Barts Health NHS Trust

BARTS HEALTH NHS TRUST

TRUST BOARD MEETING (PART 1)

There will be a meeting of the Trust Board in public on
Wednesday 5 October 2022 at 13.30pm via Webex videoconferencing
Scheduled to end by 15.30

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	13.30
2.	**APOLOGIES FOR ABSENCE:** Ms C Alexander			
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 6 July 2022 (with no outstanding actions on the action log)	58/22	Rt Hon J Smith	13.30
5.	**BOARD MEMBERSHIP** To approve changes to Trust Board membership	59/22	Rt Hon J Smith	13.30
6.	**MATTERS ARISING** To consider any matters arising from the Minutes not covered elsewhere on the agenda			
8.	**CHAIR'S REPORT** To receive the Chair's report		Rt Hon J Smith	13.40
9.	**GROUP CHIEF EXECUTIVE'S REPORT** To receive the Group Chief Executive's report		Mr S DeGaris	13.45

NHS Barts Health NHS Trust

		Paper TB	Lead	Time
10.	**PROVIDER COLLABORATION** To receive an update on recent developments	60/22	Mr M Trainer	13.50
QUALITY AND PERFORMANCE				
11.	**INTEGRATED PERFORMANCE REPORT – 2022/23 M5** To receive the report and discuss: • Operational performance • Quality and Safety • People • Financial performance	61/22	Mr C Pocklington Prof A Chesser/ Prof L Hicks Mr D Waldron Mr H Virdee	14.00
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	 62/22 63/22 64/22	Mr A Sharples Ms K Kinnaird Dr K McLean Rt Hon J Smith	14.40
STRATEGIC DELIVERY PLANS AND IMPLEMENTATION				
13.	**PEOPLE STRATEGY IMPLEMENTATION** To receive the Inclusion Matters report (incorporating WRES and WDES)	65/22	Mr A Abraham	14.50
14.	**WHIPPS CROSS REDEVELOPMENT** To note the progress report	66/22	Mr R Coulbeck	15.00
GOVERNANCE				
15.	**ITEMS FOR APPROVAL** • **INFECTION CONTROL ANNUAL REPORT** • **OVERSEAS VISITORS ANNUAL REPORT** • **RESEARCH ANNUAL REPORT**	67/22 68/22 69/22	Prof L Hicks Mr A Abraham Prof A Chesser	15.10
16.	**ANY OTHER BUSINESS**			
17.	**QUESTIONS FROM MEMBERS OF THE PUBLIC**			15.15
18.	**DATE OF THE NEXT MEETING** The next meeting of the Trust Board in public will be held on Wednesday 2 November 2022 at 11.00am in the			

	Education Centre, Newham University Hospital, Glen Road, Plaistow, London E13 8SL			
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 58/22

BARTS HEALTH NHS TRUST

TRUST BOARD MEETING (PART 1)

Minutes of the Trust Board meeting in public on
Wednesday 6 July 2022 at 11.00am in the Boardroom at Whipps Cross Hospital,
Whipps Cross Road, Leytonstone E11

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

In Attendance:
Mr S Collins (Trust Secretary)
Mr A Finney (Director of Redevelopment)
Dr I Basnett (Public Health Director)
Ms K Turner (Programme Manager)
Mr C Ridley (Commercial & Business Development Director)
Ms M Walsh (Freedom to Speak Up Guardian)
Mr S Sharma (Deputy Trust Secretary)

Apologies:
Rt Honourable J Smith (Chair)
Professor A Chesser (Chief Medical Officer)
Ms C Alexander (Chief Nurse)

** Non-voting member*

60/22 WELCOME

The Vice Chair welcomed members to the meeting, noting that the Chair had

had to give last minute apologies due to sickness absence and that he would therefore act as Chair for the meeting. He welcomed Ms Spice who had joined as a non-executive director and also welcomed Mr Abraham, attending his first meeting in his capacity as Group Director of Inclusion.

61/22 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.

62/22 MINUTES

The Minutes of the meeting of the Trust Board held in public on 4 May 2022 were received and approved.

63/22 MATTERS ARISING

The Deputy Group Chief Nurse confirmed the new Maternity Neo-Natal Board had been formed and a report would be presented to the Trust Board in September, following a scheduled visit to the Trust's maternity units by NHSE in July.

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

64/22 BOARD MEMBERSHIP

In addition to the appointments of Ms Spice and Mr Abraham, the Board was asked to note the following membership changes:

- Mr Matthew Trainer would join as a voting Board member and deputy group chief executive for Barts Health and Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) from 1 August 2022.
- Ms Joni Ferns would join as a voting Board member and non-executive director from 1 September 2022.
- Ms Sarah Teather would join as a non-voting Board member and associate non-executive director from 1 September 2022

The Trust Board was also asked to note the appointment of Mr DeGaris as the new joint Group Chief Executive for Barts Health and BHRUT from 1 August 2022.

65/22 PATIENT STORY

The Deputy Group Chief Nurse introduced the patient story. Mrs Hilary Koppel, who had formerly been an inpatient at Curie Ward in Whipps Cross Hospital, accompanied by Ward Manager Mr Mark Elliot, related her story to the Board.

She had a prior history of bone problems and had previously undergone several bouts of surgery. On this occasion, she had been admitted after fracturing her leg in a fall at home. She spoke about the outstanding level of care and compassion that she had received from all of the doctors and nurses working in the Curie Ward during her two and a half month stay. Mrs Koppel made specific mention of the quality of the beds and linen and highlighted the excellent management of the ward leadership team. The way that senior ward members had helped and advised junior staff was also highlighted and Mrs Koppel recommended that other departments in the hospital should consider how they could benefit from any learning from the management of Curie Ward. She explained how she suffered a further fall on the ward and had worried as she did not want the nurses blamed for a genuine accident. Mrs Koppel concluded by extending her compliments to the hospital's Emergency Department, which had also provided excellent care despite it being such a busy environment.

Dr McLean thanked Mrs Koppel for her describing her experience and asked whether her privacy and dignity had been maintained during her stay, recognising that these could be difficult things to achieve. Mrs Koppel felt that staff had been very gentle and respectful and that the ward layout allowed for a high level of privacy.

The Group Chief Executive also thanked Mrs Koppel for telling her story and asked if there was anything that could have been done differently to improve the level of care she received. Mrs Koppel couldn't think of anything and noted everything was 'first class', giving special credit to Mr Elliot's leadership.

On behalf of the Board, the Vice Chair thanked Mrs Koppel and the staff from the Curie Ward for sharing their story.

66/22 CHAIR'S REPORT

The Vice Chair noted some recent work on changes at both Trust Boards, partly linked to enabling the completion of terms; in addition to Ms Seary, Dr McLean and Professor Caulfield had been appointed as joint non-executive directors. He noted that the Joint Board met on 11 May to discuss strategy and key focus areas. He also noted there would be a first meeting of the Collaboration Committee later today, and this would meet every two months going forward. The Vice Chair concluded by noting the opportunity the collaboration work would provide for collective working across the region.

67/22 GROUP CHIEF EXECUTIVE'S REPORT

The Group Chief Executive highlighted work being done to support the collaboration with Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT). Board members would receive update reports on the progress of the collaboration work focusing on its priorities and those of the wider Acute

Provider Collaboration (ACP). He indicated that a regular update on the development of the Integrated Care Board (ICB) and associated structures would be presented at future Board meetings. The Group Chief Executive was pleased to be able to include in this meeting's papers a summary of the organisation's operational plan that incorporated the Trust's three main priorities: inclusion and equality; service delivery and transformation; and advancing the Trust's major strategic plans.

As the outgoing Group Chief Executive Officer, she made special mention of the 74th birthday of the NHS which she had celebrated as part of an event at Newham Hospital that week. The event provided a chance to reflect on the work of the NHS and especially the pride felt in providing excellent care during the last two years of the pandemic. She would leave with confidence about the future of the NHS and thanked her colleagues, public members, present and previous Chairs for their contributions and their support.

On behalf of the Board, the Group Chief Executive designate, Mr DeGaris, thanked Ms Williams for her outstanding service and stated that it was an honour and privilege to have been appointed to his new role. He outlined some immediate priorities to ensure an orderly transition, continuing to deliver value for money services while upholding excellent patient safety standards. Mr DeGaris confirmed the recent l appointments of Dr Neil Ashman as CEO of The Royal London & Mile End Hospitals and Mr Ralph Coulbeck's substantive appointment as CEO of Whipps Cross Hospital. Interviews for the position of Newham Hospital CEO would take place later that week, while interviews to appoint a Group Chief Operating Officer (COO) would be held in mid-August.

Mr DeGaris concluded by outlining how the ICB would fundamentally be aiming to address equity and health inequalities from a system perspective by working for their population in partnership with local Government.

68/22 BOARD ASSURANCE FRAMEWORK

The Group Director of Corporate Development introduced the Board Assurance Framework (BAF) update, detailing the three top level risks. The Board noted the strengthening of the risk management process via a refreshed format ensuring greater granularity around levels of risk assurance and ensuring a consistent approach across committees. A refresh of risk appetite work was continuing to progress and would be presented at the next Audit and Risk Committee and a subsequent Trust Board meeting.

The following points were raised in discussion:

- Dr McLean thanked the Group Director of Corporate Development and Trust Secretary for the new, clear BAF design and layout. Dr McLean highlighted an apparently lower risk appetite for financial risks compared to quality risks. The Director of Corporate Development recognised that some differences existed according to an inherent level of risk in

addressing certain objectives. However, he also noted that these domains would be a focal point of the refresh of risk appetite and anticipated that these would change.

- Ms Kinnaird recognised the importance of accurate calibration of risks and felt that further emphasis should be on the consequences of not achieving target risk scores would be.
- The Vice Chair suggested that it would be helpful to reconsider the standard formulation of risks noting that many risks had been described in the context of a failure to achieve particular standards.

The Group Director of Corporate Development was thankful for the helpful feedback, which would inform the further development of the BAF.

The Trust Board approved the BAF.

69/22 INTEGRATED PERFORMANCE REPORT

(i) Covid-19 & Access

The Deputy Group Chief Executive provided headline messages, noting that trends on Covid-19 case rates reflecting a recent rise in cases was not resulting in a corresponding increase in cases requiring critical care or high dependency and that there was no change to national Infection Prevention Control (IPC) guidance. He confirmed that the emergency departments across the Trust were seeing very high volumes and work was continuing with primary care partners to understand and adapt to this. Elective activity performance had seen a monthly improvement from 74% to 86% of pre-pandemic business as usual activity. On planned care, the Trust had reduced the number of patients waiting 104 weeks or longer to below 200 at the end of June and expected to clear a further 50 from the Patient Tracking List (PTL) in July. There would also be an upcoming focus on those patients waiting more than 78 weeks for treatment. In terms of cancer recovery, it was highlighted that the Trust was the leading organisation in the country on the faster diagnostic standard and assurance was provided on clinical oversight arrangements.

In response to a question from Mr Williams, the Deputy Group Chief Executive confirmed that a waiting list validation exercise was progressing well, with the aim being to check whether a cohort of patients still required further treatment.

In view of the national target to treat all patients waiting in excess of 78 weeks by March 2023, Dr McLean asked if there was potential for earlier completion of this objective. The Deputy Group Chief Executive noted that the Trust trajectory was aiming for clearance of this cohort of long waiters by February 2023. Dr McLean also inquired about the winter approach to ambulance handovers, recognising the potential pressures on emergency care that would be faced. The Group Chief Executive agreed that this was one of the biggest challenges for the north east London integrated care system and that it would be a key test of

whether new architecture could improve ways of working and collaboration to deliver safe and equitable access to treatment.

(ii) Quality

The Deputy Chief Medical Officer highlighted the need for performance improvement in quality governance metrics, noting the tracking of Serious Incidents (SIs) timeliness was continuing as well as assessment of learning following closure of SI investigations. She highlighted the introduction of a new patient safety framework and confirmed the results of a deep dive into a recent rise in maternity SIs at The Royal London Hospital. Details of this would be considered at the Quality Assurance Committee.

The Deputy Group Chief Nurse highlighted performance on complaints responses. Targeted work was being carried out to understand local issues and identifying opportunities for early resolution of complaints. She noted the current performance on pressure ulcer levels and the work to reduce prevalence. The Board also noted a collaboration exercise looking at joint quality improvement initiatives in the community.

(iii) People

The Group Director of People highlighted an increase in the sickness absence rate and noted a focus on improving the rate of non-medical appraisals. He noted that a new People leadership programme would be piloted with a conference scheduled for the following week to highlight the importance of developing new cultures and practices. Staffing vacancy levels were also described as an area of focus. Work was under way to improve recruitment levels, with nursing vacancies highlighted as being the biggest challenge currently.

Ms Kinnaird felt that an understanding of the impact of staffing levels on the operational plan would be beneficial and inquired about the long-term trajectories. The Group Director of People indicated that a staffing plan was in place to address winter pressures and learning around improving recruitment rates was being gained from joint work with BHRUT.

(iv) Finance

The Group Chief Finance Officer noted Month 2 and outturn headlines. He confirmed activity targets were not aligning to the planned trajectory and therefore assumed levels of income would not transpire. Costs relating to temporary staffing were cited as an ongoing issue despite a major recruitment drive. There was acknowledgement that there would be a lot of work required to achieve increased levels of activity and making progress on capital projects to support this was being encouraged. The Group Chief Finance Officer added greater than expected levels of inflation costs had contributed to the revenue

and capital position. There would now be a dependency on system conversations in order to maintain progress on achieving the regional financial target and there would be a focus on productivity and cost control discipline through Finance and Investment Committee (FIC) meetings.

Dr McLean asked about the level of engagement and commitment to meeting the financial plan and queried what changes would be needed to improve productivity and reduce costs. She felt that it would be valuable for the Board to see something relating to the triangulation of operational activity, finance and workforce targets in order to help provide direction. Dr Ashman suggested that the We Improve programme would be key to staff engagement on improving clinical productivity to benefit patients and noted, for example, that scoping meetings had been held recently in relation to theatre productivity.

Professor Caulfield noted the potential for industrial action in light of the cost-of-living increases. He was concerned of the adverse impact this could have, along with the impact of inflation and rising energy costs. The Group Chief Executive recognised that it would be part of the role of the Trust Board to exert its influence and sills.

The Vice Chair noted the need to be realistic in terms of the risks being carried and supportive when asking operational teams to achieve more activity with reduced funding levels.

The Trust Board noted the report.

70/22 REPORTS FROM BOARD COMMITTEES

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

- Following agreement at FIC earlier in the day, a paper on how financial grip is reinforced and how we improve the financial process would be developed.
- The Audit & Risk Committee (ARC) had reviewed and approved the annual report and accounts and the supporting audit of these. The design version of this would be due for presentation at the AGM in September.
- QAC had met in June and discussed a range of topics including thematic reviews of Children's Services and St Bartholomew's Hospital; tracking the level of complaints; level 3 safeguarding training; learning from a power failure at The Royal London Hospital; a limited assurance Internal Audit review of clinical audit.

71/22 PEOPLE STRATEGY IMPLEMENTATION: FREEDOM TO SPEAK UP (FTSU) REPORT

Ms Walsh, the Trust's independent FTSU Guardian introduced the report, explained her role and gave an example of a positive story of learning.

Ms Kinnaird noted the importance of accountability and ensuring visibility is clear. She sought details of how outputs from casework were used to triangulate with other cultural indicators across the organisation.

The Group Director of People confirmed that a non-executive director would be approached in due course to hold a lead role on FTSU processes, for which the employee relations team would assist.

The Trust Board noted the report.

72/22 WHIPPS CROSS REDEVELOPMEMT

The Whipps Cross Hospital Director of Redevelopment provided an update on the Whipps Cross redevelopment programme. The Board noted:

- Progress in moving the integrated delivery framework for service transformation into its 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 at Whipps Cross.
- An update on the central New Hospital Programme.

The Deputy Group Chief Nurse confirmed that the redevelopment had provided an excellent opportunity to develop multiple research strands and was pleased with the progress in this area, noting the importance of the digital strategy as a key enabler.

The Trust Board noted the progress report.

73/22 EQUITY OF ACCESS AND HEALTH INEQUALITIES

The Director of Inclusion introduced the item and he was joined by the Director of Public Health to update on work to improve equity of access and health inequalities including the development of waiting list data through an equity lens.

The Board noted and endorsed:

- Work being undertaken – and planned - on inclusion and equity and the strengthening of leadership and governance to drive progress going forward.
- Publication of equity data in relation to waiting times, which will be routinely published through the Integrated Performance Report, actions

to respond to findings 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.
- The requirement for integration with quality improvement and patient safety work.

Ms Kinnaird was pleased to see the equity data and asked how it could be used to systemically embed into business-as-usual reporting. Ms Seary noted it would be important to work with local councillors on population health and draw on lessons learned from BHRUT in terms of effectively supporting the Director of Inclusion to ensure that equity was part of everyone's remit. Dr Basnett noted the hospitals were increasingly working alongside local authority partners and there were underlying case mix differences at each site, which informed the profile of each. He added further reports would be available, on request, to Board members.

The Trust Board noted the progress report.

74/22 NUFFIELD AT ST BARTHOLOMEW'S HOSPITAL

The Commercial & Business Development Director updated the Board on the development of a standalone private patients' facility at St Bartholomew's Hospital which had opened in early May. He noted that the unit had already played a role in helping to manage recent pandemic pressures and outlined the expected benefits for patients arising from this partnership.

Dr McLean suggested that the Board were kept informed of benefits realisation from the programme. The Group Chief Executive thanked the Commercial & Business Development Director for his commitment to the project and recommended that colleagues took the opportunity to visit the facility.

75/22 ITEMS FOR APPROVAL

The Trust Board reviewed and approved the following documents:
- Auditors Annual Report.
- Group Operational Plan 2022/23.
- Establishment Review.
- Complaints Annual Report.
- Safeguarding Annual Report.

76/22 ANY OTHER BUSINESS

The Vice Chair noted this would be the final Board meeting of the outgoing Group Chief Executive, Dame Williams, and on behalf of all of the Board members, wished to thank her for all of her efforts whilst leading the Trust so inspiringly and effectively during her tenure. Waltham Forest and Newham Save

Our NHS campaign group members Terry Day and Rosamund Mykura also expressed their thanks.

77/22 QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair introduced the section of the meeting inviting questions from the public.

Questions on the following topics were received from Waltham Forest SoNHS campaign group member Terry Day: measuring service transformation progress in view of capacity assumptions for the Whipps Cross redevelopment; a review of destitute migrants' eligibility for free NHS care; and appointments booking systems at Whipps Cross.

The Deputy Group Chief Executive and Director of Redevelopment advised that:

- An Integrated Delivery Framework (IDF) comprising partners from across the integrated care system had been established to oversee the delivery of key transformation programmes. The 2022/23 IDF plan (contained within the meeting papers restated the commitment to producing a transparent annual report on progress of these programmes, drawing on metrics and measures currently under development. The metrics would not be limited to activity at Whipps Cross as hospital activity alone is not an indicator of how we are performing as a health and care system for our patients. As part of the development of the IDF annual report, a process of engaging with community organisations and patient and public representative groups would inform the measures on clinical quality of care and patient experience. In terms of the link to physical capacity of the redevelopment, a final decision on the number of overnight inpatient beds was not required at this stage as the flexible design of the new hospital allowed for up to 600 beds should that prove necessary.
- The specific case referred to in the question had been raised at the Trust Board meeting in March 2022. Following correspondence with the patient's advocate, debt recovery action had been placed on hold, pending provision of evidence of destitute status. This had been received earlier in the day of this Board meeting. It was confirmed that no payments had been accepted since this issue had been raised. In line with the Trust's public sector obligations the debt had not been rescinded in its entirety. In terms of the wider questions, it was confirmed that 63 patients were currently making contributions of £25 or less to their bills. To provide an average overdue payments figure would be misleading, as the value of the debt outstanding varied significantly across this group. He confirmed that currently 20 patients had been evidenced as destitute (with none of these currently making repayments). The Trust would continue to exercise sensitivity and understanding when dealing with patients not eligible for free NHS treatment.

- No change had been made to Whipps Cross booking systems recently. A printing company had been engaged for a number of years, albeit that letters could also be generated and sent internally. He noted that, where the patient confirms an appointment within 2 weeks, a verbal and text message accompanied an appointment confirmation letter. Monthly performance meetings were held with the postal company to cover issues such as responsiveness.

Questions on the following topics were received from Newham SoNHS campaign group member Rosamund Mykura: cladding removal and fire safety improvements at Newham; contractual arrangements for the Nuffield Health private patients' facility; and overseas visitor charging for maternity care.

The Chief Finance Officer advised that:

- All cladding has been checked and removed where necessary. Fire safety and backlog maintenance in the Gateway centre had been completed with the exception of a small number of minor improvements identified during works which remained yet to be completed.
- The contract with Nuffield Health was confidential and financial aspects of the agreements could not be disclosed. However, the Trust had negotiated appropriate protections within the contract in the event of a takeover. Nuffield Health had invested £70m into the dilapidated buildings to create a new hospital as per their press release. The Trust continued to publish all payments over £25k to third party suppliers on its website and indicated that no payments over £25k had been made to Nuffield Health in 2019-20, 2020-21 or 2021-22. There were some payments over £25k that had been made recently relating to staff redeployments from Nuffield Health to Barts Health to assist with intensive care, cardiac wards, and with COVID vaccination clinics during the Covid-19 pandemic.

The Group Director of Inclusion noted that:

- The Trust had worked with the north east London CCG to produce an Equity and Equality needs assessment for maternity services by borough. In line with national data from MBRRACE-UK this pointed towards higher levels of some risk factors, challenges to enable earlier booking, higher stillbirth rates and more neonatal admissions amongst some ethnic minority communities.
- Data on maternity and neonatal outcomes and ethnicity were being produced on a regular basis.
- The Trust was yet to refresh its earlier analysis of variations in breast feeding. Strategic work on equity in maternity services would be progressed with the new Director of Midwifery.
- In practice, the new consultant in obstetrics had been fully occupied with the response to pandemic clinical pressures, so had not yet had the opportunity to focus on public health issues.

78/22 DATE OF THE NEXT MEETING

The next meeting of the Trust Board in public would be held on Wednesday 14 September 2022 at 11.00am, with further details to be published on the website.

79/22 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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NHS
Barts Health
NHS Trust

Report to the Trust Board: 14 September 2022	TB 59/22

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

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

- Ms Rebecca Carlton, currently chief operating officer for East Kent Hospitals University NHS Foundation Trust, has been appointed as Barts Health's group chief operating officer and a non-voting Trust Board member. A start date is currently in process of being agreed and this will be confirmed in due course.
- Dr Kathy McLean and Professor Sir Mark Caulfield were appointed with effect from 1 August 2022 to serve on the board of Barking, Havering and Redbridge University Hospitals NHS Trust in addition to their current Barts Health NHS Trust non executive roles.
- Following the appointments reported at the previous Trust Board meeting, board committee membership has been refreshed and a summary of this is appended. The committee remits have also been revisited, with the Finance and Investment Committee being renamed the Finance, Investment and Performance Committee.

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 and board committee membership.

Membership of Trust Board committees 2022/23

Audit and Risk	Quality Assurance	Nominations and Remuneration	Finance, Investment and Performance	Board Collaboration Committee
Members				
Kim Kinnaird (C)	Kathy McLean (C)	Jacqui Smith (C)	Adam Sharples (C)	Jacqui Smith (C)
Kathy McLean	Mark Caulfield	All NEDs	Kim Kinnaird	Adam Sharples
Adam Sharples	Joni Ferns		Helen Spice	Kathy McLean
Helen Spice	Lesley Seary		Joni Ferns	Mark Caulfield
	Chief Operating Officer		Group Chief Executive	Lesley Seary
	Chief Medical Officer		Chief Operating Officer	Group CEO and Deputy CEO
	Chief Nurse		Chief Finance Officer	Director of Corporate Development
			Director of People	Chief Medical Officer
			Director of Strategy	Chief Finance officer
Attendees			Clyde Williams, Associate NED	Group Director of People
Chief Executive[1] or Deputy Chief Executive	Director of Improvement	Group Chief Executive		
Chief Finance Officer	Director of Corporate Development	Group Director of People		
Director of Corporate Development	Director of Quality Governance	Clyde Williams, Associate NED		
	Sarah Teather, Associate NED	Sarah Teather, Associate NED		
Others as required for specific agenda items.				
Quoracy				
2 Members	3 Members, 2 of whom are NEDs	3 NED Members	3 Members, 2 of whom are NEDs	2 NEDs, 4 Executive Directors of each trust

Board membership as at 1 September 2022
Voting members: Jacqui Smith, Adam Sharples, Helen Spice, Kathy McLean, Kim Kinnaird, Lesley Seary, Joni Ferns, Mark Caulfield, Shane DeGaris, Matthew Trainer, Hardev Virdee, Caroline Alexander, Alistair Chesser
Non voting members: Andrew Hines, Ajit Abraham, Rebecca Carlton (start tbc), Daniel Waldron, Mark Turner, Clyde Williams, Sarah Teather

[1] At least once annually

Barking, Havering and Redbridge University Hospitals NHS Trust

Barts Health NHS Trust

Report to BHRUT and Barts Health Trust Boards: 5 October 2022 (Barts Health)	TB 60/22

Title	Update on Collaboration between Barts Health and BHRUT within the North East London Acute Provider Collaborative
Accountable Director	Deputy Group Chief Executive Group Director of Corporate Development (BH)
Author(s)	Collaboration Programme Director
Purpose	To note the progress of the collaboration between Barts Health and BHRUT in the context of the emerging NEL Integrated Care System and Acute Provider Collaborative.
Previously considered by	-

Summary
The purpose of this paper is to provide an update on the collaboration between Barts Health and BHRUT in the context of the wider changes across the Integrate Care System (ICS) and the Acute Provider Collaborative (APC) and to set out the immediate areas of focus of the closer collaboration between the two Trusts.

Related Trust objectives

'Developing the North East London ICS, including place based partnerships and acute collaboration, deepening our relationship with BHRUT'. (*Barts Health 2022/23 Group Operational Plan)*

'Be a proactive contributor in our local community. Demonstrate commitment to progressing the agreed BH/BHRUT collaborative priorities through progressing the 4 urgent priorities by September 2022' *(BHRUT 2022/23 Corporate Objectives)*

Risk and Assurance	Barts Health BAF entry 15. Insufficient leadership capacity and capability and failure to evolve the group model impairs the effectiveness of the organisation and role in system leadership.
Legal implications/ regulatory requirements	Not applicable

Action required
The Trust Board is asked to note the update.

Barking, Havering and Redbridge University Hospitals NHS Trust

Barts Health NHS Trust

REPORT TO THE TRUST BOARD

UPDATE ON COLLABORATION BETWEEN THE BARTS HEALTH AND BHRUT WITHIN THE NORTH EAST LONDON ACUTE PROVIDER COLLABORATIVE

INTRODUCTION

1. Barking, Havering and Redbridge University Hospital NHS Trust (BHRUT) and Barts Health NHS Trust have been working over the last year to strengthen collaboration for the benefit of their patients, staff and the communities of North East London. This direction of travel has the strong support of NHS England, the NEL Integrated Care System (ICS) and is consistent with the further development of the NEL Acute Provider Collaborative (APC).

2. Considerable work has already been undertaken to shape the direction of travel for collaboration between the two trusts and there have been regular updates on progress, including the publication of *Closer Collaboration* document in September 2021, an update on how pooling resources is supporting the reduction of long waits in *Green Shoots of Recovery* in December 2021 and a further update in May 2022 setting out how patients are benefitting from more timely access to diagnostic scans.

3. The collaboration has continued to appoint to key posts. Three joint non-executive director roles have now been recruited to support the on-going development of the collaboration. In terms of executive leadership, a single Group CEO has been appointed across both organisations, with the BHRUT CEO also undertaking the role of Deputy Group CEO at Barts Health. There have also been several appointments of senior staff between the organisations, including the BHRUT Chief Medical Officer (CMO) appointed at Barts Health, the Royal London Hospital Deputy CMO appointed at BHRUT and the BHRUT Director of Equality, Diversity and Inclusion appointed to Whipps Cross Hospital as Medical Director.

4. Patients are continuing to benefit from closer collaboration in a range of ways that support more timely access to care. For example:

- Over 4700 patients from Barts Health have now been sent to BHRUT for their ultrasound diagnostic scan.
- Barts Health are supporting BHRUT patients who require hepatology appointments to ensure there are no unnecessary delay to appointments and treatment plans.

- Shared learning from BHRUT planned care initiatives to reduce waits across a range of specialties is being used to support targeted 'booster weeks' at Whipps Cross Hospital in ENT and Urology.

COLLABORATION IN THE CONTEXT OF THE EMERGING INTEGRATED CARE SYSTEM

5. Integrated care systems (ICSs) are partnerships that bring together all the people and organisations required to collectively plan health and care services to meet the needs of the population. The central aim is to **integrate care across different providers and settings**, joining up hospital and community-based services, physical and mental health, and health and social care.

6. The government published a bill in July 2021 setting out how it intends to reform the delivery of health services and promote integration between health and care in England through new integrated care systems. The bill included specifications on how integrated care systems (ICSs) are to be set up and the distinct statutory functions for the integrated care board (ICB) and integrated care partnership (ICP). The bill became law from 1 July 2022. The schematic below (Figure 1) outlines the key components of an ICS.

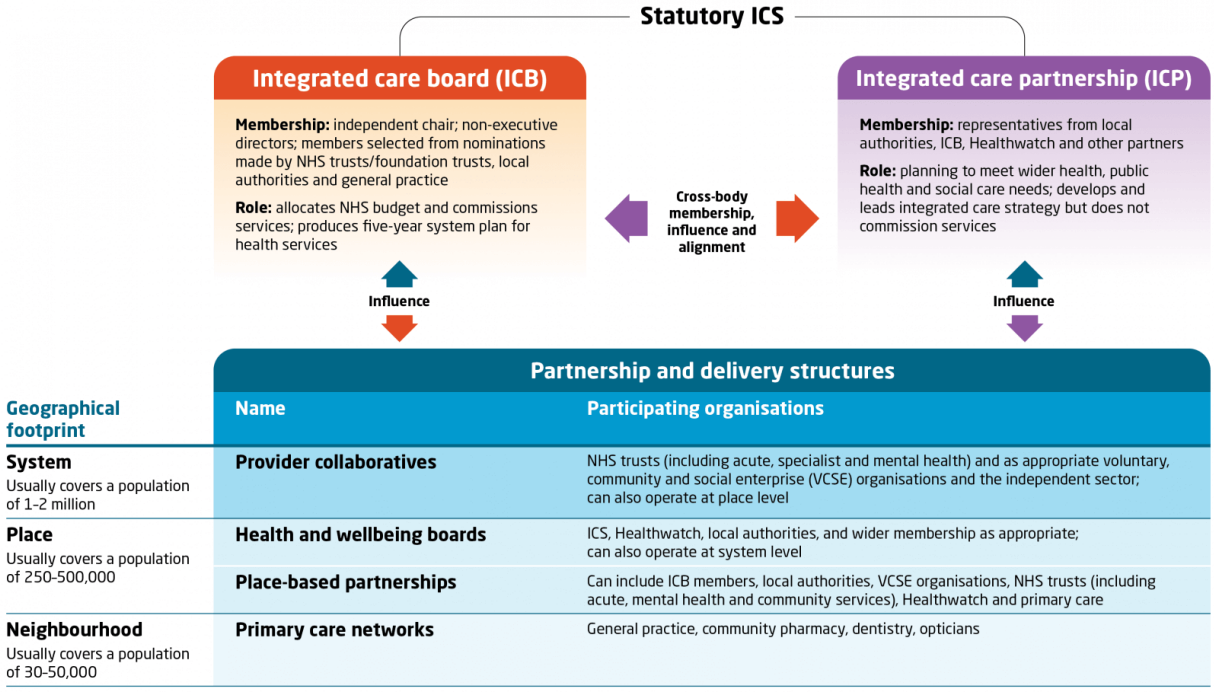


Figure 1 – The building blocks of an ICS

7. One of the core building blocks of the ICS are Provider Collaboratives, which are partnership arrangements involving two or more NHS trusts working together and

through each place-based partnership to reduce inequalities of access and outcomes; to improve resilience through mutual aid; and to improve value.

8. Aside from the legislative changes, there are many reasons for establishing an Acute Provider Collaborative (APC). By working as an APC, there is a greater opportunity to address population health challenges and deliver tangible benefits for patients, staff and our communities through:

- **Reductions in unwarranted variation** in clinical practice and outcomes to improve quality
- **Reductions in health inequalities**, including fairer and more equitable access to services across NEL
- **More efficient and more effective corporate and clinical support services** providing better services and better able to manage demand and capacity
- **Alleviation of workforce pressures and better development of staff and leadership talent** enabling improved staff experience and retention
- **Greater resilience**, for example in ensuring patient safety through improved access, new ways of working and better deployment of staff in hard-to-recruit specialties
- Transformation at scale across care pathways through **rapid spread of successful innovation**
- As strong anchors within our systems being both **good employers of local people and committed to the social and economic success of our boroughs**.

ACUTE PROVIDER COLLABORATIVE

9. The three NEL acute providers (BHRUT, Barts Health and Homerton Healthcare NHS FT) have been working together to develop the leadership arrangements and priorities for the APC. Figure 2 sets out the initial five key clinical programmes (light green boxes) alongside the three strategic priorities. This remains subject to further discussion and should be viewed as work in progress. There is also recognition that the range of clinical programmes will evolve as the APC matures.

10. Through these priorities, the APC will support delivery of the NEL ICS operating principles to:

- Improve quality and outcomes
- Secure greater equity
- Create value
- Deepen collaboration

The expectation is that within the APC framework, the **planning** takes place for each of the programmes with **delivery** undertaken by individual organisations (with Barts Health and BHRUT working together through their 'closer collaboration').

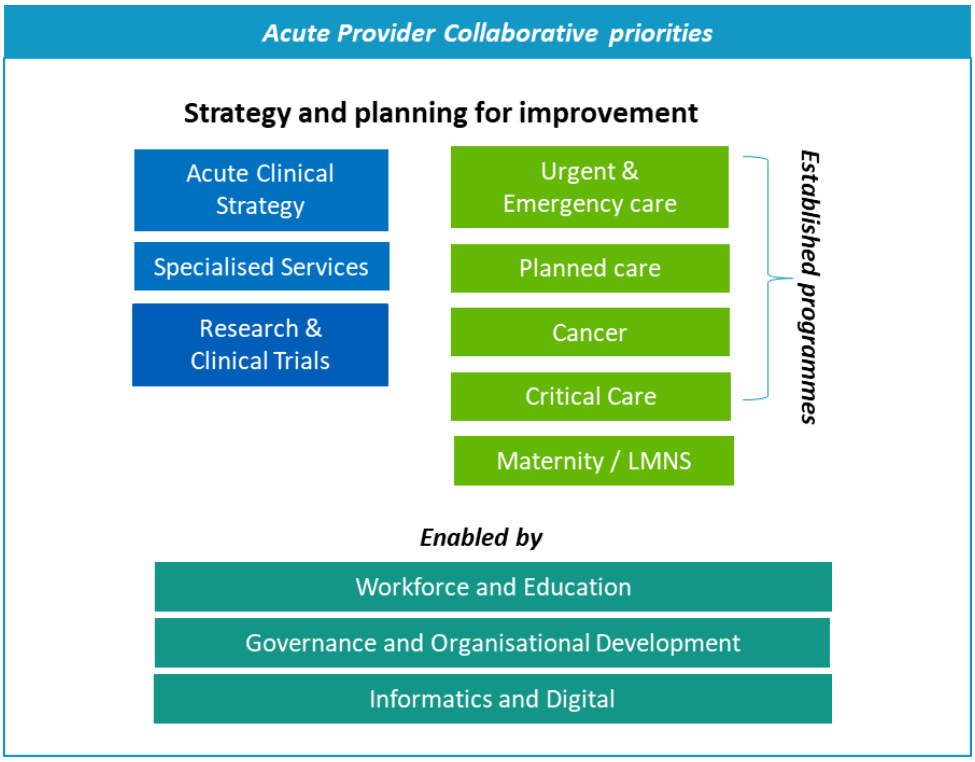


Figure 2 – Emerging APC priorities

ALIGNMENT OF BH/BHRUT COLLABORATION WITH ACUTE PROVIDER COLLABORATIVE

11. The two organisations are committed to working for the long term in 'closer collaboration' within the context of the North East London Acute Provider Collaborative and place based partnerships. Figure 3 sets out how BH/BHRUT Closer Collaboration supports delivery of ICS goals and APC plans.

12. Across BH/BHRUT, there remains an ongoing opportunity to work closely on the clinical priorities of Urgent and Emergency Care and Planned Care, with a continuing focus on the enabling activities of workforce, informatics and finance.

