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BARTS HEALTH NHS TRUST

TRUST BOARD MEETING (PART 1)

There will be a meeting of the Trust Board in public on
Wednesday 6 July 2022 at 11.00am in the Boardroom, Junction 6/7, Whipps Cross Hospital, Whipps Cross Road, Leytonstone E11 1NR
Scheduled to end by 14.00

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.	**WELCOME**		Rt Hon J Smith	11.00
2.	**APOLOGIES FOR ABSENCE:** Prof A Chesser			
3.	**DECLARATION OF INTERESTS** 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.	**MINUTES** To approve the Minutes of the meeting held on 4 May 2022 (no outstanding actions on the action log)	41/22	Rt Hon J Smith	11.00
5.	**BOARD MEMBERSHIP** To approve changes to Trust Board membership	42/22	Rt Hon J Smith	11.00
6.	**MATTERS ARISING** 6.1 Maternity services and NHSE/I visit 6.2 To consider any matters arising from the Minutes not covered elsewhere on the agenda		Ms C Alexander	
7.	**PATIENT STORY** To hear a patient story		Ms C Alexander	11.05
8.	**CHAIR'S REPORT** To receive the Chair's report		Rt Hon J Smith	11.20

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		Paper TB	Lead	Time
9.	**GROUP CHIEF EXECUTIVE'S REPORT** To receive the Group Chief Executive's report		Dame A Williams and Mr S DeGaris	11.30
QUALITY AND PERFORMANCE				
10.	**BOARD ASSURANCE FRAMEWORK** To receive and approve the BAF	43/22	Mr A Hines	11.40
11.	**INTEGRATED PERFORMANCE REPORT – 2022/23 M2** To receive the report and discuss: • Operational performance and elective recovery • Quality and Safety • People • Financial performance	44/22	Mr S DeGaris Ms C Alexander Mr D Waldron Mr H Virdee	11.50
12.	**REPORTS FROM BOARD COMMITTEES** 12.1 Finance and Investment Committee (oral) 12.2 Audit and Risk Committee 12.3 Quality Assurance Committee 12.4 Nominations and Remuneration Committee	 45/22 46/22 47/22	 Mr A Sharples Ms K Kinnaird Dr K McLean Rt Hon J Smith	12.30
STRATEGIC DELIVERY PLANS AND IMPLEMENTATION				
13.	**PEOPLE STRATEGY IMPLEMENTATION** To receive a Freedom to Speak Up report	48/22	Mr D Waldron	12.50
14.	**WHIPPS CROSS REDEVELOPMENT** To note the progress report	49/22	Mr A Finney	13.10
15.	**EQUITY OF ACCESS AND HEALTH INEQUALITIES** To note the progress report	50/22	Mr A Abraham and Dr I Basnett	13.20

GOVERNANCE				
16.	**NUFFIELD AT ST BARTHOLOMEW'S HOSPITAL** To note the opening of a private patients unit	51/22	Mr C Ridley	13.30

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17.	**ITEMS FOR APPROVAL** • **AUDITORS ANNUAL REPORT** • **GROUP OPERATIONAL PLAN (PUBLIC FACING NARRATIVE)** • **ESTABLISHMENT REVIEW** • **COMPLAINTS ANNUAL REPORT** • **SAFEGUARDING ANNUAL REPORT**	52/22 53/22 54/22 55/22 56/22	Mr H Virdee Mr M Turner Ms C Alexander Ms C Alexander Ms C Alexander	

18.	**ANY OTHER BUSINESS**			
19.	**QUESTIONS FROM MEMBERS OF THE PUBLIC**	57/22		13.40

20.	**DATE OF THE NEXT MEETING** The next meeting of the Trust Board in public will be held on Wednesday 14 September 2022 at 11.00am (venue tbc)			
21.	**RESOLUTION** 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 0642

Barts Health NHS Trust

TB 41/22

BARTS HEALTH NHS TRUST

TRUST BOARD MEETING (PART 1)

Minutes of the Trust Board meeting in public on
Wednesday 4 May 2022 at 11.00am held via Webex Videoconferencing

Present:
Rt Honourable J Smith (Chair)
Dame A Williams (Group Chief Executive)
Ms C Alexander (Chief Nurse)
Dr N Ashman (Director of Transformation)
Professor A Chesser (Chief Medical Officer)
Professor Sir M Caulfield (Non Executive Director)
Mr S DeGaris (Deputy Chief Executive)
Mr A Hines (Director of Corporate Development)*
Ms K Kinnaird (Non Executive Director)
Dr K McLean (Non Executive Director)
Mr M Turner (Interim Director of Strategy)*
Ms L Seary (Non Executive Director)
Mr A Sharples (Vice Chair)
Mr H Virdee (Chief Finance Officer)
Mr D Waldron (Director of People)*
Mr C Williams (Associate Non Executive Director) *

In attendance:
Mr S Collins (Trust Secretary)
Mr A Finney (Director of Redevelopment)
Ms A Jones (Deputy Director, People Strategy)

Apologies:
Ms K Whittaker-Axon (observing)

** Non-voting member*

40/22 WELCOME

The Chair welcomed everyone to the meeting.

41/22 BOARD MEMBERSHIP

The Chair welcomed Mr Adam Sharples, who was joining the Trust Board as a Non Executive Director (NED) and Vice Chair. The Chair also noted the extension of Clyde Williams' term as an associate NED.

42/22 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.

43/22 MINUTES

The Minutes of the meeting of the Trust Board held in public on 2 March 2022 were received and approved.

44/22 MATTERS ARISING

The Director of People confirmed plans for updates to the Trust Board on implementation of the Wellbeing strategic development plan, with the aim of reporting on progress twice a year.

There were no other matters arising to be reported back on at this meeting.

45/22 PATIENT STORY

Dr Ashman introduced the patient story and outlined the role of the organ donation team, highlighting the remarkable sacrifice for families involved and the sensitivity involved in discussions about organ donation during what was always a very difficult time.

Lisa Wilson outlined details of her experience and her role with the Trust's organ donation committee. She outlined the circumstances surrounding her son Tom's death in 2015, aged 22 years old, during his participation in a hockey practice. Having received a blow from a hockey stick, he had suffered a cardiac arrest. On arrival at hospital a consultant had informed them that Tom had suffered a brain haemorrhage from which he could not recover. Despite the overwhelming shock and grief that accompanied his subsequent death, her husband had thought of the potential benefit of Tom participating as an organ donor, having previously signed up as a donor during his fresher's week at university. An operation was undertaken to support this. Tragically, Lisa related that her husband had also died within two months of Tom's demise. During this intense period, Lisa and her daughter Pippa had written to the recipients of Tom's organ donation and had received two cards back – one from the parents of Fatima, a 2-year-old who benefited from liver transplant and one from Gordon, who received heart donation. Lisa had received some comfort and inspiration from this experience and had inquired how she could get involved further. She was invited to join the organ donation committee at The Royal London Hospital. Since then, Lisa had had the opportunity to meet Fatima at an event to celebrate organ donation at the Transplant Games and had met Gordon at a West Ham United football match, also the team that Tom

and his father had supported. These had been very emotional and inspiring meetings. Lisa felt that her involvement with the Trust's committee and in sharing her story had helped to raise awareness of the importance of organ donation. Recently this had included finding a reflective memorial place at the entrance of the renal department and had now appointed an artist, Saad Qureshi, to help create this memorial for those who have participated in organ donation. Dr Lynne Barrass thanked Lisa for all her work as an ambassador including training for young directors. She outlined some of the activities undertaken by services based in intensive care units at the Trust. During 2021/22, there were 27 donors enabling 67 patients receiving lifesaving or life-changing transplants. She noted some feedback from families about the comfort that they had felt by helping to contribute positively to others at an otherwise bleak time. Dr Barrass outlined some of the barriers to gaining consent to organ donation and emphasised the importance of effective communication and engagement with families and the wider community.

The Chair thanked Lisa for sharing her emotional story and her contribution to this vitally important service, as well as Lynne's role in progressing this service. The Chief Finance Officer asked whether there were particular barriers associated with the population served in East London and asked whether this was reflected in how the committee operated. More awareness work, as with the east London Mosque and synagogues recently, would be required. Work would also be carried out with peer colleagues at Kings Hospital and similar London hospitals to reflect on how to share learning from their experiences.

The Chief Medical Officer noted the lifesaving efforts regularly witnessed by renal physicians such as himself and the importance of the work of Specialist Nurses for Organ Donation (SNODs) and Clinical Leads for Organ Donation (CLODs). He also thanked Lisa for bravely sharing her story and was convinced that her work was improving lives for others. Dr McLean echoed her thanks and noted the role of QAC to support this work as a priority for the Trust.

The Chair thanked Lisa and colleagues for attending to share this moving and important story.

46/22 CHAIR'S REPORT

The Chair noted some recent work on changes at both Trust Boards, partly linked to terms completing and to the collaboration. In addition to Adam Sharples' appointment, Mehboob Khan and Marta Phillips had been appointed to the Barking, Havering and Redbridge University Hospital NHS Trust (BHRUT) Board. The Chair hoped to be able to confirm at the next meeting further appointments to address two vacant non-executive director posts. Interviews were also scheduled for the appointment of a Group Chief Executive and she expressed confidence that the Trust would be able to identify a strong candidate for this crucial role. Stakeholder involvement processes were taking place in parallel, and the Chair thanked those participating.

Work on the provider collaboration at Barts Health and BHRUT was continuing. The boards had not previously had the opportunity to meet, so the Chair was pleased that they would be able to address this at an initial meeting of both boards scheduled to take place on 11 May 2022.

Since the last meeting, the Chair had also visited all the teams at the Canary Wharf site and toured the new Nuffield Health facility at St. Bartholomew's Hospital. She had also attended a Futures Hub event at Newham University Hospital (NUH) with former Member of Parliament, Anne Milton, which had focused on developing local employment opportunities. The Chair noted that a report on promoting social mobility would be developed in due course reflecting the Trust's aspirations as an anchor institution in NE London. She had visited Mile End Hospital (MEH) accompanied by Dr Angela Wong, the Chief Medical Officer of the NEL Cancer Alliance, and Dr Mamta Vaidya, who had recently been appointed as Chief Medical Officer at BHRUT following her previous roles at Barts Health. The Chair had joined an introductory meeting with Zina Etheridge, the accountable officer for North East London (NEL) Integrated Care System (ICS) and had held briefings with local MPs on a range of issues, including Whipps Cross University Hospital redevelopment, for which strong cross party support existed.

47/22 GROUP CHIEF EXECUTIVE'S REPORT

The Group Chief Executive noted extremely high emergency attendances, with some record levels of Emergency Department (ED) activity. Operational teams had therefore remained under significant pressure. Despite this, the Trust had remained one of the best performers on ED waiting times. A further reduction in Covid-19 cases was seen during the last month, though a lot less critical care cases were reported. Long waits for elective surgery were acknowledged and demands were being balanced by staff.

Collaborative work was going well with system partners in Primary Care, Mental Health Trusts and with local Government. Community work was also developing well with the assistance of staff networks, in preparation for further urgent emergency care and Covid-19 challenges next winter.

The Group Chief Executive noted work on finalising its annual plan and budget, confirming that the Trust would be publishing a public-facing operational plan in the coming weeks. She was pleased to emphasise a focus on equitable access within this plan.

HRH Queen Elizabeth II had participated in an opening event for the new Queen Elizabeth Unit at RLH. The Group Chief Executive thanked all involved in making the event successful and noted that the board were incredibly grateful to the Queen for agreeing to have the unit named after her. Other

visits had included the NHSE/I Director of Transformation attending to learn about the Trust's clinical informatics development.

In terms of recent recruitment, the Trust had appointed Ajit Abraham to the role of Group Director of Inclusion and he would be introduced to the Board in his new role at the next meeting. Amanjit Jhund would also be joining the Trust as Deputy CEO for Whipps Cross University Hospital.

48/22 OPERATIONAL PLAN

The Interim Group Director of Strategy introduced the Operational Plan. He noted the priorities set out in the national guidance around elective, diagnostics, emergency care and cancer care. The plan set out the trajectories required to deliver the targets set out in the plan, including eliminating 78 week waits by 2023 and returning to pre-pandemic cancer access standards. Significant and stretching targets were noted requiring good collaboration across NE London, mutual aid and service transformation. The plan was financially balanced, excluding the economic effects of current inflation. The capital plan focused on the increased capacity required to make progress on activity as well as the Whipps Cross redevelopment and Newham fire safety works. The mechanisms to deliver the plan were set out further in the paper, with a key part being the workforce strategy.

The following observations and questions were received:

- Dr McLean felt that this was a helpfully clear plan. She asked about the level of confidence in achieving the access standards set out in the plan.
- Mr Sharples also asked about the anticipated level of impact that delivery of the plan would achieve in terms of the overall size of the waiting list, appreciating that this had built up significantly during the pandemic.
- Mr Williams recognised the important focus on equity of provision and queried if there was any prioritisation within this overall ambition to help address any specific concerns.
- The Chair recognised the challenge for the Trust's staff to accelerate activity. She asked whether this would represent a significant difference from previous workloads and working patterns.

In response to these points, the Interim Group Director of Strategy felt that it was a fair challenge in terms of the central targets appearing ambitious. However, having worked closely on this, he felt that the Trust's plan did not set any unreasonable stretches. Transformation and improvement support would need to be prioritised to support services in working through their recovery trajectories. There would be a consistent theme during the delivery phase on balancing clinical urgency with length of time waited by those on waiting lists. In relation to the query regarding relative prioritisation within the equity of access dimension, the Interim Group Director of Strategy suggested that it would be

best to consider further with colleagues and provide the Trust Board with more detail at the next meeting.

ACTION: Interim Group Director of Strategy

Ms Seary felt that the plan provided a helpful explanation of the roles and responsibilities of different elements of the NEL system, such as placed based structures. She felt that some success measures may be required to support this plan. The Interim Director of Strategy agreed and noted that building the mechanisms would require further work; he suggested that population health metrics should inform the success measures alongside some of the targets set out, such as boosting planned care delivery.

The Trust Board approved the group operational plan.

49/22 BOARD ASSURANCE FRAMEWORK

The Director of Corporate Development introduced the Board Assurance Framework (BAF) update. This had been positioned on the agenda to follow up on the prior item, quantifying the risks to the objectives set out in the group operational plan. At this stage of the year, the BAF version presented sought to refresh the core risks; subject to agreement these risks would then be worked up in more detail for submission to the Trust Board at its meeting on 6 July 2022. He outlined the principal changes to the BAF risks, as set out in the paper, including a recognition of the increased interdependencies associated with system working. He noted that the highest scored risks on the BAF reflected the challenges noted earlier in the meeting on emergency and planned care standards, workforce capacity and capability (as noted in the operational plan's stated dependency on this enabler) and informatics and cyber risk, recognising the international context informing this. He confirmed work under way to build a consistent approach to deep dive reporting on principal risks as part of board committee work programmes.

The Trust Board approved the BAF.

50/22 INTEGRATED PERFORMANCE REPORT

(i) Access and Covid-19

The Deputy Chief Executive provided headline messages, noting trends on Covid-19 case rates. He confirmed that the emergency departments across the Trust were seeing very high volumes and work was underway with primary care partners to understand and adapt to this. On planned care, the Trust had reduced the number of patients waiting 104 weeks or longer to below 300 (from a position of approximately 1800 in January). There is still further work to do to eliminate this cohort of long waiters. Timely progress was reported on MRI and CT performance, and it was hoped that this would be reflected in improvement on diagnostics standards. The Cancer backlog had increased in the last few

months which had led to an increased focus on exploring new ways of approaching this.

(ii) Quality

The Chief Nurse highlighted that some strategic sessions had been held to review patient experience and insight from these would be reported to the next Quality Assurance Committee (QAC). A reduction was reported in falls, particularly those that were device related. Focused work on reducing complaints and Serious Incidents (SIs) was ongoing with major progress reported at Newham.

The Chief Medical Officer outlined Duty of Candour (DoC) improvement work with an updated policy and a refreshed audit programme addressing recommendations from an Internal Audit review. The Trust had also decided to expand the scope to also include complications with elective procedures. In terms of the pandemic, a significant relaxation of infection control rules would be enacted from 3 May 2022, in line with Government guidance. Despite high rates of infection, the Trust is seeing continued low levels of critical care cases. Mandatory staff testing had ended and many zoning requirements were terminated as well as social distancing requirements for visitors and staff. The Trust would monitor infection rates to maintain confidence on nosocomial infection risks.

Dr McLean noted that a challenging level of improvement would be required on diagnostics, recognising this as a key enabler for other work. The Deputy Group Chief Executive noted that a diagnostics trajectory had been discussed at a recent QAC meeting and he was due to return with a further iteration of this. He recognised some improvement but equally noted the need to ramp up the pace of recovery in this area.

ACTION: Deputy Group CEO

(iii) People

The Director of People highlighted the need to increase substantive fill rates, while recognising this had exceeded 91% for the first time recently. This overall position masked some variances across specialties and sites which remained in need of further focus. Some dedicated initiatives had been put in place, designed to slow and then reverse a trend on staff attrition. Other areas requiring a further focus included staff appraisals and sickness absence given that these had been significantly disrupted during the pandemic.

Mr Williams asked about the appraisal rates, noting a particular discrepancy between clinical and non-clinical participation. He felt that this would be critical to returning to business as usual. The Director of People recognised that some drivers for differentials included a link between appraisal completion and medical revalidation. This had ensured strong participation in appraisal for this

staff group. Ms Seary noted some progress made recently at BHRUT on appraisal and appraisal satisfaction rates, suggesting that there were opportunities to revisit the approach to non-clinical staff appraisal with an emphasis on supportive conversations and staff wellbeing. Ms Kinnaird agreed that experiences outside the NHS similarly evidenced opportunities for improving the experience of appraisals. The Director of People confirmed that best practice examples were being sought and appreciated that more innovative ways of working may be needed.

Dr McLean recognised the progress made on substantive recruitment and queried whether this should be resulting in a corresponding reduction in the levels of temporary staffing. The Group Chief Finance Officer noted a continued increase in the cost base during the pandemic with increased capacity brought on stream. The system was now being asked to deliver more activity through productivity improvements. This would require cooperation on elective plans with partners and better understanding of the drivers on workforce costs. The Director of People recognised the quality and financial benefit of increasing permanent and reducing temporary staffing. He noted that the emergency pathway was often a key factor in the relative levels of bank and agency usage and collaborative sector work would be prioritised in this area.

(iv) Finance

The Group Chief Finance Officer noted Month 12 and outturn headlines. He confirmed an anticipated £400k surplus at year-end, subject to auditing. In view of the fragmented nature of the financial year, he felt that this had been a strong performance. In terms of capital, the Trust had sought to maximise the investment funds available and utilised this well to deliver a positive year-end outturn. A focus during 2022/23 would be on productivity improvements to support plans for activity, anticipating that this would be an even more challenging year.

The Trust Board noted the report.

51/22 REPORTS FROM BOARD COMMITTEES

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

- Mr Sharples confirmed the significant achievements of the finance team in delivering a strong revenue and capital outturn position. The Committee had discussed the inflationary pressures being seen and the anticipated capital allocation via the NEL system as well as other sources. The Committee recognised the challenges of managing some of the uncertainties around capital availability. Time had also been spent on a review of the sector drivers of financial strategy.

- Dr McLean noted that the Quality Assurance Committee had met and highlighted a learning review of Imaging services improvement plans and steps to monitor this at the Committee.

52/22 OCKENDON AND MATERNITY UPDATE REPORT

The Chief Nurse noted that this report reflected publication of the final reporting from this review, with some important learning for the Trust and the NHS more widely. As reported at the previous meeting, a gap analysis was under way and reporting would follow on the outputs from this exercise. An NHSE/I assurance visit was also anticipated in June and preparations were being made for this.

53/22 PEOPLE REPORT - STAFF SURVEY AND GENDER PAY GAP

The Director of People introduced the report on the staff survey and gender pay gap and noted relatively limited movement on prior year staff survey scores. The report reflected outcomes of a survey undertaken in September 2021 during a pandemic wave. Scores overall tended to be below the national average and the lack of significant movement remained a source of concern. Some positive survey results included staff views on their ability to take initiative and the quality of theTrust as a place to work; suggesting that the Quality Improvement approach adopted by the Trust had had an effect. The Trust had performed less well on other indicators such as experience of discrimination, which had remained flat since 2017.

Reflecting on these results, he recommended that there would not be a dramatic change in approach needed as the current strategies of WeBelong, Drive 95, wellbeing and leadership development were the right ones and needed to progress on implementation of these (rather than pivoting to a different approach).The gender pay gap report had highlighted improvement opportunities and work was being done to address flexible working and several other priorities identified by staff.

Ms Seary asked about steps to measure the effectiveness of strategic programmes outlined (rather than waiting for annual updates such as the WRES data and the gender pay gap report). The Director of People noted that the plans were accompanied by a number of metrics, such as an annual 3% improvement on the number of BAME staff employed at Band 8A and above. Performance on this metric had improved but there was a need to monitor this and other similar measures. Ms Seary asked how often the Trust Board might receive data such as this. It was confirmed that the Inclusion Board would review data on a quarterly basis with a plan for twice yearly reporting to the Trust Board on both wellbeing and on inclusion. It was also agreed that there would be a need to revisit the role of the Inclusion Panel and NED representation on this.

Dr McLean recognised that there seemed to be a relatively high number of process interventions on inclusion without yet seeing the benefits in terms of

outcomes and felt the need to aim for more ambitious levels of improvement. The Chair agreed that monitoring this would be important, given the time invested on this agenda. Ms Kinnaird felt that we may need to challenge ourselves further on whether the lead metrics were the right ones to drive the improvements and queried whether there may be lessons from elsewhere. The Group Chief Executive felt that some contextual factors were relevant to the experience on inclusion in the last two years of the pandemic. She felt that wider aspects such as career conversations and appraisals were part of the improvement needed. The Group Chief Executive noted some innovative leadership inclusion plans relating to the recently launched cultural intelligence programme, with Board updates planned on this.

The Trust Board noted the report.

54/22 WHIPPS CROSS REDEVELOPMENT

The Director of Redevelopment introduced the programme progress report. He reflected on progress with the integrated delivery framework for service transformation, which focused on population health improvement. Work was under way to develop an annual plan for this framework. Separately work continued on a strategy for the future of end-of-life care, with a set of proposals ready for public engagement during the summer. The Mayor of London had also confirmed support for the planning application for the redevelopment. Demolition works and creation of a temporary car parking facility had been finalised. Approval on the business case for the next stage of enabling works was now awaited. Engagement with the New Hospitals Programme team had confirmed that HM Treasury would be considering cases shortly, with the roadmap now clearer on approvals for individual schemes.

The Trust Board noted the progress report.

55/22 USE OF THE SEAL

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

56/22 ANY OTHER BUSINESS

There was no other business.

57/22 QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair introduced the section of the meeting inviting questions from the public. Questions received were displayed on screen during the meeting with the option for individuals to read their questions aloud.

A Newham Save our NHS campaign group representative, Ms Rosamund Mykura, asked questions relating to investment on Nuffield Health's new private hospital; NHS patient charging; and progress on the fire safety works at Newham.

In relation to the first question, the Group Chief Finance Officer confirmed that the commitment to invest surpluses generated related to any payments above cost being reinvested into NHS service provision. He confirmed that lease payments were being received from January 2022 onwards (ahead of opening in May 2022) and that the value of rent payable could not be publicly disclosed as commercial in confidence. He emphasised that the Trust was not liable for any costs to delays in opening this. The facility had no implications for the Trust's PFI contract and was not part of its PFI site. In answer to the second question, the Deputy Group Chief Executive confirmed that ethnicity was not a factor in determining entitlement to free NHS care. As indicated at previous meetings, the Trust did not recognise the characterisation of individuals being 'wrongly invoiced', as referred to in the question. However, he confirmed that the Trust would provide details of how many invoices were cancelled as a result of patients subsequently evidencing entitlement to treatment. On the third question, the Deputy Group Chief Executive noted that the replacement of the cladding would be completed in June 2022. He acknowledged that improvement works had taken longer than anticipated, in part due to pandemic-related supply chain and labour issues for firms engaged in this work while also recognising the challenges of undertaking works in busy and essential clinical service environments. He confirmed that, following completion of the initial phases 1 and 2, phase 3 had started and was due for completion in May 2023. He also advised that the new modular build was anticipated to be ready for clinical service use in February 2023.

58/22 DATE OF THE NEXT MEETING

The next meeting of the Trust Board in public would be held on Wednesday 6 July 2022 at 11.00am, with further details to be published on the website.

59/22 RESOLUTION

The Board resolved those 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
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Action log

Trust Board Part 1: 4 May 2022			
Page No.	Action	Lead	By
5	The Group Director of Strategy would revert on the query regarding relative prioritisation on equity of access	Interim Group Director of Strategy	6 July 2022 (item on agenda)
7	Diagnostics trajectory had been discussed at a recent QAC meeting and a follow up report would be arranged.	Deputy CEO and Director of Clinical Operations	6 July 2022

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Report to the Trust Board: 6 July 2022	TB 42/22

Title	Trust Board membership
Sponsoring Director	Chair in Common
Author(s)	Trust Secretary
Purpose	To note changes to Board membership
Previously considered by	n/a

The Trust Board is asked to note the following changes to Trust Board membership:

- Mr Matthew Trainer joins as a voting Board member and deputy group chief executive for Barts Health and Barking, Havering and Redbridge University Hospitals NHS Trust from 1 August 2022.
- Ms Helen Spice joins as a voting Board member and non-executive director (with a formal start date to be confirmed).
- Ms Joni Ferns as a voting Board member and non-executive director from 1 September 2022.
- Ms Sarah Teather joins as a non-voting Board member and associate non-executive director from 1 September 2022.

Related Trust objectives
n/a

Risk and Assurance	n/a
Related Assurance Framework entries	n/a

Legal implications/ regulatory requirements	No direct legal implications identified.

Action required by the Board
The Trust Board is asked to note the above changes to Trust Board membership.

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Report to the Trust Board: 6 July 2022	TB 43/22

Title	Board Assurance Framework
Sponsoring Director	Group Director of Corporate Development
Author(s)	Trust Secretary
Purpose	To seek approval of the revised BAF
Previously considered by	Group Directors, Risk Management Board June 2022

Executive summary

The Board Assurance Framework (BAF) provides an overview of the principal risks to delivery of the Trust's objectives. The BAF was revised to reflect development of the group operational plan for 2022/23, with the risks for quarter 1 agreed at the last meeting in May 2022. The group operational plan for 2022/23 presented at the May Trust Board meeting confirmed a high degree continuity in terms of the Trust's objectives for 2022/23. The proposed principal risks have now been discussed with lead executives following a mapping exercise to assess BAF coverage of the key risks to the new objectives. This paper sets out the BAF risks with supporting detail on controls and assurances in a revised format; and confirms that there are no proposed changes to the quarter 1 BAF risk scores.

Looking ahead, the BAF will be further refined and refreshed for the Audit and Risk Committee with a Q3 BAF submission to the Trust Board. A planned Trust Board review of risk appetite is also scheduled for Q3, following work by the risk management team and an initial exploratory executive review. It is anticipated that this Board review may result in some amendments to the risk appetite statement (for example in relation to enablers in the financial and regulatory domains).

Following approval of the principal risks, lead assurance committees will schedule BAF risk deep dive reports into their workplans with agreement to follow a common format. The intent will be to mainstream this alongside existing reporting on key domains; while allowing for review, refinement and challenge on aspects such as the self-assessed assurance levels for controls and the development of risk tolerance thresholds (or 'triggers').

Risk and Assurance	This report provides assurance in relation to all Trust objectives

Legal implications/ regulatory requirements	CQQ Well Led regulations

Action required

The Trust Board is asked to note and approve the revised Board Assurance Framework.

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 6 JULY 2022

BOARD ASSURANCE FRAMEWORK REPORT

BOARD ASSURANCE FRAMEWORK

1. The Trust Board receives the Board Assurance Framework (BAF) three times per year to discuss and agree the principal risks to the delivery of the Trust's strategic objectives. This follows a review process involving the executive Risk Management Board and lead directors. The terms of reference for the Board's principal assurance and lead committees (the Quality Assurance Committee, Finance and Investment Committee and Audit and Risk Committee) establish that the respective Committees will receive and review at each meeting a report specifically related to a BAF entry topic or a summary of all the BAF entries allocated to them (to assess whether their respective agendas sufficiently address key risks). The BAF is used to inform the development of annual work plans for these committees and their role in commissioning assurances on key controls.

2. The BAF is designed to identify the principal risks to the delivery of the Trust's objectives. Following approval of the Q1 BAF principal risks at the last Trust Board meeting in May, the attached provides the full BAF (in terms of supporting detail on controls and assurances).

3. The BAF is reviewed annually by Internal Audit to assure on its development and effectiveness. This review has informed the proposed format of the BAF to incorporate recommendations on assurance mapping featuring a RAG rating to provide an indicative self-assessment of the relative assurance levels gained in respect of controls.

CHANGES TO BAF RISKS

4. The BAF risks and related scores submitted for approval at the last meeting in May remain unchanged in this version with the exception of one risk, which has been reframed as follows:

   BAF entry 11

   Change from: 'Failure to reduce structural financial deficit in NE London impacts on medium term sustainability and strategic investment' to: **'Failure to deliver against year 1 and three year financial plans for Barts Health and BHRUT impacts on medium term sustainability and effective sector collaboration.'**

RISK APPETITE

5. Risk appetite reflects the extent to which the organisation will tolerate, accept or embrace risks – both in terms of outcomes materialising and activities undertaken – to achieve its objectives; recognizing explicitly that this will differ according to the objective/activity involved.

Fig.1 – Risk appetite scale

Avoid No risk	Averse (risk scores 1-3)	Cautious (risk scores 4-6)	Moderate (risk scores 8-12)	Open (risk scores 15+)

6. The position on the scale (Fig.1) is considered for each Trust objective and enabler. For example:

    - An 'averse' (low) risk appetite can reflect a) a requirement or decision to adopt a cautious, conservative approach to addressing objectives and accompanying risks and/or b) minimal tolerance of adverse outcomes.
    - An 'open' (higher) risk appetite may indicate that a) the approach being taken in relation to delivering an objective involves a more innovative or high risk/high reward approach either inherent in the nature of the activity (e.g. R&D); or because a more radical approach is felt to be required to unlock an intransigent issue – and/or b) reflect a recognition of higher tolerance of an adverse outcome.

7. Risk appetite sets out the context in which a given risk sits. A lower risk appetite is neither 'better' or 'worse' than a higher risk appetite. However, it does link to both the context within which the Trust operates for that objective/domain; and within this the relative appetite for higher or lower risk: reward delivery options. The risk appetite for relevant objectives and enablers are reflected in the BAF heatmap, as in recent years. The Trust Board is asked to note work under way to refresh the underpinning risk appetite statement for the Trust. The board will be further engaged on this work during Q3, to ensure views are captured and considered.

BAF FORMAT CHANGES

8. The BAF format has been amended to a) separate out 'lines of assurance' and b) introduce self-assessed RAG ratings for assurance levels in relation to these. The aim of this is to improve transparency and enable challenge. This refinement seeks to look beyond effective risk identification and balance the previous focus on this with an improved assessment of risk management effectiveness.

9. The model of disaggregated 'lines of assurance' is common in risk management theory. In line with good practice guidance these lines can be characterized as follows:
    - First line assurance includes all assurances on controls controlled by and visible to management teams including at group executive board and hospital executive board level.

- Second line assurance includes all assurance reporting controlled by and visible to board and board committee level via their workplans.
- Third line assurance includes all independent assurance reporting including commissioned Internal Audit report as well as assurances received via regulatory reports, national surveys etc.

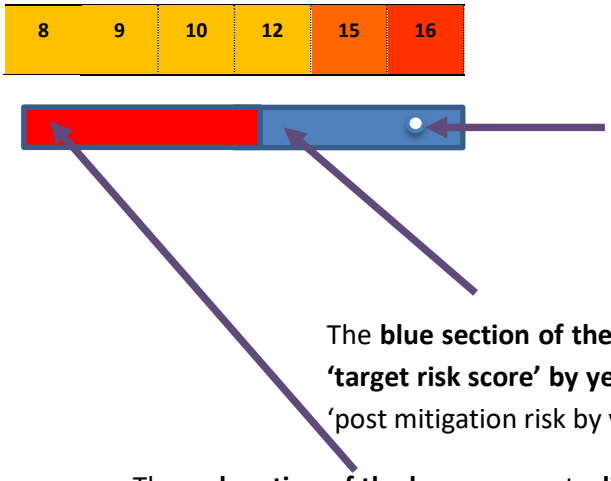
10. The RAG ratings introduced seek to provide an indicative self-assessment by the executive in two respects for each of the 'lines of assurance' detailed above. Firstly, a RAG rating is included in relation to the 'span' of controls and assurances. This should help to identify whether leaders believe that they have sufficient data and sources of intelligence to assess the status of controls relevant to the BAF risk in question. Secondly, a RAG rating on the 'assurance level' will help to provide some indication on the level of assurance that this reporting is providing currently. In doing so, it is recognised that in the context of the strategic and system-dependent nature of BAF level risks, there may be external drivers impacting on the outcomes, assurances and risk tolerance.

11. It is recognised that a RAG rating approach will be based on executive judgements and that this approach is at an early stage of development. However, it is hoped that this develops over time to support review and challenge of controls effectiveness as part of the work of board committee 'deep dive' reporting. It is planned to refine this further with executives and executive boards in coming months.

RECOMMENDATION

12. The Trust Board is asked to note and endorse the proposed Board Assurance Framework entries and note plans for further Board discussion of risk appetite during Q3.

Annex 1 - *BAF heatmap entry example*



The **white dot** represents the **'current risk score'**.

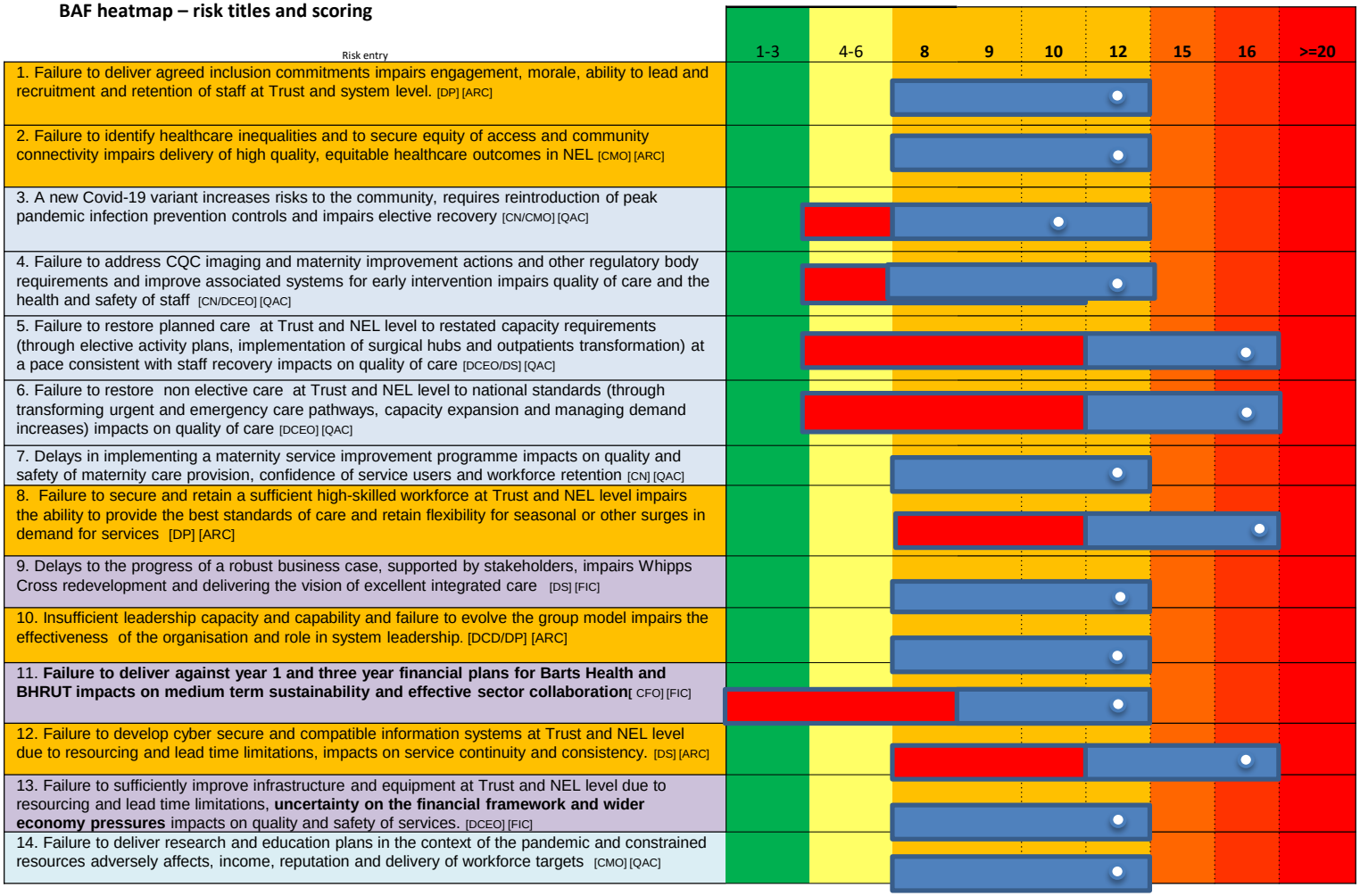
[In risk management terminology this represents the 'intrinsic existing risk']. In this example the current risk score is 16.

The **blue section of the bar** represents the **distance from 'current risk score' to the 'target risk score' by year end**. [In risk management terminology this represents the 'post mitigation risk by year end']. In this example the target risk score is 12.

The **red section of the bar** represents **distance from the 'current risk score' to the 'risk appetite'** for the corresponding objective by a separately identified date. [In risk management terminology this represents the 'target post mitigation residual risk by the strategic target date set']. In this case the relevant score is 8.

Where no red bar is shown on the heatmap, the current risk score sits within identified risk appetite 'range'.

BAF heatmap – risk titles and scoring



Bold text indicates entries that are new or have been materially amended on the BAF since last submitted to the Trust Board. Any arrows reflect changes in score since the previous version. The white dot represents the 'current risk score'. The blue section of the bar represents the distance from 'current risk score' to the target 'risk score'. The red section of the bar represents distance from the risk appetite for the corresponding objective (where no white bar is shown, the current risk is within risk appetite/tolerance). The Quality Assurance Committee has lead oversight role for risk titles shaded blue; the Finance and Investment Committee has lead oversight role for risk titles shaded purple; the Audit and Risk Committee has lead oversight role for risk titles shaded orange.

STRATEGIC OBJECTIVE 1. To create a truly inclusive organisation, without discrimination, based on a fair and just culture that helps us meet our ambition to be an outstanding place to work

Risk appetite for sub-objective relevant to risk: **8-12 (Moderate)** Risk tolerance triggers: Percentage of BAME staff 8a+ more than 1% below the target trajectory; implementation of 'WeLead' curriculum including cultural intelligence [threshold to be confirmed]; Likelihood ratio of BAME to White disciplinary cases rising above 1.6

Gap: risk score to risk appetite: 4 (current risk score 12; in year target risk score: 8; long term risk appetite: 8-12)

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span*	*Assurance level*	*Span*	*Assurance level*	*Span*	*Assurance level*	
1. Failure to deliver agreed inclusion commitments impairs engagement, morale, ability to lead and recruitment and retention of staff at Trust and system level **Executive lead:** Director of Inclusion and Director of People **Subcommittee role:** Audit and Risk Committee	*[Outset score: 12]* ***Current: 4x3 = 12*** *Target: 4x2 =8* *Datix ref: 4477*	**1.** WeBelong inclusion strategy / WeCare values **2.** Equality Objectives and Inclusion commitments **3.** Operational Plan and objective SO1. **4.** Leadership development / cultural intelligence programmes focus on E&I **5.** Analysis of annual NHS Staff survey and internal quarterly pulse surveys. **6.** NEL operational plan and steps towards joint workforce planning across sector acute providers	*Inclusion Board ToR - oversees delivery of WeBelong strategy, equality objectives and commitments **(maps to controls 1 and 2)** *Group Executive Board ToR – oversight of operational plan delivery **(3)** patient and staff survey outputs **(5)** *People Board ToR – oversees delivery of leadership development, education and training **(4)** *Staff networks and all staff webinar programme (**1, 2, 4)**		Trust Board annual reviews via Inclusion Observatory, including statutory reports ***(maps to control* 1, 2)** and Inclusion Advisory Panel assurance reporting **(1)** Trust Board approval of operational plan **(3)** Trust Board review of staff survey **(5)** QAC assurance reporting on patient feedback **(6)** Trust Board seminar – scheduled review **(7)** Trust Board seminar and Part 1 equity reports **(8)**		*Annual NHS staff and patient survey benchmarking **(5,6)** *WRES and WDES data benchmarking – 2021 results indicate requires improvement **(2,4)** *Internal Audit report Staff Engagement 20/21 (reasonable assurance) **(1, 5)** * Internal Audit report on Advocacy services 19/20 (insufficient assurance) **(1)** Internal Audit report Staff Survey 19/20 (reasonable assurance) **(5)**		*Gap: Plans delivering diversity in leadership roles* *Action: Embed 2020 inclusive recruitment practice* *Gap: % BAME staff in formal HR processes* *Action: Simplified and improved policies; cultural intelligence programme* *Gap: Assurance on consistency of implementation of inclusion actions across all hospitals / departments* *Action: Focus on inclusion issues via PRs and People Board work*

Related high risks (>15) on the risk register – Datix refs:
5660 – Pandemic impact on staff wellbeing linking to patient care (risk score 16, lead SBH CEO)
6111 – Pandemic impact on staff wellbeing linking to patient care (risk score 16, lead GCS MD)

STRATEGIC OBJECTIVE 2. To improve health and care services for all our population transforming clinical services whilst reducing health inequalities and inequities of provision

Risk appetite for sub-objective relevant to risk: **8-12 (Moderate)** Risk tolerance triggers: : Covid-19 high or very high pressure status

Gap: risk score to risk appetite: 4 (current risk score 12; in year target risk score: 8; long term risk appetite: 8-12)

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span*	*Assurance level*	*Span*	*Assurance level*	*Span*	*Assurance level*	
2. A risk of not identifying healthcare inequalities and/or not securing equity of access and community connectivity impairs delivery of high quality, equitable healthcare in NEL **Executive lead:** Chief Medical Officer and Director of Inclusion **Subcommittee role:** Audit and Risk Committee	*[Outset score: 16]* ***Current: 4x3 = 12*** *Target: 4x2 =8* *Datix ref: [tbc]*	**1.** Integrated Performance Report includes key metrics on access to healthcare services **2.** Patient Experience Strategy published with action to commission cultural intelligence and competency programme. **3.** Friends and Family Test and national patient surveys to assess and benchmark access and service quality **4.** Equity of access work led by Public Health to investigate healthcare inequalities. **5.** Development of Anchor Institution strategy, building on development of community employment and related initiatives e.g. ELBA alliance, apprenticeships, Project Search etc **6.** NEL operational plan and steps towards joint workforce planning across sector acute providers	*Inclusion Board ToR - oversees delivery of equality objectives and commitments **(maps to controls 1 and 2)** *Group Executive Board ToR – oversight of operational plan delivery **(1)** and patient survey outputs **(4)** GEB hospital performance review mechanism **(assurance on controls 1-5)** People Board and Inclusion Observatory monitoring **(2)**		Trust Board quarterly inclusion and equalities report references patient equity aspects **(assurance on controls 1-5)** Equity of access Board report covers identified risks relating to healthcare interventions and equity of access **(1-3).** Quality Assurance Committee oversight of patient experience, surveys and insight reporting **(2)**.		National inquiry and national audits on Covid-19 highlight healthcare inequalities		*Gap: Board agreed anchor institution / sustainability strategy* *Action: Agreement of an anchor institution plan* *Gap: Impact assessment required on any unintended consequences of pandemic related innovation and practice.* *Action: Impact assessment of virtual clinical under way* *Gap: Developing a more comprehensive and joined up assurance picture and communicating this* *Action: Board level focus on next steps*

Related high risks (>15) on the risk register – Datix refs:
5484 Inequitable care for patients with a learning disability (risk score 15, lead Chief Nurse)

STRATEGIC OBJECTIVE 2. To improve health and care services for all our population transforming clinical services whilst reducing health inequalities and inequities of provision
Risk appetite for sub-objective relevant to risk: **4-6 (Cautious)** Risk tolerance triggers: Nosocomial infection rates (threshold tbc) Outbreak/ward closure rate (threshold tbc); cancelled operations rate (threshold tbc)
Gap risk score to risk appetite: 8 (current risk score 15; in year target risk score: 10; long term risk appetite: 4-6)

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE	SECOND LINE ASSURANCE	THIRD LINE ASSURANCE	GAPS
Controls and assurance rating – (i) Span (ii) Assurance Level			*Span* / *Assurance level*	*Span* / *Assurance level*	*Span* / *Assurance level*	
3. A new Covid-19 variant increases risks to the NEL population, requires reintroduction of peak pandemic controls and impairs elective recovery. **Executive lead:** Chief Nurse **Subcommittee role:** Quality Assurance Committee	*[Outset score: 15]* ***Current: 5x2=10*** *Target: 5x1=5* *Datix ref: [tbc]*	**1.** Covid dashboards and integrated performance reporting. **2.** Winter plan (including high and very high-pressure plan for Covid-19 management). **3.** Segregation of clinical areas and staffing, PPE arrangements, testing and vaccination programmes to mitigate risks of Covid-19 nosocomial infections. **4.** Dedicated group IPC team in place monitoring infection risks **5.** Case management, cluster, outbreak management policy in place to minimise risk of nosocomial transmission **6.** Policies and SOPs updated to respond to pandemic issues **7.** Quality Improvement programme established with focus on safety **8.** IPC plan described in an IPC specific BAF **9.** NEL operational plan including coordination of elective plans and mutual aid.	GEB and Quality Board oversight of KPIs with peak planning arrangements on standby **(1-8)** - KPIs give assurance on nosocomial infection rates (benchmarking positively) **(3)** Infection Prevention and Control Committee and Covid IPC working group **(4-9)**	Trust Board review of IPR quality metrics **(assurance on controls 1-8)**. QAC and Quality Board thematic and exception reporting, including deep dive reviews **(1-8).** Look back reporting on Covid-19 waves with focus on identifying learning **(1-8).** Annual report on infection control received by Trust Board **(4-8)**	CQC review of plans National benchmarking reports Internal Audit of IPC BAF PHE involvement in outbreak management Internal Audit report Procurement19/20 **(4)** 2021 Reasonable assurance Internal Audit report – IPC BAF **(8)** National inquiry and national audits on Covid-19 to identify learning for future waves **(9)** National benchmarking reporting on nosocomial infections **(1-3)**	*Gap: National planning guidance assumes Covid-19 workload will not impair elective recovery* *Action: Business continuity planning*

Related high risks (>15) on the risk register – Datix refs:
3543 Crowding within Whipps Cross Emergency Department (risk score 20, lead Whipps Cross Chief Executive)
5937 Risk of Covid outbreak among staff at Whipps Cross (risk score 16, lead Whipps Cross Chief Executive)
5849, 5850, 5884 Insufficient clinical engineering workspace with no dedicated decontamination facilities (risk score 16, lead St Bartholomew's, Newham and Whipps Cross Chief Executives)
5251 Lack of sustainable antimicrobial stewardship (risk score 16, lead GCS Managing Director)
6416 Rightsizing IPC department (risk score 16, lead GCS MD)

STRATEGIC OBJECTIVE 2. To improve health and care services for all our population transforming clinical services whilst reducing health inequalities and inequities of provision

Risk appetite for sub-objective relevant to risk: **4-6 (Cautious)** Risk tolerance triggers: CQC rating deterioration; Regulatory notice received; Internal Audit or external 'insufficient assurance' review

Gap risk score to risk appetite: 8 **(current risk score 12; in year target risk score: 8; long term risk appetite: 4-6)**

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE	SECOND LINE ASSURANCE	THIRD LINE ASSURANCE	GAPS
Controls and assurance rating – (i) Span (ii) Assurance Level		Span / Assurance level	Span / Assurance level	Span / Assurance level	Span / Assurance level	
4. Failure to address CQC imaging and maternity improvement actions and other regulatory body requirements and improve associated systems for early intervention impairs quality of care and the health and safety of staff **Executive lead:** Chief Nurse, Chief Finance Officer **Subcommittee role:** Quality Assurance Committee	*[Outset score: 12]* ***Current: 4x3=12*** *Target: 4x2=8* *Datix ref: [3538]*	**1.** Approved Quality Strategy, quality assurance framework and Quality Improvement programme includes ward dashboards and Perfect Ward data. **2.** CQC action plan reporting including site deep dives. Monthly CQC BAU meeting to ensure consistent review of CQC activity. **3.** Well Led improvement plan and site self assessment processes and diagnostics to review leadership and governance capability and capacity. **4.** Hospital leadership teams hold key role in managing local quality standards with accountability framework to support clarity on roles. **5.** Three-year fire safety remediation plan and rolling programme of improvements prioritised in capital programme. **6.** Quality governance and compliance function / central Estates function have roles in monitoring regulatory activities and share learning.	Quality Performance Review mechanism for hospitals **(1-2)** Peer reviews of wards and departments [including August review of hospital imaging services] **(1-4)**. Health and Safety Committee oversight of fire safety improvement with regular reporting into Risk Management Board **(5)** Fire remediation oversight includes Trust Board and FIC oversight of investment plans and ARC oversight of regulatory/governance aspects **(5)**	Quality Assurance Committee and executive Quality Board monitoring of CQC healthcare regulations and QI programme **(1 -3)** QAC reporting on monitoring of external agency inspections and regulations **(1-3)**	CQC inspections of sites including more recent reviews of Newham diagnostics & maternity, Whipps Cross maternity and imaging; Royal London imaging **(1-4)** Related agency inspections including HSE, HEE and MHRA **(1-4)** 2021 External review of fire safety governance at Newham **(5)** 2021 Reasonable assurance Internal Audit reviews– Health and Safety/Fire **(5)** 2021 Reasonable assurance Internal Audit review - External reviews and visits **(4)** 2022 Internal Audit review of Clinical Audit programme **(1)** London Fire Brigade engaged on fire remediation implementation	*Gap: LFB Enforcement notice (extended deadline to 2024) Action: Ongoing dialogue and strong relationship with LFB to agree priority actions.* *Gap: CQC Imaging Services reviews at RLH and Whipps Cross highlighted areas for improvement in safety/risk, leadership and culture*

Related high risks (>15) on the risk register – Datix refs:
3468 Non-compliance of Fire Safety Order at Newham Hospital (risk score 15, lead Newham Chief Executive); 3619 Non-compliance of Fire Safety Order at Whipps Cross Hospital (risk score 16, lead Whipps Cross Chief Executive)
4043 Non-compliance of Fire Safety Order at SBH (risk score 16, lead SBH Chief Executive); 6428 Fire safety compliance in WX Maternity (risk score 16, lead Whipps Cross Chief Executive)
5562 Non-compliance with MHRA medicines manufacturing licence for Radiopharmacy and BHP (risk score 16, lead GCS Managing Director) ; 5267 Radiation safety staffing levels (risk score 16, lead GCS Managing Director)
2674 Neonatal facilities for medical equipment cleaning (risk score 15, lead Newham Chief Executive) 5367 Shortage of Consultant histopathologists (risk score 16, lead RLH CEO); 227 Lift failure at WX (risk score 16, lead Whipps Cross CEO)

STRATEGIC OBJECTIVE 2. To improve health and care services for all our population transforming clinical services whilst reducing health inequalities and inequities of provision

Risk appetite for sub-objective relevant to risk: **4-6 (Cautious)** Risk tolerance triggers: Adverse variance from agreed activity trajectories for each constitutional target for 3 consecutive months

Gap risk score to risk appetite: 12 **(current risk score 16; in year target risk score: 12; long term risk appetite: 4-6)**

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span*	*Assurance level*	*Span*	*Assurance level*	*Span*	*Assurance level*	
5. Failure to restore planned care at Trust and NEL level 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 **Executive lead:** Deputy Chief Executive and Director of Transformation **Subcommittee role:** Quality Assurance Committee	*[Outset score: 16]* ***Current: 4x4=16*** *Target: 4x2=8* *Datix ref: (2845)*	**1.** Operational plan, IPR and 18 Week RTT performance and data quality reporting including weekly activity tracker. Prioritisation to balance clinically urgent patients with long waiters in scheduling. **2.** Established PTL supported by single Cerner system. BHRUT digital strategy will align systems. **3.** Data validation programme and staff training programme to support 'right every time' data entry/quality and targeted on repeat errors. **4.** Independent sector support for elective patients. **5.** Establishment of surgical hubs to support high volume low complexity workstreams. **6.** Workforce planning and waiting list initiatives to address elective backlogs. **7.** Transformation programme with emphasis on care closer to home principles **8.** NEL operational plan including coordination of elective plans and mutual aid.	Business as usual RTT/Elective Care programme board and Operations Board. Escalation Covid-19 governance arrangements for pandemic higher pressure levels **(assurance on controls 1-7)**. Sector escalation meetings to review any off-trajectory RTT performance **(1)** Monitoring safe staffing models reviewing red flags and Care Hours per Patient Day across the group **(6)** Data sampling exercises and planned list validation exercises to assure on data quality **(1-3)** Clinical Board focus on transformation and impact assessment (e.g. monitoring of the impact of accelerated introduction of virtual clinics) **(7-8)**		Trust Board and Quality Assurance Committee monitoring of elective programme and operational plan delivery **(1-8)** Provider collaboration, acute provider collaborative, place and NEL ICS governance structures being developed with focus on integration and elective plans **(8)**.		NHSE/I and ICS level governance and monitoring of key metrics **(8)** Provider coordination across NEL to support targeted activity and mutual aid. **(1,8)** External review process for any potential clinical harm associated with long waits – chaired by NHS England Medical Director and GP representative **(4)** 2021 Reasonable assurance Internal Audit review – Cancer waits (**10**)		*Gap: Elective plan risks linked to pandemic and emergency care demand. Action: Board-level and site focus on prioritised elective long waiters but gaps on trajectory remain.* *Gap: Waiting list validation exercise to confirm status of patient cohort, with risk on overall waiting times Action: Exercise ongoing* *Gap: Workforce constraints impede plans for wider elective programme during pandemic. Action: Use of Independent Sector capacity and innovative approaches to patient pathways to minimise hospital lengths of stay*

Related high risks (>15) on the risk register – Datix refs:
4765 IT- Business Continuity (risk score 16, lead Group Director of Strategy); 5997 Theatre capacity for complex elective orthopaedic surgery (risk score 15, lead Royal London Chief Executive) 5590 Cessation of electivity activity during Covid 19 (risk score 15, lead Royal London Chief Executive);5825 No elective operating and reduced outpatients generating backlog (risk score 15, lead Newham Chief Executive) 5825 Elective and reduced outpatients generating backlog (risk score 15, lead Newham Chief Executive) 5860 Harm to patients awaiting diagnostic procedures in endoscopy (risk score 15, lead Newham Chief Executive) 4019 Outpatient appointment capacity (risk score 16, lead Whipps Cross Chief Executive) 5946 Prescription and supply of medicines to patients attending virtual outpatient clinics (risk score 16, lead GCS Manging Director) 5989 Consultant vacancy palliative care (risk score 15, lead Whipps Cross Chief Executive) 5825 Elective and reduced outpatients generating backlog (risk score 15, lead Newham Chief Executive); 5518 ILD Service consultant staffing (risk score 16, lead SBH Chief Executive)

STRATEGIC OBJECTIVE 2. To improve health and care services for all our population transforming clinical services whilst reducing health inequalities and inequities of provision

Risk appetite for sub-objective relevant to risk: **4-6 (Cautious)** Risk tolerance triggers: 12 hour waits for 2 months for any hospital; change to Covid pressure status/national incident/critical care surge

Gap risk score to risk appetite: 12 **(current risk score 16; in year target risk score: 12; long term risk appetite: 4-6)**

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE	SECOND LINE ASSURANCE	THIRD LINE ASSURANCE	GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span* / *Assurance level*	*Span* / *Assurance level*	*Span* / *Assurance level*	
6. Failure to restore non elective care at Trust and NEL level to national standards (through transforming urgent and emergency care pathways, capacity expansion and managing demand increases) impacts on quality of care **Executive lead:** Deputy Chief Executive **Subcommittee role:** Quality Assurance Committee	*[Outset score: 16]* ***Current: 4x4=16*** *Target: 4x3=12* *Datix ref: (1981)*	**1.** Winter Plan setting out emergency care operating model, pandemic aspects including mutual aid and transfer. **2.** Covid-19 escalation plan with identified measures in onset of medium, high and very high pressure status; including for expanded critical care and emergency care **3.** Sector approach to capacity constraints for emergency care and to address interface on ambulance transfers. **4.** BAU hospital improvement plans set out optimum conditions (internal and sector) and actions to achieve trajectories for performance. Hubs established to support sector co-ordination. **5.** Workforce and independent capacity flexed to support elective care recovery	Group Executive Board ToR – oversight of operational plan delivery **(1-5)** Adapted Covid governance arrangements in event of escalation of pressure status **(4-5)**. Business as usual NEL and London emergency and critical care governance **(3)**	Board monthly reporting via the Integrated Performance Framework **(1-5)**.	Internal Audit report Nightingale Preparedness review 20/21 **(3)**	*Gap: Emergency care performance for RLH, Newham and Whipps Cross impacted by pandemic pressures and constraints associated with measurement changes, segregation of Covid activity, and workforce supply.* *Action: Performance monitored at executive and sector levels. Review of updated IPC guidance under way.*

Related high risks (>15) on the risk register – Datix refs:
5152 Emergency Access Performance (risk score 16, lead Deputy Chief Executive) 5014 ERCP procedures (risk score 16, lead Whipps Cross Chief Executive)
3543 Crowding within the Emergency Department in Whipps Cross ED (risk score 20, lead Whipps Cross Chief Executive) 5156 Winter pressures (risk score 16, lead Whipps Cross Chief Executive)
4765 IT- Business Continuity (risk score 16, lead Group Director of Strategy)
3062 Junior doctor cover in ED (risk score 15, lead Whipps Cross Chief Executive)
5849, 5884 Insufficient clinical engineering workspace with no dedicated decontamination facilities (risk score 16, lead St Bartholomew's and Whipps Cross Chief Executives)
5850 Insufficient clinical engineering workspace with no dedicated decontamination facilities (risk score 15, lead Newham Chief Executive)
5904 Inadequate space on ICU for aspects of service (risk score 15, lead Newham Chief Executive)

STRATEGIC OBJECTIVE 2. To improve health and care services for all our population transforming clinical services whilst reducing health inequalities and inequities of provision						
Risk appetite for sub-objective relevant to risk**: 4-6 (Cautious)**		Risk tolerance triggers: Adverse variance against timelines for recommendation implementation; maternity dashboard metric/threshold tbc				
Gap risk score to risk appetite: 6		**(current risk score 12; in year target risk score: 8; long term risk appetite: 4-6)**				
PRINCIPAL RISK *(Description of risk)*	**RISK SCORE**	**CONTROLS**	**FIRST LINE ASSURANCE**	**SECOND LINE ASSURANCE**	**THIRD LINE ASSURANCE**	**GAPS**
Controls and assurance rating – (i) Span (ii) Assurance Level			*Span* / *Assurance level*	*Span* / *Assurance level*	*Span* / *Assurance level*	
7. Delays in implementing a maternity service improvement programme impacts on quality and safety of maternity care provision, confidence of service users and workforce retention **Executive lead:** Chief Nurse **Subcommittee role:** Quality Assurance Committee	*[Outset score: 12]* ***Current: 4x3=12*** *Target: 4x2=8* *Datix ref: (1981)*	**1.** Ockendon and Kirkup review recommendations and compliance submission processes **2.** Safe staffing processes and annual midwifery establishment review using national Birthrate Plus benchmarking information with outputs in 2022/23 operational plan. **3.** Survey/insight available from FFT, Hundred Voices, Women's Experience Forums. **4.** MDT training including foetal monitoring. **5.** National PMR Tool used to review perinatal deaths. Established process for maternity SIs. **6.** Continuity of care metrics developed and models of staffing being explored.	*Management assurances on controls:* Quality Board management of Ockendon and Kirkup recommendation implementation **(1, 6)** Establishment of maternity and neonatal strategy board with hospital equivalents and representation **(1,3,5,6)** IPR reports on safe staffing, NEs and SIs **(1, 5)**	Board monthly reporting via the Integrated Performance Framework **(2-3)**. QAC oversight of Ockendon and Kirkup recommendation implementation and work of executive Maternity group **(1, 6)** CNST Maternity Incentive Scheme – self assessment against key risk areas reviewed at QAC level (**2-4)**	Reasonable assurance 2021 Internal Audit report – Maternity safety **(2-4)** 2021 CQC review of NUH maternity services **(1-6)** Survey data to inform service improvement **(1-6)** NHSE/I visit in June 2022 (report awaited) **(1-6)** CNST standards met in submission **(1-6)**	*Gaps: Partial compliance on some Ockendon recommendations to be considered and approach to full compliance agreed with NEL partners (and following clarity on funding bid)* *Action: Ongoing actions and reporting on progress via Quality Board.* *Gap: Approval of long term maternity quality and safety programme* *Action: In development*

Related high risks (>15) on the risk register – Datix refs:
5968, 6347 Inadequate management and storage of CTG's - multiple sites (risk score 16, lead Director of Midwifery)
6437 – O&G consultant staffing (risk score 16, lead NUH CEO)

STRATEGIC OBJECTIVE 3. To build effective partnerships across the health and social care system and deliver social value for communities through our longer term strategic plans
Risk appetite for sub-objective relevant to risk: **8-12 (Moderate)** Risk tolerance triggers: 95% fill rate target adverse variance (threshold tbc)
Gap: risk score to risk appetite: 4 (current risk score 16; in year target risk score: 12; long term risk appetite: 8-12)

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span*	*Assurance level*	*Span*	*Assurance level*	*Span*	*Assurance level*	
8. Failure to secure and retain a sufficient high skilled workforce at Trust and NEL level impairs the Trust's ability to provide the best standards of care and retain flexibility for seasonal or other surges in demand for services. **Executive lead:** Director of People **Subcommittee role:** Audit and Risk Committee	*[Outset score: 16]* ***Current: 4x4=16*** *Target: 4x3=12* *Datix ref: (1981)*	**1.** Workforce establishment, operational plan and budget sets baseline for workforce. **2.** Focus on substantive fill rates, recruitment and retention in Drive 95 programme. **3.** Sector leadership, local employment, research and education focus to attract and retain high calibre clinical staff. Underpinned by Outstanding Place to Work programme and WeBelong inclusion work (community connectivity and development of inclusion centre and inclusion observatory) as part of aspiration to be an anchor institution. **4.** WeLead programme, Talent Management approach to develop skills and opportunities. **5.** Pandemic workforce plans developed supported by detailed people recovery and restoration plan focusing on staff welfare and wellbeing, with associated investment. **6.** Provider Collaborative extends shared learning and career opportunities across the NEL sector.	People Board oversight of key workforce metrics and controls **(1-6)** IPR reports on people and safe staffing, **(1, 5)** PR review of HEB committee progress on *drive 95* recruitment plans **(1-6)**		*Management assurances on listed controls:* Trust Board standing item on People Strategy implementation **(assurance on controls 1-5)** IPR workforce metrics reviewed monthly at Trust Board. **(assurance on controls 1-5)**		2021 Reasonable assurance Internal Audit review of employment checks **(assurance on controls 1-5)** DBS and right to work external reporting **(assurance on controls 1-5)** CQC, HEE and Deanery reporting **(assurance on controls 1-5)**		*Gap: Insufficient numbers of trained staff in key specialties (including critical care, emergency care) and clinical professions locally and nationally* *Actions: Recruitment campaigns including overseas recruitment initiatives. Outstanding Place to Work*

Related high risks (>15) on the risk register – Datix refs:
none

STRATEGIC OBJECTIVE 3. To build effective partnerships across the health and social care system and deliver social value for communities through our longer term strategic plans

Risk appetite for sub-objective relevant to risk: **Moderate (risk score 8-12)** Risk tolerance trigger: clear timelines for OBC submission by end 2021

Gap risk score to risk appetite: 0 (current risk score 12; in year target risk score: 9; long term risk appetite: 8-12)

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span*	*Assurance level*	*Span*	*Assurance level*	*Span*	*Assurance level*	
9. Delays to the progress of a robust business case, supported by stakeholders, impairs Whipps Cross redevelopment and delivering the vision of excellent integrated care **Executive lead:** Whipps Cross Chief Executive and Director of Strategy **Subcommittee role:** Finance and Investment Committee	*[Outset score: 16]* ***Current: 3x4=12*** *Target: 3x3=9* *Datix ref: (5427)*	**1.** Established programme governance and reporting arrangements, including a programme team and external expert advisors. **2.** Named as one of eight 'pathfinders' in the Government's New Hospital Programme (NHP) with the commitment to funding a new hospital subject to business case approvals **3.** Six facet survey provides baseline on the condition of the existing estate. Flooding during summer 2021 reconfirms need for a new hospital. **4.** Partnership working alongside the NHP, local health and local government as well as input from expert advisors, to finalise an Outline Business Case. **5.** Outline planning applications submitted in May '21 with planning determination expected in 2021. **6.** Extensive stakeholder, staff and community engagement. **7.** Whipps Cross health and care services strategy refreshed in November 2020 to reflect design lessons from Covid-19 pandemic. **8.** Enabling works with demolition completed and car park plans developed. Planning permission confirmed.	*Management assurances on listed controls:* Regular review of business case development by the Whipps Cross Redevelopment Programme Board, Whipps Cross Hospital Executive Board **(assurance on controls 1-8)** Whipps Cross Estate Strategy assurance provided through Hospital Executive Board **(5)**. Assurance reporting on programme confirming internal programme management on track (with anticipated timelines for news on external dependencies)		Regular review of business case development by the, Trust Board and Finance and Investment Committee **(assurance on controls 1-8)** Assurance reporting on programme confirming internal programme management on track (with anticipated timelines for news on external dependencies)		*Independent assurance:* DHSC letter from Secretary of State for Health and Social Care in 2019, confirms Whipps Cross as one of six HIP1 redevelopment schemes to share in £2.7bn funding, subject to business case approvals. Whipps Cross since confirmed by the NHP as one of eight pathfinders in the New Hospital's Programme with a collaboration agreement in place to support joint working. This includes the NHP providing feedback and assurance on the development of the plans for Whipps Cross along with other schemes.NEL ICS response to NHS Long Term plan confirmed Whipps Cross redevelopment as key capital investment priority.	*Gap: Steps required to complete the process of business case approvals including assurance on capital and revenue requirements.* *Action: The Redevelopment Team continue to work closely with the NHP with a view to finalising the Outline Business Case ahead of submission to Trust Board.*

