BARTS HEALTH NHS TRUST

TRUST BOARD MEETING (PART 1)

There will be a meeting of the Trust Board in public on
Wednesday 9 July 2025 at 11.00am in Rooms 129/30, Wolfson Institute, Charterhouse Square, London, EC1M 6BQ
Scheduled to end by 13.45

AGENDA

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

		Paper TB	Lead	Time
1.	**WELCOME**		Prof Ian Jacobs	11.00
2.	**APOLOGIES FOR ABSENCE:** Ms K Kinnaird, Prof C Knight			
3.	**DECLARATION OF INTERESTS** To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting including gifts and hospitality (accepted or refused)			
4.	**TRUST BOARD MEMBERSHIP** To note changes to Trust Board membership	49/25	Prof Ian Jacobs	
5.	**MINUTES** To approve the Minutes of the meeting held on 7 May 2025	50/25	Prof Ian Jacobs	
6.	**MATTERS ARISING** To consider any matters arising from the Minutes not covered elsewhere on the agenda		Prof Ian Jacobs	
7.	**PATIENT STORY** To hear a patient story		Ms Caroline Alexander	11.05
8.	**CHAIR'S REPORT** To receive the Chair's report		Prof Ian Jacobs	11.25

		Paper TB	Lead	Time
9.	**CHIEF EXECUTIVE'S REPORT** To receive the Chief Executive's report		Mr Shane DeGaris	11.30
10.	**WORKING IN PARTNERSHIP** To receive a place-based partnership update	51/25	Ms Ann Hepworth	11.35
QUALITY AND PERFORMANCE				
11.	**REPORTS FROM BOARD COMMITTEES** 10.1 Audit and Risk Committee 10.2 Finance Investment and Performance Committee 10.3 Nominations and Remuneration Committee 10.4 Strategy and Partnerships Committee 10.5 Quality Assurance Committee	 52/25 53/25 54/25 55/25 56/25	 Ms Helen Spice Mr Adam Sharples Prof Ian Jacobs Ms Sarah Teather Prof Hilary Thomas	11.45
12.	**INTEGRATED PERFORMANCE REPORT – 2025/26 M2** To discuss the IPR (and related assurance committee exception reports): • **Our Patients** ○ *Quality and Safety* ○ *Operational performance* ○ Equity • **Our People** • **Enablers** *Financial performance*	57/25	Prof Sanjiv Sharma / Ms Caroline Alexander Ms Rebecca Carlton Mr Ajit Abraham Mr Daniel Waldron Mr Hardev Virdee	12.25
STRATEGIC DELIVERY PLANS AND IMPLEMENTATION				
13.	**PEOPLE STRATEGY** To receive an update on the people strategy	58/25	Mr Daniel Waldron	12:55
14.	**BOARD ASSURANCE FRAMEWORK** To receive and approve revised BAF entries	59/25	Mr A Hines	13.05
GOVERNANCE				
15.	**NURSING AND MIDWIFERY ESTABLISHMENT** To approve the yearly review of establishment	60/25	Ms Caroline Alexander	13.15
16.	**YEARLY REPORTS** 16.1 Safeguarding report	61/25	Prof S Sharma / Ms Caroline	13.20

	16.2 Complaints	62/25	Alexander	
17.	**USE OF THE SEAL** To approve the use of the Trust seal	63/25	Mr Sean Collins	13.30

18.	**ANY OTHER BUSINESS**			
19.	**QUESTIONS FROM MEMBERS OF THE PUBLIC**			13.30

20.	**DATE OF THE NEXT MEETING** The next meeting of the Trust Board in public will be held on Wednesday 10 September 2025 at 11.00 in Room 5A/B, Education Centre, Mile End Hospital, Bancroft Road, London E1 4DG			
21.	**RESOLUTION** That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (section (2) Public Bodies (Admissions to Meetings) Act 1960).			

Sean Collins
Trust Secretary
Barts Health NHS Trust
020 3246 0642

Report to the Trust Board: 9 July 2025	TB 49/25

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

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

- The appointment of Professor Sanjiv Sharma and Ms Rachael Corser to the positions of Chief Medical Officer and Chief Nurse (and voting members of the Trust Board) with effect from 2 April 2025 and 25 August 2025 respectively.
- Mr Hardev Virdee, Chief Financial Officer, will also undertake the role of Deputy Chief Executive with effect from 1 September 2025.
- Ms Rebecca Carlton, Chief Operating Officer, will continue in her role and also assume voting membership of the Trust Board.

Related Trust objectives
n/a

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

Legal implications/ regulatory requirements	No direct legal implications identified.

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

TB 50/25

BARTS HEALTH NHS TRUST

TRUST BOARD MEETING (PART 1)

Minutes of the Trust Board meeting held in public on
Wednesday 7 May 2025 at 11.00am in the Board room, Junction 6, Whipps Cross Hospital, Leytonstone, E11

Present:
Professor Ian Jacobs (Chair)
Mr Adam Sharples (Vice Chair)
Mr Shane DeGaris (Chief Executive)
Professor Hilary Thomas (Non-Executive Director)
Professor Sanjiv Sharma (Chief Medical Officer)
Mr Andrew Hines (Director of Group Development) *
Ms Caroline Alexander (Chief Nurse)
Mr Hardev Virdee (Chief Finance Officer)
Ms Rebecca Carlton (Chief Operating Officer) *
Mr Daniel Waldron (Director of People) *
Ms Ann Hepworth (Director of Strategy and Partnerships) *
Dr Ajit Abraham (Director of Inclusion and Equity) *
Dr Neil Ashman (Chief Executive, Royal London and Mile End Hospitals)*
Mr Simon Ashton (Chief Executive, Newham University Hospital) *
Ms Kim Kinnaird (Non-Executive Director)
Ms Lesley Seary (Non-Executive Director)
Ms Sarah Teather (Associate Non-Executive Director) *
Mr Siva Anandaciva (NExT Director) *

In Attendance:
Mr Sean Collins (Trust Secretary)
Mr Shalin Sharma (Deputy Trust Secretary)
Ms Gurjit Mahil (Deputy CEO, Whipps Cross)
Mr Justin Creigh (Deputy CEO, St Bartholomew's Hospital)
Mr Jon Hibbs (Director of Communications)

Apologies:
Ms Joni Nelson-Ferns (Non-Executive Director)
Dr Amanjit Jhund (Chief Executive, Whipps Cross Hospital) *
Professor Charles Knight (Chief Executive, St Bartholomew's Hospital) *
Ms Helen Spice (Non-Executive Director)
Professor Sir Mark Caulfield (Non-Executive Director)
Mr Clyde Williams (Associate Non-Executive Director) *

** Non-voting member*

39/25 WELCOME

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

40/25 DECLARATION OF INTERESTS

Attendees were reminded of the need to declare any interests they may have in connection with the agenda or interests acquired since the previous meeting, including gifts and hospitality (accepted or refused).

No declarations were made.

41/25 MINUTES OF THE PREVIOUS MEETING

The Minutes of the meeting of the Trust Board held in public on 5 March 2025 were received and approved.

42/24 MATTERS ARISING

There were no matters arising.

43/25 PATIENT STORY

The Chief Nurse and Whipps Cross Medical Director introduced Mr Gary Saunders, who shared his experience of care at the hospital.

Mr Saunders recounted his recent experience as a blind patient following admission via the Emergency Department (ED). He explained that he had fractured his hip and attended the ED on a Thursday evening during what was, based on his past experience, a relatively busy time. He was eventually called by a doctor for an X-ray, at which point he had not yet received any pain medication. Unfortunately, triage was interrupted due to a police incident involving an urgent case taking priority. Racial abuse of a staff member accompanied this incident, which had been upsetting and unsavoury for all present. Mr Saunders noted that he had waited approximately five hours for an X-ray and its results, during which time he and others had no access to pain medication. Once his X-ray results were confirmed, he was admitted, awaiting a CT scan. From this point, he felt well looked after and was allocated a bed in Chestnut Ward (which he found to be a better experience than a previous stay in HDU). It was a very good facility with a single room. As a patient with a disability, he appreciated being asked what he needed. Medical staff kept him informed, though he noted he had to ask for drinks rather than a regular trolley service, which could disadvantage less proactive patients. The day after his procedure, he remained affected by the anaesthetic, and staff recognized his concern. Overall, he described a very

caring experience, including follow-up treatment exploring an osteoporosis diagnosis with ample information provided. He felt that discharge information provided by email was a positive development and supported his recovery, including self-inoculation support, and that community support steps worked well. He is still awaiting a hospital follow-up to confirm next steps.

The Chair asked about opportunities to improve pain relief. Mr Saunders stated that it was poor in the ED but good on the ward, where staff were responsive to feedback on its effectiveness. As a light sleeper, he found it difficult to sleep in the fairly noisy environment. The Whipps Cross Medical Director noted a workstream for improving analgesia and process improvements to ensure doctors inform the nurse in charge to prioritize medication delivery to the ED. Audits were in place to monitor the effectiveness of these changes.

Ms Kinnaird asked if there was confidence that the ongoing work was addressing the root cause of delays to patients receiving pain relief. The Whipps Cross Medical Director was confident that improvements had been made and reducing the time between prescription and administration in the ED by approximately 80% was helping to address this issue. Ms Kinnaird asked whether there was sufficient sensitivity in the ED to Mr Saunders as a patient with additional needs. Mr Saunders felt he was not treated differently, which had some advantages. He recognised that there could be ways to more quickly reflect known patient needs.

Professor Thomas noted that similar issues were discussed by the Quality Assurance Committee. He also noted comments about follow-up and external pressures to reduce the number of these in the future. He asked if there was a need to balance this approach. Mr Saunders felt the key was explaining the process to the individual and whether or not a follow-up would be standard practice. As a blind patient, he tended to ask more questions than some but felt that smaller wards appeared to be better at communicating. The Whipps Cross Medical Director noted important steps, including primary care interface meetings and ways to improve patient discharge information to support the increasing move towards Patient Initiated Follow-Up (PIFU) processes.

The Chair thanked Mr Saunders for joining to explain his experience at short notice and welcomed the details of the care provided and examples of opportunities for improvement. Mr Saunders noted that he had witnessed many improvements since his previous experience of care at the hospital approximately eight years ago.

44/25 CHAIR'S REPORT

The Chair reflected on how impressed he had been during his visits to each of the Trust sites and by the staff he had met. In the previous week, he had been delighted to attend the launch of the Academic Centre for Healthy Ageing at Whipps Cross Hospital, recognising an important academic health collaboration. He had also been impressed by the quality of the executive team, having attended a recent senior leadership forum.

The Chair acknowledged national changes across the NHS, with organisational challenges and changes on the horizon without a clear long-term forecast. It was possible that a reduced emphasis on the Integrated Care Board (ICB) role would require a more proactive leadership role from acute providers. He acknowledged that funding would be a key consideration for any reorganisation and it was important that a plan be developed in response. He felt that ongoing discussions with the ICB, life sciences partners and Barts Charity would be important to maintain, with the relationship between the chairs in North East London (NEL) acute providers providing a strong foundation for this dialogue.

The Chair highlighted the need to build on the Trust's successes, noting the recent 10th anniversary of the Barts Heart Centre, which had provided a step change in the quality of heart services in London. St Bartholomew's Hospital (SBH) and Royal London Hospital (RLH) were considered the 5th and 10th best hospitals in a national review based on the views of clinicians and clinical outcomes. He had begun discussions with Board colleagues on a range of initiatives for Non-Executive Directors (NEDs) to support efforts to optimise clinical activity and reduce duplication. The Chair noted that, at a time of intense pressure, it would be important to celebrate successes.

He noted his pleasure in returning to Whipps Cross after a long hiatus. He admitted that he had expected to encounter a challenged workforce operating within the constraints of an ageing infrastructure. He had been very impressed to find an energetic, enthusiastic team of staff and noted that, despite disappointment regarding delays to redevelopment plans, the evident commitment to an impressive vision for the future.

45/25 GROUP CHIEF EXECUTIVE'S REPORT

The Chief Executive extended his congratulations to the leadership team at Whipps Cross Hospital for the successful implementation of the 'DrDoctor' application. This innovative platform provided patients with text message reminders regarding appointments, and early indications demonstrated a positive impact on patient experience and service efficiency. The Trust was committed to exploring further opportunities to leverage artificial intelligence (AI) to enhance healthcare delivery.

In terms of strategic planning, the Chief Executive highlighted the publication of a model Integrated Care Board (ICB) which would inform ongoing

collaborative efforts within the health system. A number of health and care services were successfully transitioning to a neighbourhood-based model, signifying a commitment to delivering care closer to communities.

He acknowledged the significant financial challenges anticipated for the current year which would present considerable risks and necessitate difficult decisions concerning workforce and non-pay expenditure and require productivity enhancements. Colleagues would request the Board's support and guidance throughout the year in navigating these complexities.

The Chief Executive concluded the report by confirming the appointment of a new Group Chief Nursing Officer, Rachael Corser, who would assume the role during August.

46/25 WORKING IN PARTNERSHIP

The Director of Group Development provided an update to the Board on ongoing collaboration at both borough and Acute Provider Collaboration (APC) level. A review had been conducted, assessing past achievements and future priorities. He highlighted significant successes achieved through partnership working, notably the reduction of waiting times for planned surgery and substantial progress in shortening waiting times for cancer patients. Demonstrable investment in diagnostic capacity had delivered tangible outcome benefits. Looking forward, the Director of Group Development acknowledged the demanding operational and financial landscape. Future collaborative efforts would focus on a small number of specialities, initially identified as Ear, Nose, and Throat (ENT), Gynaecology, and Dermatology, to deliver enhanced benefits to patients through integrated working. The establishment of an integrated procurement function was now at an advanced stage and the Trust was considering a multi-year approach to collaboration with Barking, Havering and Redbridge University NHS Trust (BHRUT) and Homerton University Hospital NHS Foundation Trust. Joint committees were already in place to facilitate these partnerships.

Ms Teather emphasised the need to measure the impact of collaborative measures being undertaken and reflect on the potential challenges associated with prioritising these initial services for integration. She highlighted some structural issues in provision of gynaecology services across the sector and that benefits could only be realised through substantial investment in Women's Health Hubs and their integration. Ms Seary also asked about collaborative actions that could be undertaken to make a significant impact on reducing both waiting times and health inequalities. The Director of Group Development confirmed there was a clear clinical consensus that focusing on these specific services would deliver the most tangible difference to patient care. He acknowledged the challenge of accurately scoping and defining realistic goals for these initiatives. He

anticipated that more detailed information would be provided, alongside assurances regarding progress on how Women's Health Hubs would interface with acute trusts and the broader health system.

The Chair noted the importance of overcoming any negative perceptions that may arise from collaborative working and recognised that the key models and structures for this were still evolving.

The Trust Board noted the report.

47/25 INTEGRATED PERFORMANCE REPORT

(i) Quality and Safety

The Chief Nurse stated that the Care Quality Commission (CQC) revisit was ongoing. She noted that an issue with Friends and Family Test (FFT) provider downtime had now been corrected. A national C-difficile outbreak required monitoring and there were some concerns regarding traction on MRSA prevention, underlining the need to ensure best practice on infection prevention measures. The report also reflected a higher level of obstetrics incidents and steps being taken as a result.

Ms Teather welcomed the identified improvement in compliance with four-hour emergency care waiting times.

The Vice Chair asked about the benefits of FFT reporting in the context of some areas reporting response rates below 10%. The Chief Nurse explained that figures this month were an anomaly due to the technical issues identified and were normally in the 20-30% range for these services.

(ii) Operational Performance

The Vice Chair noted that the Finance, Investment, and Performance Committee had met twice since the last Board meeting. He highlighted a thematic review of theatre productivity and the importance of new IT systems supporting this. While not yet seeing a direct correlation with improved metrics, he was optimistic that changes, alongside other key improvements (such as consultant rostering), would improve productivity. Several areas had seen reduced waits, including diagnostics and cancer. Remaining areas of concern involved longer waits, and he highlighted the cutover to a new LUNA system to improve visibility and reporting of long-waiting patients. He noted strong assurances that no patient safety issues had been identified as a result of this system change. While this had increased the overall number of reported long waiters, attracting regulator interest, this was a necessary transition during an important change with longer-term benefits for reporting accuracy.

The Chief Operating Officer noted the introduction of the DrDoctor digital application and the anticipated improvements that this would provide on outpatient performance. Regarding cancer waits, progress was being seen against the three key standards, though a small number of challenged specialties remained a focus. The sarcoma pathway had been an outlier recently, although improvement was now being seen partly as a result of St Bartholomew's Hospital taking on additional work from other hospitals. On urgent and emergency care, Urgent Treatment Centre (UTC) improvements were evident at each site, but further progress was needed to meet the level of performance standards seen at other London trusts. Mental health pathways in EDs remained a challenge. She confirmed the return to tier 1 elective support and ongoing meetings to plan improvements.

The Chair asked about the ongoing situation regarding mental health patient waits in emergency departments. The Chief Operating Officer noted the active role of mental health trusts in supporting in-hospital care but confirmed that the insufficient bed capacity outside the hospitals was not being resolved. She noted the need to continue working with partners. Average length of stay for this patient cohort had reduced but progress was felt to have plateaued. The Chief Operating Officer confirmed that there were both physical capacity and financial constraints affecting progress. The Chief Executive of Newham University Hospital confirmed the rising demand for mental health services. Beyond the issue of insufficient mental health beds, a wider system concern was the lack of temporary accommodation impairing the flow of patients back into the community.

Ms Seary confirmed that there had been similar discussions at Barking, Havering and Redbridge University Hospitals NHS Trust board meetings and suggested discussing this as part of the Acute Provider Collaborative work. She expressed concern about emergency departments becoming a place of last resort for safety, particularly for younger people with mental health issues. Professor Thomas agreed that this was a national issue and there might be some learning to be gained from the NHS system in Hertfordshire. The Chief Operating Officer agreed that this was a widely acknowledged national issue and, across the group, efforts were being made to manage this pathway as safely as possible. The Deputy Chief Executive of Whipps Cross Hospital highlighted a workstream focusing on children and young people and it was clear that this was a particularly prevalent issue for Outer NEL patients. The Chair recommended escalating this to the Integrated Care Board as a known issue requiring a system approach. The Chief Executive suggested discussion of this should be in the wider context of financial constraints and 2025/26 plans.

ACTION: Chief Operating Officer

(iii) Equity

The Director of Equity and Inclusion updated on the Trust's review of waiting lists which indicated there was no significant difference in waiting times observed according to age or deprivation across the group. However, the report highlighted a statistically significant variation in waiting times for Whipps Cross patients residing in more deprived areas and this trend was being actively monitored. Some differences in average waiting times were identified based on gender and learning disability status, primarily linked to extended waiting times in gynaecology and restorative dentistry respectively. It was also noted that there had been an increase in the overall number of patients with learning difficulties attending hospitals.

Ms Seary noted the importance of prioritising efforts to reduce waiting times for restorative dentistry services. The Chief Executive of The Royal London and Mile End Hospitals noted the specialist dentistry teams were managing complex caseloads. He suggested that a visit by Non-Executive Directors to these teams would provide valuable insight into the work being done.

(iv) People

The Director of People provided an update on key workforce metrics. The sickness absence rate remained stable at 4.4% and while this figure demonstrated consistency, efforts were ongoing to reduce the figure to 4%. Regarding staff appraisals, the current completion rate stood at 67% against a target of 70%. The Trust was committed to increasing this, with an ambition to achieve closer to 90% appraisal completion during the current year.

(v) Financial Performance

The Vice Chair commended the Chief Financial Officer for successfully delivering a control total target of £11.7 million deficit in 2024/25, recognising this was a significant achievement. He noted that achieving a balanced financial plan in 2025/26 would present considerable challenges due to the absence of elective recovery funding and the need to take difficult financial decisions to meet challenging savings targets. The Chief Financial Officer also confirmed the successful delivery of the Trust's capital plan for 2024/25 within the allocated budget.

The Chief Financial Officer reported that, during 2024/25, the Trust had maximised its income by delivering a higher volume of activity than initially planned, generating an additional £70m. This was achieved despite the pressures of industrial action and increased demand for mental health services. He highlighted that managing whole-time equivalent (WTE) staff numbers would be challenging during 2025/26, given the pressures to also meet activity levels to satisfy national targets. It was confirmed that no additional national funding would be available for delivering further activity and the strategies to achieve the financial plan would focus on maximising productivity, transforming services and managing workforce costs effectively.

Ms Teather enquired about the potential for utilising AI models to predict demand levels and inform capacity modelling. The Chief Financial Officer noted the need for a whole system response to known pressures, confirming that the recent increase in temporary staffing was attributable to a high volume of annual leave taken by staff in April. The Director of People confirmed that AI models for workforce planning were being developed at a national level. The Chief Operating Officer added that the Trust was adopting new AI processes to assist staffing rotas and scheduling processes.

The Chair asked about the potential risks to the financial plan, given the stretching targets. The Chief Financial Officer stated that the plan had undergone both local and national review and was considered to carry a high level of risk, including the identified reliance on £15m in savings to be delivered by system partners. Mitigation strategies were being developed to manage these pressures. He emphasised the importance of clearly communicating these challenges to the ICB to ensure access to further support mechanisms.

The Trust Board noted the report.

48/25 REPORTS FROM BOARD COMMITTEES

The Trust Board noted the exception reports from the Audit and Risk Committee, Quality Assurance Committee, and Finance, Investment, and Performance Committee.

Ms Kinnaird highlighted recent work of the Audit and Risk Committee, including details of recent Internal Audit reviews and draft accounts work accompanied by external audit interim assessments.

Professor Thomas updated on Board Assurance Framework (BAF) risks and The Royal London Hospital progress reporting, including details of Oral and Maxillofacial Surgery improvement work.

49/25 OPERATIONAL PLAN

The Director of Strategy and Partnerships introduced the operational plan for 2025/26 and provided an update regarding the Trust's response to recent national planning guidance. It was noted that this had been discussed previously at the Finance, Investment and Performance Committee, Group Executive Board and the Financial Recovery Board. The service transformation programme had commenced and progress was noted on the Equality Impact Assessment (EQIA) process, with developments undertaken to enhance its robustness. The Director of Strategy and Partnerships also noted the challenges being faced by NEL partners, confirming collaborative work was underway to address these shared issues.

The Trust Board noted the report.

50/25 NHS STAFF SURVEY

The Director of People provided an update on the data from the previous year's staff survey, noting that the results had now been published nationally. Over 10,000 staff members had completed the survey, representing a 49% engagement rate. This score was in line with the sector average for the first time and the Trust's score for staff recommending it as a good place to work was above the sector average. Improvements had been evidenced across all nine people promise themes. The areas where improvements were requested were identified, and it was confirmed that work was ongoing to further enhance these areas.

The Chief Executive of Newham University Hospital noted that the hospital had correlated survey results with other relevant metrics over a longer period. It was also reported that improvements identified through the survey had been embedded via the establishment of effective leadership team processes.

The Deputy Director of Whipps Cross Hospital felt that the hospital had been supported by the Trust's Wellbeing Team and was now better equipped to address staff survey concerns.

The Chair raised the question of plans to address race-based discrimination, violence and abuse from managers and staff, and sexual misconduct. Ms Kinnaird commended the steps being taken to tackle these areas, emphasising that a zero-tolerance approach was necessary. The Director of People confirmed that the Trust was actively involved in a national working group focused on how to address these critical issues and additionally, a leadership strategy was still being embedded within the Trust. Ms Seary noted continued concern on reported sexual safety and suggested the need for more visible actions to address this. The Director of People acknowledged that the Trust was an outlier in terms of sexual safety. Improvements were expected to result from poster campaigns, enhanced reporting mechanisms, and the provision of training for managers and bystander training. The Director of People confirmed that the high-profile of these campaigns had raised awareness and could have contributed to greater reporting via the survey. It was agreed to provide more detailed information at the next Board meeting in relation to the Trust's work in this area, linking it to the work being undertaken by the Equity and Inclusion Board.

ACTION: Director of People

The Trust Board noted the report.

51/25 WELL LED IMPROVEMENT PLAN UPDATE

The Director of Group Development provided the Board with a six-month progress update on the Well Led Improvement Plan. The plan's focus was on enhancing organisational effectiveness across the Trust. The plan had been developed following the identification of high-impact actions, with progress made in developing clinical and enabling strategies and strengthening annual planning processes. The Director of Group Development highlighted the role of compassionate leadership conferences and reported on steps to re-establish clinical networks within the Barts Health footprint. It was confirmed that Quality Improvement plans continued to be embedded across the organisation via the Group Executive Board, which was also strengthening group board reporting mechanisms.

The Trust Board noted the report.

52/25 EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE (EPRR)

The Trust Board reviewed and approved the post assurance report and subsequent actions to maintain and improve the EPRR function, noting two areas of best practice highlighted that had been shared nationally.

The Director of Group Development confirmed cyber security plans had been developed and an internal audit of cyber security was at draft stage, prior to being reviewed by the Audit and Risk Committee.

Ms Kinnaird asked if there would be a deep dive into supply chain risk. The Director of Group Development confirmed the annual assessment would be covered at the Audit and Risk Committee, citing the work already done and the further improvement work required.

53/25 ANY OTHER BUSINESS

There was no other business.

54/25 QUESTIONS FROM MEMBERS OF THE PUBLIC

Questions were submitted by Newham Save our NHS campaign group in relation to women's health hubs, the fire enforcement notice; and any plans for introducing subsidiaries for outsourcing support services.

The Newham Chief Executive confirmed:

- Plans for a Newham women's health hub to be developed, working with NEL ICB to agree the support for this.
- The multi-year phased investment programme was designed to meet all aspects of the fire safety enforcement notice. He confirmed that, after conclusion of the phase 4 works, approximately 55% of the improvement works would remain outstanding. Work on the façade

of the Gateway centre was included in phase 4 and was expected to conclude by Quarter 4 of 2026/27.

The Chief Financial Officer indicated that the NHS was under significant pressure to deliver savings and to explore a range of opportunities. Plans for transformation programmes existed and at this stage there were no specific plans for creating a subsidiary or vehicle for outsourcing of support services. Although many trusts successfully ran subsidiaries providing such services, Barts Health did not currently operate any wholly owned subsidiaries.

The Action for Whipps campaign group highlighted concerns about the Whipps Cross estate and asked about any plans to update the baseline assessment and health and care services strategy devised in 2019 to inform the clinical and capacity modelling for any new redevelopment (to reflect ICB priorities, changes in local demographics, workforce and clinical developments).

The Director of Strategy and Partnerships confirmed that the Whipps Cross health and care services strategy (developed in the context of a Trust-wide 5-year clinical strategy) remained important. Service users and carers would be involved in development of any new pathways arising from the development of a new 5-year strategy (due to be published later this year) with priorities aligned to those set out in the 2019 Whipps Cross strategy.

55/25 DATE OF THE NEXT MEETING

The next meeting of the Trust Board in public would be held at 11am on Wednesday 9 July 2025 in Rooms 129/130, Wolfson Institute, Charterhouse Square, London, EC1M 6BQ.

Sean Collins
Trust Secretary
Barts Health NHS Trust
would020 3246 0641

Action Log

Trust Board 5 March 2025			
No.	Action	Lead	By
1	The Chief Operating Officer would escalate the issue of rising MH demands with the ICB, in the wider context of financial constraints and 2025/26 plans.	COO	July 2025
2	The Director of People would provide more detailed information at the next Board meeting in relation to the Trust's work on sexual safety/awareness, linking it to the	DOP	July 2025

	work being undertaken by the Equity and Inclusion Board.		

Report to the Trust Board: 9 July 2025	TB 51/25

Title	Working in Partnership
Accountable Director	Group Director of Strategy and Partnerships
Author(s)	Fiona Peskett, Director of Strategy and Integration
Purpose	This report provides an update in relation to the emerging health policy shift to a model of Neighbourhood Healthcare and the development of NEL ICB to a Strategic Commissioner. This will be subject to further enhancements upon the publication of The *10YHP* – due on 3 July 2025
Previously considered by	Barts Health Group Executive Board

Executive summary

Barts Health is an active partner in our three Place Partnerships in Newham, Waltham Forest and Tower Hamlets. This update focuses on the emerging policy anticipated from the publication of the *The 10 Year Health Plan (10YHP)*, and the shift to establishing a neighbourhood model of care in each borough across North East London (NEL).

The 2025/26 NEL roadmap for delivery of neighbourhoods will focus on implementing the core integrated neighbourhood team for both adults and children, enabled by a population health management approach.

The timeline for this work to be undertaken within one year, is set out through a series of outputs in each quarter of 2025/26. The actions for quarter one have been led by ICB colleagues with good engagement from Barts Health and provider partners.

Q1
- System and places to commit to the neighbourhood vision, strategy and goals
- Each place-based partnership to convene a neighbourhood delivery programme
- System-wide enabling structures mobilised, with strong links to pan-London enablers
- Neighbourhood boundaries defined by all places and agreed at system level

Q2
- Population health management platform (Optum) providing neighbourhood data
- Key make-up and functions of the integrated neighbourhood teams for adults and BCYP agreed by each place. To include: population cohort it will serve initially; membership of the team; model of care

Q3
- OD initiatives start– initially focusing on building relationships across the neighbourhood
- Early testing of the neighbourhood team model – taking a co-production approach
- Evaluation methodology and expected impact from the team agreed

Q4
- Implementation of integrated neighbourhood team– using a test and learn approach, so they will adapt over time
- Plans for Y2 developed, to focus on community connections, prevention and health inequalities

This work is of increasing importance in 2025/26 because:

- The partnership supports the Secretary of State's ambition to shift care from 'hospitals to the community' and from 'treatment to prevention';
- 18-week wait performance is enhanced by effective advice and guidance, and co-management of patients with chronic conditions between primary and secondary care;
- Urgent and Emergency Care performance is enhanced by better links between primary, community and mental health care with emergency departments, avoiding long waits and admissions; and
- Joint work to improve patients' underlying health, and to manage chronic conditions effectively, improves outcomes and avoids unnecessary hospitalisations.

Related Trust objectives	
All	
Risk and Assurance	8. Failure to develop mature and effective place-based partnerships and neighbourhood models – affects the management of emergency care mental health pathways in the short term and co-ordination of demand management in the medium term - impairing the response to population growth, and improving equity of access, experience and outcomes
Legal implications/ regulatory requirements	None Legal implications and regulatory requirements will be reviewed once *The 10YHP* has been published.

Action required

The Board is asked to:

- Note the emerging policy shifts in the NEL system;
- Approve the approach to continue pioneering Place-based integration work through the development of Integrated Neighbourhood Teams across the Barts Health footprint, including through the integration of new digital tools that span the primary-secondary care interface;
- Embed Place-based partnerships into the Group Clinical Strategy; and
- Support the convening of Place-based leaders across the Group to engage, share, learn and accelerate change.

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 9 JULY 2025

WORKING IN PARTNERSHIP

RECAP ON WORK TO DATE

1.1 Following the election of the new government in July 2024, Lord Ara Darzi was commissioned to undertake a diagnostic review of the current state of the NHS.

1.2 His report highlighted the 'critical condition' of the NHS driven by factors including austerity and the COVID-19 pandemic. He set out the need for three key shifts - *Treatment to prevention; hospital to community; and analogue to digital*, which will be explored further in *The 10YHP* (due 3rd July 2025).

1.3 Since the publication of the Darzi report, there have been major policy shifts in key areas including elective care. We have also entered an extremely challenging operating environment, with a strong focus on improving quality and performance in areas such as waiting times, coupled with significant financial challenges across the system to address.

1.4 At a local level, there are fundamental changes planned to the delivery of health and care with a focus on the development of neighbourhood health models. This work is likely to feature heavily in *The 10YHP* and development has been proceeding at pace with the recent publication of the London Case for Change and Target Operating Model, which includes a description of the new role of the Place based Integrator.

DEVELOPMENT OF NEL STRATEGIC COMMISSIONER

2.1 ICBs have been tasked to reduce their running costs by 50% and to do so at great pace, ahead of the 26/27 financial year. A Model ICB Blueprint clarifies the future role of ICBs as the Strategic Commissioner for local systems and sets out a list of functions that need to transition out of ICBs over time (although further clarity is still needed in many areas).

2.2 Functions to be transferred to providers are listed as:

- local workforce development and training;
- green plans and sustainability;
- digital leadership (enabled by national data and digital infrastructure);
- development of neighbourhood and Place-based partnerships (with ICBs retaining their commissioning role for neighbourhood health services);
- medicines optimisation (with ICBs retaining overview as part of their commissioning role);
- pathway and service development programmes (ICBs retaining strategic overview); and
- estates and infrastructure strategy.

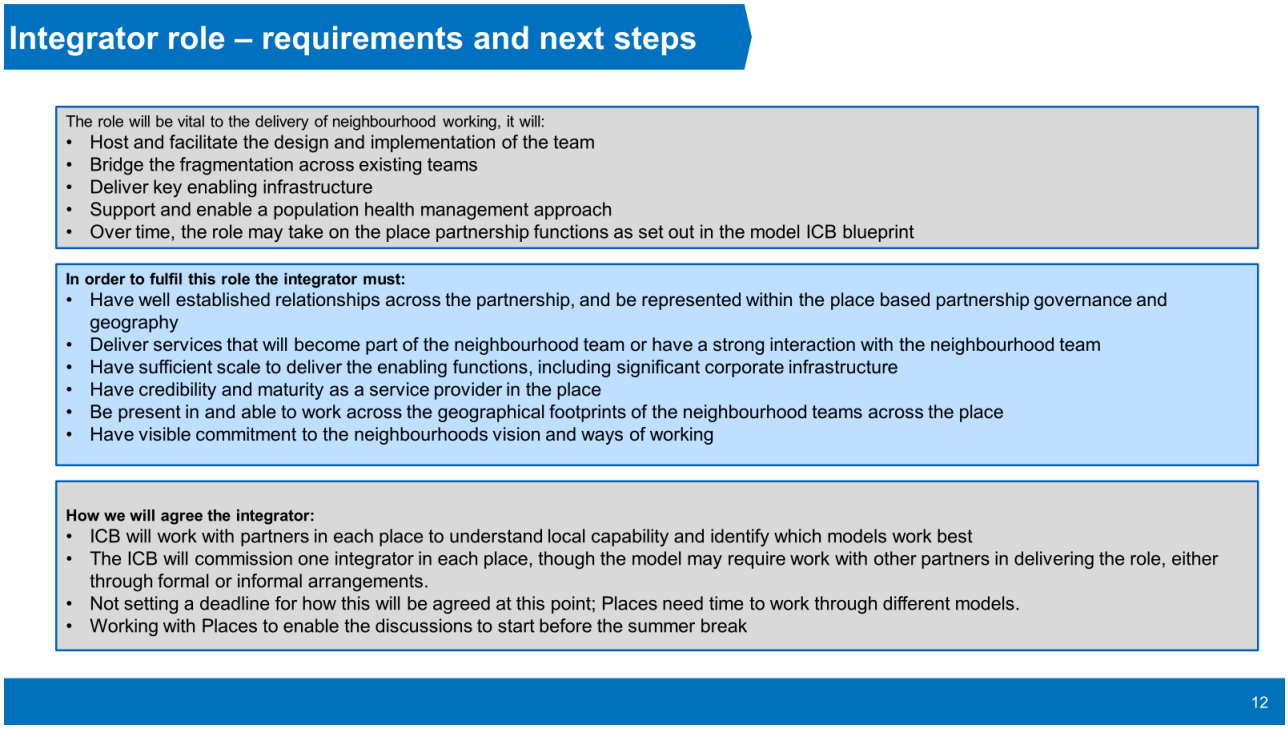
2.3 Infection prevention and control, safeguarding, SEND, NHS Continuing Healthcare and General Practice IT will also be considered for transfer, although detail about where these will go are not shared at this point.

NEIGHBOURHOOD HEALTHCARE

3.1 The London Case for Change sets out that neighbourhood health at Place is key to delivery. The structure of the operating model for neighbourhood health sets out the new role of an Integrator at Place and how this role will be undertaken by a provider organisation that is nominated by the key stakeholders in Place.

3.2 The role of the Integrator in Neighbourhood Healthcare will be to ensure the effective delivery of Integrated Neighbourhood Teams (within Place), operating a level of scale that will allow sufficient organisational resources, capacity and capabilities to be available across all associated neighbourhood teams, whilst drawing on the local knowledge, experience and relationships from local professionals and communities.

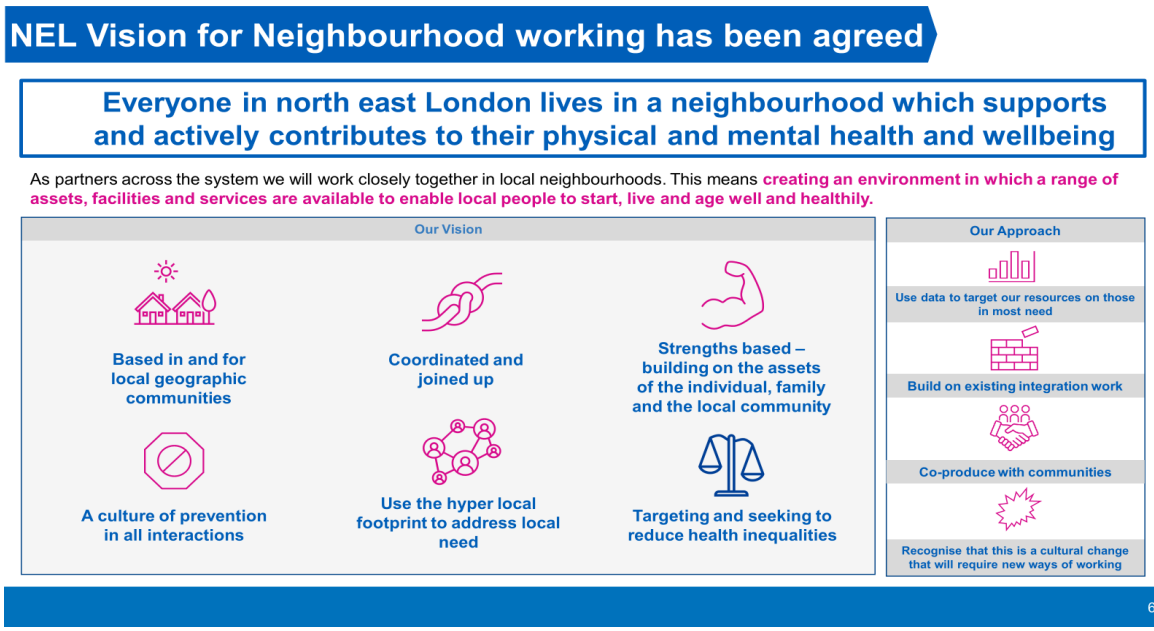
3.3 Current discussions from the NEL ICB have highlighted the following expectations for fulfilling the role of Integrator and the steps to be undertaken in determining which provider this will be.



3.4 Through continuing to engage with NEL ICB on the development of this model there is an opportunity to test different avenues of lead provider roles and partnership working.

NEL ROADMAP FOR 2025/26 DELIVERY OF NEIGHBOURHOOD HEALTHCARE

At the NEL ICB Board meeting in March 2025, the following vision was signed off.



4.1The following goals set out the outputs anticipated by moving to a neighbourhood integrated care model.

4.2 Trusts will play a fundamental role in how services are integrated locally, and work is already underway in other parts of the country where transformation of outpatient services are moving into integrated neighbourhood teams.

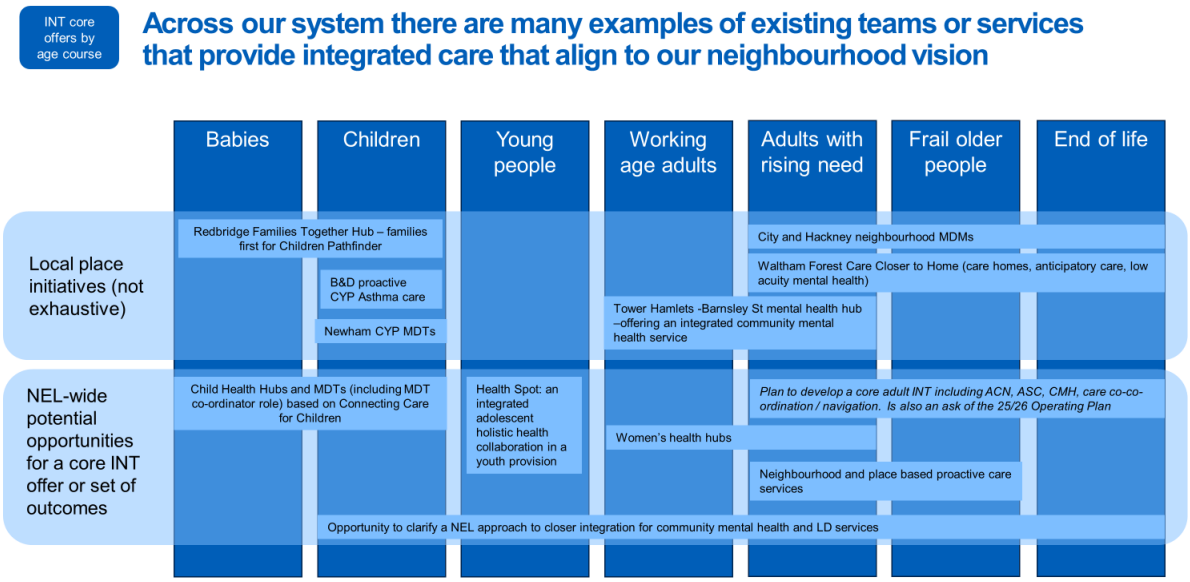
4.3 Given the recently published Barts Health clinical strategy, this presents an opportunity for us to drive forward and work collaboratively with other provider partners across our

footprint, to focus on areas such as long-term conditions delivering care that is not based in a hospital setting.

4.4 Barts Health are working in partnership with each of our Places. The table below indicates the current state and number of Integrated Care Teams, Primary Care Networks, GP practices and the population size of each of our boroughs.

London Borough	No. of INTs	No. of PCNs	No.GP Practice	Population Size
Newham	8	7	39	351,500
Tower Hamlets	4	7	36	310,300
Waltham Forest	3	7	39	278,400
Total	**15**	**21**	**114**	**917,600**

4.5 The following highlights some of the existing integrated care initiatives already underway across the 7 Places in NEL.



4.6 Given the current financial challenges that we are faced with as a Trust, change is imperative. *The 10YHP* will set out a clear vision of the specific policy choices the government will make and the trade-offs these require.

4.7 The shift from treating sickness to prevention is the ultimate prize as it will enable a truly transformational approach. The focus on prevention also clearly connects *The 10YHP* with the government's mission to build services fit for the future. Key to transformation will be ensuring services are co-designed so that needs are met, and care is truly patient centred.

4.8 We are focussed on the opportunities that can be realised through improved digital solutions, which will assist our service users and interoperability with our primary care partners, where areas of interface need a solution.

4.9 The case to continue to develop our partnership working at Place is clear. We need to collaboratively build a strategic response to population growth and need. Through the

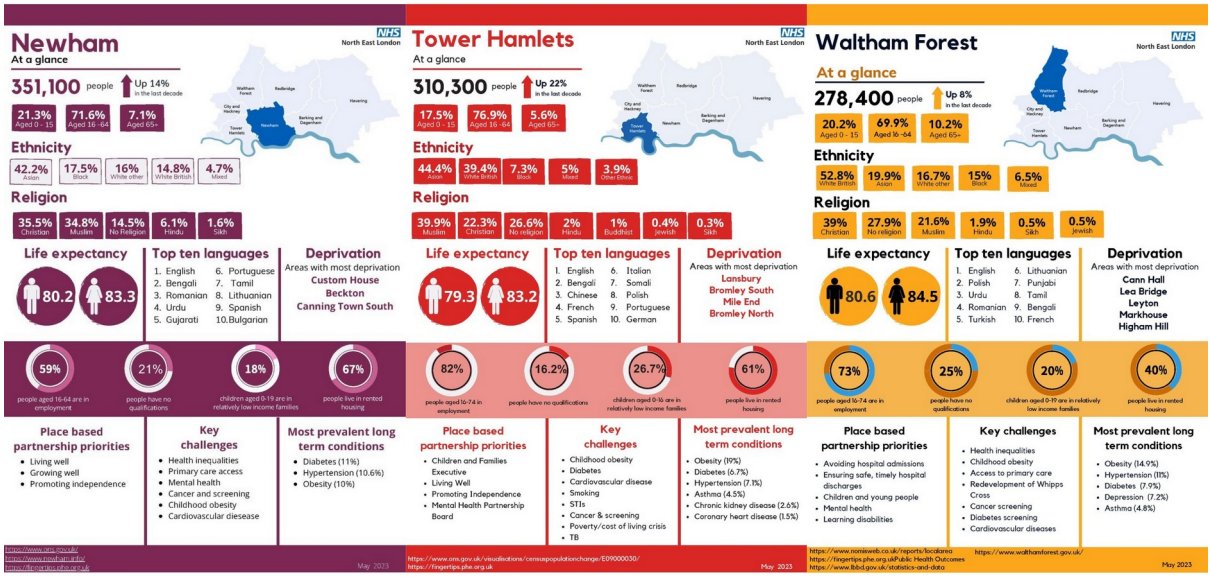
development of our integrated neighbourhood team offer at Place, we are aiming to step up our partnership working to shape delivery that responds to the community in the right Place and at the right time.

4.10 The Board is asked to:

- Note the emerging policy shifts in the NEL system;
- Approve the approach to continue pioneering Place-based integration work through the development of Integrated Neighbourhood Teams across the Barts Health footprint, including through the integration of new digital tools that span the primary-secondary care interface;
- Embed Placed-based partnerships into the Group Clinical Strategy; and
- Support the convening of Place-based leaders across the Group to engage, share, learn and accelerate change.

Appendix One

The overview below highlights the population health demographics of each of our boroughs.



Report to the Trust Board: 9 July 2025	TB 52/25

Title	Audit and Risk Committee Exception Report
Chair	Ms Helen Spice, Non Executive Director
Author(s) / Secretary	Trust Secretary
Purpose	To advise the Trust Board on work of Trust Board Committees (detailed minutes are provided to Board members separately)

Executive summary

The Audit and Risk Committee met on 11 June 2025 to discuss items on its agenda (drawn from its annual workplan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items	**BAF entries**
Annual report and accounts with letter of representations	All
External audit annual report and audit completion report	All
Provider licence	All
Internal Audit progress report and Head of Internal Audit opinion	All
BAF and high risks report	All
Information governance yearly report and DPS Toolkit	All
Counter fraud	All
Committee effectiveness	All

Key areas of discussion arising from items appearing on the agenda

Annual report and accounts

The committee considered the and endorsed the 2024/25 annual report and accounts. Following amendments to reflect Committee feedback and subsequent board approval, the final version has been published and will presented at the AGM (later in the day). External Auditors welcomed a timely and engaged process for the related audit, while recognising some challenges this year associated with new audit requirements (with any learning to be considered in due course as part of a review of the process). The committee supported the letter of representations.

External Audit report

The Committee received and discussed the audit findings report. Significant assurance was received by the Committee regarding the process supporting the annual report and accounts and noted an unqualified opinion on the accounts. The Committee noted some minor adjustments with no material issues identified. The Value for Money report and auditor annual report provided a positive assessment of Trust systems of control, while noting steps taken to address CQC findings relating to their inspection of Whipps Cross urgent and emergency care services earlier in the year. As in recent years, a S.30 letter would be issued to reflect the Trust's deficit position as regards the statutory breakeven duty.

Internal Audit reports

The committee reviewed outcomes of audits completed since the last meeting. The committee noted sustained improvement in the number of overdue management actions

arising from audit reviews. Two reasonable assurance audits were considered, relating to the Trust's inclusion governance and Newham hospital governance arrangements.

Provider Licence

The committee considered the and endorsed the 2024/25 provider licence compliance statement confirming compliance with all licence conditions, with one exception (reflecting a prudent approach to declaring non-compliance with one licence sub-clause on meeting all constitutional standards throughout the year). Following subsequent board approval the required elements of this have been published.

Information Governance yearly report and DPS Toolkit

The Committee received its yearly report on information governance and approved the Data Protection and Security toolkit for submission noting a positive self assessment (supported by an annual Internal Audit review and 'substantial' assurance equivalent rating). The Trust Board is asked to note the expanded focus on cyber security arrangements in the latest toolkit and assurance provided on this area of risk.

Integrated risk report

The Committee spent time reviewing the BAF risks, appearing later on the agenda, and high risks appearing on the risk register.

Committee effectiveness

The Committee reviewed outputs of a survey of members seeking feedback on ways of working.

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

Approval of annual report and accounts, provider licence compliance and DPS toolkit submission.

Any issues for escalation to the Board

None.

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

Action required by the Board

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

Report to the Trust Board: 9 July 2025	TB 53/25

Title	Finance, Investment and Performance Committee Exception Report
Chair	Adam Sharples, Non Executive Director (Chair)
Author(s) / Secretary	Trust Secretary
Purpose	To advise the Trust Board on work of Trust Board Committees (detailed minutes are provided to Board members separately)

Executive summary

The Committee met on 4 June and 2 July 2024 to discuss items on its agenda (drawn from its annual workplan, arising issues relevant to its terms of reference or matters delegated by the Trust Board).

Key agenda items	**BAF entries**
Operational performance (constitutional standards)	3
Operational delivery networks thematic review	7
Monthly finance reports	9.10
Workforce reports	1,2
Contracts and waivers	10
Committee effectiveness	All
Service Line Reporting	10

Key areas of discussion arising from items appearing on the agendas

Operational performance (constitutional standards) M1 and M2

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

High levels of elective activity were being recorded although the overall wait list size remained high. The focus nationally remained on elimination of 72 week and 65 week wait patient cohorts. The Committee completion of a cutover to a new LUNA system and anticipated benefits of this and noted some success of digital developments in reducing numbers of 'did not attend' patients. The Committee reviewed emergency care performance and noted the need for consistent, high performing urgent treatment centres across the group as a key success factor. Key drivers for elective and non-elective performance remained early discharges, reducing medically optimised patient numbers and stabilising the mental health emergency pathway.

Operational delivery networks thematic review

A thematic review of Operational Delivery Networks highlighted the governance supporting joined-up working across hospitals, with ODNs in place for orthopaedics, gynaecology and urology (and further ODNs being established for endoscopy and ear, nose and throat [ENT] services). The ODNs, each hosted by one of the hospitals, had a strong operational focus with emphasis on reducing variation, standardising and harmonising pathways, and improving patient experience.

Workforce The Committee reviewed the workforce metrics and noted good performance on recruitment, turnover and absence rates. The Committee noted challenges to reduce WTE headcount despite progress in non-clinical areas. It was agreed to move towards a quarterly reporting basis for a number of workforce and productivity metrics. **Monthly finance reports** The Committee discussed and noted the monthly position reports (as summarised in the IPR). As anticipated, Months 1 and 2 progress against the very challenging financial control total set for the Trust represented a concern. In addition to review of the Trust outlook, the Committee spent time reviewing sector level financial performance. Details of Cost Improvement Plans were considered and the Committee noted the related impact assessment processes to assure on maintaining quality standards. **Capital programme report** The Committee noted infrastructure challenges associated with capital and 2025/26 plans featuring a forecast spend of c.£139m.
Any key actions agreed / decisions taken to be notified to the Board -
Any issues for escalation to the Board -

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

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

Report to the Trust Board: 9 July 2025	TB 54/25

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

Date of meeting
The Nominations and Remuneration Committee met on 11 June 2025

Key areas of discussion arising from items appearing on the agenda
At this meeting the Committee approved nominations to voting board positions for the following:

- The appointment of Ms Rachael Corser to the position of Chief Nurse (and voting member of the Trust Board) with effect from 25 August 2025.
- Ms Rebecca Carlton, Chief Operating Officer, would also assume voting membership of the Trust Board.

Following the resignation of Mr Andrew Hines, the Committee agreed not to reappoint to the role of Director of Group Development (aligned with plans featuring financial restraint) and agreed changes to executive portfolios to redistribute key responsibilities.
An update was provided on a new national VSM pay framework and the Committee discussed the implications of this for the Trust's very senior manager cohort. The Committee noted other VSM appointments and changes and received the outputs from a survey of members assessing the effectiveness of the committee's ways of working.

Any key actions agreed / decisions taken to be notified to the Board
Nominations to voting board positions for the incoming Chief Nurse and incumbent Chief Operating Officer

Any issues for escalation to the Board
None.

Legal implications/ regulatory requirements	n/a

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

Report to the Trust Board: 9 July 2025	TB 55/25

Title	Strategy and Partnership Committee Exception Report
Chair	Sarah Teather, Associate Non-Executive Director
Author / Secretary	Shalin Sharma, Deputy Trust Secretary
Purpose	To advise on work of Trust Board Committees

Executive summary

The Strategy and Partnership Committee met on 3 July 2025 to discuss items on its agenda relevant to its terms of reference.

Key agenda items	**BAF entry**
• Terms of reference	All
• Strategic Context	All
• Deep dive: ICB blueprint and integrated roles	8
• Ten year organisational strategy	8,12

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

Terms of reference (ToR)

- At its inaugural meeting, the committee reviewed the ToR, which would be slightly revised following the discussion.
- The committee agreed to meet quarterly, serving to provide advice, guidance, and recommendations on strategic matters to assist the Group Executive Board. Its core purpose is to shape the long-term Trust strategy, including the continued development of the Group Model, and to explore strategic options. Key objectives include
    - Oversee the development of clinical and organisational strategy based on 10-year, 5-year, and 3-year outlooks, incorporating horizon-scanning and national policy.
    - Provide advice on healthcare trends and emerging opportunities.
    - Identify potential strategic risks and propose mitigations.
    - Review supporting enabling strategies and plans, making recommendations to the Trust Board for approval.
    - Support integration with wider sector strategy and identify further opportunities for partnerships within and beyond the NHS to enhance healthcare delivery.
    - Contribute to shaping Board seminars.

Strategic Context

- The committee noted opportunities from closer integration and improving engagement with specialist services.
- Concerns were raised regarding tertiary and inpatient hospitals potentially discontinuing services.
- There were actions to further investigate specialist services development; and assess the implications and mitigations for potential service changes in tertiary and inpatient pathways.

ICB blueprint and integrated roles

- Discussions were held around the financial basis for neighbourhood health, including transition challenges.
- The Group Director of Strategy and Partnerships identified numerous opportunities for the population, some of which may not incur significant costs or for which funding cases can be made. Specific examples included Preventative Health and Women's Health Hubs.
- There was a need to carefully distinguish between the roles of an Integrator, an Accountable Care Organization (ACO), and a Neighbourhood Provider, as these represented different functions.
- The committee discussed inviting international ACO exemplars to share their lessons learned.
- The committee agreed to explore the opportunities and risks attached to the emergence of neighbourhood health and the Integrator role.
- The committee agreed to support executive conversations with the ICB and partners to establish a NEL approach to identifying the Integrator role.

Ten year organisational strategy

- The session focused on the approach for developing a long-term vision for the Trust, emphasising a values-based, inclusive model centered on staff engagement and community involvement.
- It was agreed a robust 10-year strategy was crucial for the Trust to navigate the current healthcare landscape that was rapidly transforming due to demographic shifts, technological advancements and evolving health needs.
- The proposed strategy aimed to ensure that the Trust remained responsive, sustainable, and capable of delivering high-quality, integrated care.
- The committee agreed the necessity of a 10-year plan and endorsed the proposed framework for the development of the 10-year strategy.
- The committee approved initiation of the Discovery & Listening Phase commencing in April 2026.
- The committee agreed to look at international and domestic comparators for IHOs/integrator.
- The committee agreed to commission two pieces of work - one of the costs of early intervention and one on understanding what partners think about us to support our work on integration.

Any issues for escalation to the Board / Audit & Risk Committee

- None.

Legal implications/ regulatory requirements	-

Action required

The Trust Board is asked to note the report.

Report to the Trust Board: 9 July 2025	TB 56/25

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

Executive summary

The Quality Assurance Committee met on 14 May 2025 to discuss items on its agenda relevant to its terms of reference.

Key agenda items	**BAF**
• St Bartholomew's Hospital Quality Report	1-6, 12
• Cancer Performance Update	
• Quality Report	
• OMFS Update	
• Maternity Report	
• Estates and Facilities Report	
• Equality and Quality Impact Assessments	
• BAF 6 Deep Dive Report	
• Quality and Safety Internal Audit Reports	
• Committee Effectiveness Report	

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

St Bartholomew's Hospital Quality Report

- Progress and improvement were reported in patient care, safety and engagement were noted since the last report in September 2024.
- Governance processes and plans to support the new group clinical strategy and development of the centre of excellence were outlined.
- Risks and challenges include the imaging backlog, monitoring of IPC standards, and lack of staff morale. Exploration of ways to increase staff morale in the breast cancer centre was a priority challenge.
- The hospital acted as a role model for other group sites by sharing learning and best practice.

Cancer Performance Update

- Performance against the three cancer standards in 2024/25 was challenged, with specific services contributing to not achieving targets in March 2025.
- Gynaecology, Urology, and Colorectal services underwent deep dives, revealing a need for access policy improvements, which have since been implemented and sustained.
- Improvements were still required in imaging and histopathology.
- A deep dive on the new LUNA system was ongoing, with an update expected at the July committee meeting.

Quality Report

- High-level feedback was received from the CQC regarding Whipps Cross Hospital, with an

unannounced follow-up inspection expected.

- A record high number of mental health patients were recorded at the Trust during the CQC visit. Concerns were raised about ineffective MH patient liaison services at another NEL acute hospital and the lack of response at ICB level. Discussions were ongoing at Group Director level for escalation to the ICB.
- Actions were being taken to improve Infection Prevention and Control (IPC) following two reported MRSA infections. IPC deep dive results would be included in the next quality report.
- Focussed work was underway to close three open national safety alerts.
- Broad work was needed at Whipps Cross Hospital to address the timeliness of medication delivery.
- A Prevention of Future Deaths (PFD) notice was received at Whipps Cross Hospital, and discussions were being held with local coroners to improve responses.

OMFS Update

- An external consultant deemed the OMFS service safe, with minor improvement tasks being followed up.
- Some wider cultural improvements had been observed, including in the dental hospital. However, an ongoing case involving a single individual was being monitored weekly.
- An internal learning review found clear escalation processes exist, and externally commissioned reports will undergo executive review and board committee scrutiny.

Maternity Report

- Stillbirths were within expected rates in April, and no new cases were referred to MNSI since 28 February. 45 incidents were reported in March (down from 53 in February), all reported as moderate harm.
- Placenta medication has been aligned across the group to improve PPH rates. PPH prevention is multi-faceted, with engagement being a main focus and a need to ensure the right obstetric leadership.
- Community midwives at Whipps Cross Hospital had been updated on digital transformation processes.
- An appeal to NHS England regarding CNST compliance was successful, resulting in a rebate exceeding £3m, with planned investments to be discussed by the committee.
- Current birth centre developments were leading to an annual saving of £250k.

Estates and Facilities Report

- The Trust was in a stronger position than the previous year regarding estates risks, health and safety, cleaning standards, and workforce data recording.
- Three key risks (systems, workforce, and governance) were identified during the transition period of bringing previously externally managed staff in-house – and these were being mitigated.
- A request was made for the inclusion of soft facilities management (FM) KPIs in the report, which were available and would be shared.
- Group and hospital level support existed for recruitment and retention of older staff, and a positive apprenticeship programme was in place. System-wide succession planning was required.

Equality and Quality Impact Assessments

- The importance of appropriate processes for EQIA was highlighted, especially in the context

of current financial pressures.

- A summary of cost saving schemes was detailed, with three already signed off. Recommendations were being reviewed by the Group Executive Board.
- The purpose of the report would be made clearer, and a list of available proposals, some with significant system delivery changes, would be included. How EQIA risks were being captured would also be included.

BAF Risk Deep Dive

- Risk mitigations were considered. The "making data count" programme was crucial in strengthening audit and data outcomes.
- Confidence at group level existed in how estates were being managed.
- An item on ward accreditation would be reviewed by the committee at the next meeting.

Quality and Safety Internal Audit Reports

- Three "reasonable" and one "substantial" internal audit reports had been issued since the last meeting.
- Two recommendations regarding the remote consultations audit were outstanding, scheduled for completion in April 2026.
- The recommendation for improvement related to the SBH fertility audit had been accepted.
- Draft reports, including one on duty of candour, would be presented at the next meeting.

Committee Effectiveness Report

- The committee self-assessment survey showed generally positive results, with high scores for meeting clarity, purpose, and connectivity to the Trust board.
- Comments included the long discussion time for business matters, length of papers, and making better use of external benchmarking.
- Recent improvements in paper conciseness and effective use of meeting time were noted.

Any issues for escalation to the Board / Audit & Risk Committee

- None.

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

Action required

The Trust Board is asked to note the report.

Report to the Trust Board: 9 July 2025	TB 56/25a

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

Executive summary

The Quality Assurance Committee met on 2 July 2025 to discuss items on its agenda relevant to its terms of reference.

Key agenda items	**BAF**
• Whipps Cross Hospital Quality Report	1-6, 12
• Operational Update	
• Quality Report	
• Safeguarding Report	
• Complaints Report	
• MRSA Report	
• Maternity Report	
• Equality and Quality Impact Assessments	
• Quality and Safety Internal Audit Reports	
• Integrated Risk Report	

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

Whipps Cross Hospital Quality Report

- UEC changes implemented to help improve flow/waiting time performance.
- Temporary escalation space now closed.
- ETC improvements noted. No imminent concerns following Royal College visit in April 2025. No incidents of serious harm reported in last 12 months.
- UTC management complexities discussed.
- IPC monitoring work in ED expanded across the group, embedding good practice.

Operational Update

- UEC: performance was on plan but deteriorated in June to 68%. Hospitals working on clear plans to exit tier 1 level of oversight. UTC performance improvements were required.
- Elective: September elimination plan in place for patients waiting more than 78 weeks. Specific challenges in Gynae/ENT/Vascular with mitigations in place at Whipps Cross and The Royal London and Mile End hospitals.
- Cancer: strong performance continuing in all metrics.
- Diagnostics: Improvements reported. CT utilisation across the group prevented dramatic cessation of service. Some audiology risk reported. EPRR will act as additional governance lens.
- LUNA ToR noted following learning review.

Quality Report

- The committee received updates on paediatric audiology following an ICB report. Details of actions to be taken would be presented at the next meeting.
- Incidents of harms, two reported PFDs at Whipps Cross Hospital, two open safety alerts and the pharmacy technical service were also discussed.
- DMO1 external reporting issue looking to be resolved urgently by BIU team.

Safeguarding Report

- Training compliance continued to be a challenge for both adults and children level 3.
- Safeguarding children supervision compliance had improved.
- The committee discussed the reduction of referrals for both maternity and children since the previous reporting period.

Complaints Report

- Key risks and issues were noted, as well as achievements.
- A 29% increase in the number of reportable complaints was reported.
- The committee endorsed the improvement plan and 2025/26 priorities.

MRSA Report

- Largest number of cases (24) reported nationally between Sept 2024 and April 2025.
- Reinforcement of best practice in line care and aseptic technique prioritised along with targeted staff training and compliance monitoring on line management and blood culture pathway protocols
- Improvements noted in MRSA suppression protocols and cross-transmission prevention
- The committee supported the actions resulting from the deep dive and the plans for improvement, assurance and comment.

Maternity Report

- The Maternity Investment plan was agreed in principle. Priority schemes related to Governance Posts and Digital were agreed from this year's CNST rebate.
- Plans were progressing with LAS/NHS E London/NEL regarding Telephone triage service.
- Notice has been given to suspend intrapartum care at Barking Community Birth Centre from July 2025.
- MSSP: Plan to progress RLH and WXH to sustainability phase in December 2025.

Equality and Quality Impact Assessments

- The committee were updated on high risk EQIA's reviewed in May 2025 and visibility of low score EQIA's across the Trust.
- Key schemes were being reviewed by the EQIA Panel, who had met three times to date.
- The committee noted recommendations made by the EQIA panel
- The committee noted the number of schemes deemed as low score and the work taking place to thematically analyse any cumulative impact.
- The committee noted escalation to GEB regarding nil return on GSS Schemes

Quality and Safety Internal Audit Reports

- The committee noted the internal audit outcomes from the following audits:
- Duty of Candour Follow Up – Reasonable Assurance
- Maternity Governance – Reasonable Assurance
- MCA, LPS, DoLS Follow Up of a previous Limited Assurance Review – Substantial Assurance
- WXH3/RLH4: DOLS and Associated Mental Capacity Act Assessment Compliance – Limited Assurance
- The committee noted the progress in delivering the internal audit plan for relevant QAC

audits.

Integrated Risk Report

- BAF refreshed and Board to review in July.
- All high risks expected to reduce in the next few months.
- The committee reviewed an u[date on thematic deep dives, including noting demonstratable progress in estates and facilities.

Any issues for escalation to the Board / Audit & Risk Committee

- None.

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

Action required

The Trust Board is asked to note the report.

Barts Health Integrated Performance Report

July-25

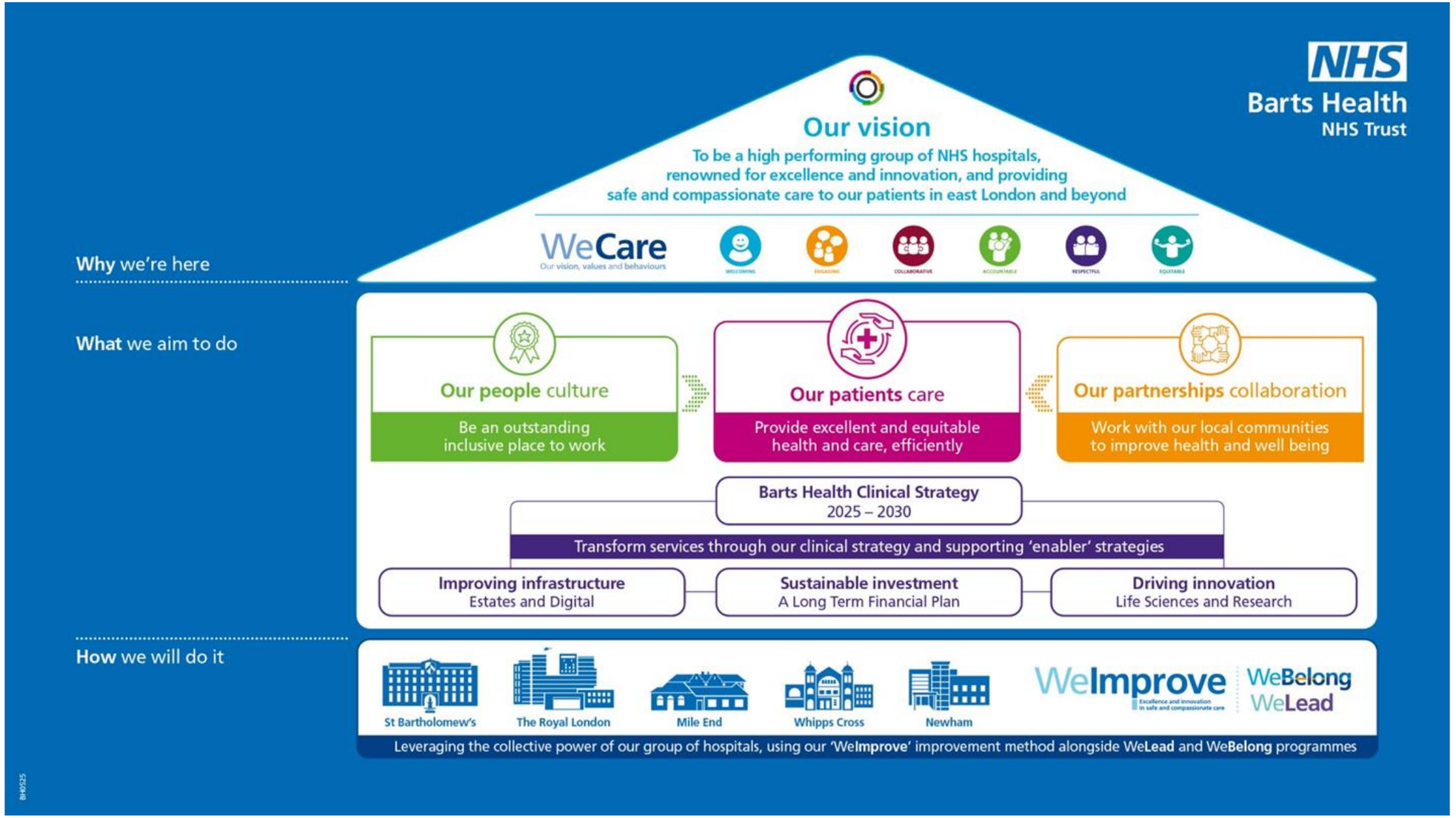
Performance for: **May-25**





Pack Contents

Barts Health Strategic Framework – sets out our vision, values and objectives as a Group, which we set our priorities and goals against.



Executive Summary

Executive Summary

Our Patients

Quality

Complaints

- There continues to be a downward trend in the number of complaints acknowledged in agreed time**.** Acknowledgement performance is a standing agenda item for the complaints management improvement group. The performance is largely driven by gaps within governance teams, with hospitals placing these on their respective risk registers and on-going monitoring through their Hospital Executive Boards. The complaints pathway model is undergoing a review which will include reviewing the interface between PALS and complaints service for promotion of early resolution opportunities.

Incidents Resulting in Harm (Moderate Harm or More)

- Women services continue to drive this increase largely related to harm categorisation accounting for 35% of these incidents in line with National reporting.

