NHS
Barts Health
NHS Trust

BARTS HEALTH NHS TRUST

TRUST BOARD MEETING (PART 1)

There will be a meeting of the Trust Board in public on
Wednesday 6 March 2024 at 11.00am in Room 2.35, Garrod Building, Turner St,
Royal London Hospital Whitechapel, E1 2BL
Scheduled to end by 13.45

AGENDA

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

		Paper TB	Lead	Time
1.	**WELCOME**		Rt Hon J Smith	11.00
2.	**APOLOGIES FOR ABSENCE:**			
3.	**DECLARATION OF INTERESTS** To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting including gifts and hospitality (accepted or refused)			
4.	**MINUTES** To approve the Minutes of the meeting held on 17 January 2024 and review the action log appended to the Minutes	14/24	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	11.00
7.	**CHAIR'S REPORT** To receive the Chair's report		Rt Hon J Smith	11.25
8.	**CHIEF EXECUTIVE'S REPORT** To receive the Chief Executive's report		Mr S DeGaris	11.30

		Paper TB	Lead	Time
9.	**PROVIDER COLLABORATION** To receive an update on recent developments	15/24	Mr M Trainer	11.35
QUALITY AND PERFORMANCE				
10.	**INTEGRATED PERFORMANCE REPORT – 2023/24 M10** To receive the report and discuss: • Operational performance • Quality and Safety • People • Financial performance	16/24	*[by exception]* Ms R Carlton Prof A Chesser / Ms C Alexander Mr D Waldron Mr H Virdee	11.45
11.	**REPORTS FROM BOARD COMMITTEES** 11.1 Finance Performance and Investment 11.2 Audit and Risk Committee	oral 17/24	Mr A Sharples Ms K Kinnaird	12.25
12.	**BOARD ASSURANCE FRAMEWORK** To receive and approve	18/24	Mr A Hines	12.35
STRATEGIC DELIVERY PLANS AND IMPLEMENTATION				
13.	**PEOPLE STRATEGY** To receive a report on the strategy refresh	19/24	Mr D Waldron	12.45
14.	**EQUITY IN CARE PROGRAMME** To receive a report on equity of access	20/24	Mr A Abraham	12.55
15.	**MATERNITY** To receive a report on Maternity quality and safety	21/24	Ms C Alexander	13.05

Barts Health NHS Trust

16.	**ANY OTHER BUSINESS**			
17.	**QUESTIONS FROM MEMBERS OF THE PUBLIC**			13.15

18.	**DATE OF THE NEXT MEETING** The next meeting of the Trust Board in public will be held on Wednesday 1 May 2024 at 11.00am in the Lecture Theatre, Education Centre, Zone 2, Newham University Hospital, Plaistow E13 8SL.			
19.	**RESOLUTION** That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section (2) Public Bodies (Admissions to Meetings) Act 1960).			

Sean Collins
Trust Secretary
Barts Health NHS Trust
020 3246 0642

NHS
Barts Health
NHS Trust

BARTS HEALTH NHS TRUST

TRUST BOARD MEETING (PART 1)

Minutes of the Trust Board meeting held in public on
Wednesday 17 January 2024 at 11.00am, Bainbridge Room, Robin Brook Centre,
St Bartholomew's Hospital, London

Present:
Rt Honourable J Smith (Chair)
Mr A Sharples (Vice Chair)
Mr S DeGaris (Group Chief Executive)
Mr M Trainer (Deputy Group Chief Executive)
Dr K McLean (Non-Executive Director)
Ms K Kinnaird (Non-Executive Director)
Ms H Spice (Non-Executive Director)
Professor Sir M Caulfield (Non-Executive Director)
Ms J Nelson-Ferns (Non-Executive Director)
Mr C Williams (Associate Non-Executive Director) *
Ms S Teather (Associate Non-Executive Director) *
Professor A Chesser (Chief Medical Officer)
Ms C Alexander (Chief Nurse)
Mr H Virdee (Chief Finance Officer)
Mr A Hines (Director of Group Development) *
Ms R Carlton (Chief Operating Officer)*
Mr D Waldron (Director of People) *
Mr A Abraham (Director of Inclusion and Equity) *
Professor C Knight (Chief Executive, St Bartholomew's Hospital) *
Dr N Ashman (Chief Executive, Royal London and Mile End Hospitals) *
Mr S Ashton (Chief Executive, Newham Hospital) *
Dr A Jhund (Chief Executive, Whipps Cross Hospital) *

In Attendance:
Mr S Sharma (Deputy Trust Secretary)
Mr A Finney (Whipps Cross Redevelopment Director)

Apologies:
Ms L Seary (Non-Executive Director)

** Non-voting member*

20/24 WELCOME

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

Apologies were noted.

21/24 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.

22/24 MINUTES OF THE PREVIOUS MEETING

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

23/24 MATTERS ARISING

There were no matters arising.

24/24 PATIENT STORY

The Trust Board received an account from Mr Jeremy Laurance, who was involved in the St Bartholomew's Hospital Patient Safety Incident Response Framework (PSIRF) planning group as a patient representative. He had also recently been a patient under the care of the Cardiology team. Mr Laurance shared his reflections on being involved in the development of PSIRF and how he had initially found integrating into the group a challenge due to the use of NHS terminology and technical discussions. He outlined some concerns he had raised with the Patient Advice and Liaison Service (PALS) about his patient experience and, along with the St Bartholomew's Hospital medical leadership team, updated the Board on things that had improved following his communication.

The Trust Board members asked questions about Mr Laurance's experience:

- Ms Teather asked whether, in his view, there may be better ways of involving patient representatives. Mr Laurance felt that using specific scenarios as examples would have helped him make more of a contribution on the patient perspective.

- Mr Sharples asked how more patient feedback could be gained and where the hospitals could make further improvements for patients. Mr Laurance recognised some challenges in securing feedback and suggested proposing small incentives for patients in order to provide a higher number of responses.

- The Chair asked whether Mr Laurance had heard of the Patient Knows Best application which was being introduced to enhance patient experience. Mr Laurance noted that he had used this app at another Trust where he had received treatment but had not been clear about how the app was in use at Barts Health currently.

The Trust Board thanked Mr Laurance for his valuable contribution.

25/24 CHAIR'S REPORT

The Chair opened by congratulating those individuals with strong links to Barts Health recognised in the King's New Year's Honours list. She confirmed that there was a strong pipeline of candidates being considered for future nominations.

The Chair thanked Barts Charity for its continued help on major developments and supporting the Barts Health Heroes nominees event that had been held recently at St Bartholmew's Hospital. The Chair highlighted the Charity's funding of robotic surgery improvements, which had led to better outcomes for patients.

The Chair noted that she had attended the yearly carol service at St Bartholomew's Hospital and celebrated the 10th anniversary of BartsAbility, while also participating in LGBTQ+ ally training. Newham University Hospital's 40th year anniversary was celebrated at a Christmas lunch event. The Chair had also visited Whipps Cross Hospital and thanked the staff who had worked to keep hospitals safe over the holiday and industrial action periods. In relation to the ongoing industrial action, she was hopeful of a timely resolution following talks between trade unions and the Government.

26/24 GROUP CHIEF EXECUTIVE'S REPORT

The Group Chief Executive congratulated nursing staff who had been recognised at the national nursing awards ceremony (with two gold and four silver medals awarded to staff and teams at the Trust). He also congratulated the Trust's Chief Finance Officer on being recognised as Finance Director of the Year at the annual awards of the Healthcare Finance Management Association. The Group Chief Executive thanked all staff who had maintained the safety of services during industrial action. From a performance perspective, all sites were delivering high quality same day emergency care services despite the extreme pressures in all emergency departments. The number of available virtual ward beds had increased and positive steps made in clearing the backlog of longest waiting patients. The financial challenges within the Trust and across the NHS remained an area of focus. On behalf of the board, the Group Chief Executive thanked hospital CEOs and their teams for their work over this period.

27/24 PROVIDER COLLABORATION – TOWARDS AN INTEGRATED GROUP

The Deputy Chief Executive introduced the report, highlighting the launch of the Acute Provider Collaboration (APC) clinical strategy in which five clinical pathways had now been established. Medical and surgery boards were up and running and the first Clinical Strategy Board meeting was due to be held at the end of the month. North East London (NEL) cancer services were reporting some of the highest performance levels in the country. Collaborative work was ongoing with the Barts Health's transport team now working at Barking, Havering & Redbridge University Hospitals (BHRUT) sites. BHRUT was continuing to integrate through procurement of a joint electronic patient record system, though the digital rollout of this was presenting some early challenges.

Dr McLean asked what the expectations of the NHS England review of the APC were and how the collaborative might contribute to meeting financial challenges. The Chief Finance Officer felt that medium term financial targets could only be achieved through collaboration efficiencies. It would require a more structured approach and longer timeframe to realise greater levels of savings. He noted that other sectors were looking at some of the lessons from the collaboration with BHRUT in framing their approach. The Deputy Chief Executive added that work was ongoing to improve relationships with the other five APCs in London as well as the NEL mental health collaborative.

Ms Kinnaird asked about the level of confidence in delivering sufficient pace of collaboration work. The Deputy Chief Executive acknowledged that some areas were harder to deliver on and that there would be some reliance on clinical specialty leads to drive changes.

28/24 INTEGRATED PERFORMANCE REPORT

(i) Quality and Safety

Dr McLean noted that the Quality Assurance Committee had met in the previous week and received assurance on various agenda items relating to the Trust's quality and safety objectives and obligations. A follow-up report was requested to provide assurances in relation to the Whipps Cross Hospital Eye Treatment Centre services and assurance around the maternity improvement programme would be considered further by the Trust Board. Progress with improving duty of candour processes had been slow, though new arrangements and monitored actions were expected to lead to measurable improvements by April. A winter quality dashboard was being designed with support from the central operations team. The committee had been impressed with the St Bartholomew's Hospital's annual quality report and an assessment of the hospital's position in relation to CQC domains would be helpful.

The Chief Medical Officer was pleased with the initial roll out of PSIRF arrangements (superseding the serious incident framework) and the way it had been introduced to clinicians who were keen to embrace the new approach. He noted that all sites had coped well in maintaining patient safety during winter pressures compounded by the impact of strike action. The Chief Nurse confirmed that all clinical negligence cases were investigated thoroughly and noted that the residual overdue serious incident investigations were being addressed. She noted that a broader maternity report had been scheduled for the 6 March 2024 Trust Board meeting.

Ms Kinnaird asked about increases in maternity incidents at The Royal London Hospital. The Chief Nurse confirmed that a high level of complexity in caseloads influenced this and it was recognised that providing a weighted average across the group would help provide context.

Mr Sharples identified an example of a statistical process control (SPC) breach were not directly referenced within the report's narrative. The Chief Medical Officer agreed that breaches should be a prompt for some supporting commentary and would review future reports to ensure that this was addressed.

ACTION: Chief Medical Officer

(ii) Operational Performance

The Chief Operating Officer outlined the key messages from the report noting that 28,000 outpatient and 2,500 elective appointments had had to be cancelled due to recent industrial action. The Trust had become more accustomed to industrial action implications and developed more efficient ways to maintain safe services and manage associated risks. Urgent Treatment Centre (UTC) type three demand was high at all sites and type one demand was particularly high at Whipps Cross Hospital. The central operations team were working with London Ambulance Service on supporting an even distribution of ambulance conveyances. Diagnostic performance had improved and a reduction in the waiting times for cancer patients had prompted a move out of tier two national oversight and support. However, urology pathways remained a complex challenge. A clinical review of long waiting patients had been completed supported by a lessons learned exercise.

Dr McLean asked what the level of confidence was to meet the key constitutional targets. The Chief Operating Officer indicated that confidence was high in clearing the cancer backlog, while elective care modelling was harder to predict in terms of outcomes. She confirmed that there was more work to do with North East London Foundation Trust on Urgent Treatment Centre arrangements and the Trust continued to prioritise review of the most urgent and clinically appropriate patients. The Chief Medical Officer added that efforts were also being made to utilise out of hospital services as much as

possible to avoid treatment bottlenecks. It was confirmed that staff training had led to positive results in terms of addressing data quality challenges.

(iii) Equity & Inclusion

The Director of Equity and Inclusion summarised the key messages in the report, confirming that waiting times for patients with learning disabilities had reduced. He highlighted progress made during 2023/24 across the three pillars of people, community and patients. While there remained more to do, notable milestones had been met in the last year with recognition of a number of Trust programmes in national awards. The ongoing work to improve outcomes for our patients and address health inequalities included the roll out of an outpatient equalities dashboard to drive improvements. Progress against these objectives would continue to be monitored closely by the inclusion and equity board.

(iv) People

The Director of People noted sustained improvements in the metrics on roster compliance and job planning, which was now above 60%. Staff turnover performance was positive with fewer leaving the Trust and progress made in recruiting permanent staff. External support was being explored to address longstanding recruitment challenges at Newham University Hospital.

Dr McLean asked why roster compliance had improved at Whipps Cross Hospital more than at other hospitals. The Director of People noted that Whipps Cross Hospital had performed well in validating and data cleansing. Progress was being seen at all other sites and the Chief Nurse highlighted the sharing of best practice examples across the group.

Ms Spice welcomed the improvement in the time to hire metric and asked if there was now a permanent solution to having identification checks completed in one location. The Director of People noted improvements made and acknowledged the importance of adding permanent clinics at Newham University Hospital and Whipps Cross Hospital to support this approach.

(v) Financial Performance

Mr Sharples noted that the Finance, Investment and Performance Committee had met twice during December and January. The December meeting had included a focus on workforce objectives including particularly the fill rate for substantive employees and a corollary reduction in temporary staffing. This benefit was not yet being realised quickly enough and related staff costs were significantly higher as a result. The meeting in January had considered ways of improving theatre productivity, which was slightly below the national average. New digital software had been trialled to improve efficiency and patient consent arrangements. In terms of operational performance, strong elective

activity levels had generated a positive income position. However, there remained concern about waiting lists. The Trust had now been place in tier one for oversight and scrutiny by NHS England. Mr Sharples noted the strains on staff during long periods of industrial action; this was particularly the case for booking and scheduling staff often responsible for relaying bad news to patients. Mr Sharples confirmed that the Trust was on track to deliver the financial control total target by year end, although deficit run rates would need to be less than £2m per month. He anticipated a demand for delivering a balanced budget in 2024/25, which would present a serious challenge in light of this year's position and underlying deficit.

The Chief Finance Officer noted that the end of year target and forecast had been based on an assumption of no further industrial action taking place. He took the opportunity to congratulate St Bartholomew's Hospital for achieving extremely low levels of temporary staffing, Newham University Hospital on nursing spend controls and a positive direction on finance metrics at The Royal London Hospital.

Ms Spice noted concern about the capital allocation for 2024/25. The Chief Finance Officer confirmed that a constrained capital position was expected and felt that flexibility and support in the approach to addressing capital shortages would be required. The Chair confirmed that the Integrated Care Board recognised this issue and was seeking central support to address the historically low allocation of capital funding for NEL.

29/24 FURTHER REPORTS FROM BOARD COMMITTEES

Audit and Risk Committee

Ms Kinnaird outlined key agenda items discussed by the Audit and Risk Committee at its November meeting. The committee had supported the appointment of external auditors and hoped to benefit from work they were now undertaking at BHRUT. The committee had received positive assurance on the embedding of management actions identified in a follow-up review of historical limited assurance audit reports. The committee had also welcomed progress made on reducing outstanding management actions. Reports on progress against the operational plan, the Board Assurance Framework (BAF) and high scoring risks were also discussed in detail. Ms Kinnaird noted that the committee had recommended that time was allocated at a future board seminar on horizon scanning.

The Trust Board noted the report and approved the appointment of Mazars LLP external auditors.

30/24 WINTER PLAN

The Chief Operating Officer summarised the plan including bed demand modelling (with a 20% increase on the bed base factored into arrangements). The report illustrated key areas of focus and interaction with system partners; an ongoing challenge to decrease the average length of stay for mental health patients; discharge initiatives and a new system control centre; and the risk of industrial action disruption.

Ms Kinnaird asked if the system control centre was now functioning fully as planned. The Chief Operating Officer emphasised the role of new technology providing real time visibility on UEC attendances. While it was still early to confirm the effectiveness of the new arrangements, positive progress was being made.

Dr McLean was pleased to see peak pressure points presented in the plan and asked how interventions might be assessed in terms of relative impact and rolled forward into future plans. The Chief Operating Officer felt that, with the urgent and emergency care workstream increasingly being managed on a sector wide basis, there was a role for system evaluation. She agreed that there would be benefits of commissioning a detailed review of the individual schemes and innovations to confirm impact.

The Trust Board noted the report.

31/24 PEOPLE STRATEGY IMPLEMENTATION - INCLUSION

The Director of People introduced the headline messages and noted the focus of the report was on the workforce elements of inclusion, with an update on the patient equity of access workstream due to be presented at the March board meeting. He was confident that the steps being taken were the right ones and progress being made in programmes designed to develop a fair and just culture. Ultimately it was of primary importance to translate this work into improving outcomes. He noted that the gender pay gap target had been achieved a year ahead of schedule and representation of ethnic minority staff in senior positions had increased from 21% to 39%. Staff network relationships continued to be built on with a recognition that more data needed to be gathered. The Director of People noted a focus for the year ahead on building a culture of compassion and kindness, with staff webinars and leadership conference events in place to support the key messages.

Following a recent visit to one of the hospitals, Mr Williams asked where feedback was captured and the progress of individual inclusion programmes reported. The Director of People noted that the Trust Board would receive progress updates including feedback and felt that there was a clear link between strategy and implementation. The Director of Inclusion and Equity added that staff survey results would help to pinpoint areas where greatest focus was required.

Ms Kinnaird commended the outstanding progress made to close the gender pay gap and significantly increase senior management representation across ethnic minorities. She supported the current efforts being made to gather further data and asked what more the board could to provide support. The Chair agreed that it would be helpful for future reports to highlight any barriers to making further progress.

32/24 WHIPPS CROSS REDEVELOPMENT

The Director of Whipps Cross Hospital Redevelopment confirmed that the outline business case for enabling works had been agreed and the full business case submitted to national colleagues in December. A review and assurance process was now underway with the national team and there was some confidence that this would be approved in February 2024. The delivery phase could then be entered into from May 2024, including the development of the first of the new car parks. NHS England had developed an overarching programme business case and, though there was no associated timeline for endorsement, the team expected that related schemes would not be delayed as a result of this process. A gap analysis of initial design work against new emerging national standards had also been developed and considered.

Dr McLean asked whether the national escalation on building costs significantly impacted on the scheme feasibility. The Director of Whipps Cross Hospital Redevelopment noted that the modelling highlighted the need for an integrated delivery framework was important and flexibility in approach to managing sector demand. Ms Kinnaird felt that it would be important to resist any suggestions of scaling back plans at this stage. Mr Williams asked about the modelling and anticipated reduction in emergency attendances. The Director of Whipps Cross Hospital Redevelopment noted that a ten year plan had been modelled for emergency admissions. He noted some relatively significant reductions in front-door demand recently with pressures being driven more by patient length of stay and acuity. The Whipps Cross CEO confirmed that work was required on demand management including driving down outpatient appointment levels.

33/24 VETERANS COVENANT

The Trust Board supported the accreditation programme. It was noted that this scheduled to conclude at the end of April 2024 with accreditation on track to be achieved.

34/24 INFECTION PREVENTION CONTROL

The Chief Nurse briefly outlined the work being done to reduce infections across the group, noting the report focusses on actions to be taken going forward. Dr McLean confirmed that the Quality Assurance Committee had reviewed this and praised the team on the work reflected in this report.

Mr Sharples noted that the report had captured median averages and suggested that future reports include trend lines to accompany this.

The Trust Board approved the report.

35/24 USE OF THE TRUST SEAL

The Trust Board approved the use of the Trust seal.

36/24 ANY OTHER BUSINESS

There was no other business.

37/24 QUESTIONS FROM MEMBERS OF THE PUBLIC

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

The Newham Save our NHS campaign group representative, Mr Alan Cooper, asked questions in relation to Newham hospital fire safety, specifically in relation to:

- *Whether the Trust had highlighted to DHSC the issues of non-compliance with regulations owing to a lack of capital;*
- *Whether the London Fire Brigade [LFB] were aware of the new modular unit and satisfied with fire safety arrangements for this;*
- *Details of any delay to fire door replacement;*
- *The Board's role in publicly highlighting the long delays to fire safety works.*
- *Details of the issues associated with Gateway Centre cladding; when issues of non-compliance were identified; and the expected length of time to complete rectification of these issues.*

The Chief Executive of Newham University Hospital confirmed that:

- Trust representatives had held meetings with NHS England regarding this risk and they were kept up to date on outputs from the Trust's meetings with LFB.
- LFB were aware of the construction of the modular building and the Trust would comply with current building regulations in completing this building.
- There had been no delays to planned works on fire doors.
- The Trust Board had consistently referred to risks associated with capital allocations (and specifically in relation to fire safety works) via the board assurance framework and other reporting in the public domain.

- The Gateway Centre cladding's rainscreen did not meet the criteria for immediate removal post-Grenfell. As part of the ongoing fire remediation work at Newham Hospital the extent of any work required (including any estimate of the time involved) to make changes to the cladding will be established by detailed surveys and examinations taking place between January and March 2024.

38/24 DATE OF THE NEXT MEETING

The next meeting of the Trust Board in public would be held on Wednesday 6 March 2024 at 11.00am in Room 2.35, Garrod Building, Turner Street, The Royal London Hospital, Whitechapel, London E1.

Sean Collins
Trust Secretary
Barts Health NHS Trust
020 3246 0641

Action Log

Trust Board 17 January 2024			
No.	Action	Lead	By
1	**IPR - Quality & Safety** The Chief Medical Officer agreed to include narrative on any SPC breaches in future IPRs.	CMO	March 2024/Ongoing

Barts Health NHS Trust

Report to Barts Health and BHRUT Trust Boards: 06 March 2024 (Barts Health part 1) 07 March 2024 (BHRUT part 1)	TB 15/24

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

Executive summary

Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), Barts Health NHS Trust and Homerton Healthcare NHS Foundation Trust are working together to address mutual challenges and deliver better care.

The ambition of the three trusts is to improve quality and access for patients through collaboration, using a co-ordinated approach to population needs, so that services are arranged around our patients, not organisational boundaries.

As an acute provider collaborative (APC) we have been working together across five clinical change programmes, which are in varying stages of development. In parallel, several corporate programmes have also been advanced through the closer collaboration between Barts Health and BHRUT.

Recognising the opportunity to strengthen collaboration even further, a series of meetings between the Chairs and CEOs of the three north east London acute Trusts have been held to consider how this could be taken forward, with a particular focus on how corporate initiatives can be progressed on a tripartite basis.

This is timely. The APC is currently reviewing its priorities for 2024/25, with each of the existing programmes developing their plans that set out their key deliverables and impact on addressing health inequalities. Discussions are continuing to develop a provisional suite of non-clinical programmes where there is benefit in the acute providers coming together. One such example is procurement where it has recently been agreed to be taken forward as part of the APC.

Barts Health NHS Trust

These associated activities are being developed in the context of the regional NHSE commissioned review on the future role and development of Provider Collaboratives in London.

Related Trust objectives
All

Risk and Assurance	This report provides assurance in relation to the evolving and maturing collaboration between Barts Health, BHRUT and Homerton Healthcare as part of an Acute Provider Collaborative – and BAF risk 10. Failure to collaborate effectively through the NEL acute provider collaborative, and through place-based partnerships, delays benefits to quality and outcomes, equity and value.

Legal implications/ regulatory requirements	None

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

Barts Health NHS Trust

REPORT TO THE TRUST BOARD

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

Introduction

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

Acute Provider Collaborative

2. The three acute providers have been working together as an Acute Provider Collaborative for 20 months, with the APC continuing to develop and mature. For 2023/24 the APC Executive agreed a portfolio of programmes to be taken forward to improve quality and access for our patients. One such area is improving access to diagnostics and elective care.

3. Collaborative working has enabled the APC to secure a three-year funding settlement of £33m of national funding to implement community diagnostic centres (CDC), providing patients with speedier and more convenient access for their scans.

4. The CDC programme is hosted by the APC and coordinates activities at a system level, manages relationships with regional teams and provides support with pathway development. In parallel, each Trust has a local project team in place to support the implementation. This initiative will soon deliver real benefit to patients across NEL.

5. The Barking Community Hospital CDC is expected to receive its first patients by the end of March 2024. In addition, the CDC at St. George's is expected to handover in May 2024, with the third CDC at Mile End hospital coming on line in July 2024. This will provide patients across NEL with local access to diagnostic scans for Xray, CT, MRI and ultrasound.

6. Similarly, there is also additional investment into increasing theatre capacity across NEL to help speed up access to treatment. Two additional theatres are due to open at King George Hospital at the end of May 2024, with an additional two theatres at Homerton Hospital to follow in April 2025.

7. The additional theatres will be managed as system capacity (rather than for each individual Trust) and will help address underlying access issues and strengthen the way in which capacity is shared across NEL. During 2023/24 nearly 3200 patients have received or are in the process of being offered a date at a neighbouring provider to expedite their care and ensure maximum use of all available capacity.

Forward Look 2024/25

8. As part of the agreed NEL system planning process, each of the clinical change programmes have reviewed and updated their objectives for 2024/25 setting out the key deliverables and impact on addressing health inequalities. These have been incorporated into the refreshed NEL ICB Joint Forward Plan.

9. With the APC continuing to evolve, and as it seeks to strengthen collaboration in areas where it makes sense for the three providers to work at scale, consideration is now being given to which corporate programmes could be incorporated into the APC. One such example is procurement where it has recently been agreed to be taken forward as part of the APC and to leverage the purchasing scale of the three providers.

10. With a potentially expanded APC, consideration is also being given to both leadership and resourcing to ensure it has the best chance of delivering on the ambition. Currently, the APC is resourced through a hybrid arrangement between colleagues from the ICB and the providers. In addition, executive colleagues recognise the need to step into a more collaborative leadership role and focus greater time and attention to the APC.

Supported development for the Acute Provider Collaborative

11. The APC is being supported by a development partner (as part of the NEL ICB commissioned system support) to help it evolve and further strengthen collaboration with partners.

12. This parallel piece of work has recently commenced and will include:

- Co-design of a shared purpose statement that makes clear the patient focus.
- Co-design of a set of collaborative leadership principles.
- Clarifying how we promote a culture of clinical collaboration.
- A set of collaborative behaviours that leaders are expected to role model with the associated accountabilities.

13. The key deliverables from this commission will be informed through an Executive development session to be held in April 2024 and are anticipated to be completed by May 2024.

NHSE review of Provider Collaboratives

14. The above activities are being progressed whilst NHSE London are also undertaking their review to consider the future role and development of provider collaboratives in London to ensure we leverage most of the opportunities offered by working together as providers.

15. The review will look at best examples of provider collaboratives nationally and how these could shape the future development of collaboratives within London. Consideration will also be given to how collaboratives can work most effectively with place-based partnerships and how we can make the most of the possibilities of collaboration to improve access and reduce health inequalities.

16. The NEL Acute Provider Collaborative are actively engaging in this process, having participated in several discussions with the review lead and responded to the formal request for information. Findings from the review will be shared with Chairs and Chief Executives in late March 2024. The development of the NEL APC will need to be sensitive to these findings as it looks to strengthen collaboration during 2024/25.

Summary

17. The Trust Board is asked to note:

- the update on improving access to diagnostic and elective care.
- the activities underway to broaden the portfolio of programmes to be incorporated into the APC.
- the associated parallel activities underway with the ICB appointed development partner and the NHSE commissioned review into the future role of provider collaboratives.

NHS
Barts Health
NHS Trust

Report to the Trust Board: 6 March 2024	TB 16/24

Title	Integrated Performance Report (Month 10)
Accountable Director	Director of Group Development
Author(s)	Director of Performance
Purpose	Performance against constitutional standards and KPIs

Executive summary

The Integrated Performance Report provides detail in relation to performance drivers and recovery actions at Trust and Hospital Site level in relation to the NHS Oversight Framework indicators. The report also identifies exceptions, including positive exceptions, where performance has outperformed usual tolerances, or where a target has been missed. The report will be presented by the respective lead directors for, quality and safety, operational performance, equity, people and finance sections.

Equity data is not reported in this IPR and will now be reported quarterly, with the next report expected in May 2024 (a separate dedicated equity of access report appears elsewhere on the agenda).

Related Trust objectives
All trust objectives

Risk and Assurance	This report provides assurance in relation to all trust objectives
Related Assurance Framework entries	All BAF entries

Legal implications/ regulatory requirements	N/A

Action required by the Board

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

Barts Health NHS Trust

Barts Health Integrated Performance Report

March-24

Performance for: **Jan-24**

Pack Contents

Mar-24

Mar-24

NHS
Barts Health
NHS Trust

Executive Summary

EXECUTIVE SUMMARY

Executive Summary

Mar-24

Quality Report

- We are in the most pressured time of year for our non-elective services, all our hospitals are coping well but our emergency departments are very busy and there are significant waits which impact on patient experience. Increased care interventions are in place to help to mitigate the risks associated with overcrowding and long waits
- The Trust is reviewing quality and safety data using statistical process control; this supports early identification of risk and enables proactive planning.
- A review of the metrics demonstrated common cause variation in the following indicator metric - **Incidents per 1000 bed days** which relates to the Learning from Patient Safety Events (LFPSE) platform which was rolled out in November.

Operational Performance

- The Group and hospital teams continue to focus on both the safe delivery of services as well as seeking to meet trajectories for March 2024 across the main constitutional standards covering elective care, urgent and emergency care and cancer and diagnostic services.
- This section reports on the performance and delivery of the Group and Hospitals in relation to constitutional standards. These objectives were reviewed in September at the request of the national team with local objectives agreed for the remainder of the financial year, September to March. The objectives for Barts Health are:
    - Urgent and Emergency Care (UEC) - 76% for 4 hrs and reduced Cat 2 Ambulance Handover
    - Cancer – 7% Backlog or 279 patients with Faster Diagnosis Standard (FDS) at 75% with a stretch to 81%
    - Elective – 0 104 week breaches, 0 78 week breaches and 1500 65 week breaches
- Detailed performance is provided in in slides 15-38 of this pack.

Equity

Equity data is not reported in this IPR and will now be reported quarterly, with the next report expected in May 2024.

People

- Substantive staff grew by 120 WTE, of which 66 WTE were registered nurses and midwives with growth across all four main hospital sites. The overall substantive fill rate increased to 93.1% and the substantive nursing and midwifery fill rate increased to 90.6%
- Pay spend as a percentage of pay bill reduced YTD from 4.25% to 4.30%. In month there was an increase of 128 WTE bank and agency used, reflecting both greater demand for strike cover and a return to normal demand post the Christmas period.

Finance

- The Trust is reporting a £27.1m deficit for the year to date at month 10, this is (£3.7m) adverse against original plan.
- Following confirmation of allocation of medical industrial action funding in November, the Trust agreed a forecast outturn target of £36.4m deficit for 2023/24 as part of an NEL system planned forecast outturn deficit of £25m.
- The £47.2m forecast outturn deficit excludes the impact of any further medical industrial action post January 2024 and also excludes the impact of IFRS16 PFI accounting changes on PDC dividends.
- The Trust continues to implement additional controls particularly in relation to pay expenditure to support financial recovery and at month 10 is on track to meet its target deficit subject to the excluded items.

NHS
Barts Health
NHS Trust

Quality Report

SUMMARY

Quality Summary

Mar-24

The data covered in this report is for the December 2023 reporting period in line with the BH approach to reporting using Statistical Process Control (SPC) methodology.

Maternity: Maternity metrics are reported within the separate maternity report being presented at Board this month.

Incidents per 1000 Bed days- A review of the metrics demonstrated a decline in the number of incidents reported of 21.8%. There has been an identified functionality Datix issue, and a server upgrade is planned for 29 February. In November, the Trust went live with Learn from Patient Safety events (LFPSE) which means the way we record harm has changed alongside an extended reporting form. This is a known national issue, with some organisations reporting a 30% reduction in incident reporting. This has been discussed at the North East London PSIRF Network and be monitored via the new PSIRF oversight group commencing in April.

External Agency Visits: The Care Quality Commission (CQC) Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) team conducted an announced inspection of the brachytherapy service at St Bartholomew's Hospital on 29 November 2023. Further virtual interviews with staff were conducted on 4 December 2023. Initial feedback from the Inspections Team has been positive specifically around staff engagement. A Human Fertilisation and Embryology Authority (HFEA) inspection of the Fertility Unit was undertaken at SBH on 13 February 2024. Early feedback is positive, and we are awaiting the draft report for factual accuracy.

Incidents of Note: An update on a recently concluded inquest including the coroners concerns and immediate actions following a Prevention of Future Death report issued at RLH

Never Events: Two Never Events were declared in December 2023, both at St Bartholomew's Hospital. The first was in relation to the misplacement of an internal marker, moderate harm as the patient required a further procedure to remove the marker. The second incident was a retained wire, no harm sustained. Both incidents are currently under investigation**.**

Duty of Candour: Improvement plans have been developed at each Hospital with a continued focus on the compliance with Duty of Candour. A Duty of Candour workshop was held in January 2024 to capture barriers which may be impacting the ability to complete, and which are multifactorial. Currently the Chief Medical Officer is reviewing all Duty of Candour letters, Duty of Candour is a standing agenda item on hospital performance reviews, and a quality improvement group will be established.

Update on the implementation of the Patient Safety Incident Response Framework (PSIRF) – Hospitals are making progress in closing outstanding Serious incident (SI) investigations. In the last month we closed 14 SI investigations. Work is progressing to develop an overarching action plan to address the findings and recommendations of completed Healthcare Safety Investigation Branch (HSIB) maternity investigations which should enable us to close 12 open SI for women's services. . The operational pressures have impacted on our ability to close all legacy SIs by end of March as planned but this remains a priority. In November there were 107 SI investigations with the remaining 69 anticipated to be closed by June.

CARING

Domain Scorecard

Mar-24

	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	●			Dec-23 (m)	<=0	33	**41**	***352***	0	18	10	13	-
Patient Feedback	C10	Written Complaints Rate Per 1,000 Staff				2023/24 Q3 (q)	SPC Breach	22.8	**22.3**	***22.3***	23.2	43.5	43.0	14.8	-
	C1	FFT Recommended % - Inpatients	●			Dec-23 (m)	>= 95%	90.8%	**89.9%**	***90.7%***	86.8%	92.8%	89.7%	91.7%	-
	C2	FFT Recommended % - A&E	●			Dec-23 (m)	>= 86%	64.1%	**60.0%**	***64.3%***	59.7%	64.0%	53.8%	-	-
	C3	FFT Recommended % - Maternity	●			Dec-23 (m)	>= 96%	87.1%	**91.1%**	***94.0%***	50.0%	87.0%	95.9%	-	-
	C20	FFT Response Rate - Inpatients	●			Dec-23 (m)	>= 23%	27.7%	**27.0%**	***30.3%***	20.9%	35.2%	28.5%	31.8%	-
	C21	FFT Response Rate - A&E	●			Dec-23 (m)	>= 12%	5.1%	**8.8%**	***7.8%***	8.5%	11.1%	6.8%	-	-
	C22	FFT Response Rate - Maternity	●			Dec-23 (m)	>= 17.5%	12.4%	**10.5%**	***15.0%***	1.0%	14.1%	15.9%	-	-
Service User Support	R78	Complaints Replied to in Agreed Time	●			Dec-23 (m)	>= 85%	78.8%	**84.4%**	***84.4%***	95.9%	86.5%	64.3%	75.0%	-
	R30	Duty of Candour	●			Dec-23 (m)	>= 100%	85.1%	**73.7%**	***80.1%***	70.0%	62.5%	90.0%	100.0%	-

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

SAFE

Domain Scorecard

Mar-24

	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	●			Dec-23 (m)	<=16	16.9	**23.6**	***20.2***	20.4	30.0	0.0	47.4	-
	S11	Clostridium difficile - Incidence	●			Dec-23 (m)	<=10	11	**15**	***123***	6	5	0	3	1
	S2	Assigned MRSA Bacteraemia Cases	●			Dec-23 (m)	<=0	1	**3**	***13***	2	1	0	0	0
	S77	MSSA Bacteraemias				Dec-23 (m)	SPC Breach	10	**6**	***107***	1	3	1	1	0
	S76	E.coli Bacteraemia Bloodstream Infections	●			Dec-23 (m)	<=20	29	**28**	***290***	14	8	2	4	0
Incidents	S3	Never Events	●		●	Dec-23 (m)	<=0	0	**2**	***5***	0	1	0	1	0
	S09	% Incidents Resulting in Harm (Moderate Harm or More)	●			Dec-23 (m)	<=1.8%	1.9%	**2.0%**	***1.6%***	1.2%	2.1%	2.3%	0.9%	-
	S45	Falls Per 1,000 Bed Days	●			Dec-23 (m)	<=9.6	3.0	**3.1**	***3.4***	2.8	3.9	2.5	4.4	-
	S25	Medication Errors - Percentage Causing Harm	●			Dec-23 (m)	<=8%	4.7%	**8.1%**	***5.5%***	4.1%	0.0%	0.0%	7.5%	-
	S49	Patient Safety Incidents Per 1,000 Bed Days			●	Dec-23 (m)	SPC Breach	40.2	**39.9**	***49.9***	30.2	50.2	45.0	41.5	-
	S53	Serious Incidents Closed in Time	●			Dec-23 (m)	>=100%	5.0%	**15.4%**	***6.5%***	25.0%	-	0.0%	50.0%	-

EFFECTIVE

Domain Scorecard

Mar-24

	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Site Comparison: Whipps Cross	Site Comparison: Newham	Site Comparison: St Bart's	Site Comparison: Other
Mortality	E1	Summary Hospital-Level Mortality Indicator	○	○	○	-	-	-	-	-	-	-	-	-	-
	E3	Risk Adjusted Mortality Index	●	○	○	Jun-23 (m)	<=100	94	**94**	***94***	92	97	-	92	-
Outcomes	0502	Cardiac Arrest 2222 Calls (Wards) Per 1,000 Admissions	●	○	○	Dec-23 (m)	<= 1.01	0.46	**0.47**	***0.54***	0.59	1.15	0.00	0.22	-

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

Domain Scorecard

Mar-24

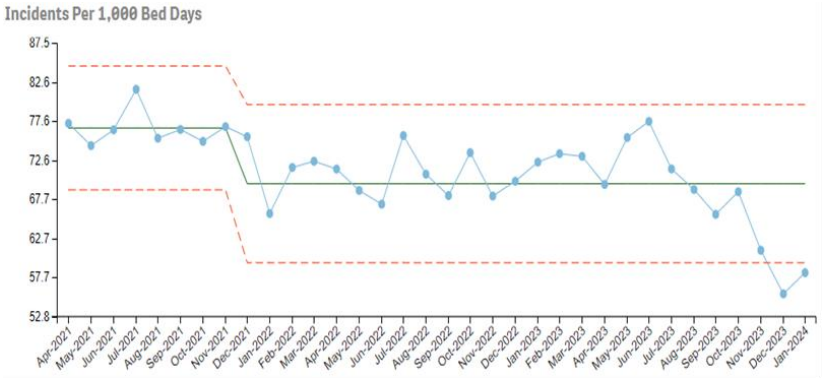
	Ref	Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Site Comparison: Whipps Cross	Site Comparison: Newham	Site Comparison: St Bart's	Site Comparison: Other
Harm Free Care	S14	Pressure Ulcers Per 1,000 Bed Days	●	○	○	Dec-23 (m)	<= 1.2	1.5	**1.6**	***1.3***	1.2	2.4	1.9	1.4	-
	S35	Pressure Ulcers (Device-Related) Per 1,000 Bed Days	○	○	○	Dec-23 (m)	SPC Breach	0.1	**0.1**	***0.1***	0.1	0.0	0.2	0.0	-

The Trust is reviewing quality and safety data using statistical process control; this supports early identification of risk and enables proactive planning. A review of the metrics demonstrated common cause variation across the indicator metrics.

SAFE

Incidents per 1000 Bed Days - Trust

Mar-24



Indicator Background:

The total number of incidents occurring at the trust per 1,000 inpatient bed days, i.e. the total number of incidents occurring at the trust divided by the number of inpatient bed days which has been multiplied by 1,000.

What is the Chart Telling us:

There is special cause variation in December suggesting a drop in incidence reported.
In November the Trust went live with Learn from Patient Safety events (LFPSE) which means the way we record harm has changed to include psychological harm and physical.

Actions Taken	Issues and Risks
The Learning from Patient Safety Events (LFPSE) platform was rolled out in November and the risk in drop of incidents being reported was anticipated. Staff are continuing to be encouraged to report incidents as normal. Some clinical areas have been experiencing problems with the functionality of Datix further hindering their ability to report incidents. The Datix Test system has been upgraded on 29 February and currently going through the testing process. Incident reporting will be monitored via the governance subgroup of the new PSIRF oversight Group commencing in March. This will ensure we benchmark against the national picture, but also internal issues such as Datix, education and training and outcomes.	The reduction in incident reporting is a national issue, following the introduction of LFPSE due to the extended length and questions contained within the reporting platform. The Trust has seen a 21.8% reduction, with some other Trusts reporting a 30% reduction. The reduction in incident reporting may mask issues of concern that are not reported. Each of the Hospital Executive teams are aware of this and are monitoring issues locally through huddles, etc.

SAFE

Prevention of Future Deaths Notice (Regulation 28)

Mar-24

In November 2022, an investigation commenced into a death of a patient, which was concluded at the end of an inquest in November 2023. The patient developed numerous infections to her Peripherally Inserted Central Catheter (PICC line) which led to sepsis. The patient underwent surgery to repair her bowel and she recovered well. Unfortunately, the patient then developed a further infection to her PICC line and died from multi-organ failure caused by septicaemia.

Despite the evidence presented during the inquest, the Coroner felt there was insufficient evidence of actions and changes that had been made to reduce line infections at the Royal London Hospital (RLH).