Related high risks (>15) on the risk register – Datix refs:
4019 Outpatient appointment capacity (risk score 16, lead Whipps Cross Chief Executive); 3543 Crowding within the Emergency Department in Whipps Cross ED (risk score 20, lead Whipps Cross Chief Executive)
5156 Winter pressures (risk score 16, lead Whipps Cross Chief Executive); 3619 Whipps Cross Fire Safety Order (risk score 16, lead Whipps Cross Chief Executive)
227 Failure of lift blocks and DDA non-compliance (risk score 15, lead Whipps Cross Chief Executive); Programme risk register held separately for redevelopment

STRATEGIC ENABLERS: Governance, leadership capacity and capability
Risk appetite for sub-objective relevant to risk: **Moderate (risk score 8-12)** Risk tolerance triggers: Board and VSM staff substantive fill rates (threshold tbc); Sustained 'high pressure' or above on Covid escalation framework; Delays to WeLead framework refresh (threshold tbc)
Gap: risk score to risk appetite: 4 (current risk score 12; in year target risk score: 8; long term risk appetite: 8-12)

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span*	*Assurance level*	*Span*	*Assurance level*	*Span*	*Assurance level*	
10. Insufficient leadership capacity and capability and failure to evolve the group model impairs the effectiveness of the organisation and role in system leadership. **Executive lead:** Director of Corporate Development and Director of People **Subcommittee role:** Audit and Risk Committee	*[Outset score: 12]* ***Current: 4x3=12*** *Target: 4x2=8* *Datix ref: [tbc]*	**1.** Group governance refresh in line with Well Led framework. **2.** Sector leadership, local employment, research and education focus to attract and retain high calibre leaders. Underpinned by Outstanding Place to Work programme and WeBelong inclusion work as part of aspiration to be an anchor institution. **3.** WeLead framework, Talent Management approach to develop skills and opportunities. **4.** Publication of 'Closer Collaboration' and development of Memorandum of Understanding following appreciative inquiry process sets out provider collaboration immediate objectives with BHRUT **5.** Refresh of collaboration objectives for 22/23 under way. **6.** Acute Provider Collaborative and place based partnerships being developed in 22/23, informing a planned review of clinical boards.	GEB and Collaboration Executive oversight of group model development and provider collaboration priorities **(1,2)** Performance Review mechanism to monitor hospital leadership effectiveness **(1)** Trust Board standing item on People Strategy implementation **(1-4)** Improvement and Sustainability Collaborative oversight of priorities for joint work with BHRUT **(4)**		Closer working of two trust boards in the provider collaboration including establishment of Board Collaboration Committee		Role of NEL ICS, JOSCs and Healthwatches in oversight of system development and place-based governance CQC oversight of Well Led domain and internal mock Well Led inspections. Review of corporate structures (GSS and HQ) and conditions required to support collaboration.		*Gap: ICS and wider system governance remains in development* *Action: Development of shadow provider collaboration agreements / APC*

Related high risks (>15) on the risk register – Datix refs:
None

STRATEGIC ENABLERS: Financial plan delivery

Risk appetite for sub-objective relevant to risk: **Moderate (risk score 8-12)** Risk tolerance triggers: ERF funding variance (threshold tbc); adverse variance to plan for 2 consecutive months (threshold tbc); Month 9 forecast submission

Gap risk score to risk appetite: 15 (current risk score 16; in year target risk score: 12; long term risk appetite: 1-4)

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span*	*Assurance level*	*Span*	*Assurance level*	*Span*	*Assurance level*	
11. Failure to deliver against year 1 and three year financial plans for Barts Health and BHRUT impacts on medium term sustainability and effective sector collaboration **Executive lead:** Chief Finance Officer **Subcommittee role:** Finance and Investment Committee	*[Outset score: 12]* ***Current: 3x4=12*** *Target: 3x3=9* *Datix ref: (1985)*	**1.** NEL system financial plan (coordinating revenue and capital allocations for providers) **2.** Monthly finance reporting details progress against operational plan and budget. **3.** System work to analyse strategic drivers of the deficit position overseen by the ICS and providers. **4.** Transformation and efficiency workstreams focus on key schemes (including theatres; workforce; outpatients; procurement) to support underlying position improvements. **5.** Service Line Reporting structures (in conjunction with Model Hospital and GIRFT data) inform targeted transformation schemes. **6.** PMO function supports hospitals and corporate directorates to identify and deliver quality, efficiency and financial improvements.	Review of financial performance at weekly GEB **(assurance on controls 1-2**). Implementation of Financial Planning Group meetings to review hospital plan progress chaired by CFO and informs PRs **(2-6).** Investment Steering Committee oversight of major investment schemes **(1,3)** Site performance review focus on progress against financial plans, CQUINs and other contractual KPIs **(2,4)**		Review of financial performance at monthly Finance and Investment Committee and Trust Board review **(assurance on controls 1-3,5**).		Dedicated NHSI support and review of Trust plans. NHSI / CQC Use of Resources assessment, with evidence of productivity improvements 2020 Internal Audit report Income and Billing **(2)** 2020 Internal Audit report Budgetary Control and Financial Reporting **(2)** 2020 Internal Audit report Treasury Management **(2)** 2021 Reasonable assurance Internal Audit review of Bank and Agency controls/usage 2021 Substantial assurance Internal Audit review of key financial controls 2021 Substantial assurance Internal Audit review of Payroll and pensions		

Related high risks (>15) on the risk register – Datix refs:
none

STRATEGIC ENABLERS: Digital strategic delivery plan and capital investment programme

Risk appetite for enabler relevant to risk**: Cautious (risk score 4-6)** Risk tolerance triggers: Adverse variance (threshold to be confirmed) against ICT metrics on downtime/breaches/implementation targets

Gap risk score to risk appetite: 12 (current risk score 16; in year target risk score: 12; long term risk appetite: 4-6)

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span*	*Assurance level*	*Span*	*Assurance level*	*Span*	*Assurance level*	
12. Failure to develop cyber secure and compatible information systems at Trust and NEL level due to resourcing and lead time limitations impacts on service continuity and consistency **Executive lead:** Director of Strategy **Subcommittee role:** Audit and Risk Committee	*[Outset score: 16]* ***Current: 4x4=16*** *Target: 4x3=12* *Datix ref: (1981)*	**1.**Ringfenced element of capital programme, to renew ICT infrastructure, PCs, data centres and networks. **2.**Approved Informatics strategic delivery plan and consolidated Millennium Cerner EPR system. **3.** Upgrades of Millennium Cerner (following consolidation of single PTL) **4.** Information Governance team and Data Security Protection Toolkit. **5**. WeConnect2 programme successfully rolled out to strengthen digital systems, electronic prescribing and documentation. **6.** BHRUT business case for new EPR system to align principal information platform across BH and BHRUT	Investment Steering Committee lead role in ensuring capital programme is appropriately specified and delivered, with Risk Management Board monitoring associated risks **(1-4)** Informatics Board oversight of ICT investment programme with 6 monthly reporting into Audit and Risk Committee on key ICT developments **(1-5)** Board and ARC review of Data Security Protection Requirements compliance **(2)**		6 monthly reporting into Audit and Risk Committee on major ICT developments **(1-5)** Trust Board review of BHRUT SOC **(6)**		Internal Audit report Data Security and protection Toolkit **(4)** 2021 Follow-up improved assurance Internal Audit report on cyber **(1)**		*Gap: Variable network performance and outtages still have potential for major impact on operational performance* *Action: Steps to improve ICT infrastructure including approved business case and phased replacement programme* *Gap: Risk of information security breaches remains high and increases with international conflicts* *Action: Steps taken to improve network security*

Related high risks (>15) on the risk register – Datix refs:

4766 Network Obsolete (risk score 20, lead Group Director of Strategy)
4765 IT business continuity (risk score 16, lead Group Director of Strategy)
4768, 4769, PC and server ageing infrastructure (risk score 16, lead Group Director of Strategy)
5931 IT security of radiotherapy equipment (risk score 16, lead Group Director of Strategy)
4767 ICT cyber security standards management and investment (risk score 16, lead Group Director of Strategy)
4770 SBH datacentre infrastructure (risk score 16, Group Director of Strategy)

STRATEGIC ENABLERS: Estates strategy and capital investment programme

Risk appetite for sub-objective relevant to risk**: Cautious (risk score 4-6)** Risk tolerance triggers: Volume of medical equipment risks identified on risk register seeking treatment via capital investment (threshold tbc); Receipt of any regulatory notices; or internal audit/external assurances indicating reasonable or insufficient assurance rating

Gap risk score to risk appetite: 4 (current risk score 12; in year target risk score: 8; long term risk appetite: 4-6)

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span*	*Assurance level*	*Span*	*Assurance level*	*Span*	*Assurance level*	
13. Failure to sufficiently improve infrastructure and equipment at Trust and NEL level due to resourcing and lead time limitations, uncertainty on the financial framework and wider economy pressures impacts on quality and safety of services. **Executive lead:** Chief Finance Officer **Subcommittee role:** Finance and Investment Committee	*[Outset score: 16]* ***Current: 4x3=12*** *Target: 4x2=8* *Datix ref: (4109 / 1990)*	**1.**Ringfenced element of capital programme for Estates backlog maintenance (including fire safety investment); and medical equipment procurement. Finance team liaison with NHSIE on securing funding. **2.** Multi-year risk based approach to medical equipment replacement programme**..** Clinical Engineering providing a co-ordination role on monitoring equipment assets, maintenance investment. **3.**Independent surveys used to support development of Trust fire safety remediation plan shared with London Fire Brigade. **4.** Three-year fire remediation plan and rolling programme of improvements (including 2020 additional in-year funding to accelerate improvements at Newham).	Investment Steering Committee lead role in ensuring capital programme is appropriately specified and delivered, with Risk Management Board monitoring associated risks **(1-5)** Medical Devices Group, RMB and ISC oversight of medical equipment risks and investment **(2)** Fire Committee, Health and Safety Committee monitoring of estates backlog and fire safety investment and risks (1-5)		FIC oversight of capital investment programme and priorities (1)		2020 external review of fire safety programme. (4) Internal Audit plan includes reviews of key infrastructure risks (1-4) CQC, HSE and other regulatory assessments of Trust infrastructiure **(1-4)**		*Gap: Absence of aggregated assessment of risks associated with specific medical equipment shortfalls* *Action: Steps to develop matrix approach to managing risks.*

Related high risks (>15) on the risk register – Datix refs:
Medical equipment risks: 2395, 5489, 5860
227 Lifts failure at WX (risk score 15, lead WX CEO)
4761 Non-compliance of Fire Safety Order within John Harrison House (risk score 16, lead Royal London Chief Executive) 4043 Non-compliance of Fire Safety Order within Kenton and Lucas (risk score 16, lead St Bartholomew's Chief Executive)
3619 Non-compliance of Fire Safety Order within Whipps Cross Hospital (risk score 16, lead Whipps Cross Chief Executive) 6045 Non-compliance with Fire Safety Management Policy (risk score 15, lead St Bartholomew's Chief Executive)

STRATEGIC ENABLERS: Research strategic delivery plan and education strategic delivery plan

Risk appetite for sub-objective relevant to risk**: Moderate (risk score 8-12)** Risk tolerance triggers: BRC accreditation outcome; loss of medical training posts (threshold tbc); failure to recover research activity downturn (threshold tbc)

Gap: risk score to risk appetite: 4 (current risk score 12; in year target risk score: 8; long term risk appetite: 8-12)

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span*	*Assurance level*	*Span*	*Assurance level*	*Span*	*Assurance level*	
14. Failure to deliver research and education plans in the context of the pandemic and constrained resources adversely affects, income, reputation and delivery of workforce targets **Executive lead:** Chief Medical Officer **Subcommittee role:** Quality Assurance Committee	*[Outset score: 12]* ***Current: 4x3=12*** *Target: 4x2=8* *Datix ref: [4925]*	**1.** Research strategic delivery plan and education strategic delivery plan **2.** Education Academy and education governance framework to manage new NHS education contract (which replaced the LDA). **3.** Improving Service Line Reporting transparency for allocation of resources and incentivising research and education activities internally. **4.** People Strategy describes development of new workforce roles and career pathways including using apprenticeships, local employment and overseas recruitment to mitigate training post losses. **5.** Brand and reputation of Trust as a recognised destination for career development and research opportunities (including apprenticeships workstream) **6.** Programme with university partners to expand nursing and midwifery student numbers by 25%. **7.** BRC bid process with significant focus in 22/23.	Education Committee and Joint Research Board oversight **(assurance on controls 1-7)** Apprenticeship Steering Group, which reports into Education Committee reviews work on new career models **(4)**. GMC and professional surveys used to monitor quality of trainee experience **(5, 6)**		QAC oversight of education and research strategic delivery plan implementation (1)		Health Education England visit and student survey findings inform planning Research grant application outcomes Internal Audit report 19/20 research and Development Governance **(1)**		*Gap: Pandemic disruption to education delivery may result in loss of training posts and/ or impair training quality* *Action: Active monitoring and management of quality of training posts via Education Academy.* *Gap: Lead time in recovering research activity reductions linked to pandemic* *Action: Monitor specific issues around the recovery of research activity and prioritise and support restarts*

Related high risks (>15) on the risk register – Datix refs:
6394 Education centre redevelopment at NUH (risk score 16, lead Newham CEO)
3062 ED junior doctor vacancies (risk score 15, lead Whipps Cross Chief Executive)

NHS
Barts Health
NHS Trust

Report to the Trust Board: 6 July 2022	TB 44/22

Title	Integrated Performance Report (Month 2)
Accountable Director	Deputy Group Chief Executive
Author(s)	Director of Performance
Purpose	Performance against constitutional standards and KPIs

Executive summary

The Integrated Performance Report provides detail in relation to performance drivers and recovery actions at Trust and Hospital Site 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 access, quality and safety, finance and people sections.

Related Trust objectives
All trust objectives

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

Legal implications/ regulatory requirements	N/A

Action required by the Board

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.

NHS
Barts Health
NHS Trust

Barts Health Integrated Performance Report

Jul-22

Performance for: **May-22**

CHANGES TO REPORT

Changes to Report

Jul-22

- **Overall Report:**
  - Some national reporting for which metrics are usually presented in the report has been temporarily suspended during the Covid-19 pandemic. For most, the performance from the last national submission before the suspension is the latest included in the report, as indicated below:
    - Dementia screening: Feb-20 performance.
    - Venous Thromboembolism (VTE) Risk Assessment: performance continues to be monitored internally.
  - The above suspended metrics have been temporarily greyed out in the report.
  - Serious Incidents Closed in Time: as previously noted, clock stops have been applied nationally to all Serious Incidents (SIs) from the Covid-19 second wave onwards. This remains in place nationally. Barts Health continues to monitor the SI process according to internal targets.
- **Targets:**
  - As part of the national imperative to recover elective and emergency services following the Covid pandemic the NHS has set out a series of activity and performance recovery milestones to be delivered over the course of the next three financial years, to March 2025. The milestones are set out on the following page with the relevant quality and safety pages of this report updated to provide views of progress towards meeting the milestones.
  - In reviewing these pages please note that NHS England has recently asked all trusts to review and resubmit their activity and long waiter clearance trajectories, as well as supporting finance and workforce plans, by 20 June 2022. The trust has resubmitted its elective activity trajectories, recalibrated to make up shortfalls in activity output recorded across quarter 1 by the end of the year. The next edition of this report will reflect those changes subject to any feedback received from NHS England.

CHANGES TO REPORT

Changes to Report

Jul-22

	Deliverable	Milestone
Elective (RTT) Waits	No one will wait longer than two years (104 weeks)	Jul-22
	Eliminate waits over 18-months (78 weeks)	Apr-23
	Eliminate waits over 65 weeks (15 months)	Mar-24
	Eliminate waits over 12 months (52 weeks)	Mar-25
Diagnostic (DM01)	95% of patients needing a diagnostic test receive it within six weeks	Mar-25
Cancer	The number of people waiting more than 62 days from an urgent referral to treatment back to pre-pandemic levels	Mar-23
	75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days	Mar-24

	Deliverable	Target
A&E	Reduce 12-hour waits in A&E	Towards zero and no more than 2%
	Minimise handover delays between ambulance and hospital, allowing crews to get back on the road and contribute to achieving the ambulance response standards	•eliminating handover delays of over 60 minutes •ensuring 95% of handovers take place within 30 minutes •ensuring 65% of handovers take place within 15 minutes
	Expanding urgent treatment centre (UTC) provision and increasingly moving to a model where UTCs act as the front door of A&E, to enable emergency medicine specialists to focus on higher acuity need within the A&E	

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Executive Summary

EXECUTIVE SUMMARY

Executive Summary

Jul-22

Covid-19 Monitoring and Recovery

Covid-19 Inpatient Activity Levels

- The fourth (Omicron) wave of the pandemic peaked on 12 January 2022 with 392 total inpatients of which 35 were in a critical care bed. Unlike the second wave impact, the fourth wave saw the majority of patients admitted to a general and acute bed with only a minority of patients admitted to critical care.

- On 22 June 2022 there were 96 Covid-19 positive patients occupying a bed of which 4 were occupying a critical care bed, this equates to 24% of the fourth wave peak in terms of total bed occupancy and 11% for critical care occupancy. It is also important to recognise that a significant proportion of Covid-19 inpatients have incidental Covid and are primarily being treated for other conditions, however the trust continues to closely monitor community case rates, which are rising, as well as inpatient volumes and acuity. The increase in community case rates is being driven by fast spreading Omicron subvariants, BA.4 and BA.5.

Covid-19 Community Cases

- Comparing the week starting 03/06/2022 to the week starting 10/06/2022 shows the following movements in the case rate per 100,000 population:
  - For Waltham Forest, an increase from 88 to 124 (+41%)
  - For Hackney & City of London, an increase from 102 to 133 (+31%)
  - For Tower Hamlets, an increase from 117 to 146 (+25%)
  - For Newham, an increase from 82 to 99 (+20%)
- As a comparator the London case rate increased from 110 to 141 (+28%) while the England case rate increased from 101 to 135 (+34%).

Executive Summary

Covid-19 Monitoring and Recovery (Continued)

Elective Activity Recovery Trajectories

- The Trust submitted 2022/23 elective activity recovery trajectories to NHS England on 28 April 22 and resubmitted reprofiled trajectories on 20 June 2022. All trusts were asked to reconsider their trajectories in light of output achieved in quarter 1 and possible stretch for the remainder of the year. Barts Health reprofiled its trajectories to deliver the same volume of output as originally proposed with the shortfall in quarter 1 recovered across the remainder of the year. The trajectories and performance in this report reflect the April 2022 submission, they will be updated once feedback has been received from NHS England in relation to the June 2022 resubmission.

- For 2022/23 NHS England set out an expectation that elective activity for the year ahead would deliver 104% of cost weighted activity against 2019/20 baseline. The core assumption being that increased activity will drive the long waiter reduction ambitions set out on page 3 of this report, namely for this year clearance of 104 week RTT waiters by July 22, 78 week RTT waiters by April 23 with a Cancer 62 day backlog reduction to pre-pandemic levels by March 23. The trusts trajectory submissions are consistent with these requirements with delivery tracked through the weekly Operations Delivery Board.

- For April and May 22 the trusts admitted (inpatient and day case) trajectory set a target of 90% and 93% of BAU against which the trust achieved 74% and 86%. For outpatients (first and follow up) the trajectory was set at 100% of BAU for both April and May 22, against which the trust achieved 98% and 107% respectively. Under-delivery of the admitted plan was influenced by sustained emergency pressures as well as the continued impact of Covid related infection control measures. However admitted month to date actuals and forecasts for June 22 suggest a continued improvement.

Vaccinations (Covid-19 and Flu)

- The current focus of the national vaccination programme is on completion of the Spring Booster for over 75s and immunosuppressed, initial vaccination for children aged 5 and above, and on-going evergreen offers, including maternity and allergy patients, and eligible inpatients.
- The Hospital Hub+ sites at Whipps Cross and Newham have now closed.
- The vaccination Allergy service will be managed by the Adult Allergy Service in St Bartholomew's Hospital from 1st July 2022.
- The vaccination team are continuing to provide the outreach service on behalf of NEL over the summer months until September, at which point the vaccination service within Barts will close.
- NHSE have issued an operational note on the next steps for the Covid-19 vaccination programme. Key points;
    - The current JCVI view is that in autumn 2022 a COVID-19 vaccine should be offered to cohorts 1-9 (residents and staff working in care homes for older adults, frontline health and social care workers, all those 65 years of age and over, adults aged 16 to 64 years in a clinical risk group). Awaiting final confirmation from JCVI.
    - Surge planning is required by systems and should not impact on primary, routine and elective care – further guidance to be issued on this.
    - Finance – from 1st September the funding mechanism will change, and systems will receive a fixed allocation with three elements – tariff for routine vaccinations, funding to support addressing inequalities and funding for surge. Further detail to follow.
- A Trust staff vaccination plan for covid and flu for 2022/23 has been developed with a delivery structure via the Employee Wellbeing Service as a BAU model, working closely with hospital sites.

EXECUTIVE SUMMARY

Executive Summary

Jul-22

Quality & Performance

Responsive

A&E 4 and 12 Hour Performance

- In May 22, 46,017 attendances were recorded, 4,335 greater than April 22 (+10%). For May 22 a performance of 69.6% was recorded against the 4-hour standard, against 73.5% in April 22; for May 22 performance was the lowest recorded since the start of the pandemic. During May 22 performance was influenced by the impact of Omicron subvariants particularly in relation to Covid bed occupancy, at the start of May 147 Covid inpatients were occupying a bed, reducing to 85 inpatients at the end of the month.
- For 2022/23 NHS England requires trusts to manage performance against a new standard, 12 hour waiting time from arrival to discharge, admission or transfer, with an operational standard of no more than 2% against all attendances. As a new metric the trust has to be confident in the quality and completeness of the data before performance is reported to the board and the public. The trust has designed and built an operations breach validation tool which is currently going through testing with staff training being undertaken at the same time. It is expected that validated performance data will be reported to the board in the August 22 edition of this report.
- Trusts are also required to apply a greater focus on reducing ambulance handover delays with an ambition of eliminating 60 minute delays and ensuring 95% of handovers take place within 30 minutes. This data also requires a validation process which is also being built. The 60 minute handover delay metric will be reported in future editions of this report once the quality and accuracy of the data is assured.
- For May 22, Barts Health recorded the highest volume of A&E attendances of any trust in England. In terms of performance against the 4 hour standard, the Trust was the ranked 11th worst performing out of 16 trusts reporting data in London and was the 3rd best performing out of the top 10 English trusts (ranked by volume of attendances).

Referral to Treatment (RTT)

- The NHS has been required to suspend elective services during peaks in the Covid-19 pandemic. This has had a significant impact on waiting lists across England, including growth in 104+, 78+ and 52+ week wait pathways. All trusts have been required to submit eradication trajectories delivering zero 104+ week waiters by the end of June 22 and zero 78+ week waiters by the end of March 23.
- The Trust has made significant progress in reducing the size of the 104+ week wait backlog. In relation to the end-month nationally submitted data the trust reported 606 pathways waiting 104+ weeks in February 2022 reducing to 205 at the end of May 2022, a reduction of 401 (-66%). However this is above the May 22 plan of 120. The 104+ week wait eradication trajectory has also been reprofiled and resubmitted on 20 June 22 but is not yet reported against until NHS England feedback has been received.
- In relation to 78+ week wait backlog volumes, these have also reduced over the course of the last four months with 1,777 pathways reported at the end of February 22 reducing to 1,330 at the end of May 22, an decrease of 447 (-25%), this is better than the trajectory of 1,391. This trajectory was also resubmitted on 20 June 22.
- In relation to delivering the national 104+ week wait eradication trajectory the trust is currently working through a waiting list validation exercise. The validation exercise will result in risk to delivering the 104+ week wait clearance in June 22, the trust is working to mitigate this risk and is keeping commissioners and NHS England closely informed of progress.

EXECUTIVE SUMMARY

Executive Summary

Jul-22

Quality & Performance

Responsive (continued)

Referral to Treatment (RTT) (continued)

- Looking at London, of the 12 Trusts reporting 104+ week waits for April 22 (the most recent national data), Barts Health ranked 12th with 0.22% of the waiting list waiting 104+ weeks or longer compared to a total London performance of 0.06%. Looking at the top 10 largest provider Trusts in England (by size of waiting list), Barts Health had the 6th highest volume and proportion of 104+ week wait pathways, but across these top 10 English providers the proportion of 104+ week wait pathways was higher than London at 0.35%.

Diagnostic 6 Week Wait Standard

- As for RTT, the impact of the Covid-19 pandemic on the diagnostic waiting list has been significant, resulting in increased waiting times. For May 22 a performance of 73.2 was recorded, an improvement on April's 70.9%. As in previous months, the greatest challenge has been in the imaging modalities, particularly non-obstetric ultrasound and MRI; imaging breaches accounted for 94% of all breaches in May 22. However progress has been made in non-obstetric ultrasound with the waiting list size close to pre-pandemic levels.

- Looking at the 18 London acute Trusts, for April 22 (the most recent national data), Barts Health was the 16th worst performing in relation to compliance against the 6 week waiting time standard. Looking at the top 10 largest provider Trusts in England (by size of waiting list), Barts Health had the 2nd largest waiting list and was the best performing.

Cancer 62 Days from GP Referral and Faster Diagnosis Standard

- Having achieved the 62 day GP standard for each month of the last two years, the Trust has failed to achieve 85% compliance since June 21. For April 22, the Trust recorded a performance of 67.7% with 111.5 pathways seen and 36 breaches. The focus is on seeing and treating the clinically prioritised most urgent patients; this work is well advanced and the cancer leadership team is now working on clearing the backlog of those patients with a slightly lower clinical priority. The cancer leadership team is working to ensure that the number of patients waiting more than 62 days from an urgent referral returns to pre pandemic levels by March 23 in line with national requirements.

- For 2022/23 NHS England has prioritised delivery of the Faster Diagnosis Standard (FDS), with 75% of patients urgently referred by their GP receiving a diagnosis or having cancer ruled-out within 28 days. The standard applies to patients who have been urgently referred for suspected cancer, have breast symptoms, or have been picked-up through cancer screening. For April 22 the trust is compliant against all three elements of the standard, achieving 82.2% at aggregate level against the 75% standard.

EXECUTIVE SUMMARY

Executive Summary

Jul-22

Quality & Performance (Continued)

Caring

- Complaints performance continues to be below our target performance of 85%. Operational pressures in both the services and governance teams at Royal London Hospital, Whipps Cross Hospital and Newham Hospital continue to impact on complaints performance. Performance improved from 73.7% to 76.2% this month. St Bart's Hospital is meeting the standard. There is ongoing focus on improving complaints performance and on ensuring early local resolution of issues wherever possible to prevent resolvable matters escalating to become formal complaints.
- Duty of Candour compliance continues to be a challenge particularly for Royal London Hospital (68.4%). St Bart's Hospital met the duty in 100% of cases and Newham Hospital and Whipps Cross Hospital in 91.7% of cases. The Hospital Leadership teams where performance is challenged are focusing on reviewing processes to increase compliance.

Safe

- Performance in closing serious incidents on time improved from 29.4% in April to 38.9% in May – this is a positive improvement trajectory . We continue to focus on high quality Serious incident investigations and that they are closed as quickly as possible but our developmental focus is currently shifting from compliance with this metric to the implementation of the Patient Safety Incident Response Framework (PSIRF). We will share with the board as our plans become clearer.
- Rates of Hospital Acquired Pressure Ulcers have not returned to pre-pandemic levels. We have seen a reduction in device related Ulcers. Rates of grade 3 and 4 ulcers fluctuate. Our specialist team reviewed a number of cases and identified the following themes: documentation, prevention and care issues. An action plan has been developed. A summit is planned to ensure strong leadership of this plan.
- Maternity - our regional assurance visit to review progress on implementation of the Ockenden recommendations took place on 21st and 22nd June. We are currently awaiting the draft report. Improvement noted in the closure of actions from SIs at Royal London Hospital and Whipps Cross Hospital. Newham Hospital continues to progress this work. There has been a rise in SIs at Royal London Hospital over the last two years. A deep dive is being planned to identify themes and review actions to ensure that human factors and a system approach to learning is being used.
- A never event was declared at Royal London Hospital in May – a retained vaginal swab. Investigation underway and early learning is being shared through the maternity Safety Improvement programme where system wide learning is being explored through human factors and using a standardised approach to improving safety.

EXECUTIVE SUMMARY

Executive Summary

Jul-22

Finance

- The Trust is reporting a deficit of £11.8m, which is a (£4.1m) adverse variance year to date against the plan for a £46m deficit submitted to NHSE/I on 28th April 2022.

- Income is (£0.7m) adverse against the year to date plan. NHS Patient Treatment income is (£0.1m) adverse and other income is (£0.6m) adverse. Sites and Services other income is (£1.2m) adverse, mainly due to reduced private patients activity. Central other income is £0.7m favourable, which includes increased funding to match expenditure for vaccination programme re-imbursement (£0.6m).

- Expenditure is (£3.4m) adverse against the year to date plan. Site and Services expenditure is (£16.1m) adverse, primarily due high cost drugs and devices (£6.4m), underachievement against the 3% recurrent efficiency savings target (£6.4m) and purchase of independent sector activity to support elective recovery (£2.0m). Temporary staffing spend remains high as a result of the on-going trend of increased bank and particularly agency staffing usage and the use of high cost off-framework agencies to meet staffing requirements. Central expenditure is £12.6m favourable which includes inflation and contingency reserves held pending NHSE/I approval of the deficit plan submitted on 28th April 2022.

- Capital expenditure for the year to date is underspent by £6.6m for exchequer funded schemes. Expenditure in Month 2 is £7.4m resulting in an adverse variance of £1.6m in-month against plan driven by one-off IFRS16 adjustment for the existing finance leases (originally planned for April), which offsets the underspend on the rest of the programme caused by the slow commencement of schemes.

- Cash balances are in line with the plan at £143m, the cash balance is due to the high closing cash balance of £86.7m in March 2022 and other movements in working capital.

- The key challenges to ensure financial plan achievement in 2022/23 include:

    - Performance against the Elective Recovery trajectory and any associated funding adjustments (the detailed basis for any adjustments has yet to be confirmed by NHSE/I)
    - Delivering improvements in productivity required to deliver the 3% efficiency savings target set within Sites and Services budgets,
    - Working with NEL system partners to secure additional inflation funding where non-pay inflationary price increases exceed the level of current Trust funding

EXECUTIVE SUMMARY

Executive Summary

Jul-22

People

- **Annualised sickness absence rates** has continued to increase to 5.15% (from 5.05%). In month sick absence for April 22 was at 4.96%, down form the 5.41% in March 22 but notably higher than the same period in 2021 (3.69%). Whilst some of this difference year on year is directly linked to COVID (with covid sick absence at 0.9% in April compared to 0.4% in April 2021). The underlying annualised rate excluding COVID is 4.28%, higher than the c.3.70% we were consistently reporting pre-pandemic. It is difficult at this stage to predict what will happen with the annualised rate moving forward, however without any significant surge in COVID cases and assuming no notable interventions to reduce underlying absence we would be looking at an annualised rate of between 4.5% to 4.7%.

- **Appraisal rates** – recorded non-medical appraisals now stand at 55.0%, down from the 56.4% reported for Apr-22; This is one of two indicators affected by the TUPE of colleagues into the Pathology Partnership 12 months ago (the other being turnover). Across our 4 main hospital sites and GSS there has been a marginal improvement, although this varies by site. The medical appraisal rate remains high at 92.0%.

- **Recruitment** –430 unconditional offers were made, up from 375 in April 22. Of these 156 were for nursing and midwifery roles, including HCAs. In addition, 1,447 Whole Time Equivalent (WTE) roles were advertised.

- The Trust's substantive staff fill rate was at 90.3%, up from 90.1%. This is driven by a reduction an increase in staff in post of 40 WTE with small increases seen across most staff groups.

- The registered nursing fill rate is currently 83.2% the same as in April, although we currently employ 80 WTE overseas nurses who are working as HCAs whilst awaiting their NMC registration and as such are not reflected in this figure.

- **Turnover** – annualised voluntary turnover has remained at 13.3% this month. This is largely a result of how this metric is calculated and the impact of the TUPE into the Pathology Partnership 12 months ago and we expect the rate to increase next month. Across the group we are seeing continued increases at Whipps, St Barts, Royal London and GSS, but a small decrease at Newham. Assuming no notable increase in the rate of leavers then we would expect turnover to stabilise in the next couple of months, however this remains hard to judge given the external impact of the cost of living and the ongoing pressures related to COVID.

- **Temporary staffing** – temporary staffing usage increased by 66 WTE compared to April, with an increase of 11 WTE agency and 55 WTE bank. The proportion of temporary staff as part of the workforce rose from to 13.8% to 14.1% whilst spend on temporary staff as a proportion of pay budget slightly increased from 16.1% to 16.2%.

Jul-22

NHS
Barts Health
NHS Trust

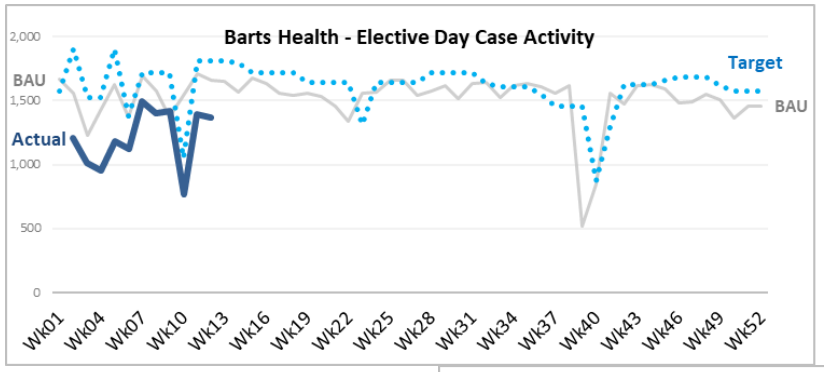
Covid-19 Monitoring and Recovery Report

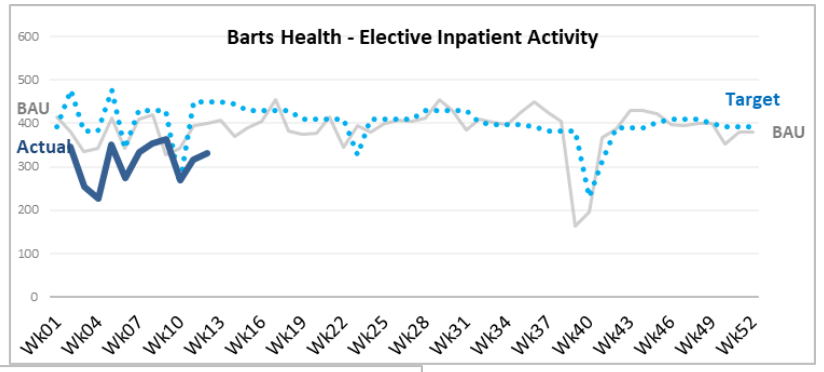
COVID-19

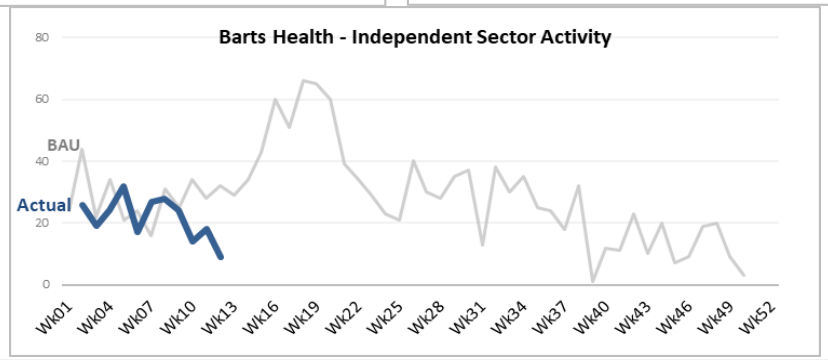
Activity

Jul-22

Elective Activity







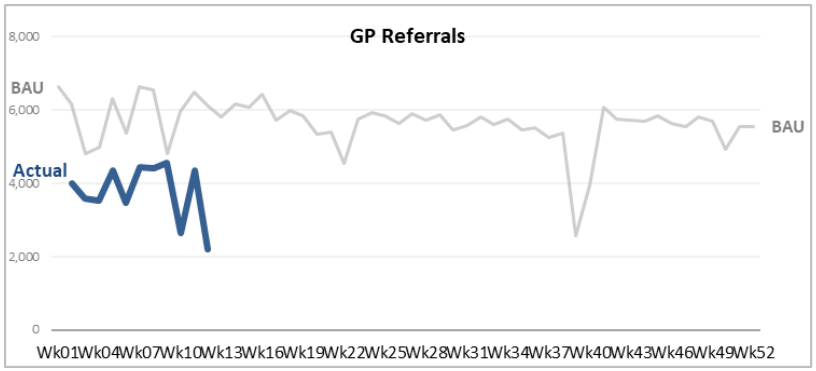
Outpatient Activity

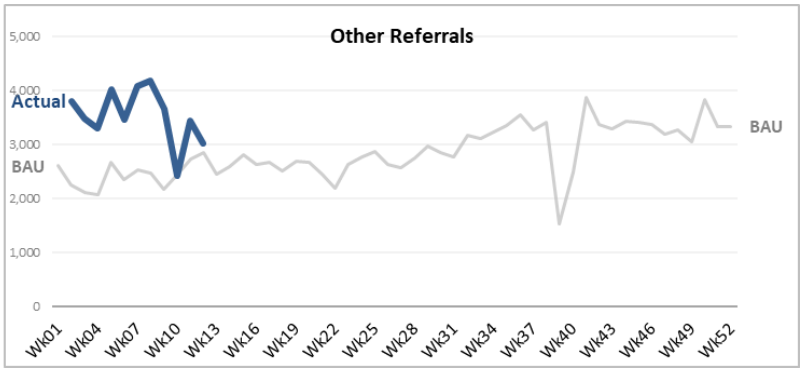
COVID-19

Activity

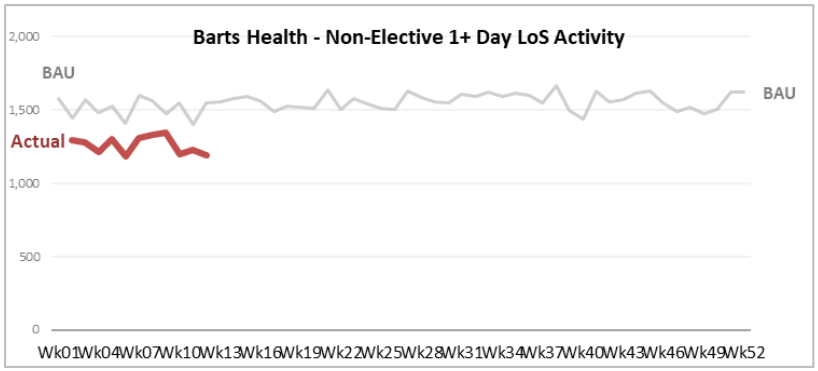
Jul-22

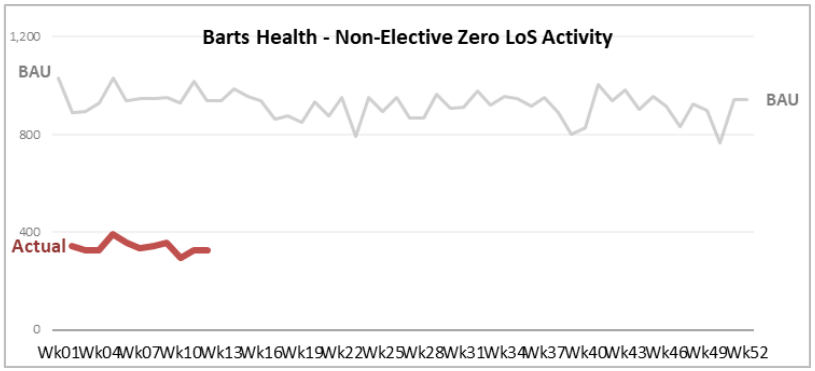
Referrals Activity





Non-Elective Activity



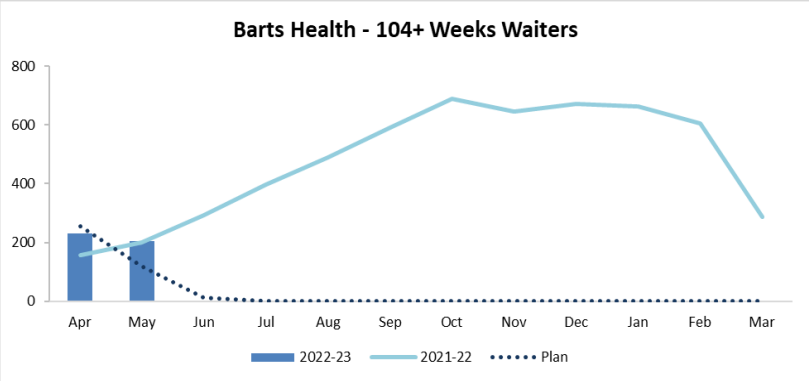


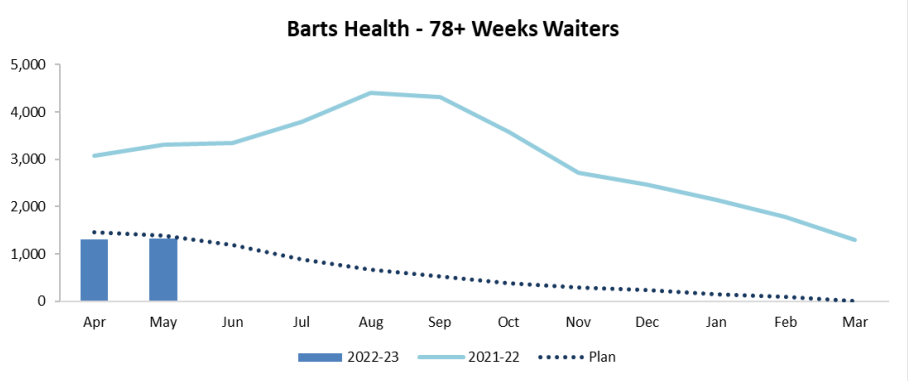
COVID-19

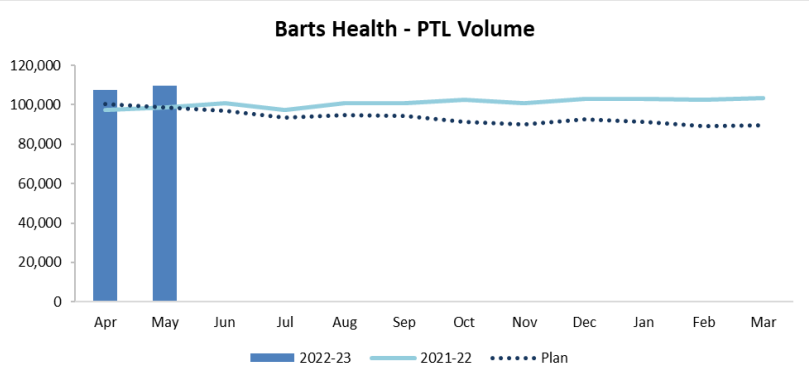
Referral to Treatment (RTT) and Diagnostic (DM01) Activity

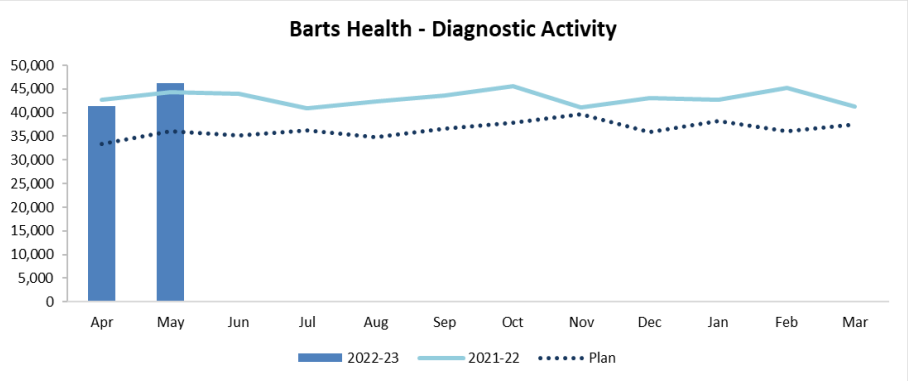
Jul-22

Barts Health						Last Month's Site Position				
Setting	Reporting Period	Feb-2022	Mar-2022	Apr-2022	May-2022	Royal London	Whipps Cross	Newham	St Bart's	Other
PTL Activty	78+ Weeks Waiters	1,777	1,306	1,309	1,330	877	341	92	18	2
	104+ Weeks Waiters	606	287	232	205	138	35	17	15	0
DM01	Diagnostic Activity	42,659	45,225	41,350	46,252	1,223	908	413	5,820	37,888
	Endosocopy	1,985	1,983	1,614	2,169	1,115	649	405	0	0
	Imaging	36,622	38,898	35,903	39,782	108	259	8	1,519	37,888
	Echocardiography	4,052	4,344	3,833	4,301	0	0	0	4,301	0
	Equivalent Month Position Last Year	*31,238*	*39,712*	*39,813*	*42,742*	*1,392*	*671*	*295*	*4,688*	*32,767*









Jul-22

NHS
Barts Health
NHS Trust

Quality & Performance Report

RESPONSIVE

Domain Scorecard

Jul-22

	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Whipps Cross	Newham	St Bart's	Other	Barts Health	Excep.
Waiting Times	A&E 4 Hours Waiting Time	●			May-22 (m)	>= 90%	73.5%	**69.6%**	***71.4%***	66.3%	73.6%	70.3%	-	-	69.6%	●
	A&E 12 Hours Waiting Time				-	-	-	-	-	-	-	-	-	-	-	
	Ambulance Handover - Over 60 mins				-	-	-	-	-	-	-	-	-	-	-	
	Ambulance Handover - Within 15 mins				-	-	-	-	-	-	-	-	-	-	-	
	Ambulance Handover - Within 30 mins				-	-	-	-	-	-	-	-	-	-	-	
	Cancer 62 Days From Urgent GP Referral	●			Apr-22 (m)	>= 85%	68.1%	**67.7%**	***67.7%***	53.1%	78.6%	68.0%	64.6%	-	67.7%	●
	Cancer 31 Day Diagnosis to First Treatment	●			Apr-22 (m)	>= 96%	97.0%	**98.4%**	***98.4%***	95.7%	97.9%	100.0%	100.0%	-	98.4%	
	Cancer 28 Day FDS Breast Symptomatic				Apr-22 (m)	-	96.8%	**98.1%**	***98.1%***	100.0%	99.0%	92.9%	99.2%	-	98.1%	
	Cancer 28 Day FDS Screening				Apr-22 (m)	-	83.3%	**93.5%**	***93.5%***	66.7%	100.0%	100.0%	100.0%	-	93.5%	
	Diagnostic Waits Over 6 Weeks	●			May-22 (m)	>= 95%	70.9%	**73.2%**	***72.1%***	58.9%	85.6%	99.9%	73.3%	-	73.2%	●
	78+ Week RTT Breaches				Mar-22 (m)		-	-		-	-	-	-	-	-	
	104+ Week RTT Breaches				Mar-22 (m)		-	-		-	-	-	-	-	-	
	Completeness of Ethnicity Recording				May-22 (m)		95.4%	**95.0%**	-	93.4%	95.9%	98.4%	93.2%	-	95.0%	

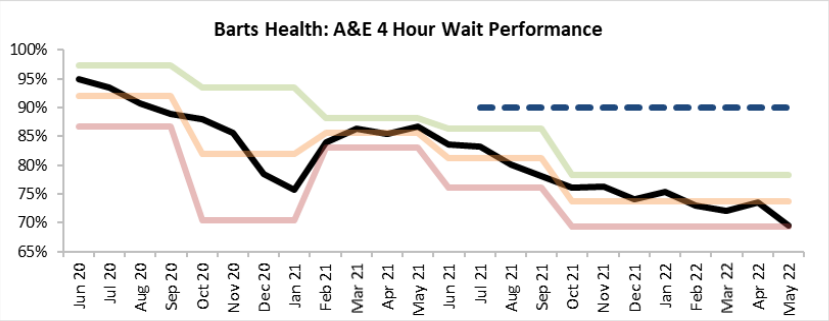
Note to table:

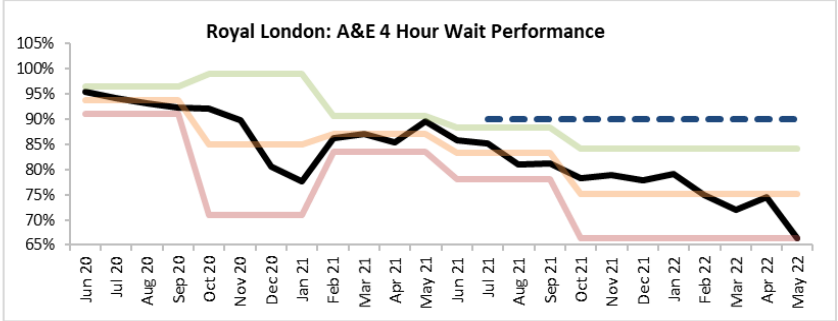
- The ambulance handover metrics are not currently reported as trust / LAS validation processes are being built, the metrics will be reported once the accuracy of the data is assured
- The last period RAG rating column for 78 and 104 RTT weeks wait is not RAG rated on the basis there was no national trajectory for last year
- The 95% target for Diagnostic six week waits is required by March 2025 so no RAG rating is applied for this year

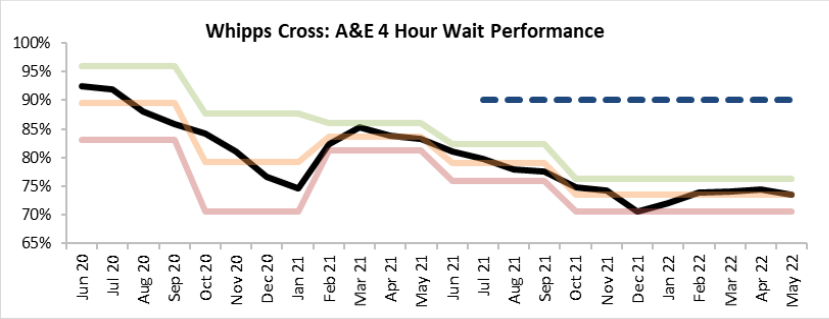
RESPONSIVE

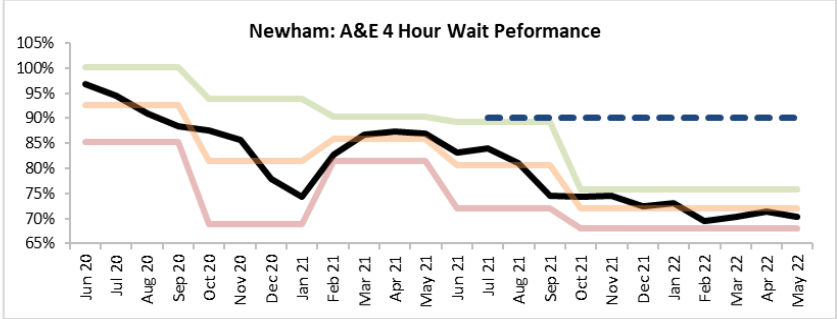
A&E 4 Hour Waiting Time

Jul-22







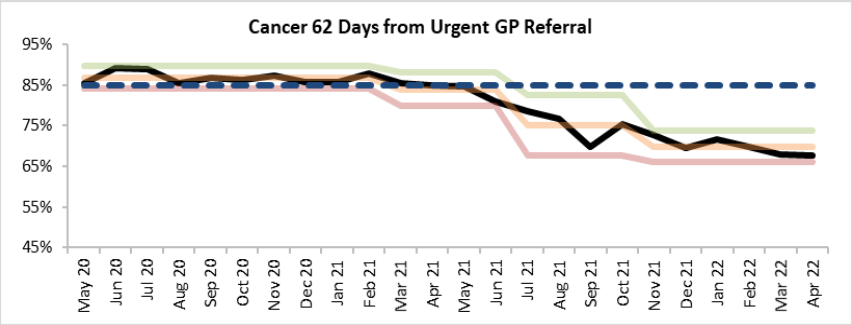


Performance Overview	Responsible Director Update
• In May 22, 46,017 attendances were recorded, 4,335 greater than April 22 (+10%). For May 22 a performance of 69.6% was recorded against the 4-hour standard, against 73.5% in April 22; for May 22 performance was the lowest recorded since the start of the pandemic. During May 22 performance was influenced by the impact of Omicron subvariants particularly in relation to Covid bed occupancy, at the start of May 147 Covid inpatients were occupying a bed, reducing to 85 inpatients at the end of the month.	• For 2022/23 NHS England requires trusts to manage performance against a new standard, 12 hour waiting time from arrival to discharge, admission or transfer, with an operational standard of no more than 2% against all attendances. As a new metric the trust has to be confident in the quality and completeness of the data before performance is reported to the board and the public. The trust has designed and built an operations breach validation tool which is currently going through testing with staff training being undertaken at the same time. It is expected that validated performance data will be reported to the board in the August 22 edition of this report. • Trusts are also required to apply a greater focus on reducing ambulance handover delays with an ambition of eliminating 60 minute delays and ensuring 95% of handovers take place within 30 minutes. This data also requires a validation process which is also being built. The 60 minute handover delay metric will be reported in future editions of this report once the quality and accuracy of the data is assured.

RESPONSIVE

Cancer 62 Days From Urgent GP Referral & Faster Diagnosis Standard

Jul-22

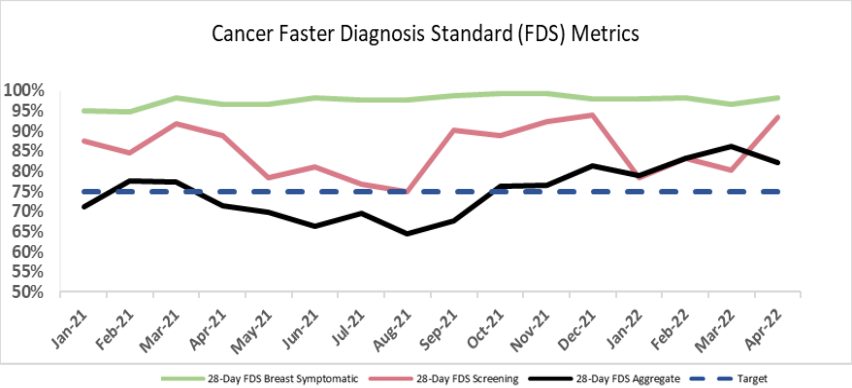


Breakdown by Tumour Sites Failing Standard - Apr-22

Tumour Site	Seen	Breaches	Performance
All Tumour Sites	**111.5**	**36**	**67.7%**
Other	1	1	0.0%
Gynaecological	7.5	4	46.7%
Lower Gastrointestinal	10.5	5.5	47.6%
Lung	7	3	57.1%
Upper Gastrointestinal	6.5	2.5	61.5%
Urological	28	9.5	66.1%
Breast	31.5	9.5	69.8%
Head and Neck	4	1	75.0%

Breakdown by Internal/External Pathways - Apr-22

Internal / External	Start Site	End Site	Seen	Breaches	Performance
Internal	Royal London	Royal London	11	4	63.6%
		Whipps Cross	1	0	100.0%
		St Bart's	6	3	50.0%
	Whipps Cross	Royal London	1	0	100.0%
		Whipps Cross	31	5	83.9%
		St Bart's	16	5	68.8%
	Newham	Royal London	3	3	0.0%
		Whipps Cross	1	0	100.0%
		Newham	4	0	100.0%
		St Bart's	11	3	72.7%
	St Bart's	St Bart's	12	5	58.3%
Transfer In	Homerton	Royal London	5	2	60.0%
	King George	Royal London	0.5	0.5	0.0%
		St Bart's	0.5	0.5	0.0%
	Queen's	Royal London	2	2	0.0%
		St Bart's	3	0.5	83.3%
	Southend	St Bart's	0.5	0	100.0%
Transfer Out	Royal London	Royal Free	0.5	0	100.0%
	Whipps Cross	Royal Free	0.5	0.5	0.0%
		UCLH	1	1	0.0%
	Newham	Royal Free	1	1	0.0%
Grand Total			**111.5**	**36**	**67.7%**



Commentary

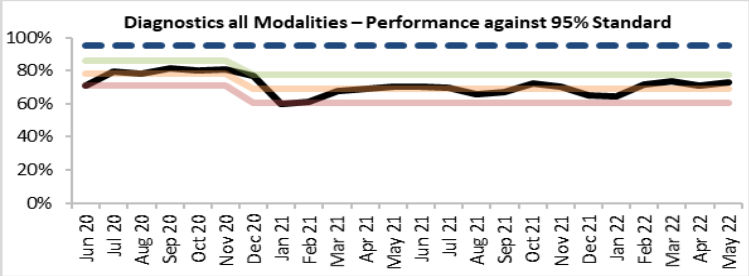
- For April 22, the Trust recorded a performance of 67.7% with 111.5 pathways seen and 36 breaches. The focus is on seeing and treating the clinically prioritised most urgent patients; this work is well advanced and the cancer leadership team is now working on clearing the backlog of those patients with a slightly lower clinical priority. The cancer leadership team is working to ensure that the number of patients waiting more than 62 days from an urgent referral returns to pre pandemic levels by March 23 in line with national requirements.

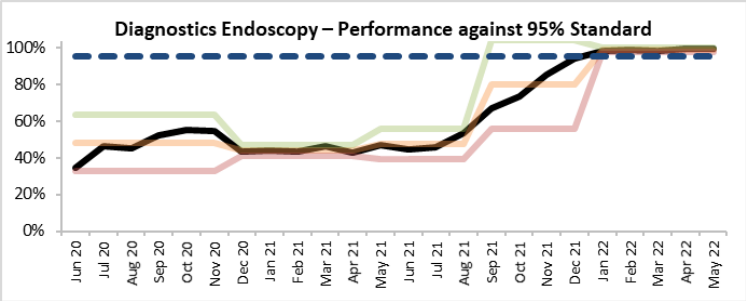
- For April 22 the trust is compliant against all three elements of the Faster Diagnosis Standard standard, achieving 82.2% at aggregate level against the 75% standard.

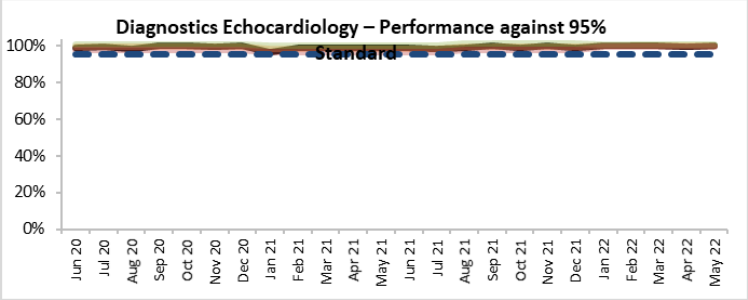
RESPONSIVE

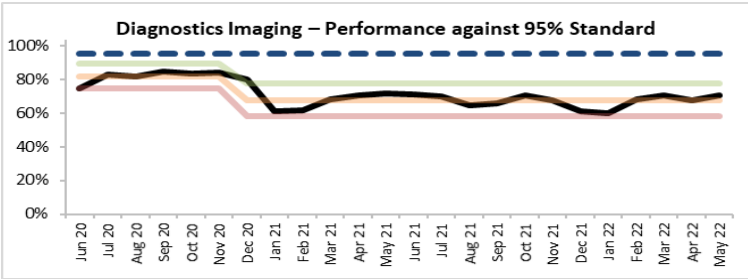
Diagnostic Waits Over 6 Weeks

Jul-22









DM01 Breakdown by Test

	Apr-22			May-22			
Test Name	**Waiting**	**Breaches**	**Performance**	**Waiting**	**Breaches**	**Performance**	**Variance in Performance**
Neurophysiology - peripheral neurophysiology	81	50	38.3%	98	56	42.9%	4.6%
Magnetic Resonance Imaging	8,971	4,709	47.5%	9,423	5,017	46.8%	-0.8%
Audiology - Audiology Assessments	829	329	60.3%	1,232	490	60.2%	-0.1%
DEXA Scan	1,379	729	47.1%	1,444	471	67.4%	20.2%
Computed Tomography	4,653	1,350	71.0%	5,175	1,446	72.1%	1.1%
Non-obstetric ultrasound	14,604	2,867	80.4%	15,000	2,307	84.6%	4.3%
Cystoscopy	160	9	94.4%	161	13	91.9%	-2.4%
Urodynamics - pressures & flows	59	11	81.4%	42	2	95.2%	13.9%
Respiratory physiology - sleep studies	28	1	96.4%	33	1	97.0%	0.5%
Colonoscopy	632	1	99.8%	647	1	99.8%	0.0%
Gastroscopy	756	2	99.7%	686	1	99.9%	0.1%
Cardiology - echocardiography	2,346	15	99.4%	2,534	2	99.9%	0.6%
Flexi sigmoidoscopy	161	0	100.0%	165	0	100.0%	0.0%
Cardiology - Electrophysiology	1	0	100.0%	7	0	100.0%	0.0%
Barium Enema	1	0	100.0%	0	0	100.0%	0.0%
Grand Total	**34,661**	**10,073**	**70.9%**	**36,647**	**9,807**	**73.2%**	**2.3%**

Commentary

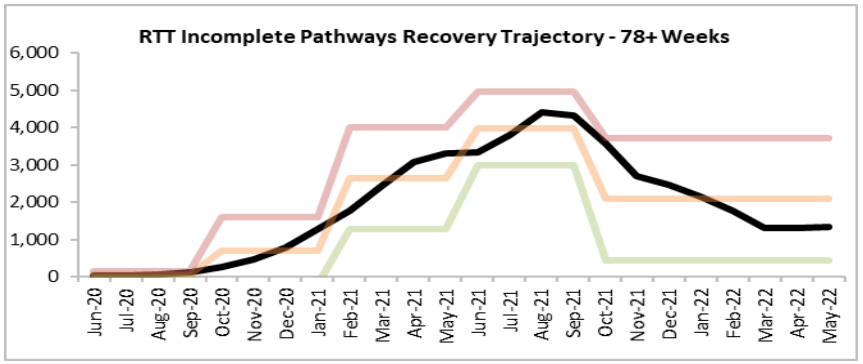
- For May 22 a performance of 73.2 was recorded, an improvement on April's 70.9%. As in previous months, the greatest challenge has been in the imaging modalities, particularly non-obstetric ultrasound and MRI; imaging breaches accounted for 94% of all breaches in May 22. However progress has been made in non-obstetric ultrasound with the waiting list size close to pre-pandemic levels.

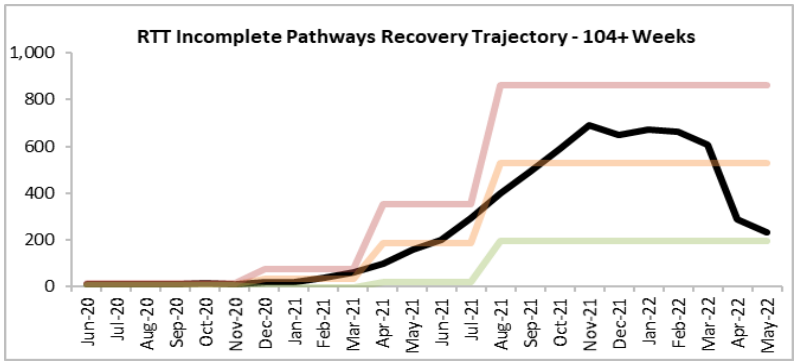
- For 2022/23 NHS England requires all trusts to deliver up to 120% of 2019/20 BAU activity across the three key modalities of:
  - Echocardiology
  - Endoscopy
  - Imaging
- The aim is to recover six week waiting times to a 95% performance standard by March 2025.

RESPONSIVE

78+ & 104+ Week RTT Breaches

Jul-22





78+ Week Wait Breaches by Weeks Waited/Specialty (Highest 10 Specialties)

Specialty Name	Actual
ENT	266
Trauma & Orthopaedics	222
Colorectal Surgery	154
Urology	119
Gynaecology	84
General Surgery	75
Paediatric Ear Nose And Throat	61
Paediatric Dentistry	46
Oral Surgery	38
Plastic Surgery	38

104+ Week Wait Breaches by Weeks Waited/Specialty (Highest 10 Specialties)

Specialty Name	Actual
ENT	43
Trauma & Orthopaedics	29
Gynaecology	15
Pain Management	14
Colorectal Surgery	12
General Surgery	9
Paediatric Ear Nose And Throat	8
Restorative Dentistry	8
Plastic Surgery	8
Paediatric Dentistry	8

Performance Overview

- The Trust has made significant progress in reducing the size of the 104+ week wait backlog. In relation to the end-month nationally submitted data the trust reported 606 pathways waiting 104+ weeks in February 2022 reducing to 205 at the end of May 2022, a reduction of 401 (-66%). However this is above the May 22 plan of 120. The 104+ week wait eradication trajectory has also been reprofiled and resubmitted on 20 June 22 but is not yet reported against until NHS England feedback has been received.
- In relation to 78+ week wait backlog volumes, these have also reduced over the course of the last four months with 1,777 pathways reported at the end of February 22 reducing to 1,330 at the end of May 22, an decrease of 447 (-25%), this is better than the trajectory of 1,391. This trajectory was also resubmitted on 20 June 22.

