gynaecology	875	6	881
Urology	736	3	739
Orthodontics	708	1	709
General Surgery	664		664

Performance Overview	Responsible Director Update
<ul style="list-style-type: none"> <li>The growth in 52 week pathways has affected all Trusts. However, given that Barts Health has the third largest waiting list in England, due to the scale of its operations, the volume of 52 week pathways will inevitably be greater than most other Trusts. It is therefore helpful to look instead at the proportion of 52 week breaches against the total waiting list.</li> <li>Looking at London, of the 17 Trusts reporting 52 week breaches for Feb-21, Barts Health ranks 17th with 15.9% of the waiting list waiting 52 weeks or longer against a total London performance of 6.9%. Turning to the top 10 largest provider Trusts (by size of waiting list) reveals that Barts Health has the third largest waiting list and the ninth highest proportion of 52 week pathways.</li> </ul>	<ul style="list-style-type: none"> <li>The Trust has produced an initial 52 week wait reduction trajectory through to the end of Jun-21, which is currently on plan, and is now working on a longer term reduction trajectory.</li> <li>The longer-term trajectory will provide additional granular focus on reducing the volume of breaches across the High Volume Low Cost (HVLC) admitted pathway, the non-admitted pathway and clearance trajectories designed to ensure that patients are not waiting for longer than 78 weeks.</li> </ul>

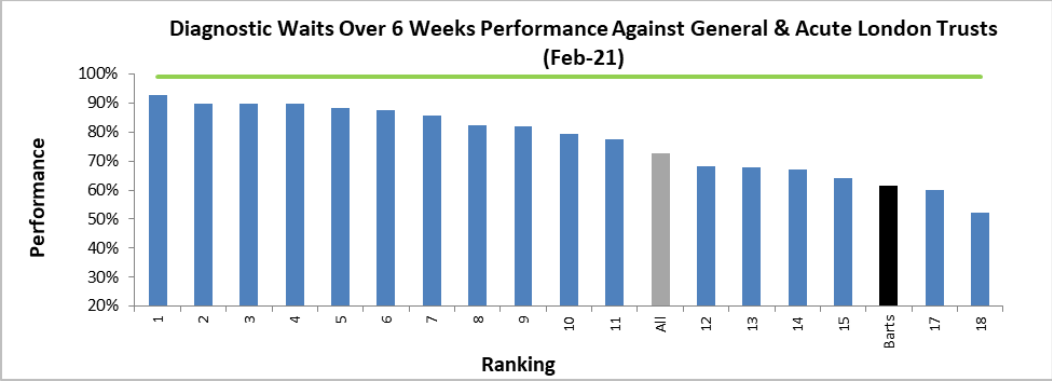
RESPONSIVE

# Benchmarking Against Other Trusts

May-21



- For Mar-21, the Trust was ranked 12<sup>th</sup> best performing of the 16 London Acute Trusts reporting data and the third best performing of the top 9 largest (by volume of attendances) Trusts in England reporting data.

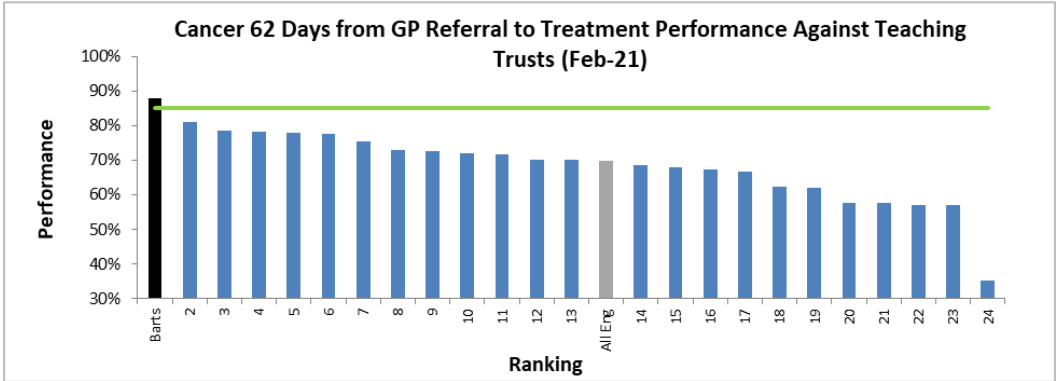
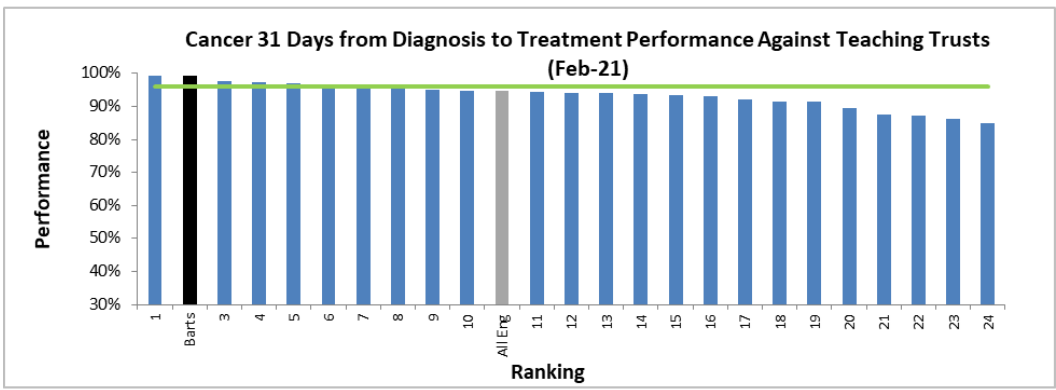
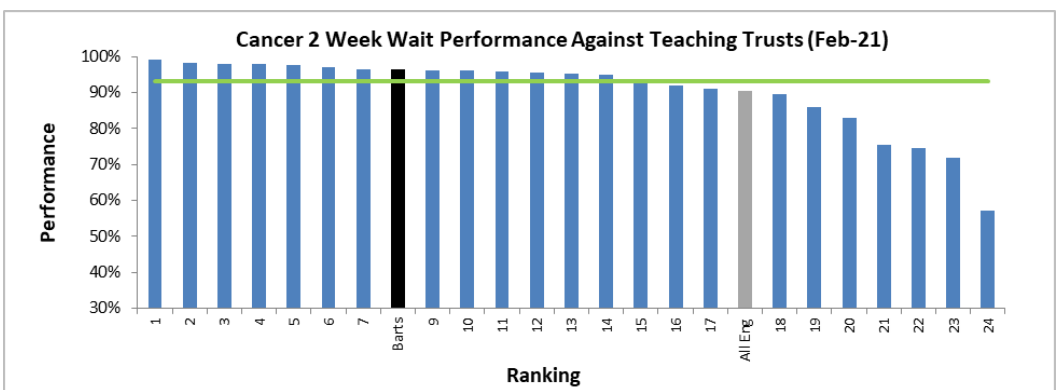


- For Mar-21, Barts Health recorded a performance of 67.4% against the 99% standard, a 6.1% improvement on Feb-21.
- For Feb-21 (the most recent month for which national data is available, Barts Health was ranked 16<sup>th</sup> best performing out of 18 London Trusts.

RESPONSIVE

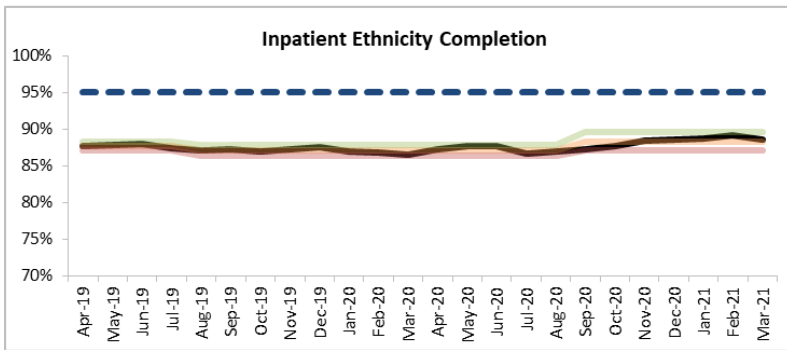
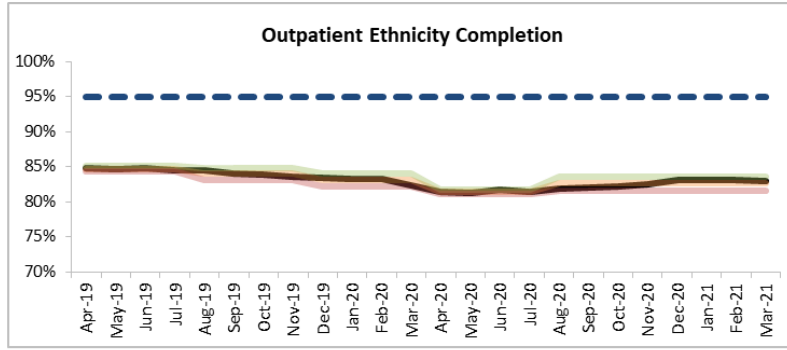
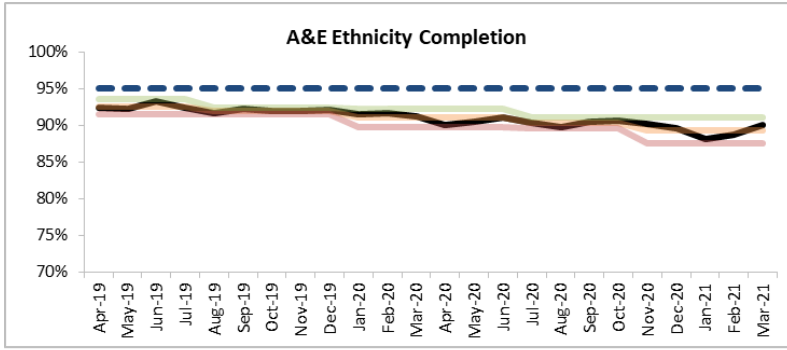
# Benchmarking Against Other Trusts

May-21



- The Trust achieved compliance against the 2 Week Wait standard in Feb-21 with a performance of 96.4% against the 93% target. This resulted in Barts Health being the eighth best performing of the peer group of 24 Teaching Trusts.
- The Trust was also compliant in Feb-21 against the 31 Day Diagnosis to Treatment standard with 229 patients treated and 2 breaches resulting in a performance of 99.1% against the 96% target. For Feb-21, Barts Health was the second best performing of the 24 Teaching Trusts.
- As mentioned previously, the Trust achieved compliance against the 62 Days from GP Referral standard for Feb-21 with a performance of 87.9% against the 85% target. This resulted in Barts Health being the best performing of the 24 Teaching Trusts.

**RESPONSIVE** **Ethnicity Recording by Activity Type** **May-21**



Site	A&E	Inpatient	Outpatient
Royal London	88.7%	85.2%	82.1%
Whipps Cross	93.1%	92.7%	87.7%
Newham	88.5%	87.4%	78.2%
St Bart's	-	90.8%	81.5%
CSS	-	87.9%	88.1%
<b>Trust</b>	<b>90.1%</b>	<b>88.5%</b>	<b>82.9%</b>

The above figures show the percentage of the activity where the ethnicity of the patient is known and has been recorded (i.e. not including where it has not been requested, recorded as not stated or the patient has refused to give it)

Performance Overview	Responsible Director Update
<ul style="list-style-type: none"> <li>The impact of Covid-19, both first and second waves, has been particularly detrimental to people living in areas of greatest deprivation and to people from Black, Asian and Minority Ethnic communities. Covid-19 risks further compounding inequalities which had already been widening. The government has tasked all health providers to work collaboratively with local communities and partners to take urgent actions to address these inequalities by ensuring those in greatest need are accessing health care provision.</li> <li>Given the context and actions described above it is critical that all hospital sites record the ethnicity of those patients referred to services or attending for treatment. The data and charts above present the proportion of patients across emergency and elective care whose ethnicity has been recorded.</li> </ul>	<ul style="list-style-type: none"> <li>Ethnicity recording in Mar-21 remains significantly below required levels. Whipps Cross is the best performing site for A&amp;E and Inpatient ethnicity recording with Group Clinical Services (CSS) the best performing for Outpatient recording. Conversely Newham is the worst performing site for A&amp;E and Outpatient recording with Royal London the worst performing for Inpatient recording.</li> <li>However, in reporting these performance data it is important to recognise that the ethnicity completeness calculation includes within the denominator those patients who were asked to provide their ethnicity but who declined to do so as well as other "not stated" reasons. These data have been provided to hospital sites to support enquiries into those categories and how improved recording may be achieved.</li> <li>The first aim is to ensure that all hospital sites across these service types record at least a 95% ethnicity completion rate.</li> </ul>

	Ref	Indicator	Exception Triggers			This Period	This Period Target	Performance			Site Comparison						Excep.
			Month Target	Step Change	Contl. Limit			Last Period	This Period	YTD	Royal London	Whipps Cross	Newham	St Bart's	CSS	Other	
Patient Experience	C12	MSA Breaches				Feb-20 (m)	<= 0	22	27	226	1	16	10	0	-	-	
Patient Feedback	C10	Written Complaints Rate Per 1,000 Staff				2020/21 Q3 (q)	SPC Breach	22.3	21.4	21.4	20.8	44.6	35.1	16.1	-	-	
	C1	FFT Recommended % - Inpatients	●			Feb-21 (m)	>=95%	84.5%	88.3%	86.8%	86.8%	89.8%	82.7%	93.3%	-	-	●
	C2	FFT Recommended % - A&E	●			Feb-21 (m)	>=86%	79.0%	77.3%	76.5%	76.2%	81.0%	74.3%	-	-	-	●
	C3	FFT Recommended % - Maternity	●			Feb-21 (m)	>=96%	95.6%	90.3%	94.5%	100.0%	100.0%	89.3%	-	-	-	●
	C20	FFT Response Rate - Inpatients	●			Feb-21 (m)	>=23%	6.9%	8.9%	8.3%	7.3%	13.3%	6.9%	9.4%	-	-	●
	C21	FFT Response Rate - A&E	●			Feb-21 (m)	>=12%	9.9%	11.1%	10.4%	11.7%	12.6%	9.0%	-	-	-	●
	C22	FFT Response Rate - Maternity	●			Feb-21 (m)	>=17.5%	4.6%	2.9%	5.3%	0.3%	0.6%	7.5%	-	-	-	●
	OH4	CQC Inpatient Survey				2018/19 (y)	-	-	85.0%	85.0%	78.0%	79.0%	80.0%	95.0%	-	-	
Service User Support	R78	Complaints Replied to in Agreed Time	●			Mar-21 (m)	>=85%	95.9%	94.5%	88.4%	96.8%	96.6%	78.9%	100.0%	-	-	
	R30	Duty of Candour	●			Feb-21 (m)	>=100%	79.5%	88.1%	82.9%	90.0%	92.9%	70.0%	100.0%	-	-	●

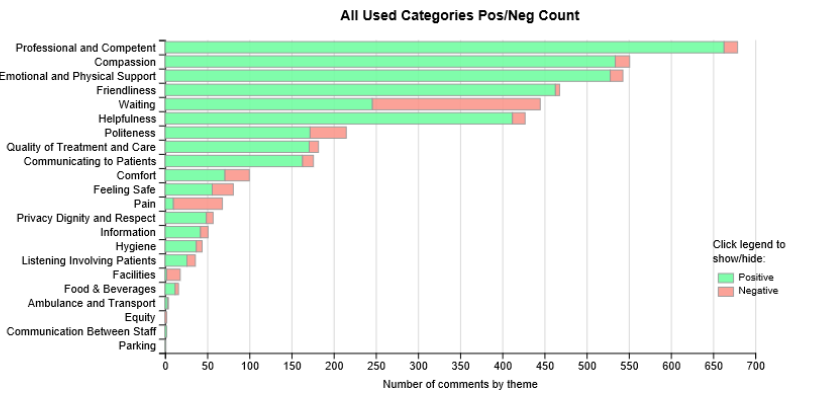
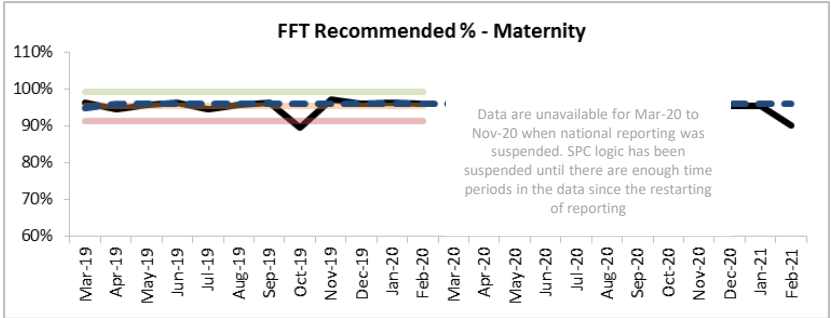
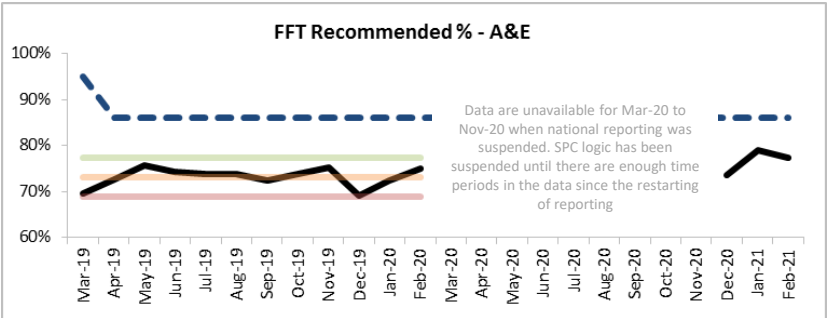
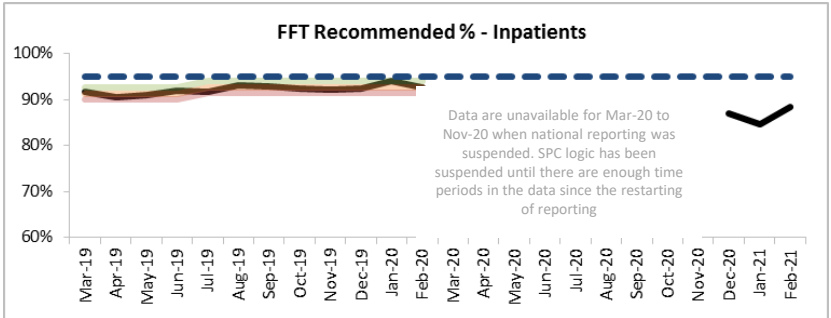
MSA breaches: Feb-20 performance from the last national submission before the temporary suspension of national reporting is the latest included in the report

\*The metric "Complaints Replied to in Agreed Time" has a Trust-wide target of 85% but an internal stretch target for sites of 95%

CARING

Friends and Family Test (FFT) Recommended %

May-21



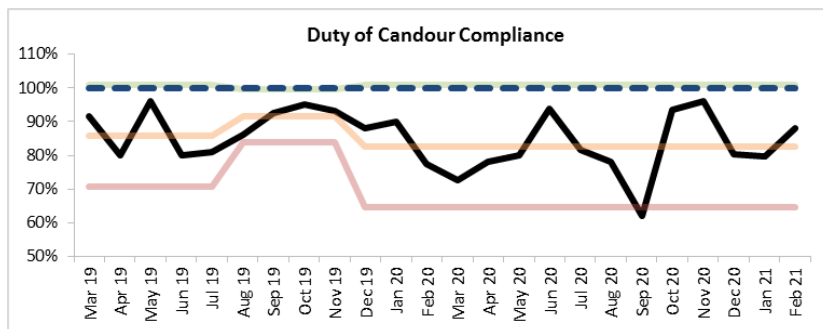
Performance Overview

- National reporting was suspended in Mar-20 so no data have been available for a number of months. The FFT question was changed when reporting resumed so the pre and post suspension results should not be directly compared.
- Paper surveys accounted for around 70% of the total responses in 2019/20, so their suspension for infection prevention reasons was a major factor in a drop in recent volumes of responses.
- Work on patient experience has been impacted by the changes due to the pandemic, whereby the Trust had to adapt care rapidly and there were changes such as staff shortages, Patient Experience Leads being redeployed, no visitors, and suspension of paper survey forms, all of which have impacted the results.
- While FFT remains the NHS's most visible source of patient feedback, there are other important national surveys such as Maternity, Adult Inpatient and Children and Young People. The Trust has paid to boost the sample size for these surveys beyond the mandated requirement to get a more balanced view of patient experience.

Responsible Director Update

- Free text comments are a rich source of insights and are used by wards, e.g. through the "You said, We did" posters. However, to manually tag (by theme and sentiment) and analyse 20,000+ comments a year is not realistic. The Trust has been selected for an NHS England Machine Learning text-mining pilot. This enables moving the discussion beyond headline figures to understanding the underlying themes, such as in the example above (Feb-21 data).
- The Trust is keen to ensure inclusion and share meaningful insights through the Inclusion Observatory. This starts with understanding the experiences of diverse patient populations.
- Given the diverse nature of the population served by the Trust, it has been decided to pilot offering the FFT in Bengali. If successful, this can be extended to other languages.





Site	No of Apologies	No of Incidents	Compliance
<b>Trust</b>	<b>37</b>	<b>42</b>	<b>88.1%</b>
Royal London	9	10	90.0%
Whipps Cross	13	14	92.9%
Newham	7	10	70.0%
St Bart's	8	8	100.0%
Other	0	0	N/A
Of Which CSS	0	0	N/A

Period	Apology Offered Within 2 Weeks	Patient Notification & Apology Offered	Written Notification	Support Offered	Further Enquiries Advised
Previous 6 Months	81.3%	100.0%	98.1%	98.1%	98.6%
This Period	88.1%	95.2%	95.2%	92.9%	97.6%

Performance Overview	Responsible Director Update
<ul style="list-style-type: none"> <li>Overall Trust performance improved to 88.1% in Feb-21, compared to 79.5% in Jan-21.</li> </ul>	<ul style="list-style-type: none"> <li>There was a significant deterioration in Duty of Candour performance after the first wave of the pandemic and a similar, but less severe, pattern is observed after the second wave.</li> <li>Performance in Feb-21 showed an improving picture and it is anticipated that this recovery will continue during the spring and summer of 2021. Note that this metric measures compliance with the Trust's internal target of 14 calendar days. Even when this target is missed, the legal Duty is complied with in most cases as the specified time-frame is "as soon as reasonably practicable".</li> </ul>

	Ref	Indicator	Exception Triggers			This Period	This Period Target	Performance			Site Comparison						Excep.
			Month Target	Step Change	Contl. Limit			Last Period	This Period	YTD	Royal London	Whipps Cross	Newham	St Bart's	CSS	Other	
Infection Control	S10	Clostridium difficile - Infection Rate	●			Mar-21 (m)	<= 16	19.8	23.4	15.8	24.7	15.7	22.0	38.3	-	-	●
	S11	Clostridium difficile - Incidence	●			Mar-21 (m)	<= 7	9	12	88	6	2	2	2	-	0	●
	S2	Assigned MRSA Bacteraemia Cases	●			Mar-21 (m)	<= 0	1	0	9	0	0	0	0	-	0	
	S77	MSSA Bacteraemias				Mar-21 (m)	SPC Breach	11	8	81	4	2	1	1	-	0	
	S76	E.coli Bacteraemia Bloodstream Infections	●			Mar-21 (m)	<= 8	11	16	151	9	1	0	6	-	0	●
Incidents	S3	Never Events	●			Mar-21 (m)	<= 0	0	1	12	0	1	0	0	-	0	●
	S09	% Incidents Resulting in Harm (Moderate Harm or More)	●			Mar-21 (m)	<= 0.9%	1.9%	1.7%	1.4%	1.3%	2.1%	1.3%	2.1%	-	-	
	S45	Falls Per 1,000 Bed Days	●			Mar-21 (m)	<= 4.8	4.4	3.7	4.2	4.0	3.7	3.0	3.7	-	-	
	S25	Medication Errors - Percentage Causing Harm	●			Mar-21 (m)	<= 4%	2.0%	2.3%	3.2%	3.0%	2.1%	1.3%	2.3%	-	-	
	S49	Patient Safety Incidents Per 1,000 Bed Days				Mar-21 (m)	SPC Breach	52.6	54.7	57.9	37.4	74.9	62.3	58.1	-	-	
	S53	Serious Incidents Closed in Time				Mar-21 (m)	>= 100%	100.0%	100.0%	39.3%	100.0%	-	100.0%	100.0%	-	-	

Serious Incidents Closed in Time: a clock stop has been applied by commissioners until the end of Mar-21

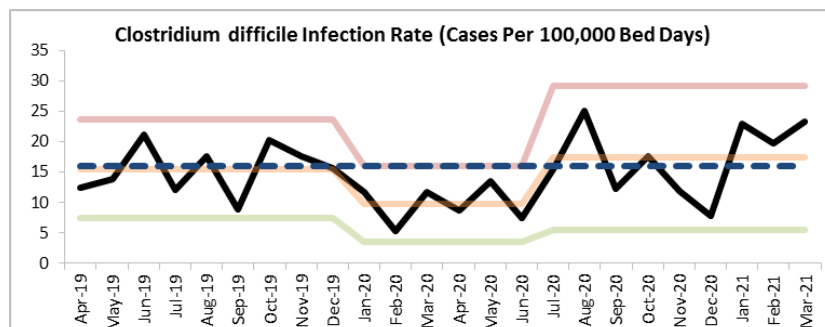
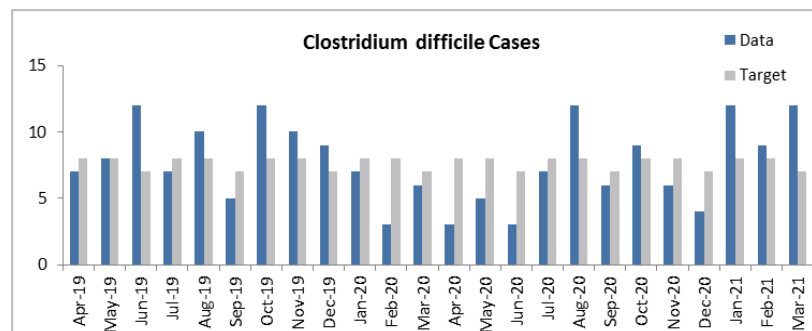
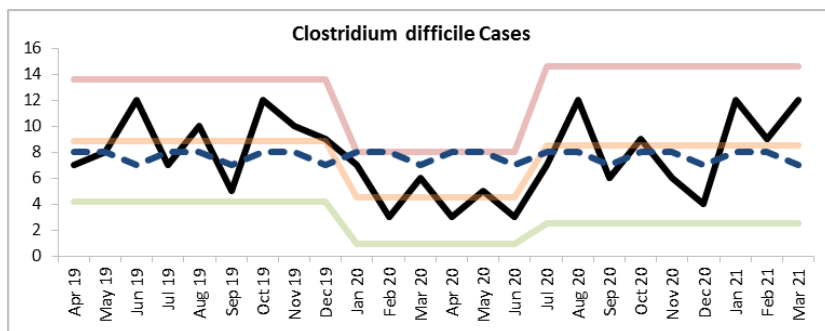
	Ref	Indicator	Exception Triggers			This Period	This Period Target	Performance			Site Comparison						Excep.
			Month Target	Step Change	Contl. Limit			Last Period	This Period	YTD	Royal London	Whipps Cross	Newham	St Bart's	CSS	Other	
Harm Free Care	S14	Pressure Ulcers Per 1,000 Bed Days	●			Mar-21 (m)	<= 0.6	1.6	1.0	1.3	0.7	1.1	1.5	1.4	-	-	
	S35	Pressure Ulcers (Device-Related) Per 1,000 Bed Days				Mar-21 (m)	SPC Breach	0.3	0.3	0.4	0.2	0.5	0.7	0.0	-	-	
	S17	Emergency C-Section Rate	●			Feb-21 (m)	<= 16.7%	17.7%	18.0%	18.6%	18.9%	19.4%	16.0%	-	-	-	
	S27	Patient Safety Alerts Overdue	●			Mar-21 (m)	<= 0	0	0	0	-	-	-	-	-	-	
Assess & Prevent	S36	VTE Risk Assessment	●			Mar-21 (m)	>= 95%	98.9%	98.5%	98.9%	98.7%	99.8%	98.2%	98.4%	-	24.2%	
	S5	Dementia - Screening				Feb-20 (m)	>= 90%	95.0%	95.5%	95.0%	93.4%	97.5%	96.8%	83.7%	-	-	
	S6	Dementia - Risk Assessment				Feb-20 (m)	>= 90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-	-	
	S7	Dementia - Referrals				Feb-20 (m)	>= 90%	73.3%	57.1%	86.4%	16.7%	100.0%	100.0%	0.0%	-	-	

Dementia metrics: Feb-20 performance from the last national submission before the temporary suspension of national reporting is the latest included in the report

SAFE

# Clostridium Difficile - Incidence

May-21



Site	Specialty	Location	No of Cases
Royal London	Gastroenterology	13C Ward	1
Royal London	General Medicine	11E Ward	1
Royal London	Neurosurgery	12E Ward	1
Royal London	Neurosurgery	4E Ward	1
Royal London	Respiratory Medicine	15C Ward	1
Royal London	Respiratory Medicine	4E Ward	1
Whipps Cross	Endocrinology	Curie Ward	1
Whipps Cross	Respiratory Medicine	Faraday Ward	1
Newham	General Surgery	East Ham Ward	1
Newham	General Surgery	West Ham Ward	1
St Bart's	Critical Care Medicine	1E Ward	1
St Bart's	Interventional Cardiology	3A Ward	1

## Performance Overview

- In 2020/21, the Trust had 88 healthcare associated cases reported against an objective of 92. This was an 8% decrease in the number of cases compared to last year (96).
- A review of all cases has not identified any direct links. The Trust has not had any outbreaks of Clostridium difficile during the past year.
- There has been an increase in antimicrobial usage throughout the year, likely linked to the national Covid-19 bundle. However, all cases were investigated as part of the post infection review (PIR) process and it was agreed that antimicrobial use was appropriate in all cases.
- Common themes continue to relate to poor documentation of stool charting, delay in the sending of stool specimens and isolating patients when they first present with symptoms of diarrhoea. Some of these have been impacted by the Covid-19 pandemic and require a re-focus in the coming months.

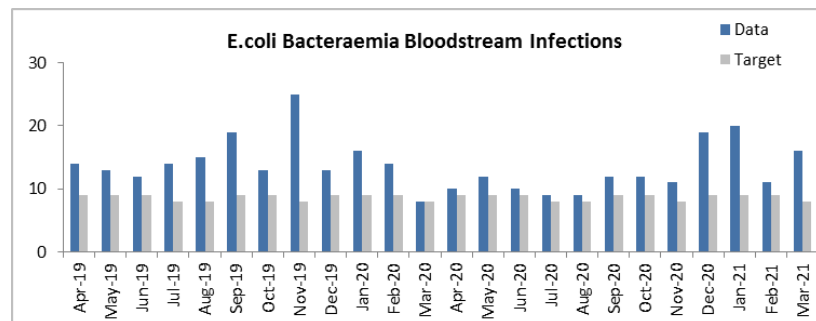
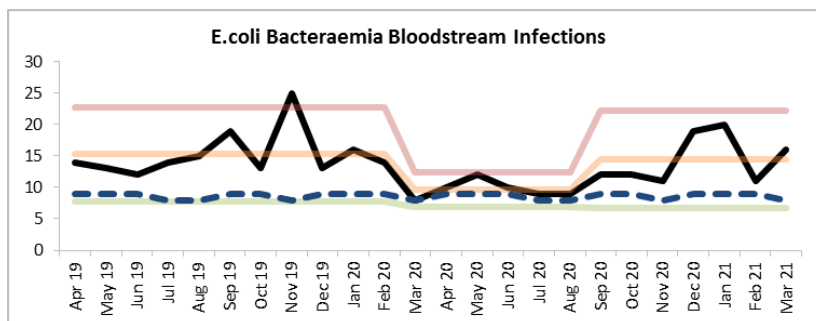
## Responsible Director Update

- Learning has been shared via multiple routes – Infection Prevention and Control (IPC) Committee, safety huddles and link practitioners programme. The controls will be cascaded in the Trust's IPC campaign over the next 6 months.

SAFE

# E.coli Bacteraemia Bloodstream Infections

May-21



Site	Location	Location Main Specialty	This Period
St Bart's	5D Ward	Clinical Haematology	5
Royal London	9F Ward	Nephrology	2
Royal London	13C Ward	General Surgery	2
Royal London	8F Ward	Obstetrics	2
Royal London	13D Ward	General Surgery	1
Royal London	11C Ward	General Medicine	1
Whipps Cross	Bracken Ward	Geriatric Medicine	1
Royal London	11E Ward	General Medicine	1
St Bart's	5B Ward	Medical Oncology	1

Site	Location	Location Main Specialty	Previous 6 Months	Mar-21
St Bart's	5D Ward	Clinical Haematology	13	5
Royal London	13C Ward	General Surgery	5	2
St Bart's	5A Ward	Medical Oncology	4	0
St Bart's	5C Ward	Clinical Haematology	3	0
Royal London	8D Ward	Paediatrics	3	0
Royal London	14E Ward	Geriatric Medicine	3	0

## Performance Overview

- In 2020/21, the Trust had 151 healthcare associated cases compared to 176 in 2019/20 (a 14% decrease).
- The source of cases continues to be associated with urinary tract infections (with and without catheters), hydration and hepatobiliary.
- The Trust also noted an increased incidence in its cancer patients at St Bart's; on review this may be associated with a change in the prophylactic antibiotic regime last year, where routine prescription of Ciprofloxacin for haematology-oncology patients was stopped.
- The Trust did not have any outbreaks of E.coli bacteraemias during the past year.

