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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 1 November 2023 at 11.00am in Room 5, Education Centre, Mile End Hospital,
Bancroft Road, London E1 4DG
Scheduled to end by 13.30

AGENDA

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

		Paper TB	Lead	Time
1.	**WELCOME**		Rt Hon J Smith	11.00
2.	**APOLOGIES FOR ABSENCE:** Ms J Nelson-Ferns			
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 13 September 2023 and review the action log appended to the Minutes	60/23	Rt Hon J Smith	11.00
5.	**MATTERS ARISING** To consider any matters arising from the Minutes not covered elsewhere on the agenda			
6.	**PATIENT STORY** To hear a patient story		Ms C Alexander	11.05
7.	**CHAIR'S REPORT** To receive the Chair's report		Rt Hon J Smith	11.30
8.	**CHIEF EXECUTIVE'S REPORT** To receive the Chief Executive's report		Mr S DeGaris	11.35

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		Paper TB	Lead	Time
9.	**PROVIDER COLLABORATION** To discuss the development of the integrated group	61/23	Mr M Trainer	11.40
QUALITY AND PERFORMANCE				
10.	**INTEGRATED PERFORMANCE REPORT – 2023/24 M6** To receive the report and discuss: • Quality and Safety • Operational performance • Equity • People • Financial performance	62/23	*[by exception]* Prof A Chesser/Ms C Alexander Ms R Carlton Mr A Abraham Mr D Waldron Mr H Virdee	11.50
11.	**REPORTS FROM BOARD COMMITTEES** 11.1 Finance Investment and Performance Committee 11.2 Audit and Risk Committee 11.3 Nominations and Remuneration Committee 11.4 Collaboration Committee	 63/23 64/23 65/23 66/23	 Mr A Sharples Ms K Kinnaird Rt Hon J Smith Rt Hon J Smith	12.30
12.	**BOARD ASSURANCE FRAMEWORK** To approve the updated Board Assurance Framework	67/23	Mr A Hines	12.40
STRATEGIC DELIVERY PLANS AND IMPLEMENTATION				
13.	**PEOPLE STRATEGY IMPLEMENTATION** To receive a report on staff wellbeing	68/23	Mr D Waldron	12.50
GOVERNANCE				
14.	**MEDICAL REVALIDATION** To receive and approve the yearly report	69/23	Prof A Chesser	13.00
15.	**ANY OTHER BUSINESS**			
16.	**QUESTIONS FROM MEMBERS OF THE PUBLIC**			13.10

Barts Health NHS Trust

17.	**DATE OF THE NEXT MEETING** The next meeting of the Trust Board in public will be held on Wednesday 17 January 2024 at 11.00am in the Bainbridge Room, Robin Brook Centre, St Bartholomew's Hospital, West Smithfield, London EC1A 7BE			
18.	**RESOLUTION** That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section (2) Public Bodies (Admissions to Meetings) Act 1960).			

Sean Collins
Trust Secretary
Barts Health NHS Trust
020 3246 0642

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BARTS HEALTH NHS TRUST

TRUST BOARD MEETING (PART 1)

Minutes of the Trust Board meeting held in public on
Wednesday 13 September 2023 at 11.00am, Board room, Junction 6/7, Whipps Cross Hospital, Whipps Cross Rd, Leytonstone

Present:
Rt Honourable J Smith (Chair)
Mr A Sharples (Vice Chair)
Mr S DeGaris (Group Chief Executive)
Dr K McLean (Non-Executive Director)
Ms L Seary (Non-Executive Director)
Ms H Spice (Non-Executive Director)
Ms J Ferns (Non-Executive Director)
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) *
Professor Sir M Caulfield (Non-Executive Director)
Ms K Kinnaird (Non-Executive Director)
Mr C Williams (Associate Non-Executive Director) *
Mr A Abraham (Group Director, Inclusion and Equity) *
Dr N Ashman (Chief Executive, Royal London and Mile End Hospitals) *
Mr S Ashton (Chief Executive, Newham Hospital) *
Mr A Jhund (Chief Executive, Whipps Cross Hospital) *

In Attendance:
Mr A Finney (Whipps Cross Hospital Redevelopment Director)
Ms L Street (Director of Quality Governance)
Mr S Collins (Trust Secretary)

Apologies:
Ms C Alexander (Chief Nurse)
Ms S Teather (Associate Non-Executive Director) *
Professor C Knight (Chief Executive, St Bartholomew's Hospital) *
Mr M Trainer (Deputy Group Chief Executive)

** Non-voting member*

76/23 WELCOME

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

meeting. A particular welcome was extended to the hospital chief executives following their appointment as board members. The Chair, on behalf of the Board, also thanked Mr Turner and Ms Street who were attending their last Trust Board meetings following completion of secondment and retirement respectively.

Apologies were noted.

77/23 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.

78/23 MINUTES OF THE PREVIOUS MEETING

The Minutes of the meeting of the Trust Board held in public on 12 July 2023 were received and approved.

79/23 MATTERS ARISING

There were no matters arising.

80/23 PATIENT STORY

The Trust Board received an account from Mr Anderson, a patient who had been a regular user of Whipps Cross hospital's services over the last 50 years, with recent care under dermatology teams. He outlined details of his most recent experiences as a patient, having been diagnosed with ankylosing spondylitis and Crohns disease many years ago and more recently suffering from skin cancers. Mr Anderson reported on the impact of an infection that had proved severe enough to result in a risk of limb loss. It had taken some time to identify the specific condition; once diagnosed his prescribed treatment needed immediate termination and he had been reassigned to the infectious disease team to enter a highly specialist treatment pathway. He noted the excellent treatment and attention of the team involved. The treatment had included anti-inflammatory drugs required with very difficult side effects impacting on his mobility and exercise. He was currently on three separate courses of antibiotics but felt that the supervision of various clinics had helped and he thanked Dr Hoque and other members of the clinical team.

The Trust Board asked questions about Mr Anderson's experience:

- The Chair asked about opportunities to improve services and Mr Anderson recognised the importance of speeding up appointments and

ensuring early treatment by the most appropriate clinical teams as key to recovery.

- Mr Hines asked whether there appeared to be sufficiently effective coordination of different hospital departments, given the number of different teams involved in his care. Mr Anderson had seen improvements in electronic systems to track different team involvements and support communication. In his case, the need for different teams to meet at multidisciplinary team discussions took time. He highlighted an important intervention by infection team made to rearrange for injections instead of tablets which he felt had made a key difference.

- The Chief Finance Officer noted Mr Anderson's proactive role in his own treatment and asked whether links between hospital dermatology and primary care appeared to have worked well. Mr Anderson reported that it had been a difficult experience initially and felt that the GP services needed to rely on the hospital dermatology team and recognised the community teams need for expert hospital specialist support. This required better communication between these organisations.

- Professor Sir Mark Caulfield noted that in the case of rare conditions, systems depended on the effectiveness of 'yellow card' scheme (open to public and patients to report) to share across medical teams to train each other and share learning nationally. He volunteered to check whether this had been pursued in his case.

- The Director of People noted recent press coverage of the Letby case where patients and staff were not sufficiently listened to. He asked whether Mr Anderson felt he had been listened to and whether he felt sufficiently supporting in the period prior to his eventual diagnosis. Mr Anderson indicated that he had generally felt listened to, although this did not result in a rapid diagnosis. He had done some of his own research and felt this had helped to prompt some exploration of alternative diagnoses. Ms Seary asked whether other patients that were perhaps less confident or articulate may be disadvantaged currently. Mr Anderson felt that it was hard to judge, although he noted that the infectious diseases team appeared particularly effective in spending time with patients and exploring the issues.

The Chair thanked Mr Anderson for sharing his valuable experiences with board members. The Chief Medical Officer added his thanks to Mr Anderson for his contribution over many years as a patient representative and critical friend to the organisation.

81/23 CHAIR'S REPORT

The Chair opened her report by reflecting on the disturbing nature of the Lucy Letby murder verdict, with the affected families in her thoughts. It would be important to make some immediate checks to ensure that the Trust's listening and safeguarding mechanisms and its responsiveness to staff concerns prioritised the safety of our patients, while recognising that a national inquiry was likely to identify further specific recommendations in due course.

An update on the Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust collaboration was scheduled on the agenda. She highlighted the importance of Barking, Havering and Redbridge University Hospitals NHS Trust being able to announce a £44m investment in a new Electronic Patient Record system (the only remaining London trust without such a system). This would be the same system as Barts Health and the Trust's informatics team were supporting this implementation. This was a key opportunity to ensure a joined up approach to patient care and sharing of information across the seven hospitals in the new integrated group.

Since the last meeting, the Chair had visited Mile End Hospital's community diagnostics centre and emerging links with Barking community hospital, a further important benefit of NE London acute collaboration. St Bartholomew's Fair was held on 30 August 2023, and the Chair recommended further events linked to the 900 year anniversary of St Bartholomew's Hospital. A meeting had been held with the Deputy Mayor regarding the NHS's role on violence against women and girls, with a focus on identifying and supporting victims of abuse and controlling behaviours. She had also joined a meeting of London chairs at which the Shadow Secretary State for Health had attended.

82/23 GROUP CHIEF EXECUTIVE'S REPORT

The Group Chief Executive welcomed hospital chief executives to their first Trust Board meeting. Their addition to the Board's membership reflected the importance of hospital leadership's increasingly strategic contributions and involvement in place-based partnerships. He reaffirmed the need to revisit patient safety mechanisms in the context of the Lucy Letby verdict. He noted the national focus on the safety of buildings using reinforced autoclaved aerated concrete in construction. This had been a known issue for NHS trusts and checks over a number of years had not found any evidence of this material across the Trust's estate, although further checks would be made. It was clear that planning and delivering seven new hospital build schemes where RAAC had been identified would be a priority for HM Government; however, there was nothing to suggest that delivering the Whipps Cross programme (and other 'cohort 3' schemes in the national New Hospitals Programme) had been de-prioritised. Operationally, industrial action by consultants and junior doctors, in addition to Unite members had had a major impact with significant cancellations and rebooking of appointments and surgery resulting. This was

clearly of great concern for patients waiting for long periods. Industrial action and a resurgence of Covid-19 and flu had informed thinking on emerging winter plans, which would be a growing focus for the Board in coming weeks, with a very challenging winter period expected. He noted some positive developments including a new multi-organisational project to increase BAME women participation in clinical trials. The Trust's high quality informatics infrastructure had been recognised by a major accreditation and he thanked the informatics team for work over an extended period to improve the quality of ICT infrastructure and cloud-based services.

The Group Chief Executive thanked Mark Turner for his contribution over the last 18 months, confirming that he was due to return from secondment to his substantive role at NHS England. In the short term, elements of his portfolio had been temporarily shared across executive team members.

The Chair joined the Group Chief Executive in thanking staff who had maintained the safety of services during industrial action, while equally recognising the rights of staff to take action.

83/23 PROVIDER COLLABORATION

The Group Chief Executive introduced the report detailing programmes to address equity of access and healthcare priorities across the sector. He highlighted revised Acute Provider Collaborative (APC) governance arrangements, which provided some delegated authority from the NEL Integrated Care Board to take forward key activities. A clear focus remained on improving system oversight framework ratings for NEL and its constituent organisations, including a strong focus on tackling emergency care performance. Collaborative work had helped to secure inward investment towards new facilities and increased diagnostic throughput at Mile End and King George's Ilford, which would be essential to addressing waiting list reductions. The confirmed investment for Barking, Havering and Redbridge University Hospitals NHS Trust to implement an Electronic Patient Record (EPR) system represented a major step forward for the organisation as well as enabling information sharing and treatment improvements benefitting patients across the whole sector.

84/23 INTEGRATED PERFORMANCE REPORT

(i) Quality and Safety

The Chief Medical Officer outlined the headline messages on quality and safety. He felt increasingly confident that maternity services were improving with stronger governance in place. A follow-up ionising radiation visit at Whipps Cross had confirmed significant improvements following criticisms arising from a visit the year before. Work was under way towards the launch of a new Patient Safety Incident Reporting Framework (PSIRF) this autumn,

with training required ahead of this. Dr McLean reported on the work of the Quality Assurance Committee including discussion of the implications and immediate response to the Lucy Letby verdict.

Mr Sharples felt that the Countess of Chester Hospital FT response to unusual patterns of deaths should prompt analysis by all NHS trust boards as to whether the key data trends would be identified and warning signs responded to. He noted for example whether a spike in maternity serious incidents in May had triggered deeper reviews. The Chair agreed and felt that the launch of a revised PSIRF approach afforded an opportunity for a reset in approach. The Chief Medical Officer indicated that there was no room for complacency. He felt that the right data was provided in reporting but the challenge would be to pick out the significant signals from the 'noise' of many metrics at different levels of the organisation and the use of soft intelligence as well as data. In terms of mortality and safeguards against harm, he noted some key roles including the role of the site medical examiner reviewing deaths. Dr McLean agreed the need for senior leaders to challenge where potential signals and risks emerged. She also noted that the Quality Assurance Committee discussion had reflected on the need to consider the Letby case further in the context of other vulnerable patient groups, such as older patients services. Ms Ferns noted the importance of a culture of openness and the experience in policing of the need to track some less direct KPIs such as appraisals and 1-1 discussions with staff. Ms Kinnaird agreed and noted that organisational culture was a key feature of Audit and Risk Committee discussions. In her capacity as a NED champion for Freedom to Speak Up, she agreed the importance of mechanisms for listening to staff and the risk of overreliance on data, emphasising the benefits of triangulation with other sources of intelligence. Ms Spice added that a qualitative view of patient feedback and complaints should be an element of this triangulation approach.

(ii) Equity

The Director of Equity and Inclusion summarised the key outcome measures on equity of access, confirming some disparities based on geography and relative levels of deprivation. He noted the key role of place-based partnerships between boroughs and hospital teams to address specific areas of concern. He noted, for example, higher 'did not attend' rates of patients from certain postcodes, with feedback suggesting that travel costs were a factor. He noted some opportunities being addressed by the public health team to improve signposting to available travel subsidy schemes.

Ms Kinnaird felt that it was important to maintain close monitoring of equity of access issues, highlighting arising issues and interventions that can make a big difference to some harder-to-reach patients.

(iii) Operational Performance

The Group Chief Operating Officer outlined the report and confirmed the hard work of teams during industrial action. All possible steps were being taken to run a safe hospital, although the increased frequency and duration of strike action was challenging. Emergency care pressures remained and capital options to improve capacity for patients attending with mental health issues were being explored. She highlighted a challenging milestone target in March 2024 to reduce the cohort of patients waiting over 65 weeks. This had been a focus of effort, particularly in more stretched specialties such as vascular and dermatology. The cancer treatment time waiting list backlog had been reduced by a quarter from its peak, but further work was required. The streamlining of cancer standards reduced the focus on waiting times until appointment but would support closer monitoring of 'straight to test/scan' timelines. She also noted the important role of 'virtual wards' currently and as part of winter planning. The Vice Chair confirmed the key features of discussion of operational performance as part of the Finance Performance and Investment Committee meetings reflected in the exception report.

The Chair asked about the W45 pilot to support ambulance handover and emergency care, which she know had been well received at Barking, Havering and Redbridge University Hospitals NHS Trust. The Chief Operating Officer noted the context of concerns about handover, divert and step processes noting the need for a holistic system approach to minimise strains and the central importance of effective communication during periods of peak pressures.

Dr McLean noted that many of the operational challenges were inter-related. She noted greater variation across the hospitals on the cancer 62-day standard, which had historically been an area of strong performance and noted the risk of harm associated with longer waits. The Chief Operating Officer noted that there was some variation across tumour groups and hospitals on waits. Issues included consistency of communication with GPs and access to diagnostics.

(iv) People

The Group Director of People noted some sustained improvements in the metrics on fill rates, staff turnover and sickness absence. Nursing and midwifery fill rates were improving but remained below 90%, with mitigation required through temporary staffing. Measures to increase workforce productivity included rotas improvements and reduced reliance on higher cost temporary staffing. Whipps Cross had performed particularly well on appraisal rates and lessons were being shared with the wider group. In the coming weeks there would be a focus on staff vaccinations and staff survey completion, with awareness campaigns in place.

Ms Seary congratulated the Whipps Cross team on progress with consultant job planning. She noted some variation and asked about the likelihood of completion these within the target date. She also highlighted issues at Barking, Havering and Redbridge University Hospitals NHS Trust with persistently high vacancy rates and suggested that some learning from the recent success of the Newham team on this would be welcomed. The Director of People noted that the targets on job planning had been set for earlier in the year than previously. While the target would be a challenge to meet, he highlighted that completion of this was a three stage process and felt that a high proportion of job planning meetings had been conducted and were awaiting sign off. He had found it hard to clearly identify the basis for improvements on staff retention, but felt that an ongoing focus on career development opportunities, flexible working and greater ownership of rostering were important to staff.

Mr Wiliams welcomed the elimination of off-framework agency usage, while noting some concern on appraisal rates despite some simplified processes. The Director of People agreed and expected to see improvements over time, alongside the roll out of career conversations and wellbeing discussions. He recognised that this required some changes in approach across a wide range of managers.

Dr McLean was encouraged by positive signs within this report. She emphasised that the relationship between temporary and substantive staff could be challenging. She recognised that front line teams were often concerned with minimising 'time to hire' and suggested that targets on this needed to be ambitious and benchmarked.

(v) Financial Performance

The Group Chief Financial Officer confirmed a £25.4m adverse variance to plan. Activity levels had been low and issues compounded by the industrial action, while inflation levels remained a significant cost factor. The identification of a recovery plan to deliver the targeted savings had been completed. Improving theatres productivity, reducing the use of temporary staff and utilising resources in non-clinical areas were key to achieving financial plan delivery. The Group Chief Financial Officer confirmed that a similar financial position was being reported across all acute hospitals in terms of deficits as a percentage of turnover, representing a major financial challenges for the NHS. A north east London recovery plan had been discussed and submitted to NHS England, with the Trust's M4 position in line with this submission. The financial recovery board would maintain oversight of this recovery plan.

The Vice Chair confirmed that the Finance Investment and Performance Committee shared the concerns on financial challenges. The overall deficit for

2023/24 anticipated in the operational plan had already been exceeded, allowing for no further slippage in year. An absolute focus would be required on reducing expenditure, with some robust analysis of productivity and pay costs. As part of its work the Committee had also supported a proposal for a shared NEL procurement function to be hosted at Homerton.

85/23 REPORTS FROM BOARD COMMITTEES

Ms Kinnaird outlined key agenda items discussed by the Audit and Risk Committee at its July meeting, including a refreshed BAF and alignment with assessments of progress on operational plan delivery; a detailed review of Freedom to Speak Up arrangements; and horizon scanning.

The Trust Board noted the other committee exception reports, with key updates having been provided during the preceding agenda items.

86/23 WHIPPS CROSS REDEVELOPMENT REPORT

The Director of Redevelopment introduced the report, highlighting the positive announcement on 17 August regarding approval of the outline business case for phase 2 enabling works. This confirmation followed an 18 month period of waiting and procurement processes that were now underway were expected to result in a preferred construction partner being appointed in the next month. A final full business case approval would then be required to enable contracts to be signed. He anticipated that risks to the timelines could arise and he would be taking a close personal involvement in overseeing progress. He recognised that seeing building works progressing on site would help grow confidence in the wider programme being realised.

The position on approvals of the main scheme remained less clear in the context of a National Hospitals Programme (NHP). A clear explanation of the methodology and assumptions to be used in establishing the overall capital requirement for each scheme remained elusive despite best endeavours. Without some clearer parameters of the indicative capital funding range, it was not possible to assess whether the eventual funding would be sufficient to meet expected capacity requirements, while all programme timescales would be dependent on the timeliness of approvals processes. Some care would therefore be required when assessing the supportive Secretary of State comments about the programme, pending the more formal business case processes and funding commitments these entailed. In the interim, the NHP's involvement had generated a significant information request process, as the central teams sought to assess a range of proposals for hospital builds and formulate a consistent response to these.

Despite these challenges, the Director of Redevelopment was pleased to note progress against a number of milestones as set out in the first annual progress report, published in August. He recognised that, at this stage of approval

processes, some of the data presented in the report posed questions rather than providing answers on aspects such as determining the capacity requirements of a new hospital.

The Chair took some encouragement from the enabling works progress and looked forward to seeing the related construction work starting as early as possible. In relation to the main scheme, she felt that there had been some improvements in terms of communication with the centre, while recognising that the primary challenge of securing timely commitments on business case approvals remained.

Dr McLean welcomed the annual progress report and noted the focus on the importance of clinical engagement with staff and partners on transformation work. She felt it would be important to use the time afforded by waiting for approvals to make as much progress on this as possible.

The Vice Chair welcomed the report and examples provided of good system working and horizon scanning across other sectors. He felt that this provided a rich new source of data and a collaborative approach. In terms of transformation and co-design with other partners, he felt that the cross-system approach being taken would be similarly relevant and useful to learn from in developing Newham and Royal London hospital services.

The Board noted the report.

87/23 RESEARCH AND DEVELOPMENT YEARLY REPORT

The Chief Medical Officer introduced the report, which had been reviewed in detail at the Quality Assurance Committee. Highlights from the year included strong performance on research activity as benchmarked with peers despite some ongoing pandemic-related slow down on non-Covid research. He welcomed the progress on creating a new Clinical Research Facility at Whitechapel with support from the Barts Charity and securing additional National Institute for Health Research (NIHR) funding. These would enable a step change on research activity, including delivering late-stage clinical trials. Under the leadership of Professor Sir Mark Caulfield an increase in Biomedical Research Centre funding secured the next 5 years of essential activity. There had been good hospital leadership engagement on widening research activity across the group, developing improved access to research activity for more staff and our patients. The Trust was also working increasingly closely with Homerton University Hospital NHS FT and Barking, Havering and Redbridge University Hospitals NHS Trust on their research agendas, with mutual benefits for all parties. The Trust's role as a research hub had been strengthened through a successful bid to host an expanded Clinical Research Network across north London. He remarked upon the strong partnership with QMUL on research and the last year had built on the strength of these foundations.

The Chair highlighted the crucial role of research and development for patient outcomes, for attracting high calibre staff and widening potential funding sources. She echoed her thanks to Barts Charity and QMUL for championing this at the Trust and at Barking, Havering and Redbridge University Hospitals NHS Trust.

88/23 HEALTH AND SAFETY YEARLY REPORT

The Chief Finance Officer introduced the report, which covered a broad span of activities and confirmed that this had been reviewed by the Quality Assurance Committee. The report provided some assurance on key activities that were subject to close regulatory attention. The report addressed the point raised earlier in relation to RAAC concrete and focused strongly on fire safety, recognising this as key risk area requiring investment.

The Chair noted an emerging theme of a rise in the levels of unacceptable violence and aggression towards staff. This represented a concerning health and safety issue and she would be keen to explore any opportunities to address this across the group and at Barking, Havering and Redbridge University Hospitals NHS Trust where similar patterns had been identified. The Chief Finance Officer agreed that, since the pandemic, there had been an evidenced rise in incidents with concerns expressed by staff reflected in the staff survey.

89/23 ANY OTHER BUSINESS

There was no other business.

90/23 QUESTIONS FROM MEMBERS OF THE PUBLIC

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

Ms Terry Day, representing Age UK Waltham Forest, provided details of the experience of an elderly patient unable to secure an appointment for a chest x-ray at the hospital, having to attend The Royal London instead. She asked why Whipps Cross hospital did not support a same-day walk in facility for urgent GP referrals, unlike other hospitals in the group and indicated that this was not compatible with the aspiration to be a centre of excellence for care of frail or elderly patients.

Dr Jhund noted that a combined service had previously existed for both community GP-referred patients and outpatients-referred patients in a single cramped facility. The equipment had become time-expired and there were several issues with the poor quality environment and inadequate changing facilities. In late 2022, some facilities had been temporarily closed for refurbishment, improving waiting room, reception and changing space, ventilation and air-conditioning. One of the two time-expired x-ray machines

had been replaced and the service reopened. The new remodelled space opened fully in April 2023. Unfortunately, due to limited capital availability, the second GP X-Ray room itself has had to remain closed awaiting funding to be identified. With only one machine operational in the GP x-ray department the service had to be closed to walk-in same day patients (albeit with options to provide this service at our neighbouring hospitals in the group). The hospital team would continue to explore capital options and to mitigate the impact for local patients in the interim.

The Newham Save our NHS campaign group representative, Mr Alan Cooper, highlighted the discrepancy between beds available per capita in England when compared with Germany and other EU nations. He asked what assumptions were used in relation to population growth in the Barts Health catchment are that would inform decisions on bed numbers in the design of a new Whipps Cross hospital. He asked how many hospital beds per 1,000 people could be anticipated in the Barts Health catchment area, after the building of the new Whipps Cross Hospital.

The Director of Strategy advised that:

- In developing early design plans for the new Whipps Cross Hospital, it was recognised that east and north east London has one of the fastest growing populations in the country. Using data from the Office of National Statistics and the Greater London Authority, the team expected the Whipps Cross Hospital catchment population to have grown by 11% over the 10 years from 2018/19 to 2028/29. This would be accompanied by a higher growth in the proportion of our older population, which is taken into account when considering the impact on demand for the hospital's and other health and care services. The assumptions used would be revisited when invited by NHS England to finalise the outline business case for the new hospital.

- The total number of beds and type of bed typically fluctuated over the course of a year to cover changing emergency and non-emergency patient requirements and care models as well as peaks in seasonal demand. However, as a baseline for this year the group had operated with approximately 1,540 general and acute beds, 132 critical care beds and 142 paediatric beds. A number of schemes in development informing the bed base included reconfiguration of ICU capacity at St Bartholomew's, surgical beds at the Royal London and Newham Hospitals and ongoing redevelopment and transformation plans at Whipps Cross Hospital. In terms of bed capacity projections, the North East London Integrated Care Board was working on a 20-year demand projection in conjunction with each Trust to assess future healthcare requirements (reflecting trends in healthcare provision, disease prevalence and population profiles within different Boroughs). The

output of this would be one of the considerations informing capacity and design plans in the Whipps Cross business case.

The Waltham Forest Save our NHS campaign group representative, Ms Terry Day, asked questions about the lack of bed occupancy metrics in the Trust's Integrated Performance Report; whether bed occupancy levels above 96% were considered safe, and why a KPI of 92% was referenced in board papers; the lack of bed occupancy levels at Whipps Cross within the annual progress report; and whether the high bed occupancy levels at Whipps Cross over the period January 2022 to June 2023 (over 98% in 4 months, and only below 95% in 2 months during this period) explained the low number of non-elective admissions in 2022/23.
The Chief Operating Officer noted that the integrated performance report focused on the drivers of high bed occupancy (such as early discharge rates, medically optimised patients remaining in hospital and access to same day treatment) more than the resulting occupancy levels. However, this outcome measure was used routinely in hourly assessments of each hospital's bed status by operational teams. She reflected on changes over time seen in terms of national best practice on bed occupancy, which indicated a gradually increasing acceptance of the high levels of bed occupancy seen in the UK. She noted the need for care in focusing exclusively on bed availability in the context of alternative bed care and admissions routes (such as same day care and virtual wards). Dr Jhund agreed that performance reporting reflected aspects where transformation efforts were being focused. For example, he noted that when bed occupancy reached the highest levels, the focus of reporting and management time was on examining treatment provided in suboptimal places (recovery areas, corridoors) or other factors impacting on timely patient treatment such as ambulance handover times.

91/23 DATE OF THE NEXT MEETING

The next meeting of the Trust Board in public would be held on Wednesday 13 September 2023 at 11.00am in the Boardroom, Junction 7, Whipps Cross Hospital, Leytonstone E11 1NR

Sean Collins
Trust Secretary
Barts Health NHS Trust
020 3246 0641

Action Log

Trust Board 13 September 2023			
No.	Action	Lead	By

	No new actions identified		

Barking, Havering and Redbridge University Hospitals NHS Trust

Barts Health NHS Trust

Report to BHRUT and Barts Health Trust Boards 1 November 2023 (Barts Health part 1) and 2 November 2023 (BHRUT part 1)	TB 61/23

Title	BHRUT and Barts Health Collaboration
Accountable Director	Group Chief Executive BHRUT CEO/Group Deputy Chief Executive
Author(s)	Group Director of Communications and Engagement (BH) Director of Communications and Engagement (BHRUT)
Purpose	To outline the next steps in relation to the collaboration between BHRUT and BH
Previously considered by	Joint Executive (24 October 2023)

Summary

Under the leadership of our Chair in Common, Group CEO and Group Deputy CEO, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) and Barts Health have been working in a closer collaboration since October 2021. Alongside this both organisations are working within a wider acute provider collaborative in north east London with Homerton Healthcare NHS Foundation Trust. In May 2023 the respective boards agreed to formalise the collaboration by working as a group of hospitals and basing this on the Barts Health model of localising where possible but centralising where necessary. The leaders of both Trusts believe even more can be achieved for patients by embedding collaboration more broadly and deeply in the way both organisations work and created the conditions for clinicians to collaborate more easily. While both Trusts remain separate statutory bodies, this paper outlines the purpose of the group, identity, and how executive leadership and board governance will evolve over the next 18 months.

Related Trust objectives
Barts Health: Acting as an effective hospital group BHRUT: Actively work with acute hospital and other provider collaboratives to broaden access to our services that reduce health inequalities

Risk and Assurance	This report provides assurance in relation to future governance of the integrated group (relates to BH BAF risk 10)

Legal implications/ regulatory requirements	Maintaining compliance with the statutory responsibilities of the Trust Boards

Action required

The Trust Boards are asked to note the next steps in relation to the collaboration between BHRUT and Barts Health.

Barking, Havering and Redbridge University Hospitals NHS Trust

Barts Health NHS Trust

REPORT TO THE TRUST BOARDS

ONE GROUP, TWO TRUSTS, SEVEN HOSPITALS

1. The NHS response to Covid-19 showed we could successfully manage an unprecedented health emergency by working together across institutions. As operational and financial pressures intensify, the NHS is applying that learning to business as usual.

2. In north east London the engine of this post-pandemic co-operative spirit is the closer collaboration between the Barts Health group and Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT). We are working within a wider acute provider collaborative in north east London with Homerton Healthcare.

3. Our informal partnership has already secured some tangible benefits for patients. We have reduced waiting times for tests, prevented unnecessary hospital admissions, and improved transport to and from hospital for those who need it.

4. In recent weeks our collaboration secured £44m funding for BHRUT to procure an electronic patient record for the first time. When this goes live it will use the same system Barts Health and Homerton have and enable patients' health records to be viewed by NHS clinicians anywhere in north east London.

5. The leaders of the two trusts believe we can achieve even more for patients if we embed collaboration more broadly and deeply in the way we both work.

6. We want to create the conditions in which our clinicians collaborate more easily, and our hospitals routinely work together, for the benefit of our patients and their communities.

7. Our aim is that, wherever they live, our patients have fair access to the best possible care, through strong local hospitals with links to specialist facilities, supported by a cost-effective infrastructure offering better opportunities for our staff.

8. Both trusts share comparable values and a collective vision to provide the highest quality care. We have a common interest in improving services for patients and reducing health inequalities among local people. We face similar performance challenges in ever-more constrained economic circumstances.

9. We believe that we can deliver better results, more effectively and efficiently, by combining our resources where appropriate. This will mean:
   - For our patients, more equal access to the best care, wherever they live.
   - For our people, more opportunities to develop meaningful careers.

- For our partners, more action together to reduce health inequalities.

10. Hence the respective boards agreed in May 2023 to formalise our collaboration by working as a group of hospitals.

11. This is based on the Barts Health model of localising where possible but centralising where necessary. That in turn means devolving operational responsibility to hospitals while using the group's scale to leverage efficiencies and ensure equity.

12. The trusts remain separate statutory bodies accountable to NHS England and regulated by the Care Quality Commission. Over the next 18 months we will move towards having a single group executive team under Shane DeGaris operating as part of a single board across the two organisations chaired by the Rt Hon Jacqui Smith.

13. This builds on the appointments of the chair in common in July 2021, the group chief executive of both trusts in May 2022, and the deputy group chief executive in July 2022.

14. The current boards will jointly oversee an open and transparent convergence process to put these governance changes into effect and appoint to the group executive and joint non-executive director posts.

15. We anticipate appointing joint executive roles covering finance, strategy and planning, and group development and digital, by April 2024. We will also appoint a joint Chief Information Officer as an early priority.

16. The hospital CEOs (including Matthew Trainer as deputy group CEO) will be board members. The group will support them by exercising consistent strategic leadership and facilitating effective corporate services in areas like procurement, informatics, and recruitment.

17. Each hospital will play a key role in local place-based partnerships, with Queen's and King George managed as a single business unit, like The Royal London and Mile End, while still within BHRUT. Over time we will refer to this model of one group, two trusts, seven hospitals by the shorthand of the Barts NHS Group.

NHS
Barts Health
NHS Trust

Barts Health Integrated Performance Report

November-23

Performance for: **Sep-23**

Pack Contents

Nov-23

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Nov-23

NHS
Barts Health
NHS Trust

Executive Summary

EXECUTIVE SUMMARY

Executive Summary

Nov-23

Quality

- Duty of candour performance is still challenged. The number of cases are small. Group Performance impacted by NUH performance and there is an improvement plan in place.
- We are seeing and increase in some infections. Detailed analysis of the causes is undertaken to support the best quality improvement plans. Key focus is line care. Monitoring of standards through peer reviews, clinical Fridays, etc continues to ensure standards are sustained.
- Serious incident - closure of investigations performance has deteriorated at some of our hospitals due to operational pressures. Work to improve this position underway, managing this back log as we transition to the new Patient safety incident response framework (PSIRF) is being managed as part of the transition plan. Plans for a soft launch of PSIRF later in November are going well and will be presented to QAC later this month.

Operational Performance

- The current context sees a continued focus on reducing elective and cancer waiting lists for services impacted by the recent industrial action (IA). In October, 1,624 outpatient appointments and 123 elective cases were cancelled and rescheduled, and overall since March 2023, there have been 25,424 outpatient appointments and 2,080 elective cases cancelled and rescheduled.
- There is a current emphasis on preparing and mobilising winter plans for urgent and emergency care, which has involved co-ordination across the group, as well as with place-based partnerships and integrated care system leads. The NHS NEL system co-ordination centre goes live in November. This will enable transparency across the system of any pressure points to support mutual aid as needed. A vaccination programme for front-line staff has commenced. The Trust has recently started a group wide virtual ward steering group. This group is focussing on expanding our current virtual ward programme as well as exploring digital enablers for remote monitoring. A further update around Winter will come back in January.
- Despite the impact of industrial action, there has still been progress on expediting care to some of our longest waiting patients, with a range of activities underway that are supporting the ongoing management of the elective waiting list. These include Text message validation, administrative validation, speciality recovery plans, collaborative capacity and the Digital Mutual Aid System,
- For Urgent and Emergency care Barts Health is in a mid-ranking position on A&E performance benchmarked with all London Trusts. There are four immediate priorities being addressed to improve operational performance: Mental Health, Ambulance Handovers, UTC Performance and Greater Discharge Focus.
- Whilst we remain in tier 2 for Cancer services good progress is being made in a number of pathways, with a specific focus this month on Urology through timed pathways. Tier 2 is a national framework reflecting regulatory concern in relation to relative performance and involves increased oversight and scrutiny.
- For diagnostics the Trust remains focussed on supporting hospitals with specific improvement plans for MRI, Cardiac CT, non-obstetric ultrasound and audiology, with oversight via our Elective Recovery Board and Hospital Performance Boards

EXECUTIVE SUMMARY

Executive Summary

Nov-23

Equity

- In this month's review of equity in waiting times, there are no significant differences in average wait times between male and female patients, between ethnic groups, or between patients living in a deprived postcode compared to those that live in wealthier postcodes.
- We did, however, note a statistically significant difference in waiting times for patients with learning disabilities. We have escalated this to the Surgery Leads and are presenting the findings to the Planned Care Board. We believe this is primarily a result of long waits at RLH for Restorative Dentistry.

People

- Substantive fill rate has continued to increase from 92.1% to 92.3% with a growth of 63 WTE. Within this we have seen a small growth (+11 WTE) in registered nursing and midwifery (moving to an 86.6% fill rate) but also growth in medical and dental staffing of 18 WTE and varying growth across other staff groups.
- Temporary staffing accounted for 12.4% of the workforce in September, with a decrease of 191 WTE, of which 114 WTE was bank and 77 WTE agency. Agency spend as a % of paybill YTD has reduced slightly to at 4.6% within month spend being £4.9m (down from £5.7m) or 4.2% of the in month pay bill
- Time to hire (advert to all checks complete) for non-medical staff was within target again this month at 9.4 weeks (against 10.4) although there was some variation at site level with Newham performing worst at 11.6 weeks. The recruitment team are working closely with Newham to identify areas of improvement in the process, including reducing shortlisting timeframes and exploring further functionality within the recruitment systems.

Finance

- The Trust is reporting a £46.5m deficit for the year to date at month 6, which is (£32.8m) adverse against plan. Excluding the impact of industrial action the Trust is performing in line with its trajectory within the financial recovery plan agreed by the NEL system.
- The key financial challenges for the Trust in achieving its plan for the year to date 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.
- Financial performance is being closely monitored by NHS England. The Trust has implemented additional controls on pay expenditure to support financial recovery.