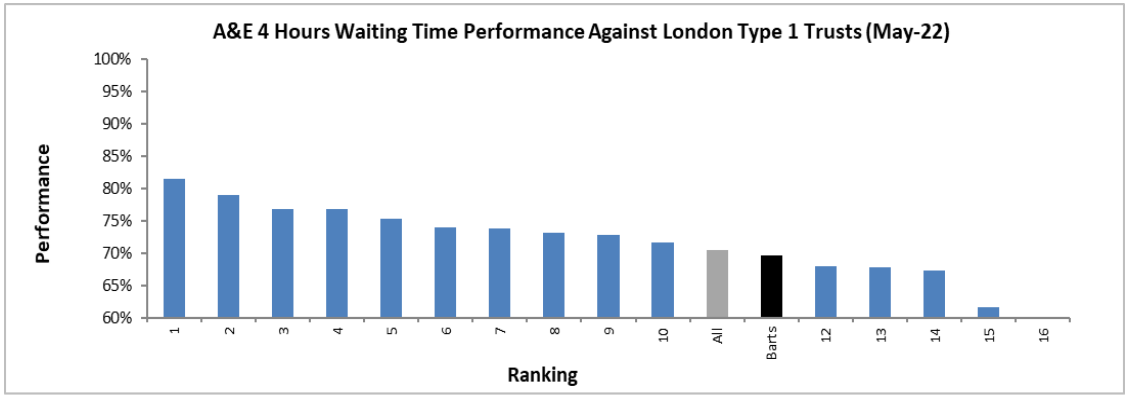
Responsible Director Update

- The Programme Director for Elective Recovery works with the hospital site Directors of Operations through a series of weekly meetings to ensure that long waiter clearance trajectories are being delivered and that if a site or specialty is off plan to agree and implement corrective action.
- Detailed tracking of each patient who is a risk of being at 104+ weeks at the end of June 22 is in place with continued support from other NEL providers on mutual aid where possible.

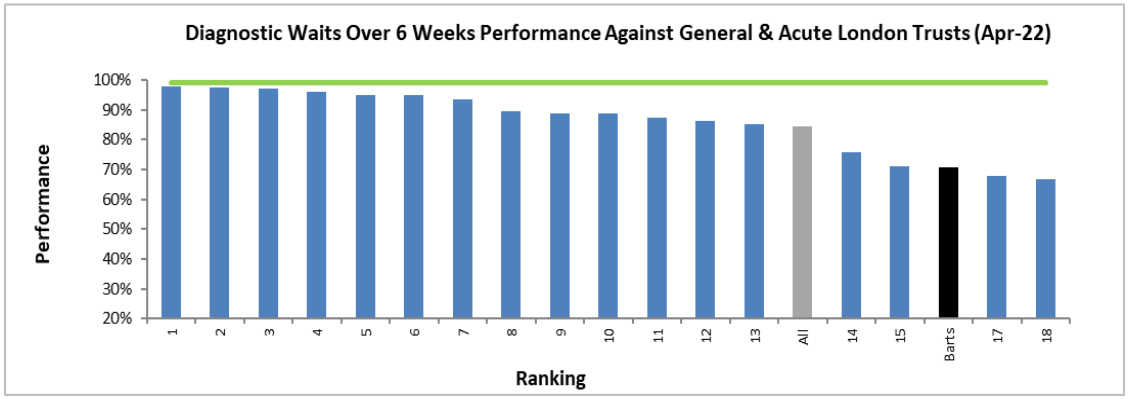
RESPONSIVE

Benchmarking Against Other Trusts

Jul-22



- For May 22, Barts Health recorded the highest volume of A&E attendances of any trust in England. In terms of performance against the 4 hour standard, the Trust was the ranked 11th worst performing out of 16 trusts reporting data in London and was the 3rd best performing out of the top 10 English trusts (ranked by volume of attendances).

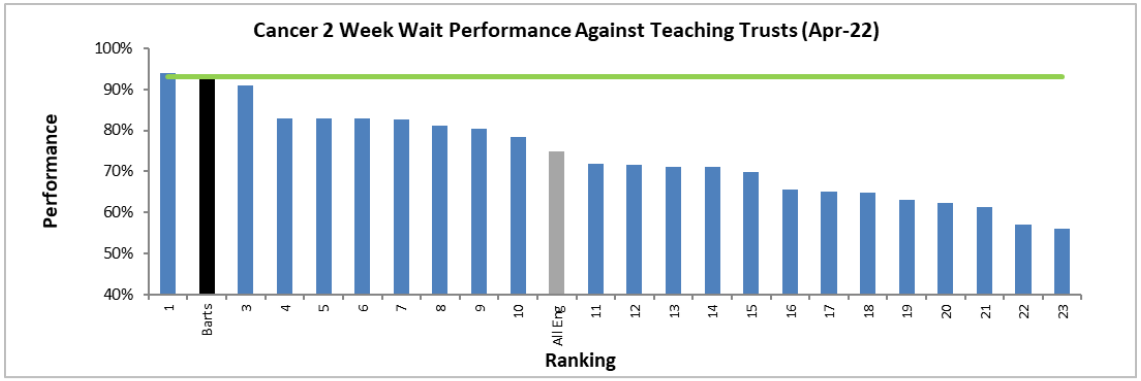


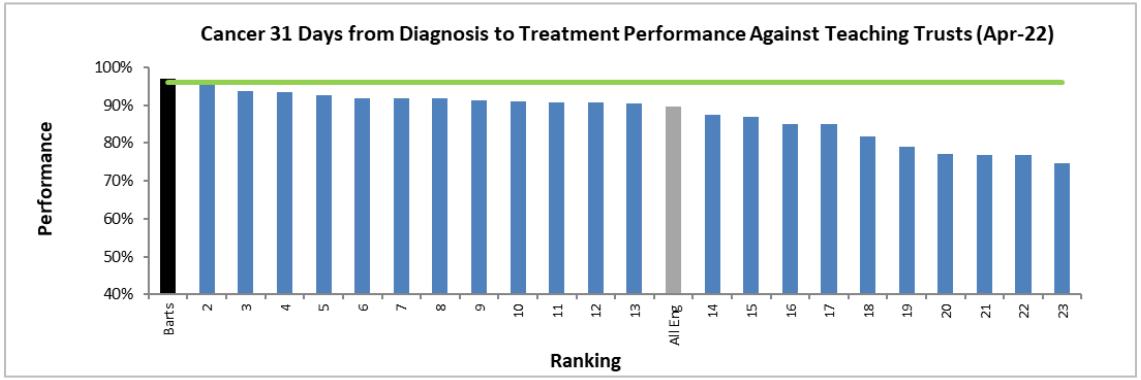
- Looking at the 18 London acute Trusts, for April 22 (the most recent national data), Barts Health was the 16th worst performing in relation to compliance against the 6 week waiting time standard. Looking at the top 10 largest provider Trusts in England (by size of waiting list), Barts Health had the 2nd largest waiting list and was the best performing.

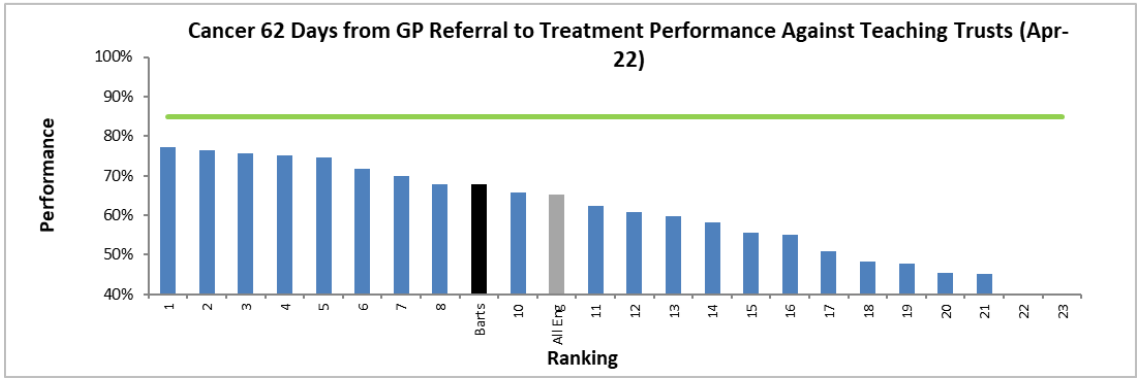
RESPONSIVE

Benchmarking Against Other Trusts

Jul-22





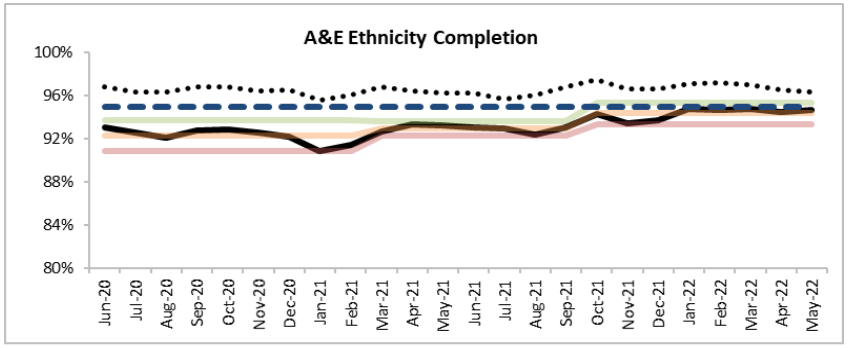


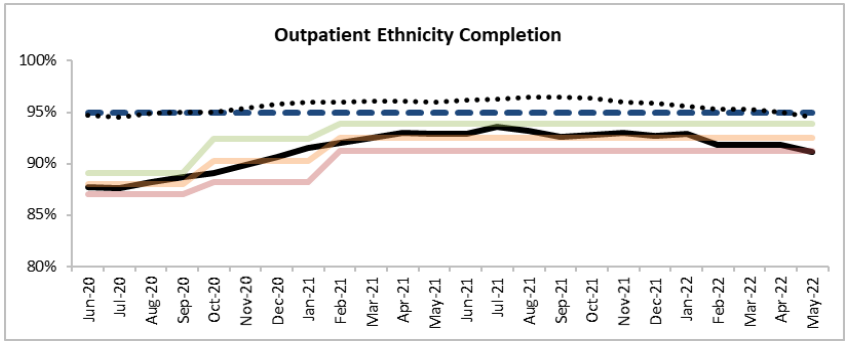
- The trust achieved compliance against the 93% two-week wait target recording a performance of 93.2% for April 22. In relation to benchmarked performance Barts Health ranked second best performing against the 23 teaching trust peer group.
- The Trust achieved compliance in April 22 against the 31 Day Diagnosis to Treatment standard, recording a performance of 98.4% against the 96% target. For April 22, Barts Health was the best performing of the 23 Teaching Trusts.
- Having achieved the 62 day GP standard for each month of the last two years, the Trust has failed to achieve 85% compliance since June 21. For April 22, the Trust recorded a performance of 67.7% and was the ninth best performing of 23 Teaching Trusts. The focus is on seeing and treating the clinically prioritised most urgent patients; this work is well advanced and the cancer leadership team is now working on clearing the backlog of those patients with a slightly lower clinical priority. The cancer leadership team is working to ensure that the number of patients waiting more than 62 days from an urgent referral returns to pre pandemic levels by March 23 in line with national requirements.

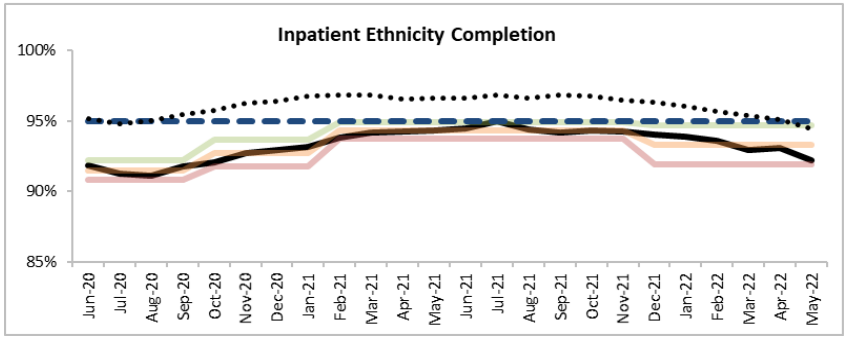
RESPONSIVE

Ethnicity Recording by Activity Type

Jul-22







Ethnicity Recording by Activity Type - % Completion - May-22

Site	A&E	Inpatient	Outpatient
Royal London	95.2%	89.2%	89.2%
Whipps Cross	93.6%	93.1%	91.0%
Newham	95.0%	95.7%	95.3%
St Bart's	-	95.6%	91.9%
Other	-	-	100.0% *
Trust	**94.7%**	**92.2%**	**91.1%**

The above figures show 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). The dotted black line shows what the % recorded would be expected to be if North East London GP data on ethnicity were to be included; this will not yet be reflected in the Trust's reported performance or NHS Digital external dashboards

Performance Overview

- Overall, Trust performance has changed little since last month, but marginal improvements have been observed in A&E with capture rates up 0.5 percentage points to 94.7%.
- Capture rates in Inpatient and Outpatient departments have dropped slightly since the previous month, by 0.6 percentage points and 0.5 percentage points respectively. However, there appears to be a decline in capture rates since Jan 22 for both.
- Newham is the highest performing site achieving 95% in all three areas.
- Royal London A&E has continued to increase capture rates up from 94.6% in the previous month.
- Capture rates for Whipps Cross have increased in A&E from 93.2% in the previous month but have dropped in Inpatient and Outpatient departments from 94.5% and 91.5% respectively.

Responsible Director Update

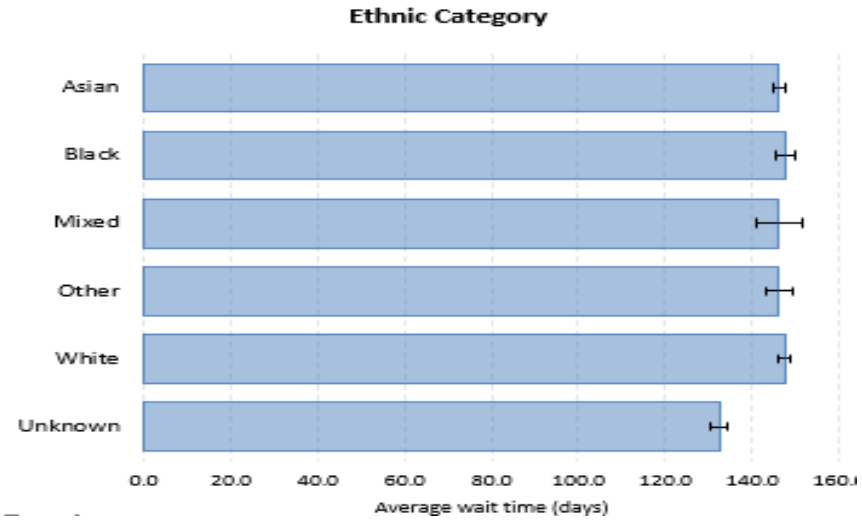
- The Trust has included achieving 95% ethnicity capture across A&E, Inpatient and Outpatient services at all sites in line with its planning objectives for 2022/2023.
- Improvements in A&E capture rates at all three sites is encouraging and we will continue to work with the team to gather and share learning across sites.
- The uploading of GP data on ethnicity contributes to improving the overall position. Additionally, the Trust is looking into the automatic download of this data, rather than manual, which would further help sites improve.

** This relates to 8 patients where ethnicity was recorded but where the site was not recorded due to a coding error.*

RESPONSIVE

Equity - Wait Times By Ethnicity

Jul-22



Ethnic Category	Average Wait (Days)	Lower CI	Upper CI
Asian	146.1	144.7	147.5
Black	147.6	145.3	149.9
Mixed	146.2	141.0	151.4
Other	146.1	143.0	149.2
White	147.6	146.3	148.9
Unknown	132.4	130.6	134.1
Grand Total	**144.4**		

Commentary

There is no statistically significant difference in waiting times between ethnic groups but further work is needed to better understand wait times for patients where the ethnicity is 'unknown'.

PTL data from May 2022 show that at Trust level, there is little difference in wait times from referral to treatment between ethnic groups. Average wait times range between 146.1 - 147.6 days across the known ethnicities.

Further the 95% confidence intervals overlap indicating that any difference in wait time is not statistically significant and could easily be due to chance.

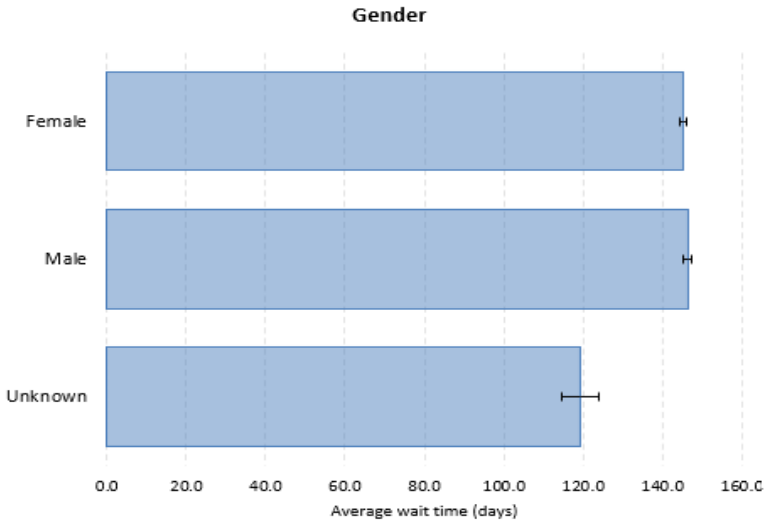
Work is currently under way to better understand wait times for patients categorised as 'Unknown' ethnicity. This is in line with Race Health Observatory recommendations and the NHS Operating Plan which state that ICSs must restore NHS services inclusively and ensure datasets are complete and timely. There patients are much less likely to have previously been in contact with the Trust than those of known ethnicity.

It is important to note that these data are not adjusted for difference between ethnic groups such as average age which could have an influence but are overall averages. The same is true of all of the slides below.

RESPONSIVE

Equity – Wait Times by Gender

Jul-22



Gender	Average Wait	Lower	Upper
Female	145.3	144.3	146.3
Male	146.4	145.2	147.5
Unknown	119.2	114.5	124.0
Grand Total	**145.4**		

Commentary

There is no statistically significant difference in waiting times between genders but further work is being undertaken to understand the difference in waits for patients where the gender is 'unknown'.

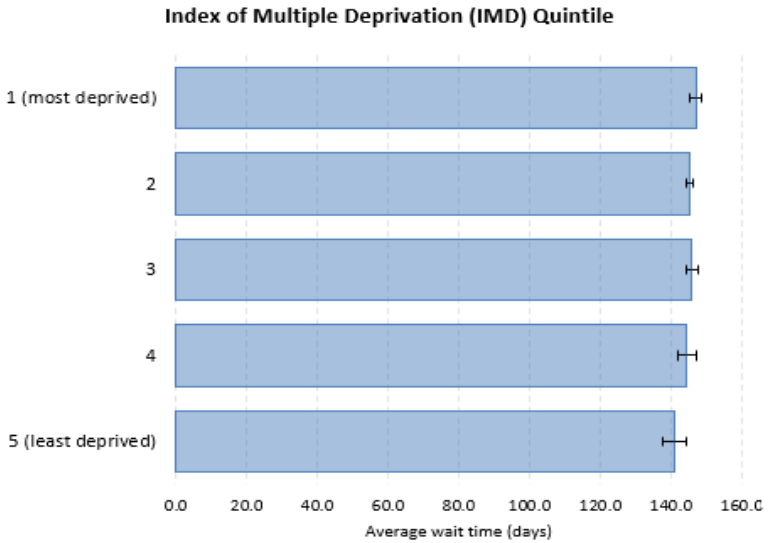
Trust-wide, the wait time from referral to treatment by gender is very similar for male patients compared with female patients (146.4 days vs 145.3 days respectively).

The group 'Unknown' gender is being investigated further.

RESPONSIVE

Equity – Wait Times By Deprivation

Jul-22



IMD Quintile	Average Wait	Lower	Upper
1 (most deprived)	147.0	145.5	148.6
2	145.4	144.3	146.6
3	146.1	144.2	147.9
4	144.6	142.0	147.2
5 (least deprived)	141.2	137.8	144.5
Grand Total	**145.7**		

Commentary

There is a minor difference between the waiting times at Trust level of those in the least deprived and the most deprived areas which is marginally above the threshold for statistical significance. We will explore this further to understand the possible reasons.

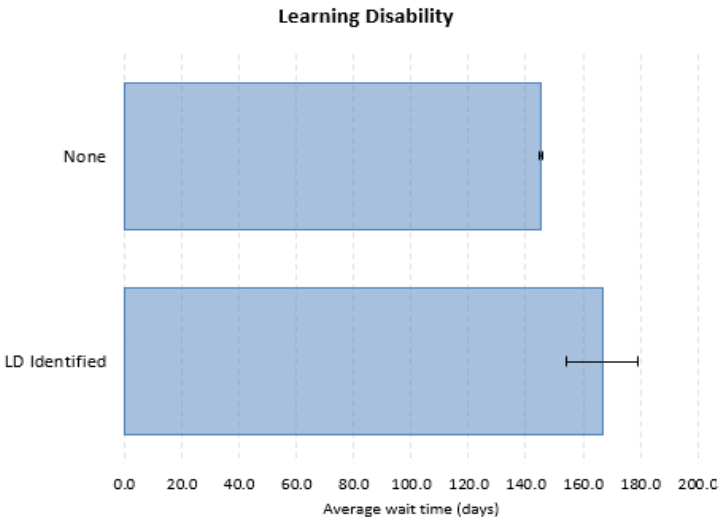
The waits for patients living in the most deprived areas (IMD quintile 1) differ only by a few percentages point from patients living in the least deprived areas (147.0 versus 141.2 days). Further the confidence intervals, don't overlap between quintiles .

However just comparing the least and most deprived the difference is 5.8 days (around 4%) which, in relation to the sample size, means it is marginally above the threshold for statistical significance, though this is not necessarily clinically significant.

RESPONSIVE

Equity – Wait Times by LD

Jul-22



LD_Flag	Average Wait	Lower	Upper
None	145.3	144.5	146.0
LD Identified	166.7	154.4	178.9
Grand Total	**145.4**		

Commentary

Patients with learning disabilities on average are waiting longer for surgery. However, this can be attributed to the specific challenges in one specialty – restorative dentistry for children. Action taken over the last period has significantly reduced the difference in wait times but there is more to do.

We first interrogated the data for patients with learning disabilities last year because it showed they were waiting on average over 125 days longer for surgery than patients without a learning disability and were twice as likely wait over a year. The cohort of patients was small (140) and we found that a large proportion were waiting for restorative dentistry. The delays were partly due to strict infection control that applied to carers and patients as many of these patients required General Anaesthetic (unlike patients without learning disabilities).

As a result, we took action as a Trust to prioritise learning disability patients for surgery. Since July 2021, the difference in average waits for patients with learning disabilities and those not identified as having learning disabilities has been reduced by nearly 100 days.

There is still a statistically significant difference in average wait times for patients with a learning disability (LD) of 21.4 days. This is 166.7 days for patients identified as having an LD compared with 145.3 days in patients not identified as having a learning disability

However, this is solely due to the specific challenges in reconstructive dentistry which we continue to work to address – and the recent easing of infection, prevention and control guidance should further support this. In the meantime we will continue to prioritise Learning Disabled patients for all specialities.

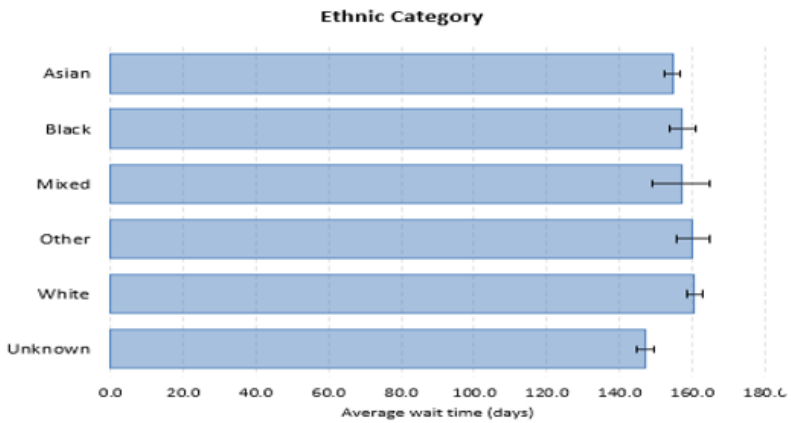
RESPONSIVE

Equity - Wait Times By Ethnicity (Sites)

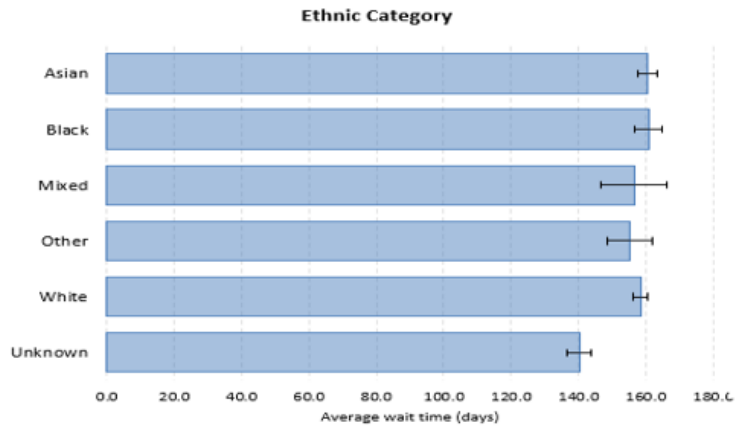
Jul-22

At hospital site level there is no statistically significant difference between the waiting times of patients by ethnic group.

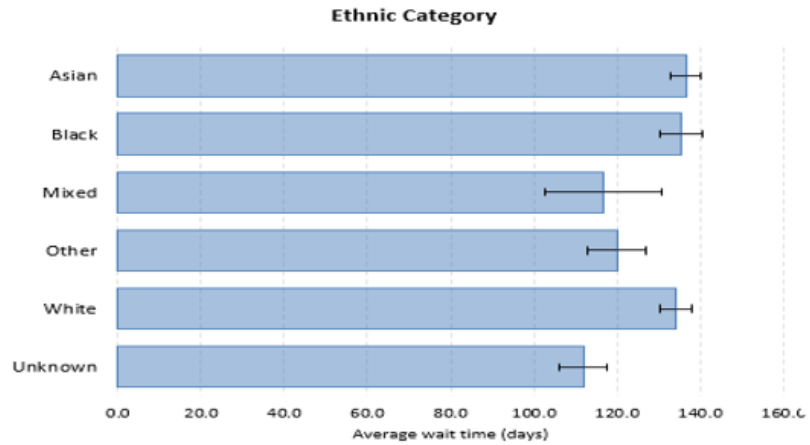
Royal London



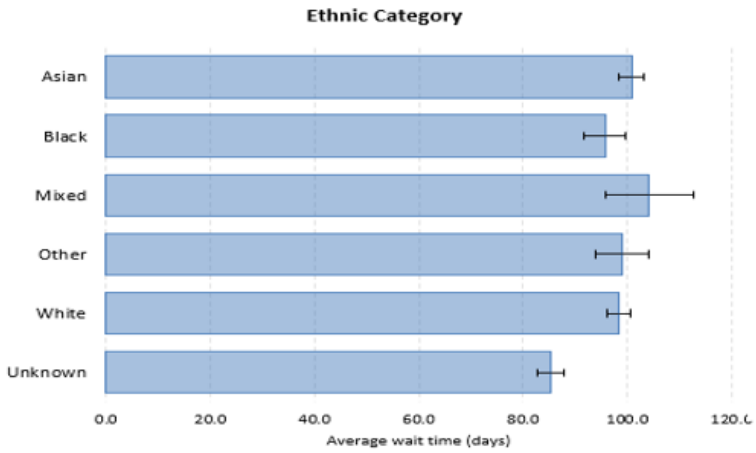
Whipps Cross



Newham



St Bart's



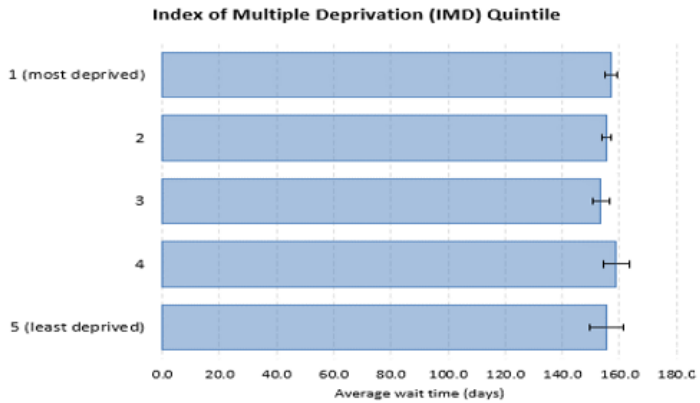
RESPONSIVE

Equity – Wait Times By Deprivation (Sites)

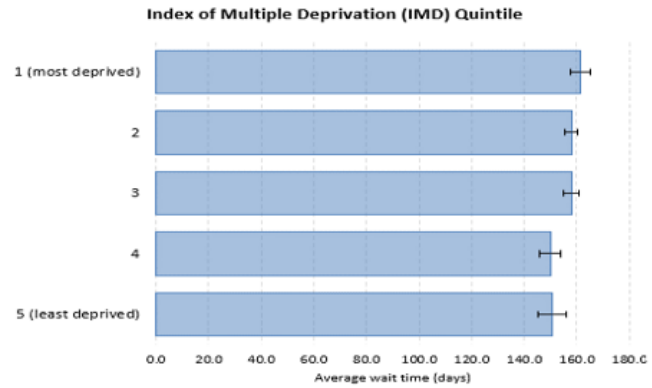
Jul-22

At hospital site level, there is no statistically significant difference in the waiting times of patients in relation to deprivation although it appears there is a minor difference at Whipps Cross between the waiting times of the most and least deprived areas - with those in the most deprived waiting 6.8% longer than those in the least deprived. We will continue to monitor this and explore the data further so we can understand the possible reasons.

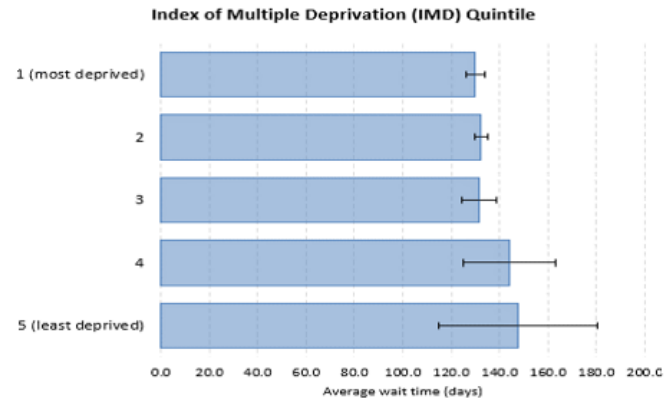
Royal London



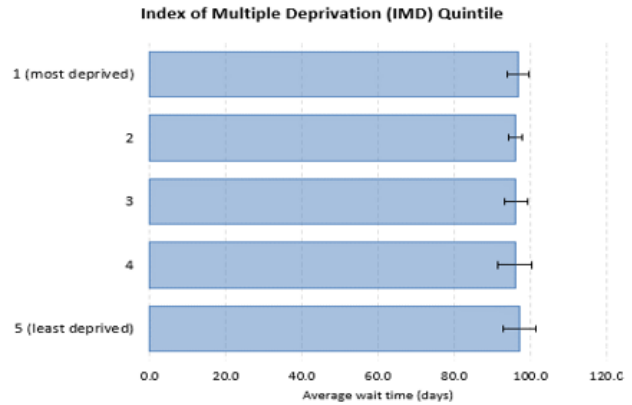
Whipps Cross



Newham



St Bart's



CARING

Domain Scorecard

Jul-22

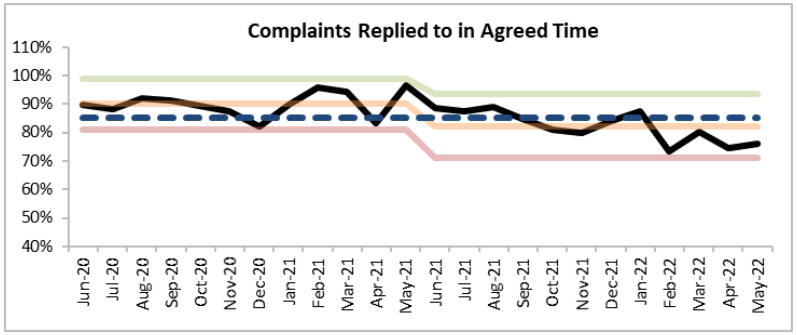
	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Site Comparison: Whipps Cross	Site Comparison: Newham	Site Comparison: St Bart's	Site Comparison: Other	Excep.
Patient Experience	C12	MSA Breaches	●	○	○	May-22 (m)	<= 0	25	**15**	***40***	1	8	6	0	-	○
Patient Feedback	C10	Written Complaints Rate Per 1,000 Staff	○	○	○	2021/22 Q4 (q)	SPC Breach	24.7	**23.8**	***23.8***	27.2	43.9	33.3	12.4	-	○
	C1	FFT Recommended % - Inpatients	●	○	○	Apr-22 (m)	>= 95%	90.3%	**90.0%**	***90.0%***	87.6%	92.8%	85.0%	91.5%	-	○
	C2	FFT Recommended % - A&E	●	○	○	Apr-22 (m)	>= 86%	61.7%	**59.7%**	***59.7%***	57.2%	67.5%	50.6%	-	-	○
	C3	FFT Recommended % - Maternity	●	○	○	Apr-22 (m)	>= 96%	94.9%	**92.7%**	***92.7%***	71.4%	93.9%	92.7%	-	-	○
	C20	FFT Response Rate - Inpatients	●	○	○	Apr-22 (m)	>= 23%	26.8%	**26.7%**	***26.7%***	21.0%	41.3%	17.7%	28.1%	-	○
	C21	FFT Response Rate - A&E	●	○	○	Apr-22 (m)	>= 12%	8.7%	**8.0%**	***8.0%***	7.6%	10.6%	6.0%	-	-	○
	C22	FFT Response Rate - Maternity	●	○	○	Apr-22 (m)	>= 17.5%	13.5%	**15.4%**	***15.4%***	1.7%	40.9%	12.2%	-	-	○
	OH4	CQC Inpatient Survey	●	○	○	2020/21 (y)	>= 85%	84.0%	**85.0%**	***85.0%***	87.0%	81.0%	75.0%	93.0%	-	○
Service User Support	R78	Complaints Replied to in Agreed Time	●	○	○	May-22 (m)	>= 85%	74.4%	**76.2%**	***75.3%***	78.0%	70.0%	73.9%	100.0%	-	●
	R30	Duty of Candour	●	○	○	Apr-22 (m)	>= 100%	81.8%	**83.0%**	***83.0%***	68.4%	91.7%	91.7%	100.0%	-	●

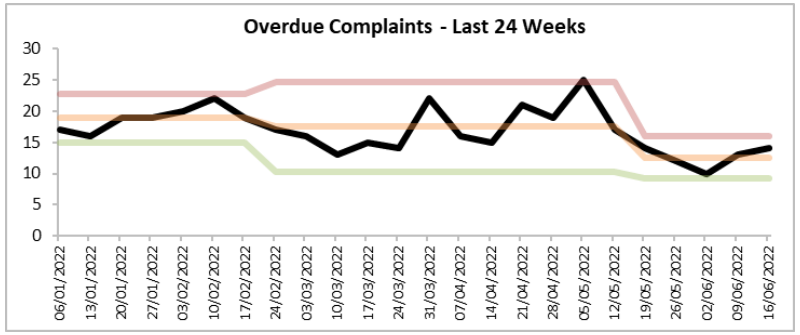
*The metric "Complaints Replied to in Agreed Time" has a Trust-wide target of 85% but an internal stretch target for sites of 95%

CARING

Complaints Replied to in Agreed Time

Jul-22





Complaints Replied to - Top 5 Subjects in Previous 6 Months

Subject	Replied in Previous 6 Months	Replied This Period
Diagnosis / Treatment	286	53
Communication - verbal / written / electronic	134	20
Delays in care	109	18
Appointments / Clinics	59	12
Security and unacceptable behaviour	43	3

Overdue Complaints - Top 5 Subjects as at 16/06/2022

Subject	Number Overdue	Working Days Overdue		
		Average	Minimum	Maximum
Diagnosis / Treatment	7	9	2	31
Delays in care	4	60	1	183
Security and unacceptable behaviour	1	4	4	4
Medication / Radiation	1	39	39	39
Communication - verbal / written / electronic	1	10	10	10

Performance Overview

- Performance across the Group in May-22 improved slightly to 76.2% compared to 73.7% in Apr-22
- Performance is above the lower control point but below the mean
- Year to date performance is also improved marginally to 75.3% , up from 73.7% in April, against a target of 85%
- Only one hospital site managed to achieve the target in April, although only small numbers of complaints were involved. Whilst the remaining sites did not achieve the target, performance this month was very much more consistent.

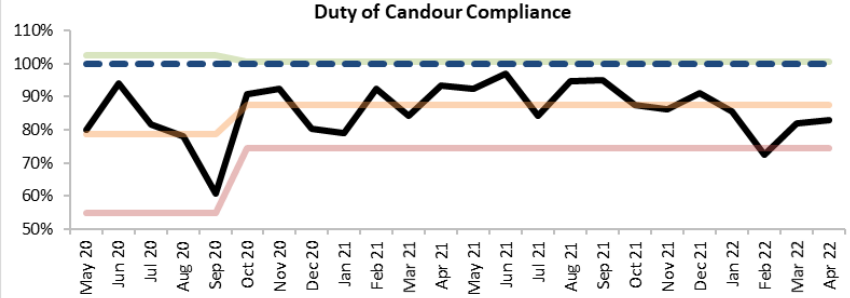
Responsible Director Update

- Operational pressures in both the services and governance teams continue to impact on complaints performance
- There is ongoing focus on improving complaints performance and on ensuring early local resolution of issues wherever possible to prevent resolvable matters escalating to become formal complaints

CARING

Duty of Candour

Jul-22



Duty of Candour Compliance by Site - Apr-22			
Site	**No of Apologies**	**No of Incidents**	**Compliance**
Trust	**39**	**47**	**83.0%**
Royal London	13	19	68.4%
Whipps Cross	11	12	91.7%
Newham	11	12	91.7%
St Bart's	4	4	100.0%

Duty of Candour Compliance - Apr-22 (All Measures)					
Period	**Apology Offered Within 2 Weeks**	**Patient Notification & Apology Offered**	**Written Notification**	**Support Offered**	**Further Enquiries Advised**
Previous 6 Months	85.0%	98.1%	96.5%	94.6%	93.1%
This Period	83.0%	93.6%	91.5%	93.6%	91.5%

Performance Overview	**Responsible Director Update**
• Performance across the Group in April improved to 83.0% from 81.8% in Mar-22 • Year to date performance in 2022/23 is 83.0%. Given that Duty of Candour is a legal duty the target is 100%. • The performance quoted relates to the trust' internal target, rather than reflecting performance against the legal duty • Just one hospital site managed to discharge the Duty in Apr-22 for all qualifying cases, although only low numbers involved. • Whipps Cross and Newham both achieved 91.7%	• The CQC will issue updated guidance in relation to known risks and complications at the end of June 2022. This will represent a change from their currently stated position • The Duty of Candour Sub-group will reconvene to assess the implications for our new policy and training package

SAFE

Domain Scorecard

Jul-22

	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Site Comparison: Whipps Cross	Site Comparison: Newham	Site Comparison: St Bart's	Site Comparison: Other	Excep.
Infection Control	S10	Clostridium difficile - Infection Rate	●	○	○	May-22 (m)	<= 16	24.1	**0.0**	***11.6***	0.0	0.0	0.0	0.0	-	○
	S11	Clostridium difficile - Incidence	●	○	○	May-22 (m)	<= 8	14	**0**	***14***	0	0	0	0	0	○
	S2	Assigned MRSA Bacteraemia Cases	●	○	○	May-22 (m)	<= 0	0	**0**	***0***	0	0	0	0	0	○
	S77	MSSA Bacteraemias	○	○	○	May-22 (m)	SPC Breach	0	**0**	***0***	0	0	0	0	0	○
	S76	E.coli Bacteraemia Bloodstream Infections	●	○	○	Mar-22 (m)	<= 8	12	**16**	***151***	6	1	4	5	0	○
Incidents	S3	Never Events	●	○	○	May-22 (m)	<= 0	1	**1**	***2***	1	0	0	0	0	○
	S09	% Incidents Resulting in Harm (Moderate Harm or More)	●	○	○	May-22 (m)	<= 0.9%	1.8%	**2.0%**	***1.9%***	2.5%	1.8%	1.6%	1.3%	-	○
	S45	Falls Per 1,000 Bed Days	●	○	○	May-22 (m)	<= 4.8	3.5	**3.5**	***3.5***	4.3	2.8	2.7	3.4	-	○
	S25	Medication Errors - Percentage Causing Harm	●	○	○	May-22 (m)	<= 4%	1.7%	**3.9%**	***3.0%***	2.8%	3.8%	8.2%	3.9%	-	●
	S49	Patient Safety Incidents Per 1,000 Bed Days	○	○	○	May-22 (m)	SPC Breach	50.8	**48.9**	***49.8***	39.2	58.5	54.1	54.6	-	○
	S53	Serious Incidents Closed in Time	●	○	○	May-22 (m)	>= 100%	29.4%	**38.9%**	***34.3%***	25.0%	37.5%	33.3%	66.7%	-	●

Serious Incidents Closed in Time: clock stops are still in place nationally and Barts Health continues to monitor the Serious Incident process according to internal targets – more details are on the "Changes to Report" page of this report.

SAFE

Domain Scorecard

Jul-22

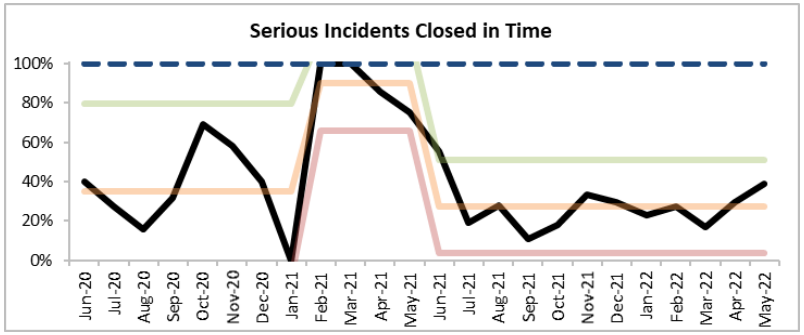
	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Site Comparison: Whipps Cross	Site Comparison: Newham	Site Comparison: St Bart's	Site Comparison: Other	Excep.
Harm Free Care	S14	Pressure Ulcers Per 1,000 Bed Days	●			May-22 (m)	<= 0.6	1.3	**1.2**	***1.3***	1.0	1.3	1.2	1.6	-	
	S35	Pressure Ulcers (Device-Related) Per 1,000 Bed Days				May-22 (m)	SPC Breach	0.1	**0.2**	***0.2***	0.2	0.2	0.2	0.2	-	
	S17	Emergency C-Section Rate				Apr-22 (m)	-	21.6%	**21.3%**	***21.3%***	21.2%	22.5%	20.6%	-	-	
	S27	Patient Safety Alerts Overdue	●			May-22 (m)	<= 0	1	**1**	***1***	-	-	-	-	-	
Assess & Prevent	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%	-	

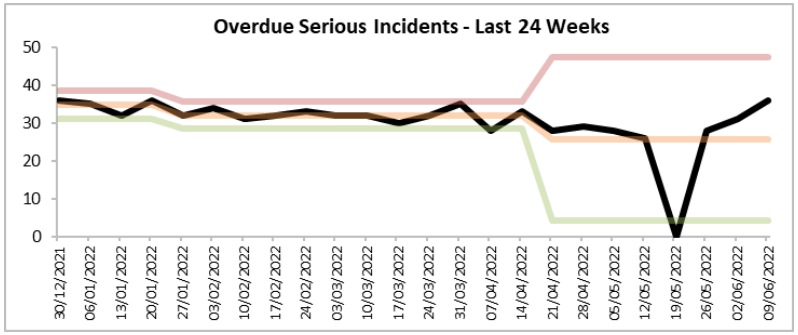
Dementia metrics: Feb-20 performance from the last national submission before the temporary suspension of national reporting is the latest included in the report.

CARING

Serious Incidents Closed in Time

Jul-22





Serious Incidents Closed - Top 5 Categories in Previous 6 Months

Category	Closed in Previous 6 Months	Closed This Period
Delays in Care	26	5
Treatment	15	1
Obstetrics	13	1
Medication	5	1

Overdue Serious Incidents - Top 5 Categories as at 09/06/2022

Incident Category	Number Overdue	Working Days Overdue		
		Average	Minimum	Maximum
Delays in Care	11	52	2	149
Obstetrics	8	45	2	128
Treatment	3	41	20	65
Patient Falls	2	73	25	121
Safeguarding Adults	2	13	2	23
Medication	2	18	8	27
Infection Control	2	3	2	4

Performance Overview

- Trust performance closing serious incidents on time improved to 38.9% in May-22. This represents a significant improvement in performance since Apr-22 when 29.4% was achieved.
- Whilst the improvement is noted, performance still remains well below the target of 100%
- May-22 performance also improved the year to date performance is 34.3% from 29.4% in Apr-22
- There has been an increase in the number of overdue reports

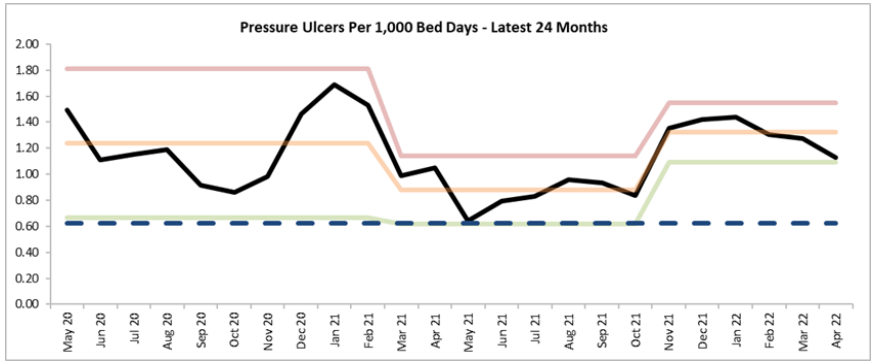
Responsible Director Update

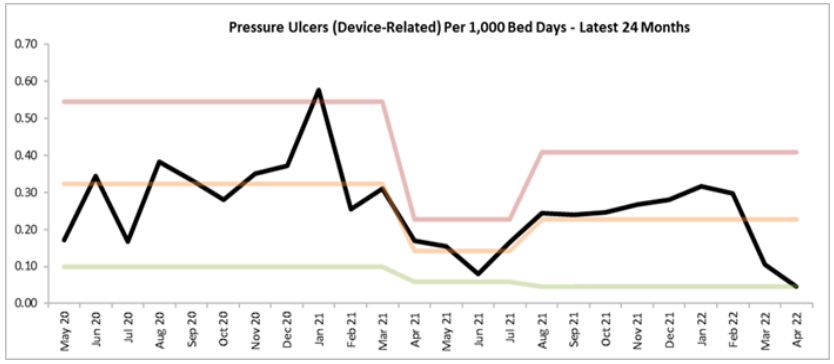
- Focus is currently shifting from compliance with this metric to the implementation of the Patient Safety Incident Response Framework (PSIRF). PSIRF will not distinguish between incidents and serious incidents
- Some incidents will qualify for a Patient Safety Incident Investigation (PSII) but there are other alternative proportionate responses (e.g. case note review; time mapping; 'being open' conversations; after action review; audit)
- The current prescribed timeframe of 60 days for completion of a Serious Incident Investigation under the Serious Incident Framework will no longer apply. Instead, the PSIRF provides for more flexible timeframes for PSIIs. Timeframes for individual PSIIs are to be agreed in consultation with the patient and/or family, although it is suggested that investigations should average three months and never exceed six months

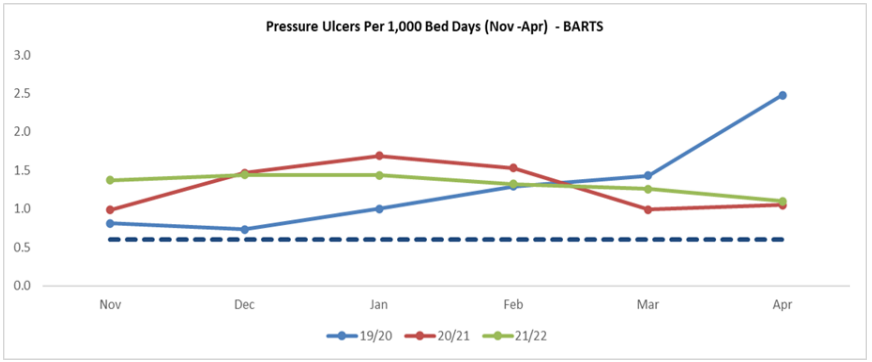
CARING

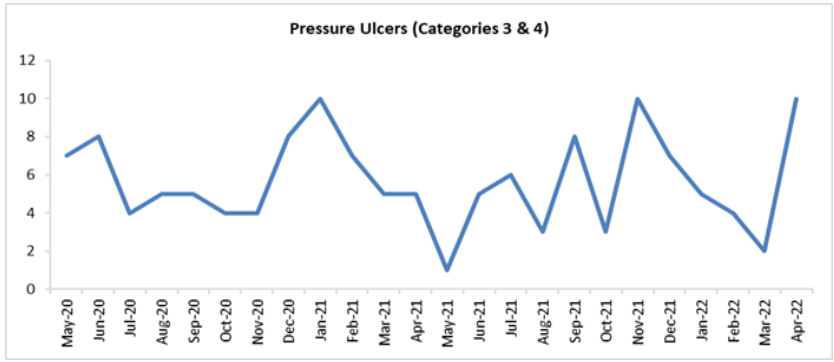
Pressure Ulcers

Jul-22









Commentary:

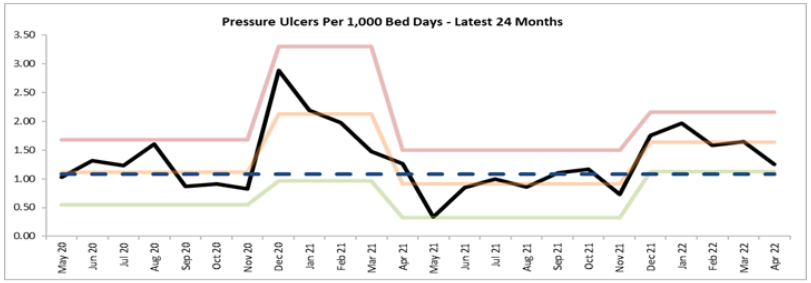
- The HAPU rate at Barts Health is above 1.0 per 1000 bed days (definition: category 2-4, unstageable and deterioration).
- A data quality issue with duplication of data caused by addition of a new ward in March has been addressed and corrected.
- Comparison of same seasonal winter period (Nov – Apr) for 19/20, 20/21 and 21/22 shows that pressure ulcer rate increased during early 2020 with the first wave of the pandemic. This period during the following years indicate some consistency and that the rate remains lower than April 2020.
- Device-related pressure ulcers have reduced.
- The numbers of category 3 and category 4 pressure ulcers are fluctuating on a month by month basis but are not showing a downward trend post pandemic.
- The national context: discussion in TVN Forum notes an increase in pressure ulcers nationally

CARING

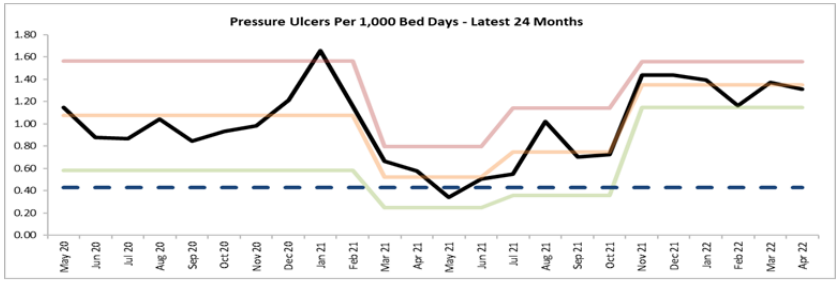
Pressure Ulcers

Jul-22

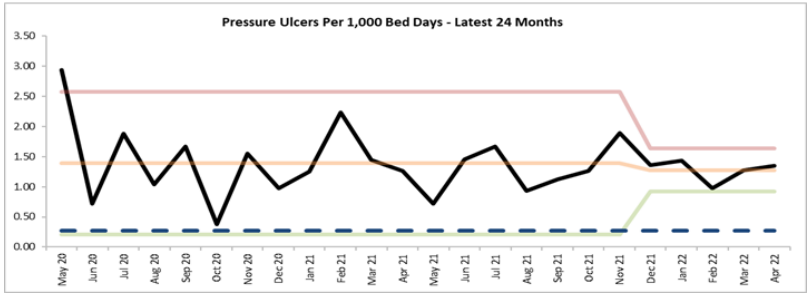
Newham



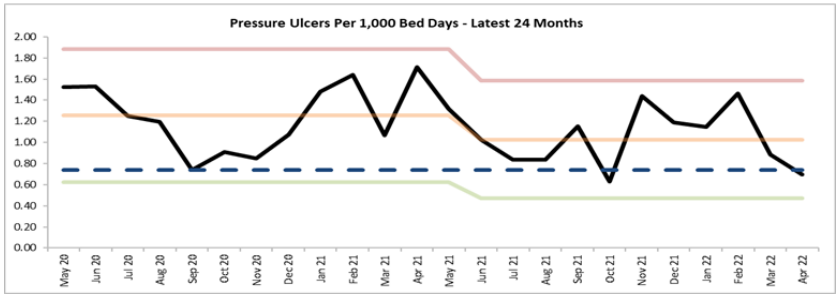
Royal London



St Bart's



Whipps Cross



Themes identified by TVN Team in specific case review of 9 pressure damage incidents (category 3, 4 and unstageable pressure damage)	Recommendations
The Tissue Viability Nurse team reviewed 9 cases of Category 3, 4 and unstageable pressure damage. The review identified issues relating to inadequate documentation, failure to prevent pressure damage and inadequate care, for various reasons.	Actions following this review: • Review targeted areas to ensure culture of prevention of pressure damage • Improve attendance at e-learning and virtual training • Further use of learning from RCA's to prevent recurring themes • Present learning at team days • Escalating "non-concordant patients" and use of alternate approaches • Learning summit covering assessment, supervision, consistent records and risk assessment • Review of the evidence regarding body mapping on Millennium • Enable Emergency departments to order hospital bed and air mattress for patients at high risk • Utilise Clinical Nurse Advisor from Linet (bed management company) for complex patients • Face-to-face training on wound assessment and documentation for targeted areas

EFFECTIVE

Domain Scorecard

Jul-22

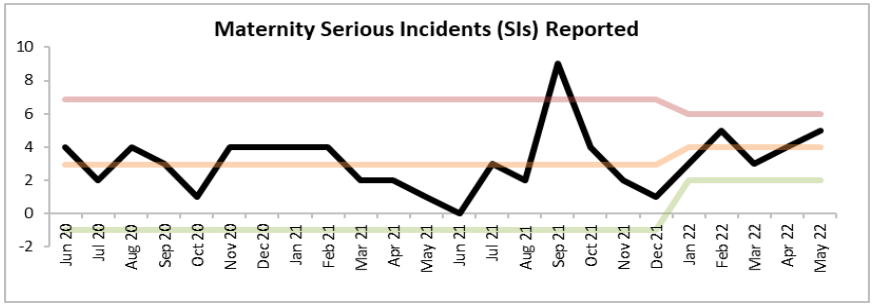
	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Site Comparison: Whipps Cross	Site Comparison: Newham	Site Comparison: St Bart's	Site Comparison: Other	Excep.
Mortality	E1	Summary Hospital-Level Mortality Indicator	●	○	○	May-22 (m)	<= 100	96	**96**	***96***	94	102	106	82	-	○
	E3	Risk Adjusted Mortality Index	●	●	○	Apr-22 (m)	<= 100	90	**90**	***90***	92	92	87	81	-	○
	E25	Number of Avoidable Deaths	○	○	○	2020/21 Q2 (q)	-	7	**4**	***11***	-	-	-	-	-	○
Outcomes	0502	Cardiac Arrest 2222 Calls (Wards) Per 1,000 Admissions	●	○	○	May-22 (m)	<= 0.51	0.72	**0.58**	***0.65***	0.13	1.51	1.20	0.21	-	○

Summary Hospital-Level Mortality Indicator and Risk Adjusted Mortality Index: these metrics are adjusted for Covid-19 (i.e. confirmed or suspected cases of Covid-19 are not included).

SPOTLIGHT

Maternity Serious Incidents (SIs)

Jul-22



Maternity SIs in Latest Month (May-22)

Theme	Royal London	Whipps Cross	Newham	Barts Health
Total Number of SIs	**4**	**0**	**1**	**5**
Of Which HSIB (Healthcare Safety Investigation Branch) Investigations	0	0	0	0
% HSIB Investigations	0.0%	-	0.0%	0.0%

Maternity SIs in Last 12 Months to May-22 - Top by Theme

Theme	Royal London	Whipps Cross	Newham	Barts Health
Total Number of SIs	**16**	**7**	**18**	**41**
Neonatal - Unanticipated admission to Neonatal unit	5	2	0	7
Antenatal - Antepartum Stillbirth	2	1	3	6
Intrapartum - Stillbirth	3	1	2	6
Neonatal - pH <7.1(arterial) at birth	3	1	1	5
Intrapartum - Retained vaginal swab/tampon	2	1	1	4

Actions on Maternity SIs in Last 12 Months to May-22 - Top by Action Type

Action Type	Royal London	Whipps Cross	Newham	Barts Health
Total Number of Actions	**22**	**19**	**79**	**120**
No actions recorded	15	4	11	30
Review / amend processes	3	2	23	28
Education and training	3	4	16	23
Share report with family	0	0	8	8
Sharing the learning	1	2	5	8

Progress Summary

- Five serious incidents (SI) were reported in May 2022. 4 at Royal London Hospital and 1 at Newham Hospital . Royal London Hospital **also referred 3 of their cases to HSIB. All cases have had immediate rapid review and learning has been identified and disseminated. Full reports from HSIB expected within 6 months**
- Royal London Hospital –Stillbirth during labour. Referred to HSIB
- Royal London Hospital – Baby born in poor condition and requiring therapeutic cooling. Referred to HSIB
- Royal London Hospital –Baby born in poor condition, requiring therapeutic cooling and probable severe brain injury. Referred to HSIB
- Royal London Hospital– retained vaginal swab – Never Event.
- Newham Hospital – ITU admission for eclampsia

Noteworthy Improvements

- Number of outstanding actions from 2020/21 and 2021/22 have dropped significantly for Royal London Hospital & Whipps Cross Hospital but 54 remaining for the Newham Hospital site. Newham Hospital continues with it's action review group which meets weekly to review progress on actions.

Risks & Issues

- There has been an increase in SIs reported at Royal London Hospital over the last 2 years. At Royal London Hospital in 2021/2022 total SIs total Sis = 11, 2022/23 YTD = 6
- **Next Steps**
- Deep dive into SIs at Royal London Hospital to identify themes and review actions to ensure that human factors and a system approach to learning is being used.
- Learning from the Never Event at Royal London Hospital will be shared through the maternity Safety Improvement programme where system wide learning is being explored through human factors and using a standardised approach to improving safety.

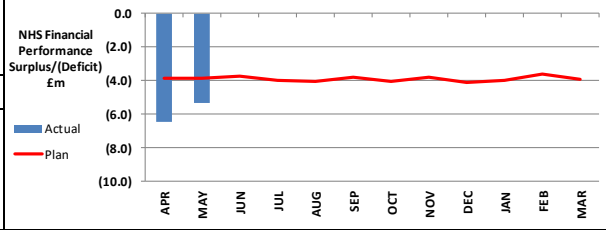
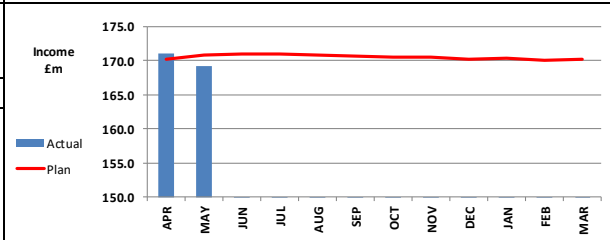
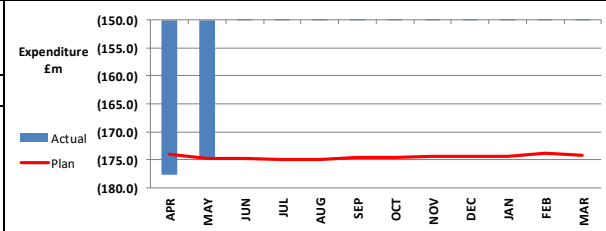
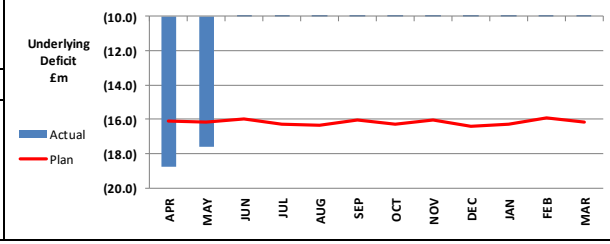
NHS
Barts Health
NHS Trust

Finance Report

KEY METRICS

Finance Key Metrics

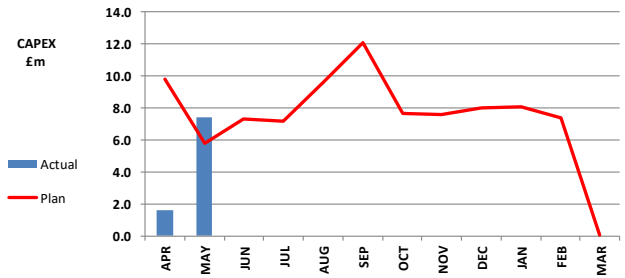
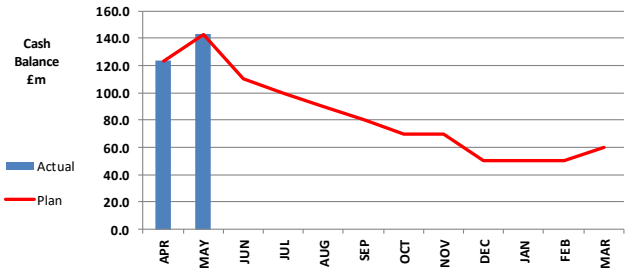
Jul-22

Metrics	Current Performance Year To Date £millions	Trend	Comments
NHS Financial Performance Surplus / (Deficit)	Plan (7.7) Actual (11.8) Variance (4.1)		The Trust is reporting a deficit of £11.8m, which is a (£4.1m) adverse variance year to date against the plan for a £46m deficit submitted to NHSE/I on 28th April 2022..
Total Income	Plan 341.0 Actual 340.4 Variance (0.7)		Income is (£0.7m) adverse against the year to date plan. NHS Patient Treatment income is (£0.1m) adverse and other income is (£0.6m) adverse. Sites and Services other income is (£1.2m) adverse, mainly due to reduced private patients activity. Central other income is £0.7m favourable, which includes increased funding to match expenditure for vaccination programme re-imbursement (£0.6m).
Total Expenditure	Plan (348.7) Actual (352.2) Variance (3.4)		Expenditure is (£3.4m) adverse against the year to date plan. Site and Services expenditure is (£16.1m) adverse, primarily due high cost drugs and devices (£6.4m), underachievement against the 3% recurrent efficiency savings target (£6.4m) and purchase of independent sector activity to support elective recovery (£2.0m). Temporary staffing spend remains high as a result of the on-going trend of increased bank and particularly agency staffing usage and the use of high cost off-framework agencies to meet staffing requirements. Central expenditure is £12.6m favourable which includes inflation and contingency reserves held pending NHSE/I approval of the deficit plan submitted on 28th April 2022.
Underlying Deficit (Deficit Excluding System Top-Up Income)	Plan (32.3) Actual (36.4) Variance (4.1)		The Trust is reporting a pre system top-up deficit of £36.4m, which is a (£4.1m) adverse variance against the year to date plan. The system top-up is an allocation the North East London system receives for its providers during the period of COVID-19 financial arrangements and effectively replaces what was known as the Financial Recovery Fund (FRF) allocation pre-pandemic. System top-up funding is primarily based on NHS England's calculation of the Trust's pre-pandemic (2019/20) underlying deficit.

KEY METRICS

Finance Key Metrics

Jul-22

Metrics	Current Performance Year To Date £millions	Trend	Comments
Capital Expenditure	Plan 15.6 Actual 9.0 Variance (6.6)		The year to date capital expenditure is £9.0m against a plan of £15.6m, which gives a year to date underspend of £6.6m for exchequer funded schemes. Expenditure in Month 2 is £7.4m resulting in an adverse variance of £1.6m against the plan, month 2 expenditure is driven by a one-off IFRS16 adjustment in month for the existing finance leases (originally planned for April), which offsets the underspend on the rest of the programme caused by the slow commencement of schemes. There is also a £9.9m programme funded by charitable donations and expenditure against donated schemes was £0.2m in Month 2 with a variance of £0.7m to plan.
Cash	Plan 143.0 Actual 143.0 Variance 0.0		Cash balances are in line with the plan at £143m, the cash balance is due to the high closing cash balance of £86.7m in March 2022 and other movements in working capital.

