Whittington Health
NHS Trust

TRUST BOARD
PUBLIC

14.00 – 17:00
Wednesday 27th June 2018

Whittington Education Centre
Room 7

NHS
Whittington Health
NHS Trust

Meeting	**Trust Board – Public**
Date & time	**27 June 2018 at 1400hrs – 1700hrs**
Venue	**Whittington Education Centre, Room 7**

AGENDA

Members – Non-Executive Directors	**Members – Executive Directors**
Steve Hitchins, Chair Deborah Harris-Ugbomah, Non-Executive Director Tony Rice, Non-Executive Director Anu Singh, Non-Executive Director Prof Graham Hart, Non-Executive Director David Holt, Non-Executive Director Yua Haw Yoe, Non-Executive Director	Siobhan Harrington, Chief Executive Stephen Bloomer, Chief Finance Officer Dr Richard Jennings, Medical Director Carol Gillen, Chief Operating Officer Michelle Johnson, Chief Nurse & Director of Patient Experience

Attendees
Norma French, Director of Workforce
Jonathan Gardner, Director of Strategy, Development & Corporate Affairs
Sarah Humphery, Medical Director, Integrated Care

Secretariat
Kate Green, Minute Taker

Contact for this meeting: Fiona.Smith19@nhs.net

Agenda Item		Paper	Action & Timing
Standing Items			
18/084	**Patient Story** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	*Verbal*	1400hrs
18/085	**Declaration of Conflicts of Interest** *Steve Hitchins, Chair*	*Verbal*	*Review 1420hrs*
18/086	**Apologies & Welcome** *Steve Hitchins, Chair*	*Verbal*	*Review 1425hrs*
18/087	**Draft Minutes, Action Log & Matters Arising 30 May 2018** *Steve Hitchins, Chair*	1	*Approve 1430hrs*
18/088	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Review 1440hrs*
18/089	**Chief Executive's Report** *Siobhan Harrington, Chief Executive*	2	*Review 1450hrs*
Patient Safety & Quality			
18/090	**Serious Incident Report Month 2** *Richard Jennings, Medical Director*	3	*Review 1500hrs*
18/091	**Eliminating Mixed Gender Hospital Inpatient Accommodation – Statement of Assurance 18-19** *Michelle Johnson, Chief Nurse & Director of Patient Experience*	4	*Approve 1510hrs*
18/092	**Whittington Health 'Next steps to outstanding'** *Michelle Johnson, Chief Nurse and Director of Patient Experience*	5	*Review 1520hrs*

18/093	**CNST for Maternity** *Carol Gillen Chief Operating Officer*	6	*Review 1530hrs*
18/094	**Fire Safety update** *Steve Bloomer, Chief Finance Officer*	7	*Review 1540hrs*
Operational Performance and Planning			
18/095	**Financial Performance Month 2** *Stephen Bloomer, Chief Finance Officer*	8	*Review 1550hrs*
18/096	**Performance Dashboard Month 2** *Carol Gillen, Chief Operating Officer*	9	*Review 1600hrs*
Strategy and Governance			
18/097	**Annual Report and Accounts (awaiting NHSI feedback)** *Steve Bloomer, Chief Finance Officer*	10	*Approve 1620hrs*
18/098	**Cyber Security** *Steve Bloomer, Chief Finance Officer* *Leon Douglas, Chief Information Officer*	11	*Receive 1630hrs*
18/099	**Provider License FT4 self-certification and board dates, bi-annual plan and terms of reference annual review** *Jonathan Gardner, Director of Strategy, Development and Corporate Affairs*	12	*Approve 1640hrs*
AOB			
	None notified to the Trust in advance		
Questions from the public on matters covered on the agenda			
	None notified to the Trust in advance		
Date of next Trust Board Public Meeting			
27 June 2018 -1400hrs-1700hrs -Whittington Education Centre, Magdala Avenue, N19 5NF			
Register of Conflicts of Interests: The Register of Members' Conflicts of Declarations of Interests is available for viewing during working hours from Trust Headquarters, Jenner Building, Whittington Health, Magdala Avenue, London N19 5NF or Fiona.smith19@nhs.net or www.whittingtonhealth@nhs.net			

Whittington Health NHS

ITEM: 1
Doc: 18/087

The minutes of the meeting of the Trust Board of Whittington Health held in public at 14.00hrs on Wednesday 30th May 2018 in the Whittington Education Centre

Present:	Stephen Bloomer	Chief Finance Officer
	Carol Gillen	Chief Operating Officer
	Deborah Harris-Ugbomah	Non-Executive Director
	Siobhan Harrington	Chief Executive
	Steve Hitchins	Chairman
	Sarah Humphery	Medical Director, Integrated Care
	Richard Jennings	Medical Director
	Michelle Johnson	Chief Nurse
	Tony Rice	Non-Executive Director
	Anu Singh	Non-Executive Director
	Yua Haw Yoe	Non-Executive Director
In attendance:	Norma French	Director of Workforce
	Kate Green	Minute Taker
	Susan Sorensen	Interim Corporate Affairs Lead

18/68 Patient Story

The Board welcomed patient Dr Jennifer O'Connor, who was accompanied by consultant cardiologist Suzanna Hardman and Matty Asante-Owusu, community sickle cell matron. Patient Experience Manager James Connell was also present. Suzanna explained that that day's patient story followed on from Richard Jennings's presentation of the results of the national heart failure audit at last September's Board meeting.

Jennifer introduced herself as an academic, a lecturer at Middlesex University. She had been diagnosed with sickle cell in the late 1950s, when her parents had been told she was unlikely to live beyond the age of 21. Five years ago she had undergone multiple admissions to ED, ITU and Mary Seacole ward, and her life had consisted of being either at work or in hospital. Between a year and eighteen months ago she had been diagnosed with heart failure and had been admitted to the Whittington Hospital as an in-patient. From that time onwards, her care could only be described as 'incredible'.

Jennifer praised not only the cardiologists but the multidisciplinary team, saying that it was at this stage in her treatment that she understood the complexity of her treatment; it took time, for example, for her medication to be regulated to ensure that no adverse reactions were caused because of the different medications she required. She commended the way Suzanna had become involved in the sickle cell protocols because of the implications these had for her cardiology treatment, and the thoroughness and interpersonal skills demonstrated by the cardiology department, saying that she had ended her time as an in-patient feeling far less frightened of hospitals than had previously been the case.

Invited to comment on any changes that might be made to improve patient experience in future, Jennifer recommended earlier involvement of patients in their care. Specifically in her case, she felt that A&E protocols required attention, adding that she had on occasion been left for several hours without pain relief therefore pain management was also key.

Board members asked questions about communications with general practice and engagement with the third sector. Jennifer informed Board members that her position as an academic gave her opportunities for educating students suffering from sickle cell about what to expect from a university environment. She also enquired what would happen to her 'patient story. Replying, Steve Hitchins said that all patient stories contributed to Board members' learning as well as helping to identify areas for improvement. He hoped in time that patient stories might be posted on the internet.

Steve thanked Jennifer, Suzanna and Matty for attending to recount Jennifer's story. He also encouraged Board colleagues to visit Matty's service in the community.

18/69 Declaration of Conflicts of Interest

69.01 No member of the Board declared any interest in any of the business to be transacted that afternoon.

18.70 Welcome and apologies

70.01 Steve Hitchins welcomed everyone to the meeting, and especially Sarah Humphery, attending her first Board meeting as newly-appointed Medical Director for Integrated Care. Apologies for absence were received from David Holt, Jonathan Gardner and Janet Burgess.

18/71 Minutes, Matters Arising & Action Log

71.01 Referring to minute 54.07, Michelle asked for an amendment to the second line so that it would read 'the national campaign to encourage patients'. Other than this, the minutes of the public Trust Board meeting held on 25th April were approved.

Action log

71.02 13.02: The assurance report on fire training would be brought to the June Board. Siobhan reported that over 400 fire marshals had now been trained.

71.03 All other items on the action log were scheduled for discussion either that afternoon or for later in the year. Long-term financial planning would be discussed at the October Board.

18.72 Chairman's Report

72.01 Steve Hitchins began his report by thanking Susan Sorensen for so ably covering the corporate affairs lead post pending the appointment of a substantive post. He went on to report on meetings and events he had participated in since the last meeting, as follows:

- with Siobhan, meeting the new Cabinet members for health and social care for the local authorities
- meeting the community providers for the sickle cell service and attending the House of Commons launch
- World Thalassaemia Day on 8th May
- visits with Dorian Cole to discuss bullying and harassment
- a meeting with Professor Duncan Lewis to discuss his work on the cultural survey
- a very well attended meeting about babies in N19
- The ED theatre performance (starring the Medical Director) focusing on scenario planning
- a meeting with 'Ambitious about Autism'

72.02 Future events and plans included:

- issuing an invitation to all new local authority councillors to visit Whittington Health in September
- attendance at the 500th anniversary concert celebrating Richard Cloudesley's legacy in Islington
- issuing an invitation to the all-party group on sickle cell and thalassaemia to visit Whittington Health later in the year
- the Trust's Open Day on 5th July, timed to commemorate the 70th anniversary of the NHS.

72.03 The Trust had made two nominations for the commemoration of the Windrush anniversary; both had been shortlisted.

18/73 Chief Executive's Report

73.01 Siobhan had circulated a written report, from which she highlighted the following:

- the issuing of a communication from the centre about the convergence of NHSI with NHSE which would mean that the system of regulation was likely to change over the next few months
- the Carter report on operational productivity, which contained some very positive comments about integrated care, but also had some hard hitting messages about productivity
- the Haringey & Islington Wellbeing Partnership had held a good whole morning meeting for 65-70 local leaders including primary care, local authority and finance; more detail on this would be brought to the June Board meeting.

73.02 This month's report stated that the Trust's contract with its local commissioners had been agreed, but Siobhan informed the Board that although there had been a point where agreement had been reached, a subsequent communication from commissioners had necessitated further negotiation. The report also showed that at the end of Month 1 the Trust was behind its planned position, and every effort would be made to ensure the organisation ended the first quarter of the new financial year in a more positive way.

73.03 ED performance stood at 86.32% in April. An escalation meeting had taken place on 9th May, which Siobhan said had been constructive, and had ended with the Trust being encouraged to be ambitious and to meet the 95% target by September. Siobhan said that one factor influencing performance had been difficulties in staffing ED during late evenings and nights, and work was under way to address this.

73.04 Reporting on the ICSU restructuring, Siobhan informed the Board that the Trust was now entering into the final two weeks of the process and that most interviews had now been conducted. There were likely to be some gaps, and a process for filling these would be brought into place shortly.

73.05 Following the private April Board meeting, Richard Jennings had brought a paper to the Board which proposed a change in the position of Responsible Officer for the Trust from Richard Jennings to Rob Sherwin. It was noted that this paper had been erroneously included in the papers for the private Board meeting, whereas it should have been a public Board paper, and should therefore be made available alongside the other public board papers on the internet together with the corresponding minute of the discussion at the private Board. Richard had clarified the forms of assurance for revalidation and fitness for practice. He reported that the GMC was happy with the split. The Board

formally approved this change. It was agreed that the relevant policies would be changed to enable Rob Sherwin to take over the case management as Responsible Officer with effect from 1st August 2018.

73.06 Siobhan concluded her report by congratulating Julie Belbin, Family Health Advisor at River Place Health Centre for gaining an Excellence Award. She also congratulated Ali Kapasi and his team for ensuring that the new GDPR regulations brought into place the previous day had been successfully implemented.

18/74 Serious Incident Report

74.01 Introducing this item, Richard Jennings said that the report contained details of serious incidents reported during April 2018, as well as providing some insight into the learning from closed cases.

74.02 Richard also informed the Board that during May, some incidents had been reported within surgery. Whilst these incidents had been quite different in nature, there had been a common theme around communications and handover, and concerns had been expressed that the Trust had not yet achieved the right model for its surgical service. It had therefore been decided there should be some external facilitation working with the surgeons to address this and to help co-create a model for the future. This was a high priority, and welcomed by consultants who were responsible for leading the way in developing these changes.

74.03 In answer to a question from Deborah Harris about the involvement of multi-disciplinary colleagues, Richard acknowledged the validity of the point, but said that it was important to guard against the group becoming too big and therefore unwieldy. Siobhan echoed this, saying that it was important that the senior consultants worked together on this. In answer to a question from Sarah Humphery about the mediation process, Norma replied that one to one interviews would be conducted with all relevant staff prior to the mediation exercise. She added that good examples of this type of working could be seen throughout the Trust.