The RLH has subsequently implemented an improvement programme and action plan for the management of lines, which incorporates:

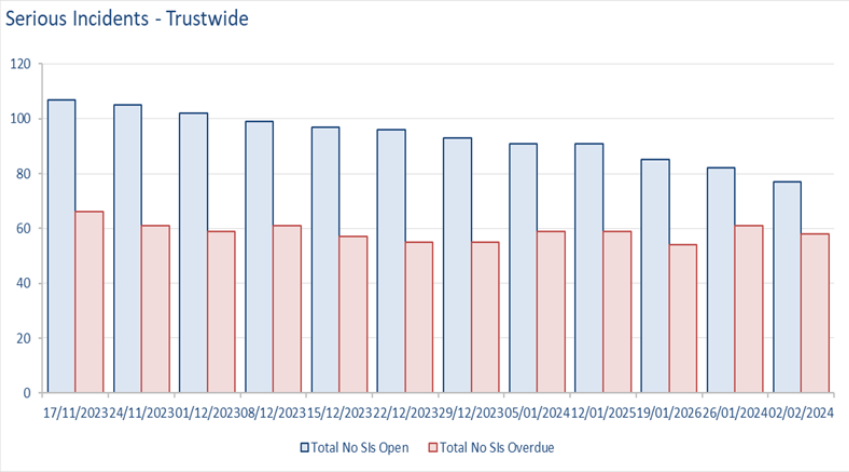
- Audit and performance
- Training and Education including Aseptic Non touch Technique (ANTT)
- Introduction of a Multi-disciplinary Line Infection Meeting

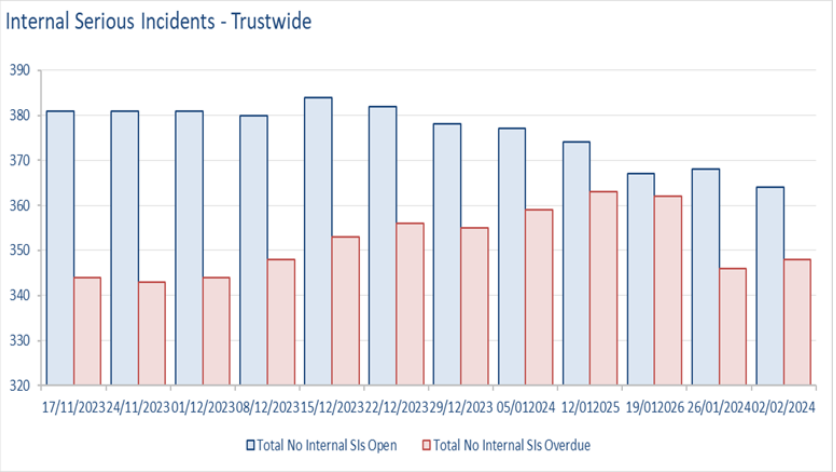
Progress is reported into the Hospital Infection Prevention and Control Committee and a full response was provided to HM Coroner in January 2024.

SAFE

PSIRF update: Serious Incidents (SIs) and internal investigations

Mar-24





SI position:
Hospitals are making progress in closing outstanding SI investigations. In the last month we closed 14 SI investigations. Work is progressing to develop an overarching action plan to address the findings and recommendations of completed HSIB maternity investigations which should enable us to close 12 open SI for women's services.
The majority of open SIs are attributed to NUH (34) and RLH (28).

Concise Internal investigation:
A number of open internal serious incident investigations (not externally reported) remains high. This number remains static and as of 2 February 2024, we have 364 open internal investigations with majority attributed to NUH (219) and RLH (96).

SAFE

External Regulatory Agency Activity

Mar-24

CQC Ionising Radiation (Medical Exposure) Regulations IR(ME)R Inspection - SBH

Background

CQC inspectors conducted an announced inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) of the brachytherapy service at St Bartholomew's Hospital on 29 November 2023. Further virtual interviews with staff were conducted on 4 December 2023.

Prior and post inspection CQC has requested copies of relevant documents and spoke with various staff of all grades from the brachytherapy department.

Summary of findings

The inspectors found staff being engaged, experienced, and cited a positive culture within the department and wider organisation, with a supportive and visible executive team who reinforced compliance with the regulations.

The service was supported by medical physics experts (MPEs), who were proactively involved in optimisation, quality assurance matters, training and worked collaboratively to fulfil the requirements of the regulations.

Recommendations and improvements

CQC identified few areas for improvement relating to the written procedures that refer to the provision of clinical audit and escalation of results when QA and machine faults occur.

In response to the findings and recommendations the service has developed an action plan with actions due for completion by March 2024.

Human Fertilisation and Embryology Authority (HFEA) – SBH

An Unannounced inspection of the SBH fertility services took place on the 13 February. There was positive feedback regarding the service and no immediate concerns were raised. It was recognised that documentation had all been submitted 12 weeks before the inspection to a high standard. The final report is to be expected to be received in 28 days. The Chief Medical Officer is the licence holder for this regulated activity.

Mar-24

NHS
Barts Health
NHS Trust

Operational Performance Report

SUMMARY

Operational Summary

Mar-24

Operational performance presented below was impacted by periods of Junior doctor industrial action during December 23 and January 24, including a six-day period during early January.

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 January 2024, 42,308 attendances were recorded, virtually the same number reported in December 2023.
- Despite recording a similar number of attendances performance for January improved from 65.8% in December 2023 to 66.6% (+0.8).
- The proportion of patients with an A&E 12-hour journey time increased from 8.7% in December to 9.0% in January (+0.3%), against a national standard of no greater than 2%.
- For January 2024, 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 13th out of 18 trusts in London and was ranked 6th out of the top 10 English trusts (ranked by volume of attendances).

Cancer

- In December 2023, the trust achieved 76.0% in relation to the Aggregate Faster Diagnosis Standard, requiring 75% of referrals to have cancer diagnosed or ruled-out within 28-days, this marks the sixth consecutive month the national standard has been achieved as well as a +0.4% improvement on the November position.
- For December 2023, the trust did not achieve the Aggregate 62-day Referral to Treatment standard, recording a performance of 61.4% against a target of 85%, however this represents an improvement of +1.7% against November's performance of 59.7%,
- During December 2023, the trust achieved the Aggregate 31-day Decision to Treat standard, recording a performance of 96.3% against a target of 96%, this marks the fifth consecutive month the national standard has been achieved.
- With continued focus from NHS England on 62-day backlog clearance, at the end of January 2024, the trust recorded 332 GP referral patients waiting longer than 62-days, an increase of 14 against the December position of 318.
- Whilst no longer a national headline measure the trust is continuing to shadow report internally against the 2-week wait from referral to first appointment standard. Please refer to later sections of this report.

Diagnostics

- For January 2024, a performance of 71.9% was recorded, a decrease of 0.9% against December's 72.8%.
- During January, 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, with those specialties contributing 83% of all breaches.

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 January 2024, the trusts admitted (inpatient and day case) trajectory set a target of 7,970 admissions against which the trust delivered 8,245 (+275 admissions).
- For outpatients (first and follow up) for the same month the trajectory set a target of 125,264 attendances, against which the trust delivered 145,123 (+19,859 attendances).
- The Trust RTT Patient Tracking List for January 2024 was 118,924 total pathways, 75 less than the December 2023 position.
- In relation to the RTT month-end nationally submitted data the trust reported five pathways waiting 104+ weeks at the end of January 2024, seven less than reported at the end of December.
- In relation to 78+ week wait backlog volumes, 427 pathways were reported at the end of January, an increase of 48 against the December 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 January, the trust recorded 2,419 pathways waiting 65+ weeks, a decrease of 209 against the December position.

SUMMARY

Operational Summary

Mar-24

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
A&E 4 Hours Waiting Time	●			Jan-24 (m)	>= 72.4%	65.8%	**66.6%**	***68.3%***	64.8%	69.1%	66.3%	-	-
A&E 12 Hours Journey Time	●			Jan-24 (m)	<=2.0%	8.7%	**9.0%**	-	7.7%	12.9%	6.8%	-	-
Ambulance Handover - Over 60 mins				Jan-24 (m)	-	139	**157**	-	44	53	60	-	-
Ambulance Handover - Over 30 mins				Jan-24 (m)	-	2124	**2283**	-	470	904	909	-	-
Cancer 62 Day Aggregate	●			Dec-23 (m)	>= 85%	59.7%	**61.4%**	62.2%	67.1%	60.2%	47.5%	64.0%	-
Cancer 31 Day Aggregate	●			Dec-23 (m)	>= 96%	96.2%	**96.3%**	96.3%	85.0%	93.0%	100.0%	99.6%	-
Cancer 28 Day FDS Aggregate	●			Dec-23 (m)	>=75%	75.6%	**76.0%**	*74.2%*	70.9%	73.3%	78.8%	93.0%	
Diagnostic Waits Over 6 Weeks				Jan-24 (m)	>= 95%	72.8%	**71.9%**	*75.7%*	54.8%	98.8%	98.5%	63.1%	100.0%
65+ Week RTT Breaches	●			Jan-24 (m)	720	2,628	**2,419**	-	1676	528	211	4	-
78+ Week RTT Breaches	●			Jan-24 (m)	0	379	**427**	5.0%	356	42	27	2	-
104+ Week RTT Breaches	●			Jan-24 (m)	0	12	**5**	-	3	1	1	0	-

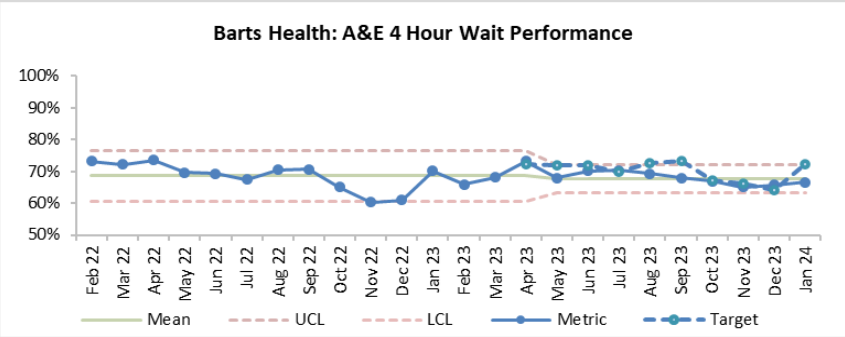
Note to table:

- The ambulance handover metrics are those reported for London Region and do not reflect a Barts Health validated position
- 78 and 104 RTT weeks wait targets are zero for 2023/24, however NHS England have set the trust a deadline of end March 24 to clear 78+ week backlog
- A 95% target for Diagnostic six week waits is required by March 2025 so no RAG rating is applied for this year

RESPONSIVE
Urgent & Emergency Care

A&E 4 Hour Waiting Time

Mar-24



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.

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 February 2022. A reducing step-change is triggered from May 2023 with a degree of variability 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 with a reduction in performance below the mean from October 23 to January 24.

Trust Performance Overview

Overall trust 4-hour performance for January was 66.6%, 5.8% below that month's target of 72.4%, set to meet the year end national recovery target of 76% by March 24. Year to date the trust is recording a performance of 68.3%.

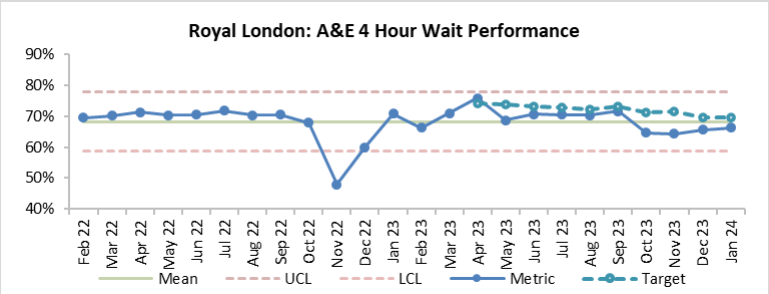
Trust Responsible Director Update

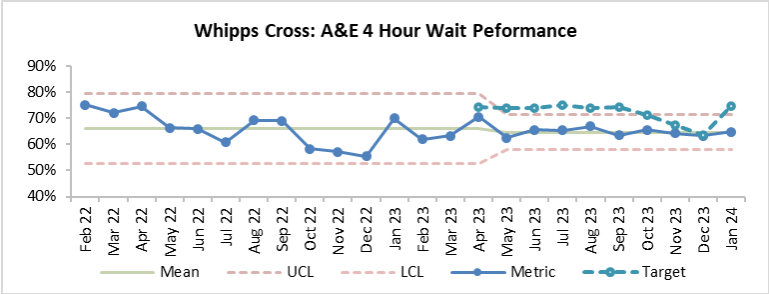
- **Overall Trust performance:** Trust performance was 66.6%, below the trajectory of 72.4%, but an improving position of 0.8% from January. Both Type 1 admitted and non-admitted performance continued on an improving trajectory, with Urgent Treatment Centre (UTC) performance remaining a key area for improvement.
- **Industrial Action: F**urther industrial action (IA) for Junior doctors continued in January, following the festive period. The Trust has implemented well-developed management arrangements for IA, however this prolonged action has created a challenge for Hospitals to maintain high levels of staffing across the period.
- **UTC performance:** UTC performance deteriorated for the Trust from 85% to 83%. This was driven by a deterioration in performance at the RLH from 78% to 75%. All partners across the Royal London and GP care group are working together on solutions to support an improving position. A number of new initiatives with a focus on streaming and productivity are being launched in March to drive a reduction in waits for our UTC patients. Investment in the service at RLH is being sought from NHS NEL given the increase in demand.
- **Admitted performance:** Type 1 admitted performance saw an improvement in performance across all the Hospitals, with a higher proportion of patients being transferred to a Hospital bed within 4 hours. This was complimented by an increase in attendances for Same Day Emergency Care (SDEC). Work continues in developing our SDEC services to maximise our admission avoidance pathways for our patients, supporting access to specialist care as fast as possible.
- **Non-admitted performance:** In January despite Type 1 Non admitted attendances remaining high performance improved to 62%
- **Drive to 76%: Daily rhythm:** The Hospitals have now implemented a daily rhythm to review yesterday's performance and problem solve any delays. Hospitals have a daily breach allowance based on forecasted attendances. Any trends and further support is underpinned through the unplanned care board. A significant part of this is improving our UTC performance.

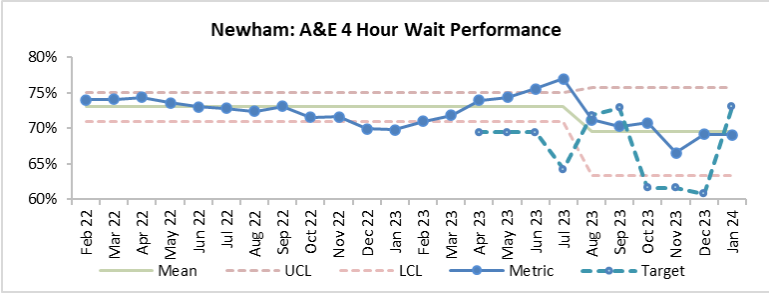
RESPONSIVE
Urgent & Emergency Care

A&E 4 Hour Waiting Time

Mar-24







Hospital Site Performance Overview

Royal London:
The Royal London recorded a performance of 64.8% in January, an increase of 1.5% against December's 63.3%. Key challenges remain across Type 3 activity at Royal London with UTC performance continuing to be variable.

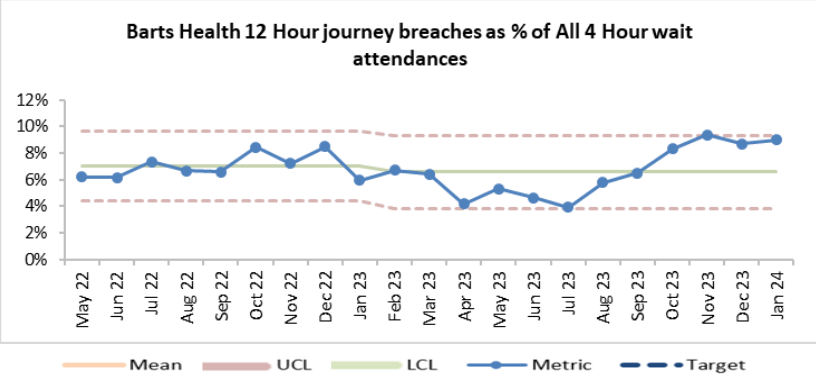
Whipps Cross:
Whipps Cross recorded a performance of 69.1% for January, the same performance as recorded for December. There is the expectation that the recent establishment of SDEC and SAU (surgical assessment unit) at Whipps Cross will lead to performance improvements.

Newham:
Newham recorded a performance of 66.3% for January, an increase of 0.7% against December's 65.6%. Work is in hand to realise the opportunities inherent in improved UTC performance at Newham.

RESPONSIVE
Urgent & Emergency Care

A&E 12 Hrs Journey time

Mar-24



Trust Performance Overview

The proportion of patients with an A&E 12-hour journey time increased from 8.7% in December to 9.0% in January (+0.3%), against a national standard of no greater than 2%.

Trust Responsible Director Update

- **Trust wide**: In January, our 12-hour journey time remained fairly static. The overall position was driven by an increase in 12 hour journey times at both Whipps Cross and the Royal London, with Newham seeing an improving position. This correlates to our mental health LoS and discharge ready positions that improved for Newham but deteriorated for the Royal London and Whipps Cross.
- **Mental Health:** Any patient waiting over 72 hrs in our Emergency departments are now being escalated to NHSE as part of a national programme, ensuring better oversight and response. This process has definitely supported a reduction in longer waits in the department, with the overall average LoS reducing to 17 hours. Work continues to support alternative pathways for our Mental health patients
- **Winter dashboard:** The Trust has re-launched a winter dashboard. This supports us with a data driven way of triangulating quality indicators with length of stay in departments and various other informative KPIs. The dashboard is reviewed weekly by the Trust senior UEC leadership team and discussed in detail at the Unplanned Care board.

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 A&E's to potential patient harm and clinical outcome.

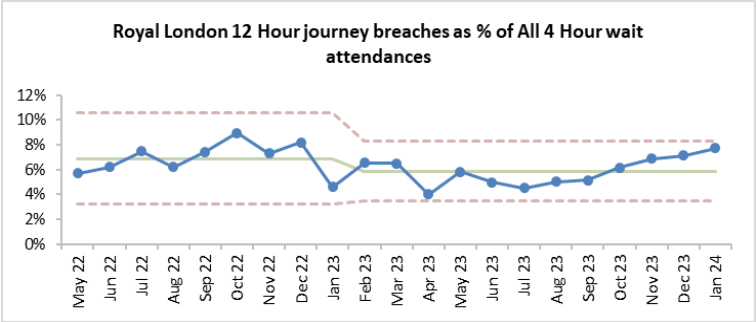
What is the Chart Telling us:

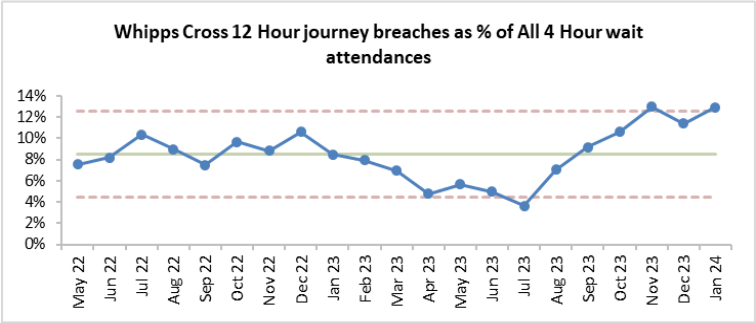
The chart presents considerable data-variability above and below the mean (Green line) however without any statistically significant breaches of the upper or lower confidence limits, however a reducing step-change is visible in the data from January 23.
July 2023 recorded the lowest proportion of 12-hour breaches up to that point in the data-series at 3.9%, however the proportion of breaches increased across August to November increasing from 5.8% to 9.4% across the period, December 23, data presents a slight decrease to 8.7% followed by a slight increase to 9.0% in January 24.

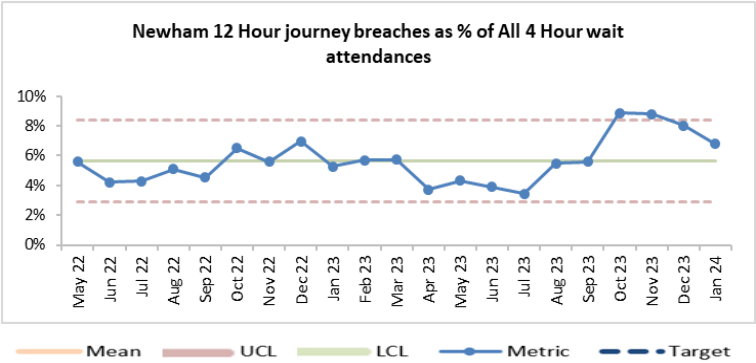
RESPONSIVE
Urgent & Emergency Care

A&E 12 Hrs Journey time

Mar-24







Hospital Site Performance Overview

Royal London:
The proportion of 12-hour wait times recorded at the Royal London was 7.7% for January 2024, an increase of 0.6% against December's 7.1%.

Whipps Cross:
The proportion of 12-hour wait times recorded at Whipps Cross was 12.9% for January 2024, an increase of 1.5% against December's 11.4%.

Newham:
The proportion of 12-hour wait times recorded at Newham was 6.8% for January 2024, a decrease of 1.2% against December's 8.0%.

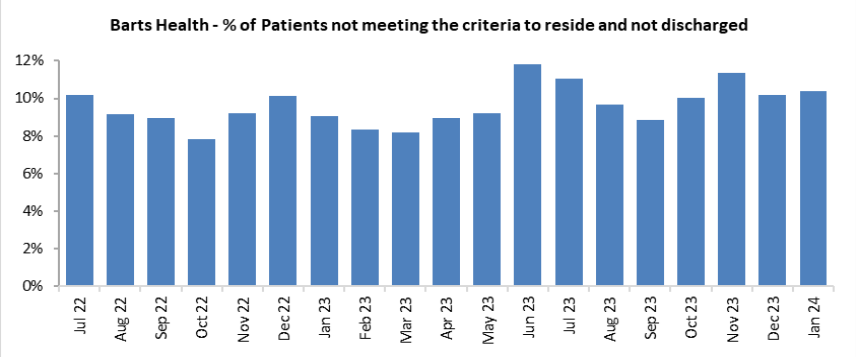
The number and proportion of 12-hour breaches is heavily influenced by the pressure A&E's are under, including patient flow challenges for example the early availability of inpatient beds and general availability of beds due to increased length of stay.

RESPONSIVE
Urgent & Emergency Care

Discharge Activity

Mar-24

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 marginally increased in January. During the month 10.4% of our bed base was occupied by patients with no criteria to reside, against 10.2% in December. Trust wide this is the equivalent of 749 patients (average across the month of 24 patients a day) and a total of 4,442 bed days.

- Whipps Cross: 13.5% equivalent to 305 patients, average across the month of 10 patients a day.
- Royal London: 11.6% equivalent to 273 patients, average across the month of 9 patients a day.
- Newham: 10.1% equivalent to 157 patients, average across the month of 5 patients a day.
- St Bart's: 1.3% equivalent to 18 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.

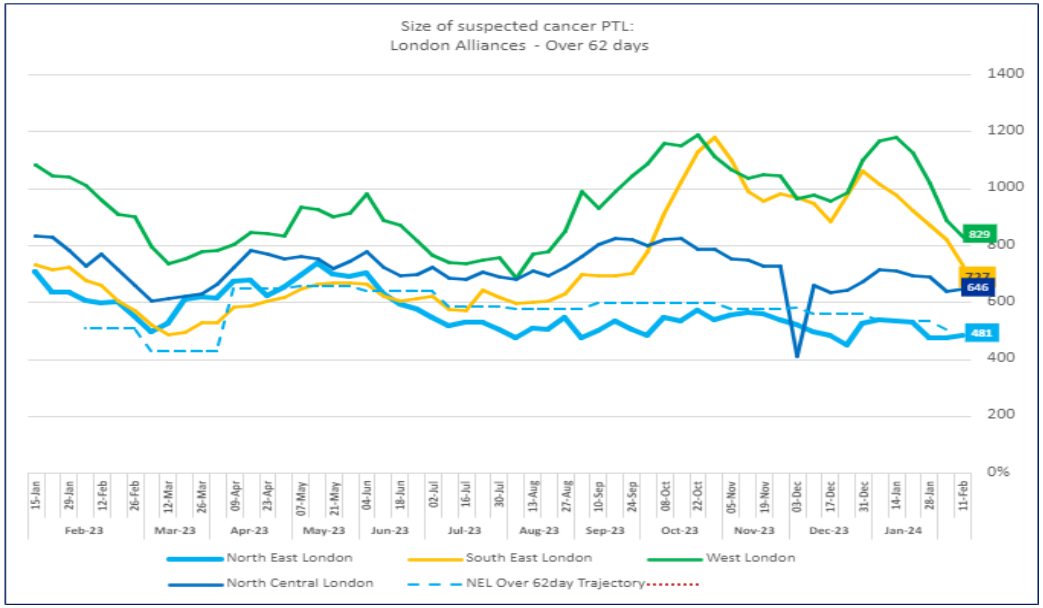
Trust Responsible Director Update

- **Discharge ready: Discharge ready is the new NHSE metric to measure our patients that no longer meet the criteria to reside.** Our patients with an historic 'discharge ready' date was 10.4% in January. .
- **Community bed capacity mapping**: We continue to map with our placed based partners to support maximising community bed capacity. We review criteria and aim to ensure all beds in the system are maximised, to meet the variable demands and needs of our patients.
- **Out of area patients:** A new process is being implemented across NEL to look at out of area patients and support this group of patients accessing care in a more timely way. Senior stakeholders will meet once a week to review complex cases and support unblocking any barriers to discharge. Work is commencing first at the Royal London, and will be rolled out to Whipps Cross and Newham if the pilot is successful. Whipps Cross is also setting up two MADE events in March with place-based partners to support a reduction in discharge ready patients.
- **Pre-11am discharges**: Our pre-11 discharges have remained static at 13%, the unvalidated pre-11am discharge position of **Newham 9.4%, Royal London 15.2%, Whipps Cross 12.0%, St Bart's: 14.0%.** An audit is underway in our discharge lounges to ensure all patients that leave the ward are captured in real time to support this position.
- **Virtual ward programme:** The occupancy of our Virtual wards across the Trust continues to grow each month with Newham achieving 85% in January. Trust wide occupancy sits at 63%.

Cancer waiting times Benchmarking performance

Cancer Benchmarking Against Other Trusts

Mar-24



- In December 23, in the published Cancer Waiting Time Standards (CWT), Barts Health achieved 2 of the 3 cancer standards, FDS (76%) this was for the sixth consecutive month and 31 Day (96.3%) this was for the fifth consecutive month.
- As of the 18th February 24, North East London Cancer Alliance (NELCA) had the second lowest backlog at 6.4% with 485 patients waiting above 62 days.
- Barts Health backlog was 8% with 279 patients waiting over 62 days. The trusts drive to five programme continues to monitor progress to deliver plans set out in H2 by March 31st 24.
- The trust has commenced capacity and demand modelling on the first new referrals, previously referred to as 2 Week Waits. This has been started at WXH due to the volume received there. This will then be rolled out to all hospitals to help improve this standard which is monitored internally. It will also help with improving FDS performance

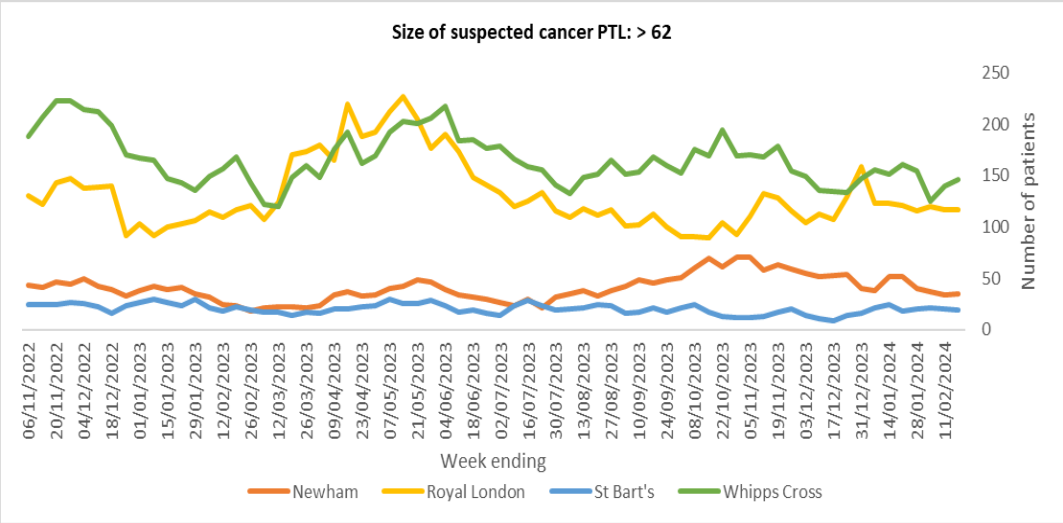
11-Feb	Over 62 days	Change in last week	% of Total PTL	Total PTL
North East London	**481**	**+6**	**6.5%**	**7456**
North Central London	646	+6	**7.3%**	8890
South East London	727	**-96**	**8.6%**	8433
West London	829	**-58**	**5.9%**	14109
England	**20786**	**-967**	**8.8%**	235284

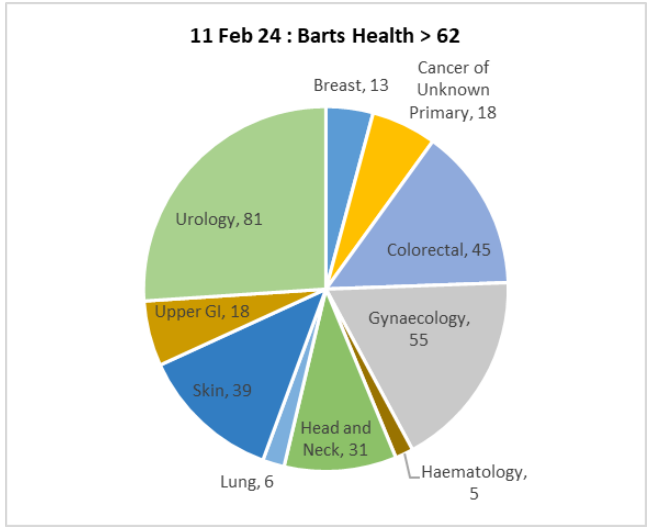
11-Feb	Over 62 days	Change in last week	% of Total PTL	Gap from NEL Over 62day Trajectory
North East London	**481**	**+6**	6.5%	24
Barking	**174**	**-2**	5.5%	29
Barts Health	**282**	+8	8.1%	76
Homerton Univ	**25**	+0	3.1%	0
London	**2683**	**-142**	6.9%	

RESPONSIVE
Cancer

Cancer > 63 Waiting List Backlog

Mar-24





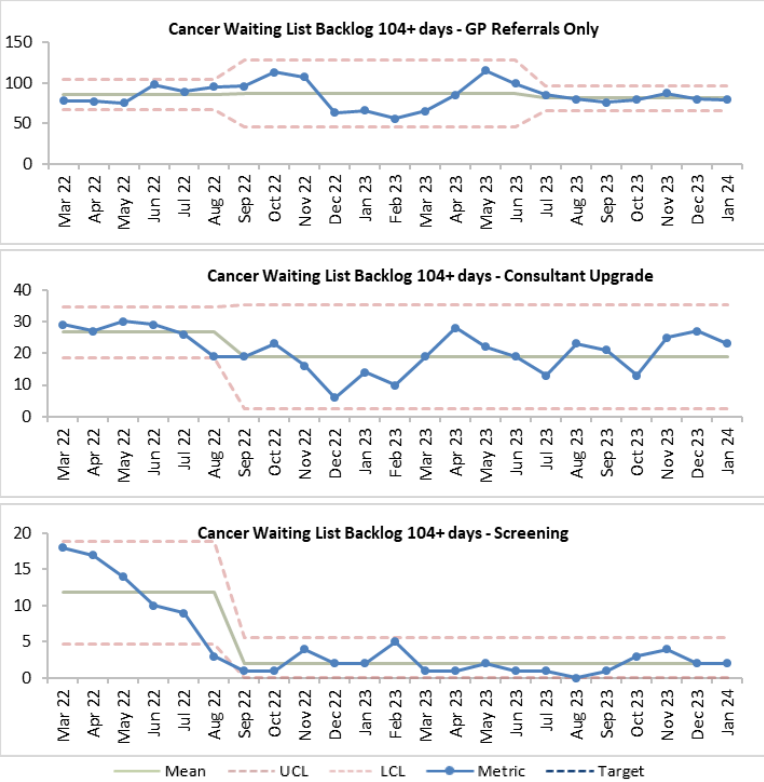
Trust Responsible Director Update

- The overall backlog for the trust is 8% for GP referrals as of 18th February 2024.
- RLH has a backlog of 11.5% (116 patients) which needs reducing to 80 to achieve their 7% target.
- WXH has a backlog of 8.5% (155 patients) which needs to reduce to 138 to achieve their 7% target.
- SBH & NUH are achieving their backlog of 7% and pushing to 5% to support the Trust's overall target.
- The tumour groups with the biggest backlog continue to be in Urology, Colorectal, Gynae and Skin all of which have plans to improve, which are detailed in the next slides.

RESPONSIVE
Urgent & Emergency Care

Cancer 104+ Waiting List Backlog

Mar-24



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 (a standard of 90%) or by a consultant upgrading the urgency of the referral (a standard of 85%) should be treated within 62 days. Historically performance against each of the standard components has been reported separately with the headline measure those patients referred by their GP.

During August NHS England announced a change to cancer waiting time standards, replacing the current set of three 62-day standards with one headline measure, the aggregate performance of all three components. The change in reporting is applicable from 1st October.

The NHS has made it a priority to clear the backlog of patients waiting longer than 62-days with the number of patients waiting no greater than at the start of the Covid pandemic by March 2024.

What is the Chart Telling us:

The three charts break out 62-day backlog for All referrals as well as for Consultant Upgrade and Screening referrals. 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 July 2022.

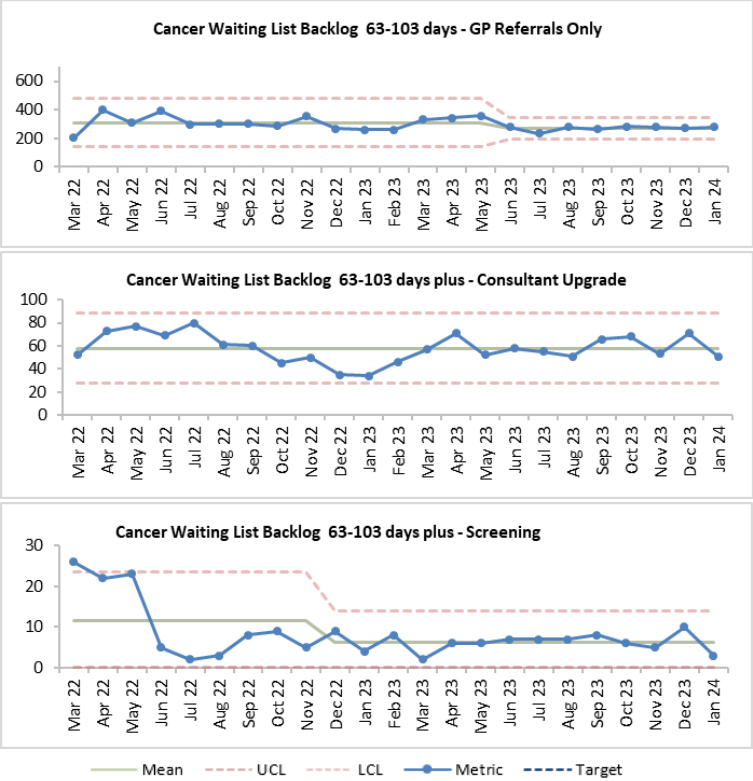
Trust Performance Overview

The charts represent the 104 cancer pathways with patients waiting greater than 104 days at the end of January 24, a decrease of five against the December position of 109. The charts present the number of patients waiting by GP referrals (79), Consultant Upgrade (23) and Screening service referrals (2). This represents all patients waiting 104 days and above. All these patients will go through the clinical harm review process, once treated.

RESPONSIVE
Cancer

Cancer 63 -103 Waiting List Backlog

Mar-24



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 (a standard of 90%) or by a consultant upgrading the urgency of the referral (a standard of 85%) should be treated within 62 days. Historically performance against each of the standard components has been reported separately with the headline measure those patients referred by their GP.

During August NHS England announced a change to cancer waiting time standards, replacing the current set of three 62-day standards with one headline measure, the aggregate performance of all three components. The change in reporting is applicable from 1st October.

The NHS has made it a priority to clear the backlog of patients waiting longer than 62-days with the number of patients waiting no greater than at the start of the Covid pandemic by March 2024.

What is the Chart Telling us:

A reducing step-change for 63+ day backlog resulting from Screening service referrals is visible in the data. However, despite some data variability, the volume of backlog for Consultant Upgrade and GP referrals is remaining relatively consistent across the last 6-months.

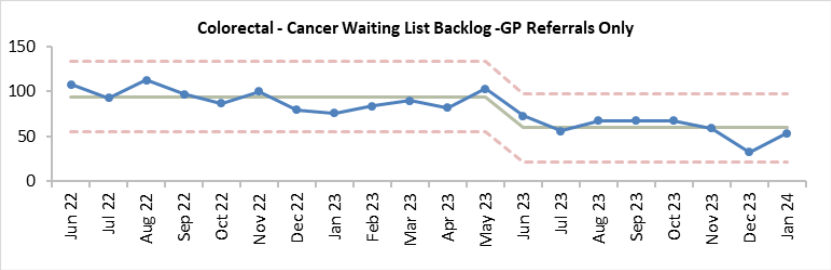
Trust Performance Overview

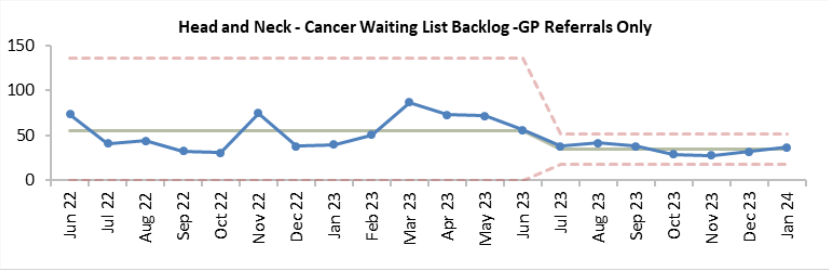
The charts represent the 306 cancer pathways waiting between 63 – 103 days at the end of January 24, a decrease of six against the December position of 312. The charts present the number of patients waiting by GP referrals (253), Consultant Upgrade (50) and Screening service referrals (3). This represents all patients waiting between 63 – 103 days.

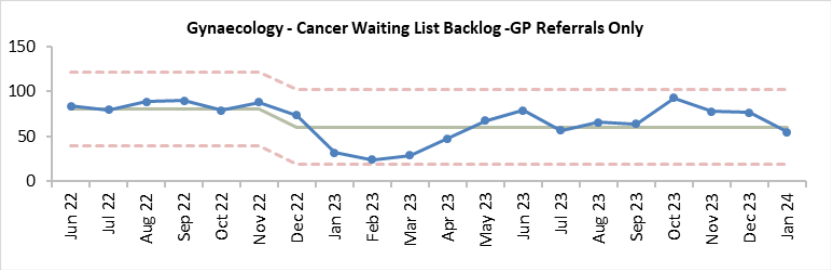
RESPONSIVE
Cancer

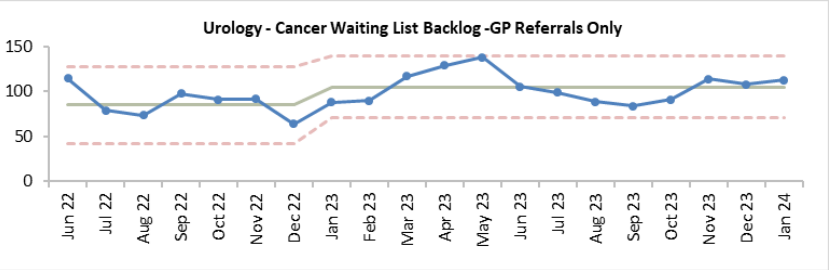
Cancer Waiting List Backlog Improvements

Mar-24







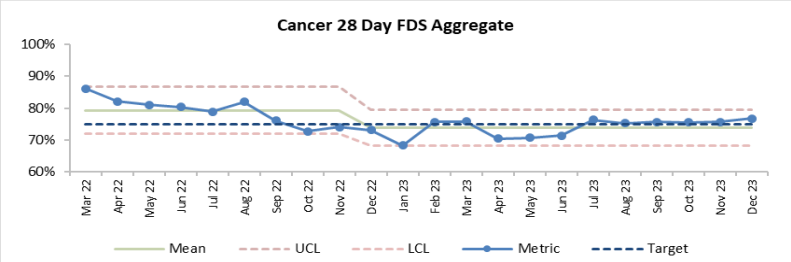


Commentary

- The Trust monitors all patients waiting over > 62 days, which is broken down in > 104 days then 63-103 days. All breaches go through the Trust's clinical harm review process. A paper was presented to the Quality Board which covered all Elective Standards on 15th February and the board was assured with the process and plans in place.
- There have been several improvements made within within Urology, Gynae, Colorectal & ENT, all have improvement plans which report into the drive to five programme. Key actions have been taken forwards. For Gynae additional theatre sessions have been secured in March. Capacity and demand has been reviewed within ENT and extra sessions have been put on for patients that require colonoscopy. Urology has put on additional template biopsy capacity and is looking to reduce this further in line with the best practice timed pathway, as well as explore one point of access for all new referrals coming into the trust.
- The biggest risk in the backlog is histopathology turnaround times, due to workforce shortages. The additional escalation route is working well after being refreshed in January 24. The partnership has recruited an additional two Gynae Histopathologists which should be in post by April 24. The Histopathology board launched in February and monitors waiting times, reporting into the Acute Provider Collaborative (APC). The Project Manager has several key tasks being worked through that should see an impact from Q1 onwards.

RESPONSIVE

Cancer Faster Diagnosis Standard Metrics (FDS) Mar-24



	Nov-23			Dec-23		
Metric Name	Seen	Breaches	%	Seen	Breaches	%
Cancer 28 Day FDS Aggregate	3,234	787	75.7%	2685	625	76.7%
Cancer 28 Day FDS Breast Symptomatic	169	8	95.3%	205	5	97.6%
Cancer 28 Day FDS Screening	11	1	90.9%	10	7	30.0%

Breakdown by Tumour Sites Failing 28 Day FDS Standard (Agrregate) - Dec-23			
Tumour Site	Seen	Breaches	Performance
All Tumour Sites	**2,685**	**625**	**76.7%**
Lung	55	14	74.5%
Testicular	23	7	69.6%
Upper Gastrointestinal	191	61	68.1%
Gynaecological	251	88	64.9%
Lower Gastrointestinal	469	209	55.4%
Haematological	11	5	54.5%
Urological	222	124	44.1%
Other	10	6	40.0%

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.