Infection prevention and Control

- The Trust recorded 24 MRSA bacteraemia cases between 1 April 2024 and 31 March 2025, exceeding the national zero-tolerance target. Of these, 18 cases were hospital-onset and 6 occurred within 28 days post-discharge. A separate thematic analysis report has been completed, which includes key findings and prioritization for 25/26 in relation to: aseptic technique training, reinforcement of best practice in relation to line care and improvements in MRSA suppression protocols and cross-transmission prevention.

Maternity and Neonates

- There are no outliers to report this month in terms of metrics. An MSSP reset and refresh meeting was held in June. This has led to NUH moving into the sustainability phase of the programme. A follow up meeting will be held in December where we anticipate RLH and WXH moving into the sustainability phase as well.

WXH Emergency Department

- The CQC revisited the ED department at WXH on 7 May 2025. This was a targeted follow up visit. We are currently awaiting the draft report. Improvements were noted in Infection Prevention and Control procedures and compliance, documentation and management of deteriorating patients. Key areas for on-going improvement focused on Mental Health pathways and capacity and flow within the department.

Operational Performance

Elective

- Following a significant period of preparation and engagement with NHS England, the Trust implemented its new Referral to Treatment (RTT) patient tracking list technology, LUNA. There are significant patient and organisational benefits for LUNA in terms of the improved data quality enhancements and there have been anticipated increases in the total PTL size in line with a fully updated and reportable PTL.
- Barts Health continues to be part of fortnightly Tier 1 oversight meetings with NHS England for both RTT and Diagnostics.
- Overall for elective care, whilst there has been good progress on 18 week RTT compliance and improvements in the RTT clearance rates, the Trust continues to address its long-waiter performance challenge as a key organisational priority. In response to this challenge, the Trust has stepped up additional governance and oversight for the longest waiting patients across all levels of the organisation.

Diagnostics

- Diagnostic waiting time performance across the Barts Health Group has been improving since December 2024. In May 2025, 80.58% of diagnostics tests were provided within 6 weeks. During May 2025, there have been improvements in performance against the diagnostic waiting time standard in Dexa scanning, MRI, neurophysiology, sleep studies and endoscopy.
- The diagnostic waiting list has remained relatively stable over the last 3 months and at the end of May was 31,491. There were concerns expressed through the Tiering process that MRI waits and volumes will need to demonstrate improvement in Q2.

Executive Summary

Operational Performance (contd)

Cancer

- The strong Barts Cancer performance from Q4 24/25 was maintained into April 2025, with compliance against all three national cancer standards: the Faster Diagnosis (FDS), 31-day and 62-day standards. The Trust had a strong benchmarked position across all three standards in April both regionally and nationally.
- There will be a tripartite focus over the summer months to sustain this strong performance position over the course of 25/26 through firstly reducing the 62 day backlog to less than 5%, secondly addressing unwarranted variation across Barts hospitals and finally continuing with improvement plans for four key tumour groups, Head and Neck, Colorectal, Gynaecology and Urology.

Unplanned Care

- Performance at the end of May demonstrates a sustained position against key national performance metrics. In May '25 the trust just missed the monthly 4-hour objective, recording a performance of 70.2% against a monthly trajectory of 70.4%. In terms of performance against the 4-hour standard, the Trust was ranked 14th out of 17 acute trusts in London and was ranked 5th out of the top 10 English acute trusts (ranked by volume of attendances).
- Type 3 performance in May was an area of concern, with the Trust's performance of 90.8% an outlier against other London providers, where the average Type 3 performance in May was 98.8%. NHS North East London NEL are about to undertake a contractual review of Type 3 provision across the ICB with the aim of delivering improvements across commissioned services including performance improvements

Our People

- In May we remained 494 WTE above the plan submitted to NHS England with substantive staff 83 WTE under plan and temporary staff 577 above plan.
- Temporary spend was at 11.2% the pay budget YTD, with agency spend at 1.3% YTD (just above target) and bank spend at 9.9% YTD above the 7.9% target.
- The substantive fill rate reduced to 91.9% for all staff and 91.3% for registered nursing and midwifery

Supporting Enablers

Finance

- The Trust is reporting a (£13.9m) deficit for the year to date at Month 2, which is (£6.0m) adverse against plan. Income and expenditure performance are planned to improve through the year as additional stretch savings within the breakeven plan start to impact with a planned surplus in the second half of the year.

- The key financial challenges for the Trust in achieving its plan for this financial year include:

    - Delivering the efficiency savings targets already set within Sites and Services budgets and the additional stretch savings target within the breakeven plan.
    - Improving productivity and control workforce costs.

NHS
Barts Health
NHS Trust

Our Patients – Care

'Providing excellent and equitable healthcare'

Improving Equity, Quality and Standards – Improve equity of access to care for our population

Summary : Improving Equity, Quality & Standards

The data covered in this report covers the Quality dashboard metrics for April 2025 reporting period in line with the Barts Health approach to reporting using Statistical Process Control (SPC) methodology. The report also provides updates from scheduled reports based on the established workplan in addition to other standing items.

Quality Indicator metrics

- **Complaints** – There continues to be a downward trend in the number of complaints acknowledged in agreed time and closure of complaints on time**.** The performance is largely driven by gaps within governance teams, with hospitals placing these on their respective risk registers and on-going monitoring through their Hospital Executive Boards. The complaints pathway model is undergoing a review which will include reviewing the interface between PALS and complaints service for promotion of early resolution opportunities. Further detail is available in the Complaints Annual Report.

- **FFT –** positive to see in-patient satisfaction ratings improving consistently across the hospitals with good response rates. Focused work in maternity and ED to improve response rates will continue. The qualitative data from FFT responses is used to inform improvements locally.

- **Incidents Resulting in Harm (Moderate Harm or More)** Women services continue to drive this increase largely related to harm categorisation accounting for 35% of these incidents in line with National reporting.

- **Infection prevention and Control -** The Trust recorded 24 MRSA bacteraemia cases between 1 April 2024 and 31 March 2025, exceeding the national zero-tolerance target. Of these, 18 cases were hospital-onset and 6 occurred within 28 days post-discharge. A separate Thematic analysis report has been completed, which includes key findings and prioritization for 25/25 in relation to: aseptic technique training, reinforcement of best practice in relation to line care and improvements is MRSA suppression protocols and cross-transmission prevention.

- **Open National Patient Safety Alerts**: 2 overdue alerts remain open; work progress to ensure compliance. These alerts are complex, and BH is not an outlier in relation to the completion of these.

- **Maternity and Neonates** – there are no outliers to report this month in terms of metrics. An MSSP reset and refresh meeting was held in June. This has led to NUH moving into the sustainability phase of the programme. A follow up meeting will be held in December where we anticipate RLH and WXH moving into the sustainability phase as well.

- **WXH Emergency Department** – the CQC revisited the ED department at WXH on 7 May 2025. This was a targeted follow up visit. We are currently awaiting the draft report. Improvements were noted in Infection Prevention and Control procedures and compliance, documentation and management of deteriorating patients. Key areas for on-going improvement focused on Mental Health pathways and capacity and flow within the department.

Domain Scorecard

Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Site Comparison: Whipps Cross	Site Comparison: Newham	Site Comparison: St Bart's	Data Quality
MSA Breaches	●			Apr-25 (m)	<=0	21	**28**	***28***	0	20	6	2	
FFT % Positive - Inpatients	●			Apr-25 (m)	>=91%	92.0%	**91.8%**	***91.8%***	89.9%	92.7%	93.8%	91.5%	
FFT % Positive - A&E	●			Apr-25 (m)	>=60%	61.8%	**61.8%**	***61.8%***	59.0%	68.9%	53.6%	-	
FFT % Positive - Maternity	●			Apr-25 (m)	>=93%	75.8%	**75.8%**	***75.8%***	70.7%	81.3%	79.4%	-	
FFT Response Rate - Inpatients	●			Apr-25 (m)	>=23%	31.7%	**27.6%**	***27.6%***	23.4%	42.8%	39.3%	19.0%	
FFT Response Rate - A&E	●			Apr-25 (m)	>=12%	6.4%	**6.4%**	***6.4%***	6.0%	8.4%	4.9%	-	
FFT Response Rate - Maternity	●			Apr-25 (m)	>=17.5%	7.3%	**7.3%**	***7.3%***	8.8%	4.6%	7.8%	-	
Complaints Replied to in Agreed Time	●			Apr-25 (m)	>=80%	79.3%	70.3%	*70.3%*	71.4%	68.3%	60.0%	100.0%	
Duty of Candour	●			Apr-25 (m)	>=100%	88.5%	**88.5%**	-	80.0%	100.0%	81.8%	100.0%	

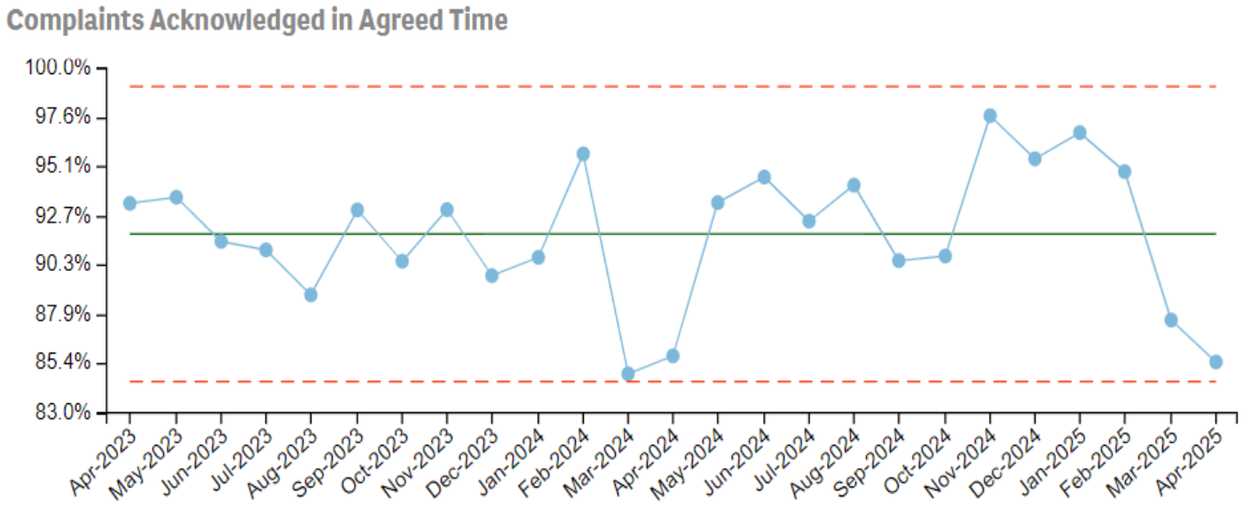
Domain Scorecard

Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Site Comparison: Whipps Cross	Site Comparison: Newham	Site Comparison: St Bart's	Data Quality
Clostridium difficile - Infection Rate	●			Apr-25 (m)	<= 16	11.8	**10.5**	***10.5***	12.5	6.1	9.5	13.4	◐
Clostridium difficile - Incidence	●			Apr-25 (m)	<= 13	8	**7**	***7***	4	1	1	1	◐
Assigned MRSA Bacteraemia Cases	●			Apr-25 (m)	<= 0	2	**4**	***4***	1	2	0	1	◐
MSSA Bacteraemias				Apr-25 (m)	SPC Breach	7	**12**	***12***	5	2	0	5	◐
E.coli Bacteraemia Bloodstream Infections	●			Apr-25 (m)	<= 29	33	**32**	***32***	11	9	4	8	◐
Never Events				Mar-25 (m)	-	0	**0**	***0***	0	0	0	0	
% Incidents Resulting in Harm (Moderate Harm or More)	●			Apr-25 (m)	<= 0.9%	3.1%	**3.0%**	***3.0%***	2.6%	3.0%	4.2%	1.5%	
Falls Per 1,000 Bed Days	●			Apr-25 (m)	<= 4.8	3.2	3.3	*3.3*	2.7	4.0	3.7	3.3	
Patient Safety Incidents Per 1,000 Bed Days				Apr-25 (m)	SPC Breach	46.4	**44.9**	***44.9***	32.6	60.2	54.9	47.9	
Pressure Ulcers Per 1,000 Bed Days	●			Apr-25 (m)	<= 0.6	1.2	**1.2**	***1.2***	1.2	1.2	1.3	1.0	
Pressure Ulcers (Device-Related) Per 1,000 Bed Days				Apr-25 (m)	SPC Breach	0.1	**0.1**	***0.1***	0.1	0.2	0.0	0.2	
Patient Safety Alerts Overdue				Apr-25 (m)	<= 0	3	**3**	***3***	-	-	-	-	
Summary Hospital-Level Mortality Indicator	●			Dec-24 (m)	<= 100	99	**100**	***100***	100	104	98	96	
Risk Adjusted Mortality Index	●			Mar-25 (m)	<= 100	88	**89**	-	91	86	80	104	
Cardiac Arrest 2222 Calls (Wards) Per 1,000 Admissions	●			Apr-25 (m)	<= 0.51	0.65	**0.84**	***0.84***	1.59	0.54	0.81	0.18	

- *Annual discharge data, ending in month indicated as 'This period', used for the generation of the indicator. Confirmed or suspected cass of Covid – 19 are excluded.*
- *The Trust is reviewing quality and safety data using statistical process control; this supports early identification of risk and enables proactive planning. A review of the metrics demonstrated common cause variation across the indicator metrics.*

Complaints Acknowledged in Agreed Time and Complaints Received (All) - Trust

IMPROVING EQUITY, QUALITY AND STANDARDS - SAFE



Indicator Definition:

Complaints Acknowledged in Agreed Time
The number of initial reportable complaints acknowledged within the agreed number of working days (which should usually be 3 working days). This is based on complaints received and considers both complaints already acknowledged and those not yet acknowledged

Complaints Received - All
The total number of initial complaints received by the trust, including both non-reportable concerns and reportable complaints

What is the Chart Telling us:

Complaints acknowledged in agreed time – The chart shows a decline in complaint acknowledgment performance against the 100% target. Notably, performance in the most recent period has reached its lowest point in the past year.

Actions taken:

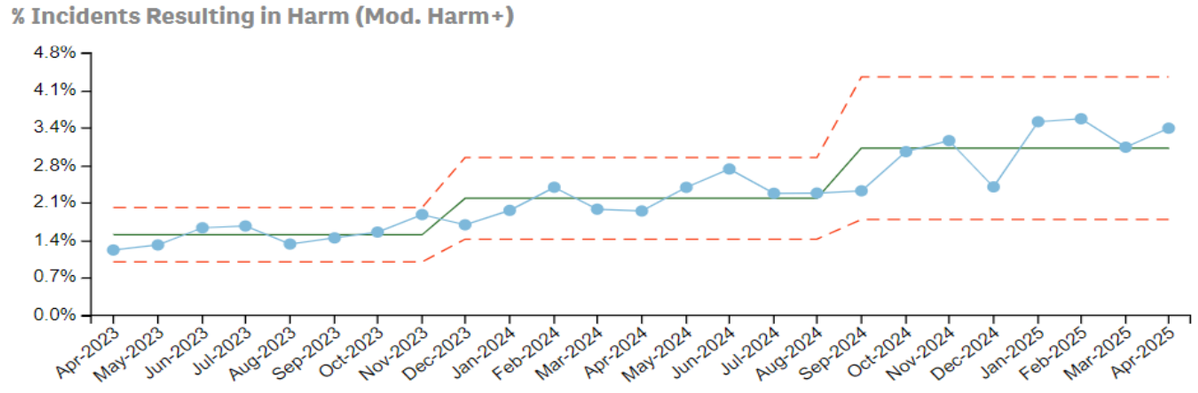
- Acknowledgement performance is a standing agenda item for the complaints management improvement group .
- improvement plan priorities include improving data quality to ensure appropriate downgrading of complaints and ensuring robust thematic triangulation with other experience of care insight to inform continuous improvement and learning from complaints to tackle the underlying themes

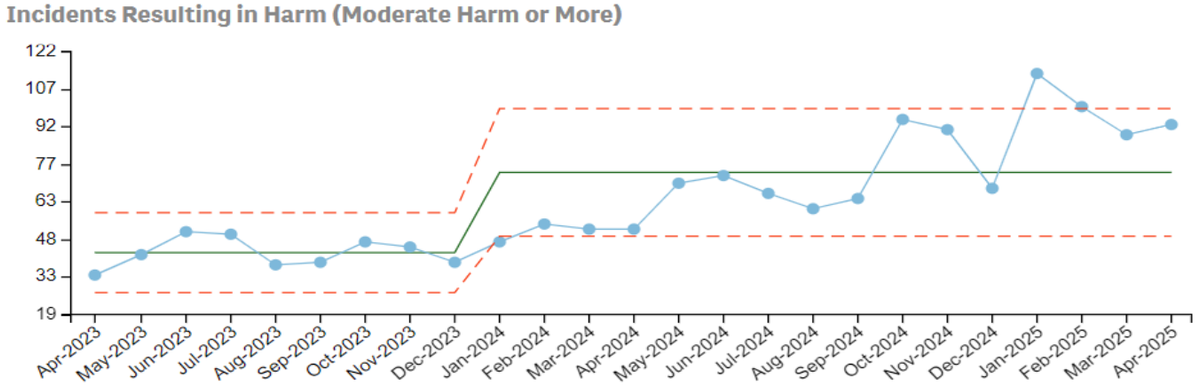
Issues and Risks:

- Acknowledgement performance below 100% means we are non-compliant with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 which informs our complaints management practice
- As part of the complaints management improvement plan, a pathway review will be completed that reports into the Experience of Care Strategic Oversight Group/Quality Board to ensure that our complaints pathway model is as responsive as possible

Incidents Resulting in Harm (Moderate Harm or More) - Trust

IMPROVING EQUITY, QUALITY AND STANDARDS - SAFE





Indicator Definition:

% Incidents Resulting in Harm (Mod Harm +)

The number of patient-related incidents occurring at the trust which caused harm (not including those which only caused low harm) divided by the total number of patient-related incidents occurring at the trust

Incidents Resulting in Harm (Moderate Harm or More)

The number of patient-related incidents occurring at the trust which caused harm (not including those which only caused low harm)

What is the Chart Telling us:

Common cause variation noted. There were 90 incidents reported as causing moderate or more harm across the group. Women services continue to drive this increase largely related to harm categorisation accounting for 35% of these incidents in line with National reporting.

Actions taken:

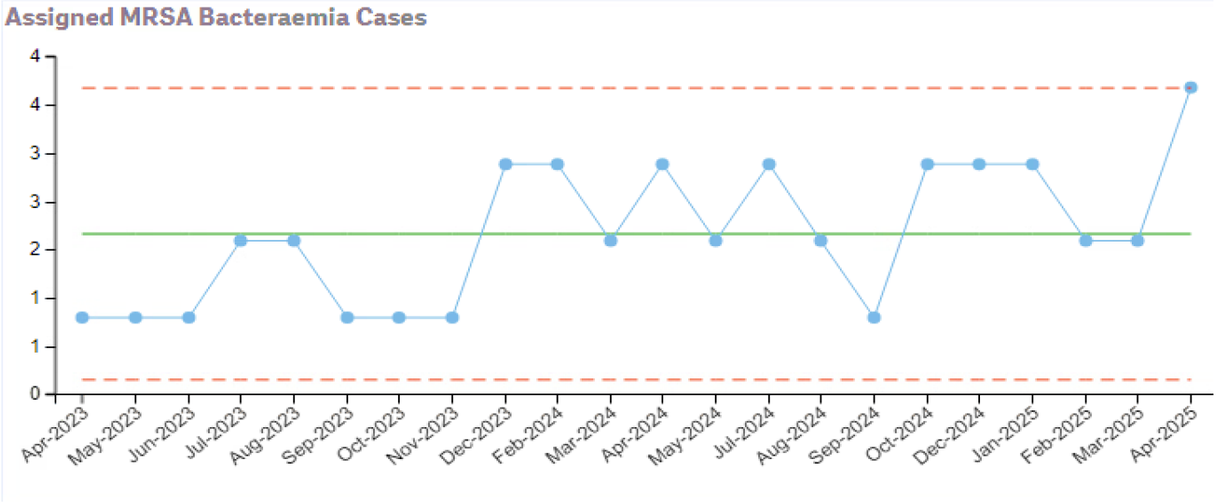
- Incidents are reviewed at Hospital Patient Safety Incidence Response Meetings.

Issues and Risks:

Improvements in reporting continue across the hospitals in line with CQC regulation 20, to ensure that all stillbirths and neonatal deaths are reported as moderate harm. Reporting of Major Obstetric Haemorrhage(MOH) and 3/4th degree tears in line with the regulation also continues to improve.

Assigned MRSA Bacteraemia Cases: Trust

IMPROVING EQUITY, QUALITY AND STANDARDS - SAFE



Indicator Definition:

The number of MRSA bacteraemia cases directly attributable to the Trust.

What is the Chart Telling us:

The Trust recorded 24 MRSA bacteraemia cases between 1 April 2024 and 31 March 2025, exceeding the national zero-tolerance target. Of these, 18 cases were hospital-onset and 6 occurred within 28 days post-discharge

Actions taken:

An internal review of all hospital-attributable cases has been completed.

To address identified gaps and strengthen infection control, the Trust has prioritised the following for 2025/26:

- Reinforcement of best practice in line care and aseptic technique
- Targeted staff training and compliance monitoring in line management, aseptic technique principles and blood culture pathway protocols
- Improvements in MRSA suppression protocols and cross-transmission prevention

These measures are instrumental in our commitment to reducing MRSA bacteraemia cases and further elevating the standard of Infection Control.

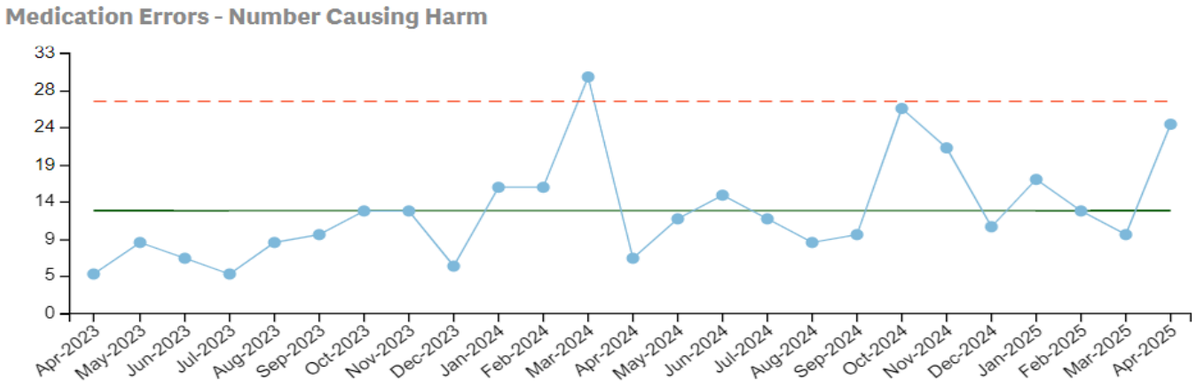
Issues and Risks:

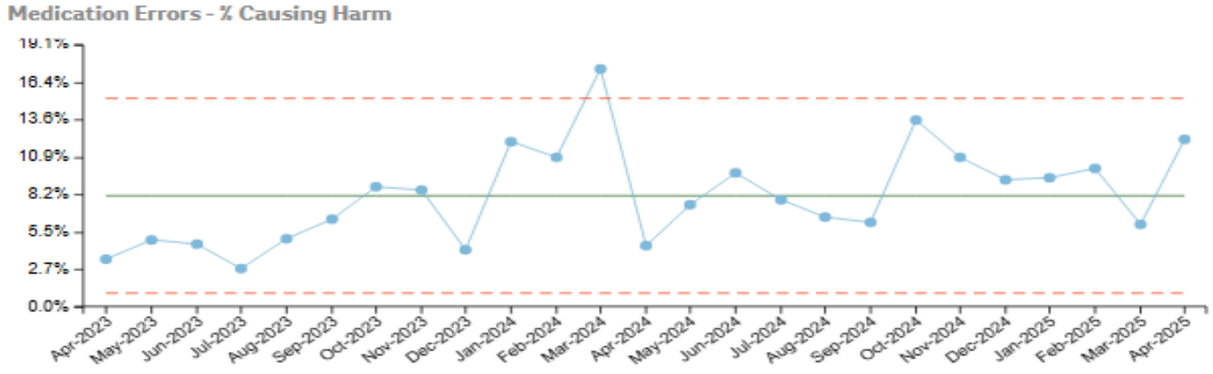
There is no official threshold set by NHS England for Healthcare-associated MRSA blood stream infection (HCA MRSA BSI); however, it is considered unacceptable (zero tolerance) for a patient to acquire an MRSA bloodstream infection whilst receiving care in a healthcare setting.

The IPC team are to conducting a thorough deep dive analysis and presenting findings and progress against the action plans to their local hospital IPC Committees.

Medication Errors – Number Causing Harm - RLH

IMPROVING EQUITY, QUALITY AND STANDARDS - SAFE





Indicator Definition:

Medication Errors – Number Causing Harm

The number of medication error incidents occurring at the trust which caused harm

What is the Chart Telling us:

Spike in incidents causing harm in April (12.7%) – all 24 were low harm incidents

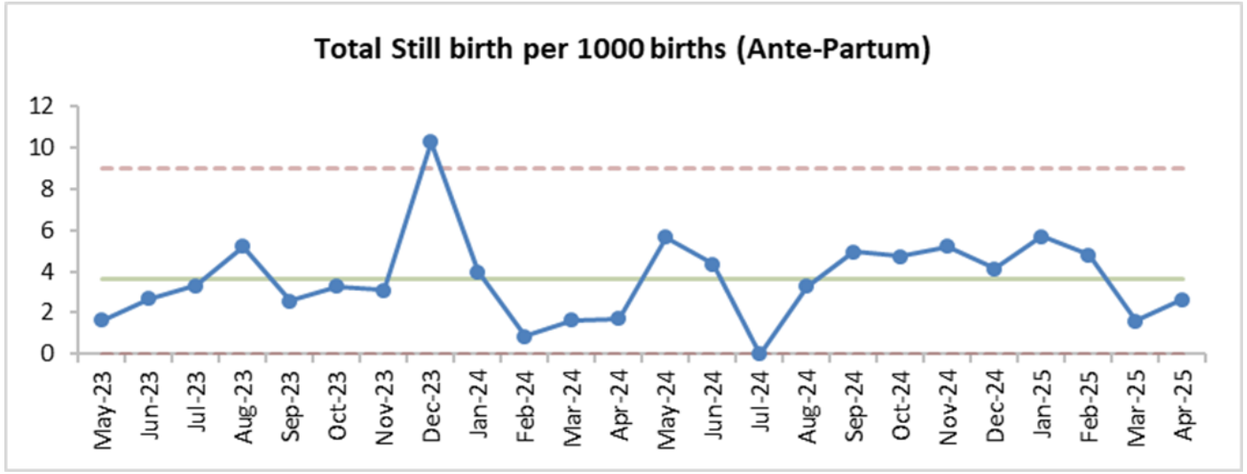
Actions taken:

- Sub-categories of incidents breakdown as 16 administration, 2 controlled drugs, 3 dispensing and 4 prescription incidents.
- The prescription tracking system has been installed and is currently in testing phase and then will be rolled out. This will allow consistent information about prescriptions, readiness and status of prescribed items.

Issues and Risks:

- Trends are monitored and overseen monthly at the Medicines Management Meeting and the Safety Committee. Actions recommended by pharmacy are cascaded at the Safety Committee

Still Births



Indicator Background:

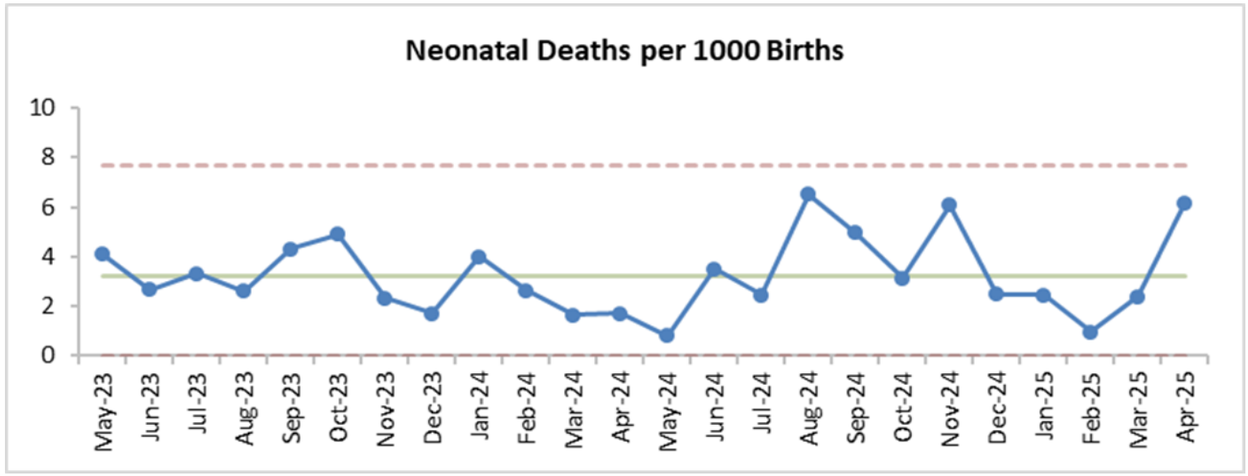
There is a national ambition to reduce stillbirth, neonatal death and brain injury by 50% by 2025. The stillbirth ambition is for the rate to decrease to 2.6 stillbirths per 1,000 births by 2025. The 2022 national rate was 4 stillbirths per 1,000 births. When compared to comparable organisations with level 3 NICU and neonatal surgery, Barts Health has slightly higher stillbirth rates. Rates across the organisation have seen a small decrease over the last five years, with the exception of a small rise during the peak of the first two waves of the pandemic, as seen in national data (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRACE) last published in 2024 for 2022 data).

What is the Chart Telling us:

There chart is telling us that overall for Barts Health there has been no significant change to the stillbirth rates.

Performance Overview	Responsible Director Update
There were 3 antenatal stillbirths in April. One was due to a fetal abnormality to a recent migrant. One case was following a significant antenatal haemorrhage, and the third to a woman on a low risk pathway who noted reduced fetal movements from the previous day.	All cases will have a perinatal mortality MDT review as per national guidelines. Further details are within the Maternity perinatal quality and safety report.

Neonatal Deaths



Indicator Background:

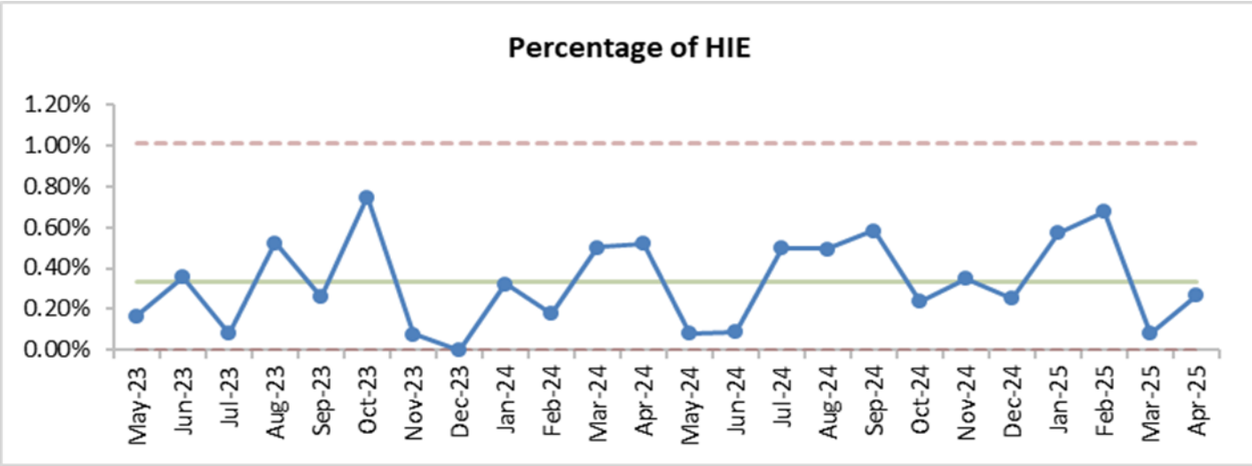
Prior to 2021, the national ambition covered all neonatal deaths, and required the neonatal mortality rate to fall to 1.5 deaths per 1,000 live births by 2025. In 2021, the ambition was revised, as outlined in the Safer maternity care progress report 2021.The ambition was changed to 1.0 neonatal deaths per 1,000 live births for babies born at 24 weeks or over (1.3 for all gestations).
When compared to comparable organisations with level 3 NICU and neonatal surgery, Barts Health has lower Neonatal death rates. MBRACE 2022 (last available data published 2024)

What is the Chart Telling us:

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

Performance Overview	Responsible Director Update
There were three neonatal deaths, one due to significant abnormality not compatible with life. The other two were extreme pre-term infants, where the mother transferred to Barts for tertiary neonatal care.	All cases will have a perinatal mortality MDT review as per national guidelines. Further details are within the Maternity perinatal quality and safety report.

HIE (Hypoxic-Ischaemic Encephalopathy)



Indicator Background:

The rates for brain injury or HIE fluctuate monthly across the sites. Cases of severe brain injury are fortunately rare. Babies who are born in poor condition at birth are reviewed by our neonatal teams to review suitability for cooling therapy which is known to reduce the severity of injury to the brain following acute onset of hypoxia during birth. Cooling therapy is known to slow down the changes in the brain which can continue to have a detrimental effect even after the hypoxic insult has occurred. Babies are cooled for 72 hours, their body temperature is reduced and they are sedated and made comfortable during this process with various medications. Bart's Health provides this therapy at the Royal London site, and we also refer babies to The Homerton hospital where needed.
Brain injury can be as a result of changes that occur during the pregnancy as a result of reduced blood flow to the placenta, but can also occur during labour, which is why foetal monitoring is a vital component of safe care. Any cases where a baby is referred for cooling and has a brain injury is referred for external review by HSIB. The data captured through Barts Health only includes cases of severe damage (HIE grades 2 &3) and babies both born and treated at Barts Health. Improvement work at Barts health focuses on foetal well being in pregnancy and good foetal monitoring during labour to identify early signs of hypoxia and to help us deliver these babies in a timely way.

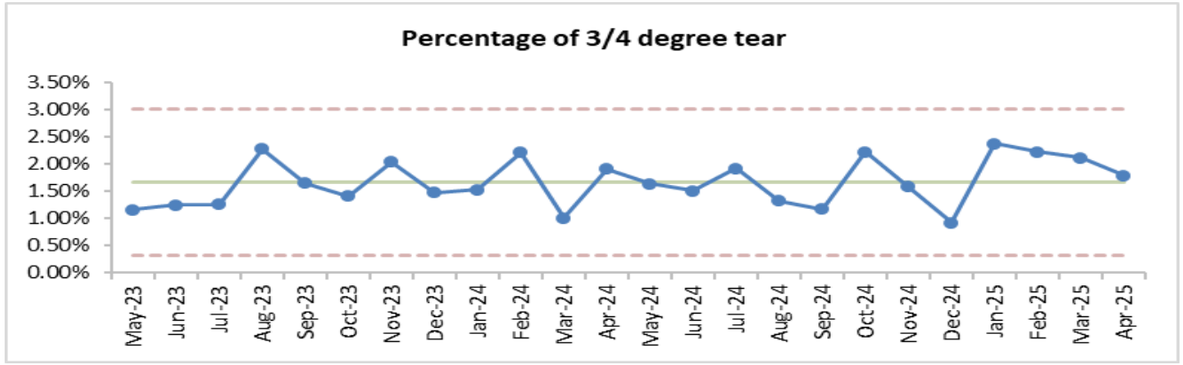
What is the Chart Telling us:

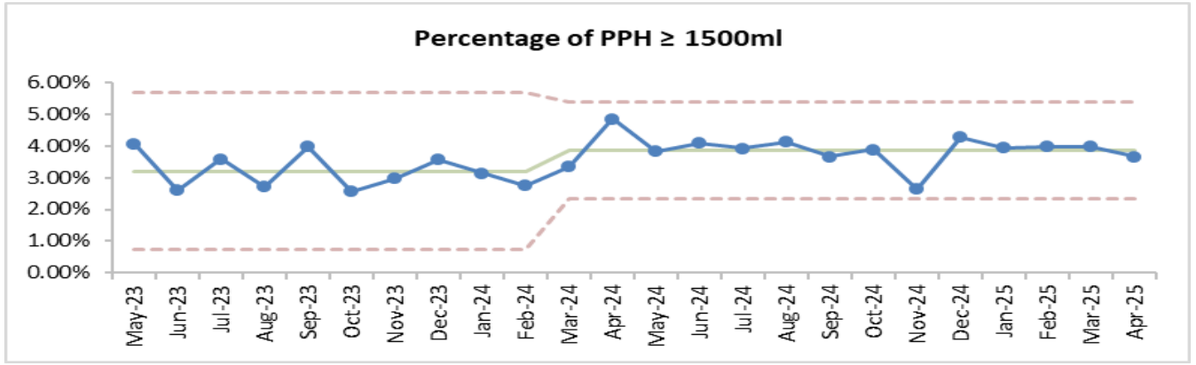
That there were 0 cases of HIE grade 2/3 in babies born within and receiving treatment at Barts Health.

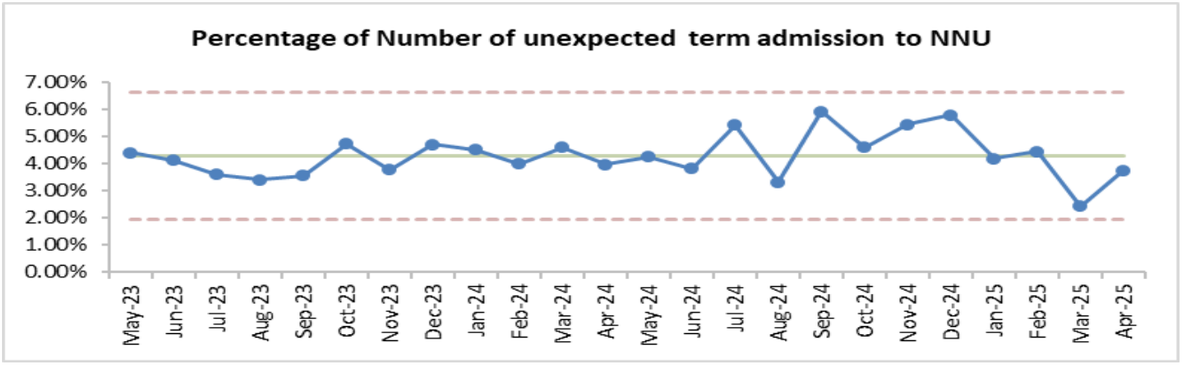
Performance Overview

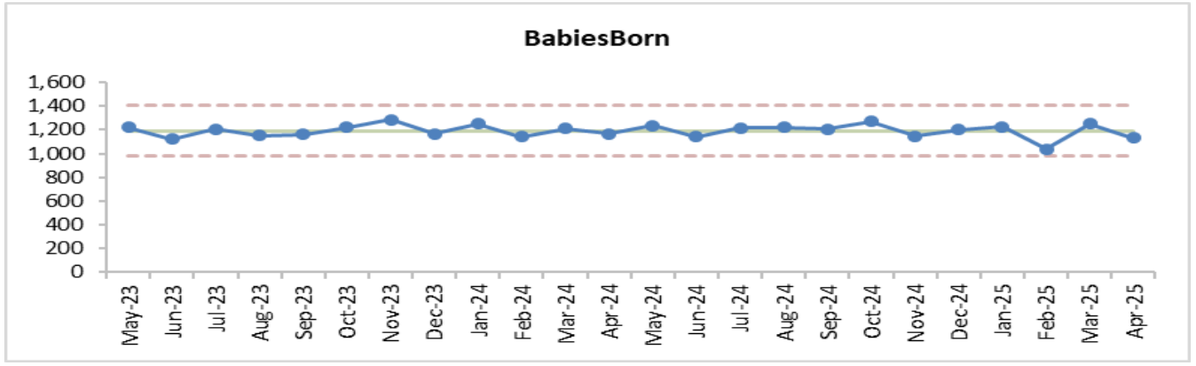
There was one case of HIE for a baby who was not born at Barts Health. No cases for births within Barts Maternity.

Maternity Signals









Performance Overview	Responsible Director Update
There were 1134 babies being born across three hospitals in April 2025. Trends are above average but showing signs of stabilising for postpartum haemorrhage (PPH) of 1500ml in all hospitals.	Services are reviewing their PPH >1500ml cases in line with PSIRF principles and have action plans to address them. There is a plan to conduct a peer review of MOH cases, and to conduct these for losses >1500mls (previously conducted for >2000ml) to help share learning and help identify any themes that have been missed. Themes from reviews have identified prolonged second stage of labour, poor compliance to risk assessments, and delays in administration of treatment uterotonics when blood loss is escalating. Loss of situational awareness and escalation have also been identified as problems.

Equity Summary

IMPROVING EQUITY AND SUSTAINING STANDARDS: IMPROVE EQUITY OF ACCESS TO CARE FOR OUR POPULATION

Equity

The Trust has reviewed its waiting lists to identify differences in wait times between patient groups at Trust level. The Trust reviewed waiting times by ethnicity, gender, learning disability status, and between patients who live in wealthier postcodes compared to those who live in more deprived postcodes. We explored differences between ethnic groups and varying levels of deprivation at hospital site level as well as at trust level. The analysis is a snapshot of data as of 19th June 2025.

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

Findings

At Trust level, we found significant differences in average waiting times for gender and learning disability status. These findings are driven largely by long waits in gynaecology skewing the gender data, and a large number of LD patients waiting for restorative dentistry services at Royal London Hospital.

Differences in waits between known ethnicities are not observed at site level, although there is some evidence of Asian and Black ethnicity patients experiencing waits above the trust average. This is also observed at Royal London and Whipps Cross sites, and black patients are waiting longer than white patients at Whipps Cross in this reporting snapshot.

There were no statistically significant differences in wait times by deprivation at both trust and site average levels in this report.

Ethnicity capture remains above 95% target across inpatient, outpatient, and A&E. We will continue to monitor for monthly trends in capture rates.

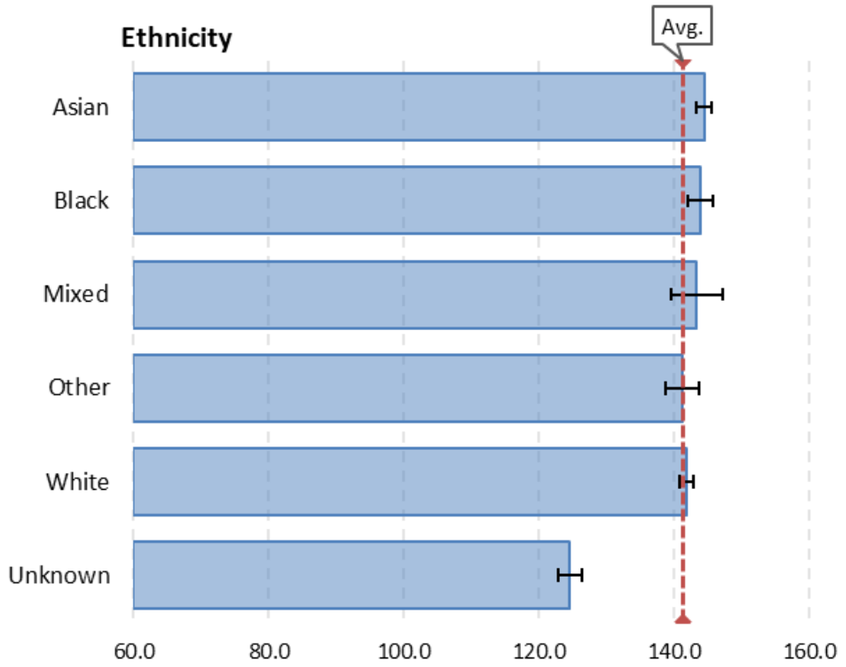
Findings for gender and learning disability have been escalated and shared through the Inclusion and Equity board and the Elective Recovery Board. For Gynaecology services, the North East London Planned Care Board is also working with sites to address waits for this specialty. Gynaecology is one of the pilot areas for ODNs (Operational Delivery Networks) with a key part of their role reducing waiting times for patients.

Next steps

We will continue to work to mitigate the increased waiting times for patients with Learning Disabilities. We will also ensure we update on the efforts to address the waits in Gynaecology across North East London. We will work with sites to monitor the disparity in patients from deprived post codes and continue to look for trends in deprivation and ethnicity more widely.

Equity - Wait Times By Ethnicity

IMPROVING EQUITY AND SUSTAINING STANDARDS: IMPROVE EQUITY OF ACCESS TO CARE FOR OUR POPULATION



Summary Data

Ethnic Category	Total Wait Time (Days)	# of Pathways
Asian	5,944,763	41,145
Black	2,277,491	15,824
Mixed	475,772	3,318
Other	1,091,954	7,731
White	6,522,968	45,973
Unknown	1,556,510	12,495

Pathways with no Week Wait details excluded

Ethnic Category	Average Wait (Days)	Lower CI	Upper CI	Median WW
Asian	144.5	143.4	145.6	16-17
Black	143.9	142.1	145.7	16-17
Mixed	143.4	139.6	147.2	16-17
Other	141.2	138.7	143.8	16-17
White	141.9	140.9	142.9	16-17
Unknown	124.6	122.8	126.3	12-13
Grand Total	**141.3**			**16-17**

Commentary

There are no statistically significant differences in wait times between patients from known ethnic categories at Trust level

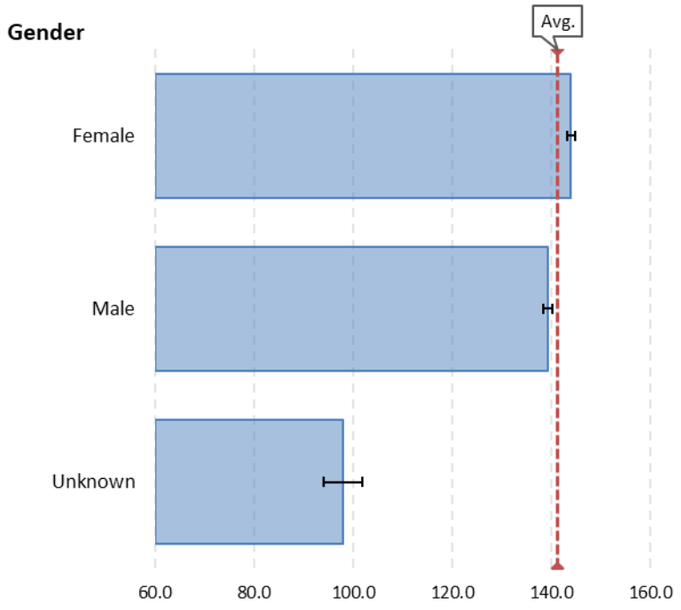
There is some evidence of Asian and black ethnicity patients waiting longer than the trust average, which we will continue to monitor closely for trends.

Patients from 'Unknown' ethnic category have the shortest average wait of 124.6 days, although we believe these patients are more likely to be urgent referrals.

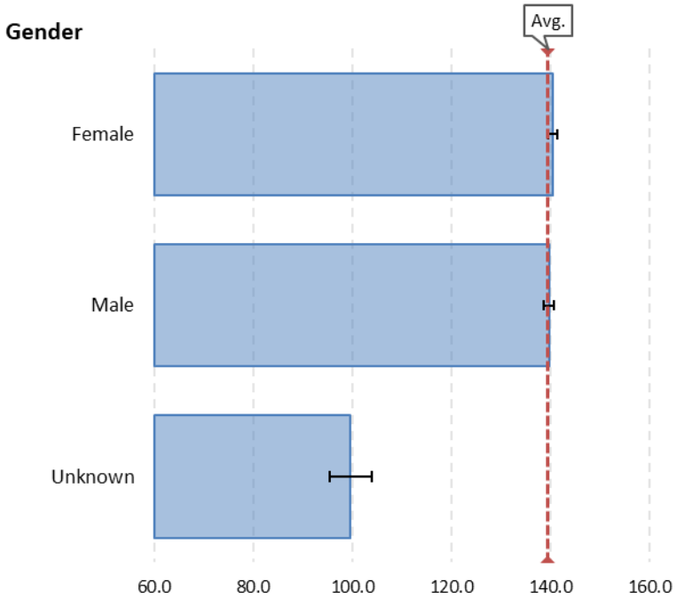
Equity – Wait Times by Gender

IMPROVING EQUITY AND SUSTAINING STANDARDS: IMPROVE EQUITY OF ACCESS TO CARE FOR OUR POPULATION

All Specialties



All Specialties **Without** Gynaecology



All Specialties

Summary Data

Gender	Total Wait Time (Days)	# of Pathways
Female	9,934,530	68,998
Male	7,764,648	55,748
Unknown	170,280	1,740

Pathways with no Week Wait details excluded

Gender	Average Wait	Lower	Upper	Median WW
Female	144.0	143.1	144.8	16-17
Male	139.3	138.4	140.2	16-17
Unknown	97.9	93.9	101.8	8-9
Grand Total	**141.3**			**16-17**

Commentary

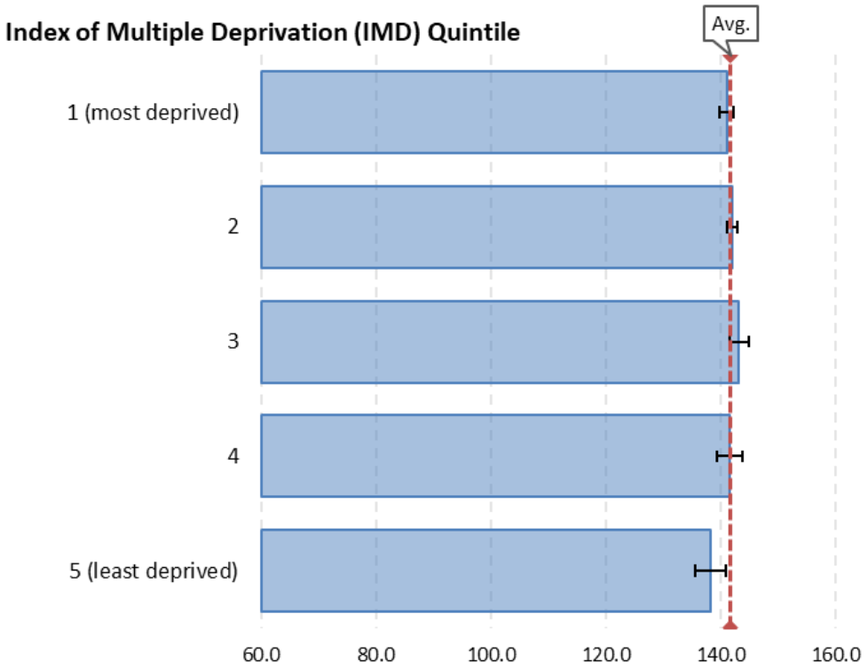
Wait times are 4.7 days longer for women than they are for men when viewed at Trust average level. This is largely due to the high number of patients waiting for gynaecology services.

When excluding gynaecology from the trust average calculation, the difference is reduced to 0.9 days and is no longer statistically significant. This finding is consistent to what we have observed in previous reporting cycles, and national reports of long waits for gynaecology.

The NEL Planned Care Team are continuing to work with site leads to agree a solution for gynaecology services, and we are working with the Elective Recovery Board to reduce this disparity. At Royal London, we have seen a positive reduction in gynaecology waiting times since the introduction of the Women's Hub. Gynaecology is also one of the pilot areas for ODNs (Operational Delivery Networks) with a key part of their role reducing waiting times for patients.

Equity – Wait Times By Deprivation

IMPROVING EQUITY AND SUSTAINING STANDARDS: IMPROVE EQUITY OF ACCESS TO CARE FOR OUR POPULATION



Summary Data

IMD Quintile	Total Wait Time (Days)	# of Pathways
1 (most deprived)	4,268,005	30,240
2	8,131,052	57,246
3	2,927,614	20,427
4	1,466,334	10,352
5 (least deprived)	868,791	6,280

Pathways with no Week Wait details excluded

IMD Quintile	Average Wait	Lower	Upper	Median WW
1 (most deprived)	141.1	139.9	142.4	16-17
2	142.0	141.1	143.0	16-17
3	143.3	141.8	144.9	16-17
4	141.6	139.5	143.8	16-17
5 (least deprived)	138.3	135.6	141.0	16-17
Grand Total	**141.8**			**16-17**

Commentary

There are no statistically significant differences in wait times between our patients from the most and least deprived post codes at Trust level.

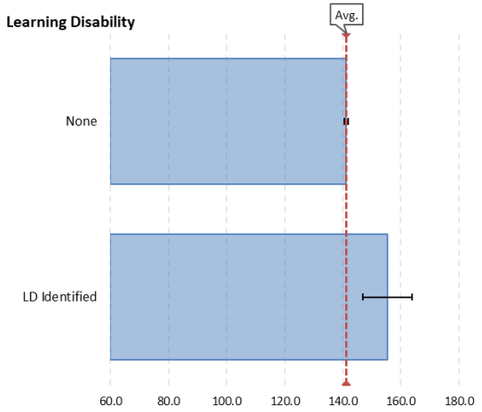
Median wait times are also consistent across all levels of deprivation.

The difference between average waits for most deprived and least deprived patients is 2.8 days, which is larger than the 1.0 day difference we observed in the May report. Whilst this difference is still not considered statistically significant, we will monitor for any further widening of the gap in average wait times in future reports.

Equity – Wait Times by LD

IMPROVING EQUITY AND SUSTAINING STANDARDS: IMPROVE EQUITY OF ACCESS TO CARE FOR OUR POPULATION

All Specialties



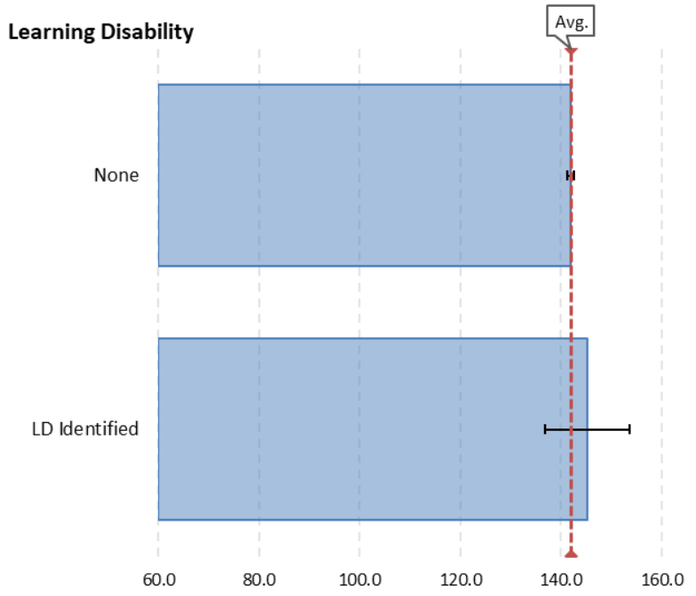
Summary Data

LD_Flag	Total Wait Time (Days)	# of Pathways
None	17,741,028	125,659
LD Identified	128,430	827

Pathways with no Week Wait details excluded

LD_Flag	Average Wait	Lower	Upper	Median WW
None	141.2	140.6	141.8	16-17
LD Identified	155.3	146.9	163.7	18-19
Grand Total	**141.3**			**16-17**

All Specialties Without Restorative Dentistry



Commentary

Patients with an identified learning disability are waiting on average 14.1 days longer than those without a learning disability. This finding is statistically significant and has been consistently observed in previous reports.

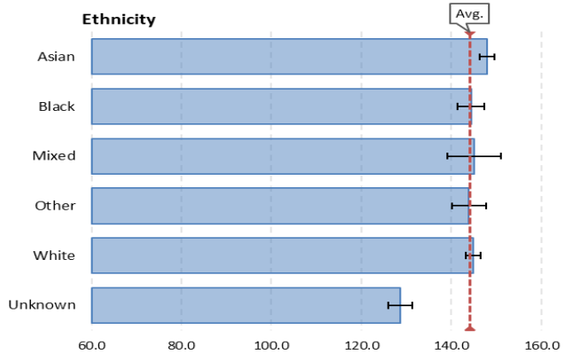
More than 12% of our LD waiting list is for Restorative Dentistry, of which they are experiencing an average wait of 226.6 days, much higher than the trust average of 141.3 days wait. When excluding restorative dentistry from the average calculation, the difference in waits for LD patients is reduced to 3.3 days, and is no longer statistically significant.

We have escalated these findings through the Inclusion and Equity Board, and the Elective Recovery Board.

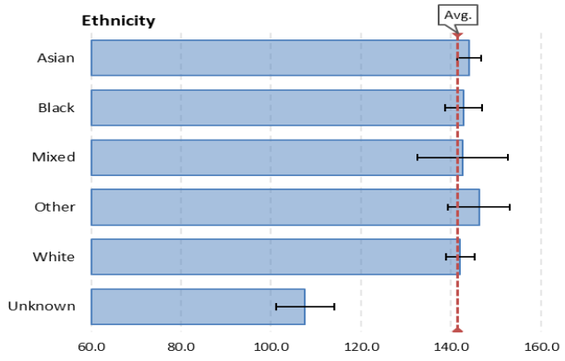
Equity - Wait Times By Ethnicity (Sites)

IMPROVING EQUITY AND SUSTAINING STANDARDS: IMPROVE EQUITY OF ACCESS TO CARE FOR OUR POPULATION

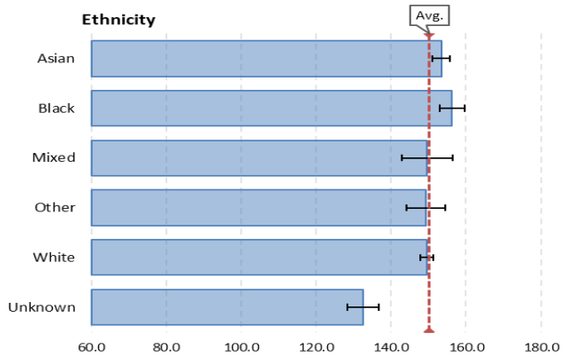
Royal London



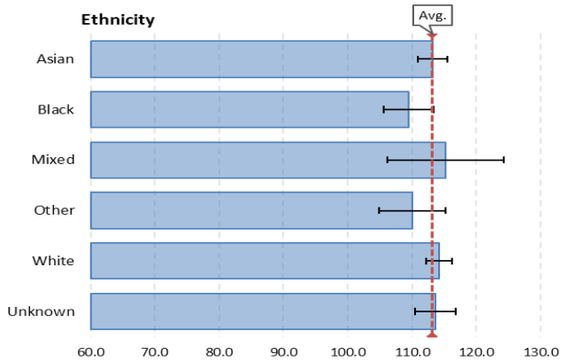
Newham



Whipps Cross



St Barts



Commentary

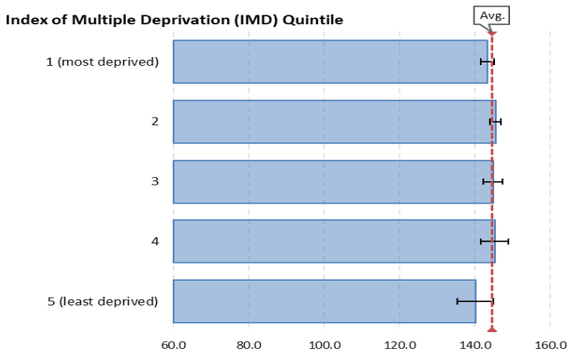
At the majority of our sites, we observe no statistically significant differences in wait times by ethnicity. At Whipps Cross, black patients are waiting on average 6.7 days longer than white patients and this is considered statistically significant. At Royal London and Whipps Cross, Asian patients are experience above average wait times.

The disparity for black patients at Whipps Cross has not been observed in previous reports, and we will continue to monitor this trend closely.

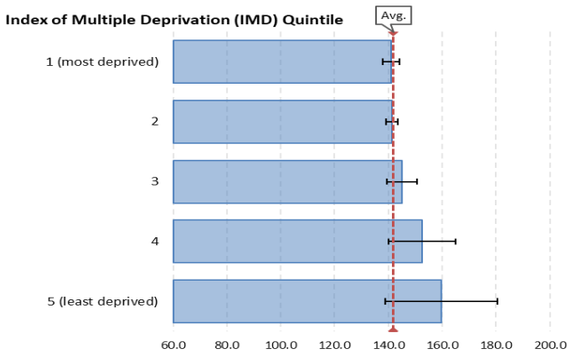
Equity – Wait Times By Deprivation (Sites)

IMPROVING EQUITY AND SUSTAINING STANDARDS: IMPROVE EQUITY OF ACCESS TO CARE FOR OUR POPULATION

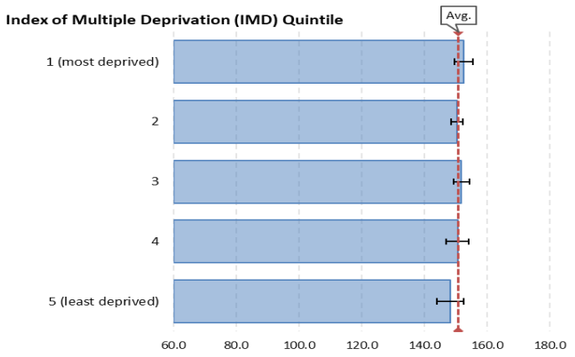
Royal London



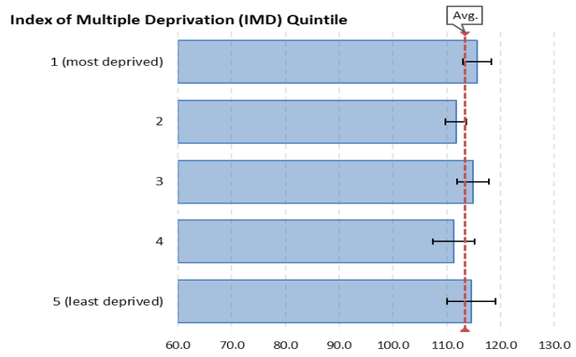
Newham



Whipps Cross



St Barts



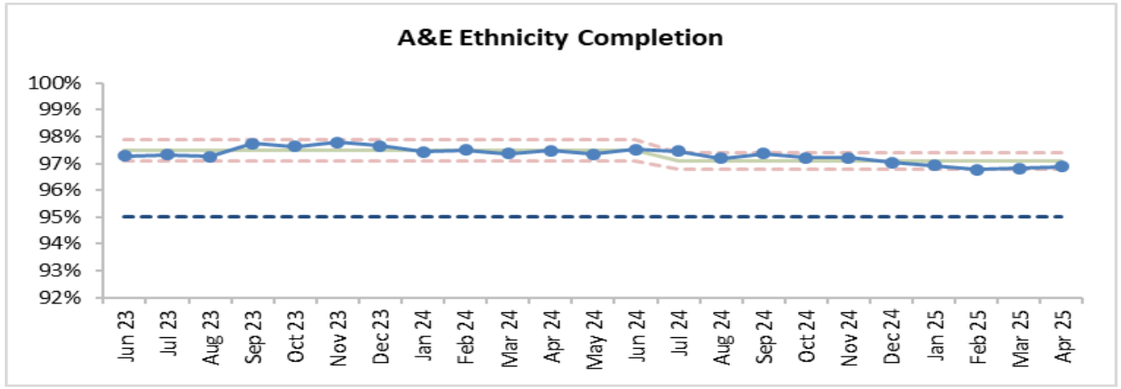
Commentary

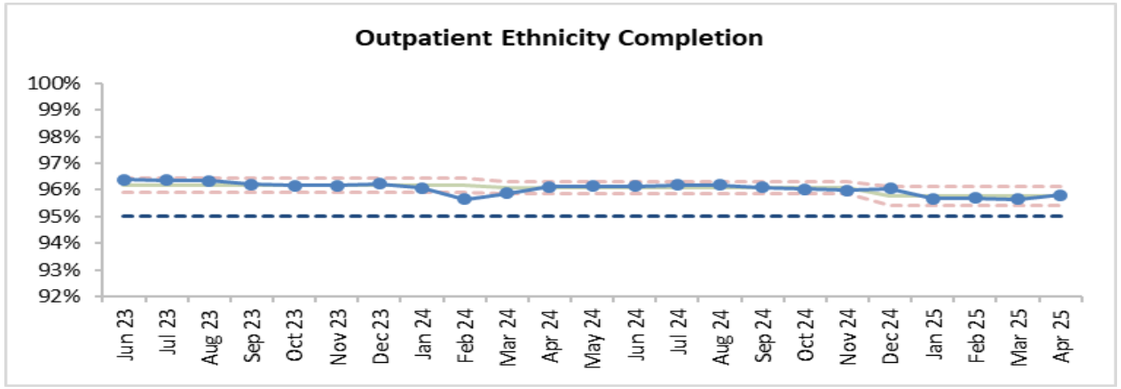
There are no statistically significant differences in wait times by deprivation observed at site level.

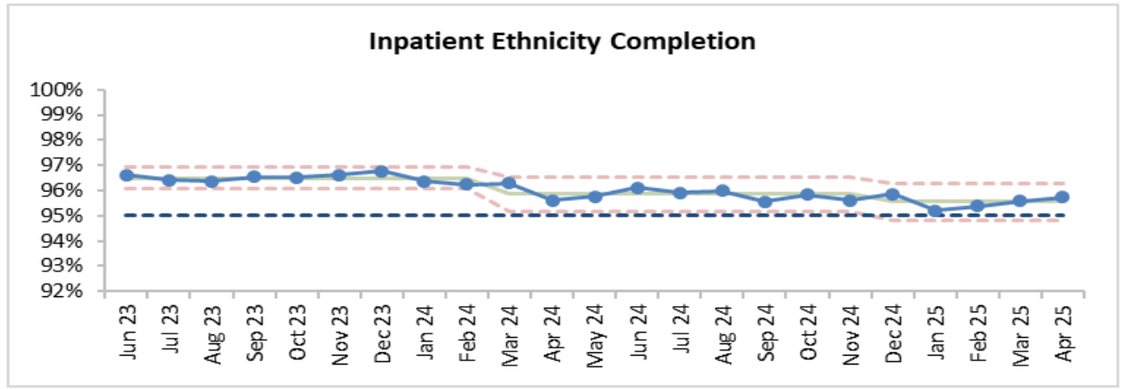
Site level findings show a varied picture of differences in waiting times by deprivation. At Whipps, our most deprived patients are waiting longest, whereas at Newham our least deprived patients are waiting longest. These findings are however not statistically significant, which is an improvement in position compared to our previous May report. We will continue to monitor closely for trends.

Ethnicity Recording by Activity Type

IMPROVING EQUITY AND SUSTAINING STANDARDS: IMPROVE EQUITY OF ACCESS TO CARE FOR OUR POPULATION







Ethnicity Recording by Activity Type - % Completion - Apr-25

Site	A&E	Inpatient	Outpatient
Royal London	96.7%	94.1%	95.5%
Whipps Cross	96.9%	97.7%	97.3%
Newham	97.1%	98.3%	98.3%
St Bart's	-	95.2%	92.7%
Trust	**96.9%**	**95.7%**	**95.8%**

Commentary

At Trust level we are exceeding the 95% data capture for ethnicity target across all areas, with particularly strong performance of 96.9% in A&E. This performance is seen across all sites and services, except inpatient at Royal London which is marginally below target at 94.1%, and outpatient at St Bart's at 92.7%.

Ethnicity information is now uploaded periodically from available GP data to improve our capture. This has also retrospectively improved historic data from previous attendances and improved our overall data capture levels. Furthermore, the approach reduces the reliance on front line staff to meet the target.

There is some evidence of downward trend, although this is likely to be upwardly corrected in future GP data uploads.

National priorities and success measures for 2025/26

Priority	Success measure
Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement*
	Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement*
	Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026
	Improve performance against the headline 62-day cancer standard to 75% by March 2026
	Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026
Improve A&E waiting times and ambulance response times	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25

*Against the November 2024 baseline, with all providers required to increase their RTT performance to a minimum of 60% and performance on wait for first appointment to a minimum of 67%

On 30 January 2025, NHS England published its operational planning guidance for 2025/26, outlining the priority areas and objectives for the service.

The 2025/26 NHS Planning Guidance sets out clear priorities to:

- Reduce elective care waiting times with three 18-weeks Referral to Treatment objectives, (1) increase the percentage of patients waiting no longer than 18-weeks to treatment, (2) increase the percentage of patients waiting no longer than 18-weeks for a first outpatient appointment, and (3) reduce the proportion of patients waiting longer than 52-weeks for treatment
- Improve cancer treatment performance against the headline 28-day Faster Diagnosis and 62-days to first treatment standards
- Improve urgent and emergency care performance against two headline measures, 4-hour and 12-hour journey times

Changes to the July 2025 Performance and Productivity Chapter

Making Data Count

- The NHS Making Data Count team provide guidance to trusts, their boards, operations teams and data professionals who have an interest in adopting best practice performance reporting techniques and data visualisations, including the use of statistical process control to inform reporting, intervention and oversight.

- Following a presentation by the NHSE Making Data Count Team to the trust board during April 25, it was agreed to fully implement the Making Data Count reporting template for the Board, Hospital Site and Divisional Performance Review packs.