18.75 Learning from deaths Quarter 3 Report

75.01 Richard began by thanking Julie Andrews who had written the report, which was intended to provide the Board with the appropriate level of assurance on the process the Trust was running as well as its performance and the learning achieved. He felt that this should be viewed as a significant success story, since procedures were now fairly robust and delivery smooth.

75.02 Graham Hart praised the quality of the report, but felt that it highlighted two important service issues, the first (para 5i)d) on page 7) was that the Trust was not yet meeting its target for electronic discharge summaries, and the second was that there were still improvements to be made to the end of life care service. It was noted that Anna Gorringe was submitting a bid to Macmillan for additional support, but there was still a need to spend more time in consideration of this. It was noted that the after death proforma had been developed locally on Nightingale Ward, then held up as an example of good practice which could be implemented Trust-wide.

18.76 Quality Account

76.01 Michelle Johnson introduced this item, informing Board members that this year's Quality Account had now been professionally designed by Juliette Marshall (to whom thanks were due). The content had been approved by the Quality Committee, and the process

for its production by the Audit & Risk Committee. There had also been a discussion at a recent Board seminar, which had focused on the Trust's priorities for 2018/19.

76.02 At the time of writing external feedback had been received from all bar the Trust's commissioners and KPMG (external auditors), plus approved CQUIN data which was being actively chased. Michelle expressed huge thanks to Wayne Blowers for his authorship of the document which had, she said, been carried out exceptionally well. Deborah added that she was aware the external auditors held Whittington up as an exemplar for the way this document was produced (this for the second year running) and she congratulated the executive team for this.

76.03 In answer to a question from Siobhan about whether any particular aspect of the Quality Account had been highlighted by the commissioners, Michelle said that they had largely focused on patient experience. Anu reported that there had been a good and productive discussion about the Quality Account at Quality Committee, but she had been concerned that some colleagues had found it difficult to submit comments. Michelle replied that she would be holding a stakeholder event in September, to which all of the ICSU triumvirates would be invited.

18/77 Financial Report

77.01 Stephen Bloomer informed the Board that the Trust had ended Month 1 £96k behind plan, declaring a £400k deficit. He was clear that if the Trust was to end the year with a surplus, there was a pressing need to significantly improve the run rate. One of the key drivers was the continued use of escalation beds – which in turn led to pressure on pay – therefore the longer those beds stay open the greater the pressure. There was also an associated risk to quality of care, which was generally the case with temporary wards.

77.02 In answer to a question from Tony Rice about what needed to be done to close these beds, Carol described the process followed, which in the short term involved looking at the various metrics (over 7 days, delayed discharge etc.) and in the longer term a piece of work modelling capacity. Stephen Bloomer added that there was also a need to look at how winter pressures were managed in future since funding streams were unlikely to be forthcoming in the way they were at present.

18/78 Performance Dashboard

78.01 Carol Gillen introduced the highlights from the performance dashboard covering the first month of 2018/19. She referred back to the ED escalation meeting referred to in the Chief Executive's report, where the key priority was the action plan, one strand of which referred to workforce capacity, particularly in the evenings and nights. The department was heavily reliant on good locum grades.

78.02 There was however good news in that there was to be an increase in staffing including the return of two consultants from maternity leave, and Carol expected to see further improvement from June. Another key factor was the management of 'front of house', and discussions were taking place with the commissioners about increasing GP capacity in the evenings and at weekends. There was also scope for directing more patients into ambulatory care. NHSI/NHSE fully expected the Trust to achieve the 95% ED target by September 2018.

78.03 All cancer targets had been met in-month, with the main national focus being on the 4 week target. RTT was on track with work in hand to continue to reduce delays. Good progress was being made with the health visiting service in Islington, but further work needed to be done in Haringey. In June the Board would receive a more detailed community dashboard.

78.04 Moving to workforce issues, it was noted that good progress continued to be made on recruitment, and Michelle added that there was now a renewed focus on the Trust's retention plan. Good inroads have been made into mandatory training, but there was a need to improve the position on appraisal rates.

78.05 Referring to the safe staffing section of the dashboard, Michelle Johnson confirmed that eighteen red shifts had been declared during the month, but none had constituted any harm. There had been over usage of HCAs, due both to a shortage of nurses and the need for one to one specialling of patients.

78.06 Implementation of ERS had reached 87%, which was an extremely good achievement, and the Trust had received a complimentary e-mail from NHS Digital. On the subject of compliments, the Board noted a comment from a patient (page 8) which read "I have enjoyed it here and I didn't want to go"!

78.07 Siobhan queried some of the figures relating to community waits, and Carol agreed that if there was any possibility of data anomalies figures needed to be revalidated. Siobhan also said that there needed to be some action around children's services and asked for an exception report. It was noted that a Community Dashboard would come to the June Board. Sarah Humphery reported on a conversation she had held with Jane Jones regarding health visitors having been moved without any consultation having taken place with GPs.

18/79 Remuneration Committee Terms of Reference

79.01 Norma French presented revised terms of reference for the Remuneration Committee which she had prepared in advance of the meeting scheduled for next month. She agreed to check that provision had been made for 'virtual meetings / chairman's action should action be required between formally scheduled meetings. Deborah Harris had some minor additional comments which she would submit outside the meeting. Subject to these, the renewed terms of reference were formally agreed. It was noted that NHSI guidance had been incorporated.

18/80 Board Assurance Framework
18/81 Risk Register Summary Report

80.01 Steve Hitchins informed the Board that it had been suggested the Board Assurance Framework (BAF) be reviewed alongside the Risk Register in order for the Board to have the opportunity to scrutinise the two side by side. This had been discussed at the April Board seminar, and also incorporated discussion about the manner in which these documents related to the Board sub-committee risk registers.

80.02 During discussion the following points were raised:

- NEDs should be responsible for approving the process rather than the detail and should be removed from the list of executive leads
- risks should be submitted to the relevant sub-committees for review
- further consideration needed to be given to the level of appetite for complex risks and situations
- further discussions were required at local level prior to submission of the documents to the assurance committees
- all relevant documents should be reviewed annually and the BAF every six months
- strategic objectives and goals needed to be reviewed and aligned with the BAF

- some of the new items on the risk register might need to be added to the BAF - this might be an item for discussion at a future Board seminar.
- Committees needed to provide statements of the assurance to the Board

80.03 Helen Taylor would put together a paper describing the process. Tony Rice commended her on the quality of the papers submitted.

81.01 Michelle reminded the Board that she had yet to add known mitigations to the risk register, adding that she had completed a considerable amount of work with Adrien Cooper to ensure compliance. Radiology, for example, had considerably reduced as a risk.

81.02 The implementation of ERS had proceeded smoothly to date, and a considerable amount of work had been carried out with Medical Records, although there was further work to do. Bed occupancy and flow had been discussed earlier in the meeting. It was noted that delivery of the estates strategy was contained within the BAF.

81.03 The Board approved the BAF.

18/82 Provider Licence Self-Certification

82.01 The Trust is required to submit an annual provider licence self-certification, and this year's submission had been scrutinised by the executive team in order to ensure any possible gaps in compliance were highlighted so they could be addressed. One such gap was the failure to meet the 4-hour target in ED; however there was already a planned trajectory for meeting this target.

82.02 It was agreed that the Chairman should sign the declaration as proposed.

18/83 Sub-committee minutes

83.01 From the minutes of the Quality Committee held on 9th May, Anu Singh highlighted the following discussions held:

- engagement with the Quality Account
- the downgrading of risks associated with the LUTS clinic
- some equipment not having been added to the asset register.

83.02 At the Workforce Assurance Committee Graham Hart had welcomed the addition of the 'deep dive' into ICSU workforce issues (on this occasion, Integrated Medicine) which he said provided a far stronger picture of life on the ground. Graham was also discussing with Norma how the committee should look at workforce planning.

18/84 Any other business

84.01 It was noted that the final accounts had been submitted to the Audit & Risk Committee the previous day; they had not been circulated as a public Board paper due to the fact that they had not yet been seen by NHSI. The Board could be assured, however, that the Head of Audit had commented favourably on improvements made, and it appeared likely that the external auditors would also give their positive approval. The Board congratulated the finance team for their considerable efforts in submitting the accounts .

Any other business

There being no other business, the meeting conclude at 4.30pm.

Action Log

Minute	**Action**	**Date**	**Lead**
13.02	Training need – to increase number of fire marshals in appropriate locations across the Trust. Assurance report to Board within six months and annually thereafter.	June 2018	SB
35.04	Nursing Establishment Review to be carried out in April with report to Board in June.	June 2018	MJ
40.05	Action plans arising from the Staff survey to be brought back to the Board following discussion at the Workforce Assurance Committee	Sept 2018	NF
73.05	Implement change in Responsible Officer to take over case management	July 2018	NF
78.07	Community dashboard to be produced with exception report on children's community services	June 2018	CG

Whittington Health NHS Trust

Trust Board

28 March 2018

Title:	Chief Executive Officer's Report for the Trust Board		
Agenda item:	**18/089**	**Paper**	**02**
Action requested:	For discussion and information		
Executive Summary:	The purpose of this report is to highlight specific issues to the Trust Board and to update the Board on local, regional and national key issues facing the Trust		
Summary of recommendations:	To note the report		
Fit with WH strategy:	This report provides an update on key issues for Whittington Health's strategic intent		
Reference to related / other documents:	Whittington Health's regulatory framework, strategies and policies		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Risks captured in risk registers and/or Board Assurance Framework		
Date paper completed:	22 June 2018		

Author name and title:		**Fiona Smith Communications & engagement lead**		**Director name and title:**		**Siobhan Harrington, Chief Executive**	
Date paper seen by EC n/a	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

CHIEF EXECUTIVE OFFICER REPORT

The purpose of this report is to highlight issues and key priorities to the Trust Board.

NEWS

Additional funding for the NHS

I was invited to attend the Prime Minister's speech to NHS leaders setting out the government's proposals for a long-term funding settlement and a ten year plan for the NHS. The government announced the NHS England budget would increase by 3.4% a year on average over the next five years.

House of Commons Health and Social Care Committee Report on Integrated Care

The House of Commons Health and Social Care Committee have undertaken an inquiry into integrated care: organisations, partnerships and systems.

The report indicates that the committee supports the move away from a competitive landscape of autonomous providers towards a more integrated collaborative, placed-based care.

The report finds that understanding of the changes has been hampered by poor communication and this has caused suspicion of the underlying proposals and missed opportunities for the co-design of local systems that work more effectively together in the best interests of service users.

The report recommendations aim to achieve more coordinated, person-centred and holistic care for patients, particularly patients with long-term conditions.

The committee makes the following recommendations:

The Government and national leaders should:

a) Develop a national transformation strategy backed by secure long-term funding to support local areas to accelerate progress towards more collaborative, place-based and integrated care;
b) Commit to a dedicated, ring-fenced transformation fund;
c) Explain the case for change clearly and persuasively, including why it matters to join up services for the benefit of patients and the public.
d) Alongside these changes, the Government should facilitate national bodies to work with representatives from across the health and care community, who should lead in bringing forward legislative proposals to overcome the current fragmentation and legal barriers arising out of the Health and Social Care Act 2012. These proposals should be laid before the House in draft and presented to us for pre-legislative scrutiny.

The report sets out areas where legislative change may need to be considered, including:

- a statutory basis for system-wide partnerships between local organisations;
- potential to designate ACOs as NHS bodies, if they are introduced more widely;
- changes to legislation covering procurement and competition;
- merger of NHS England and NHS Improvement; and
- Care Quality Commission's regulatory powers.

NHS Windrush Awards

Comfort Offorjindu, a Midwife at Whittington Health, was honoured with a Lifetime Achievement award at the NHS Windrush 70 awards. Comfort won the award based on her passion and dedication to midwifery and nursing over her career.

Eddie Kent, Security Guard at Whittington Health, who was shortlisted for an NHS Windrush award for his work in promoting Black History Month every year, narrowly missed winning in the Unsung Hero award.

HSJ Value Awards

The Whittington Health District Nursing Team won the HSJ Value Award for 'Community Health Service Redesign' for their work introducing eCommunity. eCommunity helps to improve capacity and demand management, ensuring all patients seen on time and reduces unallocated visits and administration. Because of greater efficiency the team have managed to reduce avoidable pressure ulcers and increased patient satisfaction. They won great praise from the judges, who said: "The judges were unanimous in their view that this service redesign not only meets the criteria but demonstrates a particularly strong focus on patient safety, whilst covering a number of additional areas, including agile working, developing nursing skills and increasing productivity."

