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 18 January 2023 at 11.00am in Room 1.36, 1st Floor, Garrod Building, Turner Street, The Royal London Hospital, Whitechapel E1 2AD
Scheduled to end by 13.45

AGENDA

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

		Paper TB	Lead	Time
1.	**WELCOME**		Rt Hon J Smith	11.00
2.	**APOLOGIES FOR ABSENCE:**			
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 2 November 2022 and review the action log appended to the Minutes	01/23	Rt Hon J Smith	11.00
5.	**MATTERS ARISING** 5.1 CQC maternity action plans 5.2 To consider any matters arising from the Minutes not covered elsewhere on the agenda		Ms C Alexander	
6.	**STAFF STORY** To hear a staff story		Mr D Waldron	11.10
7.	**CHAIR'S REPORT** To receive the Chair's report		Rt Hon J Smith	11.30
8.	**CHIEF EXECUTIVE'S REPORT** To receive the Chief Executive's report		Mr S DeGaris	11.25

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		Paper TB	Lead	Time
QUALITY AND PERFORMANCE				
9.	**INTEGRATED PERFORMANCE REPORT – 2022/23 M8** To receive the report and discuss: • Quality and Safety • Operational performance • People • Financial performance	02/23	Prof A Chesser / Ms C Alexander Mr C Pocklington Mr D Waldron Mr H Virdee	11.30
10.	**BOARD ASSURANCE FRAMEWORK** To receive and approve the BAF	03/23	Mr A Hines	12.20
11.	**REPORTS FROM BOARD COMMITTEES** 11.1 Finance Performance and Investment 11.2 Audit and Risk Committee 11.3 Quality Assurance Committee	04/23 05/23 06/23	Mr A Sharples Ms K Kinnaird Dr K McLean	12.30
STRATEGIC DELIVERY PLANS AND IMPLEMENTATION				
12.	**WHIPPS CROSS REDEVELOPMENT** To receive a report	07/23	Mr A Finney	12.45
13.	**PEOPLE STRATEGY IMPLEMENTATION** To receive a report	08/23	Mr D Waldron	12.55
14.	**PATHOLOGY PARTNERSHIP** To receive NHS East and South East London Pathology Partnership annual review	09/23	Mr D Monk and Mr A Knott	13.05
GOVERNANCE				
15.	**CLINICAL RESEARCH NETWORK** To approve the North Thames clinical research network governance framework	10/23	Prof A Chesser	13.20

16.	**ANY OTHER BUSINESS**			
17.	**QUESTIONS FROM MEMBERS OF THE PUBLIC**	11/23		13.25

18.	**DATE OF THE NEXT MEETING** The next meeting of the Trust Board in public will be held on Wednesday 1 March 2023 at 11.00am in the Boardroom, Junction 7, Whipps Cross Hospital, Whipps Cross Road, Leytonstone E11			
19.	**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

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BARTS HEALTH NHS TRUST

TRUST BOARD MEETING (PART 1)

Minutes of the Trust Board meeting held in public on
Wednesday 2 November 2022 at 11:00 in the Education Centre,
Newham University Hospital, Plaistow, London

Present:
Rt Honourable J Smith (Chair)
Mr A Sharples (Vice Chair)
Mr S DeGaris (Group Chief Executive)
Mr M Trainer (Deputy Group Chief Executive)
Professor Sir M Caulfield (Non-Executive Director)
Ms J Ferns (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)
Ms S Teather (Associate Non-Executive Director) *
Mr A Abraham (Group Director, Inclusion and Equity) *
Ms C Alexander (Chief Nurse)
Professor A Chesser (Chief Medical Officer)
Mr A Hines (Director of Corporate Development) *
Mr C Pocklington (Interim Chief Operating Officer) *
Mr M Turner (Interim Director of Strategy) *
Mr H Virdee (Chief Finance Officer)
Mr D Waldron (Director of People) *
Mr C Williams (Associate Non-Executive Director) *

In Attendance:
Mr S Collins (Trust Secretary)
Mr S Sharma (Deputy Trust Secretary)

Apologies:
None.

** Non-voting member*

01/23 WELCOME

The Chair welcomed Board members, staff and members of the public to the meeting.

02/23 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).

No declarations were made.

03/23 MINUTES

The Minutes of the meeting of the Trust Board held in public on 5 October 2022 were received and approved.

04/23 MATTERS ARISING

There were no matters arising.

05/23 STAFF STORY

Two senior midwives from Newham University Hospital's maternity ward, Unesu Joice Dandato and Temitope Bello, accompanied by the Newham Director of Nursing and Governance, explained how they managed the flow of women via a new triage process and maternity assessment unit. The new and innovative triaging system, based on learning from the Birmingham Symptom-specific Obstetric Triage System, introduced a colour coding system to support prioritisation according to urgency and complexity. The midwifery team outlined the benefits seen as a result of adhering to this change in approach while noting also some key dependencies linked to the unit's staffing levels, senior staff oversight to support more junior staff in decision-making, and the effective communication of the approach to service users and their families. . The primary concern of the team in sustaining this safe and efficient approach related to adequate staffing of the unit. Although staffing establishment levels had recently increased to recognise these pressures, fulfilling all shifts remained an ongoing challenge.

The Chair and Board members thanked the midwives for their presentation and their personal commitment and persistence in implementing these beneficial changes.

Ms Kinnaird noted it was helpful to hear we were now taking a risk-based approach and asked how the communication issues around understanding the rationale for some waiting shorter or longer times to be seen were being tackled. Ms Bello noted that attendance at the hospital's ante-natal classes was being strongly encouraged to develop a realistic understanding of the hospital's approach and likely labour and birth experience. She also noted the importance of effective communication and reassuring women around what is happening to them, ensuring that they understood the approach and

timescales involved in interventions. Ms Dandato confirmed that senior midwives were available on both day and night shifts to support the prioritisation and decision-making involved in triaging.

Mr Sharples asked about the challenges of addressing the national midwifery recruitment issues. The Newham Director of Nursing and Governance noted the hospital had retained 81% of its newly qualified midwives and had taken steps to research the reasons for people leaving the service when this occurred. There was a healthy pipeline of overseas recruitment in place. Ms Bello was aware of the national shortages, budgetary issues and shifts not being taken up after being scheduled.

Ms Teather noted the dependency of triaging upon staffing and asked what happened when there were staff shortages. Ms Dandato noted that mitigations were in place in the form of reverting to the pre-existing system of patient reviews.

Ms Ferns noted the improved morale and working environment and asked whether there had been other factors that had contributed to working effectively. Ms Bello indicated that communication had improved and that staff were responding with better understanding. Teamwork was also being promoted.

Mr Williams was impressed with the work done and was interested to see how effectively the hybrid electronic and paper system was working. Ms Dandato noted that electronic systems had just started to be utilised in the triage area and better results were expected when the new system was integrated into the Trust's Cerner system.

The Chief Nurse noted that a report on the development of digital systems in NE London, including timelines for completion of maternity systems (following on from initial roll out in ante-natal services) would be presented to the Board in future.

ACTION: Interim Director of Strategy and Chief Nurse

06/23 CHAIR'S REPORT

The Chair was pleased that the Board had had the opportunity to witness maternity staff being very positively engaged as part of their visit to Newham University emergency and maternity departments earlier in the day. She highlighted the importance of non-executive directors and group executives visiting hospital departments to hear directly from local leaders and witness how services were being provided.

St Bartholomew's Hospital would be celebrating its 900th year anniversary in 2023 and the Chair thanked Barts Charity for their financial contribution to the

campaign. She also thanked all staff involved in contributing to Black History Month events during October.

The Chair and Group Chief Executive had attended the North East London (NEL) joint Health & Scrutiny Committee last month to discuss how the establishment of the Acute Provider Collaborative (APC) was progressing. The Deputy Group Chief Executive would provide a further update on collaboration later in the meeting.

The Chair and the Group Chief Executive had also met with NE London MPs and council leaders to discuss the redevelopment of Whipps Cross University Hospital. This meeting had reflected a cross-party consensus on seeking to co-ordinate support for this programme. The Chair recognised that the numerous changes at central government level could increase the risks to timely business case approval processes. Progress was being made on enabling works and approval was expected to enable the appointment of a preferred bidder with completion of this stage in mid-2024. The Chair noted the importance of having cross-party agreement for the redevelopment plans and previous messages of support from the previous and the incoming Secretary of State for Health and Social Care.

The Chair added there had been a request for the Trust to submit a self-certification regarding waiting list reduction plans to NHS England by 11 November 2022. A recommendation would be made to Trust Board members in the next week relating to this submission.

07/23 GROUP CHIEF EXECUTIVE'S REPORT

The Group Chief Executive noted that Urgent and Emergency Care (UEC) pressures had continued to be reported by all NEL providers and confirmed that the Trust's hospitals remained very busy requiring significant endeavour to maintain quality and safety standards. Winter planning was underway and there would be an opportunity for Board members to comment on this later in the meeting.

He commended The Royal London Hospital and St. Bartholomew's Hospital for their recent accolades, being ranked amongst the world's smartest and best hospitals respectively.

The Group Chief Executive noted that he had attended the Trust's annual remembrance service last weekend, hosted at St Paul's cathedral for the first time since the pandemic had started, and he paid tribute to the event organisers.

He noted progress with the insourcing of facilities services, with the first tranche of Serco staff having been successfully transferred into the organisation on 1 November 2022 as part of this phased process.

08/23 PROVIDER COLLABORATION

The Deputy Group Chief Executive outlined some key developments in the APC, which had been focussing on workstreams for UEC, planned care, maternity, cancer and children & young people. The forum had also helpfully considered options for influencing research and development and specialist commissioning in NE London with the ultimate aim of informing a NEL-wide clinical strategy.

Specific work was progressing daily with Barts Health NHS Trust staff and colleagues from Barking Havering Redbridge University Hospitals NHS Trust (BHRUT) collaborating on joint work. A recent workshop provided the opportunity for the two executive teams to meet in person and it had been encouraging to see the teams' shared values and common goals for digital development and UEC resilience. In the context of significant operational pressures and recommenced CQC activity, it would be important to create space for medium-term strategic thinking about the next steps for the collaboration.

09/23 INTEGRATED PERFORMANCE REPORT

(i) Operational Performance

The Interim Chief Operating Officer confirmed that hospital Emergency Departments (EDs) were still very busy, reporting unprecedented volumes with an adverse effect on performance. The national context was challenging for patients and staff with some long waiting times and ambulance handovers. Operational leadership teams were working hard to mitigate the risks although the level of recent capacity challenges, particularly at The Royal London Hospital were recognised.

There had been a concerted focus on improving elective activity and evidence of progress had been seen in the recent reduction of patients waiting more than 104 weeks for treatment. The challenge ahead was to eliminate patients waiting more than 104 weeks by the end of December. Progress had been reported on reducing 78 week wait volumes though some specialities were having issues with booking appointments early enough. Overall, cancer waiting time performance had remained positive.

Ms Spice was encouraged by the progress with waiting time performance and requested that reporting helped the Trust Board maintain sight of how patients waiting more than 52 weeks for treatment would be tracked going forward. The Interim Chief Operating Officer agreed that this should be a part of steps to return to business-as-usual reporting, recognising that pre-pandemic this cohort of patients had been reduced to single figures. There

would be a considerable challenge to reach the required activity levels to recover this performance.

Dr McLean asked about steps to address recent cancer performance deterioration. The Interim Chief Operating Officer noted the potential for changes to ways of working would be discussed at a forthcoming leadership session, considering how to protect the elective care programme. He highlighted the Barts Health Orthopaedic Centre in Newham as an example of where capacity could be more easily ringfenced. However, he highlighted the need for balance with a recognition that emergency cases often demanded clinical prioritisation. Dr McLean recognised that some strategic choices may need to be considered to shift the emphasis from a day-to-day reactive approach.

(ii) Quality and Safety

The Group Chief Nurse highlighted strong performance on pressure ulcer and falls metrics whilst noting targeted plans were in place to improve complaints performance at The Royal London Hospital and Newham University Hospital. Discussion at the upcoming Quality Assurance Committee meeting would include how the new leadership teams were maintaining quality and safety standards while managing the current operational pressures.

Whipps Cross University Hospital remained challenged from a maternity staffing perspective. In terms of the CQC inspection of maternity units, a response had been sent to the CQC with a formal outcome report expected to return later in November. The Chief Medical Officer assured the Board that the main priority during the winter period was to keep all hospitals as safe as possible.

The Chair asked what more could be done to improve duty of candour performance. The Chief Medical Officer felt that it was important to stick to the agreed delivery plan, which also sought to improve the quality of the reports. Whipps Cross University Hospital had now achieved the target and the standard had been consistently met at St Bartholomew's Hospital. Work was ongoing with colleagues at the other hospitals on improving duty of candour performance.

The Vice Chair was concerned by the adverse trend in relation to the timeliness of serious incident (SI) investigations and growing backlog of overdue SI cases. The Chief Nurse indicated that current staffing challenges required careful balancing of priorities but acknowledged and shared the frustration. She confirmed that there was an executive review of every SI investigation outcome and that resulting themes were clustered to inform learning. Assurance was provided around new ways of working which would make the process easier to manage and this new model would be implemented in the next six to nine months. The Vice Chair was pleased to note the publication of

ethnicity data in the report and that there appeared to show no equity issues associated with this protected characteristic. The Director of Inclusion highlighted the ongoing work measuring equity of access, patient experience insight work and the ambition to have an outcomes-based focus on equity.

Ms Seary asked about actions being taken to reduce the reported inequalities for people with learning difficulties. The Director of Inclusion recognised this concern while noting that the current access trend was positive, confirming that this was a primary area of focus in the equity and inclusion workstream. He added that a key priority was developing greater data transparency so that any aspects of unfairness were not overlooked.

Dr McLean highlighted the positive progress regarding never events and confirmed that timeliness of SI investigations would be explored at the November Quality Assurance Committee.

(ii) People

The Group Director of People highlighted stable turnover metrics providing positive signs that things were improving. Temporary staffing spend was greater than for the same period last year by c.£8m and there was a continuing challenge to reduce costs. Challenges also existed to improve the number of completed appraisals and increasing the staff survey response rate (with the 23% response rate remaining 5% off trajectory). Similarly, improved efforts were being made to improve on the current 23% flu and Covid-19 vaccination rate. A number of trade unions had signalled their intention to ballot for industrial action and hospital teams were establishing mitigation and contingency plans.

Ms Seary inquired about what more could be done to reduce temporary staffing expenditure. The Group Director of People noted the primary focus was on substantive recruitment and improving the fill rate. A more co-ordinated approach to managing Bank rates was being developed at Integrated Care System (ICS) level as well as looking into the task of lowering agency costs.

Ms Ferns queried if there were any trends showing lower staff survey response rates from particular sites or protected characteristics. The Group Director of People noted that the key theme was that lower performing areas tended to be those which where clinically very busy and with reduced access to PCs. In seeking to improving the staff survey response rate, The Group Director of People noted targeting specific areas of low response and some incentives for completion, while board members recognised some advantages and disadvantages of this approach.

The Vice Chair questioned whether the low vaccination uptake was related to a gradual rollout process. The Group Director of People noted that vaccinations were offered to all staff and that there were dedicated resources available at

all hospitals and office locations to support this. He confirmed that the aim was to raise the vaccination level to 80% by the end of December; however, based on experience, the Trust could realistically expect to target 60-65% vaccination rate due its size and associated demographics.

Dr McLean asked why increasing numbers chose to work as temporary staff as a preferred method of working. The Group Director of People highlighted an increasing preference for working reduced hours to fit around lifestyles. He noted the importance of making rotas and flexible working options for substantive staff more attractive, confirming that the flexible working policy had been revised and managers encouraged to be more creative in order to assist with retention.

Professor Caulfield offered to assist with training programme expansion and provide a supply chain of staff in newly created roles such as physicians associates, noting the pitfalls associated with not adapting to the issue of insufficient workforce.

Mr Williams asked if the recruitment targets were realistic and the Group Director of People responded, noting there was an initial focus on reducing off-framework agency usage and ensuring clinical areas were staffed to safe levels. He was confident there would be an improvement in recruitment rates but was mindful about upcoming winter pressures creating increasing levels of demand.

(iii) Financial Performance

The Chief Finance Officer noted key points made at the Finance Investment and Performance Committee meeting earlier in the week. He confirmed the need to accelerate activity increases, with a need for greater productivity and efficient use of assets. Shortfalls on activity were reflected in the elective recovery funding position. Some signs of improving activity levels were being seen now, although winter pressures provided some risk to sustaining this. The central finance team were continuing to capture accurately the impact of hyper-inflation on costs.

The Chief Finance Officer noted that he and the Group Chief Executive had attended a NEL summit meeting where the regional forecast for this year had been confirmed as an estimated £50-100m over the planned budget.

Ms Kinnaird asked if any financial activity planning had been done for 2023/24. The Chief Finance Officer noted that his focus was primarily on securing a sustainable run rate in the next year and confirmed this was also a top priority for the sector. Work to identify the deficit drivers would help to identify what a sustainable position would require, while robust capital plans were being developed in anticipation of a constrained allocation next year. Mr Hines

confirmed the Trust Board Seminar on 14 December seminar would allow a further opportunity to discuss financial planning.

10/23 REPORTS FROM BOARD COMMITTEES

A report on recent activity from the Finance, Investment and Performance Committee was provided. The Vice Chair reiterated that the remit of the Finance Investment and Performance Committee had been extended to review aspects of constitutional standards performance and noted discussions on operational challenges, as highlighted earlier in the meeting. A Clinical Research Facility business case was approved and assurance was provided on the 2022/23 outlook, with the committee now concerning itself with operating at sustainable financial levels going forward. There was a plan in place to specifically focus on elements of the drivers of the deficit with a comprehensive schedule of deep dives to consider key themes.

11/23 WINTER PLAN

The Interim Chief Operating Officer introduced the winter plan. He noted that a modelled position had been developed for the Trust over winter months with a resultant gap identified between demand and capacity. He noted that this challenge was in the context of hospitals already experiencing high occupancy rates. He noted that some issues were being identified on same day care schemes and virtual ward schemes and he felt that these would be critical to addressing some of the reported staffing shortfalls. The plan identified some options on ringfencing certain capacity to maintain elective throughput. He also noted that The Royal London Hospital was already seeing pressures such as day surgery cancellations due to emergency volumes. Work was underway to address some key workforce themes including seeking greater clarity on system collaboration.

Ms Seary was interested to hear if anything more could be done to ease access issues in EDs, in the context of the current cost of living climate. She also asked if there was any news in relation winter discharge funding being released. The COO was not aware of any decision on central winter discharge funding and highlighted extensive efforts to strive for improvement in ED waiting times.

12/23 MATERNITY SERVICES

The Chief Nurse introduced the report and praised the Kirkup review of East Kent NHS Trust maternity services for the way it had allowed trusts to reflect on the findings and think independently about developing new working arrangements rather than issuing a series of mandatory actions. The Quality Assurance Committee in November would consider a detailed report on related maternity issues and the Trust Board would be informed of the actions the Trust was taking at its next meeting in January, following the publication of the CQC findings.

Where the report had identified a wide-ranging failure to listen to mothers and families, Ms Teather noted that the East Kent Trust Board had been criticised as being unresponsive. The Chief Nurse agreed that this had highlighted the need for the Trust Board to closely monitor the quality of its maternity services, to be proactive and to seek assurance when issues were escalated.

Mr Sharples suggested that it would be helpful to see the comparative data on maternity SIs to benchmark against other Trusts and particularly in light of the differing national outcomes according to ethnicity. The Chief Nurse noted the plan for a more detailed report to the Trust Board at its meeting on 18 January 2023 reflecting on its CQC report findings and key metrics following discussion of this at the Quality Assurance Committee meeting in November 2022.

13/23 PEOPLE STRATEGY IMPLEMENTATION

Gender Pay Gap Report

The Director of Inclusion introduced the report and thanked the Trust's Women's Network for their contribution in helping to reduce the gap to 11.7%. He confirmed that the Trust remained on schedule to achieve its target of 11% by 2025. There was an understanding that a pay gap existed for ethnic minorities and a commitment had been made to report this data going forward. The Group Director of People added there was positive progression of ethnic minority staff moving into Band 8a positions and relevant teams were now looking into developing these staff into more senior roles. The Chair commended the work of the Trust's BAME staff network.

Ms Ferns acknowledged the progress and was encouraged to hear that targeted inclusion interventions were increasingly informed by intersectionality. She noted the need to address these challenges in developing a highly skilled workforce and welcomed being invited to join the Inclusion Board.

Dr McLean asked if a more ambitious target could be set for reducing the gender pay gap. The Director of Inclusion noted that the Women's Network had helped to devise this target but recognised that it was a healthy challenge to consider a stretch target and he would explore this further with colleagues.

ACTION: Group Director of People

Ms Seary felt that actions arising from the NHS Workforce Race Equality Standard (WRES) often tended towards being generic and suggested the need for more specific plans on managing ethnicity pay gap issues. Mr Williams highlighted the stark imbalances reported for ethnic minorities requiring attention.

Ms Teather asked about confidence levels regarding effectiveness of data collection on equity for people with disabilities. The Director of Inclusion felt that the reported trends should provide some assurance on improvements and confirmed work under way to support staff to identify as disabled and to create a culture where people were more willing to speak out where issues arose. He highlighted the work of the Inclusion Centre on this, being led by the Deputy Group Director of People.

14/23 ST BARTHOLOMEW'S HOSPITAL 900 YEAR ANNIVERSARY

The Group Chief Executive introduced the report, which highlighted key activities as part of preparations for the SBH 900 anniversary in 2023. The Chair confirmed her attendance on the campaign's board, now chaired by Dame Alwen Williams, which had met to decide how to spend the associated budget. She noted a £10m fundraising contribution from Barts Heritage to support restoration works, and thanked Professor Sir Mark Caulfield for his involvement. The Chair promoted a number of upcoming events relating to the anniversary, including the Lord Mayor's Show on 12 November 2022.

15/23 ITEMS FOR APPROVAL

The following items were noted and approved by the Board:

- End Of Life Annual Report
- Medica Revalidation and Appraisal Annual Report
- Use of the Trust Seal

16/23 ANY OTHER BUSINESS

There was no other business.

17/23 QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair introduced the section of the meeting and invited questions from the public.

Questions were received from Newham Save our NHS campaign group representatives Alan Cooper and Rosamund Mykura on PFI, Nuffield Health finances and overseas patient charging.

- The Chief Finance Officer confirmed total PFI costs for all Trust hospitals of £122,737,000 (including £34,099,000 of interest payments) in 2020/21 and £124,675,000 (including £33,255,00 interest payments) in 2021/22. He confirmed that the Trust had received additional funding to deal with the impact of inflation on the PFI payments, however the Trust still had a funding shortfall on excess inflation costs and was

working in collaboration with NEL Integrated Care Board to resolve this shortfall.

- The Chief Finance Officer noted that a Partnership Board had been established with joint membership of Barts Health and Nuffield Health representatives and the Trust retained a contractual relationship with its tenant, Nuffield Health. Barts Charity had confirmed that there were no organisational links between themselves and Nuffield Health. Barts Health had paid £909,116 to The Holly Private Hospital in 2021/22 to treat patients on our waiting list.
- The Director of Inclusion noted that national regulations placed a legal obligation on the Trust to identify, charge and recover costs from patients not eligible for free NHS secondary care such as those visiting from overseas. He confirmed that all maternity care was categorised as immediately necessary treatment and no individual would turned away even if they had indicated that they could not afford to pay. The contents of the Maternity Action's Access Guide were noted and the team would be pleased to review new material when it became available. As Group Director of Inclusion, Mr Abraham confirmed that he would lead on this agenda. He confirmed that the question posed in relation to the use of case studies had previously been raised and responded to at the Board meeting on 5 October 2022.

18/23 DATE OF THE NEXT MEETING

The next meeting of the Trust Board in public would be held on Wednesday 18 January 2023 at 11.00am in Room 1.36, Garrod Building, at The Royal London Hospital, Whitechapel, London.

Sean Collins
Trust Secretary
Barts Health NHS Trust
020 3246 0637

Action Log

Trust Board 2 November 2022			
No.	Action	Lead	By
1	Report on the development of digital systems in NE London, including timelines for completion of maternity systems (following on from initial roll out in ante-natal services).	Interim Director of Strategy and Chief Nurse	Q4 22/23
2	Explore options to introduce a Gender Pay Gap stretch target and he would explore this further with colleagues.	Group Director of People	Completed – will form part of the 2023/24 target setting

Barts Health NHS Trust

Report to the Trust Board: 18 January 2023	TB 02/23

Title	Integrated Performance Report (Month 8)
Accountable Director	Deputy Group Chief Executive
Author(s)	Director of Performance
Purpose	Performance against constitutional standards and KPIs

Executive summary

The Integrated Performance Report provides detail in relation to performance drivers and recovery actions at Trust and Hospital Site level in relation to the NHSI single oversight framework indicators as well as the Trust's own improvement plan, Safe and Compassionate. The report also identifies exceptions, including positive exceptions, where performance has outperformed usual tolerances, or where a target has been failed. The report will be presented by the respective lead directors for access, quality and safety, finance and people sections.

Related Trust objectives
All trust objectives

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

Legal implications/ regulatory requirements	N/A

Action required by the Board

The Trust Board is asked to note the Trust's position against all standards detailed, including those indicators where sustained improvement has been made due to the actions taken, exceptions to target achievement, reasons for variation and remedial actions.

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Barts Health Integrated Performance Report

Jan-23

Performance for: **Nov-22**

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Executive Summary

EXECUTIVE SUMMARY

Executive Summary

Jan-23

Quality

- The focus on reducing overdue Serious Incident investigations has resulted in a decrease in the number of overdue incidents in November. Three serious incidents were reported in maternity during the month, two are being investigated by the Healthcare Safety Investigation Branch, with an internal investigation underway for the third.
- As a result of an increase in MRSA infection rates an increased focus is being given to understanding root causes, sharing learning and promotion of safe practice. A peer review process is being developed for the new year to support hospital sites in improving infection rates.
- The Trust has received draft reports from the London Screening Quality Assurance visit in November 2022 and follow up visit by the CQC to the Barkantine Birth Centre which will be checked for factually accuracy before returning in the new year.

Operational Performance

- *Planned Care*: Admitted activity remains below plan with a slight reduction from 7,731 admissions recorded in October to 7,649 In November. This remains at variance to trajectory and national activity levels.
- *UEC*: The Trust continued to manage high levels of attendances in our A&E departments in-month which impacted performance in relation to the 4-hour target, with performance reducing from 64.6% in October to 63.4% in November. Within this challenging context 12 hour journey times have seen an improvement from 8.2% in October to 7.2% in November.
- *Cancer*: The Trust continues on the cancer recovery trajectory, with in-month improvements across a number of metrics. The 62 day performance standard has seen an improvement to 55.5% from the previous months performance of 46.8%.
- *Diagnostics:* A further improvement from the October performance of 77.4% to 79.8% in November has been noted as diagnostic services continue to work towards delivery of the 6 week target by March 2025.

People

- Fill rate has improved by 1% to 92% with an additional 203wte in post of which 142 WTE relates to the TUPE of Security and Reception staff from SERCO
- There has been a corresponding decrease in the numbers of temporary staff with 77wte reduction in bank and a 55wte reduction in agency

Finance

- The Trust is reporting a £34.9m adverse variance for the year to date against its breakeven plan. This is due to the impact of unfunded hyperinflation pressures £18.0 m, allowance for potential ERF clawback £13.0 m by Integrated Care Boards and other budget overspends primarily relating to slippage on efficiency savings plans net of non-recurrent benefits £3.9 m.

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Quality Report

SUMMARY

Quality Summary

Jan-23

Caring

Complaints response performance continues to improve with delivery of our internal target being maintained. A trial to strengthen the alignment of the PALS, Complaints and patient experience functions to facilitate improved triangulation of the themes identified from feedback provided by service users is underway.

Results of the audits of the quality of Duty of Candour letters was presented to the Safety Committee in November. The overall findings and recommendations have been shared with hospital leadership teams to inform improvement plans. There will be further audits to monitor improvements in the quality of letters. It is anticipated that there will be an improvement in performance as revised processes are embedded.

Safe and Effective

Hospital sites continue to focus on completing investigations on time and reducing the number of overdue investigations. This is challenging due to ongoing operational pressures, despite this, both the Royal London and Newham hospitals have seen a reduction in overdue SIs in the reporting period. The Patient Safety Incident Response Framework (PSIRF) Implementation Group are now meeting monthly and a project manager has been appointed for a short period to support the early stages of the implementation programme.

As a result of an increase in MRSA bacteraemias at the Royal London Hospital a strengthened improvement plan is in place which includes a peer review later this month.

Maternity

Three serious incidents (SIs) were reported in November, two of which are being reviewed by the Safety Investigation Branch (HSIB) for suitability of investigation in line with their criteria. The third will be investigated internally as the parents have declined HSIB involvement. There has been a decrease in the number of SIs relating to maternity care provided to pregnant people who have a stillbirth, thought to be as a result of implementing the Saving Babies Lives Care Bundles version 2.

Maternity Safety Support Programme

The MSSP was set up in 2018 to support maternity services who have been identified through CQC inspections as having inadequate or requires improvement ratings in safe and well led domains. As a result of the 2022 inspections, Barts maternity services have been welcomed to the programme and have been allocated maternity improvement advisors for both midwifery and obstetrics. The advisors will commence in January 2023 with a diagnostic phase of work which will support the sites and the group identify and fine tune existing improvement plans that we have in place. Site visits and presentations to key stakeholders are planned throughout January.

Clinical Negligence Scheme for Trusts - Submission

The hospitals are finalising their evidence submissions. Assurance of the evidence submission is being undertaken by the Director of Midwifery and Governance Team. The final submission will be reviewed by the Quality Assurance Committee on 1st February on behalf of the Board for submission on 2nd February. An update on this submission will be presented to the Board at its March meeting. Our current workforce challenges have impacted on our achievement of all of the standards this year.

CARING

Domain Scorecard

Jan-23

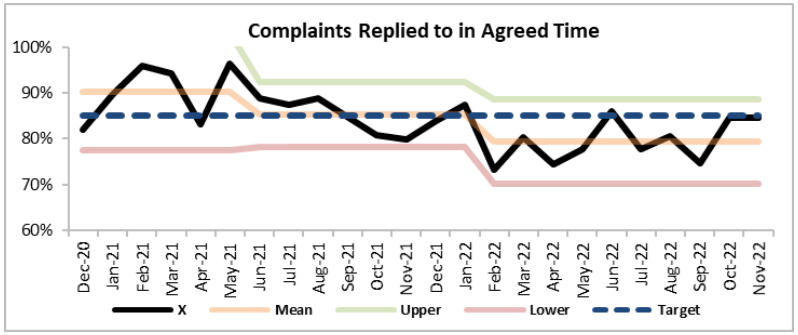
	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Site Comparison: Whipps Cross	Site Comparison: Newham	Site Comparison: St Bart's	Site Comparison: Other	Excep.
Patient Experience	C12	MSA Breaches	●	○	○	Oct-22 (m)	<=0	47	63	*287*	1	18	25	19	-	○
Patient Feedback	C10	Written Complaints Rate Per 1,000 Staff	○	○	○	2022/23 Q2 (q)	SPC Breach	22.7	22.1	*22.1*	25.2	44.9	22.4	13.3	-	○
	C1	FFT Recommended % - Inpatients	●	○	○	Oct-22 (m)	>= 95%	90.8%	90.0%	*90.1%*	84.0%	94.1%	87.5%	94.1%	-	○
	C2	FFT Recommended % - A&E	●	○	○	Oct-22 (m)	>= 86%	64.2%	59.4%	*60.5%*	57.9%	66.6%	52.0%	-	-	○
	C3	FFT Recommended % - Maternity	●	○	○	Oct-22 (m)	>= 96%	92.1%	88.1%	*92.6%*	86.2%	91.5%	76.0%	-	-	○
	C20	FFT Response Rate - Inpatients	●	○	○	Oct-22 (m)	>= 23%	30.0%	27.6%	*28.8%*	22.4%	41.0%	15.5%	35.1%	-	○
	C21	FFT Response Rate - A&E	●	○	○	Oct-22 (m)	>= 12%	11.4%	10.8%	*9.1%*	11.4%	11.9%	8.8%	-	-	○
	C22	FFT Response Rate - Maternity	●	○	○	Oct-22 (m)	>=17.5%	16.8%	14.1%	*15.8%*	7.3%	34.2%	5.9%	-	-	○
	OH4	CQC Inpatient Survey	○	○	○	2021/22 (y)	-	85.0%	0.0%	*0.0%*	79.0%	76.0%	68.0%	93.0%	-	○
Service User Support	R78	Complaints Replied to in Agreed Time	●	○	○	Nov-22 (m)	>= 85%	84.5%	84.7%	*79.8%*	88.6%	90.5%	57.1%	100.0%	-	●
	R30	Duty of Candour	●	○	○	Oct-22 (m)	>= 100%	91.7%	85.7%	*88.9%*	88.0%	95.8%	66.7%	75.0%	-	●

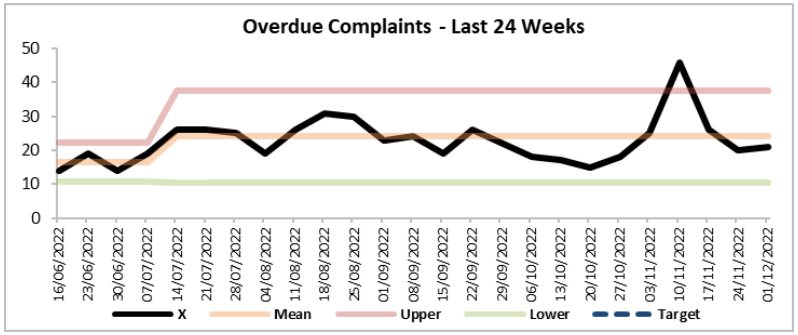
*The metric "Complaints Replied to in Agreed Time" has a Trust-wide target of 85% but an internal stretch target for sites of 95%

CARING

Complaints Replied to in Agreed Time

Jan-23





Complaints Replied to - Top 5 Subjects in Previous 6 Months

Subject	Replied in Previous 6 Months	Replied This Period
Diagnosis / Treatment	309	56
Delays in care	124	18
Communication - verbal / written / electronic	115	16
Appointments / Clinics	75	13
Maternity (New)	26	2

Overdue Complaints - Top 5 Subjects as at 01/12/2022

Subject	Number Overdue	Working Days Overdue		
		Average	Minimum	Maximum
Diagnosis / Treatment	13	17	1	39
Delays in care	5	84	1	302
Maternity (New)	1	12	12	12
Advice and Information	1	1	1	1
Appointments / Clinics	1	1	1	1

Performance Overview

- Complaints response performance has continued to improve since October and has remained on the 80% target we set ourselves locally.
- A gradual decline, in the number of complaints that remained overdue for a response each week has been noted from mid November onwards.
- This demonstrates the efficacy of plans each hospital put in place to address the previous backlog of complaints overdue for a response in recent months.
- The themes of complaints and the reasons for service users raising concerns through PALS remains consistent across both functions, with diagnosis and treatment in particular being the highest.
- It is noted that the "delays in care" in care theme in particular, at 84 days had the highest number of average number days overdue for a response. This is possibly an indication of the ongoing challenges around availability of appointments across the Trust.

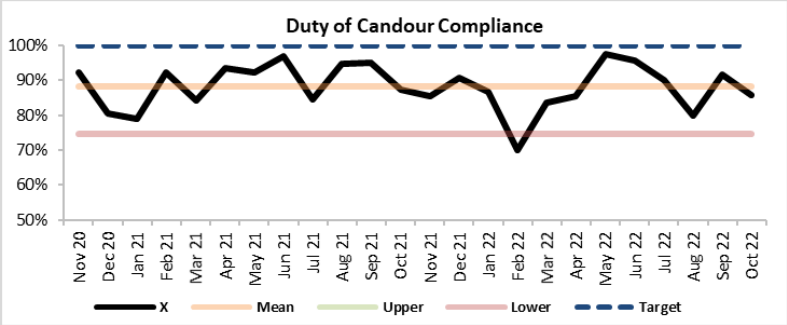
Responsible Director Update

- Proposals are currently being discussed for a 6 months trial to align the PALS, Complaints and Patient experience functions more closely to facilitate:
  - better triangulation of the themes identified from feedback provided by service users
  - easier responding to groups of themes identified in complaints by enabling access to ongoing patient experience projects across all hospitals
- bridging the gap between patient safety and patient experience in the Trust
- Further updates on developments will be provided in future reports.

CARING

Duty of Candour

Jan-23



Duty of Candour Compliance by Site - Oct-22			
Site	**No of Apologies**	**No of Incidents**	**Compliance**
Trust	**54**	**63**	**85.7%**
Newham	6	9	66.7%
Royal London	22	25	88.0%
St Bart's	3	4	75.0%
Whipps Cross	23	24	95.8%

Duty of Candour Compliance - Oct-22 (All Measures)					
Period	**Apology Offered Within 2 Weeks**	**Patient Notification & Apology Offered**	**Written Notification**	**Support Offered**	**Further Enquiries Advised**
Previous 6 Months	89.7%	100.0%	99.6%	100.0%	99.2%
This Period	85.7%	93.7%	92.1%	93.7%	85.7%

Performance Overview	**Responsible Director Update**
• Performance across the Group in October slightly declined to 85.7% from 91.7% reported in Sep-22. Year to date performance in 2022/23 remains at 88.9%. • None of the sites achieved 100% compliance in Oct-22 with Newham University Hospital sites only achieving 66.7% with 6 out of 9 qualifying incidents meeting full Duty of Candour obligations. • Improvements in compliance with Duty of Candour were reported at Royal London Hospital site in Oct-22. The site performance improved to 88% in comparison to 69.2% reported in Sep-22. • The Duty of Candour performance has slightly declined at Whipps Cross Hospital and St Bartholomew's Hospital in Oct-22 in comparison to the previous few months were both sites achieved 100% compliance in Aug-22 and Sep-22.	• As reported to the Board last month the sites completed the first audit looking at the quality of the DoC letters which was presented to the Safety Committee in November. • The overall findings and improvements required have been highlighted to the site leadership teams. • The audit tool to be revised and benchmarked against the revised DoC Policy • The sites will continue with audits of the DoC and provide a quarterly Trust level review.

SAFE

Domain Scorecard

Jan-23

	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Site Comparison: Whipps Cross	Site Comparison: Newham	Site Comparison: St Bart's	Site Comparison: Other	Excep.
Infection Control	S10	Clostridium difficile - Infection Rate	●			Nov-22 (m)	<=16	23.9	**16.6**	***18.0***	14.7	12.5	18.9	15.7	-	
	S11	Clostridium difficile - Incidence	●			Nov-22 (m)	<=9	15	**10**	***85***	4	2	2	1	1	
	S2	Assigned MRSA Bacteraemia Cases	●			Nov-22 (m)	<=0	1	**2**	***14***	1	0	1	0	0	
	S77	MSSA Bacteraemias				Nov-22 (m)	SPC Breach	14	**15**	***85***	8	1	5	1	0	
	S76	E.coli Bacteraemia Bloodstream Infections	●	●		Nov-22 (m)	<=20	24	**36**	***216***	12	12	6	6	0	●
Incidents	S3	Never Events	●			Nov-22 (m)	<=0	0	**0**	***3***	0	0	0	0	0	
	S09	% Incidents Resulting in Harm (Moderate Harm or More)	●			Nov-22 (m)	<=0.9%	2.0%	**1.7%**	***1.7%***	1.4%	1.5%	2.4%	1.9%	-	
	S45	Falls Per 1,000 Bed Days	●			Nov-22 (m)	<=4.8	3.6	**3.5**	***3.6***	3.3	3.6	3.3	4.0	-	
	S25	Medication Errors - Percentage Causing Harm	●			Nov-22 (m)	<=4%	1.6%	**5.0%**	***3.4%***	2.6%	6.0%	7.5%	6.8%	-	
	S49	Patient Safety Incidents Per 1,000 Bed Days				Nov-22 (m)	SPC Breach	56.2	**52.5**	***53.4***	44.4	59.6	54.3	63.7	-	
	S53	Serious Incidents Closed in Time	●			Nov-22 (m)	>=100%	21.1%	**11.1%**	***25.0%***	0.0%	-	14.3%	100.0%	-	●

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

SAFE

Domain Scorecard

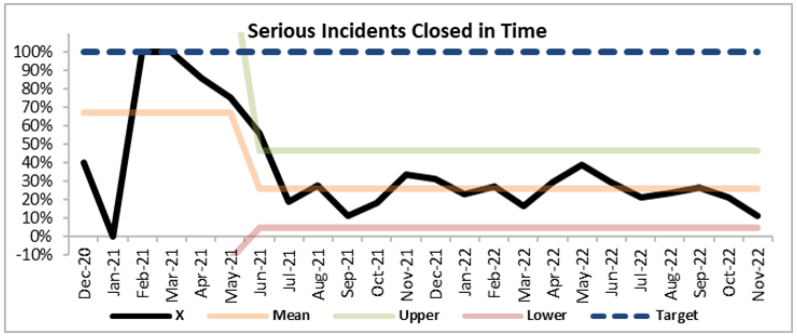
Jan-23

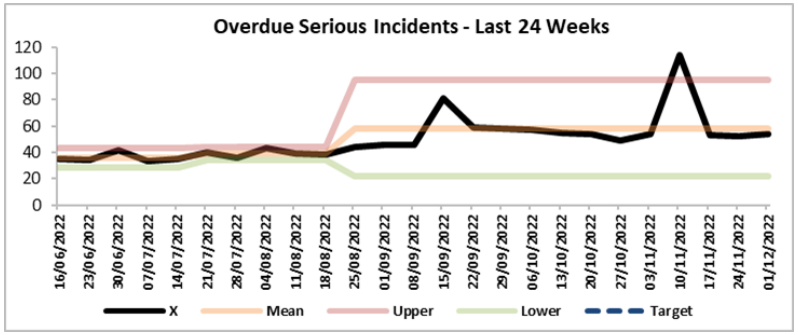
	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Site Comparison: Whipps Cross	Site Comparison: Newham	Site Comparison: St Bart's	Site Comparison: Other	Excep.
Harm Free Care	S14	Pressure Ulcers Per 1,000 Bed Days	●	○	○	Nov-22 (m)	<=0.6	1.7	**1.2**	***1.2***	1.1	2.0	0.9	0.7	-	○
	S35	Pressure Ulcers (Device-Related) Per 1,000 Bed Days	○	○	○	Nov-22 (m)	SPC Breach	0.2	**0.2**	***0.2***	0.3	0.3	0.0	0.2	-	○
	S27	Patient Safety Alerts Overdue	●	○	○	Nov-22 (m)	<=0	0	**0**	***0***	-	-	-	-	-	○

SAFE

Serious Incidents Closed in Time

Jan-23





Serious Incidents Closed - Top 5 Categories in Previous 6 Months

Category	Closed in Previous 6 Months	Closed This Period
Delays in Care	38	4
Obstetrics	17	7
Treatment	12	4
Appointments and Clinics	7	0
Patient Falls	7	0

Overdue Serious Incidents - Top 5 Categories as at 01/12/2022

Incident Category	Number Overdue	Working Days Overdue		
		Average	Minimum	Maximum
Delays in Care	17	39	1	78
Treatment	9	49	9	102
Obstetrics	9	51	5	136
Pressure Ulcers	5	37	9	57
Medication	3	26	19	36
Estates/Facilities	3	102	1	248

Performance Overview	Responsible Director Update
• There has been a further deterioration in performance in closing serious incidents (SIs) on time in this reporting period. Overall Trust performance has declined to 11.1% in Nov-22 in comparison to 21.1% reported in Oct-22. The year to date performance has slightly declined and is reported at 25%. • However, the number of overdue SIs continue to drop for both Royal London Hospital and Newham University Hospital sites in the last couple of weeks.	• Recovery of this metric remains a challenge and a focus of the Quality team. Hospital sites are being supported in the implementation of their improvement plan. • Hospital sites continue to focus on completing SI investigations on time and reducing the number of overdue investigations in the context of ongoing operational pressures • Patient Safety Incident Response Framework (PSIRF) Implementation Group are meeting monthly at the outset of the 12 month project and a project manager has now commenced to work with the central Quality Governance team to support the implementation of PSIRF.

EFFECTIVE

Domain Scorecard

Jan-23

	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Site Comparison: Whipps Cross	Site Comparison: Newham	Site Comparison: St Bart's	Site Comparison: Other	Excep.
Mortality	E1	Summary Hospital-Level Mortality Indicator	●	○	○	May-22 (m)	<=100	96	**96**	***96***	94	102	106	82	-	○
	E3	Risk Adjusted Mortality Index	●	○	○	Sep-22 (m)	<=100	91	**93**	***93***	97	90	93	87	-	○
	E25	Number of Avoidable Deaths	○	○	○	2020/21 Q2 (q)	-	**7**	**4**	***11***	-	-	-	-	-	○
Outcomes	0502	Cardiac Arrest 2222 Calls (Wards) Per 1,000 Admissions	●	○	○	Nov-22 (m)	<=0.51	0.54	**0.54**	***0.70***	0.14	2.31	0.00	0.00	-	○

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

Maternity

Maternity Dashboard – Key Metrics

Jan-23

Category	Metric	RAG Rating Red	Amber	Green	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Method of Delivery	Percentage of spontaneous vaginal birth (including vaginal breech Birth)				54.9%	54.3%	56.7%	57.6%	51.9%	53.2%	55.1%	53.9%
	Percentage of Operative Vaginal Birth				10.4%	10.9%	9.6%	10.5%	11.6%	9.0%	11.7%	9.9%
	Total Percentage of Birth by Vaginal route				65.3%	65.3%	66.3%	68.2%	63.5%	62.1%	66.7%	63.8%
Critial Incidents	Percentage PPH ≥ 1500ml	>=4%	3.1% - 3.9%	<=3	4.3%	5.1%	4.7%	3.9%	3.1%	3.8%	3.5%	4.5%
	Percentage 3/4 degree tear	>=5%	4.1% - 4.9%	<=4%	1.2%	1.4%	0.8%	1.0%	1.6%	1.2%	1.6%	1.9%
	Maternal Deaths	>1		0	0	0	0	0	0	0	0	0
Neonatal Morbidity	Number of unexpected term admission to NNU				51	40	37	43	54	41	45	47
	Neonatal Deaths				3	6	1	2	5	2	5	1
	Neonatal Deaths per 1000 births	>1.75	1.73 - 1.75	<=1.72	2.53	4.85	0.87	1.68	4.18	1.78	3.94	0.84
	HIE				1	1	0	1	0	0	2	1
	Total Still birth per 1000 births (Ante-partum)				4.22	1.62	5.22	6.72	6.69	2.66	3.94	4.22
Workforce	1:1 care in established labour	<90%	90%-94.9%	>=95%	97.1%	98.5%	98.2%	97.6%	97.9%	97.7%	96.5%	97.7%

Category	Metric	RAG Rating Red	Amber	Green	Last Month's Site Position Royal London	Whipps Cross	Newham
Method of Delivery	Percentage of spontaneous vaginal birth (including vaginal breech Birth)				55.9%	53.9%	54.3%
	Percentage of Operative Vaginal Birth				12.9%	9.9%	9.3%
	Total Percentage of Birth by Vaginal route				68.6%	63.8%	63.6%
Critial Incidents	Percentage PPH ≥ 1500ml	>=4%	3.1% - 3.9%	<=3	6.3%	4.5%	2.3%
	Percentage 3/4 degree tear	>=5%	4.1% - 4.9%	<=4%	2.2%	1.9%	2.3%
	Maternal Deaths	>1		0	0	0	0
Neonatal Morbidity	Number of unexpected term admission to NNU				15	47	21
	Neonatal Deaths				0	1	0
	Neonatal Deaths per 1000 births	>1.75	1.73 - 1.75	<=1.72	0.00	0.84	0.00
	HIE				0	1	1
	Total Still birth per 1000 births (Ante-partum)				7.8	4.22	2.25
Workforce	1:1 care in established labour	<90%	90%-94.9%	>=95%	96.6%	97.7%	99.2%

Performance Overview

- Post partum haemorrhage (PPH) rates are still higher than would be expected.
- Increasing PPH rates link to rising rates of caesarean section and induction of labour as well as obesity, maternal age and pre-eclampsia.

- Neonatal death rates at Barts health are also still outlying the national rates. These rates are not corrected for our tertiary neonatal service at Royal London Hospital. The correction of the data is undertaken on a national level through the National Perinatal Epidemiology Unit (NPEU), and reported on yearly.

Responsible Director Update

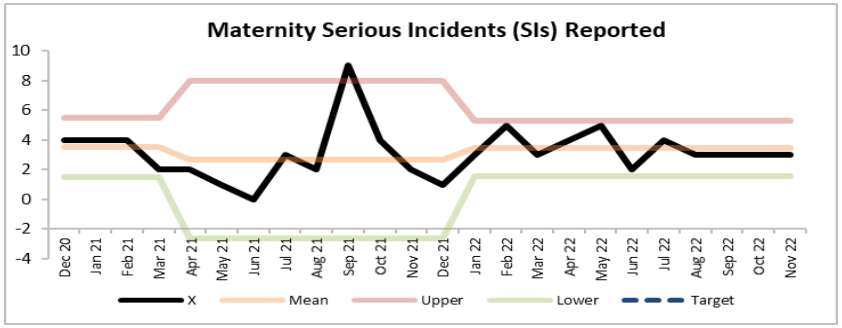
- Ongoing QI work on PPH, including risk assessment and early preventative intervention at RLH, is being shared across Bart's health maternity sites.
- Understanding our trends and population risk is key in reducing PPH and the morbidity associated with this

- Local monitoring of individual cases is important and undertaken and submitted to the NPEU using the Perinatal Mortality Review Tool (PMRT). Our local data is also presented back to the Local Maternity and Neonatal System (LMNS) as part of quality reviews and outlier reporting.