- For the Board report this process will be complete by the end of October 25, however in the meantime the Performance and Productivity chapter of this report has been updated to reflect the main Making Data Count best practice principles, these include:

    - Providing a 3x3 summary matrix view of Variation and Assurance in relation to the trusts delivery of the national elective care, cancer and urgent and emergency care performance standards
    - New user-friendly wide screen (16:9 ratio) page format
    - Removing two data point comparisons (last month against most recent month) in favour of mean performance over time and variation, expressed in terms of Improvement, Concern and No Significant Change
    - Statistical Process Control XmR charting, supporting meaningful monitoring of performance highlighting statistically significant changes over time

New Referral to Treatment Reporting Technology

On 18 June 2025, following a significant period of preparation, including engagement with NHS England, the trust implemented a new Referral to Treatment (RTT) patient tracking list technology, LUNA. The technology applies the latest national RTT definitions and ensures that every RTT applicable pathway is represented on the list, including electronic referrals.

During the launch of the new RTT reporting solution, the trust was able to identify and resolve some data quality issues. The May 2025 monthly data submission is the first from LUNA and due to improved data quality has resulted in an increase in the overall list size as well as the number of longer waiting pathways. The change to LUNA means that 11,921 incomplete pathways not included in the April submission have now been added, including 1,434 pathways where the patient had been waiting 52 weeks or more.

Operational Data Summary

Elective Care

On 18 June 25, following a significant period or preparation and engagement with NHS England, the trust implemented its new Referral to Treatment (RTT) patient tracking list technology, LUNA. LUNA is a next generation AI-powered healthcare data quality improvement tool. At its core, LUNA is all about improving patient care by ensuring accurate, reliable data that healthcare professionals can trust. Data quality is a critical issue for healthcare providers, and the consequences of inaccurate data can be significant, both in terms of patient outcomes and financial costs. The AI-powered engine is designed to:

- reduce patient risk
- minimise the need for manual data validation
- optimise the clinical decision-making process

The May 25 monthly data submission is the first from LUNA and due to improved data quality has resulted in an increase in the overall list size as well as the number of longer waiting pathways. The change to LUNA means that 11,921 incomplete pathways not included in the April submission have now been added, including 1,434 pathways where the patient had been waiting 52 weeks or more. The data included in this report reflect these changes, apart from the benchmarking data where the most recent national data relates to April 25.

- For 2025/26 the NHS has set all trusts the objective of improving elective care performance, with three Referral to Treatment (RTT) targets, for Barts Health these are, (1) increasing the number and proportion of patients waiting less than 18-weeks for a first outpatient appointment to 68.8% by March 26, (2) increasing the number and proportion of patients waiting less than 18-weeks from referral to first treatment to 60.3% by March 26, and (3) reducing the number and proportion of patients waiting longer than 52-weeks for first treatment to less than 1% by March 26.
- The trust has set activity targets designed to deliver these improvements over the course of the year, for May 25 both non admitted and admitted activity trajectories were exceeded.
- For April 25, the trust had the fifth largest RTT patient tracking list in England and the second largest in London.
- For May 25 the list contained 135,110 total pathways.
- At the end of May 25, the trust recorded 585 pathways waiting 65+ weeks, the volume of 52-weeks pathways was 5,109.
- For May 25:
  - The trust achieved the monthly 18-weeks wait for first outpatient appointment objective, recording 65.6% against the monthly trajectory of 65.0%
  - The trust achieved the monthly 18-weeks wait for first treatment objective, recording 56.4% against the monthly trajectory of 53.4%
  - The trust did not achieve the monthly 52-weeks objective, recording 3.8% against the monthly trajectory of 3.1%

Operational Data Summary

Diagnostics

For April 25, Barts Health recorded the third largest Diagnostic Patient Tracking list in England and the second largest in London. As a proportion of the Patient Tracking List, Barts Health had the 12th highest proportion of 6+ week waiters out of 17 acute trusts in London and was ranked fourth out of the top 10 English acute trusts (ranked by Patient Tracking List volume). For May 25, a performance of 80.6% was recorded, with a mean of 75.4%.

Cancer

For 2025/26 the NHS has set two headline cancer standards for all trusts, (1) improving performance against the 28-day Faster Diagnosis Standard to 80% by March 26, and (2) improving performance against the 62-day standard to 75% by March 26.

- In April 25, the trust achieved the monthly Aggregate Faster Diagnosis objective, recording a performance of 79.1% against the monthly trajectory of 75.3%.
- While no longer a national objective, during April 25, the trust achieved the Aggregate 31-day Decision to Treat standard, recording a performance of 97.2% against the previous 96% standard, this is the seventh consecutive month the standard has been achieved.
- For April 25, the trust achieved the monthly Aggregate 62-day objective, recording a performance of 74.5% against the monthly trajectory of 67.7%.

Urgent & Emergency Care

- For 2025/26 the NHS has set all trusts the objective of delivering an A&E 4-hour performance standard of 78% by March 26.
- For May 25, Barts Health recorded the second highest volume of A&E attendances of any trust in England and the highest volume in London. In terms of performance against the 4-hour standard, the Trust was ranked 14th out of 17 acute trusts in London and was ranked 5th out of the top 10 English acute trusts (ranked by volume of attendances).
- In May 25 the trust just missed the monthly 4-hour objective, recording a performance of 70.2% against a monthly trajectory of 70.4%.
- In May, 45,889 attendances were recorded, 1,487 more than the 44,402 recorded in April 25 (+3.4%).
- The proportion of patients with an A&E 12-hour journey time was 7.9% in May against a mean of 8.6%, with the national expectation that this should be a reducing trend. Barts Health is currently ranked in the 8th decile nationally on this metric benchmarked against all other acute Trusts, an improvement of one decile since last month.

Domain Scorecard

Performance							*Site Comparison*				
Metric	**This Period**	**Standards**	**Latest Value**	**Mean**	**This Period Assurance**	**Variation**	**Royal London**	**Whipps Cross**	**Newham**	**St Bart's**	**Data Quality**
% RTT patients waiting 52 weeks or more	May-25 (m)	<=3.1%	3.8%	3.0%	Hit & miss Standard	Concern	4.9%	4.5%	2.7%	0.2%	
% RTT patients waiting < 18 Weeks for first attendance	May-25 (m)	>=65.0	65.6%	64.1%	Achieving standard	Improvement	63.7%	61.8%	71.3%	74.9%	
% RTT patients waiting no longer than 18 weeks for treatment	May-25 (m)	>=53.4%	56.4%	55.4%	Achieving standard	No Significant Change	55.3%	53.3%	55.6%	66.4%	
65+ Week RTT Breaches	May-25 (m)	0	585	324	Not achieving standard	No Significant Change	486	77	22	0	
Diagnostic Waits Over 6 Weeks	May-25 (m)	>= 95%	80.6%	75.4%	Not achieving standard	No Significant Change	66.1%	91.8%	94.0%	98.6%	
Cancer 28 Day FDS Aggregate	Apr-25 (m)	>= 75.3%	79.1%	74.3%	Hit & miss Standard	Improvement	71.1%	79.5%	77.4%	79.1%	
Cancer 31 Day Aggregate	Apr-25 (m)	>= 96.6%	97.2%	96.3%	Achieving standard	No Significant Change	93.2%	97.2%	93.8%	98.3%	
Cancer 62 Days Aggregate	Apr-25 (m)	>= 67.7%	74.5%	64.6%	Hit & miss Standard	No Significant Change	56.1%	86.6%	74.1%	74.0%	
A&E 4 Hours Waiting Time	May-25 (m)	>= 70.4%	70.2%	70.2%	Not achieving standard	No Significant Change	72.2%	68.9%	68.5%	-	
A&E 12 Hours Journey Time	May-25 (m)	-	7.9%	8.6%	-	No Significant Change	6.6%	11.5%	6.3%	-	
Ambulance Handover - Over 60 mins	May-25 (m)	-	85	150	-	No Significant Change	25	49	11	-	
Ambulance Handover - Over 30 mins	May-25 (m)	-	2,159	2,203	-	No Significant Change	692	783	684	-	

* Mean represents the average value for the latest stable SPC period"

Performance Matrix

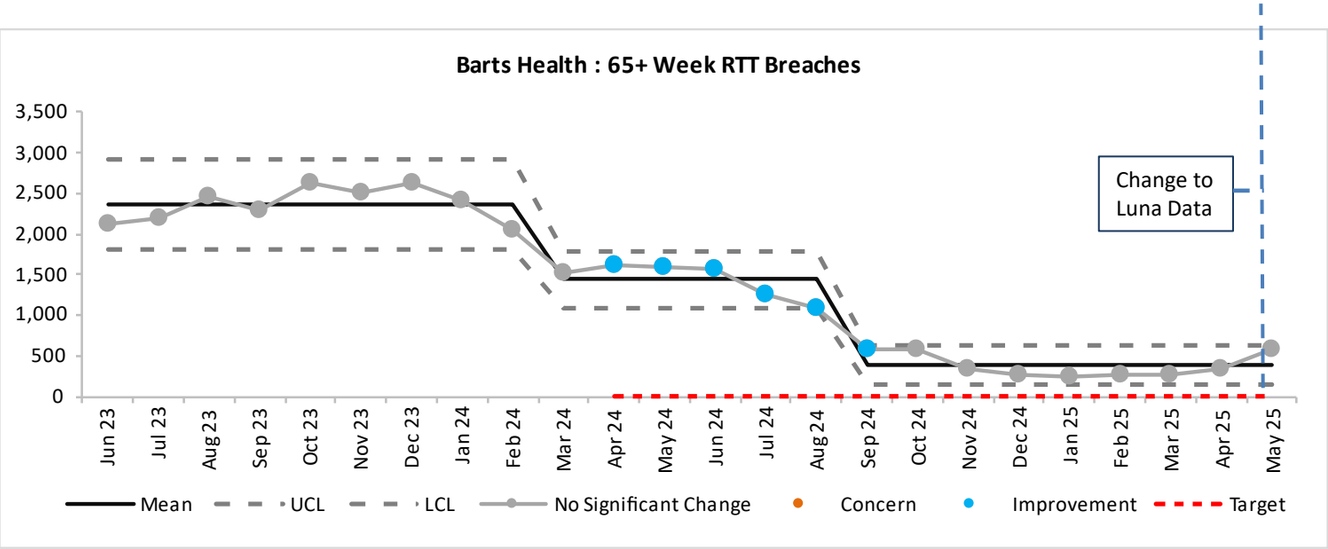
Variation	Assurance: Achieving standard	Assurance: Hit and Miss	Assurance: Not Achieving standard
Improving	% RTT patients waiting < 18 Weeks for first attendance	Cancer 28 Day FDS Aggregate	
No Change	Cancer 31 Day Aggregate % RTT patients waiting no longer than 18 weeks for treatment	Cancer 62 Days Aggregate	A&E 4 Hours Waiting Time 65+ Week RTT Breaches Diagnostic Waits Over 6 Weeks
Deteriorating	-	% RTT patients waiting 52 weeks or more	-

Summary Narrative

- **Three measures are consistently achieving their targets**, with one showing improvement and two remaining stable.
  - % RTT patients waiting < 18 weeks for first attendance (Improving)
  - Cancer 31-Day Aggregate (No Change)
  - % RTT patients waiting no longer than 18 weeks for treatment (No Change)
- **Three measures are not consistently achieving their targets (Hit and Miss)**,
  - Cancer 28-Day FDS Aggregate is showing improvement.
  - Cancer 62-Day Aggregate remains unchanged.
  - % RTT patients waiting 52 weeks or more is deteriorating.
- **Three measures are consistently missing their targets** with no signs of improvement or deterioration,
  - A&E 4-Hour Waiting Time
  - 65+ Week RTT Breaches
  - Diagnostic Waits Over 6 Weeks

65+ Week RTT Performance

INCREASING PERFORMANCE AND PRODUCTIVITY – ELECTIVE CARE



Indicator Background:

During the course of the Covid pandemic elective waiting times grew significantly with many patients waiting longer than two years for treatment. Since 2022/23 the NHS has set a number of targeted objectives to drive down the number of long-waiting patients, for 2024/25 the national objective was to clear all 65 weeks waiters by September 2024.

What are the Charts Telling us:

The SPC chart presents a period of no significant change in the volume of 65+ week waiters from June 23 to March 24. However, decreases in the volume of 65+ week wait patients and therefore an improving trend is consistently recorded across the period April to September 24. There is then a further period of no significant change between October 24 to the most recent data point, May 25. May's increase relates solely to the implementation of the new LUNA patient tracking list technology, thereby resolving several data quality issues.

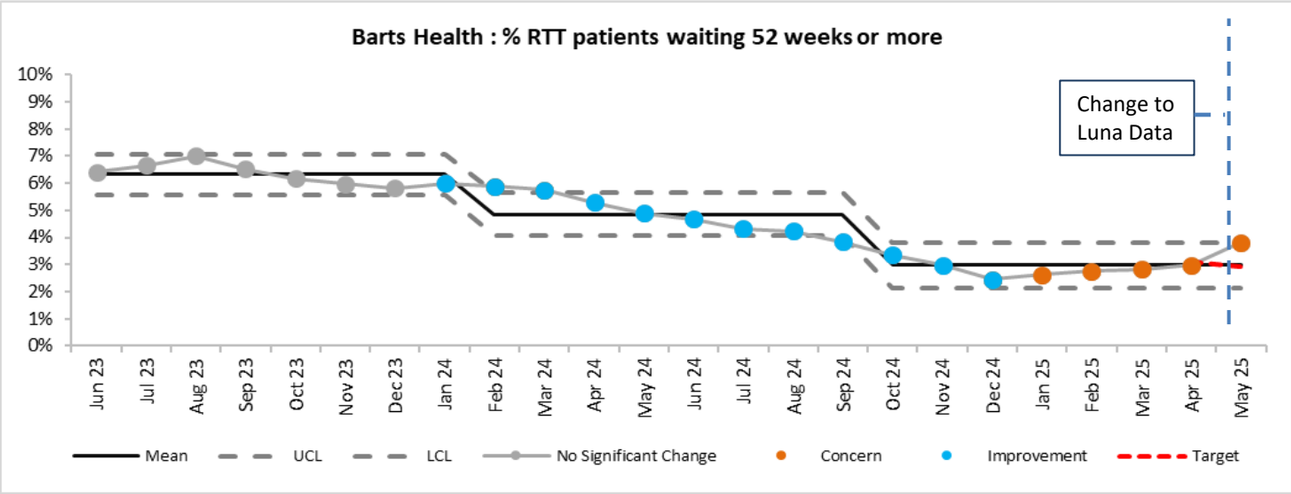
Trust Performance Overview

At the end of May 25, the trust recorded 585 pathways waiting 65+ weeks this was against a forecast position of 590. The in-month increase relates solely to the implementation of the new LUNA patient tracking list technology, thereby resolving several data quality issues.

Trust Responsible Director Update

- 65 week breaches remains challenged, the key specialties driving the breaches are Vascular, Oral Surgery, ENT and Gynaecology.
  - Vascular - demand profile indicates as significant increase in routine work. A new referral process will increase the capacity available in the Hospital for complex or clinically urgent work.
  - Oral Surgery - Barts Health has reduced referrals from outside NEL through commissioner supported restrictions.
  - ENT - are organising services into a single point of access for specialist Head and Neck and high volume low complexity work with WCH and the RLH working together to reduce waiting and improve access across the group.
  - Gynaecology - the operational delivery network connects hospitals on areas of opportunity across the group including a task and finish group on hysteroscopy. The Women's Health Hubs are established at both RLH and WCH and showing a positive reduction in waiting times. Notice has been served to the current community provider for Gynae in Newham with a WHH set to be established in Q3 2025/26.
- The Hospitals are preparing options to eradicate 65-week waits and any remaining 78+weeks wait patients, which will be triangulated with demand and capacity modelling along with productivity improvement plans. Insourcing capacity is funded until the end of June 2025 with agreement to extend this during Q2. This is enabling weekend activity to be delivered at Whipps Cross Hospital to treat ENT patients and Vascular and Oral Surgery at the Royal London Hospital. Patients are being seen in chronological order but are high volume, low complex cases therefore the 65-week breaches that remain in these specialities require in-house surgeons and weekday capacity to see and treat.
- There has been a significant increase in demand for Respiratory services and we are working to develop a future operating model that recognises the various pathways in Respiratory Medicine to release or prioritise capacity. At WCH there will be additional clinical resource deployed in July to reduce pressure in outpatients. SBH is working with WCH to improve access to Sleep Studies as part of patient diagnostic work up.

% RTT patients waiting 52 weeks or more



Indicator Background:

For 2025/26 the NHS has set a renewed focus on improving compliance with the 18-weeks Referral to Treatment standard. Additionally, as long waiting backlog has been reduced across 104, 78 and 65 week waits there is also a renewed focus on reducing 52-week waiters. By March 26 the NHS has set an expectation that no greater than 1% of the total waiting list will be waiting over 52 weeks.

What are the Charts Telling us:

The chart is telling us that across the period June to December 23 there is no significant change in the volume of 52-week waiters, with a reduction (improving trend) visible between January 24 to December 24, however increased volumes (a concerning trend) is then visible in the data between January to May 25. May's increase relates solely to the implementation of the new LUNA patient tracking list technology, thereby resolving several data quality issues.

Trust Performance Overview

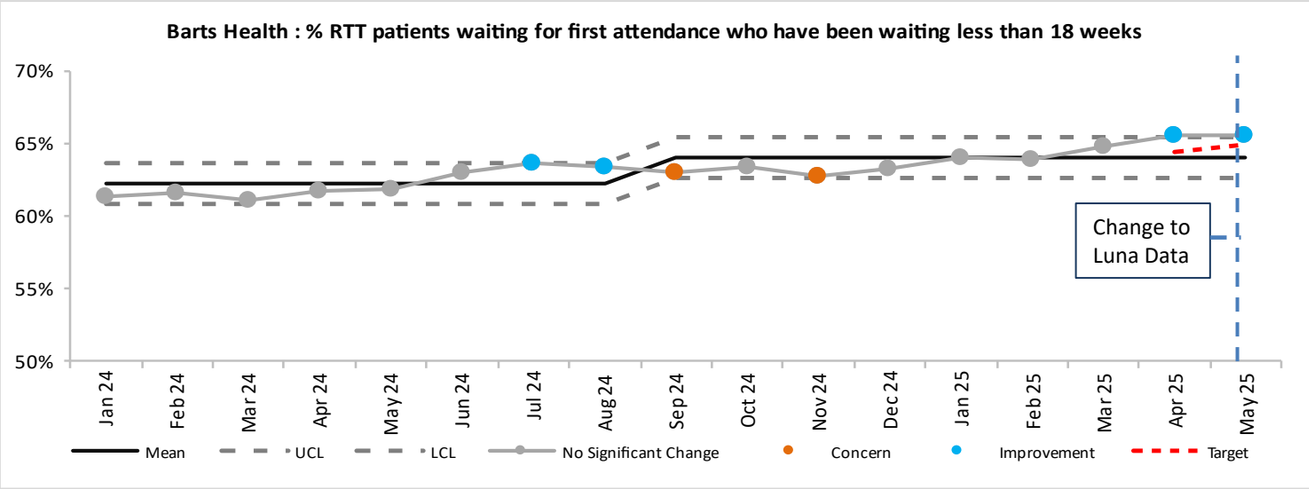
The percentage of patients waiting 52 weeks or more forms one of the key metrics in the 2025/26 elective reform plan. Performance against plan will now be reported monthly in the Board report with a description of key interventions that are planned to improve performance to less than 1% of patients waiting 52 weeks or more by the end of March 2026. For May 25 the trust recorded 5,109 fifty-two weeks pathways, May's increase relates solely to the implementation of the new LUNA patient tracking list technology, thereby resolving several data quality issues. During May the trust did not achieve the monthly 52-weeks objective, recording 3.8% against the monthly trajectory of 3.1%.

Trust Responsible Director Update

- The Trust is approximately 1% adverse against plan for the % of pathways > 52 weeks for month 1 2025/26. The key specialties driving an increase in breaches are Vascular, Oral Surgery, Paediatric ENT and Colorectal Surgery. All four specialties are below plan, with the furthest from plan being Vascular. Mitigating actions are being formalised with Hospitals to address this.
- For May 2025, most specialties are reporting static performance in this metric although Vascular and oral surgery are progressing actions to improve performance in this areas in Q2. Colorectal surgery will benefit from planned improvement working within Endoscopy.
- Insourcing capacity is targeting high volume, low complexity pathways in vascular surgery. The Royal London Hospital team have completed a demand and capacity analysis which describes a significant gap in capacity to treat the current referred demand. Vascular is one of the priority specialities the Northeast London Commissioning Lead is focussed on improving in 2025/26 and the Trust is working in collaboration to prioritise capacity for acute or complex work. A new referral protocol will come into effect to support this focus on clinically complex work.
- Patient contact is a significant part of the Trust approach to managing its waiting times for a first outpatient appointment. Our aim is to connect with patients every 12 weeks to confirm they still require treatment. Early work using DrDoctor text messaging has helped reduce the DNA rate from 12% to 9%. This will allow clinics to better manage the balance of a first appointment and any follow up appointment that is required and increase utilisation and productivity.

% RTT patients waiting for first attendance who have been waiting less than 18 weeks

INCREASING PERFORMANCE AND PRODUCTIVITY – ELECTIVE CARE



Indicator Background:

For 2025/26 the NHS has set a renewed focus on improving compliance with the 18-weeks Referral to Treatment standard. A key enabler is improving compliance with 18-weeks from referral to first outpatient appointment, with a trust level target of 68.8% to be achieved by March 26.

What are the Charts Telling us:

Performance operates within a relatively tight band within a range of 60% to 65%, with the majority of data points classified as no significant change. However, two improving data points are visible across April and May 25. It should be noted that May represents the first month of LUNA implementation, a new patient tracking list technology, which has supported resolution of several data quality issues.

Trust Performance Overview

The percentage of patients waiting less than 18-weeks from referral to first outpatient appointment forms one of the key metrics in the 2025/26 elective reform plan. Performance against plan will now be reported monthly in the Board report with a description of key interventions that are planned to improve performance to at least 68.8% of patients being seen at a first outpatient appointment within 18-weeks by March 26.

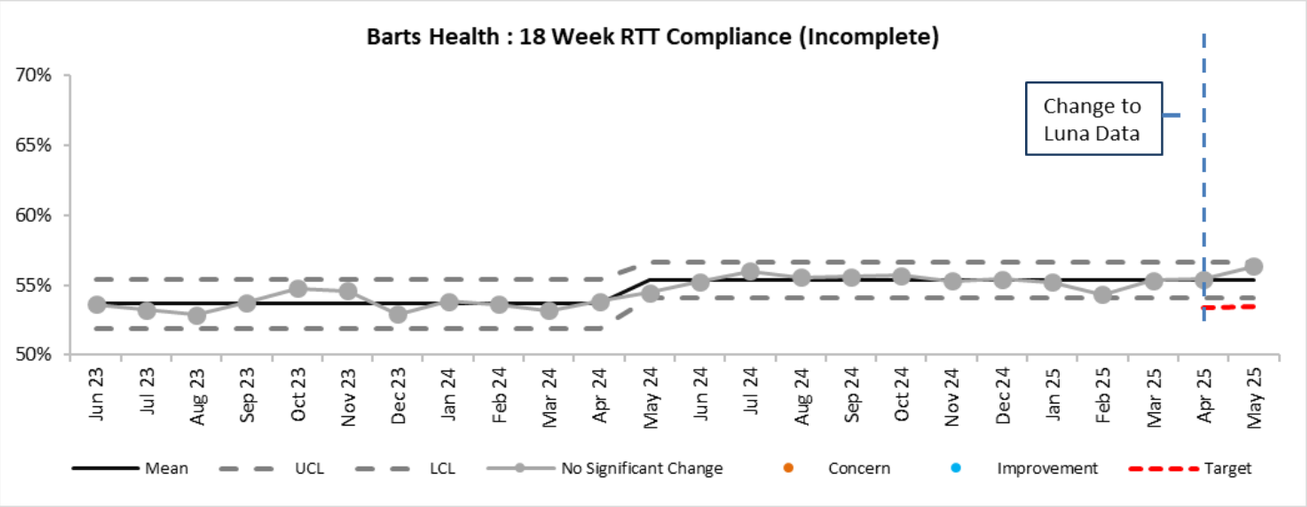
The trust achieved the monthly 18-weeks wait for first outpatient appointment objective for May, recording 65.6% against the monthly trajectory of 65.0%

Trust Responsible Director Update

- The trust is above trajectory for 18 week wait for first outpatient appointment.
- Respiratory Medicine, General Surgery, Paediatrics and Gynaecology are the 4 specialties which have largest gap from the target this is based on a specialty target position.
- Through the outpatient improvement work, the initiatives of focus are in place to support release of capacity to for new appointments. As per the request from the GIRFT team following the system meeting on 12.05.25, the trust is reviewing the 16 GIRFT specialities and the clinic templates to ensure these are standardised and support sufficient capacity for new patients.

18 Week RTT Compliance (Incomplete)

INCREASING PERFORMANCE AND PRODUCTIVITY – ELECTIVE CARE



Indicator Background:

For 2025/26 the NHS has set a renewed focus on improving compliance with the 18-weeks Referral to Treatment standard. Requiring an improvement in the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5 percentage point improvement., for Barts Health the March 26 objective is 60.3%.

What are the Charts Telling us:

The chart is telling us that performance is operating within a relatively tight range of between 53% and 56%. The entire data range, June 23 to May 25 represents a period of no significant change. However, May's increase relates solely to the implementation of the new LUNA patient tracking list technology, thereby resolving several data quality issues.

Trust Performance Overview

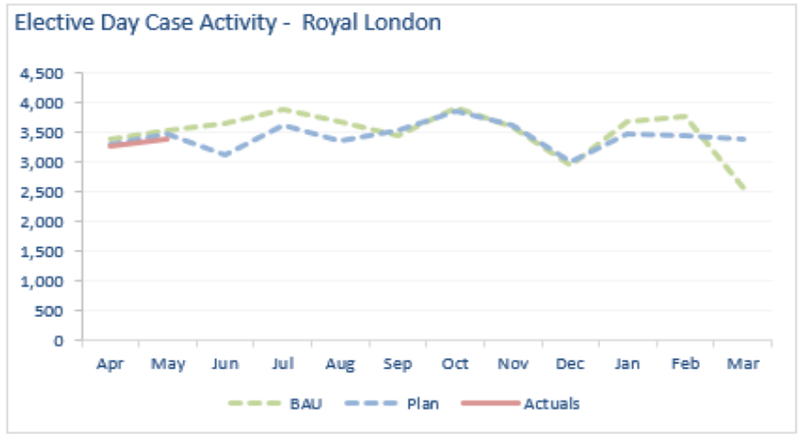
The 18-week Incomplete Performance standard forms one the key metrics in the 2025/26 elective reform plan. Performance against plan will now be reported monthly in the Board report with a description of key interventions that are planned to improve the performance standard by 5% before the end of the financial year, for Barts Health this equates to a March 26 target of 60.3%. For May the trust achieved the monthly 18-weeks wait for first treatment objective, recording 56.4% against the monthly trajectory of 53.4%

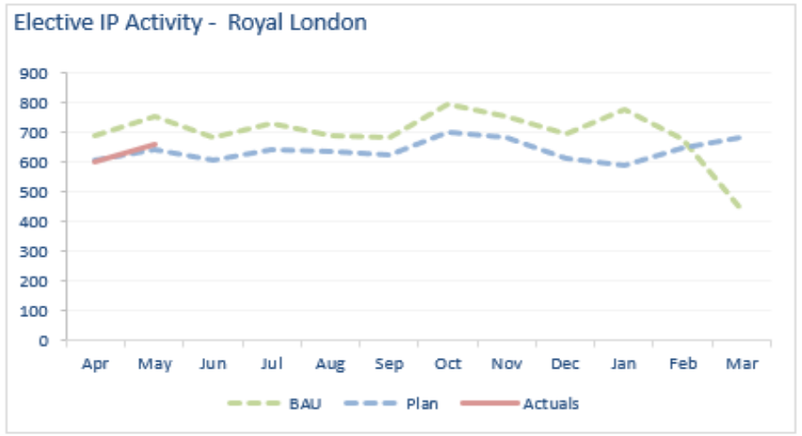
Trust Responsible Director Update

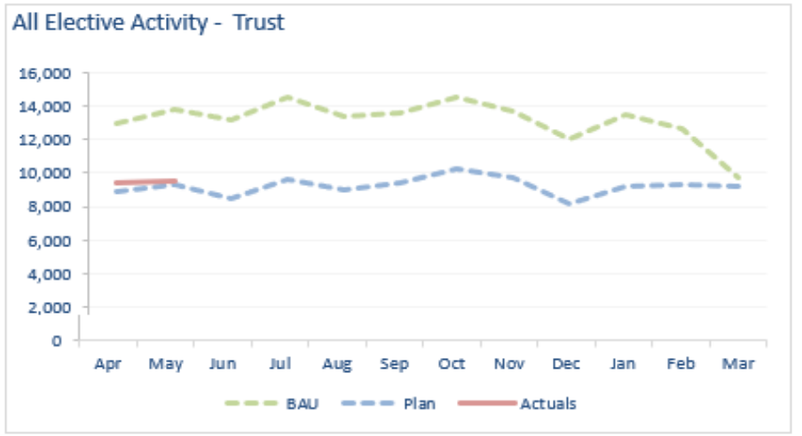
- By March 2026 the Trust needs to achieve 60.3% 18-week RTT Incomplete Performance, the Trust is performing above plan for the month of April 2025, and the forward view of May position shows positive performance above plan which is encouraging.
- The Trust is an active member of the NHSE London Outpatient Improvement Network and will be working with colleagues pan London to review and adopt best practice. Barts Health will be represented will attend from hospitals and specialties
- The performance is measured by calculating the volume and proportion of patients waiting over 18-weeks for treatment. The proportion of patients treated within the 18-week standard are made up of approximately 58% non-admitted pathways and 42% admitted pathways.
- Specialities that are performing below trajectory performance are Trauma and Orthopaedics and Respiratory Medicine. The Operational Delivery Network for Trauma and Orthopaedics are preparing to trial a single point of access for one of the challenged sub-specialities within orthopaedics and are reviewing demand and capacity within the service to develop a sustainable plan that can improve performance.
- BIU are helping to provide some analysis for specialties to enable an improvement understanding as to the volume of new appointments required to improve the performance against the standard.
- Respiratory Medicine requires attention as the waiting time to first outpatient appointment is the most challenged speciality in terms of its performance against plan. The Trust needs to improve the waiting time for first outpatient appointments to 68.8% by March 2026 and early view of May performance is reporting Respiratory being furthest from plan. The Hospitals are working in collaboration to review their respiratory services to identify opportunities to course correct the current position. In the short term an additional 200 appointments have been introduced in July.

Admitted Activity against Plan

INCREASING PERFORMANCE AND PRODUCTIVITY – ELECTIVE CARE







Admitted Elective Activity

		Barts Health						Last Month's Site Position			
		Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Royal London	Whipps Cross	Newham	St Bart's
All Elective Activity	Plan	7,690	8,942	8,447	*8,916*	8,855	***9,318***	*4,114*	*1,768*	*1,352*	*2,084*
	Actuals	8,170	9,749	8,719	*8,779*	9,426	***9,550***	*4,037*	*1,920*	*1,322*	*2,271*
	Mth variance plan	*480*	*807*	*272*	*-137*	*571*	*232*	*-77*	*152*	*-30*	*187*
Elective Day Case Activity	Plan	6,339	7,318	6,936	*7,292*	7,179	***7,541***	*3,470*	*1,464*	*1,055*	*1,552*
	Actuals	6,655	8,157	7,180	*7,105*	7,663	***7,678***	*3,380*	*1,608*	*977*	*1,713*
	Mth variance plan	*316*	*839*	*244*	*-187*	*484*	*137*	*-90*	*144*	*-78*	*161*
Elective IP Activity	Plan	1,351	1,624	1,511	*1,624*	1,676	***1,777***	*643*	*304*	*298*	*532*
	Actuals	1,515	1,592	1,539	*1,674*	1,763	***1,872***	*657*	*312*	*345*	*558*
	Mth variance plan	*164*	*-32*	*28*	*50*	*87*	*95*	*14*	*8*	*47*	*26*

Data as at 19/06/2025

Performance Overview

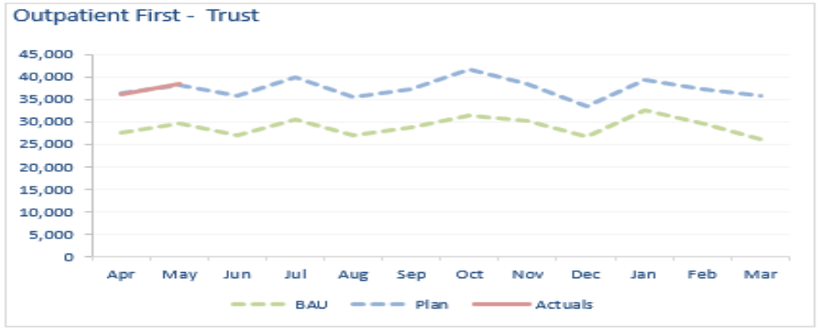
- For 2025/26 the NHS has set all trusts elective activity targets designed to pivot towards 18 week performance improvement.
- Elective activity for the first two months of the financial year is tracking against planned levels of activity across the Barts Health group.
- For May 25, the trust admitted (inpatient and day case) trajectory set a target of 9,318 admissions against which the trust delivered 9,550 (+232 admissions).

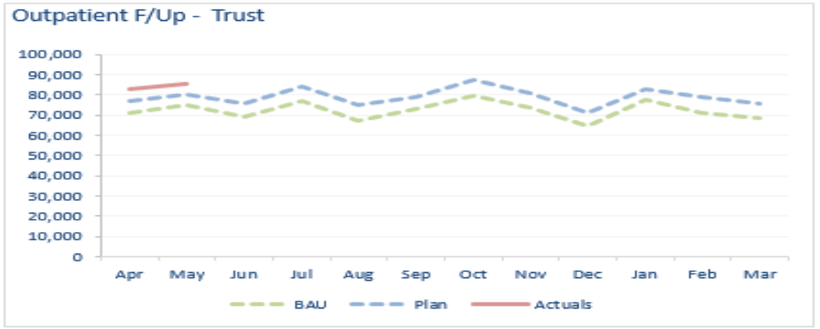
Responsible Director Update

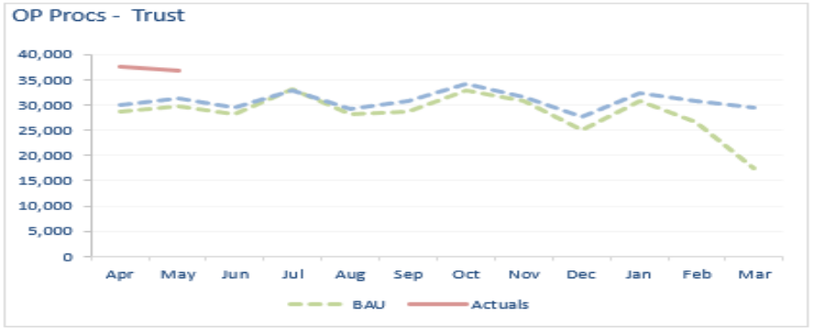
- In May 2025, Barts Health made its first referral to treatment submission using the new LUNA waiting list. At the end of May, there are 135,100 open referral to treatment pathways.
- We are delivering elective activity across the Group in line with plan. Hospitals within the Group work together to support the transfer of patients, particularly in challenged RTT specialities. This is supported by our Operational Delivery Networks (ODNs) in gynaecology, trauma and orthopaedics and urology.
- Activity is provided at the weekend through insourcing arrangements to enable reduction in our waiting list in challenged specialities – vascular surgery, ENT and oral surgery

Non-Admitted Activity against Plan

INCREASING PERFORMANCE AND PRODUCTIVITY – ELECTIVE CARE







Outpatient Activity

		Barts Health						Last Month's Site Position				
		Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Royal London	Whipps Cross	Newham	St Bart's	Other
Total OP Activity	Plan	117,369	111,914	134,062	134,435	**143,016**	**149,725**	64,630	32,719	24,363	28,014	-
	Actuals	132,409	142,853	142,909	138,401	**154,662**	**160,543**	68,199	38,580	25,525	28,239	-
	Mth variance plan	*15,040*	*30,939*	*8,847*	*3,966*	***11,646***	***10,818***	*3,569*	*5,861*	*1,162*	*225*	-
Outpatient Attendances (All) - First Attendance Excluding Procedures	Plan	28,665	34,888	32,302	32,769	**36,375**	**38,082**	16,082	11,046	4,993	5,960	-
	Actuals	32,879	38,067	35,438	33,981	***36,121***	***38,365***	14,976	11,467	5,154	6,768	-
	Mth variance plan	*4,214*	*3,179*	*3,136*	*1,212*	***-254***	***283***	*-1,106*	*421*	*161*	*808*	-
Outpatient Attendances (All)- Follow-Up Attendance Excluding	Plan	65,564	79,629	75,254	74,973	***76,711***	***80,310***	36,012	15,549	15,278	13,471	-
	Actuals	75,341	89,114	80,572	78,741	***82,983***	***85,455***	36,573	16,830	15,413	16,598	41
	Mth variance plan	*9,777*	*9,485*	*5,318*	*3,768*	*6,272*	*5,145*	*561*	*1,281*	*135*	*3,127*	*41*
Outpatient Attendances (All)- with a Procedure	Plan	23,140	28,306	26,506	*26,692*	***29,929***	***31,333***	*12,535*	*6,124*	*4,092*	*8,583*	-
	Actuals	24,249	29,355	26,899	*25,679*	***35,558***	***36,769***	*16,650*	*10,283*	*4,958*	*4,873*	*5*
	Mth variance plan	1,109	1,049	393	*-1,013*	***5,629***	***5,436***	*4,115*	*4,159*	*866*	*-3,710*	*5*

Data as at 19/06/2025

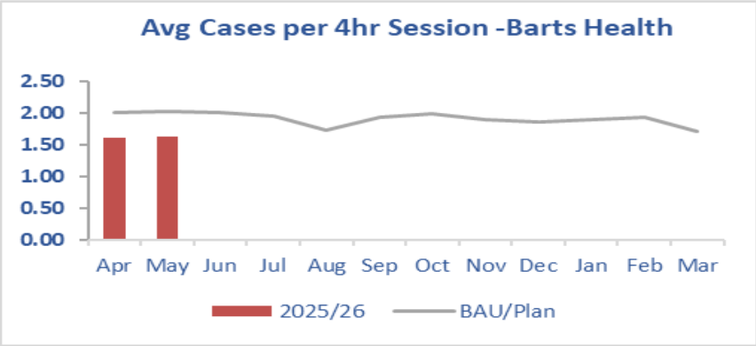
Performance Overview

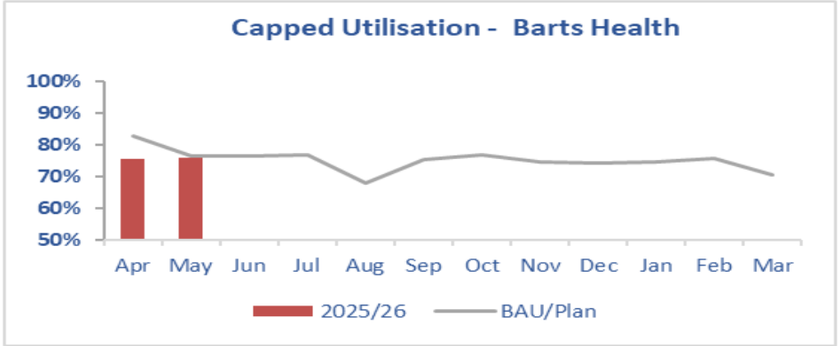
- For 2025/26, the NHS has set all trusts elective activity targets designed to pivot towards 18-week performance improvement
- First outpatient activity across the group is tracking against plan. Follow-up activity is slightly above planned levels. Outpatient attendances with a procedure are significantly above planed levels of activity.
- For outpatient attendances (first and follow-up), the trust set a target of 149,725 attendances for May 25 against which the trust delivered 160,543 (+10,818 over plan).

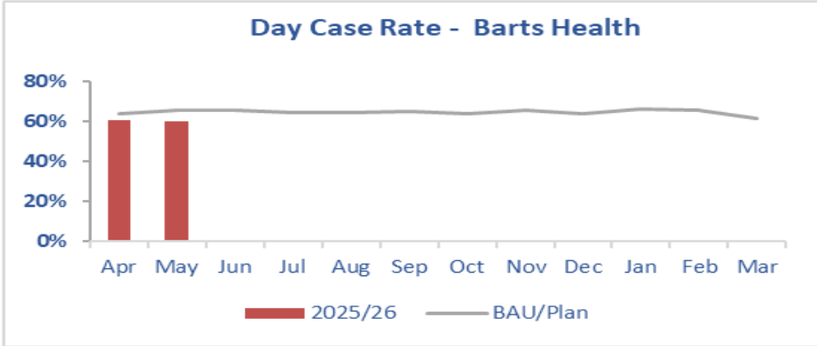
Responsible Director Update

- The Trust DNA rate for May 2025 was 9.6%, sustaining the improvement achieved in April of 9.7%. Previously in 2024/25, the DNA rate had remained consistently above 12%
- A significant contributor to the reduction in DNA's has been the successful implementation (phase 1) of the Trust Patient Engagement Portal, DrDoctor. Phase 1 includes remote consultation functionality and text message outpatient appointment reminders.
- The Clinic Template Optimisation Project has progressed with good engagement from Hospital sites. The purpose of the project is to enable the standardisation of clinic templates across services, in line with GIRFT standards . This is intended to shift activity profiles to increase first outpatient appointments and target a reduction in waits for first outpatient appointments.
- The first meeting of the digital transformation sub-group of the Outpatient Board took place on 18th June 2025. The purpose of the group is to develop a digital roadmap for outpatients and prioritise plans that lead to improvements in operational and clinical management processes. Through the Outpatient Board, the sub-group will report into both the Elective Recovery and Informatics Boards
- GIRFT review of ENT admitted and non-admitted pathways concluded with visits to Whipps Cross Hospital, Royal London Hospital and meeting the community provider Communitas. Formal feedback scheduled for 30th June 2025 and design of support offer from the GIRFT and ECIST teams will follow
- A deep dive on Remote Consultations was prepared for the Outpatient Board as part of closing the final actions from the internal audit in 2023. The deep dive outlined how Barts Health benchmarked against similar Trusts and key actions required to improve uptake as we develop a modern outpatient model
- The Hybrid Mail project has launched to implement systems and processes enabling digital letters to be sent to patients improving timeliness of communications and reducing paper and postage costs. Good engagement across hospital sites and corporate services and implementation plans in the process of being finalised

Theatre Utilisation







Theater Efficiency Activity

		Barts Health						Last Month's Site Position			
		Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Royal London	Whipps Cross	Newham	St Bart's
Avg Cases per 4hr Session	Actuals	1.61	1.67	1.59	1.60	1.60	1.63	1.47	2.23	2.03	1.05
	BAU	1.74	1.94	1.90	1.94	1.72	2.03	1.97	2.73	2.35	1.07
	Mth variance plan	*-0.13*	*-0.27*	*-0.31*	*-0.34*	*-0.12*	*-0.40*	*-0.50*	*-0.50*	*-0.33*	*-0.02*
Capped Utilisation	Actuals	73.6%	72.6%	74.6%	75.2%	75.4%	75.8%	75.9%	68.1%	77.9%	83.7%
	BAU	68.2%	75.7%	74.9%	76.0%	71.1%	76.4%	77.3%	72.0%	73.8%	81.1%
	Mth variance plan	5.4%	-3.0%	-0.2%	-0.8%	4.3%	-0.6%	-1.3%	-4.0%	4.2%	2.6%
Day Case Rate	Actuals	59.3%	62.9%	59.3%	59.4%	59.0%	60.0%	58.2%	71.4%	75.1%	17.0%
	BAU	64.2%	64.9%	66.1%	65.6%	61.2%	65.9%	65.6%	76.3%	77.0%	17.0%
	Mth variance plan	-4.9%	-2.1%	-6.8%	-6.2%	-2.2%	-5.9%	-7.5%	-4.9%	-1.9%	0.1%

Data as at 23/05/2025

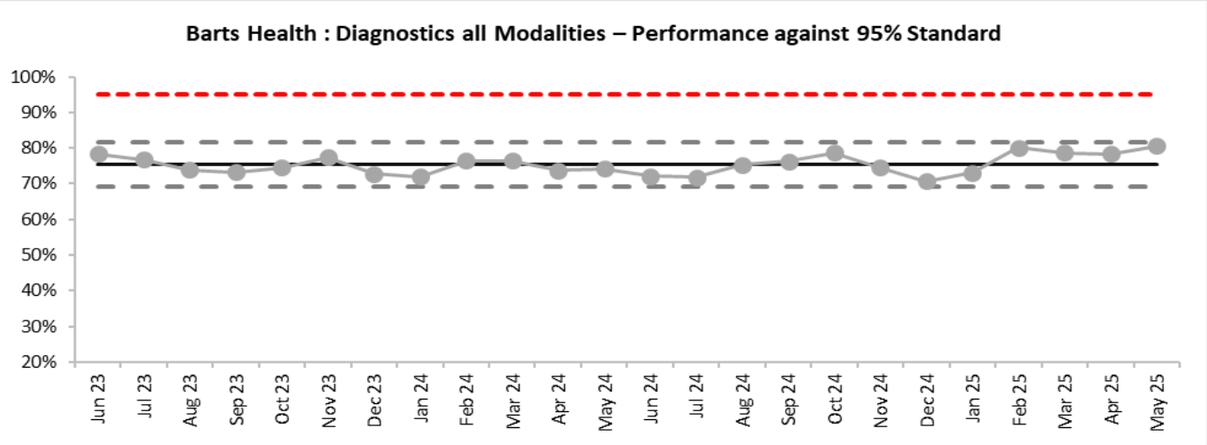
Performance Overview

- Set against internal trust data for May 1.63 cases per list were achieved against a BAU of 2.03 (-0.40%). For the same month, a capped utilisation rate of 75.8% was recorded, against a BAU of 76.4% (-0.6%) with day case rate of 60.0% was recorded against a BAU of 65.9% (-5.9%).
- Average cases per list have remained stable over the last 6 months and continue to track below the 19/20 BAU average. However, this has not impacted negatively on theatre utilisation, which remains on average at 75%. Day case rates are stable at around 60%. This is slightly lower than 19/20 BAU levels. Increasing case complexity and a shift from day case to outpatient procedures influences comparison with 19/20 BAU.

Responsible Director Update

- The Trust wide theatre improvement and productivity programme has been refreshed and was agreed at the Surgical Optimisation and Strategy Group in early June 2025. This focuses on 3 key priorities – pre-operative assessment; booking and scheduling and right place of care.
- A project group is being establishment to oversee the work on pre-operative assessment with a specific focus on rolling out digital screening and pre-surgical optimisation/
- The use of Care Coordination Solution (CCS) continues to be embedded within theatre planning and scheduling processes, underpinned by implementation of a Trust wide standard operating procedures. KPIs to demonstrate the benefit of CCS are being refreshed with a focus on driving productivity improvement along the surgical pathway and in administrative costs associated with theatre planning.
- Operational Delivery Networks (ODN) are focusing 'right place of care' including identifying further opportunities to shift procedures from inpatient to daycase and from daycase to outpatient procedures. The gynaecology ODN has established sub-groups to review uro-gynaecology, hysteroscopy and endometriosis across Barts Health.
- Demand and capacity analysis has been completed in ENT, vascular surgery and oral surgery. Recommendations for optimising capacity across the Group have been endorsed by the Elective Recovery Board and Group Executive Board.
- Recommendations from GIRFT on the Barts Health ENT model will inform the developing of the ENT ODN and the configuration of services across the Group.

Diagnostic Waits Over 6 Weeks



Trust Performance Overview

- For April 2025, Barts Health recorded the third largest Diagnostic Patient Tracking list in England and the second largest in London.
- As a proportion of the Patient Tracking List, Barts Health had the 12th highest proportion of 6+ week waiters out of 17 acute trusts in London and was ranked fourth out of the top 10 English acute trusts (ranked by Patient Tracking List volume).
- The diagnostic waiting list has remained relatively stable over the last 3 months and at the end of May 2025 was 31,491.
- Diagnostic waiting time performance across the Barts Health Group has been improving since December 2024. For May 2025, a performance of 80.6% was recorded, with a mean of 75.4%.
- During May 2025, there have been improvements in performance against the diagnostic waiting time standard in Dexa scanning, MRI, neurophysiology, sleep studies and endoscopy.

Indicator Background:

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

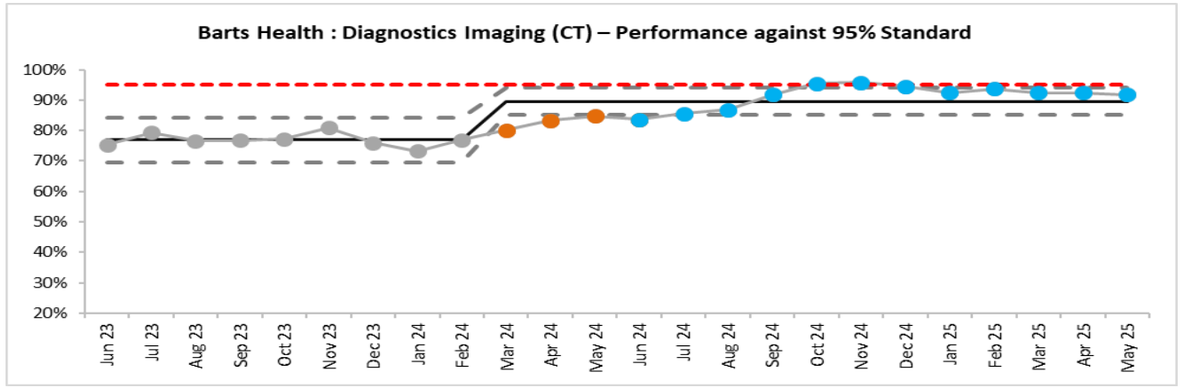
1. Outpatient Pathway
2. Diagnostic pathway
3. Admitted pathway

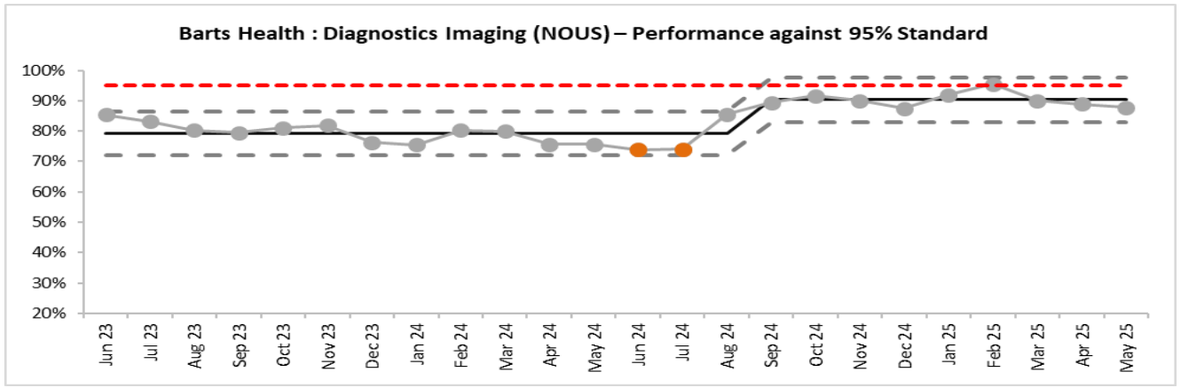
As part of the drive to reduce overall waiting times a 6-week maximum wait was set to receive a diagnostic test following referral for a test with an operational standard set of 99% of patients receiving their test within 6-weeks. The standard applies to a basket of 15 diagnostic modalities across imaging, endoscopy and physiological measurement. As part of the Covid pandemic recovery process a target of 95% was set across the NHS to be achieved by March 2025. No national standard has been set for 2026/27.

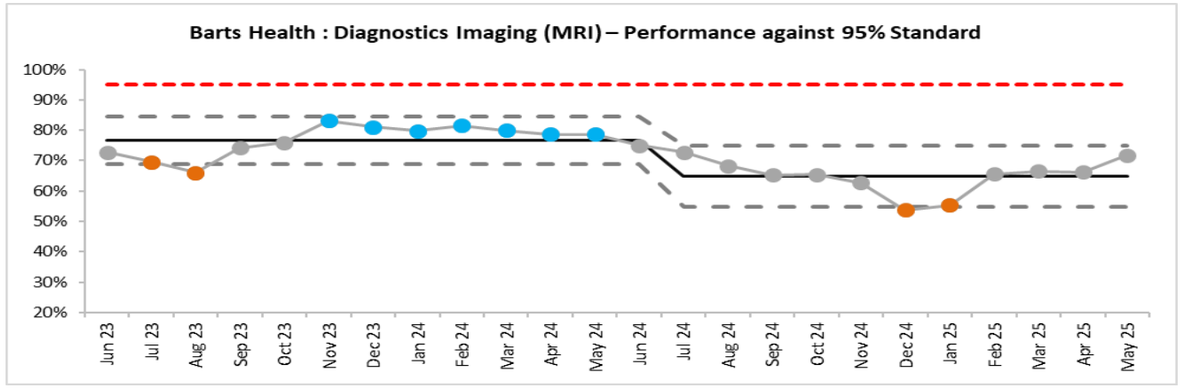
What is the Chart Telling us:

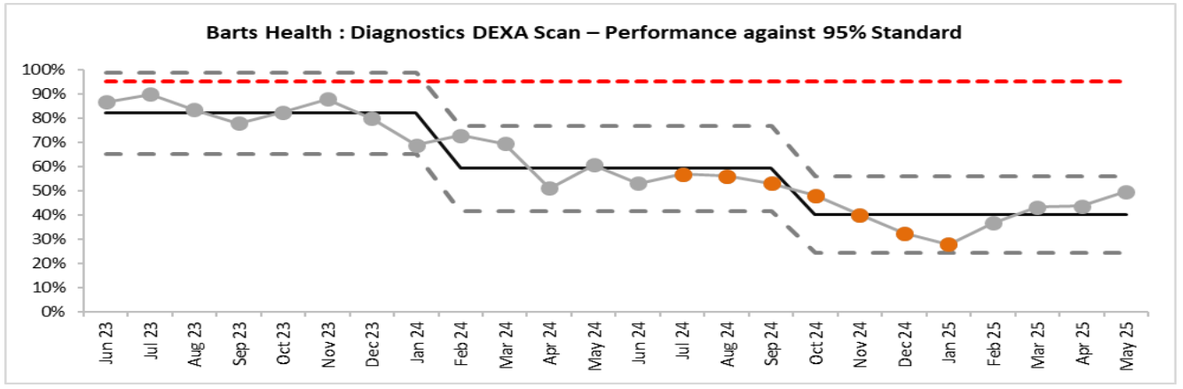
The chart presents a relatively narrow range of performance variability for the period June 2023 to May 2025, with performance operating just above or below the mean, in effect operating within a 10% band from 70% to 80%. In statistical process control terms, there is no significant change across the entire date range.

Diagnostic Waits Over 6 Weeks





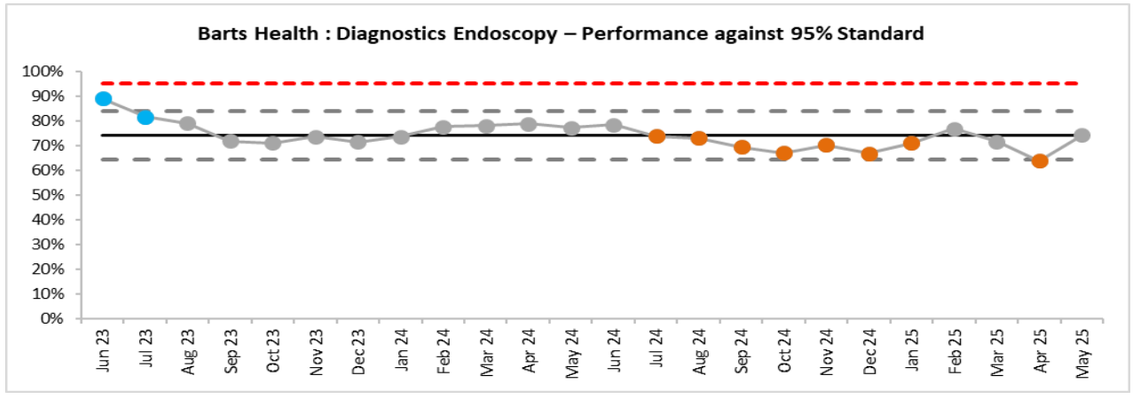


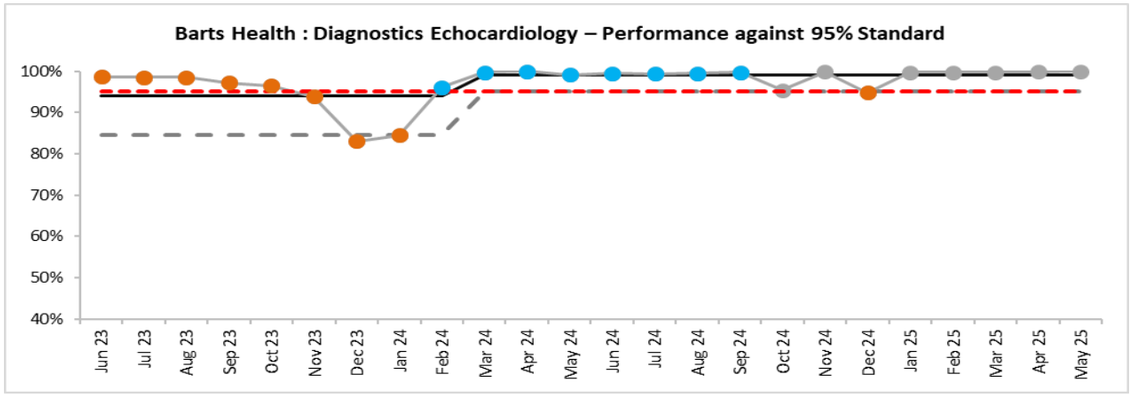


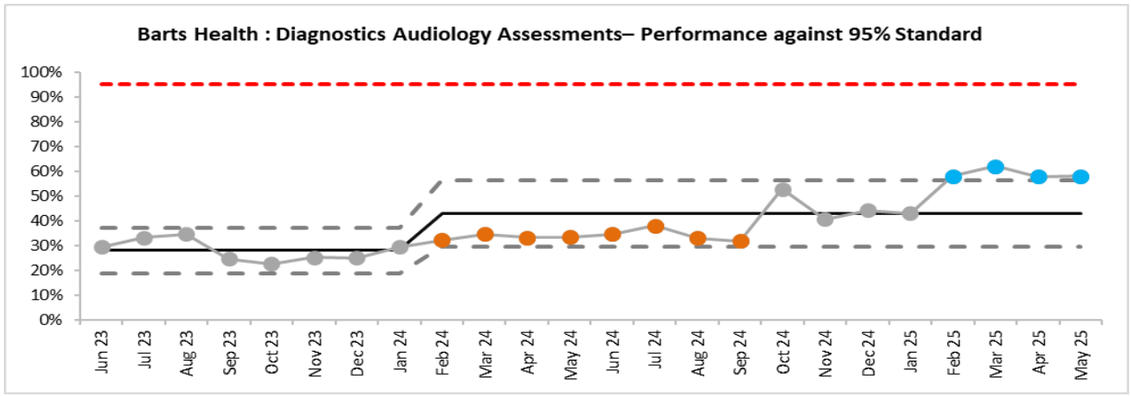
Trust Responsible Director Update

- CT waiting times across Barts Health remain relatively stable, despite the loss of a CT scanner at Newham University Hospital (NUH). The loss of capacity at Newham Hospital is being mitigated by use of CT capacity across the Group. NHSE have confirmed capital funding for the replacement of the 2nd CT scanner at (NUH). The business case for replacement has been approved and work is underway to procure and install a new scanner before the end of the financial year.
- MRI performance across Barts Health is improving and is expected to continue with the additional MRI scanner at NUH, which is now operational. This scanner was purchased with R&D and NHSE capital. It will provide an additional 7,000 MRI slots per year (3,000 R&D and 4,000 NHS). Whilst the R&D work increases, additional NHS capacity will be available.
- An additional temporary scanner at RLH is enabling a reduction in the waiting time for DEXA. Opportunities to secure capital and revenue funding for a permanent DEXA scanner are being explored to provide additional resilience for this service.

Other Diagnostic Waits Over 6 Weeks







DM01 Breakdown by Test							
	Apr-25			May-25			
Test Name	Waiting	Breaches	Performance	Waiting	Breaches	Performance	Variance in Performance
Cystoscopy	573	390	31.9%	611	386	36.8%	4.9%
Audiology - Audiology Assessments	2,152	909	57.8%	2,484	1,046	57.9%	0.1%
Urodynamics - pressures & flows	199	84	57.8%	220	84	61.8%	4.0%
Respiratory physiology - sleep studies	136	54	60.3%	97	23	76.3%	16.0%
Gastroscopy	922	322	65.1%	960	211	78.0%	12.9%
Flexi sigmoidoscopy	173	37	78.6%	221	33	85.1%	6.5%
Colonoscopy	854	167	80.4%	959	81	91.6%	11.1%
Neurophysiology - peripheral neurophysiology	142	41	71.1%	105	8	92.4%	21.3%
Cardiology - echocardiography	1,898	2	99.9%	2,308	2	99.9%	0.0%
Cardiology - Electrophysiology	0	0	100.0%	1	0	100.0%	0.0%
Grand Total	**7,049**	**2,006**	**71.5%**	**7,966**	**1,874**	**76.5%**	**4.9%**

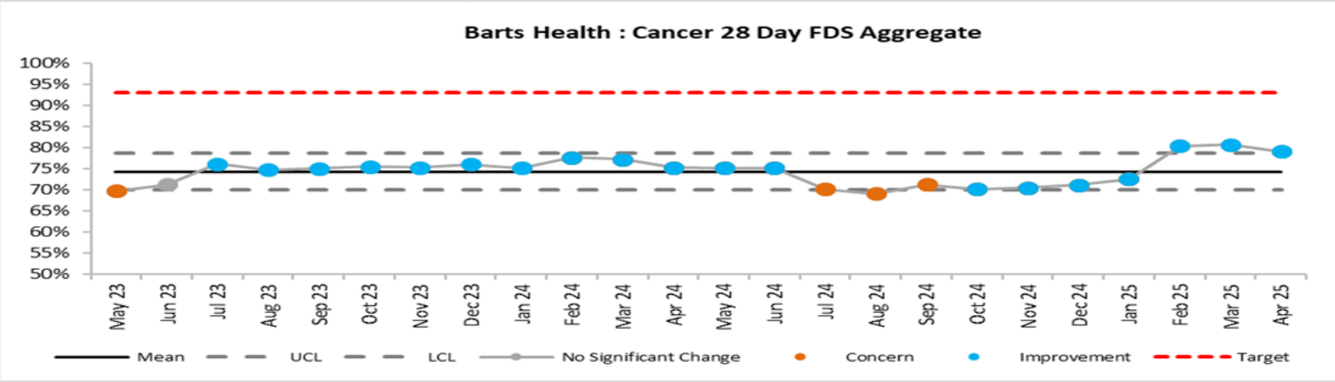
Trust Responsible Director Update

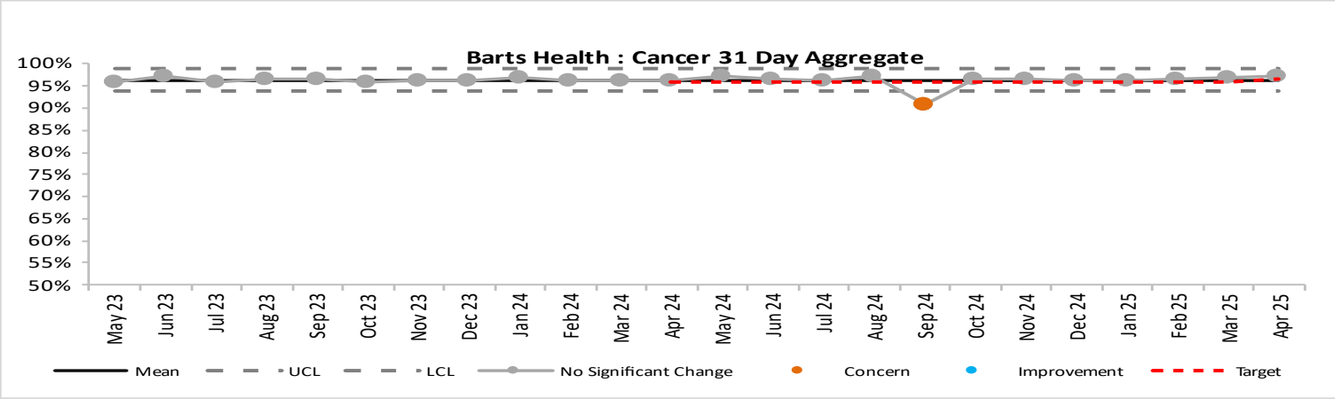
- Data quality and validation issue in endoscopy have been resolved and this is reflected in improved performance in the DM01 position. Work has commenced on the development of an ODN in endoscopy, which will build on the work of the endoscopy productivity project group. Demand and capacity analysis across the Group has been completed. Utilisation metrics for endoscopy have been agreed and a 12-point minimum standard for booking lists.

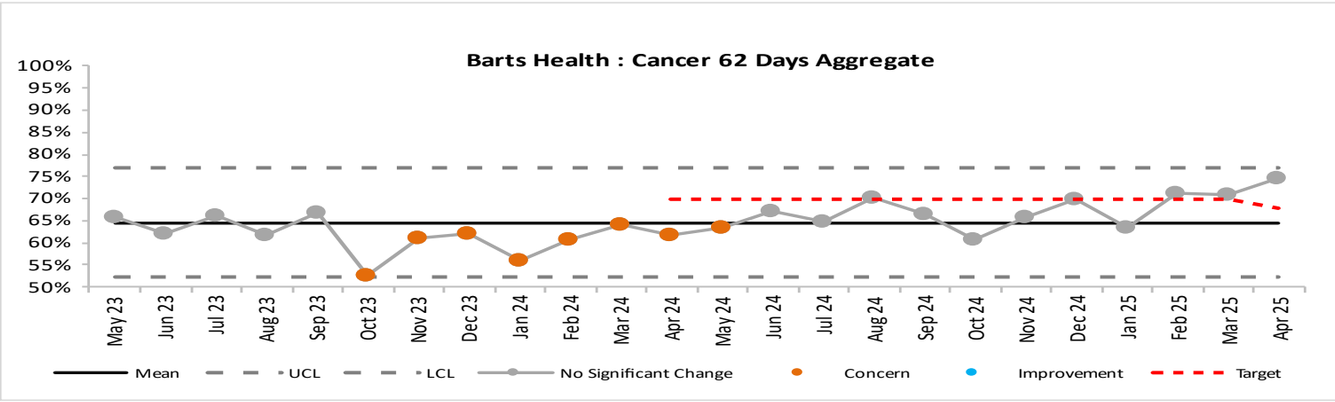
- Diagnostic waiting times continue to improve for sleep studies following capital investment in machines at St Barts Hospital (SBH). Whipps Cross Hospital and SBH are reviewing opportunities for further improvement in the waiting time for sleep studies, as the backlog is cleared at SBH.

- Waiting times for audiology assessment are improving, with progress made on clearing the backlog of adult audiology assessment. Paediatric audiology remains an areas of risk. Investment has been confirmed to right-size the workforce and recruitment to new roles has been successful. However, new vacancies are arising as staff leave for promotion opportunities. NHSE have offered resource to provide additional resilience for the service.

Cancer Waiting Times Standards







- In April 2025, Barts Health was compliant against its monthly trajectories for the Faster Diagnosis (FDS) and 62-day standards and achieved the former national standard for 31-days to Decision to Treat.

- For April 2025, the trust achieved 79.1% against the monthly trajectory of 75.3% for 28-day FDS aggregate. The target to achieve by March 2026 is 80%. The trust position benchmarked against other London providers was 13/17. The trust position benchmarked against national providers was 47/119.

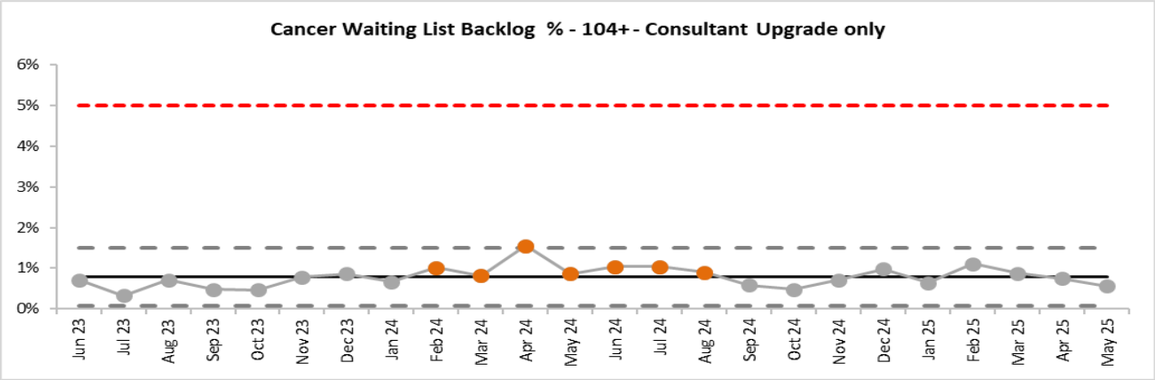
- For April 2025, the trust achieved 97.2% for the 31-day aggregate standard against the former national target of 96%. The trust position benchmarked against other London providers was 9/17. The trust position benchmarked against national providers was 31/123.

