Imperial College Healthcare NHS Trust

Public Trust Board, Reading Room items

Appendices to Item 13: Maternity Quality Assurance Oversight Report:

Appendix 1: SI summary of learning
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Appendices to Item 16: Board Committee Terms of Reference

1. Audit, Risk and Governance Committee, 2nd December 2021
2. Finance, Investment and Operational Committee, 5th May 2021
3. Quality Committee, 6th May 2021
4. Redevelopment Committee, 6th April 2021
5. People Committee, 4th May 2021
6. Remuneration and Appointments Committee, 2nd March 2021

Imperial College Healthcare NHS Trust

Appendix 1 to Maternity Quality Assurance Oversight Report

Serious Incident Summary of learning

A woman booked for maternity care in her first ongoing pregnancy and was low risk at booking. Her antenatal care was uneventful and in view of prolonged membrane rupture her labour was augmented with oxytocin at 39+6 weeks gestation. This was successful and she subsequently had a spontaneous vaginal delivery of a live female infant. She sustained a second degree tear which was sutured by a senior midwife. Post-delivery she was unable to pass urine and therefore she had an indwelling catheter inserted by the midwife caring for her; this was removed as per protocol. Later that evening, the woman reported pain at her perineum and on examination the midwife noted a cotton gauze swab inside the woman's vagina which she removed immediately. This cotton gauze swab was later identified as being part of a vaginal examination pack that was used for the urinary catheterisation. Later that night the woman developed mild temperature and was prescribed intravenous antibiotics and fluids. A speculum examination by a consultant obstetrician revealed no further retained materials.

Findings:

- An unknown number of swab gauze balls were used for cleaning prior to catheterisation which led to one being retained.
- Aseptic non touch technique (ANTT) not performed during catheterisation.

Root cause:

Aseptic Non Touch Technique was not correctly adhered to during catheterisation.

Recommendations and learning:

- Highlight with maternity staff, the importance of correct ANTT when catheterising women.
- Reflective session with the staff involved regarding ANTT and appropriate use of gauze balls in the vaginal examination packs.
- To include ANTT reminder at midwifery annual statutory/mandatory training at Bladder management session.
- Remove the vaginal examination packs that contain the gauze balls from the ward areas.

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Appendix 2

Monthly Report on the Perinatal Mortality review tool March 2021.

Imperial college Healthcare NHS trust, SMH and QCCH, started reporting on the PMRT tool from 23.12.2018

This report includes:

- Late fetal losses where the baby is born between 22^{+0} and 23^{+6} weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g.
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life.
- All neonatal deaths where the baby is born alive from 22^{+0} but dies up to 28 days after birth.
- Post-neonatal deaths where the baby is born alive from 22^{+0} but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

The PMRT is not designed to support the review of the following perinatal deaths:

- Termination of pregnancy at any gestation.
- Babies who die in the community 28 days after birth or later who have not received neonatal care.
- Babies with brain injury who survive.

(https://www.npeu.ox.ac.uk/pmrt/faqs#governance)

The total number 132 babies that fell into these categories across site since reporting began on the 20th December 2018. The graph below shows all late miscarriages, stillbirths and neonatal deaths per month since reporting started.

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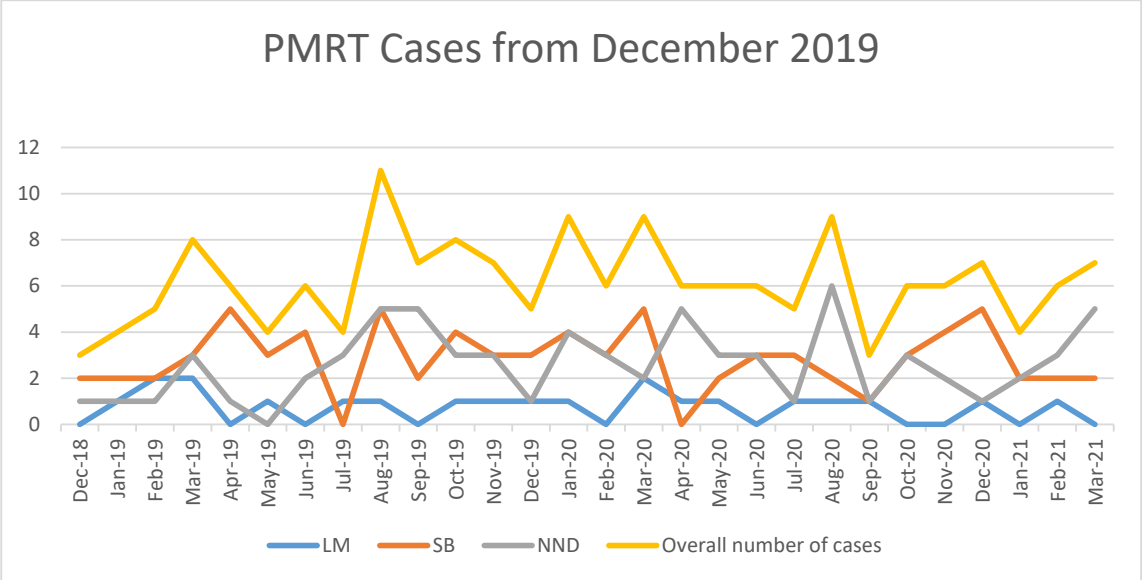

Audit period

The PMRT timeframe started on from 20 December 2018 and new standards were introduced on the 1st February 2021. The standards are below.

Required standards (all cases must be suitable for review using the PMRT)

All perinatal deaths eligible to be notified to MBRRACE-UK from Monday 11th January 2021 onwards must be notified to MBRRACE-UK within seven working days

Surveillance information where required must be completed within four months of the death

A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20th December 2019 to Monday 15th March 2021 will have been started.

At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Monday 15th March 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool.

For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion.

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Trust should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and these actions.

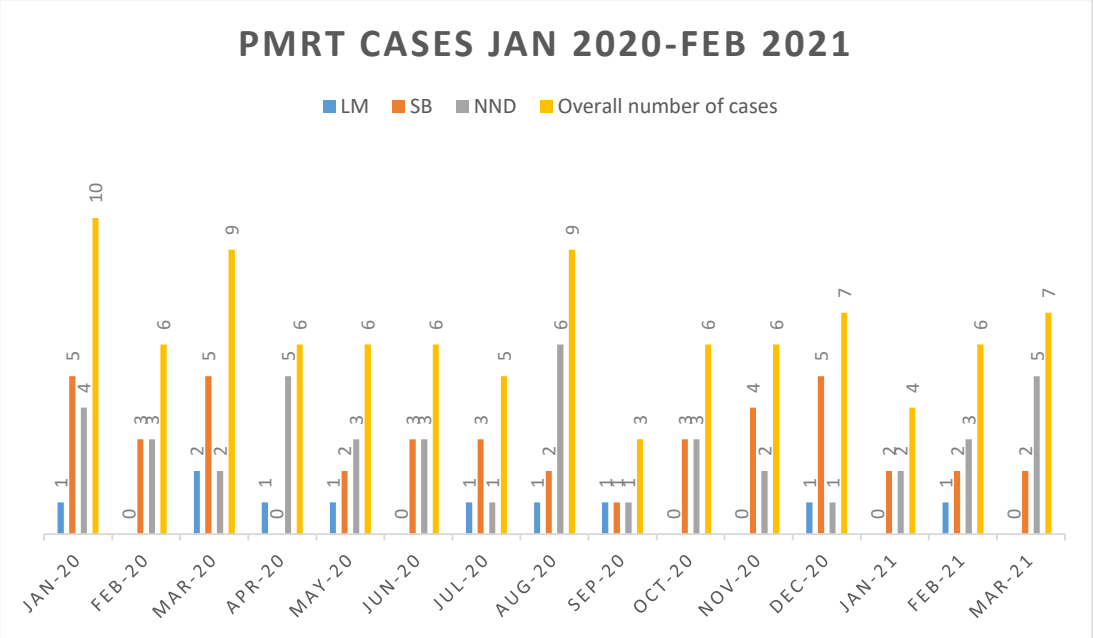
Minimum evidential requirement for the Trust Board

The perinatal mortality review tool must be used to review the care and draft reports should be generated via the PMRT. A report will be submitted to the Trust Board each quarter from Thursday 1st October 2020 onwards. This includes details of the deaths reviewed and the subsequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met.

Validation process

Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form.

NHS Resolution will use data from the PMRT, provided by MBRRACE-UK, to cross-reference against Trust self-certification. Cross referencing will be used to check that the PMRT has been used to review eligible perinatal deaths and that standards a), b) and c) have been met using the PMRT between 20 December 2019 until Thursday 15th July 2021.



Audit of standards from February 1st 2021.

Standards	Percentage achieved
All perinatal deaths eligible to be notified to MBRRACE-UK from Monday 11th January 2021 onwards must be notified to MBRRACE-UK within seven working days	100% 16 babies meet this criteria and 16 babies have been reported in 7 days
Surveillance information where required must be completed within four months of the death	100% compliance
A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies,	100% compliance

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suitable for review using the PMRT, from Friday 20 December 2019 to 15 March 2021 will have been started.	
At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Monday 15th March 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool.	Compliant to date. The cases take approximately 4 months to review so this a rolling total. We aim to review cases within 4 months (as per previous CNST standard). Overall approximately 85% compliance for all PMRT reviews (babies born here and NN transfers) to at least draft report within 4 months. Approximately 93% for babies who are born and die in the Trust to at least draft report within 4 months. One SI case has been delayed due to Covid -19 but will be reviewed at the next available opportunity
For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trust should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and these actions.	100%. leaflets given to parents in bereavement pack. The bereavement team keep in contact with the families and feedback any concerns.
Before they are discharged home all parents should be informed that a local review of their care and that of their baby will be undertaken	100%

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by the Trust. In the case of neonatal deaths parents should also be told that a review will be undertaken by the local Child Death Overview Panel (CDOP). Verbal information can be supplemented by written information.	
Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion	100% PMRT reported to Quality and Safety meetings and Quarterly reports pulled off the database for Trust Board. Next due in Aprill.
External member present for review	80% compliance overall External participant involved in the reviews of late fetal losses and stillbirths without resuscitation – 76% External participant involved in the reviews of stillbirths with resuscitation and neonatal deaths – 85% The child death review (CDOP) panel have a member present at PMRT meetings. Chelsea and Westminster continue to support the team, and where there are two sites involved in the PMRT case a member of that Trust is invited to the meeting. This has been impacted by Covid-19 but compliance continues to improve.
General Update	Of the 97 cases eligible for PMRT review from December 2019, 13 cases (13%) were NN transfers from other units that are investigated jointly by Imperial and the other trusts involved. 84 cases were babies born at Imperial, of those 21 (25%) are intrauterine transfers which we aim to complete jointly with other hospitals involved in care.

We aim to have a full multi-disciplinary review every two weeks to review all PMRT cases.

Although the PMRT standards do not specifically mention external members we hope to continue to invite colleagues from other Trusts to support our review.

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Issues and Actions from cases

Issues from cases fed back to risk meetings and Quality and Safety meeting. The box below includes action from all the PMRT completed by the Trust. From 1st October 2020 – 31st December 2020

Issue PMRT	Number of cases	PMRT action plan
This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance	**1**	Safety huddle to all staff to invite women who call with reduced fetal movements to come to hospital immediately.
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened because carbon monoxide testing was paused due to COVID-19	**8**	The Trust has an action plan in place to improve compliance but carbon monoxide testing has been on hold nationally since spring 2020 due to Covid-19
The baby had to be transferred elsewhere for the post-mortem	**5**	This is Trust Policy
It is not possible to tell from the notes whether during the early bereavement period use of a cold cot was offered/available	**3**	The use of the Cold cot is being added to the electronic checklist to make it easier to tell if it has been offered or used in future.
It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	**2**	Opportunity to take baby home is being added to the electronic checklist to make it easier to tell if it has been offered or used in future.
It was not possible to ask this mother about was not asked about domestic abuse at booking as she was seen remotely and was not alone	**2**	Clinicians have been reminded that women should be asked sensitive questions at each contact appointment. A face to face meet and greet appointment allows this to happen in a safe manner.
This mother's progress in labour was not monitored on a partogram	**2**	Remind staff of importance of monitoring women's progress in labour on a partogram
During this mothers's labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out	**1**	Remind staff of importance of timely measurement of maternal observations as well as clear documentation
From information identified earlier in the tool this mother met the national guideline criteria for screening for gestational diabetes but this does not	**1**	To remind clinicians to chase blood results, and to act upon results that appear to not have been sent.

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appear to have been identified and she was not offered screening		

Actions from cases fed back to risk meetings and Quality and Safety meeting. The box below includes action from all the PMRT completed by the Trust. From 1st October 2020 – 31st December 2020

This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance		Safety huddle to all staff to invite women who call with reduced fetal movements to come to hospital immediately.
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened because carbon monoxide testing was paused due to COVID-19		The Trust has an action plan in place to improve compliance but carbon monoxide testing has been on hold nationally since spring 2020 due to Covid-19
This mother was not assessed for the need for aspirin		Action has been undertaken to improve the screening for the need of aspirin for mothers. This information has been shared with clinicians. This information has been shared with clinicians and will be shared at teaching sessions and in the risk newsletter.
From information identified earlier in the tool this mother met the national guideline criteria for screening for gestational diabetes but this does not appear to have been identified and she was not offered screening		To remind clinicians to chase blood results, and to act upon results that appear to not have been sent. Learning to be shared on the risk newsletter and at teaching sessions.
It was not possible to ask this mother about was not asked about domestic abuse at booking as she was seen remotely and was not alone		Clinicians have been reminded that women should be asked sensitive questions at each contact appointment. A face to face meet and greet appointment allows this to happen in a safe manner.
During this mothers's labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out		Maternal pulse was performed at the same time as fetal heart rate to distinguish the two measurements, however the timing and maternal rates were not documented. Remind staff of importance of timely measurement of maternal observations as well as clear documentation. Reflection discussions with staff

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This mother had poor/no English and family members were used as interpreters during her antenatal, labour and birth		Staff have been reminded about the importance of using interpreters and made aware how to contact language line
It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home, or the cold cot was used		This has now been added to the bereavement checklist so it is easier to identity this from the notes. The bereavement team is updating the bereavement checklist to include the use of the cold cot and opportunity to take baby home, so it is easier to identify from the notes if it has been used. The electronic update was delayed due to covid-19 but the paper form is currently being updated.

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Maternity services data set summary information for maternity incentive scheme (CNST)

The second safety action is: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

This is measured against criteria published by NHS Resolution and included on the 'Revised Criteria Autumn 20' tab of this document. The table below summarises the number of criteria met by each maternity service provider by month.

			Criteria Achieved by provider by month								If 12/12 not achieved	
Organisation Code	Organisation Name (Provider)	Region	May/2020	Jun/2020	Jul/2020	Aug/2020	Sep/2020	Oct/2020	Nov/2020	Dec/2020	Recommendation made to NHS Resolution to pass as a near miss due to data or as an exception due to service pattern	Not recommended for a pass at this stage, next steps being discussed with NHS Resolution and trust
RQM	Chelsea and Westminster Hospital NHS Foundation Trust	London	5	5	5	7	10	11	10	11	Yes	
RYJ	Imperial College Healthcare NHS Trust	London	10	10	6	11	11	11	11	12		
R1K	London North West University Healthcare NHS Trust	London	8	9	9	9	11	10	10	12		
RAS	The Hillingdon Hospitals NHS Foundation Trust	London	7	7	7	8	8	8	8	12		

	Provider Achieving Criteria by month									
Criteria	May	June	July	August	September	October	November	December		
0	0	0	0	0	0	0	0	0		
1	0	0	0	0	0	0	0	0		
2	0	0	0	0	0	0	0	0		
3	5	3	2	0	0	0	0	0		
4	16	18	12	2	1	2	2	0		
5	6	5	7	10	12	13	9	0		
6	15	13	15	4	2	3	2	1		
7	28	29	28	16	9	12	6	0		
8	22	24	21	26	27	21	13	0		
9	16	15	19	29	22	14	24	2		
10	16	17	20	7	12	20	14	3		
11	0	0	0	30	39	40	55	2		
12	0	0	0	0	0	0	0	117		
13	0	0	0	0	0	0	0	0		
Total	124	124	124	124	124	125	125	125		

Revised Criteria Autumn 2020

NHS Digital

Required standard - This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.

Minimum evidential requirement for trust Board - NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. It will help trusts understand the improvements needed in advance of the assessment.
The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met.
All 13 criteria are mandatory. Items 1,2, 4 - 13 will be assessed by NHS Digital and included in the scorecard. Item 3 will be reported to NHS Resolution..

Validation process - This will be **s**elf-certification by the Board and submitted to NHS Resolution using the Board declaration form.
NHS Resolution will cross-reference self-certification against NHS Digital data.

Relevant time period - The relevant deadlines are shown against each of the criteria. The first deadline, for ensuring that two people are registered to submit the data, is Friday 30th October 2020. A MSDS data submission for August 2020 data needs to be made by Friday 30th October 2020 and the deadlines for the following four months also need to be met.
The assessment of data quality and completeness will consider data from the MSDS for December 2020. The deadline for the December 2020 data is Sunday 28th February 2021.