Healthcare People Management Association Awards

The Whittington Health HR team, together with UCLH, won the 'Innovation in HR' award at the Healthcare People Management Association annual awards for their work together in developing a new arrangement to allow staff to work at either trust without repeating a lengthy process. Patients and staff are already benefitting from this arrangement, with Whittington Health staff providing the UCLH@home service, based on Whittington Health's innovative Hospital@Home, where patients can be discharged to continue receiving care in their own home, but still under the care of a consultant.

I would like to congratulate our successful colleagues on behalf of the Board. I thank them all for living our ICARE values and for being outstanding representatives of Whittington Health.

QUALITY AND SAFETY

Emergency Pathway

Performance against the 95% target for May was 88.4%. This was lower than May 2017 which was at 93.5%.

Activity has increased on the same period as last year by 5.7%, 9228 attendances (May 18) against 8700 (May 17). Ambulance activity was up by 10.5% compared to the same time last year; 1820 (May 18) compared to 1629 (May 17).

Additionally there are a higher number of complex DTOCS and increase in number of over 75s admissions on the same period as last year.

The ICSUs are implementing the Trusts ED improvement plan. The Trust is working with key stakeholders to maintain a continued focus on reducing stranded (over 7 days) and super stranded (over 21 days) patients, and there has been good progress in reducing the latter from 18% to 14% of the hospital bed base. The Trust is expected to reduce long stay patients by a 25% by December 2018.

Cancer 62 days

The trust has missed the 62 day target by 1%. Performance was 84% against the national target of 85%. The specialities affected were Gynaecology due to patient education and Urology due to the prostate pathway. Improvement actions are underway

Community services

The Board will have an opportunity to review in more detail performance in Community Services, as an extended community access report has been included in the performance report. There is focused work with our commissioners to improve waiting times across specific community services.

FINANCIAL

May Financial Position

The Trust is reporting a £0.5m deficit for the period to the end of May (month 2) against a planned £0.3m deficit. Actual performance therefore represents an adverse variance of £0.2m.

The key driver for the adverse variance is the income performance, particularly elective and day case activity. In addition, the Trust has projected the loss of the Provider Sustainability Funding relating to A&E performance for the first quarter.

These adverse variances are partially mitigated by underspends in pay and non-pay. Although, there are significant challenges with escalation beds remaining open longer than planned and the resulting contribution this is adding to the Trusts agency spend. The agency costs are in excess of £2m at the end of May against a set ceiling spend for the year of £8.8m.

The Trust is currently awaiting confirmation of the capital allocation it will be allowed to spend for 2018/19. A revised operating plan submission is due 20th June.

OPERATIONAL MANAGEMNT CHANGES

The five ICSUs come into operation on 1 July. They are:

- Surgery and Cancer
- Emergency and Integrated medicine
- Community Health for adults
- Children and Young People Services
- Women's Health, Outpatients and Diagnostics

The majority of leadership positions have been filled and recruitment has commenced to vacant posts.

EXCELLENCE AWARD

I have great pleasure in announcing that this month's staff excellence award goes to Anne-Marie Campbell, Discharge Flow Co-Ordinator.

Anne-Marie was nominated by the team across the Jeffrey Kelson Unit (JKU), care of older adults wards).

Anne-Marie's role is to facilitate complex discharges. She liaises with social services, district nurses, equipment providers and the patient and their family. Her colleagues say that she "will do just about anything that's required to help to get patients back home".

Annemarie joined the organisation in 2010 as an administrator in the hospital social work department. When the Islington social work team moved out of the hospital we took the opportunity to keep Anne-Marie and her invaluable skills and knowledge to develop the role of the discharge Flow Co-Ordinators.

Ruth Law, Consultant Geriatrician says "Anne-Marie is so cheerful, organised and helpful and has a fabulous 'can do' attitude with our complex discharge planning. Her knowledge of all the pathways is encyclopaedic! We always know it is going to be a good day when Anne-Marie is around but she is extremely modest and doesn't realise how much she is appreciated"

Alison Kett, Head of Nursing (Integrated Medicine) says "Anne-Marie is truly amazing".

Siobhan Harrington
Chief Executive

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NHS
Whittington Health
NHS Trust

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Trust Board

June 2018

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**18/090**	**Paper**	**3**
Action requested:	It is recommended that the Board recognises and discusses the assurances contained within this report that the serious incident process is managed effectively, and that lessons learnt as a result of serious incident investigations are shared widely.		
Executive Summary:	This report provides an overview of serious incidents (SI) submitted externally via Strategic Executive Information System (StEIS) during May 2018. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis. The Board is invited to consider focussing discussion on: • Steps being taken to learn from incidents in surgery and intensive care, • Further ways in which we might disseminate learning and be assured that we are learning.		
Fit with WH strategy:	1. Integrated care 2. Efficient and Effective care 3. Culture of Innovation and Improvement		
Reference to related / other documents:	• Supporting evidence towards CQC fundamental standards (12) (13) (17) (20). • Ensuring that health service bodies are open and transparent with the relevant person/s. • NHS England National Framework for Reporting and Learning from Serious Incidents Requiring Investigation, • Whittington Health Serious Incident Policy. • Health and Safety Executive RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013).		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	**Corporate Risk 636.** Create a robust SI learning process across the Trust. Trust Intranet page has been updated with key learning points following recent SIs and RCA investigations.		
Date paper completed:	1 June 2018		

Author name and title:		**Jayne Osborne, Quality Assurance Officer and SI Co-ordinator**		**Director name and title:**		**Richard Jennings, Medical Director**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Serious Incident Monthly Report

1. Introduction

This report provides an overview of serious incidents submitted externally via Strategic Executive Information System (StEIS) during May 2018. This includes serious incident reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.

2. Background

The Serious Incident Executive Approval Group (SIEAG), comprising the Executive Medical Director/Associate Medical Director, Chief Nurse and Director of Patient Experience, Chief Operating Officer, Head of Governance and Risk and SI Coordinator meet weekly to review Serious Incident investigation reports. In addition, high risk incidents are reviewed by the panel to determine whether these meet the reporting threshold of a serious incident (as described within the NHSE Serious Incident Framework, March 2015).

3. Serious Incidents

3.1 The Trust declared eight serious incident during May 2018, bringing the total of reportable serious incidents to 14 since 1st April 2018.

All serious incidents are reported to North East London Commissioning Support Unit (NEL CSU) via StEIS and a lead investigator is assigned to each by the Clinical Director of the relevant Integrated Clinical Support Unit.

All serious incidents are uploaded to the National Reporting and Learning Service (NRLS) in line with national guidance and CQC statutory notification requirements.

3.2 The table below details the Serious Incidents currently under investigation

Category	Month Declared	Summary
Unexpected Admission to NICU Ref:8303	April 18	Term baby born in poor condition and admitted to NICU and subsequently transferred to a tertiary unit. Possible hypoxic injury, prognosis unknown at present.
Unexpected Admission to NICU Ref:8308	April 18	Full term baby born in very poor condition, admitted to NICU and subsequently died.
Confidential Information Breach Ref:8896	April 18	Staff member's medical record inappropriately accessed by another staff member.
Patient Fall Ref: 9654	April 18	A patient sustained a fractured femur following a fall whilst being restrained by hospital security.
Confidential Information Breach Ref:10532	April 18	A set of patient records could not be located after they were received from

Category	Month Declared	Summary
		storage in November 2017.
Treatment Delay Ref:12146	May 18	Following elective laporoscopic cholescystectomy surgery a patient was returned to theatre due to a suspected injury to the common bile duct.
Treatment delay Ref:12153	May 18	A patient developed septic shock five days post-surgery and was returned to theatre requiring a laparotomy.
Diagnostic Incident including delay Ref:12155	May 18	Patient was returned to theatre following an appendectomy due to developing abdominal sepsis.
Diagnostic Incident including delay Ref:12811	May 18	A delay in diagnosing a lung malignancy.
Unexpected Admision to NICU Ref: 13327	May 18	A baby was born in poor condition and transferred to Neonatal Intensive Care Unit (NICU). The baby is now on a palliative care pathway.
Return to theatre Ref:13332	May 18	A patient had surgery for a hiatus hernia, and there was an apparent delay in recognising that the patient needed to return to theatre for a complication.
Unexpected Neonatal Death Ref:13530	May18	Unexpected neonatal death following an emergency Caesarian section and prolonged neonatal resuscitation.
Unexpected death Ref:13561	May 18	A patient who was seen and discharged from the Emergency Department after being seen by the Mental Health Liason Team was readmitted as an emergency and subsequently died.

3.3 The table below detail serious incidents by category reported to the NEL CSU between April 2017 – March 2018.

STEIS 2017-18 Category	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total
Safeguarding	0	0	0	0	0	0	0	1	0	0	0	0	1
Attempted self-harm	0	0	0	0	0	0	0	0	0	0	0	0	0
Confidential information leak/loss/IG Breach	0	0	1	1	0	1	0	0	0	0	0	0	3
Diagnostic Incident including delay	0	1	1	1	1	0	1	1	0	1	0	0	7
Disruptive/ aggressive/ violent behaviour	0	0	0	0	0	0	1	0	0	0	0	0	1
Environment Incident meeting SI criteria	0	0	0	0	0	0	0	0	0	1	0	0	1
Failure to source a tier 4 bed for a child	0	0	0	0	0	0	0	0	0	0	0	0	0
Failure to meet expected target (12 hr trolley breach)	0	0	0	0	0	0	0	0	0	0	0	0	0
HCAI/Infection control incident meeting SI criteria	0	0	0	0	0	0	0	0	0	2	0	1	3

Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	0	1	0	0	0	0	1	0	0	0	0	0	2
Maternity/Obstetric incident mother only	0	0	0	0	1	0	0	0	0	0	0	0	1
Medical disposables incident meeting SI criteria	0	0	0	0	0	0	0	0	0	0	0	0	0
Medication Incident	0	0	0	1	0	0	0	0	0	0	0	0	1
Nasogastric tube	0	0	0	0	0	0	0	0	0	0	0	0	0
Slip/Trips/Falls	0	1	0	0	2	0	1	0	0	1	0	1	6
Sub Optimal Care	0	0	1	0	0	0	0	0	0	0	1	0	2
Treatment Delay	1	1	0	0	0	1	0	0	0	1	0	0	4
Unexpected death	1	0	1	0	0	0	1	0	0	1	0	0	4
Retained foreign object	0	0	0	0	1	0	0	0	0	0	0	0	1
HCAI\Infection Control Incident	0	0	0	0	1	0	0	0	0	0	0	0	1
Total	**2**	**4**	**4**	**3**	**6**	**2**	**5**	**2**	**0**	**7**	**1**	**2**	**38**

3.4 The table below details serious incidents by category reported to the NEL CSU between April 2016 – April 2018

STEIS 2017-18 Category	2016/17 Total	2017/18 Total		Apr 18	May 18	Total 18/19 ytd
Safeguarding	5	1		0	0	0
Apparent/actual/suspected self-inflicted harm meeting SI criteriarm	1	0		0	0	1
Confidential information leak/Information governance breach	6	3		2	0	2
Diagnostic Incident including delay	8	7		0	2	2
Disruptive/ aggressive/ violent behaviour	0	1		0	0	0
Environment Incident meeting SI criteria	0	1		0	0	0
Failure to source a tier 4 bed for a child	1	0		0	0	0
Failure to meet expected target (12 hr trolley breach)	1	0		0	0	0
HCAI/Infection control incident meeting SI criteria	0	3		0	0	0
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	7	2		2	2	4
Maternity/Obstetric incident mother only	2	1		0	0	0
Medical equipment/devices/ disposables incident meeting SI criteria	1	0		0	0	0
Medication Incident	0	1		0	0	0
Nasogastric tube	1	0		0	0	0
Slip/Trips/Falls	7	6		1	0	1
Sub Optimal Care	4	2		1	0	1
Surgical/invasive procedure incident meeting SI criteria	0	0		0	1	1
Treatment Delay	3	4		0	2	2
Unexpected death	10	4		0	1	0
Retained foreign object	1	1		0	0	0
HCAI\Infection Control Incident	0	1		0	0	0
Total	**58**	**38**		**6**	**8**	**14**

4. Submission of SI reports

All final investigation reports are reviewed at the weekly SIEAG meeting chaired by an Executive Director (Executive Medical Director or Chief Nurse and Director of Patient Experience). The Integrated Clinical Support Unit's (ICSU) Operational Directors or their

deputies are required to attend each meeting when an investigation from their services is being presented.