SPOTLIGHT

Maternity

Jan-23



Maternity SIs in Latest Month (Nov-22)				
Theme	**Newham**	**Royal London**	**Whipps Cross**	**Barts Health**
Total Number of SIs	**1**	**2**	**0**	**3**
Of Which HSIB (Healthcare Safety Investigation Branch) Investigations	0	0	0	0
% HSIB Investigations	0.0%	0.0%	-	0.0%

Maternity SIs in Last 12 Months to Nov-22 - Top by Theme				
Theme	**Newham**	**Royal London**	**Whipps Cross**	**Barts Health**
Total Number of SIs	**15**	**17**	**7**	**39**
Neonatal - Unanticipated admission to Neonatal unit	1	3	3	7
Intrapartum - Stillbirth	2	4	1	7
Antenatal - Antepartum Stillbirth	1	3	1	5
Neonatal - pH <7.1(arterial) at birth	1	2	2	5
Maternal admission to ITU	2	1	0	3

Actions on Maternity SIs in Last 12 Months to Nov-22 - Top by Action Type				
Action Type	**Royal London**	**Whipps Cross**	**Newham**	**Barts Health**
Total Number of Actions	**28**	**27**	**103**	**158**
Review / amend processes	2	7	31	40
No actions recorded	15	4	5	24
Review or update guidelines / documentation	2	3	19	24
Other action	1	4	17	22
Education and training	3	3	14	20

Progress Summary: There were three serious incidents (SIs) reported externally in November.
Two babies were admitted to neonatal intensive care units (NICU) for therapeutic cooling. The third SI related to a delay in diagnosis of congenital hips dysplasia.

Noteworthy Improvements: The decrease in the number of SIs relating to maternity care provided to pregnant people who had antepartum stillbirth, this reflects the impact of the Saving Babies Lives Care Bundles version 2 workstream.

Risks & Issues – midwifery staffing gaps remain the focus for maternity teams. The Trust is involved in the Capital Midwives International Recruitment drive. Ten international midwives have been offered positions at Whipps Cross Hospital. A further two interview dates are planned for 2023.

Other updates – In January, the Trust is expecting the report from London Screening Quality Assurance following their November visit and also the report on the follow up visit by the CQC to the Barkantine Birth Centre. The 'musts' from the CQC inspections in 2022 have been incorporated into each Hospital Maternity Improvement Plans and work is progressing. The National Maternity Support Programme offer starts in January which will support our units to deliver on our improvement plans.

CNST -Trust's delivery of the 10 Safety standards will be affected by the midwifery staffing gaps and operational challenges which have hampered audit and compliance data collection. The Director of Midwifery and Lead for Maternity Governance are both supporting the sites to progress the action plan to address the issue.

Jan-23

NHS
Barts Health
NHS Trust

Operational Performance Report

SUMMARY

Operational Summary

Jan-23

Summary Performance

Elective Activity Recovery Trajectories

- For November 2022 the trusts admitted (inpatient and day case) trajectory set a target of 101% of 2019/20 BAU against which the trust achieved 87% (-1,236 admissions). For outpatients (first and follow up) for the same month the trajectory set a target of 105% of BAU, against which the trust achieved 110% (+6,959 outpatient attendances). Under-delivery of the admitted plan was influenced by sustained emergency pressures and reduced bed-flow, which continued across the summer months and into the autumn/winter.

Referral to Treatment (RTT)

- In relation to the month-end nationally submitted data the trust reported 18 pathways waiting 104+ weeks at the end of November 2022, a reduction of 19 pathways against the October position. This also represents a significant reduction of 213 or 92% against the 232 reported in April 2022.
- Looking at London, of the 5 Trusts reporting 104+ week waits for October 2022 (the most recent national data), Barts Health had the greatest number, reporting 37. However it is perhaps more telling to look at the London trust with the next highest volume of 104+ week pathways, this trust recorded three 104+ week pathways, the other three trusts reported four pathways between them.

Diagnostic 6 Week Wait Standard

- For November 2022 a performance of 79.8% was recorded, an improvement of 2.5% on October's 77.4%, this represents four consecutive months of improving performance during which period performance against the diagnostic standard increased by 6.2%. As in previous months, the greatest challenge has been in the imaging modalities, particularly MRI and non-obstetric ultrasound; imaging breaches accounted for 80% of all breaches in November 2022.

Cancer 62 Days from GP Referral, backlog reduction progress and Faster Diagnosis Standard

- For October 2022 in relation to 62 days from urgent GP referral, the Trust recorded a performance of 55.5%, a significant improvement on September's 46.8% (+8.7%) with 104.5 pathways seen and 46.5 breaches, however this is below the 85% national standard. Reduced performance results from the trusts backlog clearance plan; the cancer leadership team is working to ensure that the number of patients waiting more than 62 days from an urgent referral returns to pre pandemic levels by March 2023 in line with national requirements, this requires longer waiting patients to be treated.
- The NHS has set improving Cancer treatment waiting times as one of its key priorities for this year. This includes the requirement to reduce the number of patients waiting more than 62-days from an urgent referral to treatment to pre-pandemic levels by March 2023. This requires the trust to reduce backlog to no greater than 197 patients by March 23. The November 2022 backlog reduction milestone is set at 405 against which the trust recorded 536, 131 greater than target.
- The Faster Diagnosis Standard (FDS) requires 75% of patients urgently referred by their GP to receive a diagnosis or have cancer ruled-out within 28 days. The standard applies to all patients who have been urgently referred for suspected cancer, have breast symptoms, or have been picked-up through cancer screening. For October 2022 the trust did not achieve the standard for All Urgently Referred patients (70.0%) but did achieve the standard for those referred from Screening (75.0%) and the Breast Symptoms element of the standard (99.3%), the trust did not therefore achieve compliance against the aggregate of all three elements of the standard (72.8%).

SUMMARY

Operational Summary

Jan-23

A&E 4 Hour Performance

- In November 2022, 45,125 attendances were recorded, less than a thousand more than recorded in October, given that Barts Health and the London region recorded an increase of 11% between September and October this suggests attendances stabilised for November. For November 2022 a performance of 63.41% was recorded in relation to the 4-hour standard, a reduction of 1.2% against October's 64.6%. However to set this in context London recorded a performance of 67.5% with the South East recording 68.2% and the East of England recording 65.2%. For November attendances in the London region decreased slightly, -2,076, against October, again suggesting attendances stabilised across this period. November saw a 1% improvement in patients with an A&E 12 journey time from 8.2% in October to 7.2% in November, however this remains at variance to the 2% target.

RESPONSIVE

Domain Scorecard

Jan-23

Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Whipps Cross	Newham	St Bart's	Other	Barts Health	Excep.
A&E 4 Hours Waiting Time	●			Nov-22 (m)	>=90%	66.5%	**63.5%**	***68.5%***	57.1%	71.8%	64.3%	-	-	63.5%	
A&E 12 Hours Journey Time	●			Nov-22 (m)	<=2%	8.2%	**7.2%**	-	7.3%	8.8%	5.6%	-	-	7.2%	
Ambulance Handover - Over 60 mins				Nov-22 (m)	-	530	**564**	-	149	216	199	-	-	564	
Ambulance Handover - Over 30 mins				Nov-22 (m)	-	900	**1032**	-	390	294	348	-	-	1032	
Cancer 62 Days From Urgent GP Referral	●			Oct-22 (m)	>=85%	**46.8%**	**55.5%**	***59.0%***	60.0%	49.3%	64.3%	56.9%	-	55.5%	
Cancer 31 Day Diagnosis to First Treatment	●			Oct-22 (m)	>=96%	**93.2%**	**97.4%**	***96.5%***	93.1%	100.0%	100.0%	99.1%	-	97.4%	
Cancer 28 Day FDS Breast Symptomatic	●			Oct-22 (m)	>=75%	99.7%	**99.3%**	***99.4%***	-	98.9%	100.0%	99.2%	-	99.3%	
Cancer 28 Day FDS Screening	●			Oct-22 (m)	>=75%	74.3%	**75.0%**	***84.0%***	50.0%	85.7%	80.0%	100.0%	-	75.0%	
Diagnostic Waits Over 6 Weeks	●			Nov-22 (m)	>=95%	77.4%	**79.8%**	***74.4%***	65.1%	97.3%	100.0%	80.2%	100.0%	79.8%	
78+ Week RTT Breaches	●			Nov-22 (m)	671	874	**766**		456	238	71	1	-	766	
104+ Week RTT Breaches	●			Nov-22 (m)	0	37	**18**		14	3	1	0	-	18	
Completeness of Ethnicity Recording				Nov-22 (m)		92.8%	**92.2%**	-	91.5%	91.0%	94.7%	92.7%	-	92.2%	

Note to table:

- The ambulance handover metrics are those reported for London Region and do not reflect a Barts Health validated position
- 78 and 104 RTT weeks wait is RAG rated against each wait bands recovery trajectory
- A 95% target for Diagnostic six week waits is required by March 2025 so no RAG rating is applied for this year

RESPONSIVE
Elective activity

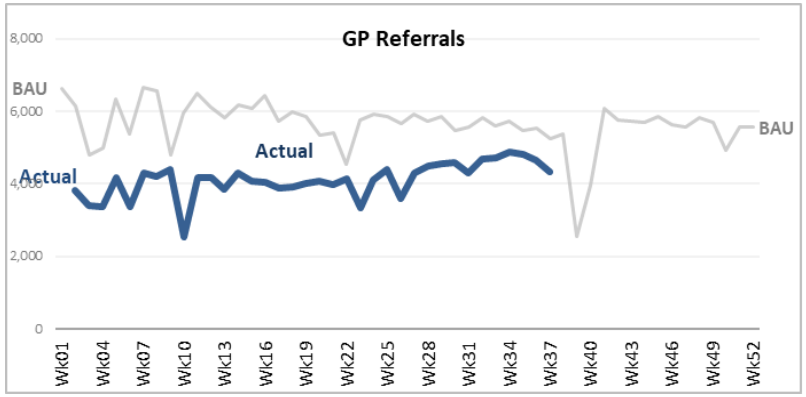
Referral Volumes

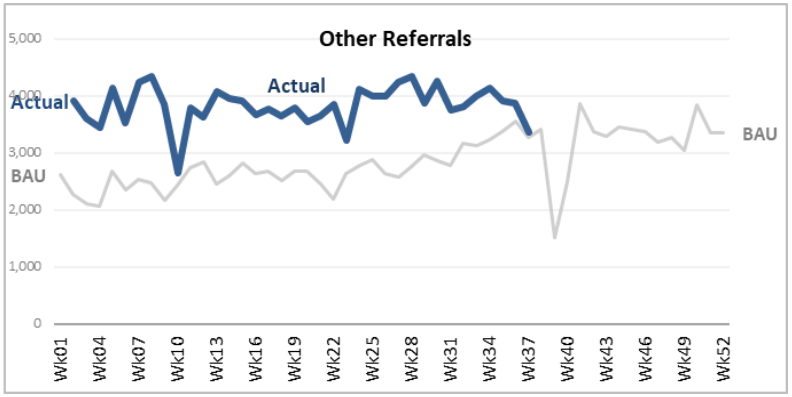
Jan-23

Referrals Activity

Referral Activity

		Barts Health						Last Month's Site Position				
		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Royal London	Whipps Cross	Newham	St Bart's	Other
GP referral	Actuals	16,655	16,813	17,760	18,004	18,910	***21,067***	*7,829*	*5,921*	*2,528*	*2,391*	*2,398*
	BAU	24,657	27,947	23,544	24,318	26,258	***23,714***	*9,276*	*8,207*	*3,395*	*2,744*	*92*
Other	Actuals	15,665	16,040	16,343	17,464	17,410	***17,136***	*7,370*	*6,399*	*1,635*	*1,728*	*4*
	BAU	10,626	12,153	10,978	11,554	12,774	***13,427***	*6,141*	*4,346*	*1,380*	*1,543*	*17*





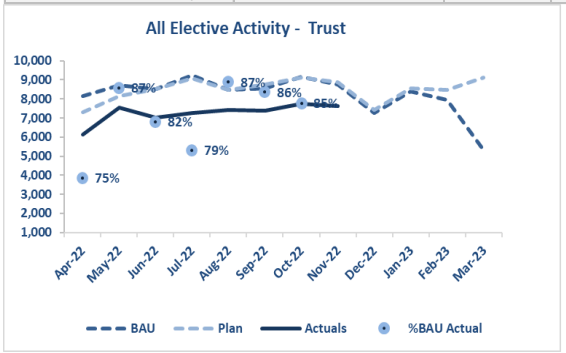
RESPONSIVE
Elective activity

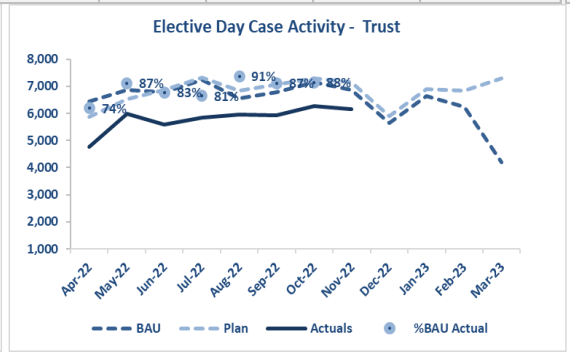
Admitted Activity against Plan

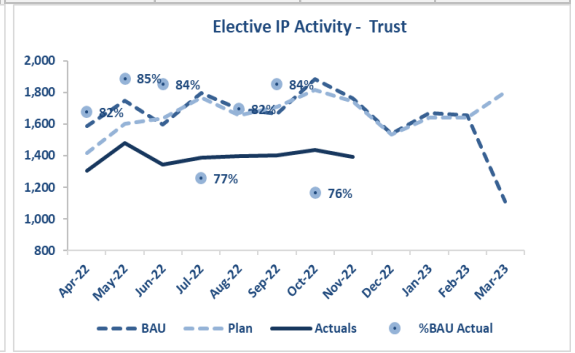
Jan-23

Admitted Elective Activity

		Barts Health						Last Month's Site Position			
		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Royal London	Whipps Cross	Newham	St Bart's
All Elective Activity	Plan	8,515	9,076	8,481	8,763	9,109	***8,885***	*4,329*	*1,919*	*1,352*	*1,219*
	Actuals	7,001	7,267	7,411	7,363	7,747	***7,629***	*3,819*	*1,526*	*1,053*	*1,231*
	Mth variance plan	*-1,514*	*-1,809*	*-1,070*	*-1,400*	*-1,362*	***-1,256***	*-510*	*-393*	*-299*	*12*
Elective Day Case Activity	Plan	6,880	7,307	6,828	7,056	7,295	***7,140***	*3,580*	*1,545*	*1,183*	*766*
	Actuals	5,599	5,840	5,971	5,921	6,265	***6,147***	*3,209*	*1,248*	*919*	*771*
	Mth variance plan	*-1,281*	*-1,467*	*-857*	*-1,135*	*-1,030*	***-993***	*-371*	*-297*	*-264*	*5*
Elective IP Activity	Plan	1,635	1,769	1,653	1,707	1,814	***1,745***	*749*	*374*	*169*	*453*
	Actuals	1,345	1,388	1,396	1,403	1,438	***1,393***	*576*	*278*	*134*	*405*
	Mth variance plan	*-290*	*-381*	*-257*	*-304*	*-376*	***-352***	*-173*	*-96*	*-35*	*-48*
Independent Sector Elective Activity	Actuals	57	39	44	39	44	***89***	*34*	*0*	*0*	*55*







Performance Overview

- For November 2022 the trusts admitted (Inpatient and Day Case) trajectory set a target of 101% of 2019/20 BAU against which the trust achieved 87% (-1,236 admissions).
- For Day Cases the trajectory set a target of 104% of BAU against which the trust achieved 90% (-944 Day Case admissions).
- For Inpatients the trajectory set a target of 99% of BAU against which the trust achieved 77% (-382 Inpatient admissions).
- During November 89 elective admissions were recorded in the Independent Sector against a BAU of 132.
- Under-delivery of the admitted plan was influenced by sustained emergency pressures and reduced bed-flow, which continued across the summer months and into the autumn/winter.

Responsible Director Update

- Through the Elective Recovery Board discussions are underway with hospital sites about actions being taken to recover activity volumes with a quantification of the impact.
- Opportunities to support improvement in activity volumes have been identified through movement of appropriate work across the group and theatre productivity intervention

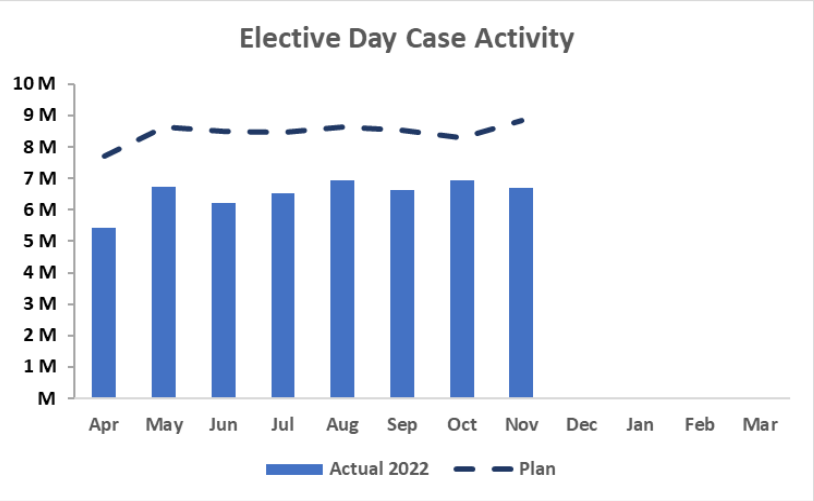
RESPONSIVE
Elective activity

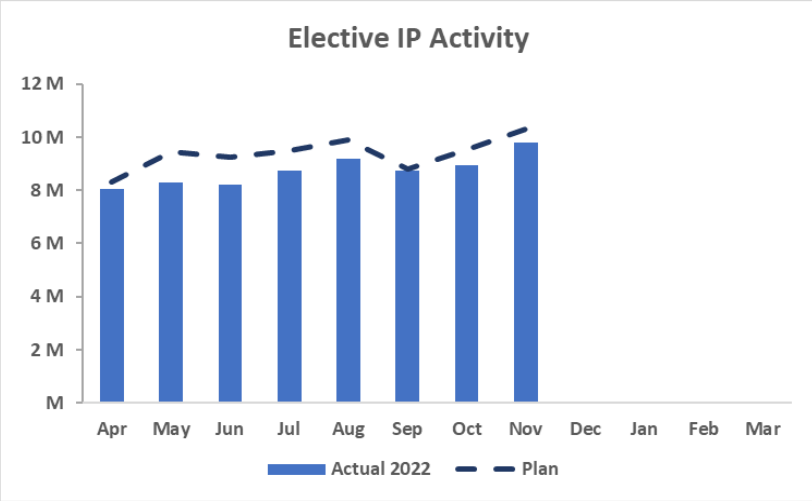
Admitted Income against Plan

Jan-23

Admitted Elective Activity

		Barts Health						November-2022 Site Position			
		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Royal London	Whipps Cross	Newham	St Bart's
Elective Day Case Activity	Plan	8.48 M	8.45 M	8.63 M	8.53 M	8.3 M	8.85 M	4.64 M	1.63 M	1.27 M	1.32 M
	Actuals	6.22 M	6.52 M	6.92 M	6.63 M	6.94 M	6.7 M	3.22 M	1.18 M	.91 M	1.39 M
	Mth variance plan	*-2.26 M*	*-1.93 M*	*-1.71 M*	*-1.9 M*	*-1.36 M*	*-2.15 M*	*-1.41 M*	*-.45 M*	*-.36 M*	*.07 M*
Elective IP Activity	Plan	9.23 M	9.49 M	9.88 M	8.78 M	9.54 M	10.32 M	3.01 M	1.33 M	1.62 M	4.36 M
	Actuals	8.2 M	8.74 M	9.18 M	8.75 M	8.96 M	9.8 M	3.17 M	.99 M	1.3 M	4.34 M
	Mth variance plan	*-1.03 M*	*-.75 M*	*-.7 M*	*-.03 M*	*-.58 M*	*-.52 M*	*.16 M*	*-.34 M*	*-.32 M*	*-.02 M*





Performance Overview

- Day cases and Inpatient admissions continues to be below the plan, and in reflection of this the Trust Admitted Income is reporting an adverse variance against the plan.
- Emergency pressures and reduced bed-flow which have been continuous from the summer months and into the autumn/winter are contributing factors of this outcome.

Responsible Director Update

- Hospital sites have developed theatre improvement programmes where there is a key focus on cases per list, reducing cancellations and late starts in order to support improvement in elective income.
- Monthly Income reviews with sites are planned to highlight the importance of accurate coding.

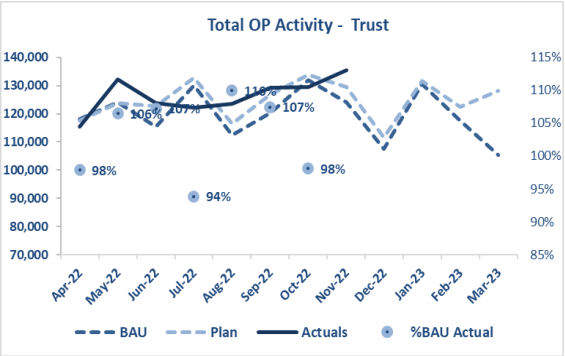
RESPONSIVE
Elective activity

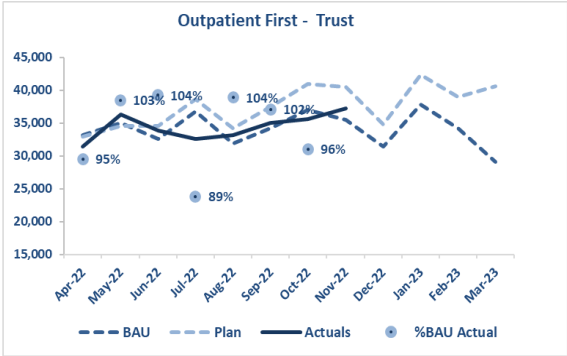
Non Admitted Activity against Plan

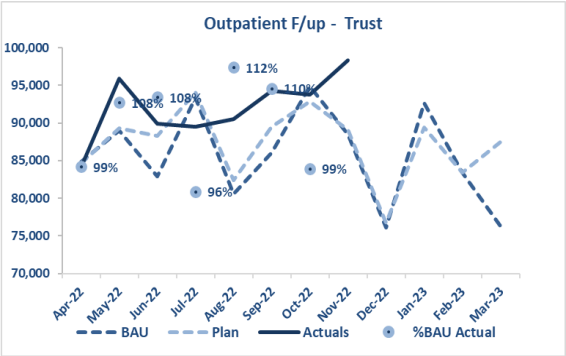
Jan-23

Outpatient Activity

		Barts Health						Last Month's Site Position				
		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Royal London	Whipps Cross	Newham	St Bart's	Other
Total OP Activity	Plan	122,785	132,675	116,575	126,880	133,767	***129,528***	*54,680*	*31,020*	*19,292*	*24,536*	-
	Actuals	123,792	122,092	123,635	129,291	129,359	***135,490***	*56,618*	*31,563*	*21,026*	*26,245*	*38*
	Mth variance plan	*1,007*	*-10,583*	*7,060*	*2,411*	*-4,408*	***5,962***	*1,938*	*543*	*1,734*	*1,709*	
Outpatient First	Plan	34,514	38,640	34,153	37,411	40,910	***40,430***	*16,655*	*12,359*	*5,469*	*5,947*	-
	Actuals	33,893	32,604	33,134	34,966	35,537	***37,173***	*14,371*	*11,819*	*5,136*	*5,847*	-
	Mth variance plan	*-621*	*-6,036*	*-1,019*	*-2,445*	*-5,373*	***-3,257***	*-2,284*	*-540*	*-333*	*-100*	
Outpatient F/up	Plan	88,271	94,035	82,422	89,469	92,857	***89,098***	*38,025*	*18,661*	*13,823*	*18,589*	-
	Actuals	89,899	89,488	90,501	94,325	93,822	***98,317***	*42,247*	*19,744*	*15,890*	*20,398*	*38*
	Mth variance plan	*1,628*	*-4,547*	*8,079*	*4,856*	*965*	***9,219***	*4,222*	*1,083*	*2,067*	*1,809*	







Performance Overview	Responsible Director Update
• For outpatients (first and follow up) the trajectory was set at 105% of BAU, against which the trust achieved 110% (+6,959 outpatient attendances). • For First attendances the trajectory set a target of 114% of BAU against which the trust achieved 106% (-2,802 attendances). • For Follow-up attendances the trajectory set a target of 101% of BAU against which the trust achieved 112% (+9,761 attendances).	• A new governance structure for out-patients has been agreed via the Elective Recovery Board and the Group Executive Board. • Outpatients has been included as part of the activity recovery work in order to understand what key actions are required at each site. • One key opportunity is around reducing the Did Not Attend rate with various initiatives underway to address this e.g. improving text messaging, letters, and booking processes.

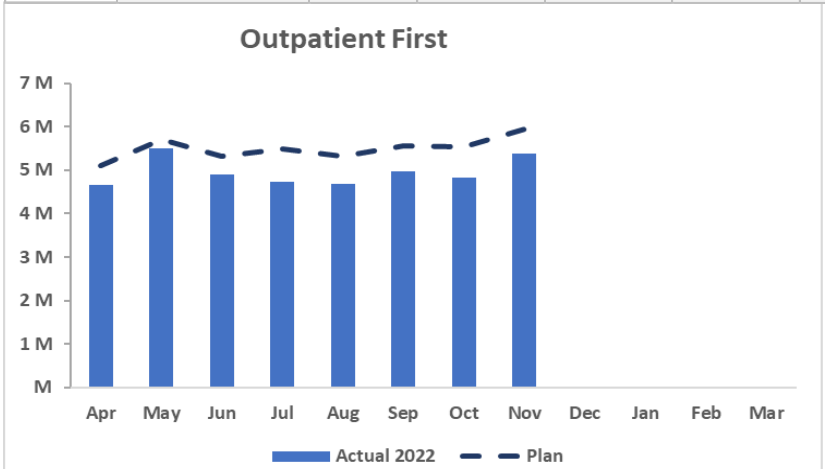
RESPONSIVE
Elective activity

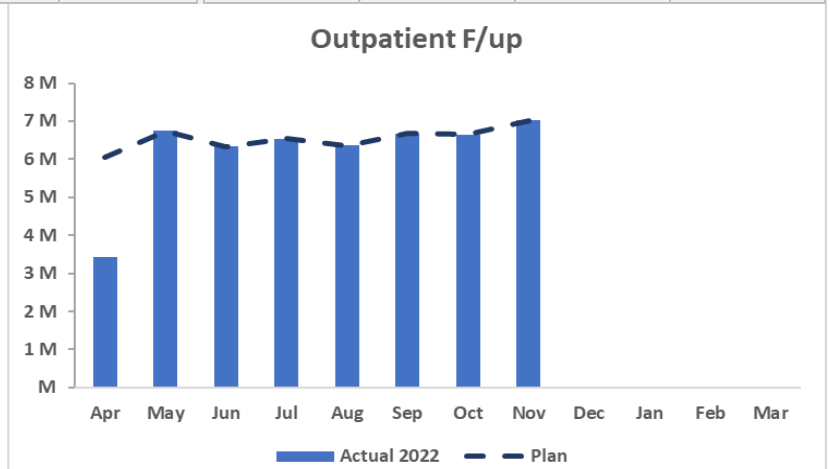
Non Admitted Income against Plan

Jan-23

Outpatient Activity

		Barts Health						November-2022 Site Position			
		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Royal London	Whipps Cross	Newham	St Bart's
Outpatient First	Plan	5.32 M	5.5 M	5.34 M	5.58 M	5.54 M	5.95 M	2.29 M	1.6 M	.87 M	1.19 M
	Actuals	4.92 M	4.73 M	4.7 M	4.98 M	4.84 M	5.39 M	1.86 M	1.59 M	.73 M	1.21 M
	Mth variance plan	*-.4 M*	*-.76 M*	*-.63 M*	*-.59 M*	*-.7 M*	*-.56 M*	*-.43 M*	*-.01 M*	*-.14 M*	*.02 M*
Outpatient F/up	Plan	6.33 M	6.54 M	6.36 M	6.68 M	6.65 M	7.02 M	3.05 M	1.43 M	.87 M	1.66 M
	Actuals	6.41 M	6.44 M	6.67 M	7.16 M	6.99 M	7.04 M	3.07 M	1.46 M	.8 M	1.71 M
	Mth variance plan	*.07 M*	*-.1 M*	*.31 M*	*.48 M*	*.34 M*	*.03 M*	*.03 M*	*.03 M*	*-.08 M*	*.05 M*





Performance Overview	Responsible Director Update
• Non Admitted activity improvements have supported delivery of the Trust Non Admitted Income against outpatient follow-up activity. • Improvements have been made in Outpatient First activity although this continues to report as adverse variance against the plan.	• Actions to support recovery of income are overseen through the Outpatients governance structure supported by Hospital level discussion at monthly Finance Performance Group meetings.

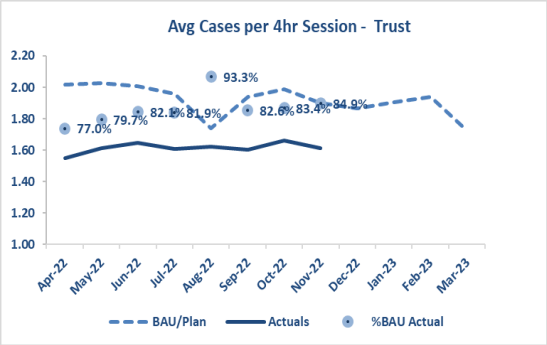
RESPONSIVE
Elective activity

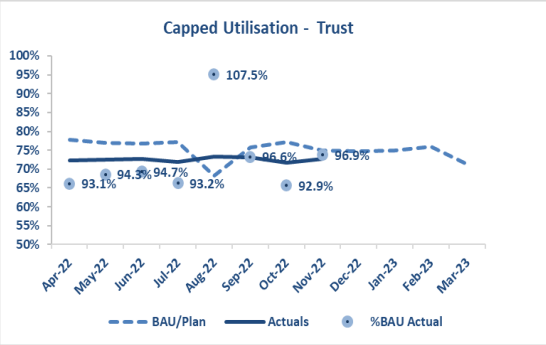
Theatre Efficiency

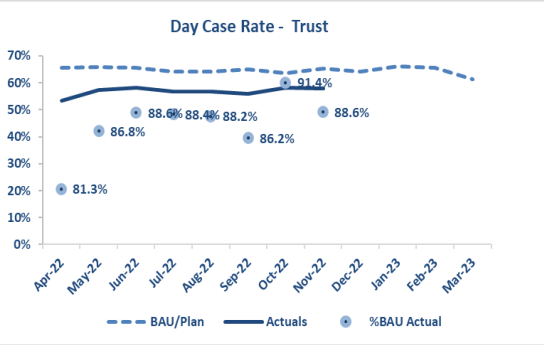
Jan-23

Efficiency Activity

		Barts Health						Last Month's Site Position			
		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Royal London	Whipps Cross	Newham	St Bart's
Avg Cases per 4hr Session	Actuals	1.65	1.61	1.62	1.60	1.66	1.61	1.45	2.18	2.13	1.04
	BAU	2.01	1.96	1.74	1.94	1.99	1.90	1.80	2.70	2.13	1.06
	Mth variance plan	*-0.36*	*-0.35*	*-0.12*	*-0.34*	*-0.33*	*-0.29*	*-0.34*	*-0.52*	*-0.01*	*-0.02*
Capped Utilisation	Actuals	72.7%	71.9%	73.3%	73.1%	71.7%	72.7%	74.3%	66.5%	75.0%	74.9%
	BAU	76.8%	77.2%	68.2%	75.7%	77.2%	75.0%	73.8%	77.8%	73.1%	76.4%
	Mth variance plan	-4.1%	-5.3%	5.1%	-2.5%	-5.5%	-2.3%	0.5%	-11.3%	1.8%	-1.5%
Day Case Rate	Actuals	58.2%	56.8%	56.7%	55.9%	58.3%	57.9%	57.3%	66.4%	74.6%	17.5%
	BAU	65.7%	64.2%	64.2%	64.9%	63.7%	65.3%	64.7%	77.3%	71.1%	22.0%
	Mth variance plan	-7.5%	-7.4%	-7.6%	-9.0%	-5.4%	-7.4%	-7.4%	-10.8%	3.5%	-4.5%







Performance Overview

- Capped Theatre Utilisation is one of the key operating theatre efficiency metrics, helping to understand the effectiveness of the operation scheduling processes of the trust in comparison to other trusts. "Capped Utilisation" refers to the Touch Time being calculated on the total volume of time the surgical team were operating, within the planned session time only. This means any Touch Time occurring within an unplanned session extension (after the planned session end time) is excluded from the calculation.
- According to most recent Model Hospital data (4 December 2022) the trust recorded a Capped Utilisation rate of 78%, higher than for the month as a whole reported above, this is due to certain activity / capacity exclusions and logic applied by Model Hospital.
- Against the London Region peer group of 20 trusts the Barts Health Capped Utilisation rate of 78% compares against a peer median rate of 77% and a national (all trusts) median of 74%. This places Barts Health in the third quartile of national performance.

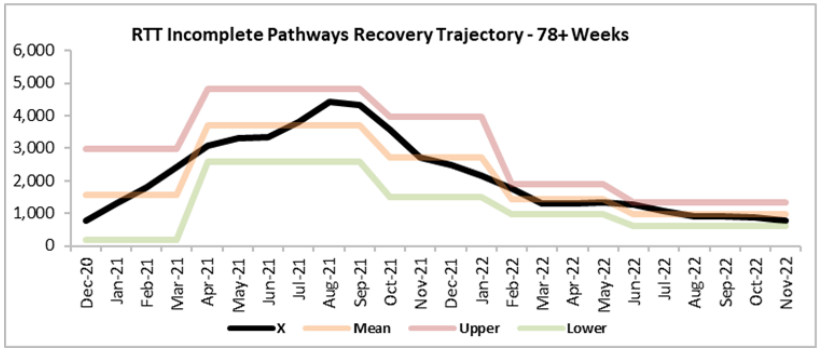
Responsible Director Update

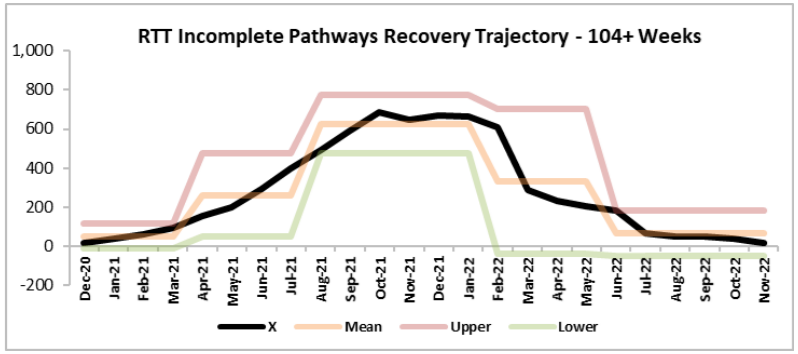
- Hospital sites have developed theatre improvement programmes which are being supported by the Quality Improvement Team and is overseen via the Elective Recovery Board.
- There is a key focus on cases per list, reducing cancellations and late starts in order to support improvement in utilisation and activity volumes.

RESPONSIVE
RTT waiting times

78+ & 104+ Week RTT Breaches

Jan-23





78+ Week Wait Breaches by Weeks Waited/Specialty (Highest 10 Specialties)	
Specialty Name	**Actual**
Trauma & Orthopaedics	130
Colorectal Surgery	108
Gynaecology	107
ENT	102
Urology	56
General Surgery	49
Respiratory Medicine	40
Oral Surgery	37
Vascular Surgery	27
Paediatric Dentistry	19

104+ Week Wait Breaches by Weeks Waited/Specialty (Highest 10 Specialties)	
Specialty Name	**Actual**
Gynaecology	8
Colorectal Surgery	4
Urology	2
Oral Surgery	1
Ophthalmology	1
ENT	1
Paediatric Ear Nose And Throat	1

Performance Overview

- In relation to the end-month nationally submitted data the trust reported 18 pathways waiting 104+ weeks at the end of November 2022, a reduction of 19 pathways against the October position. This also represents a significant reduction of 213 or 92% against the 232 reported in April 2022.
- Looking at London, of the 5 Trusts reporting 104+ week waits for October 2022 (the most recent national data), Barts Health had the greatest number, reporting 37. However it is perhaps more telling to look at the London trust with the next highest volume of 104+ pathways, this trust recorded three 104+ week pathways, the other three trusts reported four pathways between them.
- In relation to 78+ week wait backlog volumes, these have also reduced over the course of the last seven months with 1,309 pathways reported at the end of April 2022 reducing to 766 at the end of November 2022, a decrease of 543 (-41%), this is however greater than the reduction plan of 671 for November (+96).

Responsible Director Update

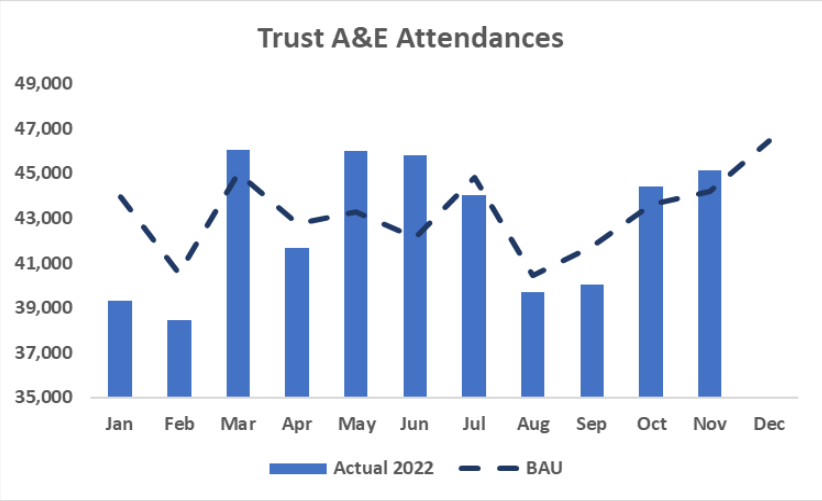
- The Programme Director for Elective Recovery works with the hospital site Directors of Operations through a series of weekly meetings to ensure that long waiter clearance trajectories are being delivered and that if a site or specialty is off plan to agree and implement corrective action.
- Detailed tracking of each patient who is a risk of being at 104+ weeks at the end of December 2022 is in place with continued support from other NEL providers on mutual aid where possible. A similar approach is now being applied to 78+ week pathways with a requirement to clear the backlog by March 2023.

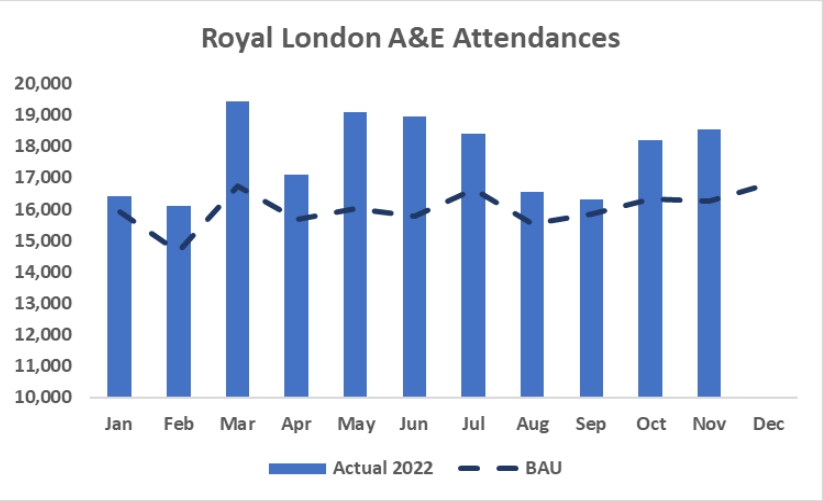
RESPONSIVE
A&E volumes and waiting times

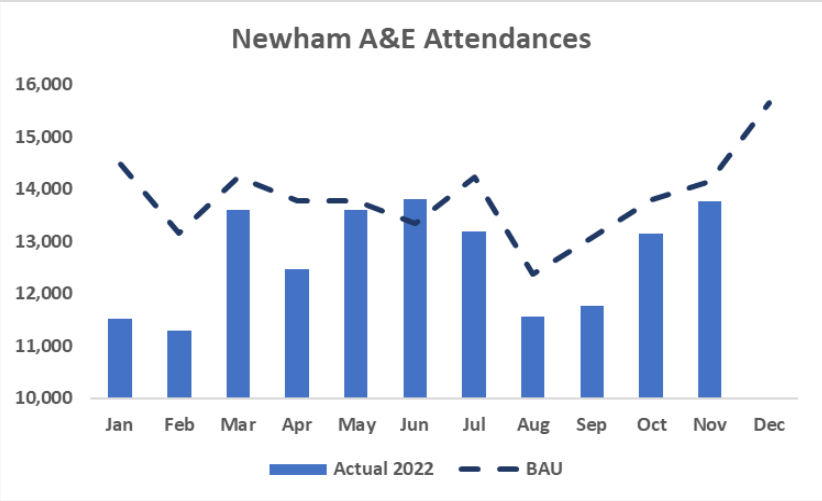
A&E Attendance Volumes and Non Elective Activity

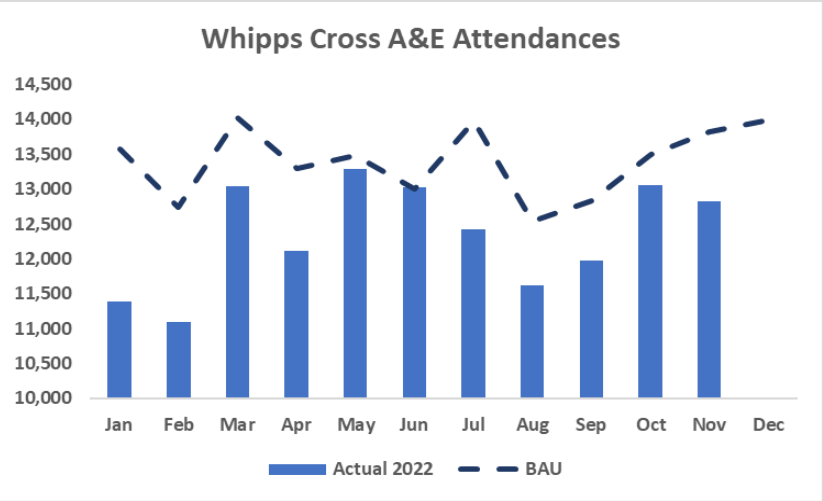
Jan-23

A&E Attendances against BAU





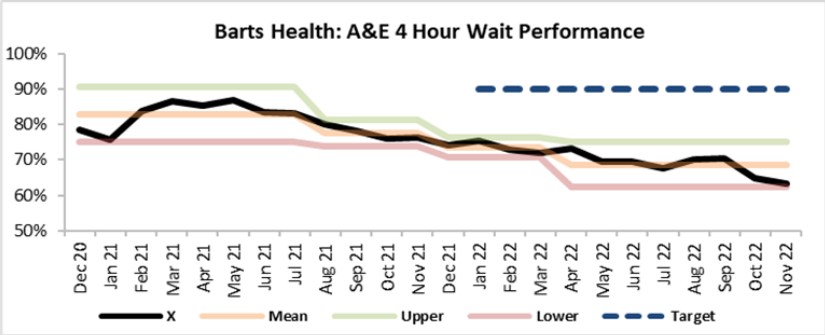


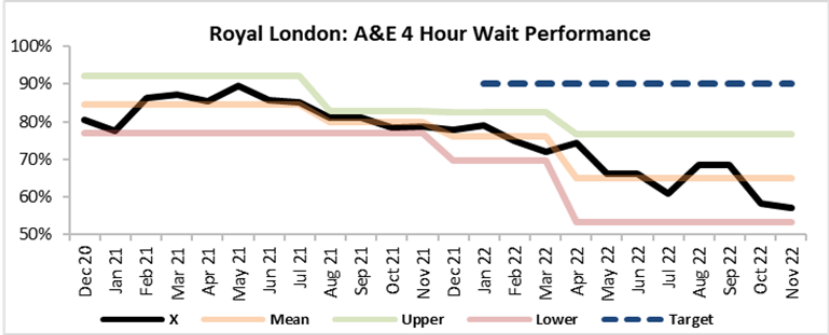


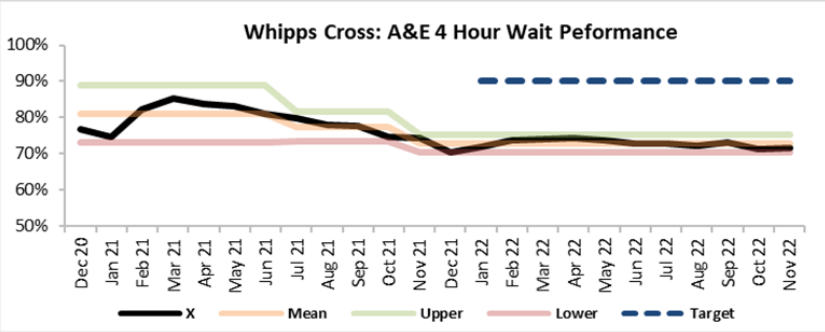
RESPONSIVE
A&E volumes and waiting times

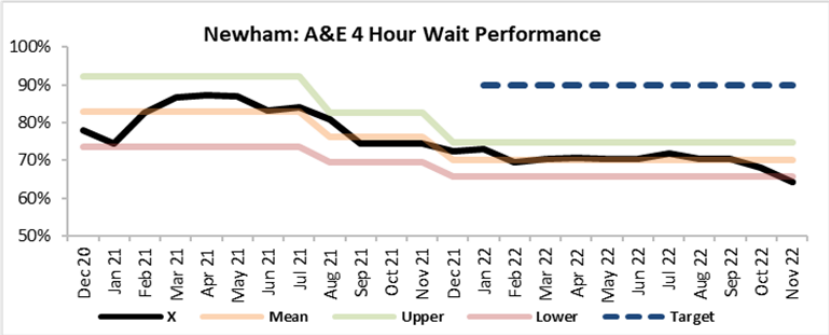
A&E 4 Hour Waiting Time

Jan-23









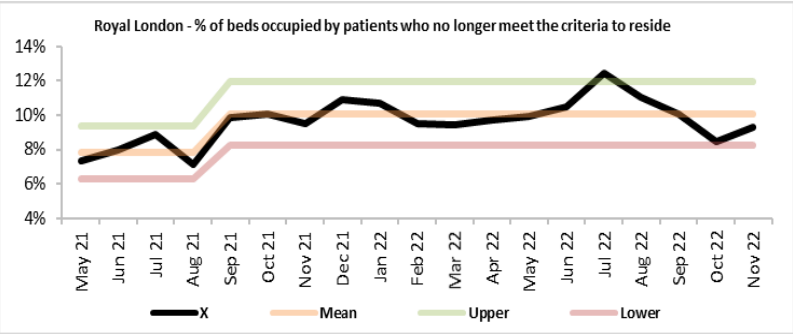
Performance Overview	Responsible Director Update
• In November 2022, 45,125 attendances were recorded, less than a thousand more than recorded in October, given that Barts Health and the London region recorded an increase of 11% between September and October this suggests attendances stabilised for November. • For November 2022 a performance of 63.4% was recorded in relation to the 4-hour standard, a reduction of 1.2% against October's 64.6% performance. • However to set this in context London recorded a performance of 67.5% with the South East recording 68.2% and the East of England recording 65.2%. For November attendances in the London region decreased slightly, -2,076, against October, again suggesting attendances stabilised across this period.	• The trust is working with its A&E provider sites to better articulate the impact of emergency pressures on the bed base and operationalise interventions designed to improve flow, including reducing foot-fall in A&E through REACH and working with system partners to improve discharge processes for those patients who no longer need to be in hospital.