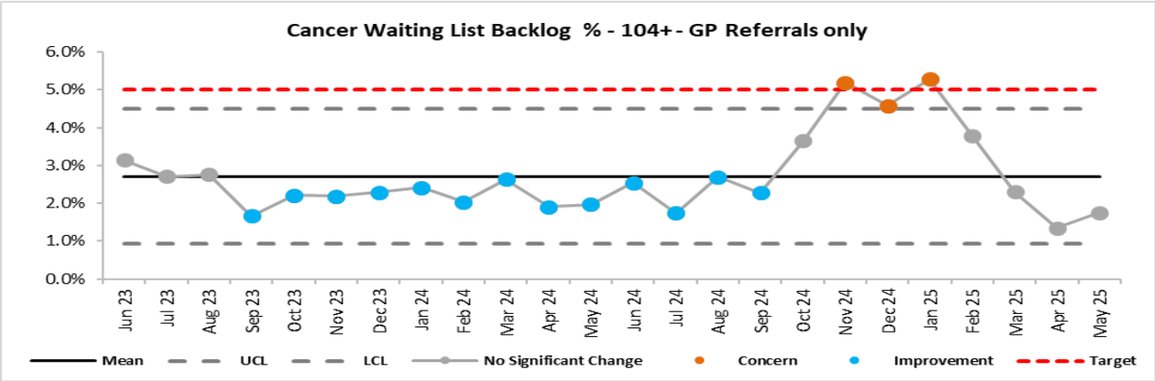
- For April 2025, the trust delivered 74.5% for the aggregate 62-day standard against the monthly trajectory 67.7%. The target to achieve by March 2026 is 75%. The trust position benchmarked against other London providers was 11/17. The trust position benchmarked against national providers was 47/122.

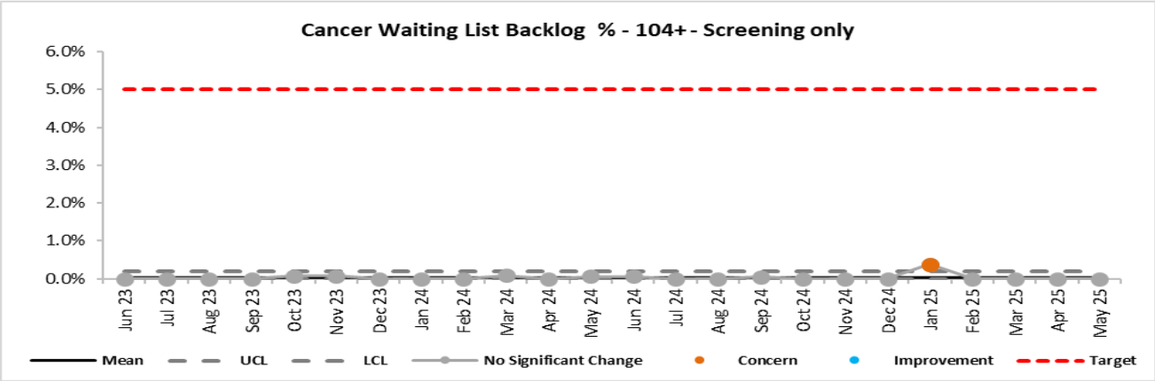
- The trust is continuing to aim for a reducing weekly backlog. The most recent submission was 7.49% for w/e 22.06.25. Work has commenced with hospitals to model how we might reduce the backlog to <5%. This will include understanding this at a service level and being clear on the actions required to reduce and sustain.

- The Trust Cancer Board met on 11.06.25. This was well attended by colleagues from across the Barts Health Group and included attendance from the North East London Cancer Alliance. At the Board, a bid for SBH to become a commissioned as a Tumour Infiltrating Lymphocyte (TIL) therapy hub for Melanoma was approved. This would support treatment for adult patients with previously treated, unresectable or metastatic melanoma. The bid process has closed and the trust waits to hear if it has been successful.

Cancer 104+ Waiting List Backlog %







Indicator Background:

The NHS has for many years set a standard that 85% of patients urgently referred by their GP for suspected cancer or urgently referred from a cancer screening programme or by a consultant upgrading the urgency of the referral should be treated within 62 days. Managing a reduction in long waiting 63-104+ days pathways is key to improving outcomes for patients and waiting times overall.

What is the Chart Telling us:

The three charts break out 104-day backlog for GP referrals as well as for Consultant Upgrade and Screening referrals. One of the charts, Screening referrals (bottom chart), presents effectively zero or single figure breaches (0% as a proportion of the waiting list), meaning backlog has been virtually eradicated over the course of the charts time-series.

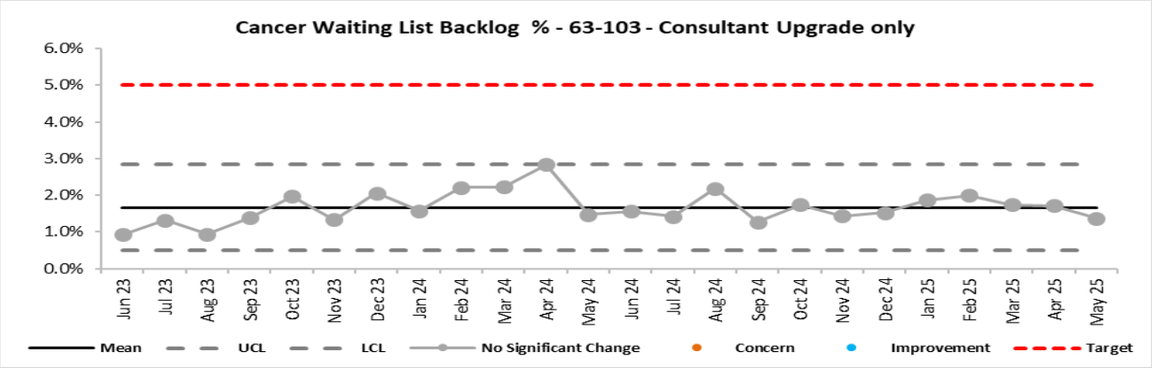
However, despite Consultant Upgrade breaches (top chart) being maintained at a relatively low volume and proportion over the course of the chart's time series there was a cause for concern increase in the volume of backlog recorded across the period February to August 24, However, between September 24 and May 25 there has been no significant change with backlog stable, but not reducing, at circa 1% of the waiting list.

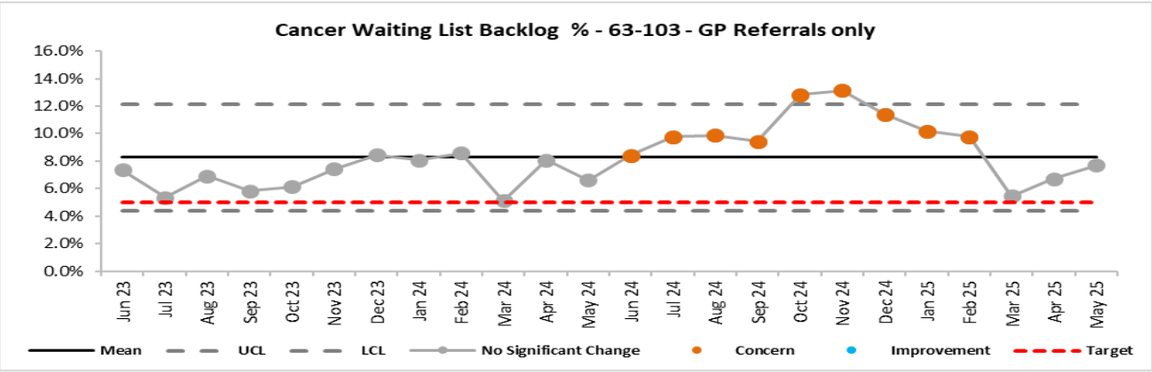
For GP referrals (middle chart), there is a cause for concern across the period November 24 to January 25, however there is then a steep reduction to below the mean from February to April 25, with a slight increase visible in May 25.

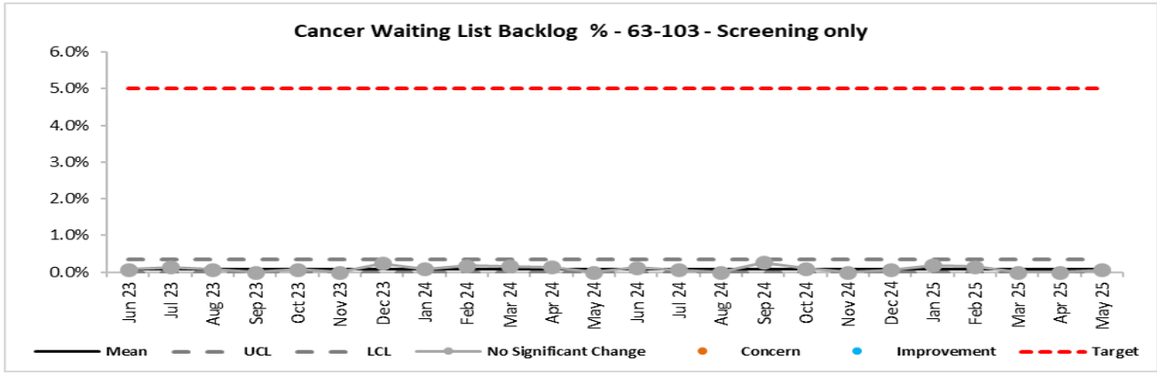
Trust Performance Overview

- The charts opposite represent the 93 cancer patients waiting greater than 104 days at the end of May 2025, a reduction of 5 against the April 2025 position of 98.
- The charts present the number of patients waiting by GP referrals (66), Consultant Upgrade (26) and Screening service referrals (1). This represents all patients waiting 104 days and above.
- In April 2025, the specialties with the highest number of patients over 104 days were; Urology (37), Gynae (29) and Colorectal (13)
- The May 25 position is included in the graphs; however this is provisional as the final national upload and submission has not been completed.

Cancer 63 -103 Waiting List Backlog %







Indicator Background:

The NHS has for many years set a standard that 85% of patients urgently referred by their GP for suspected cancer or urgently referred from a cancer screening programme or by a consultant upgrading the urgency of the referral should be treated within 62 days. Managing a reduction in long waiting 63-104+ days pathways is key to improving outcomes for patients and waiting times overall.

What is the Chart Telling us:

For GP referrals (middle chart) the proportion and volume have been above the mean from June 24 to February 25, with a concerning trend recorded across this period.

Despite some data variability, the volume of backlog for Consultant Upgrades (top chart) remains relatively consistent, apart from an uptick in April 24, across the entire time-series no significant change recorded.

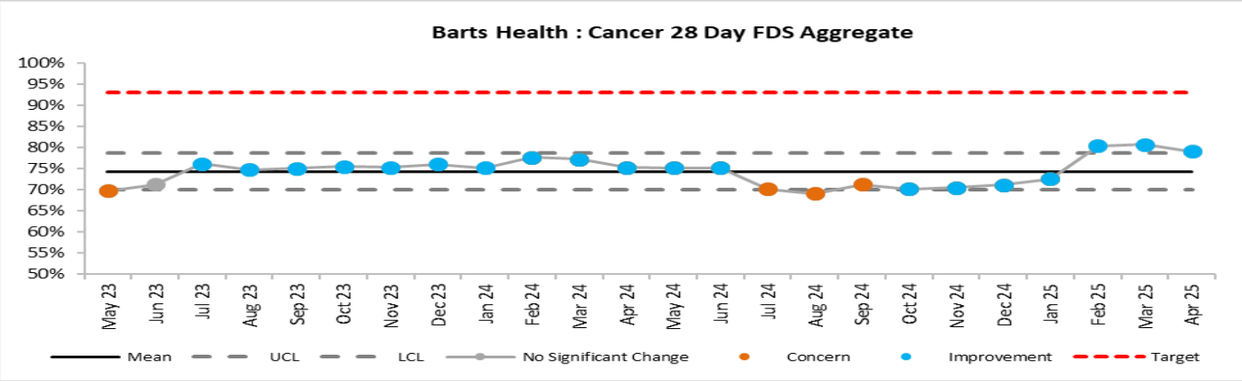
Screening referrals (bottom chart), presents zero or low figure breaches (circa 0% as a proportion of the waiting list), meaning backlog has been virtually eradicated over the course of the charts time-series.

Trust Performance Overview

- The charts opposite represent the 397 cancer patients waiting between 63 to 103 days at the end of May 2025, an increase of 40 against the April 2025 position of 357.
- The charts present the number of patients waiting by GP referrals (319), Consultant Upgrade (68) and Screening service referrals (10).
- In April 2025, the specialties with the highest number of patients waiting 63-103 days were; 96 Urology, 77 Gynae, 59 Colorectal, 46 Head and Neck.
- The May 2025 position is included in the graphs; however this is provisional as the final national upload and submission has not been completed.

Cancer Faster Diagnosis Standard Metrics (FDS)

INCREASING PERFORMANCE AND PRODUCTIVITY - CANCER



Trust Performance Overview

In April 25, the trust achieved the monthly Aggregate Faster Diagnosis objective, recording a performance of 79.1% against the monthly trajectory of 75.3%.

Indicator Background:

The 28-day Faster Diagnosis standard requires at least 77% of people who have been urgently referred for suspected cancer, have breast symptoms, or have been picked up through cancer screening, to have cancer ruled out or receive a diagnosis within 28 days.

The 28-day Faster Diagnosis standard replaced the former 2-week to first appointment standard and is considered a better measure for clinical care and patient experience. The two-week wait target simply measured the time from referral to seeing a specialist, it did not measure waiting times for diagnostic tests, results reporting and for the patients to be told whether or not they have cancer. However two-week waiting times continue to be reported to the NHS and are included on a later slide.

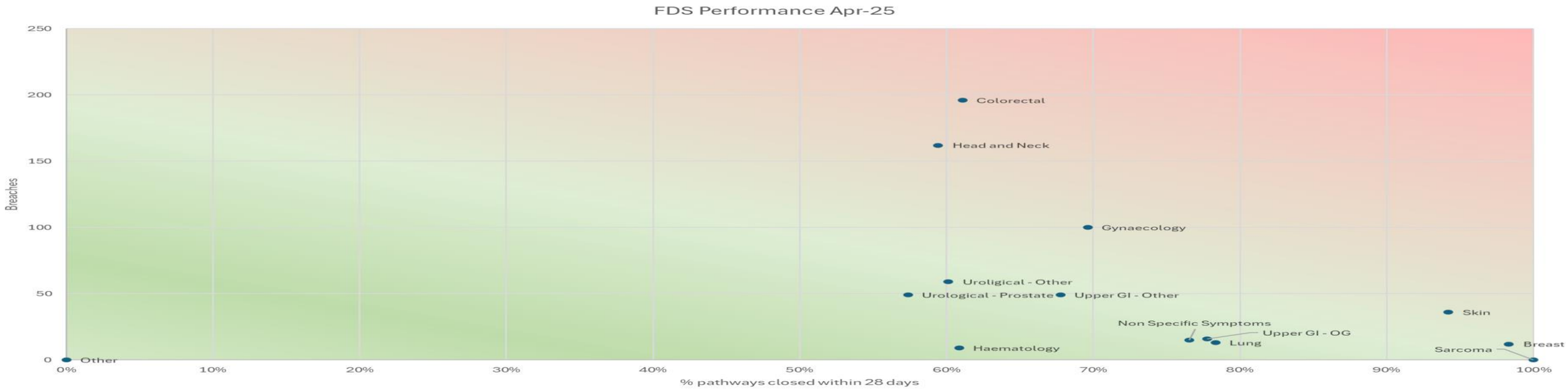
What is the Chart Telling us:

The chart presents two periods of improving performance, across July 23 to June 24 and October 24 to April 25. These two periods are dissected by one period of concern between July and September 24, when performance reduced below the mean. For most of the time series performance operates within an extremely tight margin of between 65% to 75%, a 10% band. However, for the period February to April 25 performance pushes up towards 80%.

Trust Responsible Director Update

- The FDS aggregated performance was compliant in April 2025 with performance at 79.1%. This is the 3rd consecutive month where a performance > 77% (March 2025) standard has been achieved. The May 2025 position will be submitted on 01.07.25. The current provisional position for FDS is 79.6% and validation is continuing which may result in further improvement.
- There is variation in FDS performance across the 4 Hospitals – 97.4% SBH, 79.5% WX, 77.4% NUH, 71.1% RLH. Through the hospital access meetings and fortnightly drive to 85 meeting, there is an opportunity to to understand challenges to further improvement and consider what actions can be taken to mitigate across the group.
- Sarcoma was at 100% compliance with FDS in April 2025. This service has now moved and established under the Clinical Services Division at SBH.
- The 4 tumour groups that need further intervention to move the FDS to achieve >70% are Colorectal (61.1%), Gynae (69.6%), Head and Neck (59.5%) and Urology (56.3%). A further round of deep dives with clinical oversight are planned to understand what further actions can be put in place. There are several interventions already underway including improving access to diagnostics .
- The trust has put in place a weekly meeting with other NEL acute providers to discuss cases that need to be transferred for MDT discussion and or possible treatment. This will aim to ensure that all relevant actions have been undertaken by the referring trust to try and improve pathways of care and avoid breaching the cancer performance standards.
- At the Trust Cancer Board in June 2025, the Royal London presented an equality impact assessment on the Rapid Diagnostic Clinic/Non Specific Symptoms. This service was set up as a pilot and is funded on a non recurrent basis and therefore not sustainable without top up funding. Around 40% of the referrals to the service can be returned to GPs with advice as don't require secondary care input. Meetings are in place between Barts Health and the Cancer alliance to agree next steps, alternative pathways of care for patients.

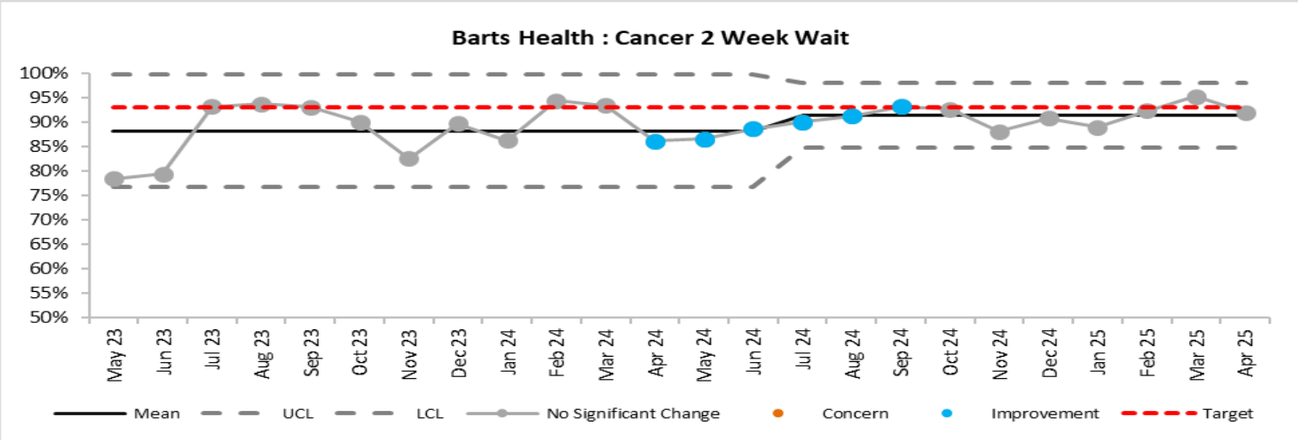
Cancer Faster Diagnosis Standard Heat Map



Month	Breast	Colorectal	Gynaecology	Haematology	Head and Neck	Lung	Non Specific Symptoms	Other	Sarcoma	Skin	Upper GI - OG	Upper GI - Other	Uroligical - Other	Urological - Prostate	Total
Apr-25	-60	80	24	3	70	4	5	-	-8	-107	-1	14	24	22	-71
Mar-25	-60	38	40	5	2	-5	2	1	7	-95	1	27	37	18	-123
Feb-25	-65	12	5	3	31	1	10	-	61	-75	-5	-1	37	20	-112
Jan-25	-45	104	110	-1	20	17	13	-1	37	-85	9	7	71	31	152
Dec-24	-64	145	94	-2	3	4	112	1	20	-77	5	22	58	29	196
Nov-24	-62	145	104	-	12	-1	78	37	20	-84	8	2	80	27	225
Oct-24	-51	257	90	1	34	-1	17	15	6	-104	11	15	66	24	243
Sep-24	-61	199	76	1	60	5	14	20	16	-94	19	9	42	9	180
Aug-24	-50	200	74	5	55	8	20	39	19	-103	24	16	55	14	261
Jul-24	-49	246	73	1	21	6	21	27	19	-131	22	22	76	28	256
Jun-24	-61	141	51	6	19	19	30	14	2	-115	29	7	33	21	64
May-24	-62	158	44	2	37	16	18	18	5	-101	7	6	42	26	66

Cancer First New (2WW)

INCREASING PERFORMANCE AND PRODUCTIVITY - CANCER



Indicator Background:

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

The 28-day Faster Diagnosis standard replaced the former 2-week to first appointment standard and is considered a better measure for clinical care and patient experience. The two-week wait target simply measured the time from referral to seeing a specialist, it did not measure waiting times for diagnostic tests, results reporting and for the patients to be told whether or not they have cancer. However two-week waiting times continue to be reported to the NHS and are included on this slide.

What is the Chart Telling us:

The chart details a period of sub target performance in the early part of the data series, with the three months following, July to September 23, achieving the target. There is also a period of improving performance recorded across April to September 24, however the more recent period between October 25 to April 25 effectively records no change.

Cancer 2WW Breakdown by Site - Apr-25

Site	Seen	Breaches	Performance	Target
Royal London	1,063	201	81.1%	93.0%
Whipps Cross	1,790	66	96.3%	93.0%
Newham	633	19	97.0%	93.0%
St Bart's	316	20	93.7%	93.0%
Barts Health	**3,802**	**306**	92.0%	**93.0%**

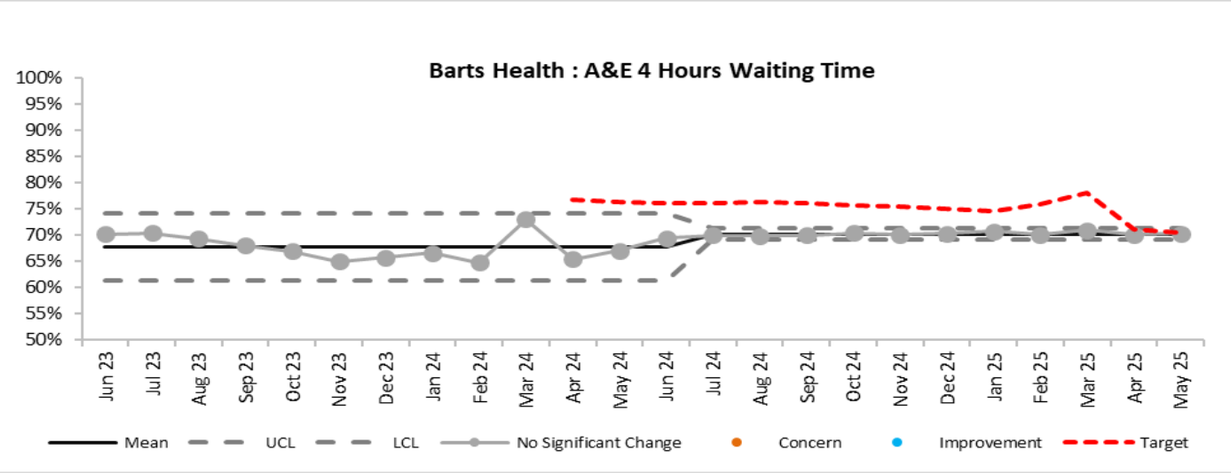
Trust Performance Overview

The trust did not achieve the former 93% standard in April 25, recording a performance of 92.0%.

Trust Responsible Director Update

- April 2025 performance was 92% which is a deterioration from 95.2% in March 2025. There is a seasonal impact in April due to bank holidays (easter) which impacts on appointments however it is recognised it is important to improve against this standard in ensure FDS performance can be sustained.
- Lung and Head and Neck were the two most challenged with ensuring patients have an appointment within 2 weeks of referral (77.6% and 81.7% respectively).
- The trust is starting to monitor via daily reports the number of patients booked for a 1st appointment in 2 weeks of referral. For May 2025, this is currently around 29%. Through drive to 85, there will be a discussion as to how we might work towards improving against this which would support the FDS position.

A&E Performance against 4 Hour Waiting Time



Indicator Background:

The A&E four-hour waiting time standard requires patients attending A&E to be admitted, transferred or discharged within four hours. From 2010 the four-hour A&E waiting time target required that at least 95% of patients were treated within four-hours. As a consequence of the impact of the Covid pandemic, during December 2022 an intermediary threshold recovery target of 76% was set to be reached by March 2024 with further improvement expected in 2024/25, now set at 78% by March 2025, the 78% target has also been set for March 26. Fundamentally the four-hour access target is a clinical quality and patient experience measure.

What is the Chart Telling us:

Over the course of the time series performance against the 4-hour standard has been consistent, operating within a relatively narrow range of 65% to 75%, with most of the data points operating just on or close to the mean of 70%. The highest performance during the time-series is recorded in March 24.

During April 24 performance reduced significantly against March's exceptionally high performance, with a new patient administration module deployed at this time, however for the period June 24 to May 25 there is no significant change.

Trust Performance Overview

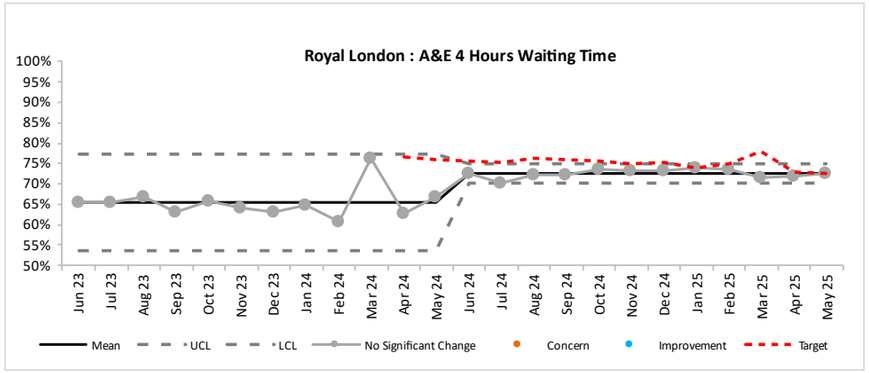
- For 2025/26 an A&E 4-hour performance standard of 78% has been set for delivery by March 26.
- In May 25 the trust did not achieve the monthly 4-hour objective, recording a performance of 70.2% against a monthly trajectory of 70.4%.
- In May, 45,889 attendances were recorded, 1,487 more than the 44,402 recorded in April 25 (+3.4%).

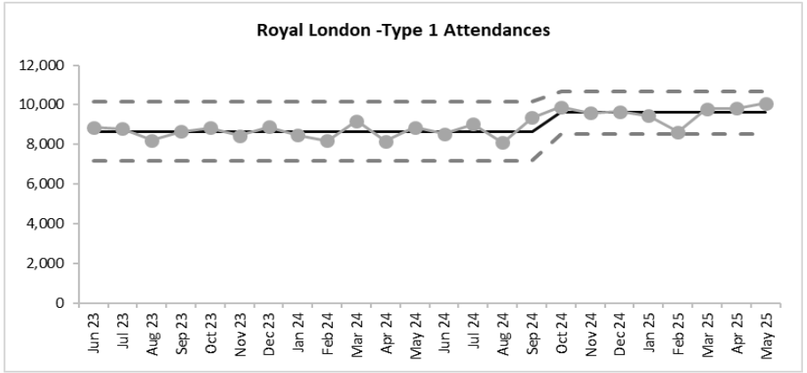
Trust Responsible Director Update

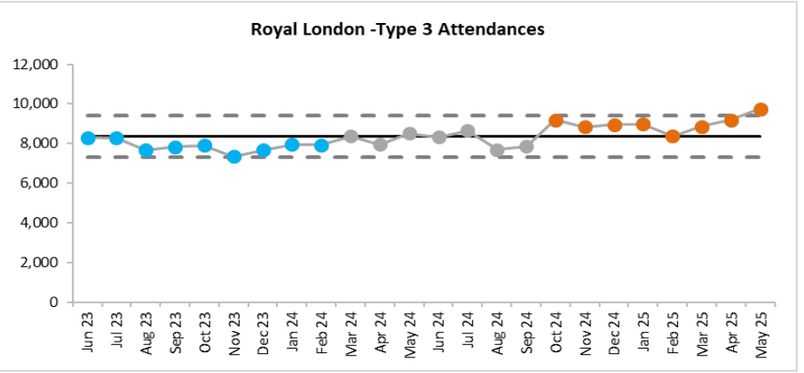
- **Overall Trust performance:** In May 2025. Trust performance was 70.25**%**, a stable position Trust wide with the Trust ranked 14 out of 17 London reporting Trusts on the four-hour standard, and 5 out of 10 nationally for performance of the largest A&Es in the country.
- **Urgent Treatment Centre (UTC) performance:** Type 3 performance deteriorated to 90.05%. NUH remained static at 86.32% , RLH deteriorated to 88.82%, WXH maintained high performance at 99%. **NUH UTC:** The UTC at Newham has undergone several PDSA cycles, including working with an external provider. Their best performing month was March at 91.5%, where an external provider covered evening shifts. This is being explored to see the impact of using an external provider full time to deliver better care and enable a productivity improvement. **WXH Cross UTC:** Although performance holds high consistently at 99%, a small increase in volume to support a reduction in Type 1 non admitted attendances is being observed, this is being driven by a joint clinical reference group for NELFT and Whipps cross. **RLH UTC:** RLH UTC performance remains a challenge. The ICB is conducting a review of all UTCs to ensure productivity, quality and performance metrics are met.
- **Type 1 Admitted performance:** Type 1 admitted performance was static at 17.7%, with WXH at 13.8 %, NUH at 11.6% and RLH at 23.8%.
- **Type 1 Non-admitted performance:** Type 1 Non admitted performance for the Trust was 61.5%. This is now a static position. All Hospitals performance is stable in this space. Non-admitted LoS has started to improve to 4.3hrs.
- **Attendances**: In May 2025, the trust saw 45.879 attendances. Type 1 non-admitted attendances accounted for the highest number of attendances, and the front door teams are focussing on alternative pathways to redirect this group of patients. This is inclusive of more same day emergency access slots being available in primary care for our streamers to redirect patients to.

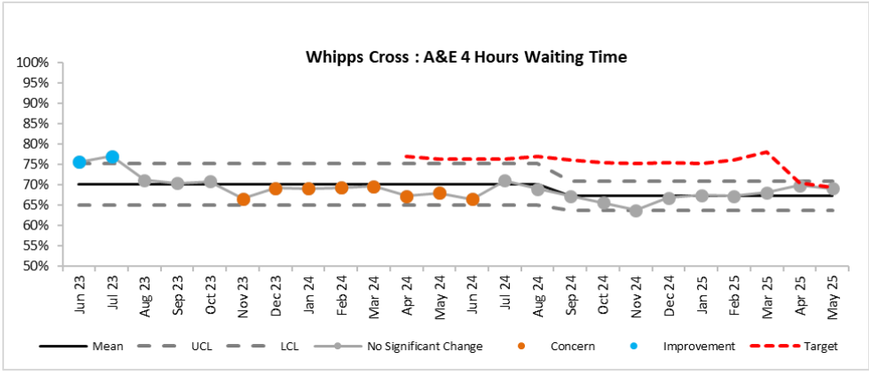
A&E Attendances & Performance against 4 Hour Waiting Time

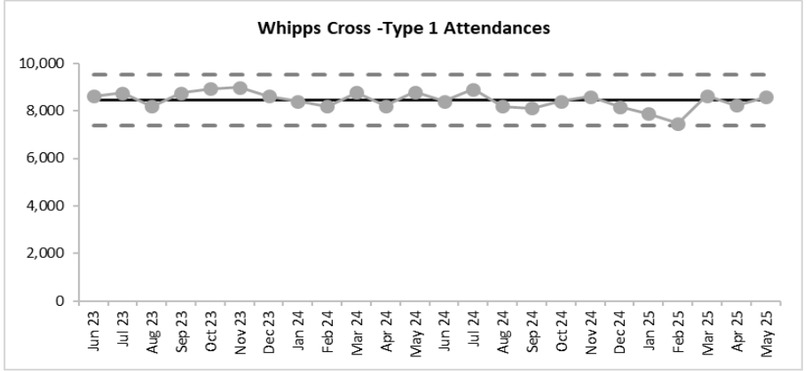
INCREASING PERFORMANCE AND PRODUCTIVITY URGENT AND EMERGENCY CARE

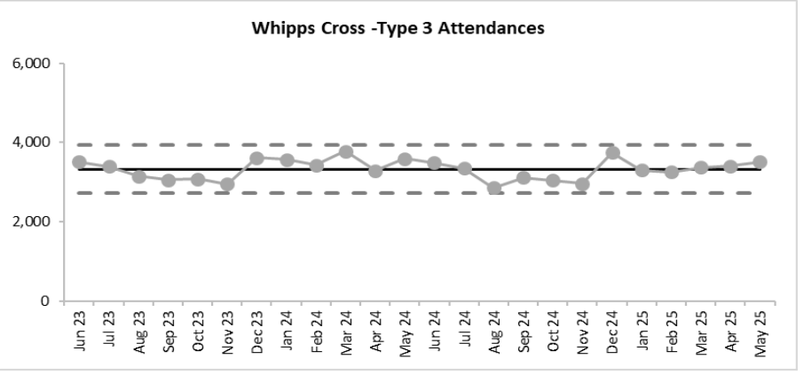


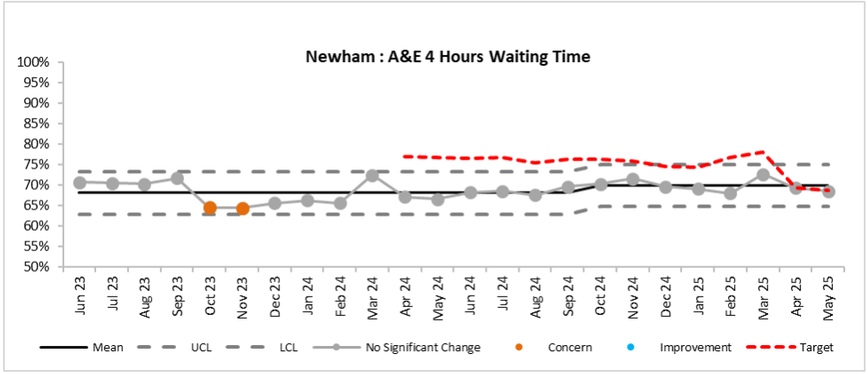


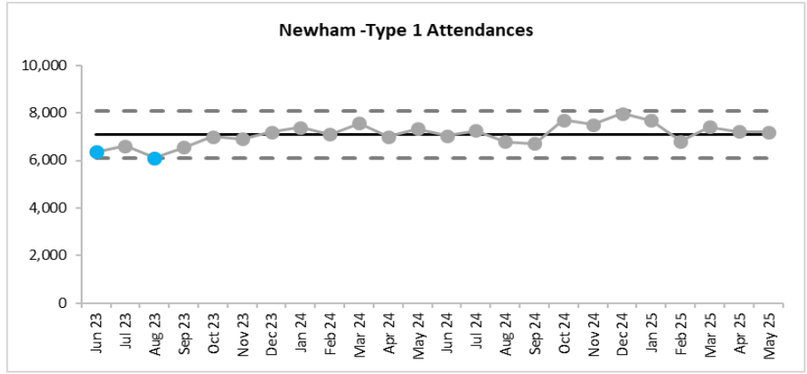


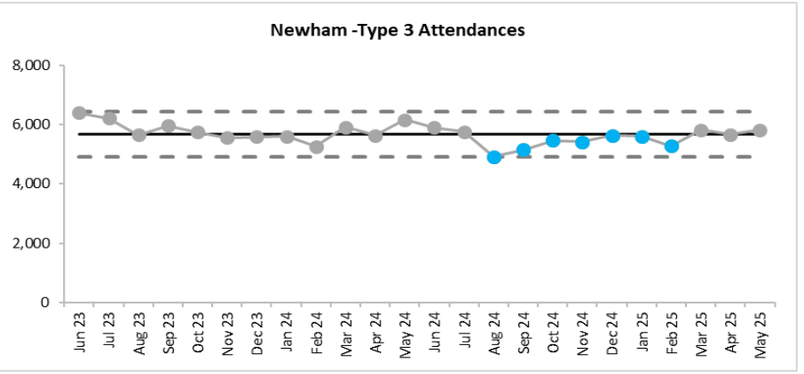




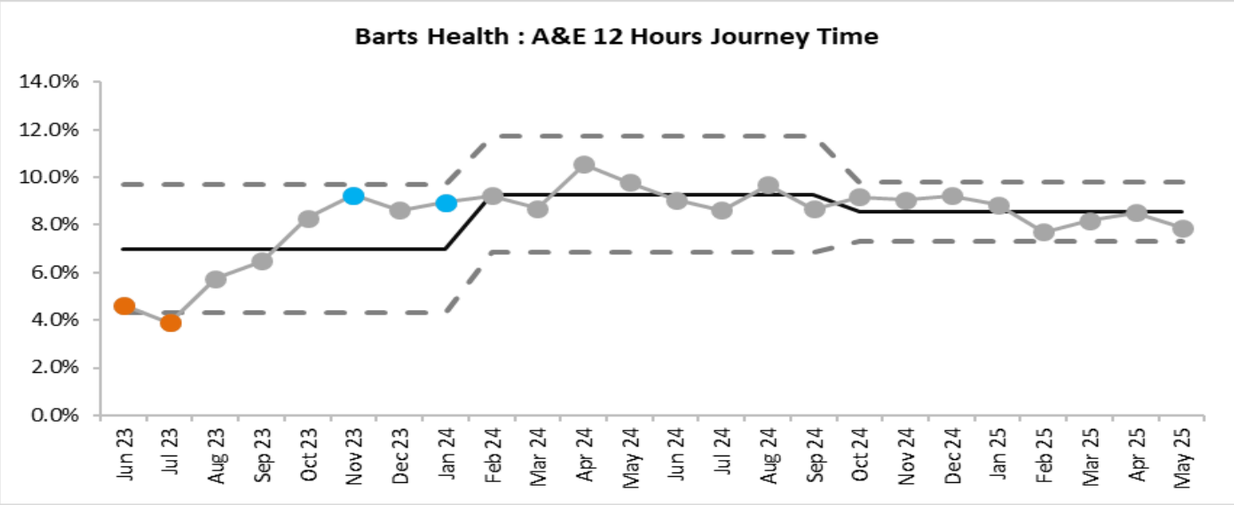








A&E 12 Hrs Journey time



Indicator Background:

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

The standard is designed to measure and improve patient experience and clinical care. As such it is a key performance and safety metric with the Royal College of Emergency Medicine noting a correlation of long waits in A&E's to potential patient harm and clinical outcomes.

What is the Chart Telling us:

The chart presents considerable data-variability above and below the mean, however there is a period of increasing journey times August to November 23 with an increasing step-change visible in the data from February 24 with both the mean and monthly data points reflecting an increase in breaches from that point in time.

The percentage of 12-hour breaches operates within a relatively tight range of no more than 3 - 4%% across October 23 to May 25, with no significant change recorded across the majority of the time series.

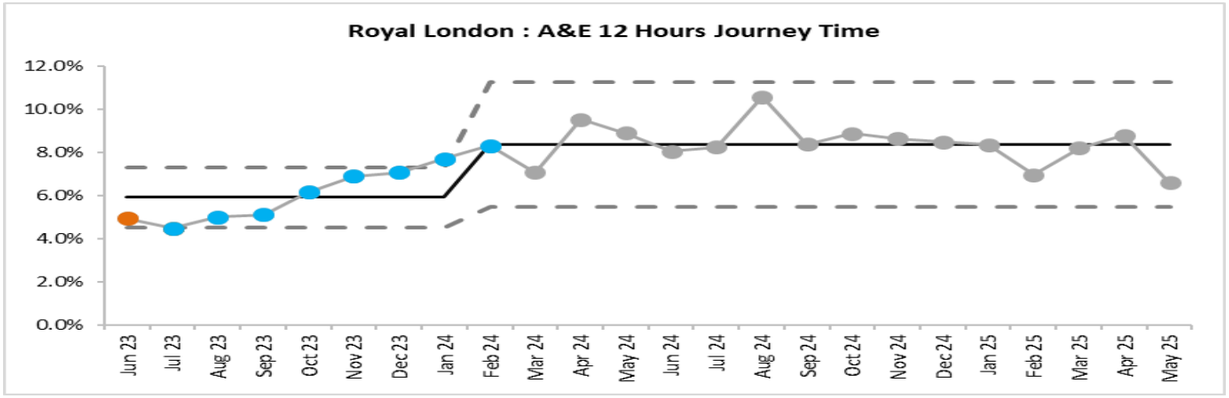
Trust Performance Overview

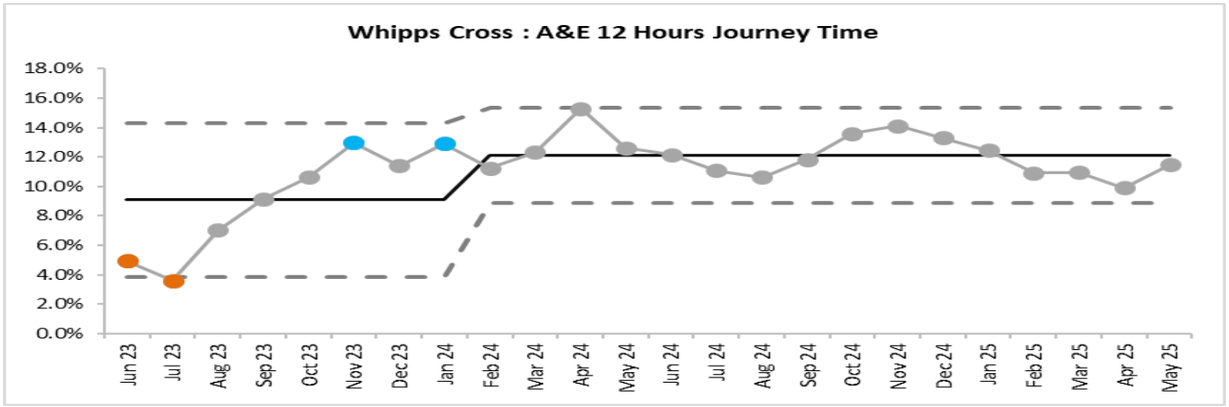
- The proportion of patients with an A&E 12-hour journey time was 7.9% in May against a mean of 8.6%, with the national expectation that this should be a reducing trend.
- Barts Health is currently ranked in the 8th decile nationally on this metric benchmarked against all other acute Trusts an improvement of one decile since last month.

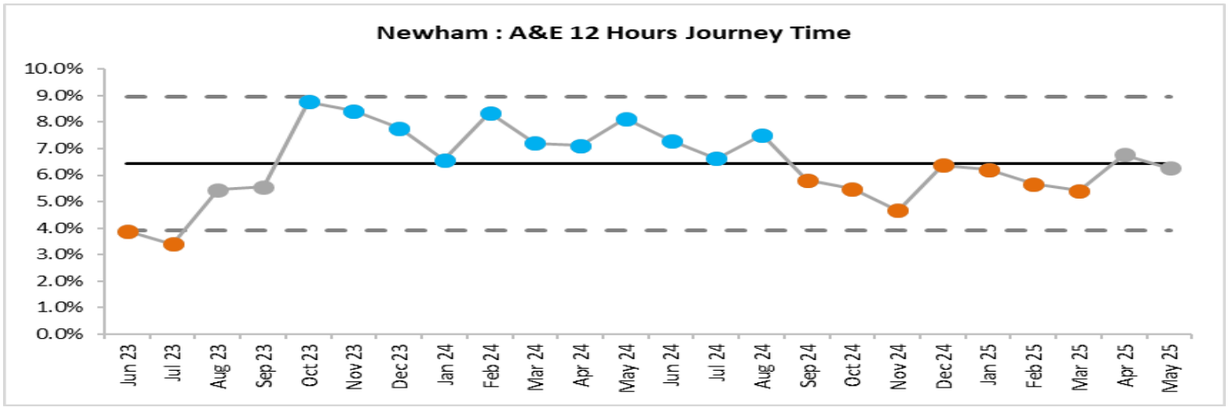
Trust Responsible Director Update

- **Trust wide**: The 12-hour position improved to 7.9% in May 2025. This is despite an increase in discharge ready patients.
- **Physical health**: A new escalation policy was launched in February 2025 ensuring that no patient should remain in ED over 48 hrs for a physical health condition. A significant improvement is being observed through implementation of this policy. This is demonstrated through the average admitted LoS which has reduced from to 15 hrs.
- **Mental Health**. In May 2025, the trust average Length of Stay (LoS) was 19 hrs hours. This has been driven by external providers no longer accessing private beds.
- **Same Day Emergency Care (SDEC):** The number of patients attending SDEC has now stabilised at around 4000 across the Trust, Whipps cross is planning to expand its SDEC footprint as part of their Emergency floor reconfiguration.
- **REACH and Frailty: F**ollowing detailed analysis and audit of 12 hr journey time it was observed that the patients over 75 are more likely to breach 12 hours. As a result of this, we are trialling a test of change in REACH with Frailty. This involves a Frailty consultant joining the team to consult for frail elderly patients. In the first week, of the calls taken 80% have avoided being conveyed to Hospital. The trial will continue into June 2025.

A&E 12 Hrs Journey time







Hospital Site Performance Overview

Royal London:
The proportion of 12-hour wait times recorded at the Royal London was 6.6% for May 2025, a decrease of 2.2% against April's 8.8%.

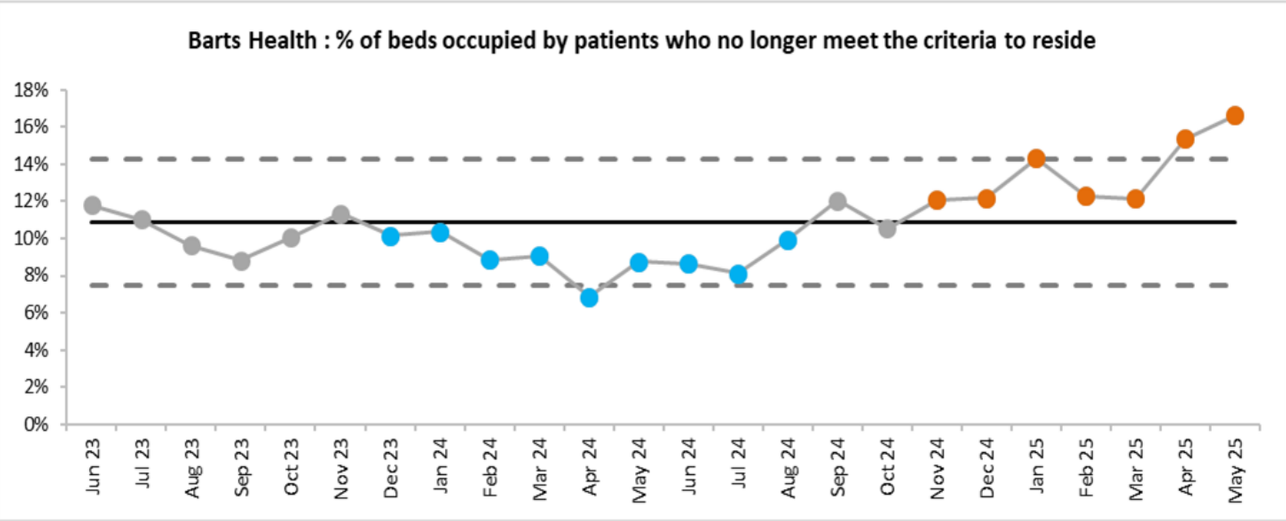
Whipps Cross:
The proportion of 12-hour wait times recorded at Whipps Cross was 11.5% for May 2025, an increase of 1.6% against April's 9.9%.

Newham:
The proportion of 12-hour wait times recorded at Newham was 6.3% for May 2025, a decrease of 0.5% against April's 6.8%.

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

Discharge Activity

INCREASING PERFORMANCE AND PRODUCTIVITY URGENT AND EMERGENCY CARE



Indicator Background:

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

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

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

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

What is the Chart Telling us:

The chart presents considerable data-variability above and below the mean, however, there is a period of improvement between December 23 and August 24, but this is followed by a period of concern, where the percentage of beds occupied by no criteria to reside patients increases across November 24 to May 25. For the months of April and May 26 the upper confidence limit is breaches, a statistically significant, or special cause event.

Trust Performance Overview

In May 2025 16.6% of our bed base was occupied by patients with no criteria to reside. Trust wide this is the equivalent of 956 patients (average across the month of 31 patients a day) and a total of 6,785 bed days.

- Royal London: 22.9% equivalent to 528 patients, average across the month of 17 patients a day.
- Whipps Cross: 18.2% equivalent to 290 patients, average across the month of 9 patients a day.
- Newham: 14.2% equivalent to 136 patients, average across the month of 4 patients a day.
- St Bart's: 2.2% equivalent to 14 patients, average across the month of less than 1 patient per day.

Trust Responsible Director Update

- **Trust wide:** In May 2025, the trust Discharge ready position increased to 16.6%. WXH at 18.2%, NUH at 14.2%, and RLH at 22.9%.
- **Pre-11am discharges:** Remains static at 10%. Work has commenced on moving the discharge window forward one hour, with incremental points to drive further.
- **Pre -5pm discharges:** 55% of Trust discharges are pre-5pm, providing a case to support that there is significant opportunity to bring out discharge profile forward.
- **Command centre roll out:** We are working across all our Hospitals to roll out our electronic bed management system, progress is now showing with all Hospitals starting to record patient discharge ready date electronically.
- **Rapid release programme:** We continue to share risk across our Hospitals with the rapid support of movement of DTAs to our wards throughout the day. This initiative balances the static performance in pre-11am discharges, as patients who are ready to be discharged on the day will be relocated on the ward and the bed space allocated to a new bed.
- **Length of stay:** Work has commenced on ensuring every day is a 'green day' for patients. This means ensuring fast access to diagnostics and specialist care and understanding any delays in our inpatient journeys. Our average adult non elective length of stay is on a downward trend at 8.8 days.

Our People - Culture

'Becoming an outstanding, inclusive place to work'

Our People Summary

SUMMARY

Creating a fair and just culture (We Belong & We Lead)

- The percentage of BAME staff in 8a+ roles saw a small reduction from 39.9% to 39.7%.

Supporting the wellbeing of our people (Retain)

- Overall annualised sickness absence reduced to 4.38% from 4.39% with marginal changes across sites.
- Recorded appraisals for non-medical staff reduced further from 64.5% to 63.0%. Improving the appraisal rate continues to be a key priority for all areas and has been focus in the June performance review meetings. However, the current focus on improving workforce productivity and restrictions on recruitment is having an impact on the ability to improve rates in some areas.
- The medical staff appraisal rate increased to 83.5%, .
- Job planning increased to 9.3% from 6.3% with Whipps Cross having the highest level of completion at 25.6%
- Statutory and Mandatory Training (all) compliance remained at 84.1% and remains below target. More detail is provided in the relevant exception page.
- Annualised voluntary turnover remained at 8.8%.

Working differently to transform care (Innovate)

- Roster compliance – approval on time reduced from 83.6% to 76.1% although the average lead time for approval remained above target at 42.3 days.
- Net hours balance was at 3.9%.

Recruiting a permanent, stable workforce (Attract)

- In May we remained 494 WTE above the plan submitted to NHS England with substantive staff 83 WTE under plan and temporary staff 577 above plan.
- The substantive fill rate reduced to 91.9% for all staff and 91.3% for registered nursing and midwifery. Further information is provided in the subsequent exception page.
- Time to Hire achieved target at group level for non-medical staff (7.8 weeks) and for medical staff (13.2weeks)
- In May temporary staff accounted for 12.7% of the workforce. Temporary spend was at 11.2% the pay budget YTD, with agency spend at 1.3% YTD (just above target) and bank spend at 9.9% YTD above the 7.9% target. Further information is provided in the subsequent exception page.

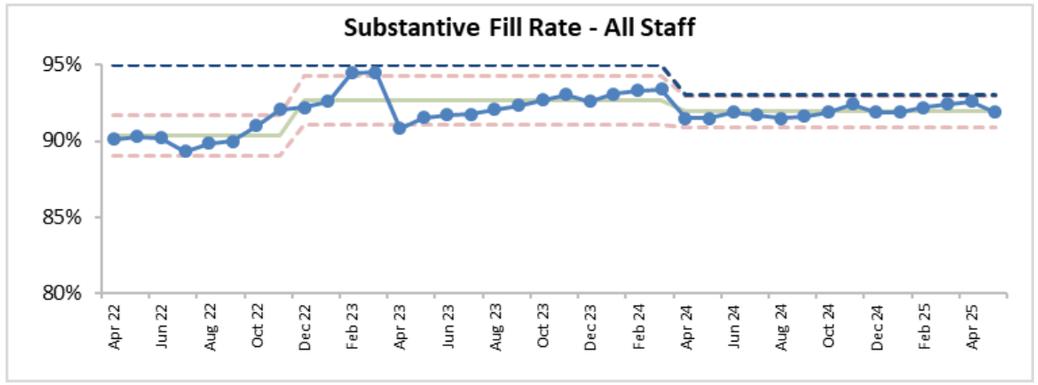
Domain Scorecard

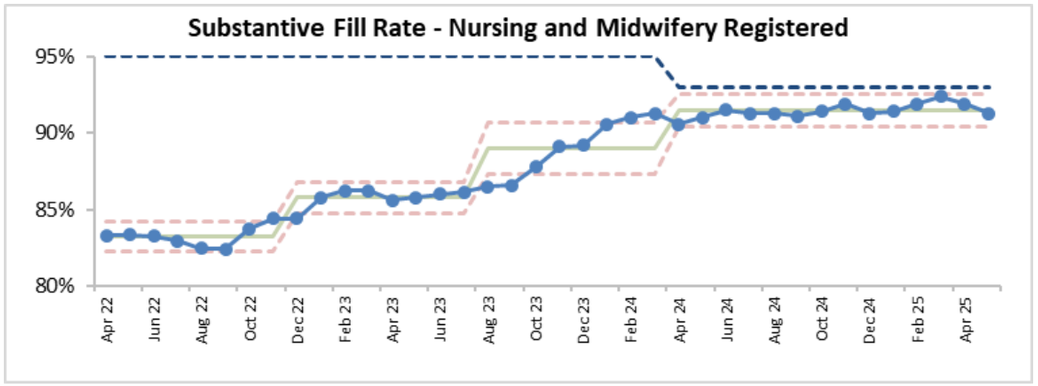
SUMMARY

	Indicator	This Period	Target	Performance: Last Period	Performance: This Period	Site Comparison: Royal London	Whipps Cross	Newham	St Bart's	Pathology Partnership	Group Support Services	Other
Creating a fair and just culture	**Percentage of BAME staff in 8a+ roles**	**May-25**	**42%**	**39.9%**	**39.7%**	**38.0%**	**48.4%**	**57.3%**	**29.0%**	**33.3%**	**36.7%**	**53.3%**
Supporting the wellbeing of our colleagues	Turnover Rate	May-25	<11%	8.8%	8.8%	9.33%	8.18%	8.83%	10.02%	9.93%	6.46%	10.41%
	Sickness Absence Rate	Apr-25	<=4.0%	4.39%	4.38%	4.23%	4.43%	4.62%	3.47%	4.07%	5.63%	2.00%
	Appraisal Rate - Non-Medical Staff	**May-25**	**>= 90%**	**64.5%**	**63.0%**	**56.4%**	**60.8%**	**50.6%**	**78.1%**	**64.1%**	**73.4%**	**28.3%**
	Appraisal Rate - Medical Staff	**May-25**	**>= 90%**	**83.4%**	**83.5%**	**80.7%**	**85.5%**	**87.5%**	**86.0%**			
	Mandatory and Statutory Training - All	May-25	>= 85%	84.1%	84.1%	81.0%	86.4%	85.4%	89.3%	89.6%	80.9%	

	Indicator (Jan 25)	This Period	Target	Last Period	This Period	Royal London	Whipps Cross	Newham	St Bart's	Pathology Partnership	Group Support Services	Other
Fostering new ways of working to transform care	Roster compliance - Nursing Units Approved on Time %	May-25		83.6%	76.1%	90.7%	72.1%	40.7%	100.0%			
	Roster compliance - Nursing Average Approval Lead Time (Days)	May-25	>=42	43.6	42.3	46.1	42.0	34.0	45.5			
	Roster compliance - Nursing Net Hours Balance %	May-25	<=7.6%	5.3%	3.9%	1.6%	2.2%	11.9%	2.7%			
	Medical and Dental Job planning completion	**May-25**	**>=95%**	6.3%	9.3%	6.7%	25.6%	11.9%	1.0%			
Recruting a permanent and stable workforce	Substantive fill rate - all staff	May-25	>=93%	92.6%	91.9%	93.6%	90.0%	92.1%	96.6%	90.1%	85.4%	104.5%
	Substantive fill rate - nursing and midwifery	**May-25**	**>=93%**	91.9%	91.3%	**90.3%**	**90.9%**	**93.0%**	**91.9%**			
	Time to Hire (Advert to All Checks Complete) - Median Weeks (Non Medical)	May-25	10.4	9.4	7.8	8.4	7.8	8.6	7.9	13.2	8.1	
	Time to Hire (Advert to All Checks Complete) - Median Weeks (Medical)	May-25	15.00	14.4	13.2	18.10	15.00	11.00	12.40			
	Temporary staff as a % of workforce	May-25		12.5%	12.7%	12.1%	17.9%	16.0%	7.6%	12.0%	11.6%	6.2%
	Pay Spend as % Pay Budget (YTD)	May-25		101.5%	101.5%	103.7%	104.5%	107.2%	100.9%	96.4%	101.1%	73.0%
	Bank Spend as % Paybill (YTD)	**May-25**	**<=7.9%**	9.8%	9.9%	9.2%	16.4%	14.6%	6.6%	5.7%	7.3%	0.5%
	Agency Spend as % Paybill (YTD)	**May-25**	**<=1.2%**	**1.5%**	**1.2%**	**1.6%**	**2.4%**	**2.4%**	**0.2%**	**0.9%**	**0.0%**	**0.0%**
	Agency Spend as % Paybill (In Month)	May-25	<=1.2%	**1.5%**	**1.2%**	1.4%	2.2%	2.1%	0.1%	0.7%	0.0%	0.0%

Substantive Fill Rate





Indicator Background:

The substantive fill rate is an indicator of the contracted Whole Time Equivalent (WTE) employed by Barts Health NHS Trust against budgeted WTE. A long-term goal is to deliver a fill rate between 93% and 95%, minimising vacancies and the need to use temporary staffing.

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

What are the Charts Telling us:

The charts here are showing our overall substantive fill rate as well as that for our registered nursing and midwifery staff group against the 93% target, the latter being our most challenging in terms of reducing gaps.

For registered nursing and midwifery, we have seen fill rate reduce to 91.3%

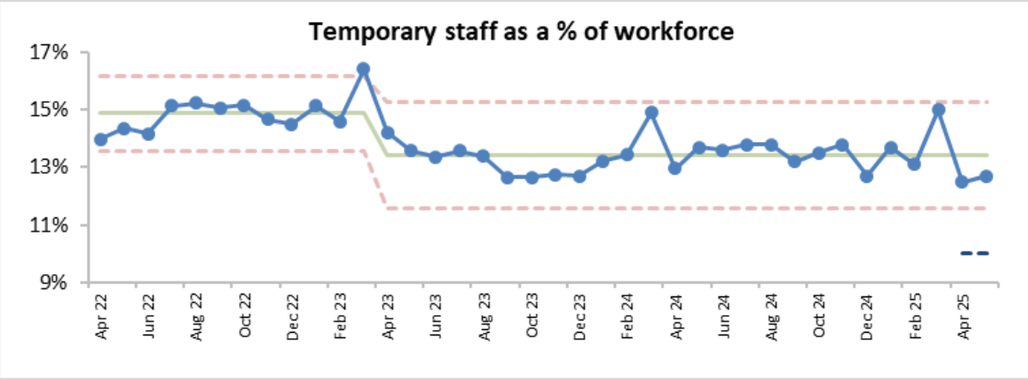
For all staff we saw the substantive fill rate reduce to 91.9%

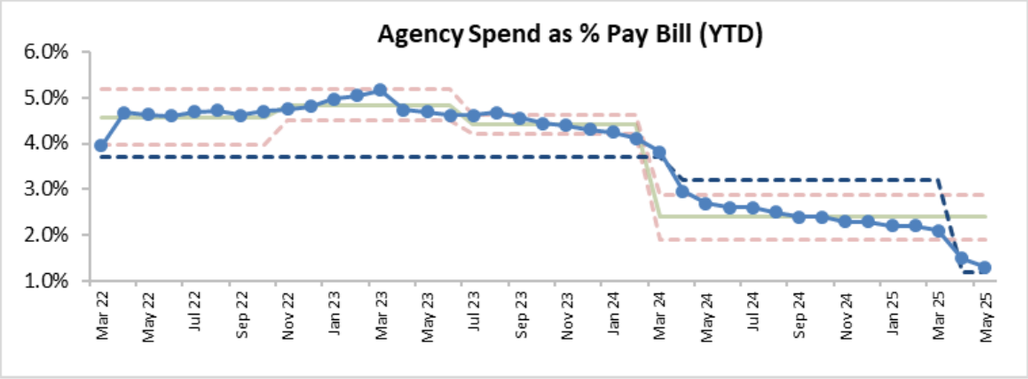
Trust Responsible Director Update

- The overall substantive fill rate reduced to 91.9% in May 2025, largely driven by an increase in the budgeted establishment, alongside a decrease in substantive staff in post of 28 WTE (equivalent of 0.1%). Both Royal London and St Bartholomew's continue to exceed the 93% target.
- The registered nursing and midwifery fill rate reduced from 91.9% to 91.3% with all sites exceeding 90% and Newham achieving 93%, the highest in the group. This reduction is the result of a small (2 WTE) increase in staffing and a 35 WTE increase in budgeted WTE. This is made up of a number of small changes across the group

Temporary Staffing

OUR PEOPLE





Indicator Background:

The Agency Spend as a % Pay Bill is a national indicator to demonstrate the proportion of pay spend on agency staff. In 23/24 the national target was 3.7% and in 24/25 it was 3.2%. For 25/26 we have set a target of 1.2% to reflect the

Temporary staff as a % of workforce is an indicator of how reliant the trust is on the temporary workforce. The target for this is to be below 10%, factoring in vacancies, sickness and parental leave

What are the Charts Telling us:

The charts here are showing our agency spend as a % pay bill against the relevant target since April 2022 and the proportion of the workforce that is temporary overall.

For agency spend YTD exceeded the new 1.2% target but reduced to 1.3%

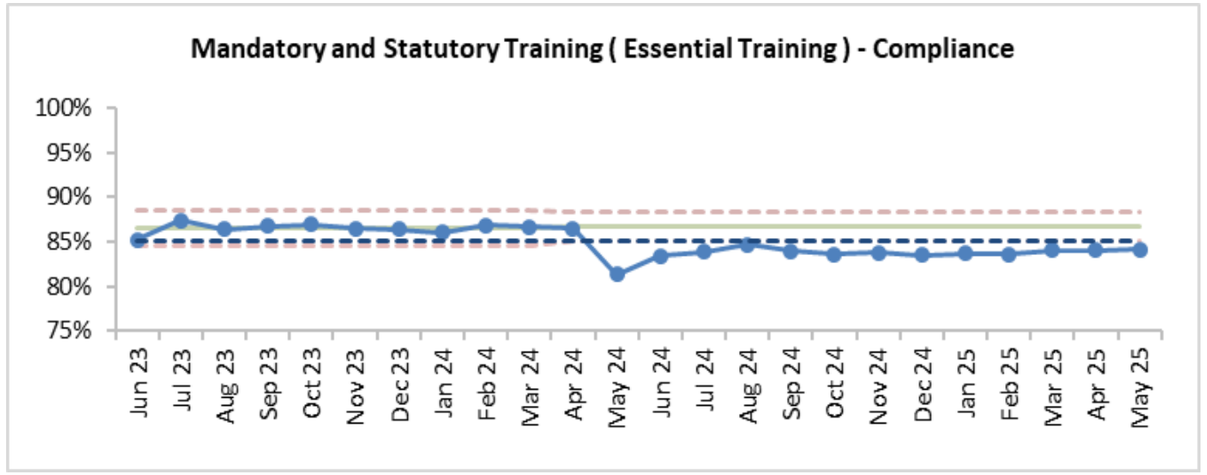
For temporary Staff as a % workforce we remain above target although saw an increase to 12.7%.

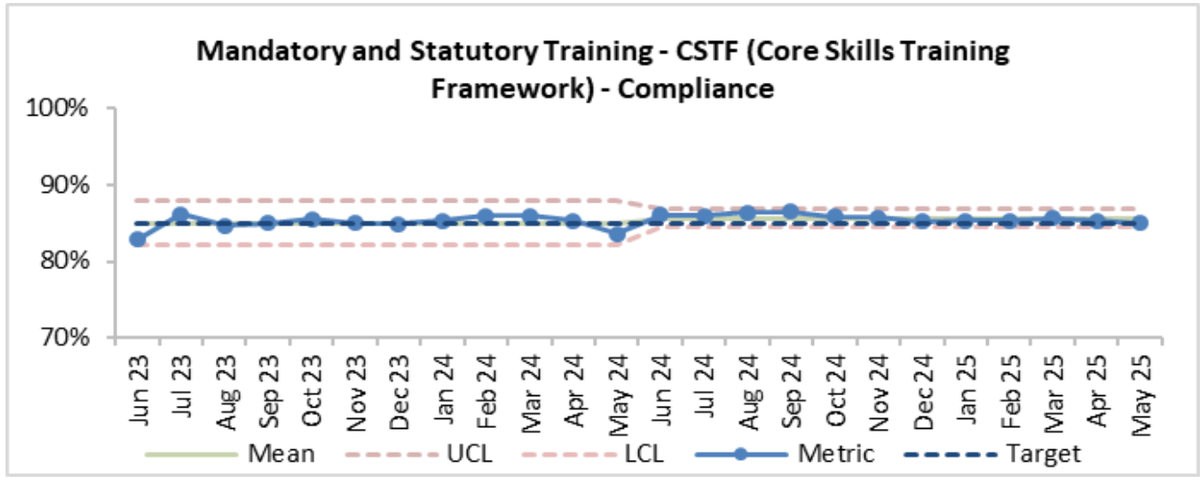
Trust Responsible Director Update

- In May 2025 we saw agency spend as a % pay bill (YTD) reduce to 1.3% which whilst down has exceeds the 1.2% target for the year. The overall agency usage reduced further by 74 WTE to 399 WTE.
- St Bartholomew's is delivering against its site target, with Whipps and Newham marginally above target (although in month for May was better than target) and Royal London was above target both YTD and in month.
- Overall temporary staff demand increased to 12.7% of the workforce, with a 104 WTE increase in bank. Overall temporary staffing use was at 2,871 WTE, up by 30 WTE.
- When compared to May 2024 there has been a reduction of 302 temporary WTE (from 3,173 to 2,871)

Mandatory and Statutory Training

OUR PEOPLE



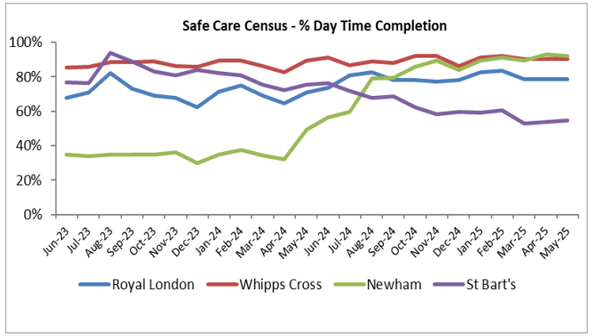


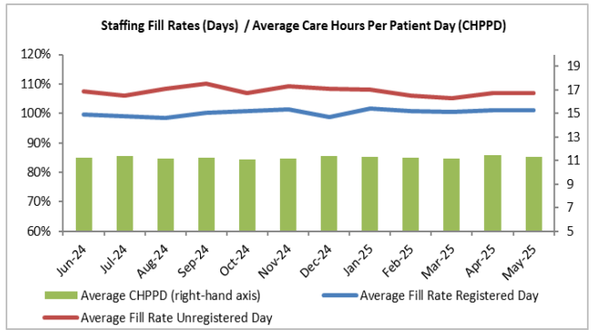
Non-mandatory competencies have been excluded from the above tables

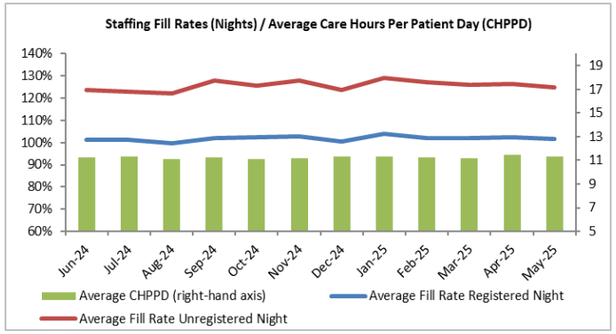
Performance Overview	Responsible Director Update
• Mandatory and Statutory Training CSTF (Core Skills Training Framework) compliance currently stands at 85.0%, a decrease of 0.3% from the last Board report but remains at the Trust target of 85% this month. Mandatory and Statutory Training (Essential Skills Training) compliance stands at 84.1, no change from the last board report, but remains below the Trust target of 85%.. • The total number of staff currently on WIRED stands at 22,054 and the team monitors over 588,700 compliance items yearly. • 7 of the Core Skills Training Framework subjects currently reported on WIRED are above the Trust target of 85%.Fire Safety is below target at 80.57%, with Infection Prevention and Control, Information Governance and Resuscitation all below 80% at 77.27.%, 73.32% and 84.96% respectively. Safeguarding Children Level 3 is also below the target at 78.78%. • Those subjects which are below target are highlighted at site PR's, together with staff groups where there is a concern and staff continue to be sent monthly reminders to complete their training.	• The third Mandatory Learning Oversight Group (MLOG) was held on 25 June which reviewed training requirements for Fire Safety, Fire Warden Training Provision, Infection Prevention and Control and Equality, Diversity and Inclusion. As required by NHSE, a schedule is in place for the group to review all 11 subjects in the Core Skills Training Framework to ascertain if there is an opportunity, where safe to do so, to streamline the staff groups required to do these subjects and if the refresh frequency can be extended. The group has significant concern for fire warden training which is now part of the Health Technical Memoranda. Whilst it is recognised that this is a requirement, if applied to band 6 roles, as suggested, this requires the provision of face to face training for circa 1000 staff and the current staffing structure on each site, given the inability to provide cross cover, will be challenged to meet this provision. • The Oliver McGowan Code of Practice, issued by Department of Health and Social care, which provieds guidance on meeting the training requirements was released on 19th June. No further information has been made available from the ICB regarding the provision of Tier 1 part 2 interactive training for non-clinical staff nor the Tier 2 part 2 one day training for clinical staff.