NHS
Barts Health
NHS Trust

Quality Report

CARING

Domain Scorecard

Nov-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
Patient Experience	C12	MSA Breaches	●			Aug-23 (m)	<=0	23	**40**	***172***	11	10	10	9	-
Patient Feedback	C10	Written Complaints Rate Per 1,000 Staff				2023/24 Q1 (q)	SPC Breach	20.5	**17.6**	***17.6***	18.5	37.7	31.6	10.3	-
	C1	FFT Recommended % - Inpatients	●			Aug-23 (m)	>=95%	90.5%	**90.8%**	***90.5%***	87.3%	93.4%	87.9%	94.6%	-
	C2	FFT Recommended % - A&E	●			Aug-23 (m)	>=86%	66.8%	**66.9%**	***66.9%***	63.9%	71.5%	64.6%	-	-
	C3	FFT Recommended % - Maternity	●			Aug-23 (m)	>=96%	98.6%	**94.4%**	***96.5%***	50.0%	96.9%	93.1%	-	-
	C20	FFT Response Rate - Inpatients	●			Aug-23 (m)	>=23%	32.0%	**30.6%**	***31.9%***	23.2%	53.3%	20.2%	34.5%	-
	C21	FFT Response Rate - A&E	●			Aug-23 (m)	>=12%	8.0%	**8.0%**	***8.1%***	8.2%	9.7%	6.0%	-	-
	C22	FFT Response Rate - Maternity	●			Aug-23 (m)	>=17.5%	18.1%	**19.1%**	***18.3%***	0.5%	31.3%	28.5%	-	-
	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	●			Aug-23 (m)	>=85%	91.3%	**84.7%**	***85.5%***	92.9%	85.0%	65.0%	88.9%	-
	R30	Duty of Candour	●		●	Jul-23 (m)	>=100%	82.0%	**69.2%**	***80.0%***	70.0%	81.8%	57.1%	64.3%	-

*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

Nov-23

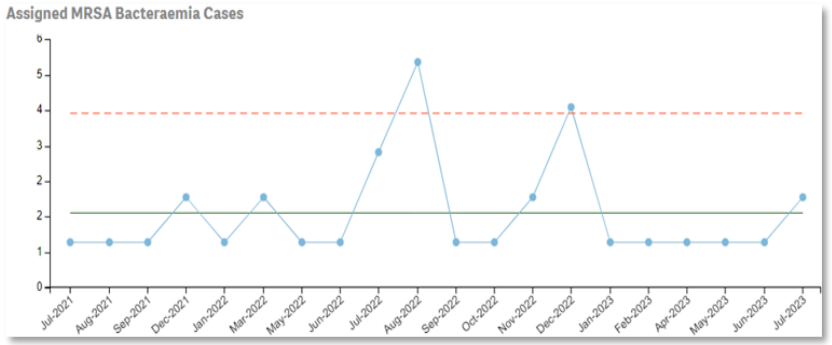
	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Site Comparison: Whipps Cross	Site Comparison: Newham	Site Comparison: St Bart's	Site Comparison: Other
Infection Control	S10	Clostridium difficile - Infection Rate	●			Aug-23 (m)	<=16	15.1	**21.3**	***21.3***	21.5	25.4	9.7	28.1	-
	S11	Clostridium difficile - Incidence	●			Aug-23 (m)	<=9	9	**13**	***63***	6	4	1	2	0
	S2	Assigned MRSA Bacteraemia Cases	●			Aug-23 (m)	<=0	2	**2**	***7***	1	0	1	0	0
	S77	MSSA Bacteraemias				Aug-23 (m)	SPC Breach	14	**14**	***58***	5	4	2	3	0
	S76	E.coli Bacteraemia Bloodstream Infections	●			Aug-23 (m)	<=20	33	**19**	***144***	8	5	4	2	0
Incidents	S3	Never Events	●			Aug-23 (m)	<=0	1	**0**	***3***	0	0	0	0	0
	S09	% Incidents Resulting in Harm (Moderate Harm or More)	●			Aug-23 (m)	<=0.9%	1.8%	**1.8%**	***1.6%***	2.0%	0.5%	3.1%	2.5%	-
	S45	Falls Per 1,000 Bed Days	●			Aug-23 (m)	<=4.8	3.3	**3.2**	***3.6***	3.0	2.9	2.9	5.1	-
	S25	Medication Errors - Percentage Causing Harm	●			Aug-23 (m)	<=4%	3.2%	**5.7%**	***4.6%***	6.0%	5.4%	5.6%	5.6%	-
	S49	Patient Safety Incidents Per 1,000 Bed Days				Aug-23 (m)	SPC Breach	55.5	**51.7**	***56.0***	40.1	64.6	53.6	63.8	-
	S53	Serious Incidents Closed in Time	●		●	Aug-23 (m)	>=100%	5.9%	**0.0%**	***8.6%***	0.0%	0.0%	0.0%	-	-

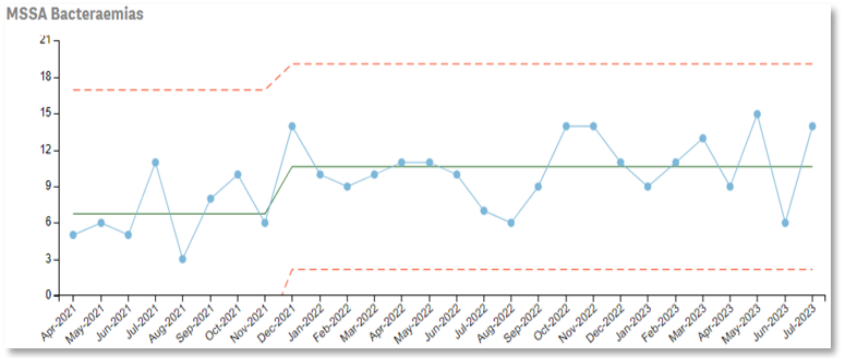
Serious Incidents Closed in Time: clock stops are still in place nationally and Barts Health continues to monitor the Serious Incident process according to internal targets – more details are on the "Changes to Report" page of this report.

CARING

MRSA and MSSA Infections (Trust)

Nov-23





Indicator Background:

MRSA
From 2013-14 the Department of Health & Social Care moved away from a fixed numerical target in favour of a policy of 'zero tolerance of avoidable infection'. It was accepted, that there would continue to be small numbers of infections seen, and that the national aim was to reach an 'irreducible minimum', with national figures supporting this contention.

MSSA
Currently there is no national threshold for MSSA bacteraemia. National data show that the general reduction in MRSA BSI has not been mirrored by a fall in MSSA bloodstream infection. This is of concern as the two organisms have similar epidemiology and pathogenesis. The Department of Health therefore introduced mandatory surveillance of MSSA bacteraemia from January 2011

What is the Chart Telling us:

MRSA
Astronomical points in August and December 2022. Five total Healthcare Associated MRSA reported up to the end of August; 2 at Whipps Cross and Newham and 1 at the Royal London.

MSSA
Benchmarking for MSSA infections is less developed than for MRSA, and the balance between healthcare-associated and other infection less clear. There has been year to year fluctuations with hospital onset cases. Cases reported have generally not been linked to location.
The renal department review their MSSA bacteraemia cases in an Multi Disciplinary Team meeting (MDT) and aim to identify any issues that may need to be improved.
The main sources of the bacteraemias are intravenous lines and pneumonia, with some cases linked to surgical site infections.

Actions taken:

A range of quality improvement programmes are in place across the organisation responding to specific needs identified. These improvement projects are anticipated to reduce the rates of infection and deliver sustainable improvements. A key focus is on line care.

Issues and Risks:

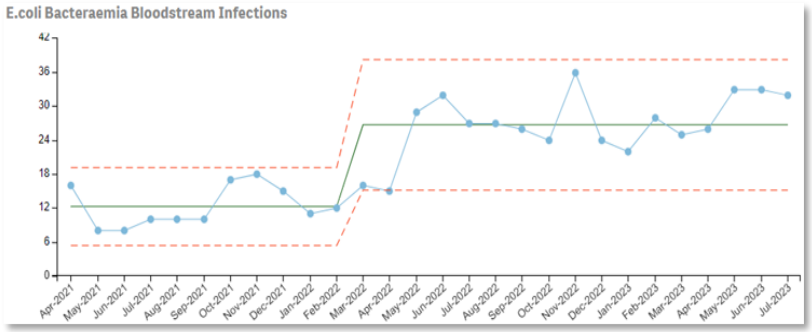
MRSA
As the Trust continues to recover and remobilise after the Covid-19 pandemic, our focus has returned to the full breadth of our IPC programme. We must remain vigilant to the challenges yet to emerge and be prepared to respond appropriately to the variety and range of pathogens that we now see. Much of this will be proactive, putting an emphasis on training, education, supporting best practice and learning from incidents and mistakes. We are doing more collaborative work with community partners, across the sector.

MSSA
The rates over the next 7 months may not return to be within statistical control. We may need additional time to fully embed the QI workstream on line care across the Trust and use PDSA cycles to support the rollout

CARING

E.coli Bacteraemia Bloodstream Infections (Trust)

Nov-23



Indicator Background:

Under the NHS Standard Contract requirements are set to minimise C. difficile infection and gram negative blood stream infections to threshold levels set by NHS England. Thresholds are based on the number of infections reported not rates of infection. For 2022/23, trust-level thresholds comprise total healthcare-associated cases (i.e. Hospital Onset Healthcare Associated (HOHA) and Community Onset Healthcare Associated (COHA)). The national ambition to reduce by half the number of healthcare associated Gram negative bloodstream infections (GNBSIs) by 2024 remains in place.
It is also relevant to note that E. coli remains the most frequent cause of bloodstream infection in the UK and we will continue with our work to identify the themes and trends to prevent avoidable infections and to improve our position nationally.

What is the Chart Telling us:

Across the Trust there have been the same number of cases reported as last month. At RLH there were slightly less numbers.

We have breached our target year to date by 53 cases as at the end of July, with St Bartholomew's (+5), Newham (+6), Whipps Cross (+13) and Royal London (+29) all over trajectory. Examining the data more closely in relation to Hospital Onset Healthcare Associated (HOHA) and Community Onset Healthcare Associated (COHA) cases highlights 49 were COHA's and 76 were HOHA's. Previous reporting methods would have resulted in a significantly lower number of cases being reported as the HOHA cases would have been the post 48 hours cases.

Actions taken:

- Investigation into the COHA cases has involved identifying the location of their previous admission and then reviewing any learning from these cases.
- The hepatobiliary cases have all had procedures prior to the bacteraemia being identified, they have all had appropriate prophylaxis.
- There continues to be a focus across our hospitals promoting early removal of urinary catheters using the HOUDINI checklist (Haematuria, Obstruction, Urological surgery/intervention, decubitus ulcer, input/output monitoring, nursing care and immobility).

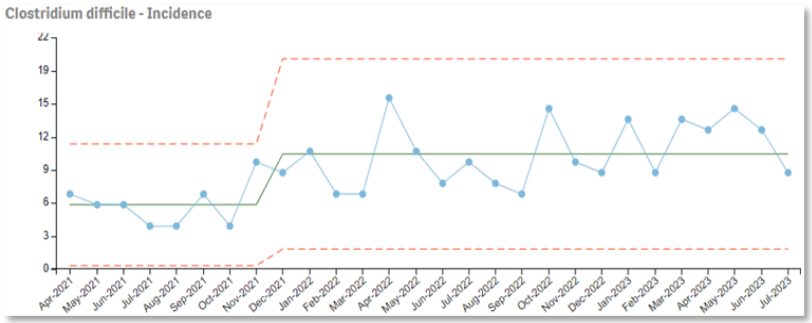
Issues and Risks:

- Devices continue to be a risk and there is a focus on documentation of devices and care of these.
- We have breached our objective this year and have a number of QI projects planned to support reductions of GNBSI's. If not implemented by each hospital we may not sustain this reduction.
- We are at risk of not meeting the national reduction plan by 2024.

CARING

Clostridium Difficile Infections (Trust)

Nov-23



Indicator Background:

For each blood stream infection and Clostridium difficile infection, cases are defined as to whether they are healthcare associated or not. For those that are health care associated they may be further defined as being:
Hospital onset healthcare associated (HOHA) - if identified on or after 3 days of admission where day 1 is the day of admission.
Community onset healthcare associated (COHA - not categorised as HOHA but discharged from hospital in the previous 28 days (including day case and Emergency Department visits), these were previously called pre 48-hour incidents and not allocated to the Trust

What is the Chart Telling us:

We had seen increased levels of CDT since late 2022 and year to date we have breached our target by 12 cases to the end of July, with St Bartholomew's (+5), Whipps Cross (+1) and Royal London (+9) all over trajectory. Newham are under trajectory by 3. Of the cases 42 were HOHA's and 7 were COHA's. Reviews of the cases has identified most of the patients were on or had previous antibiotics. No lapses of care identified.

Actions taken:

- From a national perspective, there has been a sustained increase in hospital onset Clostridioidium difficile infection (CDI) cases reported in England compared with 2019. Historical increases in CDI incidence have been linked to newly emergent strains and/or antibiotic prescribing; however, neither cause appears to explain the ongoing increase. There continues to be education about sampling and isolation of patients with diarrhoea.
- One of the concerning themes is related to repeat sampling of patients known to have C difficile, which leads to repeat cases reported on our figures, focused education is being rolled out.
- pharmacist in monitoring antibiotic prescribing with the Chief Pharmacist.

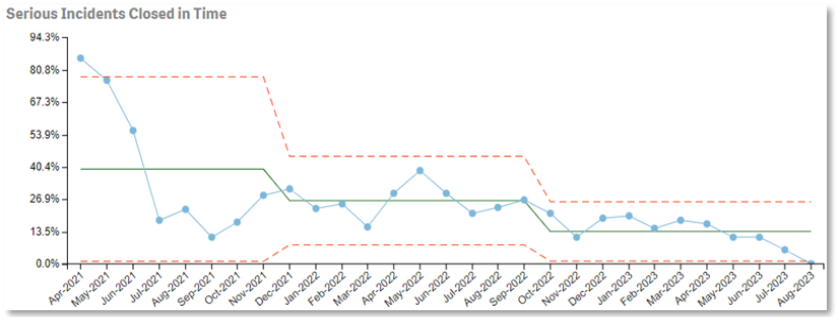
Issues and Risks:

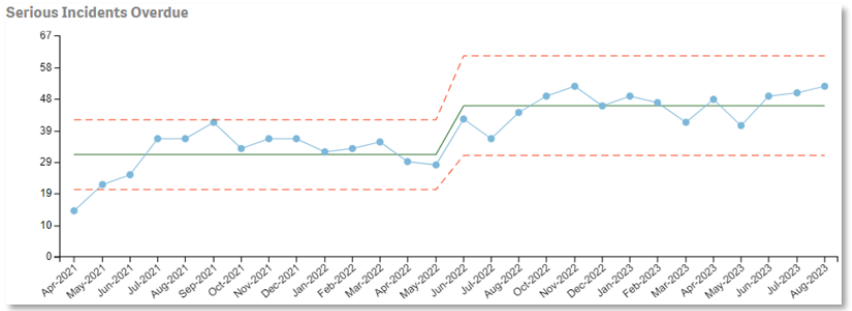
There is limited review of antimicrobial stewardship due to restricted resource, however in these cases pharmacy confirmed that they were in line with our policy.

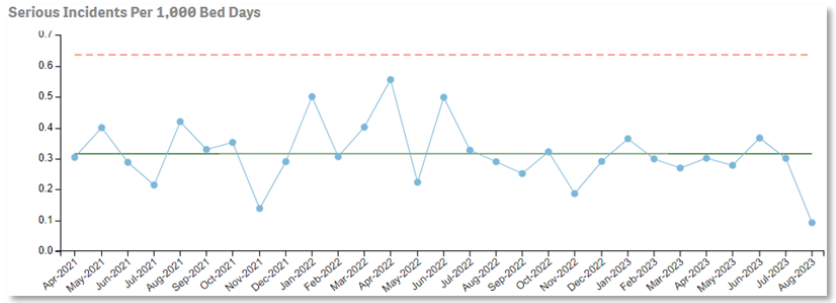
CARING

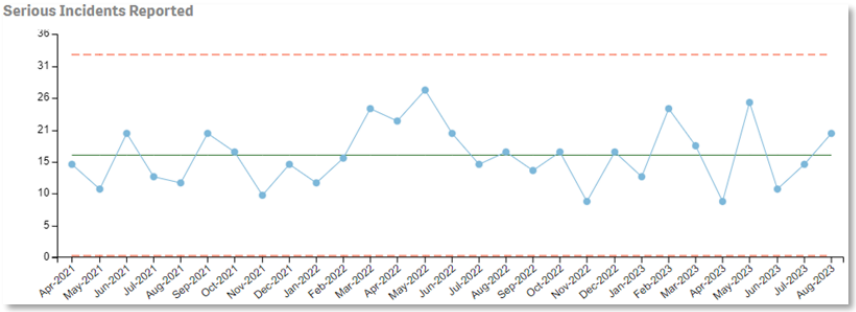
Serious Incidents Closed in Time (Trust)

Nov-23









Analysis of the current position –
The number of serious incidents closed within the timeframe has deteriorated across some of our hospitals. The impact of industrial action and operational pressures on capacity to undertake investigations is an issue

Incident to note: 1 incident of note at NUH: Failed baby abduction; this is inline with the principles of PSIRF Safety 2 principles: reporting when things go well

Actions taken
Specific issues at hospital level are monitored and plans to improve position in place. This is reviewed through dashboards and governance meetings.
Plans for clearing the backlog and timeframes are in place place and support from system offered.

Transition to PSIRF could be impacted by the backlog position. Plans to minimise disruption to implementation are being developed to support transition.

EFFECTIVE

Domain Scorecard

Nov-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	Whipps Cross	Newham	St Bart's	CSS	Other	Barts Health
Mortality	E1	Summary Hospital-Level Mortality Indicator	●	○	○	Mar-23 (m)	<=100	98	**98**	-	93	100	106	97	-	-	98
	E3	Risk Adjusted Mortality Index	●	○	○	May-23 (m)	<= 100	94	**93**	-	90	94	95	94	-	-	93
Outcomes	0502	Cardiac Arrest 2222 Calls (Wards) Per 1,000 Admissions	●	○	●	Jul-23 (m)	<= 0.51	0.43	**0.61**	***0.57***	0.28	0.83	0.42	0.98	-	-	0.61

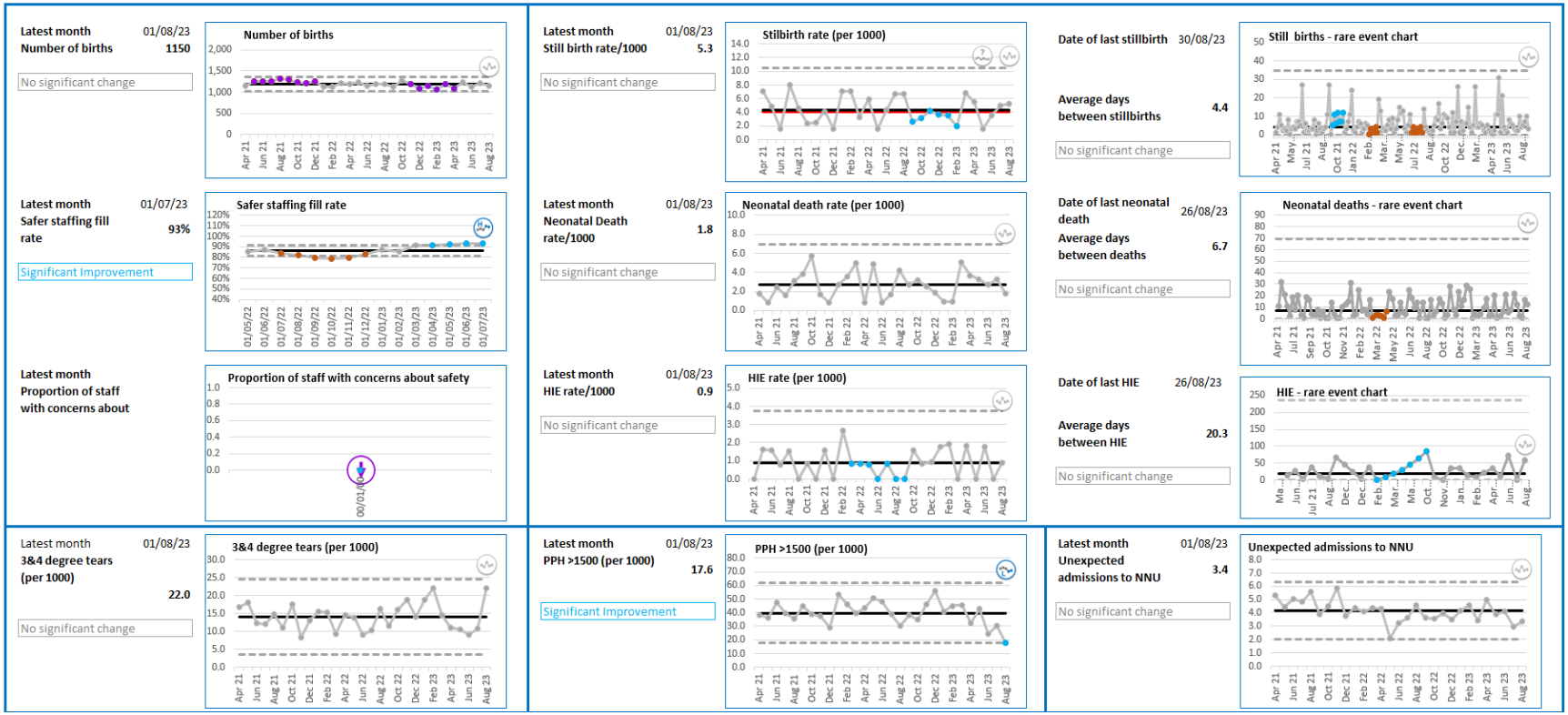
Annual discharge data, ending in month indicated as 'This period', used for the generation of the indicator. Confirmed or suspected cases of Covid – 19 are excluded.

EFFECTIVE

Reading the signals

Nov-23

Maternity overview | **Barts Health NHS Trust**

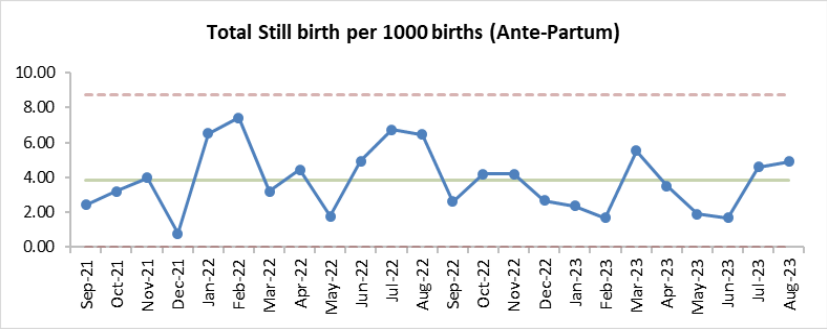


Performance Overview	Responsible Director Update
At a Trust level the chart indicates that there are no significant changes in any of the indicators except the Post Partum Heamorrhage (PPH) indicator where there has been significant improvement over time and reflects the improvement plans in place. At a hospital level there is no significant statistical difference across the hospitals apart from the neonatal death rate at RLH. The unit operates at level 3 with neonatal surgical services. Although high, it is not a national outlier and reviews are undertaken of each of the deaths as well as reported to the Local Maternity & Neonatal System and undergo a Perinatal Mortality Review (PMRT) by MBRRACE-UK. There has been an improvement in the neonatal death rates and in the intervals between neonatal deaths.	The Maternity Safety Support Team continue to work with our 3 maternity units to support our improvement programme.

EFFECTIVE

Total number of Still births (all) per 1000 births

Nov-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:

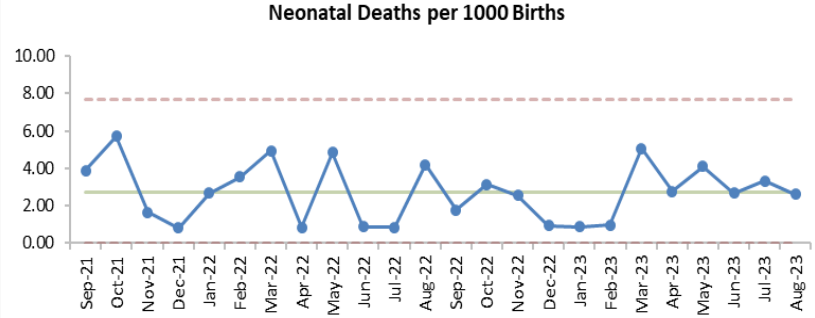
There had been an increase in March and April of which the cases are being investigated in line with usual governance arrangements and with thematic analysis to identify any themes across the group

Performance Overview	Responsible Director Update
Since the increased in rates of stillbirths in March and April 2023, the rates rose to above 4.0/1000 in July 2023.	All losses undergo the clinical review locally and also subject to the multi-disciplinary based Perinatal Mortality Review via the Tool to ensure learning from the cases. The maternity service is continuing the embedding of the Saving Babies Lives Care Bundles version 3.

EFFECTIVE

Neonatal Deaths per 1000 Births

Nov-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:

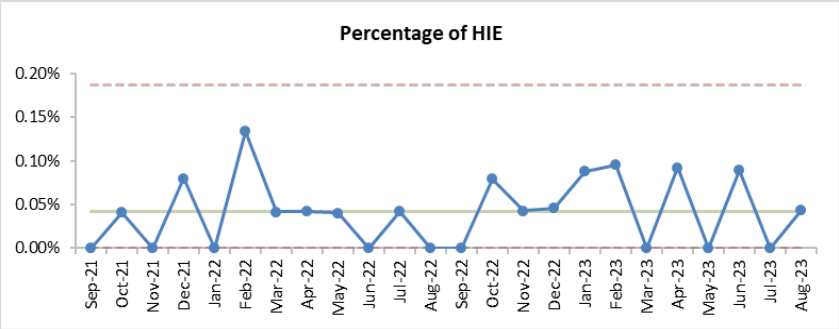
The charts tell us that thankfully neonatal deaths are rare. Because of this, that data fluctuates from month to month. Work with the Making Data Count team at NHS Improvement will support the development of a rare events chart which will assist with visualisation of performance and outcomes.

Performance Overview	Responsible Director Update
The neonatal death rate for September is 4.4/1000, sitting above the national rate of 2.62/1000 birth reflecting the referrals received by the level 3 unit at RLH which also has neonatal surgical service within the Group.	Regular review of the rates is undertaken at service level to understand the neonatal deaths of each maternity site.

EFFECTIVE

HIE (Hypoxic-Ischaemic Encephalopathy)

Nov-23



What is the Chart Telling us:

That there were no cases of diagnosed HIE in babies born within and receiving treatment at Barts Health in July.

There was however 1 case of HIE Grade 1 for a baby born at WXH who received cooling therapy at The Homerton Hospital.

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.

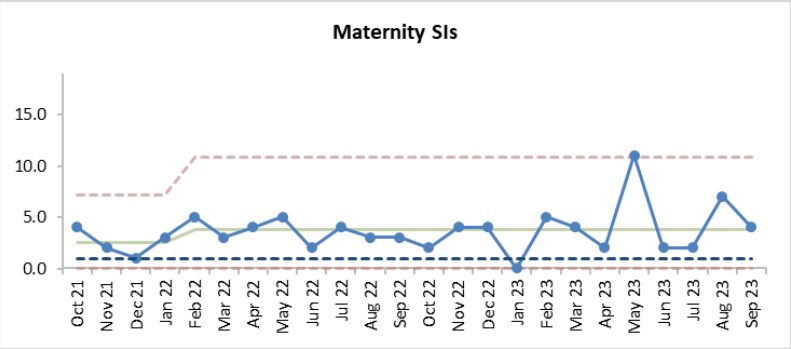
Brain injury can be as a result of changes that occur during the pregnancy as a result of reduced blood flow to the placenta, but can also occur during labour, which is why foetal monitoring is a vital component of safe care. Any cases where a baby is referred for cooling and has a brain injury is referred for external review by HSIB. The data captured through Barts Health only includes cases of severe damage (HIE grades 2 &3) and babies both born and treated at Barts Health. 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
HSIB is progressing an investigation for a case referred to them.	Barts Health is continuing its improvement work above – focusing on healthy pregnancy and adequate fetal monitoring in labour. A Foetal Monitoring Quality Improvement project is being considered.

EFFECTIVE

Maternity – Serious Incidents

Nov-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.

The Healthcare Services Investigation Branch, investigate maternity incidents that meet the Early Notification scheme (stillbirths at term, neonatal deaths, and babies sent for cooling therapy or with confirmed brain injury due to hypoxia) and maternal deaths.

Performance Overview

Focus on ensuring all serious incidents are investigated and lessons learnt. Transition across to PSIRF in place for November 23.

Nov-23

NHS
Barts Health
NHS Trust

Operational Performance Report

SUMMARY

Operational Summary

Nov-23

Summary Performance Provided By Business Intelligence

Operational performance presented below was impacted by two periods of Junior Doctor and Consultant industrial action across both August and September 2023.

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 September 2023, 41,695 attendances were recorded, 1,862 (+4.7%) more attendances than July.
- A&E 4-hour performance for September decreased from 69.2% in August 2023 to 68.0% (-1.2%).
- The proportion of patients with an A&E 12-hour journey time increased from 5.8% in August to 6.5% in September (+0.7%), against a national standard of no greater than 2%.
- For September 2023, Barts Health recorded the second highest volume of A&E attendances of any trust in England and the highest volume in London. In terms of performance against the 4-hour standard, the Trust was ranked 10th out of 18 trusts in London and was ranked 6th out of the top 10 English trusts (ranked by volume of attendances).

Cancer

- During August NHS England announced a change to cancer waiting time standards, replacing the current set of ten waiting time standards with a reduced set of three from 1 October, changes in reporting will be applied to the January 24 edition of this report when October 23 performance data will be available.
- In August 2023 a performance of 93.7% was recorded in relation to the 2 week wait standard of 93%, a further improvement of 0.6% against July's 93.1%. Breaches of the standard reduced from 253 in July to 230 in August, the number of patients seen decreased slightly from 3,664 to 3,653 across the same period meaning the proportion of patients breaching the standard reduced.
- In relation to the Faster Diagnosis Standard, requiring 75% of referrals to have cancer diagnosed or ruled-out within 28-days, for August 2023 the Trust achieved the standard for Breast Symptomatic (95.6%) and Screening referrals (83.3%), however just missed the standard for GP urgent referrals (73.8%), this resulted in the trust achieving the standard for All (aggregated) referrals, recording a performance of 75.3%, a decrease of 1.0% against July's 76.3%. This is the second consecutive month aggregated performance has achieved the national standard since March 2023.
- With continued focus from NHS England on 62 day backlog clearance, at the end of September 2023, the trust recorded 436 patients waiting longer than 63-days against a plan of 338 (+98), however this represents a slight reduction of two against the August position.

Diagnostics

- For September 2023 a performance of 73.2% was recorded, a reduction of 0.7% against August's 73.9%.
- During September the greatest challenges related to MRI, Cardiac CT and non-obstetric ultrasound long waits with audiology also remaining challenged in relation to long waits and performance.
- Opportunities for process and productivity improvements; helping to mitigate the need for additional staff, are being developed across modalities.

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 September 2023 the trusts admitted (inpatient and day case) trajectory set a target of 8,324 admissions against which the trust delivered 7,801 (-523 admissions).
- For outpatients (first and follow up) for the same month the trajectory set a target of 130,477 attendances, against which the trust delivered 129,611 (-866 attendances).
- In relation to the RTT month-end nationally submitted data the trust reported 8 pathways waiting 104+ weeks at the end of September 2023, the same number reported at the end of both July and August.
- In relation to 78+ week wait backlog volumes, 241 pathways were reported at the end of September, an increase of 37 against the August 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 September the trust recorded 2,291 pathways waiting 65+ weeks, a decrease of 164 against the August position.

RESPONSIVE

Domain Scorecard

Nov-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	●			Sep-23 (m)	>= 72.5%	69.2%	**67.9%**	***69.8%***	63.4%	70.3%	71.6%	-	-	68.0%
A&E 12 Hours Journey Time	●			Sep-23 (m)	<=2.0%	5.8%	**6.5%**	-	5.6%	5.1%	9.2%	-	-	6.5%
Ambulance Handover - Over 60 mins				Sep-23 (m)	-	81	**93**	-	16	47	30	-	-	93
Ambulance Handover - Over 30 mins				Sep-23 (m)	-	1,761	**1,813**	-	372	779	662	-	-	1,813
Cancer 31-Day Diagnosi to First Treatment	●			Aug-23 (m)	>= 96%	94.7%	**96.4%**	***95.7%***	89.0%	96.8%	100.0%	100.0%	-	*96.4%*
Cancer 62 Days From Urgent GP Referral	●			Aug-23 (m)	>= 85%	62.1%	**54.7%**	***57.9%***	41.5%	73.3%	47.1%	51.3%	-	*62.1%*
Cancer 28 Day FDS 2WW	●			Aug-23 (m)	>= 75%	74.9%	**73.8%**	***71.2%***	73.7%	71.3%	74.3%	88.4%	-	73.8%
Cancer 28 Day FDS Breast Symptomatic	●			Aug-23 (m)	>= 75%	98.4%	**95.6%**	***95.9%***	-	98.5%	96.6%	92.4%	-	95.6%
Cancer 28 Day FDS Screening	●			Aug-23 (m)	>= 75%	77.4%	**83.3%**	***88.6%***	85.7%	75.0%	84.6%	-	-	83.3%
Diagnostic Waits Over 6 Weeks	●			Aug-23 (m)	>= 99%	74.0%	**73.2%**	***76.7%***	57.4%	98.9%	91.2%	69.7%	100.0%	73.2%
65+ Week RTT Breaches	●			Sep-23 (m)	2,337	2,455	**2,291**	-	1,617	487	180	7	-	2,291
78+ Week RTT Breaches	●			Sep-23 (m)	143	204	**241**	-	188	33	16	4	-	241
104+ Week RTT Breaches	●			Sep-23 (m)	0	8	**8**	-	2	1	1	4	-	8
Completeness of Ethnicity Recording				Sep-23 (m)	-	91.6%	**92.0%**	-	91.0%	91.4%	95.7%	91.1%	-	92.0%

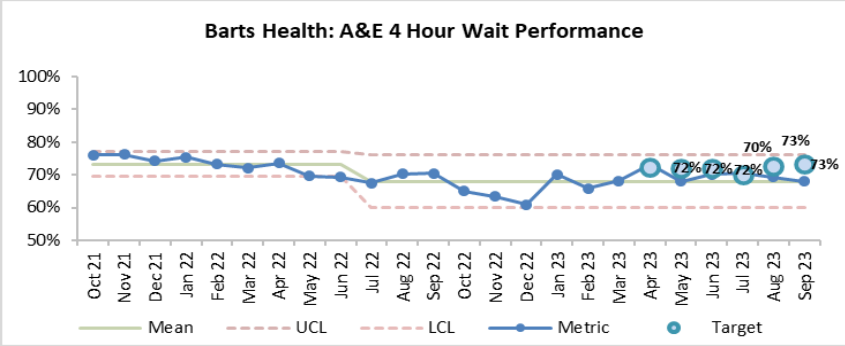
Note to table:

- 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
- 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

Nov-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

Overall Trust 4 Hour Performance in September was 67.98%, with a year to date position of 69.8% below trajectories set to meet the year end threshold recovery target of 76% by March 24

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 October 2021. A reducing step-change is triggered from June 2022 resulting from a run of 8 data-points below the 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. A degree of consistency above or close to the 70% threshold is then visible in the data across the period June to September 23.

Trust Responsible Director Update

Length of stay for our mental health patients continues to rise in our emergency department. Decreasing the length of stay for mental health patients in our emergency departments remains a central priority. Work with system partners is ongoing with a particular focus on clinical risk and engagement with CMO teams across the sector.

Urgent Treatment Centre (UTC) performance continues to be a challenge. A NEL commissioned report in relation to UTC has been received, particularly focussing on RLH and Newham and work is underway to distil key actions from this analysis to include timelines and anticipated performance impacts. Newham has already seen improvement in its UTC performance.

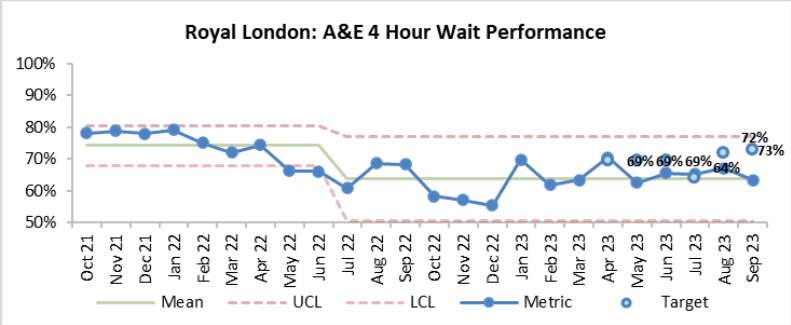
Length of stay for all patients across Barts Health is seeing an upward trend. We continue to work with colleagues from the Improvement and Transformation team to maximise virtual wards, board rounds and maximise discharge lounge usage.

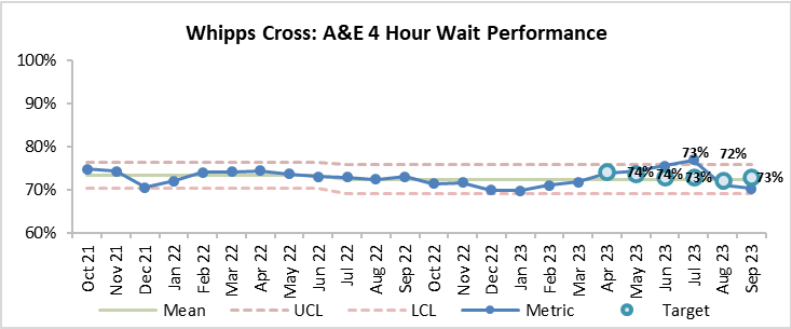
Ambulance handovers for over 60 minutes continued to remain much lower than the YTD average at 91.

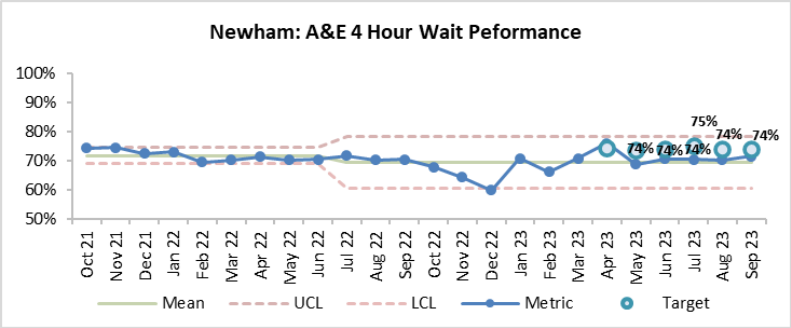
RESPONSIVE
Urgent & Emergency Care

A&E 4 Hour Waiting Time

Nov-23







Hospital Site Performance Overview

Royal London:
The Royal London recorded a performance of 63.4% for September, a decrease of 3.6% against August's 67.0%.
The Royal London has continued to have a large number of mental health patients in their department. This minimises physical capacity to enable ED teams to see and treat their patients within 4 hours. An increase in patients with a historic discharge ready date continues to put pressure on the admitted pathway. To mitigate this a rapid release protocol has been embedded to support patients to move to wards when ED becomes congested.

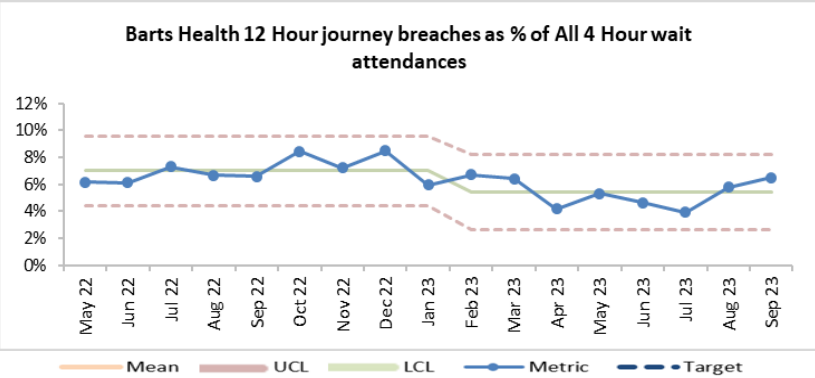
Whipps Cross:
Whipps Cross recorded a performance of 70.3% for September, a decrease of 0.9% against August's 71.2%.
There has been a marked increase in Length of stay at Whipps Cross. Medical director led board rounds are in place to review patients over 21 days to understand any barriers to discharge. SDEC and SAU are due to open in December, supporting patients who do not require an admission.

Newham:
Newham recorded a performance of 71.6% for September, an increase of 1.3% against August's 70.3%.
Both type 1 and type 3 performance improved at Newham in September. This was due to focussed improvement projects led by the Newham leadership teams. Improved signage on sites and way finding for patients also delivered marked improvements in care and patient experience.

RESPONSIVE
Urgent & Emergency Care

A&E 12 Hrs Journey time

Nov-23



Trust Performance Overview

The proportion of patients with an A&E 12-hour journey time increased from 5.8% in August to 6.5% in September (+0.7%), against a national standard of no greater than 2%, with Newham seeing the largest number of patients waiting at 9.2%.

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 statistically significant breaches of the upper and lower confidence limits, however a reducing step-change is visible in the data from January 23.
July 2023 recorded the lowest proportion of 12-hour breaches up to that point in the data-series at 3.9%, however the proportion of breaches increased in August and September to 5.8% and 6.5 respectively.

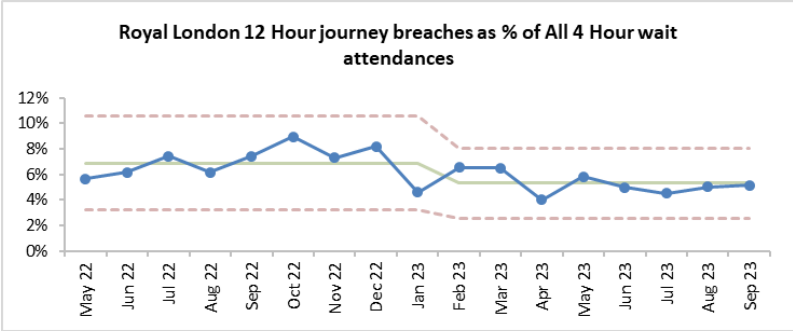
Trust Responsible Director Update

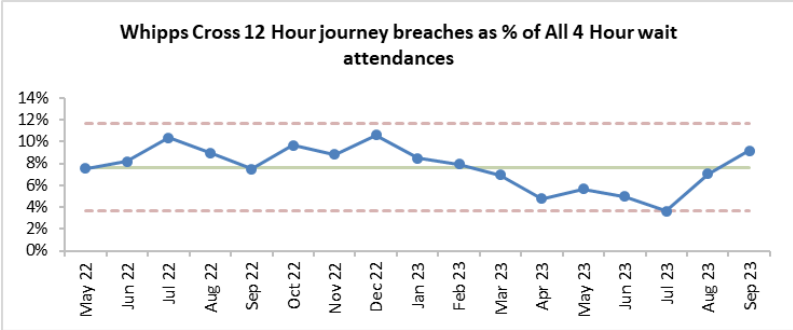
- A significant proportion of patients awaiting over 12 hours in our departments are mental health.
- Due to the increased acuity and system challenge around our admitted pathway, patients awaiting admission spent an extended time in our emergency departments.
- Across the Trust various schemes are in place to minimise risk such as rapid release to support flow out of our emergency departments. These policies are reviewed at Hospital Executive boards and overseen by the Unplanned care board.