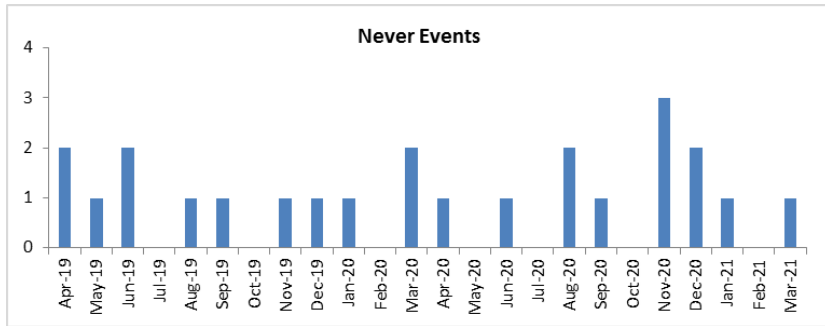
## Responsible Director Update

- There were delays in progression of the catheter care bundle due to the Covid-19 pandemic but the work on this is to due to be reviewed in the coming weeks.
- A review of the benefits of the Trust's agreed prophylactic antibiotic policy for its haematology-oncology patients will be carried out.

SAFE

# Never Events

May-21



Site	Specialty	Location	Never Event Type
Whipps Cross	General Medicine	High Dependency Unit (HDU)	Retained foreign object post-procedure

Never Event Type	Site	Number of Events
Retained foreign object post-procedure	Whipps Cross	2
Retained foreign object post-procedure	Newham	2
Retained foreign object post-procedure	St Bart's	1
Transfusion or transplantation of ABO –incompatible components or organs	Newham	1
Retained foreign object post-procedure	Royal London	1
Misplaced naso or oro-gastric tubes	Royal London	1
Unintentional connection of a patient requiring oxygen to an air flowmeter	Whipps Cross	1
Wrong route administration of medication	Whipps Cross	1
Wrong site surgery	Royal London	1
Unintentional connection of a patient requiring oxygen to an air flowmeter	St Bart's	1

Performance Overview	Responsible Director Update
<ul style="list-style-type: none"> <li>The Trust declared 12 never events in 2020/21. This compares to 12 in 2019/20, 13 in 2018/19, 8 in 2017/18, 12 in 2016/17 and 14 in 2015/16.</li> </ul>	<ul style="list-style-type: none"> <li>The last never event in 2020/21 occurred at Whipps Cross and concerned the simultaneous placement of two central venous catheters. Guide wires are used to place the catheters and one of these was left in the patient.</li> <li>Learning from this incident was shared with the other hospital sites regarding the need to use Local Safety Standard for Invasive Procedures (LocSSIPs) and undertake verbal checks to confirm that any wires inserted have been removed.</li> </ul>

	Ref	Indicator	Exception Triggers			This Period	This Period Target	Performance			Site Comparison						Excep.
			Month Target	Step Change	Contl. Limit			Last Period	This Period	YTD	Royal London	Whipps Cross	Newham	St Bart's	CSS	Other	
Mortality	E1	Summary Hospital-Level Mortality Indicator	●	●		Oct-20 (m)	<= 100	93	94	94	87	99	100	88	-	-	
	E3	Risk Adjusted Mortality Index	●			Feb-21 (m)	<= 100	69	69	69	67	70	78	60	-	-	
	E25	Number of Avoidable Deaths				2020/21 Q1 (q)	-	0	7	7	-	-	-	-	-	-	
Outcomes	0502	Cardiac Arrest 2222 Calls (Wards) Per 1,000 Admissions	●			Mar-21 (m)	<= 0.55	1.01	1.16	0.95	1.30	1.96	0.68	0.49	-	-	

Risk Adjusted Mortality Index metric is now adjusted for Covid-19 (i.e. confirmed or suspected cases of Covid-19 are not included).

Sepsis: it is not currently possible to accurately populate the metric "Sepsis 6 Antibiotic Administration (60 Mins)".

In the reporting period, two responses to Her Majesty's Coroner were sent following the issue of a Regulation 28 (Prevention of Future Deaths) notice.

#### Patient 1

##### Background

- A patient was admitted to Newham with a perforated colon and sepsis and required emergency surgery. Whilst receiving anaesthesia the patient was administered noradrenaline in error and subsequently suffered cardiac arrest. Despite attempts to resuscitate, the patient died.

##### Concerns Raised

- The patient was prescribed Tranexamic acid and noradrenaline, both drugs are supplied in glass ampoules which are similar in size, shape and colour. It would appear that one ampoule was mistaken for the other.
- A number of other environmental factors may have contributed to the error, by distracting the doctor involved

##### Actions and Learning

- Following this incident, a full comprehensive investigation was undertaken by the Trust. The report had a number of recommendations and from these a list of actions was produced. These include:
  - The introduction of pre-diluted/pre-filled vials/syringes of those high risk vasoactive drugs.
  - Tranexamic acid is now stored at a distance from all inotropes and vasoactive drugs in the anaesthetic room drug cupboards.
  - The MHRA (Medicines and Healthcare products Regulatory Agency) was contacted to report the incident, including details and photographs of packaging and vial similarities, with the request that the MHRA consider changes to packaging to make them more distinctive.
  - The physical environment has been reviewed and revised to provide a safe, clutter-free and organised environment for staff to work in.
  - Simulation training around the concept of a Sterile Cockpit has taken place with theatre teams.

#### Patient 2

##### Background

- A patient had a fall at home and was taken by ambulance to Newham. After the assessment, a treatment plan was agreed which included monitoring. Unfortunately, the patient's renal function was not closely monitored and the patient sustained an acute kidney injury. Following intensive treatment, the acute kidney injury resolved; however, the patient subsequently died.

##### Concerns Raised

- The patient was assessed to require renal monitoring, incorporating: a) Regular blood tests. b) A renal ultrasound. c) Fluid intake/output monitoring. The 3 actions were not undertaken for 4 days, after which it was discovered that the patient had deteriorated and had sustained Grade 3 acute kidney injury.
- The Trust's governance systems did not assess the case as a Serious Incident requiring investigation at the time of the incident, when lessons might have been learned sooner if this had happened.

##### Actions and Learning

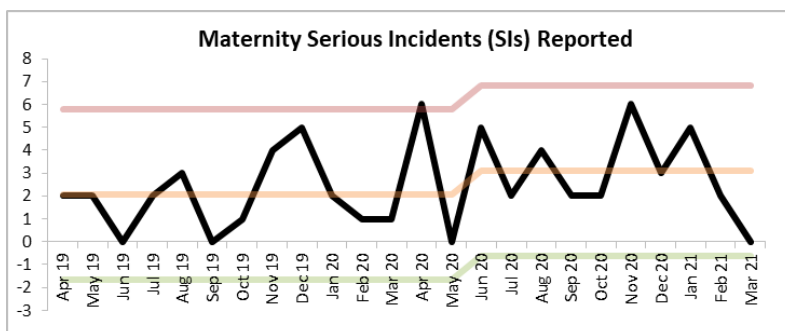
- There have been many changes to address poor handover and lack of knowledge around acute kidney injury at Newham since this incident occurred, including:
  - Establishing a second hospital site safety nurse role with a focus on deteriorating patients.
  - Implementation of the acute kidney injury bundle.
  - Standardised ward handover templates have been developed and are in use.



**SPOTLIGHT**

# Maternity Serious Incidents (SIs)

May-21



Theme	Royal London	Whipps Cross	Newham	Barts Health
<b>Total Number of SIs</b>	<b>13</b>	<b>11</b>	<b>36</b>	<b>60</b>
Of Which HSIB (Healthcare Safety Investigation Branch) Investigations	7	1	14	22
% HSIB Investigations	53.8%	9.1%	38.9%	36.7%

Theme	Royal London	Whipps Cross	Newham	Barts Health
<b>Total Number of SIs</b>	<b>13</b>	<b>11</b>	<b>36</b>	<b>60</b>
Neonatal - Unanticipated admission to Neonatal unit	2	2	8	12
Antenatal - Antepartum Stillbirth	2	2	6	10
Intrapartum - Retained vaginal swab/tampon	2	1	2	5
Neonatal - Other neonatal event	0	0	4	4
Intrapartum - Stillbirth	1	1	2	4

Action Type	Royal London	Whipps Cross	Newham	Barts Health
<b>Total Number of Actions</b>	<b>163</b>	<b>363</b>	<b>1,032</b>	<b>1,558</b>
Sharing the learning	28	124	172	324
Education and training	13	36	137	186
Review or update guidelines / documentation	22	38	119	179
Other action	8	4	144	156
Review / amend processes	31	10	113	154

**Progress Summary**

- No new serious incidents (SIs) were declared in Mar-21 and, due to the Covid-19 clock stop applied to SIs since 31/12/2020, there are no overdue SIs this quarter. Newham and Whipps Cross each reported 3 new SIs in the last quarter of 2020/21. An analysis has looked at the increased number of SIs at Newham. The number of referrals to the Healthcare Safety Investigation Branch (HSIB) and the maternal and neonatal outcomes are not disproportionate compared to the other two maternity units. However, the threshold for declaring a serious (rather than a moderate) incident is lower at Newham. Work is underway to strengthen the moderate incident investigation process, which will allow Newham reporting to become more in line with expectations.

**Noteworthy Improvements**

- No SIs related to antepartum stillbirth reported since Dec-19 for Whipps Cross and Jun-20 for Royal London.

**Risks & Issues**

- Antepartum and intrapartum stillbirths: a deep dive into stillbirths at Newham has been carried out as a comparison across the three maternity sites. The review was completed in Mar-21. Newham was not identified as having a disproportionately high number of stillbirths. However, the service is not utilising the concise reporting process (where appropriate) in addition to the SI process.
- Focus needed on closing SI actions more quickly at Newham and a more thematic approach to action plan setting there and at Royal London. The main themes from the SI actions are the focus on shared learning, proactive review of gaps in systems for provision of safe maternity care and staff education and learning in line with best practice.

**Next Steps**

- The focus is on SMART (Specific, Measurable, Achievable, Realistic, and Timely) action plan setting for Newham and Royal London to ensure uploading of all actions from the HSIB reports. Newham will continue its scrutiny of incidents which are being escalated as potential SIs.

May-21



# Finance Report



KEY METRICS

# Finance Key Metrics

May-21

	<i>Emillions</i>	<u>2020/21</u> Year To Date	
Pre Top-Up Surplus / (Deficit)	Budget	(233.2)	The Trust is reporting a pre top-up adverse variance of (£4.7m) for the full year against the Phase 3 plan submitted to NHSE/I in October.
	Actual	(237.9)	
	Variance	(4.7)	
NHS Reporting Post Top-Up Surplus/(Deficit)	Budget	(6.8)	The Trust position including system top-up is break-even, which is £6.8m favourable against the Phase 3 plan. The position includes £11.5m of additional top-up income recently notified by NHS England to support the Months 7-12 finance regime.
	Actual	0.0	
	Variance	6.8	
Total Income	Budget	1,876.1	Income is £24.4m favourable year to date against the Phase 3 plan. This includes the £11.5m of additional income for Months 7-12 finance regime and a further £9.6m income for re-imburement of the costs of activity against NHS England co-ordinated Independent Sector contracts, which are fully offset by the associated additional expenditure. Income in sites and services is (£5.5m) adverse against plan year to date with NHS Patient Treatment income adverse variance (£6.6m) for pass-through drugs, provider to provider activity and local authority activity, partially offset by a £1.0m favourable other income variance primarily relating to education and training income.
	Actual	1,900.5	
	Variance	24.4	
Total Expenditure	Budget	(1,882.9)	Expenditure is (£17.6m) adverse year to date against the Phase 3 plan. The adverse variance is driven by sites and services pay costs overspend (£6.4m year to date), primarily due to increased staffing associated with additional critical care capacity within the Queen Elizabeth Unit, and additional central expenditure notified by NHS England for Independent Sector contracts (£9.6m).
	Actual	(1,900.5)	
	Variance	(17.6)	
Capital Expenditure	Budget	85.1	The final funding from exchequer sources was £122.3m and the Trust's capital programme was £121.6m (excluding schemes funded by donated sources), which gives an underspend against the Capital Resourcing Limit of £0.7m. The Trust secured £6.2m of donated funds against the planned programme of £7.0m, and also incurred £6.2m of costs. For the year to date, expenditure relating to the Covid-19 response was £42.3m.
	Actual	121.6	
	Variance	36.5	
Cash	Plan	3.0	Cash balances are £51.2m higher than the plan of £3m, as a result of the movements in working capital. The Trust's capital and revenue loans (£593m) were converted to PDC in August and the balance of £0.4m capital loan was repaid in September. Following the debt conversion, dividends are now due to DHSC and £10.2m (based on the Trust's original plan) has been paid in year, with an expected refund due back to the Trust in 2021/22 of £4.8m.
	Actual	54.2	
	Variance	51.2	

**Key Issues**

A draft breakeven income and expenditure for the year (£6.8m favourable against the Phase 3 plan) has been reported to NHS England and is part of the delivery of an overall balanced position against the financial envelope for North East London ICS. This draft position will now be subject to external audit prior to adoption of the accounts by the Trust Board.

**INCOME &  
EXPENDITURE**

# Income & Expenditure - Trustwide

May-21

2019/20				Millions	2020/21				Annual Plan				
Year to Date					In Month								
Budget	Actual	Variance	%	Plan	Actual	Variance	%	Plan	Actual	Variance	%		
<b>Income</b>													
1,397.2	1,419.9	22.7	2 %	NHS Patient Treatment Income	128.0	125.5	(2.5)	(2)%	1,447.7	1,441.1	(6.6)	(0)%	1,447.7
26.2	5.8	(20.4)	(78)%	Other Patient Care Activity Income	0.1	(0.6)	(0.7)	(608)%	1.9	1.7	(0.2)	(9)%	1.9
120.2	124.8	4.6	4 %	Other Operating Income	10.0	10.6	0.6	6 %	109.4	110.6	1.2	1 %	109.4
<b>1,543.6</b>	<b>1,550.5</b>	<b>6.9</b>	<b>0 %</b>	<b>Total Income</b>	<b>138.2</b>	<b>135.6</b>	<b>(2.6)</b>	<b>(2)%</b>	<b>1,559.0</b>	<b>1,553.5</b>	<b>(5.5)</b>	<b>(0)%</b>	<b>1,559.0</b>
<b>Operating Expenditure</b>													
(954.0)	(968.8)	(14.8)	(2)%	Pay	(88.1)	(89.9)	(1.9)	(2)%	(1,038.8)	(1,045.2)	(6.4)	(1)%	(1,038.8)
(162.6)	(166.8)	(4.2)	(3)%	Drugs	(16.7)	(17.9)	(1.2)	(7)%	(178.8)	(172.7)	6.1	3 %	(178.8)
(138.7)	(145.2)	(6.5)	(5)%	Clinical Supplies	(11.5)	(11.3)	0.2	1 %	(137.6)	(137.0)	0.6	0 %	(137.6)
(255.4)	(265.6)	(10.2)	(4)%	Other Non Pay	(23.4)	(24.0)	(0.6)	(2)%	(298.0)	(299.9)	(1.9)	(1)%	(298.0)
<b>(1,510.8)</b>	<b>(1,546.5)</b>	<b>(35.7)</b>	<b>(2)%</b>	<b>Total Operating Expenditure</b>	<b>(139.7)</b>	<b>(143.2)</b>	<b>(3.5)</b>	<b>(3)%</b>	<b>(1,653.2)</b>	<b>(1,654.8)</b>	<b>(1.6)</b>	<b>(0)%</b>	<b>(1,653.2)</b>
<b>32.9</b>	<b>4.0</b>	<b>(28.8)</b>	<b>(88)%</b>	<b>Site &amp; Services Budgets Total</b>	<b>(1.5)</b>	<b>(7.6)</b>	<b>(6.1)</b>	<b>(407)%</b>	<b>(94.2)</b>	<b>(101.3)</b>	<b>(7.1)</b>	<b>(8)%</b>	<b>(94.2)</b>
-	-	-	- %	Nightingale Hospital & Vaccination (net)	-	(0.1)	(0.1)	- %	(30.8)	(30.8)	0.1	0 %	(30.8)
(0.0)	11.9	11.9	- %	Research & Development (net)	(0.5)	0.8	1.3	253 %	(3.2)	(0.1)	3.1	96 %	(3.2)
(32.4)	(20.5)	11.9	37 %	Central NHS PT Income	(0.9)	8.5	9.4	1033 %	24.9	36.8	12.0	48 %	24.9
				Independent Sector Contracts Expenditure		(4.0)	(4.0)	- %		(9.6)	(9.6)	- %	
11.1	8.5	(2.6)	(23)%	Central RTA & OSV Income (net)	0.3	(6.0)	(6.3)	(2061)%	1.1	(5.4)	(6.5)	(608)%	1.1
0.1	(8.6)	(8.7)	(15283)%	Central Expenditure (net)	0.0	2.6	2.5	5676 %	(3.7)	(6.9)	(3.2)	(88)%	(3.7)
(1.6)	(1.9)	(0.3)	(17)%	Reserves (net)	(1.1)	0.1	1.2	106 %	0.5	1.9	1.4	296 %	0.5
<b>10.0</b>	<b>(6.5)</b>	<b>(16.5)</b>	<b>(165)%</b>	<b>EBITDA</b>	<b>(3.7)</b>	<b>(5.8)</b>	<b>(2.1)</b>	<b>(58)%</b>	<b>(105.5)</b>	<b>(115.4)</b>	<b>(9.9)</b>	<b>(9)%</b>	<b>(105.5)</b>
(49.5)	(46.4)	3.1	6 %	Depreciation and Amortisation (net)	(4.7)	(4.9)	(0.2)	(5)%	(52.6)	(52.6)	0.0	0 %	(52.6)
(79.1)	(75.1)	4.0	5 %	Interest	(5.8)	(6.0)	(0.2)	(4)%	(64.8)	(64.5)	0.3	0 %	(64.8)
-	-	-	- %	PDC Dividends	(0.9)	4.0	4.9	541 %	(10.2)	(5.4)	4.8	47 %	(10.2)
<b>(118.7)</b>	<b>(128.1)</b>	<b>(9.4)</b>	<b>(8)%</b>	<b>Pre Top-Up Surplus/(Deficit)</b>	<b>(15.0)</b>	<b>(12.7)</b>	<b>2.3</b>	<b>15 %</b>	<b>(233.2)</b>	<b>(237.9)</b>	<b>(4.7)</b>	<b>(2)%</b>	<b>(233.2)</b>
53.3	53.3	-	- %	PSF, FRF & System Top-Up Income	11.6	17.5	5.9	100 %	143.1	154.6	11.5	- %	143.1
-	-	-	- %	Retrospective Top-Up Income	-	-	-	100 %	83.3	83.3	-	- %	83.3
<b>(65.4)</b>	<b>(74.8)</b>	<b>(9.4)</b>	<b>(14)%</b>	<b>NHS Reporting Surplus/(Deficit)</b>	<b>(3.4)</b>	<b>4.8</b>	<b>8.2</b>	<b>240 %</b>	<b>(6.8)</b>	<b>0.0</b>	<b>6.8</b>	<b>100 %</b>	<b>(6.8)</b>
	1.7			Profit On Fixed Asset Disposal		0.0				0.1			
	(1.4)			Capital Donations I&E Impact		0.4				2.6			
	(1.8)			Fixed Asset Impairments		(15.3)				(15.3)			
				Month 12 Technical Adjustments - Income*		87.2				87.2			
				Month 12 Technical Adjustments- Expenditure*		(77.1)				(77.1)			
	<b>(74.5)</b>			<b>Surplus / (Deficit)</b>		<b>(0.0)</b>				<b>(2.5)</b>			

\* NHS England funded month 12 technical adjustments are: increase in A/L accrual £15.0m, additional pension contributions £39.4m, consumables (PPE) donated by DHSC for COVID response £22.4m, equipment donated by DHSC for COVID response £10.1m and outcome of legal case A/L payment for overtime (Flowers) £0.3m.

2019/20				2020/21				2020/21								
Year to Date				In Month				Year to Date				Year End				
Budget	Actual	Variance	%	Programme Area	Budget	Actual	Variance	%	Budget	Actual	Variance	%	Capital Plan	Capital Forecast	Variance	%
19.6	18.3	1.3	7 %	Equipment (Medical and Other)	0.7	10.7	(9.9)	(1342)%	12.7	18.0	(5.3)	(42)%	10.6	18.0	(7.4)	(70)%
11.3	12.1	(0.8)	(8)%	Informatics	1.8	6.1	(4.4)	(250)%	11.9	13.3	(1.4)	(12)%	11.6	13.3	(1.7)	(15)%
17.1	12.8	4.3	25 %	Estates	1.0	6.8	(5.8)	(558)%	9.3	23.4	(14.1)	(151)%	8.8	23.4	(14.6)	(166)%
10.0	8.0	2.1	21 %	New Build and Site Vacations	1.8	1.2	0.6	32 %	28.5	15.8	12.6	44 %	31.4	15.8	15.5	50 %
9.2	9.2	0.0	0 %	PFI Lifecycle Assets	0.7	0.7	0.0	0 %	8.7	8.7	0.0	0 %	8.7	8.7	0.0	0 %
<b>67.2</b>	<b>61.0</b>	<b>6.2</b>	<b>9 %</b>	<b>Total Exchequer Programme exc Covid 19</b>	<b>6.0</b>	<b>25.5</b>	<b>(19.5)</b>	<b>(323)%</b>	<b>71.1</b>	<b>79.3</b>	<b>(8.2)</b>	<b>(12)%</b>	<b>71.1</b>	<b>79.3</b>	<b>(8.2)</b>	<b>(12)%</b>
-	-	-	-	Covid - Equipment/other	-	(0.6)	0.6	-	14.0	11.8	2.2	0.0	14.0	11.8	2.2	0.0
-	-	-	-	Covid 19 - 14/15th Floor	-	0.4	(0.4)	-	-	22.0	(22.0)	-	-	22.0	(22.0)	-
-	-	-	-	Covid 19 - Cyber Security	-	-	-	-	-	0.0	(0.0)	-	-	0.0	(0.0)	-
-	-	-	-	Covid 19 Expenditure - UEC	-	0.5	(0.5)	-	-	5.7	(5.7)	-	-	5.7	(5.7)	-
-	-	-	-	Covid 19 - Endoscopy recovery	-	-	-	-	-	1.6	(1.6)	-	-	1.6	(1.6)	-
-	-	-	-	Covid 19 - Adapt and Adopt (Diagnostic element)	-	0.1	(0.1)	-	-	0.2	(0.2)	-	-	0.2	(0.2)	-
-	-	-	-	Covid 19 - ECMO	-	-	-	-	-	0.2	(0.2)	-	-	0.2	(0.2)	-
-	-	-	-	Covid 19 - Restart	-	0.2	(0.2)	-	-	0.9	(0.9)	-	-	0.9	(0.9)	-
-	-	-	-	<b>Total Covid-19</b>	-	<b>0.7</b>	<b>(0.7)</b>	<b>-</b>	<b>14.0</b>	<b>42.3</b>	<b>(28.3)</b>	<b>(202)%</b>	<b>14.0</b>	<b>42.3</b>	<b>(28.3)</b>	<b>(202)%</b>
<b>63.5</b>	<b>62.6</b>	<b>0.9</b>	<b>1 %</b>	<b>Total Trust Funded Assets</b>	<b>6.0</b>	<b>26.2</b>	<b>(20.2)</b>	<b>(335)%</b>	<b>85.1</b>	<b>121.6</b>	<b>(36.5)</b>	<b>(43)%</b>	<b>85.1</b>	<b>121.6</b>	<b>(36.5)</b>	<b>(43)%</b>
6.3	2.6	3.6	58 %	Donated	0.6	0.7	(0.1)	(20)%	7.0	6.2	0.8	11 %	7.0	6.2	0.8	11 %
<b>69.8</b>	<b>65.3</b>	<b>4.5</b>	<b>6 %</b>	<b>Total Capital Expenditure</b>	<b>6.6</b>	<b>26.9</b>	<b>(20.3)</b>	<b>(307)%</b>	<b>92.1</b>	<b>127.8</b>	<b>(35.7)</b>	<b>(39)%</b>	<b>92.1</b>	<b>127.8</b>	<b>(35.7)</b>	<b>(39)%</b>

**Key Messages**

The final funding from exchequer funded sources was £122.3m which takes account of the planned reduction of £10.7m relating to the handing back of the unused funding for the WXH redevelopment programme caused by covid-related programme slippage. Setting the funding of £122.3m against the outturn level of expenditure of £121.6m gives an underspend against the Capital Resource Limit of £0.7m. Even were it not for the doubling in size of the programme this year and the complexity caused by covid, this is a strong performance. Against the planned donated programme of £7.0m, the Trust secured £6.2m of funds and incurred £6.2m of cost.

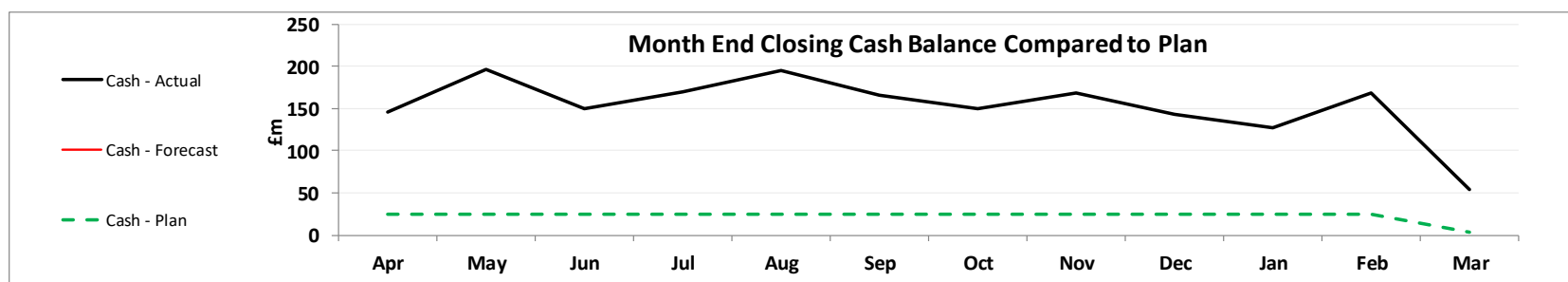
At the January meeting, the Investment Steering Committee agreed to bring forward a number of schemes from 2021/22 to ensure that the 2020/21 capital funding is fully used. The capital team worked with procurement colleagues and scheme owners to ensure that schemes were delivered and expenditure incurred whilst remaining within the funding limits.

Expenditure on (non-covid related) exchequer funded schemes in the month was £25.5m (M11: £8.8m). The cumulative exchequer expenditure (excluding Covid-19 related costs) at Month 12 was £79.3m (£53.9, M11).

The cumulative expenditure relating to funds from covid sources was £42.3m (M11: £41.5m).

	Funding			
	Capital Plan	Secured	Not Yet Secured	% Secured
Gross Depreciation	52.2	52.2	-	100 %
Repayment of PFI Finance Lease	(24.0)	(24.0)	-	100 %
Repayment of Loans / Other Finance Leases	(2.4)	(2.4)	-	100 %
<b>Net Depreciation</b>	<b>25.8</b>	<b>25.8</b>	<b>-</b>	<b>100 %</b>
NHSI Financing	32.6	32.6	-	100 %
Specific PDC: NHS Energy Efficiency Fund	0.6	0.6	-	100 %
Specific PDC: WXH Redevelopment	8.0	8.0	-	- %
Specific PDC: Helipad	-	-	-	- %
Other PDC: CIR	4.5	4.5	-	- %
Specific PDC: Covid 19 response	12.2	12.2	-	100 %
Specific PDC: Covid 19 UEC	6.4	6.4	-	100 %
Specific PDC: Covid 19 Endoscopy recovery	2.2	2.2	-	100 %
Specific PDC: Adapt and Adopt (Diagnostic element)	0.3	0.3	-	100 %
Specific PDC: Covid 19 Cyber Security	0.1	0.1	-	100 %
Specific PDC: Covid 19 14/15th Floor	20.0	20.0	-	100 %
Covid 19 14/15th Floor CDEL	4.4	4.4	-	100 %
Covid 19 - ECMO	0.1	0.1	-	100 %
Specific PDC: Covid 19 NHS Restart	1.1	1.1	-	100 %
Specific PDC: HSL1	1.1	1.1	-	100 %
Specific PDC: Dentistry Undergrads	1.2	1.2	-	100 %
Specific PDC: Rapid Testing	0.0	0.0	-	100 %
Other: NUH 2nd CT	1.5	1.5	-	100 %
<b>Planned Capital exc. Donated</b>	<b>122.0</b>	<b>122.0</b>	<b>-</b>	<b>100 %</b>
Asset Sales	0.4	0.4	-	- %
<b>Total Exchequer Funding</b>	<b>122.3</b>	<b>122.3</b>	<b>-</b>	<b>100 %</b>
Donated	7.0	6.2	0.8	88 %
<b>Planned Capital inc. Donated</b>	<b>129.3</b>	<b>128.5</b>	<b>0.8</b>	<b>99 %</b>

	Apr £m	May £m	Jun £m	Jul £m	Aug £m	Sep £m	Oct £m	Nov £m	Dec £m	Jan £m	Feb £m	Mar £m	Total £m
<b>Opening cash at bank</b>	<b>3.3</b>	<b>146.1</b>	<b>196.0</b>	<b>150.3</b>	<b>170.4</b>	<b>195.3</b>	<b>165.5</b>	<b>150.3</b>	<b>168.1</b>	<b>143.9</b>	<b>126.9</b>	<b>169.1</b>	<b>3.3</b>
<b>Cash inflows</b>													
Healthcare contracts	260.3	146.2	117.7	120.2	116.6	118.9	120.3	131.3	131.6	149.0	149.6	52.1	1,613.8
Other income	35.7	51.4	36.3	54.6	53.8	40.0	18.3	38.3	33.5	4.8	38.2	18.1	423.0
Financing - Interim Working Capital Loan	-	-	-	-	-	-	-	-	-	-	-	-	-
Financing - Capital Loans / PDC	-	-	-	0.1	592.8	-	-	-	-	-	-	90.2	683.1
<b>Total cash inflows</b>	<b>296.0</b>	<b>197.6</b>	<b>154.0</b>	<b>174.9</b>	<b>763.2</b>	<b>158.9</b>	<b>138.6</b>	<b>169.6</b>	<b>165.1</b>	<b>153.8</b>	<b>187.8</b>	<b>160.4</b>	<b>2,719.9</b>
<b>Cash outflows</b>													
Salaries and wages	(49.0)	(52.2)	(49.7)	(50.7)	(48.1)	(48.8)	(50.4)	(49.4)	(51.5)	(52.2)	(54.8)	(54.1)	(610.9)
Tax, NI and pensions	(16.0)	(36.6)	(37.6)	(36.6)	(37.0)	(36.9)	(37.5)	(36.6)	(38.8)	(37.3)	(39.1)	(78.8)	(468.8)
Non pay expenditures	(70.0)	(50.0)	(104.5)	(63.2)	(55.2)	(95.7)	(57.7)	(52.5)	(93.2)	(74.0)	(45.9)	(124.7)	(886.6)
Capital expenditure	(18.2)	(8.9)	(7.9)	(4.3)	(2.8)	(6.9)	(8.2)	(8.4)	(5.8)	(7.3)	(5.8)	(12.4)	(96.9)
Dividend and Interest payable	-	-	-	-	(2.4)	-	-	(4.9)	-	-	-	(5.3)	(12.6)
Financing - Loan repayments	-	-	-	-	(592.8)	(0.4)	-	-	-	-	-	-	(593.2)
<b>Total cash outflows</b>	<b>(153.2)</b>	<b>(147.7)</b>	<b>(199.7)</b>	<b>(154.8)</b>	<b>(738.3)</b>	<b>(188.7)</b>	<b>(153.8)</b>	<b>(151.8)</b>	<b>(189.3)</b>	<b>(170.8)</b>	<b>(145.6)</b>	<b>(275.3)</b>	<b>(2,669.0)</b>
<b>Net cash inflows / (outflows)</b>	<b>142.8</b>	<b>49.9</b>	<b>(45.7)</b>	<b>20.1</b>	<b>24.9</b>	<b>(29.8)</b>	<b>(15.2)</b>	<b>17.8</b>	<b>(24.2)</b>	<b>(17.0)</b>	<b>42.2</b>	<b>(114.9)</b>	<b>50.9</b>
<b>Closing cash at bank - actual / forecast</b>	<b>146.1</b>	<b>196.0</b>	<b>150.3</b>	<b>170.4</b>	<b>195.3</b>	<b>165.5</b>	<b>150.3</b>	<b>168.1</b>	<b>143.9</b>	<b>126.9</b>	<b>169.1</b>	<b>54.2</b>	<b>54.2</b>
<b>Closing cash at bank - plan</b>	<b>25.0</b>	<b>25.0</b>	<b>25.0</b>	<b>25.0</b>	<b>25.0</b>	<b>25.0</b>	<b>25.0</b>	<b>25.0</b>	<b>25.0</b>	<b>25.0</b>	<b>25.0</b>	<b>3.0</b>	<b>3.0</b>



### Key Messages

Cash balances are higher by £51.2m compared to the plan of £3m, as a result of the movements in working capital. The Trust's capital and revenue loans (£593m) were converted to PDC in August and the balance of £0.4m capital loan was repaid in September. Following the debt conversion, PDC dividend is due to DHSC, and £10.2m (based on our original plan) has been paid in the year, with an expected refund due back to the Trust in 2021/22 of £4.8m.