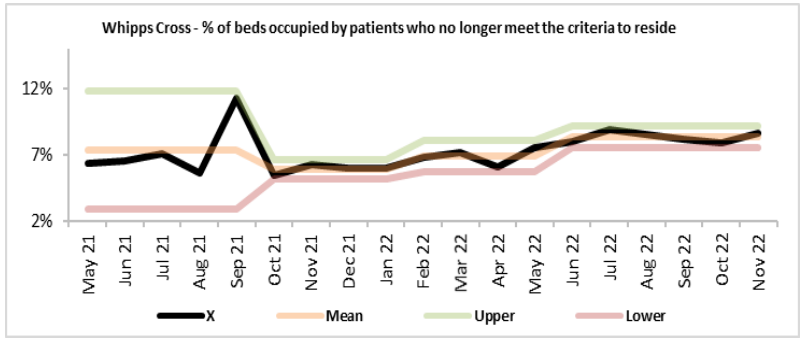
RESPONSIVE

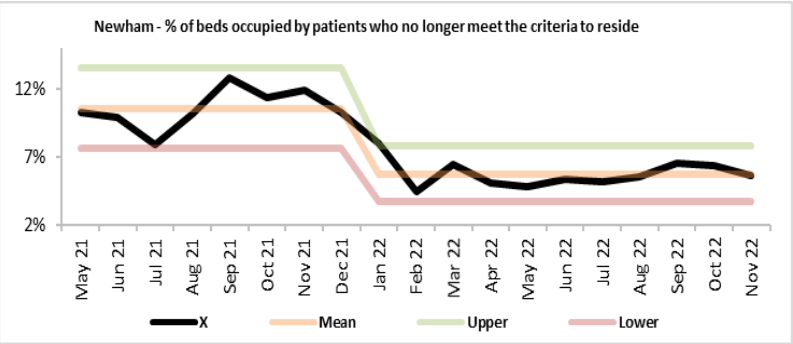
Discharge Activity

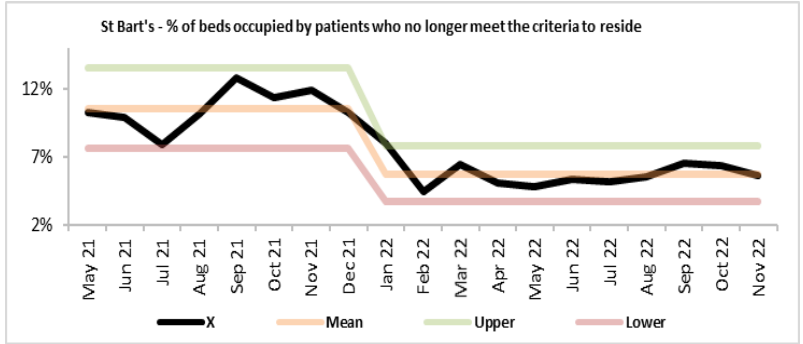
Jan-23

Percentage of beds occupied by patients who no longer meet the criteria to reside







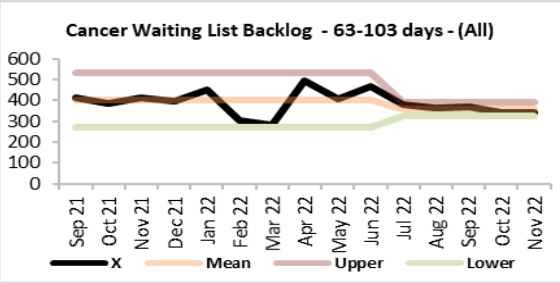


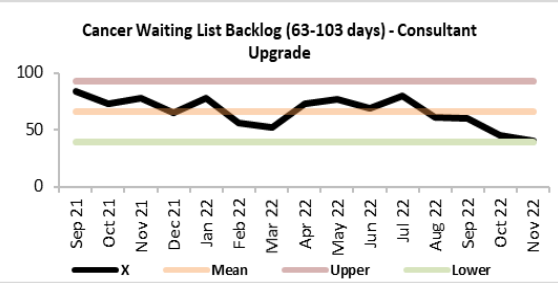
Performance Overview	Responsible Director Update
Criteria to reside is variable across the hospital sites, with Whipps Cross Hospital experiencing an increase in trend since November 2022. The hospitals continue to work internally and across systems to improve the discharge of these patients, and improve flow as part of their urgent and emergency care plans.	• The Group has appointed an Interim Director for Emergency Care Improvement who will be working closely with the sites to develop and overarching UEC plan in line with National Planning Guidance which will include work to increase the discharge opportunity within Barts Health

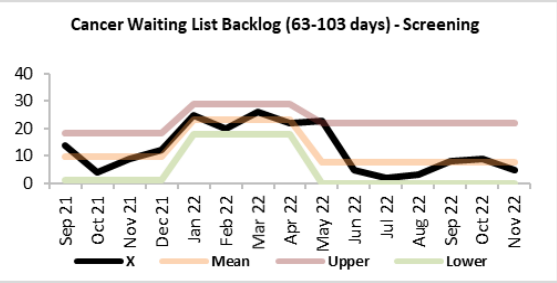
RESPONSIVE
Cancer waiting times

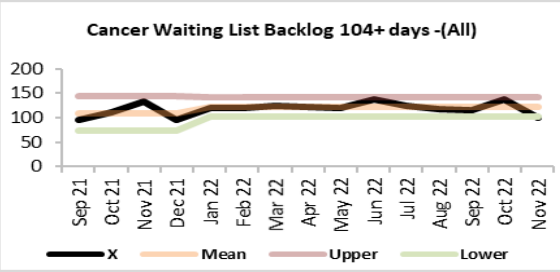
Cancer 62 Days From Urgent GP Referral

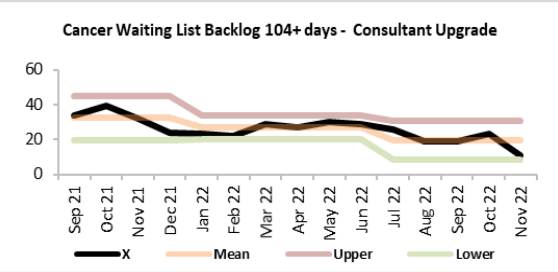
Jan-23

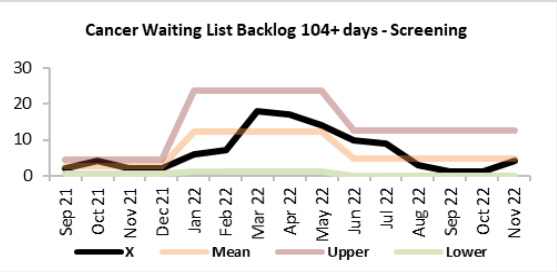












Cancer Waiting List Backlog - All - (Highest 10 Sites)	
Site	Actual - Last Month
Colorectal	108
Gynaecology	105
Head and Neck	79
Skin	45
Upper GI	29
Breast	21
Lung	21
Urology	18
Haematology	6
Cancer of Unknown Primary	5

Cancer Waiting List Backlog - Consultant Upgrade - (Highest 10 Sites)	
Site	Actual - Last Month
Gynaecology	15
Lung	10
Urology	5
Colorectal	5
Head and Neck	4
Upper GI	4
Skin	4
Other	3
Haematology	1

Cancer Waiting List Backlog - Screening- (Highest 10 Sites)	
Site	Actual - Last Month
Breast	4
Colorectal	3
Gynaecology	2

Performance Overview

The NHS has set improving Cancer treatment waiting times as one of its key priorities for this year. This includes the requirement to reduce the number of patients waiting more than 62-days from an urgent referral to treatment to pre-pandemic levels by March 2023. This requires the trust to reduce backlog to no greater than 197 patients by March 2023. The November 2022 backlog reduction milestone is set at 405 against which the trust recorded 536, 131 greater than target.
Of the 536 patients waiting longer than 63 days, 409 had waited between 63 – 103 days and 127 greater than 104 days.
The charts and tables above present the number of patients waiting by those two wait bands by All referrals, Consultant Upgrade and Screening service referrals

Responsible Director Update

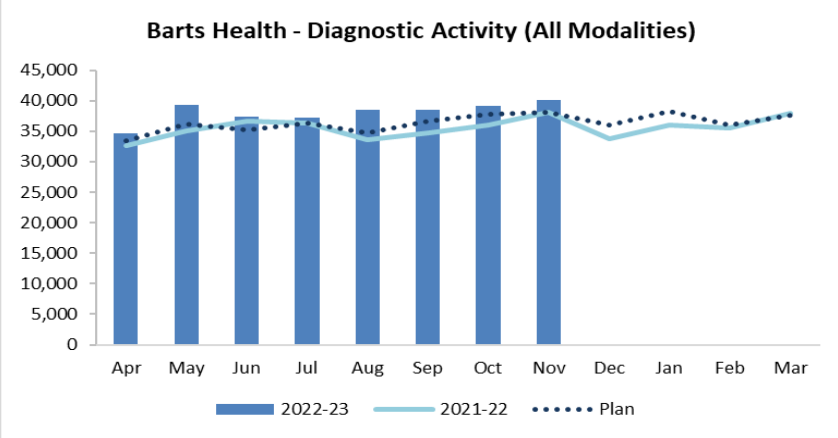
The cancer management team are working with each of the trusts hospital sites to agree and support backlog reduction plans across all tumour sites, particularly for the longest waiting patients.

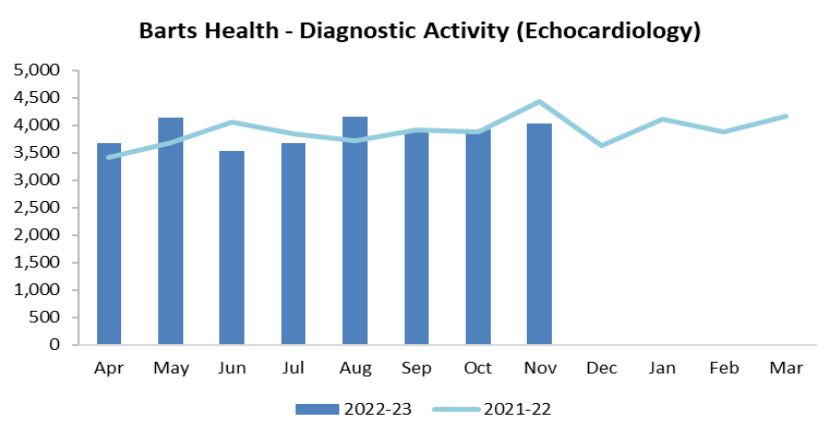
RESPONSIVE
Diagnostic waiting times

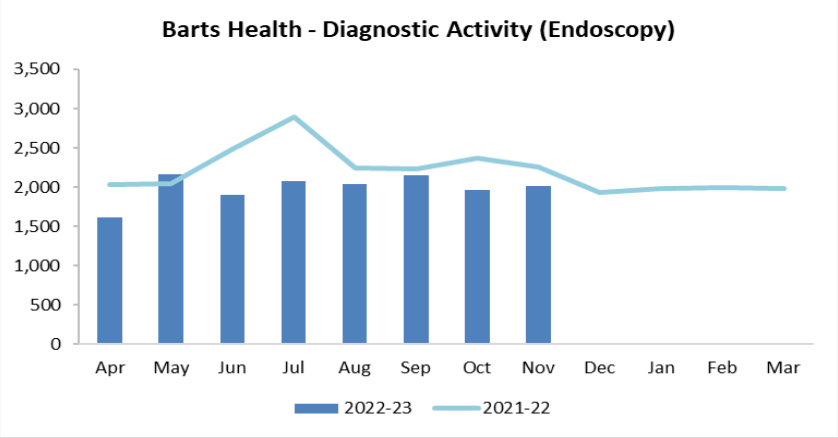
Diagnostic (DM01) Activity

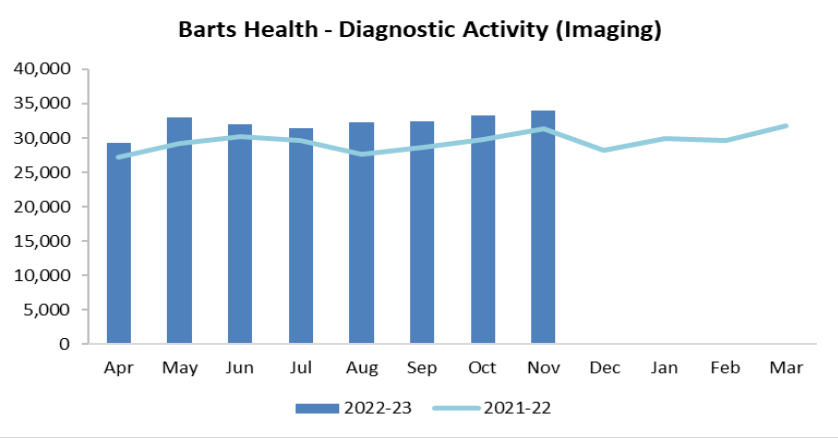
Jan-23

Barts Health						Last Month's Site Position			
Setting		Aug-2022	Sep-2022	Oct-2022	Nov-2022	Royal London	Whipps Cross	Newham	St Bart's
Diagnostics (All Modalities)	Actuals (2022-23)	38,420	38,449	39,135	40,048	13,029	10,336	8,131	8,552
	Plan	*34,743*	*36,611*	*37,790*	*39,630*	*11,625*	*9,972*	*8,149*	*9,884*
	Mth variance plan	*3,677*	*1,838*	*1,345*	*418*	*1,404*	*364*	*-18*	*-1,332*
Diagnostics	Echocardiography	4,160	3,921	3,922	4,024	-	-	-	4,024
	Endosocopy	2,043	2,144	1,960	2,007	1,008	577	422	-
	Imaging	32,217	32,384	33,253	34,017	12,021	9,759	7,709	4,528





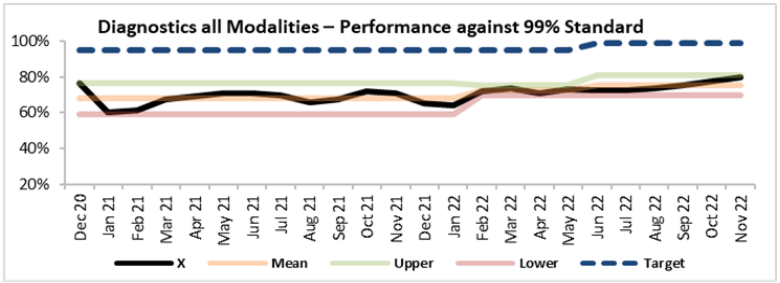


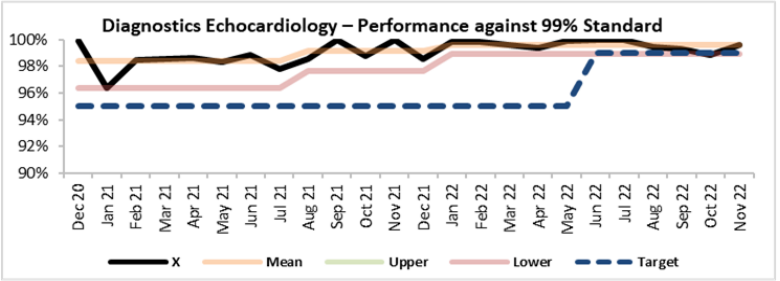


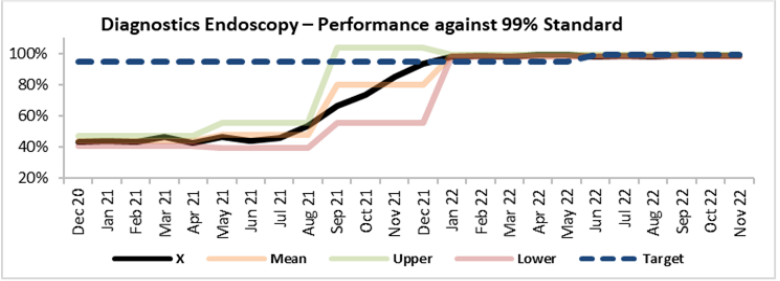
RESPONSIVE
Diagnostic waiting times

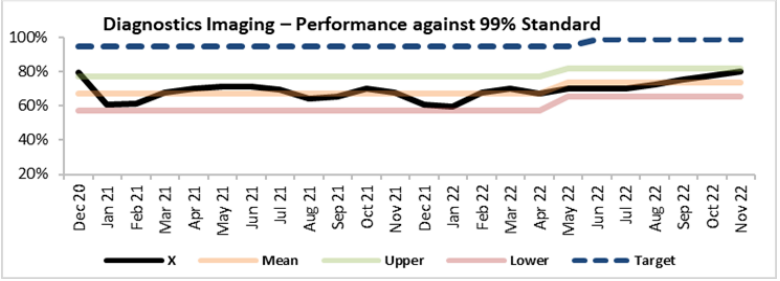
Diagnostic Waits Over 6 Weeks

Jan-23









DM01 Breakdown by Test

	Oct-22			Nov-22			
Test Name	**Waiting**	**Breaches**	**Performance**	**Waiting**	**Breaches**	**Performance**	**Variance in Performance**
Audiology - Audiology Assessments	1,772	1,210	31.7%	1,821	1,254	31.1%	-0.6%
Urodynamics - pressures & flows	66	45	31.8%	85	53	37.6%	5.8%
Neurophysiology - peripheral neurophysiology	72	28	61.1%	65	26	60.0%	-1.1%
Magnetic Resonance Imaging	7,917	3,472	56.1%	8,022	3,004	62.6%	6.4%
DEXA Scan	1,047	351	66.5%	913	121	86.7%	20.3%
Non-obstetric ultrasound	14,780	1,930	86.9%	15,608	1,971	87.4%	0.4%
Computed Tomography	3,362	306	90.9%	3,601	402	88.8%	-2.1%
Cystoscopy	132	4	97.0%	148	12	91.9%	-5.1%
Respiratory physiology - sleep studies	34	1	97.1%	58	2	96.6%	-0.5%
Gastroscopy	698	17	97.6%	681	15	97.8%	0.2%
Cardiology - echocardiography	1,887	21	98.9%	1,982	7	99.6%	0.8%
Colonoscopy	722	1	99.9%	899	2	99.8%	-0.1%
Flexi sigmoidoscopy	126	0	100.0%	159	0	100.0%	0.0%
Barium Enema	1	0	100.0%	3	0	100.0%	0.0%
Cardiology - Electrophysiology	1	0	100.0%	0	0	100.0%	0.0%
Grand Total	**32,617**	**7,386**	**77.4%**	**34,045**	**6,869**	**79.8%**	**2.5%**

Commentary

- For November 2022 a performance of 79.8% was recorded, an improvement of 2.5% on October's 77.4%, this represents four consecutive months of improving performance during which period performance against the diagnostic standard increased by 6.2%. As in previous months, the greatest challenge has been in the imaging modalities, particularly MRI and non-obstetric ultrasound; imaging breaches accounted for 80% of all breaches in November 2022.

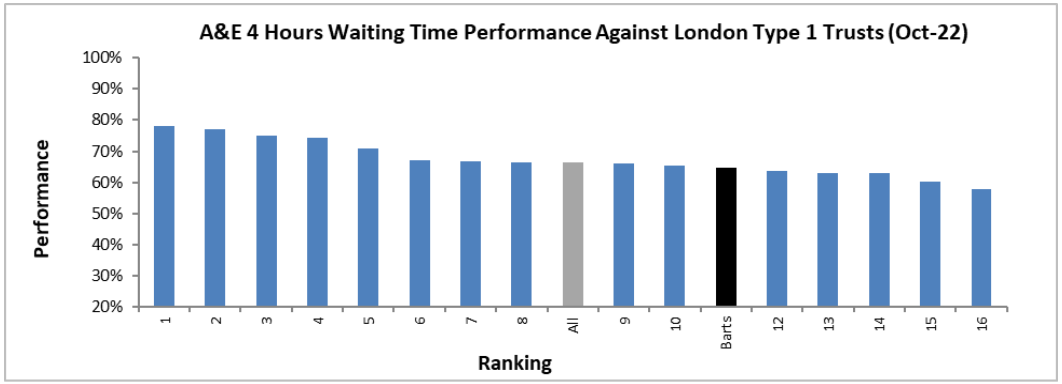
- For 2022/23 NHS England requires all trusts to deliver up to 120% of 2019/20 BAU activity across the three key modalities of:
  - Echocardiology
  - Endoscopy
  - Imaging

- The aim is to recover six week waiting times to a 95% performance standard by March 2025.

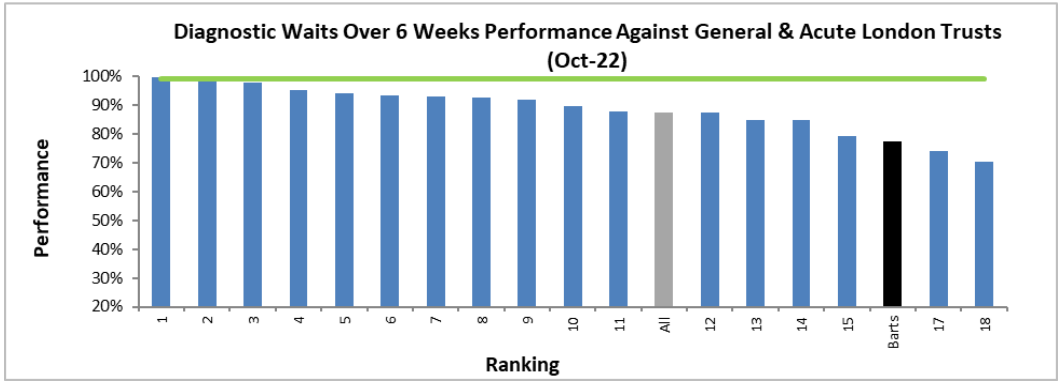
RESPONSIVE
Benchmarking performance

Benchmarking Against Other Trusts

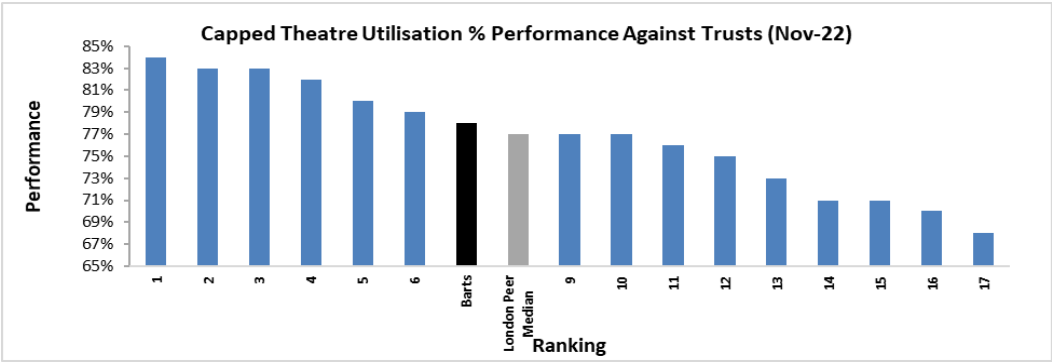
Jan-23



- For November 2022, Barts Health recorded the highest volume of A&E attendances of any trust in England. In terms of performance against the 4-hour standard, the Trust was ranked 12th out of 16 trusts reporting data in London and was the 3rd best performing out of the top 10 English trusts (ranked by volume of attendances) reporting data.



- Looking at the 18 London acute Trusts reporting data for October 2022 (the most recent national data), Barts Health was the 16th worst performing in relation to compliance against the 6 week waiting time standard. Looking at the top 10 largest provider Trusts in England (by size of waiting list), Barts Health had the 3rd largest waiting list and was the best performing.

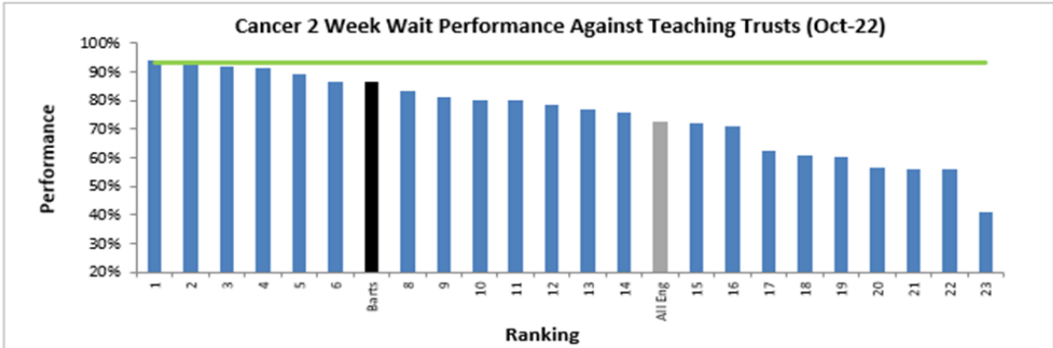


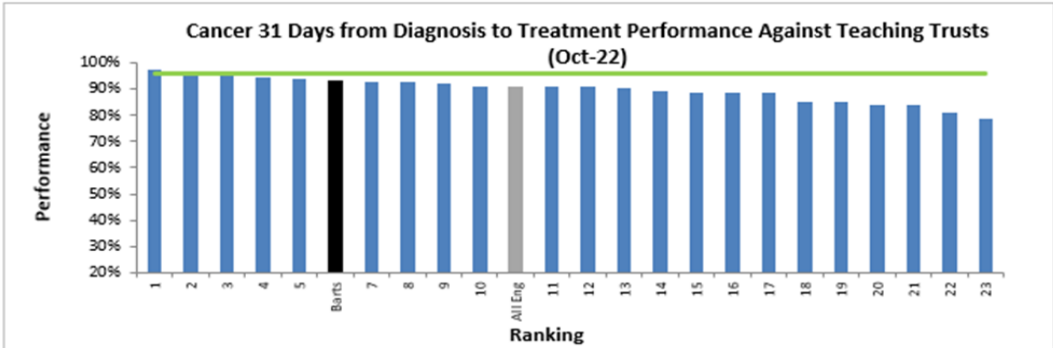
- According to most recent Model Hospital data (4 December 2022) the trust recorded a Capped Utilisation rate of 78%. Against the London Region peer group of 20 trusts, including three specialist trusts, the Barts Health Capped Utilisation rate of 78% compares against a peer median rate of 77% and a national (all trusts) median of 74%. This places Barts Health in the third quartile of national performance.
- Please note, the chart opposite only presents the individual performance for the 17 Acute trusts with the peer median against all 20 trust's (including 3 specialist trust's).

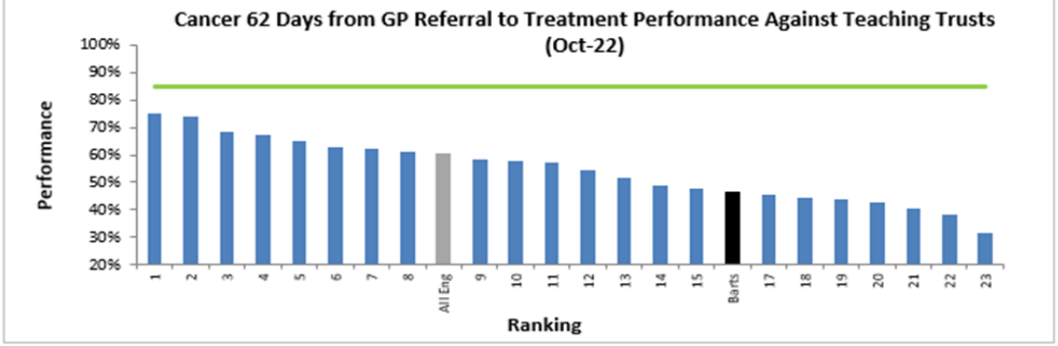
RESPONSIVE
Benchmarking performance

Benchmarking Against Other Trusts

Jan-23







- The trust did not achieve compliance against the 93% two-week wait target recording a performance of 85.0% for October 2022. As for September performance was heavily influenced by the volume of breaches recorded at the Whipps Cross Hospital site in the Skin tumour pathway. In order to increase capacity and improve patient experience the clinical team started a tele-dermatology pilot during October. In relation to benchmarked performance Barts Health ranked 7th best performing against the 23 teaching trust peer group.

- The Trust achieved compliance in October 2022 against the 31 Day Diagnosis to Treatment standard, recording a performance of 97.4% against the 96% target. For October 2022, Barts Health was the 6th best performing of the 23 Teaching Trusts.

- For October 2022 in relation to 62 days from urgent GP referral, the Trust recorded a performance of 55.5%, a significant improvement on September's 46.8% (+8.7%) with 104.5 pathways seen and 46.5 breaches, however performance was below the standard of 85%. Reduced performance results from the trusts backlog clearance plan; the cancer leadership team is working to ensure that the number of patients waiting more than 62 days from an urgent referral returns to pre pandemic levels by March 2023 in line with national requirements, this requires longer waiting patients to be treated. For October 2022 Barts Health was the 16th worst performing of 23 Teaching Trusts.

NHS
Barts Health
NHS Trust

Equity Report

SUMMARY

Equity Summary

Jan-23

Equity in our waiting lists

Analysis

- The Trust has reviewed its waiting lists to identify differences in wait times between groups at Trust level. The Trust reviewed waiting times by ethnicity, gender, between those who have been identified with a learning disability and those who have not, and between groups of patients who live in wealthy postcodes compared to those who live in deprived postcodes. We explored differences between ethnicities and between those who live in wealthy compared to poorer areas at Trust as well as hospital level. The review is a snapshot of data from 20th December 2022.

Findings

- At -Trust level, there are no significant differences in the data for waits between ethnic groups, or between male and female patients.

- This months data shows that there is a small but significant difference between waits for patients from poorer postcodes and those who live in wealthier areas, with people living in poorer post codes waiting slightly longer. Site-level data showed slightly longer waits at Royal London Hospital and Whipps Cross Hospital for people from more deprived backgrounds. However, it is uncertain whether this difference could be due to chance.

- A positive finding is that the waits for patients who have been identified as having a learning disability are not significantly longer than for patients who have not been identified as having a learning disability. Our data also shows that patients with a learning disability are less likely to wait over 52 weeks compared with patients considered not to have a learning disability. The Trust has been working to prioritise this group.

Next steps

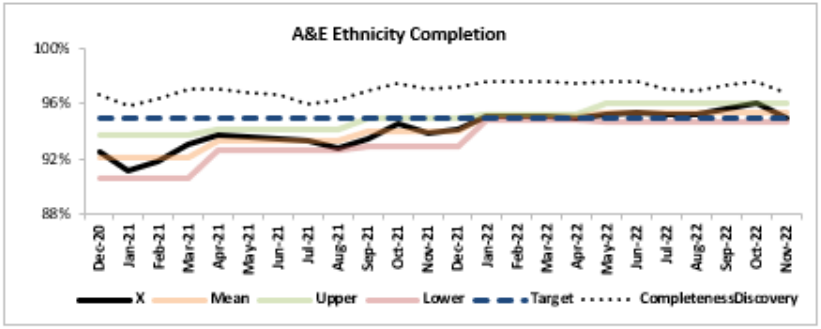
- We are continuing to work with site teams and selected specialities to better understand the difference in waiting times between patients living in wealthier postcodes and poorer postcodes to understand the reasons for this.

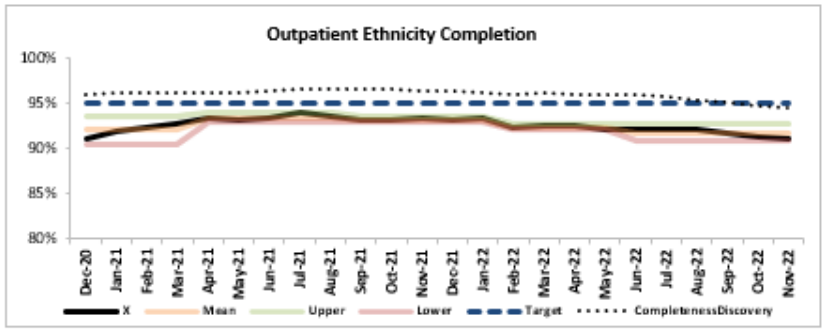
- Work is also underway to include reporting over time to allow meaningful identification and interpretation of trends.

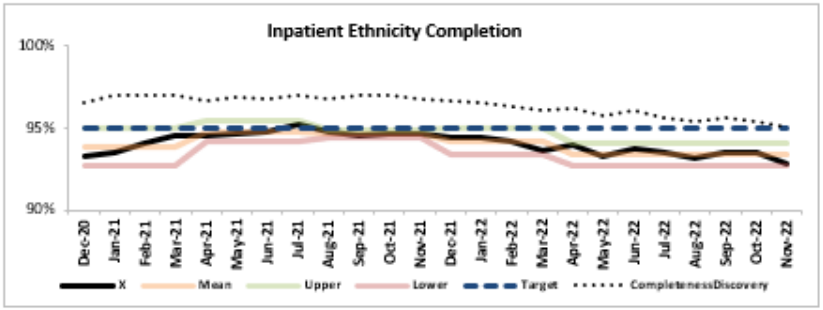
RESPONSIVE

Ethnicity Recording by Activity Type

Jan-23







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

Site	A&E	Inpatient	Outpatient
Royal London	96.3%	90.6%	90.1%
Whipps Cross	93.2%	92.7%	89.7%
Newham	95.1%	95.6%	94.3%
St Bart's	-	95.6%	92.2%
Trust	**95.0%**	**92.8%**	**91.0%**

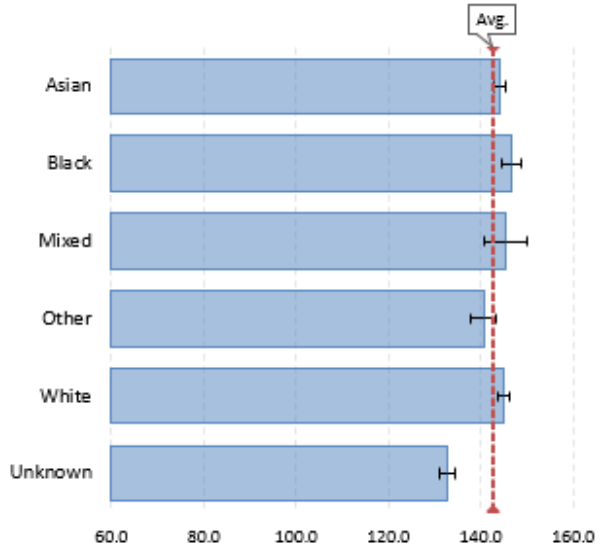
The above figures show the % activity where the ethnicity of the patient is known and has been recorded (i.e. not including where it has not been requested, recorded as not stated or the patient has refused to give it). The dotted black line shows what the % recorded would be expected to be if North East London GP data on ethnicity were to be included; this will not yet be reflected in the Trust's reported performance or NHS Digital external dashboards

Performance Overview	Responsible Director Update
• While ethnicity recording performance across all three activity areas is above 90%, November 2022 recording data reflects a marginal decline for A&E and Inpatient departments (0.9 and 0.5 percentage points, respectively). The downward trend in capture rates for Outpatients since January 2022 continues with a slight fall of 0.2 percentage points since the last reporting period. • While no site achieved 95% data collection in all three areas, Newham University Hospital has maintained a 95% capture in both A&E and Inpatients at 95.1% and 95.6%, respectively. • Whipps Cross Hospital has seen a very slight decline in capture rates across areas, with A&E, Inpatients and Outpatients decreasing by 1.2, 1.1 and 0.1, respectively. • Royal London Hospital continues to achieve the highest capture rates in A&E at 96.3%. However, opportunities still exist to improve ethnicity capture for Inpatient and Outpatient departments.	• While it is encouraging to see 90% capture and above maintained in individual areas, there has been a marginal decline in this month's performance which we believe is a consequence of staff shortages and extreme operational pressures, • The Trust is working to download GP data on ethnicity to improve overall rates of recording. • Ethnicity capture reporting is now included as part of standard divisional PR packs.

RESPONSIVE

Equity - Wait Times By Ethnicity

Jan-23



Summary Data

Ethnic Category	Total Wait Time (Days)	# of Pathways
Asian	4,774,372	33,134
Black	1,890,417	12,878
Mixed	378,317	2,599
Other	967,823	6,882
White	5,521,388	38,068
Unknown	2,563,761	19,323

Pathways with no Week Wait details excluded

Ethnic Category	Average Wait	Lower	Upper
Asian	144.1	142.8	145.4
Black	146.8	144.6	149.0
Mixed	145.6	140.9	150.3
Other	140.6	137.7	143.5
White	145.0	143.8	146.3
Unknown	132.7	131.0	134.3
Grand Total	**142.6**		

Commentary

At Trust level, there is no practical difference in wait times between patients from different ethnic groups.

On average, the longest waiters appear to belong to the 'Black' ethnic category at 146.8 days. This equates to 4.2 days difference between the 'Black' ethnicity and the average. Patients who identify as 'White" wait 3.4 days longer than the average.

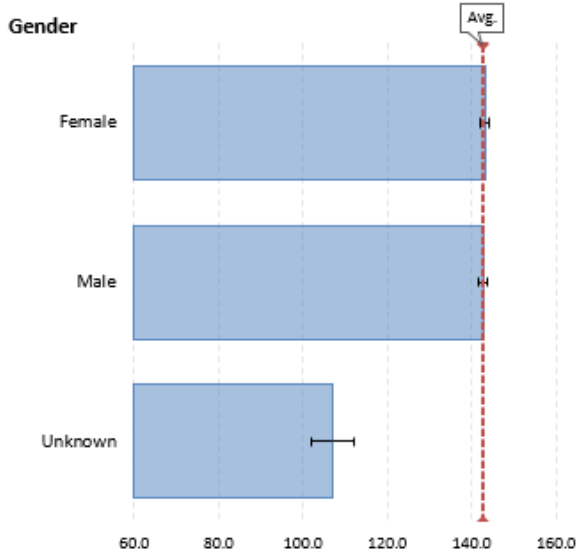
We are currently looking to understand the difference in waiting times for the 'Unknown' ethnicity group.

Work is also underway to include reporting over time to allow meaningful identification and interpretation of trends.

RESPONSIVE

Equity – Wait Times by Gender

Jan-23



Commentary

At Trust level, there is no significant difference in wait times between male and female patients.

As with last month, the wait time from referral to treatment by gender is very similar for male patients compared with female patients (142.8 days vs 143.1 days, respectively).

Additionally, although it's a very small proportion, we are investigating the data quality issues behind the "Unknown" group.

Work is underway to include reporting over time to allow meaningful identification and interpretation of trends.

Summary Data

Gender	Total Wait Time (Days)	# of Pathways
Female	8,916,521	62,299
Male	7,043,900	49,318
Unknown	135,657	1,267

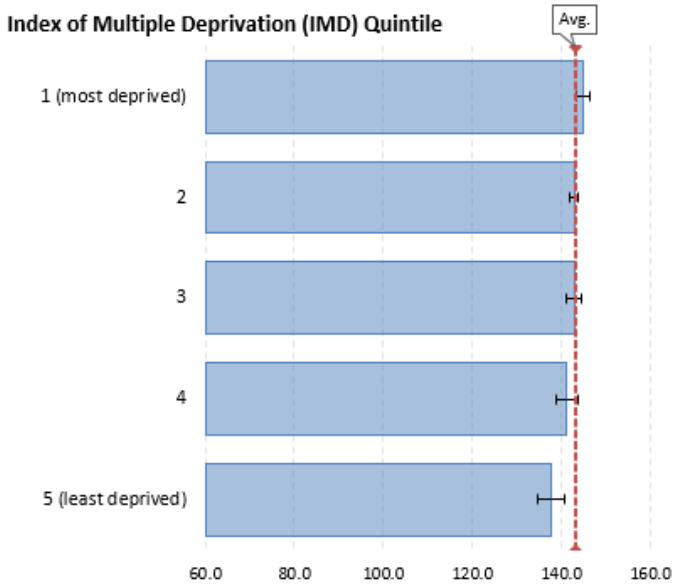
Pathways with no Week Wait details excluded

Gender	Average Wait	Lower	Upper
Female	143.1	142.2	144.1
Male	142.8	141.7	143.9
Unknown	107.1	101.9	112.2
Grand Total	**142.6**		

RESPONSIVE

Equity – Wait Times By Deprivation

Jan-23



Commentary

In this month's snapshot, at Trust level, there appears to be a small but significant difference in wait time between patients living in the wealthiest and poorest areas of 7.4 days.

The average wait time by level of deprivation is 143 days, down 1.3 days from last month.

Work is currently underway to include reporting over time to allow meaningful identification and interpretation of trends.

Summary Data

IMD Quintile	Total Wait Time (Days)	# of Pathways
1 (most deprived)	3,921,377	27,047
2	7,326,382	51,298
3	2,617,302	18,322
4	1,314,621	9,310
5 (least deprived)	772,619	5,613

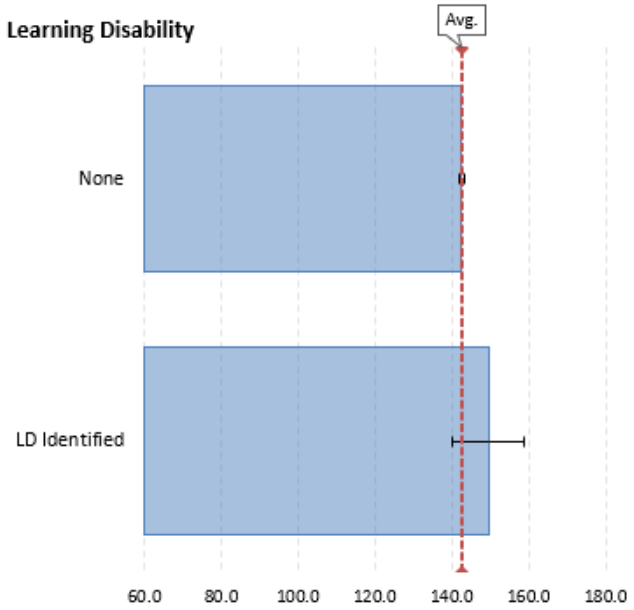
Pathways with no Week Wait details excluded

IMD Quintile	Average Wait	Lower	Upper
1 (most deprived)	145.0	143.5	146.5
2	142.8	141.8	143.9
3	142.9	141.1	144.6
4	141.2	138.8	143.6
5 (least deprived)	137.6	134.5	140.8
Grand Total	**143.0**		

RESPONSIVE

Equity – Wait Times by LD

Jan-23



Commentary

At Trust level, there is no longer a significant difference in wait times between patients who have been identified as having a learning disability and those who haven't.

Last year, data revealed that longer waits for surgery for patients with a learning disability could be attributed to one speciality, Restorative Dentistry. Action taken over the last year significantly reduced the waiting times in this speciality and, therefore, the overall waiting times for this cohort. That improvement has been sustained with the speciality.

There has also been a significant improvement in the prioritisation of patients with learning disabilities for surgery, meaning they wait less time after a procedure is booked. Patients with learning disabilities are also slightly less likely to wait over 52 weeks than patients who haven't been identified as having a learning disability.

We will be working with our clinical specialties and the sites to better understand what we can do to prioritise these patients and monitor trends.

Summary Data

LD_Flag	Total Wait Time (Days)	# of Pathways
None	15,996,798	112,220
LD Identified	99,280	664

Pathways with no Week Wait details excluded

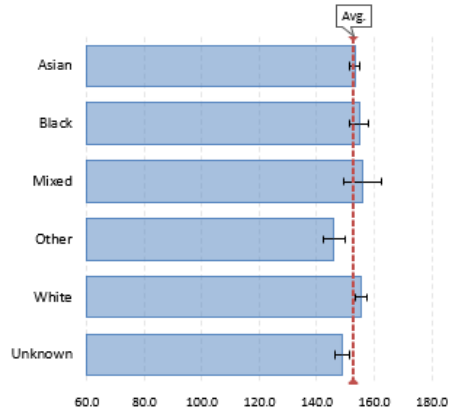
LD_Flag	Average Wait	Lower	Upper
None	142.5	141.8	143.3
LD Identified	149.5	140.1	158.9
Grand Total	**142.6**		

RESPONSIVE

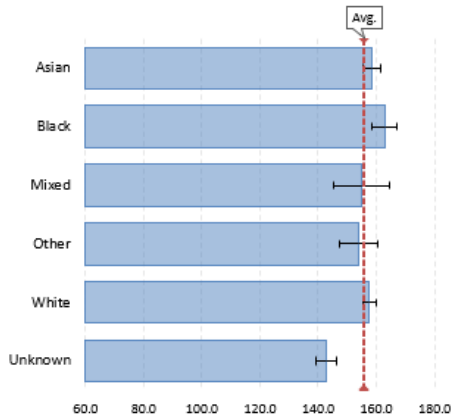
Equity - Wait Times By Ethnicity (Sites)

Jan-23

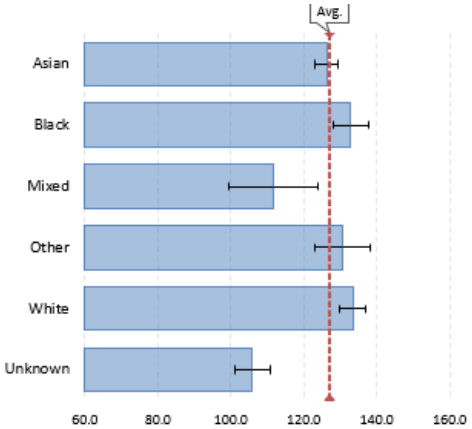
Royal London



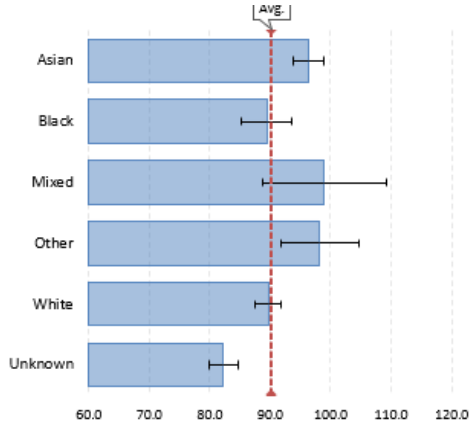
Whipps Cross



Newham



St Barts



Commentary

At site level, differences in wait times by ethnicity are not significant.

Like last month's snapshot, patients for whom ethnicity is 'unknown' appear to have shorter average wait times compared with other ethnic groups at Whipps Cross, Newham University and St. Bartholomew's Hospitals.

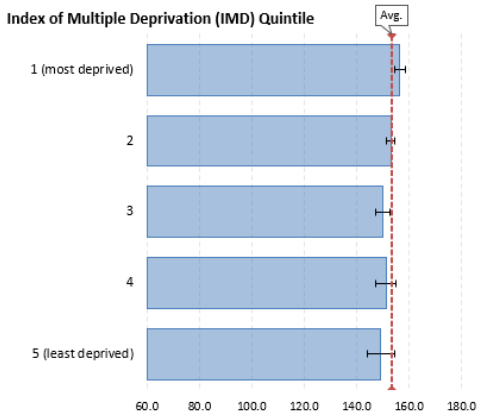
The population of 'Mixed' patients across the Trust make up only a small proportion (2.3%) of Trust patient pathways by ethnicity and therefore it can be expected that waiting times will vary from month to month. This month, at Whipps Cross Hospital and Newham University Hospitals waits for patients of 'Mixed' ethnicity were shorter compared to most other ethnic groups , and at St Bartholomew's Hospital, 'Mixed' ethnicity patients waited longer than other known ethnic groups. This broadly reflects findings from last month. We will continue to monitor for trends.

RESPONSIVE

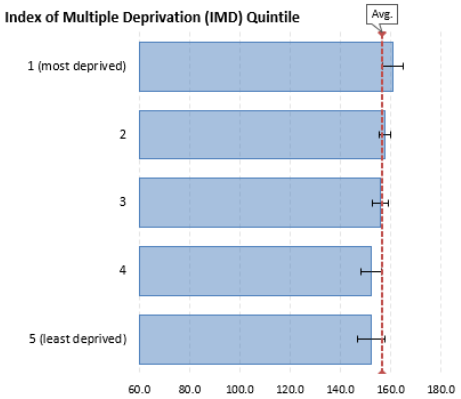
Equity – Wait Times By Deprivation (Sites)

Jan-23

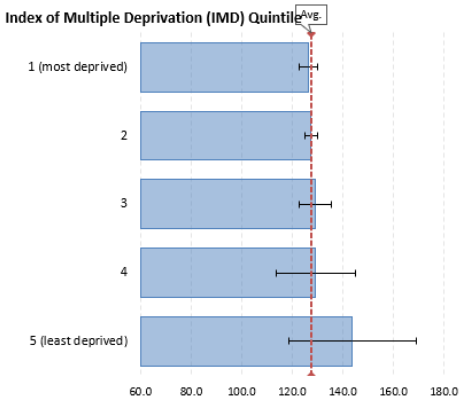
Royal London



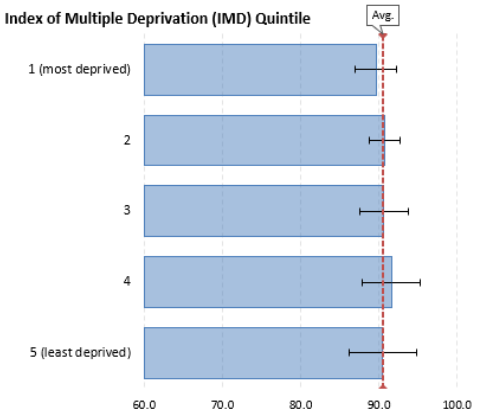
Whipps Cross



Newham



St Barts



Commentary

All site level, there are no significant differences in wait times between patients living in the most deprived postcodes and those living in the least deprived postcodes.

At the time of this snapshot on 23rd November 2022, however, the data shows a very slight trend between deprivation and longer waiting times at Royal London Hospital and Whipps Cross Hospital. This could be due to chance, as the numbers aren't big enough to be able to infer for certain. At Newham University Hospital, average waits are longer for those who live in wealthier postcodes. We will be monitoring for trends to identify any differences between groups.

NHS
Barts Health
NHS Trust

People Report

SUMMARY

People Summary

Jan-23

Growing the Workforce – Recruitment, Temporary Staffing and Turnover

Substantive Staffing

Staff in post has grown by 203 WTE of which 142 relates to the TUPE of security and reception staff from SERCO. In addition our nursing and midwifery workforce grew by 38 WTE.

The substantive fill rate is now 92.1%, up from 91.1% reported last month, however this is, in part a reflection of the SERCO TUPE. Excluding this we would have seen an improvement to 91.4%.

With the nursing and midwifery growth we saw the fill rate for that staff group improve from 83.7% to 84.3% however a significant number of vacancies remain across the group.

Recruitment

464 unconditional offers were made in November, above the plan of 385. In additional 442 conditional offers were made and 1,075 WTE advertised.