Deadline for reporting to NHS Resolution - 20th May 2021 at 12:00 noon
NHS Resolution Information on Assessment Criteria is available here

All categories are mandatory and must be met to pass Safety Action 2

Criteria	Standard	Construction
1	At least two people registered to submit MSDS data to SDCS Cloud and still working in the trust on Saturday 31st October 2020.	At least two people registered to submit MSDS data to SDCS Cloud and still working in the trust on Saturday 31st October 2020.
2	MSDSv2 webinar attended by at least one colleague from each trust in January/February 2020 (complete - all trusts attended).	MSDSv2 webinar attended by at least one colleague from each trust in January/February 2020 (complete - all trusts attended).
3	Trust Boards to confirm to NHS Resolution that they have fully conformed with the MSDSv2 Information Standards Notice, DCB1513 And 10/2018, which was expected for April 2019 data, or that a locally funded plan is in place to do this, and agreed with the maternity safety champion and the LMS. This should include submission of the relevant clinical coding in MSDSv2 in SNOMED-CT.	Trust Boards to confirm to NHS Resolution that they have fully conformed with the MSDSv2 Information Standards Notice, DCB1513 And 10/2018, which was expected for April 2019 data, or that a locally funded plan is in place to do this, and agreed with the maternity safety champion and the LMS. This should include submission of the relevant clinical coding in MSDSv2 in SNOMED-CT.
4	Made a submission relating to August 2020 -December 2020 data, submitted to deadlines October 2020 - February 2021.	Made a submission relating to December 2020 data, submitted to deadline of February 2021. A simple search to check the MSD000header table for a submission by the provider.
5	December 2020 data included all following tables MSD000 MSDS Header MSD001 Mother's Demographics MSD002 GP Practice Registration MSD101 Pregnancy and Booking Details MSD102 Maternity Care Plan MSD201 Care Contact (Pregnancy) MSD202 Care Activity (Pregnancy) MSD301 Labour and Delivery MSD302 Care Activity (Labour and Delivery) MSD401 Baby's Demographics and Birth Details MSD405 Care Activity (Baby) MSD901 Staff Details	A simple search on each table verifying that data has been submitted for each table
6	December 2020 data contained at least 90% of the deliveries recorded in Hospital Episode Statistics (unless reason understood). (MSD401)	Numerator: Number of MSD401 records in the reporting period Denominator : HES data Criteria 6 - Three Columns: HES has been calculated on the current month based in the previous years 18/19 and 19/20, and the current year 20/21. If any year has passed then an overall pass is submitted/accepted. If the number of HES deliveries for the current month for 20/21 is zero then this year will not be included in the assessment of this criteria. HES deliveries: Criteria 6 have been calculated using unsuppressed values for HES deliveries. HES deliveries shown in the 'HES 1819' and 'HES 1920' tabs are suppressed values.
7	December 2020 data contained at least as many women booked in the month as the number of deliveries submitted in the month (unless reason understood) (MSD101)	Numerator: Number of MSD101 records in the reporting period and antenatal appointment in the reporting period Denominator : Number of MSD401 records in the reporting period and babies birth date in the reporting period
8	December 2020 data contained Estimated Date of Delivery for 95% of women booked in the month (MSD101)	Numerator: Number of MSD101 records in the reporting period and antenatal appointment in the reporting period with an EDD recorded Denominator : Number of MSD101 records in the reporting period and antenatal appointment in the reporting period
9	November 2020 and December 2020 data contained valid postcode for mother at booking in 95% of women booked in the month (MSD001)	Numerator: Number of MSD101 records in the reporting period and antenatal appointment in the reporting period with a corresponding record in MSD001 where postcode is not null and with a ValidPostalcodeFlag flag of 'Y' recorded Denominator : Number of MSD101 records in the reporting period and antenatal appointment in the reporting period

10	December 2020 data contained valid ethnic category (Mother) for at least 80% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Numerator: Number of MSD101 records in the reporting period and antenatal appointment in the reporting period with a corresponding record in MSD001 where EthnicCatogoryMother is recorded with THE FOLLOWING codes (A,B,C,D,E,F,G,H,J,K,L,M,N,P,R,S) Denominator : Number of MSD101 records in the reporting period and antenatal appointment in the reporting period
11	December 2020 data contained antenatal continuity of carer plan fields completed for 90% of women booked in the month (MSD101/2)	Numerator: Number of MSD101 records in the reporting period and antenatal appointment in the reporting period with a corresponding record in MSD102 where CarePlanType = 05 and ContCarePathInd is not null Denominator : Number of MSD101 records in the reporting period and antenatal appointment in the reporting period
12	December 2020 data contained antenatal personalised care plan fields completed for 90% of women booked in the month (MSD101/2)	Numerator: Number of MSD101 records in the reporting period and antenatal appointment in the reporting period with a corresponding record in MSD102 where CarePlanType = 05 and MatPersCarePlanInd is not null Denominator : Number of MSD101 records in the reporting period and antenatal appointment in the reporting period
13	December 2020 data contained valid presentation at onset of delivery codes for 90% of births where this is applicable (MSD401)	Numerator: Number of MSD401 records in the reporting period and babies birth date in the reporting period where FetusPresentation in ('01', '02', '03', 'XX') Denominator : Number of MSD401 records in the reporting period and babies birth date in the reporting period

Technical Guidance

Where should I send any queries?	NHS Digital have a new dedicated mailbox maternity.dq@nhs.net
Why are these criteria included?	The first two years of the maternity incentive scheme saw, via Action 2, a substantial improvement in the MSDSv1.5 data submitted to NHS Digital. The data, which are published monthly and shared at record level with a range of organisations could therefore be used for a wide range of local and national purposes. It also ensured that all trusts were engaged with NHS Digital on the move to MSDSv2.0. Even so, the move to MSDSv2.0 in April 2019 saw an overall reduction in the range of data submitted to NHS Digital. The latest scheme plans to ensure that the key elements of the data, such as births, bookings, estimated date of delivery and presentation at delivery are submitted. It also focusses on key priority areas such as Continuity of Carer, Personalised Care Plans and inequalities, via both ethnic category and postcode. Publications produced by MBRRACE-UK, other publications such NHS Long Term Plan (January 2019), and the June 2020 letter regarding perinatal support for women of black and ethnic minority have identified that women from black, asian and minority ethic (BAME) groups are at higher risk of their baby dying in the womb or soon after birth. It is important that accurate ethnicity data is recorded at booking to assist with addressing the inequality in healthcare outcome gap. Action 2 also contains some activities to ensure that all trusts continue to be engaged with NHS Digital and continue to make improvements to their data.
What do we do if our clinical / organisational circumstances mean that we unable to pass one of the criteria?	There could be a reason why your data is different and does not fit with the standard assessment criteria. For example, the trust may handle a large number of bookings with the deliveries mainly taking place in a neighbouring trust. If you know that your circumstances do not fit with a criterion, please contact NHS Digital at an early stage.
How do we register additional data submitters?	Please see the information at: https://digital.nhs.uk/services/strategic-data-collection-service-in-the-cloud-sdcs-cloud
Digital Maternity Record Standards	Item 14 on the Maternity Record Standard has been removed from action two and will be progressed separately by NHSX. NHS Digital announced on 1st April 2020 that the Digital Maternity Record Standard (DMRS) compliance date has been delayed from **Monday 30th November to Sunday 28th February 2021**.
Where can I find more information about MSDSv2?	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set
Who do we contact about the maternity record standard	When year was originally launched in December 2019, it referenced the maternity record standard. · Item 14 on the Maternity Record Standard has been removed from action two and will be progressed separately by NHSX. NHS Digital announced on 1 April 2020 that the Digital Maternity Record Standard (DMRS) compliance date had been delayed from Monday 30th November 2020 to Sunday 28th February 2021. For any queries related to the maternity record standard, please email england.digitalmaternitynhsx@nhs.net

CNST Criteria Scorecard- December 2020

This scorecard explains which criteria have been met within the month for each provider.
Data in this tab is for December 2020.

Provider Data				Criteria_1 At least two people registered to submit MSDS data to SDCS Cloud and still working in the trust on 31st October 2020.	Criteria_2 MSDSv2 webinar attended by at least one colleague from each trust in January / February 2020	Criteria_3 Trust Boards to confirm to NHS Resolution that they have fully conformed with the MSDSv2 Information Standards Notice, DCB1513 And 10/2018, which was expected for April 2019 data, or that a locally funded plan is in place to do this, and agreed with the maternity safety champion and the LMS. This should include submission of the relevant clinical coding in MSDSv2 in SNOMED-	Criteria_4 Made a submission relating to August 2020 - December 2020 data, submitted to deadlines October 2020 - February 2021.								Criteria_4 All months submitted to date Yes / No	Criteria_5 December 2020 data included all following tables Submitted Tables for Current Month December 2020 data includes all of the following tables											
Organisation Code	Organisation Name	Region	Month	Yes/No	Yes/No	Trust boards to confirm to NHS Resolution	May Yes/No	June Yes/No	July Yes/No	August Yes/No	September Yes/No	October Yes/No	November Yes/No	December Yes/No	Between August and December	MSD000 MSDS Header	MSD001 Mother's Demographics	MSD002 GP Practice Registration	MSD101 Pregnancy and Booking Details	MSD102 Maternity Care Plan	MSD201 Care Contact (Pregnancy)	MSD202 Care Activity (Pregnancy)	MSD301 Labour and Delivery	MSD302 Care Activity (Labour and Delivery)	MSD401 Baby's Demographics and Birth Details	MSD405 Care Activity (Baby)	MSD901 Staff Details
RQM	Chelsea and Westminster Hospital NHS Foundation Trust	London	ecemb	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
RYJ	Imperial College Healthcare NHS Trust	London	ecemb	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
R1K	London North West University Healthcare NHS Trust	London	ecemb	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
RAS	The Hillingdon Hospitals NHS Foundation Trust	London	ecemb	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Criteria_5 All tables submitted for current reporting period	**Criteria_6_HES_Births** December 2020 data contained at least 90% of the deliveries recorded in Hospital Episode Statistics **18/19** (unless reason understood). (MSD401)	**Criteria_6_HES_Births** December 2020 data contained at least 90% of the deliveries recorded in Hospital Episode Statistics **19/20** (unless reason understood). (MSD401)	**Criteria_6_HES_Births** December 2020 data contained at least 90% of the deliveries recorded in Hospital Episode Statistics **20/21** (unless reason understood). (MSD401)	**Criteria_6_HES_Births** December 2020 data contained at least 90% of the deliveries recorded in Hospital Episode Statistics **18/19, 19/20** or **20/21** (unless reason understood). (MSD401)	**Criteria_7_Booking_and_Deliveries** December 2020 data contained at least as many women booked in the month as the number of deliveries submitted in the month (unless reason understood) (MSD101)	**Criteria_8_EDD** December 2020 data contained Estimated Date of Delivery for 95% of women booked in the month (MSD101)	**Criteria_9_Postcode** December 2020 data contained valid postcode for mother at booking in 95% of women booked in the month (MSD001)	**Criteria_10_Ethnicity** December 2020 data contained valid ethnic category (Mother) for at least 80% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	**Criteria_11_CoC** December2020 data contained antenatal continuity of carer plan fields completed for 90% of women booked in the month (MSD101/2)	**Criteria_12_PCP** December 2020 data contained antenatal personalised care plan fields completed for 90% of women booked in the month (MSD101/2)	**Criteria_13_PresentationAtOnset** December 2020 data contained valid presentation at onset of delivery codes for 90% of births where this is applicable (MSD401)
Yes/No	Yes/No		Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Yes	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Appendix 4

Imperial College Healthcare NHS Trust

Monthly report on Avoiding Term Admissions into Neonatal Units (ATAIN)

March 2021

ATAIN – required standards

The ATAIN programme is a national initiative launched in 2017 with the aim to reduce avoidable causes of harm that can lead to infants born at term (i.e. ≥ 37+0 weeks gestation) being admitted to a neonatal unit (NNU).

The purpose of this report is to demonstrate compliance with the standards set out in the Clinical Negligence Scheme for Trusts (CNST) year 3 maternity incentive scheme, Safety Action 3 (standard F and G).

The required standards are as follow:

F. An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19 period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion.

G. Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.

Evidence for standard f) to include:

- An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from ATAIN reviews.
- Evidence of an action plan to address identified and modifiable factors for admission to transitional care.
- Evidence that the action plan has been revised in the light of learning from term admissions during Covid-19. Where no changes have been made, the rationale should be clearly stated.
- Evidence that the action plan has been shared and agreed with the neonatal, maternity safety champion and Board level champion.

Evidence for standard g) to include:

- Evidence that progress with the revised ATAIN action plan has been shared with the neonatal, maternity safety champion and Board level champion.

ATAIN meetings

An ongoing review is carried out for all unanticipated term admissions to NNU. ATAIN meetings are held weekly on a Monday with attendance from the Obstetric, Midwifery and Neonatal teams. Cases from Queen Charlotte's and Chelsea Hospital (QCCH) and St Mary's Hospital (SMH) are reviewed and discussed with the aim of identifying

Report date 06.04.2021 Vanessa Battaglia

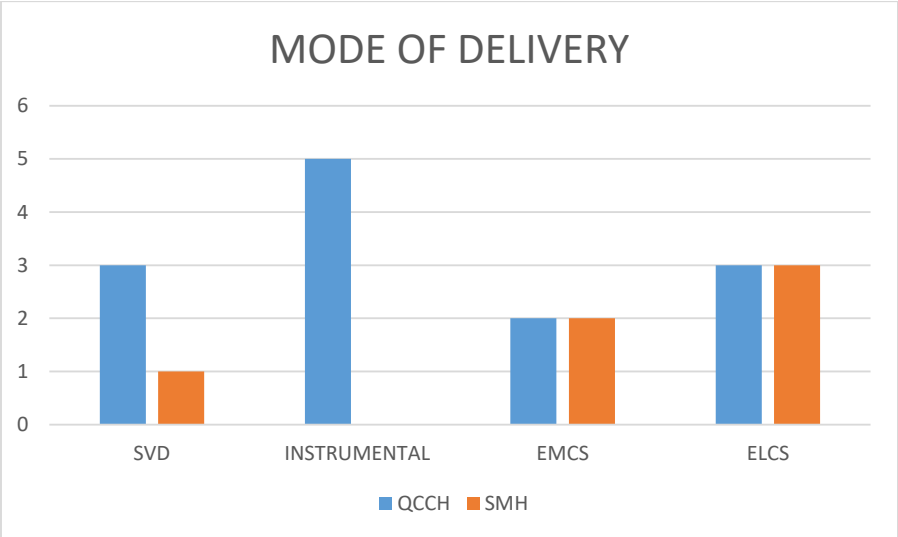
avoidable and potentially avoidable admissions to the neonatal units. All the relevant information is collected on an Excel spreadsheet.

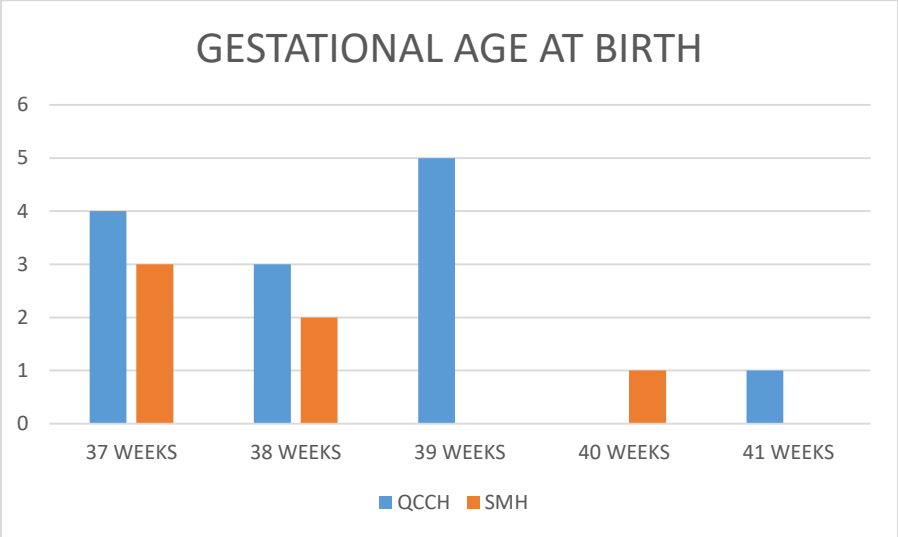
Cases March 2021

20 babies at term were admitted to the NNU in March 2021. As 1 case has not been discussed at ATAIN yet, it will be included in next month's report. Of the 19 cases included in March report, 3 were identified as being potentially avoidable admissions. 1 case has been reported as a Serious Incident and is currently under investigation.

	Unavoidable	Avoidable	Under investigation	Total
QCCH	11	2	0	13
SMH	4	1	1	6
Imperial	15	3	1	19

The chart below shows the prevalence of mode of delivery and gestational age at birth for both QCCH and SMH.





In QCCH there were 13 term admissions to NNU in March 2021, of which 2 were potentially avoidable and 2 were expected admissions. None of the admissions were readmitted from home.

Reasons for admission – unavoidable:

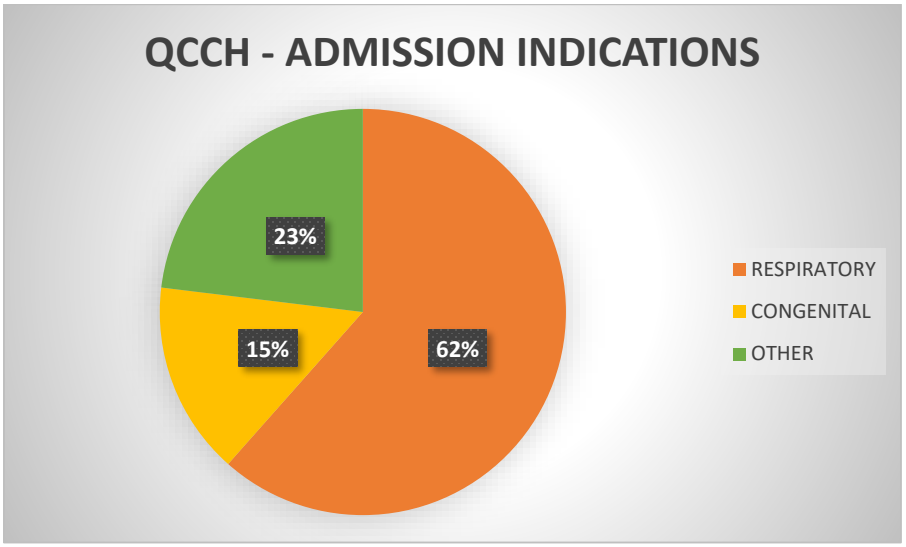
- Respiratory support **7**
- Hypoglycaemia **1**
- Focal seizures **1**

Reasons for admission – expected:

- Congenital cardiac disease **2**

Reasons for admission – avoidable:

- Respiratory distress **1**
  This baby was born at 38 week gestation by instrumental delivery. She was born in good conditions (Apgars 9 and 10), however showed respiratory distress at 8 minutes of life and required CPAP. The baby was then admitted to NNU for respiratory distress but did not require any respiratory support nor antibiotics as per Kaiser Permanente scoring. She was discharged to the postnatal ward after 6 hours and discharged home with mum on day 2. The ATAIN teams felt that this case could have been managed on the postnatal ward.
- Persistent tachycardia **1**
  This baby was born in good conditions (Apgars 9/10/10) at 39 week gestation by instrumental delivery. She was noted to be tachycardic on day 2 and was therefore admitted to NNU. Multiple ECGs were carried out which showed a sinus tachycardia. On day 3, the baby was put on antibiotics for suspected sepsis and discharged to the postnatal ward. On day 4, she was readmitted to NNU for persistent tachycardia. The cardiac investigations did not identify any issues. The baby was then diagnosed with a fracture of her right clavicle, possibly due to birth trauma. On day 6, the baby was transferred back to the postnatal ward and discharged home with mum on day 9. A more prompt injury diagnosis could have identified the cause of the tachycardia and the baby could have stayed on the postnatal ward for pain management.