During August NHS England announced a change to cancer waiting time standards, replacing the current set of three Faster Diagnosis Standards with one headline measure, the aggregate performance of all three components. The change in reporting is applicable from 1st October.

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 a later slide.

What is the Chart Telling us:

The chart presents performance against the Aggregate element of the standard. For the period February 2022 to December 2022 compliance was achieved against the 75% standard, however the Trust was non-compliant for the period January 2023 to June 2023. Since July 23 the trust achieved compliance each month with 75.6% recorded in the most recent month, November.

Trust Performance Overview

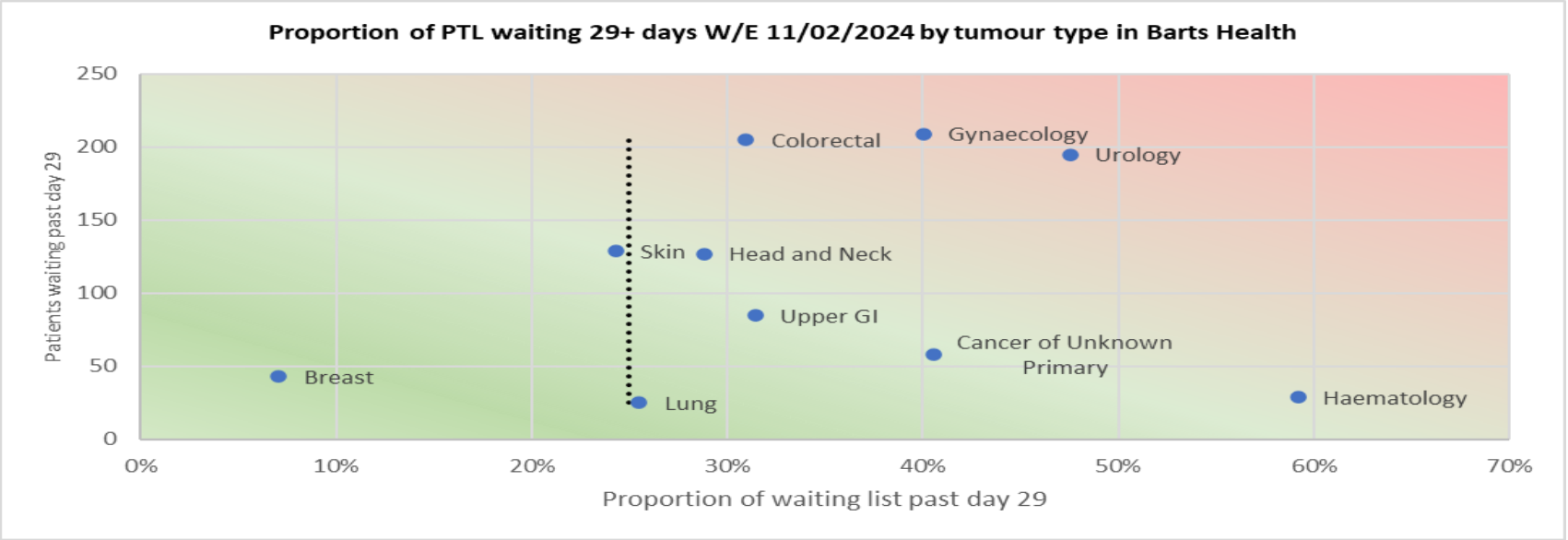
Trust Responsible Director Update

- The trust achieved aggregated FDS performance at 76% for the sixth consecutive month. The provisional data for January is over 75%.
- The screening standard was challenged in December with 7 breaches due to patient choice. This is not a risk in January 24.
- The FDS standard is challenged within the 2ww element with performance just below 75% which is made up of non-compliance in Urology, Colorectal, Gynae, Lung & Upper Gastrointestinal. All these areas have the Best Practice Time Pathway which the trust is looking to implement through the NEL Funded Operational Improvement Managers. There have been delays in bringing this additional management capacity together, due to sickness and one post needing to be re-advertised.
- There had been delays in the testicular pathway leading to breaches in the FDS. Non-Specific Symptoms delays were due to capacity shortfalls which are being addressed locally.

RESPONSIVE

Cancer Faster Diagnosis Standard Heat Map

Mar-24

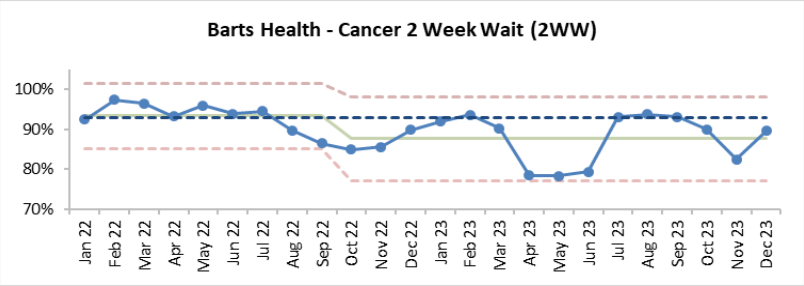


Barts Health		Breast	Cancer of Unknown Primary	Colorectal	Gynaecology	Haematology	Head and Neck	Lung	Other (Brain, Other or Paediatric)	Skin	Upper GI	Urology	Total
Maximum tolerance (% waiting 29+ days)		10%	25%	25%	25%	25%	25%	15%	25%	10%	25%	25%	25%
Current Week	11/02/2024	-18	22	40	79	17	17	10	-1	76	18	93	171
Week prior	04/02/2024	-15	35	40	39	16	3	5	0	91	9	87	144
Jan-24	28/01/2024	-5	56	72	48	15	16	9		112	1	109	284
Dec-23	31/12/2023	21	66	98	120	9	73	18	1	127	25	171	572
Nov-23	03/12/2023	0	44	64	103	2	72	9	1	141	7	153	411
Oct-23	29/10/2023	-10	32	72	140	7	59	14	2	126	13	132	403
Sep-23	01/10/2023	14	19	105	104	1	4	13	-1	117	9	98	295

RESPONSIVE

First New Report

Mar-24



Cancer 2WW Breakdown by Site - Dec-23

Site	Seen	Breaches	Performance	Target
Royal London	823	61	92.6%	93.0%
Whipps Cross	1,401	226	83.9%	93.0%
Newham	480	13	97.3%	93.0%
St Bart's	261	7	97.3%	93.0%
Barts Health	**2,965**	**307**	89.6%	**93.0%**

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

Tumour Site	Seen	Breaches	Performance
All Tumour Sites	**2,965**	**307**	**89.6%**
Brain/CNS	3	3	0.0%
Breast	587	169	71.2%
Lung	52	11	78.8%
Head and Neck	419	42	90.0%
Gynaecological	345	30	91.3%
Upper Gastrointestinal	199	14	93.0%

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 consistent delivery of the two-week standard across December 21 to July 22, performance drops below the standard for the period August 22 to January 23. A period of exceptionally low performance (although the lower confidence limit is not breached) is recorded across April to June 23. Recovery against the standard is then achieved rapidly between July and September 23, however performance has reduced below the standard for the two most recent data points, October and November 23.

Trust Performance Overview

In November 2023 a performance of 82.5% was recorded in relation to the 2 week wait standard, set at 93%, a reduction of 7.5% against October's 90.0%. Breaches of the standard increased from 356 in October to 682 in November (+326), the number of patients seen increased from 3,556 to 3,888 (+332).

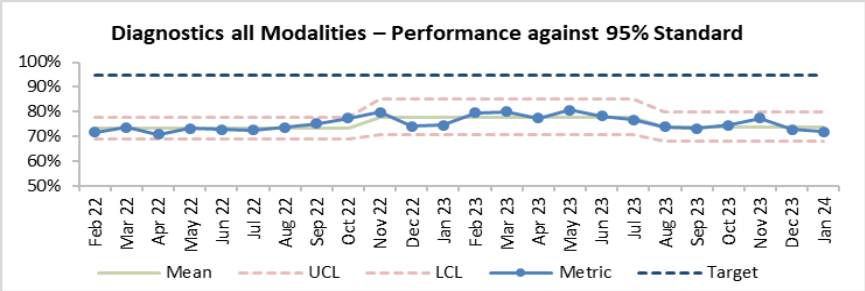
Trust Responsible Director Update

- The trust continues to monitor internally the First New Position (Previously 2WW), with performance being at 89.6% and compliance at only two Hospitals.
- The January position is at 86.1% but for February to date the trust is compliant at 93.9%
- The key pathways which were not compliant were within Breast, ENT, Gynae, followed by UGI and Lung. There has been a recording issue within Brain.
- The trust has made some further enhancements to the First New Report which continues to be used along with the updated SOP.

RESPONSIVE

Diagnostic Waits Over 6 Weeks

Mar-24



Trust Performance Overview

- For January 2024, a performance of 71.9% was recorded, a decrease of 0.9% against December's 72.8%.
- During January, 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, with those specialties contributing 83% of all breaches.

Indicator Background:

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

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

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

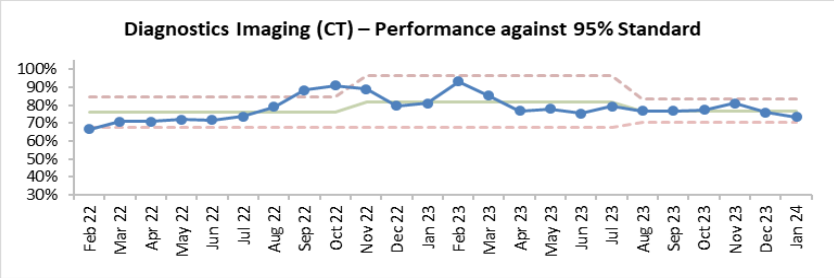
What is the Chart Telling us:

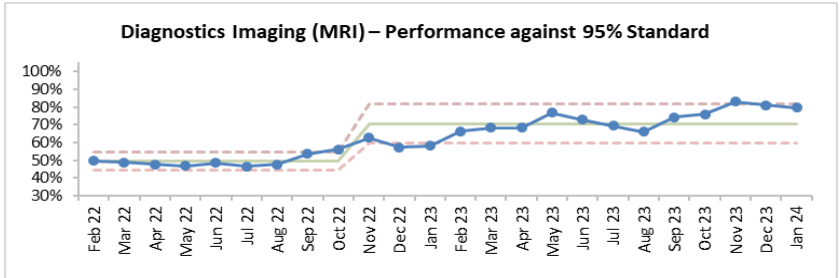
An increasing step-change may be observed from October 22. This suggests a point in time where process changes were driving performance improvement. However, a reducing step-change is visible from June 23, suggesting a slow-down in relation to service recovery, this is associated with both the winter period and a number of periods of doctor industrial action.

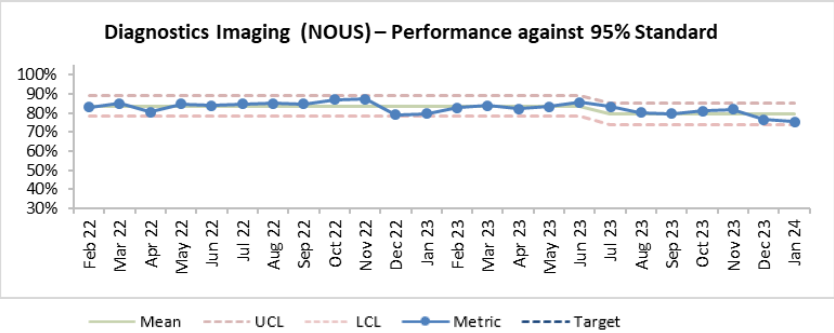
RESPONSIVE

Diagnostic Imaging Waits Over 6 Weeks

Mar-24







DM01 Breakdown by Test

	Dec-23			Jan-24			
Test Name	**Waiting**	**Breaches**	**Performance**	**Waiting**	**Breaches**	**Performance**	**Variance in Performance**
DEXA Scan	1,127	229	79.7%	1,167	365	68.7%	-11.0%
Computed Tomography	4,001	964	75.9%	4,065	1,087	73.3%	-2.6%
Non-obstetric ultrasound	17,513	4,138	76.4%	18,604	4,563	75.5%	-0.9%
Magnetic Resonance Imaging	4,902	927	81.1%	5,052	1,031	79.6%	-1.5%
Grand Total	**27,543**	**6,258**	**77.3%**	**28,888**	**7,046**	**75.6%**	**-1.7%**

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

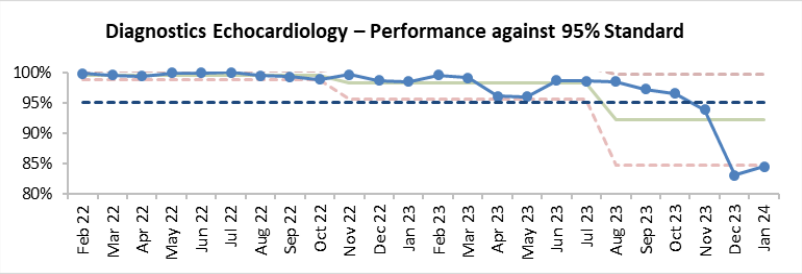
Trust Responsible Director Update

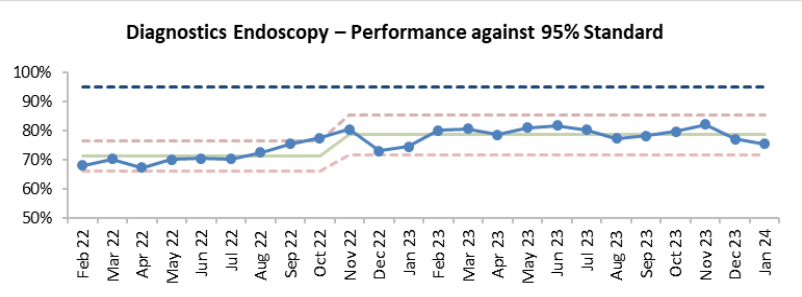
- Overall group imaging performance remains challenged, but there has been decrease in performance of 1.7% from December 23 to January 24. The main area of challenge are Dexa and CT at the RLH which saw an increase is patient choice which resulted in increased breaches in Ianuary. Work continues within non-obstetric ultrasound (NOUS) which has made progress since the deep dive at ERB in the past few months.
- The Community Diagnostic Centre at Mile End has seen an additional 40,000 diagnostics tests since launching in April 23 within MRI, CT, X Ray and Ultrasound. Support has been provided within the group to help hospitals clear their backlogs. Building work on Thames Ward is underway and due to be completed in winter 24. A presentation was given to Elective Recovery Board (ERB) in February and will be monitored through the Elective Recovery Weekly (ERW) meeting.
- A detailed review of imaging reporting turnaround times is underway which will be presented to ERB in the coming two months.

RESPONSIVE

Other Diagnostic Waits Over 6 Weeks

Mar-24





DM01 Breakdown by Test							
	Dec-23			Jan-24			
Test Name	Waiting	Breaches	Performance	Waiting	Breaches	Performance	Variance in Performance
Neurophysiology - peripheral neurophysiology	381	250	34.4%	400	331	17.3%	-17.1%
Cardiology - Electrophysiology	4	3	25.0%	5	4	20.0%	-5.0%
Urodynamics - pressures & flows	46	28	39.1%	78	58	25.6%	-13.5%
Audiology - Audiology Assessments	2,641	1,979	25.1%	2,546	1,797	29.4%	4.4%
Cystoscopy	562	338	39.9%	488	298	38.9%	-0.9%
Respiratory physiology - sleep studies	185	31	83.2%	115	28	75.7%	-7.6%
Gastroscopy	882	270	69.4%	928	205	77.9%	8.5%
Flexi sigmoidoscopy	193	36	81.3%	175	35	80.0%	-1.3%
Cardiology - echocardiography	1,989	338	83.0%	1,713	266	84.5%	1.5%
Colonoscopy	913	86	90.6%	820	99	87.9%	-2.7%
Grand Total	**7,796**	**3,359**	**56.9%**	**7,268**	**3,121**	**57.1%**	**0.1%**

NB: Imaging Modalities are shown on the preceding slides

Trust Responsible Director Update

- Physiological Measurements and Endoscopy continue to be challenged within the trust.
- A group wide review is underway for all diagnostic waits over 13-week waiters,including surveillance and planned patients.
- A Urodynamic and Endoscopy group continues to monitor and track progress. A more detailed plan on Endoscopy Utilisation is being worked up, to provide support within the trust and NEL.
- Paediatric Audiology outsourcing has been delayed. There have been weekly meetings in place since January to prepare the subcontract and paperwork. The trust is aiming to commence this in March 24. The Trust continues to put on additional extra sessions which has saw the backlog reduce by 500 cases since September 23. A paper was presented to the Quality Board in February, looking to develop a plan for the longer-term strategy of the service.

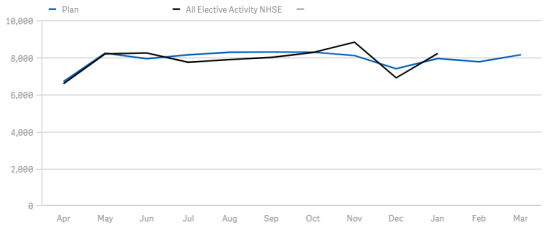
RESPONSIVE
Elective activity

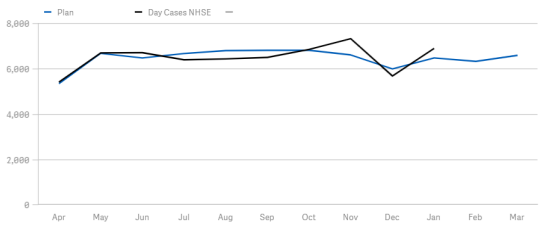
Admitted Activity against Plan

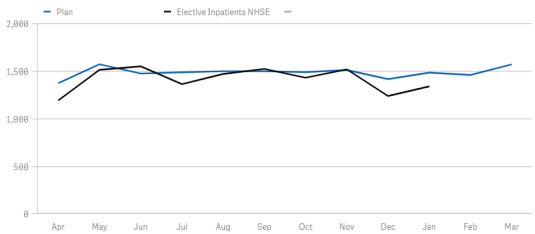
Mar-24

Admitted Elective Activity

		Barts Health						Last Month's Site Position			
		Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Royal London	Whipps Cross	Newham	St Bart's
All Elective Activity	Plan	8,308	8,324	8,312	8,132	7,420	***7,970***	*3,894*	*1,770*	*1,188*	*1,118*
	Actuals	7,913	8,032	8,294	8,853	6,925	***8,245***	*4,007*	*1,480*	*1,056*	*1,702*
	Mth variance plan	*-395*	*-292*	*-18*	*721*	*-495*	*275*	*113*	*-290*	*-132*	*584*
Elective Day Case Activity	Plan	6,807	6,823	6,822	6,618	6,002	***6,484***	*3,290*	*1,471*	*1,006*	*717*
	Actuals	6,441	6,507	6,861	7,333	5,685	***6,904***	*3,479*	*1,246*	*928*	*1,251*
	Mth variance plan	*-366*	*-316*	*39*	*715*	*-317*	*420*	*189*	*-225*	*-78*	*534*
Elective IP Activity	Plan	1,500	1,500	1,491	1,514	1,418	***1,486***	*604*	*299*	*182*	*401*
	Actuals	1,472	1,525	1,433	1,520	1,240	***1,341***	*528*	*234*	*128*	*451*
	Mth variance plan	*-28*	*25*	*-58*	*6*	*-178*	*-145*	*-76*	*-65*	*-54*	*50*







Data As at 28/02/2024

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 January 2024, the trusts admitted (inpatient and day case) trajectory set a target of 7,970 admissions against which the trust delivered 8,245 (+275 admissions).	• The validated RTT for January 2024 was 119,013. This is an increase of 14 pathways from the validated position in December 2023. • For the February period of industrial action, 141 day case or in-patient electives have been cancelled. The final situation report on cancellations for this period of industrial action will be submitted by 29.02.24. All Hospitals have been able to run more elective activity than in previous periods of industrial actions focusing on P2, cancer and long waiting cases. • The monthly elective recovery board continue to track elective activity and value weighted activity • Hospitals have been working to maintain elective activity despite pressures in urgent care

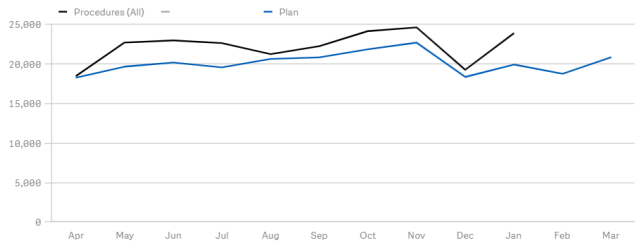
RESPONSIVE
Elective activity

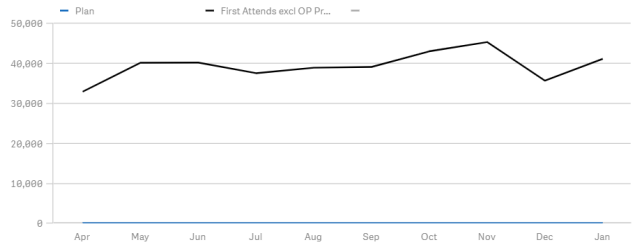
Non Admitted Activity against Plan

Mar-24

Outpatient Activity

		Barts Health						Last Month's Site Position			
		Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Royal London	Whipps Cross	Newham	St Bart's
Total OP Activity	Plan	125,187	130,476	130,236	135,097	119,630	**125,264**	*52,895*	*29,497*	*20,050*	*22,822*
	Actuals	133,543	134,558	143,160	152,003	119,203	**145,123**	*60,305*	*33,640*	*23,161*	*27,924*
	Mth variance plan	*8,356*	*4,082*	*12,924*	*16,906*	*-427*	***19,859***	*7,410*	*4,143*	*3,111*	*5,102*
Outpatient First	Plan	35,354	36,846	36,780	38,152	33,788	***35,378***	*14,680*	*11,102*	*4,849*	*4,747*
	Actuals	38,907	39,105	43,017	45,324	35,677	***41,110***	*17,003*	*12,391*	*5,624*	*6,092*
	Mth variance plan	*3,553*	*2,259*	*6,237*	*7,172*	*1,889*	***5,732***	*2,323*	*1,289*	*775*	*1,345*
Outpatient F/up	Plan	89,833	93,630	93,456	96,945	85,842	***89,886***	*38,215*	*18,395*	*15,201*	*18,075*
	Actuals	94,636	95,453	100,143	106,679	83,526	***104,013***	*43,302*	*21,249*	*17,537*	*21,832*
	Mth variance plan	*4,803*	*1,823*	*6,687*	*9,734*	*-2,316*	***14,127***	*5,087*	*2,854*	*2,336*	*3,757*





Data As at 28/02/2024

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 125,264 attendances, against which the trust delivered 145,123 (+19,859 attendances).	• For the February 24 period of industrial action, 823 outpatient appointment have been cancelled to date. • As of 26.02.24, there are 112,459 individuals enrolled onto Patient Knows Best (PKB). Pathology results access has now gone live and the next phase will be to provide access to Radiology reports. Test messages are being sent to around 700,000 individuals to encourage them to opt into access of the system. Advertising has start in local newspapers within Tower Hamlets and Newham to increase awareness. • A deep dive is being undertaken on appointment letters to seek assurance that these are readable and that patients are provided with accurate contact details. This work is expected to be complete before the end of March 24. • As part of the work around DNA reduction and mapping the outpatient ecosystem, the approach to text messaging will be reviewed to try and standardise this where possible across the organisation. • The work on the business case to support complete reprofiling of clinic templates across the organisation continues with a view to bringing the final case to the Elective Recovery Board in 2024. • The % of outpatient activity delivered virtually remains at 13.6%. The response to the remote consultation audit is being pulled together to be presented at ERB in March 2024. This includes producing guidance on the use of remote consultations for clinicians. • The Trust PIFU rate is currently at 1.63% of activity against the target of 5% . Work has started with operational and clinical leads to assess speciality readiness for PIFU, to be able to target central support to those identified and be able to progress. Imminent launch to go ahead in cardiology, immunology, Paeds and dietetics (NUH) and Geriatric medicine (RLH)

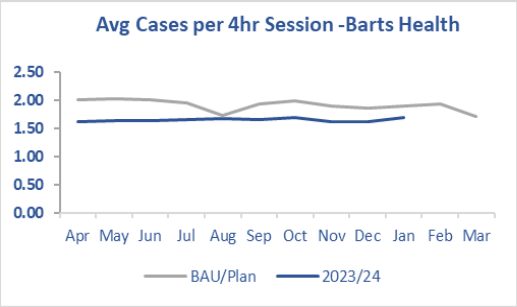
RESPONSIVE
Elective activity

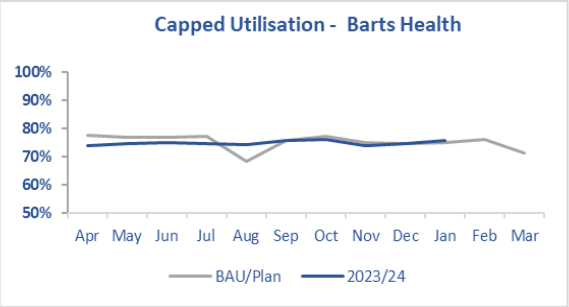
Theatre Efficiency

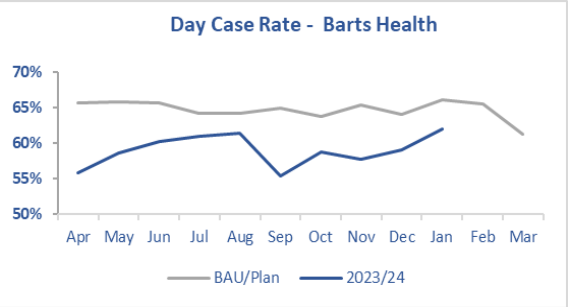
Mar-24

Theater Efficiency Activity

		Barts Health						Last Month's Site Position			
		Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Royal Londor	Whipps Cross	Newham	St Bart's
Avg Cases per 4hr Session	Actuals	1.68	1.66	1.69	1.61	1.62	1.70	1.54	2.14	1.99	0.99
	BAU	1.74	1.94	1.99	1.90	1.87	1.90	1.81	2.59	2.10	1.02
	Mth variance plan	*-0.06*	*-0.28*	*-0.30*	*-0.29*	*-0.24*	*-0.21*	*-0.27*	*-0.45*	*-0.11*	*-0.03*
Capped Utilisation	Actuals	74.3%	75.6%	75.9%	73.9%	74.6%	75.5%	76.1%	69.0%	74.2%	78.1%
	BAU	68.2%	75.7%	77.2%	75.0%	74.7%	74.9%	75.7%	74.5%	70.5%	74.4%
	Mth variance plan	6.2%	-0.1%	-1.3%	-1.1%	-0.1%	0.6%	0.4%	-5.5%	3.8%	3.7%
Day Case Rate	Actuals	61.4%	55.4%	58.8%	57.7%	59.0%	62.0%	59.0%	72.0%	73.7%	18.3%
	BAU	64.2%	64.0%	64.9%	63.7%	65.3%	64.0%	63.6%	77.5%	68.9%	17.7%
	Mth variance plan	-2.8%	-8.6%	-6.1%	-6.0%	-6.3%	-2.0%	-4.5%	-5.5%	4.8%	0.7%







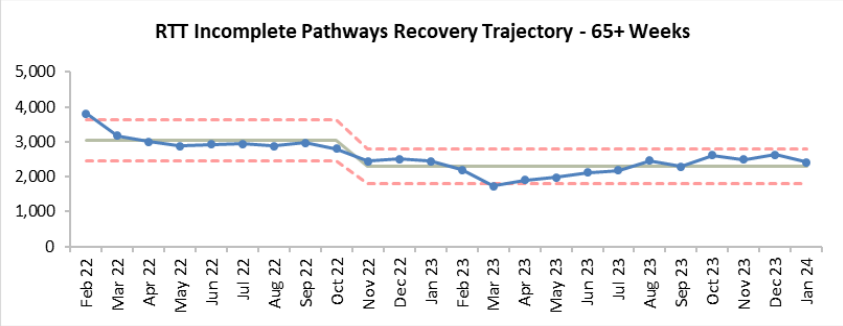
Data As at 13/02/2024

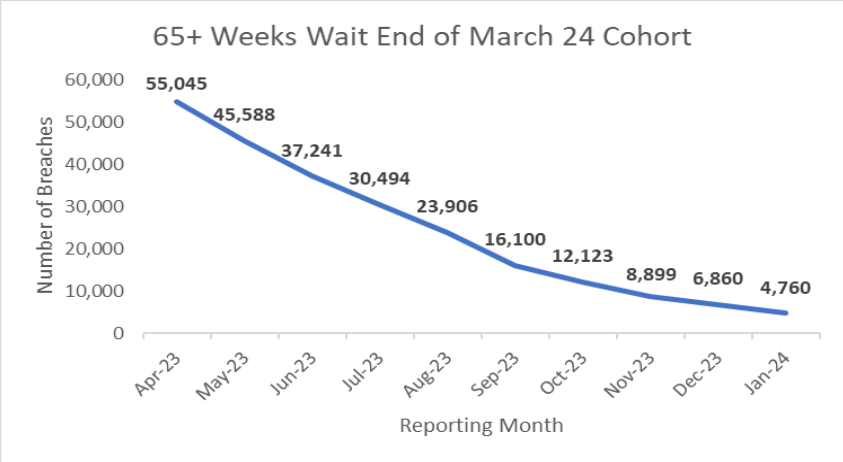
Performance Overview	Responsible Director Update
• Set against internal trust data for January 1.70 cases per list were achieved against a BAU of 1.90 (-0.21). • For the same month, a capped utilisation rate of 75.5% was recorded against a BAU of 74.9% (-0.6%). • For January a day case rate of 62.0% was recorded against a BAU of 64.0% (-2.0%).	• E-consent contract being reviewed with communication of the successful Supplier currently embargoed until contract has been signed. This is likely to be completed by early March 2024. The programme governance to support delivery will then be put in place which will include a programme board and delivery groups. A report on progress will be provided to the Elective Recovery Board (ERB) monthly meeting. • Roll out of the next phase of Care Coordination Solution (CCS) is expected to commence in April 2024. It was hoped this would be underway however there has been a slight delay which was outside of the control of the Trust. CCS use is now well embedded at Newham and the learning is being shared with the other Barts Health Hospital sites. • The next NEL Surgical Optimisation group is due to be hosted at RLH on 29.02.24. This group will discuss the plan on how the Targeted Investment funded (TIF) theatres that come on line at BHRUT (Q1 2024/25) and Homerton (Q1 2025/26) will be used as system assets to support elective activity across NEL. • Conversation on the Barts Health reset surgical optimisation group has taken place. Meeting to take place with key clinical and operational leads within the next 2/52 to agree next steps

RESPONSIVE

65+ Week RTT Activity

Mar-24





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 February 22 to March 23, driving a reducing step-change in September 22, this data suggest a period where process changes started to drive backlog reductions. However, increases in the volume of 65+ week wait patients have been recorded across the period April to December 23, with January 24 recording a decrease of 199 pathways against the December position.

The graph presents a view of the total end of March 65 week wait cohort from April 23 to January 24. This shows positive monthly reductions within this group of pathways.

Trust Performance Overview

For 2023/24 the NHS has set all trusts the objective of clearing 65+ week wait backlog volumes by March 2024. As part of H2 planning the trust committed to achieving 1500 pathways (without further Industrial action At the end of January, the trust recorded 2,419 pathways waiting 65+ weeks, a decrease of 209 against the December position.

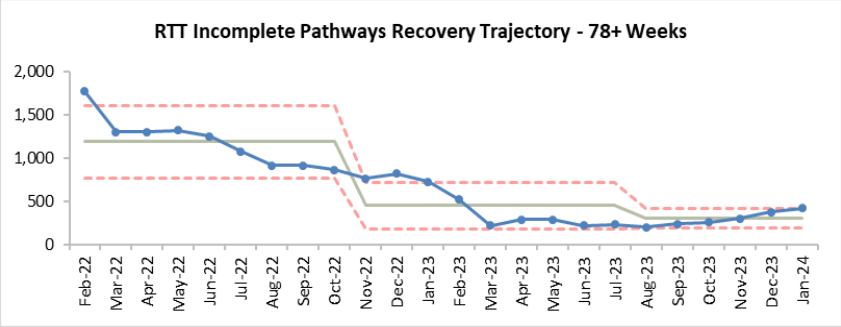
Trust Responsible Director Update

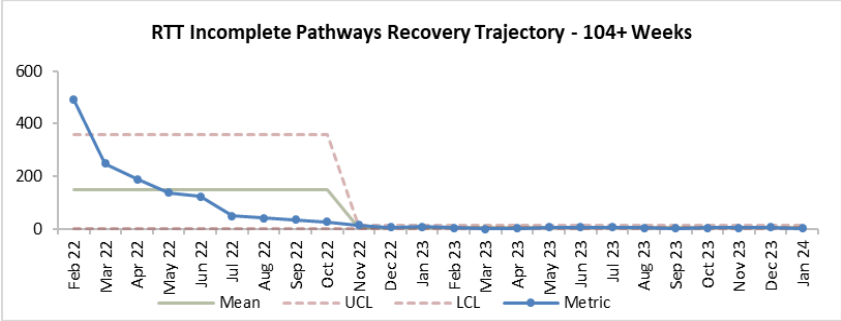
- The trust continues with a positive reduction in the total end of March 65 week wait cohort. The validated position for January 2024 showed that there were 4,760 pathways in this cohort which is a reduction of 50,285 pathways since April 2023.
- As of 31st January 2023, the Trust had 480 patients within this cohort that still required a first outpatient appointment to be booked. The largest volumes are in 2 specialties – Dermatology and Oral Surgery. Dermatology continue with insourcing support. They are booking in chronologically but with shorter notice than other specialties. Oral Surgery continues with collaborative capacity support from Homerton due to limited ability to increase capacity. Insourcing and further outsourcing opportunities continue to be scoped to mitigate this further.
- As part of the H2 planning submission, the trust submitted an exit position from 2023/24 with 1,500 65 week wait pathway remaining to clear. This was pre announcement of further industrial action which has now taken place in December, January and February. This forecast out turn is now estimated to be around 1995 pathways.
- Work is now being undertaken to gain assurance on the ability to achieve a position of 0 65 week waits by the end of September. This will be achieved through continued collaborative capacity support across North East London however there are some services which require regional speciality support for specific procedures e.g. Oral Surgery, T&O.

RESPONSIVE

78+ & 104+ Week RTT Activity

Mar-24





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 in both cases from October 22 and for 78+ also from July 23. This suggest points in time where process changes started to drive backlog reductions. However, 78+ week pathways have increased across the period September 23 to January 24.

Trust Performance Overview

- In relation to 78+ week wait backlog volumes, 427 pathways were reported at the end of January, an increase of 48 against the December position.
- In relation to the RTT month-end nationally submitted data the trust reported five pathways waiting 104+ weeks at the end of January 2024, seven less than reported at the end of December.

Trust Responsible Director Update

- Of the 5 pathways who were waiting over 104 weeks at the end of January 2024, 3 were related to Data Quality issues.
- A weekly escalation call remains with the Chief of Surgery to support confirming treatment plans for in month/ future month 104 ww risk patients.
- A daily call has been put in place to track the 78 week wait numbers, progress on booking/ confirmation of treatment plans and escalation of risks/ issues and requests for support.
- Based on the current run rate and mitigation actions there is a risk of around 160 78 week wait patients remaining at the end of March 24.
- Line by line reviews of patients continue across each Hospital site with review against application of the Trust access policy.
- ENT, Oral Surgery and T&O remain high risk pathways remaining at the end of March 25, as are dependent on collaborative capacity support at either a NEL or Regional level.

NHS
Barts Health
NHS Trust

People Report

WELL LED

Domain Scorecard

Mar-24

	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	Jan-24		38.8%	**38.9%**	35.8%	51.9%	58.9%	28.7%	34.2%	34.8%	40.0%
Supporting the wellbeing of our colleagues	Turnover Rate	Jan-24	<= 12.25%	10.4%	10.4%	10.9%	9.7%	9.6%	11.5%	13.1%	8.1%	11.3%
	Sickness Absence Rate	Dec-23	<=4%	4.45%	4.43%	4.41%	4.39%	4.80%	3.47%	4.21%	5.43%	4.30%
	Appraisal Rate - Non-Medical Staff	Jan-24	>= 90%	**57.9%**	**57.6%**	55.4%	67.4%	53.0%	69.3%	59.4%	43.8%	33.9%
	Appraisal Rate - Medical Staff	Jan-24	>= 85%	**82.2%**	**81.8%**	80.3%	82.2%	85.8%	82.4%			
	Mandatory and Statutory Training - All	Jan-24	>= 85%	**87.3%**	**87.4%**	85.5%	88.9%	86.8%	91.0%	87.2%		

	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 %	Jan-24	100%	**57.3%**	**64.3%**	40.0%	84.1%	64.5%	73.9%			
	Roster compliance - Nursing Average Approval Lead Time (Days)	Jan-24	>=42	**42.9**	**38.9**	36.0	41.6	37.8	40.7			
	Roster compliance - % Nursing Units with Blue or Cloudy Sky	Jan-24		**28.0%**	36.4%	28.9%	34.1%	51.6%	34.8%			
	Medical and Dental Job planning completion	Jan-24		**60.5%**	**67.0%**	53.6%	72.4%	76.2%	93.3%			
Growing a permanent and stable workforce	Substantive fill rate - all staff	Jan-24	95%	**92.5%**	**93.1%**	94.3%	91.2%	91.3%	97.4%	86.0%	89.6%	121.8%
	Substantive fill rate - nursing and midwifery	Jan-24	95%	**89.2%**	**90.6%**	92.4%	89.3%	86.8%	91.7%			
	Time to Hire (Advert to All Checks Complete) - Median Weeks (Non Medical)	Jan-24	10.4	**9.2**	**9.4**	9.6	9.4	9.7	9.6	5.8	8.8	
	Time to Hire (Advert to All Checks Complete) - Median Weeks (Medical)	Jan-24	15.00	**9.8**	**11.8**	12.0	12.7	12.4	10.6			
	Temporary staff as a % of workforce	Jan-24		**12.5%**	**13.0%**	11.1%	18.0%	19.6%	10.2%	0.3%	6.4%	15.2%
	Agency Spend as % Paybill (YTD)	Jan-24	3.70%	**4.30%**	**4.25%**	3.17%	5.24%	6.55%	2.20%	3.63%	6.81%	3.17%
	Agency Spend as % Paybill (In Month)	Jan-24	3.70%	**3.71%**	**3.76%**	2.24%	3.76%	5.97%	1.38%	5.02%	9.22%	2.24%

SUMMARY

People Summary

Mar-24

Fostering new ways of working to transform care:

Roster compliance – approval on time increased from 57.3% to 64.3% for rosters commencing in January with Whipps Cross Hospital continuing to have the highest level of on time approvals at 84%. The average lead time for approval reduced to 38.9 days and as such is below the 42 day target (42 days being 6 weeks in advance).

Roster compliance - % nursing units with blue or cloudy sky (a description of the combined performance of a range of metrics to give a view on the quality and assurance of the roster). At the point the rosters were due to be go live 36% of reported rosters achieved a blue or cloudy sky, a small improvement against the 28% report last month. The two main challenges for those divisions with the lowest level of compliance were around effective annual leave management (in some cases less than we would hope to see, in others more) and effective planned use of staff hours during the four week roster period.

Signed off **medical job planning** increased to 67.% in January from 60.5% at the end of December. The highest level of sign off is at St Bartholomew's at 93% followed by Newham at 76%, Whipps at 72% and Royal London at 54%. Of the job plans that have not been signed off just 13% remain at discussion stage and 19% are at 1st or 2nd sign off stage. Progress on signing off job plans continues and by mid February the overall rate was 73% with RLH achieving 63% at full sign off.

Supporting the wellbeing of our colleagues:

Overall annualised sickness absence saw a marginal decrease to 4.43% compared to 4.45% in the prior month and as such is stubbornly remaining around this level. Across the hospitals we are seeing marginal improvements (Newham 4.89% to 4.80%, St Barts 3.58% to 3.47%, The Royal London 4.49% to 4.41% and Whipps 4.44% to 4.39%), however in Group Support Services it increased to 5.43% from 5.35%

Recorded appraisals for non medical staff reduced marginally to at 57.6% from 57.9% whilst the **medical staff appraisal rate** reduced from 82.2% to 81.8%.

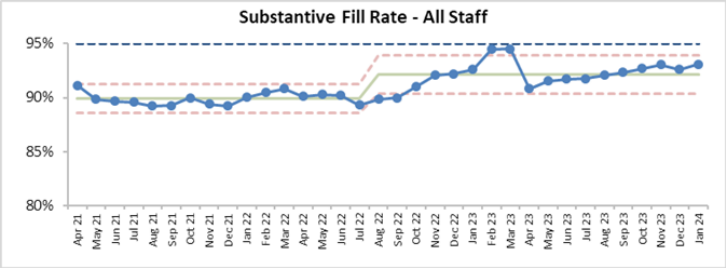
Statutory and Mandatory Training (all) compliance improved from 87.3% to 87.4% with more detail provided in the subsequent exception page.

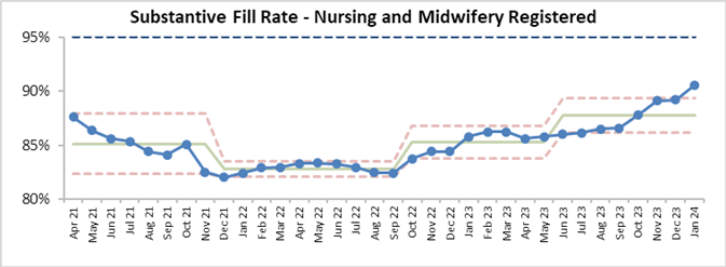
Annualised voluntary turnover has remined at 10.4%**.** There were some small variations on the previous month at hospital level with St Bartholomew's improving from 11.9% to 11.5%, The Royal London from 11.2% to 10.9% and Whipps from 9.8% to 9.7% whilst Newham saw a small increase in turnover from 9.4% to 9.6%.