Key Issues

The detailed mechanism and calculation of Elective Recovery performance adjustments is not expected to be circulated by NHSE/I until the end of quarter one, therefore no in-year adjustment for Elective Recovery Performance is included within the Trust reported position at this stage.

Key Risks & Opportunities

The key financial challenges for the Trust in achieving its plan for this financial year include:
- Performance against the Elective Recovery trajectory and any associated funding adjustments, the detailed basis for any adjustments has yet to be confirmed by NHSE/I,
- Ensuring improvements in productivity in order to deliver the 3% efficiency savings target set within Sites and Services budgets,
- The outcome of the plan re-submission process. The NEL system submitted a balanced plan on 20th June 2022 and has received and allocated to system providers only limited additional funding for inflationary pressures. The Trust will seek to negotiate further additional funding for inflationary pressures from system partners during the year.

INCOME & EXPENDITURE

Income & Expenditure - Trustwide

Jul-22

21/22 YTD		In Month			Year to Date			Annual
Prev Yr Actual	£millions	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	Income							
238.9	NHS Patient Treatment Income	128.5	129.6	1.1	250.3	249.6	(0.6)	1,523.2
0.5	Other Patient Care Activity Income	0.6	0.1	(0.5)	1.1	0.3	(0.9)	6.8
19.1	Other Operating Income	10.5	10.3	(0.2)	20.8	20.4	(0.4)	119.9
258.4	**Total Income**	**139.6**	**140.0**	**0.4**	**272.2**	**270.3**	**(1.9)**	**1,649.9**
	Operating Expenditure							
(172.5)	Pay	(89.1)	(92.5)	(3.3)	(178.3)	(183.5)	(5.2)	(1,065.9)
(29.6)	Drugs	(15.4)	(17.5)	(2.1)	(30.9)	(34.7)	(3.9)	(185.2)
(18.9)	Clinical Supplies	(11.6)	(14.0)	(2.4)	(23.2)	(25.8)	(2.6)	(137.9)
(51.3)	Other Non Pay	(24.6)	(26.2)	(1.6)	(49.1)	(53.5)	(4.4)	(282.0)
(272.3)	**Total Operating Expenditure**	**(140.8)**	**(150.2)**	**(9.4)**	**(281.4)**	**(297.5)**	**(16.1)**	**(1,671.0)**
(13.9)	**Site & Services Budgets Total**	**(1.2)**	**(10.2)**	**(9.0)**	**(9.2)**	**(27.1)**	**(17.9)**	**(21.2)**
(9.6)	Pathology Partnership (net)	(4.6)	(4.4)	0.1	(9.1)	(8.8)	0.3	(54.7)
0.0	Vaccination Programme & Nightingale (net)	-	(0.0)	(0.0)	-	(0.0)	(0.0)	-
0.0	Research & Development (net)	0.0	(0.0)	(0.0)	0.0	0.0	0.0	0.0
25.0	Central NHS PT Income	9.8	7.7	(2.1)	26.3	26.8	0.5	136.8
0.8	Central RTA & OSV Income (net)	0.6	0.8	0.2	1.1	1.2	0.1	6.8
(2.1)	Central Expenditure (net)	0.2	0.7	0.5	0.5	0.5	0.1	2.8
(7.2)	Reserves (net)	(8.3)	0.4	8.7	(16.6)	(3.8)	12.7	(112.2)
(7.0)	**EBITDA**	**(3.4)**	**(4.9)**	**(1.5)**	**(7.0)**	**(11.2)**	**(4.2)**	**(41.7)**
(8.9)	Depreciation and Amortisation (net)	(5.8)	(5.8)	-	(11.6)	(11.6)	-	(70.7)
(10.9)	Interest	(6.0)	(6.0)	0.1	(11.9)	(11.7)	0.1	(70.9)
(2.2)	PDC Dividends	(0.9)	(0.9)	-	(1.8)	(1.8)	-	(10.7)
(29.0)	**Surplus/(Deficit) Before System Top-Up**	**(16.1)**	**(17.6)**	**(1.5)**	**(32.3)**	**(36.4)**	**(4.1)**	**(194.0)**
29.2	System Top-Up Income	12.3	12.3	-	24.6	24.6	-	147.4
0.1	**NHS Reporting Surplus/(Deficit)**	**(3.9)**	**(5.3)**	**(1.5)**	**(7.7)**	**(11.8)**	**(4.1)**	**(46.6)**
0.1	*Profit On Fixed Asset Disposal*		*0.0*			*0.0*		
-	*Loss on return of COVID assets to DHSC*		-			-		
0.1	*Capital Donations I&E Impact*		*(0.1)*			*0.2*		
-	*Fixed Asset Impairments*		-			-		
0.3	**Surplus / (Deficit)**		**(5.4)**			**(11.5)**		

CAPITAL EXPENDITURE

Capital Expenditure Summary - Trustwide

Jul-22

21/22 YTD	Programme Area	In Month				Year to Date				Annual			
Actual	*£millions*	Plan	Actual	Variance	%	Plan	Actual	Variance	%	Plan	Forecast	Variance	%
0.5	Equipment (Medical and Other)	1.6	0.1	1.5	*91 %*	3.0	0.6	2.4	*82 %*	23.3	17.8	5.5	*24 %*
2.3	Informatics	0.3	0.1	0.2	*68 %*	0.4	0.1	0.2	*64 %*	8.0	5.5	2.5	*31 %*
2.0	Estates	1.0	1.8	(0.8)	*(82)%*	1.8	2.0	(0.1)	*(8)%*	7.3	41.8	(34.5)	*(476)%*
2.0	New Build and Site Vacations	2.0	0.1	1.9	*95 %*	4.3	0.2	4.1	*94 %*	33.2	28.8	4.4	*13 %*
1.4	PFI Lifecycle Assets	0.9	0.9	(0.0)	*(0)%*	1.7	1.7	(0.0)	*(0)%*	10.4	10.4	(0.0)	*(0)%*
-	Finance Lease	-	4.4	(4.4)	*- %*	4.4	4.4	-	*- %*	8.4	8.4	-	*- %*
8.1	**Total Trust Funded Assets**	**5.8**	**7.4**	**(1.6)**	***(28)%***	**15.6**	**9.0**	**6.6**	***42 %***	**90.5**	**112.7**	**(22.1)**	***(24)%***
0.7	Donated	0.9	0.2	0.7	*81 %*	1.6	0.7	0.8	*53 %*	9.9	9.9	(0.0)	*(0)%*
8.8	**Total Capital Expenditure**	**6.7**	**7.6**	**(0.9)**	***(13)%***	**17.2**	**9.7**	**7.4**	***43 %***	**100.5**	**122.6**	**(22.1)**	***(22)%***

Key Messages

The current exchequer capital plan is £90.5m as per June plan re-submission to NHSE/I. This is a decrease of £25.7m from last month due to:

(i) Revised forecast and adjusted funding of WXH Redevelopment and enabling works - net decrease of £29.8m.

(ii) Restatement of IFRS16 impact of new leases identified in month - net increase of c£4m.

The overcommitment of the capital programme £22.1m against the funded plan remains the same as Month 1 reporting.

Based on previous years' experience it is anticipated that not all schemes in the plan will be delivered due to slippage and underspends, this will be monitored closely throughout the year to allow as much funding as possible to be freed up to fund other schemes/overcommitments.

Funding of £90.5m has been identified comprising: £33.8m net depreciation; £18.6m of CRL cover (funded by internal cash reseves); £9.0m New hospital programme PDC for the WXH redevelopment and enabling works (c. £1m PDC funding confirmed to date); and Target Investment Funding (TIF) of £20.6m against three schemes including the Newham Modular Build (pending confirmation of approval).

The PDC funded schemes await formal approval at national level but to avoid delay, planning for these schemes is being progressed at risk. Negotiations are underway with NEL and NHS London to secure underspend funding to support the over committed schemes. In addition, the Trust will submit bids for any centrally released funding for items such as diagnostic equipment, elective recovery, and digital transformation as the opportunities arise.

Expenditure in Month 2 is £7.4m resulting in an adverse variance of £1.6m against the plan driven by one-off IFRS16 adjustment in month for the existing finance leases (originally planned for April), which offsets the underspend on the rest of the programme caused by the slow commencement of schemes.

There is also a £9.9m programme funded by charitable donations and expenditure against donated schemes was £0.2m in Month 2 with a variance of £0.7m to plan.

Capital Funding

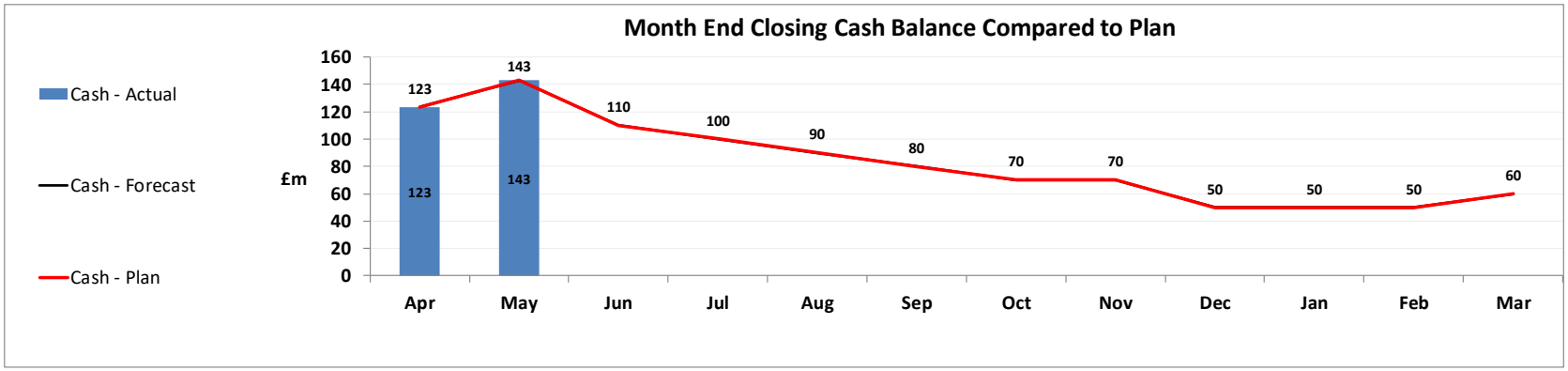
	Capital Plan	Secured/ Drawn down	Not Secured/ Drawn down	% Secured
Gross Depreciation	60.8	60.8	-	*100 %*
IFRS 16 Deprecation	9.9	9.9		*100 %*
Repayment of PFI Finance Lease	(25.3)	(25.3)	-	*100 %*
Repayment of Loan/Other Finance Leases	(1.8)	(1.8)	-	*100 %*
Repayment Other Finance Leases (IFRS16)	(9.7)	(9.7)	-	*100 %*
Net Depreciation	**33.8**	**33.8**	**-**	**100 %**
CRL (not cash backed)	18.6		18.6	*- %*
EFA	-		-	*- %*
Additional CRL from London Region(not cash backed)	-		-	*- %*
IFRS16 CRL adjustment	8.4		8.4	*- %*
PDC: WXH Redevelopment Core Programme Team	1.8	1.1	0.8	*58 %*
PDC: WXH Redevelopment NHP Development Costs	1.2		1.2	*- %*
PDC: WXH Enabling Works	6.0		6.0	*- %*
PDC: TIF NUH Modular Build BC932	14.9		14.9	*- %*
PDC: TIF Mothballed NUH Theatres	5.2		5.2	*- %*
PDC: TIF ITU Expansion SBH	0.5		0.5	*- %*
PDC: Digital Cyber	0.1		0.1	*- %*
Planned Capital exc. Donated	**90.5**	**34.9**	**55.6**	**39 %**
Asset sales	-	-	-	*- %*
Total Approved Exchequer Funding exc. Donated*	**90.5**	**34.9**	**55.6**	**39 %**
Donated	9.9	0.7	9.2	*7 %*
Planned Capital inc. Donated	**100.4**	**35.6**	**64.8**	**35 %**
*Overcommitment (plan less forecast, Pre-IFRIC)	(22.2)			
Adjustment for IFRIC	(10.4)			
Total overcommitment (per plan)	**(32.5)**			

CASHFLOW & BALANCE SHEET

Cashflow

Jul-22

£millions	Actual Apr	Actual May	Forecast Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Outturn
Opening cash at bank	**86.7**	**123.4**	**143.0**	**110.0**	**100.0**	**90.0**	**80.0**	**70.0**	**70.0**	**50.0**	**50.0**	**50.0**	**86.7**
Cash inflows													
Healthcare contracts	161.5	156.5	127.7	127.7	127.7	137.8	127.7	127.7	128.1	127.7	137.7	135.5	1,623.3
Other income	23.5	37.0	24.8	34.0	29.2	31.6	34.3	40.6	29.8	34.2	28.7	46.7	394.4
Financing - Capital Loans / PDC	-	-	-	-	-	10.4	-	-	10.8	-	-	8.5	29.8
Total cash inflows	**185.0**	**193.5**	**152.5**	**161.7**	**156.9**	**179.8**	**162.0**	**168.3**	**168.7**	**161.9**	**166.4**	**190.7**	**2,047.5**
Cash outflows													
Salaries and wages	(55.7)	(54.8)	(56.0)	(54.1)	(54.8)	(56.0)	(54.1)	(56.7)	(54.1)	(54.1)	(56.7)	(54.1)	(661.2)
Tax, NI and pensions	(18.3)	(42.9)	(40.9)	(40.9)	(40.9)	(40.9)	(40.9)	(40.9)	(40.9)	(40.9)	(40.9)	(40.9)	(470.2)
Non pay expenditures	(67.4)	(73.0)	(79.6)	(69.6)	(62.2)	(82.8)	(69.8)	(63.9)	(87.3)	(62.9)	(64.0)	(72.3)	(854.8)
Capital expenditure	(6.9)	(3.2)	(9.0)	(7.1)	(9.0)	(4.8)	(7.2)	(6.8)	(6.5)	(4.0)	(4.8)	(8.1)	(77.4)
Dividend and Interest payable	-	-	-	-	-	(5.3)	-	-	-	-	-	(5.3)	(10.6)
Total cash outflows	**(148.3)**	**(173.9)**	**(185.5)**	**(171.7)**	**(166.9)**	**(189.8)**	**(172.0)**	**(168.3)**	**(188.8)**	**(161.9)**	**(166.4)**	**(180.7)**	**(2,074.2)**
Net cash inflows / (outflows)	**36.7**	**19.6**	**(33.0)**	**(10.0)**	**(10.0)**	**(10.0)**	**(10.0)**	**-**	**(20.1)**	**-**	**-**	**10.0**	**(26.7)**
Closing cash at bank - actual / forecast	**123.4**	**143.0**	**110.0**	**100.0**	**90.0**	**80.0**	**70.0**	**70.0**	**50.0**	**50.0**	**50.0**	**60.0**	**60.0**
Closing cash at bank - plan	**123.4**	**143.0**	**110.0**	**100.0**	**90.0**	**80.0**	**70.0**	**70.0**	**50.0**	**50.0**	**50.0**	**60.0**	**60.0**



Key Messages

Cash balances are higher in line with the plan because of higher closing cash balance of £86.7m in March 2022 and other movements in working capital.

CASHFLOW & BALANCE SHEET

Statement of Financial Position

Jul-22

21/22		Actual		Forecast										
31 Mar 2022	£millions	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	21/22 v 22/23
	Non-current assets:													
1,430.8	Property, plant and equipment	1,427.8	1,467.3	1,468.3	1,471.1	1,474.5	1,481.6	1,485.1	1,490.2	1,493.1	1,494.5	1,495.1	1,496.2	65.4
0.2	Intangible assets	0.2	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	(0.1)
15.1	Trade and other receivables	15.1	17.3	17.3	17.3	17.3	17.2	17.2	17.2	17.2	17.1	17.1	17.1	2.0
1,446.1	**Total non-current assets**	**1,443.1**	**1,484.8**	**1,485.8**	**1,488.6**	**1,491.9**	**1,498.9**	**1,502.4**	**1,507.5**	**1,510.4**	**1,511.7**	**1,512.3**	**1,513.3**	**67.3**
	Current assets:													
24.3	Inventories	26.2	25.7	24.0	24.0	24.0	24.0	24.0	24.0	24.0	24.0	24.0	24.0	(0.3)
127.6	Trade and other receivables	99.2	74.4	93.9	100.9	78.7	108.4	96.0	98.0	98.3	95.3	91.6	119.5	(8.1)
86.7	Cash and cash equivalents	123.4	143.0	110.0	100.0	90.0	80.0	70.0	70.0	50.0	50.0	50.0	60.0	(26.7)
238.6	**Total current assets**	**248.8**	**243.1**	**227.9**	**224.9**	**192.7**	**212.4**	**190.0**	**192.0**	**172.3**	**169.3**	**165.6**	**203.5**	**(35.1)**
1,684.7	**Total assets**	**1,691.9**	**1,727.9**	**1,713.7**	**1,713.5**	**1,684.6**	**1,711.3**	**1,692.4**	**1,699.5**	**1,682.7**	**1,681.0**	**1,677.9**	**1,716.8**	**32.2**
	Current liabilities													
(238.9)	Trade and other payables	(254.1)	(256.2)	(225.8)	(224.5)	(194.7)	(202.1)	(210.4)	(216.8)	(177.6)	(186.3)	(182.8)	(206.0)	32.9
(18.7)	Provisions	(18.7)	(18.7)	(20.3)	(20.3)	(20.3)	(20.3)	(2.8)	(2.8)	(2.8)	(2.8)	(2.8)	(2.8)	15.9
(27.1)	Liabilities arising from PFIs / Finance Leases	(27.1)	(36.8)	(36.8)	(36.8)	(36.8)	(36.8)	(36.8)	(36.8)	(36.8)	(36.8)	(36.8)	(36.4)	(9.3)
0.0	DH Revenue Support Loan (Including RWCSF)	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	DH Capital Investment Loan	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
(284.7)	**Total current liabilities**	**(299.9)**	**(311.7)**	**(282.9)**	**(281.6)**	**(251.8)**	**(259.2)**	**(250.0)**	**(256.4)**	**(217.2)**	**(225.9)**	**(222.4)**	**(245.2)**	**39.5**
(46.1)	**Net current (liabilities) / assets**	**(51.1)**	**(68.6)**	**(55.0)**	**(56.7)**	**(59.1)**	**(46.8)**	**(60.0)**	**(64.4)**	**(44.9)**	**(56.6)**	**(56.8)**	**(41.7)**	**4.4**
1,400.0	**Total assets less current liabilities**	**1,392.0**	**1,416.2**	**1,430.8**	**1,431.9**	**1,432.8**	**1,452.1**	**1,442.4**	**1,443.1**	**1,465.5**	**1,455.1**	**1,455.5**	**1,471.6**	**71.7**
	Non-current liabilities													
(6.0)	Provisions	(5.9)	(6.0)	(5.7)	(5.7)	(5.7)	(5.7)	(5.7)	(5.7)	(5.7)	(5.7)	(5.7)	(5.7)	0.3
(917.6)	Liabilities arising from PFIs / Finance Leases	(915.9)	(945.3)	(940.3)	(940.3)	(940.3)	(931.1)	(931.1)	(931.1)	(921.9)	(921.9)	(921.9)	(913.1)	4.5
(0.5)	Other Payables	(0.3)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	0.0
0.0	DH Revenue Support Loan (Including RWCF)	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	DH Capital Investment Loan	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
(924.1)	**Total non-current liabilities**	**(922.1)**	**(951.8)**	**(946.5)**	**(946.5)**	**(946.5)**	**(937.3)**	**(937.3)**	**(937.3)**	**(928.1)**	**(928.1)**	**(928.1)**	**(919.2)**	**4.8**
475.9	**Total Assets Employed**	**469.9**	**464.4**	**484.3**	**485.4**	**486.3**	**514.8**	**505.1**	**505.8**	**537.4**	**527.0**	**527.4**	**552.4**	**76.5**
	Financed by:													
	Taxpayers' equity													
1,048.3	Public dividend capital	1,048.3	1,048.3	1,055.6	1,055.6	1,055.6	1,083.2	1,072.7	1,072.7	1,093.1	1,093.1	1,093.1	1,117.8	69.5
(874.3)	Retained earnings	(880.3)	(885.8)	(873.2)	(872.1)	(871.2)	(870.3)	(869.5)	(868.8)	(857.6)	(868.0)	(867.6)	(867.3)	7.0
301.9	Revaluation reserve	301.9	301.9	301.9	301.9	301.9	301.9	301.9	301.9	301.9	301.9	301.9	301.9	0.0
475.9	**Total Taxpayers' Equity**	**469.9**	**464.4**	**484.3**	**485.4**	**486.3**	**514.8**	**505.1**	**505.8**	**537.4**	**527.0**	**527.4**	**552.4**	**76.5**

NHS
Barts Health
NHS Trust

People Report

WELL LED

People Executive Summary

Jul-22

Looking After the Trust's People

- **Annualised sickness absence rates** has continued to increase to 5.15% (from 5.05%). In month sick absence for April 22 was at 4.96%, down form the 5.41% in March 22 but notably higher than the same period in 2021 (3.69%). Whilst some of this difference year on year is directly linked to COVID (with covid sick absence at 0.9% in April compared to 0.4% in April 2021). The underlying annualised rate excluding COVID is 4.28%, higher than the c.3.70% we were consistently reporting pre-pandemic. It is difficult at this stage to predict what will happen with the annualised rate moving forward, however without any significant surge in COVID cases and assuming no notable interventions to reduce underlying absence we would be looking at an annualised rate of between 4.5% to 4.7%.

- **Appraisal rates** – recorded non-medical appraisals now stand at 55.0%, down from the 56.4% reported for Apr-22; This is one of two indicators affected by the TUPE of colleagues into the Pathology Partnership 12 months ago (the other being turnover). Across our 4 main hospital sites and GSS there has been a marginal improvement, although this varies by site. The medical appraisal rate remains high at 92.0%.

Growing the Workforce – Recruitment, Temporary Staffing and Turnover

- **Recruitment** –430 unconditional offers were made, up from 375 in April 22. Of these 156 were for nursing and midwifery roles, including HCAs. In addition, 1,447 Whole Time Equivalent (WTE) roles were advertised.

- The Trust's substantive staff fill rate was at 90.3%, up from 90.1%. This is driven by a reduction an increase in staff in post of 40 WTE with small increases seen across most staff groups.

- The registered nursing fill rate is currently 83.2% the same as in April, although we currently employ 80 WTE overseas nurses who are working as HCAs awaiting their NMC registration and as such are not reflected in this figure.

- **Turnover** – annualised voluntary turnover has remained at 13.3% this month. This is largely a result of how this metric is calculated and the impact of the TUPE into the Pathology Partnership 12 months ago and we expect the rate to increase next month. Across the group we are seeing continued increases at Whipps, St Barts, Royal London and GSS, but a small decrease at Newham. Assuming no notable increase in the rate of leavers then we would expect turnover to stabilise around 14% in the next couple of months, however this remains hard to judge given the external impact of the cost of living and the ongoing pressures related to COVID.

- **Temporary staffing** – temporary staffing usage increased by 66 WTE compared to April, with an increase of 11 WTE agency and 55 WTE bank. The proportion of temporary staff as part of the workforce rose from to 13.8% to 14.1% whilst spend on temporary staff as a proportion of pay budget slightly increased from 16.1% to 16.2%.

- In month spend on agency for May was £4.6m and for bank was £11.3m

WELL LED

Domain Scorecard

Jul-22

Barts Health

Group	Indicator	Targets	Performance		YTD	May-22 (Site)			
		Target	Apr-22	May-22		Royal London	Whipps Cross	Newham	St Bart's
Planned vs Actual WTE	% Utilisation (Total Fill Rate)	<=100%	100.3%	100.8%	-	102.8%	102.2%	102.0%	100.7%
	Staff in Post - Actual	>=Plan	16,674	16,713		6,218	2,868	2,054	2,680
	Staff in Post - Plan	-	16,638	16,727	-	6,197	2,940	2,088	2,667
	Bank WTE - Actual	<=Plan	1,982	2,037		708	476	375	302
	Bank WTE - Plan	-	1,985	1,968	-	840	359	312	277
	Agency WTE - Actual	<=Plan	695	706		190	230	164	77
	Agency WTE - Plan	-	623	604	-	200	167	108	46
	Total Staffing - Actual	<=Plan	19,351	19,456	-	7,116	3,574	2,592	3,058
	Total Staffing - Plan	-	19,246	19,299	-	7,237	3,466	2,507	2,990
Recruitment Plans	Substantive Fill Rate - Actual	<=Plan	90.1%	90.3%	-	93.8%	85.8%	84.7%	91.5%
	Substantive Fill Rate - Plan	-	90.1%	90.6%	-	91.9%	89.8%	88.1%	92.1%
	Unconditional Offers - Actual	>=Plan	366	430	796	152	60	62	76
	Unconditional Offers - Plan	-	375	358	733	153	61	30	70
Rosters	Roster Compliance - % Approved on Time (>20 WTEs)	>=100%	22.9%	28.7%	-	13.5%	59.3%	10.5%	33.3%
Diversity	% of BME Staff at Band 8a to VSM	-	37.0%	37.0%		33%	43%	55%	24%

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

WELL LED

Domain Scorecard

Jul-22

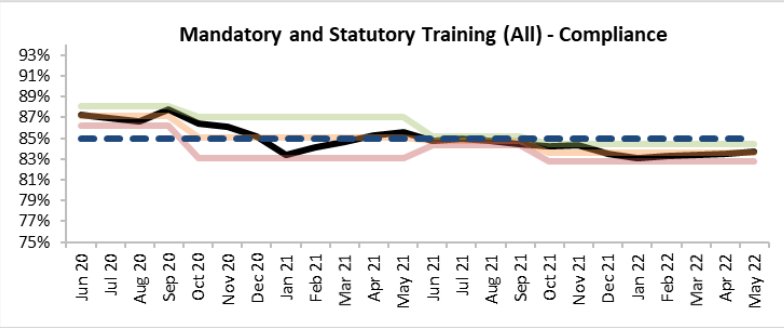
	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Site Comparison: Whipps Cross	Site Comparison: Newham	Site Comparison: St Bart's	Site Comparison: Other	Excep.
People	W19	Turnover Rate	●			May-22 (m)	<= 12.25%	13.30%	**13.31%**	***13.31%***	14.33%	12.76%	10.99%	13.76%	12.62%	
	OH7	Proportion of Temporary Staff	●			May-22 (m)	<= 11.3%	13.8%	**14.1%**	***14.0%***	12.6%	19.7%	20.8%	12.4%	7.0%	
	W20	Sickness Absence Rate	●			Apr-22 (m)	<= 3%	5.05%	**5.15%**	***5.15%***	5.26%	5.45%	5.67%	4.28%	5.09%	
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%	73.1%	
	OH6	NHS Staff Survey	●			2020/21 (y)	>= 7	7.0	**6.9**	***6.9***	7.0	6.8	6.9	7.1	7.0	
Compliance	W50	Mandatory and Statutory Training - All	●			May-22 (m)	>= 85%	83.5%	**83.7%**	***83.6%***	83.0%	86.6%	80.8%	86.1%	81.6%	●
	W11	Mandatory and Statutory Training - National	●			May-22 (m)	>= 85%	82.5%	**82.9%**	***82.7%***	81.6%	86.0%	82.1%	84.5%	81.1%	●
	W29	Appraisal Rate - Non-Medical Staff	●			May-22 (m)	>= 90%	-	**57.1%**	***57.1%***	53.7%	51.0%	51.5%	73.7%	57.1%	●
	W30	Appraisal Rate - Medical Staff	●			May-22 (m)	>= 85%	-	**92.0%**	***92.0%***	89.4%	95.1%	93.7%	94.5%	-	

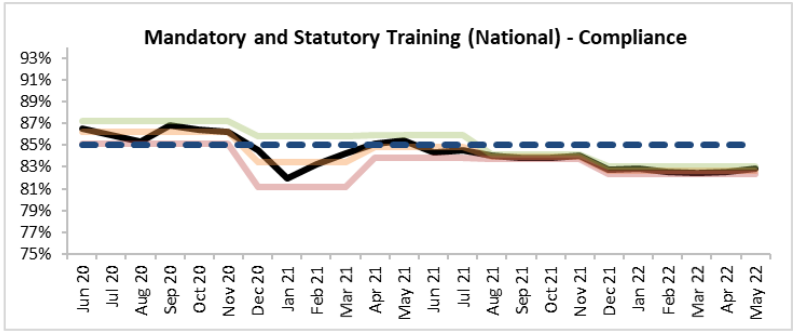
Staff Friends and Family Test (FFT): 2019/20 Q4 performance from the last national submission before the temporary suspension of national reporting is the latest included in the report

WELL LED

Mandatory and Statutory Training

Jul-22





Bottom 5 Departments: Total Number of Non-Compliant Employees			
Department	Previous 6 Months	May-22	
	Compliance	Compliance	Staff Non-Compliant
WXH Core Services	76.2%	71.5%	36
Anaesthetics-Med Staffing	80.9%	82.6%	29
A & E - Medical Staff	72.2%	74.2%	25
Cedar Ward (Surgical) WXH	81.3%	81.4%	25
GEN SURG - Medical Staff	69.5%	67.2%	21

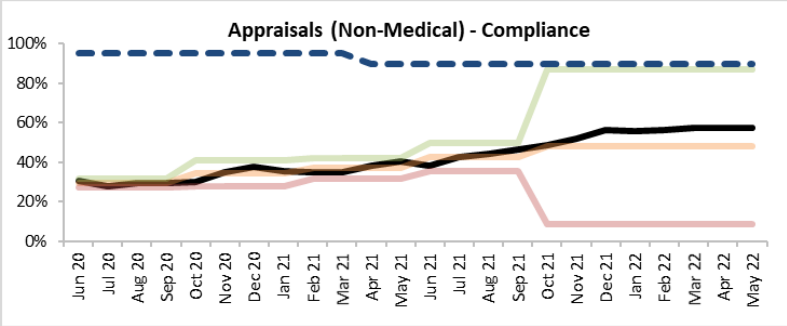
Non-mandatory competencies have been excluded from the above tables

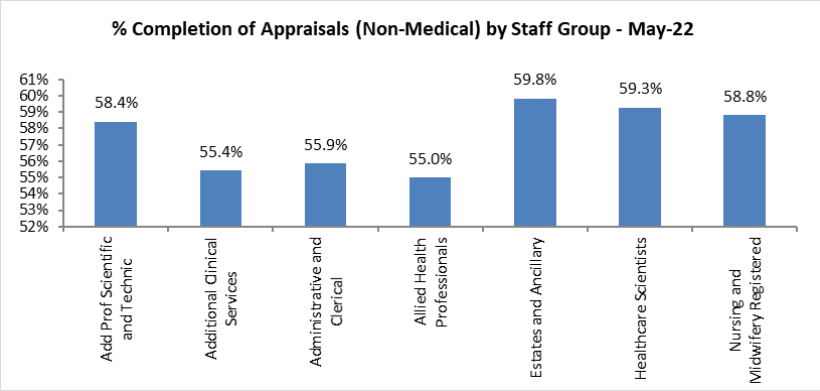
Performance Overview	Responsible Director Update

WELL LED

Appraisal Rate - Non-Medical Staff

Jul-22





Performance Overview	Responsible Director Update

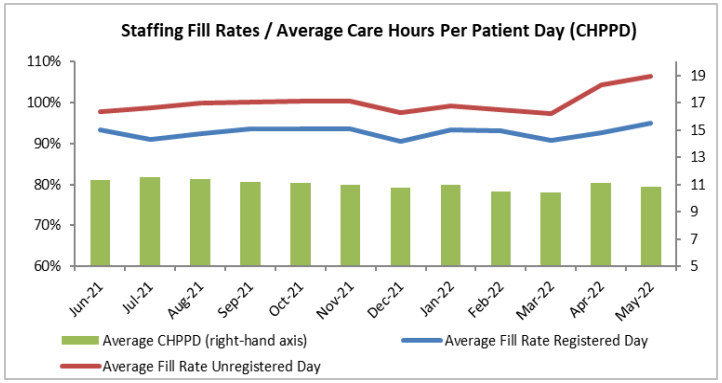
• Recorded non-medical appraisals now stand at 55.0%, down from the 56.4% reported for Apr-22; This is one of two indicators affected by the TUPE of colleagues into the Pathology Partnership 12 months ago (the other being turnover).
 	
• Across our 4 main hospital sites and GSS there has been a marginal improvement, although this varies by site as below
  • St Bartholomew's – 68.6%
  • Group Support Services – 57.0%
  • Whipps Cross – 54.5%
  • Royal London – 53.6%
  • Newham – 50.6%
	• Appraisal rates have plateaued since December, and whilst some of this will be due to the impact of the COVID wave in early 2022 we have not seen the improvements we had hoped to see at this time.
	• The hospital sites are aiming to deliver the following rates by the end of June
	  • St Bartholomew's – 73%
	  • Whipps Cross – 65%
	  • Royal London – 66%
	  • Newham – 76%

SAFE STAFFING

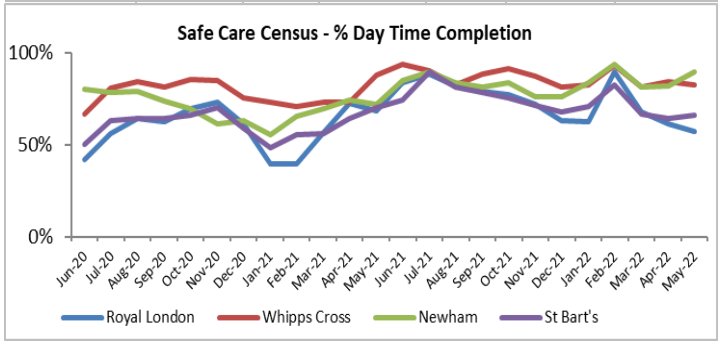
Safe Staffing

Jul-22

- Trust wide, the average fill rates remained above 90% on both day and night shifts for registered Nursing and Midwifery (RNs/RMs) and Care Staff (HCAs).
- A slight decrease was noted with the overall Care Hours Per Patient Day (CHPPD). The variance for CHPPD from April to May was 11.1 decreasing to 10.8 respectively.
- Staffing was reviewed daily. Areas that had poor staffing levels and gaps were mitigated by redeployment of staff between wards including having Senior staff work clinically to maintain services and patient safety. Shifts were reviewed and any shortages were acted upon and plans put in place to ensure patient safety was maintained.
- St Bart's average fill rates for RNs improved to 89.2% from the level of circa 80% usually reported for day shifts whilst the average fill rate for nights was >90% for both RNs and HCAs. This was an increase from the previous months. Staffing was aligned with actual demand when some areas were closed. The senior nursing team is always working closely with critical care to maintain safe nurse patient ratios. Where required, redeployment of staff to meet patients' needs was performed.
- The Women's services continue to be under pressure requiring consolidated support and flexing of some units. Low fill rates were as a result of sickness and vacancies; recruitment into the vacancies continues to ensure sustainable staffing and prevent staff burnout and stress. RLH has a Quality Improvement project for managing sickness to facilitate return to work for staff. Senior midwifery staff supported delivery of frontline care, resulting in nil adverse clinical events being reported as a result of staffing gaps.
- The total number of Red flag incidents reported across the Trust was 38. Whilst NUH had 30 reported and RLH had 8, none of the incidents caused harm to patients. Incidents were linked with by staffing levels being below 80% of plan on specific occasions, additional duties and RMN requests remaining unfilled on some occasions. The significant increase in NUH Red Flags is due to improvement activity to drive vigilance with reporting.
- Recruitment activities continue across the Trust for both domestic and internationally educated nurses. We are targeting healthcare support workers including those new to care.
- Safe staffing continues to be monitored and addressed daily through hospital site based safety huddles. Use of the Safe Care Live electronic workforce tool together with professional judgement by the senior nursing teams facilitates dynamic staff redeployment to maximise patient safety and effective us of resources.
- Safe Care Live remains at 71.5% compliance. Targeted education sessions for SafeCare, SNCT and Red Flags are being delivered by the Safe Staffing as part of preparations for the 4- week Safer Nursing Care Tool acuity-dependency deep dive scheduled for July 2023. ED SNCT is being implemented in June.



	Staffing Figures by Site - May-22					
	Average Fill Rate (Day)		Average Fill Rate (Night)		Average Care Hours Per Patient Day (CHPPD)	Safe Staffing Red Flag Incidents
Site	Registered Nurses / Midwives (%)	Care Staff (%)	Registered Nurses / Midwives (%)	Care Staff (%)		
Trust	**94.9%**	**106.5%**	**101.7%**	**122.9%**	**10.8**	**TBC**
Royal London	97.9%	101.4%	104.9%	129.2%	10.4	TBC
Whipps Cross	94.7%	120.6%	104.1%	127.4%	10.5	TBC
Newham	95.1%	102.0%	104.7%	110.8%	10.6	TBC
St Bart's	89.2%	92.9%	90.4%	114.4%	12.9	TBC



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Glossary

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Domain Scorecard Glossary

Jul-22

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 6 weeks or less 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

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Domain Scorecard Glossary

Jul-22

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	National average
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

Jul-22

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

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Domain Scorecard Glossary

Jul-22

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 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

GLOSSARY

Workforce Summary Glossary

Jul-22

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	

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Appendix

APPENDIX

Interpretation of Scorecards

Jul-22

How to Interpret the Scorecard

	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Newham	St Bart's	CSS	Other	Barts Health	Excep.
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)

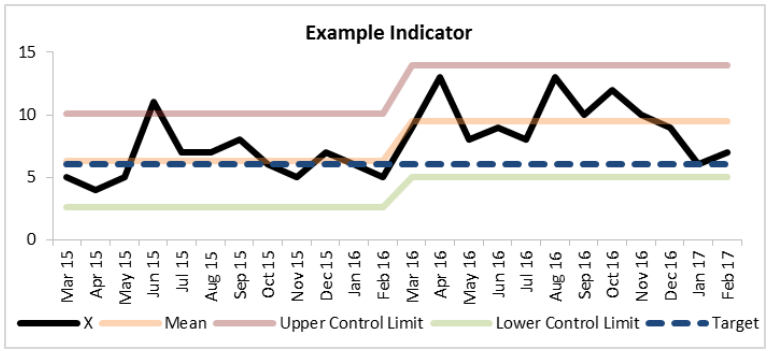
Reporting month target for reporting site

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.

APPENDIX

Safe Staffing Fill Rates by Ward and Site

Jul-22

		Registered midwives / nurses (day)		Care Staff (day)		Registered midwives / nurses (night)		Care Staff (night)		Day		Night		Care Hours Per Patient Day (CHPPD)			
Site	Ward name	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	2,103.2	1,941.5	1,064.0	874.0	1,782.5	2,047.0	713.0	713.0	92.3%	82.1%	114.8%	100.0%	720	5.5	2.2	7.7
Royal London	10F RLH	1,116.0	1,320.0	744.0	744.0	1,023.0	1,287.0	682.0	594.0	118.3%	100.0%	125.8%	87.1%	492	5.3	2.7	8.0
Royal London	11C RLH	2,449.5	2,084.5	1,418.0	1,605.0	2,495.5	2,863.5	713.0	1,092.5	85.1%	113.2%	114.7%	153.2%	684	7.2	3.9	11.2
Royal London	11E & 11F AAU	3,910.5	4,039.5	1,776.0	1,854.0	3,933.0	4,289.5	1,437.5	1,771.0	103.3%	104.4%	109.1%	123.2%	1,458	5.7	2.5	8.2
Royal London	12C RLH	1,872.0	2,029.8	1,425.0	1,358.0	1,840.0	2,012.3	1,070.5	1,081.1	108.4%	95.3%	109.4%	101.0%	765	5.3	3.2	8.5
Royal London	12D RLH	1,424.0	2,490.8	709.0	759.0	1,426.0	2,686.5	356.5	747.5	174.9%	107.1%	188.4%	209.7%	497	10.4	3.0	13.4
Royal London	12E RLH	2,778.5	2,665.5	1,426.0	1,674.2	2,495.5	2,509.3	1,426.0	1,702.5	95.9%	117.4%	100.6%	119.4%	685	7.6	4.9	12.5
Royal London	12F RLH	2,026.5	2,192.5	1,775.5	1,780.5	1,782.5	2,242.5	1,782.5	2,208.0	108.2%	100.3%	125.8%	123.9%	813	5.5	4.9	10.4
Royal London	13C RLH	1,933.0	2,691.0	711.0	853.0	1,414.5	2,499.5	713.0	954.5	139.2%	120.0%	176.7%	133.9%	795	6.5	2.3	8.8
Royal London	13D RLH	1,780.5	1,955.0	713.0	1,138.5	1,426.0	1,645.5	713.0	1,699.5	109.8%	159.7%	115.4%	238.4%	743	4.8	3.8	8.7
Royal London	13E RLH	2,033.5	2,288.0	713.0	667.0	1,679.0	2,118.0	724.5	954.5	112.5%	93.5%	126.1%	131.7%	687	6.4	2.4	8.8
Royal London	13F RLH	1,770.5	1,983.3	966.0	990.0	1,782.5	2,104.5	713.0	989.0	112.0%	102.5%	118.1%	138.7%	635	6.4	3.1	9.6
Royal London	14E RLH	1,690.5	1,794.5	1,081.0	1,046.5	1,426.0	1,575.5	1,069.5	1,219.0	106.2%	96.8%	110.5%	114.0%	778	4.3	2.9	7.2
Royal London	14F RLH	1,844.0	1,735.0	1,414.5	1,211.0	1,426.0	1,357.0	1,081.0	1,265.0	94.1%	85.6%	95.2%	117.0%	710	4.4	3.5	7.8
Royal London	3D RLH	3,195.5	2,979.3	2,150.5	1,808.5	3,208.5	3,381.0	1,782.5	2,116.0	93.2%	84.1%	105.4%	118.7%	1,000	6.4	3.9	10.3
Royal London	3E RLH	2,136.5	1,978.0	713.0	971.0	1,782.5	2,150.5	713.0	782.0	92.6%	136.2%	120.6%	109.7%	780	5.3	2.2	7.5
Royal London	3F RLH	1,572.9	1,429.5	1,069.5	839.5	1,069.5	1,610.0	713.0	632.5	90.9%	78.5%	150.5%	88.7%	268	11.3	5.5	16.8
Royal London	4E RLH	14,965.0	15,133.6	736.0	1,846.5	15,318.0	15,177.7	379.5	1,747.0	101.1%	250.9%	99.1%	460.3%	1,256	24.1	2.9	27.0
Royal London	6C RLH	3,645.5	2,967.8	356.5	471.5	3,553.3	2,834.0	356.5	494.5	81.4%	132.3%	79.8%	138.7%	218	26.6	4.4	31.0
Royal London	6E & 6F RLH	5,281.0	4,694.5	1,418.0	1,061.3	5,336.0	5,097.7	1,069.5	941.0	88.9%	74.8%	95.5%	88.0%	895	10.9	2.2	13.2
Royal London	7C RLH	1,426.0	1,333.5	356.5	586.5	1,069.5	1,035.0	356.5	759.0	93.5%	164.5%	96.8%	212.9%	381	6.2	3.5	9.7
Royal London	7D RLH	1,782.5	1,714.5	878.0	794.0	1,426.0	1,518.0	724.5	897.0	96.2%	90.4%	106.5%	123.8%	461	7.0	3.7	10.7
Royal London	7E RLH	2,852.0	2,461.0	1,069.5	948.8	2,495.5	2,346.0	1,069.5	1,018.0	86.3%	88.7%	94.0%	95.2%	635	7.6	3.1	10.7
Royal London	7F RLH	1,426.0	1,361.0	609.5	759.0	1,069.5	1,046.5	563.5	784.3	95.4%	124.5%	97.8%	139.2%	360	6.7	4.3	11.0
Royal London	8C RLH	1,670.5	1,801.8	713.0	830.5	1,426.0	1,713.5	713.0	1,012.0	107.9%	116.5%	120.2%	141.9%	564	6.2	3.3	9.5
Royal London	8D RLH	8,184.0	7,012.5	1,265.0	897.0	7,838.5	6,608.0	552.0	437.0	85.7%	70.9%	84.3%	79.2%	1,089	12.5	1.2	13.7
Royal London	8F RLH	1,483.0	1,250.0	1,782.5	1,502.0	1,069.5	1,000.5	1,069.5	1,069.5	84.3%	84.3%	93.5%	100.0%	1,482	1.5	1.7	3.3
Royal London	9E HDU RLH	1,421.5	1,000.5	356.5	138.0	1,426.0	1,049.8	0.0	264.5	70.4%	38.7%	73.6%	100.0%	291	7.0	1.4	8.4
Royal London	9E RLH	1,782.5	1,702.0	713.0	598.0	1,426.0	1,460.5	356.5	736.0	95.5%	83.9%	102.4%	206.5%	757	4.2	1.8	5.9
Royal London	9F RLH	1,782.5	1,558.5	713.0	670.0	1,424.5	1,368.5	713.0	759.5	87.4%	94.0%	96.1%	106.5%	722	4.1	2.0	6.0

APPENDIX

Safe Staffing Fill Rates by Ward and Site

Jul-22

		Registered midwives / nurses (day)		Care Staff (day)		Registered midwives / nurses (night)		Care Staff (night)		Day		Night		Care Hours Per Patient Day (CHPPD)			
Site	Ward name	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	4,624.5	5,426.0	2,495.5	2,644.7	4,634.5	5,772.0	2,139.0	2,310.5	117.3%	106.0%	124.5%	108.0%	1,177	9.5	4.2	13.7
Whipps Cross	ACACIA	966.0	859.8	460.0	626.0	713.0	723.5	713.0	911.0	89.0%	136.1%	101.5%	127.8%	337	4.7	4.6	9.3
Whipps Cross	ACORN	3,676.3	2,315.8	356.5	543.5	2,729.0	2,298.3	356.5	149.8	63.0%	152.5%	84.2%	42.0%	580	8.0	1.2	9.2
Whipps Cross	B3 WARD WXH	1,311.0	1,239.5	1,069.5	1,203.5	1,069.5	1,093.5	713.0	943.0	94.5%	112.5%	102.2%	132.3%	503	4.6	4.3	8.9
Whipps Cross	BIRCH	1,069.5	1,092.5	1,069.5	1,276.5	1,069.5	1,059.0	713.0	929.8	102.2%	119.4%	99.0%	130.4%	530	4.1	4.2	8.2
Whipps Cross	BLACKTHORN	1,069.5	1,207.5	1,069.5	1,391.5	1,069.5	1,058.0	713.0	1,012.0	112.9%	130.1%	98.9%	141.9%	539	4.2	4.5	8.7
Whipps Cross	Bracken Ward WXH	1,280.5	1,248.5	1,125.0	1,121.5	1,069.5	1,056.5	715.0	759.0	97.5%	99.7%	98.8%	106.2%	475	4.9	4.0	8.8
Whipps Cross	CEDAR	1,679.0	2,386.0	1,426.0	3,692.6	1,426.0	2,110.5	1,069.5	2,714.0	142.1%	258.9%	148.0%	253.8%	964	4.7	6.6	11.3
Whipps Cross	CHESTNUT	966.0	701.5	356.5	908.5	713.0	943.0	356.5	828.0	72.6%	254.8%	132.3%	232.3%	288	5.7	6.0	11.7
Whipps Cross	CURIE	1,419.0	1,256.0	1,069.3	1,207.3	1,426.0	1,129.0	1,069.5	1,150.0	88.5%	112.9%	79.2%	107.5%	535	4.5	4.4	8.9
Whipps Cross	DELIVERY SUITE WXH	4,874.8	3,844.7	710.0	815.0	3,548.0	2,780.6	713.0	989.7	78.9%	114.8%	78.4%	138.8%	456	14.5	4.0	18.5
Whipps Cross	ELIZABETH	1,679.0	1,659.0	609.5	524.5	1,426.0	1,427.0	207.0	355.3	98.8%	86.1%	100.1%	171.7%	535	5.8	1.6	7.4
Whipps Cross	FARADAY	1,782.5	1,532.3	713.0	995.0	1,667.5	1,747.0	356.5	642.5	86.0%	139.6%	104.8%	180.2%	472	6.9	3.5	10.4
Whipps Cross	Frail Elderly WXH	855.5	786.0	356.5	689.1	713.0	703.0	356.5	711.5	91.9%	193.3%	98.6%	199.6%	289	5.2	4.8	10.0
Whipps Cross	ICU WXH	6,060.0	5,513.5	1,869.0	1,236.0	5,115.0	5,017.2	1,364.0	790.0	91.0%	66.1%	98.1%	57.9%	287	36.7	7.1	43.8
Whipps Cross	MARGARET	1,069.5	901.0	356.5	619.2	713.0	713.5	356.5	655.5	84.2%	173.7%	100.1%	183.9%	268	6.0	4.8	10.8
Whipps Cross	MIDWIFERY WXH	767.0	688.8	359.5	227.5	713.0	440.4	356.5	327.0	89.8%	63.3%	61.8%	91.7%	53	21.3	10.5	31.8
Whipps Cross	MULBERRY	2,195.0	1,942.5	1,429.0	986.5	1,426.0	1,370.5	839.5	828.5	88.5%	69.0%	96.1%	98.7%	986	3.4	1.8	5.2
Whipps Cross	NEONATAL WXH	2,419.5	2,295.5	1,138.5	620.5	2,119.5	2,188.0	724.5	333.5	94.9%	54.5%	103.2%	46.0%	437	10.3	2.2	12.4
Whipps Cross	NIGHTINGALE	1,775.5	1,553.5	356.5	581.5	1,679.0	1,592.0	356.5	401.0	87.5%	163.1%	94.8%	112.5%	380	8.3	2.6	10.9
Whipps Cross	PEACE	1,676.5	1,767.5	816.5	1,384.0	1,058.0	1,417.5	713.0	1,296.8	105.4%	169.5%	134.0%	181.9%	419	7.6	6.4	14.0
Whipps Cross	POPLAR	1,755.0	1,410.0	1,069.5	1,114.2	1,426.0	1,174.0	1,069.5	874.0	80.3%	104.2%	82.3%	81.7%	477	5.4	4.2	9.6
Whipps Cross	PRIMROSE	1,782.5	2,046.0	1,426.0	1,713.5	1,426.0	1,989.5	1,069.5	1,495.0	114.8%	120.2%	139.5%	139.8%	780	5.2	4.1	9.3
Whipps Cross	ROWAN	1,771.0	2,061.0	1,380.0	1,851.5	1,414.5	2,048.0	1,069.5	1,633.0	116.4%	134.2%	144.8%	152.7%	792	5.2	4.4	9.6
Whipps Cross	SAGE	1,679.0	1,533.0	1,433.5	1,874.7	1,437.5	1,415.5	1,069.5	1,449.0	91.3%	130.8%	98.5%	135.5%	821	3.6	4.0	7.6
Whipps Cross	SYCAMORE	1,311.0	1,449.0	1,322.5	1,656.0	1,069.5	1,403.0	1,069.5	1,173.0	110.5%	125.2%	131.2%	109.7%	778	3.7	3.6	7.3
Whipps Cross	SYRINGA	1,426.0	1,426.0	1,782.5	1,805.5	1,069.5	1,069.5	1,069.5	1,495.0	100.0%	101.3%	100.0%	139.8%	777	3.2	4.2	7.5

APPENDIX

Safe Staffing Fill Rates by Ward and Site

Jul-22

		Registered midwives / nurses (day)		Care Staff (day)		Registered midwives / nurses (night)		Care Staff (night)		Day		Night		Care Hours Per Patient Day (CHPPD)			
Site	Ward name	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	4,338.0	4,500.8	2,492.0	2,276.0	3,921.5	4,657.5	2,495.5	2,553.0	103.8%	91.3%	118.8%	102.3%	1,470	6.2	3.3	9.5
Newham	Custom House NUH	1,426.0	1,570.3	1,069.5	1,549.0	1,069.5	1,454.0	1,426.0	1,725.0	110.1%	144.8%	136.0%	121.0%	574	5.3	5.7	11.0
Newham	DELIVERY SUITE NUH	5,516.0	5,048.0	870.5	678.5	4,876.0	4,266.5	713.0	690.0	91.5%	77.9%	87.5%	96.8%	662	14.1	2.1	16.1
Newham	EAST HAM	1,782.5	1,633.0	1,069.5	1,069.5	1,426.0	1,404.5	1,069.5	1,219.0	91.6%	100.0%	98.5%	114.0%	606	5.0	3.8	8.8
Newham	HEATHER	2,139.0	2,334.5	1,069.5	1,511.0	2,137.5	2,541.5	1,069.5	1,644.5	109.1%	141.3%	118.9%	153.8%	788	6.2	4.0	10.2
Newham	LARCH	3,060.0	2,465.0	1,973.0	1,854.0	2,150.5	2,011.7	1,782.5	1,759.5	80.6%	94.0%	93.5%	98.7%	1,541	2.9	2.3	5.2
Newham	Manor Park ITU NUH	3,522.0	3,466.7	713.0	923.0	3,565.0	3,521.0	713.0	805.0	98.4%	129.5%	98.8%	112.9%	303	23.1	5.7	28.8
Newham	MAPLE	1,367.5	1,306.6	678.5	828.0	1,104.0	1,046.5	701.5	678.5	95.5%	122.0%	94.8%	96.7%	227	10.4	6.6	17.0
Newham	NEONATAL NUH	3,128.0	2,766.0	667.0	322.0	2,885.5	2,476.0	575.0	425.5	88.4%	48.3%	85.8%	74.0%	531	9.9	1.4	11.3
Newham	NUH MIDWIFERY	1,257.5	1,071.3	356.5	310.5	1,069.5	928.6	356.5	333.5	85.2%	87.1%	86.8%	93.5%	153	13.1	4.2	17.3
Newham	RAINBOW	2,810.5	2,542.5	1,138.5	1,207.5	1,782.5	1,863.5	356.5	644.0	90.5%	106.1%	104.5%	180.6%	343	12.8	5.4	18.2
Newham	SILVERTOWN	1,805.5	2,003.5	1,069.5	1,000.5	1,748.0	2,204.0	1,046.5	1,322.5	111.0%	93.5%	126.1%	126.4%	728	5.8	3.2	9.0
Newham	STRATFORD	1,426.0	1,437.5	1,069.5	1,058.0	1,426.0	1,712.0	1,069.5	1,084.5	100.8%	98.9%	120.1%	101.4%	511	6.2	4.2	10.4
Newham	WEST HAM	1,390.0	1,098.5	1,069.5	1,023.5	1,069.5	1,552.5	1,069.5	1,115.5	79.0%	95.7%	145.2%	104.3%	654	4.1	3.3	7.3
St Bart's	1C	6,019.0	5,390.3	356.5	583.0	5,704.0	5,246.0	195.5	540.5	89.6%	163.5%	92.0%	276.5%	394	27.0	2.9	29.8
St Bart's	1D	3,208.5	2,770.0	356.5	345.0	2,844.0	2,432.0	356.5	356.5	86.3%	96.8%	85.5%	100.0%	356	14.6	2.0	16.6
St Bart's	1E	4,979.5	4,348.5	350.0	310.5	4,991.0	4,117.0	356.5	322.0	87.3%	88.7%	82.5%	90.3%	234	36.2	2.7	38.9
St Bart's	3A SBH	4,594.5	4,342.5	1,408.5	1,273.9	4,623.0	4,441.0	1,426.0	1,322.5	94.5%	90.4%	96.1%	92.7%	772	11.4	3.4	14.7
St Bart's	3D SBH	1,564.0	1,587.0	1,162.0	1,044.2	1,518.0	1,510.5	966.0	945.0	101.5%	89.9%	99.5%	97.8%	485	6.4	4.1	10.5
St Bart's	4A SBH	1,766.5	1,829.8	951.5	950.3	1,426.0	1,390.8	356.5	712.8	103.6%	99.9%	97.5%	200.0%	694	4.6	2.4	7.0
St Bart's	4B SBH	1,568.5	1,492.0	1,216.5	1,127.0	1,426.0	1,426.0	713.0	990.0	95.1%	92.6%	100.0%	138.8%	589	5.0	3.6	8.5
St Bart's	4C SBH	1,759.5	1,633.0	945.0	862.5	1,426.0	1,253.5	966.0	920.0	92.8%	91.3%	87.9%	95.2%	509	5.7	3.5	9.2
St Bart's	4D & 4E SBH	1,748.5	1,392.2	686.0	621.0	1,633.0	1,336.0	713.0	713.0	79.6%	90.5%	81.8%	100.0%	356	7.7	3.7	11.4
St Bart's	5A SBH	2,130.3	2,036.8	895.0	1,114.5	1,397.0	1,368.5	341.0	781.0	95.6%	124.5%	98.0%	229.0%	630	5.4	3.0	8.4
St Bart's	5B SBH	1,394.0	1,292.0	689.5	575.0	1,414.5	1,444.0	356.5	344.5	92.7%	83.4%	102.1%	96.6%	438	6.2	2.1	8.3
St Bart's	5C SBH	2,036.0	1,756.2	677.5	570.8	1,782.5	1,777.8	356.5	471.5	86.3%	84.2%	99.7%	132.3%	537	6.6	1.9	8.5
St Bart's	5D SBH	2,019.0	1,641.5	665.5	444.5	1,782.5	1,613.5	713.0	632.5	81.3%	66.8%	90.5%	88.7%	548	5.9	2.0	7.9
St Bart's	6A SBH	6,381.0	5,420.8	353.5	471.5	6,404.5	5,559.5	356.5	425.5	85.0%	133.4%	86.8%	119.4%	320	34.3	2.8	37.1
St Bart's	6D SBH	1,769.5	1,357.0	1,065.5	645.0	1,426.0	1,069.5	713.0	692.0	76.7%	60.5%	75.0%	97.1%	517	4.7	2.6	7.3

NHS
Barts Health
NHS Trust

Report to the Trust Board: 6 July 2022	TB 45/22

Title	Audit and Risk Committee Exception Report
Chair	Ms Kim Kinnaird, Non Executive Director (Chair)
Author(s) / Secretary	Trust Secretary
Purpose	To advise the Trust Board on work of Trust Board Committees (detailed minutes are provided to Board members separately)

Executive summary

The audit and risk committee met on 15 June 2022 to discuss items on its agenda (drawn from its annual workplan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items	**BAF entries**
External Audit completion report and draft VfM conclusion	11
Internal Audit progress report on limited assurance reviews of appraisals, security and Soft FM	8, 4, 13
Internal Audit annual report and Head of Internal Audit opinion	All
QAC exception report	3-7, 14
Annual Report and Accounts, including Annual Governance Statement, management representations letter	11
Provider licence compliance	4
IG annual report and DPS toolkit	4, 12

Key areas of discussion arising from items appearing on the agenda

Annual Report and Accounts

Following on from a review of the draft accounts on 20 April 2022, the audit and risk committee reviewed and endorsed the Trust's statutory annual report and accounts (including annual governance statement) and the related management representations letter. The committee reviewed changes made to the accounts related to receipt of capital funding late in the year. The annual report and accounts were reviewed alongside External Audit's audit completion report and endorsed. The annual report and accounts were subsequently approved by the Trust Board (incorporating changes in line with ARC recommendations) on 20 June for submission to the Department of Health and Social Care. A final design version of the annual report and accounts will be published and presented for adoption at the Trust's AGM on 21 September 2022.

External Audit

The committee received the audit completion report confirming an unqualified opinion on the accounts and highlighted no material issues, misstatements or other major findings. The committee reviewed a draft value for money assessment which would feature in the auditors' annual report. The Committee noted feedback from auditors on the high quality of working papers and responsiveness of the finance team and the smooth process this year in completing the statutory reporting and audit processes.

Internal Audit reports The Committee received and noted the Head of Internal Audit opinion, recognising that this was consistent with the Annual Governance Statement and identified control issues. Audit reviews were received providing limited assurance on the following control areas: non-medical staff appraisals; security management; and Soft FM services. For the latter two areas the areas the committee noted that control issues related primarily to contract management rather than performance. A number of management actions and learning points would taken forward as part of the transition towards insourcing of a number of the related services. **Provider licence compliance** The Committee recommended to the Trust Board (which subsequently approved) an annual statement of compliance with relevant provider licence conditions GT4 and 6, except for one subsection. This statement reflected the improved compliance self-assessment on financial duties, while recognising some ongoing operational issues with meeting national standards on waiting lists. **Other items** The Committee agreed information governance annual report and data security and protection toolkit submission, noted a report on waivers and received a report on the Quality Assurance Committee's recent activity.
Any key actions agreed / decisions taken to be notified to the Board Endorsement of the annual report and accounts; and provider licence compliance statements (subsequently signed off by the Board on 20 June 2022).
Any issues for escalation to the Board Limited assurance reviews of non-medical staff appraisals; security management; and Soft FM services.

Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and Outcomes.

Action required by the Board The Trust Board is asked to note the Audit and Risk Committee exception report.

NHS
Barts Health
NHS Trust

Report to the Trust Board: 6 July 2022	TB 46/22

Title	Quality Assurance Committee Exception Report
Chair	Dr Kathy McLean, Non-Executive Director
Author / Secretary	Shalin Sharma, Deputy Trust Secretary
Purpose	To advise on work of Trust Board Committees

Executive summary

The Quality Assurance Committee (QAC) met on 15 June 2022 to discuss items on its agenda relevant to its terms of reference, including matters related to current operational pressures, patient safety/experience, children's services, a quality report from St Bartholomew's hospital, and reports on the status of internal audit actions and Board Assurance Framework (BAF) risks.

Key agenda items	BAF entries
• Operational Performance	All
• Children's Services	2
• Quality Dashboard	2
• Internal Audit Progress Report	11
• Education Report	2
• Ockenden Report Update	2
• Safeguarding Annual Report	2
• Complaints Annual Report	2
• Quality Improvement Report	2
• St. Bartholomew's Hospital Quality Report	2
• BAF Risks	All

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

- **Operational performance: urgent & emergency care (UEC) and planned care**
  The Committee discussed current operational performance including planned care and UEC system working. Assurance was received on progress being made against the 104 week wait standard, while noting the risks and challenges ahead. It was agreed that a substantive pre-winter focused report on UEC system working, demonstrating the links to mental health presence in the Emergency Departments, and including the planned system approach for winter, would be presented at the September QAC meeting and the subsequent Trust Board. The Committee also agreed plans for delivery against the 78 week wait standard and an update on radiographer recruitment would be presented at the next meeting.
- **Children's services**
  The Committee was assured the trust is working with system partners and recognised opportunities to build community capacity. It was agreed a focused improvement report on children's services would be reviewed by QAC twice a year, going forward.
- **Power Failure at The Royal London Hospital (RLH)**

The Committee received an update on the causes of the two recent power failures. The Terms of Reference for an investigation have been agreed and include whether any incidents of patient harm occurred. An update was requested to be presented to QAC.

- **Internal Audit**
  QAC received an update on internal audit activity and in particular actions being taken in response to a limited assurance report on clinical audit. Progress was noted in significantly reducing the backlog of overdue audit actions, with action taken to improve business as usual processes.
- **St. Bartholomew's Hospital (SBH) quality report**
  QAC received a summary of progress against the hospital's quality plans. The Committee thanked the outgoing Medical Director (MD) and welcomed the new MD, Dr Andrew Wragg.
- **Education Academy report**
  QAC noted the contents of the report and noted the concerns expressed around the upcoming challenges in regard to funding changes.
- **Maternity: Ockenden Report update**
  Further assurances were received by the Committee around the actions being taken and next steps relating to the Ockenden report.
- **Safeguarding Annual Report**
  The Committee discussed the annual adult and children safeguarding report and requested an update on areas of challenge at a future QAC meeting.

Any issues for escalation to the Board

The Committee agreed there were no items that required formal escalation to the Trust Board. The Board is asked to note:

- risks in relation to clearance of 104 week waits
- follow up by QAC of the limited assurance report on clinical audit

Legal implications/ regulatory requirements	The above report provides assurance in relation to CQC Regulations and Outcomes and BAF entries as detailed above.

Action required

The Trust Board is asked to note the report.

NHS
Barts Health
NHS Trust

Report to the Trust Board: 6 July 2022	TB 47/22

Title	Nominations and Remuneration Committee Exception Report
Chair	Rt Hon Jacqui Smith, Chair
Author(s) / Secretary	Trust Secretary
Purpose	To advise the Trust Board on work of Trust Board Committees

Date of meeting
The Nominations and Remuneration Committee met on 11 May 2022 and 29 June 2022

Key areas of discussion arising from items appearing on the agenda
The Nominations and Remuneration Committee held a meeting on 11 May and 29 June 2022. At these meetings the Committee received reports and verbal updates on: the Group Chief Executive appointment; transition arrangements ahead of the departure of the current Group Chief Executive (and the promotion of the Deputy Group Chief Executive); an update on Trust Board membership and non executive appointments; an update on hospital leadership team changes; and a review of very senior manager pay bands in line with emerging national guidance.

Any key actions agreed / decisions taken to be notified to the Board
See above.

Any issues for escalation to the Board
None.

Legal implications/ regulatory requirements	n/a

Action required by the Board
The Trust Board is asked to note this exception report from the Nominations and Remuneration Committee.

Barts Health NHS Trust

Report to the Trust Board: 6 July 2022	TB 48/22

Title	Freedom to Speak Up yearly report
Accountable Director	Director of People
Author(s)	Mary Walsh – The Guardian Service, Freedom to Speak Up Del Mehet – Deputy Group Director of People
Purpose	Review of the culture that enables staff to raise concerns. At Appendix 1 is the Trust response to the Guardian Service paper, triangulating FTSU findings with other concern raising routes to understand key themes and interventions relating to improving the process.

Executive summary

- This report is a one-year activity summary of the work of the Freedom to Speak Up (FTSU) Guardian. The FTSU Guardian is a mandated role to provide an independent route for staff wishing to raise concerns. Here provided by The Guardian Service Limited, an external provider.
- Staff groups most likely to raise concerns are Admin & Clerical (33%), followed by Nurses (30%). This year is unusual in that doctors (21%) have raised concerns.
- Royal London Hospital has received the highest number of concerns at 53%. Greater engagement is taking place on all sites to increase awareness.
- This report should be presented annually at a Board meeting by the Freedom to Speak Up Guardian. This is recommended by the National Guardian Office (NGO) to ensure the independence of the employee voice to the Trust's decision makers.
- Closer working with the Inclusion team and the Guardian is being developed as the end goals of building an inclusive environment where talent can rise and a 'just' culture can flourish is compatible. This will bring consolidation of the routes to hear the employee voice and understand the worker experience.