13. Over the next two months, we will be reviewing and refreshing priorities for collaboration in light of the developments with the emerging Acute Provider Collaborative. This will include further detail on the workstreams and a suite of metrics, both tactical and strategic for each of these areas to monitor progress and demonstrate the added value of working in closer collaboration.

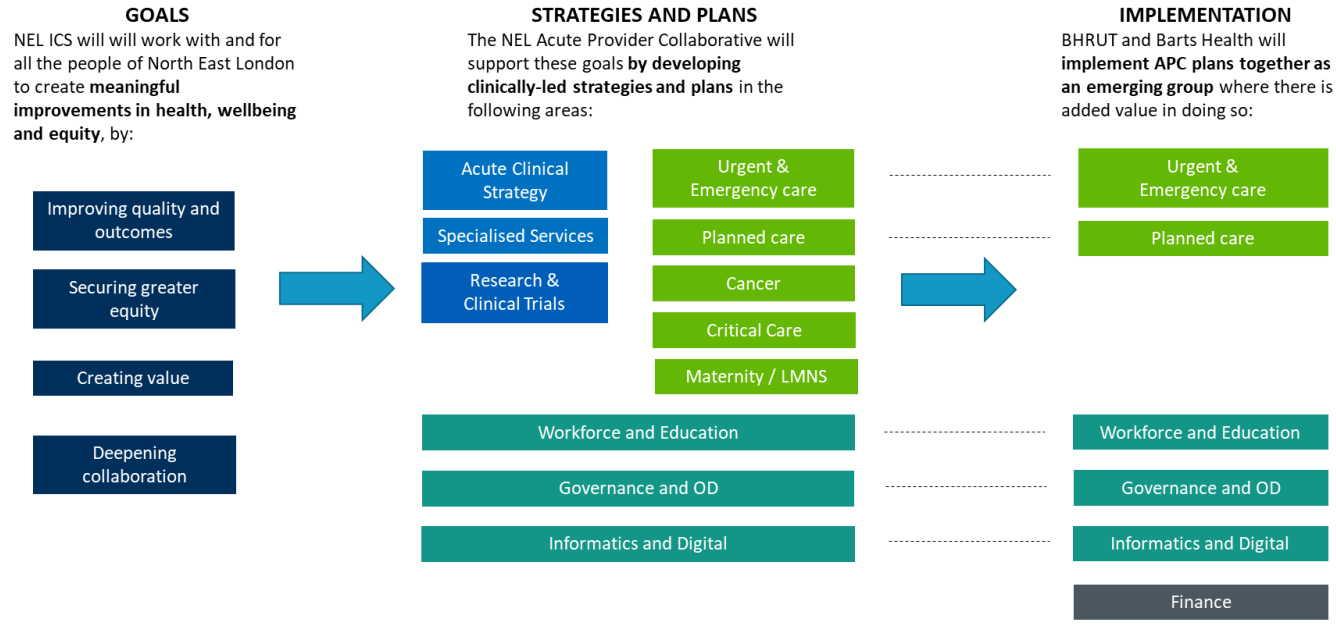


Figure 3 – BH/BHRUT Closer Collaboration supports delivery of ICS goals and APC plans

SUMMARY

14. The Trust Board are asked to note the progress on the BH/BHRUT collaboration, its relationship with the emerging Acute Provider Collaborative and how it supports delivery of the key goals of the Integrated Care System.

15. Further updates will be brought to future meetings of the public Trust Board to inform on the progress of delivery against the key priorities.

NHS
Barts Health
NHS Trust

Report to the Trust Board: 5 October 2022	TB /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 27 July 2022 and 14 September 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 progress report	10
Internal Audit progress report	All
Integrated risk report	10
Risk appetite statement	All
Standing items on waivers, losses and counter fraud	10
QAC exception report	All
Ways of working	-

Key areas of discussion arising from items appearing on the agenda

Internal Audit reports

The Committee spent the majority of its time at the two meetings reviewing outcomes of the following limited assurance audits (in addition to reviews that were assigned reasonable or significant assurance ratings):

- Enhanced care
- Staff appraisals
- Staff induction
- Newham maintenance

The Committee noted some important observations and management actions implemented since the completion of these audit reviews. It was agreed that further consideration of executive oversight of estates issues was required.

The Committee also reflected at its meeting on 14 September on the high number of overdue management actions arising from previously completed audit reviews. An agreement was reached on the level of detail that would be provided on overdue actions for the Committee to consider.

The Committee also received an update on progress against the audit plan and set out expectations for improving turnaround times on management sign off of completed audits.

Counter fraud

The Committee discussed key themes from casework, including steps to improve controls on use of fuel cards. The Committee also noted the challenges of securing the right balance of

actions taken following investigations, which had ranged from criminal prosecution to disciplinary action or no action being pursued. **Integrated risk report – BAF, high risk register and risk appetite** The Committee reviewed at both meetings key metrics relating to the high risk register and the BAF, including the steps to identify and refine risk tolerances in the BAF. A theme of discussions was a request for greater granularity on progress to mitigate risks and reduce risk scores; and for increased thematic risk reporting. The Committee reviewed and endorsed a refreshed risk appetite statement ahead of submission to the Trust Board. **Waivers** The Committee received two reports considering greater granularity of breakdowns and benchmarking of performance on waivers. **Ways of working** The Committee considered ways to maximise effective use of time through refining approaches to reporting and follow ups. This would be linked to a committee effectiveness review process planned for Q3-4.
Any key actions agreed / decisions taken to be notified to the Board
Any issues for escalation to the Board To note steps being taken to improve the timeliness in closure of management actions arising from Internal Audit reviews.

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: 14 September 2022	TB /22

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

Executive summary

The Quality Assurance Committee (QAC) met on 7 September 2022 to discuss items on its agenda relevant to its terms of reference, including matters related to current operational pressures, patient safety/experience, maternity services, a quality report from Newham University Hospital, an internal audit progress reports and a report on quality risks and the Board Assurance Framework.

Key agenda items	**BAF entries**
• Operational Performance and Quality Dashboard	All
• Maternity Services	4, 7
• Internal Audit Progress Report	All
• R&D Annual Report	11
• Infection Control Annual Report	2, 3
• Newham University Hospital Quality Report	All
• BAF and Risks	All
• Patient experience strategy	3-7
• Medicines management and EPMA electronic prescribing	4
• Regulatory compliance	4

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

- Plans to alter committee remit with constitutional standards performance to now be monitored by FPC; with plans to expand thematic assurance reporting at QAC.
- The Committee's plan to review communications with long waiters and current harm review processes.
- Positive reporting on realising benefits from electronic prescribing and opportunities to link this with national work.
- A positive presentation on the research and development annual report.
- Recent CQC inspections of maternity units and birthing units at Barts Health during August, with reports anticipated in September for factual accuracy checks ahead of publication.

Any issues for escalation to the Board

- Partial assurance on recovering trajectories for 78 and 104 week waiting time targets
- Fragility of performance on emergency care ahead of a potentially very challenging winter.

• A serious incident relating to a patient with learning disabilities identified a number of issues. The Committee noted investment to create a dedicated LD team and develop a strategy to reflect health inequalities faced by this vulnerable group. • A limited assurance review of enhanced care arrangements, noting good progress on implementing agreed actions since the review. A follow up report was scheduled for 6 months' time.	
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.	

Barts Health NHS Trust

Report to the Trust Board: 5 October 2022	TB 64/22

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 28 September 2022

Key areas of discussion arising from items appearing on the agenda
The Nominations and Remuneration Committee held a meeting on 28 September 2022. At this meeting the Committee confirmed implementation of a national pay award recommendation; noted recent appointments and terms for three hospital chief executives, a Lifesciences managing director; and approved the nomination of Rebecca Carlton as group chief operating officer and non-voting board member. A revised VSM framework was also considered approved.

Any key actions agreed / decisions taken to be notified to the Board
Details of appointments are included in the separate Board membership paper

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: 5 October 2022	TB 65/22

Title	Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES)
Accountable Director	Group Director of Equity and Inclusion (Ajit Abraham)
Author(s)	Deputy Group Director of People (Del Mehet)
Purpose	To provide the statutory 2022 WRES and WDES reports for approval/attention and to note progress against WeBelong.
Previously considered	Inclusion Board

Executive summary

As a statutory requirement, all NHS Trusts must submit the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data centrally, and publish an annual report on progress towards equality. These reports highlight the experience of people from a Black, Asian or ethnic minority background, and people with a disability respectively. These reports are also published on our website and made publicly accessible. This board paper presents the two separate reports covering WRES and WDES as appendices, to fulfil this requirement. Key findings from these reports are summarised as:

WRES:

- Noticeable improvements across 7 of the 9 metrics. For many of the metrics, this represents a continued positive trend. Increased 8a+ representation in Black, Asian and ethnic minority colleagues (BME) has been a particular success story.
- BME colleagues have equitable access to non-mandatory training year on year, and bullying and harassment from the patients and public has improved consecutively for the last two years, down to pre-covid levels.
- There has been improvement in a number of metrics for the first time, that have not traditionally changed. These metrics include, appointing BME colleagues from shortlisting, percentage of BME colleagues believing in fair progression and the percentage of people experiencing discrimination.
- This is a key achievement, but is not cause for complacency. Gaps remain between white and BME colleagues' experience at work across most metrics. Additionally, the improvements seen in the data is not always reflected in colleagues' perception/lived experience. Furthermore, Board representation remains a key issue that requires further attention.

WDES

- The report presents a mixed picture with 6 out of 13 metrics improving. The continuing positive trend in representation of people with a disability, shortlisting and reducing bullying is a key achievement. The gap between people with/without a disability across all metrics remains noticeable.

Barts Health NHS Trust

- The proportion of people with a disability that feel their work is valued decreased for the third year in a row, and the proportion of people with a disability who feel pressured to come into work increased, albeit modestly. The proportion of people accessing reasonable adjustments also decreased.
- Whilst some metrics saw an unexpected decline, there was an increase in the proportion of people with a disability who believe progression is fair, after this declining throughout the pandemic. This could represent a more optimistic future, and a change in direction which may spread to other metrics as we move into recovery.

With respect to the inclusion agenda overall, our staff networks and the inclusion centre have played a pivotal role in helping to drive forward and accelerate progress. Barts Health has accelerated and scaled our interventions throughout 2021/22. Key to making future progress, will be embedding this existing work on cultural intelligence, fair processes, enhanced inclusion capability building, the inclusive career framework and network development. Findings from the WRES and WDES report will be used to enhance existing, and develop further interventions to create further improvements into 2022/23.

As well as continuing to review WRES/WDES, we will seek to capture staff stories in a positive way to understand what is working well and to be transparent around what can be improved. This will help us understand how people's perception and lived experience compares to improvements in the WRES and WDES data, and ultimately understand if things feel different on the ground.

Related Trust objectives SO1	
Risk and Assurance	This report provides assurance in relation to objectives and 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	WRES and WDES are statutory reporting requirements

Action required

The Trust Board is asked to:

- Approve the papers which will then be published on our website
- Note the impact on delivering our 2021/22 WeBelong priority actions
- Note the WRES and WDES action plans for 2023+

Barts Health NHS Trust

Appendix 1:

NHS Workforce Disability Equality Standard

Barts Health Data Summary and Action Plan

2021 / 2022

Summary Report using data from April 2021 - March 2022

Figure 1: WDES 2021/22 On a Page: Indicators 1, 4-8 have been rounded to the nearest percent.

1. What is WDES?

The Workforce Disability Equality Standard (WDES) was introduced in April 2019 as a mandated data collection. The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of Disabled and non-disabled staff. The full list of metrics can be found here.

NHS organisations use the metrics to develop and publish an action plan. Comparisons each year enables NHS organisations to demonstrate progress towards disability equality and plan to create change. Creating workplace equality for all staff is a key commitment in the NHS People Plan and one of the overall Trust objectives at Barts Health, to be delivered through our WeBelong inclusion strategy.

In the NHS as a whole, WDES data analysis shows disabled NHS staff are : More likely to go through performance management capability processes

- More likely to experience harassment, bullying or abuse
- Less likely to feel that they have equal opportunities for career progress or promotion
- More likely to feel pressured to attend work
- Less likely to feel valued for their contribution to the organisation
- Less likely to feel engaged.
- Less likely to be appointed through shortlisting.

This report contains data for Barts Health NHS to understand the experience of our disabled staff, how we compare to the NHS as a whole and clearly articulate how we are taking steps to create a fairer workplace.

This data is based on the period April 2021 - March 2022 with metrics 4-8 using results from the staff survey that was carried out in Autumn 2021. Data has also been cross referenced against the 2021 national WDES report to understand how things are changing at Barts Health compared to the rest of the country

Note on data collection changes:

This year, the process for collecting and analysing data from metric 5 "*Percentage of staff with a long term health condition or disability believing the trust provides equal opportunities for career progression or promotion"* has changed. For comparison purposes, we have applied the same method to the previous year's data throughout this document.

2. Being Accountable: The overall picture

In order to live our values of transparency and accountability, the table below summarises progress between last year, and the picture since first reporting. Compared to the previous year, 6 out of 13 metrics have improved. Five of the metrics that improved this year have also seen consistent improvement year on year. Of the metrics that didn't improve, we have seen year on year fluctuation, with no clear trend. The only exception to this is the metric on feeling pressured to come into work, which has worsened throughout the pandemic, and staff feeling valued, which decreased for the last two years in a row.

Metric Area (overall trend)	Improved last year	2018-22 Progress	Commentary
Metric 1: Representation	**Yes**	Consistent year on year increase in most bands	Increasing representation has been a success story. This may be attributed to increased confidence in declaring a disability, as well as introducing development opportunities and fairer recruitment. A gap remains in the % of people on ESR (3.9% with a disability, and those with an LTC in staff survey (17%) .
Metric 2: Shortlisting	**Yes**	Mostly decreasing trend since 2018	As above, we have seen shortlisting for disabled colleagues become fairer since first reporting, it is now almost equitable which is a significant achievement.
Metric 3: Capability	**No**	Fluctuated year on year, increasing this year.	This metric has become an increasingly unreliable measure of the capability process. The metric is now based on a very small number of cases (less than 5) out of 16,000+ staff. This means it is no longer statistically significant. Whilst the ratio has increased over the last 2 years, the total number of capability cases has reduced.
Metric 4a: Bullying or abuse from the public	**Yes**	Consistent improvement year on year	This metric has decreased year on year, and is now ~5% below 2018/19. This is in-line with a reduction in bullying faced by all staff so the gap between people with/without a disability still exists.
Metric 4b: Bullying or abuse from managers	**Yes**	two year consecutive improvement towards pre-covid levels	This metric has decreased year on year, and is now ~3% below 2018/19. This is in-line with a reduction in bullying faced by all staff so the gap between people with/without a disability still exists and has grown slightly.
Metric 4c: Bullying or abuse from colleagues	**Yes**	Consistent improvement year on year	This metric has decreased year on year, and is now ~5% below 2018/19. This is in-line with a reduction in bullying faced by all staff so the gap between people with/without a disability still exists.
Metric 4d: Reporting harassment if experienced	**No**	First year this metric has worsened, after improvement in previous two years	After improving year on year, this metric saw a sharp reduction, thus bringing the number below 2018/19 levels. For the first time, this also means that people with a disability are less likely to report bullying than people without a disability.
Metric 5: Perception of Career Progression	**Yes**	After worsening throughout covid, this metric has increased for the first time in three years	After worsening for the previous 2 years, this metric has now increased. The proportion of people with a disability who believe in fair progression is still lower than 2018/19 levels, and the gap between people with/without a disability has remained similar.
Metric 6: Feeling pressured to come to work	**No**	Staff have felt more pressured consistently throughout the pandemic	Since 2018/19, every year since the pandemic a higher proportion of people with a disability have felt pressured to come into work. This increase has slowed this year, having gone up by 0.1%.
Metric 7: Feeling valued	**No**	Staff felt less valued in the last two years of the pandemic	Since 2019/20, all staff have felt their work is less valued year on year. This has decreased less for people with a disability which means the gap between people with/without a disability has closed, but still exists.
Metric 8: Receiving Reasonable Adjustments	**No**	No clear trend, fluctuated year on year	After increasing last year, the percentage of people accessing reasonable adjustments has reduced. Each year, this has alternated between decreasing/increasing so there is no obvious trend, but the number is now below pre-pandemic levels.
Metric 9: Staff Engagement	**No**	Decreased this year, after being static since reporting	People with/without a disability saw a reduction in engagement score this year. Although there is gap between the two, the metric for people with/without a disability has followed each other since reporting. There is no clear trend for this improving/declining.
Metric 10: Board Representation	**No**	Remained static since reporting	Board representation has not changed since reporting requiring a new approach to attracting people with a disability into these roles.

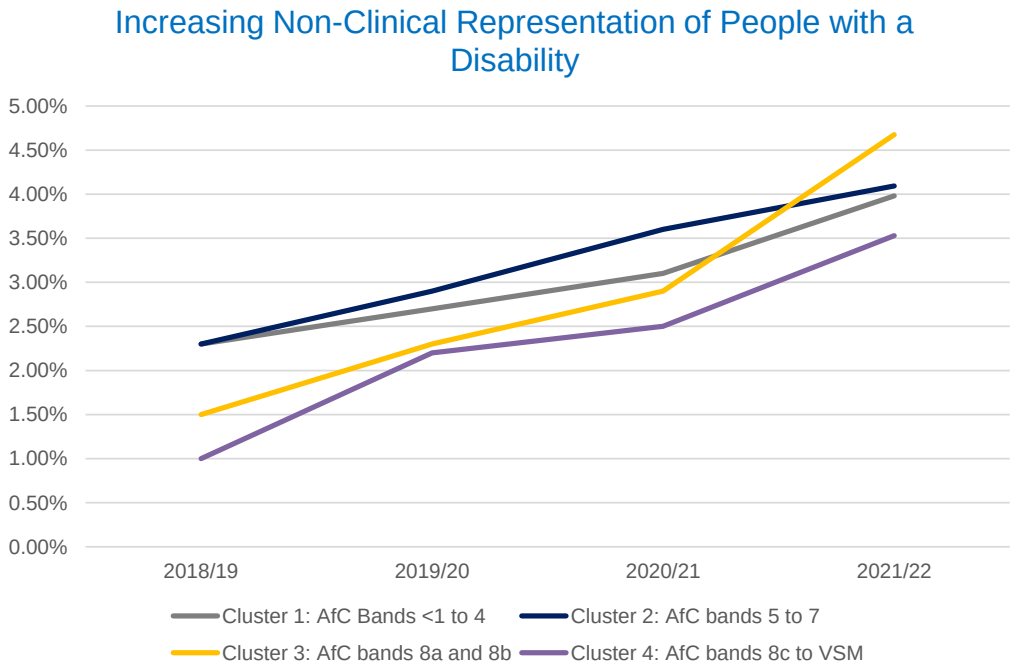
2. 2021/22 Narrative on WDES Metrics for Barts Health NHS Trust

Overview:

Metrics on the proportion of people with a disability experiencing bullying/harassment, the shortlisting ratio and representation in all bands are improving. This is a continuation of a positive trend seen in previous reporting years. For the first time in two years, we also saw an increase in the proportion of people with a disability saying the believe progression is fair.

Conversely, metrics on reporting bullying, feeling pressured to come to work, feeling valued and receiving reasonable adjustments have worsened, and are now less positive than 2018/19 levels, potentially as a result of the impact of the pandemic. Board representation and staff engagement has not seen significant change, and the number of cabaility cases over the last two years has been so low that the relatively likelihood of entering a formal process is no longer a reliable measure. A gap remains between disabled, and non-disabled staff in all metrics.

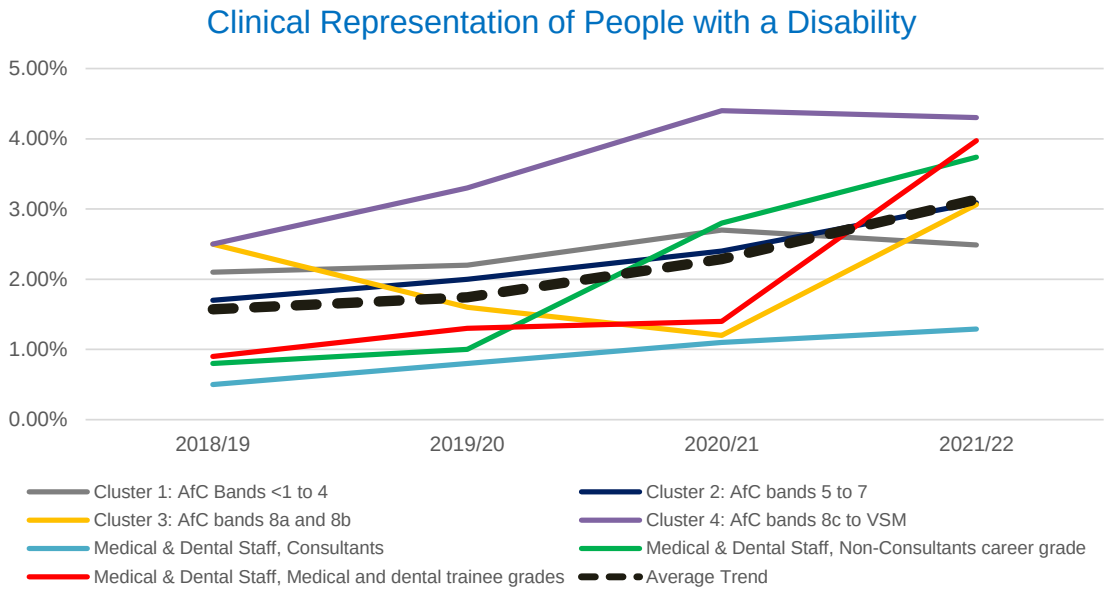
Metric 1: Representation:



Representation has consistently grown in clinical/non-clinical and senior/junior roles. This is a key achievement and has been seen year on year with WDES as a clear trend

- The biggest increases between 2020/21 and 2021/22 were seen in non-clinical 8c-VSM (+1.03%), non-clinical 8b, (+1.78%) and medical/dental staff/trainees (+2.57%).
- Whilst representation is increasing, we know that 17% of colleagues completing the staff survey noted a long-term condition, whilst 3.9% of people on ESR have a disability. This suggests there are people with a disability at Barts Health who are not recorded on ESR.
- There is a lower proportion of colleagues with a disability in clinical roles, but there is no noticeable difference in representation by seniority – for ethnicity there is a lack of representation in senior level, this isn't the case with disability.

- Consultants have the lowest representation compared to all other groups (see graph below)



This graph shows how representation for people with a disability has changed over time for clinical roles. As there are lots of different lines to follow, the dotted line represents an average of all these roles to help see what the overall trend is, which appears to be increasing consistently.

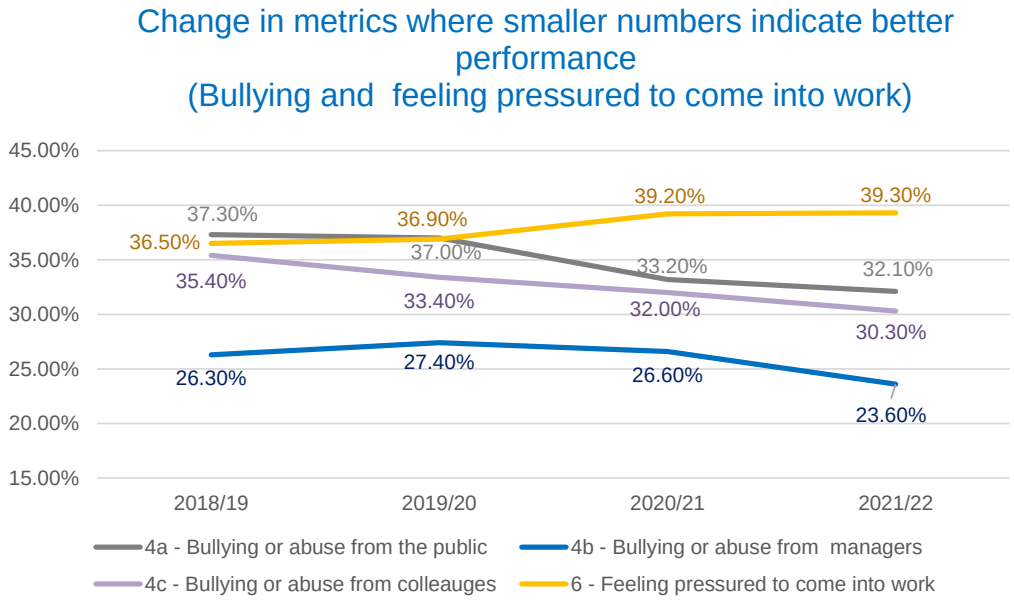
Metric 2: Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff

- Shortlisting has become fairer for colleagues with a disability, moving from a ratio of 1.3 (2020/21) to 1.17 (2021/22). This means that colleagues with a disability are almost as likely to be shortlisted as people without a disability.
- This represents a strong achievement, reducing the ratio down from 1.64 in 2018/2019
- Barts Health has implemented a range of interventions to contribute to fairer recruitment, ranging from
    - Recruitment practices have been updated and reviewed,
    - Continued application of inclusion ambassadors at interview to provide unbiased decision makers
    - Working with the wider ICS and our community to understand how to better increase access to opportunities, including project search and healthcare horizons.
    - The launch of our cultural intelligence programme to acknowledge, and address personal biases to create a fairer culture overall

Metric 3: Relative likelihood of Capability staff entering formal capability process compared to non-disabled staff

- Metric 3 has changed from 3.11 (2020/21) to 4.11 (2021/2022). The national average (see 2021 national WDES report) has also seen an increase in the relative likelihood of people with a disability entering a formal capability process, but the Barts Health figures is based on just 3 capability cases over a two-year average.

- Therefore, despite the headline metric the total number of capability cases in the Trust have decreased and are now very small, meaning metric 3 becomes unreliable as a measure. This is because when we calculate a ratio with small numbers, even a change of 1 or 2 cases can have a big effect. When the numbers become so low, they are no longer statistically significant, which means they are not deemed a reliable measure, and that any change might be due to chance.
- We can therefore gain limited insight from this metric, and seek to ensure we continue to apply best practice approaches to ER management,
- We have completed a recent learning review to understand opportunities for optimising our employee relation process, which will now include people relation leads working with sites to ensure an equitable and transparent approach.



The proportion of disabled staff experiencing any kind of bullying has decreased, whilst the proportion of staff feeling pressured to come into work has increased.

Metric 4:

A) Bullying or abuse from the public:

- The proportion of people with a disability experiencing abuse from the public has decreased for the last 3 years and appears to be on a continued improving trend, from 33.2% (2020/21) to 32.1% this year.
- There still exists a gap of 4.2% between people with/without a disability experience bullying from members of the public.
- A trust wide campaign was launched to address bullying and violence from patients, which included advice and speaking up helplines. This was accompanied by an antibullying patient facing campaign to seek to further reduce bullying.

B) Bullying or abuse from managers

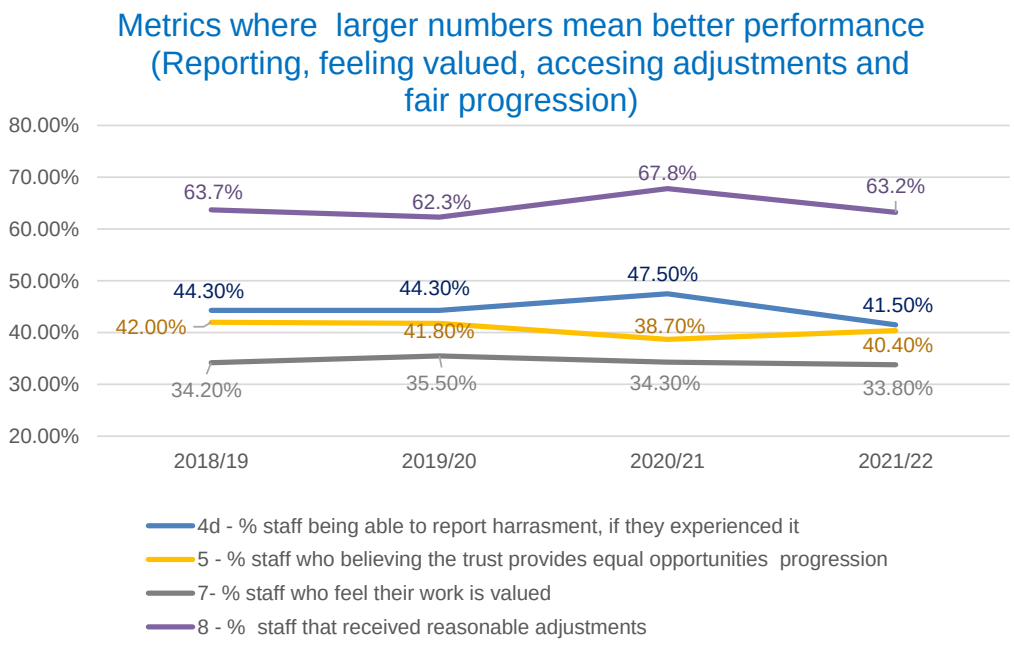
- The proportion of people with a disability experiencing bullying from managers has also reduced from 26.6% (2020/21) to 23.6% (2021/22). This continues the positive trend from the previous two years.
- Whilst things are improving, there exists a gap between people with a disability experiencing bullying from managers (23.6%) and people without a disability (14.2%)

C) Bullying or abuse from other colleagues in the last 12 months

- As with the other bullying metrics, the proportion of colleagues with a disability experiencing bullying from other colleagues reduced from 32% (2020/21) to 30.3% (21.6%). This metric has improved every year we have been recording WDES.
- A gap remains between the proportion of people with/without a disability who experience bullying from other staff of 8.7%
- To drive an increased rate of improvement to close the gap across bullying from any source we have developed increasing interventions, including:
    - Our cultural intelligence programme. The programme formally launched in April 2022, so is not covered in this reporting period, but its impact will be monitored in next year's report. Early feedback shows a 62% increase in participants cultural knowledge
    - Ensuring the expectations in our Dignity at Work policy are clearly communicated, and that behaviours that do not constitute our WeCare values are appropriately addressed.
    - Continued review of speaking up routes, to ensure we have a culture of safety in raising concerns. We have reclarified routes to seeking support or resolution and have been actively addressing behaviours where concerns have been raised.

D) Staff saying that the last time they experienced bullying they or a colleague reported it

- For the first time in three years, this metric has worsened. The proportion of people with a disability who reported bullying after experiencing it reduced from 47.5% (2020/21) to 41.5% (2021/22).
- Previously, people with a disability were more likely to report bullying than people without a disability – this is no longer the case
- Although the proportion of people experiencing bullying is decreasing, it is critical that all staff feel comfortable to report it. To address this, we are:
    - Reviewing all speaking up routes for key emerging themes, and understanding how we can increase access to speaking up
    - Developing a "you said, we did" approach to providing feedback, so we can increase confidence through demonstrating that concern raising is acted upon
    - Reclarifying our set of "acceptable behavioural standards", with the consequences for acting in a way that goes against our values being clear
    - Developing voluntary roles for speaking up and receiving support
    - Raising awareness of speaking up options (varying from informal to informal)
    - Delivering training to HR colleagues on applying our Dignity at Work, and Just Culture policies



After an improvement last year, a lower proportion of staff felt able to report bullying this year. Similarly, after increasing access to reasonable adjustments last year, there has been a reduction in 2021/22. With respect to perceived fairness of career progression, there has been fluctuation since recording, but an increase this year. The % of staff feeling valued for their work has decreased for the last 3 years but is less than 1% lower than pre- pandemic levels.

Metric 5: Percentage of Disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion.

The data collection for this metric has changed since last year, meaning the numbers included in previous WDES reports are no longer applicable. We have applied the new methodology for data from the previous years to provide an accurate comparison.

- After decreasing throughout the pandemic, for the first time in three years we have seen an increase in the percentage of people with a disability feeling the trust provides equal opportunities for progression, moving from 38.7% (2020/21) to 40.4% (2021/22).
- There remains a gap between the perceived fairness of career progression for people with/without a disability.
- Barts Health has developed an inclusive career progression framework with a series of interventions to create sustained improvement in this metric, which includes:
    - Targeted development programmes for junior colleagues up to VSM
    - Career conversation guidance and support for line managers
    - Increased stretch opportunities
    - A career mentorship and shadowing programme.
    - various cultural interventions to consider recruitment and advertising
    - Career events and roadshows to raise awareness
- Early feedback from these interventions has been positive, for example, 7 in 10 people completing the career mentorship programme said it had increased their chance of successfully securing a position, increased confidence, and increased their professional network.

Metric 6: Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

- There has been a modest increase in the proportion of people with a disability who feel pressured to come into work, from 39.2% (2020/21) to 39.3% (2021/22). There has been a worsening trend since the pandemic, but this year's increase has been much lower.
- People without a disability have also felt increasingly pressured to attend work throughout the pandemic, although this has reduced somewhat from 28.7% (2020/21) to 28.5% (2021/22) indicating there is an opportunity to also reverse this trend for people with a disability.
- It's possible this metric has been driven by pressure from covid, and there are signs the trend could be reversed. We will seek to improve this metric through our trust wide culture change programme, however, creating a step change will require a multifaceted approach with consideration on:
    - Review of workforce planning and high-pressure areas
    - Consistently applying flexible working in line with our updated policy
    - Reviewing other related policies, including capability management and leave
    - Working closely with our partnership organisation, Business Disability forum to understand other process drivers

Metric 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

- The percentage of people with a disability feeling the organisation values their work has decreased modestly from 34.3% (2020/21) to 33.8% (2021/22). This is now below pre-pandemic levels and showing a worsening trend.
- The proportion of staff who do not have a disability have seen a much sharper reduction, from 48.7% (2020/21) to 41.8% (2021/22). This has driven a close in the gap between people with/without a disability, although a gap remains.
- This indicates we have a broader issue with rewarding and valuing staff across the entire trust. In response, we will consider how to celebrate and increase exposure of colleagues across the organisation.

Metric 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

- The % of people accessing reasonable adjustments has decreased from 67.8% (2020/21) to 63.2% (2021/22). A reduction has also been seen nationally.
- After being on a 4 year high in the previous year, this metric is now below pre-pandemic levels.
- There may be implications for transitioning back from covid working that is driving this change, but further investigation will be required to understand opportunities for increasing access, including:
    - Raising awareness of our BartsAbility passport to create mutual understanding between line managers and direct report.
    - Reviewing ease of access for wellbeing services and occupational health
    - Update the sickness and leave policies to make it clear to colleagues and managers about the need to support time off for appointments.
    - Improve visibility and access to Text to help and other software.
    - Work with the employee wellbeing service to clarify the reasonable adjustment process and remove delays in using the funding.

Metric 9: The staff engagement score for Disabled staff, compared to non-disabled staff

- After remaining static for the previous 3 years, the engagement score for people with a disability reduced from 6.5 (2020/21) to 6.3 (2021/22). People who do not have a disability also saw a reduction in engagement score.
- In response, we are seeking to strengthen the voice of our staff across the trust through:
    - Increased awareness and speaking events via the BartsAbility network
    - Embedded staff diversity co-chairs within formal inclusion governance, ensuring exposure and proximity to senior leadership
    - Continuing to maximise the use of existing comms channels (WeShare, East London Observer, Twitter) as well as creating more opportunities for face to face engagement on site
    - Creating a feedback loop with staff, to demonstrate how voices are being heard

Metric 10: Disabled staff on Board (voting and non-voting)

- The percentage of people with a disability on our board has remained at 0%.
- In order to promote fairer senior development, we have designed a Future VSM Programme which will launch later in 2022. VSM stands for very senior manager. This programme is part of our inclusive career progression framework in order to improve representation in a targeted way. We are also reviewing board recruitment practices.
- As a general consideration for visible role models in senior positions, there is a lack of visible senior representation for disabled people – we will consider how we can help people with a disability link in with senior role models to identify with.

3. Complete WDES Metrics 2018-22

For transparency our full WDES metrics are included in this section, previous years are included in this table to understand any changes over time. The last two columns includes the latest WDES data from the NHS as a whole. This is to help understand if any changes over the last year are part of the national direction, or unique to Barts Health Figures included this table on the national average can be seen in full via the 2021 online national WDES report. Figures in green indicate they improved from the year before, figures in red are where they became worse.