The remit of this meeting is to scrutinise the investigation and its findings to ensure that contributory factors have been fully explored, root causes identified and that actions are aligned with the recommendations. The panel discuss lessons learnt and the appropriate action to take to prevent future harm.

On completion of the report the patient and/or relevant family member receive a final outcome letter highlighting the key findings of the investigation, lessons learnt and the actions taken and planned to improve services. A 'being open' meeting is offered in line with Duty of Candour recommendations.

The Trust has executed its duties under the Duty of Candour for the investigations completed and submitted in May 2018.

Lessons learnt following the investigation are shared with all staff and departments involved in the patient's care through various means including the Trust wide Spotlight on Safety Newsletter, 'Big 4' in theatres, and 'message of the week' in Maternity, and '10@10' in Emergency Department. The 'Big 4' is a weekly bulletin containing four key safety messages for clinical staff in theatres; this is emailed to all clinical staff in theatres, as well as being placed on notice boards around theatres. Learning from identified incidents is also published on the Trust Intranet making them available to all staff.

4.1 The Trust submitted two reports to NELCSU during May 2018.

The table below provides a brief summary of lessons learnt and actions put in place relating to a selection of the serious incident investigation reports submitted in May 2018. The Trust had seven reports due for submission of which six were submitted and one extension was given by the CCG due to waiting for the final London Ambulance Service NHS Trust (LAS) report to complete the RCA investigation.

Summary	Actions taken as result of lessons learnt include;
Ref:2655	A fire broke out in the Whittington hospital which was contained in the basement area of the PFI Building storage room. The smoke was distributed into the ventilation system resulting in the evacuation of the affected areas. No staff or members of the public were harmed. • The storage of lithium batteries has been reviewed across the trust to ensure best practice standards are maintained. • This incident underlined the importance of training an appropriate number of fire wardens. At the time of this incident there were around 100 fire wardens trained. The trust has increased this number to 450 fire wardens as of June 2018 with the intent to train more to ensure apprpriate levels are maintained throughout the trust.
Ref: 4863	Sub-optimal Care of deteriorating patient (Unexpected death) An intubated patient removed their own endotracheal tube (self-extubated), when close supervision should have prevented this. The patient subsequently dies, although it was not felt by the investigating team that the death was clearly attributable to the

Summary	Actions taken as result of lessons learnt include;
	self-extubation. • Local best practice guidelines are being updated and implemented to improve the understanding and awareness of nursing responsibilities when caring for the ventilated patient. This practice will be regularly audited against the new guidance and feed back given to the multidisciplinary team at the unit meetings. Regular teaching sessions are also being undertaken on the unit team days. • A standard Operating Procedure (SOP) is being developed to formalise and strengthen the risk assessment process of nurse/patient allocation including the management of breaks. • A full risk assessment must be completed before mittens are applied to a patient and all decisions made must be documented.

5. Shared learning

In order to ensure learning is shared widely across the organisation, a dedicated site has been created on the Trust intranet detailing a range of patient safety case studies. The Trust also runs a series of multi-disciplinary learning workshops throughout the year to share the learning from serious incidents and complaints, and learning is disseminated through 'Spotlight on Safety', the trust wide patient safety newsletter. Themes from serious incidents are captured in quarterly learning reports and an annual review, outlining areas of good practice and areas for improvement and trust wide learning.

The learning from the serious incidents references 1986 and 1980 declared in January 2018 is described in the April 2018 Public Trust Board paper "Quarterly Safety and Quality Board Report. Quarter 4 2017/18 (01 January 2018 – 31 March 2018)".

6. Summary

The Trust Board is asked to note the content of the above report which aims to provide assurance that the serious incident process is managed effectively and lessons learnt as a result of serious incident investigations are shared widely.

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Whittington Health Trust Board

Title:	**Eliminating Mixed Gender Hospital Inpatient Accommodation Statement of Assurance 18-19**		
Agenda item:	**18/091**	**Paper**	**4**
Action requested:	To discuss and approve statement		
Executive Summary:	This paper provides a statement of assurance that patients who require inpatient/day case care are cared for in single gender accommodation. Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. Patients who are admitted to hospital will only share the room or ward bay where they sleep, with members of the same gender, and same gender toilets and bathrooms will be close to their bed area. Sharing with members of another gender will only happen by exception based on clinical need (for example where patients need specialist care or equipment is needed such as in the high dependency cardiac care unit (Montuschi Ward,) and critical care unit or when patients choose to share for instance in chemotherapy or thalassaemia unit) or through agreement between staff and patient based on patient dignity.		
Recommendations:	• The statement of assurance is agreed by the Trust Board and then published onto the Trust Internet and Intranets • Any monthly reporting of breaches are contained within the Trust Board Performance Report as reported to commissioners		
Fit with WH strategy:	Aligns to clinical strategy		
Reference to related / other documents:	Complies with our regulatory framework and statutory duty NHS Standard Contract		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured on relevant risk registers as relevant		
Date paper completed:	12th June 2018		

Author name and title:		**Michelle Johnson Chief Nurse**		**Director name and title:**		**Michelle Johnson Chief Nurse**	
Date paper seen by EC	**N/A**	**Equality Impact Assessment complete?**	**Y**	**Risk assessment undertaken?**		**Legal advice received?**	**N**

Eliminating Mixed Gender Hospital Inpatient Accommodation Statement of Assurance 18-19

1. BACKGROUND

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. Whittington Health NHS Trust is committed to providing every patient with same gender accommodation because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.

Patients who are admitted to hospital will only share the room or ward bay where they sleep, with members of the same gender, and same gender toilets and bathrooms will be close to their bed area. Sharing with members of another gender will only happen by exception based on clinical need (for example where patients need specialist care or equipment is needed such as in the high dependency cardiac care unit (Montuschi Ward) and critical care unit or when patients choose to share for instance in chemotherapy or thalassaemia unit) or through agreement between staff and patient based on patient dignity.

The term 'gender' is used in this statement to refer to an individual's sense of themselves and is based on an understanding of gender as a biopsychosocial[1] developed aspect of identity. Gender describes a part of a person's identity which is wider than their biological or legal sex.

The Trust recognises that some patients (referred to as trans patients) may have changed, or be in the process of changing, the gender they live in from one gender to another, and/or may not identify as male or female.

2. WHAT DOES THIS MEAN FOR PATIENTS

Other than in the circumstances set out above, patients admitted to the hospital can expect to find the following:

Same gender-accommodation means:

- The ward bed bay will only have patients of the same gender
- The toilet and bathroom will be just one gender, and will be close to the bed area
- It is possible that there will be patients of different genders on the same ward but they will not share the sleeping area. Patients may have to cross a ward corridor to reach the bathroom, but patients will not have to walk through differently gendered areas.
- Patients may share some communal space, such as day rooms or dining rooms, and it is very likely that they will see patients of other genders as they move around the hospital (e.g. on way to X-ray or the operating theatre)

[1] 'relating to the intricate, variable interaction of biological factors (genetic, biochemical, etc), psychological factors (mood, personality, behaviour, etc.), and social factors (cultural, familial, socioeconomic etc.).'

- It is probable that visitors of another gender will come into the ward or bay this may include patients visiting each other
- It is almost certain that nurses, doctors and other staff of all genders will care for patients
- If personal assistance is required (e.g. hoist or adapted bath) then patients may be taken to a “unisex” bathroom used by people of all genders, but a member of staff will be with the patient, and other patients will not be in the bathroom at the same time
- Patients who have undergone or are undergoing a process of gender transition (trans patients) will be accommodated in the bay appropriate for the gender they are currently living in, there will be no requirement to show legal recognition in this gender
- Where there is reason to believe that a trans patient may be more comfortable being accommodated with patients of another gender or in a side room, this will be discussed with them privately and an agreement arrived at between patient and staff. Knowledge of a patient’s history of transition will not automatically lead to this question being raised where there would otherwise be no question over where a patient should be accommodated
- Patients who do not identify as male or as female will necessarily not be accommodated with other patients of the same gender or alone, but will be accommodated with either male or female patients as based on agreement between the patient and staff
- Where a patient is unable to contribute to the decision being made about their accommodation, the advice of family or carers will be sought where possible, and a decision made based on available indicators (name, manner of dress, etc) where advice is not available, until such time as the patient can contribute to the decision being made

3. STATEMENT OF ASSURANCE

- **The Whittington will not turn patients away just because a “right-gender” bed is not immediately available**
- The Board is committed to on-going delivery of single gender accommodation
- To ensure that there is an on-going process in place to measure patient experience of single gender accommodation performance is provided to the Trust Board (contained within the Performance Report)
- To ensure there is a process to track other mechanisms for determining patient experience of single gender accommodation, e.g. through patient complaints/comments from PALs
- Episodes of mixed gender accommodation breaches for non-clinical reasons will be reported to CCG commissioners through monthly performance reports and reviewed at contract meetings as required (Clinical Quality Contract Group)
- To provide information leaflets for patients on single gender accommodation and ensure they are used by staff in discussions with patients
- Delivery of single gender accommodation will always be considered when planning any new or refurbished estate development schemes
- Where there are rare occurrences of gender mixing for non-clinical reasons, a process exists to investigate the reason and take remedial actions as required to prevent future occurrence (incidents to be datixed)
- The relevant Trust policies will refer to requirement to delivering single gender accommodation and privacy and dignity

- The Trust believes that delivering single gender accommodation should be the norm. Mixing will only occur by exception for reasons of clinical justification or patient choice
- If mixing does occur, staff will attempt to rectify the situation as soon as possible, whilst safeguarding the patient's dignity and keeping the patient informed about why the situation occurred and what is being done to address it (with an indication of how long this will take)
- Issues of privacy/dignity and single gender accommodation are included in mandatory staff training and induction and the trust provides training to support the elimination of mixed gender accommodation and to promote the protection of privacy and dignity

Signed Chairman:

Signed Chief Executive:

Date:

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Whittington Health
NHS Trust

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Whittington Health Trust Board
27th June 2018

Title:	**Whittington Health 'Next Steps to Outstanding'**		
Agenda item:	**18/092**	**Paper**	**5**
Action requested:	To discuss and approve approach		
Executive Summary:	This paper provides a background to the current position of the Trust with respect to CQC grading and the steps required to move towards 'Good' to 'Outstanding'. The paper focuses on the immediate steps for the Trust and ICSUs for 2018/19 in preparation for the next CQC inspection expected by the end of the year and then the move to readiness to an overall rating of 'Outstanding' within the following 12 months. It is recognised that the focus in the paper is around ICSUs it is recognised that preparation is also required in corporate directorates in their enabling role in working with ICSUs.		
Recommendations:	Trust Board to agree the following recommendations:- 1. Over the next three months, we will develop a plan for next 2 years which sets out the key milestones and actions on the Trust's journey to becoming outstanding. This will be in parallel to the CQC inspection preparation plans for 2018/19. This will include further engagement and ownership within the ICSUs and corporate directorates. 2. Develop plan around Well Led preparation with Executive Team and ICSU Leadership Teams. 3. Communication strategy – Good to Outstanding to be developed and implemented to start within next 3 months. Nursing Directorate to develop a slide pack for delivery by ICSU and corporate directorates to start the messaging around our **#WhittHealthG-O strategy.** 4. Introduce a performance review of corporate directorates in line with the ICSU performance reviews.		
Fit with WH strategy:	Aligns to clinical strategy		
Reference to related / other documents:	Complies with our regulatory framework		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured on relevant risk registers		
Date paper completed:	20 June 2018		

Author name and title:		**Gillian Lewis, Head of Governance and Risk**		**Director name and title:**		**Michelle Johnson, Chief Nurse**	
Date paper seen by EC	**25 May 2018**	**Equality Impact Assessment complete?**	**N**	**Risk assessment undertaken?**	**N**	**Legal advice received?**	**N**

1. Background

1.1 Between 31st Oct and 2nd Nov 2017 the CQC inspected four core services across the Trust; Outpatients, Adult Critical Care, Community Children's and Young People's Services and Simmons House (Children and Adolescent Mental Health Inpatient Unit). From 28th until 30th November 2017 a series of Well-Led interviews and focus groups were held as part of the CQC inspection process. The outcome of the inspection was that Whittington Health maintained its overall rating of 'Good', and the Whittington Hospital site rating increased from 'Requires Improvement' to 'Good'.