# Statement of Financial Position

May-21

2019/20 Balance as 31 Mar 2020 £m	2020/21												Movement 2019/20 v 2020/21 £m
	Act Apr	Act May	Act Jun	Act Jul	Act Aug	Act Sep	Act Oct	Act Nov	Act Dec	Act Jan	Act Feb	Act Mar	
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
<b>1,389.7</b>	<b>Non-current assets:</b>												
0.1	1,402.9	1,410.7	1,413.9	1,414.8	1,413.6	1,418.1	1,421.1	1,424.0	1,430.2	1,435.1	1,439.3	1,388.7	(1.0)
13.4	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0
	13.6	13.7	13.7	13.7	13.7	13.7	13.6	13.6	13.7	13.8	13.9	15.8	2.4
<b>1,403.2</b>	<b>1,416.6</b>	<b>1,424.5</b>	<b>1,427.7</b>	<b>1,428.6</b>	<b>1,427.4</b>	<b>1,431.9</b>	<b>1,434.8</b>	<b>1,437.7</b>	<b>1,444.0</b>	<b>1,449.0</b>	<b>1,453.3</b>	<b>1,404.6</b>	<b>1.4</b>
	<b>Current assets:</b>												
23.4	25.3	24.9	24.6	23.8	23.0	23.5	23.1	23.1	23.8	23.5	23.2	22.0	(1.4)
193.7	200.6	168.3	198.3	183.6	150.9	167.0	164.4	161.7	188.5	164.5	143.3	128.1	(65.6)
3.3	146.1	196.0	150.3	170.4	195.3	165.5	150.3	168.1	143.9	126.9	169.1	54.2	50.9
<b>220.4</b>	<b>372.0</b>	<b>389.2</b>	<b>373.2</b>	<b>377.8</b>	<b>369.2</b>	<b>356.0</b>	<b>337.8</b>	<b>352.9</b>	<b>356.2</b>	<b>314.9</b>	<b>335.6</b>	<b>204.3</b>	<b>(16.1)</b>
<b>1,623.6</b>	<b>1,788.6</b>	<b>1,813.7</b>	<b>1,800.9</b>	<b>1,806.4</b>	<b>1,796.6</b>	<b>1,787.9</b>	<b>1,772.6</b>	<b>1,790.6</b>	<b>1,800.2</b>	<b>1,763.9</b>	<b>1,788.9</b>	<b>1,608.9</b>	<b>(14.7)</b>
	<b>Current liabilities</b>												
(185.9)	(355.1)	(382.9)	(372.0)	(380.1)	(373.9)	(374.0)	(356.9)	(377.2)	(394.6)	(362.4)	(385.9)	(176.7)	9.2
(5.3)	(2.1)	(2.1)	(2.1)	(2.1)	(2.1)	(2.1)	(2.1)	(2.1)	(2.1)	(2.1)	(2.1)	(4.1)	1.2
(26.0)	(26.0)	(26.1)	(26.0)	(26.0)	(28.4)	(26.0)	(26.0)	(26.0)	(26.0)	(26.0)	(26.0)	(26.8)	(0.8)
(536.6)	(536.7)	(536.7)	(536.7)	(536.7)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	536.6
(59.0)	(58.9)	(58.9)	(58.9)	(58.9)	(0.4)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	59.0
<b>(812.8)</b>	<b>(978.8)</b>	<b>(1,006.7)</b>	<b>(995.7)</b>	<b>(1,003.8)</b>	<b>(404.8)</b>	<b>(402.1)</b>	<b>(385.0)</b>	<b>(405.3)</b>	<b>(422.7)</b>	<b>(390.5)</b>	<b>(414.0)</b>	<b>(207.6)</b>	<b>605.2</b>
<b>(592.4)</b>	<b>(606.8)</b>	<b>(617.5)</b>	<b>(622.5)</b>	<b>(626.0)</b>	<b>(35.6)</b>	<b>(46.1)</b>	<b>(47.2)</b>	<b>(52.4)</b>	<b>(66.5)</b>	<b>(75.6)</b>	<b>(78.4)</b>	<b>(3.3)</b>	<b>589.1</b>
<b>810.8</b>	<b>809.8</b>	<b>807.0</b>	<b>805.2</b>	<b>802.6</b>	<b>1,391.8</b>	<b>1,385.8</b>	<b>1,387.6</b>	<b>1,385.3</b>	<b>1,377.5</b>	<b>1,373.4</b>	<b>1,374.9</b>	<b>1,401.3</b>	<b>590.5</b>
	<b>Non-current liabilities</b>												
(13.9)	(13.8)	(13.8)	(13.7)	(13.6)	(13.5)	(13.4)	(13.3)	(13.2)	(13.1)	(13.0)	(13.0)	(17.6)	(3.7)
(968.0)	(966.2)	(964.2)	(962.2)	(959.7)	(955.8)	(949.4)	(949.1)	(948.6)	(942.7)	(942.6)	(942.5)	(941.2)	26.8
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>(981.9)</b>	<b>(980.0)</b>	<b>(978.0)</b>	<b>(975.9)</b>	<b>(973.3)</b>	<b>(969.3)</b>	<b>(962.8)</b>	<b>(962.4)</b>	<b>(961.8)</b>	<b>(955.8)</b>	<b>(955.6)</b>	<b>(955.5)</b>	<b>(958.8)</b>	<b>23.1</b>
<b>(171.1)</b>	<b>(170.2)</b>	<b>(171.0)</b>	<b>(170.7)</b>	<b>(170.7)</b>	<b>422.5</b>	<b>423.0</b>	<b>425.2</b>	<b>423.5</b>	<b>421.7</b>	<b>417.8</b>	<b>419.4</b>	<b>442.5</b>	<b>613.6</b>
	<b>Financed by:</b>												
	<b>Taxpayers' equity</b>												
342.0	343.0	342.1	342.1	342.2	935.0	935.0	935.0	935.0	935.0	935.0	935.1	1,025.3	683.3
(851.4)	(851.5)	(851.4)	(851.1)	(851.2)	(850.8)	(850.3)	(848.1)	(849.8)	(851.6)	(855.5)	(854.0)	(853.9)	(2.5)
338.3	338.3	338.3	338.3	338.3	338.3	338.3	338.3	338.3	338.3	338.3	338.3	271.1	(67.2)
<b>(171.1)</b>	<b>(170.2)</b>	<b>(171.0)</b>	<b>(170.7)</b>	<b>(170.7)</b>	<b>422.5</b>	<b>423.0</b>	<b>425.2</b>	<b>423.5</b>	<b>421.7</b>	<b>417.8</b>	<b>419.4</b>	<b>442.5</b>	<b>613.6</b>

May-21



# People Report





Group	Indicator	Targets	Performance		YTD	Mar-21 (Site)				
		Target	Feb-21	Mar-21		Royal London	Whipps Cross	Newham	St Bart's	CSS
Planned vs Actual WTE	% Utilisation (Total Fill Rate)	<=100%	101.5%	103.7%	-	105.9%	101.9%	110.2%	98.7%	103.0%
	Staff in Post - Actual	>=Plan	15,917	15,937		5,358	2,485	1,847	2,300	1,998
	Staff in Post - Plan	-	15,774	15,817	-	5,383	2,428	1,797	2,287	1,996
	Bank WTE - Actual	<=Plan	2,018	2,237		768	407	429	273	229
	Bank WTE - Plan	-	2,078	2,085	-	626	437	358	370	230
	Agency WTE - Actual	<=Plan	400	502		91	136	125	24	80
	Agency WTE - Plan	-	480	480	-	82	173	73	42	94
	Total Staffing - Actual	<=Plan	18,334	18,677	-	6,217	3,028	2,402	2,597	2,306
	Total Staffing - Plan	-	18,333	18,383	-	6,091	3,039	2,229	2,698	2,320
Recruitment Plans	Substantive Fill Rate - Actual	<=Plan	93.7%	93.8%	-	97.6%	91.2%	92.0%	92.1%	91.6%
	Substantive Fill Rate - Plan	-	-	-	-	-	-	-	-	-
	Unconditional Offers - Actual	>=Plan	297	361	3,993	130	51	47	57	43
	Unconditional Offers - Plan	-	394	402	4,026	169	18	30	74	62
Rosters	Roster Compliance - % Approved on Time (>20 WTEs)	>=100%	38.8%	31.1%	-	40.0%	27.6%	9.5%	36.8%	-
	Nursing Roster Quality - % Blue or Cloudy Sky	-	38.2%	24.1%	-	21%	25%	30%	20%	-
	Additional Duty Hours (Nursing)	-	72,199	70,471	-	23,298	13,665	26,099	6,777	139
Diversity	% of BME Staff at Band 8a to VSM	TBC	35.1%	35.3%		29%	43%	56%	22%	40%

Target for % Utilisation (Total Fill Rate)	95% to 100%	<95%	>100%
Target for Staff in Post Actual Against Plan (% Variance)	>=0%	Between 0% and -5%	<=-5%
Targets for Bank, Agency and Total Staffing Actual Against Plan (% Variance)	<=-5%	Between 0% and -5%	>=0%
Target for Unconditional Offers Actual Against Plan (% Variance)	>=0%	Between 0% and -10%	<=-10%
Target for Roster Compliance - % Approved on Time (>20 WTEs)	>=100%	Between 90% and 100%	<=90%

Notes: YTD figures for workforce metrics are only shown where appropriate

**Looking After the Trust's People – Staff Vaccination (COVID-19), Sickness Absence Rates and Appraisal Rates**

- **Staff vaccination rates for Covid-19** are now amongst the highest in London and the Trust is “buddying” with another Hospital Trust to share learning.
- **Sickness absence rates** have increased slightly from 4.77% in Jan-21 to 4.81% in Feb-21 (annualised) but are still well below the in-month peak in Jan-21 which was 6.14%. COVID-19 related sickness absence has reduced from 3.03% at the peak to 0.41% at the end of Mar-21.
- **Appraisal rates** across medical and non-medical staff groups remain very challenged at 35% and 74% respectively. For non-medical appraisals there has been a small increase in month, covered in more detail on the exception page below. For medical appraisals, the process was relaunched in Mar-21, and this is reflected in an increase from 69% reported for Feb-21.

**We Belong**

- At present 35.3% of the Trust's Band 8A+ staff are from a Black, Asian and Minority Ethnic (BAME) background. The senior recruitment process put in place to ensure candidates from all backgrounds have an opportunity to apply for these roles is currently being reviewed now that 6 months have passed, to understand what lessons can be learnt to enhance this process further.

**New Ways of Working – Rostering**

- Roster approval compliance (rosters approved six weeks in advance) reduced to 31% from 39%, with all hospital sites at 40% or below. 42% of rosters were approved at least five weeks in advance and 61% four weeks in advance .
- Roster quality reporting indicates that just 24% of rosters that were due for approval in Mar-21 were of good or high quality across the domains of budget, fairness, safety, unavailability, effectiveness and annual leave. This is significantly affected by the low level of timely approval.

**Growing the Workforce – Recruitment, Temporary Staffing and Turnover**

- **Recruitment** – in Mar-21, 361 Whole Time Equivalent (WTE) unconditional offers were made in comparison to 297 in Feb-21. Across the last 12 months, 3,993 unconditional offers have been made which represents over 99% of planned recruitment.
- In the first round of the bulk HCSW (healthcare support workers) recruitment campaign, the Trust has successfully offered to 46 candidates against 51 vacancies identified. A further 77 candidates have been identified to form part of a talent pool for future appointments.
- Changes to countries on the red list delayed a cohort of new staff recruited from India and the Philippines whilst quarantine rules were clarified. They will now arrive at the end of Apr-21.
- The Trust's substantive staff fill rate in Mar-21 was at 93.8% with all hospital sites above a 91% fill rate. There has been an increase of 20 WTE. This position is above plan by 120 WTE, in part due student nurses, but also fixed term contracts supporting the vaccination centre at the ExCeL.
- **Temporary Staffing** – temporary staffing usage increased by 320 WTE compared to Feb-21, with the proportion of temporary staff as part of the workforce increasing from 13.1% to 14.6%. This is largely a reflection of 3 additional days in Mar-21 compared to Feb-21.
- **Turnover** – Annualised Voluntary Turnover is at a record low at 8.9% and is likely to be significantly impacted by the pandemic, both due to the reduced recruitment market (many organisations reduced their overall level of recruitment) and increased loyalty whilst supporting colleagues across the Trust. There is a recognition across Chief Nurses in London that these rates may be suppressed and it could be expected to see these rates increase, both as the labour market continues to improve but also with the risk of burnt-out colleagues leaving the NHS.

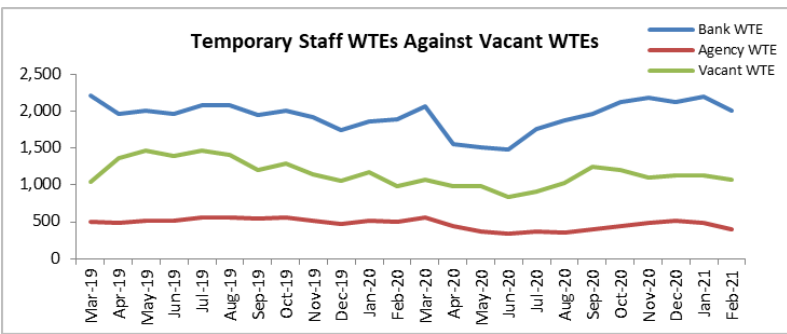
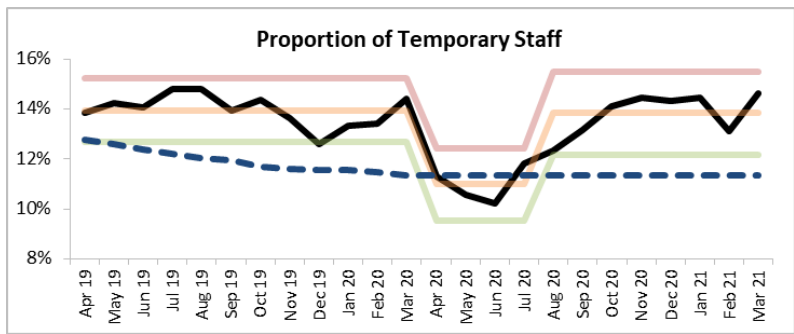
	Ref	Indicator	Exception Triggers			Performance			Site Comparison						Excep.		
			Month Target	Step Change	Contl. Limit	This Period	This Period Target	Last Period	This Period	YTD	Royal London	Whipps Cross	Newham	St Bart's		CSS	Other
People	W19	Turnover Rate	●			Mar-21 (m)	<= 12.25%	9.03%	8.91%	8.91%	8.84%	7.27%	7.61%	9.83%	10.99%	9.02%	
	OH7	Proportion of Temporary Staff	●			Mar-21 (m)	<= 11.3%	13.1%	14.6%	12.9%	13.8%	17.8%	23.0%	11.4%	13.4%	8.2%	●
	W20	Sickness Absence Rate	●			Feb-21 (m)	<= 3%	4.77%	4.81%	4.81%	4.77%	5.60%	6.08%	4.19%	3.93%	4.39%	●
Staff Feedback	C6	Staff FFT Percentage Recommended - Care				2019/20 Q4 (q)	>= 70%	77.2%	79.8%	78.3%	84.8%	79.3%	75.4%	91.8%	72.3%	73.1%	
	OH6	NHS Staff Survey	●			2020/21 (y)	>= 7	7.0	6.9	6.9	7.0	6.8	6.9	7.1	6.7	7.0	
Compliance	W50	Mandatory and Statutory Training - All	●			Mar-21 (m)	>= 85%	84.1%	84.6%	86.0%	84.2%	88.5%	83.4%	83.7%	85.6%	80.6%	●
	W11	Mandatory and Statutory Training - National	●	●		Mar-21 (m)	>= 85%	83.3%	84.2%	85.4%	84.1%	87.8%	83.6%	81.9%	85.8%	81.2%	●
	W29	Appraisal Rate - Non-Medical Staff	●	●		Mar-21 (m)	>= 95%	34.8%	35.0%	35.0%	41.7%	33.5%	47.0%	24.1%	34.8%	22.6%	●
	W30	Appraisal Rate - Medical Staff	●			Mar-21 (m)	>= 95%	68.8%	73.9%	73.9%	72.1%	73.9%	77.9%	71.0%	83.1%	-	

Staff Friends and Family Test (FFT): 2019/20 Q4 performance from the last national submission before the suspension is the latest included in the report

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# Proportion of Temporary Staff

May-21



Site	Staff Group	Average of Previous 6 Months			Mar-21			Variance
		Bank & Agency WTE	All Used WTE	%	Bank & Agency WTE	All Used WTE	%	
Royal London	All Staff Groups	813	6,105	13.3%	858	6,216	13.8%	0.5%
Whipps Cross	All Staff Groups	518	2,977	17.4%	539	3,024	17.8%	0.4%
Newham	All Staff Groups	490	2,332	21.0%	551	2,397	23.0%	2.0%
St Bart's	All Staff Groups	284	2,582	11.0%	297	2,597	11.4%	0.5%
CSS	All Staff Groups	283	2,294	12.3%	308	2,306	13.4%	1.0%
Other	All Staff Groups	172	2,065	8.3%	175	2,126	8.2%	-0.1%

## Performance Overview

- Temporary staffing usage increased in Mar-21 (+218 WTE Bank and +102 WTE agency) with the proportion of temporary staff as part of the workforce increasing from 13.1% to 14.6%. Across the hospital sites, there was an increase of 94 WTE at Newham, 69 WTE at St Bart's, 55 WTE at Whipps Cross, 53 WTE in Group Clinical Services (CSS) and 49 WTE at Royal London.
- These increases are primarily a reflection of 31 days in the month as opposed to 28 in Feb-21; adjusting for this, there is an underlying growth at Trust level of 63 WTE.

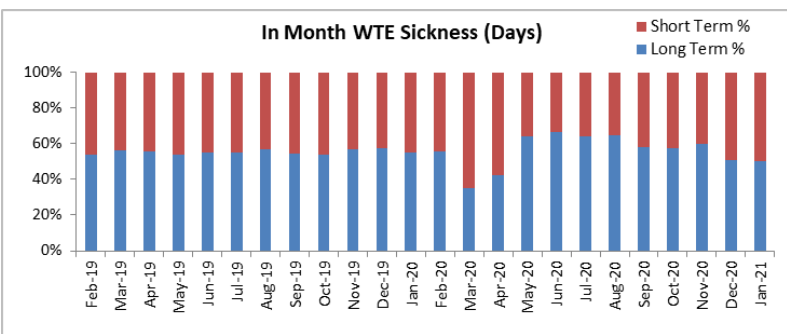
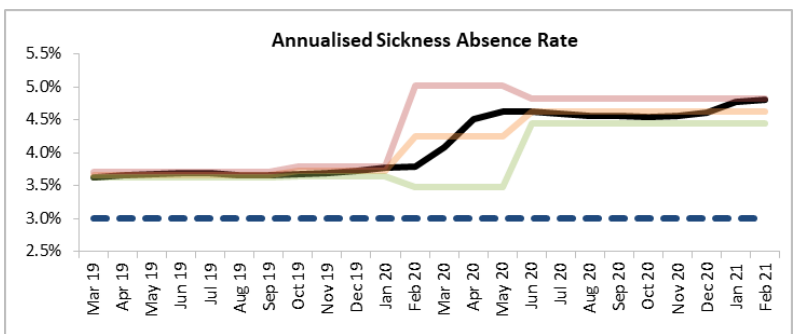
## Responsible Director Update

- All of the pandemic rates put in place for nursing have now been removed and returned to pre-pandemic rates of pay. Whilst overall numbers have not dropped off, this will have an impact on reducing cost.
- The Trust is engaging with other organisations in North East London to look at synergies that can come across Bank staffing arrangements.

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# Sickness Absence Rate

May-21



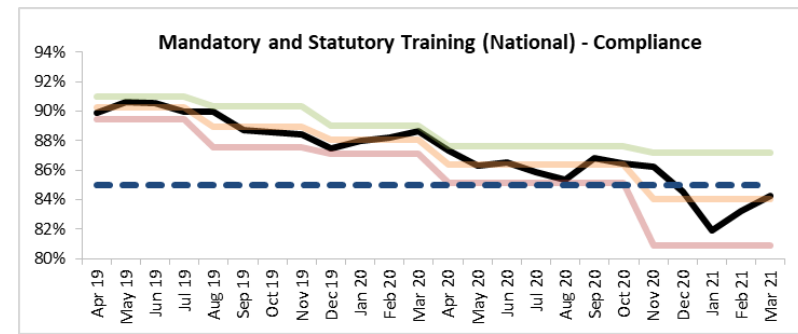
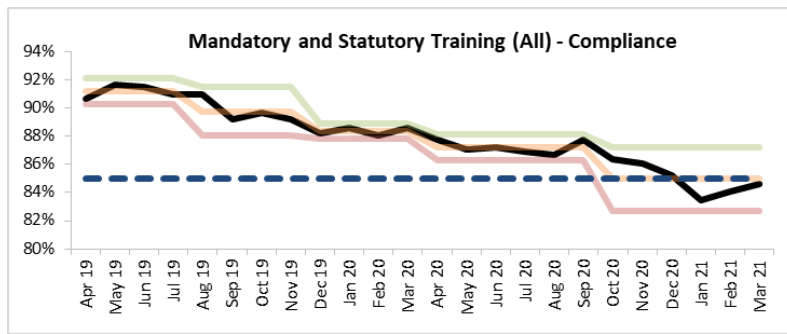
Site	Staff Group	6 Months Ago			Feb-21			Variance
		Sick WTE Days	Available WTE Days	%	Sick WTE Days	Available WTE Days	%	
Royal London	All Staff Groups	87,106	1,946,906	4.47%	93,892	1,969,245	4.77%	0.29%
Whipps Cross	All Staff Groups	46,981	889,319	5.28%	50,060	894,263	5.60%	0.32%
Newham	All Staff Groups	35,442	647,726	5.47%	40,386	664,603	6.08%	0.60%
St Bart's	All Staff Groups	33,346	835,049	3.99%	35,325	843,970	4.19%	0.19%
CSS	All Staff Groups	26,196	717,346	3.65%	28,571	727,547	3.93%	0.28%
Other	All Staff Groups	34,263	726,418	4.72%	31,821	725,414	4.39%	-0.33%

Performance Overview	Responsible Director Update
<ul style="list-style-type: none"> <li>Annualised sickness absence increased in Feb-21 to 4.81% from 4.77%, a small increase compared to the previous two months and reflecting reduced levels of COVID-19 absence experienced in month.</li> <li>Whilst annualised absence has increased, in month absence in Feb-21 was notably down from Jan-21 (4.35% from 6.14%).</li> <li>Annualised Rates are variable across the Trust:                             <ul style="list-style-type: none"> <li>Newham – 6.08%</li> <li>Whipps Cross – 5.60%</li> <li>Royal London – 4.77%</li> <li>Group Support Services – 4.69%</li> <li>St Bart's – 4.19%</li> <li>Group Clinical Services – 3.93%</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Employee Health and Wellbeing is a major focus of the People agenda. Enabling staff to rest and recover from the challenges of the last 12 months whilst focus increases on elective recovery will be a challenge.</li> <li>Whilst the Trust would expect to see annualised rates start to reduce, a reflection of the time that has passed since the first peak, a close eye needs to be kept on the impact of stress, musculoskeletal problems, Long Covid and other issues arising.</li> <li>Face to face physiotherapy services in Employee Wellbeing will recommence in May-21.</li> </ul>

WELL LED

# Mandatory and Statutory Training

May-21

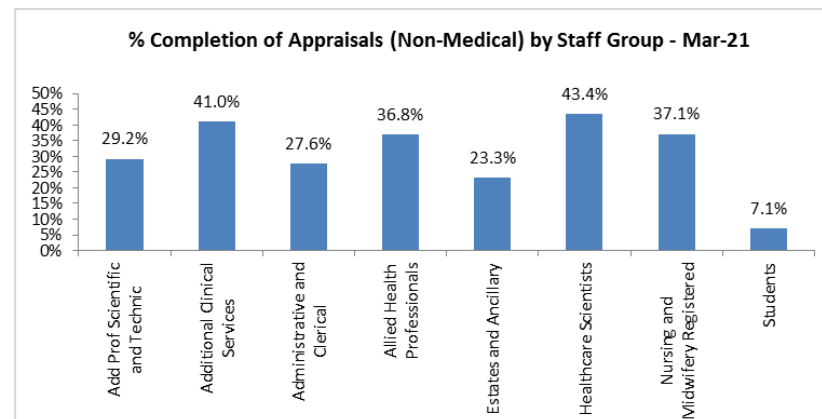
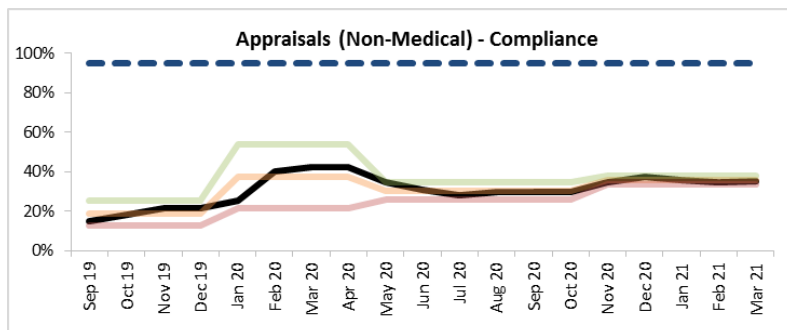


Bottom 5 Competencies: Total Number of Non-Compliant Employees			
Competency	Previous 6 Months	Mar-21	
	Compliance	Compliance	Staff Non-Compliant
Information Governance	78.2%	71.0%	4,836
Resuscitation - Basic Life Support	68.9%	66.7%	3,626
Fire Safety	78.6%	79.0%	3,499
Infection Control (Clinical)	74.7%	76.4%	2,714
Moving Handling - Clinical	80.6%	79.4%	2,384

Bottom 5 Departments: Total Number of Non-Compliant Employees			
Department	Previous 6 Months	Mar-21	
	Compliance	Compliance	Staff Non-Compliant
TRUST PATIENT TRANSPORT	82.2%	85.0%	157
Critical Care (1C, 1D, 1E & 4B Hdu) (St Bart's)	90.1%	86.2%	94
ACCU (Royal London)	88.2%	85.2%	85
A & E Nursing WC (Royal London)	85.3%	83.5%	54
Cardiology Trainees (St Bart's)	46.7%	43.2%	46

Non-mandatory competencies have been excluded from the above tables

Performance Overview	Responsible Director Update
<ul style="list-style-type: none"> <li>Trust-wide compliance against the 11 Core Skills Training Framework subjects has, as expected, continued to rise over the past month and currently stands at 84.2%, an increase of 0.9% since the last report. This is still below the Trust target of 85% but a continued rise is expected over the next few months. Overall Trust-wide compliance for all subjects currently stands at 84.6%.</li> <li>There is continued pressure on face to face training due to social distancing requirements. This, combined with a backlog in training, means that moving and handling and resuscitation training are still seeing a fall in compliance.</li> <li>There has been an increase in fire safety compliance mainly due to the use of a national e-learning package for basic fire safety. Whilst the package covers most of the training requirements, there is still a need to ensure that staff are familiar with their own place of work. The Trust will, therefore, restart face to face fire safety training for all staff.</li> </ul>	<ul style="list-style-type: none"> <li>Whilst the Trust has seen an upturn in compliance figures, the pace of recovery may be impacted over the coming months due to staff taking annual leave to recover both mentally and physically.</li> <li>The Education Academy is advertising for a mandatory and statutory training lead with a clinical background. This post will provide greater clinical oversight, help identify issues arising from serious incidents, strengthen the link between training and patient safety and work with subject matter experts to review all training materials.</li> <li>Work will continue over the coming year to further utilise technology to provide interactive and engaging training content. This will include further use of national materials, video content, introducing social learning and virtual reality.</li> </ul>



### Performance Overview

- The proportion of recorded appraisals across the Trust remains low at 35%, albeit a with a small increase noted since Feb-21.
- Performance varies across hospital sites as below:
  - Newham – 47% (+1.7%)
  - Royal London – 41.7% (no change)
  - Group Clinical Services – 34.8% (+1.3%)
  - Whipps Cross - 33.5% (+0.6%)
  - Group Support Services – 24.2% (-1.3%)
  - St Bart's – 24.1% (+1.2%)

### Responsible Director Update

- One of the key challenges identified in delivering appraisal across the Trust in the last 12 months has been the level of redeployment, with many staff working across teams in order to provide support during the pandemic.
- Whilst appraisal rates remain low and need to be encouraged, an opportunity exists to revisit the current process in order to make sure that it reflects the current needs of the Trust's workforce, including a reflection on Health and Wellbeing and taking on any learning from the medical appraisal process that can be applied.

		<----Actual---->											
		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Budgets	Target Substantive Budgeted WTE (Ledger)	16,867	16,835	16,842	16,840	16,866	16,875	16,934	16,963	16,965	16,965	16,965	16,965
	Actual Substantive Budgeted WTE (Ledger)	16,877	16,867	16,873	16,889	16,915	16,907	16,913	16,925	16,951	16,993	16,993	16,993
	Target Bank and Agency Budgeted WTE (Ledger)	306	306	306	305	305	313	332	350	350	350	350	350
	Actual Bank and Agency Budgeted WTE (Ledger)	563	569	570	572	548	548	546	547	625	698	698	448
	Target Total Budgeted WTE (Ledger)	19,307	19,277	19,286	19,287	19,309	19,337	19,425	19,468	19,474	19,516	19,516	17,315
	Actual Total Budgeted WTE (Ledger)	17,440	17,436	17,443	17,461	17,463	17,455	17,460	17,472	17,577	17,691	17,691	17,441
Recruitment and Retention	Target Contracted SIP (ESR)	15,426	15,641	15,698	15,793	15,796	15,852	15,668	15,697	15,726	15,766	15,808	15,851
	Actual Contracted SIP (ESR)	15,689	15,882	16,039	15,979	15,891	15,653	15,711	15,820	15,813	15,855	15,917	15,937
	Target Fill Rate	91.5%	92.9%	93.2%	93.8%	93.7%	93.9%	92.5%	92.5%	92.7%	92.9%	93.2%	93.4%
	Actual fill-rate	93.0%	94.2%	95.1%	94.6%	93.9%	92.6%	92.9%	93.5%	93.3%	93.3%	93.7%	93.8%
	Forecast Gap to reach 95% fill	597	352	302	204	226	179	419	418	391	351	309	266
	Actual Gap to reach 95% fill	393	149	- 9	66	179	409	358	258	293	295	249	206
	Recruitment plan (WTE Advertised Needed)	484	607	606	727	523	704	702	712	601	610	620	629
	Recruitment plan (WTE Advertised Actual)	746	444	499	453	435	541	525	644	583	599	493	814
	Recruitment plan (offers needed)	327	336	194	288	324	336	328	363	364	371	394	402
	Offers made (exc. JD)*	320	370	309	307	300	277	413	388	296	301	297	361
Utilisation	Target Bank WTE	1,787	1,788	1,789	1,790	1,791	1,834	1,960	2,011	2,032	2,069	2,078	2,085
	Actual Bank WTE (Bank Partners)	1,551	1,512	1,480	1,768	1,885	1,962	2,135	2,185	2,131	2,174	1,996	2,226
	Target Agency WTE	401	418	418	418	418	412	381	409	482	486	480	480
	Actual Agency WTE (Bank Partners)	449	370	346	375	352	405	442	483	505	467	382	501

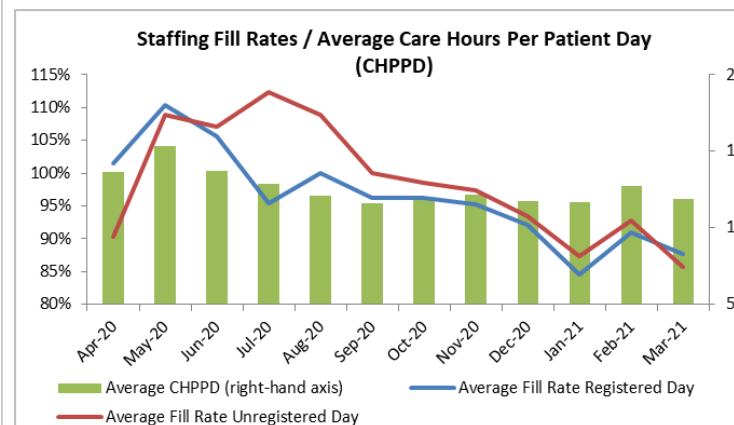


SAFE STAFFING

# Safe Staffing

May-21

- The impact of the Covid-19 pandemic on the Trust’s hospital sites continued during Mar-21, though the number of inpatients with Covid-19 reduced. The return of staff redeployed to critical care to their home wards began, alongside restoration and recovery of urgent elective services.
- Across the Trust, average fill rates in Mar-21 for Registered Nurses/Midwives (RN/RM) and Health Care Assistants (HCAs) on days dropped to 87.7% and 85.7% respectively. Night fill rate was over 92%. Whilst Whipps Cross and Newham had higher fill rates than Royal London and St Bart’s, Care Hours Per Patient Day (CHPPD) remained lowest at Whipps Cross and highest at Royal London.
- Based on safe staffing data and CHPPD, no wards across the Trust were a specific cause of concern for safe staffing during Mar-21. Nine red flags were reported in Mar-21, all at Royal London over 5 different wards. All nine were no harm incidents mitigated at the time by the actions of senior staff. Safest staffing continues to be monitored through the hospital sites’ safety huddles, with dynamic staff deployment by senior staff to areas of greatest need to mitigate risks and maintain patient and staff safety.