Metric 1: Representation

WDES Metric 1	Barts Health				National Average	
	2018/19	2019/20	2020/21	2021/22	2020	2021
1a) Non clinical Representation				3.9% overall	3.4% **(average of all staff)**	3.7% **(average of all staff)**
Cluster 1: AfC Bands <1 to 4	2.30%	2.70%	3.10%	3.98%		
Cluster 2: AfC bands 5 to 7	2.30%	2.90%	3.60%	4.09%		
Cluster 3: AfC bands 8a and 8b	1.50%	2.30%	2.90%	4.68%		
Cluster 4: AfC bands 8c to VSM	1.00%	2.20%	2.50%	3.53%		
1b) Clinical Representation				3.9% overall		
Cluster 1: AfC Bands <1 to 4	2.10%	2.20%	2.70%	2.49%		
Cluster 2: AfC bands 5 to 7	1.70%	2.00%	2.40%	3.09%		
Cluster 3: AfC bands 8a and 8b	2.50%	1.60%	1.20%	3.06%		
Cluster 4: AfC bands 8c to VSM	2.50%	3.30%	4.40%	4.30%		
Medical & Dental Staff, Consultants	0.50%	0.80%	1.10%	1.29%		
Medical & Dental Staff, Non-Consultants career grade	0.80%	1.00%	2.80%	3.74%		
Medical & Dental Staff, Medical and dental trainee grades	0.90%	1.30%	1.40%	3.97%		

Metrics 2-10: All other metrics

Metric	People with A disability at Barts Health (number in brackets = people without a disability)				National NHS Average for People with a Disability	
	2018/19	2019/20	2020/21	2021/22	2020	2021
2. Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff	1.64	1.25	1.3	1.17	1.2	1.11
3. Relative likelihood of Disabled staff entering formal capability process compared to non-disabled staff	N/A	3.33	3.11	4.11	1.53	1.94
4a) Staff experiencing harassment, bullying or abuse from patients/ service users, their relatives or other members of the public in the last 12 months	37.3% (33.3%)	37.0% (34.2%)	33.2% (29.8%)	32.1% (27.9%)	34.2% (27.4%)	31.9% (25.5%)
4b) Staff experiencing harassment, bullying or abuse from managers in the last 12 months	26.3% (17.5%)	27.4% (16.7%)	26.6% (15.5%)	23.6% (14.2%)	18.5% (10.8%)	18.5% (10.6%)
4c) Staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	35.4% (24.3%)	33.4% (24.9%)	32.0% (23.2%)	30.3% (21.6%)	26.3% (17.3%	25.6% (16.7%)
4d) Staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	44.3% (46.9%)	44.3% (49.4%)	47.5% (46.1%)	41.5% (47.1%)	N/A	
5. Percentage of Disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion.	42.0% (50.5%)	41.8% (51.1%)	38.7% (48.5%)	40.4% (48.6%)	78.6% (86.6%)	77.3% (86%)
6. Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	36.5% (25.8%)	36.9% (27.0%)	39.2% (28.7%)	39.3% (28.5%)	33.5% (23.6%)	33% (23%)
7. Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	34.2% (50.2%)	35.5% (49.5%)	34.3% (48.7%)	33.8% (41.8%)	35% (44.9%)	34.8% (45%)
8.Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	63.7%	62.3%	67.8%	63.2%	74.10%	73.80%
9.The staff engagement score for Disabled staff, compared to non-disabled staff.	6.5 (7.1)	6.5 (7.1)	6.5 (7.0)	6.3 (6.9)	N/A	
10. Disabled staff on Board (voting and non-voting)	0%	0%	0%	0%	3.00%	3.70%

4. Looking Ahead: Our WDES action plan 2021/22

In last year's WDES report, a comprehensive action plan was outlined to demonstrate key priorities. A significant number of interventions were delivered as part of this, which are listed in detail in the appendix.

Highlights included the launch of an inclusive career development framework, joining business disability forum, a variety of the BartsAbility staff network led events, and various programmes specifically designed to support people with a disability (i.e CALIBRE, Lexxic).

In response to metrics in this year's WDES report, we have refined this plan into 4 key areas, described below. We have taken this approach, as our previous plans have continued to improve bullying, representation and shortlisting, but a focused approach is needed to address metrics that have not seen significant change since reporting. This plan will be monitored through the year by the BartsAbility Network to provide assurance and visibility that we are making the difference we want to see.

Workplace Adjustments:

What is it?	Workplace adjustments are critical for colleagues with a long-term health condition or disability to be able excel and to be able to bring their whole selves to work. The adjustments may be changes in work patterns, using language that is better understood by others or may be specific equipment or resources that have been purchased from the dedicated adjustments fund. Currently we know too many people do not get these adjustments in place and have to battle unnecessarily to make sure they get them.
What is this important?	• Major issue frequently raised in network meetings by many members • Strong evidence from staff survey/WDES of a decline in people getting the adjustments they need • Continued underspend in the dedicated adjustments fund • Our business disability forum assessment highlighted tech and communications which focus on adjustments
What do we want to see?	• People get the adjustments they need easily, quickly and fairly
What will we do to achieve this?	• Work with EWS to clarify the reasonable adjustment process and remove delays in using the funding • Improve visibility and access to Text to help and other software • Update the sickness and leave policies to make it clear to colleagues and managers about the need to support time off for appointments

NeuroDifference:

What is it?	Neurodifference is a name which captures a range of differences in people's brains and behaviours. This includes autism spectrum, dyslexia and ADHD which are being recognised more frequently in people. Barts Health has a long-standing group of dyslexia champions however this has seen its membership reduce of the last few years and needs to be refreshed. In addition, as we explore the issues around neurodifference we are recognising many other areas where we should ensure we put the right focus and attention on supporting people who have different abilities and approaches in work.
What is this important?	• The Lexxic challenge highlighted the opportunity to improve how we support neurodivergent colleagues • This is a key issue for network members • External perspectives from have shown us that this is an area where no Trust has yet got it right
What do we want to see?	• We recognise that people are different and where we can do something to enable people with different needs to thrive, we put that in place
What will we do to achieve this?	• Our Dyslexia Champions and network is revitalised and to maximise the support they are able to offer colleagues • The recruitment process is improved for neurodivergent colleagues • The Neurodifference Task & Finish group will take the lead to identify and deliver improvements for neurodivergent colleagues

Speaking up:

What is it?	A key aim across Barts Health is to foster a Fair and Just culture, where all colleagues are treated fairly and with respect. Where this does not happen we want colleagues to be able to speak up and get their issues resolved quickly and without fear of retribution.
What is this important?	Frequent issues from individuals are raised through Network chairs • there is a continued gap in the levels of bullying and harassment reported in staff survey which feeds into WDES • this year has seen a decline in the number of people reporting occurrences of bullying, harassment and abuse
What do we want to see?	• People should be treated with respect and courtesy and if this doesn't happen, they should feel confident speaking up. • When we hear about unacceptable behaviour, we act on it.
What will we do to achieve this?	• Work to deliver a fair and just culture • Improve awareness and access to signposting channels • Reflect back issues to increase confidence they are being address • Targeted interventions (CQ etc.) in hot spot areas

- Event in speak up month joint with BHRUT with our Speak Up Guardian and Inclusion Signposters

Visibility:

What is it?	WeBelong, our vision for Barts Health has at its core the idea that al colleague across Barts Health should feel that this is a place where they can truly belong. No one should feel that because of their health condition or disability that they cannot bring their whole selves to work. We want to increase the visibility of colleagues with a long-term health condition or visible to demonstrate that we are all welcome here and give confidence to others to do the same.
What is this important?	• Sharing stories is a central purpose of the Network meetings • there is an Increasing gap between ESR and staff survey on the number of people who say they have a long-term health condition or disability • Low numbers of visible senior role models with a long-term health condition or disability
What do we want to see?	• Everyone should feel confident come to work as the whole person they are
What will we do to achieve this?	• Refresh our Closing the Gap and Embracing the Difference campaigns to significantly increase the number of people that declare they have a disability or long-term health condition • Put in place a calendar of events for International Day and events • Improve visibility of Role models • Stories from people who have used the BartsAbility Passport and workplace adjustments

5. Closing Statement:

There has been mixed insights from this year's report with 6 out of 13 metrics improving. Whilst the continuing positive trend in representation, shortlisting and bullying is a key achievement, the gap between people with/without a disability across all metrics remains noticeable. Furthermore, we saw that the proportion of people with a disability that feel their work is valued decreased for the third year in a row, and the proportion of people with a disability who feel pressured to come into work increased, albeit modestly. This represents a need for a different approach to reverse some of the potential negative impacts of the pandemic. Our refined action plan responds to this by focusing in on areas that haven't improved, after creating consistent impact in other areas.

This plan also seeks to address the unexpected decrease in the proportion of people accessing reasonable adjustments seen this year, increasing the profile of people with a disability to improve engagement, creating visible role models at board level and ensuring safe, clear speaking up routes to raise concerns.

Whilst some metrics saw an unexpected decline, the increase in the proportion of people with a disability who believe progression is fair increased, after declining in the pandemic. This could

represent a more optimistic future, and a change in direction which may spread to other metrics as we move into recovery, with a large body of interventions already underway.

With respect to our equity and inclusion agenda overall, Barts Health has accelerated and scaled our inclusion programme throughout 2021/22. This work has included the launch of a cultural intelligence programme, enhanced inclusion capability building, the early phases of our inclusive career framework, strengthening staff networks and much more. We are now in the second phase of our WeBelong inclusion strategy, which further embeds our ambitions. Some of the actions have been outlined in the previous section, but the workforce facing elements of the strategy can be summarised as focusing on:

Cultural Intelligence

- Building the inclusion capability of our workforce through monthly learning and development, CQ masterclasses and events.

Career Development

- Empowering staff to access more opportunities and promote fairer career development through interventions as part of the inclusive career development framework.
- This includes career mentorship, development programmes, guidance to managers, targeted training and fairer recruitment, FutureVSM programme, succession planning, e-learning, shadowing and much more

Fair and Just culture

- Embedding inclusion into business as usual through policy, behaviour and process change with a focus on ensuring equitable treatment and mutual resolution in grievance and employee relation cases.

Staff Diversity Networks

- Working with networks to engage our people to be part of a social movement where everyone takes responsibility for embedding inclusion.
- Creating a network of inclusion volunteers to signpost staff to access support whenever it is needed.

We hope that an organisational wide focus on these broader themes, paired with a targeted approach on key areas requiring improvement identified in the WDES action plan, will start to create more sustained change. This is essential to ensure an equitable experience for people with a disability and close the existing inequality gap. Whilst we have a long journey to equality ahead, we hope this comprehensive programme will create a paradigm shift in inclusion.

This document provides just a snapshot of our work towards inclusion. To find out more about how we are supporting our staff with a disability, or to learn about our overarching inclusion strategy, please contact diversityninclusion.bartshealth@nhs.net

Appendix: Progress Against Last Year's Actions (1):

Objective	2020/21 Action Plan	Progress	Linked WDES Metric(s)
Increase visibility and awareness for colleagues with a long-term condition or disability	**Currently underway** • Continue to build on the progress made in Closing the gap to ensure that all staff with a long-term condition or disability have up to date ESR records to enable support to be targeted • Embed and promote BartsAbility Passport – which is designed to for colleagues and their managers to ensure that reasonable adjustments are in place and wellbeing is a promoted • Awareness programme of support starting with recruitment and induction and on-boarding • Continue to deliver disability awareness training targeted to line managers and team leaders • Maintain progress with support for BartsAbility network including dedicated time for co-Chairs and site lead representation **Planned to start 2021/22** • Embed the values of the Disability Confident Leader recognition in our local community • Refresh the Embracing the Difference campaign to promote awareness and highlight support available for all colleagues • Distribute and promote sunflower lanyards to increase awareness of hidden disabilities	• Became disability confident leader • Joined business disability forum to grant access to learning resources, best practice, and increase the profile of people with a disability in the organisation • BartsAbility network has continued delivering a number of events to raise awareness and have been available to troubleshoot issues and provide advice regarding the BartsAbility passport • Launched the Sunflower Lanyard project to improve awareness of hidden disabilities and encourage appropriate treatment of patients and staff • Launched an in-house cultural intelligence programme in May 2022, with hundreds of staff having already attended, including all group executive members. This programme will run into 2023 to reach more staff. Those completing the masterclass have reported a 60% increase in their cultural knowledge. • Assigned dedicated cultural intelligence practitioners to each site to work with hot spot areas • Agreed protected time for volunteer inclusion related roles and some inclusion training • Kicked-off a network development programme, due to last into 2023 to develop network leadership and ensure we are responding and listening to our members • Carried out various engagement activities, including the what matters to you survey, awareness events, and inclusion training to help present key themes to leadership for action • We will continue to scale this work throughout the next 12 months	1, 2, 3, 4, 7, 8, 9
Improve support and wellbeing	**Currently underway** • Continue to improve access to reasonable adjustments • Continued support for staff returning from Shielding **Planned to start 2021/22** • Improve uptake of Text to Help software to support staff with neurodifference • All colleagues to have meaningful one to one and appraisal conversations with a focus on wellbeing, career progression and support	• Launched our wellbeing strategy to support staff • Established a neurodiversity working group to understand opportunities for improving processes • Developed updated appraisal process to ensure have an inclusion objective and wellbeing conversation with completion rates being monitored as part of a monthly data updates to the inclusion board • Participated in Lexxic programme	6,8

Appendix: Progress Against Last Year's Actions (2):

Objective	2020/21 Action Plan	Progress	Linked WDES Metric(s)
Take positive action on recruitment and career progression	**Currently underway** • Embed inclusive recruitment action plan for all senior appointments: diverse panels, agreed recruitment plans, IAs in 8a+, inclusive language • Support the first cohort of Barts Health colleagues through the Calibre programme, a bespoke leadership programme designed to address the challenges staff with a long-term condition or disability face in the workplace • Extend the project Search programme focussed on preparing people with learning disabilities, autism and/or sensory impairment into paid employment. • Working with NHS England and Improvement to develop a Learning Disability Employment Pledge in demonstration of our commitment to inclusion and learnings of inequality following COVID-19. **Planned to start 2021/22** • Career Development Programme targeted at colleagues with a long-term condition or disability • Develop an approach to understand representation of colleagues with a long-term condition or disability at all levels and relevant benchmarks • Improve exit interview process, revise questionnaire and collect data on protected characteristics • Develop talent management approach including specific focus on colleagues with a long-term condition or disability	Launched our inclusive career development framework which included a variety of interventions outlined below: • Launch of career mentorship and shadowing service, with 100+ people completing the pilot, and 70% recording increased confidence having completed the process. All staff are encouraged to access this service to be matched to their perfect mentor to receive 1-2-1 advice • Scaled project search to SBH after success at WXH • Conducted various network led events on career development, attended by hundreds of staff • Participated in CALIBRE programme • Organised a further 5 large scale career events due to kick-off in October 2022, covering specific challenges for people with a disability, and general career advice (with e-learning to follow the events) • Launched inclusive career advice guidance and mentorship training videos • In addition to these events, we have scaled an existing programme designed for underrepresented groups to have a specific set of modules for people with a disability and are increasing the number of trainers to deliver more sessions • Planned to deliver career conversation coaching to line managers to have richer conversations	1, 2, 5, 10
Fair and Just culture	**Currently underway** • Embed 'fair and just' principles in all polices specifically focused on challenges for colleagues with a long-term condition or disability **Planned to start 2021/22** • Improve awareness of options to raise concerns and learning from issues raised	• Reviewed policies including leave and capability process to reduce chance of incorrectly entering a formal process • Developing new inclusion sign poster roles to increase confidence in, and access to speaking up routes • Completed Trust wide learning review to identify improvement opportunities in employee relation processes and tracking • Embedded employee relation case tracking and resolution monitoring into hospital executive governance structures • Assigning people relation leads to all hospital sites to take a consistent approach to employee relation cases and reduce any bias	3, 4

Barts Health NHS Trust

Appendix 2:

Workforce Race Equality Standard

Barts Health Report and Data Summary

2021 / 2022

Summary Report using data from April 2021 - March 2022

4. What is WRES?

In April 2015 NHS England introduced the Workforce Race Equality Scheme (WRES). The scheme consists of nine indicators and helps NHS organisations recognise, and reduce any inequality gaps between white and Black, Asian and minority ethnic staff (BAME).

Barts Health has committed to taking a transparent and proactive approach to addressing inequality. Whilst submitting WRES data annually to NHSE is a statutory requirement, we have chosen to additionally publish a public report to improve accessibility to our data, and help drive improvements in the Trust in line with recommendations in the London Workforce Race Equality Strategy.

This pack contains the updated WRES Metrics for Barts Health for 2022, this data is based on the period April 2021 - March 2022 with metrics 5-8 using results from the staff survey that was carried out in Autumn 2021. In this summary, data from the previous year is also reported, alongside our previous submissions. This is to understand if we have improved since last year, and whether or not improvements have been made overall since first reporting, and where more needs to be done to accelerate inclusion. This report also refers to data included in the WRES national report in places to provide context for how the metrics have changed for the rest of the NHS in comparison to Barts Health.

Across Barts Health we use these indicators to ensure that we are taking active and positive steps to achieve our ambition of eliminating discrimination, ensuring equality of opportunity and promoting good relations between all people. This data is critical in monitoring our progress towards the Model Employer Goals for which we have aligned our interventions and will help us achieve our target of representative leadership by 2028.

This report contains a summary of our WRES data and our action plan is provided to show how Barts Health are closing the remaining gaps in equality, and what key interventions have been implemented in the last year.

Note on terminology:

Barts Health has fed into a national process to review, and agree updated terminology that our colleagues will better identify with. In the meantime, this document continues to use the terms BME and BAME to follow the WRES technical guidance's that ensures consistent data collection and analysis across the NHS.

Note on data collection changes:

This year, the process for collecting and analysing data from metric 7 "*Percentage BAME staff believing the trust provides equal opportunities for career progression or promotion"* has changed. For comparison purposes, we have applied the same method to the previous 2 years data throughout this document.

NHS Workforce Race Equality Standard

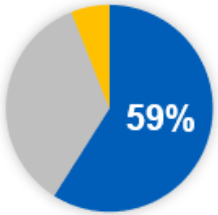
2022 Metrics | Barts Health Trust

The workforce race equality standard (WRES) is an annual collection of metrics that helps NHS organisations understand the experience of ethnically diverse employees.

This overview provides a snapshot of data from March 2022. Some of these numbers have been rounded to the nearest %.

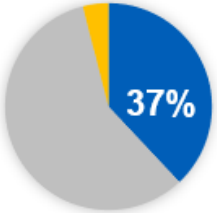
Indicator 1: Our Staff

All staff



Ethnically diverse people make up the majority of staff at Barts Health.

Staff at band 8a and above



Whilst this has improved at Barts Health each year, under representation remains a key challenge here and also for the wider NHS.

See key bottom right corner. Yellow segments of the pie represent unknown/unrecorded.

Indicator 2: Shortlisting

The relative likelihood of white staff being **appointed from shortlisting compared** to ethnically diverse staff:

1.5x

This means white staff are 1.5 times more likely to be shortlisted.

Indicator 3: Disciplinary

The relative likelihood of ethnically diverse staff entering a **formal disciplinary** process compared to white staff:

1.77x

This means ethnically diverse staff are 1.77 times more likely to enter formal disciplinary.

Indicator 4: Training

The relative likelihood of white staff **accessing non-mandatory training** compared to ethnically diverse staff:

0.7x

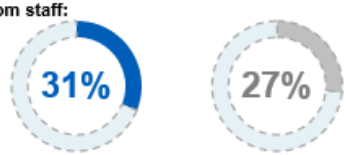
This means BME colleagues are more likely to access non-mandatory training than white colleagues.

Indicator 5: Bullying from the public

Percentage of staff experiencing harassment, bullying or **abuse from patients, relatives or public:**

Indicator 6: Bullying from staff

Percentage of staff experiencing harassment, bullying or **abuse from staff:**

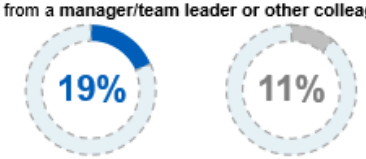


Indicator 7: Progression

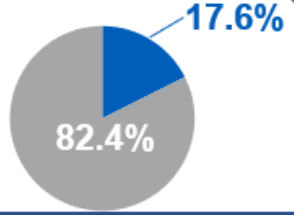
Percentage staff believing the trust provides **equal opportunities for career progression or promotion**:

Indicator 8: Discrimination

Percentage of staff personally experiencing **discrimination** at work from **a manager/team leader or other colleagues:**



Composition of the Trust Board:



= BME Staff.

=White staff

5. Being Accountable: The overall picture

When considering our journey to equality, it is important to look at WRES over time, this gives a fuller picture of how things are changing and looks beyond year-on-year fluctuations that can be due to chance. When a single metric goes up or down each year by a small amount, this is unlikely to indicate an improving/declining trend and instead suggests there has been no significant improvement/decline. The table below provides a transparent summary of our progress, which is explained in more detail throughout.

Metric Area (overall trend)	Improved last year	4 year view	2017-2022: Where are we now?
Metric 1: Representation	Yes	Consistent year on year improvement since reporting	BME Representation has been increasing consistently in senior, and non-senior positions which is a substantial achievement. There still remains a gap between our overall workforce and representation in leadership, but we are currently exceeding our target trajectory to create representative leadership by 2028.
Metric 2: Appointments from shortlisting	Yes	First noticeable improvement since reporting	White staff are 1.5x times more likely to be appointed from shortlisting. This represents a noticeable improvement after the metric has remained static for the previous two years. Whilst this is a sign things are improving, a significant gap still remains.
Metric 3: Disciplinary Process	No	Improving from 2017, but metric declined last year. Total number of disciplinary cases decreasing overall.	The total number of disciplinaries fell from 81 in 20-21 to 36 in 21-22, a decline of 56% overall. The number of cases involving white colleagues fell 62%, but the number of cases involving BME colleagues fell 40%. This has driven an increase in our metric 3, from 1.31 to 1.77, but is now based on a very small number of cases. As the total numbers of cases reduce beyond a certain point, this metric no longer becomes statistically significant and is therefore subject to fluctuation.
Metric 4: Training	No	BME staff access proportionally more training year on year	A greater proportion of BME staff continue to access non-mandatory training, albeit the gap between white/BME colleagues has closed since the previous year. We will continue to monitor training uptake to ensure this ratio remains as close to 1:1 as possible.
Metric 5 – 6: Harassment from staff and service users	Yes	Improvement 2 years in a row	The proportion of BME staff experiencing harassment from staff and service users has improved since last year, and appears to be on a downward trend. The proportion of BME staff experiencing bullying from the public is now less than white staff. A higher proportion of BME staff experience bullying from other colleagues, and currently almost 1 in 3 BME staff experience bullying showing significant work remains.
Metric 7: Career progression	Yes	Fluctuated year on year, no significant trend despite improvement this year.	The data collection process changed for metric 7. This method yields a lower % of people answering yes to believing progression is fair than the previous approach, but is more representative as it calculates a percentage based on everyone answering the question. When applying the same methodology for the previous years, we can see that the % of BME people who believe progression is fair has actually increased since last year, but remains similar to 2019 levels. Our ambitious inclusive career framework will aim to increase this percentage further to create a step change, as gap between white and BME colleagues still exists
Metric 8: Experiencing discrimination	Yes	Fluctuated year on year, no significant trend	Discrimination has decreased since last year, but remains above 2019 levels and a gap exists between white/BME staff. More will need to be done to eliminate all forms of discrimination, this includes the delivery of our cultural intelligence programme, and improved speaking up routes.
Metric 9: Board composition	Yes	First noticeable improvement since reporting	After seeing no change in board representation since reporting on WRES, we have increased representation for the first time, from 12.5% to 17.6%. This is a positive change in direction, but a 41% gap exists between the proportion of BME colleagues in our workforce overall and our board.

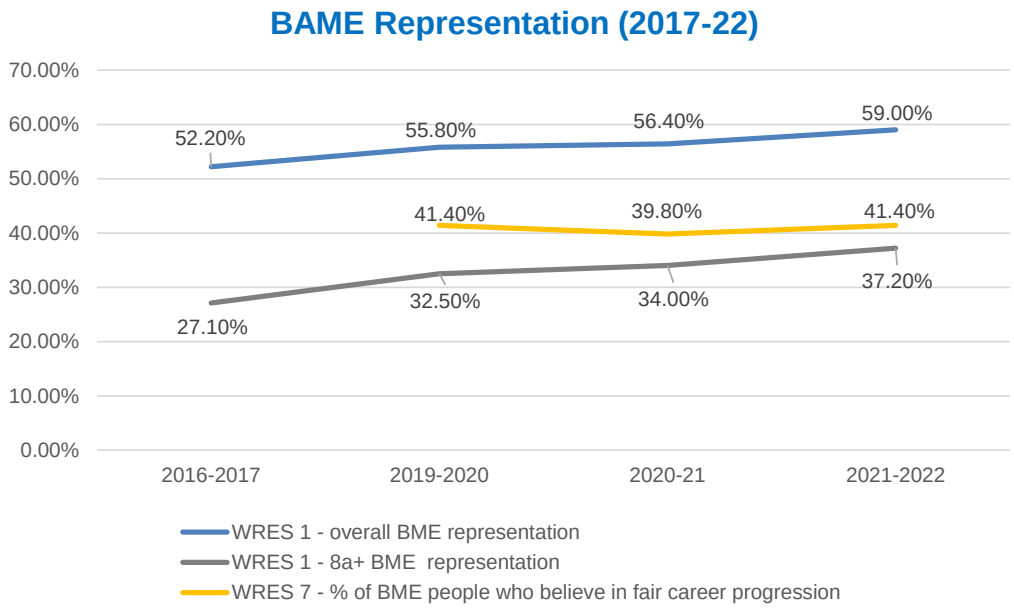
3. 2021/22 Narrative on WRES Metrics for Barts Health NHS Trust

Commentary of each metric:

Overall, 7 out of 9 metrics have shown an improvement in the last year. This improvement corresponds with the launch of our WeBelong Inclusion strategy, and that the related interventions may be starting to have an impact. Whilst there have been improvements in these 7 metrics, compared to white staff, BME staff are under-represented in the most senior roles , less likely to be shortlisted, more likely to face bullying or discrimination from colleagues (but not bullying from the public)

Metric 1: Representation

- The proportion of BME staff in the trust has grown overall. Between 2020/2021 the percentages of BME colleagues overall increased to 59%, up 2.6% from 56.4% in 2021/22
- The percentage of BME colleagues in 8a+ roles increased to 37.2%, this is up 3.2% from 34.0% in the previous year and has increased 10.1% since first reporting. This represents significant progress, with the current rate of growth above target to achieve our model employer goal.
- In 2021 national WRES report, on average, 8a+ BME leadership grew by 1.3% in the previous year, Barts Health growth in representation is almost 2.5x this figure (see section 3)



As outlined, **representation has grown consistently** at Barts Health year on year. Interestingly, the perceived fairness of career progress has not grown proportionately to this.

Metric 2: Appointments from Shortlisting

- The relative likelihood of White staff being appointed from shortlisting compared to BAME improved from 1.65x to 1.5x. This is a noticeable improvement, after remaining static for the previous 3 years, but demonstrates further work remains to make the process equitable.
- According to the 2021 national WRES report, the average relative likelihood of White staff being appointed from shortlisting compared to BAME staff has fluctuated between 1.57-1.61.
- Combined with WRES 1, this suggests that we are becoming better at attracting and appointing BME candidates which is leading to growth in BME numbers.
- Interventions that may have driven this improvement in the last year include:
    - Recruitment practices have been updated and reviewed,
    - Continued application of inclusion ambassadors at interview to provide unbiased decision makers
    - Working with the wider ICS and our community to understand how to better increase access to opportunities, including project search and healthcare horizons.
    - The launch of our cultural intelligence programme to acknowledge, and address personal biases to create a fairer culture overall

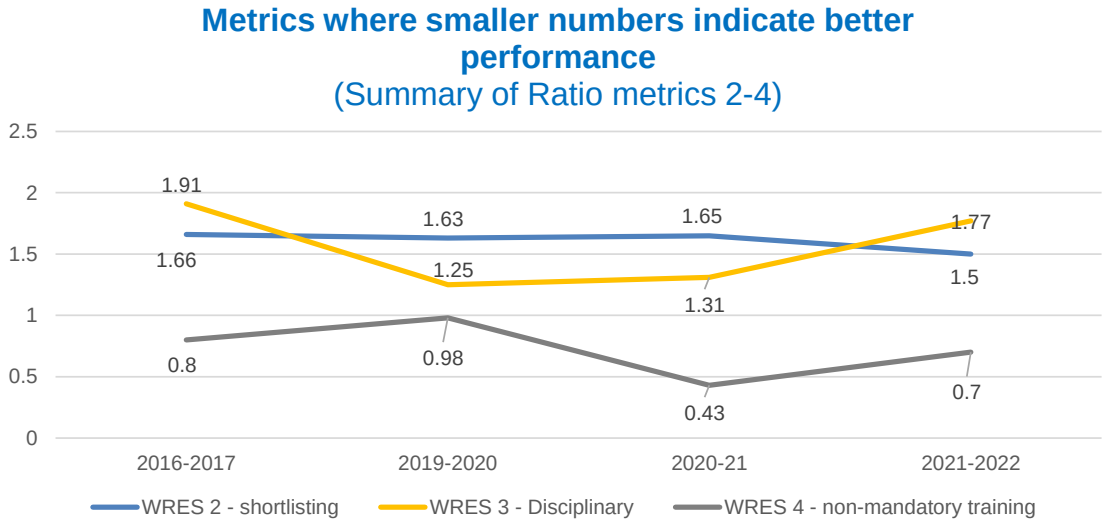
Metric 3: Disciplinary Process

- The total number of disciplinary cases for both white and BME colleagues has reduced significantly for the last two years. The total number of formal disciplinary cases fell from 81 in 2020/2021 to 36 in 2021/2022, a decline of 56%. This is due to our application of a Fair and Just Culture approach, and wider inclusion capability/awareness building.
- The total number of disciplinary cases in the Trust are now very small, meaning metric 3 becomes increasingly unreliable as a measure. This is because when we calculate a ratio with small numbers, even a change of 1 or 2 cases can have a big effect. When the numbers become so low, they are no longer statistically significant, which means they are not deemed a reliable measure, and that any change might be due to chance.
- By ethnicity, the number of cases involving white colleagues fell 62% and cases involving BME colleagues fell 40%. Therefore although fewer BME people are entering a disciplinary process overall, this has fallen more slowly than white colleagues, driving an increase in the ratio from 1.31 to 1.77.
- The fact that the number of formal cases involving BME colleagues has decreased is positive in itself, consistent application of our Fair and Just Culture process will be needed to ensure a further reduction in cases in line with white colleagues.
- We will also strengthen our informal speaking up processes to ensure we provide more avenues for resolution suitable to different needs.
- We have completed a recent learning review to understand opportunities for optimising our employee relation process, which will now include business partners working with sites to ensure an equitable and transparent approach.

Metric 4: Training

- BME people continue to have greater access to non-mandatory training. BME colleagues were more than twice as likely (0.43x) to access non-mandatory training than white colleagues last year, this has now reduced to a third more likely (0.7).
- There are different considerations in interpreting this change, which has positive and negative implications for example:

- A greater proportion of white colleagues picking-up non-mandatory training could lead to increased engagement with non-mandatory inclusion/cultural intelligence training which could have a positive impact on inclusion overall
- Even though proportionately BME colleagues access training more, the percentage of BME staff believing the trust provides equal opportunities for career progression or promotion is lower. This has implications for reviewing the content and applicability of our training, meaning we need to ensure quality, impactful career development programmes for BME people.
- Whilst BME people still access non-mandatory training proportionally more, the large increase in the proportion of white people accessing training will need to be monitored carefully to ensure this metric does not go above 1.0 to ensure equality.



Metric 5: Harassment from Patients

- BME staff experiencing harassment and bullying from both staff and service users has decreased consecutively in the last 2 years.
- The percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or public in last 12 months has reduced from 30.4% (2020 staff survey) to 28.2% (2021 staff survey).
- A lower proportion of BME staff now experience bullying and harassment from the public, than white staff.
- All sites saw an improvement for BME colleagues compared to last year, the biggest improvement was at SBH, down 5.5%, and the smallest improvement at WXH, down 0.5%
- A trust wide campaign was launched to address bullying and violence from patients, which included advice and speaking up helplines. This was accompanied by an antibullying patient facing campaign.

Metric 6: Harassment from colleagues

- The percentage of BAME staff experiencing harassment, bullying or abuse from staff decreased from 33.1% (2020 staff survey) to 31.4% (2021 staff survey)
- This is the third year bullying from staff has decreased, showing a strong positive trend at Barts Health.
- Although there have been improvements levels remain worse for BME colleagues compared to white (31% BME 27% for white), meaning 1 in 3 BME colleagues may experience bullying
- To ensure that this increase is genuine and not due to under-reporting, we are also exploring speaking up routes to staff, to ensure all colleagues are comfortable to report incidents both formally/informally

Metric 7: Career progression

The data collection for this metric has changed since last year, meaning the numbers included in previous WRES reports are no longer comparable. We have applied the new methodology for data from the previous 2 years to provide an accurate comparison.

- Based on the new measure, the proportion of BME colleagues who believe the trust provides equal opportunities for progression has improved from 39.8% (2020 staff survey) to 41.4% (2021 staff survey). This is in contrast to the national average trend, which has seen a 1% decrease.
- The percentage of BME colleagues believing the trust provides equal opportunities for career progression or promotion us 13.6% lower than White colleagues. The percentage of BME is comparable to 2019 levels, but we are optimistic this is a sign of a increasing trajectory.
- Barts Health has developed an inclusive career progression framework with a series of interventions to create sustained improvement in this metric, which includes:
    - Targeted development programmes for junior colleagues up to VSM,
    - Career conversation guidance and support for line managers
    - Increased stretch opportunities
    - A career mentorship and shadowing programme.
    - various cultural interventions to consider recruitment and advertising processes
    - Career events and roadshows to raise awareness
- Early feedback from these interventions has been positive, for example, 7 in 10 people completing the career mentorship programme said it had increased their chance of successfully securing a position, increased confidence, and increased their professional network.

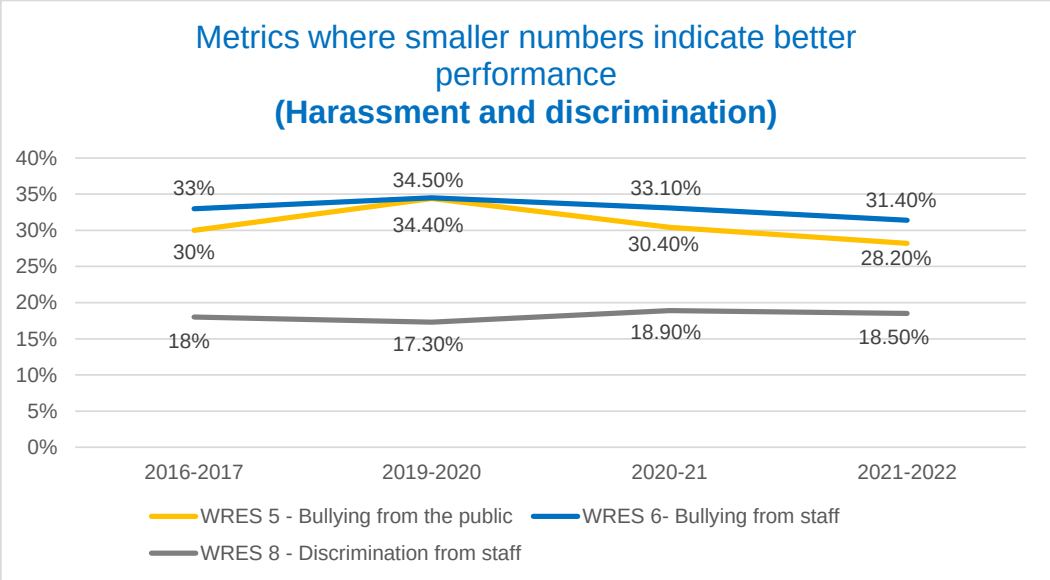
Metric 8: Experiencing discrimination

- The percentage of BME staff experiencing discrimination from a colleague or manager has improved slightly in the last year, from 18.9% (2020 staff survey) to 18.5% (2021 staff survey). This is in contrast to the 2.2% increase in discrimination seen nationally.
- Although this is a positive improvement, discrimination remains higher than it was in 2019/20, which may be an adverse impact of the covid working environment.
- In response to no significant positive trend in metric 8, we have outlined various interventions including:
    - Our cultural intelligence programme. The programme formally launched in April 2022, so is not covered in this reporting period, but its impact will be monitored in next years report. Early feedback shows a 62% increase in participants cultural knowledge

- Ensuring the expectations in our Dignity at Work policy are clearly communicated, and that behaviours that do no constitute our WeCare values are appropriately addressed.
- Continued review of speaking up routes, to ensure we have a culture of safety in raising concerns. We have reclarified routes to seeking support or resolution, and have been actively addressing behaviours where concerns have been raised.