In SMH there were 6 term admissions to NNU in March 2021, of which 1 was potentially avoidable. None of the admissions were expected. There were no babies readmitted from home.

Reasons for admission – unavoidable:

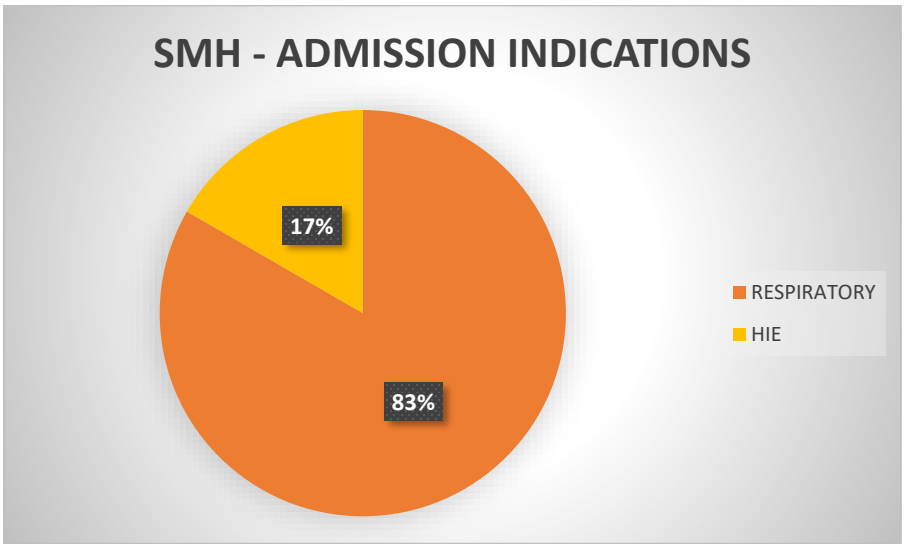
- Respiratory support **4**

Reasons for admission – under investigation:

- Respiratory support and HIE **1**

Reasons for admission – avoidable:

- Respiratory support **1**
  This was a baby that was born via elective caesarean section (ELCS) at 38 week gestation for previous caesarean sections. At 4 hours of age, the baby was admitted to NNU for respiratory support. On day 2, He was then transferred to the postnatal ward and discharged home with mum on day 4. An ELCS scheduled later than 38 gestation week could have prevented admission to NNU.



Action Plan to address local findings from ATAIN 2020

All cases of admission to the neonatal unit identified as avoidable, are investigated by the risk governance process. These are reported on the Datix system and actions identified from the investigation are followed-up via the quality and safety governance process. Learning is shared with frontline staff.

The findings from the 2020 Audit (from January to December 2020) were analysed in January 2021. The action plan was developed and progress are summarised below. Any additional themes/ actions from subsequent monthly audits will be added to the action plan below, signed off by the maternity, neonatal and board safety champions and progress overseen by the maternity directorate, children's directorate and divisional quality and safety meetings.

During the reviews in March 2021 there were no additional actions added. The finding of ELCS after 39+0 weeks gestation has been included previously within the action plan.**Local findings**	**Action**	**Lead**	**Complete by**	**Evidence of Progress and Completion**	**Progress (RAG)**
Lack of cross site multidisciplinary sharing and learning from term admissions	Weekly meetings in place attended by MDT, findings and action points discussed and documented. There is at times no obstetric consultant present due to workload on Labour wards	Serap Akmal / Lidia Tyszczuk/Lynn Sykes	May 2021	Review current workloads with consultants to ensure presence at meetings	Ongoing
Avoidable admission as a result of educational needs in Transitional Care	TC study day for midwifery staff	Education leads	Ongoing but on hold due to Covid	Number of study days have been completed and they will resume once Covid restrictions are lifted	Ongoing
	Medical/Neonatal consultant ward rounds in TC	Lidia Tyszczuk	In progress	TC ward rounds by medical team take place daily	Ongoing
	Regular bite sized teaching TC staff	Education leads / Lidia Tyszczuk	In progress	On hold due to Covid	Ongoing

Admissions for respiratory support following ELSCS and Emergency LSCS	Neonatal audit obstetric/neonatal on CS rates neonatal morbidity.	Mandish Dhanjal / Lidia Tyszczuk	May 2021	ELCS <39/40 – action plan to present ATAIN audit findings to the clinical director, to email all obstetric consultants regarding this.	Audit
Emerging themes following weekly cross site meetings to discuss term admissions	CTG concerns not recognised or escalated no differentiation of maternal pulse and foetal heart	Maternity and neonatal Risk leads	In progress	Foetal monitoring midwife to address ongoing CTG training. Safety huddles Staff completion of K2>90% Weekly CTG teaching sessions	Ongoing
	Missed MCS results especially GBS –	Midwifery managers	August 2021	Action plan for powerchart to Cerner, for staff to review blood and urine results and education that each encounter matters.	Ongoing
	TC issues – use of phototherapy and babies who could be cared for on postnatal wards	Postnatal matrons Lead midwives and neonatal team	August 2021	To discuss the guidelines with the matrons and see if these can be changed to accommodate more babies on ward.	Ongoing
	Re-admissions for jaundice	Breastfeeding lead	November 2021		Ongoing

		Postnatal matrons and community matrons			
	Bi annual presentation of findings at joint obstetric and neonatal morbidity meetings	Serap Akmal	In progress	Bi annual joint obstetric and neonatal morbidity meeting – on hold due to covid restrictions	Date TBC

Imperial College Healthcare NHS Trust

Appendix 5 CNST Maternity Incentive Scheme

Neonatal Action Plan

Local findings	Action	Lead	Complete by	Evidence of Progress and Completion	Progress (RAG)
The Trust does not meet the relevant nursing standards	Neonatal Safe Staffing Standard Operating Procedure	Fiona Stubbs	Fiona Stubbs (Lead Nurse) Lidia Tyszczuk (Head of Speciality – Neonatology	 3.2.4 Safe Staffing for the Imperial Neonatal Service SOP v2.1.zip	completed
	6 monthly nursing establishment reviews	Fiona Stubbs	Fiona Stubbs (Lead Nurse) Scott O'Brien (Head of Nursing)	Signed off at Board level Trust Board Minutes (Public) - 29 January 2020 - Approved (1).zip  16. A Safe Staffing CS.zip  16. B Safe Staffing Report.zip	completed
	Directorate risk register	Fiona Stubbs	Lidia Tyszczuk (Head of Speciality – Neonatology Scott O'Brien (Head of Nursing)	Risk number 1192  3.4.1 Risk Assessment NNU QIS staffing_v2N.B (2	completed
	Internal "Grow Your Own" specialist nursing staff into qualified in speciality posts	Matrons NICU	Tracey Omar Maryam Kharusi	Development education packages for nursing staff to assist with internal promotion/succession planning and promote qualified in speciality nursing at Band 6 level	completed

Imperial College Healthcare NHS Trust

Appendix 6

EMB Quality Group

Paper title: Midwifery Safe Staffing Levels – Bi-Annual Midwifery Staffing Oversight Report

Agenda item x and paper number

Author: Scott Johnston, Head of Midwifery
Executive Director: TG Teoh

Purpose: discussion/ information

Meeting date: 16/03/21

Executive summary

1. Introduction and background

1.1. Safe Midwifery staffing levels are vital to the provision of safe Maternity Services. The maternity service at Imperial College Healthcare NHS Trust use the nationally recommended tools and guidance to maintain safe staffing locally and guide recruitment, local escalation and day to day monitoring.

2. Purpose

The purpose of the report is to-

- Provide an update on Safe Midwifery staffing including maintaining safe midwifery staffing during the COVID peak
- Update the committee on key midwifery staffing metrics
- Update the committee on the monitoring of Midwifery Staffing Ratios as per Birthrate Plus recommendations
- Highlight key progress and ongoing work regarding safe midwifery staffing.
- Propose actions for discussion

3. Key findings

3.1. Currently the Maternity Service at Imperial College Healthcare NHS Trust is staffed to the recommended safe midwifery staffing level. The correct skill mix is in place within the midwife to birth ratio and the specialist and leadership establishment meets the recommended criteria. In line with other NWL services there has been a small decrease in the number of Births since the pandemic. Ratios and staffing numbers will be reviewed in line with the planned activity for 21/22. Safe staffing ratios will be maintained.

3.2. Regular six monthly reviews of safe staffing are undertaken as well as monitoring of actual versus planned staffing reviews in line with the Trust Safe Nursing and Midwifery Staffing Policy. Twice daily staffing huddles occur, out of hours support and communication pathways are in place in line with the updated Maternity Staffing Escalation Policy.

3.3. ICHT is committed to meeting full compliance for Year 3 CNST Maternity Incentive Scheme. A reviewed scheme has recently restarted and the service continue to strive to meet the team safety actions and are expecting to have full compliance by the new July 2021 deadline.

3.4. The COVID pandemic has not affected the safe staffing of our maternity service due to detailed planning, mitigation and oversight by the Senior Midwifery Team.

4. Recommendation

4.1. The committee is requested to note the contents and actions within this six monthly review.

Main paper

5. Discussion/key points

5.1 **Update on progress with maintaining safe Midwifery Staffing**

Midwifery staffing across the UK is a challenge in terms of recruitment and retention. ICHT, along with other London Trusts, have faced the challenge of vacancies, a lack of experienced midwives leading to skill mix challenges and a 10% turnover of staff.

The historic main source of recruitment of newly qualified midwives onto our preceptorship programme are King's and University of West London students that have been on placement with us. The first tranche of Imperial students qualifying from the University of West London have been offered midwife posts and have started employment.

Workload in maternity fluctuates due to the unpredictability of the activity leading to peaks and troughs in activity and acuity. The two labour wards can be similar to emergency departments with little control over levels of activity. In the past 6 months work has been undertaken to further improve the resilience of the service to cope with these peaks and troughs in activity. These have included;

- Updating the Maternity Staffing Escalation policy to include feedback from key frontline staff
- Twice daily Maternity Staffing Huddles continue
- The first members of the new maternity bleep holder on the QCCH site have started
- Communication and collaboration with the Trust Site Teams and on call managers
- Senior Midwife on Call rota remains in place
- Improved planning of elective activity with cross site consideration to manage workload
- Cross site working and collaboration of day to day staffing and activity shifts where possible
- Increased numbers of Midwives on call to support our increasing numbers of Home Births

5.2 **BR+ Safe Midwifery Staffing Ratio**

Birth Rate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in use in UK maternity units for a significant number of years.

The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings, and have been endorsed by the

RCM and RCOG. The interim NHS People Plan and the NHS Long Term Plans recommend services to be using evidence-based approaches to staffing by 2023.

The most recent assessment of the recommended safe staffing ratios for the maternity service are-

SMH 1:24
QCCH 1:25

The increased recommended ratio at SMH is due to the increased caesarean section rate at SMH and the high volume of postnatal activity for women that have birthed elsewhere that are cared for by SMH community midwives.

The staffing ratio and calculations take into account our explicit staffing model for Transitional care. Transitional care for babies is undertaken by midwives on our postnatal wards with support from Neonatal Medical and nursing staff. Training is provided and care is given in line with the Transitional care guideline.

Please see appendix 1 for the detailed calculations.

The actual numbers of births to date in 20/21 is slightly below plan. The plan for 21/22 is likely to be revised in line with this. The site specific staffing numbers will be adjusted and any alterations to local staffing numbers reviewed and approved as part of the safe N&M staffing process.

In conclusion-

- the current midwifery staffing funded establishment is in line with the recommended site specific safe midwifery staffing ratios
- the correct number of specialist and support worker roles are included in the ratio
- the Midwifery management and clinical leadership staffing is in line with the recommended numbers.
- Since July 2019 ICHT have been meeting the recommended BirthRate Plus ratios on both sites. There have been Birthrate plus assessments in 2018 (full assessment) and 2019 (tabletop assessment).

Action- Birthrate + reassessment will take place during 20/21.

5.3 **Actual Versus Planned Midwifery Staffing**

All maternity In-Patient (Including Intrapartum) areas report the actual v's planned midwifery and care staffing for day and night shifts alongside the other wards in the Trust

https://www.imperial.nhs.uk/about-us/who-we-are/publications/safe-nurse-and-midwife-staffing

Reporting A v P restarted in July 2020 following a pause during the first COVID Surge. Midwifery staffing was fully complaint for July, August, September and October 2020. The November and December 2020 all standards were met accept QCCH Labour Ward Care Staff on day duty which was 3% below the recommended level for each month. This was due to a number of support staff with COVID and non-COVID related sickness, vacancies and shielding. This was mitigated by staffing support from Hammersmith main theatres and redeploying staff to Labour Ward from other maternity areas. Safety was maintained.

5.4 **One to One care midwifery care in labour and Supernumerary Labour Ward Coordinator Status**

One to One midwifery care in labour is a key safety metric that is reported via Cerner and monitored on Maternity dashboard monthly at the Directorate meeting and at the NWL Local Maternity System Meeting. For the past 6 months the compliance rate reported via Cerner has improved to 99%.

This safety metric is also reported on the Intrapartum acuity tool that is completed every 4 hours on our Labour Wards and Birth Centres. For the period 17 August 2020 - 10 January 2021 no instances of inability to provide one to one care was identified on the intrapartum acuity on either of our Birth Centres or on SMH Labour Ward. During the first two months of this period there were 7 occasions identified when one to one care was not being provided on the QCCH Labour Ward but this dropped to 3 during the following three months. Reassuringly each time this was reported as being resolved by redeployment of staff.

The rosters for the Labour Wards and planned to allow one supernumerary Labour Ward Coordinator at all times. There have been 2 reported occasions via datix both at QCCH in the past six months when this did not occur. This is an improvement on the last reporting period.

Overall we are reassured by these metrics but continue to strive for 100% compliance with one to one care and labour and supernumerary Labour Ward coordinator.

<u>Actions to achieve 100% compliance</u>

1. Fully implement the 24/7 maternity bleep holder role. One person is in post and recruitment is in process for the other members of the team and is anticipated to be completed by July 2021.

2. Detailed review of each reported case of lack of compliance to identify themes or trends.

- Complete 3 month review of all cases (Mar-May 2021) to identify themes or trends. (Supernumerary Coordinator via Datix and One to One care via Cerner)
- June 21- report to Maternity Q&S meeting to identify actions.
- Switch the current ‘Red Flag’ reporting from the Birthrate Plus Acuity tool to Eroster to simplify reporting and bring maternity in line with other clinical areas in the Trust (July 2021).

5.5 **Maintaining Safe Midwifery Staffing during COVID**

The nature of maternity services meant that all the core parts of the service continued to run throughout the pandemic. The antenatal services, labour wards, birth centres, in-patient wards and the community midwifery service all continued to run with modifications. The pressure on London Ambulance Service (LAS) has reduced and was one brief (4 day) suspension of our Home Birth service due to LAS pressure.

During the second surge of COVID safe midwifery staffing was maintained by

- The return of midwives who had been seconded external to the organisation
- Voluntary cancellation of annual leave
- Cancellation of study leave

- Use of bank and agency midwives when required
- Specialist midwives undertaking rostered clinical shifts
- Shielding midwives undertaking remote video consultations with women and postnatal contact calls
- Our student midwives continued in practice during the period.

On top of the routine monitoring of safe staffing levels additional actions were taken-

- On site Senior Midwifery presence at weekends and bank holidays for two months
- Active participation in site safety huddles
- Reporting and sharing of actions and staffing challenges and solutions via NHSE and London wide networks.
- Close monitoring of risk reporting and clinical metrics. No adverse events related to midwifery staff occurred during the period.

In conclusion, safe midwifery staffing was maintained during the second surge of the COVID pandemic.

6 Conclusion

1. The funded midwifery staffing establishment fully meets the recommend standards set by Birthrate Plus. A full reassessment will take place during 21/22.
2. Mechanisms are in place to monitor and act upon shortfalls in midwifery staffing.
3. Proactive monitoring and metrics are in place to ensure that midwifery staffing remains safe

Author
Scott Johnston – Head of Midwifery

09/03/21

Imperial College Healthcare NHS Trust

Appendices:

Appendix 1

Current Midwifery Staffing ratios 20/21 (reviewed March 2021)

The midwife to Birth Ratio is calculated using consistent and nationally recognised methodology.
Calculation of the Midwife to Birth Ratio (including Specialist Midwives)

Staff included the Midwife to Birth Ratio			
	QCCH	**SMH**	
Band 7 Midwives	43.31	29.02	All funded Band 7 Clinical midwives are included
Band 6 Midwives	142	87.8	All funded band 6 Midwives are included
Specialist midwives & Consultant Midwife	3.15	2.45	See table below
Band 3 MSWs*	18.37	11.3	
Total	**206.83**	**130.57**	

*The B+ methodology allows for up to 10% of staff included in the ratio to come from the band 3 Maternity Support Worker Workforce. Therefore band 3 MSWs from our Inpatient Wards and Community have been included. For the ICHT service this equates to 9% of the overall numbers included in the ratio.
Birthrate Plus methodology expects the face to face clinical component of specialist roles to be included within the ratio. The funded posts and calculation that was approved by the Birthrate Plus assessors in 2019 have been reviewed and included as follows.

Specialist Midwives included in the Ratio			Notes
Role	**Funded w.t.e (cross site)**	**Actual w.t.e. included in the ratio**	
IT	1	0	Non-clinical role
Risk Support Midwives	2.8	0	Non-clinical role
Bereavement Midwives	2	1	50% of their role is providing clinical care.
Midwifery Education Team	4	1	Overall around 1 wte of this team is involved in providing direct clinical care
Perinatal Mental Health	1	0.5	50% of their role is providing clinical care.
Inf Diseases and Antenatal Screening	3	1	Overall around 1 wte of this team is involved in providing direct clinical care
Inf feeding	1.6	0.4	25% of their role is providing clinical care
FGM	0.5	0.2	50% of their role is providing clinical care.
Maternal Med/ Diabetes	2	1	50% of their role is providing clinical care.
Band 8 Cons MW	1	0.5	50% of their role is providing clinical care.
Total		**5.6 w.t.e**	

Imperial College Healthcare NHS Trust

Overall site specific Midwife to Birth ratio		
	QCCH	**SMH**
Recommended safe staffing Ratio	1 to 25	1 to 24
Planned Births for 20/21	5179	3114
Therefore Recommended Safe Staffing numbers	**207.16wte**	**129.75wte**
Actual Funded Staffing (for B+ purposes)	206.83 wte	130.57 wte

In addition Birthrate plus expects around 8-10% of the midwifery establishment to not be included in the clinical numbers, this include management role and a proportion of specialist midwife roles. This ensure dedicated time for safe management and leadership of the service.