Site	Average Fill Rate (Day)		Average Fill Rate (Night)		Average Care Hours Per Patient Day (CHPPD)	Safe Staffing Red Flag Incidents
	Registered Nurses / Midwives (%)	Care Staff (%)	Registered Nurses / Midwives (%)	Care Staff (%)		
Trust	87.7%	85.7%	92.9%	101.4%	11.9	9
Royal London	82.5%	74.8%	86.8%	91.3%	12.7	9
Whipps Cross	93.0%	94.2%	99.7%	106.0%	10.7	0
Newham	101.6%	92.8%	112.6%	110.7%	12.3	0
St Bart's	81.0%	94.0%	83.4%	113.8%	11.4	0

May-21



# Glossary



Domain	Sub Domain	Metric Ref	Metric Name	Description	Frequency	Target Source
Responsive	Waiting Times	R1	A&E 4 Hours Waiting Time	The number of Accident & Emergency (A&E) attendances for which the patient was discharged, admitted or transferred within four hours of arrival, divided by the total number of A&E attendances. This includes all types of A&E attendances including Minor Injury Units and Walk-in Centres	Monthly	Recovery trajectory
Responsive	Waiting Times	R35	Cancer 62 Days From Urgent GP Referral	Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer. Logic is 50/50 split for referring and treating trust/site up to and including Mar-19 then reallocation from Apr-19 as per national reporting rules	Monthly	National
Responsive	Waiting Times	R36	Cancer 62 Days From Screening Programme	Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of referral from a NHS Cancer Screening Service. Logic is 50/50 split for referring and treating trust/site up to and including Mar-19 then reallocation from Apr-19 as per national reporting rules	Monthly	National
Responsive	Waiting Times	R6	Diagnostic Waits Over 6 Weeks	The number of patients still waiting for diagnostic tests who had waited more than 6 weeks from the referral date to the end of the calendar month, divided by the total number of patients still waiting for diagnostic tests at the end of the calendar month. Only the 15 key tests included in the Diagnostics Monthly (DM01) national return are included	Monthly	National
Responsive	Waiting Times	R5	52+ Week RTT Breaches	The number of patients on incomplete 18 week referral to treatment (RTT) pathways who had waited more than 52 weeks from the referral date (or clock start date) to the end of the calendar month	Monthly	Recovery trajectory
Well Led	People	W19	Turnover Rate	The number of leavers (whole time equivalents) who left the trust voluntarily in the last 12 months divided by the average total number of staff in post (whole time equivalents) in the last 12 months	Monthly	Local
Well Led	People	OH7	Proportion of Temporary Staff	The number of bank and agency whole time equivalents divided by the number of bank and agency whole time equivalents plus permanent staff in post (whole time equivalents)	Monthly	Local
Well Led	People	W20	Sickness Absence Rate	The number of whole time equivalent days lost to sickness absence (including non-working days) in the last 12 months divided by the total number of whole time equivalent days available (including non-working days) in the last 12 months, i.e. the annualised percentage of working days lost due to sickness absence	Monthly	Local
Well Led	Staff Feedback	C6	Staff FFT Percentage Recommended - Care	The number of staff who responded that they were extremely likely or likely to recommend the trust to friends and family if they needed care or treatment, divided by the total number of staff who responded to the Staff Friends and Family Test (Staff FFT)	Quarterly	Local
Well Led	Staff Feedback	OH6	NHS Staff Survey	The overall staff engagement score from the results of the NHS Staff Survey	Yearly	National
Well Led	Compliance	W50	Mandatory and Statutory Training - All	For all mandatory and statutory training topics, the percentage of topics for which staff were competent (i.e. have completed training and were compliant)	Monthly	Local

Domain	Sub Domain	Metric Ref	Metric Name	Description	Frequency	Target Source
Well Led	Compliance	W11	Mandatory and Statutory Training - National	For the 11 Core Skills Training Framework topics, the percentage of topics for which staff were competent (i.e. have completed training and were compliant)	Monthly	Local
Well Led	Compliance	W29	Appraisal Rate - Non-Medical Staff	The number of appraisals completed for eligible non-medical staff divided by the number of eligible non-medical staff	Monthly	Local
Well Led	Compliance	W30	Appraisal Rate - Medical Staff	The number of appraisals completed for eligible medical staff divided by the number of eligible medical staff (non-compliant if 2 or more months overdue, otherwise compliant)	Monthly	Local
Caring	Patient Experience	C12	MSA Breaches	The number of patients admitted to mixed sex sleeping accommodation (defined as an area patients are admitted into), except where it was in the overall best interest of the patient or reflected their personal choice	Monthly	National
Caring	Patient Feedback	C10	Written Complaints Rate Per 1,000 Staff	The number of initial reportable complaints received by the trust per 1,000 whole time equivalent staff (WTEs), i.e. the number of initial reportable complaints divided by the number of WTEs which has been multiplied by 1,000	Quarterly	SPC breach
Caring	Patient Feedback	C1	FFT Recommended % - Inpatients	The number of patients who responded that they were extremely likely or likely to recommend the inpatient service they received to friends and family, divided by the total number of patients who responded to the inpatient Friends and Family Test (FFT)	Monthly	Local
Caring	Patient Feedback	C2	FFT Recommended % - A&E	The number of patients who responded that they were extremely likely or likely to recommend the A&E service they received to friends and family, divided by the total number of patients who responded to the A&E Friends and Family Test (FFT)	Monthly	Local
Caring	Patient Feedback	C3	FFT Recommended % - Maternity	The number of patients who responded that they were extremely likely or likely to recommend the maternity (birth) service they received to friends and family, divided by the total number of patients who responded to the maternity (birth) Friends and Family Test (FFT)	Monthly	Local
Caring	Patient Feedback	C20	FFT Response Rate - Inpatients	The total number of patients who responded to the inpatient Friends and Family Test (FFT) divided by the total number of patients eligible to respond to the inpatient FFT (i.e. all inpatient discharges in the reporting period)	Monthly	Local
Caring	Patient Feedback	C21	FFT Response Rate - A&E	The total number of patients who responded to the A&E Friends and Family Test (FFT) divided by the total number of patients eligible to respond to the A&E FFT (i.e. all A&E attendances in the reporting period)	Monthly	Local
Caring	Patient Feedback	C22	FFT Response Rate - Maternity	The total number of patients who responded to the maternity (birth) Friends and Family Test (FFT) divided by the total number of patients eligible to respond to the maternity (birth) FFT (i.e. all delivery episodes in the reporting period)	Monthly	Local
Caring	Patient Feedback	OH4	CQC Inpatient Survey	The overall experience score of patients from the CQC inpatient survey, based on the question "Patients who rated their experience as 7/10 or more"	Yearly	TBC
Caring	Service User Support	R78	Complaints Replied to in Agreed Time	The number of initial reportable complaints replied to within the agreed number of working days (as agreed with the complainant). The time agreed for the reply might be 25 working days or might be another time such as 40 working days	Monthly	Local

## GLOSSARY

## Domain Scorecard Glossary

May-21

Domain	Sub Domain	Metric Ref	Metric Name	Description	Frequency	Target Source
Caring	Service User Support	R30	Duty of Candour	The percentage of patient incidents (where harm was moderate, severe or death) where an apology was offered to the patient within 2 weeks (14 calendar days) of the date the incident was reported	Monthly	National
Safe	Infection Control	S10	Clostridium difficile - Infection Rate	The number of Clostridium difficile (C.difficile) infections reported in people aged two and over and which were apportioned to the trust per 100,000 bed days (inpatient bed days with day cases counted as 1 day each)	Monthly	National
Safe	Infection Control	S11	Clostridium difficile - Incidence	The number of Clostridium difficile (C.difficile) infections reported in people aged two and over and which were apportioned to the trust	Monthly	National
Safe	Infection Control	S2	Assigned MRSA Bacteraemia Cases	The number of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemias which can be directly associated to the trust	Monthly	Local
Safe	Infection Control	S77	MSSA Bacteraemias	The number of Methicillin-susceptible Staphylococcus aureus (MSSA) bacteraemias which can be directly associated to the trust	Monthly	Local
Safe	Infection Control	S76	E.coli Bacteraemia Bloodstream Infections	The number of Escherichia coli (E.coli) bacteraemia bloodstream infections at the trust (i.e. for which the specimen was taken by the trust)	Monthly	Local
Safe	Incidents	S3	Never Events	The number of never events reported via the Strategic Executive Information System (STEIS)	Monthly	Local
Safe	Incidents	S09	% Incidents Resulting in Harm (Moderate Harm or More)	The number of patient-related incidents occurring at the trust which caused harm (not including those which only caused low harm) divided by the total number of patient-related incidents occurring at the trust	Monthly	Local
Safe	Incidents	S45	Falls Per 1,000 Bed Days	The total number of patient falls occurring at the trust per 1,000 inpatient bed days, i.e. the total number of patient falls occurring at the trust divided by the number of inpatient bed days which has been multiplied by 1,000	Monthly	National
Safe	Incidents	S25	Medication Errors - Percentage Causing Harm	The number of medication error incidents occurring at the trust which caused harm divided by the total number of medication error incidents occurring at the trust	Monthly	Local
Safe	Incidents	S49	Patient Safety Incidents Per 1,000 Bed Days	The number of reported patient safety incidents per 1,000 bed days. This is the NHS Single Oversight Framework metric "Potential Under-Reporting of Patient Safety Incidents"	Monthly	SPC breach
Safe	Incidents	S53	Serious Incidents Closed in Time	Percentage of serious incidents investigated and closed on the Strategic Executive Information System (StEIS) before the deadline date (this is usually 60 working days after opening but is sometimes extended, e.g. in the case of a police investigation). De-escalated serious incidents are not included	Monthly	Local
Safe	Harm Free Care	S14	Pressure Ulcers Per 1,000 Bed Days	The number of new category 2, 3, 4 or unstageable pressure ulcers acquired at the trust (including those which occurred at the trust and those which deteriorated to one of those categories at the trust) per 1,000 inpatient bed days, i.e. the number of new category 2, 3, 4 or unstageable pressure ulcers acquired at the trust divided by the number of inpatient bed days which has been multiplied by 1,000	Monthly	Local
Safe	Harm Free Care	S35	Pressure Ulcers (Device-Related) Per 1,000 Bed Days	The number of new category 2, 3, 4 or unstageable medical device-related pressure ulcers acquired at the trust (including those which occurred at the trust and those which deteriorated to one of those categories at the trust) per 1,000 inpatient bed days, i.e. the number of new category 2, 3, 4 or unstageable medical device-related pressure ulcers acquired at the trust divided by the number of inpatient bed days which has been multiplied by 1,000	Monthly	SPC breach

Domain	Sub Domain	Metric Ref	Metric Name	Description	Frequency	Target Source
Safe	Harm Free Care	S17	Emergency C-Section Rate	The number of deliveries which were emergency caesarean sections divided by the total number of deliveries. Based on data frozen as at the 12th working day of the month	Monthly	Local
Safe	Harm Free Care	S27	Patient Safety Alerts Overdue	The number of NHS England or NHS Improvement patient safety alerts overdue (past their completion deadline date) at the time of the snapshot. These are a sub-set of all Central Alerting System (CAS) alerts	Monthly	National
Safe	Assess & Prevent	S36	VTE Risk Assessment	The number of adult hospital admissions (aged 18 and over) who were risk assessed for Venous Thromboembolism (VTE) divided by the number of adult hospital admissions	Monthly	National
Safe	Assess & Prevent	S5	Dementia - Screening	Percentage of patients aged 75 and above admitted as emergency inpatients, with length of stay > 72 hours, who were asked the dementia case finding question within 72 hours of admission, or who had a clinical diagnosis of delirium on initial assessment or known diagnosis of dementia, excluding those for whom the case finding question could not be completed for clinical reasons	Monthly	National
Safe	Assess & Prevent	S6	Dementia - Risk Assessment	Percentage of patients aged 75 and above admitted as emergency inpatients, with length of stay > 72 hours, who scored positively on the case finding question, or who had a clinical diagnosis of delirium, reported as having had a dementia diagnostic assessment including investigations	Monthly	National
Safe	Assess & Prevent	S7	Dementia - Referrals	Percentage of patients aged 75 and above admitted as emergency inpatients, with length of stay > 72 hours, who have had a diagnostic assessment (with an outcome of "positive" or "inconclusive") and who have been referred for further diagnostic advice in line with local pathways	Monthly	National
Effective	Mortality	E1	Summary Hospital-Level Mortality Indicator	The ratio between the actual number of patients who died following hospitalisation at the trust and the number who would be expected to die on the basis of average England figures (given the characteristics of the patients treated at the trust), multiplied by 100	Monthly	National
Effective	Mortality	E3	Risk Adjusted Mortality Index	The ratio of the observed number of in-hospital deaths with a Hospital Standardised Mortality Ratio (HSMR) diagnosis to the expected number of deaths, multiplied by 100, at trust level. This metric considers mortality on weekdays and weekends	Monthly	National
Effective	Mortality	E25	Number of Avoidable Deaths	The number of adult inpatient deaths which occurred at the trust or site which were considered avoidable	Quarterly	National
Effective	Outcomes	0502	Cardiac Arrest 2222 Calls (Wards) Per 1,000 Admissions	The number of 2222 emergency calls which were for cardiac arrests on wards (including medical emergencies leading to cardiac arrests) per 1,000 admissions, i.e. the number of calls divided by the number of admissions which has been multiplied by 1,000	Monthly	Local
Effective	Outcomes	S42	Sepsis 6 Antibiotic Administration (60 Mins)	The number of audited inpatients who deteriorated, were screened for sepsis and found to have sepsis who received antibiotics 60 minutes or less after the time of deterioration divided by the total number of audited inpatients who deteriorated, were screened for sepsis and found to have sepsis	Monthly	Local

Sub-Section	Metric	Description	Notes
Planned vs Actual WTE	% Utilisation (Total Fill Rate)	Contracted substantive WTE (plus Bank and Agency, less maternity leave) as a % of total budgeted WTE	The target is <= 100% but the figure is also of concern if it falls too far below 100% so an amber rating is applied if the figure is < 95%
Planned vs Actual WTE	Staff in Post - Actual	Substantive staff in post - actual	
Planned vs Actual WTE	Staff in Post - Plan	Substantive staff in post - plan	
Planned vs Actual WTE	Bank WTE - Actual	Bank Whole Time Equivalents (WTE) - actual	
Planned vs Actual WTE	Bank WTE - Plan	Bank Whole Time Equivalents (WTE) - plan	
Planned vs Actual WTE	Agency WTE - Actual	Agency Whole Time Equivalents (WTE) - actual	
Planned vs Actual WTE	Agency WTE - Plan	Agency Whole Time Equivalents (WTE) - plan	
Planned vs Actual WTE	Total Staffing - Actual	Substantive staff in post plus bank WTE plus agency WTE (actual)	
Planned vs Actual WTE	Total Staffing - Plan	Substantive staff in post plus bank WTE plus agency WTE (plan)	
Recruitment Plans	Substantive Fill Rate - Actual	Percentage of substantive staff in post against the substantive and locum establishment - actual	
Recruitment Plans	Substantive Fill Rate - Plan	Percentage of substantive staff in post against the substantive and locum establishment - plan	
Recruitment Plans	Unconditional Offers - Actual	Offers achieved	
Recruitment Plans	Unconditional Offers - Plan	Offers planned	
Rosters	Roster Compliance - % Approved on Time (>20 WTEs)	Percentage of rosters fully approved between 42 and 70 days in advance of the roster starting, for units with 20 WTE or more	Based on the week in which the roster was due to be approved
Rosters	Nursing Roster Quality - % Blue or Cloudy Sky	Percentage of rosters with good data quality based on 6 domains such as budget, safety, annual leave, etc. "Blue Sky" and "Cloudy Sky" rosters meet 5 or 4 of the domains respectively	Based on the week in which the roster was due to be approved
Rosters	Additional Duty Hours (Nursing)	Total nursing additional duty hours	No target can be set due to the nature of this metric
Diversity	% of BME Staff at Band 8a to VSM	Percentage of whole time equivalent staff from band 8a to very senior managers (VSM) who are black and minority ethnic	

May-21



# Appendix





APPENDIX Interpretation of Scorecards May-21

How to Interpret the Scorecard

	Ref	Indicator	Exception Triggers			This Period	This Period Target	Performance			Site Comparison						Excep.
			Month Target	Step Change	Contl. Limit			Last Period	This Period	YTD	Royal London	Newham	St Bart's	CSS	Other	Barts Health	
Waiting Times	R1	A&E 4 Hours Waiting Time	●		●	Jan-18 (m)	>=92.3%	85.5%	86.5%	86.9%	82.7%	88.8%	-	-	-	86.5%	●
	R7	Cancer 62 Days From Urgent GP Referral	●			Dec-17 (m)	>=85%	86.3%	86.5%	83.2%	86.2%	84.6%	84.3%	-	-	86.5%	
	R13	Cancer 62 Days From Screening Programme	●			Dec-17 (m)	>=90%	90.6%	88.6%	90.8%	-	-	86.8%	-	-	88.6%	●

Triggers based on current reporting month:  
**Month Target:** Where the actual has passed or failed the target. Failure = a trigger  
**Step Change:** Where a new step change has been triggered by 5 consecutive points above or below the mean (see SPC explanation below)  
**Control Limit:** Where the current reporting month actual breaches the upper or lower confidence limit (see SPC explanation below)

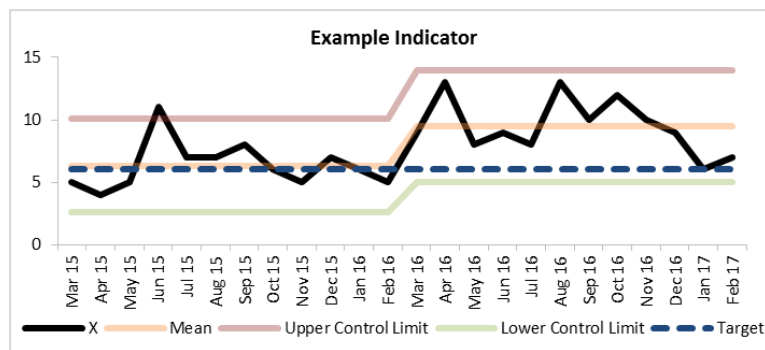
Reporting month target for reporting site

Reporting month actuals for reporting site

Reporting month actuals for other sites & trust total

Flags where there is one or more triggers and the indicator is to be reported as an exception

How to Interpret an SPC Chart



Statistical process control (SPC) is a method of quality control which uses statistical methods. When you are interpreting these SPC charts there are 3 rules that help you identify what the performance is doing. If one of the rules has been broken, this means that "special cause" variation is present in the system.

- Rule 1:** Any point outside one of the control limits (upper or lower control limits)
- Rule 2:** A run of five points all above or all below the centre line
- Rule 3:** Any unusual pattern or trends within the control

**Indication of Good or Bad performance:** to help users identify whether performance is changing in a positive or negative way, the upper and lower control limits are coloured to indicate whether a high value is good (green) or bad (red). In the example to the left, a higher value would be seen as a deterioration in performance (the upper control limit is red).

How Exceptions Are Identified For Inclusion

The general principle is to ensure that as many exceptions as possible can be included as detailed exceptions in the report without overwhelming the meeting and that hot topics or particularly important, large or otherwise noteworthy exceptions are definitely included.

- Some exceptions are not given exception pages if it is felt that the commentary and discussion would be the same as the previous month or if it is a minor or consistent exception at a time where there are many other exceptions which need to be covered, in order to focus discussions on the most important topics that month.
- When making these decisions, factors such as the number of sites with an exception for that metric, the magnitude of the exception, the context of the exception within the organisation as a whole and the number of other exceptions that month are all taken into account.

# Safe Staffing Fill Rates by Ward and Site

May-21

Site	Ward name	Registered midwives / nurses (day)		Care Staff (day)		Registered midwives / nurses (night)		Care Staff (night)		Day		Night		Care Hours Per Patient Day (CHPPD)			
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Patients at Midnight	Registered midwives / nurses	Care Staff	Overall
Royal London	10E RLH	2,139.0	1,834.0	1,117.5	747.0	1,782.5	1,771.0	713.0	782.0	85.7%	66.8%	99.4%	109.7%	751	4.8	2.0	6.8
Royal London	10F RLH	1,116.0	1,007.5	756.0	696.0	693.0	1,012.0	341.0	682.0	90.3%	92.1%	146.0%	200.0%	421	4.8	3.3	8.1
Royal London	11C RLH	2,495.0	2,252.5	1,426.0	1,369.5	2,495.5	2,507.0	713.0	1,437.5	90.3%	96.0%	100.5%	201.6%	670	7.1	4.2	11.3
Royal London	11E & 11F AAU	3,921.5	4,033.5	1,772.5	1,621.5	3,921.5	4,254.0	1,426.0	1,874.2	102.9%	91.5%	108.5%	131.4%	1,295	6.4	2.7	9.1
Royal London	12C RLH	1,879.5	2,214.3	1,426.0	1,455.5	1,886.0	2,293.0	1,069.5	1,287.0	117.8%	102.1%	121.6%	120.3%	697	6.5	3.9	10.4
Royal London	12D RLH	1,420.0	2,383.8	704.5	715.0	1,426.0	2,442.0	356.5	688.0	167.9%	101.5%	171.2%	193.0%	452	10.7	3.1	13.8
Royal London	12E RLH	2,771.5	2,996.5	1,426.0	1,549.5	2,495.5	2,794.5	1,426.0	1,670.8	108.1%	108.7%	112.0%	117.2%	695	8.3	4.6	13.0
Royal London	12F RLH	1,771.0	2,091.0	1,778.5	1,595.5	1,782.5	2,405.5	1,782.5	1,771.0	118.1%	89.7%	135.0%	99.4%	660	6.8	5.1	11.9
Royal London	13D RLH	1,765.0	1,469.5	710.5	632.5	1,426.0	1,412.5	713.0	782.8	83.3%	89.0%	99.1%	109.8%	582	5.0	2.4	7.4
Royal London	13E RLH	2,070.0	2,493.5	724.5	992.0	1,700.5	2,241.5	724.5	1,253.5	120.5%	136.9%	131.8%	173.0%	674	7.0	3.3	10.4
Royal London	13F RLH	1,794.0	2,334.5	1,012.0	1,137.5	1,805.5	2,380.5	724.5	1,150.0	130.1%	112.4%	131.8%	158.7%	632	7.5	3.6	11.1
Royal London	14E RLH	1,699.5	1,805.5	1,068.0	1,288.0	1,426.0	1,575.5	1,069.5	1,460.5	106.2%	120.6%	110.5%	136.6%	785	4.3	3.5	7.8
Royal London	14F RLH	1,863.0	1,574.0	1,081.0	977.5	1,426.0	1,483.5	1,138.5	1,276.5	84.5%	90.4%	104.0%	112.1%	687	4.5	3.3	7.7
Royal London	3D RLH	3,206.5	1,597.5	2,139.0	1,346.0	3,208.5	1,999.5	1,782.5	1,391.5	49.8%	62.9%	62.3%	78.1%	499	7.2	5.5	12.7
Royal London	3F RLH	1,547.0	773.0	1,069.5	471.5	1,069.5	632.5	713.0	471.5	50.0%	44.1%	59.1%	66.1%	282	5.0	3.3	8.3
Royal London	4E RLH	40,743.0	27,927.5	11,805.5	4,401.5	39,813.0	27,288.3	10,948.0	4,305.3	68.5%	37.3%	68.5%	39.3%	1,754	31.5	5.0	36.4
Royal London	6C RLH	4,059.5	2,845.0	356.5	299.0	3,898.5	2,706.0	356.5	322.0	70.1%	83.9%	69.4%	90.3%	123	45.1	5.0	50.2
Royal London	6E & 6F RLH	5,329.5	5,151.3	1,426.0	1,261.6	5,374.5	5,311.3	1,069.5	969.0	96.7%	88.5%	98.8%	90.6%	863	12.1	2.6	14.7
Royal London	7D RLH	1,426.0	1,440.5	356.5	793.5	1,058.0	1,150.0	356.5	414.0	101.0%	222.6%	108.7%	116.1%	344	7.5	3.5	11.0
Royal London	7E RLH	2,852.0	2,668.8	1,069.5	1,090.8	2,484.0	2,610.5	1,069.5	1,092.5	93.6%	102.0%	105.1%	102.2%	525	10.1	4.2	14.2
Royal London	7F RLH	1,422.0	1,105.8	621.0	507.0	1,058.0	1,035.0	575.0	402.5	77.8%	81.6%	97.8%	70.0%	242	8.8	3.8	12.6
Royal London	8C RLH	1,689.0	1,559.0	724.5	541.0	1,426.0	1,426.0	713.0	701.5	92.3%	74.7%	100.0%	98.4%	457	6.5	2.7	9.3
Royal London	8D RLH	8,278.8	6,644.8	1,261.0	903.8	7,889.0	6,536.0	575.0	425.5	80.3%	71.7%	82.8%	74.0%	1,000	13.2	1.3	14.5
Royal London	8F RLH	1,494.0	1,364.0	1,782.5	1,449.0	1,069.5	1,046.5	1,081.0	1,069.5	91.3%	81.3%	97.8%	98.9%	1,400	1.7	1.8	3.5
Royal London	9EF RLH	4,962.0	3,946.5	1,794.0	1,650.0	4,278.0	3,753.0	1,081.0	2,001.5	79.5%	92.0%	87.7%	185.2%	1,572	4.9	2.3	7.2

# Safe Staffing Fill Rates by Ward and Site

May-21

Site	Ward name	Registered midwives / nurses (day)		Care Staff (day)		Registered midwives / nurses (night)		Care Staff (night)		Day		Night		Care Hours Per Patient Day (CHPPD)			
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Patients at Midnight	Registered midwives / nurses	Care Staff	Overall
Whipps Cross	AAU WXH	4,634.5	5,681.0	2,495.0	2,323.0	4,634.5	5,717.5	2,139.0	2,035.5	122.6%	93.1%	123.4%	95.2%	1,087	10.5	4.0	14.5
Whipps Cross	ACACIA	966.0	843.5	448.5	575.5	713.0	713.5	713.0	741.0	87.3%	128.3%	100.1%	103.9%	330	4.7	4.0	8.7
Whipps Cross	ACORN	4,910.8	3,270.9	784.5	606.3	2,816.5	2,140.3	356.5	69.0	66.6%	77.3%	76.0%	19.4%	359	15.1	1.9	17.0
Whipps Cross	B3 Ward WXH	1,334.0	1,356.0	1,069.5	1,048.5	1,069.5	1,104.0	713.0	736.0	101.6%	98.0%	103.2%	103.2%	473	5.2	3.8	9.0
Whipps Cross	BIRCH	1,069.5	1,035.0	1,069.5	1,081.0	1,069.5	1,068.5	713.0	805.0	96.8%	101.1%	99.9%	112.9%	534	3.9	3.5	7.5
Whipps Cross	BLACKTHORN	1,069.5	832.0	1,012.0	1,230.5	1,069.5	945.0	713.0	977.0	77.8%	121.6%	88.4%	137.0%	396	4.5	5.6	10.1
Whipps Cross	Bracken Ward WXH	1,454.0	1,757.5	1,117.5	1,024.5	1,069.5	1,447.3	713.0	850.5	120.9%	91.7%	135.3%	119.3%	433	7.4	4.3	11.7
Whipps Cross	CHESTNUT	977.5	921.8	356.5	310.5	713.0	690.0	356.5	368.0	94.3%	87.1%	96.8%	103.2%	253	6.4	2.7	9.1
Whipps Cross	CONIFER	736.0	770.5	586.5	598.0	586.5	621.0	391.0	414.0	104.7%	102.0%	105.9%	105.9%	128	10.9	7.9	18.8
Whipps Cross	CURIE	1,421.5	1,334.5	1,069.5	1,230.5	1,426.0	1,426.0	1,069.5	1,277.0	93.9%	115.1%	100.0%	119.4%	395	7.0	6.3	13.3
Whipps Cross	DELIVERY SUITE WXH	4,866.5	4,091.5	705.5	1,130.5	3,726.0	3,343.3	713.0	1,041.0	84.1%	160.2%	89.7%	146.0%	478	15.6	4.5	20.1
Whipps Cross	ELIZABETH	1,690.5	1,647.0	356.5	391.0	1,426.0	1,382.5	264.5	368.0	97.4%	109.7%	96.9%	139.1%	562	5.4	1.4	6.7
Whipps Cross	FARADAY	1,069.5	1,340.5	713.0	829.0	1,046.5	1,301.0	356.5	667.0	125.3%	116.3%	124.3%	187.1%	417	6.3	3.6	9.9
Whipps Cross	Frail Elderly WXH	865.3	867.8	345.0	632.5	713.0	713.0	345.0	563.3	100.3%	183.3%	100.0%	163.3%	234	6.8	5.1	11.9
Whipps Cross	ICU WXH	6,935.5	5,712.5	1,756.5	752.5	5,740.5	5,224.0	1,364.0	454.8	82.4%	42.8%	91.0%	33.3%	340	32.2	3.6	35.7
Whipps Cross	MARGARET	932.0	904.5	520.5	462.0	713.0	716.0	345.0	368.5	97.0%	88.8%	100.4%	106.8%	274	5.9	3.0	8.9
Whipps Cross	MIDWIFERY WXH	873.0	850.8	377.5	273.0	724.5	723.5	356.5	357.5	97.5%	72.3%	99.9%	100.3%	104	15.1	6.1	21.2
Whipps Cross	MULBERRY	2,196.5	1,963.3	1,378.0	897.5	1,426.0	1,416.5	828.0	885.5	89.4%	65.1%	99.3%	106.9%	974	3.5	1.8	5.3
Whipps Cross	NEONATAL WXH	2,432.0	2,227.0	1,099.0	555.0	2,065.5	2,075.5	701.5	402.5	91.6%	50.5%	100.5%	57.4%	299	14.4	3.2	17.6
Whipps Cross	NIGHTINGALE	1,058.0	916.5	368.0	312.5	1,069.0	969.0	356.5	310.5	86.6%	84.9%	90.6%	87.1%	249	7.6	2.5	10.1
Whipps Cross	PEACE	1,690.5	1,644.5	828.0	1,223.0	1,069.5	1,069.5	712.0	1,184.5	97.3%	147.7%	100.0%	166.4%	414	6.6	5.8	12.4
Whipps Cross	PRIMROSE	1,771.0	1,438.5	1,069.5	897.0	1,426.0	1,230.5	1,069.5	989.0	81.2%	83.9%	86.3%	92.5%	865	3.1	2.2	5.3
Whipps Cross	SAGE	1,690.5	1,748.0	1,449.0	1,382.5	1,437.5	1,439.0	1,058.0	1,322.5	103.4%	95.4%	100.1%	125.0%	807	3.9	3.4	7.3
Whipps Cross	SYCAMORE	1,690.5	1,700.0	1,426.0	1,263.5	1,426.0	1,566.8	1,069.5	977.5	100.6%	88.6%	109.9%	91.4%	796	4.1	2.8	6.9
Whipps Cross	SYRINGA	1,426.0	1,368.5	1,782.5	1,771.0	1,068.5	1,068.5	1,069.5	1,506.5	96.0%	99.4%	100.0%	140.9%	727	3.4	4.5	7.9
Whipps Cross	VICTORY	1,334.0	1,288.0	1,334.0	1,242.0	1,069.5	1,069.5	1,069.5	1,058.0	96.6%	93.1%	100.0%	98.9%	572	4.1	4.0	8.1