Metric 9: Board composition

- After remaining unchanged for the last 3 years, the % BME on the Trust Board has increased to 17.6% from 12.5%
- Whilst being above the national average, the representation at board level is significantly lower than the organisation as a whole, with a 41% gap
- We have designed a FutureVSM programme as part of our inclusive career progression framework in order to improve representation in a targeted way, and are now taking a much longer term approach to succession planning, identifying potential opportunities in 12-24 months in order to create a talent pipeline that reflects the diversity of our organisation.
- Finally, we are reviewing board recruitment practices, to ensure a different approach that does not perpetuate a predominantly white board composition



Metrics on harassment/bullying have decreased from last year. Discrimination of BME staff decreased last year but remain similar to 2017 levels, whilst bullying from staff and the public has been on an improving trend for the last 2 years.

4. Complete WRES Metrics 2016-22

This table summarises current WRES data. Previous years are included in this table to understand any changes over time, **2016/17 is pulled out of sequence to help compare current progress to the first submission of data**. The last two columns includes the latest WRES data from the NHS as a whole. This is to help understand if any changes over the last year are part of the national direction, or unique to Barts Health. **The percentages quoted in graphics and coloured red/green indicate the change since the previous year for either Barts Health or National Average.**

WRES Metric	Barts Health				National WRES Data (average of all organisations - link)	
	2016/2017 First report for comparison	**2019/20**	**2020/21**	**2021/22** (change since last year)	National Average **2020**	National Average **2021** (change since last year)
1 - % Staff from BAME background	52.2%	55.8%	56.4%	59.0% **(2.6% improvement)**	21.1%	22.4% (**1.3% improvement**)
1 - % Band 8a+ Staff from BAME background	27.1%	32.5%	34.0%	37.2% **(3.2% improvement)**	7.9%	9.2% **(1.3% improvement)**
2 - Relative likelihood of White staff being appointed from shortlisting compared to BAME staff	1.66	1.63	1.65	1.5 **(0.15 improvement)**	1.61	1.61 (no change)
3 - Relative Likelihood of BAME staff entering the formal disciplinary process compared to white staff	1.91	1.25	1.31	1.77 **(0.46 increase)**	1.16	1.14 **(0.02 improvement)**
4 - Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff	0.8	0.98	0.43	0.7 **(0.27 increase)**	1.14	1.14 (no change)
5 - Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or public in last 12 months	30%	34.4%	30.4%	28.2% **(2.3% improvement)**	30.3%	28.9% **(1.4% improvement)**
6 - Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months	33%	34.5%	33.1%	31.4% **(1.7% improvement)**	28.4%	28.8% **(0.4 increase)**
7 - Percentage BAME staff believing the trust provides equal opportunities for career progression or promotion	Not available*	Not available*	39.8%	41.4% **(1.6% improvement)**	71.2%* (this figure uses an alternative calculation to those in the Barts Health column so is not an accurate comparison)	69.2%** **(1% decrease)** (this figure uses an alternative calculation to those in the Barts Health column so is not an accurate comparison)
8 - Percentage BME staff personally experiencing discrimination at work from a manager/team leader or other colleagues	18%	17.3%	18.9%	18.5% **(0.4% improvement)**	14.5%	16.7% **(2.2% increase)**

9 - % Board members from a BAME background	Not available	12.5%	12.5%	17.6% **(5.1% improvement)**	10%	12.6% **(2.6% improvement)**

Key:
Yellow: Metric based on less than 100 cases
*Does not take into account methodology change. This means that the figure should not be compared to others in the table as it has been calculated using a different approach, that yields a higher/lower result.

5. Action Plan Progress over 2021/22:

To drive the improvements seen in the data, Barts Health NHS Trust has established a robust form of governance to address opportunity areas within our inclusion agenda. A Group Inclusion Board is accountable for delivering objectives that align to London Workforce Race Equality Strategy, the NHS People Plan and other statutory reporting requirements. A dedicated Inclusion Centre drives the delivery of these objectives, and each hospital has a local inclusion committee that feeds into the board and addresses site specific considerations. The board is supported by six staff diversity networks. Last year's report outlined an action plan to address some of the disparities our WRES metrics have identified. We feel it is important to demonstrate how this action plan is being progressed. The following table includes commitments made last year, and what we have done to progress our ambitions:

Objective	Commitment in 2021 Action Plan	Progress/Next steps	Metric(s)
Leadership Development	**Currently underway** • Confirm dedicated resource for group wide cultural intelligence training • Deliver GEB and Trust Board cultural intelligence master classes (in addition to attending White Allies Programme) • Mass cultural intelligence webinars and dedicated site facilitators • Restart reciprocal mentoring programme and develop internal offer for sustainability **Planned to start 2021/22** • Design and agree a single integrated WeLead leadership programme with a golden thread of inclusion running throughout for kick-off in 2022 • Encourage adherence to training and explore protected time	• Launched an in-house cultural intelligence programme in May 2022, with hundreds of staff having already attended, including all group executive members. This programme will run into 2023 to reach more staff. Those completing the masterclass have reported a 60% increase in their cultural knowledge. • Assigned dedicated cultural intelligence practitioners to each site to work with hot spot areas • Agreed protected time for volunteer inclusion related roles and some inclusion training • Kicked-off a network development programme, due to last into 2023 to develop network leadership and ensure we are responding and listening to our members • Carried out various engagement activities, including the what matters to you survey, awareness events, and inclusion training to help present key themes to leadership for action • We will continue to scale this work throughout the next 12 months	2,3,4,5,6,8
Pause and Reflect Process	**Currently underway** • Continue to promote Just Culture and Dignity at work policies **Planned to start 2021/22** • Review and develop existing support provision Provide additional training to network leads to signpost staff to the most effective route	• Developing new Inclusion Signposter roles to increase confidence in, and access to speaking up routes • Completed Trust wide learning review to identify improvement opportunities in employee relation processes and tracking • Embedded employee relation case tracking and resolution monitoring into hospital executive governance structures • Assigning HR business partners to all hospital sites to take a consistent approach to employee relation cases and reduce any bias • Continue to refine Fair and Just culture approach	3,4,5,6
Enhanced appraisals:	**Currently underway** Ensure every member of staff has an inclusion objective (facilitated via the new appraisal process)	• Developed updated appraisal process to ensure all staff have an inclusion objective and wellbeing conversation, this is monitored indirectly through appraisal completion rates (part of our monthly inclusion board metrics) • Developed career conversation guidance for line managers, including a resource checklist for signposting staff to development opportunities	4,5,7

Progress Summary Continued:

Objective	Commitment in 2021 Action Plan	Progress/Next steps	Metric(s)
Career Advice and Talent Management	**Currently underway** • Develop talent management offer for under-represented staff • Continue to deliver career development workshops beyond cohort 38 **Planned to start 2021/22** • Provide access to 1-2-1 career coaching for BME staff	Launched our inclusive career development framework which included a variety of interventions outlined below: • Launch of career mentorship and shadowing service, with 100+ people completing the pilot, and 70% recording increased confidence having completed the process. BME staff are encouraged to access this service to be matched to their perfect mentor to receive 1-2-1 advice • Conducted various network led events on career development, attended by hundreds of staff • Organised a further 5 large scale career events due to kick-off in October 2022, covering specific challenges for BME people and general career advice (with e-learning to follow the events) • Launched inclusive career advice guidance and mentorship training videos • In addition to these events, we are scaling the more intensive BME career development programme with the continuation of cohort 38+, and increasing the number of trainers to deliver more sessions • Planned to deliver career conversation coaching to line managers to have richer conversations In addition to what staff can sign-up to already, further opportunities planned for 22/23 including a stretch opportunity framework to boost experiential learning and live job experience. Our plan for 2022+ is to increasingly scale these interventions and monitor impact.	1,4,7,9
Growing Ethnic Minority Workforce in 8a+	**Currently underway** • Support hospital level review of WRES data for local action plans **Planned to start 2021/22** • Double the number of active trained inclusion ambassadors to cover all 8+ panels and ensure protected time. • Ensure all members of GEB and HEBs conduct succession planning in their team to promote BME staff through to senior positions	Further opportunities in the framework above include: • Trust Succession planning – We are developing a succession planning guide, and asking all hospitals to identify upcoming senior positions expected to go to advert. This will be used to identify a pool of candidates who can opt into a talent list to receive support to develop competencies to apply for these roles in the future. • Future VSM programme (recruiting participants in November 2022 for 2023 launch), will take a small number of colleagues and prime them for senior roles identifies in succession planning • In the last year, we have continued to maintain over 170 inclusion ambassadors to sit on 8a+ panels as unbiased decision makers. We will continue to refine this process, as well as review board recruitment processes.	1, 2, 7 1,2,7 All Metrics

6. Closing Statement

Barts Health has seen an improvement across 7 of the 9 metrics. For many of these improvements, it represents a continued positive trend. 8a+ BME representation has been a particular success story, rising year on year, and has increased 10% since reporting in 2017. We have also seen that BME colleagues have good access to non-mandatory training year on year, and that bullying and harassment from both the patients and public have improved consecutively for the last two years, down to pre-covid levels.

We have also seen a promising improvement in a number of metrics this year, that across previous reports have remained static or fluctuated with no clear trend. Whilst it is too early to tell, we are optimistic that these improvements represent a shift in direction, following an intensive 12 months of interventions. These metrics include, relative likelihood of appointing from shortlisting, the percentage of staff believing in fair progression and the percentage of people experiencing discrimination.

These improvements are key achievements, but we must ensure we are not complacent. Their remains gaps between white and BME colleagues' experience at work across most metrics. Notably, we must ensure that both white and BME disciplinary cases are reduced at the same rate, even if numbers are now very small. We must also further embed an inclusive culture, to eliminate discrimination, and bullying from other staff, which is disproportionately directed at BME colleagues. Finally, after increasing representation at bands 2-9, we have designed an ambitious set of interventions that will aim to increase board representation in the long-term, where currently we are not representative of our community.

Barts Health accelerated and scaled our inclusion programme throughout 2021/22, which has been reflected in this years report. This work has included the launch of a cultural intelligence programme, enhanced inclusion capability building, the early phases of our inclusive career framework, strengthening staff networks and much more. We are now moving into the second phase of our WeBelong inclusion strategy, which further embeds our ambitions. Some of the actions have been outlined in the previous section, but the workforce facing elements of the strategy can be summarised as focusing on:

Cultural Intelligence

- Building the inclusion capability of our workforce through monthly learning and development, CQ masterclasses and events.

Career Development

- Empowering staff to access more opportunities and promote fairer career development through interventions as part of the inclusive career development framework.
- This includes career mentorship, development programmes, guidance to managers, targeted training and fairer recruitment, FutureVSM programme, succession planning, e-learning, shadowing and much more

Fair and Just culture

- Embedding inclusion into business as usual through policy, behaviour and process change with a focus on ensuring equitable treatment and mutual resolution in grievance and employee relation cases.

Staff Diversity Networks

- Working with networks to engage our people to be part of a social movement where everyone takes responsibility for embedding inclusion.
- Creating a network of inclusion volunteers to signpost staff to access support whenever it is needed.

Whilst we have a long journey to equality ahead, we hope this comprehensive programme will accelerate the initial positive improvements we have seen this year, to create a paradigm shift in inclusion.

This document provides just a snapshot of our work towards inclusion. To find out more about how we are supporting our staff with a disability, or to learn about our overarching inclusion strategy, please contact diversityninclusion.bartshealth@nhs.net

Appendix A: Model Employer Recommendations:

Background: The 2019 "*Model Employer: Increasing Black and minority ethnic representation at senior levels across the NHS*" report used findings from WRES nationally to create a commentary on representation across the NHS. The report outlines 3 scenarios to achieving representative leadership by 2023, 2028 and 2033. These scenarios were based on a national average of representation, and so would vary for any single trust in terms of the rate of changed required. The report was written from the NHSE perspective, with many of the priorities relating to actions for the centre, that are not specific to trusts. No specific targets were listed, the report instead recommended defining individual organisational goals for achieving representative leadership by 2028. For Barts Health, this would mean 3% year on year growth in 8a+, which has been achieved for the last 3 years. For VSM/board recruitment, an increased rate of change is required at Barts Health. Broadly, the report suggested the continuous use of WRES data/WRES action plans and various other high-level recommendations grouped into the following areas to create representative leadership:

- Leadership and cultural transformation
- Accountability and assurance
- Monitoring progress and benchmarking
- Positive action and practical support

The table below highlights how Barts Health have been taking action against recommendations in the report. Note: these recommendations were loosely defined in the report, have varying relevance for CCGs, ICS, Trusts and national bodies and have been adapted for the below summary, they do not appear as a formal list of targets in the national report.

Recommendation	Action at Barts Health
Leadership and cultural transformation	
Develop and communicate rationale for WRES and the leadership aspiration, aligned to national bodies	• WeBelong strategy has been communicated vi various channels and is embedded in Trust operating plans
Senior leaders mentor and sponsor BME staff at grades 8d and below	• Formal mentorship programme launched trust wide after a successful pilot with 100+ attending
Focus on culture and leadership across the NHS	• CQ programme launched in H2 2022, 50% of senior leaders (8d+) have completed CQ training.
Support for regional/ STP/ICO leaders on WRES and leadership aspirations	• Linked into regional and sub-regional (i.e Tower Hamlets Partnership) inclusion programmes
Demonstrate commitment to becoming an inclusive and representative employer - role modelling on race equality	• Various programme outlined in our WRES action plan, with WeBelong covering Cultural Intelligence , Career Progression, Networks, and Fair and Just processes
Recruitment drive on BME non-executive directors (NEDs) –	• Initiating review of recruitment and succession planning processes at board
Positive action and practical support	

Support and development of fit-for-purpose talent management programmes for BME managers; nurses and beyond	• Developed and launched inclusive career development framework with various interventions specifically for BME colleagues
Establish WRES expert leads within each of the seven NHS regions	• Part of WRES experts programme, with plans to increase the number of experts locally
Support for middle management staff across the NHS	• Developed guidance and training to support managers to promote career progression and supportive cultures
Diverse shortlisting and interviewing panels	• Applied Inclusion Ambassador model to all 8a+ interviews and piloted in SBH band 7 interviews
Batch interviews should be considered where appropriate	• Considering novel interview approaches through upcoming publication of inclusive advertising/selection guide
Promote success and share replicable good practice	• Shortlisted for various awards, and shared blueprints for replicating programmes via FutureNHS and communities' of practice (InclusiveHR)
Accountability and assurance	
Ensure progress on this agenda is infused within key policy levers for providers to build assurance and accountability for progress	• Provide monthly reporting at group level (via Inclusion Board) and at sites (EDI committees) on progress • Agreed formal set of targets integrated into group operating plan
Embed WRES performance and progress within performance objectives and appraisals of senior leaders	• Every member of staff should now have a personal inclusion objective as part of appraisals
Building the capability and capacity of BME staff networks across the NHS	• Planned launch of a network development programme in Nov 2022 • Formally agreed protected time for networks and allocated dedicated project support
Monitoring progress and benchmarking	
WRES processes for data collection and publication	• Annual public reporting on WRES, with corresponding action plan
Produce ethnicity pay gap data as part of existing annual WRES data reporting	• Published ethnicity pay gap for the last 2 years

Barts Health NHS Trust

Report to the Trust Board: 5 October 2022	TB 66/22

Title	Whipps Cross Redevelopment
Accountable Director	Whipps Cross Hospital CEO
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 July 2022, the Trust Board received a report 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 proposals for an Academic Centre for Healthy Ageing; and an update on the Government's New Hospital Programme (NHP). This paper provides an update on: the next stage of enabling works and the NHP; the integrated delivery framework, including our commitment to report progress on the journey to a new Whipps Cross hospital; and a communications and engagement update, including work to inform the new model of end of life care.

Related Trust objectives

- SO3 Service Transformation
- SO5 Improving our Infrastructure

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:

- approval for the next phase of enabling works, which is critical on our journey to a new Whipps Cross hospital;

- the update on the New Hospital Programme;

- progress made in mobilising the integrated delivery framework, including the development of an insight and intelligence function and first steps in the process for establishing an annual report charting the progress of key transformation programmes, both of which will be important in our continual evaluation of our future capacity assumptions; and

- the ongoing communications and engagement activities to support the redevelopment and the key transformation programmes.

Barts Health NHS Trust

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 5 OCTOBER 2022

WHIPPS CROSS REDEVELOPMENT PROGRAMME

INTRODUCTION

1. In July 2022, the Trust Board received a report 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 proposals for an Academic Centre for Healthy Ageing; and an update on the national New Hospital Programme (NHP).

2. This paper provides an update on: the next stage of enabling works, the business case for which has received backing from the previous Secretary of State for Health and Social Care and the NHP; an update on the NHP; the integrated delivery framework, including our commitment to report progress on the journey to a new Whipps Cross hospital; and a communications and engagement update, including work to inform the new model of end-of-life care across the Whipps Cross catchment area.

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 that has been reported previously, we continue to await further details from the national 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. However, a new milestone has now been reached with the approval of the next phase of our enabling works.

NATIONAL SUPPORT FOR THE NEXT PHASE OF ENABLING WORKS

4. On 18 August, the next phase of enabling works for the redevelopment of Whipps Cross Hospital received backing from the then Secretary of State for Health and Social Care and the NHP.

Barts Health NHS Trust

5. Phase two of the enabling works includes construction of a new 500-space multi-storey car park and other site-wide infrastructure works to improve access to the site. These works need to be completed before work on constructing the new hospital itself can begin.

6. We are working with NHP colleagues to confirm the timeline for release of funding and commencement of works.

NEW HOSPITAL PROGRAMME UPDATE

7. As we reported in July, we await further details from the NHP team about the next steps for our programme.

8. In the meantime, the NHP team has secured approval of its programme business case that strengthened 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. In respect of the plans for the new Whipps Cross Hospital and other similar proposals across the country, the programme business case did not provide scheme-specific assessments or endorse any agreed funding envelopes for individual schemes.

9. We will continue to work closely with NHP colleagues over the coming period to understand the next steps and to help shape NHP thinking. In the meantime, we understand that a further programme business case is now being developed which, amongst other things, will aim to secure an agreed position on the Whipps Cross programme, including a timeline for submission and approval of the OBC, the agreed route to appointing a construction partner for the main works and the overall capital envelope for delivering the new hospital.

AN INTEGRATED DELIVERY FRAMEWORK AND REPORTING ON PROGRESS

10. Working with our local health and care partners, we have mobilised a new integrated delivery framework to oversee the planning and delivery of service transformation across the Whipps Cross catchment area and accountable to the Integrated Care Board for North East London.

11. In July 2022 we, on behalf of our partners, published a summary of the integrated delivery framework plan for 2022/23. The document outlined the priority themes and key service transformation programmes for Whipps Cross and the hospital's wider catchment area.

12. At the Trust Board meeting on 6 July, we said that an insight and intelligence function would be developed as part of the framework. This work is progressing and, by October, there will be an agreed set of measures and metrics for the integrated delivery framework that reflects its three themes: (i) to keep people as healthy as possible to minimise unplanned hospital attendance; (ii) to minimise the need for hospital admission when people do need care and treatment; and (iii) when people are admitted to hospital for care and treatment, to minimise the time people spend there, with the best possible care and overall experience.

13. We are committed to publishing the first of a series of reports in 2023 to chart the progress of key transformation programmes and to be a key part of the continual evaluation of our future capacity assumptions - including overnight inpatient beds - for the new hospital. The report will cover both hospital and non-hospital activity, including primary care and social care.

14. We remain committed to working with a broad range of stakeholders - including staff and patient, public and community representative groups - to ensure measures of progress are reflective of the voices and experiences of patients and the diverse communities across the Whipps Cross catchment area. The first meeting with stakeholder representatives will be held on 29 September, with a workshop session planned for November.

COMMUNICATIONS AND ENGAGEMENT UPDATE

15. We continue our work to communicate and engage with our communities and with our local political representatives. Since the last board meeting, we have:

- hosted a visit to Whipps Cross by the previous Secretary of State for Health and Social Care, the Rt Hon Steve Barclay MP;
- produced a further redevelopment newsletter, in both digital and hard copy forms (to be published during week commencing 12 September); and
- brought together local health and care partners to strengthen collaboration on communications and engagement work as a key enabling workstream for the integrated delivery framework's priority transformation programmes.

16. We and local partners have been seeking the views of key stakeholders to inform the development of a new model of enhanced end-of-life care for the Whipps Cross Hospital catchment area. Up to now, interviews and focus groups have taken place with nine community groups who support people with a life-limiting condition or who support carers of people with a life-limiting condition. In addition, an

independent facilitator was commissioned to carry out confidential interviews with people from across Redbridge and Waltham Forest who are experiencing life-limiting conditions or bereavement; and a specialist language organisation has also enabled ten confidential interviews to be carried out with people for whom English is not their first language. Further conversations will be undertaken between now and the end of September.

17. At the time of writing, we and partners have prepared a presentation for a meeting of the Whipps Cross Joint Health Overview and Scrutiny Committee on 13 September, outlining progress to date on the development of the end-of-life care model.

CONCLUSION AND RECOMMENDATIONS

18. The **Board is asked to note:**

- approval for the next phase of enabling works, which is critical on our journey to a new Whipps Cross hospital;

- the update on the New Hospital Programme;

- progress made in mobilising the integrated delivery framework, including the development of an insight and intelligence function and first steps in the process for establishing an annual report charting the progress of key transformation programmes, both of which will be important in our continual evaluation of our future capacity assumptions; and

- the ongoing communications and engagement activities to support the redevelopment and the key transformation programmes.

Report to the Trust Board: 5 October 2022	**TB 67/22**

Title	Infection Prevention and Control Annual Report 2021 – 2022
Accountable Director	Group Chief Nurse / Executive Director of Infection Prevention & Control
Author(s)	Clinical Director of Infection Prevention & Control
Purpose	For members to be assured on all aspects of infection, prevention and control for the Trust and satisfied with the proposed measures in place to mitigate risk
Previously considered by	Reported to the Trust Infection Prevention & Control Committee and assurance received by the Trust Quality Board

Executive summary
To provide an update of the Trust performance in relation to Infection Prevention and Control activities for the last financial year 2021 / 2022.

Related Trust objectives
Reduce avoidable MRSA bacteraemia by 50%.

Risk and Assurance	This report provides assurance in relation to objective SO2.

Legal implications / regulatory requirements	To comply with the Health and Social Care Act 2008 (update 2015) and register with the Care Quality Commission (CQC).

Action required
The Board is asked to note the key points set out in this paper and the actions in place to mitigate any risks to the quality of patient care.

CONTENTS

Executive Summary and Overview

The Trust has a statutory responsibility to be compliant with the Code of Practice 2015 (known as the Hygiene Code), as required by the Health & Social Care Act (2008) [1]. Under this Act the Board of Directors are required to receive an annual report from the Director of Infection Prevention and Control (IPC). The content of the Annual Report highlights the organisation's progress against both national legislative assurance tools and related infection prevention guidance from other national bodies. The Annual Report also identifies areas of focus for the financial year 2022-23. This report details Infection Prevention and Control activity from 1st April 2021 to 31st March 2022, outlining key achievements, and is presented in context of being the second year of the COVID-19 pandemic.

The prevalence of COVID-19 decreased during the summer months of 2021. The dominant variant (which was Delta at that time) was not associated with significant morbidity and mortality in part due to the widespread uptake of vaccination as part of the national programme. There was a surge in the number of in-patient cases in late December 2021 and January 2022 to the rapid spread of the highly transmissible Omicron variant.

Throughout 2021/2022 the Trust continued to respond to the continually fluctuating levels of the background prevalence of the COVID-19 virus maintaining a balance of risk between patients who were admitted on COVID-19 and non-COVID-19 pathways. This report acknowledges the hard work and diligence of all our staff, clinical and non-clinical who play a vital role in improving the quality of patient care and experience as well as helping to reduce the risk of infections. Staff have supported visitors and colleagues to implement policies and procedures to reduce the risk of transmission of COVID-19.

The report also reflects the COVID-19 Board Assurance Framework[2] which was first issued by NHS England / Improvement the previous year. It is set out using the Hygiene Code framework, and this annual report also provides assurance of compliance with this framework.

Many of the control measures required to prevent the spread of COVID-19 build upon existing infection prevention practices. Therefore, the measures we have taken during 2021 - 22 to prevent spread of COVID-19 have also been improvements which help us to prevent the spread of other infections.

The report also sets out our priorities and plans to achieve further improvement and reductions in infection during 2022 - 23 as we move beyond the challenge of the COVID -19 pandemic.

Key achievements

The Group Infection Control Committee (GICC) has corporate responsibility for overseeing the implementation of Infection Prevention and Control activities. During 2021/22 the GICC met four times during the year, chaired by the Group Chief Nurse (GCN) / Executive Director of Infection Prevention Control (EDIPC).

The Group Chief Nurse/EDIPC commissioned an end of year review for each hospital which was presented at the GIPCC. The reviews represented an opportunity to reflect on the previous year, focus on activity and performance, celebrate achievement, and understand lessons learnt.
The Trust Infection Prevention and Control Team (IPCT) were invited to provide IPC advice and guidance to St Joseph's Hospice and the North East London (NEL) Urgent Treatment Centre through a Service Level Agreement (SLA).

The IPCT's were nominated for Bart's Health Heroes, with the Newham Team shortlisted as one of the finalists in the collaborating section for their response and support across the Trust during the first year of the pandemic.

The infection prevention response to the pandemic was led by the Director of Development on behalf of the Group Chief Medical Officer. There were two meetings a week to manage the COVID-19 response and COVID-19 recovery.

The IPC Board Assurance Framework (BAF) was extended to incorporate seasonal respiratory infections, Influenza and Respiratory Syncytial Virus (RSV), as well as SARS-CoV-2 in health and care settings for winter 2021 to 2022. The BAF was reviewed regularly in line with each new version and presented to the Quality Board. Mitigating actions were implemented to address any gaps in assurance.

In July 2021 the Government announced a new phase in the response to the pandemic, moving away from stringent restrictions on everyone's day-to-day lives, towards advising people on how to protect themselves and others, alongside targeted interventions to reduce risk. Whilst COVID-19 restrictions ended in many settings, UK Health and Security Agency (UKHSA) Infection Prevention Control guidelines remained in place for staff and visitors across all healthcare services.

The focus of national guidance moved towards a risk-based approach in healthcare facilities. Clinical areas were asked to undertake a local risk assessment using the Health and Safety Executive (HSE) Hierarchy of Controls. The risk assessment was undertaken locally, documented, and reviewed at regular intervals.

Responding to the surge in cases of the Omicron variant in the New Year required the Trust to move to another temporary phase regarding the principles of IPC guidance. There were several areas where a change in practice was introduced to support flow of patients and ensure patient safety.

There was continuous surveillance of all COVID-19 positive cases undertaken by the IPC surveillance team. The daily COVID-19 data was circulated at all levels across the Group. Each case was reviewed by the IPC nursing team to ensure that all aspects of IPC standards were being followed and any further actions required put in place.

If a case formed part of an outbreak, (defined as two or more cases of Hospital Onset COVID-19 Infection (HOCI) in a ward within a two- week period), an outbreak was declared, and control measures implemented. Daily updates on outbreaks were circulated across the Trust. Each outbreak was reported to NHSE/I and monitored daily for 28 days.

In March 2022, in line with national recommendations the Trust reviewed COVID-19 guidance on screening, testing and isolation of patients based on a risk assessment, that took into consideration the reduced virulence of the circulating variant and the need to admit patients on other pathways.

In addition, staff were no longer required to undertake PCR testing, (Pillar 2 PCR testing is no longer available), Staff were expected to continue to test using LFD twice a week and record the outcome on the government portal, where tests can also be ordered. In areas of high risk such as haematology or renal, weekly PCR testing continues.

In April 2021, a guidance document by NHS England/Improvement London was published, describing the process for undertaking an enhanced structured judgement reviews (SJRs) for those patients who

had died from hospital onset Covid-19 infections (HOCI). Lessons learnt were showed at the Trust Mortality meeting and disseminated through the BH governance meetings.

In March 2020, a strategic decision was made to restrict visiting across the Trust aligned to the national guidance produced by NHSE/I to protect patients and staff by reducing footfall to minimise the transmission of COVID-19. The visiting guidelines were shared on our intranet site with the community. Our visiting guidance supports a compassionate approach by facilitating visiting in specific circumstances, In late March 2022 reflecting the changes in the level of circulating virus, the guidance was updated to allow a more flexible and welcoming approach to supporting visitors return into the healthcare setting to visit patients.

Water sampling for Legionella and Control of Legionnaires' disease was undertaken in accordance with COSHH Regulation (2002), Approved Code of Practice L8, Health Technical Memoranda (HTM-04) and Health & Safety Guidance (HSG) 274 across Trust sites. Remedial action was successfully undertaken on outlets that did not meet the required standard.

The review of areas classified as Augmented Care for the purpose of sampling for *Pseudomonas* took place across the ORC and WTWA sites and was agreed by Water Safety Groups. Agreed schedules of sampling for *Pseudomonas* were produced and sampling continued in accordance with HTM04-01 Part C.

The management of Ventilation Systems was undertaken in accordance with HTM 03-01 Specialist Ventilation for Healthcare Premises and HSG 258; this includes the design, maintenance, and operation of ventilation systems. The Group Ventilation Systems Management Safety Policy has been revised to take account of the changes in HTM 03-01: Specialised Ventilation for Healthcare Premises which was published in June 2021.

The decontamination services provided by Steris are based at The Royal London Hospital. The decontamination service provision to the Trust has been maintained to an acceptable and satisfactory level during this period.

In accordance with the requirements of the IPC Board Assurance Framework (BAF) Trust fit testing records are now held centrally. This service is funded centrally and provided by an external provider, Sunbelt.

The COVID-19 vaccination programme commenced in December 2020. All front-line staff in the Trust were offered a COVID-19 vaccination. By the end of March 2022 we had delivered the following doses of the COVID 19 vaccine.

Vaccination	Count of course
COVID-19 1st Dose	22528
COVID-19 2nd Dose	20389
COVID-19 4th Dose	7
COVID-19 Booster	13954
COVID-19 Single Dose	13
COVID-19 Vaccination Medical Exemption	7
COVID-19 Vaccination Temporary Medical Exemption	7
Grand Total	**56905**

Key challenges

Once more in 2021-22 Bart's Health staff worked tirelessly in response to the pandemic, protecting with the COVID-19 vaccination programme, provided outstanding care for all our patients in hospital, and setting up new services for those who go on to experience long-term issues as a result of COVID-19.

Concomitantly we have done everything possible to keep our services going and to start to reduce backlogs using "Living with COVID" guidance. This is alongside our emergence from the latest wave of COVID-19 pandemic.

Going forward we will need to ensure that we minimise the risk of outbreaks of viral illness in our hospitals as we prepare for winter.

The rate of our alert organisms: Gram positive (*S. aureus*), Gram negative bacteraemias and *Clostridioides difficile* infection (CDI) have not reduced over the year.

The Trust Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia target is zero. In 2021/22 the Trust reported cases of 9 MRSA bacteraemia. Many of these were again related to device management.

Risk of a major infection/outbreak – this is a risk for any service and remains on our Risk Register for Whipps Cross and Newham Hospitals, where there were a number of outbreaks of COVID-19 infection in 2021 - 2022.

Certifying that the environment is maintained in good physical repair and condition is a continuous challenge not only due to the age of some of our estate but also with in our PFI's as they start to age. The auditing of the 2021 cleaning standards across the Trust may help us pick these up, the maintenance of the environment and cleaning standards remains a risk as we in-house soft services.

We continue to be challenged by our medical, nursing and support IPC staffing levels, a feasibility options appraisal paper was signed off by the Trust and we are now progressing this to a full business case. The current nursing, medical and support staff resource is currently insufficient to provide a proactive service.

Key plans for 2022/23

We will prioritise four key work streams over the course of 2022-23: (1) the resourcing of the Infection prevention and antimicrobial stewardship Team (business case / funding), (2) a refocus on safety - the quality Improvement projects (improvement to peripheral lines insertion / on-going care, gloves off campaign (reducing glove use, a focus on hand hygiene and reducing transmission), devising and implementing the catheter passport across NEL to reduce gram negative bacteraemias (3) continued recovery of services (4) preparing for this winter and winters beyond. COVID-19 will still be with us in 2022-23 and will still need to be managed, with the vaccination programme continuing and care being maintained for people who require hospital care or support to manage longer term symptoms following COVID-19 infection. We must also be prepared for any further peaks that may occur as the pandemic runs its course and other viruses that will impact on care delivery over the winter. In conjunction with the response to COVID-19, it is essential we prioritise recovery: improving access to services, reducing backlogs and focusing on basic fundamental of care delivery.

An annual programme is prepared by the Clinical Director of Infection Prevention and Control, agreed by the Infection Prevention and Control Committee and ratified by the Quality Board.

The programme of work is mapped to the duties of the Code of Practice thus validating the continued work to maintain compliance with the Code. Bart's Health vison and strategic aims, values, and Group and clinical service strategies, form the framework within which the Annual Plan is developed. The plan is also shaped by national plans and strategies, in particular the priorities set for the year by NHS England / Improvement.

In the coming year, the focus is on the challenge of restoring services, meeting new demands, and reducing the backlogs that have built up a result of the pandemic. Equally important is maintaining a focus on workforce and prioritising staff health and wellbeing.

The annual programme is a dynamic programme and often work streams are added to it within the year in response to unforeseen national and local drivers.

2022 'Flu / COVID 19 Campaign

On the 25th of February, the World Health Organization (WHO) finalised its recommendations for the Northern Hemisphere's 2022-23 influenza season vaccine, it was made within the context of the on-going COVID 19 pandemic, which led to record-low levels of influenza detections reported. Having fewer flu cases has its drawbacks for the next flu vaccine. Each year scientists look at the circulating strains of influenza globally, and then predict which strains are likely to be prevalent the following year and thus which to include in the flu vaccine. But with so few cases this year, there is less data on which to base their decision.

Influenza has not gone away. Australia is seeing an early flu season, with pre-pandemic prevalence, high hospitalisation requirements and a percentage of these patients requiring intensive care. The country is in a unique position being one of the first countries to face Covid and a simultaneous flu season that is similar to pre-Covid levels. We will monitor their flu season closely and learn from the successes or failures.

Looking at the UK, this may mean that our incidence of Influenza may be even greater than pre-Covid levels if we get an early spike in cases because people have not had the usual boost to their immunity from exposure to the flu virus, either from having had the vaccine or from coming into contact with the virus and developing antibodies against it.

Currently NHSE and UKHSA are considering if a 4th COVID-19 vaccine is required and if this can be administered concurrently with the seasonal influenza vaccine. The outcome of these discussions will support the approach to our campaign.

The Trust has taken the lessons from the 2021/2022 campaigns and continues to work towards the concept that all those eligible should be given a flu vaccination as soon as possible so that individuals are protected as early as possible. The IPC Team also provides support directly to clinical teams in collaboration with Pharmacy and Employee well Being to improve on uptake of the influenza vaccine to 'at risk' people using our services.

Winter

We build on our learning each year, and in particular from the pandemic, that resilient infection prevention and control arrangements are required to mitigate winter pressures. For the last 2 years during the coronavirus (COVID-19) pandemic we have had the largest NHS influenza vaccination

programmes ever. We have also seen some of the best influenza vaccine uptake levels ever achieved in many of the cohorts, with more people vaccinated than ever before.

As a result of non-pharmaceutical interventions in place for COVID-19 (such as mask-wearing, reduced social interactions and international travel) influenza activity levels were extremely low globally in 2020 to 2021 and at present continue to be low even with a late increase in activity, it did not impact on our services.

As society behaviours returns to pre-pandemic norms there is likely to be resurgence in influenza activity in winter 2022 to 2023 to levels similar to or higher than before the pandemic.

The potential for co-circulation of influenza, COVID-19 and other respiratory viruses could add substantially to pressures in the NHS in 2022 to 2023, by addition, or by prolongation of the overall period for which respiratory viruses circulate in sequence.

Challenges remain around availability of single rooms; in both Whipps Cross and Newham, we plan to mitigate this during winter season by establishing cohort bay / ward as additional capacity.

Healthcare Associated Infections

- Participating in the NEL catheter passport initiative looking at an improvement across the system to reduce *E. coli* and other gram negative bacteraemias.

- Using a Quality Improvement approach to:

    - Roll out the "Gloves Off" campaign to improve compliance with Personal Protective Equipment and Hand Hygiene.

    - Improve our compliance with line related care to support reduction of both Gram positive (*S. aureus*) and Gram negative bacteraemias.

Health and Safety

- We continue to apply the hierarchies of control to clinical areas ensuring we understand the risks associated with having infectious patients cared for in these areas.

Recruitment and business planning

- We are working on a Trust-wide business case to increase the resource of the wider infection prevention and control team to ensure we can deliver a robust and safe service, and align our establishment closer to other London Trusts. The business case will be presented to the Investment Steering Group this financial year.