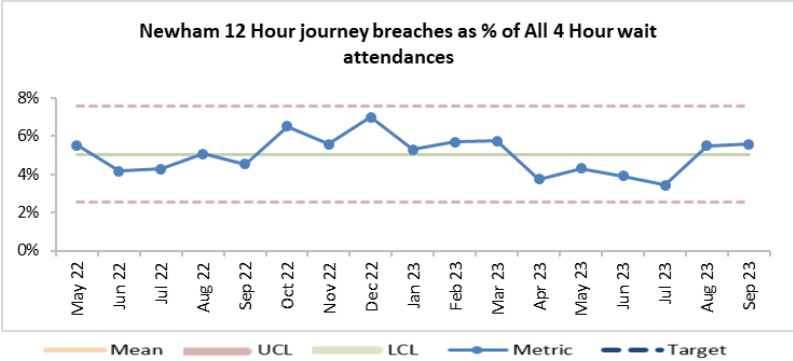
RESPONSIVE
Urgent & Emergency Care

A&E 12 Hrs Journey time

Nov-23







Hospital Site Performance Overview

Royal London:
The proportion of 12-hour wait times recorded at the Royal London was 5.1% for September 2023, an increase of 0.1% against August's 5.0%. Royal London continue to maintain their 12 hour journey time by maximising pre-11am discharges and implementation of the rapid release scheme.

Whipps Cross:
The proportion of 12-hour wait times recorded at Whipps Cross was 9.2% for September 2023, an increase of 2.1% against August's 7.1%. 12 hour journey time increased at Whipps Cross due to increased length of stay for inpatients. Mental health Length of stay continues to be a significant driver for this. Focussed improvement projects across the Hospital are looking at what is driving the Length of stay increase, as well as focussing on improving pre-11am discharges.

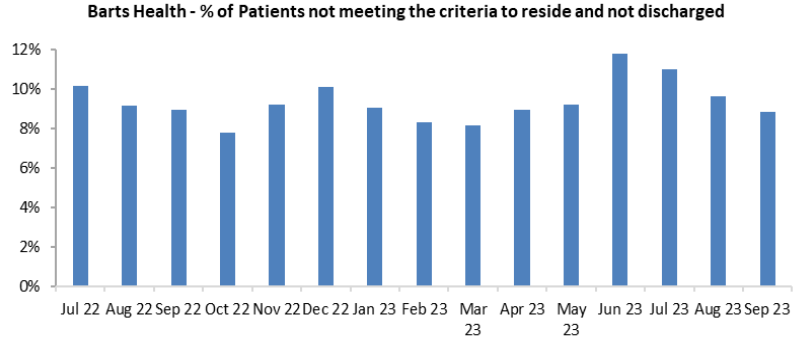
Newham:
The proportion of 12-hour wait times recorded at Newham was 5.6% for September 2023, an increase of 0.1% against August's 5.5%. Newham continue to focus on their 21 day plus Length of stay to improve their 12hr journey time. The number of no criteria to reside and patients with a historic discharge ready date is on a downward trend showing early signs of improvement through this work.

RESPONSIVE
Urgent & Emergency Care

Discharge Activity

Nov-23

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



Trust Performance Overview

The number of patients who no longer meet the criteria to reside continued to decrease in September. Marked improvements were seen at Newham and Whipps Cross, with numbers at The Royal London remaining static.
In September 2023 8.8% of our bed base was occupied by patients with no criteria to reside. Trust wide this is the equivalent of 593 patients (average across the month of 20 patients a day) and a total of 3,620 bed days.

- Whipps Cross: 14.0% equivalent to 310 patients, average across the month of 10 patients a day.
- Royal London: 8.8% equivalent to 164 patients, average across the month of 5 patients a day.
- Newham: 7.8% equivalent to 106 patients, average across the month of 4 patients a day.
- St Bart's: 0.9% equivalent to 19 patients, average across the month of less than 1 patient per day

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 Responsible Director Update

- Focussed work with both place based and out of area partners has commenced to develop a series of local MADE events as we enter the winter period to understand why patients with a historic discharge ready date are waiting longer for their onward care. The out of area focus is particularly beneficial to The Royal London, where out of area patients have an extended Length of stay in comparison to place based teams.

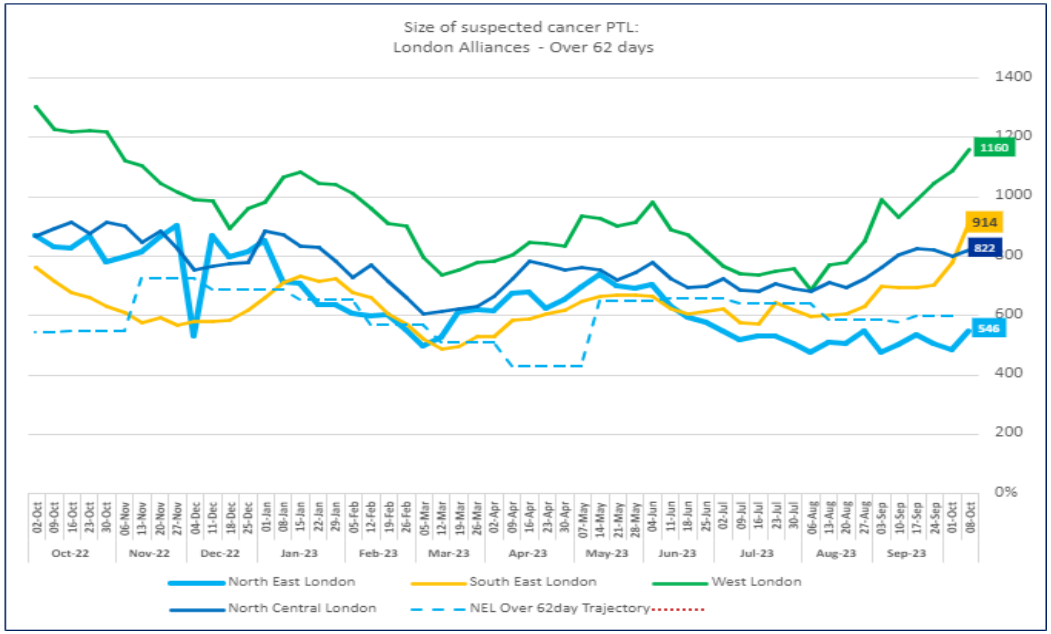
- The Trusts will maximise links with the new NHS NEL System co-ordination centre, which comes online on 1st November, to support the delivery of a system wide approach to community capacity ensuring equity and support for all patients.

- Work is underway at the Trust to maximise pre-11am discharges, develop the role of new virtual wards beds in supporting earlier discharge, and overall minimise the delays between a patient becoming discharge ready and actually being discharged.

Cancer waiting times Benchmarking performance

Cancer Benchmarking Against Other Trusts

Nov-23



08-Oct	Over 62 days	Change in last week	% of Total PTL	Total PTL
North East London	**546**	**+63**	**6.7%**	**8,148**
North Central London	822	+20	**9.0%**	9,145
South East London	914	+135	**10.0%**	9,163
West London	1,160	+72	**7.1%**	16,445
England	**25,669**	+749	**9.2%**	279,027

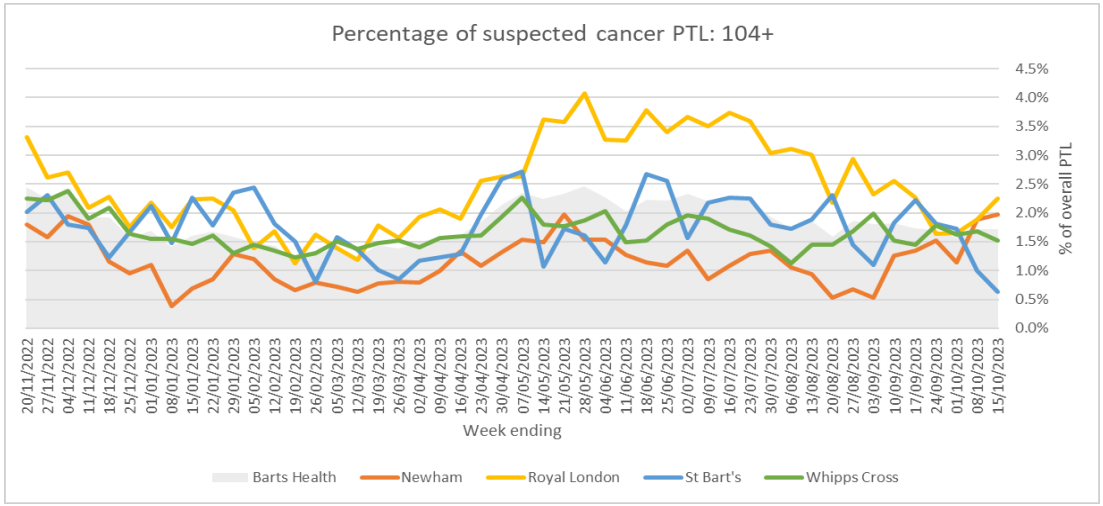
08-Oct	Over 62 days	Change in last week	% of Total PTL	Gap from NEL Over 62day Trajectory
North East London	**546**	**+63**	6.7%	50
Barking	**172**	+9	5.0%	31
Barts Health	**354**	+54	9.5%	4
Homerton Univ	**20**	+0	2.0%	8
London	**3,442**	+290	8.0%	

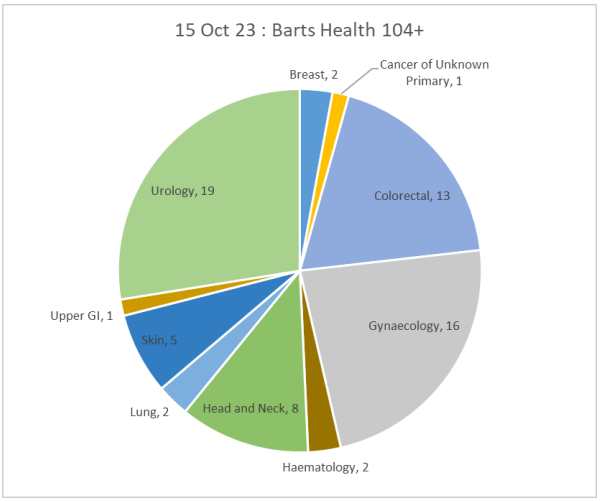
- In August, in the published Cancer Waiting Time (CWT) standards, Barts health achieved 6 of the 10 constitutional standards, an improvement from July when 5 out of the 10 standards were met.
- As at 8th October 2023, North East London (NEL) had the second lowest overall backlog within London Integrated Care Boards at 6.7%, with Barts Health having 354 patients (9.5%) waiting over 62 days.
- Barts Health continue to be in tier two, which involves bi weekly assurance meetings. Through being in tier two the Group was able to bid for some additional funds of £450,000 in order to support recovery.
- There are 2 of 3 Operational Improvement Managers now in post across NEL, focussing on the Best practice Timed Pathways for the next 12 months.
- The Cancer Performance Team are leading a series of improvements across the tumour groups of Gynae, Colorectal, Head and Neck and Urology, the areas with the greatest backlogs, which feed into the drive to five strategy that meets monthly, reporting up into the Elective Recovery Board.

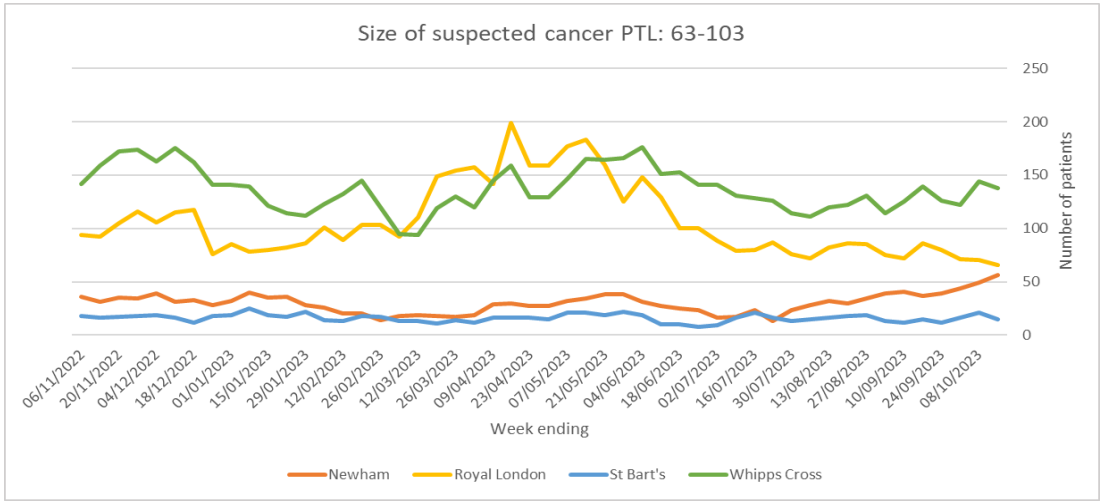
RESPONSIVE
Cancer

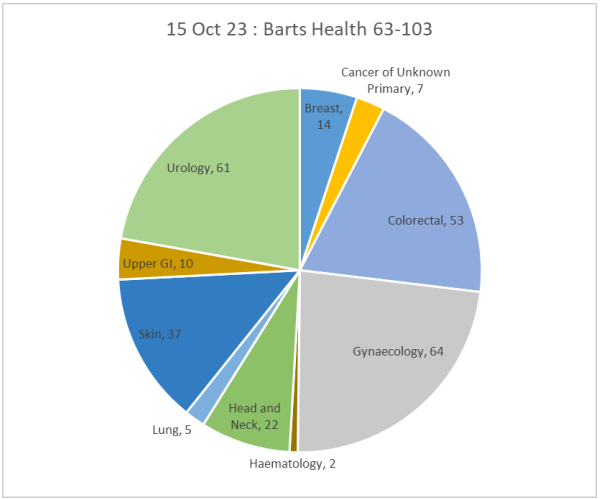
Cancer > 63 Waiting List Backlog

Nov-23





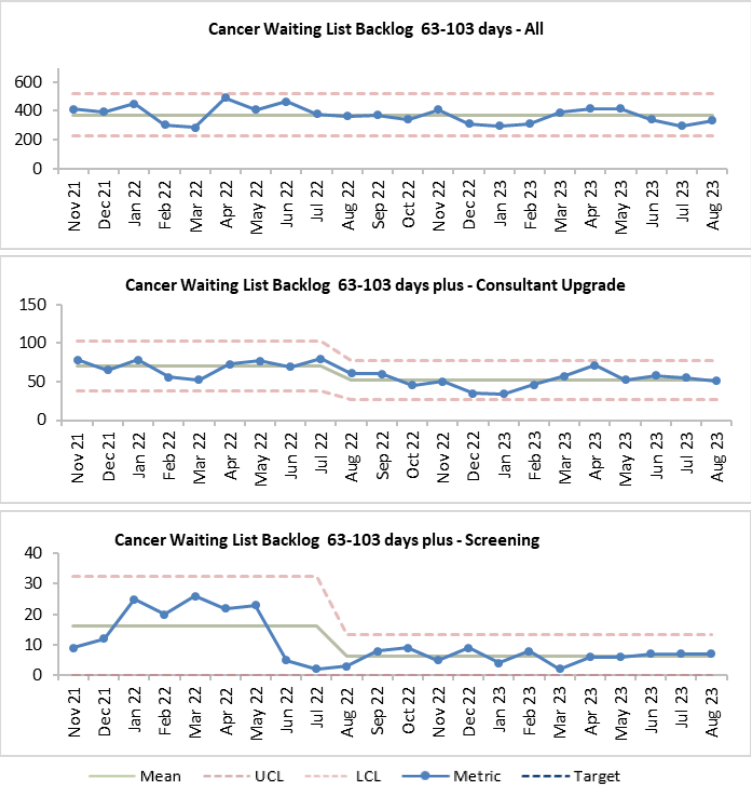




RESPONSIVE
Cancer

Cancer 63 -103 Waiting List Backlog

Nov-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 their 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, however the last three data points are showing a reduction below the mean.

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 September 2023 backlog reduction milestone is set at 338 against which the trust recorded 436, 98 above plan.

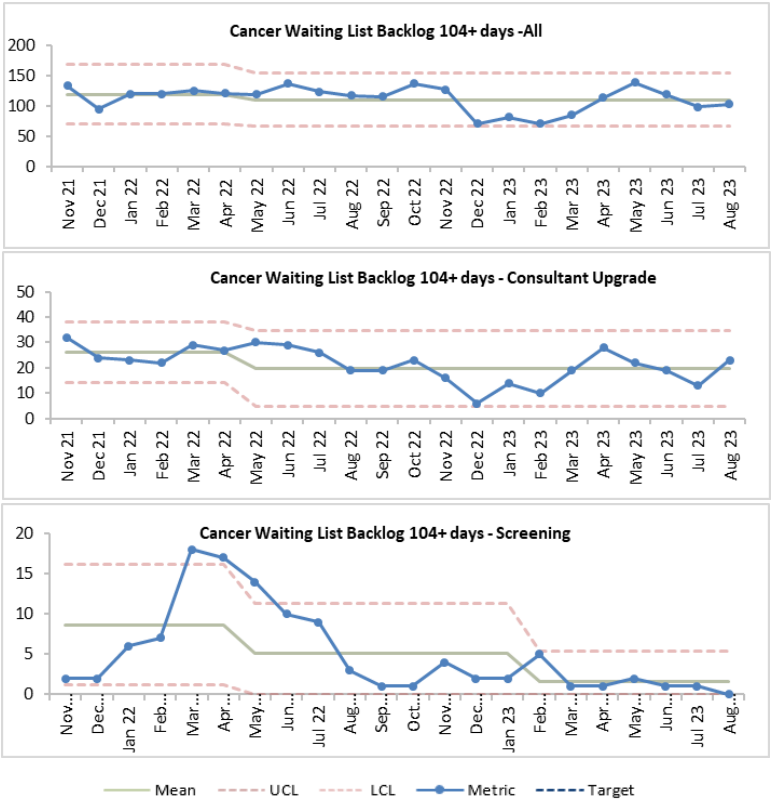
Trust Responsible Director Update

- As at 19th October the total backlog of patients waiting over 63 days was 471 of which 379 were GP referrals.
- The biggest tumour group involved Urology 94, Gynae 84, Colorectal 71 and Skin 56. All of these are monitored through daily tracking and monitoring through hospital meetings.
- There are delays within histopathology, a board is being set up through the cancer alliance to support improvements, with a new project manager who commenced in post early October to support this and work through some of the quick wins. Workforce remains the biggest challenge.
- Drive to five continues to track improvements currently being worked on within Urology, Gynae, Colorectal and Head and Neck. The cancer team are developing a plan regarding the skin pathway along with exploring Artificial Intelligence.

RESPONSIVE
Urgent & Emergency Care

Cancer 104+ Waiting List Backlog

Nov-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 2024.

What is the Chart Telling us:

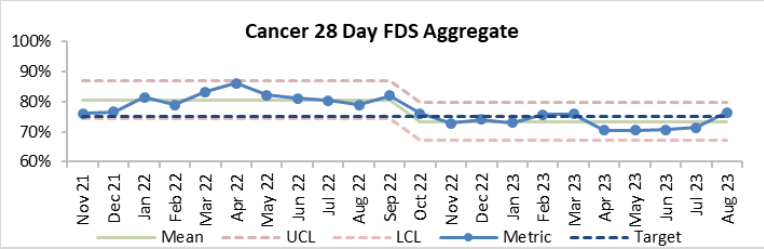
For Consultant Upgrade and Screening the charts present reducing step-changes in the data series resulting from a run of 8 data-points below the preceding mean, meaning backlog has reduced over the course of the charts time-series. The reductions have been sufficient to drive a reducing step change against All patients waiting from April 2022 with two of the last three data points recording a reducing backlog.

Trust Performance Overview

The charts opposite present the 103 cancer pathways waiting greater than 104 days at the end of August 23, an increase of 4 against the July position. The charts present the number of patients waiting by All referrals, Consultant Upgrade and Screening service referrals. This represents all patients waiting 104 days and above. All of these patients would go through the clinical harm review process, once treated.

RESPONSIVE

Cancer Faster Diagnosis Standard Metrics (FDS) Nov-23



	Jul-23			Aug-23		
Metric Name	Seen	Breaches	%	Seen	Breaches	%
Cancer 28 Day FDS Aggregate	3,126	740	76.3%	3177	786	75.3%
Cancer 28 Day FDS Breast Symptomatic	184	3	98.4%	204	9	95.6%
Cancer 28 Day FDS Screening	31	7	77.4%	24	4	83.3%

Breakdown by Tumour Sites Failing 28 Day FDS Standard (Agrregate) - Aug-23

Tumour Site	Seen	Breaches	Performance
All Tumour Sites	**3,177**	**786**	**75.3%**
Lung	43	13	69.8%
Gynaecological	320	108	66.3%
Head and Neck	313	108	65.5%
Upper Gastrointestinal	266	102	61.7%
Testicular	17	8	52.9%
Children's	2	1	50.0%
Lower Gastrointestinal	431	220	49.0%
Urological	206	112	45.6%
Haematological	30	17	43.3%
Other	5	3	40.0%
Brain/CNS	2	2	0.0%

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 chart presents performance against the Aggregate element of the standard. For the period November 2021 to September 2022 compliance was achieved against the 75% standard, however the Trust was non-compliant for the period October 2022 to January 2023. For February and March 23 the trust returned to compliance, however the standard was not achieved across April to June 23. For July and August 23 the trust returned to compliance recording a performance of 76.3% and 75.3% respectively.

Trust Performance Overview

For August 2023 the Trust achieved the standard for Breast Symptomatic (95.6%) and Screening referrals (83.3%), however just missed the standard for GP urgent referrals (73.8%), this resulted in the trust achieving the standard for All (aggregated) referrals, recording a performance of 75.3%, a decrease of 1.0% against July's 76.3%. This is the second consecutive month aggregated performance has achieved the national standard since March 2023.

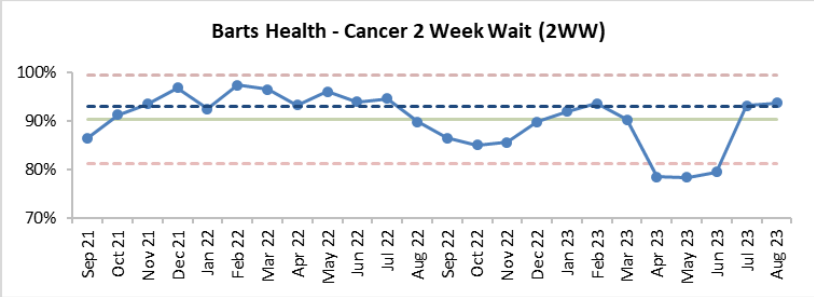
Trust Responsible Director Update

- The Group achieved aggregated Faster Diagnosis Standard (FDS) performance in August at 75.3% this was the second month in a row.
- The current September position is still being validated at 74.4%.
- Several tumour groups did not achieve the standard, they were within Lower Gastrointestinal (Colorectal) due to capacity shortfall, and one of the decontamination rooms being replaced within one hospital, followed by Urology due to lack of diagnostic capacity in several of the sub specialties, Gynae and H&N who were impacted due to staff absences, capacity shortfall and some diagnostic challenges.

RESPONSIVE

Cancer 2 Week Wait

Nov-23



Cancer 2WW Breakdown by Site - Aug-23

Site	Seen	Breaches	Performance	Target
Royal London	1,049	93	91.1%	93.0%
Whipps Cross	1,733	95	94.5%	93.0%
Newham	596	41	93.1%	93.0%
St Bart's	278	1	99.6%	93.0%
Barts Health	**3,656**	**230**	93.7%	**93.0%**

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

Tumour Site	Seen	Breaches	Performance
All Tumour Sites	**3,656**	**230**	**93.7%**
Other	80	25	68.8%
Gynaecological	409	87	78.7%
Head and Neck	359	34	90.5%

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 chart details a period of variable performance against the 93% standard for the period September 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 between March and June 2023 with April, May and June's performance dropping below the lower confidence limit, a significant reducing change in performance. However, performance significantly improved across July and August with the standard achieved in both of those months.

Trust Performance Overview

In August 2023 a performance of 93.7% was recorded in relation to the 2 week wait standard of 93%, a further improvement of 0.6% against July's 93.1%. Breaches of the standard reduced from 253 in July to 230 in August, the number of patients seen decreased slightly from 3,664 to 3,653 across the same period meaning the proportion of patients breaching the standard reduced.

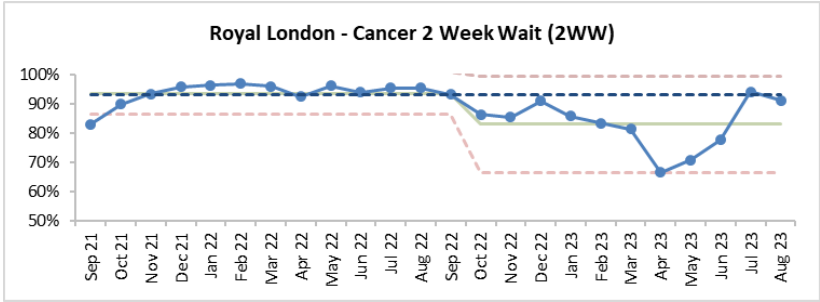
Trust Responsible Director Update

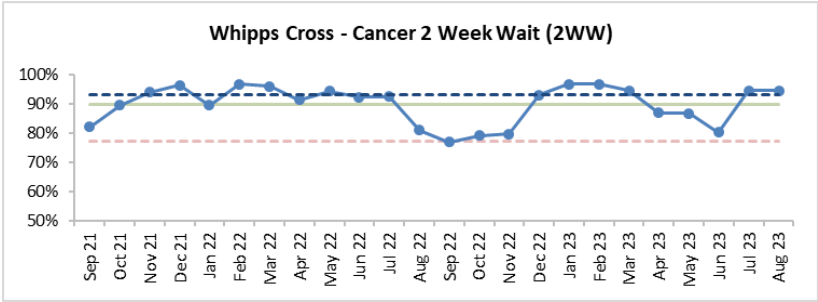
- The Group achieved the 2WW standard in August at 93.7% for the second month in a row.
- The Current September position is 92.2% which is still being validated before upload on the 1st November 2023.
- The challenges in August were within Gynae, H&N (ENT) and the Rapid Diagnostic Service known as Non Specific Symptoms (tabled above as other), due to a capacity shortfall. Another area of concern is within Skin, for which a mitigation plan is being developed.
- A group was established at the beginning of October to monitor changes to CWT standards, which now has a first new report in place within the BIU platform.

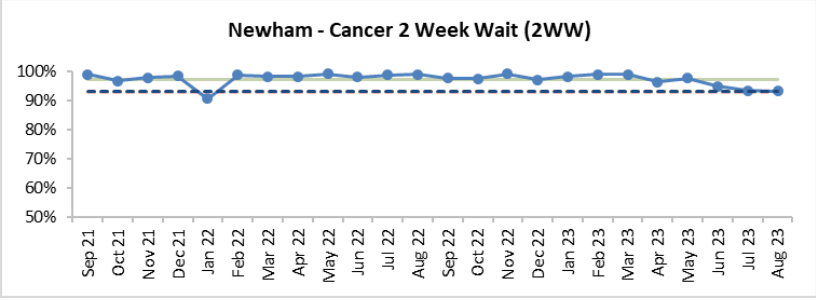
RESPONSIVE

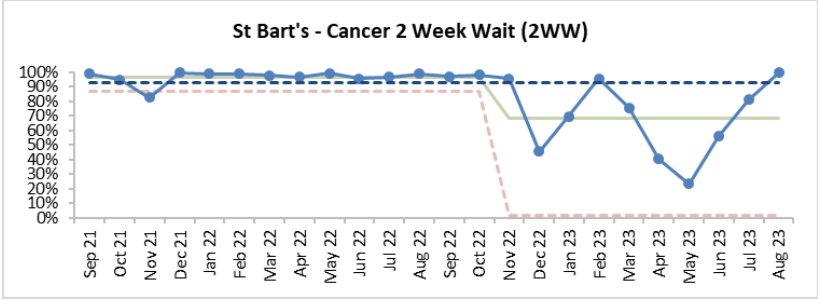
Cancer 2 Week Wait

Nov-23









Performance by hospital site against the 93% standard for July 23

For August 2023 three of the trusts four hospital sites exceeded the national standard:

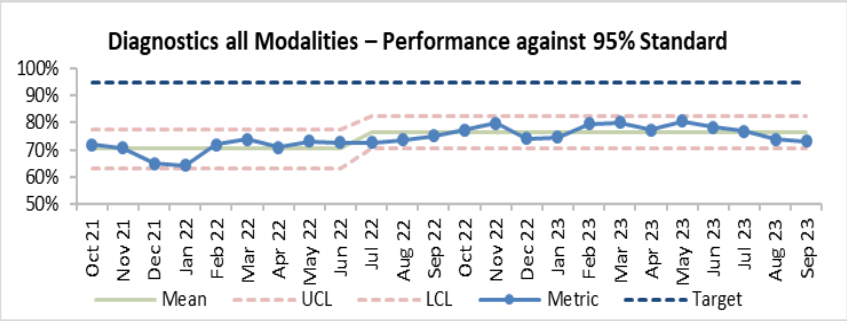
- St Bart's: 99.6%, this represents a sustained and significant performance improvement as presented graphically in the bottom right graph above. St Barts's have improved performance by 76.1% from a low of 23.5% recorded in May 23 to 99.6% recorded in August 23. To put this in context there was only one breach of the standard in August against 278 patients seen.
- Whipps Cross: 94.5%
- Newham: 93.1%

- Royal London did not achieve the standard, recording a performance of 91.1%. The majority of breaches were recorded in Skin, Upper Gastrointestinal and Other tumour site pathways.

RESPONSIVE

Diagnostic Waits Over 6 Weeks

Nov-23



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.

Trust Performance Overview

- For September 2023 a performance of 73.2% was recorded, a reduction of 0.7% against August's 73.9%. Imaging performance improved from 77.8% to 78.3%, whilst other modalities declined from 62.0% to 56.6%.
- The greatest challenges related to non-obstetric ultrasound (NOUS) and audiology long waits and performance.
- Some improvement has been seen for MRI and Cardiac CT long waits and performance, but some challenge remains. CT 6-week wait performance is not compliant (76.7%). This is directly associated with cardiac CT (47.7%).
- Endoscopy was DM01 compliant within one hospital, with two being noncompliant due to IA and capacity shortfall due to decontamination room being refurbished.
- Dexa performance at end September 23 is 77.8%. Mitigations are in place at the Royal London, and these challenges are not expected to be long-term.
- Physiological Measurements & Endoscopy continues to be challenged in several modalities, all of which have recovery plans in place or being developed. Some of which were impacted by IA.

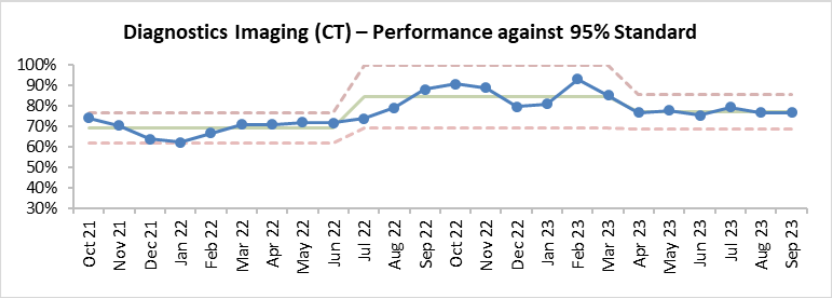
What is the Chart Telling us:

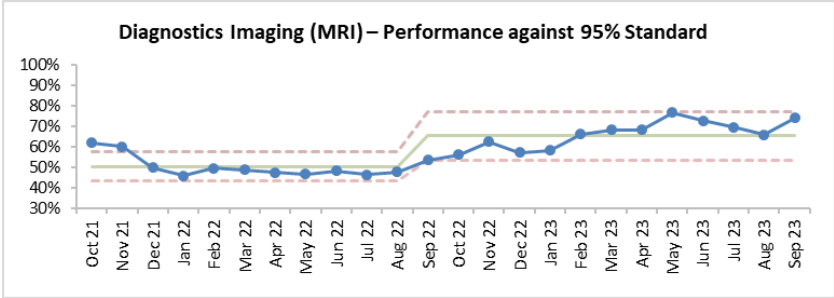
An increasing step-change (resulting from a run of 8 data-points above the preceding mean) may be observed from July 2022. This suggests a point in time where process changes started to drive breach reductions and performance improvement. Performance has been above or at the mean for the period February to July 23, however the last two data points have dropped below the mean.

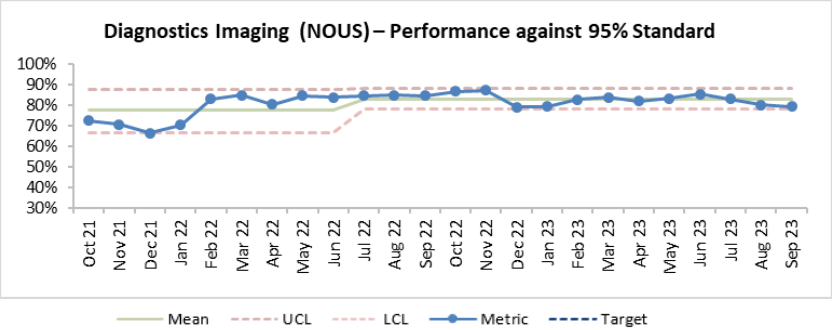
RESPONSIVE

Diagnostic Imaging Waits Over 6 Weeks

Nov-23







	Aug-23			Sep-23			
Test Name	**Waiting**	**Breaches**	**Performance**	**Waiting**	**Breaches**	**Performance**	**Variance in Performance**
Magnetic Resonance Imaging	5,127	1,740	66.1%	4,681	1,210	74.2%	8.1%
Computed Tomography	3,273	763	76.7%	3,245	755	76.7%	0.0%
DEXA Scan	1,129	189	83.3%	1,172	260	77.8%	-5.4%
Non-obstetric ultrasound	18,292	3,611	80.3%	18,725	3,829	79.6%	-0.7%
Grand Total	**27,821**	**6,303**	**77.3%**	**27,823**	**6,054**	**78.2%**	**0.9%**

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

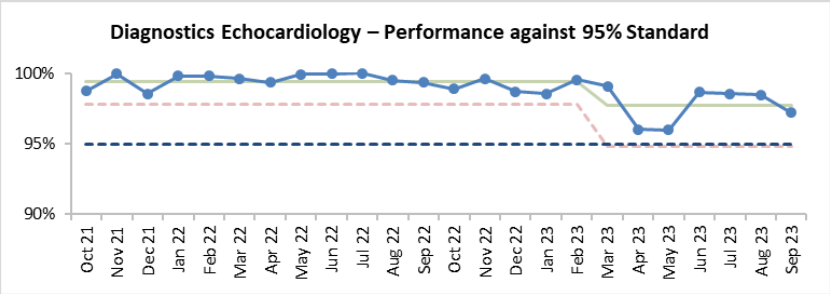
Trust Responsible Director Update

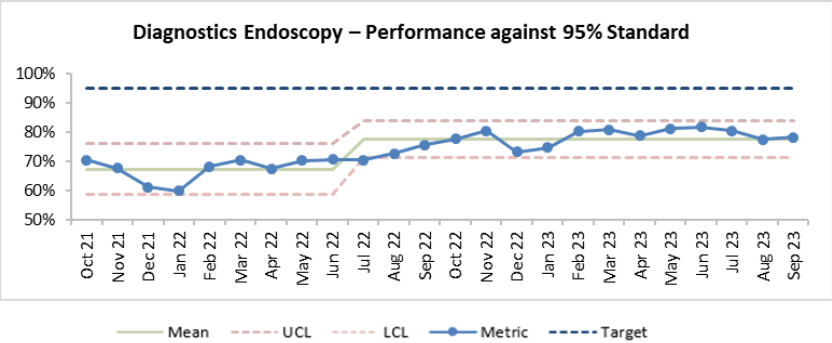
- Imaging modalities are broadly delivering overall against operating plan recovery performance commitments. Whilst Non-obstetric ultrasound (NOUS) is ahead of plan, CT and MRI are behind plan. The aggregate position (for MRI, CT and NOUS) is 78.3% vs 81.6% plan, with fewer patients waiting than forecasted, but more CT Cardiac and NOUS patients waiting more than six weeks than forecasted. NOUS performance has declined at the Royal London, whilst it is has improved at other sites.
- Latest data shows only 50 patients are waiting more than 13 weeks without an appointment, compared to 3,600 patients in January 2021.
- Opportunities to share MRI and CT capacity (including cardiac) across hospitals have been agreed by using capacity at Newham and Mile End; and other opportunities are being investigated.
- MRI and CT performance is much improved at the Royal London and their efforts are now focussed on NOUS via a local recovery forum. Collaborative NOUS capacity provided by Barking Havering and Redbridge Trust for Royal London Hospital may be pursued in the early new year. NOUS and MRI breaches account for 39.6% and 12.5% of all DM01 breaches at the end of September 2023 - a similar position to August 2023.
- Growth in imaging diagnostics demand continues, but activity is delivered above plan at more than 110% of 19/20 levels. Discussions are underway to review and consolidate the medium-term dependency on mobile MRI scanners and outsourcing, which should help mitigate the need for additional staff and reduce operating running costs. This is part of a wide-ranging review of staffing across NEL for all diagnostic services. This includes the future resourcing needs of clinical diagnostic centres and imaging training academies that are currently dependent on non-recurrent programme funding to operate.
- Following national guidance, reviews of pathways are continuing in support of direct access for cancer and urgent referrals and demand management opportunities.

RESPONSIVE

Other Diagnostic Waits Over 6 Weeks

Nov-23





	Aug-23			Sep-23			
Test Name	**Waiting**	**Breaches**	**Performance**	**Waiting**	**Breaches**	**Performance**	**Variance in Performance**
Urodynamics - pressures & flows	113	106	6.2%	104	79	24.0%	17.8%
Audiology - Audiology Assessments	3,268	2,140	34.5%	3,374	2,540	24.7%	-9.8%
Neurophysiology - peripheral neurophysiology	230	127	44.8%	260	148	43.1%	-1.7%
Cystoscopy	347	169	51.3%	449	252	43.9%	-7.4%
Cardiology - Electrophysiology	1	1	0.0%	2	1	50.0%	50.0%
Respiratory physiology - sleep studies	243	115	52.7%	297	114	61.6%	8.9%
Gastroscopy	982	224	77.2%	990	312	68.5%	-8.7%
Flexi sigmoidoscopy	194	45	76.8%	221	51	76.9%	0.1%
Colonoscopy	809	53	93.4%	781	73	90.7%	-2.8%
Cardiology - echocardiography	1,723	26	98.5%	1,860	52	97.2%	-1.3%
Grand Total	**7,910**	**3,006**	**62.0%**	**8,338**	**3,622**	**56.6%**	**-5.4%**

NB: Imaging Modalities are shown on the preceding slides

Trust Responsible Director Update

- In September the group saw a deterioration in both Physiological measurements and Endoscopy, with the exception of ECHO which achieved 97.2% which was the second month in a row they were compliant.
- Audiology has a business case approved to be supported by external provider to help clear the backlog within six months. The plan is for this provider to commence in Q3.
- Neurophysiology had a historic mismatch in data which has since been resolved and which is now supporting a business case which will help treat the complex patients, the simpler patients continue to be outsourced.
- Sleep studies is compliant at two hospitals, the third changed the booking process to mirror that of the other two hospitals, which subsequently created a backlog. Both hospitals are exploring supporting the challenged hospital.
- Endoscopy is monitoring utilisation through the bi weekly BH meeting. One hospital (RLH) has a decontamination room out of action, so capacity is being explored at other hospitals to support patients progressing on their pathways whilst a replacement room is completed.
- Urodynamics is relocating the service from RLH to Newham and Whipps Cross and a recovery trajectory is being developed with the support of Divisional colleagues.