Site	Ward name	Registered midwives / nurses (day)		Care Staff (day)		Registered midwives / nurses (night)		Care Staff (night)		Day		Night		Care Hours Per Patient Day (CHPPD)			
		Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Patients at Midnight	Registered midwives / nurses	Care Staff	Overall
Newham	AAU NUH	4,366.5	4,529.5	2,852.0	3,065.5	4,278.0	4,757.8	2,852.0	3,198.0	103.7%	107.5%	111.2%	112.1%	1,375	6.8	4.6	11.3
Newham	Custom House NUH	1,679.0	1,804.5	1,414.5	1,587.0	1,380.0	1,691.5	1,069.5	1,575.5	107.5%	112.2%	122.6%	147.3%	610	5.7	5.2	10.9
Newham	DELIVERY SUITE NUH	6,258.0	5,170.0	1,233.5	760.0	5,347.0	4,187.7	1,069.5	722.5	82.6%	61.6%	78.3%	67.6%	710	13.2	2.1	15.3
Newham	EAST HAM	1,782.5	1,544.0	1,069.5	966.0	1,426.0	1,381.0	1,058.0	1,035.0	86.6%	90.3%	96.8%	97.8%	490	6.0	4.1	10.1
Newham	HEATHER	1,782.5	2,484.0	1,426.0	1,651.5	1,781.5	2,484.0	1,426.0	2,024.0	139.4%	115.8%	139.4%	141.9%	687	7.2	5.4	12.6
Newham	LARCH	5,221.5	5,094.5	2,687.4	2,232.0	3,151.0	3,549.0	2,127.5	1,978.0	97.6%	83.1%	112.6%	93.0%	1,368	6.3	3.1	9.4
Newham	Manor Park ITU NUH	2,495.5	4,730.0	345.0	655.5	2,495.5	4,853.0	356.5	793.5	189.5%	190.0%	194.5%	222.6%	292	32.8	5.0	37.8
Newham	NEONATAL NUH	3,059.0	2,849.0	425.5	425.5	2,806.0	2,624.0	586.5	391.0	93.1%	100.0%	93.5%	66.7%	492	11.1	1.7	12.8
Newham	NUH MIDWIFERY	1,077.0	1,028.5	345.0	274.0	1,012.0	1,038.0	356.5	356.5	95.5%	79.4%	102.6%	100.0%	155	13.3	4.1	17.4
Newham	PLAISTOW	1,598.5	1,504.5	1,414.5	1,127.0	1,426.0	1,345.5	1,426.0	1,473.2	94.1%	79.7%	94.4%	103.3%	572	5.0	4.5	9.5
Newham	RAINBOW	2,825.5	2,310.0	1,200.5	861.5	1,824.5	1,897.5	391.0	575.0	81.8%	71.8%	104.0%	147.1%	378	11.1	3.8	14.9
Newham	SILVERTOWN	1,909.5	2,276.0	1,069.5	1,092.5	1,782.5	2,254.0	1,069.5	1,419.0	119.2%	102.2%	126.5%	132.7%	698	6.5	3.6	10.1
Newham	STRATFORD	1,069.5	1,582.5	1,069.5	1,173.0	1,069.5	1,713.5	1,046.5	1,115.5	148.0%	109.7%	160.2%	106.6%	379	8.7	6.0	14.7
Newham	WEST HAM	2,219.5	1,035.0	1,506.5	885.5	1,334.0	1,265.0	1,046.5	920.0	46.6%	58.8%	94.8%	87.9%	538	4.3	3.4	7.6
St Bart's	1C	6,141.0	5,239.5	356.5	322.0	5,807.5	4,932.0	207.0	230.0	85.3%	90.3%	84.9%	111.1%	414	24.6	1.3	25.9
St Bart's	1D	3,208.5	1,969.5	356.5	473.5	2,852.0	2,081.5	356.5	529.0	61.4%	132.8%	73.0%	148.4%	322	12.6	3.1	15.7
St Bart's	1E	4,979.5	4,038.3	356.5	381.5	4,991.0	3,818.0	356.5	316.5	81.1%	107.0%	76.5%	88.8%	258	30.5	2.7	33.2
St Bart's	3A SBH	4,462.0	3,363.0	1,426.0	1,077.2	4,473.5	3,484.5	1,426.0	1,219.0	75.4%	75.5%	77.9%	85.5%	663	10.3	3.5	13.8
St Bart's	3D SBH	1,322.5	1,316.0	1,023.5	874.0	920.0	862.5	747.5	713.0	99.5%	85.4%	93.8%	95.4%	277	7.9	5.7	13.6
St Bart's	4A SBH	1,782.5	1,311.0	966.0	991.8	1,426.0	1,138.5	356.5	494.5	73.5%	102.7%	79.8%	138.7%	691	3.5	2.2	5.7
St Bart's	4B SBH	1,598.5	701.5	1,242.0	912.5	1,426.0	885.5	713.0	644.0	43.9%	73.5%	62.1%	90.3%	627	2.5	2.5	5.0
St Bart's	4D & 4E SBH	1,757.0	1,412.5	713.0	583.0	1,644.5	1,207.5	713.0	460.0	80.4%	81.8%	73.4%	64.5%	332	7.9	3.1	11.0
St Bart's	5A SBH	2,174.8	2,268.4	876.0	968.3	1,309.0	1,280.5	341.0	660.0	104.3%	110.5%	97.8%	193.5%	645	5.5	2.5	8.0
St Bart's	5B SBH	1,425.0	1,167.3	701.5	713.0	1,426.0	1,161.5	356.5	701.5	81.9%	101.6%	81.5%	196.8%	432	5.4	3.3	8.7
St Bart's	5C SBH	2,144.5	1,702.5	701.5	897.0	1,782.5	1,552.5	345.0	701.5	79.4%	127.9%	87.1%	203.3%	491	6.6	3.3	9.9
St Bart's	5D SBH	2,140.5	2,084.5	713.0	966.0	1,771.0	2,024.0	713.0	1,012.0	97.4%	135.5%	114.3%	141.9%	646	6.4	3.1	9.4
St Bart's	6D SBH	1,759.5	1,686.5	1,069.5	713.0	1,426.0	1,635.0	713.0	680.5	95.9%	66.7%	114.7%	95.4%	545	6.1	2.6	8.7

<b>Report to the Trust Board: 5 May 2021</b>	<b>TB 14/21</b>
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<b>Title</b>	Quality Assurance Committee Exception Report
<b>Chair</b>	Dr Kathy McLean, Non-Executive Director
<b>Author(s) / Secretary</b>	Deputy Trust Secretary
<b>Purpose</b>	To advise on work of Trust Board Committees

**Executive summary**

The Quality Assurance Committee met on 21<sup>st</sup> April 2021 to discuss items on its agenda relevant to its terms of reference, performance against 2020/21 Quality Objectives and agree Quality Objectives for 2021/22.

<b>Key agenda items</b>	<b>BAF entries</b>
• <i>Review of 20/21 Quality Objects and setting 2021.22 Quality Objectives;</i>	2,3,6
• <i>Quality Dashboard</i>	2,3,6
• <i>Patient Experience Report;</i>	6,
• <i>St Bartholomew’s Hospital Quality Assurance Report;</i>	2,3,6,
• <i>Mortality – Learning from Deaths Report;</i>	1-5
• <i>Research Update;</i>	12
• <i>Medicines Governance Board End of Year Report (Jan 2020 – Nov 2020)</i>	5
• <i>Quality Risks &amp; Board Assurance Framework Report</i>	ALL

**Any key actions / decisions taken to be notified to the Board**

- The Committee discussed the performance against 2020/21 Quality Objectives which were framed around the Trust’s Quality Strategy. It was agreed that despite the challenges of covid good progress was made against Quality Objectives but more work was needed to monitor work taking into account Quality Improvement Initiatives and clinical audit.
- The Committee considered key quality issues related to never event reporting for the quarter and were assured that in most cases no harm to patients had resulted; Waiting time performance was discussed which included elective recovery and long waiters agreeing that a clinical harm review should be undertaken to assess and mitigate any clinical risk to patients and also report on any A&E admissions as a result of long waits.
- The Committee noted good progress made on the delivery of covid vaccinations with 87% of BH staff estimated as having received their first dose of the vaccine and continued work to promote take-up across all ethnic groups and to support vaccinations in local communities.
- The Committee noted good progress has been made in the work to improve patient experience at the Trust, focussed work had been undertaken to convert data into actionable insights. The committee supported next steps to operationalise the recommendations.
- The Committee considered the Mortality report noting that the number of “avoidable

<p>deaths” at the Trust over the past year remained consistent and low compared to the total number of and deaths taking into account the number of covid related deaths. The Committee received assurance on the work of medical examiners now deployed across all four hospitals and that a separate mortality review on covid deaths would be undertaken and reported to the Committee in due course.</p> <ul style="list-style-type: none"> <li>• The Committee discussed the impact of the Covid 19 pandemic has on the Trust’s research and development activities, however the Trust had made good insights into Covid studies resulting in increased income from research. A refreshed strategy would be submitted to the Committee in due course.</li> <li>• The Committee received and noted the Annual Report of the Medicines Governance Board.</li> <li>• The Committee reviewed quality themed risks including high risks on the Trust Risk Register detailing risk movement at Q4. The Committee also considered board assurance risks related to the meeting agenda receiving assurance that current levels of controls, actions and monitoring for the high risks were in place and appropriate. The Committee also noted work around high impact low probability risks and were assured that appropriate plans were also in place.</li> </ul>	
<p><b>Any issues for escalation to the Board</b></p> <p>The Committee noted the following to be escalated/notified to the Board:</p> <ul style="list-style-type: none"> <li>• That the plans around elective recovery and long waiters be considered with a clinical harm review to assess and mitigate any clinical risk to patients .</li> </ul>	
<p><b>Legal implications/ regulatory requirements</b></p>	<p>The above report provides assurance in relation to CQC Regulations and Outcomes and BAF entries as detailed above.</p>
<p><b>Action required</b></p> <p>The Trust Board is asked to note the report and approve the appended ToR (agreed by the Committee following their two-yearly review).</p>	

**BARTS HEALTH NHS TRUST**  
**QUALITY ASSURANCE COMMITTEE**  
**TERMS OF REFERENCE**

**1. Authority**

- 1.1 The Quality Assurance Committee is constituted as a standing committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.
- 1.2 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to cooperate with any request made by the Committee.
- 1.3 The Committee is authorised by the Trust Board to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

**2. Purpose**

- 2.1 The Quality Assurance Committee will provide assurance to the Trust Board on the quality of clinical services; that there is an effective system of internal control across the clinical activities of the organisation; delivery of the organisation's quality objectives . This will include review of:
- Strategic priorities and quality priorities in relation to clinical outcomes, patient experience and safety of patients and service users;
  - Compliance with regulatory standards and statutory requirements;
  - Clinical Effectiveness and Internal Audit programmes ensuring these provide a suitable level of coverage;
  - Quality and safety risks on the Board Assurance Framework which have been assigned to the Quality Assurance Committee and high risks on the risk register relating to quality and safety.
  - The effectiveness and assurance in relation to hospitals discharging operational duties and Clinical Boards in relation to the reduction of variation of clinical outcomes.
  - The embedding of Quality Improvement methodology.
  - The annual Quality Account.

- 2.2 Through the steps outlined in paragraph 2.1, the Quality Assurance Committee will provide assurance to the Trust Board via the Audit and Risk Committee that effective systems are in place and the associated assurance processes are optimal. The Committee may initiate reviews based on its own tracking and analysis of quality trends flagged up through the regular performance reporting to the Board and specific issues where it requires additional assurance about the effectiveness of the systems in place to deliver items listed at 2.1 and any quality and safety matters arising from the Trust's recent operational and quality and safety performance – as identified through the Quality Dashboard and spotlight report.
- 2.3 The Quality Assurance Committee will also be responsible for identifying and reviewing, on behalf of the Trust Board, proposed quality improvement priorities set annually, aligned to the Trust's quality strategy.

### **3. Membership**

- 3.1 The Committee shall be appointed by the Trust Board and be composed of:

- Four Non Executive Directors
- Chief Executive and/or Deputy Chief Executive
- Chief Medical Officer
- Chief Nursing Officer

In attendance by standing invitation:

- Director of Corporate Development
- Director of Quality Improvement
- Director of Quality Governance

- 3.2 One Non Executive Director will be appointed as the Chair of the Quality Assurance Committee and another will be appointed as the Vice Chair by the Trust Board. At least one member of the Quality Assurance Committee should preferably have relevant clinical experience or qualifications. One of the Non Executive Director members of the Quality Assurance Committee should also be a member of the Trust's Audit and Risk Committee.
- 3.3 A quorum shall be four members, at least two of whom should be Non Executive members of the Trust Board.
- 3.4 Members should make every effort to attend all meetings of the Committee and will be required to provide an explanation to the Chair of the Committee if they fail to attend four meetings in a calendar year. If a member fails to attend more than four meetings in a calendar year the Chair of the Committee will consider the appropriate action to be taken, including the option of recommending to the Trust Board the removal of the member from the Committee. The Committee Secretary will monitor attendance by members and report this to the Chair of the Committee on a regular basis.



#### **4. Attendance**

- 4.1 Site Chief Executives and Clinical Board Chairs will be invited to attend to support any exception reports requested. Other Non Executive Directors shall be welcome to attend and all members of the Trust Board will receive papers to be considered by the Committee.
- 4.2 The Committee may invite other Trust staff to attend its meetings as appropriate. In particular, where appropriate, the Committee will invite clinical teams to attend its meetings to provide assurance on key governance and risk issues.
- 4.3 The Trust Secretary will ensure that the Trust Office provides a Secretary to the Committee and appropriate administrative support to the Chair and committee members. This shall include agreement of the agenda with the Chair and attendees, collation of papers, taking the minutes and keeping a record of matters arising and issues to be carried forward and advising the Committee as appropriate.

#### **5. Frequency of meetings**

- 5.1 Meetings will generally be held on a bimonthly basis, with a minimum of five meetings a year.

#### **6. Reporting**

- 6.1 The Quality Assurance Committee will receive regular exception reports covering quality and safety issues escalated from the Quality Board and Risk Management Committee. The Committee will also receive regular exception reports from any sub-committee it establishes.
- 6.2 The approved minutes of the Quality Assurance Committee's meetings will be circulated to all Trust Board members for information and an exception report presented to the next Trust Board meeting following each Committee meeting to draw to the attention of the Trust Board any issues that require disclosure to the full Board.
- 6.3 The Quality Assurance Committee will provide an annual report to the Audit and Risk Committee on the effectiveness of its work and its findings, including its review of relevant Board Assurance Framework entries and audit reports covering areas within its terms of reference. This will assist the Audit and Risk Committee in discharging its responsibility for providing assurance to the Trust Board in relation to all aspects of governance, risk management and internal control. In addition, a Quality Assurance Committee exception report will be included as a standing item on the Audit and Risk Committee agenda for information enabling the Chair of the Quality Assurance Committee to report back on the work of the Quality Assurance Committee. If there is any perceived ambiguity regarding the relative roles of the Audit and Risk Committee and the Quality Assurance Committee in this respect, the committee chairs will liaise to agree a satisfactory approach.

## 7. Review

- 7.1 The Terms of Reference should be reviewed by the Committee and approved by the Trust Board at least every two years.

## 8. Duties

### **Governance, internal control, performance and risk**

- 8.1 To review the establishment and maintenance of an effective system of governance, performance and internal control in relation to clinical services, research and development, and education and training in order to ensure the delivery of safe, high quality, patient-centred care.
- 8.2 To receive and review at each meeting those entries on the Trust's Board Assurance Framework (BAF) which are to be overseen by the Quality Assurance Committee (or deep dive reviews of specific entries according to the workplan). Agreement on the allocation of oversight of BAF risks between the Quality Assurance Committee, Finance and Investment Committee and the Audit and Risk Committee will involve the chairs of the committees and will be endorsed by the Trust Board. The full BAF will be received by the Trust Board at least three times a year.
- 8.3 To receive regular reports on high risk register entries relating to quality and safety.
- 8.4 To advise the Trust Board on the appropriate quality and safety indicators and benchmarks for inclusion on the Trust Integrated Performance Framework and supporting data quality for these metrics. To support the development and ongoing monitoring of ward quality and safety dashboards. At the request of the Trust Board (and in line with paragraph 2.1), the Quality Assurance Committee will include within its work plan agree reviews of operational performance where there is ongoing non-compliance with constitutional standards e.g. in the event of suspension of reporting against the 18 Weeks Referral to Treatment Time standards. This will include a review of performance against recovery trajectories and supporting governance arrangements.

### **Quality and safety reporting**

- 8.5 The Committee will receive reports on the Trust's CQC improvement plans (*Safe and Compassionate – Getting to Good and Outstanding*) and arising inspection or other reports from the CQC and other key regulatory agencies with roles in relation to quality and safety of care.
- 8.6 To receive, at least annually (or more frequently as agreed with the Chair in the workplan), assurance reports in relation to:

- Complaints.

- Research and development.
- Education and training.
- Health and Safety.
- Infection Prevention and Control.
- Clinical Effectiveness (see paragraph below).
- Aggregated analyses of adverse events (including serious incidents, never events, claims and litigation) to identify common themes and trends and gain assurance that appropriate actions are being taken to address these.
- Patient experience (see paragraph below) including national patient surveys (including inpatient, maternity and cancer survey).
- Safeguarding children and adults.
- Maternity services.

The Committee will receive other reports based on key quality and safety themes (identified and agreed by the Chair and lead executives as part of its work plan).

- 8.7 To receive other reporting from executive groups established to support related care and quality improvement work (e.g. Quality Board).
- 8.8 To receive and review the Quality Account and any other key non-financial governance submissions to national bodies and to make recommendations for sign off by the Trust Board.

#### **Audit and assurance**

- 8.9 To review the annual Clinical Effectiveness programme and receive assurances from Internal Audit on quality and safety reviews (including an in-depth review on a three-yearly basis regarding the capability of the Trust's Clinical Effectiveness function).
- 8.10 To receive details of all national clinical audits where the Trust is identified as an outlier or a potential outlier. This should include but not be limited to mortality outlier alerts.
- 8.11 To review the Internal Audit operational plan and more detailed work programme and to make recommendations, subject to Audit and Risk Committee approval, on the clinical, research and development, and education and training aspects of the Internal Audit annual work plan.

- 8.12 To receive and review the findings of Internal and External Audit reports covering patient safety, quality and experience, research and development, and education and training, and to assure itself that the management of the Trust is implementing the agreed recommendations in a timely and effective way.

#### **External Assurance**

- 8.13 To receive all reports on the Trust produced by the Care Quality Commission and to seek assurance on the actions being taken to address recommendations and other issues identified.
- 8.14 To ensure that the Trust learns from national and local reviews and inspections; emerging national best practice; national enquiries on healthcare services and implements all necessary recommendations to improve the safety and quality of care.
- 8.15 To receive reports on significant concerns or adverse findings highlighted by external bodies in relation to clinical quality and safety and the actions being taken by management to address these (including, specifically, any external quality reviews commissioned by the Trust Board or conducted by third parties and due for publication, with potential stakeholder or media interest).
- 8.16 To ensure the work of the Committee is informed by and feeds into the work of the Trust's Quality Board (and any associated executive patient experience groups), including reviewing key messages from survey findings and ensuring a specific focus on sharing best practice, promotion of and learning from patient experience.

**Reviewed by the Quality Assurance Committee: tbc**  
**Last Approved by Trust Board: 12 September 2018**

<b>Report to the Trust Board: 5 May 2021</b>	<b>TB 15/21</b>
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<b>Title</b>	Nominations and Remuneration Committee Exception Report
<b>Chair</b>	Ian Peters, Chairman
<b>Author(s) / Secretary</b>	Trust Secretary
<b>Purpose</b>	To advise the Trust Board on work of Trust Board Committees

<b>Date of meeting</b>	The Nominations and Remuneration Committee met on 17 March 2021
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<b>Key areas of discussion arising from items appearing on the agenda</b>	The Nominations and Remuneration Committee held a meeting on 7 March 2021. At this meeting the Committee received an updated on application of national guidance on consultant clinical excellence awards; an inflationary uplift to Very Senior Management grade staff; the establishment of a pathology partnership managing director post; an annual update on gender pay gap; executive succession planning (including the appointment to the interim Director of People post and proposals for Lifesciences leadership); and Fit and Proper Persons regulations consultation. The Committee also reviewed details of recent employment tribunals findings to consider any learning.
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<b>Any key actions agreed / decisions taken to be notified to the Board</b>	See above.
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<b>Any issues for escalation to the Board</b>	None.
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<b>Legal implications/ regulatory requirements</b>	n/a
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<b>Action required by the Board</b>	The Trust Board is asked to note this exception report from the Nominations and Remuneration Committee.
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<b>Report to the Trust Board: 5 May 2021</b>	<b>TB 16/21</b>
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<b>Title</b>	WeBelong Update and progress
<b>Accountable Director</b>	Deputy Group Director of People
<b>Author(s)</b>	Inclusion Centre Programme Manager Deputy Group Director of People
<b>Purpose</b>	Update on progress against WeBelong, summarise emerging Trust inclusion priorities and approach for 2021/22.
<b>Previously considered by</b>	Inclusion Board, April 2021

### Executive summary

This paper reports progress of delivery of the commitments set out in WeBelong. Measurable progress has been made on these commitments and more broadly to achieve the ambition of WeBelong. The Trust ambition is to co-produce a second phase of WeBelong that will accelerate work to establish Barts Health as an anchor institution. To do so, networks, hospital committees, the Inclusion Board, Advisory Panel and leadership webinars have been engaged to co-develop priorities into an implementation plan over May. This implementation plan will closely align with mandated actions in the NHS People Plan. Once the priority areas are agreed with staff, specific metrics and milestones will be developed to ensure a continued commitment to make a sustained impact in inclusion.

### Related Trust objectives

To create an inclusive organisation by taking a systematic Trust-wide approach to eliminating discrimination and racial inequality

<b>Risk and Assurance</b>	Assurance in relation to the above objective
<b>Related Assurance Framework entries</b>	1. Failure to deliver agreed inclusion commitments impairs improvements in: organisational culture, staff experience, development of all talent, morale, recruitment and retention of staff and organisational performance

<b>Legal implications/regulatory requirements</b>	The content of this paper is in line with our Public Sector Equality Duty requirements and relates to a KLOE under the 'Well-led' domain of CQC inspection framework.
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### Action required:

The Trust Board is asked to note:

- Progress since the publication of WeBelong; and steps to confirm renewed commitments to ensure continued progress in our road to equality.
- Staff engagement on a preliminary list of key focus areas, for Board

consideration, to expand on WeBelong in 2021/22.

- A detailed implementation programme being developed with staff during May to determine how and when this work should be delivered.
- Engaging the WelImprove methodology and approach in continuously enhancing the programme.

## BARTS HEALTH NHS TRUST

### REPORT TO THE TRUST BOARD: 5 MAY 2021

#### WEBELONG PROGRAMME UPDATE REPORT

##### INTRODUCTION AND PURPOSE

1. Barts Health is committed to taking a systematic Trust-wide approach to eliminating discrimination and inequality and creating a safe and inclusive place to work. The Trust is also committed to acting as an anchor institution within the community, providing employment, investment in the local area and addressing health and social inequalities. The commitment to do so was outlined in the [WeBelong Inclusion Strategy](#) (November 2020).
2. Measurable progress has been made towards the five commitments outlined In WeBelong Inclusion Strategy. This paper will review progress made in the last 6 months and sets out the approach to continuing to the deliver the goals of WeBelong.
3. Barts Health has invested in further capacity for its inclusion programmes and will co-develop its priorities for 2021/22 to ensure staff (through inclusion committees and networks) are steering this second phase of WeBelong. This process will apply the principles of Welmprove to ensure we are continuously improving the programme and responding to staff needs.

##### REVIEW OF PROGRESS IN 2020/21

4. Progress has been made against all WeBelong commitment areas and a concerted effort is being made to fully achieve our ambitions over 2021. The commitments and outcomes of WeBelong are:

**2021/22 Commitment 1: To change the senior recruitment processes in the light of staff feedback and best practice for inclusion with effect from 30 September 2020**

5. The period following the introduction of the revised appointments process has shown a positive impact in shortlisting of female and ethnic minority staff compared to the period before its introduction. For female applicants the percentage shortlisted increased by 7.0%. For BAME applicants the percentage shortlisted increased by 7.1%. There has also been a modest improvement in BAME appointments overall.

Shortlisted for interview	Feb 20 – Jul 20	Aug 20 – Jan 21
Female	22.4%	29.4% (+7.0%)
BAME	25.6%	32.7% (+7.1%)



6. A review is underway to ascertain where improvements in the current process could be made. As part of this we will also be looking to see how the role of the Inclusion Ambassador could be strengthened in the decision making process.

**2021/22 Commitment 2: Inequalities between individuals entering disciplinary and grievance procedures will be equalised by 31 March 2021.**

7. Improvements in the Trust's policies has led to the number of disciplinaries reducing. The Dignity at Work, Grievance and Disciplinary polices have been reviewed and refreshed which has resulted in the total number of disciplinaries reducing from 114 (March 19) to 53 (March 21 *provision data not yet published*). The increased likelihood of BAME staff facing a disciplinary compared to white staff has also improved from 1.76 (March 19) to 1.25 (March 20). The position for 20/21 will be updated when the March 2021 WRES data is published.

Disciplinary	April 19 to Mar 20	White	BAME	Unknown	Total
	Cases	21	40	20	81
	Staff in Post	6,110	9,343	1,303	16,756
	Likelihood	0.3%	0.4%	1.5%	0.5%
	Rel Likelihood BAME v W	1.25			
	April 18 to Mar 19	White	BAME	Unknown	Total
	Cases	27	69	18	114
	Staff in Post	6,025	8,759	1,626	16,410
	Likelihood	0.4%	0.8%	1.1%	0.7%
	Rel Likelihood BAME v W	1.76			

8. Informal resolution will now be a key measure that is captured from April 2021. This will provide more insight as the number of formal cases are so low. This will also uncover whether managers are using informal routes of resolution fairly.

**2021/22 Commitment 3: All top leaders will be reciprocal mentors, with the first 200 in mentorship pairs by 31 March 2021**

9. The Reciprocal Mentoring for Inclusion programme has been commissioned and is a systemic leadership development intervention designed to create transformational change and enable a culture of diversity, equality and inclusion, where the power of difference is valued. It provides opportunities for individuals from all under-represented groups to work as 'partners in progress' with senior leaders in a relationship where knowledge and understanding of their different lived experiences creates awareness and insights that directly contributes towards the creation of a more equitable and inclusive organisation.
10. The first cohort matched 40 participants. By June we are expecting to achieve our desired position of 200 participants.

**2021/22 Commitment 4: All senior leaders will act as career mentors and offer this to all staff who would like mentoring**

11. A career development programme is being developed to provide a wide-reaching approach to developing staff, building on the success of our previous Career Development Programme where 27% of 411 participants have secured a promotion to a higher band.

**2021/22 Commitment 5: New inclusion governance arrangements give staff a stronger voice and a share in decision-making**

12. Governance changes have been made to enable staff networks and inclusion representatives to take more of a lead in steering the agenda without having the full burden of delivering projects themselves. This will be expanded in 2021/22 through the co-design of the second phase of WeBelong. As well as this, we have secured, on behalf of Network co-chairs, additional protected time to actively support the co-Chairs to deliver on behalf of their networks, allocated executive sponsors to champion each network and invested in providing a full-time project officer to give dedicated support to networks across the Trust. Barts Health is developing the 2021/22 strategy with staff networks, Hospital committees and citizens to be responsive to their needs.

**Key areas of further progress**

13. Barts Health is committed to being transparent and acknowledging where inequality exists. The Trust has published a number of reports highlighting inequalities based on gender ([Gender Pay Gap Report](#)), disability ([WDES action plan](#)), race (WRES) and more (End of Year report, Inclusion Matters Report). These additional areas are key priorities of our on-going programme
14. A modest improvement has been made between the 2019 and 2020 WRES reports on closing the gap between relative shortlisting prospects for white and BAME staff. However, a gap remains - this will be addressed as part of further overhauls in recruitment processes. Whilst the numbers of BAME staff in VSM and senior positions has increased significantly, BAME staff are more likely to experience discrimination or bullying – this will also be a key area of focus for 2021.
15. The Gender Pay Gap (GPG) report has been published as part of our statutory obligations and the recommendations of this will be reviewed through a newly established GPG Taskforce group.
16. Barts Health has commissioned a cultural intelligence programme which will be scaled into an integrated training offer across the Trust to develop a just culture, linking to WeLead. Developing culturally intelligent leadership (CQ) is a key commitment in creating a truly inclusive organisation in WeBelong. It promotes positive understanding and engagement with diversity, where all talent is developed and used, and services are best tailored to meet diverse need of communities and service users. The programme will be roll out from June starting with the Trust Board leadership. Alongside this we will be developing our own internal capability within Barts Health through a facilitators development programme.

17. Additional staffing resource has been added to the Inclusion Team to build on the developments to date and ensure accelerated delivery of our commitments in 21/22. The team will develop a set of specific metrics aligned to each commitment using the QI approach through WeLead to improve delivery. This will include frequent monitoring of key measures rather than waiting for the annual staff survey or publication of WRES metrics. These will be agreed and monitored by the Inclusion Board.

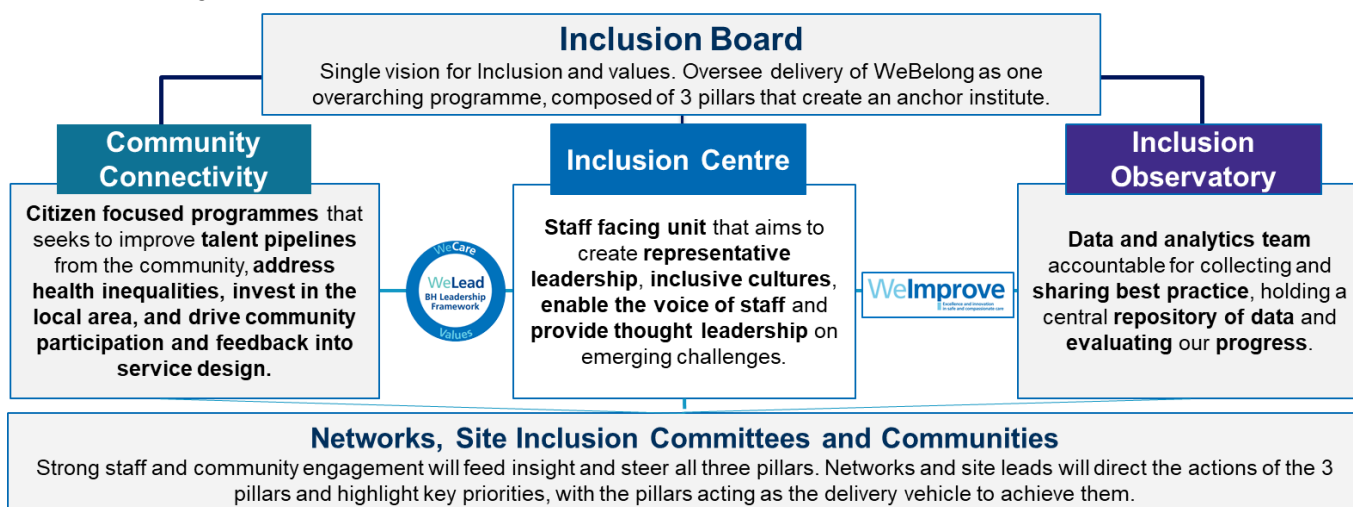
**DEVELOPING OUR 2021/22 PRIORITIES**

18. To deliver on ambitions of further reducing these inequalities, a three-pillar delivery model has been created with an expanded team to provide increased capacity. Each pillar is accountable for a key area of focus that when taken together, will establish an Anchor institute. Significant engagement has been undertaken with staff networks, the Inclusion Board, Inclusion Advisory Panel, hospital committees and senior leaders to support the co-design of our key priorities. These will be incorporated into our operating plan and we will further refresh the WeBelong strategy to reflect the feedback

19. The three pillars will form part of our integrated approach to delivery of the ambitions of WeBelong:

- **Community Connectivity:** Addressing inequality and developing closer ties in the community
- **Inclusion Centre:** Promoting equality in the workplace and addressing structural disparity
- **Inclusion Observatory:** Learning from best practice, monitoring and evaluating progress.

20. These pillars are linked by the Inclusion Board, which feeds directly into the Group Executive and Trust Boards. To support the Trust, an Inclusion Advisory panel has been formed drawing from national experts in the field of inclusion and designated NEDs.



## RECOMMENDATIONS

21. The Trust Board is asked to note:

- Promising progress made since the publication of WeBelong. Barts Health will make a series of renewed commitments to ensure continued progress in our road to equality.
- A detailed implementation programme will be developed with staff over May to determine how and when these key areas of focus should be delivered. This plan will contain specific milestones.
- The updated inclusion programme will form an integral part of the Operating Plan which will be discussed at the June board seminar and at the July Trust Board meeting.