Safe Staffing

OUR PEOPLE







Staffing Figures by Site - May-25

Site	Average Fill Rate (Day)		Average Fill Rate (Night)		Average Care Hours Per Patient Day (CHPPD)	Safe Staffing Maternity Red Flag Incidents	Safe Staffing Nursing Red Flag Incidents
	Registered Nurses / Midwives (%)	Care Staff (%)	Registered Nurses / Midwives (%)	Care Staff (%)			
Trust	**101.2%**	**107.0%**	**101.7%**	**124.7%**	**11.3**	**60**	**7**
Royal London	108.2%	114.2%	108.3%	138.2%	11.7	37	7
Whipps Cross	96.3%	101.6%	98.0%	114.3%	10.8	14	0
Newham	102.5%	106.0%	103.9%	120.9%	10.5	9	0
St Bart's	90.6%	102.8%	89.2%	118.9%	12.4	0	0

Trust Responsible Director Update

The Trust continued to maintain an average fill rate exceeding 95% for Registered Nurses (RNs), Midwives (RMs), and Healthcare Assistants (HCAs) across both day and night shifts, with the exception of HCAs on day shifts at SBH. This was associated with fluctuating activity, staffing being dynamically adjusted in line with actual demand.

Average Care Hours Per Patient Day (CHPPD) for the trust were calculated at 11.3; Model Hospital shows an average of 9.5 for 'recommend peers' (last reported in March 2025). For the same period last year, the CHPPD was 11.0 for the Trust showing stability in the rate. The elevated CHPPD at organisational level is attributed primarily linked to the presence of a relatively large number of specialist and critical care services within the Barts Health Group, demonstrated by St Barts Hospital (SBH) having the highest figures as it hosts a significant proportion of specialist and critical care units. Senior Nursing Workforce Leads continue to undertake specialty mapping across wards reported through the monthly safe staffing return to support appropriate benchmarking at ward level.

All four hospitals within the Trust continue to experience demand for enhanced therapeutic observation of care (EToC) for at-risk patients, often resulting in staffing levels exceeding planned establishments. Use of ETOC increased in May compared to April 2025 and compared to the same period last year. A comprehensive cross trust improvement programme is in place refine ETOC models to meet the dual objective of ensuring quality care and effective use of resources.

Patient safety remains a key priority. Senior nursing teams continue to address staffing concerns through safety huddles, dynamically reallocating staff or deploying senior clinical staff where necessary to maintain safe care.

In May, general nursing Red Flag incidents (RFIs) were 7, compared to 6 in April, all of which were reported by Newham where there has been focussed work to drive reporting. None were associated with patient harm. The overall low rate aligns with the good shift fill. Maternity services recorded 60 RFIs via BirthRate Plus, continuing the downward trend. All incidents were addressed in real-time and reviewed through maternity governance processes. It should be noted that maternity red flags have broader range of triggers than are used in nursing, hence the large difference seen in reported numbers.

Underlying workforce trends: overall substantive fill rates across nursing and midwifery are in an increasingly strong position, and in line with the trust target. Senior nurses from each hospital are working in partnership with People team colleagues to address remaining gaps and evolve recruitment process to maximise productivity and efficiency. Sickness absence continues to affect staffing rosters; however, sustained fill rates provide assurance that shift coverage has remained largely unaffected.

Safe Care Compliance: Acuity and dependency scoring compliance via the Safe Care reporting tool stood at 81.6% for day shifts. Although this a slight reduction from April 2025, this remains on an upward trajectory compared to the 74.1% compliance for the same period in 2024. Continued emphasis is placed on embedding Safe Care into daily practice, particularly within safety huddles, to support real-time identification of staffing gaps and dynamic redeployments to facilitate balanced, prioritised staffing.

Supporting Enablers

Finance Summary

- The Trust is reporting a (£13.9m) deficit for the year to date at Month 2, which is (£6.0m) adverse against plan. Income and expenditure performance are planned to improve through the year as additional stretch savings within the breakeven plan start to impact with a planned surplus in the second half of the year.

- Income is (£3.2m) adverse against plan for the year to date at Month 2. Hospital sites and group services income is £0.4m favourable. Elective Recovery Funding (ERF) income is reported in line with plan in month 2. The effective ERF cap in 2025/26 means that the plan cannot be delivered through ERF overperformance. It is assumed at month 2 that ERF will not underperform plan therefore no ERF clawback will be incurred, these assumptions will be reviewed once fully coded data for the period becomes available. Central income is (£3.6m) adverse, primarily due to underperformance on Research & Development income (£1.6m), which is fully offset by the associated expenditure underspend, and under recovery on overseas patient income (£0.8m).

- Expenditure is (£2.8m) adverse against plan for the year to date at Month 2. Hospital sites and group services pay expenditure is (£8.2m) adverse. The variance is due to overspends against base budgets of (£0.4m) and unallocated pay savings targets (£7.7m). Achieving the WTE reduction plan is key to delivery of the pay savings target. Hospital sites and group services non-pay expenditure is (£7.0m) adverse, key overspends include unallocated non-pay savings targets (£2.5m), passthrough drugs (£1.7m), which is fully offset by the associated income overperformance, independent outsourcing costs (£1.4m) and non-clinical non-pay (£1.1m). Central areas including reserves are £12.4m favourable, this is mainly due to release of non-recurrent benefits and reserves ahead of the original plan schedule and Research & Development underspend, which is offset by the associated income underperformance.

- The Trust plan for 2025/26 is to reduce overall staffing levels by over 1,000wte primarily through reducing non-clinical staffing and reducing the use of temporary (bank and agency) clinical staffing, while maintaining strong control of clinical substantive staffing levels. Actual total WTE have reduced from 22,194wte in month 11 2024/25 to 22,069wte in month 2 2025/26, a reduction of 125wte.

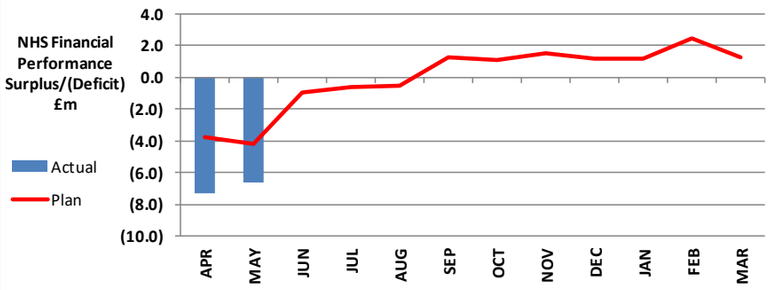
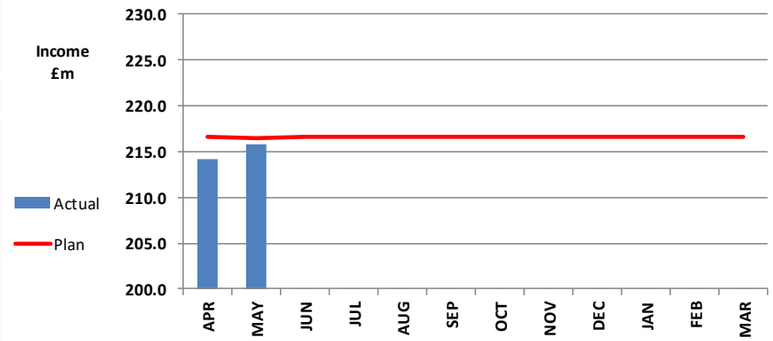
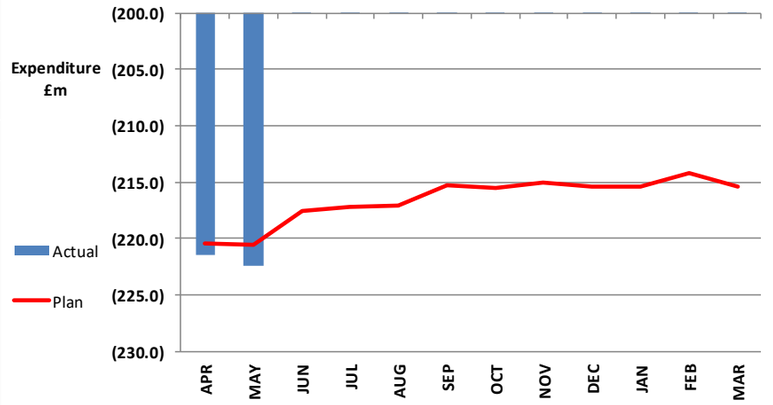
- Capital expenditure for the year to date is £6.7m, which is (£10.3m) behind plan. Charitable funded expenditure for the year to date is £0.3m.

- Cash balances in May 2025 are higher by £25.6m compared to the plan of £20.0m. The Trust has a higher balance, as a result of the higher closing cash balance of £46.4m in March 2025, and other movements in working capital.

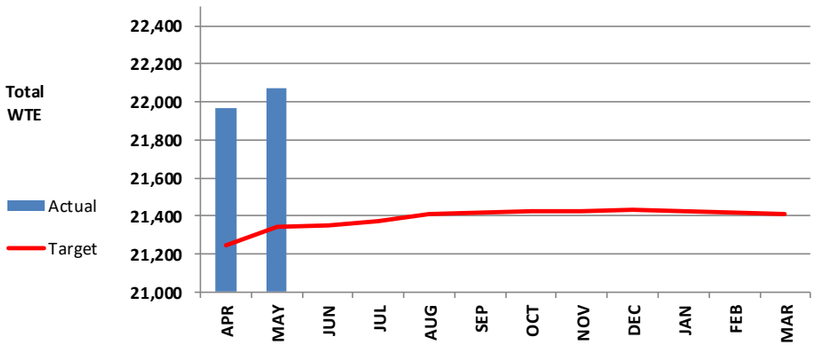
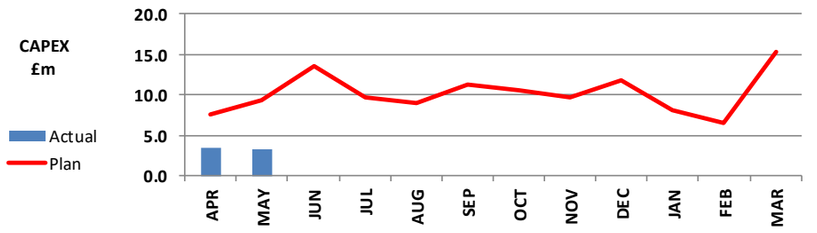
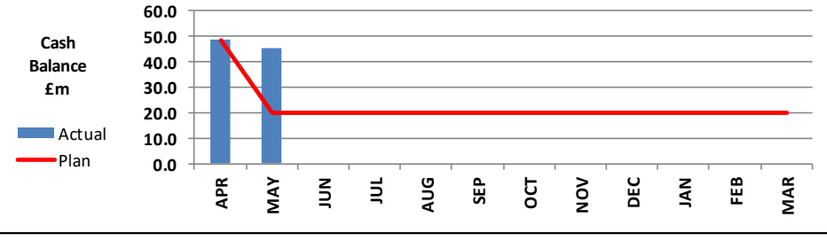
- The key financial challenges for the Trust in achieving its plan for this financial year include:

    - Delivering the efficiency savings targets already set within Sites and Services budgets and the additional stretch savings target within the breakeven plan.
    - Improving productivity and control workforce costs.

Finance Key Metrics

Metrics	Current Performance Year To Date £millions	Trend	Comments
NHS Financial Performance Surplus / (Deficit)	Plan (7.9) Actual (13.9) Variance (6.0)		The Trust is reporting a (£13.9m) deficit for the year to date at Month 2, which is (£6.0m) adverse against plan. The plan is for income and expenditure performance to improve from Month 3 (June) when the additional £32.8m stretch savings target agreed as part of the breakeven plan start to impact, with a planned surplus position in the second half of the year.
Total Income	Plan 433.1 Actual 429.9 Variance (3.2)		Income is (£3.2m) adverse against plan for the year to date at Month 2: - Hospital sites and group services income is £0.4m favourable. Elective Recovery Funding (ERF) income is reported in line with plan in month 2. The effective ERF cap in 2025/26 means that the plan cannot be delivered through ERF overperformance. It is assumed at month 2 that ERF will not underperform plan therefore no ERF clawback will be incurred, these assumptions will be reviewed once fully coded data for the period becomes available. - Central income is (£3.6m) adverse, primarily due to underperformance on Research & Development income (£1.6m), which is fully offset by the associated expenditure underspend, and under recovery on overseas patient income (£0.8m).
Total Expenditure	Plan (441.0) Actual (443.8) Variance (2.8)		Expenditure is (£2.8m) adverse against plan for the year to date at Month 2: - Hospital sites and group services pay expenditure is (£8.2m) adverse. The variance is due to overspends against base budgets of (£0.4m) and unallocated pay savings targets (£7.7m). Key overspends against base budgets are: premium rate costs for consultants and junior doctors bank staffing (£2.3m), and nursing and health care assistant staffing numbers above budget level (£1.2m). These overspends are partially offset by underspends for non-clinical staff vacancies of £2.6m. Achieving the WTE reduction plan is key to delivery of the pay savings target. -Hospital sites and group services non-pay expenditure is (£7.0m) adverse, key overspends include unallocated non-pay savings targets (£2.5m), passthrough drugs (£1.7m), which is fully offset by the associated income overperformance, independent outsourcing costs (£1.4m) and non-clinical non-pay (£1.1m). - Central areas including reserves are £12.4m favourable, this is mainly due to release of non-recurrent benefits and reserves ahead of the original plan schedule and Research & Development underspend, which is offset by the associated income underperformance.

Finance Key Metrics

Metrics	Current Performance Year To Date £millions		Trend	Comments
Whole Time Equivalent (Worked WTE)	Target	21,295		The Trust plan for 2025/26 is to reduce overall staffing levels by over 1,000wte primarily through reducing non-clinical staffing and reducing the use of temporary (bank and agency) clinical staffing, while maintaining strong control of clinical substantive staffing levels. Actual total WTE have reduced from 22,194wte in month 11 2024/25 to 22,069wte in month 2 2025/26, a reduction of 125wte. The reduction is in temporary staffing expenditure, it should be noted that a lower level of temporary staffing is normally seen in the first two months of the financial year because substantive staff take a high level of annual leave in March (due to annual leave carry forward restrictions) and because of the number of bank holidays when elective services are reduced during April and May.
	Actual	22,019		
	Variance	(724)		
Capital Expenditure	Plan	16.9		In May 2025 the Trust submitted a draft capital plan to NHSE via the NEL ICB for £138.7m comprised of a £122.3m Exchequer programme and £16.5m programme funded by charitable donations and grants. There was an increase in the exchequer programme of £0.3m following approval of a scheme for Net Zero - Solar. Capital expenditure for the year to date is £6.7m, which is (£10.3m) behind plan. Charitable funded expenditure for the year to date is £0.3m.
	Actual	6.7		
	Variance	(10.3)		
Cash	Plan	20.0		Cash balances in May 2025 are higher by £25.6m compared to the plan of £20.0m. The Trust has a higher balance, as a result of the higher closing cash balance of £46.4m in March 2025, and other movements in working capital. The 2025/26 pay award for Agenda for Change (AfC) staff (3.6%) and Doctors & Dentists (4%) backdated to April 2025 has now been announced and will be paid to staff in August 2025. The Trust is awaiting further information from NHSE regarding the future funding of the pay award.
	Actual	45.6		
	Variance	25.6		

Key Issues

The Trust is reporting a (£13.9m) deficit for the year to date at Month 2, which is (£6.0m) adverse against plan.

Key Risks & Opportunities

The key financial challenges for the Trust in achieving its plan for this financial year include:

- Delivering the efficiency savings targets already set within Sites and Services budgets and the additional stretch savings target within the breakeven plan.
- Improving productivity and control workforce costs.

Income & Expenditure - Trustwide

Last Year		In Month			Year to Date			Annual
YTD Actual	£millions	Plan	Actual	Variance	Plan	Actual	Variance	Plan
308.1	NHS Patient Treatment Income	167.7	169.4	1.7	329.2	330.7	1.5	2,003.8
0.8	Other Patient Care Activity Income	0.6	0.4	(0.2)	1.3	0.8	(0.5)	7.6
23.1	Other Operating Income	12.6	12.3	(0.3)	25.3	24.6	(0.7)	152.5
332.0	**Total Sites & Group Services Income**	**180.9**	**182.1**	**1.2**	**355.7**	**356.1**	**0.4**	**2,163.9**
7.8	Pathology Partnership Income	4.0	4.1	0.1	8.0	8.1	0.1	47.8
9.0	Research & Development Income	7.1	6.8	(0.3)	14.3	12.7	(1.6)	85.7
50.6	Central NHS PT Income	22.6	21.4	(1.2)	51.7	50.4	(1.3)	281.3
2.9	Central RTA & OSV Income	1.7	1.3	(0.4)	3.4	2.6	(0.8)	20.5
402.3	**Total Income**	**216.4**	**215.7**	**(0.7)**	**433.1**	**429.9**	**(3.2)**	**2,599.1**
(225.3)	Pay	(119.1)	(122.5)	(3.4)	(236.8)	(244.9)	(8.2)	(1,424.6)
(43.2)	Drugs	(19.0)	(20.2)	(1.1)	(39.8)	(41.9)	(2.1)	(249.6)
(36.0)	Clinical Supplies	(17.9)	(18.2)	(0.2)	(36.4)	(36.4)	(0.0)	(220.7)
(51.9)	Other Non Pay	(24.0)	(25.8)	(1.8)	(48.5)	(53.4)	(4.9)	(284.2)
(356.4)	**Total Site & Group Services Expenditure**	**(180.1)**	**(186.7)**	**(6.6)**	**(361.4)**	**(376.6)**	**(15.2)**	**(2,179.2)**
(16.5)	Pathology Partnership Expenditure	(8.3)	(8.5)	(0.1)	(16.6)	(16.8)	(0.3)	(99.3)
(8.4)	Research & Development Expenditure	(7.1)	(6.8)	0.3	(14.3)	(12.7)	1.6	(85.7)
(0.9)	Central RTA & OSV Recievables Provisions	(0.6)	(0.5)	0.1	(1.2)	(1.0)	0.2	(7.4)
2.3	Central Expenditure & Reserves	(7.9)	(3.7)	4.2	(14.9)	(4.6)	10.2	**(32.0)**
(379.8)	**Total Operating Expenditure**	**(204.1)**	**(206.2)**	**(2.1)**	**(408.4)**	**(411.8)**	**(3.4)**	**(2,403.7)**
(13.0)	Depreciation and Amortisation (net)	(6.6)	(6.6)	0.0	(13.1)	(13.1)	(0.0)	(78.7)
(18.0)	Interest	(9.9)	(9.6)	0.3	(19.5)	(18.9)	0.6	(116.9)
0.1	Profit On Fixed Asset Disposal	0.0	0.0	0.0	0.0	0.0	(0.0)	0.1
(410.9)	**Total Expenditure**	**(220.6)**	**(222.4)**	**(1.8)**	**(441.0)**	**(443.8)**	**(2.8)**	**(2,599.1)**
(24.4)	**Sites & Group Services Contribution**	**0.8**	**(4.6)**	**(5.4)**	**(5.7)**	**(20.5)**	**(14.8)**	**(15.4)**
15.8	**Central Income & Expenditure**	**(5.0)**	**(2.1)**	**2.9**	**(2.2)**	**6.6**	**8.8**	**15.4**
(8.5)	**NHS Reporting Surplus/(Deficit)**	**(4.2)**	**(6.7)**	**(2.5)**	**(7.9)**	**(13.9)**	**(6.0)**	**0.0**

Capital Expenditure Summary - Trustwide

24/25 YTD	Programme Area	In Month				Year to Date				Annual			
Prev Yr Actual	*£millions*	Plan	Actual	Variance	%	Plan	Actual	Variance	%	Draft Capital Plan	Approved Capital Programme	Variance	%
0.5	Equipment (Medical and Other)	0.7	0.1	0.6	*90 %*	0.8	0.2	0.6	*74 %*	23.2	23.2	-	*- %*
0.1	Informatics	-	(0.1)	0.1	*- %*	-	0.2	(0.2)	*- %*	3.8	3.8	-	*- %*
0.7	Estates	1.9	1.0	0.9	*47 %*	3.6	1.4	2.2	*61 %*	44.2	44.2	0.0	*0 %*
0.6	New Build and Site Vacations	5.2	0.7	4.4	*86 %*	9.4	1.8	7.6	*81 %*	32.7	32.7	-	*- %*
2.5	PFI Lifecycle Assets	1.6	1.6	(0.0)	*(0)%*	3.1	3.1	(0.0)	*(0)%*	18.7	18.7	-	*- %*
-	Finance Lease	-	-	-	*- %*	-	-	-	*- %*	-	-	-	*- %*
4.4	**Total Trust Funded Assets**	**9.3**	**3.3**	**6.0**	***65 %***	**16.9**	**6.7**	**10.3**	***61 %***	**122.5**	**122.5**	**0.0**	***0 %***
-	Grants	0.1	0.0	0.1	*84 %*	0.1	0.1	0.0	*29 %*	6.5	6.5	-	*- %*
5.9	Donated	0.1	0.1	0.0	*26 %*	0.3	0.2	0.1	*24 %*	10.0	10.0	-	*- %*
10.2	**Total Capital Expenditure**	**9.5**	**3.4**	**6.1**	***65 %***	**17.3**	**7.0**	**10.4**	***60 %***	**139.0**	**139.0**	**0.0**	***0 %***

Key Messages

2025/26 position. In May 2025 the Trust submitted a draft capital plan to NHSE via the NEL ICB for £138.7m comprised of a £122.3m Exchequer programme and £16.5m programme funded by charitable donations and grants. There was an increase in the exchequer programme of £0.3m following approval of a scheme for Net Zero - Solar.

Funding. The Trust received additional external funding of £0.3m for a net zero solar scheme. The Estates safety funding of £27.7m has also been confirmed. The Trust CRL allocation for 2025/26 has not been fully confirmed. Further business cases have been requested via NEL for Constitutional Standards funded schemes. Senior Trust directors are making strong representations to NEL and NHSL to have the draft plan confirmed in full. Following guidance from NEL, the draft plan includes overprogramming of 5%, £2.2m. In previous years the experience has been that the overprogramming funding has been clawed back in the final months of the year, so cautious approach is being taken; this funding will only be deployed when there is greater certainty that it will be confirmed. On 21 May 2025, Financial Oversight Board agreed to commence the capital programme at risk because further delay would make it difficult to deliver to the current target. NEL have been advised of this by the Trust. As the opportunities arise, bids will be made for any central funding that is released for programmes such as diagnostic equipment, digital transformation and cyber security etc.

Performance. The Trust had expenditure of £3.4m in May 2025, of which £0.1m was on schemes funded from charitable donations. The capital programme as forecast to NHSE in March 2025 is currently £10.3m behind plan. It is noted that once the plan is submitted, the forecast is fixed for the year and cannot be amended. The seeming underspend is a timing difference which has arisen following changes in the profile of expenditure and the delay in commencing the 2025/26 capital programme pending confirmation of funding approval of the NEL estates safety fund and Constitutional Standard funded schemes due to the requirement for additional business cases. It is expected that the majority of schemes will catch up and be delivered in year. The capital Steering and Assurance Group is monitoring the pipeline of 2025/26 schemes not yet at business case stage and has challenged all investment leads to provide a firm date for scheme commencement. Some 2025/26 projects have been approved by IDG, notably the first stages of the WXH Bridging the Gap programme for the year, but are yet to commence. The delegated programmes for PFI MES, replacement medical equipment, backlog maintenance and Informatics have been approved - all at an earlier stage than in 2024/25, and are now progressing to the business cases for individual projects.

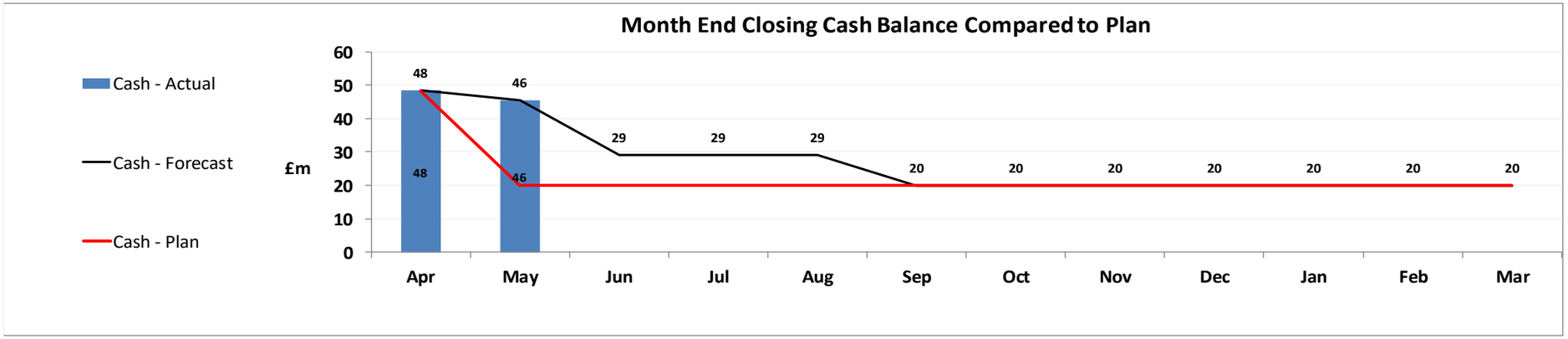
Forecast. As at month 2, in the absence of a fully approved capital plan, the Trust is holding its forecast in line with the draft plan submitted. A full reforecast is to be undertaken in June overseen by the Capital and Assurance Steering Group. This will enable any slippage to be identified and recommendation made for mitigations.

Capital Funding

	Capital Plan	Secured	Not Yet Secured	% Secured
Gross Depreciation	78.7	78.7	-	*100 %*
Repayment of PFI principal	(50.7)	(50.7)	-	*100 %*
Repayment Other Finance Leases (IFRS16)	(14.6)	(14.6)	-	*100 %*
Net Depreciation	**13.4**	**13.4**	**-**	**100 %**
CRL (not cash backed)	52.7	52.7	-	*100 %*
PDC - HIP 1 Whipps Cross Hospital Redevelopment Enabling Works	14.6	14.6	-	*100 %*
PDC - RLH Biplane	0.7		0.7	*100 %*
PDC - NHS national energy efficiency funding-SBH & NUH SubMetering	0.1	0.1	-	*100 %*
PDC - SBH Linac	2.5		2.5	*- %*
PDC - Net Zero	0.3	0.3	-	*100 %*
PDC - Estates Safety	27.7	27.7	-	*100 %*
PDC - constitutional standards	10.5		10.5	*- %*
Planned Capital exc. Donated	**122.5**	**108.8**	**13.7**	**88.8 %**
Asset sales	-	-	-	*- %*
Total Approved Exchequer Funding exc. Donations/Grants	**122.5**	**108.8**	**13.7**	**88.8 %**
Grants	6.5		6.5	*- %*
Donations	10.0		10.0	*- %*
Planned Capital inc. Donations/Grants	**139.0**	**108.8**	**30.2**	**78.3 %**

Cashflow

£millions	Actual Apr	May	Forecast Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Outturn
Opening cash at bank	**46.4**	**48.4**	**45.6**	**29.1**	**29.1**	**29.1**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**46.4**
Cash inflows													
Healthcare contracts	197.2	184.7	199.5	192.5	192.5	192.5	192.5	192.5	192.5	192.5	192.5	258.4	2,379.8
Other income	47.6	23.2	36.6	27.2	37.6	41.1	34.6	29.1	29.6	22.2	31.1	35.5	395.4
Financing - Revenue Loans /Capital PDC	-	-	-	-	-	-	-	-	15.0	-	-	41.1	56.1
Total cash inflows	**244.8**	**207.9**	**236.1**	**219.7**	**230.1**	**233.6**	**227.1**	**221.6**	**237.1**	**214.7**	**223.6**	**335.0**	**2,831.3**
Cash outflows													
Salaries and wages	(75.7)	(74.6)	(75.1)	(75.1)	(75.1)	(75.1)	(75.1)	(75.1)	(75.1)	(75.1)	(75.1)	(75.1)	(901.3)
Tax, NI and pensions	(56.7)	(57.8)	(56.1)	(56.0)	(56.1)	(56.0)	(56.1)	(56.0)	(56.2)	(56.1)	(56.1)	(56.1)	(675.3)
Non pay expenditures	(96.9)	(73.9)	(119.4)	(85.0)	(95.0)	(109.1)	(84.1)	(85.0)	(101.5)	(78.0)	(86.7)	(131.6)	(1,146.2)
Capital expenditure	(13.5)	(4.4)	(2.0)	(3.6)	(3.9)	(2.5)	(11.8)	(5.5)	(4.3)	(5.5)	(5.7)	(72.2)	(134.9)
Dividend and Interest payable	-	-	-	-	-	-	-	-	-	-	-	-	-
Total cash outflows	**(242.8)**	**(210.7)**	**(252.6)**	**(219.7)**	**(230.1)**	**(242.7)**	**(227.1)**	**(221.6)**	**(237.1)**	**(214.7)**	**(223.6)**	**(335.0)**	**(2,857.7)**
Net cash inflows / (outflows)	**2.0**	**(2.8)**	**(16.5)**	**-**	**-**	**(9.1)**	**-**	**-**	**-**	**-**	**-**	**-**	**(26.4)**
Closing cash at bank - actual / forecast	**48.4**	**45.6**	**29.1**	**29.1**	**29.1**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**
Closing cash at bank - plan	**48.4**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**



Key Messages

Cash balances in May 2025 are higher by £25.6m compared to the plan of £20.0m. The Trust has a higher balance, as a result of the higher closing cash balance of £46.4m in March 2025, and other movements in working capital. The 2025/26 pay award for Agenda for Change (AfC) staff (3.6%) and Doctors & Dentists (4%) backdated to April 2025 has now been announced and will be paid to staff in August 2025. The Trust is awaiting further information from NHSE regarding the future funding of the pay award.

Statement of Financial Position

24/25		Actual		Forecast									
31 Mar 2025	£millions	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	24/25 v 25/26
	Non-current assets:													
1,581.6	Property, plant and equipment	1,612.3	1,606.9	1,624.3	1,627.6	1,630.3	1,635.5	1,641.3	1,648.9	1,656.1	1,659.6	1,662.1	1,670.5	88.9
0.1	Intangible assets	6.7	6.5	6.5	6.4	6.3	6.1	6.0	5.9	5.8	5.7	5.5	5.4	5.3
16.2	Trade and other receivables	16.1	16.0	16.0	15.9	15.9	15.8	15.8	15.7	15.7	15.6	15.6	15.6	(0.6)
1,597.9	**Total non-current assets**	**1,635.1**	**1,629.4**	**1,646.8**	**1,649.9**	**1,652.5**	**1,657.4**	**1,663.1**	**1,670.5**	**1,677.6**	**1,680.9**	**1,683.2**	**1,691.4**	**93.6**
	Current assets:													
34.1	Inventories	37.4	38.6	37.4	37.4	37.4	37.4	37.4	37.4	37.4	37.4	37.4	37.4	3.3
140.8	Trade and other receivables	110.0	103.0	126.1	124.8	121.3	126.5	124.4	121.9	128.6	118.5	123.8	137.8	(3.0)
34.4	Cash and cash equivalents	48.4	45.6	29.1	29.1	29.1	20.0	20.0	20.0	20.0	20.0	20.0	20.0	(14.4)
209.3	**Total current assets**	**195.8**	**187.2**	**192.6**	**191.3**	**187.8**	**183.9**	**181.8**	**179.3**	**186.0**	**175.9**	**181.2**	**195.2**	**(14.1)**
1,807.2	**Total assets**	**1,830.9**	**1,816.6**	**1,839.4**	**1,841.2**	**1,840.3**	**1,841.3**	**1,844.9**	**1,849.8**	**1,863.6**	**1,856.8**	**1,864.4**	**1,886.6**	**79.5**
	Current liabilities													
(304.5)	Trade and other payables	(316.2)	(310.9)	(321.6)	(322.9)	(321.4)	(320.0)	(321.4)	(323.8)	(320.2)	(311.0)	(315.4)	(295.8)	8.7
(10.6)	Provisions	(3.7)	(3.7)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	9.6
(61.7)	Liabilities arising from PFIs / Finance Leases	(65.3)	(65.3)	(62.6)	(62.6)	(62.6)	(62.6)	(62.6)	(62.6)	(62.6)	(62.6)	(62.6)	(63.8)	(2.1)
0.0	DH Revenue Support Loan (Including RWCSF)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
0.0	DH Capital Investment Loan	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(376.8)	**Total current liabilities**	**(385.2)**	**(379.9)**	**(385.2)**	**(386.5)**	**(385.0)**	**(383.6)**	**(385.0)**	**(387.4)**	**(383.8)**	**(374.6)**	**(379.0)**	**(360.6)**	**16.2**
(167.5)	**Net current (liabilities) / assets**	**(189.4)**	**(192.7)**	**(192.6)**	**(195.2)**	**(197.2)**	**(199.7)**	**(203.2)**	**(208.1)**	**(197.8)**	**(198.7)**	**(197.8)**	**(165.4)**	**2.1**
1,430.4	**Total assets less current liabilities**	**1,445.7**	**1,436.7**	**1,454.2**	**1,454.7**	**1,455.3**	**1,457.7**	**1,459.9**	**1,462.4**	**1,479.8**	**1,482.2**	**1,485.4**	**1,526.0**	**95.7**
	Non-current liabilities													
(5.0)	Provisions	(5.4)	(5.4)	(5.6)	(5.6)	(5.6)	(5.6)	(5.6)	(5.6)	(5.6)	(5.6)	(5.6)	(5.6)	(0.6)
(1,644.0)	Liabilities arising from PFIs / Finance Leases	(1,715.1)	(1,709.8)	(1,713.6)	(1,708.7)	(1,703.9)	(1,699.0)	(1,694.1)	(1,689.3)	(1,684.4)	(1,679.6)	(1,674.7)	(1,668.6)	(24.6)
(0.5)	Other Payables	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5
0.0	DH Revenue Support Loan (Including RWCF)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
0.0	DH Capital Investment Loan	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(1,649.5)	**Total non-current liabilities**	**(1,720.3)**	**(1,715.2)**	**(1,719.2)**	**(1,714.3)**	**(1,709.5)**	**(1,704.6)**	**(1,699.7)**	**(1,694.9)**	**(1,690.0)**	**(1,685.2)**	**(1,680.3)**	**(1,674.1)**	**(24.7)**
(219.1)	**Total Assets Employed**	**(274.6)**	**(278.5)**	**(265.0)**	**(259.6)**	**(254.2)**	**(246.9)**	**(239.8)**	**(232.5)**	**(210.2)**	**(203.0)**	**(194.9)**	**(148.1)**	**71.0**
	Financed by:													
	Taxpayers' equity													
1,105.4	Public dividend capital	1,133.1	1,133.1	1,133.1	1,133.1	1,133.1	1,133.1	1,133.1	1,133.1	1,148.1	1,148.1	1,148.1	1,189.1	83.7
(1,734.7)	Retained earnings	(1,839.2)	(1,843.2)	(1,829.7)	(1,824.3)	(1,818.9)	(1,811.6)	(1,804.5)	(1,797.2)	(1,789.9)	(1,782.7)	(1,774.6)	(1,777.4)	(42.7)
410.2	Revaluation reserve	431.5	431.6	431.6	431.6	431.6	431.6	431.6	431.6	431.6	431.6	431.6	440.2	30.0
(219.1)	**Total Taxpayers' Equity**	**(274.6)**	**(278.5)**	**(265.0)**	**(259.6)**	**(254.2)**	**(246.9)**	**(239.8)**	**(232.5)**	**(210.2)**	**(203.0)**	**(194.9)**	**(148.1)**	**71.0**

Glossary

2024/25 Priorities & Operational Planning

The key 2024/25 NHS England (NHSE) Urgent and Emergency Care, Elective, Cancer and Diagnostic performance objectives and milestones are set-out in the table opposite. However, a number of high-priority operational standards sit alongside these and include:

Urgent & Emergency Care

- ✓ Systems are also asked to reduce the proportion of waits over 12 hours in A&E compared to 2023/24.
- ✓ NHSE will operate an incentive scheme for providers with a Type 1 A&E department achieving the greatest level of improvement and/or delivering over 80% A&E 4-hour performance by the end of the year.
- ✓ Maintain acute G&A beds as a minimum at the level funded and agreed through operating plans in 2023/24

Elective Care

- ✓ Individual system activity targets are the same as those agreed for 2023/24, consistent with the national value weighted activity target of 107%.
- ✓ Make significant improvement towards the 85% day case and 85% theatre utilisation expectations where these are not already being met, using Getting it Right First Time (GIRFT) and moving procedures to the most appropriate settings.
- ✓ Continue to shift the balance of outpatient activity towards clock-stopping, ensuring that the wait to first appointment continues to reduce. To support this, NHSE have introduced a new metric measuring the proportion of all outpatient attendances that are for first or follow-up appointments attracting a procedure tariff (the proportion of activity that is pathway completing). To meet the national ambition of 46% NHSE are asking systems to deliver a 4.5 percentage point improvement against their 2022/23 baseline up to a maximum local ambition of 49%.

The trust is currently completing performance trajectories and activity plans consistent with delivering the North East London ICB requirements in relation to the national objectives set-out above, with a local submission deadline of 23 April and a national submission deadline of 2 May.

The Operational Performance chapter of this report (pages 18 to 41) will be updated to provide monthly and year to date views of delivery against the performance and activity objectives set out above and opposite for the April 24 edition of the report.

	Objective	Deadline
Urgent & Emergency Care	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	Mar-25
Elective Waits	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)	Sep-25
	Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%	Mar-25
	Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to a national value of 46% across 2024/25	Mar-25
Cancer	Improve performance against the headline 62-day standard to 70% by March 2025	Mar-25
	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Mar-28
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	Mar-25

Domain Scorecard Glossary

GLOSSARY

Domain	Sub Domain	Metric Ref	Metric Name	Description	Frequency	Target Source
Responsive	Waiting Times	R1	A&E 4 Hours Waiting Time	The number of Accident & Emergency (A&E) attendances for which the patient was discharged, admitted or transferred within four hours of arrival, divided by the total number of A&E attendances. This includes all types of A&E attendances including Minor Injury Units and Walk-in Centres	Monthly	Recovery trajectory
Responsive	Waiting Times	R8	Cancer 2 Week Wait	Percentage of patients first seen by a specialist for suspected cancer within two weeks (14 days) of an urgent GP referral for suspected cancer	Monthly	National
Responsive	Waiting Times	R35	Cancer 62 Days From Urgent GP Referral	Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer. Logic is 50/50 split for referring and treating trust/site up to and including Mar-19 then reallocation from Apr-19 as per national reporting rules	Monthly	National
Responsive	Waiting Times	R36	Cancer 62 Days From Screening Programme	Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of referral from a NHS Cancer Screening Service. Logic is 50/50 split for referring and treating trust/site up to and including Mar-19 then reallocation from Apr-19 as per national reporting rules	Monthly	National
Responsive	Waiting Times	R6	Diagnostic Waits Over 6 Weeks	The number of patients still waiting for diagnostic tests who had waited 6 weeks or less from the referral date to the end of the calendar month, divided by the total number of patients still waiting for diagnostic tests at the end of the calendar month. Only the 15 key tests included in the Diagnostics Monthly (DM01) national return are included	Monthly	National
Well Led	People	W19	Turnover Rate	The number of leavers (whole time equivalents) who left the trust voluntarily in the last 12 months divided by the average total number of staff in post (whole time equivalents) in the last 12 months	Monthly	Local
Well Led	People	OH7	Proportion of Temporary Staff	The number of bank and agency whole time equivalents divided by the number of bank and agency whole time equivalents plus permanent staff in post (whole time equivalents)	Monthly	Local
Well Led	People	W20	Sickness Absence Rate	The number of whole time equivalent days lost to sickness absence (including non-working days) in the last 12 months divided by the total number of whole time equivalent days available (including non-working days) in the last 12 months, i.e. the annualised percentage of working days lost due to sickness absence	Monthly	Local
Well Led	Staff Feedback	C6	Staff FFT Percentage Recommended - Care	The number of staff who responded that they were extremely likely or likely to recommend the trust to friends and family if they needed care or treatment, divided by the total number of staff who responded to the Staff Friends and Family Test (Staff FFT)	Quarterly	Local
Well Led	Staff Feedback	OH6	NHS Staff Survey	The overall staff engagement score from the results of the NHS Staff Survey	Yearly	National
Well Led	Compliance	W50	Mandatory and Statutory Training - All	For all mandatory and statutory training topics, the percentage of topics for which staff were competent (i.e. have completed training and were compliant)	Monthly	Local

Domain Scorecard Glossary

GLOSSARY

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

Domain Scorecard Glossary

GLOSSARY

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

Domain Scorecard Glossary

GLOSSARY

Domain	Sub Domain	Metric Ref	Metric Name	Description	Frequency	Target Source
Safe	Harm Free Care	S17	Emergency C-Section Rate	The number of deliveries which were emergency caesarean sections divided by the total number of deliveries. Based on data frozen as at the 12th working day of the month	Monthly	Local
Safe	Harm Free Care	S27	Patient Safety Alerts Overdue	The number of NHS England or NHS Improvement patient safety alerts overdue (past their completion deadline date) at the time of the snapshot. These are a sub-set of all Central Alerting System (CAS) alerts	Monthly	National
Safe	Assess & Prevent	S7	Dementia - Referrals	Percentage of patients aged 75 and above admitted as emergency inpatients, with length of stay > 72 hours, who have had a diagnostic assessment (with an outcome of “positive” or “inconclusive”) and who have been referred for further diagnostic advice in line with local pathways	Monthly	National
Safe	Saving Lives	S87	Saving Lives: Central Venous Catheter Care Bundle (Continuing Care)	The percentage of central venous catheter care bundle audits carried out (for patients with continuing care) in which the results were all found to be fully compliant. The audit consists of monthly observations on catheter injection ports, catheter access, catheter replacement, hand hygiene, etc.	Monthly	TBC
Safe	Saving Lives	S88	Saving Lives: Central Venous Catheter Care Bundle (On Insertion)	The percentage of central venous catheter care bundle audits carried out (on insertion of catheters) in which the results were all found to be fully compliant. The audit consists of monthly observations on catheter type, insertion site, safe disposal of sharps, hand hygiene, etc.	Monthly	TBC
Effective	Mortality	E1	Summary Hospital-Level Mortality Indicator	The ratio between the actual number of patients who died following hospitalisation at the trust and the number who would be expected to die on the basis of average England figures (given the characteristics of the patients treated at the trust), multiplied by 100	Monthly	National
Effective	Mortality	E3	Risk Adjusted Mortality Index	The ratio of the observed number of in-hospital deaths with a Hospital Standardised Mortality Ratio (HSMR) diagnosis to the expected number of deaths, multiplied by 100, at trust level. This metric considers mortality on weekdays and weekends	Monthly	National
Effective	Outcomes	0502	Cardiac Arrest 2222 Calls (Wards) Per 1,000 Admissions	The number of 2222 emergency calls which were for cardiac arrests on wards (including medical emergencies leading to cardiac arrests) per 1,000 admissions, i.e. the number of calls divided by the number of admissions which has been multiplied by 1,000	Monthly	Local

Workforce Summary Glossary

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

Appendix

Interpretation SPC Charts

APPENDIX

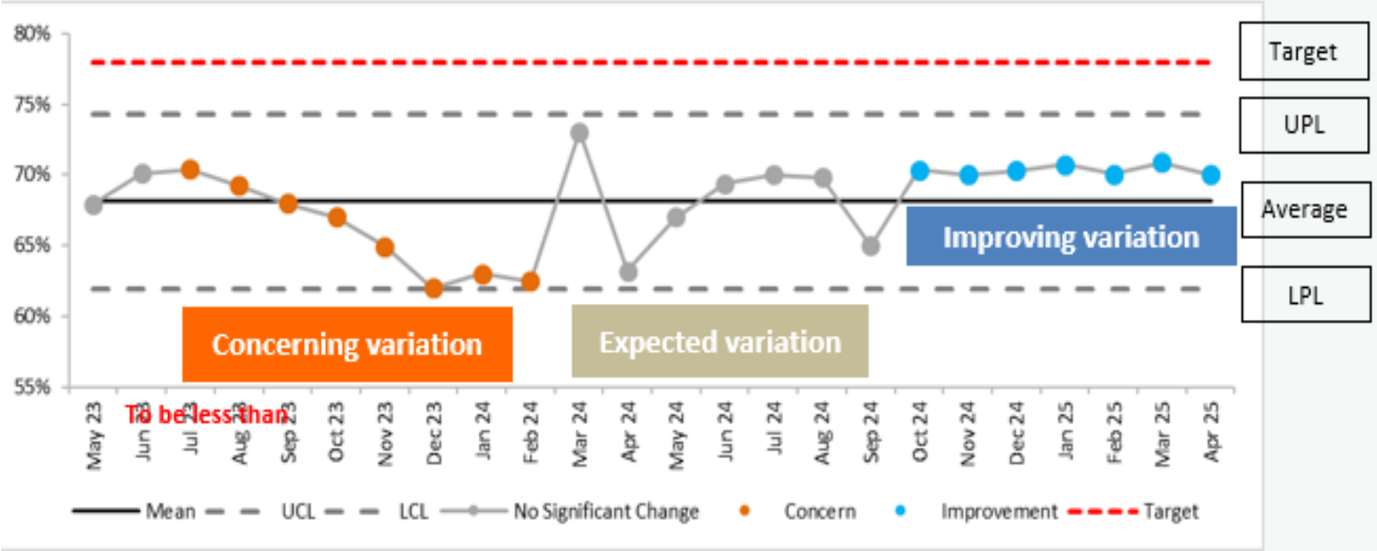
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated and improvement actions implemented;

Blue – there is a pattern of improvement which should be learnt from;

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable.



The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard (the **red** line) can be achieved always, never (as in this example) or sometimes.

SPC charts therefore describe not only the type of variation in data, but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

Safe Staffing Fill Rates by Ward and Site

APPENDIX

		Registered midwives / nurses (day)		Care Staff (day)		Registered midwives / nurses (night)		Care Staff (night)		Day		Night		Care Hours Per Patient Day (CHPPD)			
Site	Ward name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Patients at Midnight	Registered midwives / nurses	Care Staff	Overall
Royal London	10E RLH	2,166.5	2,170.5	1,069.5	1,426.0	2,139.0	2,138.0	1,069.5	1,562.0	100.2%	133.3%	100.0%	146.0%	780	5.5	3.8	9.4
Royal London	10F RLH	1,116.0	1,380.0	744.0	1,032.0	1,023.0	1,035.0	341.0	957.0	123.7%	138.7%	101.2%	280.6%	483	5.0	4.1	9.1
Royal London	11C RLH	2,850.0	2,844.3	1,426.0	1,382.5	2,852.0	2,852.5	713.0	920.5	99.8%	96.9%	100.0%	129.1%	701	8.1	3.3	11.4
Royal London	11E & 11F AAU	3,818.0	4,368.7	1,782.5	1,751.2	3,564.0	4,138.3	1,426.0	1,920.5	114.4%	98.2%	116.1%	134.7%	1,425	6.0	2.6	8.5
Royal London	12C RLH	1,897.5	2,424.5	1,426.0	1,414.5	1,828.5	2,414.5	1,069.5	1,437.0	127.8%	99.2%	132.0%	134.4%	810	6.0	3.5	9.5
Royal London	12D RLH	1,425.3	2,183.7	1,069.5	1,613.0	1,426.0	2,131.5	713.0	1,690.5	153.2%	150.8%	149.5%	237.1%	522	8.3	6.3	14.6
Royal London	12E RLH	2,748.5	3,359.8	1,426.0	1,395.5	2,495.5	3,082.2	1,426.0	1,438.0	122.2%	97.9%	123.5%	100.8%	724	8.9	3.9	12.8
Royal London	12F RLH	2,033.5	2,262.0	1,782.5	2,027.0	1,781.0	2,116.0	1,782.5	2,208.0	111.2%	113.7%	118.8%	123.9%	816	5.4	5.2	10.6
Royal London	13C RLH	1,917.5	2,196.5	713.0	943.0	1,782.5	2,024.0	713.0	1,196.0	114.6%	132.3%	113.5%	167.7%	778	5.4	2.7	8.2
Royal London	13D RLH	1,782.5	2,822.5	713.0	809.0	1,426.0	2,435.5	713.0	966.0	158.3%	113.5%	170.8%	135.5%	770	6.8	2.3	9.1
Royal London	13E RLH	2,035.5	2,866.0	713.0	1,042.0	1,679.0	2,639.2	713.0	1,184.5	140.8%	146.1%	157.2%	166.1%	738	7.5	3.0	10.5
Royal London	13F RLH	1,782.5	2,276.5	966.0	1,138.8	1,782.5	1,919.2	713.0	1,149.1	127.7%	117.9%	107.7%	161.2%	717	5.9	3.2	9.0
Royal London	14E & 14F RLH	4,034.5	4,071.3	2,185.0	2,553.0	2,852.0	3,245.0	2,150.5	2,783.0	100.9%	116.8%	113.8%	129.4%	1,574	4.6	3.4	8.0
Royal London	3D RLH	4,289.5	4,443.8	2,576.0	2,714.0	3,507.5	3,715.5	2,116.0	2,242.5	103.6%	105.4%	105.9%	106.0%	1,170	7.0	4.2	11.2
Royal London	3E RLH	2,172.0	2,242.5	1,069.5	1,367.5	2,138.3	2,207.3	1,069.5	1,472.0	206.5%	255.7%	206.5%	275.3%	1,608	11.1	7.1	18.1
Royal London	3F RLH	2,233.0	2,105.0	701.5	583.0	2,081.5	1,914.8	678.5	609.5	94.3%	83.1%	92.0%	89.8%	264	15.2	4.5	19.7
Royal London	4E RLH	13,921.5	14,749.7	713.0	598.0	13,926.5	14,538.1	356.5	470.5	211.9%	167.7%	208.8%	264.0%	2,550	45.9	1.7	47.6
Royal London	6C RLH	2,876.2	2,850.2	207.0	239.3	2,576.0	2,530.0	184.0	230.0	99.1%	115.6%	98.2%	125.0%	198	27.2	2.4	29.5
Royal London	6E RLH	1,424.5	1,989.6	713.0	667.0	1,426.0	1,798.5	356.5	356.5	139.7%	93.5%	126.1%	100.0%	369	10.3	2.8	13.0
Royal London	6F RLH	3,548.8	3,501.3	706.0	685.0	3,557.0	3,579.5	713.0	703.5	98.7%	97.0%	100.6%	98.7%	594	11.9	2.3	14.3
Royal London	7C RLH	1,426.0	1,481.5	586.5	1,114.2	1,069.5	1,127.0	552.0	1,182.0	103.9%	190.0%	105.4%	214.1%	420	6.2	5.5	11.7
Royal London	7D RLH	1,817.0	1,961.8	724.5	851.0	1,426.0	1,588.1	713.0	885.5	108.0%	117.5%	111.4%	124.2%	406	8.7	4.3	13.0
Royal London	7E RLH	2,831.0	3,112.3	1,069.5	1,985.0	2,481.8	2,815.7	1,069.5	2,159.9	109.9%	185.6%	113.5%	202.0%	724	8.2	5.7	13.9
Royal London	7F RLH	2,093.0	2,234.0	540.5	989.3	1,794.0	1,866.0	356.5	919.8	106.7%	183.0%	104.0%	258.0%	465	8.8	4.1	12.9
Royal London	8C RLH	1,966.0	1,857.5	713.0	710.0	1,426.0	1,472.0	711.5	711.5	94.5%	99.6%	103.2%	100.0%	559	6.0	2.5	8.5
Royal London	8D RLH	9,438.8	8,754.3	644.0	0.0	8,643.5	7,825.3	0.0	0.0	92.7%	0.0%	90.5%		1,126	14.7	0.0	14.7
Royal London	8F RLH	1,752.0	1,734.0	1,111.8	1,090.8	1,069.5	1,069.5	1,069.5	1,069.5	99.0%	98.1%	100.0%	100.0%	1,494	1.9	1.4	3.3
Royal London	9E RECA	1,069.5	1,412.5	356.5	322.0	1,069.5	1,414.5	356.5	356.5	132.1%	90.3%	132.3%	100.0%	187	15.1	3.6	18.7
Royal London	9E RLH	1,794.0	1,939.0	713.0	930.5	1,426.0	1,564.0	713.0	1,221.0	108.1%	130.5%	109.7%	171.2%	731	4.8	2.9	7.7
Royal London	9F RLH	1,780.0	1,932.2	713.0	808.5	1,426.0	1,555.5	713.0	943.5	108.5%	113.4%	109.1%	132.3%	618	5.6	2.8	8.5

Safe Staffing Fill Rates by Ward and Site

APPENDIX

		Registered midwives / nurses (day)		Care Staff (day)		Registered midwives / nurses (night)		Care Staff (night)		Day		Night		Care Hours Per Patient Day (CHPPD)			
Site	Ward name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Patients at Midnight	Registered midwives / nurses	Care Staff	Overall
Whipps Cross	AAU WXH	4,431.5	5,023.3	2,494.8	2,390.7	3,921.5	4,894.8	2,495.5	2,616.2	113.4%	95.8%	124.8%	104.8%	1,378	7.2	3.6	10.8
Whipps Cross	ACACIA	966.0	970.8	460.0	461.5	712.5	728.0	713.0	713.5	100.5%	100.3%	102.2%	100.1%	353	4.8	3.3	8.1
Whipps Cross	Acorn	3,703.5	2,778.3	356.5	414.5	2,852.0	2,277.8	345.0	299.0	75.0%	116.3%	79.9%	86.7%	400	12.6	1.8	14.4
Whipps Cross	B3 WARD WXH	1,322.5	1,437.5	1,134.3	1,125.3	1,069.5	1,193.6	713.0	1,012.0	108.7%	99.2%	111.6%	141.9%	540	4.9	4.0	8.8
Whipps Cross	BIRCH	1,069.5	1,303.8	1,069.5	1,150.0	1,069.5	1,104.0	713.0	933.5	121.9%	107.5%	103.2%	130.9%	550	4.4	3.8	8.2
Whipps Cross	BLACKTHORN	1,069.5	1,233.0	1,069.5	1,134.5	1,069.5	1,035.0	713.0	1,006.5	115.3%	106.1%	96.8%	141.2%	514	4.4	4.2	8.6
Whipps Cross	Bracken Ward WXH	1,322.5	1,514.0	1,069.5	1,127.0	1,069.5	1,173.0	713.0	991.5	114.5%	105.4%	109.7%	139.1%	541	5.0	3.9	8.9
Whipps Cross	Cedar	1,426.0	1,409.1	1,426.0	1,645.5	1,069.5	1,161.5	1,069.5	1,368.5	98.8%	115.4%	108.6%	128.0%	524	4.9	5.8	10.7
Whipps Cross	CHESTNUT	966.0	966.0	356.5	901.0	713.0	1,058.0	356.5	851.0	100.0%	252.7%	148.4%	238.7%	383	5.3	4.6	9.9
Whipps Cross	Conifer	1,419.0	1,418.0	1,423.5	1,345.5	1,069.5	1,069.5	1,069.5	1,230.5	99.9%	94.5%	100.0%	115.1%	433	5.7	5.9	11.7
Whipps Cross	CURIE	1,426.0	1,287.9	1,069.5	1,449.0	1,069.5	1,000.5	1,069.5	1,472.0	90.3%	135.5%	93.5%	137.6%	559	4.1	5.2	9.3
Whipps Cross	DELIVERY SUITE WXH	6,582.5	5,903.3	1,427.5	1,275.5	5,382.0	5,117.3	1,426.0	1,334.5	89.7%	89.4%	95.1%	93.6%	432	25.5	6.0	31.6
Whipps Cross	ELIZABETH	1,667.5	1,993.0	356.5	415.5	1,414.5	1,771.5	356.5	379.5	119.5%	116.5%	125.2%	106.5%	558	6.7	1.4	8.2
Whipps Cross	FARADAY	1,382.5	1,295.3	681.0	816.5	1,426.0	1,093.0	356.5	768.8	93.7%	119.9%	76.6%	215.6%	467	5.1	3.4	8.5
Whipps Cross	ICU WXH	6,925.5	5,892.2	1,366.5	715.7	6,380.0	5,525.1	1,364.0	522.7	170.2%	104.7%	173.2%	76.6%	852	53.6	5.8	59.4
Whipps Cross	MARGARET	1,068.0	1,068.0	356.5	310.5	713.0	713.0	356.5	368.0	100.0%	87.1%	100.0%	103.2%	311	5.7	2.2	7.9
Whipps Cross	MULBERRY	2,165.0	2,032.2	1,654.5	1,194.5	1,437.5	1,446.1	1,426.0	1,300.5	93.9%	72.2%	100.6%	91.2%	1,187	2.9	2.1	5.0
Whipps Cross	NEONATAL WXH	2,857.5	2,642.0	390.5	174.0	2,562.0	2,414.8	0.0	0.0	92.5%	44.6%	94.3%		452	11.2	0.4	11.6
Whipps Cross	NIGHTINGALE	1,426.0	1,357.0	356.5	414.0	1,426.0	1,092.5	356.5	429.3	95.2%	116.1%	76.6%	120.4%	388	6.3	2.2	8.5
Whipps Cross	PEACE	1,679.0	1,655.0	1,426.0	1,472.0	1,069.5	1,069.5	1,069.5	1,196.0	98.6%	103.2%	100.0%	111.8%	475	5.7	5.6	11.4
Whipps Cross	Poplar	1,782.5	1,667.5	1,069.5	1,115.5	1,426.0	1,299.0	1,069.5	954.5	93.5%	104.3%	91.1%	89.2%	616	4.8	3.4	8.2
Whipps Cross	Primrose	1,782.5	1,920.5	1,426.0	1,851.5	1,426.0	1,541.0	1,069.5	1,989.5	107.7%	129.8%	108.1%	186.0%	860	4.0	4.5	8.5
Whipps Cross	ROWAN	1,781.0	1,802.0	1,426.0	1,978.0	1,426.0	1,437.5	1,069.5	2,058.5	101.2%	138.7%	100.8%	192.5%	837	3.9	4.8	8.7
Whipps Cross	SAGE	1,679.0	2,047.0	1,467.3	1,428.3	1,426.0	1,782.5	1,069.5	1,069.5	121.9%	97.3%	125.0%	100.0%	540	7.1	4.6	11.7
Whipps Cross	Sycamore	1,678.5	1,680.7	1,426.0	1,541.1	1,423.5	1,414.2	1,058.0	1,333.8	100.1%	108.1%	99.3%	126.1%	811	3.8	3.5	7.4
Whipps Cross	SYRINGA	1,426.0	1,426.0	1,736.5	1,771.0	1,069.5	1,069.5	1,426.0	1,643.3	100.0%	102.0%	100.0%	115.2%	769	3.2	4.4	7.7

Safe Staffing Fill Rates by Ward and Site

APPENDIX

		Registered midwives / nurses (day)		Care Staff (day)		Registered midwives / nurses (night)		Care Staff (night)		Day		Night		Care Hours Per Patient Day (CHPPD)			
Site	Ward name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Patients at Midnight	Registered midwives / nurses	Care Staff	Overall
Newham	BECKTON	1,250.0	1,250.0	1,069.5	1,069.5	1,069.5	1,069.5	0.0	0.0	100.0%	100.0%	100.0%		400	5.8	2.7	8.5
Newham	Custom House NUH	1,423.5	1,563.0	1,065.0	1,207.5	1,069.5	1,172.0	1,069.5	1,265.0	109.8%	113.4%	109.6%	118.3%	591	4.6	4.2	8.8
Newham	DELIVERY SUITE NUH	5,148.0	5,143.1	713.0	666.0	4,991.0	4,971.5	701.5	686.8	99.9%	93.4%	99.6%	97.9%	625	16.2	2.2	18.3
Newham	Gallions Reach (ITU)	4,278.0	4,220.5	713.0	678.5	4,278.0	4,243.5	713.0	678.5	98.7%	95.2%	99.2%	95.2%	295	28.7	4.6	33.3
Newham	HEATHER	2,127.5	2,230.3	1,426.0	1,678.0	1,782.5	1,863.0	1,069.5	1,610.0	104.8%	117.7%	104.5%	150.5%	747	5.5	4.4	9.9
Newham	LARCH	3,484.0	3,509.8	1,709.5	1,713.8	2,288.5	2,452.1	1,437.5	1,499.0	100.7%	100.2%	107.1%	104.3%	1,851	3.2	1.7	5.0
Newham	Manor Park	1,426.0	1,495.9	878.0	713.0	1,426.0	1,506.5	713.0	701.5	104.9%	81.2%	105.6%	98.4%	458	6.6	3.1	9.6
Newham	MAPLE	1,068.0	1,070.8	713.0	690.0	1,069.5	1,058.0	713.0	690.0	100.3%	96.8%	98.9%	96.8%	206	10.3	6.7	17.0
Newham	NEONATAL NUH	3,265.0	3,094.2	0.0	0.0	3,369.5	2,956.3	0.0	0.0	94.8%		87.7%		595	10.2	0.0	10.2
Newham	NUH MIDWIFERY	1,076.5	1,104.1	348.5	348.5	1,069.5	1,075.8	356.5	357.5	102.6%	100.0%	100.6%	100.3%	137	15.9	5.2	21.1
Newham	NUH Upton Park	2,488.5	2,657.5	1,426.0	1,885.5	2,495.5	2,852.0	1,426.0	1,771.0	106.8%	132.2%	114.3%	124.2%	763	7.2	4.8	12.0
Newham	Plashet	1,782.5	2,024.0	1,069.5	1,286.8	1,414.5	1,862.0	1,069.5	1,449.0	113.5%	120.3%	131.6%	135.5%	763	5.1	3.6	8.7
Newham	RAINBOW	2,844.0	2,991.5	1,085.5	959.0	1,782.5	2,093.0	356.5	368.0	105.2%	88.3%	117.4%	103.2%	318	16.0	4.2	20.2
Newham	Silvertown	1,782.5	1,843.8	1,065.5	1,111.5	1,426.0	1,564.0	1,069.5	1,276.5	103.4%	104.3%	109.7%	119.4%	686	5.0	3.5	8.4
Newham	Stratford	1,426.0	1,628.8	1,069.5	1,194.5	1,424.5	1,564.0	1,069.5	1,288.0	114.2%	111.7%	109.8%	120.4%	473	6.8	5.2	12.0
Newham	Tayberry	1,782.5	1,759.5	1,426.0	1,587.0	1,426.0	1,414.5	1,069.5	1,610.0	98.7%	111.3%	99.2%	150.5%	779	4.1	4.1	8.2
Newham	THISTLE	1,778.5	1,788.0	1,421.5	1,435.8	1,426.0	1,426.0	1,069.5	1,564.0	100.5%	101.0%	100.0%	146.2%	744	4.3	4.0	8.4
St Bart's	1C	6,037.0	4,729.5	356.5	356.5	5,761.5	4,657.5	207.0	207.0	78.3%	100.0%	80.8%	100.0%	361	26.0	1.6	27.6
St Bart's	1D	3,208.5	2,403.5	356.5	402.5	2,852.0	2,129.5	356.5	391.0	74.9%	112.9%	74.7%	109.7%	297	15.3	2.7	17.9
St Bart's	1E	4,968.0	3,894.8	356.5	326.0	4,991.0	3,760.5	356.5	276.0	78.4%	91.4%	75.3%	77.4%	264	29.0	2.3	31.3
St Bart's	3A SBH	4,991.0	4,945.0	1,426.0	1,357.0	4,991.0	4,982.5	1,426.0	1,437.5	99.1%	95.2%	99.8%	100.8%	1,010	9.8	2.8	12.6
St Bart's	3D SBH	1,575.5	1,863.0	1,207.0	1,431.0	1,529.5	1,472.0	966.0	942.0	118.2%	118.6%	96.2%	97.5%	495	6.7	4.8	11.5
St Bart's	4A SBH	1,777.0	1,776.0	1,058.0	1,023.5	1,426.0	1,414.5	356.5	724.5	99.9%	96.7%	99.2%	203.2%	679	4.7	2.6	7.3
St Bart's	4B SBH	1,591.0	1,587.5	1,234.5	1,009.8	1,426.0	1,426.0	713.0	690.0	99.8%	81.8%	100.0%	96.8%	556	5.4	3.1	8.5
St Bart's	4C SBH	1,782.5	1,587.0	966.0	820.0	1,426.0	1,345.5	966.0	839.5	89.0%	84.9%	94.4%	86.9%	575	5.1	2.9	8.0
St Bart's	4D & 4E SBH	1,679.0	1,533.5	741.5	661.0	1,621.5	1,207.5	713.0	644.0	91.3%	89.1%	74.5%	90.3%	467	5.9	2.8	8.7
St Bart's	5A SBH	1,980.0	2,078.1	877.5	1,233.8	1,452.0	1,553.3	341.0	873.2	105.0%	140.6%	107.0%	256.1%	624	5.8	3.4	9.2
St Bart's	5B SBH	1,426.0	1,429.8	713.0	701.5	1,069.5	1,060.0	356.5	598.0	100.3%	98.4%	99.1%	167.7%	451	5.5	2.9	8.4
St Bart's	5C SBH	2,139.0	2,506.1	713.0	885.5	1,782.5	2,215.8	356.5	725.8	117.2%	124.2%	124.3%	203.6%	592	8.0	2.7	10.7
St Bart's	5D SBH	2,139.0	2,226.0	713.0	851.0	1,782.5	1,925.8	713.0	1,070.5	104.1%	119.4%	108.0%	150.1%	693	6.0	2.8	8.8
St Bart's	6A SBH	6,417.0	5,132.5	356.5	425.5	6,417.0	5,117.5	356.5	379.5	80.0%	119.4%	79.7%	106.5%	303	33.8	2.7	36.5
St Bart's	6D SBH	1,449.0	1,413.4	713.0	632.1	1,081.0	1,059.0	713.0	782.8	97.5%	88.7%	98.0%	109.8%	494	5.0	2.9	7.9

Barts Health
People Strategy
2025-2030+

Progress Update and Forward Look

Trust Board
9th July 2025

People Strategy - Introduction

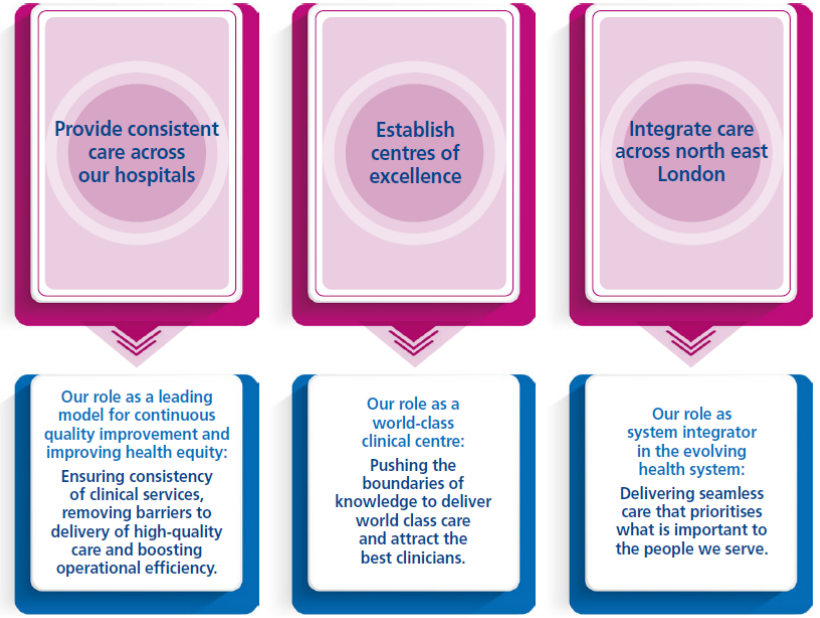
- **The purpose of this paper** is to update the Board on delivery of strategy and outline the next steps, including the priorities for Year 1 and how these will be delivered across our hospitals and services.
- The refreshed **Barts Health NHS Trust People Strategy was last presented at Trust Board in March 2024.** At the time, the development of the Group Clinical Strategy began, so in order to align to this and to be able to support the Clinical Strategy as one of its enablers, we decided to progress our People Strategy in draft form ('Year 0') prior to launching the strategy for its Year 1 alongside the Clinical Strategy.
- Since the People Strategy refresh, **the wider context has been changing** and our delivery had to adapt to this, e.g., enhanced focus on workforce productivity and innovation, changes in the wider NHS structures and the development of the **new NHS 10-Year Health Plan** and the three left shifts: moving care from hospitals to communities, leveraging digital technology, and focusing on prevention over treatment.
- With the focus on **workforce productivity,** at the current time, these actions have been prioritised in Year 1 and pulled forward in each pillar to reflect the importance of this work.
- In reviewing the strategy, we have **ensured alignment to our Group Operating Plan (GOP)** so that the People section of the GOP includes the same pillars as those of the People Strategy to enable effective measurement and tracking of progress.
- A key focus for our People Strategy is to enable and support our Clinical Strategy, particularly through **innovation, integration, workforce productivity and transformation.**
- Next steps include focusing on our **People Strategy plan for Year 1** alongside our delivery of the GOP 2025/26 and continuing to improve our NHS Staff Survey scores.