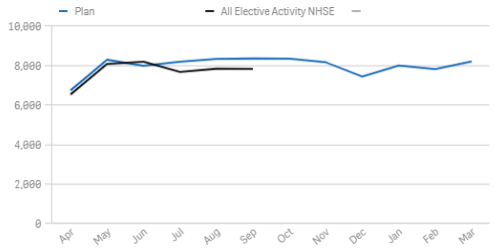
RESPONSIVE
Elective activity

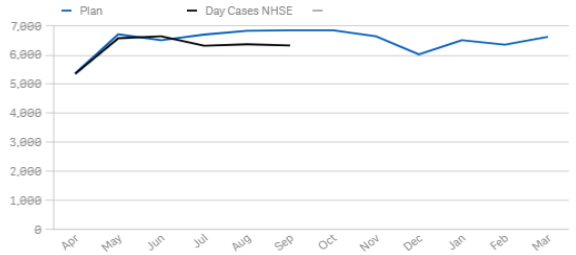
Admitted Activity against Plan

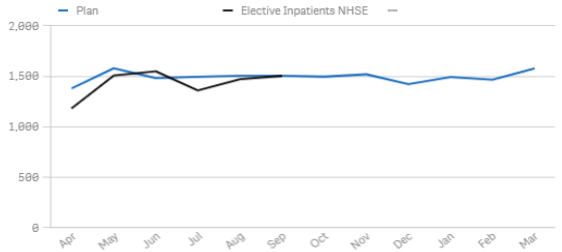
Nov-23

Admitted Elective Activity

		Barts Health						Last Month's Site Position			
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Royal London	Whipps Cross	Newham	St Bart's
All Elective Activity	Plan	6,726	8,260	7,961	8,167	8,308	***8,324***	*4,023*	*1,850*	*1,328*	*1,123*
	Actuals	6,519	8,053	8,162	7,656	7,812	***7,801***	*3,642*	*1,505*	*1,156*	*1,498*
	Mth variance plan	*-207*	*-207*	*201*	*-511*	*-496*	*-523*	*-381*	*-345*	*-172*	*375*
Elective Day Case Activity	Plan	5,351	6,686	6,484	6,678	6,807	***6,823***	*3,435*	*1,526*	*1,125*	*737*
	Actuals	5,340	6,552	6,619	6,300	6,346	***6,303***	*3,047*	*1,224*	*1,010*	*1,022*
	Mth variance plan	*-11*	*-134*	*135*	*-378*	*-461*	*-520*	*-388*	*-302*	*-115*	*285*
Elective IP Activity	Plan	1,375	1,573	1,476	1,489	1,500	***1,500***	*588*	*324*	*203*	*386*
	Actuals	1,179	1,501	1,543	1,356	1,466	***1,498***	*595*	*281*	*146*	*476*
	Mth variance plan	*-196*	*-72*	*67*	*-133*	*-34*	*-2*	*7*	*-43*	*-57*	*90*







Data As at 19/10/2023

Performance Overview	Responsible Director Update
• 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 September 2023 the trusts admitted (inpatient and day case) trajectory set a target of 8,324 admissions against which the trust delivered 7,801 (-523 admissions).	• As at 8 October the validated RTT PTL was 121,045 • The total number of elective cases cancelled due to Industrial Action in October was 123 and from March – October 2023 is 2080, this is both day case and inpatient. • There is under utilised capacity which has not been quantified in the cancellation numbers as hospital operational teams avoid booking into slots that may have to be cancelled. • However, Since June there has been an reduction in the cancelation rate. This is due to 2 factors : improved data capture and holding of capacity (hospital teams not booking into all capacity over the course of a month in order to avoid having to cancel). Work continues with BIU to deliver an estimate of the impact of un-booked capacity. • The cross site surgical optimisation group meets regularly and has been focusing on tactical movement of services. Updates are provided to the Elective Recovery Board (ERB) and focus remains on opportunities to agree further long-term moves particularly of high volume, low complexity cases (HVLC).

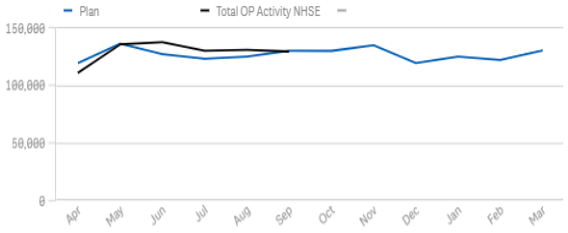
RESPONSIVE
Elective activity

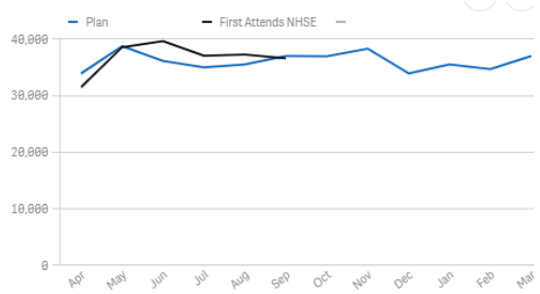
Non Admitted Activity against Plan

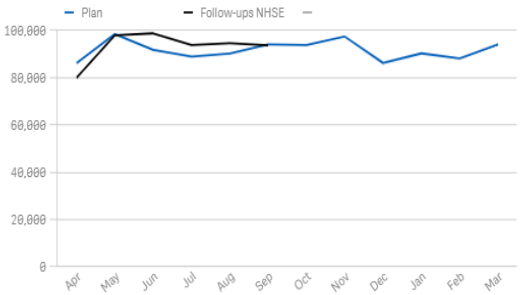
Nov-23

Outpatient Activity

		Barts Health						Last Month's Site Position			
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Royal London	Whipps Cross	Newham	St Bart's
Total OP Activity	Plan	119,595	136,608	127,368	123,379	125,187	***130,477***	*54,477*	*31,121*	*21,101*	*23,778*
	Actuals	111,126	135,899	137,766	130,299	131,269	***129,611***	*52,012*	*30,737*	*21,842*	*25,020*
	Mth variance plan	*-8,469*	*-709*	*10,398*	*6,920*	*6,082*	***-866***	*-2,465*	*-384*	*741*	*1,242*
Outpatient First	Plan	33,777	38,575	35,970	34,843	35,354	***36,847***	*14,668*	*11,961*	*5,266*	*4,952*
	Actuals	31,389	38,382	39,441	36,911	37,088	***36,451***	*14,378*	*10,913*	*5,542*	*5,618*
	Mth variance plan	*-2,388*	*-193*	*3,471*	*2,068*	*1,734*	***-396***	*-290*	*-1,048*	*276*	*666*
Outpatient F/up	Plan	85,818	98,033	91,398	88,536	89,833	***93,630***	*39,809*	*19,160*	*15,835*	*18,826*
	Actuals	79,737	97,517	98,325	93,388	94,181	***93,160***	*37,634*	*19,824*	*16,300*	*19,402*
	Mth variance plan	*-6,081*	*-516*	*6,927*	*4,852*	*4,348*	***-470***	*-2,175*	*664*	*465*	*576*







Data As at 19/10/2023

Performance Overview	Responsible Director Update
• 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 outpatients (first and follow up) for the same month the trajectory set a target of 130,477 attendances, against which the trust delivered 129,611 (-866 attendances).	• Industrial action in October has led to the cancellation of 1,624 outpatient appointments with 25,424 being cancelled since March 2023 due to IA. Despite the impact of industrial action as highlighted above, there has still been progress on expediting care to some of our longest waiting patients. There have also been a range of initiatives undertaken to ensure that patients' elective care is progressing and a specific clinical harm review process has also put in place. • The Further Faster gap analysis has identified patient DNA rates a key area of improvement. Improving clinic templates and promoting the use of patient-initiated follow-ups (PIFU) are key areas of opportunity. Prioritisation of actions at site level is underway. • At the end of September 2023, 73,700 patients had enrolled onto Patient Knows Best (PKB) (August 64,000), which gives patients secure access to their health record via an online portal. 1,850 are registering each week, 10,000 patients are logging in each week. In September, functionality for patients to see letters and Maternity discharge summaries went live and work is on-going to provide visibility of test results. • Patient Initiative Follow Up (PIFU) is when a patient initiates an appointment when they need one, based on their symptoms and individual circumstances. A PIFU Dashboard launched in September alongside a toolkit to support wider rollout. Uptake rates continue to improve, at the end of September Gastroenterology, Occupational Therapy, T&O were at over 3% and Physiotherapy at 11%.

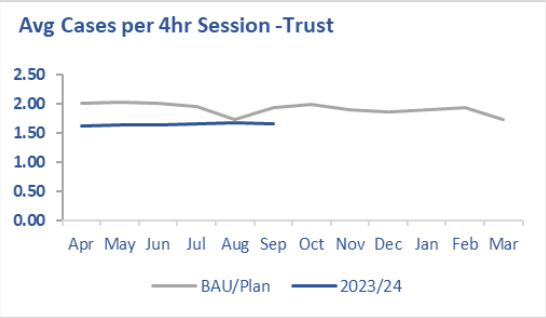
RESPONSIVE
Elective activity

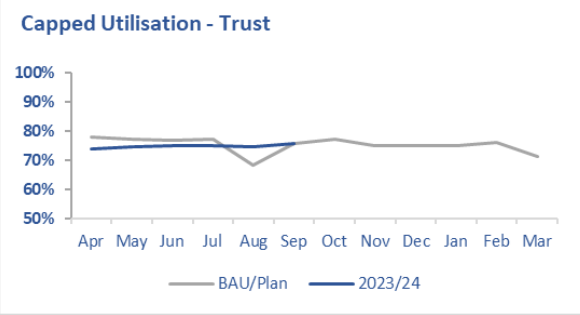
Theatre Efficiency

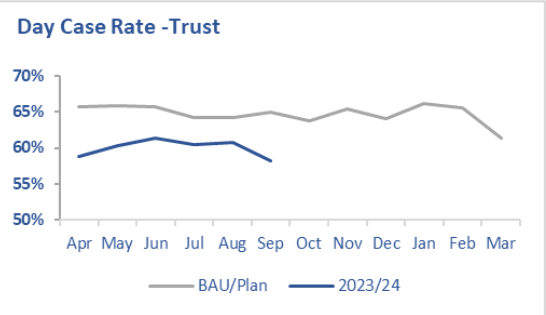
Nov-23

Efficiency Activity

		Barts Health						Last Month's Site Position			
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Royal London	Whipps Cross	Newham	St Bart's
Avg Cases per 4hr Session	Actuals	1.67	1.64	1.62	1.65	1.68	1.66	1.55	2.16	2.14	1.00
	BAU	2.02	2.03	2.01	1.96	1.74	1.94	1.81	2.66	2.20	1.15
	Mth variance plan	*-0.34*	*-0.39*	*-0.39*	*-0.31*	*-0.06*	*-0.28*	*-0.27*	*-0.50*	*-0.07*	*-0.14*
Capped Utilisation	Actuals	74.0%	74.6%	75.4%	74.6%	74.0%	75.6%	78.4%	67.2%	79.3%	76.1%
	BAU	77.7%	77.0%	76.8%	77.2%	68.0%	75.7%	74.6%	75.2%	74.3%	80.6%
	Mth variance plan	-3.7%	-2.4%	-1.4%	-2.6%	6.0%	-0.1%	3.8%	-8.0%	5.0%	-4.5%
Day Case Rate	Actuals	55.6%	57.0%	58.0%	60.4%	61.0%	58.2%	55.3%	69.3%	74.9%	14.2%
	BAU	65.6%	65.9%	65.7%	64.2%	64.0%	64.9%	63.5%	77.5%	73.1%	20.3%
	Mth variance plan	-10.0%	-8.9%	-7.7%	-3.8%	-3.0%	-6.7%	-8.2%	-8.1%	1.8%	-6.1%







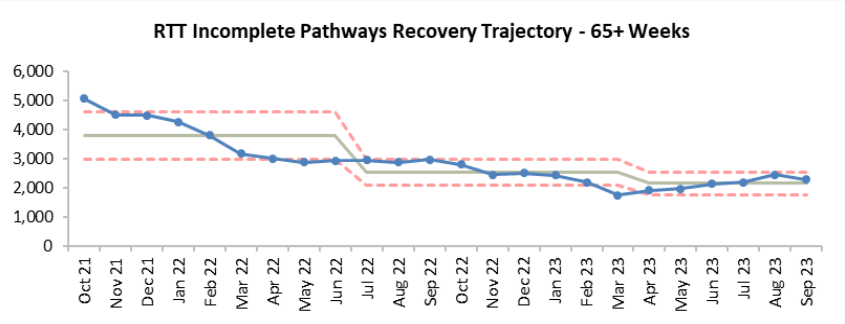
Data As at 19/10/2023

Performance Overview	Responsible Director Update
• Set against internal trust data for September 1.66 cases per list were achieved against a BAU of 1.94 (-0.28). • For the same month, a capped utilisation rate of 75.6% was recorded against a BAU of 75.7% (-0.1%). • For September a day case rate of 58.2% was recorded against a BAU of 64.9% (-6.7%).	• The Barts Health Planned Care programme board, chaired by the Chief of Surgery, is reviewing this data set and under taking a deep dive with Hospitals in order to identify good practice and opportunities within specialties that can be adopted across hospitals in order to promote a step change. • A non-elective T&O theatres improvement project continues with teams currently testing the 'golden patient' protocol to identify any issues with embedding this, alongside raising visibility of the 36-hour turnaround time for theatres. • Care Coordination Solution (CCS) is live across all theatres at Newham, Barts Health Orthopaedic Centre (BHOC). The theatre session management module is in use, a few issues have been identified and work is ongoing to resolve them. The waiting list module is not yet live with further sampling required before roll out. • BHOC had a NHS Surgical Hub accreditation visit on 17.10.2023. Initial feedback has been very positive. In particular the culture and inclusivity of the unit and the way the network has been used to optimise the delivery of elective orthopaedic care at the hub and some of the operational developments to reduce fallow rates attracted particularly positive comments.

RESPONSIVE

65+ Week RTT Activity

Nov-23



Trust Performance Overview

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 September the trust recorded 2,291 pathways waiting 65+ weeks, an increase of 164 against the July position.

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:

The SPC chart presents a sustained reduction in 65+ week waiters from September 21 to March 23, driving reducing step-changes in May 22 and March 23, this data suggests points in time where process changes started to drive backlog reductions. However increases in the volume 65+ week wait patients have been recorded across the period April to August 23, with August breach volumes approaching the upper confidence limit.

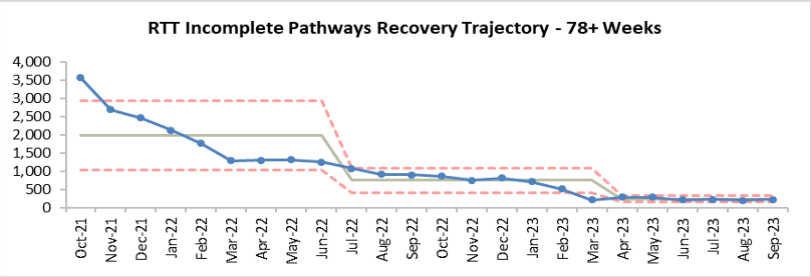
Trust Responsible Director Update

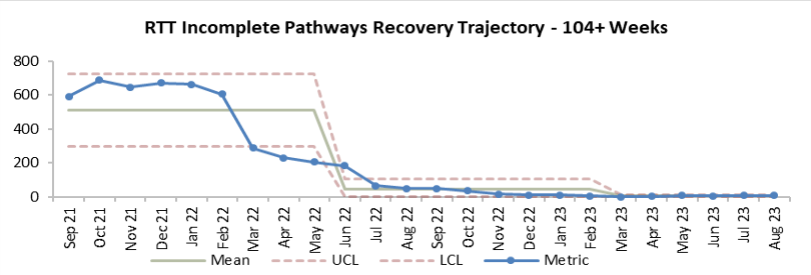
- The high level run rate for patients who will be 65 weeks by the end of March 2023 remains positive.
- As of 08th October 23, there were 5,204 patients who needed a 1st appointment booked, this was 1,096 fewer than the previous week. This improving picture is being driven by increased bookings, removals due to treatments, and removals other than treatment (ROTT).
- The 2 largest specialties contributing to the pathways left to book at the end of October are Dermatology and Oral Surgery. Both of these have low volumes of conversion to surgery (3% and 6% respectively). They therefore remain a low risk to achieving 0 65 week wait pathways left by the end of March 2024.
- A short business case was submitted to NHSE London to fund the Digital Mutual Aid System (DMAS) programme, which acts as a portal for NHS Trusts to request capacity. This has had a positive response although below the amount requested. This funding will provide scope to support delivery of the DMAS programme.
- Transfers of patients to BHRUT have been successful with more than 250 patients moving for their first outpatient appointment, teams continue to identify and contact other patients to offer them this opportunity across a wide range of specialities including respiratory medicine, gastroenterology and vascular. This highlights benefits of a successful collaborative approach across BHRUT and Barts Health.
- Working with an external provider the Trust has sent out more than 25,000 text messages to patients who have been waiting >12 weeks and have not been validated or have a future appointment. To date almost 10,000 response have been received, those who do not respond to the text will now receive a letter asking them to confirm if an appointment is still required.
- Administrative validation work to date has resulted in the removal of 1035 patients for the >65 week waiting cohort across the Trust.
- Industrial action remains a continued risk to our 65-week clearance plan due to the need to cancel patients as well as rebook and look to prioritise cancer, urgent patients and long waiters.
- Regular tracking of actions is being undertaken to reduce the 65 week wait cohort

RESPONSIVE

78+ & 104+ Week RTT Activity

Nov-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) in both cases from June 22 and March 23. This suggest points in time where process changes started to drive backlog reductions.

Trust Performance Overview

- In relation to 78+ week wait backlog volumes, 241 pathways were reported at the end of September, an increase of 37 against the August position.
- In relation to the RTT month-end nationally submitted data the trust reported 8 pathways waiting 104+ weeks at the end of September 2023, the same number reported at the end of both July and August.

Trust Responsible Director Update

- Hospitals continue to undertake detailed tracking of each of these patients as well as future breaches and work continues to support chronological booking to ensure that the patients who have been waiting for the longest time are seen first where clinically appropriate.
- Hospitals are supported by group infrastructure, with issues escalated and resolved as required.

Nov-23

NHS
Barts Health
NHS Trust

Equity Report

SUMMARY

Equity Summary

Nov-23

Ethnicity capture
Trust performance across A&E, Inpatients and Outpatients remains above 90%. However, there has been a marked decrease overall since December 2022 which is of concern and has been raised with site leads. We are also working to embed a regular digital download of ethnicity data from GP records in the coming months for missing records.

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, learning disability status, and between groups of patients who live in wealthier postcodes compared with those who live in deprived postcodes. We explored differences between ethnic groups and varying levels of deprivation (by postcode) at Trust, as well as hospital level. The analysis is a snapshot of data from 20th October 2023.

We now include median wait times in our analyses. This is because waiting times are often not a standard distribution and are skewed by a few very long waiters. The median is considered a better summary statistic than the mean or average in those circumstances.

Findings
At Trust level, there are no significant differences in average wait times between ethnic groups or between male and female patients.

In this month's snapshot, we did note a statistically significant difference in waiting times for patients with learning disabilities. We have escalated this to the Surgery Leads and are presenting the findings to the Planned Care Board. We believe this is primarily a result of long waits at RLH for Restorative Dentistry.

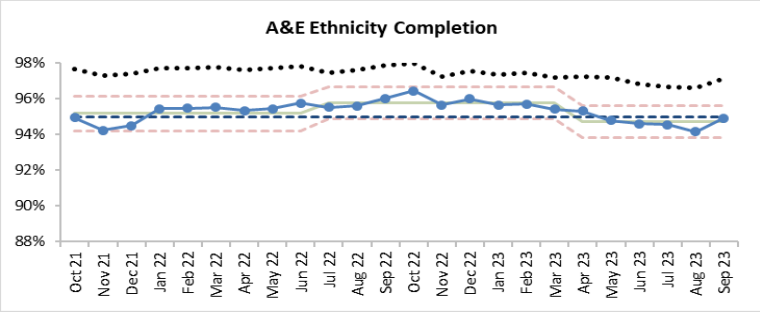
Unlike last month, there were no significant differences in wait times between patients from deprived postcodes and patients from wealthier postcodes. Therefore, as last month's finding seems to be incidental, we do not believe there is a correlation between deprivation and wait times.

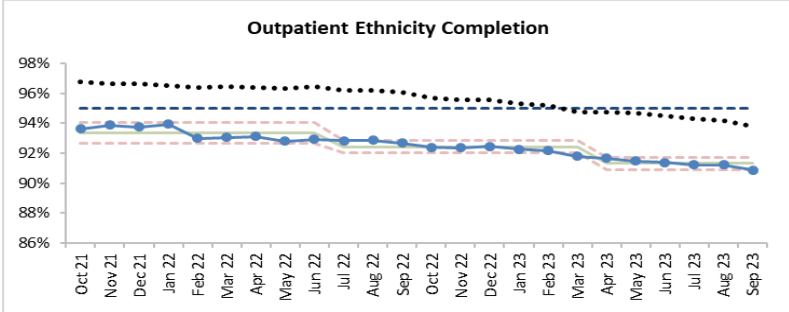
Next steps
We will continue to work with our Divisional Teams to mitigate the slight increase in the waiting times for patients with Learning Disabilities and address data quality.

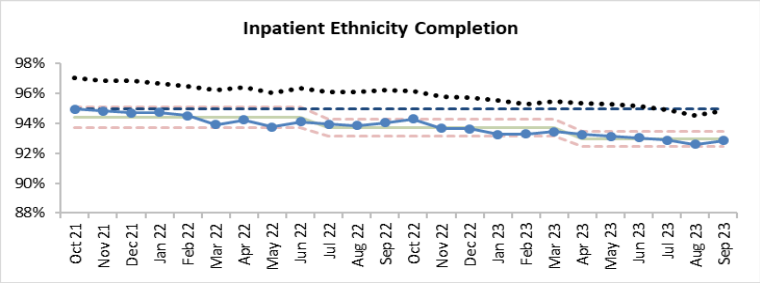
RESPONSIVE

Ethnicity Recording by Activity Type

Nov-23







Ethnicity Recording by Activity Type - % Completion - Sep-23

Site	A&E	Inpatient	Outpatient
Royal London	96.1%	89.4%	89.4%
Whipps Cross	92.8%	93.4%	90.4%
Newham	95.5%	96.5%	95.6%
St Bart's	-	95.3%	90.1%
Trust	**94.9%**	**92.8%**	**90.9%**

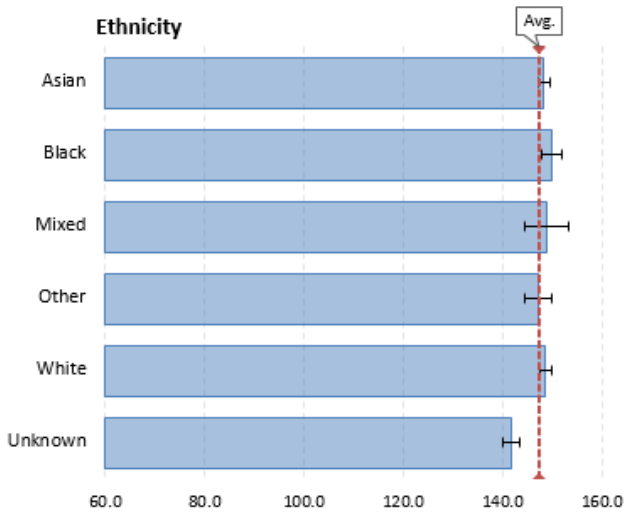
The above figures show the % activity where the ethnicity of the patient is known and has been recorded (i.e. not including where it has not been requested, recorded as not stated or the patient has refused to give it). The dotted black line shows what the % recorded would be expected to be if North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

Performance Overview	Responsible Director Update
• Trust performance across all three activity areas remains above 90%. However, there has been an increase in capture rate across all three activity areas since the last reporting period. • Newham Hospital achieved the highest capture rate in Inpatient and Outpatient at 96.5% and 95.6% respectively. This is an increase of 1.6 and 3.7 percentage point, respectively. • St Barts has shown a decline in capture rate in Outpatient by 1.6 percentage point since the last reporting. • Royal London continues to achieve the highest capture rates in A&E at 96.1%. However, there is a decrease in capture rates in Outpatient by 0.1 percentage point. • Whipps Cross has an increase capture rates for A&E and Inpatient by 0.4 and 0.4 percentage points.	• It is encouraging to see 95% capture being achieved across the three activity areas of Newham, A&E at Royal London and Inpatient at St Barts, • Led by an analyst at St. Barts, we have recently trialled digitally downloading ethnicity data from GP records that is missing in our data set. We are working with ICT to embed this function/download so that it happens at regular intervals.

RESPONSIVE

Equity - Wait Times By Ethnicity

Nov-23



Summary Data

Ethnic Category	Total Wait Time (Days)	# of Pathways
Asian	5,408,290	36,455
Black	2,108,803	14,078
Mixed	422,919	2,839
Other	1,078,701	7,326
White	6,066,544	40,815
Unknown	2,934,109	20,705

Pathways with no Week Wait details excluded

Ethnic Category	Average Wait (Days)	Lower CI	Upper CI	Median WW
Asian	148.4	147.1	149.6	16-17
Black	149.8	147.8	151.8	16-17
Mixed	149.0	144.5	153.5	16-17
Other	147.2	144.5	150.0	16-17
White	148.6	147.4	149.8	16-17
Unknown	141.7	140.1	143.3	14-15
Grand Total	147.4			**14-15**

Commentary

At Trust level, there are no statistically significant differences in wait times between patients from known ethnic groups. This is consistent with findings from last month.

The longest waiters identify as belonging to the 'Black' ethnic category with an average wait of 149.8 days. This is 2.6 days longer than the shortest waiters belonging to the 'Other' ethnic category. We have not found any statistically significant differences in wait times between any of the known ethnicity groups. This means we cannot infer with confidence if the differences seen in wait times are directly related to ethnicity, or if this is due to random chance.

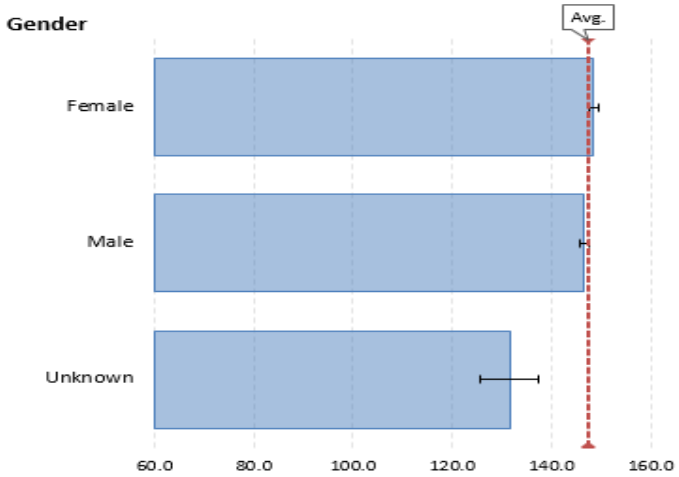
We believe the shorter waits for unknown ethnic groups may be as they are more likely to be urgent referrals.

Median wait times are 16 – 17 weeks for all known ethnic categories.

RESPONSIVE

Equity – Wait Times by Gender

Nov-23



Commentary

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

The wait time from referral to treatment by gender is similar for male patients when compared with female patients (146.6 days vs 148.4 days respectively). This month, the median wait has however fallen to 14-15 weeks for male patients and remained at 16-17 weeks for female patients.

Patients of 'unknown' gender are shown to have significantly shorter wait times compared to those of known genders. We will continue to monitor trends in this data.

Summary Data

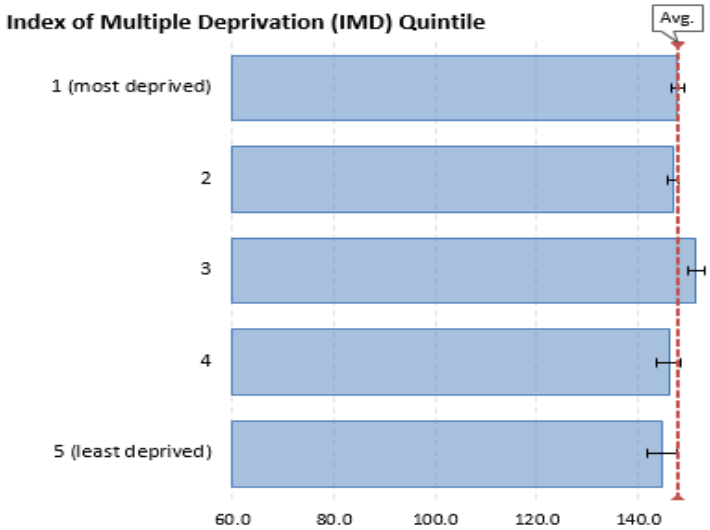
Gender	Total Wait Time (Days)	# of Pathways	Pathways with no Week Wait details excluded
Female	10,169,563	68,513	
Male	7,643,551	52,138	
Unknown	206,252	1,567	

Gender	Average Wait	Lower	Upper	Median WW
Female	148.4	147.5	149.3	16-17
Male	146.6	145.6	147.6	14-15
Unknown	131.6	125.8	137.4	12-13
Grand Total	147.4			**14-15**

RESPONSIVE

Equity – Wait Times By Deprivation

Nov-23



Summary Data

IMD Quintile	Total Wait Time (Days)	# of Pathways
1 (most deprived)	4,338,020	29,362
2	8,140,089	55,432
3	2,941,966	19,431
4	1,497,641	10,256
5 (least deprived)	888,311	6,137

Pathways with no Week Wait details excluded

IMD Quintile	Average Wait	Lower	Upper	Median WW
1 (most deprived)	147.7	146.3	149.1	14-15
2	146.8	145.8	147.9	14-15
3	151.4	149.7	153.1	16-17
4	146.0	143.6	148.4	14-15
5 (least deprived)	144.7	141.8	147.7	14-15
Grand Total	147.6			**14-15**

Commentary

This month, there is no statistically significant difference in wait times between patients in the most deprived postcodes, and those in the least deprived postcodes.

These findings show an improvement in position when compared to last month's report, as median wait times have fallen to 14-15 weeks for all patients except those in the third quintile of deprivation, which remains at 16-17 weeks.

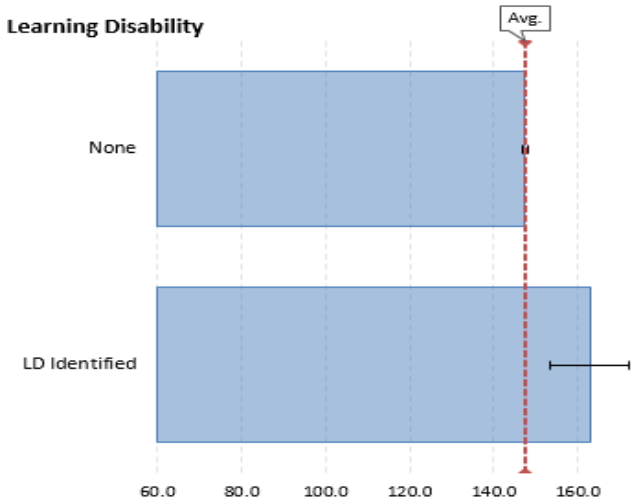
There is evidence of patients in the third quintile of deprivation having significantly longer wait times than those in the least deprived postcodes, with an average difference of 6.7 days.

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

RESPONSIVE

Equity – Wait Times by LD

Nov-23



Commentary

This month, there is a statistically significant difference in waiting time for patients identified as having a learning disability (LD).

Last month we reported early signs of the average wait difference between LD and non-LD patients growing, with a mean difference of 15 days. This month, the difference is 15.5 days. The median waits also show a growing difference, as those who have not been identified as having a learning disability have a median wait or 14-15 weeks, while the median wait for those with a learning disability is 18-19 weeks.

Most patients with an LD waiting for surgery are at Royal London, with 22 waiting for surgery in Restorative Dentistry.

We have escalated this growing disparity to Divisional Leads and are presenting findings to the Planned Care Board.

Summary Data

LD_Flag	Total Wait Time (Days)	# of Pathways
None	17,893,707	121,446
LD Identified	125,659	772

Pathways with no Week Wait details excluded

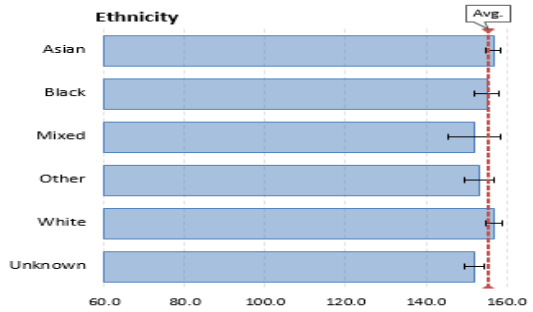
LD_Flag	Average Wait	Lower	Upper	Median WW
None	147.3	146.7	148.0	14-15
LD Identified	162.8	153.6	171.9	18-19
Grand Total	147.4			**14-15**

RESPONSIVE

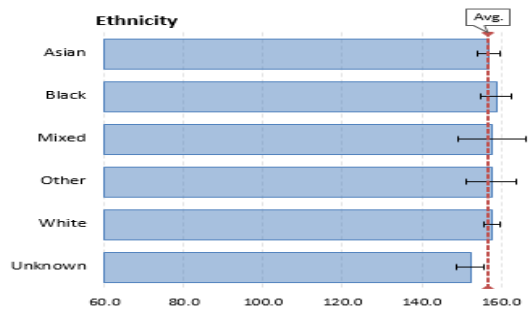
Equity - Wait Times By Ethnicity (Sites)

Nov-23

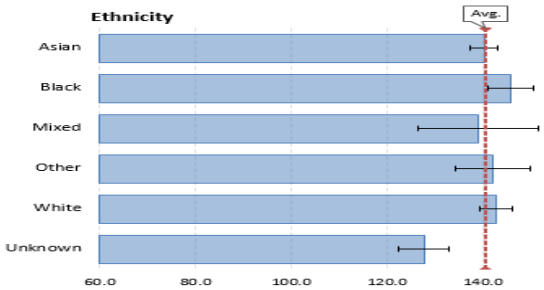
Royal London



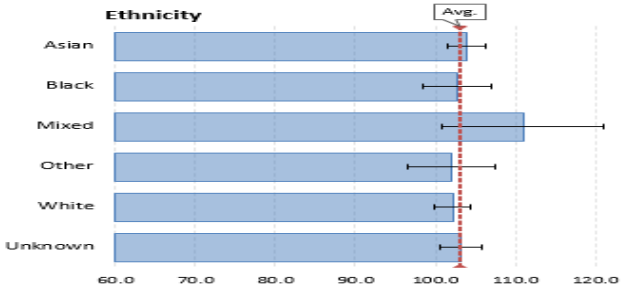
Whipps Cross



Newham



St Barts



Commentary

At the site level, we did not identify any significant differences in wait times between ethnic categories. However, there appears to be greater variation in wait times at Newham and St Barts.

This broadly reflects findings from last month. Average wait times across all ethnic categories has decreased from last reporting period by 5.9 days to 147.4 days. Median wait time is 14 – 15 weeks. These findings may be skewed by the 'Unknown' ethnic category. When comparing wait times for known ethnic categories, median wait time is 16 – 17 weeks. We believe patients in the 'Unknown' category are more likely to be urgent referrals and previously unknown to the Trust. We are investigating data quality issues and will continue to monitor trends.

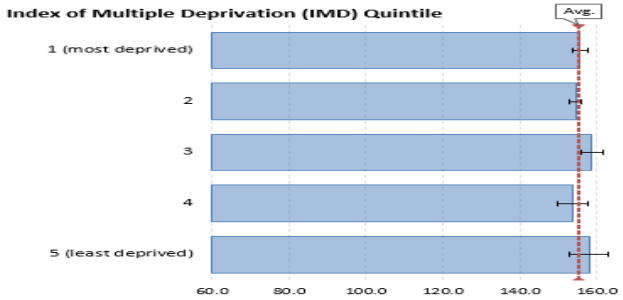
Work to automatically download ethnicity data from primary care is underway to reduce the number of 'Unknown' pathways.

RESPONSIVE

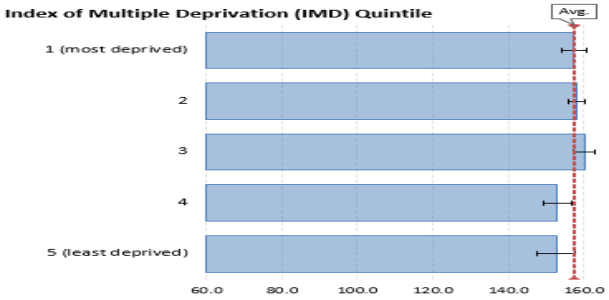
Equity – Wait Times By Deprivation (Sites)

Nov-23

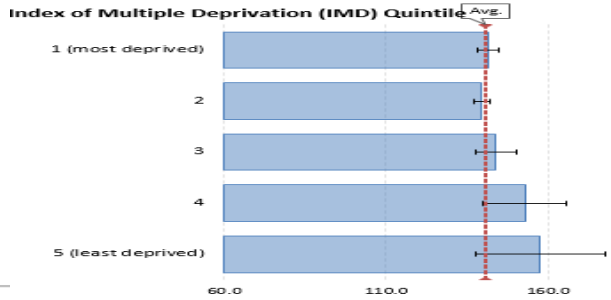
Royal London



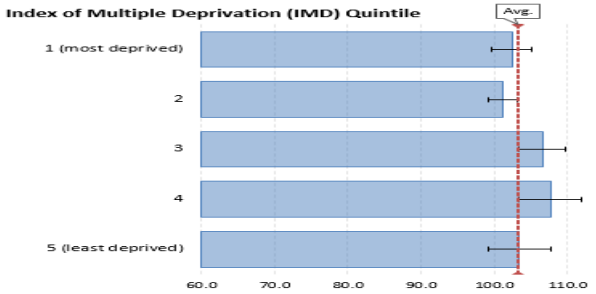
Whipps Cross



Newham



St Barts



Commentary

At site level, there are no statistically significant differences in wait times between patients living in the most deprived areas (IMD 1) and least deprived areas (IMD 5).

There does appear to be some variation in wait times between patients living in IMD 2 – 4 areas at Whipps Cross and St Barts Hospitals, where there are small differences in wait times of less than 1 day. These are not of concern yet as they appear to be incidental findings. We will continue to monitor for trends.

The longer wait times from last reporting period for Whipps Cross Hospital patients living in the most deprived areas compared with the least deprived areas appears to have resolved and is no longer statistically significant. The average wait times for deprivation at Whipps Cross Hospital is 157.4 days this month and the difference in wait times has reduced from 10 days reported in the July IPR to 5 days. Median wait times has also reduced from 18 – 19 weeks from last reporting period to 16 – 17 weeks.

At Newham, wait times for patients living in the most deprived areas appear to be decreasing. Average wait times by deprivation have reduced from 146.2 to 140.9 days. However, patients from IMD 4 and 5 areas continue to wait longer than other patients. Median wait times at Newham for IMD 4 and 5 area patients is 18 – 19 weeks compared with the overall median for Newham of 14 – 15 weeks. This is likely not an accurate reflection of these patients seeking care elsewhere.