<b>Report to the Trust Board: 5 May 2021</b>	<b>TB 17/21</b>
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<b>Title</b>	Embedding Equity into Recovery
<b>Accountable Director</b>	Director of Public Health and Chief Medical Officer
<b>Author(s)</b>	Kate Turner, Strategy Programme Manager Ian Basnett, Director of Public Health
<b>Purpose</b>	To provide an update on the Trusts equity work, describe how we are embedding equity in the planning and delivery of our services, and responding to guidance, and to share and agree next steps.
<b>Previously considered by</b>	Group Executive Board

**Executive summary**

Equity is an important component of quality. In March 2017 Barts Health NHS Trust established a cross-site, multi-disciplinary Equity Working Group to support focus on equal access, opportunity, and quality of care for Barts Health patients. The Trust has been using routinely collected patient data to review aspects such as access, process, outcomes, and experience to identify opportunities to improve equity. COVID-19 has highlighted inequalities in health. North East London boroughs have been severely impacted, experiencing some of the highest mortality rates in the UK. The pandemic has created both an immediate short term need to enact plans to mitigate harm caused by inequalities, and to address systemic healthcare inequalities beyond the current crisis. The Trust has proactively taken significant measures to ensure services are provided equitably during recovery. The primary purpose of this report is to provide an update on the Trusts equity work, describe how we are embedding equity in the planning and delivery of our services in the next phase, and responding to guidance, and to share and agree on next steps.

<b>Related Trust objectives</b>	
<p><b>Barts Health Corporate Objectives:</b> SO1: Safe and Compassionate Care and SO2: Efficient and Effective Care</p> <p><b>Barts Health Equality Objectives:</b> To ensure improved access and patient experience for all, irrespective of their protected characteristic group identity, using equalities monitoring data effectively to identify where we need to focus our efforts in improving both patient access, outcomes and experience. To promote effective use of Equalities Monitoring data, using patient and population data to shape our Clinical Strategy.</p>	

<b>Risk and Assurance</b>	
<b>Related Assurance Framework entries</b>	2. Failure to identify healthcare inequalities and to secure equity of access and community connectivity impairs delivery of high quality, equitable healthcare outcomes

<b>Legal implications/ regulatory requirements</b>	The content of this paper is in line with our Public Sector Equality Duty requirements and relates to a KLOE under the 'Well-led' domain of CQC inspection framework.
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<b>Action required:</b> The Trust Board is asked to note progress, discuss and agree next steps.
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**BARTS HEALTH NHS TRUST**

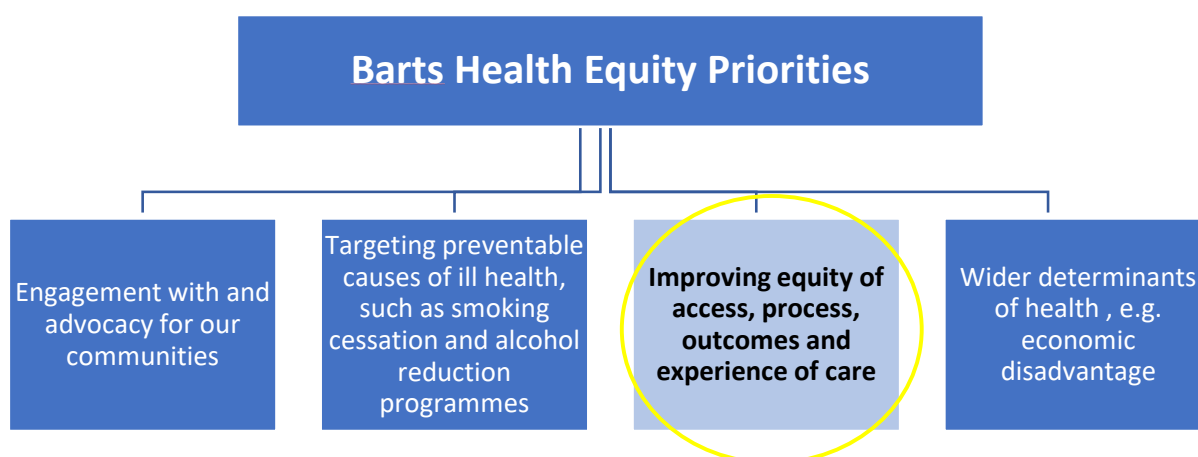
**REPORT TO THE TRUST BOARD: 5 MAY 2021**

**IMPROVING QUALITY AND EMBEDDING EQUITY**

**INTRODUCTION**

1. Equity is an important element of quality (Appendix 1). Improving equity involves both addressing potentially avoidable inequalities, and working to ensure our services don't unintentionally disadvantage any group (Appendix 2).
2. Barts plays an integral and influential role in North East London's Health System and reducing health inequities for marginalised groups. As such, the Trust has developed Equity priorities: community engagement, targeting preventable disease, improving equity of care, and addressing wider determinants of health, e.g. through serving as an anchor institution (Figure 1).

*Figure 1: Barts Health's Equity Priorities*



3. This paper focuses only on the third of these areas, improving equity of care. However, the Trust has also:
  - Increased its engagement with local communities, sharing information on service utilisation, providing advocacy, and working with local communities on health messaging to minimise the impact of COVID.
  - Maintained a long-standing programme addressing preventable causes of ill health amongst patients such as smoking cessation and diet advice, and staff initiatives such as flu and COVID vaccines.

- A well-established team addressing the socio-economic causes of ill health in local communities. We have brought together improving sustainability, inclusion, and addressing racism under the banner of an ‘Anchor Institution’. This includes the Trust’s work with schools, recruiting local apprentices, and training young people to work at Barts Health. It also includes the Trust’s work to achieve the goals set out in the *NHS People Plan* and the letter *Implementing phase 3 of the NHS response to the COVID-19 pandemic* to have a more diverse workforce, particularly at a senior level with a focus on social mobility and inclusion.
4. COVID-19 has highlighted and intensified inequalities in health in the UK. North East London boroughs have been severely impacted, experiencing some of the highest mortality rates in the UK.
  5. Policymakers have responded to these inequalities, and in July, NHSE released guidance<sup>1</sup> declaring that health services must consider health inequalities as they plan service restoration and set out eight urgent actions to address inequality. Further guidance, released in late March<sup>2</sup>, states that health providers should use waiting lists to identify and address disparities by Ethnic group and in the bottom 20% deprivation decile. At least 25% of outpatient appointments are expected to continue remotely.
  6. This paper provides an overview of the Trust’s work on equity pre-COVID. It then describes how the Trust is approaching equity and addressing inequalities in the healthcare it provides in the next phase and beyond, including how the Trust has responded to the actions published in NHS E guidance. It concludes by setting out the next steps.

## PRE-COVID EQUITY WORK

7. Since 2017, the Trust has been using routinely collected patient data to review aspects of access, process, outcomes, and experience to identify opportunities to advance equity. We have focused on inequalities with regard to gender, ethnicity, age, social deprivation, and disability, where data are available.
8. The Trust agreed to an initial set of equity indicators (Appendix 3), worked with each clinical board to identify an equity priority (Appendix 4), and started work

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<sup>1</sup> NHS, Implementing Phase 3 of the NHS response to the COVID-19 pandemic, July 2020, <https://www.england.nhs.uk/wp-content/uploads/2020/08/implementing-phase-3-of-the-nhs-response-to-covid-19.pdf>;

<sup>2</sup> NHS, 2021-2022 Priorities and operational planning guidance, March 2021, <https://www.england.nhs.uk/publication/2021-22-priorities-and-operational-planning-guidance/>



to create a Trust-wide Equity Strategy.

9. In many of the analyses to date, the Trust found no disparities for patients from protected groups, or for patients who are living in areas of high deprivation. Key findings can be found in Appendix 5.
10. Where inequity has been identified, the Trust has conducted further work to understand and address the issue. One of our most significant findings has been a positive correlation between increasing age with four-hour breaches in the Emergency Department and subsequent risk of re-admission. In response to these findings the Trust initiated a cross-site programme to improve care for frail patients.
11. Further work will address the integration of findings within the wider context of community engagement and place-based people participation. Current ICS work across NEL will enable a coherence of workstreams and standards.

**RESTART: RESPONDING TO THE GUIDANCE**

12. While many of the Trust’s ongoing initiatives were already aligned to the eight recommendations set out in the July Guidance, to ensure plans were in place for all eight urgent actions and oversee the delivery of the requirements, the Trust created an Equity Task and Finish Group. The Group is chaired by the Director of Strategy and co-chaired by the Director of Public Health (Table 1; Appendix 6). In the subsequent guidance released at the end of March 2021, systems have been asked to focus on five priority areas in the first half of 2021/22, distilled from the initial 8 actions. Table 1 lists the Phase 3 actions. Guidance has also linked five new requirements with system funding.

*Table 1: NHSE ‘Phase 3’ Requirements*

NHSE ‘Phase 3’ Requirements
Action 1: Protect the most vulnerable from COVID
Action 2: Restore services inclusively*
Action 3: Develop digitally enabled care pathways in ways which increase inclusion*
Action 4: Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes*
Action 5: Particularly support those who suffer mental ill health
Action 6: Strengthen Leadership and Accountability

Action 7: Ensure datasets are complete and timely\*

Action 8: Collaborate locally in planning and delivering action to address health inequalities\*

\* Indicates key priority area for 2021-2022 as per March NHSE guidance

Action 5 is outside the scope of this summary; we will be working with our ICS partners to address Action 5 when we receive more details. Actions 6 and 8 involve ongoing collaborations with our local partners are addressed briefly in Appendix 8.

## **ACTION 1: PROTECTING THE MOST VULNERABLE FROM COVID**

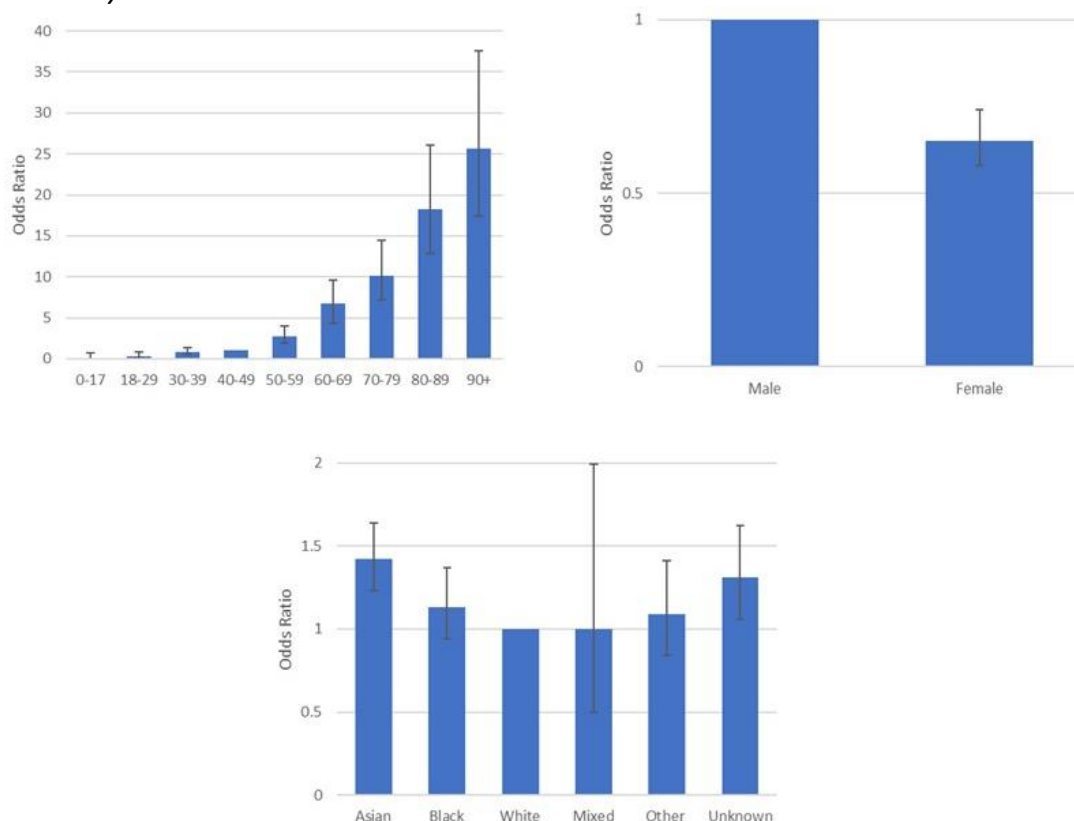
13. The Trust took early action to understand and address COVID's impact on equity in staff and patient care.

### **Patient admissions and mortality**

14. Barts Health and Queen Mary University of London (Apea et al., 2020) undertook analysis of the first peak to better understand inequalities by ethnic group. A review of 3170 COVID-19 admissions found:
  - BAME patients admitted to Barts Health Hospitals with COVID-19 were disproportionately younger than White patients.
  - The median age of Asian patients was 14 years younger than the overall median.
  - Asian and Black patients were at increased risk of death after adjusting for age and sex. These associations could not be accounted for by comorbid disease and other risk factors.
15. A similar but separate analysis found that overall survival rates across the Trust were better than the national average.
16. Following the second peak, the Public Health team compared data on morbidity and mortality from the first and second wave. Differences in data definitions mean that direct comparison between this analysis and Apea et al. paper above should not be made.
17. This analysis included 2923 admissions during Wave 1 (March - July 2020) and 5895 in Wave 2 (August 2020- January 2021). A provisional analysis of mortality suggest that the relative risk of dying were 21% lower (95% confidence intervals 31% to 13%) lower in wave 2 paired to wave 1 (adjusted for sex, age, ethnic group and comorbidities).
18. Our findings align to the national picture. Disparities relate to a mixture of factors including a higher risk of exposure, comorbidities, and the long-standing issues relating to race in society.
19. The comparison analysis found:
  - Compared to Wave 1, more patients from younger age groups were admitted in Wave 2 than Wave 1.
  - Of all patients admitted, a greater proportion were Asian/Asian British (particularly Bangladeshi patients) in Wave 2 (35%, 2092) compared with Wave 1 (27%, 782), with decreases in the proportion of patients in Wave 2 who are

- Black/Black British (17%/487 to 11%/677) or White (38%/1114 to 33%/1932).
- Proportion of patients admitted to ITU was 20% (583/2923) in Wave 1 and 17% (994/5895) in Wave 2. Following adjustment for other factors, odds of ICU admission peaks at 60-69 years, with 41% (95% CI 34%-48%) higher odds in men than women. Asian patients and Black patients have a 39% (95% CI 21%-61%) and 45% (95% CI 21%-74%) higher odds of admission compared with White patients.

Figure 2: Mortality among patients diagnosed with COVID-19 during admission to Barts NHS Trust or in the 30 days prior to admission, by demographic group, using a multiple logistic regression model adjusting for age, sex, ethnic group and co-morbidities. March 2020 to January 2021.



20. A more detailed analysis on Peak 2 is in preparation.

### Increasing patient engagement

- 21. The Trust has established a Barts Interfaith Community Group which includes approximately 40 member organisations including interfaith organisations from across the 5 boroughs, Black and Minority Ethnic community organisations, Public Health Leads and Engagement Leads from London Commissioning Groups.
- 22. The group has been providing support to communities impacted by COVID, including addressing vaccine hesitancy in BME communities.

### Inpatients with learning disabilities in Peak 1

- 23. The hospital survival rate for the 29 patients with learning disabilities (LD) admitted with COVID-19 (in Peak 1) was lower than that of the general Barts Health inpatient population, although these are small numbers and not adjusted for pre-existing conditions. A review of these patients admitted between March

and early May 2020 explored the demographic and health profile of the patients, and the hospital care they received, to assess whether any themes could be identified. Findings included some good practice as well as areas for improvement including the application of the Mental Capacity Act, avoiding assumptions about individuals, and making reasonable adjustments which the hospitals are working to address. Furthermore, a proposal is underway to support the funding of additional nursing staff and medical education resources to improve care for patients with LD.

24. Anecdotal feedback from the Learning Disability lead suggests that the care for people with LD has been significantly improved in the second wave. A follow-up analysis is underway reviewing care in Peak 2.

### **Staff absences and redeployment**

25. The Trust reviewed 5500 staff absences between March and April 2020. Over half of the absences were due to a positive COVID-19 test, with more still due to self-isolation and shielding. Ethnic minority staff were at higher risk of absence compared to White staff.
26. The Trust also found disparities between ethnicities in the redeployment of staff, with some ethnic groups overrepresented in comparison to the proportion of these ethnicities in the staff of the respective hospitals. At Royal London Hospital, a higher proportion of White staff were redeployed to ACCU, at Newham, higher proportions of Filipino staff were redeployed; Redeployment data was not available for Whipps Cross.
27. To address disparities, the Trust implemented:
  - Risk assessments for every employee
  - Anonymised redeployment and staff review of the process
  - Cultural intelligence training for managers
28. After the second peak, a repeat analysis found that the Trust significantly reduced redeployment disparities.
29. At Royal London, White staff were overrepresented in redeployment in the first peak but Asian employees were overrepresented in the second. At NUH, Asian (Filipino) staff were over-represented in the first peak. In the second peak, a significantly larger proportion of White employees were redeployed; Asian employees were still overrepresented, but by a much smaller proportion than during the first peak. Employees who selected “other” for their ethnicity were overrepresented in the second peak at both Royal London and NUH. Redeployment data from Whipps Cross Hospital was not available for the first peak, but White staff were overrepresented in the second.

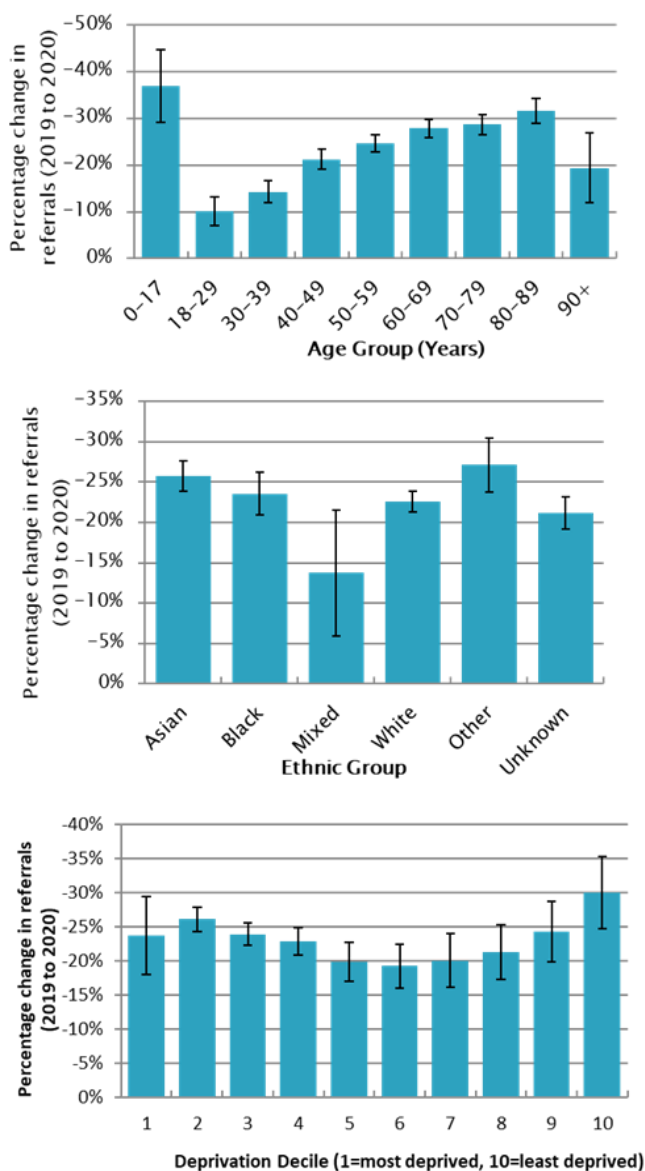
## **ACTION 2: RESTORE SERVICES INCLUSIVELY**

30. In order to ensure the Trust restored services inclusively, in the initial de-escalation period after the first peak, the Trust compared activity pre-COVID with that of the de-escalation period in Outpatient, Elective and Emergency Care. The analysis examined variables such as age, gender, ethnicity, and deprivation to find opportunities to improve equity as the Trust restored services. While disparities were observed between April and September of 2020, they were significantly diminished by January (entering the second peak).
31. Now, as the Trust recovers from the second COVID peak, we are again monitoring activity to ensure that services are restored equitably. In addition, we are trialling new tools to measure and monitor dimensions of equity.

### **Cancer referral activity**

32. In order to explore whether there was any evidence of inequalities in cancer referral sources, referrals from March to November 2020 were analysed against referrals from the same period in 2019. There were 32053 referrals to Barts Cancer Services in this period in 2020, which was 9698 lower than the same period in 2019. The analysis found disparities in sex, age, ethnic group and deprivation. Men have a significantly greater reduction in referrals compared to women. Further details on age, ethnic group and deprivation shown below.

Figure 3: Cancer referrals by demographics



**Age**

Children have the highest reduction (-37%) in referrals. However, this is based on a small number and may be a result of changes in referral patterns. In adults there is a general trend of increasing drop in referrals with age.

**Ethnic group**

Asian patients (26%) and patients of 'Other' ethnic groups, and 'mixed' ethnic groups have seen the greatest overall reduction in referrals.

**Deprivation**

There is a general trend of greater drops in referrals among the most deprived and least deprived groups. The drop among the least deprived may represent either a move to private healthcare or that wealthier residents may have been more likely

Source: Public Health Team, Somerset Cancer Register, March 2021

The Trust is conducting further analysis and working with our ICS partners to review population data to better understand these trends.



### Non-attendance in emergency care

33. In light of the new 111 triage system, the Trust is reviewing access to emergency care. As part of this review, researchers phoned 53 patients and asked about their reasons for non-attendance to in-person Emergency Care after triage.

Table 2: Reasons for non-attendance (DNA) to Emergency Care

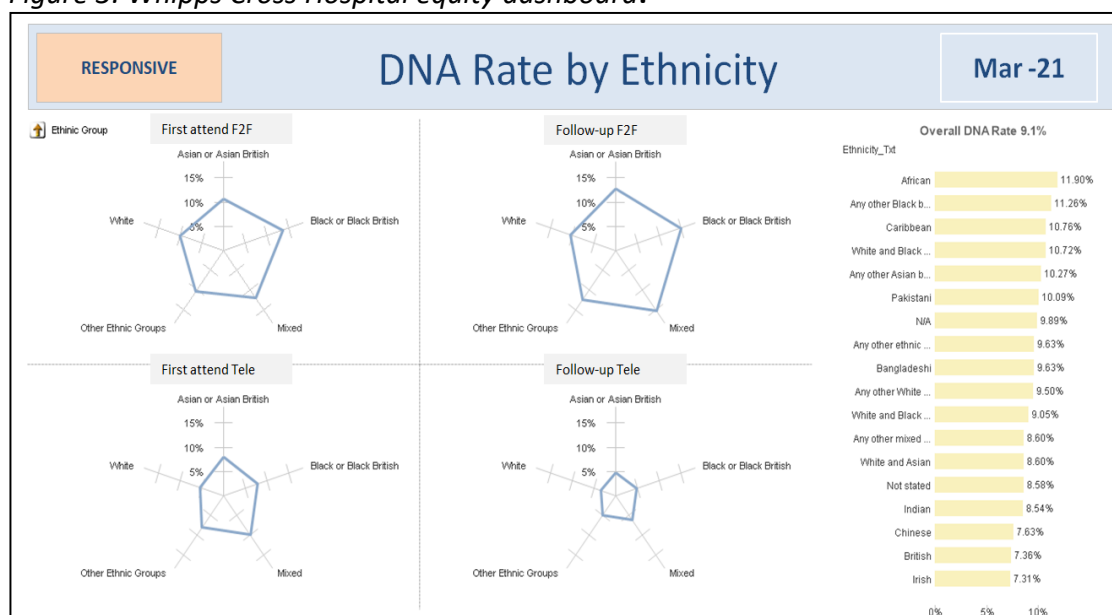
Reasons for DNA	N
Couldn't take time off work	2
Did not have the means to travel	4
Didn't understand 111 advice	4
Did not have time	5
Worried COVID-19 at the hospital	6
Childcare issues	6
Sought medical assistance elsewhere	7
Symptoms changed	12
Didn't agree with 111 advice	14
Other (did not receive call back, felt too unwell to go, etc.)	13
<b>Total</b>	<b>53</b>

34. The Public Health team are working with NHS 111 to undertake an equity audit of the North East London 111 service, examining access, process and outcome indicators, as well as qualitative reviews of SUIs to look for equity themes.

### Equity dashboards

35. The Trust is also piloting equity dashboards to understand how best to routinely monitor dimensions of equity for services (Figure 3). These dashboards indicate how rates of attendance vary with several factors of identity, including ethnic group, deprivation, gender, and age.

Figure 3: Whipps Cross Hospital equity dashboard.



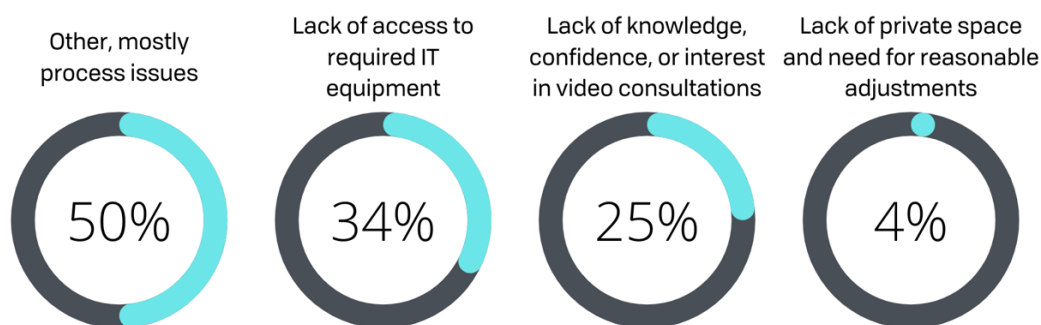
**ACTION 3: DEVELOP DIGITALLY ENABLED CARE PATHWAYS IN WAYS WHICH INCREASE INCLUSION**

36. Ahead of recent guidance, the Trust initiated a significant work programme, COVID Outpatients Group (CoVOG) Equity subgroup, to increase equity in outpatient services. A significant portion of this work is focused on improving equity in virtual appointments. Working with a few services, and using a QI approach, CoVOG are using routinely collected data, interviews with service users and non-attenders, and clinician feedback to identify disparities and improve equity. Working closely with our patient engagement leads, the group will pilot interventions; findings from these pilots will be shared across the Trust.

**DNAs in video outpatient appointments**

37. In October 2020, 92 patients were telephoned to ask for their reasons for non-attendance to video outpatient appointments. Analysis of patient-identified reasons for non-attendance of video clinics found that lack of access to the necessary equipment and lack of knowledge and confidence were both major issues, particularly in older age groups. The most frequent DNA reason was operational factors; these included patients who didn't get the letter, couldn't get into the virtual waiting room, or forgot to attend.

Figure 4: Reasons for DNA in virtual Outpatient Appointments



38. A review of video consultations in physiotherapy incorporated surveys of both patients and clinicians. Patients with lower e-literacy, less confidence with digital services, poor access to internet/technology, and with English as a second language were identified as those who found accessing video consultations challenging. Other issues noted included technology failures during the call and privacy concerns.
39. To help reduce these barriers, the Trust has been piloting a digital inclusion scheme to help better understand interventions that are needed to ensure equity of access to digital pathways. Initial findings point to the need for digital support, support accessing connectivity and digital equipment, improved language and learning disability advocacy, the need for safe private spaces, accessible versions of letters and general improved communication.
40. Under the auspices of the Health Foundation, the Trust will also be undertaking a project to support and inform the scale up of video consultations in non-English speaking communities. They will be working closely with members of the community and local charities to co-design and explore a combined community/health approach, using QI methodology.

### Reviewing access to advocacy services

41. Barts Health advocacy services is a free and confidential service aimed at ensuring everyone has equal access to healthcare through the provision of bilingual advocacy, interpreting, translation and telephone interpreting services. The advocacy service have reported a drop in the number of consultations in comparison to pre-COVID rates. They also note that advocates have been involved in very few video calls. The Equity sub-group are working with the advocacy service to examine the causes using both service data and clinician and patient feedback. There will be QI work to look specifically at improving use of interpreters in video consultations starting in April.

#### **ACTION 4: ACCELERATE PREVENTATIVE PROGRAMMES**

42. While responsibility for many of the preventive programmes sits within primary care, Barts is taking action where possible. For example, the Trust has implemented Trust wide smoking cessation and moderate drinking programmes for patients, and has a large flu and COVID vaccine programme for all employees.
43. As COVID pressure falls away, it will be important that we restart our programme of work including opportunistic health promotion for smoking and safer drinking.
44. One area of focus within the Trust has been to increase midwifery continuity of carer (CoC). In January 2020, Barts Health achieved 44%, exceeding the national March 2020 target of 35% of women booked onto a CoC pathway by 28 weeks of pregnancy. The service is reviewing continuity of care to understand the impact of COVID and working alongside the Local Maternity System to meet guidance requirements.

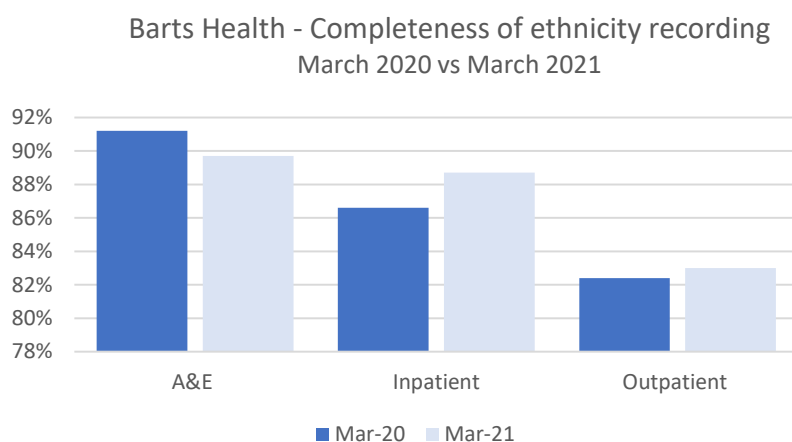
#### **ACTION 7: ENSURE DATA SETS ARE COMPLETE AND TIMELY**

45. One of the aspirations that was set out in the NHSE guidance was for providers to achieve 100% ethnicity capture by December 2020.

##### **Review of ethnicity capture**

46. While the Trust's ethnicity recording falls short of our 100% target, when compared to March 2020, the Trust has made some progress and observed a slight increase in recording in Inpatient and Outpatient services. In 2021, Inpatient collection was 88.7% compared to 86.8% in 2020; Outpatient collection was 83% compared to 82% in 2020. Recording in A&E is slightly below 2020 levels.

Figure 5. Ethnicity recording rates



47. Although there are still improvements to be made, all sites have increased monitoring of ethnicity data collection and have embedded this completion metric into performance reviews. St. Bartholomew’s Hospital, in particular, has made significant improvements with a new process that the Trust is hoping to replicate on other sites.

Figure 6: Monitoring of ethnicity recording at St. Bartholomew’s Hospital

SBH has seen a 5% improvement in ethnicity capture over the last year. Steps taken to achieve this progress include:

- Daily reports and monitoring.
- Weekly review by the Hospital Executive Board.
- The Team is also exploring tackling challenges through QI improvement methodology.

48. The Trust has also embedded ethnicity capture in a Trust-wide initiative to improve data collection, which is due to begin in July 2021.

**NEXT STEPS**

49. As we move forward into recovery from the acute phase of the pandemic, the Trust has embedded equity across its large clinical transformation programmes and identified several equity priorities.

50. These newly-defined equity priorities ensure we both address the NHSE guidance including the five priorities set out in recent guidance from 2021-2022, and continue to improve equity and address inequalities in care (Table 3). Each priority has specific objectives that will dictate our next steps. For example, the

Trust plans to further investigate non-attendance and pilot interventions to increase attendance. The full Equity Task and Finish Workplan can be found in Appendix 7.