1.2 The report identified a number of areas for improvement, as well as four regulatory actions requiring immediate mitigating action. The Trust has developed a detailed CQC improvement plan to address these issues.

1.3 Whittington Health aspires to be an 'Outstanding' organisation, and so in addition to the CQC improvement plan which addresses the areas highlighted in the 2017 inspection report, the Trust is developing its plan to move to readiness to an overall rating of 'Outstanding' within the following 12 months.

2.0 Good to Outstanding

2.1 Whittington Health recognises that becoming an 'Outstanding' integrated care organisation is about our business as usual being outstanding; however, it wants to be recognised externally by the CQC and this requires strategy and preparation and . In order to be rated as 'Outstanding' Trusts need to provide excellent patient care, look after the welfare of their staff, be a key driver for performance, research and innovation regionally and nationally and actively share best practice both within the Trust and with the wider NHS.

2.2 This is an ambitious but absolutely achievable goal for the next 2 years, and will require an integrated approach involving our staff, patients, commissioners and local public, across a number of work streams from estates development, to workforce management to patient/public engagement and involvement.

2.3 The Trust aims to increase the number of core services rated as 'Good' and 'Outstanding' each year and to achieve an overall rating of 'Outstanding' by end of 2019/2020. During this time, the Trust will need to maintain its 'Good' overall rating while gradually moving specific core services and the well-led domain to 'Outstanding' through targeted quality improvement initiatives. This will be recognised by internal review processes as well as by assurance visits by CCG/NHSE and regulators.

3.0 Year 1 - 2018/19

3.1 For 2018/19 the Trust's priority will be to focus on the areas of 'Requires Improvement' highlighted in the CQC inspection of October/November 2017 (report published February 2018), and to ensure that the 'Good' ratings achieved in December 2015 (report published July 2016) are maintained across our core services in the annual CQC inspection expected 2018/19.

3.2 As part of the revised CQC methodology for regulating health and social care services, more focused inspections are now undertaken, based on previous ratings and information received from a variety of sources including stakeholder feedback, performance data and independent reviews. The CQC have stated that they will carry out inspections of specific core services, followed by an

inspection of the well-led key line of enquiry at trust level approximately annually. This is anticipated during 2018-19.

3.3 The CQC use a Trusts' previous ratings as a guide to setting maximum intervals for re-inspecting its core services alongside its inspection of the well-led key question. However, these are maximum timeframes and the CQC will return more frequently depending on the information received from CQC Insight and key stakeholders. The maximum intervals for inspection are set as follows;

- one year for core services rated as inadequate
- two years for core services rated as requires improvement
- three and a half years for core services rated as good
- five years for core services rated as outstanding.

3.4 Based on this methodology, it is expected that the CQC will return to carry out unannounced inspections of the core services rated 'Good' in July 2016 report no later than June 2019. This includes 6 core services in the hospital (Medical Care, Urgent and Emergency Services, Surgery, Maternity and Gynaecology, Services for Children and Young People and End of Life Care) and 2 core services in the community (Adult Community and CAMHS services). Community End of Life Care and Community Dental Services were both rated as 'Outstanding' in the July 2016 report.

3.5 There are two key aspects to the short-term plan;

1. CQC Improvement Plan • Each core service inspected has a detailed CQC improvement plan which is monitored by the relevant ICSU Board • The Quality and Risk team maintain oversight of the full CQC improvement plan and any concerns are escalated to TMG on a monthly basis • Quality Committee receive regular updates and a formal six-monthly report on progress to provide assurance to the Trust Board and the CCG
Preparation for next CQC inspection (expected before June 2019) • For the upcoming inspection the trust will follow a similar preparation process to 2015 • Continue with existing peer review programme (currently twice monthly) • Develop a simplified self-assessment tool for ICSUs to complete by end July • Conduct targeted peer reviews based on self-assessments and ICSU requests • Complete Provider Information Request (PIR) once received from CQC • At point PIR is received increase peer review programme to weekly, develop targeted action plan for any improvement areas, and share good practice examples across the Trust • Final six weeks before expected unannounced inspections (usually 12 weeks after PIR according to CQC guidance) conduct targeted 'quick-fire' mock inspections, hold staff awareness sessions on what to expect from a CQC inspection in line with pre-inspection preparation plan

4.0 Year 2 - 2019 – 2020

4.1 This next period is critical in terms of getting to outstanding. It requires a shift in staff culture and ambition and also the language that the Trust speaks. There are a number of important elements to the Trust's journey to outstanding.

4.2 The implementation of key existing strategies at the Trust will be instrumental in becoming an 'outstanding' organisation. These include measuring and pushing further against the following strategies;

- Clinical Strategy
- Estates Strategy
- Patient Experience Strategy
- Quality Improvement Strategy
- Recruitment and Retention Strategy

4.3 **Focus on quality** (patient safety, patient experience and clinical effectiveness) and sharing best practice

4.4 The Trust needs to go further in developing its **open and honest patient safety culture** which actively shares learning both internally, externally and nationally. This has already developed significantly as evidenced by the increase in patient safety reporting and the well-attended multi-disciplinary learning workshops, grand rounds and patient safety events across the Trust. This is a Trust wide development need.

4.3 **Focus on Quality Improvement**: Whittington Health has already taken steps to become more pro-active in identifying areas for quality improvement through the development of the quarterly aggregated learning report on incidents, complaints, and claims; the peer review programme; quarterly learning from death reviews; annual serious incident review and thematic reviews of patient feedback. Combined with performance data, this information is used to prioritise areas for quality improvement and shared learning. The Quality Improvement strategy outlines the plans to increase training to give staff the skills and support to carry out quality improvement projects.

4.4 **Focus on patient/people engagement and involvement**: Whittington Health is currently developing a Patient Experience Strategy. This will set out our key objectives to improve patient and carer experience throughout Whittington Health and include clear success measures. Plans for 2018/19 include: recruiting patient representatives to relevant Trust Board committees, involving patients in the quality improvement projects underway and reviewing the quality and availability of patient information across the Trust.

4.5 **Focus on well-led**: A key aspect of the CQC inspection model is being a well-led organisation. The CQC guidance highlights the differences between a 'good' and an 'outstanding' organisation in terms of Board engagement, organisational development and effective governance. This will be used as a tool to target areas for particular focus.

5.0 What Next

5.1 Over the next three months, we will develop a plan for next 2 years which sets out the key milestones and actions on the Trust's journey to becoming outstanding. This will be in parallel to the CQC inspection preparation plans for 2018/19. This will include further engagement and ownership within the ICSUs and corporate directorates.

5.2 Develop plan around Well Led preparation with Executive Team and ICSU Leadership Teams.

5.3 Communication strategy – Good to Outstanding to be developed and implemented to start within next 3 months. Nursing Directorate to develop a slide pack for delivery by ICSU and corporate directorates to start the messaging around our **#WhittHealthG-O strategy**.

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Whittington Health NHS Trust

Trust Board Meeting
27 June 2018

Title:	**Clinical Negligence Scheme for Trusts Incentive scheme**		
Agenda Item	**18/094**	**Paper**	**06**
Action requested:	The Board is asked to approve the Trust's participation in the incentive scheme and approve the self-certification report.		
Executive Summary:	Whittington Health NHS Trust paid £5,653,804 to the Clinical Negligence Scheme for Trusts (CNST) for our maternity premium for 2018/19. NHS Resolution is trialling an incentive scheme in which making progress against ten required 'maternity safety actions', will give us a rebate of 10% of this CNST maternity premium. At Whittington Health the maternity services do fulfil, or are progressing towards, all ten maternity safety actions. The action plan and evidence for them are presented here.		
Summary of recommendations:	Following examination of the evidence, it recommended that the self-certification report is approved by the Board and signed by the Executive Medical Director on behalf of the Board ready for discussion with Commissioners then submission to NHS Resolution by 29th June 2018.		
Fit with WH strategy:	'To deliver consistent, high quality, safe services' 'To support our patients/users in being active partners in their care' 'To be recognised as a leader in the fields of multi-professional education'		
Reference to related / other documents:	NHS Resolution Maternity Incentive Scheme: https://resolution.nhs.uk/maternity-incentive-scheme/		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	BAF 4, BAF 5, BAF 15		
Date paper completed:	19th June 2018		

Author name and title:		**Chandrima Biswas Clinical Director**		**Director name and title:**		**Richard Jennings Medical Director**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Board report on Whittington Health - progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

SECTION A: Evidence of Trust's progress against 10 safety actions:

Introduction

Obstetrics/Maternity is the highest-cost specialty in terms of litigation claims within the NHS (1). In the UK between April 2000 and March 2010, Cerebral palsy (£1.2 billion); Cardiotocograph (CTG) interpretation (£466 million pounds) and management of labour (£424 million) made up the categories with the highest value of claims. In 2016/17, maternity spend on negligence was approximately £500 million. In addition to the financial costs, the non-financial costs, for instance, of an avoidable cerebral palsy to the child, the child's family, the NHS and society are immeasurable.

At Whittington Health, Maternity Services pay over £5 million annually to cover our litigation premium, to the Clinical Negligence Scheme for Trusts (CNST). This constitutes more than half of the total Trust premium. (Table1)

Table1: CNST premium contributions for Whittington Health:

	Maternity	Remainder of Trust	Total
2017/18	£5,649,163	£5,092,660	£10,741,823
2018/19	£5,653,804	£5,239,716	£10,893,520

Background

What is the CNST Incentive Scheme?

NHS Resolution, under direction from the Department of Health, is trialling the CNST Maternity Incentive Scheme for 2018/19. The Trust will be given a rebate of our contribution (calculated at 10% of our maternity premium), if we demonstrate progress against ten 'maternity safety actions' (see below). The actions and our compliance are listed in table 2 below. A summary of evidence of our compliance is also listed. The completed action plan for presentation to, and approval by, the Trust Board is presented in Appendix 1.

Table 2: Requirements and summary of evidence that we fulfil requirements, for the CNST incentive scheme

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	The NPMRT was introduced as a pilot in December 2017 and as a standard tool in April 2018. We are currently using the tool for term perinatal deaths (stillbirths and neonatal deaths up to 28 days after birth). Since December 2017 we have had 4 babies in this group, all of whom have been entered onto the NPMRT. We plan to use the tool for all stillbirths greater than 30 weeks gestation from September 2018; and all perinatal deaths from 22 weeks gestation, and all post-neonatal deaths where the baby dies after 28 days following care in a neonatal unit, from January 2019.	**Yes**
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	We have submitted data to a sufficient standard (i.e for at least 80% births) in all 10 criteria listed, to the Maternity Services Data Set.	**Yes**
3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	We have transitional care services, as evidenced by our Neonatal Operational Delivery Network; payment for transitional care services from Commissioners, and our own audits describing the number and category of Transitional Care babies per month. ATAIN (Avoiding Term Admissions Into the Neonatal unit) programme – including an e-learning programme for health care professionals, has been rolled out and implemented; and a package for identification and treatment of babies at risk of hypoglaecmia, hypothermia, jaundice and respiratory distress, is currently used as part of transitional care on the postnatal ward. Our community midwives already carry Transcutaneous Bilirubinometers (TcB) in the community to screen babies at home and where possiable avoid unnecessary readmissions due to neonatal jaundice.	**Yes**