Related Trust objectives	Fair and Just Culture
Risk and Assurance	Assurance in relation to the below risk
Related Assurance Framework entries	BAF entry 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
Legal implications/ regulatory requirements	Equality Act

Action required: The Trust Board is asked to note key themes emerging from staff survey and speaking up routes to understand the current state of staff experience and concern raising, consider recommendations outlined and support the subsequent delivery of more developed action plans

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 6 JULY 2022

THE GUARDIAN SERVICE REPORT 1 APRIL 2021 – 31 MARCH 2022

Executive Summary

1. This report is an activity summary of the work of the Freedom to Speak Up (FTSU) Guardian undertaken during the last accounting year. The FTSU Guardian is a mandated role to provide an independent route for staff wishing to raise concerns. At Barts this is provided by The Guardian Service Limited, an independent and external provider.
2. Staff groups most likely to raise concerns are Admin & Clerical (33%), followed by Nurses (30%). This year is unusual in that doctors (21%) have raised concerns but mainly around one issue and so this staff group is showing as significant.
3. Royal London Hospital has received the highest number of concerns at 53% and St. Bartholomew's has just 2. Newham 11%, Whipps Cross 17%, Group Support Services 12% and not disclosed 4%. Greater engagement is taking place on all sites to increase awareness of how to raise concerns.
4. This report should be presented annually at a Board meeting by the Freedom to Speak Up Guardian. This is recommended by the National Guardian Office (NGO) to ensure the independence of the employee voice to the Trust's decision makers.
5. Closer working with the Inclusion team and the Guardian is being developed as the end goals of building an inclusive environment where talent can rise and a 'just' culture can flourish is compatible. This will bring consolidation of the routes to hear the employee voice and understand the worker experience. Speaking up should be a positive experience.

Background

6. The role of Freedom to Speak Up Guardians and the National Guardian were established in 2016 following the tragic events at MidStaffordshire NHS Foundation Trust and recommendations from Sir Robert Francis QC's Freedom to Speak Up Review.

7. The Guardian Service is an independent and confidential staff liaison service and has been employed at Barts Health since 2016. It was established in 2012 by the then National NHS Patient Champion in response to The Francis Report. It is growing by reputation and now provides a service to Trusts, local authorities and membership organisations throughout the UK.

8. The Guardian Service is advertised throughout all the Barts hospital and corporate sites as an independent organisation. This encourages staff to speak up freely and without fear of reprisal. The CQC focuses on the requirements of Trusts to have an open and responsive raising concerns culture as part of the well led framework. The Guardian Service supports the Board to promote and comply with the National Guardian Office (NGO) national reporting requirements.

Purpose

9. The purpose of this paper is to provide an activity report with further insight and narrative around the concerns raised throughout the year, supplementary to the monthly numerical reports provided to the Trust.

Raising concerns and escalation

10. The Guardian Service operates using this RAG rating. Where an issue is agreed for escalation, the following system is used:

Red	These scenarios require immediate escalation and response within 12 hours. The Group Chief Medical Officer and Group Chief Nurse are also informed.
Amber	A response is required within 48 hours
Green	A response is required with 72 hours

11. From 1 April 2021 to 31 March 2022, 98 cases were raised to the FTSU Guardian.

12. Of the 98 cases during the year:

- 18 were classified as a 'red concern' (e.g., patient or staff safety)
- 36 amber concerns (e.g., allegations of bullying, poor behaviours)

- 41 related to a 'green concern' (regarding a change in work conditions, seeking to understand a process, and get some ideas on how to find a resolution).
- There have been 3 cases with no discernible risk.

Confidentiality of the concerns raised

13. Many staff call the Guardian to talk through a concern and to get ideas or options on how to deal with the issue themselves. Others wish to off-load, and some want to check on a particular policy or procedure. This information is kept confidential as there is no need to escalate the details to anyone else. Speaking up confidentially is when the worker speaking up reveals their identity to the Guardian on the condition that it will not be disclosed further without their consent (unless legally required to do so).

14. All staff are given the following information at the outset:

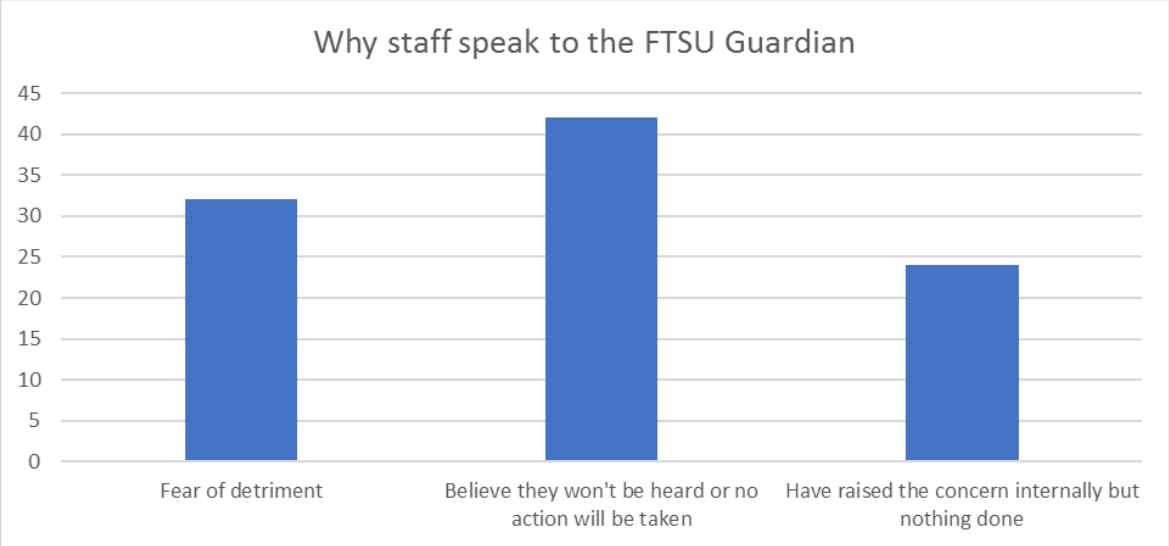
- everything discussed is utterly confidential and will not be divulged to anyone without their express permission.
- concerns about patient or staff safety must be escalated immediately but can be done so anonymously.

15. The 48 concerns that were kept entirely confidential between the person raising the concern and the Guardian were a variety of seeking opinion and options for resolution on a situation they have encountered. Workers who spoke up felt listened to and supported by the Guardian. They appreciated having an impartial person to speak to who had the time to listen to the matter. In most cases, this was enough to enable the individual to resolve the concern themselves, or it gave them the level of comfort they needed to continue in a perhaps difficult role but with some knowledge of the resources available to support them. They were always given the opportunity to return for another conversation.

16. Of the 50 cases that were escalated to managers within the Trust, all were dealt with promptly. Many were escalated to the HR Business Partner (HRBP) who was able to explain the situation and the Guardian was able to pass on the reassurance. Other times the HRBP undertook to find out more information and liaise with the relevant management team to bring about a resolution. On other occasions the Guardian escalated to the relevant management directly and helped facilitate a resolution by passing on information so that the situation could be investigated, and action taken. The Guardian followed through to ensure a conclusion to the satisfaction of the person raising the concern is reached.

Why Speak Up?

17. Staff call the Guardian because they want a conversation with an independent party who has the time to listen to their concern. They are often fearful, having found themselves in a situation where, for a variety of reasons, they feel powerless. They may fear recrimination. Sometimes they are worrying unnecessarily and once a process is explained, or likely explanation for a scenario given, they are satisfied. Other times they find themselves in an environment where trusted relationships have broken down or there is an element of abuse of power, and they do not see any action being taken to resolve the situation.



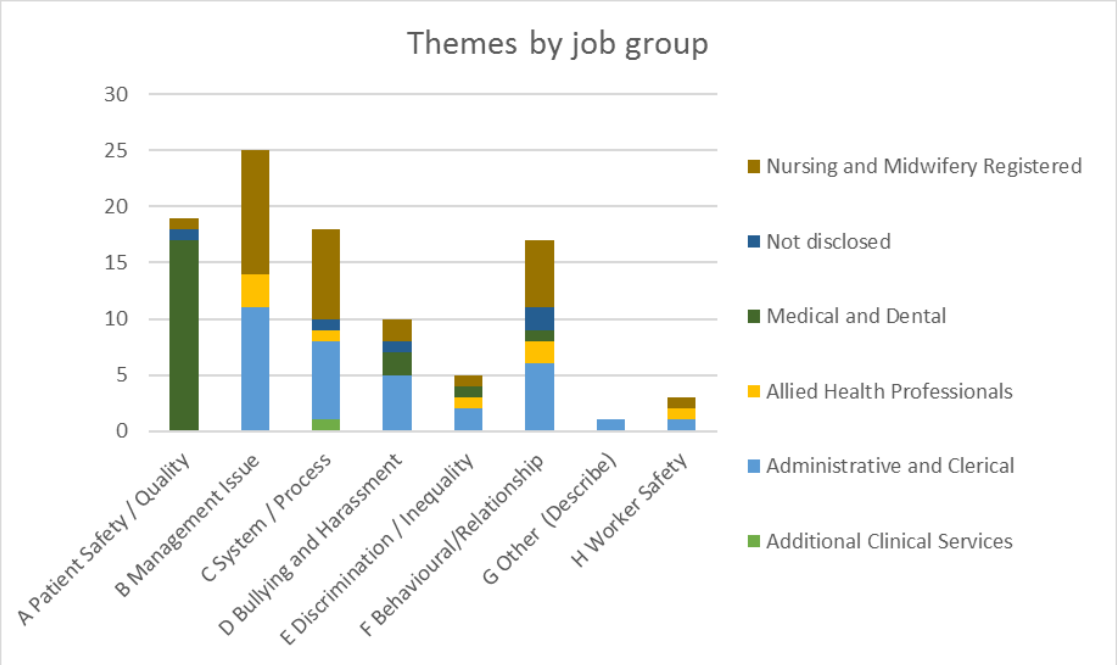
Themes

18. The charts below illustrate how concerns are distributed by location, job group and professional level:

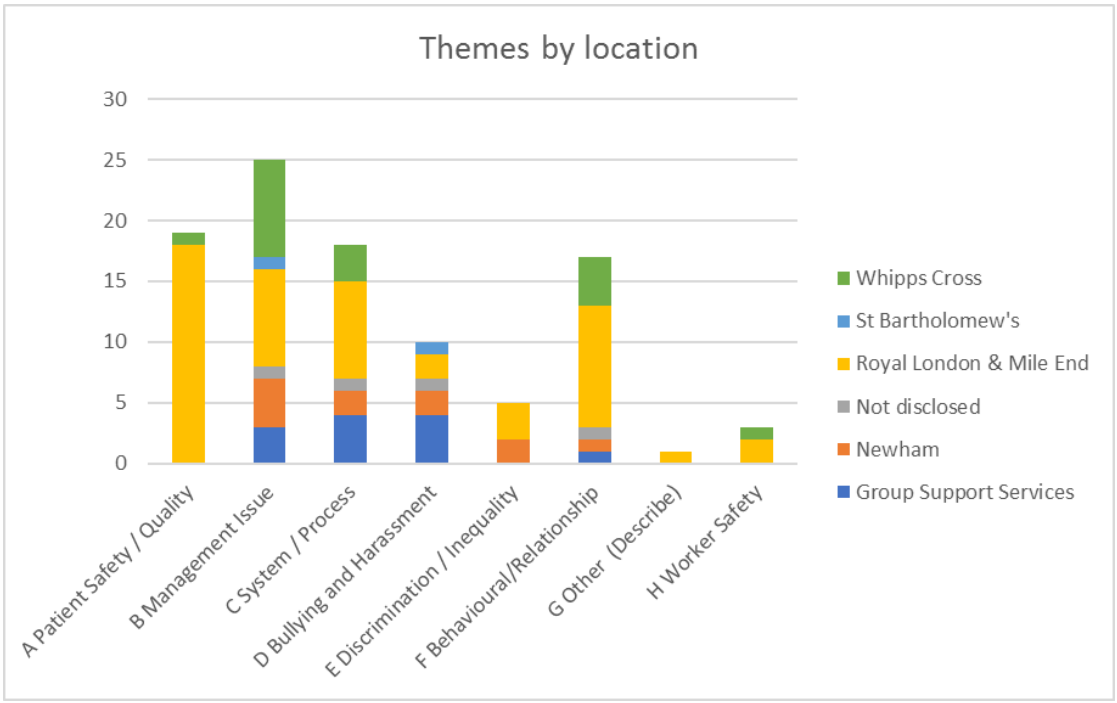
Job groups

19. Most concerns are raised by Admin & Clerical Staff (33%), followed by Nurses and Midwives (30%). This has been the case for several years. Admin & Clerical staff report feeling unfairly, harshly managed, and often short staffed with substantial workloads. This group will also include some middle managers who feel they are on the receiving end of poor behaviours from both senior and junior colleagues, often having to navigate difficult personalities and deliverables.

20. There is an unusually high number of doctors (21%) speaking up this year due to a patient safety concern raised by a group of consultants and junior doctors. This is being addressed by the undertaking of an external review due to be carried out by The Royal College of Surgeons in August 2022.

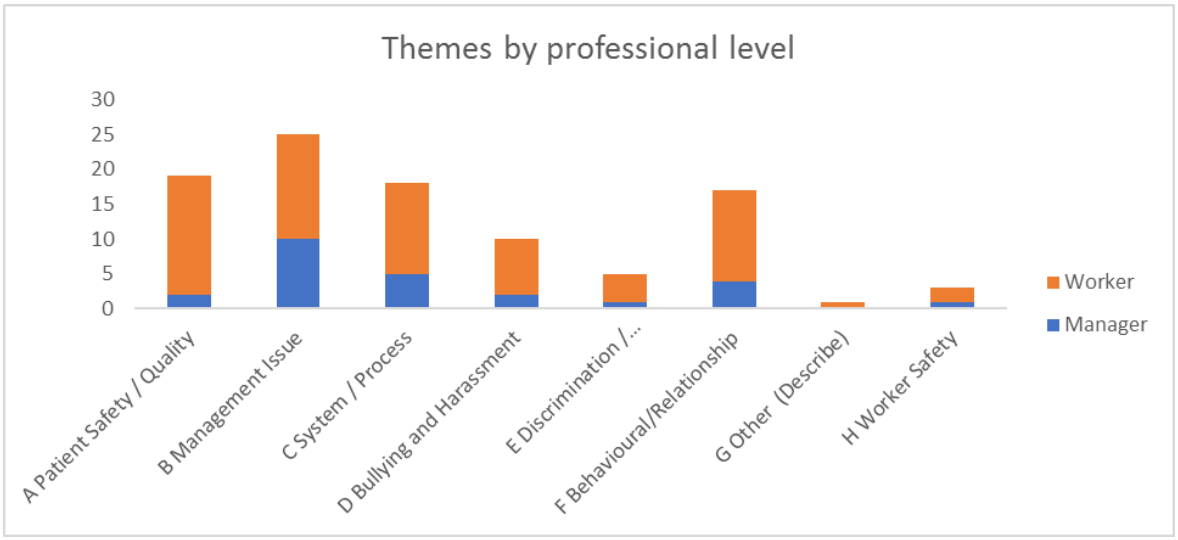


Locations



21. More than half of all concerns have been raised at Royal London Hospital (53%). St Batholomews Hospital has received just two concerns in the same period.

Professional level



Assessment of Themes:

Patient Safety / Experience / Quality

22. There were patient safety concerns raised by 19 people in this period.

Site	Issue raised	Escalated to	Resolution / Outcome
Royal London	Anonymous report of a staff member taking a Covid vaccine home and injecting someone who was outside the current criteria.	Director of Nursing	Suitable supervision was in place and there was no risk to patients
Royal London (x 16)	Consultants and Junior Doctors feel there is a less than satisfactory outcome for patients in a speciality	Deputy Group Medical Director	An external review will take place in August/September by the Royal College of Surgeons
Royal London	Staff member raised a datix re. inappropriate medicine given to a child	Associate Director of Nursing	A review satisfied the ADoN there was no patient safety risk but a team intervention is planned to build more cohesion and trust.
Whipps Cross	Staff member was spoken to rudely when calling for urgent patient assistance	Associate Director of Nursing	Staff were reminded of the expected Trust values and behaviours

Management Issues:

23. Concerns raised in this category amounted to 25 of the 98 (25.5%) concerns raised in total. Staff perceptions surrounding accountability, leadership, resources - adequate staffing, guidance, development etc. These were raised within the context of:

- Some staff felt they were not always respected when speaking to their line managers. They felt not listened to, and their perception was that their concerns were dismissed or ignored.
- Some staff felt their managers had different relationships with some team members and showed favouritism towards them. Some reported an abuse of power by managers and manipulating staff to achieve an end goal, rather than engaging.
- Some were concerned about staffing levels while transitioning to a new system which appeared very labour intensive. They appreciated that perhaps gains would be made in the end but didn't feel informed or involved in the process.
- Some managers felt undermined by the staff they were trying to supervise who were intractable and had difficulty in managing expectations/day-to-day activity.
- Some staff felt not well supported while dealing with personal issues that required flexible working arrangements.
- The fall out from the Employment Tribunal case at Whipps Cross regarding race discrimination left some staff feeling undermined, unvalued, and attacked by colleagues.
- Some staff feel that bank nurses get the heavy workload and are expected to be more flexible than agency or permanent staff.

- One manager reported asking in various ways for assistance in ICT issues resulting in clinics being cancelled. Under-resourced in respect of PCs. This issue arose through partnership working between Barts and another NHS Trust.

Systems / Process

24. Concerns raised in this category numbered 18 of the 98 (18%) concerns raised in total.

- Mistrust in the processes being used to address performance improvement; disciplinary; reasonable adjustments, workplace assessments and managers role/responsibilities; misunderstanding around being sick and doing bank shifts; recruitment and the administration of tests; job evaluations; seconded roles that are not made permanent.
- A manager felt unsupported in taking action to dismiss a member of staff who was not competent; and other staff were very distressed when threatened with failing probation without any prior notice while working in unsupported circumstances.
- Some staff talked about feeling frustrated that requests for flexible working are not being accepted in a manner that allows for work life balance and the demands of childcare.

Bullying and Harassment Concerns:

25. Concerns raised in this category numbered 10 of the 98 concerns raised (10%).

- They included alleged behaviours of micro-management, incivility and shouting aggressively at staff or creating an atmosphere where people are afraid to professionally disagree.
- Staff have reported being on the sidelines of poor behaviour and getting caught up in it. Feeling fearful of being interviewed about conflicts between colleagues.
- Sometimes a high performer has been frustrated at being picked up for something by their supervisor when they see poor behaviour of colleagues being ignored or going unchecked.

Discrimination and Inequality:

26. Concerns raised in this category numbered 5 of the 98 concerns (5%) raised in total.

- Some staff members had the perception that racial discrimination played a part in how operational decisions were made and staff selected for development opportunities and promotion.
- One concern related to a staff member not feeling supported with their disability. This person felt compared to non-disabled staff rather than judged against the requirements of the job description.
- A manager reported feeling coerced by their manager to move a disabled member of staff to a role where they would fail.
- A worker had concerns about racism that were not being addressed.
- A transgender, non-binary person was insulted by a colleague in another department who made a very personal and inappropriate remark intended to wound.

Behaviour / Relationship:

27. Concerns raised in this category numbered 17 of the 98 (17%) concerns raised in total.

- These concerns include relationship problems and culture clashes, including a demand for a return to working on site, rather than at home.
- Staff members feel excluded from their team and hear people gossiping. Sometimes managers discussing confidential issues in public.
- A lack of understanding of some processes or a feeling of persecution, leads to friction between staff members and line managers. Return to work interviews, performance management, reasonable adjustments for disabled employees are key examples.
- There are examples of individuals feeling disconnected from their departmental colleagues, a perception of incivility, opinion clashes and/or a feeling that staff

members are not being supported by their managers. Sometimes difficult conversations are avoided by managers allowing poor behaviour to go unchecked.

Worker Safety

28. There were 3 concerns that related to staff safety:

- Lead aprons were not being screened annually to protect staff in X-ray
- A member of staff reported being touched inappropriately by their manager.
- A conflict with a member of staff in another department has caused fear of stalking.

Communication

29. The Guardian attends the various People Committees where learnings resulting from issues are shared. This is scheduled for a quarterly update on themes and areas of interest so that action and learnings can be dealt with in a timely fashion.

30. The Guardian attends meetings and events to brief staff about the service which encourages staff to speak up to their manager or contact the FTSUG. During the pandemic inductions moved online and so in person attendance no longer happens. The use of MS Teams and Zoom meetings have enabled greater reach in some circumstances.

31. Site walk arounds and meetings have now recommenced and so the Guardian is frequently in person at all the Trust Hospitals or offices. These dates are advertised on Twitter and internally.

32. The Guardian Service has prepared a toolkit – A reflective guide, available online to all teams of Barts to examine their practice and ensure an open culture. This will be promoted during October 'Speak Up' month.

Visits and briefings over the last year includes:

• Trust-wide Shielding group
• Whistleblowing webinar to Team Leaders
• Staff Partnership Forum
• Schwartz Round
• Divisional meeting of the Children's Hospital at RLH
• Occasional Doctors' Induction at the RLH Education Centre,
• ECAT Divisional meeting at RLH
• Junior Doctors Forums at WXH, NUH, SBH and RLH,
• Medical Education Committees at SBH and NUH
• Diversity & Inclusion Executive meetings at RLH,
• Listening interventions with the OD team at cross-site Imaging and NUH Maternity.
• Walk arounds on all sites to ensure staff have access to flyers and posters. All the Wellbeing rooms are supplied with flyers.

33. Bi-monthly and most recently fortnightly meetings are held with the People Relations/Inclusion team to discuss the monthly activity reports which includes emerging themes and outcome of cases. No individual can be identified by the report thus ensuring confidentiality. The FTSU action plan is monitored at these meetings.

34. Closer working is being developed between the different channels to raise concerns and liaison between the Guardian, the Inclusion Signposters, Inclusion Ambassadors and Well Being Leads.

Data supplied to the National Guardian Office

35. Data is supplied on a quarterly basis to the National Guardian Office (NGO) and is then published on their website. For the sake of comparison, here is the annual number of concerns raised at Barts for the last four years:

Recent years	Total No Cases	Anonymous		Patient Safety		Bullying & Harassment		Suffered a detriment	
		Actual	%	Actual	%	Actual	%	Actual	%
Total 2018/19	107	12	13	4	4	15	16	0	0
Total 2019/20	120	15	13	4	3	21	18	1	1
Total 2020/21	129	20	15.5	5	4	11	8.5	1	0.7
Total 2021/22	98	10	10	19	19	10	10	0	0

36. The number of bullying concerns is reducing as is the number of individuals who choose to speak up anonymously, i.e.. without giving their name to the FTSU Guardian. When someone speaks up anonymously, no one knows their identity. In comparison, speaking up confidentially is when the worker speaking up reveals their identity to the Guardian on the condition that it will not be disclosed further without their consent (unless legally required to do so).

37. There has been an increase in the number of patient safety concerns due to a group of doctors raising a collective issue. More detail is on pages 6 and 7.

38. From this data, which is gleaned from 400 organisations in primary and secondary care, independent providers and national bodies, the NGO calculates the average number of concerns raised per quarter.

Small sized trusts (less than 5000 employees) - 22.6 concerns
Medium sized trusts (5,001 to 10,000 employees) - 26 concerns

Large sized trust (10,001 plus employees) - 32.7 concerns – compared to 24 per quarter for Barts

39. Therefore, in comparison with other large Trusts Barts should expect to see a higher number of concerns raised.

Recommendations

40. The Trust Board should promote the FTSU service as a trusted route to raise concerns and actively encourage staff to access.

41. Triangulation of data and route cause analysis will be undertaken by the People Relations team and shared quarterly with the Hospital Executive Boards.

Triangulating Speaking Up at the Trust **Appendix** 1

Introduction

1. This short paper appends the recent Guardian Service Twelve Month Review Report for Barts Health NHS Trust" covering the period April 2021-March 2022. The paper triangulates findings from other speaking up, or concern raising routes to understand emerging themes, and define recommendations to improve confidence, utilisation and the effectiveness of speaking up routes.

2. The Freedom to Speak up Guardian Service described in the above paper, is one of many routes to raise concerns. Alternatives include:
    a. Confidential Care (CiC): Confidential employee assistance programme.
    b. Trade Unions/staff representatives: Workplace advice and support
    c. Investigation Services Team: Independent whistleblowing for serious concerns
    d. Line managers: Day to day concerns and general guidance
    e. Staff Diversity Network: Inclusion related support specific to a protected characteristic
    f. Employee Wellbeing Service: Occupational Health experts
    g. Employee relations: Formal and informal completions and resolution
    h. Inclusion Signposters: Informal conversations and advice on where best to raise concerns
    i. Organisational Development: Delivering cultural interventions to specific teams who has requested support.

3. These routes all exist for a specific purpose and provide multiple routes for raising concerns, so that colleagues are not restricted if any single concern raising route does not feel appropriate to them (i.e. they may not be able to speak to their line manager). A limitation of this approach is that we have a large number of informal conversations, with concerns and data not being recorded centrally. This means it is difficult to understand themes and feelings in the organisation and respond collectively as a group. There is also limited coordination between these services, which can sometimes be difficult to navigate as a member of staff.

Emerging Findings Across Speaking Up Routes:

4. Reviewing data from the staff survey, CiC, Employee Relations and OD helps build an overall picture of speaking up, and staff experience.

5. There are 14 questions from the **staff survey** that relate to issues of discrimination, bullying and violence and raising concerns. 8116 responded to the 2021 staff survey at Barts Health, which had the following themes:
    a. **Levels of discrimination have remained static** at Barts Health, and the impact is worse for colleagues from Black, Asian and Minority Ethnic backgrounds
    b. **Bully and harassment is lessening** however the number of staff experiencing bullying from managers is 16%.
    c. **Just 57% of staff feel safe to raise concerns** and there is a lack of confidence in staff feeling that their concern will be addressed effectively.
    d. Benchmarking against other London acute trusts shows that Barts Health is the **third highest level for discrimination, fourth highest for bullying from managers and seventh for bullying from colleagues**. In terms of confidence in reporting the situation is slightly better with Barts in the middle of the range.

6. Reviewing cases from employee relations, CiC, and Guardian Service corroborates these findings. Key themes from the three include:
    a. **A fraction of bullying and harassment in the staff survey is being picked up in CIC, ER tracker and Guardian services**. There were 15 CIC cases and 44 ER tracker Dignity at work cases relating to bullying in last year, suggesting staff are not reporting bullying, or they are being picked up in informal routes.
    b. **Concern raising activity doesn't correlate to expected bullying levels**: RLH makes up most users of the Guardian service but isn't an outlier in bullying

c. **Pressure may be creating heightened anxiety** which could be affected workplace cultures: Within the 274 CiC Contacts in the last year, 110 (40%) related to "pressure". 56 cases were due to leave/absence.
d. **ER tracker cases are decreasing**. Due to the small numbers of cases, it is not possible to accurately determine if ethnicity is a predictor for outcome.
e. **Informal resolution is common, with some variation across site:** The majority of the cases opened in the last year have been resolved informally with improvement notes issued for conduct concerns being used to resolve many cases.
f. **Pause and reflect is not yet fully embedded or reported across the trust:** Based on the records captured in the ER tracker only 50% (12 of 24) of formal cases had a pause and reflect stage recorded.

7. The OD team often responds to areas requiring culture change, or team coaching and can therefore provide valuable insight on how staff are feeling. Insights from OD, help us further understand the situation at Barts Health. And include:
    a. **Wellbeing and rest:** Due to staff shortages staff are not always able to take annual leave or they feel obligated to work during annual leave. Working under continued pressure from reduced staffing and higher patient acuity without sufficient rest areas or protected time is creating difficult environments
    b. **Culture, Compassion and Inclusion:** There seems to be embedded cultures of inappropriate and disruptive behaviours, enabled by lack of consequence/ acknowledgement by some management.
    c. **Management**: Colleagues report feeling like 1:1s are infrequent or 'tick box' with managers and peers alike often feeling short for time to meaningfully check in with one another or have compassion in conversations.

Recommended Action:

8. In summary, there is under utilisation of speaking up services, at least in part due to lack of confidence in reaching a resolution. Given the high incidence of bullying and harassment, efforts should be made to increase the credibility, and awareness of speaking up to help support resolution. Furthermore, there is an opportunity to address drivers of bullying, which relate to working environments, as well as culture. To address these themes, the following recommendations are suggested (this paper provides high level recommendations for discussion, more detailed action planning will be developed separately):

9. <u>Improve Data and Coordination:</u>
    a. Routinely collect insight across speaking up routes to understand utilisation and emerging themes
    b. Improve data collection to capture informal concern raising
    c. Encourage cross working between concern raising routes where appropriate to ensure greater integration that can implement group wide interventions

10. <u>Improve our Processes and Support to Mangers</u>
    a. Provide guidance and support to managers on what support to access
    b. Work closely with directorates with high levels of bullying to understand issues and provide support to address them
    c. Actively ensuring workforce planning can alleviate pressures and support wellbeing
    d. Reinforce the importance of taking annual leave and opportunities to rest
    e. Continue to embed Just Culture and Dignity at work policies

11. <u>Increase Engagement and Culture</u>
    a. Deliver interventions in WeBelong including CQ and inclusion training across sites
    b. Demonstrate effective resolution of cases to build confidence in the services
    c. Create a feedback loop with staff to show how we are actively listening
    d. Regular 1-2-1s and team huddles to open dialogues

12. <u>Increase Awareness</u>
    a. Continue to engage managers to champion inclusion and compassion

b. Raise awareness of signposting routes, Wellbeing strategy and create simple guidance to help colleagues navigate and access support
c. Embed Inclusion Signposters in sites

Themes From the Staff Survey and Related Cases Picked up in CiC, Guardian Service and ER (covering 2021/22) Appendix 2

Theme	Staff Survey	CiC, and ER Cases
Bullying, harassment, abuse	• 84% did not experience bullying or abuse from managers, 1.4% better than last year • 77% did not experience bullying from colleagues, 1.3% better than last year • 71% not experienced bullying from patients/relatives, 1.4% better than last year • For the different ethnic groups, the 'other' group (which in Barts is mainly people from the Philippines) has the worse outcomes and white staff experience the lowest levels of bullying and abuse. • Asked whether the last time bullying was experienced they reported it, a higher percentage of Black staff said yes, with the percentage of white staff being the lowest. • Bullying and harassment varies across hospitals dependent on the source (public/patient, managers, colleagues). • GSS has the best performance overall.	**Relating to bullying and harassment:** • 15 CIC cases • 44 Dignity at work cases relating to bullying in last year • 10 bullying cases to The Guardian Service
Discrimination	• 85% did not experience discrimination from colleagues or managers, 0.5% worse than last year • By site this was 87% GSS, 86% SBH, 85% RLH, 83% WXH, 81% NUH not experiencing discrimination, with GSS and SBH being the best performing sites. • 87% did not experience discrimination from patients' relatives, 0.7% worse than last year	**Relating to Discrimination:** • 0 CIC cases • 3 ER grievances and 3 ER disciplinary cases relating to discriminatory behaviour • 5 discrimination cases to The Guardian Service
Violence	• 99% did not experience violence from managers, 0.1% worse than last year • 97% did not experience violence from colleagues, 0.4% worse than last year • 86% of people haven't experienced violence from patients, which is 1.4% better than last year • Overall violence is low, but a higher number of staff still experience it due to patients – given the size of the trust even small percentages can result in hundreds of staff being impacted. • For violence from patients the worst affected sites are RLH (81%) and WXH (80%) – GSS has very low levels as would be expected (95.8%) due to less proximity to patients. • Violence levels from managers and colleagues is close across sites, but Whipps is lowest for both across Barts and has lower percentages of staff saying they reported it.	**Relating to violence:** • 0 CIC cases • 5 disciplinary cases relating to assault not specifically of/from colleagues
Reporting	• 57% of staff would feel safe to raise concerns. • 69% would feel confident reporting unsafe clinical practice, 0.4% worse than last year • 66% reported violence, 3.3% worse than last year • 46% reported bullying and abuse, 0.6% worse than last year • Less than half of people (46%) feel the organisation would address the concerns and slightly more than half (54%) think clinical concerns would be addressed. • Around feeling safe, confident and if they would raise concerns, white staff were the most likely. Mixed staff felt the least safe to speak up, although lower confidence was also seen in Black, Asian and other staff.	
Service	Insight	
CIC Last 12 months	• 274 contacts in the last 12 months, with 110 (40%) relating to "pressure" which could be contributing to creating an environment where negative staff interactions are more likely. • 56 cases were due to leave/absence, indicating scope for clarifying/communicating processes and appropriate manager responses. • 15 cases related to bullying and harassment, which is not representative of the numbers impacted in the staff survey	
ER Tracker	• ER cases have decreased over the last 12 months, with 52 dignity at work cases (bullying is mostly picked up in this case type), 86 disciplinaries and 33 grievances. • 44 of 52 dignity at work cases were bullying and harassment. By ethnicity, this was 8 Asian, 10 black, 7 white, and 17 unknown staff. • 3 counts of discrimination, and 1 case of bullying was picked up in disciplinary cases. A further 3 cases of discrimination were picked up in grievances. Compared to the total number of staff experiencing bullying, these numbers are low. • Most of the cases opened in the last year have been resolved informally with improvement notes being used to resolve many cases. • There appears to be some differences between sites with the number of informal cases, sites with strong ratios include SBH (13 informal cases compared with 3 formal) and RLH (11 informal and 2 informal) • Based on the records captured in the ER tracker only 50% (12 of 24) of formal cases had a pause and reflect stage recorded. This should be done for all case to progress to a formal stage, indicating more can be done to embed pause and reflect. • Of the disciplinary cases that went to a formal stage the record of pause and reflect being carried out does not show any pattern relating to either ethnicity or site.	

Barts Health NHS Trust

Report to the Trust Board: 6 July 2022	TB 49/22

Title	Whipps Cross Redevelopment
Accountable Director	Group Chief Executive
Author(s)	Alastair Finney, Redevelopment Director, Whipps Cross Hospital
Purpose	To provide an update on the Whipps Cross redevelopment programme
Previously considered by	Group Executive Board

Executive summary

In May 2022, the Trust Board received a report on: progress with mobilising the integrated delivery framework, including a new programme board to oversee the development of a coherent strategy for the future of end-of-life care; the Greater London Authority's endorsement of the local planning authority's determination for the new hospital; the completion of the first phase of our 'enabling works'; an update on the NHP; and, finally, our continuing communications and engagement work with community groups, local residents and political representatives. This paper provides an update on: the integrated delivery framework as it moves from mobilisation to delivery phase, the Greater London Authority's endorsement of the local planning authority's determination for the wider site; a collaborative project, working with Queen Mary University of London, on the joint development of an Academic Centre for Healthy Ageing; and finally, an update on the NHP.

Related Trust objectives	
3. To build effective partnerships across the health and social care system and deliver social value for communities through our longer term strategic plans	
Risk and Assurance	Assurance in relation to below BAF entry
Related Assurance Framework entries	9. Delays to the progress of a robust business case, supported by stakeholders, impairs Whipps Cross redevelopment and delivering the vision of excellent integrated care
Legal implications/ regulatory requirements	None

Action required by the Board

The Board is asked to note:

- progress in moving the integrated delivery framework for service transformation into delivery phase, including the publication of the summary plan for 2022/23 and the focus on developing the insight and intelligence function to measure delivery;
- the GLA's recent endorsement of Waltham Forest Council's planning determination

for the development of the wider site;

- the positive progress in developing proposals for The Academic Centre for Healthy Ageing; and
- the update on the New Hospital Programme.

Barts Health NHS Trust

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 6 JULY 2022

WHIPPS CROSS REDEVELOPMENT PROGRAMME

INTRODUCTION

1. In May 2022, the Trust Board received a report on: progress with mobilising the integrated delivery framework, including a new programme board to oversee the development of a coherent strategy for the future of end-of-life care; the Greater London Authority's (GLA's) endorsement of the local planning authority's determination for the new hospital; the completion of the first phase of our 'enabling works'; an update on the national New Hospital Programme (NHP); and, finally, our continuing communications and engagement work with community groups, local residents and political representatives.

2. This paper provides an update on: the integrated delivery framework as it moves from mobilisation to delivery phase; the GLA's endorsement of the local planning authority's determination for the wider site; a collaborative project, working with Queen Mary University of London, on the joint development of proposals for an Academic Centre for Healthy Ageing; and finally, an update on the NHP.

WHIPPS CROSS REDEVELOPMENT UPDATE: SUMMARY POSITION

3. Whilst overall the programme remains in a strong position, given the progress experienced over the last year or so, which has been reported previously, we continue to await further details from the NHP team about the next steps - including a timeline for submitting the Outline Business Case (OBC) and the use of an alliance commercial framework that could be the route towards appointing a construction partner.

A COLLABORATIVE APPROACH TO SERVICE TRANSFORMATION

4. In May 2022, we reported that we were continuing to work with our local health and care partners to mobilise a new integrated delivery framework, to oversee the planning and delivery of service transformation across the Whipps Cross catchment area. This framework for closer collaboration between partners is emphasising the importance of a system-wide approach to transformation, which will lead to

improvements in the health and wellbeing of our local population in a way that also supports a new Whipps Cross hospital.

5. During the last two months, we and our partners have been focussing on establishing a system-wide service transformation plan for 2022/23, outlining the priorities and focus areas of transformation plans for the year, for Whipps Cross and across the hospital's catchment area in Waltham Forest and Redbridge. This has been completed, and a summary of the plan is attached at Appendix 1. The plan outlines how transformation programmes align to three of the core themes that describe our collective ambition for transformation, which are: to keep people healthy to avoid unplanned hospital attendance; to minimise the need for hospital admission when people need care and treatment; and to minimise the time people spend in hospital, with the best possible care and overall experience, when people are admitted.

6. The ability to measure success in how services are being improved is an important function of this integrated delivery framework and the plan outlines the next steps to ensure we can describe, transparently, the impact of service change and transformation. As part of the framework, we are developing an Insight and intelligence function, through which we will be agreeing a set of measures and metrics on the delivery of transformation programmes, and across our three themes.

7. The plan also reiterates the commitment of partners working together - and with input from patient and community groups - to develop a transparent annual reporting process to chart progress in delivering service transformation, in a way that can inform a continual evaluation of capacity assumptions (including beds) for the new hospital.

OUTLINE PLANNING APPROVAL

8. In June, the second of our two planning applications – that relating to the proposed development of the wider site after the new hospital is completed – has completed the GLA Stage 2 process whereby the Mayor of London has determined the application will not be called in and Waltham Forest planning authority may now conclude the process to enable the release of the Planning Decision Notice, which we expect in the near future.

9. This represents a further significant milestone that the redevelopment programme has achieved, having already received approval for the first of our two planning applications – the hybrid application for the new hospital and multi-storey car park.

DEVELOPING AN ACADEMIC CENTRE FOR HEALTHY AGEING

10. Over several months, clinical leads from Barts Health and academic leads from Queen Mary University of London have been working together on a proposal to establish a new local research and education centre - the Academic Centre for Healthy Ageing (ACHA) - linked directly to the planned redevelopment of Whipps Cross Hospital. The proposed Centre will support the development of better local health and care services to improve the quality of life for older people across the Whipps Cross catchment area and across north east London. As key beneficiaries of the proposed Centre, there is a commitment to listen to and work in collaboration with our local community to understand how best to support as many people as possible to live full and productive lives as they get older, as the project develops.

11. The proposal has two main objectives centred on research and education. First, the Centre would generate new applied research focussed on the prevention of clinical frailty and recovery following trauma and acute illness. Second, it plans to help educate and train our health and care workforce to deliver better services for older people and their families, by attracting and sustaining a world class clinical workforce including skilled researchers and services equipped with the right skills and capabilities to care for people with complex health and care needs.

12. Positive initial funding discussions to establish the core education and research faculty have been held with Barts Charity and the project is currently in the application process for funding, the outcome of which we hope to hear towards the end of the 2022/23.

NEW HOSPITAL PROGRAMME UPDATE

13. As we reported in May, we await further details from the NHP team about the next steps for our programme - including a timeline for submitting the OBC and the use of an alliance commercial framework that could be the route towards appointing a construction partner.

14. In the meantime, the NHP team has continued to progress its programme business case and we understand the next steps are its consideration by Ministers. Its purpose is to strengthen the case to Treasury in justifying the strategic, financial and

economic rationale of the national programme and how the programme needs to organise itself and engage with the construction market to ensure delivery. We know that the national programme business case does not provide scheme-specific assessments, nor would its endorsement mean agreed funding envelopes for individual schemes. Further discussions would need to take place between the NHP team and Treasury on what its endorsement means for schemes such as Whipps Cross.

15. We will continue to work closely with NHP colleagues over the coming period to understand the next steps.

CONCLUSION AND RECOMMENDATIONS

16. The Board is asked to note:

- progress in moving the integrated delivery framework for service transformation into delivery phase, including the summary plan for 2022/23 and the focus on developing the insight and intelligence function to measure delivery;

- the GLA's recent endorsement of Waltham Forest Council's planning determination for the development of the wider site;

- the positive progress in developing proposals for the Academic Centre for Healthy Ageing; and

- the update on the New Hospital Programme.

North East London Health & Care Partnership

Integrated Delivery Framework

Plan for 2022/23

July 2022

The Integrated Delivery Framework

North East London Health & Care Partnership

The proposed redevelopment of Whipps Cross Hospital presents a **once-in-a-lifetime opportunity** to build a brand new state-of-the-art hospital to provide the highest quality healthcare for people in north east London. However, the programme is more than about building a hospital. It is also an opportunity to deliver system-wide transformation across the whole catchment area in a way that drives improvements in the population's health and wellbeing, reduces health inequalities and supports the new Whipps Cross Hospital.

Why set up the Integrated Delivery Framework and what is its purpose?

- We have a collective aspiration to drive improvements in the population's health and wellbeing through a set of service transformation programmes, which can only be successfully delivered by health and care partners across the Whipps Cross catchment working together.

- In order to meet the challenge, an Integrated Delivery Framework (IDF) has been established to oversee and ensure the delivery of a set of interdependent service transformation programmes, which will make a critical contribution to delivering a new Whipps Cross Hospital in north east London and will benefit our patients and local communities.

The IDF membership and its objectives

North East London Health & Care Partnership

The IDF is made up of organisations across the local health and care system - North East London (NEL) Integrated Care System (ICS); Barts Health NHS Trust; North East London NHS FT (NELFT); Waltham Forest Council; and Redbridge Council. An IDF senior executive team provides oversight of all the activities within the scope of the IDF, identifying and managing risks and issues across the in-scope programmes, escalating these to the individual organisations as required, and reporting on progress.

Objectives	Provide a single programmatic approach to oversee the delivery of service transformation required to support the new Whipps Cross Hospital ahead of 2026/27, including robust governance arrangements for monitoring and reporting progress of system-wide programmes
	Manage the interdependencies between the hospital redevelopment programme and system transformation programmes and be clear where accountability and responsibility for the delivery of these programmes sit
	Manage the enabling workstreams that are critical to delivering the hospital redevelopment and system transformation programmes
	Align system-wide assumptions on activity, finance and associated key performance assumptions and modify these as required to reflect the actual and expected impact of service transformation programmes on acute and system-wide activity
	Support the system in deploying the appropriate resources (funding and people) to enable effective implementation of system-wide service transformation programmes

The IDF – a reminder of where we are

North East London Health & Care Partnership

- Improvements in healthcare across the Whipps Cross catchment area can only be delivered through a set of interdependent system and service transformation programmes.

- The IDF is about recognising that we need a system-wide approach to transform and improve health and care services. These changes will improve health and wellbeing and reduce health inequalities for our local population. This is why it is represented by organisations, across the health and care system, that have a part to play in delivering the change needed.

- As the IDF has mobilised, we now need to focus on our plan for delivery:

What are our activity targets in the context of the new Whipps Cross?

What are we focussing on in 2022/23?

What are our enablers?

How will we know if transformation is successful?

A reminder of the ambition

North East London Health & Care Partnership

The outputs from demand and capacity modelling undertaken for the Whipps Cross redevelopment business case highlight the challenge associated with **doing something** compared with **what the position would be if we did nothing***.

Urgent and Emergency Care	2018/19 Baseline	2028/29 'Do Nothing'	2028/29 'Do Something'	2028/29 vs baseline
ED Attendances	101,602	111,690	49,269	-52,333, **reduction of 52%**
UTC Attendances	43,594	45,501	77,490	+33,896, **increase of 78%**
SDEC Attendances	0	0	18,969	+18,969, **new service**
Total – UEC Attendances (excl eye treatment)	**145,196**	**157,191**	**145,728**	+532, **increase of 0.4%**

Admitted Patient Care	2018/19 Baseline	2028/29 'Do Nothing'	2028/29 'Do Something'	2028/29 vs baseline
Spells	78,282	94,703	91,349	+13,067, **increase of 17%**
Occupied Bed Days	210,552	205,019	188,764	-21,788, **reduction of 10%**

Outpatient Services	2018/19 Baseline	2028/29 'Do Nothing'	2028/29 'Do Something'	2028/29 vs baseline
First Attendances (Referrals)	123,255	155,431	76,133	-47,122, **reduction of 38%**
Follow Up Attendances	184,340	271,056	90,294	-94,046, **reduction of 51%**
Virtual / Digital Appointments	0	0	166,428	+166,428, new service
Total – OP Attendances / Appointments	**307,595**	**426,487**	**332,855**	+25,260, **increase of 8%**

'Front door' activity is lower, as are occupied bed days. There is also an aspiration to move to 50% 'virtual' across all outpatient appointments

In the context of hospital activity, the modelling establishes an ambition for delivering significant system-wide service transformation ahead of the new hospital

Note: *'Do nothing' from a modelling perspective reflects the application of population growth with no service transformation. In respect of Admitted Patient Care, it assumes the implementation of the Barts health surgical strategy recommendations.

Where are we now?

North East London Health & Care Partnership

We recognise a significant amount of time has passed since the baseline year of 2018/19, so it is important that we evaluate the period since then to where we are now

Review of 2019/20, including system led assurance

- In the summer of 2020, our external experts CF revisited the modelling to sense check projection compared to 2019/20 and to sense check the opportunity assumptions. **The analysis confirmed the original modelling should not change.**
- The analysis also **confirmed the original opportunity benchmarking** and, in fact, indicated there **could be further opportunity** (which was noted but not reflected in the modelling).

Impact of COVID since 2019/20

- We cannot, nor should we, ignore the impact that COVID has had on activity in the health and care system. This has meant that **we have been unable to rely on data / activity since 2019/20** as an indicator of 'success'.

We have delivered change during COVID

- **Transformation is not starting today**. As a system, **we have already delivered change that has improved services** and outcomes for our local communities.
- Examples include the establishment of borough-based **integrated discharge hubs**, enabling **3,569 discharges into the community** during 2021/22, which continues to operate today. Transformation programmes across Barking & Dagenham, Havering and Redbridge (BHR) led to Whipps Cross (WX) **ED attendances for 65+ yr old Redbridge residents 15% below 19/20 levels** (890 fewer attendances) with **Emergency Admissions at WX for older and frail Redbridge patients 28% below 19/20 levels** (899 fewer admissions).

The question now is around what are we doing today and in the future - is it enough and how will we measure success?

We have three themes in describing transformation

North East London Health & Care Partnership

In 2022/23, the IDF will initially be focussing on those programmes that have the potential to make the biggest improvements in how services will be delivered for our local communities. Across the system, we are investing in programmes that will enable better care for our population, grouped across three themes:

Theme 1: Keeping people healthy to avoid unplanned hospital attendance

Theme 2: When people need care and treatment, minimise the need for hospital admission

Theme 3: When people are admitted, minimise the time they spend in hospital with the best possible care and overall experience

We are focussing on these three key themes in planning for 2022/23

North East London Health & Care Partnership

The three themes give a focus on those transformation programmes that have the potential to have the biggest impact on how care is delivered to local people:

Theme 1: Keeping people healthy to avoid unplanned hospital attendance	**Theme 2:** When people need care and treatment, we minimise the need for hospital admission	**Theme 3:** When people are admitted, minimise the time they spend in hospital with the best possible care and overall experience
We have focussed on the plans and milestones for: - ***Care Close to Home*** in Waltham Forest - **Long Term Conditions** schemes in Redbridge - **Older People & Frailty** schemes in Redbridge	**We have focussed on the plans and milestones for:** - Relaunch the **Medical Rapid Assessment Unit**, **Frailty Assessment Units** and **SDEC Unit** - Further development of the **Regional Emergency Access Care Hub** (REACH) - Developing the **new Urgent Treatment Centre (UTC) model**, with a draft business case by the end of 2022/23	**We have focussed on the plans and milestones for:** - ***Home First*** in Waltham Forest - Projects in the hospital focussed on improving flow to **reduce delays in discharge** - Expansion of the '**virtual ward**' programme

We have also focussed on the Whipps Cross catchment area **Specialist Palliative and End-of-Life Care** programmes, which thread through all three core themes. This includes the establishment of **single, integrated programme** and a **comprehensive review of the current local model** to support the development of a new model. We plan to publish a set of proposals by the end of September 2022.

The IDF has a number of key enablers, without which we will not be able to deliver

North East London Health & Care Partnership

The IDF is also focussing on **enabling workstreams -** these are outlined below, including the plans for 2022/23:

Digital	- to **bring co-ordination** across system digital leads, and have **oversight of key programmes and co-dependencies that will enable the NEL ICS Digital Board to prioritise schemes** strategically in support of transformation
Workforce	- to look at **new and innovative solutions** and develop new clinical / operational roles needed for transformation - to ensure we are **aligned with current and emerging national thinking on workforce transformation**
Community Estates	- to focus on understanding better the scale, quality and location of facilities across all IDF partners' estate through the **production of a holistic view** of the community estate - to ensure there is an **integrated and aligned approach to identifying and delivering community estate solutions**
Clinical advice and oversight	- to create a form of **clinical senate**, consisting of a Core Council of clinical and care professionals - to address **risks / issues through best practice** and **engaging on proposals** that impact workforce / strategic intentions
Communications and engagement	- to **strengthen ties with local community organisations** on the planning and delivery of service transformation - to work collaboratively to ensure that the **Whipps Cross Joint Health Overview and Scrutiny Committee is able to fulfil its responsibilities**
Finance	- to work with system colleagues to explore how **the financial regime can incentivise and support investment in transformation in the right place at the right time**

Primary Care is also a critical part of transformation delivery. We will ensure it is embedded within all aspects of the transformation programmes, as well as the enablers, where necessary

Measuring success in 2022/23

North East London Health & Care Partnership

- We are now agreeing what we will look at to determine success in 2022/23 and beyond. Measurement will include the following:

  (i) **ED attendances and emergency admissions**, reflecting the ambitions of *Care Closer to Home*, Long Term Conditions programmes and the work being done in the hospital, which includes the relaunch of the SDEC, increasing 999 REACH referrals and the development of the Urgent community response service

  (ii) **Discharge numbers including community provision**, reflecting the ambitions of *Home First* and the 'virtual ward' programme

  (iii) **The delivery of specific milestones / deliverables** for transformation programmes that are critical to their success. For example, the recruitment of community nurses and care co-ordinators are essential for the successful delivery of *Home First* and *Care Closer to Home* respectively. The principle will also apply for other programmes

  (iv) **'Virtual' outpatient appointments**, reflecting the ambition to move towards a target of 50% by the time the new hospital is completed

We have identified, and continue to work on, the enablers, metrics and success criteria – it now needs to come together

North East London Health & Care Partnership

The previous pages highlight that the critical parts of the system have clear priorities for 2022/23, backed up by a plan to develop a set of metrics and measures of success. The task now for the IDF, as a system assurance function, is to **bring this together cohesively** so that we are able to articulate what we are delivering, and how we are delivering it as a health and care system. The focus in the short to medium term will be to:

(i) Ensure metrics and success criteria are final, agreed and embedded within programmes;

(ii) Capture the interdependencies between metrics and measures of success. For example, focussing on hospital discharges alone and in isolation from the performance and provision of community services / social care will not tell the full story;

(iii) Ensure there is an aligned 'one version of the truth' in terms of how we define performance, how we measure performance, and what data sources we use to make the assessment; and

(iv) Put the infrastructure in place to be in a position to be able to report in a meaningful transparent way.

What does this mean for 2022/23 →

We will develop an **Insight and Intelligence function** that allows the IDF to understand **how transformation delivery translates into metrics and success criteria from a system perspective**. Rather than just reporting, we will **interpret what it really means for the Redevelopment** and the journey to the new hospital. Importantly, this will lay the foundation for longer term ambitions (see next page)

North East London Health & Care Partnership

Looking ahead

During 2022/23, the IDF will also be focussing on **Insight and Analysis.** We need to understand what successful delivery means in terms of activity, but also in other ways. **In 2022/23, we will:**

Develop and design a transparent annual reporting process. This will:	Work towards the ambition to a more integrated approach to articulating an annual plan for activity. This will:
- **engage and involve partners**, including **patient and community groups** - **chart the progress** on transformation - look at **more than just activity metrics** and **more than just hospital activity**	- be informed by **regular insight and analysis** - **evaluate outcomes** across programmes - have a more **consistent and aligned** methodology to demonstrate **year-on-year** movements in activity

This is a key priority for the IDF during this year and beyond. We need to be able to understand what we are delivering as a system, what it actually means and how it aligns to the planned redevelopment of Whipps Cross Hospital. The IDF represents a new opportunity for local partners to work together to realise this shared ambition.

NHS
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Report to the Trust Board: 6 July 2022	TB 50/22

Title	Equity of Access and Health Inequalities
Accountable Director	Ajit Abraham – Group Director of Inclusion and Equity
Author(s)	Ian Basnett – Director of Public Health Kate Turner – Strategy Programme Manager
Purpose	To update on our work to improve equity of access and health inequalities and to publish, for the first time, waiting list data through an equity lens
Previously considered by	Group Executive Board

Executive summary

Addressing health inequalities and equity is at the core of our values, vision and objectives as set out in our 2022/23 Group Operational Plan. This matters because of the diversity of our staff and of the population we serve and was underlined by our experience of responding to COVID-19. The breadth of our work goes beyond those who attend our hospitals and reaches deep into our communities, including:

- Action to target preventable causes of ill health, such as smoking cessation and alcohol reduction programmes
- Engagement with, and advocacy for our communities – building on our work to encourage COVID vaccination uptake
- Advancing our role as an anchor institution - creating employment opportunities for local young people
- Improving equity of access, process, outcomes and experience of care – this is described in more detail below.

This paper particularly focuses on equity of care. It provides an overview of the national and local system context before describing our work programme at Barts Health and our increasing focus at system level, working with our local partners. A key priority is restoring elective services equitably and we are, for the first time, publishing waiting list data through an equity lens. This marks an important step in our journey towards identifying and addressing the challenges we face in providing equitable services for our patients and we plan to build on this over the coming months.

Related Trust objectives	
Objectives 1 and 2	
Risk and Assurance	Assurance in relation to below BAF risk

Related Assurance Framework entries	2. A risk of not identifying healthcare inequalities and/or not securing equity of access and community connectivity impairs delivery of high quality, equitable healthcare in NEL
Legal implications/ regulatory requirements	None

Action required by the Board

The Board are asked to note and endorse:

- the work being undertaken – and planned - on inclusion and equity and the strengthening of leadership and governance to drive progress going forward
- the publication of equity data in relation to waiting times, which will be routinely published through our Integrated Performance Report, the action to respond to that data and the intent to widen the scope of data collection and publication on equity over time
- the intent for regular board reports on health inequalities and equity

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REPORT TO THE TRUST BOARD

EQUITY OF ACCESS AND HEALTH INEQUALITIES

INTRODUCTION

1. Addressing health inequalities and equity is at the core of our values, vision and objectives as set out in our 2022/23 Group Operational Plan. This matters because of the diversity of our staff and of the population we serve and was underlined by our experience of responding to COVID-19. The breadth of our work goes beyond those who attend our hospitals and reaches deep into our communities, including:

    - Action to target preventable causes of ill health, such as smoking cessation and alcohol reduction programmes
    - Engagement with, and advocacy for our communities – building on our work to encourage COVID vaccination uptake
    - Advancing our role as an anchor institution - creating employment opportunities for local young people
    - Improving equity of access, process, outcomes and experience of care – this is described in more detail below.

2. This paper particularly focuses on equity of care. It provides an overview of the national and local system context before describing our work programme at Barts Health and our increasing focus at system level, working with our local partners. A key priority is restoring elective services equitably and we are, for the first time, publishing waiting list data through an equity lens. This marks an important step in our journey towards identifying and addressing the challenges we face in providing equitable services for our patients and we plan to build on this over the coming months.

NATIONAL AND LOCAL SYSTEM CONTEXT

3. COVID-19 highlighted the urgent need to prevent and manage ill health in groups that experience health inequalities. Integrated Care Systems have been charged with leading this work and in 2021/22, five priority areas were established: restoring NHS services inclusively, mitigating against digital exclusion, ensuring data sets are complete and timely, accelerating preventative programmes and strengthening leadership and accountability.

4. Following this, the national Core20PLUS5 approach was introduced in 2021/22[1]. The approach defines a target population cohort (the most deprived 20% of the national population) and identifies 5 focus clinical areas for improvement – maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypotension. The 22/23 national NHS planning guidance reinforced the importance of systems addressing health inequalities through this approach.

5. Tackling inequalities in outcomes, experience and access is a core strategic purpose of Integrated Care Systems. North East London Integrated Care System is committed to focusing on preventing ill-health and tackling health inequalities by redoubling efforts on the five priority areas and building on the Core20PLUS5 approach to support the reduction of health inequalities experienced by adults, children and young people.

6. A NEL Population Health and Health Inequalities Steering Group has now been established – which we are supporting the development of and which includes senior Barts Health representation – with workstreams on: population health management, equity in health and care services, embedding prevention and addressing the wider determinants of health through being an 'Anchor' system.

BARTS HEALTH APPROACH

Understanding our population and empowering our staff

7. We serve some of the most deprived parts of London, and amongst the most ethnically diverse parts of England. We are creating a **population health profile** to help our staff better understand the needs of our population in order to ensure our services are fit for purpose. This will be a comprehensive picture, illustrating some of the root causes of poor health such as the large numbers of people experiencing social exclusion and health risks from wider determinants such as air pollution, unemployment, poor quality or insecure housing, food insecurity and social isolation. We will publish the key analysis from this later in the year, connecting to the population analysis undertaken by NEL ICS on a wider footprint.

8. As such, tackling health inequalities and addressing equity in care is at the core of our organisational values, vision and objectives. Our work begins with our staff – about 17,000 - and our commitment to becoming an **inclusive organisation** supported by our webelong strategy. We aim to create a just and fair culture that values all our staff, celebrating their diversity and empowering them to bring their cultural intelligence to bear in improving services for our patients.

[1] Core20PLUS5 - An Approach to Reducing Health Inequalities, published in November 2021

Improving Equity Of Care

9. We have a longstanding programme of work, key elements of which are described below against the five national priorities on health inequalities (listed in paragraph 3).

i) Restoring NHS services inclusively

10. We are monitoring our elective waiting times for the largest 15 specialties in relation to ethnicity, deprivation, gender and learning disabilities to ensure we are restoring services equitably – see the data[2] in our Integrated Performance Report (but also attached here for ease as an appendix). It indicates:
    - on **ethnicity** - there is no statistically significant difference in waiting times at Trust level between ethnic groups but further work is needed to better understand waiting times for patients where the ethnicity is 'unknown'.
    - on **gender** - there is no statistically significant difference in waiting times at Trust level but further work is being undertaken to understand the difference in waits for patients where the gender is 'unknown'
    - on **deprivation** - there is a minor difference between the waiting times at Trust level of those in the least deprived and the most deprived areas (with the most deprived waiting longer) which is marginally above the threshold for statistical significance. We will explore this further to understand the possible reasons.
    - on **learning disability** – the data indicates that patients with learning disabilities on average are waiting longer for surgery. However, this can be attributed to specific challenges in one specialty – restorative dentistry for children. The action we have taken has significantly improved this, but there is more to do (further detail on this below).
    - at **hospital site level** there is no statistically significant difference between the waiting times of patients by ethnicity or deprivation, although it appears there is a minor difference at Whipps Cross between the waiting times of those in the least deprived and most deprived areas (with the latter waiting marginally longer). We are exploring this data further to understand the possible reasons.

11. We first interrogated the data for patients with learning disabilities last year because it showed they were waiting on average over 125 days longer for surgery than patients without a learning disability and were twice as likely to wait over a year. The cohort of

[2] It is important to note that these data are not adjusted for difference between ethnic groups such as average age which could have an influence, but are overall averages. The data in this report represents a single month (May '22). It is though part of a live database and we will continue to monitor the data each month to see if there is any evidence of trends and to identify areas where further investigation might be needed.

patients was small (140) and we found that a large proportion were waiting for restorative dentistry. The delays were partly due to strict infection control that applied to carers and patients as many of these patients required General Anaesthetic (unlike patients without learning disabilities).

12. As a result, we took action as a Trust to prioritise learning disability patients for surgery. Since July 2021, the difference in average waits for patients with learning disabilities and those not identified as having learning disabilities has been reduced by nearly 100 days. While there is still a significant difference, this is solely due to the specific challenges in restorative dentistry which we continue to work to address – and the recent easing of infection, prevention and control guidance should further support this. Outside of that specific specialty issue, there is no statistical difference in waiting times for this group of patients. In the meantime we will continue to prioritise Learning Disabled patients for all specialities.

13. Going forward, we will continue to publish our waiting list data in this way routinely as part of our Integrated Performance Report and when we see disparities, we will - as we have with Learning Disabilities - seek to understand the underlying causes and take action. We will also, as described further below, increasingly expand our data publication over time to cover other services and protected characteristics.

14. Although the overall picture described above is encouraging in relation to equity, we are far from complacent and will keep this under review. We know that patients wait longer for surgery in some specialties at some of our hospitals compared to others. The reasons for this are likely to be multi-faceted and include, for example, the different case mix and complexity of surgeries carried out. However, we intend to undertake an analysis of surgical waits by borough of residence to understand if there is an inequity in waiting times by geography. We will report on this at a future Board.

15. We have also begun piloting an Outpatient Equity Dashboard which will enable services to review a series of data, such as missed appointments (DNAs), patient and hospital cancellations by protected characteristics and deprivation. We aim to publish the outcome of the pilot once it is complete.

ii) Mitigate against digital exclusion

16. The expansion of virtual appointments, catalysed by the response to the pandemic, provided real benefits for many patients. However, we are committed to understanding where there may be disparities in how different groups of people are accessing virtual appointments. We are analysing this further as part of completing the outpatients pilot.

17. We are committed to increasing the uptake of advocacy for digital appointments. We're currently working with our digital advocacy service team to undertake a baseline assessment and gap analysis to identify interventions to improve uptake. To support this our Patient Engagement team has been working closely with the Roma and Albanian communities to better understand barriers to accessing digital appointments. We know there is a paradigm shift here that we need to bring about if we're ever to truly say that our population have equal access because it remains the case that it's easier to access hospital if you speak English.

iii) Ensure datasets are complete and timely

18. We currently have over 90% data captured in terms of the proportion of patient episodes where ethnicity is captured in our A & E, Inpatient and Outpatient services. This has seen some recent improvement but there is further work to do. Our aspiration is to reach 100%, with 95% achievement in 2022/23.

19. Our waiting list PTL figures though record the proportion of individuals where ethnicity is captured and this is lower – at 83% - reflecting patients on the waiting list who have not yet entered our services (which is the point ethnicity is recorded). We are looking at better capturing ethnicity in those patients by improving the download of data from primary care data sets. While we routinely collect information on age, ethnicity, gender and deprivation, we have less data on other protected characteristics – for example languages spoken. We are developing a Trust-wide programme to increase data quality.

20. Beyond access to our services we plan to expand our understanding of our services by carrying out work to look at the equity in the **outcomes** of care, with a view to doing that more systematically and also the **experience** of care. On the latter we are piloting the use of the friends and family test in Bengali to see if it improves the richness of data and if successful we will broaden that to more ethnic groups.

iv) Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes

21. We continue to promote vaccination amongst staff and in communities, particularly amongst groups with lower uptake, working with clinical leaders from ethnic minority backgrounds. Meanwhile the Public Health team has recently appointed a new Tobacco Dependence Team in order to improve the impact of the smoking cessation programme,

v) Strengthen leadership and accountability

22. There is a clear link (as described in paragraph 8) between our key strategic objectives of becoming an inclusive organisation and delivering services for our patients that address inequalities and inequities of care. As the scale of our ambition grows, it follows that we need to strengthen the leadership and governance to drive and oversee progress. To this end, a new Group Director of Inclusion and Equity has been

created and the first incumbent, Mr Ajit Abraham, a consultant specialising in general surgery, trauma and liver disease is due to take up post at the beginning of July.

23. The role will provide strategic leadership and oversight, working across the Group, with hospital sites and the wider health and social care system, to embed inclusion and equity throughout everything we do, hardwiring it into the culture of our organisation and in the way we view the quality of our care for the patients we serve. We know this needs to penetrate our staff at every level – from our plans to roll out our cultural intelligence training to 12,000 members of staff by June 2023, to embedding equity in our Trust-wide improvement methodology – 'weimprove', which in September, will run an 'Equity in QI course' for QI specialists and coaches.

24. We are using Mr. Abraham's appointment as an opportunity to review and strengthen our programme of work and our internal governance arrangements for inclusion and equity – as well as how we relate to the new NEL ICS architecture as that is established. We will update the Board on this in due course.