NHS
Barts Health
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People Report

SUMMARY

People Summary

Nov-23

Fostering new ways of working to transform care

- Roster compliance – approval on time marginally improved from 55.9% for rosters commencing in September with Whipps having the highest level of on time approvals at 91%. The average lead time for approval was 40.2 days.
- Roster compliance - % nursing units with blue or cloudy sky (signifiers of threshold performance against compliance) is our quality metric for rosters. It is not reported this month as we make the previously identified change in the timing of this data cut, which we are not able to retrospectively make due to system limitations. Reporting on this metric will return from next month.

Supporting the wellbeing of our colleagues

- As a group annualised voluntary turnover appears to have stabilised at 10.6% for the second month, although performance across the hospitals is variable with continued improvement at St Bartholomew's (12.2% from 12.4%) and in the Pathology Partnership (from 12.1% to 11.7%) but a small deterioration at Newham (from 9.2% to 9.5%) although the site remains well within target. In September we saw a small increase in Nursing and Midwifery turnover from 12.1% to 12.3%.
- Annualised sickness has stabilised at 4.43% for the second month, reflecting significant COVID peaks no longer contributing to the rate. Further information is covered in the following exception page.
- Recorded appraisals for non medical staff showed a further, small, drop from 58.9% to 58.2% in month, remaining below target, whilst for medical staff it reduced from 87.1% to 87.0% but remained above target. A revised appraisal framework support package for non medical staff is being rolled out from the end of October, along with incorporating career conversations into the appraisal process.
- Statutory and Mandatory Training (all) compliance increased slightly from 87.3% to 87.4% with more detail provided in the subsequent exception page.

WELL LED

Domain Scorecard

Nov-23

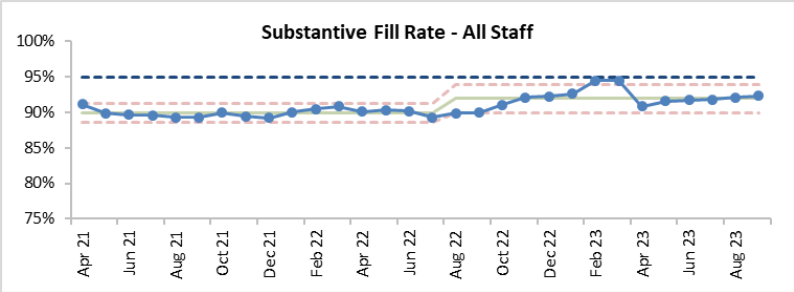
	Indicator	This Period	This Period Target	Performance: Last Period	Performance: This Period	Site Comparison: Royal London	Whipps Cross	Newham	St Bart's	Pathology Partnership	Group Support Services	Other
Creating a fair and just culture	Percentage of BAME staff in 8a+ roles	Sep-23		38.9%	**39.2%**	36.5%	50.3%	57.6%	26.9%	36.7%	36.6%	40.6%
Supporting the wellbeing of our colleagues	Turnover Rate	Sep-23	<= 12.25%	10.6%	**10.6%**	11.4%	10.3%	9.5%	12.2%	11.7%	7.0%	9.8%
	Sickness Absence Rate	Aug-23	<=4%	4.43%	**4.43%**	4.42%	4.47%	5.14%	3.63%	4.52%	4.93%	2.35%
	Appraisal Rate - Non-Medical Staff	Sep-23	>= 90%	58.9%	**58.2%**	57.0%	74.0%	50.0%	58.0%	70.0%	48.0%	30.0%
	Appraisal Rate - Medical Staff	Sep-23	>= 85%	87.1%	**87.0%**	86.0%	89.0%	85.0%	87.0%			
	Mandatory and Statutory Training - All	Sep-23	>= 85%	87.3%	**87.4%**	86.2%	90.1%	86.9%	91.4%	83.2%		

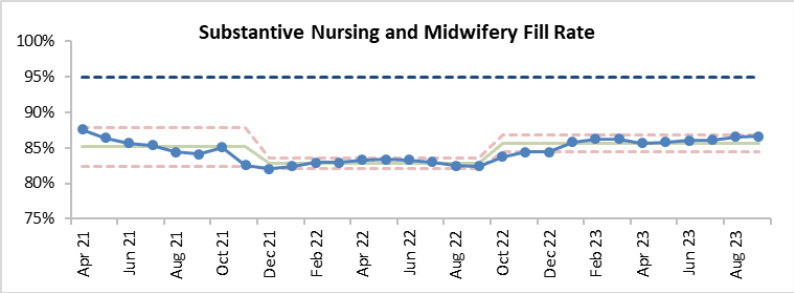
	Indicator	This Period	This Period Target	Last Period	This Period	Royal London	Whipps Cross	Newham	St Bart's	Pathology Partnership	Group Support Services	Other
Fostering new ways of working to transform care	Roster compliance - Nursing Units Approved on Time %	Sep-23	100%	48.3%	**55.9%**	33.3%	90.9%	51.6%	39.1%			
	Roster compliance - Nursing Average Approval Lead Time (Days)	Sep-23	>=42	34.8	**40.1**	34.0	48.0	38.0	35.0			
Growing a permanent and stable workforce	Substantive fill rate - all staff	Sep-23	95%	92.1%	**92.3%**	93.3%	90.5%	88.1%	95.1%	90.6%	90.9%	120.4%
	Substantive fill rate - nursing and midwifery	Sep-23	95%	86.5%	**86.6%**	88.3%	88.9%	80.2%	85.6%			
	Time to Hire (Advert to All Checks Complete) - Median Weeks (Non Medical)	Sep-23	10.4	9.6	**9.4**	10.6	10.1	11.6	9.9	10.2	8.6	
	Time to Hire (Advert to All Checks Complete) - Median Weeks (Medical)	Sep-23	15.00	13.6	**10.8**	9.9	11.9	13.6	11.0			
	Temporary staff as a % of workforce	Sep-23		**13.3%**	**12.4%**	13.4%	16.6%	19.1%	11.0%	14.3%	2.0%	1.0%
	Agency Spend as % Paybill (YTD)	Sep-23	3.70%	4.7%	4.6%	3.5%	5.7%	7.5%	2.6%	3.4%	6.3%	0.1%

PEOPLE

Growing a permanent and stable workforce

Nov-23





Indicator Background:

The substantive fill rate is an indicator of the contracted WTE employed by Barts Health NHS Trust against budgeted WTE. A long term goal is to deliver a 95% fill rate, minimising vacancies and the need to use temporary staffing.

The period between November 2022 and March 2023 is skewed in part due to the TUPE in of Soft FM services over that period and the budgeted WTE for these services being accurately reflected from April 2023

What are the Charts Telling us:

The charts here are showing our overall substantive fill rate as well as that for our registered nursing and midwifery staff group against the 95% target, the latter being our most challenging in terms of reducing gaps. For both we are seeing improved fill rates month on month since April 23.

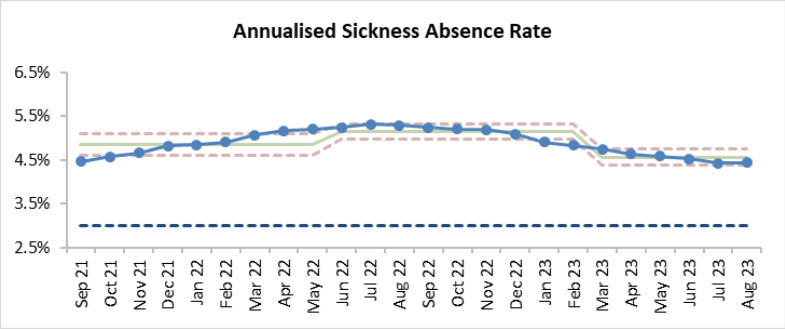
Commentary

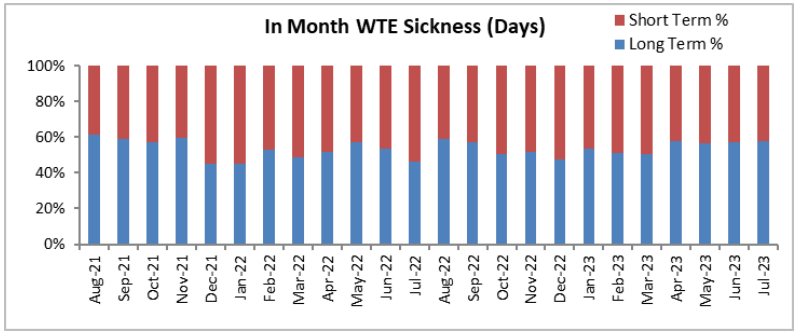
- The substantive fill rate has continued to increase from 92.1% to 92.3% with a growth of 63 WTE. Within this we have seen a small growth (+11 WTE) in registered nursing and midwifery (moving to an 86.6% fill rate) but also growth in medical and dental staffing of 18 WTE and varying growth across other staff groups.
- Time to hire (advert to all checks complete) for non-medical staff was within target again this month at 9.4 weeks (against 10.4) although there was some variation at site level with Newham performing worst at 11.6 weeks. The recruitment team are working closely with Newham to identify areas of improvement in the process, including reducing shortlisting timeframes.
- Time to hire (advert to all checks complete) for medical staff was within target at 10.8 weeks (against 15) and was met across all sites.
- Temporary staffing accounted for 12.4% of the workforce in September, with a decrease of 191 WTE, of which 114 WTE was bank and 77 WTE agency.
- Agency spend as a % of paybill YTD has reduced slightly to at 4.6% within month spend being £4.9m (down from £5.7m) or 4.2% of the in month pay bill.

WELL LED

Sickness Absence Rate

Nov-23





Annualised Sickness Absence Rate by Site

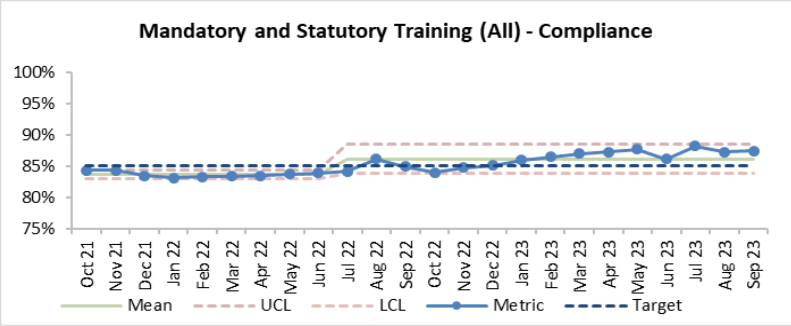
		6 Months Ago			Aug-23			
Site	Staff Group	Sick WTE Days	Available WTE Days	%	Sick WTE Days	Available WTE Days	%	Variance
Royal London	All Staff Groups	113,977	2,324,124	**4.90%**	104,487	2,363,087	**4.42%**	**-0.48%**
Whipps Cross	All Staff Groups	52,700	1,061,944	**4.96%**	48,983	1,095,908	**4.47%**	**-0.49%**
Newham	All Staff Groups	41,268	766,395	**5.38%**	40,164	781,818	**5.14%**	**-0.25%**
St Bart's	All Staff Groups	40,082	1,002,690	**4.00%**	37,100	1,020,659	**3.63%**	**-0.36%**
Other	All Staff Groups	49,355	980,289	**5.03%**	56,106	1,206,962	**4.65%**	**-0.39%**

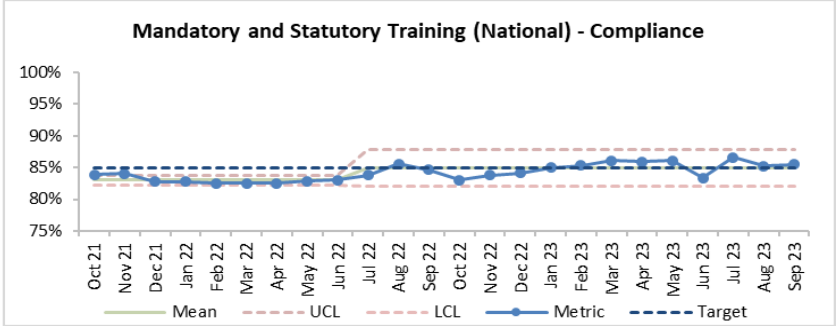
Performance Overview	Responsible Director Update
At Group level the sickness absence rate has stabilised at 4.43% and remains above the target of 4.00%. Across the group only St Barts is achieving the target at 3.63% with absence at Newham highest at 5.14% (with Emergency Care being a real challenge at 6.46%). GSS sickness stands at 4.93% much of which is driven by absence across our estates and facilities teams for which short term support is being put in place to help managers.	Sites continue to monitor sickness absence closely with interventions including: • Bite size absence management training • Assurance meetings to address long term and short term patterns • Wellbeing and occupational health interventions where appropriate • Employee Wellbeing Services continue to provide proactive support including chasing any managers on cases where they have not received referral after the long term sick trigger point.

WELL LED

Mandatory and Statutory Training

Nov-23





Bottom 5 Competencies: Total Number of Non-Compliant Employees

Competency	Previous 6 Months	Aug-23	
	Compliance	Compliance	Staff Non-Compliant
Fire Safety	86.7%	84.2%	3,119
Safeguarding Children L2	77.3%	78.4%	2,715
Resuscitation - Basic Life Support	78.0%	78.2%	2,383
Safeguarding Adults L1	88.1%	88.3%	2,317
Safeguarding Children L1	88.7%	89.0%	2,167

Bottom 5 Departments: Total Number of Non-Compliant Employees

Departments	Previous 6 Months	Aug-23	
	Compliance	Compliance	Staff Non-Compliant
RLH - Cleaning (Other)	44.8%	72.1%	156
WXH - Cleaning (Other)	48.3%	66.5%	142
NUH - Cleaning (Other)	18.7%	45.2%	132
TRUST PATIENT TRANSPORT (Other)	80.8%	82.1%	101
SBH - Cleaning (Other)	30.7%	51.4%	95

Non-mandatory competencies have been excluded from the above tables

Performance Overview

- Compliance with the Core Skills Training Framework currently stands at 85.68%, a decrease of 0.80% from the last Board report and is above the Trust target of 85% this month. Essential Skills training compliance has decreased by 0.42% from 91.44% to 91.02% in Aug and is also above the Trust target of 85%.
- Subjects within the Core Skills Training Framework are mostly above the Trust target of 85% with the exception of fire safety, IPC for clinical staff, Information Governance, Resuscitation and Safeguarding Adults level 2 where addition work on the TNA is ongoing.
- The WIRED system currently monitors training for 21,149 staff (an increase of 25% in 5 years) and 442,469 compliance items.

Responsible Director Update

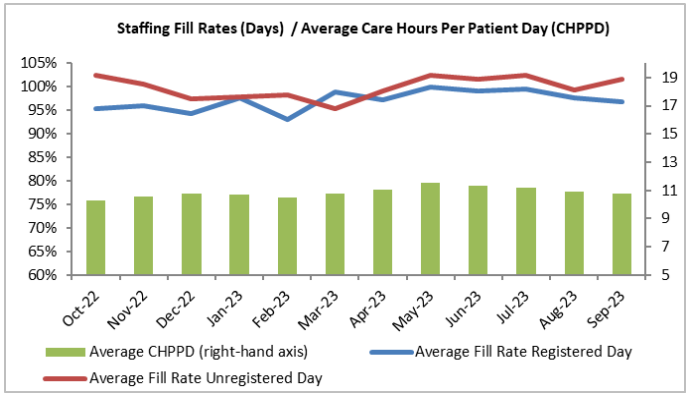
- Monthly reminders continue to be sent to non-compliant staff together with data added to site PR packs.
- Compliance with Information Governance continues to improve following work undertaken by the Information Governance tea,.
- Fire Safety is of concern due to the number of fire officers available to run training courses. To mitigate the risk online training has been reinstated to ensure staff are able to undertake training, however this will need to be reviewed in line with London Fire Brigade and Skills for Health CSTF requirements.
- Work continues to improve compliance for ex-Serco staff (see above). It is expected that the majority fo these staff will become compliant over the coming months and systems are in place to assist those staff where English may not be their first language and/or their digital literacy may be low.
- A trial of interactive dummies for resuscitation training will be going live shortly. At the completion of the trial a full evaluation will be undertaken to review effectiveness and value for money.

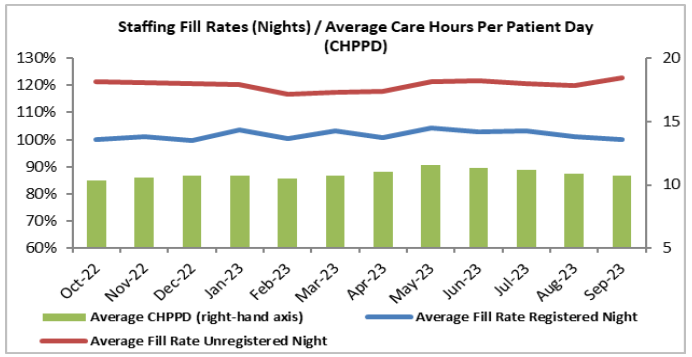
SAFE STAFFING

Safe Staffing

Nov-23

- The Trust's average fill rates for both Registered Nursing and Midwifery (RNs/RMs) and for Care Staff (HCAs) continues to be above 95% for both day and night shifts.
- Fill rates for each hospital site remained above 90% target for RNs/RMs and for HCAs across both day and night shifts.
- 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. A pilot audit was undertaken in July; results are being processed.
- Overall average Care Hours Per Patient Day (CHPPD) were at 10.7 in contrast with last month's 10.9. The CHPPD remain above last published peer averages (9.1, 'recommended'; 8.9 'region'; June 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.
- CHPPD trend dipped again slightly from 10.9 in August to 10.7 in September. The NHSE data request which feeds CHPPD reporting covers all staff booked, inclusive of additional staff for enhanced care. Enhanced care utilisation remain high in some areas due to the changing health needs of our patients. Shifts are approved At ADoN level.
- 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 in a timely manner.
- Red Flag incidents(RFIs) recorded on Datix were 17 in September compared to 13 in August, correlating with high CHPPD and sustained good overall average fill-rates. Maternity is currently using a dual system comprised of Birthrate plus and Datix. Birthrate plus captured 99 RFIs making the total of all RFIs 116.This is the first time all RFIs have been captured in this report.
- Red Flag data collection and reporting processes are being updated following discussion at NMAHP Board I September. New process due to be piloted November-December due to logistics of the process.
- Recruitment activity continues across the 4 hospitals as part of the Drive 95 programme. The impact of bespoke programmes is being realised in maternity and ED departments as is the successful international recruitment programme across all areas.
- Acuity and dependency scoring has continued its upward trajectory on Safe Care with day-time census compliance . Compliance increased slightly to 85.2% after having dipped in July but remains low when compared to August which saw an increase to 89.6%. Compliance is being monitored on a daily basis to support continuous improvement.
- Outputs reviewed at site safety and staffing huddles to support deployment decisions incorporating Safe Care. Data is triangulated to inform safety decisions.





	Staffing Figures by Site - Sep-23					
	Average Fill Rate (Day)		Average Fill Rate (Night)		Average Care Hours Per Patient Day (CHPPD)	Safe Staffing Red Flag Incidents
Site	Registered Nurses / Midwives (%)	Care Staff (%)	Registered Nurses / Midwives (%)	Care Staff (%)		
Trust	**96.9%**	**101.7%**	**100.1%**	**122.8%**	**10.7**	**17**
Royal London	100.8%	101.7%	105.8%	135.7%	10.7	15
Whipps Cross	95.6%	103.2%	98.1%	115.4%	10.1	0
Newham	97.2%	100.0%	100.3%	111.8%	10.6	2
St Bart's	90.5%	100.2%	91.1%	125.1%	12.2	0

Nov-23

NHS
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Finance Report

EXECUTIVE SUMMARY

Finance Executive Summary

Nov-23

- The Trust is reporting a £46.5m deficit for the year to date at month 6, which is (£32.8m) adverse against plan. The adverse variance is primarily due to the net impact of medical staff industrial action of £25.4m for the year to date (additional pay costs £11.5m, reduced ERF income £11.0m). Excluding the impact of industrial action the Trust is in line with its trajectory within the financial recovery plan agreed by the NEL system.

- Income is £17.7m favourable against plan for the year to date at month 6. NHS Patient Treatment income is £12.0m favourable overall, this is driven by £7.5m central non-recurrent benefits and £3.2m over performance on passthrough drugs which is offset by associated additional expenditure. Other income is £5.7m favourable, which is driven by £5.9m release of central non-recurrent benefits from balance sheet review within the year to date position.

- Expenditure is (£50.5m) adverse against plan for the year to date at month 6. Site and Services pay expenditure is (£38.5m) adverse driven by (£20.0m) of unallocated pay savings targets and (£18.4m) of overspends for medical and other clinical temporary staffing. The position includes the impact of the medical pay awards which were paid in September, backdated to April and were fully funded. Sites and Services non-pay expenditure is (£16.9m) adverse year to date, key overspends include unallocated non-pay savings targets (£5.6m), increased expenditure on Estates Transport and Soft FM costs (£2.9m), outsourced activity to the independent sector (£3.0m) and loss of maternity incentive payment (£1.5m). There is an overspend for passthrough and devices which offsets with favourable income variance. Central expenditure and reserves are £4.9m favourable year to date, due to release of one-off benefits and a £2.1m favourable variance for interest receivable as a result of high cash balances.

- Cash balances in September 2023 are lower by £6m compared to a plan of £30m, as a result of additional payments made in month including the first half of the year dividend payments of £7.9m to DHSC. 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) was paid to staff in June 2023. The 2023/24 pay award for Medical staff, backdated to April 2023 (circa £13.4m, funded by the ICBs) was paid to staff in September 2023. An assumption has been made that capital spend will be spread evenly over the coming months, thereby removing the need for an external revenue loan of £40m previously envisaged. This will be monitored closely over the coming months.

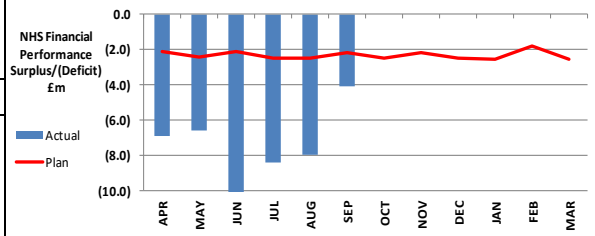
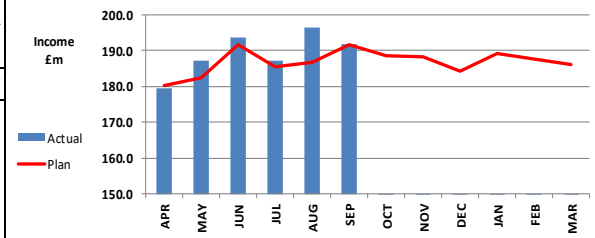
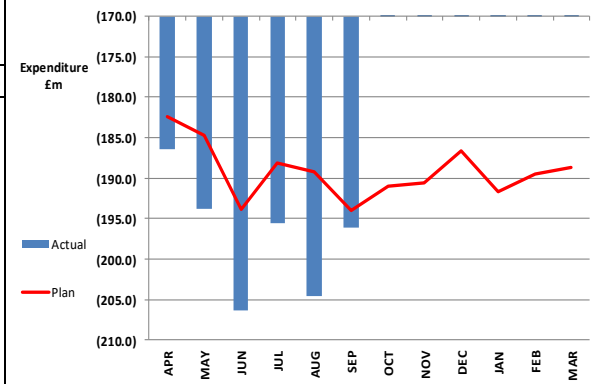
- The key financial challenges for the Trust in achieving its income and expenditure plan for the year include:
  - Delivery of the Elective Recovery Fund activity trajectory and the associated funding,
  - Improving productivity to reduce temporary staffing costs and deliver the efficiency savings targets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

- Financial performance is being closely monitored by NHS England. The Trust has implemented additional controls on pay expenditure to support financial recovery.

KEY METRICS

Finance Key Metrics

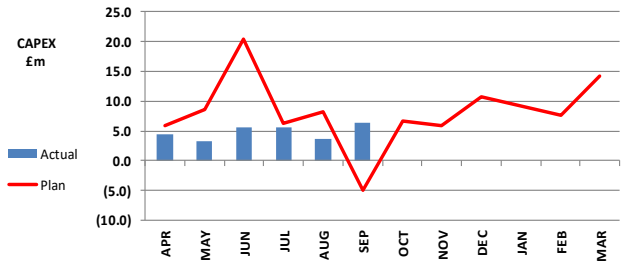
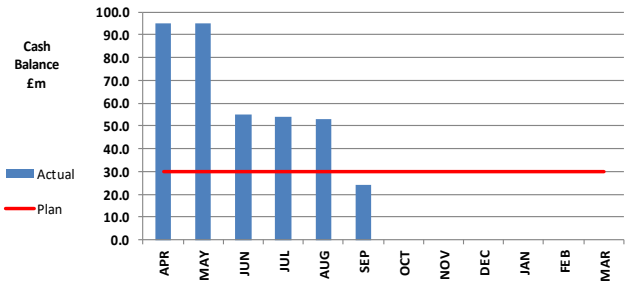
Nov-23

Metrics	Current Performance Year To Date £millions	Trend	Comments
NHS Financial Performance Surplus / (Deficit)	Plan (13.7) Actual (46.5) Variance (32.8)		The Trust is reporting a £46.5m deficit for the year to date at month 6, which is (£32.8m) adverse against plan. The adverse variance is primarily due to the net impact of medical staff industrial action of £25.4m for the year to date (additional pay costs £11.5m, reduced ERF income £11.0m). Excluding the impact of industrial action the Trust is in line with its trajectory within the financial recovery plan agreed by the NEL system.
Total Income	Plan 1,118.4 Actual 1,136.1 Variance 17.7		Income is £17.7m favourable against plan for the year to date at month 6. NHS Patient Treatment income is £12.0m favourable overall. This is driven by £7.5m central non-recurrent benefits and £3.2m over performance on passthrough drugs which is offset by associated additional expenditure. Other income is £5.7m favourable, which is driven by £5.9m release of central non-recurrent benefits from balance sheet review within the year to date position.
Total Expenditure	Plan (1,132.2) Actual (1,182.6) Variance (50.5)		Expenditure is (£50.5m) adverse against plan for the year to date at month 6. Site and Services pay expenditure is (£38.5m) adverse driven by (£20.0m) of unallocated pay savings targets and (£18.4m) of overspends for medical and other clinical temporary staffing. The position includes the impact of the medical pay awards which were paid in September, backdated to April and were fully funded. Sites and Services non-pay expenditure is (£16.9m) adverse year to date, key overspends include unallocated non-pay savings targets (£5.6m), increased expenditure on Estates Transport and Soft FM costs (£2.9m), outsourced activity to the independent sector (£3.0m) and loss of maternity incentive payment (£1.5m). There is an overspend for passthrough and devices which offsets with favourable income variance. Central expenditure and reserves are £4.9m favourable year to date, due to release of one-off benefits and a £2.1m favourable variance for interest receivable as a result of high cash balances.

KEY METRICS

Finance Key Metrics

Nov-23

Metrics	Current Performance Year To Date £millions	Trend	Comments
Capital Expenditure	Plan 44.6 Actual 29.0 Variance (15.6)		Capital Expenditure in M6 is £6.3m. The YTD variance of £15.6m can be attributed to delays in closing old year schemes, VAT recoveries as well as major schemes running behind their forecasts. Expenditure against donated schemes was £0.1m (£0.1m, M5); £1.7m YTD. There are delays with a number of significant schemes which will result in a cost pressure against the 2024/5 capital plan. Work is ongoing with investment leads to reach stable position and expected outturn.
Cash	Plan 30.0 Actual 24.0 Variance (6.0)		Cash balances in September 2023 are lower by £6m compared to a plan of £30m, as a result of additional payments made in month including the first half of the year dividend payments of £7.9m to DHSC. 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) was paid to staff in June 2023. The 2023/24 pay award for Medical staff, backdated to April 2023 (circa £13.4m, funded by the ICBs) was paid to staff in September 2023. An assumption has been made that capital spend will be spread evenly over the coming months, thereby removing the need for an external revenue loan of £40m previously envisaged. This will be monitored closely over the coming months.

Key Issues

The key financial challenges for the Trust in achieving its income and expenditure plan for the 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 Risks & Opportunities

Financial performance at month 6 is in line with the financial recovery plan agreed with NEL ICB.The NEL system position is being closely monitored by NHS England.
The Trust has implemented additional controls on pay expenditure to support financial recovery.

INCOME & EXPENDITURE

Income & Expenditure - Trustwide

Nov-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									
783.8	NHS Patient Treatment Income	158.9	159.5	0.6		845.3	849.2	3.9		1,705.7
1.5	Other Patient Care Activity Income	0.6	0.2	(0.4)		3.5	1.7	(1.8)		6.9
61.3	Other Operating Income	10.7	11.0	0.3		63.0	65.0	2.0		125.3
846.6	**Total Income**	**170.1**	**170.6**	**0.5**		**911.8**	**915.9**	**4.1**		**1,837.9**
	Operating Expenditure									
(571.1)	Pay	(114.0)	(120.0)	(6.0)		(626.1)	(664.6)	(38.5)		(1,248.8)
(103.0)	Drugs	(17.5)	(17.6)	(0.1)		(103.9)	(107.5)	(3.6)		(209.0)
(83.7)	Clinical Supplies	(15.6)	(15.2)	0.3		(93.5)	(92.1)	1.4		(187.7)
(159.0)	Other Non Pay	(23.7)	(24.6)	(0.9)		(140.5)	(155.2)	(14.7)		(279.3)
(916.8)	**Total Operating Expenditure**	**(170.8)**	**(177.5)**	**(6.7)**		**(964.0)**	**(1,019.4)**	**(55.4)**		**(1,924.8)**
(70.1)	**Site & Services Budgets Total**	**(0.7)**	**(6.9)**	**(6.2)**		**(52.3)**	**(103.5)**	**(51.3)**		**(86.9)**
(26.2)	Pathology Partnership (net)	(4.4)	(4.6)	(0.3)		(27.8)	(28.7)	(0.9)		(55.6)
0.0	Vaccination Programme & Nightingale (net)	-	0.0	0.0		-	(0.0)	(0.0)		-
(1.1)	Research & Development (net)	0.0	0.0	0.0		0.0	0.0	(0.0)		0.0
58.3	Central NHS PT Income	(0.0)	(0.9)	(0.8)		77.6	85.8	8.2		146.3
3.6	Central RTA & OSV Income (net)	1.0	0.9	(0.1)		5.9	4.2	(1.7)		11.8
7.9	Central Expenditure (net)	(0.2)	(0.0)	0.2		(0.6)	7.7	8.3		(1.2)
(3.3)	Reserves (net)	3.7	8.7	4.9		(5.5)	(3.0)	2.5		(19.7)
(30.9)	**EBITDA**	**(0.5)**	**(2.8)**	**(2.3)**		**(2.7)**	**(37.6)**	**(34.9)**		**(5.3)**
(35.1)	Depreciation and Amortisation (net)	(6.4)	(6.4)	0.0		(38.1)	(38.1)	0.0		(76.7)
(34.8)	Interest	(6.8)	(6.4)	0.4		(41.5)	(39.4)	2.1		(82.9)
(5.3)	PDC Dividends	(1.3)	(1.3)	0.0		(7.8)	(7.8)	0.0		(15.5)
0.1	Profit On Fixed Asset Disposal	0.0	0.0	0.0		0.0	0.1	0.0		0.1
-	Loss on return of COVID assets to DHSC	-	-	-		-	-	-		
(106.1)	**Surplus/(Deficit) Before System Top-Up**	**(15.0)**	**(16.9)**	**(1.9)**		**(90.0)**	**(122.8)**	**(32.8)**		**(180.4)**
75.4	System Top-Up Income	12.9	12.9	0.0		76.3	76.3	-		152.6
(30.7)	**NHS Reporting Surplus/(Deficit)**	**(2.1)**	**(4.1)**	**(1.9)**		**(13.7)**	**(46.5)**	**(32.8)**		**(27.8)**

CAPITAL EXPENDITURE

Capital Expenditure Summary - Trustwide

Nov-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 Sept 2023	Approved Plan M6	Variance	%	
2.2	Equipment (Medical and Other)	1.5	0.6	0.9	*59 %*	5.4	2.1	3.3	*0.0*		11.5	15.2	(3.7)	*(32)%*	
1.2	Informatics	0.4	0.2	0.3	*63 %*	2.9	2.2	0.7	*0.0*		6.2	11.1	(4.8)	*(78)%*	
10.8	Estates	0.3	0.5	(0.2)	*(54)%*	5.3	3.4	1.9	*0.0*		7.1	10.5	(3.4)	*(48)%*	
3.4	New Build and Site Vacations	2.7	4.0	(1.3)	*(47)%*	24.8	15.0	9.8	*0.0*		49.0	49.5	(0.5)	*(0.0)*	
5.2	PFI Lifecycle Assets	1.0	1.0	0.0	*0 %*	6.3	6.3	(0.0)	*(0.0)*		12.6	12.6	-	*0 %*	
-	New Build - Diagnostics	-	-	-	*- %*	-	-	-	-		-	-	-	*- %*	
4.8	Finance Lease	(10.9)	-	(10.9)	*100 %*	-	-	-	-		12.1	12.1	-	*- %*	
27.6	**Total Exchequer programme**	**(4.9)**	**6.3**	**(11.2)**	***228 %***	**44.6**	**29.0**	**15.6**	***0.0***		**98.6**	**111.0**	**(12.4)**	***(0.0)***	
-															
27.6	**Total Trust Funded Assets**	**(4.9)**	**6.3**	**(11.2)**	***228 %***	**44.6**	**29.0**	**15.6**	***35 %***	*	**98.6**	**111.015**	**(12.4)**	***(13)%***	
2.1	Donated	0.9	0.1	0.8	*91 %*	5.2	1.7	3.5	*68 %*		10.3	10.3	-	*(0)%*	
29.7	**Total Capital Expenditure**	**(4.1)**	**6.4**	**(10.4)**	***257 %***	**49.8**	**30.7**	**19.1**	***38 %***		**108.9**	**121.3**	**(12.4)**	***(11)%***	

Key Messages

2023/24 position. The approved exchequer capital plan is £111m (£120.5m, M5) against the funded capital plan of £98.6m (£119m, M5); The plan has decreased over the prior month due to hand back of IFRS16 CRL cover of net £10.4m for leases removed because they will occur in future years, as well a reduction of £10m to reflect the revised programme for WXH enabling works. The decrease is offset by £12.4m of over commitment for urgent schemes for informatics, estates back log/fire safety and medical equipment replacement which are being progressed following support FIP to proceed at risk.

Discussions continue between Trust senior directors and both NEL and NHSE London about the insufficiency of the Trust CRL allocation with a view to securing an increase. While NEL are aware that the Trust has over committed the capital programme by £12.4m, they have requested that we hold on including the additional schemes in the monthly PFR.

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

Funding. The Trust has been awarded £2.1m of NHP funding for the WXH enabling works scheme and £461k of PDC for the Paediatric observation rooms at RLH.

Expenditure in M6 is £6.3m. The YTD variance of £15.6m can be attributed to delays in closing old year schemes, VAT recoveries as well as major schemes running behind their forecasts including the following:-
(£3.7m) - MEH CDC - delays during the procurement process for the design and build contractors and a 2 month design delay, resulting in c£6m of funding handed back causing a cost pressure in 2024/25. The project completion date will slip from December 2023 to September 2024.
(£2.3m) - NUH modular build - delays due to supply chain and labour issues which have put the programme behind schedule by c9 weeks. Some planning condition works will be a cost pressure in 2024/5.
(£1.7m) - SBH ITU - delayed along with the CRF due to Trust and CHL working through legal issues relating to payment requirements, deed of variation and JCT contract Procurement via CHL as a VE. Minimal spend expected in 2023/24, with a risk of significant cost pressure in 2024/25 unless a deal can be made with NEL/NHSE to broker the funding.
(£1m) - Modular Build Fit out - timing difference that will be caught up.
(£1.3m) - NUH fire programme - timing delay that will be caught up.
(£1.1m) - CAU - timing delay 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.
(£0.7m) - VAT recoveries and close out of old year schemes which will be offset against cost pressures.

Expenditure against donated schemes was £0.1m (£0.1m, M5); £1.7m YTD.

Forecast - As noted above there are delays with a number of significant schemes which will result in a cost pressure against the 2024/5 capital plan. Work is ongoing with investment leads to reach stable position and expected outturn.

Capital Funding

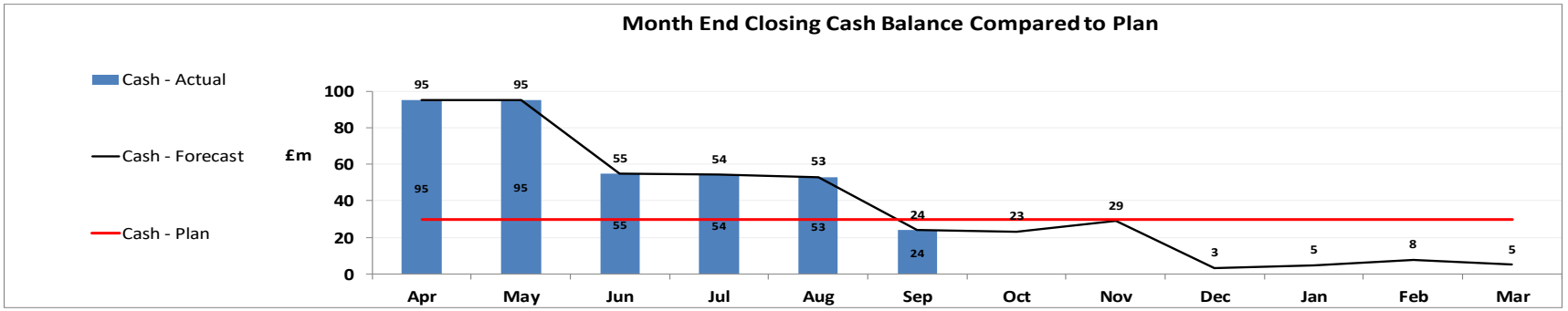
	Capital Plan	Secured	Not Yet Secured	% Secured
Gross Depreciation	76.7	76.7	-	*100 %*
Repayment of PFI principal	(26.0)	(26.0)	-	*100 %*
Repayment Other Finance Leases (IFRS16)	(11.3)	(11.3)	-	*100 %*
Net Depreciation	**39.5**	**39.5**	**-**	**100 %**
CRL (not cash backed)	13.7	13.7	-	*100 %*
Add CRL - Neonatal cot capacity RLH (not cash backe	0.7	0.7	-	*100 %*
EFA	-		-	*- %*
Additional CRL from NHSE/NEL (not cash backed)	-		-	*- %*
IFRS16 CRL adjustment	12.1		12.1	*- %*
Other Leases CRL adjustment			-	
PDC: WXH Redevelopment core programme team	1.7	1.1	0.5	*68 %*
PDC: WXH Redevelopment NHP Enabling works costs	2.1	2.1	-	*100 %*
Specific PDC: WXH Enabling works	-		-	
TIF NUH Modular Build and Mothballed Theatres	6.3	6.3	-	*100 %*
TIF - ITU Expansion SBH	11.1	11.1	-	*100 %*
ACTIF - RLH/WXH	2.7	2.7		*100 %*
PDC- MEH CDC	8.3	8.3	-	*100 %*
PDC - LIMS	0.1	0.1	-	*100 %*
PDC - Paeds Observation rooms	0.5	0.5	-	*100 %*
Planned Capital exc. Donated	**98.6**	**85.9**	**12.7**	**87.1 %**
Asset sales	-	-	-	*- %*
***Total approved Exchequer funding ex donated**	**98.6**	**85.9**	**12.7**	**87.1 %**
Donated	10.3	1.7	8.7	*16.0 %*
Planned Capital inc. Donated	**108.9**	**87.6**	**21.3**	**80.4 %**
*CRL overspend	(12.4)			

CASHFLOW & BALANCE SHEET

Cashflow

Nov-23

£millions	Actual						Forecast						
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Outturn
Opening cash at bank	**60.2**	**95.0**	**95.1**	**54.8**	**54.2**	**53.1**	**24.0**	**23.2**	**29.0**	**3.3**	**4.9**	**7.8**	**60.2**
Cash inflows													
Healthcare contracts	155.9	166.0	203.3	167.7	169.7	174.0	163.6	168.7	165.6	165.6	160.6	180.2	2,040.9
Other income	42.5	24.7	17.4	28.9	30.5	33.8	39.6	27.5	19.1	38.5	26.7	33.7	362.9
Financing - Revenue Loans / Capital PDC	-	-	-	-	-	3.1	-	-	19.7	-	-	19.3	42.1
Total cash inflows	**198.4**	**190.7**	**220.7**	**196.6**	**200.2**	**210.9**	**203.2**	**196.2**	**204.4**	**204.1**	**187.3**	**233.2**	**2,445.9**
Cash outflows													
Salaries and wages	(61.1)	(65.0)	(94.4)	(68.0)	(70.5)	(71.5)	(69.1)	(69.1)	(69.1)	(69.1)	(69.1)	(70.0)	(846.0)
Tax, NI and pensions	(30.7)	(46.4)	(46.6)	(65.6)	(50.2)	(48.3)	(54.8)	(51.0)	(51.0)	(51.0)	(51.0)	(51.0)	(597.6)
Non pay expenditures	(63.7)	(76.2)	(116.8)	(57.7)	(76.6)	(108.2)	(76.7)	(66.9)	(106.0)	(77.9)	(58.8)	(101.3)	(986.8)
Capital expenditure	(8.1)	(3.0)	(3.2)	(5.9)	(4.0)	(4.1)	(3.4)	(3.4)	(4.0)	(4.5)	(5.5)	(5.9)	(55.0)
Dividend and Interest payable	-	-	-	-	-	(7.9)	-	-	-	-	-	(7.8)	(15.7)
Total cash outflows	**(163.6)**	**(190.6)**	**(261.0)**	**(197.2)**	**(201.3)**	**(240.0)**	**(204.0)**	**(190.4)**	**(230.1)**	**(202.5)**	**(184.4)**	**(236.0)**	**(2,501.1)**
Net cash inflows / (outflows)	**34.8**	**0.1**	**(40.3)**	**(0.6)**	**(1.1)**	**(29.1)**	**(0.8)**	**5.8**	**(25.7)**	**1.6**	**2.9**	**(2.8)**	**(55.2)**
Closing cash at bank - actual / forecast	**95.0**	**95.1**	**54.8**	**54.2**	**53.1**	**24.0**	**23.2**	**29.0**	**3.3**	**4.9**	**7.8**	**5.0**	**5.0**
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 September 2023 are lower by £6m compared to a plan of £30m, as a result of additional payments made in month including the first half of the year dividend payments of £7.9m to DHSC.