4). Can you demonstrate an effective system of medical workforce planning?	We have used the Royal College of Obstetricians and Gynaecologists (RCOG) workforce monitoring tool template to demonstrate that there were NO middle grade sessions on labour ward filled by consultants acting down from other sessions (the standard is no more than 20%).	**Yes**
5). Can you demonstrate an effective system of midwifery workforce planning?	We use an evidence-based tool, Birthrate Plus, to calculate our midwifery staffing establishment. Currently our ratio is 1:28. We are currently working towards 90/10 split (birth rate tool) were we have recruited to band 3 MSW and nursery nursey on the postnatal ward and band 4 MSW in the community children's centres. We have specialist midwives and a 7 day rota covering Newborn and Infant Physical Examination (NIPE). Our labour ward co-ordinators are rostered to be supernumerary.	**Yes**
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	We are compliant with all four elements of the Saving Babies Lives care bundle. The elements are: Reducing smoking in pregnancy; risk assessment and surveillance for fetal growth restriction; raising awareness of reduced fetal movements; and effective fetal monitoring during labour. **Reducing smoking in pregnancy** Whittington Health has a pilot site for the introduction of carbon monoxide (CO) monitors from 2015. Women identified as smokers at booking are offered referral to smoking cessation. Rates of women offered CO testing, those smoking at booking; and those smoking at delivery, are presented. **Risk assessment and surveillance for fetal growth restriction** We introduced the GAP/GROW system of detection of fetal growth restriction using customised symphysis-fundal height measurements for low risk women; and customised ultrasound estimated fetal weight charts for high risk women, who are scanned according to our local guideline, which is based on the RCOG guideline (2). We have increased the number of scan slots to 2-3 sessions per week depending on service needs. We present audits on our use of the low-risk and high risk pathways as evidence. **Raising awareness of reduced fetal movements** We updated our guidance on	**Yes** **Yes** **Yes**

	reduced fetal movements in 2016, which includes leaflet, given to woman at booking; Mama Academy folders for handheld notes, (Information of reduced fetal movements on outside of the folders); and information of what to do if she experiences reduced fetal movements at ever antenatal visit. This last is done via a checklist to remind staff about the information they must give the woman. We follow an algorithm in our guideline based on the RCOG guidance (3). Evidence of this has been presented. **<u>Effective fetal monitoring during labour.</u>** Records of training in CTG interpretation and intermittent auscultation; and audits on our buddy system ('Fresh Eyes') are presented.	**Yes** **Yes**
7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	Whittington Health has an active user forum, the Maternity Voices Partnership that meets quarterly. Agenda and minutes of these meetings are provided.	**Yes**
8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	All staff working within the maternity services are required to attend our Multi-professional in-house training (Known as PrOMPT: Practical Obstetric Multi-Professional Training) at least annually. They also take part in monthly 'live' drills in the Clinical areas. Evidence is presented.	**Yes**
9). Can you demonstrate that the trust safety	The Trust maternity safety champions (Clinical Director and Head of Midwifery) meet with our Board-level champion (the Medical Director) to discuss locally collected	**Yes**

champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	clinical measures (maternity dashboard), inspection reports such as CQC, and feedback from women via FFT). This is bi-monthly in 2018 and evidence is presented. Can give minutes from performance reviews, CQRG as well as the minutes form the meeting Head of Midwifery and Clinical Director with Board level champion (Executive Medical Director), the Serious Incident Executive Approval Group (SIEAG) and the Patient Safety Committee.	
10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?	We have reported all qualifying events to NHS Resolution early Reporting Scheme. From April 2018 this has been within 30 days as required.	**Yes**

References

1. NHS litigation authority Ten years of Maternity Claims 2000-2010 An analysis of NHS Litigation Authority Data.
2. Royal College of Obstetricians and Gynaecologists Green Top Guideline No.31 Small-for-gestational-age Fetus, Investigation and Management (2013).
3. Royal College of Obstetricians and Gynaecologists Green Top Guideline No.37 Reduced Fetal Movements (2011).

SECTION C: Sign-off

……..
For and on behalf of the Board of Whittington Health confirming that:
•The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.

•The content of this report has been shared with the commissioner(s) of the Trust's maternity services

•If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B

Position:
Date:

We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

……..

Trust Name **Whittington Hospital NHS Trust (The)**

This document should be used when completing Section B of the Board report for the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme when a specific request for a discretionary CNST incentive payment is being made.

An action plan should be completed for each maternity safety action where the necessary progress was not met. This will allow NHS Resolution to consider the Trust's recovery plan and any associated request for a discretionary CNST incentive payment.

	Funds Requested
Action plan 1	NIL
Action plan 2	NIL
Action plan 3	NIL
Action plan 4	NIL
Action plan 5	NIL
Action plan 6	NIL
Action plan 7	NIL
Action plan 8	NIL
Action plan 9	NIL
Action plan 10	NIL

Total Sum Requested -

Sign-off process

For and on behalf of Whittington Hospital NHS Trust (The)

Name:

Position:

Date: 27/06/2018

Section B : Action Plan details for Whittington Hospital NHS Trust (The)

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action	Q1 NPMRT	**To be met by**	Q2 2018/19

Work to meet action	*The NPMRT was introduced as a pilot in December 2017 and as a standard tool in April 2018. We are currently using the tool for term perinatal deaths (stillbirths and neonatal deaths up to 28 days after birth). Since December 2017 we have had 4 babies in this group, all of whom have been entered onto the NPMRT. We plan to use the tool for all stillbirths greater than 30 weeks gestation from September 2018; and all perinatal deaths from 22 weeks gestation, and all post-neonatal deaths where the baby dies after 28 days following care in a neonatal unit, from January 2019.*

Does this Action Plan have Executive Level Sign Off	No	**Action plan agreed by HoM and/or clinical director?**	Yes

Action plan owner	*Breavement Lead and Jane Laking*
Lead executive director	*Does the action plan have executive sponsorship?- No*
Details of any request for funding support from the incentive fund, if required	*NIL*

Reason for not meeting action	*Please explain why the Trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the Trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 2

Safety action	Q2 MSDS	**To be met by**	Q1 2018/19

Work to meet action	*MET*

Does this Action Plan have Executive Level Sign Off	No	**Action plan agreed by HoM and/or clinical director?**	No

Action plan owner	*IT dept and IT Midwfe*
Lead executive director	*Does the action plan have executive sponsorship?*
Details of any request for funding support from the incentive fund, if required	*NIL*
Reason for not meeting action	*Please explain why the Trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the Trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action	Q3 Transitional Care	**To be met by**	Q1 2018/19

Work to meet action	*MET*

Does this Action Plan have Executive Level Sign Off	No	**Action plan agreed by HoM and/or clinical director?**	Yes

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Details of any request for funding support from the incentive fund, if required	*NIL*
Reason for not meeting action	*Please explain why the Trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the Trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action	Q4 Medical Workforce Planning	**To be met by**	Q1 2018/19

Work to meet action	*MET*

Does this Action Plan have Executive Level Sign Off	No	**Action plan agreed by HoM and/or clinical director?**	Yes

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Details of any request for funding support from the incentive fund, if required	*NIL*
Reason for not meeting action	*Please explain why the Trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the Trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action	Q5 Midwifery Workforce Planning	**To be met by**	Q1 2018/19
Work to meet action	*MET*		
Does this Action Plan have Executive Level Sign Off	No	**Action plan agreed by HoM and/or clinical director?**	Yes
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Details of any request for funding support from the incentive fund, if required	*NIL*		
Reason for not meeting action	*Please explain why the Trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the Trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action	Q6 SBL Care Bundle	**To be met by**	Q1 2018/19
Work to meet action	*MET*		
Does this Action Plan have Executive Level Sign Off	No	**Action plan agreed by HoM and/or clinical director?**	Yes
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Details of any request for funding support from the incentive fund, if required			*NIL*
Reason for not meeting action	*Please explain why the Trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the Trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action	Q7 Patient Feedback	**To be met by**	Q1 2018/19

Work to meet action	*MET*

Does this Action Plan have Executive Level Sign Off	No	**Action plan agreed by HoM and/or clinical director?**	Yes

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Details of any request for funding support from the incentive fund, if required	*NIL*
Reason for not meeting action	*Please explain why the Trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the Trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action	Q8 In House Training	**To be met by**	Q2 2018/19

Work to meet action	*Book staff into PROMPT training and ensure they attend as rostered on a yearly basis, and actively follow up non attenders.Month on month these figures have improved.Lead consultant Obstetrician and Anaesthetist to take an active role in ensuring new and existing staff are aware of the requirements, and book themselves onto the training as required. PDM to be given an up to date list of current trainees, with start and finish dates, to ensure current databases are maintained*

Does this Action Plan have Executive Level Sign Off	No	**Action plan agreed by HoM and/or clinical director?**	Yes

Action plan owner	*HOM, CD, DO*
Lead executive director	*Does the action plan have executive sponsorship?*
Details of any request for funding support from the incentive fund, if required	*NIL*
Reason for not meeting action	*Our previous working TNA had targets of 75% of staff being trained within a 15 month period, to allow for sickness etc. The new CNST requires 90% compliance within 12 months. Although the majority of our figures were good, this is a significant change in targets and requirements which will take time to recitfy.*
Rationale	*with more staff taking ownership of data, and staff being aware of their requirements, a belt and braces approach should ensure robust compliance*
Benefits	*If more of the multi disciplinary team are trained on a regular basis, the key messages are known by all members of the MDT and positive outcomes in emergency situations are more likely to be achieved. The added benefit of local training is the improvement in teamworking*
Risk assessment	*The risks of not meeting the safety action plan would be that staff would be less likely to have current information and know current work practices, which is more likely to lead to harm*

	How?	**Who?**	**When?**
Monitoring	maintaining of training databases	PDM, Consultant education leads in Obs and Anaesthetics	Monthly, dropping to quarterly once sustainable figures are achieved on a regular basis.

Action plan 9

Safety action	Q9 Safety Champions	**To be met by**	Q1 2018/19

Work to meet action	*MET*

Does this Action Plan have Executive Level Sign Off	No	**Action plan agreed by HoM and/or clinical director?**	Yes

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Details of any request for funding support from the incentive fund, if required	*NIL*
Reason for not meeting action	*Please explain why the Trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the Trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action	Q10 ENS	**To be met by**	Q1 2018/19

Work to meet action	*MET*

Does this Action Plan have Executive Level Sign Off	No	**Action plan agreed by HoM and/or clinical director?**	Yes

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Details of any request for funding support from the incentive fund, if required	*NIL*
Reason for not meeting action	*Please explain why the Trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the Trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Whittington Health
NHS Trust

Executive Offices
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Magdala Avenue, London
N19 5NF

Whittington Health Trust Board

27th June 2018

Title:	**Fire Safety June - Update**		
Agenda item:	**18/094**	**Doc**	**7**
Action requested:	Review and Note		
Executive Summary:	This paper updates the Board with the actions being taken in relation to fire safety compliance, and details the improvements made to date. Additionally the paper updates the Board on the outcome of the serious incident investigation that followed the fire that occurred on the hospital site on 17 January 2018. Delivery of Fire Safety improvements are monitored through the Fire Strategy Group, the Trust Management Group and the Health & Safety Committee, which reports to the Quality Committee, a sub-committee of the Trust Board. The Board is asked to note that the Trust is partially compliant with the operational management elements of the NHSE Health Technical Memoranda (HTM) 05 (Fire Safety) requirements and expects to be fully compliant by the end of quarter 3 2018/19. Work to ensure compliance with the physical environment elements of fire safety is continuous as part of the Trusts estate life cycle and is a priority for the Capital Monitoring Group when allocating funds each year.		
Summary of recommendations:	The Board is asked review the progress made to date and to note that the Trust is expected to be fully compliant with the operational management elements of the HTM requirements by the end of quarter 3 2018/19.		
Reference to related / other documents:	Health Technical Memoranda (HTM) 05 (Fire Safety) and the Regulatory Reform (Fire Safety) Order 2005		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	DATIX Risk 801 Fire Marshals and Warden Provision and Training		
Date paper completed:	19.06.18.		

Author name and title:		Adrien Cooper Director of Environment		Director name and title:		Stephen Bloomer, Chief Finance Officer	
Date paper seen by EC		Equality Impact Assessment complete?		Quality Impact Assessment complete?		Financial Impact Assessment complete?	

1.0 Purpose

This paper updates the Trust Board with the current status of the Trust in relation to fire safety and details the improvements made, and when the Trust is expected to reach compliance with the fire safety regulations.

Additionally the Board will be updated on the outcome of the serious incident investigation that followed the fire that occurred on the hospital site on 17th January 2018.

2.0 Background

Fire Safety law is set out in the Regulatory Reform (Fire Safety) Order 2005 (commonly referred to as the RRO) and NHS organisations' obligations are included in the NHSE guidance Health Technical Memoranda (HTM) 05 (Fire Safety). The HTM provides practical instruction on how fire safety should be proactively managed to protect patients, staff and visitors while using NHS premises.

HTM 05 compliance requires operational management systems to be in place and the physical environment to meet the standards set out in the guidance.

Compliance with the physical environment standards forms part of the Trust's annual capital investment plans, and this work will be continuous as part of the ongoing Trust estate life cycle.

Operational management system requirements include the need for a Fire Safety Policy and procedural documents that are live, tested and staff are trained to use. The Trust has in place the elements required for compliance with the operational management system requirements, and the focus of the Fire Safety Group is to ensure these are sustainable to achieve full compliance by Q3 2018/19.

The Trust's Fire Safety Policy complies with HTM 05 requirements.