Safe ratio of Management/Leadership roles	
Funded Specialist Midwives that are not included in the ratio	13.3wte
Midwifery Leadership team (Band 8a to 8d)	16wte
Overall Funded establishment (Band 2-8)	356 wte
As a percentage of overall funded establishment	**8.2%**

Imperial College Healthcare NHS Trust

Appendix 7 Imperial College Healthcare NHS Trust Continuity of Care (CofC) Action Plan 2021/2022

Site	Team	Status	Compliance with national CofC definition	Model	Planned WTE	Actual WTE	Target MW:booking-birth ratio (attrition rate 32%)	Capacity (Planned WTE by target ratio)	Current capacity (Actual WTE x actual ratio, Team Leader - 20%)
SMH	Birth centre – Focus is OOA low risk	Operational	Antenatal – yes (Bookings restarting) Intrapartum – yes if within BC only Postnatal – Yes PN check BC & phone call	2	6	6	1:60-89	360- 534	348-516
SMH	Birth centre – Focus is in-area	Operational	Antenatal – yes Intrapartum – yes if within BC only Postnatal – Yes PN check in community	4	2	2	1:60-89	120 - 178	
SMH	Blue - Social complex	Operational	Antenatal - yes Intrapartum – yes (limited) Postnatal - yes	1	6 (5.8)	2.8	1:32-47	192 - 282	147 – 262
SMH	Lilac – OOA low risk	Operational	Antenatal - yes Intrapartum - yes Postnatal – AB2 PN check (by IP MW) & phone call on clinic day, factored into model	2b	6-8	6	1:70-104 (1:34-49)	490 - 728	190 - 274
SMH	Green – maternal medicine	Operational	Antenatal – yes- 6.5.clinics-vast capacity Intrapartum – yes Postnatal – AB2 PN check (by IP MW) & phone call (in clinic)	2b	6-8	8	1:70-104 (1:78-111)	490 – 728	421 - 600
SMH	Orange – fetal medicine/ multiples	Operational	Antenatal – yes, mostly obstetric led Intrapartum - yes Postnatal – AB2 PN check & phone call	2b	6-8	7	1:70-104 (1:67-97)	490 – 728	402 - 582
SMH	Gold – IVF/ recurrent misc	Operational	Antenatal - yes Intrapartum - yes Postnatal – AB2 PN check & phone call	2b	6-8	8	1:70-104 (1:39-56)	490- 728	267-382
SMH	Ruby – FGM/ OOA VBAC/ HIV	Operational	Antenatal - yes Intrapartum - yes Postnatal – AB2 PN check & phone call	2b	6-8	6	1:70-104 (1:86-122)	490 – 728	240-344

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Site	Team	Status	Compliance with national CofC definition	Model	Planned WTE	Actual WTE	Target MW:birth ratio (attrition rate 8%)	Capacity (Planned WTE x Ratio)	Current capacity (Actual WTE x ratio, -Team leader 20%)
QCCH	Birth centre – OOA low risk	Operational	Antenatal – yes Intrapartum – yes only in BC only Postnatal – Yes PN check BC & phone call	2	7.5	7.8	1:60- 65	450-488	456 - 494
QCCH	Birth centre – Focus is in-area	Operational	Antenatal – yes Intrapartum – yes if within BC only Postnatal – Yes PN check in community	4	3	2	1:60-89	120 - 178	
QCCH	Social complex caseload	AN & PN Operational	Antenatal - yes Intrapartum – yes (limited) Postnatal - yes	1	6 (5.8)	4.8	1:32 - 35	192 - 210	115 - 126
QCCH	Multiples	Operational	Antenatal - yes Intrapartum – ELCS on weekdays Postnatal – PN check and phone call	2b	3-4	4	1:40 - 44	120-132	86 – 95 (43 – 48)
QCCH	Prem clinic, rec miscarriage, mid trimester loss – Dove team	Operational	Antenatal – start 8/3/21 Intrapartum – start 8/3/21 Postnatal – ward visit & phone call start 8/3/21	2	7-8	3	1:50 – 54	340 - 367	120-130
QCCH	Diabetes – Eagle team	Not operational	Antenatal - planned Yes Intrapartum – planned Yes Postnatal – Planned - In area Full care Out of area ward visit & phone call	2	7-8	2	1:56 -60	380 – 408	0
QCCH	Cygnet	Operational	Antenatal - yes Intrapartum - yes Postnatal - 2 PN contacts (ward visit & phone call after discharged, on day 7)	2	8	7	1:40 – 44	320 - 353	272 – 299
QCCH	Private	Operational	Antenatal - yes Intrapartum - yes Postnatal - yes	1	3	3	1:20 - 22	60-66	60 - 66
Cross site	Homebirth	Operational	Antenatal - yes Intrapartum – yes & will continue IP care Postnatal - yes	1	6	6	1:36 - 39	209 - 226	173 – 187

Team	Task	Lead	Expected completion date	Expected capacity once all changes have taken place	Completion evidence	Status & completed date Complete Not started In progress
Cross Site Homebirth Team	Produce a team booklet and roll out supportive signposting	Matron (SK)	January 2021	209 – 226 (QCCH)	Team booklet produced	In progress
Birth Centres both sites	Plan for a consultation with group practice to produce Hybrid teams	Matron (EP)	December 2020	20% of all births in the Trust. Approx 2000 cross site. QCCH (60%)– 1200 SMH (40%)- 800 Minus the previous birth centre numbers.	Consultation paper to be produced. Out of area women will continue in the previous model (model 2). In area proposing a hybrid. Consultation.	Model is being worked on with the numbers available to ensure it fits continuity and includes as many women as possible safely. Compliant for SMH, needs recruitment in QCCH
	Reconfigure clinic lists and referral pathway	Matron	March 2021		Clinic list on Cerner will be updated	In progress
	Birth Prep to be reconfigured	Matron	March 2021		Clinic list for birth prep appointments on Cerner created	In progress
	New model to be up and running	Matron	March 2021		Clinic lists on Cerner and E-roster	In progress

	Produce a team booklet and roll out supportive signposting	Team leaders	March 2021		Team booklet produced	In progress
Caseload Teams	Staffing to increase for safe service	Matron (SK) /Lead midwife (FB)	January 2021	QCCH: 180 – 196 SMH: 180 - 263	Recruitment process started, EOI out and updated on E-roster	Currently on-call for limited intrapartum care due to workforce issues reducing capacity for intraprtum care. Only antenatal and Postnatal continuity at the moment.
	Produce a team booklet and roll out supportive signposting	Team leaders	March 2021		Team booklet produced	In progress
Diabetic QCCH – Eagle team	EOI COC diabetic team	Lead midwife	November 2020	QCCH - 380 – 408	EOI – has been emailed out	EOI emailed to all staff – update in Nov no applications yet, to remain open
	Recruiting (7-8) WTE and supernumary time	Lead midwife	February 2021		Appointing the midwives for the team, the team to care for Prev GDM women and T1 & T2, in and out of area. Evidence will be on E-roster	02.3.21 1 WTE MW applied and start date to be confirmed
	Team to be up and running with clinic template on Cerner	Lead midwife	March 2021		Cerner template, E-roster with team and women received continuity of care	Project document in process

	Produce a team booklet and roll out supportive signposting	Team leader	March 2021		Team booklet produced	In progress
Pre-term birth team – Dove team	Recruiting (7-8) WTE and supernumary time	Lead midwife	February 2020	QCCH - 340 - 367	Appointing the midwives for the team, the team to care for Prev GDM women and T1 & T2, in and out of area. Evidence will be on E-roster	3 WTE midwives recruited – still on-going
	Produce a team booklet and roll out supportive signposting	Team leader	March 2021		Team booklet produced	In progress
Cygnet Team	Produce a team booklet	Team leader	January 2021	QCCH - 320 - 353	Team booklet produced	In progress
	Virtual drop in for women to meet the team	Team leader	January 2021		Keep a log of the women, launch with the women. Evidence women are accessing service.	In progress
	Evaluation of team	MTP project manager	January 2021		Evaluation produced to evaluate success of team and project improvement	In progress
Lilac Team	Extend clinic hours to 8.5 hour days for 4 midwives per clinic	Lead Midwife (DO)	April 2021	381-545 women SMH Midwife ratio – 1:59-83	On E-roster	In progress - Clinic schedules being amended
	Produce a team booklet and roll out supportive signposting	Matron	April 2021		Team booklet completed	Booklet has gone to comms, email address agreed. Plan to

						ask for teams to be on Website
Orange Team	Change criteria for Orange Team and start taking on Pre-Term birth women	Matron (JT)	March 2021	322-460 women SMH Midwife ratio – 1:47-67	On Cerner documentation.	Awaiting antenatal form to be updated
	Extend clinic hours to 8.5 hour days for 3 midwives per clinic	Lead midwife	April 2021		E-roster	In progress - Clinic schedules being amended
	Produce a team booklet and roll out supportive signposting	Matron	April 2021		Team booklet completed	Booklet has gone to comms, email address agreed. Plan to ask for teams to be on Website
Gold Team	Extend clinic hours to 8.5 hour days for 3 midwives per clinic	Lead Midwife (DO)	March 2021	400-572 women SMH Midwife ratio – 1:51-73	E-roster	In progress - Clinic schedules being amended Awaiting increase in referrals to team
	Add another midwife list on Friday (once room back from sonographers)	Matron	April 2021		E-roster and Cerner clinic template	Matron to look into, one midwife already on a long day
	Link into Gynae ER to pick up referrals and book them at 8 week, offering an extra appt.	Lead midwife	April 2021		In Cerner documentation, half booking by phone to start linking in the teams	Team leader exploring the pathway to encourage referrals to team

	Produce a team booklet and roll out supportive signposting	Matron	April 2021		Team booklet completed	Booklet has gone to comms, email address agreed. Plan to ask for teams to be on Website
Green Team	Produce a team booklet and roll out supportive signposting	Matron	April 2021	421 – 600 SMH	Team booklet completed	Booklet has gone to comms, email address agreed. Plan to ask for teams to be on Website.
Ruby Team	Produce a team booklet and roll out supportive signposting	Team Leaders	April 2021	324-462 women SMH Midwife ratio – 1:67-97	Team booklet completed	Booklet has gone to comms, email address agreed. Plan to ask for teams to be on Website.
Multiples QCCH	Produce a team booklet and roll out supportive signposting	Team Leader	April 2021	83- 96 QCCH	Team booklet produced	Booklet has gone to comms, email address agreed. Plan to ask for teams to be on Website.
ANC mixed risk teams in QCCH	4 teams to be started in the antenatal clinic and to marry up with a hybrid teams on delivery suite to offer continuity	Lead Midwife (CM)	March 2022	Approx 2484 - 2700 women QCCH BAME stats – No previous figures	Clinic templates	Not started, sorting out the other teams first
SMH safeguarding	Include Dionne's team (1 list a week) and safeguarding team (3 lists a week) into current teams	Lead Midwife	March 2022	Approx 175-200 women SMH BAME stats – No previous figures	Cerner documentation and clinic templates edited	Currently moving 2 lists in Lilac team, 1 list on Thursday in Orange to take the safeguarding cases within original teams.

Maternal medicine QCCH	Model 2, maternal medicine and HDU midwives.	Lead Midwife/ HDU Matron	March 2022	Unknown at present-	E-roster team to be set up	HDU matron orientating – will take this forward
Private (Stanley Clayton Team)	Add in Postnatal phone call for all women	Lead Midwife (SP, QCCH)	April 2021	QCCH - 60 - 66	Documentation on Cerner of the postnatal phone call	In progress - Cerner diary in development

Peer review assessment against Ockenden immediate and essential actions

Trust: Imperial College Healthcare NHS Trust

Date: 08 March 2021

Imperial team present: Scott Johnson, Head of Midwifery
Miss Mandish Dhanjal, Clinical Director, Consultant Obstetrician and Gynaecologist
Louise Frost, Lead Midwife

SECTION 1: Immediate and Essential Actions 1 to 7				Assessment criteria	FINAL COMPLIANCE	GROUP COMMENTS
Immediate and Essential Action 1: Enhanced Safety						
IEA 1	Q1		Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.	**Confirmation of a Maternity Services Dashboard** **Confirmation this is seen by the LMNS at least Quarterly** Both Actions met = Yes (Green) One Action met = Partial (Amber) Neither action met = No (Red) Missing Information = Bright Yellow	Yes	Dashboard in place. Data shared with LMS
IEA 1	Q2		External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.	**Confirmation of external specialist opinion on reviews** Action met = Yes (Green) Action not met = No (Red) Missing Information = Bright Yellow	Yes	External panellist review on all listed cases
IEA 1	Q3		All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months	Confirmation that SI **GO TO Trust Board** (n.b. not a sub group of board such as Quality group) Confirmation that a *SUMMARY* of SI key issues goes to Trust Board Confirmation that SI **GO TO LMNS Board** Confirmation that a **SUMMARY** of SI key issues goes to LMNS Board Each of the above happen **quarterly** All Actions met = Yes (Green) Some Action met = Partial (Amber) No action met = No (Red)	Partial	All SIs are reviewed at a sub-group of the Trust Board. Currently, not all SIs are reviewed at the LMS's SI working group. The working group reviews numbers and themes.
Link to Maternity Safety actions:						
IEA 1	Q4	Action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	**Confirmation that PMRT is undertaken** see PMRT Tab All standards met = Yes (Green) Some standards = Partial (Amber) No standards met = No (Red)	Yes	Verbal confirmation that the Trust is using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard
IEA 1	Q5	Action 2	Are you submitting data to the Maternity Services Dataset to the required standard?	**Confirmation that Monthly score card completed** (13 mandatory criteria) All criteria completed = Yes (Green) Some criteria completed = Partial (Amber) No criteria completed met = No (Red)	Yes	Trust is compliant with Safety Action 2: MSDS
IEA 1	Q6	Action 10	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?	Confirmation that **100% of** cases are reported to HSIB & NHS Resolution = YES (GREEN) Confirmation that **100%** of cases are reported to **EITHER HSIB OR NHS Resolution** = Partial (AMBER) Confirmation that **SOME** cases are reported to HSIB & NHS Resolution = Partial (AMBER) Confirmation that **SOME** cases are reported to EITHER HSIB OR NHS Resolution = Partial (AMBER) Cases are reported to **NEITHER** HSIB & NHS Resolution = NO (RED) Missing Information = Bright Yellow	Yes	Submission confirmed 100% of qualifying cases reported HSIB and NHSR - verbal confirmation at Peer Review meeting.
Link to urgent clinical priorities:						
IEA 1	Q7	(a)	A plan to implement the Perinatal Clinical Quality Surveillance Model	Confirmation that Trust / LMNS / ICS responsibilities of the model are implemented = Model Implemented (BLUE) Confirmation that there is a plan to implement the model = YES (Green) No plan referenced = NO (RED) Missing Information = Bright Yellow	Partial	The new principles for quality surveillance remain in development in London, although are nearly finalised. Similarly the ICS/LMS' is also in the process of working up their new approach. At this stage it is difficult for any trust to be fully compliant. However, Imperial is willing and supporting the development of the new model.
IEA 1	Q8	(b)	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Confirmation that SI go to Trust Board (n.b. not a sub group of board such as Quality group) **Confirmation that SI go to LMNS Board** **Each of the above happen Monthly** All Actions met = Yes (Green) Some Action met = Partial (Amber) No action met = No (Red)	Partial	All SIs are reviewed at a sub-group of the Trust Board. Currently, not all SIs are reviewed at the LMS's SI working group. The working group reviews numbers and themes.
Immediate and Essential Action 2: Listening to Women and Families						
IEA 2	Q9		Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	No expectation that this action is met - national guidance awaited		
IEA 2	Q10		The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.	No expectation that this action is met - national guidance awaited		
IEA 2	Q11		Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	Confirmation of an identified Trust Board Non Exec = Yes (GREEN) No Reference to an identified Non -Exec responsible for Maternity Services = No (RED)	Yes	Trust has NED in place
Link to Maternity Safety actions:						
IEA 2	Q12	Action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Confirmation that Parents are involved = YES (Green) Confirmation that PMRT is undertaken BUT parents not referenced = Partial (AMBER) PMRT not used = No (RED) Missing Information = Bright Yellow	Yes	All parents are provided with information re PMRT process, outcome of case review, able to comment and ask questions.
IEA 2	Q13	Action 7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Confirmation of approach to gathering Service User feedback (i.e. 15 steps / FFT / You Said We Did) **AND** MVP in place that **COPRODUCES** services = Yes (GREEN) Confirmation of an MVP = Partial (AMBER) Confirmation of Service User feedback **BUT** no MVP = Partial (AMBER) No MVP or Service User feedback = No (RED) Missing Information = Bright Yellow	Yes	Verbal information provided. During Nov/Dec 2020, 7 week engagement project on how to make improvements. Weekly "Big Room" QI meetings with the MVP and staff has started as a result. The onset of COVID-19 meant a need for new patient information - MVPs asked to comment MVP chairs across NWL meet regularly and support LMS projects.
IEA 2	Q14	Action 9	Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	Identified Safety Champions **WORKING WITH** Exec and Non Exec Board Leads for Maternity = Yes (GREEN) Identified Safety Champions **BUT** no reference to working with Exec and Non Exec Board Leads for Maternity = Partial (AMBER) No mention of identified Safety Champions = No (RED) Missing Information = Bright Yellow	Yes	HoM is midwifery safety champion, CD is the obstetric safety champion Divisional Director, Professor TG Teoh, Consultant Obstetrician is the Executive Safety Champion, Non-executive champion in place. Monthly meetings with ED and NED to escalate any safety / financial issues / concerns. Monthly quality and safety meeting in place - another opportunity to escalate concerns. Professor TG Teoh - offers weekly "Talk to TG" sessions on both sites.