Introduction

This report demonstrates how the Trust Infection Prevention and Control (IPC) team has engaged in Health Care Associated Infection (HCAI) Prevention and Control during the period 2021-2022. This year has continued to pose a challenge, not just to the Trust but the wider Integrated Care System with respect to the management of the COVID-19 pandemic. The team continue to embody The Bart's Health values, working hard to keep the patient at the centre of everything we have achieved and ensuring staff safety was paramount.

The IPCT were fully engaged in keeping patients and staff safe during the second year of the COVID-19 pandemic, 2021-2022, much of which has been achieved in conjunction with partner organisations. On reflection, there has been some return to normal IPC activities, the pressures of the pandemic on our team and the Trust in general, with IPC workload and continued staff absences through the on-going waves, have meant that overall, our healthcare associated performance has not been where we would have preferred it to be compared to our local and national peers. Wherever possible and as requested, we have continued to help with planning and managing elective activity to try to reduce the backlog created by the pandemic.

Governance Arrangement

Once again, the IPC team has been fully occupied keeping staff and patients safe during the second year of the COVID-19 pandemic though other infections and areas of prevention have also required attention. IPC requires constant vigilance and agile responses. The importance of the infection prevention and control standards being delivered to the highest possible level was emphasised as we observed rises in infections posing challenges to our Trust for staff and patients.

Site based Infection Prevention Groups, chaired by the Hospital Director Infection Prevention & Control (HDIPC), is informed by COVID-19 the steering group and report into the Trust Infection Prevention & Control Committee. This enhanced governance structure provides opportunity for discussion around localising and implementing the changing guidance. Improving our ability to confirm a consistent and more agile awareness of the rapidly altering response to the pandemic.

Integrated governance, risk management and internal control

The Trust IPC response to the pandemic was led by the Group Chief Nursing Officer (GCNO) supported by the Group Chief Medical Officer (GCMO). In September 2021, the agenda changed to combine our approach to response and recovery and these meetings chaired by the Director of Improvement were held two to three times a week depending on our need.

In July 2021 the Government announced a new phase in the response to the pandemic, moving away from stringent restrictions on everyone's day-to-day lives, towards advising people on how to protect themselves and others, alongside targeted interventions to reduce risk. Whilst COVID-19 restrictions ended in many settings, UKHSA Infection Prevention Control guidelines remained in place for staff and visitors across all healthcare services. The focus of national guidance moved towards a risk-based approach in healthcare facilities.

In line with Government guidance, everyone accessing or visiting healthcare settings across the Trust were still required to continue to wear a fluid resistant facemask (FRSM), to reduce the risk of infection with COVID-19 to themselves and others. The use of FRSM in non- clinical buildings across the Trust did not cease until March 2022.

All staff undertaking/assisting with an Aerosol Generating Procedure (AGP) were required to wear an FFP3 respirator, (for which they had been fit tested). In addition, staff were encouraged to make a personal risk assessment when choosing whether to wear an FFP3 respirator.

Clinical areas were asked to undertake a local risk assessment using the Health and Safety Executive (HSE) Hierarchy of Controls. The risk assessment was documented and reviewed at regular intervals and included:

- Increasing ventilation by opening windows, putting extractors into window, use of air filter machines
- Encouraging patients and visitors to wear a FRSM.
- Reviewing the number of people in one room/area to allow for social distancing
- Encouraging staff to have the vaccination and perform twice weekly lateral flow testing to protect themselves and others

In November 2021 IPC guidance for health and care settings during the COVID-19 pandemic was updated. The overall theme of the new guidance was to move to a broader strategy of managing seasonal respiratory viral infections, including COVID-19 but also other infections such as Influenza and Respiratory Syncytial Virus (RSV). There was an emphasis on local decision making around patient pathways and management of risk. The guidance was used to update local policy. The key points included:

- Removal of the COVID-19 high, medium, and low risk care pathways so that everyone without symptoms of a respiratory illness would follow the same precautions, such as at least 1 metre physical distancing instead of 2 metres
- Physical distancing reduced to at least 1 metre, increasing whenever feasible to 2 metres, for non-respiratory patients across all health and care settings – this could expedite the faster treatment of people with non-respiratory conditions across health and care settings
- Screening, triaging, and testing for COVID-19 continued. All patients were screened on admission and on days 3, 5-7 and in accordance with BH policy every 7 days thereafter
- The inpatient isolation period for COVID-19 cases or contacts is reduced from 14 days to 10 days, except for those patients who were immuno-supressed

Responding to the surge in cases of the omicron variant in the New Year required the Trust to move to another temporary phase regarding the principles of IPC guidance. There were several areas where a change in practice was introduced to support flow of patients and ensure patient safety. The new BH Spring guidance for Managing SARS-CoV-2 Omicron wave were based on updated national and London guidance. Changes/additions to IPC precautions included:

- Cohorting of patients who had been exposed to COVID-19 during their in-patient stay (contact cases) inpatient isolation period for COVID-19 cases or contacts is reduced from 14 days to 10 days
- Mixing cohorts of exposed patients on designated wards to increase bed capacity
- On declaration of an outbreak the ward was assessed by the outbreak management team and depending upon the number of patients identified as COVID-19 positive ward may have remained open. Staff screening during outbreaks ceased.

This guidance was altered further in March 2022 as although COVID-19 continued to circulate, the current variant appeared less virulent and most in-patients who were found to have COVID-19 were asymptomatic. Those who were symptomatic had significantly reduced severity of illness.

The Group Chief Nurse Officer (GCNO) / Executive Director of Infection Prevention & Control (EDIPC) commissioned an end of year review for each Hospital within the group. The HDIPC shared their review at the Trust Infection Prevention & Control Committee.

The Trust's Infection Prevention and Control structure (see **Appendix 1**) supports frontline staff in the delivery of clean safe care. It promotes and monitors robust IPC practices, ensuring it is of sufficiently high standards.

Specialist advice is provided to clinicians throughout the hospital by the IPC Team. A Consultant Microbiologist is the designated Lead Infection Prevention and Control Doctor (LIPCD), the other Infection Diseases / Microbiology / Virology consultants provide reactive support for operational issues. Out of hours advice is provided by a Specialist Registrar or Consultant in Microbiology, this arrangement ensures the Trust has 24 hour cover 7 days a week. We are also mindful of a significant resource deficit that is detailed in a business case which will be progressed this financial year.

Our newly designed Trust IPCC has enjoyed a very successful year with good attendance from each hospital; lessons learnt shared, and our forward plan is to work in a system going forward, this is reflected in our working alliance with the two acute providers in North East London

Board Assurance Framework

NHS England/Improvement (NHSE/I), continued to further develop the IPC Board Assurance Framework (BAF) to support all healthcare providers to effectively self-assess their compliance with UK Health Security Agency (UKHSA) Infection prevention and control policies and procedures.

The IPC Board Assurance Framework (BAF) was extended to incorporate seasonal respiratory infections, Influenza and Respiratory Syncytial Virus, as well as COVID-19 in health and care settings for winter 2021 to 2022. The BAF was reviewed regularly in line with each new version and presented to the Quality Board. Mitigating actions were implemented to address any gaps in assurance.

Procurement contracts

Infection prevention and control has implications for the whole Trust and their advice is important in ensuring that the risk of infection is minimised. The IPCT continued to play a pivotal role in reviewing new stock and equipment purchased on behalf of the Trust. We are also consulted in materials for refurbishments across the Trust.

Policies

All IPC policies, procedures and guidelines are available for staff to view on the Trust Intranet.

Implementation of the new UK Health Security Agency (UKHSA) CPE policy is underway. We are working with the Microbiology laboratory to ensure that there is adequate capacity for testing and to be sure the laboratory is fully equipped and staffed and therefore ready to deal with the projected increase in samples being received.

During 2021-22 we made some progress on revision of outstanding policies. Due to the demands and changing guidance during the ongoing pandemic our policy focus was directed at responding to changes in COVID-19 guidance. However, we were able to review almost all outstanding policies during the end of 2021 -22 and the early part of 2022 -23.

We monitor adherence to a number of our Key Standards to Prevent Infection with a programme of quarterly auditing via our electronic system with reporting in real time. The national High Impact Intervention audit tools issued by NHS Improvement have been used as the basis for the monitoring tools. The compliance information is included routinely within divisional reports to the Hospital Infection Prevention Groups, supporting detailed review of good practice as well as identifying areas which require further support to achieve the standards expected. As part of our annual review, we will launch the Key Standards to Prevent Infection for 2022-23.

Progress Summary of the Annual Programme of Activities (APA)

The Trust continues to have a comprehensive programme of infection prevention and control activities; this is available from the IPCT. The plan is divided into ten key work streams reflecting the Health and Social Care Act 2008 (updated 2015) and thus supports our declaration of full compliance with the act. Most actions are on-going and progress is reviewed at Hospital IPC Groups and by exception at the Trust-wide Committee.

Each hospital marks themselves against their action for progress and assurance information, this is presented quarterly at the Hospital IPC Groups.

In addition to the work streams related to delivery of the Health and Social Care Act, the annual programme of activities focuses on actions required to meet key priorities for the reduction of HCAIs. In 2021 – 2022 we used a bundle approach, grouping specific actions staff may concentrate on within their hospital that would reduce the risk of infections. Due to our staffing levels we were unable to sustain this and had to focus on our response to COVID and restarting services.

Development of IPC Practices and Education and Training of Staff

Throughout 2021 - 22 we continued to require all staff to complete the electronic mandatory training rather than face-to-face sessions, in order to reduce the risk of COVID-19 infection. Ward-based training and electronic resources have remained in place to support staff respond to the pandemic during the year.

This has included FFP3 mask fit testing, and correct selection, donning and doffing of personal protective equipment. We continue to utilise national training resources which are available as well as **bespoke** packages tailored to the needs of our staff.

Fit Testing FFP3 Respirators

The importance of robust fit testing of disposable FFP3 face masks continues to be central to ensuring the safety of staff dealing with COVID-19 patients and patients with other respiratory infections.

Significant progress has been made within the Trust on the delivery of Fit Mask Testing since the commencement of the pandemic and the continued use of our contracted partner, Sunbelt Rentals, in conjunction with a stabilised supply chain, has ensured the provision of a robust

programme of Fit Testing on all sites which crucially has the ability to adapt and flex to our organisational requirements.

To date more than 32,500 tests have been undertaken for substantive and Bank Partners staff, for undergraduates commencing placements in Barts Health and for staff deployed from other organisations including St John's Ambulance and Army personnel.

Link Practitioners

The infection prevention link staff programme recommenced in 2021 -22 with digital education sessions being held. These focused on a number of key infection prevention issues including cleanliness, device management and surveillance. As we move beyond the pandemic and into 2022 - 23 we will refresh the programme and refocus on fundamentals of care associated with prevention of infection.

World Antibiotic Awareness Week November 2021

Comms were developed and cascaded out to the organisation, with an allocated space within WeShare focused on resistance and the antibiotics prescribed for Covid patients.

Teaching and training for Junior Doctors. The following sessions were conducted for junior doctors:

	RLH/Barts	WXH	NHM
FY1	8/12/2021 12:45 - 13:45	02/02/2022 13:00-14:00	19/01/2022
FY2	20/01/2022 14:00 - 15:00	08/12/2021 14:00-15:00	20/01/2022 12:30-13:30

TDM training sessions were also run for all the junior pharmacists across the different sites of the hospital.

The IPC Team have also provided support to:

- Awareness Campaigns
  - Flu
  - Norovirus
  - World Hand Hygiene Day May 2021
  - Infection Prevention and Control Week October 2021
  - Antimicrobial awareness day November 2021
  - Ad hoc sessions related to COVID 19
  - Updates on donning and doffing Personal protective clothing

- All members of the IPC Team have had the opportunity to attend meetings which offer updates and networking. These provide evidence for revalidation of their registration. Five members of the team have had the opportunity to continue with their studies either towards a post graduate diploma in Infection Prevention and Control or standalone modules/courses, which is equipping them with the latest knowledge and understanding of infection control practice, thus enabling them to develop and implement proactive strategies to reduce the spread of infection.

Estates and Facilities

Hard Facilities Management (FM)

We have continued to build on the improved working relationships and collaborative approach between the Estates and Facilities Teams with clinical teams. Regular scrutiny and review sessions are held on each hospital to maintain focus on the importance of the environment to ensure safe care.

For 2021-2022, the Trust have been committed to capital investment funding into refurbishment and backlog maintenance schemes in order to improve the environment and infrastructure, to support quality patient care and a safe working environment. The IPC teams both at site and Trust-wide level have continued to be involved in the planning and agreement of specifications of projects, through to the commissioning and operational opening of clinical areas, ensuring that projects are built to the appropriate standards.

A key focus on all environmental projects has been where practical compliant with IPC guidance e.g. improved access to hand hygiene facilities, isolation rooms and maintenance of an aging estate.

Health & Safety

With the devolvement of Health and Safety (H&S) roles and responsibilities to hospital level from the 4th January 2022; each of the Barts Health Group Hospitals now have an imbedded H&S forum, of which the local infection prevention nurse is a key stakeholder. These meetings [whilst acting as the local H&S forum] monitor local safer sharp issues/injuries as well as receiving reports from local water and HVAC committees.

Risk assessment templates have now been provided via the central H&S SME to sites covering various topics such as COSH, Entonox exposure, COVID assessment and other areas to synergise a uniform approach to assessments across the group.

All Trust wide H&S policies are now being updated to indicate this devolved responsibility and how this is overseen by the Group H&S committee.

Ventilation Safety Committee

The Group Ventilation Safety Committee met on 16/05/22 following a pause for COVID reasons in early 2022 and is principally concerned with ensuring that Trust ventilation systems are inspected, tested, maintained and operated safely across all 5 sites. Written updates are provided by sites and PFI partners.

- MEH - theatre is currently utilised with a reduced scope of use and an enhanced maintenance programme. Capital projects are planning a project to remediate.

- WXH – Annual reverification programme has commenced and is progressing to plan.

- SBH ward 6a -Isolation rooms have had annual verification carried out.

Risks, and significant Issues

SBH pathology building Air Handling Unit is being renewed and relocated to a more serviceable location.

The group also has a remit of ensuring that clinical staff are aware of any risks these systems may pose to clinical activity. In line with national guidance, an external Authorising Engineer (AE) Ventilation is in place to audit the management of the Trust's ventilation systems and appoint Authorised Persons (APs). APs are in place at all Trust hospitals to manage the ventilation systems.

All critical ventilation systems are verified in accordance with HTM 03-01 and systems are broadly compliant. Where there is a lack of compliance there are additional controls in place which are actively reviewed and managed via the Estates Team or our PFI partners.

Our specialist units such as theatres, endoscopy and your intensive care units have additional ventilation in line with guidance. However, one of our continuing challenges during the pandemic is that much of our hospital estate was built to have natural ventilation only. This means we cannot guarantee that the amount of fresh air entering those areas will fully dilute or remove all COVID-19 virus which may be present. As part of our work to improve this in 2021 -22 we commenced a programme of installing air scrubbers in key areas, to help minimise airborne virus risks.

Priorities for next period

- Ventilation policy to be reviewed by trust policy committee with a view to being approved and published.
- Implement 2022/23 capital projects at a site level for those projects that have a ventilation element.
- Progress tender exercise for Ventilation Authorising Engineer services across the group
- All sites have now established ventilation safety groups (or equivalents).
- HTM training completed for SBH Ventilation Authorised Person (AP).

Decontamination

Throughout 2021-2022 the Decontamination team have continued to support and monitor local areas to ensure that there is comprehensive management of medical devices across the Trust. This has included:

- Ensuring medical devices are purchased using the agreed procurement process, identifying any decontamination requirements and processes for any local cleaning. Working closely with clinical engineering, infection prevention and control and the procurement team when there were additional demands for medical devices because of the continued pandemic.
- Local SOPs were in place and up to date and compliant with manufacturers IFUs and current standards.

- Training programmes have been agreed records have been retained and reflected in local training files.

- The compliance of processes employed within Sterile Services continues to be monitored both through the contract management team as part of the agreed service KPIs as well as during the service review meetings between Trust and Steris

- The Trust has appointed an Authorising Engineer for decontamination under a 4 year contract

The Trust is looking to complete the transfer to a new Sterile Services Specification during 2022, with the support of an external Sterile Services Consultant, the work to facilitate this new specification and to introduce this as part of a new interim contract

Water Safety Committee

A number of water system improvements have been prioritised, to address legacy issues. There is a Water Safety Policy in place, which defines the Trust's approach to minimising Legionnaires' disease, *Pseudomonas aeruginosa* infections and scalding (in accordance with the NHS HTM04-01 (Parts A-C and Supplement), HSE HSG274 (Parts 1-3), *Legionella* ACoP (L8))

There are also individual site based Water Safety plans(s) in place, which are monitored and reported upon at Local Water Safety Groups (LWG's)

The water safety policy and procedures were developed to establish assurance and governance. Water hygiene issues are managed and monitored at Site Level by EFM leads, Appointed Persons (APs), Local Water Safety Group (LWSG), Water Management Committee, Local and Trust wide Infection Prevention and Control Committee (IPCC) and Trust H&S Committees.

Within the hospital, the most significant infection risks from the water supply are caused by a species of *Legionella* bacteria and other water borne organisms such a *Pseudomonas* species. The latter type of bacteria is usually problematic in high risk units (also referred to as Augmented Care Units).

The water outlets in the areas designated as "Augmented Care Units" are routinely tested for *Pseudomonas sp*. These tests are carried out at each hospital site, twice per year, and have been continuing for over 5 years.

Results for 2021/22 continue to indicate that the majority of water outlets in the augmented care units are consistently negative; however, regular water testing provides assurance that no patients are being put under unnecessary risk.

The control of legionella in the water systems of large buildings, such as hospitals, is a complex business, but relies primarily on the frequency of usage, good design and effective maintenance and monitoring to recognised standards, e.g. Hot and Cold water temperatures.

All water outlets are designated to be flushed regularly in accordance with the laid down protocol to ensure that prolonged stagnation does not occur in these outlets and water temperatures are monitored to ensure that they are within prescribed limits. The performance of water systems is monitored continuously and reviewed by the Local Water Safety Groups (LWSG's) at each hospital.

In most areas this is maintained by normal control systems through a robust monitoring and risk assessment regimen, in areas where baseline water temperatures cannot be maintained. Additional

controls have been introduced, which in combination with regular cleaning, disinfection and flushing have been effective in controlling the *Legionella* risk.

Site based *Legionella* risk assessments are conducted every 2 years or when they are required, mainly as a result of significant changes to water systems, or the installation of new systems.

Problems identified in risk assessments are addressed by the Water APs, HOEs and EFM Leads at their respective sites, in a risk assessed, timely manner.

In March 2022, Trust Estates, water safety, monitoring and maintenance contracts were awarded to the Urban Environment and Safe Water companies, based on wider standardisation, optimum data reporting and trend analysis.

The Water Management Committee (WMC) meets quarterly to discuss items on its agenda and matters arising relevant to its terms of reference. A number of water system improvements were continuing to be prioritised and actioned, to address legacy performance issues. These relate to both water temperatures and/or *Legionella* counts.

A new Water Authorised Engineer (AE) has been appointed following a tendering process, where the incumbent AE was unsuccessful. The New AE commenced duties from 1 July 2022.

Authorised Persons (AP) and Competent Persons (CP) are appointed at their respective sites

Soft Facilities and Bed Management (FM)
Insourcing

Soft Facilities Management (SFM) services across the Trust are currently provided by Serco as part of a strategic partnership contract which commenced on 1st November 2017. The SFM partnership delivers Cleaning, Patient Catering, Security, Portering, Reception, Helpdesk, Linen & Laundry and NEPTS Support services (Fleet) for the Trust.

On 28th October 2021, Serco wrote to advise the Trust of its intention to terminate the contract and provide the Trust with 18 months' notice, thereby announcing their intention to cease providing any services on 30th April 2023. Serco had identified an intention to continue working with the Trust despite the contract providing them with significant financial losses (£19m in the four years until 1st November 2021) and had put forward a number of proposals to adjust the contract fixed price and efficiency mechanism.

National Standards of Cleanliness

New national standards of cleanliness can into force on 4th May 2022. Barts Health is fully compliant with the new standards and star ratings are being submitted and presented in all required locations.

Processes are in place for areas that are failing to achieve at least 3 stars when action plans need to be devised and put into place. The group chief nurse, group director of EFM, Director of IPC and the relevant site ADoNs are issued a copy of the action log so that progress can be monitored.

Surgical Site Infection Surveillance Service (SSIS)

Surgical site infection (SSI) is a healthcare-associated infection in which a wound infection occurs following a surgical procedure. Mandatory surveillance of surgical site infections began in 2004, specifying each Trust should conduct surveillance for at least one orthopaedic surgical category for one period in a financial year.

The categories include total hip replacement, total knee replacement, repair of neck of femur, and reduction of long bone fracture. In addition to the orthopaedic surgery surveillance, there are 14 other categories, which can be reported. In Barts Hospital we do continuous surveillance on cardiac surgery (coronary artery bypass grafts and non-coronary artery bypass grafts). The Trust carries out continuous surveillance in total hip replacement and total knee replacement. This surveillance relies upon reporting by the orthopaedic teams as the IPC and Microbiology teams are not resourced to support this on a regular basis.

However, due to the COVID-19 pandemic, our elective orthopaedic surgery was transferred to the Gateway Centre at Newham. The pandemic interrupted elective orthopaedic surgery; and we have restarted our surveillance programme.

Antimicrobial Review Committee (ARC)

The regular work of the ARC was severely impacted by COVID-19 throughout this financial year; however, the skills of the team were used to significantly support the pandemic through the production of treatment guidelines and clinical review of patients.

Steps were also made to improve stewardship through EPMA and QI work.

The ARC continued to meet on the following dates Wednesday 21st April, 13th May, 2nd June, 28th July 2021, 11th August, 9th September, 13th October, 11th November, 8th December, 23rd February, and 23rd March 2022.

COVID-19 Activity

Introduction of COVID treatments

Between 1st April 2021 and March 2022, **17** COVID-19 drug alerts/updates were issued by the Department of Health. See **appendix 2** for further details.

As evidence and new NHSE recommendations were released throughout the pandemic, guidelines needed to be written or updated on intranet and MicroGuide. New drugs were incorporated onto the formulary by production of DTC review and submission to panel. EMPA care plans would be written / updated for introduction of new drugs/changes in regimens.

Teaching and training would be delivered to pharmacy, doctors, and nurses. On-going surveillance was carried out to assess compliance with prescribing.

- Equity of access
- Work was initiated, in collaboration with public health to review all positive COVID-19 patients to ensure therapy is being offered equitably. There have been some reports that suggested a

significant variation in which groups of patients are being offered this, both within NEL and London region. This is still work in progress to provide assurance of equity of access to pharmacological treatments for COVID-19. A form has been designed for use in EPMA to help prompt this decision making. This work is ongoing into 2022.

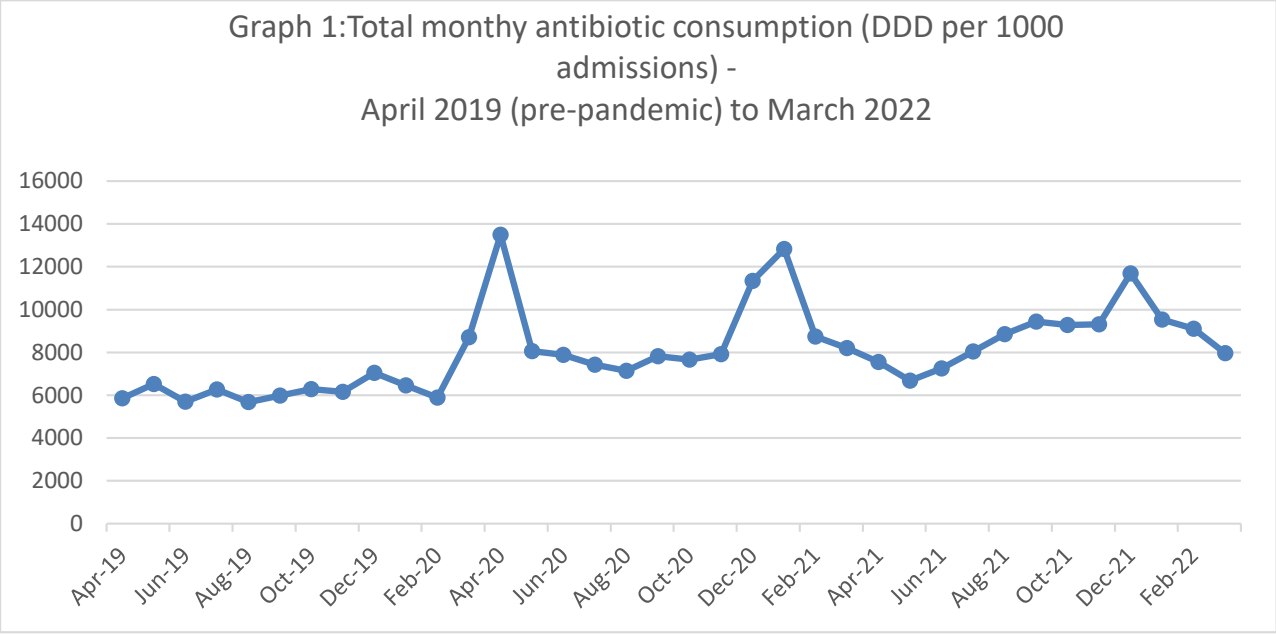
Antimicrobial consumption

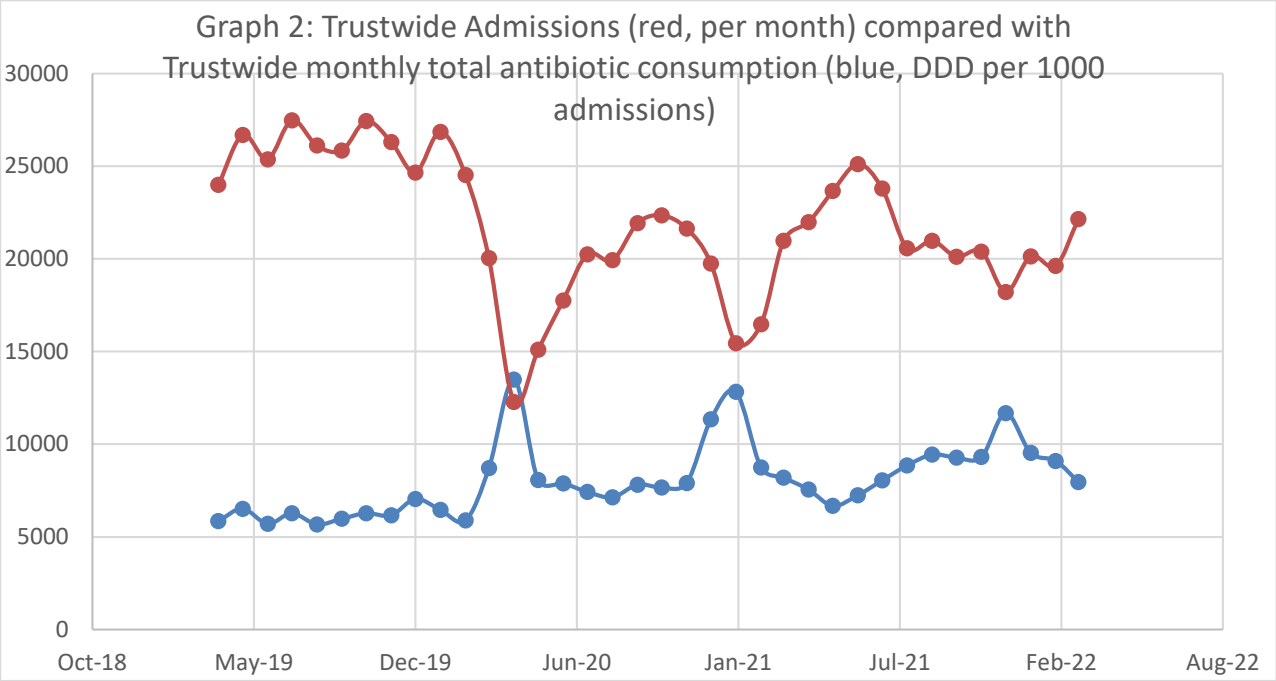
The COVID-19 pandemic saw an increase in antimicrobial usage in line with surges in the pandemic. Graph 1 shows the antibiotic usage per 1000 admissions before the pandemic in April 2019, throughout the peaks of the pandemic, leading up to March 2022. A clinical audit in antibiotic prescribing did show a high use of antibiotics amongst patients admitted for COVID-19. As soon as evidence became available that acute COVID-19 was not associated with a high incidence of bacterial infection (as had been expected from experience with Influenza), MicroGuide was updated appropriately.

However, DDDs per 1000 admissions is difficult to determine the relationship between admitted patients and antibiotic usage.

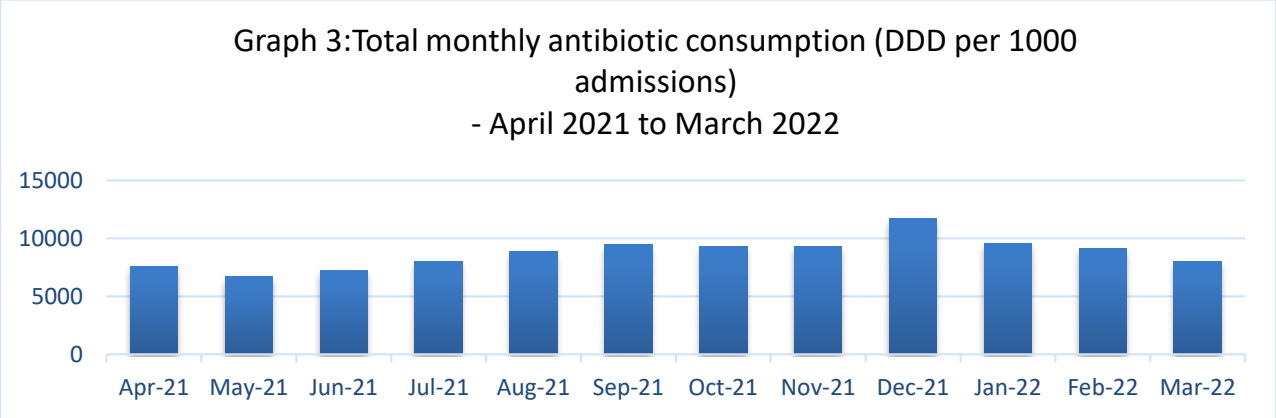
As new wards opened, stock would be issued out from pharmacy. Where ward stock levels are high, this negates the need to issue stock from pharmacy hence the usage was seen as routine/stationary –

During the COVID-19 surges, admission rates were relatively low, and as more stock was moved this had an inverse relationship - creating a surge in DDDs per 1000 admissions – demonstrated by graph 2.





Graph 3 focuses on antibiotic usage in 2021/22. This shows more seasonal variation as opposed to the peaks seen in the pandemic.



UK Health Security Agency (formerly Public Health England)

The Trust has been delayed in submitting data to 'finger-tips' due to staff shortages. The data on fingertips has therefore been taken from DEFINE which does not accurately reflect activity within the Trust.

Appointments for OPAT (Outpatient Parenteral Antibiotic Service) and antimicrobial stewardship

The OPAT service continued albeit with fewer referrals due the pandemic.

- SBH: Appointed 1 consultant microbiologist, 1 pharmacist, 1 nurse for OPAT.
- Newham: appointed 1 consultant Microbiologist and 2 nurses

- RLH and Newham combined – 1 pharmacist to support OPAT between the sites
- Whipps Cross – service commissioned only by Waltham Forest; continues as previously funded, *viz* 3 consultant PAs; 2 community nurses; no service commissioned for Redbridge or West Essex.

Elastomeric devices

- From September 2021, patients were identified who could benefit from OPAT elastomeric device.
  3 DTC applications were made, and 1 patient successfully received piperacillin / tazobactam elastomeric device treatment.

Antimicrobial Stewardship

Ward rounds restarted in some areas as the peak of the pandemic subsided, as staffing levels would allow.

Ward rounds commenced at SBH site in haem-onc areas, elderly care at WXH, and in very limited areas at RLH and NUH.

KPI audits:

KPI audits carried out at RLH, NUH and WXH on the 5th of May 2021 and at SBH in February 2021.

The percentage of patients on antimicrobials in 2021 ranged from 27%(WXH) to 33%(NUH). This is slightly below the national average at 35%. This is a significant reduction from 2020 which ranged from 36%(RLH) to 67% (SBH). Antimicrobial prescribing was lower across all sites in 2021 compared to the audit in 2020.

- The KPI audit showed good compliance of 92% for initiation of antibiotics.
- The remaining KPIs for documenting indication, duration and reviewing at 48-72 hours were much poorer with 68% for documented indication on drug chart and notes, 70% for documented duration, and 52% for review at 48-72hrs.
- Full compliance to all antimicrobial KPIs was only achieved in 49% of prescriptions.

CRS referrals: Recent work with EPMA pharmacy team to develop a referral service through CRS whereby clinical teams and pharmacists can request a review by antimicrobial pharmacy / infection doctor has not been implemented due to insufficient staffing resource in AMS pharmacy and microbiology.

European Committee on Antimicrobial Susceptibility Testing (EUCAST) review of antibiotic susceptibility and dosing

The EUCAST Steering Committee made a number of changes to its classification of susceptibility of organisms to many groups of drugs. Standard testing categories include Sensitive (S), Resistant (R) and Intermediate (I) to emphasize the relationship between breakpoints and exposure of the organism for the antimicrobial agent at the site of infection. This year there was widespread introduction of a new category that Barts Health have called D – or 'Dose dependant' This means the organism is susceptible to the antimicrobial but at increased exposure, achieved either through higher dose or reduced

interval of dosing.

ARC worked with microbiology lab methods group to introduce the change, updated antibiotic guidelines, and effectively communicated the changes across the organisation.

EMPA role out

The Antimicrobial team helped to finalise the antimicrobial section of EPMA.

Gaps were identified in the design which we hope to support development of in future years.

AMS team is continuously involved with EPMA for each new drug coming to formulary (e.g. drugs for COVID-19)

Safety/Incidents in Antibiotic prescribing

ARC monitored all the incidents related to antimicrobial prescribing. The key areas identified were as follows:

- **Penicillin Allergy**
    - Incidents occurred with Penicillin allergy patients being given antibiotics containing penicillin.
    - A safety improvement plan was produced which incorporated some of the elements below.
    - Penicillin mini audit result performed at NUH in a small sample of nursing staff as a snapshot. This showed that Penicillin allergy cards are necessary to improve the knowledge of which antibiotic contain penicillin. The Penicillin allergy traffic light posters were removed from clinical areas and the current Penicillin allergy cards were printed in 2012.
    - In 2021/22 ARC updated the penicillin allergy cards, printed and distributed across the Trust. Posters were redesigned and have been ordered for distribution around the hospital, which will be distributed during the summer of 2022.
    - QI project work conducted at Newham to identify reasons for error and improve practice.
- **Teicoplanin**
    - We had several incidents of possible Teicoplanin reaction, one of them fatal. Other reports had been noted across the country.
    - This was escalated to the Lead UK Antimicrobial Pharmacist and network. MHRA were asked to investigate.
    - Surgical prophylaxis guidelines were also reviewed with the view to reduce Teicoplanin usage and hence reduce incidents.

- **Serious Incidents**
    - ARC helped investigate SI around a patient who passed away after missing antibiotics for 3 days.

- **Therapeutic Drug Monitoring (TDM) Antimicrobials**
    - These include the commonly used antibiotics vancomycin, teicoplanin, gentamicin and amikacin, although TDM on other antimicrobials are also performed
    - Incidents relating to TDM drugs were identified every month.
    - TDM antibiotics training is being rolled out to pharmacy and doctors across sites.
    - EPMA new alert to be updated after a recent SI causing ototoxicity
    - EPMA was used to identify patients on TDM drugs. The Antimicrobial pharmacists actively reviewed these patients each day as to assess prescriptions, supported the pharmacists in reviewing these patients and helped to reduce prescribing errors.

General guidelines written/updated

Neomycin for bowel sterilisation (update) with PIL

Update on CIVAS for PD peritonitis treatment - continuous IP ceftazidime

Gentamicin guidelines (update)

COVID-19 treatment in pregnancy

CQUIN and Contract Planning for 2022/23

The 2022/23 Contract and CQUINs were discussed at the latter end of 2021/22.

The ICD/Trust chose CQUIN for Community Acquired Pneumonia as the CQUIN for 2022/23. There was also a CQUIN for UTI (CCG2: Appropriate prescribing for UTI in patients over 16years +). This was not selected, however there may be a requirement to report on this in 2022/23.

Staffing

AMS capacity added to risk register with score 16 and was approved.

Business case in progress to support increased resources for antimicrobial stewardship (AMS) and poor NICE compliance.