Our international recruitment campaign for 2022 has been successful with 235 IENs being recruited against our NHSE target of 230. A further 111 are in the pipeline for early 2023. Alongside this there is a plan to recruit overseas for 56 midwives, the majority of whom will be based at Whipps Cross. Plans for further overseas recruitment in 2023/24 are currently being developed.

The Emergency Department workforce group, that meets fortnightly to review recruitment, is stepping up a marketing campaign similar to our previous, successful, campaign for Critical Care. Alongside this recruitment into the three emergency departments continues to be prioritised.

Turnover

Annualised voluntary turnover reduced to 13.2%, and improvement from 13.4% reported last month. More detail is covered in the exception page that follows.

Proportion of temporary

The proportion of temporary staff reduced from 14.9% in October to 14.2% in November. This reflects a 132 WTE drop in temporary staffing (77 WTE bank and 55 WTE agency) . Bank and agency spend as a % of pay budget was at 13.77% with £8.8m spent on bank and £5.1m on agency. YTD this is 15.95% with spend of £89.8m and £38.6m respectively. The target for the year on agency spend is £42.3m or less,

Sickness Absence

Whilst sick absence in month went up, it was still lower than in October 21 which meant annualised absence has dropped slightly to 5.18%. The in month increase is seasonal (we tend to see an increase in October), however higher than in the similar period pre-pandemic, driven by higher levels of absence recorded as cough/cold/flu. A similar level of in month absence is expected to be reported for November.

Roster Compliance

Roster compliance (rosters approved 6 weeks in advance) reduced from 55% to 38%. A piece of work is being undertake to understand the causes of the low levels of roster compliance at Royal London and it's potential impact on temporary staffing demand

WELL LED

Domain Scorecard

Jan-23

	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Site Comparison: Whipps Cross	Site Comparison: Newham	Site Comparison: St Bart's	Site Comparison: Other	Excep.
People	W19	Turnover Rate	●			Nov-22 (m)	<= 12.25%	13.45%	**13.22%**	***13.22%***	14.38%	12.06%	10.78%	13.90%	12.61%	●
	OH7	Proportion of Temporary Staff	●			Nov-22 (m)	<= 11.3%	14.9%	**14.2%**	***14.6%***	13.1%	20.2%	19.8%	11.8%	7.0%	●
	W20	Sickness Absence Rate	●			Oct-22 (m)	<= 3%	5.22%	**5.18%**	***5.18%***	5.31%	5.36%	5.61%	4.24%	5.37%	
Staff Feedback	C6	Staff FFT Percentage Recommended - Care				2019/20 Q4 (q)	>= 70%	77.2%	**79.8%**	***78.3%***	84.8%	79.3%	75.4%	91.8%	73.1%	
	OH6	NHS Staff Survey	●			2020/21 (y)	>= 7	7.0	**6.9**	***6.9***	7.0	6.8	6.9	7.1	7.0	
Compliance	W50	Mandatory and Statutory Training - All	●			Nov-22 (m)	>= 85%	84.0%	**84.8%**	***84.4%***	83.9%	86.6%	82.4%	87.5%	83.5%	●
	W11	Mandatory and Statutory Training - National	●			Nov-22 (m)	>= 85%	83.0%	**83.8%**	***83.6%***	82.3%	86.0%	83.2%	86.4%	82.4%	
	W29	Appraisal Rate - Non-Medical Staff	●			Nov-22 (m)	>= 90%	53.1%	**52.4%**	***52.4%***	51.8%	57.0%	48.5%	57.1%	49.7%	
	W30	Appraisal Rate - Medical Staff	●			Nov-22 (m)	>= 95%	76.7%	**76.3%**	***76.3%***	-	-	-	-	76.3%	

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

WELL LED

Domain Scorecard

Jan-23

Barts Health

Group	Indicator	Targets	Performance		YTD	Nov-22 (Site)			
		Target	Oct-22	Nov-22		Royal London	Whipps Cross	Newham	St Bart's
Planned vs Actual WTE	% Utilisation (Total Fill Rate)	<=100%	101.8%	102.9%	-	103.4%	104.4%	103.1%	101.3%
	Staff in Post - Actual	>=Plan	16,919	17,122		6,363	2,933	2,127	2,727
	Staff in Post - Plan	-	17,009	17,087	-	6,301	3,040	2,193	2,725
	Bank WTE - Actual	<=Plan	2,108	2,031		735	490	350	285
	Bank WTE - Plan	-	1,857	1,837	-	742	304	296	229
	Agency WTE - Actual	<=Plan	851	796		228	253	176	82
	Agency WTE - Plan	-	530	519	-	174	122	101	37
	Total Staffing - Actual	<=Plan	19,878	19,948	-	7,326	3,676	2,653	3,093
	Total Staffing - Plan	-	19,396	19,442	-	7,217	3,466	2,591	2,991
Recruitment Plans	Substantive Fill Rate - Actual	<=Plan	91.1%	92.1%	-	94.5%	87.9%	86.8%	92.3%
	Substantive Fill Rate - Plan	-	92.1%	92.5%	-	92.9%	92.8%	92.2%	94.0%
	Unconditional Offers - Actual	>=Plan	470	464	1,522	179	91	41	67
	Unconditional Offers - Plan	-	384	385	1,505	156	63	46	71
Rosters	Roster Compliance - % Approved on Time (>20 WTEs)	>=100%	54.5%	38.4%	-	27.8%	48.3%	40.0%	42.9%
	Nursing Roster Quality - % Blue or Cloudy Sky	-	27.8%	18.8%	-	21%	19%	23%	10%
	Additional Duty Hours (Nursing)	-	97,752	93,257	-	37,201	25,639	17,346	11,665
Diversity	% of BME Staff at Band 8a to VSM	-	36.3%	37.0%		33%	43%	54%	24%

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

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

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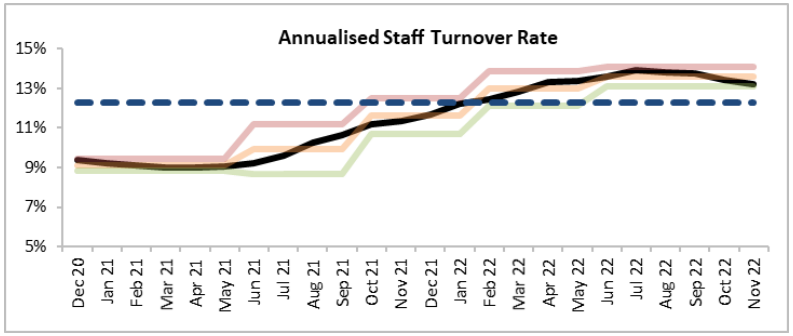
Turnover Rate

Jan-23



Annualised Staff Turnover - Highest by Site/Staff Group (by Staff Leaving in Latest Year)

		6 Months Ago			Nov-22			
Site	Staff Group	12-Month Leavers	Average Workforce	%	12-Month Leavers	Average Workforce	%	Variance
Royal London	Nursing and Midwifery Registered	383	2,160	**17.74%**	366	2,181	**16.79%**	**-0.95%**
Other	Administrative and Clerical	144	1,243	**11.55%**	165	1,293	**12.78%**	**1.23%**
St Bart's	Nursing and Midwifery Registered	148	902	**16.41%**	139	899	**15.46%**	**-0.95%**
Royal London	Additional Clinical Services	107	879	**12.21%**	133	883	**15.01%**	**2.79%**
Whipps Cross	Nursing and Midwifery Registered	128	1,029	**12.45%**	123	1,054	**11.68%**	**-0.76%**

Performance Overview

- The annualised voluntary turnover rate has reduced further for the 4th consecutive month.
- Across Barts Health we have seen
  - Newham University Hospital improve from 11.1% to 10.8%
  - The Royal London Hospital improve from 14.7% to 14.4%
  - Whipps Cross Hospital improve from 12.2% to 12.1%
  - Pathology Partnership stay stable at 13.9%
  - St Bartholomew's deteriorate slightly from 13.8% to 13.9%
  - GSS improve from 12% to 11.5% although this is affected by the TUPE of SERCO staff
- We have also seen improvements as a group across most staff groups including Nursing and Midwifery going from 14.9% to 14.7% and Allied Health Professionals from 19.8% to 18.2%

Responsible Director Update

Since April 2022 Barts Health has been part of the People Promise exemplar programme with a project manager funded by NHSE. As part of this a retention programme has been underway aiming to understand what makes staff feel valued and stay working at Barts Health.

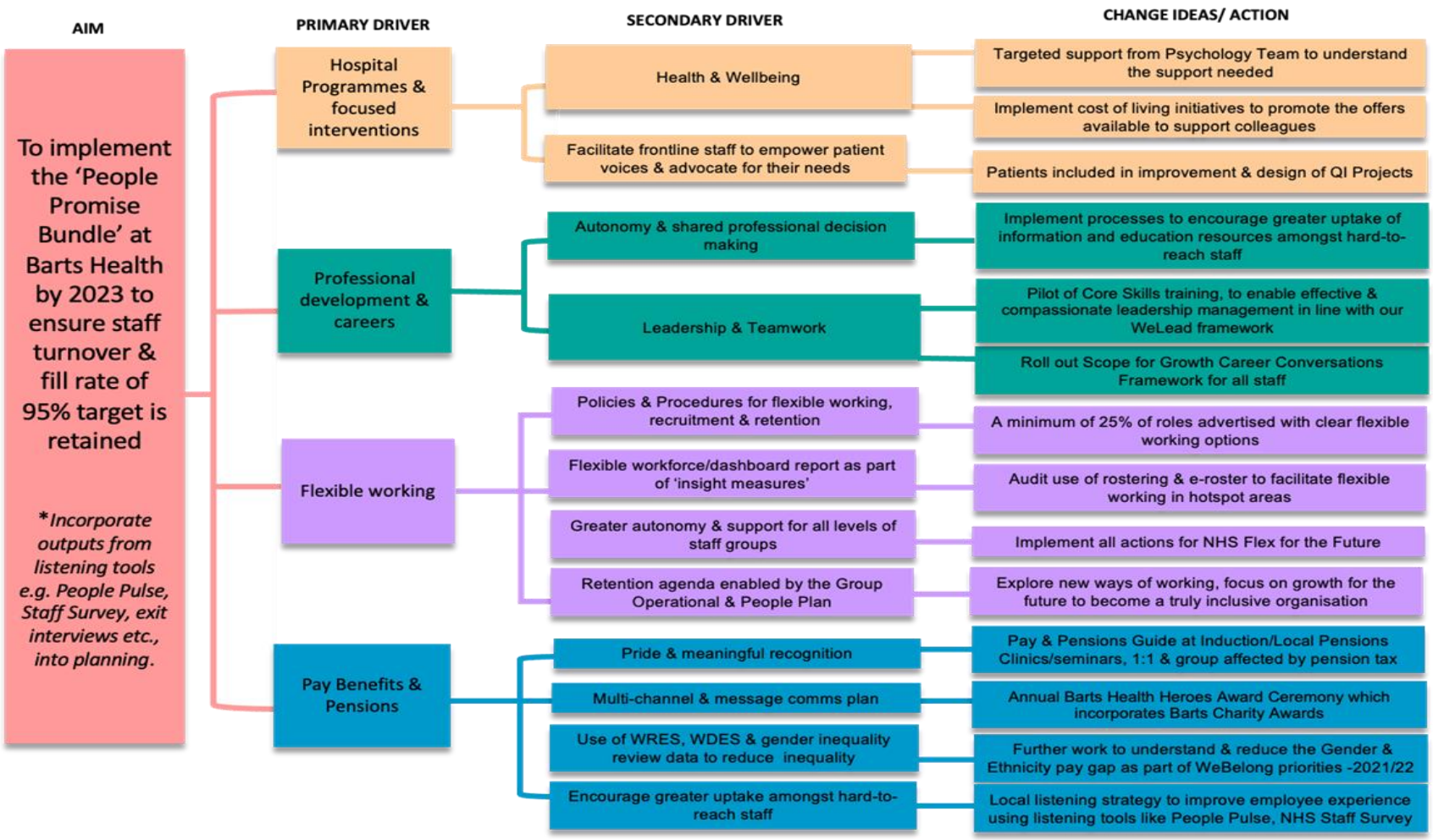
The next slide provides the driver diagram sitting behind the work of the exemplar programme.

One of the key successes of the programme has been the focussed work with ACCU at Royal London Hospital Hospital and we have seen turnover there reduce from 27.3% in April 22 to 21.2% in November 22.

Going into the next calendar year the programme will have a renewed focus on, amongst other things, flexible working including piloting team based rostering, changing recruitment forms to help identify roles suitable for flexible working and embedding conversations as part of the appraisal process

Exemplar Programme Driver Diagram

Jan-23



To enable delivery of the Group Operational & People Plan to become a truly inclusive organisation, without discrimination, based on a fair and just culture.

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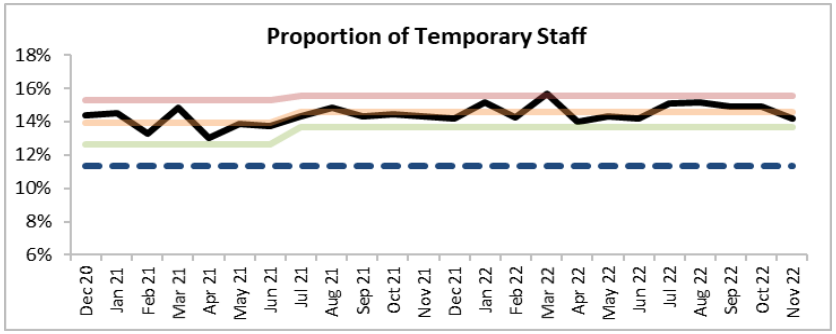
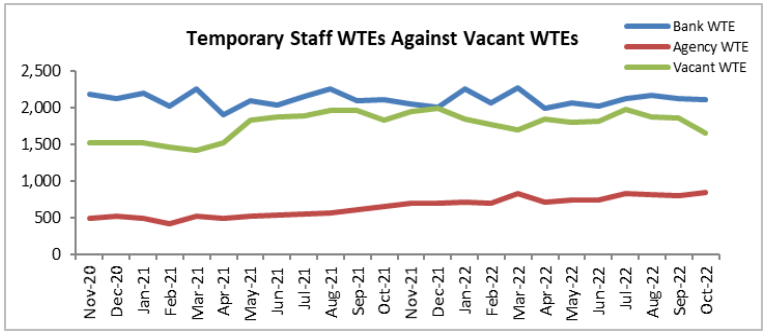
Proportion of Temporary Staff

Jan-23





Proportion of Temporary Staff by Site

		Average of Previous 6 Months			Nov-22			
Site	**Staff Group**	**Bank & Agency WTE**	**All Used WTE**	**%**	**Bank & Agency WTE**	**All Used WTE**	**%**	**Variance**
Royal London	All Staff Groups	955	7,209	**13.2%**	963	7,326	**13.1%**	**-0.1%**
Whipps Cross	All Staff Groups	737	3,607	**20.4%**	743	3,676	**20.2%**	**-0.2%**
Newham	All Staff Groups	544	2,627	**20.7%**	526	2,653	**19.8%**	**-0.9%**
St Bart's	All Staff Groups	385	3,097	**12.4%**	366	3,093	**11.8%**	**-0.6%**
CSS	All Staff Groups	20	244	**8.1%**	20	240	**8.4%**	**0.3%**
Other	All Staff Groups	232	2,817	**8.2%**	208	2,961	**7.0%**	**-1.2%**

Performance Overview

- The proportion of temporary staff reduced from 14.9% in October to 14.2% in November. This reflects a 132 WTE drop in temporary staffing (77 WTE bank and 55 WTE agency) .
- Whilst Whipps Cross Hospital and Newham University Hospital significantly higher users of temporary staffing than Royal London Hospital and St Bartholomew's all sites have seen a reduction in the proportion of temporary staff as follows
  - Whipps Cross Hospital 20.2% (from 20.6% - down 11 temp WTE)
  - Newham University Hospital 19.8% (from 21.0% - down 43 temp WTE)
  - Royal London Hospital 13.1% (from 13.4% - down 14 temp WTE)
  - St Bartholomew's 11.8% (from 12.2% - down 15 temp WTE)

Responsible Director Update

- Partnership working across the APC has resulted in all three organisations establishing similar bank rates for AfC roles supporting a more robust and consistent supply
- Agreement has been reached with APC partners on a consistent approach to managing rate escalations over winter. to ensure any proposals for inducements are consulted on prior to decisions to implement
- Focus works with stakeholders involved in Temporary Medical staffing continues with a programme of work covering rates, governance and booking processing being launched across all sites
- Work on developing a consistent group wide medical rate card, governance and booking process is progressing well. Given the current pressure on staffing we are not aiming to reduce rates over the winter period.
- NHSE monitoring of shifts paid a rate which that breach the new London Local Rate card (refreshed in October) commenced from in November and this should start to bring greater consistency to rates being paid across London over the coming months.

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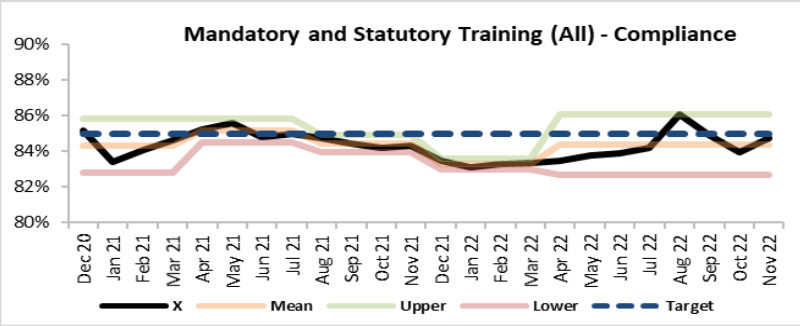
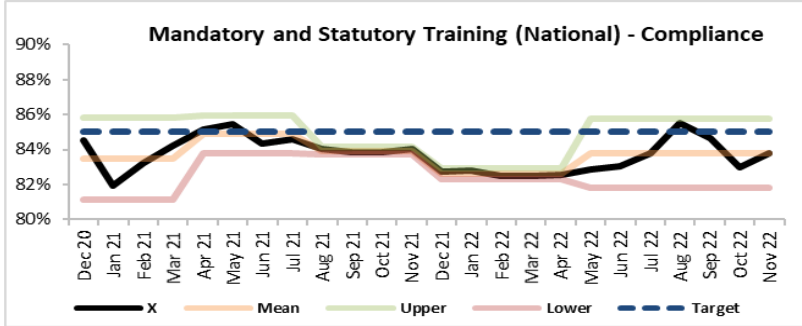
Mandatory and Statutory Training

Jan-23





Bottom 5 Competencies: Total Number of Non-Compliant Employees

Competency	Previous 6 Months	Nov-22	
	Compliance	Compliance	Staff Non-Compliant
Information Governance	78.8%	80.4%	3,476

Bottom 5 Departments: Total Number of Non-Compliant Employees

Department	Previous 6 Months	Nov-22	
	Compliance	Compliance	Staff Non-Compliant
A & E Helicopter Service	74.4%	71.4%	62
BRC 2017-2022	85.5%	77.2%	20
COVID19 Costs - NUH	11.5%	10.8%	20
Staff Salaries Only (Pearse)	45.1%	49.5%	20
Whipps Cross Development Team Capitalised Costs	91.0%	82.7%	18

Non-mandatory competencies have been excluded from the above tables

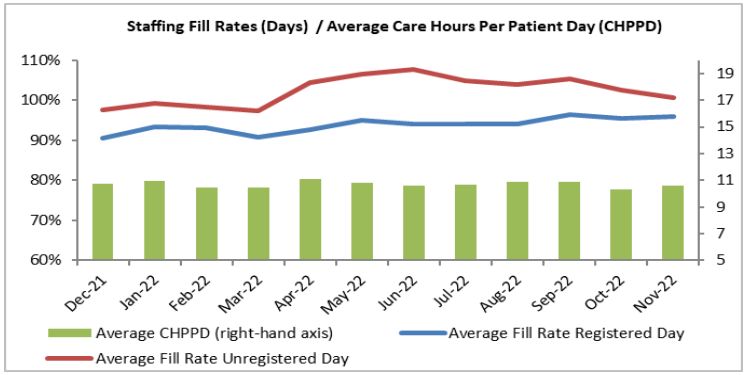
Performance Overview	Responsible Director Update
• Trust wide compliance against the 11 Core Skills Training Framework subjects has improved over the past month and currently stands at 85.64%. This is above the Trust target of 85%. • Overall training compliance across all subjects is also increasing but is still marginally sitting under the Trust target of 85%. • Departments listed in the bottom 5 have particularly volatile compliance rates due to the number of staff in each department. This is a particular issue where one member of staff is non-compliant for a number of subjects at the same time. • Work is continuing with the Information Governance (IG) team on raising compliance with targeted emails being sent to staff from the IG team.	• All staff receive monthly emails to alert them of non –compliance or subjects that are within 3 months of expiring. • Statutory and mandatory training data is included in site PR packs with spotlights on specific issues. • Work is continuing with the Safeguarding team on analysing the new training needs analysis and ensuring it has been correctly applied in accordance with the intercollegiate document. The Safeguarding team are also in the process of developing an action plan to address compliance as a result of the impact of TNA changes. • Work is continuing with the Millennium training team to identify areas where the new training needs analysis has been incorrectly applied and make amendments as quickly as possible. • A sub group of the soft FM Steering Group, is being set up to review the education and training implications of the SERCO staff moving across to Barts Health. This will support with the appropriate identification of relevant statutory, mandatory and essential skills training required by transferring staff and enable the correct programming of WIRED for compliance reporting • A new Duty of Candour package has been created and was released on the 12th October 22. There are 3,304 staff who have now completed the training and compliance sits at 31.21%.

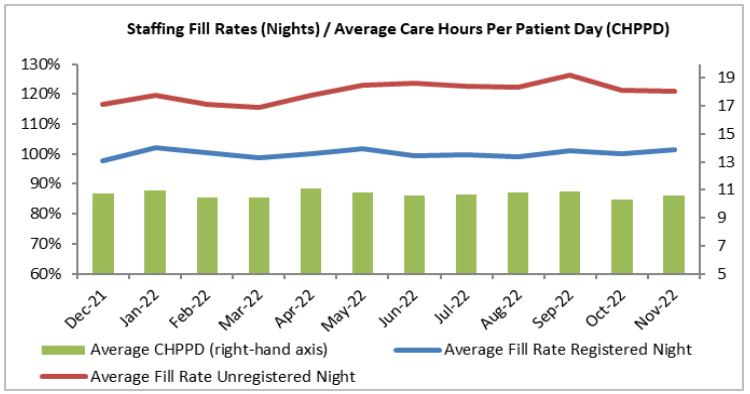
SAFE STAFFING

Safe Staffing

Jan-23

- Overall average fill rates at organisational level remained above for 95% for November, for both Registered Nursing and Midwifery (RNs/RMs) and for Care Staff (HCAs) on both day and night shifts.
- Overall average Care Hours Per Patient Day (CHPPD) increased slightly to 10.6 in November (10.3 in October). This metric is stable for the trust but remains above the last published London average (9.0; September 2022). This is reflective of the high number of specialist and critical care units within the organisation. Speciality mapping for the CHPPD data return has been reviewed and refreshed to improve accuracy of ward level benchmarking.
- Each site continues to experience day-to-day staffing pressures. These are assessed and mitigated via staffing huddles held at each site daily/twice daily. Actions include in-shift redeployments, Ward Managers working clinically and Practice Development Nurses undertaking clinical duties as required.
- Pressure continue across the maternity units. Embedded proactive management processes as described in previous reports remain in place.
- Demand for enhanced care shifts continues. Sites have increased vigilance with review processes to ensure appropriate prioritisation of resources. Enhanced Care Policy update in final stages. Business case in process to strengthen Enhanced Care Team at Royal London Hospital.
- Winter pressures has seen the opening of additional capacity, staffed through deployment of substantive staff to lead shifts, supported by temporary staffing.
- A total of 12 Red flag incidents were reported across the Trust, a decrease of 2 compared to October. These were all reported by Newham University Hospital (2), Royal London Hospital (9) and Whipps Cross Hospital (1).
- Incidents were mitigated in real time to prevent patient harm and ensure safety was prioritised. It is noted that staff impact is not measured, but is associated with increased pressure during the shift.
- Work continues to ensure suboptimal staffing incidents which meet the Red Flag criteria are categorised accordingly therefore increase in reported Red Flags is anticipated for future months.





	Staffing Figures by Site - Nov-22					
	Average Fill Rate (Day)		Average Fill Rate (Night)		Average Care Hours Per Patient Day (CHPPD)	Safe Staffing Red Flag Incidents
Site	Registered Nurses / Midwives (%)	Care Staff (%)	Registered Nurses / Midwives (%)	Care Staff (%)		
Trust	**95.9%**	**100.5%**	**101.3%**	**121.1%**	**10.6**	**12**
Royal London	100.1%	99.8%	106.0%	132.6%	10.2	9
Whipps Cross	92.5%	105.0%	98.7%	117.2%	10.3	1
Newham	96.5%	98.3%	102.2%	109.7%	10.3	2
St Bart's	91.4%	94.9%	94.2%	116.5%	12.6	0

NHS
Barts Health
NHS Trust

Finance Report

EXECUTIVE SUMMARY

Finance Summary

Jan-23

Finance

- The Trust has reported to NHS England a (£34.9m) adverse variance for the year to date due to the impact of unfunded hyper-inflation pressures (£18.0m), allowance for potential ERF clawback (£13.0m) by Integrated Care Boards (ICBs) and other budget overspends primarily relating to slippage on efficiency savings plans (£3.9m).

Income

Income is (£8.2m) adverse against the year to date plan. NHS Patient Treatment income is (£6.0m) adverse, which is primarily due to allowance for potential ERF clawback (£13.0) for underperformance against the 104% elective recovery activity target. The clawback provision is partially offset by over-performance on high cost drugs. Other income is (£2.3m) adverse for the year to date, with the key shortfall being for reduced private patients income at St. Bartholomew's Hospital.

Expenditure

Expenditure is (£26.7m) adverse against the year to date plan. Site and Services expenditure is (£50.8m) adverse due to the underachievement against the 3% recurrent efficiency savings target, hyper-inflation pressures, high cost drugs costs and the purchase of independent sector activity to support elective recovery. Temporary staffing costs to date remain higher than plan with the key drivers of the adverse variance being non-elective activity pressures, high staff sickness absence, use of off-framework agency staff and slippage against recurrent efficiency savings plans. Central expenditure is £23.8m favourable which is due to the release of non-recurrent benefits and reserves, which is partly offsetting the adverse variances within the sites.

- Capital expenditure to date is £41.7m against a plan of £63.3m which results in an adverse variance of £21.5m for the exchequer funded schemes. The significant underspend to date helps manage the level of overcommitment since the start of the year. The variance can be attributed to factors including the slow start of schemes such as Newham University Hospital 2nd CT (£1.6m), delays experienced in major schemes such as Whipps Cross Hospital Redevelopment (£3.5m) due to uncertainties around national funding, delay with the PFI legal agreement on the Newham University Hospital Modular Build (£8.4m), contractor related delays Newham University Hospital Fire Programme (£1.5m) and delays in progressing the Kenworthy Road lease (£3.6m).

- The Trust cash balance is £112.9m which is higher than plan because of the higher closing cash balance of £86.7m in March 2022, lower capital expenditure and other movements in working capital.

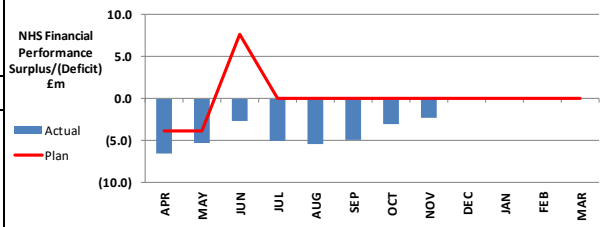
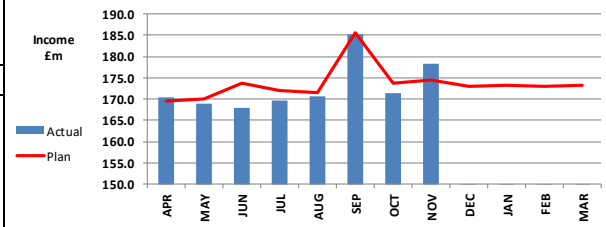
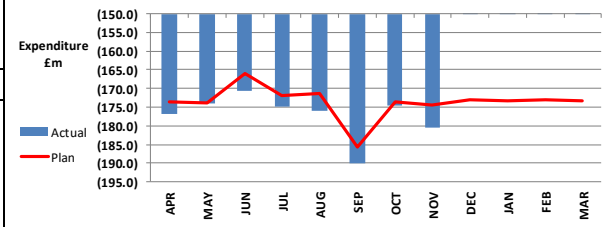
Key Challenges

- The Trust is considering an NEL ICB proposal that it report a forecast outturn income and expenditure deficit of (£19m) for 2022/23 as part of an NEL system forecast deficit of (£35m) that has been agreed with NHS London. The proposed (£19m) deficit incorporates the ICB understanding that ERF funding will not now be clawed back from local systems in 2022/23 and includes additional funding of £3m for mental health enhanced care nursing costs to be provided by NEL ICB. Subject to consideration, a revised forecast will be formally submitted as part of month 9 financial reporting under the NHS England protocol for changes to in-year revenue financial forecasts.

KEY METRICS

Finance Key Metrics

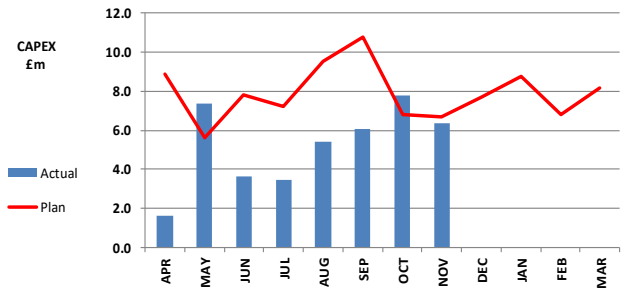
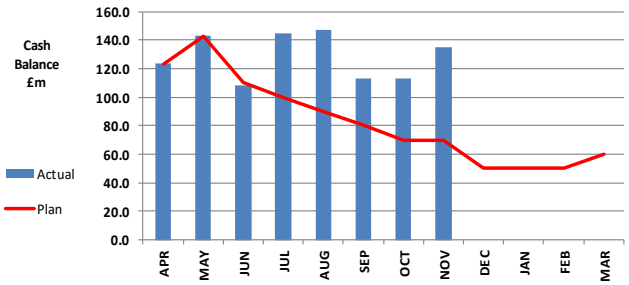
Jan-23

Metrics	Current Performance Year To Date £millions	Trend	Comments
NHS Financial Performance Surplus / (Deficit)	Plan 0.0 Actual (34.9) Variance (34.9)		The Trust has reported to NHS England a (£34.9m) adverse variance for the year to date due to the impact of unfunded hyper-inflation pressures (£18.0m), allowance for potential ERF clawback (£13.0m) by Integrated Care Boards (ICBs) and other budget overspends primarily relating to slippage on efficiency savings plans (£3.9m).
Total Income	Plan 1,390.7 Actual 1,382.5 Variance (8.2)		Income is (£8.2m) adverse against the year to date plan. NHS Patient Treatment income is (£6.0m) adverse, which is due to Elective Recovery Fund (ERF) under-performance partially offset by an over-performance on high cost drugs. Allowance for clawback of 75% of ERF allocations for the year to date (£13.0m) by the ICB has been assumed in the Trust's position reflecting elective underperformance against the 104% target for non-specialised activity for the year to date. Other income is (£2.3m) adverse for the year to date, with the key shortfall being for reduced private patients income at St.Bartholomews Hospital.
Total Expenditure	Plan (1,390.7) Actual (1,417.4) Variance (26.7)		Expenditure is (£26.7m) adverse against the year to date plan. Site and Services expenditure is (£50.8m) adverse due to the underachievement against the 3% recurrent efficiency savings target, hyper-inflation pressures, high cost drugs costs and the purchase of independent sector activity to support elective recovery. Temporary staffing costs to date remain higher than plan with the key drivers of the adverse variance being non-elective activity pressures, high staff sickness absence, use of off-framework agency staff and slippage against recurrent efficiency savings plans. Central expenditure is £23.8m favourable which is due to the release of non-recurrent benefits and reserves, which is partly offsetting the adverse variances within the sites.

KEY METRICS

Finance Key Metrics

Jan-23

Metrics	Current Performance Year To Date £millions	Trend	Comments
Capital Expenditure	Plan 63.3 Actual 41.7 Variance (21.5)		Capital expenditure to date is £41.7m against a plan of £63.3m which results in an adverse variance of £21.5m for the exchequer funded schemes. The significant underspend to date helps manage the level of overcommitment since the start of the year. The variance can be attributed to factors including the slow start of schemes such as NUH 2nd CT (£1.6m), delays experienced in major schemes such as WXH Redevelopment (£3.5m) due to uncertainties around national funding, delay with the PFI legal agreement on the Newham Modular Build (£8.4m), contractor related delays Newham Fire Programme (£1.5m) and delays in progressing the Kenworthy Road lease (£3.6m).
Cash	Plan 70.0 Actual 134.7 Variance 64.7		Cash balances are higher than plan because of the higher closing cash balance of £86.7m in March 2022, lower capital expenditure and other movements in working capital.

Key Issues

'The Trust is considering an NEL ICB proposal that it report a forecast outturn income and expenditure deficit of (£19m) for 2022/23 as part of an NEL system forecast deficit of (£35m) that has been agreed with NHS London. The proposed (£19m) deficit incorporates the ICB understanding that ERF funding will not now be clawed back from local systems in 2022/23 and includes additional funding of £3m for mental health enhanced care nursing costs to be provided by NEL ICB. Subject to consideration, a revised forecast will be formally submitted as part of month 9 financial reporting under the NHS England protocol for changes to in-year revenue financial forecasts.

Key Risks & Opportunities

The key financial challenges for the Trust in achieving its £19m forecast outturn deficit for the financial year are:
- Managing additional costs resulting from increasing non-elective activity over the winter period including variations in the level of COVID and Flu prevalence.
- Managing any additional costs arising as a result of industrial action within the wider NHS.
- Delivering improvements in productivity and recurrent costs over the remainder of the year in order to minimise the recurrent exit run rate deficit carried into 2023/24.

INCOME & EXPENDITURE

Income & Expenditure - Trustwide

Jan-23

21/22 YTD Prev Yr Actual	£millions	In Month Plan	In Month Actual	In Month Variance		Year to Date Plan	Year to Date Actual	Year to Date Variance		Annual Plan
	Income									
136.6	NHS Patient Treatment Income	142.0	141.6	(0.4)		1,066.3	1,061.8	(4.5)		1,590.9
0.4	Other Patient Care Activity Income	0.6	0.4	(0.1)		4.5	2.1	(2.5)		6.8
11.2	Other Operating Income	10.6	11.1	0.5		84.6	83.5	(1.1)		125.2
148.2	**Total Income**	**153.1**	**153.1**	**(0.0)**		**1,155.4**	**1,147.3**	**(8.0)**		**1,722.9**
	Operating Expenditure									
(96.4)	Pay	(93.7)	(97.7)	(4.0)		(746.6)	(765.9)	(19.3)		(1,119.3)
(17.1)	Drugs	(15.3)	(17.0)	(1.6)		(123.6)	(136.0)	(12.4)		(185.3)
(13.9)	Clinical Supplies	(13.5)	(17.2)	(3.6)		(108.7)	(113.9)	(5.2)		(163.6)
(26.4)	Other Non Pay	(25.3)	(26.6)	(1.2)		(195.8)	(209.7)	(13.9)		(295.4)
(153.7)	**Total Operating Expenditure**	**(147.9)**	**(158.4)**	**(10.5)**		**(1,174.7)**	**(1,225.5)**	**(50.8)**		**(1,763.6)**
(5.6)	**Site & Services Budgets Total**	**5.2**	**(5.3)**	**(10.5)**		**(19.3)**	**(78.2)**	**(58.8)**		**(40.8)**
-	Pathology Partnership (net)	(4.7)	(4.6)	0.1		(36.8)	(36.1)	0.6		(55.1)
-	Vaccination Programme & Nightingale (net)	-	(0.0)	(0.0)		-	0.0	0.0		-
-	Research & Development (net)	0.0	-	(0.0)		0.0	0.0	(0.0)		0.0
(117.6)	Central NHS PT Income	0.8	3.6	2.7		66.3	64.8	(1.5)		108.7
-	Central RTA & OSV Income (net)	0.6	0.4	(0.2)		4.5	4.8	0.3		6.8
-	Central Expenditure (net)	0.2	4.3	4.1		1.7	13.8	12.2		2.5
-	Reserves (net)	(2.0)	(0.6)	1.4		(15.9)	(4.3)	11.6		(20.9)
(123.2)	**EBITDA**	**0.1**	**(2.4)**	**(2.5)**		**0.5**	**(35.1)**	**(35.6)**		**1.3**
-	Depreciation and Amortisation (net)	(5.9)	(5.9)	0.0		(47.0)	(47.0)	0.0		(70.9)
-	Interest	(5.8)	(5.6)	0.2		(46.8)	(46.1)	0.7		(70.2)
-	PDC Dividends	(0.9)	(0.9)	0.0		(7.1)	(7.1)	0.0		(10.7)
(123.2)	**Surplus/(Deficit) Before System Top-Up**	**(12.5)**	**(14.8)**	**(2.3)**		**(100.5)**	**(135.4)**	**(34.9)**		**(150.5)**
117.6	System Top-Up Income	12.5	12.5	-		100.5	100.5	-		150.5
(5.6)	**NHS Reporting Surplus/(Deficit)**	**(0.0)**	**(2.3)**	**(2.3)**		**0.0**	**(34.9)**	**(34.9)**		**-**
-	*Profit On Fixed Asset Disposal*		-				*0.1*			
-	*Loss on return of COVID assets to DHSC*		-				-			
-	*Capital Donations I&E Impact*		*(0.1)*				*1.1*			
-	*Fixed Asset Impairments*		-				-			
(5.6)	**Surplus/(Deficit)**		**(2.4)**				**(33.7)**			

CAPITAL EXPENDITURE

Capital Expenditure Summary - Trustwide

Jan-23

21/22 YTD	Programme Area	In Month				Year to Date					Annual			
Prev Yr Actual	£millions	Plan	Actual	Var	%	Plan	Actual	Var	%		Plan submitted NHSL June 22	Trust approved forecast programme	Var	%
7.5	Equipment (Medical and Other)	1.5	1.3	0.3	*17 %*	15.1	6.2	8.9	*59 %*		23.8	17.8	6.0	*25 %*
4.1	Informatics	0.4	0.4	(0.1)	*(22)%*	4.8	1.6	3.2	*66 %*		6.4	5.5	1.0	*15 %*
19.6	Estates	0.5	2.7	(2.2)	*(418)%*	6.3	16.4	(10.2)	*(163)%*		8.5	36.8	(28.3)	*(334)%*
9.1	New Build and Site Vacations	3.2	1.1	2.1	*67 %*	21.1	5.7	15.4	*73 %*		30.4	27.2	3.2	*0.0*
5.8	PFI Lifecycle Assets	0.8	0.9	(0.0)	*(1)%*	6.9	6.9	(0.0)	*(0)%*		10.4	10.4	(0.0)	*(0)%*
	New Build - Diagnostics	0.2	-	0.2	*100 %*	0.6	-	0.6	*100 %*		6.6	6.6	(0.0)	*(0)%*
	Finance Lease	-	-	-	*- %*	8.4	4.8	3.6	*42 %*		8.6	8.6	-	*(0)%*
46.0	**Total Exchequer programme**	**6.7**	**6.4**	**0.3**	***5 %***	**63.3**	**41.7**	**21.5**	***34 %***		**94.6**	**112.8**	**(18.2)**	***(0.0)***
46.0	**Total Trust Funded Assets**	**6.7**	**6.4**	**0.3**	***5 %***	**63.3**	**41.7**	**21.5**	***34 %***	*	**94.6**	**112.8**	**(18.2)**	***(19)%***
1.8	Donated	0.8	0.6	0.2	*30 %*	7.4	3.2	4.2	*57 %*		9.9	9.9	(0.0)	*(0)%*
47.8	**Total Capital Expenditure**	**7.5**	**6.9**	**0.6**	***8 %***	**70.7**	**45.0**	**25.8**	***36 %***		**104.6**	**122.7**	**(18.2)**	***(17)%***

Key Messages

The current funded exchequer capital plan is £94.6m which compared to the forecast outturn programme of £112.8m indicates and overcommitment of £18.2m. These numbers are unchanged from those reported last month.

Capital Funding:

We have received notification by email that the revised TIF bid for for the Newham Modular Build has been approved and await receipt of the MOU to confirm the funding profile. In the revised bid £11.4m was requested for 2022/23 (compared to £14.9m in the original bid. Total charitable funds of £3.2m have been secured. We have been advised that unlike previous years, there is unlikely to be any regional/national capital programme slippage available for reallocation to support the capital programme over commitment noted above so a proposal will be presented to December ISC on options to recalibrate the capital programme to reduce forecast expenditure down to the balance plan level, remove the overcommitment element of the programme and manage the risk to year end so that the Trust does not exceed CRL.

Capital Expenditure:

Expenditure in M8 is £6.4m against the revised plan of £6.7m, an underspend of £0.3m.

The cumulative expenditure at M8 is £41.7m against a plan of £63.3m, an adverse variance of £21.5m for the exchequer funded schemes. The significant underspend to date helps manage the level of overcommitment since the start of the year. The variance can be attributed to factors including the slow start of schemes such as NUH 2nd CT (£1.6m), delays experienced in major schemes such as WXH Redevelopment (£3.5m) due to uncertainties around national funding, delay with the PFI legal agreement on the Newham Modular Build (£8.4m), contractor related delays Newham Fire Programme (£1.5m) and delays in progressing the Kenworthy Road lease (£3.6m). A refreshed forecast will be presented to December ISC for consideration; The current level of unfunded over commitment will need to be removed from the capital programme

Donated Programme

There is also a £9.9m programme funded by charitable donations; expenditure to date against donated schemes is £3.2m with an adverse variance of £4.2m to plan. The main driver of the underspend is for Mile End Hospital Renal Unit (£1.5m) due to delays in design layouts and commencement of the fit out.

Capital Funding

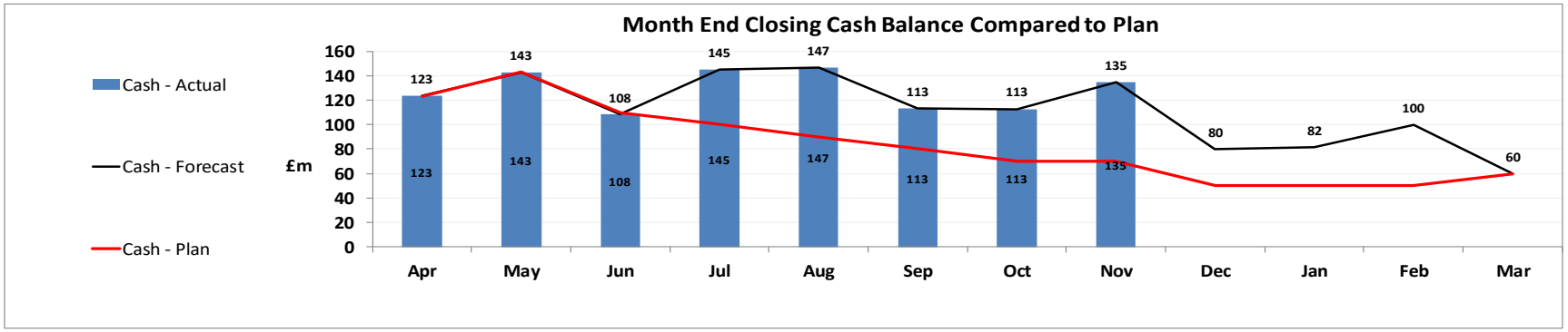
	Capital Plan	Secured	Not Secured	% Secured
Gross Depreciation	60.8	60.8	-	*100 %*
IFRS 16 deprecation	9.9	9.9		*100 %*
Repayment of PFI principal	(25.3)	(25.3)	-	*100 %*
Repayment Loans / Finance Leases	(1.8)	(1.8)	-	*100 %*
Repayment Finance Leases (IFRS16)	(9.7)	(9.7)	-	*100 %*
Net Depreciation	**33.8**	**33.8**	**-**	**100 %**
CRL (not cash backed)	16.5		16.5	*- %*
IFRS16 CRL adjustment	8.58		8.6	*- %*
PDC:WXH Redevelopment core team	1.82	1.1	0.8	*58 %*
PDC:WXH Redevelopment NHP costs	1.16		1.2	*- %*
Specific PDC: WXH Enabling works	6.00		6.0	*- %*
PDC:TIF NUH Modular Build BC932	14.90		14.9	*- %*
PDC- Mothballed NUH Theatres	2.00	2.0	-	*100 %*
PDC:ITU Expansion SBH	1.04	1.0	-	*100 %*
PDC:Digital cyber	0.22		0.2	*- %*
PDC:NUH 2nd CT	1.2	1.2	-	*100 %*
PDC- MEH CDC	6.6	6.6	-	*100 %*
PDC:MRI Acceleration Upgrades	0.8	0.8	-	*100 %*
Planned Capital exc. Donated	**94.6**	**46.5**	**48.2**	**49 %**
***Total approved Exchequer funding ex don**	**94.6**	**46.5**	**48.2**	**49 %**
Donated	9.9	2.6	7.3	*27 %*
Planned Capital inc. Donated	**104.6**	**49.1**	**55.4**	**47 %**
*Overcommitment (plan less forecast)	(18.2)			
Adjustment for IFRICAdjustment for IFRIC	(10.4)			
Total overcommitment	**(28.5)**			

CASHFLOW & BALANCE SHEET

Cashflow

Jan-23

£millions	Actual								Forecast				
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Outturn
Opening cash at bank	**86.7**	**123.4**	**143.0**	**108.4**	**144.8**	**146.8**	**113.0**	**112.9**	**134.7**	**79.7**	**81.7**	**99.9**	**86.7**
Cash inflows													
Healthcare contracts	161.5	156.5	150.9	159.3	160.5	173.1	161.9	154.4	151.2	151.2	151.2	155.4	1,887.1
Other income	23.5	37.0	16.5	40.5	25.7	13.4	41.0	42.7	16.5	26.7	22.1	32.9	338.5
Financing - Capital Loans / PDC	-	-	-	-	-	-	-	-	-	-	12.7	17.1	29.8
Total cash inflows	**185.0**	**193.5**	**167.4**	**199.8**	**186.2**	**186.5**	**202.9**	**197.1**	**167.7**	**177.9**	**186.0**	**205.4**	**2,255.4**
Cash outflows													
Salaries and wages	(55.7)	(54.8)	(57.0)	(58.6)	(56.4)	(66.8)	(58.8)	(59.8)	(60.3)	(57.3)	(57.3)	(60.4)	(703.2)
Tax, NI and pensions	(18.3)	(42.9)	(42.4)	(43.8)	(43.1)	(41.1)	(52.6)	(45.3)	(44.0)	(44.0)	(44.0)	(44.0)	(505.5)
Non pay expenditures	(67.4)	(73.0)	(100.8)	(57.1)	(81.4)	(105.0)	(83.2)	(65.0)	(108.4)	(67.1)	(57.8)	(97.7)	(963.9)
Capital expenditure	(6.9)	(3.2)	(1.8)	(3.9)	(3.3)	(2.0)	(8.4)	(5.2)	(10.0)	(7.5)	(8.7)	(37.9)	(98.8)
Dividend and Interest payable	-	-	-	-	-	(5.4)	-	-	-	-	-	(5.3)	(10.7)
Total cash outflows	**(148.3)**	**(173.9)**	**(202.0)**	**(163.4)**	**(184.2)**	**(220.3)**	**(203.0)**	**(175.3)**	**(222.7)**	**(175.9)**	**(167.8)**	**(245.3)**	**(2,282.1)**
Net cash inflows / (outflows)	**36.7**	**19.6**	**(34.6)**	**36.4**	**2.0**	**(33.8)**	**(0.1)**	**21.8**	**(55.0)**	**2.0**	**18.2**	**(39.9)**	**(26.7)**
Closing cash at bank - actual / forecast	**123.4**	**143.0**	**108.4**	**144.8**	**146.8**	**113.0**	**112.9**	**134.7**	**79.7**	**81.7**	**99.9**	**60.0**	**60.0**
Closing cash at bank - plan	**123.4**	**143.0**	**110.0**	**100.0**	**90.0**	**80.0**	**70.0**	**70.0**	**50.0**	**50.0**	**50.0**	**60.0**	**60.0**



Key Messages

Cash balances are higher than plan because of the high closing cash balance of £86.7m in March 2022, and other movements in working capital since that date, including lower capital spend.