The Group Clinical Strategy 2025 - 2030+ and Group Operating Plan 2025/26

The **purpose of our People Strategy** is to enable and support the delivery of the new **Group Clinical Strategy** and our **Group Operating Plan 2025/26** with its 5-year group priority to be in the **top 3 London Acute Trusts to work for by 2030** as reported by NHS Staff Survey.

It is also to ensure that we continue to develop a culture in which all our staff feel engaged and a sense of belonging so that they are motivated and empowered to deliver safe, effective and compassionate care and **focus on saving lives, improving health outcomes, and enhancing the quality of life for our patients.**

Within the wider, national context, we will continue to review and refine our People Strategy on an annual basis to ensure alignment with the changing operating context and **the upcoming NHS 10-Year Health Plan.**



Barts Health in 25/26 | Our patients care | Our people culture | Our partnerships collaboration | Sustainable investment | Improving infrastructure | Driving innovation | How we will do it

Our People culture — Be an outstanding inclusive place to work

People – 5 year Group Priority

To be in the top 3 London Acute trusts to work for by 2030 as reported by NHS Staff Survey

Annual Goals *Priorities for delivery*	Key Drivers *Supporting delivery of annual goals*	Watch Metrics *Continuously monitor/improve*	Strategic Initiatives *Key progammes of work*	Governance *Oversees delivery*
Improving staff wellbeing – continue to place the wellbeing of our people at the centre of all we do - increasing our NHS Staff Survey score on the 'People Promise - 'We Are Safe And Healthy'.	• Increase medical and non-medical appraisal rates to 90%. • Roll out team-based rostering to a further 10 areas. • Achieve sickness target of 4%.	• Board IPR • People dashboard • NHS Staff Survey	• Group Retention Programme • Group Appraisal Programme	People Board
Reducing our reliance on temporary staffing – reducing agency spend as % of pay bill to 1.2% and Bank as a % of pay bill <7.9%.	• Reductions in bank and agency usage rates, supported by the establishment of workforce controls. • Creation of a single digital front door for staff by Q4 providing a one-stop-shop for all 'people related' queries.	• Board IPR • People dashboard • NHS Staff Survey	• Workforce Controls Oversight • Medical Workforce Productivity Programme • Enhanced Care Review Programme • Single Front Door Programme	Workforce Resourcing Board
Creating an inclusive organisation - improving diversity within our senior roles by increasing the % of BAME colleagues in 8A+ roles to 42%.	• NHS Staff Survey: % of staff believing we offer equal career opportunities for progression (WRES 7) - increase to 46% • Development of our Leadership Strategy to launch in Q3.	• Inclusion dashboard • Board IPR • NHS Staff Survey	• WeBelong Programme • WeLead Programme	People Board

People Strategy

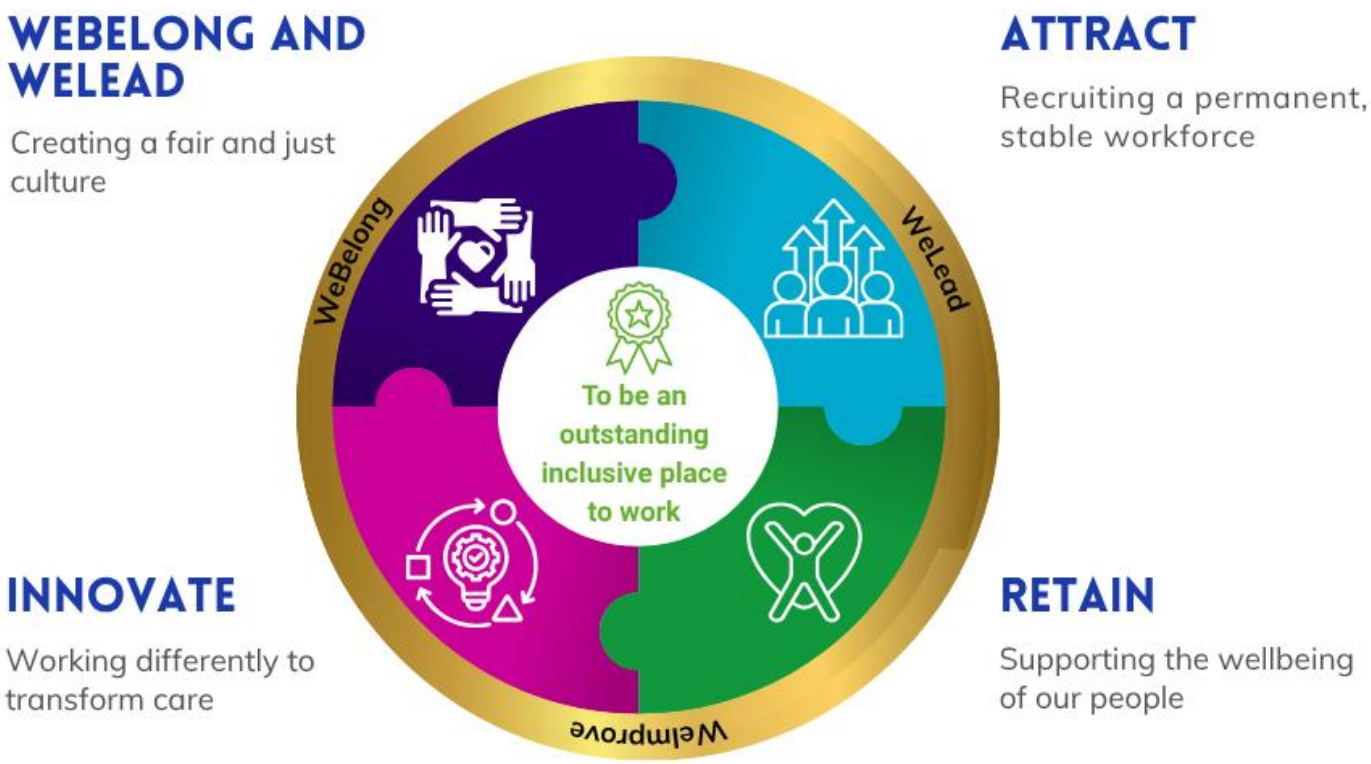
People Strategy

Barts Health NHS Trust

In the Group Operating Plan, we have set an overarching 5-year People Priority - to be in the top 3 London Acute Trusts to work for by 2030 as reported by NHS Staff Survey.

The strategy is built around 4 pillars underpinned by three critical **'golden threads' – inclusion,** covered in our **WeBelong strategy, leadership,** covered in our **WeLead framework,** and **WeImprove,** our approach to quality improvement (QI) using a **Quality Management System methodology (QMS).** These influence everything we do and how the work under the strategy pillars is progressed and delivered.

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



People Strategy at a Glance

People – 5-year Group Priority:
To be in the top 3 London Acute Trusts to work for by 2030 as reported by NHS Staff Survey

Barts Health NHS Trust

People Strategy Pillar	Our strategic goals:	How we will achieve these:
ATTRACT Recruiting a permanent, stable workforce	**To deliver a permanent and stable workforce, reducing reliance on temporary workforce and improving patient care**	• **Reduce** reliance on **temporary staffing,** ensuring that we consistently **operate within our budgeted establishment** • Ensure that our **employment offer is attractive** to people across all generations, including those who have yet to join the workforce • Work with our **local communities** and partners across the NEL footprint to create **work opportunities** for our local community • Engage and collaborate **in partnerships** seeking more innovative ways of working
RETAIN Supporting the wellbeing of our people	**To have a sustainable approach to how we care for our people, improving work experience and retention**	• Continue to create an **environment where our people's wellbeing is priortised,** through the work of our **hospital wellbeing teams** and group health and wellbeing services such as **Employee Wellbeing Service** and **Psychological Support Service** • Scale up our retention programme across all hospitals, including the roll out of **team-based rostering across the organisation** • Deliver outstanding actions of the **people promise bundle** whilst upskilling our people to deliver this locally, using our **WeImprove Quality Management System (QMS) methodology** • Use our scale as a group to further develop a compelling **employee value proposition**
INNOVATE Working differently to transform care	**To have a sustainable workforce model that supports the transformation of care**	• In line with the ambition of our **Group Clinical Strategy, Group Operating Plan and the NHS 10-Year Health Plan,** develop a workforce **transformation plan** that supports **new models** of care and **improved productivity** • Ensure workforce transformation plans are aligned to the **Education and Training Strategy** • Accelerate **digital and artificial intelligence (AI)** opportunities to **improve productivity and user experience,** expand beyond back-office functions to deliver innovate ways to approach patient care delivery
WEBELONG and WELEAD Creating a fair and just culture	**To create an inclusive and compassionate organisational culture through leadership and our commitment to inclusion**	• **Eradicate all** forms of **discrimination**, bullying, harassment and **unwanted sexual behaviour** • Continue to progress our work on **accessible career opportunities**, ensuring **more diversity in our senior roles** • Continue to **improve representation in leadership positions** and launch our group wide **Leadership Strategy** that combines our leadership offer, outlining capability requirements and access to training • Support evolving **leadership behaviours for WeImprove** and use **a coaching-based approach** to leadership

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

People Strategy 2024/25 Progress

The next section sets out **an outline for our People Strategy across its 4 pillars** – Attract, Retain, Innovate, WeBelong and WeLead and our priorities assigned to each of the pillars. To help bring key programmes of work to life, a number of **case studies** have been included alongside the pillar priorities.

It further sets out **our progress from Year 0, 2024/25** across these areas and our **plan for Year 1 delivery.**

Attract: Recruiting a permanent, stable workforce

The Vision: We aim to achieve stable permanent workforce across all staff groups and reduce our reliance on temporary staffing so that we operate within our staffing budgets.

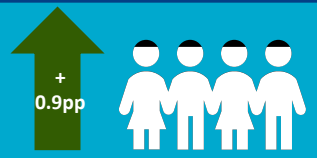
Barts Health NHS Trust

About this pillar	By actively attracting and recruiting into our vacancies, including those 'hard to fill' positions we aspire to reduce our reliance on temporary staffing, thereby enhancing the quality of patient care and solidifying our commitment to excellence in healthcare delivery.
What will we do?	• Achieve **stable permanent workforce** across all staff groups and **reduce our reliance on temporary staffing** so that we **operate within our staffing budgets** • Ensure that our **employment offer is attractive** to people across all generations, including those who have yet to join the workforce • Work with our partners to increase our local workforce supply and **support NEL's vision of 'one workforce'** where people can move seamlessly between our hospitals and across the NEL footprint; engage and collaborate **in partnerships**
How will we measure success?	• 95.0% overall substantive fill rate • 93.0% nursing fill rate • <1.2% agency as % of pay bill • <7.9% bank as % of pay bill • Apprenticeship starts • Number of people recruited from our local communities
Timeframe	• **Year 0 and Year 1-** Increasing substantive fill rate (ALL) and N&M fill rate to 93%, reducing agency as a % of pay bill to <1.2% and bank to <7.9% • **Year 5-** Achieve a substantive fill rate of 95% for all staff groups, eliminate agency use and reduce our temporary staff spend to ensure that we consistently operate within our staffing budgets. Have a range of mature programmes to support local employment

Attract: Recruiting a permanent, stable workforce - 2024/2025 Progress

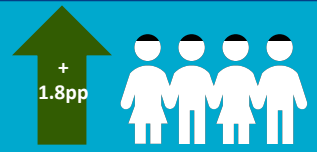
Barts Health NHS Trust

Substantive Fill Rate



We ended the year at 92.4% (target: 93%) by March 2025.

Nursing and Midwifery Fill Rate



We ended the year at 92.4% (target: 93%) by March 2025.

Community Engagement

24 new apprentices and 152 individuals were hired from local community programmes, supporting local employment and workforce development.

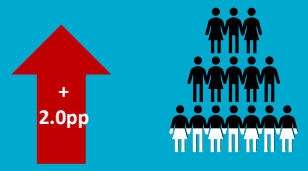
Staff Survey

34.0% (+1.2 pp above the national average) reported having enough staff to do their job properly.

Staff Survey

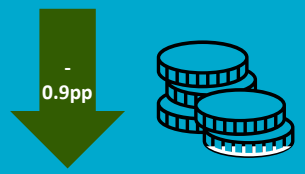
62.6% of our staff said they would recommend the organisation as a place to work (+1.1 pp). We score above our benchmark group by +1.72 pp.

Temporary Staffing



Temporary staffing as a % of workforce was 15.0% (target: 10%) indicating ongoing challenges in staffing stability.

Agency Spend



Agency spend as a percentage of the pay bill was well-controlled at 2.1% (target: ≤3.2%).

Last year, we made improvements on our fill rates, both overall and for our priority area of Nursing and Midwifery, ending the year just under 93% for both. We have successfully decreased our agency spend to 2.1% of pay spend, which was below our target of 3.2%. However, our temporary staffing as a % of workforce increased overall, and with our continued productivity challenges, we need to continue to focus on our temporary staffing spend this year and ensure that we operate within our staffing budgets.

Retain: Supporting the wellbeing of our people

The Vision: To deliver a sustainable approach to how we care for our people, improving work experience and retention, ultimately leading to Barts Health becoming an outstanding and inclusive place to work.

Barts Health NHS Trust

About this pillar	This pillar focuses on exploring new and innovative ways of working and looking after our people, helping them to flourish by prioritising their wellbeing and creating a safe, healthy and inclusive environment.
What will we do?	• Scale up our **retention programme** across all hospitals, including the roll out of **team-based rostering across the organization** • Provide support **by tackling discrimination,** linking the work of our fair and just culture to retention • Continue to build on the **work of our hospital wellbeing teams** and group services such as **Employee Wellbeing Service** and **Psychological Support Service** • Deliver outstanding actions of the bundle of interventions aligned to the people promise, designed to reduce turnover and leaver rate whilst upskilling our people to deliver this locally, using our WeImprove QMS methodology • Use our scale as a group to further develop a compelling **employee value proposition**
How will we measure success?	• 4% sickness • Increase both medical and non-medical appraisal rates to 90% • 100% People Promise bundle implemented at Barts Health • Increasing our NHS Staff Survey score on the People Promise theme of We Are Safe and Healthy • Roll out team-based rostering to a further 10 areas
Timeframe	• **Year 0 and Year 1**- sickness levels at 4% or below, 90% completion of non-medical appraisals, people promise bundle implemented 96%, improvement in our We Are Safe And Healthy staff survey score. Launch staff retention campaign: Bloom at Barts to promote Barts Health employee value proposition • **Year 5-** 100% People Promise bundle implemented and rolled out to the whole organisation, considered an exemplar and leader in our sector

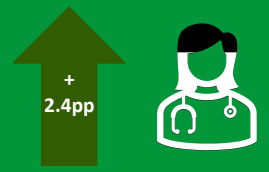
Retain: Supporting the wellbeing of our people - 2024/2025 Progress

Barts Health NHS Trust

Appraisal: Non-Medical

Appraisal rates improved but are still below target for non-medical staff (65.7%, target: 70%)

Appraisal: Medical



Appraisal rates improved for medical staff (84.4%, target: 85%).

Staff Survey

Of those that had their appraisal, 33.3% believe their appraisal helped them to improve how they do their job (+1.78). We scored above our benchmark group by +7.6 pp.

Staff Survey

51.4% of staff report believing the organisation is committed to helping them balance their work and home life.

Sickness

Our sickness absence reduced from the start of the year but has seen an increase in recent months. As of March 2025, sickness absence is at 4.39%.

Voluntary Turnover

Our voluntary turnover metric has stayed consistently low at 9% as of March 2025. This puts us as one of the best trusts across London.

Retention

As part of the Exemplar Retention Programme, 96% of the People Promise bundle was implemented. We improved in all 9 staff survey element scores and were recognised for this improvement by NHSE.

We made positive progress through our retention programme and flexible working programme. 51% of our colleagues reported that our organisation is committed to helping them balance their work and home life. Our turnover stayed consistently low at 9% which is one of the lowest in London. Although our appraisal compliance increased, we did not achieve our interim target of 70% for non-medical appraisals. We continue to keep our focus on this area and aim to achieve a 90% completion rate for both medical and non-medical appraisals in 25/26. We made positive progress on sickness in the year but fell short of our 4% target.

Attract

One effect of the pandemic was the massive demand on temporary staffing, including a huge rise in off framework agency spending. In order to address this, multiple strategies were employed. We partnered with the LPP Framework and collaborated with other London Trusts and moved the workers around, avoiding transfer fees. Several framework agencies agreed to attract the workers back, which saved between 20-50% of cost depending on the off framework agency charges.

When SERCO transferred to us, they used 100% agency for their temporary workforce and many of them were off framework. A very intensive campaign was stood up with many of the agency workers persuaded to transfer to Bank.

Today, we have 0 off framework bookings within our group and Estates and Facilities are at 100% Bank which is the best performance in London.

Retain

Since April 2022, our group retention programme has focused on implementing interventions aligned to the People Promise and reduced turnover rates through targeted actions and listening to staff. We're now launching a new retention brand, Bloom at Barts, to bring it all together, unify our efforts, create a clear identity, and embed retention across the employee journey. Moving from isolated actions to a clear retention brand touching every part of the employee lifecycle. It will launch initially through key corporate channels. With the expectation it will be embedded by teams across the employee lifecycle this year, including: induction, appraisals, career conversations, long service and staff recognition.

Innovate: Working differently to transform care

The Vision: To achieve a sustainable workforce model that supports transformation, using innovative ways to increase productivity and maximise the benefits from working at scale.

About this pillar	This pillar is about all types of innovation, including new ways of working to transform care, working innovatively in partnerships and digital innovation e.g. artificial intelligence (AI) and robotic automation.
What will we do?	• In line with the ambition of our **Group Clinical Strategy, Group Operating Plan and the NHS 10-Year Health Plan,** develop a workforce **transformation plan** that supports **new models** of care, **improved productivity** and increased levels of **local employment** • Ensure workforce transformation plans are aligned to the **Education and Training Strategy** • **Accelerate digital and artificial intelligence (AI) opportunities** to expand **beyond back-office** functions to deliver innovate ways to approach patient care delivery • Ongoing role out of enhanced and innovative electronic workforce deployment systems including **team-based rostering**
How will we measure success?	• Range of new and expanded scope roles in place across the trust breaking down traditional professional boundaries • New workforce models in place to support the implementation of the Group Clinical Strategy and NHS 10-Year Health Plan • Implementation of digital solutions across a range of workforce processes to improve productivity and user experience • Transformation of people systems through the adoption of new digital and AI opportunities • Improvement across data quality and user experience metrics
Timeframe	• **Year 0 and Year 1-** Develop workforce transformation plans for professional staff groups and to support operational process transformation. Develop solution for a single People service digital front door and AI enabled recruitment system. Continued roll out of team-based rostering • **Year 5-** We aim to fully embed new roles, workforce models and innovative ways of partnership working improving both productivity and the quality of care. We will have embraced the changes set out in the NHS 10-Year Health Plan with workforce models aligned to integrated neighbourhood care models. Implementation of new digital people systems and solutions that improve productivity and user experience through the use of new technology and scaling

Innovate: Working differently to transform care - 2024/25 Progress

Barts Health NHS Trust

Team-Based Rostering

Rolled out in 27 areas, showing improved flexibility scores (all areas scored above 6.5 in their We Work Flexibly element score in the Staff Survey compared to our benchmark average of 6.24).

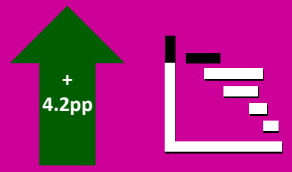
Rostering

74.4% of Nursing units are approved on time as of March 2025.

Digital Enhancements

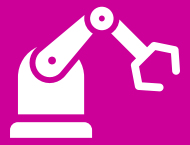
People Digital Improvement Programme is identifying further opportunities to widen the use of technology, automation, and AI, including the development of a Single Digital Front Door.

Job Planning



Medical and Dental Job Planning Completion is improving but remains below the 85% target overall (80.7%).

Robotic Process Automation (RPA



20 automated processes now perform work equivalent to c10–12 WTE, delivering net efficiencies equivalent to 7 WTE.

Recruitment System

Working with an external partner, the development of a new Permanent Recruitment System is progressing at pace. The new system is being designed to address recruitment challenges faced by the NHS, with built in automation and AI that will reduce administration time, increase the efficiency of recruitment processes, improve recruitment outcomes, and release time back to Hiring Managers.

Last year, we introduced team-based rostering as an innovative way of flexible working. We surpassed our target of 10 areas and rolled out to 27 of them which was reflected in improved flexibility scores in our NHS Staff Survey. In these areas, the scores were higher than our national benchmark. We improved our medical and dental job planning by 4.2pp, but it remains below the target and needs to continue to be a focus by developing team job planning and metrics for monitoring delivery against the plans. This year, our focus will also be on developing new workforce models to support the Group Clinical Strategy and digital innovation through increased automation and use of AI to build a People queries one stop shop and new recruitment system.

Innovate

The Outpatient Transformation Programme aims to optimise the Outpatient Service by influencing appointment demand, managing outpatient capacity effectively and enhancing where and how we provide advice, diagnostics, care and treatment. It is tied to the group 5-year objectives and annual goals with the aim of providing faster elective care and improving patient and staff experience.

Part of this programme will look at using our digital and workforce enablers. We will consult with our people across the organisation on how they work to enable workforce and process transformation and explore new ways of working that support a more forward looking digitally enabled outpatient service.

WeBelong and WeLead: Creating a fair and just culture

The Vision: To eradicate all forms of discrimination and inequality, ensure inclusivity and belonging for all our people fully embedding a culture of compassionate and inclusive leadership whilst continuing to upskill our leaders through the work of our leadership community.

Barts Health NHS Trust

About this pillar	Underpinned by our WeLead framework **for leadership development,** this pillar is centred on developing our leaders to be compassionate and inclusive.
What will we do?	• **Eradicate all** forms of **discrimination, bullying, harassment and unwanted sexual behaviour** • Continue to **improve representation in leadership positions** • Develop and launch a group wide **Leadership Strategy** that combines our leadership offer, outlining capability requirements and access to training • **Work with our partners to build a wider system leadership culture where everyone has an opportunity to develop and lead** • Develop and embed **leadership behaviours for WeImprove and the roll out of a Quality management approach**
How will we measure success?	• WeBelong success measures • WRES and WDES metrics • Train up to 3000 colleagues in bystander training on sexual safety in our hot spot areas across the group, followed up by a survey to see where improvements have been made (Year 1) • Improving diversity within our senior roles by increasing the % of BAME colleagues in 8A+ roles to 42% (Year 1) • Increase the percentage of Barts colleagues believing we offer equal career opportunities for progression (WRES 7) to 46% (Year 1) • Reduce the percentage of Barts colleagues that report personally experiencing discrimination from other staff to 9.4% to be in line with our benchmark group (Year 1) • Launch of a group Leadership Strategy with a refreshed management and leadership development offer along with team and individual coaching programmes
Timeframe	• **Year 0 and Year 1-** Achieve 25/26 WeBelong and Group Operating Plan objectives summarised above. Launch group Leadership Strategy and development offer including team and individual coaching programmes • **Year 5-** Fair, just and positive culture of compassionate and inclusive leadership embedded in line with WeBelong and our refreshed group-wide WeLead strategy. Reduction in experience of unwanted sexual behaviour and consistent improvement in staff survey metrics

WeBelong and WeLead: Creating a fair and just culture - 2024/2025 Progress

Barts Health NHS Trust

WRES & WDES

+ 0.5pp

Positive trends in 3 out of 4 WRES and all 9 WDES Staff Survey questions. BAME representation in Band 8a+ roles has remained stagnant at 39.5% as of March 2025 (target: 41%).

Leadership Development

+ 0.1pp

Continued rollout of the Inclusive Career Development Framework with tailored programs for BAME, disabled, and female staff. 48.5% of our people believe the organisation act fairly with regard to career progression / promotion. We are an outlier and score -7.55 pp below the benchmark average.

WeImprove

2840 Barts colleagues completed QI training in 2023/2024. 61% of these colleagues were from a BME background. 34% were at a band 8a+. Equity and Inclusion QI projects included Equity in Cardiac Care at St Bartholomew's Hospital Trust, Racial & Cultural Inclusion in Pharmacy and St Bartholomew's Staff LGBTQ+ Network Improvement Project.

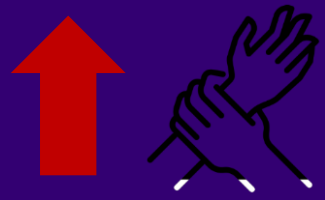
Discrimination

Over 1,700 staff completed Cultural Intelligence training and 740 completed Active Bystander training, targeting areas with higher incidents of discrimination. Of those that have experienced discrimination 68.9% of our people say this was on the grounds of their ethnic background. We are an outlier and are +12.8 pp away from our benchmark group.

Sexual Safety

The "It's Not Just" Sexual Safety Campaign launched to raise awareness. This may explain an increase (+0.1 pp) of staff that report being a target of unwanted behaviour of a sexual nature from patients (8.0%) and +0.1pp from staff (5.9%). We are an outlier and are +2.3 pp above the benchmark average for unwanted sexual behaviour from staff.

Violence and Abuse



14.9% (+1.0 pp) of staff have experienced violence from patients/service users, their relatives or other members of the public in the last 12 months.

Although sexual safety reporting has gone up, this could be due to the increased awareness and training resulting from our 'It's Not Just' communications campaign and the work of our steering group.

Over 1700 of colleagues have now completed our Cultural Intelligence (CQ) training and 740 completed the bystander training in our discrimination hot spot areas.

Our focus for this year will continue to be on eliminating discrimination, ensuring sexual safety and further improvement across our WRES and WDES metrics.

WeBelong

Cultural Intelligence (CQ) training gives our people enhanced self-awareness of how culture influences our interactions with others and the ability to work effectively in a culturally diverse place. Below is some of the feedback we have received.

Participant - “It is a safe space to learn and discuss experiences.”

Participant – “This course gives individuals the opportunity to reflect, not only on others but upon our own bias perceptions and actions.”

Ray Singh, Trainer – “I’ve seen laughter, tears, anger and all other emotions while delivering Cultural Intelligence (CQ) training for RLH. CQ provides our staff with an insight on how their own cultural intelligence can be brought to the surface - It’s all there and needs the space to show its colours.”

WeLead

We are developing our group Leadership Strategy (due to launch this Autumn) which will outline capability requirements and a curated Barts Health training and development offer in line with the updated national leadership framework. As part of this strategy, we are launching a number of team coaching models, including TED and Affina, in addition to our internal 1:1 coaching register.

The well-established Affina Team Journey programme has had great success rates and is about creating a high-performing team and the ability to engage, enthuse, inspire, motivate and support - attributes valued particularly during these often difficult times of transformation and productivity challenges.

Spotlight on Sexual Safety and Discrimination

NHS Barts Health

Below are some of the key highlights from our work in 2024/25 on sexual safety and discrimination our two priority areas identified through the NHS Staff Survey.

Sexual Safety:

- Signed up to the national Sexual Safety Charter and, in line with the national framework, introduced our new Sexual Safety policy, supported by the new communications campaign ‘It’s not just’
- Ran hospital and Trust wide sexual safety climate surveys to better understand the experience of our staff, the hot spots and priority areas for driving improvement
- Dedicated GEB training and awareness session on sexual safety and additional bespoke bystander training session
- Integration of sexual safety content into the corporate induction and the WeLead leadership development programme for managers
- Trained 1000 people in active bystander training, focused on hot spot areas informed by our data, and held two sexual safety webinars, with a third one in the pipeline
- Dedicated training programme delivered to our People teams to support greater consistency, eliminate bias and ensure a high degree of sensitivity in the management of complaints and sexual safety cases
- Rolled out sexual safety buddy support and developed a new reporting system.

Spotlight on Sexual Safety and Discrimination

Barts Health

Below are some of the key highlights from our work in 2024/25 on sexual safety and discrimination our two priority areas identified through the NHS Staff Survey.

Discrimination:

- Over 1700 of colleagues have now completed our Cultural Intelligence (CQ) training
- Ongoing work with promoting our WeBelong strategy and celebrating diversity through inductions, inclusion awards, roadshows and visits etc.
- Inclusive recruitment training is underway informed by our own experience and best practice gathered from other organisations
- Continued rollout of the Inclusive Career Development Framework with tailored programmes for BAME, disabled, and female staff
- 48.5% of our people believe the organisation acts fairly with regard to career progression / promotion

- **Ethnicity:** Progressed work across the group promoting our anti-racism initiative through site level signings, workshops and roadshows, and a webinar aligned to race equality
- **Disability:** Continued the work around safe to share, through initiatives such as the WDES café, to increase the confidence for staff to share their disability status. Increased our disability fundamentals training and then brought it all together in the new Disability Policy
- **Religion and Belief:** Demystifying Ramadan webinars ran through Ramadan as well as activities aligned to anti-islamophobia month
- **Sexual Orientation:** We have been awarded the HIV confident charter for our work on promoting HIV awareness, launched a dedicated mentoring service for LQBTQ+ colleagues and had a number of events to celebrate Pride month including 50 colleagues marching at London pride.

Looking into the Future and Areas of Focus

People Strategy Plan for Year 1

The following 2 slides set out our priorities for 2025/26 the first full year of our People Strategy

ATTRACT

Recruiting a permanent, stable workforce

- **Ensure we operate within our staffing budgets by reducing our use of temporary staff and cutting our worked WTE by 1100**
- Achieve <1.2% agency target as a % of pay bill and <7.9% bank target
- **Improve compliance with the London medical bank rates** through reducing vacancies in hard to fill areas and expanding our medical bank
- Achieve a **substantive fill rate of 93%** across all staff groups
- **Increase local employment by 160 people** through our local employment and work experience programmes including Community Works for Health, Healthcare Horizons and Project Search

RETAIN

Supporting the wellbeing of our people

- **Support** our **people** and engage **managers** by focusing on burnout and psychological safety to reduce our sickness levels to 4%
- Continue to **improve our We Are Safe and Healthy** People Promise theme score in our NHS Staff Survey, through our group **retention programme, including tackling the current issues faced by our people (e.g., cost of living) and flexible working**
- Achieve **90% completion** rate for both medical and non-medical **appraisals** by Q4, as set out in our appraisal improvement plan
- Focus **team-based rostering** to **10 new areas**, including for those staff groups previously not captured, e.g., AHPs
- In line with building stable, permanent workforce, we will aim to secure long-term **funding for our Psychology Support Service** (PSS) post January 2027
- **Launch staff retention campaign: Bloom at Barts** to promote Barts Health employee value proposition

People Strategy Plan for Year 1

Barts Health NHS Trust

INNOVATE

Working differently to transform care

- In line with the ambition of our Group Clinical Strategy, Group Operating Plan, and the NHS 10-Year Health Plan, develop a **workforce transformation plan for each profession** that focuses on workforce productivity and new models of care
- Continue to develop our approach to medical productivity through the roll out of medical e-rostering, team job planning and system for capturing clinical activities
- Support **OPD and clinical records workforce transformation** through the implementation of the new digital enablers
- Accelerate digital and **artificial intelligence (AI) opportunities** and create **a single digital front door** for all People queries
- **Implement new recruitment system** with built in automation and AI which will improve the administration involved in the recruitment process and release time back to hiring managers

WEBELONG and WELEAD

Creating a fair and just culture

- Focus on eradicating all forms of **discrimination** and improve our performance across WRES and WDES metrics, through continued focus on training, e.g., Cultural Intelligence (CQ) and our wider inclusion training offer
- Continue to **improve representation in leadership positions** (to 42% from 39.5% 2024/25 baseline)
- Continue to build on our work on sexual safety and train up to 3000 colleagues, by end of Q4, in bystander training in our hot spot areas, followed by a survey to determine progress made
- Use the NHSE Sexual Safety Charter Assurance Framework to evaluate our progress against the charter best practice actions
- Launch a group wide **Leadership Strategy**, outlining capability requirements and a curated Barts Health training and development offer in line with the updated national leadership framework
- Launch TED and Affina team coaching models along with an internal 1:1 coaching register

Report to the Trust Board: 9 July 2025	**TB 59/25**

Title	BAF 2025/26
Sponsoring Director	Group Director of Corporate Development
Author(s)	Trust Secretary
Purpose	Trust Board review for approval
Previously considered by	GEB, ARC 11 June 2025

Executive summary

The attached heatmap details the proposed BAF risks for 2025/26. This builds on discussion at the Trust Board regarding the Trust's operational plan, reflecting continuity of the Patients, People and Partnerships objectives and refinement of the supporting annual goals and enablers. The high degree of continuity of objectives from the prior year is reflected in a high proportion of BAF risks (as barriers to delivering principal objectives) being carried forward. The attached BAF heatmap provides details of BAF risks as reframed by lead directors and highlights one change in risk score since the 2024/25 quarter 4 BAF (linked to workforce productivity). The Audit and Risk Committee, at its meeting on 11 June, reviewed a 'bridge' mapping BAF risks from the prior year to 2025/26 to highlight amendments since quarter 4 and to assure BAF risks coverage against amended Trust objectives.

The BAF reflects the Trust's current risk profile with the highest scored risks shown for BAF entries in relation to workforce productivity (entry 2); urgent and emergency care standards delivery (entry 3); development of place-based partnerships and response to demand growth (entry 8); capital investment requirements at Newham and Whipps Cross (entry 9); and delivery of expenditure reductions (entry 10).

Of the above entries, the following risks reflect the greatest 'distance from risk appetite' (informing relative prioritization) - urgent and emergency care standards delivery (entry 3); capital investment requirements at Newham and Whipps Cross (entry 9); and delivery of expenditure reductions (entry 10).

Each BAF risk is assigned to one of the Trust Board's committees and 'deep dive' reports are provided through the year to provide the respective committees with the opportunity to review the key controls, assurances and performance against identified risk tolerance triggers (linked to operational plan success metrics). Exception reporting from committees to the Trust Board will highlight any key findings from this work. A deep dive schedule for the BAF risks is appended.

Following board approval of the principal risks being proposed the full BAF will be developed and presented to the Trust Board for approval at its September 2025 meeting.

Risk and Assurance	All
BAF entries	All

Legal implications/ regulatory requirements	Statutory requirement for production of an annual report and accounts

Action required:
The Trust Board is asked to approve the BAF entries and risk scores appearing on the heatmap and to note the schedule of BAF deep dive reports.

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 9 JULY 2025

BOARD ASSURANCE FRAMEWORK AND OPERATIONAL PLAN OVERSIGHT

BOARD ASSURANCE FRAMEWORK

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

2. The attached version of the BAF heatmap has been refreshed to explicitly map the BAF risks to the revised 2024/26 objectives (the people, patients and partnerships pillars) and supporting yearly goals and enablers in the 2025/26 annual plan. Recognising the continuity of the principal objectives and enablers (with most carried forward from the 2024/25 operational plan), and following review by the executive, a high proportion of BAF risks have been carried forward from 2024/25 with relatively minor amendments to risk wording. There has been one change in risk score highlighted in the BAF heatmap in relation to workforce productivity (entry 2).

3. As in previous years, a series of executive lead review meetings has informed the framing of the revised BAF risks and calibration of risk scores reflected in the attached BAF. Subject to the Board's approval of the BAF risks identified, the full BAF will be presented in September in the previously agreed format (for which a 'substantial' assurance Internal Audit rating was received in 2024/25). The format of the full BAF includes cross referencing to the wider Trust risk register to support a 'bottom-up' assessment of aggregated risks.

4. The Audit and Risk Committee reviewed proposed BAF risks at its meeting on 11 June 2025. The Audit and Risk Committee reviewed a 'bridge' mapping BAF risks from the prior year to 2025/26 to highlight amendments to risk framing and risk scores since quarter 4 and to assure BAF risks coverage against amended Trust objectives.

5. Each of the group's hospitals has developed a parallel 'hospital assurance framework' (HAF) with a consistent format aligned to the BAF. The HAFs have been reviewed as part of each hospital's regular exception reports into the executive Risk Management Board; and also considered periodically at performance reviews (with each HAF considered at the June round of hospital Performance Reviews).

2025/26 OPERATIONAL PLAN – OVERSIGHT OF DELIVERY AGAINST OBJECTIVES; AND RISKS IDENTIFIED IN THE BAF

6. The Barts Health operational plan for 2025/26 was approved by the Trust Board at its meeting in May 2025 and details key priorities in our mission to provide safe, compassionate and efficient care for the people of North East London, whilst continuing on our journey to be an outstanding place to work.

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

8. The Group Executive Board (GEB) has agreed the proposed approach to tracking operational plan delivery and risk through:
    - Group boards and board committee agendas aligned to objectives and associated BAF risks delegated to board committees for oversight.
    - Group boards (senior executive boards) will oversee metrics and progress against annual goals identified in the operational plan with supporting data dashboards and a refreshed IPR aligned with *Making Data Count* principles and SPC methodology.
    - A quarterly self-assessment of current performance and risks to delivery against metrics and measures in the operational plan will continue to be reported to GEB and the Trust Board. This will be aligned with the revised NHS oversight framework.
    - The plan's annual goals will inform BAF risk tolerances, serving as indicators that could trigger further review at board committee level where targets are breached. This approach will support the separate 'deep dive' reporting that provides a checkpoint for board committees to consider BAF risks in more detail.
9. As described in the above section, board committees and group boards will use the BAF as a tool to understand and manage the level and trajectory of strategic risks. BAF risks are overseen on behalf of the Board by the following board committees according to their roles in relation to the following objectives and risk themes:

    - Quality Assurance Committee – quality risks.

- Finance Investment and Performance Committee – financial and performance delivery risks.
- Audit and Risk Committee – governance and people (on behalf of the Board) risks.

RISK APPETITE STATEMENT

10. A risk appetite statement sets out the context in which a given objective sits. The Board last approved its risk appetite statement in March 2024 and the outputs of this exercise was mapped to the revised Trust objectives for 2025/26.

11. The benefits of a risk appetite statement include:

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

    - A framework for setting and revisiting 'tolerance' thresholds that inform escalation on reporting of risks.

    - Refining the use of the BAF, with consideration of relative 'distance from risk appetite' as a prioritising consideration.

    - A nationally recognised signifier of risk maturity, with the ability to replicate the group risk appetite for cascade at hospital level through their equivalents to the BAF (hospital assurance frameworks).

BAF DEEP DIVE REPORTING

11. A schedule of deep dive reporting (see draft proposal at appendix 2) will be agreed with Board committees. To support consistency, an agreed format is in place for these reports. This format places emphasis on scrutinising the effective management of risks through RAG ratings for each line of assurance and risk triggers as referenced in this report. This seeks to evolve the approach from one focusing on risk identification and risk score calibration towards a more balanced approach to the 'joined up' management of both performance and risks.

RECOMMENDATION

12. The Trust Board is asked to note and approve: the Board Assurance Framework risks for 2025/26 (BAF heatmap at appendix 1) and the proposed schedule of deep dive reports (at appendix 2).

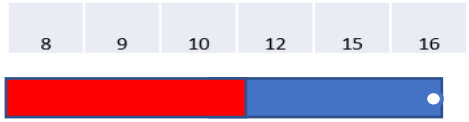
	Objectives	Board Assurance Framework - heatmap	Risk Score
	Annual goals / Appetite	Risk entry	1-3 | 4-6 | 8-9 | 10 | 12 | 15 | 16 | >=20
PEOPLE	Creating an inclusive organisation (moderate risk appetite)	1. **Failure to develop a consistent well-led, inclusive, culture in the context of resource challenges – impairs staff engagement and productivity – impacting on delivery of workforce plans, staff retention and care quality [DP/DEI] [ARC]**	
	Improving staff wellbeing (moderate risk appetite)		
	Reducing reliance on termporary staffing (cautious risk appetite)	2. **Failure to improve workforce productivity and deliver identified temporary staffing and WTE headcount reductions – impacts on activity, workforce and savings plans - impairing operational plan delivery [DP] [FIP]**	
PATIENTS	Enhance patient safety (cautious risk appetite)	3. **System-wide resourcing constraints – increases pressures on acute urgent and emergency care services – impacting on consistent delivery of emergency care access standards [COO] [FIP]**	
	Better patient experience (open risk appetite)	4. **Reduced scope for investing in quality improvement initiatives – impairs the ability to deliver change at the required scale – impacting on our ability to transform services [COO] [QAC]**	
		5. **A failure to identify quality risks (including potential unintended consequences of savings and efficiency plans) – introduces potential for suboptimal care or compounds in-year resourcing constraints - impacting on service quality and regulatory compliance [CN] [QAC]**	
	Improve maternity care (cautious risk appetite)	6. **Insufficient investment in staffing and maternity digital systems - affects our ability to improve maternity care, exit support programme and secure incentive funding – impacting on high quality care and service delivery [CN] [QAC].**	
PARTNERSHIPS	Ensure patients who are medically fit can leave hospital sooner (moderate risk appetite)	7. **Failure to coordinate and optimise cross-site working within the Trust's group operating model – affects capacity, efficiency and unwarranted variation – impacting on waiting times and delivery of productivity improvements [COO] [ARC]**	
	Drive wider social value in NEL (open risk appetite)		
	Deepen community relationships (open risk appetite)	8. **Failure to develop mature and effective place-based partnerships and neighbourhood models – affects the management of emergency care mental health pathways in the short term and co-ordination of demand management in the medium term - impairing the response to population growth, and improving equity of access, experience and outcomes (DSP/DEI) (FIP)**	
ENABLERS	Capital plan delivery (averse risk appetite)	9. **Capital funding constraints – impairs required estates investment at Whipps Cross and Newham – resulting in regulatory non-compliance and suboptimal care settings (CFO) (FIP)**	
	Revenue plan delivery (averse risk appetite)	10. **Delivering expenditure reductions in the context of income constraints – results in failure to deliver required financial run rates – impacting on delivery of the operational and financial plan. [CFO] [FIP]**	
	Strengthen cyber security (moderate risk appetite)	11. **An increase in cyber attacks and failure to harness AI developments effectively – impacts on systems security and productivity – impacting on clinical service delivery and continuity of care [DGD] [ARC].**	
	Enable the ability to access data securely for research and innovation (open risk appetite)	12. **Delays to deliver major strategic investments (including Clinical Research Facility and lifesciences programmes) to support research activity – impairs progress on translational research, resulting in poorer health outcomes through lack of opportunities to take part in research, reputational damage with key stakeholders including funders, commercial, academic and community partners and patients, and significant loss of NIHR funding in the next CRF competition - limiting ambitions to provide world-class research, education and equitable care (CMO) (QAC)**	

Key

Subobjective/risk appetite heading – a risk appetite is assigned to each subobjective rating from ‘averse’ (shaded dark blue) to ‘open’ (light blue).

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

Risk score section-



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

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

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

BAF Deep Dive schedule	Deep dive due
1. Failure to develop a consistent well-led, inclusive, culture in the context of resource challenges – impairs staff engagement and productivity – impacting on delivery of workforce plans, staff retention and care quality [DP/DEI] [ARC]	ARC: Nov 25 (DP)
2. Failure to improve workforce productivity and deliver identified temporary staffing and WTE headcount reductions – impacts on activity, workforce and savings plans - impairing operational plan delivery [DP] [FIP]	FIP: Sep 25 (DP)
3. System-wide resourcing constraints – increases pressures on acute urgent and emergency care services – impacting on consistent delivery of emergency care access standards [COO] [FIP]	FIP: Apr 26 (COO)
4. Reduced scope for investing in quality improvement initiatives – impairs the ability to deliver change at the required scale – impacting on our ability to transform services [COO] [QAC]	QAC: Mar 26 (COO)
5. A failure to identify quality risks (including potential unintended consequences of savings and efficiency plans) – introduces potential for suboptimal care or compounds in-year resourcing constraints - impacting on service quality and regulatory compliance [CN] [QAC]	QAC: Jan 26 (CN)
6. Insufficient investment in staffing and maternity digital systems - affects our ability to improve maternity care, exit support programme and secure incentive funding – impacting on high quality care and service delivery [CN] [QAC].	QAC: Nov 25 (CN)
7. Failure to coordinate and optimise cross-site working within the Trust's group operating model – affects capacity, efficiency and unwarranted variation – impacting on waiting times and delivery of productivity improvements [COO] [ARC]	ARC: Sep 25 (DSP)
8. Failure to develop mature and effective place-based partnerships and neighbourhood models – affects the management of emergency care mental health pathways in the short term and co-ordination of demand management in the medium term - impairing the response to population growth, and improving equity of access, experience and outcomes (DSP/DEI) (FIP)	FIP: Oct 25 (DSP)
9. . Capital funding constraints – impairs required estates investment at Whipps Cross and Newham – resulting in regulatory non-compliance and suboptimal care settings (CFO) (FIP)	FIP: Nov 25 (CFO)
10.Delivering expenditure reductions in the context of income constraints – results in failure to deliver required financial run rates – impacting on delivery of the operational and financial plan. [CFO] [FIP]	FIP: Feb 26 (CFO)
11. An increase in cyber attacks and failure to harness AI developments effectively – impacts on systems security and productivity – impacting on clinical service delivery and continuity of care [DGD] [ARC].	ARC: Feb 26 (DSP)
12. Delays to deliver major strategic investments (including Clinical Research Facility and lifesciences programmes) to support research activity – impairs progress on translational research, resulting in poorer health outcomes through lack of opportunities to take part in research, reputational damage with key stakeholders including funders, commercial, academic and community partners and patients, and significant loss of NIHR funding in the next CRF competition - limiting ambitions to provide world-class research, education and equitable care (CMO) (QAC)	QAC: Sep 25 (CMO)

Report to the Trust Board: 9 July 2025	TB 60/25

Title	Nursing, Midwifery and Therapies Establishment Review 2024/25
Sponsoring Director	Group Chief Nurse
Author(s)	Director of Nursing, Workforce and Professional Standards Group Director of Midwifery
Purpose	To provide Trust Board with the outcome of the NMAHP 2024/25 safe staffing review and assurance of the process used in the review.
Previously considered by	Group Executive Board 15th April 2025 Trust Board (Part 2) May 2025

Executive summary

This paper outlines the process and outcome of the Barts Health safe staffing NMAHP Establishment Review for 2024/25, alongside recommended establishment changes and the funding approach. The paper outlines the process undertaken, recommended changes to the hospitals' establishments and the resourcing strategy. Safe staffing priorities to be driven collectively by the NMAHP leadership team during 2025/26 are highlighted.

The NMAHP 2024/25 safer staffing establishment review was undertaken in line with the Trust's Safe Staffing Policy for Nursing and Midwifery (COR/POL/197/2024/001), covered inpatients, Emergency Departments and maternity. The triennial Birthrate Plus assessment for the trust was reported in January 2025 and is incorporated into this review.

Safer staffing reviews utilise evidence-based, accredited tools to triangulate activity and acuity and dependency data (demand), workforce metrics (supply) and quality outcomes to assess whether staffing establishments are higher, or lower, than is required to care for the quantity and complexity of patients in each service. Where the quantitative process identifies a gap, these can be closed by:

- Transformation initiatives, such as closing escalation capacity, consolidating services or seeing patients in an alternative setting;
- Professional judgement on whether gaps are appropriate, such as through an assessment that a service is safe and high quality despite showing a deficit, or that other mitigations are in place to reduce risk;
- Adding posts to establishments, and thus increasing cost; or
- Bearing additional risk and managing this throughout standard quality and safety governance including through completing an Equality and Quality Impact

Assessment.

Given the financial pressure faced by the Trust, and nationally, we are having to take difficult decisions on whether, how and when to implement additional investment in establishments. Hospital Executive Boards will need to re-allocate resources internally to support agreed expansions. This builds on previous history of investment and good productivity. Business cases will be prepared where new investment remains indicated. A revised position will be assessed through a mid-year establishment review.

For midwifery and neonatal services, the Maternity Incentive Scheme rebate will be used to fund the prioritised governance posts and high-risk clinical gaps.

Workforce and Productivity Trends

Model Hospital benchmarking demonstrates overall productive use of the nursing, midwifery and therapies resource, with Barts Health in the highest performing quartile for the Weighted Activity Unit (WAU) metric for nursing, midwifery, and therapies, though some wards and units have potential scope to improve ward-based productivity based on the Care Hours Per Patient Day (CHPPD) metric.

NMAHP leaders are continuing to drive productivity this year through:

- Focussing on enhanced care productivity, which has been our biggest area of WTE growth;
- Supporting wards/units that show scope to improve CHPPD to do so;
- Piloting comprehensive digital job plans for AHPs and CNSs;
- Reviewing outpatient services.

Establishment Review Outcomes

1. Nursing and Allied Health Professionals' Review

The quantitative assessments were peer-reviewed by Hospital Directors of Nursing and subject-matter experts, then signed off at the NMAHP Workforce Board.

The inpatient reviews identified the following changes to right-size establishments. These will be achieved through reallocation of existing hospital resources.

Hospital	Safe Staffing Priorities
Whipps Cross Hospital (WXH)	• Nursing: increased staffing in the Margaret Centre, Rowan Ward and Primrose Ward to strengthen night staffing and due to increased acuity and complex care needs • Practice Development: 12-month fixed term contract post to support ED targeted actions
Newham University Hospital (NUH)	• Neuro Service (therapies): Requires an uplift to align the service to national clinical guidelines, improve service delivery and reduce patient length of stay
Royal London Hospital (RLH)	• Nursing: increased staffing on 10E, 10F and 3D due to increase in variety and complexity of procedures and

	service reconfiguration • Therapies – increased posts required across specialities to safely meet service demands
St Bartholomew's Hospital (SBH)	• Therapies - Barts Heart Centre: Additional OT outstanding from 2023-24 review

The ED reviews identified uplifts were needed across multiple bands, totalling the following WTEs per hospital:

Hospital	WTE
WXH	17.3
NUH	37.9
RLH	62.8

2. Midwifery and Neonatal Review

For midwifery, the triennial Birthrate Plus audit was reported in January 2025. The outcomes were presented to the HEBs; the need for priority-based workforce plans to resolve the establishment gaps was supported. The report was also discussed and professionally signed off at the Maternity and Neonatal Strategy Group.

The 2025 Birthrate Plus audit revealed a marked shift in case mix, indicating high-complexity pregnancies. Postnatal care demands have also risen significantly due to cross-boundary booking patterns. Triage attendances grew by around 40%. The recommended midwife-to-birth ratios have increased to match the increasing complexity requirements across the service.

The outcome of the assessment shows a requirement for an additional 95.3 WTES.

A phased 2-3 year investment plan proposes additional recruitment of clinical, specialist, and governance roles to close this gap. Critical to this is the provision of safe care and being able to enter the sustainability phase of the Maternity Safety Support Programme (MSSP) and compliance with Maternity Incentive Scheme (MIS) standards.

Future service efficiency may come from:

- Consolidating homebirth services
- Reconfiguring intrapartum services, such as suspending underutilised birth centres
- Centralising elective caesarean services

The recommendations were supported by the Group Executive Board in April 2025.

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

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

Action required by the Trust Board

The Trust Board is asked to:

- Note the outcome of the 2024/25 nursing, midwifery and allied health professionals' establishment review, including the findings of the triennial Birthrate Plus review.
- Note and support groupwide, multidisciplinary actions to alleviate ED demand where the biggest impact is felt.
- Note the progress with improving productivity during 2024/25 and support the NMAHP priority actions identified for 2025/26.
- Approve the continued approach of funding any recommended uplifts from within hospital allocated budgets; where uplifts are not applied, risks to be recorded, mitigated and monitored via hospital governance processes.
- Note the proposal to align midwifery and neonatal workforce establishment with Birthrate Plus recommendations through an investment plan over 2-3 years, with governance and high risk posts prioritised for funding via the MIS rebate.

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 9 JULY 2025

NURSING, MIDWIFERY AND ALLIED HEALTH PROFESSIONALS (NMAHP) ESTABLISHMENT END OF YEAR REVIEW 2024-25

INTRODUCTION

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

2. Additionally, the Maternity Incentive Scheme requires trusts to undertake a triennial midwifery review utilising the accredited Birth Rate Plus tool. For Barts Health, this was reported in January 2025.

3. This paper reports on the outcome of the 2024/25 NMAHP establishment review, including the Birthrate Plus recommendations, and the associated resourcing strategy.

HIGH LEVEL SUMMARY OF OUTCOME

4. The 2024/25 review identified recommendations for establishment changes for nursing and therapies in inpatient settings and EDs and for midwifery staffing across the maternity services.

5. Review of cumulative historic investment and productivity data supported the approach that, in line with the resourcing strategy agreed for the 2022/23 and 2023/24 reviews, no new central funding would be applied for recommendations regarding inpatient nursing and allied health professionals. Establishment changes will need to be facilitated through realigning resources from within baseline budgets.

6. For EDs, there will be a re-channelling of resources released through changes in the delivery model for ED and from across the broader workforce. Business cases to be progressed where relevant.

7. For Maternity, a pragmatic 3-year workforce plan with phasing in of posts on a prioritised basis. This will align with availability of qualifying midwives, service reconfiguration and cross-NEL working. The Maternity Incentive Scheme rebate will be considered for priority midwifery posts.

8. For all areas, where funding is not realigned, residual gaps to be risk assessed, mitigated, and monitored via Hospital Executive Board (HEB) governance structures and issues escalated via Hospital Performance Reviews and the Workforce Board.

BACKGROUND AND PURPOSE

9. Developing Workforce Safeguards (NHSE, 2018) requires trusts to formally review their nursing establishment in order to facilitate the allocation of resources according to need and thus achieve the right staff, with the right skills, in the right place and at the right time.

10. This is to be undertaken utilising the triangulated methodology prescribed by the NQB (2016) and NHSE (2018). Clinical and managerial professional judgement and scrutiny are a crucial element of the process and are used to interpret the results from evidence-based tools and patient outcome data considering the local context, alongside comparisons with peers, in a meaningful way.

HISTORIC INVESTMENT

11. Prior to 2023/24, the trust had uplifted NMAHP staffing via the safer staffing establishment review process from central resources, prioritising this ahead of other funding allocations. This was exclusive of increases via other funding streams such as business planning and external funding initiatives.

12. Significant central resources were allocated over a five-year period to right-size the NMAHP establishments as shown in the summary table below. Allied Health Professionals were included in the integrated NMAHP process from the 2021/22 budget setting. Summary of investment over successive years is shown below.

NMAHP Safe Staffing Investment 2018/19 - 2022/23

Year	WTE	£000
2018/19	22.1	777
2019/20	41.7	1,971
2020/21	39	1,857
2021/22	35.6	1,526
2022/23	64.6	3,129

PROCESS AND GOVERNANCE OF THE 2024/25 END OF YEAR ESTABLISHMENT REVIEW

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

- HEB safe staffing reviews

    - Ward-to-Board review of staffing demand and capacity, utilising acuity-dependency data drawn from the accredited Safer Nursing Care Tools, workforce and roster data, quality metrics and professional judgement.
    - Adult and children's therapies were included in the HEB reviews.
    - Emergency Departments (EDs) were included for the first time. The hospitals undertook detailed analysis. Findings were discussed and endorsed by the Urgent and Emergency Care Delivery Group.
    - The outcomes of the hospital safe staffing reviews were presented to the HEBs and signed off by the Hospital Chief Executive Officers (HCEOs) as Senior Responsible Officers.
- Peer Review was undertaken by the Hospital Directors of Nursing and Professional Leads followed by discussion at the NMAHP Workforce Board and professional sign-off.
- For maternity, the triennial Birthrate Plus audit took place. This uses evidence-based methodology to look at all types of maternity activity in the community and hospital settings to calculate staffing requirements.
- The outcomes of the Birthrate Plus review were presented to the HEBs; the need for priority-based workforce plans to resolve the establishment gaps was supported. The report was also discussed and professionally signed off at the Maternity and Neonatal Strategy Group.
- NEL peer review: the trust's establishment review process was reviewed by the NEL Safer Staffing Group. It was found to be aligned to the approaches of the other acute trusts in the ICS.

NURSING, MIDWIFERY AND AHP WORKFORCE AND PRODUCTIVITY TRENDS

Workforce trends

14. Nursing and midwifery have a stable substantive fill rate of 91% against a target 93% (range: 86% at Whipps Cross - 95% at St Bartholomews).

15. Vacancy hotspot areas have a targeted programme in place. Mitigations are in place regarding Band 5 vacancies at Newham and Whipps Cross, these are offset by specific Band 4 roles.

16. For AHPs, fill rate is significantly below target for Band 5 and 6 Occupational Therapists and, with the exception of St Bartholomew's, Band 7 and 8a radiographers. This is a national phenomenon.

17. Work at Barts Health to improve retention among this staff group includes the OT Retention project and progression of e-job planning.

18. Further detail is illustrated in Appendix 1.

Productivity Trends

19. Productivity has improved consistently during 2024/25, with effective programmes including flexible working and the reduction of specialist and enhanced rates for Bank resulting in near zero breaches.

20. Model Health System (which incorporates Model Hospital) publishes productivity measures for nursing, midwifery and allied health professionals, indicating where there may be opportunity for improved efficiency. This benchmark data suggests overall good productivity for the NMAHP professions at Barts Health.

21. Cost per WAU is the headline productivity metric used within the Model Hospital. It shows the amount spent by an organisation to produce one Weighted Activity Unit (WAU) for the specified staff group.

22. For 2023/24 Barts Health remained in quartile 1 for both Nursing and Midwifery and Allied Health Professionals, with some of the lowest costs per WAU among 'recommended' and 'region' peer groups. It should be noted that despite latest published data being used, this is from 2023/24.

23. Care Hours Per Patient Day (CHPPD) looks specifically at ward-based nursing and midwifery. It is a measure of ward productivity which enables comparison across wards, specialities and organisations.

24. Data published in December 2024 shows Barts Health as being the fourth highest in the country at 11.4. Nine other London trusts were also in the fourth quartile, with UCH, GSST and St Georges showing higher average CHPPD than Barts Health.

25. Organisational level data is a blunt tool, and it is skewed by the high number of critical care and specialist beds at Barts Health. Throughout the year hospitals have reviewed speciality mapping to improve accuracy of benchmarking.

26. The metric should not be viewed in isolation; however, it does indicate average staffing levels are unlikely to be unsafe. Also, there may be opportunity to further increase productivity, which we aim to do through reviewing our model of enhanced care in 2025/26.

27. Costs per WAU and CHPPD data trends are illustrated in Appendix 2.

OUTCOME OF THE 2024/25 ESTABLISHMENT REVIEW

a) NURSING AND ALLIED HEALTH PROFESSIONALS

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

29. Since 2017/18 Ward Managers have remained 100% supervisory at Barts Health demonstrating the value placed on ward managers and enabling them to role model

and deploy exemplary leadership. They will continue to facilitate delivery of productivity and quality improvements within their wards.

30. Establishment pressures, categorised as Safe Staffing priorities requiring reallocation of existing hospital resources and/or risk mitigation, are summarised below.

- **Inpatient Reviews**

31. The inpatient reviews identified the following changes to right-size establishments. These will be achieved through reallocation of existing hospital resources.

Summary of Safer Staffing Priorities Identified in the Inpatient Reviews

Hospital	Safe Staffing Priorities
Whipps Cross Hospital (WXH)	• Nursing: increased staffing in the Margaret Centre, Rowan Ward and Primrose Ward to strengthen night staffing and due to increased acuity and complex care needs • Practice Development: 12-month fixed term contract post to support ED targeted actions
Newham University Hospital (NUH)	• Neuro Service (therapies): Requires an uplift to align the service to national clinical guidelines, improve service delivery and reduce patient length of stay
Royal London Hospital (RLH)	• Nursing: increased staffing on 10E, 10F and 3D due to increase in variety and complexity of procedures and service reconfiguration • Therapies – increased posts required across specialities to safely meet service demands
St Bartholomew's Hospital (SBH)	• Therapies - Barts Heart Centre: Additional OT outstanding from 2023-24 review

- **Emergency Department reviews**

32. The Emergency Departments (ED) are facing continuous demand and pressure beyond capacity. Provision of care to mental health patients represents a significant proportion of departmental workload. Overcrowding requires increased staffing; extended lengths of stay has significantly increased the demand for nursing care beyond the traditional ED models of care.

33. A series of targeted interventions are underway to remodel services. Staffing related actions include:
    - Adjusting staffing levels per shift to match acuity and dependency needs.
    - Optimising skill mix to ensure appropriate leadership, oversight, seniority and experience across shifts.
    - Enhanced practice development to ensure appropriate education, training and development of the workforce for safe, quality care.
    - Provision of additional leadership to strengthen senior leadership capacity to provide strategic oversight and drive improvements.
    - Rectifying historic budget anomalies.
    - Transforming models of care for mental health patients

34. The table below summarises the increase in whole-time equivalents required, across various bands, as identified in the ED reviews.

Summary of Increased Whole Time Equivalent Requirements for the Emergency Departments

Hospital	WTE
WXH	17.3
NUH	37.9
RLH	62.8

35. Continued work is taking place via the operational and clinical management teams to assess the impact of changes in the delivery model and to explore options to re-channel resources from across the broader workforce. Therefore, no new central funding is requested at this point. Business cases will be progressed where indicated.

36. ED staffing is our biggest challenge and greatest risk and is reflected in the Risk Register with mitigations.

PRIORITY ACTIONS FOR 2025/26

37. A series of priority actions were identified in the 2023/24 year-end establishment review. Progress with these is shown in Appendix 3.

38. Themes emerging from the 2024/25 review focus on delivering improved productivity without negatively impacting patients and staff experience:
    - Deliver a targeted programme to improve enhanced care productivity throughout 2025/26.
    - Support wards/units that show scope to improve CHPPD to do so.
    - Pilot comprehensive, digitally enabled job planning for AHPs and CNS'
    - In collaboration with wider MDT, undertake transformative review of service models.

39. The enhanced care programme, agreed by the NMAHP senior leadership team, is designed to support initiatives identified by each of the hospitals and facilitate cross-group sharing of successful interventions at pace.

b) MIDWIFERY

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40. Barts Health continues to implement the recommendations from the NHSE Three Year Single Delivery Plan for Maternity and Neonatal Services and from the Maternity Safety Support Programme (MSSP). These have identified the need for sustainable investment and improvements in governance and staffing establishments.

41. Despite the declining birth rate over the past five years in England, the projected growth in the number of women and people of childbearing age resident in NEL over the next 10 years will result in a net increase in deliveries. Demand for maternity and neonatal services will therefore increase over time.

42. Further, these pregnancies and births are becoming increasingly complex, demonstrated by the rising trend in the proportion of babies born by caesarean section over the last five years. Acuity data from 2024 indicated that for delivery

suites and inpatient areas, the staffing establishments did not always meet the patient acuity demand.

The Birthrate Plus Review Findings

43. The triennial Birthrate Plus review was completed in January 2025. This looks at all types of maternity activity in the community and hospital settings to calculate recommended staffing levels based on activity and acuity.

44. The review validated the need to increase staffing levels, due to an increase in births and overall activity including:
    - A decrease in births suitable for low-risk settings, driving more activity into the acute services. NUH has seen a 10% increase in the most complex cases.
    - Community based postnatal care activity exceeding the number of births conducted by the service. For both NUH and WXH this is as many as 2,000 additional patient care episodes.
    - Triage attendances ('maternity ED') increasing by 40% compared to 2021.
    - A 10% increase in induction of labour, in line with the national picture.
    - Increased number of babies requiring postnatal stays longer than 72hrs, for clinical and social vulnerability reasons, across all three units.
    - Increased workload associated with complexity of mother and/baby; for example, preterm births and associated medical and obstetric comorbidities.
    - Increase activity in specialist services such as Fetal and Maternal Medicine, for example diabetic clinics, perinatal mental health and other services for women with medical and obstetric comorbidities.

Midwife to Birth Ratios

45. Birthrate Plus recommends specific midwife to birth ratios, to provide an overall standard within which hospitals can balance activity and staffing levels. The table below shows the recommended ratios over the last three reviews, the changes clearly highlighting the increasing trends in complexity across all maternity units within Barts Health over the last 6-9 years.

Recommended Birth:Midwife Ratios

Recommended overall ratios based on all births	NUH	RLH	WCH
2025 - Births to 1 WTE Midwife	19.0	20.0	22.0
2022 - Births to 1 WTE Midwife	22.5	21.6	24.0
2018 - Births to 1 WTE Midwife	25	23	26

Establishment Uplifts

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46. The review identified establishment increases were required to meet clinical, management and governance demands.

47. The table below shows shortfalls in the current establishment compared to the Birthrate Plus recommendations. It includes clinical roles i.e. postnatal ward Health Care Support Workers, Registered Nurses and Registered Midwives from Bands 5-8

and also Specialist Midwives. This is inclusive of a 24% uplift as recommended by the MSSP and Ockenden reviews to support the increase in training requirement.

Establishment Shortfalls

Total Clinical, Specialist and Management WTE	NUH	RLH	WCH
Birth Rate Plus recommended WTE	311.98	296.82	213.95
Current funded WTE	269.95	255.38	202.30
Variance Clinical roles	-30.70 WTE	-31.04 WTE	-10.31 WTE
Variance Specialist/Management roles	-11.33 WTE	-10.40 WTE	-1.52 WTE
Total Variance	**-42.03 WTE**	**-41.44 WTE**	**-11.83 WTE**
GRAND TOTAL	**-95.3 WTE**		

Maximising efficiency opportunities

48. Opportunities to improve efficiency and thus release resources for priority work include:
    - Implementing a cross-trust approach to homebirth provision and Telephone Triage/Maternity Helpline services.
    - Exploration of opportunities to redirect staffing resources to departments with the greatest need whilst maintaining choice for service users.
    - Partnership working with partners across the North East London Integrated Care Board to review demand and capacity, funding models and resource allocation.

Maternity and Neonatal Workforce Strategy

49. A workforce strategy is in development, which will include:
    - Tracking the number of midwives qualifying across Barts Health over the coming year and into 2026/27. This will identify an internal pipeline for recruitment of clinical midwives.
    - Skill mix reviews that consider the 90:10 split between midwives and nurses/maternity support workers (who can provide postnatal care under the supervision of a midwife).
    - A prioritisation review of the additional specialist midwifery roles that are required as part of the national recommendations following the Ockenden and East Kent maternity reviews.

50. The proposal is for hospitals to have establishment increases in line with the numbers of students qualifying over the next 2-3 years until they reach their Birthrate Plus recommended increased establishment. Specialist roles would be established as the clinical establishment increases.

Funding Strategy

51. A pragmatic approach to investment will be implemented, phased over 2-3 years and taking into account the student midwife pipelines. The governance posts will be prioritised as they are deemed essential by the MSSP and to meet the requirements of the MIS/CNST. It is proposed to fund these from the MIS Year 6 rebate. The remainder of the MIS funds will be used to fill risk assessed gaps, for example the triage service.

52. Risks associated with staffing gaps will continue to be managed through regular monitoring and escalation of the daily acuity and activity and partnership working across the North East London maternity and neonatal system, which is reviewing demand and capacity within maternity and neonatal services.

53. Efficiency opportunities will be exploited.

54. Presently, block contracts for maternity services are calculated on numbers of births, which are being explored through the ICB, as this funding does not cover the care provided to postnatal pathways for women who do not birth at Barts. This is being explored with the ICB contracting teams.