PEOPLE

Growing a permanent and stable workforce

Mar-24





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 registered nursing and midwifery we are seeing improved fill rates month on month since April 23 with positive special cause variation for Nursing and Midwifery in January where the fill rate went from 89.2% to 90.6%

For all staff we saw an increase of the substantive fill rate to 93.1%

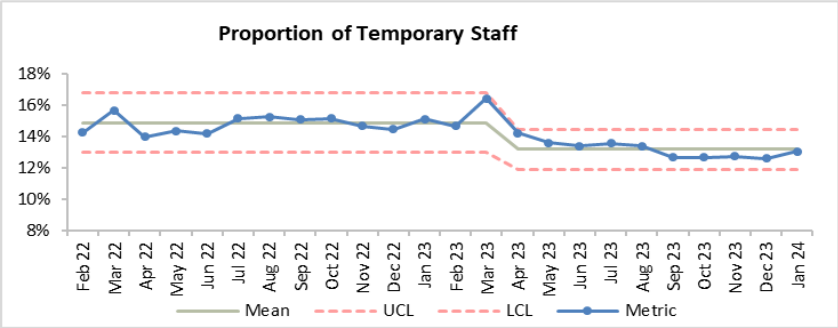
Commentary

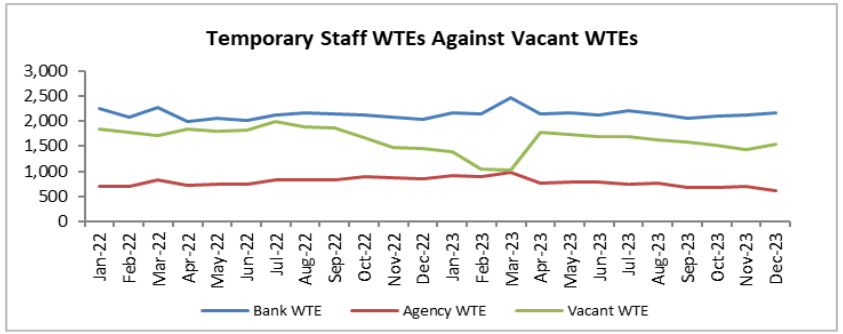
- In January we saw a small increase of 19 WTE budgeted establishment which combined with a notable increase of 120 contracted WTE resulted in the overall reported fill rate increasing from 92.6% to 93.1%.
- The growth in staff in post is primarily with registered nursing and midwifery with an increase of 66 WTE, including 23 newly qualified nurses, and 28 nurses awaiting full registration working as HCAs.
- All four main hospital sites saw a growth in staffing, with the most significant being at The Royal London with 70 WTE, followed by St Bartholomew's with 35 WTE.
- The nursing fill rate has continued to increase to 90.6% with both St Bartholomew's and The Royal London exceeding 91%.
- Time to hire for non-medical staff was at 9.4 weeks and for medical staff it was 11.8 weeks, both meeting their respective targets at group and site level.

WELL LED

Proportion of Temporary Staff

Mar-24





Proportion of Temporary Staff by Site

		Average of Previous 6 Months			Jan-24			
Site	Staff Group	Bank & Agency WTE	All Used WTE	%	Bank & Agency WTE	All Used WTE	%	Variance
Royal London	All Staff Groups	1,031	7,478	**13.8%**	954	7,552	**12.6%**	**-1.2%**
Whipps Cross	All Staff Groups	652	3,734	**17.5%**	687	3,815	**18.0%**	**0.6%**
Newham	All Staff Groups	532	2,741	**19.4%**	555	2,830	**19.6%**	**0.2%**
St Bart's	All Staff Groups	366	3,262	**11.2%**	340	3,346	**10.2%**	**-1.1%**

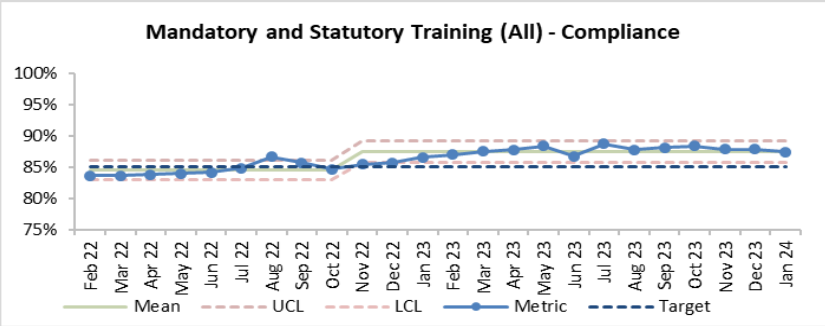
Commentary

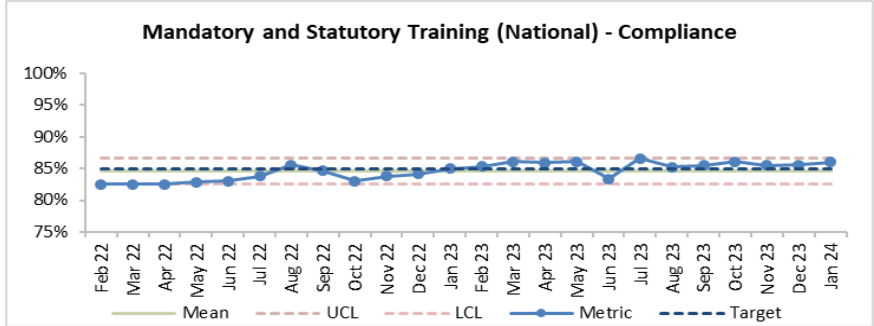
- The proportion of temporary staff used increased to 13.0% from 12.6%, reflecting an increase 128 WTE to 2,903 WTE in total, of which 2246 WTE is bank and 657 WTE is agency.
- In part this increase reflects a return to normal demand following the Christmas period and is also partly driven by greater demand for strike cover, however despite continued substantive growth, especially in our nursing workforce, we are not seeing the benefits of this with reduced demand for temporary cover. A piece of work has been started to look at the top 25 areas of demand and how this relates to vacancies and recruitment activity to see if further support can be put in place.
- Agency spend as a % pay bill reduced to 4.25% YTD from 4.30%, although continues to exceed the 3.7% target. In month it was 3.76%, up from 3.71% in the previous month however in month figures are subject to fluctuation due to the flow of invoices. The four hospital sites are all showing in month agency spend as a proportion of pay bill lower than the YTD figure, however group support services remains challenged with a significant amount of agency usage in our Soft FM services.

WELL LED

Mandatory and Statutory Training

Mar-24





Bottom 5 Competencies: Total Number of Non-Compliant Employees

Competency	Previous 6 Months	Jan-24	
	Compliance	Compliance	Staff Non-Compliant
Fire Safety	84.3%	83.8%	3,374
Safeguarding Children L2	78.0%	78.2%	2,946
Resuscitation - Basic Life Support	78.2%	77.6%	2,625
Infection Control (Clinical)	81.2%	79.3%	2,521
Moving Handling - Clinical	84.4%	84.2%	2,091

Bottom 5 Departments: Total Number of Non-Compliant Employees

Departments	Previous 6 Months	Jan-24	
	Compliance	Compliance	Staff Non-Compliant
RLH - Cleaning (Other)	74.5%	81.1%	96
NUH - Cleaning (Other)	58.1%	79.7%	79
BHRUT Patient Transport (Other)	13.7%	43.3%	73
Restorative Dentistry (Royal London)	65.7%	63.6%	70
8D - NICU (Royal London)	83.5%	81.5%	64

Non-mandatory competencies have been excluded from the above tables

Performance Overview

- Compliance with the Core Skills Training Framework currently stands at 86.30%, an increase of 0.50% from the last Board report and is above the Trust target of 85% this month. Essential Skills training compliance has decreased by 1.2% from 90.39% to 89.19% in January 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 3.
- Staff transferring from Serco have made exceptional progress in undertaking training with only the cleaning staff below the Trust target and it is expected that this will exceed 85% by the end of 2023/24.
- The WIRED system currently monitors training for 21,798 staff and 511,886 compliance items.

Responsible Director Update

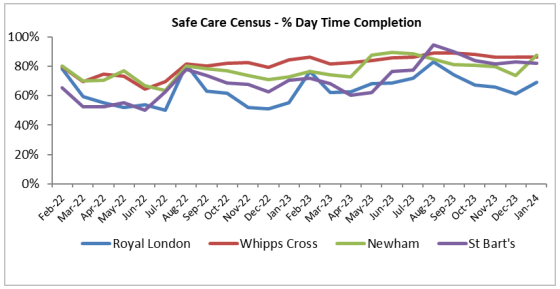
- BHRUT Transport have made great progress in undertaking training with the expectation that compliance will hit 70% by end of March 24 from a baseline of 0%.
- The Oliver McGowan Mandatory Training for Learning Disabilities and Autism part 1 is now live on all staff profiles. Progress towards the85% target will be provided in future Board reports.
- The training needs analysis for moving and handling will be changing for the Trust to align with the Core Skills Training Framework. This will have a major effect on compliance rates as the refresher period for inanimate loads training will reduce from 5 to 3 years. Further information will be available in site PR packs.
- Monthly reminders continue to be sent to all staff who are non-compliant or due to expire shortly and statutory and mandatory training is a key element of site PR packs

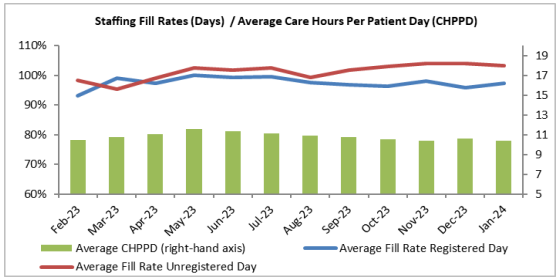
SAFE STAFFING

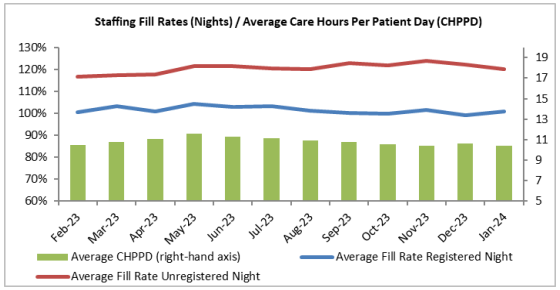
Safe Staffing

Mar-24

- The Trust's average fill rates on both day and night shifts for both Registered Nursing and Midwifery (RNs/RMs) and for Care Staff (HCAs) remained above 95%.
- Fill rates for our 4 hospitals continued to remain above 90% target for both day and night shifts for RNs/RMs and for HCAs trust-wide.
- The overall average Care Hours Per Patient Day (CHPPD) were stable at 10.4 same as last month December. The CHPPD remain above last published peer averages (9.0, 'recommended peers'; 8.7 'region'; November 2023). CHPPD data is less useful at organisation level - the high number of specialist and critical care units within the Barts Health Group will result in high overall CHPPD.
- The changing health needs of our patients remain high due to the increased utilisation of Enhanced care costs in most areas. All Hospitals are ensuring that demand is assessed in line with policy and that 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.
- Nursing Red Flag incidents(RFIs) captured on Datix on were 5, an increase of 1 from December's value of 4. Maternity captured 173 RFIs via Birthrate plus compared to 128 last month. This reflected an increase of 28%. It should be noted that the criteria for Red Flags differs between maternity and nursing, with the maternity system including a broader range of triggers. The incidents were reported as not resulting in harm.
- Red Flag data collection, reporting and governance processes for nursing are being updated following discussion at NMAHP Board in September. Enabling work is under way , with the new process due to be piloted in March with a view of going Live in April.
- Recruitment activity continues across our 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 had dipped slightly in its trajectory on Safe Care with day-time census compliance but has increased to 80.1% from 75.5%. Compliance is being monitored daily to support continuous improvement.
- Outputs reviewed at site safety and staffing huddles to support deployment decisions







Staffing Figures by Site - Jan-24

Site	Average Fill Rate (Day)		Average Fill Rate (Night)		Average Care Hours Per Patient Day (CHPPD)	Safe Staffing Maternity Red Flag Incidents	Safe Staffing Nursing Red Flag Incidents
	Registered Nurses / Midwives (%)	Care Staff (%)	Registered Nurses / Midwives (%)	Care Staff (%)			
Trust	97.2%	103.3%	100.9%	120.0%	10.4	5	173
Royal London	99.0%	103.9%	104.0%	132.4%	10.4	1	127
Whipps Cross	96.5%	104.5%	100.0%	110.8%	9.7	0	19
Newham	102.5%	105.4%	106.8%	115.6%	10.0	3	30
St Bart's	89.8%	95.8%	90.9%	117.9%	12.4	1	0

NHS
Barts Health
NHS Trust

Finance Report

EXECUTIVE SUMMARY

Finance Executive Summary

Mar-24

- The Trust is reporting a £27.1m deficit for the year to date at month 10, this is (£3.7m) adverse against original plan. The year to date position includes the impact of junior doctor industrial action in December and January, the loss of clinical negligence premium maternity incentive discount in 2023/24 and the associated claw back of the previous two financial years. The year to date position also includes a reduction in the projected PDC dividend due to the transition to IFRS 16 for PFI liabilities. The impact of IFRS 16 PFI accounting changes is subject to further consideration nationally and the Trust is awaiting further clarification on the treatment.

- Income is £83.4m favourable against plan for the year to date at month 10. NHS Patient Treatment income is £70.3m favourable overall. This is driven by medical industrial action funding of £19.1m, ERF overperformance £25.5m, overperformance on passthrough drugs £14.6m (which is offset by associated additional expenditure) and £10.7m central non-recurrent benefits released into the year to date position. Other income is £13.1m favourable, which is driven by £3.2m favourable Royal London Hospital variance primarily for pathology tests provided to other NHS bodies, £3.0m education income per the latest education contract schedule released by NHS England and £4.9m for release of central non-recurrent benefits from balance sheet review.

- Expenditure is (£87.1m) adverse against plan for the year to date at month 10. Site and Services pay expenditure is (£55.3m) adverse driven by (£32.7m) of unallocated pay savings targets, premium rate costs for medical bank expenditure for both consultants and junior doctors (£14.7m) and by temporary staffing wte in excess of establishment for Soft FM staffing (£5.9m). Additional medical staffing costs incurred for cover on industrial action days have been fully funded within site budgets. Sites and Services non-pay expenditure is (£39.6m) adverse year to date, key overspends excluding passthrough drugs and devices are unallocated non-pay savings targets (£9.3m), outsourced activity to the independent sector (£5.8m), increased expenditure on Estates Transport and Soft FM costs (£4.1m) and loss of clinical negligence premium maternity incentive discount (£2.5m). The overspend for passthrough drugs and devices (£14.3m) offsets with favourable income variance. Central expenditure and reserves are £7.8m favourable year to date, which includes the claw back of the clinical negligence premium maternity incentive discount for the previous two financial years and a reduction in the projected PDC dividend due to the transition to IFRS 16 for PFI liabilities.

- Following confirmation of allocation of medical industrial action funding in November, the Trust agreed a forecast outturn target of £36.4m deficit for 2023/24 as part of an NEL system planned forecast outturn deficit of £25m. The £36.4m target deficit excluded both the financial impact of any further industrial action post October 2023 and the impact of transition to IFRS 16 for PFI liabilities on PDC dividend costs. The forecast outturn has now been amended to £47.2m deficit for 2023/24 to incorporate the impact of December and January medical industrial action. The £47.2m forecast outturn deficit excludes the impact of any further medical industrial action post January 2024 and also excludes the impact of IFRS16 PFI accounting changes on PDC dividends.

- The Trust continues to implement additional controls particularly in relation to pay expenditure to support financial recovery and at month 10 is on track to meet its target deficit subject to the excluded items.

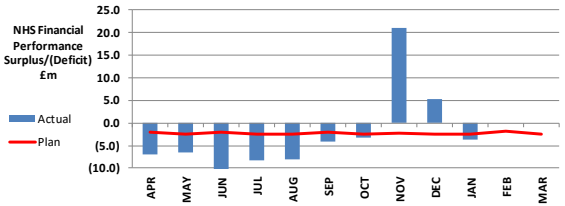
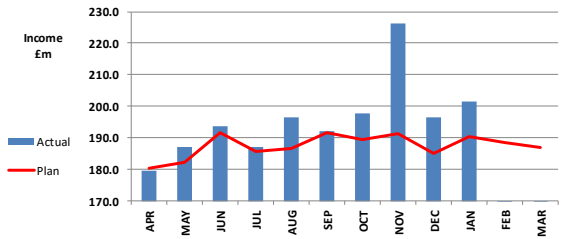
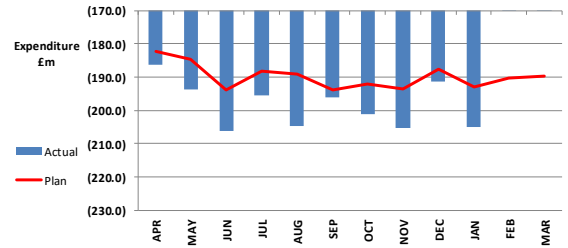
- Capital Expenditure in month 10 is £4.3m. The year to date underspend of £23.0m can be attributed major schemes running behind their forecasts. The delays will result in a forecast underspend of £20.8m in 2023/24 and a cost pressure of £13.5m in 2024/25. Additional schemes are being brought forward from 2024/25 and committed to alleviate the underspends and reduce the cost pressures in the new financial year.

- Cash balances in January 2024 are lower by £4.3m compared to a plan of £30.0m, as a result of movement in working capital. The transition to IFRS 16 for PFI liabilities processed in December has resulted in a £14.9m benefit from PDC dividend due to DHSC later in the year. The impact of IFRS 16 PFI accounting changes is subject to further consideration nationally and the Trust is awaiting further clarification on the treatment. 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 METRICS

Finance Key Metrics

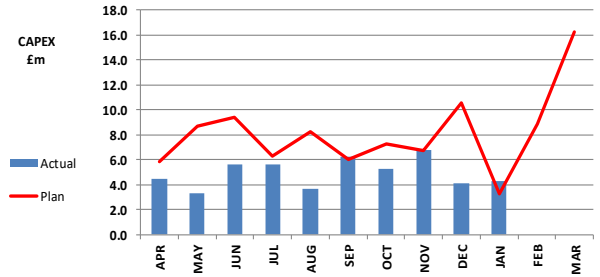
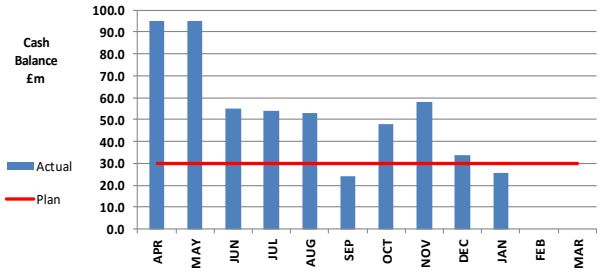
Mar-24

Metrics	Current Performance Year To Date £millions	Trend	Comments
NHS Financial Performance Surplus / (Deficit)	Plan (23.4) Actual (27.1) Variance (3.7)		The Trust is reporting a £27.1m deficit for the year to date at month 10, which is (£3.7m) adverse against plan. The year to date position includes the impact of junior doctor industrial action in December and January, the loss of clinical negligence premium maternity incentive discount in 2023/24 and the associated claw back of the previous two financial years. The year to date position also includes a reduction in the projected PDC dividend due to the transition to IFRS 16 for PFI liabilities. The impact of IFRS 16 PFI accounting changes is subject to further consideration nationally and the Trust is awaiting further clarification on the treatment.
Total Income	Plan 1,874.7 Actual 1,958.1 Variance 83.4		Income is £83.4m favourable against plan for the year to date at month 10. NHS Patient Treatment income is £70.3m favourable overall. This is driven by medical industrial action funding of £19.1m, ERF overperformance £25.5m, overperformance on passthrough drugs £14.6m (which is offset by associated additional expenditure) and £10.7m central non-recurrent benefits released into the year to date position. Other income is £13.1m favourable, which is driven by £3.2m favourable Royal London Hospital variance primarily for pathology tests provided to other NHS bodies, £3.0m education income per the latest education contract schedule released by NHS England and £4.9m for release of central non-recurrent benefits from balance sheet review.
Total Expenditure	Plan (1,898.1) Actual (1,985.3) Variance (87.1)		Expenditure is (£87.1m) adverse against plan for the year to date at month 10. Site and Services pay expenditure is (£55.3m) adverse driven by (£32.7m) of unallocated pay savings targets, premium rate costs for medical bank expenditure for both consultants and junior doctors (£14.7m) and by temporary staffing wte in excess of establishment for Soft FM staffing (£5.9m). Additional medical staffing costs incurred for cover on industrial action days have been fully funded within site budgets. Sites and Services non-pay expenditure is (£39.6m) adverse year to date, excluding passthrough drugs and devices key overspends are unallocated non-pay savings targets (£9.3m), outsourced activity to the independent sector (£5.8m), increased expenditure on Estates Transport and Soft FM costs (£4.1m) and loss of clinical negligence premium maternity incentive discount (£2.5m). The overspend for passthrough drugs and devices (£14.3m) offsets with favourable income variance. Central expenditure and reserves are £7.8m favourable year to date, which includes the claw back of the clinical negligence premium maternity incentive discount for the previous two financial years and a reduction in the projected PDC dividend due to the transition to IFRS 16 for PFI liabilities.

KEY METRICS

Finance Key Metrics

Mar-24

Metrics	Current Performance Year To Date £millions	Trend	Comments
Capital Expenditure	Plan 72.5 Actual 49.5 Variance (23.0)		Capital Expenditure in month 10 is £4.3m. The year to date underspend of £23.0m can be attributed major schemes running behind their forecasts. The delays will result in a forecast underspend of £20.8m in 2023/24 and a cost pressure of £13.5m in 2024/25. Additional schemes are being brought forward from 2024/25 and committed to alleviate the underspends and reduce the cost pressures in the new financial year. Expenditure against donated schemes is £0.3m in month 10 and £2.7m year to date.
Cash	Plan 30.0 Actual 25.7 Variance (4.3)		Cash balances in January 2024 are lower by £4.3m compared to a plan of £30.0m, as a result of movement in working capital. The 2022/23 pay rise award for Agenda for Change (AfC) staff (circa £32m, and funded by NHS England), and the 5% backdated 2023/24 AfC uplift (funded by NHSE and ICBs) 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. The transition to IFRS 16 for PFI liabilities processed in December has resulted in a £14.9m benefit from PDC dividend due to DHSC later in the year. The impact of IFRS 16 PFI accounting changes is subject to further consideration nationally and the Trust is awaiting further clarification on the treatment. 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

Following confirmation of allocation of medical industrial action funding in November, the Trust agreed a forecast outturn target of £36.4m deficit for 2023/24 as part of an NEL system planned forecast outturn deficit of £25m. The £36.4m target deficit excluded both the financial impact of any further industrial action post October 2023 and the impact of transition to IFRS 16 for PFI liabilities on PDC dividend costs. The forecast outturn has now been amended to £47.2m deficit for 2023/24 to incorporate the impact of December and January medical industrial action. The £47.2m forecast outturn deficit excludes the impact of any further medical industrial action post January 2024 and also excludes the impact of IFRS16 PFI accounting changes on PDC dividends. The Trust continues to implement additional controls particularly in relation to pay expenditure to support financial recovery and at month 10 is on track to meet its target deficit subject to the excluded items.

Key Risks & Opportunities

The key financial challenges for the Trust in achieving its revised forecast outturn deficit target for the financial year include:
- Managing additional costs resulting from the delivery of the winter plan for emergency and urgent care.
- Managing additional premium costs that may be incurred to meet activity requirements for the delivery of elective waiting times targets.
- Year end arrangements for final determination of Elective Recovery over performance income have yet to be confirmed by NHS England.
- The potential impact of further medical industrial action in 2023/24.

INCOME & EXPENDITURE

Income & Expenditure - Trustwide

Mar-24

Last Year		In Month				Year to Date				Annual
YTD Actual	£millions	Plan	Actual	Variance		Plan	Actual	Variance		Plan
	Income									
1,326.1	NHS Patient Treatment Income	148.4	157.0	8.6		1,425.1	1,460.6	35.5		1,708.5
2.4	Other Patient Care Activity Income	0.6	0.5	(0.1)		5.8	3.1	(2.6)		6.9
106.2	Other Operating Income	11.4	14.6	3.2		109.2	115.6	6.5		131.5
1,434.7	**Total Income**	**160.4**	**172.1**	**11.8**		**1,540.0**	**1,579.4**	**39.4**		**1,846.9**
	Operating Expenditure									
(963.1)	Pay	(110.5)	(113.9)	(3.4)		(1,055.1)	(1,110.4)	(55.3)		(1,265.3)
(171.3)	Drugs	(18.2)	(19.9)	(1.7)		(174.6)	(188.4)	(13.8)		(208.9)
(140.4)	Clinical Supplies	(15.9)	(17.9)	(2.0)		(157.1)	(160.2)	(3.1)		(188.3)
(263.4)	Other Non Pay	(24.0)	(26.6)	(2.6)		(237.0)	(259.7)	(22.6)		(283.6)
(1,538.2)	**Total Operating Expenditure**	**(168.5)**	**(178.3)**	**(9.8)**		**(1,623.7)**	**(1,718.7)**	**(94.9)**		**(1,946.2)**
(103.6)	**Site & Services Budgets Total**	**(8.2)**	**(6.2)**	**2.0**		**(83.7)**	**(139.2)**	**(55.5)**		**(99.3)**
(45.3)	Pathology Partnership (net)	(4.7)	(4.8)	(0.1)		(46.4)	(47.5)	(1.1)		(55.9)
0.0	Vaccination Programme & Nightingale (net)	-	0.0	0.0		-	(0.0)	(0.0)		-
0.0	Research & Development (net)	0.0	0.0	0.0		0.0	0.0	(0.0)		0.0
102.8	Central NHS PT Income	9.4	7.4	(2.0)		122.3	157.1	34.8		148.6
6.2	Central RTA & OSV Income (net)	1.0	1.0	0.0		9.8	7.3	(2.5)		11.8
22.3	Central Expenditure (net)	(0.1)	(0.6)	(0.5)		(1.0)	(2.2)	(1.2)		(1.2)
(3.0)	Reserves (net)	1.9	(0.8)	(2.8)		(7.4)	(3.8)	3.6		(11.6)
(20.6)	**EBITDA**	**(0.7)**	**(4.0)**	**(3.3)**		**(6.4)**	**(28.4)**	**(22.0)**		**(7.6)**
(58.9)	Depreciation and Amortisation (net)	(6.4)	(6.3)	0.2		(63.8)	(62.2)	1.7		(76.7)
(57.5)	Interest	(6.8)	(6.5)	0.3		(67.5)	(63.9)	3.6		(80.6)
(8.9)	PDC Dividends	(1.3)	0.5	1.8		(12.9)	-	12.9		(15.5)
0.2	Profit On Fixed Asset Disposal	0.0	0.0	0.0		0.1	0.2	0.1		0.1
(145.7)	**Surplus/(Deficit) Before System Top-Up**	**(15.2)**	**(16.3)**	**(1.1)**		**(150.6)**	**(154.3)**	**(3.7)**		**(180.4)**
125.5	System Top-Up Income	12.7	12.7	-		127.1	127.1	-		152.6
(20.3)	**NHS Reporting Surplus/(Deficit)**	**(2.5)**	**(3.6)**	**(1.1)**		**(23.4)**	**(27.1)**	**(3.7)**		**(27.8)**

CAPITAL EXPENDITURE

Capital Expenditure Summary - Trustwide

Mar-24

22/23 YTD	Programme Area	In Month				Year to Date				Annual			
Prev Yr Actual	*£millions*	Plan	Actual	Variance	%	Plan	Actual	Variance	%	M10 (PFR) Capital Plan	Internally Approved Plan M10	Variance	%
8.7	Equipment (Medical and Other)	0.6	0.6	0.1	*9 %*	9.2	7.1	2.1	*23 %*	12.2	15.2	(3.0)	*(25)%*
3.1	Informatics	0.2	1.5	(1.3)	*(531)%*	6.2	5.8	0.4	*7 %*	8.2	11.8	(3.6)	*(44)%*
22.9	Estates	0.9	0.5	0.3	*38 %*	7.4	5.9	1.6	*21 %*	10.7	10.5	0.2	*2 %*
12.0	New Build and Site Vacations	(1.1)	0.6	(1.7)	*155 %*	34.7	19.5	15.1	*44 %*	41.8	43.7	(2.0)	*(0.0)*
8.7	PFI Lifecycle Assets	1.1	1.1	(0.0)	*(0)%*	10.6	10.6	(0.0)	*(0)%*	12.6	12.6	-	*0 %*
4.4	Finance Lease	1.6	-	1.6	*100 %*	4.4	0.6	3.8	*86 %*	12.1	12.1	-	*- %*
59.8	**Total Exchequer programme**	**3.3**	**4.3**	**(1.0)**	***(30)%***	**72.5**	**49.5**	**23.0**	***0.0***	**97.7**	**106.0**	**(8.3)**	***(0.0)***
-													
59.8	**Total Trust Funded Assets**	**3.3**	**4.3**	**(1.0)**	***(30)%***	**72.5**	**49.5**	**23.0**	***32 %***	**97.7**	**106.0**	**(8.3)**	***(9)%***
4.0	Donated	0.3	0.3	0.0	*4 %*	4.8	2.7	2.1	*44 %*	5.6	5.6	-	*- %*
63.8	**Total Capital Expenditure**	**3.6**	**4.6**	**(1.0)**	***(27)%***	**77.3**	**52.2**	**25.1**	***32 %***	**103.3**	**111.6**	**(8.3)**	***(8)%***

Key Messages

2023/24 position. The internally approved exchequer programme is £106.0m (£111.5m in Month 9), which includes £12.4m agreed overspend. This compares to a funded plan of £99.5m resulting in an overspend of £6.5m (£7.4m in Month 9); the reduction since Month 9 is due to an additional allocation of CRL of £0.9m. The Trust is working with NEL/NHSE to secure a balanced plan position. The funded plan of £99.5m is greater than the Month 10 PFR plan of £97.7m which shows a seeming overspend of £8.3m. The PFR value is superseded due to a timing difference in the confirmation of how much PDC could be brokered into 2024/25. This will be updated in the Month 11 PFR.

The programme funded by charitable donation is £5.6m.

Funding. The Trust received confirmation of additional CRL of £0.9m which is being used to support the emergency informatics programme as well as further PDC of £400k for CDC equipment and £60k for blood monitors. PDC was drawn in February.

Expenditure in Month 10 is £4.3m. The year to date variance of £23.0m can be attributed major schemes running behind their forecasts including the following:-

Externally Funded

(£6.8m) - 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. c£10m underspend in 2023/24 will be used to mitigate internally funded schemes shortfalls. There remains a same level cost pressure in 2024/25; discussions continue with NEL/NHSL for further funding support to mitigate this.

(£2.1m) - NUH mothballed theatres - this scheme is on pause indefinitely as funding is insufficient to deliver the scheme. There will be an underspend of £2.9m in 2023/24 which will not be utilised so the related funding will not be drawn down.

(£3.8m) - Equipment leases - scoping is underway to use this for additional cloud storage and Azure credits.

Internally funded

(£3.8m) - NUH modular build - delays due to supply chain and labour issues which have put the programme behind which along with planning condition works result in a £1.6m cost pressure in 2024/25.

(£1.5m) - Unified comms - timing delay that will be caught up.

(£1.1m) - NUH fire programme - timing delay that will be caught up.

(£1.0m) - PFI MES/RMES - timing delay that will mainly be caught up apart from a a small amount of underspend.

Expenditure against donated schemes is £0.3m (£0.4m in Month 9); £2.7m year to date.

Forecast - As noted above there are delays with a number of high value externally funded schemes which will result in a £20.8m underspend in 2023/24 and a cost pressure of £13.5m in 2024/25, reduced from £22.8m reported in Month 9. The reduction in cost pressure occurs because £5.9m of external funding for the MEH CDC has now been brokered to 2024/25 and the £3.3m cost pressure for the mothballed theatres has fallen away because the scheme is not going forward in its current form, as it is expected to cost significantly in excess of the funding available and NEL is undertaking a capacity and demand review on theatre space now that new facilities at BHRUT and Homerton are coming on line. The remaining significant cost pressures are: - SBH ITU c£10.2m, MEH CDC £1.7m and NUH modular build £1.6m. Additional schemes are being brought forward from 2024/25 and committed to alleviate the remaining £1.7m underspend in the CDC and reduce the cost pressures in the new financial year.

Capital Funding

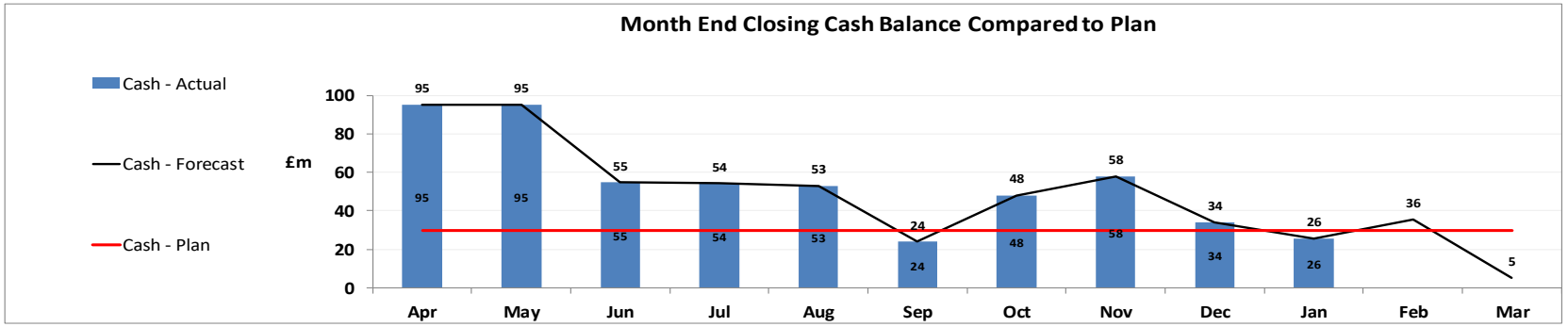
	Capital Plan	Secured/ Drawn	Not Yet Secured	% Secured
Gross Depreciation	76.7	76.7	-	*100 %*
Repayment of PFI principal	(26.0)	(26.0)	-	*100 %*
Repayment Other Finance Leases (IFRS16)	(11.3)	(11.3)	-	*100 %*
Net Depreciation	**39.5**	**39.5**	**-**	**100 %**
CRL (not cash backed)	13.7	13.7	-	*100 %*
Add CRL - Neonatal cot capacity RLH (not cash backed)	0.7	0.7	-	*100 %*
EFA	-	-	-	*- %*
Agreed overcommitment NHSE/NEL	-	-	-	*- %*
Additional CRL from NHSE/NEL (not cash backed)	5.9	5.9	-	*- %*
IFRS16 CRL adjustment	12.1	12.1	-	*100 %*
PDC: WXH Redevelopment core programme team	1.4	1.2	0.2	*87 %*
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	3.5	2.9	*55 %*
TIF - ITU Expansion SBH	11.1	11.1	-	*100 %*
ACTIF - RLH/WXH	2.7	2.4	0.2	*92 %*
PDC - MEH CDC	2.8	2.8	-	*100 %*
PDC - LIMS	0.2	0.2	-	*100 %*
PDC - Paeds Observation rooms	0.5	0.5	-	*100 %*
PDC - Cyber Security	0.2	0.2	-	*100 %*
PDC - We Connect	0.4	0.4	-	*100 %*
PDC - Paediatrics (ARCET)	0.1	0.1	-	*100 %*
Planned Capital exc. Donated	**99.5**	**96.3**	**3.3**	**96.7 %**
Asset sales	-	-	-	*- %*
***Total approved Exchequer funding ex donated**	**99.5**	**96.3**	**3.3**	**96.7 %**
Donated	5.6	2.7	2.9	*48.2 %*
Planned Capital inc. Donated	**105.1**	**99.0**	**6.2**	**94.1 %**
*CRL overspend	(6.5)			

CASHFLOW & BALANCE SHEET

Cashflow

Mar-24

£millions	Actual Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Forecast Feb	Mar	Outturn
Opening cash at bank	**60.2**	**95.0**	**95.1**	**54.8**	**54.2**	**53.1**	**24.0**	**48.0**	**57.9**	**33.9**	**25.7**	**35.7**	**60.2**
Cash inflows													
Healthcare contracts	155.9	166.0	203.3	167.7	169.7	174.0	180.1	166.9	189.2	173.7	166.6	182.3	2,095.4
Other income	42.5	24.7	17.4	28.9	30.5	33.8	48.7	28.8	18.3	19.9	40.0	27.4	360.9
Financing - Revenue Loans / Capital PDC	-	-	-	-	-	3.1	-	-	-	-	2.2	11.4	16.7
Total cash inflows	**198.4**	**190.7**	**220.7**	**196.6**	**200.2**	**210.9**	**228.8**	**195.7**	**207.5**	**193.6**	**208.8**	**221.1**	**2,473.0**
Cash outflows													
Salaries and wages	(61.1)	(65.0)	(94.4)	(68.0)	(70.5)	(71.5)	(65.8)	(66.7)	(64.1)	(69.5)	(72.3)	(70.3)	(839.2)
Tax, NI and pensions	(30.7)	(46.4)	(46.6)	(65.6)	(50.2)	(48.3)	(54.9)	(50.2)	(50.0)	(51.2)	(50.7)	(51.0)	(595.8)
Non pay expenditures	(63.7)	(76.2)	(116.8)	(57.7)	(76.6)	(108.2)	(79.6)	(64.9)	(114.6)	(79.2)	(70.8)	(114.4)	(1,022.7)
Capital expenditure	(8.1)	(3.0)	(3.2)	(5.9)	(4.0)	(4.1)	(4.5)	(4.0)	(2.8)	(1.9)	(5.0)	(16.1)	(62.6)
Dividend and Interest payable	-	-	-	-	-	(7.9)	-	-	-	-	-	-	(7.9)
Total cash outflows	**(163.6)**	**(190.6)**	**(261.0)**	**(197.2)**	**(201.3)**	**(240.0)**	**(204.8)**	**(185.8)**	**(231.5)**	**(201.8)**	**(198.8)**	**(251.8)**	**(2,528.2)**
Net cash inflows / (outflows)	**34.8**	**0.1**	**(40.3)**	**(0.6)**	**(1.1)**	**(29.1)**	**24.0**	**9.9**	**(24.0)**	**(8.2)**	**10.0**	**(30.7)**	**(55.2)**
Closing cash at bank - actual / forecast	**95.0**	**95.1**	**54.8**	**54.2**	**53.1**	**24.0**	**48.0**	**57.9**	**33.9**	**25.7**	**35.7**	**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 January 2024 are lower by £4.3m compared to a plan of £30.0m, as a result of movement in working capital. The 2022/23 pay rise award for Agenda for Change (AfC) staff (circa £32m, and funded by NHS England), and the 5% backdated 2023/24 AfC uplift (funded by NHSE and ICBs) 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. The transition to IFRS 16 for PFI liabilities processed in December has resulted in a £14.9m benefit from PDC dividend due to DHSC later in the year. The impact of IFRS 16 PFI accounting changes is subject to further consideration nationally and the Trust is awaiting further clarification on the treatment. 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

Mar-24

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	1,583.9	1,584.2	1,583.1	1,581.2	1,633.6	1,637.2	43.0
0.1	Intangible assets	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.5	0.5	0.5	0.5	0.4
16.8	Trade and other receivables	16.8	16.7	16.7	16.6	16.6	16.5	16.5	16.5	16.4	16.4	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**	**1,600.5**	**1,600.8**	**1,600.0**	**1,598.1**	**1,650.8**	**1,653.8**	**42.8**
	Current assets:													
31.4	Inventories	32.1	32.2	33.9	32.9	32.3	33.0	33.2	33.2	34.6	33.5	31.4	31.4	0.0
145.5	Trade and other receivables	132.0	123.8	92.4	125.7	101.0	123.9	106.5	126.9	148.5	146.0	107.9	156.5	11.0
60.2	Cash and cash equivalents	95.1	95.1	54.8	54.2	53.1	24.0	47.9	57.9	34.0	25.8	35.7	5.0	(55.2)
237.1	**Total current assets**	**259.2**	**251.1**	**181.1**	**212.8**	**186.4**	**180.9**	**187.6**	**218.0**	**217.1**	**205.3**	**175.0**	**192.9**	**(44.2)**
1,848.2	**Total assets**	**1,868.5**	**1,857.1**	**1,786.4**	**1,817.4**	**1,788.1**	**1,782.6**	**1,788.1**	**1,818.8**	**1,817.1**	**1,803.4**	**1,825.8**	**1,846.7**	**(1.4)**
	Current liabilities													
(290.0)	Trade and other payables	(320.3)	(318.8)	(263.7)	(305.9)	(288.0)	(285.8)	(297.7)	(310.6)	(307.1)	(300.6)	(328.1)	(310.2)	(20.2)
(2.8)	Provisions	(2.9)	(2.9)	(2.9)	(2.9)	(2.9)	(2.9)	(2.9)	(2.9)	(2.9)	(2.9)	(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)	(37.3)	(37.3)	(60.0)	(60.0)	(60.0)	(59.2)	(21.9)
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)**	**(337.9)**	**(350.8)**	**(370.0)**	**(363.5)**	**(390.9)**	**(372.2)**	**(42.1)**
(93.0)	**Net current (liabilities) / assets**	**(101.3)**	**(107.9)**	**(122.8)**	**(133.3)**	**(141.8)**	**(145.1)**	**(150.3)**	**(132.8)**	**(152.9)**	**(158.2)**	**(215.9)**	**(179.3)**	**(86.3)**
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**	**1,450.2**	**1,468.0**	**1,447.1**	**1,439.9**	**1,434.9**	**1,474.5**	**(43.5)**
	Non-current liabilities													
(5.9)	Provisions	(5.9)	(5.9)	(6.0)	(6.1)	(6.1)	(6.2)	(6.3)	(6.3)	(5.9)	(5.8)	(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)	(893.8)	(890.7)	(1,650.8)	(1,645.8)	(1,640.9)	(1,648.1)	(732.9)
(0.5)	Other Payables	(0.3)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	0.0	0.0	0.0	0.5
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)**	**(900.6)**	**(897.5)**	**(1,657.2)**	**(1,651.6)**	**(1,647.6)**	**(1,654.7)**	**(733.2)**
596.5	**Total Assets Employed**	**589.6**	**582.8**	**570.2**	**562.0**	**553.8**	**553.1**	**549.6**	**570.5**	**(210.1)**	**(211.7)**	**(212.7)**	**(180.2)**	**(776.7)**
	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	1,083.7	1,083.7	1,083.7	1,083.7	1,083.7	1,106.4	25.8
(900.9)	Retained earnings	(907.8)	(914.6)	(927.2)	(935.4)	(943.6)	(947.4)	(950.9)	(930.0)	(1,710.6)	(1,712.2)	(1,713.2)	(1,714.4)	(813.5)
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	427.8	11.0
596.5	**Total Taxpayers' Equity**	**589.6**	**582.8**	**570.2**	**562.0**	**553.8**	**553.1**	**549.6**	**570.5**	**(210.1)**	**(211.7)**	**(212.7)**	**(180.2)**	**(776.7)**

NHS
Barts Health
NHS Trust

Glossary

GLOSSARY

Operational Planning 2023/24 & 2024/25

Mar-24

The key 2023/24 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 sit alongside these and 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

The Operational Performance chapter of this report (pages 17 to 40) provides monthly and year to date views of delivery against the performance and activity objectives set out above and opposite.