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) was paid to staff in June 2023. The 2023/24 pay award for Medical staff, backdated to April 2023 (circa £10.2m, funded by the ICBs) was paid to staff in September 2023.

An assumption has been made that capital spend will be spread evenly over the coming months, thereby removing the need for an external revenue loan of £40m previously envisaged. This will be monitored closely over the coming months.

CASHFLOW & BALANCE SHEET

Statement of Financial Position

Nov-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	1,588.5	1,587.9	1,585.0	1,585.1	1,618.2	1,620.9	1,626.2	1,629.9	1,633.6	1,633.5	39.3
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	16.6	16.6	16.5	16.7	16.7	16.7	16.7	16.7	16.2	(0.6)
1,611.1	**Total non-current assets**	**1,609.3**	**1,606.0**	**1,605.3**	**1,604.6**	**1,601.7**	**1,601.7**	**1,635.0**	**1,637.7**	**1,643.0**	**1,646.7**	**1,650.4**	**1,649.7**	**38.7**
	Current assets:													
31.4	Inventories	32.1	32.2	33.9	32.9	32.3	33.0	31.4	31.4	31.4	31.4	31.4	31.4	0.0
145.5	Trade and other receivables	132.0	123.8	92.4	125.7	101.0	123.9	129.2	132.7	118.6	110.9	114.0	149.5	4.0
60.2	Cash and cash equivalents	95.1	95.1	54.8	54.2	53.1	24.0	23.2	29.0	3.3	4.9	7.8	5.0	(55.2)
237.1	**Total current assets**	**259.2**	**251.1**	**181.1**	**212.8**	**186.4**	**180.9**	**183.8**	**193.1**	**153.3**	**147.2**	**153.2**	**185.9**	**(51.2)**
1,848.2	**Total assets**	**1,868.5**	**1,857.1**	**1,786.4**	**1,817.4**	**1,788.1**	**1,782.6**	**1,818.8**	**1,830.8**	**1,796.3**	**1,793.9**	**1,803.6**	**1,835.6**	**(12.5)**
	Current liabilities													
(290.0)	Trade and other payables	(320.3)	(318.8)	(263.7)	(305.9)	(288.0)	(285.8)	(251.9)	(265.5)	(223.8)	(223.3)	(234.3)	(265.9)	24.1
(2.8)	Provisions	(2.9)	(2.9)	(2.9)	(2.9)	(2.9)	(2.9)	(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)	(37.3)	(37.3)	(37.3)	(37.3)	(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**	**(360.5)**	**(359.0)**	**(303.9)**	**(346.1)**	**(328.2)**	**(326.0)**	**(296.7)**	**(310.3)**	**(268.6)**	**(268.1)**	**(279.1)**	**(309.2)**	**20.9**
(93.0)	**Net current (liabilities) / assets**	**(101.3)**	**(107.9)**	**(122.8)**	**(133.3)**	**(141.8)**	**(145.1)**	**(112.9)**	**(117.2)**	**(115.3)**	**(120.9)**	**(125.9)**	**(123.3)**	**(30.3)**
1,518.1	**Total assets less current liabilities**	**1,508.0**	**1,498.1**	**1,482.5**	**1,471.3**	**1,459.9**	**1,456.6**	**1,522.1**	**1,520.5**	**1,527.7**	**1,525.8**	**1,524.5**	**1,526.4**	**8.4**
	Non-current liabilities													
(5.9)	Provisions	(5.9)	(5.9)	(6.0)	(6.1)	(6.1)	(6.2)	(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)	(905.8)	(902.7)	(899.5)	(896.8)	(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	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
(921.6)	**Total non-current liabilities**	**(918.4)**	**(915.3)**	**(912.3)**	**(909.3)**	**(906.1)**	**(903.5)**	**(937.8)**	**(937.8)**	**(927.3)**	**(927.3)**	**(927.3)**	**(918.2)**	**3.3**
596.5	**Total Assets Employed**	**589.6**	**582.8**	**570.2**	**562.0**	**553.8**	**553.1**	**584.3**	**582.7**	**600.4**	**598.5**	**597.2**	**608.2**	**11.7**
	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	1,083.7	1,080.6	1,080.6	1,100.3	1,100.3	1,100.3	1,113.3	32.7
(900.9)	Retained earnings	(907.8)	(914.6)	(927.2)	(935.4)	(943.6)	(947.4)	(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**	**570.2**	**562.0**	**553.8**	**553.1**	**584.3**	**582.7**	**600.4**	**598.5**	**597.2**	**608.2**	**11.7**

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Operational Planning 2023/24

Nov-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

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Domain Scorecard Glossary

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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	R8	Cancer 2 Week Wait	Percentage of patients first seen by a specialist for suspected cancer within two weeks (14 days) of an urgent GP referral for suspected cancer	Monthly	National
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
Well Led	People	W19	Turnover Rate	The number of leavers (whole time equivalents) who left the trust voluntarily in the last 12 months divided by the average total number of staff in post (whole time equivalents) in the last 12 months	Monthly	Local
Well Led	People	OH7	Proportion of Temporary Staff	The number of bank and agency whole time equivalents divided by the number of bank and agency whole time equivalents plus permanent staff in post (whole time equivalents)	Monthly	Local
Well Led	People	W20	Sickness Absence Rate	The number of whole time equivalent days lost to sickness absence (including non-working days) in the last 12 months divided by the total number of whole time equivalent days available (including non-working days) in the last 12 months, i.e. the annualised percentage of working days lost due to sickness absence	Monthly	Local
Well Led	Staff Feedback	C6	Staff FFT Percentage Recommended - Care	The number of staff who responded that they were extremely likely or likely to recommend the trust to friends and family if they needed care or treatment, divided by the total number of staff who responded to the Staff Friends and Family Test (Staff FFT)	Quarterly	Local
Well Led	Staff Feedback	OH6	NHS Staff Survey	The overall staff engagement score from the results of the NHS Staff Survey	Yearly	National
Well Led	Compliance	W50	Mandatory and Statutory Training - All	For all mandatory and statutory training topics, the percentage of topics for which staff were competent (i.e. have completed training and were compliant)	Monthly	Local

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Domain Scorecard Glossary

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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

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Domain Scorecard Glossary

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

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Domain Scorecard Glossary

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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	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
Safe	Saving Lives	S87	Saving Lives: Central Venous Catheter Care Bundle (Continuing Care)	The percentage of central venous catheter care bundle audits carried out (for patients with continuing care) in which the results were all found to be fully compliant. The audit consists of monthly observations on catheter injection ports, catheter access, catheter replacement, hand hygiene, etc.	Monthly	TBC
Safe	Saving Lives	S88	Saving Lives: Central Venous Catheter Care Bundle (On Insertion)	The percentage of central venous catheter care bundle audits carried out (on insertion of catheters) in which the results were all found to be fully compliant. The audit consists of monthly observations on catheter type, insertion site, safe disposal of sharps, hand hygiene, etc.	Monthly	TBC
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	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

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Workforce Summary Glossary

Nov-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)

Nov-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)

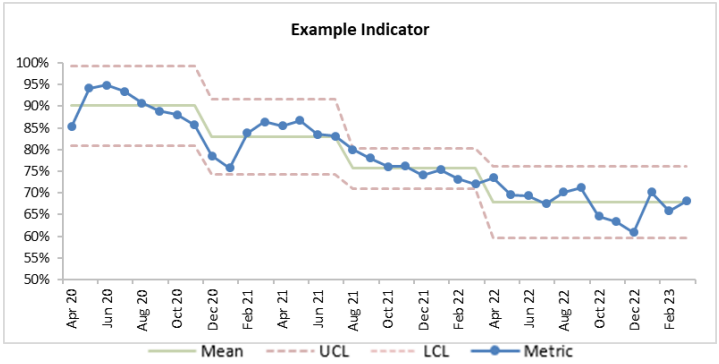
Reporting month target for reporting site

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 i.e. 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) i.e.. 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

Nov-23

		Registered midwives / nurses (day)		Care Staff (day)		Registered midwives / nurses (night)		Care Staff (night)		Day		Night		Care Hours Per Patient Day (CHPPD)			
Site	Ward name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Patients at Midnight	Registered midwives / nurses	Care Staff	Overall
Royal London	10E RLH	2,070.0	2,389.0	1,023.5	1,470.5	1,725.0	2,085.5	690.0	1,782.5	115.4%	143.7%	120.9%	258.3%	776	5.8	4.2	10.0
Royal London	10F RLH	1,080.0	1,620.0	731.0	851.0	990.0	1,474.0	330.0	616.0	150.0%	116.4%	148.9%	186.7%	504	6.1	2.9	9.0
Royal London	11C RLH	2,742.5	2,708.7	1,401.0	1,346.3	2,748.5	3,038.0	701.5	1,081.0	98.8%	96.1%	110.5%	154.1%	680	8.5	3.6	12.0
Royal London	11E & 11F AAU	3,997.5	4,602.5	1,725.0	1,725.0	3,795.0	4,485.0	1,380.0	1,988.5	115.1%	100.0%	118.2%	144.1%	1,409	6.4	2.6	9.1
Royal London	12C RLH	1,828.5	2,326.5	1,380.0	1,392.5	1,771.0	2,348.0	1,035.0	1,343.8	127.2%	100.9%	132.6%	129.8%	778	6.0	3.5	9.5
Royal London	12D RLH	1,380.0	1,941.0	690.0	959.0	1,380.0	1,977.0	333.5	746.8	140.7%	139.0%	143.3%	223.9%	497	7.9	3.4	11.3
Royal London	12E RLH	2,686.5	3,060.8	1,380.0	1,532.5	2,413.5	2,857.7	1,380.0	1,816.3	113.9%	111.1%	118.4%	131.6%	669	8.8	5.0	13.9
Royal London	12F RLH	1,962.0	2,031.0	1,725.0	1,732.0	1,725.0	1,840.0	1,725.0	2,012.5	103.5%	100.4%	106.7%	116.7%	797	4.9	4.7	9.6
Royal London	13C RLH	1,952.5	2,189.5	690.0	841.0	1,380.0	1,644.5	690.0	966.5	112.1%	121.9%	119.2%	140.1%	759	5.1	2.4	7.4
Royal London	13D RLH	1,725.0	1,831.8	690.0	874.0	1,380.0	1,575.5	690.0	1,081.0	106.2%	126.7%	114.2%	156.7%	701	4.9	2.8	7.6
Royal London	13E RLH	1,966.5	2,184.5	695.8	788.5	1,621.5	1,870.3	690.0	1,071.8	111.1%	113.3%	115.3%	155.3%	710	5.7	2.6	8.3
Royal London	13F RLH	1,736.5	2,225.0	931.5	1,064.5	1,725.0	2,150.5	690.0	1,046.5	128.1%	114.3%	124.7%	151.7%	691	6.3	3.1	9.4
Royal London	14E & 14F RLH	3,239.5	4,445.0	2,760.0	2,702.5	2,760.0	4,016.0	2,219.5	3,093.5	137.2%	97.9%	145.5%	139.4%	1,479	5.7	3.9	9.6
Royal London	3D RLH	3,995.5	3,864.8	2,610.5	1,887.0	3,105.0	3,488.5	1,725.0	1,945.0	96.7%	72.3%	112.4%	112.8%	1,077	6.8	3.6	10.4
Royal London	3E RLH	2,058.5	2,138.0	690.0	1,056.5	1,725.0	1,817.0	690.0	1,104.0	103.9%	153.1%	105.3%	160.0%	799	4.9	2.7	7.7
Royal London	3F RLH	1,526.5	2,059.0	1,035.0	782.0	1,035.0	2,083.5	678.5	839.5	134.9%	75.6%	201.3%	123.7%	460	9.0	3.5	12.5
Royal London	4E RLH	13,468.0	13,592.0	1,035.0	977.7	13,478.0	13,515.2	1,046.5	945.5	100.9%	94.5%	100.3%	90.3%	1,325	20.5	1.5	21.9
Royal London	6C RLH	4,348.5	3,028.1	793.5	287.5	3,507.5	2,722.8	690.0	368.0	69.6%	36.2%	77.6%	53.3%	175	32.9	3.7	36.6
Royal London	6E & 6F RLH	5,741.8	4,362.3	1,425.5	1,281.3	5,163.5	4,660.8	1,035.0	910.5	76.0%	89.9%	90.3%	88.0%	929	9.7	2.4	12.1
Royal London	7C RLH	1,380.0	1,299.5	345.0	724.5	1,035.0	1,012.0	345.0	770.5	94.2%	210.0%	97.8%	223.3%	350	6.6	4.3	10.9
Royal London	7D RLH	1,725.0	1,628.5	847.5	655.5	1,380.0	1,370.5	690.0	713.0	94.4%	77.3%	99.3%	103.3%	354	8.5	3.9	12.3
Royal London	7E RLH	2,760.0	2,540.3	1,019.0	1,443.8	2,403.5	2,313.5	1,035.0	1,826.3	92.0%	141.7%	96.3%	176.4%	655	7.4	5.0	12.4
Royal London	7F RLH	1,380.0	1,299.5	586.5	908.5	1,035.0	1,000.5	529.0	920.0	94.2%	154.9%	96.7%	173.9%	327	7.0	5.6	12.6
Royal London	8C RLH	1,914.0	2,141.6	690.0	768.0	1,380.0	1,642.0	678.5	917.0	111.9%	111.3%	119.0%	135.2%	534	7.1	3.2	10.2
Royal London	8D RLH	9,844.0	7,977.3	1,552.5	629.0	8,601.5	6,813.0	448.5	460.0	81.0%	40.5%	79.2%	102.6%	924	16.0	1.2	17.2
Royal London	8F RLH	1,735.5	1,683.0	1,475.5	1,424.5	1,035.0	989.0	1,380.0	1,345.5	97.0%	96.5%	95.6%	97.5%	1,496	1.8	1.9	3.6
Royal London	9E HDU RLH	1,380.0	1,104.0	0.0	0.0	1,380.0	1,115.5	0.0	11.5	80.0%		80.8%		169	13.1	0.1	13.2
Royal London	9E RLH	1,725.0	1,736.5	690.0	989.0	1,368.5	1,459.0	690.0	1,253.5	100.7%	143.3%	106.6%	181.7%	742	4.3	3.0	7.3
Royal London	9F RLH	1,725.0	1,706.5	690.0	750.0	1,380.0	1,380.0	690.0	816.5	98.9%	108.7%	100.0%	118.3%	704	4.4	2.2	6.6

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Safe Staffing Fill Rates by Ward and Site

Nov-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	4,496.5	5,220.2	2,403.5	2,400.8	4,485.0	5,172.3	2,070.0	2,135.5	116.1%	99.9%	115.3%	103.2%	1,218	8.5	3.7	12.3
Whipps Cross	ACACIA	931.5	933.0	448.5	497.5	690.0	692.5	690.0	714.0	100.2%	110.9%	100.4%	103.5%	351	4.6	3.5	8.1
Whipps Cross	ACORN	3,577.5	2,846.3	345.0	495.5	2,760.0	2,347.3	345.0	140.0	79.6%	143.6%	85.0%	40.6%	385	13.5	1.7	15.1
Whipps Cross	B3 WARD WXH	1,276.5	1,159.0	1,035.0	1,322.5	1,035.0	1,046.5	690.0	1,081.0	90.8%	127.8%	101.1%	156.7%	496	4.4	4.8	9.3
Whipps Cross	BIRCH	1,035.0	1,253.0	1,035.0	1,196.0	1,035.0	1,046.5	690.0	1,081.0	121.1%	115.6%	101.1%	156.7%	528	4.4	4.3	8.7
Whipps Cross	BLACKTHORN	1,035.0	1,242.0	1,023.5	1,319.0	1,035.0	1,035.0	690.0	1,106.5	120.0%	128.9%	100.0%	160.4%	472	4.8	5.1	10.0
Whipps Cross	Bracken Ward WXH	1,276.5	1,375.0	1,046.5	1,023.5	1,035.0	1,128.0	690.0	770.5	107.7%	97.8%	109.0%	111.7%	500	5.0	3.6	8.6
Whipps Cross	CEDAR	1,373.3	1,266.0	1,375.5	1,414.5	1,035.0	931.5	1,035.0	1,276.5	92.2%	102.8%	90.0%	123.3%	515	4.3	5.2	9.5
Whipps Cross	CHESTNUT	931.5	959.0	345.0	790.0	690.0	1,012.0	345.0	896.5	103.0%	229.0%	146.7%	259.9%	363	5.4	4.6	10.1
Whipps Cross	CONIFER	1,380.0	1,536.5	1,380.0	1,393.5	1,035.0	1,322.5	1,035.0	1,322.5	111.3%	101.0%	127.8%	127.8%	447	6.4	6.1	12.5
Whipps Cross	CURIE	1,380.0	1,370.0	1,035.0	1,138.5	1,035.0	977.5	1,035.0	1,230.5	99.3%	110.0%	94.4%	118.9%	517	4.5	4.6	9.1
Whipps Cross	DELIVERY SUITE WXH	5,701.5	5,117.9	1,380.0	1,207.0	4,818.5	4,267.3	1,380.0	1,315.0	89.8%	87.5%	88.6%	95.3%	533	17.6	4.7	22.3
Whipps Cross	ELIZABETH	1,565.5	1,571.0	345.0	426.5	1,380.0	1,371.0	345.0	414.0	100.4%	123.6%	99.3%	120.0%	536	5.5	1.6	7.1
Whipps Cross	FARADAY	1,374.5	1,212.0	690.0	812.0	1,368.5	1,379.5	345.0	345.0	88.2%	117.7%	100.8%	100.0%	476	5.4	2.4	7.9
Whipps Cross	Frail Elderly WXH	847.5	779.0	345.0	343.8	690.0	690.0	345.0	355.5	91.9%	99.7%	100.0%	103.0%	279	5.3	2.5	7.8
Whipps Cross	ICU WXH	6,888.0	5,020.2	1,356.0	358.5	6,182.0	4,532.0	1,331.0	385.0	72.9%	26.4%	73.3%	28.9%	261	36.6	2.8	39.4
Whipps Cross	MARGARET	1,035.0	1,001.8	345.0	402.5	690.0	690.0	345.0	425.5	96.8%	116.7%	100.0%	123.3%	294	5.8	2.8	8.6
Whipps Cross	MULBERRY	2,227.0	1,993.8	1,695.0	1,012.5	1,380.0	1,318.3	1,312.0	1,104.3	89.5%	59.7%	95.5%	84.2%	1,117	3.0	1.9	4.9
Whipps Cross	NEONATAL WXH	2,297.0	2,091.1	1,088.0	574.0	2,084.0	2,067.0	701.5	310.5	91.0%	52.8%	99.2%	44.3%	364	11.4	2.4	13.9
Whipps Cross	NIGHTINGALE	1,380.0	1,342.5	345.0	360.5	1,380.0	1,367.8	345.0	356.5	97.3%	104.5%	99.1%	103.3%	382	7.1	1.9	9.0
Whipps Cross	PEACE	1,610.0	1,611.0	1,334.0	1,541.0	1,035.0	1,324.5	1,035.0	1,354.5	100.1%	115.5%	128.0%	130.9%	441	6.7	6.6	13.2
Whipps Cross	POPLAR	1,748.0	1,737.0	1,069.5	966.0	1,380.0	1,288.0	1,046.5	920.0	99.4%	90.3%	93.3%	87.9%	530	5.7	3.6	9.3
Whipps Cross	PRIMROSE	1,725.0	1,722.5	1,378.5	1,759.5	1,380.0	1,403.0	1,035.0	1,771.0	99.9%	127.6%	101.7%	171.1%	795	3.9	4.4	8.4
Whipps Cross	ROWAN	1,725.0	1,725.0	1,380.0	1,690.0	1,380.0	1,403.0	1,035.0	1,667.5	100.0%	122.5%	101.7%	161.1%	809	3.9	4.2	8.0
Whipps Cross	SAGE	1,621.5	1,644.5	1,378.0	1,764.3	1,380.0	1,369.0	1,035.0	1,425.5	101.4%	128.0%	99.2%	137.7%	765	3.9	4.2	8.1
Whipps Cross	SYCAMORE	1,276.5	1,626.0	1,380.0	1,610.0	1,035.0	1,380.0	1,035.0	1,383.0	127.4%	116.7%	133.3%	133.6%	785	3.8	3.8	7.6
Whipps Cross	SYRINGA	1,380.0	1,391.5	1,679.0	1,748.0	1,035.0	1,058.0	1,380.0	1,667.5	100.8%	104.1%	102.2%	120.8%	745	3.3	4.6	7.9

APPENDIX

Safe Staffing Fill Rates by Ward and Site

Nov-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	1,380.0	1,714.4	1,035.0	1,178.7	1,378.5	1,679.0	1,035.0	1,265.0	124.2%	113.9%	121.8%	122.2%	579	5.9	4.2	10.1
Newham	Custom House NUH	1,380.0	1,337.0	1,035.0	1,161.5	1,035.0	1,035.0	1,380.0	1,518.0	96.9%	112.2%	100.0%	110.0%	589	4.0	4.5	8.6
Newham	DELIVERY SUITE NUH	4,770.5	4,482.3	690.0	666.1	4,680.5	4,228.7	690.0	690.0	94.0%	96.5%	90.3%	100.0%	570	15.3	2.4	17.7
Newham	EAST HAM	1,736.5	1,667.5	1,035.0	1,012.0	1,380.0	1,380.0	1,035.0	1,115.5	96.0%	97.8%	100.0%	107.8%	664	4.6	3.2	7.8
Newham	HEATHER	2,099.5	2,287.0	1,035.0	1,396.0	2,058.5	2,310.5	1,035.0	1,380.0	108.9%	134.9%	112.2%	133.3%	694	6.6	4.0	10.6
Newham	LARCH	3,297.5	2,600.8	1,988.5	1,846.8	2,070.0	1,947.8	1,725.0	1,704.5	78.9%	92.9%	94.1%	98.8%	1,481	3.1	2.4	5.5
Newham	Manor Park ITU NUH	4,140.0	3,335.0	690.0	540.5	4,140.0	3,323.5	690.0	655.5	80.6%	78.3%	80.3%	95.0%	271	24.6	4.4	29.0
Newham	MAPLE	1,099.0	964.0	690.0	609.5	977.5	886.8	690.0	621.0	87.7%	88.3%	90.7%	90.0%	236	7.8	5.2	13.1
Newham	NEONATAL NUH	3,208.5	3,034.0	632.5	414.0	3,036.0	2,857.0	621.0	356.5	94.6%	65.5%	94.1%	57.4%	470	12.5	1.6	14.2
Newham	NUH MIDWIFERY	1,027.8	969.7	345.0	318.8	1,035.0	994.5	345.0	346.0	94.3%	92.4%	96.1%	100.3%	118	16.6	5.6	22.3
Newham	PLASHET	1,537.5	1,905.5	1,035.0	1,046.5	1,380.0	1,816.3	1,035.0	1,068.8	123.9%	101.1%	131.6%	103.3%	724	5.1	2.9	8.1
Newham	RAINBOW	2,696.0	2,307.3	943.0	871.5	1,725.0	1,703.0	345.0	345.0	85.6%	92.4%	98.7%	100.0%	280	14.3	4.3	18.7
Newham	SILVERTOWN	1,713.5	1,897.5	1,017.0	1,000.5	1,679.0	1,942.0	1,035.0	1,425.5	110.7%	98.4%	115.7%	137.7%	628	6.1	3.9	10.0
Newham	STRATFORD	1,368.5	1,482.7	1,035.0	1,044.8	1,380.0	1,459.3	1,035.0	1,230.0	108.3%	100.9%	105.7%	118.8%	494	6.0	4.6	10.6
Newham	Tayberry	2,413.0	2,576.0	1,035.0	1,046.5	2,415.0	2,587.2	1,035.0	1,229.7	106.8%	101.1%	107.1%	118.8%	677	7.6	3.4	11.0
Newham	THISTLE	1,722.5	1,995.4	1,035.0	1,115.5	1,725.0	2,057.5	1,035.0	1,184.5	115.8%	107.8%	119.3%	114.4%	595	6.8	3.9	10.7
Newham	WEST HAM	1,260.5	1,264.0	1,023.5	1,030.5	1,035.0	1,035.0	333.5	747.5	100.3%	100.7%	100.0%	224.1%	616	3.7	2.9	6.6
St Bart's	1C	5,842.0	5,036.3	345.0	253.0	5,129.0	4,696.0	195.5	276.0	86.2%	73.3%	91.6%	141.2%	400	24.3	1.3	25.7
St Bart's	1D	3,112.0	2,546.5	345.0	414.0	2,760.0	2,187.0	345.0	333.5	81.8%	120.0%	79.2%	96.7%	352	13.4	2.1	15.6
St Bart's	1E	4,811.5	3,956.5	345.0	264.5	4,818.5	3,817.5	345.0	287.5	82.2%	76.7%	79.2%	83.3%	249	31.2	2.2	33.4
St Bart's	3A SBH	4,826.0	4,391.0	1,376.0	1,380.0	4,828.5	4,589.5	1,380.0	1,436.3	91.0%	100.3%	95.1%	104.1%	943	9.5	3.0	12.5
St Bart's	3D SBH	1,506.5	1,722.0	1,168.5	1,197.8	1,460.5	1,474.0	931.0	931.0	114.3%	102.5%	100.9%	100.0%	550	5.8	3.9	9.7
St Bart's	4A SBH	1,722.0	1,673.3	1,035.0	987.5	1,380.0	1,380.0	345.0	807.0	97.2%	95.4%	100.0%	233.9%	711	4.3	2.5	6.8
St Bart's	4B SBH	1,537.5	1,507.5	1,192.5	1,036.5	1,380.0	1,380.0	690.0	841.5	98.0%	86.9%	100.0%	122.0%	570	5.1	3.3	8.4
St Bart's	4C SBH	1,725.0	1,621.5	931.5	900.0	1,368.5	1,299.5	931.5	1,043.0	94.0%	96.6%	95.0%	112.0%	557	5.2	3.5	8.7
St Bart's	4D & 4E SBH	1,658.0	1,401.0	690.0	632.5	1,564.0	1,150.0	690.0	678.5	84.5%	91.7%	73.5%	98.3%	351	7.3	3.7	11.0
St Bart's	5A SBH	2,172.0	2,279.9	864.5	1,081.4	1,408.0	1,604.9	330.0	694.0	105.0%	125.1%	114.0%	210.3%	589	6.6	3.0	9.6
St Bart's	5B SBH	1,380.5	1,447.8	686.5	733.0	1,368.5	1,385.3	345.0	713.0	104.9%	106.8%	101.2%	206.7%	454	6.2	3.2	9.4
St Bart's	5C SBH	2,064.0	2,080.7	690.0	909.5	1,725.0	1,799.3	345.0	989.0	100.8%	131.8%	104.3%	286.7%	602	6.4	3.2	9.6
St Bart's	5D SBH	2,054.5	1,933.0	690.0	700.0	1,725.0	1,670.3	690.0	782.0	94.1%	101.4%	96.8%	113.3%	725	5.0	2.0	7.0
St Bart's	6A SBH	6,210.0	5,093.5	345.0	276.0	6,210.0	5,323.0	345.0	253.0	82.0%	80.0%	85.7%	73.3%	254	41.0	2.1	43.1
St Bart's	6D SBH	1,403.0	1,322.5	719.3	676.8	1,035.0	1,024.0	690.0	690.0	94.3%	94.1%	98.9%	100.0%	457	5.1	3.0	8.1

NHS
Barts Health
NHS Trust

Report to the Trust Board: 1 November 2023	TB 63/23

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 4 October and 23 October 2023 to discuss items on its agenda (drawn from its annual workplan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items	**BAF entries**
Operational performance (constitutional standards)	5,6
Monthly finance report	13
Capital programme report	14
Contracts and waivers	13
Cancer – urology report	5
Winter plan	5, 6
Newham fire safety programme update	14
Workforce thematic update	1, 4

Key areas of discussion arising from items appearing on the agenda

Operational performance (constitutional standards)

The Committee reviewed in detail performance against operational constitutional standards, with a focus on urgent and emergency care; waiting list reductions; cancer and diagnostics performance (with key details appearing in the Trust Board's IPR). The additional challenge of industrial action disruption to clinical activity was a key theme discussed.

Monthly finance reports

The Committee discussed and noted the monthly position reports (as summarised in the IPR). The committee reviewed delivery against savings plans and received an exception report from the executive Financial Recovery Board. In addition to review of the Trust outlook, the Committee spent time reviewing the development and outputs of sector level scrutiny; and revisions to the NEL sector financial plan.

Capital programme report

The Committee noted the significant challenges associated with capital constraints in 2023/24 with an expected CRL overshoot. Steps to more sustainably fund longer term capital pressures associated with fire safety improvements were discussed, with a business case in development.

Procurement

The Committee confirmed an additional role in review of major contracts and waivers ahead of Board approval.

Workforce A deep dive review of workforce metrics was considered; noting the key dependencies within the operational plan in relation to substantive recruitment, productivity and key controls (such as rostering and job planning). **Winter plan** The Committee discussed initial plans in relation to winter pressures, including additional capacity and wards, staff vaccinations and working with partners.
Any key actions agreed / decisions taken to be notified to the Board -
Any issues for escalation to the Board -

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: 1 November 2023	TB 64/23

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 20 September 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**
Internal Audit progress report	All
BAF and high risks report	All
QAC exception report	All
Letby case	All
Operational plan – performance and risk Q1 assessment	All
Standing reports on counter fraud, waivers and losses and special payments	13
Cyber	All

Key areas of discussion arising from items appearing on the agenda

Internal Audit reports

The committee reviewed outcomes of audits assigned reasonable or substantial assurance ratings. The committee discussed a limited assurance review of compliance with the Better Payments Practice Code. The committee also 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. Time was spent on the work of counter fraud services to raise awareness and to investigate casework.

Letby case

The Committee considered implications arising from the Countess of Chester case, the role of the Committee as lead on Freedom to Speak Up and options to strengthen staff and patient listening mechanisms.

Operational plan – performance and risk Q1 assessment

The Committee reviewed the format and content of a Q1 assessment of operational plan delivery.

BAF and high risks report

The Committee spent time reviewing the mapping of BAF risks to objectives, committee roles and risk appetites. Aligned with the reporting on operational plan delivery, a full BAF with risk tolerance triggers was considered by the Committee. In relation to other high risks appearing on the risk register, it was agreed to develop a more rigorous review and sign off approach.

Cyber The Committee discussed cyber security arrangements, ICT infrastructure and accreditation.
Any key actions agreed / decisions taken to be notified to the Board None.
Any issues for escalation to the Board Partial assurance on the management of very high scored risks (20+) on the risk register.

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.

Barts Health NHS Trust

Report to the Trust Board: 1 November 2023	TB 65/23

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 6 October 2023

Key areas of discussion arising from items appearing on the agenda
At this meeting the Committee received and agreed the proposed approach for VSM pay (subject to national confirmation of award recommendations for 2023/24) and the approved the phased reconfiguration of executive positions and portfolios as part of the move towards a single board for the integrated group. This followed support of the collaboration committee and the Barking, Havering and Redbridge University Hospitals NHS Trust nominations and remuneration committee.

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: 1 November 2023	TB 66/23

Title	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 4 October 2023 to discuss Acute Provider Collaborative developments and agree steps to move closer towards an integrated group of hospitals across Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust.

1. *Acute Provider Collaborative working*
2. *BH / BHRUT integrated group update*

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.
- Agreeing a shared purpose for the integrated group (as one group operating across two organisations comprising seven hospitals).
- Communications and engagement in relation to the next phase of integrated working.
- Executive roles – agreeing steps towards a single executive team for the integrated group. This included discussion of the composition and portfolios; Trust Board membership balance; and proposals for a phased timetable for recruitment.
- A review of progress on a temporary staffing workstream (designed to secure benefits of collaboration through alignment of systems and rates).

A separate paper with further details on the above appears under the provider collaboration agenda item.

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 Trust Board: 1 November 2023	TB 67/23

Title	Board Assurance Framework and Operational Plan Oversight
Sponsoring Director	Group Director of Corporate Development
Author(s)	Sean Collins, Trust Secretary
Purpose	To approve the revised BAF and introduce the approach to overseeing delivery of the operational plan
Previously considered by	Risk Management Board September 2023 Audit and Risk Committee 20 September 2023 Group Executive Board 17 October 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, reflecting steps taken since July to engage the Trust Board and board committees in design and mapping of risks, refining risk descriptions and calibrating risk scores.

BAF format

Specifically, the review of BAF format has included approval of a risk appetite statement in relation to Trust objectives; and an alignment with new arrangements for oversight of performance and risks to delivery of the operational plan. The associated mapping of objectives to executive boards has also supported clearer assurance routes. As a result, the BAF format now includes for each risk details of performance and risk KPIs to be tracked quarterly; with identified tolerances serving as triggers for prioritised risk management activity.

BAF risk changes

In addition to the format refinements above, the following are the main changes to BAF risk since the last submission:

- Addition of details of controls and assurances for BAF entries 3 (A failure to successfully engage our people on our Quality Improvement approach impairs our ability to improve and transform services) and 8 (Insufficient systems to identify hotspots in a large complex organisation impacts on aspirations to provide 'good and outstanding' rated services across the group).
- Reduction of the risk score in relation to BAF entry 10 (Failure to collaborate effectively as an integrated group across Barts Health and BHRUT delays benefits realisation and improved patient outcomes) from 4x3=12 to 4x2=8. This reflects significant collaboration across clinical teams and progress on sector and group governance proposals (with progress towards an integrated group summarized in a separate report at this meeting).
- Updated details of cross-referenced high risks appearing on the risk register and refinement of listed controls and assurances.

Risk profile
The highest scored BAF risks (and those at greatest variance to risk appetite) relate to workforce capacity and capability; delivery of planned elective activity; sector mental health capacity impact on emergency care; and financial plan delivery. These have remained highly scored risks for the duration of the financial year, reflecting the operational and financial pressures reported to the Board in recent months. A key factor underpinning each of the workforce and operational risks has been the impact of industrial action and inflationary pressures on productivity, activity and finances.

Risk management next steps
Informed by performance against KPIs and risk tolerances, a revised prioritised BAF deep dive schedule has been identified for the remainder of the year and incorporated in Board committee workplans. A second quarterly review of operational plan performance and risk will be considered by the Audit and Risk Committee later in the month; outputs of this will inform the next BAF submission in 2024.

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.

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 1 NOVEMBER 2023

BOARD ASSURANCE FRAMEWORK

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 agreed a risk appetite statement and tolerances following a board seminar. The approach to this has been aligned to the wider context of assessing 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.

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

5. The Barts Health operational plan for 2023/24 details key priorities and objectives for 2023/24. Work over recent months with group boards (executive boards reporting into the group executive board) and hospitals has included steps to identify a set of key operational plan deliverables that will also serve as 'tolerances' and triggers for BAF risks.

6. 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.

7. 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 review the key metrics identified in the operational plan through existing data dashboards and reports utilised within routine governance forums. This will inform a quarterly self-assessment of current performance and risks to delivery against metrics and measures in the operational plan.
    - The above tolerances will inform the identification of triggers for escalation / de-escalation for board committees (to seek additional assurances or recalibrate risk scores).

8. 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.

BAF risks – changes since last report

9. 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); and

financial pressures (entry 13). The above entries also reflect the greatest distance from risk appetite.

10. In addition to the format refinements detailed in the section above, the following are the main changes to BAF risk since the last submission:

    • Addition of details of controls and assurances for BAF entries 3 (A failure to successfully engage our people on our Quality Improvement approach impairs our ability to improve and transform services) and 8 (Insufficient systems to identify hotspots in a large complex organisation impacts on aspirations to provide 'good and outstanding' rated services across the group).

    • Reduction of the risk score in relation to BAF entry 10 (Failure to collaborate effectively as an integrated group across Barts Health and BHRUT delays benefits realisation and improved patient outcomes) from 4x3=12 to 4x2=8. This reflects significant collaboration across clinical teams and progress on sector and group governance proposals (with progress towards an integrated group summarized in a separate report at this meeting).

    • Updated details of cross-referenced high risks appearing on the risk register and refinement of listed controls and assurances.