The Fire Safety Policy places a mandatory obligation on Trust employees to ensure they proactively minimise the risk of fire by applying their fire safety training in their day to day activities. Fire training is mandatory for all staff employed by Whittington Health.

The Trust's designated Responsible Officer for the RRO is the Director of Environment.

Day to day fire safety management duties are delegated to the Deputy Director of Facilities as named Fire Safety Manager under HTM 05.

3.0 Fire Incident on the hospital site

A fire broke out in a storage room within the PFI maintenance contractor's office area located in the basement level of the PFI building, also known as A Block, at 16.09hrs on 17 January 2018.

The fire was quickly extinguished, preventing the fire from spreading further. Smoke from the fire rose to the roof top plant room area via an interconnecting service riser. From there the smoke was drawn into the ventilation systems and subsequently distributed into Mary Seacole South, parts of Nightingale and the Radiology department, and to a lesser extent other areas of the hospital.

The smoke prompted the evacuation of patients from Mary Seacole South into Ambulatory Care and evacuation from the Imaging department. Patients were moved in accordance with progressive horizontal evacuation techniques. Patients were kept informed by staff and reassured of their safety during and after the incident.

Although some patients experienced minor coughing due inhalation of smoke, clinicians reported that no patient was directly or indirectly harmed.

London Fire Brigade was in attendance from 16.17hrs, and their initial actions were to make safe the area where the fire had started.

LFB conducted further checks throughout the affected areas and confirmed when wards and departments were safe to re-occupy.

LFB conducted a formal fire investigation including interviewing the Trust's Responsible Officer.

LFB left site at approximately 2130hrs.

The Trust initiated a Serious Incident (SI) investigation. The investigation found that the Trust's commitment to fire safety and fire incident preparedness meant that staff were trained and equipped to react calmly and readily.

The SI investigation recommended that the Trust should review the fire safety systems of the PFI building working with the PFI building owners to ensure remediation of any non-compliance is addressed.

The Trust has developed an action plan that addresses the findings of the Serious Incident investigation. Delivery of the actions is monitored via the Fire Strategy Group, Health & Safety Committee and Quality Committee. The Responsible Officer is also required to report back to the Serious Incident Panel on a regular basis and to update the Trust Board on a six-monthly basis.

4.0 Compliance with Health Technical Memoranda (HTM) 05 (Fire Safety)

The following outlines the progress made to date on key compliance requirements and details improvements that are currently underway and when the Trusts expects to be fully compliant.

4.1 Physical compliance

Physical compliance with HTM 05 is a priority for the Capital Monitoring Group when prioritising the allocations of Capital funds every year, as the work to ensure fire safety is continuous as part of the Trusts estate life cycle. Allocations vary each year due to the varying elements of works to improve fire safety across the diverse and aging Whittington Health estate. Works on the Victorian elements of the estate on the hospital site can be complex and lengthy.

The Trust has committed £300K this financial year for direct improvements to building and engineering systems related to fire safety. The capital allocation for 2018/19 will be used to remediate fire safety risks within the hospital site and this work is expected to complete in autumn 2019.

The Responsible Officer reports progress on the improvements made to meet the compliance requirements of HTM 05 to the Trust Management Group on a six-monthly basis.

4.2 Operational management compliance

The Trust has in place the elements required for operational management compliance, and the focus of the Fire Safety Group is to ensure these are sustainable to achieve full compliance by Q3 2018/19. The following outlines the further actions required for the Trust to achieve full compliance with the operational management elements of HTM 05 by Q3 2018/19

4.3 **The Trust Fire Policy**

The Trust's Fire Policy has been updated and is compliant with HTM 05. The updated policy separates the policy elements from the procedural element. The revised documents more clearly define the organisation's compliance standards and the actions that are required to reduce the risk of fire. The procedural element details how the Trust will meet the compliance requirements and the actions required to proactively respond to fire incidents.

Following the January fire incident, the procedural document was further updated and reviewed. The London Fire Brigade Healthcare liaison officer reviewed the document and recognises it as robust.

The procedural document was further tested in a live fire drill exercise in April.

The live drill involved a multi-disciplinary team that included representation from emergency planning, site management, nursing, CENCOM (switchboard), security and estates.

Further improvements to the fire procedures have followed the learning from the live fire drill.

4.4 Procedural documents

In addition to the Fire Policy and Procedure, further documents are required for full compliance with the Fire Management System element of HTM 05. These include a Whittington Health specific Fire Design Guide for new buildings and refurbishments

and Requirements for Contractors. These are in development and will be completed by Q3 2018/19.

4.5 Key Mandated Fire Safety Roles

4.5.1 The appointed Authorised Engineer (Fire Safety)

The role of Authorised Engineer (Fire Safety) is mandatory in accordance with HTM 05. The Trust is out to tender to commission a consultant to undertake the role going forward. The contract award date is 1st August 2018.

To ensure current compliance the Trust has appointed an experienced interim Authorising Engineer (Fire Safety) who is assisting the Responsible Officer to fast tracking non-compliance remediation.

The interim Authorising Engineer is undertaking the Trust's fire safety annual audit which will be completed by 30th June 2018.

The audit will provide oversight and inform necessary further actions. The audit forms part of Trust governance and assurance with regard fire safety.

4.5.2 The Fire Safety Advisor.

The Trust wishes to employ a substantive Fire Safety Advisor. Recruitment however is challenging and despite advertising on several occasions, recruitment has been unsuccessful.

The Trust has appointed an interim fire safety consultancy to provide fire safety training, fire risk assessments and day to day fire safety advice.

It is our intention now to formally tender the ongoing provision of Fire Safety Advice during the summer to ensure the Trust has continuous and robust fire safety support.

4.5.3 Fire wardens

In August 2017 the Trust had forty fire wardens. The Trust has set its own target establish and train 300 fire wardens by 31 March 2018.

The Health and Safety Team are working with the ICSUs to determine the number of fire wardens required by department and clinical area.

By January 2018 the number of trained fire wardens had increased to 110, and the more recent figures show that 456 fire wardens have now been trained, exceeding the Trust target.

The Trust is committed to continuing to increase the number of trained wardens and to ensure all clinical and non-clinical environments have a designated fire warden.

To further the organisation's fire safety readiness the Trust will undertake quarterly fire drills, testing different care settings and updating the Fire Procedure document as appropriate.

4.6 The Fire Strategy Group

The frequency of Fire Strategy Group meetings has increased from quarterly to monthly.

The Fire Strategy Group meetings are chaired by the Responsible Officer. Independent assurance is provided by the appointed Authorising Engineer (Fire Safety).

A Memorandum of Understanding to improve collaborative engagement between the LFB and the Trust is now in place and secures the regular attendance of London Fire Brigade Healthcare Liaison officer to the Fire Safety Group meeting.

User engagement is through the attendance of the named Responsible Person's for Fire Safety representing each ICSU. ICSU's have engaged positively to address any shortfalls identified. This is evidenced by the actions taken to increase the number of fire wardens.

Clinical engagement from the ICSU's further promotes fire safety as an organisational responsibility.

5.0 Conclusion

Having reviewed its compliance with the HTM 05 Fire Safety guidance, the Trust has implemented several improvements to meet the compliance requirements.

HTM 05 compliance requires operational management systems to be in place and the physical environment to meet the standards set out in the guidance.

The Trust has a Fire Safety Policy that is compliant with HTM 05.

The Trust has procedural documents that are live and tested, and staff are trained to use these. Although the Trust has in place the elements required for compliance, some of these are provided through interim consultants and the focus of the Fire Safety Group is to ensure these are sustainable to achieve full compliance with operational management systems element of HTM05 by Q3 2018/19.

The Trust has reviewed the action plan following the fire incident at the hospital site in January 2018 and learning is reflected in the operational management procedures. The Trust is engaged with the LFB to review the remedial actions taken following the fire.

Work to ensure compliance with the physical environment elements of HTM 05 is continuous as part of the Trusts estate life cycle and is a priority for the Capital Monitoring Group when allocating funds each year.

The Trust has committed £300K this financial year for direct improvements to building and engineering systems related to fire safety. The capital allocation for 2018/19 is being used to remediate fire safety risks within the hospital site and this work is underway and expected to complete in autumn 2019.

Delivery of the improvements is monitored through the Fire Strategy Group, the Trust Management Group and the Health & Safety Committee, which reports to the Quality Committee, a sub-committee of the Trust Board.

Whittington Health NHS Trust

Magdala Avenue
London N19 5NF

Whittington Health NHS Trust

Trust Board

27 June 2018

Title:	May (Month 2) 2018/19 – Financial Performance		
Agenda item:	**18/095**	**Paper**	**8**
Action requested:	To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends.		
Executive Summary:	The Trust is reporting a £0.5m deficit for the period to the end of May (month 2) against a planned £0.3m deficit. Actual performance therefore represents an adverse variance of £0.2m. The key driver for the adverse variance is the income performance, particularly elective and day case activity. In addition, the Trust has projected the loss of the Provider Sustainability Funding relating to A&E performance for the first quarter. These adverse variances are partially mitigated by underspends in pay and non-pay. Although, there are significant challenges with escalation beds remaining open longer than planned and the resulting contribution this is adding to the Trusts agency spend. The agency costs are in excess of £2m at the end of May against a set ceiling spend for the year of £8.8m. The Trust is currently awaiting confirmation of the capital allocation it will be allowed to spend for 2018/19. A revised operating plan submission is due 20th June.		
Summary of recommendations:	To note the financial results relating to performance during May 2018		
Fit with WH strategy:	Delivering efficient, affordable and effective services. Meet statutory financial duties.		
Reference to related / other documents:	Previous monthly finance reports to the Trust Board. Operational Plan papers. Board Assurance Framework (Section 3).		
Date paper completed:	18 June 2018		

Author name and title:	**Anis Choudhury Head of Financial Planning and Analysis**			**Director name and title:**		**Stephen Bloomer Chief Financial Officer**	
Date paper seen by EC	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

1. Financial Overview

The Trust is reporting a £0.5m deficit for the period to the end of May (month 2) against a planned deficit of £0.3m. Actual performance therefore represents an adverse variance of £0.2m.

The main reason for the Trusts year to date adverse position is the underperformance of income against plan. In total, including Provider Sustainability Funding (PSF), the income performance is £0.9m behind plan. The PSF underperformance contributes £0.3m of this variance, which is a result of the assumption that the Trust will not achieve its improvement trajectory target for A&E performance. The Trust is currently achieving 87.4% against a target of 92.4%. In addition, the Trust is also behind plan in delivering additional income opportunities by £0.3m year to date. The remaining under achievement can be attributed to a number of smaller negative variances.

The Trust is reporting a positive variance in relation to both pay and non-pay in the year to date position.

The pay budget for the Trust is reflective of the anticipated funding levels required to address the recent NHS pay settlement. The increase in salaries will be funded centrally and will result in an uplift of the income position and should not result in a cost pressure to the organisation. In contrast, the current actual costs being reported are not inclusive of this settlement. The expected cost is in the region of £0.4m to £0.5m per month. Therefore after adjusting for this the current pay position is in the region of £0.6m overspent. This adjusted overspend is as a result of the unfunded escalation beds remaining open and contributing to the year to date agency spend which is in excess of £2m.

Non pay expenditure increased in month 2 to £7.3m, overspending by £0.2m. This was mainly on Premises costs and Supplies and Services across a number of ICSUs.