CASHFLOW & BALANCE SHEET

Statement of Financial Position

Jan-23

21/22		Actual								Forecast				
31 Mar 2022	£millions	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	21/22 v 22/23
	Non-current assets:													
1,430.8	Property, plant and equipment	1,427.8	1,467.3	1,463.8	1,461.1	1,460.4	1,461.0	1,463.1	1,463.5	1,493.1	1,494.5	1,495.1	1,502.3	71.5
0.2	Intangible assets	0.2	0.2	0.2	0.2	0.1	0.1	0.2	0.5	0.1	0.1	0.1	0.1	(0.1)
15.1	Trade and other receivables	15.1	17.3	17.2	17.2	17.2	17.1	17.1	17.0	17.2	17.1	17.1	17.1	2.0
1,446.1	**Total non-current assets**	**1,443.1**	**1,484.8**	**1,481.2**	**1,478.5**	**1,477.7**	**1,478.2**	**1,480.4**	**1,481.0**	**1,510.4**	**1,511.7**	**1,512.3**	**1,519.4**	**73.4**
	Current assets:													
24.3	Inventories	26.2	25.7	25.7	25.9	26.3	27.1	26.7	27.2	24.0	24.0	24.0	24.0	(0.3)
127.6	Trade and other receivables	99.2	74.4	111.4	86.2	63.6	93.1	77.1	52.8	88.1	83.0	74.4	119.5	(8.1)
86.7	Cash and cash equivalents	123.4	143.0	108.4	144.8	146.8	113.0	112.9	134.7	79.8	81.8	87.3	60.0	(26.7)
238.6	**Total current assets**	**248.8**	**243.1**	**245.5**	**256.9**	**236.7**	**233.2**	**216.7**	**214.7**	**191.9**	**188.8**	**185.7**	**203.5**	**(35.1)**
1,684.7	**Total assets**	**1,691.9**	**1,727.9**	**1,726.7**	**1,735.4**	**1,714.4**	**1,711.4**	**1,697.1**	**1,695.7**	**1,702.3**	**1,700.5**	**1,698.0**	**1,722.9**	**38.3**
	Current liabilities													
(238.9)	Trade and other payables	(254.1)	(256.2)	(261.7)	(277.9)	(264.7)	(270.7)	(263.6)	(269.7)	(197.2)	(205.8)	(202.9)	(246.0)	(7.1)
(18.7)	Provisions	(18.7)	(18.7)	(18.7)	(18.7)	(18.7)	(18.7)	(16.3)	(13.2)	(2.8)	(2.8)	(2.8)	(2.8)	15.9
(27.1)	Liabilities arising from PFIs / Finance Leases	(27.1)	(36.8)	(36.9)	(36.9)	(36.9)	(36.9)	(36.9)	(36.9)	(36.8)	(36.8)	(36.8)	(36.4)	(9.3)
(284.7)	**Total current liabilities**	**(299.9)**	**(311.7)**	**(317.3)**	**(333.5)**	**(320.3)**	**(326.3)**	**(316.8)**	**(319.8)**	**(236.8)**	**(245.4)**	**(242.5)**	**(285.2)**	**(0.5)**
(46.1)	**Net current (liabilities) / assets**	**(51.1)**	**(68.6)**	**(71.8)**	**(76.6)**	**(83.6)**	**(93.1)**	**(100.1)**	**(105.1)**	**(44.9)**	**(56.6)**	**(56.8)**	**(81.7)**	**(35.6)**
1,400.0	**Total assets less current liabilities**	**1,392.0**	**1,416.2**	**1,409.4**	**1,401.9**	**1,394.1**	**1,385.1**	**1,380.3**	**1,375.9**	**1,465.5**	**1,455.1**	**1,455.5**	**1,437.7**	**37.8**
	Non-current liabilities													
(6.0)	Provisions	(5.9)	(6.0)	(6.0)	(6.0)	(6.0)	(6.1)	(6.1)	(6.1)	(5.7)	(5.7)	(5.7)	(5.7)	0.3
(917.6)	Liabilities arising from PFIs / Finance Leases	(915.9)	(945.3)	(940.6)	(938.5)	(936.3)	(931.3)	(929.1)	(927.0)	(921.9)	(921.9)	(921.9)	(913.1)	4.5
(0.5)	Other Payables	(0.3)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	0.0
(924.1)	**Total non-current liabilities**	**(922.1)**	**(951.8)**	**(947.1)**	**(945.0)**	**(942.8)**	**(937.9)**	**(935.7)**	**(933.6)**	**(928.1)**	**(928.1)**	**(928.1)**	**(919.2)**	**4.8**
475.9	**Total Assets Employed**	**469.9**	**464.4**	**462.3**	**456.9**	**451.3**	**447.2**	**444.6**	**442.3**	**537.4**	**527.0**	**527.4**	**518.5**	**42.6**
	Financed by:													
	Taxpayers' equity													
1,048.3	Public dividend capital	1,048.3	1,048.3	1,048.3	1,048.3	1,048.3	1,048.3	1,048.3	1,048.3	1,093.1	1,093.1	1,093.1	1,084.0	35.7
(874.3)	Retained earnings	(880.3)	(885.8)	(887.9)	(893.3)	(898.9)	(903.0)	(905.6)	(907.9)	(857.6)	(868.0)	(867.6)	(867.4)	6.9
301.9	Revaluation reserve	301.9	301.9	301.9	301.9	301.9	301.9	301.9	301.9	301.9	301.9	301.9	301.9	0.0
475.9	**Total Taxpayers' Equity**	**469.9**	**464.4**	**462.3**	**456.9**	**451.3**	**447.2**	**444.6**	**442.3**	**537.4**	**527.0**	**527.4**	**518.5**	**42.6**

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CHANGES TO REPORT

Changes to Report

Jan-23

- ***Overall Report, changes since the December 22 edition:***
  - *The order of the Operational Performance pages have been amended to present five main storylines:*
    1. *Elective activity*
    2. *Referral to Treatment waiting times*
    3. *A&E volumes and waiting times*
    4. *Cancer waiting times*
    5. *Diagnostic waiting times*

  - *Due to currently low Covid community case rates and inpatient volumes, Covid reporting has been suspended. Should the situation change the Covid pages will be restored in future editions.*
  - *Admitted and Non Admitted income against plan is now included in the Elective Activity chapter of the report*
  - *The benchmarking section now includes a view of Barts Health capped theatre utilisation against the London Region peer group.*

- ***Covid national reporting suspensions:***
  - *Some national reporting for which metrics are usually presented in the report has been temporarily suspended during the Covid-19 pandemic. For most, the performance from the last national submission before the suspension is the latest included in the report, as indicated below:*
    - *Dementia screening: Feb-20 performance.*
    - *Venous Thromboembolism (VTE) Risk Assessment: performance continues to be monitored internally.*
  - *The above suspended metrics have been temporarily greyed out in the report.*
  - *Serious Incidents Closed in Time: as previously noted, clock stops have been applied nationally to all Serious Incidents (SIs) from the Covid-19 second wave onwards. This remains in place nationally. Barts Health continues to monitor the SI process according to internal targets.*

- ***Targets:***
  - *As part of the national imperative to recover elective and emergency services following the Covid pandemic the NHS has set out a series of activity and performance recovery milestones to be delivered over the course of the next three financial years, to March 2025. The milestones are set out on the following page with the relevant quality and safety pages of this report updated to provide views of progress towards meeting the milestones.*
  - *In reviewing these pages please note that NHS England asked all trusts to review and resubmit their activity and long waiter clearance trajectories, as well as supporting finance and workforce plans, by 20 June 2022. The trust resubmitted its elective activity trajectories, recalibrated to make up shortfalls in activity output recorded across quarter 1 by the end of the year. This edition of Board Report reflects those changes.*

CHANGES TO REPORT

Changes to Report

Jan-23

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

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

GLOSSARY

Domain Scorecard Glossary

Jan-23

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

GLOSSARY

Domain Scorecard Glossary

Jan-23

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

GLOSSARY

Domain Scorecard Glossary

Jan-23

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

GLOSSARY

Domain Scorecard Glossary

Jan-23

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

GLOSSARY

Workforce Summary Glossary

Jan-23

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

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Appendix

APPENDIX

Interpretation of Scorecards

Jan-23

How to Interpret the Scorecard

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

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

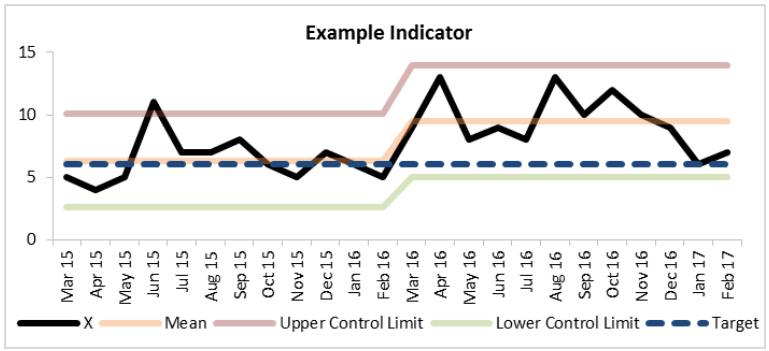
Reporting month target for reporting site

Reporting month actuals for reporting site

Reporting month actuals for other sites & trust total

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

How to Interpret an SPC Chart



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

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

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

How Exceptions Are Identified For Inclusion

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

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

APPENDIX

Safe Staffing Fill Rates by Ward and Site

Jan-23

		Registered midwives / nurses (day)		Care Staff (day)		Registered midwives / nurses (night)		Care Staff (night)		Day		Night		Care Hours Per Patient Day (CHPPD)			
Site	Ward name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Patients at Midnight	Registered midwives / nurses	Care Staff	Overall
Royal London	10E RLH	2,070.0	2,078.5	1,035.0	1,019.5	1,725.0	1,877.2	690.0	1,022.8	100.4%	98.5%	108.8%	148.2%	773	5.1	2.6	7.8
Royal London	10F RLH	1,080.0	1,500.0	720.0	696.0	990.0	1,419.0	660.0	506.0	138.9%	96.7%	143.3%	76.7%	486	6.0	2.5	8.5
Royal London	11C RLH	2,760.0	2,450.0	1,380.0	1,391.5	2,760.0	2,691.1	690.0	1,092.5	88.8%	100.8%	97.5%	158.3%	700	7.3	3.5	10.9
Royal London	11E & 11F AAU	3,681.0	3,759.0	1,736.5	1,688.5	3,680.0	3,945.0	1,395.5	1,667.5	102.1%	97.2%	107.2%	119.5%	1,437	5.4	2.3	7.7
Royal London	12C RLH	1,817.0	2,745.4	1,380.0	1,313.5	1,782.5	2,839.5	1,035.0	1,115.5	151.1%	95.2%	159.3%	107.8%	791	7.1	3.1	10.1
Royal London	12D RLH	1,380.0	2,384.6	690.0	837.7	1,380.0	2,465.0	345.0	781.0	172.8%	121.4%	178.6%	226.4%	488	9.9	3.3	13.3
Royal London	12E RLH	2,705.5	2,676.8	1,380.0	1,356.8	2,415.0	2,450.5	1,380.0	1,449.5	98.9%	98.3%	101.5%	105.0%	696	7.4	4.0	11.4
Royal London	12F RLH	1,978.0	2,263.0	1,725.0	1,576.0	1,713.5	1,999.3	1,736.0	2,021.5	114.4%	91.4%	116.7%	116.4%	806	5.3	4.5	9.8
Royal London	13C RLH	1,886.0	1,981.0	690.0	749.0	1,380.0	1,628.0	690.0	851.0	105.0%	108.6%	118.0%	123.3%	784	4.6	2.0	6.6
Royal London	13D RLH	1,725.0	1,700.0	690.0	713.0	1,380.0	1,495.0	690.0	816.5	98.6%	103.3%	108.3%	118.3%	698	4.6	2.2	6.8
Royal London	13E RLH	1,978.0	2,379.0	701.5	856.0	1,633.0	2,143.2	724.5	977.5	120.3%	122.0%	131.2%	134.9%	734	6.2	2.5	8.7
Royal London	13F RLH	1,720.5	2,052.0	943.0	967.0	1,725.0	2,093.0	690.0	1,023.5	119.3%	102.5%	121.3%	148.3%	640	6.5	3.1	9.6
Royal London	14E RLH	1,633.0	1,782.5	1,058.0	1,014.0	1,380.0	1,552.5	1,035.0	1,058.0	109.2%	95.8%	112.5%	102.2%	735	4.5	2.8	7.4
Royal London	14F RLH	1,798.0	1,357.0	1,380.0	1,184.5	1,380.0	1,345.5	1,046.5	1,242.0	75.5%	85.8%	97.5%	118.7%	765	3.5	3.2	6.7
Royal London	3D RLH	4,002.0	4,212.5	2,622.0	2,272.0	3,105.0	3,948.5	1,725.0	2,139.0	105.3%	86.7%	127.2%	124.0%	1,126	7.2	3.9	11.2
Royal London	3E RLH	2,070.0	2,293.5	631.0	1,035.0	1,725.0	2,047.0	690.0	1,345.5	110.8%	164.0%	118.7%	195.0%	763	5.7	3.1	8.8
Royal London	3F RLH	1,545.0	1,801.3	1,035.0	862.5	1,035.0	1,782.5	690.0	678.5	116.6%	83.3%	172.2%	98.3%	409	8.8	3.8	12.5
Royal London	4E RLH	14,441.5	14,334.5	690.0	1,183.0	14,835.0	14,607.5	345.0	1,121.5	99.3%	171.4%	98.5%	325.1%	1,244	23.3	1.9	25.1
Royal London	6C RLH	3,446.0	2,792.1	345.0	267.3	3,450.0	2,971.0	345.0	347.0	81.0%	77.5%	86.1%	100.6%	241	23.9	2.5	26.5
Royal London	6E & 6F RLH	5,120.0	4,590.6	1,380.0	1,126.5	5,175.0	4,661.4	1,035.0	863.5	89.7%	81.6%	90.1%	83.4%	925	10.0	2.2	12.2
Royal London	7C RLH	1,380.0	1,449.0	345.0	870.5	1,035.0	1,322.8	345.0	954.5	105.0%	252.3%	127.8%	276.7%	371	7.5	4.9	12.4
Royal London	7D RLH	1,713.5	1,447.3	855.0	676.3	1,358.0	1,475.0	667.0	782.0	84.5%	79.1%	108.6%	117.2%	464	6.3	3.1	9.4
Royal London	7E RLH	2,760.0	2,452.8	1,035.0	1,075.3	2,415.0	2,308.8	1,035.0	1,351.0	88.9%	103.9%	95.6%	130.5%	627	7.6	3.9	11.5
Royal London	7F RLH	1,380.0	1,253.5	598.0	651.3	1,023.5	1,127.0	552.0	828.0	90.8%	108.9%	110.1%	150.0%	362	6.6	4.1	10.7
Royal London	8C RLH	1,629.5	1,811.5	686.5	948.5	1,380.0	1,734.5	678.5	1,046.0	111.2%	138.2%	125.7%	154.2%	506	7.0	3.9	10.9
Royal London	8D RLH	7,936.5	6,706.5	1,230.5	624.5	7,590.0	6,382.5	552.0	402.5	84.5%	50.8%	84.1%	72.9%	979	13.4	1.0	14.4
Royal London	8F RLH	1,555.5	1,403.5	1,610.0	1,288.0	1,035.0	1,000.5	1,138.5	1,288.0	90.2%	80.0%	96.7%	113.1%	1,578	1.5	1.6	3.2
Royal London	9E HDU RLH	1,380.0	1,037.0	345.0	299.0	1,380.0	1,022.5	0.0	322.0	75.1%	86.7%	74.1%		298	6.9	2.1	9.0
Royal London	9E RLH	1,713.5	1,662.5	690.0	816.5	1,368.5	1,380.0	345.0	1,161.5	97.0%	118.3%	100.8%	336.7%	716	4.2	2.8	7.0
Royal London	9F RLH	1,725.0	1,740.0	690.0	864.5	1,380.0	1,380.0	690.0	1,081.0	100.9%	125.3%	100.0%	156.7%	688	4.5	2.8	7.4

APPENDIX

Safe Staffing Fill Rates by Ward and Site

Jan-23

		Registered midwives / nurses (day)		Care Staff (day)		Registered midwives / nurses (night)		Care Staff (night)		Day		Night		Care Hours Per Patient Day (CHPPD)			
Site	Ward name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Patients at Midnight	Registered midwives / nurses	Care Staff	Overall
Whipps Cross	AAU WXH	4,495.5	4,825.5	2,411.0	2,545.5	4,485.0	4,732.2	2,070.0	2,161.4	107.3%	105.6%	105.5%	104.4%	897	10.7	5.2	15.9
Whipps Cross	ACACIA	943.0	901.0	431.8	553.3	690.0	700.0	678.5	804.5	95.5%	128.1%	101.4%	118.6%	314	5.1	4.3	9.4
Whipps Cross	ACORN	3,760.0	2,516.5	345.0	817.0	2,739.5	2,348.5	348.3	482.3	66.9%	236.8%	85.7%	138.5%	665	7.3	2.0	9.3
Whipps Cross	B3 WARD WXH	1,258.5	1,238.0	1,018.5	1,150.3	1,035.0	1,034.3	690.0	954.5	98.4%	112.9%	99.9%	138.3%	472	4.8	4.5	9.3
Whipps Cross	BIRCH	1,035.0	1,184.5	1,035.0	1,092.5	1,035.0	1,035.0	690.0	724.5	114.4%	105.6%	100.0%	105.0%	474	4.7	3.8	8.5
Whipps Cross	BLACKTHORN	1,034.5	1,184.0	1,035.0	1,127.0	1,035.0	1,023.5	690.0	899.0	114.5%	108.9%	98.9%	130.3%	480	4.6	4.2	8.8
Whipps Cross	Bracken Ward WXH	1,279.5	1,267.0	1,092.5	1,143.0	1,035.0	1,058.0	690.0	839.5	99.0%	104.6%	102.2%	121.7%	471	4.9	4.2	9.1
Whipps Cross	CEDAR	1,372.0	1,204.0	1,380.0	1,799.5	1,035.0	1,023.5	1,035.0	1,391.5	87.8%	130.4%	98.9%	134.4%	521	4.3	6.1	10.4
Whipps Cross	CHESTNUT	931.5	913.0	345.0	851.0	700.5	1,034.0	345.0	782.0	98.0%	246.7%	147.6%	226.7%	337	5.8	4.8	10.6
Whipps Cross	CURIE	1,380.0	1,173.5	1,035.0	1,253.5	1,380.0	1,059.0	1,046.5	1,219.0	85.0%	121.1%	76.7%	116.5%	535	4.2	4.6	8.8
Whipps Cross	DELIVERY SUITE WXH	4,807.5	3,656.2	690.0	705.5	3,672.0	3,145.8	690.0	956.5	76.1%	102.2%	85.7%	138.6%	527	12.9	3.2	16.1
Whipps Cross	ELIZABETH	1,633.0	1,646.0	345.0	425.5	1,380.0	1,509.0	345.0	345.0	100.8%	123.3%	109.3%	100.0%	573	5.5	1.3	6.9
Whipps Cross	FARADAY	1,721.5	1,613.5	678.5	718.5	1,633.0	1,610.0	345.0	643.5	93.7%	105.9%	98.6%	186.5%	429	7.5	3.2	10.7
Whipps Cross	Frail Elderly WXH	847.5	753.5	345.0	635.0	690.0	668.5	345.0	575.0	88.9%	184.1%	96.9%	166.7%	259	5.5	4.7	10.2
Whipps Cross	ICU WXH	6,763.5	5,748.0	1,866.0	541.5	6,193.0	5,206.0	1,320.0	308.0	85.0%	29.0%	84.1%	23.3%	309	35.4	2.7	38.2
Whipps Cross	MARGARET	1,035.0	958.0	345.0	337.0	690.0	691.0	345.0	425.5	92.6%	97.7%	100.1%	123.3%	231	7.1	3.3	10.4
Whipps Cross	MIDWIFERY WXH	741.0	568.9	345.0	184.0	678.5	433.7	345.0	323.0	76.8%	53.3%	63.9%	93.6%	0			
Whipps Cross	MULBERRY	2,028.0	1,414.4	1,322.4	735.4	1,366.5	1,094.0	805.0	869.5	69.7%	55.6%	80.1%	108.0%	973	2.6	1.6	4.2
Whipps Cross	NEONATAL WXH	2,407.0	2,366.5	1,162.0	643.5	2,049.8	2,226.5	727.0	276.5	98.3%	55.4%	108.6%	38.0%	415	11.1	2.2	13.3
Whipps Cross	NIGHTINGALE	1,725.0	1,483.5	345.0	425.0	1,633.0	1,495.0	345.0	436.3	86.0%	123.2%	91.5%	126.5%	382	7.8	2.3	10.1
Whipps Cross	PEACE	1,633.0	1,599.5	1,380.0	1,402.8	1,023.5	1,267.8	1,035.0	1,137.7	97.9%	101.6%	123.9%	109.9%	434	6.6	5.9	12.5
Whipps Cross	POPLAR	1,679.0	1,599.0	1,035.0	1,046.5	1,376.0	1,201.0	1,035.0	943.0	95.2%	101.1%	87.3%	91.1%	498	5.6	4.0	9.6
Whipps Cross	PRIMROSE	1,725.0	2,243.0	1,380.0	1,642.5	1,380.0	2,104.5	1,035.0	1,558.0	130.0%	119.0%	152.5%	150.5%	819	5.3	3.9	9.2
Whipps Cross	ROWAN	1,725.0	1,681.0	1,380.0	1,551.3	1,380.0	1,670.0	1,035.0	1,460.5	97.4%	112.4%	121.0%	141.1%	745	4.5	4.0	8.5
Whipps Cross	SAGE	1,633.0	1,627.0	1,380.0	1,713.5	1,380.0	1,311.0	1,035.0	1,472.0	99.6%	124.2%	95.0%	142.2%	783	3.8	4.1	7.8
Whipps Cross	SYCAMORE	1,269.0	1,682.5	1,265.0	1,705.3	1,035.0	1,497.0	1,023.5	1,414.5	132.6%	134.8%	144.6%	138.2%	793	4.0	3.9	7.9
Whipps Cross	SYRINGA	1,380.0	1,299.5	1,723.5	1,725.0	1,035.0	1,035.0	1,035.0	1,367.5	94.2%	100.1%	100.0%	132.1%	739	3.2	4.2	7.3

APPENDIX

Safe Staffing Fill Rates by Ward and Site

Jan-23

	Registered midwives / nurses (day)		Care Staff (day)		Registered midwives / nurses (night)		Care Staff (night)		Day		Night		Care Hours Per Patient Day (CHPPD)			
Ward name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Patients at Midnight	Registered midwives / nurses	Care Staff	Overall
AAU NUH	4,209.0	4,832.0	2,415.0	2,127.5	3,795.0	4,645.5	2,415.0	2,346.0	114.8%	88.1%	122.4%	97.1%	1,450	6.5	3.1	9.6
Custom House NUH	1,380.0	1,358.0	1,035.0	1,313.0	1,035.0	1,012.5	1,380.0	1,725.0	98.4%	126.9%	97.8%	125.0%	593	4.0	5.1	9.1
DELIVERY SUITE NUH	5,367.8	4,593.6	690.0	540.5	4,554.0	4,018.3	690.0	678.5	85.6%	78.3%	88.2%	98.3%	656	13.1	1.9	15.0
EAST HAM	1,722.3	1,711.8	1,035.0	989.0	1,380.0	1,368.5	1,035.0	1,115.5	99.4%	95.6%	99.2%	107.8%	665	4.6	3.2	7.8
HEATHER	2,057.5	1,981.5	1,035.0	1,218.5	2,047.0	2,093.0	1,035.0	1,161.5	96.3%	117.7%	102.2%	112.2%	751	5.4	3.2	8.6
LARCH	3,121.5	2,780.5	1,907.3	1,887.5	2,024.0	1,890.5	1,725.0	1,656.0	89.1%	99.0%	93.4%	96.0%	1,550	3.0	2.3	5.3
Manor Park ITU NUH	3,423.0	3,264.8	690.0	632.5	3,427.0	3,381.0	690.0	655.5	95.4%	91.7%	98.7%	95.0%	304	21.9	4.2	26.1
MAPLE	1,122.5	989.0	690.0	690.0	1,023.5	1,012.5	690.0	678.0	88.1%	100.0%	98.9%	98.3%	194	10.3	7.1	17.4
NEONATAL NUH	3,185.5	2,610.5	667.0	402.5	3,185.5	2,566.5	563.5	287.5	81.9%	60.3%	80.6%	51.0%	490	10.6	1.4	12.0
NUH MIDWIFERY	1,206.0	1,067.3	345.0	304.3	1,035.0	937.5	345.0	345.0	88.5%	88.2%	90.6%	100.0%	115	17.4	5.6	23.1
RAINBOW	3,004.0	2,749.5	1,104.5	1,023.0	1,736.5	2,266.5	345.0	448.5	91.5%	92.6%	130.5%	130.0%	432	11.6	3.4	15.0
SILVERTOWN	1,724.0	1,794.0	1,035.0	1,173.0	1,725.0	1,713.5	1,012.0	1,667.5	104.1%	113.3%	99.3%	164.8%	633	5.5	4.5	10.0
STRATFORD	1,365.0	1,980.5	1,035.0	1,150.0	1,378.5	2,068.5	1,035.0	1,150.0	145.1%	111.1%	150.1%	111.1%	556	7.3	4.1	11.4
WEST HAM	1,238.0	1,215.0	989.0	966.0	1,035.0	1,046.5	345.0	678.5	98.1%	97.7%	101.1%	196.7%	530	4.3	3.1	7.4
1C	5,838.0	4,978.0	345.0	421.5	5,119.0	4,704.0	207.0	368.0	85.3%	122.2%	91.9%	177.8%	296	32.7	2.7	35.4
1D	3,077.0	2,441.5	345.0	333.5	2,760.0	2,357.5	345.0	345.0	79.3%	96.7%	85.4%	100.0%	341	14.1	2.0	16.1
1E	4,788.5	4,062.5	345.0	414.0	4,818.5	4,063.5	345.0	356.5	84.8%	120.0%	84.3%	103.3%	272	29.9	2.8	32.7
3A SBH	4,457.0	4,197.5	1,362.5	1,273.2	4,485.0	4,254.5	1,380.0	1,345.0	94.2%	93.4%	94.9%	97.5%	918	9.2	2.9	12.1
3D SBH	1,541.0	1,633.0	1,169.0	1,173.0	1,495.0	1,575.0	943.0	988.5	106.0%	100.3%	105.4%	104.8%	522	6.1	4.1	10.3
4A SBH	1,707.5	1,656.0	914.0	897.0	1,380.0	1,380.0	345.0	805.0	97.0%	98.1%	100.0%	233.3%	663	4.6	2.6	7.1
4B SBH	1,538.0	1,481.0	1,190.0	1,172.3	1,380.0	1,345.5	690.0	863.3	96.3%	98.5%	97.5%	125.1%	563	5.0	3.6	8.6
4C SBH	1,715.0	1,541.0	936.0	839.5	1,380.0	1,207.5	943.0	816.5	89.9%	89.7%	87.5%	86.6%	500	5.5	3.3	8.8
4D & 4E SBH	1,657.0	1,584.0	673.0	575.0	1,587.0	1,368.5	690.0	690.0	95.6%	85.4%	86.2%	100.0%	376	7.9	3.4	11.2
5A SBH	2,132.8	2,217.0	890.0	923.3	1,386.0	1,619.8	330.0	572.0	104.0%	103.7%	116.9%	173.3%	623	6.2	2.4	8.6
5B SBH	1,376.5	1,347.5	686.5	632.5	1,379.0	1,322.5	333.5	644.0	97.9%	92.1%	95.9%	193.1%	439	6.1	2.9	9.0
5C SBH	2,042.5	1,938.3	669.0	644.0	1,690.5	1,938.6	345.0	391.0	94.9%	96.3%	114.7%	113.3%	551	7.0	1.9	8.9
5D SBH	2,056.0	2,051.0	640.0	575.0	1,725.0	1,742.0	690.0	759.0	99.8%	89.8%	101.0%	110.0%	666	5.7	2.0	7.7
6A SBH	6,185.3	5,793.0	341.5	322.0	6,223.0	6,003.0	345.0	333.5	93.7%	94.3%	96.5%	96.7%	327	36.1	2.0	38.1
6D SBH	1,706.5	1,307.5	999.0	724.5	1,380.0	1,092.5	690.0	770.5	76.6%	72.5%	79.2%	111.7%	507	4.7	2.9	7.7

Barts Health NHS Trust

Report to the Trust Board: 18 January 2023	TB 03/23

Title	Board Assurance Framework
Sponsoring Director	Group Director of Corporate Development
Author(s)	Trust Secretary Head of Risk Management
Purpose	To endorse the revised BAF
Previously considered by	Risk Management Board, Group Executive Board ARC 23 November 2022

Executive summary

The Board Assurance Framework (BAF) provides an overview of the principal risks to delivery of the Trust's objectives. The proposed principal risks have since been discussed with lead executives and this paper sets out proposed updates to BAF risks and supporting detail on controls and assurances. The BAF's revised format places greater emphasis on the management of risks (i.e. beyond identification and calibration of risks) which will support the review and challenge 'deep dive' process led by Board committees in respect of their assigned BAF entries. The BAF also reflects the further board level review of risk appetite (and risk tolerance) with a one sider risk appetite statement featuring as part of the revised risk management strategy. Following review of the BAF, it is anticipated that the risk appetite statement will be considered further by the Board as part of developing a 2023/24 BAF.

This report reflects on a series of external drivers (including emergency care pressures, inflation, and workforce constraints) that have had an overall effect of the Trust's risk profile remaining high; with fewer BAF risk scores reducing in the way anticipated at the outset of the year.

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

Legal implications/ regulatory requirements	CQQ Well Led regulations

Action required

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

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 18 JANUARY 2023

BOARD ASSURANCE FRAMEWORK REPORT

BOARD ASSURANCE FRAMEWORK

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

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

3. The format of the BAF includes cross referencing to the wider Trust risk register. The refresh of the cross referenced risk register entries in Quarter 2 has clearly identified a significant increase in the number of high risks recorded in relation to regulation and operational pressures. While this may not be a surprise given the level of operational pressures and recommencing of some regulatory activity paused during the pandemic, this suggests a healthy development of the Trust's wider risk reporting culture, the use of and therefore accuracy of risk registers across our hospitals.

HIGHEST SCORED BAF RISKS AND CHANGES TO BAF RISK SCORES

4. The Trust's strategic and operational plans set out the approach being taken to mitigate and ultimately reduce its highest risks. A number of drivers, many of which are external, have had a significant impact on the organisation's ability to improve its risk profile (including high emergency care attendances and acuity, hyperinflation and workforce constraints). The highest scored risks on the BAF are reflected in the Group Executive Board's priority agenda items: namely, elective care restoration (risk score 16), emergency care (risk score 20), workforce constraints (risk score 16), cyber security and digital

enablers (risk score 16). *In relation to the latter BAF entry, the executive has recognised progress on cyber security measures albeit in the context of increased international risks. Recognising the key role of digital development as a collaboration enabler, the executive has agreed to pause and reflect on how to reframe and calibrate this risk going forwards.*

5. The following are the key proposals for changes to BAF risk scores in this iteration:

   - **BAF entry 3. A new Covid-19 variant increases risks to the NEL population, requires reintroduction of peak pandemic controls and impairs elective recovery (risk score moves from 5x2=10 to 5x1=5).**

     The proposed reduction in risk score reflects the executive's view, based on horizon scanning and surveillance that there is a reducing likelihood of a variant of Covid-19 which would significantly disrupt existing infection prevention measures, while also reflecting improved management and reducing acuity of Covid-19 currently. With this reduction the intention would be to reassigning this entry to the risk register subsequently.

   - **BAF entry 6. The absence of system-wide solutions to improving urgent and emergency care capacity and resilience at Trust and NEL level (through transforming pathways, expanding capacity and managing demand) impacts on quality of care (risk score moves from 4x4=16 to 4x5=20).**

     While recognising board level discussions highlighting a relatively higher level of regulatory focus on the Trust's waiting list position, the level of urgent and emergency care pressures seen during summer and autumn has been unprecedented. The increase of each hospital's emergency care risk register entries to a risk score of 20 suggests this has effectively crystallised. It is clear that UEC risks are a key driver of the related elective waiting time risk.

   - **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 (risk score reduces from 3x4=12 to 3x3=9).**

     The proposed risk score revision reflects some gradual improvement in terms of a post pandemic return towards business-as-usual education and research activity, in addition to some positive indicators relating to the Trust's research aspirations, including a highly successful Biomedical Research Centre bid and grants to support the establishment of a clinical research facility.

BAF DEEP DIVE REPORTING

6. A schedule of deep dive reporting has been agreed with Board committees. In line with the Board's recommendation to develop a consistent approach, a format has been identified for these reports which places a greater emphasis on scrutinising the effective management of risks using some measurables such as assurance RAG ratings and risk

triggers. This seeks to evolve the approach from one focusing more on risk identification and risk score calibration.

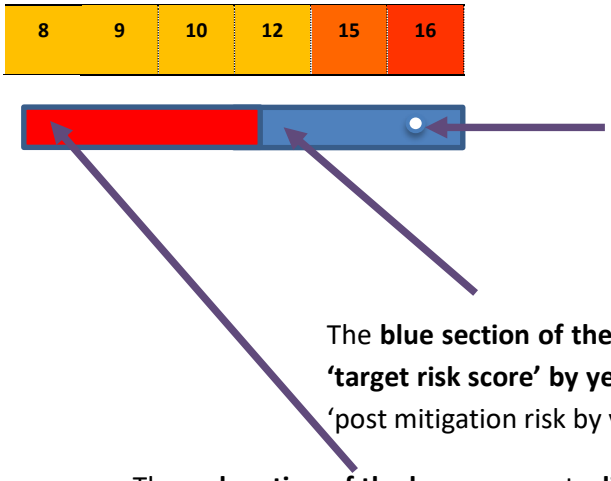
RISK APPETITE

7. Risk appetite reflects the extent to which the organisation will tolerate, accept or embrace risks – both in terms of outcomes materialising and activities undertaken – to achieve its objectives; recognizing explicitly that this will differ according to the objective/activity involved. The BAF reflects the current board approved risk appetite statement (which is summarised separately in the risk management strategy).

RECOMMENDATION

8. The Trust Board is asked to note and endorse the proposed Board Assurance Framework entries and note plans for further Board discussion of risk appetite during Q4.

Annex 1 - *BAF heatmap: key*



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

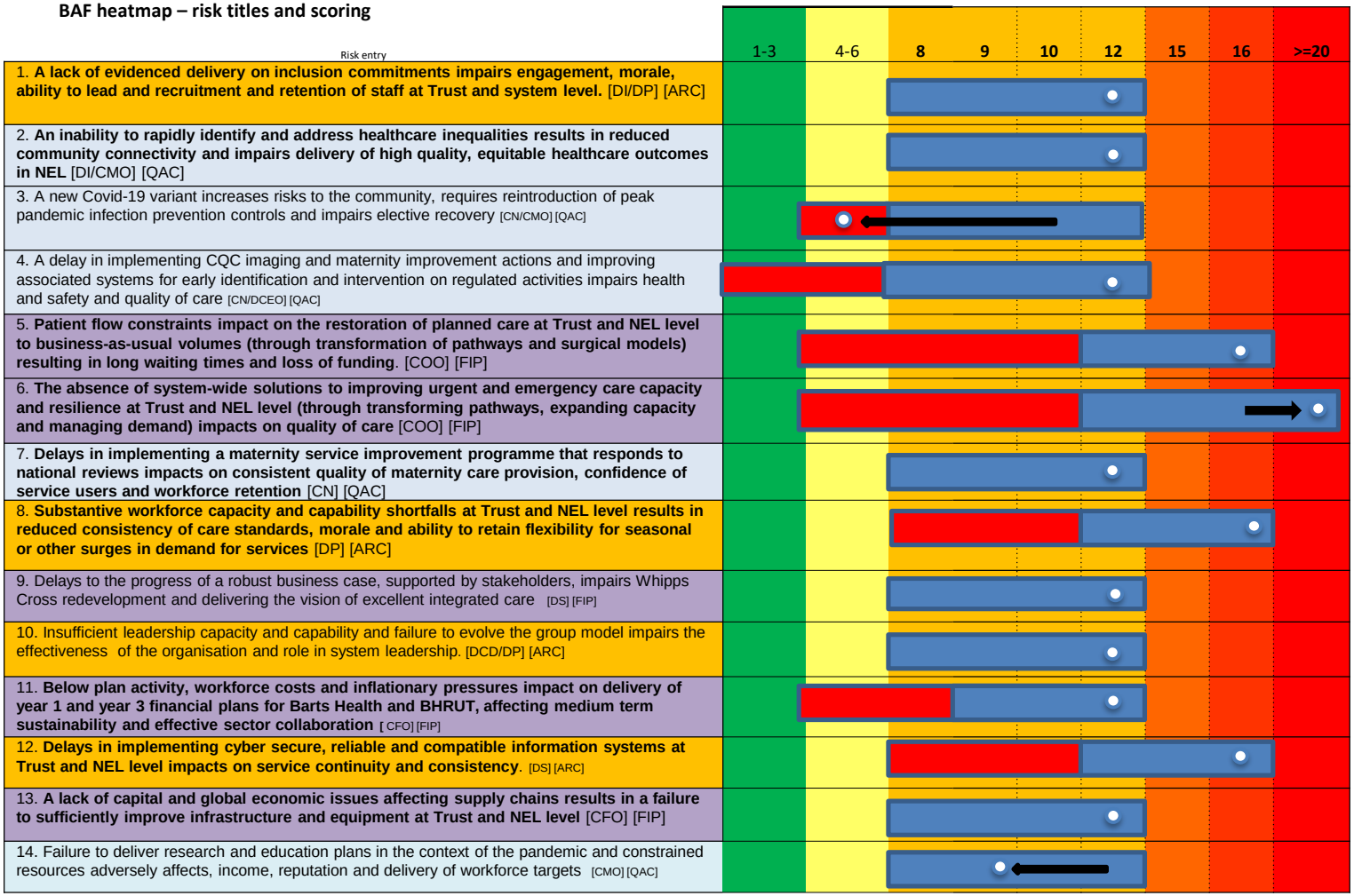
[In risk management terminology this represents the 'intrinsic existing risk']. In this example the current risk score is 16.

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

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

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

BAF heatmap – risk titles and scoring



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

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

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

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

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span*	*Assurance level*	*Span*	*Assurance level*	*Span*	*Assurance level*	
1. A lack of evidenced delivery on inclusion commitments impairs engagement, morale, ability to lead and recruitment and retention of staff at Trust and system level **Executive lead:** Director of Inclusion and Director of People **Subcommittee role:** Audit and Risk Committee	*[Outset score: 12]* ***Current: 4x3 = 12*** *Target: 4x2 =8* *Datix ref: 4477*	**1.** WeBelong inclusion strategy / WeCare values supported by staff diversity networks and reporting on WRES/WDES, Stonewall ratings and Gender Pay Gap **2.** Equality Objectives and Inclusion commitments **3.** Operational Plan focus (one of three strategic objectives). **4.** Leadership development / cultural intelligence programmes focus on E&I **5.** Analysis of annual NHS Staff survey and internal quarterly pulse surveys. **6.** NEL operational plan and steps towards joint workforce planning across sector acute providers. **7.** Established line managers and all staff webinar programme with inclusion focus.	*Inclusion Board ToR - oversees delivery of WeBelong strategy, equality objectives and commitments **(maps to controls 1-3)** *[6 monthly update on people strategy at GEB in Nov 2022]* *Group Executive Board ToR – oversight of operational plan delivery **(3)** patient and staff survey outputs **(5)*** *People Board ToR – oversees delivery of leadership development, education and training **(4)*** People Board and Inclusion Observatory monitoring **(2, 7)***		Trust Board annual reviews via Inclusion Observatory, including statutory reports ***(maps to control* 1-3)** *[confirms positive progress on WRES/WDES and Gender Pay Gap metrics]* Trust Board approval and oversight of operational plans **(3,6)** Trust Board review of staff survey **(5)** QAC regular assurance reporting on patient experience / feedback **(1,5,7)**		*Annual NHS staff and patient survey benchmarking. Pulse surveys (**5,7**) *WRES and WDES data benchmarking – 2022 results indicate moderate improvement **(2,4)** *Internal Audit report Staff Engagement 20/21 (reasonable assurance) **(1,5)** * Internal Audit report on Advocacy services 19/20 (insufficient assurance) **(1)***		*Gap: Plans delivering diversity in leadership roles* *Action: Embed 2020 inclusive recruitment practice* *Gap: % BAME staff in formal HR processes* *Action: Simplified and improved policies; cultural intelligence programme* *Gap: Assurance on consistency of implementation of inclusion actions across all hospitals / departments* *Action: Anticipated Well Led review in 2023 will provide third party assurance*

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

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

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

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

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span*	*Assurance level*	*Span*	*Assurance level*	*Span*	*Assurance level*	
2. An inability to rapidly identify and address healthcare inequalities results in reduced community connectivity and impairs delivery of high quality, equitable healthcare outcomes in NEL **Executive lead:** Chief Medical Officer and Director of Inclusion **Subcommittee role:** Quality Assurance Committee	*[Outset score: 16]* ***Current: 4x3 = 12*** *Target: 4x2 =8* *Datix ref: [7136]*	**1.** Integrated Performance Report includes key metrics on access to healthcare services **2.** Patient Experience Strategy published with action to commission cultural intelligence and competency programme. **3.** Friends and Family Test and national patient surveys to assess and benchmark access and service quality **4.** Equity of access work led by Public Health to investigate healthcare inequalities. **5.** Development of Anchor Institution strategy, building on development of community employment and related initiatives e.g. ELBA alliance, apprenticeships, Project Search etc **6.** NEL operational plan and steps towards joint workforce planning across sector acute providers	*Inclusion Board ToR - oversees delivery of equality objectives and commitments **(maps to controls 1 and 2)** *Group Executive Board ToR – oversight of operational plan delivery **(1)** and patient survey outputs **(4)** GEB hospital performance review mechanism **(1-6)** Quality Board role on monitoring population health outcomes **(1-6)**		Trust Board regular inclusion and equalities report references patient equity aspects **(assurance on controls 1-5)** Equity of access Board report covers identified risks relating to healthcare interventions and equity of access **(1-3).** Quality Assurance Committee oversight of patient experience, surveys and insight reporting **(2)**		National inquiry and national audits on Covid-19 highlight healthcare inequalities		*Gap: Board agreed anchor institution / sustainability strategy* *Action: Agreement of an anchor institution plan* *Gap: Impact assessment required on any unintended consequences of pandemic related innovation and practice.* *Action: Impact assessment of virtual clinics under way* *Gap: Identified risks for patients with learning disabilities during pandemic* *Action: Scheduled QAC thematic review of patients with learning disabilities*

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

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

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE	SECOND LINE ASSURANCE	THIRD LINE ASSURANCE	GAPS
Controls and assurance rating – (i) Span (ii) Assurance Level			*Span* / *Assurance level*	*Span* / *Assurance level*	*Span* / *Assurance level*	
3. A new Covid-19 variant increases risks to the NEL population, requires reintroduction of peak pandemic controls and impairs elective recovery. **Executive lead:** Chief Nurse **Subcommittee role:** Quality Assurance Committee	*[Outset score: 15]* ***Current: 5x1=5*** *Target: 5x1=5* *Datix ref: 7137*	**1.** Covid dashboards and integrated performance reporting. **2.** Winter plan (including high and very high-pressure plan for Covid-19 management). **3.** Segregation of clinical areas and staffing, PPE arrangements, testing and vaccination programmes to mitigate risks of Covid-19 nosocomial infections. **4.** Dedicated group IPC team in place monitoring infection risks **5.** Case management, cluster, outbreak management policy in place to minimise risk of nosocomial transmission **6.** Policies and SOPs updated to respond to pandemic issues **7.** Quality Improvement programme established with focus on safety **8.** IPC plan described in an IPC specific BAF **9.** NEL operational plan including coordination of elective plans and mutual aid.	GEB and Quality Board oversight of KPIs with peak planning arrangements on standby **(1-8)** - KPIs give assurance on nosocomial infection rates (benchmarking positively) **(3)** Infection Prevention and Control Committee and Covid IPC working group **(4-9)**	Trust Board review of IPR quality metrics **(assurance on controls 1-8)**. QAC and Quality Board thematic and exception reporting, including deep dive reviews **(1-8).** Look back reporting on Covid-19 waves with focus on identifying learning **(1-8).** Annual report on infection control received by Trust Board **(4-8)**	CQC review of plans National benchmarking reports Internal Audit of IPC BAF PHE involvement in outbreak management Internal Audit report Procurement19/20 **(4)** 2021 Reasonable assurance Internal Audit report – IPC BAF **(8)** National inquiry and national audits on Covid-19 to identify learning for future waves **(9)** National benchmarking reporting on nosocomial infections **(1-3)**	*Gap: National planning guidance assumes Covid-19 workload will not impair elective recovery* *Action: Business continuity planning*

Related high risks (>15) on the risk register – Datix refs:
3543 Crowding within Whipps Cross Emergency Department (risk score 20, lead Whipps Cross Chief Executive)
5849 Insufficient clinical engineering workspace with no dedicated decontamination facilities (risk score 16, lead St Bartholomew's Chief Executive)
6392 Infection Prevention & Control (IPC) and Antimicrobial Stewardship (AMS) Chronic Resource Shortfall (16) Group Chief Nurse
6416 Rightsizing IPC department (risk score 16, Royal London CEO)
4650 MRI scans delays due to capacity < demand and Covid backlog (risk score 16, lead Royal London Chief Executive)

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

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

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

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

Related high risks (>15) on the risk register – Datix refs:
3468 Non-compliance of Fire Safety Order at Newham Hospital (risk score 15, lead Newham CEO); 5367 Shortage of Consultant histopathologists (risk score 16, lead RLH CEO); 5320 Delays to patient care due to obsolete Fluoroscopy machine (risk score 16, lead Newham CEO); 4650 MRI scans delays due to capacity < demand and Covid backlog (risk score 16, lead Royal London CEO); 6547 Delays to patient care due to insufficient capacity/staffing in CT imaging, with radiation risk due to lack of RPS time (risk score 16, lead Royal London CEO); 6512 Radiography Unsafe Staffing with concurrent risk to radiation safety due to a lack of rostered RPS time (risk score 15, lead Royal London CEO); 6764 Inadequate staffing levels in Ultrasound establishment for B3-Imaging Assistant (risk score 15, lead Royal London CEO); 5874 Capacity not matching demand due to lack of second bi-plane (risk score 16, lead Royal London CEO); 6720 Risk to MRI on-call cover at RLH also serving Homerton, WXH, NUH, SBH (risk score 16, lead Royal London CEO); 6804 Risk of unreported significant Findings as a result of backlog of reporting of images for CT, MRI and X-ray images (risk score 16, lead Royal London CEO); 4615 Insufficient resource in Radiology (risk score 15, lead Whipps Cross CEO ; 2674 Neonatal facilities for medical equipment cleaning (risk score 15, lead Newham CEO); 6846 CTG monitors unable to monitor maternal observations (risk score 16, lead Newham CEO); 6647 Multiple methods of documentation throughout the maternity pathway does not capture all data and assurance required (risk score 16, lead Newham CEO); 6646 Current antenatal care pathway not adequately meeting the needs of the service (risk score 16, lead Newham CEO); 6923 Potential scan capacity issues affecting gap and grow being fully implemented. (risk score 15, lead Newham CEO); 6509 Obstetric ultrasound machine replacement (risk score 15, lead Royal London CEO); 7104 Due to lack of Bereavement support in Gynaecology there is a risk of adverse psychology harm (risk score 16, lead Royal London CEO); 6882 Obs & Gynae Medical Staffing (risk score 16, lead Royal London CEO); 7048 Risk Barkantine centre will not be able to re-open due to lack of regulatory compliance (risk score 16, lead Royal London CEO); 6598 Persistent national and local midwifery staff shortages contribute to the quality of care provided and affects safety levels (risk score 20, lead Whipps Cross CEO)

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

Risk appetite for sub-objective relevant to risk: **4-6 (Cautious)** Risk tolerance triggers: Adverse variance from agreed activity trajectories for each constitutional target for 3 consecutive months (-); Eliminate 104 week waits by end Dec 22;

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

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

Related high risks (>15) on the risk register – Datix refs:
4765 IT- Business Continuity (risk score 16, lead Group Director of Strategy); 5997 Theatre capacity for complex elective orthopaedic surgery (risk score 15, lead Royal London Chief Executive); 4019 Outpatient appointment capacity (risk score 16, lead Whipps Cross Chief Executive); 6717 EPRR Service under resourced (risk score 16, lead Gp Director of Ops); 5320 Delays to patient care due to obsolete Fluoroscopy machine (risk score 16, lead Newham CEO); 6832 Increased vacancy across nursing and midwifery resulting in unfilled shifts on daily basis across the site (risk score 16, lead Newham CEO); 6615 Medical consultant capacity is not sufficient to deliver daily consultant review (risk score 16, lead Newham CEO); 6733 Lack of staffing in the Urgent Treatment Centre (risk score 16, lead Newham CEO); 6620 shortage of paediatric nurses within paediatric ED (risk score 16, lead Newham CEO); 6515 insufficient staffing level across therapies in stroke unit (risk score 15, lead Newham CEO); 6735 No Home Oxygen Service provision NUH (risk score 15, lead Newham CEO); 113 Delay of critical care admission (risk score 16, lead Royal London CEO); 5477 Delays in histology reporting for cancer patients within General Surgery impacting diagnosis and treatment (risk score 16, lead Royal London CEO); 3816 Increased mortality and morbidity due to long waiting times for emergency orthopaedic surgery (risk score 16, lead Royal London CEO); 2550 Outpatient Haemodialysis Capacity (risk score 16, lead Royal London CEO); 3571 lack of inpatient beds will result in patients being cared for in recovery (risk score 16, lead Royal London CEO); 4650 MRI scans delays due to capacity < demand and Covid backlog (Risk score 16, lead Royal London CEO); 6547 Delays to patient care due to insufficient capacity/staffing in CT imaging, with radiation risk due to lack of RPS time (risk score 16, lead Royal London CEO); PLUS OTHERS: 6763, 6673; 6676; 6789; 6416; 6636; 6512; 6764; 6302; 6798; 5997; 6967; 6253; 6430; 6800; 4613; 6536; 5014; 104; 6650 6423