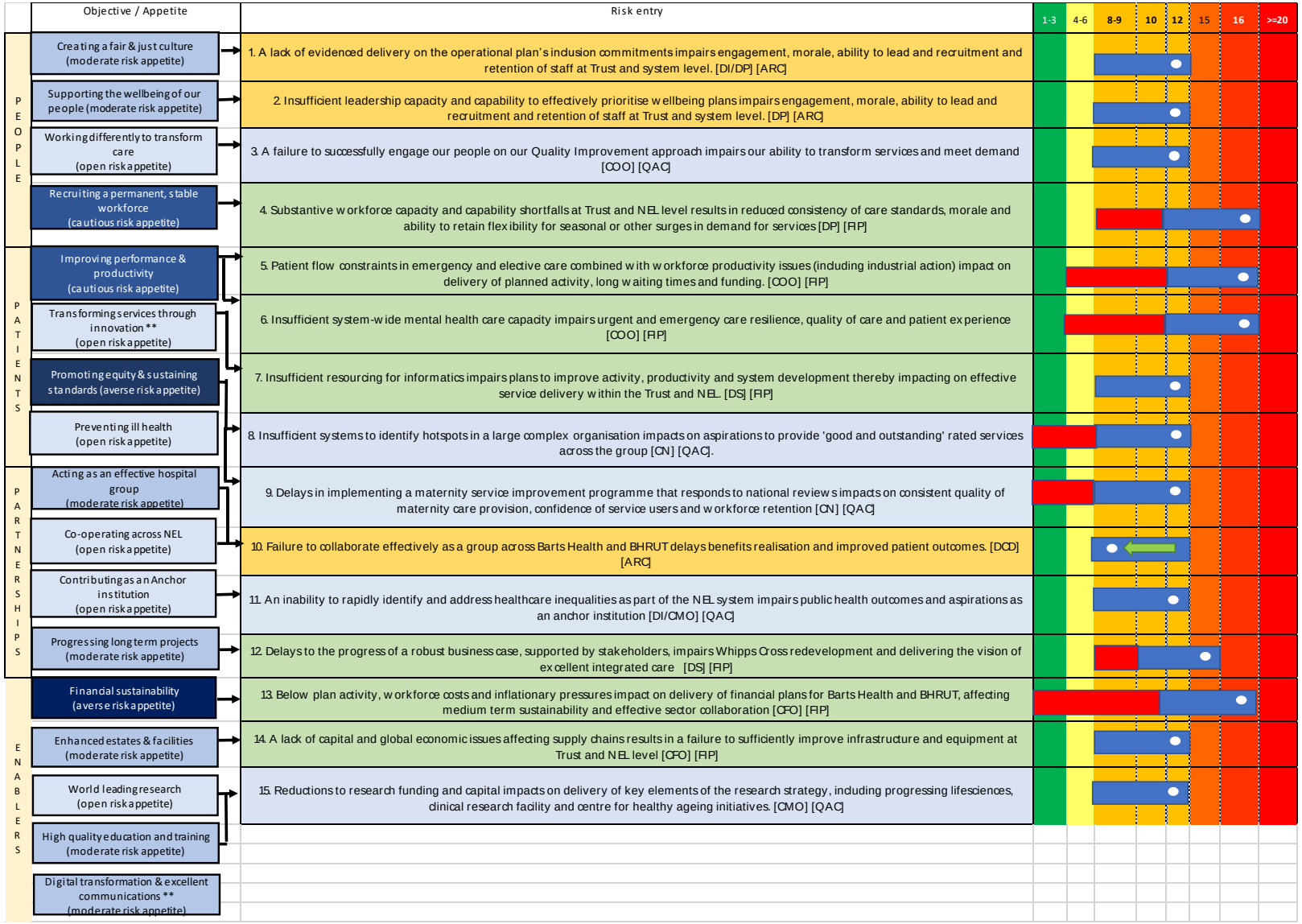
NEXT STEPS AND AREAS FOR FURTHER DEVELOPMENT

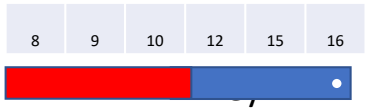
11. Following board review of performance against operational plan KPIs in Quarter 1, an assessment for Quarter 2 will be considered by the Audit and Risk Committee on 22 November 2023. As this approach is embedded, it will inform the development and monitoring arrangements for a 2024/25 operational plan and objectives.

12. Informed by performance against KPIs and risk tolerances, a revised prioritised BAF deep dive schedule has been identified for the remainder of the year and incorporated in Board committee workplans.

RECOMMENDATION

13. 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.


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 indusion 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]
Recruiting a permanent, stable workforce (cautious 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] [FIP]
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. Insufficient 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]
High quality education and training (moderate risk appetite)
Digital transformation & excellent communications ** (moderate risk appetite)



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 Risk appetite for sub-objective relevant to risk: **8-12 (Moderate)** Gap: risk score to risk appetite: **4**		
Risk tolerance triggers:	**WRES 1A: % BAME staff in 8A+ roles from 37% to 41%:**	**Q1 assessment = ON TRACK**
	Reduce gender pay gap from 11.7% to 11% in leadership roles	**Q1 assessment = ON TRACK**
	ESR declaration rates: closing the disparity between the declaration rate in ESR and the annual staff survey	**Q1 assessment = ON TRACK**

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	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	
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, 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: Assurance on consistency of implementation of inclusion actions across all hospitals / departments* *Action: Anticipated Well Led review in 2023 will provide third party assurance* *Gap: disparity in bullying, harassment and discrimination between BAME and white colleagues and disabled and non disabled colleagues*

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

STRATEGIC OBJECTIVE 1b Supporting the wellbeing of our people		
Risk appetite for sub-objective relevant to risk: **Moderate (risk score 8-12) Gap to risk score = 4**		
Risk tolerance triggers:	**Increase satisfaction with 'We work flexibly' score from 5.6 to 6 in NHS survey**	**Q1 assessment = BEHIND SCHEDULE**
	Reduce sickness absence from 5.07% to 4%	**Q1 assessment = ON TRACK**

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Sufficient sources (ii) Assurance Level	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	
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: [6568]*	**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)**		Closer working of two trust boards in the provider collaboration including establishment of Board Collaboration Committee **(1-6)**		Role of NEL ICS, JOSCs and Healthwatches in oversight of system development and place-based governance **(1-6)** CQC oversight of Well Led domain and internal mock Well Led inspections. **(1-6)**		*Gap: Staff survey evidencing consistent improvement on wellbeing scores* *Action: Communications plan to support wellbeing interventions*

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

STRATEGIC OBJECTIVE 1c. Working differently to transform care	
Risk appetite for enabler relevant to risk: **Open (risk score 15-16) Gap risk score to risk appetite**	
Risk tolerance triggers: QI training delivered in line with NHS dosing model	**Q1 assessment = BEHIND SCHEDULE**
First Steps in QI training delivered in line with NHS dosing model	**Q1 assessment = ON TRACK**
Number of QI projects registered	**Q1 assessment = BEHIND SCHEDULE**

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Sufficient sources (ii) Assurance Level	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	
3. A failure to successfully engage our people on our Quality Improvement approach impairs our ability to improve and transform services **Executive lead:** Chief Operating Officer **Subcommittee role:** Quality Assurance Committee	*[Outset score: 16]* ***Current: 4x3=12*** *Target: 4x2=8* *Datix ref: 7433*	1. Dedicated teams in place across the Group and at hospital level to drive the increase in QI capability 2. 10 year QI model developed, aligned to NHS and IHI guidance, setting out expectations of growth in QI capacity across levels of capability. Training offered aligned to the model. 3. QI training aligned to support delivery of organisational priorities. 4. Community of Practice launch in November, engaging a wider network of individuals in QI and provide further skills development. 5. WeImprove embedded within operating plan. 6. Trust wide WeImprove awards to celebrate and share QI project achievements to a wider audience. 7. WeImprove strategic refresh aligned to NHS Impact in Autumn 23. 8. Communications strategy to support WeImprove in development.	GEB oversight of WeImprove strategic priorities and delivery (1-8). Hospital governance established providing oversight of QI project and capability building delivery (1, 2, 3, 4, 5, 6). Boards receive relevant reports on progress against programme delivery (5, 6) Group wide QI leads and faculty developed providing strategic direction, planning and oversight of delivery across the Group. (1-8)		WeImprove annual update to the Board (1-8)		NHSE visibility and assurance through NHS IMPACT delivery and expectations. (1,2,7) Strategic partnership with the Institute for Healthcare Improvement (IHI) providing assurances on quality of delivery and areas of focus. (1,2,7) CQC oversight of Well led domain. International and national engagement in awards, sharing best practice to raise the profile of Barts Health QI work.		*Tracking and recording of Projects through a single Group wide portal.* *Action: Procurement underway in partnership with the Clinical Effectiveness Unit.* *Current 'dosing' model for training and awareness based on numbers pre Serco transfer. Teaching capacity provided insufficient to respond to additional requirements.* *Action: Re running model to reflect current workforce numbers. Reviewing approach to delivery of training to increase availability.*

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

STRATEGIC OBJECTIVE 1d. Recruiting a permanent stable workforce		
Risk appetite for sub-objective relevant to risk: **4-6 (Cautious)**	**Gap: risk score to risk appetite: 12**	
Risk tolerance triggers:	**Increasing substantive fill rate (ALL) from 92.6% to 95%**	**Q1 assessment = BEHIND SCHEDULE**
	Increase nursing and midwifery substantive fill rate from 87.5% to 95	**Q1 assessment = BEHIND SCHEDULE**
	Reduce agency spend from 5.02% to 3.7	**Q1 assessment = BEHIND SCHEDULE**

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Sufficient sources (ii) Assurance Level	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	
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:** Finance Investment and Performance 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. 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, flexible working, career development framework and Talent Management approach to develop skills and opportunities – part of wider retention plan. **5.** Provider Collaborative extends shared learning and career opportunities across the NEL sector.	People Board oversight of key workforce metrics and controls **(1-5)** 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 **(1-5)**		*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 and hospital drive to 95 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* *Retention plan links to We Lead and flexible working*

Related high risks (>15) on the risk register – Datix refs: ***Lead: Group People Director - 7248 ICT Skills and Staff shortages (risk score 20); 7230 Risk of a halt to the Barts Health NHS Trust kidney and stem cell transplant service due to lack of Consultant Clinical Scientist in Pathology Partnership (risk score 20); 6711 Critical Care Resourcing (People Services) (risk score 15); Lead: Group Director of Operations - 6717 EPRR Service under resourced (risk score 16, lead Group Director of Ops); Lead: Newham Chief Executive - 7197 Lack of senior medical staffing within ED (risk score 16); 6832 Vacancy across nursing and midwifery workforce within the clinical areas and within the senior nursing leadership team (risk score 16); 6515 insufficient staffing level across therapies (OT/PT/SLT/dietetics) in NUH stroke unit to meet stroke standards - RCP 2016 (risk score 15); 7232 Urology cover for ED and inpatients at NUH (risk score 15); 6321 Inadequate nursing support for POSCU services (risk score 15); 7172 Significantly long waits in ED due to challenging bed pressures risk score 16); 6735 There is currently no Home Oxygen Service provision NUH (risk score 15); 6620 shortage of paediatric nurses within paediatric ED (risk score 16); 6733 Lack of staffing in the Urgent Treatment Centre (risk score 16); 6615 Medical consultant capacity is not sufficient to deliver daily consultant review (risk score 16); Lead: Royal London Chief Executive - 6547 CT staffing is highly reliant on agency staff and bank overtime at RLH site with radiation risk due to lack of RPS time (risk score 16); 7273 Delay in Imaging Ultrasound Head and Neck examinations RLHSBHMEH (risk score 16); 7444 Delays in Ultrasound Imaging (risk score 16); 7436 Insufficient capacity to meet demand for paediatric patients requiring sleep studies at RLH (risk score 16); 6416 Rightsizing the Department of Infection and Addressing Consultant Underpayments (risk score 16);6636 Unsafe Service - due to critical staffing levels at Barts Heath Haematology Departments (risk score 16); 6676 Mismatch between Clinical Neurophysiology demand and capacity (risk score 16); 6709 Risk to staffing MRI Scanners x3 at weekends and evenings (risk score 16); 6763 Clinical risk to paediatric audiology patients on waiting lists, and system risks due to pressures on paediatric audiology (risk score 16); 6789 Pharmacy staffing within the inpatient dispensary (risk score 16); 6512 Inability to offer statutory compensatory rest and protected RPS time for Core radiographers (radiation risk) (risk score 15); 6798 Lack of Ophthalmic capacity in RLH theatres has significant implications on patient care and service delivery (risk score 16); 5997 Harm and poor patient experience due to length of wait for complex elective orthopaedic surgery (risk score 15);***

Lead: St Bartholomew's Chief Executive - 7311 Risk to provision of clinical oncology service (consultant staffing) (risk score 16); 4613 Non-compliance with NHSE Service Specification for Severe Asthma (risk score 16); 6294 Negative impact on patient care and operational performance, due to vascular lab closures caused by lack of staffing resilience (risk score 16); 6430 Risk to provision of Breast Imaging Services due to staffing shortage (risk score 16); 7055 Significantly reduced staffing levels with the potential to affect nuclear medicine physics service provision (risk score 16); 6800 Insufficient management of complex nutrition needs for SBH patients (risk score 16);, 6958 Inability to meet cancer waiting time targets due to Therapeutic Radiographer staffing levels (risk score 16); 6904 Delays in provision of outpatient chemotherapy (risk score 16); Lead: Whipps Cross Chief Executive - 7427 A lack of injection clinic capacity could lead to delayed clinical assessment and risk of sight loss to patients (risk score 20), 7214 Lack of non-admitted capacity for Glaucoma (risk score 20); 7216 Lack of capacity in retina clinic (risk score 20); 6650 Delay in care for routine care for women on Colposcopy pathway (risk score 16); 7212 Mismatch between demand and capacity in WXH Neuro-Ophthalmology service (risk score 16); 7384 Dermatology skin 2ww - patient demand exceeding capacity (risk score 16); 7429 Critical Care Technologists (risk score 16); 7253 Unable to meet full needs of the service due to a shortage of junior doctors (risk score 16); 5156 Risk to patient safety related to operational seasonal pressures (risk score 16); 6598 Persistent national and local midwifery staff shortages contribute to the quality of care provided and affects safety levels (risk score 16); 7173 ERCP Service Viability (risk score 16); 6423 Junior doctor gaps in medicine (risk score 15); 7255 Delay to Care and Risk of Harm due to lack

STRATEGIC OBJECTIVE 2a. Improving performance and productivity		
Risk appetite for sub-objective relevant to risk: **4-6 (Cautious)** **Gap score to risk appetite: 12**		
Risk tolerance triggers:	**By March '24, no patient waiting more than 65 weeks to start consultant led treatment**	**Q1 assessment = BEHIND SCHEDULE**
	Improve theatre utilisation to 85%	**Q1 assessment = BEHIND SCHEDULE**
	Delivery of 109% value weighted activity against 19/20 baseline	**Q1 assessment = BEHIND SCHEDULE**

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Sufficient sources (ii) Assurance Level	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	
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: 4x3=12* *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.** Surgical hubs created to support high volume low complexity workstreams. **6.** Workforce planning and waiting list initiatives for 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:;

Lead: Group Director of Operations - 5152 Emergency Access Performance (risk score 16); Lead: Group Director of People - 6711 Critical Care Resourcing (People Services) (risk score 16) Lead: Newham Chief Executive - 4094 Lack of physical capacity to Review patients in ED (risk score 15); 5320 Delays to patient care due to obsolete Fluoroscopy machine (risk score 16); 7135 Mental health patients staying long periods in the emergency department (risk score 16); 7172 Significantly long waits in ED due to challenging bed pressures (risk score 16); 7197 Lack of senior medical staffing within ED (risk score 16); 7269 Risk to patient safety due to industrial action by junior doctors (risk score 15); Lead: Whipps Cross Chief Executive - 3062 Low Junior Doctors at registrar level within ED (risk score 15); 3543 Overcrowding in the Emergency Department (risk score 20); 5156 Risk to patient safety related to operational seasonal pressures (risk score 16); 6423 Junior doctor gaps in medicine (risk score 15); 4019 Outpatient appointment capacity (risk score 16); 7272 Failure to deliver safe care due to Junior Doctors industrial action (risk score 16); 7429 Critical Care Technologists (risk score 16); 7430 No reliable clinical pathway for Patient First Community Diagnostic Service (risk score 16); 7431 limited ortho-geriatric support for complex medical patients on orthopaedic wards (risk score 15); Lead: Royal London Chief Executive - 113 Delay of critical care admission (risk score 16); 1816 Increased mortality and morbidity due to long waiting times for emergency orthopaedic surgery (risk score 16); 2550 Outpatient Haemodialysis Capacity (risk score 16); 3571 lack of inpatient beds will result in patients being cared for in recovery (risk score 16); 3816 Increased mortality and morbidity due to long waiting times for emergency orthopaedic surgery (risk score 16);4650 MRI scans delays due to capacity < demand and Covid backlog (risk score 16); 5477 Delays in histology reporting for cancer patients within General Surgery impacting diagnosis and treatment (risk score 16); 5997 Theatre capacity for complex elective orthopaedic surgery (risk score 15); 6253 Risk of DMO1 failure due to delays in diagnosis and treatment within the Redbridge Audiology service (risk score 15); 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); 6676 Mismatch between Clinical Neurophysiology demand and capacity (risk score 16); 6720 Risk to MRI on call cover at RLH due to unagreed rate (risk score 16); 6763 Clinical risk to paediatric audiology patients on waiting lists, and system risks due to pressures on paediatric audiology (risk score 16); 6915 Critical Overcrowding ED (risk score 16,); 7155 Lack of safe and suitable environment for assessment and care of patients with mental health presentations (risk score 16); 7157 No enhanced care provision for Mental Health Patients in ED (risk score 16); 7169 Non-compliant Neurosurgery on-call rota (risk score 16); 7281 Blood Fridges Theatres (risk score 16); 7436 Insufficient capacity to meet demand for paediatric patients requiring sleep studies at RLH (risk score 16); 7444 Delays in Ultrasound Imaging (risk score 16); Lead: St Bartholomew's Chief Executive - 7264 Failure to deliver safe and timely care due to both Junior Doctors and Medical Consultant industrial action (risk score 16); 7432 Provision of the Group diagnostic imaging and cardiac echo services (Q Pulse) (risk score 16);

STRATEGIC OBJECTIVE 2a. Improving performance and productivity		
Risk appetite for sub-objective relevant to risk: **4-6 (Cautious)** **Gap risk score to risk appetite: 12**		
Risk tolerance triggers:	**A&E 4 hour waiting time**	**Q1 assessment = BEHIND SCHEDULE**
	A&E 12 hours journey time	**Q1 assessment = BEHIND SCHEDULE**
	Reduce bed occupancy to 92% or below	**Q1 assessment = ON TRACK**

PRINCIPAL RISK *(Description of risk)*	RISK SCORE	CONTROLS	FIRST LINE ASSURANCE		SECOND LINE ASSURANCE		THIRD LINE ASSURANCE		GAPS
		Controls and assurance rating – (i) Sufficient sources (ii) Assurance	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	
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:
Lead: Royal London Chief Executive - 6938 Risk of vulnerable patients absconding from the Emergency department (risk score 16); 7157 No enhanced care provision for mental health patients in the emergency department (risk score 16); 7155 Lack of safe and suitable environment for assessment and care of patients with mental health presentation (risk score 16); Lead: Newham Chief Executive - 7135 Mental health patients staying long periods in the emergency department (risk score 16)

STRATEGIC OBJECTIVE 2b. Transforming services through innovation and ENABLER: Digital transformation and excellent communications		
Risk appetite for enabler relevant to risk: **Moderate (risk score 8-12) Gap risk score to risk appetite: 0**		
Risk tolerance triggers:	**Implementation of trustwide Unified Comms Business Case**	**Q1 assessment = ON TRACK**
	Millennium go lives for theatres, perioperative, critical care and ED uplift across all sites in April 2024	**Q1 assessment = ON TRACK**
	Patients Know Best (PKB) for NEL ICS expansion	**Q1 assessment = ON TRACK**

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	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	
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 Group Development **Subcommittee role:** Audit and Risk Committee	*[Outset score: 16]* ***Current: 4x3=12*** *Target: 4x2=8* *Datix ref: 4109*	**1.**Ringfenced element of capital programme, to renew ICT infrastructure, PCs, data centres and networks. **2.**Approved Informatics strategic delivery plan and consolidated Millennium Cerner EPR system. **3.** Upgrades of Millennium Cerner (following consolidation of single PTL) **4.** Information Governance team and Data Security Protection Toolkit. **5**. WeConnect2 programme successfully rolled out to strengthen digital systems, electronic prescribing and documentation. **6.** BHRUT business case for new EPR system to align principal information platform across BH and BHRUT 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)**		Trust Board approval of BHRUT EPR business case **(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)** HIMMS accreditation on infrastructure / cyber **(1,3)**		*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:
Lead: Group People Director - 7248 ICT Skills and Staff shortages (risk score 20)Lead Group Director of Strategy: 7291 Unsupported Software for PC and Applications (risk score 20); 4769 PC/EUDs ongoing replacement of ageing devices (risk score 20); 6671 ICT - Cyber Security (risk score 16); 7031 Telecomms Ageing (risk score 16); 4768 Server obsolete (risk score 16); 7250 IT - Business Continuity (Group) (risk score 16); 7249 IT - Business Continuity (SBH) (risk score 16); 7285 Network refresh programme for WXH (risk score 16); 6883 ICT Provision to obstetrics at RLH (risk score 16); 7294 Volume of vulnerabilities raised under CareCerts (risk score 15); 7098 Risk of harm to electro convulsive therapy patients within theatres due to lack of information on CRS (risk score 16);7101 - Impact of BHRUT network integration for Pathology Partnership (risk score 15); 7103 Potential LGT change of EPR risk to how reports are delivered to clinicians (risk score 16)

STRATEGIC OBJECTIVE 2c. Promoting equity and sustaining standards		
Risk appetite for sub-objective relevant to risk: **1-3 (Averse)** **Gap risk score to risk appetite: 8**		
Risk tolerance triggers:	**PSIRF implementation by November'23**	**Q1 assessment – BEHIND SCHEDULE**
	Implementation of clinical audit policy	**Q1 assessment – ON TRACK**
	Rescuing of Deteriorating patients – improve time to administration of antibiotics for high risk patients with sepsis	**Q1 assessment – BEHIND SCHEDULE**

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	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	
8. Insufficient systems to identify hotspots in a large complex organisation impacts on aspirations to provide 'good and outstanding' rated services across the group. **Executive lead:** Chief Nurse **Subcommittee role:** Quality Assurance Committee	*[Outset score: 12]* ***Current: 4x3=12*** *Target: 4x2=8* *Datix ref: 7434*	1. Central governance function (including infection control and safeguarding) oversees quality framework and reporting. 2. Qliksense, Datix and Tendable tools for tracking key metrics risks and incidents at ward through to group level 3. Insight function supports patient involvement and co-design of service improvement 4. Policy framework and PSIRF implementation to support just culture, shared learning. 5. IPR tracks monthly key metrics including staffing. Accompanied by thematic rolling reporting on key areas (mortality, complaints etc). 6. Hospital quality plans and Well Led plan, tracking progress and any response to prior recommendations. 7. Established QI approach and alerts system (outliers, HSIB etc).	Quality Board provides hospital and executive oversight of quality framework and horizon scanning, with trustwide quality groups reporting in.(1-7) Strategic and BAU CQC groups oversee quality plans (6) PRs and bimonthly quality deep dives led by CMO/CN Peer review programme with focus on key themes (maternity, infection control etc)		Quality Assurance Committee oversight, links to ARC and input to Trust Board		Annual internal audit review of CQC domain related governance (2023 significant assurance rating). CQC visits support trend of improving ratings of services. Involvement in national Maternity Safety Support Programme		Review of quality reporting to consider reporting on outliers and NCEPOD findings. Absence of an established ward accreditation approach. Action: to explore options in 24/25 post PSIRF implementation

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 2c. Promoting equity and sustaining standards		
Risk appetite for sub-objective relevant to risk: **1-3 (Averse)** **Gap risk score to risk appetite: 8**		
Risk tolerance triggers:	**Updated maternity dashboard by June '23 to enable HEBs and GEB to review trend data**	**Q1 assessment – ON TRACK**
	Neonatal deaths per 1000 births	**Q1 assessment – ON TRACK**
	Increase permanent workforce to 95% or more of funded establishment	**Q1 assessment – ON TRACK**

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	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	
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: (3538)*	**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.	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:
Lead: Newham Chief Executive - 6846 Procurement of 12 Wired Philips Healthcare Avalon FM30 Intrapartum Fetal Monitor CTG (risk score 16); 7309 Not providing holistic risk assessments throughout pregnancy and on presentation labour (risk score 16,); 6647 Multiple methods of documentation throughout the maternity pathway does not capture all data and assurance required (risk score 16); 6437 Increase O&G Consultant establishment to support sustainability of Consultant Labour Ward 98 hour presence & Separate rotas (risk score 16); 6811 E8 Scan Machines due for replacement since 2018 (risk score 15); 6646 Current antenatal care pathway not adequately meeting the needs of the service (risk score 16); 6923 Potential scan capacity issues affecting gap and grow being fully implemented. (risk score 15); Vacancy across nursing and midwifery workforce within the clinical areas and within the senior nursing leadership team (risk score 16)
Lead: Royal London Chief Executive - 7340 Inadequate Midwifery staff to provide safe and responsive care within maternity services (risk score 20); 6882 Obs & Gynae Medical Staffing (risk score 16); 6883 ICT Provision to maternity staff (risk score 16)
Lead: Whipps' Cross Chief Executive - 7255 Delay to Care and Risk of Harm due to lack of home visits by Community Midwifery Team (risk score 15); 7253 Unable to meet full needs of the service due to a shortage of junior doctors (risk score 16); 6598 Persistent national and local midwifery staff shortages contribute to the quality of care provided and affects safety levels (risk score 16)

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)** **Gap: risk score to risk appetite: 4**		
Risk tolerance triggers:	**Delivery of agreed APC programme milestones and metrics**	**Q1 assessment – ON TRACK**
	Delivery of integrated group priority enabler milestones and metrics	**Q1 assessment – ON TRACK**
	Delivery of Barts Health Well-led improvement plan	**Q1 assessment – ON TRACK**

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	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	
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 Group Development **Subcommittee role:** Audit and Risk Committee	*[Outset score: 12]* ***Current: 4x2=8*** *Target: 4x2=8* *Datix ref: [7138]*	1. Barts Health and BHRUT have prioritised six enabling workstreams (workforce, organisational development, corporate services, digital, financial sustainability, leadership development) 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 five clinical transformation programmes (planned care, cancer, critical care, maternity and babies, children and young people) plus cross-cutting work on specialised services, research and clinical strategy, and supporting the NEL-led urgent and emergency care programme. 3. A programme plan has been agreed to operate as an integrated group across Barts Health / BHRUT, using the CQC well led framework.	Joint executive oversees development of the integrated group (1,3) Acute Provider Collaborative executive group oversees delivery of APC programmes (2). Group Executive Board receives regular updates on provider collaboration (1-3)		Board Collaboration Committee assures the development of the integrated group (1,3). APC joint committee assures progress of the APC (2). Joint board seminars are held 6 monthly across BH / BHRUT (1-3). Part 1 and 2 Trust Board meetings receive regular updates on provider collaboration (1,3).		Role of NEL ICS, JOSCs and Healthwatches in oversight of system development and place-based governance (1,2,3). CQC oversight of Well Led domain and internal mock Well Led inspections.(1,3). Internal audit of provider collaboration benefits realisation. (1,3).		*Gap: operating model for the integrated group is not yet in place.* *Action: implementation of programme plan with assurance through Board gateways..* *Action: seek additional external resources to support the change process.* *Gap: limited resource available to support APC ambitions.* *Action: draw resources from ICB and trusts, and align objectives to the available resources.*

Related high risks (>15) on the risk register – Datix refs:
Lead: Group Director of Strategy - 7101 Impact of BHRUT network integration for Pathology Partnership (risk score 15)

STRATEGIC OBJECITVE 2d. Preventing ill health		
Risk appetite for sub-objective relevant to risk: **15-16 (Open)** **Gap: risk score to risk appetite: 0**		
Risk Tolerance Triggers:	**Achieving 95% ethnicity capture rates across A&E, Inpatient and Outpatient Services**	**Q1 assessment – BEHIND SCHEDULE**
	70% of hospital inpatients having their smoking status documented on admission	**Q1 assessment – BEHIND SCHEDULE**
	50% of hospital inpatients having their alcohol harm risk levels documented on admission	**Q1 assessment – BEHIND SCHEDULE**

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	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	
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: [7136]*	**1.** Integrated Performance Report includes key metrics on access to healthcare services **2.** Patient Experience Strategy published with action to commission cultural intelligence and competency programme. **3.** Friends and Family Test and national patient surveys to assess and benchmark access and service quality **4.** Equity of access work led by Public Health to investigate healthcare inequalities. **5.** Development of Anchor Institution strategy, building on development of community employment and related initiatives e.g. ELBA alliance, apprenticeships, Project Search etc **6.** NEL operational plan and steps towards joint workforce planning across sector acute providers	*Inclusion Board ToR - oversees delivery of equality objectives and commitments **(maps to controls 1 and 2)** *Group Executive Board ToR – oversight of operational plan delivery **(1)** and patient survey outputs (**4**) GEB hospital performance review mechanism **(1-6)** Quality Board role on monitoring population health outcomes **(1-6)**		Trust Board regular inclusion and equalities report references patient equity aspects **(assurance on controls 1-5)** Equity of access Board report covers identified risks relating to healthcare interventions and equity of access **(1-3).** Quality Assurance Committee oversight of patient experience, surveys and insight reporting **(2)**		National inquiry and national audits on Covid-19 highlight healthcare inequalities		*Gap: Board agreed anchor institution / sustainability strategy* *Action: Agreement of an anchor institution plan* *Gap: Impact assessment required on any unintended consequences of pandemic related innovation and practice.* *Action: Impact assessment of virtual clinics under way* *Gap: Identified risks for patients with learning disabilities during pandemic* *Action: Scheduled QAC thematic review of patients with learning disabilities*

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

STRATEGIC OBJECTIVE 3d. Progressing long term projects and STRATEGIC OBJECTIVE 3c. Anchor institution		
Risk appetite for sub-objective relevant to risk: **Moderate (risk score 8-12) Gap risk score to risk appetite: 8**		
Risk tolerance trigger:	**Commencement of phase 2 of the programme's enabling works, subject to business case approval by DHSC & NHSE**	**Q1 assessment – ON TRACK**
	National approval of the outline business case	**Q1 assessment – ON TRACK**

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	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	
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 **Subcommittee role:** Finance, Investment and Performance Committee	*[Outset score: 16]* ***Current: 3x5=15*** *Target: 3x3=9* *Datix ref: (5427)*	**1.** Established programme governance and reporting arrangements, including a programme team and external expert advisors. **2.** Named as one of eight 'pathfinders' in the Government's New Hospital Programme (NHP) with the commitment to funding a new hospital subject to business case approvals **3.** Six facet survey provides baseline on the condition of the existing estate. Flooding during summer 2021 reconfirms need for a new hospital. **4.** Partnership working alongside the NHP, local health and local government as well as input from expert advisors, to finalise an Outline Business Case. **5.** 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 1-7)** 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) (1-7)		Regular review of business case development by the, Trust Board and Finance and Investment Committee **(assurance on controls 1-7)** Assurance reporting on programme confirming internal programme management on track (with anticipated timelines for news on external dependencies)**(assurance on controls 1-7)**		*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. **(4)**		*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:
Lead: Whipps Cross Chief Executive - 3543 Crowding within the Emergency Department in Whipps Cross ED (risk score 20); 4019 Outpatient appointment capacity (risk score 16); 5156 Risk to patient safety related to operational seasonal pressures (risk score 16); 3687 Drainage issues at WXH leading to potential floods and loss of services (risk score 15.;
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) Gap risk score to risk appetite: 15**		
Risk tolerance triggers:	**Adverse variance to plan**	**Q1 assessment – BEHIND SCHEDULE**
	Agency spend as a % of pay bill	**Q1 assessment – BEHIND SCHEDULE**
	Performance against capital plan	**Q1 assessment – BEHIND SCHEDULE**

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	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	
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:
Lead: Group People Director - 7230 Risk of a halt to the Barts Health NHS Trust kidney and stem cell transplant service due to lack of Consultant Clinical Scientist in Pathology Partnership (risk score 20)
Lead: Newham Chief Executive - 6529 NUH SAF 5: Performance against the financial plan (risk score 20)
Lead: Royal London Chief Executive - 4736 RLH SAF 5: May not be able to achieve our financial targets (risk score 20); 5874 Single biplane unit may lead to delays for time sensitive cases and/or the RLH service must shut during breakdowns or services (risk score 16)
Lead: St Bartholomew's Chief Executive 6294 Negative impact on patient care and operational performance, due to vascular lab closures caused by lack of staffing resilience (risk score 16)

STRATEGIC ENABLERS: Enhanced estates and facilities		
Risk appetite for sub-objective relevant to risk: **Moderate (risk score 8-12) Gap risk score to risk appetite:**		
Risk tolerance triggers:	**Performance against capital programme delivery plans**	**NO Q1 ASSESMENT**
	Projects being delivered on programme, on budget and meeting approved brief	**NO Q1 ASSESMENT**
	Value of unfunded capital risks with datix score of 15 and above	**Q1 assessment – BEHIND SCHEDULE**

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	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	
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:)*	**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 **(4-5)**. 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

Lead: Group Director Estates - 5586 Deteriorating lantern roof on pathology and museum block at SBH (risk score 20); Lead Group Director of Strategy: 7291 Unsupported Software for PC and Applications (risk score 20); 4769 PC/EUDs ongoing replacement of ageing devices (risk score 20); 6671 ICT - Cyber Security (risk score 16), 7031 Telecomms Ageing (risk score 16); 4768 Server obsolete (risk score 16); 7250 IT - Business Continuity (Group) (risk score 16); 7249 IT - Business Continuity (SBH) (risk score 16); 7285 Network refresh programme for WXH (risk score 16); 6883 ICT Provision to obstetrics at RLH (risk score 16); 7294 Volume of vulnerabilities raised under CareCerts (risk score 15); Lead: Newham Chief Executive - 3468 Non-compliance of the Fire Safety Order (law) within the Newham Hospital (risk score 20); 1163 Loss of main circuit breakers will result in catastrophic failure and potential loss of service to patients (risk score 16); 7087 Potential loss of Gateway Surgical Centre Theatre 1 and 2 during high temperatures in heatwave conditions (risk score 16), 5930 Chiller Plant Failure(risk score 16); 6447 The impact of non-compliant Mechanical Ventilation within majority In-Patient areas which fails to meet current HTM requirements (risk score 16); 6236 A fire affecting GSC cladding (external wall system) which is non-compliant to Fire Safety regulations (risk score 15); Lead: Royal London Chief Executive - 4740 RLH SAF 9: Capital requirements may be higher than the capital allocation (risk score 15); 6634 UKPN electrical MEH capacity exceeded. Additional services cannot be supported (risk score 15) Lead: Whipps Cross Chief Executive - 3619 Non-compliance of Fire Safety Order within Whipps Cross Hospital (risk score 16); 1419 Failure of medical gas pipeline infrastructure affecting patient services (risk score 16); 1406 Risk of serious harm and prosecution due to the failure to manage electrical safety on Hospital Sites (risk score 15); 3687 Drainage issues at WXH leading to potential floods and loss of services (risk score 15); 220 Contamination of WX site water resulting in legionnaire's disease (risk score 16);Lead: St Bartholomew's Chief Executive - 7192 Risks associated with supply chain issues in SBH Theatres (risk score 16)4740 RLH SAF 9: Capital requirements may be higher than the capital allocation (risk score 15, lead Royal London CEO), 6634 UKPN electrical MEH capacity exceeded. Additional services cannot be supported (risk score 15, lead Royal London CEO); 3619 Non-compliance of Fire Safety Order within Whipps Cross Hospital (risk score 16, lead Whipps Cross Chief Executive), 1419 Failure of medical gas pipeline infrastructure affecting patient services (risk score 16, lead Whipps Cross Chief Executive), 1406 Risk of serious harm and prosecution due to the failure to manage electrical safety on Hospital Sites (risk score 15, lead Whipps Cross Chief Executive), 3687 Drainage issues at WXH leading to potential floods and loss of services (risk score 15, lead Whipps Cross Chief Executive), 220 Contamination of WX site water resulting in legionaire's disease (risk score 16, lead Whipps Cross Chief Executive); 7192 Risks associated with supply chain issues in SBH Theatres (risk score 16, lead St Bart's Chief Executive); I

STRATEGIC ENABLERS: World leading research and high-quality education and training		
Risk appetite for sub-objective relevant to risk: **Moderate (risk score 8-12 Gap: risk score to risk appetite: 0**		
Risk tolerance triggers:	**Progress on commercial and research income: number of portfolio trials**	**NO Q1 ASSESMENT**
	Implementation of collaborative actions to increase research turnover by 10%	**NO Q1 ASSESMENT**

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	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	*Assurances sufficient?*	*Assurance rating?*	
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 **(1)**		Health Education England visit and student survey findings inform planning Research grant application outcomes **(1)** Positive outcomes in research funding (including BRC) and investment (CRF) in 2022/23 **(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:
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Barts Health NHS Trust

Report to the Trust Board: 1 November 2023	TB 68/23

Title	Wellbeing Strategy Update
Sponsoring Director	Group Director of People
Author(s)	Paula Oates, Director of People Strategy and Programmes, Delvir Mehet, Group Deputy Director of People
Purpose	This paper provides an update on the progress of our Group Wellbeing Strategy to date and outlines recommendations for further strategy implementation and development opportunities.
Previously considered by	People Board

Executive Summary

Our aim to become an outstanding and inclusive place to work is outlined in our People Strategy, our Group Operational Plan 2023-24 People Priorities and our WeBelong, and WeLead frameworks. Looking after our people is integral to this approach and our Wellbeing Strategy sets out our priorities in line with compassionate and inclusive leadership culture we aim to foster as an organisation.

The wellbeing of our people interacts with every single component of our people metrics whether it is productivity, sense of belonging, turnover, or sickness. Studies (CIPD, 2023, King's Fund, 2022) have shown an interface between wellbeing, productivity and engagement. These, in the context of our financial recovery, play an integral part in creating a thriving workforce able to effectively deliver care to our patients.

It has been a very challenging 12 months for our people with the demands of the elective recovery, cost of living crisis and a long period of industrial action and the pressure on our clinical teams and our administration booking teams, especially, has been profound. In this post-Covid area, the importance of our wellbeing has never been greater, with our people reporting stress and burnout (2022 NHS Staff Survey data). Wellbeing has now been recognised as a necessity (including updates to 2023 CQC regulations) if we are going to effectively face the productivity challenges.

Our overall NHS Staff Survey score on 'we are safe and healthy' People Promise theme does not currently meet the national benchmark level, scoring at 5.7 (2022 NHS Staff Survey data) with national average of 5.9 and best organisations scoring 6.4.

This paper provides an update on the progress of our Wellbeing Strategy to date, referencing the relevant people metrics such as NHS Staff Survey, turnover, retention, and

our Psychological Support Service and Employee Wellbeing Service data as a way of triangulation and measurement.

We have seen some good progress over the past 12 months including the work of our Violence and Aggression group that resulted in decline in our colleagues experiencing physical violence, the roll out of our WeLead programme, the success of our Cultural Intelligence programme; the work of our Psychology Support Service that had prevented our colleagues from potential self-harm and suicide (as identified in 33% of contacts) and seeing our turnover decrease by 3 percentage points in year as a result of focussed retention work.

However, we also recognise that to develop this important work further, we need to build on our progress, ensuring that our attention is given to increasing our health and wellbeing benchmark within the NHS Staff Survey to bring it closer to / above the national average.

We will continue to collaborate with Barts Charity to identify future opportunities.
We propose that local hospital wellbeing metrics dashboards are developed to measure the progress at this level, and we commit to an annual review of our Wellbeing Strategy to help us shape future priorities.

Related Trust objectives	
To become an outstanding and inclusive place to work	

Risk and Assurance	All
Related Assurance Framework entries	11. A failure to effectively communicate across a large organisation to lead and embed consistent values, behaviours and accountability, impacts on delivering workforce goals

Legal implications/ regulatory requirements	Potential litigation resulting from failure to look after our people / 2023 CQC regulations

Action required:
The Trust Board is asked to note and comment on the following updates:

- the progress to date on our Wellbeing Strategy;
- the associated programmes of work and relevant people metrics triangulation and future recommendations.

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 1 NOVEMBER 2023

WELLBEING STRATEGY UPDATE

1. INTRODUCTION / PURPOSE

The wellbeing of our people interacts with every single component of our people metrics whether it is productivity, sense of belonging, turnover, or sickness. Studies (CIPD, 2023; King's Fund, 2022) have shown an interface between wellbeing, productivity and engagement. These, in the context of our financial recovery, play an integral part in creating a thriving workforce able to effectively deliver care to our patients.