Dr Caoimhe NicFhogartaigh, consultant in microbiology and infectious diseases, and consultant lead for antimicrobial stewardship left the Trust in December 2021. Her considerable leadership in this role is recognised. Dr Albert Mifsud, locum consultant, agreed to take on the role.

Surveillance and Performance against Alert Organisms

The Trust continues to report on the infections required by the mandatory surveillance programme facilitated by Public Health England:

- *Clostridioides difficile* infection (CDI)
- Meticillin-resistant *Staphylococcus aureus* (MRSA) blood stream infections (bacteraemia)
- Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia
- *Escherichia coli* blood stream infection
- *Klebsiella* species blood stream infection
- *Pseudomonas aeruginosa* blood stream infection

National criteria are applied to establish whether cases of these infections are attributable to the Trust (hospital onset (HO) or healthcare associated (HA)). For bacteraemia cases when the sample is taken on the day of admission or the following day it is considered to be community onset (CO) but samples taken after that time are considered to be hospital onset (HO). For CDI the thresholds for attribution changed from 1 April 2019 meaning there are now four categories of infection:

- Hospital onset healthcare associated (HOHA): cases that are detected in hospital three or more days after admission
- Community onset healthcare associated (COHA): cases that occur in the community (or within 2 days of admission) when the individual has been an in-patient in the Trust reporting the case in the previous 4 weeks.
- Community onset indeterminate association (COIA): cases that occur in the community (or within 2 days of admission) when the individual has been an in-patient in the Trust reporting the case in the previous 12 weeks but not in the most recent 4 weeks.
- Community onset community associated (COCA): cases that occur in the community (or within 2 days of admission) when the individual has not been an in-patient in the Trust reporting the case in the previous 12 weeks

The Trust HCAI objectives for *Clostridioides difficile* infection (CDI), Meticillin Resistant *Staphylococcus aureus* (MRSA) and Gram-negative bloodstream infections (GNBSI) are determined nationally and usually received from NHSEI prior to the start of the financial year to plan and inform a Trust wide response. Due to the national pandemic, national objectives for 2020-21 were suspended and objectives for 2021-22 were not issued until July 2021. As part of our quality improvement commitment to patients, staff and stakeholders, we reviewed our performance for the period 2019-20 and set internal quality improvement objectives for 2021-22 based on our outturn for 2019-20. Once the national objectives were received from NHSEI we switched to these.

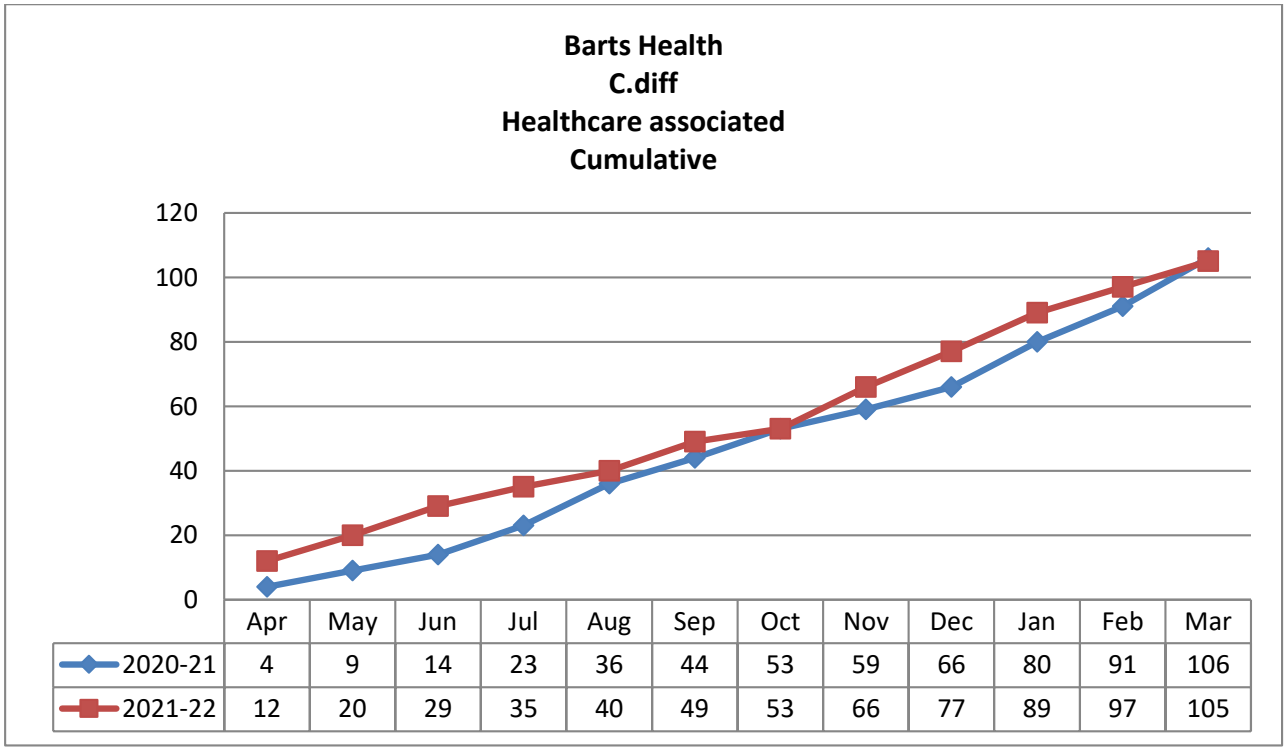
In December of 2021- January 22, we commissioned an internal audit of our gram-negative bacteraemia incidents and noted a discrepancy with the performance data published by Barts Health and that reported nationally by UKHSA. A look back exercise in conjunction with UKHSA identified that the data discrepancies related to a change in the reporting criteria. This change in categorisation had previously been applied to *E. coli* infection in 2019-20 and the remainder of our mandatory reported infections are now categorized as Hospital Onset Healthcare Associated (HOHA) and Community Onset Healthcare Associated (COHA). UKHSA confirmed that this change had not been clearly communicated through their normal communication channels at the time.

All our IPC performance is reviewed and discussed at a number of forums; the site IPC groups, the Trust IPC committee, performance reviews and the quality board.

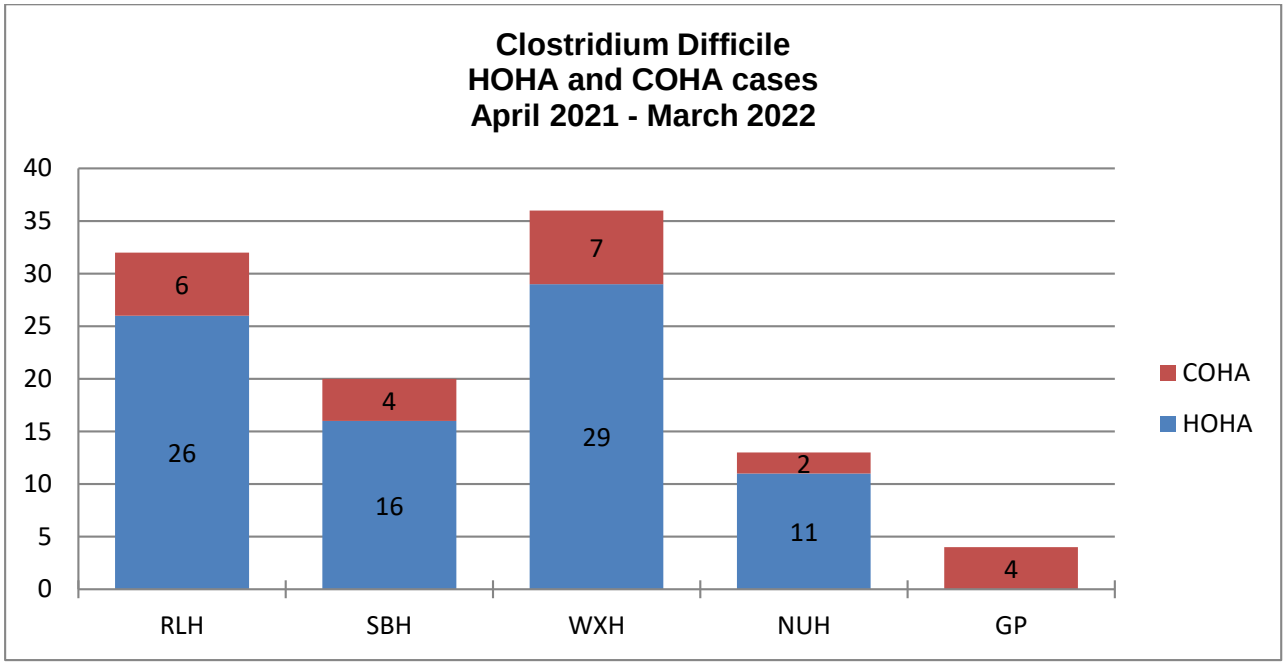
Barts Health performance compared to other London Hospitals can be found in appendix 3. The charts detail the 2021/2022 HCAI rates using KH03 occupied overnight beds data (per 100,000) considering Hospital Onset - Healthcare Associated (HOHA) cases and Community Onset Healthcare Associated (COHA).

Clostridioides difficile

Healthcare related *C. difficile* infections continue to be a significant safety concern with a renewed focus given the national rise which is being experienced across NHS England providers. This was seen in 2020 and is on-going, still relating to changes made in response to the COVID Pandemic, In light of this NHSEI will be hosting national workshops to share lessons learnt and ideas for improvement. The total number of *C. difficile* cases recorded at BH during 2021-2022 was 105 against an objective of no more than 118 cases. Of these 105 cases, 23 were classified as COHA.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2020-21	4	9	14	23	36	44	53	59	66	80	91	106
2021-22	12	20	29	35	40	49	53	66	77	89	97	105

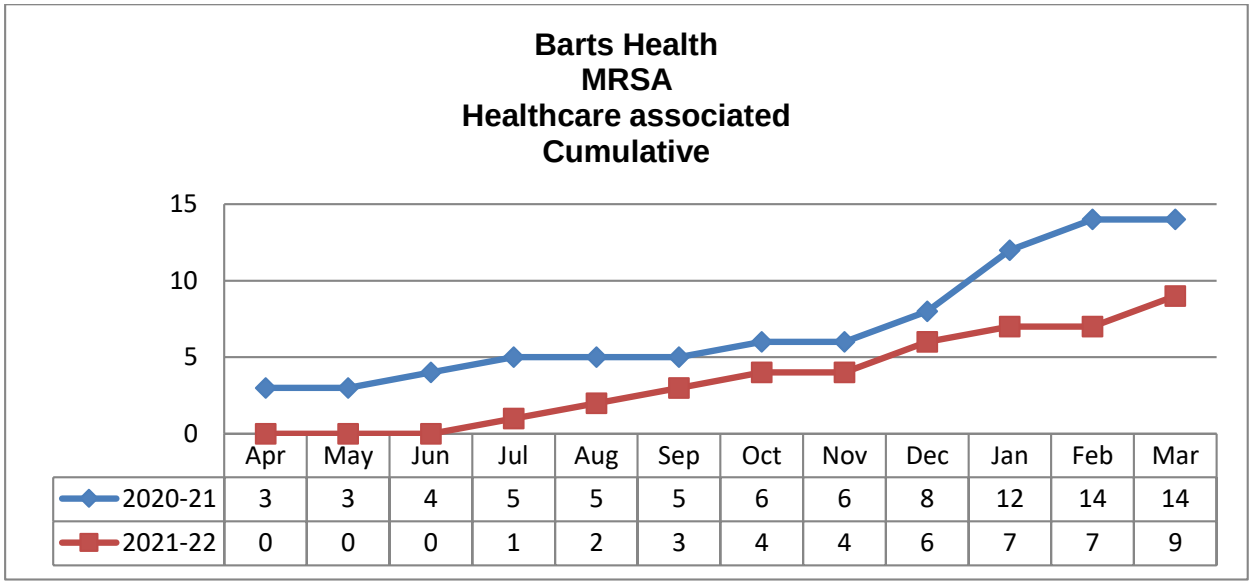


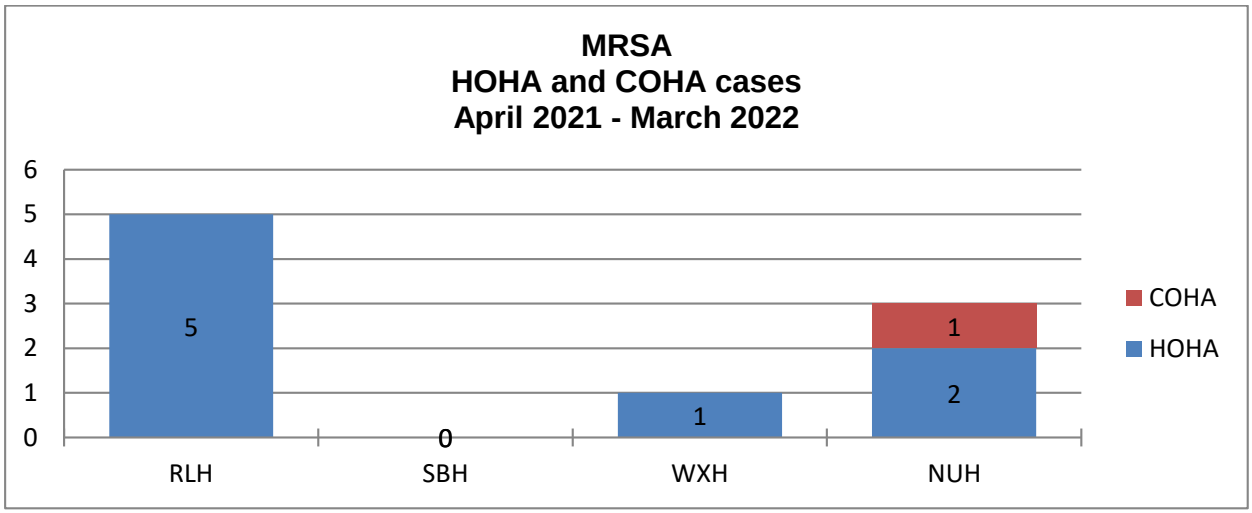
The above graph details the number of Healthcare Associated C.*diff* infections and which site they were allocated to. Overall, for the year there were 82 HOHA and 23 COHA cases across the Trust (four of which were samples from GP surgeries)

Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia (bloodstream infections)
Mandatory MRSA bacteraemia (BSI) surveillance has been undertaken since April 2001 by all NHS Trusts in England. As an organisation we have a zero tolerance approach to avoidable healthcare associated infections (HCAI). BH data is represented in the graphs below. In 2021- 22, we recorded nine which is a reduction on the previous year. Of the nine cases recorded, eight were Hospital Onset Healthcare Associated (HOHA) and one was Community Onset Healthcare Associated (COHA).

We continued to investigate each case of MRSA bloodstream infection via Root Cause Analysis (RCA) followed by a Post Infection Review (PIR) with our commissioners. The PIR process helps to identify any lessons learned for sharing across the organisation and provides opportunities for targeted education sessions.

During 2022-23 we will take the opportunity to resume the work of our HCAI Quality Improvement Group, which was paused during the pandemic, to focus on improvements that will enable us to reduce our numbers of bloodstream infections. Appendix 4 Demonstrates our position against our peer group, as recorded nationally, is above the average amongst acute trusts. Although we have seen a reduction in the number of cases this year compared to the last, there is still work to do to reduce the incidences of MRSA bloodstream infection in our patient population.



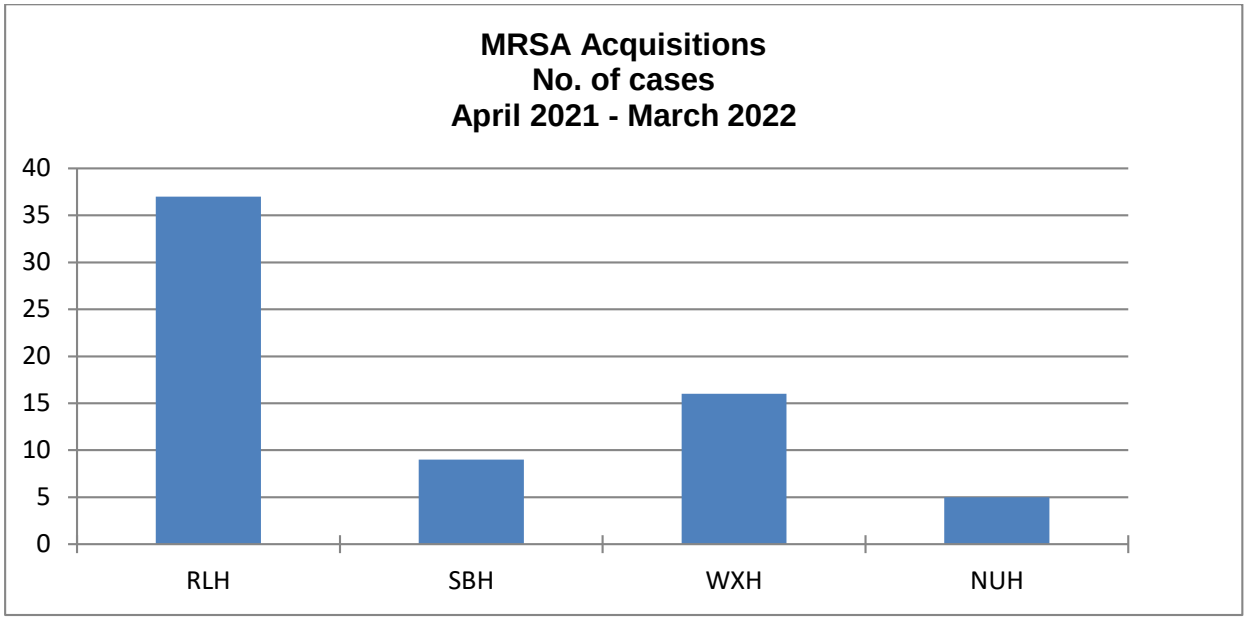


The above graph details the number of Healthcare Associated MRSA bacteraemia and which site they were allocated to. Overall, for the year there were eight HOHA and one COHA cases across the Trust.

Trust Wide acquisition of MRSA

The Trust records any instance of MRSA colonisation acquisition in inpatients. This is defined as an individual with a negative admission screen for MRSA who subsequently tests positive on any specimen. Each case is subject to an investigation to identify if any lessons can be learned and applied.

To the end of March 2022 there have been 67 such acquisitions compared with 62 last year. As this is not a mandatory indicator, we do not know how we compare to other NHS trusts, nevertheless we should aim to reduce this by improving practice.



Gram negative bacteraemia

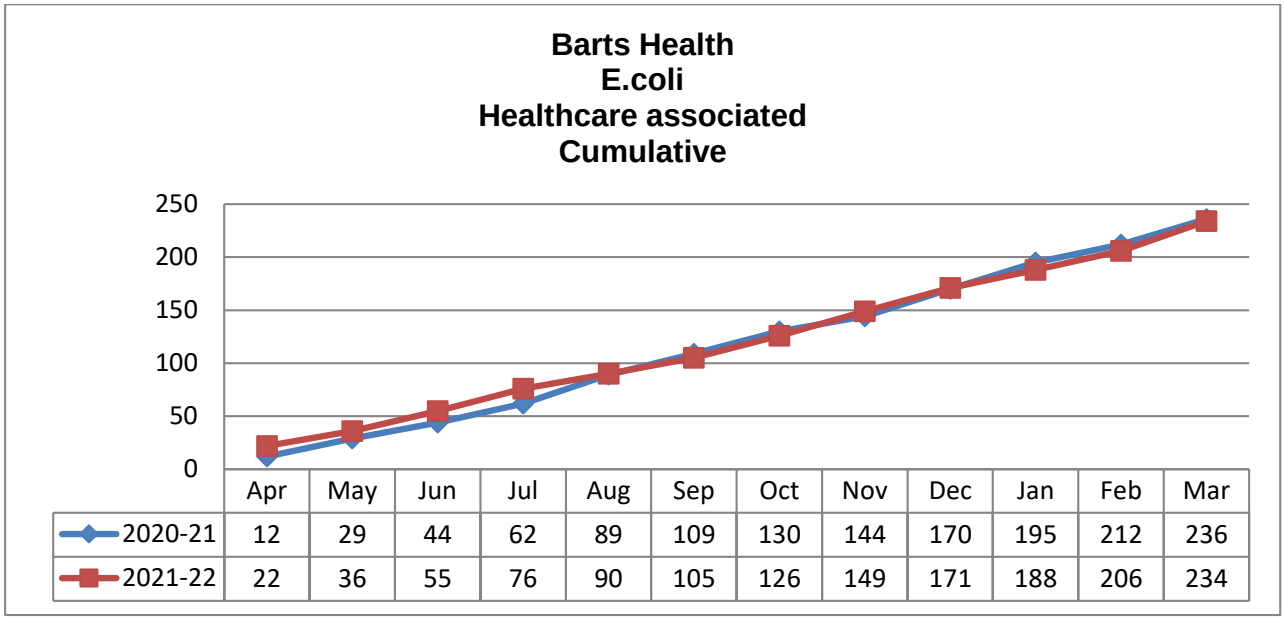
Nationally there has been an increase in *E. coli* bacteraemia numbers over recent years, with the majority of these bacteraemias occur in the community and are identified when the patient is admitted to hospital. The national ambition to reduce by half the number of healthcare associated Gram negative bloodstream infections (GNBSIs) by 2024 remains in place.

Of the gram negative bacteraemias, E.*coli* are by far the most numerous pathogen isolated. Since 2011 there has been a requirement to report *E.coli* bacteraemias. This was extended in 2017 to include reporting of *Klebsiella* and *Pseudomonas aeruginosa* bacteraemias.

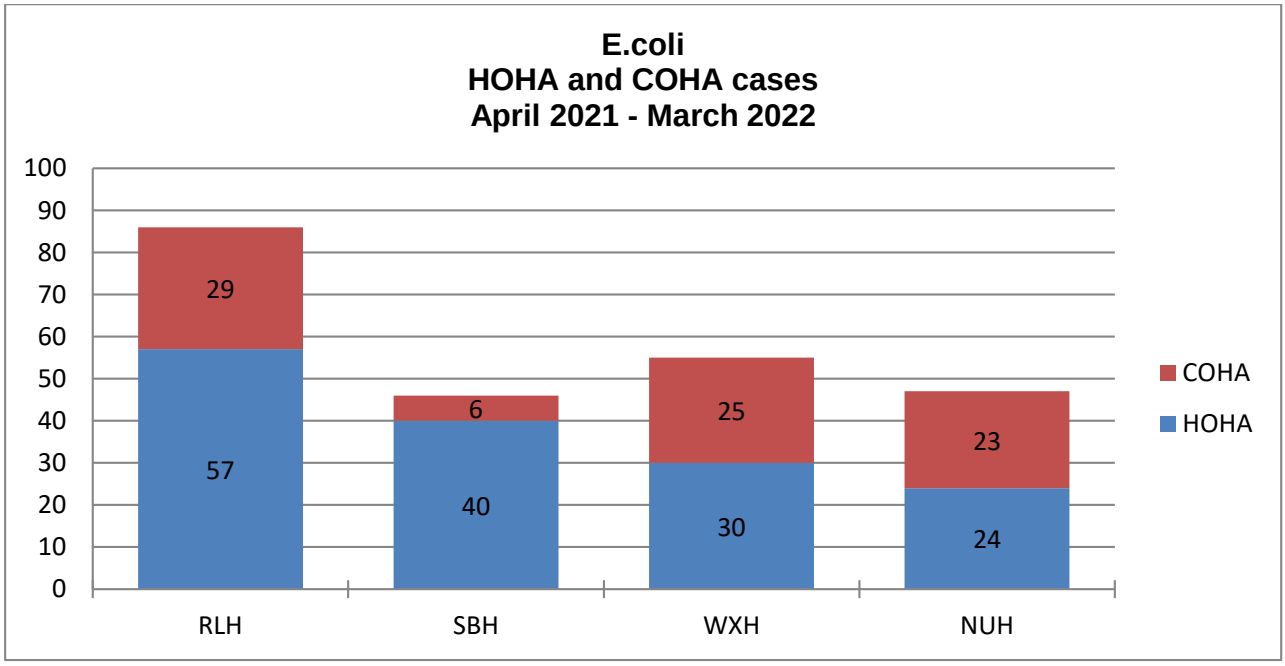
E. coli

The total number of *E.coli* bacteraemias identified in the Trust in 2021-22 was 234 broadly similar to the previous 4 years. The Trust investigates all cases of *E. coli* bacteraemia that may be linked to Trust care, for example those cases developing more than 2 days after admission or if the bacteraemia is linked to a urinary catheter where there has been trust staff involvement in the care of the catheter. Any learning identified from these investigations is implemented across the organisation.

Appendix 5 shows performance against our peers and it can be seen, that we are not performing well. It is also relevant to note that *E.coli* remains the most frequent cause of bloodstream infection in the UK and we will continue with our work to identify the themes and trends to prevent avoidable infections and to improve our position nationally.



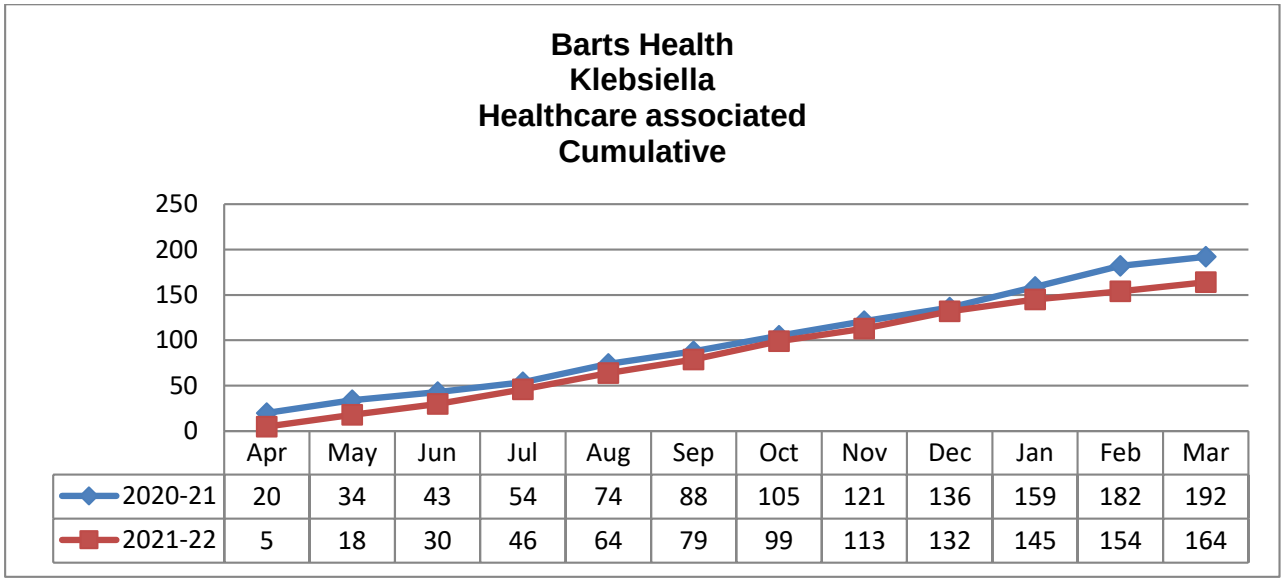
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2020-21	12	29	44	62	89	109	130	144	170	195	212	236
2021-22	22	36	55	76	90	105	126	149	171	188	206	234



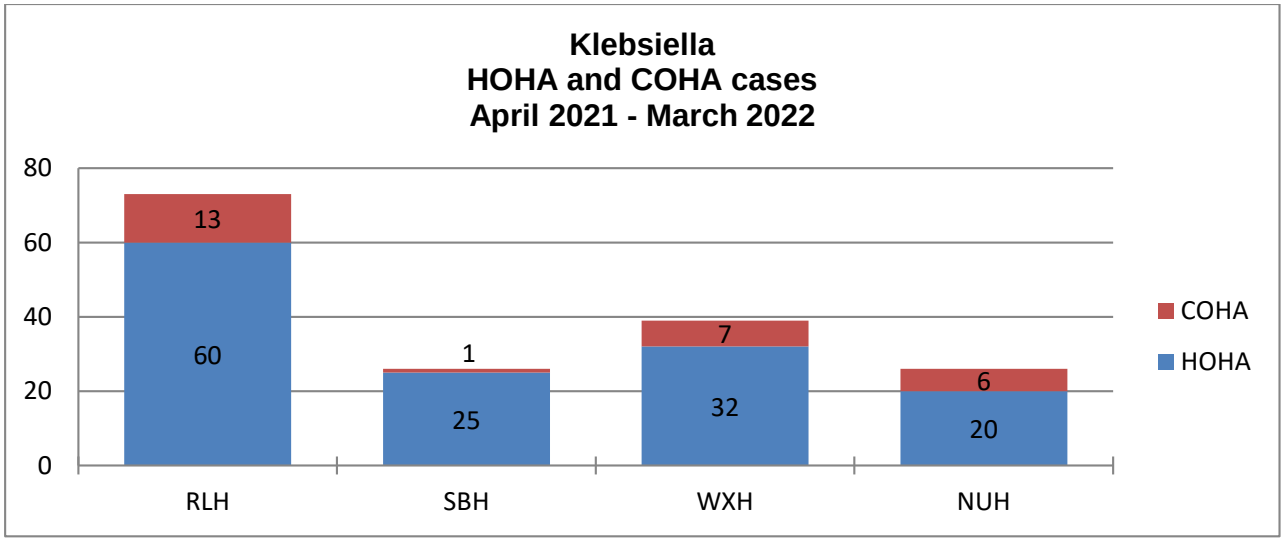
The above graph details the number of Healthcare Associated *E.coli* bacteraemia and which site they were allocated to. Overall, for the year there were 151 HOHA and 83 COHA cases across the Trust. The high ratio of COHA: HOHA from the acute Trust sites needs further study, but may reflect the common cause of *E.coli* bacteraemia – urinary catheters.

Klebsiella sp.

In 2021-22 we recorded 164 cases against a national objective of no more than 122 cases; with 27 of these categorized as COHA.

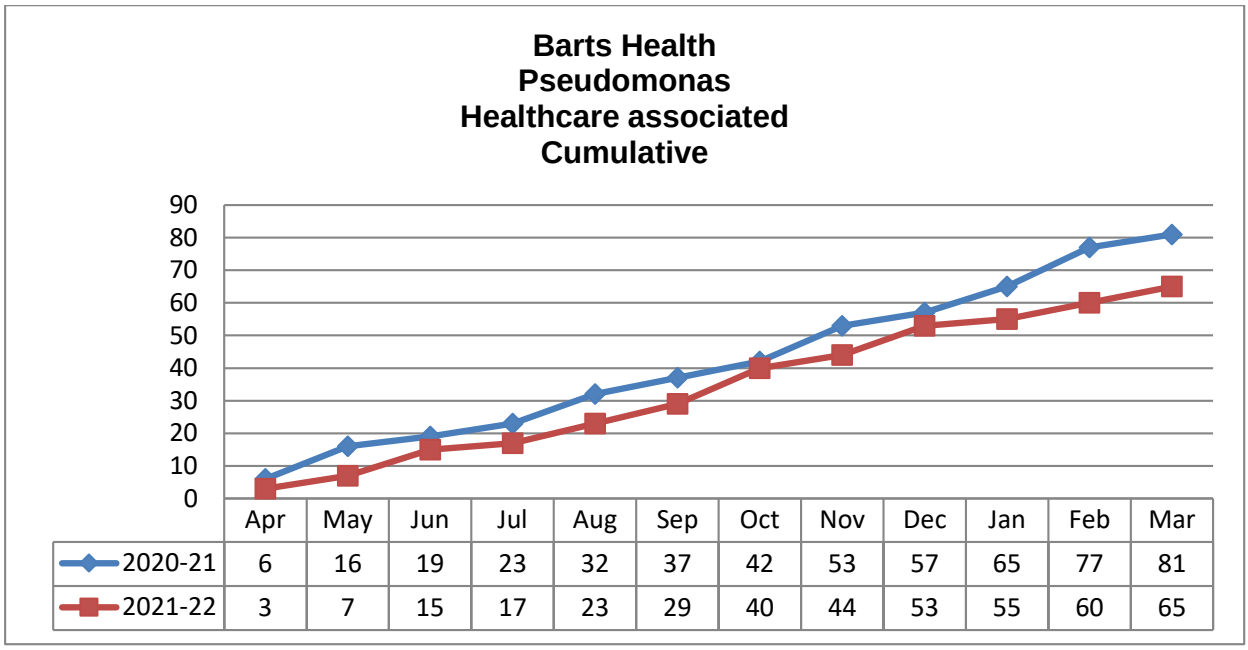


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2020-21	20	34	43	54	74	88	105	121	136	159	182	192
2021-22	5	18	30	46	64	79	99	113	132	145	154	164

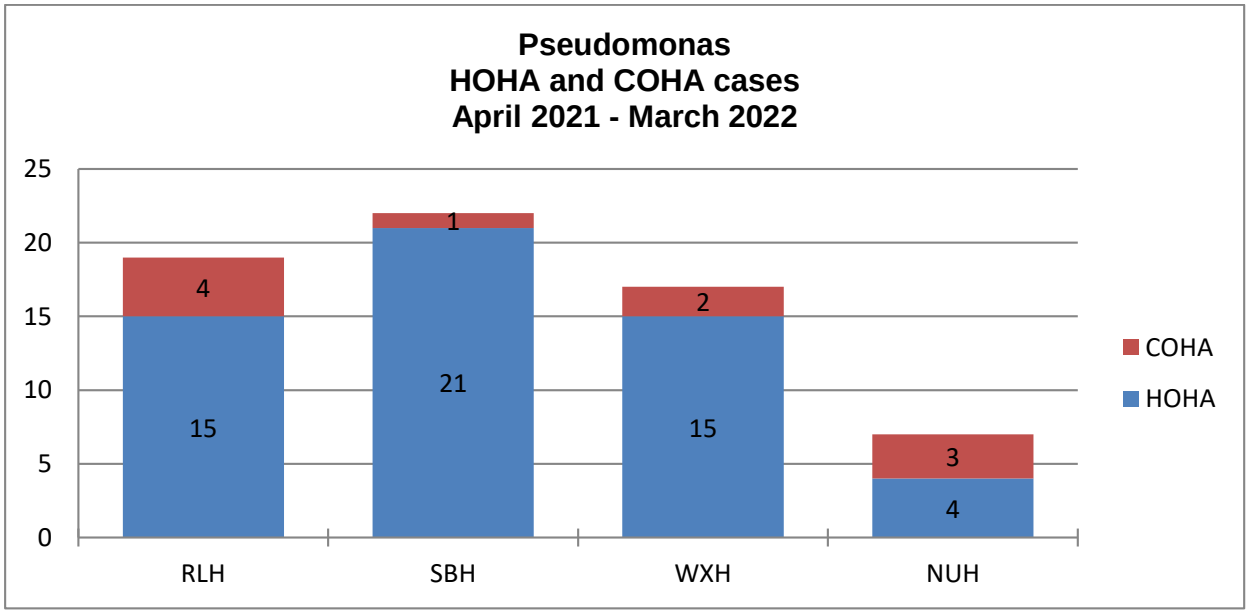


The above graph details the number of Healthcare Associated Klebsiella bacteraemia and which site they were allocated to. Overall, for the year there were 137 HOHA and 27 COHA cases across the Trust.

Pseudomonas aeruginosa



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2020-21	6	16	19	23	32	37	42	53	57	65	77	81
2021-22	3	7	15	17	23	29	40	44	53	55	60	65



In 2021-22 we recorded 65 Health Associated cases against a national objective of no more than 69 cases; with 55 of these categorized as HOHA and 10 COHA.