Link to urgent clinical priorities						
IEA 2	**Q15**	A	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Same score as Q13	Yes	Verbal information provided. During Nov/Dec 2020, 7 week engagement project on how to make improvements. Weekly "Big Room" QI meetings with the MVP and staff has started as a result. The onset of COVID-19 meant a need for new patient information - MVPs asked to comment MVP chairs across NWL meet regularly and support LMS projects.
IEA 2	**Q16**	B	In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.	Confirmation of an identified Trust Board Executive Director **AND** a Non Executive Director = Yes (GREEN) Confirmation of an identified Trust Board Executive Director **EITHER / OR** a Non Executive Director = Partial (AMBER) **No Reference** to an identified Executive OR Non -Exec responsible for Maternity Services = No (RED) Missing Information = Bright Yellow	Yes	Named NED maternity safety champion within the Trust
Immediate and essential action 3: Staff Training and Working Together						
IEA 3	**Q17**		Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.	**Training together:** Confirmation of MDT training **AND** this is validated through the LMNS x 3 per year = Yes (GREEN) Confirmation of MDT training BUT this **IS NOT** validated through the LMNS x 3 per year = Partial (AMBER) **No Reference** to MDT training = No (RED) Missing Information = Bright Yellow	Partial	NWL LMS dashboard includes metrics around trust training and compliance levels - not robust enough
IEA 3	**Q18**		Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.	**Working together:** Confirmation of **ALL** criteria requested = Yes (GREEN) Confirmation of **SOME** criteria requested BUT must include Consultant Led = Partial (AMBER) No Reference to **Consultant Led** ward rounds = No (RED) Missing Information = Bright Yellow	Yes	Established twice daily, 7 days a week, consultant-led and present multidisciplinary ward rounds on the labour ward.
IEA 3	**Q19**		Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only (e.g. Maternity Safety Fund, Charities monies, MPET/SLA monies etc that is specifically given for training)	Confirmation of ring fenced Maternity training budget = Yes (GREEN) Confirmation of Maternity training budget **BUT NOT** ringfenced = Partial (AMBER) No reference to Maternity training budget = No (RED)	Yes	Verbal confirmation that all external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose.
Link to Maternity Safety actions:						
IEA 3	**Q20**	Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	See Section 2	Yes	
IEA 3	**Q21**	Action 8	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	90% achieved on MDT training of all Staff groups (Obstetrics / Anaesthetists / Maternity / Neonates / Support Workers) = Yes (GREEN) 90% not met OR not MDT OR not all staff groups referenced = Partial (AMBER) No = Red	Partial	Currently not meeting 90% compliance - due to challenges from Covid-19. Plan in place to rapidly undertake staff training.
Link to urgent clinical priorities						
IEA 3	**Q22**		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	See Q18	Yes	Established twice daily, 7 days a week, consultant-led and present multidisciplinary ward rounds on the labour ward.
IEA 3	**Q23**		The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	See Q17	Yes	Training plan in place.
Immediate and essential action 4: Managing Complex Pregnancy						
IEA 4	**Q24**		Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	Agreement reached on Criteria for referral to Mat Med Specialist Centre = YES (GREEN) Actively working with Regional team to develop Mat Med Network processes = Partial (AMBER) **No reference to** or **NOT** actively working with = No (RED)	Yes/Partial	Some pathways are established in NWL. The LMS is overseeing further development on all pathways - full clinical engagement from Imperial. London has a well established Maternal Medicine regional network that has been working on establishing pan-London pathways across all specialities and supporting the ICS and LMS in the formulation of the five centres. Imperial has been actively involved.
IEA 4	**Q25**		Women with complex pregnancies must have a named consultant lead	Yes = Green No = Red Missing information = Bright Yellow	Yes	Evident information provided in submission
IEA 4	**Q26**		Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	Referenced to specialist involvement AND management plans developed = YES (GREEN) No reference to specialist involvement or plans developed = No (RED) Missing information = Bright Yellow	Yes	A plan is formalised using the information system (Cerner) - all staff can view it at every contact. MDT meetings facilitated and MDT agreement on management plan. MDT review discussed with all women and care plan agreed.
Link to Maternity Safety actions:						
IEA 4	**Q27**	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Confirmation of compliance with **ALL** elements = YES (GREEN) Confirmation of compliance with **SOME** elements = Partial (AMBER) No compliance with **ANY** elements = No (RED) Missing Information = Bright Yellow	Partial	Not yet fully compliant. On track to be compliant by July 2021.
Link to urgent clinical priorities:						
IEA 4	**Q28**	A	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	Confirmation of consultant lead **AND** regular Audit of Compliance in place = YES (GREEN) Confirmation of consultant in place **BUT** no regular audit = Partial (AMBER) No named consultant **OR** audit = No (RED) Missing Information = Bright Yellow	Partial	Audit to be undertaken.
IEA 4	**Q29**	B	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Confirmation that Trust is developing their local actions as part of an agreed Network approach = Yes (GREEN) **No reference** to local Trust actions required to work as part of the agreed Network = No (RED) Missing Information = Bright Yellow	Yes	Fully engaged, both locally and regionally, and understand what steps are required. London has a well established Maternal Medicine regional network that has been working on establishing pan-London pathways across all specialities and supporting the ICS and LMS in the formulation of the five centres. Imperial has been actively involved.
Immediate and essential action 5: Risk Assessment Throughout Pregnancy						
IEA 5	**Q30**		All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	Risk Assessment at **EVERY** AN Contact = YES (GREEN) Risk assessment at **SOME** AN contact = Partial (AMBER) No Risk Assessment = No (RED) Missing Information = Bright Yellow	Yes	Information system, Cerner, includes a field on risk assessment at AN appointments - but it is not mandatory field. Recommendation to audit and change field in system to mandatory.
IEA 5	**Q31**		Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Review of place of birth in risk assessment at **ALL** AN contacts = YES (GREEN) Review of place of birth in risk assessment at **SOME** AN contact = Partial (AMBER) No review of place of birth = No (RED) Missing Information = Bright Yellow	Partial	Regional response: This question was felt by all reviewers and MVPs to be inappropriate in the assessment criteria. Agree that conversations around place of birth needs revisiting during pregnancy, but to have this at all contacts is not considered woman centred or personalised, and the woman risks being harrassed and receiving heavy handed care when agreement has been reached. The emphasis of this would be better placed from 36 weeks onwards, but not again starting the conversation in PoB, but more around an assessment of 'risk'.
Link to Maternity Safety actions:						

IEA 5	**Q32**	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	See Q27	Partial	Not yet fully compliant. On track to be compliant by July 2021.
Link to urgent clinical priorities:						
IEA 5	**Q33**	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.		Are PCSPs in place **AND** are they audited = YES (GREEN) PCSP in place but **NO** audit = Partial (AMBER) No PCSP = No (RED) Missing Information = Bright Yellow	Partial	No audit undertaken
Immediate and essential action 6: Monitoring Fetal Wellbeing						
IEA 6	**Q34**	All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.		**BOTH** MW and Obstetrician in place = YES (GREEN) **EITHER** MW or Obstetrician in place = Partial (AMBER) **NEITHER** MW or Obstetrician in place = No (RED) Missing Information = Bright Yellow	Partial	No obstetric lead. Maternity transformation funding supported staff release for training. Midwife(s) fulfilling role but not formal lead midwife for fetal monitoring. Permanent full time Lead midwife for FM post will be in place soon.
IEA 6	**Q35**	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - Improving the practice of monitoring fetal wellbeing - Consolidating existing knowledge of monitoring fetal wellbeing - Keeping abreast of developments in the field - Raising the profile of fetal wellbeing monitoring - Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported - Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. - The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. - They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. - The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.		JD fulfils **ALL** criteria = YES (GREEN) JD fulfils **SOME** criteria **BUT** review planned = Partial (AMBER) JD doesn't reflect **ANY** criteria OR Some criteria but **NO REVIEW planned** = No (RED) Missing Information = Bright Yellow	Partial	See above. Plans for an obstetric lead on both sites
Link to Maternity Safety actions:						
IEA 6	**Q36**	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	See Q27	Partial	Not yet fully compliant. On track to be compliant by July 2021.
IEA 6	**Q37**	Action 8	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	See Q21	Partial	Currently not meeting 90% compliance - due to challenges from Covid-19. Plan in place to rapidly undertake staff training.
IEA 6						
	Q38	Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.		See Q34	Partial	No obstetric lead. Maternity transformation funding supported staff release for training. Midwife(s) fulfilling role but not formal lead midwife for fetal monitoring. Permanent full time Lead midwife for FM post will be in place soon.
Immediate and essential action 7: Informed Consent						
IEA 7	**Q39**	All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.		**ALL** place of birth information easily accessible = Yes (GREEN) **SOME** place of birth information easily accessible = Partial (AMBER) **NO** place of birth information easily accessible = No (RED)	Yes	Information system (Cerner) prompts mode of delivery conversation. Further mode of births are explained in the virtual AN classes. Maternal request for c-section - women are booked to the birth options clinic. This information is not readily available on the Trust website. Place of birth information is available. Trust website incorporates 'google translate'. Mum and Baby APP contains a lot of relevant and up to date information for women - a new version of the App is coming out soon, which will contain translated information. Trust offers PRISM - a five-week online antenatal course to prepare women and partners for the birth of their baby.
IEA 7	**Q40**	All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care		**ALL** information is easily accessible = Yes (GREEN) **SOME** information easily accessible = Partial (AMBER) **NO** information easily accessible = No (RED)	Partial	Difficult to evidence Regional team have remarked to national team that the action needs further explanation and defining.
IEA 7	**Q41**	Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care		Confirmation that trust **HAS** a method of recording decision making processes that includes women's participation & informed choice= Yes (GREEN) Confirmation of **WORKING TO** embed a method of recording decision making processes that includes women's participation & informed choice= Partial (AMBER) **NO mention** of a method of recording decision making processes that includes women's participation & informed choice= No (RED) Missing Information = Bright Yellow	Yes	Refer to Q39
IEA 7	**Q42**	Women's choices following a shared and informed decision-making process must be respected		Reference made to how Women's choices are respected and evidenced = Yes (GREEN) Reference **NOT** made to how Women's choices are respected and evidenced = No (RED)	Yes	
Link to Maternity Safety actions:						
IEA 7	**Q43**	Action 7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	See Q13	Yes	Refer to Q15
Link to urgent clinical priorities:						
IEA 7	**Q44**	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.		All information **ON** trust website = Yes (GREEN) **PLAN** for information or SOME information on trust website = Partial (AMBER) **NOT** on **OR NO PLAN** to be on trust website = No (RED)	Partial	Refer to peer reviewer comments

SECTION 2: WORFORCE PLANNING			ASSESSMENT CRITERIA	FINAL COMPLIANCE	GROUP COMMENTS
Link to Maternity Safety Actions:					
Q45	Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard **Based on a Birthrate Plus assessment taken place within the last three years**	Midwifery workforce planning system **in PLACE** = Yes (GREEN) Midwifery workforce planning system **in DEVELOPMENT** = Yes (GREEN) **NO** Midwifery workforce planning system in place = No (RED)	Yes	BR+ review carried out in 2009
Q46	Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard? **Based on a Birthrate Plus assessment taken place within the last three years**	Confirmation of a maternity workforce gap analysis **AND** a plan in place (with confirmed timescales) to meet BR+ standards = Yes (GREEN) Confirmation of a maternity workforce gap analysis **BUT NO** plan in place (with confirmed timescales) to meet BR+ standards = Partial (AMBER) **NO** gap analysis or plan in place (with confirmed timescales) to meet BR+ standards = No (RED)	Yes	BR+ review in 2019 derived a birth to midwife ratio 1:23, 1:24. Was fully funded by the Trust Board. Another review is planned in 2021/22
Midwifery Leadership					
Q47		Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director	Yes = GREEN No = RED	Yes	HoM professionally accountable to Chief Nurse, managed by the Divisional Director.
Q48		Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: 1. A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service 2. A lead midwife at a senior level in all parts of the NHS, both nationally and regionally 3. More Consultant midwives 4. Specialist midwives in every trust and health board 5. Strengthening and supporting sustainable midwifery leadership in education and research 6. A commitment to fund ongoing midwifery leadership development 7. Professional input into the appointment of midwife leaders	**Meets ALL** that apply = Yes (GREEN) **Meets SOME** that apply = Partial (AMBER) **Meets NONE** that apply = No (RED) **Note - Trusts would not lead on actioning all seven steps**	Partial	No Director of Midwifery at Imperial
NICE Guidance related to maternity					
Q49		We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.	**ALL** guidance assessed & implemented = Yes (GREEN) **SOME** guidance assessed & implemented = Partial (AMBER) **NO** guidance assessed & implemented = No (RED)	Yes	Verbal confirmation that all maternity NICE guidelines are regularly reviewed.

Appendix 9

Imperial College Healthcare NHS Trust

Maternity Quality Assurance Oversight Report Glossary

Anaesthesia Clinical Services Accreditation (ACSA) scheme - is based on a relevant and robust set of standards set by the profession, for the profession. Domains one to four aim to cover all aspects of general anaesthetic care provided in all hospitals in the UK.

Apgar scores - is a test given to newborns soon after birth. This test checks a baby's heart rate, muscle tone, and other signs to see if extra medical care or emergency care is needed. The test is usually given twice: once at 1 minute after birth, and again at 5 minutes after birth.

Auscultation - is a method of periodically listening to the fetal heartbeat.

Avoiding Term Admissions into Neonatal (ATAIN) units - is a programme of work to reduce harm leading to avoidable admission to a neonatal unit (NNU) for infants born at term, i.e. ≥ 37 +0 weeks gestation. A central aim of the work is to prevent harm leading to separation of mother and baby.

Birth centre - are maternity units that are usually staffed by midwives. They aim to offer a homely, rather than clinical, environment. Birth centres are especially good at supporting women who want a birth without medical interventions.

British Association of Perinatal Medicine (BAPM) framework for practice - provides guidance on optimal activity levels and additional guidance on medical staffing for Local Neonatal Units (LNUs) and Special Care Units (SCUs) in the UK. It is aimed at individuals, organisations and government bodies involved in the provision, planning and commissioning of neonatal care.

CNST Maternity Incentive Scheme - supports the delivery of safer maternity care. The scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in year two, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Continuity of care - describes consistency in the midwife or clinical team that provides care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour and the postnatal period. Women who receive midwifery-led continuity of carer are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth and report significantly improved experience of care across a range of measures. Pre-term birth is a key risk factor for neonatal mortality.

Cardiotocograph (CTG) - is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy. The machine used to perform the monitoring is called a cardiotocograph, more commonly known as an electronic fetal monitor (EFM).

Cooling treatment - or mild hypothermia may be offered to a baby if they are suspected of having moderate or severe HIE to help with the healing process. The treatment needs to be started within the first 6 hours after birth. A special cooling mattress is used to lower the baby's temperature to between 33 and 34 degrees centigrade for 72 hours. The mattress is filled with fluid that can be cooled or warmed according to your baby's needs.

Cord blood gas - analysis is an objective measure of the fetal metabolic condition at the time of delivery. By determining fetal acid-base status, it helps identify infants at risk for neonatal encephalopathy.

Early Notification Scheme - investigates serious brain injuries that happen to children at birth. Its aim is to speed up the investigation of these incidents and give families answers as soon as possible after serious injuries. The scheme requires trusts to report all maternity incidents that have led to severe brain injury.

Evacuation of retained products - is a small operation to remove any remaining products of conception that are still inside the uterus (womb).

Grade 1 caesarean section - is one that is done if there is an immediate threat to the baby's or mother's life.

Health Safety Investigation Branch (HSIB) - conduct independent investigations of patient safety concerns in NHS-funded care across England.

Hypoxic ischaemic encephalopathy - is a type of brain dysfunction that occurs when the brain doesn't receive enough oxygen or blood flow for a period of time. Hypoxic means not enough oxygen; ischemic means not enough blood flow; and encephalopathy means brain disorder.

Induction of labour - In an induced labour, or induction, labour processes are started artificially. It might involve mechanically opening the cervix, breaking the waters, or using medicine to start off contractions.

K2 training package - is an interactive, online, e-learning tool, offering certification for fetal monitoring and maternity crisis management, with a CTG training simulator, Competency Assessments and Learning Pathways, enabling tailored learning to improve core knowledge and test skills.

Local Maternity System - is the mechanism through which it is expected that a sector will collaboratively transform maternity services, with a focus on delivering high quality, safe and sustainable maternity services and improved outcomes and experience for woman and their families. This includes a group of people who are involved with either providing, receiving or commissioning maternity care.

Major Obstetric Haemorrhage - refers to any kind of excessive bleeding inclusive or above 1500ml during pregnancy, child birth, or in the postpartum period.

Maternal and Neonatal Health Safety Improvement Programme - A programme to support improvement in the quality and safety of maternity and neonatal units across England – formerly known as the Maternal and Neonatal Health Safety Collaborative.

Maternity Services Data Set - is a patient-level data set that captures information about activity carried out by Maternity Services relating to a mother and baby(s), from the point of the first booking appointment until mother and baby(s) are discharged from maternity services.

Maternity Voices Partnership - is a NHS working group: a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care.

Midwifery education – two full day training for midwives which includes all training needs identified for the 12 month period.

Multiparous woman - (multip) has given birth more than once. A grand multipara is a woman who has already delivered five or more infants who have achieved a gestational age of 24 weeks or more, and such women are traditionally considered to be at higher risk than the average in subsequent pregnancies.

National Perinatal Mortality Review Tool (PMRT) - The aim of the PMRT programme is introduce the PMRT to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales. The PMRT has been designed with user and parent involvement to support high quality standardised perinatal reviews on the principle of 'review once, review well'.

Ockenden report Immediate and Essential Actions (IEA) - After reviewing 250 cases and listening to many more families, this first report identifies themes and recommendations for immediate action and change, both at The Shrewsbury and Telford Hospital NHS Trust and across every maternity service in England.

Oxytocin - is a natural hormone that causes the uterus to contract used to induce labour, strengthen labour contractions during childbirth, control bleeding after childbirth.

Perinatal Clinical Quality Surveillance Model – includes five principles for improving oversight for effective perinatal clinical quality to ensure a positive experience for women and their families. They integrate perinatal clinical quality into developing integrated care system (ICS) structures and provide clear lines for responsibility and accountability for addressing quality concerns at each level of the system.

Personalised Care and Support Plan (PCSP) - people have proactive, personalised conversations which focus on what matters to them, paying attention to their clinical needs as well as their wider health and wellbeing.

PRactical Obstetric Multi-Professional Training (PROMPT) - is a multi-professional obstetric emergencies training package that has been developed by

PMF for use in local maternity units with the aim of reducing preventable harm to mothers and their babies.

Saving Babies Lives Care Bundle - The bundle aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice.

SCORE culture survey - is a way of measuring and understanding culture that exists within organisations and teams. It is an anonymous, online tool that teams can use to assess their culture. It provides an overview but also detail in specific focus areas such as communication and staff burn out.

Second degree tear - is a tear in the skin and muscle of the perineum, which is the area between the vagina and anus.

Term gestation - at 37 weeks, pregnancy is considered full-term.

Tertiary maternal medicine service - receives referrals from GPs and hospitals across the UK and internationally. The service provides outpatient and inpatient care for women affected with any medical disease in pregnancy, as well as pre-pregnancy counselling. Obstetric medicine is the specialist care of pregnant women who either have pre-existing medical diseases, or have specific pregnancy-related diseases that can affect any organ in the body.

Transitional Care - means 'in between care' and is for babies who need a little more nursing care and monitoring than the routine care that all babies receive on the maternity ward. It supports babies to stay with their mother rather than going to the Special Care Baby Unit.

