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BARTS HEALTH NHS TRUST

TRUST BOARD MEETING (PART 1)

There will be a meeting of the Trust Board in public on
Wednesday 12 July 2023 at 11.00am in the Education Centre meeting room, Zone 2, Newham University Hospital, Glen Road, Plaistow
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 3 May 2023 and review the action log appended to the Minutes	34/23	Rt Hon J Smith	11.00
5.	**MATTERS ARISING** To consider any matters arising from the Minutes not covered elsewhere on the agenda			
6.	**TRUST BOARD MEMBERSHIP** To note changes to membership	35/23	Rt Hon J Smith	11.00
7.	**PATIENT STORY** To hear a patient story		Ms C Alexander	11.05
8.	**CHAIR'S REPORT** To receive the Chair's report		Rt Hon J Smith	11.30

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		Paper TB	Lead	Time
9.	**CHIEF EXECUTIVE'S REPORT** To receive the Chief Executive's report		Mr S DeGaris	11.35

10.	**PROVIDER COLLABORATION** To approve the North East London Acute Provider Collaborative Joint Committee Terms of Reference and recent developments	36/23	Mr M Trainer	11.40
QUALITY AND PERFORMANCE				
11.	**INTEGRATED PERFORMANCE REPORT – 2023/24 M2** To receive the report and discuss: • Quality and Safety • Operational performance • Equity • People • Financial performance	37/23	*[by exception]* Prof A Chesser / Ms C Alexander Ms R Carlton Mr A Abraham Mr D Waldron Mr H Virdee	11.45
12.	**REPORTS FROM BOARD COMMITTEES** 12.1 Finance Performance and Investment 12.2 Audit and Risk Committee 12.3 Quality Assurance Committee 12.4 Nominations and Remuneration Committee 12.5 Board Collaboration Committee	 38/23 39/23 40/23 41/23 42/23	 Mr A Sharples Ms K Kinnaird Dr K McLean Rt Hon J Smith Rt Hon J Smith	12.25
13.	**IMPROVEMENT AND TRANSFORMATION REPORT** To receive a WeImprove progress report	43/23	Ms R Carlton	12.35
14.	**NURSING, MIDWIFERY AND AHP SAFE STAFFING** To receive a report on the establishment review process	44/23	Ms C Alexander	12.45
15	**BOARD ASSURANCE FRAMEWORK** To approve the BAF and note the approach to operational plan oversight	45/23	Mr A Hines	12.55
STRATEGIC DELIVERY PLANS AND IMPLEMENTATION				
16.	**OPERATIONAL PLAN 2023/24** To receive the public facing summary	46/23	Mr M Turner	12.55
17.	**WHIPPS CROSS REDEVELOPMENT** To receive an update report	47/23	Mr A Finney	13.00

18.	**PEOPLE STRATEGY IMPLEMENTATION** To receive a report on Freedom to Speak Up	48/23	Mr D Waldron	13.10

GOVERNANCE				
19.	**YEARLY REPORTS** To note the yearly reports on: • Complaints management • Safeguarding	49/23	Ms C Alexander	13.20

20.	**ANY OTHER BUSINESS**			
21.	**QUESTIONS FROM MEMBERS OF THE PUBLIC**			13.25

22.	**DATE OF THE NEXT MEETING** The next meeting of the Trust Board in public will be held on Wednesday 13 September 2023 at 11.00am in the Boardroom, Junction 7, Whipps Cross Hospital, Leytonstone E11 1NR			
23.	**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
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BARTS HEALTH NHS TRUST

TRUST BOARD MEETING (PART 1)

Minutes of the Trust Board meeting held in public on
Wednesday 3 May 2023 at 11.00am in the Great Hall, North Wing, St Bartholomew's Hospital, West Smithfield, London EC1A

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)
Dr K McLean (Non-Executive Director)
Ms K Kinnaird (Non-Executive Director)
Ms L Seary (Non-Executive Director)
Ms H Spice (Non-Executive Director)
Ms S Teather (Associate Non-Executive Director) *
Mr C Williams (Associate Non-Executive Director) *
Mr A Abraham (Group Director, Inclusion and Equity) *
Ms C Alexander (Chief Nurse)
Professor A Chesser (Chief Medical Officer)
Mr H Virdee (Chief Finance Officer)
Mr A Hines (Director of Corporate Development) *
Ms R Carlton (Chief Operating Officer)*
Mr D Waldron (Director of People) *
Mr M Turner (Interim Director of Strategy) *

In Attendance:
Ms S Nimmo (Group Director of Midwifery)
Mr J Hibbs (Group Director of Communications)
Mr S Collins (Trust Secretary)
Mr S Sharma (Deputy Trust Secretary)

Apologies:
Ms J Ferns (Non-Executive Director)

** Non-voting member*

37/23 WELCOME

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

Apologies were noted.

38/23 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.

39/23 MINUTES OF THE PREVIOUS MEETING

The Minutes of the meeting of the Trust Board held in public on 1 March 2023 were received and approved.

40/23 MATTERS ARISING

There were no matters arising.

41/23 STAFF STORY

The Board heard from five members of staff, from a variety of backgrounds (including domestic ancillary services, portering and security), who had been recently transferred into Trust employment from previous engagement with Serco, following the Trust's commitment to insource these services. They each gave accounts of their experiences since working for the Trust. A key theme of the accounts provided was that there had been many benefits of this change, including more opportunities for training and staff development as well as the positive feeling of being included in part of the Trust's 'family' working as part of a wider team and more directly connected with satisfying work to support patient care.

Ms Teather asked how the work culture felt different now that they were working at the Trust. In response, the prevailing view was that that there was a more inclusive feeling that teams were co-operating for the benefit of service users, reduced work in silos, in addition to a 'blame free' culture.

Dr McLean asked how the staff felt about their future career opportunities. The staff members reported that training had empowered more team members to progress in their careers and in turn provide training for newer members in the department.

Mr Sharples asked if there were any obstacles or frustrations felt by the new staff. The response reflected on a number of new things to adapt to and that there were opportunities to simplify some processes.

The Group Chief Operating Officer highlighted the importance of an open and honest culture and wanted to know whether the staff members felt that issues

could be raised and escalated where needed. Staff members felt assured that escalation processes were in place and welcomed the approach of leaders to receiving feedback.

In response to a question from Ms Kinnaird about retaining positive aspects of previous ways of working, staff members highlighted the opportunities to look more externally including relationships with community services and local partners.

The Group Chief Finance Officer noted the importance of recognising that over a thousand individuals had been transferred into Trust employment since the end of last year and the importance of capturing the benefits to the organisation that were available.

The Group Director of People was inspired to hear the enthusiasm of the newly transferred staff and encouraged them to continue to share their stories and ideas. He confirmed that a priority for the organisation was tackling violence and aggression and was pleased to see the passion of security team members to help in tackling this. He noted the overarching need for a flexible workforce and encouraged colleagues to explore opportunities to extend and broaden their roles.

42/23 CHAIR'S REPORT

The Chair noted there two strikes had been held by junior doctors since the last meeting. Board members recognised the strength of feeling around a real terms drop in pay and the right to take action, while also acknowledging this had an impact on services and would increase waiting times. There had been a collective effort to mitigate the impact to patients across the Trust. The Chair felt that, going forward, provision of services during similar levels of industrial action would be unsustainable and hoped that negotiations with unions could be concluded quickly. She outlined the challenging financial climate, noting regular conversations with the Integrated Care Board as well as national colleagues around developing realistic financial plans that recognise the high demand for care, emphasising that high quality of care for patients remained the overriding priority. The Chair thanked the Chief Executive of Barts Heritage and colleagues for supporting a series of events during March to commemorate the 900th anniversary of St. Bartholomew's Hospital. She confirmed that the Great Hall would shortly be closed for renovation work, with an opportunity for public visits prior to this temporary closure. The Chair outlined her recent activity including a tour of Newham University Hospital in March. The Chair confirmed that the redevelopment of Whipps Cross University Hospital remained a high priority despite delays to the timescale for completion.

43/23 GROUP CHIEF EXECUTIVE'S REPORT

The Group Chief Executive acknowledged that operational planning and delivery was currently a challenge for all hospitals, while driving activity and maintaining good quality and safe services. The financial challenges faced were being driven by hyper-inflation and there was work ongoing to consider operational opportunities. He praised all staff involved in covering shifts during the periods of industrial action and confirmed that the Trust would not be directly impacted by nursing strikes due to take place later that week. He confirmed that the Chief Executive of Whipps Cross University Hospital, Mr Ralph Coulbeck, would be stepping back from his role. There was a high level of interest in terms of candidates to succeed in this position, with an appointment expected to be made in the next six weeks. He welcomed the achievement of nurses at St. Bartholomew's Hospital on innovative clinical practice, with teams inserting a tube to the heart via the patient's wrist for the first time. He confirmed that the insourcing of taff from Serco had now been successfully completed, and noted his particular thanks to the Estates and Facilities Management team for making this transition effective.

44/23 PROVIDER COLLABORATION

The Group Deputy Chief Executive introduced the report and highlighted the additional investment from the Acute Provider Collaborative (APC) into planned care services. He added that joint theatres and community diagnostic centre expansion was progressing and trusts were collaborating on a speciality by speciality basis to identify areas where equity and waiting times could be improved. Joint work was also ongoing to optimise dedicated mental health capacity and reduce the number of mental health patients attending acute hospital sites; and to reduce the amount spent on agency staffing. NHS England Specialised Commissioning would be supporting greater access to the transformative mechanical thrombectomy service and key developments had been advanced for people receiving renal dialysis. He was also looking forward to the rollout of electronic patient records at BHRUT later in the year.

Ms Kinnaird was pleased to see benefits were being realised and asked how the collaboration's objectives were being balanced against the financial constraints. The Group Deputy Chief Executive noted there was a mix of top down and bottom-up priorities being identified that were creating opportunities to work together more closely and efficiently. Ms Kinnaird noted it would be helpful for the Board to have sight of the collaboration's main objectives/top priorities. The Chair agreed it would be important for the Board to have greater sight of the planned areas of improvement and timescales for delivery as part of this standing reporting.

ACTION: Deputy Group Chief Executive

Dr McLean asked whether collaboration ambitions were sufficiently stretching and if there were any other barriers to progress, in addition to financial constraints. The Group Deputy Chief Executive felt that, in the context of financial efficiencies requirements, workstreams had been progressing well and the ambitions set out remained realistic.

Mr Sharples noted that the intent of creating integrated care systems was to provide a framework for collaboration across organisational boundaries and asked whether there was emerging evidence of achieving gains without changing organisational structures. The Group Director of Corporate Development indicated examples of the benefits of reducing variation and a 'getting it right first time' approach across patient pathways.

45/23 INTEGRATED PERFORMANCE REPORT

(i) Quality and Safety

The Group Chief Nurse highlighted an improvement in complaints performance and noted that inpatient Friends and Family Test data was now more insightful due to wards having visibility of patient comments. Hospital acquired pressure ulcers continued to be a challenge and the Trust was working on this with the north east London system and community providers. The maternity reporting dashboard had now evolved to include external benchmarking, as previously requested by the Board.

Dr McLean confirmed that the Quality Assurance Committee had met in April and summarised some of the key agenda topics. This had included a lengthy discussion of maternity services with an output aiming simplify the related reporting.

Ms Seary was pleased to see the improvement in complaints performance. She asked what was being to address the large amount of reported grade four pressure ulcers at Newham University Hospital. The Group Chief Nurse confirmed that long waiting times had had an impact on this and there was a focus on helping temporary staff to better understand their roles and responsibilities to mitigate pressure sore risks.

The Chair asked about the apparently slow progress in improving Duty of Candour performance. The Group Chief Medical Officer noted there was now more emphasis and confidence in the quality of the responses while he acknowledged that the compliance timelines were difficult to meet. He added that, in the vast majority of cases, compliance was missed by only one or two days rather than an extended delay.

Ms Spice asked whether any learning was shared between the sites in relation to fluctuation in the Friends and Family Test response rates and feedback. The

Group Chief Nurse confirmed that hospital quality leads met regularly and shared their learning from surveys.

Professor Caulfield highlighted a change in the resistance profile for e-Coli bacteraemia bloodstream infections and wanted to know if this related to a need for sterilisation improvements. The Group Chief Medical Officer was aware of the change and noted the introduction of new ways in prescribing antibiotics (adopted in March) which had led to some improvements.

(ii) Operational Performance

The Group Chief Operating Officer noted the high attendances recorded in Urgent & Emergency Care during March, 9.7% more than in February. She added that despite the significant increase in attendances, Accident & Emergency (A&E) 4-hour performance had improved by 2.3% from the previous month. The proportion of patients with an A&E 12-hour journey time improved slightly from 6.7% in February to 6.4% in March, against a national standard of no greater than 2%. The Trust was ranked eighth out of sixteen Trusts in London and was the second best performer out of the largest ten Trusts in England. Looking back over the year, the Trust's reported performance position averaged 67.7% last year, in the context of the greatest volume of attendances ever recorded in the organisation. The Group Chief Operating Officer wanted to formally thank all of the booking, administrative and clerical staff for their hard work during the junior doctor industrial action. Major challenges were being experienced in relation to the level of mental health patients requiring care, particularly at the Royal London Hospital. In total, 1900 mental health patients had been treated since January 2023. The Trust was working to support these patients with mental health provider colleagues. The Trust was also working to maximise capacity across all sites and looking to achieve equitable access with the help of the Acute Provider Collaborative. In terms of elective care, the introduction of a new theatre utilisation and scheduling tool was expected to prove very beneficial. Faster diagnosis in regard to cancer reporting performance was noted while there were ongoing productivity challenges in diagnostics.

Mr Sharples was pleased with the progress made in reducing in waiting times while remaining concerned with the amount of time people were waiting for audiology appointments. The Group Chief Operating Officer confirmed that this was an area where strategy development was being focussed on and she felt that more could be done with community partners. Mr Sharples noted that the organisation was still running at below business as usual (BAU) elective levels. Linking this to the year's operational delivery challenge to achieve over 9% higher than BAU activity, it would appear very hard to close the gap. He added the Board would need to provide adequate support to the system in order to best deal with the upcoming challenges. Ms Seary felt that it would be helpful to understand how much of the solution to audiology service was within the Trust's control and where responsibility of the Integrated Care

Board lay. Board members would want to understand any timetable for strategy improvements and the potential for audiology performance to be stabilised. The Group Chief Operating Officer acknowledged there were challenges to recruit paediatric audiologists and there was a need to develop the workforce sufficiently to manage the demand.

Ms Seary noted the growing challenges in mental health care provision. It was confirmed that the Trust had been working on improving the service for mental health patients with North East London Foundation Trust in an effort to ease the pressures.

Ms Teather asked whether any learning was available from those organisations with higher elective activity rates. The Group Chief Operating Officer noted the use of benchmarking (via model hospital and other tools) and confirmed engagement with the *Getting It Right First Time (GIRFT)* initiative was a key enabler. Other best practice would be shared with the Board in due course.

Dr McLean asked if there was confidence in plans to achieve the expected cancer performance standards this year. The Group Chief Operating Officer noted that discussions around this had been held with the Cancer Alliance. The Trust had a strong history on cancer performance, providing some confidence. Performance was currently only at a small variance from trajectory, suggesting that benefits of improvement plans were starting to be realised.

(iii) Equity

The Group Director of Inclusion and Equity reported no obvious gender or ethnicity differences in relation to accessing services. Equity of access across NEL remained a major area of focus and would be incorporated into leadership plans. He added that an ongoing decline in ethnicity data capture rates, particularly in outpatients settings, was of concern and would be escalated to the Addressing Inequalities in Care Group. The Trust was working to download GP data on ethnicity to improve overall rates of recording. Ethnicity reporting was now included as part of standard divisional performance reviews.

Ms Teather asked about data availability on equity outcomes. The Group Director of Inclusion and Equity noted that he had met with senior service leads, including in Maternity, to link the work being done there with the inclusion agenda.

(iv) People

The Group Director of People highlighted that the fill rate in March was above 92% with the addition of an extra 180 whole time equivalents (WTE). He noted that recruitment in nursing had improved from 83% to 86% but was still presenting a challenge. Sickness absence continued to be on a downward trend. Statutory and Mandatory training remained above 85% and

improvements had been reported in the completion rate of non-medical appraisals. Staff turnover had decreased from 13% to 12% and the cost of temporary staff represented 5.2% of overall pay spend, with a target to reduce this to 3.7%). He noted the need for further work on roster quality and compliance.

Dr McLean asked about staff retention controls and suggested exploring what other NHS organisations were doing in this regard. The Group Chief Nurse noted that workforce bookings processes and related controls were being refreshed, following some easing of these during the pandemic.

Ms Spice asked how the Trust could achieve filling recruitment gaps across the sites. The Group Director of People noted improvement targets were being set for some areas of low productivity and this would be tracked in order to establish clear links to recruitment gaps.

(v) Financial Performance

The Group Chief Finance Officer noted headlines for year-end performance while confirming that this remained subject to audit. The budget deficit at the start of the year had been narrowed from £27m to £13m. There had been a number of pressures throughout last year, some of which would roll into the current financial year. He noted a significant challenge to deliver the 2023/24 financial plan. The Trust had over-committed against its capital programme and, at ICS level, the capital spend had exceeded its allocation in 2022/23. This underlined the scarce capital resource and challenge to manage this.

46/23 REPORTS FROM BOARD COMMITTEES

Reports were received from Board committees.

Finance, Investment and Performance Committee

Mr Sharples congratulated the Group Chief Financial Officer and central finance team for delivering against stretching targets in 2022/23. Mr Sharples noted this year's budget would be very tough to deliver and there would not be the required funds to do some of things the Trust wanted, particularly from an investment and efficiency perspective.

Audit and Risk Committee

Ms Kinnaird outlined key agenda items and confirmed review of the annual report and accounts, noting that external auditors were pleased with the progress and smooth process supporting this. Ms Kinnaird noted that management of overdue audit actions was still a challenge and there was more work to do to finalise the Board Assurance Framework and risk appetite statement, connecting this to the Trust's strategic objectives.

47/23 MORTALITY REPORT

The Group Chief Medical Officer introduced the annual report following its review by the Quality Assurance Committee in April. Outcomes indicated that the Trust's mortality rates were within the expected parameters or better and that it had an efficient deep dive system in place for any outliers. A system of learning was also in place with investigations into all deaths occurring via an incident review process and oversight of the mortality review group. Reporting systems had been improved following some deprioritisation during the Covid pandemic. Specific mortality review processes were in place for individuals with learning disabilities and children. Plans for the coming year included internally reviewing all deaths including those in the community.

Ms Kinnaird asked about steps to learn and improve. The Group Chief Medical Officer recognised that there were always going to potential improvements and accepted instances of repeat errors (albeit in a tiny proportion of cases). Dr McLean felt that the emphasis needed to be on sustaining improvements and ensuring that these were consistently monitored.

Mr Sharples asked if there was anything more that could be done to reduce hospital acquired Covid-19 infection. The Group Chief Medical Officer confirmed the Trust's strong record on rates of infection, while noting that the use of side rooms reduced risks. Real time investigation processes were carried out in the event of any outbreak.

48/23 OPERATIONAL PLAN 2023/24 AND STRATEGY

The Interim Director of Strategy introduced the plan and set out the context, noting that financial challenges represented a recurring theme. There would be a requirement for a further step in the process prior to submission of the final plan and an update would be provided at the next meeting in July.

The Board endorsed the plan and noted the timetable for submission of the final plan.

49/23 PEOPLE STRATEGY IMPLEMENTATION: STAFF SURVEY

The Group Director of People noted the report was based on nine themes and was used as a key starting point for setting Trust-wide people plans. This year had seen a drop in the response rate, with 37% of staff completing the questionnaire. This was just below the national average and saw the Trust maintain its position at the top of the lower quartile of hospitals in the country. This fell short of the Trust's ambition and new areas of focus around staff

engagement were included in the report. Bank staff responses were confirmed as being in line with the national average.

Ms Teather agreed that the reasons for lower response rates, particularly among substantive staff, should be explored. The Group Director of People agreed that it was a disappointing response rates, noting also that no organisation in North East London had achieved 50% or higher response rates.

Mr Williams was keen to understand why the Trust ranked poorly as a place to work when compared to other organisations. The Group Director of People noted that it was difficult to understand why there was this level of variation and acknowledged there was a lot more work to do in order to change staff perceptions. People teams at each hospital were driving the required action plans but more could be done to remind line managers of their responsibilities to promote and sustain engagement. Mr Williams observed that the staff survey responses differed from his experience of staff feedback during Board visits. The Group Director of People noted it was hard to know the exact reasons for this but was anticipating that improvements would be seen in the coming year.

Ms Seary asked if there was any qualitative research being done in relation to the standard for a friend or relative recommending the Trust as a place for treatment. The Group Director of People confirmed that research was being done at hospital level.

Dr McLean noted the low response rate and agreed with Mr Williams around responses not triangulating with what was witnessed by Board members during their contacts with staff. The Group Director of People emphasised the importance of raising the level of engagement in order to increase the response rate. He also noted that University College Hospitals NHS FT had been approached, with the intention to learn more about their successful staff engagement methods.

Ms Kinnaird felt that it would be beneficial to see what was being done differently as a result of survey findings and to measure pulse point through the year to test the effectiveness of interventions. She also hoped to see a clearer action plan on improving response rates.

Professor Caulfield indicated that he would be pleased to share details of QMUL's approach. He noted that a typical reason for low response rates was the perception that engaging would not lead to changes. He felt that visibility of senior staff could be a key factor in addressing misconceptions.

The Group Director of People confirmed that a review group would be examining weekly response rates and planned communication interventions and leadership conferences would help generate the sense that people know what is happening in the wider organisation.

50/23 BOARD AND BOARD COMMITTEE TERMS OF REFERENCE

The Group Director of Corporate Development confirmed terms of reference had been reviewed for the Trust Board and board committees. Informing this process, committee effectiveness reviews of all Board committees had been completed by the Trust Secretary and shared with the respective groups. The Chair noted there would be a further opportunity to review the terms of reference and outcomes of the committee effectiveness reviews at the scheduled joint Board development session.

The revised terms of reference were approved.

51/23 USE OF THE SEAL

The Trust Board approved use of the Trust seal.

52/23 ANY OTHER BUSINESS

There was no other business.

53/23 QUESTIONS FROM MEMBERS OF THE PUBLIC

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

The Newham Save our NHS campaign group representative, Ms Rosamund Mykura, asked questions about overseas patient charging and the role of Nuffield Health's unit based at St Bartholomew's Hospital.

In relation to the first question, The Director of Inclusion and Equity noted that for the past three years the Trust had published an annual report on the implementation of the NHS charging regulations for overseas patients. These provided figures for the numbers of relevant patients invoiced at each of our hospitals going back to 2018/19. The commitment to regular annual publication had been made in response to frequent questions from the Save our NHS groups. The contents of the annual reporting were updated to reflect interest in the subject, such as a request last year to incorporate a breakdown by ethnicity. The next report was due to be published in September but in the interim, a further request for a breakdown by gender was provided at a board meeting earlier this year. This had shown that there were more women than men among the numbers invoiced at The Royal London and Newham hospitals. This reflected a preponderance of maternity patients among those seeking care. Services had repeatedly made clear that anyone requiring urgent treatment, including maternity care, were treated immediately and before any inquiries were made about their eligibility for free NHS care. The numbers of overseas patients account for less than 1% of inpatient activity at our hospitals. The Paying Patients Team reviewed internal processes in 2020 to support fair, consistent and equity

in the approach across the Trust supported by a training programme for staff in patient-facing roles.

In relation to the second question, the Interim Director of Strategy confirmed that the Trust had formally agreed to the branding of 'Nuffield Health at St Bartholomew's Hospital' with a related agreement governing the arrangements between the two parties. The refurbishment of this previously unused estate had received full planning consent.

Waltham Forest Save our NHS campaign group representative, Ms Terry Day asked questions about bed capacity and the deep dive into pressure ulcers at Whipps Cross Hospital.

The Chair indicated that the requester would receive a written response from relevant executives to the detailed queries raised at the meeting.

54/23 DATE OF THE NEXT MEETING

The next meeting of the Trust Board in public would be held on Wednesday 12 July 2023 at 11.00am in the Lecture Theatre Education Academy, Zone 2, Newham University Hospital, Glen Road, Plaistow E16.

Sean Collins
Trust Secretary
Barts Health NHS Trust
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Action Log

Trust Board 3 May 2023			
No.	Action	Lead	By
1	The standing report would incorporate details of the collaboration's key objectives and timescales for delivery	Group Deputy Chief Executive	July 2023

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Report to the Trust Board: 12 July 2023	TB 35/23

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

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

- The reappointment of Ms Lesley Seary, with the extension of her existing term as non executive director until 31 July 2026. This reappointment also applies to Ms Seary's role on the board of Barking, Havering and Redbridge University Hospitals NHS Trust. This follows the similar extension to the term of Professor Sir Mark Caulfield as a joint non executive director until 19 March 2027.
- Following approval by the Nomination and Remuneration Committee of the proposal to add the four hospital chief executives to board membership, the Trust Board is asked to note the appointment of Dr Neil Ashman, Prof Charles Knight, Mr Simon Ashton and Dr Amanjit Jhund to the Trust Board with effect from 1 September 2023. This nomination reflects the increasingly strategic role of hospital leaders in the sector and the development of the group model.

Related Trust objectives
n/a

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

Legal implications/ regulatory requirements	No direct legal implications identified.

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

Report to Barts Health and BHRUT Trust Boards: 6 July 2023 and 12 July 2023	**TB 36/23**

Title	Provider Collaboration Update
Accountable Director	Group CEO Group Deputy CEO / Trust CEO (BHRUT)
Author(s)	Collaboration Director
Purpose	To update the Board on collaboration between the three acute providers in North East London
Previously considered by	-

Executive summary

The three acute providers of Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), Barts Health NHS Trust and Homerton Healthcare NHS Foundation Trust are working together to address mutual challenges and deliver better care, using a co-ordinated approach to population needs, so that services are arranged around our patients, not organisational boundaries.

The ambition of the three trusts is to improve quality and access for patients through collaboration. Working together as an acute provider collaborative (APC) they have agreed to take forward clinical transformation programmes across six clinical pathways and three cross-cutting strategic themes.

Shadow governance arrangements for the APC have been in place for approaching 12 months, with a monthly Executive and Quarterly Board. The proposal is to now formalise APC arrangements by establishing a joint committee between the three acute providers and the Integrated Care Board (ICB). Proposed Terms of Reference (ToR) for the APC have been developed with the ICB retained legal advisors with input from all four organisations.

The objectives and priorities of APC joint committee will be confirmed in relation to the programme plans that have been developed.

The full Terms of Reference (with an accompanying summary version) are presented to the Board for approval.

Related Trust objectives
All

Risk and Assurance	This report provides assurance in relation to the evolving and maturing collaboration between BHRUT and Barts Health and its relationship with the Acute Provider Collaborative.

Legal implications/ regulatory requirements	None

Action required
The Trust Board is asked to APPROVE the North East London Acute Provider Collaborative Joint Committee Terms of Reference.

REPORT TO THE TRUST BOARD

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

Introduction

In north east London, the three acute providers of Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), Barts Health NHS Trust and Homerton Healthcare NHS Foundation Trust are working together as an acute provider collaborative (APC) to address mutual challenges and deliver better care, using a co-ordinated approach to population needs, so that services are arranged around our patients, not organisational boundaries.

This builds on the collaboration already underway between BHRUT and Barts Health who are working as an integrated group of seven hospitals, facilitated by several joint appointments, including a Chair in Common, three joint non-executive directors and a single Group CEO, with the BHRUT CEO also undertaking the role of Deputy Group CEO.

The May 2023 Trust Board update on collaboration provided an overview of the APC programmes, recognising that they are at varying stages of maturity, with some well-established across the system, while others are still confirming their scope and areas of focus. The update also summarised notable achievements during 2022/23 that include improved patient access and significant investment into infrastructure projects.

The purpose of the paper is to set out proposals to formalise the governance of the APC that would allow for future delegation and the potential to exercise functions currently undertaken by the ICB. Such arrangements are being established with a view to enabling the NHS Partner Organisations to work collaboratively, with a shared purpose, and at scale across multiple places in North East London. For example, delegation of the commissioning of specialised services would enable the APC to undertake and make decisions centred on population-based planning, focussed on whole pathways to reduce inequalities, improve quality outcomes and provide equitable and effective provision across North East London.

Acute Provider Collaborative

The three acute providers have been working together as an Acute Provider Collaborative, for approaching a year, with the APC continuing to develop and mature. At inception, the providers' priority was to put in place workable governance arrangements quickly, to enable them to move forwards with their work as soon as possible and be able to take decisions collaboratively. Accordingly, the Shadow APC Board and Shadow APC Executive were established.

The Shadow APC Board and Shadow APC Executive have been established as consultative forums. This means that:

- Neither the Shadow APC Board nor the Shadow APC Executive themselves hold delegation from the providers or the ICB.
- Decisions can only be taken within the shadow forums to the extent that individuals 'in the room' hold delegated responsibility from their organisation.

The shadow arrangements take a further important step towards integration by ensuring that the perspective of the ICB is brought to the discussions. Both the Shadow APC Board and Shadow APC Executive each have a member drawn from the ICB.

Evolving the NEL Acute Provider Collaborative Governance Arrangements

NHS England set out expectations in *Working together at scale* (August 2021), that all Trusts/FTs providing Acute Services be part of one or more provider collaboratives, *"working together to agree plans and deliver benefits of scale."* The deadline for doing so was to coincide with the passage of the Health and Care Act 2022, which passed on 1 July 2022.

The legislation passed did not substantively dictate how a provider collaborative should be established and does not prescribe the form of a provider collaborative. Consequently, the August 2021 guidance recognised that *"Systems and their constituent providers have flexibility to decide how best to arrange provider collaboratives.* However, NHS England's statutory guidance, which was formally published in September 2022, set an expectation that these new flexibilities are not used until April 2023.

From 1 April 2023, NHSE signalled that they would be more agreeable to the flexibilities in the legislation which allow joint committees or external delegation of functions from one body to another, to be utilised.

In anticipation of this, the APC, the ICB and their legal advisors have been reviewing options to evolve the APC governance with the following priorities of the providers to be reflected in future arrangements:

- Remove duplication of the ICB APC sub-committee that was established in July 2022[1]

[1] On 1 July 2022 the Board of the ICB approved outline terms of reference for the Acute Provider Collaborative Sub-Committee ('the APC Sub-Committee'). However, much of the important substance of the terms of reference was still to be developed and agreed (e.g. as to the functions which the APC Sub-Committee would be exercising; as to membership; and chairing). By its nature, the APC Sub-Committee, as a sub-committee of the ICB, was only intended to take decisions around functions that had been delegated to the sub-committee internally within the ICB. It was not intended that the NHS providers' functions be delegated to that sub-committee. Whilst the governance arrangements for the APC Sub-Committee were still being considered, the providers' priority was to put in place workable governance arrangements quickly, to enable them to move

- The three NHS providers are keen to work together and find a means of streamlining their governance. Duplication of effort should be avoided.
- Maintaining non-executive scrutiny over executive decision-makers should remain an important feature.
- The functions which are in and out of scope of the APC's work will vary from time-to-time: partners want to limit the need to keep redrafting terms of reference when the scope changes.

An options appraisal was undertaken and discussed at the December 2022 meeting of the APC Shadow Board. In developing options, providers expressed a requirement to maintain the sovereignty of the boards of each organisation with reporting lines into each of their respective boards.

The **recommendation to achieve the above is to establish a joint committee** using the new powers in section 65Z5 of the Health and Care Act 2022. This would enable the partners to come together in a streamlined way to take joint decisions around functions which the providers' respective boards delegate into that joint committee.

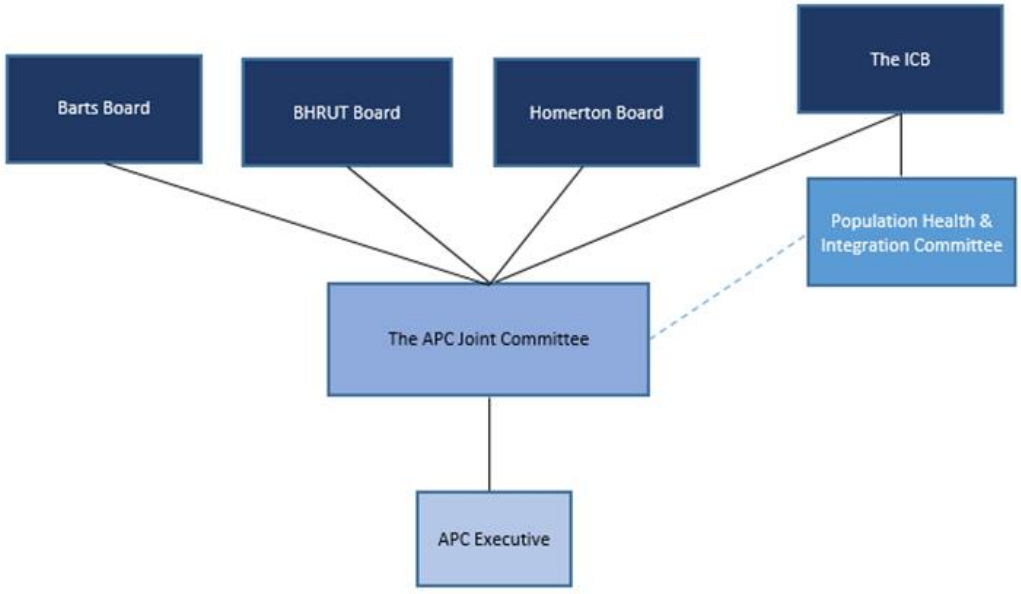


Figure 1 – Proposed APC Joint Committee structure and reporting

An important aspect which the four organisations as ICS partners considered is *what role do the ICB and the ICB's functions play in the arrangements?* (i.e.) *How do we get to a point where the providers can take decisions around the ICB's functions as well as their own?* Having reviewed the options, the recommendation was to make the ICB a party to the APC Joint

forwards with their work as soon as possible and be able to take decisions collaboratively. Accordingly, the Shadow APC Board and Shadow APC Executive were established.

Committee. This was considered to be a 'fully integrated option,' in the sense that decisions could be around both ICB functions and providers functions' within the same forum and the individuals taking the decision would be from both the ICB and the providers.

The joint committee would provide a statutory basis for all four organisations to take collective responsibility for an agreed set of functions – enabling joint decision-making and risk-sharing approaches, whilst creating transparency and clarity of accountability with organisations working together as an Acute system.

The Terms of Reference were discussed at the June 2023 APC Shadow Board and agreed, with a recommendation to progress through Trust/ICB Boards for approval as set out below:

- 06 July BHRUT Trust Board
- 12 July Barts Health Trust Board
- 26 July Homerton Healthcare Trust Board
- 26 July ICB Board

Establishing the NEL Acute Provider Collaborative Joint Committee

Subject to all parties agreeing and approving the Terms of Reference, the APC will establish a joint committee at the earliest opportunity. Once established, the joint committee will establish an APC Executive sub-committee to support the joint committee to provide direction and oversight to the APC.

The APC joint committee will be a new endeavour for all the partners and expect that this will be an evolutionary process. As such, all are committed to reviewing its effectiveness and ways of working formally at least annually on discharging its responsibilities, delivering its objectives and complying with its terms of reference.

Further discussion will also be required with all partners to consider:

- What could be delegated and which ICB functions could be exercised by the joint committee and when this should commence.
- Developing a partnership agreement to address operational matters such as resourcing, risk management, dispute resolution and management of conflicts.
- Developing the vision and purpose of the APC for inclusion as a core component within the Terms of Reference.

Summary:

The Trust Board are asked to **APPROVE** the Terms of Reference for the APC Joint Committee

Appendices:

Appendix 1: North East London Acute Provider Collaborative Terms of Reference (Full version)

Appendix 2: North East London Acute Provider Collaborative Terms of Reference (Summary version)

North East London Acute Provider Collaborative Joint Committee

TERMS OF REFERENCE
DRAFT

Introduction	1. The NHS North East London Integrated Care Board ('**ICB**') and the following NHS providers of acute services, who are all partners of the North East London Integrated Care System ('**ICS**'), have come together to form the North East London Acute Provider Collaborative ('**APC**'). 2. The NHS providers of acute services are: (a) Barts Health NHS Trust ('**Barts Health**') (b) Barking, Havering and Redbridge University Hospitals NHS Trust ('**BHRUT**') (c) Homerton Healthcare Hospital Foundation Trust ('**Homerton Healthcare**'). 3. For the purpose of these terms of reference, the providers and the ICB shall be known as the **'NHS Partner Organisations.'** 4. The APC Joint Committee, whose governance arrangements are described in these terms of reference, is the collective governance vehicle for joint decision-making by the NHS Partner Organisations in relation to acute services. 5. It has been established with a view to enabling the NHS Partner Organisations to work collaboratively, with a shared purpose, and at scale across multiple places in North East London, to: reduce inequalities in health outcomes, access and experience; improve resilience (e.g. by mutual aid); and ensure that specialisation and consolidation can occur where this will provide better outcomes and value.
Status	6. Section 65Z5 of the National Health Service Act 2006 (as amended) (the '**2006 Act'**) permits Integrated Care Boards, NHS trusts, and NHS foundation trusts to exercise their functions jointly with each other, subject to: (a) Regulations made by secondary legislation, which may constrain that joint exercise of functions, limit the power in relation to certain functions of one or more of those organisations, or impose conditions on the exercise of that power. (b) The expectations of statutory guidance about the exercise of this power, which is published by NHS England under section 65Z7 and which the NHS Partner Organisations must have regard to. 7. Section 65Z6 permits the organisations to arrange for the functions which are exercisable jointly to be exercised by a joint committee and, if they wish, for one or more of the organisations or the joint committee itself to establish and maintain a pooled fund.

	8. Arrangements made under section 65Z5 and section 65Z6 may be made on such terms as may be agreed between the organisations, including terms as to payment. 9. An NHS foundation trust is also permitted by section 47A of the 2006 Act to enter into arrangements for the carrying out, on such terms as it considers appropriate, of any of its functions jointly with any other person. NHS trusts have an equivalent power under paragraph 18 of Schedule 4 to the 2006 Act. 10. Integrated Care Boards also have powers under section 12ZA of the 2006 Act, in relation to arrangements they have made with service providers, which includes a power to confer discretions on those services providers. 11. By virtue of the powers described above, and in accordance with each of their constitutional and governance arrangements, the NHS Partner Organisations have formally established the APC Joint Committee.
Authority	12. The APC Joint Committee is authorised by the Boards of the NHS Partner Organisations to take all necessary actions to fulfil the remit described within these terms of reference, including commissioning reports and creating groups. The APC Joint Committee is permitted to establish sub-committees.
Role of the APC Joint Committee	13. The APC Joint Committee has been established in order to: (a) Provide the NHS Partner Organisations with the ability to collaboratively direct and oversee the delivery of high-quality patient care relating to acute services in North East London; (b) Ensure the development of further collaboration between the NHS Partner Organisations; (c) Enable collaboration with an emphasis on minimising health inequalities, striving to: embed joint accountability, improve equity of access to appropriate and timely health services; and ensure that people participation is at the heart of the activities of the APC's work; (d) Coordinate improved resilience of services (e.g. by mutual aid) where it is the case that action across the NHS Partner Organisations and/or the ICS is required and ensure that specialisation and consolidation can occur where this will provide better outcomes and value; (e) Ensure and encourage the engagement of the partner organisations of the ICS, with a view to shaping the future of acute services across North East London; (f) Lead the development of the ICS strategy and planning for acute services, and put in place arrangements to ensure its delivery with ICS partners including the seven place-based partnerships; (g) Provide assurance to the NHS Partner Organisations on the delivery of the ICS's strategy and plans for acute services and the

NHS Long Term Plan, and agree mitigations where there are significant delivery risks;

(h) Enable the joint exercise of the functions which have been delegated to the APC Joint Committee by the NHS Partner Organisations, in a simple and efficient way ('the **Delegated Functions**').

14. In particular, the APC Joint Committee shall oversee and assure the work of the APC Executive which has been established as a sub-committee of the joint committee.

15. **Annex 1** lists the Delegated Functions, which have been delegated to the APC Joint Committee by the NHS Partner Organisations and, in relation to which, the APC Joint Committee may take decisions which shall be binding on each of the NHS Partner Organisations. It is expected that the arrangements described in these terms of reference will evolve, including to bring further functions within scope over time. For the avoidance of doubt, no party can delegate its functions into the APC Joint Committee without the agreement of all the NHS Partner Organisations.

16. Annex 1 is divided into two respective parts, setting out the functions delegated by the ICB and the functions delegated by the provider NHS Partner Organisations. It also records whether the APC Joint Committee has delegated a function to a sub-committee, and the sub-committee's role in respect of that function.

17. The Delegated Functions shall be exercised with particular regard to the APC Joint Committee's priorities and objectives, as described in the **APC Plan**, which the APC Joint Committee shall approve on behalf of the NHS Partner Organisations. A summary of the APC Joint Committee's priorities and objectives shall be contained at **Annex 2**.

18. In addition, the APC Joint Committee will support the NHS Partner Organisations to achieve the aims and the ambitions of:

(a) The Joint Forward Plan;

(b) The Joint Capital Resource Use Plan;

(c) The Integrated Care Strategy prepared by the NEL Integrated Care Partnership;

(d) The joint local health and wellbeing strategies and associated needs assessments prepared by the eight health and wellbeing boards;

(e) The plans prepared by the seven place-based partnerships, within the ICS's area; and

(f) The developing ICB Financial Framework.

19. The APC Joint Committee will prioritise its work against:

(a) The strategic priorities of the ICS and the ICS operating principles set out on the ICB's website, here;

(b) Relevant plans and priorities developed by the NHS Partner Organisations.

	20. In supporting the NHS Partner Organisations to discharge their statutory functions and deliver the strategic priorities of the ICS, the APC Joint Committee will, in turn, be supporting the ICS with the achievement of the 'four core purposes' of Integrated Care Systems, namely to: (a) Improve outcomes in population health and healthcare; (b) Tackle inequalities in outcomes, experience and access; (c) Enhance productivity and value for money; (d) Help the NHS support broader social and economic development. 21. The APC Joint Committee is also a key component of the ICS, enabling it to meet the 'triple aim' of better health for everyone, better care for all and efficient use of NHS resources.
Chairing Arrangements	22. The Chair of the APC Joint Committee will be the Chair of Homerton Healthcare. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference. 23. The Deputy Chair of the APC Joint Committee will be Chair in Common of Barts Health and BHRUT.
Membership	24. The APC Joint Committee shall have the following members drawn from the NHS Partner Organisations, as follows: Barts Health/BHRUT roles: (a) Chair in Common (b) Group Chief Executive Officer / Accountable Officer for Barts Health and BHRUT (c) Executive Director for Barts Health and BHRUT (d) Joint Non-Executive Director Homerton Healthcare: (e) Chair (f) Chief Executive (g) Executive Director (h) Non-Executive Director ICB: (i) Chief Executive (j) Chief Finance and Performance Officer (k) Chief Medical Officer 25. When determining the membership of the APC Joint Committee, active consideration will be made to diversity and equality.

	26. With the permission of the Chair of the APC Joint Committee, the members of the APC Joint Committee set out above may nominate a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf. The decision of the Chair regarding authorisation of nominated deputies is final.
Participants	27. The APC Collaboration Director will have a standing invitation to attend meetings of the APC Joint Committee, aside from in rare circumstances when the Chair determines that it is appropriate for only members of the APC Joint Committee to be present. 28. The APC Joint Committee may invite others to attend meetings, where this would assist it in its role and in the discharge of its duties. This shall include other colleagues from the partner organisations within the ICS, professional advisors or others as appropriate, at the discretion of the Chair of the APC Joint Committee. In particular, the APC Joint Committee may invite: (a) The Senior Responsible Officers for the APC programmes; (b) Individuals who can bring the perspective of the local authorities in North East London; the Voluntary, Community and Social Enterprise sector; Healthwatch; Patients and services users.
Collaborative working and substructures	29. In exercising its responsibilities, the APC Joint Committee shall work with other provider collaboratives, joint committees, committees, or sub-committees which have been established by the NHS Partner Organisations or wider partners of the ICS. This may include, where appropriate, aligning meetings or establishing joint working groups. 30. In particular, the APC Joint Committee will, as appropriate, work with: (a) The place-based governance structures within the ICS; (b) The North East London MHLDA Collaborative, the North East London Community Health Collaborative, the North East London VCSE Collaborative and the North East London Primary Care Collaborative. 31. The APC Joint Committee may delegate any of the Delegated Functions to the APC Executive and any other sub-committees which it establishes in accordance with these terms of reference. 32. Where a function has been delegated by the APC Joint Committee to a sub-committee it shall be recorded in **Annex 1.** All sub-committees established within the APC's governance must operate under terms of reference approved by the APC Joint Committee. 33. The APC Joint Committee or its sub-committees may establish transformation boards, working groups or task and finish groups. All groups established within the APC's governance must operate under terms of reference approved by the APC Joint Committee or the APC sub-committee which established them.

Key duties relating to the exercise of the Delegated Functions	34. When exercising any Delegated Functions, the APC Joint Committee will ensure that it acts in accordance with, and that its decisions are informed by, the relevant policies and procedures which have been developed by the NHS Partner Organisations to support those functions and to inform the commissioning, provision and delivery of any relevant services. 35. When exercising a function which has been delegated by an NHS Partner Organisation, the APC Joint Committee will have particular regard to the statutory obligations imposed on that organisation, and that organisation's policies and procedures. As particularly relevant to the Delegated Functions, these include, but are not limited to, the statutory duties set out in the 2006 Act. Key duties are listed in **Annex 3.** The NHS Partner Organisations will also have due regard to the public sector equality duty under section 149 of the Equality Act 2010. 36. All sub-committees or groups established within the APC's governance must also have due regard to the applicable statutory duties which apply to the NHS Partner Organisations.
Resource and financial management	37. The NHS Partner Organisations have made arrangements to support the APC and the exercise of the Delegated Functions. 38. Further information about resource allocation and financial management is contained in the NHS Partner Organisations' standing financial instructions and associated policies and procedures, which includes the ICB Financial Framework. The NHS Partner Organisations are currently working together to finalise the formal aspects of accountability and responsibility for financial decision-making for activities in scope of the APC Joint Committee, and will update the terms of reference once finalised. 39. Financial decisions need to be made in the line with the Standing Financial Instructions of the organisation at the source of the funding; where this is multiple organisations this will need to be taken through all organisations' approval routes.
APC Partnership Agreement	40. In due course, the NHS Partner Organisations will consider entering into a partnership agreement to address operational matters including: (a) Details of the operational resource to support the APC Joint Committee to meet its responsibilities with regards to the Delegated Functions; (b) Risk and gain share agreements between the NHS Partner Organisations; (c) The process for commissioning / securing professional advice (including external advice); (d) Terms for withdrawal from the APC Joint Committee; (e) Dispute resolution; (f) Information sharing; (g) Management of conflicts of interest;

	(h) Complaints handling. 41. The partnership agreement will supplement these terms of reference. To the extent that there is any conflict between the terms of reference and the agreement, these terms of reference shall prevail.
Meetings	*Scheduling meetings* 42. The APC Joint Committee will ordinarily meet quarterly, and, as a minimum, shall meet on three occasions each year. Additional meetings may be convened on an exceptional basis at the discretion of the Chair. 43. The Chair of the ICS, the Boards of the NHS Partner Organisations, or the ICB's Population Health and Integration ('PH&I') Committee may ask the APC Joint Committee to convene further meetings to discuss particular issues on which they want the APC Joint Committee's advice. *Quoracy* 44. In order for a meeting to be quorate there must be at least six members in attendance, which shall include a non-executive and an executive from each of Homerton Healthcare, the ICB and the collaboration between Barts Health and BHRUT. 45. If any member of the APC Joint Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. Nominated deputies who have been authorised by the Chair shall count towards quorum. 46. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. *Voting* 47. The APC Joint Committee will ordinarily reach conclusions by consensus. When this is not possible, the Chair may call a vote. Only members of the APC Joint Committee may vote. Each member is allowed one vote and a simple majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the APC Joint Committee will hold the casting vote. The result of the vote will be recorded in the minutes. Decisions taken shall be binding on each of the NHS Partner Organisations. *Papers and notice* 48. A minimum of seven clear days' notice and dispatch of meeting papers is required. Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed. Supporting papers must be distributed at least five clear working days ahead of the meeting. 49. On occasion it may be necessary to arrange urgent meetings at shorter notice. In these circumstances the Chair will give as much notice as

	possible to members. Urgent papers shall be permitted in exceptional circumstances at the discretion of the Chair. *Virtual attendance* 50. It is for the Chair to decide whether or not the APC Joint Committee will meet virtually by means of telephone, video or other electronic means. Where a meeting is not held virtually, the Chair may nevertheless agree that individual members may attend virtually. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting. How a person has attended a meeting shall be specified in the meeting minutes. *Recordings of meetings* 51. Except with the permission of the Chair, no person admitted to a meeting of the APC Joint Committee shall be permitted to record the proceedings in any manner whatsoever, other than in writing. *Minutes* 52. The minutes of a meeting will be formally taken in the form of key points of debate, actions and decisions and a draft copy circulated to the members of the APC Joint Committee together with the action log as soon after the meeting as practicable. The minutes shall be submitted for agreement at the next meeting where they shall be signed by the Chair. *Governance support* 53. Governance support to the APC Joint Committee will be provided by the ICB's Governance Team. *Confidential information* 54. Where confidential information is presented to the APC Joint Committee, all attendees will ensure that they treat that information appropriately in light of any confidentiality requirements and information governance principles.
Conflicts of interest	55. Conflicts of interests will be managed in accordance with relevant policies, procedures and joint protocols developed by the ICS, which shall be consistent with the NHS Partner Organisations' respective statutory duties and applicable national guidance.
Disputes	56. Where there is any uncertainty about whether a matter relating to a Delegated Function is within the remit of the APC Joint Committee in its capacity as a decision-making body, including uncertainty about whether the matter relates to: (a) a matter for determination by a Board or other governance structure of an NHS Partner Organisations; or

	(b) determination by a placed-based committee of the ICB or another provider collaborative, then the matter will be referred to the relevant Trusts' Board in the case of a provider function, or the PH&I Committee or Board of the ICB in the case of an ICB function. 57. Where any other dispute arises between the NHS Partner Organisations, which is connected to the operation of the APC and its work, this shall be resolved in accordance with the dispute resolution procedure which has been agreed between the NHS Partner Organisations.
Referral to the ICB's Population Health & Integration Committee	58. Where any decision before the APC Joint Committee which concerns an ICB function is novel or contentious or repercussive across services which fall outside its remit, then the APC Joint Committee shall give due consideration to whether the decision should be referred to the PH&I Committee of the ICB and reported to the ICB Board, as per the arrangements described at paragraphs 64-69 below. Where the APC Joint Committee does decide to make such a referral, the Chair will action this on behalf of the APC Joint Committee. 59. Where a matter is referred to the PH&I Committee under paragraph 58, the Committee (at an appropriate meeting) shall consider and determine whether to accept the referral and make a decision on the matter. Alternatively, the PH&I Committee may decide to refer the matter to the Board of the ICB, one its committees or subcommittees, or to a joint committee or other collaborative for determination. The PH&I Committee will keep the Chair of the Committee informed of its actions in relation to any referral from the APC Joint Committee and the Chair shall in turn ensure that the APC Joint Committee is keep updated. 60. In addition to the APC Joint Committee's ability to refer a matter to the PH&I Committee of the ICB, the Board of the ICB, or its Chair and the Chief Executive (acting together), may also require a referral of any decision falling with paragraph 58 to the Board of the ICB.
Behaviours and Conduct	61. Members will be expected to behave and conduct business in accordance with: (a) The policies, procedures and governance documents that apply to them, including any jointly developed procedures or codes developed by the ICS. (b) The NHS Constitution; (c) The Nolan Principles. 62. Members must demonstrably consider equality diversity and inclusion implications of the decisions they make.

	63. Members will seek to act in the best interests of the population of the ICS area, rather than representing the individual interests of the NHS Partner Organisations.
Accountability, reporting, and shared learning	64. The APC Joint Committee is established by and ultimately accountable to the Boards of the NHS Partner Organisations and the Joint Committee shall report to the Boards accordingly through the provision of the information described at paragraph 66 below. 65. In addition to this, a committee of each of the NHS Partner Organisations' Boards may be given operational oversight of the exercise of the relevant organisation's respective functions. This includes: (a) The ICB's Population Health and Integration Committee in respect of the ICB functions. 66. A copy of the meeting minutes along with a summary report shall be shared with the above committee(s) for information and assurance. The report shall set out matters discussed and pertinent issues, together with any recommendations and any matters which require disclosure, escalation, action or approval. 67. The APC Joint Committee will also report to the NHS Partner Organisations' committees for quality and finance, where its work is relevant to the functions of those committees, or as otherwise requested by those committees. 68. **Annex 4** shows the APC Joint Committee's governance, including its usual reporting lines. *Sharing learning and raising concerns* 69. Where the APC Joint Committee considers that an issue, or its learning from or experience of a matter, to be of importance or value to the North East London health and care system as a whole, or part of it, it may bring that matter to the attention of the Director who is responsible for governance within the ICB for onward referral to the PH&I Committee, the Chair or Chief Executive of the ICB, the Integrated Care Partnership or to one or more of ICB's committees or subcommittees as appropriate.
Review	70. The APC Joint Committee will review its effectiveness at least annually and provide an annual report to the PH&I Committee and Boards of the NHS Partner Organisations on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference. 71. These terms of reference, including membership and chairing arrangements, will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Boards of the NHS Partner Organisations for approval.

Annex 1 – Delegated Functions (for the commencement of year one)

Part A: Functions delegated by the Board of the ICB

Role of the APC Joint Committee:		Role of the APC Executive:
Planning		
The APC Joint Committee will undertake the following specific activities in the domain of Planning:		-
1	Making recommendations to the PH&I Committee of the ICB in relation to, and contributing to, the Joint Forward Plan and Joint Capital Resource Use Plan and other system plans, in so far as it relates to the provision of, and the need for, acute services in the ICB's area and the exercise of the ICB's functions.	To prepare such recommendations for consideration by the APC Joint Committee.
2	Overseeing, and providing assurance to the PH&I Committee regarding, the implementation and delivery of the Joint Forward Plan, and Joint Capital Resource Use Plan, the Integrated Care Strategy and other system plans or strategies (including the joint local health and wellbeing strategies and associated needs assessments), in so far as they require the exercise of ICB functions relating to acute services.	To monitor implementation and report to the APC Joint Committee, as appropriate.
3	Developing and approving the APC Plan and assuring implementation and delivery of the plan, in so far as that requires the exercise of ICB functions. *The APC Plan shall be developed by drawing on population health management tools and in coproduction with service users and residents of North East London. It is aimed at ensuring delivery of the Joint Forward Plan, the Integrated Care Strategy and other system plans (including joint local health and wellbeing strategies and associated needs assessments), in so far as they require the exercise of functions relating to acute services.* *In particular, this shall include the development and approval of the APC's priorities and objectives set out in Annex 2.* *The APC Plan shall be tailored to meet particular local needs in specific places, where appropriate, but shall always maintain ICB-wide operational, quality and financial performance standards.*	To lead on developing and preparing the plan for approval by the APC Joint Committee, and overseeing its implementation.
4	Reviewing plans developed by the seven place-based partnerships in relation to the provision of services relating to acute services, with a view to ensuring appropriate cohesion across the ICB area. This shall include reviewing such plans, making recommendations to the relevant Place ICB Committee and sharing learning.	To lead on such matters.
Leadership and engagement		

The APC Joint Committee will undertake the following specific activities in the domain of Leadership and engagement:		-
1	Responsibility on behalf of the ICB for engagement with partner organisations within the ICS (including primary care) on matters relating to acute services with a view to ensuring that such needs are considered within wider system planning.	To lead on such matters.
2	Providing leadership, on behalf of the ICB, on matters relating to acute services across the ICB's area, and working with ICS partners and NHS England as required. This shall include responsibility, on behalf of the ICB, for developing the vision and culture of the Collaborative, and engaging staff in that regard.	To lead on such matters.
3	Driving and overseeing service user and citizen participation, in relation to the exercise of ICB functions relating to acute services.	[ ]
Governance		
The APC Joint Committee will undertake the following specific activities in the domain of Governance:		-
1	Responsibility on behalf of the ICB for developing the governance framework of the APC, including: • making recommendations to the ICB on the commissioning functions which should be within the scope of the APC; • establishing the sub-structures necessary to facilitate delivery of the Delegated Functions; • putting in place the documentation necessary to ensure robust governance and assurance.	To make recommendations to the APC Joint Committee in relation to such matters. Leading on horizon scanning for examples of best practice.

Part B: Functions delegated by each of the Boards of Barts Health, BHRUT and Homerton Healthcare (for the purposes of this section, "the Trusts")

Role of the APC Joint Committee:		**Role of the APC Executive:**
Planning		
The APC Joint Committee will undertake the following specific activities in the domain of Planning:		-
1	Making recommendations to the Trusts' Boards in relation to, and contributing to, the Joint Forward Plan and Joint Capital Resource Use Plan, and other relevant system plans or strategies, in so far as it relates to the provision of, and the need for, acute services in the ICB's area and exercise of the Trusts' functions.	To prepare such recommendations for consideration by the APC Joint Committee.

2	Developing and approving the APC Plan and assuring implementation and delivery of the plan, in so far as that requires the exercise of the relevant Trust's functions.	To lead on developing and preparing the plan for approval by the APC Joint Committee, and overseeing its implementation.
3	Overseeing, and providing assurance to the Trusts' Boards regarding, the implementation and delivery of the Joint Forward Plan and Joint Capital Resource Use Plan, and other relevant system plans or strategies, in so far as they require the exercise of the APC functions.	To monitor implementation and report to the APC Joint Committee, as appropriate.
4	Providing information to the Trusts' Boards for the purposes of each Trust's duty to prepare its annual report for provision to NHS England, in so far as NHS England has requested, or those reports require, information connected with the exercise of the APC's functions.	[ ]
Leadership and engagement		
The APC Joint Committee will undertake the following specific activities in the domain of Leadership and engagement:		-
1	Responsibility on behalf of the Trusts for engagement with partner organisations within the ICS (including primary care) on matters relating to the provision of, and the need for, acute Services with a view to ensuring that such needs are considered within wider system planning.	To lead on such matters.
Governance		
The APC Joint Committee will undertake the following specific activities in the domain of Governance:		-
1	Responsibility on behalf of the Trusts for developing the governance framework of the APC, including: • making recommendations to the Trusts' Board on the functions which should be within the scope of the APC, • establishing the sub-structures necessary to facilitate delivery of the Delegated Functions; • putting in place the documentation necessary to ensure robust governance and assurance.	To make recommendations to the APC Joint Committee in relation to such matters. Leading on horizon scanning for examples of best practice.

Annex 2- APC Joint Committee objectives and priorities

The following priorities and objectives are summarised from the current APC Plan:

1	*[To be populated once plan developed]*
2	
3	
4	

Annex 3 – Key statutory duties

Key duties of the ICB:

- Section 14Z32 – Duty to promote the NHS Constitution
- Section 14Z33 – Duty to exercise functions effectively, efficiently and economically
- Section 14Z34 – Duty as to improvement in quality of services
- Section 14Z35 – Duty as to reducing inequalities (and the separate legal duty under section 149 of the Equality Act 2010, the Public Sector Equality Duty)
- Section 14Z36 – Duty to promote involvement of each patient
- Section 14Z37 – Duty as to patient choice
- Section 14Z38 – Duty to obtain appropriate advice
- Section 14Z39 – Duty to promote innovation
- Section 14Z40 – Duty in respect of research
- Section 14Z41 – Duty to promote education and training
- Section 14Z41 – Duty to promote integration
- Section 14Z43 – Duty to have regard to the wider effect of decisions
- Section 14Z44 – Duties as to climate change etc
- Section 14Z45 – Public involvement and consultation (and the related duty under section 244 and the associated Regulations to consult relevant local authorities)
- Section 14Z30 – Registers of interests and management of conflicts of interest
- Section 223GB – Financial requirements on the ICB [where set by NHS England]
- Section 223GC – Financial duties of the ICB: expenditure
- Section 223L – Joint financial objectives for the ICB [where set by NHS England]
- Section 223M – Financial duties of the ICB: use of resources
- Section 223N – Financial duties of the ICB: additional controls on resource use
- [Section 223LA – Financial duties of the ICB: expenditure limits]

Key statutory duties of Barts Health, BHRUT, Homerton:

Foundation trusts

- Section 63 - Duty to exercise functions effectively, efficiently and economically
- Section 63A - Duty to have regard to the wider effect of decisions
- Section 63B – Duties in relation to climate change

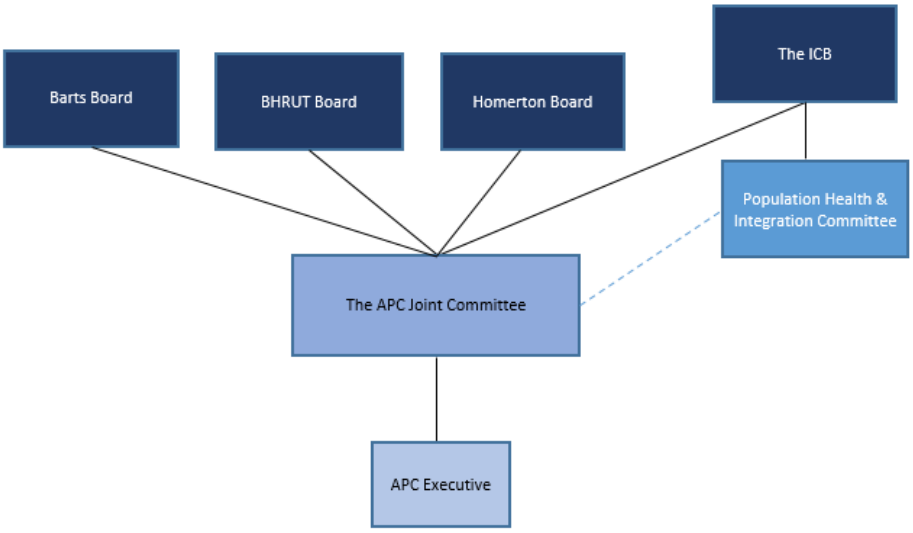
Trusts

- Section 26 - Duty to exercise functions effectively, efficiently and economically
- Section 26A - Duty to have regard to the wider effect of decisions
- Section 26B – Duties in relation to climate change

Foundation trusts and trusts

- Section 223L – Joint financial objectives [where set by NHS England]
- Section 223M – Financial duties: use of resources
- Section 223N – Financial duties: additional controls on resource use
- [Section 223LA – Financial duties: expenditure limits]
- Section 242 – Public involvement and consultation

Annex 4 – Governance Diagram



[*Drafting note:* A fuller governance diagram with reporting lines and a key will be inserted, and can include any other relevant committees, e.g. of the Trusts]

North East London Acute Provider Collaborative Joint Committee and Executive

SUMMARY TERMS OF REFERENCE
DRAFT

Introduction

1 Background

1.1 NEL ICB, Barts Health, BHRUT, and Homerton Healthcare (the '**NHS Partner Organisations**') who are all partners of the North East London ICS, have come together to form the North East London Acute Provider Collaborative (the '**APC**').

1.2 The APC operates in accordance with terms of reference, which provide a comprehensive framework for its operation. This document provides a summary of those terms of reference.[1]

The APC Joint Committee and Executive

2 Role and function

2.1 The APC Joint Committee, established by the NHS Partner Organisations in reliance on the new flexibilities introduced by the Health and Care Act 2022, is the collective governance vehicle for joint decision-making by the NHS Partner Organisations in relation to acute services.

2.2 It has been established to enable the NHS Partner Organisations to work collaboratively, with shared purpose, and at scale across multiple places in North East London, to: reduce inequalities in health outcomes, access and experience; lead the development of the ICS strategy and planning for acute services; and to enable the joint exercise of certain functions which have been delegated to the Joint Committee with the agreement of all the NHS Partner Organisations. No party can delegate its functions into the APC Joint Committee without the agreement of all the NHS Partner Organisations.

2.3 One of the primary functions of the APC Joint Committee is to oversee, scrutinise and assure the work of its only current sub-committee, the APC Executive. The intended role of the APC Executive is to support the APC Joint Committee in providing direction and oversight of the APC's work. Accordingly, the APC Joint Committee is permitted to delegate to the APC Executive.

2.4 Annex 1 of the APC Joint Committee's terms of reference identifies the delegated functions that the APC Joint Committee has assumed from the NHS Partner Organisations. Annex 1 also sets out whether the APC Joint Committee has delegated aspects of these functions to the APC Executive. The APC Executive must exercise functions delegated to it consistently with the role given to it by the APC Joint Committee and in accordance with the priorities and objectives agreed in the North East London APC Plan.

[1] These summary terms of reference provide an overview of the key aspects of the fuller terms of reference. In the case of any conflict, between the two sets of terms of reference, the fuller set shall prevail.

2.5 Decisions of the APC Joint Committee and the APC Executive are collective decisions, and will be binding the NHS Partner Organisations.

3 Membership

3.1 The APC Joint Committee is comprised of both executive and non-executive members from each of the NHS Partner Organisations. A number of the executive members of the APC Joint Committee will make up membership of the APC Executive, along with other executives from the NHS Partnership Organisations including members who can provide significant clinical input.

3.2 The APC Joint Committee will be chaired by the Chair of Homerton Healthcare, and the Deputy Chair will be the Chair in Common of Barts Health and BHRUT. The Chair of the APC Executive will be the Group CEO of Barts Health and BHRUT, and the Deputy Chair of the APC Executive will be CEO of Homerton Healthcare.

4 Meeting frequency and administration

4.1 The APC Joint Committee will ordinarily meet on a quarterly basis, while the APC Executive will meet more frequently on a monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Chair.

4.2 Except in the case of urgent meetings, 7 clear days' notice and circulation of an agenda is required. Supporting papers shall be distributed 5 clear days ahead of the meeting. Meetings may be held virtually.

5 Review

5.1 The APC Joint Committee will review its effectiveness at least annually and provide an annual report to the ICB's Population Health & Integration Committee and the Boards of the NHS Partner Organisations regarding its work on discharging its responsibilities, delivering its objectives and complying with its terms of reference.

5.2 Similarly, the APC Executive will provide the APC Joint Committee with an annual report summarising its conclusions from the work it has done during that year.

Looking forward

6 The APC Joint Committee is currently set to carry out delegated functions from both the Board of the ICB and the Boards of the Trusts with respect to [planning, leadership and engagement, and governance]. Further functions, however, can be – and are intended to be – delegated to the APC Joint Committee (and thereby the Executive) over time.

NHS
Barts Health
NHS Trust

Barts Health Integrated Performance Report

July-23

Performance for: **May-23**

Pack Contents

Jul-23

Jul-23

NHS
Barts Health
NHS Trust

Executive Summary

EXECUTIVE SUMMARY

Executive Summary

Jul-23

Quality
An exception was noted this month in the percentage of falls resulting in harm. Analysis identified the exception of the result as three falls at Newham Hospital. Incidents have been investigated and themes noted. It is envisaged that falls will be a theme within the Incident Response Plan when the Patient Safety Incident Response Framework is implemented. Hospital sites have undertaken audits of Duty of Candour letters to review the quality and responses, and to identify areas of good practice and support continuous improvement. The updated maternity Dashboard will go live in QlikSense in October 2023, with greater functionality, and updated measures to bring it in line with national reporting as per National Maternity Dashboard.