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

Risk appetite for sub-objective relevant to risk: **4-6 (Cautious)** Risk tolerance triggers: bottom quartile on 4 hour wait, 12 hour waits and ambulance handover; change to Covid pressure status/national incident/critical care surge (+)

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

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE	SECOND LINE ASSURANCE	THIRD LINE ASSURANCE	GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span* / *Assurance level*	*Span* / *Assurance level*	*Span* / *Assurance level*	
6. The absence of system-wide solutions to improving urgent and emergency care capacity and resilience at Trust and NEL level (through transforming pathways, expanding capacity and managing demand) impacts on quality of care **Executive lead:** Acting Chief Operating Officer **Subcommittee role:** Finance Investment and Performance Committee	*[Outset score: 16]* ***Current: 4x5=20*** *Target: 4x3=12* *Datix ref: (1981)*	**1.** Winter Plan setting out emergency care operating model, pandemic aspects including mutual aid and transfer. **2.** Covid-19 escalation plan with identified measures in onset of medium, high and very high-pressure status; including for expanded critical care and emergency care **3.** Sector approach to capacity constraints for emergency care and to address interface on ambulance transfers. **4.** BAU hospital improvement plans set out optimum conditions (internal and sector) and actions to achieve trajectories for performance. Hubs established to support sector co-ordination. **5.** Workforce and independent capacity flexed to support elective care recovery	Role of Unplanned Care Board to oversee UEC Trustwide response (1-3) Business as usual NEL and London emergency and critical care governance **(3)** Group Executive Board ToR – oversight of operational plan and winter plan delivery **(1-5)** Adapted Covid governance arrangements in event of escalation of pressure status **(4-5)**.	Board monthly reporting via the Integrated Performance Framework **(1-5)**.		*Gap: Emergency care performance for RLH, Newham and Whipps Cross impacted by pandemic pressures and constraints associated with measurement changes, segregation of Covid activity, and workforce supply.* *Action: Performance monitored at executive and sector levels. Review of updated IPC guidance under way. Need to develop triangulation of UEC KPIs with workforce metrics to establish links.*

Related high risks (>15) on the risk register – Datix refs:
5152 Emergency Access Performance (risk score 16, lead Deputy Chief Executive)
5014 ERCP procedures (risk score 16, lead Whipps Cross Chief Executive)
3543 Crowding within the Emergency Department in Whipps Cross ED (risk score 20, lead Whipps Cross Chief Executive)
5156 Winter pressures (risk score 16, lead Whipps Cross Chief Executive)
4765 IT- Business Continuity (risk score 16, lead Group Director of Strategy)
3062 Junior doctor cover in ED (risk score 15, lead Whipps Cross Chief Executive)
5849 Insufficient clinical engineering workspace with no dedicated decontamination facilities (risk score 16, lead St Bartholomew's Chief Executive)
6717 EPRR Service under resourced (risk score 16, lead Gp Director of Ops)

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

Risk appetite for sub-objective relevant to risk**: 4-6 (Cautious)** Risk tolerance triggers: Adverse variance against timelines for recommendation implementation; maternity dashboard metric/threshold tbc

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

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE	SECOND LINE ASSURANCE	THIRD LINE ASSURANCE	GAPS
Controls and assurance rating – (i) Span (ii) Assurance Level		Span / Assurance level	Span / Assurance level	Span / Assurance level	Span / Assurance level	
7. Delays in implementing a maternity service improvement programme impacts on quality and safety of maternity care provision, confidence of service users and workforce retention **Executive lead:** Chief Nurse **Subcommittee role:** Quality Assurance Committee	*[Outset score: 12]* ***Current: 4x3=12*** *Target: 4x2=8* *Datix ref: (1982)*	**1.** Ockendon and Kirkup review recommendations and compliance submission processes **2.** Safe staffing processes and annual midwifery establishment review using national Birthrate Plus benchmarking information with outputs in 2022/23 operational plan. **3.** Survey/insight available from FFT, Hundred Voices, Women's Experience Forums. **4.** MDT training including foetal monitoring. **5.** National PMR Tool used to review perinatal deaths. Established process for maternity SIs. **6.** Continuity of care metrics developed and models of staffing being explored.	*Management assurances on controls:* Quality Board management of Ockendon and Kirkup recommendation implementation **(1, 6)** Establishment of maternity and neonatal strategy board with hospital equivalents and representation **(1,3,5,6)** IPR reports on safe staffing, NEs and SIs **(1, 5)**	Board monthly reporting via the Integrated Performance Framework **(2-3)**. Trust Board May and November 2022 reports on maternity including national recommendations and CQC inspection updates **(1-6)** QAC oversight of Ockendon and Kirkup recommendation implementation and work of executive Maternity group **(1, 6)** CNST Maternity Incentive Scheme – self assessment against key risk areas reviewed at QAC level (**2-4)**	Reasonable assurance 2021 Internal Audit report – Maternity safety **(2-4)** 2021 CQC review of NUH maternity services **(1-6)** Survey data to inform service improvement **(1-6)** NHSE/I visit in June 2022 (report awaited) **(1-6)** CNST standards met in submission **(1-6)**	*Gaps: Partial compliance on some Ockendon recommendations to be considered and approach to full compliance agreed with NEL partners (and following clarity on funding bid)* *Action: Ongoing actions and reporting on progress via Quality Board.* *Gap: Approval of long term maternity quality and safety programme* *Action: Action plans in place with wider programme In development*

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

6846 CTG monitors unable to monitor maternal observations (risk score 16, lead Newham Chief Executive);
6647 Multiple methods of documentation throughout the maternity pathway does not capture all data and assurance required (risk score 16, lead Newham Chief Executive)
6646 Current antenatal care pathway not adequately meeting the needs of the service (risk score 16, lead Newham Chief Executive)
6923 Potential scan capacity issues affecting gap and grow being fully implemented. (risk score 15, lead Newham Chief Executive)
6509 Obstetric ultrasound machine replacement (risk score 15, lead Royal London Chief Executive)
7104 Due to lack of Bereavement support in Gynaecology there is a risk of adverse psychology harm (risk score 16, lead Royal London Chief Executive)
6882 Obs & Gynae Medical Staffing (risk score 16, lead Royal London Chief Executive)
7048 Risk Barkantine centre will not be able to re-open due to lack of regulatory compliance (risk score 16, lead Royal London Chief Executive)

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

Risk appetite for sub-objective relevant to risk: **8-12 (Moderate)** Risk tolerance triggers: 95% fill rate target adverse variance (threshold tbc)

Gap: risk score to risk appetite: 4 **(current risk score 16; in year target risk score: 12; long term risk appetite: 8-12)**

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span*	*Assurance level*	*Span*	*Assurance level*	*Span*	*Assurance level*	
8. Substantive workforce capacity and capability shortfalls at Trust and NEL level results in reduced consistency of care standards, morale and ability to retain flexibility for seasonal or other surges in demand for services. **Executive lead:** Director of People **Subcommittee role:** Audit and Risk Committee	*[Outset score: 16]* ***Current: 4x4=16*** *Target: 4x3=12* *Datix ref: (6566)*	**1.** Workforce establishment, operational plan and budget sets workforce baseline. **2.** Drive 95 Focus on substantive fill rates, recruitment and retention. **3.** Sector leadership, local employment, research and education focus to attract and retain high calibre clinical staff. Underpinned by Outstanding Place to Work programme and WeBelong inclusion work (community connectivity and development of inclusion centre and inclusion observatory) as an anchor institution. **4.** WeLead programme, Talent Management approach to develop skills and opportunities. **5.** Pandemic workforce plans supported by detailed people recovery and restoration plan focusing on staff welfare and wellbeing, with associated investment. **6.** Provider Collaborative extends shared learning and career opportunities across the NEL sector. **7.** National contingency plans for industrial action.	People Board oversight of key workforce metrics and controls **(1-6)** IPR reports on people and safe staffing, **(1, 5)** PR review of HEB committee progress on *drive 95* recruitment plans **(1-6)**		*Management assurances on listed controls:* Trust Board standing item on People Strategy implementation **(assurance on controls 1-5)** IPR workforce metrics reviewed monthly at Trust Board. **(assurance on controls 1-5)**		2021 Reasonable assurance Internal Audit review of employment checks **(assurance on controls 1-5)** DBS and right to work external reporting **(assurance on controls 1-5)** CQC, HEE and Deanery reporting **(assurance on controls 1-5)**		*Gap: Insufficient numbers of trained staff in key specialties (including critical care, emergency care) and clinical professions locally and nationally* *Actions: Recruitment campaigns including overseas recruitment initiatives. Outstanding Place to Work* *Gap: Assurance on workforce plans to adapt to anticipated levels of winter pressures.* *Action: Winter plan development and work with NEL partners during winter months will*

Related high risks (>15) on the risk register – Datix refs:
6832 Increased vacancy across nursing and midwifery resulting in unfilled shifts on daily basis across the site (risk score 16, lead Newham CEO); 6615 Medical consultant capacity is not sufficient to deliver daily consultant review (risk score 16, lead Newham CEO); 6733 Lack of staffing in the Urgent Treatment Centre (risk score 16, lead Newham CEO); 6620 shortage of paediatric nurses within paediatric ED (risk score 16, lead Newham CEO); 6515 insufficient staffing level across therapies in stroke unit (risk score 15, lead Newham CEO); 4650 MRI scans delays due to capacity < demand and Covid backlog (Risk score 16, lead Royal London CEO)6547 Delays to patient care due to insufficient capacity/staffing in CT imaging, with radiation risk due to lack of RPS time (risk score 16, lead Royal London CEO); 6763 Clinical risk to paediatric audiology patients on waiting lists, and system risks due to pressures on paediatric audiology (risk score 16, lead Royal London CEO); 6673 lack of dialysis capacity (risk score 16, lead Royal London CEO); 6676 Clinical Neurophysiology capacity < demand (risk score 16, lead Royal London CEO); 6789 Pharmacy staffing within the inpatient dispensary (risk score 16, lead Royal London CEO); 6416 Rightsizing IPC department (risk score 16, MD GCS changed to: Royal London CEO); 6636 Unsafe Service - due to critical staffing levels at Barts Heath Haematology Departments (risk score 16, lead Royal London CEO); 6512 Radiography Unsafe Staffing with concurrent risk to radiation safety due to a lack of rostered RPS time (risk score 15, lead Royal London CEO); 6764 Inadequate staffing levels in Ultrasound establishment for B3-Imaging Assistant (risk score 15, lead Royal London CEO); 6798 Lack of Ophthalmic capacity in RLH theatre (risk score 15, lead Royal London CEO); PLUS OTHERS: 6430; 6800; 4613; 6536; 5014; 104; 6650; 6423; 6711; 7074; 6237; 3062

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

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

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

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

Related high risks (>15) on the risk register – Datix refs:
4019 Outpatient appointment capacity (risk score 16, lead Whipps Cross Chief Executive); 3543 Crowding within the Emergency Department in Whipps Cross ED (risk score 20, lead Whipps Cross Chief Executive)
5156 Winter pressures (risk score 16, lead Whipps Cross Chief Executive);
Programme risk register held separately for redevelopment

STRATEGIC ENABLERS: Governance, leadership capacity and capability

Risk appetite for sub-objective relevant to risk: **Moderate (risk score 8-12)** Risk tolerance triggers: Board and executive turnnover (+); Sustained 'high pressure' or above on Covid escalation framework (+); Delays to WeLead framework refresh (threshold tbc); Well Led outputs / internal self assessment

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

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span*	*Assurance level*	*Span*	*Assurance level*	*Span*	*Assurance level*	
10. Insufficient leadership capacity and capability and failure to evolve the group model impairs the effectiveness of the organisation and role in system leadership. **Executive lead:** Director of Corporate Development and Director of People **Subcommittee role:** Audit and Risk Committee	*[Outset score: 12]* ***Current: 4x3=12*** *Target: 4x2=8* *Datix ref: [7138]*	**1.** Group governance refresh in line with Well Led framework. **2.** Sector leadership, local employment, research and education focus to attract and retain high calibre leaders. Underpinned by Outstanding Place to Work programme and WeBelong inclusion work as part of aspiration to be an anchor institution. **3.** WeLead framework, Talent Management approach to develop skills and opportunities. **4.** 22/23-23/24 Closer Collaboration Plan in place setting our priority enabler workstreams, objectives, leadership, governance, milestones and risks. **5.** Acute Provider Collaborative clinical transformation programmes established with programme management arrangements in place and resources hosted under Barts Health group directors **6.** APC clinical leadership model under development to support priority APC programmes. **7.** Hospital CEOs and hospital executive teams participating in borough partnerships. **8.** Group, hospital and division level self-assessment and action plan against CQC well led framework.	GEB and Closer Collaboration Executive oversight of group model development and closer collaboration priorities **(1,4)** Performance Review mechanism to monitor hospital leadership effectiveness **(1)** Trust Board standing item on People Strategy implementation **(1-3)** Shadow Acute Provider Collaborative Executive oversight of APC programmes (5-7) Closer Collaboration Executive oversight of Barts Health / BHRUT closer collaboration plan supported by steering groups (4). GEB oversight of CQC well led planning **(8)**. GEB oversight of Band 8a succession planning programme and roll out of career development programme **(1)**.		Shadow APC Board in place. Barts Health / BHRUT board collaboration committee in place with oversight of *closer collaboration* plan. Board oversight of CQC well led planning and group development.		Role of NEL ICS, JOSCs and Healthwatches in oversight of system development and place-based governance CQC oversight of Well Led domain.		*Gap: shadow APC governance arrangements need to be made substantive for 23/24* *Action: Finalise terms of reference to meet ICB and provider governance requirements.* *Gap: limited management resource identified for certain APC programmes eg urgent and emergency care.* *Action: (1) discussions with NEL ICB to ensure visibility of resource mapping to place and provider collaboratives (2) identify internal resource which can be aligned to APC programmes.*

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

STRATEGIC ENABLERS: Financial plan delivery
Risk appetite for sub-objective relevant to risk: **Cautious (risk score 4-6)** Risk tolerance triggers: ERF funding variance (-); adverse variance on monthly run rate (-); Month 9 forecast submission (-)
Gap risk score to risk appetite: 15 (current risk score 16; in year target risk score: 12; long term risk appetite: 1-4)

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span*	*Assurance level*	*Span*	*Assurance level*	*Span*	*Assurance level*	
11. Below plan activity, workforce costs and inflationary pressures impact on delivery of year 1 and year 3 financial plans for Barts Health and BHRUT, affecting medium term sustainability and effective sector collaboration [CFO] [FIP] **Executive lead:** Chief Finance Officer **Subcommittee role:** Finance Investment and Performance Committee	*[Outset score: 12]* ***Current: 3x4=12*** *Target: 3x3=9* *Datix ref: (1985)*	**1.** NEL system financial plan (coordinating revenue and capital allocations for providers) **2.** Monthly finance reporting details progress against operational plan and budget. **3.** System work to analyse strategic drivers of the deficit position overseen by the ICS and providers. **4.** Transformation and efficiency workstreams focus on key schemes (including theatres; workforce; outpatients; procurement) to support underlying position improvements. **5.** Service Line Reporting structures (in conjunction with Model Hospital and GIRFT data) inform targeted transformation schemes. **6.** PMO function supports hospitals and corporate directorates to identify and deliver quality, efficiency and financial improvements.	Review of financial performance at weekly GEB **(assurance on controls 1-2**). Implementation of Financial Planning Group meetings to review hospital plan progress chaired by CFO and informs PRs **(2-6).** Investment Steering Committee oversight of major investment schemes **(1,3)** Site performance review focus on progress against financial plans, CQUINs and other contractual KPIs **(2,4)** Revised executive board governance in Q4 to link planning, finance and activity **(1,6)**.		Review of financial performance at monthly Finance and Investment Committee and Trust Board review **(assurance on controls 1-3,5**).		Dedicated NHSI support and review of Trust plans. NHSI / CQC Use of Resources assessment, with evidence of productivity improvements 2020 Internal Audit report Income and Billing **(2)** 2020 Internal Audit report Budgetary Control and Financial Reporting **(2)** 2020 Internal Audit report Treasury Management **(2)** 2021 Reasonable assurance Internal Audit review of Bank and Agency controls/usage 2021 Substantial assurance Internal Audit review of key financial controls 2021 Substantial assurance Internal Audit review of Payroll and pensions		*Gap: Clarity on revised NEL arrangements for specialist commissioning.* *Action: Q4 work with ICB and NEL partners to agree approach* *Gap: Assurance reporting on financial plan efficiency schemes* *Action: Plans to establish a new financial sustainability group to monitor and report on hospital level progress*

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

STRATEGIC ENABLERS: Digital strategic delivery plan and capital investment programme

Risk appetite for enabler relevant to risk**: Moderate (risk score 8-12)** Risk tolerance triggers: Adverse variance (threshold to be confirmed) against ICT metrics on downtime/breaches/implementation targets

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

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span*	*Assurance level*	*Span*	*Assurance level*	*Span*	*Assurance level*	
12. Delays in implementing cyber secure, reliable and compatible information systems at Trust and NEL level impacts on service continuity and consistency. **Executive lead:** Director of Strategy **Subcommittee role:** Audit and Risk Committee	*[Outset score: 16]* ***Current: 4x4=16*** *Target: 4x3=12* *Datix ref: (4109)*	**1.**Ringfenced element of capital programme, to renew ICT infrastructure, PCs, data centres and networks. **2.**Approved Informatics strategic delivery plan and consolidated Millennium Cerner EPR system. **3.** Upgrades of Millennium Cerner (following consolidation of single PTL) **4.** Information Governance team and Data Security Protection Toolkit. **5**. WeConnect2 programme successfully rolled out to strengthen digital systems, electronic prescribing and documentation. **6.** BHRUT business case for new EPR system to align principal information platform across BH and BHRUT	Investment Steering Committee lead role in ensuring capital programme is appropriately specified and delivered, with Risk Management Board monitoring associated risks **(1-4)** Informatics Board oversight of ICT investment programme with 6 monthly reporting into Audit and Risk Committee on key ICT developments **(1-6)** Information Governance Committee and ARC oversi Board and ARC review of Data Security Protection Requirements compliance **(4)**		6 monthly reporting into Audit and Risk Committee on major ICT developments **(1-5)** ARC review of IG annual report and DPST tookit **(4)** Trust Board review of BHRUT SOC **(6)**		Internal Audit report Data Security and protection Toolkit **(4)** 2021 Follow-up improved assurance Internal Audit report on cyber **(1)**		*Gap: Variable network performance and outtages still have potential for major impact on operational performance* *Action: Steps to improve ICT infrastructure including approved business case and phased replacement programme* *Gap: Risk of information security breaches remains high and increases with international conflicts* *Action: Steps taken to improve network security*

Related high risks (>15) on the risk register – Datix refs:
4766 Network Obsolete (risk score 20, lead Group Director of Strategy)
4765 IT business continuity (risk score 16, lead Group Director of Strategy)
4767 ICT cyber security standards management and investment (risk score 16, lead Group Director of Strategy)
4768 Server ageing infrastructure (risk score 16, lead Group Director of Strategy)
5931 IT security of radiotherapy equipment (risk score 16, lead Group Director of Strategy)

STRATEGIC ENABLERS: Estates strategy and capital investment programme

Risk appetite for sub-objective relevant to risk: **Moderate(risk score 8-12)** Risk tolerance triggers: Volume of medical equipment risks identified on risk register seeking treatment via capital investment (+); Receipt of any regulatory notices; or internal audit/external assurances indicating reasonable or insufficient assurance rating (+)

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

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

Related high risks (>15) on the risk register – Datix refs
5861 Frequent leaks of contaminated fluid (sewage) through the ceiling in theatre 6, 4th floor, RLH (risk score 16, lead Royal London CEO)
4718 Risk of contamination re leaks from Renal Unit 9th Floor to the 8th Floor NICU, (risk score 16, lead Royal London CEO)
3468 Non-compliance with Fire Safety Management Policy (risk score 15, lead Newham Chief Executive)
4740 RLH SAF 9: Capital requirements may be higher than the capital allocation (risk score 15, lead Royal London CEO):
19 Non-compliance of Fire Safety Order within Whipps Cross Hospital (risk score 16, lead Whipps Cross Chief Executive)

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

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

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

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span*	*Assurance level*	*Span*	*Assurance level*	*Span*	*Assurance level*	
14. Failure to deliver research and education plans in the context of the pandemic and constrained resources adversely affects income, reputation and delivery of workforce targets **Executive lead:** Chief Medical Officer **Subcommittee role:** Quality Assurance Committee	*[Outset score: 12]* ***Current: 3x3=9*** *Target: 3x2=6* *Datix ref: [4925]*	**1.** Research strategic delivery plan and education strategic delivery plan **2.** Education Academy and education governance framework to manage new NHS education contract (which replaced the LDA). **3.** Improving Service Line Reporting transparency for allocation of resources and incentivising research and education activities internally. **4.** People Strategy describes development of new workforce roles and career pathways including using apprenticeships, local employment and overseas recruitment to mitigate training post losses. **5.** Brand and reputation of Trust as a recognised destination for career development and research opportunities (including apprenticeships workstream) **6.** Programme with university partners to expand nursing and midwifery student numbers by 25%. **7.** BRC bid process with significant focus in 22/23.	Education Committee and Joint Research Board oversight **(assurance on controls 1-7)** Apprenticeship Steering Group, which reports into Education Committee reviews work on new career models **(4)**. GMC and professional surveys used to monitor quality of trainee experience **(5, 6)**		QAC oversight of education and research strategic delivery plan implementation – twice yearly reporting (1)		Health Education England visit and student survey findings inform planning Research grant application outcomes **(1)** Positive outcomes in research funding (including BRC) and investment (CRF) in 2022 **(1)**		*Gap: Pandemic disruption to education delivery may result in loss of training posts and/ or impair training quality* *Action: Active monitoring and management of quality of training posts via Education Academy.* *Gap: Lead time in recovering research activity reductions linked to pandemic* *Action: Monitor specific issues around the recovery of research activity and prioritise and support restarts*

Related high risks (>15) on the risk register – Datix refs:
3062 ED junior doctor vacancies (risk score 15, lead Whipps Cross Chief Executive)

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Report to the Trust Board: 18 January 2023	TB /23

Title	Finance, Investment and Performance Committee Exception Report
Chair	Mr Adam Sharples, 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 Committee met on 11 January 2023 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**
Operational performance (constitutional standards)	5,6
Monthly finance report	11
Capital programme report	13
NEL forecast report	11
BAF deep dive (entry 11 – delivery of financial plan)	11
Financial and operational planning 2023/24	All

Key areas of discussion arising from items appearing on the agenda

Operational performance (constitutional standards)

The Committee reviewed in detail performance against operational constitutional standards, with a focus on urgent and emergency care; waiting list reductions; cancer and diagnostics performance (with key details appearing in the Trust Board's IPR).

Monthly finance report

The Committee noted a challenging M8 period, with income and expenditure impacted by the lead up to the winter period. The overall run rate was not however significantly affected and required no change to the predicted year-end outturn position.

Capital programme report

The Committee noted a significant challenge to achieve its yearly Capital Resource Limit target with the overcommitted programme affected by inflationary cost increases. It was noted that major commitments would continue to be funded, although some less time-critical investment, for example in ICT kit, would be slowed in the final quarter (unless additional central capital funding was identified). Positive news was received on TIF funding for estates works at Newham. The Committee noted a historically challenged capital allocation for NEL compared to some regions.

BAF deep dive

The committee received a BAF entry deep dive report in a newly devised format, emphasising the principal controls, assurances and risk triggers relating to the following BAF risk: *Below plan activity, workforce costs and inflationary pressures impact on delivery of year 1 and year 3 financial plans for Barts Health and BHRUT, affecting medium term sustainability and effective sector collaboration*. The Committee noted that this provided a

helpful mechanism for exploring and assessing the related risk factors. **NEL forecast outturn** The Committee endorsed a sector proposal for a revised NEL forecast outturn. To achieve this revised forecast, financial performance improvements would be required by acute providers in the sector.
Any key actions agreed / decisions taken to be notified to the Board Approval of NEL outturn forecast amendment
Any issues for escalation to the Board Improvements in the number of those on waiting lists for 72 and 104 weeks. Highly challenged emergency care position across the group and nationally. To note challenges to achieving the capital (CRL) duty for 22/23.

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 exception report.

NHS
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Report to the Trust Board: 18 January 2023	TB /23

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 23 November 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	All
Internal Audit progress report	All
Integrated risk report including BAF	All
BAF deep dive (entry 10 – leadership capacity/capability)	10
Risk management strategy	All
Standing items on waivers, losses and counter fraud	11, 13
QAC exception report	All
CNST premia	11
Ways of working and horizon scanning	-

Key areas of discussion arising from items appearing on the agenda

Risk Management strategy

The Committee reviewed and endorsed the revised three-year risk management strategy, noting how this linked to developing the risk maturity of the organisation. The Committee made some recommendations to strengthen responses to the accompanying SWOT analysis and develop accompanying communications to reach a wide audience, while recognising good progress and supporting the strategy.

Integrated risk report

The Committee reviewed key metrics relating to the high risk register and agreed updates to the BAF (appearing separately on the Board's agenda), including refinements to risk triggers and RAG ratings of assurances. A theme of discussions was a request for greater granularity in reporting on progress to mitigate risks on the risk register and reduce risk scores; and for increased thematic risk reporting.

BAF deep dive

The committee received a BAF entry deep dive report in a newly devised format, emphasising the principal controls, assurances and risk triggers relating to the following BAF risk: *Insufficient leadership capacity and capability and failure to evolve the group model impairs the effectiveness of the organisation and role in system leadership*. The Committee

noted that this provided a helpful mechanism for exploring and assessing the related risk factors.

Internal Audit reports

The Committee reviewed outcomes of the following audits that were assigned reasonable or significant assurance ratings:

- Whipps Cross maintenance review.
- Whipps Cross workforce planning.

The Committee also reflected on reductions in the 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 existing audit plan (noting a number of audits due to complete in Q4) and the development of next year's plan – due for approval in February.

External Audit report

The Committee received the audit strategy memorandum which outlined the planned audit approach for the 2022/23 audit and an initial assessment of key risks.

Waivers

The Committee received reports benchmarking performance on waivers noting an improving trend.

CNST premia

A report was considered in relation to the level of premia (which had risen over a number of years) and the scope to influence this. The paper set out key factors informing premia including historic claims experience, recognising also the long lead times involved with many high value case. The paper also highlighted the growth of the Trust's premia when compared with the overall increase for the whole NHS during this period

Declarations of interest

A scheduled of declared interests, gifts and hospitality was received ahead of scheduled publication

Ways of working

The Committee considered ways to maximise effective use of time through refining approaches to reporting and follow ups. A dedicated discussion of horizon-scanning was supported by a review of recent national policy developments.

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

Approval of risk management strategy.

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.

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Report to the Trust Board: 18 January 2023	TB /23

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

Executive summary

The Quality Assurance Committee (QAC) met on 16 November 2022 to discuss items on its agenda relevant to its terms of reference, including matters related to winter operational pressures, patient safety/experience, maternity services, a quality report from the Royal London Hospital, internal audit progress reports and a report on quality risks and the Board Assurance Framework (BAF). A dedicated winter plan implementation meeting was also held on 14 December to assure on quality and safety aspects of care during this period (in addition to updates on board visits, QI programme development and maternity).

Key agenda items	**BAF entries**
• Quality Dashboard	All
• Winter Planning	All
• Maternity Services	All
• Patient Experience, Engagement and Insight	3-7
• Annual Inpatient Survey	3-7
• Internal Audit and Limited Assurance Internal Audit Reports	4,7
• Royal London Hospital Quality Report	All
• BAF and Integrated Risk Report	All
• Learning Disabilities Report	1,2
• Equity of Access Report	1,2
• Quality Improvement programme	All

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

- The Committee's plan to further monitor winter progress on constitutional standards of performance, from a quality and safety perspective, at a supplementary QAC meeting in December.
- The Committee's plan to continue to review current harm review processes and implement real-time, rapid learning from serious incident reporting.
- Actions taken on improvements following recent CQC findings from inspections of maternity units and birthing units in August 2022.
- The Committee's plans to continue to review quality dashboard metrics including a scheduled review of this year's mortality reporting.
- The Committee's plan to complete limited assurance internal audit reports and monitor the status of other national audits.
- The Committee's plan to monitor progress against harm induced by falls following findings from a coroner inquest into a serious incident that led to a patient death. A

Prevention of Future Deaths report was received by Barts Health in relation to this case.

- Updates on BAF risks held by the Committee were provided during the meeting and a schedule of deep dives had been put in place.
- A limited assurance Internal Audit report relating to the governance risk and control framework in operation of maternity serious incidents would be reviewed at the January QAC meeting.

Any issues for escalation to the Board

- Partial assurance on winter plans. A further update on mitigating workforce gaps and the causes of real time harm would go to an additional QAC meeting in December.
- Partial assurance for maternity services (to deliver safe, high-quality services by providing well informed challenge and support to maternity leaders). Progress updates were provided at the additional QAC meeting in December. A maternity CNST update would be provided for Board consideration.
- A report into equity of access identified positive progress and highlighted innovations in relation to dealing with improving health inequalities faced by ethnic minority patient groups.
- Improvement work to be delivered on a number of key safety metrics at the Royal London Hospital with an updated quality report to be reviewed by the Committee within six months.
- A report detailing findings from the Trust's Annual Inpatient Survey would be presented at the Board meeting in early 2023.
- The Committee discussed key actions arising from the Board visits held in November (summary appended).

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 Committee is asked to note the report.

Annex - Board visits

Trust Board members visited ED and maternity units at Newham University Hospital on the day of the 2 November 2022 Trust Board meeting.

Minutes of the 2 November Part 2 Trust Board meeting summarise reflections and feedback provided by NEDs at this meeting. This feedback, in addition to collated comments from executives was shared and discussed at the December QAC meeting – with the intention of this session being to follow up any specific actions arising from this.

- The Committee agreed that the board visits arrangements should evolve and be refined over time. The purpose should remain clear and avoid assuming an 'inspection' or formal assurance role, while aiding 'soft intelligence' and visibility.
- Processes should support timely feedback to hospital leads to cascade with teams involved.
- Any specific actions to take forward should be handled via QAC (including via the scheduled hospital reports to QAC) to close the loop.
- Outputs from Board visits should be aligned with future QI programme interventions.
- Visiting a range of areas in small groups would be more valuable than focusing on a small number of service areas.
- The approach to Board visits would be mirrored at BHRUT.
- A small number of specific improvement actions arising from the Newham visit had been agreed and followed up.

Barts Health NHS Trust

Report to the Trust Board: 18 January 2023	TB 07/23

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

Executive summary

In September 2022, the Trust Board received a report on: the next stage of enabling works, the business case for which has received backing from the previous (and now re-appointed) Secretary of State for Health and Social Care and the national New Hospital Programme (NHP); an update on the NHP itself; 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. This paper provides an update on: the latest position on the NHP; the national process for the approval of the next stage of enabling works; progress on the development a framework for an 'annual report' that will chart the progress of key transformation programmes and the journey to the new hospital; the collaborative project, working with Queen Mary University of London, on the joint development of proposals for an Academic Centre for Healthy Ageing.

Related Trust objectives	
• Service Transformation enablers	
Risk and Assurance	Assurance in relation to the below BAF risk.
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:

- the update on the New Hospital Programme and the potential impact on the key programme milestones for the programme for the redevelopment of Whipps Cross hospital;

- the current position in relation to the approval for the next phase of enabling works, which is critical on our journey to a new Whipps Cross hospital;
- progress made in the development of a framework for an 'annual report' and the associated stakeholder engagement, including the plan going forward as we work towards its development and publication; and
- the continuing good progress in developing proposals for the Academic Centre for Healthy Ageing.

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 18 JANUARY 2023

WHIPPS CROSS REDEVELOPMENT PROGRAMME

INTRODUCTION

1. In September 2022, the Trust Board received a report on: the next stage of enabling works, the business case for which has received backing from the previous (and now re-appointed) Secretary of State for Health and Social Care and the national New Hospital Programme (NHP); an update on the NHP itself; 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.

2. This paper provides an update on: the latest position on the NHP; the national process for the approval of the next stage of enabling works; progress on the development a framework for an 'annual report' that will chart the progress of key transformation programmes and the journey to the new hospital; the collaborative project, working with Queen Mary University of London, on the joint development of proposals for an Academic Centre for Healthy Ageing.

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 - and continues to be reported - 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.

NATIONAL NEW HOSPITAL PROGRAMME UPDATE

4. As previously reported to Trust Board, in the first part of 2022 the NHP team secured approval of a programme business case that strengthened the case to Treasury in justifying the strategic, financial and economic rationale of the national hospital building programme and how the programme needed to organise itself and engage with the construction market to ensure delivery. That programme business case did not provide scheme-specific assessments or endorse any agreed funding envelopes for individual schemes.

5. The NHP then developed a further programme business case on the 'cohort 3' schemes (including Whipps Cross Hospital) and the 'cohort 4' schemes, the aim of which was to estimate the overall cost of delivery and secure agreement to a programmatic approach to the design and delivery of all schemes. We understand the programme business case was considered by the government's major projects review group (MPRG) at its meeting on 6 December 2022 but that it did not contain scheme-specific recommendations.

6. At the time of writing, NHP colleagues have shared no specific feedback on the outcome of the MPRG discussions, so immediate next steps for the Whipps Cross redevelopment programme remain unclear. However, if the case was endorsed by the MPRG and subsequently by Treasury Ministers, we anticipate a national announcement early in 2023.

7. We had hoped that a decision on the Whipps Cross programme would be taken before the end of 2022. Given clear next steps for the national programme have yet to be communicated, we should not expect to report anything specific on the Whipps Cross programme before February 2023 at the earliest. In the meantime, we continue to stress to NHP colleagues the importance of agreeing a date for the submission of our outline business case for our preferred option for redeveloping the hospital, of agreeing the preferred 'route to market', and of having an agreed capital envelope within which to deliver the programme.

8. We can point to good progress on all the work over the last 18 months that has been within our direct control. However, given the pace of progress that we continue to experience in relation to the national programme, we now must report that our previous high-level programme assumptions – with construction on the main hospital works commencing in 2024 – risk no longer being feasible. Having reviewed the key programme milestones, we now assume construction of the main hospital works can only commence in 2025 at the earliest, which would mean construction potentially completing towards the end of 2028/29. These are assumed best estimates at this stage and have not been shared and agreed with NHP colleagues.

9. We will continue to work as closely as we can with NHP colleagues so that, at the point that specific decisions on Whipps Cross appear imminent, we can agree updated programme timelines for the planning and delivery of a new Whipps Cross Hospital.

UPDATE ON PHASE 2 ENABLING WORKS

10. Phase two of the enabling works for the redevelopment includes a new 500-space multi-storey car park that needs to be completed before construction work on the new hospital itself can begin.

11. In August 2022, the business case for the works received public backing from the then (and subsequently re-appointed) Secretary of State for Health and Social Care, as well as securing support from the NHP leadership team.

12. Since then, we have continued to engage with national colleagues - including the NHP team and NHS England and the Department of Health and Social Care as part of their review and assurance of the business case - ahead of its formal approval. That process has been rigorous and challenging, with the Whipps Cross team having to respond to multiple queries within tight deadlines. Given the time that had elapsed since the business case was first submitted to national colleagues, we were asked to update and re-submit the business case that included an updated capital cost estimate.

13. We had anticipated the business case's formal approval before the end of 2022. However, that did not materialise and we continue to work closely with national colleagues to understand and address outstanding issues. At the time of writing, we do not have an agreed date for its approval.

14. In parallel to the national decision-making process, we undertook - during Autumn 2022 - early market engagement to help us understand the market and commercial position. This work will inform our commercial strategy for the Client Invitation to Tender as we continue to finalise the procurement framework documents for the enabling works. However, given the delay in the business case's approval, we have paused this work and we will not initiate formal procurement until approval of the business case is secured.

15. We therefore now anticipate a delayed start to the construction of the multi-storey car park, with work potentially beginning in September 2023 and completing in Autumn 2024 (subject to the business case's approval).

AN INTEGRATED DELIVERY FRAMEWORK AND REPORTING ON PROGRESS

16. 2022 saw the establishment of an Integrated Delivery Framework for overseeing the planning and delivery of service transformation within the hospital and in community services across all the Whipps Cross Hospital catchment area. Work is ongoing to understand in more detail the impact that the delivery of transformation will have on hospital activity and on the health and wellbeing of our population.

17. We have been continuing to develop a framework for an 'annual report' that will chart the progress of key transformation programmes and the journey to the new hospital. The report will be a source of continual evaluation of our future capacity assumptions, including overnight inpatient beds, for the new hospital. We have committed to co-designing the report with key stakeholders.

18. An initial meeting with stakeholders took place on 28 September and a workshop subsequently took place on 30 November, which discussed the design and content of the report including metrics and measures. Attendees included key clinical staff, patient and public representatives, and community groups.

19. A framework for the report is currently being completed, which will inform further engagement sessions with stakeholder groups early in 2023, to begin the development of the report. It is anticipated that the first report will be published during the summer of 2023.

DEVELOPING AN ACADEMIC CENTRE FOR HEALTHY AGEING

20. In July 2022, we reported that clinical leads from Barts Health and academic leads from Queen Mary University of London (QMUL) had been working together on a proposal to establish a new local research and education centre - the Academic Centre for Healthy Ageing (ACHA) - linked directly to the planned redevelopment of Whipps Cross Hospital. The proposed Centre will support the development of better local health and care services to improve the quality of life for older people across the Whipps Cross catchment area and, more widely, across north east London.

21. Following positive discussions with Barts Charity, the full funding application for ACHA was submitted to Barts Charity on 30 October, which was the culmination of a significant amount of work completed jointly between QMUL, Barts Health and other local partner organisations.

22. The funding application is in the final stages of review by the Charity and we anticipate a positive outcome in March 2023. Assuming that to be the case, Barts Health and QMUL will then work together to mobilise the new Centre as a key priority for 2023/24.

CONCLUSION AND RECOMMENDATIONS

23. The Board is asked to note:

- the update on the New Hospital Programme and the potential impact on the key programme milestones for the programme for the redevelopment of Whipps Cross hospital;

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

- progress made in the development of a framework for an ‘annual report’ and the associated stakeholder engagement, including the plan going forward as we work towards its development and publication; and

- the continuing good progress in developing proposals for the Academic Centre for Healthy Ageing.

Report to Trust Board: 18 January 2023	TB 08/23

Title	People Strategy – Update on the People Plan 2022/23
Accountable Director	Daniel Waldron, Group Director of People
Author(s)	Aurea Jones, Director of People Strategy Delvir Mehet, Deputy Group Director of People Liam Slattery, Director of People Services Andy Vince, Head of People Systems & Insight
Purpose	To update The Trust Board on progress with delivering the People Plan 2022/23 and to take a forward look at priorities for 2023/24. The Trust Board is asked to note and comment on the update of progress with delivery of this year's People Plan and to discuss the proposed priorities for 2023/24.

Executive Summary
The paper provides the Trust Board with a reminder of the People Plan for 2022/23 and how it fits with the Group's objective 'To be a high performing group of NHS hospitals renowned for Excellence and innovation and providing safe and compassionate care to our patients in east London and beyond'. The paper gives an update on progress with delivery both in the narrative and in the measures that we use to track performance. It then goes on to set out draft priorities for the Group's People Plan for 2023/24 that reflect progress made this year and feedback from colleagues across the Group about what matters to them.

Related Trust objectives	All
Risk and Assurance	This report provides assurance in relation to all the Trust objectives.
Related Assurance Framework entries	8. Substantive workforce capacity and capability shortfalls at Trust and NEL level results in reduced consistency of care standards, morale and ability to retain flexibility for seasonal or other surges in demand for services
Legal implications/ regulatory requirements	None

RECOMMENDATION
The Trust Board is asked:

- To note and comment on the update of progress with delivery of this year's People Plan
- To discuss the proposed and advise on the proposed priorities for 2023/24

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People Plan 2022/23
Progress Report

Trust Board

January 2023

Introduction

The Barts Health People Strategy 2019 – 2022 set the aim of becoming and outstanding place to work and has four pillars:

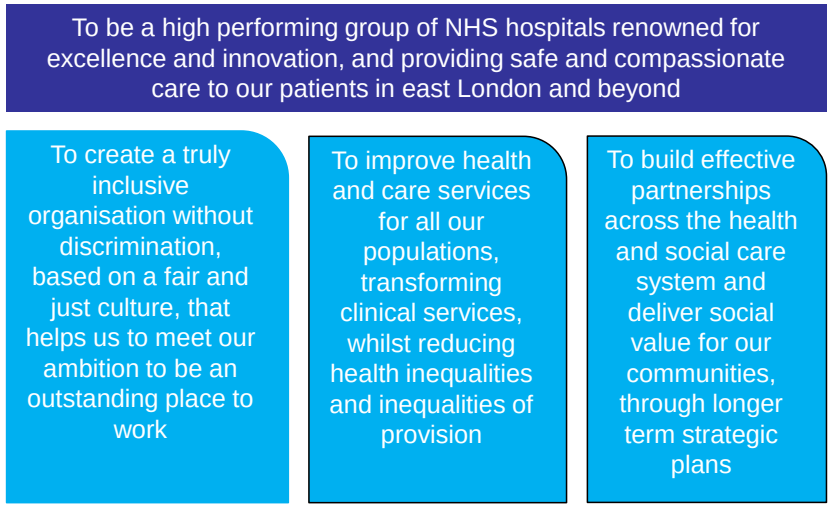
- Building the future workforce
- Strengthening leadership and staff led change
- Creating a healthy and inclusive organisation
- Shape your Story

Once the 'We Are the NHS: People Plan' (the NHS People Plan) and NHS People Promise was published in 2020, we reviewed the People Strategy, to ensure alignment of objectives.

To demonstrate this alignment, we then adopted the titles of the four NHS People Plan Pillars, to shape our annual people plan that continues the delivery against our original objective to become an outstanding place to work.

The four pillars of the NHS People Plan are:

- Looking after our people
- Belonging in the NHS
- New ways of working and delivering care
- Growing for the future



Inclusion, equity and delivering our People Plan 2022/23 Summary

NHS Barts Health NHS Trust

Objective	People Plan Pillars	Priorities/Actions	Headline Metrics
To create a truly inclusive organisation, without discrimination, based on a fair and just culture that helps us meet our ambition to be an outstanding place to work	**WeBelong** (including our Inclusion Objective)	• Expansion of career development, particularly for women and black, Asian and ethnic colleagues • Train all colleagues in inclusion essentials and cultural intelligence • Grow the number of voluntary inclusion roles • Further promote inclusive leadership and our just culture and continue to decrease disparity in disciplinary cases • Achieve 3% per year representation growth to achieve representative leadership by 2028	WRES 1a: Percentage of BAME staff in 8a+ roles WRES 2: Relative likelihood of white vs. BME applicants shortlisted WRES 3: Relative likelihood of BME vs. white staff entering disciplinary process WRES 7&8: Staff Survey career progression & discrimination Gender pay gap target of 11% *Process Measures:* • Numbers in mentoring pairs & enrolled on career development programme • Ethnic profile of internal promotions • Review ethnic profile of all pause and reflect cases
	Supporting the wellbeing and belonging of our colleagues	• Embed our Health and Wellbeing Strategy, by getting the basics right and developing our sustainable offer • Improve retention by participation in a Retention People Promise Exemplar Programme and delivery of plan • Aim to become a flexible employer (flexible working) • Focus on career development by setting up a robust process for a number of local initiatives • Embed our Violence &Aggression (V&A) outputs from the V&A collaborative	• Tracking our NHS Staff Survey actions with People Pulse • Vacancy rate (Drive for 95) • Appraisal rates (target 90%) • Sickness absence (target 3%) • Winter Vaccination rates
	New ways of working	• New roles – as we transform care, promote new roles and new ways of working, as part of the planning • Aim to be a flexible employer – utilising learning from NHS Flex for the Future Programme and our action plan • We will continue to aim to substantiate and increase our attainment for e-job planning and e-rostering • Working with system partners to resolve shared workforce issues	• Roster compliance - target of rosters approved 6 weeks in advance • Job planning completion level • % of roles advertised as flexible • NHS Staff Survey: percentage satisfaction with Q5h (opportunities for flexible working)
	Growing for the future	• Focus on reshaping of workforce planning and delivering on 'Drive for 95' recruitment plan • Agree and deliver an international recruitment plan for 2022/23 • Integrate service/workforce demand & supply • Development of a core effective manager and leader programme • Anchor Organisation – build our local workforce supply • Recruit students who train with us into substantive roles • Increase supply, by exploring new supply routes through the introduction of new roles	• Recruitment - offers made against plan • International recruitment – offers against plan • Turnover rate (target 12.25%)

We Belong (1)

NHS Barts Health NHS Trust

Objectives	Progress	Measures
Expansion of career development	Launched the inclusive career development framework, including: • **Career Mentorship** and shadowing service (195 people have signed up to the programme as a mentor or mentee). In our pilot evaluation, 70% of those surveyed stated it had increased their career prospects. • **Career conversation guidance**, stretch assignment guidance, piloting scope for growth model with Leadership Academy. • Expansion of train the trainer model for BME and women's career development programme, with eight new facilitators, with one cohort concluded this year and two more starting in Feb and May 23. • In partnership with HEBs, developed a **VSM Succession Planning Framework,** to ensure local succession plans are in place for all roles at 8c+ and medical equivalent roles, to support progression into VSM role; this will launch in Feb 23. • Expansion of career development programmes, with an **e-learning resource** for 900 staff. • Strengthened appraisal template and guidance, embedding equality objectives, what matters to you conversation and signposting to resources.	**Covering WRES (black, Asian and ethnic minority colleagues) and WDES (colleagues with a disability) 2021-22, headline areas of improvement include:** • WRES 1: (8a+ representation) improved from 34% to 37.2% • WRES 2: (shortlisting) gap closed from 1.65 to 1.5 • WRES 7: (% people perceiving progression to be fair) increased from 39.8% to 41.4% • WRES 8: (discrimination) decreased from 18.9% to 18.5% • WDES 1: (non clinical 8a-b representation) improved from 2.9% to 4.68%, (clinical 8a-b representation) improved from 1.2% to 3% • WDES 2: (shortlisting) gap closed from 1.3 to 1.17 • WDES 4c: (bullying from colleagues) decreased from 32% to 30% • WDES 5: (% people perceiving progression to be fair) improved 38.7% to 40.4%) The WRES and WDES annual reports and action plans have been published on the Website, they set out key areas of focus for improvement including: • **WRES,** career development for BAME colleagues in increasing the number of BAME colleagues in 8a+ and VSM roles • **WDES**, ensuring colleagues with a disability are able to access workplace adjustments
Train all colleagues in inclusion essentials and cultural intelligence	• 1,026 people have completed **Cultural Intelligence (CQ),** including the majority of senior leaders. An evaluation framework has been developed, to allow the ongoing impact of the programme. • Plans have been agreed at the Inclusion Board to ensure **sustainability, through integrating CQ with the 'inclusion essentials'** learning and development programme from Apr 23. • Our programme of **inclusion awareness events**, training, and development programmes, have reached over 2,000 participants in the last 12 months.	
Grow the number of voluntary inclusion roles	• Inclusion Ambassador training has secured new volunteers to replace volunteers stepping down from the role or leaving the Trust; total **IAs currently sits at 129**. • We have 51 **Inclusion Signposters** and our new regular forum has provided a space for continuous learning, sharing experience and providing pastoral support. • We have grown the number of **network co-chairs and site leads,** the staff network development programme continues, with the aim of mobilising existing network memberships to be more active volunteers in the inclusion space. • **Inclusion objectives embedded into appraisals,** to encourage more people to come forward in volunteer roles and engage in other inclusion activities.	

We Belong (2)

Objectives	Progress	Measures
Further promote just culture	• **22 colleagues have completed Northumbria University's Principles and Practice of Restorative Just Culture** (RJC) course. An alumni group has been created, to build on existing work on fair and just culture and embed just culture principles across the Trust. • Continuing to support interventions related to the **just culture** approach to embed this in our response to the Verita review. WRES bullying metrics have improved since last year.	**Other metrics:** • The total number of formal disciplinary cases so far in 2022/23 is 36, of which 19 (53%) involve BAME colleagues • Median Gender Pay Gap for 2021/22 (to be reported in March 2023) was 11.7%
Achieve 3% pa rep growth to achieve representative leadership by 2028	• BME **representation at 8a+ increased** 3.2% (34% to 37.2%) over 2021-22 WRES reporting period, exceeding target. • Mitigations are being put in place to **translate 8a-c growth into the most senior roles**. • Growth in the **% of people with a disability in 8a-VSM** was also seen (2.5% to 3.53%)	

Supporting the wellbeing and belonging of our colleagues (1)

NHS Barts Health NHS Trust

Objectives	Progress	Measures
Embed Wellbeing Strategy – get the basics right & develop a sustainable offer	Wellbeing Strategy - deliver year 1 priorities: • £2.5m investment in **getting the basics right** • Barts Charity approved a further 3 years funding for the **Psychology Support Service** • **Wellbeing leads** established at each hospital and all permanent **wellbeing hubs** open • We have reviewed our **appraisal** processes, working with an external consultant, to provide an overview of current thinking and with colleagues from across our hospitals. This has resulted in an improvement framework, that we will be piloting with teams across the hospitals, to test and further develop appraisals across our Group of hospitals.	**Staff Survey:** • Response rate 2021: 47% • Target for 2022: set at 50% • Early indications are that there has been a fall in completion rate. • My organisation takes positive action on health and wellbeing 2021: 56.4% **Vacancy rate**: • 8.6% (Dec 2022); 10.2% (Sept 2022) • The registered nursing and midwifery vacancy rate is 15.7% (Dec 2022); 17.8 (Sept 2022) **Substantive fill rate**: • 91.4% (excluding SERCO TUPE) against a plan of 92% and YE plan of 93% (Nov 2022) • **Fill rate for nursing and midwifery** 84.3% (excluding 133 IENs/Students awaiting registration) against a plan of 89% and YE plan of 91.6% (Nov 2022) **Appraisal rate**: • 55% non-medical (Nov 2022)
Improve retention through participation in Retention People Promise Retention Exemplar Programme	Trust is a Pilot site for the **NHSE Exemplar Programme,** which concludes in June 2023. NHSE is reviewing options for an extension of the programme. Sharing learning from participation across our hospitals and in support of specific teams. The programme focuses on: • **Pay and Pensions** – In addition to day to day advice provided by our Pensions department, we have reviewed our education and information offer and will be rolling out a revised programme of webinars in the new year, for staff at different stages of their career. We have updated our pensions recycling policy and are waiting for the national guidance before we publish it. • **Career and development** – Barts Health is also a pilot site for the NHSE Medic Career Conversations Programme. This programme is designed to test the hypothesis that structured conversations with senior doctors about their motivations at work, career and retirement plans, and changes that would encourage them to stay longer, will enable team-centred discussions around what changes are possible and enable better succession planning. 350 consultants and 60 SAS and Trust Grade doctors have been invited to take part. 70 doctors have expressed an interest in participating and the career conversations will take place up until 31 March.	