Table 3. Equity Priorities

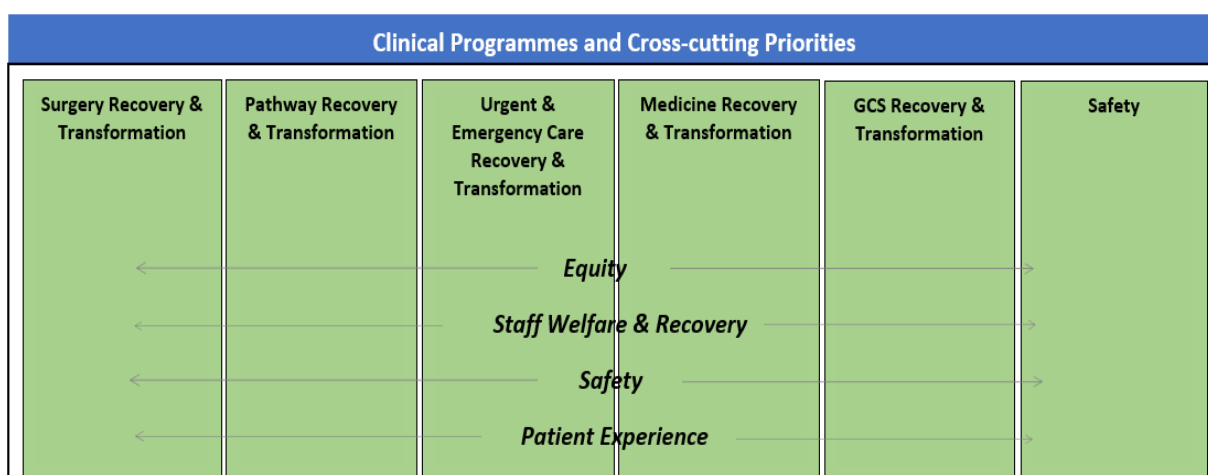
#	Priority	Objectives
1	Ensure elective access and independent sector arrangements are equitable	<ul style="list-style-type: none"> <li>Review waiting lists</li> <li>Review correlation between DNA's and gender, ethnicity and deprivation at both Barts and IS.</li> <li>If disparities identified, devise and pilot interventions</li> <li>Review equity of referral pathways (endoscopy, cancer) across sites reviewing correlation between longer waits and gender, ethnicity and deprivation</li> </ul>
2	Review equity of new Emergency Care pathways	<ul style="list-style-type: none"> <li>Review impact of new emergency pathways on access to Emergency Care by age, ethnicity, and deprivation.</li> </ul>
3	Test and minimize interventions to minimize inequities in remote consultations	<ul style="list-style-type: none"> <li>To understand reasons for non-attendance, and for F2F attendance</li> <li>Test interventions in services</li> <li>Develop best practice materials for rolling out virtual consultations</li> </ul>
4	Continue to follow-up and address previously identified inequities	<ul style="list-style-type: none"> <li>To demonstrate that disparities in Emergency Care, care for patients with LD, and access to insulin pumps are better understood and addressed.</li> </ul>
5	Address priority requirements set out by NHSE	<ul style="list-style-type: none"> <li>Achieve targets sets out in Phase 3 actions as set out in July and March guidance.</li> </ul>
6	Improve ethnicity capture across the Trust	<ul style="list-style-type: none"> <li>To improve ethnicity capture across the Trust by 5-10% in inpatient, outpatient and emergency services.</li> <li>Share best practice for capturing ethnicity in virtual outpatient settings across the Trust</li> </ul>
7*	Deliver staff and patient vaccination with pace, efficiency and equity, addressing 'vaccine hesitancy' in BAME groups	
8*	Develop trust Anchor institution strategy as a vehicle for supporting wider post-Covid recovery	
9*	Prevention	

\* Outside scope of Equity Task and Finish Group

51. The Trust has also embedded equity as a cross-cutting priority in its Clinical Programmes (Figure 6). Cross-cutting priorities for the next phase include Equity, Staff Welfare and Recovery, Safety, and Experience. These priorities will be

central to the work of Clinical Programmes in 2021-2022. By adding equity as a cross cutting priority, the Trust commits to reviewing aspects of access, process, outcomes, and experience, across each of our major programmes.

Figure 7: Clinical Programmes and Cross-cutting Priorities



### New requirements

52. The most recent guidance has signalled an increasing focus on equity. To qualify for ERF funding, systems are required to demonstrate their elective recovery plan supports five new requirements, (Gateway criteria and monitoring in Table 4 below), and that systems are prioritising and addressing 5 of the 8 urgent actions set out in the July 'Phase 3' Guidance, refer to Table 1.

Table 4: New requirements for ERF funding

Gateway criteria and monitoring	
1.	Use waiting list data to identify disparities in relation to ethnicity and deprivation.
2.	Use system performance frameworks to identify disparities in relation to ethnicity and deprivation.
3.	Prioritise service delivery by taking account of the most deprived and black and minority ethnic populations for patients on the waiting list and not on the waiting list, including through proactive case finding.
4.	Evaluate the impact of elective recovery plans on addressing pre-pandemic and pandemic-related disparities in waiting lists, including for clinically prioritised cohorts.
5.	Demonstrate how the ICS's SRO for health inequalities will work with the Board and partner organisations to use local population data to address inequalities in access, experience and outcomes and ensure that performance reporting allows monitoring of progress

53. While we are working with local and regional partners on a more comprehensive plan to address the new requirements, work including an analysis of our waiting lists, has already begun.

## CONCLUSION

54. Barts Health is committed to providing the highest quality care for its communities, and in doing so, has embraced equity as one of its six core values.
55. While the Trust has been actively identifying opportunities to improve equity of care for some time, the pandemic has presented an unparalleled opportunity to shape services in a way that reduces inequalities in care – both now and in the future.
56. Barts Health has responded to this opportunity by increasing the scale and pace of equity programmes, including establishing an Equity Task and Finish Group, and increasing patient engagement. Furthermore, the Trust is taking extensive steps to scrutinise equality in access, process, and outcomes of its services, and address any inequalities identified. The Trust has also embedded Addressing Health Inequalities, or Equity, as a cross-cutting requirement in the next phase.
57. While this paper focused on only one of Barts Health’s equity priorities, addressing equity of care, the Trust has adopted a holistic approach to improving equity, including driving forward programmes to increase community engagement and inclusion, targeting preventable disease, and addressing wider determinants of health. See Figure 1.
58. Barts Health has approached this challenge not as a one-off endeavour, but as an ongoing journey to continuously improve quality and increase equity.
59. We would welcome feedback from the Board on the proposed programme of work and on any additional areas they would like us to explore.



## Appendix 1: Equity as a critical component of quality.

### Equity and Quality

Equity is a critical component of quality

#### Quality of Care – Maxwell 6

- Effectiveness
- Efficiency
- **Equity**
- Appropriateness
- Acceptability
- Accessibility

#### Linking Disparities to Quality and Safety

Inequities in healthcare among different groups (eg language or socioeconomic status) have been linked to:

- increased medical errors
- prolonged length of stay
- avoidable hospital admissions and readmissions
- as well as over and under utilisation of procedures

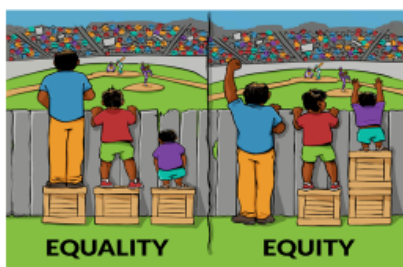
#### Don Berwick IHI – IOM Crossing the Quality Chasm 2001

- Safety
- Effectiveness
- Patient centered
- Timeliness
- Efficiency
- **Equity ?1st**

Ref: Alexander et al, 1999; Ash and Brandt, 2006; Carbone et al, 2003; Cohen et al 2005; Divi et al, 2007; Hux et al 2003; Jiang et al, 2005; Rathmore et al, 2003.

## Appendix 2: Defining Equity

### Defining Equity



“Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically.”  
 — World Health Organization

#### Equity in Healthcare: Inverse Care Law

How does equity relate to health care?

Research shows that equity groups may experience differences in the availability, accessibility, & quality of health services aimed at preventing, treating, & managing diseases.

#### Protected Characteristics/Equity Groups

Age	Race
Disability	Sexual Orientation
Gender Reassignment	<b>Other Dimensions</b>
Marriage or Civil Partnership	Deprivation
Pregnancy or Maternity Care	Location
Religion	
Sex	

**Appendix 3: Initial basket of indicators**

	INDICATOR	RATIONALE	STATUS
1.	OP DNA rates	ACCESS	Initial investigation complete.
2.	ED wait for assessment (4 Hour wait)	ACCESS	Initial investigation complete.
3.	Diagnostic Waits	ACCESS	Initial investigation complete.
4.	Cancer stage at presentation	SAFETY	Initial investigation complete.
5.	Incidents	SAFETY	Initial investigation complete.
6.	Screening take up rates	SCREENING	Initial investigation complete.
7.	Breast feeding rates	EFFECTIVENESS / OUTCOMES	Initial investigation complete.
8.	Utilisation of stand-alone maternity units	ACCESS	Initial investigation complete.
9.	Maternity - gestation at time of booking	EFFECTIVENESS / OUTCOMES	Initial investigation complete.
10.	Complaints / compliments	PATIENT EXPERIENCE	Initial investigation complete.
11	Learning Disability	IDENTIFYING PATIENT NEED	Initial investigation complete.

**Appendix 4: Clinical Board Priorities**


BOARD	EQUITY OF CARE
<b>Cancer</b>	<ul style="list-style-type: none"> <li>Review of access to services by ethnic group, with a focus on late stage diagnosis in A&amp;E.</li> </ul>
<b>Cardiovascular</b>	<ul style="list-style-type: none"> <li>Review access to pacemakers, access to defibrillators</li> <li>Patients likely to decline surgery</li> </ul>
<b>Children's Health</b>	<ul style="list-style-type: none"> <li>Children with complex needs Qi project</li> <li>Sickle Cell</li> </ul>
<b>Emergency Care</b>	<ul style="list-style-type: none"> <li>ED waits for older people</li> </ul>
<b>Medicine</b>	Diabetes <ul style="list-style-type: none"> <li>Foot Health</li> <li>Type 1</li> <li>Access to insulin pumps</li> </ul>
	<ul style="list-style-type: none"> <li>Access to Endoscopy</li> </ul>
<b>Surgery</b>	See Cardiovascular
<b>Women &amp; Newborn Health</b>	<ul style="list-style-type: none"> <li>Reviewing access to care by ethnic group</li> <li>Review breastfeeding rates by Ethnic Group</li> <li>New consultant appointed with both Public Health and Obstetrics qualification to regularly review data and work with the Equity Data Working Group.</li> </ul>
<b>Sexual Health</b>	<ul style="list-style-type: none"> <li>Regularly review data on protected characteristics and innovation fully embedded into QI cycle.</li> </ul>

**Appendix 5: Key findings (pre-COVID)**

Data	Rationale	Key Findings
Datix	Access	The 80-90 age group have the highest number of reported incidents but are the second smallest cohort of patient attendances. 42% of these were pressure ulcers.
Complaints PALS & AIRS	Experience	Outpatients had the highest proportion of complaints, a large number related to communication. There is insufficient data to determine whether there is a link with Language. Further analysis showed no significant differences in the complaints by ethnic group, age, deprivation or sex.
A&E 4-hour breeches	Access/ Process	Elderly patients >70 were significantly more likely to breach the 4-hour target. 24% of patients ages 60-69, breached where approx 33% of 70-79 and 41% of 90-99 (Age $R^2 = 0.9863$ ).
Cardiac	Access/ Outcome	<p>The DNA rate was greater in Black and Mixed ethnicities, at the extremes of age, and in those living in more deprived communities. Admissions were more likely non-elective in men, Black and Asian ethnicities, the homeless, those aged over 80 or aged 40-49.</p> <p>Patients admitted for ACS were more likely to have had known angina/previous MI if Asian, but there was no variation by social deprivation. Death following ACS did not vary significantly by gender, ethnicity or deprivation (only by age). Smokers with ACS were less likely to receive cessation advice if male, young, or live in a more deprived community. Those with a raised BMI were less likely to receive dietary advice if female.</p>
Medicine/ Diabetes	Access/ Outcomes	Those living in most deprived areas are less likely to have access to an insulin pump than those living in more wealthy areas.
Oncology	Access	<p>Men had a greater rate of DNA and admissions were more likely non-elective. Variations by ethnicity and social deprivation were less clear, but the sample size was smaller.</p> <p>Insufficient data detect variations in stage for cancer, looking at emergency presentations</p>
Outpatients	Access	From Outpatients data, the highest proportion of DNAs came from the most deprived deciles.
28 – Day Readmission	Outcomes	Deprivation and age influenced the likelihood of readmission within 28 days of an operation. In fact, those ages 18-69 had a readmission rate of approximately 6%, while those between 80-89 were nearly 12% likely to be readmitted.
SHMI	Outcomes	Our risk-adjusted mortality rate is consistently below the national average. Broken down by ethnicity, the mortality rate is slightly higher among white patients, yet lower among Black patients and lowest of all among those from an Asian background.

## Appendix 6: Terms of Reference, Task and Finish Group

## Equity and Phase 3 Requirements – Task and Finish Group

<p>Frequency: By-weekly Duration: 1 hour Location: Microsoft Teams Chair/SRO: Ralph Coulbeck Deputy- Chair: Ian Basnett</p>	<p><b>Reporting</b></p> <ul style="list-style-type: none"> <li>Updates to the Quality Assurance Committee, the Equality and Inclusion Forum, and the Clinical Transformation Board</li> </ul> <p><b>Assurance</b></p> <ul style="list-style-type: none"> <li>Held to account through regular updates to the Clinical Transformation Board.</li> </ul>	<p><b>Decision making</b></p> <p>The Task and Finish Group has the authority to take decisions within the scope of the objectives set out below. If consensus cannot be reached, the Chair has the right to take the final decision or to escalate the matters to the Clinical Transformation Board.</p> 
<p><b>Objectives</b></p> <ul style="list-style-type: none"> <li>To address inequalities and promote equity at Barts Health Trust by working on and delivering content for the eight Phase 3 requirements.</li> <li>Assess and leverage resources needed to meet requirements</li> <li>Agree project plans and other project documentation as required to deliver the requirements and related outputs in the time specified.</li> <li>Outline and communicate clearly any risks and issues that could impact on delivery, develop and propose mitigations.</li> <li>Ensure regular reporting to the Clinical Transformation Board, plus other identified Barts Health governance <i>fora</i>.</li> <li>Disseminate guidance for the requirements as it emerges</li> <li>Share information about Equity related projects and programmes to promote best practice and facilitate alignment.</li> <li>Work to align Barts Equity work with that of NEL and WEL</li> </ul>		
<p><b>Membership roles</b></p> <ul style="list-style-type: none"> <li>Director of Strategy</li> <li>Director of Public Health</li> <li>Director of Transformation</li> <li>Director of Performance</li> <li>Director of Service Development and Team Transformation</li> <li>Public Health Specialty Registrar</li> <li>CoVOG Representative</li> <li>CovEG Representative</li> <li>Elective Recovery Representative</li> <li>Site leads (WXH, MEH, SBH, RLH, NUH)             <ul style="list-style-type: none"> <li>SBH, CEO (<i>Others TBC</i>)</li> </ul> </li> <li>Strategy Programme Manager</li> <li>Strategy Support Officer</li> </ul> <p><b>Ad hoc membership</b></p> <p>As relevant to the objectives of embedding Equity and meeting the Phase 3 requirements.</p>	<p><b>Quorum</b></p> <p>There will need to be at least one representative from Public Health, BIU and at least one representative from the Recovery Workstreams.</p>	<p><b>Inputs</b></p> <ul style="list-style-type: none"> <li>Updates from CoVog</li> <li>Updates from CoVeg</li> <li>Update from Elective Surgery</li> <li>Update on data capture from BIU</li> <li>Programme plan</li> <li>Other inputs as required</li> </ul> <p><b>Outputs</b></p> <ul style="list-style-type: none"> <li>Action Log within 3 working days.</li> <li>Summary reports, via Chair, to the Clinical Transformation Board</li> <li>Submission of individual requirements</li> </ul> <p><b>Other</b></p> <ul style="list-style-type: none"> <li>Terms of reference to be reviewed again in December 2020.</li> </ul>

**Appendix 7: Equity Task and Finish Group Programme Plan**

EQUITY TASK AND FINISH GROUP PROGRAMME PLAN			ASSIGNED TO	TIMELINE
<b>Action 1: Protect the vulnerable from COVID</b>				
1.1	ICS plan for improving insight into population health and protecting vulnerable		Integrated Care System	16/11/20
1.2	Analysis exploring:			
1.2.1	COVID Mortality, and including a deep-dive on COVID in patients with learning disabilities (LD)			
	Initial analysis C-19 Mortality	Complete	Public Health Team with support from QMUL	Ongoing
	Initial Analysis LD	Complete		
	Secondary Analysis	31/03/21 Patricia Handley		
1.2.2	Staff absences			
	Initial analysis	Complete		
	Secondary analysis	May 2021		
<b>Action 2: Restore NHS services inclusively</b>				
2.1	Improve data capture on ethnicity		All Services	Ongoing
2.2	Conduct restart analysis for Emergency Care, Outpatients, Elective and Referrals		Barts Business Intelligence	Ongoing
	Initial analysis	Complete		
2.3	Conduct review of accessible materials:			
2.3.1	Review Emergency Care Data		Katie Gallagher/Ian Basnett	Ongoing
	Initial analysis	Complete		
2.3.2	Surgery Analysis: Before and After Data; and Cancellations		Surgery Board, Equity Working group, Barts BIU	Ongoing
	Initial analysis	30/04/21 Natalie Mizen		
2.3.4	Cancer Analysis: Before and After Data; Review 2ww Referrals; Emergency Presentations		Cancer Board, Equity Working Group, Barts BIU	Ongoing
	Before and after data, 2ww referral data analysis	Complete		
	Follow up analysis	30/04/21 Sarah Wallace		
2.3.5	Children and Young People Analysis: A&E attendances; Dental extractions; Sector wide pathway work		Children’s Board, Phase 3 Task and Finish, support from BIU	Ongoing
2.4	Prepare monthly returns		Barts Business Intelligence	Ongoing
2.5	Work with specialised commissioning to meet mandatory ethnicity capture		Barts Business Intelligence	Ongoing
2.6	Update on new guidance and key metrics		Public Health Team	Complete
<b>Action 3: Develop digitally enabled care pathways in ways which increase inclusion</b>				

3.1	Review of 111 First		Barts BIU, 111, COVEG	Complete
3.2	Review of Total Triage in General Practice		Integrated Care System	31/03/21
3.3	Review of Virtual Outpatients:		Barts BIU, COVOG	Ongoing
3.3.1	Findings from Renal Pilot			
	Initial analysis	Complete		
	Secondary analysis	31/05/21 Sarah Wallace	COVOG	
3.3.2	Findings from Respiratory Pilot			
	Initial data analysis	31/05/21	COVOG	
3.3.3	Virtual Pharmacy Data Analysis			
	Initial data analysis	31/05/21 Deniece Boyer	COVOG	
3.3.4	Review of Access to Advocacy Services			
	Initial analysis	In Progress	COVOG , Advocacy Service	
4.4	Review of Digitally Enabled Mental Health		WEL partners	31/03/20
<b>Action 4: Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes</b>				
4.1	Flu Programme		Barts, WEL partners	date
4.2	Preventative support and support for long term conditions		WEL partners	date
4.3	Annual health checks for those with LD's, 67% on Ld register to 75 to 23/24		WEL partners	date
4.4	35% of pregnant women receiving continuity of care			
	Initial data analysis	Complete	Barts Health's Women and Newborn Board	31/05/21
	Post-COVID re-evaluation of progress	31/05/21		
<b>Action 5: Particularly support those who suffer mental ill health.</b>				
5.1	Collecting information on mental health.		Public Health Team	TBC
5.2	Ensure completeness of ethnicity data to the Mental Health Services Data		BIU, WEL partners	31/03/21
5.3	Digitally enabled mental health		WEL partners	TBC
<b>Action 6: Strengthen Leadership and Accountability</b>				
6.1	Nominate a named Executive at Board level for tackling inequalities		BH Group Executive Board	Complete
6.2	Primary care networks to nominate a Clinical Director/health equality lead		WEL Partners	Complete
<b>Action 7: Ensure Datasets are complete and timely</b>				
7.1	Improve comprehensive data collection on Ethnicity		BIU, Barts Services	Ongoing

7.2	Retrospectively update and complete the COVID-19 Hospital Episode Surveillance System.		BIU	TBC
7.3	Work to capture ethnicity for specialised commissioning		BIU	TBC
<b>Action 8: Collaborate locally in planning and delivering action</b>				
8.1	System plans due that take into account all 7 actions		ICS	Complete
8.3	Linking to the Waltham Forest and East London (WEL) Inequalities Framework, and contributing to the sector-wide plan		ICS/ Phase 3 Task & Finish Group	Complete
<b>9: Further Trust Equities Work Outside of NHSE Phase 3 Requirements</b>				
9.1	Deprivation and access to insulin pumps			
	Initial Analysis	Complete	Public Health Team	31/05/21
	Secondary Analysis	31/05/21 Sarah Morgan		
9.2	Endoscopy DNA project			
	Initial Analysis	31/05/21 Lorna Darknell	Endoscopy Service	31/05/21
9.3	Haem-oncology transplant project			
	Initial Analysis	31/05/21 Yosef Amel Riazat -Kesh	Haem-Oncology	31/05/21
9.4	Elective care waiting list and prioritisation: ethnicity and deprivation analysis			
	Initial Analysis	31/05/21	BIU RTT performance	31/05/21



**Appendix 8. Actions 6 and 8****Action 6: Increase leadership and accountability**

The Trust took immediate steps to address the requirement to nominate an Executive at Board Level. Ralph Coulbeck, the Group Director of Strategy, is now the named Executive for tackling inequalities and Chair of the Equity Task and Finish Group.

In addition, the Equity Task and Finish Group has strengthened accountability around addressing inequalities; membership includes leaders from member hospitals ensuring Executive engagement and oversight at site level.

**Action 8: Collaborate locally in planning and delivering action to address health inequalities**

We are working closely with partners in our Integrated Care System to share best practices, address inequalities by geography, and tackle disparities which are outside the control of acute care, such as referrals from Primary Care to specialist treatment.

<b>Report to the Trust Board: 5 May 2021</b>	<b>TB 18/21</b>
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<b>Title</b>	Whipps Cross Redevelopment
<b>Accountable Director</b>	Ralph Coulbeck, Group Director of Strategy
<b>Author(s)</b>	Alastair Finney, Redevelopment Director, Whipps Cross
<b>Purpose</b>	To provide an update on the progress of the Whipps Cross redevelopment programme
<b>Previously considered by</b>	Group Executive Board

#### Executive summary

In March 2021 the Trust Board received a report on the progress of the Whipps Cross Redevelopment programme, with particular reference to; the emergence of the national new national hospital programme (NHP), progress in developing the Outline Business Case (OBC), and extensive communications and engagement work ahead of the submission of planning applications. This paper provides an update on the programme, including; the development of the OBC and longer term programme plan assumptions in the context of our engagement and collaboration with the NHP, two major milestones reached with the commencement of demolition of the disused buildings on the site of the former nurses accommodation and the submission of our planning applications as well as our ongoing, extensive, communications and engagement work.

#### Related Trust objectives

- SO3 Service Transformation

<b>Risk and Assurance</b>	Assurance in relation to the below risk
<b>Related Assurance Framework entries</b>	7. Delays to the progress of a robust business case, supported by stakeholders, impairs Whipps Cross redevelopment and delivering the vision of excellent integrated care
<b>Legal implications/ regulatory requirements</b>	None

#### Action required by the Board

The Trust Board is asked to note:

- the latest position on progress with the OBC – and longer-term programme plan assumptions - in the context of our engagement and collaboration with the NHP team;
- two major milestones reached, with the commencement of demolition of the disused buildings on the site of the former nurses accommodation and the submission of our planning applications to the Local Planning Authority (LPA); and
- our recent extensive – and ongoing - communications and engagement work.

## **BARTS HEALTH NHS TRUST**

### **REPORT TO THE TRUST BOARD: 5 MAY 2021**

#### **WHIPPS CROSS REDEVELOPMENT PROGRAMME**

##### **INTRODUCTION**

1. In March 2021 the Trust Board received a report on the progress of the Whipps Cross Redevelopment programme, with particular reference to: the emergence of the national New Hospital Programme (NHP); progress in developing the Outline Business Case (OBC); and extensive communications and engagement work ahead of the submission of planning applications.
2. This paper provides an update on the programme, including: the development of the OBC and longer term programme plan assumptions in the context of our engagement and collaboration with the NHP team; two significant milestones reached with the commencement of demolition of the disused buildings on the site of the former nurses' accommodation and the submission of our planning applications; and our ongoing, extensive, communications and engagement work

##### **OUTLINE BUSINESS CASE (OBC) PROGRESS AND NEW HOSPITAL PROGRAMME**

3. Overall, the programme continues to make significant progress across all workstreams as we finalise the OBC and, as part of this, work in collaboration with the NHP team.
4. The Clinical and Functional brief, which informs the size, shape and configuration of the new hospital building was completed earlier this year. From this, our Architect Led Design Team, Ryder Architecture, have been developing the hospital design to RIBA Stage 2<sup>1</sup> (which is required for the OBC) and the design of the first of two multi-storey car parks. Despite the operational challenges of the pandemic, this process has enjoyed significant staff engagement through a series of 'design sprint' workshops and over 30 focus groups. This has informed our planning applications, which are described in further detail in the section below (planning approval is expected to be required ahead of Government approval of the OBC)
5. As the design work for this stage of the programme is finalised, we are working with our cost advisors to estimate the capital investment required for the new hospital - a 'cost plan' - in line with the costing methodology required by HMT's Green Book guidance for capital business cases, which follows the 'five case model'<sup>2</sup>. In line with HMT Guidance, the cost plan is the key input to complete the value for money

<sup>1</sup> The RIBA (Royal Institute of British Architects) plan of work is the definitive model for the design and construction process of buildings, consisting of 8 stages. Stage 2 is the level of design required for OBC.

<sup>2</sup> The Green Book is guidance issued by HM Treasury on how to appraise policies, programmes and projects. The Five Case Model is the approach for developing business cases recommended by HM Treasury

assessment of the project (the 'Economic Case) and the affordability assessment (the 'Finance Case'). Together these form the fulcrum of the OBC 'five case model' and sit alongside the case for investment (the 'Strategic Case'), the funding and procurement strategy (the 'Commercial Case') and the delivery and oversight arrangements (the 'Management Case').

6. As one of 40 hospital development schemes in the NHP, we are working closely with national colleagues as we finalise our OBC. As with other Trusts, the NHP team is providing support and constructive challenge to our thinking across a range of key themes such as Digitisation, Net Zero Carbon' Modern Methods of Construction (MMC) and healthcare planning. We are, in turn, as one of the more advanced Trusts within the programme, supporting and informing the approach of the NHP to delivering the ambition of building 40 new hospitals by 2030.
7. Subject to the outcome of these discussions in the coming weeks, we expect to complete the OBC in late Spring/early Summer ahead of submission to NHS England / NHS Improvement and the Government for approval. In the meantime the NHP is exploring opportunities, through a commercial approach, to maximise the benefits of a national programme, both in terms of value for money and market readiness for a 'pipeline' of major schemes. For this reason, our procurement of a main works contractor – which we could have launched earlier this year following pre-market engagement we undertook in 2020 - remains on hold, which will mean a delay in the appointment of a contractor.
8. Whilst this does not impact our OBC timescales, it will likely delay the completion of our Full Business Case and therefore the commencement of construction of the new hospital. However, at this stage, subject to further discussions with the NHP team, we anticipate that the benefits of being in a national programme and of utilising MMC to accelerate construction timescales, means it will remain feasible to maintain our expected new hospital completion date of Autumn 2026. This means our overall programme plan remains intact, albeit with additional risk now built into that timescale.

#### **OUTLINE PLANNING APPLICATION**

9. In order to gain OBC approval nationally, we should expect to be required to have received outline planning approval for the new hospital. Following extensive engagement and consultation on our emerging designs for the hospital and the proposals for development of the wider site after the new hospital is completed, we have submitted our planning applications to the Local Planning Authority (LPA). This is a significant milestone for the programme. It is the culmination of extensive engagement with Waltham Forest Council, Redbridge Council, the Greater London Authority (GLA) and the City of London Corporation, as well as with the public and staff through two phases of pre-planning application consultation (see further detail in paragraphs 18 and 19).

10. We have submitted two ‘hybrid’ planning applications:
- one hybrid planning application for the hospital development (outline) and the first of the two multi-storey car parks (full); and
  - one hybrid planning application for the residential development including up to 1,500 homes with 50% affordable (outline) and change of use for the retained ‘heritage’ buildings and details of access only approved in full, with all other matters reserved.
11. The overarching design vision, is to create ‘a hospital in a garden and a garden in a hospital’, connecting the hospital more strongly to the local areas and the neighbouring Epping Forest, with the healing benefits that that can provide. Key principles of the hospital design include:
- a cluster of ward modules around a central hub, allowing different departments to work together more effectively and helping to minimise walking distances for patients and staff, making the hospital easy to get around with better wayfinding;
  - more space for clinical activity and significantly more single rooms for patients;
  - the flexibility and adaptability to respond to changing healthcare needs in the future; and
  - an exemplar sustainable building that is designed to achieve the target of net zero carbon.
12. The proposals aim to transform the wider Whipps Cross site with improved transport and access links with new walking and cycling routes, new green and public spaces, new homes and community facilities. We also propose to retain key elements of the ‘heritage’ buildings including the chapel, along with the ‘bookend pavilions’ to the original ward blocks, celebrating the character of the original building at the heart of the development.
13. The planning applications, including a set of detailed accompanying documentation are subject to a validation process by the LPA. Once validated, the applications will be published online and a 30-day formal statutory consultation will begin, led by the LPA. That is likely to commence in May. We anticipate a decision on the planning applications in the autumn of this year.
14. Subject to planning and business case approvals, we expect construction of a new 500-space multi-storey car park to begin in early 2022 with the construction of the new hospital beginning in spring 2023 and completed in autumn 2026. The car park – which will be the first of two for the new hospital - will provide for a mix of staff and visitor parking and will include bays for ‘blue badge’ disabled parking.
15. Our ambition is to reduce the need for car usage (for staff in particular) through delivering an active travel plan, targeting a reduction of between 25% and 40% in

the number of car parking spaces for the new hospital compared to current provision.

## DEMOLITION WORKS

16. Following a procurement process, in March we appointed Squibb Group Limited to carry out the demolition of disused buildings on the site of the former nurses' accommodation and the work is under way. This the first phase of the 'enabling works' that allows us to move forward to make the site ready for the construction of the new hospital and will include the temporary re-provision of car parking spaces. The second phase will include the construction of the first of the two car parks.
17. The demolition, funded by the Government as part of its endorsement of the Strategic Outline Case last year, is being undertaken in five phases in order to limit disruption and mitigate the impact of noise and dust. As each old building is removed, new temporary surface parking will take its place, thereby maintaining car parking provision on the site. The current hospital will remain fully operational during the demolition process. We anticipate the demolition will take a number of months and be completed by the end of 2021. Demolition vehicles enter and leave the site via James Lane, via a dedicated entrance adjacent to the energy centre, keeping demolition traffic away from the main hospital entrances and exits.

## COMMUNICATIONS AND ENGAGEMENT

18. Since the last board meeting in March, extensive communications and engagement activity has continued to take place and, as we near the conclusion of the OBC, we are beginning to look ahead to the next phase of communications and engagement on the programme.
19. We recently completed the second phase of our pre-planning applications consultation in which we had excellent engagement from the public and staff. This included three public meetings, attended by 135 people, and three staff meetings attended by 140 people. The meetings were an opportunity for the team to present the latest designs and to take questions, thoughts and ideas. A brief summary of the meetings, including key feedback themes, has been published on our website alongside a video of the presentations and a Frequently Asked Questions document. Alongside this, we have received emails through our dedicated inbox and have had well over 1,000 responses to our online survey.
20. Over the course of the consultation, the responses fell into a number of clear themes:
  - **Hospital design and development** – including, for example, the proposed location and height of the hospital buildings and car park, the importance of retaining land adjacent to the new hospital for potential expansion and the importance of improving public transport access to the hospital;

- **Development of the residual site** – including, for example, the proposed development of new residential units and community facilities once the new hospital is completed, the proposed scale of the housing development, the importance of affordable housing, the retention of the ‘heritage’ buildings and proposed access and exit routes; and
- **Wider redevelopment proposals** - the public also took the opportunity to feed back ideas or express concerns on other aspects of the redevelopment proposals, including the future of clinical services currently provided by the hospital - including specialist palliative and end-of-life care in the Margaret Centre - and the justification for the modelled capacity of the new hospital - including the number of overnight inpatient beds - and its dependency on improvements in primary care and community services locally.

21. In relation to three specific areas where we have heard concerns from local people:

- **Margaret Centre** – the new hospital will continue to provide specialist palliative and end-of-life care. Working with partner organisations across the local integrated care system, and through engaging patients’ representatives, we are reviewing the future model of care and how specialist palliative and end-of-life care services will be configured in the new hospital.
- **Construction Logistics** – alongside our pre-planning application consultation, we undertook a four-week informal consultation on a long list of options for vehicles accessing the construction site access options, to identify a shortlist of viable options to include in the planning application. As part of this, we engaged with various stakeholders, including a local resident group – PACT<sup>3</sup> - and the Whipps Cross Patients’ Panel.
- **Car Parking** – we have, throughout the pre-planning application consultation period, listened to concerns from our closest residents – particularly through meetings of our residents’ representative forum, about the proposals for the multi-storey car park. As a result, we have made a number of changes, including reducing the number of spaces from 700 to 500, moving the car park further away from the residential boundary and, most recently, reducing the height of the car park further from seven to six storeys.