Operational Performance – *A summary performance analysis is provided on Slide 18 with detailed performance reports in this section.*
The on-going Industrial Action continues to be a focus for operational teams as mid to longer term improvement plans and the momentum behind elective recovery stalls with each service interruption. The planning for the next round of both junior and senior medical staff Industrial Action is well underway and this includes the close management of elective pathways to ensure those patients who are clinically urgent, including cancer services, are seen.

In Emergency Care the improvement plans are well underway with a positive story for Whipps Cross Hospital. At Newham we are seeing improvements in recruitment to support the actions in the Emergency Department and at the Royal London a significant programme of work to improve patient flow. This will ensure inpatient beds are available as early in the day as possible for patients needing admission.

In elective care we are working to improve outpatient services and have recently joined a pilot, 'Further Faster' with the Getting it Right First Time national team. This will ensure we are learning from other organisations about what works well for their services and adopting best practice and innovative ideas to do things differently.

Cancer services have been reviewing all patients waiting in key specialties to ensure every element of the patients care and treatment is timely. We are using this approach to understand and correct any delays in these pathways across the BH group.

Equity
In this month's snapshot, at Trust level, there are no significant differences in the data for waits between ethnic groups, or between male and female patients. On average, patients living in the most deprived postcodes waited 5.6 days longer than those living in the least deprived postcodes, which is a small but statistically significant difference.

There is a widening gap in wait times between patients in the most deprived and least deprived postcodes which will be brought to the attention of site leads.

People
We welcomed in the remainder of our Soft FM colleagues from SERCO in May with over 1,100 TUPE, (Transfer of Undertakings (Protection of Employment) across.
There is a mixed position across key workforce metrics

- Agency spend YTD remains at 4.7% against a target of 3.7%
- Substantive fill rate is at 91.5% against a target of 95% although for registered nursing and midwifery fill is at 85.7%
- Annualised sickness absence continues to reduce and is now at 4.65%

Finance
The Trust is reporting a (£13.5m) deficit for Month 2, which is (£8.9m) adverse against plan.
The key financial challenges for the Trust in achieving its plan for this financial year include:

- Delivery of the Elective Recovery Fund activity trajectory and the associated funding,
- Improving productivity to reduce temporary staffing costs and deliver the efficiency savings targets set within Sites and Services budgets.
- The impact of industrial action by medical staff.

NHS
Barts Health
NHS Trust

Quality Report

EXECUTIVE SUMMARY

Quality Summary

Jul-23

Quality
The format and presentation of the quality data continues to reflect the evolving approach to reporting using Statistical Process Control (SPC) methodology and work is ongoing to embed this change across the full range of quality reporting, with the Quality Dashboard now live in the WeInform platform. This methodology allows us to identify metrics that require further investigation and reporting based on trend performance within SPC control limits. Where a metric is flagging as red in the scorecard but not then detailed in the board report signifies that based on the trend data it remains within the SPC control limits and does not require further investigation.

Falls
An exception was noted this month in the percentage of falls resulting in harm. Analysis identified the exception was the result of three falls at Newham Hospital. Incidents have been investigated and themes noted. It is anticipated that falls with be a theme within the Incident Response Plan when the Patient Safety Incident Response Framework is implemented.

Duty of Candour
Performance in responding within the timeframe continues to fluctuate – local issues being identified and managed by the hospital leadership teams. Audits of Duty of Candour letters as part of our improvement plan have taken place. This audit reviewed the quality of responses to identify areas of good practice and support continuous improvement. Areas of good practice included: A personalised letter with a sincere apology and details of a single point of contact included. Areas for improvement include: linking the letter to a verbal discussion and provision of a Duty of Candour leaflet. Each hospital is implementing an action plan in response to their specific issues. Regular Audit will continue to monitor improvement.

Maternity
The Updates for the maternity Dashboard will go live in Qliksense in October 2023. A “Reading the Signals” one page quality and safety summary for maternity metrics has now been received in Draft form and once reviewed will support maternity reporting.

Postpartum haemorrhage rates at RLH are higher than both national averages as well as corrected averages as per MBRACE group for Level 3 maternity centres providing high risk maternity care. QI work is underway, which has been shared across NEL and local teams and focuses on risk assessment, early intervention and prevention and staff education. Stillbirth rates had come in line with national trends, however, increases seen again in March and April. All cases will be reviewed using the national perinatal mortality review tool and through the incident review framework where indicated. Continued work with the Saving Babies Lives Care bundle will support improvements. Neonatal death rates are not corrected for our tertiary neonatal service at Royal London Hospital on the data set, but can be reviewed for 2021 in the latest MBRACE report online. Our adjusted and stabilised rate for neonatal deaths is 2.26:1000, which is broadly in line with similar organisations.
There were 4 maternity Sis in month. Some early learning relating to recognition of deterioration and escalation have been identified, and specific learning shared with clinical teams as part of the various opportunities for learning that are shared including at team huddles, messages of the week, hot topics and more formal education updates.

CARING

Domain Scorecard

Jul-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	●			Apr-23 (m)	<= 0	45	**37**	***37***	0	13	19	5	-	
Patient Feedback	C10	Written Complaints Rate Per 1,000 Staff				2022/23 Q4 (q)	SPC Breach	22.3	**20.7**	***20.7***	26.7	36.5	24.0	10.8	-	
	C1	FFT Recommended % - Inpatients	●			Apr-23 (m)	>= 95%	91.2%	**89.1%**	***89.1%***	85.7%	93.5%	86.9%	90.1%	-	
	C2	FFT Recommended % - A&E	●			Apr-23 (m)	>= 86%	66.0%	**68.1%**	***68.1%***	62.6%	75.0%	66.2%	-	-	
	C3	FFT Recommended % - Maternity	●			Apr-23 (m)	>= 96%	91.5%	**97.1%**	***97.1%***	100.0%	98.9%	94.7%	-	-	
	C20	FFT Response Rate - Inpatients	●		●	Apr-23 (m)	>= 23%	26.9%	**36.8%**	***36.8%***	31.0%	53.6%	27.3%	39.2%	-	
	C21	FFT Response Rate - A&E	●			Apr-23 (m)	>= 12%	6.3%	**9.6%**	***9.6%***	9.4%	11.7%	7.9%	-	-	
	C22	FFT Response Rate - Maternity	●			Apr-23 (m)	>= 17.5%	19.4%	**16.2%**	***16.2%***	2.1%	34.6%	17.6%	-	-	
	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	●			Apr-23 (m)	>= 85%	90.0%	**84.4%**	***84.4%***	82.4%	96.8%	28.6%	100.0%	-	
	R30	Duty of Candour	●			Mar-23 (m)	>= 100%	88.0%	**82.4%**	***86.8%***	84.2%	91.7%	71.4%	83.3%	-	

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

SAFE

Domain Scorecard

Jul-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
Infection Control	S10	Clostridium difficile - Infection Rate	●			Apr-23 (m)	<= 16	22.4	**23.0**	***23.0***	38.2	6.8	0.0	38.2	-
	S11	Clostridium difficile - Incidence	●			Apr-23 (m)	<= 9	14	**13**	***13***	10	1	0	2	0
	S2	Assigned MRSA Bacteraemia Cases	●			Apr-23 (m)	<= 0	0	**1**	***1***	0	1	0	0	0
	S77	MSSA Bacteraemias				Apr-23 (m)	SPC Breach	13	**9**	***9***	4	1	2	2	0
	S76	E.coli Bacteraemia Bloodstream Infections	●			Apr-23 (m)	<= 20	25	**25**	***25***	15	5	0	5	0
Incidents	S3	Never Events	●			Apr-23 (m)	<= 0	0	**1**	***1***	0	1	0	0	0
	S09	% Incidents Resulting in Harm (Moderate Harm or More)	●			Apr-23 (m)	<= 0.9%	1.6%	**1.9%**	***1.9%***	1.7%	1.1%	3.2%	1.7%	-
	S45	Falls Per 1,000 Bed Days	●			Apr-23 (m)	<= 4.8	4.2	**3.5**	***3.5***	3.4	3.4	2.9	4.9	-
	S25	Medication Errors - Percentage Causing Harm	●			Apr-23 (m)	<= 4%	5.5%	**4.5%**	***4.5%***	3.5%	1.9%	5.9%	8.3%	-
	S49	Patient Safety Incidents Per 1,000 Bed Days				Apr-23 (m)	SPC Breach	56.4	**53.7**	***53.7***	41.7	65.5	59.6	63.5	-
	S53	Serious Incidents Closed in Time	●			Apr-23 (m)	>= 100%	25.0%	**9.1%**	***9.1%***	14.3%	0.0%	0.0%	0.0%	-

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

Jul-23

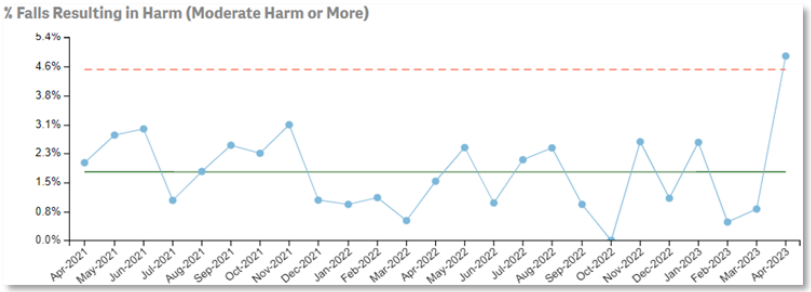
	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Site Comparison: Whipps Cross	Site Comparison: Newham	Site Comparison: St Bart's	Site Comparison: Other
Harm Free Care	S14	Pressure Ulcers Per 1,000 Bed Days	●			Apr-23 (m)	<= 0.6	1.5	**1.5**	***1.5***	1.4	2.1	0.8	1.5	-
	S35	Pressure Ulcers (Device-Related) Per 1,000 Bed Days				Apr-23 (m)	SPC Breach	0.2	**0.1**	***0.1***	0.2	0.0	0.0	0.0	-
	S27	Patient Safety Alerts Overdue	●			Apr-23 (m)	<= 0	0	**0**	***0***	-	-	-	-	-

SAFE

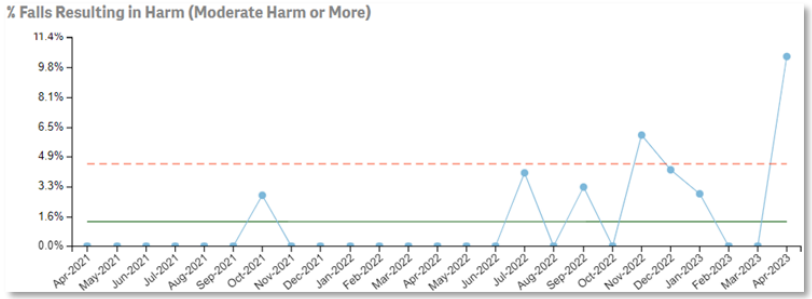
Indicator: % Falls Resulting in Harm

Jul-23

Trust



NUH



Indicator Background:

The NHS definition of a fall is an event which causes a person to, unintentionally, rest on the ground or lower level, and is not a result of a major intrinsic event (such as a stroke) or overwhelming hazard. falling has an impact on quality of life, health and healthcare costs. (NICE CG161, Falls in older people; assessing risk and prevention)
Falls are categorised as follows:
Slips – is to accidently slide or move out of position from someone's grasp resulting in a person losing their footing for a short distance
Trips – is to stumble accidentally often overran obstacle causing the person to lose their balance, this is either corrected or causes a person to fall
Falls – an unintentional unexpected loss of balance resulting in coming to rest on the floor, the ground or an object below knee level (NICE QS86, Falls in older people)

What is the Chart Telling us:

The chart identifies a data point outside of the control limit warranting further investigation in April. It was identified that the exception was driven by falls reported at Newham Hospital.

Performance Overview

The falls resulting in harm rate of 10.7% in April was due to three falls, one fall each in Beckton Ward, Clinical Decision Unit, and Silvertown Ward. All falls were unwitnessed.

- Falls with harm are subject to investigation and review in the hospital site harm-free meeting.
- Review of the data highlights:
  - Reported falls are predominantly unwitnessed
  - Challenges with observation of patients within the Emergency setting.
  - Suboptimal use of documentation and falls care plan for patients at risk of fall.
  - Inaccurate falls risk assessment completion in electronic records and notes.

Responsible Director Update

- A thematic review in preparation for Patient safety Incident Response Framework identifies falls as an area for improvement as part of the incident response plan, with an associated QI programme.
- Use of the SEIPS (human-factors) model to consider how various factors have influenced incidents and outcome.

EFFECTIVE

Domain Scorecard

Jul-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
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	●	●	○	Apr-23 (m)	<= 0.51	0.67	**0.83**	***0.83***	0.48	0.63	1.93	0.95	-

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

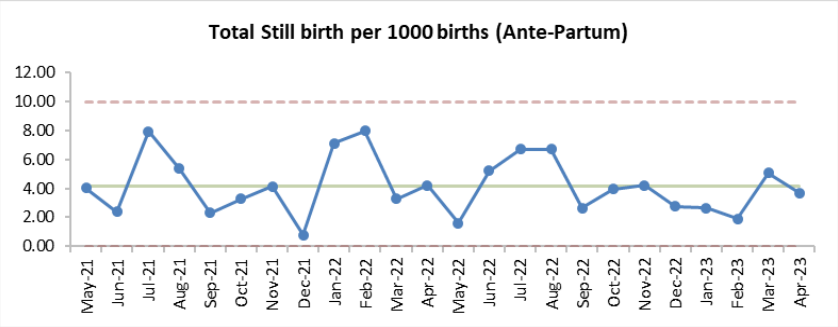
Jul-23

		RAG Rating															Last Month's Site Position		
Category	Metric	Red	Amber	Green	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Royal London	Whipps Cross	Newham
Method of Delivery	Percentage of spontaneous vaginal birth (including vaginal breech Birth)				56.4%	54.5%	56.8%	57.8%	52.0%	53.1%	55.0%	53.9%	50.5%	53.3%	49.3%	52.1%	54.5%	55.1%	56.1%	52.9%
	Percentage of Operative Vaginal Birth				10.3%	10.9%	9.5%	10.7%	11.7%	8.9%	11.7%	9.9%	10.2%	10.6%	11.7%	11.4%	11.1%	15.8%	9.1%	8.2%
	Total Percentage of Birth by Vaginal route				66.7%	65.4%	66.3%	68.5%	63.7%	62.1%	66.7%	63.8%	60.7%	63.9%	61.0%	63.5%	65.6%	70.9%	65.2%	61.1%
Critial Incidents	Percentage PPH ≥ 1500ml	>=4%	3.1% - 3.9%	<=3	4.4%	5.1%	4.7%	3.9%	3.1%	3.8%	3.5%	4.5%	5.5%	4.1%	4.5%	4.6%	3.2%	5.2%	1.1%	2.8%
	Percentage 3/4 degree tear	>=5%	4.1% - 4.9%	<=4%	1.2%	1.4%	0.9%	1.0%	1.6%	1.2%	1.6%	1.9%	1.4%	1.9%	2.2%	1.5%	1.1%	1.3%	0.4%	1.4%
	Maternal Deaths	>1		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Neonatal Morbidity	Number of unexpected term admission to NNU				51	26	37	43	54	41	45	47	38	47	48	40	54	22	12	20
	Neonatal Deaths				2	6	1	1	5	1	5	1	2	2	1	4	5	2	2	1
	Neonatal Deaths per 1000 births	>1.75	1.73 - 1.75	<=1.72	1.69	4.85	0.87	0.84	4.18	0.89	3.93	0.84	1.84	1.75	0.95	3.38	4.60	5.13	7.52	2.31
	HIE				1	1	0	1	0	0	2	1	1	2	2	0	2	0	1	1
	Total Still birth per 1000 births (Ante-partum)				4.22	1.62	5.22	6.71	6.69	2.66	3.93	4.22	2.76	2.63	1.90	5.07	3.68	5.13	3.76	2.31
Workforce	1:1 care in established labour	<90%	90%-94.9%	>=95%	95.8%	98.5%	98.3%	97.4%	97.9%	97.7%	96.3%	97.7%	97.3%	98.5%	98.6%	97.4%	93.5%	90.8%	96.1%	94.4%

EFFECTIVE

Total number of Still births (all) per 1000 births

Jul-23



Indicator Background:

There is a national ambition to reduce stillbirth, neonatal death and brain injury by 50% by 2025. The stillbirth ambition is for the rate to decrease to 2.6 stillbirths per 1,000 births by 2025. The 2020 national rate was 3.8 stillbirths per 1,000 births unchanged since 2019.

What is the Chart Telling us:

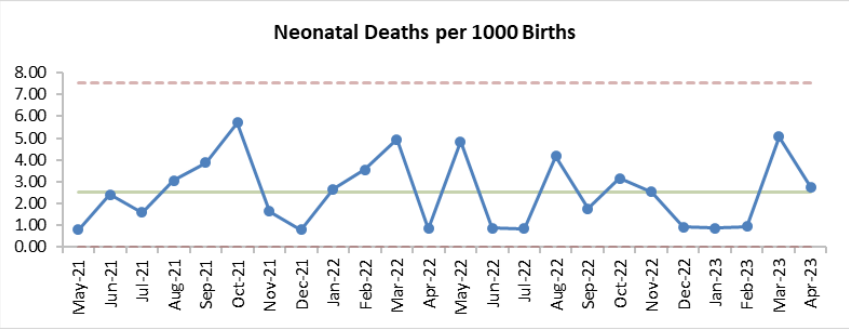
There has been increased rates seen in March and April which are being reviewed in line with governance requirements.

Performance Overview	Responsible Director Update
Stillbirth rates had come in line with national trends, however increases have been seen again in March and April. All cases will be reviewed using the national perinatal mortality review tool and through the incident review framework where indicated. Continued work with the Saving Babies Lives Care bundle will support improvements, and work with the NHS Improvement – Making data count teams, will support improved reporting from next months as SPC charts for safety and quality matrices are now in draft form. In month there were 6 cases. One relates to a case of concealed pregnancy and stillbirth at home unattended. Case reviewed in line with safeguarding requirements, and formal outcome from the coroner is awaited. Two women had a history of repeated reduced fetal movements, one baby had a known abnormality which increases risk of stillbirth, one lady had raised blood pressure, and one with no other known risk factors.	Further work is needed to understand our local population and what targeted approach is required to address any inequalities. In 2022 22% of maternities were of Bangladeshi ethnicity and accounted for 32% of stillbirths, 42% neonatal deaths and 26% BBAs. This data will be used to inform and focus the work on reducing inequalities led by the consultant Midwives across Barts, which is drawing on the data from the North East London review, local outcome measures, and most importantly feedback from women and community groups. Focus of access to early booking, information in accessible forms, and risk assessment will be the pillars of this work. The updated Saving Babies Lives Care Bundle v3 has now been published, and there is a focus on outcome measures, not simply adherence to guidelines and standards. This work will be supported by the local maternity and neonatal system (LMNS), and a QI approach adopted to understand the impact of our interventions across different population groups. The care bundle includes monitoring of growth restriction in babies, diabetes care, fetal monitoring training for staff, management of and education for women and staff on reduced fetal movements, optimisation of the pre-term infant, and smoking cessation.

EFFECTIVE

Neonatal Deaths per 1000 Births

Jul-23



Indicator Background:

Prior to 2021, the national ambition covered all neonatal deaths, and required the neonatal mortality rate to fall to 1.5 deaths per 1,000 live births by 2025. In 2021, the ambition was revised, as outlined in the Safer maternity care progress report 2021.The ambition was changed to 1.0 neonatal deaths per 1,000 live births for babies born at 24 weeks or over (1.3 for all gestations).

What is the Chart Telling us:

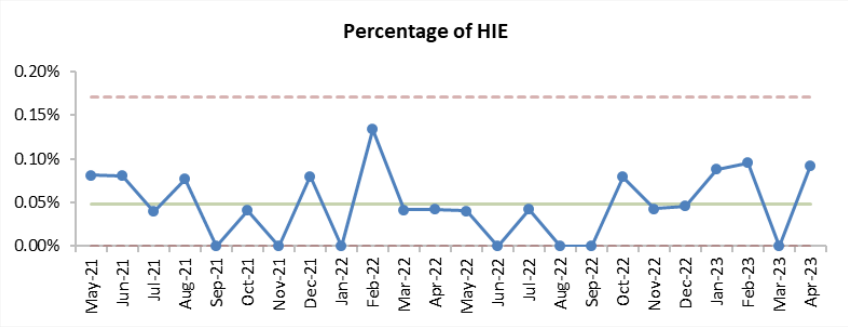
The charts tell us that thankfully neonatal deaths are rare. Because of this, that data fluctuates from month to month. Work with the Making Data Count team at NHS Improvement will support the development of a rare events chart which will assist with visualisation of performance and outcomes.

Performance Overview	Responsible Director Update
Neonatal death rates are not corrected for our tertiary neonatal service at Royal London Hospital on this data set, but can be seen for 2021 in the latest MBRACE report online. Our adjusted and stabilised rate for neonatal deaths is 2.26:1000, which is broadly in line with similar organisations. In month there were 3 neonatal deaths, two cases are for babies born at the extremes of prematurity, and one for a baby who was born with multiple known abnormalities.	Further work is needed to understand our local population and what targeted approach is required to address any inequalities. In 2022 22% of maternities were of Bangladeshi ethnicity and accounted for 32% of stillbirths, 42% neonatal deaths and 26% BBAs. This data will be used to inform and focus the work on reducing inequalities led by the consultant Midwives across Barts, which is drawing on the data from the North East London review, local outcome measures, and most importantly feedback from women and community groups. Focus of access to early booking, information in accessible forms, and risk assessment will be the pillars of this work.

EFFECTIVE

HIE

Jul-23



What is the Chart Telling us:

Nil of note for March for babies born and receiving treatment in neonatal facilities at Barts health.

Indicator Background:

The rates for brain injury or HIE fluctuate monthly across the sites, Cases of severe brain injury are fortunately rare. Babies who are born in poor condition at birth are reviewed by our neonatal teams to review suitability for cooling therapy which is known to reduce the severity of injury to the brain following acute onset of hypoxia during birth. Cooling therapy is known to slow down the changes in the brain which can continue to have a detrimental effect even after the hypoxic insult has occurred. Babies are cooled for 72 hours, their body temperature is reduced and they are sedated and made comfortable during this process with various medications. Bart's Health provides this therapy at the Royal London site, and we also refer babies to The Homerton hospital where needed.

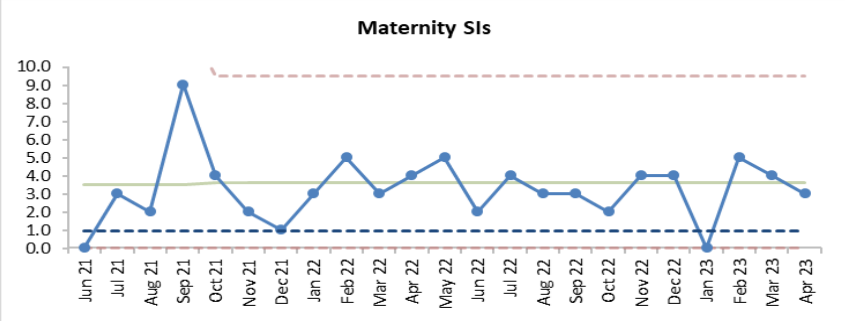
Brain injury can be as a result of changes that occur during the pregnancy as a result of reduced blood flow to the placenta, but can also occur during labour, which is why foetal monitoring is a vital component of safe care. Any cases where a baby is referred for cooling and has a brain injury is referred for external review by HSIB. Improvement work at Barts health focuses on foetal well being in pregnancy and good foetal monitoring during labour to identify early signs of hypoxia and to help us deliver these babies in a timely way.

Performance Overview	Responsible Director Update
This data has been taken from Maternity Dashboard and only from babies born and treated at Barts Health. Work with the ODN has started to ensure we are capturing babies born at Barts who have treatment and diagnosis for HIE at other centres.	Initial review finding are that the HIE rates being expressed through current dashboards, underrepresent the numbers of babies who have care for labour and birth at Barts Health and who sustain brain injury. This is because the patient is diagnosed and treated for brain injury (including cooling) at another facility. The babies who transfer between units are therefore not reported on any hospital dashboard, but the Neonatal ODN are collecting this data and will be adding it to their monthly dashboard. Yearly data shows that case numbers are 30-50% higher when all cases are included regardless of neonatal care location. Further detail to be reviewed in the strategic maternity and neonatal group.

EFFECTIVE

Maternity - Sis

Jul-23



Indicator Background:

An SI is an incident in which a patient, member of staff or members of the public suffers serious injury, major permanent harm, or unexpected death, (or the risk of death or injury), on hospital premises. It could be an incident where the actions of healthcare staff are likely to cause significant public concern. It can also be an incident that might seriously impact upon the delivery of service plans and/or may attract media attention and/or result in litigation and/or may reflect a serious breach of standards or quality of service.

In maternity some incidents will still be declared as Sis even if it was not deemed that there was a lapse in care standards due to the serious impact this may have on the woman or baby and the opportunity for learning.

Performance Overview	Responsible Director Update
During the month of March there were 6 maternity serious incidents reported, however two incidents had a delay in recording to STEIS, so 4 incidents in month. Rapid learning is shared at site level, and across the sites as part of the senior midwifery leadership weekly meetings. Learning is also filtered through to the clinical simulation programme and educational updates for staff.	There were three cases related to HIE/Cooling (NB data issues with HIE data as detailed in previous slide). A de-escalation request for one case has been requested as there were no care issues identified during an internal investigation. There were two cases relating to significant postpartum haemorrhage >1500mls (both reported to STEIS in March but occurred in Feb), and one case relating to a maternal readmission and transfer to ITU following a stroke. Joint investigation between obstetrics and the stroke team is underway. Some early learning relating to recognition of deterioration and escalation have been identified, and specific learning shared with clinical teams as part of the various opportunities for learning that are shared including at team huddles, messages of the week, hot topics and more formal education updates.

Jul-23

NHS
Barts Health
NHS Trust

Operational Performance Report

SUMMARY

Operational Summary

Jul-23

Summary Performance

Urgent & Emergency Care

- For 2023/24 the NHS has set a 76% A&E performance standard to be achieved by all trusts by March 2024.
- In May 2023, 44,395 attendances were recorded, 5,636 (+14.5%) more than recorded in April.
- A&E 4-hour performance for May reduced from April's 73.2% to 67.9%, a 5.3% reduction.
- The proportion of patients with an A&E 12-hour journey time increased from 4.2% in April to 5.3% in May (+1.1%), against a national standard of no greater than 2%.
- For May 2023, 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 11th out of 16 trusts reporting data in London and was ranked 6th out of the top 10 English trusts (ranked by volume of attendances) reporting data.

Cancer

- In April 2023 a performance of 78.5% was recorded in relation to the 2 week wait standard of 93%, a reduction of 11.7% against March's 90.2%. Breaches of the standard increased from 332 in March to 641 in April (+309), performance for the month was impacted by Industrial Action which occurred between 11 - 15 April as well as the Easter holiday period.
- Barts Health has had strong aggregated performance for the Faster Diagnosis Standard, requiring that at least 75% of patients should wait no longer than 28 days from referral to finding out whether or not they have cancer, whilst performance against the standard has been challenged since October 22, the trust returned to compliance in both February and March 2023. For April the trust achieved the standard for Breast Symptomatic and Screening referrals, however did not achieve the standard for All (aggregated) referrals, recording a performance of 70.4%, a reduction of 5.3% against March's 75.7%.
- With continued focus from NHS England on 62 day backlog clearance as at 11 June 2023 North East London (NEL) had the second lowest backlog of the London Integrated Care Boards (ICBs), with 619 patients waiting over 62 days, at 7.1% of the total waiting list, this represented the second lowest proportion of long waiters of any of the London ICBs.

Diagnostics

- For May 2023 a performance of 80.6% was recorded, a movement of 3.2% against April's 77.4%.
- In May the greatest challenge remained in MRI, non-obstetric ultrasound (NOUS) and audiology. MRI breaches accounted for 20.1%, NOUS breaches 44.4% and Audiology breaches 15.9% of all breaches in the month.
- Opportunities for process and productivity improvements; helping to mitigate the need for additional staff, are being developed.

Elective Care

- For 2023/24 the NHS has set all trusts elective activity targets designed to return activity to greater than pre-pandemic levels and support the clearance of long-waiter backlog. For May 2023 the trusts admitted (inpatient and day case) trajectory set a target of 8,260 admissions against which the trust delivered 7,919 (-341 admissions).
- For outpatients (first and follow up) for the same month the trajectory set a target of 136,608 attendances, against which the trust delivered 132,926 (-3,682 attendances).
- Admitted and Outpatient activity was impacted by the three Public Holiday's resulting in fewer working days in the month.
- The validated Referral to Treatment waiting list for May 2023 was 117,793, an increase of 900 against April's 116,893.
- In relation to the RTT month-end nationally submitted data the trust reported 8 pathways waiting 104+ weeks at the end of May 2023, an increase of 5 pathways against the April position.
- In relation to 78+ week wait backlog volumes, 292 pathways were reported at the end of May, a reduction of 2 against the April position.
- For 2023/24 the NHS has set all trusts the objective of clearing 65+ week wait backlog volumes by March 2024. At the end of May the trust recorded 1,977 pathways waiting 65+ weeks, an increase of 69 against the April position, against the clearance trajectory of 1,813 this was 164 greater than plan.

RESPONSIVE

Domain Scorecard

Jul-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
A&E 4 Hours Waiting Time	●			May-23 (m)	>= 72%	73.2%	**67.9%**	***70.4%***	62.4%	74.4%	68.7%	-	-	67.9%
A&E 12 Hours Journey Time	●			May-23 (m)	<=2.0%	4.2%	**5.3%**	-	5.8%	5.6%	4.3%	-	-	5.3%
Ambulance Handover - Over 60 mins				May-23 (m)	-	370	**510**	-	90	232	188	-	-	510
Ambulance Handover - Over 30 mins				May-23 (m)	-	1,313	**1,338**	-	415	412	511	-	-	1,338
Cancer 62 Days From Urgent GP Referral	●			Apr-23 (m)	>= 85%	64.8%	**59.6%**	***59.6%***	60.3%	64.6%	43.8%	55.4%	-	59.6%
Cancer 31 Day Diagnosis to First Treatment	●			Apr-23 (m)	>= 96%	96.2%	**93.9%**	***93.9%***	91.0%	91.7%	100.0%	96.4%	-	***93.9%***
Cancer 28 Day FDS 2WW	●			Apr-23 (m)	>= 75%	74.2%	**68.8%**	***68.8%***	65.9%	64.9%	78.9%	83.8%	-	68.8%
Cancer 28 Day FDS Breast Symptomatic	●			Apr-23 (m)	>= 75%	91.2%	**87.6%**	***87.6%***	-	86.7%	90.7%	86.6%	-	87.6%
Cancer 28 Day FDS Screening	●			Apr-23 (m)	>= 75%	73.3%	**84.8%**	***84.8%***	82.4%	0.0%	93.3%	-	-	84.8%
Diagnostic Waits Over 6 Weeks	●			May-23 (m)	>= 95%	77.4%	**80.7%**	***79.1%***	71.3%	95.1%	93.7%	73.0%	100.0%	80.7%
65+ Week RTT Breaches	●			May-23 (m)	1,944	1,908	**1,977**		1,232	539	193	12	1	1,977
78+ Week RTT Breaches	●			May-23 (m)	0	294	**292**		186	54	52	0	-	292
104+ Week RTT Breaches	●			May-23 (m)	0	3	**8**		6	1	1	0	-	8
Completeness of Ethnicity Recording				May-23 (m)		91.7%	**91.8%**	-	91.2%	91.7%	92.9%	92.0%	-	91.8%

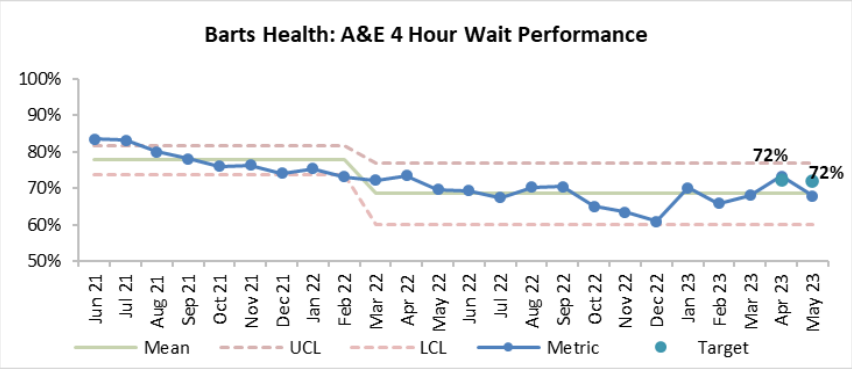
Note to table:

- The A&E target presents monthly trajectory values designed to deliver the national ambition of 76% 4-hour performance by March 2024
- 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 targets are zero for 2023/24, however NHS England have set the trust a deadline of end June 23 to clear 78+ week backlog
- A 95% target for Diagnostic six week waits is required by March 2025 so no RAG rating is applied for this year

RESPONSIVE
Urgent & Emergency Care

A&E 4 Hour Waiting Time

Jul-23



Indicator Background:

The A&E four-hour waiting time standard requires patients attending A&E to be admitted, transferred or discharged within four hours. From 2010 the four-hour A&E waiting time target required that at least 95% of patients were treated within four-hours.

As a consequence of the impact of the Covid pandemic, during December 2022 an intermediary threshold recovery target of 76% was set to be reached by March 2024 with further improvement expected in 2024/25. Fundamentally the four-hour access target is a clinical quality and patient experience measure.

Trust Performance Overview

- In May 2023, 44,395 attendances were recorded, 5,636 (+14.5%) more than recorded in April.
- A&E 4-hour performance for May reduced from April's 73.2% to 67.9%, a 5.3% reduction.

What is the Chart Telling us:

The data records a reducing trend in relation to performance against the 4-hour standard since the start of the data-series in June 2021. A reducing step-change is triggered from February 2022 resulting from a run of 8 data-points below the preceding mean. A degree of variability is visible in the data from December 2022, with that month recording the lowest performance in the data-series and April 2023 recording the highest since April 2022 with May performance reducing to below the mean.

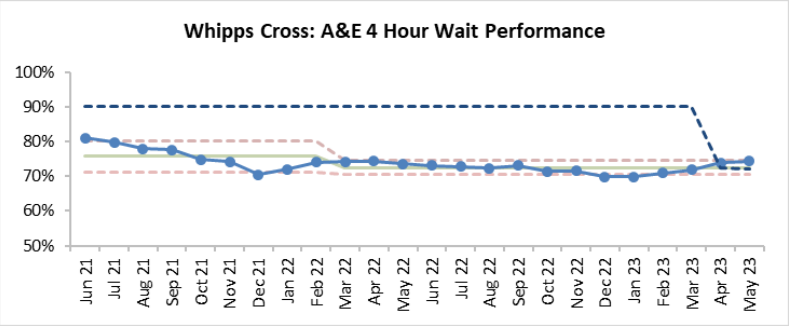
Trust Responsible Director Update

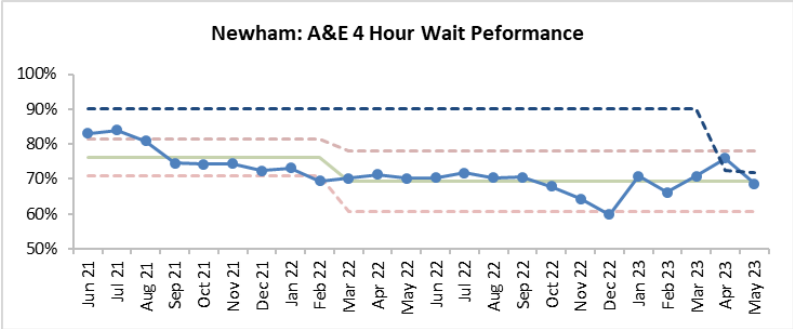
- During late May and early June, the Trust planned for a further period of industrial action by the BMA. Early indications are that this planning was successful with better resilience in our Urgent Emergency Care (UEC) Rotas across the group and higher levels of Elective Activity maintained. No significant safety concerns were reported throughout the period.
- Mental Health patients' waiting for extended periods of time continue to present a safety and performance risk for both patients and staff. In response to the ongoing issues (particularly impacting Whipps and RLH) a CEO Escalation meeting was held NEL-wide on 15 June. The outputs from this meeting amongst other things include a "Mental health in ED" summit. The outputs will also need to include a clearer position on mental health capacity across NEL as this is currently a key challenge.
- Whipps Cross continues to met the submitted 4-hour trajectory.
- RLH and Newham and both challenged in the delivery of the UEC trajectories although, there is some early evidence of improved performance at Newham.
- As a result of this underperformance, the Urgent Care Board (UCB) has requested that each of the Hospitals produce revised trajectories using year-to-date performance as the base line.
- UCB focus in May and June has been on these recovery plans. At RLH, UTC performance is responsible for the biggest deviation from trajectory (although there are other factors at play). Significant performance variation can be seen in type 3 activity and work is underway with the Commissioners who are responsible for this service with a focus on more robust staffing arrangements and escalation.
- Short term recovery at RLH will also address flow challenges aiming for earlier in the day discharges. This work is being comprehensively supported by Group Improvement &Transformation (I&T) teams who started on site in early June. RLH has also planned to improve short term performance through focused work in Ambulatory Care and stream away models. Delivery on the revised trajectory will be overseen weekly at UCB.
- At Newham some improvement is evident in June however, the Hospital is still below trajectory. The key areas of work again overseen by UCB include improvement in nursing resilience in Newham 's UTC, increased senior leadership in ED through an increase in direct time for patient care and the introduction and embedding of a new escalations policy across UTC/ED.

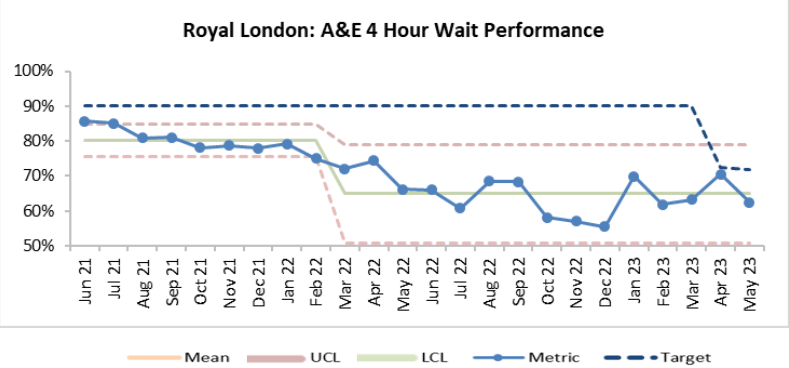
RESPONSIVE
Urgent & Emergency Care

A&E 4 Hour Waiting Time

Jul-23







Hospital Site Performance Overview

Whipps Cross:
For May 2023 Whipps Cross recorded a performance of 74.4%, an improvement of 0.4% against April's 74.0%. Between April and May attendances increased by 1,641 from 11,621 to 13,262, an increase of 14.1%.

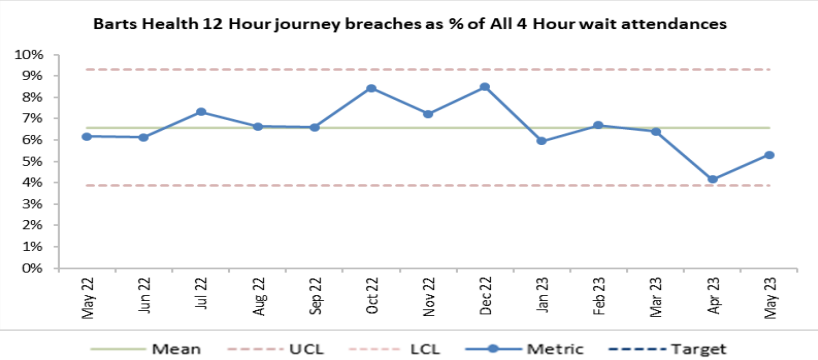
Newham:
For May 2023 Newham recorded a performance of 68.8%, a significant reduction of 7.1% against April's 75.9%. Between April and May attendances increased by 1,663 from 11,740 to 13,403, an increase of 14.2%.

Royal London:
For May 2023 the Royal London recorded a performance of 62.4%, a significant reduction of 8.2% against April's 70.6%. Between April and May attendances increased by 2,332 from 15,398 to 17,730, an increase of 15.1%.

RESPONSIVE
Urgent & Emergency Care

A&E 12 Hrs Journey time

Jul-23



Trust Performance Overview

Hospital site performance:
The proportion of patients with an A&E 12-hour journey time increased from 4.2% in April to 5.3% in May (+1.1%), against a national standard of no greater than 2%.

Indicator Background:

The NHS has two methods for measuring twelve-hour A&E waiting times. The first, also referred to as "trolley waits", refers to the elapsed time from the point a decision is made to admit a patient to the point the patient leaves A&E to be admitted to a hospital bed. As such the standard only measures waiting time against the twelve-hour threshold for patients requiring admission and does not include the period prior to a decision to admit being made.

The second method measures the elapsed time from the moment a patient attends A&E to the time they are admitted, discharged or transferred. As such this version of the standard is referred to as the "total journey time" as it measures all elements of the patients journey regardless of whether or not they require admission.

Both versions of the standard are designed to measure and improve patient experience and clinical care. However, it is the "journey time" standard reported in this section of the performance report. 12 hour journey time is a key performance and safety metric with the Royal College of Emergency Medicine noting a correlation of long waits in EDs to potential patient harm and clinical outcome.

What is the Chart Telling us:

The chart presents considerable data-variability above and below the mean (Green line) however without any continuous trends visible in the data or statistically significant breaches of the upper and lower confidence limits.

April 2023 recorded the lowest proportion of 12-hour breaches in the entire data-series stretching back to April 2022 at 4.2%, however breaches increased in May to 5.3%.

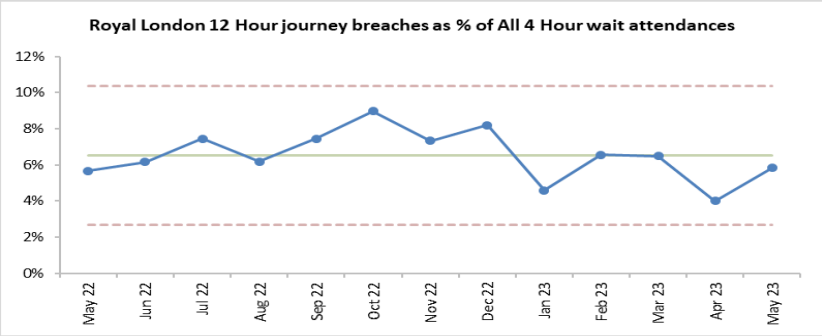
Trust Responsible Director Update

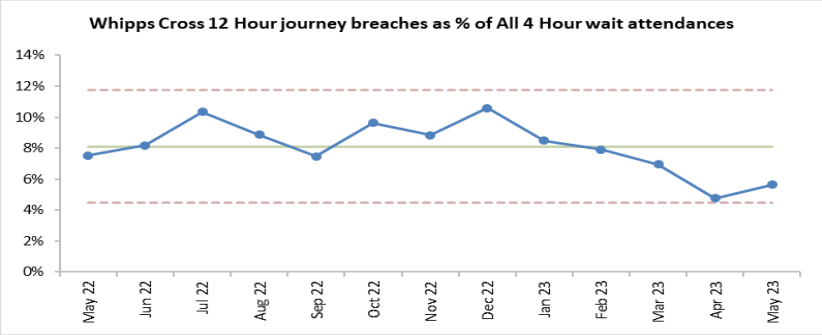
- Extended waits for Mental Health patients are a significant contributory factor at Whipps Cross. In May, 109 patient waited more than 12 hours at Whipps Cross of which 29 were mental health patients.
- All hospitals have a continued challenge to make the required threshold of 2%.
- May 23 saw a deterioration in performance in each of the Hospitals which is possibly, a reflection of some of the operating pressure experience.
- Hospital recovery activity supported by Improvement and Transformation is focusing on improved flow and early discharge both of which will improve performance against this threshold
- The UCB is sharpening its focus on 12-hour waits with some early evidence of improvement thus far in June.

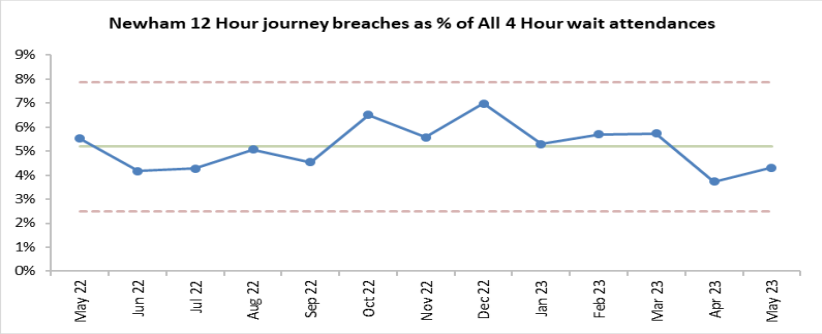
RESPONSIVE
Urgent & Emergency Care

A&E 12 Hrs Journey time

Jul-23







Mean UCL LCL Metric Target

Hospital Site Performance Overview

Royal London:
The proportion of 12-hour wait times recorded at the Royal London was 5.8% for May 2023, an increase of 1.8% against April's 4.0%.

Whipps Cross:
The proportion of 12-hour wait times recorded at Whipps Cross was 5.7% for May 2023, an increase of 0.9% against March's 4.8%.

Newham:
The proportion of 12-hour wait times recorded at Newham was 4.3% for May 2023, an increase of 0.6% against April's 3.7.

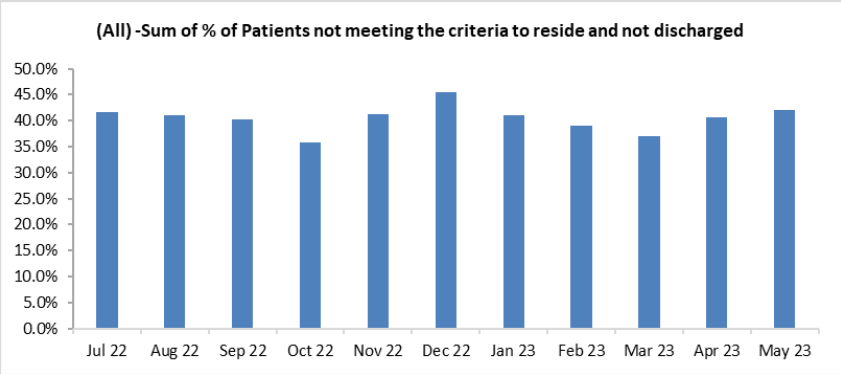
The number and proportion of 12-hour breaches is heavily influenced by the pressure A&E's are under, including the volume of attendances, during May 5,636 more attendances were recorded against April (+14.5%).

RESPONSIVE
Urgent & Emergency Care

Discharge Activity

Jul-23

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



Indicator Background:

Once people no longer need hospital care, being at home or in a community setting (such as a care home) is the best place for them to continue recovery. However, unnecessary delays in being discharged from hospital are a problem that too many people experience. Not only is this bad for patients but it also means the bed cannot be used for someone who needs it, either waiting for admission from A&E or waiting for an elective admission from the waiting list.

In order to focus attention on this issue all hospitals are required to review their patients every day against what are known as the "criteria to reside". Where a patient no longer needs to be in a hospital bed then they also no longer meet the criteria to reside and should have an active plan in place to discharge them, in some cases with support from health and social care services, or they may require a residential placement in a community setting. Lack of community resources or inefficient hospital discharge processes can result in such patients remaining in a hospital bed.

It is these patients that are reported in this section of the Board report. While there is no national target, the number and proportion of no criteria to reside patients should be as small as possible and reducing over time.

A new national discharge ready metric will be reported on a daily basis and replaces the 'no criteria to reside' category. This return and discharge processes requires continuing close partnership working between Local Authorities, social care colleagues and acute providers.

Trust Performance Overview

- In May 2023 9.2% of our bed base was occupied by patients with no criteria to reside. Trust wide this is the equivalent of 753 patients (average across the month of 24 patients a day) and a total of 4,003 bed days.
- Royal London: 11.8% equivalent to 312 patients, average across the month of 10 patients a day.
- Whipps Cross: 10.5% equivalent to 273 patients, average across the month of 8 patients a day.
- Newham: 9.7% equivalent to 157 patients, average across the month of 5 patients a day.
- St Bart's: 0.9% equivalent to 13 patients, average across the month of less than 1 patient per day

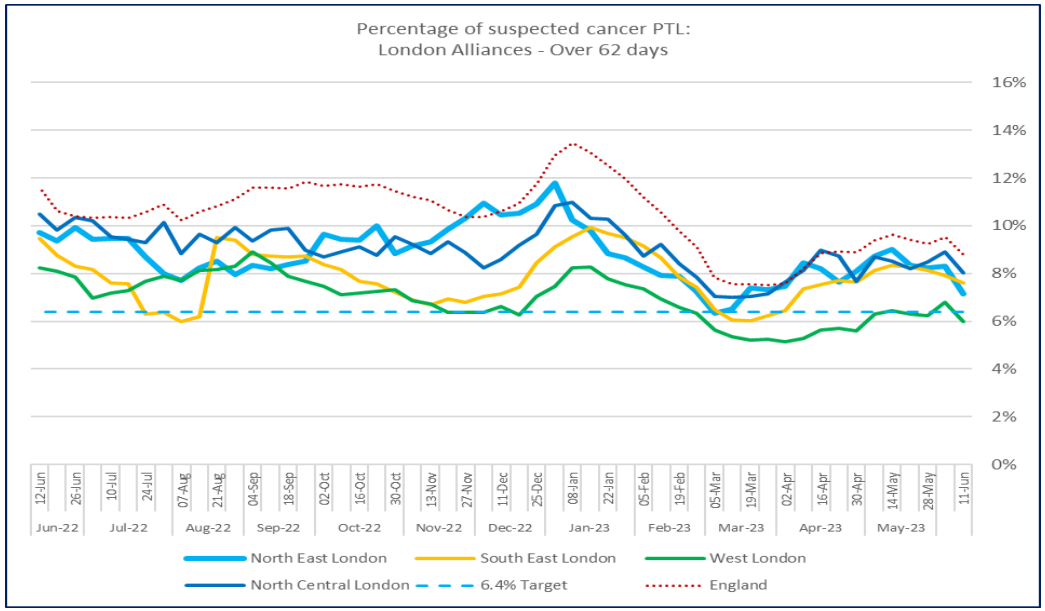
Trust Responsible Director Update

- The Group continues to focus on criteria to reside activity in the non-complex cohort of patients were there is greater early opportunity to improve flow and reduce the number of medically optimised patients.
- The National ambition is to achieve 33% of discharges before 11am. May 23 data for the Group showed 56% of discharges before 5pm.
- This opportunity is recognised by the Hospitals as it will improve flow, reduce pressures in our ED and lower the rate of elective cancellation.
- Hospital plans, supported by our Improvement and Transformation teams are focusing on improved capacity and capability in Same Day Emergency Care, Virtual Wards and Flow. These workstreams should allow UCB to oversee earlier rates of discharge at its weekly meeting.
- A summary of I&T focus by site:
    - RLH - focus on bringing discharge forward in the day and rapid release. Engagement session with RLH senior team, led by Hospital CEO, to clarify role and focus of I&T support. Communication with wards in place, launch of rapid improvement on 10th July.
    - NUH - focus on strengthening project plans, ownership and areas of focus. Connected with site QI team.
    - WX - agreed focus on standing up SDEC and surgical assessment unit. Collaborative model across unplanned care, aligned to redevelopment team and site QI team.

Cancer waiting times Benchmarking performance

Cancer Benchmarking Against Other Trusts

Jul-23



11-Jun	Over 62 days	Change in last week	% of Total PTL	Gap from 6.4% Target
North East London	**619**	**-63**	**7.1%**	**-64**
North Central London	716	-59	8.0%	-144
South East London	609	-42	7.6%	-95
West London	887	-96	6.0%	61
England	**22609**	**-1571**	**8.8%**	-975

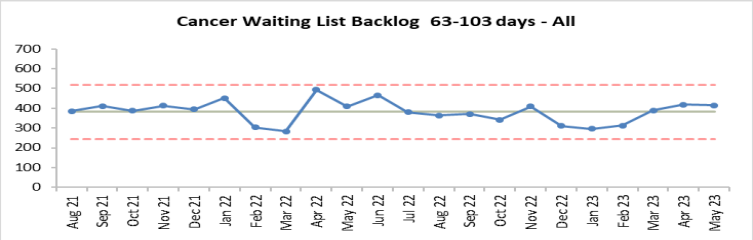
11-Jun	Over 62 days	Change in last week	% of Total PTL	Gap from 6.4% Target
North East London	619	-63	7.1%	-64
Barking	**179**	**-17**	**5.1%**	**44**
Barts Health	**411**	**-42**	**9.8%**	**-141**
Homerton Univ	**29**	**-4**	**3.0%**	**32**
London	2831	-260	7.0%	-242

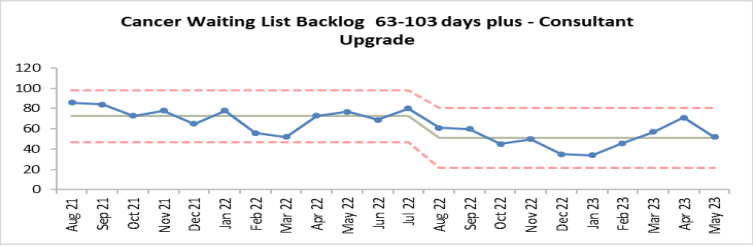
- In April, in the published CWT standards, Barts Health achieved 3 of the 10 constitutional standards at the treatment end of the pathway, which meant NEL was the best performing cancer alliance nationally, achieving 2 of the 10 standards, compared to 1-4 within other alliances.
- As at 11 June 2023, North East London (NEL) has the second lowest overall backlog against the London Integrated Care Boards, with 619 patients, at 7.1% compared to West London who had a backlog of 6%.
- The Barts Health backlog has reduced from > 12% in May to 9.8% in June with 411 patients waiting over 62 days. Due to the increased backlog (In May) NHS England has placed Barts Health in the Tier Two performance category, with bi-weekly assurance meetings established from 15th June.
- An eight week programme of clinical and operational >62 day backlog review has commenced at the beginning of June, chaired by the Group Chief Operating Officer, with the Cancer Clinical Lead, Group Director and hospital senior managers to identify themes for improvement, to date Urology and Colorectal have taken place.

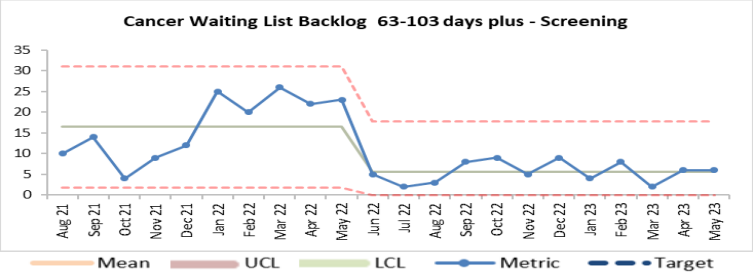
RESPONSIVE
Cancer

Cancer 63 -103 Waiting List Backlog

Jul-23







Indicator Background:

The NHS has for many years set a standard that 85% of patients urgently referred by their GP for suspected cancer, or urgently referred from a cancer screening programme or by a consultant upgrading the urgency of the referral should be treated within 62 days.

What is the Chart Telling us:

Despite reducing step-changes for 63+ day backlog resulting from Consultant Upgrade and Screening service referrals this has not been sufficient to drive a reducing step-change against All 63+ day backlog, with three of the last four data points showing an increase, with a slight reduction in May.

Trust Performance Overview

- The NHS has set the reduction in the number of patients waiting more than 62-days from an urgent referral to treatment as a priority for 2023/24. This requires the trust to reduce backlog to no greater than 279 patients, pre-pandemic levels, by March 2024.
- The May 2023 backlog reduction milestone is set at 378 against which the trust recorded 554, 22 greater than April and 176 greater than plan.

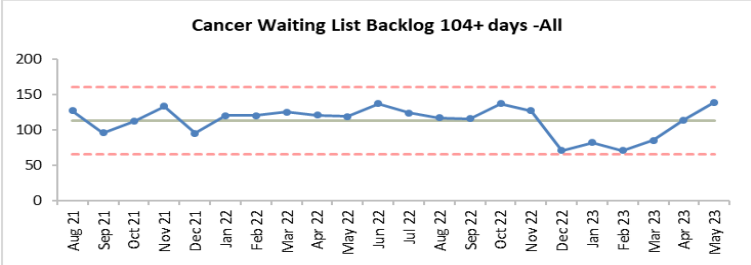
Trust Responsible Director Update

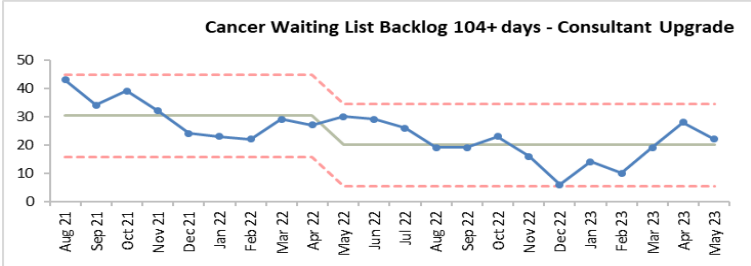
- As at 22nd June the total backlog is 477 of that 391 are GP referrals, 79 are consultant upgrades and 7 are screening.
- The current GP backlog related to the 214 Urology , 82 Colorectal and 73 ENT patients. Urology delays due to flexi and template biopsy diagnostic capacity. There were delays in seeing ENT and Urology patients within two weeks, which has led to influx of patients now in the backlog awaiting diagnosis, which are being tracked daily. Colorectal delays in Endoscopy capacity and poor bowel prep.
- A detailed review for the upgrade patients is planned for WC 26th June 23.
- The reviews into Colorectal and Urology have highlighted some key themes, which has resulted in further reviewed planned in the summer into other specialities. The key themes were, adherence to the trust access policy, improve escalation within the group, diagnostic and histopathology delays with plans to mitigate.

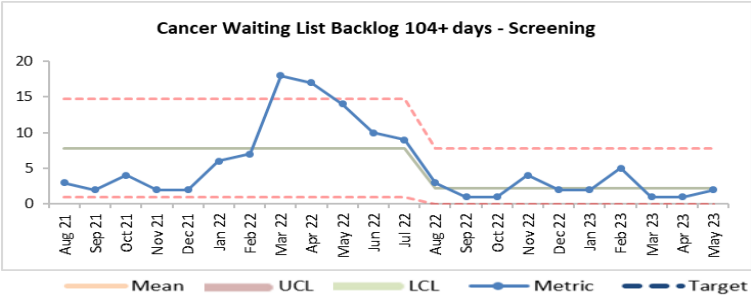
RESPONSIVE
Urgent & Emergency Care

Cancer 104+ Waiting List Backlog

Jul-23







Indicator Background:

The NHS has for many years set a standard that 85% of patients urgently referred by their GP for suspected cancer, or urgently referred from a cancer screening programme or by a consultant upgrading the urgency of the referral should be treated within 62 days.

The NHS has made it a priority to clear this backlog with the number of patients waiting longer than 62 days no greater than at the start of the Covid pandemic by March 2023.

What is the Chart Telling us:

For Consultant Upgrade and Screening the charts present reducing step-changes in the data series resulting from a run of 8 data-points below the preceding mean, meaning backlog has reduced over the course of the charts time-series. However, the reductions have been insufficient to drive a reducing step change against All patients waiting with the last three data points recording an increase in backlog.

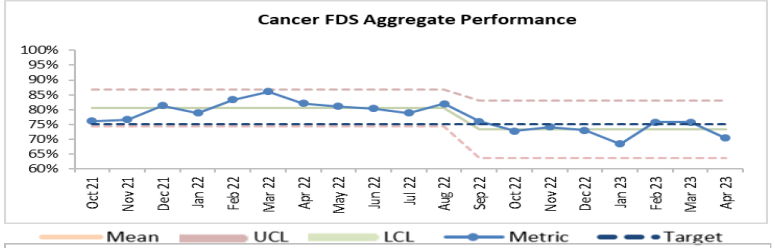
Trust Performance Overview

- The charts opposite present the 139 cancer pathways waiting greater than 104 days, an increase of 25 against the April position. The charts present the number of patients waiting by All referrals, Consultant Upgrade and Screening service referrals. This represents all patients waiting 63 days and above. All of these patients would go through the clinical harm review process, once treated.

RESPONSIVE

Cancer Faster Diagnosis Standard Metrics

Jul-23



Cancer Faster Diagnosis Standard (FDS) Metrics

	Mar-23			Apr-23			
Metric	**Seen**	**Breaches**	**%**	**Seen**	**Breaches**	**%**	**Variance**
28-Day FDS Aggregate	3,034	737	75.7%	2,441	722	70.4%	-5.3%
Cancer 28 Day FDS Breast Symptomatic	262	23	91.2%	185	23	87.6%	-3.7%
Cancer 28 Day FDS Screening	28	5	82.1%	33	5	84.8%	2.7%

Breakdown by Tumour Sites Failing 28 Day FDS Aggregate

Tumour Site	Seen	Breaches	Performance
All Tumour Sites	**2441**	**722**	**70.4%**
Brain/CNS	6	2	66.7%
Breast	431	55	87.2%
Breast Symptomatic	185	23	87.6%
Children's	5	1	80.0%
Gynaecological	204	84	58.8%
Haematological	20	10	50.0%
Head and Neck	270	105	61.1%
Lower Gastrointestinal	355	186	47.6%
Lung	35	9	74.3%
Skin	454	35	92.3%
Testicular	18	12	33.3%
Upper Gastrointestinal	200	84	58.0%
Urological	214	110	48.6%
Other	44	6	86.4%

Indicator Background:

Over the last two years the 28-day Faster Diagnosis Standard has been introduced. The standard requires at least 75% of people who have been urgently referred for suspected cancer, have breast symptoms, or have been picked up through cancer screening, to have cancer ruled out or receive a diagnosis within 28 days.

The Faster Diagnosis Standard is considered a better measure for clinical care and patient experience than the two-week wait target. The two-week wait target simply measured the time from referral to seeing a specialist, it did not measure waiting times for diagnostic tests, results reporting and for the patients to be told whether or not they have cancer. However two-week waiting times continue to be reported to the NHS and are included on the next page.

What is the Chart Telling us:

The SpC chart presents performance against the GP Urgently Referred element of the standard. For the period December 2021 to August 2022 compliance was achieved against the 75% standard, however the trust was non-compliant for the period September 2022 to April 2023.

Trust Performance Overview

Performance against the 75% standard has been challenged since October 2022, however the trust returned to compliance against the aggregated element of the standard in February and March, but performance reduced below the standard in April. For April the trust achieved the standard for Breast Symptomatic and Screening referrals, however did not achieve the standard for All (Aggregated) referrals, recording a performance of 70.4%, a reduction of 5.3% against March's 75.7%.

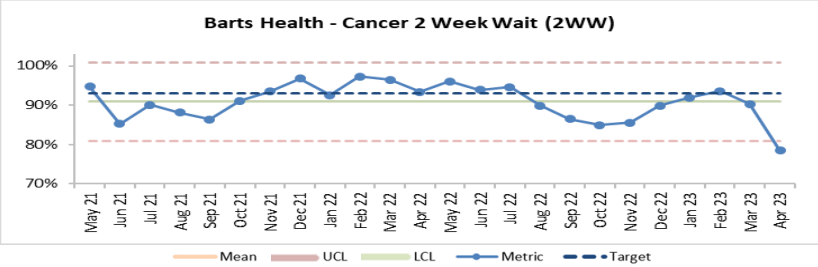
Trust Responsible Director Update

- As at 22nd June the total backlog is 477 of that 391 are GP referrals, 79 are consultant upgrades and 7 are screening.
- The current GP backlog related to the 214 Urology , 82 Colorectal and 73 ENT patients. Urology delays due to flexi and template biopsy diagnostic capacity. There were delays in seeing ENT and Urology patients within two weeks, which has led to influx of patients now in the backlog awaiting diagnosis, which are being tracked daily. Colorectal delays in Endoscopy capacity and patients who have had difficulty in re test preparation.
- The testicular breaches in April were due to 2WW capacity shortfall that was cleared in May 23, so will not longer be a risk.
- A detailed review for the upgrade patients is planned for WC 26th June 23.
- There has been two deep dives into Colorectal and 1 into Urology, both with further meetings planned during the summer. The key themes were, adherence to the trust access policy, improve escalation within the group, diagnostic and histopathology delays.
- There is an NEL MDT Engagement Event planned for 5th July, chaired by the MDT Improvement Lead. The purpose of this is to share best practice and look at opportunities for learning.

RESPONSIVE

Cancer 2 Week Wait

Jul-23



Cancer 2WW Breakdown by Site - Mar-23

Site	Seen	Breaches	Performance	Target
Royal London	1,720	320	81.4%	93.0%
Whipps Cross	3,386	188	94.4%	93.0%
Newham	1,108	12	98.9%	93.0%
St Bart's	592	144	75.7%	93.0%
Barts Health	**6,806**	**664**	90.2%	**93.0%**

Breakdown by Tumour Sites Failing Cancer 2WW Standard - Mar-23

Tumour Site	Seen	Breaches	Performance
All Tumour Sites	**3,403**	**332**	**90.2%**
Urological	350	58	83.4%
Head and Neck	414	65	84.3%
Breast	644	73	88.7%
Gynaecological	417	42	89.9%
Upper Gastrointestinal	262	26	90.1%
Lung	74	7	90.5%
Skin	537	42	92.2%

Indicator Background:

The Cancer two-week wait standard has been in place for many years and requires at least 93% of patients urgently referred by their GP for suspected cancer to receive a first outpatient appointment within two-weeks. The standard also requires 93% of patients with breast symptoms, where cancer is not suspected, to receive a first hospital assessment within two-weeks.

Over the course of the last two years the 28-day Faster Diagnosis Standard, reported on the previous page, has been introduced as a better measure of clinical care and patient experience as it includes waiting times for diagnostic tests, results reporting and for the patient to be told whether or not they have cancer.

What is the Chart Telling us:

The SpC chart details a period of variable performance against the 93% standard for the period May 2021 to January 2022. However, the trust returned to compliance between February 2022 and July 2022, before returning to non compliance between August 2022 to January 2023. The trust was non compliant in the last two months of the data series, March and April 2023 with April's performance dropping below the lower confidence limit, a significant reducing change in performance.

Trust Performance Overview

In April 2023 a performance of 78.5% was recorded in relation to the 2 week wait standard of 93%, a reduction of 11.7% against March's 90.2%. Breaches of the standard increased from 332 in March to 641 in April (+309), performance for the month was impacted by Industrial Action which occurred between 11 - 15 April as well as the impact of the Easter holiday period.