In relation to 2024/25, planning guidance has been delayed until late January or early February 2024, once this guidance has been received this page will be updated with the national planning priorities for next year. It is anticipated that these will build on the current objectives set out above. NHS England will also work with ICBs and providers to agree a standard set of metrics that all executive teams and boards should use as a minimum to track productivity alongside service delivery. Once published views of the productivity metrics will be developed and incorporated within this report.

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

GLOSSARY

Domain Scorecard Glossary

Mar-24

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

GLOSSARY

Domain Scorecard Glossary

Mar-24

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

GLOSSARY

Domain Scorecard Glossary

Mar-24

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

GLOSSARY

Domain Scorecard Glossary

Mar-24

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

GLOSSARY

Workforce Summary Glossary

Mar-24

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	

NHS
Barts Health
NHS Trust

Appendix

APPENDIX

Interpretation of Scorecards (New QV)

Mar-24

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)

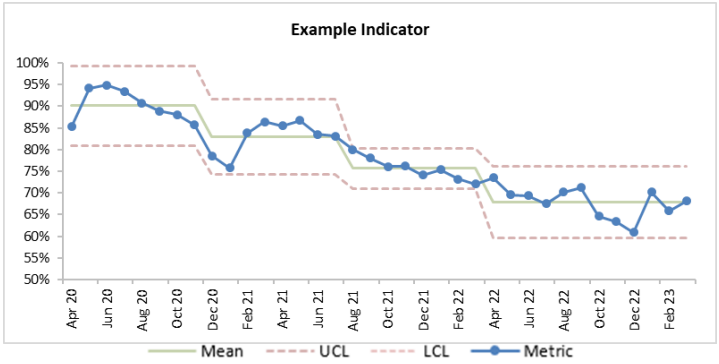
Reporting month target for reporting site

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

Mar-24

		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	2,138.5	2,109.2	1,069.5	1,437.5	1,782.5	1,777.5	713.0	1,644.5	98.6%	134.4%	99.7%	230.6%	798	4.9	3.9	8.7
Royal London	10F RLH	1,114.0	1,340.5	744.0	936.0	1,023.0	1,223.0	341.0	759.5	120.3%	125.8%	119.6%	222.7%	505	5.1	3.4	8.4
Royal London	11C RLH	2,852.0	2,956.3	1,433.5	1,299.5	2,852.0	3,314.0	713.0	1,081.0	103.7%	90.7%	116.2%	151.6%	768	8.2	3.1	11.3
Royal London	11E & 11F AAU	4,328.5	4,537.0	1,782.5	1,686.8	3,921.5	4,173.5	1,426.0	1,840.0	104.8%	94.6%	106.4%	129.0%	1,512	5.8	2.3	8.1
Royal London	12C RLH	1,874.5	1,942.5	1,426.0	1,529.5	1,839.0	1,946.0	1,069.5	1,690.5	103.6%	107.3%	105.8%	158.1%	810	4.8	4.0	8.8
Royal London	12D RLH	1,426.0	1,719.8	713.0	954.5	1,426.0	1,692.5	713.0	1,173.0	120.6%	133.9%	118.7%	164.5%	500	6.8	4.3	11.1
Royal London	12E RLH	2,775.0	3,262.9	1,426.0	1,401.3	2,495.5	3,011.3	1,426.0	1,504.3	117.6%	98.3%	120.7%	105.5%	726	8.6	4.0	12.6
Royal London	12F RLH	2,047.0	2,369.0	1,782.5	1,833.4	1,782.5	2,139.0	1,782.5	1,932.0	115.7%	102.9%	120.0%	108.4%	833	5.4	4.5	9.9
Royal London	13C RLH	1,951.0	2,081.5	713.0	794.5	1,782.5	1,920.5	711.5	1,103.0	106.7%	111.4%	107.7%	155.0%	791	5.1	2.4	7.5
Royal London	13D RLH	1,782.5	1,851.5	713.0	1,046.5	1,426.0	1,574.0	713.0	1,299.5	103.9%	146.8%	110.4%	182.3%	752	4.6	3.1	7.7
Royal London	13E RLH	2,047.0	2,366.5	713.0	725.5	1,690.5	2,106.0	713.0	897.0	115.6%	101.8%	124.6%	125.8%	775	5.8	2.1	7.9
Royal London	13F RLH	1,782.5	2,369.0	977.5	1,028.5	1,782.5	2,334.5	713.0	1,069.5	132.9%	105.2%	131.0%	150.0%	690	6.8	3.0	9.9
Royal London	14E & 14F RLH	3,772.0	3,880.5	2,369.0	2,538.0	2,852.0	3,208.5	2,150.5	2,679.5	102.9%	107.1%	112.5%	124.6%	1,574	4.5	3.3	7.8
Royal London	3D RLH	3,565.0	3,351.0	2,137.0	1,869.5	3,553.5	3,856.5	2,139.0	2,150.5	94.0%	87.5%	108.5%	100.5%	1,008	7.2	4.0	11.1
Royal London	3E RLH	2,127.5	2,403.0	701.5	1,138.5	1,782.5	2,223.5	713.0	1,150.0	112.9%	162.3%	124.7%	161.3%	778	5.9	2.9	8.9
Royal London	3F RLH	1,860.0	1,911.0	839.5	632.5	1,656.0	1,913.0	690.0	609.0	102.7%	75.3%	115.5%	88.3%	464	8.2	2.7	10.9
Royal London	4E RLH	13,880.8	14,270.9	943.0	931.5	13,880.5	14,149.7	943.0	759.0	102.8%	98.8%	101.9%	80.5%	1,299	21.9	1.3	23.2
Royal London	6C RLH	4,208.5	3,506.4	517.5	345.0	3,450.0	2,945.0	517.5	425.3	83.3%	66.7%	85.4%	82.2%	217	29.7	3.5	33.3
Royal London	6E & 6F RLH	5,957.0	4,816.3	1,427.0	1,103.5	5,370.5	5,233.5	1,069.5	900.5	80.9%	77.3%	97.4%	84.2%	951	10.6	2.1	12.7
Royal London	7C RLH	1,368.5	1,357.0	621.0	879.3	1,069.5	1,174.0	575.0	977.5	99.2%	141.6%	109.8%	170.0%	364	7.0	5.1	12.1
Royal London	7D RLH	1,771.0	1,647.3	765.5	746.5	1,426.0	1,495.0	713.0	848.1	93.0%	97.5%	104.8%	118.9%	384	8.2	4.2	12.3
Royal London	7E RLH	2,849.8	2,610.5	1,069.5	1,584.7	2,495.5	2,426.0	1,069.5	1,957.0	91.6%	148.2%	97.2%	183.0%	678	7.4	5.2	12.7
Royal London	7F RLH	1,357.0	1,596.0	345.0	782.0	966.0	1,173.0	356.5	1,113.5	117.6%	226.7%	121.4%	312.3%	347	8.0	5.5	13.4
Royal London	8C RLH	1,990.5	2,184.0	701.5	769.0	1,426.0	1,658.0	712.5	897.0	109.7%	109.6%	116.3%	125.9%	584	6.6	2.9	9.4
Royal London	8D RLH	10,195.8	7,982.0	1,599.8	436.0	8,854.0	7,168.5	322.0	276.0	78.3%	27.3%	81.0%	85.7%	1,075	14.1	0.7	14.8
Royal London	8F RLH	1,823.0	1,761.0	1,494.0	1,362.5	1,069.5	1,058.0	1,426.0	1,369.5	96.6%	91.2%	98.9%	96.0%	1,796	1.6	1.5	3.1
Royal London	9E HDU RLH	1,426.0	1,089.8	0.0	0.0	1,426.0	1,081.0	0.0	0.0	76.4%		75.8%		177	12.3	0.0	12.3
Royal London	9E RLH	1,782.5	1,771.0	713.0	1,092.5	1,426.0	1,483.5	713.0	1,265.0	99.4%	153.2%	104.0%	177.4%	792	4.1	3.0	7.1
Royal London	9F RLH	1,771.0	1,914.5	713.0	751.5	1,426.0	1,577.0	713.0	851.5	108.1%	105.4%	110.6%	119.4%	608	5.7	2.6	8.4

APPENDIX

Safe Staffing Fill Rates by Ward and Site

Mar-24

		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	6,137.5	6,651.3	3,640.0	3,468.2	5,704.0	6,569.3	3,197.0	3,019.1	108.4%	95.3%	115.2%	94.4%	1,969	6.7	3.3	10.0
Whipps Cross	ACACIA	954.5	964.5	425.5	480.0	713.0	718.0	713.0	760.5	101.0%	112.8%	100.7%	106.7%	348	4.8	3.6	8.4
Whipps Cross	ACORN	3,714.5	2,704.0	356.5	522.5	2,852.0	2,307.5	356.5	310.5	72.8%	146.6%	80.9%	87.1%	544	9.2	1.5	10.7
Whipps Cross	B3 WARD WXH	1,334.0	1,245.0	1,067.5	1,471.5	1,069.5	1,081.0	713.0	1,057.0	93.3%	137.8%	101.1%	148.2%	518	4.5	4.9	9.4
Whipps Cross	BIRCH	1,068.5	1,386.3	1,069.5	1,235.5	1,069.5	1,184.5	713.0	872.5	129.7%	115.5%	110.8%	122.4%	556	4.6	3.8	8.4
Whipps Cross	BLACKTHORN	1,069.5	1,299.5	1,069.5	1,082.5	1,069.5	1,069.5	713.0	839.5	121.5%	101.2%	100.0%	117.7%	522	4.5	3.7	8.2
Whipps Cross	Bracken Ward WXH	1,332.5	1,345.0	1,068.5	1,068.5	1,069.5	1,104.0	713.0	713.0	100.9%	100.0%	103.2%	100.0%	509	4.8	3.5	8.3
Whipps Cross	CEDAR	1,435.9	1,640.7	1,408.0	1,484.0	1,069.5	1,368.5	1,069.5	1,288.5	114.3%	105.4%	128.0%	120.5%	546	5.5	5.1	10.6
Whipps Cross	CHESTNUT	977.5	805.0	356.5	920.0	712.0	1,012.0	356.5	828.0	82.4%	258.1%	142.1%	232.3%	391	4.6	4.5	9.1
Whipps Cross	CONIFER	1,426.0	1,540.0	1,403.0	1,690.5	1,069.5	1,265.0	1,069.5	1,459.5	108.0%	120.5%	118.3%	136.5%	478	5.9	6.6	12.5
Whipps Cross	CURIE	1,425.5	1,382.0	1,069.5	1,173.0	1,070.7	989.0	1,069.5	1,242.0	96.9%	109.7%	92.4%	116.1%	535	4.4	4.5	8.9
Whipps Cross	DELIVERY SUITE WXH	5,924.3	5,449.1	1,426.0	1,254.5	5,002.5	4,360.9	1,426.0	1,323.5	92.0%	88.0%	87.2%	92.8%	530	18.5	4.9	23.4
Whipps Cross	ELIZABETH	1,644.5	1,649.0	322.0	546.0	1,426.0	1,426.0	356.5	483.5	100.3%	169.6%	100.0%	135.6%	557	5.5	1.8	7.4
Whipps Cross	FARADAY	1,424.0	1,259.0	713.0	990.0	1,426.0	1,426.0	356.5	526.3	88.4%	138.8%	100.0%	147.6%	479	5.6	3.2	8.8
Whipps Cross	ICU WXH	6,964.0	5,642.5	1,392.0	504.0	6,391.0	5,403.0	1,364.0	352.0	81.0%	36.2%	84.5%	25.8%	372	29.7	2.3	32.0
Whipps Cross	MARGARET	1,069.0	1,060.5	356.5	322.0	713.0	713.0	356.5	356.5	99.2%	90.3%	100.0%	100.0%	292	6.1	2.3	8.4
Whipps Cross	MULBERRY	2,322.5	1,931.0	1,763.5	1,198.0	1,426.0	1,385.3	1,449.0	1,230.5	83.1%	67.9%	97.1%	84.9%	1,221	2.7	2.0	4.7
Whipps Cross	NEONATAL WXH	2,387.3	2,156.5	1,097.0	600.8	2,147.5	1,985.5	701.5	357.0	90.3%	54.8%	92.5%	50.9%	374	11.1	2.6	13.6
Whipps Cross	NIGHTINGALE	1,414.5	1,391.5	356.5	444.5	1,426.0	1,425.7	356.5	448.5	98.4%	124.7%	100.0%	125.8%	387	7.3	2.3	9.6
Whipps Cross	PEACE	1,685.5	1,685.5	1,334.0	1,357.0	1,068.5	1,082.0	1,058.0	1,104.0	100.0%	101.7%	101.3%	104.3%	466	5.9	5.3	11.2
Whipps Cross	POPLAR	1,782.5	1,702.0	1,069.5	1,230.5	1,426.0	1,381.3	1,069.5	1,171.5	95.5%	115.1%	96.9%	109.5%	664	4.6	3.6	8.3
Whipps Cross	PRIMROSE	1,771.0	2,048.0	1,426.0	1,725.0	1,426.0	1,739.5	1,069.5	1,782.5	115.6%	121.0%	122.0%	166.7%	860	4.4	4.1	8.5
Whipps Cross	ROWAN	1,782.5	1,805.5	1,426.0	1,587.0	1,426.0	1,437.5	1,069.5	1,598.5	101.3%	111.3%	100.8%	149.5%	838	3.9	3.8	7.7
Whipps Cross	SAGE	1,681.0	1,651.0	1,462.3	1,581.3	1,426.0	1,426.0	1,069.5	1,253.5	98.2%	108.1%	100.0%	117.2%	821	3.7	3.5	7.2
Whipps Cross	SYCAMORE	1,320.0	1,676.5	1,334.0	1,798.5	1,069.5	1,426.0	1,069.5	1,472.0	127.0%	134.8%	133.3%	137.6%	831	3.7	3.9	7.7
Whipps Cross	SYRINGA	1,426.0	1,434.5	1,736.5	1,782.5	1,069.5	1,069.5	1,426.0	1,713.5	100.6%	102.6%	100.0%	120.2%	802	3.1	4.4	7.5

APPENDIX

Safe Staffing Fill Rates by Ward and Site

Mar-24

		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	1,435.5	1,725.0	1,069.5	1,219.0	1,426.0	1,715.0	1,069.5	1,471.5	120.2%	114.0%	120.3%	137.6%	583	5.9	4.6	10.5
Newham	Custom House NUH	1,425.0	1,449.0	1,069.5	1,391.5	1,069.5	1,092.5	1,426.0	1,805.5	101.7%	130.1%	102.2%	126.6%	609	4.2	5.2	9.4
Newham	DELIVERY SUITE NUH	4,747.0	4,263.5	713.0	666.5	4,852.0	4,455.3	713.0	701.5	89.8%	93.5%	91.8%	98.4%	708	12.3	1.9	14.2
Newham	EAST HAM	1,780.5	1,784.5	1,069.5	1,104.0	1,437.5	1,449.0	1,081.0	1,173.0	100.2%	103.2%	100.8%	108.5%	716	4.5	3.2	7.7
Newham	HEATHER	2,139.0	2,829.5	1,092.5	1,242.0	2,150.5	2,630.5	1,069.5	1,265.0	132.3%	113.7%	122.3%	118.3%	775	7.0	3.2	10.3
Newham	LARCH	3,355.0	3,103.5	2,128.5	2,054.0	2,265.5	2,238.2	1,782.5	1,725.0	92.5%	96.5%	98.8%	96.8%	1,779	3.0	2.1	5.1
Newham	Manor Park ITU NUH	4,266.5	4,025.0	713.0	793.5	4,288.5	4,105.5	713.0	759.0	94.3%	111.3%	95.7%	106.5%	339	24.0	4.6	28.6
Newham	MAPLE	1,073.5	819.5	713.0	608.0	1,069.5	828.0	713.0	599.0	76.3%	85.3%	77.4%	84.0%	155	10.6	7.8	18.4
Newham	NEONATAL NUH	3,392.5	2,794.0	713.0	713.0	3,082.0	2,855.0	724.5	552.0	82.4%	100.0%	92.6%	76.2%	574	9.8	2.2	12.0
Newham	NUH MIDWIFERY	1,090.5	886.3	356.5	307.0	1,058.0	958.9	356.5	345.0	81.3%	86.1%	90.6%	96.8%	130	14.2	5.0	19.2
Newham	PLASHET	1,596.5	2,029.5	1,069.5	1,138.5	1,426.0	1,963.0	1,069.5	1,265.0	127.1%	106.5%	137.7%	118.3%	752	5.3	3.2	8.5
Newham	RAINBOW	2,888.5	2,598.3	1,079.0	1,046.5	1,782.5	1,865.0	368.0	379.5	90.0%	97.0%	104.6%	103.1%	366	12.2	3.9	16.1
Newham	SILVERTOWN	1,770.8	2,025.3	1,069.5	1,219.0	1,437.5	1,632.5	1,046.5	1,494.5	114.4%	114.0%	113.6%	142.8%	743	4.9	3.7	8.6
Newham	STRATFORD	1,417.0	1,638.9	1,081.0	1,207.5	1,426.0	1,932.0	1,081.0	1,161.5	115.7%	111.7%	135.5%	107.4%	544	6.6	4.4	10.9
Newham	Tayberry	2,472.5	3,000.7	1,069.5	1,000.5	2,495.5	3,139.5	1,069.5	1,196.0	121.4%	93.5%	125.8%	111.8%	722	8.5	3.0	11.5
Newham	THISTLE	1,762.0	1,852.5	1,069.5	1,157.0	1,782.5	1,875.5	1,079.0	1,160.5	105.1%	108.2%	105.2%	107.6%	775	4.8	3.0	7.8
Newham	WEST HAM	1,357.0	2,098.8	1,069.5	1,205.0	1,058.0	1,679.0	356.5	1,115.5	154.7%	112.7%	158.7%	312.9%	919	4.1	2.5	6.6
St Bart's	1C	6,129.5	4,867.8	356.5	586.5	5,290.0	4,867.5	207.0	425.5	79.4%	164.5%	92.0%	205.6%	420	23.2	2.4	25.6
St Bart's	1D	3,208.5	2,213.0	356.5	356.5	2,852.0	2,106.5	356.5	356.5	69.0%	100.0%	73.9%	100.0%	273	15.8	2.6	18.4
St Bart's	1E	4,991.0	3,810.5	356.5	529.0	4,991.0	3,841.0	356.5	621.0	76.3%	148.4%	77.0%	174.2%	297	25.8	3.9	29.6
St Bart's	3A SBH	4,989.5	4,717.2	1,426.0	1,332.2	4,991.0	4,853.0	1,426.0	1,357.0	94.5%	93.4%	97.2%	95.2%	936	10.2	2.9	13.1
St Bart's	3D SBH	1,598.5	1,678.5	1,265.0	1,225.5	1,543.0	1,418.0	977.5	977.5	105.0%	96.9%	91.9%	100.0%	519	6.0	4.2	10.2
St Bart's	4A SBH	1,782.5	1,771.0	1,069.5	1,034.0	1,426.0	1,410.8	356.5	839.5	99.4%	96.7%	98.9%	235.5%	722	4.4	2.6	7.0
St Bart's	4B SBH	1,598.5	1,579.5	1,241.0	1,098.0	1,426.0	1,437.5	713.0	759.0	98.8%	88.5%	100.8%	106.5%	561	5.4	3.3	8.7
St Bart's	4C SBH	1,782.5	1,667.5	977.5	793.5	1,426.0	1,334.0	977.5	851.0	93.5%	81.2%	93.5%	87.1%	559	5.4	2.9	8.3
St Bart's	4D & 4E SBH	1,690.5	1,462.5	713.0	644.0	1,644.5	1,449.0	713.0	655.0	86.5%	90.3%	88.1%	91.9%	450	6.5	2.9	9.4
St Bart's	5A SBH	2,199.0	3,057.5	915.0	872.1	1,474.0	2,016.1	341.0	672.3	139.0%	95.3%	136.8%	197.1%	657	7.7	2.4	10.1
St Bart's	5B SBH	1,426.0	1,378.3	713.0	642.3	1,426.0	1,403.5	356.5	586.5	96.7%	90.1%	98.4%	164.5%	432	6.4	2.8	9.3
St Bart's	5C SBH	2,134.0	2,043.1	709.0	655.5	1,782.5	1,786.3	356.5	448.5	95.7%	92.5%	100.2%	125.8%	568	6.7	1.9	8.7
St Bart's	5D SBH	2,139.0	1,979.0	713.0	569.5	1,782.5	1,732.0	713.0	782.0	92.5%	79.9%	97.2%	109.7%	660	5.6	2.0	7.7
St Bart's	6A SBH	6,405.5	5,498.0	356.5	425.5	6,417.0	5,244.0	356.5	483.0	85.8%	119.4%	81.7%	135.5%	312	34.4	2.9	37.3
St Bart's	6D SBH	1,456.5	1,370.8	766.5	665.5	1,069.5	1,058.0	713.0	701.5	94.1%	86.8%	98.9%	98.4%	458	5.3	3.0	8.3

Barts Health NHS Trust

Report to the Trust Board: 6 March 2024	TB 17/24

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 21 February 2024 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
External audit memorandum	All
BAF and high risks report	All
QAC exception report	3, 8, 9, 11, 15
Operational plan – performance and risk Q3 assessment	All
Standing reports on counter fraud, waivers and losses and special payments	All
Informatics and cyber security	7
Newham fire safety programme	14
Inclusion – BAF deep dive report	1

Key areas of discussion arising from items appearing on the agenda

Internal Audit reports

The committee reviewed outcomes of audits completed since the last meeting. The committee noted a sustained improvement in the number of overdue management actions arising from audit reviews. Following consultation with key board leads, the Committee approved the 2024/25 Internal Audit plan.

Newham fire safety

The Committee discussed a Newham fire safety programme limited assurance Internal Audit report. The Committee reflected on the enforcement notice arising from a 2020 London Fire Brigade inspection and highlighted the challenging circumstances faced at the time of this inspection and the complicating factors in the period since in terms of addressing deficiencies set out by LFB. As referenced below, it was agreed to develop a Trust Board report setting out next steps.

Operational plan – performance and risk Q3 assessment

The Committee reviewed the format and content of a Q3 assessment of operational plan delivery. It was agreed that this innovative approach would benefit particularly from refinement in the articulation of success measures to track in 2024/25, to include an assessment of a realistic level of ambition. It was noted that the Board would be engaged in the refresh of the strategic risks in the BAF and risk appetite for 2024/25 with learning from

good practice in other organisations.

Risk management reports

The Committee spent time reviewing the BAF risks, risk tolerances and high risks appearing on the risk register. The committee spent time reviewing high risks scored at 20 on the risk register. A deep dive review of the BAF entry relating to staff inclusion was also considered, recognising good progress against reported Workforce Race Equality Scheme metrics and an ambition to improve the position on disabilities inclusion KPIs.

Losses special payments and write offs

The Committee noted the report and requested further information at a future meeting on fertility services storage and pharmacy waste.

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

Approval of the 2024/25 Internal Audit plan.

Any issues for escalation to the Board

The Trust Board is asked to note a recommendation from the Committee that a report is provided in Part 1 to set out some key details of the Newham fire safety programme, recognising the impact in recent years associated with the pandemic, inflation, regulatory developments and changes in the market. This will inform the development of a business case seeking external approval and funding for completion of the remaining stages of the programme.

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.

Report to the Trust Board: 6 March 2024	TB 18/24

Title	Board Assurance Framework
Sponsoring Director	Director of Group Development
Author(s)	Sean Collins, Trust Secretary Jason Bryan, Head of Risk Management
Purpose	To agree revisions to the Quarter 4 BAF
Previously considered by	Group Executive Board Audit and Risk Committee 21 February 2024

Executive summary

The Board Assurance Framework (BAF) sets out the principal risks to the delivery of the Trust's objectives. This version represents the Quarter 4 position and details updates made since the Quarter 2 BAF was approved by the Trust Board.

The Quarter 4 BAF features updated positions against risk tolerance triggers to reflect outputs of the Q3 assessment of progress against the operational plan; refreshed high risk cross references; and changes to risk scores, controls and assurances arising from 1-1 discussions with lead executives. The following key changes are highlighted:

- Amendment of BAF risk 10 wording from *'Failure to collaborate effectively as an integrated group across Barts Health and BHRUT delays benefits realisation and improved patient outcomes' risk score 4x2=8* to ***'Failure to collaborate effectively through the NEL acute provider collaborative, and through place-based partnerships, delays benefits to quality and outcomes, equity and value' (risk score 4x3=12).*** *This change reflects the redefined emphasis of acute collaboration during Q3/4 and steps to agree the APC workstreams and approach to assuring progress.*

- Revision to risk score for BAF entry 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'* from 4x4=16 to **4x3=12**. This reflects sustained progress in Q2-Q4 on workforce KPIs including substantive fill rates, staff turnover and WRES inclusion metrics. In reducing the risk score as framed, the Committee is asked to note the recognition of other workforce related pressures including industrial action disruption and temporary staff pay costs.

- Revision to risk score for BAF entry 8. '*Insufficient systems to identify hotspots in a large complex organisation impacts on aspirations to provide 'good and outstanding' rated services across the group'* from 4x3=12 to **3x3=9.** This reflects progress on embedding improved management information systems, maturity of hospital governance, performance review and audit assurance) and assurances on CQC related governance arrangements - providing assurance that the likely extent and scope of any unidentified issues has reduced.

- Revision to risk score for BAF entry 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'* from 4x3=12 to **4x2=8.** This reflects stabilisation of research activity and associated funding post-pandemic and provisionally securing funding sources (including charity bids) for major programmes including the clinical research facility and centre for healthy ageing.

The revised risk profile featured on the Q4 BAF heatmap highlights an emphasis on financial and operational challenges (reflected in the Trust Board's agendas focusing on financial revenue and capital targets, emergency care pressures, the implications of industrial action and the Trust's waiting list size and profile). The cross referenced risk register entries also reflect a significant increase in the volume of identified high risks in relation to risks requiring capital treatment and risks associated with emergency care (the 'bottom-up' risk profile).

Next steps
The next step will be to refresh the BAF for 2024/25 reflecting the development of the 2024/25 operational plan and objectives, informed by feedback from the Audit and Risk Committee, building on the approach developed in the last two years and incorporating any learning from good practice examples elsewhere. The target will be to enable a Board discussion of draft BAF risks and risk appetite statement in May 2024. Separately, the Trust's risk management function will take a lead role in a high level review of NEL acute provider (and ICS) BAFs during Quarter 1 with the aim of assessing the relative alignment of sector risks and to discuss shared risk management principles. Within the Trust's governance structure, steps will be taken to embed a prioritised BAF deep dive schedule. Recent board committee reviews have considered BAF risks on wellbeing; group model development; identification of hotspots; and staff inclusion.

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 approve the Quarter 4 BAF.

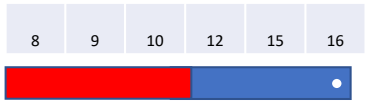

Objective / Appetite
Risk entry
1-3
4-6
8-9
10
12
15
16
>=20
PEOPLE
Creating a fair & just culture (moderate risk appetite)
1. A lack of evidenced delivery on the operational plan's inclusion commitments impairs engagement, morale, ability to lead and recruitment and retention of staff at Trust and system level. [DI/DP] [ARC]
Supporting the wellbeing of our people (moderate risk appetite)
2. Insufficient leadership capacity and capability to effectively prioritise wellbeing plans impairs engagement, morale, ability to lead and recruitment and retention of staff at Trust and system level. [DP] [ARC]
Working differently to transform care (open risk appetite)
3. A failure to successfully engage our people on our Quality Improvement approach impairs our ability to transform services and meet demand [COO] [FIP]
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] [ARC]
PATIENTS
Improving performance & productivity (cautious risk appetite)
5. Patient flow constraints in emergency and elective care combined with workforce productivity issues (including industrial action) impact on delivery of planned activity, long waiting times and funding. [COO] [FIP]
Transforming services through innovation ** (open risk appetite)
6. Insufficient system-wide mental health care capacity impairs urgent and emergency care resilience, quality of care and patient experience [COO] [FIP]
Promoting equity & sustaining standards (averse risk appetite)
7. Insufficient resourcing for informatics impairs plans to improve activity, productivity and system development thereby impacting on effective service delivery within the Trust and NEL. [DS] [FIP]
Preventing ill health (open risk appetite)
8. Failure of systems to identify hotspots in a large complex organisation impacts on aspirations to provide 'good and outstanding' rated services across the group [CN] [QAC].
PARTNERSHIPS
Acting as an effective hospital group (moderate risk appetite)
9. Delays in implementing a maternity service improvement programme that responds to national reviews impacts on consistent quality of maternity care provision, confidence of service users and workforce retention [CN] [QAC]
Co-operating across NEL (open risk appetite)
Failure to collaborate effectively through the NEL acute provider collaborative, and through place-based partnerships, delays benefits to quality and outcomes, equity and value. [DGD] [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)

Key

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

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

Risk score section-



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

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

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

STRATEGIC OBJECTIVE 1a. Creating a fair & just culture 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%: Q3 assessment = ON TRACK**
	Reduce gender pay gap from 11.7% to 11% in leadership roles Q3 assessment = ON TRACK
	ESR declaration rates: closing the disparity between the declaration rate in ESR and the annual staff survey Q3 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?*	
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 joint workforce initiatives (on agency pay rates etc) 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)** 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 including WeBelong report and statutory reporting ***(maps to control* 1, 2)** *[confirmed positive progress on key WRES metrics 4a to 9a during 23/24]* 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 provide more frequent local feedback (**5,7)** WRES and WDES data benchmarking – 2023 results indicate improved scores on key WRES metrics (4a - 9a) during 23/24 **(2,4)** Internal Audit reports – sickness absence (substantial assurance)**;** people relations (reasonable assurance); honorary contracts (reasonable assurance; **(1,5)** Internal Audit reports on hospital people processes: Newham staff OD; RLH consultant recruitment and people processes (limited assurance) **(1,5)**		*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**	**Q3 assessment = BEHIND SCHEDULE (REVISED DOWNWARDS SINCE LAST QUARTER)**
	Reduce sickness absence from 5.07% to 4%	**Q3 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?*	
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.** 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 includes wellbeing **(1-4)** ARC oversight and wellbeing deep dive in Q3 **(1-5)**		Closer sector working of trust boards, establishment of workforce and Board Collaboration Committee **(1-5)**		Role of NEL ICS, JOSCs and Healthwatches in oversight of system development and place-based governance **(1-5)** CQC oversight of Well Led domain and internal mock Well Led inspections. **(1-5)**		*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	**Q3 assessment = BEHIND SCHEDULE**	**(REVISED DOWNWARDS SINCE LAST QUARTER)**
Number of QI projects registered	**Q3 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.		*Gap: Tracking and recording of Projects through a single Group wide portal.* *Action: Procurement underway in partnership with the Clinical Effectiveness Unit.* *Gap: Development of a quality management system to embed priorities in ward programmes upwards using standardised SBC methodology.* *Action: GEB endorsed proposal for QMS approach (Feb 2024)* *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%**	**Q3 assessment = BEHIND SCHEDULE**
	Increase nursing and midwifery substantive fill rate from 87.5% to 95	**Q3 assessment = BEHIND SCHEDULE**
	Reduce agency spend from 5.02% to 3.7	**Q3 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: 4x3=12*** *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)**		DBS and right to work external reporting **(assurance on controls 1-5)** CQC, HEE and Deanery reporting **(assurance on controls 1-5)** External support on workforce supporting the development of a new workforce dashboard **(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 - 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 (20); 7525 The risk of patient harm due to significant delays in Cellular Pathology results (16); 3577 Non-compliance with statutory times of routine Cytogenetics and Molecular Haematology tests (16). Lead: Group Director Estates – 7530 Impact of lack of risk assessments covering Fire Safety, Health and Safety topics across the Trust (16)

Lead: Newham Chief Executive - 7197 Lack of senior medical staffing within ED (15); 6832 Vacancy across nursing and midwifery workforce within the clinical areas and within the senior nursing leadership team (16); 7232 Urology cover for ED and inpatients at NUH (15); 6321 Inadequate nursing support for POSCU services (15); 6735 There is currently no Home Oxygen Service provision NUH (15); 7113 Risk to patient safety - Lack of consultants in OPS (16); 3967 Controls for managing violence and aggression towards staff at Newham University Hospital (16); 7597 ED and inpatients may be left alone in the imaging waiting room out of hours (OOH) if patients are not sent with an escort (16); 7309 Not providing holistic risk assessments throughout pregnancy and on presentation labour (15); 6437 Increase O&G Consultant establishment to support sustainability of Consultant Labour Ward 98 hour presence & Separate rotas (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 (16); 7273 Delay in Imaging Ultrasound Head and Neck examinations RLHSBHMEH (16); 7444 Delays in Ultrasound Imaging (16); 6416 Rightsizing the Department of Infection and Addressing Consultant Underpayments (16); 6676 Mismatch between Clinical Neurophysiology demand and capacity (16); 6709 Risk to staffing MRI Scanners x3 at weekends and evenings (15); 6763 Clinical risk to paediatric audiology patients on waiting lists, and system risks due to pressures on paediatric audiology (16); 6789 Pharmacy staffing within the inpatient dispensary (16); 6512 Inability to offer statutory compensatory rest and protected RPS time for Core radiographers) (16); 6798 Lack of Ophthalmic capacity in RLH theatres has significant implications on patient care and service delivery (16); 5997 Harm and poor patient experience due to length of wait for complex elective orthopaedic surgery (15); 7625 Children's Immunology Service (16); 7483 Insufficient Epilepsy Capacity leading to inappropriate care for patients (16); 7484 Lack of therapies input into Multi-Disciplinary Team (MDT) Service for patients with Motor Neurone Disease (16); 7559 Therapies Provision to ED (15); 7574 Unfunded Therapies Posts (15); 7471 Insufficient Haemodialysis capacity to meet current demand and future growth (20); 6915 Critical Overcrowding ED (20); 7582 Critical Overcrowding in ED Adult Resuscitation rooms leads to patient safety concerns and our ability to function as an MTC (16); 7558 Insufficient neurosurgery weekend medical staffing (16); 6804 Risk of unreported significant Findings as a result of backlog of reporting of images for CT, MRI and X-ray images (15); 6084 There is a patient safety risk within Oral Surgery and Dental as a result of delays in referral processing and vetting (16); 7516 Vulnerability of the Interventional Radiology Service on elective cases and on-call (16); 6503 retention and recruitment/ radiation safety risk/ lack of career progression (16); 6610 risk of delayed diagnosis and treatment of patients, with concurrent radiation protection risk due to lack of RPS time (15); 5367 Shortage of Consultant histopathologists in post resulting in adverse TAT and delays to patient's on cancer pathways (16); 7340 Inadequate Midwifery staff to provide safe and responsive care within maternity services (16); 6882 Obs & Gynae Medical Staffing (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 (16); 7055 Significantly reduced staffing levels with the potential to affect nuclear medicine physics service provision (16); 6800 Insufficient management of complex nutrition needs for SBH patients (16);, 6958 Inability to meet cancer waiting time targets due to Therapeutic Radiographer staffing levels (16); 5267 Radiation safety staffing levels – Trust compliance with radiation safety regulations (16); 3646 Lack of follow up on abnormal pathology & imaging results (16); 7549 WXH Resus demand is greater than capacity (6 spaces) (16); 7395 Failure to deliver safe provision of services within constitutional standards (15); 3062 Low Junior Doctors at registrar level within the Emergency Department (15).

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 (20), 7214 Lack of non-admitted capacity for Glaucoma (20); 7216 Lack of capacity in retina clinic (20); 6650 Delay in care for routine care for women on Colposcopy pathway (16); 7212 Mismatch between demand and capacity in WXH Neuro-Ophthalmology service (16); 7384 Dermatology skin 2ww - patient demand exceeding capacity (16); 7429 Critical Care Technologists (16); 7253 Unable to meet full needs of the service due to a shortage of junior doctors (16); 5156 Risk to patient safety related to operational seasonal pressures (16); 6598 Persistent national and local midwifery staff shortages contribute to the quality of care provided and affects safety levels (20); 6423 Junior doctor gaps in medicine (15); 7406 Risk of clinical harm associated with long waits for heart failure OP appointments (network) (16); 7431 limited ortho-geriatric support for complex medical patients on orthopaedic wards (15); 7550 Overcrowding of the WXH Emergency Assessment Area with adverse impact on quality and safety (20).

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** — **Q3 assessment = BEHIND SCHEDULE (revised trajectory now set in national letter)**
	Improve theatre utilisation to 85% — **Q3 assessment = BEHIND SCHEDULE**
	Delivery of 109% value weighted activity against 19/20 baseline — **Q3 assessment = ON TRAJECTORY (REVISED UPWARDS SINCE LAST QUARTER)**

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 monthly. Escalation via weekly cross Trust escalation mtg. GEB review of long waiters via operational report.**(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 board reporting to ERB on programme of work and milestones including national Further Faster Programme**(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)**. Refreshed approach to implementing the Surgical Strategy include the movement of services to create Centres of Excellence and Surgical Hubs. Reporting to ERB and GEB .		NHSE/I and ICS level governance and monitoring of key metrics Tier 1 regulatory engagement with national elective team. Weekly review of long waiters by specialty and actions **(8)** Provider coordination across NEL to support targeted activity and collaborative capacity. **(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) 2023 Remote consultation Audit – limited assurance (8)	*Gap: Elective plan risks linked to emergency care demand.* *Action: Board-level and site focus on prioritised elective long waiters and chronological booking but gaps on trajectory remain as H2 elective plans for 23/24 assumed no further industrial action (3 episodes since November 23).* *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 People - 6711 Critical Care Resourcing (People Services) (16); 7230 Risk of a halt to the Barts Health NHS Trust kidney and stem cell transplant service due to lack of Consultant Clinical Scientists (16) 3577 Non-compliance with statutory times of routine Cytogenetics and Molecular Haematology tests (16); 7414 Increased demand for SIHMDS labs from Mid and South Essex Trust: demand exceeding capacity and potential loss of income (16); 7615 Risk Associated with EZ2 Connect Nucleic Acid Extraction Machine: Increased Workload Leading to Capacity Issues and Delayed Test (16).

Lead: Newham Chief Executive - 7135 Mental health patients staying long periods in the emergency department (16); 7172 Significantly long waits in ED due to challenging bed pressures (16); 7197 Lack of senior medical staffing within ED (15); 7269 Risk to patient safety due to industrial action by junior doctors (15); 6321 Inadequate nursing support for POSCU services (15); 6735 There is currently no Home Oxygen Service provision (15); 7597 ED and inpatients may be left alone in the imaging waiting room out of hours (OOH) if patients are not sent with an escort (16); 7057Long length of stay leading to congestion in the Emergency Department (16)

Lead: Whipps Cross Chief Executive – 3062 Low Junior Doctors at registrar level within ED (15); 6423 Junior doctor gaps in medicine (15); 4019 Outpatient appointment capacity (16); 7429 Critical Care Technologists (16); 7430 No reliable clinical pathway for Patient First Community Diagnostic Service (16); 6650 Delay in care for routine care for women on Colposcopy pathway (16; 7384 Dermatology skin 2ww - patient demand exceeding capacity (16);); 6423 Junior doctor gaps in medicine (15); 7427 Increased risk to patients from lack of capacity within the injection service (ETC) (20); 7406 Risk of clinical harm associated with long waits for heart failure OP appointments (network) (16); 7550 Overcrowding of the WXH Emergency Assessment Area with adverse impact on quality and safety (20); 7549 WXH Resus demand is greater than capacity (6 spaces) (16); 3062 Low Junior Doctors at registrar level within the Emergency Department (15)

Lead: Royal London Chief Executive - 3571 lack of inpatient beds will result in patients being cared for in recovery (16); 3816 Increased mortality and morbidity due to long waiting times for emergency orthopaedic surgery (16); 5477 Delays in histology reporting for cancer patients within General Surgery impacting diagnosis and treatment (15); 5997 Theatre capacity for complex elective orthopaedic surgery (15); 6253 Risk of DMO1 failure due to delays in diagnosis and treatment within the Redbridge Audiology service (15); 6547 Delays to patient care due to insufficient capacity/staffing in CT imaging, with radiation risk due to lack of RPS time (16); 6676 Mismatch between Clinical Neurophysiology demand and capacity (16); 6763 Clinical risk to paediatric audiology patients on waiting lists, and system risks due to pressures on paediatric audiology (16); 6915 Critical Overcrowding ED (20); 7444 Delays in Ultrasound Imaging (16); 7273 Delay in Imaging Ultrasound Head and Neck examinations (16); 6512 Inability to offer statutory compensatory rest, protected RPS time (radiation risk) and decreased skill mix (16); 7483 Insufficient Epilepsy Capacity leading to inappropriate care for patients (16); 7484 Lack of therapies input into Multi-Disciplinary Team (MDT) Service for patients with Motor Neurone Disease (16); 6416 Rightsizing the Department of Infection and Addressing Consultant Underpayments (16); 6709 Risk to staffing MRI Scanners x3 at weekends and evenings (15); 7559 Therapies Provision to ED (15); 6798 Lack of Ophthalmic capacity in RLH theatres has significant implications on patient care and service delivery (16;); 7582 Critical Overcrowding in ED Adult Resuscitation rooms leads to patient safety concerns and our ability to function as an MTC (16); 6804 Risk of unreported significant Findings as a result of backlog of reporting of images for CT, MRI and X-ray images (15); 7516 Vulnerability of the Interventional Radiology Service on elective cases and on-call (16); 6610 risk of delayed diagnosis and treatment of patients, with concurrent radiation protection risk due to lack of RPS time (15); 5367 Shortage of Consultant histopathologists in post resulting in adverse TAT and delays to patient's on cancer pathways (16). 5477 Delays in histology reporting for cancer patients within General Surgery impacting diagnosis and treatment (15); 4575 Harm and poor patient experience due to length of wait for limb reconstruction (16); 4735 SAF 4: Activity growth exceeds contract assumptions - ED 4 Hours (15); 7522 Pharmacy provision to the surgical division (16); 7539 Delay to Care and Risk of Harm, due to telephone consultations at 16/40 and lack of clinics on Cerner, resulting in EMIS being u (16); 7543 Delay to patient care due to lack of telephone access in the Barkantine Birth centre (15).