Imperial College Healthcare NHS Trust

AUDIT, RISK & GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1. Constitution

1.1. The Board hereby resolves to establish a Committee of the Board to be known as the Audit, Risk and Governance Committee ("the Committee"). The Committee is a non-executive committee and as such has no delegated authority other than that specified in these terms of reference.

2. Authority

2.1. The Committee is authorised to:

2.1.1. Seek any information it requires from any employee of the Trust in order to perform its duties, and to call any employee to a meeting of the Committee as and when required.

2.1.2. Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, via the Trust company secretary.

2.1.3. Publish in the Trust's annual report, details of any issues that cannot be resolved between the Committee and the board. If the board has not accepted the Committee's recommendation on the external auditor appointment, reappointment or removal, the annual report should include a statement explaining the Committee's recommendation and the reasons why the board has taken a different position.

3. **Role (objective)**

3.1. To provide the board of Imperial College Healthcare NHS Trust ("the Trust") with the assurance that adequate processes of corporate governance, risk management, audit and internal control are in place and working effectively. The Committee will operate in two parts, Part I: Audit, and Part II: Risk and Governance.

4. **Membership**

4.1. Members of the Committee shall be appointed by the Trust chairperson on behalf of the Trust board.

Part I Audit & Part II Risk and Governance

4.1.1. For Part I, the Committee shall be made up of a minimum of three members, all of whom shall be non-executive directors. At least one member shall have recent and relevant financial experience and the Committee as a whole shall have competence relevant to the health service. For Part II, the membership will also include the Chief financial officer, Director of nursing and Medical director. The chair of the board shall not be a member of the Committee.

4.1.2. The chief financial officer, director of nursing and medical director will attend all meetings.

4.1.3. The chief executive will be invited to attend any meeting and should attend at least annually to discuss with the Committee the process for assurance that supports the annual governance statement.

4.1.4. Only members of the Committee have the right to attend and vote at Committee meetings.

4.1.5. The Committee may require other officers of the Trust and other individuals to attend all or any part of its meetings.

4.1.6. The chair of both parts of the Committee will be a non-executive director. In the absence of the Committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

4.1.7. Internal and external audit representatives will always attend both parts of the meeting, unless by prior agreement with the chair. The Committee shall meet privately with the internal and external auditors at least once a year.

5. **Quorum**

5.1. The quorum for the meeting will be two non-executive director members for Part I and Part II and the addition of two executive directors for Part II; the meeting will then be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

6. **Frequency of meetings and attendance requirements**

6.1. The Committee will normally meet at least four times a year at appropriate intervals in the financial reporting and audit cycle and otherwise as required.

6.2. Outside of the formal meeting programme, the Committee chair will maintain a dialogue with key individuals involved in the Trust's governance, including the Trust board chair, the chief executive, the finance director, the external audit lead partner and the head of internal audit.

6.3. Committee members should aim to attend all scheduled meetings but must attend a minimum of half of scheduled meetings. The secretary of the Committee shall maintain a register of attendance which will be published in the Trust's annual report.

7. Declarations of Interest

7.1. All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required to not participate in a discussion or otherwise limit their involvement in the meeting. The director of corporate governance can provide advice on reporting Declarations of Interests.

8. **Duties**

8.1. The Committee (across Part I and Part II) should carry out the following duties for the Trust:

8.2. **Financial Reporting**

8.2.1. The Committee shall monitor the integrity of the financial statements of the Trust, including its annual report and any formal announcements relating to the Trust's financial performance and review and report to the board on significant financial reporting issues and judgements which those statements contain having regard to matters communicated to it by the auditor.

8.2.2. The Committee shall review the annual report and financial statements before recommending them to the Trust board, in particular, the Committee shall review and challenge where necessary:

- the application of significant accounting policies and any changes to them;
- the methods used to account for significant or unusual transactions where different approaches are possible;
- whether the Trust has adopted appropriate accounting policies and made appropriate estimates and judgements, taking into account the external auditor's views on the financial statements;
- the clarity and completeness of disclosures in the financial statements and the context in which statements are made; and
- all material information presented with the financial statements, including the strategic report and the corporate governance statements relating to the audit and to risk management.

8.2.3. The Committee should also ensure that the systems for financial reporting to the board of directors, including those of budgetary control, are subject to review as to completeness, integrity and accuracy of the information provided to the Trust board.

8.2.4. The Committee shall review any other statements requiring board approval which contain financial information first, where to carry out a review prior to board approval would be practicable and consistent with any prompt reporting requirements under any law or regulation including the Listing Rules, Prospectus Rules and Disclosure Guidance and Transparency Rules sourcebook.

8.2.5. Where the Committee is not satisfied with any aspect of the proposed financial reporting by the Trust, it shall report its views to the board.

8.3. **Governance, Risk Management and Internal Control**

8.3.1. The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the Trust's goals.

8.3.2. In relation to the management of risk, the Committee will:

- Review the process under which the Trust sets its risk appetite;
- Oversee and advise the Trust board on the current risk exposures of the Trust, and the effectiveness of the Trust's risk management systems;
- Keep under review the effectiveness of the Trust's risk management and risk assessment processes ensuring the use of both qualitative and quantitative measures in assessment;
- Refer to other board committees any risks that require further scrutiny by its respective membership;
- Review the effectiveness and timeliness of actions to mitigate critical risks including receiving exception reports on overdue actions;
- Review the statements to be included in the annual report concerning risk management;
- Review the governance arrangements in place to ensure effectiveness of learning from incidents Trust-wide is achieved; and

8.3.3. The Committee will seek assurance that the Trust board's oversight and management of the delivery of the strategic objectives and in managing strategic, financial and operational risks, is effective, via implementation of the Board Assurance Framework.

8.3.4. The Committee will seek assurance that the monitoring of due diligence on any integration or partnership arrangement is appropriate.

8.3.5. The Committee will seek assurance on behalf of the Trust board that the design and application of the control environment in core financial processes are fit for purpose and reflect both public and commercial sector best practice.

8.3.6. In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with CQC Standards), together with any accompanying head of internal audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the board of directors;
- an effective system of management of performance and finance across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;
- the Board Assurance Framework and the underlying integrated assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements;
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State directions and as required by NHS Protect.

8.3.7. In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

8.3.8. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

8.4. **Internal Audit**

8.4.1. The Committee shall ensure that there is an effective Internal Audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the chief executive and board of directors. This will be achieved by:

- approval of the appointment or termination of appointment of the head of internal audit
- consideration of the provision of the internal audit service, the cost of the audit;

- review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
- consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the internal and external auditors to optimise audit resources;
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and
- annual review of the effectiveness of internal audit.

8.4.2. More details regarding the Committee's responsibilities relating to internal audit are included in Appendix 1.

8.5. **External Audit**

8.5.1. The Committee shall review the work and findings of the external auditor and consider the implications and management's responses to their work. This will be achieved by:

- appointment of the external auditor, as far as the relevant rules and regulations permit;
- discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensure co-ordination, as appropriate, with other external auditors in the local health economy;
- discussion with the external auditors of their local evaluation of audit risks and assessment of the organisation and associated impact on the audit fee; and
- review all external audit reports (together with the appropriateness of management responses), including agreement of the annual audit letter before submission to the Trust board.

8.5.2. The Committee will review any proposal considered for commissioning work outside the annual audit plan (in its role as the Audit Panel) prior to approval.

8.5.3. More details regarding the Committee's responsibilities relating to external audit are included in Appendix 1.

8.6. **Auditor Panel**

8.6.1. NHS trusts are required to appoint their own external auditors and directly manage the resulting contract and the relationship; trusts are required to have an auditor panel to advise on the selection, appointment and removal of external auditors and on maintaining an independent relationship with them.

8.6.2. In accordance with The Local Audit and Accountability Act 2014, and The Local Audit (Health Services Bodies Auditor Panel and Independence) Regulations 2015, the Trust has nominated the Committee (Part I) as the Auditor Panel for the Trust.

8.6.3. The Auditor Panel will advise the Trust board on the selection and appointment of the external auditor.

8.6.4. The Trust board must consult and take account of the Auditor Panel's advice on the selection and appointment of the Trust board on the appointment of external auditors, and publish a notice on the website within 28 days of appointing the auditor providing details of appointment, and noting auditor panel advice.

8.6.5. The Auditor panel must advise on the Trust's policy on use of auditors for the provision of non-audit services.

8.6.6. Auditor panel business must be identified clearly and separately on the agenda.

8.7. **Management**

8.7.1. The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

8.7.2. They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

8.8. **Narrative reporting**

8.8.1. Where requested by the board, the Committee should review the content of the annual report and accounts and advise the board on whether, taken as a whole, it is fair, balanced and understandable and provides the information necessary for stakeholder to assess the Trust's

performance, business model and strategy and whether it informs the board's statement in the annual report on these matters that is required under the Code.

8.9. **Compliance, speaking-up and fraud**

8.9.1. The Committee shall review the adequacy and security of the Trust's arrangements for its employees, contractors and external parties to raise concerns, in confidence, about possible wrongdoing in financial reporting or other matters or any other matters of concern including patient care, safety and bullying (including the Freedom to Speak up Guardian). The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action. In particular the Committee will:

- review the adequacy of the policies and procedures for all work related fraud and corruption as required by the counter fraud and security management service;
- approve and monitor progress against the operational counter fraud plan;
- receive regular reports and ensure appropriate action in significant matters of fraudulent conduct and financial irregularity;
- monitor progress on the implementation of recommendations in support of counter fraud;
- receive the annual report of the local counter fraud specialist; and
- review the Trust's systems and controls for the prevention of bribery and receive reports on non-compliance

8.10. **Standing Orders and Standing Financial Instructions**

8.10.1. The Committee will review on behalf of the Trust board any proposed changes to the Standing Orders and Standing Financial Instructions.

8.10.2. The Committee will examine the circumstances of any departure from the requirements of Standing Orders and Standing Financial Instructions.

8.10.3. The Committee will monitor the Declarations of Interest & Hospitality policy with reference to the codes of conduct and accountability thereby providing assurance to the board of probity in the conduct of business.

8.10.4. The Committee will review schedules of losses and compensations annually.

9. **Other assurance functions**

9.1. The Committee will ensure that other board committees receive findings of other significant assurance functions as appropriate, both internal and external to the organisation, including the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors, and professional bodies with responsibility for the performance of staff or functions (for example Royal Colleges and accreditation bodies).

9.2. In addition, the Committee will be cognisant of the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. The Committee will work and liaise as necessary with all other board committees ensuring interaction between committees and with the board is reviewed regularly, taking particular account of the impact of risk management and internal controls being delegated to different committees.

10. **Reporting responsibilities**

10.1. The Committee chair shall report formally to the board on its proceedings after each meeting on all matters within its duties and responsibilities and shall also formally report to the board on how it has discharged its responsibilities.

11. Engagement with stakeholders

11.1. The Committee chair should attend the annual general meeting to answer any stakeholder questions on the Committee's activities.

12. **Meeting administration**

12.1. The Trust secretary will attend each meeting and they or their nominee shall act as the secretary of the Committee and ensure that the Committee receives information and papers in a timely manner to enable full and proper consideration to be given to issues.

12.2. Meetings of the Committee may be called by the secretary of the Committee at the request of any of its members or at the request of the external audit lead partner or head of internal audit if they consider it necessary.
12.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda and supporting papers shall be forwarded to each member of the Committee, any other persons required to attend, no later than five working days before the date of the meeting.
12.4. The secretary will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance.
12.5. Members and those present should state any conflicts of interest and the secretary should minute them accordingly.
12.6. Minutes of Committee meetings should be circulated promptly to all members of the Committee and, once agreed, to all members of the Trust board unless a conflict of interest exists or unless, exceptionally, it would be inappropriate to do so.

13. **Other matters**
13.1. The Committee shall:
13.1.1. Have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for advice and assistance as required.
13.1.2. Be provided with appropriate and timely training relating to Audit Committee business, both in the form of an induction programme for new members and on an ongoing basis for all members.
13.1.3. Give due consideration to all relevant laws and regulations, the provisions of the Code and published guidance, the requirements of the FCA's Listing Rules, Prospectus Rules and Disclosure Guidance and Transparency Rules sourcebook and any other applicable rules, as appropriate.
13.1.4. Oversee any investigation of activities which are within its terms of reference.
13.1.5. Ensure that a periodic evaluation of the Committee's performance is carried out.
13.1.6. At least annually, review its constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the board for approval.

14. **Work Programme**
14.1. The Committee will prepare an annual work programme detailing the items expected to be considered at each meeting.
14.2. The work programme is to be a living document, updated for each meeting.
14.3. Review of the work programme is to be a standing agenda item.

15. **Monitoring and Review**
15.1. The Trust board will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the Chair of the Committee might provide.

Reviewed: October 2020

Appendix 1 – Audit, Risk and Governance Committee responsibilities relating to Internal and External Audit [ICSA guidance]

Internal audit

The Committee shall:

- approve the appointment or termination of appointment of the head of internal audit
- review and approve the role and mandate of internal audit, monitor and review the effectiveness of its work, and annually approve the internal audit charter ensuring it is appropriate for the current needs of the organisation
- ensure internal audit has unrestricted scope, the necessary resources and access to information to enable it to fulfil its mandate, ensure there is open communication between different functions and that the internal audit function evaluates the effectiveness of these functions as part of its internal audit plan, and ensure that the internal audit function is equipped to perform in accordance with appropriate professional standards for internal auditors
- ensure the internal auditor has direct access to the board chair and to the Committee chair, providing independence from the executive and accountability to the Committee
- carry out an annual assessment of the effectiveness of the internal audit function and as part of this assessment:
  - meet with the head of internal audit without the presence of management to discuss the effectiveness of the function
  - review and assess the annual internal audit work plan
  - receive a report on the results of the internal auditor's work
  - determine whether it is satisfied that the quality, experience and expertise of internal audit is appropriate for the business
  - review the actions taken by management to implement the recommendations of internal audit and to support the effective working of the internal audit function
- monitor and assess the role and effectiveness of the internal audit function in the overall context of the Trust's risk management system and the work of compliance, finance and the external auditor
- consider whether an independent, third party review of processes is appropriate

External Audit

The Committee shall:

- consider and make recommendations to the board, to be put to shareholders for approval at the AGM, in relation to the appointment, re-appointment and removal of the Trust's external auditor
- develop and oversee the selection procedure for the appointment of the audit firm in accordance with applicable Code and regulatory requirements, ensuring that all tendering firms have access to all necessary information and individuals during the tendering process
- if an external auditor resigns, investigate the issues leading to this and decide whether any action is required
- oversee the relationship with the external auditor. In this context the Committee shall:
  - approve their remuneration, including both fees for audit and non-audit services, and ensure that the level of fees is appropriate to enable an effective and high-quality audit to be conducted
  - approve their terms of engagement, including any engagement letter issued at the start of each audit and the scope of the audit
- assess annually the external auditor's independence and objectivity taking into account relevant law, regulation, the Ethical Standard and other professional requirements and the group's relationship with the auditor as a whole, including any threats to the auditor's independence and the safeguards applied to mitigate those threats including the provision of any non-audit services
- satisfy itself that there are no relationships between the auditor and the Trust (other than in the ordinary course of business) which could adversely affect the auditor's independence and objectivity
- agree with the board a policy on the employment of former employees of the Trust's auditor, taking into account the Ethical Standard and legal requirements, and monitor the application of this policy

- monitor the auditor's processes for maintaining independence, its compliance with relevant law, regulation, other professional requirements and the Ethical Standard, including the guidance on the rotation of audit partner and staff
- monitor the level of fees paid by the Trust to the external auditor compared to the overall fee income of the firm, office and partner and assess these in the context of relevant legal, professional and regulatory requirements, guidance and the Ethical Standard
- assess annually the qualifications, expertise and resources, and independence of the external auditor and the effectiveness of the external audit process, which shall include a report from the external auditor on their own internal quality procedures
- seek to ensure coordination of the external audit with the activities of the internal audit function
- evaluate the risks to the quality and effectiveness of the financial reporting process in the light of the external auditor's communications with the Committee
- develop and recommend to the board the Trust's formal policy on the provision of non-audit services by the auditor, including prior approval of non-audit services by the Committee and specifying the types of non-audit service to be preapproved, and assessment of whether non-audit services have a direct or material effect on the audited financial statements.68 The policy should include consideration of the following matters
- threats to the independence and objectivity of the external auditor and any safeguards in place -
- the nature of the non-audit services
- whether the external audit firm is the most suitable supplier of the non-audit service
- the fees for the non-audit services, both individually and in aggregate, relative to the audit fee –
- the criteria governing compensation.
- meet regularly with the external auditor (including once at the planning stage before the audit and once after the audit at the reporting stage) and, at least once a year, meet with the external auditor without management being present, to discuss the auditor's remit and any issues arising from the audit.
- discuss with the external auditor the factors that could affect audit quality and review and approve the annual audit plan, ensuring it is consistent with the scope of the audit engagement, having regard to the seniority, expertise and experience of the audit team
- review the findings of the audit with the external auditor. This shall include but not be limited to, the following
  - a discussion of any major issues which arose during the audit
  - the auditor's explanation of how the risks to audit quality were addressed
  - key accounting and audit judgements
  - the auditor's view of their interactions with senior management
  - levels of errors identified during the audit72
- review any representation letter(s) requested by the external auditor before it is (they are) signed by management
- review the management letter and management's response to the auditor's findings and recommendations
- review the effectiveness of the audit process, including an assessment of the quality of the audit, the handling of key judgements by the auditor, and the auditor's response to questions from the Committee.

Imperial College Healthcare NHS Trust

FINANCE, INVESTMENT AND OPERATIONS COMMITTEE
TERMS OF REFERENCE

1. Constitution

1.1. The Board hereby resolves to establish a Committee of the Board to be known as the Finance, Investment and Operations Committee ("the Committee"). The Committee is a Non-Executive Committee and as such has no delegated authority other than that specified in these Terms of Reference.

2. **Authority**

2.1.1. The Committee is authorised to:

2.1.2. Seek any information it requires from any employee of the Trust in order to perform its duties, and to call any employee to a meeting of the Committee as and when required.

2.1.3. Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, via the Trust company secretary.

3. **Role (objective)**

3.1. The purpose of the Finance, Investment & Operations Committee is to provide oversight on behalf of the Board of Imperial College Healthcare NHS Trust ("the Trust"), on the financial and operational planning and management, and transformation activities, which contribute to the achievement of strategic goals.

3.2. The Committee will seek assurance that efficient and effective budget and financial management arrangements are in place for the Trust. It will undertake, on behalf of the Trust board, thorough and objective reviews of financial policy and financial performance issues, reviewing the risks to the financial position, advising the Trust board on finance issues and investment strategy, including those relating to the Trust's estate.