22. We continue to keep people informed about the commencement and progress of the demolition works through established staff and public communications channels, our website (including the publication of a Frequently Asked Questions document) and a recent letter drop to over 2,000 local residences. Moreover, we have continued to hold meetings in March and April with residents’ groups, both about the demolition and the development of our designs ahead of the planning applications.

23. After a brief hiatus in light of Covid-19 pressures both on the hospital and on members of our Community Forum, we were able to hold a meeting of the Forum in

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<sup>3</sup> The Panhandle Action Community Team (PACT) involves residents living on streets adjacent to the area of the site colloquially known as the ‘panhandle’ (ie. the disused strip of land between the hospital and Lea Bridge Road).

March and have the next one planned for May. We are working with forum members to help us to scope and plan the next phase of our community participation and involvement, looking beyond the OBC, and are looking at a number of potential areas including the next stage of hospital design, the development of our active travel plans and a potential Whipps Cross history project.

## **CONCLUSION AND RECOMMENDATION**

24. In conclusion, the development of the OBC is continuing to progress well, with significant milestones passed in recent weeks, underpinned by comprehensive communications and engagement activity. The key task over the coming weeks is to continue to work in close collaboration with the NHP team with the aim of finalising the OBC and agreeing next steps, particularly on procurement, which will enable us to firm up our programme plan assumptions for the longer term.

25. The Trust Board is asked to note:

- the latest position on progress with the OBC – and longer-term programme plan assumptions - in the context of our engagement and collaboration with the NHP team;
- two major milestones reached, with the commencement of demolition of the disused buildings on the site of the former nurses accommodation and the submission of our planning applications to the Local Planning Authority (LPA); and
- our recent extensive – and ongoing - communications and engagement work.



<b>Report to the Trust Board: 5 May 2021</b>	<b>TB 19/21</b>
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<b>Title</b>	Responding to Deaths Report
<b>Accountable Director</b>	Chief Medical Officer
<b>Author(s)</b>	Victoria Thickett, Charlotte Hopkins, Tricia Handley and Nick Bunker
<b>Purpose</b>	To ensure Trust Board is informed of Trust progress against the NQB mortality requirements.
<b>Previously considered by</b>	Group Executive Board 13 April 2021

<p><b>Executive summary</b></p> <p>This report provides a summary of the progress of the current work stream against the National Quality Board (NQB) mortality requirements, which will ensure that these expectations are met at Barts Health.</p>
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<b>Related Trust objectives</b>	
We will maintain a relentless focus on delivering high quality, safe and compassionate care for our patients and achieving our 2020/21 quality priorities to ensure a consistently good patient experience.	

<b>Risk and Assurance</b>	Assurance in relation to the below BAF entry.
<b>Related Assurance Framework entries</b>	4. Failure to address CQC, London Fire Brigade and other regulatory body requirements and improve associated systems for early intervention impairs quality of care and the health and safety of staff

<b>Legal implications/ regulatory requirements</b>	NHSI and the NQB required every trust to have a mortality review group and to implement a framework for responding to deaths; including reviewing every inpatient death by April 2020.
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<p><b>Action required:</b></p> <p>The Board is asked to note progress against these requirements</p>
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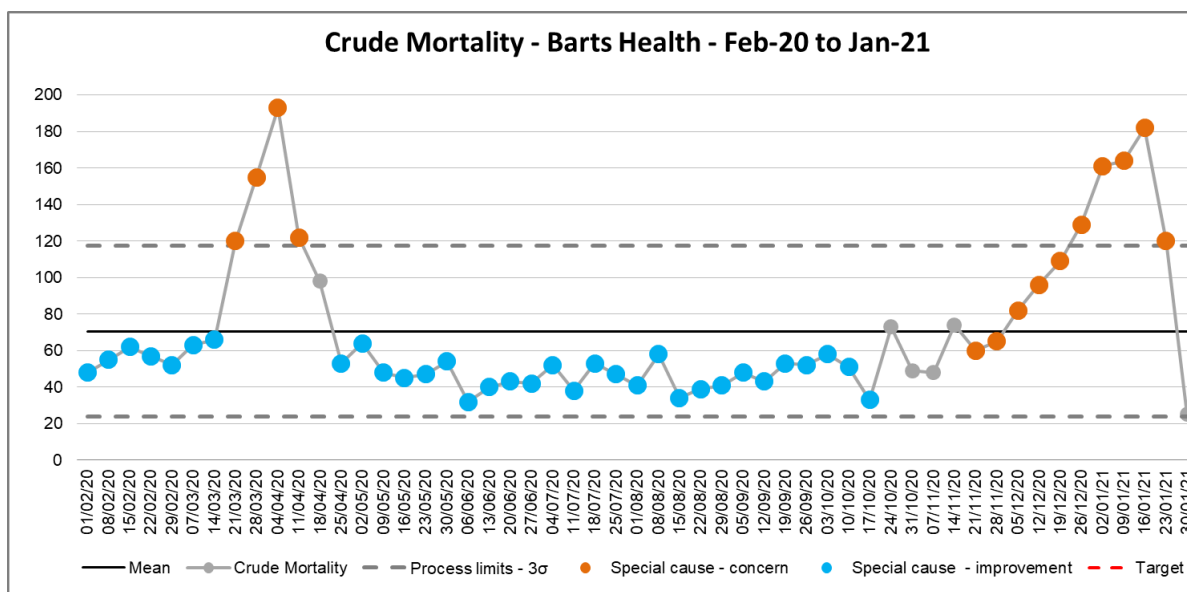
**BARTS HEALTH NHS TRUST**

**REPORT TO THE TRUST BOARD: 5 MAY 2021**

**RESPONDING TO DEATHS**

**INTRODUCTION**

1. Barts Health has around 3000 inpatient deaths per year, each of which requires an appropriate level of review by the clinical team. Regular review allows the team to highlight both good and sub-optimal care, and share this amongst clinicians at each level of experience to facilitate a more open and supportive working environment.
2. The global Covid-19 pandemic has impacted death figures across England including those at Barts Health. Crude mortality figures for March and April 2020 saw the Trust gain a respective increase of 52% (250 to 379) and 126% (235 to 530) in inpatient deaths compared to these months in the previous year with the majority of patients recorded with a diagnosis of covid-19. May to October 2020 saw decreased monthly figures, which can be explained by lower overall activity across the Trust. Mortality rates per 1000 patients during this period remained higher than previous months again due to the lower inpatient activity. November 2020 marked the start of an increase which has since seen a return to higher numbers of inpatient deaths than the previous year, respectively increasing 64% (269 to 440) in December 2020 and 176% (241 to 666) in January 2021.



3. Barts Health has a risk-adjusted mortality rate within the expected range as compared to the national baseline. Barts Health Standardised Hospital Mortality Index (SHMI) for October 2019 to September 2020 remains constant at 0.93. This implies that Barts Health has fewer deaths than would be expected when taking account of the patients and morbidity treated. Deaths of patients with documented Covid-19 infection have been excluded from the SHMI calculation.

National SHMI Data – October 2019 to September 2020



Source: NHS Digital

SUMMARY

- Since July 2017, Barts Health has collated and published quarterly figures around the clinical review of all adult inpatient deaths and declared any avoidable deaths identified following this review. The covid pandemic has had a substantial impact on the Trust’s capacity to conduct mortality review in 2020/21.

Responding to Deaths figures – October 2019 to September 2020

Site	Number of Deaths within scope	Number of Deaths Reviewed	Number considered Avoidable Deaths
Newham	564	227 (40%)	6
Royal London	1020	584 (57%)	2
St Bartholomew’s	450	357 (79%)	1
Whipps Cross	1057	473 (45%)	5
Nightingale	20	20 (100%)	0
<b>Total</b>	<b>3111</b>	<b>1255 (40%)</b>	<b>14</b>

The number of “avoidable deaths” remains consistent and low compared to the total number of deaths. There is no standardised definition of an “avoidable death”, and clinical teams are asked to make a professional judgement. All deaths deemed potentially avoidable have been through the serious incident investigation process, which leads to a root cause analysis and an action plan to ensure lessons are learned when applicable. The next of kin are informed of the outcome of such investigations as standard practice.

THEMES AND LEARNING

- Clinical Mortality Review under the Learning from Deaths framework has identified a range of areas for improvement opportunities and informed existing safety workstreams.

6. Reviews show a need for improved dissemination of local operating policies to improve consistency, measures being built into clinical systems to support staff to highlight potential medication issues and improved communication of abnormal results or significant findings.
7. Delays which affecting care remain common theme, reinforcing the importance of timely diagnosis, escalation and treatment. Improvement in these areas is being driven by work improving care of the deteriorating patient, sepsis recognition and NEWS training. Additionally, scheduling issues due to the Covid-19 pandemic have highlighted the need for improved flagging of urgent operations.
8. A Trustwide action plan is in place to support safe insertion of nasogastric tubes, including standardised documentation and additional training on interpretation of x-ray images.
9. Key successes have been the implementation of the Improve Care Skills Program facilitating training and development for nursing staff with regards to acute care.

#### **LEARNING FROM DEATHS PROCESS UPDATE**

10. The Trust Mortality Review Group is planning to pilot the new Datix mortality module in March 2021 for roll out in April 2021.
11. Online completion of the forms will in the future allow the Clinical Effectiveness Unit to conduct a regular audit to ensure all deaths are being reviewed and enable the Trust to provide updates to the Board and to NHSI around any identified avoidable deaths. Additionally, this will provide a range of previously unavailable data around the cause of death and co-morbidities that will inform both sharing and learning within the Trust and support deeper and more accurate coding.

#### **MEDICAL EXAMINER ROLE**

12. Medical examiners form an important part of the learning from deaths process. This is a clinical role held by an experienced consultant that takes responsibility for accurately completing the death certificate and any referrals, an initial review of the care provided and, most importantly, serves as a contact for the patient's family. Work has been on-going to expand the service across the whole trust to meet the national programme deadline and ensure that Barts Health medical examiners work meets national expectations. While the current pandemic has caused delays, we now have a fully staffed and functioning service across each of our main hospital sites. All existing medical examiners have completed or are registered on the national training programme which includes a number of distance learning modules and a face to face day at the Royal college of Pathologists.

#### **Deaths within specialist patient groups**

13. National data show that the number of deaths notifications of people with learning disabilities has increased by 134% this year, and that the impact of Covid-19 on people with learning disabilities is at a younger age range than in the wider population. At Barts Health, the in-hospital survival rate from Covid-19 for patients with learning disabilities is lower than for the general Covid-19 inpatient population. An audit was undertaken to understand how care was delivered to inpatients with learning disabilities and Covid-19 at Barts Health during the pandemic, and to identify any changes that could be made to improve the patient experience and care for future Covid-19 inpatients with learning disabilities at Barts Health.

14. 33 people with learning disabilities were admitted to Barts Health and tested positive for Covid-19 from 27<sup>th</sup> November 2020 to 12<sup>th</sup> February 2021, in comparison to 30 patients (29 people plus one suspected who died prior to swabbing) from 29<sup>th</sup> February 2020 to 10<sup>th</sup> May 2020. Of the 33 inpatients with learning disabilities who completed an admission and had a positive Covid-19 swab or diagnosis, 8 died in hospital during this period, in comparison to 15 deaths during the earlier wave.
15. Clinical notes were reviewed for the 30 inpatients with learning disabilities and Covid-19 seen during the first wave. Themes arising were mainly around documentation: the importance of establishing a baseline with this heterogenous patient group when working with variation in accuracy, level of detail and differences in recorded input from family and carer's, along with multiple sets of notes across services. Additionally, use of the hospital passport was varied and this was found to impact when and how reasonable adjustments were implemented during treatment. Completion of general adult and mental capacity assessments was around 63% and 70%, respectively.
16. Informal review during the most recent period of increased admissions has shown improved recording of baseline information, decision making and increase ceilings of care in more patients following ICU admission. Full review for patients the further 33 inpatients seen since November 2020 has commenced and this will inform recommendations to address any further identified issues.
17. Barts Health continues to participate in the Learning Disabilities Mortality Review Programme (LeDeR) study. Deaths are identified and reviewed by the Lead Nurse, though local mortality review informs this specialist review which is submitted externally to LeDeR. Case reviews are then presented at the Trust Mortality Review Group.
18. The Child Death process is under review nationally and the mortality review Group with the Children's safeguarding team are working together to understand the implications this will have for Barts Health.

## RECOMMENDATION

19. The Trust Board is asked to note the report and comment.

<b>Report to the Trust Board: 5 May 2021</b>	<b>TB 20/21</b>
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<b>Title</b>	Guardian of Safe Working yearly report
<b>Accountable Director</b>	Chief Medical Officer
<b>Author</b>	Dr Robert Serafino Wani, Guardian of Safe Working
<b>Purpose</b>	To report on the trainee doctor contract provisions and safe working hours for trainee doctors in t Barts Health.

<p><b>Executive summary</b></p> <p>The role of the guardian of safe working hours (GoSW) is designed to reassure trainee doctors and employers that rotas and working conditions are safe for trainees and patients. The guardian oversees the work schedule review process and seeks to address concerns relating to hours worked. They support safe care for patients through protection and prevention measures to stop doctors working excessive hours and have the power to levy financial penalties where safe working hours are breached. The trainees can highlight periods of unsafe working through the exception reporting process, which informs their clinical team, and the GoSW of a breach. Following an exception report action to protect the trainee, and in some cases to prevent future occurrences, should be taken. This report summarises the submission and response to exception reports for safe working hours and gives some insight to training post vacancies that HEE pass on to the Trust</p>
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<b>Related Trust objectives</b>	
Developing our People	

<b>Risk and Assurance</b>	This report provides assurance in relation to below BAF risk
<b>Related Assurance Framework entries</b>	1. Failure to deliver agreed inclusion commitments impairs improvements in: organisational culture, staff experience, development of all talent, morale, recruitment and retention of staff and organisational performance

<b>Legal implications/ regulatory requirements</b>	EWTD
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<p><b>Action required by the Board</b></p> <p>The Trust Board is asked to note the report and comment on the issues raised.</p>
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## **BARTS HEALTH NHS TRUST**

### **REPORT TO THE TRUST BOARD: 22 JANUARY 2020**

## **GUARDIAN OF SAFE WORKING YEARLY REPORT ON THE TRAINEE DOCTOR CONTRACT**

### **EXECUTIVE SUMMARY**

1. This Guardian of Safe Working (GoSW) report covers the period 1 November 2019 to 31 January 2021 and reports on the 437 Exception Reports (ER) for breaches of scheduled working hours in this period.
2. Most of these reports (~80%) were submitted by more junior trainees (FY1 and FY2).
3. Exception reports have given important insight into trainee working patterns and conditions during the challenging pandemic year
4. Despite the obvious working challenges the most significant issues have been dealt with quickly and efficiently with growing consultant engagement.
5. There has been only one reported immediate safety concern for working hours but this was not associated with any patient safety concern.
6. The GoSW and the Trust remain vigilant of under reporting of breaches to the safe working rules, yet we are encouraged by increased awareness and engagement in the process from all parties.

### **BACKGROUND TO THE JUNIOR DOCTOR CONTRACT, THE ROLE OF EXCEPTION REPORTS AND HOW WE MONITOR TRAINEE VACANCIES**

7. The junior doctor contract applies only to trainees working under Health Education England (HEE) approved training programmes. Details of the contract can be found in many places (including the Trust intranet, the BMA and NHS employers' websites).
8. Significant changes were approved by members of the BMA and NHS employers and which were implemented in stages up to August 2020.
9. The exception reporting system remains the way that trainees report breaches of their working hours and the role of the GoSW remains to help oversee the safe working of trainees in line with their agreed work schedule.
10. Every trainee is given access to the exception reporting system (Allocate) which allows them to contemporaneously report breaches in their working hours from the expected rota – this is an exception report (ER).

11. A monthly report of vacancies is extrapolated from HEE data as they fail to fill a training post. These are vacancies are discussed as part of the contractual obligation of this report.

## CONTENTS

12. This report will comment on the following

- *Aggregated data on exception reports in Barts Health*
- *Summary of work schedule reviews*
- *Details of fines levied against departments for safety issues*
- *Details of trainee rota allocation and gaps / vacancies*
- *A qualitative narrative including areas of persistent concern and / or good practice and progress made across the Trust*

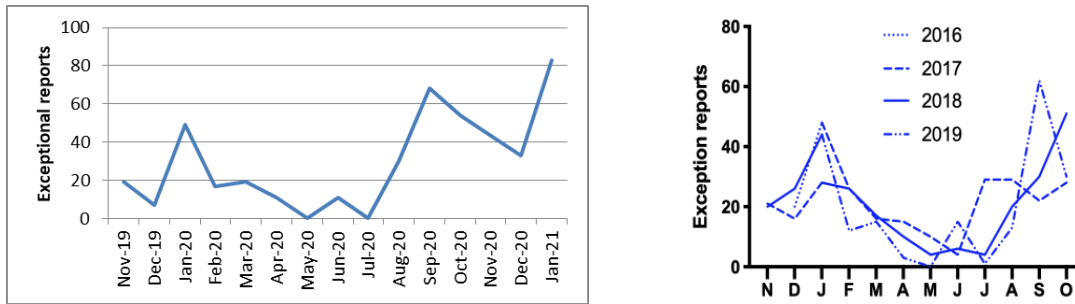
## AGGREGATED DATA ON EXCEPTION REPORTS

### *Cumulative Exception Reports (ERs) – Work Schedule Related*

13. In Barts Health (as at November 2019) there were 1064 HEE allocated training posts. All trainees are working under the new Terms and Conditions of Service.
14. The number of trainees available to submit reports fluctuates due to the variable vacancy rate in Health Education England (HEE) allocated posts (6-8% on any given month) – discussed in detail later.
15. There have been 437 exception reported during the time covered in this report (15 months) which has been extended to beyond a year for practical reasons relating to the coronavirus pandemic
- This is lower than the third year (2018-19) 425 reported (in 12 months).
  - Interpretation of data during a pandemic is difficult as there may be under reporting.
16. One was reported as an immediate safety concern for working hours but this was not associated with a clinical safety concern.
17. Exception reporting follows in a similar pattern of peaks around change over time and the winter months with troughs as doctors get more used to their roles and the rota errors found at the beginning of the job are corrected.



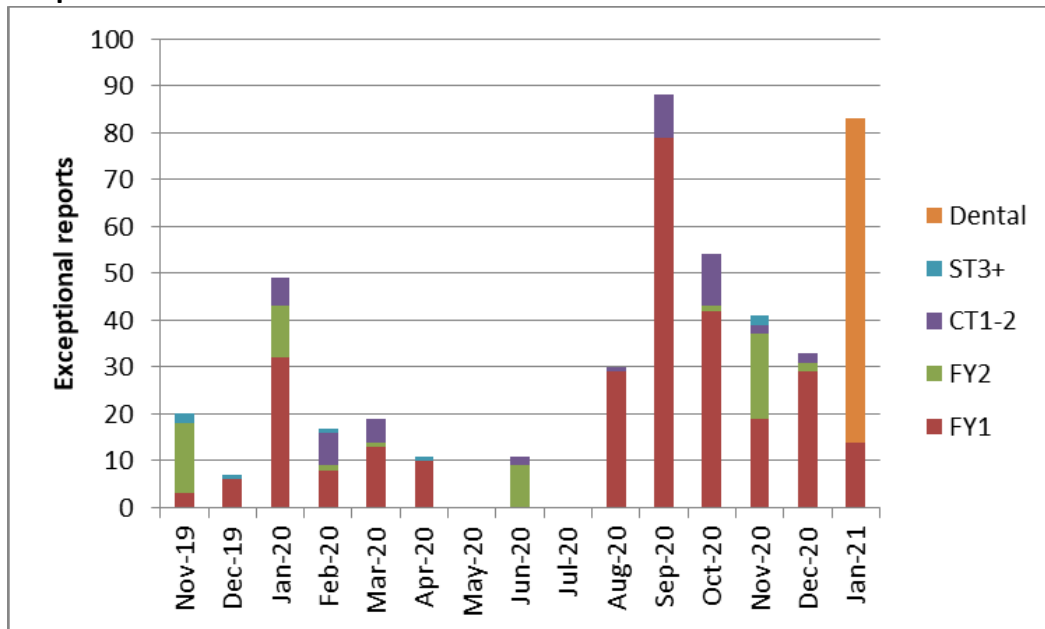
Graph 1



18. Graph 2 shows that the predominant exception reporting group are FY1's. However, there was an increased number of ERs from dental trainees compared to previous years. This was because they were mobilized quickly to the COVID rota without optimal communication leading to dissatisfaction amongst the trainees. This issue was spotted and addressed quickly.

- The report rate remains low, and it still follows that the more senior you are the less likely you are to exception report.
- The reasons for this are verbally reported as being related to individual priority on training experience over 'clock watching', personal professionalism and ability to work with the system to manage working hours.
- There is clear evidence however that when there is insufficient support and / or major rota issues, the more senior grades will ER.

Graph 2

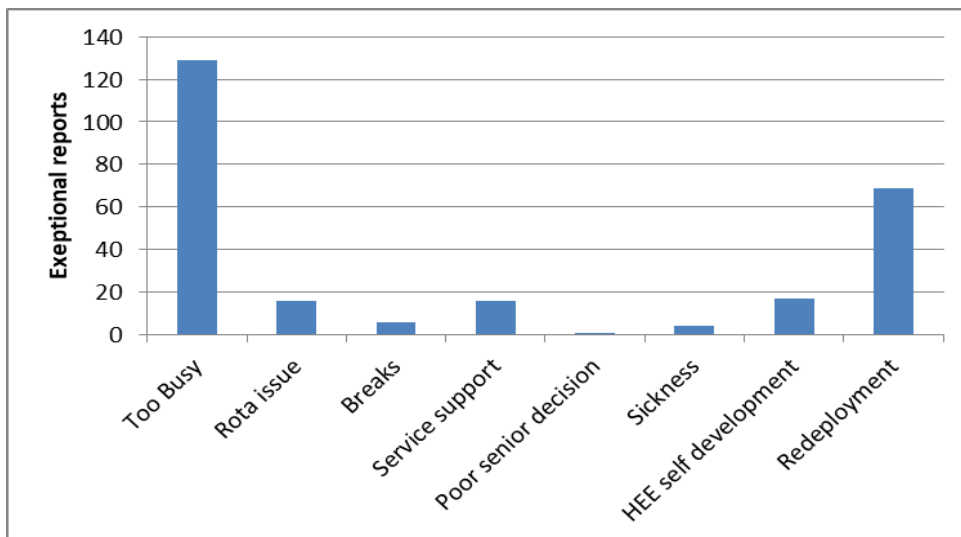


## EXCEPTION REPORTS – REASONS

18. The exception reports can be split into 8 broad categories from the comments and reasons made by the trainee in the exception report (these are compared with the first year of ER in Graph 3). This year includes two new categories, 'redeployed' and HEE self-development:

- Trainee doctors remain busy but pandemic and redeployment has had an impact
- Improvements in IT have positively impacted issues trainees had with service support
- Increased awareness of the new contract among consultants has led to better senior decision making despite the obvious challenges this year
- The impact of vacancies has become more prominent during the pandemic

**Graph 3**



## EXCEPTION REPORTS – OUTCOMES

19. Of the 437 exception reports in this year
- 19% received TOIL
  - 34% received additional payments
  - 0.5% lead to work schedule reviews
  - 41% required more information or were yet to be addressed
20. There is a noticeable increase in the number of exceptional reports that were not closed. Though the vast majority of these were addressed, technical and software problems made it difficult to close the ER after two weeks have elapsed from when they were raised. The pandemic has understandably made more working hours breaches predictable and in addition made it harder for trainees and supervisors to close those reports. However, awareness of trainee working patterns and well-being has been a trust wide focus in combination with

increased JD forums and concerted effort of the GoSW to be visible and accessible has helped to offset some of the concerns.

## **SUMMARY WORK SCHEDULE REVIEWS**

21. There have been 2 work schedule reviews this year (14 last year). All have had acceptable solutions within 6 weeks and implemented within 2 weeks.

## **DETAILS OF FINES LEVIED FOR SAFE WORKING ISSUES**

22. There was one immediate safety concerns requiring a fine to be levied against a department in the time of this report. This occurred as a result of two different working patterns (rota) merging into one week's actual work leading a trainee working for 73 hours (1 hours extra). The trainee raised this with the department and the GoSW. The GoSW discussed with the division the reason behind breach. Though it was a single occurrence it was avoidable.

## **DETAILS OF TRAINEE ROTA ALLOCATION AND GAPS / VACANCIES**

23. There was disruption to rotations during the pandemic therefore it is impossible to report accurately on trainee allocation and vacancies

## **A QUALITATIVE NARRATIVE INCLUDING AREAS OF PERSISTENT CONCERN AND / OR GOOD PRACTICE**

24. During the pandemic the upsurge rotas meant trainees worked >1:3 weekend frequency. This was a temporary arrangement with the approval of the GoSW following discussion in the junior doctors' forum. All these rotas are now back to normal work patterns and are compliant. During the second wave of the pandemic the primary concern of the GOSW has been the well-being of the trainees. This has been addressed through regular engagement at the Junior doctors forum or personal communication to ensure all concerns are addressed or escalated in timely fashion

## **SITUATIONS REQUIRING CONTINUED VIGILANCE**

25. In August 2020 HEE introduced 2 hours per week of self-development time for FY1 trainees. This has not been built into the work schedule as a result of the pandemic. This is something the education academy is looking to include in the work schedule of the FY1 trainees.

## **POSITIVE DEVELOPMENTS**

26. The trainees across the Trust responded exceptionally to the difficult period of surge during the pandemic accepting short notice changes to working patterns, stretched

working hours and reductions in the ability to take desired leave. Despite the challenges and accepting that some delays due to the pandemic were inevitable, significant issues with rota patterns discrepancies and unsafe working hours continue to be responded to with impressive speed. There continue to be strong Junior Doctors fora with positive junior / senior engagement in all sites and increased engagement from GoSW and site leadership teams despite the pandemic. The GoSW continued to focus on trainee working hours during the pandemic and addressing issues raised in real time. The new GoSW remains an influential member of the national committee and continues to engage and share experience with regional GoSW. The support from the Trust Exec and senior clinicians in particular the CMO is strong and readily available. In addition, the technical and administrative contributions of Neil McCarten (HR specialist), Martyn Clark (Deputy Director Education & Quality and Lucy Hamer (Education support officer) to the role and the executive reports, is outstanding and invaluable.

#### *Objectives for post pandemic*

20. Some immediate objectives are to update the GoSW website and to relaunch the Allocate reporting system amongst trainees and supervisors focusing on modifications and updates to the reporting process

#### **RECOMMENDATIONS**

27. The Trust Board is asked to note this report and for comments on the issues raised in this report.

<b>Report to the Trust Board: 5 May 2021</b>	<b>TB 21/21</b>
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<b>Title</b>	Use of the Trust Seal
<b>Sponsoring Director</b>	Trust Secretary
<b>Author(s)</b>	As above
<b>Purpose</b>	To seek Trust Board ratification of use of the Seal, pursuant to Standing Order 21.2.
<b>Previously considered by</b>	n/a

#### **Executive summary**

This paper documents the use of the Trust Seal on the following occasions:

##### **29 March 2021**

- A deed of settlement in respect of additional Kenton and Lucas works between Capital Hospitals Ltd and Barts Health NHS Trust.
- A deed of appointment for Whipps Cross redevelopment demolition and asbestos removal services between Barts Health NHS Trust and Squibb Group Ltd.

##### **9 April 2021**

- A renewal lease for Plot D (car park), Royal London Hospital between the Secretary of State for Health and Social Care and Barts Health NHS Trust.
- A renewal lease for Plot D2 (car park), Royal London Hospital between the Secretary of State for Health and Social Care and Barts Health NHS Trust.
- A renewal lease and letter of variation to the Services Agreement for David Hughes Building, Royal London Hospital between the Secretary of State for Health and Social Care and Barts Health NHS Trust.
- A renewal sublease for ground floor David Hughes Building, Royal London Hospital between Barts Health NHS Trust and East London NHS Foundation Trust.
- A renewal sublease for 2<sup>nd</sup> floor David Hughes Building, Royal London Hospital between Barts Health NHS Trust and London Borough of Tower Hamlets.

#### **Related Trust objectives**

n/a

#### **Risk and Assurance**

n/a

#### **Related Assurance Framework entries**

n/a

#### **Legal implications/ regulatory requirements**

The Trust's lawyers were involved in drawing up the documents requiring sealing.

**Action required by the Board**

The Trust Board is asked to ratify the use of the Seal on the occasions listed above.

## Questions for the Barts Health NHS Trust Board meeting on 5 May 2021

### A. Waltham Forest Save Our NHS (Ms Terry Day)

#### 1. Future of the haemodialysis unit in the new Whipps Cross Hospital

We understand that currently the haemodialysis unit for local kidney patients at Whipps Cross is one of the largest satellite dialysis units in London

- How many kidney patients does it serve currently ?*
- What are the plans to re-provide the renal haemodialysis unit in the new hospital at Whipps Cross?*
- how many patients will it be possible to, and is it planned to, treat in the haemodialysis unit in the new hospital?*
- Will any of the future provision be provided by third party providers, rather than directly by Barts Health?*

We understand that the majority of the patients who attend 3 days weekly for dialysis are local, that many of them are socio-economically deprived and that many are very frail with co-morbidities....so that having an easy to access service is essential.

- If the dialysis unit is not going to be provided like for like in the new hospital, where will these patients be treated?*
- how will renal emergencies be dealt with in A+E at the new Whipps Cross ?*
- Have the existing kidney patient group who use Whipps Cross been consulted about the future of dialysis in the new hospital?*

#### 2. Future of Therapies and Audiology in the new Whipps Cross Hospital

- Will there be a full department for Therapies in the new hospital and will the current provision for Therapies be reprovided on site like currently?*
- Will there be a full Audiology Dept at the future Whipps Cross hospital and will all Audiology services be provided on site like currently ?*
- Will any Audiology or Therapy services be provided by third party providers in the future, rather than being directly provided by Barts Health?*

#### 3. Future of the Eye Department at the new Whipps Cross

There is currently an excellent Eye department at Whipps Cross with a model of integrated care that works very well. We have heard rumours that this specialist eye department will not be re-provided as a whole unit in the new hospital but that parts of the service will be based elsewhere and the successful integrated service fragmented.

- are the rumours we have heard correct?*
- What are the plans for eye services in the new Whipps Cross?*
- Will there be a full Eye Department at the new Whipps Cross using the excellent model of integrated care currently in use?*
- Will any Eye services be moved elsewhere once the new Whipps Cross is built?*

*Will any Eye services be provided by third party providers in the future, rather than directly provided by Barts Health?*

### B. Questions from Ms S Ritten

- Will the trust clarify what is happening to the Woodbury Centre which provides inpatient psychiatric care to local people over the age of 65 years? It is currently run by NELFT. Will this continue? If there is no plans for it to remain at this site will the same provision continue and where will patients be expected to travel?*
- It has been revealed that the Margaret centre will cease to exist. What is happening to the Woodlands day unit (haematology) and the Connaught day centre. (rehabilitation services for*

*the elderly) Will they be relocated to the main hospital. If they are not going to be provided on site where will they be located and who will be responsible for operating them?*

3. *51 beds are being lost. Which speciality services will no longer have beds or will have reduced beds at the new Whipps Cross?*

### **C. Newham Save our NHS questions (Ms Ros Mykura/Mr Alan Cooper)**

#### **1. NHS Private contracts.**

*1a. How much did Barts Trust pay InHealth in the financial year 2020-2021?*

*1b. In 2019-20 Barts Trust paid InHealth £805,172 for the outsourcing of MR scans. What is the total that the trust paid to Inhealth that year? (805K seems low because in January 2020 Barts said it expected to pay InHealth £1.9 million in that financial year 2019-2020.)*

*In 2018-2019 Barts Trust paid InHealth £705,000*

#### **2 NE London NHS Trusts & the North East London Integrated Care System (NELICS)**

Barts NHS Trust and Barking, Havering and Redbridge University Hospitals Trust sharing their top management team is unwelcome news, implying that the problem is management, not the lack of funding to the NHS.

*How will the rationing of NHS resources by joint managers from two trusts impact Newham Hospital, which desperately needs investment?*

#### **3 Newham Hospital Maternity**

Barts additional support for Newham maternity is welcomed, as is the black and ethnic minority midwives' report from East London Local Maternity Systems. (ELLMS)

*3a Will Barts consider 'culture' in terms of the patient experience as well as the staff experience, and include the hidden impact on hundreds of women of Barts outrageous NHS patient charging procedures, targeting hundreds of Newham maternity patients using the following methods: advance-tracing by phoning targeted names on the waiting list; 'burden of proof' turned by Barts on to individuals to 'prove' entitlement to free maternity care; wrongly denying free NHS maternity care to Newham maternity patients?*

*3b What is the ethnicity of the 29 Newham maternity patients who were wrongly invoiced for maternity care by Barts Trust in 2019-2020?*

#### **4. Structural racism and the NHS Hostile Environment**

*What is the ethnicity of the (trust wide) 839 patients who were wrongly invoiced for NHS care by Barts Trust in 2018-2019?*