Lead: St Bartholomew's Chief Executive - 6294 impact on patient care and operational performance, due to vascular lab closures caused by lack of staffing resilience (16); 5267 Radiation safety staffing levels – Trust compliance with radiation safety regulations (16); 6958 Risk of patient harm due to departmental Therapeutic Radiographer staffing levels being 30% lower than national recommendations (16); 7055 Significantly reduced staffing levels with the potential to affect nuclear medicine physics service provision (16)

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**	**Q3 assessment = BEHIND SCHEDULE**
	A&E 12 hours journey time	**Q3 assessment = BEHIND SCHEDULE**
	Reduce bed occupancy to 92% or below	**Q3 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	*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 logged in the Operational Hub 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)** Introduction of ICS System Co-ordination Centre to balance risk and support escalation across the emergency care pathway with specific visibility 24/7 on MH delays		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 *Action:* *NEL has opened 12 additional mental health beds and has shared plans to improve access to community teams and MH inpatient LOS.* *Escalation at 72hrs introduced requiring visibility of waits and actions to mitigate risk signed off at ICS system co-oridination centre, GOLD Executive for Acute and MH provider*

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 (16); 7155 Lack of safe and suitable environment for assessment and care of patients with mental health presentation (16); 7412 Care and Management of Children in Acute Mental Health Crisis (16); 7397 SAF 14: Mental Health Provision (20).
Lead: Newham Chief Executive - 7135 Mental health patients staying long periods in the emergency department (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**	**Q3 assessment = BEHIND SCHEDULE**
Millennium go lives for theatres, perioperative, critical care and ED uplift across all sites in April 2024	**Q3 assessment = ON TRACK**
Patients Know Best (PKB) for NEL ICS expansion	**Q3 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)** 2023 Reasonable assurance Internal Audit reports on ICT network segmentation; and AI systems **(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: 6671 ICT - Cyber Security (risk score 20); 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); 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); 7591 Any end-point Device attached to network can expose vulnerabilities and needs configuration and monitoring with controlled access (20); 7590 Lack of data access controls can result in data leakage and exploitation (20); 7592 Lack of network security enforcement and technologies exposes the trust to exploitable vulnerabilities (16); 7589 Software not within current versions increases CareCertAlerts/AttackVector, reduces functionality/performance/security (16); 6891 Adequate controls around electronic records to support paperless/paper light strategy (including disposal rules in systems) (16); 7035 Viewpoint – computers WS PC's (15);7539 RLH / MEH Delay to Care and Risk of Harm, due to telephone consultations at 16/40 and lack of clinics on Cerner (16); 7543 RLH / MEH Delay to patient care due to lack of telephone access in the Barkantine Birth centre (15); 6723 Imaging facilities at Barkantine Outreach Dental Clinic (15); 6647 Lack of end to end digital maternity solution (16); 7500 WXH Women and birthing people receive sub-optimal care and potentially poorer outcomes as a result not having a single integrated EPR system (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**	**Q3 assessment – ON TRACK**
	Implementation of clinical audit policy	**Q3 assessment = BEHIND SCHEDULE**
	Rescuing of Deteriorating patients – improve time to administration of antibiotics for high risk patients with sepsis	**Q3 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?*	
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: 3x3=9*** *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) CNST		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) **(1-7)** CQC visits support trend of improving ratings of services. Involvement in national Maternity Safety Support Programme 2023 Reasonable assurance Internal Audit review – Integrated Performance review **(1-7)**		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:
None

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**	**Q3 assessment – BEHIND SCHEDULE (REVISED DOWNWARDS SINCE LAST QUARTER)**
	Neonatal deaths per 1000 births	**Q3 assessment – BEHIND SCHEDULE (REVISED DOWNWARDS SINCE LAST QUARTER)**
	Increase permanent workforce to 95% or more of funded establishment	**Q3 assessment – BEHIND SCHEDULE (REVISED DOWNWARDS SINCE LAST QUARTER)**

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 (5 of 10 compliant in 2023) reviewed at QAC and signed off by Board (**2-5)**		Reasonable assurance 2021 Internal Audit report – Maternity safety **(2-4)** Part of national Maternity Safety Support Programme – gateway review due in 2024/25 **(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:* Identified key enablers for maternity improvements include digital investment Action: Business case development *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 (16); 7309 Not providing holistic risk assessments throughout pregnancy and on presentation labour (15); 6647 Multiple methods of documentation throughout the maternity pathway does not capture all data and assurance required (16); 6437 Increase O&G Consultant establishment to support sustainability of Consultant Labour Ward 98 hour presence & Separate rotas (16); 6646 Current antenatal care pathway not adequately meeting the needs of the service (16); 6923 Potential scan capacity issues affecting gap and grow being fully implemented. (15); 6832 Vacancy across nursing and midwifery workforce within the clinical areas and within the senior nursing leadership team (16)
Lead: Royal London Chief Executive - 7340 Inadequate Midwifery staff to provide safe and responsive care within maternity services (16); 6882 Obs & Gynae Medical Staffing (16); 6893 Inadequate number of Resuscitaires in Maternity Department (16); 7454 TC & Postnatal antibiotics (15)
Lead: Whipps' Cross Chief Executive - 7253 Unable to meet full needs of the service due to a shortage of junior doctors (16); 6598 Persistent national and local midwifery staff shortages contribute to the quality of care provided and affects safety levels (20); 7500 Women and birthing people receive sub-optimal care and potentially poorer outcomes as a result not having a single integrated EPR system (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**	**Q3 assessment – ON TRACK**
	Delivery of integrated group priority enabler milestones and metrics	**Q3 assessment – BEHIND SCHEDULE (REVISED DOWNWARDS SINCE LAST QUARTER)**
	Delivery of Barts Health Well-led improvement plan	**Q3 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 through the NEL acute provider collaborative, and through place-based partnerships, delays benefits to quality and outcomes, equity and value. **Executive lead:** Director of Group Development **Subcommittee role:** Audit and Risk Committee	*[Outset score: 12]* ***Current: 4x3=12*** *Target: 4x2=8* *Datix ref: [7138]*	1. The hospitals within the Group are active within their borough-based place-based partnerships. 2. As a member of the NEL acute provider collaborative (APC), the Trust is contributing to and hosting clinical transformation programmes (planned care, cancer, critical care, specialised services and maternity plus cross-cutting work on research and clinical strategy. It is supporting the NEL-led urgent and emergency care and babies, children and young people programmes. 3. Ongoing collaboration with Barking, Havering and Redbridge trust on corporate infrastructure, digital, workforce and financial improvement will be reviewed, refreshed and taken forward under APC governance.	Group Executive Board receives regular updates on provider collaboration (2-3). Group Executive Board receives periodic updates on place-based partnerships (1). Acute Provider Collaborative executive group oversees delivery of APC programmes (2). Joint executive with BHRUT continues to oversee 'closer collaboration' workstreams pending transition under the APC (3). Group Executive Board and Hospital Executive Boards oversee well-led improvement plan (1-3).		Board Collaboration Committee continues to assure collaboration with BHRUT and through the APC (2-3). APC joint committee assures progress of the APC (2,3). Joint board seminars are held to discuss system collaboration (1-3). Part 1 and 2 Trust Board meetings receive regular updates on provider collaboration (2,3). Board receives updates on well-led improvement (1-3).		Role of NEL ICS, JHOSCs and HealthWatches in oversight of system development and place-based governance (1-3). CQC oversight of Well Led domain (1,3). Internal audit of provider collaboration benefits realisation. (1-3).		Gap: transition of 'closer collaboration' workstreams into APC not yet confirmed. *Action: programme plan to be approved by APC executive and APC joint committee, to include organisational development.* Gap: limited resource available to support APC ambitions. *Action: draw resources from business as usual funding within 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 OBJECTIVE 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**	**Q3 assessment – BEHIND SCHEDULE**
	70% of hospital inpatients having their smoking status documented on admission	**Q3 assessment – BEHIND SCHEDULE**
	50% of hospital inpatients having their alcohol harm risk levels documented on admission	**Q3 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**	**Q3 assessment – ON TRACK**
	National approval of the outline business case	**Q3 assessment – WILL NOT DELIVER (REVISED DOWNWARDS SINCE LAST QUARTER)**

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 Investment and Performance 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 – 7550 Overcrowding of the WXH Emergency Assessment Area with adverse impact on quality and safety (20); 7549 WXH Resus demand is greater than capacity (6 spaces) (16); 4019 Outpatient appointment capacity (16); 5156 Risk to patient safety related to operational seasonal pressures (16); 3687 Drainage issues at WXH leading to potential floods and loss of services (15); 3619 Non-compliance of the Fire Safety Order within Whipps Cross Hospital Site (16); 1418 Backlog Maintenance - lift compliance lack of investment, risk of breaking down (16); 220 Contamination of WX site water resulting in legionaire's disease (15)
Programme risk register held separately for redevelopment

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**	**Q3 assessment – BEHIND SCHEDULE**
	Agency spend as a % of pay bill	**Q3 assessment – BEHIND SCHEDULE**
	Performance against capital plan	**Q3 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.** Corporate and external support 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 2-7).** 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 **(6-7)**		Review of financial performance at monthly Finance Investment and Performance Committee and Trust Board review **(assurance on controls 1-3,5**).		NHSI / CQC Use of Resources assessment, with evidence of productivity improvements 2023 Substantial assurance Internal Audit report on financial sustainability **(2-7)** 2023 Substantial assurance Internal Audit report on activity costing **(2)** ICS level review of sector financial drivers of deficit and sustainability **(1).**		*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 and ongoing sector discussions regarding NEL capital envelope.*

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 (16); 7101 Impact of BHRUT integration (15)
Lead: Newham Chief Executive - 6529 NUH SAF 5: Performance against the financial plan (20); 7517 Risk to the delivery of the Newham financial plan within the defined financial envelope (16)
Lead: Royal London Chief Executive - 4736 RLH SAF 5: May not be able to achieve our financial targets (15); 7625 Children's Immunology Service (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 (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**	**Q3 assessment – BEHIND SCHEDULE**
	Projects being delivered on programme, on budget and meeting approved brief	**Q3 assessment – BEHIND SCHEDULE**
	Value of unfunded capital risks with datix score of 15 and above	**Q3 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: 7437*	**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 triangulating associated risks requiring capital treatment **(1-5)** 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)		Internal audit of NUH 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 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 and ongoing sector discussions regarding NEL capital envelope.* *Gap: Aggregated assessment of risks associated with capital shortfalls* *Action: matrix approach to managing risks requiring capital treatment.*

Related high risks (>15) on the risk register – Datix refs
Lead: Group Director Estates – 7322 Forecasting Trajectory of current EFM Approved Risk's increasing due to lack of Funding (16); 6875 Envair negative & positive pressure isolators - end of serviceable life & non-compliance EU GMP Annex1 Regulatory updates (20); 7530 Impact of lack of risk assessments covering Fire Safety, Health and Safety topics across the Trust (16)
Lead: Group Director of People - 7525 The risk of patient harm due to significant delays in Cellular Pathology results (16); 7615 Risk Associated with EZ2 Connect Nucleic Acid Extraction Machine: Increased Workload Leading to Capacity Issues and Delayed Test (16) 7357 Lack of an electronic Blood Tracking Solution at the Homerton University Hospital (HUH) risking patient safety (16); 6757 Main Lifts in the RLH P&P building are regularly out of service risking urgent blood product service (16) 4686 Insufficient body freezer spaces to prevent the decomposition of patients in storage (16)
Lead: Newham Chief Executive - 3468 Non-compliance of the Fire Safety Order (law) within the Newham Hospital (20); 1163 Loss of main circuit breakers will result in catastrophic failure and potential loss of service to patients (16); 6447 The impact of non-compliant Mechanical Ventilation within majority In-Patient areas which fails to meet current HTM requirements (16); 6236 A fire affecting GSC cladding (external wall system) which is non-compliant to Fire Safety regulations (15); 6846 Procurement of 12 Wired Philips Healthcare Avalon FM30 Intrapartum Fetal Monitor CTG (16); 7457 A fire in or affecting the roof void without a working watermist system (15); 6675 Ultrasound machines are no longer fit for purpose and are in need of urgent replacement (16); 3459 There is potential for the NUH Pharmacy Robot to breakdown, leading to delays in medicines supplies to areas at NUH (16); 5320 There is a risk of delays to patient care due to potential breakdown of the obsolete Phillips Eleva Fluoroscopy machine (20); 5322 There is a risk of delays to patient care due to potential breakdown of the obsolete X-ray equipment at Shrewsbury Road (16); 7150 Generator capacity and resilience (16); Lead: Royal London Chief Executive – 7471 Insufficient Haemodialysis capacity to meet current demand and

future growth (20); 4740 RLH SAF 9: Capital requirements may be higher than the capital allocation (15); 6634 UKPN electrical MEH capacity exceeded. Additional services cannot be supported (15); 6723 Imaging facilities at Barkantine Outreach Dental Clinic (15); 6893 Inadequate number of Resuscitaires in Maternity Department (16); 6253 Risk of DMO1 failure due to delays in diagnosis and treatment within the Redbridge Audiology service (15); 7155 Lack of safe and suitable environment for assessment and care of patients with mental health presentations. (16); 6967 Lack of access to 11th floor gym space presents a risk to supporting the acute rehabilitation & functional optimisation (15); 7134 Replacement incubators (15); 7452 Safe Environment (lack of storage on ward 8D) (15); 6816 End of life decontamination machines causing damage to ultrasound machines (16); 6796 General/Paeds Ultrasound machines coming to end of life (16); 7560 Inability to use Windows 7 EEG equipment due to cyber security risk resulting in loss of service provision (15); 7585 Paediatric ED CPAP Machines (16); 7512 Both Mini C-arm X-ray devices in theatres are obsolete and affecting orthopaedic and plastic surgery schedules across theatres (16); 7518 Dispensary robot has reached it's end of life (16); 7160 replacement of complete, obsolete, neonatal patient GE monitors (15); 7350 Risk to mammography service at MEH due to failing machine (16); 5874 Single biplane unit may lead to delays for time sensitive cases and/or the RLH service must shut during breakdowns or services (16); 6703 There is a risk of late diagnosis and loss of patient data - due to an Obsolete RetCam3, this may lead to an adverse incident (16); 7131 Shortage of desk space and computer equipment on site for the imaging admin and clerical team (15); 7089 Broken doors leading to theatres from ACCU (16)

Lead: Whipps Cross Chief Executive – 3619 Non-compliance of Fire Safety Order within Whipps Cross Hospital (16); 3687 Drainage issues at WXH leading to potential floods and loss of services (15); 220 Contamination of WX site water resulting in legionnaire's disease (15); 7216 Increased risk to patients from lack of capacity in retina clinic (20); 7214 Increased risk to patients from lack of glaucoma non admitted capacity (20); 1418 Backlog Maintenance - lift compliance lack of investment, risk of breaking down (16); 7211 Failure to meet national guidelines in Retinopathy of Prematurity screening (16); 7215 Obsolete indirect laser in ophthalmic theatre 2 (16); 7213 Ageing and failing Ophthalmology Microscopes (16); 7210 Insufficient capacity for Paediatric Ophthalmology (16); 7173 ERCP Service Viability (16)

Lead: St Bart's Chief Executive – 7620 Unsafe structural elements within the Pathology Building such as Glazing, brick work (16); 6738 Breast Imaging Service at SBH at risk due to ageing mammography equipment in x-ray Room 5 – mammography and intervention (15); 7167 Poor image quality on cardiac US machines (9 machines) (16); 6701 Risk of major harm / service cancellations if Medtronic NIM Neuro-monitor system fails (15)

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**	**Q3 ASSESMENT – ON TRACK**
	Implementation of collaborative actions to increase research turnover by 10%	**Q3 ASSESMENT – BEHIND SCHEDULE (REVISED DOWNWARDS SINCE LAST QUARTER)**

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: 4x2=8*** *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 and Lifesciences programmes **(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 in Q1 on research funding* *Action: Joint Research Office stabilising research activity and funding – with progress on charity and research bids for major programmes.*

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

NHS
Barts Health
NHS Trust

Report to the Trust Board: 6 March 2024	TB 19/24

Title	People Strategy Update
Accountable Director	Daniel Waldron, Executive Group Director of People
Author(s)	Paula Oates, Director of People Strategy Delvir Mehet, Deputy Group Director of People
Purpose	This paper provides an update on our refreshed, draft People Strategy prior to being discussed at Trust Board on 6th March 2024.
Previously considered by	People Board: 15 December 2023 and 16 February 2024; Hospital Executive Boards (RLH and MEH, SBH, WX and NUH in November, December and February); Group Executive Board

Executive summary

- We started the review and refresh of our current **Barts Health NHS Trust People Strategy (2019)** in September 2023. The refreshed strategy is set against a current backdrop of **healthcare challenges**, including continued strike action and recovery and productivity challenges, but also **opportunities** such as digital innovation and partnership working, including our Acute Provider Collaborative, and crucially the opportunities to harness new roles and new ways of working to achieve our aim to achieve our overall strategic goal **to become an outstanding and inclusive place to work.**
- The refreshed strategy is **aligned to key national and regional plans** which are setting the context for much of this work. These include the **NHS People Plan, Our NHS People Promise, and the NHS Long Term Workforce Plan** (LTWP). We are also linking locally, **aligning with NEL People and Culture Strategy** (currently in draft, expected completion March 2024).
- **Locally,** our People Strategy **aligns to our Group Operational Plan** People Priorities and will be iteratively developed alongside the group organisational and clinical strategies (currently in development).
- The strategy encompasses the **four pillars of the operational plan and throughout it is** underpinned by the **'golden threads'** of WeBelong, Wellbeing, WeImprove and WeLead. The plan is centred on **four pillars** aligned to the Group **operational plan:**
  - Recruiting a permanent, stable workforce
  - Supporting the wellbeing of our people

- Working differently to transform care
- Creating a fair and just culture

- **Significant engagement and co-production has taken place with key stakeholders** both internally, where we engaged with 20 different hospital and professional groups and externally. We will develop this strategy further with plans for more stakeholder engagement in the future, including more internal and external stakeholders including Trust Board.
- This will be followed by **localised Hospital strategies** including specific **implementation plans** and metrics with **measurable outcomes**.
- The plan also includes a proposal for a **new multi-professional board** which will encompass the emerging priorities from the Clinical and Organisational Strategies. This will **accelerate the workforce transformation** and embed **new ways of working**.
- We are about to **conclude the first part of the key stakeholder engagement** and will continue to seek further engagement alongside development of the Group clinical strategy.

Related Trust objectives: 1a Creating a fair and just culture.	
Risk and Assurance	This report provides assurance in relation to the above objective and BAF risks 1-4
Legal implications/ regulatory requirements	Potential legal implications from not creating a compassionate and inclusive place to work.

Action required

The Trust Board is asked to engage in the development of the people strategy and comment on the ambitions.

Barts Health NHS Trust

Barts Health NHS Trust

People Strategy Update

Trust Board

6th March 2024

Executive Summary

NHS
Barts Health
NHS Trust

- With the expiry of our current people strategy we have the opportunity to **develop a new Strategy**, looking forward over the next **five years** to ensure we continue to provide the **excellent and equitable health and care** we strive to deliver. In addition to **addressing the challenges** we know we face, it is important to **seize opportunities in accelerating** workforce transformation, **new ways of working** and the **introduction of new roles**.
- Our evolving People Strategy is **aligned to our Group Operational Plan** and **integrates with the National, Regional and ICB People plans**. As we develop our **refreshed Clinical Strategy and Organisational Strategy** we will ensure that we integrate the most up to date thinking on the potential of our workforce and adapt the People Strategy.
- It is vital we have an **agile mindset** that will allow our people strategy to evolve and respond to new and emerging challenges and opportunities - this will allow us to address **immediate operational and financial challenges** such as the drive to improve productivity, reduce temporary staffing and ensure we **create the right conditions to harness emerging opportunities**.
- Embedded throughout the elements of the strategy are our **golden threads of WeBelong, Wellbeing, WeImprove and WeLead.** The plan is centred on **four pillars** aligned to the Group **operational plan:**
  - Recruiting a permanent, stable workforce
  - Supporting the wellbeing of our people
  - Working differently to transform care
  - Creating a fair and just culture
- Our plan is **designed to be iterative** as we **co-produce** with the wide range of key **stakeholders**, including, crucially, the Trust Board.
- In order to aid and accelerate workforce transformation, new roles and embed new ways of working, it is proposed **a new Workforce Transformation Board** is created to feed directly into the People Board.

Guiding Design Principles

NHS Barts Health NHS Trust

- Our starting point for developing the new People Strategy includes a number design principles. We have used these to shape our evolving strategy:
  - **Evolutionary,** aligning with the current **two-year operational plan** and developing the People Strategy in tandem as we define and co-create our **new Clinical and Organisational Strategies.**
  - **Balancing** the need to address **immediate challenges** and create a **foundation for the future;** recognising our immediate short term drivers for improved workforce productivity and wider efficiencies whilst also accelerating the workforce transformation which is key for future transformation.
  - **Harnessing** the opportunity to create a culture of innovation and transformation, maximising the impact of the **Hospital of the Future** programme and **Education and Training Strategy** to make this a reality.
  - **Flexibility,** recognising the year from April 2024 will be **transitional.** As our plans are developed, we will ensure that **all leaders** across the Trust **play an active role in the delivery** of the strategy meaning that the individual **ambitions at each Hospital and GSS are recognised.**

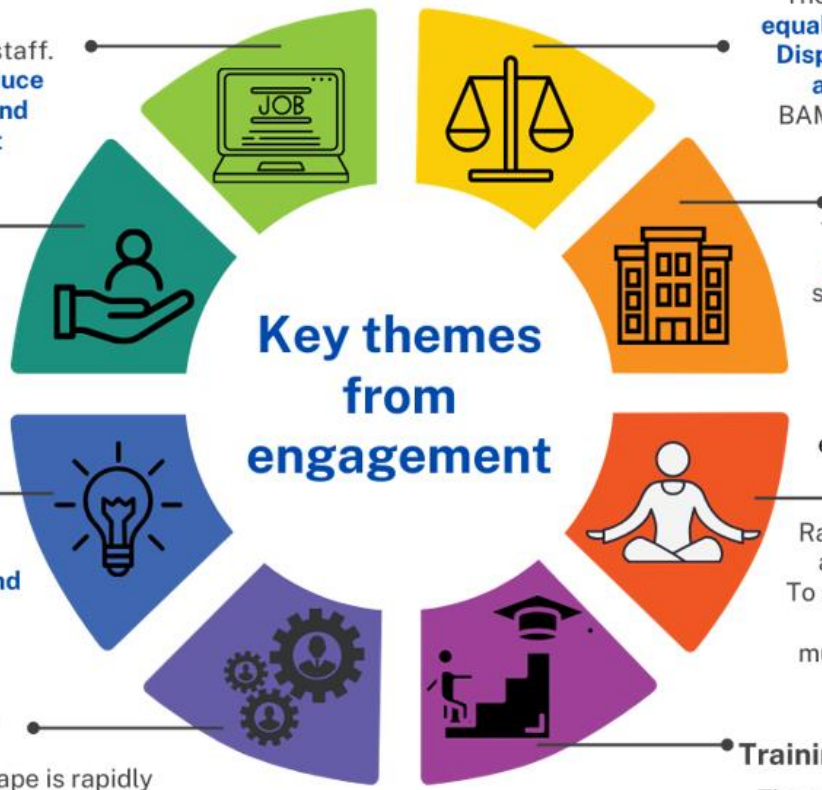
Group Operational Plan

Barts Health NHS Trust

Our Group Operational Plan focuses on three elements – our people, our patients and our partnerships. The People Strategy is aligned to 'our people' element of the Group Operational Plan.

Themes Identified Through Engagement

Barts Health NHS Trust



Recruitment

A conflict exists between the ambition to hire locally and the current reliance on international staff. There is also a need to **reduce reduce the reliance on temporary staff and adopt more inclusive recruitment practices.**

Retention

Workforce shortages have a direct impact on patient care and staff experience. There is a need for **robust and strategic approaches to retention, to reduce staff turnover and sustain safe staffing levels.**

Leadership & Culture

There is a need for **leadership and culture to reflect our workforce and the local communities** that we serve.

Innovation & Transformation

The health and social care landscape is rapidly evolving. For example, the ageing population and increase in patients with complex long term health conditions, will require **transformation of how we deliver care,** through the **development of new roles** and **introduction of advanced technologies.**

Equity & Inclusion

There is a need for **fairer and more equal opportunities for progression. Disparities in the levels of bullying and harassment** experienced by BAME and disabled staff must also be **eradicated.**

Getting the Basics Right

The importance of **consistently getting the basics right** for our staff cannot be underestimated. Our people should be able to work in an **environment that meets their basic needs,** that supports healthy choices and encourages healthy behaviours.

Wellbeing

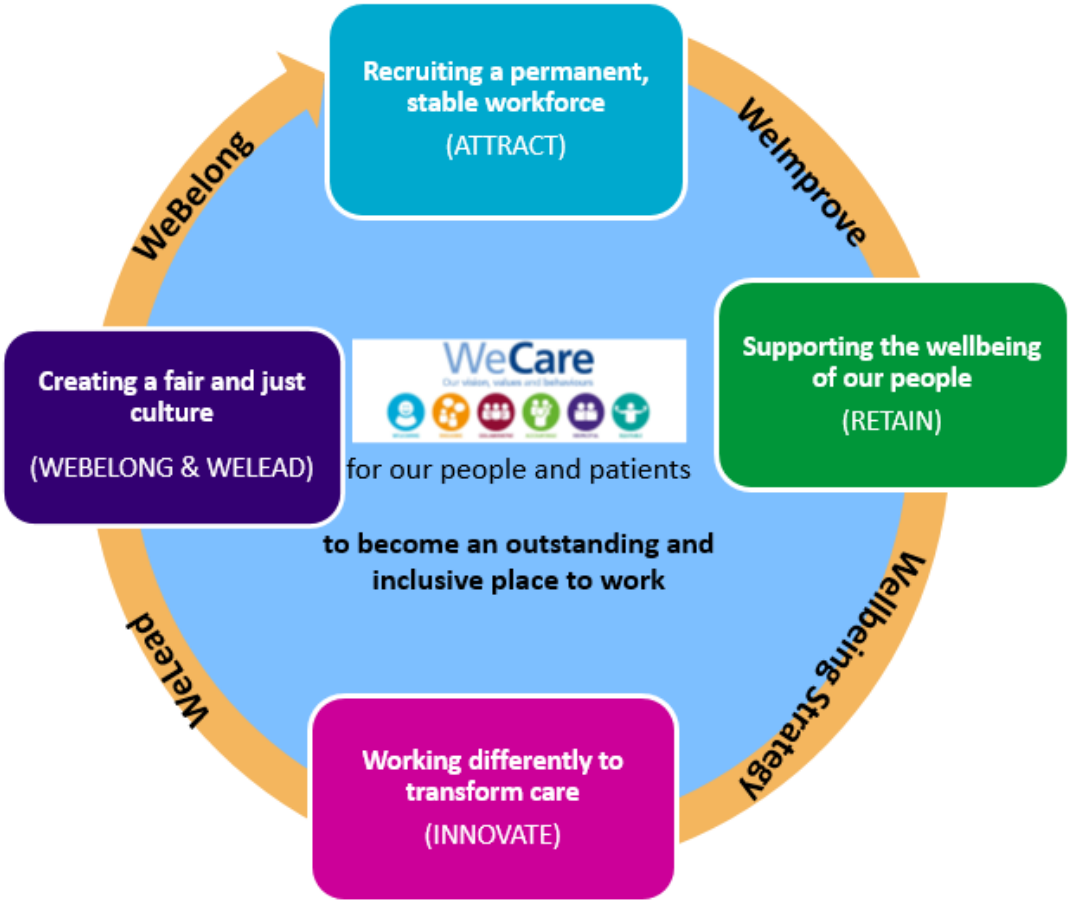
Rates of low morale and burnout are increasing across the NHS. To safeguard the delivery of safe, high quality patient care, we must **ensure that the health and wellbeing of our people is recognised as a key priority**

Training & Career Development

There is a need to **develop open and transparent career pathways** (from temporary to permanent employment) for all employees, supported by clear, agreed performance objectives and individual training and development plans that **promote life-long learning.**

New People Strategy Pillars and Golden Threads

Barts Health NHS Trust



The strategy pillars are underpinned by four critical **'golden threads' – inclusion**, covered in our **WeBelong strategy, leadership,** covered in our **WeLead framework, wellbeing,** covered in our **Wellbeing Strategy** and **WeImprove**, our approach to **quality improvement (QI).** These influence everything we do and how the work under the strategy pillars is progressed and delivered.

With our **WeCare values at the heart of the design process, our people strategy pillars have been designed around the key stages of the employee life cycle**, whilst holding our vision of becoming an outstanding and inclusive place to work.

People Strategy at a Glance

NHS
Barts Health
NHS Trust

People Strategy Pillar	Our strategic goals:	How we will achieve these:
Recruiting a permanent, stable workforce (ATTRACT)	**To deliver a permanent and stable workforce, reducing reliance on temporary workforce and improving patient care**	• **Reduce** reliance on **temporary staffing** and **international recruitment** • Ensure that our **employment offer is attractive** to people across all generations, including those who have yet to join the workforce and in line with our **WeBelong** strategy • Work with our partners to increase our local workforce supply and **support NEL's vision of 'one workforce'** where people can move seamlessly between our hospitals and across the NEL footprint; engage and collaborate **in partnerships,** e.g., APC, seeking more innovative ways of working
Supporting the wellbeing of our people (RETAIN)	**To have a sustainable approach to how we care for our people, improving work experience and retention**	• Scale up the **NHSE Exemplar programme** across all hospitals, including the roll out **team-based rostering across the organisation** • Deliver outstanding actions of the **people promise bundle** whilst upskilling our people to deliver this locally, using our **WeImprove QI methodology.** • Using our scale as a group to further develop a compelling **employee value proposition**
Working differently to transform care (INNOVATE)	**To have a sustainable workforce model that supports the transformation of care**	• In line with the ambition of our **clinical strategy, NHS Long Term Workforce Plan,** and our **Hospital of the Future** project, develop a plan that focuses on workforce transformation and the creation of new roles which will include developing and embedding apprenticeships and agreeing local employment targets • Plans for workforce transformation will be aligned to the **Education and Training Strategy** • Accelerate **digital and artificial intelligence (AI)** opportunities to expand **beyond back office** functions to deliver innovate ways to approach patient care delivery
Creating a fair and just culture (WEBELONG and WELEAD)	**Inclusion is a core commitment in ensuring inclusivity and belonging for all our people, where all forms of discrimination and inequality are eradicated**	• **Eradicate all** forms of **discrimination**, bullying, harassment and unwanted sexual behaviour • Continue to **improve representation in leadership positions and d**evelop a group wide **leadership strategy** that combines our leadership offer, outlining capability requirements and access to training • Co-create a leadership strategy for the group, work **with our partners to build a wider system leadership culture where everyone has an opportunity to develop and lead** • Support evolving **leadership behaviour for WeImprove and use a coaching-based approach to leadership**

Underpinned by four golden threads - WeBelong, WeLead, WeImprove and Wellbeing Strategy and strong operational and financial performance, capacity and demand alignment, digital strategy and healthcare analytics

Recruiting a permanent, stable workforce (Attract)

Barts Health NHS Trust

The Vision: At the end of Year 5, we aim to deliver a permanent and stable workforce, reducing our reliance on temporary workforce and improving patient care whilst enabling our people to be more flexible when designing their own team-based rotas, swapping shifts and having an increased sense of wellbeing and job satisfaction.

About this pillar	By actively attracting and recruiting into our vacancies, including those 'hard to fill' positions we aspire to reduce our reliance on temporary staffing, thereby enhancing the quality of patient care and solidifying our commitment to excellence in healthcare delivery.
Where are we now?	• Improving fill rates supported by agreed site plans • Developing integrated workforce plans • Developing consistent Group-wide temporary staffing rates and governance • Maximising the benefit of our diverse local community to grow our own future workforce
What will we do?	• **Reduce** reliance on **temporary staffing** and **international recruitment** • Ensure that our **employment offer is attractive** to people across all generations, including those who have yet to join the workforce and in line with our **WeBelong** strategy • Work with our partners to increase our local workforce supply and **support NEL's vision of 'one workforce'** where people can move seamlessly between our hospitals and across the NEL footprint; engage and collaborate **in partnerships,** e.g., APC, seeking more innovative ways of working • Achieve the ambitions for workforce growth set out in the Long Term Workforce Plan
How will we measure success?	• The metrics will be aligned to the annual Group Operational Plan • Overall fill rate • Nursing fill rate • Agency as % pay bill • Apprenticeship starts • People recruited from our local communities
Timeframe	• **Year 1 and year 2-** increasing substantive fill rate (ALL) increased to 93.5%, N&M fill rate to be 3 percentage points above end March 2024 figure, decreasing agency as a % of pay bill to 3.2% • **Year 5-** Achieve a substantive fill rate of 95% for all staff groups, decreasing agency as a % of pay bill to below 3.2%

What will this mean for me?

It is important to have a good recruitment strategy because it ensures that the workforce has the relevant skills and abilities for the organisation's current and future needs"

Luise Clifton-Bittasi
Matron, Outpatients Department
Whipps Cross Hospital

Supporting the wellbeing of our people (Retain)

NHS Barts Health NHS Trust

The Vision: The work under this pillar will aim to deliver a sustainable approach to how we care for our people, improving work experience and retention through maximising our learning from participation in the NHS England's Exemplar Programme and rolling this out to the whole organisation, ultimately leading to Barts Health becoming an outstanding and inclusive place to work, our strategic vision achieved.

About this pillar	This pillar focuses on exploring new and innovative ways of working and looking after our people and helping them to flourish by prioritising their health and wellbeing and creating a safe, inclusive environment.
Where are we now?	• The Trust has been part of the **NHS England's Retention Exemplar Programme** to improve the experience of our people and ensure they stay well, working with us for longer • The key retention priority areas the programme has been focusing on hospital focused interventions and flexible working, **promoting inclusion and wellbeing**
What will we do?	• Scale up the **NHSE Exemplar programme** across all hospitals, including the roll out **team-based rostering across the organisation** • Deliver outstanding actions of **the people promise bundle** whilst upskilling our people to deliver this locally, using our **WeImprove QI methodology.** • Using our scale as a group to further develop a compelling **employee value proposition**
How will we measure success?	• The metrics will be aligned to the annual Group Operational Plan as appropriate • 100% People Promise bundle implemented at Barts Health • % annualised voluntary turnover • sickness • Relevant Staff Survey measures
Timeframe	• **Year 1 and year 2**- turnover below 11%, sickness below 4%, people promise bundle implemented 90%, NHS staff survey themes score improved, progress against our Wellbeing Strategy • **Year 5-** 100% People Promise bundle implemented rolled out to the whole organisation, considered an exemplar and leader in our sector

What will this mean for me?

"An organisation that strives to enable flexible working for all – whatever that may look like – from true part time working, to the flexibility to do the school drop-off two days a week – is an organisation that retains its staff. Barts Health has been at the forefront of the NHS England 'We Work Flexibly' campaign. I look forward to the Trust really committing to practical solutions on flexible working for managers and staff alike, most crucially regarding modernising the way we manage rotas."

Dr Rifca Le Dieu
Clinical Reader and Honorary Consultant and Barts Health Champion of Flexible Working and SRTT Lead

Working differently to transform care (Innovate)

Barts Health NHS Trust

The Vision: for end of Year 5 is to have a sustainable workforce model that supports the transformation of care and new ways of working by removing the burden on our people to perform tasks that can be replaced by technology. To work innovatively and effectively in partnerships, e.g. Acute Provider Collaborative.

About this pillar	This pillar is about all types of innovation including new ways of working to transform care, working innovatively in partnerships and digital innovation e.g. artificial intelligence (AI) and robotic automation.
Where are we now?	• A small number of new roles (e.g., nursing and physician associates) and apprenticeships are in place • A level of automation has been introduced within our recruitment systems • We have established some of the working partnerships that will form the basis of our future **innovative working,** e.g. **Acute Provider Collaborative (APC)** • We have started to refresh our **WeImprove** approach to quality improvement (QI) that will help us progress and review our journey of innovation as an organisation
What will we do?	• In line with the ambition of our **clinical strategy, NHS Long Term Workforce Plan,** and our **Hospital of the Future** project, develop a plan that focuses on workforce transformation and the creation of new roles which will include embedding apprenticeships and agreeing a local employment target • Plans for workforce transformation will be aligned to the aims of **Education and Training Strategy** • **Accelerate digital and artificial intelligence (AI) opportunities** to expand **beyond back office** functions to deliver innovate ways to approach patient care delivery
How will we measure success?	• The metrics will be aligned to the annual Group Operational Plan as appropriate • Areas for digitalisation identified • AI options explored, but also acknowledging the challenges AI can pose to our people • Data quality metrics • Acute Provider Collaborative (APC) metrics
Timeframe	• **Year 1 and Year 2-** we aim to identify priority services and initiate workforce transformation and digital innovation pilots. • **Year 5-** We aim to fully embed new roles, workforce models and innovative ways of partnership working with novel ways of working across NEL sector.

What will this mean for me?

"I am excited to see how the increased use of automation and AI can support colleagues do their jobs in more interesting and exciting ways."

Andrew Vince
Head of People Systems & Insight
Group Support Services

Creating a fair and just culture (WeBelong and WeLead)

Barts Health NHS Trust

The Vision: At the end of Year 5, we will have eradicated all forms of discrimination and inequality, ensured inclusivity and belonging for all our people and developed a group wide leadership strategy, fully embedding a culture of compassionate and inclusive leadership whilst continuing to upskill our leaders through the work of our leadership community which will be critical to our success as a learning and evolving organisation.

About this pillar	Underpinned by our WeLead framework **for leadership development,** this pillar is centred on developing our leaders to be compassionate and inclusive leaders.
Where are we now?	• Continue our work to build **a compassionate, just and positive culture** • Deliver our **Cultural Intelligence Programme** • We developed our **WeLead** framework centred around compassionate and inclusive leadership and set up a leadership community; **Newham Hospital** are in the process of developing their **own version of WeLead** training programme that is expected to positively affect the hospital's culture • Our **Education Academy** has a vast offer of leadership development and management skills programmes and accredited programmes Leadership
What will we do?	• **Eradicate all** forms of **discrimination, bullying, harassment and unwanted sexual behaviour** • Continue to **improve representation in leadership positions** and develop a group wide **leadership strategy** that combines our leadership offer, outlining capability requirements and access to training • Co-create a leadership strategy for the group, work **with our partners to build a wider system leadership culture where everyone has an opportunity to develop and lead** • Support evolving **leadership behaviours for WeImprove and use a coaching-based approach to leadership**
How will we measure success?	• The metrics will be aligned to the annual Group Operational Plan as appropriate • WeBelong success measures • Relevant Staff Survey measures • Relevant **WeImprove** quality improvement (QI) metrics
Timeframe	• **Year 1 and Year 2-** steady increase in BAME representation at bands 8A and above, improved WRES, WDES metrics • **Year 5- Fair, just and positive** culture of compassionate and inclusive leadership embedded in line with **WeBelong** and our new group wide **WeLead strategy**

What will this mean for me?

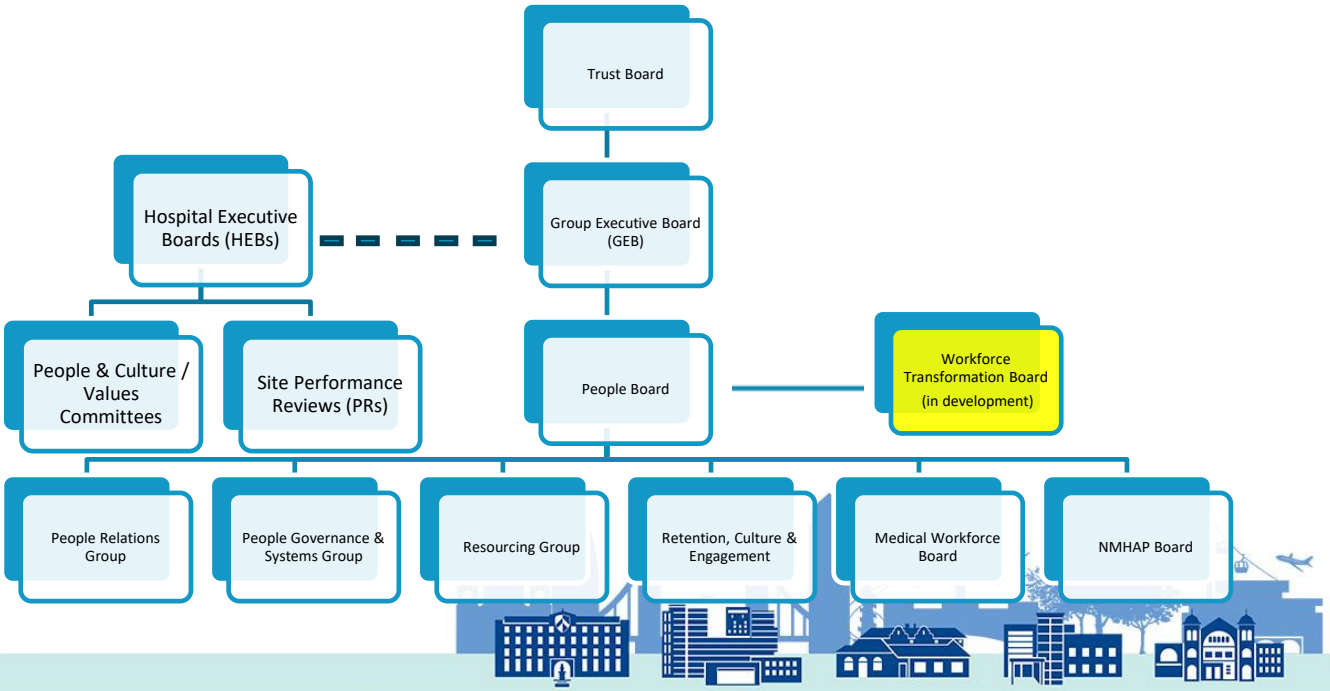
"It is great to see the Trust commit to increasing the % of BAME staff in senior positions across the organisation. It is widely recognised that diversity across teams has significant benefits; providing better opportunities for creativity, problem-solving and decision- making. Having a workforce representative of our local population will ensure the staff and trust continues to go from strength to strength."