RECOMMENDATIONS

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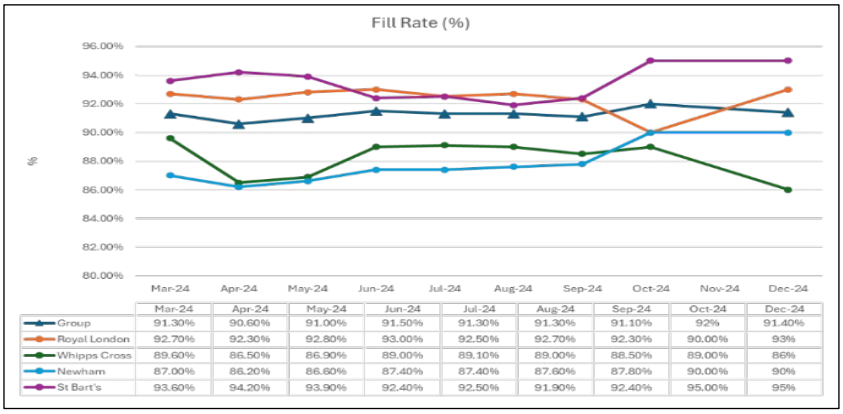
55. The Trust Board is asked to:

- Note the outcome of the 2024/25 nursing, midwifery and allied health professionals' establishment review, including the findings of the triennial Birthrate Plus review.
- Note and support groupwide, multidisciplinary actions to alleviate ED demand where the biggest impact is felt.
- Note the progress with improving productivity during 2024/25 and support the NMAHP priority actions identified for 2025/26.
- Approve the continued approach of funding any recommended uplifts from within hospital allocated budgets; where uplifts are not applied, risks to be recorded, mitigated and monitored via hospital governance processes.

- Note the proposal to align midwifery and neonatal workforce establishment with Birthrate Plus recommendations through an investment plan over 2-3 years, with governance and high risk posts prioritised for funding via the MIS rebate.

APPENDIX 1 NURSING, MIDWIFERY AND AHP WORKFORCE TRENDS 2025/25

Nursing and Midwifery Substantive Fill Rates March - December 2024



	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Dec-24
Group	91.30%	90.60%	91.00%	91.50%	91.30%	91.30%	91.10%	92%	91.40%
Royal London	92.70%	92.30%	92.80%	93.00%	92.50%	92.70%	92.30%	90.00%	93%
Whipps Cross	89.60%	86.50%	86.90%	89.00%	89.10%	89.00%	88.50%	89.00%	86%
Newham	87.00%	86.20%	86.60%	87.40%	87.40%	87.60%	87.80%	90.00%	90%
St Bart's	93.60%	94.20%	93.90%	92.40%	92.50%	91.90%	92.40%	95.00%	95%

AHP vacancies and substantive fill rates by band and hospital December 2024

Vacant WTE	NUH	SBH	RLH	WXH	Other
CHIROPODIST - BAND 7	0.00	0.00	-2.00	0.00	0.00
DIETITIANS - BAND 5	0.00	0.00	-0.92	0.03	0.00
DIETITIANS - BAND 6	-0.84	0.00	-0.44	1.00	0.00
DIETITIANS - BAND 7	-0.05	0.09	-4.85	-0.82	0.00
DIETITIANS - BAND 8A	0.00	-1.20	0.00	0.00	0.00
OCC THERAPIST - BAND 5	2.00	-1.00	-0.80	1.20	0.00
OCC THERAPIST - BAND 6	3.00	2.00	7.30	5.30	0.00
OCC THERAPIST - BAND 7	2.80	2.10	4.02	0.50	0.00
OCC THERAPIST - BAND 8A	0.00	-1.00	0.87	0.20	0.00
OCC THERAPIST - BAND 8B	0.00	0.00	-1.00	0.00	1.00
OCC THERAPIST - BAND 8C	0.00	0.00	0.85	0.00	1.00
ORTHOPTIST - BAND 6	0.60	0.00	0.60	0.00	0.00
ORTHOPTIST - BAND 7	0.00	0.00	0.20	-3.60	0.00
ORTHOPTIST - BAND 8A	0.00	0.00	-0.80	0.00	0.00
ORTHOPTIST - BAND 8B	0.00	0.00	0.00	0.00	0.00
PAMS - OTHER: HIV/AIDS	0.00	0.00	0.00	0.00	0.00
PAMS BAND 5	0.00	0.00	-0.80	-0.80	0.80
PAMS BAND 6	0.00	0.00	0.58	0.00	0.00
PAMS BAND 7	0.00	0.00	-0.12	-1.45	0.00
PAMS BAND 8A	0.00	0.00	0.40	0.00	0.00
PAMS BAND 8B	0.00	0.00	0.00	0.00	0.00
PHYSIOTHERAPIST - BAND 5	0.00	-0.68	2.33	1.37	0.00
PHYSIOTHERAPIST - BAND 6	-2.00	0.30	6.95	-0.93	0.16
PHYSIOTHERAPIST - BAND 7	0.24	-0.46	-1.21	0.19	1.83
PHYSIOTHERAPIST - BAND 8A	0.16	1.21	-1.39	0.05	0.00
PHYSIOTHERAPIST - BAND 8B	0.00	0.00	-1.00	0.00	0.00
PHYSIOTHERAPIST - BAND 8C	0.00	0.00	-0.05	0.00	0.00
RADIOGRAPHER - BAND 5	-3.46	-5.00	8.47	-0.10	0.00
RADIOGRAPHER - BAND 6	-1.99	-2.07	5.92	1.99	0.00
RADIOGRAPHER - BAND 7	12.42	-7.97	19.09	3.13	-1.00
RADIOGRAPHER - BAND 8A	3.44	-1.82	2.60	-3.96	0.40
RADIOGRAPHER - BAND 8B	0.00	-1.05	0.00	0.00	0.00
RADIOGRAPHER - BAND 8C	0.00	0.00	0.00	0.00	0.00
SPEECH THERAPIST - BAND 5	0.00	0.00	1.80	0.00	0.00
SPEECH THERAPIST - BAND 6	0.00	2.00	4.72	1.00	0.00
SPEECH THERAPIST - BAND 7	-1.50	0.00	-0.59	0.50	-0.57
SPEECH THERAPIST - BAND 8A	0.00	1.00	1.75	0.00	-0.40
Grand Total	14.82	-13.55	52.48	4.80	3.22

Source: M09 Finance Data

Fill Rate	NUH	SBH	RLH	WXH	Other
CHIROPODIST - BAND 7					
DIETITIANS - BAND 5	100.0%	100.0%	122.5%	98.5%	
DIETITIANS - BAND 6	120.2%	100.0%	102.9%	66.7%	
DIETITIANS - BAND 7	100.9%	98.8%	115.5%	120.2%	
DIETITIANS - BAND 8A	100.0%	175.0%	100.0%	100.0%	
OCC THERAPIST - BAND 5	60.0%	150.0%	108.0%	85.0%	
OCC THERAPIST - BAND 6	40.0%	33.3%	74.2%	48.5%	
OCC THERAPIST - BAND 7	58.8%	47.5%	84.0%	94.7%	100.0%
OCC THERAPIST - BAND 8A		200.0%	85.3%	90.9%	
OCC THERAPIST - BAND 8B					
OCC THERAPIST - BAND 8C			37.0%		
ORTHOPTIST - BAND 6	0.0%		72.7%	100.0%	
ORTHOPTIST - BAND 7	100.0%		90.9%	357.1%	
ORTHOPTIST - BAND 8A			140.0%	100.0%	
ORTHOPTIST - BAND 8B			100.0%	100.0%	
PAMS - OTHER: HIV/AIDS					
PAMS BAND 5			130.8%		
PAMS BAND 6	100.0%		94.9%		
PAMS BAND 7	100.0%	100.0%	102.4%	704.2%	
PAMS BAND 8A			71.4%		
PAMS BAND 8B	100.0%		100.0%		
PHYSIOTHERAPIST - BAND 5	100.0%	107.3%	90.0%	92.5%	
PHYSIOTHERAPIST - BAND 6	113.3%	97.7%	85.3%	105.2%	95.2%
PHYSIOTHERAPIST - BAND 7	97.6%	102.2%	102.6%	99.0%	35.3%
PHYSIOTHERAPIST - BAND 8A	97.8%	79.9%	106.6%	99.4%	
PHYSIOTHERAPIST - BAND 8B			133.3%		
PHYSIOTHERAPIST - BAND 8C			114.3%		
RADIOGRAPHER - BAND 5	130.0%	127.8%	75.0%	100.4%	
RADIOGRAPHER - BAND 6	107.9%	104.4%	91.3%	94.7%	
RADIOGRAPHER - BAND 7	46.9%	112.6%	71.0%	89.6%	
RADIOGRAPHER - BAND 8A	73.5%	111.2%	84.7%	166.0%	
RADIOGRAPHER - BAND 8B	100.0%	135.6%	100.0%	100.0%	
RADIOGRAPHER - BAND 8C		100.0%			
SPEECH THERAPIST - BAND 5	100.0%		87.9%	100.0%	
SPEECH THERAPIST - BAND 6	100.0%	0.0%	84.3%	66.7%	
SPEECH THERAPIST - BAND 7	400.0%	100.0%	101.9%	88.1%	168.7%
SPEECH THERAPIST - BAND 8A	100.0%	50.0%	86.4%	100.0%	
Grand Total	90%	106%	91%	98%	82%

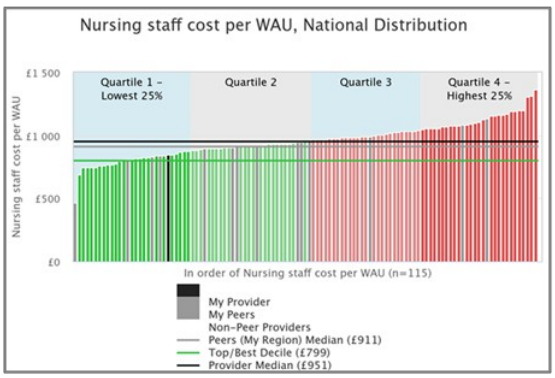
Source: M09 Finance Data

APPENDIX 2 NURSING, MIDWIFERY AND AHP PRODUCTIVITY BENCHMARKS 2024/25

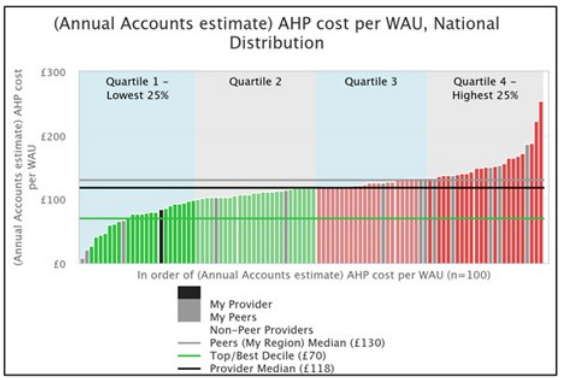
1. Cost per WAU

This shows how Barts Health costs per Weighted Activity Unit benchmark against other organisations. Higher-than-average cost per WAU suggests the organisation spends more on this staff group per unit of activity compared to other organisations, a lower cost per WAU suggests a lower spend. Data is updated annually; the charts below are the most recent available and cover the year 2023/24.

Nursing (including midwifery) and AHP Costs per WAU



Nursing staff cost per WAU 2023/24. Peer group- Region



AHP staff cost per WAU 2023/24: Peer group - region

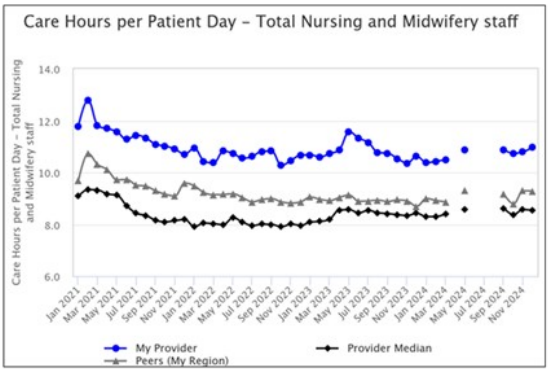
- Provider value (Barts Health) £850
- Peer median (region) £911
- Peer median (recommended peers) £887
- Provider median(national) £951

- Provider value (Barts Health) £84
- Peer median (region) £130
- Peer median (recommended peers) £137
- Provider median(national) £119

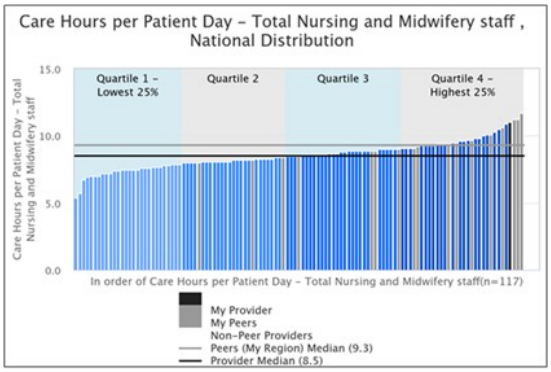
2. Care Hours Per Patient Day (CHPPD)

CHPPD is calculated by adding the hours of registered and unregistered staff together then dividing by the number of inpatients at 23.59 hours.

Nursing and Midwifery CHPPD Trends



CHPPD trends June 2021 – November 2024



CHPPD Nov 2024: region

APPENDIX 3 UPDATE ON PRIORITY ACTIONS PROGRESSED 2024/25

Theme	Action	Update March 2025
Systems and Processes	Monitoring additional duties related to care of bariatric patients	Added to booking reasons: establishing baseline
	Progress roster efficiencies including net hours	Net hours balances significantly improved
	Scrutiny of additional duties	Embedded in all hospitals. Engaged safely with 95% SIP restrictions and rate breech programmes
	Escort model for intrahospital transfers	Scoping led by SBH. Risk assessments completed. *Forward funding model to be agreed*
	Continue to develop AHP safer staffing & productivity guidelines	AHP Pro contributing to national programme. Job planning established
NMAHP Workforce	Further embed RNA role	Plans across hospitals, SBH exemplar. Summit April2025.
	Continue to roll out Flexible working: improving rostering programme	Roil out as per schedule; waiting list to join; funding bid to enable sustainable project management submitted
	Review HSCW programme in line with NHS staff Council profiles	Partnership with People Service, nursing and finance. Implements April 2025
	NUH pilot Recruitment, Retention and Wellbeing Lead Nurse role	Post trialled for 9 months, continuation plan to be agreed post evaluation
	New roles and mapping: Hospital of the future and ACPs	ACPs confirmed and mapped
Enhanced Care	NUH and RLH models for patients with mental health needs	NUH pilot progressing, emerging evidence of decreased RMN usage. Project evaluation due April 2025.
	Integration of enhanced care authorisation processes and millennium	Authorisation processes under review, nuance for local need. Await audit findings
Leadership & supervision	Collaboration between Senior Nurses for Workforce	Joint working established e.g. new SNCT data collection
	Work with Centre for Teams to explore innovation, effectiveness and efficiency	NMAHP programme
	Targeted development in workforce planning through Band 7 development programme	Teaching sessions delivered, embedding in programmes.

Report to the Trust Board: 9 July 2025	TB 61/25

Title	Safeguarding Annual Report 2024/25
Accountable Director	Chief Nurse
Author(s)	Clare Hughes, Associate Director for Safeguarding
Purpose	To update the Trust Board on progress against the delivery of the safeguarding adults and children's activity in the Trust in line with national guidance and approve he recommendations.
Previously considered by	Quality Assurance Committee

Executive summary

Barts Health NHS Trust has a statutory responsibility to safeguard and promote the welfare of children and adults. The purpose of this combined Safeguarding Children and Adults Annual Report is to provide assurance to the Board against statutory elements of the Safeguarding Adults and Children's agenda and update on the progress of objectives in 2024/25.

Notable achievements over the past year include:

- Level 3 safeguarding adults training needs analysis (TNA) has been agreed and reflected on WIRED
- Response to the TNA for level 3 adults training has been very positive and we are ahead of the planned trajectory. When change applied to WIRED compliance dropped to 10% by year end it was 44%
- Improvement made to safeguarding data collection, BIU have worked with Associate Director of Safeguarding to improve the data reporting.
- Development of Trust wide audit schedule and a number of audits have been completed this reporting period.
- Delivery of Trust Board Safeguarding Training which was well received.
- Continue to work closely with borough Local Authority Designated Officers (LADOs) and Person in Position of Trust (PiPoTs) teams to ensure allegations are managed in timely manner.
- Embedding fact-finding meetings at hospital level where there are allegations against staff
- Level 4 safeguarding children conference being planned for 10th October 2025.
- Successful recruitment into the safeguarding teams ended the year with only 1 vacancy for administration position.
- The safeguarding adults alert form on millennium is now being rolled out across the Trust.

Key Issues and risks identified within the report include:

- Training compliance continues to be a challenge for both adults and children level 3.
- Safeguarding children supervision compliance has improved however remains below the 85% target.

Safeguarding referrals:

- We have seen a reduction of referrals for both maternity and children since the previous

reporting period. This is potentially inaccurate as a number of boroughs now require referrals to be made via a portal and these may not always be sent to the safeguarding teams.

- Adult referrals have seen a year-on-year increase, however the increase this year was 28% compared to 51% last year.
- Top themes for maternity referrals are domestic abuse, other, poor engagement (including late or no booking) and previous involvement with children social care (CSC)
- Top themes for children referrals are: parental concerns, child mental health, exploitation, and domestic abuse
- Top themes for safeguarding adults are neglect/acts of omission, self-neglect, domestic abuse and physical abuse.
- Domestic abuse referrals for adults have increased by 28% this year which is the theme that has seen the largest increase.

Related Trust objectives: To improve health and care services for all our population - transforming clinical services whilst reducing health inequalities and inequities of provision

Risk and Assurance	The report sets out the current key risks to the Safeguarding agenda and how they are being mitigated.

Legal implications/ regulatory requirements	Safeguarding Children is governed by a range of legal and regulatory requirements including: "Working Together to Safeguard Children (2018)" which sets out how organisations and individuals should work together to safeguarding and promote the welfare of children and young people in accordance with the Children Acts 1989 and 2004: the Care Quality Commission's Essential Standard of Quality and Safety Outcome 7 (Regulation 11) on safeguarding people who use services from abuse

Action required

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 9 JULY 2025

SAFEGUARDING CHILDREN AND ADULTS ANNUAL REPORT 2024/24-5

1. INTRODUCTION

This combined Children and Adults Safeguarding Annual Report informs the Trust Board and Partnership Boards on progress made in delivering the Safeguarding agenda during the period April 2024 - March 2025.

Directors of Nursing for Newham University Hospital (NUH), Whipps Cross Hospital (WXH), St Bartholomew's (SBH) and The Royal London Hospital (RLH) are responsible for reporting to their Hospital Executive Boards. This overarching report reflects trust wide activity.

The objectives of this report are to provide:

- Assurance that the Trust continues to fulfil its statutory responsibilities in relation to Safeguarding Children as stated in Section 11 of the Children's Act 1989/2004 and the Care Act 2014
- Assurance that the Trust is compliant with Care Quality Commission (CQC) Fundamental Standards (Safe, Effective)
- An update to internal and external stakeholders on the developments in relation to safeguarding
- Identify areas of risk in relation to its statutory responsibilities during the reporting period.

2. OVERVIEW

Barts Health provides secondary care to the local communities within North East London (NEL) and specialist tertiary care to patients beyond NEL. The Trust has a responsibility to provide effective and seamless services directly to all patients and indirectly by providing services to family members.

Staff have a responsibility to safeguard and promote the welfare of all patients and work in line with Trust Safeguarding Policies. All patients are best safeguarded when professionals are clear about what is required of them individually and in how they need to work together. The Trust's safeguarding team promotes an All Age Safeguarding approach.

National Statutory Guidance underpinning organisational responsibilities:

- Children's Act 1989 provides the legal framework for the protection of children from harm.
- Children Act 2004, Section 11 imposes a specific duty on NHS organisations to make arrangements to safeguard and promote the welfare of children
- Mental Capacity Act 2005
- Care Act 2014

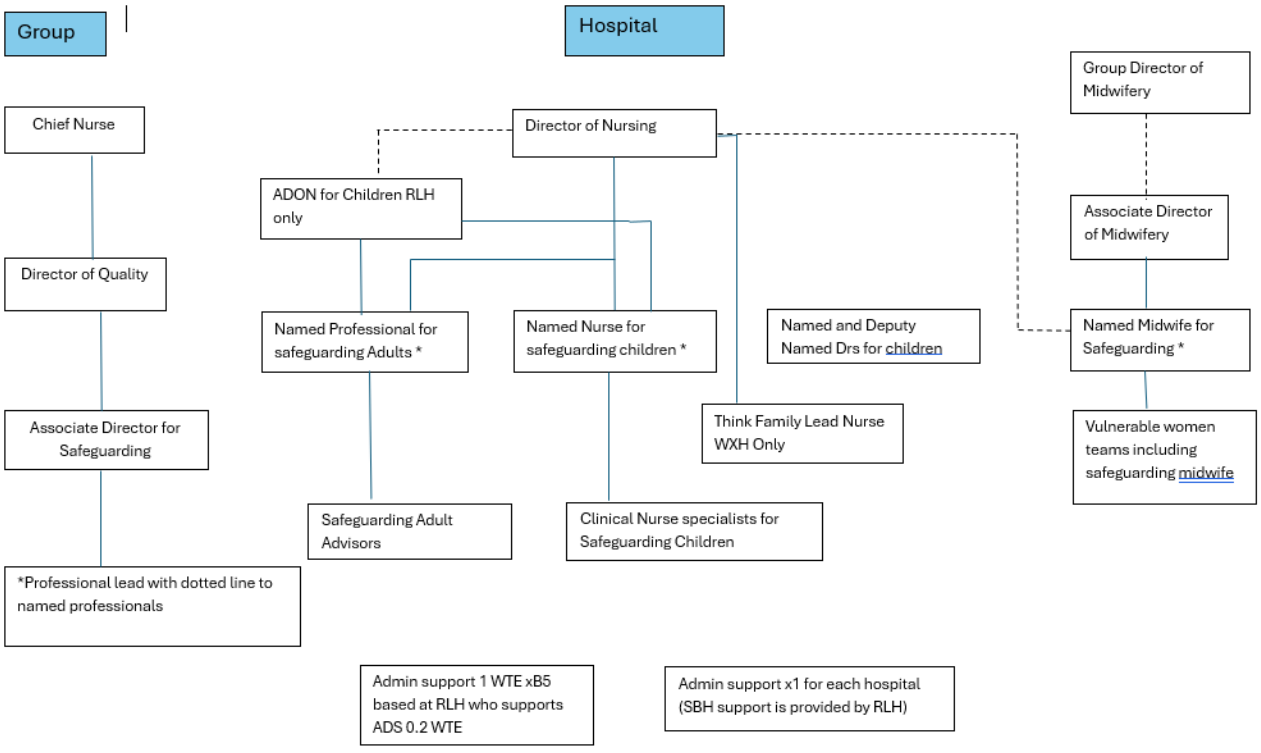
- Domestic Abuse Act 2021
- Children and Social Work Act 2107; Section 16 adds a new section to Children Act 2004,
- Working Together to Safeguard Children: A Guide to Interagency Working to Safeguard and Promote the Welfare of Children 2023
- Safeguarding Vulnerable People in the Reformed NHS. Accountability and Assurance Framework (2022)
- Pan-London Policies and Procedures for Adult Safeguarding
- London Child Protection Procedures
- Intercollegiate Documents: Adults 2018 and Children 2019

As well as complying with National Guidance, Barts Health complies with regulations as identified by the Care Quality Commission (CQC) to ensure babies, children and vulnerable adults are effectively safeguarded.

3. SAFEGUARDING TEAM STRUCTURE

The Chief Nurse is the Trust's Executive Lead for Safeguarding with day-to-day leadership devolved to the Director of Quality, the Associate Director of Safeguarding (ADS) at Group is responsible for leading on strategic plan and holds the professional leadership role in the delivery of the Safeguarding Agenda working closely with the hospital executive leads and safeguarding teams. The Directors of Nursing (DoNs) hold executive responsibility for safeguarding at a hospital level. Safeguarding team members are based in each of our hospitals and manged at a hospital level except St Bartholomew's (SBH) whose safeguarding advisor for adults and children is managed via the RLH team.

The Safeguarding Structure across the Trust:



The team supports staff to deliver effective interventions to identify and respond to safeguarding concerns. This is achieved through training, supervision, and supportive advice to enable all staff to achieve competencies appropriate to their role and relevant national/local guidance.
As with the previous reporting period, the capacity within the safeguarding team throughout the course of 2024/25 has been impacted by vacancies and increasing activity. At the time of completing this report there is only one vacancy across the Trust which is in the process of being actively appointment to. One of the hospitals has had period of not having a Named Nurse for Safeguarding Children in post which has been mitigated by support from the ADS and the other Named Nurses across the Trust.

After approval of permanent funding for the Named Nurse for Child Death this post was recruited to in April 2024 and the post has been embedded into the Chief Nurse directorate under the management of the ADS.

The Deputy Chief Medical Officer represents the medical leadership at the Trust Integrated Safeguarding Committee. There is strong engagement from the hospital Medical Directors for safeguarding matters. Each hospital where there are children's services has a Named and a Deputy Named Doctor for safeguarding children as per statutory requirements. There are not medical leads for safeguarding adults this is not a statutory requirement in the same way as it is for children.

4. SAFEGUARDING GOVERNANCE

Our governance structure supports a strategic and operational response to safeguarding. The Integrated Safeguarding Assurance Committee (ISAC) chaired by the Chief Nurse, receives assurance via hospital safeguarding meetings, chaired by the DoNs, and the Trust-wide Named Professionals Strategic meeting chaired by the Associate Director for Safeguarding. ISAC monitors compliance against strategic priorities and promotes engagement with our local partners. The hospital meetings monitor site assurance including action plans from serious incidents, child practise reviews (CSPR), serious adult reviews (SARs) and deaths related domestic abuse reviews (DRDARs).

ISAC reports to the Quality Board and Group Executive Board. The Quality Assurance Committee undertakes assurance on behalf of the Trust Board.

During the current reporting period we have worked with Business Intelligence Unit (BIU) to support the enhancement of the safeguarding data which is reported at hospital and Trust level meetings. This has seen an improvement in the reporting of data for safeguarding activity including equity data. There are further plans to develop reporting further, including analysis of equity data. the ADS will work with inclusion teams to support this piece of work.

5. SAFEGUARDING TRAINING

Safeguarding Training Compliance		
	Children	Adults
Level 1	**91%↑**	**90% ↑**
Level 2	**86% ↑**	**90% ↑**
Level 3	**78% ↑**	**44% ↓**

Target compliance levels for the Trust are set at 85% and it is noted that the compliance for all levels of training apart from Level 3 for adults has seen an increase since the last reporting period. Level 3 compliance continues to be a challenge for children. Each hospital monitors training compliance and have actions in place to increase the compliance to the required target of 85%.

The training needs analysis (TNA) for adults' level 3 was approved and applied to WIRED in September 2024. This saw a significant decrease in training compliance which we were expecting and as such produced an action plan and trajectory to how compliance would be reached. At the time of making changes to WIRED the compliance dropped to 10%. At the time of completing this report the compliance has increased to 44%. Actions taken to increase the compliance have included:

- Trust wide approach to delivery of training
- Increased the number of training sessions a month.
- Changed the rooms to accommodate 50-60 staff at each session.
- Ad hoc training has been delivered where capacity within the safeguarding team has allowed.
- Staff able to attend training at any hospital across the Trust.
- Face to face training session reduced to half a day.

The trajectory has a target of reaching Trust wide compliance within 24 months. However, we are currently four months ahead of the trajectory and should the increase continue at the current rate we hope to meet 85% compliance within in just over 18 months.

There has been a directive from NHSE that all Trusts are to use the eLearning for health (ELfH) modules for Level 1 and 2 for both Adults and Children. This was put on hold whilst the training packages were reviewed and updated to ensure they meet the competencies within the intercollegiate documents. The adult training has now been updated and Named Professionals in the Trust have reviewed the revised ELfH and we are happy with the contents. This will be moved to WIRED and used as the L1 and 2 for adults with guidance add for staff to access WIRED for local information about the safeguarding team and how to access support and advise. The ELfH updates are still in progress for children's L1 and 2 and once ready we will follow the same process as with adults and review the package before adding to WIRED.

Training compliance is monitored via the hospital safeguarding meetings and has also been part of the agenda on the hospital performance reviews (PR)reviews throughout this reporting period.

The Trust Board received safeguarding training within this reporting period which was case based to emphasis the complexities of the safeguarding situations that staff across the organisation must manage. The session was well received.

6. SAFEGUARDING POLICIES

Safeguarding policies that have been reviewed and ratified at Trust Policy Committee this year:

- Chaperone
- Missing and/or Absconding Patients
- Therapeutic Restraint
- Safeguarding Children Supervision

The following policies have been reviewed and shared at numerous committees and are expected to be ratified by end of Q1 25-26:

- Management of Allegations of Abuse or Neglect Against Professionals
- Safeguarding Children

The following policies are being reviewed currently and expected to be ratified by Q2 25-26:

- Responding to Domestic Abuse
- Safeguarding Training - this will become a combined adult and children policy now we have agreed the adult TNA.

There are actions within the recently complete internal audit in relation to mental capacity (MCA) and deprivation of Liberty (DoLs) to strengthen both the safeguarding adults and missing person policy. These changes will be reflected in the current in date policies and taken to the Trust policy committee for approval.

7. SAFEGUARDING SUPERVISION

Supervision for safeguarding children is part of statutory and mandatory requirements and is an essential aspect of ensuring that staff are confident and supported in their work with vulnerable children and families (Working Together 2023). Staff who are mapped to need level 3 children's training (with some exceptions) are required to have yearly supervision.

Current compliance is at 72% which has shown an increase of 6% since the previous reporting period and remains significantly below the target of 85%. Potential risks of staff not having effective supervision are identified as:

- Staff not being adequately supported with emotionally challenging situations.
- Personal feelings and beliefs having impact on decision making process.
- Potential for missed opportunities to identify and respond to safeguarding situations.

Supervision can be achieved in several formats: attendance at Mortality and Morbidity meetings; formal group sessions; informal/ad hoc supervision when seeking advice in relation to a caseload. The safeguarding team provide regular group supervision sessions across the hospitals although there have been some challenges to release staff to attend the sessions due to capacity in their clinical areas.

The hospital safeguarding teams are focusing on high-risk areas providing regular adhoc supervision sessions via team meetings. Extra staff are being identified to train to become supervisors, this will allow supervision to be delivered outside of normal working areas and to reach those staff groups who predominately work outside of core hours.

Further mitigations in place to counteract the risks are:

- Out of hours support from the on-call Named Nurse for Safeguarding
- MDT meetings held in high-risk areas on a weekly basis.

We have secured funding for supervision children training which will increase the number of trained supervisors and in turn increase the capacity and availability of supervision. This is expected to have a positive impact on the compliance with supervision and the quality of supervision.

The named nurses and midwives continue to receive external supervision from an independent specialist. This was reviewed after the initial 12 months, and all staff found the supervision to be beneficial and asked for it to be continued. This supervision will continue to be reviewed on a 12 monthly basis to ensure it remains fit for purpose. The named nurses and midwives have direct access to the place based designated nurses for safeguarding children across NEL.

Within adult safeguarding there is not a statutory requirement for staff to attend formal supervision however as with children's, the safeguarding professionals provide ad hoc/informal supervision with staff members by discussing/supporting staff with safeguarding cases. The named professionals for safeguarding adults currently receive supervision from the designated professionals within the ICB.

All named professionals also have access to the Associate Director for Safeguarding for both informal and formal supervision.

8. SERIOUS CASE REVIEWS AND SERIOUS INCIDENTS

During the reporting period Barts Health has contributed to several Rapid Reviews (RR), Child Safeguarding Practice Reviews (CSPR), Safeguarding Adult Reviews (SARs) and Deaths Related to Domestic Abuse Reviews (DRDARs).The terminology for DRDARs has recently changed from Domestic Homicide Reviews (DHRs) this now takes into consideration deaths such as suicide where domestic abuse was considered a factor in a person taking their own life. Named professionals across the safeguarding team have actively participated in the reviews and where required clinical teams have been involved in the practitioner events to explore the learning. Several of the reviews have been concluded during the reporting period and 7-minute briefings have been shared across the Trust; these will also be available on WeShare as a resource for learning for staff. Below shows the total number of reviews that Barts Health have contributed to in the reporting period. Several of the DHR reviews highlighted below were included in the data for 2022-23 report. This is due to the length of time they have taken to complete which was not unexpected due to the complex nature of the reviews.

Number of reviews Barts Health have participated in this reporting period.

Number of cases by category	
Child Safeguarding Practise Reviews (CSPR)	7
Safeguarding Adult Reviews (SAR)	8
Domestic Abuse Related Death Review (DARDR) previously DHRs	10

Themes arising from reviews are set out below:

- Early identification of concerns and escalation
- Professional curiosity
- Neglect as presenting factor
- Self-neglect and mental health concerns
- Importance of robust Mental Capacity Assessments (MCA)
- Was not brought processes for vulnerable adults
- Complex discharge processes
- Cultural competence
- Use and importance of HEADSS assessment tool
- Perplexing presentations
- Information sharing and collaborative working
- Homelessness and safeguarding processes within acute settings
- Adultification

Where there has been immediate learning for the Trust, this has been addressed and actions have been put in place:

- Safeguarding training has been updated to reflect the findings from reviews.
- Dissemination of 7-minute briefings.
- Targeted work with specific teams has taken place on assessing and managing risk Improvement in documentation regarding safeguarding issues and liaison with agencies.

9. PSIRF

Hospital safeguarding team members participate in the weekly patient safety meetings across the Trust. This ensures there is a safeguarding voice within the meetings to capture potential safeguarding issues. The below tables show the outcome for incidents that have a confirmed learning response.

Outcome of learning response - Children	November 2023-March 2024	April 2024- March 2025
Managed via Datix	16	33
PSII	0	0
After Action Review	0	1
Improvement pathway	0	0
MDT review	0	1
Total	16	35

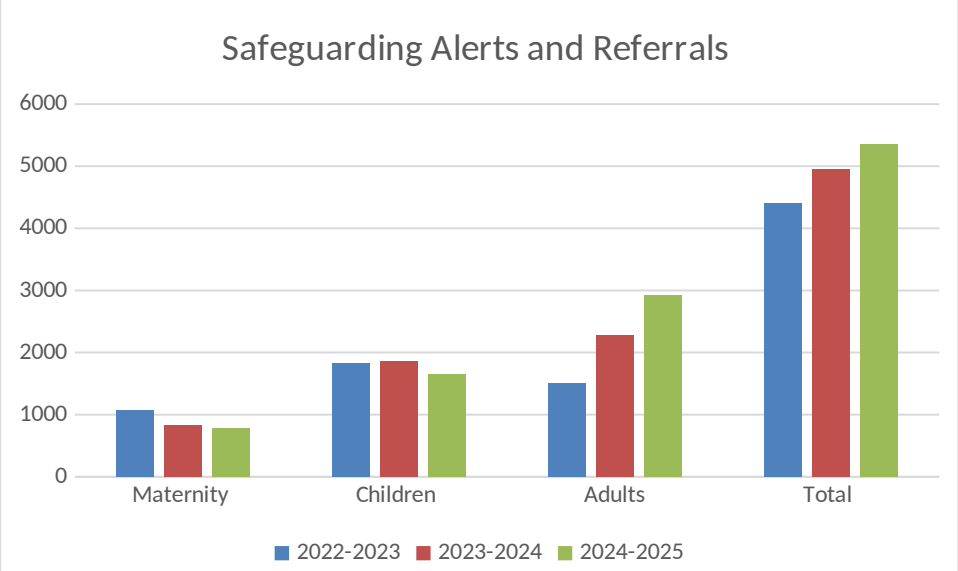
Outcome of learning response - Adults	November 2023-March 2024	April 2024-March 2025
Managed via Datix	56	131
PSII	1	0
After Action Review	1	1
Improvement pathway	7	2
MDT review	1	1
Total	70	135

Those cases requiring improvement pathways, after action reviews are in relation to:

- Unexpected child death
- Patient absconded
- Allegation against a staff member

10. SAFEGUARDING ACTIVITY

The Trust serves several local authorities (LA) with clear processes in place for making referrals to the core LA within the relevant geographical area for the referring hospital. The hospital based safeguarding teams collect data regarding the number of referrals and alerts made by BH staff where there are safeguarding concerns. The table below show the number of referrals that have been raised against and by the Trust, with comparable data included for the previous year.



Both maternity and children have seen a decrease in the number of referrals reported this year with 6% and 11% respectively, this reduction could be as a result of a number of boroughs now using online portals for their referral process and the safeguarding teams may not have been notified of referrals. There continues to be a year-on-year increase in the number of safeguarding adult alerts raised, however the increase for this reporting period is 28% compared to the previous year of 51%. What we are unable to report on is the number of alerts sent to adult social care that are deemed to reach threshold for section 42 enquires and those redirected to non-statutory support, this relies on accurate responses from the local authorities.

There has been a year-on-year reduction in the number of referrals made to children's social care from maternity services. However there has been a 110% increase in the number of referrals made due to poor engagement of women and these covers; late booking and did not attend (DNA) episodes of care. We have also completed an audit to look for any trends and themes in reasons for poor engagement the findings are highlighted within the audit section of this report. We have seen a 43% increase in the number of 'other' reasons for referrals, this will need to be explored further to ensure we are recording themes adequately to understand trends and themes of referrals.

For children there appears to be a downward trend in the reason for referrals being made to children social care with exploitation, child mental health and domestic abuse all seeing a reduction. However, the number of referrals made because of a parent being a patient for issues such as drug and alcohol misuse, parental mental health concerns or domestic abuse has seen a 31% increase compared to the previous year.

Adult alerts have seen the largest increase as mentioned above and the top 4 themes have remained the same. All themes of referrals have seen an increase in the last year as can be seen below.

For maternity the top 4 reasons for referrals to children social care and the percentage change from previous year are:

- Domestic Abuse 37% of referrals - increase of 4%
- Other 23% of referrals - increase of 43%
- Poor engagement, late bookers, or no booking 22% of referrals - increase of 110%
- Previous children social care involvement 14% - decrease of 15%

The top 4 reasons for referrals to children social care and the percentage change from previous year are:

- Parental Concerns 32% of referrals - increase of 31%%
- Child mental health 22% of referrals - decrease of 26%
- Exploitation (that includes assault) 13% of referrals - decrease of 24%%
- Domestic Abuse 6% of all referrals - decrease of 6%

The top 4 reasons for safeguarding adult alerts and the percentage change from previous year are:

- Neglect/acts of omission 31% - increase of 26%.
- Self-neglect 22% - increase of 17%
- Domestic abuse 14% of all referrals which has been a 28% increase since last year
- Physical abuse 8%

There has been a total of 143 safeguarding adult concerns raised against Barts Health by external agencies which is an increase of 19%. The main reason for the external alerts continues to be due to neglect/acts of omission and this includes hospital acquired pressure ulcers. Themes and outcomes are monitored via hospital safeguarding meetings and raised by exception to ISAC when required.

11. SAFEGUARDING AUDITS

There was a Trust wide safeguarding audit schedule for 2024-25. Most of the audits have been completed with 3 in progress at the time of completing this report.

Audits completed:

- Maternity
    - Quality of Referrals
    - Late and non-booked women - were there identified safeguarding concerns?
    - Themes and ethnicity- are there links between ethnicity and reasons for referrals?
- Children
    - Delays in discharge where there are safeguarding concerns
    - Supervision - in progress
    - Quality of referrals- in progress

- Adults
    - Making Safeguarding Personal
    - Self-Neglect
    - Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs)
- All Age Safeguarding
    - Domestic Abuse - in progress

Findings from audits:

- Safeguarding children's issues where not seen as a significant reason for delays to discharge. Where this was an issue, it was found to be cases that related to mental health concerns
- Most delays were seen when discharging children from ED
- Basic information missing from referral forms
- Housing and homelessness repeatedly factors seen in self-neglect cases
- Parents/ carers and patients not routinely informed of referrals being made - this was across both maternity and adults. Children's result were not available at time of completing report.
- Adult referrals have noted significant improvement in the description or concerns and the care needs of patients
- There is limited correlation between late bookers and safeguarding concerns within maternity - large proportion of women booking late is due to recent arrival into the UK
- Knowledge and understanding of MCA and Dols processes are increasing.

Audits planned for 2025-26

- Maternity
    - Safer sleep conversation
    - Client reasons for declining vulnerable team care
    - Quality of documentation
- Children
    - Section 85 referrals
    - Supervision Policy
    - Use of safeguarding children on call
- Adults
    - Dols and MCA
    - Making Safeguarding Personal and quality of referrals
    - Self-Neglect

Internal Audits

A review of the Safeguarding Part 1 audit is currently being conducted as the initial audit found limited assurance. We are expecting the findings of these review to be shared during Q1 of 2025-26.

The internal audit team have completed an audit in relation to the process for MCA and Dols. The findings from this audit have been shared in June 2025 so outside of the current reporting period for the annual

report. During these actions from the previous internal audit for MCA and Dols were reviewed and found to be completed. The current audit has given a limited assurance in relation to:

- Insufficient evidence of discussions with patients and their appropriate parties regarding a DOLS application
- Limited evidence of required additional and supporting evidence where MCA assessments are completed to support DOLS applications.

There actions are summarised below the completion of which will be monitored at hospital safeguarding meetings with exception reporting to ISAC:

- Strengthening the Safeguarding Adults at Risk of Harm policy regarding the frequency and monitoring of MCA assessments
- MCA and Dols audit tool to be reviewed and updated to included:
    - The applications contain correct patient information
    - Documentation within patient records
- Standardised Trust proforma to document best interest decisions following MCA assessment
- Amendments to be made to the Missing Person policy to include inclusion of documentation and the missing person log.

12. ALLEGATIONS AGAINST STAFF RELATING TO SAFEGUARDING CONCERNS

The Trust policy for management of allegations of abuse and neglect made against staff members has been reviewed and consultation has taken place. It is due to be presented to the Trust Policy committee in Q1 of 2025-26. The roles and responsibilities of staff have been strengthened within the policy and the process flow chart has been updated to ensure all staff are aware of the required process.

The role of the Local Authority Designated Officer (LADO) is set out in HM Government guidance - Working Together to Safeguard Children 2023. Within HR, the Director of People works closely with the safeguarding team to ensure there is appropriate HR representation throughout the LADO process.

The ADoS has had contact from borough LADOs and PiPoTs regarding 23 concerns related to Barts Health staff across this reporting period. The majority of these contacts have been in relation to concerns within the private lives of our staff where there is potential transferable risks to their professional lives. There have been 4 contacts which relate directly to care/actions taken within Barts Health. All 4 of these cases have been unsubstantiated and since closed and the staff members directly involved have been supported appropriately through the process. The below table shows the outcome for these contacts:

Outcome of LADO/PiPoT contacts	
Unsubstantiated - closed with no further action	17
Ongoing police investigation	5
Charged by CPS and waiting final outcome	1

Each hospital is at different stages of embedding fact-finding meetings when allegations are made from patients towards staff. These allegations are mainly in relation to adult patients rather than children incidents.

Themes of allegations

- Rough handling - this is the most common allegation
- Inappropriate language used towards a patient
- Physical assault
- Sexual assault

Outcomes from fact-finding meetings have been:

- No evidence found to substantiate concerns
- Restriction of staff member whilst further investigation takes place
- Reporting matter to the police for further investigation
- Rasing safeguarding concern to local authority against the Trust

The ADoS continues to work with the hospitals and People teams to support with the management of these allegations and ensure safeguarding issues are recognised and responded to in a timely manner.

13. PARTNERSHIP WORKING

The Trust continues to demonstrate a high level of commitment to partnership working through active participation in key external meetings. Barts Health has representation on five Safeguarding Children Partnership Boards (SCPB) and Safeguarding Adult Boards (SABs) (Newham, Tower Hamlets, Waltham Forest, Redbridge and Hackney). Throughout the reporting period some of the boards have moved to a mix of face to face and virtual meetings rather than all virtual. Attendance from Barts Health staff has been maintained with the move back to some face-to-face meetings. During the reporting period there have been several partnership events across the system and Barts Health has been represented at each of these.

The hospital DoNs or nominated representation are members of the partnership boards for their local boroughs. The named professionals at each hospital attend the subgroups of the partnerships. The Associate Director for Safeguarding is actively involved with the partnerships across the Barts Health footprint.

There are several safeguarding clinical reference groups (CRGs) across the NEL footprint with the ADoS being a co-chair for 2 of these groups. Each named professional across the Trust has been nominated to participate in CRGs to ensure we have representation and active involvement across the NEL footprint.

14. CHILD DEATH REVIEWS

Named Nurse for Child Death post was successfully substantively recruited to in June 2024. The post has been filled since August 2022.

Across the NEL system there are currently two child deaths hubs with the inner NEL hub being managed via Newham council and the outer NEL managed under the ICB. Whilst the review completed in 2022 of the child death processes and pathways across NEL recommended the two hubs remain separate there was an

emphasis of some process that should be joined. The scene of collapse visits by health professionals was one of these processes. A task and finish group was created, including both CDR hubs and the CDR nurses with Barts Health and the Homerton to review and standardise the standard operating procedure for child death across NEL. This work has not progressed due to staffing and financial constraints.

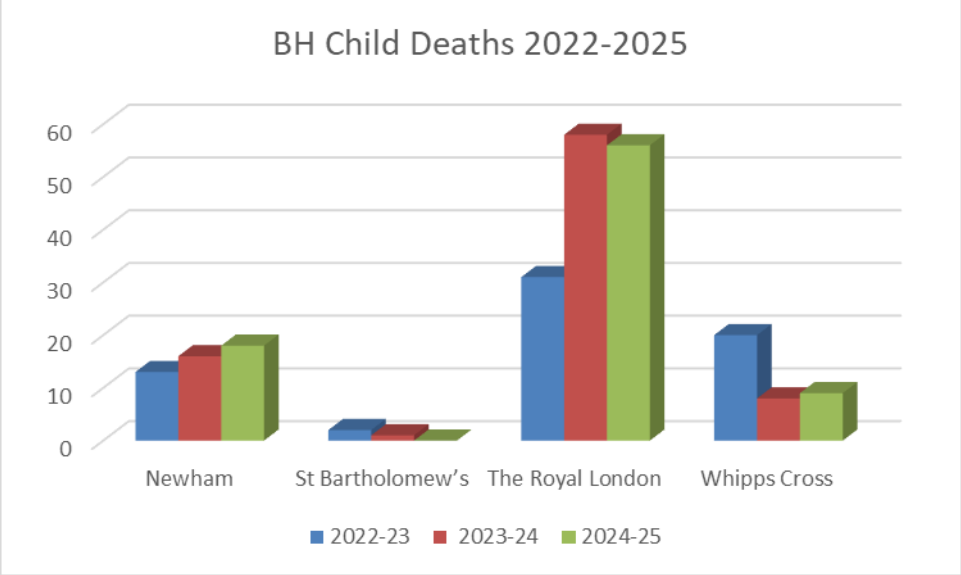
The Named Nurse for Child Death continues to chair Joint Agency Response (JAR) meetings for all Barts Health deaths for children in Barking & Dagenham, Havering, and Redbridge, as well as providing cover for the Designated Doctor in Tower Hamlets, Newham, and Waltham Forest if they are on leave or have a conflict of interest. Child Death Review (CDR) meetings are held monthly for each of the 2 NEL Child Death Review Hubs. The back log of legacy child death reviews is now resolved. Prior to the Named Nurse starting in post in August 2022 there were a total of 78 CDR meetings outstanding. Child death reviews are now being completed within 3-6 months of an expected/explained death.

PMRT reviews delayed at RLH – internal and external escalations. Mitigation: plan in place by RLH neonatal team – this has reduced by two thirds.

Engagement with bereaved families of children who had an explained death, challenging to ensure they are fully aware of child death review process, working alongside child death review hubs to use the NCMD CDR involving parents/families toolkit, by Q2 – 2025-2026.

The family liaison work has increased with consistent contact with families whose children have died and been brought into any of Barts Health's Emergency Departments. This is providing initial support in the first few weeks' post child death, especially when awaiting postmortem.

The Named Nurse for Child Death and other key Barts Health staff are working internally and with partner agencies across NEL to address unsafe sleeping practices and promote all system partners training surrounding conversations with families regarding safe sleeping in line with The Lullaby Trust and the NMCD report on SUDIC published in December 2022.



An additional 57 children have died outside of BH hospitals but known to the Trust.

Nationally there has been an increase in child mortality. For Barts Health the embedding of the Named Nurse for Child Death role has strengthened the data capture to ensure we are aware of all deaths of neonates and children across the Trust.

15. EXTERNAL INSPECTIONS

During this reporting period there have been no external inspections for safeguarding within Barts Health.

16. DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

The Deprivation of Liberty Safeguards (DoLS) ensures adults who cannot consent to their care are protected whilst in hospital if there is a risk that their care and treatment could deprive them of their liberty.

During this reporting period an internal audit was commissioned to review the DoLS and MCA processes. The final report with the findings has been shared and reflected in the previous section of this report relation to audits.

Each hospital continues to:

- Complete audits to review the process and knowledge of staff
- Increased awareness of the processes through safety huddles, adhoc teaching and team meetings

We have seen a year-on-year increase in the number of DoLS applications made by each hospital:

Number of Dols Applications		
2022-23	2023-24	2024-25
651	845 ↑	1275 ↑

From the applications made by Barts Health:

- 25% of patients were discharged prior to Local Authority assessing and approving application.
- 10% of applications were withdrawn
- 6% of all applications were assessed and approved by Local Authority
- 5% of patients died prior to assessment taking place

The responsibility for assessing and approving Dols applications sits with the local authorities. We are aware there are capacity issues with the local authorities being able to assess and approve Dols applications this is not an issue that Barts Health alone experience. The Dols administration teams support by the named professional safeguarding adult leads at each hospital will send reminder notifications to local authorities where patients remain in hospital for 2 weeks or longer and have a Dols.

17. DOMESTIC ABUSE

Domestic Abuse referrals have seen an increase by 6% and 28% within maternity and adults and remains within the top 4 reasons for referrals in adults and children and the most common reason in maternity. All hospitals continue to be supported by Independent Domestic Violence Advocates (IDVAs) either remotely or hospital based.
The number of new Domestic Abuse Related Death reported incidents have reduce within the last year and below is the status of the reviews that Barts Health are contributing to:

On hold due to inquest or criminal proceedings	1
Final reports completed	3
Awaiting Home Office approval	3
On-going reviews	3

Current learning for the Trust from the DHRs is:

- Professional curiosity
- Documentation
- Education
- Partnership working including referral processes
- How we manage patients where there is a potential risk to others due to criminal convictions.

The Domestic Abuse policy is currently being reviewed and expected to be ratified by Q2 2025-26.

18. RISKS AND ISSUES

Training:

- Level 3 for both children and adults are below target compliance.
- Reduced numbers of staff trained could potentially result in staff not equipped with knowledge and skills to identify safeguarding cases.

Mitigation:

- Availability of training has been increased along with the capacity for each session
- Trajectories are in place for how compliance will be increased and these are monitored both at hospital and Group level through safeguarding meetings
- Guidance tools and policies are easily accessible on We Share
- Staff have access to safeguarding professionals during core hours and for children issues access to on call Named Nurse/ADS

Vacancies:

- Throughout the year there have been periods of hospitals not being full staffed in their safeguarding teams

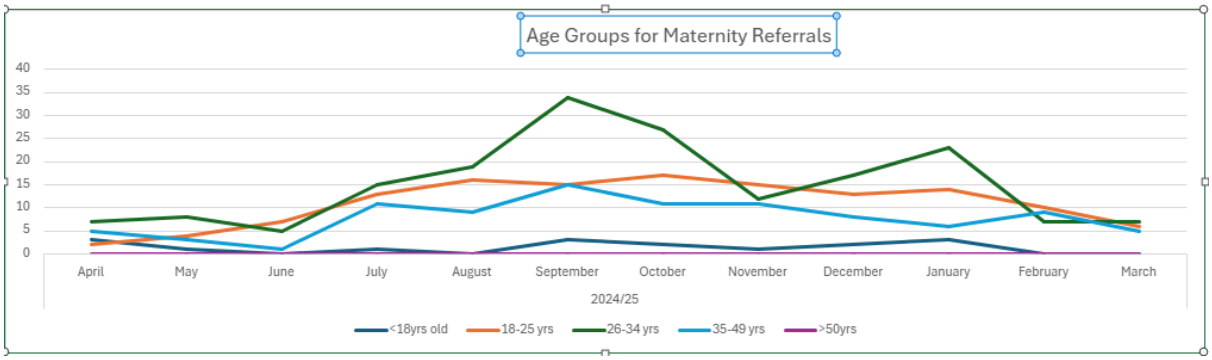
- At year end there is only 1 administrative post that it vacant, this is currently being actively recruited too.

Mitigation:

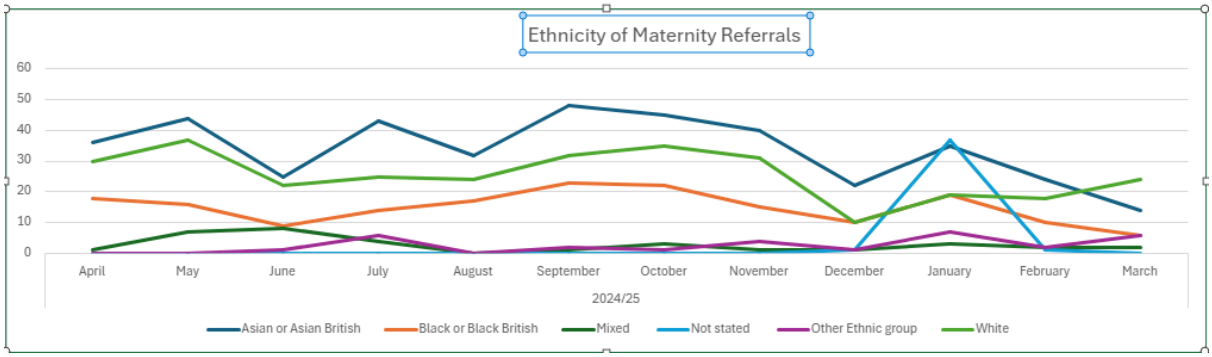
- ADS has offered support to areas of depletion.
- Recruitment has taken place
- The wider safeguarding teams supporting where possible.
- Where a named professional post is vacant hospitals have been asked to add this to Risk Register

19. REDUCING INEQUITY

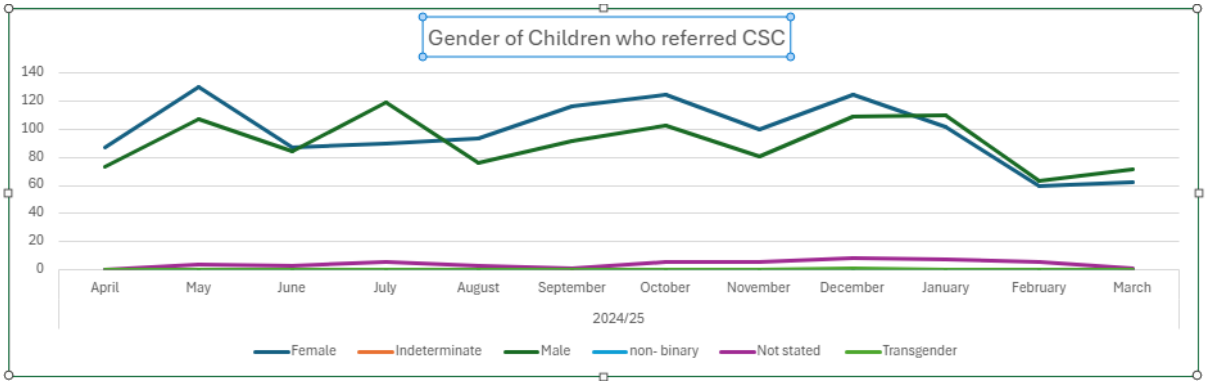
The safeguarding dashboards were reviewed and updated this reporting year to enable us to capture equality data from the referrals made by the Trust to both adults and children social care.



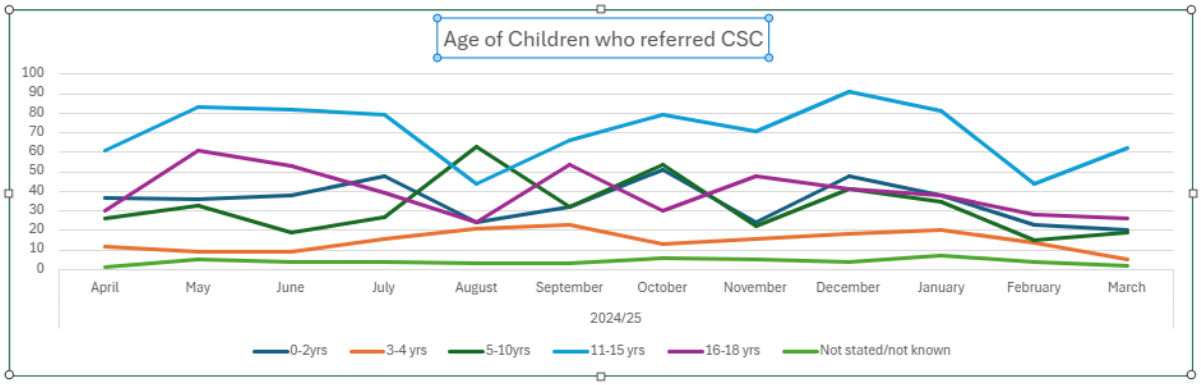
From the referral data women within the age group 26-34 years old were shown to be the highest referral rate with 18–25-year-olds being the second highest.



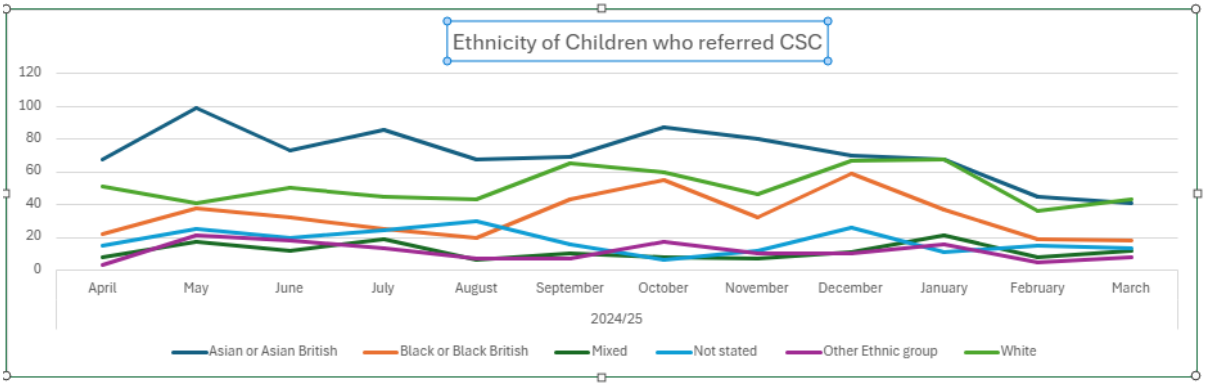
We saw more referrals for women from an Asian or Asian British background followed by white and then black or black British background. From an audit completed by maternity looking at themes of referrals and comparing ethnicity it was found there was an over representation of referrals made for women from both white and black backgrounds compared to the number of women who were booked for maternity care during Q3 of this year.



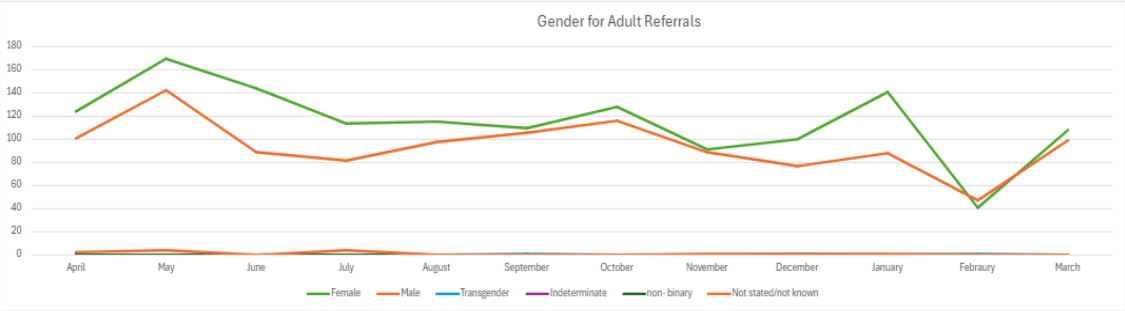
The difference between boys and girls being referred to children social care was a small difference with overall slightly more referrals for girls than boys. We have seen a very small number of children who identify as transgender being referred and no children who identify as non-binary or indeterminate.



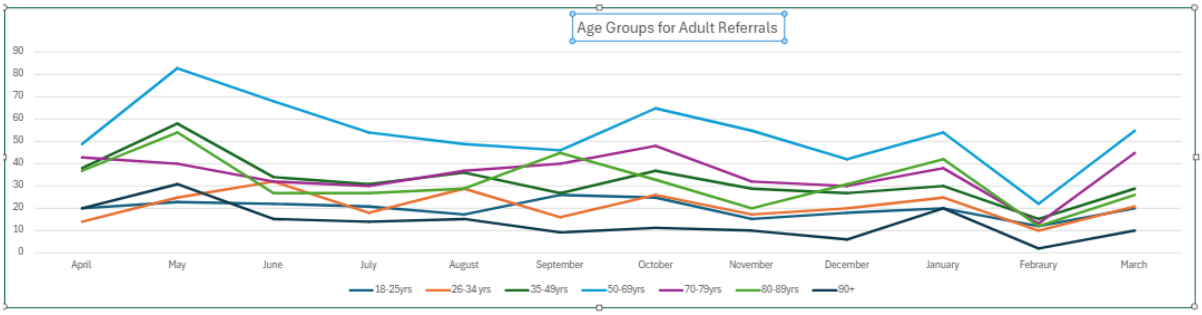
Children within adolescent years have been the highest number of referrals made to children social care in this previous year and this correlates with the themes of the referrals we have seen with child mental health and exploitation being in the top 4 reasons for referrals.



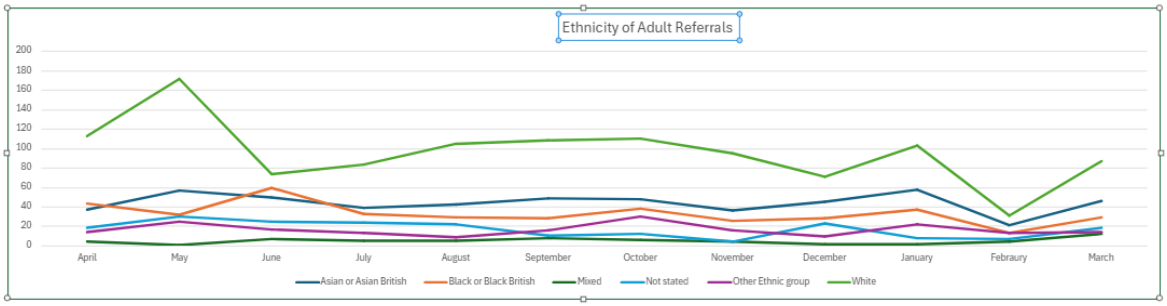
The ethnicity breakdown for children referrals to children social care shows the same picture to that of the maternity referrals.



As with children the gender gap between male and female patients being referred is similar with slightly more females than males being referred. The domestic abuse referrals will have some impact on this finding as many of these referrals are for women who are victims compared to men.



We have seen more referrals for 50–69-year-olds which fits with the self-neglect cohort of patients.



Unlike with maternity and children referrals we have received more referrals for adults from a white background than any other ethnic group.

As part of the work plan for 2025-26 we will be working with the diversity and inclusion and public health teams to explore what the ethnicity data is telling us for safeguarding compared to the demographic detail about patients who use Barts Health services.

20. ACHIEVEMENT OF 2024/25 WORK PLAN

Most of the work plan for 24/25 has been completed or partially completed. Those that have been partially completed are expected to be fully met within the first half of 24/25.

Objective	Action	Achieved
To have a standardised audit programme and audit tool for key safeguarding issues across the Trust.	The Trust wide audit schedule is in place an audits have been completed with the findings reported at hospital safeguarding committees and ISAC	Yes
Development of our Strategic Safeguarding Priorities for the Trust	Workshops were held with a variety of staff groups to decide on what the safeguarding priorities should be. A strategy has been developed with six priorities and will be launched in the summer 2025-26	Yes
Completion of internal audit actions	Internal audits have been completed	Yes
To explore hosting a Level 4 Safeguarding Children Conference	We will be holding the 1st Barts Health Level 4 Safeguarding Children Conference on 10th October 2025.	Yes
Safeguarding alert form on CRS to be embedded into practice	A phased roll out of the safeguarding adult alert form on millennium is in progress with all hospitals now using the new process. The previous process will continue for 6 months after the Trust wide roll out has been completed to ensure it is embedded into practice.	Yes
Strengthen the use of inequity data to support and inform service delivery and change	The revised hospital safeguarding dashboards now collect equity data. We now need to work with the inclusion and equity teams to analyse the safeguarding data with Barts Health patient demographics.	Yes
Embed safeguarding in HR investigations where appropriate	Standard operating procedure has been completed for employment relations investigations where safeguarding issues are a component Internal investigation team have embedded safeguarding into their process map when completing staff investigations. ADS has participated in several People directorate and business meetings raising the profile of safeguarding	Yes

21. PLANS FOR 2025/26

Each hospital has a work plan for the coming year, aligned with the strategic priorities for the trust and taking account of local differences.

Below is a summary of the Group level plans for the coming year:

	Objective	Action Owner	Implementation Date
1	To launch the Safeguarding Strategy	Associate Director for Safeguarding	August 2025
2	Develop an action plan in line with the six priorities from the Safeguarding Strategy	Associate Director of Safeguarding	September 2025
3	Review and complete any internal audit actions from the MCA and DoLS and review of Safeguarding part 1 internal audits	Associate Director of Safeguarding	October 2025
4	To analyse the equality data to support the development of safeguarding practises if gaps are identified	Associate Director for safeguarding	January 2026
6	To ensure all safeguarding policies are reviewed within reasonable time frame and kept up to date	Associate Director of Safeguarding	January 2026

Report to the Trust Board: 9 July 2025	TB 62/25

Title	Barts Health NHS Trust Complaints and PALS Yearly Report (2024/25)
Author	Central Complaints Manager, Director of Patient Experience and Community Engagement, Hospital Associate Directors of Governance
Exec Director	Chief Nurse
Date	June 2025

Executive Summary	The Trust has a statutory duty to prepare an annual report on its handling and consideration of complaints. The purpose of this report is to fulfil this duty and provide a Trust-wide overview of complaints and concerns as reported through formal complaints and early resolution processes between 1 April 2024 and 31 March 2025. **Key achievements in 2024/25**: • Learning from complaints has informed improvement initiatives at Group and Hospital level, including outpatient appointment letters, PALS transformation project at RLH, improvements in the WXH emergency department, QI improvement projects in end-of-life care at SBH, and initiatives to transform complaints into positive change at NUH. • We reviewed the Trust-wide renegotiation standard operating procedure (SOP) and introduced a limit of two renegotiations to improve experience of our complaints process. • We developed and launched new statutory and mandatory digital complaints management training package for staff across the Trust. The training was shortlisted as a finalist in the 2024 national Patient Experience Network Awards (PENA) • Internal response quality audit found all standards achieved 90% compliance or higher, with adequate signposting to further information achieving 100%. **Key issues and risks in 2024/25** • 29% increase in the number of reportable complaints: it is reasonable to consider the increase reflects the current context and pressures in the NHS system, as well as continued national year-on-year increase in complaints. • An increase was noted across three key themes: diagnosis/treatment, communication, and appointment/clinics • Increase in complaints largely driven by emergency care, medicine (in particular, emergency medicine), women and children, and cardiology • 91.4% of reportable complaints were acknowledged within the stipulated timescale, against the 100% national standard • 77.7% of complaints received were responded to within negotiated timescale, against the 80% key performance indicator standard • An increase in reopened complaints (141 compared to 97 in 2023/24) • Complainant demographic data has been limited

	• Complainant satisfaction insight has not been consistently obtained
	• Service performance has been challenged due to issues such as staff turnover, staff skill mix, reduced resourcing across governance teams, and challenges recruiting to key complaints management posts. Capacity in Governance teams are on the Risk Register for RLH and NUH.
	
	Improvement plans for 2025/26
	• Hospital-level improvement plans will be monitored at Hospital Executive Boards
	• Trust-wide improvement plan priorities:
	  ○ Ensure consistent completion of complainant satisfaction audit
	  ○ Increase reporting on complainant demographic data
	  ○ Ensure complaints themes and trends are triangulated with other insight to inform continuous improvement and feed into Quality Management System.
	  ○ Review complaints pathway model, including review of opportunities for digital solutions, and the PALS and Complaints interface to increase opportunities for early resolution.
	  ○ Implement recommendations from NHS England Experience of Care Improvement Framework self-assessments relating to complaints and early resolution.
	  ○ Produce Trust-wide SOP for responding to complaints attached to incidents (AARs) to ensure consistency in process.
	  ○ Provide training to address data quality issues.

Implications (Financial/ Inclusion & equity/ Quality/)	A failure to learn from Never Events, serious incidents and complaints adversely impacts on quality and safety.

Recommendations	The Trust Board is asked to note the report and endorse improvement plan priorities.