Supporting the wellbeing and belonging of our colleagues (2)

NHS Barts Health NHS Trust

Objectives	Progress	Measures
Improve retention through participation in Retention People Promise Retention Exemplar Programme (continued)	• Our plans to review our approach to **Exit Interview** and Stay Meetings for all staff groups have not progressed as fast as we had planned. We continue to use the current exit reporting tool to inform our work about what motivates people to stay or to leave the organisation and plan to review the exit interview process in 2023/24.	• **Sickness absence**: 5.15 % excluding COVID absence; 5.52% including COVID • **Winter vaccination rates**: As at 7th October: Flu at 2,441 (93% of trajectory) and Covid Booster at 2,583 (98% of Trajectory) • **% roles advertised as flexible** – method of capturing in development • **NHS Staff Survey**: Satisfaction with People Promise 'We Work Flexibly' 2021 results: ❖ Organisation average 5.9 ❖ Barts Health 5.7 - Newham 5.6 - Whipps Cross 5.4 - RLH 5.6 - St Bartholomew's 5.7 - GSS 6.3 - Pathology Partnership 6.0
Become a flexible employer – key focus of the Retention People Promise Exemplar Programme	• **Flexible working** - Agile working policy agreed and established. • **Flexible working policy** has been reviewed and agreed with an accompanying draft guide for managers on flexible working in train. The draft guide is informed by outputs from staff and team leader focus groups. • We have focused on building flexibility in clinical areas with **self-rostering,** by sharing learning on flexible working, to encourage change in management practice. • We are working to support key clinical areas to introduce self rostering, e.g. RLH ACCU 3F, where feedback from colleagues included the desire for more flexible working. As a result, we are working with the team to pilot team-based rostering. • We are exploring how **e-Rostering might best support flexible working,** to track progress. • To support the target of ensuring that a minimum of 25% (NHSE target) of permanent roles are advertised with clear flexible working options, we have agreed an amendment to the recruitment process, that will track permanent roles advertised as flexible option and allow the monitoring for requests for flexible working.	
Embed Violence and Aggression outputs from the collaborative	• The work to launch and embed our approach to reducing **violence and aggression** was started, with some training being delivered and hospitals developing action plans. The work was paused as the pandemic started and we are in the process of reviewing progress with implementation to renew our focus.	

New Ways of Working (1)

Barts Health NHS Trust

Objectives	Progress	Measures
New roles - as we transform care, we promote new roles and ways of working	• Work programmes have re-commenced across the Group, to develop and promote the inclusion of **Nursing Associates, Advanced Care Practitioners and Physician Associates** in the multi-disciplinary team. All three programmes are developing career frameworks and seeking to promote adoption of the roles to assist with workforce supply and improve substantive workforce numbers. **Medical Support Workers**: Clinical Support Programme and Scheme for Refugee Doctors – recruited over 45 MSWs across our hospitals, providing clinical and structured support programme for refugee doctors to assist MSWs securing a medical post in the NHS, broadening our points of access. • Exploring new options for hotspot areas, such as the **Anaesthetic Assistant** and we have opened access to Anaesthetic posts utilising the **CESR** route. • We are hosting 2 Workforce transformation and planning pilots for the APC, covering UEC and the Mile End diagnostic hub. These programmes will explore new workforce models and develop our approach to integrated workforce planning.	• **Roster compliance**: 46.1% • **Job Planning** completion rate: 37% at Jan 2023, with target of 100% for March 2023. Sign off rate was 62% in March 2022. • **Staff Survey** 2021: Q6: 'My organisation is committed to helping me balance my work and home life': 40% • **% roles advertised as flexible** – method of capturing in development
Progress with e-job planning and e-Rostering	• **e-Rostering**: Nursing & Midwifery rosters are all on HealthRoster and work is continuing to fully utilise the system and increase the efficiency of workforce deployment. For Ward Based areas, self-rostering is now being promoted, with 8 areas live and plans for roll-out to continue throughout 2023/24. All other staff groups are at initial implementation, with the next phase of work focusing on increasing utilisation of the system, for example, Medical & Dental (Consultant and SAS) job plans will be interfaced into HealthRoster once they are signed off. The Nursing Dashboard reporting on the deployment of the workforce is live and a Medics dashboard will be published for 2023/24, with the development of a dashboard for HealthCare Scientists, Pharmacy and Allied Health Professionals to follow. The booking of Bank shifts for Consultants via HealthRoster will be piloted, whilst there is a review of the full roll-out plan for 2023/24. • **Job planning:** 2022-23 job plan cycle is now fully underway. Job planning is promoted as a contractual requirement for all Consultants and SAS Doctors, with a focus on team job planning demand and capacity.	

New Ways of Working (2)

Objectives	Progress	Measures
Working with system partners to resolve shared system issues	• Continue our partnership with **Barts Charity,** focusing on wellbeing. • Working in collaboration with partners across the ICB and London on implementing **common bank rates** and payments for additional hours. Temporary Staffing Bank rates for AfC roles are now closely aligned across NEL APC, as are consultant rates. Focus is now on junior doctor rates. • Collaborating with partners on wellbeing, with KeepingWELL NEL and building a shared approach to supporting colleagues across the system with **cost of living** pressures. • Work has started to develop a **Workforce Strategy for the ICS**. At the first workshop, partners from across health, social care and the voluntary sector agreed that the strategy would cover key challenges, including: transformation, recruitment, retention, health and wellbeing, inequality, growing our talent and developing a NEL employment deal.	

Growing for the Future (1)

Barts Health NHS Trust

Objectives	Progress	Measures
Drive for '95	• **Hotspot areas** in Critical Care and midwifery have now been expanded, with a new campaign for ED staffing being launched in the final quarter of the year. • Increased recruitment activity, along with recent decreases in turnover rates, have resulted in the **vacancy level improving** to 91.4% over an April 2022 figure of 90.1%. The plan for year end is to achieve 93%. • There are 133 nurses (IENs/Students) awaiting registration before end of Q4. Assuming attrition does not out perform BAU recruitment, this will improve the current registered nursing & midwifery fill of 84.3% to 86.4%. • **Process improvement,** supported by deployment of RPA technology, is approximately halfway through the first phase of the programme, with 6 processes live. A further 7 processes are planned to go-live across Q4 2022/23 and Q1 2023/24. In readiness for the completion of Phase 1, candidate processes are being reviewed for Phase 2. • **Recruitment into 2023/24** is expected to remain at the same high levels as seen in 2022/23.	• **Recruitment offers against plan:** offers for 3,980 WTE against 3,425 WTE in plan (Dec 2022) • The registered **nursing and midwifery pipeline** offers for 1,413 WTE against 1,377 WTE in plan (Dec 2022) • **International recruitment offers against plan:** To date, 152 IENs have arrived, with another 42 offers made. • The initial deployment of **RPA** technology is delivering a 2.5% efficiency within recruitment activity this year. • **Turnover rate:** 13.4% (Nov 2022), a fall over the previous 3 months. Turnover was at 13.3% in April 2022.
International recruitment plan	• We recruited 235 IENs to the end of December 2023, against our NHSE target of 230. We have a further 111 IENs planned in 3 cohorts across Q4 for 2022/23 and Q1 of 2023/24, the last cohort being in June 2023. • HEBs are finalising demand for IENs beyond June 2023 and commissioning will be confirmed before end of Q4 2022/23. • We have commissioned the recruitment of 56 International Midwives, with 12 offers already made.	
Integrating service/workforce demand and supply planning	• We have been piloting a new **integrated planning template** that integrates activity workforce and finance data. This integrated template will be used to inform the 2023/24 planning process and support improved triangulation of activity, workforce and finance data. It is a first step towards improved workforce planning.	

Growing for the Future (2)

Objectives	Progress	Measures
Core effective manager and leader programme	• We are implementing our **WeLead leadership framework,** with the development of a core leadership programme, that focuses on compassionate leadership and just culture. The WeLead leadership programme is for colleagues who are new to leadership roles. It has been piloted at Newham Hospital and will now be rolled out across all the hospitals in February, March and April 2023 and with further cohorts planned throughout the year. A WeLead delivery group has been set up to manage the roll-out and further development of the programme.	• **Healthcare Horizons** result: 183 young people have been recruited to roles in the NHS (124 at Barts Health – with 90%+ retention rate). • **Apprenticeships:** 690 across the Group. 95% of people who complete an apprenticeship with Barts Health stay in the Trust.
Anchor organisation building local workforce supply	**Community Works for Health Programme includes**: • **Project Search** over 30 internships so far this year. • **Healthcare Horizons** careers and employment scheme - since its start in 2019, the scheme has engaged schools and colleges in future NHS careers, with 388 work experience placements created for local school students, 169 career events delivered, engaged nearly 3,000 young people from our local communities, and over 100 students receiving online mentoring. In 2022, we launched the **Barts Health Futures Hub** in partnership with Newham College, working with the college to encourage young people into careers in the NHS. • We continue to develop **apprenticeships,** particularly clinical apprenticeships, as new frameworks become available.	

People Priorities for 2023/24

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

NHS Barts Health NHS Trust

People Plan Pillars	Outcomes	Programmes of work	Measures
WeBelong	Inclusion is a core commitment in ensuring inclusivity and belonging for all our people, where all forms of discrimination and inequality are eradicated	• Embed career development and succession planning • Continue our work to build a fair and just culture • Deliver the next phase of the Cultural Intelligence Programme • Continue the development of the staff networks • Continue to improve representation in leadership positions	• WRES 1a: Percentage of BAME staff in 8a+ roles • WRES 2: Relative likelihood of white vs. BME applicants shortlisted • WRES 3: Relative likelihood of BME vs. white staff entering disciplinary process • WRES 7&8: Staff survey career progression & discrimination • Gender pay gap target of 11% • Ethnic profile of internal promotions
Supporting the wellbeing and belonging of our colleagues	To have a sustainable approach to how we care for our people, improving work experience and retention	• Continue to deliver the wellbeing strategy ambitions, developing our offer in response to feedback • Maximise our learning and impact from being a part of the Retention Exemplar programme, with a focus on flexible working • Pilot and roll-out a revised approach to appraisals • Roll-out the WeLead leadership programme • Renew our focus on engagement	• Tracking our NHS Staff Survey actions with People Pulse • Vacancy rate (Drive for 95) • Appraisal rates • Sickness absence • Winter Vaccination rates • NHS Staff Survey: Satisfaction with People Promise 'We Work Flexibly' • Number of colleagues attending leadership development programmes
New ways of working	To have a sustainable workforce model that supports the transformation of care	• Collaboration with system partners to develop shared workforce plans and functions • Manage the SERCO TUPE and staff transition • Develop a Group wide approach to assessing and improving workforce productivity • Promote new roles and ways of working, to improve workforce supply and support service transformation	• Roster compliance • Job planning completion • % of roles advertised as flexible
Growing for the future	To deliver a permanent and stable workforce, reducing reliance on temporary workforce and improving patient care	• Drive to 95 – supported by agreed improvement plan • Develop integrated WF plans • Develop consistent Group wide temporary staffing rates and governance • Build local WF supply as an Anchor organisation	• Substantive fill rate - all staff • Substantive fill rate - nursing and midwifery • Time to Hire • Temporary staff as a % of workforce

Barts Health NHS Trust

Report to the Trust Board: 18 January 2023	TB 09/23

Title	Pathology Partnership
Accountable Director	Director of People and Independent Chair
Author(s)	David Monk, Independent Chair Andrew Knott, Managing Director
Purpose	To receive NHS East and South East London Pathology Partnership annual review: • Rationale for the Pathology Partnership • Highlights of our first year: continuing transformation • Future challenges and opportunities
Previously considered by	GEB

Executive summary

One of 29 national pathology networks (5 in London), the partnership was formed on 1 May 2021. Co-owned by Barts Health, Homerton Healthcare and Lewisham and Greenwich trusts, it is an arms-length organisation hosted by Barts Health with staff employed by Barts Health. 70% of all diagnoses made in the NHS involve pathology; the partnership covers a population of circa 3m people and carries out circa 100,000 tests a day.

Related Trust objectives
SO 3.

Risk and Assurance	Assurance in relation to above objective

Legal implications/ regulatory requirements	No specific requirement

Action required

The Committee is asked to review and approve the annual report

East and South East London Pathology Partnership

NHS East and South East London Pathology Partnership

Our first year

2021/22 Annual Review

Contents

1. An introduction to the Pathology Partnership

The NHS East and South East London Pathology Partnership is a new organisation.

We provide pathology from laboratories at seven hospital sites and serve acute, GP and community patients across a population of 3.5 million in East and South East London, in addition to providing specialist services on a regional and national basis.

The Partnership is part-way through a complex transformation to reshape the service into a new Target Operating Model of a network comprising a high volume 'hub' laboratory at the Royal London Hospital and six smaller 'Essential Service' Laboratories, all underpinned by a single, shared Laboratory Information Management System and Quality Management System.

We were formed on 1 May 2021 and are jointly owned by Barts Health NHS Trust, Homerton Healthcare NHS Foundation Trust and Lewisham and Greenwich NHS Trust. The organisation is hosted by Barts Health.

2. Executive summary: our first year

The Partnership…

…carries out over 100,000 tests each day

…has 813 WTE staff (March 22)

…has operating costs of £111m (2021/22)

…is organised into three Operational divisions:

- Blood Sciences
- Cellular Pathology & Cancer Diagnostics
- Microbiology & Virology

...runs laboratories at:

1. Homerton University Hospital
2. Newham Hospital
3. Queen Elizabeth Hospital
4. Royal London Hospital
5. St Bartholomew's Hospital
6. University Hospital Lewisham
7. Whipps Cross Hospital

The Partnership's first year has been a success, but has not been without expected and unexpected challenges.

Any major service transformation faces the challenge of balancing the pressures of on-going service delivery with timely and safe implementation of the planned transformation. To date, this has been achieved.

We have successfully delivered the initial planned phases of our three year transformation into an integrated network set out in the Full Business Case (FBC) approved by the boards of the three partner trusts in July 2020, whilst delivering the first year savings set out in an update to the FBC approved by boards in February/March 2021. These savings were planned to be low in the first year due to non-recurrent transitional costs but recurrently amounted to £494k. At the same time, we have continued to maintain and develop the delivery of pathology services, including major changes outside of the planned transformation, such as COVID testing and Cellular Pathology.

NHS England assessed the performance of all pathology networks using a 'maturity matrix' assessment tool. In March 2022 NHS England's initial assessment of the Partnership concluded:

"…we have placed the Network as being in the early phases of the 'Maturing' phase of the Matrix reflecting the fact that it is still relatively early on in its development since formation. Although there is some underlying variation in domains (Governance, Leadership, Operational, IT & Digital, Workforce), this reflects a strong performance overall, exceeding the national expectation that all networks meet the 'Developing' maturity status by December 2022."

2.1 Key achievements

Our achievements include:

- ***Approval of a detailed Collaboration Agreement between the Trusts***, setting out the legal basis and governance of the new Partnership. Signature of the Collaboration Agreement allowed the Partnership to be formed on 1 May 2021;
- ***Consultation and TUPE transfer of staff*** from Homerton and Lewisham and Greenwich to Barts Health upon formation of the new organisation;
- ***Establishment and delivery of a new, integrated management structure*** through a consultation with managers and scientific staff of grade 8B and above (completed May 2021) and a second phase with band 8A staff (completed September 2021);
- ***Embedding of new governance structures,*** including a Strategic Management Board (with executive-directors from owner trusts), Clinical Board, Operations Board and Quality and Governance Board and monthly performance meetings with trusts;
- ***Strong clinical engagement and collaboration across partner trusts*** to agree standardised tests required for work transfer and a single, integrated LIMS;
- ***Moving Homerton's GP work to the hub laboratory in July 2021,*** with standardisation of tests, IT links, staff consultations, communications and staff transfers to enable the rebuilding of Homerton's laboratory;
- ***Separation and safe transfer of Lewisham and Greenwich's GP work to Synlab***, the other South East London pathology provider, completed in November 2021. The decision to move GP work was made by SEL commissioners in September 2020;
- ***Moving Homerton's Microbiology and Virology work to the hub laboratory in December 2021***, with standardisation of tests, IT links, staff consultations, communications and staff transfers to enable the rebuilding of Homerton's laboratory. Urgent virology testing for COVID has been kept at Homerton;
- ***Mobility consultation*** with staff to enable rotation of relevant staff between the hub laboratory and Essential Service Laboratories to strengthen resilience and training (completed March 2022);
- ***Collaborative working with Homerton Estates team on redevelopment and re-equipping of existing laboratory*** into an Essential Services Laboratory as a prelude to full integration of the Homerton laboratory onto the Partnership's single Laboratory Information Management System (LIMS) in January 2023.

Use of pathology

NHS England estimate that 95% of clinical pathways rely on access to pathology services

NHS England's The Digital First pathology report (2014)

2.2 Challenges

The first year of the Partnership has not been without its challenges. The management team has needed to balance transformation and 'Business as Usual' pressures. Some of the major challenges included:

Recruitment and retention. The single biggest long-term challenge facing the Partnership - like many other services - is a continued shortage and turnover of appropriately skilled staff. As of April 2022 the vacancy rate was 12.2%. This is a national pathology issue and has a particularly strong impact in London, where transport links enable much greater mobility of staff between employers.

Two of the five London networks are non-NHS and so have flexibility to offer bonuses and pay rates outside of normal NHS terms and conditions. Particularly for junior grades that do not require specialised qualifications, any further erosion of relative pay in comparison to alternative non-pathology employment options will continue to place additional pressures on the service. The Partnership is responding to these challenges by developing a recruitment and retention strategy, which is showing early signs of success (see box).

Grow your own

A key element of the Partnership's recruitment and retention strategy is the on-going development of a 'grow your own' programme to create a better structured progression for Biomedical Scientists through band 4, 5 and 6 by the use of Annex 21 training positons, including linking attainment of qualifications with pay progression. This is initially being developed in Blood Sciences. Staff feedback has been very positive.

Service changes beyond the transformation. The Target Operating Model set out within the Full Business Case focussed on the transformation of core Blood Sciences and Microbiology/ Virology where automation enables high volume, non-urgent work to be undertaken at a hub laboratory. Other services were treated 'As-Is' within the FBC, without any significant changes to the service delivery model or funding of these services.

Changes to Cellular Pathology are not part of the Target Operating Model transformation, but a significant amount of management time has been spent in the first year and beyond to develop and implement business cases to improve the performance of Cellular Pathology for Barts Health and Homerton Healthcare patients (which is a key constituent part in cancer diagnosis). Cellular Pathology is a highly manual discipline and analysis identified that workload had increased 48% over seven years (by numbers of slides) without commensurate increases to staffing or the number of dissection tables required for the increased workload. With elective recovery, workload has now exceeded pre-pandemic levels. With the approval of Barts Health and Homerton Healthcare, additional staff are being recruited and three new dissection tables are being installed.

Ensuring adequate staffing for COVID testing placed particular pressures on the Partnership's Virology team and also highlighted the value of Point of Care Testing (POCT) for COVID, which was used in Emergency Departments and other locations to maintain the flow of patients around hospitals. As recognition of the value of POCT has grown, the Partnership is currently starting a piece of work with trust POCT Committees to ensure that the quality control and training elements of POCT provided by the Partnership meets the developing needs of the trusts.

There have also been developments in our specialist laboratories. For example, we made a successful bid to host the National Acute Lymphoblastic Leukaemia Minimal Residual Disease (ALL MRD) monitoring service. From 1st November 2021, this specialist laboratory provides accredited testing for England, the devolved nations and Ireland, and also provides a private service for The London Clinic and Mater Dei Hospital, Malta.

Procurement. One of the benefits of a network is gaining greater economies of scale from consolidating procurement contracts, but the contraction of the pathology marketplace into networks has meant that suppliers will fiercely contest lost contracts. One of major contractual consolidations undertaken by the Partnership was for logistics, which was delayed by legal challenges but is is now fully operational.

Establishing an activity baseline and counting. The FBC was written during the pandemic when normal clinical activity was severely disrupted. Hence, there was no clear multi-year trend activity and the FBC used historic 2018-19 (pre-pandemic) data as the baseline. One of the challenges experienced by all pathology networks is that there are no set standards for counting activity and each laboratory's LIMS has historically counted activity differently. In the first year of the Partnership work has continued at a very detailed level to standardise counting to enable accurate data on activity growth to be

produced. This work is still continuing. It will only be when all laboratories move onto the shared LIMS that standardised activity counting will happen automatically.

Potential integration of Barking, Havering and Redbridge into the network. In March 2022 NHS England sought a plan to integrate Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) into the network. North East London ICS (NEL), BHRUT and the Partnership worked collaboratively on a plan. Discussions are continuing with NHS England about this plan, funding and the pace of any integration. BHRUT has a pathology laboratory at each of its two hospital sites.

The shared view of the Partnership, BHRUT and NEL is that the integration of BHRUT into the Partnership will require the approval of an Outline Business Case and Full Business Case to clearly articulate the benefits and risks of any expansion of the network.

BHRUT was originally identified by NHS England as being a member of our pathology network, but BHRUT chose not to participate in any network (see section 3). The pandemic saw increased links, with a significant volume of COVID activity being carried out at the Royal London Hospital (RLH) hub laboratory for BHRUT. The RLH hub laboratory also provides some specialist testing for BHRUT.

A key challenge will be to ensure that time spent planning for the integration of BHRUT does not detrimentally impact the delivery of our existing transformation or BAU service provision. True integration of BHRUT will require BHRUT laboratories to use the Partnership's integrated LIMS. Because BHRUT does not currently have an Electronic Patient Record (EPR) system, any work undertaken to roll-out and integrate the Partnership's LIMS with BHRUT's existing clinical systems would be discarded at the point that BHRUT implements an EPR and a new LIMS: EPR integration would be required.

2.3 Risks

Risks are reviewed monthly by the management team, by the Partnership's Quality and Governance Board and by the Strategic Management Board (see section 4). Barts Health is the host trust and consequently, high level risks are escalated through the Barts Health risk management process, to the Royal London Hospital Executive Board and Barts Health Group Executive Board.

At the end of the first year, the Partnership had four high risks (scored 16 or above), three of which related to staffing shortages and one to an unsupported IT system used for Cellular Pathology at University Hospital Lewisham.

3. Why the trusts formed the Partnership

The Partnership was formed in response to a national initiative by NHS England to consolidate pathology services across England into networks to reduce "unwarranted variation in services and deliver efficiencies".

In 2017 NHSE set out a requirement for the existing 122 pathology services in England to be transformed into 29 networks. NHS England proposed the grouping of trusts to form each network, but trusts were given the opportunity to decide which network to join. The NHS Long-Term Plan committed the NHS to establishing pathology networks across England by December 2021.

The rationale for pathology networks was set out in the Carter Review of 2008[1] which described adopting a hub and spoke model of pathology to improve the quality of services and drive efficiencies. This was driven by the increasing use of automation in the core disciplines of Blood Sciences and Microbiology to centralise high volumes of non-urgent tests from acute hospitals, GPs and the community into hub laboratories, whilst establishing spokes (Essential Service Laboratories) on acute sites to undertake a more limited repertoire of urgent tests for acute patients.

Creating a hub and spoke model is a significant undertaking: it requires the standardisation of tests across the network (requiring the agreement of clinicians), standardising analytical equipment, robust logistics, new staffing structures and for the network to be underpinned by a single, shared Laboratory Information Management System (LIMS) to enable test processing and results to be shared across locations.

The Partnership's network builds upon previous work by Barts Health to set up a hub laboratory at the Royal London Hospital (Whitechapel) and to create Essential Service Laboratories at the three other hospitals in the Barts Health group (St Bartholomew's, Newham and Whipps Cross), all sharing a LIMS. Hence, the transformation requires agreement of standardised testing to meet the clinical requirements of all three trusts and then to roll out the single LIMS first to Homerton Healthcare and then to Lewisham and Greenwich.

The original network configuration proposed by NHS England and described as 'London network 3' was Barts Health, Barking, Havering and Redbridge and Homerton Healthcare. Barking, Havering and Redbridge chose not to join any network whilst Lewisham and Greenwich opted to join our network because was an entirely NHS service in contrast to the outsourcing of pathology which had taken place in South East London.

A Full Business Case to set up the Partnership was produced by an external specialist consultancy called Lifecycle and was approved by Trust Boards in July 2020 and approved by NHS England in December 2020. Our network was one of the last to be approved by NHS England.

NHS England identified the following non-financial benefits from pathology consolidation. The headline non-financial benefits from the FBC are also shown for comparison.

NHS England	FBC
Quicker, more advanced and reliable screening test results for patients	Patient safety and experience
Reduced unwarranted variation in quality and cost between laboratories	Clinical sustainability and quality
Enhanced career opportunities for staff	Flexibility, adaptability and responsiveness
Strengthened resilience through networked laboratories	Operational sustainability and innovation

Other specific non-financial benefits to trusts were set out in the FBC and include the rebuilding of the pathology laboratory at Homerton Healthcare and a sustainable pathology service that remains entirely within the NHS for Lewisham and Greenwich.

[1] Carter review in 2008, Report of the second phase of the review of NHS pathology services in England https://webarchive.nationalarchives.gov.uk/20130124044941/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_091984.pdf

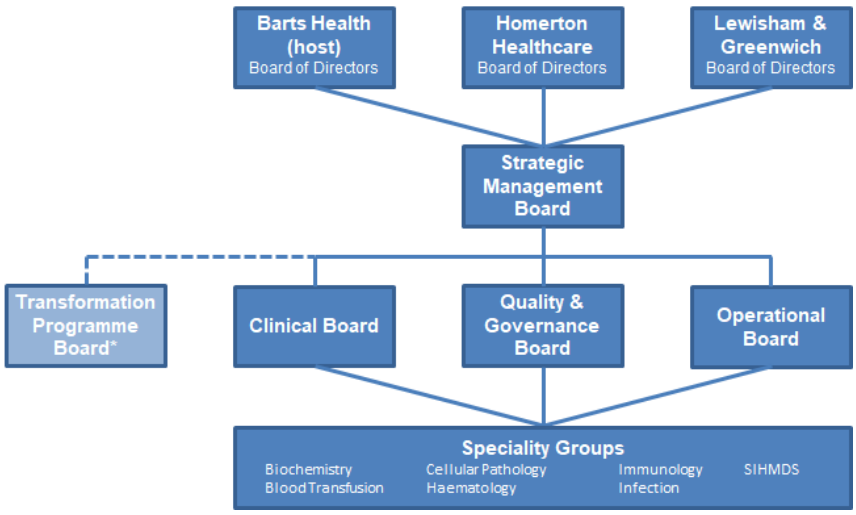
Moving to a hub and ESL structure across the three Trusts, as set out in the Target Operating Model in the revised FBC (February 2021), will ultimately generate a financial saving per annum of £5.5m (4.8%) compared to the As Is / Do nothing scenario. Across the ten years of the financial model this will mean a total saving of £31.8m. This will be achieved mainly by reductions in non-pay costs as well as overheads but also includes productivity/efficiency savings as a result of economies of scale around consolidation and automation.

4. Governance

Historically, pathology services have not always had high visibility within trusts. The creation of the Partnership has resulted in stronger scrutiny and challenge, whilst also recognising that working across three trusts has added complexity to governance arrangements.

The Partnership is not a separate legal entity, but instead is an arms-length organisation hosted by Barts Health with an independent Chair and each Partner trust having an equal vote on Partnership business and decisions.

The Partnership's governance is set out in a detailed Collaboration Agreement approved by the boards of the three trusts. The basic governance structure is shown below:



* Only during transformation period. Not part of permanent governance set out in Collaboration Agreement

4.1 Strategic Management Board

The Strategic Management Board (SMB) provides strategic management and oversight of the Pathology Partnership. The SMB is accountable to the board of directors of each of the trusts.

Each of the three trusts has two executive director representatives on the SMB and each trust has a single vote. The SMB is led by a non-voting independent Chair and also includes five non-voting directors from the Partnership. Following an open recruitment process, David Monk was appointed as the independent Chair of the Partnership in September 2021.

The current members of the SMB are shown overleaf:

Independent Chair:	David Monk	Lewisham & Greenwich:	Louise Crosby Chief Nurse
Barts Health:	Alistair Chesser Group Medical Director	Partnership:	Tom Butler Clinical Director
Barts Health:	Daniel Waldron Group Director of People	Partnership:	Andrew Knott Managing Director
Homerton Healthcare:	Dylan Jones Chief Operating Officer	Partnership:	Nicky Mowatt Finance Director
Homerton Healthcare:	Julia Simon Director of Strategic Implementation & Partnerships	Partnership:	Charlotte Mustoe Operations Director
Lewisham & Greenwich:	Kate Anderson Director of Corporate Affairs	Partnership:	Robin Sanham Quality& Improvement Director

One of the intended benefits of having two representatives per partner trust is to mitigate against lost institutional memory. Since the formation of the Partnership there have been a significant number of changes to trust representation, with none of the above trust representatives being an original member of SMB at the formation of the Partnership on 1 May 2021.

4.2 Clinical Board

The Clinical Board represents pathology service users across primary and acute care and facilitates the SMB in clinical decision-making for the networked pathology service. The Clinical Board provides inputs and advice on the changing pathology landscape across the network and clinical risk as well as regularly reviewing current practices and matters relating to clinical quality, performance, reporting, demand optimisation, test selection, etc.

The Clinical Board is chaired by the Partnership's Clinical Director and includes clinical leads from trusts, Partnership staff, GP and patient representatives, plus Specialty clinical and scientific leads as appropriate to the agenda (see 4.6).

Patient leadership

NHS England have commented that the inclusion of patient leadership at Clinical Board level is a pioneering innovation and have used the Partnership as an exemplar for other pathology networks in the UK. The Clinical Board is starting to lead on public engagement, including highlighting the role of the Partnership as an anchor institution, embedded in local communities.

4.3 Operational Board

The purpose of the Operational Board is to monitor the operational and financial performance of the Partnership and advise the Partnership Strategic Management Board of any operational and financial issues or changes required to deliver and maintain a safe, high quality and efficient networked pathology service.

The Operational Board is chaired by the Partnership's Operations Director and includes representatives from the Pathology Partnership and operational and finance representatives from the three trusts. The remit includes reviewing performance metrics.

4.4 Quality and Governance Board

The purpose of the Quality and Governance Board is to ensure robust quality assurance and clinical governance across the Partnership and to escalate where appropriate to the SMB.

The Quality and Governance Board is chaired by the Partnership's Quality and Governance Director and includes Partnership staff and governance representatives from the three trusts.

4.5 Transformation Board

A Transformation Phase 2 Implementation Programme Board is in place to oversee the current phase of the transformation (see section 5). It is chaired by the Partnership's Managing Director and reports to SMB. It replaced a Programme Board that steered the first phase of transformation and will be replaced with a future Programme Board for phase 3 of the transformation, with each of the programme Boards having different groups of trust and Partnership stakeholders as appropriate to that phase of the project. The Transformation Board will fall away when the Partnership's planned transformation is complete and does not form part of the governance arrangements set out in the Collaboration Agreement.

4.6 Speciality Groups

The Specialty Groups bring together clinical, scientific, operational, and quality management leadership and expertise to enable the Specialty Laboratories at all sites to provide a high quality and efficient service across the Partnership. Each Speciality has a clinical lead and a scientific lead. There are Speciality Groups for:

- Biochemistry;
- Blood Transfusion;
- Cellular Pathology;
- Haematology;
- Immunology;
- Infection;
- Transplantation;
- Specialist Integrated Haematological Malignancy Diagnostic Service (SIHMDS).

4.7 Risk management

Partnership risks are reviewed at the Quality and Governance Board with the Partnership's risks also being reviewed by the SMB. Each trust has a Quality representative at the Quality and Governance Board. Relevant risks are taken to each Trust's risk committees on an exception basis. As Barts Health is the host to the Partnership, the Partnership also provides updates and attends Barts Health Group Risk Management Meeting on a regular six monthly cycle.

4.8 Intelligent customer meetings

The Partnership's Collaboration Agreement distinguishes the relationship between the trusts as owners of the Partnership and the trusts as customers of the Partnership. SMB meetings focus on ownership issues. On a monthly basis the Partnership meets with clinical, operational and finance representatives from each trust to discuss any issues relating to services provided to the Trust by the Partnership and any services provided by the individual trust to the Partnership. These meetings build upon performance discussions at the Operational board to drill down into any issues and actions specific to the trust.

Pathology consultants continue to be directly employed by each trust. The division at each trust containing these consultants was identified at the formation of the Partnership as having the most appropriate expertise to hold the Partnership accountable and so represents the trust in these intelligent customer meetings. The three divisions identified were:

Barts Health: Group Clinical Services

Homerton Healthcare: Emergency Medicine and Rehabilitation Services

Lewisham and Greenwich: Allied Clinical Services Division

Subsequently, Barts Health undertook a reorganisation and the services provided by Group Clinical Services were absorbed within individual hospital sites. An interim arrangement was put in place and a review was undertaken by Barts Health to determine alternative arrangements. Consequently, work is currently underway to work through the governance mechanism of the Partnership linking through the Royal London Hospital. As also articulated in this review, further work also needs to take place to develop a comparable forum to intelligent customer meetings for the wider range of services that the Partnership purchases from Barts Health as the host to the Partnership, such as Payroll, Recruitment and Estates.

4.9 Internal Audit review

Barts Health commissioned an internal audit of the Partnership as part of its 2021/22 annual internal audit plan. The audit evaluated the Bart's Health's hosting arrangements and focussed on corporate governance (including the Pathology Partnership's relationship with the three trusts), risk management and financial control. The report was shared with the SMB. To quote the report "Overall, 'Reasonable' assurance is given regarding the governance arrangements and risk and control framework in operation over the NHS East and South East London Pathology Partnership."

Ten 'medium' priority recommendations were made in the internal audit report, all of which were accepted and have either been already actioned or are in the process of being actioned.

4.10 Integrated Care System governance

Increasingly, NHS England's London pathology team is seeking to work via or in conjunction with ICS representatives. The Partnership operates across both North East London ICS and South East London ICS which has created some added complexity. There is not yet complete clarity about governance arrangements for pathology within ICS' and the ICS will be developing this in the coming months.

4.11 Accreditation and regulatory oversight

The Partnership operates within a number of regulatory regimes and accreditation frameworks:

UKAS (United Kingdom Assessment Service) assessments verify that services operate to requirements set out in ISO15189, including the operation of a quality management system.

MHRA (Medicines and Healthcare products Regulatory Agency) is responsible for regulation of blood transfusion.

HTA (Human Tissue Authority) regulates the safe use of human tissue and organs.

NICE (The National Institute for Health and Care Excellence) evaluates diagnostic technologies.

PQAD (Pathology Quality Assurance Dashboard) is a NHS England high level dashboard to provide high level comparable metrics between pathology providers.

GIRFT national report on pathology (Getting It Right First Time) is a national programme designed to improve treatment and care. A specific report on pathology made a wide-ranging series of recommendations which the Partnership is implementing.

Richards Review - Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England, particularly focussing on diagnostic centres outside of acute hospitals such as Community Diagnostic Centres.

NHSE network maturity – a tool to evaluate pathology network, described in section 7.

5. Delivering the first twelve months of the transformation

5.1 Key transformational service changes

The Partnership moved from formation in May 2021 straight into delivering the first phase of transformation in July 2021.

The key service changes completed to date to deliver the Partnership's Target Operating Model are:

Phase 1a	Move of Homerton Healthcare GP Direct Access work to hub laboratory at Royal London Hospital underpinned by work on standardising tests and IT infrastructure (July 2021). This freed up laboratory space to enable the rebuilding of the Homerton laboratory.
Phase 1c	Upgrading of LIMS software at Barts Health laboratories in October 2021 in readiness for future implementation of digital pathology. This will be the software used for the single LIMS across all three trusts. The phasing of this change was moved (and hence the numbering is out of sequence).
Outside of transformation	Transfer of Lewisham and Greenwich GP Direct Access work to Synlab in November 2021. The loss of Lewisham and Greenwich's GP work was potentially identified in the FBC and became a reality. An update to the FBC was produced in recognition of this change and approved by trust boards in February/March 2021.
Phase 1b	Move of Homerton Healthcare Microbiology and Virology to hub laboratory underpinned by work on standardising tests and IT infrastructure (December 2021). This move also enables the rebuilding of the Homerton laboratory.

Future phases of the transformation to deliver the Partnership's Target Operating Model are:

Phase 2	Completion of rebuilding of Homerton Healthcare's laboratory as an Essential Services laboratory (led by Homerton Healthcare). Re-equipping of laboratory, test standardisation, full implementation of single LIMS and consequent staffing changes to fully integrate the service into the Partnership's network (January 2023).
Phase 3	Full Implementation of single LIMS and consequent staffing changes to transform Queen Elizabeth Hospital and University Hospital Lewisham laboratories into ESLs (with the addition of Cellular Pathology) and fully integrate the service into the Partnership's network (December 2023).

Work started on Phase 2 of the transformation almost straight after completion of Phase 1. The rebuilding of the Homerton laboratory was led (and funded) by Homerton Healthcare with very active involvement by the Partnership. The rebuilding of the laboratory will modernise the working environment for staff. As building work neared completion, in July 2022 the Partnership took over overall responsibility for programme management. The current target date for moving the newly rebuilt and re-equipped Homerton laboratory onto the single LIMS is 31 January 2023.

Developing a shared LIMS requires agreement by clinicians on standardising tests. Although Homerton is moving first onto the shared LIMS, there needs to be agreement by clinicians from all three partner trusts on test standardisation to avoid the need for any reworking when Lewisham and Greenwich also

move onto the shared LIMS. Work to date on agreeing standard tests - including Microbiology and Virology which has already moved from Homerton to the hub – has been very positive.

5.2 Impact of transformation on staff

The transformation has a big impact on staff and in the first 12 months the Partnership has carried out seven separate staff consultations. Further consultations will be required as the transformation progresses into Phase 2 and Phase 3.

The impact of introducing a hub and ESL model is significant. Centralising non-urgent work at the hub requires some staff to move their base to the hub laboratory. Because ESLs only carry out a limited repertoire of (mainly Blood Science) tests for urgent, acute patients, affected staff need to rotate between the hub laboratory and ESLs to maintain skills and training. The increased use of automation also enables changes to be made to the skill mix to make more effective use of skilled staff, who are in short supply. At the same time a new, integrated management structure is required to operate the Partnership as an arms-length network.

In the first 12 months the Partnership has carried out consultations on:

May 2021	TUPE transfer of Lewisham and Greenwich pathology staff to Barts Health as host of the Pathology Partnership
May 2021	TUPE transfer of Homerton Healthcare pathology staff to Barts Health as host of the Pathology Partnership, also covering transfer of staff to as part of move of GP work to the hub
May 2021	New management structure covering managerial and scientific staff of band 8B and above
September 2021	New management structure covering managerial and scientific staff at band 8A. It was necessary to have the 8B+ managers in post to have the resources available to carry out the second consultation
September 2021	Transfer of Homerton Microbiology and Virology work and staffing to hub laboratory
November 2021	TUPE transfer of four drivers employed by Lewisham and Greenwich to City Sprint, Synlab's logistics provider as a consequence of the transfer of Lewisham and Greenwich's GP Direct access work to Synlab
March 2022	Mobility consultation to enable flexible working across all Partnership sites

The consultations have been carried out with strong collaboration and input from staffside. Every member of staff has been involved in one or more consultations and we have has endeavoured to ensure that specific groups of staff are not subjected to multiple consultations in a short time.

No redundancies have been made as a result of the staff changes.

The move of Lewisham and Greenwich's GP direct access work to Synlab resulted in a significant amount of time discussing with South East London CCG and Synlab whether laboratory staff should TUPE transfer with the GP work. The Partnership successfully argued that TUPE was not applicable, except for four drivers whose role was specifically to collect GP samples.

5.3 Contractual enabling of transformation

Another key enabler of the transformation in the first year has been putting in place contracts to consolidate onto a single LIMS, to standardise analytical equipment and for a single logistics contract to move samples to the appropriate laboratory in the network, including collecting samples from GPs and other community providers. Consolidation, retendering and renegotiation of major contracts is also a significant area for delivering non-pay efficiencies. Because the Partnership is hosted by Barts Health, all contractual relationships with suppliers for the Partnership are via Barts Health. In the first year of operation, all pathology contracts that existed prior to the Partnership have been legally novated (transferred) across to Barts Health.

One consequence of the national consolidation of pathology into 29 networks is that nationally contracts have grown in scale and there is more at stake for suppliers who win or lose contracts.

In the first year three critical contracts have been renegotiated/tendered:

- The Managed Equipment Service (MES) previously held solely by BHT for the provision of analytical equipment and consumables has been through a formal negotiation process to extend the contract to include the other two trusts. This change enables the Partnership to deliver economies of scale through larger volumes.

- The Partnership has expanded the BHT LIMS contract to include the other two partners and work is underway to move all to a cloud-based single integrated LIMS. This will provide more visibility of results across the Partnership and better enable cross-site working.

- The Partnership has tendered and implemented a new contract for provision of courier services across the Partnership. The Partnership faced a series of lengthy legal challenges from one of the losing incumbent suppliers which resulted in a six month delay in implementing the contract and significant time spent addressing the legal challenges. .Although initially delayed due to legal issues this contract is now fully operational.

The Collaboration Agreement contained high level service level agreements (SLAs) between the Partnership and the partner trusts for support services provided to the Partnership such as IT, Estates, Finance, HR, etc. Most support services are provided by Barts Health as the host, but smaller SLAs for IT and Estates are held with the other two Partners. The Partnership and partner trusts are continuing to work together to develop more detailed SLAs for support services. The Collaboration Agreement also sets out a SLA and Key Performance Indicators Is for the provision of services by the Partnership to the partner trusts.

All SLAs/contracts for the Partnership to provide pathology services to other customers have remained with the respective trust (which keeps the income).

6. Year one BAU performance and significant operational issues

We cannot completely separate business as usual from transformation as they are inextricably linked, and the same management team is leading both.

Performance (turnaround times) has generally been good during the first year, with the main area of challenge being in Cellular Pathology provided at the Royal London hospital for Barts Health and Homerton Healthcare patients. Cellular Pathology was not part of the transformational change programme set out within the FBC for the Partnership, but a number of long-term historic issues related to under-staffing and equipment in conjunction with large increased demand has caused severe reductions in performance against the Royal College of Pathologists' 10 day turnaround standard for samples of suspected cancer. There is also a national shortage of Histopathology consultants, who play an integral role in delivering these turnaround times, and historically consultant vacancies at the Royal London had masked laboratory staffing and infrastructure issues.

Consequently, we have worked on business cases to strengthen the laboratory service, in conjunction with the Histopathology lead at the Royal London Hospital. A significant investment in additional scientific staff as well as additional dissection tables was approved by Barts Health and Homerton in via two business cases in February and March 2022 as part of a recovery plan to improve performance.

As with any operational service, there have been unanticipated issues which have taken up a significant amount of management time. This has included managing a national shortage of blood tubes which required active coordination across the healthcare system and managing demand to reduce tube usage. Because of the types of tube in short supply, this was much more of an issue for Barts Health and Homerton Healthcare and NEL GPs than Lewisham and Greenwich.

COVID has had an impact on all disciplines within Pathology, both in terms of staff sickness affecting service delivery, but also within Virology which provides COVID testing and where there have been challenges to provide additional temporary staff to carry out required levels of testing. The service has seen a stepped increase in activity following the recovery of activity levels within the partner trusts' hospitals.

Recruitment has continued to be a major operational challenge and staffing shortages have remained consistent. Our vacancy rate has been:

2021/22											
May	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**April**
12.8%	12.1%	11.8%	13.0%	14.6%	13.7%	14.6%	14.7%	10.8%	11.3%	11.4%	12.2%

Having five pathology networks in London and relatively good public transport links makes London a very competitive employment market for pathology. This is compounded by two of the networks being non-NHS and so having flexibility to offer bonuses and pay rates outside of normal NHS terms and conditions.

Many of our less senior roles do not require specialised qualifications. A growing concern is that continuing inflationary pressures increase the pay differential between pathology salaries and alternative non-pathology employment options and so make it harder to recruit and retain junior staff. The Partnership is developing a recruitment and retention plan, which is covered in section 8.

One of the challenges that the Partnership faces in terms of tracking demand and performance is the lack of reliable and comparable data, for different reasons, for each of the partner trusts. Until all trusts are using the same integrated LIMs inconsistencies with data and performance reporting will continue but a significant amount of work is continuing to be done to rectify some fundamental data quality issues and to standardise data as far as possible. Looking to the future, data will be loaded into a single data

warehouse which will allow activity trends to be reported alongside workforce and financial data and enable better business and operational decisions.

Financial performance has been good with the Partnership staying within budget in 2021/22 with an underspend of £3.1m which was shared across the partner trusts. However, this was largely due to a large number of vacancies in laboratory and scientific roles due to recruitment challenges offset by recurrent overspends in non-pay consumables. Transitional cost budgets also have not been fully spent in the first year mainly due to contingencies remaining unused. The planned savings for the first year were small, but the Partnership delivered £494k recurrent savings against a target of £632k. The shortfall was due to slight delays in the transformation pipeline but was covered in-year by non-recurrent savings and is planned to recover as the transformation progresses.

7. NHS England's evaluation of network

Nationally, NHS England is using a tool called the 'maturity matrix' to assess the development of pathology networks. Each network is evaluated against seven main domains, 18 domain sub-categories and subject areas, which are broken down into a total of 38 sub-sets to assess each network's current level of maturity and plans for the next two years (to 2024/25).

NHS England has identified five levels of maturity – 'Pre-emerging', 'Emerging', 'Developing', 'Maturing' and 'Thriving'. Every network is required to reach 'Developing' status by December 2022 and to achieve 'Maturing' status by 2024/25, irrespective of when it was formed. The Partnership was the last of the five London networks to be set up.

A regionally and nationally moderated assessment of plans was completed by NHS England, which said of the Partnership:

> "Following the moderation exercise, we have placed the Network as being in the early phases of the 'Maturing' phase of the Matrix reflecting the fact that it is still relatively early on in its development since formation. Although there is some underlying variation in domains (Governance, Leadership, Operational, IT & Digital, Workforce), this reflects a strong performance overall, exceeding the national expectation that all networks meet the 'Developing' maturity status by December 2022.
>
> "We would like to recognise and thank (the Partnership) for the significant work undertaken to develop the Network in line with the Long-Term Plan recommendations."

NHS England's evaluation is summarised below:

Pathology Domain	Domain Sub-Category	Maturity Stage	Domain Maturity Stage
Governance	Executive Governance Structure	Developing	Developing
	Clinical Governance	Developing	
	Commercial Structure	Maturing	
Leadership	Network Leadership	Developing	Maturing
Operational	Laboratory Operating Model	Developing	Emerging
	Clinical Laboratory Operational Forum	Emerging	
	Point of Care Testing	Emerging	
Quality	Quality	Maturing	Maturing
	Continuous Improvement	Developing	

Pathology Domain	Domain Sub-Category	Maturity Stage	Domain Maturity Stage
IT & Digital	LIMS, Ordercomms and Interoperability	Emerging	Emerging
	Digital Histopathology	Emerging	
Workforce	Workforce Strategy	Developing	Developing
	Recruitment & Retention	Developing	
	Training and Education	Developing	
Shared Supply Chain	Asset Ownership	Maturing	Maturing
	MES Replacement	Maturing	
	Financing Options	Maturing	
	Procurement	Maturing	

8. The year ahead

As set out in section 5.1, the Partnership is now firmly focussed on delivering Phase 2 of the transformation to rebuild and re-equip Homerton's laboratory as an Essential Services Laboratory and move Homerton onto the single LIMS. The rebuilding of Homerton's laboratory has added additional complexity to the critical path to complete this phase of the transformation and there have been delays to completion of the building work, However, we are currently on track for an agreed date of 31 January 2023. At this point Homerton will be fully integrated into the network. Technical data cleaning work has also begun in preparation for Phase 3 to move Lewisham and Greenwich onto the single LIMS.

Monkey Pox testing

When the recent Monkey Pox outbreak first started, samples needed to be sent away to a national centre for testing.