Joe McQuillan
Group Director of Allied Health Professionals

Governance

Barts Health NHS Trust

- The People Board will be responsible for overseeing delivery of the strategy with twice yearly updates reported to the Trust Board
- In order to aid and accelerate workforce transformation, new roles and embed new ways of working, it is **proposed a new Workforce Transformation Board** (in yellow) is created to feed directly into the People Board.
- Aligned hospital People Strategies will be progressed through the work of hospital site **People & Culture / Values Committees** and monitored by **HEBs** and regularly reported on and progressed through **PRs** as well as the **People Board Subgroups.**



Trust Board Ask and Next Steps

Barts Health NHS Trust

- Trust Board is asked to engage in the development of People Strategy and provide thoughts on the ambitions, recognising its iterative nature as we move into the coming transitional year.
- Further engagement with key stakeholders including Staff Partnership Forum on 2nd April.
- Hospitals will develop their localised people strategies with specific implementation plans and measurable outcomes over the coming months.
- As our other plans are crystalised, we will be linking to our newly developed Education and Training Strategy and creating the right multiprofessional engagement to truly align the People Strategy with our developing Organisational and Clinical strategies.

Appendix 1 – Groups Engaged With (Internal)

Barts Health NHS Trust

Group / Forum	Date
Group Executive Board	Feb 24
People Board	Dec 23, Feb 24
RLH and MEH HEB	Nov 23, Feb 24
SBH HEB	Dec-23
WX HEB	Nov-23
NUH HEB	Nov-23
People Directorate Executive (PDE)	Oct-23, Feb 24
People Directorate Team Meeting	Oct-23
JLNC	Nov-23
Physician Associates Board	Nov-23
WX People & Values Committee	Jan-24
SBH People Committee	Jan-24
RLH People & Culture Committee	Feb-24
Wellbeing Leads meeting	Dec-23
Focus group with imaging colleagues	Dec-23
Focus group with a mixture of Nursing and Therapy colleagues	Jan-24

Appendix 1 – Groups Engaged With (Internal) Continued

NHS Barts Health NHS Trust

Group / Forum	Date
Focus group with Core Services divisional leadership team, WX	Jan-24
Focus group with WX wellbeing team	Jan-24
RLH AHP board meeting	Jan-24
Nursing board meeting Newham	Feb-24
St Barts focus group with Nursing Leads	Feb-24

Appendix 2 – Planned Engagement (Internal)

Barts Health NHS Trust

Group / Forum	Date
Trust Board	Mar-24
SPF	Mar-24
NMHAP Board	tbc
Divisional medicine board, RLH	Mar-24
W&C divisional board, Whipps Cross	Mar-24
ACP Meeting	tbc
AHP Board	tbc
HRBP Network Meeting	Mar 24
GSS Directorates SLT Meetings	Mar, Apr

NHS
Barts Health
NHS Trust

Report to the Trust Board: 6 March 2024	TB 20/24

Title	Equity in Care Programme at Barts Health
Accountable Director	Group Director for Equity and Inclusion
Author(s)	Oscar Jakubiel Smith, Strategy Lead; Kate Turner, Programme Manager; and, Dr Ian Basnett, Director of Public Health.
Purpose	To provide an update on the Trusts equity work, and to share next steps. The report reflects contributions from the Public Health, Life Sciences, and Research departments, the Academic Centre for Health Ageing, and, the East London Cardiovascular Disease Prevention (ELoPE) Programme.
Previously considered by	Inclusion and Equity Board; Group Executive Board

The Equity Programme was established to reduce health inequities by playing an advisory and advocacy role - leading strategic projects and analyses to identify and investigate known and unknown disparities in how people access our services; as well as monitoring outcomes and experience of healthcare services.

The strategic projects of the Equity programme have involved the development and wide availability of information and disaggregated data across the organisation to inform decision making. Additionally, to identify and respond to disparities we have carried out investigations including into Emergency Care and waiting list performance through an equity lens.

Programme leads work closely with Trust functions including Business Intelligence and Patient Engagement to ensure we are evidence-informed and listening to the needs of our population. We also leverage our relationships with community, voluntary, research and other health sector organisations to ensure we are taking a holistic approach to the health needs of our population, bringing together relevant skills and expertise.

Looking forward, we are aiming to mature the governance and accountability of equity across the organisation in how we embed this as routine operational practice. We are continuing to strengthen our data capability and are working with colleagues to design novel interventions to improve access, outcomes and experience for disadvantaged groups.

Related Trust objectives SO1: Safe and Compassionate Care and SO2: Efficient and Effective Care
All

Risk and Assurance	Assurance in relation to the below BAF risk.
Related Assurance Framework entries	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
Legal implications/ regulatory requirements	The contents of this paper are in line with our Public Sector Equality Duty requirements and relates to a KLOE under the 'Well-led' domain of CQC inspection framework.

Recommendation

The Trust Board is asked to note and approve the report.

Equity in Care Programme Barts Health

2023-2024 Summary Report

What have we **achieved this year and** how will we **continue to embed Equity into 2024 and beyond?**

Table of Contents

1. Summary

1.1 Executive Summary

At Barts Health, 'equitable' is one of our core 'WeCare' values, making equity central to the work we do as an organisation. One of the strands of being an equitable organisation is in how we provide care to our patients and communities. To make progress in the area, the 'Equity Programme' was established as part of our corporate strategy team, working in close collaboration with the Public Health team. The Equity Programme works to enact positive change in reducing health inequities by playing an advisory and advocacy role in carrying out strategic projects and analyses to identify and investigate known and unknown disparities in how our services are accessed, and the patient outcomes and experience of our healthcare.

Our ambitions to become an outstanding organisation, an inclusive place to work for our people and an equitable provider of care for our patients are intrinsically linked to creating a fair and just healthcare system that addresses the diverse needs of every individual. An inclusive workplace encourages the development of culturally competent care, where healthcare providers are better equipped to understand and meet the unique needs of a diverse patient population; this enhances the overall quality and effectiveness of healthcare services provided in hospitals.

Key messages from the Equity Programme:

- More than two thirds of our patient population live in the top 20% areas of deprivation nationally. Deprivation is strongly correlated with complexity of health needs and should therefore be considered in our patient groups.
- We are anticipating population growth of 20% in our local areas in the next 20 years, which will require effective planning and response to meet the needs of our population.
- Strategic projects have involved the development and availability of evidence and disaggregated data across the organisation to inform decision making, such as through the launch of our outpatient equity dashboard.
- To identify and respond to disparities we carry out a variety of analyses, which have recently included investigations into Emergency Care and waiting list performance through an equity lens.
- We work closely with other trust functions including Business Intelligence and Patient Engagement to ensure we are evidence informed and listening to the needs of our population.
- 'Equitable' is a WeCare value of the organisation and as such the reduction of inequities is a shared goal of all our colleagues, of whom the success of our programme of work is dependent upon in enacting meaningful change.
- We continue to leverage and improve relationships with community, voluntary, research and other health sector organisations to ensure we are taking a holistic approach to the health needs of our population, bringing together relevant skills and expertise.
- Looking forward, we are aiming to mature the governance and accountability of equity across the organisation in how we embed this as routine operational practice. We are continuing to strengthen our data capability and are working with colleagues to design novel interventions to improve access, outcomes and experience for disadvantaged groups.

2. Introduction

2.1 Health Equity

The terms ‘equity’ and ‘equality’ are often used interchangeably; however, they carry different meanings.

Equality means given in equal measure. It is about being the same. However, there are inequalities in the distribution of health across the population owing to genetic, social, geographical and other factors. There may also be inequalities in resource distribution, likely due to lack of resource or funding.

Equity means given in a measure proportionate to need. This is where people are given what they need to be successful. It’s about fairness and has strong ties to social **justice**.

At Barts, we are focussing on ‘equity’ as our approach to patient access and experience of care. Health equity is essential to ensure that everyone has the opportunity to achieve their full health potential, regardless of their social or economic circumstances. Improving health equity is at the heart of Barts Health’s vision and values.

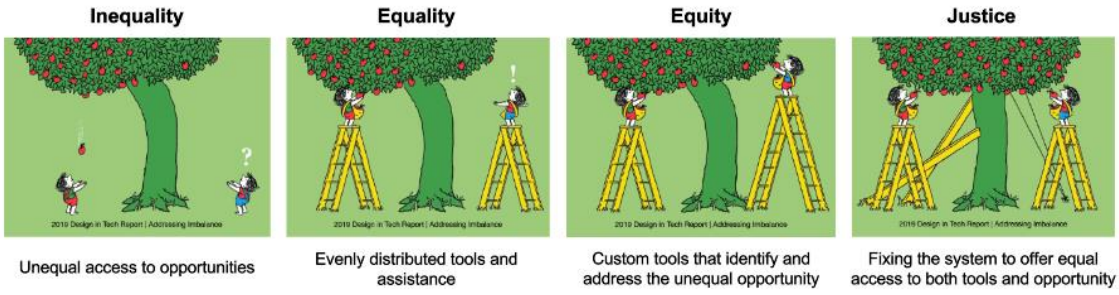


Figure 1: Sequence of pictures to highlight Equity definitions

2.2 The People We Serve

Barts Health serves one of the most diverse populations in the country. Many of our patients belong to marginalised groups that are underserved and face significant health and socio-economic disadvantages. These barriers often result in inequity of access and experience of services, and in some cases the treatment received and healthcare outcomes.

The infographic below summarises some of the challenges faced by our local populations and highlights the need for embedding equity of care throughout the Trust.

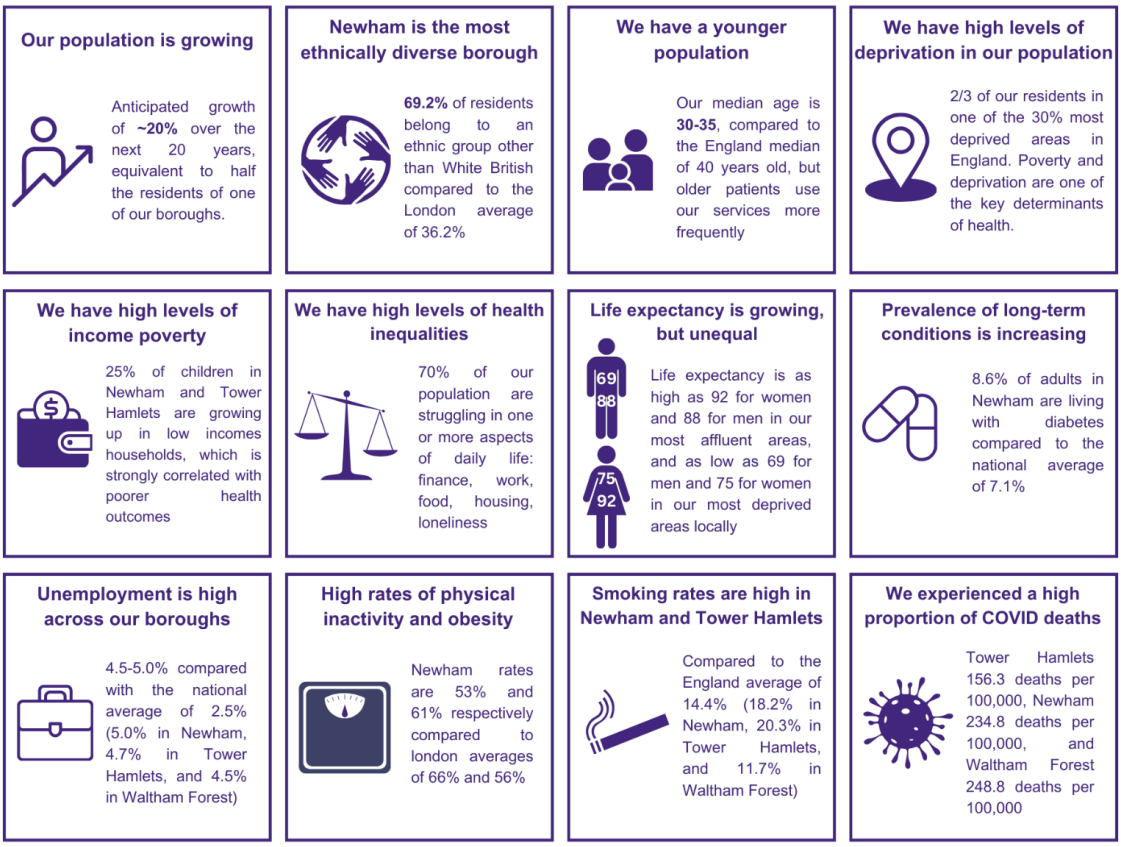


Figure 2: Our local population in numbers. Source: ONS Census 2021[1]

2.3 Barts Health Strategic Objectives

Published in 2023, our strategic objectives in *We are Barts Health* outline how we intend to operate for the foreseeable future to achieve our goals.

Our three objectives are:

1. To provide excellent and equitable health and care for our patients
2. To become an outstanding and inclusive place to work for our people
3. To work together with our partners and local communities

These objectives are intrinsically linked and are all needed to create a fair and just healthcare system that addresses the diverse needs of every individual. An inclusive workplace encourages the development of culturally competent care, where healthcare providers are better equipped to understand and meet the unique needs of a diverse patient population; this enhances the overall quality and effectiveness of healthcare services provided in hospitals. At Barts, more than half of our employees come from our local areas, meaning our employees are also our patients.

2.4 Equity and Inclusion at Barts Health

Equity is a core part of the vision and values of Barts Health Trust. Our approach to improving health equity is multi-faceted and includes the work we do as an Anchor Institution to address the wider determinants of health, our work to improve prevention, the engagement work we do with our communities and our work to continuously improve the equity of the care we deliver.

WeBelong is our trustwide Inclusion strategy, launched in November 2020 with a focus on creating compassionate and inclusive leadership, and delivering a fair and just culture which enables delivery of our WeCare values. Part of this strategy is to work in community partnership to promote equity by restoring services inclusively and, in our role as an anchor institution, address the wider determinants of health. The Equity programme works closely with the trust Inclusion centre, reporting in to the monthly Equity and Inclusion board to ensure alignment.

While we have been reviewing equity in aspects of our care for some time, the unequal impact of COVID on our population, and the subsequent recovery of our services, presented a significant opportunity to improve equity. In 2021, the Trust responded to this by establishing an Equity Programme, supported by Strategy and Public Health colleagues at Barts Health and with Ian Basnett, Director of Public Health, providing clinical input.

This report focuses primarily on the work we are doing in pursuit of equity in the care we provide: equity of access to our services, equity in treatment , and equity in outcomes for our patients.

3. The Equity Programme

The Trust's Equity Programme comprises a portfolio of projects to improve equity, including strategic projects, data analysis and examining access and experience, prevention, and our equity work with partners. Key projects and achievements are outlined in the subsections below.

3.1 Strategic Projects

Our strategic projects are designed to help in our systematic approaches to improving equity. Two of these are our internal website and a trust-wide outpatient equity dashboard which enables us to review the equity of our outpatient appointments.

Webpage

We are in the final stages of collaborating with the Communications Team around the development of an internal web page on equity in care. The page will provide information about the Equity Programme, signpost to equity resources, and provide examples of best practices from across the Trust.

The Outpatient Equity Dashboard

To strengthen our approach to tackling inequalities in access to patient care, in collaboration with our Business Intelligence Unit, we launched a dashboard in July 2023 that enables us to review access data by ethnicity, age, gender and deprivation and understand the differences between our patient groups. The implementation of this tool has allowed us to develop engagement and improvement projects such as improving DNA rates in patients from deprived backgrounds, for example, in young, black male service users who were identified as experiencing barriers to accessing care and attending appointments.

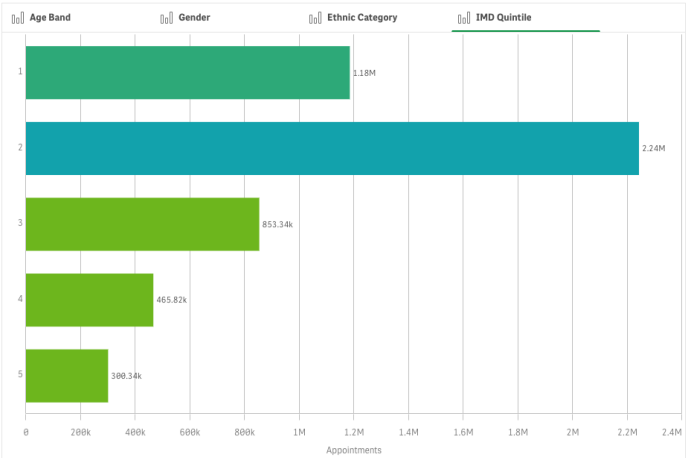


Figure 3: Graph from the Outpatient Equity Dashboard showing the number of our patients belonging to different deprivation quintiles. 1 represents the most deprived postcodes, and 5 represents the least deprived postcodes.

3.2 Analyses and Findings

To further understand the needs of our population, we use data to explore differences in access, outcomes, treatment and experience between patient groups, and investigate suspected barriers or disparities. Examples of our work are outlined below.

Remote Emergency Access Coordination Hub (REACH) Analysis

Revealed that usage for our emergency care phone line service was significantly higher for white women compared to other ethnic groups. In response, we are trialling the use of translation services to improve access for this patient group.

Electronic Prescribing and Medicines Administration (EPMA) Analysis

Gave assurance that our move from paper-based to electronic medication prescribing has led to no significant changes in medication error rates. We found that medication error rates reported are higher in men compared to women, which we are investigating with our pharmacy colleagues

CHKS Outcomes Analysis

CHKS are a leading provider of healthcare intelligence and quality improvement products and services. They evaluated mortality rates by ethnicity and observed that mortality rates are currently lower than expected for all ethnic categories.

Emergency Care Data Analysis

Revealed differences by hospital site based on factors such as age, gender, ethnicity, and deprivation. There was evidence of disparities for certain ethnic groups, age categories, and disabilities which are being explored with relevant site leads. This analysis was based on national performance measures such as time to admission, and time to treatment.

North East London (NEL) 'Was Not Brought' Analysis

Highlighted that young people show the highest non-attendance rate of all age groups, and there is some evidence to suggest this is highest over the summer period. This was a collaborative project with colleagues across NEL, and we are working with relevant leads to understand this disparity and make improvements.

Cardiac Care Analysis

This analysis is currently underway to investigate if gender disparities exist in the identification of heart attacks in emergency care between men and women.

Did Not Attend (DNA) Data Analysis

Data from our outpatient equity dashboard has highlighted that patients from deprived postcodes and young black men are the most likely to not attend outpatient hospital appointments. Working with our community participation colleagues to better understand the underlying causes, we have launched a communications campaign around supporting patients with travel costs for their outpatient appointments.

CASE STUDY: Analysis of our Waiting Lists

Each month, the Business Intelligence Unit collates data from our outpatient waiting list for each site, with data disaggregated by gender, ethnicity, deprivation and learning disability. The Equity team review these trends monthly as part of our trust wide integrated performance review, providing recommendations for corrective action when needed.

This has had a positive impact on our approach to monitoring and prioritising Learning Disability patients on our waiting list. Through the monthly reporting, we identified patients were waiting significantly longer on average for outpatient appointment, with a difference of over 100 days.

Since highlighting this disparity to the planned care board, we have been able to implement prioritisation for patients with Learning Disabilities for surgical specialties where they are at greatest risk, which has had a positive impact in reducing wait times for this patient group.

3.3 Access and Experience

"The NHS provides a comprehensive service, available to all […] paying particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population"

- NHS Constitution

The first principle of the NHS constitution places focus on underserved communities. Building on this, the Equity Programme is identifying and addressing disparities in access and experience for our patients.

This has been facilitated by the launch of our outpatient equity dashboard to understand the data we collect, but also requires engagement with our communities to understand their experience of care, and how this can be improved.

Patient Experience

The Trust is committed to collecting patient experience data from patients who are representative of our population. We are working closely with our Director of Insight to better understand the experience of our patients. For example, we have increased the number of languages our Friends and Family Tests is available in, and work to collect data on the demographics of our respondents. We are also working to collect demographic information in our complaints data, which will help us to identify any disparities.

Engaging Young, Black, Men

Through our equity dashboard, we identified that young, black male service users are at greater risk of missing their outpatient appointments compared to other demographics, and we were keen to understand the underlying causes of this. To do so, we held focus groups with young black male patients who attend Renal, Hypertension and Sickle Cell clinics.

The insights these patients provided have been instrumental in understanding how we can better design our services to improve access and experience. We identified that many of the findings can be applied more broadly to our general population, such as in how we can improve communication with our patients, and in providing travel subsidy for those who need it. Our community participation colleagues are taking this work forward to further engage with young black men and identify ways in which we can improve our approach.

Figure 4: Image from one of our engagement activities with young, black men

(consent for image use obtained)

Engaging Patients Living in Deprived Areas

To better understand underlying reasons as to why our patients living in deprived areas are more likely to miss outpatient appointments, we partnered with our hospital volunteers and Project SEARCH to gain insights from this patient group. Project SEARCH is a community programme that supports people with learning difficulties to gain employment, to understand reasons why patients might miss their outpatient appointments and to help improve access and experience for patients living in the most deprived catchment areas.

Through this exercise, our volunteers were able to engage over 500 individuals at Whipps Cross from deprived areas, and identified a common theme that these patients may have barriers in meeting the cost of transport to and from hospital appointments. To support this, we have launched a communications campaign to raise awareness that travel costs can be reimbursed through the NHS Healthcare Travel Costs Scheme for those eligible. We are acutely aware that many from our local population rely on a cash economy, and we are working to ensure instant cash reimbursement is easily available. Figure 5 below shows a trustwide decline in DNA rates for our most deprived patients since the implementation of this project.

Figure 5: Monthly changes in the percentage of missed appointments (DNA rate) in our most deprived patient group (IMD1)

Deaf and Hard of Hearing Work

After receiving feedback from deaf and hard of hearing patients about how we can improve their experience when accessing our services, the Royal London and Mile End Hospitals (RLH/MEH) launched a pilot to test a number of interventions. These included the creation of an email address and inbox for individuals unable to contact the hospitals via phone, leaflets with images of British Sign Language included in outpatient letters and exploring British Sign Language training for ward and administrative staff. Additionally, RLH and MEH introduced a webchat function in September 2022. More work is needed to quantify the benefit to deaf and hard-of-hearing patients but there is potential for a trust-wide rollout of this initiative.

Assistance Animals

To improve the experience of our services for patients with assistance animals, a standard operating procedure (SOP) for use at RLH and MEH has been drafted and ratified by the relevant committees, including the Infection, Prevention and Control Committee. Work is now underway for the trust-wide adoption of a policy to provide guidance to staff around the presence of assistance animals on trust grounds, building on the existing SOP.

Improving Access to Breast Screening for Somali Women

According to 2021 census data, the Somali community make up around 2% of the population in Tower Hamlets and face significant health inequalities. To increase breast screening rates for Somali women in our boroughs, the trust is working in partnership with local Health Promotion and Screening Leads and has held a number of drop-in sessions for these women. They can ask questions and gather information about screening and seek medical advice for concerns related to breast health. This initiative is in partnership with Coffee Afrik, a voluntary organisation that represents the needs of the Somali population (and a member of Coffee Afik is part of the Project Team).

3.4 Improving Governance

The strength of the Equity Programme is in many ways dependent on our ability to influence meaningful change across the organisation. To this end, we appointed a new Group Director of Inclusion and Equity in July 2022. The post holder is tasked with providing strategic leadership and oversight and working across the group, including with hospital sites and the wider health and social care system, to embed inclusion and equity throughout everything we do. Our aim is to hardwire equity into the culture of our organisation, and in the way we view the quality of our care for the patients we serve.

We have also started a number of other initiatives to strengthen our leadership and governance to drive and oversee progress related to equity.

Documenting Disparities

We regularly review disaggregated data for our outpatient services through trust performance review. In addition, we are logging findings from our analyses to be shared with relevant leads. This enables us to compile our evidence and share knowledge quickly and effectively with key stakeholders throughout the organisation.

Strengthening our partnerships

The work of the Equity Programme does not exist in isolation, and we are particularly aligned with community engagement, participation and insight colleagues to link identified disparities with insight from affected groups. This enables us to better understand barriers our patient groups face and better inform our decision making. The Trust is forming a programme executive with leads from each of these areas to co-ordinate efforts and align priorities. We are further supported with data insights from our Business Intelligence Unit colleagues.

Embedding Equity Data within Operations

The launch of our outpatient equity dashboard is intended to enable a systematic approach to reviewing the performance of our services through an equity lens. This is being rolled out through our site patient access meetings, to ensure we are considering the differences in patient access in different demographic groups. Additionally, we are working with our Business Intelligence Unit colleagues to develop further equity dashboards for inpatient services.

3.5 Partnership Working

In addition to patient experience and engagement, we hold a number of partnerships both internally and externally to help drive forward the Equity Programme. This section provides a non-exhaustive overview of some of our key partners.

Barts' Role in North East London's Integrated Care System

Barts Health is part of North East London's Integrated Care System (NEL ICS), which brings together organisations in our local area to deliver joined-up health and care services. As the biggest acute provider in North East London, we have a significant role to play and are working with our partners on a number of initiatives across the NEL equity in health and care workstreams and the population health inequalities steering group.

Was Not Brought Rates in Children's Services as a Priority

In line with addressing DNA rates for adults, improving 'Was Not Brought' rates for babies, children, and young people is a national priority. The trust is adopting a North East London approach and working with the NEL Insights Team to acquire data that will help identify which patient cohorts are more likely to miss their appointments. We are working with public health colleagues to analyse the data for variation; interventions to address this can then be co-designed and developed. The comms campaign promoting the NHS Healthcare Travel Costs Scheme (see above) also makes special mention of babies, children, young people, and their carers.

Work at "Place"

Newham, Whipps Cross and Royal London each have a number of projects related to health equity at "Place" level, or within the boroughs the hospital serves. They are developing strong relationships with partners in their boroughs, particularly with local voluntary organisations, local authorities, and community and primary care providers. This work feeds into our monthly Equity Programme meetings, to allow us to share best practice and seek input and challenge from colleagues. Examples are outlined in the table below. As St Barts primarily serves patients outside their local borough (City of London), their partnership working is more closely tied to the charitable organisations and system wide prevention (see Cardiovascular Disease Prevention Section 4.1)

Site	Equity work example
Newham	The "Well Newham Challenge" with Newham council, with a variety of projects funded to improve the health of local residents to address non-medical and social factors impacting their health.
Whipps Cross	The "Social deprivation screening project" aims to identify patients in immediate need and signpost them to relevant services such as food banks, hostels and charities locally in Waltham Forest
Royal London and Mile End	The "Hospital at Home" project has partnered with local patients to provide hospital level care from the comfort of a child's home. Since launch, over 100 patients have been treated.

3.6 CORE20PLUS5

CORE20PLUS5 is an NHS England and NHS Improvement approach that supports the reduction of health inequalities at national and system levels. It defines the most deprived 20% of the population in 5 clinical areas (Maternity, Severe Mental Illness, Chronic Respiratory Disease, Early Cancer Diagnosis and Hypertension Case Finding) as the target population for intervention.

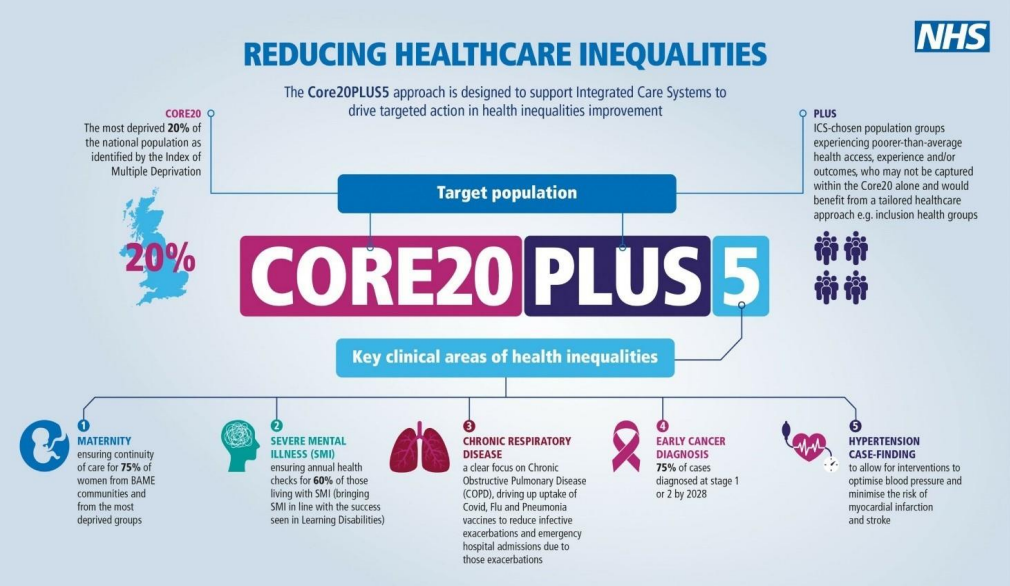


Figure 6: Schematic summarising CORE20PLUS5 principles. Source: NHS England

The Trust is cooperating closely with our system partners on this approach, which is complementary to our work within the Trust. For example, through the ELoPE Programme (See Cardiovascular Prevention, Section 4.1), the Trust is working with system partners on innovative ways to reduce hypertension. Further, the Trust's Public Health department are appointing a Nicotine Addiction team, primarily focused on deprived patients, and we also continue to work with system partners to improve equity in cancer treatment. Additionally, there is a version of CORE20PLUS5 specifically relating to babies, children and young people with clinical focus areas of asthma, diabetes, epilepsy, oral health and mental health. And lastly, as mentioned above, we have plans to work with colleagues in maternity to develop an equity work programme which is also a focus area of the CORE20PLUS5.

4. Prevention

The Public Health team lead on a number of prevention focussed programmes of work outside of but closely linked to the Equity Programme. Examples of these initiatives are outlined in the sections below.

4.1 Cardiovascular Disease Prevention

Given our population demographics and high rates of cardiovascular disease, in 2016 the Heart Centre Board approved a proposal to increase activity in Cardiovascular Disease Prevention. The result was ELoPE, or the East London Cardiovascular Disease Prevention Programme. Today, ELoPE is made up of activity within our hospitals, including staff CVD health, social prescribing, and Making Every Contact Count.

The Programme is active across North East London, and forms the basis of Barts' Department of Prevention. Still in development, the programme seeks to improve CVD outcomes and make Barts a vanguard site for how secondary care can deliver on CVD prevention, both within its walls and beyond. More information can be found here.

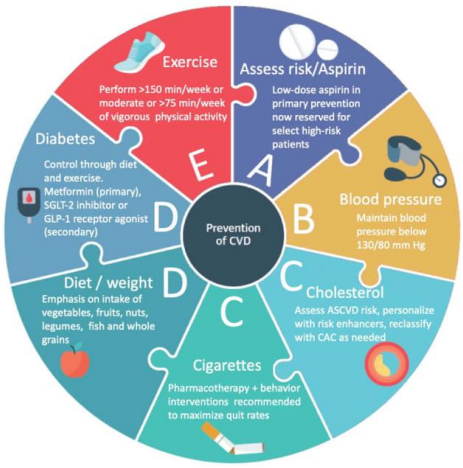


Figure 7: ABCDE model of CVD prevention

4.2 Social Prescribing

Social prescribing is an approach used by the NHS to help patients improve their health, wellbeing and social welfare. They do this by connecting them to community services such as fitness classes, social events and translation services. These services could be run by the council or a local charity. In addition, with the support of Barts Charity, a number of posts across Barts Health have been funded to embed social prescribing and provide this to our patients at greatest need.

An example of such work is the Children and Young people's social prescriber at Royal London Hospital, who works with patients with long-term or medically unexplained conditions. The integrated service provides holistic support, connecting young people to local initiatives and community based services for practical and emotional support. The service aims to increase young people's connection with others and their local services, empowering them to take control of their own health and wellbeing. This additionally aims to reduce health inequalities by addressing the wider non-medical factors influencing health, such as loneliness, emotional distress, debt, poor housing and physical inactivity.

4.3 Reducing Smoking and Alcohol Use and Referring to Social Welfare Advice

Smoking is the leading risk factor for mortality in the UK, and there is strong evidence that tobacco services in secondary care can reduce readmission rates, wound infections, and longer term of heart disease, stroke, cancer and premature death. Because of this, there is an estimated net saving of £13 per patient referred to stop smoking support with medication each year over 4 years, as well as the health benefits for our patients[3].

Figure 8: Data illustrating impact of the Tobacco Dependence Service

Led by Barts's Department of Public Health, the trust has an in-house tobacco dependence service for hospital inpatients and a smoking-in-pregnancy service in maternity. Both services work in partnership with the community smoking cessation services commissioned by boroughs. We have an Alcohol Harm Reduction strategy with quality improvement projects set up and there is also a seven day a week alcohol care team at the Royal London Hospital. An additional nurse is also being employed at Whipps Cross with a young person focus and we are seeking funding for specialist alcohol support at Newham.

Figure 9: Data illustrating impact of the Alcohol Care Team at Royal London Hospital

As many health disparities are attributable to socio-economic factors, social prescribing pilots are being set up across the trust as proof that social welfare advice in secondary care works.

5. Other Trust Equity Initiatives

In addition to the portfolio of work within the Trust's Equity Programme, there are several other key initiatives that aim to reduce inequalities.

5.1 Academic Centre for Healthy Ageing at WXH

Our elderly population often have multiple co-morbidities and complex healthcare needs. Despite policy and practice changes to improve care for an ageing population, there are still gaps in research and knowledge. To help address these gaps, a new Academic Centre for Healthy Ageing (ACHA) at Whipps Cross Hospital is being established following a successful £6 million Barts Charity bid between Barts Health and Queen Mary University London (QMUL).

Figure 10: Example of Healthy Ageing activity

The ACHA is taking a unique and innovative approach by placing research at the front line to create a 'living laboratory'. It will bring together a network of clinicians, researchers, policymakers and local communities across North East London to support people to live healthier for longer.

5.2 Barts Health's Clinical Research Facility

Barts Trust in collaboration with QMUL have received funding to establish a clinical research facility at the Royal London Hospital, to increase access to research for our diverse communities.

Evidence shows that people living in high deprivation areas[4], those from Black, Asian and minority ethnic communities and inclusion health groups[5] are most at risk of experiencing health inequalities. National Institute for Health and Care Research (NIHR) data[6] has revealed that UK geographies with the highest burden of disease also have the lowest number of patients taking part in research. The postcodes where research recruitment is low also aligns closely to areas where earnings are lowest, and indices of deprivation are highest. The poorest people in our communities have a 60% higher prevalence of long term conditions than the wealthiest and 30% higher severity of disease. People of South Asian ethnic origin are at greater risk of developing Type 2 Diabetes and cardiovascular disease, and people with an African or Caribbean family background are at greater risk of sickle cell disease[7].

Limited local data indicates that there has been a small increase in research participation among Black and Asian minority ethnic groups since 2021 (from 31% of research participants to 35%) however this is still far from reflective of the local population and appears to be particularly disproportionate in areas where there is an increased risk of disease in these groups e.g. cardiovascular (27% of research participants) and respiratory (25% of research participants) disease[8].

5.3 Equity in Training and Education

The Barts Health Education Academy have been taking forward a number of initiatives to improve equity and inclusion for our staff members and patient population. All staff at Barts complete mandatory training in Equality, Diversity and Human Rights, and this is renewed on a 3-yearly basis. It has also been recognised that inclusive working and training environments and systems are crucial to delivering safe and effective patient care, as well as for our staff wellbeing. To achieve this, there are a number of improvements being driven forward by the Education Academy including increasing recruitment of international medical graduates, a new commitment to maximise opportunities for locally employed doctors who are representative of our patient population, career development and training plans for Trust Grade (overseas employed) doctors, and strengthening our Freedom to Speak Up Guardian service for all staff members to be able to voice their concerns.

5.4 Equity in Maternity and Neonatal Care

Maternity care is a clinical area of focus in the national NHS Core20Plus5 initiative, previously mentioned is section 3.6 of this report. In response to known disparities in health outcomes for the Black, Asian and minority ethnic groups patient groups, a working group was set up within maternity at Barts Health to raise awareness around health inequalities, and provide a structure to provide accountability and consistency in monitoring the various workstreams in this area. This group has now expanded to work with partner organisations across the North East London Integrated Care System, with three main workstream areas of staff experience, patient experience, and maternity outcomes. In addition to work with NEL colleagues, we are working with the Race and Health Observatory Learning and Action Network to tackle inequities locally.

Examples of maternity projects:

- Women's Health Literacy – a community led research project with Elly charity, working with groups of women of whom English is not their first language to improve health literacy.
- BAME women at Newham Forum – led by a Patient Experience Midwife for women who are pregnant to discuss common pregnancy questions in a safe space, with a midwife who is racially concordant with them.
- Barts Health Somali Community Engagement Officer – bringing midwifery and health advocacy to this patient group, through providing drop in sessions for women to attend.
- BirthRights Human Rights in maternity care training pilot – training provided to our medical teams at Newham hospital to identify improvements for women's experience and personalised safe care choices.

6. Looking Forward

While we have made significant progress to date, we are looking forward, agreeing priorities and plans for next year and beyond to strengthen our approach to tackling health inequities, and respond to identified risks.

This year we established three main priorities which span over the next few years, each with a number of workstreams:

Priority 1: Influencing organisational and sector-level change to improve how we gain and utilise insight to inform equitable service improvement and provision of care.

Our work plans include:

- Improving the quantitative data we capture on protected characteristics at Trust level Embedding the utilisation of our quantitative data on protected characteristics across our organisational and site level priorities
- Embedding governance and reporting mechanisms to ensure Equity becomes business as usual.
- Embedding governance and reporting mechanisms to ensure Equity becomes business as usual.
- Strengthening partnerships with patient engagement and insights teams to better understand our population needs.

How will we know if we are successful?

- We will achieve 95% ethnicity capture on all sites.
- Hospitals will utilise data on ethnicity and deprivation to regularly evaluate the access of our services.
- The Trust will have adopted a equality assessment tool for cost savings projects over 100K.
- There will be regular meetings to coordinate activities between Engagement, Equity, Inclusion and Insight leads.

Priority 2: Using our insights to create targeted interventions to reduce identified disparities.

Our work plans include:

- Targeted work for patients with Learning Disabilities.
- Improving maternity outcomes for BAME patients
- Targeted intervention for those living in deprived postcodes
- Analysis of specific areas of interest as they arise.

How will we know if we are successful?

- There will be no difference in waiting time for surgery between patients with Learning Disabilities and those without.
- 70% of BAME patients will see a midwife before 12 weeks and 6 days of pregnancy
- Utilisation of the national travel subsidy will increase by 20%, meaning more patients will be reimbursed for travel and able to access our services.

Priority 3: Improving how we communicate with our patients

Our work plans include:

- Improving access to translation services
- Improve our approach to communicating with patients with low levels of health literacy
- Improving the availability of medicines information in the language and format our patients need > Translation of RX in local majority languages
- Improving the way we communicate with patients with a disability or sensory loss

How will we know if we are successful?

- Our sites will be able to report on how many people needed translation services and how they were able to meet the needs of those patients over a given timeframe.
- We will roll out a training programme for clinicians to improve how they communicate with patients with low levels of health literacy.
- We will have prescriptions translated in our majority languages.
- The Trust will be fully compliant with the Accessible Information Standards.

Achievements for 2023 and deliverables for 2024 and 2025 can be found in Appendix 1.

6.1 Programme risks and mitigations

There are several challenges that the Trust must overcome to scale the Equity Programme and improve equity of care. Equity Programme risks include a significant reduction in programme capacity and engagement and buy-in from staff during extreme operational pressures. We are working to mitigate programme capacity by applying for additional funding in the spring. To improve engagement, we are working to demonstrate how improving equity can contribute to increased efficiency.

Other challenges to achieving equity at scale include achieving the Accessible Information Standards, or the standard that sets out how we must meet the communication support needs and service users with disability, impairment or sensory loss, and ensuring that patients who require translation have access to timely and adequate language services. For both of these areas, the Trust has made recent positive progress. However, there is still room for improvement in order to meet the needs of our communities in full.

6.2 Closing remarks

The Equity Programme has grown tremendously in the past two years, moving from analysis of individual services to systematic monitoring and interventions. We have strengthened leadership and accountability and increased the breadth of our projects. However, in our endeavour to improve healthcare outcomes for all, it is crucial to acknowledge that achieving equity and inclusion require a constant effort and continual monitoring, assessment, and intervention. One of our primary goals is to continue to better embed equity and inclusion into our business-as-usual operations.

Working with our system partners, we have the power to reshape our services, ensuring that quality, equity, and inclusion are inseparable companions and meet the needs of all our community. This report shows how far we've come and how much we've achieved in improving equity for our patients, but we have more work to do and we must maintain focus on this area for the benefit of the community we serve.