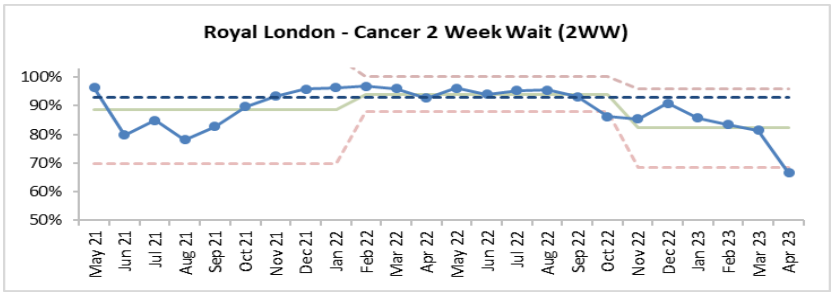
Trust Responsible Director Update

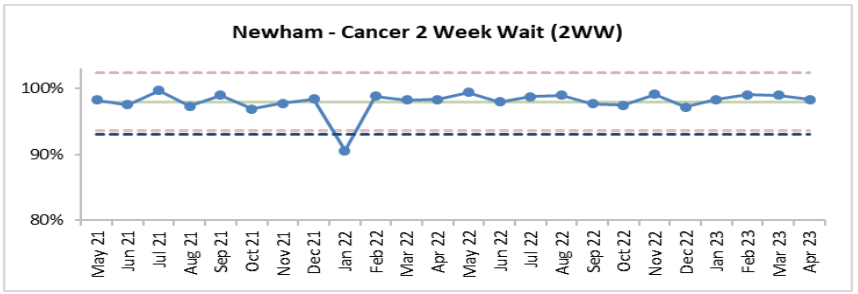
- The April 2ww position was 78.5% with 2980 attendances.
- May's position was 78.3% with 3392 attendances, which is higher than the 22/23 average of 3123. This was due to Breast (288), ENT (132) and Gynaecology (126).
- The group saw fewer cancelled 2WW in June compared to two previous strikes.
- The trust was non complaint with the 93% standard in March 2023 with a performance of 90.2%. Performance was primarily driven by the Royal London and also St Bart's, both Whipps Cross and Newham were compliant with the standard. At the Royal London the greatest volume of breaches were recorded in Head & Neck, Urology and Skin. At St Bart's the greatest volume of breaches were recorded in Breast.
- Breast and ENT have committed to a compliant position in July 2023. Gynae is continuing to utilise capacity within the group. Skin are looking to in source to free up capacity which would ensure compliance of the 2WW standard.

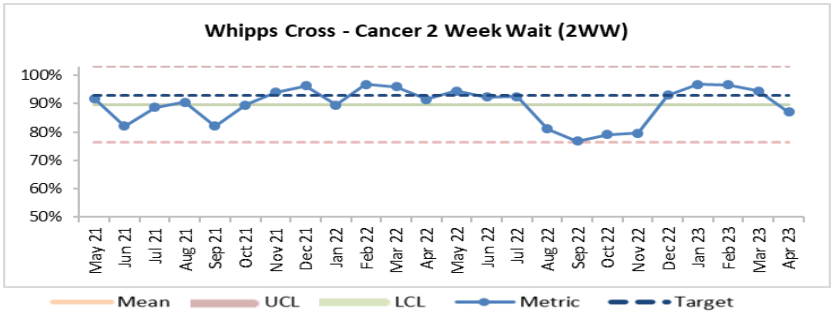
RESPONSIVE

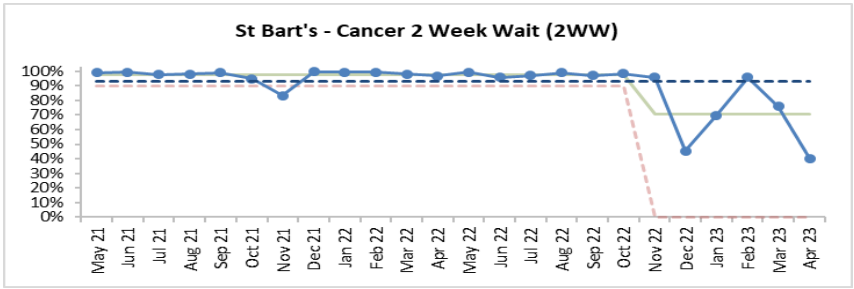
Cancer 2 Week Wait

Jul-23









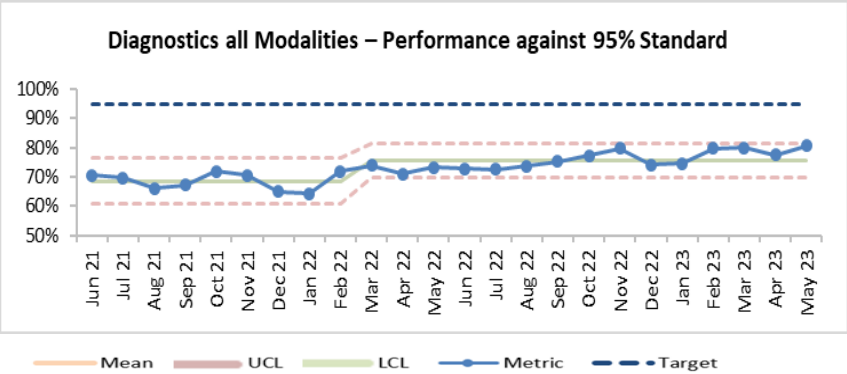
Performance by hospital site against the 93% standard:

- Newham: 96.4%, this exceeded the national standard.
- Whipps Cross: 87.0%, the greatest volume of breaches were recorded in Skin, Gynaecology and Breast, there were 188 breaches overall against 1,443 total referrals.
- Royal London: 66.6%, the greatest volume of breaches were recorded in Urology, ENT and Skin, there were 274 breaches overall against 820 total referrals.
- St Bart's: 40.3%, the greatest volume of breaches were recorded in Breast, there were 163 breaches overall against 273 total referrals. 160 of the breaches related to Breast against 236 referrals for the Breast service.

RESPONSIVE

Diagnostic Waits Over 6 Weeks

Jul-23



Trust Performance Overview

- Overall DM01 performance increased by 3.23% from April to 80.6% in May.
- Endoscopy achieved 99.6% in May against all three modalities.
- Imaging modalities are delivering overall against recovery commitments for MRI, CT and NOUS. The greatest challenges are related to MRI long waits, Cardiac CT long waits and performance, and non-obstetric ultrasound (NOUS) waiting list size.
- MRI breaches account for 20.1% of all DM01 breaches at the end of May 2023; a reduction compared to April 2023.
- CT 6 week wait performance is not compliant (77.8%) and has improved but there is a declining position associated with cardiac CT (51.9%).
- Dexa performance has seen a decline month on month (76.6%) associated with capacity challenges at the Royal London; which are being mitigated and are not expected to be a long term challenge.
- Barium Enema performance (0%) is related to meeting the needs of a individual patient. There are no operational concerns.

Indicator Background:

During the period when Referral to Treatment was being introduced across the NHS three key stages of treatment were identified, each to take no longer than six weeks, 18 weeks in total. The three key stages of treatment were:

1. Outpatient Pathway
2. Diagnostic pathway
3. Admitted pathway

As part of the drive to reduce overall waiting times a 6-week maximum wait was set to receive a diagnostic test following referral for a test with an operational standard set of 99% of patients receiving their test within 6-weeks. The standard applies to a basket of 15 diagnostic modalities across imaging, endoscopy and physiological measurement. As part of the Covid pandemic recovery process a target of 95% has been set across the NHS to be achieved by March 2025.

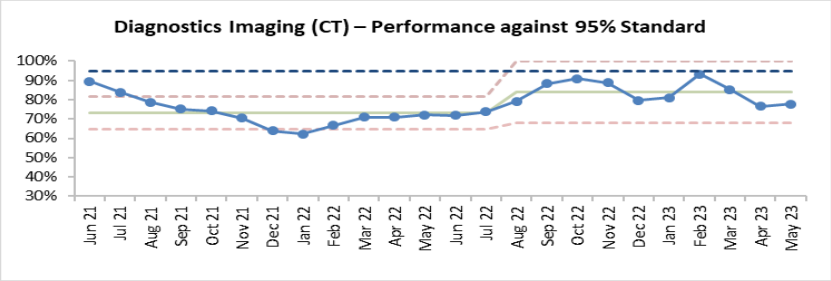
What is the Chart Telling us:

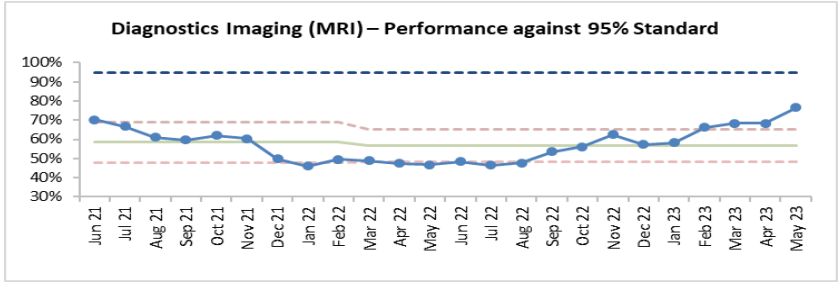
An increasing step-change (resulting from a run of 8 data-points above the preceding mean) may be observed from February 2022. This suggest a point in time where process changes started to drive breach reductions and performance improvement. Performance has been above the mean for the last four consecutive data points.

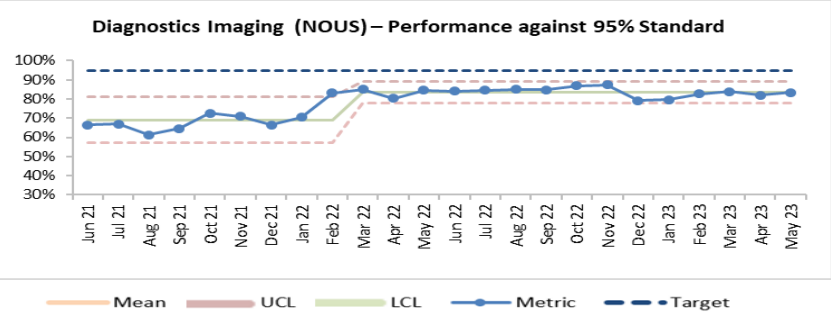
RESPONSIVE

Diagnostic Imaging Waits Over 6 Weeks

Jul-23







DM01 Breakdown by Test							
	Apr-23			May-23			
Test Name	Waiting	Breaches	Performance	Waiting	Breaches	Performance	Variance in Performance
Barium Enema	4	3	25.0%	1	1	0.0%	-25.0%
DEXA Scan	1,125	162	85.6%	1,159	271	76.6%	-9.0%
Magnetic Resonance Imaging	5,877	1,863	68.3%	5,776	1,346	76.7%	8.4%
Computed Tomography	2,946	687	76.7%	3,337	741	77.8%	1.1%
Non-obstetric ultrasound	17,175	3,075	82.1%	17,871	2,974	83.4%	1.3%
Grand Total	**27,127**	**5,790**	**78.7%**	**28,144**	**5,333**	**81.1%**	**2.4%**

Trust Responsible Director Update

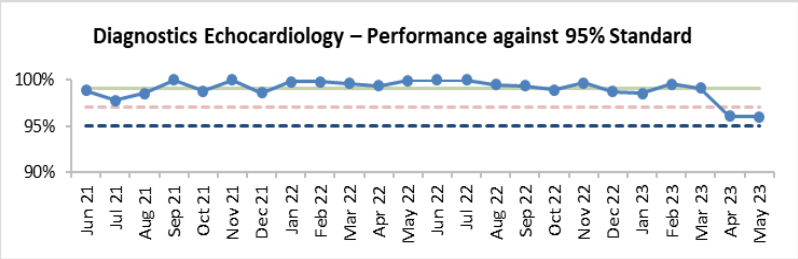
NB: Modalities apart from Imaging are shown on the slide that follows

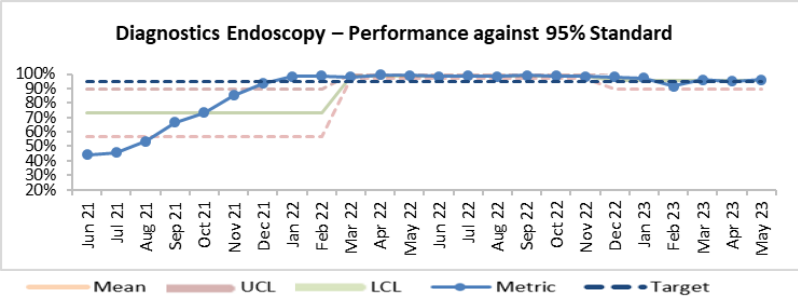
- Imaging performance is improving at the Royal London and St Barts Hospital, whilst it is has declined at the other Hospital sites. The net impact is improved equity of access across Barts hospitals. Growth in demand remains a concern, but activity is delivered above plan at more than 110% of 19/20 levels and waiting list sizes are reducing. Only 103 patients are waiting more than 13 weeks without an appointment.
- Following national directive a reviews of pathways are continuing in support of direct access for cancer and urgent referrals and demand management opportunities. Opportunities for process and productivity improvements, helping to mitigate the need for additional staff are being developed.
- Work is being completed to update and enhance monitoring of the plan for activity, performance, productivity, finance and workforce KPIs. Data is being reviewed by hospital teams and modality networks to understand variation in minutes booked between hospitals.
- Opportunities to share expanded MRI and CT capacity across hospitals have been agreed through the use of new capacity at Newham and Mile End.
- Discussions are underway to review and consolidate the medium term dependency on mobile MRI scanners and outsourcing.
- Standardised digital solutions and standard operating procedures (SOPs) are being implemented to support enhanced patient communications and to share patient information between hospitals; supporting collaborative capacity. SOP work has been completed at RLH and the next phase is to translate this across to Whipps Cross and St Barts Cardiac Imaging services.
- The Annual National Imaging Data Collection has been completed and signed off through the Elective Recovery Board. The information is used to support planning and service improvements across Barts Health; and across North East London through the Imaging Network. It is also used to support service benchmarking via the Model Hospital information portal.

RESPONSIVE

Other Diagnostic Waits Over 6 Weeks

Jul-23





NB: Imaging Modalities are shown on the preceding slides

DM01 Breakdown by Test							
	Apr-23			May-23			
Test Name	Waiting	Breaches	Performance	Waiting	Breaches	Performance	Variance in Performance
Urodynamics - pressures & flows	134	116	13.4%	132	114	13.6%	0.2%
Audiology - Audiology Assessments	2,061	1,346	34.7%	1,860	1,066	42.7%	8.0%
Cystoscopy	214	79	63.1%	278	80	71.2%	8.1%
Neurophysiology - peripheral neurophysiology	72	22	69.4%	79	12	84.8%	15.4%
Cardiology - echocardiography	2,020	80	96.0%	1,917	77	96.0%	-0.1%
Respiratory physiology - sleep studies	201	109	45.8%	293	8	97.3%	51.5%
Gastroscopy	658	7	98.9%	747	5	99.3%	0.4%
Colonoscopy	838	4	99.5%	997	2	99.8%	0.3%
Flexi sigmoidoscopy	131	0	100.0%	156	0	100.0%	0.0%
Cardiology - Electrophysiology	0	0	100.0%	2	0	100.0%	0.0%
Grand Total	**6,329**	**1,763**	**72.1%**	**6,461**	**1,364**	**78.9%**	**6.7%**

Trust Responsible Director Update

- The DM01 Group continues to meet monthly, with a focus on ensuring reporting is correct and adherence to the diagnostic handbook.
- We are focused on reducing waits in Endoscopy. A refresh of the BH Endoscopy Group meeting to be launched in July, focussing on reducing waits < 7 days for cancer patients which will improve patient access and FDS performance. This group will also review DNAs and pre test information for patients.
- Urodynamics & Neurophysiology are challenged within the group, a review of this service is planned for last week in June 23.
- The Acute Provider Collaborative (APC) Launched an Audiology Group on 26th June 2023, chaired by BH Group Director to help develop the strategy across the system. The focus of this group is to set the longer term strategy, reduce any variation in access and develop system workforce plans. We will then see the benefit of this to patients, who will have timely access to testing.

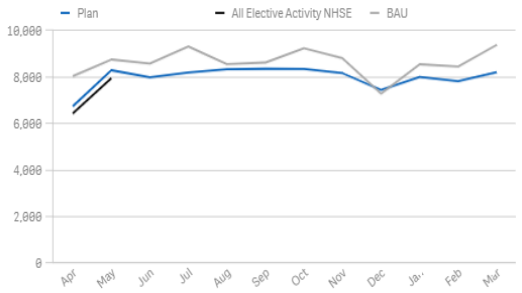
RESPONSIVE
Elective activity

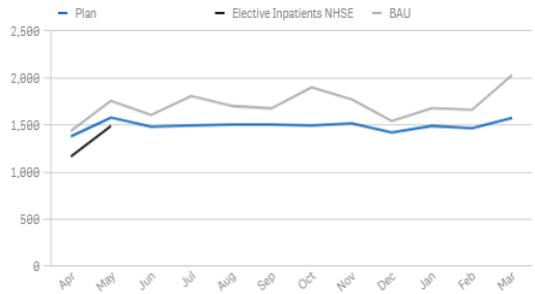
Admitted Activity against Plan

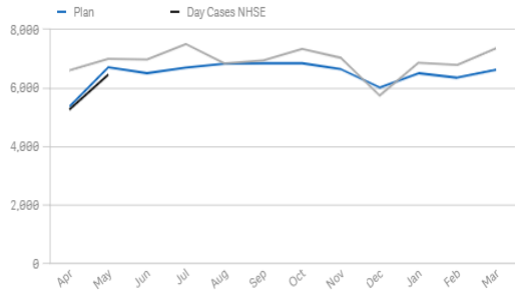
Jul-23

Admitted Elective Activity

		Barts Health						Last Month's Site Position			
		Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Royal London	Whipps Cross	Newham	St Bart's
All Elective Activity	Plan	7,421	8,536	8,464	9,104	6,726	***8,260***	*4,038*	*1,921*	*1,203*	*1,098*
	Actuals	6,526	8,034	7,706	8,463	6,254	***7,919***	*3,840*	*1,521*	*1,138*	*1,420*
	Mth variance plan	*-895*	*-502*	*-758*	*-641*	*-472*	*-341*	*-198*	*-400*	*-65*	*322*
Elective Day Case Activity	Plan	5,887	6,896	6,825	7,303	5,350	***6,686***	*3,374*	*1,618*	*1,005*	*689*
	Actuals	5,237	6,727	6,374	7,030	5,097	***6,434***	*3,273*	*1,220*	*980*	*961*
	Mth variance plan	*-798*	*-334*	*-706*	*-630*	*-253*	***-252***	*-101*	*-398*	*-25*	*272*
Elective IP Activity	Plan	1,534	1,640	1,639	1,801	1,376	***1,574***	*664*	*303*	*198*	*409*
	Actuals	1,289	1,307	1,332	1,433	1,157	***1,485***	*567*	*301*	*158*	*459*
	Mth variance plan	*-262*	*-362*	*-329*	*-392*	*-219*	*-89*	*-97*	*-2*	*-40*	*50*







Data As at 21/06/2023

Performance Overview

- For 2023/24 the NHS has set all trusts elective activity targets designed to return activity to greater than pre-pandemic levels and support the clearance of long-waiter backlog.
- For May 2023 the trusts admitted (inpatient and day case) trajectory set a target of 8,260 admissions against which the trust delivered 7,919 (-341 admissions).
- Admitted activity was impacted by the three Public Holiday's resulting in fewer working days in the month.

Responsible Director Update

- The validated RTT PTL for May 23 was 117,793 which is an increase of 900 pathways from April 23 and due to Industrial action and an increased number of bank holidays during May 23
- Elective Recovery Board (ERB) has started to receive reports from hospitals on activity against plan and actions being taken to where plans are not delivering. For example focus on reducing avoidable cancellations which will increase numbers. Further deep dives are planned during July 23 to triangulate this with finance and workforce data
- During May 23, day case activity was 341 under plan with In-patient activity 89 under plan. Royal London has been impacted by unplanned care pressure which has resulted in having to use beds in the day surgery unit. They have a plan to try and protect this moving forward in order to support elective activity
- During the week of Industrial action, 315 elective cases were cancelled. However the trust was able to deliver 30% more elective activity that the March period of IA

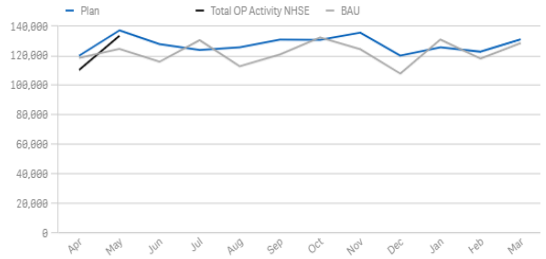
RESPONSIVE
Elective activity

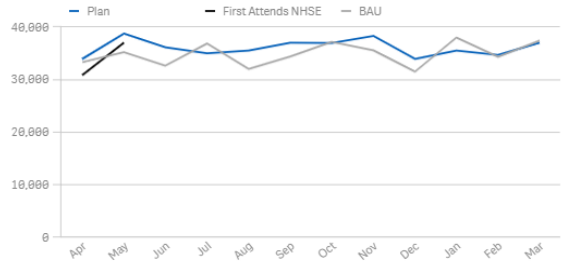
Non Admitted Activity against Plan

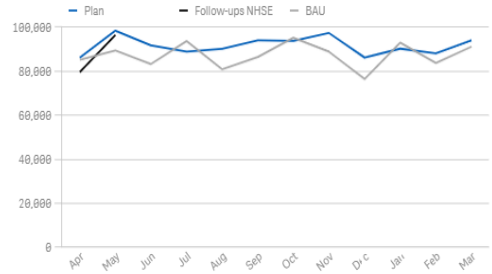
Jul-23

Outpatient Activity

		Barts Health						Last Month's Site Position				
		Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Royal London	Whipps Cross	Newham	St Bart's	Other
Total OP Activity	Plan	111,548	131,775	122,446	128,044	119,595	***136,608***	*57,549*	*33,006*	*21,225*	*24,828*	*0*
	Actuals	113,074	132,544	124,080	136,872	108,522	***132,926***	*54,255*	*31,049*	*21,690*	*25,880*	*52*
	Mth variance plan	*1,526*	*769*	*1,634*	*8,828*	*-11,073*	***-3,682***	*-3,294*	*-1,957*	*465*	*1,052*	*52*
Outpatient First	Plan	34,788	42,371	39,022	40,608	33,777	***38,575***	*15,868*	*12,945*	*4,645*	*5,117*	-
	Actuals	30,883	35,753	34,233	37,198	29,938	***36,858***	*14,142*	*11,366*	*5,506*	*5,844*	-
	Mth variance plan	*-3,905*	*-6,618*	*-4,789*	*-3,410*	*-3,839*	***-1,717***	*-1,726*	*-1,579*	*861*	*727*	
Outpatient F/up	Plan	76,760	89,404	83,424	87,436	85,818	***98,033***	*41,681*	*20,061*	*16,580*	*19,711*	*0*
	Actuals	82,191	96,791	89,847	99,674	78,584	***96,068***	*40,113*	*19,683*	*16,184*	*20,036*	*52*
	Mth variance plan	*5,431*	*7,387*	*6,423*	*12,238*	*-7,234*	***-1,965***	*-1,568*	*-378*	*-396*	*325*	*52*







Data As at 21/06/2023

Performance Overview	Responsible Director Update
• For outpatients (first and follow up) for the same month the trajectory set a target of 136,608 attendances, against which the trust delivered 132,604 (-4,004 attendances). • Non Admitted activity was impacted by the three Public Holiday's resulting in fewer working days in the month.	• Clinical speciality sessions have started for the Further Faster programme of work which is aiming to target backlog clearance more quickly through sharing of improvement initiatives across peer organisations. Attendance from clinical and operational colleagues has been put in place. • PIFU has been rolled out within T&O and we are seeing a positive uptake of this which is it hoped will support a reduction in follow-up. • Review against Getting it Right First time (GIRFT) standards has been completed for T&O, Urology and Ophthalmology. The improvement and transformation team are now working with services to agree actions and milestones. • The Improvement and Transformation team are undertaking a comprehensive improvement programme of work at Whipps Cross Eye Treatment Centre. This will provide focus on governance and culture. • As of 9th of June 23, there were 41,172 patients enrolled on Patient Knows Best (PKB). This is 14% of the eligible population. Communications continue in order to encourage uptake of the platform • In May 23 there was a variance of 1,717 1st appointments and 1,965 follow up appointments against plan • During the week of Industrial Action in June 23, 5,403 outpatient appointments were cancelled. • All Hospitals have described schemes via ERB to support increase in Out-patient 1st activity. This includes focus on DNA, cancellation and coding • Barts Health initiated a peer review relating to validation and PTL management. This is being facilitated by the Acute Provider Collaborative and through this we have identified areas to standardise practice across NEL in how we manage admitted and non admitted pathways • The Trust is working with the APC with an aim to lifting referral restrictions which will respond to the letter received from NHSE relating to offering patients a choice of provider for treatment. This is being discussed at the NEL planned care board in July 2023 with a timeline to be agreed.

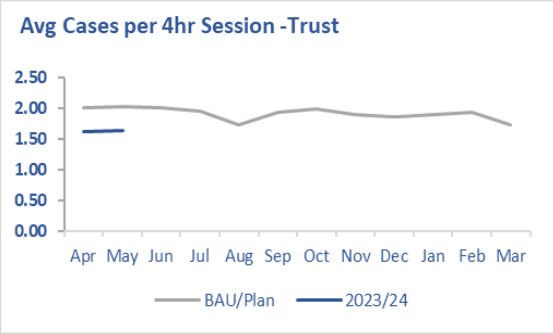
RESPONSIVE
Elective activity

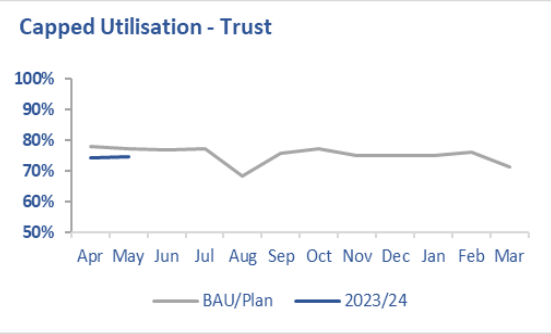
Theatre Efficiency

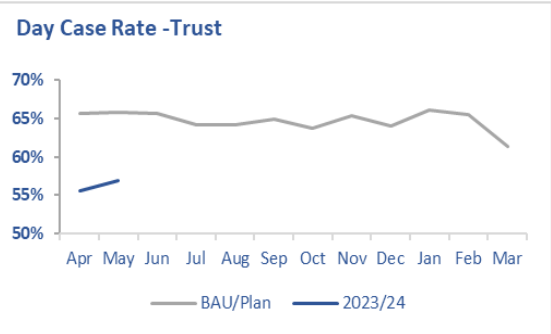
Jul-23

Efficiency Activity

		Barts Health						Last Month's Site Position			
		Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Royal London	Whipps Cross	Newham	St Bart's
Avg Cases per 4hr Session	Actuals	1.59	1.58	1.63	1.70	1.67	1.64	1.47	2.22	2.07	0.99
	BAU	1.87	1.90	1.94	1.72	2.02	2.03	1.97	2.73	2.35	1.07
	Mth variance plan	*-0.28*	*-0.33*	*-0.30*	*-0.02*	*-0.34*	*-0.39*	*-0.50*	*-0.51*	*-0.28*	*-0.08*
Capped Utilisation	Actuals	69.3%	71.2%	74.8%	73.3%	74.0%	74.6%	76.0%	68.6%	73.0%	80.2%
	BAU	74.7%	74.9%	76.0%	71.1%	77.7%	77.0%	77.6%	73.3%	74.3%	81.5%
	Mth variance plan	-5.4%	-3.7%	-1.2%	2.2%	-3.7%	-2.4%	-1.7%	-4.7%	-1.3%	-1.3%
Day Case Rate	Actuals	57.6%	58.2%	59.2%	61.6%	55.6%	57.0%	56.2%	65.6%	70.3%	13.5%
	BAU	64.0%	66.1%	65.5%	61.4%	65.6%	65.9%	65.6%	76.3%	77.0%	17.0%
	Mth variance plan	-6.4%	-7.9%	-6.3%	0.2%	-10.0%	-8.9%	-9.4%	-10.7%	-6.7%	-3.5%







Data As at 21/06/2023

Performance Overview

- Set against internal trust data for May 1.64 cases per list were achieved against a BAU of 2.03 (-0.39).
- For the same month, a capped utilisation rate of 74.6% was recorded against a BAU of 77.0% (-2.4%).
- For May a day case rate of 57.0% was recorded against a BAU of 65.9% (-8.9%).

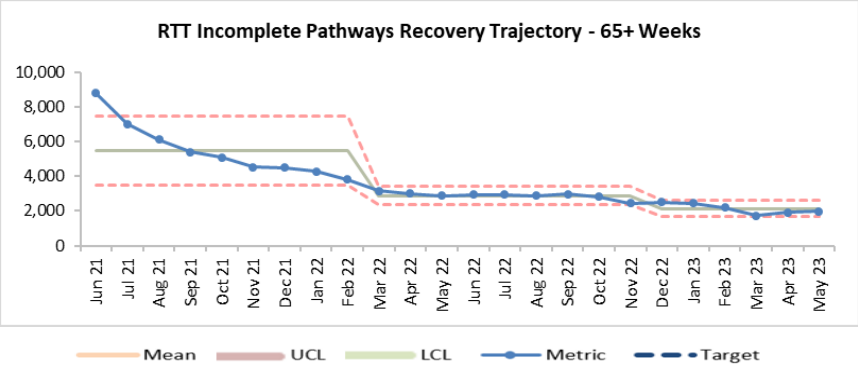
Responsible Director Update

- The trust continues to see a positive reduction in fallow sessions particularly at WX through the cross site Surgical Optimisation Group
- A thematic deep dive on theatre productivity has been produced and will be presented to FIPC on 28.06.23
- Review of key theatre metrics from April/May shows an improvement against 2022/23 however these are not yet at 2019/20 baseline.
- The CCS (Care Coordination Solution) programme roll out has been delayed from June - July 23. Updates continue to be provided to Elective Recovery Board on progress.
- A summary of key improvement actions from Theatres experience groups by Hospital is provided as a monthly update to Elective Recovery Board. There is a continued focus on scheduling via the 6-4-2 process, reducing cancellations and trying to increase case numbers per list.
- BHOC has submitted an application to go forward as part of the next tranche for Surgical Hub accreditation. At the visit to KGH BHRUT in July 23, the team will provide and insight as to the process of accreditation and lessons learned which the trust will look to adopt.

RESPONSIVE

65+ Week RTT Activity

Jul-23



Indicator Background:

During the course of the Covid pandemic elective waiting times grew significantly with many patients waiting longer than two years for treatment. Since 2022/23 the NHS has set a number of targeted objectives to drive down the number of long-waiting patients, these include:

- Zero 104 week wait patients by July 2022
- Zero 78 week wait patients by April 2023
- Zero 65 week wait patients by March 2024
- Zero 52 week wait patients by March 2025

Trust Performance Overview

- For 2023/24 the NHS has set all trusts the objective of clearing 65+ week wait backlog volumes by March 2024.
- For 2023/24 the NHS has set all trusts the objective of clearing 65+ week wait backlog volumes by March 2024. At the end of May the trust recorded 1,977 pathways waiting 65+ weeks, an increase of 69 against the April position, however against the clearance trajectory of 1,813 this was 164 greater than plan.

What are the Charts Telling us:

The SpC chart presents a sustained reduction in 65+ week waiters across the data-series. There are two reducing step-changes (resulting from a run of 8 data-points below the preceding mean) from February and November 2022. These suggest points in time where process changes started to drive backlog reductions.

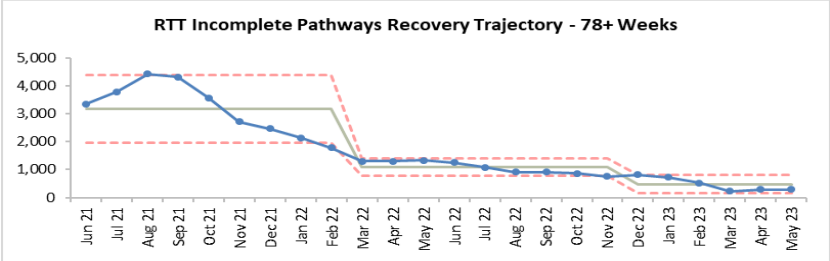
Trust Responsible Director Update

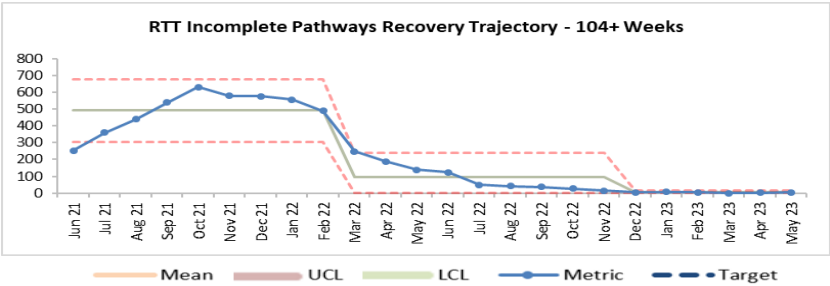
- The Trust has committed to having 0 patients waiting over 65 weeks by the end of March 2024.
- The Trust is continuing to see a weekly reduction in the total risk cohort that is being tracked until March 2024, however there is a slight increase in the actual number of patients waiting more than 65 weeks
- The Trust continues to move patients who have not yet had a first appointment within a range of Surgical specialities to Homerton and Independent Sector providers. The 3 Acute Chief Executives Officers from across NEL have met and agreed a commitment to tackling inequity in waiting times across providers
- Chief Operating Officers have meet with the North East London (NEL) Director of Planned Care to discuss moving towards a shared PTL in order to improve equity of waiting times
- The Trust has registered on the Digital Mutual Aid System (DMAS) which was requested through the recent patient choice letter from NHSE. The trust is in discussion with 4 providers who have responded to requests and are working up an options appraisal which will go to Elective Recovery Board.
- The BIU modelling work on 65 week wait clearance has been shared with operational colleagues and discussions are underway as to how to progress this. This work has also been shared with colleagues from other systems across London in order for them to learn from this proposed approach.

RESPONSIVE

78+ & 104+ Week RTT Activity

Jul-23





Indicator Background:

During the course of the Covid pandemic elective waiting times grew significantly with many patients waiting longer than two years for treatment. Since 2022/23 the NHS has set a number of targeted objectives to drive down the number of long-waiting patients, these include:

- Zero 104 week wait patients by July 2022
- Zero 78 week wait patients by April 2023
- Zero 65 week wait patients by March 2024
- Zero 52 week wait patients by March 2025

What are the Charts Telling us:

Both the 78+ and 104+ weeks wait SpC charts present reducing step-changes (resulting from a run of 8 data-points below the preceding mean) from February 2022 and March 2022 respectively. This suggest a point in time where process changes started to drive backlog reductions.

Trust Performance Overview

- In relation to the RTT month-end nationally submitted data the trust reported 8 pathways waiting 104+ weeks at the end of May 2023, an increase of 5 pathways against the April position.
- In relation to 78+ week wait backlog volumes, 292 pathways were reported at the end of May, a reduction of 2 against the April position.

Trust Responsible Director Update

- Of the 104 May breaches, 4 of the 8 patients have a confirmed treatment plan for June 23. The other patients have provisional plans for July 23.
- The Trust committed to the clearance of patients waiting 78 weeks by the end of June 2023. The Trust was on track until mid/end of may however the trust then saw a reduction in run rate. This was due to Unplanned Care pressure and lack of uptake of Waiting list initiatives to enable additional capacity to be put in place
- During June the trust has seen a further impact due to the 3 day period of industrial action. This has resulted in a reduction of the weekly run rate by around 50-70 long waiter cases
- Line by line review of all June 78ww breaches has taken place with Group oversight. Through this review opportunity has been identified around application of the access policy relating to management of DNA and patient fitness. This has supported mitigation of the position for the end of June. The plan is to continue with this oversight in order to reduce tip in risk during July and August.
- The trust continues to look at opportunity to utilise collaborative capacity to support long waiting patients from NEL providers and SWLEOC for T&O
- It is forecasted that the trust will have around 225 78ww breaches at the end of June 23. 150 of this was due to internal pressure and 75 from impact of Industrial action in June 23

NHS
Barts Health
NHS Trust

Equity Report

SUMMARY

Equity Summary

Jul-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 **wealthier** postcodes as 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 of a snapshot of data from 19th June 2023.

There was an error in ethnicity capture data; therefore, this data was not analysed this month.

Findings

At Trust level, there are no significant differences in the data for waits between ethnic groups, or between male and female patients. Patients living in the most deprived postcodes on average waited 5.6 days longer than those living in the least deprived postcodes, which is a small but statistically significant difference.

Similar to last month, the difference in wait for patients with Learning Disabilities is approximately 7 days. However, the numbers are not big enough to rule out that the difference may be due to chance. The distribution of waiting times often has some outliers meaning the median can better describe the data. The median wait for both groups is 16-17 weeks.

Next steps

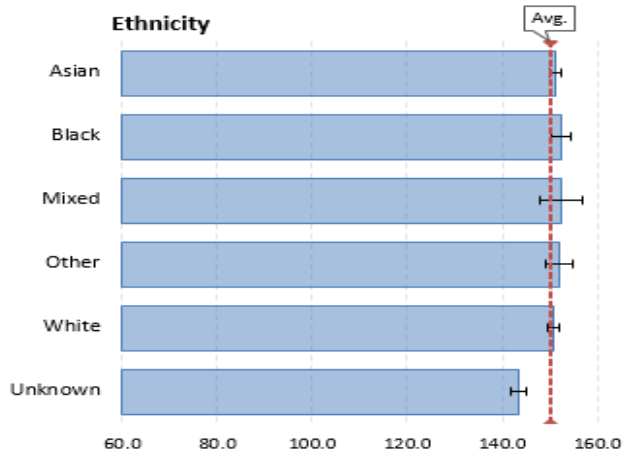
There is a widening gap in wait times between patients in the most deprived and least deprived postcodes which will be brought to the attention of site leads.

We are also working with our analytics team to improve these reports, including adding graphs which enable us to better view and interpret trends over time.

RESPONSIVE

Equity - Wait Times By Ethnicity

Jul-23



Summary Data

Ethnic Category	Total Wait Time (Days)	# of Pathways
Asian	5,427,359	35,890
Black	2,096,321	13,755
Mixed	418,173	2,743
Other	1,113,205	7,331
White	6,108,976	40,506
Unknown	2,959,592	20,635

Pathways with no Week Wait details excluded

Ethnic Category	Average Wait (Days)	Lower CI	Upper CI	Median WW
Asian	151.2	150.0	152.5	16-17
Black	152.4	150.4	154.4	16-17
Mixed	152.5	147.8	157.1	16-17
Other	151.8	149.1	154.6	16-17
White	150.8	149.6	152.0	16-17
Unknown	143.4	141.8	145.0	14-15
Grand Total	**150.0**			**16-17**

Commentary

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

In this snapshot, the longest waiters identify as belonging to the 'Black' ethnic category with an average of 149.7 days. This equates to 1.3 days difference, on average, between the longest and shortest waiters by known ethnicity. This is different from last month's snapshot, where patients who identified as 'Mixed' waited the longest. However, the numbers aren't big enough to infer for certain if this difference is due to chance. We have not found any significant relationship between longer waiting times and any identified ethnicity.

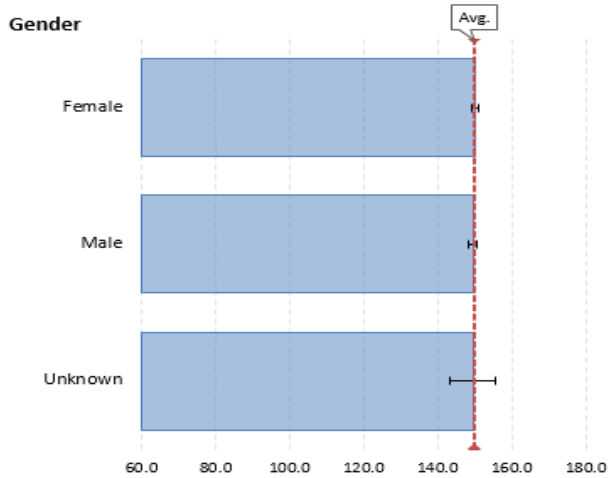
We believe the shorter waits for unknowns may be as they are more likely to be urgent referrals.

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

RESPONSIVE

Equity – Wait Times by Gender

Jul-23



Commentary

At trust level, there is no practical difference in wait times between male and female patients, as well as those of unknown gender.

As with last month, the wait time from referral to treatment by gender is very similar for male patients compared with female patients (150.3 days vs 149.5 days, respectively). The median wait time is between 16-17 weeks for these two genders.

Additionally, we continue to investigate data quality issues in the very small proportion of patients of unknown gender. The number of patients of unknown gender has decreased in comparison to last month (1,495 vs 1,971).

Summary Data

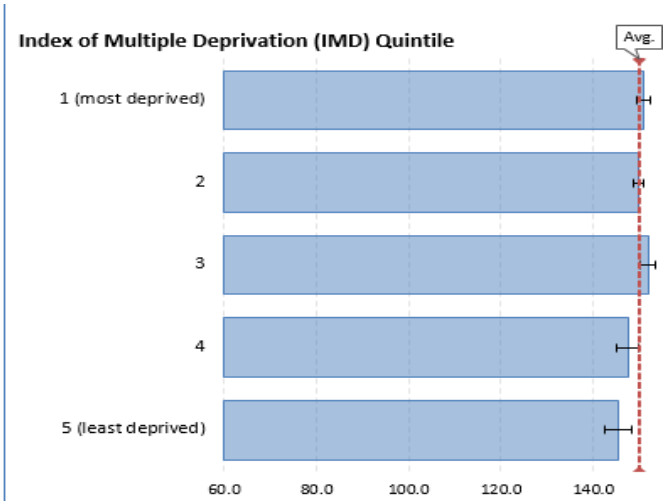
Gender	Total Wait Time (Days)	# of Pathways	Pathways with no Week Wait details excluded
Female	10,105,675	67,232	
Male	7,794,360	52,133	
Unknown	223,591	1,495	

Gender	Average Wait	Lower	Upper	Median WW
Female	150.3	149.4	151.2	16-17
Male	149.5	148.5	150.6	16-17
Unknown	149.6	143.4	155.7	14-15
Grand Total	**150.0**			**16-17**

RESPONSIVE

Equity – Wait Times By Deprivation

Jul-23



Summary Data

IMD Quintile	Total Wait Time (Days)	# of Pathways
1 (most deprived)	4,347,407	28,794
2	8,229,408	54,971
3	2,946,401	19,409
4	1,493,632	10,132
5 (least deprived)	868,288	5,971

Pathways with no Week Wait details excluded

IMD Quintile	Average Wait	Lower	Upper	Median WW
1 (most deprived)	151.0	149.6	152.4	16-17
2	149.7	148.7	150.7	16-17
3	151.8	150.1	153.5	16-17
4	147.4	145.1	149.7	16-17
5 (least deprived)	145.4	142.5	148.3	16-17
Grand Total	**149.9**			**16-17**

Commentary

In this month's snapshot, at Trust Level, there is a small but statistically significant difference in wait times between patients living in the most deprived postcodes, and those in the least deprived postcodes. This is different from last month when there was no statistically significant difference.

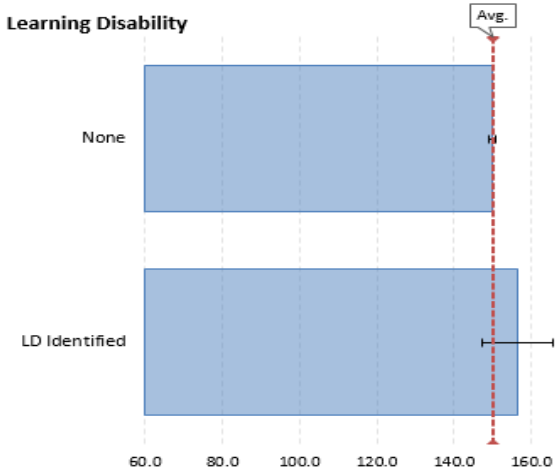
Patients in the most deprived postcodes see an average wait of 151.0 days when compared to the average wait of 145.4 days for patients in the least deprived postcode areas (5.6 day difference). The median wait time is 16-17 weeks for all groups.

We will be investigating this further to understand underlying reasons, and continue to monitor for trends in the data.

RESPONSIVE

Equity – Wait Times by LD

Jul-23



Commentary

This month, there is no statistical difference in wait times between patients identified as having a learning disability and those who haven't.

Patients with Learning Disabilities wait on average approximately 6.7 days longer. However, the numbers are not big enough to infer for certain if this is due to chance.

In the past, there was a disparity in waiting times for patients with learning disabilities. We found the disparity to be due to longer waits at Royal London, particularly in Restorative Dentistry, which has a high proportion of patients in this cohort. Action taken over the last year significantly reduced the waiting times in Restorative Dentistry, and therefore, the overall waiting times for this cohort. We are working with our Analytics Team to add separate data on this specialty.

We are also working with our Analytics Team to include graphs to show trends over time.

Summary Data

LD_Flag	Total Wait Time (Days)	# of Pathways
None	18,006,511	120,112
LD Identified	117,115	748

Pathways with no Week Wait details excluded

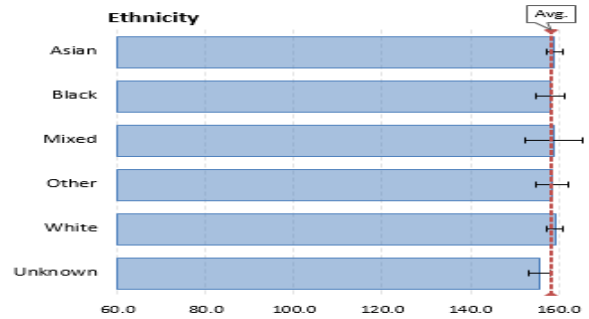
LD_Flag	Average Wait	Lower	Upper	Median WW
None	149.9	149.2	150.6	16-17
LD Identified	156.6	147.4	165.7	16-17
Grand Total	**150.0**			**16-17**

RESPONSIVE

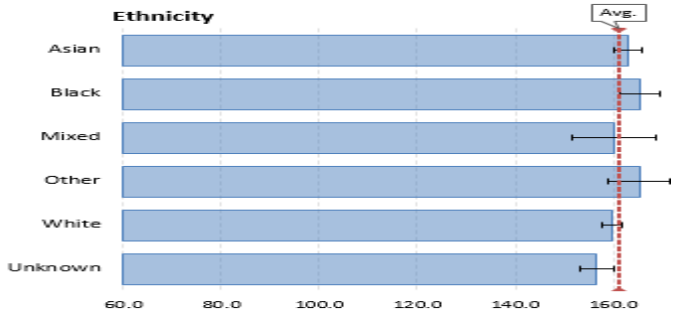
Equity - Wait Times By Ethnicity (Sites)

Jul-23

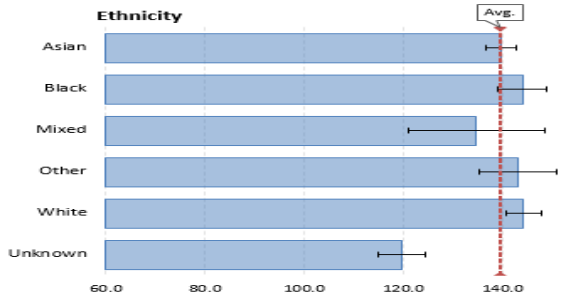
Royal London



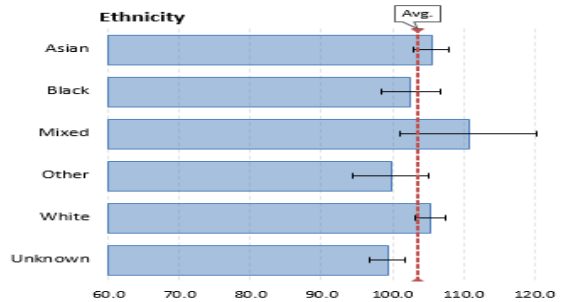
Whipps Cross



Newham



St Barts



Commentary

This month, there are no practical differences in wait times between patients of known ethnicities across all sites.

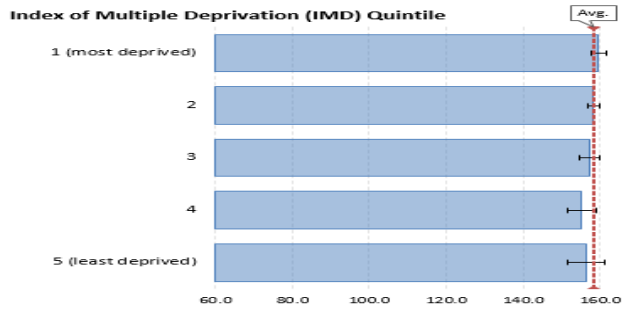
At Newham and St Barts sites there is greater variation in wait times by ethnicity, however these are not statistically significant. This is most notably seen in 'Mixed' and 'Unknown' ethnicity groups at both sites where the numbers are smaller. The difference in wait time for 'unknown' ethnicity groups at these sites is significant when compared to other ethnicities, however we believe these patients are more likely to urgent referrals. We are investigating data quality issues and will continue to monitor trends.

RESPONSIVE

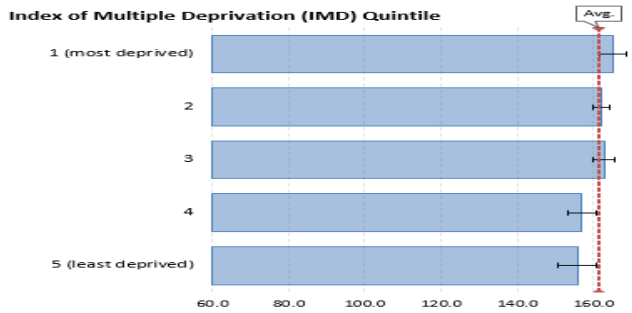
Equity – Wait Times By Deprivation (Sites)

Jul-23

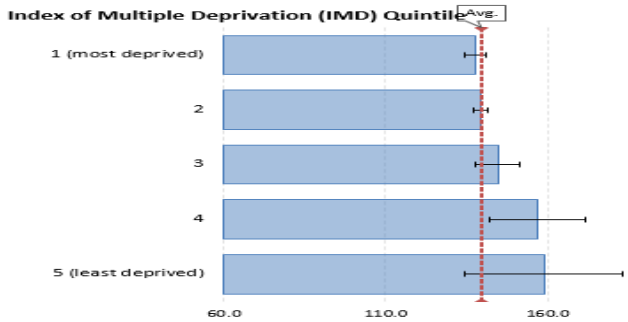
Royal London



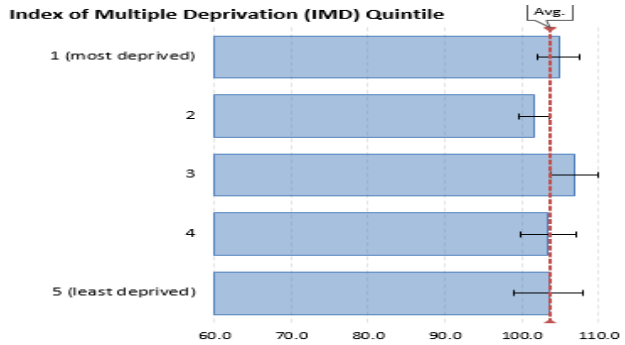
Whipps Cross



Newham



St Barts



Commentary

There are no practical differences in wait times across sites by level of deprivation.

The Newham site shows a trend for patients living in the least deprived postcodes waiting, on average, longer than those in the most deprived postcodes.

Jul-23

NHS
Barts Health
NHS Trust

People Report

SUMMARY

People Summary

Jul-23

Growing the Workforce – Recruitment, Temporary Staffing and Turnover

Substantive Staffing

There was a significant increase in staff in post this month of 1,135 WTE, of which 1,109 WTE related to the final stage of the Soft FM TUPE. Our substantive fill rate now stands at 91.5% and we saw an increase in registered nursing and midwifery staff of 19 WTE with the substantive fill rate for this group at 85.7%

Across the group we have seen the following changes

- Newham from 86.2% to 86.5%, nursing and midwifery at 79.7%
- St Barts from 92.9% to 93.2%, nursing is at 81.5%
- RLH from 93.4% to 93.0% (+38 WTE in budget and +7 WTE SIP), nursing and midwifery is at 88.8%
- WXH from 89.7% to 90.0%, nursing and midwifery is at 87.4%
- Path Part from 90.6% to 91.7%
- GSS from 85.4% to 90.8%

Turnover

Annualised voluntary turnover improved to 11.3% from 11.9%. Whilst this is impacted by the effect of the Soft FM TUPE on the calculation, we have seen improvements across all four hospital sites as follows

- Newham from 10.4% to 10.1%
- St Barts from 13.4% to 13.2%
- Royal London from 12.6% to 12.4%
- Whipps from 11.1% to 10.7%

Temporary Staffing

Agency spend was at 4.7% of pay spend in May and 4.7% year to date – both exceeding the 3.7% target.
Bank and agency WTE remained stable at 2891 WTE (subject to finalisation). The impact of bank holidays and strike days make it difficult to compare to previous years.

Annualised Sickness Absence

In month sickness absence (for April as 1 mth in arrears) has dropped to below 4% for the first time in since May 2021 (now at 3.76%). Annualised is at 4.65%. Since December long term sick has reduced from 2.64% to 2.17%

Roster Compliance

72.6% of rosters were fully approved on time (at least 6 weeks in advance) up from 63%, with Whipps achieving over 90%. The average lead time for rosters laid down was 40.6 days. If all rosters were laid down in time this would exceed 42 days.

40.5% of monitored nursing rosters were of good quality, factoring in planned and unplanned absence, when laid down with three out of four sites achieving around 45% of rosters

WELL LED

Domain Scorecard

Jul-23

	Ref	Indicator	This Period	This Period Target	Performance		Site Comparison					
					Last Period	This Period	Royal London	Whipps Cross	Newham	St Bart's	Pathology Partnership	Group Support Services
Creating a fair and just culture		Percentage of BAME staff in 8a+ roles	May-23		38.1%	**38.1%**	34.1%	47.9%	54.0%	25.4%	33.3%	36.0%
Supporting the wellbeing of our colleagues	W19	Turnover Rate	May-23	<= 12.25%	11.86%	**11.30%**	12.40%	10.70%	10.10%	13.20%	12.60%	6.80%
	W20	Sickness Absence Rate	Apr-23 (m)	<=4%	4.74%	**4.63%**	4.66%	4.75%	5.26%	3.78%	4.88%	5.24%
	W29	Appraisal Rate - Non-Medical Staff	May-23	>= 90%	58.9%	**59.5%**	61.0%	65.0%	46.0%	57.0%	68.0%	67.0%
	W30	Appraisal Rate - Medical Staff	May-23	>= 85%	87.4%	**83.5%**	82.3%	88.1%	82.1%	83.6%		
	W50	Mandatory and Statutory Training - All	May-23		87.3%	**87.7%**	86.3%	89.7%	87.5%	90.4%		85.2%
Fostering new ways of working to transform care		Roster compliance - Nursing Units Approved on Time %	May-23		62.9%	**72.6%**	60.0%	93.3%	68.2%	68.4%		
		Roster compliance - Nursing Average Approval Lead Time	May-23	>=42	40.90	**40.6**	32.0	51.0	39.0	38.0		
		Roster compliance - % Nursing Units with Blue or Cloudy Sky	May-23		32.8%	**40.5%**	43.9%	44.2%	46.2%	19.0%		
Growing a permanent and stable workforce		Substantive fill rate - all staff	May-23	95%	90.8%	**91.5%**	93.0%	90.0%	86.5%	83.2%	91.7%	90.8%
		Substantive fill rate - nursing and midwifery	May-23	95%	85.6%	**85.7%**	88.8%	87.4%	79.7%	81.5%		
		Time to Hire (Advert to All Checks Complete) - Median Weeks (Non Medical)	May-23	10.4	9.20	**9.80**	9.20	8.20	9.30	12.00	8.40	9.70
		Time to Hire (Advert to All Checks Complete) - Median Weeks (Medical)	May-23	15.00	14.20	**12.20**	12.40	9.10	10.50	21.00		
	OH7	Temporary staff as a % of workforce	May-23		14.0%	**13.3%**	14.6%	19.7%	23.5%	13.3%	13.9%	2.8%
		Agency Spend as % Paybill (YTD)	May-23	3.70%	4.7%	**4.7%**	3.5%	6.1%	8.4%	3.0%	3.6%	5.7%

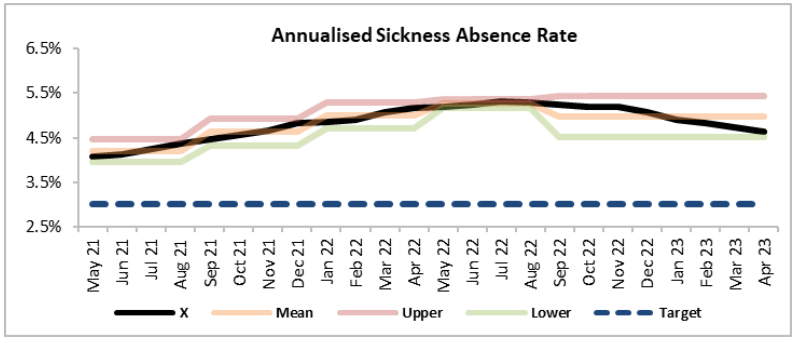
Target for % Utilisation (Total Fill Rate)	95% to 100%	<95%	>100%
Target for Staff in Post Actual Against Plan (% Variance)	>=0%	Between 0% and -5%	<=-5%
Targets for Bank, Agency and Total Staffing Actual Against Plan (% Variance)	<=-5%	Between 0% and -5%	>=0%
Target for Unconditional Offers Actual Against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

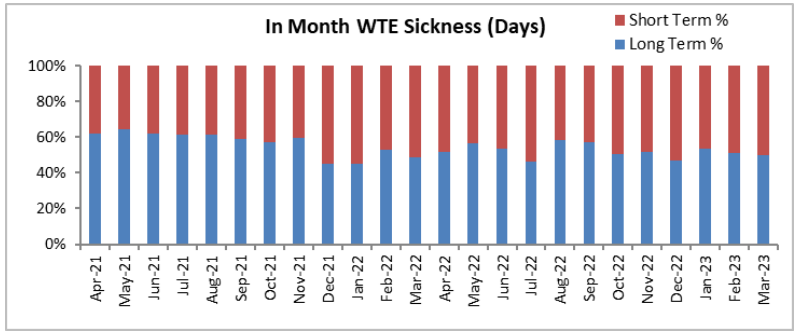
Notes: YTD figures for workforce metrics are only shown where appropriate

WELL LED

Sickness Absence Rate

Jul-23



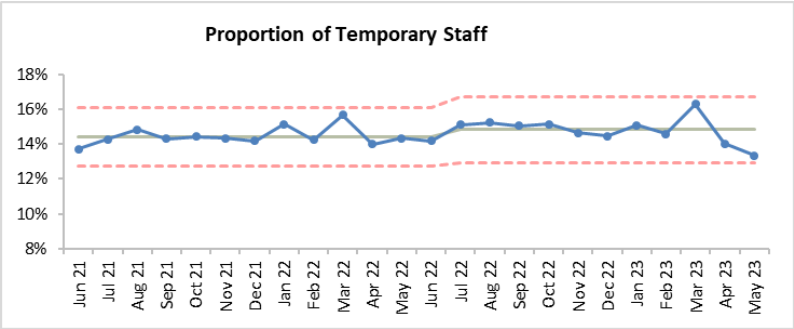


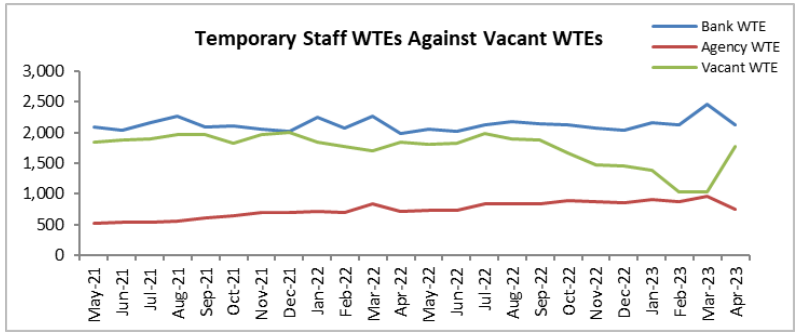
Performance Overview	Responsible Director Update
• Annualised sickness absence has continued to reduce, now at 4.63% down from 4.74% report in the previous month. • There is notable variation across sites with St Bartholomew's the lowest at 3.78% and Newham the highest at 5.26%.	• The employee wellbeing service continues to support our sites with the management of sickness absence, providing support including reasonable adjustment recommendations, capability assessments and psychological therapy • The team regularly handles around 80 management referrals on a weekly basis, which equates to over 4,000 a year. • As well as supporting staff and managers in the present the service has a five year strategy with aims including increasing services across the system with the use of enhanced technology, service innovation and clear service user pathways

WELL LED

Temporary Staffing

Jul-23



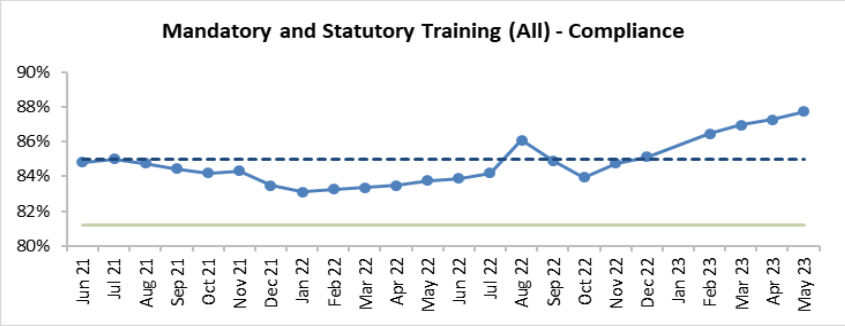


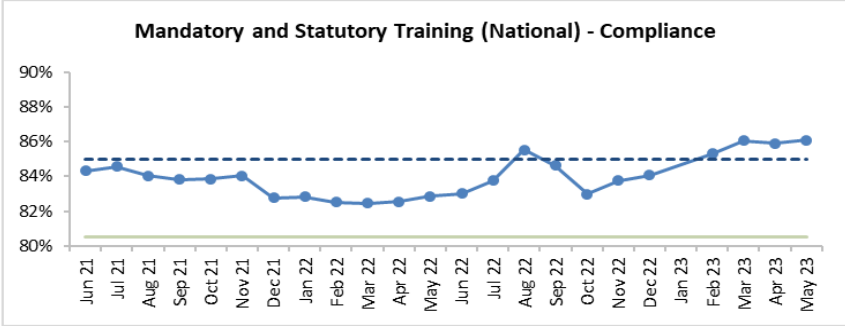
Performance Overview	Responsible Director Update
• Temporary staff as a proportion of the workforce dropped from 14.0% to 13.3%, largely as a reflection of the overall increase in workforce due to the Soft FM TUPE. This varied across sites from 13.3% at St Bartholomews to 23.5% at Newham. • Agency spend as a % of paybill YTD remained at 4.7% and above the target of 3.7%. The Royal London and St Barts remain below the target, however Whipps Cross (6.1%) and Newham (8.4%) are notably above it.	• As part of the ongoing work to reduce pay costs and reliance on agency staff a workforce resourcing board has been set up feeding into the finance recovery board. Objectives of this board include of the delivery of the 23/24 financial savings plan across the group, resolving issues that go across the group in order to release financial savings and taking action to ensure delivery of plan.

WELL LED

Mandatory and Statutory Training

Jul-23





Bottom 5 Competencies: Total Number of Non-Compliant Employees

Competency	Previous 6 Months	May-23	
	Compliance	Compliance	Staff Non-Compliant
Safeguarding Children L2	74.1%	77.3%	2,990
Resuscitation - Basic Life Support	78.5%	77.1%	2,603
Fire Safety	87.6%	87.5%	2,336
Moving Handling - Clinical	84.0%	83.8%	2,074
Safeguarding Adults L1	88.1%	89.2%	2,027

Bottom 5 Departments: Total Number of Non-Compliant Employees

Departments	Previous 6 Months	May-23	
	Compliance	Compliance	Staff Non-Compliant
Safeguarding Children L2 (Barts Health)	74.1%	77.3%	2,990
Resuscitation - Basic Life Support (Barts Health)	78.5%	77.1%	2,603
Moving Handling - Clinical (Barts Health)	84.0%	83.8%	2,074
Infection Control (Clinical) (Barts Health)	82.7%	83.8%	1,897
Safeguarding Children L3 (Barts Health)	50.6%	59.9%	1,383

Non-mandatory competencies have been excluded from the above tables

Performance Overview

- Compliance for the Core Skills Training Framework subjects currently stands at 86.87% which is above the Trust target of 85%. Compliance for Essential to Role training currently stands at 91.09% which is also abov e the Trust target.
- All sites are currently showing compliance above the Trust target with GSS slightly below for the Core Skills Training Framework subjects.
- Face to Face training subjects, including Resuscitation and Moving and Handling are currently below the Trust target and work is ongoing to push staff to complete these subjects.
- Safeguarding Children and Adults has had the training needs analysis altered for these subjects to bring them into line with the intercollegiate documents on safeguarding adults and children. These are currently being monitored by the Integrated Safeguarding Committee chaired by the Chief Nurse.

Responsible Director Update

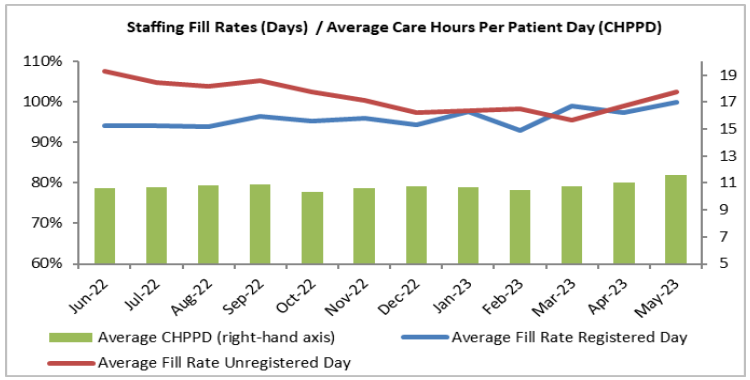
- In order to enable management of compliance at site level, Statutory and Mandatory training continues to be included in the site PR packs with an exception report and spotlight subjects.
- Monthly reminders continue to be sent to non compliant staff.
- Fire safety will return to face to face only from September 2023 in line with the CSTF framework and London Fire Brigade requirements. Staff are being given time to complete elearning if that is their preferred method of training.
- Work to review the suitability of training materials for staff transferring from SERCO has already begum with meetings with the Soft FM subject matter experts and staff group leads. This work will commence with staff groups which transferred in November 2022 as they have now reached the end of their six month grace period .
- An upgrade for the WIRED reporting system is currently being planned due to advancements in ICT making the current system not fit for purpose. The initial design will be taken to the June Education Committee meeting for approval then through the ICT and IG new projects process.