It has been a very challenging 12 months for our people with the demands of the elective recovery, cost of living crisis and a long period of industrial action and the pressure on our clinical teams and our administration booking teams, especially, has been profound. In this post-Covid area, the importance of our wellbeing has never been greater, with our people reporting high levels of stress and burnout (2022 NHS Staff Survey data). Wellbeing has now been recognised as a necessity, including being reflected in the updates to 2023 CQC regulations, if we are going to effectively face the current productivity challenge.

Working with over 3,000 colleagues across our Group, we developed a Wellbeing Strategy, approved by Trust Board in March 2022, in order to ensure that we not only build on our recent learning from Covid to create a sustainable approach to health and wellbeing, but also further our approach to become an outstanding and inclusive place to work.

Our aim to become an outstanding and inclusive place to work is outlined in our People Strategy, our Group Operational Plan 2023-24 People Priorities and our WeBelong and WeLead frameworks. Looking after our people is integral to this approach and our Wellbeing Strategy sets out to achieve this, intended for all our colleagues across Barts Health including all of our colleagues employed by partner organisations.

We are still in the early stages of embedding our wellbeing offer and developing a culture in which wellbeing of our staff is prioritised. In the 2022 staff survey our overall score on 'we are safe and healthy' People Promise theme was 5.7 below the national average of 5.9, with the best organisations scoring 6.4.

This paper provides an update on the progress of our Wellbeing Strategy to date referencing the relevant people metrics such as NHS Staff Survey, turnover, retention, and our Psychological Support Service and Employee Wellbeing Service data as a way of triangulation and measurement.

2. BACKGROUND

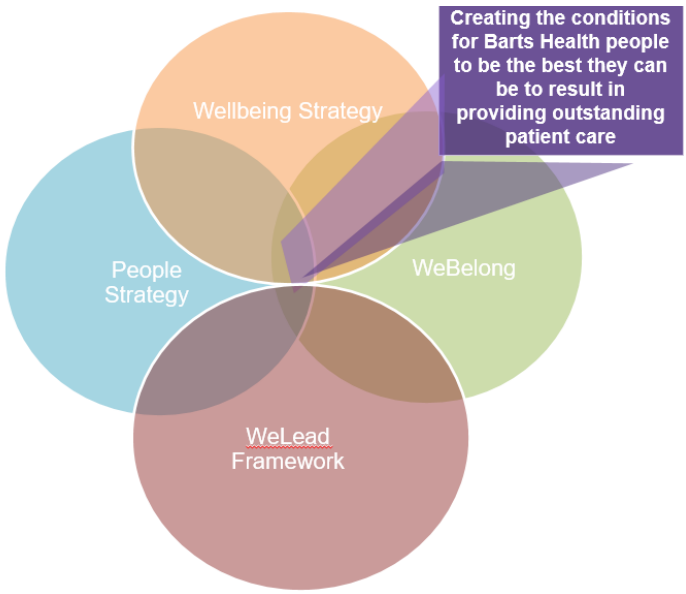
Wellbeing has been at the forefront of the wider NHS agenda for some time now, including the recently published Long Term Workforce Plan (2023). In addition to this, the 2023 CQC regulation changes highlighted wellbeing as a priority area to focus on by putting 'people at the heart of the service' and the requirement for employers to prioritise workforce wellbeing. All these point to a greater need to create and maintain a culture of compassionate and inclusive leadership where our people are supported and thriving.

Considering the recent developments and acknowledging the importance of our learning from Covid, we developed a sustainable approach to health and wellbeing. An approach that reflects not only our recent experience but also builds on our existing core health and wellbeing offer.

Our Wellbeing Strategy was co-designed with over 3,000 colleagues from across the Group, engaging with people at every level which ensured that the strategy is underpinned by what matters to our people and helps us to achieve our vision of being an outstanding and inclusive place to work.

Using the co-design approach, we also recognised the interdependencies between the Wellbeing Strategy, People Strategy, WeBelong and our leadership framework, WeLead, as they all provide a systemic and sustainable approach for creating the conditions for our people to be at their best and able to provide outstanding patient care (**Diagram 1** below illustrates this). In addition to this, we have drawn on the available literature to support what we do and have collaborated with external partners to facilitate our learning.

Diagram 1: Interdependencies of our People Strategies



3. WELLBEING STRATEGY PROGRESS UPDATE

The Wellbeing Strategy identified nine priorities many of which have clear interdependencies to the People Strategy (PS), WeBelong (WEBS), WeLead Framework (WLF), and the Wellbeing Strategy (WBS). The 9 priorities are set out below alongside the strategy where the priority is hosted.

1. Ensuring **basic wellbeing needs are met** for every person at Barts Health (WBS)

2. **Protecting time and flexibility** for all people to have team time and breaks and to access wellbeing enhancing initiatives and promote agile working (PS)

3. Encouraging **autonomy and sense of belonging,** decision making locally to empower people-driven changes (WEBS)

4. Promoting and enabling access to regular **wellbeing activities** on site (psychological support, financial wellbeing, exercise classes) (WBS)

5. Providing **suitable, sustainable facilities** that promote all dimensions of health and wellbeing (green space, technology, rest spaces, healthy food) (WBS)

6. Improve **communication** – encourage curiosity and ensure people feel listened to and heard, and actions followed. (PS)

7. Support everyone's development and specifically focus on our team leaders' **development opportunities** to enable them to be the best they can to support their own and others' wellbeing (WLF and WEBS)

8. Review ability for people to maintain **physical wellbeing** at work (cycling, seating, stairs) (WBS)

9. Provide **equitable support for all people** to truly embed an inclusive wellbeing culture (WEBS and WLF)

The nine priority areas were then developed into four key themes and mapped out as outlined in **Table 1** below. These are:

- Getting the basics right
- Team Leader development
- Psychological support
- Continuing to deliver our existing core wellbeing offer

Table 1 – Key Themes

Priority:	Relates to Key Themes:
Ensuring **basic wellbeing needs are met** for every person at Barts Health (WBS)	Getting the basics right
Protecting time and flexibility for all people to have team time and breaks and to access wellbeing enhancing initiatives and promote agile working (PS) Encouraging **autonomy and sense of belonging,** decision making locally to empower people-driven changes (WEBS)	Getting the basics right Team Leader development
Promoting and enabling access to regular **wellbeing activities** on site (psychological support, financial wellbeing, exercise classes) (WBS)	Psychological support Continuing to deliver our existing core wellbeing offer
Providing **suitable, sustainable facilities** that promote all dimensions of health and wellbeing (green space, technology, rest spaces, healthy food) (WBS)	Getting the basics right
Improve **communication** – encourage curiosity and ensure people feel listened to and heard, and actions followed. (PS)	Team Leader development
Support everyone's development and specifically focus on our team leaders' **development opportunities** to enable them to be the best they can to support their own and others' wellbeing (WLF and WEBS)	Team Leader development
Review ability for people to maintain **physical wellbeing** at work (cycling, seating, stairs) (WBS)	Getting the basics right Continuing to deliver our existing core wellbeing offer
Provide **equitable support for all people** to truly embed an inclusive wellbeing culture (WEBS and WLF)	Team Leader development

An action plan has been developed for each of the themes, which is summarised in Diagram 2 below with section 3.1 onwards providing a progress update for each theme.

Diagram 2: Wellbeing Key Priorities and Their Areas of Focus

Getting the basics right	- Curious to understand why this is so difficult to change - Establish a baseline of basic metrics - Develop local improvement projects to make changes - Make sense of what we learn and embed the learning - Violence and aggression campaign launched
Team Leader development	- Clarity of expectations of a Team Leader - Team Leader webinars / leadership forums - Protected time to access learning and development - Team Leaders development programmes
Psychological support	- Psychological drop-in sessions - Team support, building psychological safety - Compassionate leadership model - Dedicated psychology support available on all sites - Access to online support
Continuing to deliver our existing core offer	- Employee Wellbeing Service (EWS); - Confidence in Care (CiC) service that offer a confidential information, support and counselling on a wide range of work, personal and family issues to our people; - Growing number of Mental Health First Aiders; - Variety of offers to support physical and financial wellbeing - Sharing best practice

3.1. GETTING THE BASICS RIGHT

We cannot impress enough how much getting the basics right means to our people. The culture change required to embed the changes needs our managers to be fully supported and equipped with the skills to support their own and their team's wellbeing.

We recognise that we have not made the progress in this area that we had hoped, in part due to the industrial action and need to prioritise improvements in productivity. We are now re-focussing our work on getting the basics right and developing a revised set of actions. This work is led by the Wellbeing Leads Group, with representatives from each hospital site and is reported to and monitored by People Board.

Highlights and points to note on progress with this theme include:

- In our 2022 NHS Staff Survey, we saw significant improvements in physical violence experienced by colleagues, mostly at The Royal London and Newham hospitals.
- As an NHSE Exemplar Site Programme site we are focusing on addressing the fundamentals of retention aligned to the NHS People Promise. This includes targeted programmes of work supporting flexible working and the use of e-rostering to support teams and individuals to have more control over the hours they work. Our focussed retention programme has resulted in a 3-percentage point reduction in turnover in the last 12 months (from 13.5% in October 2022 to 10.6% in September 2023).
- Our focus on recruitment through the 'Drive for 95' programme is starting to make progress, with substantive workforce numbers increasing, providing greater stability and continuity to our teams. Our substantive fill rate is now at 92.3% with SBH being the first hospital to meet the 95% target in September.

Further details of progress against the actions for getting the basics right are set out in table 2.

Table 2 – Getting the basics right

Getting the basics right	2023-24 Progress
Curious to understand why this is so difficult to change	• We continue to develop our understanding through annual NHS Staff Survey and our quarterly Pulse Survey data, as well as anecdotally at a local level.
Establish a baseline of basic metrics	• Metrics have been established and are being monitored through 'Supporting the wellbeing of our people' pillar of the People Priorities for 2023-24.
Develop local improvement projects to make changes	• We appointed a Wellbeing Lead on each hospital site who leads on improvement projects locally. • Each hospital have a wellbeing plan overseen and monitored by their People Director / HEB as well as a Group Wellbeing Leads meeting that meets monthly. • Examples of hospital site progress include: ○ Wellbeing Ambassadors and Wellbeing Walk Rounds at SBH; ○ TRiM (Trauma Risk Management) facilitators, Health and Wellbeing Newsletter and wellbeing representation at all morning huddles at RLH ○ WHX have created smaller departmental wellbeing hubs across the hospital to compliment the main wellbeing space. ○ Shuttle bus service running and expected to be extended to mornings at NUH.
Make sense of what we learn and embed the learning	• At local level, our Wellbeing leads from each hospital site meet monthly to share learning and set shared priorities. • At a regional and ICS level wellbeing leads come together monthly to share best practice. • At national level, we are part of the NHSE Retention Exemplar Site programme, focusing on flexible working and building capacity to manage rostering flexibly.
Violence and aggression reduction campaign launched	• A Violence and Aggression Group has been established to progress this important and is starting to have an impact. • In the 2022 NHS Staff Survey question ''In the last 12 months, how many times have you personally experienced physical violence at work from patients, service users, their relatives or other members of the public?' the trust scored 13.5% which compares favourably to the benchmark average of 15.0%. This was as reduction of 0.7 percentage points from 2021.

3.2. TEAM LEADER DEVELOPMENT

We recognise that the cultural shift required to embed, maintain and sustain wellbeing lies in the ability of our leaders and their compassionate and inclusive leadership, therefore, Team Leader development has been one of our key priorities.

In 2023/24, we are rolling out the WeLead core leadership and management skills programme, focusing on colleagues new to leadership roles. The programme covers modules on HR, finance and compassionate leadership which is a golden thread of the programme and a key part of 'how we lead at Barts Health' message. To date 170 new managers have attended the programme across our hospital sites.

The programme complements the wide portfolio of accredited leadership development offered by the Education Academy. In the last 12 months over 400 learners have attended programmes provided by the academy.

The next stage in our Team Leader development programme will be to develop a team approach in coaching and leadership development in line with the research and teachings of Prof. Michael West. The evidence suggests that having a team based approach has a greater impact on culture change and it will also provide the opportunity to focus on supporting teams in most need of support.

The refreshed WeBelong Strategy also has a focus on developing our leaders through its continued focus on career development to improve representation in leadership positions, work to build a fair and just culture and Cultural Intelligence programme.

Further details of progress against the actions for Team Leader development are set out in table 3.

Table 3 – Team Leader development

Team Leader development	2023-24 Progress
Clarifying the expectations of a Team Leader	• WeLead leadership programme with its focus on compassionate and inclusive leadership and 'how we lead at Barts Health' aims to set clear expectations for our team leader community. • A key aim of the regular leadership and Pass it on Webinars is to reinforce the key elements of the Team leader role.
Protected time to access learning and development	• Releasing staff for training continues to be an ongoing challenge due to operational pressures. • Study Leave Policy due to be reviewed in 2023-24 and will seek to find innovative solutions to protected time challenge.
Team Leader webinars / leadership forums	• Team Leader webinars in place and successfully running with positive feedback from colleagues who have attended. • Webinars have now been supplemented with a monthly webinar for Team Leaders to support the new Pass it On Communications initiative aimed at ensuring cascade of key messages each month

Team Leader development	2023-24 Progress
Team Leader development programmes	• A new WeLead programme for manager new to Barts Health has been rolled out across the group this year. As of October 2023, 170 new managers attended the programme. The programme covers essential information for new managers as well as a focus on compassionate and inclusive leadership senior leadership. • The WeLead programme compliments the comprehensive programme of accredited courses and bit size learning provided by the Education Academy. In the last 12 months, The Education Academy delivered ILM Level 2, 3 and 4 Leadership & Management training attended by 305 colleagues in total. The Education Academy also delivered Apprenticeship Leadership programmes (including Level 7 senior leader MBA/MSc) attended by 101 colleagues. • We continue to offer targeted development programmes and courses as part of our WeBelong strategy such as our Cultural Intelligence, with 1,295 colleagues completing this in 2023 since its launch in May 2022. • Our Inclusive Career Development Programme has been completed by circa 700 staff, across 41 Cohorts since its launch in 2022. • We also launched a career mentorship programme, which has successfully matched over 100 staff members with senior leaders throughout the organisation.

3.3. PSYCHOLOGICAL SUPPORT

Psychological support has been identified as a key priority of ongoing support for our people. Almost 20% of all occupational health referrals in the last 12 months have been related to mental health and wellbeing and our people continue to report burnout (39.1% compared to the national average of 34.8% according to 2022 NHS Staff Survey).

Our Psychological Support Service (PSS) team (currently 5.5 WTE) have been providing a well-received support to our people since 2020 and in 2022/23, we secured funding from Barts Charity for a further three years with the proposal to carry out a feasibility study for the future service in that period.

Between 1st March 2021 and 23rd February 2023, the Psychological Support Service team have recorded a total of 19,348 contacts. This has included all session types, 1,212 of which were individuals seen on a 1:1 basis (consultation / assessment, including Well Manager consultations) and 9,315 colleagues seen in groups, plus a variety of other forms of contact and facilitation.

Some of the themes emerging from team and individual sessions included wellbeing support, relationships, coping with changes, anxiety and trauma.

33% of individual cases have involved a risk of self-harm or suicide. Studies show this type of risks can be eradicated almost completely through improving connection and direct clinical assessment and intervention.

The activity for the Psychological Support Service has been spread out proportionately across our sites, with 43% of activity being recorded at RLH and MEH, 20% at SBH, 19% at WX, and 18% at NUH.

The service evaluation carried out between September 2021 and February 2023 has received excellent feedback, with 97% of respondents saying they felt supported by the psychologist and 97% saying they would recommend the service to their colleagues.

Further details of progress against the actions for psychological support are set out in table 4.

Table 4 – Psychological support

Psychological support	2023-24 Progress
Psychological drop-in sessions	• A total of 19,348 contacts between March 2021 and February 2023.
Team support, building psychological safety	• 9,315 colleagues seen in groups between March 2021 and February 2023, • Creating conditions for colleagues to be curious and feel listened to and heard.
Compassionate leadership	• Themes emerging with links to compassionate leadership from team sessions included relationships, team connection and addressing the feeling of being unsupported, online guide to compassionate conversations available on WeShare. • Compassionate leadership focus of recent leadership conference • Central theme of all leadership development including WeLead programme
Dedicated psychological support available across the whole of Barts Health	• Psychological support now available across our Group with funding secured from Barts Chariy until 2026.
Access to online support	• Online webpages on WeShare now include a self-referral form for easier access as well as details of types of support and how to contact the team. • External Care in Confidence accessible online • Range of online NHS wellbeing resources available to all staff.

In terms of next steps, the service will focus on developing a risk based approach and developing joint pathways with the Employee Wellbeing Service to ensure a more streamlined offer and collaboration with external partners (ICS, Confidene in Care and Public Health). The service is currently undergoing an external evaluation in order to support its future direction.

3.4. CONTINUING TO DELIVER OUR EXISTING WELLBEING OFFER

We have continued to focus on developing our core wellbeing offer covering physical, financial and psychological wellbeing. Key elements of the offer include

- Free access to an external wellbeing service, Confidence in Care (CiC), which provides support and advice on a wide range of work, personal and family issues to our people. Access to free online and face to face counselling is included as part of the service.
- A network of Mental Health First Aiders available across all our sites. The network continues to grow with training available throughout the year.
- A range of physical exercise classes across our sites as well as discounted gym membership. We continue to support active travel through improving secure cycle storage, access to Brompton cycle hire, Santander bike discounts and discounts on new bikes through the cycle to work scheme.
- We offer a wide range of financial support and advice services including
    - A comprehensive guide setting out support available from the trust as well as community and charitable organisations in response to the cost of living pressure staff are experiencing
    - Salary advance, allowing staff to access a proportion of their salary early in the month through our partnership with WageStream
    - A comprehensive salary sacrifice and discount offer covering everything from white goods to care leasing
    - financial coaching and guidance through Wagestream and CiC
    - Pension clinics.

Collaboration and sharing of good practice takes place at a group, ICS and regional level. At a Group level our wellbeing forum brings leads together to share learning and good practice. Since the pandemic the ICS has had an active wellbeing network (KeepingWellNEL) which coordinates a number of wellbeing programmes across NE London including access to remote wellbeing support and programmes aimed at alleviating the impact of the cost of living crisis. At a regional and national level regular webinars and learning events are held to support dissemination of best practice and national initiatives.

4. CONCLUSION

It has been a very challenging 12 months for our people with the demands of the elective recovery, cost of living crisis and a long period of industrial action and the pressure on our teams has been profound. Wellbeing interfaces all of our people metrics (productivity, turnover, sickness, sense of belonging) and if we are going to effectively face these challenges, we will need to continue to keep wellbeing at the forefront of all we do.

At Barts Health, we developed a focussed, quantifiable approach to our people's wellbeing, outlined in our Wellbeing Strategy, in order to ensure that we not only build on our recent learning from Covid, but also further it to achieve our ambition to become an outstanding and inclusive place to work.

We have seen some good progress over the past 12 months including:

- The work of our Violence and Aggression group that resulted in a decline in number of colleagues experiencing physical violence from patients, service users and relatives;
- Our continued focus on compassionate and inclusive leadership, including the roll Out of our WeLead programme and the success of our Cultural Intelligence Programme;
- The work of our Psychology Support Service that had prevented our colleagues from potential self-harm and suicide (as identified in 33% of contacts); and
- seeing our turnover decrease by 3% in year.

However, we also recognise that to progress this important work further, we need to build on our progress, ensuring that our attention is given to increasing our health and wellbeing benchmark within the NHS Staff Survey to bring it closer to / above the national average, with a particular focus on stress and pressure as reported by our colleagues.

We also recognise that we need to re-focus our work on getting the basics right and develop a revised set of priorities in this area thorough working with the hospital Wellbeing Leads.

This will necessitate a robust governance process and ownership by the Hospital Executive Boards and Group Support Services Leads, underpinned by local wellbeing metrics dashboard to be developed in order to measure the impact at this level.

We will continue our collaboration with Barts Charity, demonstrating value and learning from the investment received to date and working to identify further priority areas for support.

Each year, we will review progress to inform further development of our Wellbeing Strategy priorities.

5. NEXT STEPS AND RECOMMENDATIONS

The next steps in further delivering our Wellbeing Strategy are to:

- Achieve / surpass the NHS Staff Survey national benchmark level for health and wellbeing ('we are safe and healthy' People Promise theme), currently scoring at 5.7 (2022 NHS Staff Survey data) with national average of 5.9, and best organisations scoring 6.4.

- Develop local hospital sites wellbeing dashboards to measure the impact at this level.

- Continue to work with Barts Charity, collaboratively identifying further wellbeing opportunities.

- Review progress to inform the development of our priorities annually.

Barts Health NHS Trust

Report to the Trust Board: 1 November 2023	TB 69/23

Title	Medical Appraisals and Revalidation - Annual Organisational Audit (AOA) Board Report
Accountable Director	Chief Medical Officer
Author(s)	Dr Liat Sarner, Responsible Officer Barts Health
Purpose	To offer assurance to Group Executive Board members on the overall medical compliance rate and audit process for doctors
Previously considered by	Responsible Officer and Advisory Group (ROAG) People Board

Executive summary
The year end compliance report for medical appraisals is provided for information prior to sign off by the Group CEO; this details the information required by NHS England in relation to medical appraisal rates and how this is monitored overall for non-training grade medical staff as part of the Responsible Officer role (RO) duties and established in 2010 as a statutory requirement of each designated body.

Related Trust objectives / enablers

- Objective 1b Supporting the wellbeing of our people
- World leading research and high-quality education and training

Risk and Assurance	This provides assurance on compliance with Medical appraisal rates

Legal implications/ regulatory requirements	Regulatory requirement

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

Barts Health NHS Trust

BARTS HEALTH NHS TRUST

REPORT TO THE GROUP EXECUTIVE BOARD: 1 NOVEMBER 2023

DESIGNATED BODY ANNUAL BOARD REPORT 2023
ANNUAL ORGANISATIONAL AUDIT (AOA)

INTRODUCTION

1. The framework of quality assurance (FQA) for responsible officers (ROs) was first published in 2014. NHS England requires designated bodies to produce an annual board report and statement of compliance on appraisal rates for doctors for all non-training career grade staff. For Barts Health the total of individuals in scope of this is circa 2074 WTE.

ASSURANCES

2. This paper provides assurance on the overall compliance with medical appraisal rates, supports continuous and improvement quality improvement programmes and acts as evidence for CQC inspections. Between April 2022 and March 2023 a total of 1817 appraisals took place, agreed exceptions totalled 170 covering sickness, maternity leave, and sabbaticals. Appendix A details the submission and statement of compliance.

NEXT STEPS

3. Next steps for the Responsible Officer and Deputy Responsible Officer during 2023/24 are to work with appraisal leads at each hospital as one of the recommendations of the external audit undertaken to increase compliance of the overall appraisal rate and review appraiser training and review the quality of appraisal conversation aligned to the revised Appraisal and revalidation policy November 2023.

RECOMMENDATION

4. The Trust Board is asked to note the report demonstrating how the statement of compliance for appraisal rates for non-training grade medical staff across the group is undertaken with clear governance aligned to NHSE requirements.

Liat Sarner
Responsible Officer

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020 but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g., consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board of Barts Health NHS Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Dr Liat Sarner has been in post as Responsible Officer (RO) since September 2022. She undertook the appropriate training in June 2022 Actions from last year: Review RO office infrastructure including consideration of deputy RO and revalidation leads. Deputy RO and revalidation leads in place, RO office infrastructure scoping in progress

2. The designated body provides sufficient funds, capacity, and other resources for the responsible officer to carry out the responsibilities of the role.

No There has been no capacity increase in HR/operational support for the RO office for the last 7 years and number of doctors connected to Barts Health Designated body has increased by more than 100%. Number of connected Doctors now 2333. A scoping exercise is in progress to align the appropriate administrative resources to the RO office and 5 appraisal leads have been appointed and are now supporting revalidation and appraisal across the Trust. Action for next year: Complete scoping exercise and submit business case if required to increase resources

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes We now have 2333 non-training doctors connected to our designated body Operational procedures are in place to constantly cleanse the list matching with ESR and liaising with bank partners to ensure the appropriate Doctors are connected Action for next year:

Further work with bank partners to ensure Doctors that work limited sessions are connected to the right DB

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes The Medical Revalidation and Appraisal policy is under review by the Trust. MIAD undertook an extensive external review of this policy and all recommendations will be incorporated into the revised policy

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

MIAD conducted an extensive review of the appraisal and revalidation system at Barts Health in Q4 22/23 with the final report shared June 2023.

The review included a quality review of 50 input and output forms, surveys of appraisers and appraisees, a review of relevant policies and interviews with members of the RO team.

Recommendations included:

1) Implementation of MPIT form for all starters (process started 1 August 2023 with medical recruitment team, needs periodic review)
2) Development of appraisal lead structure (now in place)
3) Increased administration support for medical professional standards manager (scoping exercise in progress)
4) Appraiser training to restart -Dates secured for Autumn 2023
5) Development of medical appraisal SOP
6) Implementation of revalidation checklist (now in place)
7) Appraiser network development
8) Appraisee feedback mechanism implemented (Action completed)
9) Increased support for IMG starting appraisal cycle (Training booked)
10) Robust monitoring process to provide assurance all Doctors captured in appraisal process
11) Connect clinical governance processes to capture complaints and significant incidents
12) Cross speciality appraisals (process of allocation started)
13) Include appraiser role in scope of practice and allocate time in job plans

Action for next year:

Complete all actions from the MIAD review above

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Drs registered on staff bank can connect to our DB if they undertake adequate number of shifts. Induction for registering with bank includes statutory and mandatory training around governance systems. If connected to Barts DB they are supported with CPD, appraisal and revalidation and use the governance system in full.

We have appointed 5 appraisal leads, and will ensure that one has responsibility for appraisal and revalidation of temporary staff connected to our DB.

Action for next year:

Scope and support need and governance of bank Doctors

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

We use the electronic PReP appraisal system which incorporates the essential criteria for appraisal based on the up-to-date MAG 2022 form, including a detailed section on scope of practice. There is a section included to cover any significant events or complaints. The form has been modified to include discussions around the impact of the pandemic and wellbeing. The system also embeds patient and colleague feedback.

Action from last year:

Explore use of Prep to facilitate remote patient feedback

Comments: No progress on this front, meeting scheduled with premier IT sept 2023

Action for next year:

Scope further improvements in Prep and look at other systems on the market

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

There is a SOP in place for the management of late appraisals with a clear process to follow with standardised communication and escalation processes. Overdue appraisal data is reviewed at ROAG and escalated to relevant medical director and site-based appraisal lead for follow-up.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

Appraisal rates 91% March 2023. Recent trend of appraisees due for revalidation not having adequate evidence for recommendation and deferral requirements.

Action from last year:

Institute appraisal lead structure which has been completed

Action for next year:

Clear communication with all Doctors to define their responsibility to be ready for revalidation in a timely manner and the support available to achieve this

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Policy in place expires 30/11/23 current policy being updated with MIAD recommendations for approval in October 2023.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

The Trust has 488 trained appraisers. The list is actively managed and there is a process under way to redistribute appraisees to ensure an equal spread. We are currently undertaking an audit of diversity of appraisers at each site. Appraisal refresher training sessions have been scheduled for Autumn 2023.

Action for next year:

Reach out for new appraisers encouraging applications from a more diverse consultant and non-consultant body

Appraisal leads to scope out delivering in house training

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

The last formal appraisal training was undertaken by MIAD in April 2022 using a blended approach of webinars and E-learning.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

3 further refresher sessions are planned for Autumn 2023, and we are planning training for new appraisers in the new year with the support of the education academy.

The recent MIAD review identified several areas that required improvement within both input and output forms which included:

1) removal of identifiable 3rd party information
2) full scope of practice and inclusion of job plan
3) letters of good standing from other organisations from other places of work
4) Using college CPD summaries to provide evidence of CPD and reflection
5) Clarity on what constitutes QIA that is reflected on appropriately
6) The practice of reviewing and learning from significant events within appraisees speciality/directorate as part of learning events analysis as per PSIRF
7) Trust needs to be confident Doctors are advised if they are involved in a complaint as from the review the numbers seen were low
8) Drs need to reflect adequately as the review conducted showed a low volume of reflection.
9) The summary from appraisers must provide the RO with an overview of the appraisee and provide assurance that an appropriate discussion has taken place

Comments:

Action for next year:

MIAD training to include findings from the review

Appraisal leads to create supportive material for appraisees and appraisers on intranet e.g., sample good practice output form

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Since last year we have set up a ROAG with representation from the RO office, RO, deputy RO, appraisal leads, equality and diversity, education and medical directors. Appraisal and revalidation data is presented at this group with specific cases discussed where appropriate.

Revalidation decisions are minuted and documented on a revalidation checklist developed and implemented in February 2023 (shared with appraisee)

Appraisal compliance data is shared with medical workforce board, people board, appraisal leads, hospital sites and medical directors on a monthly basis.

The external quality assurance MIAD review conducted this year presented at medical workforce and people board. The AOA will be presented at group executive board

Action for next year:

Review data shared with relevant boards and include other metrics e.g., deferral rates, quality of appraisal, consider peer review with other hospitals in ICB

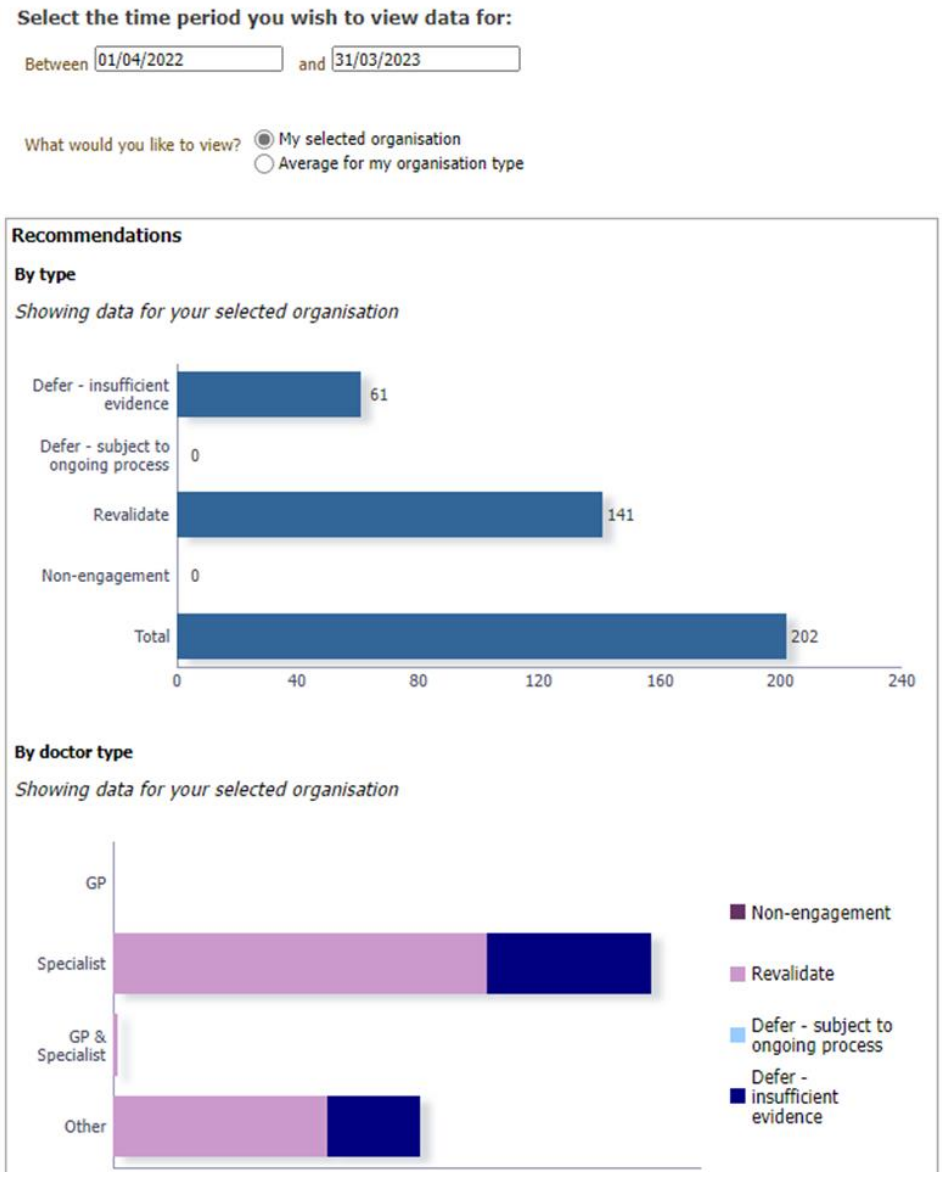
Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	**2074**
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	**1817**
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	**257**
Total number of agreed exceptions (includes long term sickness over 3m, maternity leave, career breaks and sabbatical)	**170**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.



2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Revalidation meetings are conducted weekly looking prospectively at evidence collected to ensure that any gaps are resolved prior to revalidation dates. Doctors are given regular reminders within the 12 months prior to revalidation from the RO office and GMC of the date of revalidation and the requirements they need to present. The Doctors portfolio is reviewed in detail at last 4 weeks prior to the revalidation date. A revalidation checklist, which was introduced in Feb 2023, is completed for each portfolio which details the evidence and any gaps or where there is insufficient evidence. It acts as an audit trail for deferral decisions and the specific reasons why a deferral has been made. All check lists are shared with the Dr currently, and they are supported to complete any missing requirements. Despite this, an increase in deferrals has been seen in the last 6 months, the majority of which are due to doctors not having the requisite information in time (2 weeks prior to revalidation date)

Doctors who are significantly overdue with appraisals are contacted directly by the RO office and supported by local appraisal leads, clinical leads and medical directors to engage with the process. Any further concerns with non-engagement are discussed with the GMC employee liaison officer.

Action for next year:

Include deferral data in reports and share with medical directors

Newsletter to detail data and remind doctors of the requirements and expectations

Email to all non-training medical staff from RO stating concerns regarding increased rate of deferral to be sent

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

The documentation of QI and Significant events is a formal part of the appraisal process. Electronic evidence of clinical effectiveness activity can be linked with the appraisal system. The Trust has a robust governance structure which all doctors are expected to participate with.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Our systems interface with other data capture systems such as statutory and mandatory training. Evidence of significant events such as serious incidents and complaints are uploaded manually to the doctor's appraisal documents.

Actions for next year:

Ensure statements of good standing from other organisations included in appraisals

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns.

There are regular meetings between the RO and the GMC Employment Liaison officer. Formal policies are in place to manage any FTP concerns (MHPS) and a whistleblowing policy and a freedom to speak up process (FTSU) with medical HR advisors at each hospital and Head of Medical People Relations for the Trust. Each hospital Medical Director manages any FTP concerns (with support from RO and CMO) which are reported monthly via the medical HR teams to the Trust, and Non-executive director responsible

Action for next year: review just culture approach with MHPS Policy and

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

ER software is used for monitoring which is reported monthly to the NED on the Trust Board

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

The RO completes MPIT forms for RO-to-RO transfer of information which is coordinated by the revalidation manager. RO-to RO conversations take place where required. Actions for next year Trust to implement request for MPIT forms for all new starters

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

There are robust processes in place for responding to concerns about doctors' performance and fair and free from bias and discrimination including pause and reflect processes prior to any decision regarding formal action and involvement with Head of people in any process. The JLNC and Medical council are kept up to date with any policies. There is a freedom to speak up guardian in the Trust and robust whistle blowing policies in place

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

This is managed by the central medical recruitment team. We have good working relationships with bank partners regarding locums and receive monthly reports. Data cleanse is underway to ensure bank doctors are undertaking enough shifts to be connected to Barts Health. Action for next year: Include MPIT forms for all new starters

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

Overall conclusion:

General review of actions since last Board report

Since the last report 5 appraisal leads have been appointed for each Trust site with 2 appraisal leads appointed to Royal London Hospital as well as an Interim Deputy RO to support RO.

An external audit has been undertaken by MIAD and recommendations are being implemented at present to ensure quality appraisals are taking place (see appendix)

For those that are overdue, regular supportive reminders are sent and one to one support is available where required. This will further improve with the appointment of appraisal leads.

Current Issues

- We have 231 more connected medics compared to last report which has resulted in higher number of appraisals with Barts Health.
- Compliance has reduced from 94% in March 2022 to 91% in March 2023.
- Since 2021 report we have had 431 more doctors to connect to us via GMC.
- Deferrals have increased with doctors not managing to demonstrate the required evidence for revalidation in a timely fashion
- The increased numbers of connected Doctors have not been matched with an increase in the administrative capacity in the RO office
- Recent external quality review identified opportunities for improvement

New Actions:

- MPIT forms to be requested for all new starters
- Appraisal policy review to include amendments as suggested by external review
- Additional training and refresher courses for new and existing appraisers will be delivered and findings from the review will be included
- Appraisal network to be set up
- Further supportive materials to be created targeting appraisers and appraisees around quality improvements required e.g., what QIA activity to include, remove 3rd party identifiable information, letter of good standing, job plans, full scope of practice
- Ensure complaints are shared with appraisee
- Encourage adequate reflection within appraisal

- Improve quality of output form to include an overview to aid the RO in making revalidation decisions
- Appraiser network to be set up as part of appraisal lead role for each site to ensure appraisers are supported.
- Appraisal leads will be given lead roles to develop specific areas e.g., international Doctors, appraisal systems, comms/intranet information, training, quality review
- Complete scoping exercise on establishment for RO office

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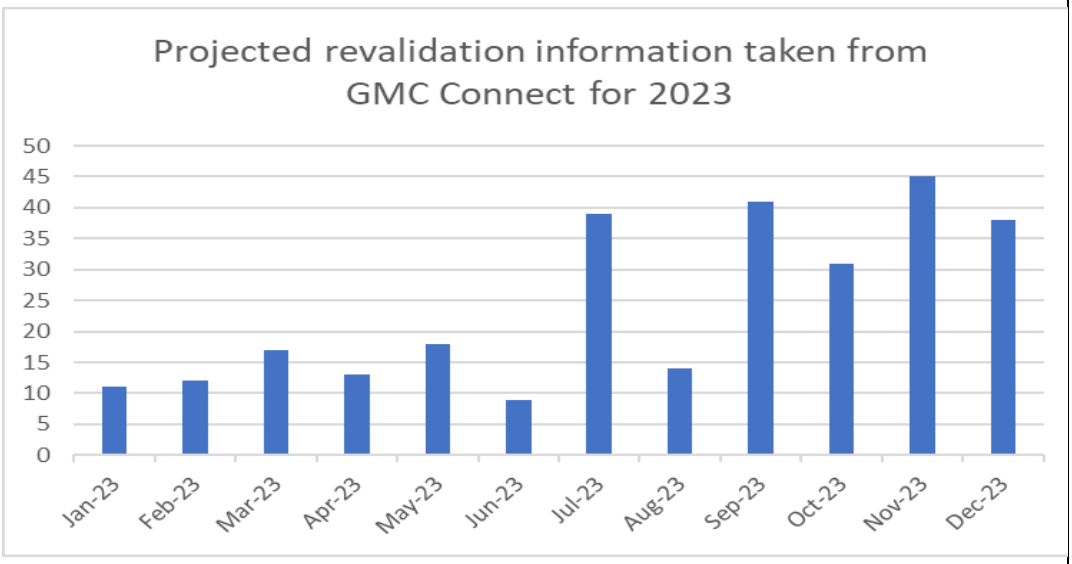

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Overall conclusion:

We have seen an increase of 10% of prescribed medics compared to the last report in relation to number of appraisees at Barts Health.

An increase in deferrals since the last report is of concern and the RO office will be implementing communication and training to support doctors to have evidence ready in time for revalidation. The recent appointment of appraisal leads will enable more local support is available.

Further work will continue in relation to overdue appraisals, quality assurance and further training for appraisers with the support of our newly appointed appraisal leads

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body: Barts Health NHS Trust

Name: Shayne De Garis Signed: _ _ _ _ _ _ _ _ _ _

Role: Group Chief Executive Officer

Date: 11th September 2023

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