Our virology laboratory rapidly developed in-house testing for Monkey Pox, which sped up getting positive and negative results to patients, reduced costs and meant our LIMS could be used to send out results which saved time for clinicians and laboratory staff.

At Lewisham and Greenwich work is also taking place to move the Cellular pathology team at University Hospital Lewisham off an unsupported LIMS and onto the current LIMS used by all other pathology services operating at Lewisham and Greenwich. This work is a requirement for Phase 3 of the transformation to move Lewisham and Greenwich from their current LIMS onto the Partnership's shared LIMS.

The Partnership will also be working collaboratively with Lewisham and Greenwich on a potential redevelopment to part of the trust's estate at University Hospital Lewisham which could impact on the Cellular Pathology laboratory at this hospital. No date has yet been set for the redevelopment work.

Work will be continuing to drive up performance of Cellular Pathology at the Royal London hub. An action plan is in place to ensure the delivery of performance improvements as additional staff are recruited and trained and three new dissection tables are installed to remedy a major process bottleneck.

Barts Charity has provided funding to develop digital histopathology at Barts and work will be taking place on this project in 2021/22. Longer term funding has also been bid for from NHS England to extend the roll-out of digital histopathology to other sites in the network in future years. Funding has also been obtained for the development of digital haematology to enable blood slides to be digitalised and shared across the network.

The Partnership's Quality team are working on the roll-out of a single Quality Management System (QMS) across the Partnership. This will standardise and simply Quality Management and is an essential requirement for us to move all of our laboratories onto a single UKAS accreditation as the Homerton and Lewisham and Greenwich laboratories are integrated into the network.

There is also going to be an expansion of UKAS laboratory accreditation to include Point of Care Testing (POCT) within the main laboratory accreditation, with pathology laboratories being responsible for POCT Quality Assurance and training. The growing importance of POCT has been illustrated by the successful use of POCT for COVID testing in partner trusts' Emergency Departments and other locations to maintain the flow of patients around hospitals. The Partnership is currently starting a piece of work with trust POCT Committees to ensure that the quality control and training elements of POCT provided by the Partnership meets the developing needs of the trusts. NHS England is placing increased emphasis on POCT and it is one of the dimensions covered in maturity matrix evaluations (see 7).

With Integrated Care Boards (ICBs) being established on 1 July 2022, NHS England is increasingly seeking to ensure that there is joined-up governance and working between pathology networks and ICBs and more work still needs to be done in this area. The Partnership works across both North East London and South East London systems which adds complexity, but has been manageable to date.

A long-standing challenge faced by pathology services is that increased or new activity by other parts of healthcare systems can increase the demand for pathology tests and staffing without there being any additional funding to cover the additional workload in pathology. The Partnership is working to become increasingly embedded into each of the trusts' activity planning processes to build wider system changes into our planning and funding.

Finally, as set out in the next section, NHS England is seeking to integrate Barking, Havering and Redbridge University Hospitals NHS Trust's pathology service into our pathology network. Work to date has already taken up a significant amount of management time.

9. Integrating BHRUT into the network

In March 2022 NHS England wrote to Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), the Partnership, Barts Health (as host to the Partnership) and North East London ICS (NEL) asking the organisations to work together "to develop a plan to create a networked solution for pathology services at BHRUT."

NHS England set out that "The pathology services at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) currently remain outside of any Pathology Network" and that "the solution should offer improvements to the sustainability and quality of services delivered for the population of East London as well as representing best use of available resources irrespective of current network membership."

BHRUT, NEL and the Partnership have worked collaboratively on a plan. NEL commissioned a specialist pathology consultancy (which also worked on the Partnership's FBC) to assist in developing this plan. One particular issue identified by BHRUT is to ensure that any future configuration of pathology services must be able to address significant population growth forecast for their geography. BHRUT has a pathology laboratory at each of its two hospital sites.

Under the Partnership's Collaboration Agreement signed by all three trusts, any new partner or major customer needs to be approved by the boards of all three trusts.

The shared view of the Partnership, BHRUT and NEL is that the integration of BHRUT into the Partnership will require the approval of an Outline Business Case and Full Business Case by all parties (including partner trusts) to clearly articulate the benefits, costs, saving and risks of any expansion of the network. It is anticipated that there are likely to be capital requirements associated with the integration. Any revised model must not disadvantage any of the existing partner trusts within the Partnership.

Work will also need to be undertaken to determine the most appropriate legal arrangements for adding another trust to the Partnership (whether as partner, customer or another arrangement) and is likely to require significant changes to the existing Collaboration Agreement.

The plan submitted to NHS England focusses on the development of an OBC and FBC because only when options are explored and worked through in detail will it be possible to commit to a meaningful timeline for integrating BHRUT into the network.

A key challenge will be to ensure that time spent planning for the integration of BHRUT does not detrimentally impact distract the delivery of our existing transformation or BAU service provision. The timing of the Partnership's future transformation phases have been factored into the plan submitted to NHS England. NHS England recognised in their letter that "work involved in developing and implementing this (integration plan) will require significant management time and bandwidth from all parties." Therefore, we believe that it is important that there is a properly resourced and funded integration team in place which adds the necessary capacity to avoid a significant risk to the existing transformation and BAU service.

As set out in section 5.3, the Partnership has committed to a number of major contracts required to establish the network. Adding a new member will require renegotiation/re-tendering of these contracts and potentially will be more complex than establishing a new network.

Integration of BHRUT will require BHRUT laboratories to use the Partnership's shared LIMS, which will need to interface with BHRUT's clinical systems. All three existing trusts in the Partnership use Cerner as their Electronic Patient Record (EPR) system, but BHRUT does not yet have an EPR. Any work undertaken to roll-out and integrate the Partnership's LIMS with BHRUT's existing clinical systems would need to be discarded at the point that BHRUT implements an EPR and, when this happens, a new LIMS: EPR integration would be required.

Discussions are continuing with NHS England about this plan, funding and the pace of any integration.

NHS
Barts Health
NHS Trust

Report to the Trust Board: 18 January 2023	TB 10/23

Title	Clinical Research Network (CRN) governance arrangements
Accountable Director	Chief Medical Officer
Author(s)	Dr Sharon Barrett (Chief Operating Officer, CRN North Thames)
Purpose	To seek approval of CRN North Thames governance arrangements
Previously considered by	Joint Research Board

Executive summary
The National Institute for Health Research (NIHR) Clinical Research Network (CRN) is the clinical research delivery arm of the NHS in England. Barts Health NHS Trust acts as host to the Clinical Research Network. A mandated obligation for the Trust as host is to approve the CRN Governance Arrangements

Related Trust objectives
Leading the way in research and education

Risk and Assurance	This report provides assurance in relation to section 4.3 of the Performance and Operating Framework that Host Organisational Board delivers on the LCRN contract in terms of overarching governance.
Related Assurance Framework entries	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	The Barts Health Group Chief Executive Officer is the Accountable Officer for the Department of Health and Social Care (DHSC) LCRN contract and its delivery

Actions required:
The Trust Board is asked to approve the attached governance framework.

NIHR | Clinical Research Network North Thames

NIHR CRN North Governance Framework

Consultation in use from September 2021

Version 6

Version	Date	Changes Made
1.0	Oct 2013	Governance Framework presented to the Partnership Board (agreed 11Nov 2013)
2.0		Updated framework to include scheme of delegation, Host Board Controls, Assurance Framework, Business Continuity Arrangements and escalation process' and financial controls.
3.0	Aug 2016	Biannual update and updated to reflect the changes recommended from 14/15 CRN Finance Audit
4.0		Changes made to V4 never implemented or signed off
5.0	Dec 2018	Biannual update including changes to Senior Management and leadership Team . PA
5.1	Jan 2019	Formatting & updated branding - GH
5.2	Feb 2019	Addition of chart - GH
6.0	Sep 2021	Significant changes made and approved by Executive Group 24/09/2021

1. Introduction

1.1. The National Institute for Health Research (NIHR) Clinical Research Network (CRN) is the clinical research delivery arm of the NHS in England. Its purpose is to ensure patients and healthcare professionals from all parts of the country are able to participate in and benefit from clinical research; integrate health research and patient care; improve the quality, speed and coordination of clinical research; increase collaboration with industry partners and ensure that the NHS can meet the health research needs of industry.

1.2. Before April 2014, there were over 100 clinical research networks in England hosted by NHS Trusts in adjacent localities. From April 2014, there will be only one research "Network" of the NIHR CRN in each NHS region, these are termed Local Clinical Research Networks (LCRNs). The formal name of the LCRN in the North Thames region is NIHR CRN: North Thames (the LCRN). Barts Health NHS Trust (the Trust) successfully applied to host this network on behalf of the NIHR and local Partner Organisations.

1.3. The Trust is committed to providing safe high-quality care and has developed a range of policies, systems and processes which together comprise robust and integrated Assurance and Escalation, and Risk Management Frameworks. The principles of which have informed this document to ensure high-level, informed accountability of the Trust Board for the good governance of the LCRN.

1.4. This document describes the processes and controls established by the LCRN to ensure good governance. This document provides governance assurances for delivery of the Department of Health issued Contract and Performance Operating Framework which is concerned with (i) the transition of 10 NIHR research networks into the NIHR CRN North Thames and (ii) the hosting of the LCRN after fully transitioned.

2. Purpose

2.1. This framework describes the LCRN's scheme of delegation, Board controls and assurances, assurance framework and risk management system, and escalation process for the management of the LCRN.

2.2. This framework will be reviewed by the LCRN Executive Group on a bi-annual basis in order to reflect any changes in governance, assurance and escalation processes.

3. General principles

3.1. In accepting the Authority's contract for the LCRN, the LCRN Host Organisation will note these General Principles in relation to LCRN Governance, as set out in section A.3. of the CRN POF:

- Work within clear accountability arrangements
- Ensure equity of access in respect of research participation and opportunities
- Patient and public involvement and engagement
- Partnership working (with LCRN Partners) and collaborative decision making
- Transparency
- Consistency

3.2. The **LCRN Host (Barts Health) Organisation Board** shall decide the arrangements for monitoring and assurance in respect of LCRN contract delivery and compliance, subject to these minimum requirements:

- The Board approves the LCRN Governance Arrangements
- The Board approves the LCRN Scheme of Delegation
- The Board approves the LCRN Annual Plan
- The Board receives the LCRN Annual Report

3.3. The **LCRN Host Barts Organisation** shall maintain a simple Scheme of Delegation document in relation to the LCRN Hosting (Leadership and Management) function that sets out the key matters that are delegated, and the individual or committee/board to whom authority is delegated (see section 5)

3.4. The **LCRN Host Barts Organisation**, along with the LCRN leadership, are responsible for developing governing structures, systems, terms of reference and local working practices for working for the LCRN. The specific governance requirements required are detailed in this framework and in respect of:

3.4.1.1. The Accountable Officer
3.4.1.2. The nominated Executive Director
3.4.1.3. Scheme of delegation and Host Board controls and assurances

3.4.1.4. Assurance framework and risk management system
3.4.1.5. Escalation process
3.4.1.6. CRN North Thames Leadership and Management Groups.

3.5. NHS patients, carers and the public are the key stakeholders in NIHR CRN research and are to be included in LCRN governance arrangements. Patient, carer or public representatives have been included in the agreed membership of the Partnership and Executive Groups.

3.6. LCRN governance arrangements are required to be formally signed off by the Trust Board and by the national CRN Coordinating Centre.

4. Accountable Officer and nominated Executive Director

4.1. The **CRN North Thames Accountable Officer** is the Trust's Group Chief Executive Officer, **Shane deGaris**.

4.2. The **Nominated Executive Director** for the CRN North Thames is the Barts Health Trust's Medical Director Dr Alistair Chesser.

5. Scheme of Delegation

5.1. This Scheme of Delegation should be approved by the Host Organisation Board

5.2. The LCRN Bart's Health Host Organisation's Chief Executive Officer, **Shane deGaris** is the **Accountable Officer** for the Department of Health and Social Care (DHSC) LCRN contract, and therefore for delivery against and compliance with that contract.

5.3. The LCRN Host Organisation shall maintain a simple Scheme of Delegation document (see appendix 1) in relation to the LCRN Hosting (Leadership and Management) function that sets out the key matters that are delegated, and the individual or committee/board to whom authority is delegated. **Dr Alistair Chesser** is the LCRN **Host Organisation Nominated Executive Director** for the LCRN

5.4. Informed by the LCRN contract and Performance Operating Framework, the Trust Board has agreed a specific scheme of delegation of authority to the core **LCRN Executive Leadership Team** (Clinical Directors and Chief Operating Officers) to ensure good governance of the LCRN.

5.5. The Host Trust has appointed **Professor Margaret Johnson** (Royal Free) **and Professor David Wheeler** (Royal Free) as the **Co-Clinical Directors**. The Co-Clinical Directors have local overall responsibility for the LCRN reporting to the Nominated Executive Director and the national CRN Coordinating Centre. The Clinical Directors also lead in the engagement of the regional clinical and research community, promoting research and building clinical research capacity. The Trust has appointed a **Deputy Clinical Director**, **Dr Paul Fleming** (Homerton) who reports to the Co-Clinical Directors and whose remit is to support the Co-Clinical Directors.

5.6. The Host Trust has appointed **Dr Sharon Barrett** as **Chief Operating Officer** in March 2021, who is responsible for the day-to-day operational delivery of the contract and overall operational management of the network. The Chief Operating Officer (COO) reports to the LCRN Clinical Directors and the national CRN Coordinating Centre. The Board understands that it is a contractual obligation to ensure that the Chief Operating Officer is a Trust employee.

5.7. The Trust through partnership has appointed **Adeeba Asghar** **as Deputy Chief Operating Officer** in May 2021 (dCOO) who reports to the Chief Operating Officer.

5.8. **LCRN Executive Leadership Team** is the high-level decision making and ratification group for LCRN business, and that is accountable to the LCRN Host Organisation Board

5.9. The **LCRN Executive Leadership Team** is in place to oversee day-to-day management of the LCRN and to make decisions on additional funding streams, business cases, strategic plans and core team staffing. This group is made up of some voting Executive members of the LCRN.

5.10. The **LCRN Executive Leadership Team** will meet on a weekly basis. Any decisions are minuted and shared with the wider Executive Group who meet formally on a quarterly basis. A minimum of three voting members are required to make decisions.

5.11. In accordance with the LCRN Contract Support Document (CSD088), LCRN Governance voting members LCRN Executive Leadership shall be:

- Host Organisation Nominated Executive Director
- LCRN Clinical Director and any Co-Directors
- LCRN Chief Operating Officer
- LCRN Deputy Chief Operating Officer

Additional non-voting members may be invited at the discretion of the Nominated Executive Director and/or the LCRN Clinical Director (see section 6.4.1 Executive Group).

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5.12 LCRN Senior Management Team

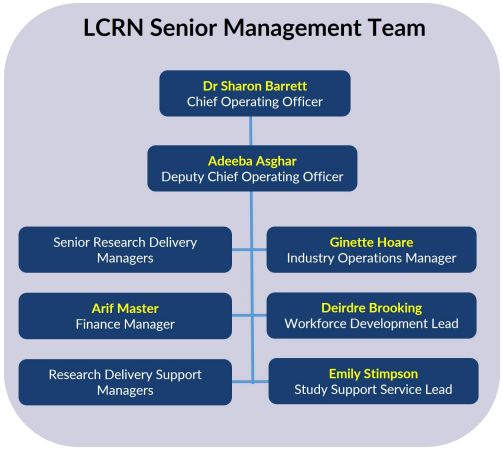
5.12.1 As per the Performance and Operating Framework and LCRN Contract Support Document CSD007, LCRN Minimum Financial Controls (Version v4.3 February 2021). Section Funding Allocations - ControlsFA1toFA7 - the objective is to ensure funding is allocated to support the delivery of CRN Portfolio research activity and is used solely for these purposes.

5.12.2 Within CRN North Thames, applications or requests for CRN funding are directed through the **LCRN Senior Management Team**.

5.12.4 The **LCRN Senior Management Team** will meet on a weekly basis and where funding decisions require ratification, these are passed onto the **LCRN Executive Leadership Team** who meet formally on a weekly basis.

5.12.5 A minimum of six voting members in the **LCRN Senior Management Team** are required to make decisions

5.12.6 Members of the **LCRN Senior Management Team** include, Chief Operating Officers, Research Delivery Managers, Industry Operations Manager, Study Support Service Manager, Senior Finance Manager and Workforce Development Lead



5.12.7 Approval limits are set out in section 13; Financial controls

5.12.8 Where decisions about funding and/or redistributions in-year are made, these are summarised and sent to the CRN Finance Team to record and make the appropriate adjustments.

5.12.9 Updated Terms of Reference can be found here

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6. Mandatory LCRN governance groups

6.1. A documented scheme of delegation for financial decisions for the LCRN exists which is formally approved and subject to annual review (see section 12).

6.2. The **LCRN Executive Leadership Team** shall put in place the following LCRN governance arrangements;

6.2.1. **LCRN Executive Group**
6.2.2. **LCRN Clinical Research Leadership Group**
6.2.3. **LCRN Operational Management Group**
6.2.4. LCRN Partnership Group

6.3. **LCRN Executive Group**

6.3.1. The Nominated Executive Director shall convene the **LCRN Executive Group**.

6.3.2. The membership and business of the **LCRN Executive Group** shall be in accordance with the Model Terms of Reference set out in Annex 1 of CSD003 LCRN Governance document.

6.3.3. In 2021, membership of the **LCRN Executive Group** was expanded to include R&D members from partner organisations who represent academic, acute, primary care, mental health trusts and public health and social care.

6.3.4. The extended **LCRN Executive Group** membership would be reviewed after twelve months.

6.3.5. Representative members of the **LCRN Executive Group** are requested to send a deputy to meetings in their absence.

6.3.6. The **LCRN Executive Group** shall be chaired by either the Host Organisation Nominated Executive Director or the LCRN Clinical Director, by mutual agreement

6.3.7. Meeting frequency and duration of the **LCRN Executive Group** shall be determined by the business requirement, with an expectation to meet at least once a quarter.

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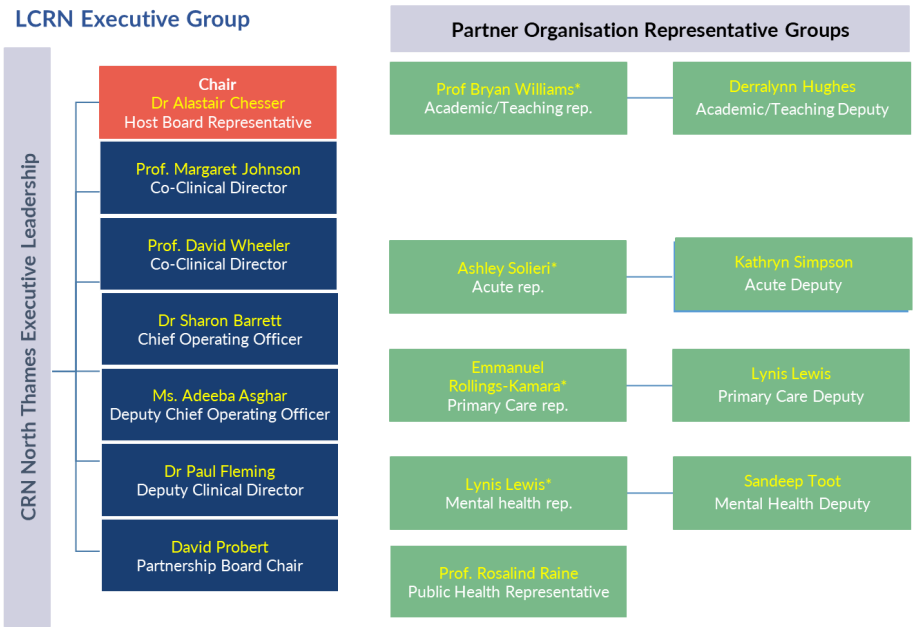
6.3.8. Fig 1



6.3.9. In accordance with the LCRN Contract Support Document (CSD088), LCRN Governance voting members LCRN Executive Leadership shall be:

6.3.9.1. Host Organisation Nominated Executive Director: Alistair Chesser

6.3.9.2. LCRN Clinical Directors; Margaret Johnson, David Wheeler, Paul Fleming

6.3.9.3. LCRN Chief Operating Officer; Sharon Barrett

6.3.9.4. LCRN Deputy Chief Operating Officer; Adeeba Asghar

6.3.9.5. **The LCRN Executive Leadership Team** have also extended the membership of this group to the Partnership Board Chair; David Probert

6.3.10. **Voting**

6.3.10.1. The **LCRN Executive Group** is expected to make decisions by consensus. In formulating strategy and making

6.3.10.2. decisions, the **LCRN Executive Group** should always have regard to the best interests of the LCRN Partners as a whole, and not the specific interests of any one party or sector

6.3.10.3. Should voting be required, only the voting members shall vote.

6.3.10.4. The Chair shall not have a casting vote.

6.3.10.5. No individual member or combination of members shall have a power of veto

6.3.11. **Quoracy** - A minimum of three voting members are required for the meeting to be quorate

6.3.12. **Business -** To support the LCRN Clinical Director and LCRN Chief Operating Officer in the development of LCRN strategies, proposals, and plans to approve:

- LCRN Strategies
- LCRN Annual Plan
- LCRN Annual Financial Plan
- LCRN Annual Report to the National CRN Coordinating Centre
- LCRN Public Annual Report

6.3.13. The **LCRN Executive Group** is expected to approve these documents pursuant to the recommendations of the **LCRN Partnership Group**. In the event that the **LCRN Executive Group** does not support the recommendations of the **LCRN Partnership Group**, then the matter must revert to the Partnership Group for consideration.

6.3.14. The **LCRN Executive Group** should maintain oversight of LCRN governance, leadership and management arrangements, which should be in line with guidance issued by the National CRN Coordinating Centre

6.3.15. The **LCRN Executive Group** should review performance against the LCRN Strategies, LCRN Annual Plan, LCRN Annual Financial Plan, and Key Performance Indicators

6.3.16. The **LCRN Executive Group** should maintain oversight of compliance with the provisions of the DHSC LCRN Host Organisation contract

6.3.17. The **LCRN Executive Group** should ensure maintenance of a sound system of LCRN internal control and risk management;

6.3.18. The **LCRN Executive Group** should ensure good relationships between the LCRN Leadership and Management Teams with LCRN Partners based on the mutual understanding of CRN purposes and policies;

6.3.19. The **LCRN Executive Group** should ensure patient, carer and public involvement and engagement is embedded in the activities and structures of the LCRN;

6.3.20. The **LCRN Executive Group** should receive advice from, and liaise with, the **LCRN Clinical Research Leadership Group** and **LCRN Operational Management Group** on LCRN strategic and operational issues

6.3.21. The **Executive Group** should ensure that risks to the efficient and effective management and delivery of the LCRN arising from internal Host Organisation policies, procedures and instructions are identified and mitigated.

6.3.22. Updated Terms of Reference can be found here

6.4. **LCRN Partnership Group**

6.4.1. **The LCRN Partnership Group, (**known as UCLP Executive Partners Group) is the formal forum of LCRN Partners. Its role is to provide active oversight, discussion and constructive challenge in relation to LCRN strategies, plans, activities, and performance in order to support the LCRN to achieve its ambitions for the benefit of all LCRN Partners.

6.4.2. The LCRN Clinical Director shall convene the **LCRN Partnership Group (see appendix 2 for list of members)**

6.4.3. The Chair shall be selected and appointed by invitation of the **LCRN Executive Group**.

6.4.4. The membership and business of the **LCRN Partnership Group** shall be in accordance with the Model Terms of Reference set out in Annex 2 of CSD088 LCRN Governance document.

6.4.5. Meeting frequency of the **LCRN Partnership Group** shall be a minimum of three meetings per year.

6.4.6. Business

6.4.6.1. advise the **LCRN Executive Group** on LCRN strategies, proposals, and plans through independent thinking and constructive dialogue;

6.4.6.2. review the following documents, confirm whether or not they are supported by the **LCRN Partnership Group**, and make recommendations to the LCRN Executive Group in respect of their formal approval:

- LCRN Strategies
- LCRN Annual Plan (drafted April - June)
- LCRN Annual Financial Plan (drafted January - March)
- LCRN Annual Report to the CRNCC (drafted July - September)
- LCRN Public Annual Report

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6.5. LCRN Clinical Research 'Specialty' Leadership Group

6.5.1. The LCRN Clinical Research 'Specialty' Leadership Group (formerly known as Clinical Leadership Group) that includes the LCRN Clinical Research Speciality Leads and is advisory to the LCRN Leadership Team.

6.5.2. The LCRN Clinical Directors shall convene the The LCRN Clinical Research 'Specialty' Leadership Group.

6.5.3. The membership of the The LCRN Clinical Research 'Specialty' Leadership Group shall include the Clinical Directors (Chair) and the **LCRN Clinical Research Specialty Leads** and Senior Management Team.

6.5.4. Meeting frequency and duration ofThe LCRN Clinical Research 'Specialty' Leadership Group shall be determined by the business requirement, with an expected minimum of one meeting every two months.

6.5.5. The role of the The LCRN Clinical Research 'Specialty' Leadership Group is to advise the LCRN Leadership Team with particular respect to:

- changes in national policies and priorities in relation to health and care research and implications for the LCRN;
- the LCRN study portfolio and the balance of the portfolio across Specialties, sites, patient groups and study composition;
- equality, diversity and inclusion in relation to LCRN studies and strategies to expand
- research participation
- resource allocations
- general clinical intelligence and advice to support LCRN research delivery.

6.6.5 Updated Terms of Reference can be found here

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6.6. LCRN Operational Management Group

6.6.1. The LCRN Chief Operating Officer shall convene the LCRN Operational Management Group.

6.6.2. The membership of the LCRN Operational Management Group shall include the Chief Operating Officer (Chair) and the LCRN senior management team and representatives from the following teams; industry, workforce, communications, finance and patient and public involvement and engagement (See Fig 2).

6.6.3. Fig 2

6.6.4. The role of LCRN Operational Management Group is to ensure effective LCRN management and performance. It will:

6.6.4.1. (a) act as the forum to address cross-divisional and operational issues;

6.6.4.2. (b) liaise with theLCRN Clinical Research Leadership Group regarding performance issues, resource allocation, the balance of the LCRN portfolio and availability of opportunities in the LCRN area for all patients to participate in research;

6.6.4.3. (c) monitor the day-to-day operational performance of the LCRN, in particular delivery of objectives;

6.6.4.4. (d) work with the CRN Coordinating Centre at an operational level on national work relating to the LCRN.

6.6.5. This group does not make decisions on funding applications or requests. This sits with the Senior Management Team.

6.6.6. Meeting frequency and duration shall be determined by the business requirement, with an expected minimum of one meeting of one hour per month.

6.6.7. Updated Terms of Reference can be found here

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7. Role of LCRN Partners in LCRN Governance

7.1. LCRN Partners should support the LCRN Leadership Team in effecting good governance by;

7.1.1. ensuring compliance with the provisions of the LCRN Partner Agreement;

7.1.2. ensuring that the Partner is appropriately and actively represented in meetings of the LCRN Partnership Group;

7.1.3. supporting and cooperating with the LCRN Host Organisation in governance-related matters, including audit;

7.1.4. (Category A Partners only) Receiving the LCRN Public Annual Report each year at the Partner organisation's Board and receiving a supplementary report from the LCRN Partnership Group representative

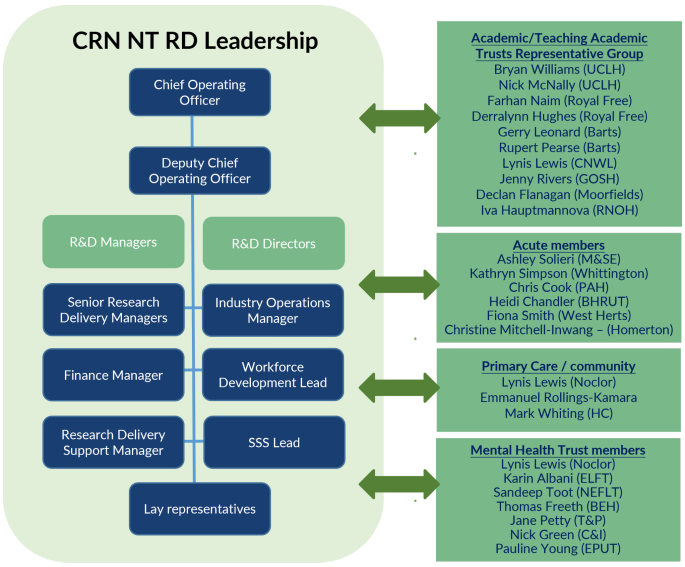
7.2. In Jan 2021, CRN North Thames introduced the **Research Delivery Leadership Group**. This replaced the CRN North Thames Advisory Board which historically met quarterly.

7.3. The role of **Research Delivery Leadership Group** is to ensure leadership and management of research delivery and cross divisional workstreams within CRN North Thames (NT) and present recommendations/proposals to senior management i.e. the NT Executive Group.

7.4. The role of **Research Delivery Leadership Group** will be chaired by a NT Chief Operating Officer (COO) and in the absence of the COO, the deputy COO will chair the meeting.

7.5. Meeting frequency of the **Research Delivery Leadership Group** and duration shall be determined by the business requirement, with an expected minimum of one meeting every two months.

7.6. Fig 3 The role of **Research Delivery Leadership Group**



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8. Other LCRN groups

8.1. Finance working group

8.1.1. The role of the CRN North Thames Finance Group is to support, review and submit recommendations to the CRN North Thames Executive Group about CRN North Thames (NT) financial management.

8.1.2. This is not a decision-making group there is no need for there to be quorate representation although it is expected that members regularly attend the meetings.

8.1.3. This group reports directly to the CRN NT Executive Group who meet every two months

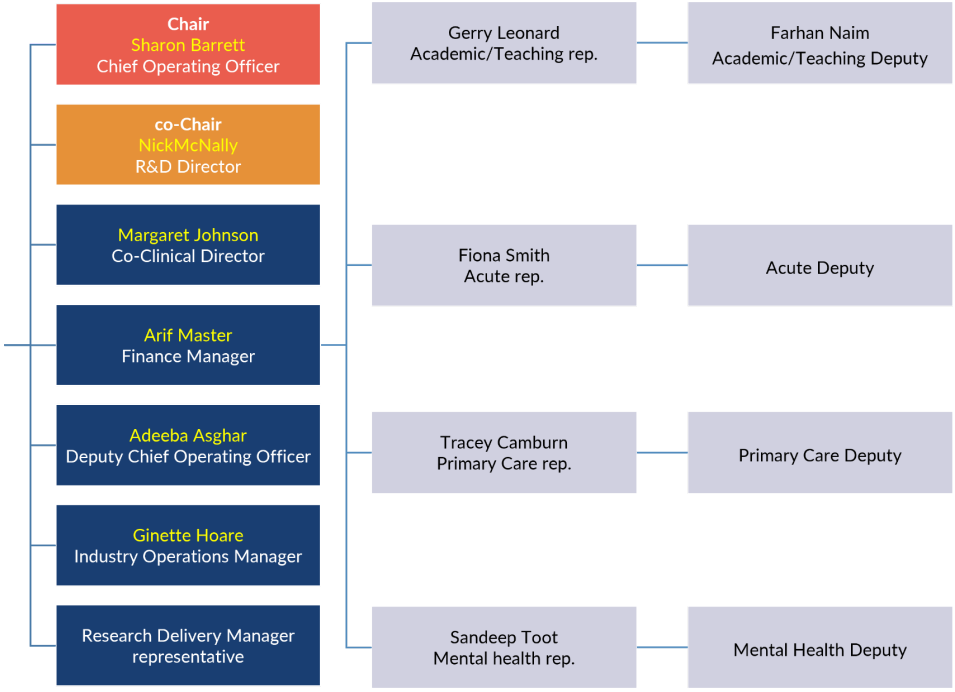
8.1.4. This group to review and change membership ahead of the next fiscal year

8.1.5. The CRN North Thames Executive Group will be chaired by NT Chief Operating Officer and co-chaired by Farhan Naim.

8.1.6. Meeting frequency and duration shall be determined by the business requirement, with an expected minimum of one meeting every two months

8.1.7. Fig 4 CRN NT Finance Working Group

CRN NT Finance Working Group



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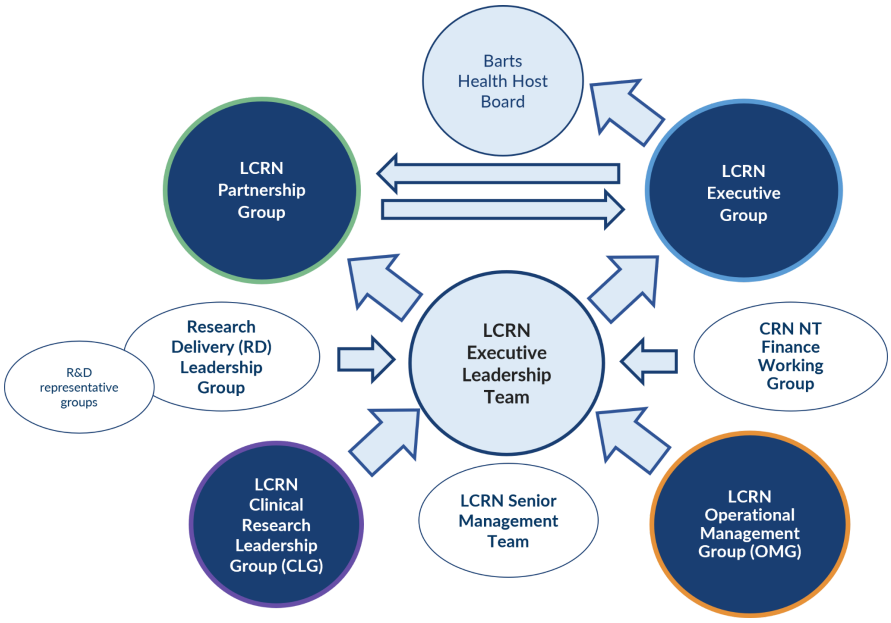
9. LCRN Governance structure

9.1. A diagram of the LCRN governance structure is included as Figure 5 outlining mandated governance groups.



10. Assurance framework

10.1. The LCRN is committed to supporting safe high-quality research and has developed a range of policies, systems and processes to clarify how issues or concerns which may detrimentally impact upon the LCRN are escalated throughout the organisation.

10.2. This section describes the structure and systems through which the LCRN Leadership and Management Groups, and the Trust board receive assurance.

10.3. The assurance framework describes how the LCRN is able to identify, monitor, escalate and manage issues in a timely fashion and at an appropriate level.

10.3.1. The LCRN has an open and learning culture encouraging monitoring and comments and concerns to be communicated relating to issues that impact on LCRN delivery. Internal sources for such opportunities will originate from staff and management as well as the governance structures for the LCRN. External sources of assurance may be obtained from;
Partners

- Stakeholder feedback and engagement
- Patients, carers and the public
- Host audit programme
- CRN Coordinating Centre
- Stakeholder and public survey results.

10.3.2. It is important that the LCRN has the capability to respond to issues or concerns in a timely fashion. In practice the response required varies considerably accordingly to the nature of the issue or concern. In some cases, immediate action may be required. In other cases, and particularly with more complex or longstanding issues, the commissioning of a full report may be appropriate response. However, the response must always be:

- Timely
- Proportionate
- Comprehensive
- Inclusive
- Effective

10.4. Internal and External Sources of Assurance

10.4.1. Regular review of performance data will be reviewed on a monthly basis through the governance groups of the LCRN. Standardised reporting will be agreed for relevant meetings and where necessary action plans developed. Where risk is identified as significant to strategic objectives issues will be identified and highlighted on the CRN risk register

10.5. CRN North Thames Risk Register

10.5.1. Clause B.3.2.5 of The 2021/22 Performance and Operating Framework sets out the expectation that "Where issues in respect of the LCRN Performance Indicators are identified, the LCRN Leadership Team shall put in place a remedial action plan, to be agreed with the National CRN Coordinating Centre. This should be documented in the LCRN's Risk Register." It is therefore implicit that each LCRN should maintain a Risk Register. Further, the Risk Register should support the LCRN Leadership Team in their risk management and risk response.

10.6. LCRN Host Organisation Annual Review

10.6.1. The Trust must review its role in discharging the Department of Health contract for hosting the LCRN and provide a report on this within the LCRN Annual Plan. This report must be shared with the LCRN Partnership Group.

10.7. LCRN Auditing Arrangements

10.7.1. The Trust is obliged to ensure that LCRN activity is included in the local internal audit programme of work. Audit should be proportionate to the activity and risks identified.

10.8. Breaches of Data Protection

10.8.1. The CRN North Thames has a separate policy on how to handle and escalate breaches of data protection that can be found within the governance process for the CRN North Thames

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11. Business continuity arrangements

11.1. The Trust has a responsibility to ensure that robust local business continuity arrangements are in place for the LCRN, to ensure continuity of service in the event of an emergency.

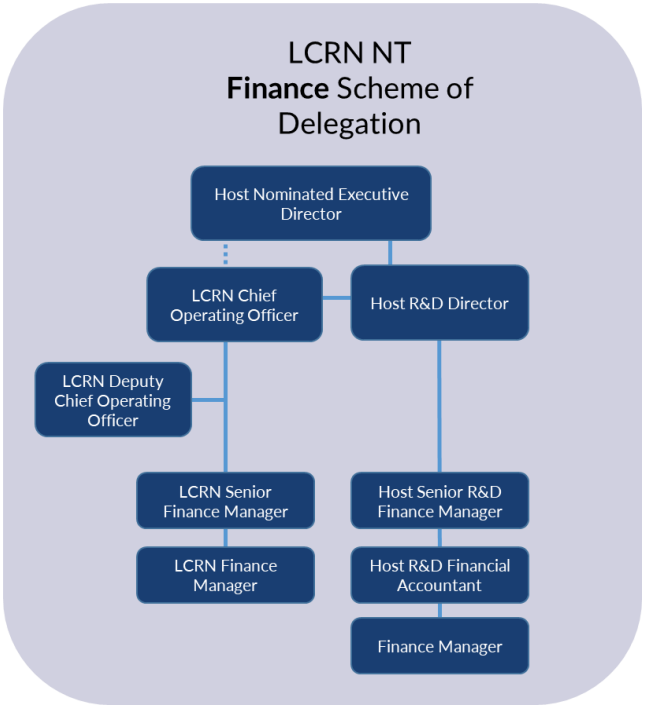
11.2. The LCRN arrangements are laid out in a separate detailed document alongside the local urgent public health plan that can be found within the governance process for the CRN North Thames.

12. Financial controls

12.1. The CRN and Host Trust have financial controls in place that are described in a Financial Management Standard Operating Procedure that can be found within the governance process for the CRN North Thames.

12.2. The Chief Operating Officer (COO) is accountable for the operational management of the LCRN, which includes responsibility for the conduct, performance, financial control and governance of the LCRN.

12.3. The LCRN working with the Host will appoint a finance manager within the Host to manage day-to-day expenditure (invoicing and payments to partner organisations)



12.4. The financial management, budgeting and reporting of LCRN funding is managed by suitably qualified and experienced finance staff both within the LCRN Host Organisation and in LCRN Partners, commensurate with the level of funding

12.5. Responsibility for approving payments is clearly allocated and is in accordance with the LCRN Host Organisation's Scheme of Delegation and authorised signatory list.

12.6. The LCRN has a responsibility for making sure CCG Excess Treatment Cost (ETC) payments from CCG ETC Financial Objective - to ensure the payment of CCG Excess Treatment Costs is made and accounted for, as instructed by the CRNCC.

12.7. Funding to Partners is clearly allocated and is in accordance with the LCRN Host

12.8. Organisation's Scheme of Delegation and authorised signatory list.

12.9. Activities outlined in this document are subject to an internal audit at least once every three years.

12.10. There are approval limits to approve financial spend (i.e. contingency/strategic applications) and depends on the values;

12.10.1. Up to **£75K** to the **Chief Operating Officers** for approval

12.10.2. Up to **£750K** the **LCRN Senior Management Team** to review and approve applications, followed by **Executive Leadership Team** ratification

12.10.3. Up to **£2m** to **CRN North Thames Executive Leadership Team** to review applications, followed by **LCRN Partnership Group, (**known as UCLP Executive Partners Group) and Host Board representative.

12.10.4. **Annual budget** allocation **CRN North Thames Executive Group** followed by **LCRN Partnership Group, (**known as UCLP Executive Partners Group) and Host Board approval

12.11. The Chief Operating Officer and LCRN finance team will meet with the Host Trust R&D Senior Management every quarter to review finances and LCRN budget

12.12. The Host Trust Board will instruct an external auditor to undertake review for LCRN finances every three years.

12.13. Risk management process

12.14. The Trust operates within a clear risk management framework which sets out how risk is identified, assimilated into the risk register, reported, monitored and escalated through the Trust's governance structures. The framework is set out in the Risk Management Policy and is supported by relevant policies, including the Risk Assessment Policy and Policy for reporting and management of incidents including the investigation of Serious Untoward incidents.

12.15. The LCRN has implemented a risk management framework, based loosely on the Trust framework, which includes an action plan and risk register. The action plan documents the work required of the host organisation in the establishment of the LCRN. In addition, a risk register has also been created by the LCRN. Both documents are reviewed monthly by the LCRN Executive Group.

12.16. Both strategic and operational risks are captured within the LCRN risk register. Each risk is assigned a risk owner and a score based on the likelihood of occurrence and the impact to the LCRN. Risk scores take into consideration any mitigating actions and are reviewed regularly.

13. Escalation process

13.1. This process describes the escalation route of issues or concerns or risks which could threaten the delivery of the Host's obligations with regards to the delivery of the Department of Health contract and Performance Operating Framework.

13.2. There are identified points of contact within LCRN management, the Host organisation, and the national CRN Coordinating Centre for concerns and issues to be escalated

13.3. Agreed escalation routes and levels are:
13.4. LCRN Clinical Director
13.5. Nominated Executive Director
13.6. The Trust Chief Executive Officer
13.7. National CRN Coordinating Centre.
13.8. The level of the organisation at which an issue should be addressed also varies considerably. The principle of subsidiarity is generally followed i.e. the lowest level consistent with providing an effective response. If one level finds that it cannot provide an effective response, it has a duty to escalate to the next level. However, escalation should not be used simply to pass on a problem.

14. Review

14.1. The Governance Framework will be subject to further development as the Trust hosting requirements and LCRN arrangements become embedded.

14.2. The Governance Framework will be reviewed on an annual basis by the LCRN Executive Group and by the Trust Board.

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Appendix 1: simple Scheme of Delegation

	Decision	Accountable Officer	Nominated Exec Director	Host Board	Partnership Board	Executive Leadership Team	Executive Group	Clinical Leadership	Clinical Directors	Chief Operating Officer
		Alwen Williams	Alistair Chesser		David Probert				Margaret Johnson	Sharon Barrett
Systems, structures, and governance	Sign contracts and variations to contracts	X								
	Nominate Executive Director	X								
	Review Executive membership annually		X			X			X	X
	Shall convene the LCRN Executive Group		X							
	Receives the LCRN Annual Report	X	x	X	X		x			
	Approves the Governance Arrangements			X						
	Approves the LCRN Scheme of Delegation			X						
	Review and approve Annual Plan			X	X		X	X	X	
	Review and approve LCRN Strategy				X		X	X	X	
	Review and approve Annual Report				X		X			
	Review and approve Annual Financial Plan				X		X		x	X
	Advise the LCRN Executive Group on LCRN strategies, proposals, and plans				X			x		
Funding	Central spend / top slice: agree					X	X		X	X
	Receive and respond to external finance audit					X			X	X
	Develop trust wide procurement strategies and efficiency savings					X	X	X	X	X
	Programme									
	Advise the LCRN Leadership Team						X	X		
Staffing	Shall appoint Chief Operating Officer								X	
	Shall convene the LCRN LCRN Clinical Research Leadership Group					X			X	
	shall conduct an annual appraisal with the LCRN Chief Operating Officer								X	
	shall be responsible for the day-to-day delivery of the LCRN contract and overall operational management of the Network									x
	Responsible for appointing LCRN core team									X
Strategy	Management of risk: establish register, review and monitor					X	X		X	X
	Advise on LCRNs vision and strategy, agreeing key priorities and key performance indicators (HLOs) against which progress towards achieving the vision can be measured					X	X	X	X	X
Governance	Governance structure (committees) for the trust: establish and					X	X		X	X
	review annually									
	Terms of reference for governance committees (agree annually)					X	X			
	Annual self-review of Executive Group and committee performance:						X			

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Appendix 2: Chief Executive Membership of the UCLPartners Executive Group

First Name	Last Name	Job Title	Organisation
Caroline	Clarke	Group Chief Executive	Royal Free London NHS Foundation Trust
Christine	Allen	CEO	West Hertfordshire Hospitals NHS Trust
Matthew	Trainer	CEO	Barking, Havering and Redbridge University Hospitals NHS Trust
Mark	Caulfield	Vice Principal for Health and Professor of Clinical Pharmacology	Queen Mary University of London
Martin	Kuper	CEO	Moorfields Eye Hospital NHS Foundation Trust
David	Probert	CEO	University College London Hospitals NHS Foundation Trust
Nnenna	Osuji	Chief Executive	North Middlesex University Hospital NHS Trust
Jinjer	Kandola	CEO	Barnet, Enfield and Haringey Mental Health NHS Trust
Paul	Scott	Chief Executive Officer	Essex Partnership University NHS Foundation Trust
David	Lomas	Vice-Provost Health / Academic Director	UCL
Siobhan	Harrington	CEO	Whittington Health NHS Trust
Verity	Brown	Pro Vice-Chancellor, Impact & Innovation	University of East London
Shane	DeGaris	Group Chief Executive	Barts Health NHS Trust
Clare	Panniker	Chief Executive	Mid and South Essex NHS Foundation Trust
Paul	Jenkins	Chief Executive	Tavistock and Portman NHS Foundation Trust
Oliver	Shanley	CEO Interim	North East London NHS Foundation Trust
Paul	Fish	Chief Executive Officer	Royal National Orthopaedic Hospital NHS Trust
Elliot	Howard-Jones	CEO	Hertfordshire Community NHS Trust
Lance	McCarthy	Chief Executive	The Princess Alexandra Hospital NHS Trust
Matthew	Shaw	CEO	Great Ormond Street Hospital for Children NHS Foundation Trust
Paul	Calaminus	Interim Chief Executive	East London NHS Foundation Trust
Tracey	Fletcher	Chief Executive	Homerton University Hospital NHS Foundation Trust
Jacqui	Van Rossum	Acting Chief Executive	North East London NHS Foundation Trust
Angela	Harden	Professor of Health Sciences	City University London

Barts Health NHS Trust public board meeting: Wednesday 18 January 2023
Written questions from members of the public

Newham Save our NHS campaign group (Ros Mykura/Alan Cooper)

Question	Reply at meeting
Barts NHS Trust 2/3 year contract with private provider Nuffield Health Private Hospital to supply NHS breast cancer surgery a. Does the contract with Nuffield Health involve re-siting the NHS team, still employed by the NHS, to the private hospital, or will this work be provided by Nuffield staff on private pay and conditions- in which case, what happens to staff in the current NHS team? b. Is Barts going to continue spending £10 million with American private provider Healthcare Corporation of America (HCA) as it did in 2021, as reported in the press, or, which other private hospitals will Barts use for NHS patients? c. How many of its own beds will Barts keep at St Bartholomew's Hospital for any private patients, and will this include private breast surgery, or will private breast surgery be available at Nuffield Health Private Hospital, allowing paying patients to jump the NHS queue for breast surgery?	**Mark Turner** **Chris Pocklington** **Mark Turner**
NHS patient charging The Chief Executive of Newham Hospital expressed interest in finding out more about NHS charging practice from charity 'Maternity Action' during a Newham Maternity Health Inequality session at Newham Council Scrutiny Commission last autumn. What progress has been made?	**Ajit Abraham**
Fire Safety work at Newham Hospital Are there any delays in the published schedule for completion of remaining work?	**Hardev Virdee**

WF Save our NHS campaign group (Terry Day)

Impact of delays at Whipps Cross A&E a. Does the Board consider that delays in ambulance handovers, and delays in admitting seriously ill patients from A&E are causing any harm to patients, or increasing the rate of avoidable deaths? b. What proportion of ambulance handovers were over 60 minutes at Whipps Cross during Oct, Nov and December 2022? What is the hospital's target for ambulance handovers?	**Chris Pocklington**

c. How many, and what proportion of the total of seriously ill patients seen at Whipps Cross A&E, were forced to remain in A&E for longer than 12 hours in Oct, Nov and Dec 2022? d. What was the bed occupancy rate at Whipps Cross in Oct, Nov and Dec 2022? Does the Board consider these rates to be safe?	
Re-admittance of elderly patients within 30 days a. Does the Board consider that monitoring the readmittance within 30 days of discharged patients is a useful indicator of the safeness and quality of hospital discharge processes? b. How many elderly patients discharged from Whipps Cross A&E had to be readmitted within 30 days of discharge in Oct, Nov and Dec 2022? c. Is the Board satisfied with Trust's rate of readmittance within 30 days of discharge of elderly patients?	**Chris Pocklington**
Risk of "warehousing" of elderly patients in care homes a. Given the recent Government announcement of block-purchase of care home beds for placement of "medically optimised" elderly patients, how many, and what proportion of total patients at Whipps Cross, does the Trust expect to utilise that facility? b. What action has the Trust taken/can the Trust take to lessen the risk that frail elderly patients are simply "warehoused" in care homes, without access to therapy or rehabilitation, against the patient's and against the family's wishes?	**Chris Pocklington**