SAFE STAFFING

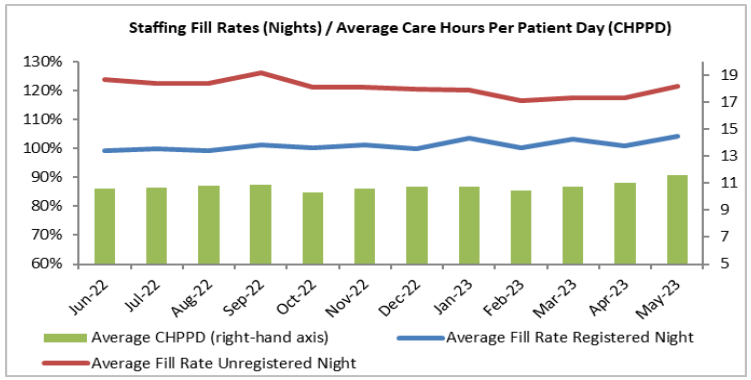
Safe Staffing

Jul-23

- Trust-level average fill rates were at or marginally above 100% for Registered Nursing and Midwifery (RNs/RMs) and for Care Staff (HCAs) across both day and night shifts.
- At hospital level, average fill-rates were above the 90% target for all sites for Registered Nursing and Midwifery (RNs/RMs) and for Care Staff (HCAs) across both day and night shifts.
- All hospitals reported increased use of enhanced care, primarily to support patients with mental health needs or with safety risks such as falls. All requests for associated additional staffing are approved at ADoN level.
- The Tendable audit system has been updated to strengthen questions regarding use of enhanced care following review of the Enhanced Care Policy earlier in the year. The first refreshed audit will take place in July.
- Overall average Care Hours Per Patient Day (CHPPD) were at 11.6. This is above last published London average (9.1; January 2023). CHPPD data is less useful at organisation level - the high number of specialist and critical care units within the Barts Health Group will result in high overall CHPPD.
- The CHPPD trend continues slightly upward, this is reflective of the increased enhanced care shifts. The NHSE data request which feeds CHPPD reporting covers all staff booked, inclusive of additional staff for enhanced care.
- Where incidences of day-to-day staffing pressures occurred at individual ward level across the sites, risks were reviewed and mitigated through dynamic redeployment and/or with senior staff working clinically when required.
- There were no staffing Red Flag incidents recorded in May. This correlates with high CHPPD and sustained good overall average fill-rates. This indicates that staffing is overall likely in line with demand.
- Work continues to review Red Flag reporting and response processes to ensure it is an effective safety measure and accurate indicator.
- Recruitment activity continues across each site as part of the Drive 95 programme. The impact of bespoke programmes is beginning to be seen in maternity and ED departments as is the successful international recruitment programme across all areas.
- Use of the SafeCare demand and capacity tool continued its upward trajectory, with day-time census compliance at 76.5% (May 2023) compared to 64.2% (May 2022). Compliance is being monitored on a daily basis to support continuous improvement.
- Outputs reviewed at site safety and staffing huddles to support deployment decisions.



Site	Staffing Figures by Site - May-23					
	Average Fill Rate (Day)		Average Fill Rate (Night)		Average Care Hours Per Patient Day (CHPPD)	Safe Staffing Red Flag Incidents
	Registered Nurses / Midwives (%)	Care Staff (%)	Registered Nurses / Midwives (%)	Care Staff (%)		
Trust	**100.1%**	**102.5%**	**104.3%**	**121.5%**	**11.6**	**0**
Royal London	104.0%	101.7%	110.7%	129.0%	11.0	0
Whipps Cross	96.9%	104.8%	99.5%	115.9%	10.8	0
Newham	105.9%	104.7%	108.9%	118.3%	13.0	0
St Bart's	91.4%	95.7%	93.8%	120.0%	13.1	0



NHS
Barts Health
NHS Trust

Finance Report

EXECUTIVE SUMMARY

Finance Executive Summary

Jul-23

- The Trust is reporting a (£13.5m) deficit for Month 2, which is (£8.9m) adverse against plan.

- Income is £4.2m favourable against plan in Month 2. Sites are reporting elective recovery under performance in month 2 (£1.2m) but it is assumed within the overall position that ERF clawback will not be applied, due to the impact of junior doctor industrial action in April. NHS Patient Treatment income is therefore £0.4m favourable overall. Other income is £3.8m favourable, which includes £4.5m one-off non-recurrent benefits that have been included in the year to date position.

- Expenditure is (£13.1m) adverse against plan in Month 2. Site and Services expenditure is (£16.2m) adverse, the adverse variance is due to underachievement against recurrent efficiency savings targets, overspending for medical and nursing staffing and non-pay overspends including healthcare outsourcing, Soft FM contact exit costs and patient transport costs. Temporary staffing costs to date remain higher than plan. Additional budget funding of £2.6m was allocated from reserves to offset the additional consultant locum costs incurred by sites in April due to Junior Doctor industrial action. Central expenditure and reserves are £3.1m favourable which is primarily due to release of ERF clawback risk reserve, reflecting the reporting assumption that ERF clawback will not be applied. There is also a favourable variance for interest receivable (£0.6m).

- Capital Expenditure in M2 is £3.3m which is £5.4m behind the plan. The YTD variance of £6.7m can be attributed to delays in closing old year schemes, VAT recoveries as well as major schemes running behind their forecasts including the following: (£1.2m) - NUH fire programme, (£1.3m) - CAU, (£1.3m) - MEH CDC, (£0.7m) - The modular build scheme, (£0.5m) IT infrastructure, (£0.5m) - VAT recoveries and close out of old year schemes. Expenditure against donated schemes was £0.2m (£0.3m, M1).

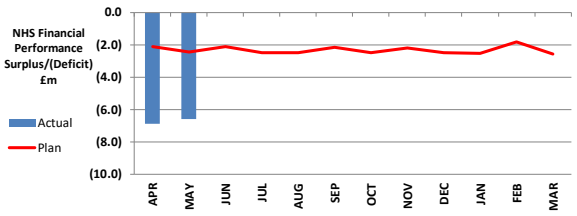
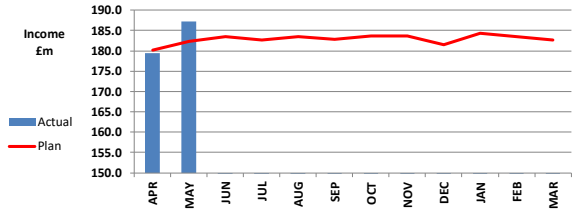
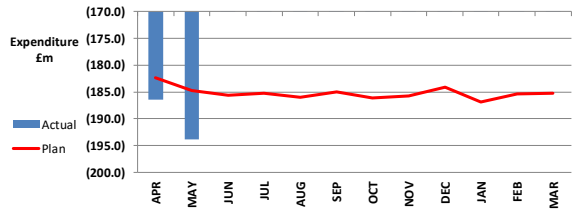
- Cash balances in May 2023 are £65.1m higher than plan, as a result of the higher closing cash balance of £60.2m in March 2023, and other movements in working capital. The 2022/23 bonus payment for Agenda for Change (AfC) staff (circa £32m, and funded by NHS England), and the 5% backdated 2023/24 AfC uplift (funded by NHSE and ICBs) will be paid to staff in June 2023. An assumption has been made that external support would be required in form of revenue loan funding totalling £40m to be taken in December 2023 and March 2024, however this will be monitored closely over the coming months.

- The key financial challenges for the Trust in achieving its plan for this financial year include:
    - Delivery of the Elective Recovery Fund activity trajectory and the associated funding,
    - Improving productivity to reduce temporary staffing costs and deliver the efficiency savings targets set within Sites and Services budgets.
    - The impact of industrial action by medical staff.

KEY METRICS

Finance Key Metrics

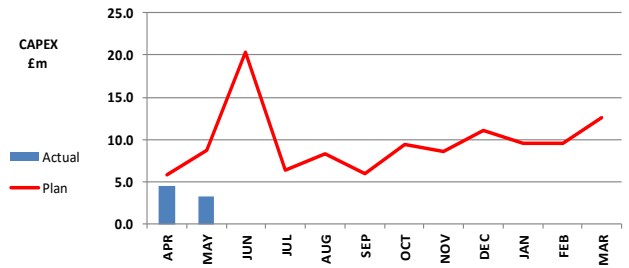
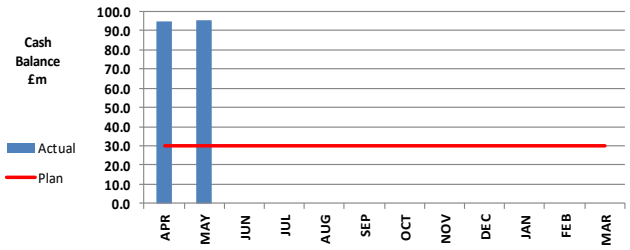
Jul-23

Metrics	Current Performance Year To Date £millions	Trend	Comments
NHS Financial Performance Surplus / (Deficit)	Plan (4.5) Actual (13.5) Variance (8.9)		The Trust is reporting a £13.5m deficit for Month 2, which is (£8.9m) adverse against plan.
Total Income	Plan 362.6 Actual 366.7 Variance 4.2		Income is £4.2m favourable against plan in Month 2. Sites are reporting elective recovery under performance in month 2 (£1.2m) but it is assumed within the overall position that ERF clawback will not be applied, due to the impact of junior doctor industrial action in April. NHS Patient Treatment income is therefore £0.4m favourable overall. Other income is £3.8m favourable, which includes £4.5m one-off non-recurrent benefits that have been included in the year to date position.
Total Expenditure	Plan (367.1) Actual (380.2) Variance (13.1)		Expenditure is (£13.1m) adverse against plan in Month 2. Site and Services expenditure is (£16.2m) adverse, the adverse variance is due to underachievement against recurrent efficiency savings targets, overspending for medical and nursing staffing and non-pay overspends including healthcare outsourcing, Soft FM contact exit costs and patient transport costs. Temporary staffing costs to date remain higher than plan. Additional budget funding of £2.6m was allocated from reserves to offset the additional consultant locum costs incurred by sites in April due to Junior Doctor industrial action. Central expenditure and reserves are £3.1m favourable which is primarily due to release of ERF clawback risk reserve, reflecting the reporting assumption that ERF clawback will not be applied. There is also a favourable variance for interest receivable (£0.6m).

KEY METRICS

Finance Key Metrics

Jul-23

Metrics	Current Performance Year To Date £millions	Trend	Comments
Capital Expenditure	Plan 14.6 Actual 7.8 Variance (6.7)		Capital Expenditure in M2 is £3.3m which is £5.4m behind the plan. The YTD variance of £6.7m can be attributed to delays in closing old year schemes, VAT recoveries as well as major schemes running behind their forecasts including the following: (£1.2m) - NUH fire programme, (£1.3m) - CAU, (£1.3m) - MEH CDC, (£0.7m) - The modular build scheme, (£0.5m) IT infrastructure, (£0.5m) - VAT recoveries and close out of old year schemes. Expenditure against donated schemes was £0.2m (£0.3m, M1).
Cash	Plan 30.0 Actual 95.1 Variance 65.1		Cash balances in May 2023 are £65.1m higher than plan, as a result of the higher closing cash balance of £60.2m in March 2023, and other movements in working capital. The 2022/23 bonus payment for Agenda for Change (AfC) staff (circa £32m, and funded by NHS England), and the 5% backdated 2023/24 AfC uplift (funded by NHSE and ICBs) will be paid to staff in June 2023. An assumption has been made that external support would be required in form of revenue loan funding totalling £40m to be taken in December 2023 and March 2024, however this will be monitored closely over the coming months.

Key Risks & Opportunities
The key financial challenges for the Trust in achieving its plan for this financial year include: - Uncertainty regarding delivery the Elective Recovery Fund activity trajectory and the associated funding, - Ensuring improvements in productivity in order to reduce temporary staffing costs and deliver the efficiency savings target sets within Sites and Services budgets. - The impact of industrial action by medical staff.

INCOME & EXPENDITURE

Income & Expenditure - Trustwide

Jul-23

PY 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									
249.6	NHS Patient Treatment Income	136.6	137.9	1.2		265.1	264.2	(0.9)		1,662.1
0.3	Other Patient Care Activity Income	0.6	0.3	(0.3)		1.2	0.7	(0.5)		6.9
20.4	Other Operating Income	10.5	10.7	0.2		20.5	20.5	0.0		122.2
270.3	**Total Income**	**147.7**	**148.8**	**1.1**		**286.7**	**285.4**	**(1.3)**		**1,791.2**
	Operating Expenditure									
(183.5)	Pay	(98.7)	(105.9)	(7.2)		(194.2)	(206.3)	(12.1)		(1,170.9)
(34.7)	Drugs	(16.9)	(16.8)	0.1		(32.4)	(32.0)	0.4		(209.2)
(25.8)	Clinical Supplies	(15.4)	(17.3)	(1.9)		(30.6)	(30.1)	0.5		(187.7)
(53.5)	Other Non Pay	(23.2)	(24.7)	(1.4)		(48.1)	(53.2)	(5.1)		(269.2)
(297.5)	**Total Operating Expenditure**	**(154.3)**	**(164.7)**	**(10.5)**		**(305.3)**	**(321.6)**	**(16.2)**		**(1,837.0)**
(27.1)	**Site & Services Budgets Total**	**(6.5)**	**(15.9)**	**(9.3)**		**(18.6)**	**(36.1)**	**(17.5)**		**(45.8)**
(8.8)	Pathology Partnership (net)	(4.5)	(4.2)	0.4		(9.1)	(8.8)	0.2		(54.5)
(0.0)	Vaccination Programme & Nightingale (net)	-	(0.0)	(0.0)		-	(0.0)	(0.0)		-
0.0	Research & Development (net)	0.0	(0.0)	(0.0)		0.0	(0.0)	(0.0)		0.0
26.8	Central NHS PT Income	13.2	12.6	(0.6)		33.0	34.2	1.2		146.2
1.2	Central RTA & OSV Income (net)	1.0	0.7	(0.3)		2.0	1.4	(0.6)		11.8
0.5	Central Expenditure (net)	(0.0)	4.8	4.8		(0.1)	4.6	4.7		(0.6)
(3.8)	Reserves (net)	(3.5)	(2.9)	0.6		(8.0)	(5.6)	2.4		(62.1)
(11.2)	**EBITDA**	**(0.5)**	**(4.9)**	**(4.5)**		**(0.8)**	**(10.4)**	**(9.5)**		**(5.0)**
(11.6)	Depreciation and Amortisation (net)	(6.3)	(6.3)	(0.0)		(12.7)	(12.7)	(0.0)		(76.7)
(11.7)	Interest	(7.0)	(6.7)	0.3		(13.8)	(13.2)	0.6		(82.9)
(1.8)	PDC Dividends	(1.3)	(1.3)	0.0		(2.6)	(2.6)	0.0		(15.5)
0.0	Profit On Fixed Asset Disposal	0.0	0.0	(0.0)		0.0	0.0	0.0		0.1
-	Loss on return of COVID assets to DHSC	-	-	-		-	-	-		
(36.3)	**Surplus/(Deficit) Before System Top-Up**	**(15.1)**	**(19.3)**	**(4.2)**		**(29.9)**	**(38.8)**	**(8.9)**		**(180.0)**
24.6	System Top-Up Income	12.7	12.7	(0.0)		25.4	25.4	(0.0)		152.2
(11.8)	**NHS Reporting Surplus/(Deficit)**	**(2.4)**	**(6.6)**	**(4.2)**		**(4.5)**	**(13.5)**	**(8.9)**		**(27.8)**

CAPITAL EXPENDITURE

Capital Expenditure Summary - Trustwide

Jul-23

22/23 YTD	Programme Area	In Month				Year to Date					Annual				
Prev Yr Actual	£millions	Plan	Actual	Variance	%	Plan	Actual	Variance	%		Funded Balanced Plan Mar 2023	Plan M2	Variance	%	
0.6	Equipment (Medical and Other)	0.5	(0.7)	1.3	*235 %*	0.9	0.4	0.5	*0.0*		11.5	11.5	-	*- %*	
0.1	Informatics	1.2	0.7	0.5	*42 %*	1.2	0.7	0.5	*0.0*		6.2	6.2	-	*- %*	
2.0	Estates	1.4	0.7	0.7	*53 %*	3.1	1.3	1.7	*0.0*		7.1	7.1	-	*(0)%*	
0.2	New Build and Site Vacations	4.5	1.6	2.9	*65 %*	7.2	3.3	4.0	*0.0*		55.8	55.8	-	*(0.0)*	
1.7	PFI Lifecycle Assets	1.1	1.1	(0.0)	*(0)%*	2.1	2.1	(0.0)	*(0.0)*		12.6	12.6	-	*0 %*	
	New Build - Diagnostics	-	-	-	*- %*	-	-	-	-		-	-	-	*- %*	
4.4	Finance Lease	-	-	-	*- %*	-	-	-	-		23.0	25.1	(2.1)	*(9)%*	
9.0	**Total Exchequer programme**	**8.7**	**3.3**	**5.4**	***62 %***	**14.6**	**7.8**	**6.7**	***0.0***		**116.3**	**118.4**	**(2.1)**	***(0.0)***	
-															
9.0	**Total Trust Funded Assets**	**8.7**	**3.3**	**5.4**	***62 %***	**14.6**	**7.8**	**6.7**	***46 %***	*	**116.3**	**118.4**	**(2.1)**	***(2)%***	
0.7	Donated	0.9	0.2	0.7	*82 %*	1.7	0.5	1.2	*72 %*		10.3	10.3	-	*(0)%*	
9.7	**Total Capital Expenditure**	**9.5**	**3.5**	**6.1**	***64 %***	**16.3**	**8.3**	**8.0**	***49 %***		**126.6**	**128.7**	**(2.1)**	***(2)%***	

Key Messages

2023/24 position. The Trust has submitted an original balanced capital plan of £116.3m now adjusted to £118.4m to cover the lease extension of St. Martin Le Grand. This is insufficient to meet the Trust's needs for capital indicating at this time a funding shortfall of c£45m.

Both NEL and NHSE London are aware of the challenges faced by the CRL allocation for NEL and are working with Senior Directors of the Trust to secure an increase in CRL in the financial year. To support the request for funds the Trust has provided a detailed justification of key requirements. However in order to continue to provide safe services without interruption it is now clear that there is a requirement to fund some activities at risk until the allocation is resolved. Proposals are to be circulated in June 2023.

In addition to the exchequer programme, there is a programme of £10.3m funded from charitable donations.

The initial £23m of cover for IFRS16 lease adjustments has been increased by £2.1m to cover the cost of a short term lease at Saint Martin Le Grand. We have also received an MOU for £1.06m of the requested £13.7 New hospital programme PDC for the WXH redevelopment programme continuation. The remaining value is dependent on approvals from NHP. There are no other changes to funding.

Expenditure in M2 is £3.3m which is £5.4m behind the plan. The YTD variance of £6.7m can be attributed to delays in closing old year schemes, VAT recoveries as well as major schemes running behind their forecasts including the following:-
(£1.2m) - NUH fire programme - timing delay that will be caught up
(£1.3m) - CAU - due to an initial non compliant ventilation which has now been resolved, the revised plan is scheduled to complete with an 8 week delay in November 2023.
(£1.3m) - MEH CDC - due to delays during the procurement process for the design and build work contractors, it is not expected that the full funding allocation will be used which will result in a cost pressure in 2024/25, mitigations are underway to avoid worsening the situation. It is currently anticipated that the project completion date will slip from December to May.
(£0.7m) - The modular build scheme - due to supply chain and labour issues which have put the programme behind schedule by c5 weeks.
(£0.5m) IT infrastructure - Unified comms -Timing delay which will be caught up
(£0.5m) - VAT recoveries and close out of old year schemes
Expenditure against donated schemes was £0.2m (£0.3m, M1).

Capital Funding

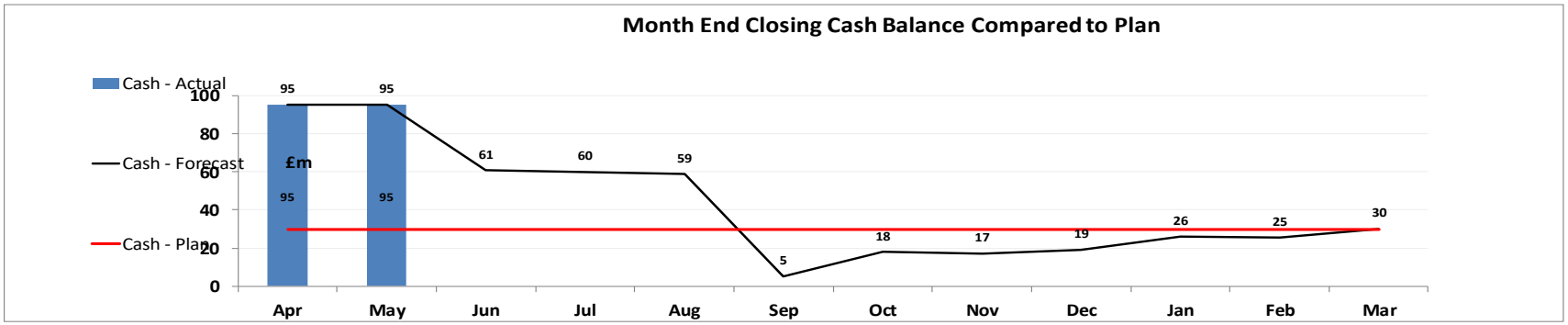
	Capital Plan	Secured/ Drawdown	Not Secured/ Drawdown	% Secured
Gross Depreciation	76.7	76.7	-	*100 %*
Repayment of PFI principal	(26.0)	(26.0)	-	*100 %*
Repayment Other Finance Leases (IFRS16)	(11.3)	(11.3)	-	*100 %*
Net Depreciation	**39.5**	**39.5**	**-**	**100 %**
CRL (not cash backed)	13.7	13.7	-	*100 %*
Add CRL - Neonatal cot capacity RLH (not cash ba	0.7	0.7	-	*100 %*
EFA	-		-	*- %*
Additional CRL from NHSE/NEL (not cash backed)	-		-	*- %*
IFRS16 CRL adjustment	25.1		25.1	*- %*
Other Leases CRL adjustment			-	
PDC: WXH Redevelopment core programme team	1.7	1.1	0.6	*63 %*
PDC: WXH Redevelopment NHP Development costs	12.0		12.0	*- %*
Specific PDC: WXH Enabling works	-		-	
TIF NUH Modular Build and Mothballed Theatres	6.3	6.3	-	*100 %*
PDC - ITU Expansion SBH	11.1	11.1	-	*100 %*
PDC- MEH CDC	8.3	8.3	-	*100 %*
PDC - LIMS	0.1	0.1		*100 %*
Planned Capital exc. Donated	**118.4**	**80.7**	**37.7**	**68 %**
Asset sales	-	-	-	*- %*
***Total approved Exchequer funding ex donated**	**118.4**	**80.7**	**37.7**	**68 %**
Donated	10.3	0.5	9.8	*5 %*
Planned Capital inc. Donated	**128.7**	**81.2**	**47.6**	**63 %**
*CRL overspend	-			

CASHFLOW & BALANCE SHEET

Cashflow

Jul-23

£millions	Actual Apr	May	Forecast Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Outturn
Opening cash at bank	**60.2**	**95.0**	**95.1**	**60.6**	**59.9**	**58.7**	**5.3**	**17.9**	**17.2**	**19.0**	**25.9**	**25.3**	**60.2**
Cash inflows													
Healthcare contracts	155.9	166.0	199.4	163.4	162.4	161.7	162.1	162.3	161.3	161.3	161.3	211.6	2,028.7
Other income	42.5	24.7	13.6	45.6	28.7	19.3	39.5	28.4	19.2	38.4	28.1	35.8	363.8
Financing - Capital Loans / PDC	-	-	-	-	-	-	-	-	55.0	-	-	24.4	79.4
Total cash inflows	**198.4**	**190.7**	**213.0**	**209.0**	**191.1**	**181.0**	**201.6**	**190.7**	**235.5**	**199.7**	**189.4**	**271.8**	**2,471.9**
Cash outflows													
Salaries and wages	(61.1)	(65.0)	(93.9)	(68.1)	(69.9)	(66.7)	(64.5)	(65.4)	(66.7)	(64.5)	(65.4)	(66.7)	(817.9)
Tax, NI and pensions	(30.7)	(46.4)	(46.1)	(66.8)	(49.0)	(49.0)	(49.0)	(49.0)	(49.0)	(49.0)	(49.0)	(49.0)	(582.0)
Non pay expenditures	(63.7)	(76.2)	(104.3)	(71.3)	(68.9)	(105.9)	(68.0)	(66.9)	(106.0)	(66.1)	(59.1)	(103.6)	(960.0)
Capital expenditure	(8.1)	(3.0)	(3.2)	(3.5)	(4.5)	(5.0)	(7.5)	(10.1)	(12.0)	(13.2)	(16.5)	(40.0)	(126.6)
Dividend and Interest payable	-	-	-	-	-	(7.8)	-	-	-	-	-	(7.8)	(15.6)
Total cash outflows	**(163.6)**	**(190.6)**	**(247.5)**	**(209.7)**	**(192.3)**	**(234.4)**	**(189.0)**	**(191.4)**	**(233.7)**	**(192.8)**	**(190.0)**	**(267.1)**	**(2,502.1)**
Net cash inflows / (outflows)	**34.8**	**0.1**	**(34.5)**	**(0.7)**	**(1.2)**	**(53.4)**	**12.6**	**(0.7)**	**1.8**	**6.9**	**(0.6)**	**4.7**	**(30.2)**
Closing cash at bank - actual / forecast	**95.0**	**95.1**	**60.6**	**59.9**	**58.7**	**5.3**	**17.9**	**17.2**	**19.0**	**25.9**	**25.3**	**30.0**	**30.0**
Closing cash at bank - plan	**30.0**	**30.0**	**30.0**	**30.0**	**30.0**	**30.0**	**30.0**	**30.0**	**30.0**	**30.0**	**30.0**	**30.0**	**30.0**



Key Messages

Cash balances in May 2023 are higher by £65.1m compared to a plan of £30m, as a result of the higher closing cash balance of £60.2m in March 2023, and other movements in working capital.

The 2022/23 pay rise award for Agenda for Change (AfC) staff (circa £32m, and funded by NHS England), and the 5% backdated 2023/24 AfC uplift (funded by NHSE and ICBs) will be paid to staff in June 2023. An assumption has been made that external support would be required in form of revenue loan funding totalling £40m to be taken in December 2023 and March 2024,

CASHFLOW & BALANCE SHEET

Statement of Financial Position

Jul-23

22/23		Actual		Forecast										
31 Mar 2023	£millions	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	22/23 v 23/24
	Non-current assets:													
1,594.2	Property, plant and equipment	1,592.4	1,589.2	1,610.9	1,611.6	1,614.3	1,614.7	1,618.2	1,620.9	1,626.2	1,629.9	1,633.6	1,640.3	46.1
0.1	Intangible assets	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0
16.8	Trade and other receivables	16.8	16.7	16.7	16.7	16.7	16.7	16.7	16.7	16.7	16.7	16.7	16.7	(0.1)
1,611.1	**Total non-current assets**	**1,609.3**	**1,606.0**	**1,627.7**	**1,628.4**	**1,631.1**	**1,631.5**	**1,635.0**	**1,637.7**	**1,643.0**	**1,646.7**	**1,650.4**	**1,657.0**	**46.0**
	Current assets:													
31.4	Inventories	32.1	32.2	31.4	31.4	31.4	31.4	31.4	31.4	31.4	31.4	31.4	31.4	0.0
145.5	Trade and other receivables	132.0	123.8	111.1	111.0	112.3	113.0	116.2	121.6	158.4	132.0	141.1	139.5	(6.0)
60.2	Cash and cash equivalents	95.1	95.1	60.6	59.9	58.7	5.3	17.9	17.2	18.8	25.9	25.3	30.0	(30.2)
237.1	**Total current assets**	**259.2**	**251.1**	**203.1**	**202.3**	**202.4**	**149.7**	**165.5**	**170.2**	**208.6**	**189.3**	**197.8**	**200.9**	**(36.2)**
1,848.2	**Total assets**	**1,868.5**	**1,857.1**	**1,830.8**	**1,830.7**	**1,833.5**	**1,781.2**	**1,800.5**	**1,807.9**	**1,851.6**	**1,836.0**	**1,848.2**	**1,857.9**	**9.8**
	Current liabilities													
(290.0)	Trade and other payables	(320.2)	(318.8)	(246.2)	(247.9)	(252.7)	(212.4)	(233.6)	(242.6)	(243.8)	(265.4)	(278.9)	(241.5)	48.5
(2.8)	Provisions	(2.9)	(2.9)	(2.8)	(2.8)	(2.8)	(2.8)	(2.8)	(2.8)	(2.8)	(2.8)	(2.8)	(2.8)	0.0
(37.3)	Liabilities arising from PFIs / Finance Leases	(37.3)	(37.3)	(42.0)	(42.0)	(42.0)	(42.0)	(42.0)	(42.0)	(42.0)	(42.0)	(42.0)	(40.5)	(3.2)
0.0	DH Revenue Support Loan (Including RWCSF)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
0.0	DH Capital Investment Loan	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(330.1)	**Total current liabilities**	**(360.4)**	**(359.0)**	**(291.0)**	**(292.7)**	**(297.5)**	**(257.2)**	**(278.4)**	**(287.4)**	**(288.6)**	**(310.2)**	**(323.7)**	**(284.8)**	**45.3**
(93.0)	**Net current (liabilities) / assets**	**(101.2)**	**(107.9)**	**(87.9)**	**(90.4)**	**(95.1)**	**(107.5)**	**(112.9)**	**(117.2)**	**(80.0)**	**(120.9)**	**(125.9)**	**(83.9)**	**9.1**
1,518.1	**Total assets less current liabilities**	**1,508.1**	**1,498.1**	**1,539.8**	**1,538.0**	**1,536.0**	**1,524.0**	**1,522.1**	**1,520.5**	**1,563.0**	**1,525.8**	**1,524.5**	**1,573.1**	**55.1**
	Non-current liabilities													
(5.9)	Provisions	(5.9)	(5.9)	(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(0.8)
(915.2)	Liabilities arising from PFIs / Finance Leases	(912.2)	(908.9)	(941.1)	(941.1)	(941.1)	(930.6)	(930.6)	(930.6)	(920.1)	(920.1)	(920.1)	(911.1)	4.1
(0.5)	Other Payables	(0.3)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	0.0
0.0	DH Revenue Support Loan (Including RWCF)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(35.3)	0.0	0.0	(40.0)	(40.0)
0.0	DH Capital Investment Loan	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(921.6)	**Total non-current liabilities**	**(918.4)**	**(915.3)**	**(948.3)**	**(948.3)**	**(948.3)**	**(937.8)**	**(937.8)**	**(937.8)**	**(962.6)**	**(927.3)**	**(927.3)**	**(958.2)**	**(36.7)**
596.5	**Total Assets Employed**	**589.7**	**582.8**	**591.5**	**589.7**	**587.7**	**586.2**	**584.3**	**582.7**	**600.4**	**598.5**	**597.2**	**614.9**	**18.4**
	Financed by:													
	Taxpayers' equity													
1,080.6	Public dividend capital	1,080.6	1,080.6	1,080.6	1,080.6	1,080.6	1,080.6	1,080.6	1,080.6	1,100.3	1,100.3	1,100.3	1,120.0	39.4
(900.9)	Retained earnings	(907.8)	(914.6)	(905.9)	(907.7)	(909.7)	(911.2)	(913.1)	(914.7)	(916.7)	(918.6)	(919.9)	(921.9)	(21.0)
416.8	Revaluation reserve	416.8	416.8	416.8	416.8	416.8	416.8	416.8	416.8	416.8	416.8	416.8	416.8	0.0
596.5	**Total Taxpayers' Equity**	**589.6**	**582.8**	**591.5**	**589.7**	**587.7**	**586.2**	**584.3**	**582.7**	**600.4**	**598.5**	**597.2**	**614.9**	**18.4**

NHS
Barts Health
NHS Trust

Glossary

GLOSSARY

Operational Planning 2023/24

Jul-23

On Wednesday 22 March 23, Barts Health submitted its 2023/24 activity and performance trajectories to North East London ICB for onwards submission to NHS England by 30 March 23.

The key NHS England Urgent and Emergency Care and Elective performance objectives and milestones are set-out in the table opposite. However a number of high-priority operational standards are expected to sit alongside these once the 2023/24 NHS Oversite metrics are published, these may include:

- ✓ A&E 12-hour journey times, measuring the wait time from arrival to departure, rather than the previous version of the standard which measured wait time from decision to admit to admission
- ✓ Ambulance handover delays of greater than 30 and 60 minutes

In relation to Activity, North East London, including Barts Health, were set an objective by NHS England to deliver 109% of Value Weighted Activity against 2019/20 baseline.

Submitted activity trajectories achieve the 109% objective with a 0.3% contribution relating to improved Outpatient Procedure Recording. NHS England has prescribed the Activity types contributing to the Value Weighted total, these include:

- ✓ First outpatient appointments
- ✓ First and follow up outpatient procedures
- ✓ Elective ordinary (inpatient) admissions
- ✓ Day case admissions

	Objective	Deadline
Urgent & Emergency Care	76% of patients seen within 4-hours	Mar-24
	Achieve 92% G&A bed occupancy	No deadline published
Elective Waits	Eliminate waits of over 65 weeks	Mar-24
	Eliminate waits of over 52 weeks	Mar-25
Cancer	Meet the 75% cancer faster diagnosis standard	Mar-24
	Continue to reduce the number of patients waiting over 62 days	
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks to 95%	Mar-25

GLOSSARY

Domain Scorecard Glossary

Jul-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

Jul-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

Jul-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

Jul-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

Jul-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

Jul-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 (New QV)

Jul-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	Newham	St Bart's	CSS	Other	Barts Health	Excep.
Waiting Times	R1	A&E 4 Hours Waiting Time	●		●	Jan-18 (m)	>=92.3%	85.5%	86.5%	*86.9%*	82.7%	88.8%	-	-	-	86.5%	●
	R7	Cancer 62 Days From Urgent GP Referral	●			Dec-17 (m)	>=85%	86.3%	86.5%	*83.2%*	86.2%	84.6%	84.3%	-	-	86.5%	
	R13	Cancer 62 Days From Screening Programme	●			Dec-17 (m)	>=90%	90.6%	88.6%	*90.8%*	-	-	86.8%	-	-	88.6%	●

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

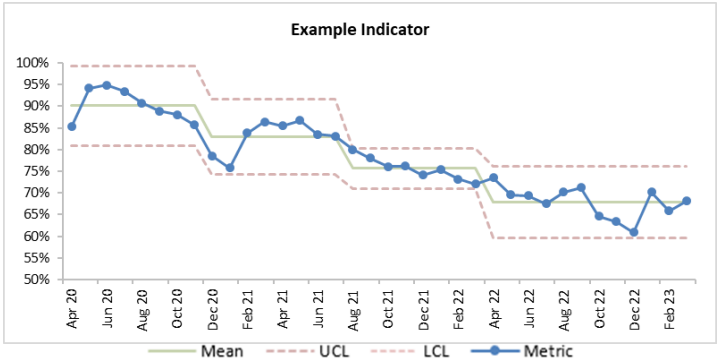
Reporting month target for reporting site

Reporting month actuals for reporting site

Reporting month actuals for other sites & trust total

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

How to Interpret an SPC Chart



Statistical Process Control (SPC) charts using the Individual metric (X shown as blue data points on a line) and it's moving Range (XmR) allows you to identify statistically significant changes in data. The red dotted lines (upper or lower process limits) represent the expected range for data points, if variation is within expected limits - that is, normal. If there is a target, then this will be shown using a black dotted line.

When you are interpreting these SPC charts there are a couple of things that help you identify what the performance is doing.

If any point is outside any of the red dotted lines, then this means that "special cause" variation is present in the system ie that data point is unusual and should be investigated.

A step consists of at least 8 data points. A step change is only triggered after the minimum step run and by the next 8 data points ALL being one side of the preceding step mean (green line) ie. ALL above or ALL below. In the example to the left the first step has a mean of 90.15% and a step change occurs in Dec 2020 as 8 data points have elapsed in the first step and the next 8 data points are all below the first step mean.

How Exceptions Are Identified For Inclusion

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

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

APPENDIX

Safe Staffing Fill Rates by Ward and Site

Jul-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	2,139.0	2,482.0	1,069.5	1,143.0	1,782.5	2,132.8	713.0	1,253.5	116.0%	106.9%	119.6%	175.8%	765	6.0	3.1	9.2
Royal London	10F RLH	1,116.0	1,176.0	744.0	773.5	1,023.0	1,122.0	341.0	484.0	105.4%	104.0%	109.7%	141.9%	493	4.7	2.6	7.2
Royal London	11C RLH	2,850.0	2,745.0	1,475.5	1,330.3	2,852.0	2,840.5	713.0	1,092.5	96.3%	90.2%	99.6%	153.2%	612	9.1	4.0	13.1
Royal London	11E & 11F AAU	3,921.5	5,006.7	1,782.5	1,897.5	3,921.5	4,957.3	1,426.0	1,909.0	127.7%	106.5%	126.4%	133.9%	1,452	6.9	2.6	9.5
Royal London	12C RLH	1,874.5	2,250.0	1,426.0	1,465.3	1,840.0	2,252.5	1,069.5	1,450.0	120.0%	102.8%	122.4%	135.6%	798	5.6	3.7	9.3
Royal London	12D RLH	1,426.0	2,342.8	713.0	1,230.0	1,426.0	2,371.5	356.5	1,152.0	164.3%	172.5%	166.3%	323.1%	544	8.7	4.4	13.0
Royal London	12E RLH	2,797.5	3,137.1	1,426.0	1,607.5	2,495.5	2,806.0	1,426.0	1,771.0	112.1%	112.7%	112.4%	124.2%	732	8.1	4.6	12.7
Royal London	12F RLH	2,048.0	2,453.0	1,782.5	1,791.0	1,782.5	2,242.5	1,781.0	1,989.5	119.8%	100.5%	125.8%	111.7%	821	5.7	4.6	10.3
Royal London	13C RLH	1,943.5	2,073.5	713.0	1,002.5	1,426.0	1,663.5	713.0	1,357.0	106.7%	140.6%	116.7%	190.3%	773	4.8	3.1	7.9
Royal London	13D RLH	1,782.5	2,116.0	713.0	713.5	1,426.0	1,804.5	713.0	690.0	118.7%	100.1%	126.5%	96.8%	727	5.4	1.9	7.3
Royal London	13E RLH	2,104.5	2,623.3	724.5	727.0	1,690.5	2,419.0	713.0	863.5	124.6%	100.3%	143.1%	121.1%	707	7.1	2.2	9.4
Royal London	13F RLH	1,782.5	2,024.0	977.5	1,104.0	1,782.5	2,150.5	713.0	943.0	113.5%	112.9%	120.6%	132.3%	691	6.0	3.0	9.0
Royal London	14E & 14F RLH	3,367.0	3,582.7	2,725.5	2,357.5	2,852.0	3,163.5	2,139.0	2,323.0	106.4%	86.5%	110.9%	108.6%	1,483	4.5	3.2	7.7
Royal London	3D RLH	4,128.5	4,912.0	2,725.5	2,473.5	3,174.0	5,052.5	1,782.5	2,481.0	119.0%	90.8%	159.2%	139.2%	1,084	9.2	4.6	13.8
Royal London	3E RLH	2,139.0	2,069.8	713.0	1,134.0	1,782.5	1,794.0	713.0	1,161.5	96.8%	159.0%	100.6%	162.9%	764	5.1	3.0	8.1
Royal London	3F RLH	1,598.5	2,022.0	1,069.5	931.5	1,069.5	2,050.5	713.0	747.5	126.5%	87.1%	191.7%	104.8%	381	10.7	4.4	15.1
Royal London	4E RLH	13,894.0	15,046.3	1,069.5	1,264.7	13,903.5	14,908.7	1,069.5	1,138.5	108.3%	118.2%	107.2%	106.5%	1,273	23.5	1.9	25.4
Royal London	6C RLH	4,480.5	3,417.3	816.5	330.1	3,599.5	2,955.5	713.0	379.5	76.3%	40.4%	82.1%	53.2%	160	39.8	4.4	44.3
Royal London	6E & 6F RLH	5,958.8	4,830.8	1,426.0	1,187.5	5,359.0	4,988.5	1,069.5	977.5	81.1%	83.3%	93.1%	91.4%	804	12.2	2.7	14.9
Royal London	7C RLH	1,426.0	1,521.5	356.5	667.0	1,069.5	1,196.0	356.5	724.5	106.7%	187.1%	111.8%	203.2%	413	6.6	3.4	9.9
Royal London	7D RLH	1,782.5	1,847.3	885.5	659.8	1,426.0	1,667.5	701.5	769.6	103.6%	74.5%	116.9%	109.7%	443	7.9	3.2	11.2
Royal London	7E RLH	2,852.0	2,966.5	1,069.5	1,291.5	2,495.5	2,774.3	1,069.5	1,736.5	104.0%	120.8%	111.2%	162.4%	700	8.2	4.3	12.5
Royal London	7F RLH	1,426.0	1,334.0	609.5	807.5	1,058.0	1,127.0	563.5	851.0	93.5%	132.5%	106.5%	151.0%	386	6.4	4.3	10.7
Royal London	8C RLH	1,930.5	1,961.0	780.5	808.5	1,426.0	1,484.5	701.5	736.0	101.6%	103.6%	104.1%	104.9%	584	5.9	2.6	8.5
Royal London	8D RLH	8,229.5	7,132.5	1,265.0	388.3	7,808.5	6,957.0	575.0	540.5	86.7%	30.7%	89.1%	94.0%	1,061	13.3	0.9	14.2
Royal London	8F RLH	1,809.5	1,698.0	1,448.5	1,584.0	1,069.5	1,071.5	1,426.0	1,426.0	93.8%	109.4%	100.2%	100.0%	1,478	1.9	2.0	3.9
Royal London	9E HDU RLH	1,416.5	1,025.5	0.0	0.0	1,426.0	1,092.5	0.0	0.0	72.4%		76.6%		177	12.0	0.0	12.0
Royal London	9E RLH	1,782.5	1,667.5	713.0	883.0	1,414.5	1,449.0	713.0	1,000.5	93.5%	123.8%	102.4%	140.3%	745	4.2	2.5	6.7
Royal London	9F RLH	1,781.5	1,747.5	713.0	925.0	1,426.0	1,417.5	713.0	1,196.5	98.1%	129.7%	99.4%	167.8%	733	4.3	2.9	7.2

APPENDIX

Safe Staffing Fill Rates by Ward and Site

Jul-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	4,630.5	5,468.8	2,502.0	2,689.1	4,634.5	5,422.5	2,139.0	2,347.2	118.1%	107.5%	117.0%	109.7%	1,177	9.3	4.3	13.5
Whipps Cross	ACACIA	977.5	991.8	448.5	554.7	713.0	718.6	713.0	828.5	101.5%	123.7%	100.8%	116.2%	353	4.8	3.9	8.8
Whipps Cross	ACORN	3,720.0	2,842.5	356.5	449.0	2,852.0	2,220.3	356.5	334.5	76.4%	125.9%	77.8%	93.8%	445	11.4	1.8	13.1
Whipps Cross	B3 WARD WXH	1,334.0	1,208.5	1,065.5	1,435.5	1,069.5	1,115.5	713.0	1,081.0	90.6%	134.7%	104.3%	151.6%	515	4.5	4.9	9.4
Whipps Cross	BIRCH	1,068.5	1,284.0	1,046.5	1,439.5	1,069.5	1,080.5	713.0	1,161.5	120.2%	137.6%	101.0%	162.9%	531	4.5	4.9	9.4
Whipps Cross	BLACKTHORN	1,058.0	1,306.0	1,060.0	1,344.0	1,069.5	1,069.5	690.0	1,161.5	123.4%	126.8%	100.0%	168.3%	516	4.6	4.9	9.5
Whipps Cross	Bracken Ward WXH	1,334.0	1,380.0	1,063.5	1,285.8	1,069.5	1,161.5	711.5	1,113.5	103.4%	120.9%	108.6%	156.5%	515	4.9	4.7	9.6
Whipps Cross	CEDAR	1,426.0	1,173.0	1,426.0	1,774.5	1,069.5	943.0	1,069.5	1,449.0	82.3%	124.4%	88.2%	135.5%	473	4.5	6.8	11.3
Whipps Cross	CHESTNUT	977.0	919.5	356.5	736.0	713.0	977.5	356.5	851.0	94.1%	206.5%	137.1%	238.7%	254	7.5	6.2	13.7
Whipps Cross	CONIFER	1,426.0	1,263.5	1,426.0	1,696.5	1,069.5	1,046.5	1,081.0	1,357.0	88.6%	119.0%	97.8%	125.5%	438	5.3	7.0	12.2
Whipps Cross	CURIE	1,426.0	1,312.0	1,080.0	1,165.5	1,426.0	922.0	1,069.5	1,299.5	92.0%	107.9%	64.7%	121.5%	504	4.4	4.9	9.3
Whipps Cross	DELIVERY SUITE WXH	6,018.0	5,697.5	1,419.0	1,216.2	5,244.0	4,999.7	1,426.0	1,370.5	94.7%	85.7%	95.3%	96.1%	532	20.1	4.9	25.0
Whipps Cross	ELIZABETH	1,690.5	1,672.5	355.5	436.5	1,426.0	1,427.0	356.5	425.5	98.9%	122.8%	100.1%	119.4%	566	5.5	1.5	7.0
Whipps Cross	FARADAY	1,714.5	1,695.5	711.3	813.8	1,598.5	1,757.3	356.5	379.5	98.9%	114.4%	109.9%	106.5%	458	7.5	2.6	10.1
Whipps Cross	Frail Elderly WXH	870.5	788.0	356.5	562.0	713.0	713.0	368.0	561.5	90.5%	157.6%	100.0%	152.6%	292	5.1	3.8	9.0
Whipps Cross	ICU WXH	7,020.0	6,104.9	1,693.5	817.5	6,436.6	5,545.8	1,353.0	532.0	87.0%	48.3%	86.2%	39.3%	322	36.2	4.2	40.4
Whipps Cross	MARGARET	1,118.0	1,077.8	396.8	403.8	701.5	713.0	356.5	391.0	96.4%	101.8%	101.6%	109.7%	220	8.1	3.6	11.8
Whipps Cross	MULBERRY	2,330.0	1,928.2	1,759.0	1,003.0	1,426.0	1,430.5	1,426.0	1,184.0	82.8%	57.0%	100.3%	83.0%	1,015	3.3	2.2	5.5
Whipps Cross	NEONATAL WXH	2,460.0	2,225.3	1,185.0	539.0	2,058.5	2,080.3	713.0	414.5	90.5%	45.5%	101.1%	58.1%	446	9.7	2.1	11.8
Whipps Cross	NIGHTINGALE	1,701.0	1,415.5	356.5	365.5	1,679.0	1,424.3	356.5	358.5	83.2%	102.5%	84.8%	100.6%	398	7.1	1.8	9.0
Whipps Cross	PEACE	1,690.5	1,795.0	1,426.0	1,403.0	1,069.5	1,334.0	1,069.5	1,104.5	106.2%	98.4%	124.7%	103.3%	434	7.2	5.8	13.0
Whipps Cross	POPLAR	1,736.5	1,646.0	1,054.5	939.5	1,414.5	1,184.5	1,058.0	793.5	94.8%	89.1%	83.7%	75.0%	435	6.5	4.0	10.5
Whipps Cross	PRIMROSE	1,782.5	2,256.5	1,421.5	1,618.0	1,426.0	1,912.0	1,069.5	1,363.0	126.6%	113.8%	134.1%	127.4%	838	5.0	3.6	8.5
Whipps Cross	ROWAN	1,781.5	1,771.0	1,424.0	1,792.0	1,426.0	1,508.5	1,081.0	1,630.5	99.4%	125.8%	105.8%	150.8%	779	4.2	4.4	8.6
Whipps Cross	SAGE	1,690.5	1,712.5	1,437.8	1,752.8	1,426.0	1,483.5	1,069.5	1,426.0	101.3%	121.9%	104.0%	133.3%	769	4.2	4.1	8.3
Whipps Cross	SYCAMORE	1,327.0	1,671.3	1,397.5	1,445.5	1,069.5	1,459.8	1,069.5	1,253.5	125.9%	103.4%	136.5%	117.2%	777	4.0	3.5	7.5
Whipps Cross	SYRINGA	1,426.0	1,391.5	1,778.5	1,777.5	1,069.5	1,058.0	1,069.5	1,435.8	97.6%	99.9%	98.9%	134.2%	759	3.2	4.2	7.5

APPENDIX

Safe Staffing Fill Rates by Ward and Site

Jul-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
Newham	BECKTON	1,426.0	1,952.8	1,069.5	1,023.5	1,426.0	1,991.5	1,069.5	1,138.0	136.9%	95.7%	139.7%	106.4%	570	6.9	3.8	10.7
Newham	Custom House NUH	1,414.5	1,771.7	1,069.5	1,287.8	1,069.5	1,344.4	1,414.5	1,620.5	125.3%	120.4%	125.7%	114.6%	569	5.5	5.1	10.6
Newham	DELIVERY SUITE NUH	5,114.0	4,992.9	713.0	673.1	4,738.0	4,716.5	713.0	713.0	97.6%	94.4%	99.5%	100.0%	634	15.3	2.2	17.5
Newham	EAST HAM	1,794.0	2,038.5	1,058.0	1,189.8	1,425.0	1,752.0	1,069.5	1,287.8	113.6%	112.5%	122.9%	120.4%	643	5.9	3.9	9.7
Newham	HEATHER	2,127.5	2,668.0	1,069.5	1,453.5	2,139.0	2,725.5	1,069.5	1,403.0	125.4%	135.9%	127.4%	131.2%	780	6.9	3.7	10.6
Newham	LARCH	3,350.0	3,042.5	2,030.5	1,983.5	2,185.0	2,183.0	1,794.0	1,771.0	90.8%	97.7%	99.9%	98.7%	1,481	3.5	2.5	6.1
Newham	Manor Park ITU NUH	4,278.0	3,335.0	713.0	782.0	4,243.5	3,488.0	713.0	724.5	78.0%	109.7%	82.2%	101.6%	303	22.5	5.0	27.5
Newham	MAPLE	1,069.5	1,035.0	713.0	701.5	1,069.5	1,063.0	713.0	713.5	96.8%	98.4%	99.4%	100.1%	217	9.7	6.5	16.2
Newham	NEONATAL NUH	3,645.5	3,402.0	793.5	563.5	3,346.5	3,166.5	747.5	552.0	93.3%	71.0%	94.6%	73.8%	596	11.0	1.9	12.9
Newham	NUH MIDWIFERY	996.5	1,032.0	356.5	292.3	1,081.0	1,042.0	356.5	356.5	103.6%	82.0%	96.4%	100.0%	83	25.0	7.8	32.8
Newham	PLASHET	1,598.5	2,452.5	1,069.5	1,364.0	1,426.0	2,224.5	1,067.0	1,587.0	153.4%	127.5%	156.0%	148.7%	779	6.0	3.8	9.8
Newham	RAINBOW	2,573.0	2,576.0	977.5	1,092.5	1,782.5	1,829.5	356.5	598.0	100.1%	111.8%	102.6%	167.7%	332	13.3	5.1	18.4
Newham	SILVERTOWN	1,771.0	2,001.0	1,069.5	1,184.5	1,759.5	1,888.0	1,056.0	1,633.0	113.0%	110.8%	107.3%	154.6%	705	5.5	4.0	9.5
Newham	STRATFORD	1,410.5	1,882.0	1,092.5	1,012.0	1,414.5	1,955.0	1,069.5	1,115.0	133.4%	92.6%	138.2%	104.3%	517	7.4	4.1	11.5
Newham	Tayberry	2,912.5	3,222.0	1,391.5	1,332.5	2,806.0	3,295.7	1,391.5	1,564.0	110.6%	95.8%	117.5%	112.4%	0			
Newham	THISTLE	1,368.5	1,651.0	828.0	891.5	1,380.0	1,679.0	828.0	1,023.5	120.6%	107.7%	121.7%	123.6%	0			
Newham	WEST HAM	1,322.5	1,350.5	1,081.0	1,070.0	1,069.5	1,089.0	345.0	862.5	102.1%	99.0%	101.8%	250.0%	580	4.2	3.3	7.5
St Bart's	1C	6,114.5	5,011.3	356.5	532.3	5,554.7	5,250.0	218.5	437.0	82.0%	149.3%	94.5%	200.0%	365	28.1	2.7	30.8
St Bart's	1D	3,208.3	2,581.5	356.5	414.0	2,852.0	2,484.0	356.5	425.5	80.5%	116.1%	87.1%	119.4%	365	13.9	2.3	16.2
St Bart's	1E	4,991.0	4,247.5	356.5	356.5	4,991.0	4,198.5	356.5	425.5	85.1%	100.0%	84.1%	119.4%	286	29.5	2.7	32.3
St Bart's	3A SBH	4,976.0	4,624.5	1,426.0	1,263.6	4,991.0	4,680.5	1,426.0	1,368.5	92.9%	88.6%	93.8%	96.0%	878	10.6	3.0	13.6
St Bart's	3D SBH	1,597.5	1,690.5	1,238.0	1,416.3	1,529.5	1,574.3	977.5	1,046.5	105.8%	114.4%	102.9%	107.1%	522	6.3	4.7	11.0
St Bart's	4A SBH	1,782.5	1,863.0	1,065.5	1,080.3	1,426.0	1,541.0	356.5	897.0	104.5%	101.4%	108.1%	251.6%	671	5.1	2.9	8.0
St Bart's	4B SBH	1,598.5	1,586.0	1,238.0	1,193.0	1,426.0	1,529.5	713.0	782.0	99.2%	96.4%	107.3%	109.7%	577	5.4	3.4	8.8
St Bart's	4C SBH	1,778.5	1,748.0	962.0	782.5	1,414.5	1,472.0	977.5	989.0	98.3%	81.3%	104.1%	101.2%	610	5.3	2.9	8.2
St Bart's	4D & 4E SBH	1,721.5	1,868.5	709.0	655.5	1,644.5	1,644.0	713.0	713.0	108.5%	92.5%	100.0%	100.0%	391	9.0	3.5	12.5
St Bart's	5A SBH	2,139.8	2,203.7	912.0	962.8	1,474.0	1,702.0	341.0	627.0	103.0%	105.6%	115.5%	183.9%	567	6.9	2.8	9.7
St Bart's	5B SBH	1,422.5	1,333.0	713.0	552.0	1,414.5	1,368.5	356.5	644.0	93.7%	77.4%	96.7%	180.6%	414	6.5	2.9	9.4
St Bart's	5C SBH	2,134.0	2,030.6	709.5	597.0	1,782.5	1,768.8	356.5	368.0	95.2%	84.1%	99.2%	103.2%	569	6.7	1.7	8.4
St Bart's	5D SBH	2,127.5	1,942.5	713.0	829.0	1,782.5	1,752.5	713.0	890.5	91.3%	116.3%	98.3%	124.9%	627	5.9	2.7	8.6
St Bart's	6A SBH	6,406.0	5,849.3	356.5	322.0	6,394.0	5,600.5	356.5	333.5	91.3%	90.3%	87.6%	93.5%	318	36.0	2.1	38.1
St Bart's	6D SBH	1,782.5	1,422.1	1,065.5	701.5	1,426.0	1,069.5	714.5	772.5	79.8%	65.8%	75.0%	108.1%	493	5.1	3.0	8.0

NHS
Barts Health
NHS Trust

Report to the Trust Board: 12 July 2023	TB 38/23

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 28 June 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
Theatres and outpatients thematic report	5
Monthly finance report	13
Capital programme report	14
NEL finance report	13
Costings report	13
Clinical research facility business case	15

Key areas of discussion arising from items appearing on the agenda

Clinical research facility business case

The Committee reviewed and endorsed the business case for development of a CRF based in the main RLH hospital towers, following funding support from Barts Charity. The Committee noted the potentially ground-breaking benefits for inclusion and equity associated with this development as well as the alignment with aspirations on lifesciences and world-class research.

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). The additional challenges of industrial action had impacted on the ability to fulfil activity plans and reduce waiting lists.

Theatres and outpatients thematic report

The Committee had a focussed discussion on theatres utilisation and outpatients transformation, which represent key enablers for achieving our stretching operational plan.

Monthly finance report

The Committee discussed and noted the M2 position (as detailed in the IPR). The committee undertook an early review of savings plans and delivery against these, noting the oversight role of the newly established Financial Recovery Board.

Capital programme report

The Committee noted the significant challenges associated with capital constraints in

2023/24. The Committee noted a historically challenged capital allocation for NEL compared to some regions and ongoing dialogue in relation to this. While recognising that additional capital funding sources were sometimes identified in year, the Committee noted the likelihood that the Trust would exhaust the current capital allocation relatively soon and the potential need to proceed with essential investment that exceeded this envelope.
Any key actions agreed / decisions taken to be notified to the Board -
Any issues for escalation to the Board Capital allocation remains inconsistent with essential investment requirements.

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.

Barts Health NHS Trust

Report to the Trust Board: 12 July 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 14 June 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**
Annual report and accounts	All
External Audit findings report and draft auditors annual report	All
Internal Audit progress report	All
BAF	All
QAC exception report	All
Provider licence compliance	All
Information Governance annual report and DPS toolkit	All

Key areas of discussion arising from items appearing on the agenda

Annual report and accounts

The committee considered the and endorsed the annual report and accounts. Following subsequent board approval the final version was published and presented at the AGM on 5 July 2023.

BAF report

The committee received the draft Board Assurance Framework, following approval of the principal risks by the Board. The discussion of this item informed a subsequent dedicated board seminar held in June with a focus on risk appetite and principal risks to the operational plan.

Internal Audit reports

The committee reviewed outcomes of audits assigned reasonable or substantial assurance ratings. The committee also discussed a limited assurance review of consultant recruitment process at The Royal London and noted similar hospital reviews considered in full by the Quality Assurance Committee. The committee noted good progress in reducing the number of overdue management actions arising from audit reviews.

External Audit report

The Committee received and discussed the audit findings report following the 2022/23 audit of the annual report and accounts. Significant assurance was received by the Committee regarding the process supporting the annual report and accounts, with strong working arrangements between the finance and audit functions.

Provider licence compliance report The committee discussed and approved the self-declared compliance with shadow licence conditions, indicating one area of non-compliance (in relation to delivery against constitutional NHS standards). This declaration was subsequently approved by the Board and published. **Information Governance yearly report and DPS Toolkit** The Committee received its yearly report on information governance and approved the Data Protection and Security toolkit. The latter submission reflected a self-declared 'compliance met' assessment (supported by an annual Internal Audit review process) including in relation to IG training requirements for staff.
Any key actions agreed / decisions taken to be notified to the Board Declaration of compliance with the DPS Toolkit.
Any issues for escalation to the Board None

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

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

NHS
Barts Health
NHS Trust

Report to the Trust Board: 12 July 2023	TB 40/23

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 14 June 2023 to discuss items on its agenda relevant to its terms of reference.

Key agenda items	**BAF entries**
• Clinical Harm Review	All
• Quality & Safety Internal Audits	All
• Organ Donation	All
• Safeguarding	All
• Complaints	7
• Maternity	All
• Health Improvement	All
• Education	All
• Quality BAF Risks	2,7,10,11
• Newham University Hospital Quality Report	All

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

Clinical Harm Review

- The committee took reasonable assurance from the report. Some further areas would be addressed by the Deputy Group Chief Medical Officer, specifically around gathering prospective patient experience outcomes and monitoring the progress in 'hot spot' areas.
- The Deputy Group Chief Medical Officer would work with the patient experience leadership team to explore alternative ways of getting direct patient feedback on their perception of harm. This would be via a smaller section of long waiting patients on RTT/cancer pathways**.**

Quality & Safety Internal Audits

- The Chair confirmed that limited assurance audit outcomes specific to sites would be followed up by this committee with senior leadership teams.
- Internal Audit were thanked by the Chair and Group Chief Medical Director for help in closing all overdue management actions which had been previously reviewed by this committee.

Organ Donation Annual Report

- The committee took substantial assurance from the report.
- Ms Ferns was keen to hear more about how we were trying to engage with the local population in the next report. It was agreed that members of the organ donation team would attend at the next meeting when this item was scheduled for review.

Safeguarding Adults and Children Annual Report

- The committee took reasonable assurance from the report, agreeing there was more work to be done to raise training compliance levels.
- The Director of Quality Governance agreed to address refinements in the safeguarding annual report prior to the Trust Board meeting.

Complaints Annual Report

- The committee took reasonable assurance from the report, noting the remaining work to be done to improve complaints handling.

Maternity Report

- The committee took partial assurance from the report, noting there needed to be closer monitoring of some of the issues and risks and more focus on the issues at Royal London Hospital, while recognising workforce limitations and local population.

Health Improvement Report

- The committee took substantial assurance from the report and agreed to the recommendations in the paper.

Education Academy Report

- The committee took reasonable assurance from the report and agreed to receive an update from the education academy twice a year, going forward**.**

BAF Risks

- The committee noted the report and the related refreshed BAF risks and deep dive schedule ahead of a scheduled board seminar.

Newham University Hospital Quality Report

- The committee was pleased the progress was being made in all areas requiring improvement. Key achievements, risks and challenges were discussed.

Any issues for escalation to the Board

There were no items requiring escalation to the Board.

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 Board is asked to note the report.

Barts Health NHS Trust

Report to the Trust Board: 12 July 2023	TB 41/23

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

Date of meeting
The Nominations and Remuneration Committee met on 21 June 2023

Key areas of discussion arising from items appearing on the agenda
At this meeting the Committee approved the nomination of hospital chief executives as non-voting Trust Board members; received and agreed the proposed approach for VSM pay (awaiting national pay body award recommendations for 2023/24); approval of a revised VSM framework; and noted recent appointments to senior positions (including specifically the Whipps Cross Chief Executive, the Managing Director of Barts Lifesciences, Director of R&D and Director of UEC).

Any key actions agreed / decisions taken to be notified to the Board
None.

Any issues for escalation to the Board
None.

Legal implications/ regulatory requirements	n/a

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

Barts Health NHS Trust

Report to the Trust Board: 12 July 2023	TB 42/23

Title	Board Collaboration Committee Exception Report
Chair	Rt Hon Jacqui Smith (Chair)
Author(s) / Secretary	Trust Secretary
Purpose	To advise the Trust Board on work of Trust Board Committees (detailed minutes are provided to Board members separately)

Executive summary

The Board Collaboration Committee met on 3 May 2023 to discuss progress on collaboration workstreams. A meeting of the Trust Boards of Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust was also held on 10 May 2023.

1. *Acute Provider Collaborative working*
2. *BH / BHRUT integrated group update*
3. *Communications and engagement*

BAF entries

10. Failure to collaborate effectively as a group across Barts Health and BHRUT delays benefits realisation and improved patient outcomes.

Key areas of discussion arising from items appearing on the agenda

Focussed discussions were held in relation to:

- The North East London acute provider collaborative and progress on partnership working in clinical workstreams.
- Corporate support services options for closer working
- Communications and engagement
- Financial drivers

There were updates on other collaboration workstreams by exception (temporary staffing; medical education; leadership development; digital; and the integrated group model)

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

None

Any issues for escalation to the Board

None

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.

Report to the Board: 12 July 2023	TB 41/23

Title	WeImprove Update
Accountable Director	Group Chief Operating Officer
Author(s)	Director Improvement and Transformation Director Quality Improvement Programme
Purpose	- Update the Board on recent national developments and expectations from NHS England on the role of a shared NHS improvement approach to support trusts to create the culture and conditions for continuous improvement within their organisations - Provide information on the state of readiness of the current WeImprove programme to support delivery - Inform the Board on the alignment of the Improvement and Transformation team to use WeImprove methodology to support delivery of the trusts priorities.
Previously considered by	Improvement and Transformation Update - Group Executive Board 23/05/23

Executive summary

'WeImprove' is the Barts Health approach to using quality improvement (QI) tools and techniques to make improvements (safety, efficiency, performance, wellbeing etc) across the organisation. The QI methodology used in Barts Health is the Model for Improvement (Institute for Healthcare Improvement). The 'WeImprove' road map and evidence-based method provide a structure to ensure that improvements are successful and sustainable, rather than just short-term fixes.

Through the publication of NHS England's Continuous Improvement Review and NHS Impact, a clear expectation has been set for Trusts to grow their QI capacity and capability, and to fully embed QI into the culture of the organisation.

Building on the work of the last 4 years, Barts Health is well placed to continue the improvement journey and embed continuous improvement more fully across the organisation, as a way of doing things.

Supporting delivery of 'WeImprove', the Improvement and Transformation team came together on 1 September 2022. Following a presentation to the Group Executive Board (GEB) on 18 February 2023, and subsequent updates sharing the programmes of work being

supported by the team, GEB members requested the team focus on fewer programmes/projects aligned directly to supporting the Trust priorities and areas of greatest challenge. Responding to requests from the Hospital site Chief Executives, a refined focus was agreed allowing for enhanced support in unplanned care and the eye treatment centre at Whipps Cross Hospital.

As it is not the intended purpose of this report to provide detailed information on progress and impact of WeImprove and associated projects, reference is made to key deliverables in the IPR. It is also proposed that this could be the focus of a future Board Seminar.

Related Trust objectives
Our Patients (care) • Providing excellent and equitable health and care • Increasing performance and productivity • Transforming services through innovation • Improving equity, quality and standards Our Partnerships (collaboration) • Working together with our local communities • Collaborating across NEL

Risk and Assurance	Supports mitigation of following BAF risks: • 2 - Equity of Access • 5 - Patient Flow constraints • 6 - Access to Treatment/Capacity • 7 - Implementing a maternity service improvement programme • 11 - Performance against the financial and operational plan

Legal implications/ regulatory requirements	CQC Well-led Regulation

Action required
The Trust Board is asked to note the contents of the paper

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 12 JULY 2023

WEIMPROVE UPDATE

1. NHS ENGLAND: NHS IMPACT

1.1 In April 2023, NHS England published the NHS Delivery and Continuous Improvement Review. The Review considered how the NHS, working in partnership, can both deliver effectively on its current priorities and continuously improve quality and productivity in the short, medium, and long term.

1.2 The Review's recommendations were consolidated into three actions, which were endorsed by NHS England's Board:

- Establish a national improvement board to agree a small number of shared national priorities on which NHS England, with providers and systems, will focus our improvement-led delivery work
- Launch a single, shared 'NHS improvement approach'
- Co-design and establish a Leadership for Improvement programme

1.3 Aligned to the review, NHS England also launched NHS Impact – a single, shared NHS improvement approach that will be used to support trusts to create the culture and conditions for continuous improvement within their organisations.