Working with our system partners to deliver improvements

25. Increasingly it will be our collaboration with BHRUT (and the Acute Provider Collaborative) and our work at 'place' level with wider system partners in NEL ICS that will enable us to make a lasting impact on the population health challenges across North East London – from collaborating on urgent and emergency care delivery, to identifying mutual aid to help reduce inequities of waiting times, to wider clinical transformation through the creation of elective surgical hubs. In particular, the contribution of our hospital sites in 'place based' care relating to health inequalities, health prevention and chronic illness will be key in driving improvement.

26. As we evolve our approach in Barts Health, as described in this paper, we will continue to work ever more closely with system partners. For example, we are working with NEL ICS to consider how we can uniquely contribute to improving care in the 5 priority clinical areas in Core20Plus - maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension.

27. Important work in these areas has already begun, for example, through the Elope Programme[3], we are working with system partners on innovative ways to reduce hypertension and we're supporting NEL ICS to develop an equity strategy for maternity that will be rolled out for women and their families across the ICS.
28. Working with our system colleagues should give us the opportunity to expand our horizons beyond North East London and look at the equity of care for our patients not just within our own local health and social care system but with other systems.

[3] The Elope programme works to support the prevention of cardiovascular disease across North East London.

CONCLUSION AND NEXT STEPS

29. This paper demonstrates the central importance of inclusion and equity to our values, our vision and objectives as an organisation. It provides an overview of our programme of work and how that is evolving – both internally and in working with our partners. We are in the foothills of a long journey to better understand and respond to the needs of our diverse population and to reduce health inequalities and inequities in the care we provide.

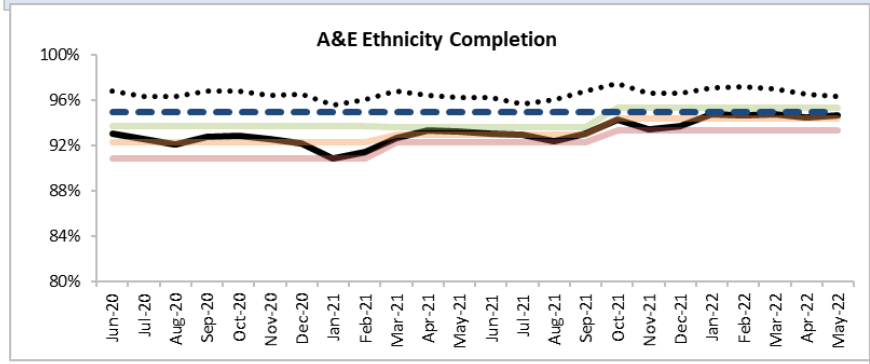
30. Our publication of data on equity in relation to waiting times is an important step in this which will be routinely incorporated into our monthly Integrated Performance Report. We have demonstrated where we have taken action to address disparities and we will continue to do this as we expand the data we collect and publish over time, shining a light on the areas that require further investigation and action. We anticipate taking regular reports to the Board, both on our wider work on health inequalities and, in particular, our work to improve the equity of care for patients.

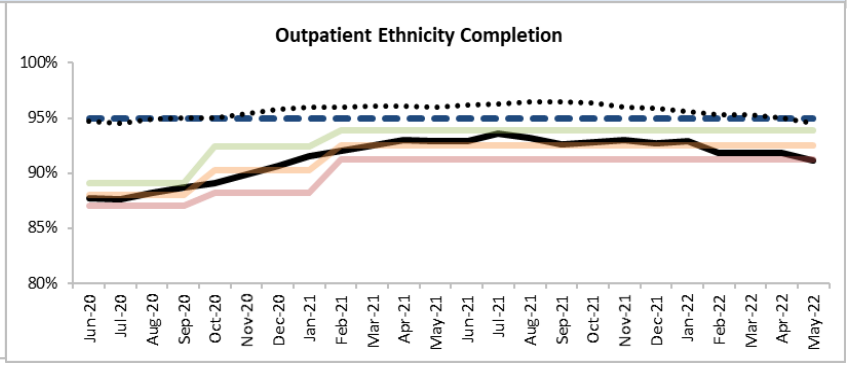
31. The Trust Board is asked to note and endorse:
    - the work being undertaken – and planned - on inclusion and equity and the strengthening of leadership and governance to drive progress going forward;
    - the publication of equity data in relation to waiting times, which will be routinely published through our Integrated Performance Report, the action to respond to that data and the intent to widen the scope of data collection and publication on equity over time;
    - the intent for regular board reports on health inequalities and equity.

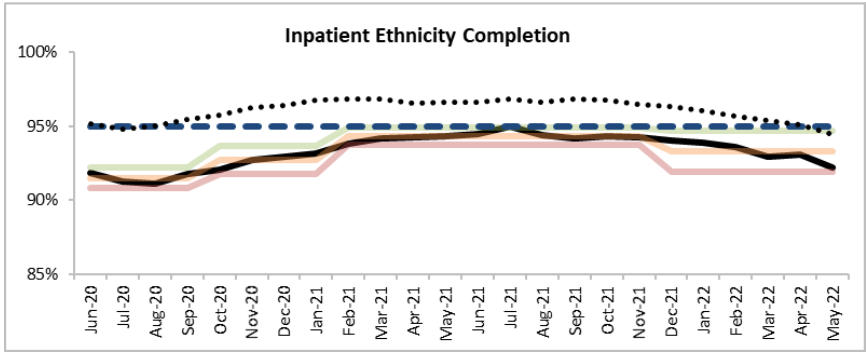
RESPONSIVE

Ethnicity Recording by Activity Type

Jul-22







Ethnicity Recording by Activity Type - % Completion - May-22

Site	A&E	Inpatient	Outpatient
Royal London	95.2%	89.2%	89.2%
Whipps Cross	93.6%	93.1%	91.0%
Newham	95.0%	95.7%	95.3%
St Bart's	-	95.6%	91.9%
Other	-	-	100.0% *
Trust	**94.7%**	**92.2%**	**91.1%**

The above figures show 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). The dotted black line shows what the % recorded would be expected to be if North East London GP data on ethnicity were to be included; this will not yet be reflected in the Trust's reported performance or NHS Digital external dashboards

Performance Overview

- Overall, Trust performance has changed little since last month, but marginal improvements have been observed in A&E with capture rates up 0.5 percentage points to 94.7%.
- Capture rates in Inpatient and Outpatient departments have dropped slightly since the previous month, by 0.6 percentage points and 0.5 percentage points respectively. However, there appears to be a decline in capture rates since Jan 22 for both.
- Newham is the highest performing site achieving 95% in all three areas.
- Royal London A&E has continued to increase capture rates up from 94.6% in the previous month.
- Capture rates for Whipps Cross have increased in A&E from 93.2% in the previous month but have dropped in Inpatient and Outpatient departments from 94.5% and 91.5% respectively.

Responsible Director Update

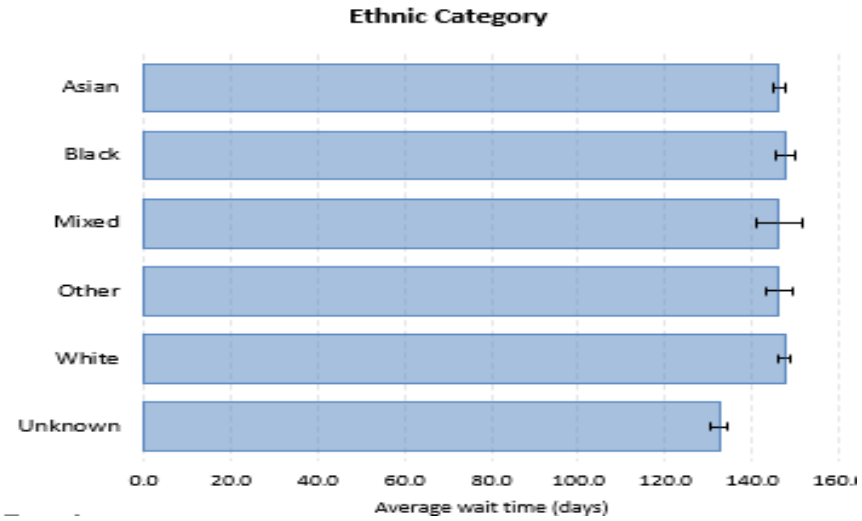
- The Trust has included achieving 95% ethnicity capture across A&E, Inpatient and Outpatient services at all sites in line with its planning objectives for 2022/2023.
- Improvements in A&E capture rates at all three sites is encouraging and we will continue to work with the team to gather and share learning across sites.
- The uploading of GP data on ethnicity contributes to improving the overall position. Additionally, the Trust is looking into the automatic download of this data, rather than manual, which would further help sites improve.

** This relates to 8 patients where ethnicity was recorded but where the site was not recorded due to a coding error.*

RESPONSIVE

Equity - Wait Times By Ethnicity

Jul-22



Ethnic Category	Average Wait (Days)	Lower CI	Upper CI
Asian	146.1	144.7	147.5
Black	147.6	145.3	149.9
Mixed	146.2	141.0	151.4
Other	146.1	143.0	149.2
White	147.6	146.3	148.9
Unknown	132.4	130.6	134.1
Grand Total	**144.4**		

Commentary

There is no statistically significant difference in waiting times between ethnic groups but further work is needed to better understand wait times for patients where the ethnicity is 'unknown'.

PTL data from May 2022 show that at Trust level, there is little difference in wait times from referral to treatment between ethnic groups. Average wait times range between 146.1 - 147.6 days across the known ethnicities.

Further the 95% confidence intervals overlap indicating that any difference in wait time is not statistically significant and could easily be due to chance.

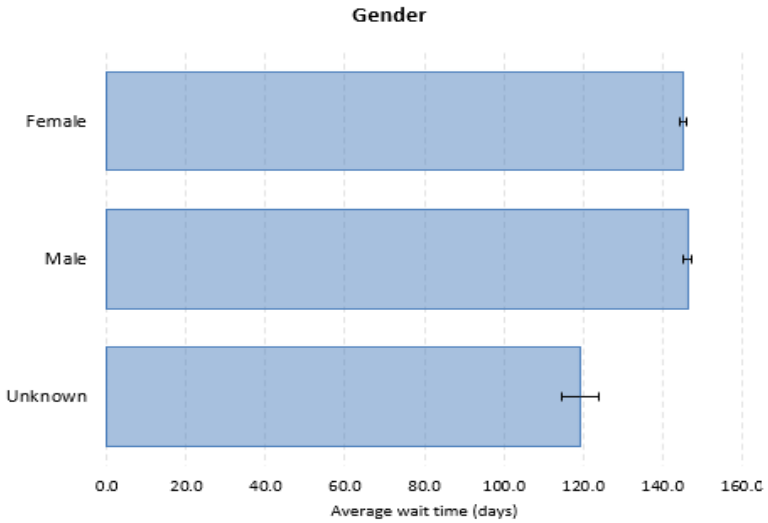
Work is currently under way to better understand wait times for patients categorised as 'Unknown' ethnicity. This is in line with Race Health Observatory recommendations and the NHS Operating Plan which state that ICSs must restore NHS services inclusively and ensure datasets are complete and timely. There patients are much less likely to have previously been in contact with the Trust than those of known ethnicity.

It is important to note that these data are not adjusted for difference between ethnic groups such as average age which could have an influence but are overall averages. The same is true of all of the slides below.

RESPONSIVE

Equity – Wait Times by Gender

Jul-22



Gender	Average Wait	Lower	Upper
Female	145.3	144.3	146.3
Male	146.4	145.2	147.5
Unknown	119.2	114.5	124.0
Grand Total	**145.4**		

Commentary

There is no statistically significant difference in waiting times between genders but further work is being undertaken to understand the difference in waits for patients where the gender is 'unknown'.

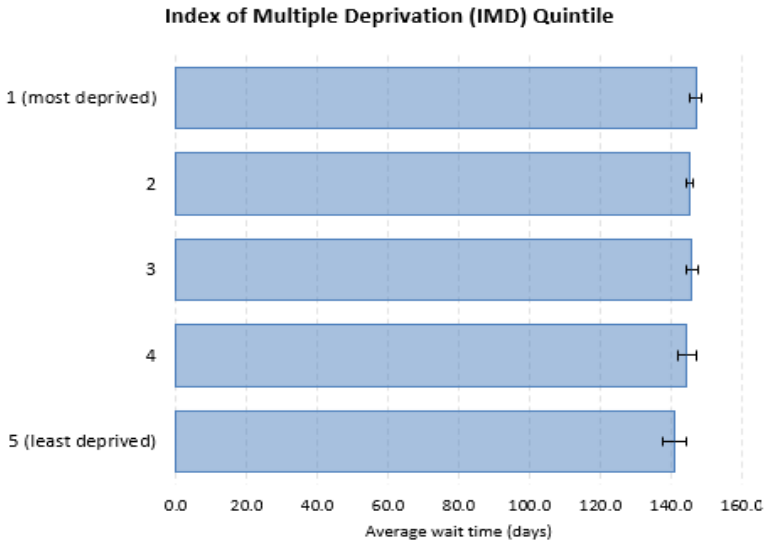
Trust-wide, the wait time from referral to treatment by gender is very similar for male patients compared with female patients (146.4 days vs 145.3 days respectively).

The group 'Unknown' gender is being investigated further.

RESPONSIVE

Equity – Wait Times By Deprivation

Jul-22



IMD Quintile	Average Wait	Lower	Upper
1 (most deprived)	147.0	145.5	148.6
2	145.4	144.3	146.6
3	146.1	144.2	147.9
4	144.6	142.0	147.2
5 (least deprived)	141.2	137.8	144.5
Grand Total	**145.7**		

Commentary

There is a minor difference between the waiting times at Trust level of those in the least deprived and the most deprived areas which is marginally above the threshold for statistical significance. We will explore this further to understand the possible reasons.

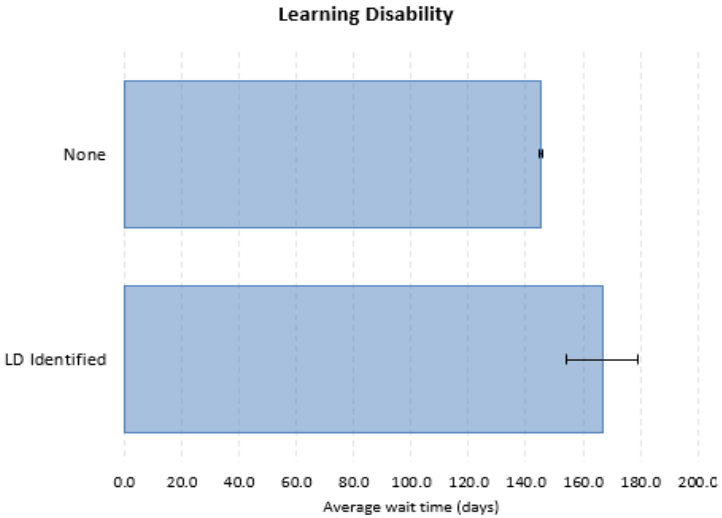
The waits for patients living in the most deprived areas (IMD quintile 1) differ only by a few percentages point from patients living in the least deprived areas (147.0 versus 141.2 days). Further the confidence intervals, don't overlap between quintiles .

However just comparing the least and most deprived the difference is 5.8 days (around 4%) which, in relation to the sample size, means it is marginally above the threshold for statistical significance, though this is not necessarily clinically significant.

RESPONSIVE

Equity – Wait Times by LD

Jul-22



LD_Flag	Average Wait	Lower	Upper
None	145.3	144.5	146.0
LD Identified	166.7	154.4	178.9
Grand Total	**145.4**		

Commentary

Patients with learning disabilities on average are waiting longer for surgery. However, this can be attributed to the specific challenges in one specialty – restorative dentistry for children. Action taken over the last period has significantly reduced the difference in wait times but there is more to do.

We first interrogated the data for patients with learning disabilities last year because it showed they were waiting on average over 125 days longer for surgery than patients without a learning disability and were twice as likely wait over a year. The cohort of patients was small (140) and we found that a large proportion were waiting for restorative dentistry. The delays were partly due to strict infection control that applied to carers and patients as many of these patients required General Anaesthetic (unlike patients without learning disabilities).

As a result, we took action as a Trust to prioritise learning disability patients for surgery. Since July 2021, the difference in average waits for patients with learning disabilities and those not identified as having learning disabilities has been reduced by nearly 100 days.

There is still a statistically significant difference in average wait times for patients with a learning disability (LD) of 21.4 days. This is 166.7 days for patients identified as having an LD compared with 145.3 days in patients not identified as having a learning disability

However, this is solely due to the specific challenges in reconstructive dentistry which we continue to work to address – and the recent easing of infection, prevention and control guidance should further support this. In the meantime we will continue to prioritise Learning Disabled patients for all specialities.

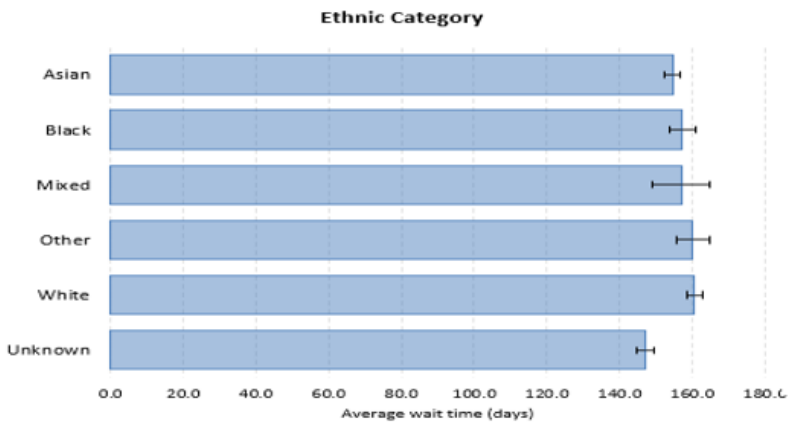
RESPONSIVE

Equity - Wait Times By Ethnicity (Sites)

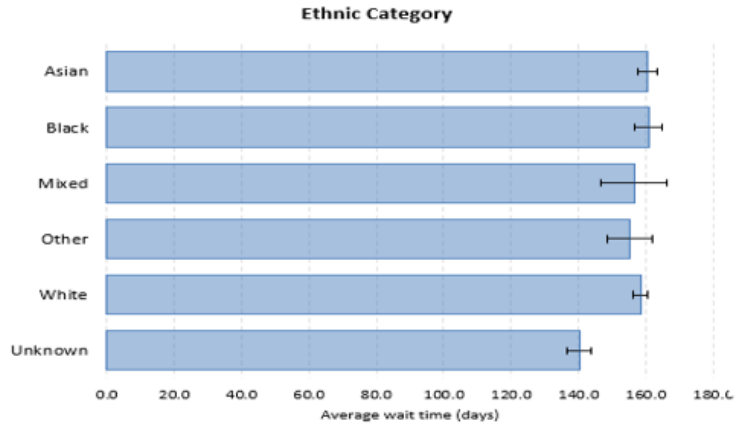
Jul-22

At hospital site level there is no statistically significant difference between the waiting times of patients by ethnic group.

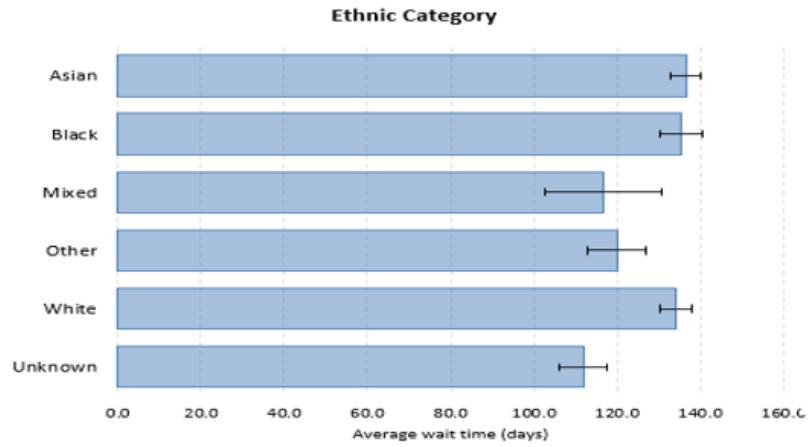
Royal London



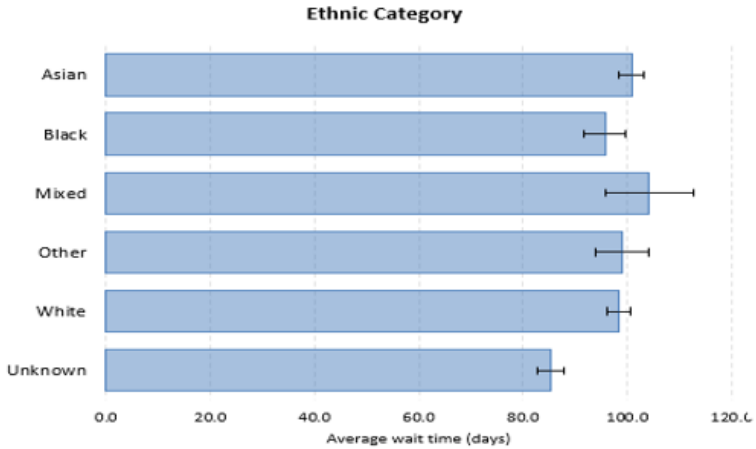
Whipps Cross



Newham



St Bart's



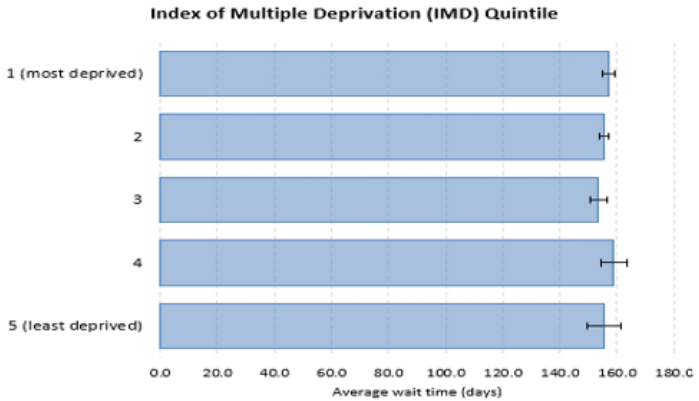
RESPONSIVE

Equity – Wait Times By Deprivation (Sites)

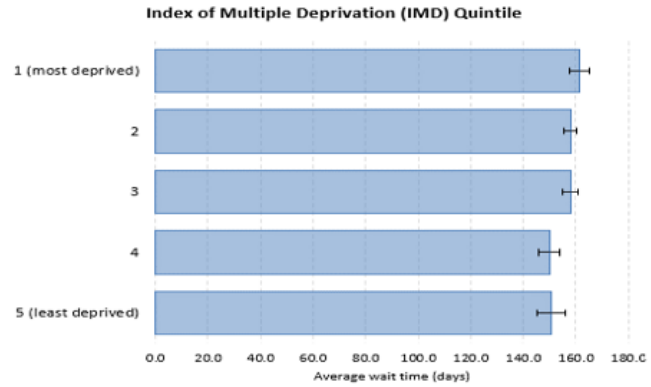
Jul-22

At hospital site level, there is no statistically significant difference in the waiting times of patients in relation to deprivation although it appears there is a minor difference at Whipps Cross between the waiting times of the most and least deprived areas - with those in the most deprived waiting 6.8% longer than those in the least deprived. We will continue to monitor this and explore the data further so we can understand the possible reasons.

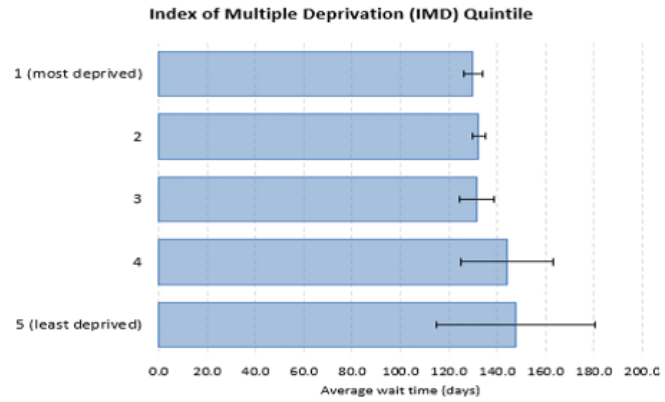
Royal London



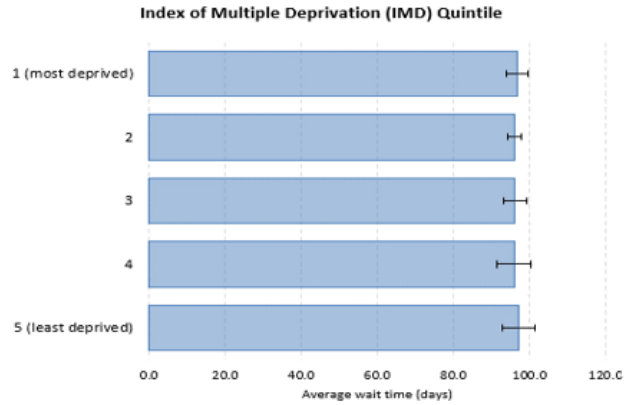
Whipps Cross



Newham



St Bart's



Barts Health NHS Trust

Report to the Trust Board: 6 July 2022	TB 51/22

Title	Standalone private patients' facility at St Bartholomew's Hospital
Accountable Director	Chief Financial Officer
Author(s)	Group Commercial and Business Development Director
Purpose	To update the Trust Board on the development of a standalone private patients' facility at St Bartholomew's Hospital
Previously considered by	Finance and Investment Committee 1 June 2022 Trust Board 6 April 2016

Executive summary

Following a procurement process and contract approval in 2017 of the Nuffield Health partnership a standalone private patients' facility called *Nuffield Health at St Bartholomew's Hospital* opened on 3 May 2022.

Related Trust objectives

2. To restart and transform clinical services to provide equitable access, high quality outcomes and a focus on population health
3. To make progress on our longer-term strategic priorities

Risk and Assurance	Risks included in the Business Case and Legal Report are reviewed and joint risks are managed at the Partnership Board.
Related Assurance Framework entries	n/a

Legal implications/ regulatory requirements	The Trust's legal advisers have been involved throughout the process

Action required by the Board

The Trust Board is asked to note the opening of *Nuffield Health at St Bartholomew's Hospital* on 3 May 2022.

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 6 JULY 2022

PRIVATE PATIENT PARTNERSHIP AT ST BARTHOLOMEW'S HOSPITAL

INTRODUCTION

1. Following a competitive procurement process[1] the Trust selected Nuffield Health as the preferred provider for a Private Patient Partnership[2] which included the design, build, funding and operation of a standalone private patients' facility at St Bartholomew's Hospital.

2. The standalone private patients' facility is split over two buildings: the RSQ and Old Pathology Block. Both buildings were in a dilapidated state and the Trust did not have the resources to develop them. Substantial structural work has been undertaken (see Appendix 1 for pictures).

3. Following Trust approval of the Full Business Case in March 2016 and subsequent approval by NHSE/I, agreements were signed on 3 May 2017 with Nuffield Health.

4. Construction commenced in July 2018 following a delay of 41 weeks in achieving planning permission and completion of the enabling works. Construction was subsequently delayed by 46 weeks due principally to Covid-19.

5. Practical Completion and CQC Registration by Nuffield Health were achieved in April 2022 and *Nuffield Health at St. Bartholomew's Hospital* opened on 3 May 2022.

NUFFIELD HEALTH

6. Nuffield Health is a charity with almost 60 years of history and experience of delivering private healthcare across the UK. Their mission is to improve the health of the UK and, as a not-for-profit organisation, their surpluses are reinvested into providing healthcare.

7. Nuffield Health has a national network comprising 37 Acute Private Hospitals, 41 Medical Centres and 113 Fitness and Wellbeing Centres and this includes a strong referral base in London from their extensive London presence which also includes corporate sites and corporate clients.

[1] OJEU Notice 2014/S 159-286272
[2] See Open Trust Board Paper TB 52/16

8. Nuffield Health view *Nuffield Health at St Bartholomew's Hospital* as their 'flagship' London hospital, and it is the first and only private hospital in the City of London. In 2021[3] Nuffield Health also acquired four other hospitals in London.

9. *Nuffield Health at St Bartholomew's Hospital* consists of: 55 beds, including 7 critical care beds; 4 operating theatres including a cardiac hybrid theatre; a cardiac catheterisation lab; 26 consultation rooms; 1 full diagnostic imaging suite including MRI, CT, ultrasound, mammography and general X-Ray; treatment rooms and support facilities.

10. *Nuffield Health at St Bartholomew's Hospital* specialises in private cardiac surgery, cardiology, orthopaedics, cancer care and women's health.

11. The standalone private patients' facility at St Bartholomew's Hospital is part of a new health and wellbeing campus for Nuffield Health, meaning patients will have access to the new Nuffield Health Fitness & Wellbeing Centre in Barbican.

12. Nuffield Health currently runs free to access community clinics from the campus, including Joint Pain and COVID-19 rehabilitation programmes. Patients who have long-term symptoms of COVID will be able to refer themselves directly or through a GP or NHS referral.

13. The standalone private patients' facility at St Bartholomew's Hospital will be an intrinsic part of the St Bartholomew's Hospital site and will be physically and operationally independent from NHS clinical activities. The facility has been and will continue to be funded and staffed entirely by Nuffield Health.

BENEFITS TO BARTS HEALTH

14. The partnership agreement will contribute to and benefit the Trust in the following key ways:

- Aligns with and enhances clinical services such as the Barts Heart Centre.
- Supports the wider Trust financial position.
- Utilises previously vacant estate in a dilapidated condition (see Appendix 1) and returns this to use for health services with the Trust as landlord.
- Captures an improved share of the London private patient healthcare market.
- Provides funds from Nuffield Health for certain Trust provided NHS support services.
- Facilitates various Partnering initiatives.
- Enables NHS waiting list work whilst Nuffield Health ramps up its private patient activity.

[3] The Parkside Private Hospital Wimbledon, Highgate Private Hospital, Cancer Centre London, The Holly Private Hospital

- Attracts and retains staff.

15. The benefits of the partnership included a transfer of the capital and financing risk, a transfer of the operational risk and cost, and increased value of the estate upon its return to the NHS. The construction cost and any escalation of that cost was fully funded by Nuffield Health.

16. There was no sale of assets. The Trust leases the land and buildings to Nuffield Health, which has invested £70m in transforming the building and equipping the unit for use as a modern private healthcare facility. The completed facility will be handed back to Barts Health at the end of the 30-year contract term in April 2052.

17. The buildings represent less than 1.5% of Barts Health's total-built estate and with operations commencing the standalone private patients' facility at St Bartholomew's Hospital provides a multi-million pound revenue stream, and revenue streams from other Partnership initiatives over its lifetime, to the Trust to be invested back into NHS services.

18. *Nuffield Health at St Bartholomew's Hospital* provides the flexibility for Barts Health consultants to see private patients at a site that is closer to their primary NHS work.

19. The standalone private patients' facility at St Bartholomew's Hospital is adding specialised healthcare capacity to the City of London.

20. At times of crisis Nuffield Health have demonstrated their commitment to the partnership. The partnership has already seen twenty members of the Nuffield Health hospital team being seconded into Barts Health hospitals in late 2021 to support in intensive care, cardiac wards, and with COVID vaccination clinics.

21. As part of Nuffield Health's planning consent, the following was also agreed, and has been built, which will exclusively be to the benefit of Barts Health and The Heritage Trust - principally the Great Hall:

- Construction of the North Wing lift (to dimensions agreed with the Friends of the North Wing).
- Creation of a storage/catering area of approx. 75sqm in the basement of the NH PPU demise (shell and core and drainage installed).
- Installation of ventilation ductwork from basement kitchen to roof.

BENEFITS TO PATIENTS

22. With the opening of the hospital in May 2022, Nuffield Health have agreed in principle to support the development of services through waiting list activity, aligned to the Trust's services development plan.

23. *Nuffield Health at St Bartholomew's Hospital* further enhances the global reputation of the site as a centre of clinical and academic excellence.

24. The partnership enables both parties to build expertise together to the benefit of patients. This includes the provision of a wider range of services to patients on the site utilising St Bartholomew's site services (Maggie's at Barts, Radiotherapy, education and research).

25. The income generated by the Trust from the partnership and the different service agreements is reinvested to support NHS services and patients.

26. Nuffield Health have expertise in integrated connected care, leveraging their health and wellbeing facilities.

HEALTH AND WELLBEING

27. The Agreements included a number of 'partnership initiatives' such as on Health & Wellbeing.

28. A fixed number of free Nuffield Health health checks will be offered each year by Nuffield Health physiologists to certain staff groups[4] across the Trust to increase accessibility and engagement.

29. A Nuffield Health physiotherapy service will be provided in addition to cover those staff undertaking the health checks.

30. In parallel a research study will be undertaken funded by Nuffield Health into the effect of this activity.

31. Nuffield Health are also providing subsidised gym membership to all Barts Health staff at any Nuffield Health wellbeing centres (currently 40% discount).

32. All staff will be given access to the Nuffield Health *Health and Wellbeing* app and *Covid rehab* app, which would normally only be available to Nuffield Health gym and Corporate members.

RECOMMENDATION

33. The Trust Board is asked to note the progress of the partnership with Nuffield Health and the opening of *Nuffield Health at St Bartholomew's Hospital* on 3 May 2022.

[4] Initially targeting Band 2 and 3 permanent staff at the trust

Appendix 1

TRANSFORMATION OF TWO DILAPIDATED BUILDINGS TO *NUFFIELD HEALTH AT ST BARTHOLOMEW'S HOSPITAL*

FROM OLD PATHOLOGY BLOCK TO NEW INPATIENT HOSPITAL

FROM OLD RSQ BUILDING TO NEW OUTPATIENT HOSPITAL

FROM OLD INTERNAL RSQ BUILDING TO NEW OUTPATIENT HOSPITAL

Auditor's Annual Report

Barts Health NHS Trust
Year ended 31 March 2022

20 June 2022

mazars

Contents

01

Section 01:

Introduction

1. Introduction

Purpose of the Auditor's Annual Report

Our Auditor's Annual Report (AAR) summarises the work we have undertaken as the auditor for Barts Health ('the Trust') for the year ended 31 March 2022. Although this report is addressed to the Trust, it is designed to be read by a wider audience including members of the public and other external stakeholders.

Our responsibilities are defined by the Local Audit and Accountability Act 2014 and the Code of Audit Practice ('the Code') issued by the National Audit Office ('the NAO'). The remaining sections of the AAR outline how we have discharged these responsibilities and the findings from our work. These are summarised below.

Opinion on the financial statements
We issued our audit report on 20 June 2022. Our opinion on the financial statements was unqualified.

Value for Money arrangements
In our audit report issued we reported that we had completed our work on the Trust's arrangements to secure economy, efficiency and effectiveness in its use of resources and had not issued recommendations in relation to identified significant weaknesses in those arrangements. Section 3 provides our commentary on the Trust's arrangements

Wider reporting responsibilities
In line with group audit instructions issued by the NAO, on 20 June 2022 we reported that the Trust's consolidation schedules were consistent with the audited financial statements.

Under section 30 of the Local Audit and Accountability Act 2014, we have reported the Trust's expenditure has exceeded it's income by £72,442,000 for the three year period ended 31 March 2022, in breach of the statutory breakeven duty.

02

Section 02:

Audit of the financial statements

2. Audit of the financial statements

The scope of our audit and the results of our opinion

Our audit was conducted in accordance with the requirements of the Code, and International Standards on Auditing (ISAs).

The purpose of our audit is to provide reasonable assurance to users that the financial statements are free from material error. We do this by expressing an opinion on whether the statements are prepared, in all material respects, in line with the financial reporting framework applicable to the Trust and whether they give a true and fair view of the Trust's financial position as at 31 March 2022 and of its financial performance for the year then ended. Our audit report, issued on 20 June 2022 gave an unqualified opinion on the financial statements for the year ended 31 March 2022.

Qualitative aspects of the Trust's accounting practices

Audit teams may wish to bring certain matters to the public's attention in relation to the client's accounting practices and matters discussed with management that were reported in the Audit Completion Report. It is not mandatory to include matters in this section, but where the audit team feels matters should be brought to the public's attention, then they can be reported here.

2. Audit of the financial statements

Internal control recommendations

As part of our audit we considered the internal controls in place that are relevant to the preparation of the financial statements. We did this to design audit procedures that allow us to express our opinion on the financial statements, but this did not extend to us expressing an opinion on the effectiveness of internal controls. We identified the following deficiencies in internal control as part of our audit.

Description of deficiency

Our documentation of controls in respect of journal entries confirmed that when users are given permissions within Oracle to post journals, they are linked with designated approvers, these being above the user in the overall hierarchy for the same area. Therefore, when created by the user, a journal is sent to the relevant group of appropriate approvers, who then approve the journal for posting.

During audit testing of journals a systems issue was identified for a small group of users when all of the relevant approvers are 'out of office'. In this instance the journal created is then automatically delegated back to the original poster for them to self-authorise.

Potential effects

As a result the user is able to create and then approve journals which gives rise to a failure to ensure segregation of duty. As the journals are not reviewed by a manager / approver this could result in incorrect or fraudulent entries being approved.

We tested in detail two of these journals and found no indication of inappropriate entries.

Recommendation

Management should engage Oracle to implement a fix to the control failure. We also recommend management consider training be provided to appropriate staff on the approval policies and the importance of segregation of duties.

Management response

A fix to Oracle was requested as soon as the Trust became aware of the issue, and this fix was implemented within 2 working days. The importance of segregation of duties, and following the correct approval policies, has been reinforced to all Finance staff. A senior finance officer has carried out a review of all of the journals that were self-approved, and identified no errors.

03

Section 03:

Our work on Value for Money arrangements

3. VFM arrangements – Overall summary

Approach to Value for Money arrangements work

We are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The NAO issues guidance to auditors that underpins the work we are required to carry out and sets out the reporting criteria that we are required to consider. The reporting criteria are:

Financial sustainability - How the Trust plans and manages its resources to ensure it can continue to deliver its services

Governance - How the Trust ensures that it makes informed decisions and properly manages its risks

Improving economy, efficiency and effectiveness - How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

Our work is carried out in three main phases.

Phase 1 - Planning and risk assessment

At the planning stage of the audit, we undertake work so we can understand the arrangements that the Trust has in place under each of the reporting criteria; as part of this work we may identify risks of significant weaknesses in those arrangements.

We obtain our understanding or arrangements for each of the specified reporting criteria using a variety of information sources which may include:

- NAO guidance and supporting information
- Information from internal and external sources including regulators
- Knowledge from previous audits and other audit work undertaken in the year
- Interviews and discussions with staff and directors

Although we describe this work as planning work, we keep our understanding of arrangements under review and update our risk assessment throughout the audit to reflect emerging issues that may suggest there are further risks of significant weaknesses.

3. VFM arrangements – Overall summary

Phase 2 - Additional risk-based procedures and evaluation

Where we identify risks of significant weaknesses in arrangements, we design a programme of work to enable us to decide whether there are actual significant weaknesses in arrangements. We use our professional judgement and have regard to guidance issued by the NAO in determining the extent to which an identified weakness is significant.

We did not identify any risks of significant weakness for 2021/22.

Phase 3 - Reporting the outcomes of our work and our recommendations

We are required to provide a summary of the work we have undertaken and the judgments we have reached against each of the specified reporting criteria in this AAR. We do this as part of our Commentary on VFM arrangements which we set out for each criteria later in this section.

We also make recommendations where we identify weaknesses in arrangements or other matters that require attention from the Trust. We refer to two distinct types of recommendation through the remainder of this report:

- **Recommendations arising from significant weaknesses in arrangements**

  We make these recommendations for improvement where we have identified a significant weakness in the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Where such significant weaknesses in arrangements are identified, we report these (and our associated recommendations) at any point during the course of the audit.

- **Other recommendations**

  We make other recommendations when we identify areas for potential improvement or weaknesses in arrangements which we do not consider to be significant but which still require action to be taken

The table on the following page summarises the outcomes of our work against each reporting criteria, including whether we have identified any significant weaknesses in arrangements or made other recommendations.

3. VFM arrangements – Overall summary

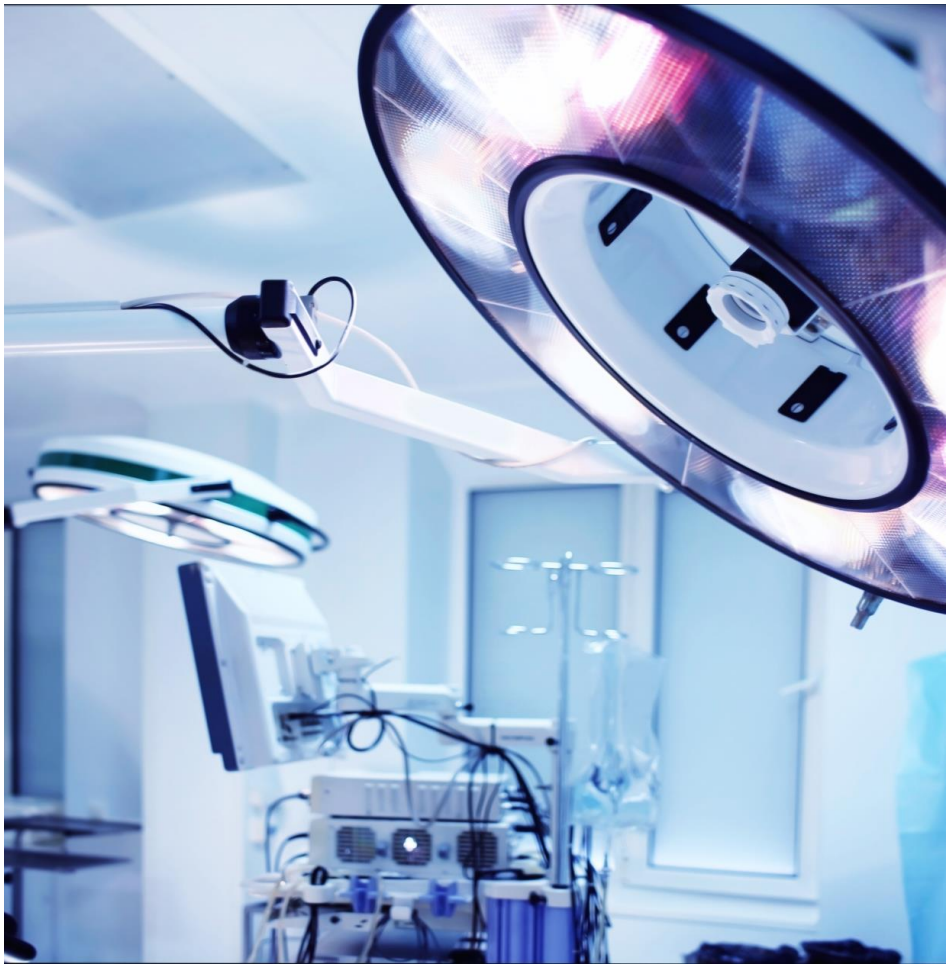
Overall summary by reporting criteria

Reporting criteria	Commentary page reference	Identified risks of significant weakness?	Actual significant weaknesses identified?	Other recommendations made?
Financial sustainability	12	No	No	No
Governance	17	No	No	No
Improving economy, efficiency and effectiveness	21	No	No	No

3. VFM arrangements

Financial Sustainability

How the body plans and manages its resources to ensure it can continue to deliver its services



3. VFM arrangements – Financial Sustainability

Overall commentary on Financial Sustainability

Background to the NHS financing regime in 2021/22

Following the onset of the Covid-19 pandemic in March 2020, the original NHS Planning Guidance 2020/21 was suspended and a new financial regime implemented. The second half of 2020/21 saw further changes with a move to “system envelopes”, whereby funding allocations covering most NHS activity were made at the system level, including resources to meet the additional costs of the COVID-19 pandemic. The 2021/22 financial year was again split into two halves, with a different funding regime being applied in each half. These regimes were largely a continuation of those from 2020/21, as introduced in response to COVID-19, with system envelopes and block payment arrangements remaining in place, with additional financial support through the Elective Recovery Fund (ERF) to seek to restore elective services.

The 2021/22 H1 period (April 2021 to September 2021) system envelope comprised adjusted CCG allocations, system top-up and COVID-19 fixed allocation, these being based on the H2 2020/21 system envelopes as adjusted for known pressures and policy priorities. The 2021/22 H1 guidance also confirmed that block payment arrangements would remain in place for relationships between NHS commissioners and NHS providers. The guidance for 2021/22 H2 period (October 2021 to March 2022) confirmed that the arrangements would stay broadly consistent with a continuation of the H1 framework, with the H2 system envelopes containing further adjustments for further known pressures, including the impact of pay awards and increased efficiency requirements.

Over the course of the year and into 2022/23, the focus of the funding regime has shifted from responding to the immediate challenges caused by COVID-19 to supporting the recovery in the healthcare system. This has increased the need for collaborative working between commissioners and providers, with local systems expected to work together to deliver a balanced position in 2021/22. Where local systems were successful and exceeded target activity levels, additional funding was available through the Elective Recovery Fund. Planning guidance for 2022/23 supports the move back to local agreement of contracts and requires systems to achieve a break even position each year. This will necessitate further collaboration through the planning process, as individual organisations work together to achieve system-level outcomes.

The Trust’s financial planning and monitoring arrangements

In the early stages of the pandemic the Trust approved and submitted a revised financial plan covering the 2020/21 financial period, which included a requirement for top-up funding to support the Trust to achieve its forecast financial position.

As noted, the NHS was operating under special financial arrangements for the first half of 2021/22. As part of its preparation of financial plans, the issued national financial guidance is reviewed by the senior finance team and the implications of change, and impact on the Trust, is assessed. The budgeting process ensures the Trust’s performance is in line with short- and medium-term plans

3. VFM arrangements – Financial Sustainability

Overall commentary on Financial Sustainability - continued

The Trust's financial performance for 2021/22 was in line with phase 3 of the financial plan submitted to NHSE/I, with the performance reporting pack (as presented regularly to the Board) consistently identifying a small surplus in comparison to budget. The Board and individual Hospital sites make use of these monthly reporting packs to monitor the performance, and any areas of potential overspend or general poor performance.

Within its financial statements, the Trust has reported an outturn position of a £20.4m deficit as at 31 March 2022 (2020/21 - £2.5m deficit). After adjusting for the impact of impairments, capital grants and donations, the adjusted outturn at 31 March 2022 is a £0.6m surplus (2020/21 - £0.1m surplus) against total income of £2bn (2020/21 - £1.9bn income). We have considered the arrangements in place in respect of budget management as part of the Governance criteria on page 18.

During the year the Trust has continued to report the overall financial position to the Finance and Investment (F&I) Committee, and then subsequently to the Board through both updates from the F&I Committee chair and the integrated performance report. We reviewed a sample of reports that had been presented for 2021/22, noting these contain a clear summary of the Trust's performance, together with detailed variances and supporting details in respect of the movements. The reports, which include details on the position against the Trust's key finance metrics and supporting analysis of figures, also include updated forecasts to the end of the financial year.

Where they impact on budget setting, significant changes that are associated with hospital developments, and which require business case approvals, are completed through the Investment Steering Committee. Processes ensure that costs associated with these changes are considered within the developed financial plans.

The Trust's arrangements for the identification, management and monitoring of funding gaps and savings

During 2021/22 the Trust has maintained its overall reported financial performance, with the additional funding received to assist in responding to the pandemic having continued to provide support for this achievement. The Trust's originally submitted long term plan covering the period 2020/21-2023/24 projected a total deficit of £109m before considering support funding. As part of the move to Integrated Care System (ICS) arrangements (North East London Health and Care Partnership - NEL HCP), and the associated operational plan that the Trust has contributed to, the Trust will be preparing a revised financial plan for the period covering 2022/23 to 2024/25.

The Trust is aware that to ensure longer term financially sustainability there is a need to ensure the overall efficiency of its service delivery within the ICS is improved, as well as manage the ongoing financial burden that arises from payments for the Private Finance Initiative (PFI) schemes at The Royal London and Newham University hospitals. At 31 March 2022, total future payments committed in respect of PFI schemes were calculated as £4.7bn and are payable until 2048 (£4.6bn at 31 March 2021). The Trust continues discussions with NHSE/I on the future funding of the PFI payments.

3. VFM arrangements – Financial Sustainability

Overall commentary on Financial Sustainability - continued

Previously the Trust has identified and achieved efficiency savings, but it recognises future achievements will be influenced by requirements of the national funding arrangements and judgements on local deliverability against the needs of the NEL HCP, combined with the overall longer term financial position of the Trust. The Trust recognises that development, support and performance management of Directorates will also be critical to delivering good financial (and operational) performance.

The Trust's internal arrangements for cost improvements were re-invigorated during the latter part of 2021/22 following the suspension of arrangements for the initial part of the year. The Trust is working with the NEL HCP partners to manage within the system financial envelope and has agreed some steps within the operational plans to assist with this, and it also continues to explore further additional funding sources with NEL HCP to address any remaining gap.

The Trust's arrangements and approach to 2021/22 financial planning

For the first half of 2021/22 the NHS remained under the financial arrangements as had been in place for the second half of 2020/21, with system funding envelopes. Block payments remained in place for relationships between CCGs and NHS providers. NHS England and improvement (NHSE/I) nationally calculated CCG and NHS provider organisational plans as the default positions for systems and organisations. During 2021/22 the ERF has also been in place, providing support for NHS healthcare systems to work together to restore elective services following the extensive impact of the pandemic on service activity. These then provide a starting point for budget management without the need to complete an extensive planning process.

The Trust has a detailed Revenue Budget Setting Policy to support its development of financial plans and these have been updated to reflect the impact of the ICS in developing the financial plans for 2022/23. The Revenue Budget Setting Policy of the Trust includes consideration of assumptions around staffing levels, pay awards, inflation, known commitments and Trust developments, and planned funding levels from the Government's spending review and the local health system plans. The Trust's well-developed budget setting process, which has been utilised for a number of years, will support the development of the financial plan for the 2022/23 to 2024/25 period.

During 2020/21 the Trust developed its 'Next Phase' plan setting out the initial plans for recovery from the pandemic, to supporting the Trust's objective to restart and transform clinical services to provide equitable access, high quality outcomes and a focus on population health. As the pandemic continued through 2021/22 the Trust continued to monitor progress and has used this to understand changes to feed into the developing plans for 2022/23. Activity, finance and workforce plans for future periods will be monitored at both Trust and ICS level, as Trust performance is linked with delivery of other NHS providers in the region.

Throughout the period the Trust has been keen to understand the full extent of financial pressures facing its own plans, which link with the plans developed in cooperation with other partners in the NEL HCP, and therefore its internal financial reporting, completed at all levels within the Trust, has included analysis of costs and income across the twelve month period of 2021/22.

3. VFM arrangements – Financial Sustainability

Overall commentary on Financial Sustainability - continued

We have reviewed the underlying assumptions and supporting analysis previously used by the Trust to compile financial plans and we have considered the level of financial commitments that the Trust currently has. We will continue to review the methodology used by the Trust as it develops financial plans to support the ICS operational plan and the available funds as set out in the three-year revenue and capital settlement covering 2022/23 to 2024/25 detailed in the Spending Review.

The Trust closely monitors current financial performance to ensure it is aware of financial issues and can identify mitigating actions to bridge these gaps where possible. As part of this there is a continued recognition, and appropriate ongoing high level challenge, that the financial gap from the future commitments on PFI contracts will not easily be resolved.

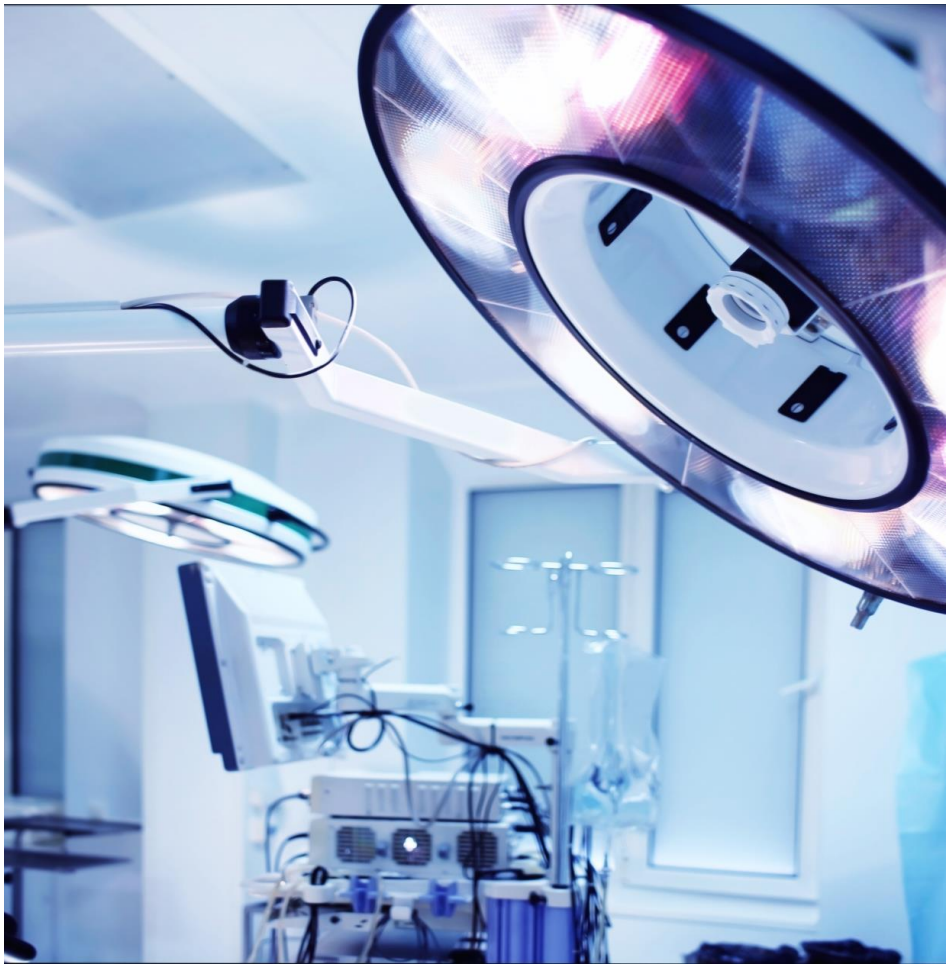
Overall conclusion

We are therefore satisfied that there is not a significant weakness in the Trust's arrangements in relation to financial sustainability.

3. VFM arrangements

Governance

How the body ensures that it makes informed decisions and properly manages its risks



3. VFM arrangements – Governance

Overall commentary on Governance

The Trust's risk management and monitoring arrangements

There is a comprehensive risk management system in place within the Trust. This is embedded into the governance structure and is supported by a Trust-wide Risk Management process. Trust leadership plays a significant role in implementing and monitoring the process through the work of the Risk Management Board.

The Risk Management Board approve Risk Strategy Work plans to support the implementation of the Risk Management Strategy throughout the year. The plans support the Trust's overall strategy and its risk management objectives through the identification of improvements and steps that aim to strengthen the Trust's risk maturity. All risks, whether externally and internally generated, are managed and monitored through the Trust's Integrated Risk Report.

A Non-Executive Director chairs the Audit and Risk Committee, and the Committee receives regular risk reports. Integrated Risk Reports, including changes to risks within the Board Assurance Framework (BAF), are presented to meetings of the Committee to allow for scrutiny and challenge, with deep dives in individual BAF risks planned for review across the year.

The Trust Board receives the BAF throughout the year to discuss and review changes in risks, as well as the principal risks to the delivery of the Trust's strategic objectives, reflecting input from non-executive and executive director discussions as appropriate and details of controls and assurances for each entry. The BAF retains a close link to the Trust's risk register and allows for ongoing monitoring of 'bottom up' risk reporting that cross references to the related high risks that appear on the risk register.

The BAF has been developed over time to include a risk appetite/tolerance dimension to improve the understanding and management of individual risks, as well as a 'heatmap' that analyses the current score against both the target risk score and the risk appetite. During 2021/22 the BAF has been expanded to include details of triggers / thresholds for the BAF risks, and this will be further discussed as part of the development of the 2022/23 BAF. From review of minutes of Board meetings, we have confirmed detailed discussion and challenge has taken place on these high-level risks which are linked to the Trust's strategic objectives, and associated enablers.

The Trust has appointed internal auditors and local counter fraud specialists to provide assurance over the effective operation of internal controls, and arrangements in place to prevent and detect fraud. Risk based work plans are agreed with management at the start of the financial year and reviewed and challenged by the Audit and Risk Committee as part of final approval process. The impact of the pandemic over the past two years has reduced the volume of work the teams have been able to complete, although work levels remain reasonable for the areas of risk within the Trust.

We have reviewed the Internal Audit Plans for 2021/22 and 2022/23, alongside the Progress reports that are presented to each Audit and Risk Committee meeting which include summary of the overall assessment, detailed issues and recommendations arising from work completed. Review of reporting includes follow up review of recommendations to identify areas with delays in responding, which allows the Committee to hold management to account on behalf of the Board. While a number of limited assurance reports have been issued in 2021/22, review has confirmed these do not give rise to potential weakness in arrangements and are being appropriately reviewed and followed up by the Trust through the Audit and Risk Committee.

3. VFM arrangements – Governance

Overall commentary on Governance - continued

Through our attendance at Audit and Risk Committee meetings we have confirmed the Committee makes effective use of reports, and the associated findings, from internal audit through detailed discussions on issues within the report area and the potential for associated issues within other aspects of the Trust's operation.

The Trust's arrangements for budget setting and budgetary control

The Trust operates on a divisional basis, with each hospital site effectively considered to be a separate part of the 'Group', which represent the whole of the Trust. The Trust Budget covers the entirety of the Group and is generally derived from annual budget setting process completed by the individual hospital sites and core services.

The process is one that, in a normal period, is derived from the Trust's overall budget setting policy, but has been amended during the pandemic and changes in the structure of the NHS (creation of Integrated Care Systems). Financial planning assumptions are outlined in the Revenue Budget Setting Policy, including detailed consideration on the base point of costs and key assumptions around pay and non-pay costs, and the link with the establishment of statutory Integrated Care Systems (ICS).

The 2022/23 Financial Plan is being developed to reflect both the North East London (NEL) ICS operational plan and the best available information and assumptions including funding growth, inflation costs, cost pressures, activity levels, efficiency plans and service priorities. The developing budgets will also reflect the Government's 2021 Spending Review which gave the NHS a revenue and capital settlement covering 2022/23 to 2024/25 as well as the proposals and assumptions in the Trust Financial Plan. Developed budgets are reconsidered throughout the year as part of performance monitoring to address issues identified or respond to changes in activity.

Monthly budget and financial monitoring reports are produced both at Hospital, Directorate and Group level and responsible finance teams work with the Hospital and / or service teams as well as individual Budget Holders to understand variances and ensure appropriate corrective action is implemented. Individual hospital sites and services complete monthly performance review meetings to discuss both the year to date and forecast positions.

A monthly summary Trust Financial Reporting Pack provides a range of information and associated narrative on overall performance across activity and financial information, and this is also made available to the Group Executive Board. Reported financial information includes key finance metrics identified by the Trust, as well as subjective income and expenditure positions, working capital and balance sheet positions.

The financial data forms part of the monthly Integrated Performance Report, which sets the data against a range of operational and quality indicators. This allows for a rounded consideration of both the Trust's performance against its key Quality & Performance areas (Responsive, Caring, Safe, Effective) but also against other key aspects such as COVID-19 response / recovery and People issues, all of which is supported by a range of data on people / workforce matters.

3. VFM arrangements – Governance

Overall commentary on Governance - continued

The Trust's decision-making arrangements and control framework

The Trust has a well-established governance structure in place, details of which are set out within its Annual Governance Statement, and is supported by the Trust's Constitution and scheme of delegation. Group and Hospital Executive Directors have clear responsibilities linked to their roles and the Committee structure in place at the Trust (split at a group and hospital level) allows for effective oversight of the Trust and Hospital operations and activity across the various sites.

As noted above, there is detailed financial information available to enable full understanding of the position at Hospital and overall Trust level, with issues discussed at the monthly sites and services performance review meetings, and subsequently with the Group Executive Board. Through this process non-finance Directors and Non-Executive Directors are able to challenge assumptions within assessments and analysis of the performance and forecasts.

In line with NHSI/E guidance, the Trust requires all staff to declare interests, including offers of gifts and hospitality.

The Trust has a full suite of governance arrangements in place, as set out in the Trust's Annual Report and Annual Governance Statement. We have reviewed these arrangements as part of our audit and confirmed they were consistent with our understanding of the Trust's arrangements, in particular, that they were in place and operating. This includes arrangements such as registers of interests being maintained and published and the Board completing an annual review and self-certification of its compliance with the conditions of the NHS provider licence.

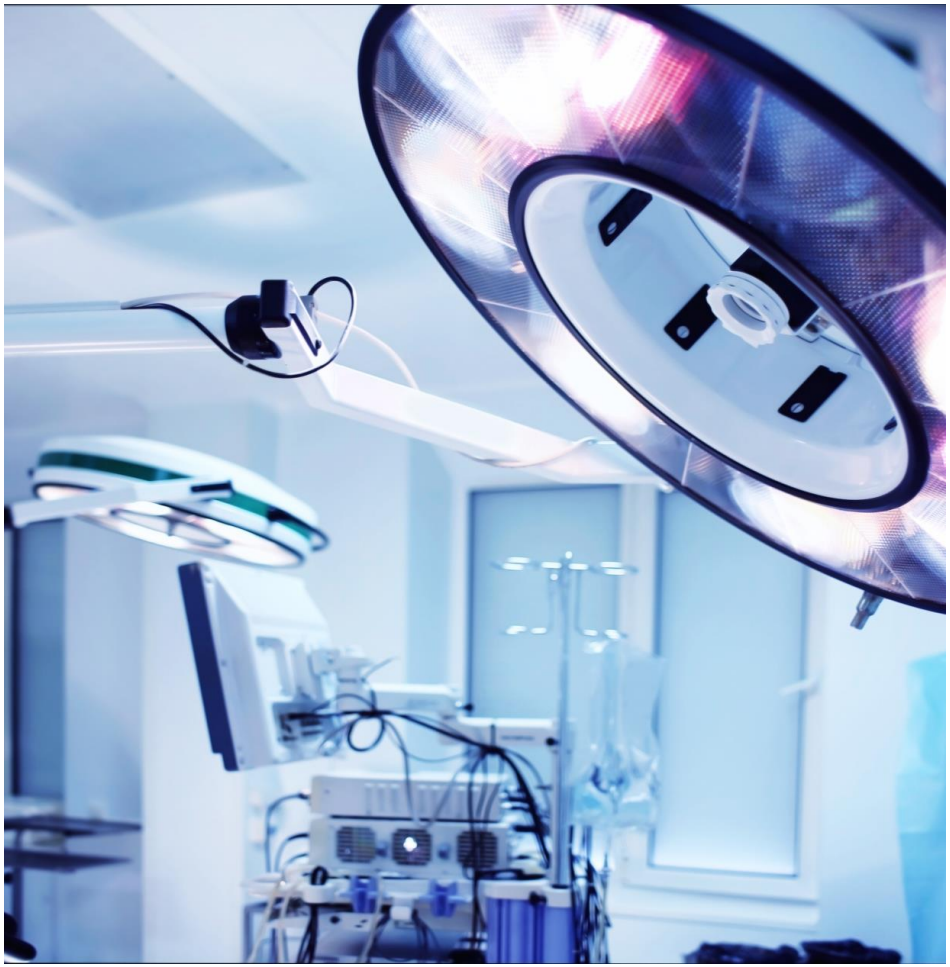
Overall conclusion

We are therefore satisfied that there is not a significant weakness in the Trust's arrangements in relation to governance.

3. VFM arrangements

Improving Economy, Efficiency and Effectiveness

How the body uses information about its costs and performance to improve the way it manages and delivers its services



3. VFM arrangements – Improving Economy, Efficiency and Effectiveness

Overall commentary on Improving Economy, Efficiency and Effectiveness criteria

The Trust's arrangements for assessing performance and evaluating service delivery

While the impact of the pandemic has restricted the comparisons that are available, the Trust has previously made use of benchmarking data, including model hospital data, operational efficiency metrics and safer staffing data to identify areas for its Cost Improvement Programmes.

The Trust produces a range of operational indicators within its integrated performance report to measure performance and identify both opportunities for improvement and areas of high performance, with indicators analysed into the four main areas (Responsive, Caring, Safe, Effective) and further into performance by individual sites where appropriate. Named directors are responsible for providing an overview of current performance and notes on possible changes as a result of known issues or responses that have been made.

The Board receives a broad range of performance information, both operational and finance and including the above information, at each meeting. In 2021/22 the Board has received a wide range of performance related reports. Throughout the year the Board has again given much consideration to the continued impact of the COVID-19 pandemic on performance, with performance reporting having been expanded to allow for assessment of both current performance and how the Trust is recovering. We have reviewed the performance information provided to the Board along with the documentation of subsequent review and challenge, and can confirm we consider the Board effectively holds managers to account where performance improvements are required.

The Trust's arrangements for effective partnership working

The increasing national move towards greater integration of services across the health and social care sector and away from the more service focused internal market, has been reflected in the way that the Trust has worked with partner organisations across the North East London Integrated Care System (NEL ICS) to deliver a sustainable financial position for the wider area, while also addressing the Trust's overall financial sustainability. The Trust actively contributed to working within the NEL ICS, which enabled it to share learning and plan together how they managed the response to COVID-19 for the region.

During the year the Trust has made a further significant move towards greater collaboration, with a Memorandum of Understanding agreed between the Trust and the Board of Barking, Havering and Redbridge University Hospital NHS Trust. Following this has been the appointment of a Chair-in-common as well as a joint Group Chief Executive for both organisations. The closer working is illustrated from other steps, such as the digital alignment agreed within the business case and the consistency in the green plans and the commitment to sustainable development. Other areas are being actively investigated for further closer working.

The Trust also continues to give active consideration to wider partnership working outside of the NEL ICS, with the East and South East London Pathology Partnership having come into operation during the year, with the Trust hosting the service shared with other London trusts. In addition, as part of the development of proposals for the revision of the Whipps Cross site the Trust is working with local partners through a new programme board, which includes other trusts and hospices, to develop a single, coherent strategy for the future of specialist palliative and end-of-life care for people at the site.