3.3. The Committee will also be sighted on operational performance and planning, focusing specifically on ensuring there is alignment between financial plans and priorities for operational delivery.

3.4. It will have oversight of the development and implementation of the Trust's Transformation programme, including monitoring the progress in delivering the key projects that support the achievement of financial and operational performance.

4. **Membership**

4.1. Members of the Committee shall be appointed by the Trust Chair, on behalf of the Trust board. The committee shall be made up of five members; three non-executive directors; Chief executive; and Chief financial officer.

4.2. Only members of the Committee have the right to attend and vote at Committee meetings; other officers of the Trust and other individuals may be required to attend all or any part of the Committee's meetings.

4.3. The chair of the Committee will be an independent non-executive director. In the absence of the Committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

4.4. In addition to the Members, the deputy chief financial officers and divisional directors are expected to attend Committee meetings; others may be invited on an 'as needs' basis.

5. **Quorum**

5.1. The meeting quorum is three members, of which two must be non-executive directors; the meeting will then be competent to exercise all or any of the authorities, powers and discretions vested in, or exercisable by, the Committee.

6. **Frequency of meetings and attendance requirements**

6.1. The Committee will normally meet six times a year at appropriate times in the reporting cycle and otherwise as required.

6.2. Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

7. Declarations of Interest

7.1. All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required to not participate in a discussion or otherwise limit their involvement in the meeting. The Director of Corporate Governance can provide advice on reporting Declarations of Interests.

8. **Duties**

8.1. The Committee should carry out the following duties for the Trust:

8.1.1. Advise the Trust board on financial policies;

8.1.2. Recommend to the Trust board, the Trust's medium and long term financial strategy (capital and revenue) including the underlying assumptions and methodology used, ahead of review and approval by the Trust board;

8.1.3. Review the Business Plan including the annual revenue and capital budget prior to submission to the Trust board for approval;

8.1.4. Review the Trust's financial performance and forecasts (including performance against Cost Improvement Programmes) and identify the key issues and risks requiring discussion or decision by the Trust board;

8.1.5. Review compliance with the self-assessment quality checklist for the annual national cost collection or other equivalent submission;

8.1.6. Review, at the request of the Trust board, specific aspects of financial performance where the Trust board requires additional scrutiny and assurance;

8.1.7. Review the Trust's projected and actual cash and working capital;

8.1.8. Approve and keep under review, on behalf of the Trust board, the Trust's investment and borrowing strategies and policies;

8.1.9. Ensure the Trust operates a comprehensive budgetary control and reporting framework (but acknowledging that the Audit, Risk & Governance committee is responsible for systems of financial control);

8.1.10. Review the financial risks;

8.1.11. Establish the overall methodology, processes and controls which govern the Trust's investments;

8.1.12. Evaluate, scrutinise and monitor costs and funding relating to investments (such as Redevelopment and any major pandemic or other incident requiring additional scrutiny of costs)), including regular review of the capital programme ensuring value for money;

8.1.13. Review, and recommend to Trust board, the Trust's treasury management and working capital and estates strategies;

8.1.14. Review and recommend to Trust board, the Trust's estates strategies and ensure the associated funding arrangements are in place.

8.1.15. Review post project evaluations for capital and revenue projects (above £5million) approximately 12 months after go live of project to review whether anticipated outcomes/savings had been achieved;

8.1.16. Evaluate and scrutinise the financial and commercial validity of individual investment decisions over £5m recommended for approval by the executive management board,

including the review of outline and final business cases, and service development tenders and procurement contracts, for onward recommendation for approval by the Trust board. The current delegated limit for the Trust is £15 million;

8.1.17. Have oversight of all business cases approved by the executive committee below the value of £5m;

8.1.18. Consider quality implications for all financial cases and escalate to the Quality Committee as appropriate.

8.1.19. Review operational planning and performance for the Trust, including activity, capacity and winter planning, identifying the key issues and risks requiring discussion or decision by the Trust board where these issues and risks impact on financial performance and planning;

8.1.20. Review performance against such plans and identify the key issues and risks requiring discussion or decision by the Trust board where these issues and risks impact on financial performance and planning;

8.1.21. Review the Transformation programme and receive progress reports on key projects within that programme.

8.1.22. Refer other matters to other Committees as appropriate.

8.1.23. To receive updates and understand emerging system level risks and the strategic and financial impacts on the Trust and consider how collaboration with the ICS can help in managing ICHT specific financial risks.

9. **Reporting responsibilities**

9.1. The Committee will report to the Trust board on its proceedings after each meeting.

9.2. The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

10. Engagement with stakeholders

10.1. The Committee chair should attend the annual general meeting to answer any stakeholder questions on the Committee's activities.

11. **Meeting administration**

11.1. The Trust company secretary or their nominee shall act as the secretary of the Committee

11.2. Meetings of the committee may be called by the secretary of the Committee at the request of any of its members or where necessary.

11.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda and supporting papers, shall be forwarded to each member of the committee, and any other person required to attend, no later than five days before the date of the meeting.

11.4. The secretary shall minute the proceedings of all meetings of the Committee, including recording the names of those present, and any conflicts of interest.

11.5. Minutes of committee meetings should be circulated to all members of the Committee, and once approved, minutes are reported to the private Trust board.

12. **Other matters**

12.1. The committee will:

12.1.1. have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;

12.1.2. be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;

12.1.3. give due consideration to laws and regulations;

12.1.4. at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Trust board for approval, any changes it considers necessary.

13. **Work Programme**

13.1. The Committee will prepare a work programme covering at least the 12 months following each meeting, detailing the items expected to be considered at each meeting, grouped under heading aligned with the Duties detailed above.
13.2. The Work Programme is to be a living document, updated for each meeting.
13.3. Review of the Work Programme will be reviewed by the Committee on an annual basis.

14. **Monitoring and Review**
14.1. The Trust board will monitor the effectiveness of the committee through receipt of a written report following each meeting and the Committee's minutes.
14.2. The secretary will assess agenda items to ensure they comply with the Committee's responsibilities.

Reviewed: April 2021

Imperial College Healthcare NHS Trust

QUALITY COMMITTEE

TERMS OF REFERENCE

1. Constitution

1.1. The Board hereby resolves to establish a Committee of the Board to be known as the Quality Committee ("the Committee"). The Committee is a Non-Executive Committee and as such has no delegated authority other than that specified in these Terms of Reference.

2. Authority

2.1. The Committee has the following delegated authority:

2.1.1. The authority to seek any information it requires from any employee of the Trust in order to perform its duties, and to call any employee to a meeting of the Committee as and when required.

2.1.2. The authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, via the Trust company secretary.

3. Role (objective)

3.1. To obtain assurance that high quality care is being delivered across Imperial College Healthcare NHS Trust ("the Trust") and there is continuous improvement in the quality of services and outcomes in relation to the safety of services, the effectiveness of services, the quality of the experience undergone by patients. The Committee will also ensure that the quality strategy supports the Trust's strategic goals and is being implemented and that continuous improvement is evidenced; to ensure that robust clinical governance structures, systems and processes (including those for clinical risk management and service user safety) are in place across all services and are line with national, regional and commissioning requirements; to have input into quality aspects of major initiatives; onward referral of appropriate issues to relevant Committees for further review or action; and review and approval (or recommendation for approval by the Trust Board) of required quality-related annual reports.,

4. Membership

4.1. The Committee chair (a Non-Executive director) and Committee members will be appointed by the Trust Chair. The Committee will comprise three non-executive directors, the medical director, the director of nursing, the chief executive and the divisional directors.

4.2. Only members of the Committee have the right to attend and vote at meetings; officers of the Trust and other individuals may be required to attend all or any part of Committee meetings. Non-executive directors are invited to attend any board Committee they wish and will notify the secretary of the Committee when they have a specific meeting that they would like to attend.

4.3. In the absence of the Committee chair, or a nominated deputy, members present will agree that one among them will chair the meeting.

5. **Quorum**

5.1. The meeting quorum is three members, of which two are non-executive directors; the meeting will then be competent to exercise all or any of the authorities, powers and discretions vested in, or exercisable by, the Committee.

6. **Frequency of meetings and attendance requirements**

6.1. The Committee will normally meet bi-monthly; additional meetings can be convened by agreement with the Committee Chair.

6.2. Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of scheduled meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

7. **Declarations of Interest**

7.1. All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required to not participate in a discussion or otherwise limit their involvement in the meeting. The Director of Corporate Governance can provide advice on reporting Declarations of Interests.

8. **Duties -** The Committee should carry out the following duties for the Trust:

8.1. **Safety**

8.1.1. Obtain assurance that the Trust has effective mechanisms for managing clinical risk, including clinical risk associated with clinical trials and improving service user safety, learning from incidents and taking action to reduce risks and improve clinical quality;

8.1.2. Receive and review a thematic summary of the lessons learned from serious adverse incidents; individual 'never' events; coroners' post-mortem reports; medico-legal cases and trend analysis of clinical incidents and be assured that actions are being taken to address issues and share learning;

8.1.3. Receive and review quality implications of business cases, as appropriate.

8.1.4. Obtain assurance that robust safeguarding structures, systems and processes are in place to safeguard children and young people and vulnerable adults;

8.1.5. Obtain assurance that the Trust is compliant with the Mental Health Act and its associated Code of Practice and the Mental Capacity Act;

8.1.6. The Committee will review the quality-related risks on the Corporate Risk Register and will identify emerging quality risks

8.2. **Effective**

8.2.1. Establish and oversee the Quality Strategy underpinned by the Trust's strategic goals.

8.2.2. Review the impact on quality of care arising from estates and facilities matters such as hotel services.

8.2.3. Approve and assure delivery of the annual programme of Trust-wide clinical audits.

8.2.4. Obtain assurance that NICE Guidelines and Technology Appraisals are implemented.

8.2.5. Obtain assurance that there are robust systems for undertaking nationally mandated audits, receive summary results and monitor the implementation of recommendations.

8.2.6. Oversee the Trust's work on Care Quality Commission's (CQC) improvement reviews.

8.2.7. Work with partners to agree a consistent approach to defining and measuring quality, collecting information from providers, and delivering a single vision of high-quality care.

8.3. **Well-led**

8.3.1. Determine whether the Trust is maintaining and improving the quality of patient care and health outcomes within the context of delivering the NHS Long Term Plan.

8.3.2. Obtain assurance that robust quality governance structures, systems, and processes, including those for clinical risk management and service user safety, are in place across all services, and developed in line with national, regional and commissioning requirements.
8.3.3. Nurture a quality improvement culture across the Trust and celebrate achievement in quality improvement.
8.3.4. Obtain assurance that efficiency programmes are not having a detrimental effect on quality through the cost improvement process (CIP).
8.3.5. Approve and assure delivery of all quality governance plans including CQC inspection action plans, and quality improvement methodology.
8.3.6. Obtain assurance that the divisional quality groups are effectively coordinating quality and clinical governance activity within the Trust.
8.3.7. Ensure that board assurance framework reflects the assurances for which the Committee has oversight, and that risks highlighted are appropriately reflected on the risk registers.

8.4. **Caring**
8.4.1. Approve and assure delivery of the Trust's patient and public engagement plans, and the patient experience plans/strategy, and obtain assurance that these plans are keys element of the work of quality and clinical governance teams across the Trust.
8.4.2. Receive assurance that appropriate safeguarding arrangements are in place and effectively monitored.

8.5. **Responsive**
8.5.1. Obtain assurance that patient access targets are being delivered.
8.5.2. Obtain assurance that effective channels are in operation for communicating and managing issues of clinical governance to relevant managers, staff and external stakeholders.
8.5.3. Obtain assurance that clinical recommendations resulting from complaints including those investigated by the Parliamentary and Health Service Ombudsman have been implemented.

9. **Reporting responsibilities**
9.1. The Committee will report to the Trust board on its proceedings after each meeting.
9.2. The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

10. Engagement with stakeholders
10.1. The Committee chair should attend the annual general meeting to answer any stakeholder questions on the Committee's activities.

11. **Meeting administration**
11.1. The Trust company secretary or their deputy shall act as the secretary of the Committee.
11.2. Meetings of the Committee may be called by the secretary at the request of any of its members or where necessary.
11.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.
11.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

11.5. Minutes of Committee meetings should be circulated to all members of the Committee and, once approved, to all members of the Trust board (unless a conflict of interest exists).

12. **Other matters**

12.1. The Committee will:

12.1.1. The Committee will discuss any matter which any member of the Committee believes to be of such importance that it should be brought to the attention of the Committee, by agreement of the Committee chair.

12.1.2. Have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required.

12.1.3. Be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members.

12.1.4. Give due consideration to legislation and regulations.

12.1.5. Review both its effectiveness and terms of reference on an annual basis, and recommend to the Trust board for approval, any changes it considers necessary.

13. **Work Programme**

13.1. The Committee will prepare an annual work programme detailing the items expected to be considered at each meeting.

13.2. The Work Programme is to be a living document, updated for each meeting.

13.3. Review of the Work Programme is to be a standing agenda item.

14. **Monitoring and review**

14.1. The Trust board will monitor the effectiveness of the Committee through receipt of the Committee's minutes and any further written or verbal reports that the chair of the Committee might provide.

14.2. The secretary will review all agenda items to ensure they align with the Committee's responsibilities.

Reviewed: 6 May 2021

Imperial College Healthcare NHS Trust

REDEVELOPMENT BOARD COMMITTEE

TERMS OF REFERENCE

1. Constitution

1.1. The Board hereby resolves to establish a Committee of the Board to be known as the Redevelopment Programme Board Committee ("the Committee"). The Committee is a Non-Executive Committee and as such has no delegated authority other than that specified in these Terms of Reference.

2. Authority

2.1. The Committee has the following delegated authority:

2.1.1. The authority to seek any information it requires from any employee of the Trust in order to perform its duties, and to call any employee to a meeting of the Committee as and when required.

2.1.2. The authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, via the Trust company secretary.

3. **Role (objective)**

3.1. To receive assurance, on behalf of the Trust Board, regarding the delivery of all aspects of the redevelopment programme, including achievement of workstream milestones and deliverables, and risks associated with the overall programme. To provide oversight and support to any commercial negotiations or procurement processes required for redevelopment. To identify the key issues and risks requiring discussion or decision by the Trust Board and advise accordingly.

4. **Membership**

4.1. Members of the Programme Board Committee will be appointed by the Chair, on behalf of the Trust Board. The Programme Board shall be chaired by the Trust Chair and membership made up of three Non-executive Directors, the Chief Executive Officer, the Chief Financial Officer, the Medical Director, Director of Redevelopment, The work of the Committee will be supported by other workstream leads, including Director of Estates and Facilities, Director of Communications, Director of strategy, Research and Innovation and Deputy Chief Financial Officer.

4.2. Only members of the Programme Board Committee have the right to attend and vote at Programme Board Committee meetings. Other attendees including the Director of Nursing will be invited by the Chair from time to time as appropriate. The Programme Board Committee may require other directors or officers of the Trust to attend Programme Board Committee meetings.

4.3. In the absence of the Programme Board Committee chair and/or an appointed deputy, the remaining Non-executive Directors present shall elect one of themselves to chair the meeting.

5. Quorum

5.1. The meeting quorum is four members, of which at least two are Non-executive Directors and one Executive Director; the meeting will then be competent to exercise

all or any of the authorities, powers and discretions vested in or exercisable by the Programme Board Committee.

6. **Frequency of meetings and attendance requirements**

6.1. The Programme Board Committee will meet bi-monthly at appropriate times in the reporting cycle and otherwise as required.

6.2. Programme Board Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The secretary of the Programme Board Committee shall maintain a register of attendance.

7. **Declarations of Interest**

7.1. All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required to not participate in a discussion or otherwise limit their involvement in the meeting. The Trust Secretary can provide advice on reporting Declarations of Interests.

8. **Duties**

The Programme Board Committee should carry out the following duties for the Trust:

8.1. **Redevelopment programme Committee assurance**

8.1.1. The Programme Board Committee shall make recommendations to the Trust Board on the redevelopment transformation programme, performance issues, financial issues, including investment and risks associated with the overall redevelopment programme and will provide oversight and support to any commercial negotiations or procurement processes required for redevelopment.

8.1.2. Specifically the Programme Board Committee will:

- oversee the work of the Executive Delivery Group, which is responsible for the day to day management of the programme;
- review the redevelopment programme and identify key issues with progress and assess the impact on the Trust business that requires discussion or decision by the Trust Board;
- review partnership arrangements between Trust and key stakeholders and advise the Trust Board of impact and issues that require discussion or decision by the Trust Board;
- review the quality of the healthcare facilities being developed to ensure Trust transformational objectives are being met and advise the Trust Board of issues that require discussion or decision by the Trust Board;
- review the redevelopment programme risk register and identify the key issues and risks requiring discussion or decision by the Trust Board;
- ensure the redevelopment programme operates a comprehensive budgetary control.

8.2. **Redevelopment programme management and reporting**

8.2.1. The Programme Board Committee shall review and recommend to the Trust Board:

- the Trust's investment strategy in so far as this is relevant to the redevelopment of the Trust sites, including:
- establish the overall methodology, processes and controls which govern the approach to site redevelopment;
- evaluate, scrutinise and monitor investment relating to site redevelopment;

prepare post project evaluations for capital projects and for revenue projects related to redevelopment which have a whole life contract value of £5 million and above;
- review and recommend to Trust Board the Trust's estate strategies;
- within limits set out in the standing orders, standing financial instructions, scheme of delegation and matters reserved to the Trust Board, the Programme Board Committee shall recommend, evaluate and scrutinise the financial and commercial validity of relevant individual investment decisions, including the review of outline and final business cases. The current delegated capital limit for the Trust is £15million.

8.2.2. The Programme Board Committee will also refer issues and decisions to other Board Committees as appropriate.
- The Finance, Investment and Operations Committee will consider and make recommendations to the Trust Board in relation to business cases for investment and use of financial resources, as appropriate and in accordance with the Trust's Scheme of Delegated Authority and Standing Orders.
- The Audit, Risk and Governance will have oversight of the programme's risk management approach, in accordance with its remit to ensure a robust system of internal control.
- The Quality Committee will have oversight and will input into the programme as appropriate, in particular in relation to any building and service design.

8.2.3. The Programme Board Committee will have oversight of the Trust's interaction with external bodies and regulators such as the Government, NHS England and NHS Improvement.

9. Reporting responsibilities

9.1. The Programme Board Committee will report to the Trust Board on its proceedings after each meeting.

9.2. The Programme Board Committee shall make whatever recommendations to the Trust Board it deems appropriate on any area within its remit where action or improvement is needed.

9.3. A synopsis of key items discussed will be included in the annual report to the Trust Board.

10. Engagement with stakeholders

10.1. The Committee chair should attend the annual general meeting to answer any stakeholder questions on the Committee's activities.