1.4 NHSE's expectation is that all providers and Integrated Care Systems (ICS), will embed an improvement approach and culture that includes five components, underpinning a systematic approach to continuous improvement:

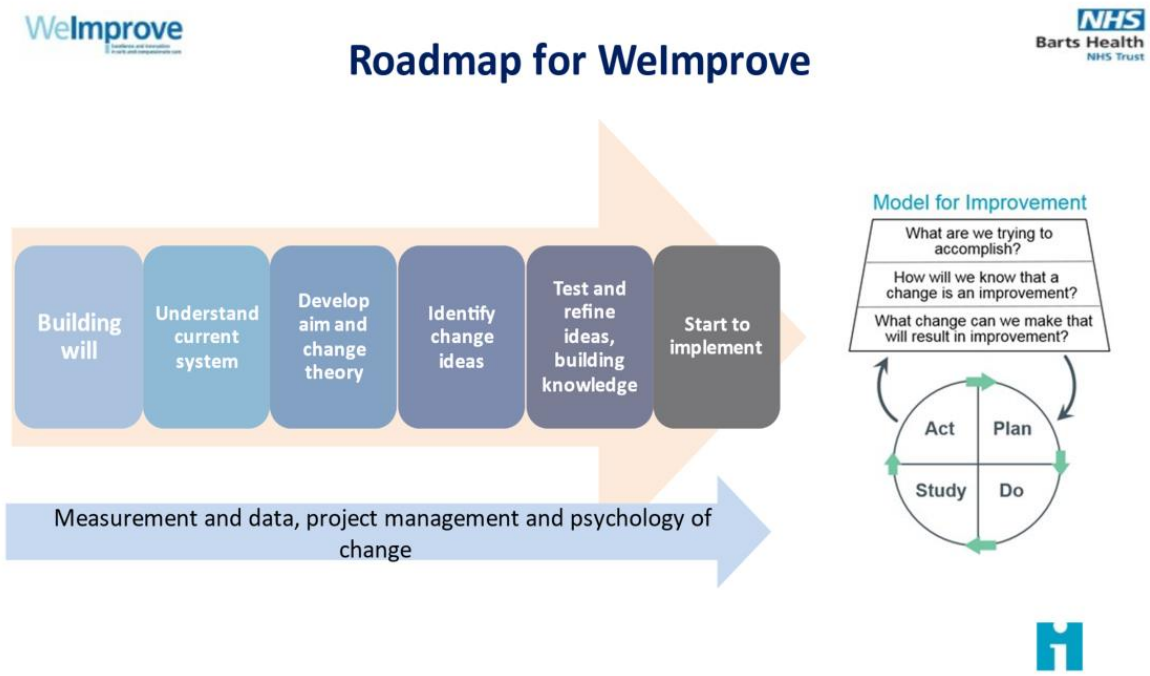
- Building a shared purpose and vision
- Investing in people and culture
- Developing leadership behaviours
- Building improvement capability and capacity
- Embedding improvement into management systems and processes

1.5 When these 5 components are consistently used, systems and organisations create the right conditions for continuous improvement and high performance, responding to today's challenges, and delivering better care for patients and better outcomes for communities. Implementation of the recommendations is commencing at a national level, with further detail being developed in the coming months.

1.6 Given the heightened level of focus on the growth and use of QI methodology to generate sustainable improvements for our challenged areas, it is imperative that the wider organisations QI capability and capacity grows across all levels of seniority and role. The risk of this not being achieved is significant to the delivery of our improvement objectives. A BAF entry is therefore being proposed to maintain visibility and ensure the risk is managed effectively.

2. WEIMPROVE PROGRAMME

2.1 WeImprove is the approach to using quality improvement (QI) tools and techniques to make improvements (safety, efficiency, performance, wellbeing etc) across the organisation. The QI methodology used in Barts Health is the Model for Improvement (Institute for Healthcare Improvement). This WeImprove road map and evidence-based method provide a structure to ensure that improvements are successful and sustainable, rather than short-term fixes.

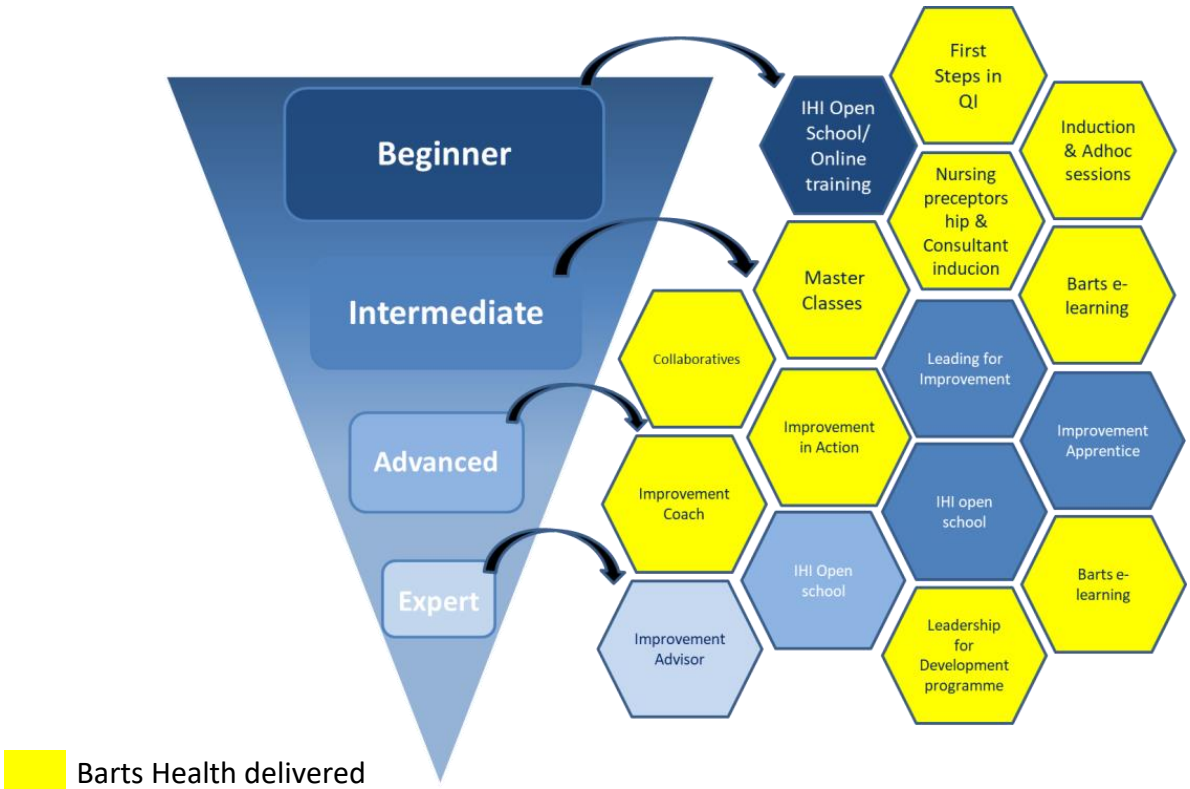


2.2 In supporting the understanding and application of QI tools and the Model for Improvement, Barts Health commenced a partnership with the Institute for HealthCare Improvement (IHI) in November 2018. The Trust is in its fifth year in partnership with the IHI, with a greater emphasis on leadership and strategic development, linked to international and national learning. Aligned to our original plan, delivery of QI teaching through our internal Barts Health faculty has grown substantially, with a focus on application of the methodology aligned to trust priorities and challenges.

2.3 Barts Health have substantially increased improvement capability and capacity over the first 4 years with many examples of both small and large-scale projects, and a regularly growing number of staff led improvement projects across the organisation.

2.4 To support ongoing delivery, a 10-year dosing model has been agreed across Barts Health, to systematically deliver a growth in QI capacity and capability at a sustainable rate. The dosing model represents the “dose” of QI expertise required by approximate numbers of people in the organisation i.e., greater number of people are expected to undertake the basic QI offer (First Steps in QI). The calculations for the dosing model are informed by IHI’s work and the NHS Improvement publication on “Building capacity and capability for improvement: embedding quality improvement skills in NHS providers” (NHS Improvement, 2017).

2.5 The delivery model directly aligns to a combination of teaching offers provided through the QI Faculty, the apprenticeship levy provider, and the IHI, depending on level of programme complexity (detailed below).



2.6 Working in collaboration with the Business Information Unit and Group leadership there have been significant developments in the use of Statistical Process Control (SPC) across the trusts core performance and oversight packs. This enhanced use of SPC in 'QlikSense' is proving valuable in identifying and demonstrating improvements.

2.7 Key to the programme's delivery is celebrating and sharing success and learning across the organisation and beyond. In March 2023, Barts Health held the first WeImprove awards, celebrating projects across the organisation who have delivered improvement, using QI methodology. The short-listed teams have since been nominated for Barts Health Heroes awards, following the additional WeImprove category. Project teams have shared Barts Health success at international forums (BMJ/IHI Quality Safety conference May 23, IHI Forum December 22) and recently being shortlisted for a HSJ award.

2.8 In 23/24 WeImprove is focusing on building on the successes and work to date ensuring that Barts Health is in a good place to respond to the expectations of NHSE through NHS Impact and the Continuous Improvement Review:

- Consolidating QI within fundamental processes of the trust
- Continuing to develop our internal capacity and capability
- Demonstrating the value and impact of our collective improvement work through evidenced impact and measurement (benefits realisation, equity, sustainability, financial)

- Alignment of QI capability to support delivery of trust priorities including implementation of the Patient Safety Incident Response Framework
- Further alignment and integration of WeImprove, WeBelong, and WeLead
- Providing improvement leadership across NEL
- Maximising opportunities for collaborative alignment and joint improvement work with Barking Havering and Redbridge NHS Trust
- Share learning and celebration across Barts Health to create improvements at scale.

3. IMPROVEMENT AND TRANSFORMATION TEAM – PROGRAMME AND PROJECT DELIVERY

3.1 Under the strategic priority of WeImprove, the Improvement and Transformation team came together on 1st September 2022, drawing together the existing Improvement team and a number of individuals from the previous Clinical Transformation Team. Existing portfolios of individuals were also transferred to the new team. The new team bring together a combination of QI, project management and operational skills.

3.2 In the first year, the Improvement and Transformation have used the WeImprove methodology to support their own development. Focusing on clarifying the purpose and role of the team; developing the team infrastructure to support delivery, informed by staff feedback and surveys; enhancing and building skills across QI and project management; delivering core projects and programmes of work; and clarifying the needs and expectations of the hospitals and wider Group. Developing and strengthening the team is ongoing.

3.3 The team continue to lead the development of the WeImprove programme shaping the strategic direction; capacity and capability building across all levels including curriculum development and teaching; and developing the infrastructure to underpin the programme. In addition, the Improvement and Transformation teamwork in collaboration with teams across Barts Health and wider partners, applying the WeImprove methodology (combining QI and project management skills) to improve and transform services for our patients, communities and staff.

3.4 Using the expertise across Improvement and Transformation, the team are drawing together a combination of QI and project management tools to strengthening the processes underpinning the projects being supported. Specifically adding rigour and clarity on aim, scope, measurement and impact.

3.5 The team are working with Deputy Chief Finance Officer – Strategic Finance, and costings team to implement the benefits realisation framework in order to clarify and strengthen the visibility of impact for the projects being supported by the team.

3.6 On 21st February the team provided Group Executive Board (GEB) with a presentation of the programmes of work they have been supporting following the transition to a single team, with a further update paper on 18th April. Feedback from GEB requested the team reprioritise and focus on fewer more specific programmes/projects aligned to the trust priorities and challenges.

3.7 On 23rd May 23, the Improvement and Transformation team proposed a reprioritisation based on the following underlying principles:

- Focus on fewer programmes and projects aligned to Trust priorities of safety, recovery and operational delivery, and efficiency/productivity opportunities
- "Commission" to be agreed with hospital(s)/teams to ensure strengthened focus on scope, expected outcomes, roles and responsibilities, measures, governance, and review points including the realisation of quantifiable benefits using the Benefits Framework
- Deployment of I&T resource is aligned to Trust objectives and opportunities that are time sensitive and that offer high value return on quality improvement, efficiency and productivity and emerging models of best practice
- Maintained focus of WeImprove methodology and leadership of WeImprove in line with NHSE's Continuous Improvement Review and implementation of PSIRF. Includes development of QI infrastructure, teaching, and coaching, underpinned by a 10 year dosing model.

3.8 The Group Executive Board agreed the proposed areas of focus for the Improvement and Transformation team (a summary of the presentation provided is attached in the appendices). This allowed for support to be directed to areas of greatest concern and challenge for the hospitals and across the Group, specifically unplanned care and the eye treatment centre. The areas of focus are set out in the appendices.

3.9 Withdrawal or refined support for some programmes has been important in order to release additional capacity and respond to the urgency of need. Plans have been enacted by the team to provide clear handover plans and/or transition arrangements as appropriate. These have been shared with the relevant executive level board to ensure visibility of associated risks.

3.10 The Improvement and Transformation team programme and project areas will be reviewed by the Group Executive Board in October 2023, with the intention of confirming the focus for the remainder of the financial year and aligned to planning for 2024/25.

Improvement and Transformation Team Programmes of work

April - May 2023

Introduction

- This presentation sets out the response feedback from the I&T presentation on 21/02 and the follow up paper on 18/04.
- It describes the reprioritisation and focus on fewer and more specific programmes/projects aligned to the Trust objectives and challenges
- The programme described is based on the current workforce and budget.

GEB are asked to:

- Discuss and agree the proposed areas for the I&T team to apply focus and support.
- Commit to supporting transition arrangements where impacted
- Agree a mid point review in October 2023
- Support maintaining I&T team capacity in 2023-4

WeImprove Original programmes/projects intended to be supported by I&T in 23/24

NHS Barts Health NHS Trust

GEB	Quality Board	Elective Recovery Board	Elective Recovery Board	Unplanned Care Board
1)WeImpove: QI Programme	**2) Patient Safety**	**3) Elective Recovery**	**4) Outpatients**	**5) Unplanned Care**
• Development and implementation of Trust wide QI strategy • Maximising learning through networks and contracts (ie. IHI, Health Alliance Improvement Europe, alignment with Clinical Effectiveness Unit) • Capacity and capability building (leadership, clinical, non clinical, teaching, coaching)	• Deteriorating patients • Maternity Safety • Consent • PSIRF implementation	• Imaging and diagnostics • Surgical hubs (T&O, urology, ENT, general surgery, ophthalmology) • Specialty support – ophthalmology • Community pathways • Theatre efficiency (RLH & WX) • Care Co-ordination Service • Clinical Networks	• Outpatients Transformation (Follow Up appt reduction, DNA reduction, Specialist Advice, PIFU, Pathways, working in 10 high volume medical & surgical specialties) • IMCOE	• REACH expansion (moving to BAU) • SDEC • Virtual ward • Hospital flow including discharge – maximising benefits of white boards

New areas in 23/24
Limited or withdrawal

WeImprove enabling delivery

Partnership with patients and communities

Embedding equity into everything we do

Integrating sustainability into our programmes

Key Principles underpinning proposed programme focus

- Focus on fewer programmes and projects aligned to Trust priorities of safety, recovery and operational pressures, and efficiency/productivity opportunities
- “Commission” to be agreed with hospital(s)/teams to ensure strengthened focus on scope, expected outcomes, roles and responsibilities, measures, governance and review points including the realisation of quantifiable benefits using the Benefits Framework
- Deployment of I&T resource is aligned to Trust objectives and opportunities that are time sensitive and that offer high value return on quality improvement, efficiency and productivity and emerging models of best practice
- Maintained focus of WeImprove methodology and leadership of WeImprove in line with NHSE’s Continuous Improvement Review and implementation of PSIRF. Includes development of QI infrastructure, teaching, and coaching, underpinned by a 10 year dosing model.

Work Requested and Proposed Approach (1)

Programme	Proposed approach	Rationale
Patient Safety		
• **Deteriorating patients** • **Maternity Safety** • **Consent** • **PSIRF implementation**	Monitoring/supervision Continue E-package procurement only Continue	• Risk to delivery of key programmes given safety agenda (maternity) and national requirements (PSIRF). • Site lead collaboration • Consent not yet in improvement/change space
Unplanned Care		
• **REACH expansion (moving to BAU)** • **SDEC** • **Virtual ward** • **Supporting implementation of hospital improvement plans including discharge (where required).**	Exit complete– moved to BAU Continue where part of delivery plan Continue –all sites Invest	• Significant pressure and focus of unplanned care. Requests from hospitals to support delivery plans requiring front loaded response in first 6 months • Opportunities to maximise impact of white boards ready for Winter 23/24 • Site requirements will vary in areas of focus for the I&T team
Outpatients		
• **Outpatients Transformation (FU appt reduction, DNA reduction, Specialist Advice, PIFU, Pathways, working in 10 high volume medical & surgical specialties)** • **IMCOE**	Continue Handover to RLH team post completion of preliminary business case.	• Achievable impact across efficiency and productivity agenda. Phased implementation to respond to needs of service and targeted impact. • IMCOE – service awaiting charity funding to continue. Further work to be commissioned separately if required.

Work Requested and Proposed Approach (2)

Imaging and Diagnostics	Proposal	Rationale
• **Network support**	Task focused support	• Significant resource focused on supporting NEL wide network • Plans in discussion across APC on future model and support needed. Work plan being finalised- anticipated support until the end of December 2023
• **Endoscopy**	Exit	• Currently stable move to BAU
Elective Recovery		

• **Surgical hubs:**
  • **T&O**
  • **Urology**
  • **ENT**
  • **General surgery**
	
	Exit – end May
	Continue – specific focus
	Exit
	Do not commence
		• Hospitals taking leadership of surgical hubs with limited support required on specific areas.
		• TURBT focus

• **Specialty support – ophthalmology**	Continue	• Significant risk across multiple agendas. Requires enhanced support
• **Community pathways** • **Theatre efficiency (RLH)** • **CCS (IECCPP)** • **Clinical Networks**	Move to BAU Move to BAU Continue Move to BAU	• BAU activity • Exit plan agreed. Deloitte commissioned • Separately funded • Transfer to hospital and clinical leadership

I&T Programme Support Summary 23/24

	Unplanned Care	Patient Safety	Outpatients	Elective Recovery
Continue as is	• SDEC (RLH, NUH) • Virtual ward • Supporting implementation of hospital improvement plans including discharge (where required).	• Maternity Safety • PSIRF implementation	• Outpatients Transformation (FU appt reduction, DNA reduction, Specialist Advice, PIFU, Pathways, working in 10 high volume medical & surgical specialties)	• Imaging and diagnostics (dependent on network development) • Specialty support – ophthalmology (WX) • Care Co-ordination Service
Amended Support offer		• Deteriorating patients • Consent	• IMCOE (RLH) from end June following completion of preliminary business case	• Endoscopy • Surgical hubs (T&O, urology, ENT, general surgery, ophthalmology) • Community pathways • Theatre efficiency (RLH) (end May) • Clinical Networks

* All Trust wide unless stated

Key Risks

Key Risks*	Mitigation
Gaps created in currently supported areas – loss of traction and support	Clear exit plans to be agreed and adhered to. Where gaps remain any associated risks to be escalated to appropriate Board for action.
Pace of transition of team to respond to urgency of need	Workstream leads to work closely with sites and service leads to agree timelines and ensure exit plan is agreed and adhered to. Escalate to appropriate Board where required.
Impact on individuals in the I&T team re remit and moving expectations, given significant team flux over the last 18 months	• Agreement to remain focused on key areas for minimum 6 months. • Limit movement where possible to ensure ability to maintain relationships and complete pieces of work. • Team and individual development programme to be continued
Capacity and readiness of local team to work in collaboration and responsively to I&T team. Impact on delivery of key priority areas where team are not able to respond.	• Key deliverables and timelines to be agreed with SROs and leads. • Escalation through to relevant Boards and groups where appropriate. • Clear review points in place.
Lack of ability to demonstrate and achieve desired impact due to issues beyond the control of the I&T team	Strengthened processes to demonstrate and report progress, with clear governance and review points to escalate challenges where required.
Capacity of team insufficient to respond to level of demand and provide continuity	Recruit into vacant posts providing ability to create succession plan and continuity of support from the team.

* Further detailed risks and mitigations for individual projects to be developed separately as part of handover process.

Steps completed by end June following GEB approval

- Finalised proposals/approaches for exiting projects and programmes to limit impact and manage any associated risk
- Detailed proposals agreed and implemented through appropriate governance (Elective Recovery Board, Quality Board, Unplanned Care Board)
- Finalised unplanned care requirements of hospitals and phasing of resource ask
- Worked with existing and current programmes to define commission, benefits etc more clearly and consistently

Report to the Trust Board: 12 July 2023	TB 44/23

Title	Nursing, Midwifery and Therapies Establishment Review 2022/23
Sponsoring Director	Group Chief Nurse
Author(s)	Director of Nursing, Workforce and Professional Standards
Purpose	To provide Trust Board with the outcome of the NMAHP 2022/23 safe staffing review and assurance of the process used in the review.
Previously considered by	GEB 18 April 2023 Quality Assurance Committee 19th April 2023 and Part 2 Board 2nd May 2023

Executive summary

In line with National Quality Board guidance Barts Health undertakes regular nursing and midwifery establishment reviews reflecting the principles of best practice. This paper outlines the governance process of the safe staffing review for end of year 2022/23, the outcome in terms of recommended changes to the establishment, the resourcing strategy and safe staffing priorities for 2023/24. The recommendations from this review were supported by GEB and QAC in April 2023.

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

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

Action required by the Trust Board

The Trust Board is asked to:

- Note the outcome of the 2022/23 Nursing, Midwifery and AHP establishment review.
- Approve the move to funding any recommended uplifts from within Hospital allocated budgets, with risks recorded, mitigated and monitored via hospital governance processes.
- Note the ongoing nature of some of the actions agreed in the 2022/23 safe staffing review.
- Support the priority actions for 2023/24 .

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 12 JULY 2023

NURSING, MIDWIFERY AND ALLIED HEALTH PROFESSIONALS (NMAHP) ESTABLISHMENT END OF YEAR REVIEW

INTRODUCTION

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

2. This paper reports on the outcome of the 2022/23 NMAHP establishment review, including the associated resourcing strategy.

HIGH LEVEL SUMMARY OF OUTCOME

3. The 2022/23 review identified recommendations by Hospital Executive Boards (HEBs) regarding establishment changes that spanned service reconfiguration, service development and safer staffing.

4. Review of cumulative investment and productivity data supported the proposal that no new central funding be allocated for this financial year.

5. Identified safer staffing requirements to be supported via:
    - Realignment of resources at hospital level
    - Efficient use of resources via consistent and effective roster efficiencies driven by hospital Directors of Nursing (DoNs) and People Directors
    - Residual gaps to be risk assessed, mitigated, and monitored via HEB governance structures
    - Revised position to be assessed via mid-year establishment review.

GOVERNANCE OF THE 2022/23 END OF YEAR ESTABLISHMENT REVIEW

6. As in previous years, the safe staffing review was conducted in line with the Safe Staffing Policy for Nursing and Midwifery (COR/POL/197/2019/01). Steps in the process included:

    - Hospital Director of Nursing (DoNs)-led ward-to-board review of staffing demand and capacity utilising acuity-dependency data, workforce and roster data, quality metrics and professional judgement.
    - Recommendations reviewed by Hospital Executive Board (HEB). Outcomes captured in HEB paper.

- HEB papers Peer Reviewed by hospital DoNs and Group Professional Leads
- Chief Nurse-led Confirm and Challenge review of HEB papers to pose critical challenge and gain assurance that the proposed changes were warranted. Investment requests were duly categorised as Safer Staffing or Service development

- New for this year, the HEB staffing reviews were discussed at Finance and Performance Group (FPG) meetings, where the HEB responsibility for allocating resource was clarified.

7. Although Allied Health Professional (AHPs) remain outside the scope of the current safe staffing policy, adult and children's inpatient therapies were included in the HEB reviews.

8. The triennial Birthrate Plus audit of maternity staffing, which is an external evidence-based process, took place in Quarter 4 of 2021/22, with establishments uplifted in line with the report's recommendations. No further recommendations were identified at this point.

HISTORIC INVESTMENT

9. The trust has made year-on-year investment in NMAHP safe staffing, with resource being prioritised ahead of other funding allocations. Over the last five years a total £9.2 million has been invested, right-sizing establishments by an additional 198 whole time equivalent nursing, midwifery, and therapy staff.

Table 1 NMAHP Safe Staffing Investment 2018/19 - 2022/23

Year	WTE	£000
2018/19	22.1	777
2019/20	41.7	1,971
2020/21	39	1,857
2021/22	30.6	1,526
2022/23	64.6	3,129

FUNDING APPROACH 2023/24

10. It is proposed that no new central investment is currently indicated.

11. The decision is based on:

- Significant increase in funded establishments in preceding years
- Objective productivity measures (SNCT, CHPPD) do not indicate funding gaps overall
- Potential resource available through improving roster efficiencies.

12. Where professional judgment indicates a safer staffing gap, HEBs are to prioritise this through resource allocation via their internal budget setting process.

13. Where safe staffing gaps remain, these will be managed via the hospital's risk management process, with risk clearly articulated, mitigated, and monitored.

14. Other staffing increase requests and service development will be progressed through business planning processes.

15. Each hospital will progress at pace a programme of roster scrutiny and efficiency improvement to maximise effective use of resources. Resolving inefficiencies will enable redistribution of released resource.

16. Demand, capacity and risk will be reassessed via mid-year establishment review.

PRODUCTIVITY BENCHMARKING

17. The Model Health System (formerly Model Hospital) information service publishes several productivity measures for nursing, indicating where there may be opportunity for improved efficiency.

18. These measures support benchmarking against national averages and selected peers.

- **Weighted Activity Unit (WAU)**

19. A WAU is a standardised unit of healthcare output which provides a currency for measuring productivity. It measures how costs compare to output: the lower the cost of producing a WAU, the more productive an organisation is seen to be.

20. Cost per WAU can be broken down into cost components to help indicate where an organisation may be more, or less, productive than its peers.

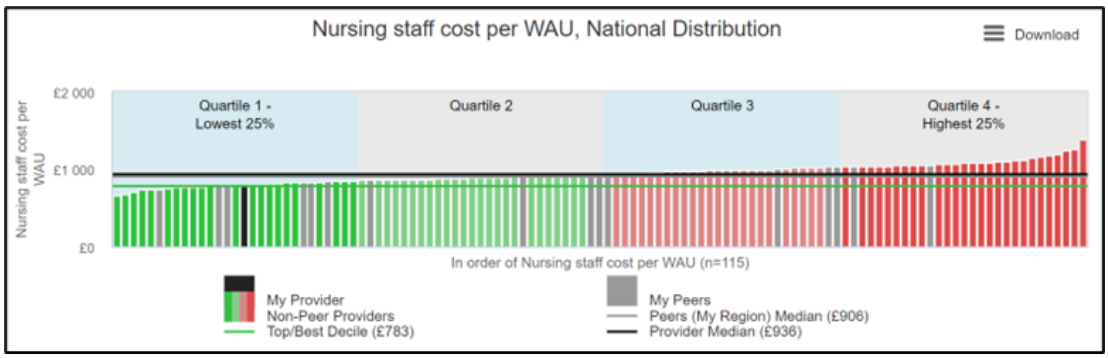
21. A higher-than-average nursing staff cost per WAU suggests the organisation spends more on this staff group per unit of activity. A lower cost per WAU suggests a spend lower than a typical organisation.

22. NHSE advise that cost per WAU should be used to benchmark relative efficiency against peers in the same financial year. The data is refreshed annually, in April.

23. The last published data (for financial year 2021/22) showed Barts Health Nursing WAU at £795. This performance was below peer group median and among the best in the country, as shown in Table 2 below: the lower the line to left, the lower the nursing cost per WAU.

24. This data indicates that in 2021/22, overall nursing cost productivity compared favourably to other organisations.

Table 2 Nursing WAU 2021/22 (Data Source: Model Hospital)



- **Care Hours Per Patient Day**

23. Care Hours Per Patient Day (CHPPD) is a measure of ward productivity which enables comparison across wards, specialities and organisations. It is calculated by adding the hours of registered and unregistered staff together then dividing by the number of inpatients at 23.59 hours.

24. CHPPD data (Model Hospital, January 2023) shows Barts Health as being third highest in the country at 10.7 and second highest in London (London average 9.1) – see Table 3 and 4 below.

25. Data over time shows Barts Health to be persistently above national and peer (London) averages – see Table 5 below.

26. Variation at organisational level is not wholly unwarranted, given the number of critical care and tertiary beds. However, drill-down shows variation across several wards, including general specialities.

27. The data is based on actual staffing (i.e., it includes additional duties above planned/funded template).

28. The metric should not be viewed in isolation, but it does indicate average staffing levels are unlikely to be unsafe.

Table 3 CHPPD January 2023 - national

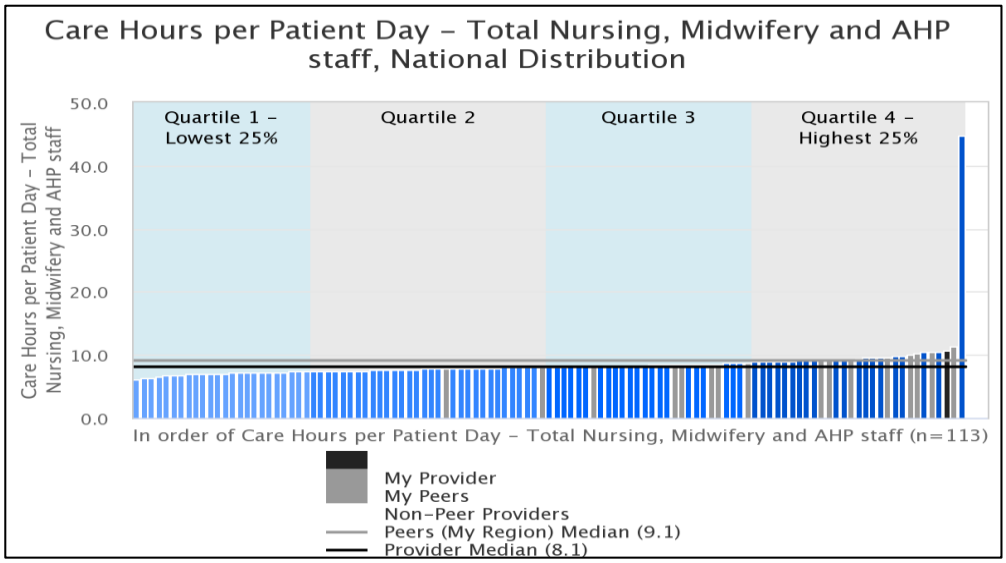


Table 4 CHPPD January 2023 - London

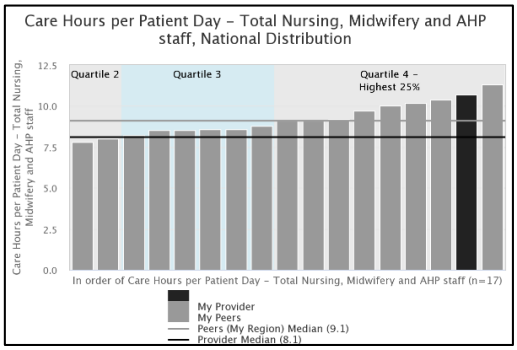
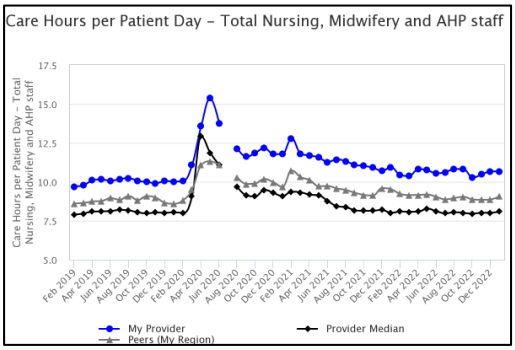


Table 5 CHPPD Trends 2019 onwards



29. The WAU measure looks at total nursing resource cost in terms of activity, whereas CHPPD only refers to nursing hours used per patient at ward level.

30. The inference is that nurse resourcing overall is comparatively low.

STRENGTHENING BENCHMARKING

31. Throughout and during the recovery stage of the Covid 19 pandemic, benchmarking was difficult due to the novel ways of working in response to operational pressures including frequent specialty changes and staff redeployment and altered staff:patient ratios.

32. With CHPPD, ward-level data is the most specific but for this to be reliable the specialities need to be mapped appropriately. Similarly, acuity-dependency data needs to be recorded consistently via appropriate, evidence-based tools.

33. Further, no metric can be viewed in isolation, data must be triangulated with quality metrics and professional judgement.

34. This last year has seen a re-set of wards with return to speciality-basing, a reinstating of robust nursing and midwifery workforce governance processes and focused training.

35. This improved stability will enable increased use of, and confidence in benchmarking for 2023/24. Examples to illustrate how we will look at this going forward include:

- NHSE facilitated Masterclass in use of CHPPD – June 2023.
- Ward-by-ward confirmation/correction of speciality mapping used in monthly safer staffing returns (data from these is used by Model Hospital).
- Validation exercise to assess whether sustained variation, where detected, is warranted.
- Ensure choice of acuity-dependency and staffing demand tool is appropriate to the specific clinical area.
- Safer staffing monitoring processes to include benchmarking information and exception reporting.

OUTCOME OF THE 2022/23 ESTABLISHMENT REVIEW

36. No changes were proposed relating to the commitment of 21% headroom for nursing and midwifery establishments as agreed in 2015 (parental leave headroom being held centrally).

37. Ward Managers remain 100% supervisory at Barts Health, as they have since 2017/18 demonstrating the value placed on ward managers and enabling them to be in the strongest position to role model and deploy exemplary leadership.

38. Establishment pressures categorised as Safe Staffing issues requiring reallocation of existing hospital resources and/or risk mitigation are summarised in Table 6 below.

Table 6 Safer Staffing Changes for 2023/24

Hospital	Safe Staffing Priorities – Nursing and Therapies
Whipps Cross Hospital	Outstanding funding for trauma and orthopaedic staffing Fund for respiratory enhanced care Fund for Sycamore ward staffing gap. Note: This has been submitted to the hospital prioritisation list to consider for funding and/or service reconfiguration
St Bartholomew's Hospital	Therapy staff – Barts Heart Centre and Barts Cancer Centre
Newham University Hospital	Therapy staff – Stroke Service and Speech and Language Therapy Service
Royal London Hospital	Nursing – Ward 13C and 12 D

Midwifery

37. The triennial Birth Rate Plus audit was completed in Quarter 4 2022/23. The establishments were fully uplifted in line with the report's recommendations.

38. No further changes were recommended at this point.

39. The Group Director of Midwifery continues to work with the midwifery leads, reassessing staffing needs and priorities contemporaneously, directing resources accordingly and progressing recruitment initiatives.

SAFE STAFFING PRIORITIES FOR 2023/24

40. Progress was made with all actions agreed for 2022/23 as part of last year's establishment review. Some require ongoing work which will be subsumed into business as usual or addressed within this year's work programme.

41. The overarching theme for this year's priority actions is enabling safety through maximising productivity and effective use of existing resources.

42. Enabling workstreams centre around: Systems and Processes; NMAHP Workforce; Enhanced Care; Leadership and Supervision. Further detail is provided in Appendix 1.

RECOMMENDATIONS

43. The Trust Board is asked to:

- Note the outcome of the 2022/23 Nursing, Midwifery and AHP establishment review.
- Approve the move to funding any recommended uplifts from within Hospital allocated budgets, with risks recorded, mitigated and monitored via hospital governance processes.
- Note the ongoing nature of some of the actions agreed in the 2021/22 safe staffing review.
- Support the priorities for 2023/24 (Appendix 1).

Appendix 1

Themes emerged from the safe staffing reviews which, along with ongoing actions to be taken forward from 2022/23, lead to the following priorities for the coming year:

Systems and Processes

- Drive improved safety and productivity through
  - consistent use of Safecare to identify staffing gaps and available resources
  - maximising roster efficiencies including staff utilisation, lead times, net hours balance, effectiveness and skill mix
  - Increased scrutiny of additional duties
- Continue to develop AHP Safer Staffing guidelines

NMAHP Workforce

- Agree NMAHP workforce annual plan aligned to overarching NMAHP strategy and BH People Plan
- Continue work to embed Nursing Associate (NA) role into the workforce, creating a sustainable deployment plan and career pathway
- Progress HEE Flexible Working: Improving Rostering programme, applying lessons across nursing and midwifery teams

Enhanced Care

- Audit compliance with strengthened Enhanced Care Policy requirements
- NUH and RLH to progress and embed site specific models of care for patients with concurrent acute physical illness and mental health needs

Leadership and supervision

- Further develop the hospital Senior Nurse Workforce role, embedding where newly established
- Provide training and support to Band 6 and above NMAHP leaders to support safer staffing and productivity agendas

Report to the Trust Board: 12 July 2023	TB 45/23

Title	Board Assurance Framework and Operational Plan Oversight
Sponsoring Director	Group Director of Corporate Development
Author(s)	Sean Collins, Trust Secretary Joanne Middleton, Director of Performance
Purpose	To approve the revised BAF and introduce the approach to overseeing delivery of the operational plan
Previously considered by	Risk Management Board, Audit and Risk Committee, Trust Board seminar 21 June 2023

Executive summary

The Board Assurance Framework (BAF) sets out the principal risks to the delivery of the Trust's objectives. This report provides an updated BAF and also highlights some proposed areas for further work to reflect outputs from a board seminar held on 21 June. This seminar represented an opportunity for the Board to consider in more detail the proposed BAF risks and risk appetite statement for 2023/24; and also to consider the respective roles of executive group boards and assurance committees; and the relationship between the oversight of performance and risk management in delivering the operational plan.

This covering paper is accompanied by a risk appetite statement (TB 45/23a); a summary of KPI and BAF risk oversight arrangements (TB 45/23b); the BAF heatmap (TB 45/23c) and the main detail of the BAF (TB 45/23d) - with the exception of fully worked up entries for newly proposed BAF risks 3 and 8.

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

Legal implications/ regulatory requirements	CQQ Well Led regulations

Action required

The Trust Board is asked to note and approve: the Board Assurance Framework; the approach to oversight of the operational plan; and areas for further development during 2023/24.

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 12 JULY 2023

BOARD ASSURANCE FRAMEWORK AND OPERATIONAL PLAN OVERSIGHT

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 format of the BAF includes cross referencing to the wider Trust risk register and captures the risk appetite for corresponding objectives. This version of the BAF heatmap has been amended in response to feedback and more explicitly maps risks to the 12 objectives (which support the people, patients and partnerships pillars) in the annual plan.

3. The Trust Board reviewed proposed BAF risks and a draft risk appetite statement in March and it was subsequently agreed to hold a board seminar (held on 21 June 2023) to explore this in more detail – in the wider context of delivery of the operational plan.

RISK APPETITE STATEMENT

4. A risk appetite statement sets out the context in which a given objective sits. The benefits of a risk appetite statement include:

    - Supporting shared understanding - at multiple levels across the group - of the relative level of risk and innovation we are comfortable with in seeking to achieve our objectives; and what in terms of outcomes may be tolerated. This is particularly important given the size of Barts Health and different leadership groups engaged in decision-making and empowers wider teams on approach and when to escalate.

    - A framework for setting and revisiting 'tolerance' thresholds. This assists the Board and its committees to identify some key KPIs and standards to be considered in pursuit of objectives; and support 'holding to account'.

- A nationally recognised signifier of risk maturity. The benefits of a Board approved risk appetite statement also enables the risk appetite and tolerance concept to be developed at hospital level through their equivalent of the BAF (site assurance frameworks). It further legitimises the existing use of 'distance from risk appetite' as a prioritising consideration when managing risks at all levels.

5. The Board discussed its risk appetite at its meeting in March and, more recently, at a Board seminar held on 21 June with the outputs included at **Annex A (TB 45/23a) and in the BAF heatmap (TB 45/23c)**. This includes the following recommended specific changes (with other proposed refinements for future consideration detailed in paragraph 21):

   - Risk appetite for subobjective 1b 'Supporting the wellbeing of our people' moving from 'open' to 'moderate'.
   - Risk appetite for subobjective 1c 'Supporting the wellbeing of our people' moving from 'open' to 'moderate'.

2023/24 OPERATIONAL PLAN – OVERSIGHT OF DELIVERY AGAINST OBJECTIVES; AND RISKS IDENTIFIED IN THE BAF

6. The Barts Health operational plan for 2023/24 is provided separately on the agenda and details key priorities and objectives for 2023/24 in our mission to provide safe, compassionate and efficient care for the people of North East London, whilst continuing on our journey to be an outstanding place to work.

7. Work over recent months with group boards (executive boards reporting into the group executive board) and hospitals has included steps to identify key operational plan deliverables. This has been conducted in the context of the Trust's vision, values, objectives; and principles set out in the Trust's Accountability Framework (including those related to respective roles, delegation and escalation). The Accountability Framework has been published separately on the Trust's website for transparency.

8. The Group Executive Board (GEB) has agreed a proposed approach to providing assurance that we are on track to deliver the plans that we have set out in the operational plan, with an accompanying opportunity to highlight risks to delivery and mitigating actions to these throughout the year.

9. The key components that will drive the oversight process are as follows:

   - Committee agendas will be closely aligned to the objectives and associated BAF risks delegated to committees for oversight.

- Group boards (senior executive boards) will undertake at least monthly review of the metrics and measures identified in the operational plan through existing data dashboards and reports utilised within routine governance forums.
- Group boards will undertake a quarterly self-assessment of current performance and risks to delivery against metrics and measures in the operational plan - to be reported to GEB, board committees and the Trust Board.
- Selected metrics from the operational plan are being aligned to relevant BAF risks as indicators that would trigger further review at board committee level. Metrics identified as BAF KPIs will inform the identification of triggers for escalation / de-escalation. When trigger thresholds are reached, board committees may request additional assurances from group boards, executive risk owners (or other assurance sources) to provide confidence that risks are being managed effectively and whether further measures or a change of approach are required. Conversely, if KPIs and assurances are indicating a positive trajectory, a board committee should consider a risk for a reduction in score, de-escalation to the operational risk register/closure and/or reduced reporting frequency. As indicated, the Accountability Framework will provide a supporting tool in determining the practical approach to this.

Self-Assessment Process: delivery against operational plan objectives

10. Key metrics as described above and other deliverables in the plan have been mapped to group boards. The Business Intelligence Unit is now reviewing all metrics detailed in the plan to ensure they are within existing reporting templates.

11. Group boards will use the accountability framework to support an approach to regular and routine discussion of these deliverables, with escalation of risks and issues via established governance reporting. Aligned with this, each group board will undertake a quarterly self-assessment of all metrics and milestones they have accountability for (with the Finance Recovery Board will hold a cross-cutting role, overseeing delivery of the finance and activity components of the operational plan, linking across other group boards). Definitions of ‘status’ against plan have been agreed for consistency:

12. This process is designed to support a discussion about delivery against plan at regular intervals throughout the year from both a performance and risk perspective. Annex A provides a schematic, summarising how the above will link into the BAF.

Status	What we mean by this
On track	All core deliverables have been met so far & will be met by year end
Behind schedule	Behind against proposed trajectory/actions, but we will hit the deliverable by year end
Behind schedule – limited assurance	Behind against proposed trajectory/actions, remedial actions required, limited assurance on end of year outturn position
Will not deliver	For reasons explained in the narrative, will not meet end of year target – with suggested next steps

BOARD ASSURANCE FRAMEWORK 2023/24

13. The BAF has been developed for 2023/24 reflecting the revised objectives set out in the operational plan. As in previous years, a process involving executive lead review has informed the framing and calibration of risk scores reflected in the attached BAF.

14. As described in the above section, board committees and group boards will use the BAF as a tool to understand and manage the level and trajectory of strategic risks (through KPIs, assurances and gaps). BAF risks are overseen on behalf of the Board by the following board committees:
    - Quality Assurance Committee – quality risks.
    - Finance Investment and Performance Committee – financial and performance risks.
    - Audit and Risk Committee – governance and people (on behalf of the Board) risks.

Board seminar outputs

15. The Trust Board reviewed the draft BAF and risk appetite statement at its seminar on 21 June 2023.

16. The BAF heatmap accordingly reflects the following changes recommended by the Trust Board in their seminar sessions:

    - Risk appetite amendments detailed earlier in this paper.
    - Remapping of the identified informatics resourcing against subobjective 2b *'Transforming services through innovation'.*

- Risk wording amended for BAF entries 5 (elective activity risk) and 10 (healthcare inequalities).
- The development of two additional BAF risks to objectives. The heatmap reflects the inclusion of a new risk 3: “A failure to successfully engage our people on our Quality Improvement approach impairs our ability to transform services and meet demand. (risk score 12)” and a new risk 8: “Failure of systems to identify hotspots in a large complex organisation impacts on aspirations to provide 'good and outstanding' rated services across the group (risk score 12)”. The wording, scoring and supporting detail of controls and assurances of these draft risks remain subject to further development in conjunction with lead executives.

17. The BAF reflects the Trust’s current risk profile with the highest scored risks shown for BAF entries in relation to workforce capacity and capability (entry 4); drivers of elective delivery (entry 5); mental health care in emergency settings (entry 6); delays to Whipps Cross redevelopment (entry 12); and financial pressures (entry 13).

    The above entries also reflect the greatest distance from risk appetite - alongside entries relating to quality risks on CQC regulation (entry 8) and maternity (entry 9).

AREAS FOR FURTHER DEVELOPMENT

18. Other themes from seminar feedback which will require further consideration in coming months (some of which extend beyond risk appetite and risk management activity) include:

    - Embedding the approach set out in this report to assessing delivery against the operational plan from a performance and risk perspective to inform assessment of the key risks to delivering our objectives. A cycle of reporting against key plan deliverables will be developed as part of this.

    - Developing an increased role of group boards on the review of BAF risks (bringing the management of performance and risk closer together) feeding into the work of the Trust Board and its committees.

    - Identifying for each BAF risk the most relevant KPIs to use as ‘triggers’; and setting an upper and lower threshold for tolerances (building on the recent enhancements of the ‘SPC’ format for performance reporting. The Audit and Risk Committee, at its meeting on 19 July, will discuss potential ‘triggers’ in more detail ahead of this approach being rolled out more fully.

    - Consideration of risks associated with sector integration beyond those reflected in the BAF risk relating to the collaboration with BHRUT. This includes specifically a proposal to revisit the current BAF entry 10 (currently framed in relation to the collaboration) to expand this to encompass risks associated with wider NEL integrated working.

- An ongong refinement in approach to risk appetite – reflecting, for example, that some differentiation may be required within the subobjective headings.

BAF DEEP DIVE REPORTING

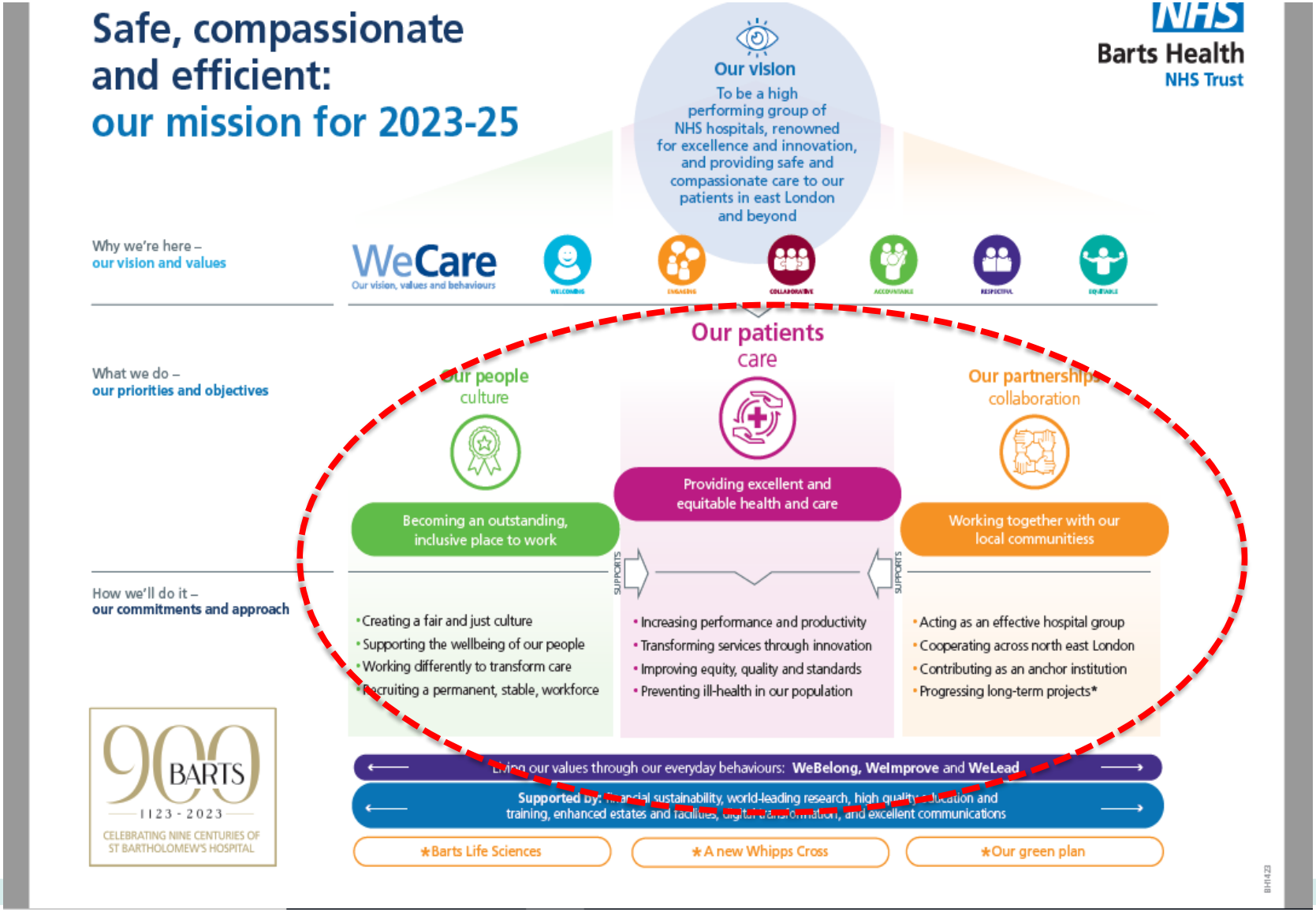
19. A schedule of deep dive reporting already agreed with Board committees will be further refined following the recent further development of the BAF. In line with the Board's recommendation to develop a consistent approach, a format has been identified for these reports which places a greater emphasis on scrutinising the effective management of risks using some measurables such as assurance RAG ratings and risk triggers as referenced in this report. This seeks to evolve the approach from one focusing on risk identification and risk score calibration towards a more balanced approach to management of performance and risks to the plan.

RECOMMENDATION

20. The Trust Board is asked to note and approve: the Board Assurance Framework; the approach to oversight of the operational plan; and areas for further development during 2023/24.

The Board has agreed our 23/24 Group objectives

NHS Barts Health NHS Trust



Risk appetite for each objective

Barts Health NHS Trust

Our People: **Objective 1 Becoming an outstanding, inclusive place to work**	*Our Patients:* **Objective 2 Providing excellent and equitable health and care**	*Our Partnerships:* **Objective 3 Working together with our local communities**
1a Creating a fair and just culture **MODERATE (8-12)**	2a Improving performance and productivity **CAUTIOUS (4-6)**	3a Acting as an effective hospital group **MODERATE (8-12)**
1b Supporting the wellbeing of our people **OPEN (15-16)**	2b Transforming services through innovation **OPEN (15-16)**	3b Cooperating across north east London **OPEN (15-16)**
1c Working differently to transform care **MODERATE (8-12)**	2c Promoting equity and sustaining standards **AVERSE (1-3)**	3c Contributing as an anchor institution **OPEN (15-16)**
1d Recruiting a permanent, stable, workforce **CAUTIOUS (4-6)**	2d Preventing ill-health in our population **OPEN (15-16)**	3d Progressing long-term projects **MODERATE (8-12)**

Enabler: Financial Sustainability	**(Averse risk appetite range 1-3)**
Enabler: Digital Transformation & Excellent Communications	**(Moderate risk appetite range 8-12)**
Enabler: Enhanced Estates & Facilities	**(Moderate risk appetite range 8-12)**
Enabler: World leading Research	**(Open risk appetite range 15-16)**
Enabler: High Quality Education & Training	**(Moderate risk appetite range 8-12)**

Risk appetite scoring

Barts Health NHS Trust

AVERSE (1-3)	CAUTIOUS (4-6)	MODERATE (8-12)	OPEN (15-16)
Very low tolerances on performance variation (+/-). We prefer ultra-safe delivery options to achieve this objective and have no appetite for higher risk / reward opportunities	Low tolerances on performance variation (+/-). We prefer safe delivery options to achieve this objective and have minimal appetite for higher risk/ reward opportunities	Moderate tolerances on performance variation (+/-). We are willing to consider a range of potential delivery options and moderate risk/reward opportunities to achieve this objective – and are open to innovative approaches	Greater tolerances on performance variation (+/-). We are willing to consider all potential delivery options and higher risk/ higher reward opportunities to achieve this objective and eager for innovative approaches that improve delivery prospects
An averse risk appetite reflects a relatively low tolerance for risk in activity to deliver this objective – risks scores beyond the range of **1-3** exceed this appetite.	A cautious risk appetite reflects a relatively low tolerance for risk in activity to deliver this objective while accepting some inherent risk –risks scores beyond the range of **4-6** exceed this appetite	A moderate risk appetite reflects a moderate tolerance / acceptance of the need for some higher risk: reward activity to deliver this objective – risks scores beyond the range of **8-12** exceed this appetite	An open risk appetite reflects acceptance of the need for some higher risk: reward activity to deliver this objective –risks scores beyond the range of **15-16** exceed this appetite

Objective 1 (People): BAF risks and oversight

Barts Health NHS Trust

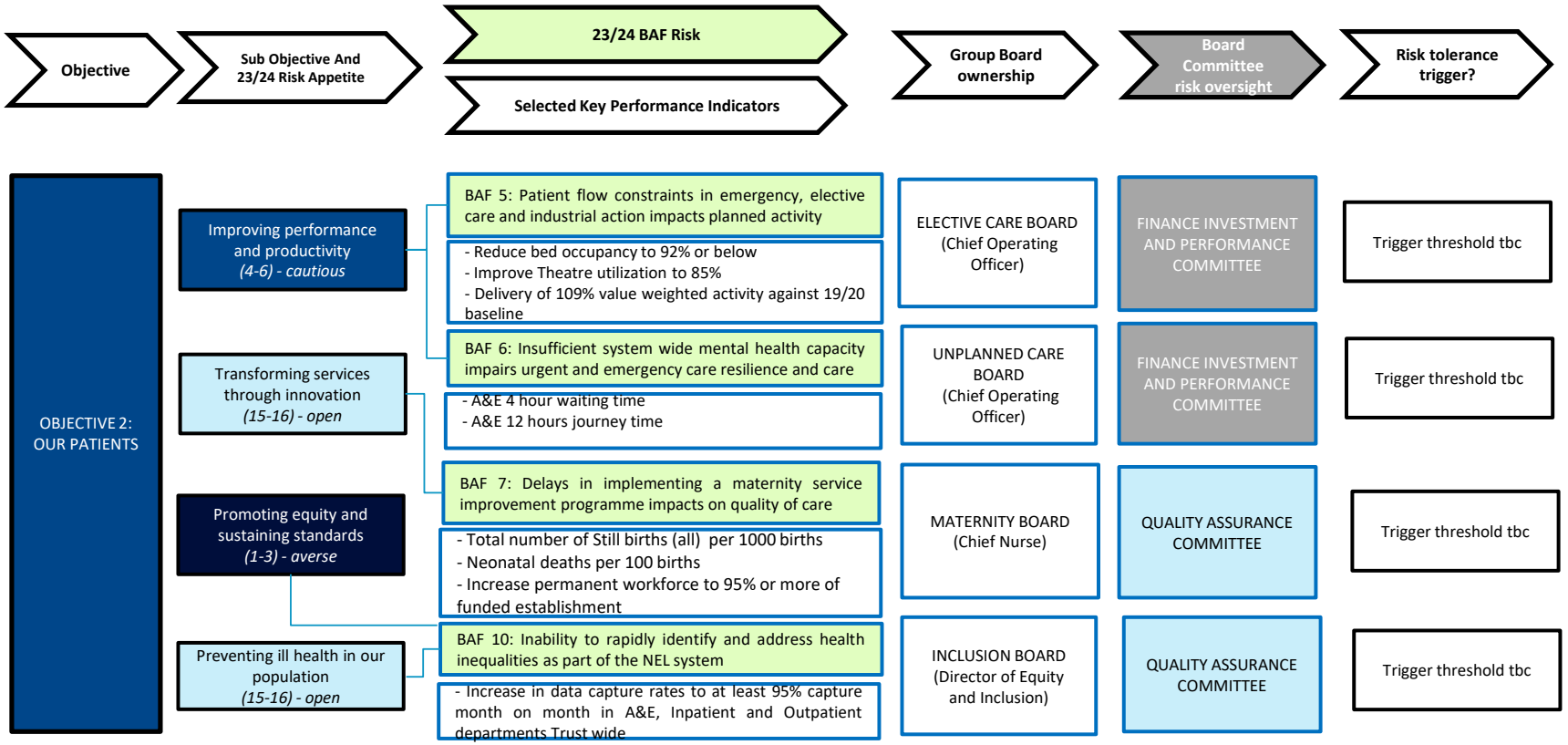
Objective	Sub Objective And 23/24 Risk Appetite	23/24 BAF Risk	Selected Key Performance Indicators	Group Board ownership	Board Committee risk oversight	Risk tolerance trigger?
OBJECTIVE 1: OUR PEOPLE	Creating a fair & just culture *(8-12) - moderate*	BAF 1: Lack of delivery on Operational Plan inclusion commitments impairs morale, recruitment and retention	- WRES 1A: % BAME staff in 8A+ roles from 37% to 41% - WRES 2: Reduce BAME shortlisting gap - Reduce gender pay gap from 11.7% to 11% in leadership roles	INCLUSION BOARD (Director of Inclusion and Equity)	AUDIT AND RISK COMMITTEE	Trigger threshold tbc
	Supporting the wellbeing of our people *(15-16) - open*	BAF 2: Insufficient leadership capability to prioritise wellbeing plans impairs morale, recruitment / retention	- Rollout the WeLead Leadership programme - Reduce sickness absence from 5.07% to 4 % - Increase satisfaction with 'We work flexibly' score from 5.6 to 6 in NHS Survey	PEOPLE BOARD (Director of People)	AUDIT AND RISK COMMITTEE	Trigger threshold tbc
	Working differently to transform care *(8-12) - moderate*	BAF 3: Insufficient resourcing for informatics impairs improved activity, productivity and system development	- Gain funding approval for shared EPR with BHRUT - WeConnect expansion of EPMA: removal of drug & anaesthetic charts, device integration and realtime data access	INFORMATICS BOARD (Director of Strategy)	FINANCE INVESTMENT AND PERFORMANCE COMMITTEE	Trigger threshold tbc
	Recruiting a permanent stable workforce *(4-6) – cautious)*	BAF 4: Substantive workforce capacity and capability shortfalls at Trust and NEL level reduces care standards	- Reach 100% roster compliance from 41.7% as at March 2023 - Increase substantive fill rate from 92.6% to 95% - Reduce agency spend from 5.02% to 3.7%	PEOPLE BOARD (Director of People)	AUDIT AND RISK COMMITTEE	Trigger threshold tbc

Risk appetite - key

AVERSE (1-3)	CAUTIOUS (4-6)	MODERATE (8-12)	OPEN (15-16)
Very low tolerances on performance variation (+/-). We prefer ultra-safe delivery options to achieve this objective and have no appetite for higher risk / reward opportunities	Low tolerances on performance variation (+/-). We prefer safe delivery options to achieve this objective and have minimal appetite for higher risk/ reward opportunities	Moderate tolerances on performance variation (+/-). We are willing to consider all potential delivery options and moderate risk/reward opportunities to achieve this objective - open to innovative approaches	Greater tolerances on performance variation (+/-). We are willing to consider all potential delivery options and higher risk/ higher reward opportunities to achieve this objective and eager for innovative approaches that improve delivery prospects

Objective 2 (Patients): BAF risks and oversight

Barts Health NHS Trust

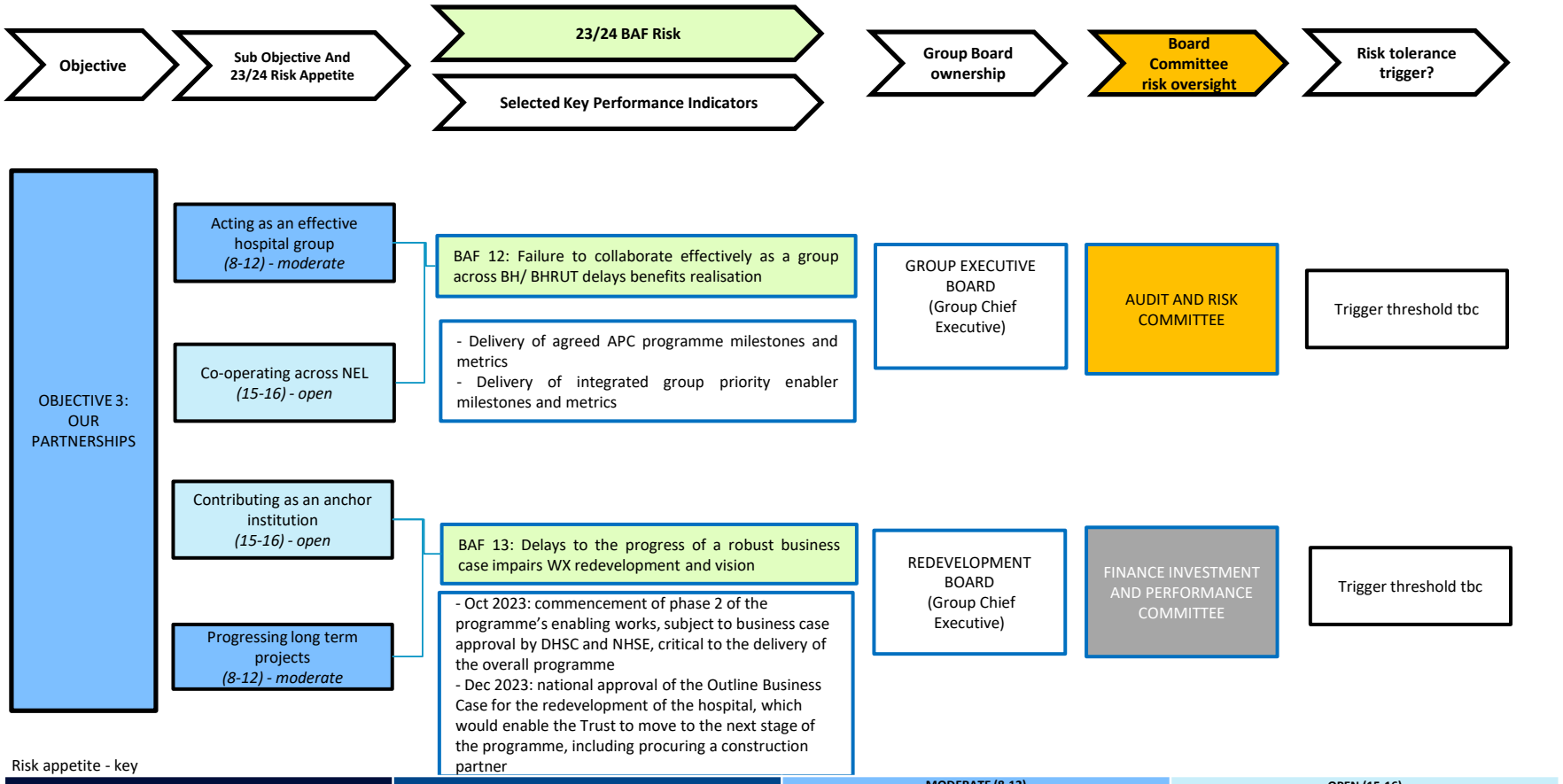


Risk appetite - key

AVERSE (1-3)	CAUTIOUS (4-6)	MODERATE (8-12)	OPEN (15-16)
Very low tolerances on performance variation (+/-). We prefer ultra-safe delivery options to achieve this objective and have no appetite for higher risk / reward opportunities	Low tolerances on performance variation (+/-). We prefer safe delivery options to achieve this objective and have minimal appetite for higher risk/ reward opportunities	Moderate tolerances on performance variation (+/-). We are willing to consider all potential delivery options and moderate risk/reward opportunities to achieve this objective - open to innovative approaches	Greater tolerances on performance variation (+/-). We are willing to consider all potential delivery options and higher risk/ higher reward opportunities to achieve this objective and eager for innovative approaches that improve delivery prospects

Objective 3 (Partnerships): BAF risks and oversight

Barts Health NHS Trust



Risk appetite - key

AVERSE (1-3)	CAUTIOUS (4-6)	MODERATE (8-12)	OPEN (15-16)
Very low tolerances on performance variation (+/-). We prefer ultra-safe delivery options to achieve this objective and have no appetite for higher risk / reward opportunities	Low tolerances on performance variation (+/-). We prefer safe delivery options to achieve this objective and have minimal appetite for higher risk/ reward opportunities	Moderate tolerances on performance variation (+/-). We are willing to consider all potential delivery options and moderate risk/reward opportunities to achieve this objective - open to innovative approaches	Greater tolerances on performance variation (+/-). We are willing to consider all potential delivery options and higher risk/ higher reward opportunities to achieve this objective and eager for innovative approaches that improve delivery prospects

Enablers: BAF risks and oversight

Barts Health NHS Trust

Objective	Sub Objective And 23/24 Risk Appetite	23/24 BAF Risk	Selected Key Performance Indicators	Group Board ownership	Board Committee risk oversight	Risk tolerance trigger?
ENABLERS	Financial sustainability *(1-3) - averse*	BAF 8: Below plan activity , workforce costs and inflationary pressures impact on delivery of BH/BHRUT financial plan	- Variance to financial plan - Agency spend as % of pay bill - Increase in theatre utilization to 85%	FINANCIAL RECOVERY BOARD (Chief Finance Officer)	FINANCE INVESTMENT AND PERFORMANCE COMMITTEE	Trigger threshold tbc
	Digital transformation & excellent communications *(8-12) - moderate*	[See BAF 3 risk mapped also to objective 1c] Insufficient resourcing for informatics impairs improved activity, productivity and system development				
	Enhanced estates & facilities *(8-12) - moderate*	BAF 9: Lack of capital and supply chain issues results in failure to improve infrastructure and equipment.	- Performance against capital plan	FINANCIAL RECOVERY BOARD (Chief Finance Officer)	FINANCE INVESTMENT AND PERFORMANCE COMMITTEE	Trigger threshold tbc
	World leading research *(15-16) - open*	BAF 11: Reductions in research funding and capital impacts on delivery of research strategy including life sciences	- Progress on commercial and research income: number of portfolio trials measured via the Trust's performance dashboard	QUALITY BOARD (Chief Medical Officer & Chief Nurse)	QUALITY ASSURANCE COMMITTEE	Trigger threshold tbc
	High quality education and training *(8-12) - moderate*					

Risk appetite - key

AVERSE (1-3)	CAUTIOUS (4-6)	MODERATE (8-12)	OPEN (15-16)
Very low tolerances on performance variation (+/-). We prefer ultra-safe delivery options to achieve this objective and have no appetite for higher risk / reward opportunities	Low tolerances on performance variation (+/-). We prefer safe delivery options to achieve this objective and have minimal appetite for higher risk/ reward opportunities	Moderate tolerances on performance variation (+/-). We are willing to consider all potential delivery options and moderate risk/reward opportunities to achieve this objective - open to innovative approaches	Greater tolerances on performance variation (+/-). We are willing to consider all potential delivery options and higher risk/ higher reward opportunities to achieve this objective and eager for innovative approaches that improve delivery prospects

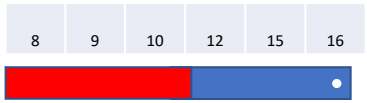

Objective / Appetite
Risk entry
1-3
4-6
8-9
10
12
15
16
>=20
PEOPLE
Creating a fair & just culture (moderate risk appetite)
1. A lack of evidenced delivery on the operational plan's inclusion commitments impairs engagement, morale, ability to lead and recruitment and retention of staff at Trust and system level. [DI/DP] [ARC]
Supporting the wellbeing of our people (moderate risk appetite)
2. Insufficient leadership capacity and capability to effectively prioritise wellbeing plans impairs engagement, morale, ability to lead and recruitment and retention of staff at Trust and system level. [DP] [ARC]
Working differently to transform care (open risk appetite)
3. A failure to successfully engage our people on our Quality Improvement approach impairs our ability to transform services and meet demand [COO] [QAC]
Working differently to transform care (moderate risk appetite)
4. 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 [DP] [ARC]
PATIENTS
Improving performance & productivity (cautious risk appetite)
5. Patient flow constraints in emergency and elective care combined with workforce productivity issues (including industrial action) impact on delivery of planned activity, long waiting times and funding. [COO] [FIP]
Transforming services through innovation (open risk appetite)
6. Insufficient system-wide mental health care capacity impairs urgent and emergency care resilience, quality of care and patient experience [COO] [FIP]
Promoting equity & sustaining standards (averse risk appetite)
7. Insufficient resourcing for informatics impairs plans to improve activity, productivity and system development thereby impacting on effective service delivery within the Trust and NEL. [DS] [FIP]
Preventing ill health (open risk appetite)
8. Failure of systems to identify hotspots in a large complex organisation impacts on aspirations to provide 'good and outstanding' rated services across the group [CN] [QAC].
PARTNERSHIPS
Acting as an effective hospital group (moderate risk appetite)
9. Delays in implementing a maternity service improvement programme that responds to national reviews impacts on consistent quality of maternity care provision, confidence of service users and workforce retention [CN] [QAC]
Co-operating across NEL (open risk appetite)
10. Failure to collaborate effectively as a group across Barts Health and BHRUT delays benefits realisation and improved patient outcomes. [DCD] [ARC]
Contributing as an Anchor institution (open risk appetite)
11. An inability to rapidly identify and address healthcare inequalities as part of the NEL system impairs public health outcomes and aspirations as an anchor institution [DI/CMO] [QAC]
Progressing long term projects (moderate risk appetite)
12. Delays to the progress of a robust business case, supported by stakeholders, impairs Whipps Cross redevelopment and delivering the vision of excellent integrated care [DS] [FIP]
ENABLERS
Financial sustainability (averse risk appetite)
13. Below plan activity, workforce costs and inflationary pressures impact on delivery of financial plans for Barts Health and BHRUT, affecting medium term sustainability and effective sector collaboration [CFO] [FIP]
Enhanced estates & facilities (moderate risk appetite)
14. 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 [CFO] [FIP]
World leading research (open risk appetite)
15. Reductions to research funding and capital impacts on delivery of key elements of the research strategy, including progressing lifesciences, clinical research facility and centre for healthy ageing initiatives. [CMO] [QAC]

Key

Objective/risk appetite heading – a risk appetite is assigned to each objective rating from 'averse' (shaded dark blue) to 'open' (light blue).