3. VFM arrangements – Improving Economy, Efficiency and Effectiveness

Overall commentary on Improving Economy, Efficiency and Effectiveness criteria - continued

The Trust's arrangements for commissioning services

The Trust has a Procurement Department, with appropriately professionally qualified staff, for the management of processes, supported by internal procedures (Financial Instructions) and external requirements (such as EU Procurement Regulations 2015) governing the acquisition of goods and services. During the year the Trust has reviewed its Standing Orders and Standing Financial Instructions, identifying a number of changes to procedures. The Trust has made particular changes to its Procurement regulations to reflect Brexit, as well as providing two additional grounds for not requiring a tender.

The Procurement Department makes use of the 5 Case Business Case process to support any work done, including areas where service transformation is envisaged as a result of the Procurement. This process includes Options Appraisals for alternative delivery and investment appraisal to derive best options based on strategic outcomes. This specification process exists to allow the Trust to ensure that the selected option and supplier gives best value for money.

The Trust makes full use of the functionality within the externally managed Oracle system, which is used to regulate all transactions in accordance with its hierarchy delegation, which is aligned with the Procure to Pay process to ensure compliance. Overall, this is supported by the Trust's 'No PO No Pay' policy which aims to ensure payments are not made without appropriate authorisations.

The Trust has a Standards of Business Conduct Policy in place to mitigate the risk of conflicts of interests arising, with conflicts of interest being monitored prior to completion of procurement and evaluations to ensure there is transparency in decision making. Our review of Board and Audit and Risk Committee meeting papers and minutes confirms these are up to date and published on a regular basis.

Overall conclusion

We are therefore satisfied that there is not a significant weakness in the Trust's arrangements in relation to Improving Economy, Efficiency and Effectiveness.

04

Section 04:

Other reporting responsibilities and our fees

4. Other reporting responsibilities and our fees

Matters we report by exception

The Local Audit and Accountability Act 2014 provide auditors with specific powers where matters come to our attention that, in their judgement, require specific reporting action to be taken. Auditors have the power to:

- issue a report in the public interest;
- make a referral to the Secretary of State; and
- make a written recommendation to the Trust which must be responded to publicly.

Paragraph 2(1) of Schedule 5 of the National Health Service Act 2006 provides that each NHS Trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to the revenue account.

This duty is known as 'the breakeven duty'. The phrase 'taking one year with another' has been interpreted by the Department of Health and Social Care and HM Treasury as meaning that the duty is met if income equals or exceeds expenditure over a three-year rolling period, or exceptionally a five-year rolling period with the agreement of NHS Improvement (NHSI).

Considering the 'Statutory breakeven duty: a guide for NHS trusts' issued by NHSI in April 2018, we have reason to believe that Barts Health NHS Trust has taken a course of action which has breached the Trust's breakeven duty for the three-year period ending 31 March 2022. The Trust's expenditure has exceeded its income for the three-year period ending 31 March 2022 by £72,442,000. Under section 30 of the Local Audit and Accountability Act 2014, we have referred the matter to the Secretary of State.

We are also required to report if, in our opinion, the governance statement does not comply with relevant guidance or is inconsistent with our knowledge and understanding of the Trust. We did not identify any matters to report in this regard.

Reporting to the NAO in respect of consolidation data

The NAO, as group auditor, requires us to report to them whether consolidation data that the Trust has submitted is consistent with the audited financial statements. We have concluded and reported that the consolidation data is consistent with the audited financial statements.

4. Other reporting responsibilities and our fees

Fees for work as the Trust's auditor

We reported our proposed fees for the delivery of our work under the Code of Audit Practice in our Audit Strategy Memorandum presented to the Audit and Risk Committee in November 2021. Having completed our work for the 2021/22 financial year, we can confirm that our fees, agreed with the Group CFO, are as follows:

Area of work	2021/22 fees
Planned fee in respect of our work under the Code of Audit Practice	£119,900
Additional fees in respect of additional work on the pathology partnership and new provisions	£6,000
Total fees	**£125,900**

Fees for other work

We confirm that we have not undertaken any non-audit services for the Trust in the year.

Suresh Patel, Partner

Mazars
30 Old Bailey
London
EC4M 7AU

Mazars is an internationally integrated partnership, specialising in audit, accountancy, advisory, tax and legal services*. Operating in over 90 countries and territories around the world, we draw on the expertise of 40,400 professionals – 24,400 in Mazars' integrated partnership and 16,000 via the Mazars North America Alliance – to assist clients of all sizes at every stage in their development.

*where permitted under applicable country laws.

mazars

WeCare
Our vision, values and behaviours

NHS
Barts Health
NHS Trust

Our Group Operational Plan for 2022/23

Introduction from the Group CEO

We have a lot to be proud of in the Barts Health group of hospitals. Our staff and supporters responded magnificently to the unprecedented challenges posed by Covid-19. In the face of the greatest health emergency in the history of the NHS, our people worked selflessly and tirelessly to keep our hospitals open and our patients safe. Our story is one of resilience, determination, and adaptation.

We are now emerging from the worst of the pandemic into uncharted territory of a different sort. The NHS is seeking to put itself on a fresh footing, recognising the reality of living with Covid-19. This means not only clearing the backlog of less urgent operations that build up during the pandemic, but also reconnecting with the themes of the NHS long-term plan that we began implementing when coronavirus took off. We reflect this in our own group operating plan by setting ourselves three objectives for the year ahead - becoming an inclusive organisation for staff, transforming care for patients, and building effective local partnerships.

The lessons we learned from Covid reinforce our vision for the future. We are moving into a new era of collaboration. The constituent parts of the NHS are now working together rather than competing in an internal marketplace. We each have a role in a national network of local systems aiming to provide better care for patients, improved health and wellbeing for everyone, and sustainable use of resources.

Our closer collaboration with Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) is part of this and underpins our plans. When I retire this summer, my successor Shane DeGaris will be the first joint Group Chief Executive for both trusts. Having been my deputy, he is ideally placed to take the organisation forward, and continue our improvement journey to becoming 'good' and 'outstanding' in all areas, in the wider context of the north east London (NEL) integrated care system.

Personally, I am stepping down with mixed emotions. Next year will mark 900 years since the founding of St Bartholomew's hospital, 40 years since the opening of Newham hospital, and 75 years of the NHS. I am proud to have been part of the NHS for the whole of my working life. This job is the best of it, leading talented and inclusive people in serving some of the most culturally diverse and socially deprived parts of the country. Thank you so much for everything you do to continue to provide safe and compassionate care for all our patients and their communities.

"Personally, I am stepping down with mixed emotions.

I am proud to have been part of the NHS for the whole of my working life."

Alwen Williams.

Dame Alwen Williams

Group Chief Executive

May 2022

The national and local context

The NHS nationally set a clear mandate for local integrated care systems to deliver in 2022/3. Our challenge in NEL is that we serve some of the most diverse and deprived communities in the country, and they are expected to expand rapidly over the next decade. Covid-19 shone an uncomfortable light on health inequalities, and death rates were correspondingly higher among our population. To take a snapshot: Newham has the biggest proportion of people of colour in England, Tower Hamlets is one of the most densely populated boroughs in London, and unemployment in Waltham Forest is above the national average.

From 1 July an integrated care board for NEL will bring together leaders of the local NHS, local authorities, and other interested parties. The Barts Health group will play a key role in two respects. On the one hand, we are part of a collaborative of acute providers with Homerton Healthcare NHS Foundation Trust (HHFT) and BHRUT.

On the other, our own hospitals are located firmly within four of the seven borough-based partnerships that will be the building blocks of the new system – St Bartholomew's in the City of London, The Royal London in Tower Hamlets, Newham in the borough of Newham, and Whipps Cross in Waltham Forest.

We pioneered the group model as a way of leveraging benefits from operating at scale while also delivering effective local services. It means we can treat patients from across and outside London through the specialist services at St Bartholomew's and The Royal London, while also enabling Newham and Whipps Cross to offer local care to some neighbouring residents of Barking and Redbridge respectively.

It also puts us in a strong position to take forward our collaboration with BHRUT. This grew out of working together through the pandemic, and now makes us the cornerstone of the NEL-wide acute provider collaborative. Under the leadership of our chair in common, Rt Hon Jacqui Smith, and the appointment of Shane DeGaris as joint Group Chief Executive, our two trusts are collaborating closely while remaining separate bodies. Working together will not only benefit our patients but enable us to be a powerful voice for all citizens of NEL.

NHS priorities for acute providers

- Invest in people and culture
- Respond to Covid-19 and plan ahead
- Expand planned care and reduce waiting
- Improve urgent and emergency care
- Exploit digital opportunities
- Use resources effectively
- Work collaboratively with local partners
- Address population health inequalities

Group Objectives 2022/23

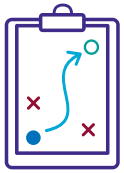
NHS
Barts Health
NHS Trust

Our vision To be a high-performing group of NHS hospitals, renowned for excellence and innovation, and providing safe and compassionate care to our patients in East London and beyond.

Group objectives

To create a truly inclusive organisation, without discrimination, and meet our ambition to be an outstanding place to work

To improve health and care services for all our population - transforming clinical services whilst reducing health inequalities and inequities of provision



To build effective partnerships across the health and social care system and deliver social value for communities through our longer term strategic plans

We will achieve this by…

- Creating an inclusive leadership
- Establishing a fair and just culture
- Supporting the wellbeing of all colleagues
- Promoting equity as an anchor institution
- Reducing waits for elective, emergency and cancer care
- Staying Covid-safe and ready
- Implementing new care models
- Focusing on the fundamentals of quality
- Advancing integrated care
- Life sciences, research and education
- Going green for sustainability
- Progressing our strategic priorities

Key Enablers

- Strong and sustainable finances
- Estates and Informatics strategies
- Our 'weimprove' quality improvement method

Creating an inclusive organisation for staff

Objective 1

To create a truly inclusive organisation, without discrimination, based on a fair and just culture that helps us meet our ambition to be an outstanding place to work.

We recently set out a bold ambition to eliminate racism, discrimination and inequality in our inclusion strategy, A Place where We Belong. Making further progress towards this as part of our long-held strategic goal of being an outstanding place to work is our biggest priority this year. We signalled its significance by appointing Mr Ajit Abraham, a surgeon and co-chair of the Inclusion and Equity Board, as our first group director for inclusion and equity.

Creating inclusive leadership

The ability to function effectively in culturally diverse situations is critical for anyone working in an organisation where 56% of employees identify themselves as ethnic minority. We put the promotion of cultural intelligence at the heart of our WeLead programme for developing leaders and are rolling out a shorter version of inclusion awareness training for all staff, aiming to reach 12,000 colleagues by June 2023.

We intend our leadership group to be fully representative of our staff by 2028. The proportion of senior positions (Band 8a plus) filled by colleagues from an ethnic minority background increased by four percentage points last year to 37.4%. We aim for another annual increase of three percentage points as we further expand career development for women and ethnic minority colleagues. We aim to further reduce the gender pay gap from 12.7% to 11%.

Establishing a fair and just culture

We made good progress in reducing disparities in our grievance and disciplinary procedures, yet too many staff continue to highlight unfair experiences at work. Our 'new era' people policies are now in place to ensure our recruitment, retention and employment processes are equitable, and we will implement them consistently so all staff feel they belong and can bring all their talents to work.

We now require all staff to agree a personal inclusion objective through the appraisal process. We expect them to discuss career progression in regular compassionate conversations with their manager, who in turn will be supported to promote development opportunities, manage talent and undertake succession planning.

Promoting equity as an anchor institution

We monitor equity of access, outcomes and experience to tackle health inequalities, including reviewing waiting lists. For example, we will give priority to patients with learning disabilities after discovering that on average they waited longer for surgery.

As part of this programme we now have ethnicity data for almost all our patients, which allows us to ensure we are managing our waiting lists fairly and equitably. We are considering how to publish this data in a format that is most useful for our patients and communities.

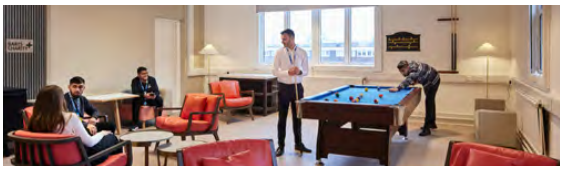
The starkest inequity of all is the length of time some people have had to wait, which is why we are prioritising those who have waited the longest for planned care. Our analysis indicates there are differences by site in most surgical specialties, which potentially puts patients living in some geographic areas at a disadvantage. As part of our elective recovery drive our hospitals will help each other address these disparities across the group.

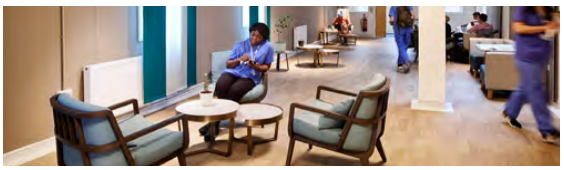
We will also build on our success in recruiting local people into jobs, internships and apprenticeships in our hospitals by purchasing goods and services from local businesses where possible.

Supporting the wellbeing of all colleagues

We will sustain the pioneering support we introduced during the pandemic, based on the wellbeing hubs and psychological support team funded by Barts Charity. We will focus on getting the basics right so staff feel safe, can access drinking water and hot food, and know their IT works and their belongings are secure.

As an exemplar site for the NHS People Promise we will promote flexible working opportunities as well as career development. We will also roll-out the lessons from work on reducing violence and aggression by the public. We listen to our people through a new quarterly People Pulse to supplement feedback from the annual NHS Staff Survey and shape our approach.





Transforming care for our patients

Objective 2

To improve health and care services for all our population – transforming clinical services whilst reducing health inequalities and inequities of provision.

Our three-year partnership with the Institute for Healthcare Improvement showed that quality improvement is increasingly our way of working here and leads to results. We intend to adopt WeImprove as the preferred change approach across the group and align this closely with the parallel development of WeBelong and WeLead. With targeted training for staff, a focus on project impact, and a greater emphasis on measurement, we can embed WeImprove within operational delivery as our method for resolving issues and generating solutions.

In line with NHS expectations, we set local targets to reduce the numbers waiting for routine treatment or diagnosis. More than 103,000 people are waiting for planned procedures, many because of the backlog caused by the pandemic. However, in the last quarter of 2021/22 we cut by 75% those waiting two years or more, to 287.

Reducing waits for elective, emergency and cancer care

We will maximise capacity across our hospitals to ensure no-one waits two years or more for a planned procedure by July, no-one waits 18 months by March 2023, and no-one waits for a year by March 2025.

We will do this by increasing our elective activity and booking in those waiting longest first. Hospitals will be more productive by opening new operating theatres and/or making more efficient use of them. To clear the backlog of long waits we will invoke mutual aid from neighbouring NHS hospitals and use the independent sector.

We will return the numbers waiting for diagnostic scans to pre-pandemic levels, through a combination of the extra capacity of the new early diagnostic centre at Mile End and enhanced cooperation between hospital imaging services across NEL.

We anticipate doing 50,000 more MRI, CT and ultrasound scans, plus thousands of extra endoscopies. This will also enable us to reduce the numbers waiting two months for a cancer diagnosis to pre-pandemic levels, under 200 a month.

We will manage demand in outpatients by giving more initial 'advice and guidance' to GPs, offering telephone and video clinics rather than face-to-face appointments, and encouraging patients to initiate follow-ups rather than scheduling them automatically.

We will improve access to urgent and emergency care, working with partners to eliminate long waits, reduce ambulance handover delays, and get treated patients home sooner.

Our emergency departments are seeing as many patients as before the pandemic, with a marked increase in walk-ins. Seven out of ten attendees get treated within the 4-hour national standard, but we believe about a third of A&E visits could be more appropriately dealt with by working with GPs through Urgent Care Centres.

Staying Covid safe and ready

Covid cases came down during the spring and restrictions were eased, but we are still treating Covid-positive patients and must be prepared for any resurgence in numbers. Hospitals will keep some infection prevention and control measures in place and require staff and visitors to wear masks in common or clinical areas. The previous restrictions did limit our capacity for planned care. The new rules will help us expand, while still allowing us to identify vulnerable patients early and treat respiratory patients in separate secure areas.

In the most recent wave (four) most Covid patients were admitted to general beds and did not require critical care. A significant proportion were primarily treated for other conditions. We have critical care capacity on standby at the Queen Elizabeth Unit at The Royal London, recently opened (virtually) by Her Majesty. We will use the learning from the successful Covid vaccination programme to improve take-up of the 'flu vaccine and any Covid boosters required for our staff.

Implementing new care models

We set up our nine clinical boards to safeguard clinical standards and reduce unwarranted variation in outcomes, and now want to bring their expertise to bear on achieving our operational challenges through transforming services. This will help us be better prepared to manage the extra pressures anticipated next winter.

The key to elective recovery is establishing surgical centres of excellence that can do high volumes of less complex operations, particularly daycases. With NEL partners we want to build on early work done in Ear, Nose and Throat (ENT) and ophthalmology at Whipps Cross, and in orthopaedics and gynaecology at Newham. For example, using improvement initiatives the ENT team at Whipps Cross did 70 cases in a 'booster week' instead of the usual 30, and the Eye Treatment Centre averaged 16-20 cataract operations a day in a similar burst.

In urgent and emergency care, we are developing pathways for Same Day Emergency Care. We want to extend to GPs the REACH (Remote Emergency Access Coordination Hub) service which advises ambulance crews about patients that don't need to come to A&E. We also intend to expand the PRU (Physicians Response Unit) which treats incident victims on the spot.

Our clinical boards will also focus on renewing the group's clinical strategy for 2023 and beyond, working with partners across NEL to take a population health approach that addresses inequalities and meets the unique needs of our communities.

Focusing on the fundamentals of quality

We conceived our quality strategy before the pandemic to guide our improvement journey towards becoming good and outstanding. One of its strategic goals, to be an outstanding place to work, is effectively incorporated within the over-arching inclusion objective set out earlier; but the other two goals remain distinct – providing excellent patient safety, and the best possible patient experience. We set a series of specific quality objectives to drive these in 2022/23.

On safety, we will appoint six specialists to help deliver the national safety programme across our hospitals, and 50 local champions to support a strong safety culture on the wards. We will launch a new dashboard offering greater depth and breadth of insight into potential harm. We will continue to use quality improvement techniques to keep patients safe, focusing on spotting deteriorating patients, reducing error in planned procedures, and improving medicines administration.

On experience, we will increase patient and community participation in decision-making, and ensure feedback is incorporated in service development. We will offer the Friends and Family Test in different languages, and explore alternative ways of capturing feedback from patients. And we will take steps to improve the experience of women using maternity services in line with the Ockenden recommendations.

Building effective local partnerships

Objective 3 To build effective partnerships across the health and social care system and deliver social value for communities through our longer-term strategic plans.

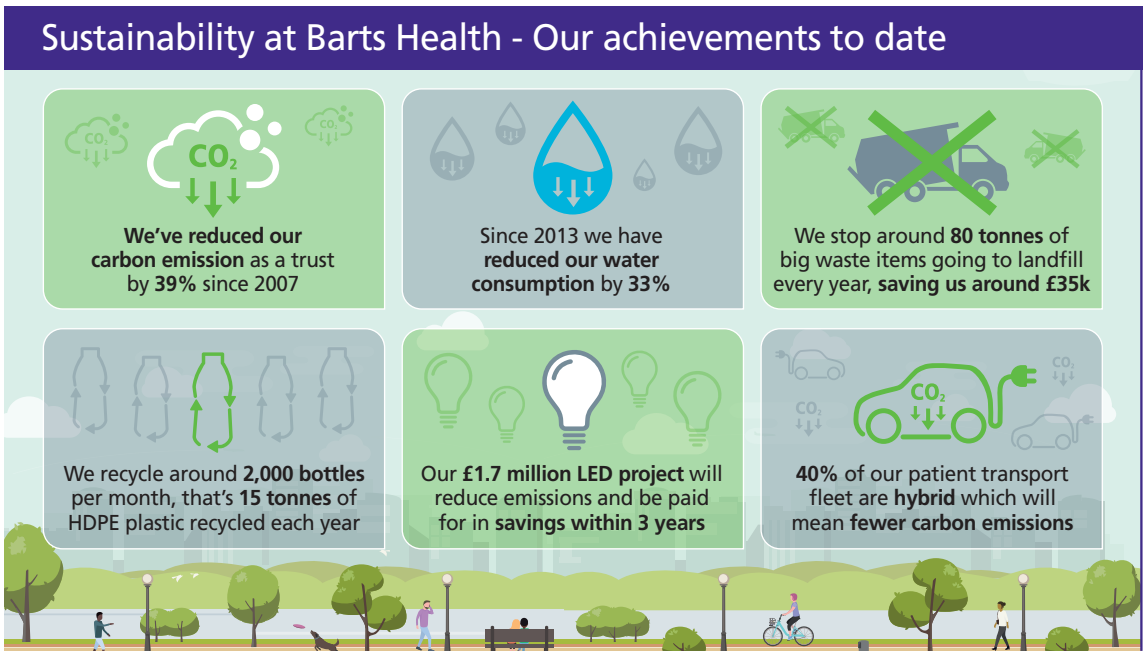
Advancing integrated care

We will continue collaborating with BHRUT in the context of the NEL integrated care system, whose key component is the acute provider collaborative with HHFT. Building on existing ad hoc arrangements for offering mutual aid, the three trusts will work together on planned care, cancer, critical care, and maternity services.

Meanwhile under our Chair in common we will work with BHRUT on improving urgent and emergency care, developing neurosciences, networking specialised services and increasing participation in research. The two trusts will seek to align our separate organisational support functions, such as digital strategy and our approach to recruitment and retention, and procurement. Both will also actively contribute to NEL work on financial sustainability and planning for population growth.

Going green for sustainability

We will take forward the Green Plan commitments we developed with BHRUT to meet the NHS net carbon zero target by 2040, and recruit a dedicated sustainability team. As well as reducing emissions we will identify measures to reduce waste, water use and air pollutants. For example, we are piloting reusable sharps containers to cut the amount of plastic sent for incineration. We will encourage staff to cycle to work or use public transport, and reduce car parking space on our sites.



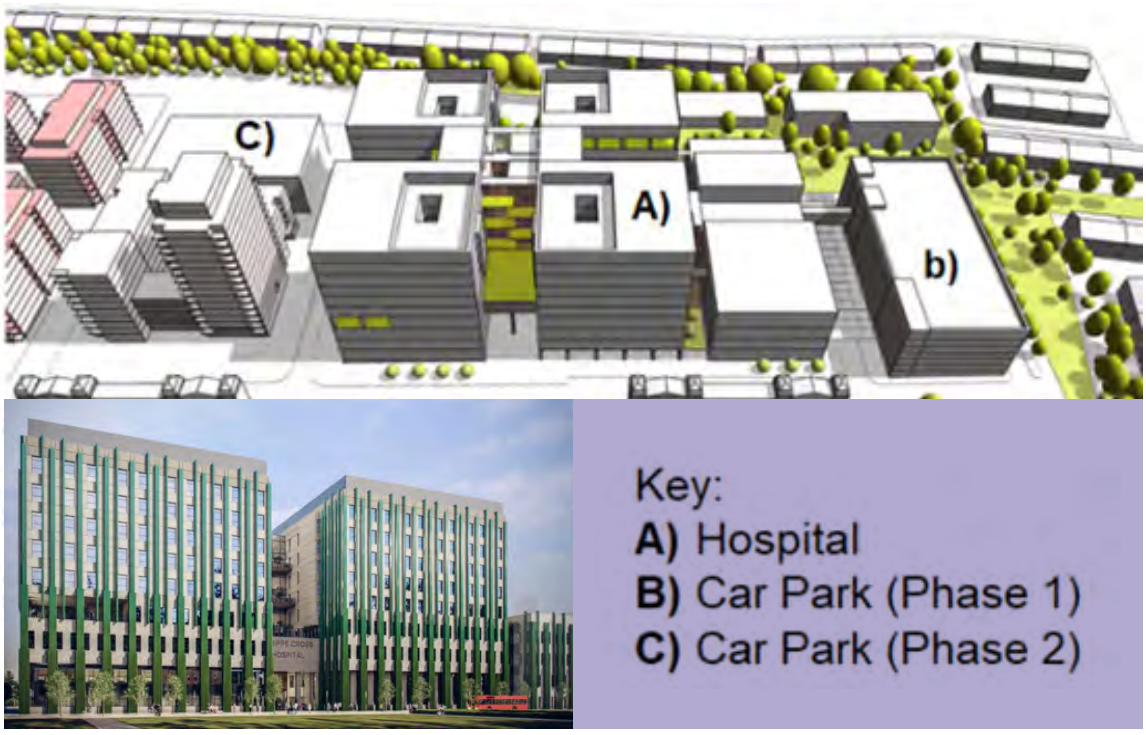
Life sciences, research and education

Subject to planning approval for the prospective life sciences campus on vacant land around The Royal London in Whitechapel, we expect to select site developers later this year. Meanwhile we will foster further links between clinical staff and commercial partners to research and develop new products and services from bench to bedside. We seek a Barts Charity grant to create an integrated data warehouse and access service for researchers into the early detection and treatment of diseases.

With our academic partners at Queen Mary University of London (QMUL) we will revive our non-Covid research programmes, recruit 12,000 patients to clinical trials, and increase our research income to over £27m (with one-third from commercial sources). Our Education Academy will speed up the introduction of training for new roles like medical support workers and advanced clinical practitioners.

Progressing our strategic priorities

Chief among our longer-term ambitions remains the redevelopment of Whipps Cross hospital. We have planning permission but await Government approval to start work on a new multi-storey car park and submit our Outline Business Case for constructing a new hospital to open between 2026-28. Meanwhile we will continue to engage with local people, and work with local partners on plans for improved end-of-life care, other care closer to home, and the wider redevelopment of the site.



With 2023 marking the 900th anniversary of St Bartholomew's as the country's oldest hospital, we will support the Barts Charity fundraising campaign for a new breast cancer centre at the hospital and a bespoke clinical research facility at The Royal London. Consolidating breast surgery on one site will reduce variations in clinical standards and address the poor outcomes for the hundreds of east London women diagnosed with the disease each year.

In anticipation of Newham hospital's 40th birthday next year we will invest to meet the health needs of a rapidly growing borough population with relatively high levels of deprivation. We anticipate constructing two new modular buildings (to house an intensive care unit and a general ward), re-opening two mothballed operating theatres, and installing a new CT scanner.

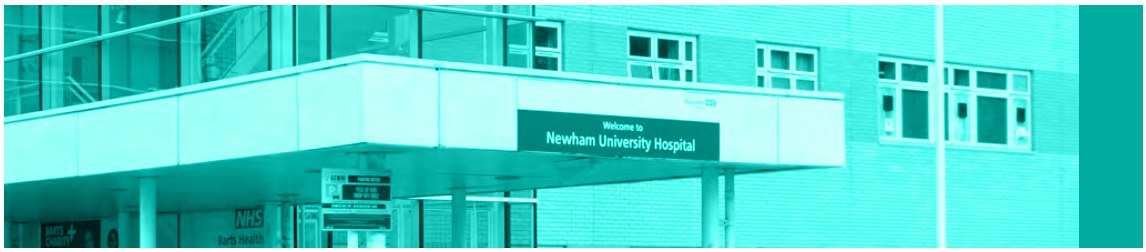
Making a difference across the group

St Bartholomew's Hospital

Even though we treated urgent cases from across London during the pandemic, we now have more patients waiting for heart surgery with more advanced disease. We will open 36 extra beds to do another 600 operations a year, and more weekend working will enable 60 more, reducing the average length of stay from five days to three. A new catheterisation lab at the Barts Heart Centre – the 11th - will create capacity for a further 1,000 cases.

We will reduce waiting times for cancer patients by opening 16 extra chemotherapy bays and making our 12-bedded acute assessment unit permanent, following its success in keeping vulnerable cancer patients safe during the pandemic. We will use the new Nuffield Health private hospital on the Smithfield campus to do some breast surgery at NHS rates and continue to use independent sector scans to reduce waiting times for diagnosis.

To make our staff profile representative of our communities we will require an inclusion ambassador to attend senior interview panels for Band 7 recruitment. We will offer placements as porters, ward hosts and catering assistants on the Project Search internship scheme for young adults with special educational needs.



Newham Hospital

As part of fire safety improvement works across the hospital we refurbished two operating theatres that were closed during the pandemic. This means we now have six elective theatres: four in the Gateway Centre will run six days a week, and we will do more Super Saturdays in gynaecology, too. We are employing 10 extra doctors this year so consultant-led ward rounds can take place five days a week, help detect early signs of deterioration, and enable treated patients to get home faster.

We are working with the local authority, primary care and mental health on a five-year health and care plan for the borough. This will improve access to services as close to home as possible in three areas – growing well (for 0–25-year-olds); living well (for working-age adults); and promoting independence (for older people). We are also running a pilot project with Healthwatch Newham to monitor the views of patients after discharge so we can improve the experience of leaving hospital.

Whipps Cross Hospital

Our highest priority is to address the pressure on urgent and emergency services. We will treat more patients through same day emergency care and in our Urgent Care Centre, and work with partners to reduce delays in ambulance handovers.

To increase the productivity of planned care and cut waiting lists we will improve scheduling and re-organise theatres, alongside developing a high-volume surgical centre in urology as well as ENT and opthalmology. We will invest in imaging to reduce waiting times for diagnostics.

Improving the quality of care is a key strand of our plan and we will lower infection rates and reduce the number of medication safety incidents. We will listen to patient feedback and engage with local communities, focusing on how the hospital's approach to access and waiting can help reduce health inequalities.

We will invest in staff facilities and psychological support to maintain the health and wellbeing of our people, strengthen our staff diversity networks, and recruit to more permanent posts in stroke, orthopaedics, respiratory, maternity and imaging.

The Royal London and Mile End hospitals

This year makes a significant milestone as Jackie Sullivan steps down in June after six years as our Chief Executive.

A key priority is the wellbeing of our staff, recognising the impact this has on patient experience. We will recruit more permanent employees, reducing the proportion of temporary workers, and aim to increase the proportion of female staff and those that identify as Black, Asian or minority ethnic at Band 7 and above.

The increase in substantive staff and relaxation of Covid infection rules will enable us to increase activity in surgery and outpatients, with more weekend lists and Super Saturday clinics, reducing waiting lists. To further improve access and increase capacity we aim to complete capital investments in a new Community Diagnostic Centre and renal unit at Mile End.

Our new Patient and Family Contact Centre Hub will help patients and families navigate services and raise any concerns in real time. With the Macmillan information hub for cancer patients already co-located in the same space, we will invite third sector organisations to share the space through 'pop ups' to support community engagement and good use of resources.

Group Support Services

Finance

After breaking even last year we expect to declare a similar position for 2021/2 with a modest (£554,000) surplus – a fraction of one per cent of our £2 billion income. We benefited from extra national funds during the pandemic, which allowed us to invest nearly £90m in staffing, wellbeing, equipment and IT in response to Covid. It also masked some challenges, such as rising pay costs yet falling activity.

Our run-rate of spending over income is increasing and we face inflation pressures like a substantial hike in energy prices. We hope national inflation adjustments will allow us to set a balanced budget in 2022/3. We have less capital to spend on infrastructure (£42m) following a change in the national allocation formula. Managing resources will be challenging, and we will do this by improving productivity and working closely with system partners.

Informatics

In our drive to go paperless we will roll-out electronic prescribing of medicines to paediatric and maternity services. We will upgrade equipment and networks in line with the NHS adoption of Office 365, continue to migrate data from our physical datacentres onto the Cloud, and finalise wireless connectivity in our hospitals. These steps will strengthen infrastructure resilience and improve cyber security. Digitising cellular and histopathology services will also support the consolidation of diagnostics across NEL.

People

We expect to maintain our establishment of about 19,000 staff. We no longer need some taken on for Covid but they will be offset by employing more nurses and midwives to ensure safe staffing levels. We are reviving our 'Drive to 95' to grow our permanent workforce and reduce reliance on temporary workers. We expect to increase the proportion of substantive staff from 90% to 93%.

We will continue to recruit some nurses from overseas and target clinical shortages in anaesthetics and critical care, while mindful of our responsibilities as a major local employer. We will bring about 1,800 contract employees in-house by May 2023 when Serco stop providing portering, cleaning and patient catering services.

WeBelong
Becoming a truly inclusive organisation

Designed and produced by the Barts Health design and communications team

BH4122

NHS
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Report to the Trust Board: 6 July 2022	TB 54/22

Title	Nursing, Midwifery and Therapies Establishment Review 2021/22
Sponsoring Director	Group Chief Nurse
Author(s)	Director of Nursing, Workforce and Professional Standards
Purpose	To provide Trust Board with the outcome of the NMAHP 2021/22 safe staffing review and assurance of the process used in the review
Previously considered by	Quality Assurance Committee 20 April 2022 Trust Board 4 May 2022

Executive summary

In line with National Quality Board guidance Barts Health undertakes regular nursing and midwifery establishment reviews reflecting the principles of best practice. This paper outlines the governance process of the safe staffing review for end of year 2021/22, the outcome in terms of changes to the establishment, the financial impact and safe staffing priorities for 2022/23. The recommendations from this review were supported by GEB in March 2022 and approved by the Board at its meeting in May 2022 to incorporate into the group operational plan and budgets. The report is provided as an item for information for transparency purposes.

Related Trust objectives

Provider of excellent patient safety. Providing the best possible patient experience. An outstanding place to work.

Risk and Assurance	This report provides assurance on nursing, midwifery and therapies staffing levels
Related Assurance Framework entries	-
Legal implications/ regulatory requirements	NHSI will carry out an annual assessment of compliance with the Developing Workforce Safeguards (2018) through the Single Oversight Framework

Action required by the Trust Board

The Trust Board is asked to note the report for information.

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 4 JULY 2022

NURSING, MIDWIFERY AND THERAPIES ESTABLISHMENT END OF YEAR REVIEW

INTRODUCTION

1. In line with national guidance (National Quality Board 2016; Developing Workforce Safeguards, NHSI 2018) Barts Health undertakes regular nurse and midwifery (N&M) establishment reviews reflecting the principles of best practice. Staffing for inpatient therapies across the group was included in this end of year review.

2. This paper reports on the outcome of the 2021/22 safe staffing review which is being incorporated into budget setting for 2022/23.

HIGH LEVEL SUMMARY OF OUTCOME

3. The 2021/22 end of year establishment review identified changes to skill mix and staffing levels which in total increased the nursing, midwifery and allied health professional's establishment across the hospitals by 93.3. WTE.

4. The associated investment cost for 2022/23 is £4.1m, consisting of:

    - Nursing ward establishments 53.1 WTE £2.4m
    - Midwifery establishment 28.7 WTE £1.0m (phased implementation, £1.6m recurrently)
    - Therapies establishment 11.5 WTE £0.7m

GOVERNANCE OF THE 2021/22 END OF YEAR ESTABLISHMENT REVIEW

5. The process for the establishment reviews followed the same process as in previous years which is outlined in the Safe Staffing Policy for Nursing and Midwifery (COR/POL/197/2019/01). Although Allied Health Professional (AHPs) have yet to be added to the safe staffing policy, adult and children's inpatient therapies were included in the HEB reviews.

6. The three-yearly Birthrate Plus audit of maternity staffing took place in Quarter 4 which is an external, evidence-based process. This has provided the basis for the maternity safer staffing recommendations.

7. Due to the continued impact of the Covid-19 pandemic and continuous improvement processes, there were a number of differences this year, including:

    - SNCT audit data remains unreliable due to service changes, significant variation in activity and the previous audit pause (a minimum of 2 data sets at six monthly

intervals are required). Therefore, Professional Judgement continued to be more heavily exercised in the Hospital Executive Board (HEB) reviews.

- Similarly, Model Hospital data regarding Care Hours Per Patient Day (CHPPD) has not been used for benchmarking at this point.
- The Group Executive Confirm and Challenge (GEC&C) process was extended and strengthened. The Peer Reviews processes introduced last year were continued, a Professional Leads review meeting was introduced and, considering the significant investment requested in the HEB reviews, an additional NMAHP, People and Finance leads meeting was held to agree strategic approach.
- Changes recommended by the Hospital Executive Boards (HEBs) were categorised as Safe Staffing, Covid-19, or service/business development. Appropriate funding routes for the categories were agreed with the Chief Financial Officer.
- This paper relates to the changes categorised as safer staffing.

8. The GEC&C panel was chaired by the Chief Nurse. The Group Chief Finance Officer and Group Director of People also sat on the panel. The objective being to obtain assurance for the Board that the correct processes were followed for the staffing reviews, the level of confidence in the staffing decisions were correct and critical challenge was provided for the proposed changes.

OUTCOME OF THE 2021/22 ESTABLISHMENT REVIEW

9. No changes were proposed to the commitment of 21% headroom for nursing and midwifery (N&M) as agreed in 2015 (parental leave headroom being held centrally).

10. Within our establishments Ward Managers remain 100% supervisory at Barts Health as they have since 2017/18 demonstrating the value placed on ward managers and enabling them to be in the strongest position to role model and deploy exemplary leadership.

Nursing

11. A detailed list of changes to ward establishments as a result of the safe staffing review is shown at Appendix 1 with changes to the revised ward Whole Time Equivalent (WTE) staffing and planned Care Hours per Patient Day (CHPPD) being shown at Appendix 2 to 5. The changes are summarised below:

    - At WCH 20.8 WTE Registered Nurse (RN) and 19.7 WTE Health Care Assistants (HCA) across 4 areas
    - At RLH an increase of 5.2 WTE RNs, 4.8 WTE Nursing Associates (NA) and 2.6 WTE HCAs across 5 areas plus 1 Band 6 post to move from Ward 12 E to 12 F
    - At SBH nil changes
    - At NUH an uplift of 5 posts from B5 to B6 on Rainbow Ward

Midwifery

12. The Birthrate Plus (BR+) report was received in February 2022. The Director of Midwifery (DoM) reviewed the outcomes in conjunction with the Associate DoMs, applying professional judgement and expertise.

13. BR+ is an evidence-based framework for maternity workforce planning based on clinical activity and acuity. The tool is utilised nationally and was used as the benchmark for maternity staffing by the Ockenden review. It identifies a hospital-specific midwife to birth ratio in line with the acuity scoring outcomes and case mix. The case mix is unique to each service as it reflects the clinical and social needs of women, local demographics, clinical decision making and adherence to national guidelines.

14. The BR+ report found an increase in the acuity of mothers and babies since the previous assessment in 2018. The most noticeable change is in Whipps Cross Hospital with an overall increase of 15%, the other sites' acuity has increased by between 4 to 5%.

15. For all 3 hospitals, the increase is in Category V (mother and/or baby require a very high degree of support or intervention), and this is a similar finding in most maternity units in England in the past 3 years.

16. In light of the increased acuity the BR+ report recommended the following changes to the midwife:birth ratio:

Table 1Birthrate Plus recommended midwife:birth ratios 2018 and 2022

Hospital	**2018**	**2022**
NUH	1:25	1:22
RLH	1:23	1:21
WCH	1:26	1:24

17. The clinical staffing ratios recommended in the Birthrate Plus® audit will require funding with a phased approach to achieve the recommended midwife to birth ratio.

18. Professional judgement was applied to identify additional posts required, as summarised below:

- At WCH 6.3 WTE Specialist Midwives across 4 areas
- At RLH an increase of 5.0 WTE Specialist Midwives across 5 areas plus 8.0 WTE frontline midwives
- At NUH 9.4 WTE Specialist Midwives across 6 areas.

Allied Health Professionals (AHPs)

19. Both adult and children's AHPs were included in the BH safe staffing review focusing on Physiotherapy, Occupational Therapy (OT), Dietetics and Speech & Language Therapy (SLT) as the main AHP providers of acute ward based inpatient care.

20. In the absence of an existing standardised methodology for AHP Safer Staffing Barts Health adopted a triangulation approach considering 3 key elements:

- External evidence where this exists e.g., National clinical standards, professional body guidance, external benchmarking, etc.
- Internal evidence - local risk assessment and evidence of harm or near miss, via clinical audit, datix etc.
- Expert professional judgement

21. The outcome of the adult therapies staffing identified the following requirement:
    - At WCH nil
    - At RLH 7.0 WTE across 2 areas
    - At SBH 2.0 WTE Speech and Language Therapists
    - At NUH 2.5 WTE Dieticians across 2 areas

SAFE STAFFING PRIORITIES FOR 2022/23

22. Some actions agreed for 2021/22 as part of last year's safe staffing review have not progressed as expected due to the Covid pandemic. Where appropriate these actions have been carried forward into 2022/23. Further themes emerged from this year's safe staffing review combined with carried forward actions lead to the following priorities for the coming year:

<u>Systems and Processes</u>

a. Develop AHP Safe Staffing Policy
b. Consistently use SafeCare live to record redeployment decisions and track in real time on health roster
c. Implement ED SNCT
d. Revisit and refine establishment review processes (timelines, multidisciplinary approach, report format)
e. Strengthen use of safer staffing data (compliance, quality, benchmarking)

<u>NMAHP Workforce</u>

f. Develop NMAHP workforce strategy, aligned to overarching NMAHP strategy and BH People Plan.
g. Develop our strategic approach to Trainee Nursing Associates (TNAs); AHP apprenticeships; ward-based therapy roles and review band 2 and 3 roles.
h. Continue work to embed the Nursing Associate (NA) role into the workforce, to be reflected in skill-mix changes within future safe staffing reviews

<u>Enhanced care</u>

n. Further develop BH approach to Enhanced Care across all categories of support, aligning with business planning and commissioning processes where required
o. In collaboration with NEL/ELFT, progress the new RLH model of care for patients with concurrent acute physical illness and mental health needs and spread across BH.

<u>Leadership and Supervision</u>

q. Utilise the learning from the Covid pandemic to strengthen NMAHP clinical leadership in relation to safe staffing

23. The above priorities are being further refined and mapped into existing work streams where appropriate.

Appendix 1 Detailed outcome of the safe staffing review

Nursing: Total investment £2.4m

Whipps Cross:

- 7.5 wte HCAs for Peace Ward for falls reduction
- 5.3 wte Band 6 RNs for maternity theatres.
- 2.2 wte RNS and 1.6 wte HCAs for Chestnut Ward to correct establishment post implementation of Surgical Strategy service changes.
- 13.3 wte RNS and 10.6 HCAs For Cedar Ward to correct establishment post implementation of Surgical Strategy service changes.

St Bartholomew's: Nil

Newham:

- Uplift 5.0 wte B5 to B6 on Rainbow Ward to strengthen in-charge skill mix

Royal London:

- 2.2 wte Band 4 NAs to facilitate 1:1 care of during early pregnancy loss
- 1.0 wte Band 6 to move to Ward 12 E from Ward 12 F to right-size establishments
- 2.6 wte RNs for 10F to substantiate increased night cover
- 2.6 wte B4 NAs for 14E for provision of skilled fundamental care
- 2.6 wte RNs for AAU to ensure safe transfers of care
- 2.6 WTE HCAs for 14F to substantiate successfully piloted posts

Therapies: Total investment £0.7m

Whipps Cross: Nil

St Bartholomew's:

- 1.0 wte Band 7 SLT and 1.0 wte Band 6 SLT in light of GPICS standards.

Newham:

- 1.0 wte Band 7 and 1.5 wte Band 6 dieticians to establish service on Stroke and AAU thus improving patient safety and standards of care

Royal London:

- 2.0 wte Band 5 physios and 1.0 wte Band 7 OT for ward 3D to substantiate piloted posts
- 4.0 wte Band 5 physios for respiratory medicine to enable 7 day working.

Maternity: total investment £1.0m (phased implementation; £1.6m recurrently)

Whipps Cross:

- Quarter 1: 1.0 wte Band 7 diabetic specialist; 1.0 wte Band 7 NIPE lead midwife
- Quarter 2: 1 wte Band 7 & 0.7 wte Band 6 for Maternity help line
- Quarter 4: 2.6 wte Band 6 for triage

Newham:

- Quarter 1: 2.2 wte Band 7 Maternity Pathway co-ordinator; 1.0 wte Band 7 Bereavement midwife; 1.0 wte Band 7 Deputy CPF
- Quarter 2: 3 wte Band 6 for Triage; 1.7 wte Bans 6 helpline; 1.0 wte Acorn

Royal London:

- Quarter 1: 4.0 wte Band 6 frontline midwives; 1.0 wte Band 7 Foetal Medicine; 1.0 wte Bereavement
- Quarter 2: Band 6 frontline midwives
- Quarter 3: 1.0 wte Band 7 Digital Specialist; 1.0 wte Diabetes Specialist
- Quarter 4: 1. 0 wte Band 7 Maternal medicine

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Appendix 2: RLH Ward establishments with planned CHPPD

SAFER STAFFING REVIEW OUTCOME 2022/23

					Current Rota	21-22 Budgeted Establishment			Safer Staffing Review Changes: Establishment Changes				Safer Staffing Review: Proposed Establishment			Planned
Site	Category	CC	Cost Centre Name		Funded Beds	Qualified Nurse WTE	HCA WTE	Total Nursing & HCAs WTE	Qualified Nurse WTE	HCA WTE	Total Nursing & HCAs WTE	Total Nursing & HCAs £000	Qualified Nurse WTE	HCA WTE	Total Nursing & HCAs WTE	CHPPD based on 100% Occupancy
RLH	EMERGENCY DEPT	AEC200	NURSE PRACTITIONERS		0	9.9	-	**9.9**			-		9.9	-	**9.9**	
RLH	EMERGENCY DEPT	AEJ300	A & E NURSING WC		0	118.9	22.3	**141.2**			-		118.9	22.3	**141.2**	
RLH	EMERGENCY DEPT	AEP300	PAEDIATRIC A/E		0	29.0	-	**29.0**			-		29.0	-	**29.0**	
RLH	RENAL	NNE300	WARD 9E		25	24.4	7.8	**32.2**			-		24.4	7.8	**32.2**	6.9
RLH	RENAL	NNF300	WARD 9F		25	24.4	10.4	**34.8**			-		24.4	10.4	**34.8**	7.5
RLH	RENAL	RHD300	RENAL HDU		6	20.2	2.6	**22.8**			-		20.2	2.6	**22.8**	20.3
RLH	WARDS	AWE300	WARD 12E (AW4)		24	40.4	20.8	**61.2**	(1.0)	-	**(1.0)**	**-51**	39.4	20.8	**60.2**	13.4
RLH	WARDS	FMF300	12C		26	28.1	18.2	**46.3**			-		28.1	18.2	**46.3**	9.5
RLH	WARDS	FML300	10F		16	14.1	7.9	**22.0**	2.6	-	**2.6**	**143**	16.7	7.9	**24.6**	8.2
RLH	WARDS	FMS300	WARD 11C		26	41.9	15.6	**57.5**			-		41.9	15.6	**57.5**	11.8
RLH	WARDS	FPA300	AAU		52	60.0	23.4	**83.3**	2.6	-	**2.6**	**143**	62.6	23.4	**85.9**	8.9
RLH	WARDS	FPM300	14E		26	23.6	15.6	**39.2**	-	2.6	**2.6**	**110**	23.6	18.2	**41.8**	8.6
RLH	WARDS	FPQ300	WARD 14F		26	24.6	18.2	**42.8**	-	2.6	**2.6**	**93**	24.6	20.8	**45.4**	9.4
RLH	WARDS	FSN300	12D		17	21.8	7.8	**29.6**			-		21.8	7.8	**29.6**	9.3
RLH	WARDS	LAW300	WARD 12F		26	28.8	26.0	**54.8**	1.0	-	**1.0**	**51**	29.8	26.0	**55.8**	11.5
RLH	WARDS	CRW300	WARD 13E (CARDIO/RESP WARD)		26	28.1	10.4	**38.5**			-		28.1	10.4	**38.5**	7.9
RLH	WARDS	CTA100	WARD 11D		0	7.7	1.5	**9.2**			-		7.7	1.5	**9.2**	
RLH	WARDS	FAF300	WARD 13F		22	27.0	12.3	**39.2**			-		27.0	12.3	**39.2**	9.6
RLH	WARDS	FPA301	WARD 13D		25	24.4	10.4	**34.8**			-		24.4	10.4	**34.8**	7.4
RLH	WARDS	MAR300	WARD 13C		26	25.5	10.4	**35.9**			-		25.5	10.4	**35.9**	7.4
RLH	WARDS	HRD300	WARD 3E		26	29.7	11.4	**41.1**			-		29.7	11.4	**41.1**	8.5
RLH	WARDS	SAU300	WARD 3F MONITORED UNIT		12	21.8	13.6	**35.4**			-		21.8	13.6	**35.4**	15.8
RLH	WARDS	TRC300	WARD 10E		26	28.8	14.0	**42.8**			-		28.8	14.0	**42.8**	8.8
RLH	WARDS	FND300	8C - GYNAE WARD - RLH		20	24.6	10.4	**35.0**	-	2.2	**2.2**	**100**	24.6	12.6	**37.2**	10.0
RLH	OTHER	FWE300	6B		25	15.5	6.7	**22.2**			-		15.5	6.7	**22.2**	4.7
RLH	OTHER	PAU300	7D PASSU		16	22.0	8.2	**30.2**			-		22.0	8.2	**30.2**	10.1
RLH	WARDS	FER400	WARD 7E		24	39.9	15.6	**55.5**			-		39.9	15.6	**55.5**	12.4
RLH	WARDS	FWA300	7F		12	19.2	8.5	**27.7**			-		19.2	8.5	**27.7**	12.4
RLH	WARDS	FWB300	7C SURGERY		12	19.1	7.1	**26.2**			-		19.1	7.1	**26.2**	11.7
RLH	CRITICAL CARE	FMV300	ACCU		50	210.8	7.8	**218.6**			-		210.8	7.8	**218.6**	23.4
RLH	WARDS	HDU300	6C - PICU		8	70.3	6.3	**76.6**			-		70.3	6.3	**76.6**	51.3
RLH TOTAL					**625**	**1,124.3**	**350.9**	**1,475.2**	**5.2**	**7.4**	**12.6**	**589**	**1,129.5**	**358.3**	**1,487.8**	**11.1**

Appendix 3: WCH Ward establishment with Planned CHPPD

SAFER STAFFING REVIEW OUTCOME 2022/23

								Safer Staffing Review Changes				Safer Staffing Review			
				Current Rota	21-22 Budgeted Establishment			Establishment Changes				Proposed Establishment			Planned
Site	Category	CC	Cost Centre Name	Funded Beds	Qualified Nurse WTE	HCA WTE	Total Nursing & HCAs WTE	Qualified Nurse WTE	HCA WTE	Total Nursing & HCAs WTE	Total Nursing & HCAs £000	Qualified Nurse WTE	HCA WTE	Total Nursing & HCAs WTE	CHPPD based on 100% Occupancy
WXH	EMERGENCY DEPT	182005	A & E - MAJORS SERVICE	0	90.0	14.5	**104.6**			-		90.0	14.5	**104.6**	
WXH	EMERGENCY DEPT	182010	A & E - PAEDIATRIC UNIT	11	29.1	5.0	**34.1**			-		29.1	5.0	**34.1**	
WXH	EMERGENCY DEPT	182020	A & E - MINORS SERVICE	0	12.0	-	**12.0**			-		12.0	-	**12.0**	
WXH	OTHER	182023	AMBULATORY CARE	0	6.8	1.1	**7.9**			-		6.8	1.1	**7.9**	
WXH	WARDS	182090	ELIZABETH WARD WXH	10	23.7	4.8	**28.5**			-		23.7	4.8	**28.5**	15.3
WXH	WARDS	182015	BLACKTHORN WARD	17	16.6	13.0	**29.6**			-		16.6	13.0	**29.6**	9.3
WXH	WARDS	182016	AAU ACUTE MEDICINE WARDS	59	70.5	33.8	**104.3**			-		70.5	33.8	**104.3**	9.5
WXH	WARDS	182030	SYCAMORE WARD	27	18.4	17.1	**35.5**			-		18.4	17.1	**35.5**	7.0
WXH	WARDS	182035	SYRINGA WARD	26	19.3	20.4	**39.7**			-		19.3	20.4	**39.7**	8.2
WXH	WARDS	182040	BIRCH WARD	18	16.6	13.0	**29.6**			-		16.6	13.0	**29.6**	8.8
WXH	WARDS	182045	SAGE WARD	27	24.6	18.2	**42.8**			-		24.6	18.2	**42.8**	8.5
WXH	WARDS	182060	BRACKEN WARD	18	18.4	13.0	**31.4**			-		18.4	13.0	**31.4**	9.4
WXH	WARDS	182065	WARD B3	17	18.4	13.0	**31.4**			-		18.4	13.0	**31.4**	9.9
WXH	WARDS	182070	NIGHTINGALE WARD	12	26.6	5.2	**31.8**			-		26.6	5.2	**31.8**	14.2
WXH	WARDS	182075	FARADAY WARD	16	26.6	7.8	**34.4**			-		26.6	7.8	**34.4**	11.5
WXH	WARDS	182080	CURIE WARD	18	22.3	15.5	**37.8**			-		22.3	15.5	**37.8**	11.2
WXH	WARDS	182215	PEACE WARD	19	21.0	11.1	**32.2**	-	7.5	**7.5**	**266**	21.0	18.6	**39.7**	11.2
WXH	WARDS	182840	OBSTETRIC THEATRE STAFFING - WXH	0	10.7	1.9	**12.6**	5.3	-	**5.3**	**311**	16.0	1.9	**17.9**	
WXH	WARDS	183420	ACACIA WARD	12	13.2	8.5	**21.8**			-		13.2	8.5	**21.8**	9.7
WXH	WARDS	182135	MARGARET CENTRE	11	14.0	5.2	**19.2**			-		14.0	5.2	**19.2**	9.3
WXH	WARDS	182535	CHESTNUT WARD (SURGICAL)	12	13.7	5.2	**18.9**	2.2	1.6	**3.8**	**180**	15.9	6.8	**22.7**	10.1
WXH	WARDS	182545	CEDAR WARD (SURGICAL)	18	23.6	18.2	**41.8**	13.3	10.6	**23.9**	**1,023**	36.9	28.8	**65.7**	19.6
WXH	WARDS	182560	ROWAN WARD (SURGICAL)	29	25.1	17.0	**42.2**			-		25.1	17.0	**42.2**	7.8
WXH	WARDS	182565	POPLAR WARD (SURGICAL)	29	24.4	15.6	**40.0**			-		24.4	15.6	**40.0**	7.4
WXH	WARDS	182775	PRIMROSE WARD (SURGICAL)	29	25.2	16.8	**41.9**			-		25.2	16.8	**41.9**	7.7
WXH	WARDS	182760	ACORN UNIT	21	54.1	9.6	**63.6**			-		54.1	9.6	**63.6**	16.2
WXH	WARDS	CM6925	WXH FOREST ASSESSMENT UNIT	7	11.4	5.2	**16.6**			-		11.4	5.2	**16.6**	12.7
WXH	CRITICAL CARE	182905	ITU UNIT	14	79.5	22.8	**102.2**			-		79.5	22.8	**102.2**	39.1
WXH TOTAL				**477**	**755.9**	**332.3**	**1,088.2**	**20.8**	**19.7**	**40.5**	**1,780**	**776.7**	**352.0**	**1,128.7**	**10.9**

Appendix 4 NUH ward establishment with planned CHPPD

SAFER STAFFING REVIEW OUTCOME 2022/23

								Safer Staffing Review Changes				Safer Staffing Review					
				Current Rota	21-22 Budgeted Establishment			Establishment Changes				Proposed Establishment				Planned	
Site	Category	CC	Cost Centre Name	Funded Beds	Qualified Nurse WTE	HCA WTE	Total Nursing & HCAs WTE	Qualified Nurse WTE	HCA WTE	Total Nursing & HCAs WTE	Total Nursing & HCAs £000	Qualified Nurse WTE	HCA WTE	Total Nursing & HCAs WTE		CHPPD based on 100% Occupancy	
NUH	EMERGENCY DEPT	102201	ECAM PRACTICE DEVELOPMENT NURSES	0	4.0	-	**4.0**			-		4.0	-	**4.0**			
NUH	EMERGENCY DEPT	102504	A & E - NURSING STAFF	0	83.2	21.3	**104.6**			-		83.2	21.3	**104.6**			
NUH	EMERGENCY DEPT	102506	PAEDS - A&E NURSING	0	26.4	2.5	**29.0**			-		26.4	2.5	**29.0**			
NUH	WARDS	102116	ACUTE ASSESSMENT UNIT	52	66.3	31.2	**97.5**			-		66.3	31.2	**97.5**		10.0	
NUH	WARDS	102117	HEATHER WARD	26	32.2	15.6	**47.8**			-		32.2	15.6	**47.8**		9.8	
NUH	WARDS	102118	CUSTOM HOUSE WARD	20	19.2	18.2	**37.4**			-		19.2	18.2	**37.4**		10.0	
NUH	WARDS	102122	STRATFORD WARD	25	21.8	15.6	**37.4**			-		21.8	15.6	**37.4**		8.0	
NUH	WARDS	102123	PLASHET WARD	26	21.8	15.6	**37.4**			-		21.8	15.6	**37.4**		7.7	
NUH	WARDS	102125	SILVERTOWN WARD	18	21.8	15.6	**37.4**			-		21.8	15.6	**37.4**		11.1	
NUH	WARDS	102130	WEST HAM WARD - SURGERY	20	19.2	15.6	**34.8**			-		19.2	15.6	**34.8**		9.3	
NUH	WARDS	102133	EAST HAM WARD	25	24.4	15.6	**40.0**			-		24.4	15.6	**40.0**		8.6	
NUH	WARDS	102640	GSC MAPLE WARD 2ND FLOOR	18	21.8	10.4	**32.2**			-		21.8	10.4	**32.2**		9.6	
NUH	WARDS	104603	RAINBOW WARD	18	38.9	11.1	**50.0**	-	-	-	**55**	38.9	11.1	**50.0**		14.9	
NUH	WARDS	104401	NEONATAL UNIT - NEWHAM	23	44.9	11.4	**56.3**			-		44.9	11.4	**56.3**		13.1	
NUH	CRITICAL CARE	102530	ITU	8	36.7	5.2	**41.9**			-		36.7	5.2	**41.9**		28.1	
NUH	OTHER	102221	JASMINE - UROLOGY	0	2.0	1.0	**3.0**			-		2.0	1.0	**3.0**			
NUH	OTHER	102224	JASMINE - ENDOSCOPY	0	13.1	9.3	**22.4**			-		13.1	9.3	**22.4**			
NUH	OTHER	102335	SURGERY NON CLINICAL NURSING	0	5.0	-	**5.0**			-		5.0	-	**5.0**			
NUH	OTHER	102660	CLOVE WARD	12	4.7	1.9	**6.6**			-		4.7	1.9	**6.6**			
NUH TOTAL				**291**	**507.3**	**216.9**	**724.3**	**-**	**-**	**-**	**55**	**507.3**	**216.9**	**724.3**		**10.6**	

Appendix 5 SBH ward establishment with planned CHPPD

SAFER STAFFING REVIEW OUTCOME 2022/23

								Safer Staffing Review Changes				Safer Staffing Review			
				Current Rota	21-22 Budgeted Establishment			Establishment Changes				Proposed Establishment			Planned
Site	Category	CC	Cost Centre Name	Funded Beds	Qualified Nurse WTE	HCA WTE	Total Nursing & HCAs WTE	Qualified Nurse WTE	HCA WTE	Total Nursing & HCAs WTE	Total Nursing & HCAs £000	Qualified Nurse WTE	HCA WTE	Total Nursing & HCAs WTE	CHPPD based on 100% Occupancy
SBH	WARDS	AMD100	3A CCU (1)	36	75.7	20.8	**96.5**			-		75.7	20.8	**96.5**	14.4
SBH	WARDS	FAW200	CARDIAC SURGERY POST OP (4A)	22	24.4	9.7	**34.0**			-		24.4	9.7	**34.0**	8.3
SBH	WARDS	FBW200	CARDIAC SURGERY POST OP (4B)	20	22.8	14.0	**36.8**			-		22.8	14.0	**36.8**	9.8
SBH	WARDS	FHL200	SBH WARD 6D	25	26.6	13.0	**39.6**			-		26.6	13.0	**39.6**	8.5
SBH	WARDS	FME200	SBH WARD 3D	20	23.6	16.0	**39.6**			-		23.6	16.0	**39.6**	10.6
SBH	WARDS	RAD200	SBH WARD 4C	23	24.4	14.1	**38.5**			-		24.4	14.1	**38.5**	9.0
SBH	WARDS	HZD100	4D	20	25.1	10.4	**35.5**			-		25.1	10.4	**35.5**	9.5
SBH	WARDS	FGG200	BODLEY SCOTT II WARD 5D	23	29.6	11.4	**41.0**			-		29.6	11.4	**41.0**	9.5
SBH	WARDS	FGI200	5C WARD	20	29.6	7.8	**37.4**			-		29.6	7.8	**37.4**	10.0
SBH	WARDS	FGM200	G.H.F. BARTS WARD 5A	22	28.6	10.3	**38.9**			-		28.6	10.3	**38.9**	9.5
SBH	WARDS	FJP200	RAHERE WARD 5B	16	21.8	7.8	**29.6**			-		21.8	7.8	**29.6**	9.9
SBH	CRITICAL CARE	ADT100	ICNARC	0	5.8	-	**5.8**			-		5.8	-	**5.8**	
SBH	CRITICAL CARE	FGT200	CRITICAL CARE (1C, 1D, 1E & 4B HDU)	53	299.6	19.7	**319.3**			-		299.6	19.7	**319.3**	32.3
SBH	OTHER	CAU200	SBH WARD 3C	25	12.1	7.4	**19.6**			-		12.1	7.4	**19.6**	4.2
SBH	OTHER	FGN200	SBH FRANCES FRASER	0	5.8	1.9	**7.7**			-		5.8	1.9	**7.7**	
SBH	OTHER	FGR200	PERCIVALL POTT WARD	14	4.0	2.0	**6.0**			-		4.0	2.0	**6.0**	
SBH	OTHER	FJH200	PAGET WARD 7A (MED ONC)	98	55.6	6.5	**62.1**			-		55.6	6.5	**62.1**	
SBH	OTHER	FSC200	FERTILITY CENTRE - SBH	0	51.3	6.5	**57.9**			-		51.3	6.5	**57.9**	
SBH TOTAL				**437**	**766.4**	**179.1**	**945.5**	**-**	**-**	**-**	**0**	**766.4**	**179.1**	**945.5**	**13.3**

NHS
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NHS Trust

Report to the Trust Board: 6 July 2022	TB 55/22

Title	Complaints Annual Report 2021/22
Accountable Director	Chief Nursing Officer
Author(s)	Head of Complaints -Central Complaints and PALS Teams
Purpose	To provide a summary of reportable complaints and PALS activity received in 2021/22
Previously considered by	Complaints Improvement Group, Quality Board Group Executive Board, Quality Assurance Committee

Executive summary

The work on complaints management was impacted by changes implemented in response to the pandemic. Redeployment of complaints teams' staff across the group and the hospitals during the year meant many activities teams would usually be engaged in were either paused or progressed slowly. Covid related sickness also impacted significantly on teams and performance throughout the year. Notwithstanding that, each hospital continued with ensuring complaints management was delivered across the Trust. As our audits and surveys suggest there is scope for further improvement, we continue to review our processes, making progress against set standards. In particular:

- this year, using the draft complaints standards framework currently being piloted by the Parliamentary Health Service Ombudsman (PHSO) we undertook a self-assessment against the maturity matrix tool within the standards. The outcome indicated high quality standards in our complaints management.
- we have had bi-monthly complaints management improvement group meetings with focused agendas on continually improving quality and learning lessons from patients' experience and the feedback they provide though the complaints process
- we improved reporting systems at an operational level which ensured frequent visibility of performance against set standards and prompt responding to quality issues in our processes before they impacted negatively on quality and patients' experience

To address the areas of quality improvement identified, a detailed plan for the next year has been developed and outlined in section 6.1 of the report. Our plans for improvements amongst others include: peer reviews and individual hospital deep dives to ensure consistency and enhance patients' experience of our complaints handling.

Related Trust objectives	
SO1 Safe and Compassionate Care	
Risk and Assurance	The report sets out the current key risks to the above objective.

Related Assurance Framework entries	1. A failure to learn from Never Events, serious incidents and complaints adversely impacts on quality and safety
Legal implications/ regulatory requirements	Supports compliance with The Local Authority Social Services and National Health Service Complaints Regulations (England) Regulations 2009

Action required: The Trust Board is asked to approve this report

Barts Health NHS Trust

BARTS HEALTH NHS TRUST
PALS & COMPLAINTS ANNUAL REPORT 2021/22

1. INTRODUCTION

This report provides information on reportable complaints, issues and concerns reported via our PALS & Patient Family Contact Centre, (collectively known as early resolution systems) and the complaints process to the Trust between 1 April 2021 and 31 March 2022 compared with the previous year.

The report also examines the quality of our complaints management, using a self-assessment maturity matrix tool, part of the Parliamentary Health Service Ombudsman's (PHSO) draft standards framework for complaints management. The framework, currently being piloted across the NHS, serves as a universal quality improvement and monitoring tool for complaints management across the NHS and the Trust volunteered alongside others, across the country to be a pilot site.

The Early Resolution and Complaints Teams work together with hospital governance teams to ensure service users are aware of the options available to them when they wish to raise concerns or report problems with care. Furthermore, the teams ensure that: service users' concerns are heard and responded to, action is taken to prevent re-occurrence and credible improvements are achieved.

The pandemic impacted on how complaints management was undertaken during the year, however with better knowledge from the first year of the pandemic, and its impact, with some preparation, the effects were not as impactful as the previous year. Covid related sickness and redeployment did however reduce the numbers of staff available to manage complaints at different points during the year. Despite this, negotiating longer timescales, prompt resolution at frontline and using existing early resolution services meant we were able to continue with business as close to usual as possible without adversely affecting patients' experience.

2. DATA ANALYSIS

2.1 Complaints received

This year, the Trust received **1,579** complaints compared with the previous year when **1,295** cases were recorded. Although this was a 21% increase compared with the last year, the numbers remain significantly lower than pre-pandemic times which in 2019/20 was **1,867**.