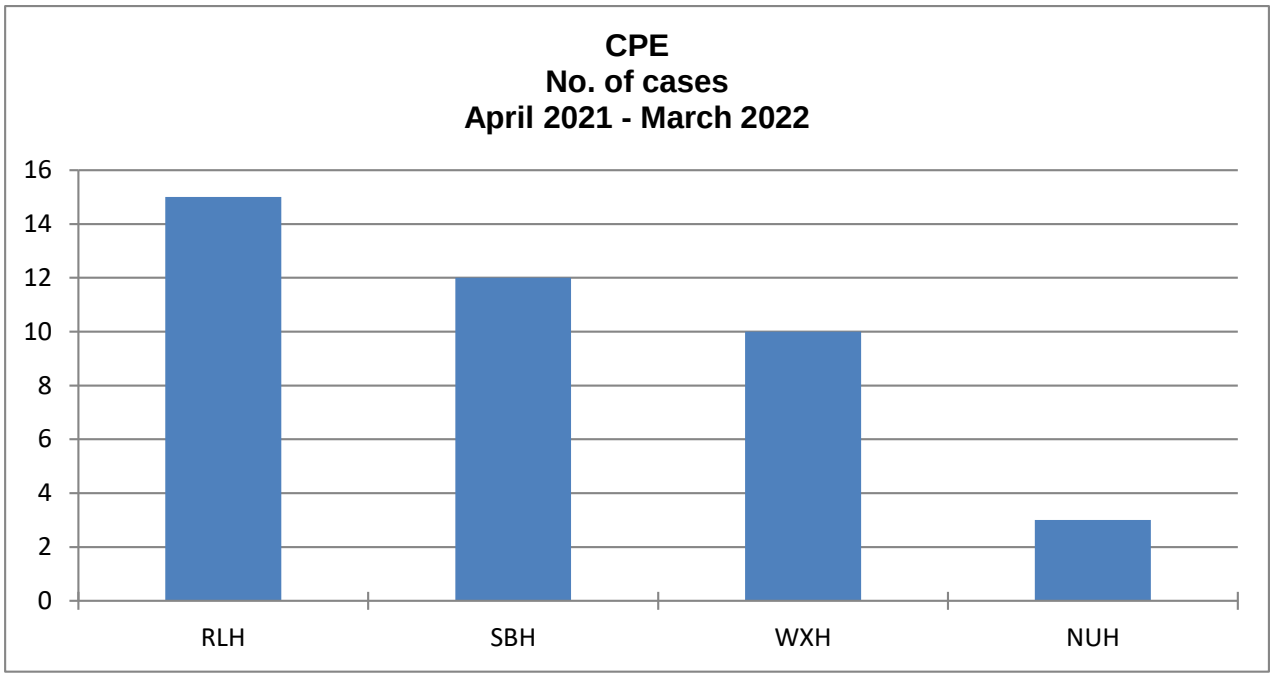
Carbapenemase Producing *Enterobacteriaceae* (CPE)

There are different types of Carbapenemases, of which KPC, OXA-48, NDM and VIM enzymes are currently the most common. Rapid spread of carbapenem-resistant bacteria has potential to pose an increasing threat of 'untreatable' infections at a local and national level.

Over the last five years, there has been a rapid increase in the incidence of infection and colonisation in patients in the UK by multi-drug resistant Carbapenemase-producing organisms. In addition, a number of clusters and outbreaks have been reported in England.

The recommendations made in the PHE toolkit are already in place at Barts Health, we had a screening programme fully funded at the end of 2019 but the pandemic delayed its implementation. An updated framework of actions to contain CPEs was produced by PHE in 2020.

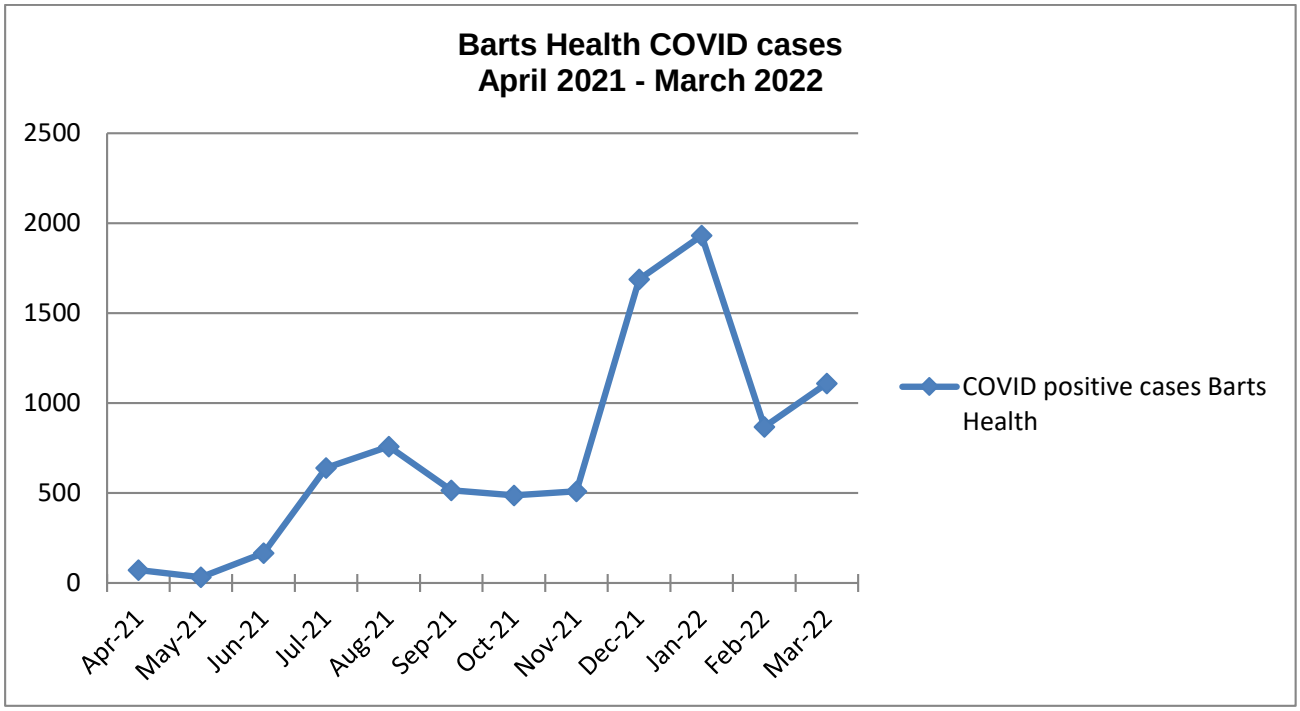
The Trust continues to see a number of sporadic cases, 40 episodes during 2021/22



Viral infections

SARS CoV-2:

Despite our efforts, in line with many other trusts, we were unable to fully contain this highly transmissible virus and reported 41 outbreaks during 2021 - 22. Each outbreak was reported and managed in line with national requirements.



Overview of Changes to COVID-19 Patient Screening, Testing and Isolation from March 2022

In line with national recommendations the Trust reviewed COVID-19 guidance on screening, testing and isolation of patients based on a risk assessment, that took into consideration the reduced virulence of the circulating variant and the need to admit patients on other pathways. There has been a reduction in the requirement for Polymerase chain reaction (PCR) testing for staff and patients with an emphasis on the use of lateral flow devices (LFD) where testing is still required.

The Trust has continued to use PCR testing in most cases, with exceptions being in low-risk elective cases, due in the main to challenges to maintaining accuracy of external reporting.

Staff are expected to continue to test using LFD twice a week and record the outcome on the government portal. Testing kits were provided through Trust procurement. Symptomatic staff were advised to undertake an LFD test if they develop COVID-19 symptoms. If positive they were asked to self-isolate for a minimum of five days and return to work after two consecutive daily LFD tests, starting no sooner than day five. Staff who were still LFD positive at day 10 would undertake a local risk assessment with their line manager.

Staff working in areas where patients are immunocompromised, such as bone marrow transplant units continued to access COVID-19 screening through PCR testing on a weekly basis.

Review on Harm and Mortality associated with HOCI

In April 2021 a guidance document by NHS England/Improvement was published, describing the process for undertaking an enhanced structured judgement reviews (SJRs) for those patients who had died from hospital onset COVID-19 infections (HOCI).

The guidance identified that the standard SJR mortality review proforma did not interrogate the cause or potential impact of any type of nosocomial infection, and that the mortality review and the infection prevention and control (IPC) review processes were not always linked.

The mortality leads in each hospital worked with both clinical teams to undertake the review and lessons learnt were shared at the Trust Quality Board and disseminated through the BH mortality meetings. A further round of these reviews is required for subsequence waves of the pandemic.

Adherence to IPC principles across the Trust, the effective testing and cohorting of patients, and the multi-disciplinary engagement on all sites were uppermost in our prevention strategy to reduce the risk of nosocomial transmission. The table below demonstrate our success, Barts Health were listed in the top six Trusts in London with the **lowest** rates of nosocomial COVID-19 cases. However, the use of PPE in the pandemic setting was a particular challenge, preventing correct hand hygiene due to long sleeve gowns and was associated with some of the increases seen in our infection rates.

Organisation	Proportion of probable and definite hospital onset infections against all new diagnoses & admitted patients
London Wide	**9.2%**
North Middlesex University Hospital NHS Trust	79.6%
Epsom and St Helier University Hospitals NHS Trust	52.4%
Chelsea and Westminster Hospital NHS Foundation Trust	33.3%
University College London Hospitals NHS Foundation Trust	27.3%

London North West University Healthcare NHS Trust	21.4%
Croydon Health Services NHS Trust	20.2%
Homerton University Hospital NHS Foundation Trust	16.7%
Whittington Health NHS Trust	14.3%
Royal Free London NHS Foundation Trust	13.3%
The Hillingdon Hospitals NHS Foundation Trust	12.5%
King's College Hospital NHS Foundation Trust	8.8%
Bart's Health NHS Trust	**8.6%**
Lewisham and Greenwich NHS Trust	6.7%
St George's University Hospitals NHS Foundation Trust	5.9%
Kingston Hospital NHS Foundation Trust	3.1%
Guy's and St Thomas' NHS Foundation Trust	2.7%
Imperial College Healthcare NHS Trust	0%

*Data sourced from national COVID 19 Acute Daily SitRep for the period 01/04/2021 to 31/03/2022

Norovirus

Between April 2021 and March 2022, there were no wards closures due to vomiting and diarrhoea at Bart's Health. Outbreaks of norovirus are controlled by containment, enhanced infection control procedures, and environmental cleaning and decontamination. We had sporadic cases in two of our hospitals, all of which were controlled.

Seasonal Influenza

The UK saw an extremely low number of Influenza cases during this winter and, therefore, Barts Health was not affected as in previous years with seasonal Influenza. We had no outbreaks caused by Influenza.

Employee Wellbeing Service

Activity has been focussed very much around pre-employment pathways and ensuring staff have adequate screens in place prior to going into role. In addition COVID-19 health risk assessments and vaccinations, consults post infection and health impact assessments have been a large use of EWS time.

Covid activity related data

Calls and e-mails into EWS	20229
Calls and e-mails responded to:	10179
LFT tests done	21047
LFT positives captured	1076
Covid Vaccinations entered into Health records.	18133

Covid vaccinations group wide	
First dose	27,007
Second dose	23, 292
3rd Booster	15, 172
Medically exempt	12
Single doses	14
Total	65,497

Needle Stick Injury (NSI) & contamination injuries reported incidents Barts Group Wide (2021-YTD 2022):

The Royal London

RLH: The highest prevalence for contamination injuries are Medical/Surgical (94), Theatres (50) A&E (33) they have the highest prevalence of injuries.

	High		High Total	Low			Low Total	Grand Total
	Sharps Injury	Splash Incident		Other	Sharps Injury	Splash Incident		
Total	**21**	**8**	**29**	**5**	**165**	**30**	**200**	**229**

WXH - The highest prevalence for contamination injuries are Medical/Surgical (16), Theatres (11), Maternity (10)

	High	High Total	Low			Low Total	Grand Total
	Sharps Injury		Other	Sharps Injury	Splash Incident		
Total	**4**	**4**	**3**	**31**	**8**	**42**	**46**

SBH - The highest prevalence for contamination injuries are Medical/Surgical (22), Theatres (16), ICU (7)

	High		High Total	Low		Low Total	Grand Total
	Sharps Injury	Splash Incident		Sharps Injury	Splash Incident		
Total	**9**	**1**	**10**	**29**	**9**	**38**	**48**

NUH – The highest prevalence for contamination injuries are Medical/Surgical (21), Maternity (13), Theatres (5), A&E (5)

	High	High Total	Low			Low Total	Grand Total
	Sharps Injury		Other	Sharps Injury	Splash Incident		

Total	**4**	**4**	**4**	**37**	**2**	**43**	**47**

Pathology Partnership – Medical/Surgical (6)

	Low	**Low Total**	**Grand Total**
	Sharps Injury		
Grand Total	**6**	**6**	**6**

Flu immunity recorded at the completion of the last Flu campaign 2021.

Frontline Staff Group	**Vaccinated**	**Total Eligible Frontline**	**% Vaccinated Frontline**	**Declined**	**% Declined Frontline External**
AHP	631	926	68.1%	52	5.6%
Frontline Support	2,197	4,270	51.5%	384	9.0%
Medical	2,132	2,874	74.2%	16	0.6%
Nursing	3,119	5,205	59.9%	567	10.9%
Grand Total	**8,079**	**13,275**	**60.9%**	**1,019**	**7.7%**

Site	RLH	WXH	NH	SBH	GSS	GSS
% uptake in eligible group	51.1%	53.4%	45.8%	65.5%	51.1%	40.1%

Development of services meeting demand:

1. Embedding Exposure to COVID-19 health risk screening into the PPQ process for all new starters. This has been achieved.
2. Placing a new exposure risk assessment on the SHS portal for staff to access and report new health conditions which may put them at risk of exposure, for review. This has been achieved.

Laboratory

Microbiology and Virology Laboratory services are provided by the East and South East London NHS Pathology Partnership (ESEL) which is located in the purpose built Pathology Laboratory at Royal London Hospital. This provides a full range of diagnostic services, linking with the national reference laboratory network for specialised testing which cannot be performed locally.

The laboratory has been reassessed in 2021 -22 and continues to have has full (UKAS) accreditation ISO Standard 15189, confirming it operates an effective and quality controlled system.

Throughout 2021-22 the laboratory has maintained sufficient increased capacity to provide all the required testing for COVID-19 for the health system across North East London, via a range of rapid and standard tests.

In 2022 -23 the laboratory will continue with work to further extend the range and number of rapid testing platforms available for other infections. This includes molecular based testing for enteric pathogens including a wider range of viruses to assist in the control of infection.

All of the laboratory's standard operating procedures are version controlled and maintained on Q-pulse; a quality management system.

The Laboratory has sufficient capacity to support infection prevention & control, providing additional support in the management of outbreaks.

Conclusion

2021 - 2022 has been another exceptional year for IPC, and the importance of a specialist medical and nursing IPCT recognised. The IPCT has continued to lead the Trust response to a global COVID-19 pandemic as well as maintaining the required ongoing core IPC programme to reduce healthcare associated infections. The report evidences the commitment, dedication, and hard work of all staff at all levels of the organisation to work together to achieve safe standards of patient care in unparalleled circumstances.

As this report demonstrates, there is no room for complacency. To maintain patient safety and reduce the risk of infection it is essential to continue adherence to IPC practices by all members of staff. It is imperative that practice and attitudes do not return to pre-pandemic practices.

The COVID-19 pandemic has placed enormous strain on IPC resources. However, the IPCT have met the challenge well and collaborative working, with directorate colleagues, has continued to ensure IPC practices are supported and maintained across all clinical services. The depth and breadth of this working can be seen within the IPC Board Assurance Framework. Looking ahead, it is also evident that

the emergence of resistant organisms and antimicrobial resistance remains a real challenge in modern healthcare.

The reduction of gram-negative bacteraemia infections remains a challenge. Most cases develop in the community rather than inpatient services and therefore further work nationally and locally is ongoing to understand the root cause and appropriate strategies to try and reduce the incidence.

The focus for the IPCT and the Trust remains on improving and maintaining infection prevention and control practices, supporting patient care pathways across the health economy, and enhancing and improving clinical practice. The IPCT will continue to undertake robust reviews and scrutiny of each case of infection, working with colleagues and clinicians, to identify learning and ensure the continued high standard of patient care. It is noted that this pandemic highlighted the extreme demand on IPC services and the marked resource gaps with in our service, with pressure on existing service personal remaining high. This needs to be addressed as a priority if we are going to be able to maintain services, support additional priorities, and avoid poor staff retention.

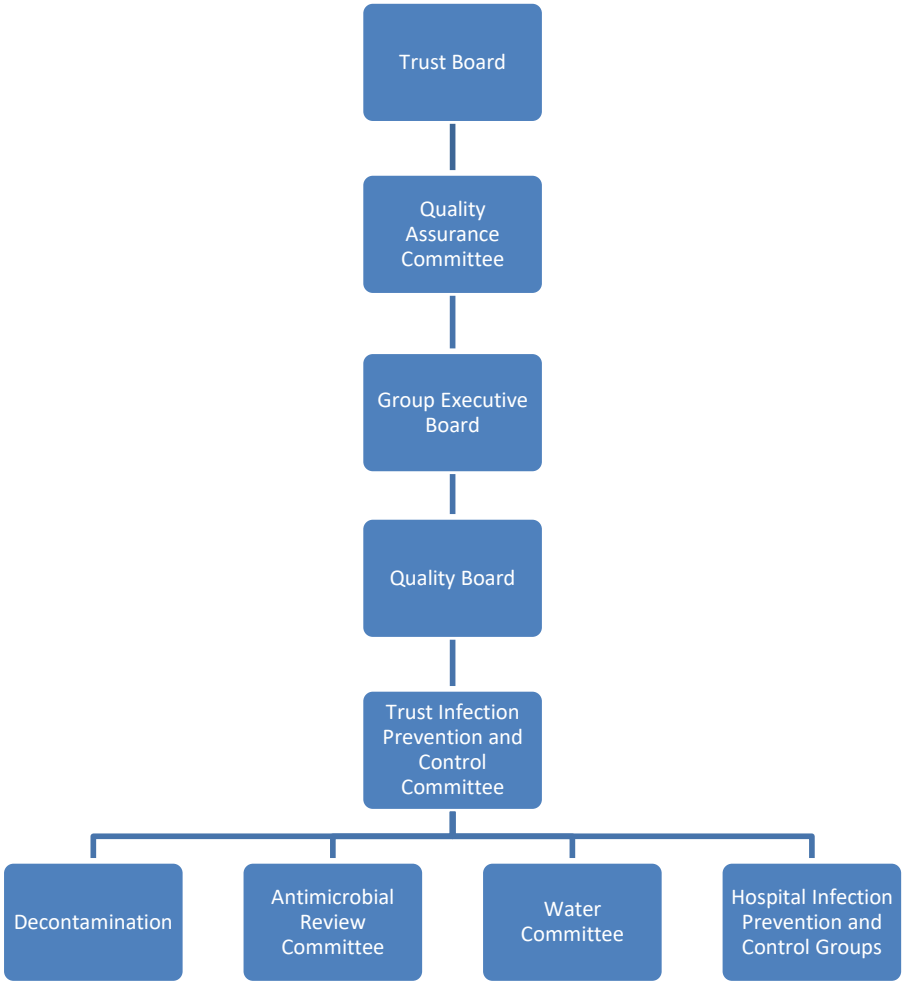
Nationally there is a high demand for specialist IPC nurses and recruitment remains challenging. It is unclear what the future holds post pandemic, with possible increases in antibiotic resistance infections and new national initiatives to address the increase in gram negative infections. However, it is clear IPC specialists will be front and foremost in ensuring our staff and patients safety

Resetting to normal services will provide new hurdles and we must also be prepared for a challenging winter. While this will make up a large part of our workload for 2022/23 we also need to ensure that we monitor and reduce other infections and that our staffs maintain a high level of compliance with training.

The plans for 2022/23 are detailed in the IPC work plan and summarised at the beginning of this report.

Appendix 1 - IPC Structure

INFECTION PREVENTION & CONTROL COMMITTEE STRUCTURE



Appendix 2

COVID drug related CAS Alerts between April 2021 and March 2022

24 February 2022 (Remdesivir)

24 February 2022 (Antivirals and neutralising monoclonal antibodies in hospitalised patients)

31 January 2022 Interleukin-6 inhibitors (tocilizumab or sarilumab) for adult patients hospitalised due to COVID-19

28 January 2022 (Palivizumab passive immunisation against respiratory syncytial virus (RSV) in at risk pre-term infants)

27 January 2022 (Antivirals and neutralising monoclonal antibodies in the treatment of COVID-19 in hospitalised patients)

27 January 2022 (Antivirals or neutralising monoclonal antibodies (nMABs) for non-hospitalised patients with COVID-19)

24 December 2021 (Neutralising monoclonal antibody and intravenous antiviral treatments for patients in hospital with COVID-19 infection)

16 December 2021 (Neutralising monoclonal antibodies or antivirals in hospitalised patients)

16 December 2021 (Neutralising monoclonal antibodies or antivirals for non-hospitalised patients)

14 December 2021 (Withdrawal of the Recommendation for Consideration of Inhaled Budesonide as a Treatment Option for COVID-19)

08 December 2021 (Neutralising monoclonal antibodies)

28 November 2021 (Variant B.1.1.529)

04 November 2021 (Ronapreve)

17 September 2021 (Ronapreve)

12 September 2021 (Interleukin-6 inhibitors)

29 June 2021 (Palivizumab)

14 June 2021 (Update: Remdesivir)

Appendix 3 - *Clostridioides difficile* Rates

The tables below shows the Trust performance against the objective for COHA and HOHA cases for 2021/22 compared with 2020/21.

C.diff Hospital Onset, Healthcare Associated rate based on cases per 100,000 occupied bed days

Organisation Name	2020/21	2021/22
THE ROYAL MARSDEN NHS FOUNDATION TRUST	69.27	58.88
UNIVERSITY COLLEGE LONDON HOSPITALS NHS	26.87	28.45
ROYAL FREE LONDON NHS FOUNDATION TRUST	16.11	18.24
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	13.58	17.54
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	12.66	16.66
KINGSTON HOSPITAL NHS FOUNDATION TRUST	10.51	15.42
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	9.76	15.08
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	15.28	14.23
BARTS HEALTH NHS TRUST	14.90	13.88
WHITTINGTON HEALTH NHS TRUST	9.71	13.60
EPSOM AND ST HELIER UNIVERSITY	13.45	12.68
HOMERTON UNIVERSITY HOSPITAL NHS	10.43	12.52
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS	7.02	11.81
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS	13.35	11.71
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	11.26	10.92
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	7.08	10.62
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	11.11	10.53
CROYDON HEALTH SERVICES NHS TRUST	5.67	9.07
LEWISHAM AND GREENWICH NHS TRUST	7.45	9.00
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	7.80	7.80
GREAT ORMOND STREET HOSPITAL	11.85	5.92
MOORFIELDS EYE HOSPITAL NHS	0.00	0.00

C.diff Community Onset, Healthcare Associated rate based on cases per 100,000 occupied bed days

Organisation Name	2020/21	2021/22
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	102.01	408.03
ROYAL FREE LONDON NHS FOUNDATION TRUST	211.52	282.03
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	191.45	250.35
KINGSTON HOSPITAL NHS FOUNDATION TRUST	120.52	223.83
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	132.54	210.86
THE ROYAL MARSDEN NHS FOUNDATION TRUST	127.35	201.63
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	122.56	175.09
BARTS HEALTH NHS TRUST	114.37	146.13
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	138.29	138.29
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	137.89	124.10
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	189.20	110.36
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	88.18	104.21
CROYDON HEALTH SERVICES NHS TRUST	205.48	88.06
WHITTINGTON HEALTH NHS TRUST	130.74	87.16
LEWISHAM AND GREENWICH NHS TRUST	206.72	73.83
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	79.58	69.63
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	52.73	63.27
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	83.89	55.93
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	57.85	52.59
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	33.07	0.00
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	0.00	0.00
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	0.00	0.00

Appendix 4 - MRSA Rates

A comparison with other Teaching Trusts shows that Barts Health has had a reduction in the rate.

MRSA Hosptial Onset, Healthcare Associated
Rate based on cases per 100,000 occupied bed days

Organisation Name	2020/21	2021/22
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	1.41	2.83
BARKING, HAVERING AND REDBRIDGE UNIVERSITY	2.23	2.23
KINGSTON HOSPITAL NHS FOUNDATION TRUST	1.40	2.10
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	1.18	1.48
BARTS HEALTH NHS TRUST	1.52	1.35
UNIVERSITY COLLEGE LONDON HOSPITALS NHS	1.58	1.19
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	2.37	1.18
CHELSEA AND WESTMINSTER HOSPITAL NHS	1.42	1.06
HOMERTON UNIVERSITY HOSPITAL NHS	5.22	1.04
WHITTINGTON HEALTH NHS TRUST	1.94	0.97
ROYAL FREE LONDON NHS	1.82	0.91
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	0.83	0.83
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0.66	0.66
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	2.34	0.58
CROYDON HEALTH SERVICES NHS TRUST	0.56	0.56
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	1.41	0.46
LEWISHAM AND GREENWICH NHS TRUST	1.24	0.31
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS	0.00	0.00
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	0.00	0.00
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	0.00	0.00
THE HILLINGDON HOSPITALS NHS	0.66	0.00
THE ROYAL MARSDEN NHS	0.00	0.00

MRSA Community Onset, Healthcare Associated
Rate based on cases per 100,000 occupied bed days

Organisation Name	2020/21	2021/22
ROYAL FREE LONDON NHS FOUNDATION TRUST	11.75	47.01
CHELSEA AND WESTMINSTER HOSPITAL NHS	0.00	31.64
LEWISHAM AND GREENWICH NHS TRUST	0.00	29.53
KINGSTON HOSPITAL NHS FOUNDATION TRUST	0.00	17.22
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS	5.59	11.19
BARTS HEALTH NHS TRUST	31.77	6.35
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	6.02	6.02
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	0.00	5.26
BARKING, HAVERING AND REDBRIDGE UNIVERSITY	14.73	0.00
CROYDON HEALTH SERVICES NHS TRUST	29.35	0.00
EPSOM AND ST HELIER UNIVERSITY	0.00	0.00
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS	0.00	0.00
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	19.90	0.00
HOMERTON UNIVERSITY HOSPITAL NHS	0.00	0.00
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	0.00	0.00
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	0.00	0.00
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	0.00	0.00
ST GEORGE'S UNIVERSITY HOSPITALS NHS	17.51	0.00
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	0.00	0.00
THE ROYAL MARSDEN NHS FOUNDATION TRUST	0.00	0.00
UNIVERSITY COLLEGE LONDON	0.00	0.00
WHITTINGTON HEALTH NHS TRUST	21.79	0.00

Appendix 5 - *E.coli* Rates

A comparison with other Teaching Trusts, using a rate based on cases per 100,000 occupied bed days,

E.coli Hosptial Onset, Healthcare Associated Rate based on cases per 100,000 occupied bed days

Organisation Name	2020/21	2021/22
THE ROYAL MARSDEN NHS FOUNDATION TRUST	57.14	69.27
HOMERTON UNIVERSITY HOSPITAL NHS	20.87	32.34
UNIVERSITY COLLEGE LONDON HOSPITALS NHS	35.17	32.01
BARKING, HAVERING AND REDBRIDGE UNIVERSITY	22.98	26.81
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	31.93	26.01
BARTS HEALTH NHS TRUST	25.56	25.56
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	23.03	24.91
ROYAL FREE LONDON NHS FOUNDATION TRUST	25.23	22.80
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	16.97	21.78
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	20.19	21.52
WHITTINGTON HEALTH NHS TRUST	11.65	21.37
LEWISHAM AND GREENWICH NHS TRUST	13.96	19.86
CROYDON HEALTH SERVICES NHS TRUST	17.01	17.58
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS	12.88	17.57
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	17.70	16.99
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	12.87	16.38
KINGSTON HOSPITAL NHS FOUNDATION TRUST	15.42	14.72
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	6.00	10.66
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	0.00	10.40
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	11.53	7.69
GREAT ORMOND STREET HOSPITAL	17.77	5.92
MOORFIELDS EYE HOSPITAL NHS	0.00	0.00

E.coli Community Onset, Healthcare Associated rate Based on cases per 100,000 occupied bed days

Organisation Name	2020/21	2021/22
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	1326.11	1836.15
BARKING, HAVERING AND REDBRIDGE UNIVERSITY	898.33	1310.67
LEWISHAM AND GREENWICH NHS TRUST	516.80	664.46
CROYDON HEALTH SERVICES NHS TRUST	469.67	645.79
ROYAL FREE LONDON NHS FOUNDATION TRUST	775.59	622.82
BARTS HEALTH NHS TRUST	533.71	527.36
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	560.29	385.20
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	238.75	348.17
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	325.33	319.31
KINGSTON HOSPITAL NHS FOUNDATION TRUST	309.91	309.91
CHELSEA AND WESTMINSTER	316.35	305.81
WHITTINGTON HEALTH NHS TRUST	108.95	305.05
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS	206.93	296.42
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	186.15	282.68
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	299.56	268.03
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	307.31	261.21
UNIVERSITY COLLEGE LONDON HOSPITALS NHS	240.48	224.45
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	152.50	115.69
THE ROYAL MARSDEN NHS FOUNDATION TRUST	127.35	95.51
GREAT ORMOND STREET HOSPITAL	33.07	0.00
MOORFIELDS EYE HOSPITAL NHS	0.00	0.00

Barts Health NHS Trust

Report to the Trust Board: 14 September 2022	TB 68/22

Title	Overseas Visitors Annual Report
Accountable Director	Deputy Chief Executive
Author(s)	Deputy Chief Financial Officer, Operational Finance
Purpose	To provide an annual report on implementation of NHS (Charges to Overseas) Regulations 2015
Previously considered by	-

Executive summary
This paper provides an update on the Trust's implementation of the national guidance in relation to overseas visitors. Charging is a sensitive issue and the Trust is committed to being transparent, fair and equitable to patients and staff in fulfilling our statutory obligations. This report outlines activities in the last year to support this objective.

Related Trust objectives
SO1 - Safe and Compassionate Care

Risk and Assurance	This report provides assurance in relation to the above objective.
Related Assurance Framework entries	-

Legal implications/ regulatory requirements	National Health Services (Charges to Overseas Visitors) Regulations 2015 and related DHSC guidance

Action required
The Trust Board is asked to approve the annual report.

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 14 SEPTEMBER 2022

ANNUAL UPDATE ON OVERSEAS VISITORS

INTRODUCTION

1. This paper provides an update on the Trust's implementation of the national guidance in relation to overseas visitors.

2. Like all NHS trusts, Barts Health has a legal duty to recover costs from patients who are not entitled to NHS treatment.

3. However, those who need care that is clinically deemed urgent or immediately necessary - including all maternity care - will always be treated promptly, even if a patient indicates that they cannot afford to pay.

4. The Barts Health group of hospitals serves one of the most diverse communities in the country with a catchment of around 2.5 million people living in east London. We take pride in providing quality care for all our patients, and do not want to deter anyone from seeking treatment.

5. We are committed to ensuring our hospitals are consistent, clear and equitable in applying the national eligibility and charging rules around overseas visitors.

LEGAL OBLIGATIONS

6. National regulations stipulate that patients must be "ordinarily resident" in the United Kingdom(UK) to qualify for free NHS-funded hospital care. This means living here lawfully, with a settled purpose, for the time being. Nationals of countries outside the UK who have indefinite leave to remain in the UK are eligible for free NHS care, but many British nationals who now live overseas may not be.

7. Any patient not entitled to free care must be charged for treatment they receive unless a medical or service exemption applies. Where charges apply, the Trust cannot waive the fees in whole or part.

8. Those who need care that is clinically deemed to be immediately necessary (including maternity care) or urgent care will always be treated in a timely way. We do not turn such patients away. However, treatment is not necessarily free of charge simply by virtue of being provided on an immediately necessary or urgent basis.

9. With effect from October 2017, the Trust has a legal duty to recover the costs of clinically routine treatment from patients before treatment is given.

COVID-19 and other new exemptions from charge

10. The diagnosis and treatment of Covid-19 is free to everyone in order to protect the wider public health. No patient is denied treatment for Covid-19 on the basis of being unable to pay.

11. The Trust website was updated to confirm that overseas visitors to England including anyone living in the UK without permission would not be charged for the testing, treatment and vaccine for Covid-19 to reflect national policy.

12. During the year there were new policy changes to reflect international events which included the introduction of the Home Office Afghan Resettlement Programme and exemptions from charge for patients ordinarily resident in Ukraine.

13. Together with our local partners, we have maintained focus on supporting our patients, their families, and the wider community throughout the pandemic by providing as much information as possible. This includes assurance that NHS services continue to provide urgent and emergency care, and people should not delay seeking treatment or advice if they or a member of their family is unwell.

WORKING WITH OUR COMMUNITIES

14. We work closely with patients and their advocates to understand their concerns and share information about how we apply the regulations. We continue to use their feedback to inform our approach to information sharing which includes;

- Developing a comprehensive training package to increase knowledge and awareness among reception and administrative staff, ensuring all new patients are asked about their residency status. This will be rolled out and form part of our statutory and mandatory training requirement for all frontline staff in 2022/2023 subject to operational priorities. In the interim our Overseas Visitors Team continue to offer specialist advice and support to colleagues and their patients including team training.

- Working with NHS England and Improvement, local Trusts and other partners to further improve the support and services we offer in this area. This includes collaboration with North East London(NEL) providers to share and agree best practice to develop a consistent approach.

OVERSEAS VISITORS TEAM

15. We have a well-established and experienced Overseas Visitors Team. It provides advice and support to patients to help them understand their and our obligations around entitlement and payment.

16. Several of the team are multi-lingual. In addition the team can draw on the language skills of our Advocacy Service to help communicate with patients whose first language is not English.

17. Patients can contact the Overseas Visitors Team directly or via the Patient Advice and Liaison Service (PALS). Further information, including how patients can access guidance and support, is available on the Trust website.

18. The Overseas Visitors Team attend national seminars to keep their knowledge up to date and share best practice. This included EU Exit training on the EU Settlement Scheme to ensure changes in national policy are deployed timely and the team can provide clarity on eligibility to all our patients.

ADAPTING OUR APPROACH

19. We recognise that charging is a sensitive issue and are committed to being transparent, fair and equitable to patients and staff in fulfilling our statutory obligations.

20. We listen to the views of our patients and engage with the community to address their concerns in order to provide the best possible care.

21. Early engagement with our patients offers greater scope to give reassurance and support on eligibility for NHS treatment.

22. During the pandemic the Overseas Visitors Team have continued to pro-actively engage and support individuals to check their eligibility for NHS treatment by telephone. Experience has shown that reaching out proactively to patients and being able to answer their queries informally continues to improve relationships.

23. We also put extra checks and balances into our processes to reduce the need for reminder letters whilst focusing on pro-active engagement. Sending someone a bill for treatment remains an action of last resort, in those cases where we are either sure the individual is not eligible for free treatment or (despite our best efforts) have been unable to ascertain their status. We also offer patients the option of staged payment plans to spread out the cost of care following an assessment of their income and expenditure.

24. We continue to identify effective and innovative ways of working, consolidating our administrative processes and adopting best practice as part of an ongoing programme aimed at improving our effectiveness.

25. We have observed that patients continue to respond in a positive manner to improvements in communication at a personal level and our positive approach to managing relationships with them. Our Notice of Charge process continues to have a positive impact on the timeliness of response from our patients which enables us to conclude our enquiries more quickly.

26. Following the deadline for applications for the EU Settlement Scheme at the end of June 2022 requests for information from the Home Office to support assessment of eligibility for free NHS care increased significantly we were advised. Delays in their service exceeded 4 weeks. Treatment and care for our patients was not impacted although status checking enquiries took longer in some instances.

FINANCIAL INFORMATION ON OVERSEAS PATIENTS CHARGES IN 2021/22 AND COMPARISON WITH 2020/21

27. The number of chargeable patients increased in the year and was broadly back to pre pandemic levels. Patients treated for Covid-19 only remained exempt from charge.

28. Cash recovered from individual overseas patients decreased slightly in 2021/22 and remained significantly below pre pandemic levels. Lower cash recovery may reflect ongoing reductions in tourism to the UK.

29. We pro-actively evaluate waiting list information, which leads to earlier patient contact to establish eligibility to free NHS secondary care. Using technology to identify patients in real time facilitates timely contact, greatly reducing the need for follow up enquiries. Effective use of ICT systems like NHS Spine and Trust patient notes also supports us in assessing chargeable status. Patients/their advocates are given several opportunities to engage with us and demonstrate their eligibility before any invoices are sent.

30. However, if such evidence is not received within a reasonable period we are obliged to send an invoice. If subsequent evidence is then provided, that invoice will be cancelled.

31. Of the 1,089 patients charged in 2021/22, 73 patients had their charges cancelled when the patient subsequently produced documentation that proved their eligibility to free NHS treatment.

32. Payments received under EU reciprocal schemes were £46K in 2021/22 compared to £1,704K in 2020/21. Most of the 20/21 payments related to patients who had been treated in previous financial years.

33. The EU reciprocal schemes continue despite the UK's departure from the EU. However under the financial regime operating since the pandemic much of the funding for EU reciprocal patients is now deemed to be included in the Trust's financial envelope and therefore cannot be separately invoiced or identified. The £46K are payments received on top of the Trust's financial envelope and relate to 46 patients.