Risk entry heading – each risk is colour-coded according to which lead board committee it is assigned to.
(ARC = orange, QAC = blue, FIP = green)

Risk score section-



The white dot represents the 'current risk score' (corresponding to the risk score shown at the top of the column) – in the above example '16'

The blue section of the bar represents the distance from 'current risk score' to the 'target risk score' by year end (corresponding to the risk score shown at the top of the column that the far left hand side of the blue bar) – in the above example '12'

The red section of the bar represents the distance from the 'current risk score' to the 'risk appetite' where this exceeds the year-end target risk score (corresponding to the risk score shown at the top of the column that the far left hand side of the red bar) – in the above example 8

STRATEGIC OBJECTIVE 1a. Creating a fair & just culture (8-12)
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

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 the operational plan's 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 and 2)*** *[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, 2)** and Inclusion Advisory Panel assurance reporting **(1)** *[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)**		*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 1b Wellbeing of our people
Risk appetite for sub-objective relevant to risk: **Moderate (risk score 8-12** Risk tolerance triggers: Board and VSM staff substantive fill rates (threshold tbc); Sustained 'high pressure' or above on Covid escalation framework; Delays to WeLead framework refresh (threshold tbc)
Gap: risk score to risk appetite: 4

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. Insufficient leadership capacity and capability to effectively prioritise wellbeing plans impairs engagement, morale, ability to lead and recruitment and retention of staff at Trust and system level. **Executive lead:** Director of People **Subcommittee role:** Audit and Risk Committee	*[Outset score: 12]* ***Current: 4x3=12*** *Target: 4x2=8* *Datix ref: [tbc]*	**1.** Group governance and accountability framework refreshed in line with Well Led framework. **2.** Wellbeing strategy (as 1 of 4 'pillars' of People plan) – identifies partnerships with Barts Charity and other stakeholders to resource initiatives **3.** 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. **4.** WeLead framework, Talent Management approach to develop skills and opportunities. **5.** Publication of 'Closer Collaboration' setting out provider collaboration's immediate objectives **6.** Acute Provider Collaborative and place based partnerships provide locality focus.	People Board and health and wellbeing group monitors implementation of wellbeing strategy **(2)** GEB and joint executive oversight of group model development and provider collaboration priorities **(1,3-6)** Performance Review mechanism to monitor hospital leadership effectiveness **(1)** Trust Board standing item on People Strategy implementation **(1-4)** Improvement and Sustainability Collaborative oversight of priorities for joint work with BHRUT **(4-6)**		Closer working of two trust boards in the provider collaboration including establishment of Board Collaboration Committee		Role of NEL ICS, JOSCs and Healthwatches in oversight of system development and place-based governance CQC oversight of Well Led domain and internal mock Well Led inspections.		*Gap: ICS and wider system governance remains in development* *Action: Development of shadow provider collaboration agreements / APC with ToRs now in place*

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

STRATEGIC OBJECTIVE 1d. Permanent stable workforce

Risk appetite for sub-objective relevant to risk: **4-6 (Cautious)** Risk tolerance triggers: 95% fill rate target adverse variance (threshold tbc)

Gap: risk score to risk appetite: 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*	
4. 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 baseline for workforce. **2.** Focus on substantive fill rates, recruitment and retention in Drive 95 programme. **3.** Sector leadership, local employment, research and education focus to attract and retain high calibre clinical staff. Underpinned by Outstanding Place to Work programme and WeBelong inclusion work (community connectivity and development of inclusion centre and inclusion observatory) as part of aspiration to be an anchor institution. **4.** WeLead programme, Talent Management approach to develop skills and opportunities. **5.** Pandemic workforce plans developed supported by detailed people recovery and restoration plan focusing on staff welfare and wellbeing, with associated investment. **6.** Provider Collaborative extends shared learning and career opportunities across the NEL sector.	People Board oversight of key workforce metrics and controls **(1-6)** Financial Recovery Board's workforce sub-group monitors implementation of financial plan. IPR reports on people and safe staffing (sourced from Allocate and manual systems) **(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: **3543 Crowding within the Emergency Department (risk score 20, lead Whipps Cross CEO); 5152 Emergency Access Performance (risk score 16, lead Group COO); 7197 Lack of medical staffing within ED (risk score 16, lead Newham CEO); 3571 Risk of sub-optimal care due to the use of Post-operative Recovery (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); 6676 Mismatch between Clinical Neurophysiology demand and capacity (risk score 16, lead Royal London CEO); 6709 Risk to staffing MRI Scanners x3 at weekends and evenings (risk score 16, lead Royal London CEO); 6720 Risk to MRI on call cover at RLH due to unagreed rate (risk score 16, lead Royal London CEO); 6965 Frequent closure of the mechanical thrombectomy service due to INR staffing (risk score 16, lead Royal London CEO); 7169 Non-compliant Neurosurgery on-call rota (risk score 16, lead Royal London CEO); 7170 Low junior medical staffing impacting patient care and discharges (risk score 16, lead Royal London CEO); 7196 Non-compliant Paediatric ED SHO rota (risk score 16, lead Royal London CEO); 7263 Lack of capacity to operate on paediatric spinal patients (risk score 16, lead Royal London CEO); 5156 Risk to patient safety related to operational seasonal pressures (risk score 16, lead Whipps Cross CEO); 7272 Failure to deliver safe care due to Junior Doctors industrial action pressures (risk score 16, lead Whipps Cross CEO); 6711 Critical Care Resourcing (risk score 15, lead Gp COO); 6321 Inadequate nursing support for POSCU services (risk score 15, lead Newham CEO); 6515 insufficient staffing level across therapies in NUH stroke unit to meet stroke standards (risk score 15, lead Newham CEO); 7269 Risk to patient safety due to industrial action by junior doctors (risk score 15, lead Newham CEO); 6915 Critical Overcrowding (risk score 15, lead Royal London CEO); 7264 Failure to deliver safe care due to Junior Doctors industrial action Overcrowding (risk score 15, lead St Bart's CEO); 3062 Low Junior Doctors at registrar level within the Emergency Department (risk score 15, lead Whipps Cross CEO); 6423 Junior doctor gaps in medicine (risk score 15, lead Whipps Cross CEO***

STRATEGIC OBJECTIVE 2a. Performance and productivity

Risk appetite for sub-objective relevant to risk: **4-6 (Cautious)** Risk tolerance triggers: Bed occupancy / elective cancellations / industrial action notices / criteria to reside

Gap risk score to risk appetite: 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*	
5. Patient flow constraints in EDs and wards, delays to outpatients transformation and workforce productivity issues (including industrial action) impact on delivery of planned activity, long waiting times and funding **Executive lead:** 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 targeted staff training programme to support 'right every time' data entry. **4.** Independent sector support for elective waiting lists. **5.** Establishment of surgical hubs to support high volume low complexity workstreams. **6.** Workforce planning and waiting list initiatives to address elective backlogs. **7.** Theatres Sentinel Metrics Dashboard and fallow list reduction process. **8.** Outpatient dashboard and Outpatients transformation programme focusing on assessment against GIRFT best practice principles **9.** NEL operational plan including coordination of elective plans and mutual aid. **10.** Clinical harm review process led by Deputy CMO	Oversight at Elective Recovery Board. Escalation to weekly GEB review of long waiters **(assurance on controls 1-8)**. Data Quality Committee established to provide oversight of RTT data quality **(1,3)** 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)** Outpatient Transformation board reporting to ERB on programme of work and milestones **(7)** Monthly NEL Planned Care Board and sector escalation meetings **(1,4, 8)**	Trust Board and Finance Investment and Performance Committee monitoring of elective programme and operational plan delivery **(1-8)** Provider collaboration, acute provider collaborative, place and NEL ICS governance structures established with focus on surgical optimisation, outpatient and out of hospital transformation **(8, 9)**.	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)** 2022 Reasonable Assurance - Internal audit relating to Routine Diagnostic Imaging elective waiting times (1) 2022 limited assurance Internal Audit review – RTT Data Quality (1-3)	*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: Planned implementation of LUNA platform to provide overview of all waiting lists. Continued roll out of DQ training across hospitals* *Gap: Workforce constraints impede plans for wider elective programme 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);1816 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 2a. Performance and productivity								
Risk appetite for sub-objective relevant to risk: **4-6 (Cautious)**		Risk tolerance triggers: Mental health assessments / LOS / inpatients						
Gap risk score to risk appetite: 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*	
6. Insufficient system-wide mental health care capacity impairs urgent and emergency care resilience, quality of care and patient experience **Executive lead:** Chief Operating Officer **Subcommittee role:** Finance Investment and Performance Committee	*[Outset score: 16]* ***Current: 4x4=16*** *Target: 4x=12* *Datix ref: (1981)*	**1.** North East London System escalation policy outlining interventions in periods of capacity challenges for Mental Health pathways **2.** Daily SITREP and data shared with Mental Health colleagues to ensure a collective understanding of patients waiting for beds and assessment in EDs or inpatient beds **3.** Review of OPEL status at system level to include MH patients waiting for admission or assessment. **4.** Established place-based communication to review mental health capacity pressures through Surge meetings **5.** Specific daily calls with acute trusts, MH Trusts and surge to manage and escalate where delays or risk **6.** Internal trust escalation for Group Operations Director and COO for Executive escalation	Hospitals are proactively working with colleagues in NELFT and EFT on a daily basis to optimise the right pathways for this patients group (1-5) Business as usual NEL and London emergency and critical care governance **(1-6)** Unplanned Care Board oversees UEC Trustwide response (1-6) Group Executive Board ToR – oversight of challenges and impact to patients due to long waits, and high occupancy in emergency departments **(5-6)**		Board monthly reporting via the Integrated Performance Framework **(1-6)**.		NEL Urgent and Emergency Care board Acute Provider collaborative		Gap: The data and current experience is showing 100% increase in Length of stay for patients with Mental Health illness We are seeing cluster of patients due to long waiting (although overall similar number since 2017) this impacts on patient experience and very high cubicle occupancy to manage and flow all patients in EDs

Related high risks (>15) on the risk register – Datix refs:
7157 No enhanced care provision for mental health patients in the emergency department (risk score 16, lead Royal London Chief Executive)
7155 Lack of safe and suitable environment for assessment and care of patients with mental health presentation (risk score 16, lead Royal London Chief Executive)
7135 Mental health patients staying long periods in the emergency department (risk score 16, lead Newham Chief Executive)

STRATEGIC OBJECTIVE 2b. Transforming services through innovation
Risk appetite for enabler relevant to risk: **Open (risk score 15-16)** Risk tolerance triggers: Adverse variance (threshold to be confirmed) against ICT metrics on downtime/breaches/implementation targets
Gap risk score to risk appetite: 0

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Span (ii) Assurance Level	*Span*	*Assurance level*	*Span*	*Assurance level*	*Span*	*Assurance level*	
7. Insufficient resourcing for informatics impairs plans to improve activity, productivity and system development thereby impacting on effective service delivery within the Trust and NEL. **Executive lead:** Director of Strategy **Subcommittee role:** Audit and Risk Committee	*[Outset score: 16]* ***Current: 4x3=12*** *Target: 4x2=8* *Datix ref: (1981)*	**1.**Ringfenced element of capital programme, to renew ICT infrastructure, PCs, data centres and networks. **2.**Approved Informatics strategic delivery plan and consolidated Millennium Cerner EPR system. **3.** Upgrades of Millennium Cerner (following consolidation of single PTL) **4.** Information Governance team and Data Security Protection Toolkit. **5**. WeConnect2 programme successfully rolled out to strengthen digital systems, electronic prescribing and documentation. **6.** BHRUT business case for new EPR system to align principal information platform across BH and BHRUT 7. Business case in development for right-sizing informatics teams	Investment Steering Committee lead role in ensuring capital programme is appropriately specified and delivered, with Risk Management Board monitoring associated risks **(1-4)** Informatics Board oversight of ICT investment programme with 6 monthly reporting into Audit and Risk Committee on key ICT developments **(1-5)** Board and ARC review of Data Security Protection Requirements compliance **(2)**		6 monthly reporting into Audit and Risk Committee on major ICT developments **(1-5)** Trust Board review of BHRUT SOC **(6)**		Internal Audit report Data Security and protection Toolkit assures on IG aspects of workplans **(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* *Gap: Identified shortfalls in staffing to support commitments to BH-BHRUT digital strategies* *Action: business case development*

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 OBJECTIVE 2c. Equity and sustaining standards	
Risk appetite for sub-objective relevant to risk: **1-3 (Averse)**	Risk tolerance triggers: Adverse variance against timelines for recommendation implementation; maternity dashboard metric/threshold tbc
Gap risk score to risk appetite: 8	

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 in implementing a maternity service improvement programme impacts on quality and safety of maternity care provision, confidence of service users and workforce retention **Executive lead:** Chief Nurse **Subcommittee role:** Quality Assurance Committee	*[Outset score: 12]* ***Current: 4x3=12*** *Target: 4x2=8* *Datix ref: (1981)*	**1.** Maternity safety support programme, Ockendon and Kirkup review recommendations and CNST 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:* Maternity Board and Quality Board management of improvement and compliance programmes **(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. People Board and GEB role on review of safe staffing and yearly establishment reviews **(1, 5)**		Board monthly reporting via the Integrated Performance Framework **(2-3)**. Trust Board reports on maternity including national recommendations and CQC inspection updates **(1-6)** QAC oversight of improvement programme, CNST and Ockendon and Kirkup recommendation implementation plus 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 3b: Co-ordinating across NEL and STRATEGIC OBJECTIVE 3a. Acting as an effective hospital group	
Risk appetite for sub-objective relevant to risk: **Moderate (risk score 8-12)**	Risk tolerance triggers:
Gap: risk score to risk appetite: 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*	
10. Failure to collaborate effectively as an integrated group across Barts Health and BHRUT delays benefits realisation and improved patient outcomes. **Executive lead:** Director of Corporate Development **Subcommittee role:** Audit and Risk Committee	*[Outset score: 12]* ***Current: 4x3=12*** *Target: 4x2=8* *Datix ref: [tbc]*	1. Barts Health and BHRUT have prioritised six enabling workstreams for 2023/24, each led by an SRO with governance in place. 2. As a member of the NEL acute provider collaborative, the Trust is contributing to and hosting six clinical transformation programmes (planned care, UEC, cancer, critical care, maternity and babies, children and young people) plus cross-cutting work on specialised services, research and clinical strategy. 3. Work is in progress on designing an operating model for an integrated group, using the CQC well led framework, with 23/24 a transition year.	Collaboration executive oversees development of the integrated group (1,3) Shadow Acute Provider Collaborative executive oversee delivery of APC programmes (2). Group Executive Board receives regular updates on provider collaboration.		Close working of two trust boards in the provider collaboration including establishment of Board Collaboration Committee Board collaboration committee assures the progress of the integrated group (1,3). Shadow APC board assures progress of the APC. Joint board seminars are held 6 monthly with BHRUT (1-3). Part 1 Trust Board meetings receive regular updates on provider collaboration.		Role of NEL ICS, JOSCs and Healthwatches in oversight of system development and place-based governance CQC oversight of Well Led domain and internal mock Well Led inspections. Internal audit of provider collaboration benefits realisation.	*Gap: operating model for the integrated group is not yet in place.* *Action: operating model to be developed and approved by the boards in 23/24.* *Gap: limited resource available to support APC ambitions, particularly in relation to urgent and emergency care.* *Action*: Rescope programmes where required within available resource.

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

STRATEGIC OBJECITVE 3c. Contributing as an Anchor institution and STRATEGIC OBJECTIVE 2d. Preventing ill health
Risk appetite for sub-objective relevant to risk: **15-16 (Open)** Risk tolerance triggers: : Covid-19 high or very high pressure status
Gap: risk score to risk appetite: 0

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. An inability to identify and address healthcare inequalities as part of the NEL system impairs public health outcomes and aspirations as an anchor institution **Executive lead:** Chief Medical Officer and Director of Inclusion and Equity **Subcommittee role:** Quality Assurance Committee	*[Outset score: 16]* ***Current: 4x3 = 12*** *Target: 4x2 =8* *Datix ref: [tbc]*	**1.** Integrated Performance Report includes key metrics on access to healthcare services **2.** Patient Experience Strategy published with action to commission cultural intelligence and competency programme. **3.** Friends and Family Test and national patient surveys to assess and benchmark access and service quality **4.** Equity of access work led by Public Health to investigate healthcare inequalities. **5.** Development of Anchor Institution strategy, building on development of community employment and related initiatives e.g. ELBA alliance, apprenticeships, Project Search etc **6.** NEL operational plan and steps towards joint workforce planning across sector acute providers	*Inclusion Board ToR - oversees delivery of equality objectives and commitments **(maps to controls 1 and 2)** *Group Executive Board ToR – oversight of operational plan delivery **(1)** and patient survey outputs (**4**) GEB hospital performance review mechanism **(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 3d. Progressing long term projects and STRATEGIC OBJECTIVE 3c. Anchor institution
Risk appetite for sub-objective relevant to risk: **Moderate (risk score 8-12)** Risk tolerance trigger: clear timelines for business case approval
Gap risk score to risk appetite: 2

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 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: 3x5=15*** *Target: 2x5=10* *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.** Extensive stakeholder, staff and community engagement. **6.** Whipps Cross health and care services strategy refreshed in November 2020 to reflect design lessons from Covid-19 pandemic. **7.** 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:* May 2023 confirmation of national funding for Cohort 3 schemes and Secretary of State for Health and Social Care confirmation that Whipps Cross enabling works will proceed.		*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: Financial plan delivery
Risk appetite for sub-objective relevant to risk: **Averse (risk score 1-3)** Risk tolerance triggers: adverse variance to plan for 2 consecutive months (threshold tbc); Agency spend as % of pay bill
Gap risk score to risk appetite: 15 (current risk score 16; in year target risk score: 12; long term risk appetite: 1-3)

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. Below plan activity, workforce costs and inflationary pressures impact on delivery of 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: 4x4=16*** *Target: 4x3=12* *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. **7.** Quality impact assessment process supports efficiency and cost improvement plan design.	Review of financial performance at dedicated Financial Recovery Board **(assurance on controls 1-2**). Implementation of Financial Planning Group meetings to review hospital plan progress chaired by CFO and informs PRs **(2-6).** FRB and 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)** Financial Recovery Board's workforce sub-group monitors implementation of financial plan. CIP quality impact		Review of financial performance at monthly Finance and Investment Committee and Trust Board review **(assurance on controls 1-3,5**).		Dedicated NHSI support and review of Trust plans. NHSI / CQC Use of Resources assessment, with evidence of productivity improvements 2020 Internal Audit report Income and Billing **(2)** 2020 Internal Audit report Budgetary Control and Financial Reporting **(2)** 2020 Internal Audit report Treasury Management **(2)** 2021 Reasonable assurance Internal Audit review of Bank and Agency controls/usage 2021 Substantial assurance Internal Audit review of key financial controls 2021 Substantial assurance Internal Audit review of Payroll and pensions	

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

STRATEGIC ENABLERS: Enhanced estates and facilities
Risk appetite for sub-objective relevant to risk: **Moderate (risk score 8-12)** Risk tolerance triggers: Capital resource limit breach; 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*	
14. 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: 4x4=16*** *Target: 4x2=8* *Datix ref: (4109 / 1990)*	**1.** Ringfenced element of capital programme for Estates backlog maintenance (including fire safety investment); and medical equipment procurement. **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. **5.** NEL system approach to capital allocation and exploring opportunities for additional funding.	Financial Recovery Board role on delivery of financial plan. 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)** Estates Board monitoring of estates backlog and fire safety investment and risks (1-3)	FIPC oversight of capital investment programme as standing agenda item (1)	Commissioned internal audit and external reviews of fire safety programme. management (4) Internal Audit plan includes reviews of key infrastructure risks (1-4) CQC, HSE and other regulatory assessments of Trust infrastructiure **(1-4)** London Fire Brigade's close involvement on Newham (and other site) fire improvement plans. (4)	*Gap: Lack of definitive position on NEL capital allocation may result in a potential capital overshoot to meet statutory and regulatory obligations* *Action: Scoping work on statutory backlog investment work required in year and ongoing sector discussions regarding NEL capital envelope.* *Gap: Absence of aggregated assessment of risks associated with capital 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: World leading research and high-quality education and training and STRATEGIC OBJECTIVE 3d, Progressing long term projects
Risk appetite for sub-objective relevant to risk: **Open (risk score 15-16)** Risk tolerance triggers: BRC accreditation outcome (+); loss of medical training posts (-); failure to recover research activity downturn (+)
Gap: risk score to risk appetite: 0

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*	
15. Reductions to research funding and capital impacts on delivery of key elements of the research strategy, including progressing lifesciences, clinical research facility and centre for healthy ageing initiatives **Executive lead:** Chief Medical Officer **Subcommittee role:** Quality Assurance Committee	*[Outset score: 12]* ***Current: 4x3=12*** *Target: 4x2=8* *Datix ref: [4925]*	**1.** Research strategy and education strategic delivery plan. **2.** Improving Service Line Reporting transparency for allocation of resources and incentivising research and education activities internally. **3.** Partnership with QMUL and other academic partners supporting reputation of Trust as a recognised destination for career development and research opportunities; and input to major initiatives (BLS, CRF and centre for health ageing) **4.** Business case for development of clinical research facility at RLH. **5.** Established Lifesciences programme with senior programme staffing and relationships with industry and lifescience centres. **6.** Education Academy and education governance framework to manage new NHS education contract (which replaced the LDA).	Joint Research Board oversight **(assurance on controls 1-7)** Apprenticeship Steering Group, which reports into Education Committee reviews work on new career models **(4)**.		QAC oversight of research strategic delivery plan implementation – twice yearly reporting (1) Trust Board yearly progress update on research strategy.		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 2022/23 **(1)**		*Gap: Lack of certainty on research funding* *Action: Joint Research Office coordinating approach to research grant bids and research opportunities.*

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

Barts Health NHS Trust

Report to the Trust Board: 12 July 2023	TB 46/23

Title	Group Operational Plan 2023/24
Accountable Director	Group Director of Strategy and Planning
Author(s)	Greg Madden, Business Planning
Purpose	Update on the conclusion of the annual planning process for 2023/24
Previously considered by	GEB

Executive summary

NHS England published operational and financial planning guidance for the NHS on 23rd December 2022. The national planning process requires Integrated Care Boards – in our case North East London ICB - to submit a system wide plan to NHS England.

This paper provides a high-level overview of the national planning parameters, how our plans respond to them, and the strategic fit with our vision and objectives as a Group.

Our mission is to provide safe, compassionate and efficient care for the population of North East London. Over the last period, we have been developing our plans for the coming year, working across the organisation, through the lens of our vision, values and strategic objectives, to;

- provide excellent and equitable health and care for our **patients**
- become an outstanding and inclusive place to work for our **people**
- work together with our **partners and communities**

As with other organisations across the NHS, the key challenge this year, in the context of a constrained financial environment with high inflation, is to deliver improvements for patients in a sustainable way through achieving greater productivity and efficiency in all that we do.

As part of the process of developing our plan, we refined our strategic objectives and in May these were published as part of *We are Barts Health*, a public and staff facing document which summarised our current position and direction of travel as a group of hospitals.

We have now published *Safe, Compassionate and Efficient: Our group operational plan for 2023/4.* This document builds on the strategic direction of travel charted in *We Are Barts*

Barts Health NHS Trust

Health to set out in more detail our short-term plans to maintain quality care for patients while improving performance in challenging financial circumstances.

Related Trust objectives	
All	
Risk and Assurance	The annual plan sets out the Trust's objectives.
Related Assurance Framework entries	All
Legal implications/ regulatory requirements	None

Action required by the Board

The Board is asked to:

- note the update on the conclusion of operational planning for 2023/24, acknowledging the work that has been undertaken across the organisation and with North East London ICB;
- note our key priorities for 23/24 in our mission to provide safe, compassionate and efficient care for the people of North East London, whilst continuing on our journey to be an outstanding place to work;
- note the publication of *Safe, Compassionate and Efficient: Our group operational plan for 2023/4.*

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 12 JULY 2023

BARTS HEALTH GROUP OPERATIONAL PLAN

INTRODUCTION

1. NHS England published operational and financial planning guidance for the NHS on 23 December 2022. The national planning process requires Integrated Care Boards – in our case North East London ICB - to submit a system wide plan to NHS England.

2. We contributed to the North East London (NEL) ICB operational plan which was submitted to NHS England on 4 May. This paper provides a high-level overview of the national planning parameters and how our plans respond to them in the context of our vision and objectives as an organisation.

2023/24 GROUP OPERATIONAL PLAN

3. This year's national planning guidance [1]identifies three core priorities for the NHS in England:
   - recovering core services and productivity;
   - making progress in delivering the key ambitions in the Long Term Plan (LTP)
   - continuing transforming the NHS for the future.

4. As with other organisations across the NHS, the key challenge this year, in the context of high demand and a constrained financial environment with high inflation, is to deliver improvements for patients in a sustainable way through achieving greater productivity and efficiency in all that we do.

5. Our mission is to provide safe, compassionate and efficient care for the population of North East London. As part of the process of developing our plans, we refined our strategic objectives and in May these were published as part of *We are Barts Health*, a public and staff facing document which summarises our current position and direction of travel as a group of hospitals and our immediate priorities for the coming year.

6. We have now published *Safe, Compassionate and Efficient: our group operational plan for 2023/4.* This document builds on the strategic direction of travel charted In *We Are Barts Health* to set out in more detail our short-term plans to maintain quality care for patients while improving performance in challenging financial

[1] 2023/24 priorities and operational planning guidance

circumstances. A separate paper is included on this agenda detailing the planned approach to monitoring plan delivery (performance and risk management).

Patient Priorities

7. **Improving planned care** – in the last year, thanks to the heroic efforts of staff, we ended 2022/3 without anyone being forced to wait two years for planned treatment, having also dramatically cut the numbers waiting 18 months (78 weeks) by 80%. This is despite the challenges of coping with industrial action. We plan to build on this during this year and meet the national target of eliminating over 65 week waits for treatment by March 2024 and do this alongside continuing to meet key national standards for accessing cancer care and improving waiting times for diagnostic tests.

8. We will do this through becoming more productive, supported by our improvement and transformation programmes. For example implementation of the Trust Care Co-ordination Solution (CCS) to improve theatre scheduling, ensuring we maximise utilisation of theatre capacity across the group and our outpatient transformation programme, including a focus on reducing unnecessary follow up appointments.

9. **Improving unplanned care** - the urgent and emergency care system remains under significant pressure. As an organisation we are committed to achieving the national target of no less than 76% of patients seen and treated within 4 hours in A and E in March ’24 and to support that by reducing our adult general and acute bed occupancy to 92% or below. We’ll also continue our daily focus on reducing ambulance handover times and eliminating 12 hour waits in Emergency Departments. This aligns with NHSE’s delivery plan for recovering urgent and emergency care services.[2]

10. We will continue to work closely with system partners, including through transformation programmes such as reducing front door attendances through our Remote Access Co-ordination Hub, Improving Patient Flow in the hospital through Same Day Emergency Care and ensuring timely discharge of patients eg through an expansion in virtual wards.

11. Although COVID restrictions have now been lifted in our hospitals, we remain vigilant to future threats and ready to activate surge capacity if ever required.

[2] Delivery plan for recovering urgent and emergency care services

12. **Improving quality and equity** – as we continue on our path towards 'Good and Outstanding', we will maintain our focus on the fundamentals of care and tackling inequalities and inequities of provision. This includes our patient safety strategy, a key part of which is implementing our Patient Safety Incident Response Framework. We will deliver the national maternity standards and as we roll out our maternity improvement plan we will ensure compliance with recommendations from the Ockenden review and increasing fill rates for maternity staff.

13. Meanwhile, through our patient and community engagement, participation and experience strategy we are strengthening the community and patient voice within all our work, as we systematically gather and act on feedback from our patients.

People priorities

14. We want to be an outstanding place to work, where our talented and dedicated staff have the best environment and support to deliver safe and compassionate care to patients. The four pillars of our People plan aim to do this through:
    - **Creating a fair and just culture** - through our 'We Belong' strategy we aim to embed inclusivity and equity in all we do. Our dedicated Inclusion Centre team is offering bespoke cultural intelligence training to staff and recruiting more inclusion ambassadors for job selection panels. We're determined to improve career progression for people from BAME backgrounds and will monitor our progress through the Workforce Race Equality Standards (WRES).

    - **Supporting the wellbeing of our people –** we are grateful to Barts Charity for enabling us to invest in wellbeing hubs in each hospital and we now have a network of health and well being leads who actively support managers and their teams to improve work experience on the wards and in offices.

    - **Working differently to transform care** – we will continue to embrace new roles and ways of working in both clinical and support areas, such as growing the numbers of Nursing Associates and Physician Associates.

    - **Recruiting a permanent, stable, workforce** – like all NHS organisations we need to reduce our reliance on temporary workforce, both to improve care and reduce cost. Through our 'Drive to 95' programme, we aim to recruit more permanent staff, increasing our substantive staff fill rates to 95% and reducing our agency pay bill.

Working with our partners and communities

15. We will only deliver our ambitions for our patients and communities through effective working across our Group of hospitals and with our wider partners in North East London, specifically through:

    - **our closer collaboration with BHRUT** – together we aim to support clinical collaboration by progressing mutual improvement and transformation projects and by working more closely on the back office functions that support them, like procurement, finance, estates management and planning.

    - **collaborating across North East London** – for example through the NEL Acute Provider Collaborative which sees the three acute trusts working together on immediate clinical improvement and transformation programmes in a number of areas as well as working closely with partners at 'place' level at each of our hospital sites, particularly our local boroughs.

    - **contributing as an anchor institution** – as the biggest employer in east London and a major purchaser of goods and services, our group of hospitals play a key role in economic regeneration and environmental improvement. We will insist suppliers pay the London living wage and we will extend the reach of schemes such as Healthcare Horizons which aim to provide more employment opportunities for young people with disabilities.

    - **progressing our long term projects** – we look forward to making progress on the redevelopment of Whipps Cross following the Government's recent positive announcement confirming this will be funded, as well as continuing our work to develop Barts Life Sciences in Whitechapel and celebrating the 900 year anniversary of St Bartholomew's hospital with the development of a new breast cancer centre of excellence.

<u>Financial Sustainability</u>

16. The NHS faces very challenging times – with high demand for services, staffing vacancies, high levels of inflation and a constrained capital settlement. The national planning guidance sets out the expectation for all Integrated Care Systems to deliver net system financial balance, including a 2.2% efficiency target and we need to play our part in that.

17. We ended 2022/3 with a small deficit of £13m – just 0.6% of our turnover. Our continuing challenge for 2023/4 is to intensify that focus on managing resources wisely by improving our efficiency and effectiveness even further. Our financial plan for the rest of this year includes the expectation that across the board all departments and divisions in our hospitals and support services will make cost improvements worth up to 5% of their budget.

18. We have identified three themes across the group where we need to make significant progress to achieve this:
    - **Increasing elective productivity**, through better use of operating theatre time, space and staffing;
    - **Reducing the cost of temporary staffing**, particularly through agencies;
    - **Making savings in corporate services**, especially where we can find shared solutions with our partners at BHRUT

19. The capital allocation for North East London is extremely constrained, despite inflationary pressures, which means we face challenges in managing our expenditure against existing contractual obligations and priorities for investment whilst mitigating risk.

20. Indeed access to capital is one of the key constraints highlighted by a recently published report by the Institute of Government, *'The NHS Productivity Puzzle – Why has hospital activity not increased in line with funding and staffing'*[3]. This analysis will be helpful in informing our approach to improving productivity.

21. **The Board is asked to:**

- note the update on the conclusion of operational planning for 2023/24, acknowledging the work that has been undertaken across the organisation and with North East London ICB

- note our key priorities for 23/24 in our mission to provide safe, compassionate and efficient care for the people of North East London, whilst continuing on our journey to be an outstanding place to work

- note the publication of *Safe, Compassionate and Efficient: Our group operational plan for 2023/4*

[3] *The NHS productivity puzzle Why has hospital activity not increased in line with funding and staffing?*

WeCare
Our vision, values and behaviours

NHS
Barts Health
NHS Trust

Safe, compassionate and efficient: our mission for 2023-25

NHS Barts Health NHS Trust

Our vision

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

Why we're here – **our vision and values**

WeCare
Our vision, values and behaviours

WELCOMING · ENGAGING · COLLABORATIVE · ACCOUNTABLE · RESPECTFUL · EQUITABLE

What we do – **our priorities and objectives**

Our patients care

Providing excellent and equitable health and care

Our people culture

Becoming an outstanding, inclusive place to work

Our partnerships collaboration

Working together with our local communitiess

SUPPORTS

SUPPORTS

How we'll do it – **our commitments and approach**

- Creating a fair and just culture
- Supporting the wellbeing of our people
- Working differently to transform care
- Recruiting a permanent, stable, workforce

- Increasing performance and productivity
- Transforming services through innovation
- Improving equity, quality and standards
- Preventing ill-health in our population

- Acting as an effective hospital group
- Cooperating across north east London
- Contributing as an anchor institution
- Progressing long-term projects*

Living our values through our everyday behaviours: **WeBelong, WeImprove** and **WeLead**

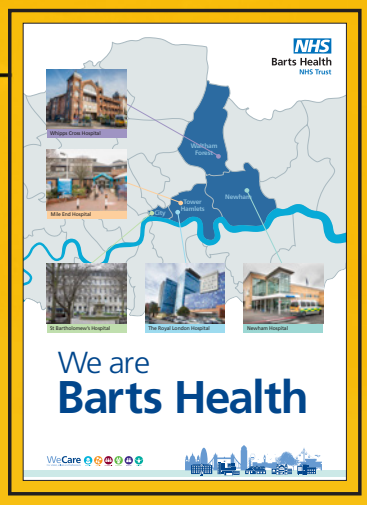
Supported by: financial sustainability, world-leading research, high quality education and training, enhanced estates and facilities, digital transformation, and excellent communications

*Barts Life Sciences · *A new Whipps Cross · *Our green plan

900 BARTS 1123 - 2023 CELEBRATING NINE CENTURIES OF ST BARTHOLOMEW'S HOSPITAL

Safe, Compassionate and Efficient

This document builds on the strategic direction of travel charted in We Are Barts Health to set out in more detail our short-term plans to maintain quality care for patients while improving performance in challenging financial circumstances.



Introduction from the Group CEO

These are tough times. Prices of goods and services are rising, the cost of living is going up, inflation is eating into the income of households and organisations alike. Sometimes it feels we have to run to stand still.

The NHS may be a national treasure but it is not immune from the pressures we all face in our daily lives. As one of the biggest trusts, we are a microcosm of the health service, and more visible to the general public. Like the NHS as a whole, we have more income and more staff than ever before. Like the rest of the NHS, we must show that we can live within our means.

Recently we gathered together several hundred senior leaders from across the group to discuss how we can meet this challenge together. We all agreed that our staff are doing a great job in helping us provide safe and compassionate care of the highest quality for huge numbers of patients.

The pressure is most acute in our emergency departments, where demand remains at record levels, and this has a knock-on effect through the hospitals and into support services. Yet overall, we have not quite recovered the level of patient activity we recorded before the pandemic.

Although some areas have skills shortages, and there are not always enough staff available to fill some shifts, we employ more people now than we did pre-Covid. Yet we are doing fewer routine operations and outpatient clinics - and seeing fewer patients. This report sets out the steps we are taking to address that challenge.

It supplements the strategic direction of travel we set out in We Are Barts Health by showing in more detail how we are implementing our group objectives. It also highlights how are hospitals are implementing their own operating plans for 2023/4 within the context of a group that is working ever more closely with our neighbours across north east London.

In thanking staff for their efforts on all fronts, we are asking our people to work even better together to make the most of our resources. We want everyone to think about what they could do differently to help us meet this challenge we face. We recognise our people already work hard, and we are grateful. The question is, how can we work better, together, to further improve outcomes for our patients?

There is no single answer. Everyone's working circumstances are different. Each team will need to find bespoke solutions that work for it. Together, small steps at local level will enable us to make a big difference. We want everyone to consider what we can do within our teams and workplaces to improve the efficiency and effectiveness of our activities, as we continue to provide safe and compassionate care for all patients. We are all in this together, and together we will come through.

Shane DeGaris

Group Chief Executive for Barts Health NHS Trust and
Barking, Havering and Redbridge University Hospitals NHS Trust

July 2023

Our group operational plan for 2023/4

Record numbers of people are waiting for NHS care, whether urgent or planned. Along with every other NHS trust our operational priorities are to eliminate long waits for routine treatment and reduce delays in A&E, while maintaining the quality of care in our hospitals. These performance objectives are hardly new but achieving them has proved problematic. Indeed, the paradox of the pandemic is that the NHS now has more money and more staff yet is treating fewer patients.

Our Group Operational Plan for 2023/4 recognises that we must meet expectations to increase elective activity and improve unplanned care within our existing budget. Our targets are the national constitutional standards, to end elective waits of over 78 weeks, and ensure 76% of urgent cases are seen within four hours in A&E, by April 2024. We will also speed up access to cancer treatment and implement urgent improvements to maternity services in line with the Ockenden review.

Our group operational plan for 2023/4

The NHS is labour intensive and about two-thirds of our £2.2bn turnover pays for our 19,000 staff. The workforce has grown since the pandemic and recently increased significantly by bringing our domestic and security staff in-house. However at any time about 3,000 of all jobs are filled by temporary employees and our challenge this year is to turn as many of them as possible into permanent posts.

Activity levels below what we planned adversely affected our finances last year, along with the high cost of temporary staffing and the effects of hyperinflation. Nevertheless, by making hard decisions in a harsh economic climate, we ended 2022/3 with a small deficit of £13m – just 0.6% of our turnover. Our continuing challenge for 2023/4 is to intensify that focus on managing resources wisely by improving our efficiency and effectiveness even further.

In anticipation we began the annual business planning round earlier than in previous years. We worked up our plans within the context of our strategic objectives - to provide excellent and equitable care for our patients; to become an outstanding and inclusive place to work; and to work together with our partners and communities. We also incorporated the discipline of financial recovery into the development of our hospital operating plans.

We identified three themes across the group where we need to make significant progress this year so that we balance the books and can continue to provide improvements for patients on a sustainable basis:

- **Increasing elective productivity,** through better use of operating theatre time, space, and staffing. We aim to increase the theatre utilisation rate from below 75% to 85% and the proportion of day cases from under 60% to 85%. This may involve moving patients across the group.
- **Reducing the cost of temporary staffing,** particularly from expensive agencies. We aim to increase the fill-rate for substantive posts from 94% (86% for nurses) to 95% across the board. We also aim to cut the bill for agency staff by a quarter, from over 5% of the pay bill to 3.7%.
- **Making savings in corporate services,** especially where we can find shared solutions for transforming workforce, finance, estates, and IT through closer collaboration with our partners at BHRUT.

Baked into our financial plan for the rest of this year is the expectation that across the board all departments and divisions in our hospitals and support services will make cost improvements worth up to 5% of their budget. This is an ongoing effort and in the first quarter teams identified 167 separate schemes together worth more than £45m without compromising patient safety or the provision of compassionate care.

This endeavour would be challenging enough in normal times, let alone a period during which doctors went on strike several times and employers faced an added pay bill following industrial action by nurses and ambulance workers. Contingency planning for future disruption is now routine but we are not abandoning the operational targets we set in line with national expectations,

Our efforts are also hampered by national constraints on capital spending which is affecting our ability to invest in maintaining or replacing buildings and equipment. Fortunately, we have already secured £50m of dedicated transformation funding. This will enable us to refurbish unused theatre capacity at Newham and build a new intensive care unit with 14 critical care beds and 26 general beds. It will also allow us to create an additional 14 critical care beds and 22 cardiac surgery beds at St Bartholomew's hospital.

We are also fortunate to benefit from a £14m Barts Charity grant that will allow us to open a state-of-the-art clinical research facility on the 14th floor of The Royal London hospital in June 2024. This will replace the current temporary unit on the 11th floor, freeing up bed capacity but crucially enabling us to conduct more clinical trials, broaden the range of patients taking part, and increase our research income.

Productivity and quality for patients

Elective care

We ended 2022/3 without anyone forced to wait two years for planned treatment, having also dramatically cut the numbers waiting 18 months (78 weeks) by 80%. We are determined to maintain that trend and make further inroads into our record waiting list of over 110,000 patients so that no-one waits for more than 65 weeks to start consultant-led treatment by April 2024.

Nevertheless the real key to achieving additional activity is transforming services and developing new ways of working. Offering more virtual appointments in outpatient clinics, for example, and encouraging patients to initiate follow-ups when they need them, will free up staff and space capacity to deploy elsewhere.

For the longer term we will be looking at redesigning service pathways to fit changing patterns of patient need. Here is where our group model proves its worth. We started with orthopaedic surgery, which used to be run as separate services on three hospital sites. Now the 57 surgeons work as part of a co-ordinated network and their patients get expert treatment at the appropriate centre of excellence.

For example, most routine hip and knee operations are performed in the Barts Health Orthopaedics Centre (BHOC) adjacent to Newham hospital. It has doubled it's activity and is now doing more than 80 operations a week, including some from Homerton Healthcare. Frailty fractures are tackled in a specialist fragility unit at Whipps Cross which has a safety record above the national average. Meanwhile, complex bone and joint surgery is done at The Royal London hospital in conjunction with the major trauma centre there. Patients still have outpatient appointments at their local hospital, but by travelling for surgery to a specialist centre they get treatment that is faster, fairer and of consistently high quality. This has contributed to a dramatic and ongoing fall in the numbers of people waiting more than a year for a planned orthopaedic procedure.

A successful clinical network model is already well-established on a wider north east London footprint through the Cancer Alliance. Ours is regularly the best-performing network in London, though as a legacy of Covid we also have one of the biggest backlogs, with over 600 patients waiting longer than 62 days for treatment. By next March we aim to reduce this by 30% to pre-pandemic levels. Early diagnosis is critical to savings lives, so our focus will be to continue to ensure that at least 75% of patients who are urgently referred by their GP for suspected cancer are spotted or have it ruled out within 28 days.

On diagnostics generally, the opening of the Early Diagnosis Centre at Mile End means we are now assessing 10 per cent more patients than before the pandemic. We intend that no-one will wait more than three months for a test or scan by July and want nine out of ten patients to wait less than six weeks by April 2024. We are also aiming for a 10 per cent increase in productivity through digital initiatives that will give patients easier access to services and share clinical information between hospitals.

Under NHS financing rules, improving our overall elective performance will earn us extra income. Our target is to achieve 109% of the weighted value of activity done in 2019/20, the year before the pandemic. On both activity and financing our plans are closely aligned with those of our partners in the acute provider collaborative for north east London, BHRUT and Homerton Healthcare.

Emergency care

The three trusts are also working closely on mutual improvements to emergency care. The three Barts Health A&E departments together have over half a million attendances every day, the biggest caseload in country, yet their workload is dependent on the wider emergency care system, including ambulances and GPs at the front door to community services and social care at the back of the hospitals.

Productivity and quality for patients

For example, our unique collaboration with the London Ambulance Service through the Remote Access Emergency Care Hub (REACH) is reducing unnecessary arrivals in A&E by diverting patients to more appropriate treatment earlier. An independent study by the Health Economics Unit found that over a year this pioneering scheme should result in about 6,000 fewer ambulance conveyances, 3,000 fewer emergency department attendances, and 300 fewer hospital admissions, saving over 2,000 bed-days and £1.5 million in current costs. No wonder it is being closely studied by other NHS trusts as well as being extended to BHRUT.

We also reorganised our emergency departments to set up a Same Day Emergency Care (SDEC) unit in each, in the process installing 62 extra beds and 10 specialist chairs. In the same way that Urgent Treatment Centres on each site filter out those patients who can be treated quickly and appropriately on the spot, the SDEC model within each A&E tackles urgent cases that can be treated quickly thus avoiding any risk of delay to those life-threatening emergencies that require a full response.

Boosted by these two developments, we aim to reduce the number of ambulance arrivals delayed over 30 minutes, avoid anyone spending over 12 hours in A&E (6%), and cut general bed occupancy in our hospitals to below 92% by April 2024. Our target of achieving 76% seen or treated within the national four hour standard compares with 68% for 2023/4, when we recorded the greatest number of ED attendances ever (514,816).

Equity of care

As we set out in our group objectives, and in line with our WeBelong approach to inclusion and diversity, our plans to improve patient care have a strong equity dimension. Our public health department undertakes an ongoing analysis of key services to ensure that access is fair for all groups of patients with protected characteristics. Any discrepancies in the data are flagged to the relevant department. For example, we are currently tested a number of interventions to reduce the proportion of young black males (and people living in the most deprived postcode areas) who fail to turn up for appointments, We intend to capture the full range of equity data for 95% of patients and embed it in the running of all services. When clinicians have the insight they need to respond to the health needs of our diverse population we can make real progress in reducing local health inequalities.

National statistics show that the mortality rate at Barts Health and its constituent hospitals is consistently as expected for our patient population. Nevertheless in line with the rest of the NHS we will have a major focus this year on enhancing our culture of patient safety. Part of this will be delivered through the work of our new patient safety specialists, and part through training staff in operating a new system for reporting, responding to and learning from safety incidents.

This will be particularly relevant in maternity, where we are in the forefront of the national drive to reduce stillbirths, neonatal deaths and brain injuries at birth. Our maternity teams at Whipps Cross, Newham and The Royal London listen to their patients and families and reflect their concerns in seeking innovative ways to make improvements in access, provide personalised care, and reduce health inequalities.

Productivity and quality for patients

WeBelong, WeImprove and WeLead

As a group of hospitals, united by a clear vision and strong values, we are seeking to develop common approaches to core areas of our working lives so that they become the way we do things round here. These are common approaches to how we put our WeCare values into practice and give them expression in our day jobs. Our ambition is that everybody in #TeamBartsHealth embraces them.

They are not the names of separate programmes or workstreams, although there is dedicated resource for each. The equality and inclusion, quality improvement, and leadership development teams respectively are helping others embrace the relevant behaviours, so we all embed them in our own work.

Neither are they mutually exclusive. One aim of WeLead, for example, is to foster inclusive leadership that is culturally intelligent, in line with WeBelong. The spirit of transformation that is at the heart of WeImprove is more likely to take off when embraced by senior managers, in line with WeLead.

And we want our equitable value to permeate all our activities so everyone feels WeBelong - in an organisation that is free from discrimination, where everyone is treated fairly and respectfully, and in which all individuals have opportunities to develop their talents and progress their careers. This approach doesn't stop at our doors, either, but embraces our patients and the local population from which they come.

WeBelong

Becoming a truly **inclusive** organisation

WeImprove

Excellence and innovation in safe and compassionate care

WeLead

Our hospital operating plans

St Bartholomew's hospital

We are a specialist hospital, home to the biggest cardiac unit in Europe, the second largest cancer centre in London, and an expert source of respiratory, fertility and endocrinology services. As the oldest hospital in the country we are using our 900th anniversary to transform local services and protect our historic spaces for the next generation.

We are investing in people by training staff in more advanced procedures. For example, band 6 nurses in the cath labs learned to perform a radial access puncture – a small incision in the wrist through which a catheter is sent to the heart. This is something that previously only experienced doctors would do. We want to roll out similar programmes in other areas to retain their cohorts of specialist staff.

Heart centre staff are pioneering the use of remote monitoring to prepare patients for procedures like angiograms. This so-called "virtual wards" also helps spot those who may need to be treated sooner. The same technology is used to send patients home promptly after an operation, reducing the average length of stay from 3-5 days to 1-2 days and freeing up beds for other people in need.

We will open a new cancer acute assessment unit – effectively an A&E for cancer patients who experience side effects to their treatment – in a permanent home in the KGV building later this year. This will help reduce pressure on the emergency departments at other Barts Health hospitals. Meanwhile, we are continuing plans to create a centre of excellence for breast cancer surgery to serve the whole of east London. The Barts Charity is raising funds for this project as part of our wider 900th anniversary campaign.

To reduce diagnostic waiting times and meet increased demand for screening across east London, we will offer a seven-day service for both CT and MRI scans. By adopting new working patterns the breast cancer diagnostic service is already operating at 135% of pre-pandemic levels.

We will strengthen our contribution as an anchor institution in east London by extending our cardiovascular disease prevention programme to partner with more schools and local businesses. Our cycling rehab programme for heart attack patients, run by a professional instructor and specialist cardiac nurse, will also reach more communities this year.

Restoration work on the hospital's Grade I listed North Wing, including the Great Hall and the staircase murals painted by William Hogarth, will begin this summer. This is overseen by Barts Heritage, a specialist charity established by the Trust in time for the anniversary year, with the long-term goal of providing a mixed cultural and education space open to public use.

Our hospital operating plans

The Royal London and Mile End hospitals

The Royal London contains both a specialist hospital treating chronic and complex diseases, and a district general hospital offering urgent, maternity, and medical care. Mile End is a community hospital providing treatment for patients with long-term conditions and hosts a diagnostic centre. Together we serve the population of Tower Hamlets, one of the fastest-growing boroughs in Britain. Its population grew by almost a quarter in a decade and has the largest proportions of Bangladeshis (35%) and Muslims (40%) in the country. Its residents are among the most deprived, with almost a third of adults economically inactive and over half of children from low-income families. We will continually adapt to meet the changing and challenging healthcare needs of these patients.

Over half our own people identify themselves as Black, Asian or ethnic minority, and we are committed to ensuring everyone feels WeBelong at work. Hundreds of colleagues pledged to treat others with dignity and respect through the 'See ME First' campaign, urging staff to wear badges showing they offer anti-discrimination support.

We plan to retain and recruit over the next three years by cumulatively implementing two, four, six and then eight improvements in response to themes highlighted in the last staff survey. We started by revising our approach to violence and aggression. A robust escalation process empowers staff to manage abusive patients or visitors, and provides training so staff understand what triggers aggressive behaviour and how they can calm the situation.

Our plans balance improvements in core areas like emergency care with transformation to strengthen specialist services. For example, stroke patients are getting life-altering care thanks to our imaging biplane that uses two rotating cameras to capture X-rays from all angles. A second machine would enable our mechanical thrombectomy service – already the largest in the country – to perform more procedures and prevent long-term disability for severe strokes.

We host one of London's major trauma centres and recently boosted facilities for victims with complex injuries by opening eight Rapid Access Acute Rehabilitation beds. This £1.25m investment provides quicker and fairer access to services like physiotherapy, occupational therapy, speech and language therapy, and dietetics.

We will open a new "home from home" dialysis centre at Mile End in January to improve access and treatment for people with chronic kidney disease. Less than a third of homes in north east London are suitable for home dialysis, and hospital treatment can be inflexible and tiring. The new centre will allow patients to book a session that is convenient for them, including overnight if necessary.

As a major employer in Tower Hamlets, we are key players in our local place-based partnership. Our chief executive, Dr Neil Ashman, is the designated integrated care lead overseeing efforts to improve the links between acute and community services. We are also actively involved in the borough's plans to reach net-zero.

Our hospital operating plans

Whipps Cross hospital

We want to be an outstanding community-based hospital and a centre of excellence for integrated care, laying the foundations for the new hospital that will be built on our site. The redevelopment of our estate continues to be our top strategic priority and the team is doing its utmost to ensure we will be able to deliver the updated facilities that our patients and local communities deserve. With local partners we will this year publish an integrated delivery report on our progress.

Meanwhile we are improving facilities and processes within the existing hospital. We piloted Same Day Emergency Care last winter and will further transform the safe flow of patients from the front-door through the wards by employing dedicated discharge matrons. We will also offering more remote monitoring through "virtual wards" where patients can receive some of their care at home.

We are seeing rising numbers of cancer referrals so to increase access we submitted a joint bid (with The Royal London and St Bartholomew's) to Barts Charity to fund a surgical robotics programme in speciality areas like gynaecology and urology. Surgeons using robotic technology will enable us to increase elective capacity and reduce waiting times for patients. A purpose-built surgical assessment unit is also in the pipeline which will help expand capacity and further reduce waiting times. Although capital funding is constrained nationally, we also want to invest significant capital in essential upgrades including maintaining important equipment and strengthening infection control.

Thanks to a £6.6 million grant from Barts Charity, we will establish an Academic Centre for Healthy Ageing at the hospital in collaboration with Queen Mary University London. This will bring together clinicians, external experts and community interests to undertake research and translate it into benefits for patients.

Our hospital is home to a diverse workforce and over half identify as Black, Asian or ethnic minority. We are working hard to ensure everyone feels included through our WeBelong approach. For example, colleagues at all levels are involved in a working group monitoring feedback from the latest staff survey. After extensive conversations across the hospital we refreshed our wellbeing strategy. This puts fresh emphasis on getting the basics right – like ensuring colleagues feel safe at work, have a comfortable space for breaks, and access to drinking water at all times.

We will continue to support teams to upskill and transform their ways of working, for example by providing the opportunity for individuals to work with a coach to help them articulate and achieve change within their departments.

Under the banner "We are stronger together!" we are active members of the Waltham Forest Health and Care Partnership. This co-ordinate efforts across the local NHS, borough council and wider community to deliver more joined-up care and reduce avoidable differences in health across our population.

Our hospital operating plans

Newham hospital

We serve one of the most diverse boroughs in England, with seven out of ten people hailing from a Black, Asian or minority ethnic community. It is one of the country's most deprived areas, with many residents living in challenging socio-economic circumstances that often lead to poorer health and greater demand for services. The population is forecast to grow by 100,000 over the next 20 years.

To ensure the sustainability of accessible, equitable and high-quality patient care, we must continue to grow and develop the hospital alongside planned investment in wider health and social care infrastructure in the borough.

During this our 40th anniversary year, we are building two new wards to provide extra capacity. We will be able to use the 26-bed general ward in a flexible way to meet varying needs, such as a surgical recovery space to reduce our elective care backlog. A purpose-built intensive care unit will provide the highest standards of care for the most critically-ill in a state-of-the-art environment.

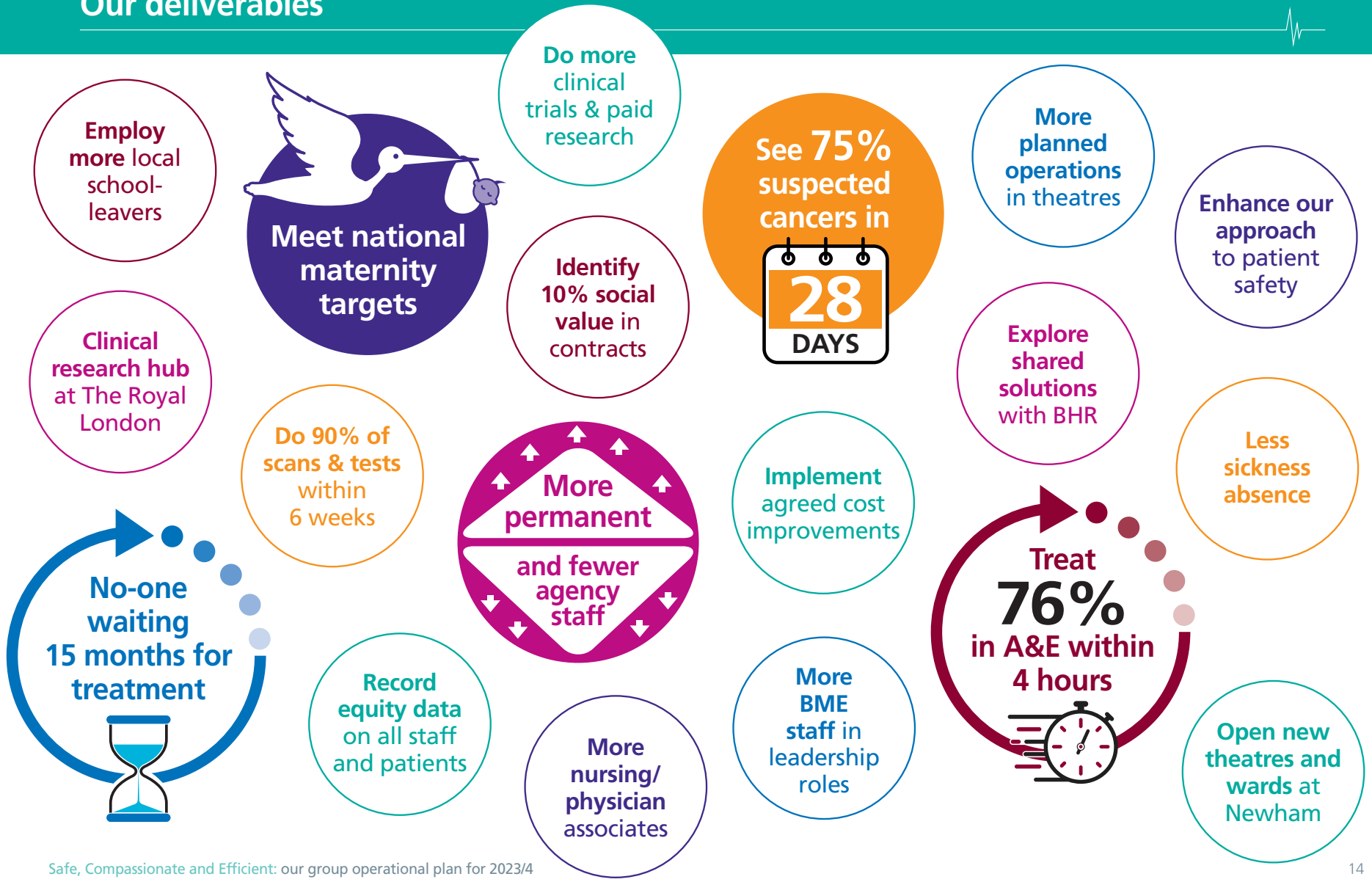
In addition, we recently opened a new CT scanner which uses a lower radiation dose and allows us to carry out coronary scans. Because it is more efficient, this machine effectively cuts the time taken to prepare, examine and diagnose patients. Together these investments will help us deliver challenging activity targets, such as reducing waiting list backlogs, while also improving treatment.

We are investing in our leaders through a bespoke WeLead programme as part of our efforts to make the hospital an attractive place for all to work. This aims to unlock the multidisciplinary potential of leaders across the hospital by developing their individual and teamwork skills. We are also supporting staff wellbeing by rolling out education sessions for managers on best practice in recruitments and making reasonable adjustments in the workplace.

Working with our partners in health and local government we are taking a wider approach to improving health outcomes in the borough to ensure all patients are seen and treated equally. For example, work is underway to improve and enhance the respiratory and cardiology models of care in Newham, We also employ a dedicated team of engagement experts who are working with and involving patients in developing and delivering services to meet patients' needs.

We are proud to play a leading role in the Newham Place-Based Partnership. We are working with the borough council to deliver elements of its 50 Steps programme; working with local colleges to design Level 4/5 education courses that support employment in the NHS; and using the borough's Local Infrastructure Forum to review space opportunities on the hospital estate.

Our deliverables



WeBelong
Becoming a truly inclusive organisation

Designed and produced by the Barts Health design and communications team

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Barts Health NHS Trust

Report to the Trust Board: 12 July 2023	TB 47/23

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

Executive summary

This paper provides an update on the programme for the redevelopment of Whipps Cross Hospital in the context of the national New Hospital Programme, the further development of an 'annual report' that will chart the progress of key transformation programmes and the journey to the new hospital, and the mobilisation of the new Academic Centre for Healthy Ageing.

Related Trust objectives	
3d. Progressing long term projects and 3c. Anchor institution	
Risk and Assurance	Assurance in relation to the below BAF entry
Related Assurance Framework entries	12. 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 recent announcements relating to the national New Hospital Programme;
- the progress made on the first 'annual report' charting the progress of key transformation programmes and the journey to the new hospital; and
- Barts Charity's award of a grant to support the mobilisation of the new Academic Centre for Healthy Ageing to be based at Whipps Cross Hospital.

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 12 JULY 2023

WHIPPS CROSS REDEVELOPMENT PROGRAMME

INTRODUCTION

1. In January 2023, the Trust Board received an update on the latest position on the programme for the redevelopment of Whipps Cross Hospital in the context of the national New Hospital Programme (NHP), as well the process for the approval of the next stage of enabling works, progress on the development of a framework for an 'annual report' that will chart the progress of key transformation programmes and the journey to the new hospital and, finally, the work with Queen Mary University of London on the joint development of proposals for an Academic Centre for Healthy Ageing (ACHA).

2. This report provides an update on the redevelopment programme in the light of a recent Government announcement on the NHP, the further development of the 'annual report', and the mobilisation of ACHA.

WHIPPS CROSS REDEVELOPMENT UPDATE: SUMMARY POSITION

3. We reported previously our view that the redevelopment programme was in a strong position, given the progress experienced over the last two years, but that we were awaiting further details from the national NHP team about the next steps, including a timeline for submitting an Outline Business Case (OBC) and the use of a possible alliance commercial framework that could be the route towards appointing a construction partner.

4. Despite the uncertainty, we have continued to work as closely as we can with the national NHP team through ongoing engagement and a series of national workshops that have begun to help them develop NHP 'products' – eg. standardisation of elements of hospital design – in more detail.

5. Meanwhile, the Government has renewed its commitment to its manifesto commitment to build 40 new hospitals by 2030, backed by a total of £20 billion investment of capital by 2030/31. The Government also confirmed that Whipps Cross remained one of the hospitals where construction of the new building would be completed by 2030. Since 25 May, further details on next steps have begun to emerge from NHP, allowing us to begin to plan the next phase of the work programme.

NEW HOSPITAL PROGRAMME – CURRENT POSITION AND NEXT STEPS

6. On 25 May, the Secretary of State for Health and Social Care set out, in a statement to the House of Commons, the Government's continued commitment - through its New Hospital Programme (NHP) - to building 40 new hospitals by 2030, including Whipps Cross Hospital, saying that it "will now proceed and be fully funded and constructed".

7. This timeline is consistent with our own updated milestone assumptions, previously reported to the Board, which anticipate construction of the new hospital beginning no earlier than 2025 at the earliest and, therefore, completing in winter 2028/29. These assumptions have not been shared and agreed with the NHP.

8. The announcement was a very welcome development and has moved us another step forward on the journey to building a new hospital, which would realise our vision for a significantly better working environment for staff to provide even better care for local people.

9. Since 25 May 2023, NHP colleagues have shared with the Trust, in confidence, an indicative capital envelope to act as a working assumption for funding the redevelopment of the hospital. This acts as the springboard to help determine the detailed next steps for individual schemes such as Whipps Cross.

10. We are also experiencing a welcome step change in engagement with the NHP team. We are now working closely with colleagues to understand the methodology underpinning the indicative capital allocation, including the opportunities that being part of the NHP will bring to delivering our programme at renewed pace and with reduced construction costs.

11. On 30 June 2023, the Parliamentary Under-Secretary of State at the Department of Health and Social Care, Lord Markham, visited Whipps Cross Hospital, during which we reminded him of our vision and proposals for the new hospital, demonstrated the case for investment whilst touring parts of the hospital and emphasised our state of readiness to move forward and progress the programme.

12. Over the coming weeks we will be working closely with colleagues from the NHP to agree the next steps and timelines for completing our business case for the new hospital. In parallel, we are working with them to agree a pathway to approval of the business case for phase two of the enabling works, which includes the first of two

multi-storey car parks, which needs to be completed before work on the new hospital itself can begin.

AN INTEGRATED DELIVERY FRAMEWORK AND REPORTING ON PROGRESS

13. We have continued to develop 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.

14. Through a series of workshops, we have co-designed the report with clinical staff, patient and community representatives and colleagues from across our local health and care system. The most recent workshop discussed the metrics to be included in the report in more detail.

15. The report is currently being drafted and we will share a draft of the report with stakeholders before it is finalised for further comment and endorsement. It is anticipated that the report will be published in late August.

DEVELOPING AN ACADEMIC CENTRE FOR HEALTHY AGEING

16. Clinical leads from Barts Health and academic leads from Queen Mary University of London (QMUL) have worked 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 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.

17. The proposal was reviewed by Barts Charity's Board of Trustees in March and we are pleased that the Board awarded a grant of £6.6 million to mobilise the Centre. An ACHA Board has been established, chaired by the Whipps Cross Hospital Chief Executive. The ACHA Board will now oversee the mobilisation of the Centre, including recruitment to key leadership positions, the development of ACHA's brand and the progression of early collaboration opportunities.

CONCLUSION AND RECOMMENDATIONS

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

- the recent announcements relating to the national New Hospital Programme;

- the progress made on the first 'annual report' charting the progress of key transformation programmes and the journey to the new hospital; and

- Barts Charity's award of a grant to support the mobilisation of the new Academic Centre for Healthy Ageing to be based at Whipps Cross Hospital.

Report to the Trust Board: 12 July 2023	TB 48/23

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

Executive summary

- The number of concerns raised this year has almost doubled since last year.
- Less escalation, more confidential conversations this year - 64%, compared to 49% last year.
- No increase in 'red' concerns compared to last year. No actual patient harm was reported.
- There has been a reversal in *Job groups that raise most concerns*. Admin & Clerical Staff (26% - down from 33% last year), followed by Nurses and Midwives (36% - up from 30%).
- Royal London Hospital (39% - down from 53% last year) follows the trend of previous years, with most concerns. Whipps Cross (19% - up from 17%), Newham (18% - up from 11%), St Bartholomew's (11% - up from just 2 last year), GSS (10% - down from 12%) and non-disclosed (1% - down from 4%). Pathology Partnership (1.5%) had concerns raised in March 2023 for the first time.
- There is a 4% increase in *fear being a reason for speaking to the Guardian*.
- Quarterly summary reports (pages 8-13) are prepared for each location and presented to the local Hospital Executive Boards (or similar, ie People & Values Committee).