BARTS HEALTH NHS TRUST

REPORT TO THE TRUST BOARD: 9 JULY 2025

COMPLAINTS AND PALS YEARLY REPORT

1. Background

This report provides a Trust-wide overview of complaints and concerns as reported through formal complaints and early resolution processes between 1 April 2024 and 31 March 2025.

Our complaints and early resolution functions ensure that service users' concerns are heard and responded to, action is taken to prevent reoccurrence, wider learning is taken forward, and improvements are made to processes, monitored through an improvement plan overseen by the Complaints Management Improvement Group.

In addition to the formal complaints processes in place, our hospital Patient Advice and Liaison Service (PALS) teams provide the early resolution function which empowers service users to first consider prompt, informal resolution of concerns where possible. Working closely with the complaints, Access and Issues Resolution Service (AIRS) and hospital governance teams, PALS ensure service users are aware of the options available to them when they wish to raise concerns or report problems with care.

The GP complaints process, although not for use by complainants, serves as another early warning system for primary care providers to bring concerns to the attention of the Trust on behalf of their patients.

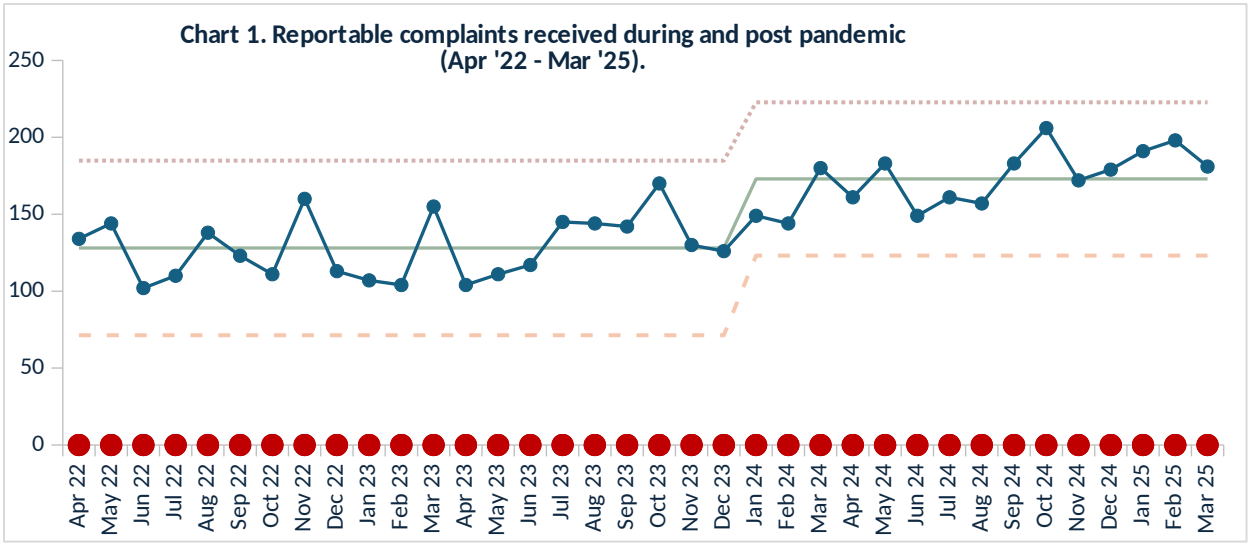
2. Key data analysis

2.1. Reportable complaints

The Trust recorded **2,121** complaints in 2024/25, a **29%** increase compared with 2023/24 when **1,641** complaints were recorded and there was an increase of **9%** from the year before.

Given the specialities largely driving the increase in complaints (see section 2.1 below), it is reasonable to consider that the increase reflects the current context and pressures in the NHS system. Whilst national complaints data for 2024/25 has not yet been published, there has been a recent year-on-year national increase, and it is anticipated that this trend will continue. Benchmark comparison with similar organisations will be undertaken when this data becomes available.

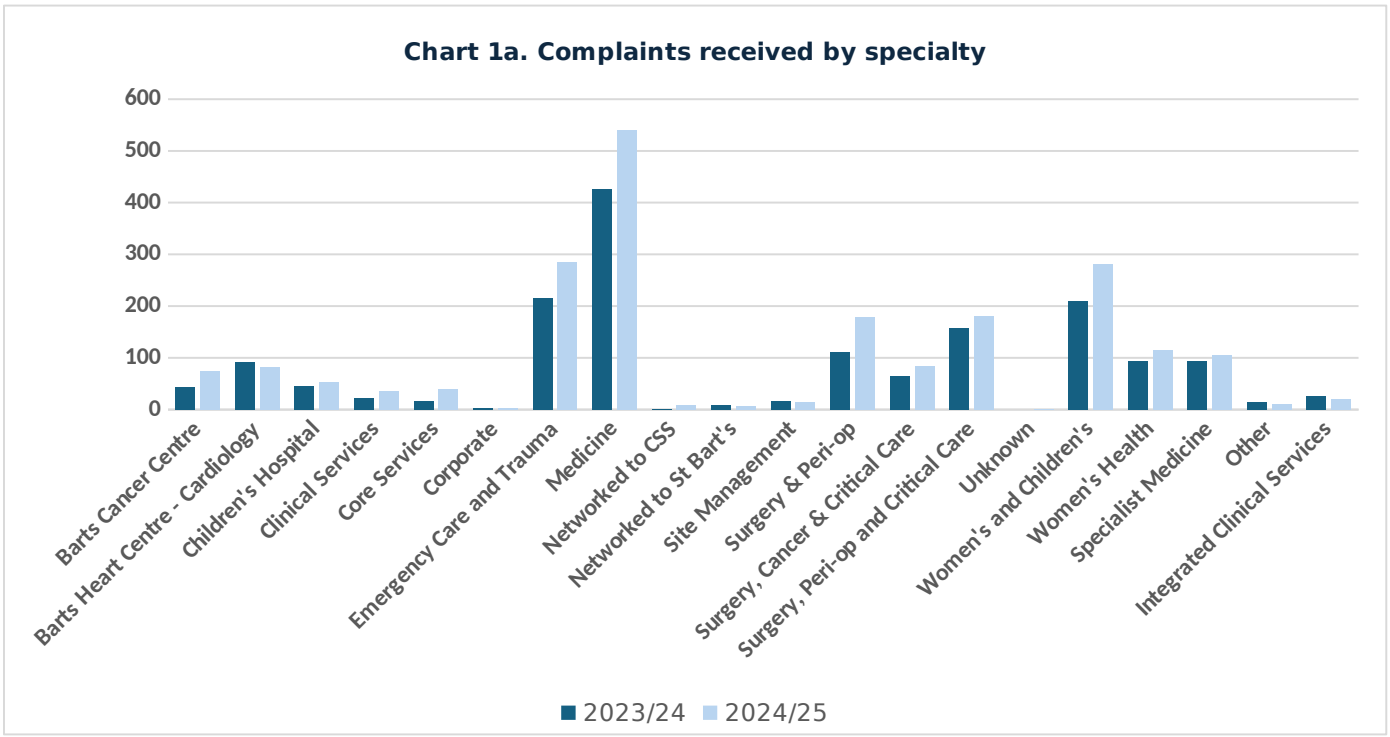
It is acknowledged however that all learning must be used as an opportunity to improve the quality of our care, and it is essential that our complaints insight helps inform our response to managing such pressures. Alongside genuine concerns reported in our complaints, it was also noted that data quality was a contributory factor in the increase in complaints received. There is further detail on this in section 8.4 of this report.



1.2 Complaints received by specialty

Chart 1a below shows that majority of the increase in complaints this year were driven by emergency care, medicine (in particular, emergency medicine), women and children, and cardiology complaints. A further deep dive into this showed that there was a **23.3%** increase in diagnosis and treatment complaints, and a **24.29%** increase in delays in care complaints.

These were mainly around issues such as inadequate medical care, general lack of care, poor communication, poor staff attitude, dissatisfactory surgery outcomes, delays in A&E, inadequate information, general delays around care.

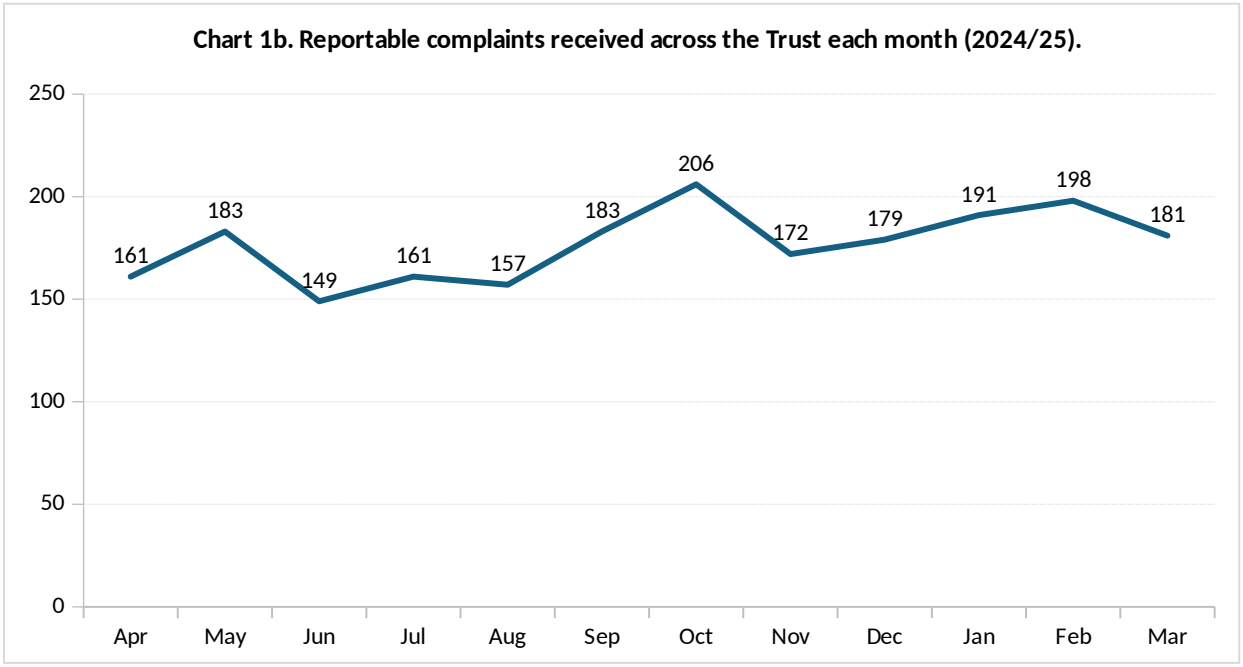


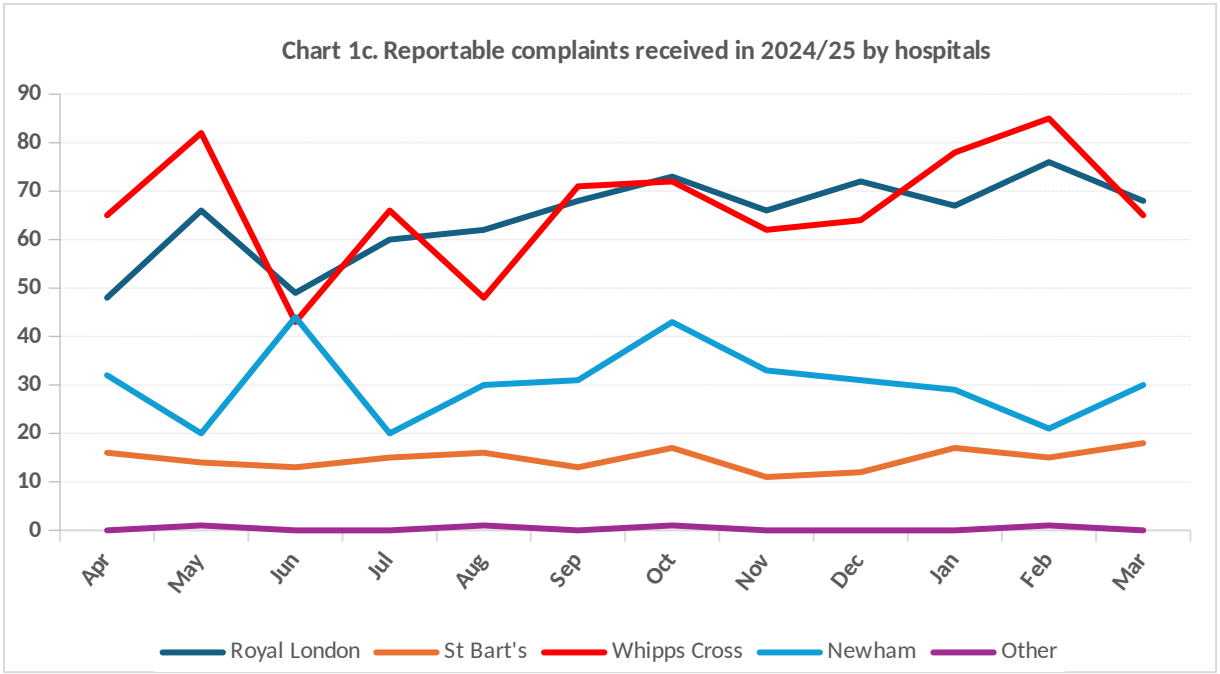
1.3 Complaints received by month.

Chart 1b below provides a breakdown of all reportable complaints received each month during 2024/25.

As noted in chart 1c, a sharp increase in complaints received at Whipps Cross Hospital was noted in May and February, and for Newham where an increase was noted in June compared with other months.

On the same chart, a very small number of complaints were recorded as "other". These are formal complaints which were received by other Trusts or independent contractors but required some input from the Trust.



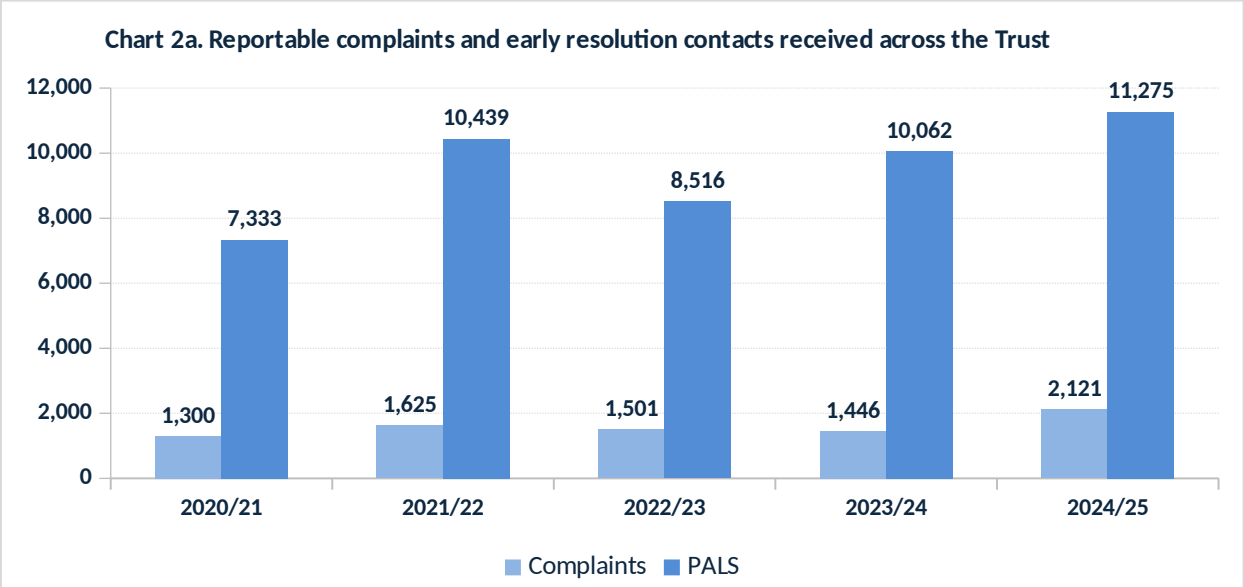


1.4 Early resolution activity - Trust

Our key priority in complaints management remains to ensure processes are convenient and accessible to our service users. With that in mind, PALS and AIRS play a key part in enabling service users to:

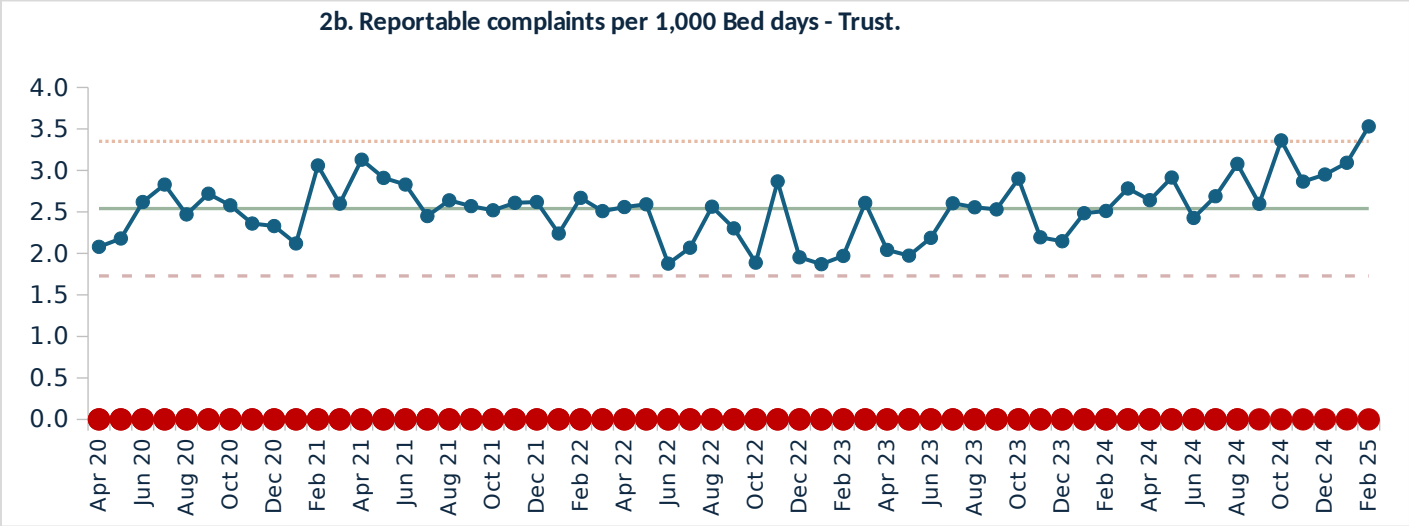
- raise concerns in real time and expect prompt resolution
- gain clarity about the complaints process at each hospital and how to make a complaint
- promote access to services where there might be immediate concerns rather than make a complaint and wait longer
- get support with making a complaint should this become necessary.

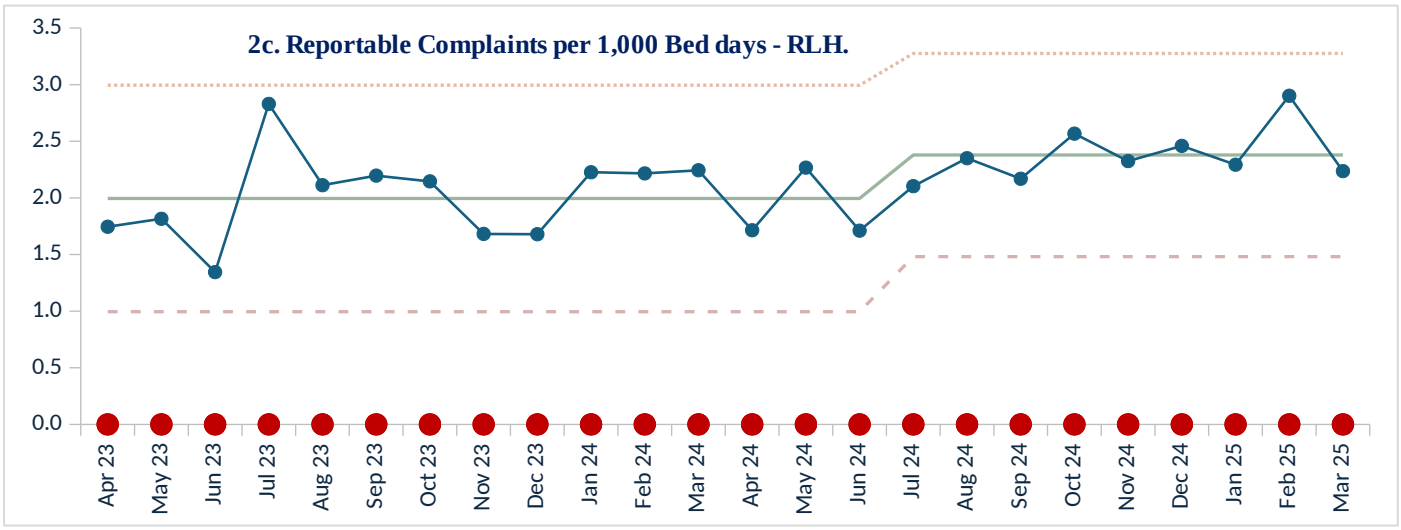
Chart 2a. The Trust recorded a **12.05%** increase in early resolution contacts, compared with the previous year. Consistent with complaints themes, an increase in the number of emergency care contacts about communication, appointments and clinics were a contributory factor in the overall increase in contacts this year.



1.5 Complaints activity per 1,000 bed days – Trust and Hospitals

Charts 2b – 2f. below give a breakdown of complaints received per 1,000 bed days across the Group and in each hospital.




2c. Reportable Complaints per 1,000 Bed days - RLH.
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
Mar 24
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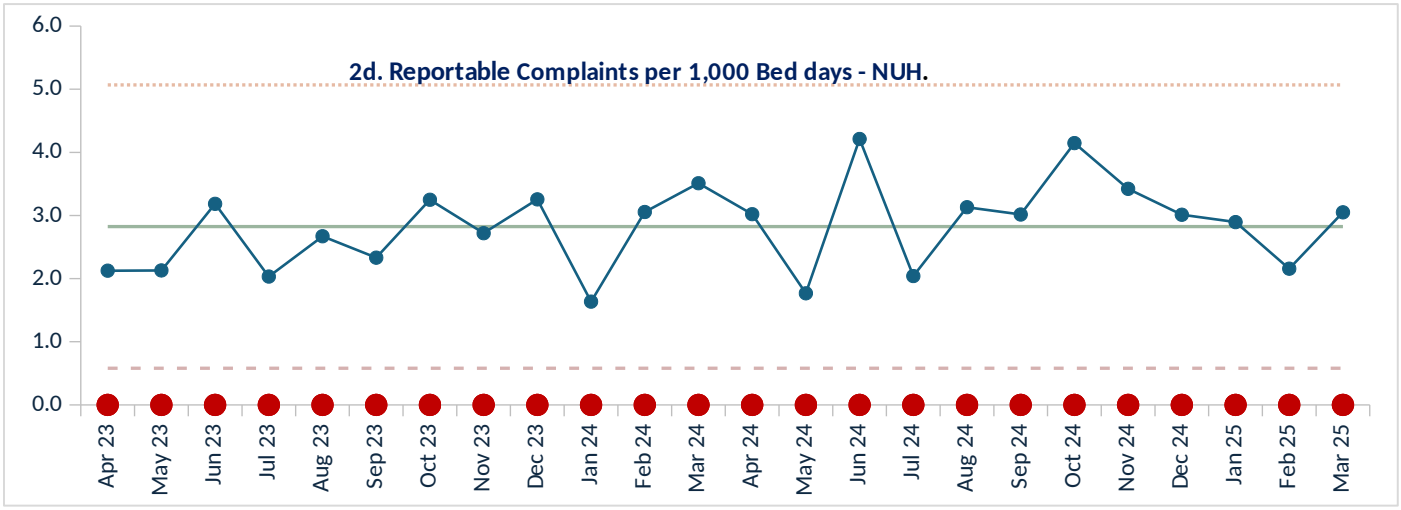
May 24
Jun 24
Jul 24
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Jan 25
Feb 25
Mar 25


2d. Reportable Complaints per 1,000 Bed days - NUH.
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
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May 24
Jun 24
Jul 24
Aug 24
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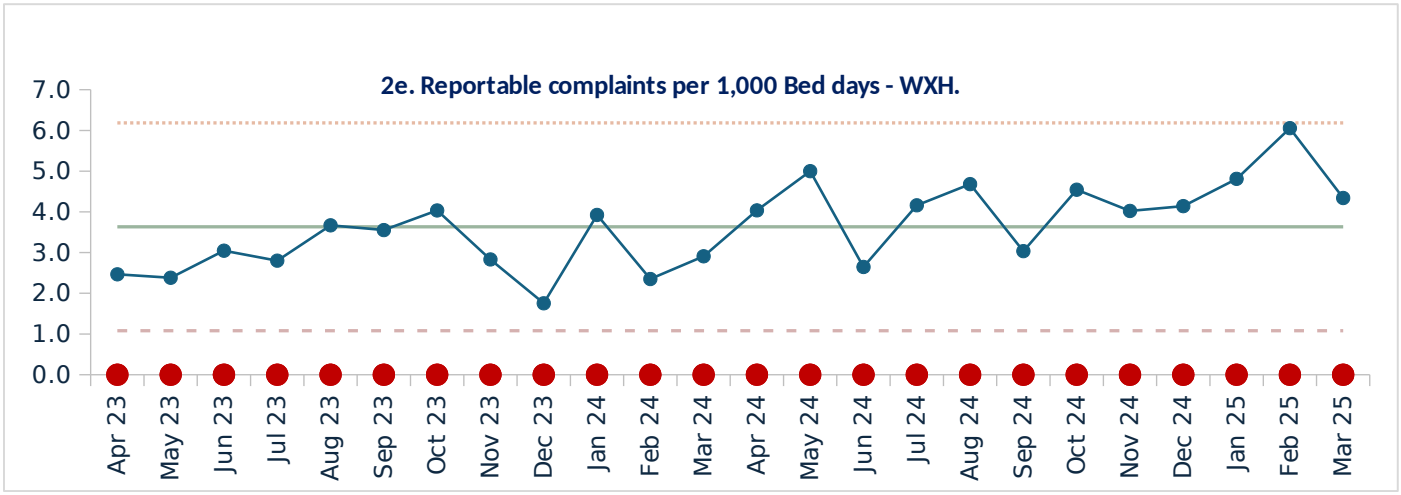
Nov 24
Dec 24
Jan 25
Feb 25
Mar 25


2e. Reportable complaints per 1,000 Bed days - WXH.
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr 23
May 23
Jun 23
Jul 23
Aug 23
Sep 23
Oct 23
Nov 23
Dec 23
Jan 24
Feb 24
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Apr 24
May 24
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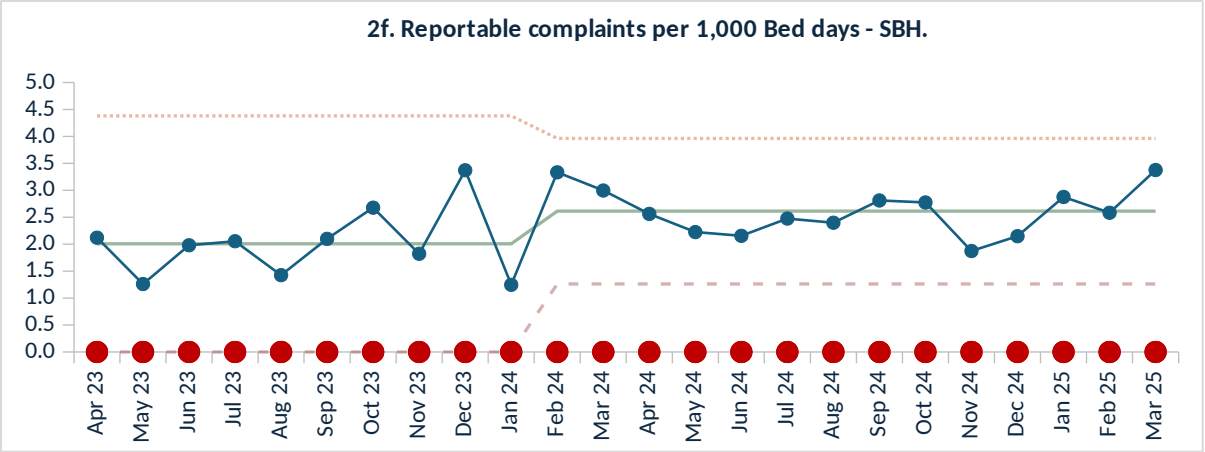


1.6 Complainant demographic data – Trust

Demographic data is obtained using the "person affected" MRN/NHS number where this is provided. Records are linked to the Trust's Cerner data through which complainants' demographic details can be obtained. It is important to acknowledge that complainant reticence in providing this data has been a continuing issue across the NHS which has been attributed to perceived concerns of discrimination.

A significant number of complaints records had little demographic data attached to them. In some cases, this was a data quality issue, but in most the minimal availability of data was because the person complaining was not always the patient and did not provide any demographic data. Improving the availability of demographic data had been identified as an improvement priority for 2024/25, however this was deferred until 2025/26 due to pressures within complaints services and staffing issues.

From the available demographic data, **Table 1, 2 and chart 2g** below provide an overall breakdown of data available in the complaints closed this year indicating that:

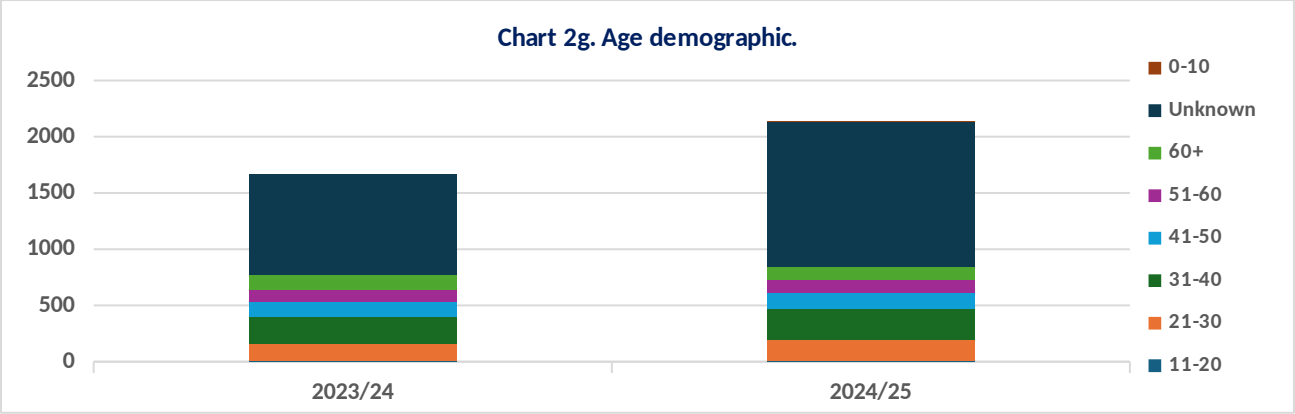
- the majority of the complainants with demographic data were White British
- the majority were female
- the data total in the various categories exceeded the number of complaints recorded during the year as in some cases the demographic data of both the primary and secondary contacts on records were captured.

Given the large proportion of complaints where the demographics are not known, this breakdown is only provided for information and should not be statistically interpreted.

Table 1 – Ethnicity Demographics	
Ethnicity	**No. of records**
Asian - Any Other Asian Background	46
Asian or Asian British - Bangladeshi	128
Asian or Asian British - Indian	35
Asian or Asian British - Pakistani	39
Black - Any Other Black Background	34
Black or Black British - African	49
Black or Black British - Caribbean	31
Mixed - Any Other Mixed Background	15
Mixed - White and Asian	5
Mixed - White and Black African	2
Mixed - White and Black Caribbean	5

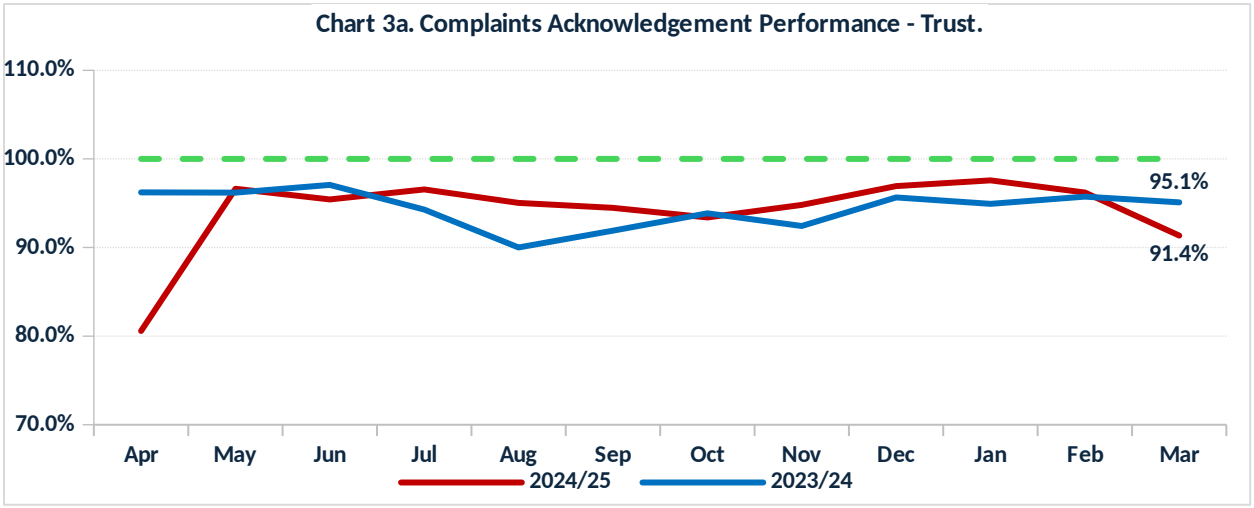
Other - Any Other Ethnic Group	55
Other - Chinese	4
Other - Not Stated	24
Patient Refused	22
White - Any Other White Background	119
White - British	220
White - Irish	10
(blank)	1290
Grand Total	**2133**

Table 2 - Sex Demographic	
Gender	**No. of records**
Female	594
Male	249
(blank)	1290
Grand Total	**2133**



2. **Complaints acknowledgement performance – Trust**

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 require Trusts to acknowledge all reportable complaints within three working days. This year, **91.4%** of reportable complaints were acknowledged within the stipulated timescale, a decrease compared to the previous year when **95.1%** of complaints were acknowledged within the target timeframe. Achieving this target is a core aim of our improvement activity for 2025/26.



3. **Complaints response performance – Trust**

We recognise that sometimes complex complaints may require additional time to be investigated and responded to. In such cases, discussing delays with complainants and mutually agreeing a renegotiated timescale is necessary.

In 2024/25, the Trust responded to **77.7%** of complaints received within a negotiated timescale, compared with **82.5%** in 2023/24. A number of contributory factors were noted to have been the cause of this decrease in performance. These included the increase in volume of complaints received, the complex nature of some of the complaints received, and a change in our renegotiation process.

In a small number of cases, it was noted that timescales were renegotiated more than twice resulting in cases that were considerably overdue. A fuller update on renegotiated complaints is provided in section **7.3** below.

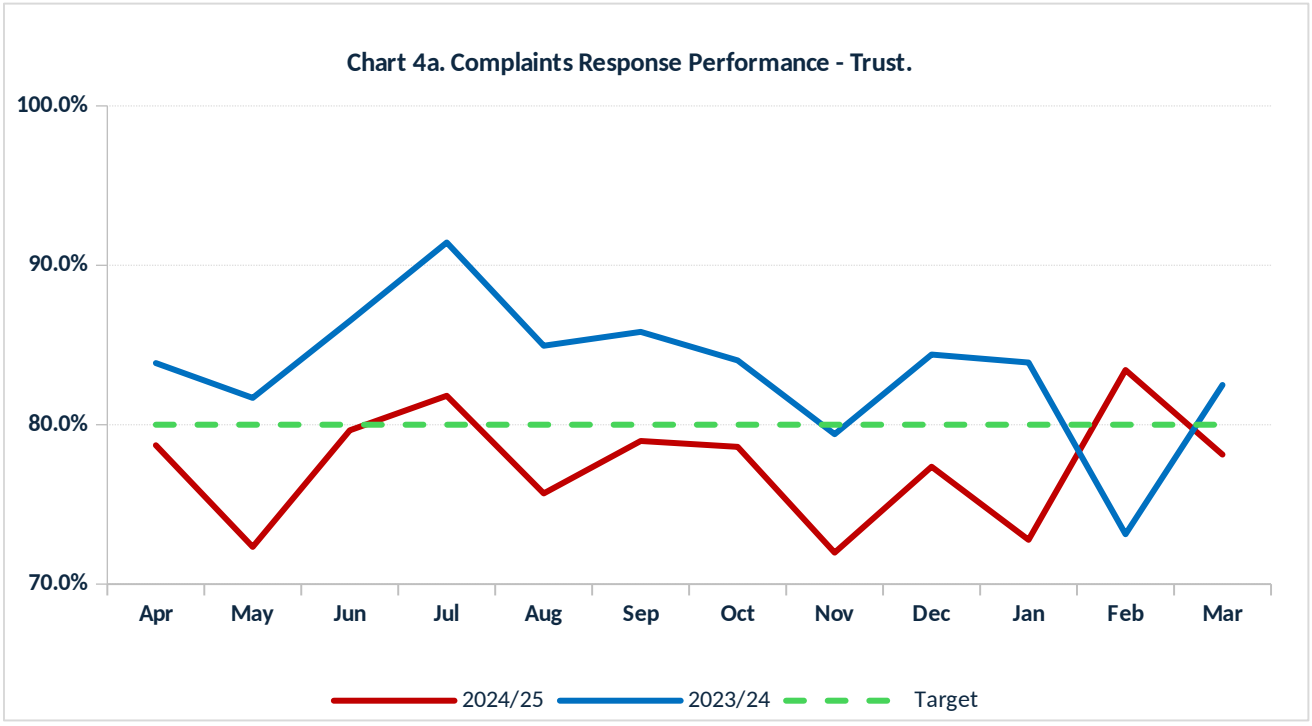
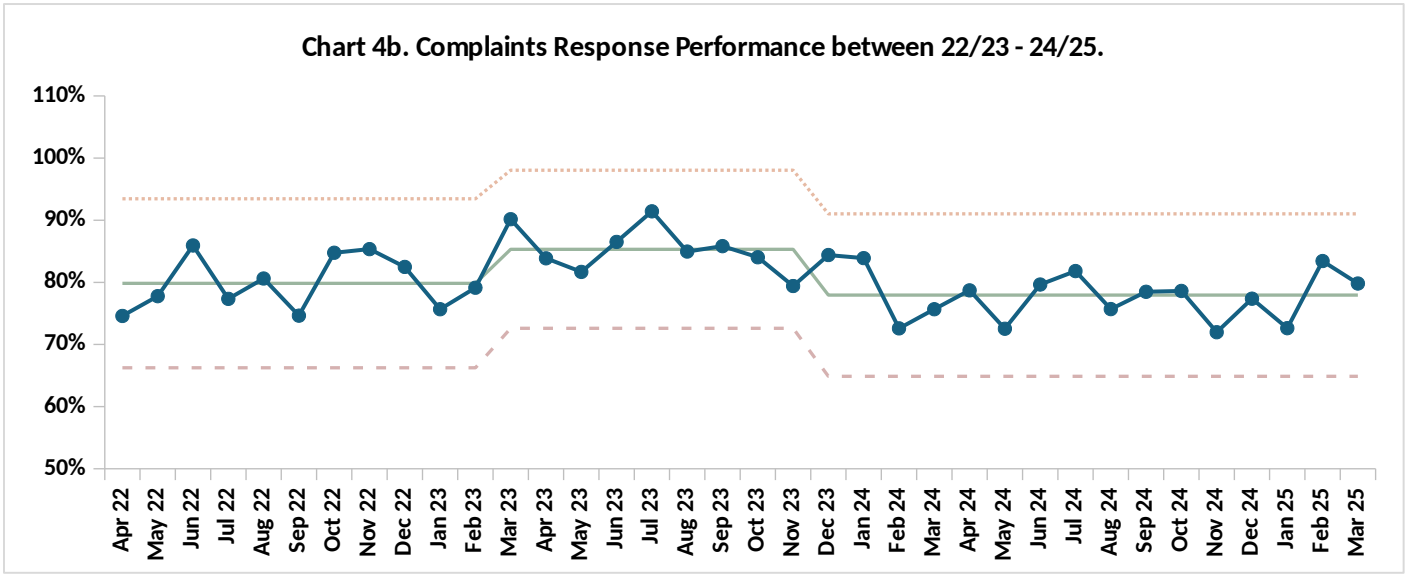
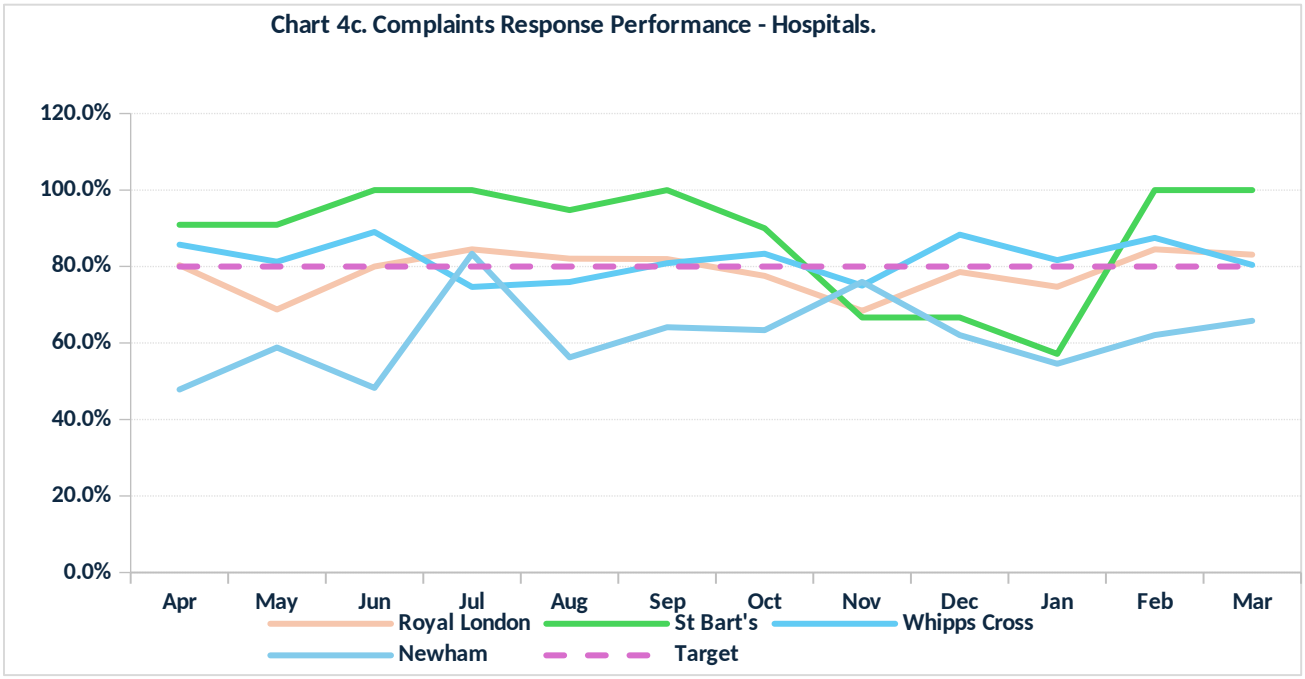


Chart 4b below gives some insight into overall response performance month on month during 2024/25 compared with the previous two financial years.



3.2 Complaints response performance - Hospitals

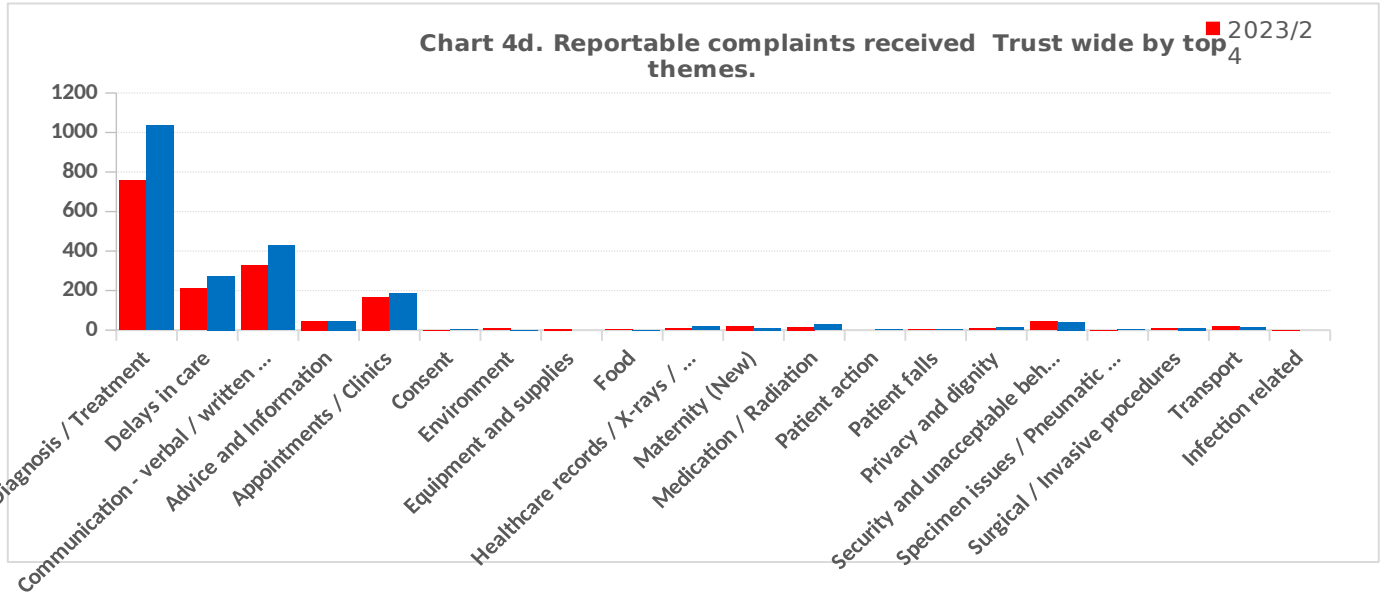
As noted in **Chart 4c**, there were dips in performance across all hospitals throughout the year. Compared with the other hospitals, there were more challenges at Newham University Hospital (NUH) in achieving the 80% performance standard. A key factor has been the difficulty in successfully recruiting to the substantive Complaints Lead post and the lack of dedicated senior leadership for this portfolio has led to challenges. The Trust is actively supporting the hospital with strengthening implementation of complaints processes and improving business resilience. Further details on improvement actions underway is outlined in NUH's hospital-level report.



3.3 Complaints and early resolution contacts by top themes - Trust

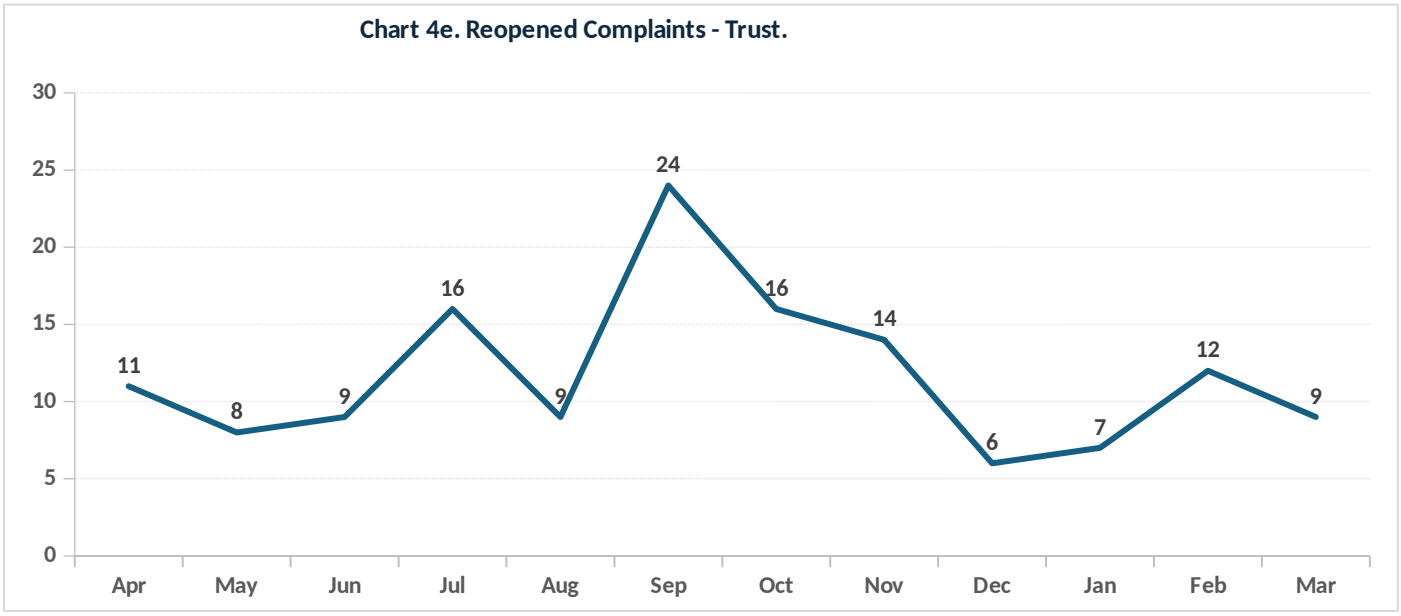
The top areas of concern in 2024/25 remain the same as previous years, with diagnosis/treatment, communication and appointments/clinics featuring as the top three themes. A deep dive into the themes identified that concerns mainly fell into the following sub-theme categories: inadequate medical care, general lack of care, poor communication, poor staff attitude, dissatisfactory surgery outcomes, delays in accident and emergency

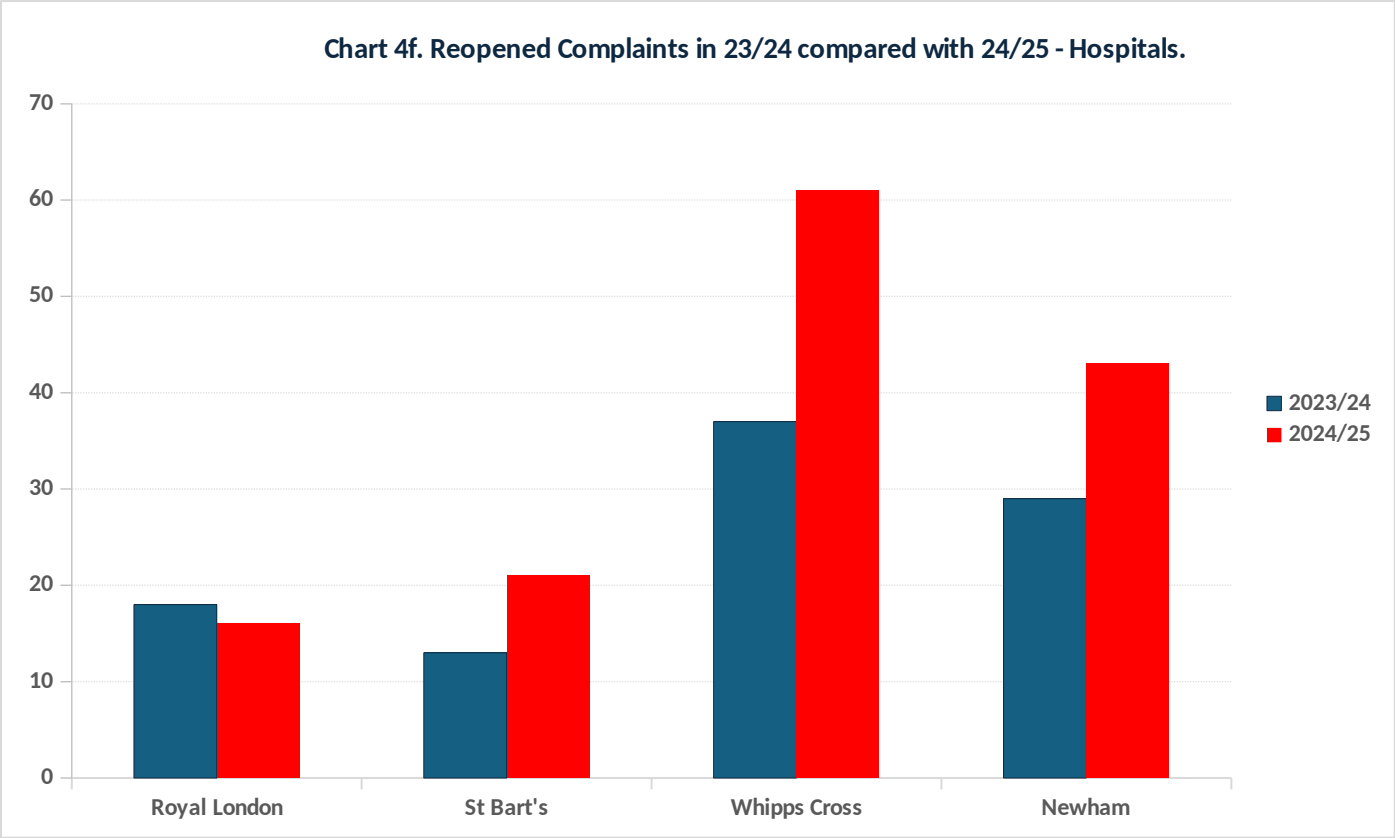
departments, inadequate information, and general delays around care. Each hospital has provided a fuller update in their respective annual reports.



3.4 Reopened complaints – Trust

A total of **141** complaints were reopened this year compared with **97** complaints in 2023/24. It can be seen in **Chart 4e** below that following a peak in September 2024, the number of reopened cases has decreased again. In the absence of complainant satisfaction audit data in 2024/25, it is unclear if complainant experience contributed to this increase in reopened cases or if the increase aligns generally with the increase in complaints received. The 2025/26 improvement plan includes a plan to address this process gap which is discussed further below.





4. **Parliamentary and Health Service Ombudsman (PHSO) cases**

At the time of reporting, there were nine open PHSO cases and a further 19 were under assessment by the PHSO. In 2024/25, four PHSO cases were closed, each of which recommended financial recompense for complainants. **Table 3** below provides a summary of each case and the recommendations made by the PHSO. All recommendations have been acted upon.

Table 3	**Description**
ID. 117680 NUH Partially Upheld Closed 18.09.24.	**Case description** - complaint raised about the nursing care a covid-19 patient received prior to his demise. **Failings identified -** The PHSO found that whilst the DNACPR order was appropriate, the patient and his family were not informed or consulted about it. These failings meant the family did not know about the DNACPR at the time and did not realise how ill the patient was. There were further failings in the Trust's complaint handling, by not having an open and transparent response to the issue of the patient's deterioration added to the family's distress. **Recommendations made -** The PHSO recommended that the Trust apologise to the family, review the learning from this case, including the need for doctors to discuss DNACPR orders with patients and their families before putting them in place. The Trust should also pay £700, in recognition of the distress caused.
ID. 140424 SBH	**Case description** - Family raised a complaint regarding end-of-life care and communication following their father's death. Whilst they were satisfied that their

Partially Upheld Closed 18.07.24.	father received excellent care from SBH, they feel that they were unprepared for what felt like a sudden death; it appears from his records that the medical staff were aware that treatments were no longer effective, but this was not communicated to the patient or the family. **Failings identified -** Trust did not inform the patient and his family of his poor prognosis, and that he was likely to be approaching his end-of-life, around three months before his death. This meant that the patient's wife and her family lost an opportunity to prepare and plan for his death which caused them significant distress. During his final admission the Trust delayed telling his wife and her family that he was likely to be in his final days of life, they were only told a few hours before his death. It was noted that this failing would not have made a significant difference to the patient's end-of-life care due to the speed of his deterioration. **Recommendations made –** Recommendation to apologise to the patient's wife and her family and pay £1,500 in recognition of the distress that was caused to them from being unable to prepare properly for the patient's death.
ID. 86332 RLH Partially Upheld Closed 25.10.24.	**Case description** - Patient has various concerns about the handling of her appendix surgery and subsequent care. She believes that there were delays at various points in her treatment. She believes that the procedure has had long term consequences for her health that were avoidable. **Failings identified -** The PHSO identified failings in the Trust delaying the patient's first operation, the consultant not attending the first operation, and then not first attempting the second operation laparoscopically. The PHSO was able to link these to some of the impacts the patient had claimed, as well as the loss of opportunity identified. **Recommendations made -** The PHSO recommended that the Trust acknowledges its mistakes, apologises to the patient for them, and pays her £3,750, and create an action plan within three calendar months of the date of the final report.
ID. 21763 WXH Partially upheld Closed 10.10.24	**Case description** - Daughter would like to know why she wasn't contacted sooner than 20 minutes prior to her mother passing away. She states there was no discussion re. End of Life and she was advised that the cause of death was pseudomonas, but the death certificate says pneumonia. **Failings identified -** Failings regarding communication of DNACPR decision identified. The patient's daughter could have been told earlier that the patient had deteriorated. **Recommendations made -** For emotional distress, PHSO have requested that the Trust pay £850.

5. **Learning from complaints (2024/25)**

An effective complaints process ensures that complaints lead to a greater understanding of Trust-wide issues that can be triangulated with other insight and utilised to inform programmes of work. Learning from complaints is overseen

at hospital level through Hospital Executive Boards, and at Group-level through the patient experience, engagement, and participation governance route, reporting to the Experience of Care Strategic Oversight Group.

An example of learning from complaints in 2024/25 is around appointment communication which has helped inform the Outpatients Transformation Programme, seeking to improve our clinic appointment letter model and use of digital solutions, and has subsequently been incorporated as a key patient experience metric for our Group Operating Plan in 2025/26.

Our hospitals continue to ensure that they use the themes and learning from their complaints and PALS feedback and this is explored further in each respective hospital annual report. For example, at the Royal London Hospital, a major focus of recent work has been around the PALS transformation project which has involved a full redesign of the service, following wide engagement with inpatient wards and clinical divisions. This transformation includes the development of a new way of working, clear alignment with the hospital's clinical divisions, and improved handling of emails, attending to face-to-face contacts, and both phone and Datix enquiries.

At WXH, the emergency department has implemented a number of initiatives to improve patient experience including provision of hot meals and comfort rounding. The Treatment Escalation Spaces have curtains to promote privacy and dignity whilst patients who are deemed suitable wait for beds. Definitive solutions to reduce congestion and associated waiting times are being implemented, in partnership with North East London Foundation Trust.

At SBH, all complaints from families of deceased patients have fed into the SBH End of Life Care Group for consideration. The Group is progressing QI projects which aim to address the types of issue we have seen raised this year, reporting into the hospital Quality and Improvement board.

At WXH, complaints have been used alongside other forms of engagement, for example a World Café focused on Transforming Complaints into Positive Change, which aimed to understand how users want services to respond to feedback and drive meaningful change and will directly inform the hospital's consolidated improvement plan for 2025/26.

6. Learning from complaints (2025/26)

Looking forward to 2025/26, there are opportunities to strengthen the learning opportunities across the Group, some of which are outlined below.

Patient and Community Insight Group

A new Trust-wide Patient and Community Insight Group (PCIG) has launched in June 2025 to provide a forum to triangulate experience of care insight, including complaints themes, to inform areas of focus for improvement across the Trust. There will be a clear process for ensuring themes and trends are fed through to quality improvement and the Quality Management System (QMS). The PCIG will report into the Experience of Care Strategic Oversight Group.

Experience of Care Improvement Framework

The new Experience of Care Improvement Framework (NHS England, 2025) has been published, and a Group-wide self-assessment will be undertaken in 2025. The framework underscores the importance of learning from complaints and PALS alongside other sources of feedback and the maturity matrix will indicate areas for improvement in our processes that will be taken forward through the Complaints Management Improvement Group (see section 8 below).

Experience of Care Strategy (2026-2029)

The current patient experience, engagement, and participation strategy expires at the end of 2025. The areas of focus for the new Experience of Care strategy will be informed by insight, of which complaints and PALS themes are a key source. Triangulated with other feedback, the strategy will ensure there is the structure and accountability in place to inform improvements in experiences of care across the Group.

7. Improving our complaints management processes

The Complaints Management Improvement Group (CMIG) continues to address and adopt solutions to improve the complaints management process across the Group. In 2025/26, in addition to the existing governance structure, exception reports to the Experience of Care Strategic Oversight Group will ensure that more timely escalation and resolution of emerging issues will be put in place and that early senior level oversight and discussion can take place as needed.

In addition, a pathway review will be completed that reports into the Experience of Care Strategic Oversight Group/Quality Board to ensure that our complaints pathway model is as responsive as possible. Utilising internal audit and national framework standards, the review will include reviewing opportunities for digital solutions, and the interface between PALS and complaints service for promotion of early resolution opportunities. It is also noted that early engagement from clinical leaders can reduce the need for patients to utilise formal complaints and early resolution processes in the first place, and how this behavioural practice can be increased will also be considered.

7.2 Complaint response quality audit

As part of our performance quality monitoring and to support continuous improvement in our complaints service, we have developed audit standards based on statutory requirements and our complaints policy. To achieve this, we review the responses to a random selection of reportable complaints closed during the year. In 2024/25, a total of 293 responses were reviewed. **Table 4** below summarises the standards set and the Trust's performance against each. In the majority of cases reviewed, the standards were achieved, with all standards achieving 90% compliance and above.

Table 4.	Standard	Yes	No	Partial
1.	Was a full response provided?	98%	0%	2%
2.	Was our response empathic enough?	99%	0%	1%
3.	Was the Trust's standard template used?	96%	4%	0%
4.	Was adequate signposting to additional information provided?	100%	0%	0%
5.	Was a named contact for further discussion, if required provided?	90%	2%	8%
6.	Was each response quality checked and signed off by a hospital executive?	98%	2%	0%

7.3 Complainant satisfaction audit

The complainant satisfaction audit is important to understand complainant's experiences of our hospital complaints processes to inform improvement. The audit process was devolved from the central complaints team to the hospitals. The audit requires hospitals to contact a random selection of complainants to conduct semi-structured interviews regarding their experience of using our complaints processes.

This year, competing priorities and staffing pressures have meant that hospitals have struggled to complete audits each quarter. A review of the complainant satisfaction audit, including of the effectiveness of the devolution of its

delivery to hospitals will be reviewed by the CMIG and a plan agreed to ensure that these important audits are completed in 2025/26.

7.4 Renegotiating timescales

We recognise that sometimes complex complaints may require additional time to be investigated and responded to. In such cases, discussing delays with complainants and mutually agreeing a renegotiated timescale is necessary.

In 2024/25, we undertook a review of our renegotiation processes and recognised that in some cases, complaints were renegotiated too many times resulting in excessive response delays. As a result of this, we revisited our renegotiation standard operating procedure (SOP) and introduced a limit of two renegotiations. As the change in process embedded and complaints managers made the necessary adjustments, some delays occurred in responding. We do however anticipate this will improve once the process becomes fully embedded.

7.5 Data quality anomalies

NHS Trusts are required to report on complaints activity through the NHS Digital KO41 reporting portal. The Central Complaints Team (CCT) undertake the submission on behalf of the Trust. Data quality plays a crucial part in how we are benchmarked nationally, and we must therefore have the right standard of data quality.

The quality of our complaints data often means that numerous validation errors are encountered when we attempt to upload submission. This necessitates the CCT go through each hospitals' records before submission, to identify anomalies in the data. This takes a considerable amount of time and is reported to the hospitals' governance teams so any data issues can be addressed.

Anomalies identified include incorrect coding, performance data omissions and inaccurate downgrading of records. For example, downgrading of complaints that have been deescalated is best practice; however, this must be marked on Datix so that formal response timescales are deactivated. Where this does not happen, such complaints show up on reports as overdue for as long as the complaint is not downgraded appropriately. Such data anomalies affect performance, inflate the number of complaints reported and takes a lot of time to address at the end of the financial year.

Improving data quality has been identified as a priority area for improvement in 2025/26. Whilst there have been staffing challenges within the hospital teams, it is considered that there are data quality improvements that can be addressed readily to improve service efficiency.

8. Complaints Management Training

In July, we launched our statutory and mandatory digital complaints management training package for staff across the Trust. The three e-learning packages are as follows:

- Level 1 – Early resolution
- Level 2 – Processes, Trust policy and regulations
- Level 3 – An overview for executives

The range of tools within the training cater for diverse learning styles, including videos developed based on patients' experiences in our outpatients' services across our hospitals. The training was shortlisted as a finalist in the 2024 national Patient Experience Network Awards (PENA). In addition, the videos made the Barts Health list of top 100 most-watched videos across the Trust.

Table 5. shows the number of staff compliant with training since its launch. Each hospital has been asked to review their training plan to ensure we have an effective trajectory for compliance for levels 2 and 3.

Table 5. Subject	Staff count	No. compliant	Compliance %
Level 1 – Early resolution	10,615	8,563	80.67%
Level 2 – Policy, procedure, regulations	9,738	5,869	60.27%
Level 3 – An overview for executives	113	40	35.40%
Total	**20,446**	**14472**	**70.78%**

9. Improvement plans

9.2 Update on 2023/24 improvement plan

Each year a complaints improvement plan is agreed and monitored through the CMIG. **Table 6** below lists the key priorities agreed in 2023/24. Detailed information about performance against planned improvements for each hospital can be found in their individual annual reports.

Table 6	Key priority	Lead	Updates
1	Explore opportunities from the Patient & Family Contact Centre (PFCC) approach used during the pandemic to be incorporated systematically into our model to ensure that we are responding to issues as quickly as possible	Director of Quality Governance and Hospital DoNs	This was put on hold as there is a group-wide review pending.
2	Hospital process reviews to ensure consistency, improved quality of responses, as well as oversight and accountability at executive level across the Trust.	Hospital DoN & Hospital Heads of Governance	**Complete** – This was reviewed in the complaints management improvement group and process agreed.
3	Quarterly complainant satisfaction and response quality audits	Hospital Heads of / AD for Governance	This was devolved from the Central Complaints Function to the hospitals and an update is provided in the body of this report._
4	Launch of new complaints training modules and increased visibility across the Trust	Central complaints Team	**Complete –** Three modules developed and live.

9.3 Improvement plan for 2025/26

The key priorities for 2025/26 are outlined in **table 7** below. The improvement plan incorporates priorities previously identified for focus in 2024/25 that have not been completed, alongside key areas that have been identified from learning in 2025/26. The improvement plan will be monitored at CMIG, reporting into Hospital governance teams and the Experience of Care Strategic Oversight Group.

Table 7	Improvement Priority	Lead/ Oversight	Target
1	**Learning from complaints**: Ensure consistent completion of complainant satisfaction audit to enable systematic learning from complainant experience insight.	CCT / CMIG	Quarter 2

2	**Learning from complaints**: Increase reporting on complainant demographic data to understand and improve accessibility of complaints process and inform learning from complaints.	CCT & Hospitals / CMIG	Quarter 3
3	**Learning from complaints**: Ensure complaints themes and trends are triangulated with other insight through the Patient and Community Insight Group (PCIG), with robust process to inform continuous improvement and feed into Quality Management System.	Director of PE & CE / PCIG	Quarter 1
4	**Process**: Review complaints pathway model, including review of opportunities for digital solutions, and the PALS and Complaints interface to increase opportunities for early resolution.	CCT & Hospitals / CMIG / EoC SOG	Quarter 3
5	**Process**: Implement recommendations from NHS England Experience of Care Improvement Framework self-assessments relating to complaints and early resolution.	Director of PE&CE / CMIG	Quarter 4
6	**Process**: Produce Trust-wide SOP for responding to complaints attached to incidents (AARs) to ensure consistency in process.	CCT & Hospitals / CMIG	Quarter 1
7	**Process**: Provide training to address data quality issues.	CCT / CMIG	Quarter 3

10. **Risks**

A failure to learn from Never Events, serious incidents and complaints adversely impacts on quality and safety.

11. **Implications**

It is noted that the improvement plan priorities seek to address areas identified as opportunities to improve the complaints process itself, as well as the structures that support learning from complaints and concerns, to inform continuous improvement in patient experience.

12. **Recommendations**

13. 1 The Board is asked to note the report and endorse the improvement plan priorities.

Report to the Trust Board: 9 July 2025	TB 63/25

Title	Use of the Trust Seal
Sponsoring Director	Trust Secretary
Author(s)	As above
Purpose	To seek Trust Board ratification of use of the Seal, pursuant to Standing Order 21.2.
Previously considered by	n/a

Executive summary

This paper documents the use of the Trust Seal on the following occasions:

26 February 2025

- A deed of settlement between PLACE Group Limited, Oracle Security Services Limited and Barts Health in relation to Security Services provision.

31 March 2025

- A sublease relating to part of basement and third floor, Sir Ludwig Guttman Health and Wellbeing Centre, Stratford, E15 between NHS Property Services Ltd and Barts Health NHS Trust.
- A grant of Easement over land lying to the East of Glen Road Plaistow between Barts Health NHS Trust and Cadent Gas Limited.
- Agreement granting Rights to deploy electronic communications apparatus at The Royal London Hospital, Whitechapel E1 between Barts Health NHS Trust and EE Limited.

23 April 2025

- A right of First Offer Agreement and Lease relating to 4 floor, 125 London Wall, London EC2Y 5AJ between CSC Trustees 2 (Guernsey) Limited and CSC Management (Guernsey) Limited and Barts Health NHS Trust.

Related Trust objectives
n/a

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

Legal implications/ regulatory requirements	The Trust's lawyers were involved in drawing up the documents requiring sealing.

Action required by the Board

The Trust Board is asked to ratify the use of the Seal on the occasions listed above.