34. The following tables show overseas patients charged in 2020/21 and 2021/22 and show the ethnicity of charged overseas patients

Patients charged in 2021/22

Sites	Number of invoices	Number of patients invoiced	Payments received £000s
Newham	399	335	312
Royal London	497	390	148
St Bartholomews	134	122	106
Whipps Cross	258	242	91
Total for overseas patients	**1,288**	**1,089**	**657**
Payments received under EU reciprocal schemes			**46**
Total			**703**

Patients charged in 2020/21

Sites	Number of invoices	Number of patients invoiced	Payments received £000s
Newham	284	235	213
Royal London	340	254	360
St Bartholomews	107	84	62
Whipps Cross	117	109	58
Total for overseas patients	**848**	**682**	**693**
Payments received under EU reciprocal schemes			**1704**
Total			**2397**

Note: Payments received may relate to invoices raised in previous years. The cash received under EU reciprocal schemes in 2020/2021 mostly related to 2019/2020 invoices.

Overseas receipts may not agree to the figures stated in the accounts due to differing categorisation of the values received under the EU reciprocal schemes.

Ethnicity of overseas patients charged in 2021/22 and 2020/21

	2021/22	2020/21
Any other ethnic group	98	60
Asian	322	219
Black (African, Caribbean and any other Black)	143	78
Mixed background	24	9
Not known or Not stated	180	179
White	322	137
Total	**1089**	**682**

Ethnicity of overseas patients who after the invoice had been raised provided documentation that proved their eligibility

	2021/22	2020/21
Any other ethnic group	6	4
Asian	18	11
Black (African, Caribbean and any other Black)	8	1
Mixed background	1	0
Not known or Not stated	16	15
White	24	13
Total	**73**	**44**

Note: Ethnicity data has been taken from the Trust patient administration systems

Barts Health NHS Trust

Report to the Trust Board: 5 October 2022	TB 69/22

Title	R&D Annual Report 2021/22
Accountable Director	Chief Medical Officer
Author(s)	Gerry Leonard, Director of Joint Research Office Rupert Pearce, Director of Research
Purpose	Update on R&D Progress
Previously considered by	Quality Assurance Committee – August 2022

Executive summary

The Covid-19 pandemic again affected research activities this year. Recruitment to many of our clinical trials and research studies was impacted for most of the year by surges in Covid-19 infections and hospitalisations. Although our studies were not formally suspended, recruitment was, as anticipated, less than we have achieved in pre-Pandemic years. Nevertheless, BH recorded the highest number of recruits to NIHR portfolio studies in our Network this year and the total number of patients actively involved in our research studies and trials, whether in treatment modalities or tissue donation and participating in questionnaire studies is around 32,000.

Our financial performance was also good this year and our total income was £27,821K exceeding our forecasts by 9%. Our income from commercial clinical trials was strong, particularly from the vaccine studies we continue to be involved in and our income of £8,332k was 16% above our forecast for the year.

One of the major challenges we have faced this year has been managing the desire of our researchers and external funders to set up new studies that in many cases have been on hold during the last two years because of the pandemic. The number of studies on our portfolio and in set-up is increasing and we anticipate a very positive drive by our researchers to re-start their programs and offer our patients the opportunity to be involved in leading-edge research in 22/23.

Two major applications for funding through the National Institute for Health Research large infrastructure programme were submitted last year. Our bid for Clinical Research Facility support funding was successful and will have a significant impact on achieving our vision of creating a world-class facility at the Royal London Hospital site. Our bid for Biomedical Research Centre funding has reached the final selection round and the results will be published early next year. Our major research risks are identified in Appendix 3 to this report.

On balance, considering all the unusual difficulties that our researchers had to deal

with, 2021/22 turned out to be a good year for research at Barts Health.

Related Trust objectives
SO 3.

Risk and Assurance	Assurance in relation to BAF entry 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

Legal implications/ regulatory requirements	No specific requirement

Action required
The Committee is asked to review and approve the annual report

NHS
Barts Health
NHS Trust

R&D ANNUAL REPORT 2021/22

Barts Health NHS Trust - Research & Development

www.jrmo.org.uk

www.bartshealth.nhs.net/takepart

TABLE OF CONTENTS

EXECUTIVE SUMMARY

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INTRODUCTION

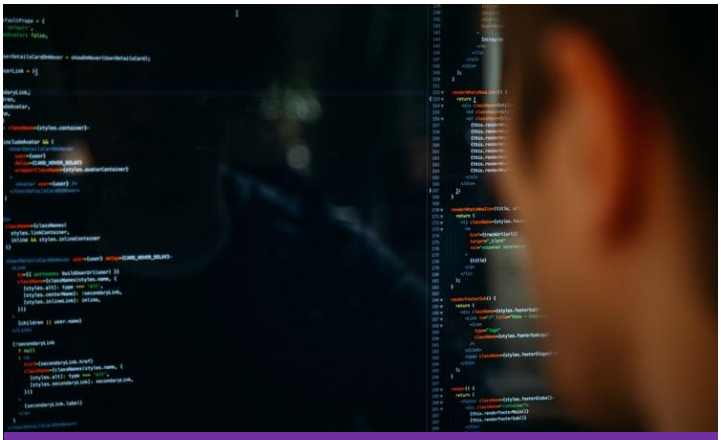
In setting out our objectives for this year we took account of the fact that the continuing Covid-19 pandemic would impact on research and the top line targets we set reflected what we anticipated that impact might be. Throughout the year we navigated several infection surges but continued our input to Covid-19 vaccine and treatment studies and managed a large increase in the number of new trials and studies our research community were eager to participate in, a clear indication of our researcher's commitment to the Trust's drive to grow our research activities.

Our report this year includes stories from our research groups that illustrate the real impact that our research can have on the way we deliver healthcare now and, in the future, introducing innovative approaches to the delivery of treatment and therapies to our patients. These are only a small sample of the wide range of research activities, across all our specialities, that our research groups are delivering to our patients.

RESEARCH IMPACT STORIES

AI at Barts Life Sciences spares patient's limb amputation

New ground-breaking AI technology has helped Barts Life Sciences (BLS) identify people at risk from diabetic complications. Patient data reviews that would have taken clinicians over 100 years to complete can now be done in weeks using new technology, supplied by Clinithink. The system was used to scan 14m documents to find patients with diabetic foot disease (DFD), a potentially serious, life changing complication. Using the new software our researchers found 30% more patients with diabetes and 375% more patients with DFD than would normally be expected. In the next phase of work planned by Dr Sophie Williams, the lead research data scientist, the characteristics extracted by the software will be used to determine whether patients most at risk from DFD can be predicted. There are over 3,000 patients with DFD in London alone. This technology and how it's benefitting patients and clinicians was featured on inews.



AI scanning underway

New class of drug leads to 30% reduction in cancer deaths

A new class of drug known as 'antibody-drug conjugates' (ADCs), designed to target chemotherapy directly at bladder cancer cells has increased survival rates by 30%, according to results from a phase III clinical trial led in the UK by Prof Tom Powles at Barts Health. This research found that the risk of death was 30% lower with the new drug than with chemotherapy, with a median survival of approximately 13 months for the new drug. 40% of patients had a complete or partial positive reaction to the ADC therapy, compared to 18% on standard chemotherapy; side effects were manageable and similar to chemotherapy. The results were published in the New England Journal of Medicine and presented at the 2021 American Society of Clinical Oncology's Genitourinary Cancers Symposium.

Prof Tom Powles

Heart Centre researcher wins prestigious award

In October Dr Rebecca Hughes of Barts Health won the British Society of Cardiovascular Magnetic Resonance (BSCMR) Annual Young Investigator Award. She discovered that all the patients in her study, with apical hypertrophic cardiomyopathy, also had impaired blood flow within small arteries at the tip of the heart. Dr Hughes' research uses the novel 'perfusion mapping' technique developed at Barts Health to visualise and quantify blood flow. Clinical research fellow Dr Hughes said: "In research, it is very rare for a new finding to be 100% prevalent. This new insight has the potential to change how we understand the development of the disease, how we diagnose it, and suggests avenues to explore for targeted treatment options in future. It is a privilege to be part of the research team at Barts Heart Centre under the supervision of Professor James Moon, and I am delighted to have won such a prestigious award." More information can be found on the Trust website.

Dr Rebecca Hughes with Dr Mark Westwood, President of BSCMR

New approach to traumatic brain injuries revolutionises diagnosis and treatment


A human brain

New research led by Barts Health and Queen Mary, suggests that biochemical analysis of brain tissue could be used for diagnosis and prognosis of severe traumatic brain injury (TBI) to improve patient outcomes and save billions in future clinical trials. The study, led locally by Dr Chris Uff and Dr Ping Yip and published in Biomedicines Journal in February, is the first to look at what happens to the injured brain at a cellular and molecular level in the acute phase. The study involved 25 adult patients – with brain biopsies obtained shortly after injury undergoing specialised analysis called immunohistochemistry. This analysis revealed previously unknown cellular and biomolecular changes, allowing the researchers to 'score' the severity of injury using their own novel grading system. That information could determine whether patients might benefit from certain treatments. Current neuroimaging techniques such as CT and MRI and based on the Glasgow Coma Scale developed in 1974, lack the resolution to detect cellular and molecular changes, so this adds significantly to the diagnostic tools available.

PERFORMANCE AGAINST OBJECTIVES 2021/ 2022

Successful bid for major NIHR CRF funding

Barts Health was awarded, for the first time, prestigious funding for a National Institute for Health Research (NIHR) Clinical Research Facility (CRF) at the Royal London Hospital. This is a major enabler and will attract further research investment. NIHR feedback was that the community and patient engagement strategy, led by Dr Vanessa Apea, Neeta Patel and Prof Chloe Orkin, was "exemplary". Our application to Barts Charity to fund the associated building works and underpinning support costs for the CRF is progressing with the Charity incorporating fundraising for the Facility into its Barts 900 campaign. Our CRF is designed to capture the best elements of current early-phase trial teams, build an inclusive model with equity of access for all our patients and so provide the infrastructure that enables research to grow at Barts Health.

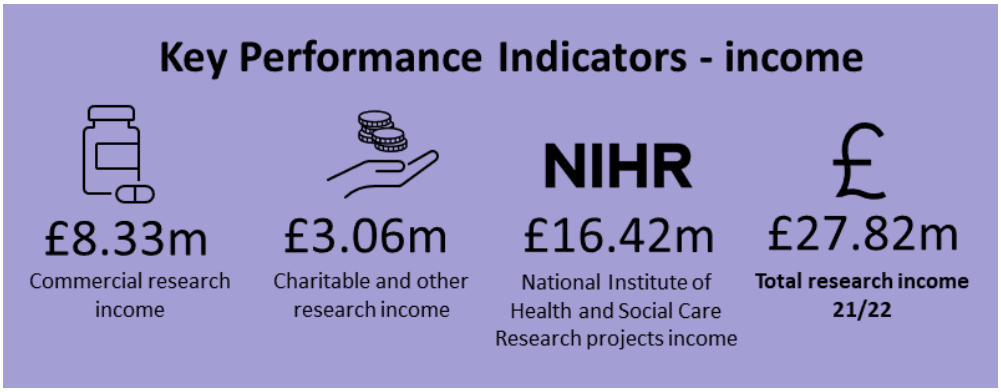
Re-start programme

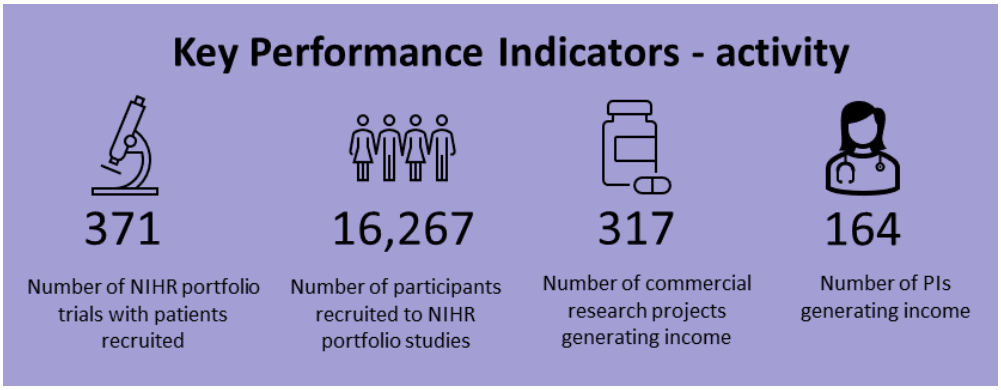
For the last two years the number of studies actively recruiting patients has declined as studies and trials were suspended or recruitment halted, due to the pandemic. As the situation eased a managed recovery process was initiated by the NIHR, with the objective of reinvigorating research activity in the NHS, identifying priority studies that trusts should focus on in their re-start programmes. In addition, the number of new studies coming through from pharmaceutical companies and academic institutions significantly increased as organisations released new studies from their development portfolios that have steadily accumulated but couldn't start because of the situation in trusts. The result has been a significant increase in the number of studies seeking start up approval, putting huge pressure on the JRMO Governance and Contracting staff. A managed re-start programme was set up to prioritise projects in accordance with NIHR guidelines. As a result, we had seventeen Covid-19 studies open to recruitment in 21/22 and 157 other studies were 're-started'.

Covid-19 Research

We have continued to follow national guidelines on Covid 19 prioritisation of Urgent Public Health projects this year and supported participation in seventeen Covid-19 vaccine and treatment studies recruiting 5,272 subjects to them. Following the successful delivery of the ENSEMBLE-2 vaccine trial, the centre has delivered an additional four Covid-19 and other vaccine trials. The centre has also moved to a permanent base at Mile End Hospital, where it will continue to have a specific focus on vaccines trials.

FINANCIAL PERFORMANCE AND INITATIVES





Research Finances

In forecasting outturn for 2021/22, the continuing impact of the pandemic was considered and a conservative estimation of total income of £25.5m calculated. In the event actual outturn was £27.8m, 9% above forecast and roughly the same as our 20/21 outturn. Commercial income outturn was £8.3m against a target of £7.2m and although less than our 20/21 outturn, which was boosted from significant income received from our vaccine trials, it does indicate an increase in commercial trials activity due to the positive impact of our research re-start programme. See Table 1 for high level KPI breakdown and Appendix 1 for Clinical Board breakdown.

Activity Indicators

This year we recruited over 16,000 patients to our NIHR portfolio studies, the highest recruitment rate in our Network region and in the top five in the UK, which was on a par with our outturn projections. The number of trials we recruited to has also risen significantly which reflects the effort put into our research re-start program.

Table 1: Actual Outturn 2021/22	2021/22 Target £000	2020/21 Outturn £000	Inc/ Dec %	2021/22 Outturn £000	RAG
Commercial Research Income	**7,180**	9,573	-25%	**8,332**	
NIHR Projects Income	**16,000**	16,070	0%	**16,426**	
Charitable and Other Income	**2,343**	2,232	5%	**3,064**	
Total Income (NIHR, Commercial and Other)	**25,523**	**27,875**	**-8%**	**27,821**	
Number of portfolio trials with patients recruited in current FY	**230**	191	20%	**371**	
Number of portfolio patients recruited in current FY	**16,000**	15,965	0%	**16,267**	
Number of commercial research projects generating income in last 12 months	**370**	439	-16%	**317**	
Number of PIs generating income in last 12 months	**185**	160	16%	**164**	

Life Sciences Research

During 2021/22 The Barts Life Sciences research programme of artificial intelligence (AI) and machine learning projects, launched five new projects working with industry partners, ranging from using AI Intelligence to improve the diagnosis of thyroid cancer to establishing digital visual biomarkers indicative of disease progression and disease stability in children with optic pathway glioma using a vision-science video game. The Data Sciences team have Continued the delivery of the Covid-19 Dataset for national requirements in addition to undertaking a range of initiatives with the NIHR Health informatics Collaborative and other partners that use data to address a range of important healthcare issues, developing tools and models in reproducible analytical pipelines to support research across the Trust for example, using patient notes to predict vascular complications of diabetic foot.

Other Strategic initiatives

Once again, the impact of the pandemic has impacted on some of our planned activities this year. But significant progress has been made in many areas.

Biomedical Research Centre (BRC)

Our ambitious and strong bid for a much-enlarged BRC was submitted this year reflecting our aim to expand the scope of our research activities to four interrelated themes from the current single funded theme. Success in this bid will enable a step change in the range of research activities that we can engage in with our partner Queen

Mary University of London and enable significantly increased future financial support from the NIHR.

People Initiatives

Our priorities this year were centred around improving our people capacity in research, reinvigorating those initiatives that were either suspended or stalled as a result of the pandemic and focusing on our research recovery activities. Our consultant leadership programme was reduced this year and we continued to work with QMUL to establish new clinical academic roles in areas where research activity is low. Our Whipps Cross Hospital Academic Centre for Healthy Ageing proposal is progressing with Barts Charity and we are optimistic that this innovative initiative will be funded. This will create at least two senior clinical academic posts in geriatric medicine at WXH. Our drive to engage more of our nursing and allied health professionals in leading research has not made the progress that we had hoped for and this will be an area of focus for the coming year. We also plan to explore options for managing our research delivery staff establishment with a view to developing a more flexible and responsive research workforce.

Patient and public involvement and engagement

Building on work started in July 2020 to support our community engagement on the topic of vaccines research, our priority has been to support our researchers to engage with groups historically under-represented in research. We have also delivered or participated in several online events, workshops and discussion forums about research, health inequalities and effective community engagement. Outputs include the production of a culturally sensitive short animation, which has been made available to our research workforce as a tool to support community engagement.

There has been a notable increase in the number of requests from researchers seeking PPIE advice and guidance. In particular, the number of queries relating to 'payment for involvement'. Working with JRMO senior finance manager and others we have introduced new payments guidance for researchers.

Other work has included, in partnership with Trust, Queen Mary and our CRN comms departments, the production of a number of case studies, press releases and/ or videos about Barts Health research activity, including Medicago, RECOVERY, and the Barts 900 charity bid. By way of example, please see Karen's story on the next page.

During 2021/22, we also reinstated our PPIE practitioners network, comprised of PPIE leads from across Barts Health, Queen Mary and regional partners (e.g. UCL Partners, CRN:NT); relaunched NIHR Patient Research Experience Survey (PRES) (see Appendix 4 for 21/22 results) and; re-established our Patient Research Champion programme; activities which were either paused or greatly reduced during the pandemic.

TRIAL PARTICIPANT EXPERIENCE

Karen's story - published: 21 May 2021, Clinical Research Network: North Thames

As a nurse herself, Karen was caring for others when she was struck with Covid-19 in November 2020.

She was admitted to Whipps Cross Hospital with double Covid-related pneumonia and moved to the acute respiratory ward, where she was invited to take part in the RECOVERY trial. She immediately grasped the opportunity and feels that her participation may have helped her leave hospital sooner than she might otherwise have done. She says:

"I said yes straight away. I wanted to take every opportunity as even if it didn't benefit me, it might have benefited someone else. Any information was desperately needed then."

Karen received several treatments on the trial, including dexamethasone, which was later shown to assist recovery and reduce deaths in patients who were ventilated or receiving oxygen. She remembers:

"I was very poorly and felt it could have gone either way, but in a short time began to make a fast recovery. It felt really good to be part of the research.

"It was such a scary time. No one really knew what to do about Covid then and I was very scared. It was a horrible feeling to know you are diagnosed with double pneumonia right in the middle of a pandemic but everyone on the trial was so positive. They said 'we've learnt so much already, we'll get you through this'.

"I thought previous trials have been going on to lead to this point and without those, we wouldn't have made progress already. It made a lot of sense to help carry on and contribute more to the knowledge."

Whilst the trial was searching for new treatments, Karen herself was not a stranger to research. Fifteen years ago, she had been diagnosed with a sarcoma (a rare form of cancer). As a result, she had already taken part in several trials into radiotherapy, genomics, and the effect of hormones on sarcomas. She has even been involved as an NIHR CRN patient representative for sarcoma studies, as well as contributing to patient reviews in cancer trial protocols.

Karen was discharged from her Covid-19 admission at the beginning of December but was then affected by 'Long-Covid'. She feels grateful not to have suffered with all possible symptoms, but her muscles were initially badly affected.

As an avid walker, she had plans to stride 50km for charity this year but for some time, was struggling to walk to the door. It took a long time to recover her energy and her thinking and concentration were also affected.

Six months on, she is at last feeling better. Karen is walking again; can soon re-join her walking groups and is looking forward to returning to work. Finally, some good news too, as she is delighted to have been recently discharged after her 15 years of cancer.

With so much behind her now and with so much ahead to look forward to, Karen reflects on the important part that research has played for her.

"It feels so good to be walking again and back in the forest but I'm so glad I could be part of the research. No matter what the field, clinical trials are so essential in developing better patient care and to improving peoples' outcomes.

"I'm just grateful. It feels like everyone is pulling together with research. Even if a trial shows a treatment isn't working, it's still good because we are learning what not to waste time on."

When asked what message she'd give to others who are considering getting involved, she says:

"Don't be scared of research. You could benefit directly yourself and so many other people as well. I would encourage anyone to take part in clinical trials. Without people taking part, we wouldn't know what we know about treatments already."

FORWARD OBJECTIVES: 2022/23

In setting out our plans for the year ahead we will re-focus on the delivery of our five-year strategy by re-starting our research programmes as our hospitals return to business as usual. We will also re-visit the strategic plan which is due for renewal in 2024 and work with our primary academic partner, QMUL, to construct a new five-year Joint Research Policy.

One feature of the drive to set up new studies is that although we have more active studies on our portfolio, recruitment to these studies is low, raising questions about their viability in terms of recruiting to target or their financial viability, something that has been recognised at national level. It is clear that the NIHR have concerns about this and national measures have been put in place to curb the number of studies on the national portfolio by removing those that, in the opinion of the NIHR, are not viable propositions (see Appendix 2 Letter from Professor Lucy Chappell and Dr Louise Wood). This could impact on our grant funding and possibly commercial trial income. Our objective this year will be to put in place measures to protect our portfolio and work with our investigators to ensure recruitment levels are sustained, directing available resources to supporting those studies that can attain recruitment targets.

Once again other objectives have been impacted by the pandemic and our plans for 2022/23 will include refreshing and re-invigorating our programmes to reflect the new post-pandemic environment in which research will take place.

Objectives 2022/23

1. Re-start programme and study set-up.

- We will review our study start-up procedures, introduce a proportionate review process for low-risk projects to enable us to streamline and speed up our JRMO Capacity and Capability reviews and provide additional training for our researchers and their support staff in how they can work with the JRMO to facilitate a quick turnaround of projects submitted for Trust approval.
- We will continuously review the position as the pandemic progresses, implementing relevant procedures should the UK face another surge in Covid-19 cases.

2. Portfolio Review

We will construct a system for continuous portfolio review geared towards ensuring that our studies recruit to time and to target. This will enable us to put in place

measures to protect our portfolio and work with our investigators to ensure recruitment levels are sustained directing available resources to supporting those studies that can attain recruitment targets.

3. Covid-19 Research

- We will continue to follow national guidelines on Covid-19 prioritisation of Urgent Public Health projects and
- Support participation in Covid-19 vaccine studies at the Mile End vaccine trials centre.

4. Finance and Performance Metrics

The Trust met all of its financial targets in 21/22 and once again this was largely due to a strong performance in recruiting to both commercial Covid-19 treatment and vaccine studies, maintaining activity levels in our cancer research programme and the effects of our re-start activities. This year it is likely that Covid-19 related recruitment will drop substantially. Although our project start-up activity is high, this has not been followed by a significant increase in patient recruitment, although we expect recruitment to accelerate as we move into and through the new year. For this reason, our forecast income has been pitched at a conservative level and will be reviewed and perhaps amended at month 6, as the position on re-start becomes clearer. Table 2 shows 22/23 forecasts.

Table 2: Forecasts 22/23	2022/23 Forecast £000	2021/22 Outturn £000	Inc/Decr %
Commercial Research Income	**9,165**	8,332	10%
NIHR Projects Income	**16,000**	16,426	0%
Charitable and Other Income	**3,370**	3,064	10%
Total Income (NIHR, Commercial and Other)	**28,535**	**27,821**	3%
Number of portfolio trials with patients recruited in current FY	***390***	371	5%
Number of portfolio patients recruited in current FY	***17,894***	16,267	10%
Number of commercial research projects generating income in last 12 months	***350***	317	10%
Number of PIs generating income in last 12 months	***170***	164	4%

5. Consultant leadership: Support ten consultants to become research active within two years.

Although this initiative was suspended during the pandemic it will be re-visited and revitalised next year. Consideration will be given to opening the initiative for new applicants in 2022.

6. Clinical academic leadership

The initial objective was to establish two new clinical academic roles in partnership with Queen Mary University of London, in departments with little or no current research activity and a post in Orthopaedics was filled in 2020. Work on this is on-going and our Whipps Cross Hospital Academic Centre for Healthy Ageing proposal is progressing with Barts Charity. We are optimistic that this innovative initiative will be funded. This will create at least two senior clinical academic posts in geriatric medicine at WXH with several avenues being explored for developing similar roles in partnership with QMUL.

7. Widening our Partnerships

Our new partnership with Barking, Havering & Redbridge University NHS Trust will further increase the population that our trusts jointly serve, and this provides us, as partners, with an opportunity to expand our research offer to communities in both organisations. Through partnership working we will share expertise, best practice in delivering research, collaborative opportunities and academic knowledge and know-how. We are actively talking with our opposite numbers at BHRUT about how we can support and work with them and are looking forward to engaging with colleagues from the Homerton as our collaboration expands.

8. Nursing and allied health professionals

This will be an area of focus this year and we will work with leaders within the Trust for nursing, midwifery and allied health professionals to promote multi-professional research activities in the Trust as part of the review of the current strategy.

9. Infrastructure funding

The following major projects are underway. We will review the bid outcomes as they are announced and work with our research teams to help manage their programmes.

- **Biomedical Research Centre**: The bid was submitted in 2020 and we will be informed of the outcome later this year. Our objective will be to work with the BRC senior leadership team to implement the new five-year award if the application is, as expected, successful.
- **Clinical trials infrastructure, NIHR bid:** Our application was successful for the first time and we will work with the NIHR to revise our delivery programme in line with the available funding. We will also ensure that a holistic funding plan is presented in our Outline business case to the Trust Board that incorporates NIHR, Barts Charity and commercial income sources.

Post Hoc Note

We have recently been informed that our BRC bid has been successful and The Trust, in partnership with QMUL, has been awarded a five year grant of close to £21m. This compares to a current award value of approximately £6.5m and is a significant achievement by the team led by Professor Sir Mark Caulfield. We will now work to implement the new BRC programme which will start in December 2022.

10. Bioinformatics and information governance

The initiative led by our Life Sciences colleagues to develop a secure data facility with robust information governance procedures to support research using NHS patient data will be continued next year. The shared objective will be to establish a service which enables our internal research community and external partners to conduct research using our patient data. The Lifesciences teams' ambitious programme of work for 2022/23 will include research and development projects in the early detection and prevention of disease, stratified medicine, patient outcome predictions and improvements in the management of patients in a variety of hospital environments.

11. Barts Health Research Strategy Review

Our original plan was to re-visit the Trust's five-year strategy in preparation for the development of a new five-year strategy in 2023 but work on this was put on hold whilst the R&D leadership team dealt with contingent issues that arose as a result of the pandemic, changes to the Trust's Clinical Leadership team and the appointment of Professor Sir Mark Caulfield as QMUL's Vice Principal for Health. It has been agreed that work on a new Joint Research Strategy will begin this year to synchronise the future for research that our organisations will jointly and severally engage in.

12. Patient & Public Involvement and Engagement (PPIE)

We will continue to work to ensure that we maximise the opportunities for Patient and Public Involvement and Engagement in our research. We will:

- Actively support inclusion, diversity and equity in our research endeavours.
- We will support the involvement of patient groups who are often excluded from participation in research.
- We will embed standards, reporting and a culture of feedback and evaluation to demonstrate and evidence the impact of PPIE on our research programmes.
- We will champion reward, recognition and payment for those involved in our PPIE activities.
- We will strengthen and build upon existing work by the NIHR and others and learn and share knowledge and experience of PPIE throughout our organisation.

Rupert Pearse
Clinical Director of Research
29th July 2022

Gerry Leonard
Director of Research Development

APPENDIX 1: KEY PERFORMANCE INDICATORS: OUTTURN BY CLINICAL BOARDS 2021/22

Actual Outturn 2021/22	2021/22 Target £000	2020/21 Outturn £000	Inc/Dec %	AHS £000	Cancer £000	Cardiovascular £000	Childrens Health £000	CSS £000	Medicine £000	Surgery £000	Womens Health £000	Other £000	Total £000
Commercial Research Income	**7,180**	9,573	-25%		*2,227*	*1,010*	*124*	*706*	*4,029*	*235*	*0*	*1*	***8,332***
NIHR Projects Income	**16,000**	16,070	0%	5,497	*969*	*2,231*	*535*	*766*	*2,802*	*505*	*448*	*2,672*	***16,426***
Charitable and Other Income	**2,343**	2,232	5%		*86*	*1,406*	*108*	*128*	*797*	*422*	*82*	*36*	***3,064***
Total Income (NIHR, Commercial and Other)	**25,523**	**27,875**	**-8%**	**5,497**	**3,282**	**4,646**	**767**	**1,600**	**7,628**	**1,162**	**529**	**2,709**	***27,821***
Number of portfolio trials with patients recruited in current FY	***230***	191	20%	*0*	*71*	*45*	*19*	*14*	*134*	*67*	*11*	*10*	***371***
Number of portfolio patients recruited in current FY	***16,000***	15,965	0%	*0*	*566*	*2,207*	*1,550*	*80*	*9,589*	*1,467*	*529*	*279*	***16,267***
Number of commercial research projects generating income in last 12 months	***370***	439	-16%	*0*	*69*	*52*	*15*	*22*	*134*	*24*	*0*	*1*	***317***
Number of PIs generating income in last 12 months	***185***	160	16%	*0*	*18*	*29*	*12*	*11*	*63*	*23*	*4*	*4*	***164***

Notes: 1) Combined Emergency Care & Trauma with Medicine; 2) Combined Inactive Project with CSS

APPENDIX 2: NIHR LETTER: URGENT ACTION TO ADDRESS THE CURRENT RESEARCH DELIVERY CHALLENGES IN THE NHS

Department of Health & Social Care

NIHR | National Institute for Health Research

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39 Victoria Street
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SW1H 0EU

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E: Louise.Wood@dhsc.gov.uk
Lucy.Chappell@dhsc.gov.uk

Sent via email

17 February 2022

Dear colleagues

URGENT ACTION TO ADDRESS THE CURRENT RESEARCH DELIVERY CHALLENGES IN THE NHS

We are writing to update you on continued efforts to support the delivery of research and our commitment to support a diverse and balanced portfolio of studies.

We remain committed to delivering on the ambitions set out in Saving and Improving Lives: the future of UK clinical research delivery, and to supporting the recovery of UK clinical research delivery system needed to enable this. However, clinical research delivery is facing unprecedented challenges at present, and we believe there is now an urgent need and an opportunity to reset to build a stronger future.

The Managed Recovery process was implemented in spring 2021 and has had a degree of success. Studies selected by research funders and sponsors for inclusion in the Managed Recovery cohort have recruited more quickly than those on our wider portfolio. However, this has not had the effect of clearing the path for other studies paused or delayed in the early stages of the pandemic to return to the levels of recruitment that would normally be expected.

The Clinical Research Network currently supports studies from a wide range of non-commercial and commercial funders, with around 20% being directly NIHR-funded. The number of studies in the portfolio is currently higher than ever before. This is accounted for by the additional COVID-19 studies; other research that has remained on the portfolio from before the pandemic that has been paused or delayed by pandemic-related challenges; together with new studies being funded and coming into the system. In addition, the number of studies in set up is now much higher than prior to the pandemic, further increasing the workload for NHS R&D offices and research delivery teams. This is taking place in the context of the recovery of NHS services and the ongoing pandemic, with the most recent omicron wave significantly impacting staffing levels across the system. Throughout this the resilience of the workforce has been remarkable.

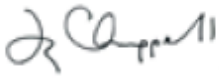
We have consulted with stakeholders across the research system and the NHS and have heard consistently that we now need to take radical action to address the situation. Data available through the NIHR portfolio management systems has confirmed this and emphasises the need for an expedited approach. We have therefore initiated work at pace

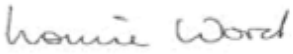
to develop options for a revised approach. It is likely that this will include closing some studies that are struggling in the current context. Subject to agreement from Ministers, we will share plans with partners and stakeholders in the first weeks of March 2022.

In developing options, we will consider the open portfolio, new studies coming into the system, supporting sites to make transparent and realistic assessments of capacity and capability, and potential implications of any changes on the future portfolio and UK ecosystem.

The aim of this work is to ensure that the research ecosystem can continue to flourish. We are committed to undertaking this essential work in a transparent and informed way so that together we are able to deliver on the potential of clinical research to tackle health inequalities, improve the lives of people across the UK and to boost economic recovery.

Yours sincerely





Prof Lucy Chappell
CEO
Chief Scientific Advisor

Dr Louise Wood CBE
Deputy CEO
Director: Science, Research & Evidence

National Institute for Health Research – Department for Health and Social Care

APPENDIX 3: IDENTIFIED RESEARCH RISKS

There are currently two corporate R&D risks:

(i) Inaccuracies with research invoicing leading to a reduction in income

Not all research income is being invoiced accurately or on time possibly leading to income loss. Inaccuracies often caused by communication issues between research teams, JRMO and commercial sponsors. Sponsors then dispute or refuse to pay invoices.

There is an SOP in place that directs staff through the invoicing process and staff are fully trained in the procedure. However, the process for collecting patient activity data from research groups, pricing that information and constructing invoices via credit control is complex and there can be considerable interactions with companies that refuse to pay invoices that are marginally in error because somewhere in the information exchange chain an error has occurred. Controls are still in the process of being worked through. Additional investment in training or systems is being established and changes being made. However, there remain concerns, particularly as commercial research increases in importance due to the reduction in NIHR/ Govt funding, and a new paper has been called for by the Trust's Research Board. A review of internal arrangements has concluded now, and a staff consultation on consequential changes to work practices, team restructuring, and Job Descriptions is proceeding.

The risk rating has already reduced, due to changes to date, and it is hoped can be significantly mitigated (leading hopefully to risk closure) by Autumn 2022. It is currently deemed moderate consequence, might happen or recur occasionally (score 9).

(ii) Reduction in UK Government research funding to Barts Health

Reduced infrastructure and support funding from NIHR, and other Government funding bodies, for Barts Health research.

NIHR and other Government funding bodies are reducing funds to support research for NHS Trusts. Influencing NIHR funding decisions is almost entirely outside of our control and the only way to address reductions in funding is to focus on generating income from other funding streams, commercial, charities and non-Government funding in general. This continues to be an issue and impact remains uncertain during this post-pandemic period with other sources of research funding restricted. The situation is now stabilising, and a substantive review of income-related risks can be undertaken in FY 22/23.

This risk is currently deemed moderate consequence, might happen or recur occasionally (score 9).

APPENDIX 4: NIHR PATIENT RESEARCH EXPERIENCE SURVEY 2021/22

"I have been well looked after with tests, appointments, follow ups etc. The team of doctors and nurses kept me updated and always came up with solutions to my problems". Cancer study participant, aged 65-74

In 2021/22, we again took part in the NIHR Patient Research Experience Survey (PRES), a key means of gathering feedback from patients who take part in our studies and to learn what works best for them. The feedback we gather from the survey enables us to make targeted changes in the way we undertake our research in the future. This a key part of PRES, where we can make improvements as a result of the survey. This highlights our commitment to continuously monitor our performance and adjust the way we deliver research.

We were pleased to discover the overwhelmingly positive feedback of our participants' research experiences. Here are some key figures from our 21/22 PRES campaign:

- 92% of participants felt prepared for the study before it took place
- 92% of participants knew who to contact during the study
- Throughout the trial, 95% of participants reported feeling respected by researchers

Due to recovery from the Covid-19 pandemic, we received significantly fewer responses during this year compared to previous years. Nonetheless, we collected 137 responses, equal to a second-place finish within the NIHR CRN: North Thames network. Providing us with a significant amount of patient feedback to help us better understand what is important to patients taking part in our studies, we use this feedback make improvements, where they are likely to have the greatest impact.

Changes made in response to PRES

- Contacting patients by phone/in clinics and giving them the option to receive study information via their mode of conversation.
- Consider offering virtual follow-ups for patients who must travel further, as, and where possible dependent on study protocol.
- Improving ways to share study results with trial participants – currently, each study has its own dissemination SOP; the local plan is to streamline this process and create an SOP to be applied to all studies.
- Improve the dissemination of research results using infographics and other formats (such as videos), ensuring we share study results with staff and patients in a more streamlined process across all studies.
- Improve visibility of research by ensuring that current information about relevant research (for example, current trials or updates) is featured on the Barts Health website and made available in our clinics and waiting areas.

For more information about NIHR PRES at Barts Health, contact Neeta Patel, Associate Director, Research Engagement neeta.patel6@nhs.net