Related Trust objectives	Fair and Just Culture (part of the overarching priority of creating a truly inclusive workplace)

Risk and Assurance	
Related Assurance Framework entries	This report provides assurance in relation to objectives and BAF entry 1. A lack of evidenced delivery on the operational plan's inclusion commitments impairs engagement, morale, ability to lead and recruitment and retention of staff at Trust and system level and BAF entry 2. Insufficient leadership capacity and capability to effectively prioritise wellbeing plans impairs engagement, morale, ability to lead and recruitment and retention of staff at Trust and system level
Legal implications/ regulatory requirements	Equality Act

Action required:

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

NHS
Barts Health
NHS Trust

The Guardian Service
Here to listen

Barts Health NHS Trust

Freedom to Speak Up Annual Report
1 April 2022 to 31 March 2023

Table of Contents

1. Executive summary

- The number of concerns raised this year has almost doubled since last year. The top 3 themes are like previous years – Management, Systems and Process, Behaviour.
- There has been less escalation and more confidential conversations this year - 64%, compared to 49% last year.
- No increase in 'red' concerns compared to last year. No actual patient harm was reported.
- There has been a reversal in Job groups that raise most concerns. Admin & Clerical Staff (26% - down from 33% last year), followed by Nurses and Midwives (36% - up from 30% last year).
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- There is a 4% increase in fear being a reason for contacting the Guardian.
- Quarterly summary reports (pages 8-13) are prepared for each location and presented to the local Hospital Executive Boards (or similar, ie People & Values Committee).

2. Purpose of the paper

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

3. Background to Freedom to Speak Up

Following the Francis Inquiry[1] 2013 and 2015, the NHS launched 'Freedom to Speak Up' (FTSU). The aim of this initiative was to foster an open and responsive environment and culture throughout the NHS enabling staff to feel confident to speak up when things go or may go wrong; a key element to ensure a safe and effective working environment.

4. The Guardian Service

The Guardian Service Limited (GSL) is an independent and confidential staff liaison service. It was established in 2013 by the National NHS Patient Champion in response to The Francis Report. The Guardian Service provides staff with an independent, confidential 24/7 service to raise concerns, worries or risks in their workplace. It covers patient care and safety, whistleblowing, bullying, harassment, and work grievances. We work closely with the National Guardian Office (NGO) and attend the FTSU workshops, regional network meetings and FTSU conferences. The Guardian Service is advertised throughout the Trust as an independent organisation. This encourages staff to speak up freely and without fear of reprisal. Freedom to Speak Up is part of the well led agenda of the CQC inspection regime. The Guardian Service supports the Trust's Board to promote and comply with the NGO national reporting requirements.

The Guardian Service Ltd (GSL) was implemented in Barts Health NHS Trust in July 2016.

Communication and marketing have been achieved by meeting with senior staff members, joining team meetings, site visits, the Intranet and the distribution of flyers and posters across the organisation. All new staff will become aware of the Guardian Service when undertaking the corporate induction programme weekly at Mile End Hospital.

5. Access and Independence

Being available and responsive to staff are key factors in the operation of the service. Many staff members, when speaking to a Guardian, have emphasised that a deciding factor in their decision to speak up and

[1] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

contacting GSL was that the Guardians are not NHS employees and are external to the Trust. This has also been useful in respect of being an objective sounding board which can help re-frame the situation confronting the individual or give some other point of view for consideration.

6. Categorisation of Calls and Agreed Escalation Timescales

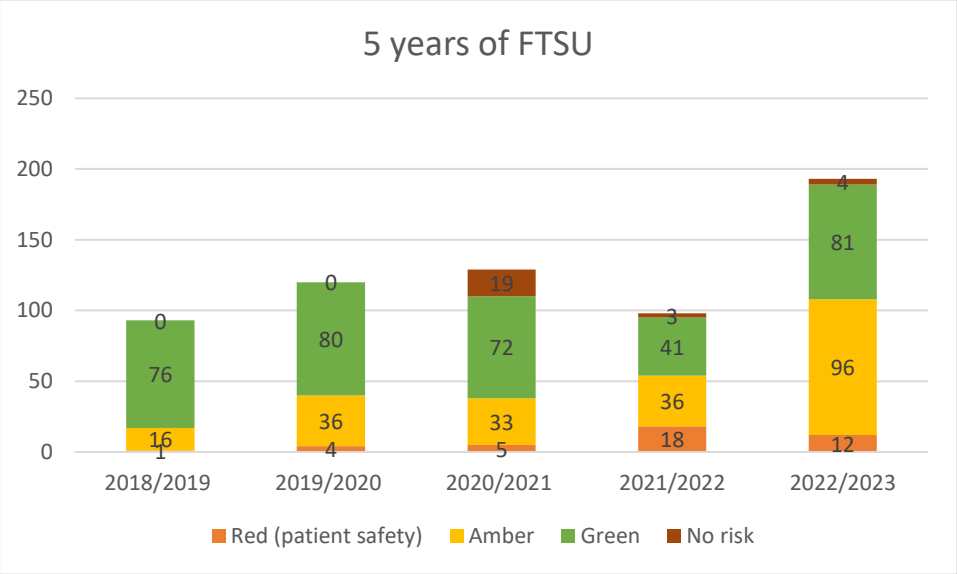
The following timescales have been agreed and form part of the Service Level Agreement for the small number of concerns that need to be escalated.

Call Type	Description	Total No of concerns	Agreed Escalation Timescales
Red	Includes patient and staff safety, safeguarding, danger to an individual including self-harm. The Group Chief Medical Officer and Group Chief Nurse are also routinely informed.	12 (all were escalated)	Response required within 12 hours
Amber	Includes bullying, harassment, and staff safety.	96 (30 escalated)	Response required within 48 hours
Green	General grievances e.g., a change in work conditions.	81 (27 escalated)	Response required within 72 hours
White	No discernible risk to organisation.	4	No organisational response required

Open cases are continually monitored, and regular contact is maintained by the Guardian with members of staff who have raised a concern to establish where ongoing support continues to be required. This can be via follow up phone calls and/or face to face meetings with staff who are in a situation where they feel they cannot escalate an issue for fear of reprisal. Guardians will also maintain contact until the situation is resolved or the staff member is satisfied that no further action is required. Where there is a particular complex case, setbacks, or avoidable delays in the progress of cases that have been escalated, these would be raised with Delvir Mehet, Deputy Group Director of People, the organisational lead for the Guardian Service at regular monthly meetings.

Escalated cases are those which are referred to an appropriate manager, at the request of the employee, to ensure that appropriate action can be taken. As not all employees want their manager to know they have contacted the GSL, they may progress the matter themselves or take no further action. There are circumstances where cases are escalated later by the Guardian. A staff member may take time to consider options and decide a course of action that is right for them. A Guardian will keep a case open and continue to support in such cases. In a few situations contact with the Guardian is not maintained by the staff member.

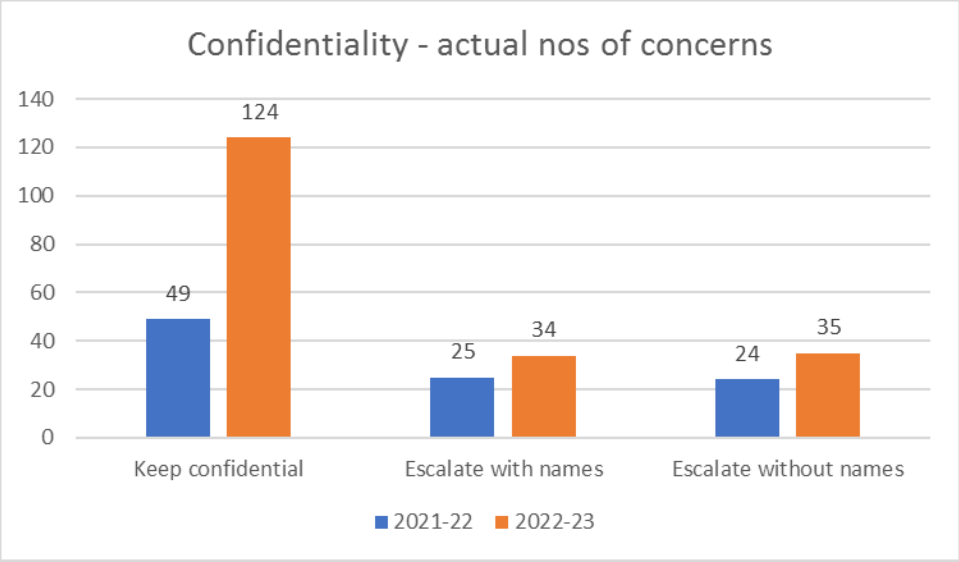
7. Number of concerns



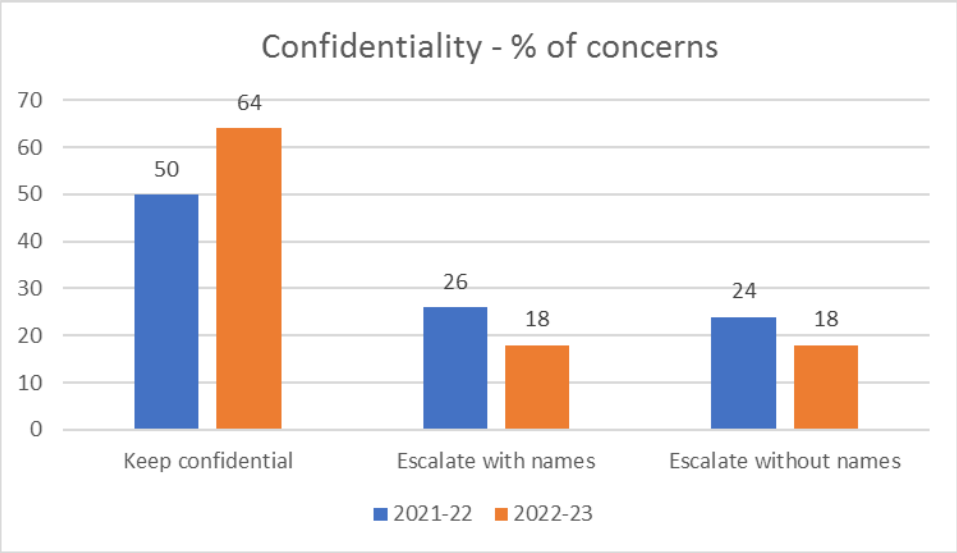
Considering FTSU was set up to address patient safety concerns, there is always a relatively small number in the 'red' category requiring immediate action, but all the other barriers faced by employees to doing their best work obviously impact on patient safety and experience due to attrition and lack of engagement. Patient safety concerns are at the bottom of the graph above.

The number of concerns raised this year has almost doubled since last year. This may be due to more publicity, on site presence and organisational/management communications encouraging speaking up. More concerns enable more conversations around reaching resolution, discussion of possible options and when escalated allows the Trust to take action to explain or resolve.

8. Confidentiality



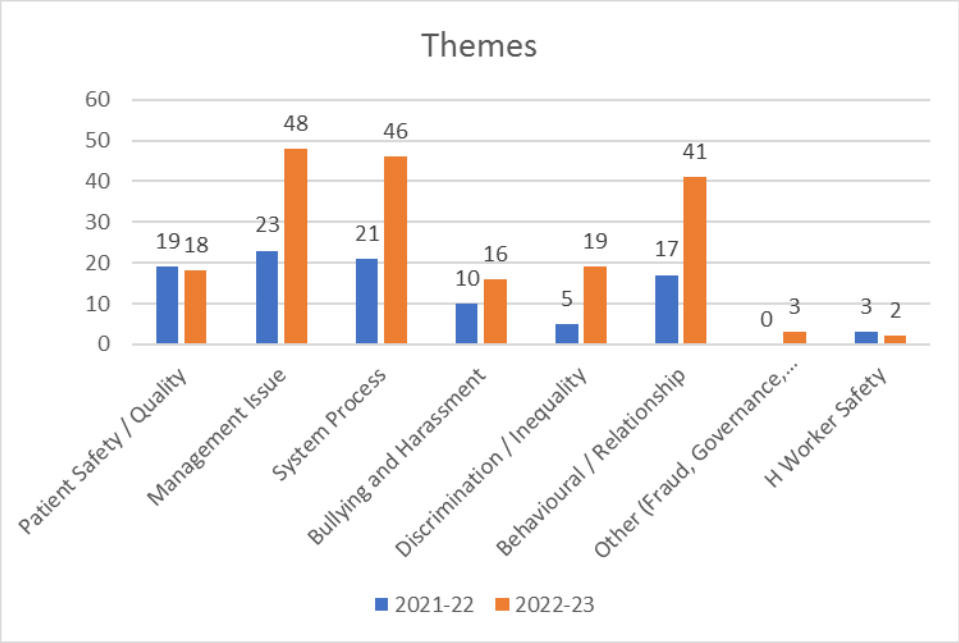
The confidentiality charts show (above) the actual number of concerns raised over the last two years and (below) the percentage breakdown of action taken as requested by the individual raising the concern.



During 2022-23 there has been less escalation. Most people who raise concerns want a private, unbiased conversation with the Guardian who, as a trusted partner of the Trust, can listen, question, explain, coach, encourage, signpost, and offer a variety of different options to obtain resolution. This often addresses the fear of recrimination, can re-frame the situation described and empowers the individual to tackle the situation themselves.

9. Themes

Concerns raised are broken down into the following categories.



Potential Patient safety issues or 'red' concerns

The Group Chief Medical Officer and Group Chief Nurse are also routinely informed of all 'red' concerns.

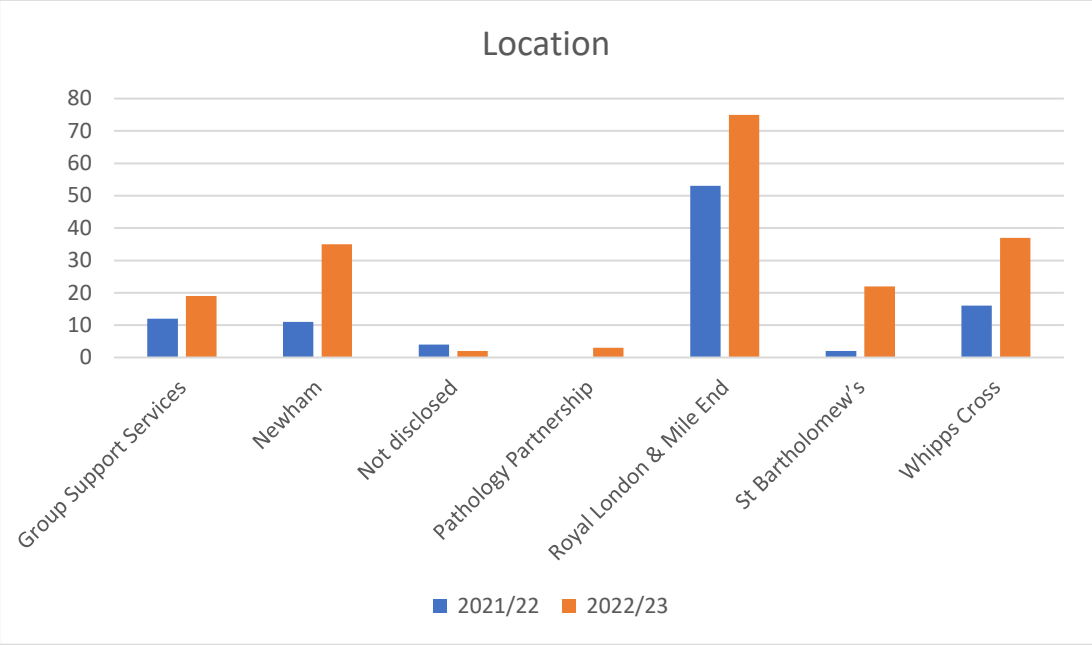
There are some patient safety concerns not categorised as 'red' due to their non-urgent nature as dealt with at the time but raised afterwards to ensure organisational learning.

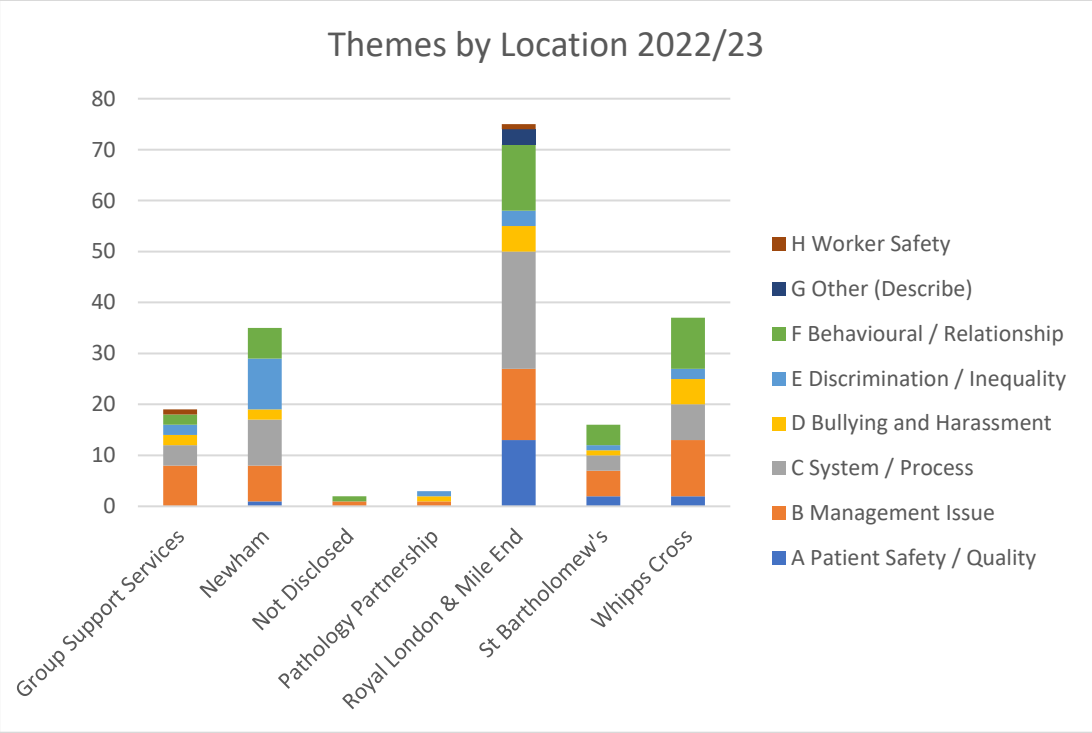
Location	Issue raised	Escalated to	Resolution
Newham (amber concern)	Lack of teamwork between Nurses and HCAs is impacting on patient safety	Staff member had raised with ADoN	A grievance process was followed
Royal London (x9) (red)	Staff numbers inadequate to meet patient acuity. Lack of HCA per patient.	Director of Nursing	Review of staffing criteria
Royal London (amber)	Staff member felt a lack of supervision and support from nursing and consultant colleagues	ADoN	Responsibilities for all concerned defined
Royal London (amber)	No working escalation path for dealing with emergencies. Lack of support from nursing and consultant colleagues	ADoN	Responsibilities for all concerned defined
Royal London (amber)	Staff member felt the service response to a visitor falling ill was inadequate and lacked compassion	Director of Nursing	DoN spoke to Matron and put out communication
Royal London (red)	Admin staff requesting patient bloods	ADoN	Management plan in place
Royal London (red) (Governance)	Allegation that a member of staff allowed external people access to the computer system	Acting Clinical Manager	Investigation has taken place
St. Bartholomew's (red)	Staff numbers inadequate to safely give medication yet more patients are admitted	Matron	Recruitment is on-going
St. Bartholomew's (amber)	Problems with patient transport	Patient Transport	Reminder of protocols was distributed
Whipps Cross (amber)	Staff member felt 'do not attempt resuscitation' markers were on learning disabled patients without full consultation with the patient.	Director of Nursing	Review with Safeguarding was undertaken
Whipps Cross (amber)	Obsolete equipment was reported.	Medical Director	Equipment is not within Barts' responsibility or environs

No patient harm resulted from any of the above. They were raised to the Guardian and escalated to senior management to alert to the possibility of harm.

Themes by Location

Here is a detailed breakdown of the themes by location below with brief narrative specific to the site.





Group Support Services: Year End Summary

Presented to the Group Nursing Directorate on 8 June 2023

Themes	Nos
Patient Safety / Quality	0
Management Issues	8
Systems and Processes	4
Bullying and Harassment	2
Discrimination / Inequality	2
Behaviour / Relationship	2
Other	0
Worker safety	1
Total	19

Job groups	Nos
Additional Prof., Scientific and Technical	5
Admin & Clerical	11
Estates and Ancillary	2
Nursing & Midwifery	1
Total	19

Confidentiality	Nos
Keep confidential	14
Escalate with name	5
Escalate without name	0

Open/Closed Status	Nos.
Written / verbal outcome	16
Chose not to pursue	2
Open / ongoing	1

Division	Nos
Chief Nurse	1
Medical Director	3
Strategy	2
Corporate Development	3
Estates & Facilities	4
Education Academy	2
People	2
Finance	2
Total	19

Theme narrative:

- **Management** – feeling micromanaged by unreasonable manager, feeling their role is disregarded by manager, frustration at hierarchy in dept, fears for viability of unit, fears due to excessive sickness, fears due to unreliable colleague, conflict re completion of workload.
- **System & Process** – Dignity at Work grievance acknowledgement by manager, capability process started without SMART objectives, disciplinary process felt unwarranted.
- **Bullying & Harassment** – feeling ostracised during phased return to work, feeling bullied by manager.
- **Discrimination / Inequality** – lack of disability reasonable adjustments, working from home due to disability.
- **Behaviour / Relationship** – lack of engagement with new manager, feeling blamed by senior manager.
- **Worker safety** - behaviour of manager is erratic.

Royal London Hospital: Year End Summary

Presented to the RLH Hospital Executive Board on 10 July 2023

Themes	Nos
Patient Safety / Quality	13
Management Issues	15
Systems and Processes	23
Bullying and Harassment	5
Discrimination / Inequality	2
Behaviour / Relationship	14
Other	2
Worker safety	1
Total	75

Job groups	Nos
Additional Clinical Services	8
Additional Prof., Scientific and Technical	5
Allied Health Professional	5
Admin & Clerical	16
Healthcare Scientist	1
Medical & Dental	9
Nursing & Midwifery	30
Students	1
Total	75

Division	Nos
Allied Health, Diagnostics & Cancer	7
Children And Young People	10
Emergency Care & Trauma	13
Not disclosed	1
Medicine	9
Site Management	9
Surgery, Peri-Operative & Critical Care	13
Women's Health	13
Total	75

Confidentiality	Nos
Keep confidential	39
Escalate with name	16
Escalate without name	20

Open/Closed Status	Nos.
Written / verbal outcome	57
Chose not to pursue	9
Open / ongoing	9

Theme narrative:

- **Patient safety** concerns: (x9) colleagues spoke up about lack of staffing to meet patient acuity; hostile colleagues creating an unsupported environment; poor response to visitor falling ill; admin staff requesting bloods.
- **Management**: concerns related to managers not treating people with respect when errors are made, blaming, relationship breakdown, and not sharing appropriate information about long-term objectives for role and/or department; management/leaders behaviours not in line with Trust values
- **Systems / Process** concerns related lack of understanding of how A/L is calculated with extra bank holidays; Covid procedures being relied upon asking staff to rotate to other sites when situation had changed; resignation due to lack of flexible working for childcare.
- **Bullying** concerns featured managers asking 'who spoke up'; redeployed while investigation is carried out; subjected to irrational behaviour of senior person.
- **Discrimination / Inequality** concern related to staff doing the same role on different bands, new manager disregarding previously effective reasonable adjustments.
- **Behaviour / Relationship** concern relate to the breakdown of trust between people who must work together (x4), being shouted at, poor behaviour displayed (x3), accused of causing trouble (x2); received no explanation of allocation of duties; feeling disbelieved re. heath condition.
- **Other**: dispute re. Trust accommodation.
- **Worker safety**: impact on staff of patient live-streaming from clinical area.

St. Bartholomew's Hospital: Year End Summary

Presented to Hospital Executive Board on 2 May 2023

Themes	Nos
Patient Safety / Quality	2
Management Issues	6
Systems and Processes	3
Bullying and Harassment	1
Discrimination / Inequality	1
Behaviour / Relationship	9
Other	0
Worker safety	0
Total	22

Job groups	Nos
Admin & Clerical	2
Additional Prof., Scientific and Technical	2
Allied Health Professional	5
Healthcare Scientist	2
Medical & Dental	3
Nursing & Midwifery	8
Total	22

Division	Nos
Cancer Centre	1
Clinical Services	10
Heart Centre	11
Site Management	0
Total	22

Confidentiality	Nos
Keep confidential	10
Escalate with name	2
Escalate without name	10

Open/Closed Status	Nos.
Written / verbal outcome	14
Chose not to pursue	2
Open / ongoing	6

Theme narrative:

- **Patient safety** concerns regarding lack of staffing resulting in pressure in the administration of chemotherapy, and patient transport for discharge.
- **Management** – a team spoke up about the imposition of local flexible working guidance that felt unfair and disconnected to the needs of patients and staff work/life balance. Another team spoke up about the lack of cooperation with another team which impacts their functioning. Lack of compassion for staff mistakes.
- **Systems / Process** concerns related to e-rostering and clinic attendance. 2 related to redeployment and/or reasonable adjustments to support physical and mental ill health.
- **Bullying** concerns relate to inappropriate behaviours by a more senior colleague.
- **Discrimination / Inequality** concern related to being treated differently as a mother in a male dominated domain.
- **Behaviour / Relationship** concerns related to feeling micromanaged by a manager who undermines and causes anxiety; passive aggressive manager, colleague who is competitive and non-cooperative; manager who doesn't like being challenged; feeling hurt by an abrasive interaction with manager; toxic atmosphere between 2 services; lack of understanding of personal situation.

Newham University Hospital: Year End Summary

Themes	Nos
Patient Safety / Quality	1
Management Issues	7
Systems and Processes	9
Bullying and Harassment	2
Discrimination / Inequality	10
Behaviour / Relationship	6
Other	0
Worker safety	0
Total	**35**

Job groups	Nos
Admin & Clerical	10
Nursing & Midwifery	18
Additional Clinical Services	6
Medical & Dental	1
Total	**35**

Division	Nos
Clinical Support Services	0
Emergency Care & Acute Medicine	14
Site Management	1
Surgery & Cancer	7
Women's & Children's Health	13
Total	35

Confidentiality	Nos
Keep confidential	17
Escalate with name	6
Escalate without name	12

Open/Closed Status	Nos.
Written / verbal outcome	31
Chose not to pursue	0
Open / ongoing	4

Theme narrative:

- **Management** – feeling that managers insist on certain 'waste of time' jobs being done without giving an explanation or justification, lack of visibility of senior staff on the wards, OH recommendations ignored, following through on suggestions or requests for improvements.
- **Systems / Process** concerns related to lack of adherence to policies on flexible working, grievance, reasonable adjustments, probation extension, recruitment, disciplinary.
- **Bullying** concerns relate to inappropriate behaviours by a manager.
- **Discrimination / Inequality** concerns related to unfair recruitment and behaviour by a manager, staff felt not valued, and favoritism was rife.
- **Behaviour / Relationship** concerns related to lack of trust between a team and their manager, lack of humanity/discretion in dealing with bereavement leave, offensive messages on WhatsApp, issuing formal notes about performance without any opportunity for conversation prior to weekend or annual leave.

Pathology Partnership: Year End Summary

Themes	Nos
Patient Safety / Quality	0
Management Issues	1
Systems and Processes	0
Bullying and Harassment	1
Discrimination / Inequality	1
Behaviour / Relationship	0
Other	0
Worker safety	0
Total	**3**

Job groups	Nos
Healthcare Scientist	3
Total	**3**

Division	Nos
Blood Sciences	0
Cellular Pathology	3
Corporate	0
Governance	0
Infection / Microbiology	0
Not disclosed	0
Pathology IT	0
Total	3

Confidentiality	Nos
Keep confidential	1
Escalate with name	1
Escalate without name	1

Open/Closed Status	Nos.
Written / verbal outcome	2
Chose not to pursue	0
Open / ongoing	1

Theme narrative:

- **Management** concern related to fear of the return-to-work process and lack of action to tackle difficult working relationships.
- **Bullying** concern related to inappropriate behaviours by a managers and colleagues.
- **Discrimination / Inequality** concern related to lack of concise management to address poor behaviours and favoritism/clique culture.

Whipps Cross Hospital: Year End Summary

Presented to People and Values Committee on 9 June 2023 and Staff Partnership Forum on 21 June 2023.

Themes	Nos
Patient Safety / Quality	2
Management Issues	11
Systems and Processes	7
Bullying and Harassment	5
Discrimination / Inequality	2
Behaviour / Relationship	10
Other	0
Worker safety	0
Total	37

Job groups	Nos
Additional Clinical Services	2
Admin & Clerical	9
Allied Health Professional	6
Medical & Dental	3
Nursing & Midwifery	14
Estates	3
Total	37

Division	Nos
Not disclosed	2
Site Management	3
Surgery & Cancer	8
Emergency Care & Acute Medicine	6
Core Services	6
Women & Children	12
Total	37

Confidentiality	Nos
Keep confidential	23
Escalate with name	5
Escalate without name	9

Open/Closed Status	Nos.
Written / verbal outcome	25
Chose not to pursue	6
Open / ongoing	6

Theme narrative:

- **Patient safety** concern regarding 'do not attempt resuscitation' markers on learning disabled patients without full consultation with the patient. The other related to obsolete equipment.
- **Management** – feeling that managers allow poor behaviour to go unchecked, are not accessible enough to junior staff, do not answer reasonable questions about meeting the needs of the service in conjunction with working flexibly, do not step in quickly enough to sort out problems,
- **Systems / Process** concerns related to length of time taken to agree reasonable adjustments and obtain equipment following long term ill health, fairness of recruitment process, and confirmation into a higher banded role.
- **Bullying** concerns relate to inappropriate behaviours by a peer, shouted at by a senior leader, undermined by manager. Threatening behaviour by a manager.
- **Discrimination / Inequality** concerns related to racist management behaviour.
- **Behaviour / Relationship** concerns related to gossip being spread by a peer, supervision and behaviours of a junior team is unchecked, lack of trust within a team. Non-supportive working environment. Tone and message of a manager caused offense. Unfriendly relations.

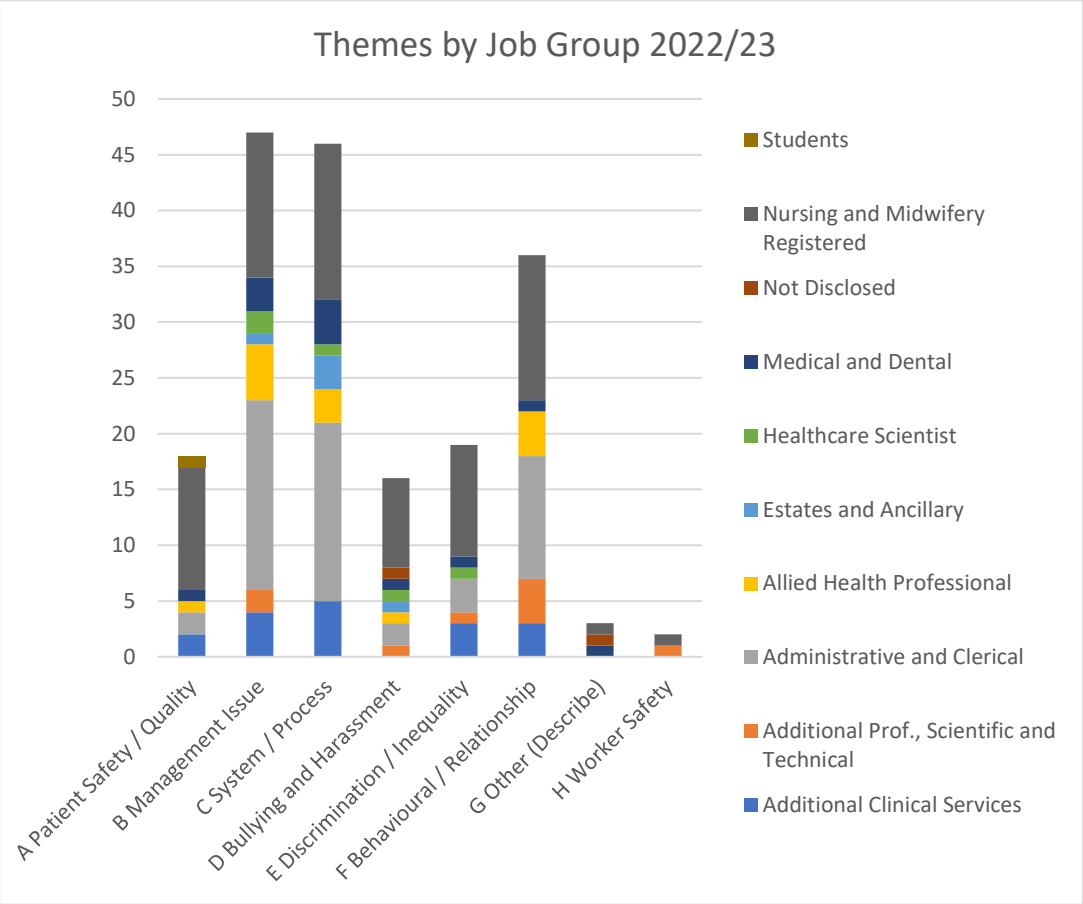
Themes by Job Group

The top 3 job groups speaking up this year are Nursing & Midwifery, Admin & Clerical, and Additional Clinical Services. Most concerns are usually raised by Admin & Clerical Staff (26% this year, compared to 33% last year), followed by Nurses and Midwives (36%, compared to 30% last year). This has been the case for several years but has reversed this year. Nurses and Midwives have reported feeling concerned about

unfair recruitment, leaders building a power base of people like them, difficult relationships with managers who don't treat the whole team fairly.

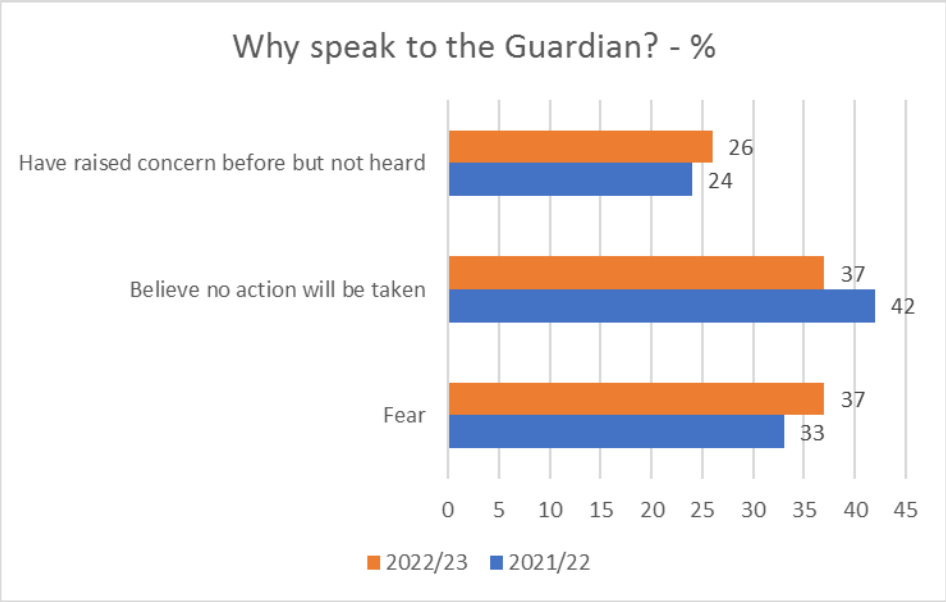
Admin & Clerical staff reported feeling disappointed with management requests that often didn't make sense and the lack of engagement in a quality conversation to identify workable solutions. Feeling that management were following instructions from above without using their discretion.

Additional Clinical Services (9%) reported feeling frustrated with the imposition of processes that weren't working, lack of acceptance of flexible working requests, and conflicts between colleagues that made lives and work very difficult.



10. Why do staff use The Guardian Service?

Guardians are available to support people to speak up when they feel unable to do so by other routes. They ensure that people who speak up are thanked, that the issues they raise are responded to and make sure that the person speaking up receives feedback on the actions taken. This feedback loop helps people to feel valued and encourages them to continue to engage with FTSU Guardians.



There above graph shows a 4% increase in fear compared to last year.

11. Detriment

No one has reported suffering a detriment.

12. Action taken to improve the Freedom to Speak Up Culture

Attendance at regular meetings and events to brief on FTSU. This includes:

- LGBTQ+ Network and BartsAbility meetings
- Freedom to Speak up Steering Group
- Inclusion Signposters
- Staffside Partnership Forum
- Corporate induction – weekly
- Doctors induction
- Diversity & Inclusion meetings
- Medical Education Committee
- Junior Doctors Forums
- Hospital Executive Boards (or equivalent)
- Health & Wellbeing Boards
- WeLead – leadership training

Regular meetings with Deputy Director of People, Head of People Relations, and ER Project Manager to discuss activity, cases and the service. Similar meetings are held with Directors of People and CEOs at each Hospital. Regular meetings are also held with the Non-Executive Director.

Visits are made to all sites regularly and advertised on the Events calendar on the WeShare intranet and Twitter.

13. Learning and Improvements

The Guardian has contributed to various initiatives including the Patient Safety Incident Response Framework (PSIRF), We Lead training and Team Leader webinars. The Guardian Service toolkit has been shared – The Power of Speaking Up.

The Guardian routinely meets every fortnight with other Guardian (GSL) colleagues from across England, Scotland, and Wales. This contributes to continued learning of how to best address complex concerns and aids the sharing of best practice.

Guardians attend the meetings and events organised by the National Guardian Office (NGO), to keep up to date with developments.

Guardians have minimum of two sessions per annum with a Psychotherapist and can have additional sessions when/if required. Guardians are trained Mental Health First Aiders. Guardians are provided with resilience training.

14. Comments & Recommendations

- There have been a small number of hotspots exacerbated by inaction of senior people to tackle inappropriate behaviour that has trickled down to cause distress and untenable working environments. The same performance management protocols and SMART objectives at every level of the organisation should be followed to deliver a workplace that is fair and equitable.
- Managers are often dealing with complex situations, such as staff returning to work from long term sickness absence. Managers need to feel supported to deal with the occasional situation where an individual is unable to return to their substantive post due to an acquired disability and need, perhaps a career conversation about other opportunities within the Trust.
- Managers to be encouraged to participate in training or refresher training in speaking up, listening up and following up which is now available on WeShare. It is expected that the executive lead for FTSU and the Non-Executive Director will use the National Guardian Office (NGO) guidance available from the NGO self-review tool to help the board reflect on its current position. The high level Trust response is being prepared by the People Relations/Inclusion Team in conjunction with the Guardian and will be presented to the People Executive Team in August 2023.

15. Staff Feedback

Staff generally are thankful of having an independent person who has time to listen to their concerns.

Report to the Trust Board: 12 July 2023	TB 49/23

Title	Complaints Annual Report
Accountable Director	Chief Nursing Officer
Author(s)	Head of Complaints
Purpose	To provide a summary of reportable complaints and early resolution activity received in 2022/23
Previously considered by	Quality Board, Group Executive Board

Executive summary

The work on complaints management during the year has continued focusing consistently on improving the quality of service users' experience.

With a structured improvement plan to guide progress each year, we have used quality improvement methodologies to ensure continuous improvement is firmly embedded in our complaints management.

We continue to ensure our processes are accessible and service users can raise concerns with us, drawing our attention to their experiences when we might not have "got it right".

In particular this year this has included:

- being a pilot site for the Parliamentary Health Service Ombudsman (PHSO) draft complaints standards, and undertaking a project focused on embedding early resolution of concerns as a key part of the front end of our complaints management.
- undertaking an overhaul of our complaints management training to ensure access for Trust employees to the level of training appropriate to their roles.
- individual hospital annual complaints reporting and the handover of auditing responsibilities to hospitals
- continuing with annual improvement planning, delivering and monitoring set priorities via a bi-monthly complaints management improvement group meetings with focused agendas on continually improving quality and learning lessons from patients' experience and the feedback they provide though the complaints process.
- a realignment of our central complaints management and patient experience functions to further enhance triangulation of reporting on feedback provided by our service users
- our improvement plan for 23/24 and the necessary improvements required to increase "sign off" of reportable complaints by an executive director

Related Trust objectives	
SO1 Safe and Compassionate Care	
Risk and Assurance	The report sets out the current key risks to the above objective.
Related Assurance Framework entries	8. CQC regulation compliance
Legal implications/ regulatory requirements	Supports compliance with The Local Authority Social Services and National Health Service Complaints Regulations (England) Regulations 2009

Action required:
The Trust Board is asked to note and approve the report

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 12 JULY 2023

PALS & COMPLAINTS ANNUAL REPORT 2022/23

1. INTRODUCTION

This report provides information on reportable complaints, issues and concerns reported via our early resolution systems and the complaints process for the Trust between 1 April 2022 and 31 March 2023 compared with the previous year.

The Early Resolution and Complaints Teams work together with hospital governance teams to ensure service users are aware of the options available to them when they wish to raise concerns or report problems with care. Furthermore, the teams ensure that: service users' concerns are heard and responded to, action is taken to prevent re-occurrence and credible improvements are achieved.

Alongside established joint work that already takes place across Early Resolution and Complaints functions, towards the end of the year, an even stronger alignment between our Patient Experience and Complaints functions was developed. As part of a 6-month pilot, the Patient Experience and Complaints Functions are being delivered under the leadership of the Director of Insight and Patient Experience, to further enhance the triangulation of feedback received from service users across multiple channels.

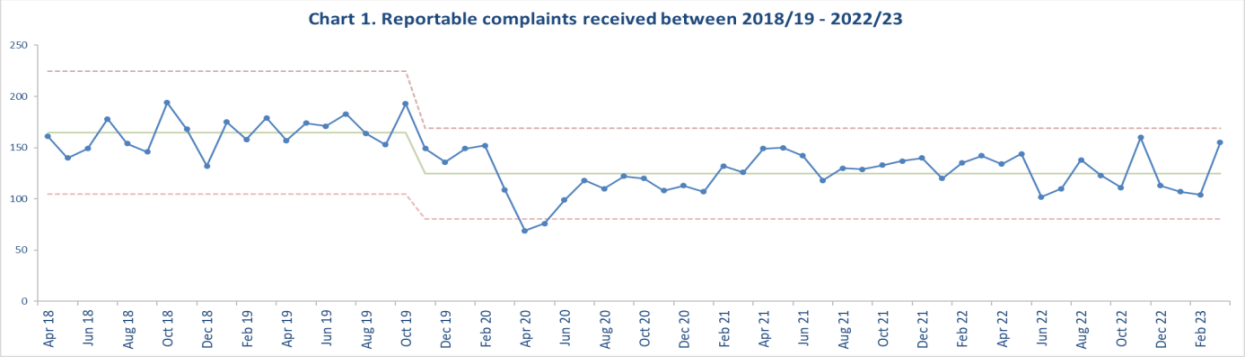
2. DATA ANALYSIS

2.1 Complaints received.

This year, the Trust received **1501** complaints compared with the previous year when **1,579** cases were recorded. This is a 5% decrease compared to the previous year, (which is not statistically significant in itself), but the numbers remain lower than pre-pandemic times which in 2019/20 was **1,867**.

There was no reason identified for the decrease observed, however, increased complexity in the types of cases and the needs of our complaints has been noted in the last two years.

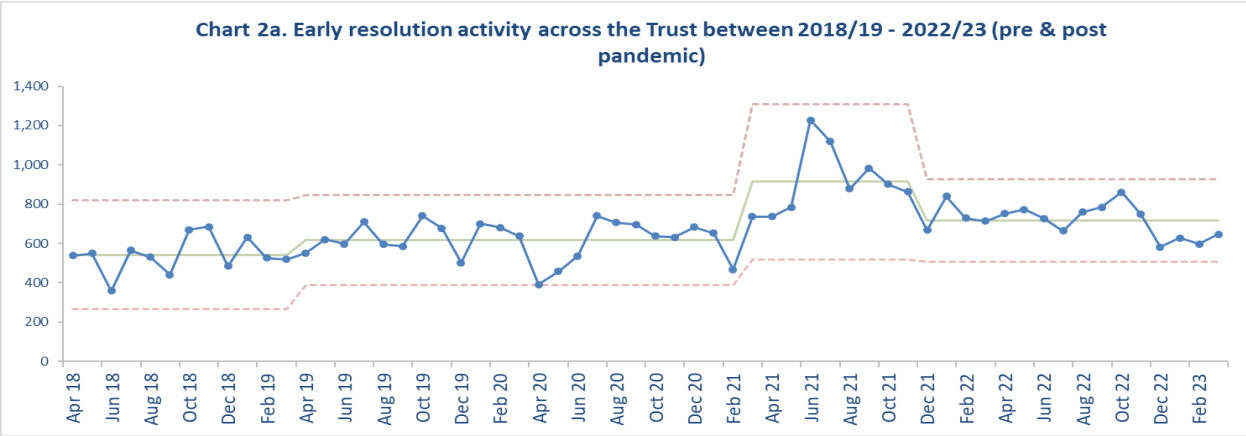
Chart 1 below gives a breakdown of complaints received each month, pre pandemic to date.



2.2 Early resolution activity received across the Trust pre and post pandemic.

Chart 2a gives a breakdown of early resolution activity each month, across the Trust, pre and post pandemic. During the year, overall, the Trust recorded **8,516** early resolution contacts, compared with the previous year when a total of **10,259** contacts were recorded.

Redefining which activity is logged, challenges keeping up with logging activity, staff turnover and absences were contributory factors in recording activity on the system.



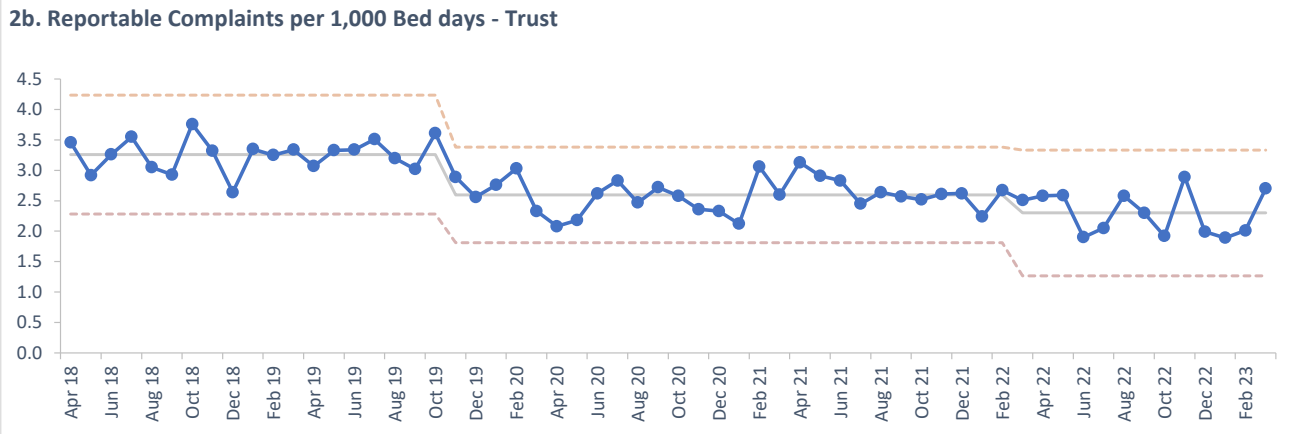
2.3 Barts Health performance against national data on written complaints in the NHS

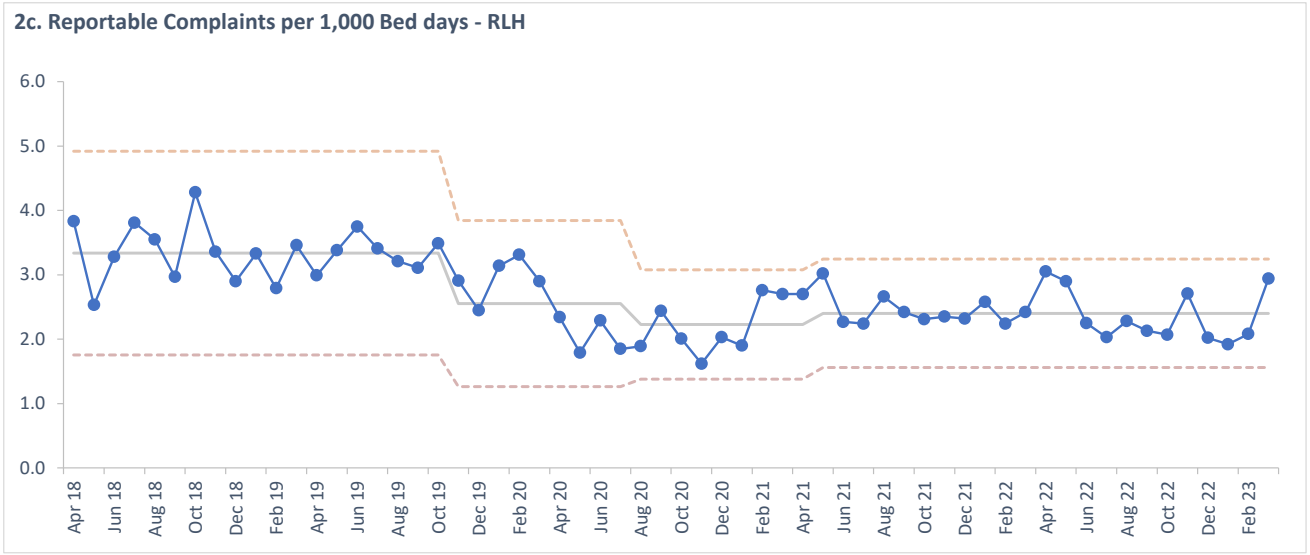
National complaints benchmarking data is provided by NHS Digital (NHSD), drawing on the KO41a data submitted by all NHS Trusts.

Since last year, NHSD have changed reporting frequency from quarterly to annual reporting. As a result, at the time of writing this report, the full national data set for 2022/23 was not yet available on the national portal.

2.4 Complaints activity per 1,000 bed days across the Trust

Charts 2b – 2f. below give a breakdown of complaints received per every 1,000 bed days across the Trust and across individual hospitals.




2c. Reportable Complaints per 1,000 Bed days - RLH
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
Apr 19
Jun 19
Aug 19
Oct 19
Dec 19
Feb 20
Apr 20
Jun 20
Aug 20
Oct 20
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Feb 21
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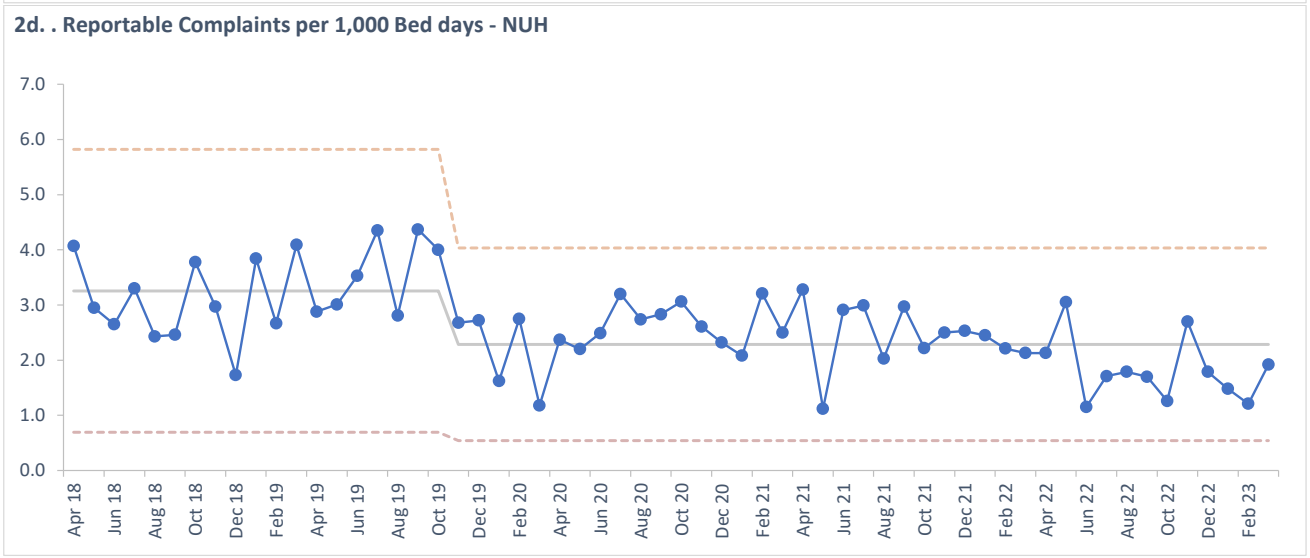
2d. . Reportable Complaints per 1,000 Bed days - NUH
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6.0
5.0
4.0
3.0
2.0
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0.0
Apr 18
Jun 18
Aug 18
Oct 18
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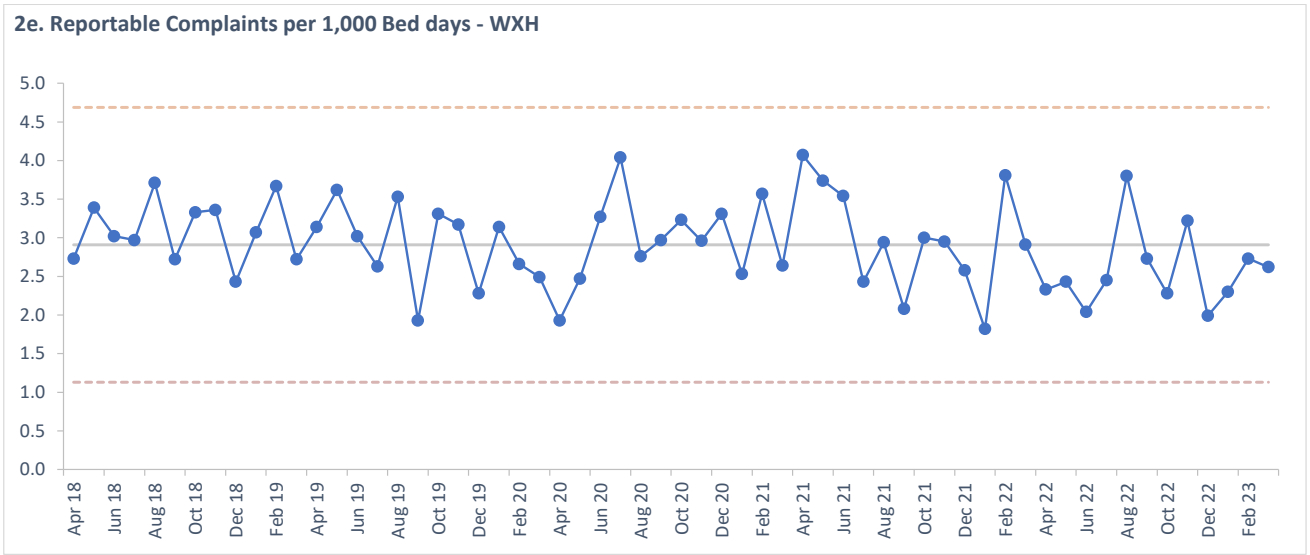
2e. Reportable Complaints per 1,000 Bed days - WXH
5.0
4.5
4.0
3.5
3.0
2.5
2.0
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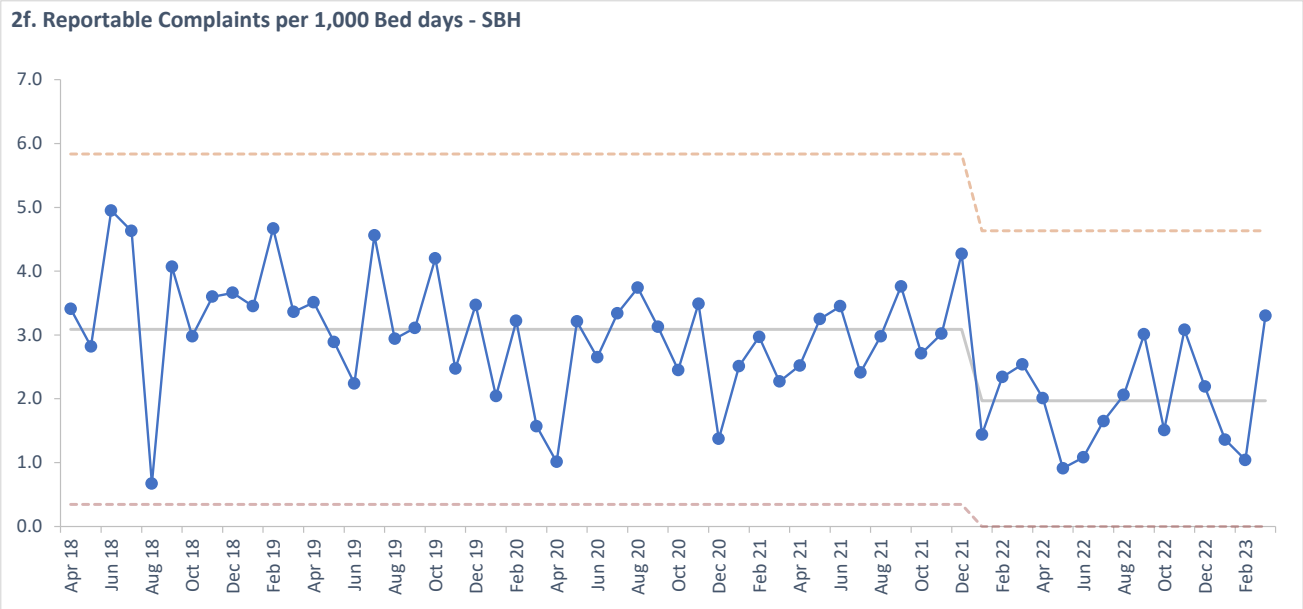


2.5 Analysis of the demographic data of complainants across the Trust

Demographic data is obtained using "the person affected" MRN / NHS number where this is available in the complaint information provided. Those records are linked to the Trust's Cerner data, and we can obtain complainants' demographic details that way.

There is always a high number of "null" returns, in demographic data recorded as not all complainants are the person affected and even when they are, not all complainants who are the person affected provide MRN / NHS numbers. This is particularly the case where the complaint is of a non-clinical nature.

Some data quality issues were noted to be a contributory factor. This has been included as an area for training and improvement in our improvement plans for next year.

In other cases where the complaint is received directly via the on-line or paper forms, some complainants prefer not to disclose this information. Bearing in mind that some complainants fear reprisal and are generally reluctant to provide demographic data when it is requested, the relevant fields in the risk management system have not been made compulsory. This ensures that we do not systematically prevent people who do not wish to provide this data from complaining.

Nevertheless, from the data presented in **table 2-4**, we identified that the majority of our complainants during the year were "White British", followed by "Asian / Asian British" service users of Bangladeshi, Indian, Pakistani and "other" Asian backgrounds.

There was a higher number of females in comparison to male complainants and the age bracket of most complainants was within the 31-40 group followed by the 21-30 age group.

Table 2 – Ethnicity Demographics	
Ethnicity	**Number of complainants**
Asian - Any Other Asian Background	25
Asian or Asian British - Bangladeshi	79
Asian or Asian British - Indian	38
Asian or Asian British - Pakistani	33

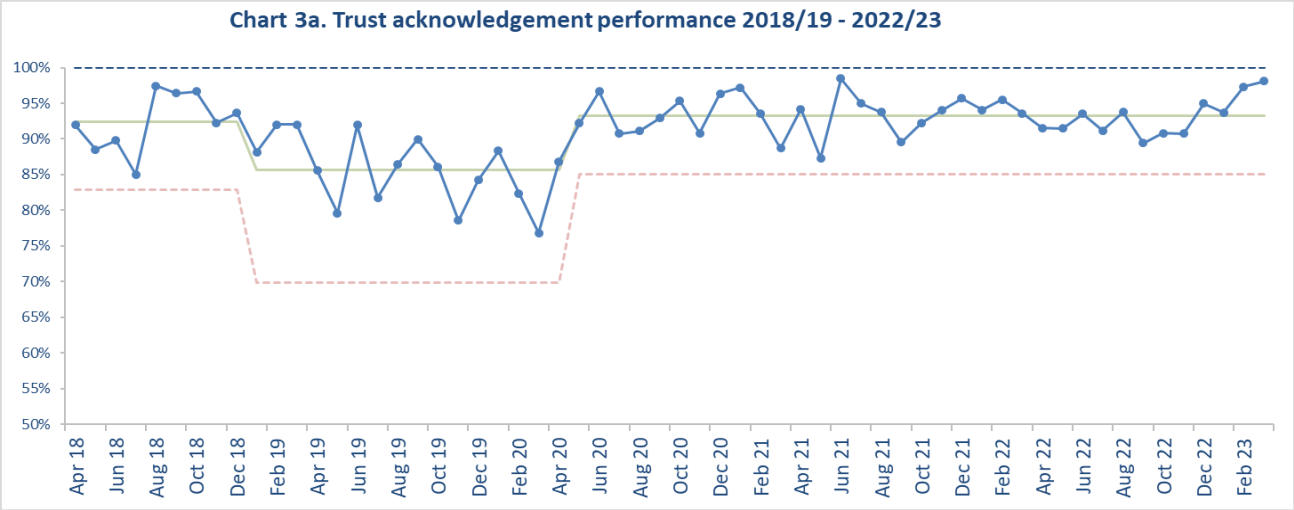
Black - Any Other Black Background	25
Black or Black British - African	44
Black or Black British - Caribbean	27
Mixed - Any Other Mixed Background	13
Mixed - White and Asian	1
Mixed - White and Black African	2
Mixed - White and Black Caribbean	7
Other - Any Other Ethnic Group	40
Other - Chinese	5
Other - Not Stated	39
Patient Refused	12
White - Any Other White Background	92
White - British	196
White - Irish	3
*Null	820

Table 3 - Gender Demographic	
Gender	**No. of complainants**
Female	453
Male	227
Unspecified	1
*Null	820

Table 4. Age Demographics	
Age	**No of complaints**
0-10	7
11-20	20
21 - 30	255
31 – 40	446
41 – 50	234
51 – 60	221
60+	204
*Null	114

3. Complaints acknowledgement performance

3.1 The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 require Trusts to acknowledge all reportable complaints within 3 working days. Overall, in **chart 3a** below, acknowledgement performance rose to **98.1%,** edging closer to achieving the 100% target we set ourselves as a Trust.

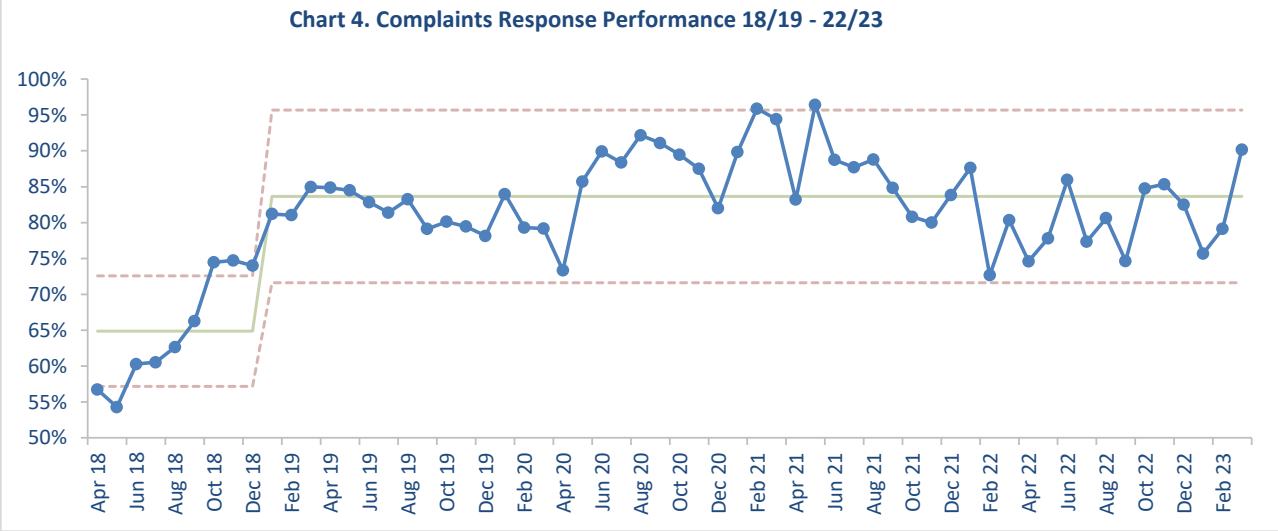


4. Complaints response performance Trust wide

4.1 As a Trust, we aim to respond to 80% of our reportable complaints within the negotiated time agreed with complainants. During the year, the Trust responded to **80.6%** of the complaints received within the negotiated timescale, compared with the previous year when we reported an **85%** performance.

The benefits of a weekly sitrep, bimonthly improvement group meetings and an intuitive dashboard have helped with this. They have enabled hospitals to follow performance daily and address any potential issues that might affect our response rate. By so doing, we have continued to maintain high standards with our response performance.

Chart 4 below gives some insight into performance month on month pre and post pandemic, indicating that some months whilst performance may drop, with consistent monitoring, we are able to recover quickly. This ensures that the over position at the end of the year meets the standard we set ourselves as a Trust.

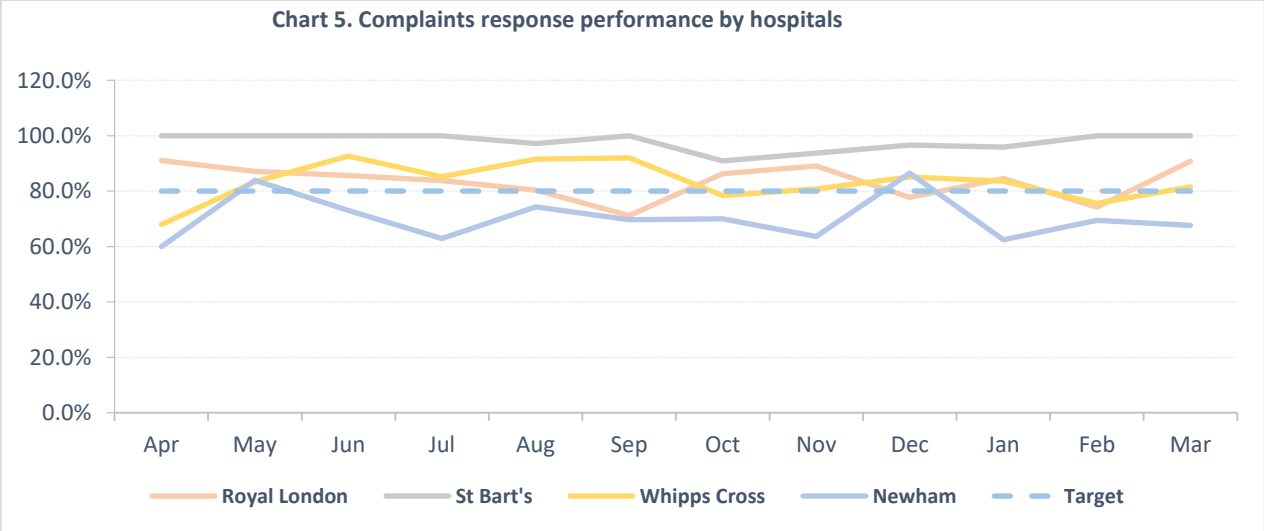


4.2 Complaints response performance by hospitals

Chart 5 shows individual hospital's performance against the 80% standard set for responding to reportable complaints. St Bartholomew's hospital remained consistently above the target throughout the year, with

others occasionally falling below. Newham hospital however appeared more challenged than the other hospitals with regard to responding in a timely manner. Staff turnover, challenges recruiting as well as reviews and changes to complaints quality assurance processes were contributory factors.