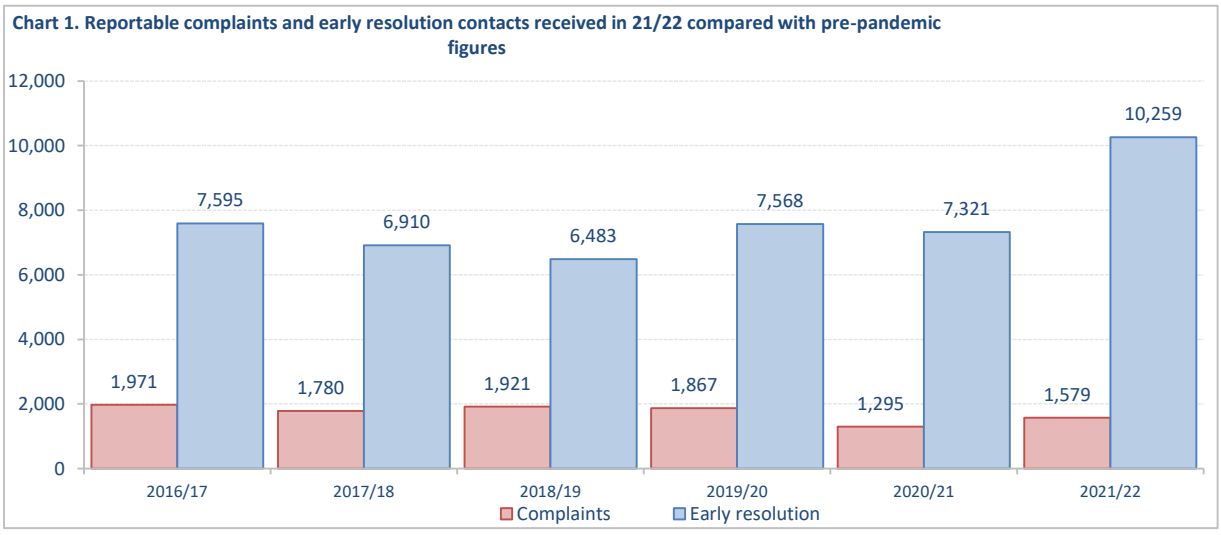
The relaxation and subsequent end of lockdown measures imposed at the height of the pandemic meant resumption of face-to-face appointments in our hospitals, a change in visiting rules and an increased foot fall, could have been contributory factors in the increased number of complaints received.

During the same period, the Trust recorded **10,259** early resolution contacts, compared with the previous year when a total of **7,321** contacts were recorded.

Chart 1 below provides a breakdown of complaints and early resolution contacts received across the Trust during this year compared with pre-pandemic years.

The increase in activity was attributed to; a backlog of early resolution data entered during the year at the Royal London Hospital, a permanently established Patient Family Contact Centre (PFCC) at the Royal London Hospital and a temporary PFCC at Newham Hospital alongside an existing PALS team at the height of the pandemic.

Through activity from the early resolution processes in place across hospitals and through the Complaints Standards Framework pilot being undertaken, we are aware that our service users prefer prompt and early resolution of concerns to the existing complaints process which they have often described as bureaucratic.



2.2 Barts Health performance against national data on written complaints in the NHS

National complaints benchmarking data is provided by NHS Digital, drawing on the KO41a data submitted by all NHS trusts. At the time of writing only data for quarters one and two in 2021/22 are available which provides the number of new complaints per 10,000 finished consultant episodes (FCE). The data indicates that in quarter one of 2021/22 Barts Health received 66 complaints per 10,000 FCEs ranking the organisation 129 out of 139 trusts. In quarter 2, 61.9 complaints were received with a ranking of 117 out of 139 trusts.

The national average in quarter one was 36.7 and in quarter two 39.6. Despite an increase in the use of local resolution solutions within the trust, Barts Health receives more complaints than most other NHS Trusts. This highlights the need to focus further on ensuring that concerns are dealt with at an early stage and do not unnecessarily progress to being formal complaints.

2.3 Analysis of the demographic data of complainants

This data is obtained using "the person affected" MRN / NHS number where this is available in the complaint information provided. Those records are linked to the Trust's Cerner data and we are able to obtain complainants' demographic details that way.

There will always be a high number of "null" returns, in the data reported as not all complainants are the person affected and not all complainants who are the person affected provide MRN / NHS numbers, especially if their complaint is of a non-clinical nature.

In other cases where the complaint is received directly via the on-line or paper forms, some complainants prefer not to disclose this information. Overall, many complainants fear reprisal and are generally reluctant to provide any demographic data when it is required.

Table 1 - 3 below provide statistics and insight into the demographics of our complainants. Overall, the data suggests that service users within the age range of 19 - 40 were the highest age groups complaints come from. In addition, the data suggests that most of our complaints come from our white – British and Asian / Asian British – Bangladeshi service users.

Table 1. Gender Demographics	
Gender	**No. of complaints**
Female	470
Male	233

Table 2. Age Demographics	
Age	**No of complaints**
0-18	14
19-30	129
31-40	223
41-50	122
51-60	104
61-70	64
71-80	41
80+	6
NULL	716

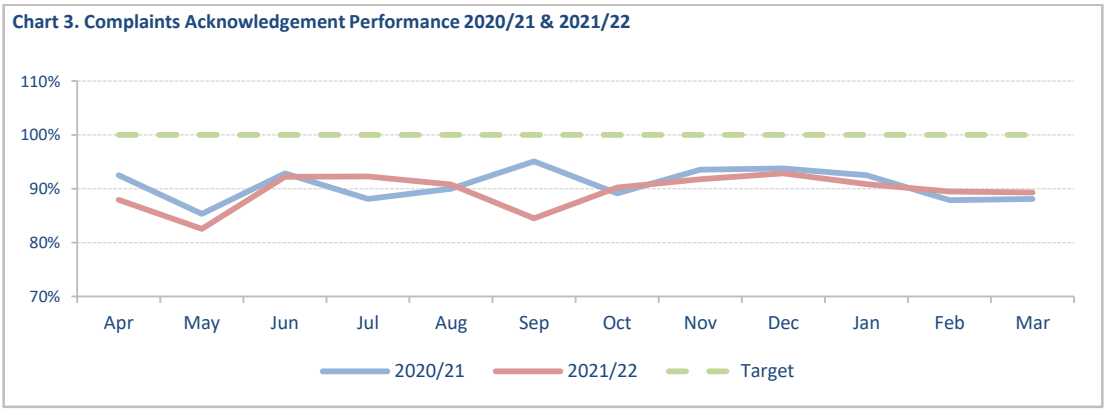
Table 3. Ethnicity Demographics	
Ethnicity	No. of complaints
Asian - Any Other Asian Background	39
Asian or Asian British - Bangladeshi	67
Asian or Asian British - Indian	42
Asian or Asian British - Pakistani	28
Black - Any Other Black Background	28
Black or Black British – African	39
Black or Black British - Caribbean	23
Mixed - Any Other Mixed Background	11
Mixed - White and Asian	2
Mixed - White and Black African	5
Mixed - White and Black Caribbean	7
Null	717
Other - Any Other Ethnic Group	33

Other - Chinese	4
Other - Not Stated	56
Patient Refused	13
White - Any Other White Background	87
White - British	215
White - Irish	3

3. Complaints acknowledgement performance

3.1 The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 require that Trust's acknowledge all reportable complaints within 3 working days. The overall acknowledgment performance for the Trust during the year was 89% against a standard of 100%. Compared with the previous year when performance was 91%, this is a slight decrease, however, this is an improvement on pre-pandemic performance. Performance in 2019/20 the year before the pandemic was 82%.

A number of contributory factors including staff absence and reaching complainants to be able to negotiate management plans were some of the reasons for delays in acknowledging complaints within the agreed standard.



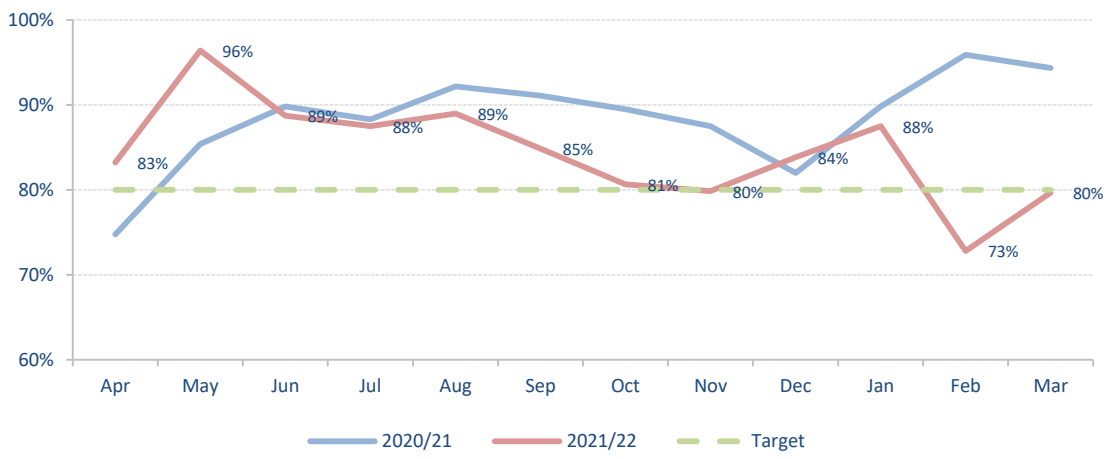
3.2 **Acknowledgement performance since inception of 100% threshold.**

The Trust has never met the 100% threshold, in spite of putting in numerous improvement plans including regular audits and an intuitive dashboard reporting system. Since 2015/16, the performance has been broadly stable within the range of 84% - 97% and currently 89%. Some of the reason we do not meet the standard include not being able to reach the complainant and key staff absence.

4. Complaints response performance

4.1 Overall, the Trust response performance during the year was 85% compared with 88% the previous year. The benefits of a weekly sitrep and an intuitive dashboard that helps hospitals to follow performance on a daily basis and address any potential issues that might affect performance, have been a significant contributory factor in how the Trust has continued to maintain high standards with our response performance.

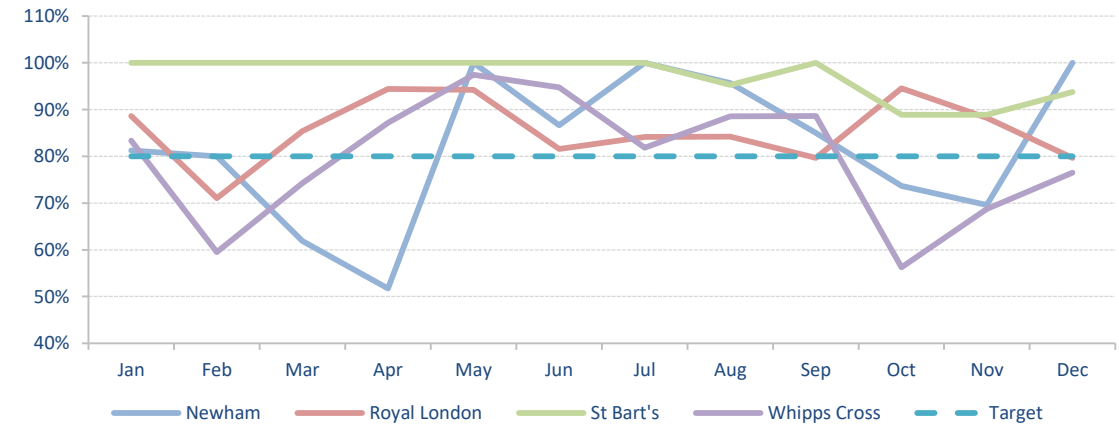
Chart 3a. Complaints response performance in 21/22 compared with and 20/21



4.2 Complaints response performance by hospitals

Chart 3b below shows individual hospital's performance against the 80% standard set for responding to reportable complaints. Although Newham and Royal London Hospitals were the most challenged sites with regard to responding to complaints on time, by the end of the financial year performance overall improved.

Chart 3b. Complaints response performance by hospitals



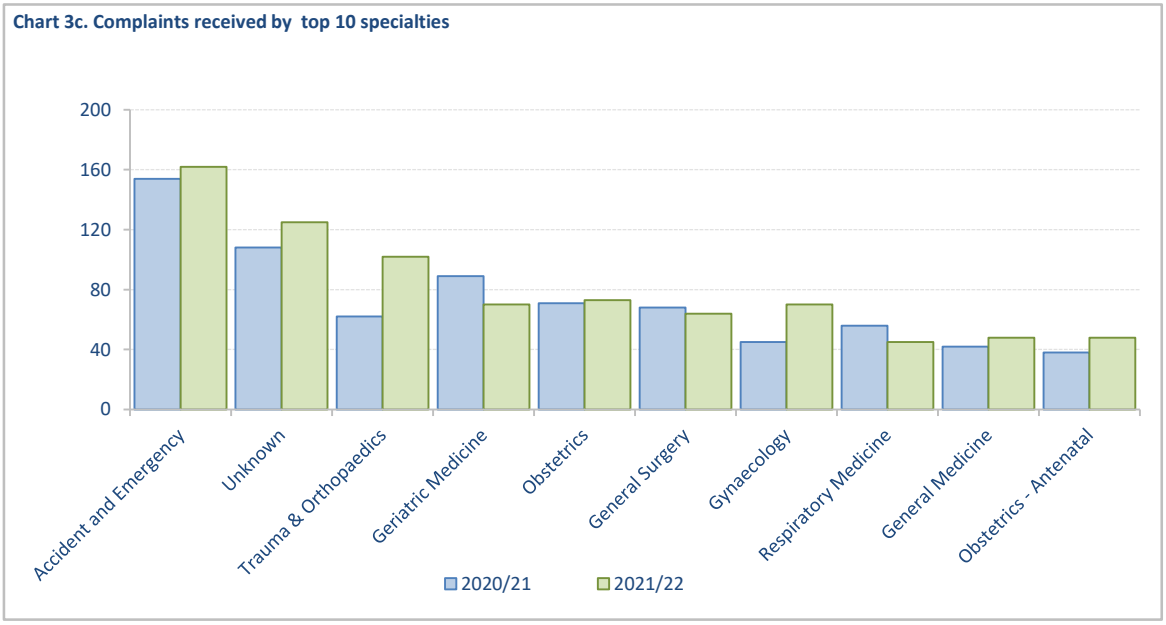
Staffing levels and sickness absence across divisions and governance teams were noted to be contributory factors in the dips in performance.

4.3 Complaints received by top 10 specialties

As noted in chart 3c, the top ten specialties included a considerable number of contacts for which their speciality was listed as unknown. A deep dive further into the data suggested that the majority of them belonged within the site management team (SMT) division but were not about the specialties listed many of which are non-clinical services.

In addition, concerns were about issues that did not sit specifically within any clinical area and so could not be allocated to any specialty in particular within the SMT division. Also, some miscoding of cases was noted to be a reason for cases being inappropriately assigned to the SMT division.

This will now be added as a standing agenda item for the complaints management improvement group to discuss reviewing this category and consider other options for ensuring the complaints reported within this category are better reported.



4.4 Complaints and PALS contacts received by top 5 themes

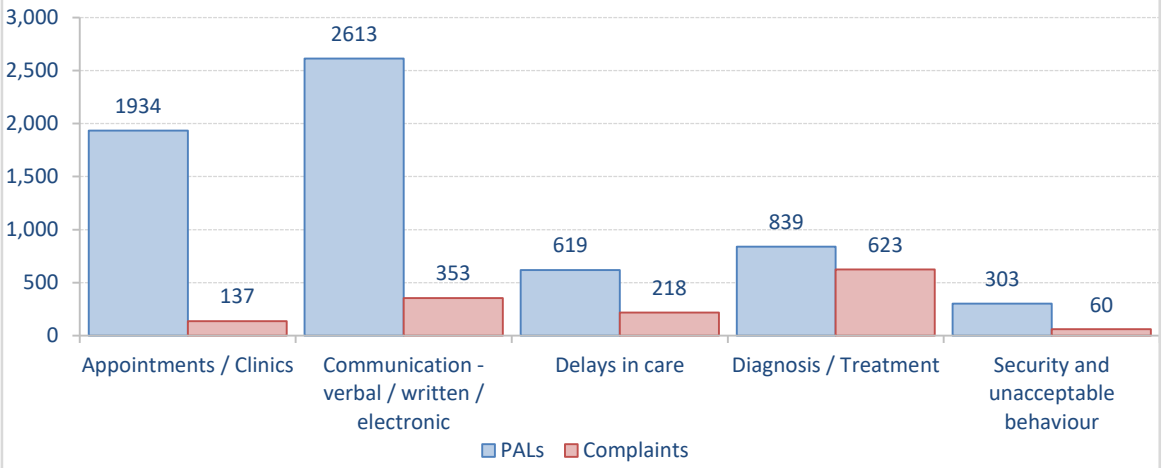
As noted in chart 3d below, appointments, communication, diagnosis, and treatment continue to be high on the list of concerns for service users. Triangulating themes from complaints with other patient experience feedback and actions taken to address those, as noted in section 6 have continued to demonstrate how we use feedback from service users to improve patients' experiences of care.

Appointment issues emerge as a significant concern for complainants with many raising concerns about the length of time they are having to wait to be seen.

Within the elective recovery programme which has been initiated, we are connecting with patients who have waited up to 2 years for their appointments. All patients within this category have now been contacted and a plan has been put in place to ensure that we have no patients waiting more than 2 years by the end of June 2022.

A wider patient contact exercise is also currently being planned to ensure that the Trust stays connected to patients within, and others who could potentially fall into, this category.

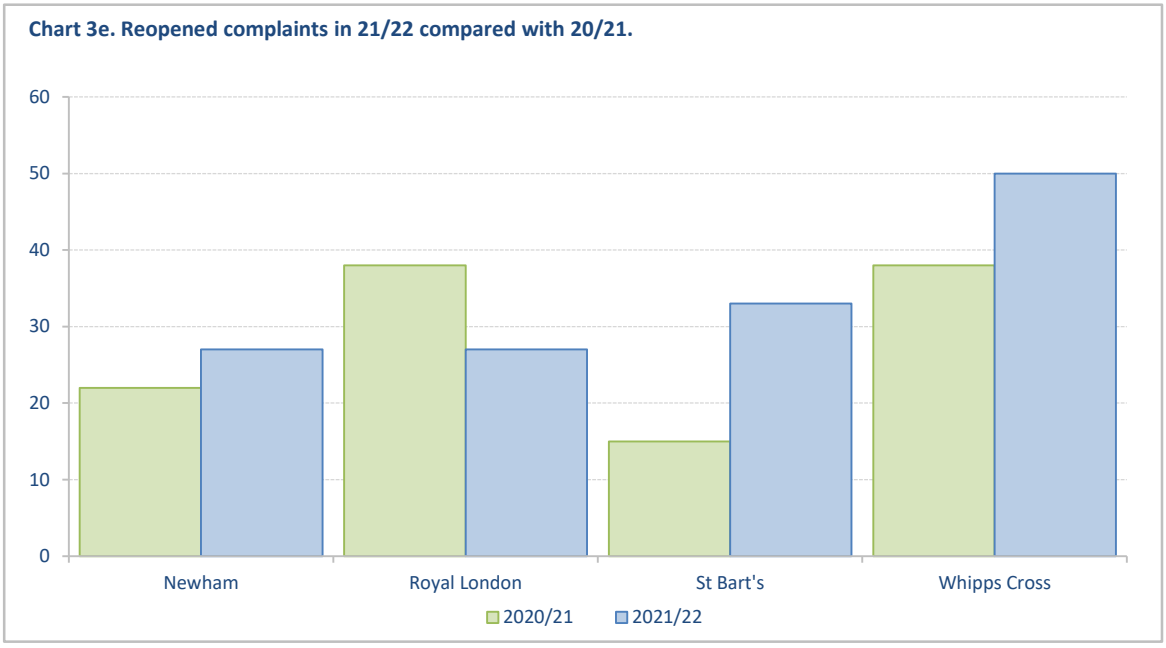
Chart 3d. Complaints and PALS contacts received by top 5



4.5 Reopened complaints received during the year compared with the previous year

A total of 137 complaints were reopened compared with 113 during the previous year. Our complaints response audit, detailed further in section 5 below suggest that there are still some areas of our process that need to be improved to give complainants a better experience when they raise concerns with us.

The increase noted correlates directly with the number of complaints received during the year.



5. Audits undertaken during the year

5.1 Response quality audit

As part of our improvement plan, we carry out a number of audits during the year. The audits assure us of the quality of our complaints management. One of these, the "response quality audit" is a key quality indicator for measuring how well we respond to concerns raised and how well we provide reassurance of reducing or preventing reoccurrences of the concerns that led to the complaints made.

In line with our policy, we review our responses against set standards, assessing our complaints management culture against the standards we set in our policy.

Table 4 below summarises these standards and the Trust's performance against each. Notably, over half the responses reviewed were not quality checked and signed off by a hospital executive. This partly demonstrates non-compliance with Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 which require executives to be accountable officers for complaints management in Trusts.

Overall, the audit suggests that whilst a high number of the responses reviewed, met most of the standards, there is still scope for further improvement. These have been identified and included in our improvement plan below for next year.

Table 4	Standard	Yes	No	Partially
1.	Was a full response provided?	71%	16%	13%
2.	Was our response empathic enough?	80%	19%	1%
3.	Was the Trust's standard template used?	72%	20%	8%
4.	Was adequate signposting to additional information provided?	80%	20%	-
5.	Was a named contact for further discussion, if required provided?	73%	21%	5%
6.	Was each response quality checked and signed off by a hospital executive?	49%	51%	-

5.2 Complainant satisfaction survey

The complainant satisfaction survey takes a collaborative / engagement approach and invites our complainants to join us in improving our processes, by giving feedback, so others can have a better experience.

At the end of each quarter, from a random selection of cases closed during the year, we contact complainants. When we call, we confirm where the caller is from, the reason for the call and then ask if complainants would like to help make improvements by giving feedback on their experiences of using the process.

During this year, there has been more reticence than usual on the part of complainants towards engaging in the survey. Apart from "just not wanting to" or "just not being in the mood", calls not being picked up, timing etc were some of the reasons complainants did not wish to engage. Nevertheless, we were able to obtain meaningful feedback that has enabled us to reflect on and review how we manage complaints.

Table 5 below gives a snapshot of the volume of data considered for the audits and the number of records considered for the audit versus the number of surveys eventually completed.

Table 5. survey activity	No of records suitable for surveys	Randomly selected records used to conduct surveys	No. of actual surveys completed
Q1	427	88	49
Q2	405	85	53
Q3	756	86	39
Q4	700	92	33

Table 6 suggests that there is still some way to go to improving complainants' experience of the process as the majority of those surveyed thought the process was only fair and a decline in experience of the process was noted from quarter 2 onwards.

Whilst undertaking the survey, some complainants were unable to separate their "complaint content" from the "process experience" or from their feelings about the NHS as a whole, resulting in mixed emotions which played out in the survey and their responses to the survey.
Operational pressures during the pandemic also meant there were challenges which could have impacted on our ability to respond and manage all complaints to the highest standard.

Table 6. Survey performance	Excellent/Good	Fair	Poor	No answer
Q1	33%	41%	24%	2%
Q2	9%	16%	75%	-
Q3	13%	31%	54%	2%
Q4	13%	27%	60%	-

6. During the year, we have continued to focus on quality of complaints management and triangulating themes with other patient experience feedback received. Through the patient experience committee which meets monthly, all the feedback is discussed and updates on projects addressing these are highlighted. Examples of some of these projects are listed below in **table 7** below.

Table 7. Subject/ Sub-subject	Issue of concern	Outcome / Action Taken
Nutrition & Hydration	Concerns around inpatients not receiving enough hydration in-between mealtimes and in particular young adults not receiving enough hydration in-between mealtimes.	The nutrition and hydration group led by lead dieticians and senior nurses now have scheduled meetings and have made some significant improvements, working alongside SERCO and nursing staff. Improvements include: - more collaborative working between dieticians and nursing staff - timetable of hydration rounds roles and responsibilities implemented on wards

		- prompt escalation processes in place between the ward and SERCO to highlight any food related concerns
Communication	Patient experienced known, but severe side effects as a result of treatment.	A review of the advice and guidance on side effects was undertaken by the pharmacy team. An electronic standard proforma was subsequently developed for clinical staff to use with patients at each follow up appointment so that possible symptoms are reiterated, and ongoing monitoring can be undertaken at each appointment.
Communication	Feedback from complaints, FFT, Bereavement Surveys and word of mouth from bereft families indicated concerns in relation to absence of clarity in informing loved ones their relative was at end of life, delays in appointments and staff attitude.	The feedback received was used to design training for staff in the services concerned A patients' charter to explain expectations for patients was designed and implemented in outpatients is being used in staff 1 to 1's and staff inductions.

7. Complaints Management Training.

7.1 The central complaints team (CCT) leads on providing complaints training for staff across the Trust. Each year, pre-booked sessions are agreed with the Learning and Development team and ad-hoc sessions are also provided where services request for sessions suitable to their individual needs. Towards the end of the 2021, a gradual return to delivering face to face sessions began, albeit in much smaller numbers than usual due to social distancing requirements. Virtual sessions however remain a favourite amongst staff with attendance numbers being higher than pre pandemic times when only face to face sessions were delivered. Overall, a total of 115 participants attended the 11 sessions delivered with a mix of staff from different services across the Trust in attendance. Feedback from participants as noted below suggested that many found the sessions very useful, with being able to practise drafting response letters being a key component of the training which many are keen to see this integrated into the virtual sessions going forward. E-learning packages, incorporating writing response letters are currently being explored with the learning and development team.

The training modules delivered included:

- understanding the Trust's formal complaints process
- investigating techniques
- multiple service / organisation complaints
- Datix – Complaints Management module
- NHS complaints regulations
- Duty of Candour
- managing complex complaints and complex complainants
- local resolution process
- stage 2 complaints with the Parliamentary Health Service Ombudsman (PHSO)
- targeting specific areas of need in individual services

7.2 **Staff Complaints Training**

Staff groups that attended the training sessions included ward sisters, consultants, therapists, nurse education facilitators, managers and non-clinical staff.

In **table 8** below is some of the narrative feedback staff provided on their evaluation forms.

Table 8.

1. As the responsible consultant for governance for the eye department, I frequently deal with complaints, so the training was very helpful for me.
2. It was reassuring to know that what I am doing is correct. Useful to know what support is available
3. I was sad to hear that this session will not be delivered anymore. Personally, I don't think e-learning gives the staff the chance to ask questions and discuss
4. All information given was useful and helpful, very clear and easy to understand.
5. It was all very useful, knowing how to respond in a complaint letter without over apologising and keeping the response succinct
6. I found all the session very useful for providing a structured way to answer complaints and the tools were very useful
7. Trainer was very friendly and approachable. I felt comfortable participating and asking questions I had. The writing a complaint response exercise was good to apply what we had learnt and we an opportunity to clarify any queries
8. I did not know about the 'peace model of investigating' – so this was a great insight for me! Trainer had a relaxed way of teaching and I really liked it.

9. The all session was very informative and has certainly changed my view on complaints handling. I thoroughly enjoyed the course and learnt a lot more than I thought- Telecoms Lead
10. I don't believe there was a least useful part of the training as it was all relevant and up to date
11. I joined a bit later in the programme, but I think the delivery was brilliant and the illustration of the slides were useful and knowledgeable
12. Thank you for having me in this training and I hope to join the training in relation to Datix
13. The entire session was useful as it provided a useful overview of handling complaints

8. Focus on Parliamentary and Health Service Ombudsman (PHSO)

8.1 The PHSO is responsible for implementing stage 2 of the NHS and Social Care Complaints Regulations. To that end, where complainants remain dissatisfied with actions taken at a local level, they have the option of contacting the PHSO for an independent review of their complaint. In March 2020 the PHSO paused the processing of complaints to support Trusts across the country with their COVID efforts. In the last 6-9 months this has returned to normal, with requests now coming into the Trust for both existing and new cases. As a direct result of this, no PHSO complaints were closed during 21- 22. The Trust currently has 16 open PHSO cases, 4 of which were received between 1 April 2021 - 31 March 22 as shown below in table 9 is a description of the cases received. All the cases concerned are awaiting further contact from the PHSO following their review/investigation.

Table 9. ID	Description
101494	Partner of a deceased patient is unhappy with the nursing & medical care he received while admitted. Also not happy with the contents and the delays in receiving the investigation report she received.
102530	Family of former inpatient do not believe he received thorough care, and are concerned that he appeared to make a recovery only to die several days later. His regular medication was also switched, and upon his death, the family received two death certificates with differing information.
107519	Patient is unhappy with care she received when she delivered her baby.
78001	Wife complaining about the delay in her husband's treatment, and they were not told that he had cancer.

8.2 **NHS Complaints Standards Framework – Pilot update.**

Last year the PHSO launched the new NHS Complaints Standards framework which is being piloted by several Trusts across the country including Barts Health. Due to pandemic pressures, redeployment and staffing levels across complaints teams, the project was paused until February 2022. With the focus of our pilot being on improving access for children, young people and people with learning disabilities two focus groups were set up. One with the Youth Empowerment Squad, a group of young people interested in the health and experiences of young people within Barts Health and the other with Whipps Cross interns from Project SEARCH, which provides work placements for young people with special education needs. The latter is pending.

The data from the self-assessment and the focus group undertaken indicated that whilst our formal complaints process was mature, early resolution as an option was not always conspicuous enough for service users who might be less able to make use of the formal process which many of the aforementioned groups often found too bureaucratic. To that end, the project has focused on strengthening the front end of our complaints process, making it more accessible for groups of service users who may find that much easier and quicker than the formal complaints route. Below in **table 10** are the progress updates.

Table 10.Project Timeline	**Progress**
Spring 2021	1. Self-assessment undertaken 2. Youth Empowerment Squad Focus Group 3. Project title confirmed 4. Project update at national webinar 5. PHSO catch up meeting 1
Autumn 2021	6. Project awareness raising to patient Experience Group and Complaints Improvement Group 7. Complaints policy review 8. Datix review 9. PHSO catch up meeting 2 10. Project evaluation with PHSO

9. Improvement plans

9.1 Update on 2021 – 22 improvement plan

Last year we set ourselves some key priorities, which are listed in **table 11** below. All of them, except one which has been included in next year's improvement plan, as reported in the body of this report were either achieved or are actively underway.

Table 11	Key priority	Update
1	Pilot of new complaints standards	Progress reported in 8.2 above
2	Quarterly satisfaction and response quality audits	Reported in section 5 above
3	Improve acknowledgement response performance to 95% - 100%	Reported in section 3 above
4	Analysis of complainant demographic data	Reported in 2.3 above
5	Explore opportunities from the Family Contact approach used during the pandemic to be incorporated systematically into our model	Included in action plan for 2022/23

6.1. Improvement plan for 2022 - 2023

In partnership with all hospitals in the Trust, the corporate complaints team will be focusing on a number of key priorities during 2022/23 to continue improving our complaints management processes for patients and their families.

The key areas of focus are outlined in **table 12** below

Table 12	**Action**	**Lead**	**Timeline / By when**
1	Complaints Seminar/wellbeing event for all complaints managers and handlers across the Trust to improve psychological wellbeing	Central Complaints Team	Dec 2022
2	E-learning response writing training to improve access to training for staff across the Trust and increase quality of responses	Central Complaints Team	August 2022
3	Each hospital to undertake deep dive into complaints handling in their divisions and identify targeted training	Hospital Heads of Governance	Dec 2022
4	Explore opportunities from the Family Contact approach used during the pandemic to be incorporated systematically into our model to ensure that we are responding to issues as quickly as possible	Director of Quality Governance and Hospital DoNs	Jan 2023
5	"Unknown" complaints category review and	Central	September

	recoding	Complaints Team & Complaints Management Improvement Group	2022
6	Complainants' demographic data / ethnicity focus to help us understand how equitable access to our complaints processes are for the diverse communities we serve.	Central Complaints Team, Hospital Governance teams & Complaints Management Improvement Group	December 2022
7	Individual Hospital Annual reports to be produced and presented at Hospital Executive Boards	All Hospitals' Heads of governance	March 2023
8	Quarterly Audits - Complainants Satisfaction - Response quality audits.	Hospital Heads of Governance	June, Sept, Dec 2022 & March 2023
9	Hospital process reviews to: ensure consistency, improve quality of responses, as well as oversight and accountability at executive level across the Trust.	Hospital DoN & Hospital Heads of Governance	July 2022
10	Peer review of complaints processes.	Central Complaints Team, Heads of Governance & Improvement Group	March 2023
11	Individual Hospital review of executive level response "sign off" process to improve performance	Hospital DoN & Hospital Heads of Governance	March 2023

Author – Bumi Akinmutande
Central Complaints Manager
Final – 27th June 22

Barts Health NHS Trust

Report to the Trust Board: 6 July 2022	TB 56/22

Title	Safeguarding Children and Adults Annual Report April 2021- March 2022
Accountable Director	Chief Nurse
Author(s)	Clare Hughes, Head of Safeguarding Lynn Street, Director of Quality Governance
Purpose	To update the Trust Board on progress against the delivery of the safeguarding adults and children's activity in the Trust in line with national guidance and approve he recommendations.
Previously considered by	Integrated Safeguarding Assurance Committee, Quality Board Group Executive Board, Quality Assurance Committee

Executive summary

Barts Health NHS Trust has a statutory responsibility to safeguard and promote the welfare of children and adults. The purpose of this combined Safeguarding Children and Adults Annual Report is to provide assurance to the Board against statutory elements of the Safeguarding Adults and Children's agenda and update on the progress of objectives in 2021/22. Notable achievements over the past year include:

- Strengthened the visibility of safeguarding children at hospital-based meetings, using hospital based expertise to drive improvements in service delivery.
- Greater awareness of PREVENT and an increase in the number of referrals made by the Trust
- Identified gaps in knowledge and understanding of mental capacity assessments and DoLS in preparation for implementing Liberty Protection Safeguards (LPS) within the Trust. Audits have been completed across the Hospitals and have been used to support the work within the Task and Finish LPS group.

Key Issues and risks identified within the report:

- Capacity within the safeguarding team has been impacted by vacancies, long term sickness and increasing activity, compounded by the effects of the Covid pandemic. A feasibility proposal was completed to increase investment in the team.
- Safeguarding training compliance has seen a decline particularly within adult safeguarding at level 3
- Safeguarding supervision compliance has deteriorated
- Lower than expected referrals via the allegations of abuse and neglect made against staff process
- Changes in Deprivation of Liberty Safeguards and planning for Liberty Protection Safeguards implementation
- The Child Death Review (CDR) process and the interface with CDR Hub - there is currently a review on-going within NEL to look at the child death processes across the system.

Safeguarding referrals:

The top three reasons for referrals to children social care are: child mental health, parental mental health and youth violence

Top themes for safeguarding adults are: discharge concerns, neglect/acts of admission, self-neglect and domestic abuse

Barts Health NHS Trust

The report includes updates on safeguarding audit activity, partnership working, PREVENT, domestic abuse and reducing inequity, and progress against 2021/22 objectives and plans for 2022/23

Related Trust objectives Improve patient care, further improving safety, clinical outcomes and patient experience

Risk and Assurance	The report sets out the current key risks to the Safeguarding agenda and how they are being mitigated.

Legal implications/ regulatory requirements	Safeguarding Children is governed by a range of legal and regulatory requirements including: "Working Together to Safeguard Children (2018)" which sets out how organisations and individuals should work together to safeguarding and promote the welfare of children and young people in accordance with the Children Acts 1989 and 2004: the Care Quality Commission's Essential Standard of Quality and Safety Outcome 7 (Regulation 11) on safeguarding people who use services from abuse

Action required The Trust Board is asked to approve the Safeguarding Children and Adults Annual Report

Barts Health NHS Trust

Safeguarding Children and Adults Annual Report
April 2021 – March 2022

INTRODUCTION

This combined Children and Adults Safeguarding Annual Report informs the Trust Board and Partnership Boards on progress made in delivering the Safeguarding agenda during the period April 2021 - March 2022.

Directors of Nursing for Newham University Hospital (NUH), Whipps Cross Hospital (WXH), St Bartholomew's (SBH) and The Royal London Hospital (RLH) are responsible for reporting to the Hospital Executive Boards. This overarching report reflects trust wide activity.

The objectives of this report are to provide:

- Assurance that the Trust continues to fulfil its statutory responsibilities in relation to Safeguarding Children as stated in Section 11 of the Children's Act 1989/2004 and the Care Act 2014
- Assurance that the Trust is compliant with Care Quality Commission (CQC) Fundamental Standards (Safe, Effective)
- An update to internal and external stakeholders on the developments in relation to safeguarding
- Identify areas of risk in relation to its statutory responsibilities during the reporting period

OVERVIEW

Barts Health provides secondary care to the local communities within North East London (NEL) and specialist tertiary care to patients beyond NEL. The Trust has a responsibility to provide effective and seamless services directly to all patients and indirectly by providing services to family members.

Staff have a responsibility to safeguard and promote the welfare of all patients and work in line with Trust Safeguarding Policies. All patients are best safeguarded when professionals are clear about what is required of them individually and in how they need to work together. The Trust's safeguarding team promotes a 'Think Family' approach.

National Statutory Guidance underpinning organisational responsibilities:

- Children's Act 1989 provides the legal framework for the protection of children from harm
- Children Act 2004, Section 11 imposes a specific duty on NHS organisations to make arrangements to safeguard and promote the welfare of children
- Mental Capacity Act 2005
- Care Act 2014
- Domestic Abuse Act 2021
- Children and Social Work Act 2107; Section 16 adds a new section to Children Act 2004,
- Working Together to Safeguard Children: A Guide to Interagency Working to Safeguard and Promote the Welfare of Children (August 2018), provides guidance on legislative requirements and expectation on individual services to safeguard and promote the welfare of children and provides a clear framework for Local Safeguarding Children Boards (LSCB) to monitor the effectiveness of local services
- Safeguarding Vulnerable People in the Reformed NHS. Accountability and Assurance Framework (2019)
- Pan-London Policies and Procedures for Adult Safeguarding
- London Child Protection Procedures

- Intercollegiate Documents: Adults 2018 and Children 2019

As well as complying with National Guidance, Barts Health complies with regulations as identified by the Care Quality Commission (CQC) to ensure babies, children and vulnerable adults are effectively safeguarded.

SAFEGUARDING TEAM STRUCTURE

The Chief Nurse is the Trust's Executive Lead for Safeguarding with day to day leadership devolved to the Director of Quality Governance. Directors of Nursing hold executive responsibility for safeguarding at a hospital level. Safeguarding team members are based in each of our hospitals except St Bartholomew's (SBH) whose service is provided by the RLH team.

Since May 2020 the adults and children safeguarding teams have worked as one team, promoting greater collaboration and strengthening the 'Think Family' model for safeguarding across the organisation.

The Safeguarding Team consists of:

- Head of Safeguarding
- 3 Named Nurses for Safeguarding Children
- 3 Safeguarding adult co-ordinators
- 3 Named Doctors for Safeguarding Children
- 3 Named Midwives
- 7 Safeguarding Children Advisors
- 3 Safeguarding Children Midwives
- PA who supports the service
- 3 Administration support

The team supports staff to deliver effective interventions to identify and respond to safeguarding concerns. This is achieved through training, supervision, and supportive advice to enable all staff to achieve competencies appropriate to their role and relevant national/local guidance.

The capacity within the safeguarding team throughout the course of 2021/22 has been impacted by vacancies, long term sickness and increasing activity, compounded by the effects of the COVID pandemic. During this period the team has provided cross site cover and have supported each other throughout these challenging times.

A risk assessment and benchmarking exercise identified gaps in capacity predominately within the adult establishment of the team. A feasibility proposal was submitted to the Investment Steering Committee identifying the need for additional staff to manage the workload, create resilience within the team and provide career progression opportunities.

SAFEGUARDING GOVERNANCE

Our governance structure supports a strategic and operational response to safeguarding. The Integrated Safeguarding Assurance Committee (ISAC) chaired by the Chief Nurse, receives assurance via hospital safeguarding meetings, chaired by the DoNs, and the Trust-wide operational group chaired by the Head of Safeguarding. ISAC monitors compliance against strategic priorities and promotes engagement with our local partners. The hospital meeting's monitor site assurance including action plans from serious incidents, child practise reviews (CSPR), serious adult reviews (SARs) and domestic homicide reviews (DHRs).

ISAC reports to the Quality Board and Group Executive Board. The Quality Assurance Committee undertakes assurance on behalf of the Trust Board.

An established safeguarding children dashboard informs our internal governance forums and is shared with the designated nurses within NEL CCG with relevant data also being shared with NEL safeguarding partnership boards.

SAFEGUARDING TRAINING

Safeguarding Training Compliance		
	Children	Adults
Level 1	**87%**	**87%**
Level 2	**83%**	**85%**
Level 3	**78%**	**44%**

Target compliance levels for the Trust are set at 85% and it is noted that the compliance for Level 2 safeguarding children training has dropped below the target. Level 3 compliance is significantly below the 85% target for both adults and children.

Level 1 and 2 for both Adults and Children is accessed via WeShare and the level 2 module for children has been updated in line with intercollegiate requirements.

Delivery of training has been impacted by the COVID pandemic, including the impact of face-to-face training being paused. Reinstating face to face training remains challenging for level 3 adults training due to capacity within the team. Training provision is under review with plans to combine adults and children level 3 training into a full day 'Think Family' session. This will support the release of staff from clinical areas with a positive effect on the overall compliance.

The training needs analysis review, as per the revised safeguarding children policy, remains outstanding with acute safeguarding concerns taking priority during the pandemic. This piece of work is expected to have been completed by the end of Q1 22/23.

The Trust Board gave positive feedback following their yearly update in July 2021:

Thank you so much for the session at Board this morning. As I said in my summary, it was important, educational and engaging.

SAFEGUARDING POLICIES

Safeguarding policies that have been reviewed and amended:

- **Training policy** – the policy was amended in 2020.
    - The level 2 training package has been updated and is now live on WeShare
    - Training Needs Analysis (TNA) has required updating - this has been a complex process and is expected to be completed by the end of Q1 22/23.
- **Sudden Unexpected Death of a Child Policy** – The policy has been reviewed and presented to the Trust Policy Group for ratification, following amendments it will be published on WeShare
- **Safeguarding Supervision Policy** – the policy has been amended and ratified. The Training Needs Analysis is being completed.

- **The Protection of Adults at Risk of Harm Policy** requires updating and it is planned for completion by Q2 22/23

The safeguarding team have been consulted on the review of the DBS policy that has been updated and approved by the Trust Policy Group. Since the policy has been updated, a positive increase in the number of positive DBS returns has been seen.

SAFEGUARDING SUPERVISION

Supervision for safeguarding children is part of statutory and mandatory requirements and is an essential aspect of ensuring that staff are confident and supported in their work with vulnerable children and families (Working Together 2018). Staff who are mapped to need level 3 children's training (with some exceptions) are required to have yearly supervision, this is expected to increase to twice yearly for targeted groups.

Current compliance is at 69%, significantly below the target of 85%. Potential risks of staff not having effective supervision are identified as;

- Staff not being adequately supported with emotionally challenging situations
- Personal feelings and beliefs having impact on decision making process
- Potential for missed opportunities to identify and respond to safeguarding situations

Supervision can be achieved in several formats: attendance at Mortality and Morbidity meetings; formal group sessions; informal/ad hoc supervision when seeking advice in relation to a caseload. The safeguarding team provide regular group supervision sessions across the hospitals although there have been some challenges to release staff to attend the sessions due to capacity in their clinical areas.

Further mitigations in place to counteract the risks are:

- Named Nurses and Midwives developed an insight to supervision training programme for the safeguarding children advisors
- Barts Health have led on developing group supervision for safeguarding children advisors across NEL with a launch expected in Q1 22/23
- Out of hours support from the on call Named Nurse for Safeguarding
- MDT meetings held in high-risk areas on a weekly basis

Tavistock supervision has unfortunately been suspended since September 2021. This has had a negative impact on the named nurses and midwives as they found the group supervision with other named professionals across London very beneficial. The supervision for the named Doctors has not been affected. Alternative supervision is being explored should the Tavistock supervision not be reinstated.

Within adult safeguarding there is not a statutory requirement for staff to attend formal supervision however as with children's the safeguarding professionals provide ad hoc/informal supervision with staff members by discussing/supporting staff with safeguarding cases.

SERIOUS CASE REVIEWS AND SERIOUS INCIDENTS

During the reporting period Barts Health has contributed to a number of Rapid Reviews (RR), Child Safeguarding Practice Reviews (CSPR), Safeguarding Adult Reviews (SARs) and Domestic Homicides (DHR). Named professionals across the safeguarding team have actively participated in the reviews and where

required clinical teams have been involved in the practitioner events to explore the learning. All reviews ae ongoing.

Number of cases by category	
CSPR	2
SAR	3
DHR	2

Themes arising from reviews are set out below:

- Early identification of concerns and escalation
- Professional curiosity
- Importance of face-to-face reviews
- Recording of visitors
- Think family approach - identification of family members and siblings
- Robust and concise record keeping
- The importance of the voice of child/ vulnerable patient
- Information sharing

Where there has been immediate learning for the Trust this has been addressed and actions have been put in place:

- Safeguarding training has been updated to reflect the findings from reviews
- Targeted work with specific teams has taken place on assessing and managing risk Improvement in documentation regarding safeguarding issues and liaison with agencies
- Development of discharge checklist for safeguarding children cases on CRS

SERIOUS INCIDENTS

Staff are asked to complete an SI proforma if they think an incident may have resulted in a serious incident, these proformas are then reviewed at the weekly hospital SI meetings. The meetings are multidisciplinary and allow staff to explore the incident to decide the most appropriate action or investigation type.

Outcome of SI proforma - Children	2020/2021	2021/2022
Managed via Datix	8	12
StEIS (externally reportable SI)	1	2
Concise	4	1
M&M Meeting	1	4
Specialists team review	1	4
Total	15	23

Outcome of SI proforma - Adults	2020/2021	2021/2022
Managed via Datix	5	1
StEIS (externally reportable SI)	3	5
Concise	9	2
M&M meeting	0	1

Specialist team review	2	4
Review meeting only	2	0
Total	21	13

Themes identified from the SIs relate to:

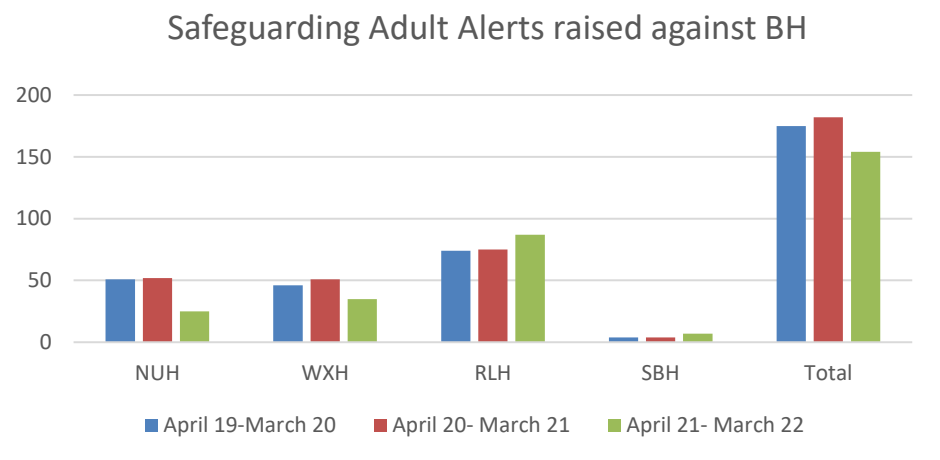
- Discharge concerns
- Absconding patients
- Allegations of abuse against staff members
- Aggressive patients
- Child Death in 2021/22 100% of SI proformas for children were due to child death compared to 68% the previous reporting period

Early learning from these SIs relate to:

- Communication
- Discharge
- Chaperone policy
- Documentation

SAFEGUARDING ACTIVITY

The Trust serves several local authorities (LA) with clear processes in place for making referrals to the core LA within the relevant geographical area for the referring hospital. The hospital based safeguarding teams collect data regarding the number of referrals and alerts made by BH staff where there are safeguarding concerns. The tables below show the number of referrals that have been raised against and by the Trust, with comparable data included for the previous 2 years.



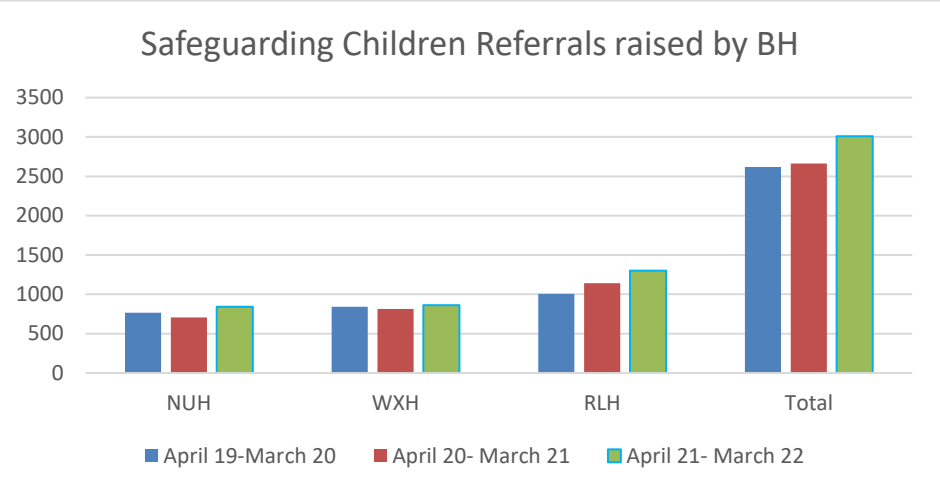
In previous years parental mental health accounted for the highest referrals from NUH and WXH with youth violence being the highest concern at RLH. A change is noted in 21/22 with child mental health now being the highest recorded concern at NUH and WXH and 'other' reasons for RLH. Youth violence is now the 3rd highest reason for referral at RLH.

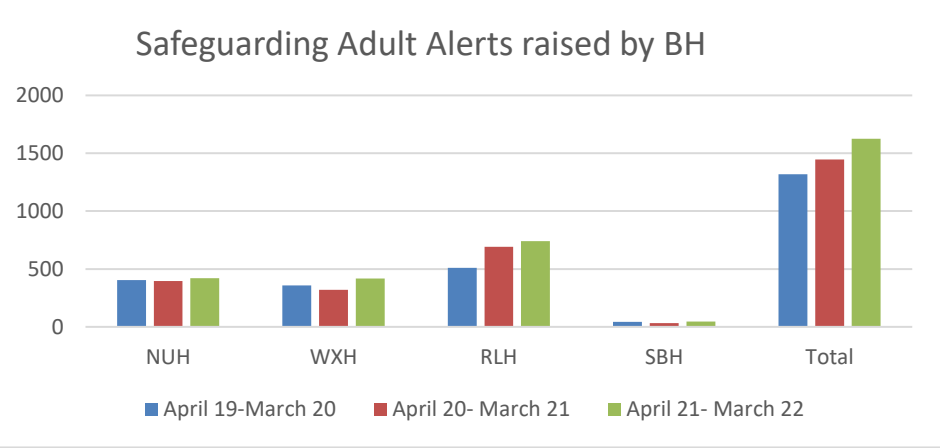
The top 3 reasons for referrals to children social care are:

- Child mental health
- Parental mental health
- Youth violence (now to be referred to as Harm outside the home)

For maternity the top 3 reasons for referrals to children social care are:

- Female genital mutilation
- Domestic abuse
- Maternal mental health





The Children's Society has developed new guidance related to terminology when referring to exploitation which will require a review of the themes currently used to record reasons for referrals.

Within adult safeguarding there has been an overall increase in the number of safeguarding alerts. WXH and SBH have seen the biggest increase (30% and 39% respectively). NUH saw the lowest increase of 6%.

Discharge concerns have driven the highest number of alerts raised across the Trust as a whole and work continues with the discharge hubs and the local authority to ensure these risks are minimised.

Other themes for safeguarding adults are:

- Neglect/acts of ommission
- Self-neglect (WXH site saw an increase of 30% in these alerts)
- Domestic abuse

There has been a total of 154 safeguarding adult concerns raised against Barts Health. These are combination of those raised by external agencies and those raised internally. Themes and outcomes are monitored via ISAC.

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SAFEGUARDING AUDITS

Audit activity and outcomes across the hospitals, completed by the safeguarding team has been identified in the hospital annual reports. Audit activity covered:

- Communication with external agencies
- CP-IS (child protection information system, this system holds information regarding CYP who are either subject to a child protection plan or looked after)
- MCA and DoLS
- SAPAT (Safeguarding adult partnership audit tool)
- Safeguarding children's referrals

Key findings:

- 18% of referrals made to children social care (CSC) have had no further action resulting in 82% of referrals being appropriate for either Early Help or statutory involvement.
- The re-audits of CP-IS have shown the number of 'not known' returns are negligible
- The need to make changes to the CRS documentation for mental capacity assessments prior to the implementation of LPS
- There is evidence that suggests there is good communication between agencies where safeguarding concerns are raised.
- A gap in MCA knowledge has been identified and this has been included in the implementation plan for LPS.

ALLEGATIONS AGAINST STAFF RELATING TO SAFEGUARDING CONCERNS

The Trust has a policy for managing allegations of abuse and neglect made against staff members.

The role of the Local Authority Designated Officer (LADO) is set out in HM Government guidance - Working Together to Safeguard Children 2018. Within HR, the Director of People works closely with the safeguarding team to ensure there is appropriate HR representation throughout the LADO process.

During 2021/22, fourteen cases have been raised with the Head of Safeguarding. The majority of these cases have not progressed to an Allegation Against Staff and Volunteers (ASV) meeting due to either the members of staff working in adult areas and not having access to under 18-year-olds in their professional life, or them not being substantive members of staff.

For unsubstantiated cases, support has been offered to the staff members. There are 2 cases still awaiting a final outcome due to on-going police investigations. Risk assessments and mitigations have been put in place to support the members of staff, patients and protect the Trust.

There is an ongoing issue in relation to the low number of concerns raised for the size of Trust. Potential reasons are cited as:

- Staff are not informing their managers when there is a concern in their private life that could affect them professionally

- Managers are not aware of the correct process and managing all cases locally
- HR leads are not aware of the correct process and not contacting the Head of Safeguarding

The 'Allegation Against Staff' policy has been strengthened to support the LADO process and an additional training need identified. Training for senior managers and HR staff stalled due to the pandemic and will be carried over into 22/23.

PARTNERSHIP WORKING

The Trust continues to demonstrate a high level of commitment to partnership working through active participation in key external meetings. Barts Health has representation on four Safeguarding Partnership Boards (SPB) and Safeguarding Adult Boards (SABs) (Newham, Tower Hamlets, Waltham Forest and Redbridge). The boards continue to meet virtually, enabling the ongoing participation of Barts Health at these meetings.

As part of the newly formed NEL ICS the safeguarding structure was reviewed. The Barts Health safeguarding team continues to develop strong partnership working at Place and through NEL quality and safeguarding forums.

CHILD DEATH REVIEWS

Following changes announced in Working Together (2018) an overarching Child Death Review Hub (CDR Hub), hosted by Newham Council, was created. There is currently a review of child death processes and pathways across the NEL network. It is anticipated that there will be a consultation paper from the review by the end of Q2.

Concerns about how the hub interfaces with the Trust have been raised by the Head of Safeguarding, including how the deaths of children who reside in other boroughs are managed. The CCG has committed to part time funding, fixed for one year, for a member of staff to support the child death processes within Barts Health.

EXTERNAL INSPECTIONS

During this reporting period there were no external inspections.

PREVENT

Barts Health was identified as an outlier in relation to the lack of referrals compared to other NHS organisations. As a result, the NHSE PREVENT lead ran a bespoke workshop for the Trust in September 2021. The workshop focussed on the reasons why an individual is vulnerable to exploitation/radicalisation and how staff can recognise potential risks.

Compliance with the PREVENT training has dropped during this reporting period and is currently at 83% across the Trust, against the target of 85%. This is monitored at hospital level via their safeguarding meetings. Managers have been asked to promote and ensure compliance is met by their teams.

DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

The Deprivation of Liberty Safeguards (DoLS) ensures adults who cannot consent to their care are protected whilst in hospital if there is a risk that their care and treatment could deprive them of their liberty. An audit looking at both the documentation and knowledge of DoLS and Mental Capacity Act assessments identified

gaps in knowledge and understanding across all hospital sites including inconsistent reporting of applications and missed opportunities for application of DoLS. These risks are mitigated by members of the safeguarding team attending safety huddles and being available for support and advice.

LIBERTY PROTECTION SAFEGUARDS (LPS)

The Mental Capacity (Amendment) Bill passed into Law in May 2019, replacing the existing Deprivation of Liberty Safeguards (DoLS) with Liberty Protection Safeguards (LPS). A significant change is the inclusion of children aged 16-17 within its scope. Care is still to be provided in line with the Mental Capacity Act (2005). The proposed implementation date of October 2020 has been delayed and is now expected to be confirmed for 2023. A Task and Finish group has been convened to support implementation, including an assessment of resources required.

DOMESTIC ABUSE

Domestic Abuse referrals have continued to rise across the Trust. It is the second most common reason for referral in maternity services and 3rd highest for adults overall. Since the removal of lockdown restrictions and staff returning to the workplace, we now have Independent Domestic Violence Advocates (IVDAs) based part time at both Newham and Whipps Cross, with a youth IVDA at the Royal London Hospital. Solace also supports adult victims within Tower Hamlets and this is managed remotely from within the hospital.

Numbers of domestic homicide reviews (DHR) increased in 22/23 and the Trust are actively involved in three reviews and awaiting commissioning decisions on a further 5 potential cases. These will be monitored at the appropriate hospital meetings.

RISKS AND ISSUES

The impact of the Covid operational pressures has led to a decline in compliance with both level 3 training and supervision as highlighted earlier in the report. This could cause potential risks that staff are not equipped with the training and knowledge to identify possible safeguarding cases. This risk is mitigated by:

- Ensuring the safeguarding team are available to support and advise staff
- The on-call service for safeguarding children meaning all staff have 24 hour access to named nurse/ head of safeguarding

Stability of the referral tracker for Safeguarding adults - this is being mitigated via manual count currently. However, this will be replaced once the Safeguarding adult alert is embedded in CRS as reports will be run via CRS allowing an accurate reporting mechanism.

Liberty Protection Safeguards implementation - there is a Trust wide task and finish group that is identifying the gaps and completing an implementation proposal for the roll out of LPS expected to be in April 2023

Capacity within the safeguarding workforce - there has been a year-on-year increase in the number of identified safeguarding cases however there has not been an investment made in the team. This risk was recorded on the corporate risk register. A feasibility proposal to increase capacity within the team was submitted to the Investment Steering Committee. This is to reflect the growth in the activity and has been bench marked against other organisations.

The Child Death process and the interface with CDR Hub - there is currently a review on-going within NEL to look at the child death processes across the system.

REDUCING INEQUITY

The safeguarding team captures data from referrals to inform and support an understanding of potential inequity in issues affecting children and adults. It was a priority for 21/22 to analyse this information and use it to inform planning within our hospitals and the wider system. A challenge is to decrease the number of referrals where the ethnicity has not been recorded. Although some progress was made it remains a priority for the coming year and will incorporate a more in-depth analysis of maternity equalities data which is not currently reflected within this report.

For children, the highest number of referrals overall are for children with Asian ethnicity, followed by white.

All hospital sites reported the age group of 11–15-year-olds as having the highest number of referrals, correlating with the age group associated with child mental health concerns. It is also noted that there are higher numbers safeguarding concerns for girls compared to boys except in the 0–2-year-old age group.

ACHIEVEMENT OF 2020/21 WORK PLAN

It has been recognised that achievements for the 2021/22 work plan have not progressed as much as we would have hoped This was due to the impact of the pandemic and the capacity within the safeguarding team across Barts Health.

The following objectives were achieved:

- Continue to strengthen the visibility of safeguarding children at hospital-based meetings, using hospital based expertise to drive improvements in service delivery.
- Raise the awareness of PREVENT and increase the number of referrals made by the Trust
- Identify gaps in knowledge and understanding of mental capacity assessments and DoLS in preparation for implementing LPS within the Trust. Audits have been completed across the Hospitals and have been used to support the work within the Task and Finish LPS group.
- Each hospital site to produce a site level SGA Annual Report for 2021/22. This year the Hospital teams have produced a combined safeguarding report which will be shared at the respective safeguarding meetings and Hospital Executive Boards.

The following objectives have been partially achieved:

- Embedding the safeguarding adult referral and DoLS forms in CRS. The form has been approved by the change team for CRS and we are awaiting a go-live date.
- Serious Case Reviews and Child Practise Review action plans; whilst most recommendations have been completed there remain a small number of amber actions which are being monitored.
- Review of the Leadership of the safeguarding adults and children team to move to an integrated model for safeguarding:

- Due to the pandemic this work was put on hold but is expected to be completed and implemented by Q3 22-23.
- Recruit a Named Nurse for Child Death Review Process. Recruitment was a challenge however successful recruitment has now taken place. The new post holder is due to commence in post.

The following objective has not been progressed and is being reviewed to determine whether it is achievable:

- To have a standard referral form for children social care that will be embedded into CERNER and used across all hospital sites. A number of Local Authorities have moved across to the use of portals for referrals to children social care, a further review of this action will take place in 22-23.

PLANS FOR 2022/23

Each hospital has a work plan for the coming year, aligned with the strategic priorities for the trust and taking account of local differences.

Below are a summary of the plans moving forward into the next reporting period:

	Objective	Action Owner	Lead	Implementation Date
1	To ensure there is a consistent, supportive and equal pathway for all children and young people and their families when their child dies in our care	Head of Safeguarding	Head of Safeguarding and Director of Nursing for Children	September 2022
3	Review of the Leadership of the safeguarding adults and children team to move to a devolved model for safeguarding	Director of Quality Governance	Director of Quality Governance	Sept 2022
4	Further develop the Trust wide safeguarding dashboard to support assurance at hospital and trust boards	Director of Quality Governance	Head of Safeguarding	July 2022
5	Safeguarding audit programme to be strengthened with recommendations embedded into service	Head of Safeguarding	Hospital Safeguarding Leads	June 2022
6	Strengthen partnership working to shape and develop safeguarding services in North East London ICS	Group Chief Nursing Officer	Director of Quality Governance Head of Safeguarding Directors of Nursing	Throughout 22-23
7	Continue to strengthen	Hospital Directors of	Hospital Senior	Throughout 22-

	the visibility of safeguarding at hospital-based meetings.	Nursing	Leadership Teams/Hospital Safeguarding Leads	23
8	Roll out the changes in how to make referrals for safeguarding adults once referral form embedded into CRS	CNIO & Director of Development	Head of Safeguarding	October 22
9	Develop and agree a group plan, and hospital Implementation programme for roll out of LPS.	Chief Nursing Officer	Director of Quality Governance Head of Safeguarding Directors of Nursing	November 2022
10	Strengthen the use of inequity data to support and inform service delivery and change.	Director of Public Health	Public Health Team Head of Safeguarding	February 2023

Barts Health NHS Trust public board meeting: Wednesday 6 July 2022
Written questions from members of the public

From: Terry Day, WF Save our NHS

Questions to Barts NHS Trust Board	
1 Service transformation At your Board meeting in Nov 2022 it was stated: • that an annual reporting process on progress in service transformation would be put in place; • that input from patient and community groups on what should be measured would be sought; • that measures would not be limited to hospital activity, but would also capture changes in community services and primary care; • that the process for measuring success of service transformation and capacity implications would be transparent 1A What progress has been made on each of (a) to (d) above? 1B If, as it appears, no measurement system is yet in place, how can the Board possibly know if the assumptions made regarding capacity of the new hospital are reliable?	**To reply:** **Alastair Finney / Shane DeGaris**
2 Review of charging destitute migrants A) how many migrants are being made to pay £25 or less per month? B) What is the average length of time such payments will last before the bill is paid-off? C) Has the review been concluded and, if so, how many destitute migrants were being charged? D) Has the Trust made any changes to its systems as a result of a shocking case we drew to the attention of the Chair?	**To reply:** **Shane DeGaris**
3 Appointment booking system at Whipps Cross A) has the appointment booking system at Whipps Cross been outsourced to a private provider? B) Has any action been taken to identify how many such errors have occurred and to correct the system so that such errors do not continue?	**To reply:** **Shane DeGaris**

From: Rosamund Mykura, Newham Save our NHS

Questions to Barts NHS Trust Board	
1 Fire Safety work at Newham Hospital 1a Have all four faces of the Gateway building had the external cladding removed?	**To reply:** **Hardev Virdee**

1b Has the cladding removal work at the Gateway building started? 1c When will the £3million fire safety work at the Gateway building be completed?	
2 Nuffield Health private facility 2a How much money has private provider Nuffield Health paid Barts NHS Trust, prior to 2022 when Nuffield Health started to pay Barts for their lease, since Nuffield Health started years of their building work on-site at St Bartholomew's NHS Hospital in the City of London? 2b Are there any legal or other constraints in Barts NHS Trust's business arrangements with private provider Nuffield Health to stop another private healthcare business, such as a huge predatory US healthcare businesses competitor seeking to take over the Nuffield Health private hospital business located in the City of London at St Bartholomew's NHS Hospital site? 2c. Has much has Barts NHS Trust paid private healthcare business Nuffield Health in the financial years 2019-2020, 2020-2021, 2021-2022?	**To reply:** **Hardev Virdee**
3 Equity Data Working Group and NHS maternity charging 3a. What has been the progress at the Barts Equity Data Working Group in reviewing maternity patients' access to care by ethnic group in the last year? 3b. Has the new consultant (appointed with both Public Health and Obstetrics qualifications to regularly review data) reviewed the ethnicity of the hundreds of Barts maternity patients over the years invoiced by Barts NHS Trust even though the Trust knew it did not have evidence to deny them free NHS maternity care?	**To reply:** **Ajit Abraham**