11. Meeting administration

11.1. Proceedings and papers in relation to this Programme Board Committee are commercially sensitive. Members and attendees to ensure confidentiality is maintained at all times.

11.2. The Trust secretary or their nominee shall act as the Secretary of the Programme Board Committee.

11.3. Meetings of the Programme Board Committee may be called by the Secretary of the Programme Board Committee at the request of any of its members or where necessary.

11.4. Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Programme Board, any other person required to attend and all other

Non-executive Directors, no later than five working days before the date of the meeting. Supporting papers shall be sent to Programme Board Committee members and to other attendees as appropriate, at the same time.

11.5. The secretary shall minute the proceedings of all meetings of the Programme Board Committee, including recording the names of those present and in attendance.

11.6. Members and those present should state any conflicts of interest and the secretary should minute them accordingly.

11.7. Minutes of Programme Board Committee meetings should be circulated promptly to all members of the Programme Board Committee and, once agreed, to all members of the Trust Board unless a conflict of interest exists.

12. Other matters

12.1. The Programme Board Committee:

- will have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;
- members will be provided with appropriate and timely training as required, both in the form of an induction programme for new members and on an ongoing basis for all members such as increasing knowledge around legal aspects of a redevelopment programme, design principles etc;
- will give due consideration to laws and regulations;
- will at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Trust board for approval, any changes it considers necessary.
- the chair of the Programme Board Committee will normally attend the annual general meeting prepared to respond to any questions on the Programme Board Committee's activities.

13. Work Programme

13.1. The Committee will prepare an annual work programme detailing the items expected to be considered at each meeting.

13.2. The Work Programme is to be a living document, updated for each meeting.

13.3. Review of the Work Programme is to be a standing agenda item.

14. Monitoring and Review

14.1. The Trust Board will monitor the effectiveness of the Programme Board Committee through receipt of the Programme Board Committee's minutes and such written or verbal reports that the chair of the Programme Board Committee might provide.

14.2. The secretary will assess agenda items to ensure they comply with the Programme Board Committee's responsibilities.

14.3. The secretary will monitor the frequency of the Programme Board Committee meetings and the attendance records to ensure minimum attendance figures are complied with. The attendance of members of the Programme Board Committee will be reported in the annual report.

Reviewed: April 2021

Imperial College Healthcare NHS Trust

Terms of Reference – People Committee

1. Constitution

1.1. The Board hereby resolves to establish a Committee of the Board to be known as the People Committee ("the Committee"). The Committee is a Non-Executive Committee and as such has no delegated authority other than that specified in these terms of reference.

2. Authority

2.1. The Committee has the following delegated authority:

2.1.1. The authority to seek any information it requires from any employee of the Trust in order to perform its duties, and to call any employee to a meeting of the Committee as and when required.

2.1.2. The authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, via the Trust company secretary.

3. Role (objective)

3.1. To monitor, review and report to the Board on the cultural and organisational development of the Trust, and on the strategic performance and impact of the Trust as a significant employer, educator and partner in health and care. To receive and provide the Board of Imperial College Healthcare NHS Trust ("the Trust") with assurance with regard to:

3.1.1. the identification of strategic people and workforce priorities for the Trust as a significant employer and as a partner in training, education, and development of health and care capacity in the locality.

3.1.2. the organisation's understanding of strategic workforce needs (including well-being, recruitment, retention, development of people, and organisational capacity) and the quality and effectiveness of plans to deliver them.

3.1.3. the implementation of key HR controls, including recruitment and retention, and performance management including appraisal systems.

3.1.4. the commitments of the NHS Constitution and the stated values of the Trust and standards of behaviour are being practiced at all levels of the organisation, based on evidence.

3.1.5. The achievement of key deliverables in relation to the equality, diversity and inclusion (EDI) plan, and to monitor key metrics in relation to EDI.

3.1.6. the Trust's legislative and regulatory compliance as an employer, including anticipation of, and planning for, future requirements.

3.1.7. the development of staff governance in the organisation, including staff engagement processes, with the Committee acting as the oversight Committee.

3.1.8. strategic issues relating to ethics and duty of care in the conduct of Trust affairs (including whistleblowing) and to the Trust's equality duty.

4. **Membership**

4.1. The Committee chair (a non-executive director) and Committee members will be appointed by the Trust Chair. The Committee will comprise three non-executive directors, the chief executive, director of people and organisational development, medical director, director of nursing, director of communications, and the divisional directors.

4.2. Only members of the Committee have the right to attend and vote at meetings; officers of the Trust and other individuals may be required to attend all or any part of Committee meetings. Non-executive directors are invited to attend any Board Committee they wish and will notify the secretary of the Committee when they have a specific meeting that they would like to attend.

4.3. In the absence of the Committee chair, members present will agree that one among them will chair the meeting.

5. **Quorum**

5.1. The meeting quorum is three members, of which two are non-executive directors; the meeting will then be competent to exercise all or any of the authorities, powers and discretions vested in, or exercisable by, the Committee.

6. **Frequency of meetings and attendance requirements**

6.1. The Committee will normally meet six times a year; additional meetings can be convened by agreement with the Committee Chair.

6.2. Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of scheduled meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

7. **Declarations of Interest**

7.1. All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required to not participate in a discussion or otherwise limit their involvement in the meeting. The Director of Corporate Governance can provide advice on reporting Declarations of Interests.

8. **Duties -** The Committee duties include:

8.1. **People Strategy**

8.1.1. Review the development and delivery of the Trust's sustainable workforce strategy, focusing on:

- Strategic workforce information and planning.
- Recruitment and retention.
- Staff experience and engagement, reward, recognition, health and wellbeing
- Education, learning and organisational and leadership development.
- Equality and diversity.

8.1.2. Provide assurance that the Trust's People Strategy and policies effectively respond to national and regional people strategies and policies.

8.1.3. Review strategic intelligence and research evidence on people and work, and distil their relevance to the Trust's strategic priorities.

8.2. **Culture & Values**

8.2.1. The role of the committee would be to oversee the development and delivery of the programme of work related to culture, including oversight of the measures of culture, including sources of staff feedback.

8.2.2. Oversee the coherence and comprehensiveness of the ways in which the Trust engages with staff and with staff voices, including the staff survey, and report on the intelligence gathered, and its implications to the Board. This includes raising concerns and freedom to speak up reports to the People Committee and Board.

8.2.3. Oversee the development and delivery of the Trust's strategy and improvement programmes on Equality, Diversity and Inclusion ensuring full compliance with statutory duties in this area.

8.3. **Organisational Capacity**

8.3.1. The role of the People Committee would be to oversee the development and delivery of a strategy regarding a sustainable workforce (more generally). That would include development of new roles, recruitment and retention etc. The safe staffing report would be an example of a source of assurance.

8.3.2. Assess the workforce strategies and plans to support transformational change, service redesign and pathways of care that make best use of new technologies, the use of apprenticeships, introduction of new roles and innovative working across traditional professional and organisational boundaries.

8.3.3. Review plans for ensuring the development of leadership and management capability, including the Trust's approach to succession planning and talent management.

8.4. **Education and training**

8.4.1. Review the Trust's strategy and performance as a provider and enabler of health and care education.

8.4.2. Review the Trust's current and future educational and training needs to ensure they support the strategic objectives of the organisation in the context of the wider health and care system.

8.4.3. Review the Trust's strategic contribution to the development of the health and care workforce.

8.4.4. Secure the necessary assurances about the Trust's compliance with the practice requirements of professional and regulatory bodies for all staff.

8.5. **Staff Health and Well-Being**

8.5.1. Oversee the development and delivery of a Trust Staff Health and Well-being Strategy

8.5.2. Review the accessibility and impact of the health and well-being strategy and improvement programmes, in particular, for staff with protected characteristics.

8.6. **Performance and Progress Reporting**

8.6.1. Establish a succinct set of key performance and progress measures relating to the full purpose and function of the Committee, including:

- the Trust's strategic priorities on people
- national performance targets
- organisational culture
- equality, diversity and inclusion
- workforce utilisation
- staff health and well-being
- health and safety
- strategic communications

8.6.2. Review progress against these measures and seek assurance around any performance issues identified, including proposed corrective actions.

8.6.3. Receive and review reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being taken to address these.

8.6.4. Ensure the credibility of sources of evidence and data used for planning and progress reporting to the Committee, and to the Board in relation to the Committee's purpose and function.

8.6.5. Ensure alignment of the Board assurances and consistent use of data and intelligence, by working closely with the Audit & Risk, Quality & Safety and Finance & Performance Committees.

8.6.6. Review and shape the quality-related content of periodic workforce reports to the Board.

8.6.7. Review the following formal reports to the Board as part of the Annual Cycle of Business:

- Annual People Report
- Equality and Diversity Annual report

8.7. **Statutory Compliance**

8.7.1. Ensure statutory and regulatory compliance and reporting requirements in people related areas.

9. **Reporting responsibilities**

9.1. The Committee will report to the Trust Board on its proceedings after each meeting.

9.2. The Committee will make whatever recommendations to the Trust Board it deems appropriate on any area within its remit where action or improvement is needed.

10. Engagement with stakeholders

10.1. The Committee chair should attend the annual general meeting to answer any stakeholder questions on the Committee's activities.

11. **Meeting administration**

11.1. The Trust company secretary or their deputy shall act as the secretary of the Committee.

11.2. Meetings of the Committee may be called by the secretary at the request of any of its members or where necessary.
11.3. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.
11.4. The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.
11.5. Minutes of Committee meetings should be circulated to all members of the Committee and, once approved, to all members of the Trust Board (unless a conflict of interest exists).

12. **Other matters**
12.1. The Committee will:
12.1.1. The Committee will discuss any matter which any member of the Committee believes to be of such importance that it should be brought to the attention of the Committee, by agreement of the Committee chair.
12.1.2. Have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required.
12.1.3. Be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members.
12.1.4. Give due consideration to legislation and regulations.
12.1.5. Review both its effectiveness and terms of reference on an annual basis, and recommend to the Trust Board for approval, any changes it considers necessary.

13. **Work Programme**
13.1. The Committee will prepare an annual work programme detailing the items expected to be considered at each meeting.
13.2. The Work Programme is to be a living document, updated for each meeting.
13.3. Review of the Work Programme is to be a standing agenda item.

14. **Monitoring and review**
14.1. The Trust Board will monitor the effectiveness of the Committee through receipt of the Committee's minutes and any further written or verbal reports that the chair of the Committee might provide.
14.2. The secretary will review all agenda items to ensure they align with the Committee's responsibilities.

Updated: 25 February 2021
Board: 31 March 2021
People Committee: 4 May 2021

NHS
Imperial College Healthcare
NHS Trust

REMUNERATION & APPOINTMENTS COMMITTEE TERMS OF REFERENCE

1. Constitution

1.1. The Board hereby resolves to establish a Committee of the Board to be known as the Remuneration and Appointments Committee ("the Committee"). The Committee is a Non-Executive Committee and as such has no delegated authority other than that specified in these Terms of Reference.

2. Authority

2.1. The Committee has the following delegated authority:

2.1.1. The authority to seek any information it requires from any employee of the Trust in order to perform its duties, and to call any employee to a meeting of the Committee as and when required.

2.1.2. The authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, via the Trust company secretary or director of people and organisational development.

2.1.3. In order to ensure the business of the Committee is not unduly held up between meetings, the Chair may take Chair's action between meetings. Any such decisions thus taken will be reported to the next meeting. This may include authorisation of contractual severance payments to staff other than Executive Directors as required by NHS Improvement or the Department of Health. Where substantive or sensitive decisions are required outside of scheduled meetings then the Chair may convene an extraordinary meeting of the Committee.

3. Role (objective)

3.1. To act on behalf of the Trust board in:

- Agreeing and overseeing the process for appointing executive directors and other direct reports to the chief executive as listed in the Appendix 1;
- Agreeing the remuneration and terms of service of executive directors and all other director level reports to the chief executive officer, and noting the remuneration of all other very senior managers (VSM);
- Monitoring the performance and the development of executive directors;
- Ensuring that Equality and Diversity has appropriate priority in leadership development and succession;
- Review, and recommend approval to the Chairman where appropriate, requests by executive directors to act as non-executive directors in other organisations or in similar roles;
- Ensuring that effective plans are in place to provide continuity of leadership in the event of extended executive director absence or vacancy;
- Approving any severance payments that are proposed for executive directors, for direct reports to the chief executive officer, and any other very senior managers and others as may be required by NHS Improvement and the Department of Health.

4. Membership and quorum

4.1. Members of the committee shall be appointed by the Chair of the Trust board. The committee shall be made up of three members:

- The Chair of the Trust board
- Two non–executive directors.

4.2. Only members of the Committee have the right to vote at the Committee meetings; other officers of the Trust and other individuals may be required to attend all or any part of its meetings.

4.3. The chair of the Committee will be a non-executive director, appointed by the Chair of the Trust board.

4.4. In addition to the Members, the following are required to attend all meetings of the Committee:

- Chief executive
- Director of people & OD
- Trust company secretary.

4.4.1. They will, however, be excluded from Committee discussions in relation to them.

5. Quorum

5.1. A quorum necessary for the transaction of business shall be two members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

6. Frequency of meetings and attendance requirements

6.1. The Committee will meet as required and at least twice a year. The timetable of meetings will be agreed between the Chair of the Committee and the Director of people & OD.

6.2. Members are expected to attend at least 75 per cent of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

7. **Declarations of Interest**

7.1. All members and attendees of the Committee must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. The chair of the Committee will determine if there is a conflict of interest such that the member and/or attendee will be required to not participate in a discussion or otherwise limit their involvement in the meeting. The Trust secretary can provide advice on reporting Declarations of Interests.

8. **Duties**

8.1. The Committee shall carry out the following duties for the Trust:

8.1.1. *Trust board composition*

- regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Trust board and make recommendations to the Trust board with regard to any changes.
- give full consideration to and make plans for succession planning for the chief executive officer and other executive directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed, in particular on the board in future.
- be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.
- be responsible for identifying and nominating a candidate, for approval by the Trust board, to fill the position of chief executive officer.
- before an appointment is made evaluate the balance of skills, knowledge and experience on the Trust board, and, in the light of this evaluation, prepare a

description of the role and capabilities required for a particular appointment. In identifying suitable candidates the Committee will use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; consider candidates on merit against objective criteria.

8.1.2. *Appointment of executive directors*

- nominate one or more members to be actively involved with the chief executive officer in the appointment of executive director and executive team member posts, and in the design of the selection process on behalf of the Committee.
- ensure that the selection process is based on: an agreed role and person specification; the use or other involvement of any third party recruitment professionals; an interview panel to include the chief executive officer, an agreed non-executive director or directors, an external assessor representing NHS Improvement/DH or successor bodies and such other persons as may be agreed to be helpful.
- ensure that posts are openly advertised and that the appointment procedure at all times complies with the Trust's policies, standards and general procedures on recruitment and selection. This will include ensuring compliance with fit and proper person regulations (FPP).
- keep the Trust board informed of the process, procedures and timetable to which it is working, as appropriate.

8.1.3. *Remuneration of executive directors*

- agree on behalf of the Trust board the remuneration and terms of service of the executive directors and that the executive directors are fairly rewarded for their contribution to the Trust, having proper regard to its circumstances and performance, and to the provision of any national arrangements or directives for such staff where relevant. Approve the remuneration policy for executive directors and executive team members, including approving the performance criteria for bonuses where appropriate and agreed. For the Chief executive, the Committee will advise the Chair regarding the framework for bonuses, in accordance with contract of employment.
- agree and review annually the remuneration policy framework for very senior managers (VSM) not on national contracts, including executive directors. Determination of the salaries of very senior managers, other than executive directors, is delegated to the chief executive officer or relevant executive director, advised by the director of people & OD and working within the agreed policy framework. The committee will review annually the earnings of such managers including senior clinicians and clinical managers.
- establish the parameters for the remuneration and terms of service for the appointment of executive directors, with delegated authority of the chief executive officer to agree starting salaries within the agreed parameters.
- agree the termination of contract of executive directors and the payment of any redundancy or severance packages in line with prevailing national guidance.

8.1.4. *Performance and Succession Planning*

- monitor the performance both individually and collectively of the executive directors in the context of their responsibilities and objectives, inputting into the annual review of performance by the Chief executive and receiving a summary of the final outcomes of the appraisal.
- ensure the capability of potential or nominated deputies for executive directors to effectively deputise during periods of extended absence on the part of the Executive directors.
- oversee an assessment of the capability and succession potential of the Trust leaders in order to identify any strategic gaps requiring appropriate intervention and

to receive assurance regarding the succession plans for directors and talent management; including assurance regarding equality in the succession planning.

9. **Reporting responsibilities**

9.1. The committee chair shall report to the board after each meeting on the nature and content of its discussion, recommendations and action to be taken.

9.2. The Committee shall make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

9.3. The Committee shall oversee the production of an annual report of the Trust's remuneration policy and practices which will be part of the Trust's Annual Report.

10. Engagement with stakeholders

10.1. The Committee chair should attend the annual general meeting to answer any stakeholder questions on the Committee's activities.

11. Executive lead and meeting administration

11.1. The director of people and OD shall support the Committee in advising the Committee on employment issues and procedures, and shall agree agendas and papers with the committee Chair.

11.2. The Committee shall be supported administratively by the Trust company secretary, who will distribute papers, take the minutes and keep a record of matters arising and issues to be carried forward.

12. Other matters

12.1. The Committee will:

- have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;
- be provided with appropriate and timely training, both in the form of an induction programme for new members and on an on-going basis for all members
- give due consideration to laws and the regulatory framework within which the Trust operates;
- at least once every two years review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Trust board for approval, any changes it considers necessary.

13. **Work Programme**

13.1. The Committee will prepare an annual work programme detailing the items expected to be considered at each meeting.

13.2. The Work Programme is to be a living document, updated for each meeting.

13.3. Review of the Work Programme is to be a standing agenda item.

14. **Monitoring and review**

14.1. The Trust board will monitor the effectiveness of the Committee through a summary of the Committee's minutes and any further written or verbal reports that the chair of the Committee might provide.

14.2. The secretary will review all agenda items to ensure they align with the Committee's responsibilities.

Approved: 2 March 2021

Appendix 1

Posts for which the Committee has responsibility

EXECUTIVE DIRECTORS
Chief executive
Chief finance officer
Medical director
Director of nursing
OTHER DIRECTOR LEVEL DIRECT REPORTS TO CHIEF EXECUTIVE
Divisional directors
Director of people & organisation development
Chief information officer
Director of communications
Director of redevelopment
Director, Imperial Private Healthcare
Director of transformation
Director of operational performance
Director of strategy, research and innovation
Director of Corporate governance & trust secretary