Barts Health NHS Trust

Appendix: Equity planning priorities 2023-2025

		Success Measures		
Priority 1	Programme of work	2023 Achieved	2024 Finalising	2025 Proposed
1. Influencing organisational and sector-level change to improve how we gain and utilise insight to inform equitable service improvement and provision of care.	1. Improving the quantitative data we capture on protected characteristics at Trust level	Rollout of a Trust-wide initiative to improve ethnicity capture using patient education, manager education and manual upload of data from other datasets.	Achieve ethnicity capture 95% on all sites Regular, automatic upload of GP ethnicity data to Barts systems	Record gender expression beyond binary sex assigned at birth
	2. Embedding the utilisation of our quantitative data on protected characteristics across our organisational and site level priorities	Rollout of the Equity dashboard Published waiting list data by ethnicity, gender, age, deprivation and Learning Disability to monitor equity in recovery	Disaggregated patient data to be used in all access meetings. Creation of an in-patient dashboard	Rollout of an inpatient equity dashboard
	3. Embedding governance and reporting mechanisms to ensure Equity becomes business as usual.	Ethnicity capture reviewed in all site access meetings	Trust-wide adoption of equality assessment tool for all cost savings projects over 100k.	Identification of equity related quality indicators to be included in Board reports
	4. Strengthening partnerships with patient engagement and insights teams to better understand our population needs.	Better integration with Inclusion. The Inclusion Board became the Equity and Inclusion Board. The deputy director of patient experience and community engagement and deputy director of inclusion were appointed.	Establish a Programme Executive to improve coordination between Engagement, Equity, Inclusion, and Insight Leads	To produce joint plans clearly linking identified disparities with engagement

		Success Measures		
Priority 2	**Programme of work**	**2023** **Achieved**	**2024** **Finalising**	**2025** **Proposed**
2. Using our insight to create targeted interventions to reduce identified disparities Develop targeted interventions for the most vulnerable. I.e. Where we have identified disparities exist	2.1 Targeted work for patients with Learning Disabilities.	Reduced the disparity for patients with LD waiting for surgery by 100 days.	Completely eliminate the disparity between patients with and without Learning Disabilities waiting for surgery. Pilot prioritising LD patients for outpatient appointments at St Barts Rollout of Oliver McGowan Training	TBC
	2.2 Improving maternity outcomes for BAME patients	Application for Race and Health Observatory's Maternal and Neonatal Health Working Group	Establish baseline and targets	TBC
	2.3 Targeted intervention for those living in deprived postcodes	Communications campaign to raise awareness of the National Travel Subsidy Social Prescribing Pilot at Whipps Cross, "Times are Hard"	Will depend on final results of the pilot	TBC
	2.4 Activity dependant on findings from ongoing analysis	TBC	TBC	TBC

		Success Measures		
Priority 3	Programme of work	2023 Achieved	2024 Finalising	2025 Proposed
3. Improving how we communicate with our patients General interventions to improve equity in the care we provide	3.1 Improving access to translation services	Improved access to translation for maternity services.	RLH is conducting an audit of access to translation in inpatient services. Findings to determine next steps.	TBC
	3.2 Improve our approach to communicating with patients with low levels of health literacy	Library services introduced an Assessment of literacy/health needs required comms skills & training being set up (Hayley) NUH has created a health literacy workstream	TBC	TBC
	3.3 Improving availability of medicines information in the language and format our patients need > Translation of RX in local majority languages	TBC	Pilot translation of RX in local majority languages.	Trust wide roll out RX translation in X majority languages.
	3.4 Improving the way we communicate with patients with a disability or sensory loss	Added fields for data capture for disability or sensory loss so that reasonable accommodations can be made	TBC	TBC

7. References

[1] https://www.ons.gov.uk/census

[2] https://www.nat.org.uk/about-hiv/hiv-statistics

[3] www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/deprivation/

[4] www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/inclusion-health-groups/

[5] evidence.nihr.ac.uk/collection/why-we-need-more-inclusive-research/

[6] www.northeastlondonhcp.nhs.uk/wp-content/uploads/2023/06/NEL-Joint-forward-plan-June-2023-vFINAL.pdf

[7] NIHR ODP Clinical Research Network: North Thames, Oct 202

[8] https://www.npeu.ox.ac.uk/mbrrace-uk/data-brief/maternal-mortality-2020-2022

Barts Health NHS Trust

Report to the Trust Board: 6 March 2024	TB 21/24

Title	Maternity Report
Accountable Director	Group Chief Nurse
Author(s)	Shereen Nimmo, Group Director of Midwifery
Purpose	To provide assurance and information
Previously considered by	Quality Board and Quality Assurance Committee

Executive summary

This report offers assurance to the Barts Health Board on maternity services, emphasising risk awareness, improvement strategies, and achievements. Through the Maternity Safety Support Programme (MSSP) and collaborative partnerships, comprehensive reviews of systems and governance have been conducted, informing ongoing safety enhancements. National perinatal mortality reviews highlight persistent challenges, particularly in ethnic disparities, despite Barts Health demonstrating relatively lower stillbirth and neonatal death rates. Efforts to address these inequities are underway through equity-focused initiatives aligned with anti-racism frameworks.

Maternity initiatives focus on quality improvements, resulting in positive outcomes such as reduced postpartum haemorrhage rates. Governance enhancements include the establishment of operations groups and pursuit of quadrumvirate leadership models. However, challenges in demand and capacity persist due to rising care complexity. Initiatives to meet national standards, workforce recruitment challenges, and clinical leadership changes underscore ongoing efforts to ensure compliance and enhance patient care. Insights from service users highlight commendable care aspects alongside areas for improvement. Ongoing digital transformation initiatives signal progress towards streamlined services.

The Board is asked to recognise the ongoing journey of improvement in maternity services, emphasising the importance of addressing disparities and supporting ongoing quality improvement and assurance efforts. The development of our dynamic improvement plans and strengthened governance and leadership model will help us to increase the pace of improvement across the organisation during 2024/25. The support of the MSSP specialist advisers has been invaluable.

Related Trust objectives
2c. Promoting equity and sustaining standards

Risk and Assurance	Assurance in relation to: BAF Risk 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; and risks on the Trust risk register

Legal implications/ regulatory requirements	Regulation 15 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Action required

The Trust Board is asked to note and discuss:

- the contents of the report, in particular the focus on our response to key risks identified, in particular demand & capacity, workforce, governance and informatics;
- the recent approval by the ISC for the maternity informatics business case & the plans for CTG monitoring; and
- the plan for Birthrate+ in Autumn 2024 and the business cases in response to MSSP diagnostics, in particular in obstetric and governance roles which are going through scrutiny processes.

Barts Health NHS Trust

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 6 MARCH 2024

MATERNITY PROGRAMME

1. Report Overview

The purpose of this report is to provide assurance to the Barts Health Board on our maternity services. This report will outline the mechanisms in place to "hear the signals" that are coming up through our maternity services, so that the Board can understand the key risks and issues, our improvement plans and celebrate success in its achievements.

We are enrolled onto the maternity safety support programme (MSSP) and are working with both maternity and obstetric improvement advisors to review systems and processes across clinical care as well as governance, leadership and culture across the services. Through the Local Maternity & Neonatal system (LMNS) and the Acute Provider Collaborative Maternity and Neonate Oversight Group we are able to review our services, gain greater understanding of our populations and their health needs by exploiting the public health and equity data that is emerging, and use this to build on the safety improvement work that is already underway.

2. Perinatal outcomes and the national ambition rates

The most recent national review of perinatal mortality is the MBRRACE-UK Perinatal Mortality Surveillance includes UK perinatal deaths for births from 1 January 2021 to 31 December 2021. Nationally, an increase in the stillbirth rate was seen in all gestational age groups, except for babies born at 37 to 41 completed weeks' gestational age, where there was a modest 3% reduction from 1.23 per 1,000 total births in 2020 to 1.19 in 2021. Barts have stillbirth and neonatal death rates slightly below our comparator group averages in this data set. Our comparator group is with Trusts with a level 3 neonatal intensive care service and with a neonatal surgical service. These are services offering the most complex levels of neonatal care, which attracts referrals in from across the region and beyond. The data shows the unadjusted rates for stillbirths and neonatal deaths across Barts, as a percentage of all births which includes babies with significant abnormalities who are not expected to survive.

Appendix 1 contains statistical process control (SPC) charts related to both infant and maternal outcomes across Barts Health. SPC is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action. For example, in December we saw an increase in the stillbirth rate that required

thematic review. In the month, there were 4 cases attributed to women who had not booked for antenatal care, 4 cases where fetal abnormality was not compatible with life, but where the parents had decided to continue with their pregnancy. These sad cases contributed to the rise that we saw in month. When the case data is plotted in a chart (appendix 1) which tracks a 12 month rolling average, the current peak is an unfortunate natural variation in the data, our stillbirth numbers are stable.

This data is considered and reviewed monthly at hospital and group level, and the Quality Assurance Committee. This data is also included in our Integrated Performance Report every month. We provide exception reports to the local maternity and neonatal system as part of the perinatal quality surveillance tool in addition, in order that as a system we can identify themes that may exist across organisational boundaries.

2.1 Outcomes and a focus on Equity and Equality

Wide ethnic inequalities in perinatal mortality continued to be seen in the national data, but stillbirth and neonatal mortality rates for babies of black ethnicity increased at a higher rate than for babies of Asian and White ethnicity. Babies of Black ethnicity now have the highest rates of both stillbirth and neonatal death. Economic deprivation also significantly impacted outcomes.

MBRACE published two follow up reports in January 2024, which further investigates any differences in the quality-of-care provision for mothers of Asian and White ethnicity whose pregnancy ends in stillbirth or neonatal death; and for quality-of-care provision for mothers of Black and White ethnicity whose pregnancy ends in stillbirth or neonatal death. Both national reports found that quality of care was more likely to be poor in Asian and Black mothers. Barts Health has been working with the Local Maternity and Neonatal System (LMNS) to understand the outcomes for our local population and commenced leading on work with the LMNS to understand the inequities in our system through the Equity and Equality workstream.

We have an anti-racism working group in line with the Capital Midwife Anti-Racism Framework, which has included the review of our outcome data and received updates from the Equity and Equality working group. Along with colleagues from the ICS in NEL, we have commenced the NHS Race and Health Observatory, Learning and Action Network for maternity. This is a 15-month project with colleagues from the Local maternity and neonatal system and North East London Foundation Trust. The new learning and action network aims to kickstart maternal or neonatal improvement programmes that specifically focus on tackling ethnic inequalities in care, combining quality improvement with explicit anti-racism principles to drive clinical transformation

3. Maternal outcomes

Across Barts Health, teams have embarked on a number of Quality Improvement projects

which fit around improvements to safer procedures and recognition of deterioration. The work relating to reduction of postpartum haemorrhage, including multi-disciplinary team training and drills and robust risk assessments at the onset of labour and before planned caesarean section have started demonstrating improvements in haemorrhage rates as seen in appendix 1.

QI projects on the reduction of retained swabs after vaginal birth, has won a local QI award and was short listed nationally at the HSJ awards.

4. Developments in governance, planning and delivery

The Group Strategic Oversight Group and Hospital Maternity and Neonatal Committees have become well established since the report to the March 2023 Board. The Acute Provider Collaborative Maternity and Neonate Oversight Group is also well established and is strengthening strategic relationship across the NEL system.

The Maternity Safety Support Programme (MSSP) has been providing support to the Trust since January 2023. The MSSP undertook a review of governance of maternity and neonatal services within the Trust and have identified a number of areas of focus in relation to the governance structure and how the Group model operates.

As part of their assessment, the MSSP are expecting to see a maternity and neonatal quadrumvirate of leadership that is: Head of Midwifery, Obstetrician, Neonatologist, Managerial lead. With the way that the Barts Health group model is structured, the MSSP are expecting to see this quadrumvirate model at both Hospital and Group level. The quadrumvirates are being developed at each hospital with different complexities of service leadership being resolved. Further work is underway to finalise the quadrumvirate at Group level. The Group obstetric lead has been confirmed as Mrs Sujatha Thamban, who takes up this role from 1st April and will attend the Trust Board and QAC alongside the Group Director of Midwifery to ensure the Board receives a full overview of maternity services. Development of the quadrumvirates is being supported through the national quad leadership programme for maternity, and local leadership development across midwifery leadership roles has been in progress through 2023 and into 2024.

The Group Chief Operating Officer has developed a new maternity operations group that reports into the strategic maternity and neonatal group. This group will focus on the support of further developing the Maternity Operational Pressures Escalation Levels (OPEL) framework, and the process where mutual aid can be sought from across the system at times of increased activity and acuity. The group will also focus on the maternity incentive scheme standard delivery from an operational and evidential perspective and take a pro-active approach to early identification of challenges in meeting the standards. The group has also embarked on the development of an operational dashboard that will support the access to care and planned care standards in maternity such as outpatient and booking, induction of labour, caesarean section and postnatal care. This dashboard will complement our current reporting on outcome and workforce metrics.

4.1 Maternity activity and acuity

Significant challenges in demand and capacity have developed over the last few years in maternity due to the increasing complexity of care required by women and birthing people and the increased in planned care activity, namely induction of labour which has been advocated through programmes such as the Saving Babies Lives Care Bundle, which seeks to reduce stillbirths and neonatal deaths.

Whilst births and bookings have not significantly changed over the last few years, the number of women with additional complexity in their care has increased. We have more women being induced and more women having caesarean sections now than we have previously seen, this has significantly increased our length of stay and bed occupancy.

The OPEL escalation Framework (described above) has been used on a number of occasions since it was launched and we have experienced pressure across all of our units at different times. There is a daily huddle across our hospitals to support demand management and staffing risks with NEL wide calls for mutual aid when pressures cannot be managed within the Group. Work has started to explore more coordination of elective activity across NEL.

Northeast London have commenced a review to look at how maternity and neonatal services can meet the changing needs of women and babies. In order to do this a review of demand and capacity across our maternity and neonatal services has started. The work is intended to inform how the system can plan for the future and ensure that the needs of local people are met through provision that is safe, high quality and accessible. The birth rate is increasing, especially in Barking and Dagenham and Newham, and a higher proportion of births involve more complex care, leading to more women requiring care and treatment in acute maternity services. Building on the work already carried out by HealthWatch in North East London to engage with women and families across our population, the review will continue to involve local women and their families to help us shape maternity and neonatal services that are safe, high quality and accessible for all. The first stage of this project involves collating and analysing data and looking at future projections. We should be in a position to discuss initial findings in the summer of 2024.

4.2 Three Year Single Delivery Plan for maternity and neonates: Dynamic improvement plans

With the support of the MSSP, each of the hospitals has developed an overarching dynamic improvement plan which aligns with the Single Delivery Plan and other national recommendations and incorporates the recommendations from the MSSP diagnostic. The improvement plans will be delivered through a matrix of hospital-based work streams and Group-wide work streams. Progress, risks and issues will be reported through Hospital Executive Boards, and the Strategic Maternity and Neonatal Group with exceptions escalated to QAC.

The MSSP are happy with the direction of travel for the Trust and the engagement in the programme. They have however highlighted some concern with the pace of improvements in some areas. With the development of the dynamic improvement plans and improved governance structures it will be easier to identify and provide oversight and challenge by the executive teams.

5. Ockenden updates

Following the publication of the Three-Year Single Delivery plan for Maternity and Neonatal services, the submission of Ockenden action evidence has been channelled into dynamic improvement plans, supported by the MSSP. Outstanding actions such as the development of the maternity websites and patient information continues as a workstream supported by the communications team and patient experience midwives. The independent advocate role has now commenced across the system, which will support women and families who have had a poor outcome where they require support with investigation and advocacy. The standard for competence for labour ward coordinators has now also been published, with a plan to roll out training and development as a system in 2024.

The centralised monitoring of mothers and babies during labour (CTGs) remains outstanding and is being developed alongside our digital systems. We are developing our arrangements whilst capital cases are considered.

6. NHS Resolution Maternity Incentive Scheme (MIS) update

Barts Health submitted compliance with 5 standards for this year of the scheme. This reflects varying levels of compliance at each hospital as to be compliant for a standard all hospitals must comply. External assurance of our level of compliance with the standards was externally assured by the Local Maternity and Neonatal System (LMNS) leads and our MSSP Maternity Improvement Advisors

We have not yet achieved in the following standards:

- Use of the perinatal mortality review tool
- Safe Midwifery staffing
- Saving Babies Lives Care Bundle
- Multidisciplinary training
- Ward to Board Assurance

Action plans have been developed to support achievement of these standards. Support funding from NHS Litigation has been requested for the development of more robust pathways for the timely review of perinatal deaths and the Saving Babies Lives Care bundle, with a focus on cross site collaboration. The development of training faculties at each hospital which include protected time for members of the multidisciplinary teams to deliver the training, development of governance teams against MSSP recommendation and roles to support capacity and flow in the maternity units has also been requested.

The financial impact for the Trust will not be felt in the overall Trust financial position, as the

additional income from achieving 10 standards in the form of a rebate was not factored into Trust income in 2024/25 as it has been done previously. The financial advantage is that additional income from action plans to achieve compliance going forward will offset any revenue business cases that were planned by the hospitals in the areas describes for the first year of the new scheme. The new maternity and neonatal quality and safety toolkit will help with assurance and timely oversight of progress with these standards.

7. Maternity Workforce

7.1 Midwifery

The NHS workforce in England rose by 14.1% between December 2019 and March 2023, up almost 160,000 full time equivalent (FTE) staff. Yet the number of midwives rose just 1.1%, with only 247 additional midwives over the same period (RCM, 2023). While the number of births nationally has reduced, the decrease is neither linear nor a reason for complacency. Births can, and do, go up, but even if they do not, the complexity of maternity care has increased in recent years. Across Barts Health, numbers of births and women presenting for care has remained stable with increasing complexity. As of November, there were 114 whole time vacancies for midwives across Barts Health (16% vacancy rate). Recruitment remains challenging, with Midwifery becoming a less attractive option as a career. The national shortage of Midwives makes it harder to tackle the vacancy shortages at Barts health. Our pipelines need to continue to focus on domestic and overseas recruitment. Our current recruitment pipeline would bring our overall vacancy rate to around 8%.

So far 7 internationally educated Midwives have arrived, and a further 7 planned before April. There are a remaining 32 candidates in the pipeline, who are working on their English language courses and theory tests in their home country. We have recruited a large number of preceptor midwives into our service with a further 13 in the pipeline from recent recruitment waiting to start in the service. This brings challenge as we need to ensure these midwives are supported in their adaptation and early career. Additional clinical practice support for internationally educated midwives was funded by NHS England, and we have just received confirmation that preceptor support midwives will be funded for a further year. We will be closely monitoring the effectiveness of our support to preceptees.

We have also supported 4 midwives who returned to midwifery practice in 2023 and had our first 6 midwives qualify through the midwifery apprenticeship programmes. We will also continue to support student midwives who are qualified nurses through our partner higher education institutes. Staffing fill rates can be seen in appendix 1.

We use the nationally accredited Birthrate Plus Acuity tool to record staffing and acuity on our labour wards. This tool is demonstrating that we do not always have sufficient midwives on duty to meet to meet the complexity of patients on our wards. This data is used to inform decisions about managing demand in real time and to support longer term workforce planning.

There is a good culture of reporting staffing incidents on Datix, and recording of “red flag” incidents, which is where staffing has directly impacted the provision of care. The main area of reporting is that there are delays in the provision of induction of labour, and an inability to provide 1:1 care in labour to all women and for the coordinator on labour ward to be supernumerary in order to maintain a helicopter view of activity and safety on the wards.

There is a full review of maternity acuity, activity and workforce planned in autumn 2024 in line with the time scales recommended nationally using Birthrate plus for independent assurance.

7.2 Obstetrics

There have been changes in obstetric leadership at all hospitals, with new clinical directors being appointed. Two of the hospitals have also split the clinical directors’ roles so that obstetrics has dedicated obstetric leadership, with the third hospital currently reviewing this with job plan reviews. All hospitals have business plans in development for consultant expansion that builds in the additional roles and responsibilities needed to be complaint with standards from the Royal College of Obstetrics and Gynaecology (RCOG), NHS Resolution, and Saving Babies Lives Care bundle.

All hospitals were asked to review their arrangements to ensure that consultants have compensatory rest periods after on-call sessions. This has been benchmarked, and whilst none of the hospitals are currently compliant, they have all submitted improvement plans to Hospital Executive Boards and the Local Maternity and Neonatal System. Consultant presence audits occur monthly on all labour wards, and attendance in line with RCOG recommendations are all above 90% compliant. Action plans for shortfalls are presented through governance structures at hospital level.

7.3 Neonatal staffing

Neonatal Nursing is compliant for the national standard at both Whipps Cross and The Royal London, however there is a small gap at Newham Hospital. Recruitment plans are in place, and an action plan has been submitted to the neonatal network. Funding has been assured for the continuation of specialty training in neonatal nursing, as staffing standards do require us to have 70% of the workforce as qualified in specialty. In addition, last year the neonatal network has funded governance nursing hours at each hospital.

Neonatal nursing support on the postnatal wards for babies requiring transitional care is not compliant in any of our hospitals at present. Not having this resource delays discharges from the neonatal units and also contributes to longer separations of mothers and their babies where they need additional support. Business cases to support compliance are under development.

7.4 Neonatal Medical staffing

The neonatal medical workforce is compliant against the standards at The Royal London hospital. Both Whipps and Cross and Newham have some gaps in their middle grade levels. This means that there are times when there is not a dedicated registrar for the neonatal unit, but that the doctor is also covering paediatrics and the emergency department. Mitigations, including consultant on-call cover and back fill using bank are in place to support safety. The neonatal network has funded an additional consultant for Newham hospital and will be recruited to early 2024.

8 Insights from service users and Maternity Voices Partnership (MVP) Co-production

The Maternity and Neonatal Voices partnerships have now been taken over by HealthWatch. The Chairs remain in post following transition. They have developed an action plan for 2024 activity which is in line with the national guidance and is focused on hearing from women from marginalised and ethnically diverse groups.

Women's feedback has praised midwives for their compassionate care, but also demonstrated frustrations with waiting times in clinics, delays in induction of labour pathways and delays getting admitted to labour wards and thus access to timely pain relief. The MNVP chairs are invited to attend the QI projects that are working on these standards and are often represented by the patient experience midwives when they cannot attend. The goal is to ensure that there is co-production at every stage, and that equity and inclusion are always considered in improvement action. Our patient experience midwives continue to work with third sector organisations and attend community groups where women gather. They attend to have conversations about maternity care and offer midwifery advice, and gain trust from our communities and to build working relationships.

The CQC national maternity experience report was published in February 2024, outlining birthing peoples experiences who birthed in a Barts Health Hospital in February 2023. We invited 2,546 maternity service users to take part in the survey with 782 (32% response) completed survey's being returned. This was slightly below the previous year's response (35%) and below the average response rate for all Trusts (41%). When making comparisons with other Trusts, Barts Health were 'about the same' for 22 questions, 'somewhat worse than expected' for 7, 'worse than expected' for 19 and 'much worse than expected' for 6. Our most improved result, and one where we also score higher than the average across England, is that eight out of ten patients found their partner was able to stay with them as long as they wanted. Key areas of focus for the hospitals include advise on infant feeding, being left alone at a time who worried them, support on the postnatal ward and at home following birth. Patient experience midwives in our hospitals are developing action plans in partnership with local maternity and neonatal groups to address the CQC findings. These action plans and the progress against them will be reported on through hospital governance structures, the patient experience committee and through to the local maternity and neonatal system (LMNS).

9. Specific Hospital Innovations and Updates

The Royal London Hospital has had a record number of new starters, with 38 newly qualified midwives and 2 international educated midwives commence in the last few months. This had

taken their establishment fill rate about 95%. The additional support for newly qualified midwives at this scale is being scoped out by the hospital Director of Nursing and Associate Director of Midwifery to ensure that the preceptors have the best possible experience. Cultural development and diagnostic work are underway in the maternity department, following a number of staff listening events and feedback. This will be combined with a safety culture review as part of the national perinatal leadership programme. The Barkantine Birthing Centre remains closed to births until there is consistent confidence in midwifery staffing levels. This will be reviewed again in April and next steps agreed then.

Whipps Cross Hospital has been praised for its inventive education sessions and developments by the MSSP. Newham and Whipps Cross have also had a successful induction of labour (IOL) workshops with women. The workshops sets expectations of IOL under current staffing circumstances; offer of support to women and their birthing partners as well as how to access senior midwife should they wish to escalate anything; this approach will be rolled out across our other hospitals.

The Barking Community Birth Centre (BCBC) stand-alone centre managed by Newham Hospital had suspended birth care for 8 months whilst improvement work in the areas of risk assessment, guideline development and staff training were completed. The improvement work was completed in line with the agreed timetable and the service reopened on 5th February.

Newham Hospital maternity services have been supporting learning and development in Zimbabwe through fundraising events supported by staff. This obstetric emergency skills training will be delivered by an obstetrician and a number of midwives working at Newham.

10. Maternity Digital Transformation

Barts Health and Barking Havering and Redbridge NHS Trust (BHRUT) are working collaboratively in developing digital requirements in our maternity areas with early stages of financial approval being achieved. The work aligns with developments and systems in North East London, the national what good looks like framework and builds on the maternity digital strategy that was submitted to the ICS in October 2022.

An investment case has been approved by the Barts Health investment steering committee (ISC). There is a new process that requires NEL and London region sign off which is in progress. A tender process has commenced with BHRUT as leads. BH will work in conjunction with BHRUT, subject to final approval, with the intention of the provider being selected and contracts awarded in May 2024. Integration work will commence immediately, with a plan to implement in Spring 2025 and is linked to BHRUT EPR go live timelines for April 2025.

In the interim a current state review has been undertaken regarding the existing mixed economy of paper and Oracle. Prioritised optimisation is in place whilst the new procurement arrangements are developed.

A pilot regarding digital CTG is being established as an immediate solution at RLH. This will be used to evaluate and build wider shared learning across the group. A capital investment case for group wide CTG to be procured and implemented as a concurrent activity to the digital system is in development with a plan for ISCRP in March 2024.

Electronic prescribing and medicines administration (ePMA) is live within maternity and will continue to be used along with the core millennium EPR system. Any third party best of breed digital solution for maternity will be integrated to enable the most viable solution.

Working with BHRUT as a collaborative will enable consistency. The Homerton Hospital already have Oracle, millennium and are integrating Badgernet as their maternity solution.

Securing this new informatics system and digital CTG is a significant element of our maternity improvement plan and will mitigate a number of risks that the services are managing.

11. In conclusion

All trusts face heightened external scrutiny and tougher national requirements following the high profile national maternity reviews.. The maternity services are on a path of recovery and improvement after the Covid pandemic, loss of workforce, and the challenging and changing landscapes of demand for maternity and neonatal care.

Deaths are very rare, and our death rates are below the national average when the data is adjusted for case mix. Yet we cannot be complacent, as while the stillbirth rate is coming down, the neonatal death rate is increasing, more babies born very prematurely are now being resuscitated, and getting pathways right from this group of babies is key and starts during pregnancy. Notably the stillbirth rate for Black women is double that of white, and the neonatal death rate is triple for Black and mixed-race women, and double for Asian women. This matters because seven out of ten of our patients are Black or minority ethnic, with almost a quarter of women from Asian or Bangladeshi heritage. With partners we set up a multi-professional group across north east London to tackle inequalities experienced by families from black and Asian heritage groups, and are embarking in a national project to improve diabetes care for women from the global majority

With all the challenges, there are also bright spots in our services. Our maternity teams engage with quality improvement and service transformation, links are being made with communities and groups that previously we have not, which brings a wealth of intelligence and feedback which continues to drive improvement. The development of our dynamic improvement plans and strengthened governance and leadership model will help us to increase the pace of improvement across the organisation during 2024/25. The support of the MSSP specialist advisers have been invaluable.

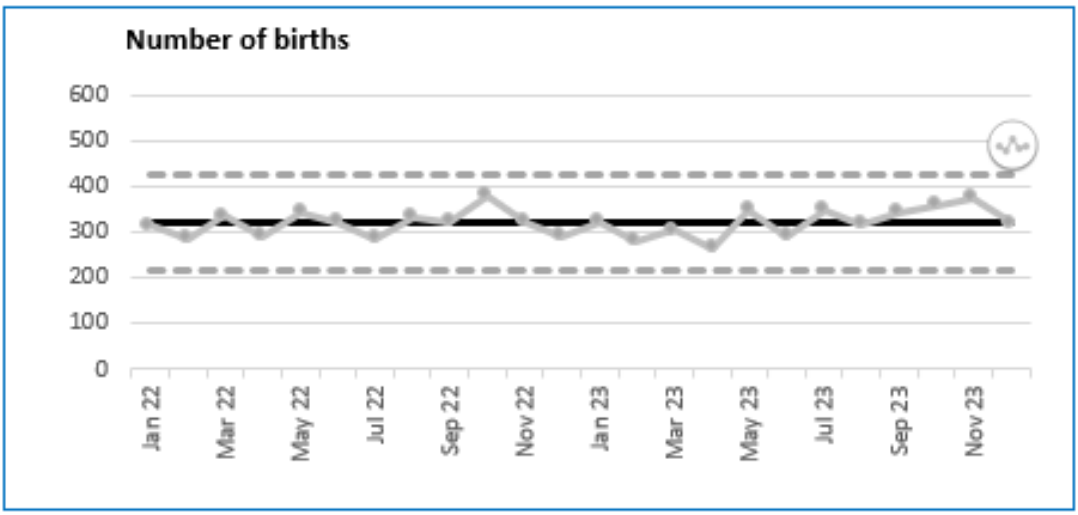
The Board is asked to note and discuss:

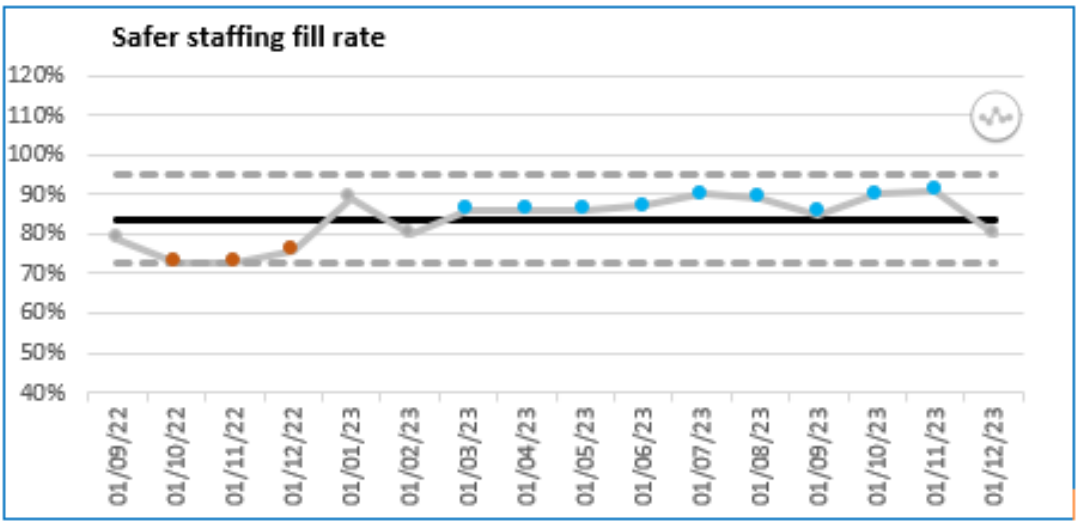
- the content of the report, in particular the focus on our response to key risks identified, in particular demand & capacity, workforce, governance and informatics

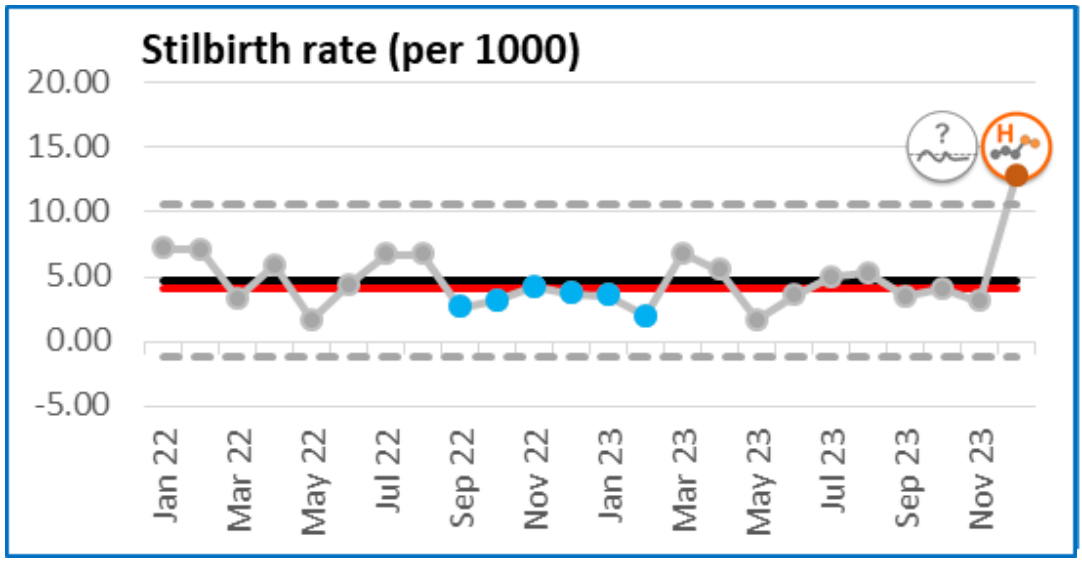
- the recent approval by the ISC for the maternity informatics business case & the plans for CTG monitoring
- the plan for Birthrate+ in Autumn 2024 and the business cases in response to the MSSP diagnostics, in particular in obstetric and governance roles which are going through scrutiny processes.

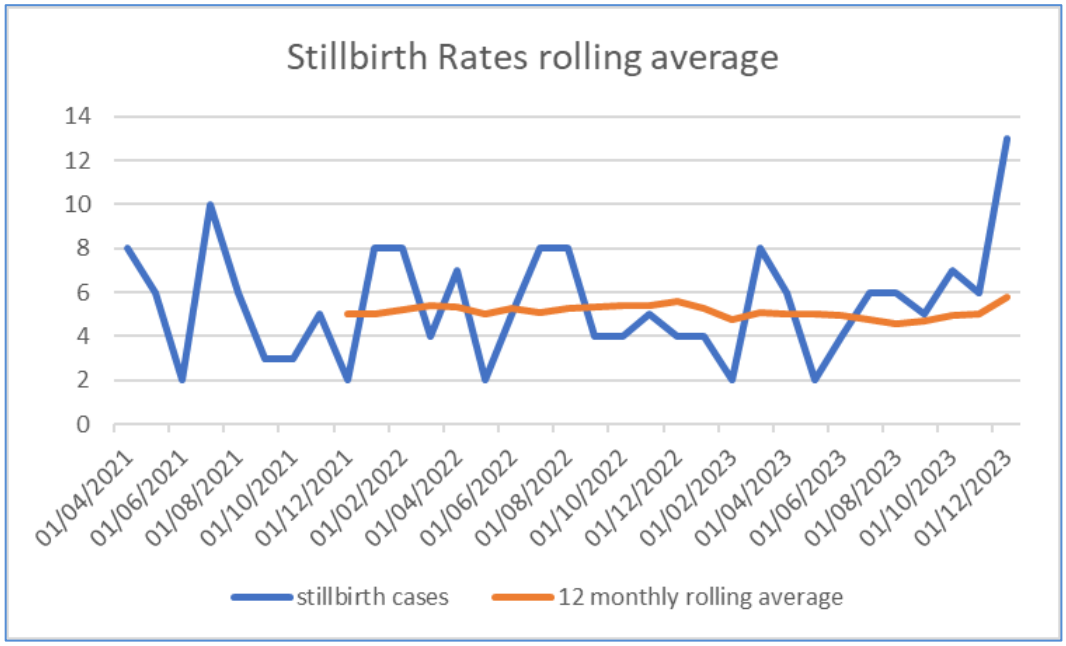
Barts Health NHS Trust

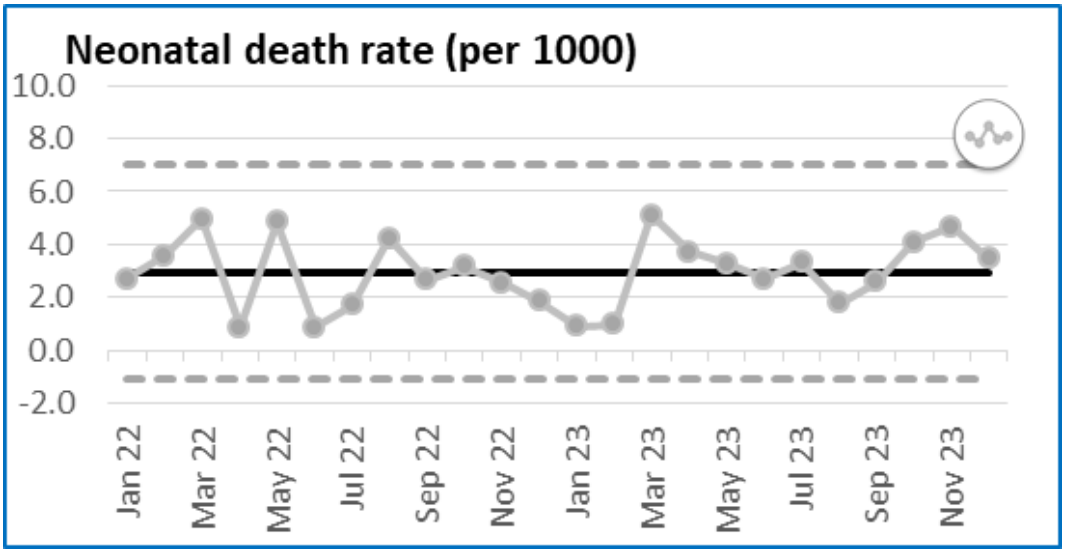
Appendix 1

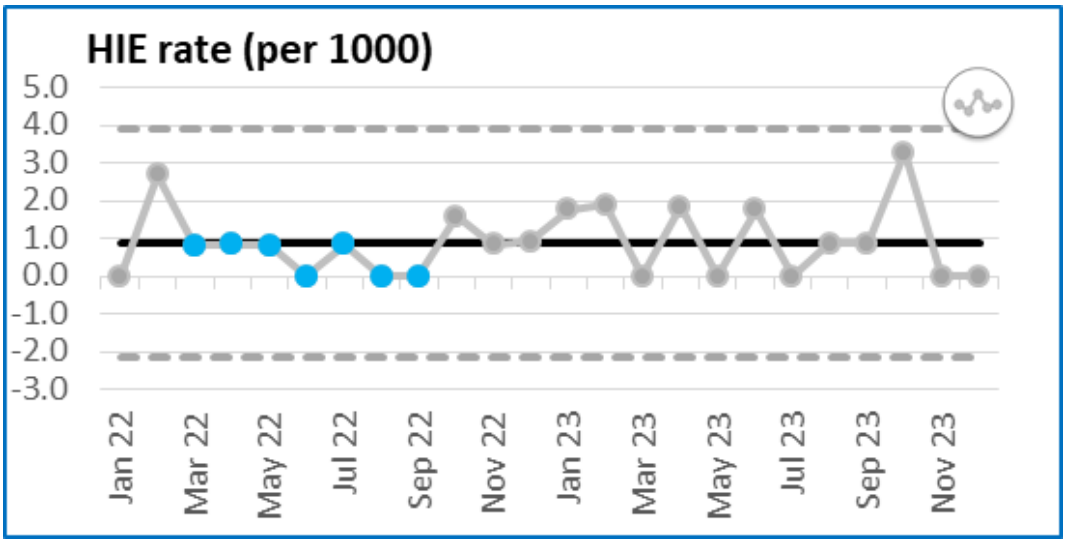


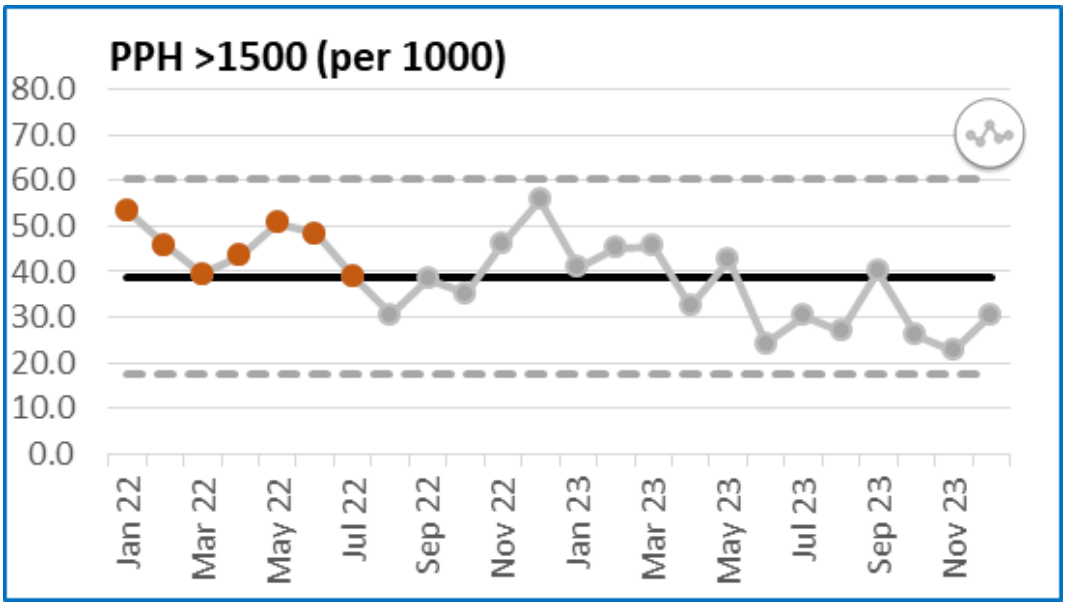





Stillbirth Rates rolling average
14
12
10
8
6
4
2
0
01/04/2021
01/06/2021
01/08/2021
01/10/2021
01/12/2021
01/02/2022
01/04/2022
01/06/2022
01/08/2022
01/10/2022
01/12/2022
01/02/2023
01/04/2023
01/06/2023
01/08/2023
01/10/2023
01/12/2023
stillbirth cases
12 monthly rolling average


Neonatal death rate (per 1000)
10.0
8.0
6.0
4.0
2.0
0.0
-2.0
Jan 22
Mar 22
May 22
Jul 22
Sep 22
Nov 22
Jan 23
Mar 23
May 23
Jul 23
Sep 23
Nov 23


HIE rate (per 1000)
5.0
4.0
3.0
2.0
1.0
0.0
-1.0
-2.0
-3.0
Jan 22
Mar 22
May 22
Jul 22
Sep 22
Nov 22
Jan 23
Mar 23
May 23
Jul 23
Sep 23
Nov 23


PPH >1500 (per 1000)
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Jan 22
Mar 22
May 22
Jul 22
Sep 22
Nov 22
Jan 23
Mar 23
May 23
Jul 23
Sep 23
Nov 23