The hospital has put in place improvements to address these issues and have included improving the quality of complaints management in the hospital as an item in their change plans for the coming year.



4.3 Complaints received across the Trust by top themes

Although the number of complaints and early resolution contacts we received during the year decreased, the top reasons for service users raising concerns remained the same. As noted in **chart 6**, diagnosis / treatment, delays in care, and appointment concerns were slightly higher in proportion this year compared with the previous year.

The realignment of complaints and patient experience functions has aided the triangulation of data, thereby enabling a better understanding of the common themes across functions and getting solutions to complaints themes in particular, through ongoing patient experience projects across the Trust.

Table 5 below provides some insight into changes that are being made at hospital level, in response to complaints and to improve patients' experience.

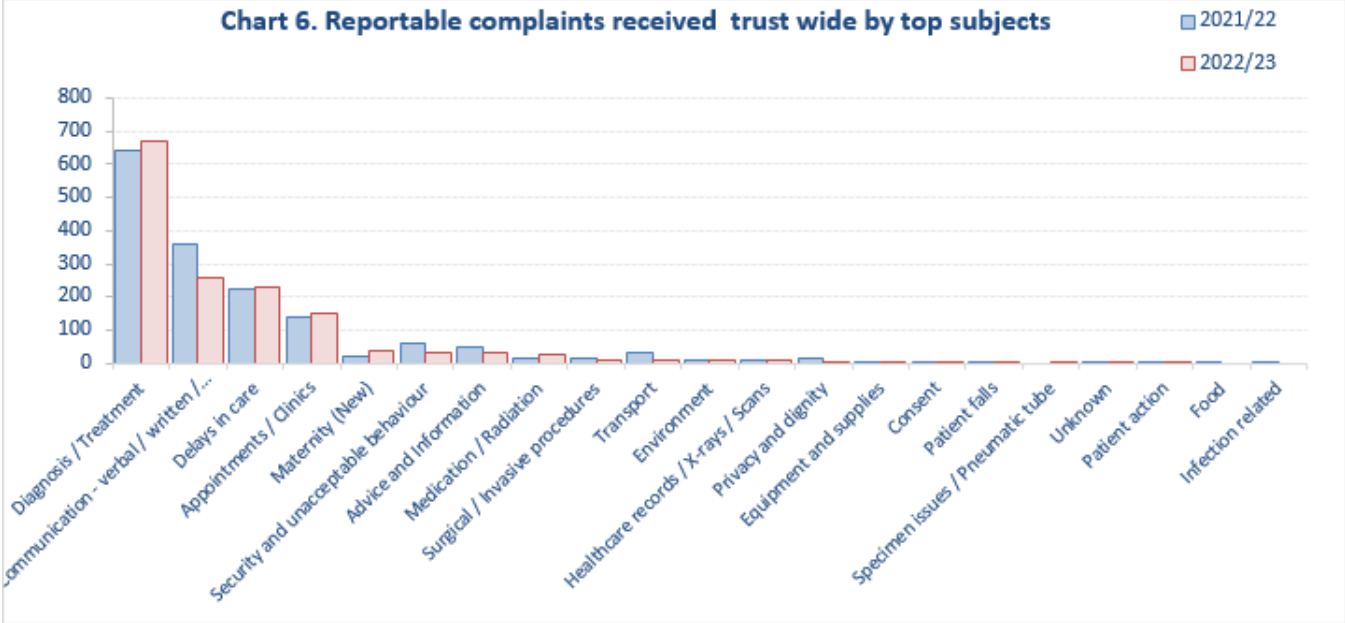


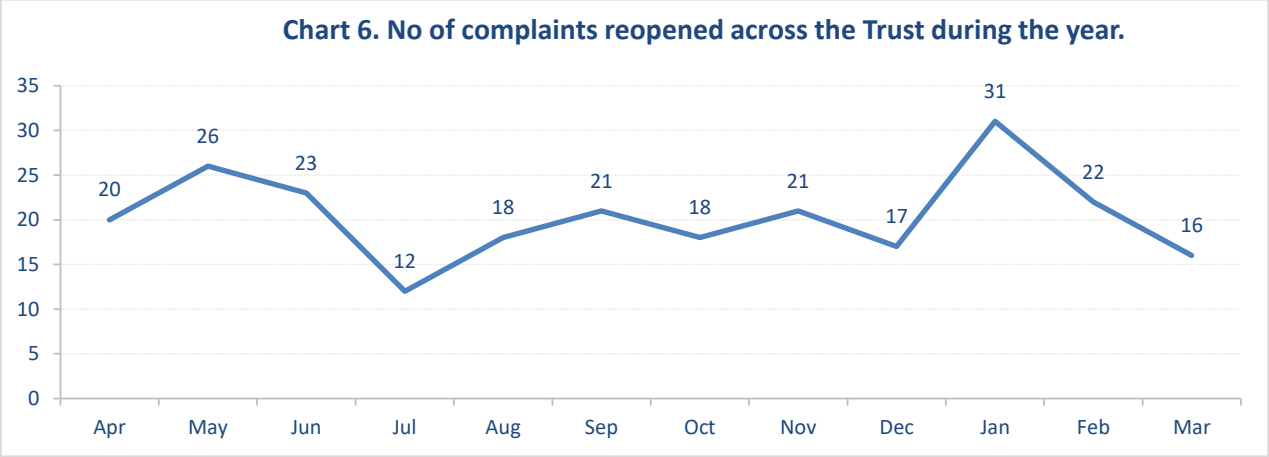
Table 5 Hospitals	Theme	Changes in response to themes
SBH	Communication	- The palliative care team have instigated a training programme with the medical and clinical oncology medical teams aimed at improving communication around end-of-life care following complaints from families that they were not being kept fully, and compassionately informed. ----------
	Appointments	- The radiotherapy team have identified support services and circulated information around video translation services for deaf patients and the location of the equipment that staff can use to facilitate communication with patients who rely on sign language. This was instigated by receipt of a complaint from a deaf patient who was left without translation when the sign language interpreter booked was unable to attend for her appointment
NUH	Diagnosis / Treatment	- Review of language used in responses, to avoid stock phrases and any indication that complaint respond letters are based upon a template rather than an individualised empathic letter to bereft relatives. - Ongoing QI project in ED around administration of analgesia to reduce the time patients have to wait for pain relief.
WXH	All complaints	- Hospital identified a need for training in managing complaints generally and so commenced delivering local complaints management training.
RLH	Communication	- The Children's Hospital in collaboration with the Central Appointments Service have an ongoing project, to enhance the quality of communication afforded patients with the aim being to

		reduce delays in appointments. ----------
	Diagnosis / Treatment	- Focus on sickle cell patients with an ongoing project aimed at improving the quality of care provided to patients.

4.4 Reopened complaints received during the year across the Trust compared with the previous year

Although there was a spike in the number of complaints reopened in January, the numbers decreased quickly in the following months. Whipps Cross Hospital in particular were noted to have the highest number of reopened complaints for the past two years, with St Bartholomew's seeing a significant decrease this year compared with the previous year.

Proactive interventions on the part of the hospitals such as sharing good practice in determining which complaints should be reopened and developing a SOP to aid the process have helped in ensuring that going forward complaints are only reopened when it is necessary to do so.



5. Audits undertaken across the Trust during the year

As part of our improvement plan, we undertake a number of audits to assure ourselves and our stakeholders that we continue to deliver a high standard complaints management. These audits are key indicators for measuring the quality of our responses to service users and the quality of service users' experience whilst using our services. A key part of our "We Statements" and our commitment to listening to feedback we receive as well as understanding and responding fully to concerns raised.

Although audits are currently undertaken centrally, from next year onwards, each hospital will undertake their own audits as part of their local complaints management improvement plans.

5.1 Response quality audit

Using set standards outlined in our policy, we review a number of randomly selected responses to complaints that have been closed during each quarter. **Table 6** below suggests that the quality of our responses are improving although there is still some way to go with achieving a 100% performance with executive signoff of responses.

Compared with last year when only 71% of responses audited were considered a full response, this year 83% of response fully addressed the issues raised by complainants. In addition, 83% of responses audited demonstrated compassion towards complainants' experiences compared with 80% in the previous year.

Overall, assurance that an executive director signs off complaint responses still requires improvement as only 57% of responses reviewed were signed by a director.

Table 6 below summarises these standards and the Trust's performance against each.

Table 6	Standard	Yes	No	Partially
1.	Was a full response provided?	83%	17%	-
2.	Was our response empathic enough?	83%	16%	1%
3.	Was the Trust's standard template used?	72%	20%	8%
4.	Was adequate signposting to additional information provided?	83%	17%	-
5.	Was a named contact for further discussion, if required provided?	71%	17%	12%
6.	Was each response quality checked and signed off by a hospital executive?	57%	43%	-

5.2 Complainant satisfaction survey

As part of closing the loop and completing the cycle in the life of complaints, the complainant satisfaction survey invites randomly selected complainants to tell us what they think about the process and what their experiences have been. At the end of each quarter, a selection of "suitable cases" are chosen from each hospital's case load. Suitable cases exclude those where there has been any kind of loss.

Having used postal surveys in the past, with only a small number of surveys returned, the central complaints team now actively call complainants to invite them to partake in the surveys.

When complainants are contacted, the caller confirms their identity, verifies the complainant's identity, explains the reason for the call and our plans for improving patients' experience as part of "closing the complaints loop" and the value complainants' feedback adds to the process.

Some complainants are willing to engage in the process and provide valuable insight that helps us make tangible improvements. In other cases, complainants may choose not to engage in the process, giving a range of reasons including dissatisfaction with the outcome of their complaint, with "just not in the mood" or "just not interested" being amongst the reasons people gave.

As **table 7** below indicates, there continues to be some degree of reticence on the part of complainants towards engaging in the survey. Apart from the aforementioned reasons, calls not being picked up, timing etc were some of the reasons complainants did not engage in the surveys. Nevertheless, we obtained some meaningful feedback that has enabled us to reflect on and review how we manage complainants' experience.

Table 7 also provides a summary of the volume of data considered for the audits whilst **table 8** gives a summary of how the complainants surveyed felt about the process.

Overall, the data suggests that the level of complainants' satisfaction generally requires improvement. This has been added to our improvement plan for the coming year.

Table 7. Quarters	No. of closed cases pulled	No. not wishing to partake in the survey	No. of unanswered calls (abandoned after 2 attempts)	No. of actual surveys completed
Q1	95	17	32	46
Q2	82	24	14	44
Q3	83	11	25	47
Q4	90	20	20	50

Table 8	Excellent	Good	Fair
%age performance	8%	21.3%	66.8%

6. Complaints Management Training

6.1 Training Review

As part of piloting the Parliamentary Health Service Ombudsman (PHSO) draft complaints standards, a review of our complaints training indicated that improvements were required to ensure that:

- the right staff got the right complaints training.
- all staff are adequately skilled and equipped in resolving concerns early so issues are not unnecessarily escalated to formal complaints.
- better streamlined methods of measuring engagement with complaints training and its impact on addressing early resolution of concerns are implemented.

Although complaints training has always been delivered in the Trust, turn out for sessions was often low. In addition, there was an imbalance between the volume of staff across the Trust who required training compared with the number of facilitators available to deliver the training.

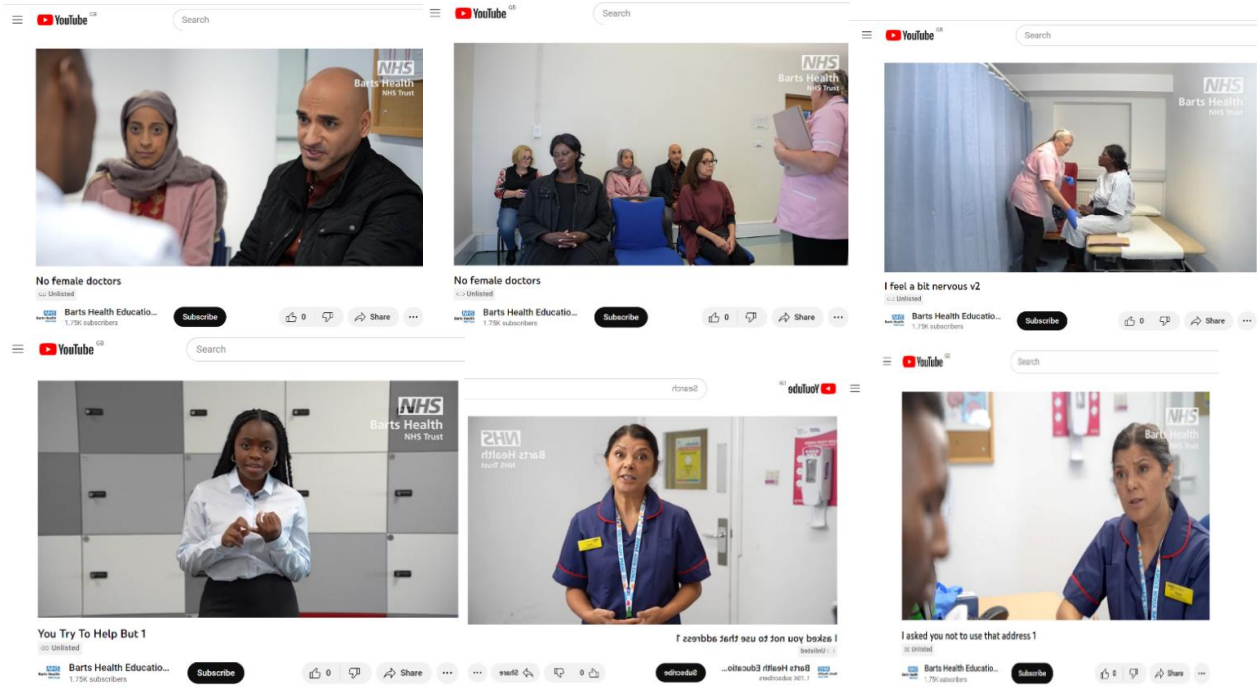
During the pandemic on-line training was introduced and the number of participants increased considerably. It still did not address the issue of volume of staff who required training. In response to this, e-learning packages alongside some classroom sessions was considered a more feasible option.

From our review, we recognised that it was crucial that we are able to demonstrate that:

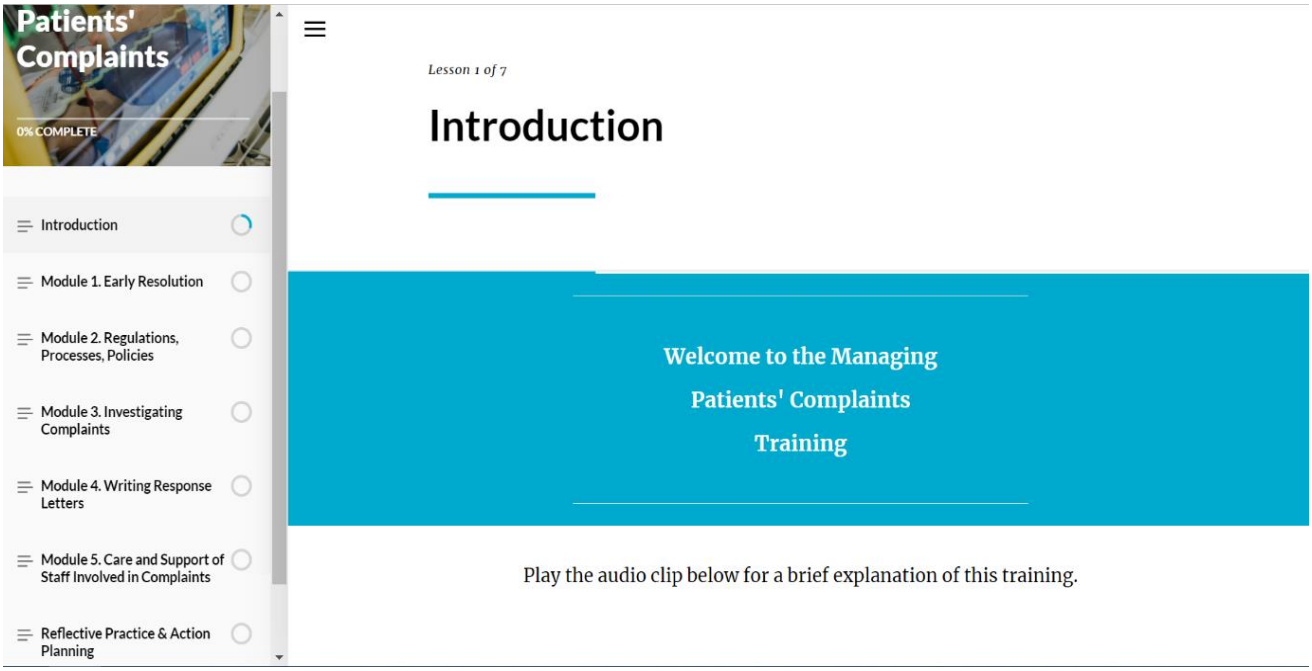
1. all employees of Barts Health are trained to the standard required for their respective roles
2. that our training packages are responsive to changes in local and national complaints management guidelines
3. the impact of our complaints training is seen in the way staff handle complaints
4. the impact of our training is recognised in our patients' description of their experience of the complaints process

With this in mind, two new complaints training courses have now been developed.

Level 1 which consists of a suite of **early resolution** videos demonstrating how concerns about care can begin to emerge and how to locally manage them promptly to prevent unnecessary escalation. This course will feature on all employees learning and development "Wired" profiles. On completion, every employee in the Trust will be aware of the Trust's commitment to resolving concerns promptly and the actions each of us must within our areas of service delivery to address these.



Level 2, the e-learning course on **managing patients' complaints** provides in depth training with various learning styles integrated into the course to keep participants engaged. With 5 modules and an opportunity for reflection and action planning at the end of the course, participants learn about everything concerning early resolution, regulations, investigating, caring for staff during the complaints process and more.



The course has been put together for staff who have operational responsibilities for complaints management. These staff groups include:

- clinicians, band 5 nurses & AHP upwards
- managers
- associate directors with responsibilities for patient care and or governance
- team leaders / supervisors in clinical areas with responsibility for patient care with patient care responsibilities
- hospital governance teams and other staff across the Trust who have hands on management / responsibility for patient care, managing complaints, investigating complaints, coaching teams and delivering patients complaints management training within their hospitals, divisions and service areas. Alongside the e-learning package there will be some classroom sessions to complement the package. This will ensure staff who may find this style of learning more suitable to their learning needs more helpful.

The assessment process will include evidence of reflective learning and an action planning piece to be completed at the end of training.

Alongside the e-learning packages we will continue delivering some classroom sessions, which will focus more intently on cases studies, investigating and writing outstanding complaint responses. These will also be beneficial for staff who prefer the face-to-face method of learning, as indicated in feedback in **table 9** below, received from attendants at previous training sessions.

6.2 Training delivered during the year

During the year, a total of 80 staff from across the Trust were trained in complaints management which was delivered through Microsoft teams and some classroom sessions. The numbers trained this year were fewer than previous years as the number of sessions were reduced as part of transitioning to the new e-learning modules.

Below in **table 9** is some of the feedback from participants.

Table 9.

1. All the sessions were good but steps to address the complaint I enjoyed the most because it was relevant to my role as a clinical Site Manager personally.
2. I am not a fan of Teams Training. I prefer face to face as I feel more engaged and thus contribute more. Also feel that if it were face to face, you could practice writing complaints and receive feedback which would be beneficial. Legislation, timeline information, and complaints procedures were very useful.
3. Good to get an overview of the complaints process. I think I would have benefitted more from a F2F training for this although it was still a good introduction.
4. The clear points about what to consider and include in the process of investigating, meetings and letter writing were very useful.
5. It would be useful to see and discuss examples of bad/poorly written letters and good letters. I know that there are templates but to see real examples and discuss what makes them good is always useful.
6. The trainer gave us a complaint scenario and requested that we demonstrate how we would answer the complaint. This practical example aided my understanding of Barts Health NHS Trust complaint approach, by allowing the group to offer their input and communicate different response approaches which the trainer was able to provide direct feedback to.
7. Very useful and informative.
8. For me, all the sub-topics discussed are relevant and useful in handling complaints. The guide in preparing a good response, drafting a response, responding to the complaint issues which included the structure and style of writing are easy to grasp and comprehend. It would be nice though to add the case study and discuss the appropriate way to respond.
9. Perhaps a more detailed session on how to respond to written complaints and different methods to use can be provided.
10. Information regarding the Trust's policy regarding complaints was very useful. The life cycle of complaints to be aware of for self, patient's and colleagues should one be asked was useful.
11. The six steps to local resolution was helpful as they are simple and straight forward guidance points. Especially when dealing with a complaint live on a ward for example.
12. One or two more complex complaints scenarios would make us more responsible and attentive in our daily work.
13. Provide pre course reading material so we have some idea about the topic allowing us to engage better.
14. The training is very useful and effective as it is.

7. Focus on Parliamentary and Health Service Ombudsman (PHSO)

7.1 The PHSO is responsible for implementing stage 2 of the NHS and Social Care Complaints Regulations. To that end, where complainants remain dissatisfied with actions taken at a local level, they can contact the PHSO for an independent review.

In March 2020 the PHSO temporarily paused processing of complaints to support Trusts across the country with their COVID efforts. 9 months later, PHSO activity across the NHS returned to normal and investigations continued. As a result of the pause, the Trust had no closed complaints last year.

During the year before the pause, a total of **8** of our complaints were investigated and closed. 6 were partially upheld and **2** were not upheld at all. In comparison, this year, **7** of our complaints were reviewed by the PHSO. 1 was returned for local resolution and further discussion between the Trust and the complainant, whilst the other **6** were investigated and either fully or partially upheld. Overall, a decrease in the number of our cases investigated by the PHSO during this year was noted.

The details of the cases investigated and closed during the year are provided in **table 10** below.

Table 10. ID	**Description**
ID 86019 – WXH – Partially upheld	Failings in the nursing care, communication and complaints handling identified. Recommendations were that although the Trust has already identified the failings, this has been acknowledged by the Trust it had not sufficiently demonstrated learning. Therefore, the Trust was advised to write to the complainants to explain actions taken to prevent the failings identified from reoccurring.
ID.49047 - WXH – partially upheld	Failings identified: 1. in relation to the patient's liver biopsy and the method used carry it out 2. in the length of time, it took to organise a local resolution meeting (LRM) Recommendations Trust advised to: 1. acknowledge the failings identified, apologise for the distress and impact of these 2. acknowledge and apologise for the failings in how long it took to arrange an LRM and to produce an action plan, reflecting on why these failings occurred and what actions need to be taken to prevent similar failings 3. pay £5,000 in recognition of the impact these failings had on the patient
ID.101494 – WXH - Upheld	Failings in the care provided, treatment and communication identified. Recommendations included: 1. writing to the patient's wife to acknowledge the failings identified in the report and provide an apology 2. paying the patient's wife £10,000, in recognition of the distress caused

	3. producing an action plan describing the steps taken, or those that will be taken to ensure failings identified will not reoccur.
ID.94820 – NUH – Upheld	Failings in the communication on the ward identified and delay in administering analgesia to the deceased also identified. Recommendations included writing to the complainant to apologise for their experience and to pay a £500 financial remedy in recognition for the injustice suffered.
ID.85735 – SBH – Partially upheld	Although one service failure was identified, the PHSO could not see any evidence that this led to injustice. As a result, no recommendations were made.
ID.73976 – RLH - Partly upheld	Failings identified – 1. Doctors did not appropriately address concerns about proceeding with the PEG-J procedure; 2. the paediatric gastroenterologist's actions during a meeting held. 3. the removal of the patient's diagnosis of EDS from two letters to doctors outside of the Trust without reasons for doing so 4. two volumes of the patient's records misplaced and took too long to share meeting minutes requested 5. delays in the Trust's handling of complaints raised and inadequate response to complaints about safeguarding measures and removing the patient's EDS diagnosis from her referral letters. **6.** No failings identified in how long it took to transfer the patient's care to another trust. Recommendations made included: 1. a further apology, acknowledgement of failings and their impact to be documented in a letter to the patient and her parents. 2. Trust to explain in writing what lessons were learnt from its communication and the quality of listening the patient and her family received 3. Letter to state what the Trust has done or will do to prevent the failings identified from happening in future

7.2 **NHS Complaints Standards Framework – Launch.**

Following the release of the NHS Complaint Standards in early 2021, the PHSO ran a pilot with several NHS organisations between 2021-22 to develop supporting materials, training and guidance that would help the NHS embed the Standards into our complaints management. As a Trust, we took part in the pilot which resulted in a review of our complaints training and our approach to early resolution. In addition, we hosted a visit from the Ombudsman, where we discussed our plans for piloting the framework, our focus on early

resolution of concerns. We also organised a visit to our Patient & Family Contact Centre at Royal London Hospital, where we introduced the Ombudsman to our approach to early resolution of concerns.

As reported in section 6 above, we revamped our complaints training to include emphasis on all staff responsibility for early resolution of concerns at frontline and we reviewed our complaints policy, refreshing our early resolution cycle within the policy.

8. Improvement plans

8.1 Update on 2022 – 23 improvement plan

As always, we set ourselves a number of key priorities. Last year we set ourselves some key priorities, which are listed in **table 11** below. All of them, except one which has been included in next year's improvement plan, as reported in the body of this report were either achieved or are actively underway.

Table 11	Key priority	Responsible	Updates
1	Complaints Seminar/wellbeing event for all complaints managers and handlers across the Trust to improve psychological wellbeing	Central Complaints Team	Carried forward to 23-24 in light of pending new complaints standards framework
2	E-learning response writing training to improve access to training for staff across the Trust and increase quality of responses	Central Complaints Team	Achieved. Reported in section 5
3	"Unknown" complaints category review and recoding	Central Complaints	Pending procurement of new risk management system.
4	Complainants' demographic data / ethnicity focus to help us understand how equitable access to our complaints processes are for the diverse communities we serve.	Central Complaints Team, Hospital Governance teams & Complaints Management Improvement Group	Achieved. Reported in section 2.3 above
5	Individual Hospital Annual reports to be produced and presented at Hospital Executive Boards	All Hospitals' Heads of governance	Achieved. Appendix 1-4,
6	Quarterly Audits - Complainants Satisfaction - Response quality audits.	Central Complaints Team	Achieved. Reported in section 6

7	Peer review of complaints processes.	Central Complaints Team, Heads of Governance & Improvement Group	Achieved. Reported in section 5

8.2 Improvement plan for 2023 – 2024

As part of our continued drive to improve patients' experience of our processes and the quality of our complaints management across the Trust, each year we agree an improvement plan. The plan encourages a focused and collaborative approach, through our complaints management improvement group (CMIG) to ensuring quality is embedded firmly at the centre of our processes.

The key areas of focus for the coming year are outlined in **table 12** below.

Table 12	**Action**	**Lead**	**Timeline / By when**
1	Each hospital to undertake a deep dive into complaints handling in their divisions and identify actions targeted at recurring themes	Hospital Heads / Associate Directors of Governance	Nov 2023
2	Explore opportunities from the Family Contact approach used during the pandemic to be incorporated systematically into our model to ensure that we are responding to issues as quickly as possible	Director of Quality Governance and Hospital DoNs	October 2023
3	Individual Hospital review of executive level response "sign off" process to improve performance	Hospital DoN & Hospital Heads of Governance	November 2023
4	Hospital process reviews to ensure consistency, improved quality of responses, as well as oversight and accountability at executive level across the Trust.	Hospital DoN & Hospital Heads of Governance	September 2023
5	Quarterly reporting of PHSO cases to the Board as well as annual reporting schedule, as part of patient experience reporting cycle	Central Complaints Team	August 2023 onward
6	Quarterly complainant satisfaction and response quality audits	Hospital Heads of / AD for Governance	June 2023 onwards
7	Use existing risk management systems to aid collating data on Patient experience projects	Heads of Patient Experience &	September

	which address complaint themes	Central Complaints Team	2023
8	Launch of new complaints training modules and increased visibility across the Trust	Central complaints Team	August 2023
9	Develop “early resolution” metrics for addition to the new risk management systems when the system is procured	Central Complaints Team & Hospital Patient Experience Leads	March 2024
10	Complainant demographic data quality review and data collection improvement	Heads of / AD for Governance	January 2023
11	Using PEX principles to improve complainants’ satisfaction	Central Complaints’ Team	March 2024

NHS
Barts Health
NHS Trust

Report to the Trust Board: 12 July 2023	TB 49/23a

Title	Safeguarding Annual Report 2022/23
Accountable Director	Chief Nurse
Author(s)	Clare Hughes, Associate Director for Safeguarding
Purpose	To update the Trust Board on progress against the delivery of the safeguarding adults and children's activity in the Trust in line with national guidance and approve he recommendations.
Previously considered by	Integrated Safeguarding Assurance Committee; Quality Board

Executive summary

Barts Health NHS Trust has a statutory responsibility to safeguard and promote the welfare of children and adults. The purpose of this combined Safeguarding Children and Adults Annual Report is to provide assurance to the Board against statutory elements of the Safeguarding Adults and Children's agenda and update on the progress of objectives in 2022/23. Notable achievements over the past year include:

- Devolvement of the safeguarding team took place in October 2022. Safeguarding is now operationally managed at hospital level and is in the Director of Nursing portfolio.
- Establishment of Associate Director of Safeguarding role at Group level
- Further develop the Trust wide safeguarding dashboard to support assurance at hospital and trust board.
- Continue to strengthen the visibility of safeguarding at hospital-based meetings.
- Feasibility proposal to invest in the safeguarding workforce was agreed and 4 new safeguarding advisor posts for adults created. All but one post appointed to final post being recruited too.
- Named Nurse for Child Death has been recruited. The post has had very positive impact both internally and externally, however it is only fixed term.

Key Issues and risks identified within the report include:

- Training needs analysis (TNA) for safeguarding children reviewed and applied to WIRED has had significant impact on compliance at Level 2 and 3. Recovery plan in process.
- Safeguarding TNA for adults needs to be reviewed in line with intercollegiate guidance. It is expected to have a significant impact in the same way children's TNA did. Proposal and action plan to be developed.
- Safeguarding children supervision remains at same level as last year and is currently below compliance.
- Lower than expected referrals via the allegations of abuse and neglect made against

staff process.

- Named Nurse for Child Death role does not have permanent funding, which needs to be sourced
- There has been a delay in the 'go-live' of the safeguarding adults alert on CRS due to patient flow issues identified

Safeguarding referrals:

- Reasons for referrals to children social care from maternity include: domestic abuse and previous children social care involvement.
- Reasons for referrals to children social care include child mental health and parental concerns such as substance misuse and mental
- Top themes for safeguarding adults are: neglect/acts of omission, self-neglect and physical abuse

The report includes updates on safeguarding audit activity, partnership working, PREVENT, domestic abuse and reducing inequalities, and progress against 2022/23 objectives and plans for 2023/24

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

Risk and Assurance	The report sets out the current key risks to the Safeguarding agenda and how they are being mitigated.

Legal implications/ regulatory requirements	Safeguarding Children is governed by a range of legal and regulatory requirements including: "Working Together to Safeguard Children (2018)" which sets out how organisations and individuals should work together to safeguarding and promote the welfare of children and young people in accordance with the Children Acts 1989 and 2004: the Care Quality Commission's Essential Standard of Quality and Safety Outcome 7 (Regulation 11) on safeguarding people who use services from abuse

Action required

The Trust Board is asked to review and discuss the Safeguarding Children and Adults Annual Report prior to submission for approval at the Quality Assurance Committee.

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 12 JULY 2023

SAFEGUARDING CHILDREN AND ADULTS ANNUAL REPORT 2022/23

INTRODUCTION

This combined Children and Adults Safeguarding Annual Report informs the Trust Board and Partnership Boards on progress made in delivering the Safeguarding agenda during the period April 2022 - March 2023.

Directors of Nursing for Newham University Hospital (NUH), Whipps Cross Hospital (WXH), St Bartholomew's (SBH) and The Royal London Hospital (RLH) are responsible for reporting to their Hospital Executive Boards. This overarching report reflects trust wide activity.

The objectives of this report are to provide:

- Assurance that the Trust continues to fulfil its statutory responsibilities in relation to Safeguarding Children as stated in Section 11 of the Children's Act 1989/2004 and the Care Act 2014
- Assurance that the Trust is compliant with Care Quality Commission (CQC) Fundamental Standards (Safe, Effective)
- An update to internal and external stakeholders on the developments in relation to safeguarding
- Identify areas of risk in relation to its statutory responsibilities during the reporting period

OVERVIEW

Barts Health provides secondary care to the local communities within North East London (NEL) and specialist tertiary care to patients beyond NEL. The Trust has a responsibility to provide effective and seamless services directly to all patients and indirectly by providing services to family members.

Staff have a responsibility to safeguard and promote the welfare of all patients and work in line with Trust Safeguarding Policies. All patients are best safeguarded when professionals are clear about what is required of them individually and in how they need to work together. The Trust's safeguarding team promotes a 'Think Family' approach.

National Statutory Guidance underpinning organisational responsibilities:

- Children's Act 1989 provides the legal framework for the protection of children from harm
- Children Act 2004, Section 11 imposes a specific duty on NHS organisations to make arrangements to safeguard and promote the welfare of children
- Mental Capacity Act 2005
- Care Act 2014
- Domestic Abuse Act 2021
- Children and Social Work Act 2107; Section 16 adds a new section to Children Act 2004,
- Working Together to Safeguard Children: A Guide to Interagency Working to Safeguard and Promote the Welfare of Children (August 2018), provides guidance on legislative requirements and expectation on individual services to safeguard and promote the welfare of children and provides a clear framework for Local Safeguarding Children Boards (LSCB) to monitor the effectiveness of local services
- Safeguarding Vulnerable People in the Reformed NHS. Accountability and Assurance Framework (2019)

- Pan-London Policies and Procedures for Adult Safeguarding
- London Child Protection Procedures
- Intercollegiate Documents: Adults 2018 and Children 2019

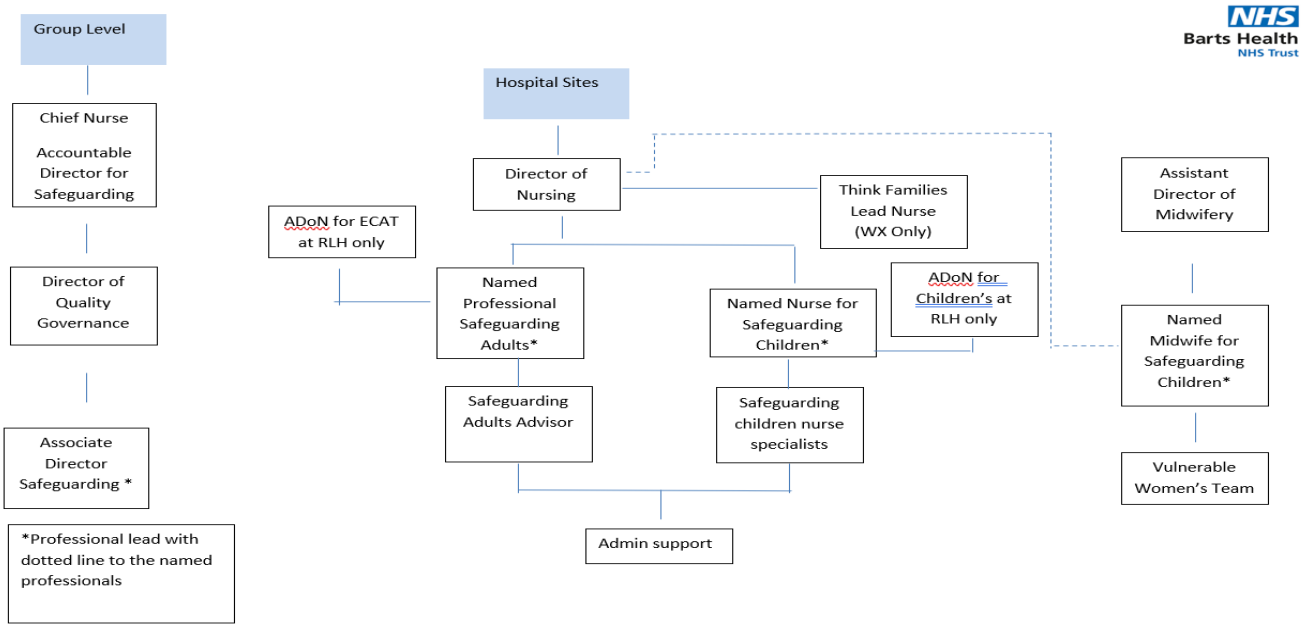
As well as complying with National Guidance, Barts Health complies with regulations as identified by the Care Quality Commission (CQC) to ensure babies, children and vulnerable adults are effectively safeguarded.

SAFEGUARDING TEAM STRUCTURE

The Chief Nurse is the Trust's Executive Lead for Safeguarding with day-to-day leadership devolved to the Director of Quality Governance. Directors of Nursing hold executive responsibility for safeguarding at a hospital level. Safeguarding team members are based in each of our hospitals except St Bartholomew's (SBH) whose service is provided by the RLH team.

The safeguarding model was reviewed along with other Group wide services with the decision to devolve the operational management to the hospitals. In October 2022 the hospital based safeguarding teams were transitioned and safeguarding now sits within the Director of Nursing portfolio. An Associate Director of Safeguarding role was established and is part of the Chief Nurse portfolio, this role will play a key role in the delivery of the Safeguarding Agenda throughout the trust in accordance with national and local guidance and legislation and be responsible for ensuring that comprehensive and robust arrangements are in place for safeguarding in all services. A memorandum of understanding has been produced to support the delivery of the safeguarding agenda across the Trust.

The Safeguarding Structure across the Trust:



The team supports staff to deliver effective interventions to identify and respond to safeguarding concerns. This is achieved through training, supervision, and supportive advice to enable all staff to achieve competencies appropriate to their role and relevant national/local guidance.
The capacity within the safeguarding team throughout the course of 2022/23 has been impacted by vacancies, long term sickness and increasing activity. During this period the team has provided cross site cover and have supported each other throughout these challenging times.

A feasibility proposal submitted to the Investment Steering Committee was approved and as a result four new posts were agreed. These posts were to support the adult establishment and also the creation of a safeguarding adult and children advisor post based at SBH which is the first time they have had dedicated safeguarding support based at the hospital. All but one post has been appointed to with the final post being actively recruited to.

SAFEGUARDING GOVERNANCE

Our governance structure supports a strategic and operational response to safeguarding. The Integrated Safeguarding Assurance Committee (ISAC) chaired by the Chief Nurse, receives assurance via hospital safeguarding meetings, chaired by the DoNs, and the Trust-wide operational group chaired by the Associate Director for Safeguarding. ISAC monitors compliance against strategic priorities and promotes engagement with our local partners. The hospital meetings monitor site assurance including action plans from serious incidents, child practise reviews (CSPR), serious adult reviews (SARs) and domestic homicide reviews (DHRs).

ISAC reports to the Quality Board and Group Executive Board. The Quality Assurance Committee undertakes assurance on behalf of the Trust Board.

During the current reporting period a safeguarding dashboard has been embedded which informs ISAC and the external partners of high-level safeguarding assurance and activity.

SAFEGUARDING TRAINING

Safeguarding Training Compliance		
	Children	Adults
Level 1	**88%↑**	**88% ↑**
Level 2	**75% ↓**	**87% ↑**
Level 3	**56% ↓**	**49% ↑**

Target compliance levels for the Trust are set at 85% and it is noted that the compliance for Level 2 safeguarding children training has dropped below the target. Level 3 compliance is significantly below the 85% target for both adults and children.

Level 1 and 2 for both Adults and Children is accessed via WeShare and the level 2 module for children has been updated in line with intercollegiate requirements.

The training needs analysis (TNA) for safeguarding children was completed and applied to WIRED in Q3, this has a significant impact on the compliance for both L2 and L3. Due to the impact on compliance the training is now 'blue' on WIRED, which is for new or significantly changed training TNA and resulted the training being excluded from the main body of statutory and mandatory reporting for 1 year. This is in line with the Statutory and Mandatory Training policy. The safeguarding children's teams have doubled the number of face-to-face trainings each month in order to meet 85% compliance by Q3 2023-24. Non-compliant staff and their managers have been sent reminders to complete their training.

Delivery of L3 training for adults has remained a challenge due to vacancies within the workforce. Recruitment has now taken place and it is expected that face-to-face training will be available across all hospitals by Q2.

The TNA for safeguarding adults will be reviewed during Q1 2023-24, as with children's it is anticipated to have a significant impact on the compliance. There will be a Trust wide action plan and trajectory to improve compliance which will be monitored at hospital and Trust level.

The development of a combined 'Think Family' has been delayed from the work plan for 22/23, this will be actioned within Q1 of 2023/24 with the aim to pilot the new training in Q2.

The Trust Board did not receive an update on safeguarding training in 22/23 there is on-going discussions to arrange a date before the end of Q2 2023/2.

SAFEGUARDING POLICIES

Safeguarding policies that have been reviewed and amended:

- **Training policy for Safeguarding Children** – the policy was amended in 2020. TNA has been updated and was applied to WIRED in October 2022.
- **Sudden Unexpected Death of a Child Policy** – Policy has been ratified at Trust Policy Committee and is now live on We Share.
- **Mental Health Act Policy** – the policy has been amended and ratified and is live on We Share

The Protection of Adults at Risk of Harm Policy has been reviewed and amended. It is due to be presented to the Trust Policy Committee in April 2023.

The following policies are due for review in the following reporting period:

- The Chaperone Policy
- Management of Allegations of Abuse or Neglect Against Professionals
- Responding to Domestic Abuse
- Missing and/or Absconding Patients
- Therapeutic Restraint

SAFEGUARDING SUPERVISION

Supervision for safeguarding children is part of statutory and mandatory requirements and is an essential aspect of ensuring that staff are confident and supported in their work with vulnerable children and families (Working Together 2018). Staff who are mapped to need level 3 children's training (with some exceptions) are required to have yearly supervision, this is expected to increase to twice yearly for targeted groups.

Current compliance is at 69%, significantly below the target of 85%. Potential risks of staff not having effective supervision are identified as;

- Staff not being adequately supported with emotionally challenging situations
- Personal feelings and beliefs having impact on decision making process
- Potential for missed opportunities to identify and respond to safeguarding situations

Supervision can be achieved in several formats: attendance at Mortality and Morbidity meetings; formal group sessions; informal/ad hoc supervision when seeking advice in relation to a caseload. The safeguarding team provide regular group supervision sessions across the hospitals although there have been some challenges to release staff to attend the sessions due to capacity in their clinical areas.

Further mitigations in place to counteract the risks are:

- Named Nurses and Midwives developed an insight to supervision training programme for the safeguarding children advisors

- Barts Health have led on developing group supervision for specialists nurses for safeguarding children across NEL which has now been in place for a year and has received very positive feedback from those staff who attend.
- Out of hours support from the on call Named Nurse for Safeguarding
- MDT meetings held in high-risk areas on a weekly basis

Tavistock supervision was withdrawn for the named nurses and midwives in September 2021, we have been fortunate to secure external supervision for this group of staff which has been positively received. The named Doctors have continued to receive their supervision at the Tavistock which is group supervision with other named Doctors across London.

Within adult safeguarding there is not a statutory requirement for staff to attend formal supervision however as with children's the safeguarding professionals provide ad hoc/informal supervision with staff members by discussing/supporting staff with safeguarding cases. The named professionals for safeguarding adults currently receive supervision from the designated professionals within the ICB.

The named professionals for safeguarding adults are going to review the NEL wide supervision model for the nurses specialists for safeguarding children to see if a similar model can be embedded for the safeguarding adult advisors across the NEL network.

All named professionals also have access to the Associate Director for Safeguarding for both informal and formal supervision.

SERIOUS CASE REVIEWS AND SERIOUS INCIDENTS

During the reporting period Barts Health has contributed to a number of Rapid Reviews (RR), Child Safeguarding Practice Reviews (CSPR), Safeguarding Adult Reviews (SARs) and Domestic Homicides (DHR). Named professionals across the safeguarding team have actively participated in the reviews and where required clinical teams have been involved in the practitioner events to explore the learning. All reviews ae ongoing.

Number of cases by category	
CSPR	2
SAR	4
DHR	10

Themes arising from reviews are set out below:

- Early identification of concerns and escalation
- Professional curiosity
- Adverse childhood experiences
- Recording of visitors
- Think family approach - identification of family members and siblings
- Robust and concise record keeping
- The importance of the voice of child/ vulnerable patient
- Information sharing
- Monitoring the movement of patients around the hospital

Where there has been immediate learning for the Trust this has been addressed and actions have been put in place:

- Safeguarding training has been updated to reflect the findings from reviews

- Targeted work with specific teams has taken place on assessing and managing risk Improvement in documentation regarding safeguarding issues and liaison with agencies

SERIOUS INCIDENTS

Staff are asked to complete an SI proforma if they think an incident may have resulted in a serious incident, these proformas are then reviewed at the weekly hospital SI meetings. The meetings are multidisciplinary and allow staff to explore the incident to decide the most appropriate action or investigation type.

Outcome of SI proforma - Children	2020/2021	2021/2022	2022/2023
Managed via Datix	8	12	24
StEIS (externally reportable SI)	1	2	3
Concise	4	1	1
M&M Meeting	1	4	1
Specialists team review	1	4	2
Total	15	23	31

Outcome of SI proforma - Adults	2020/2021	2021/2022	2022/2023
Managed via Datix	5	1	2
StEIS (externally reportable SI)	3	5	2
Concise	9	2	5
M&M meeting	0	1	1
Specialist team review	2	4	6
Review meeting only	2	0	0
Total	21	13	16

Themes identified from the SIs relate to:

- Discharge concerns
- Absconding patients
- Allegations of abuse against staff members
- Aggressive patients
- Missed safeguarding/lack professional curiosity
- Child Death makes up the majority of the SI proformas for children, this are all deaths that were not expected

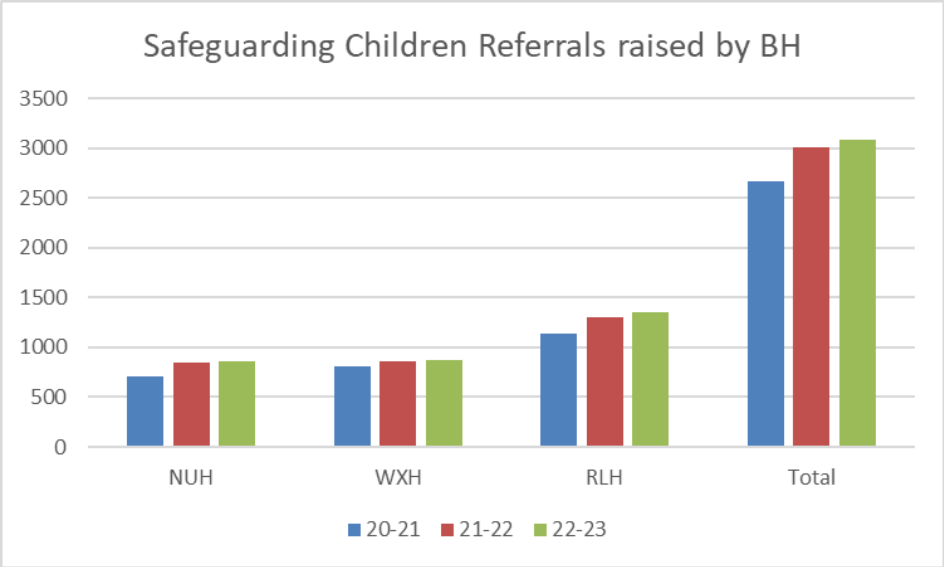
Early learning from these SIs relate to:

- Communication
- Discharge
- Chaperone policy
- Documentation
- Professional curiosity

SAFEGUARDING ACTIVITY

The Trust serves several local authorities (LA) with clear processes in place for making referrals to the core LA within the relevant geographical area for the referring hospital. The hospital based safeguarding teams

collect data regarding the number of referrals and alerts made by BH staff where there are safeguarding concerns. The tables below show the number of referrals that have been raised against and by the Trust, with comparable data included for the previous 2 years.



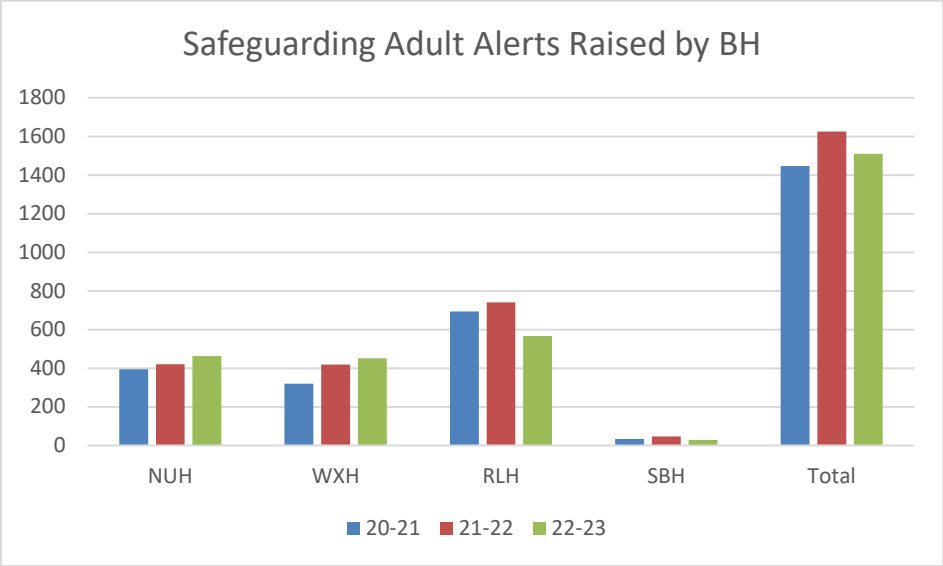
There has been a notable change in the reasons for referrals compared to previous years. Child mental health has remained the highest reason for referrals. However there has been an increase in the number of children and young people who are experience mental health concerns with increasing levels of complexities, this has had the largest impact at NUH. For the first time in a number of years the number of referrals made due to exploitation (which includes assaults) has dropped to the 4th highest number of referrals. Within maternity female genital mutilation was the highest number of referrals in 21-22, in this reporting period this has now changed to 'other' which includes issues such as police involvement, relinquished babies and late bookers.

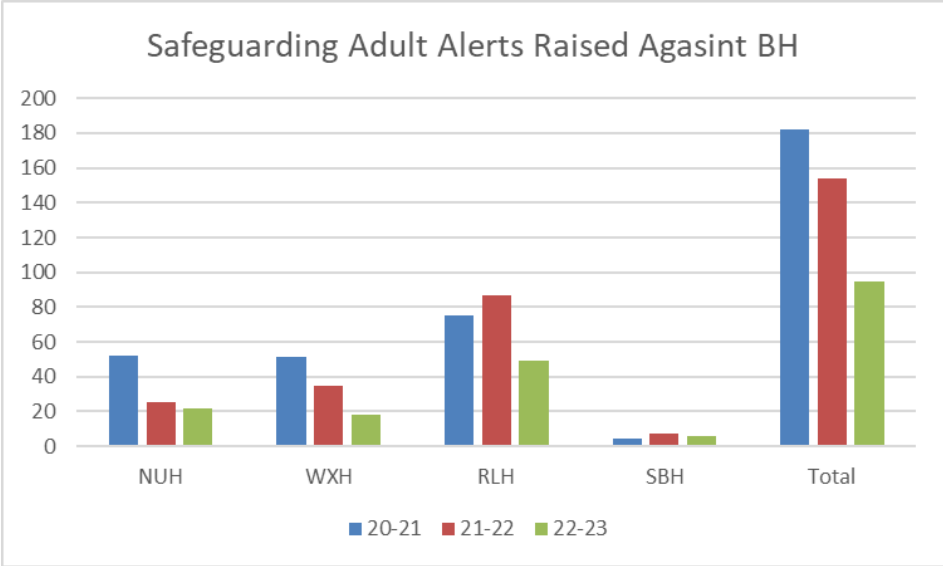
The top 4 reasons for referrals to children social care are:

- Child mental health 24% of referrals
- Other 20% of referrals (such as section 85, housing issues, young carers, early help)
- Parental Concerns 19% of referrals
- Exploitation (that includes assault) 17% of referrals Exploitation

For maternity the top 4 reasons for referrals to children social care are:

- Other 26% of referrals (including homeless, non-engagement and late booker)
- Domestic abuse 25% of referrals
- Previous children social care involvement 13% of referrals
- Maternal mental health 9% of referrals





Within adult safeguarding there has been an overall decrease (9.5%) in the number of safeguarding alerts. Despite both WXH and NUH both seeing a 8% and 10% increase in the number of alerts raised.

The top reasons for alerts being raised are similar to 21/22 with the only change being seen in the number of physical abuse alerts raised.

The top 4 themes for adult alerts:

- Neglect/acts of omission 44% of alerts
- Self-neglect 23% of alerts
- Physical abuse 11% of alerts
- Domestic abuse 9% of alerts

There has been a total of 95 safeguarding adult concerns raised against Barts Health by external agencies. Themes and outcomes are monitored via hospital safeguarding meetings and raised by exception to ISAC when required.

SAFEGUARDING AUDITS

Audit activity and outcomes across the hospitals, completed by the safeguarding team has been identified in the hospital annual reports. Audit activity covered:

- Communication with external agencies
- Use of body maps in safeguarding children cases
- MCA and DoLS
- SAPAT (Safeguarding adult partnership audit tool)
- Paediatric liaison
- The voice of the child/user
- The vulnerable women's guideline within maternity
- The recording of Was Not Brought (WNB) to appointments.

Key findings:

- Compliance with the vulnerable women's guideline is maintained across the hospitals at over 85%
- Voice of the child was only present in 39% of referrals audited.
- Voice of adult was identified in 60% of safeguarding adult alerts raised.
- There is evidence that suggests there is good communication between agencies where safeguarding concerns are raised.
- A gap in MCA knowledge and Dols process has been identified. The majority of significant harm safeguarding children cases are identified by clinical teams however correct processes are not always followed.
- Limited assurance that WNB processes are being followed.

ALLEGATIONS AGAINST STAFF RELATING TO SAFEGUARDING CONCERNS

The Trust has a policy for managing allegations of abuse and neglect made against staff members.

The role of the Local Authority Designated Officer (LADO) is set out in HM Government guidance - Working Together to Safeguard Children 2018. Within HR, the Director of People works closely with the safeguarding team to ensure there is appropriate HR representation throughout the LADO process.

Each borough has developed their PiPoT (person in position of trust) and these processes are being embedded into practise within the local authorities and the Trust. The review of the Trust policy Managing Allegations of Abuse or Neglect Against Staff will ensure both PiPoT and LADO processes are reflected.

During 2023/23, fifteen cases have been raised with the Associate Director of Safeguarding. Whilst a number of these allegations met the threshold for an Allegation Against Staff and Volunteers (ASV) meeting, formal disciplinary processes have been limited due to either the concern being managed locally and not meeting disciplinary threshold or cases are still under police investigation. In all cases, a risk assessment has been completed and mitigation has been put in place to ensure the safety of patients, staff and the trust whilst the cases are being investigated. Staff have either been moved to non-patient facing duties, suspended or remained in their current roles with enhanced support and/or supervision.

There is an ongoing issue in relation to the low number of concerns raised for the size of Trust. Potential reasons are cited as:

- Staff are not informing their managers when there is a concern in their private life that could affect them professionally
- Managers are not aware of the correct process and managing all cases locally
- Business partner leads are not aware of the correct process and not contacting the Associate Director of Safeguarding

The Head of Investigation services has recently contacted the Associate Director of Safeguarding to explore how the investigation process can be strengthened when there is possible safeguarding concerns.

Safeguarding has now been added to the investigation process pathway and as a result there have been several contacts to ask for support and advise in relation to safeguarding. To further strengthen the links between investigation/HR and safeguarding there are plans for the Associate Director for Safeguarding to be invited to business partner meetings to raise awareness.

The 'Allegation Against Staff' policy is due to be reviewed and amended during 23/24 reporting period.

PARTNERSHIP WORKING

The Trust continues to demonstrate a high level of commitment to partnership working through active participation in key external meetings. Barts Health has representation on four Safeguarding Partnership Boards (SPB) and Safeguarding Adult Boards (SABs) (Newham, Tower Hamlets, Waltham Forest and Redbridge). The boards continue to meet virtually, enabling the ongoing participation of Barts Health at these meetings. Each partnership is starting to explore moving back to face to face meetings and have held a number of in person partnership events which Barts Health staff have attended.

The hospital DoNs or nominated representation are members of the partnership boards for their local boroughs. The named professionals at each hospital attend the subgroups of the partnerships. The Associate Director for Safeguarding is actively involved with the partnerships across the Barts Health footprint.

As part of the newly formed NEL ICS, the safeguarding structure was reviewed. The Barts Health safeguarding team continues to develop strong partnership working at Place. The Associate Director for Safeguarding meets regularly with the Associate Directors for Safeguarding within NEL ICB. There are on-going discussions regarding the ICB safeguarding forum being inclusive of safeguarding professionals across North East London partners.

Key staff from Barts Health have been involved in forums to discuss and plan the model for the designated Doctor post across NEL.

CHILD DEATH REVIEWS

The Named Nurse for child death post was recruited into from August 2022. The post was initially for an 8 months fixed term, this has been extended until 31st October 2023, with plans to complete a feasibility proposal for a substantive post in the new financial year. This role has received positive feedback both internally and externally and has been seen as a vital in ensuring the Trust meets their obligations in managing child deaths whilst supporting bereaved families and clinical teams.

The current post is hosted by RLH but holds a Trust wide function and works very closely with the Associate Director for Safeguarding for professional support and supervision. Links have been made with the medical examiners to ensure processes are aligned and to reduce duplication of work.

The child death review (CDR) hub for Waltham Forest, Newham, Tower Hamlets and City and Hackney (WELC) hosted by Newham council has now been operating for 1 year. The hub is currently working to secure an extended contract for the family liaison officers working out of the CDR hub employed by Child Bereavement UK.

Barking & Dagenham, Havering and Redbridge CDR hub are reviewing their team, as it has been recognised that there is a gap in service provision with this hub team not including a family liaison officer to support families.

The review of child death processes and pathways across NEL was completed and a report issued in July 2022, this highlighted the need for a scene of collapse team that can work across NEL.

A task and finish group was created, including both CDR hubs and the CDR nurses with Barts Health and the Homerton to review and standardise the standard operating procedure for child death across NEL.

Ongoing work is needed with partner agencies across NEL to address unsafe sleeping practices and promote all system partners training surrounding conversations with families regarding safe sleeping in line with The Lullaby Trust and the NMCD report on SUDIC published in December 2022.

Child Deaths per hospital – April 2022 – March 2023

Hospital	Q1	Q2	Q3	Q4	Totals	Trust %
Newham	2	3	2	6	13	**20%**
St Bartholomew's	0	2	0	0	2	**3%**
The Royal London	11	11	6	3	31	**47%**
Whipps Cross	1	8	6	5	20	**30%**
Totals	**14**	**24**	**14**	**14**	**66**	**100%**

EXTERNAL INSPECTIONS

Maternity services were inspected by CQC within this reporting period. The inspection found that safeguarding processes were safe, and staff know how to access support and advice as required. The training and supervision compliance was recognised as being below the target of 85%

PREVENT

Barts Health was identified as an outlier in relation to the lack of referrals compared to other NHS organisations. As a result, the NHSE PREVENT lead ran a bespoke workshop for the Trust in September 2021 and this was repeated again in November 2022, unfortunately the attendance was below expected. The workshop focussed on the reasons why an individual is vulnerable to exploitation/radicalisation and how staff can recognise potential risks.

Compliance with the PREVENT training is 89%

DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

The Deprivation of Liberty Safeguards (DoLS) ensures adults who cannot consent to their care are protected whilst in hospital if there is a risk that their care and treatment could deprive them of their liberty. During Q1 it was noted there had been a 65% decrease in the number of DoLs applications compared to Q1 20-21. The hospitals highlighted this within safety huddles and some of the sites completed audits. These processes have had a positive impact and the number of DoLs applications has increased and in Q4 there were 239 DoLs applications which is what we would expect to see in a large NHS Trust.

An internal audit was commissioned reviewing MCA/Dols processes to inform the Trust in potential gaps in preparation for the implementation of LPS. At the time of completing the annual report the findings of the audit have not been shared and are expected to be available in Q1 23-24.

LIBERTY PROTECTION SAFEGUARDS (LPS)

The Mental Capacity (Amendment) Bill passed into Law in May 2019, replacing the existing Deprivation of Liberty Safeguards (DoLS) with Liberty Protection Safeguards (LPS). A significant change is the inclusion of children aged 16-17 within its scope. Care is still to be provided in line with the Mental Capacity Act (2005).

The Code of Practise (CoP) was consulted on during the summer of 2022 we are still waiting for the final CoP to be published with an implementation date to be confirmed.

DOMESTIC ABUSE

Domestic Abuse referrals have not risen in the same rate as they did during 21-22. It remains the second most common reason for referral in maternity services but has dropped from 3rd to 4th highest reason for adults overall. NUH and WXH continue to be supported by Independent Domestic Violence Advocates (IVDAs) based part time within the hospitals, with a youth IVDA at the Royal London Hospital. Solace also supports adult victims within Tower Hamlets and this is managed remotely from within the hospital. There are on-going discussions with Tower Hamlets and Solace regarding a collocated IDVA for adult victims at RLH.

Numbers of domestic homicide reviews (DHR) has significantly increased in 22/23 particularly in London Borough of Newham and the Trust are actively involved in ten reviews. A number of these reviews are expected to be completed within the first half of 23-24, these will be monitored at the appropriate hospital meetings.

Early learning for the Trust from the DHRs is:

- Professional curiosity
- Documentation
- Education
- Partnership working including referral processes.

RISKS AND ISSUES

The impact of operational pressures and safeguarding team capacity has resulted in reduced compliance with both level 3 training and supervision as highlighted earlier in the report. The revised TNA has also had a significant effect on compliance with safeguarding children training. This could cause potential risks that staff are not equipped with the training and knowledge to identify possible safeguarding cases. This risk is mitigated by:

- Ensuring the safeguarding team are available to support and advise staff
- The on-call service for safeguarding children meaning all staff have 24 hour access to named nurse/ head of safeguarding

The TNA for safeguarding adult training needs to be reviewed and updated to reflect the intercollegiate guidance. It is recognised that this will have a negative impact on training compliance. An options paper for how the risk will be mitigated whilst ensuring increased compliance for training will be produced and shared at ISAC and NMAHP for Leadership engagement and approval.

There has been a delay in implementing the safeguarding adult alert form on CRS as there were issues identified with patient flow within CRS. A workshop with key staff from safeguarding, digital clinical teams and CRS is to be arranged in Q1 with aim to implement the new process by the start of Q2. In the meantime, the referral tracker for safeguarding adults has become unstable and as such the Named Professionals have developed a work around excel database.

Liberty Protection Safeguards implementation – there has been further delay in confirmation of an implementation date for LPS. Through audit it has been recognised there are gaps in knowledge of the MCA and DoLs processes. There is expected to be an action plan from the Internal audit which will inform and support the increased awareness and knowledge.

The Named Nurse for Child Death - the Trust were given fixed term funding which ends in April 2023, whilst we have managed to extend this post for a further six months a feasibility proposal needs to be completed to secure permanent funding for this vital role.

The devolvement of the safeguarding team is still in its infancy, to support the transition a memorandum of understanding has been produced and an internal audit has been commissioned to be completed in Q1/2. The ToR for the Trust operational meeting has been reviewed and strengthened to support the Trust wide functions for safeguarding.

The number of allegations against professionals, where safeguarding is a factor, reported to the Associate Director for Safeguarding is lower than expected for an organisation of this size. There are on-going discussions with HR business partners and the internal investigation team to strengthen the processes and ensure there is appropriate safeguarding oversight when required.

REDUCING INEQUITY

The safeguarding team captures data from referrals to inform and support an understanding of potential inequity in issues affecting children and adults. It was a priority for 21/22 to analyse this information and use it to inform planning within our hospitals and the wider system. A challenge is to decrease the number of referrals where the ethnicity has not been recorded. This remains a challenge and staff are reminded through training and feedback the importance of completing ethnicity data.

In maternity the top three categories of ethnicity recorded of the patients where there is a safeguarding concern raised is:

1. White
2. Black
3. Asian

For children, the ethnicity for referrals to children's social care differs across the hospitals. However, this is not always reflective of the census for the borough for example young people from an Asian background account for the highest number of referrals followed by young black people. The Newham census shows there is a higher percentage of white people who live in the borough.

For all hospital sites the data shows us there is a higher number of 11-15yr olds referred to children social care and overall from all age groups there are more females than males referred. This data correlates with the information we know about young people suffering with mental health issues that attend the hospitals in crisis.

The data for safeguarding adult alerts raised shows the highest number of alerts raised are for male patients over the age of 60 and identify as white this includes all patients who identify as being white.

ACHIEVEMENT OF 2022/23 WORK PLAN

Most of the work plan for 22/23 has been completed or partially completed. Those that have been partially completed are expected to be fully met within the first half of 23/24.

The following objectives were achieved:

- Review of the Leadership of the safeguarding adults and children team to move to a devolved model for safeguarding.
- Further develop the Trust wide safeguarding dashboard to support assurance at hospital and trust boards.
- Continue to strengthen the visibility of safeguarding at hospital-based meetings.

The following objectives have been partially achieved:

- Embedding the safeguarding adult referral and DoLS forms in CRS. The form has been approved by the change team for CRS and we are awaiting a go-live date.
- To ensure there is a consistent, supportive and equal pathway for all children and young people and their families when their child dies in our care. There is current a Named Nurse for Child Death in post however only on fixed term funding.
- Strengthen partnership working to shape and develop safeguarding services in Northeast London ICS Strengthen the use of inequity data to support and inform service delivery and change

PLANS FOR 2022/23

Each hospital has a work plan for the coming year, aligned with the strategic priorities for the trust and taking account of local differences.

Below are a summary of the plans moving forward into the next reporting period:

	Objective	Action Owner	Lead	Implementation Date
1	To have a standardised audit programme and audit tool for key safeguarding issues across the Trust.	Associate Director of Safeguarding	Operational Safeguarding meeting	July 2023
2	Review of safeguarding adults training TNA and development of action plan	Associate Director for Safeguarding	Director of Quality Governance Associate Director for Safeguarding and Named Professionals for Safeguarding	September 2023
3	Standardised training presentation for all levels of safeguarding training	Associate Director for Safeguarding	Operational Safeguarding meeting	July 2023
4	Internal Audit of Safeguarding post devolvement	Director of Quality Governance	360 Assurance Team	June 2023
5	Implementation of Action Plan from Internal Audit for MCA/DOLs/LPS	Group Chief Nursing Officer	Director of Quality Governance Associate Director of Safeguarding Directors of Nursing	Throughout 22-23
6	Safeguarding alert form on CRS to be embedded	CNIO & Director of Development	Director of Nursing	July 23

	into practice			
7	Strengthen the use of inequity data to support and inform service delivery and change.	Director of Public Health	Public Health Team Associate Director of Safeguarding	February 2024
8	Embed safeguarding in HR investigations where appropriate	Director of People	Deputy Director of People and Associate Director of Safeguarding	September 2023