Statement of comprehensive income

2018/19, Month 02 (May 2018)

Statement of Comprehensive Income	In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	YTD Actuals (£000s)	Variance (£000s)	FULL YEAR BUDGET (£000s)
NHS Clinical Income	22,683	22,706	22	45,010	45,942	932	280,370
Non-NHS Clinical Income	1,578	1,061	(518)	3,156	2,207	(949)	0
Other Non-Patient Income	2,097	1,956	(141)	4,193	3,905	(288)	36,187
Income CIPs	175	0	(175)	283	0	(283)	
Total Income	**26,533**	**25,722**	**(811)**	**52,642**	**52,055**	**(587)**	**316,557**
Pay	(18,646)	(18,047)	599	(37,292)	(36,975)	317	(222,445)
Non-Pay	(7,104)	(7,322)	(218)	(14,062)	(13,706)	356	(82,966)
Total Operating Expenditure	**(25,750)**	**(25,369)**	**381**	**(51,354)**	**(50,680)**	**674**	**(305,411)**
EBITDA	**783**	**353**	**(430)**	**1,288**	**1,374**	**86**	**11,146**
Depreciation	(542)	(426)	116	(1,082)	(1,132)	(50)	(6,500)
Dividends Payable	(431)	(430)	1	(861)	(837)	24	(5,174)
Interest Payable	(279)	(290)	(11)	(555)	(571)	(16)	(3,341)
Interest Receivable	1	5	4	2	10	8	12
P/L on Disposal of Assets	0	0	0	0	0	0	0
Total	**(1,251)**	**(1,141)**	**110**	**(2,496)**	**(2,529)**	**(33)**	**(15,003)**
Net Surplus / (Deficit) - before IFRIC 12 and PSF	**(468)**	**(788)**	**(320)**	**(1,208)**	**(1,155)**	**53**	**(3,857)**
Provider Sustainability Fund (PSF)	469	657	188	938	657	*(281)*	*9,380*
Net Surplus / (Deficit) - before	**1**	**(131)**	**(132)**	**(270)**	**(499)**	**(229)**	**5,523**
Add back							
Impairments	0	0	0	0	0	0	(51)
IFRS & Donate	(6)	(5)	(1)	(12)	(13)	1	899
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**7**	**(126)**	**(132)**	**(258)**	**(486)**	**(230)**	**4,675**

2. Income & Activity

Clinical income overall was below plan despite having additional unplanned bed capacity available for the whole month. Analysing the position further:

- Planned care income for Elective and Day Case activity was below plan by over £0.3m year to date. This is despite operational emphasis to drive performance in these areas, as the first quarter has traditionally been challenging to the organisation.
- Maternity pathways and deliveries were £0.1m behind plan in month (£0.2m behind plan year to date).
- Medicine and Surgery ICSUs were furthest from plan, primarily in Trauma and Orthopaedics and General Surgery.
- Unplanned care continues to be ahead of plan by £0.1m in month (£0.5m year to date) driven primarily by non-elective inpatients.

Other income was behind plan driven primarily by lower education income which is as a result of budget phasing rather than underperformance.

Provider sustainability funding is £0.3m adverse year to date. This position reflects a prudent approach, recognising that the Trust may not achieve its target trajectory for A&E performance.

The tables below provide the split of income and activity by category.

Category	In Month Income Plan	In Month Income Actual	In Month Variance	YTD Income Plan	YTD Income Actual	YTD Variance
Accident and Emergency	1,188	1,222	33	2,338	2,364	26
Ambulatory Care	357	405	48	698	760	62
Adult Critical Care	640	437	(203)	1,259	954	(305)
Community Block	5,934	5,934	0	11,867	11,867	0
Day Cases	1,190	1,120	(70)	2,326	2,139	(188)
Diagnostics	260	299	39	508	550	42
Direct Access	1,020	999	(22)	1,994	1,951	(43)
Elective	818	878	59	1,600	1,462	(138)
High Cost Drugs	656	609	(47)	1,312	1,305	(7)
Maternity - Deliveries	1,190	1,150	(40)	2,341	2,218	(124)
Maternity - Pathways	792	686	(106)	1,548	1,431	(116)
Non-Elective	3,389	3,450	60	6,670	7,166	496
OP Attendances - 1st	922	1,058	136	1,802	1,963	161
OP Attendances - follow up	823	790	(32)	1,608	1,501	(107)
OP Procedures	396	399	3	773	788	14
Other Acute Income	1,442	794	(649)	2,856	2,725	(131)
CQUIN	489	474	(15)	966	932	(34)
Total SLA	**21,506**	**20,701**	**(805)**	**42,465**	**42,076**	**(390)**
Marginal Rate	0	0	0	0	0	0
	21,506	**20,701**	**(805)**	**42,465**	**42,076**	**(390)**
Other Clinical Income	2,756	3,065	310	5,701	6,070	370
Other Non Clinical Income	2,272	1,956	(316)	4,476	3,909	(568)
Total Other	**5,027**	**5,022**	**(6)**	**10,177**	**9,979**	**(198)**
Total	**26,533**	**25,722**	**(811)**	**52,642**	**52,055**	**(587)**
Provider Sustainability Fund	469	657	188	938	657	(281)
Revised Total	**27,002**	**26,379**	**(623)**	**53,580**	**52,711**	**(869)**

Category	In Month Activity Plan	In Month Activity Actual	In Month Variance	YTD Activity Plan	YTD Activity Actual	YTD Variance
Accident and Emergency	8,772	9,229	457	17,260	17,875	615
Ambulatory Care	1,458	1,645	187	2,850	3,056	206
Adult Critical Care	1,512	1,234	(278)	2,975	2,635	(340)
Community Block						
Day Cases	1,559	1,511	(48)	3,046	3,025	(21)
Diagnostics	2,636	3,070	434	5,151	5,507	356
Direct Access	100,066	94,394	(5,672)	195,584	187,907	(7,677)
Elective	209	220	11	408	390	(18)
High Cost Drugs						
Maternity - Deliveries	326	330	4	641	622	(19)
Maternity - Pathways	747	656	(91)	1,461	1,365	(96)
Non-Elective	1,619	1,725	106	3,185	3,308	123
OP Attendances - 1st	5,111	5,538	427	9,990	10,635	645
OP Attendances - follow up	13,253	12,116	(1,137)	25,904	24,019	(1,885)
OP Procedures	2,282	2,479	197	4,461	4,864	403
Other Acute Income	7,261	7,263	(409)	14,203	13,390	(813)
CQUIN						
Grand Total	**146,811**	**141,410**	**(5,812)**	**287,121**	**278,598**	**(8,523)**

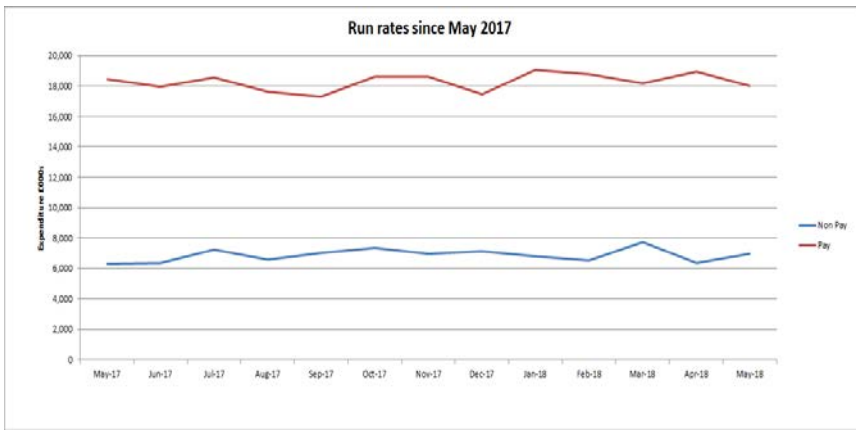
3. Monthly Run Rates – Expenditure

The year to date combined expenditure position is favourable. Key points of note include:

- **Pay**
  - Total pay expenditure for May was £18.0m, which is £0.9m lower than the month 1 pay spend and £0.2m lower than the twelve month rolling average.
  - The in-month reduction in pay is largely the result of the reprofiling of £0.5m of costs in Surgery (Ophthalmology) over the financial year rather than 1 month
  - During May the Trust continued to operate with additional escalation bed capacity. The cost of this was £0.2m.
  - Within total pay expenditure, agency costs were £1.2m. This is 6.7% of the total pay costs for the month, up from 5.5% in month 1 and higher than the 4.3% average for 2017/18. In financial terms agency costs were £0.2m higher than month 1.
  - The agency ceiling target for 2018/19 is £8.8m (£9.5m 17/18). Total agency costs at month 2 are c. £2,2m. Therefore a quarter of the annual ceiling has been expended within the first 2 months of the financial year.

- **Non Pay**
  - Non pay expenditure for May was £7.3m, which is similar to the 12 month average but £0.9m more than month 1
  - This related to increased spending on Premises (utilities costs and fire safety) as well as Supplies and Services across a number of ICSUs.

The graph below provides the pay and non-pay expenditure run rates over a 13 month period from May 2017 to May 2018.



4. Cost Improvement Programme

As part of plans to achieve its control total for 2018/19 the Trust has set a CIP target of £16.5m. The target has been split into three categories:

1. Flow through – the full year effect of schemes that commenced during the last financial year
2. 2% target for cost improvements within each ICSU
3. Transformational schemes that span across the organisation, the scope of which has been derived from analysing model hospital/carter metrics and other benchmarking data

To date £14.6m of plans have been identified across the categories:

- Flow through - £2.7m
- ICSU 2% target - £5.1m
- Transformational schemes - £6.8m

In addition to the £14.6m of plans that have been identified a further £0.9m has been scoped for the transformational schemes, which is being validated to confirm the actual level of delivery possible in 2018/19. Depending upon the level of delivery possible, the current unidentified gap against the full target is in the range of £1.0m to £1.9m.

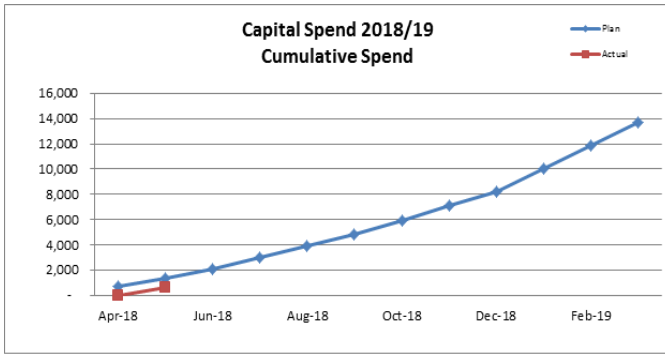
The PMO continues to work with the ICSUs and Corporate functions to identify and develop plans to ensure delivery of the Trust's CIP requirement and has appropriate governance arrangements in place, including the Trust Management Group overseeing progress and being responsible for ensuring corrective actions are undertaken.

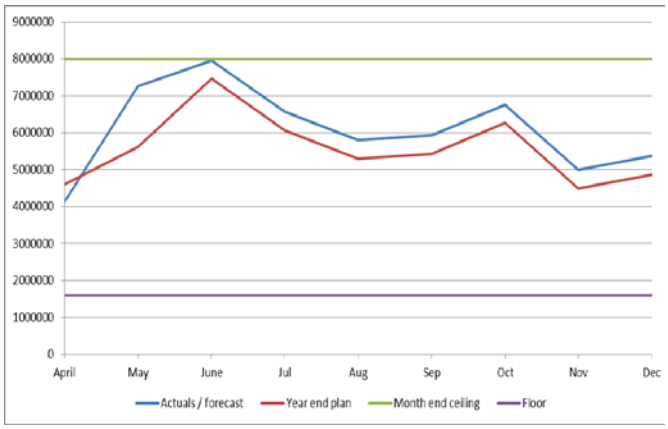
In-year delivery – Month 2

The Trust's CIP programme for 2018/19 has been profiled across the year based on the proposed implementation dates for individual schemes. Based on this profile expected delivery, as at Month 2 was £1.4m, with actual delivery recorded as £0.9m.

	Month 2 - Year to Date			
	Plan £'000	Actual £'000		Variance £'000
Flow Through	437	393	89.9%	(44)
ICSU 2%	619	353	57.0%	(266)
Transformational Schemes	335	103	30.7%	(232)
	1,391	849	61.0%	(542)

5. Statement of Financial Position





THE WHITTINGTON HEALTH NHS TRUST

Statement of Financial Position

	As at 31 May 2018 £000	Plan 31 May 2018 £000	Year to Date Plan variance 31 May 2018 £000
Property, plant and equipment	214,522	216,982	(2,460)
Intangible assets	4,909	4,348	561
Trade and other receivables	678	656	22
Total Non Current Assets	**220,109**	**221,986**	**(1,877)**
Inventories	1,199	1,355	(156)
Trade and other receivables	32,782	31,134	1,648
Cash and cash equivalents	7,268	5,624	1,644
Total Current Assets	**41,249**	**38,113**	**3,136**
Total Assets	**261,358**	**260,099**	**1,259**
Trade and other payables	43,314	39,212	4,102
Borrowings	19,393	1,711	17,682
Provisions	1,303	1,391	(88)
Total Current Liabilities	**64,010**	**42,314**	**21,696**
Net Current Assets (Liabilities)	**(22,761)**	**(4,201)**	**(18,560)**
Total Assets less Current Liabilities	**197,348**	**217,785**	**(20,437)**
Borrowings	38,831	59,487	(20,656)
Provisions	890	842	48
Total Non Current Liabilities	**39,721**	**60,329**	**(20,608)**
Total Assets Employed	**157,627**	**157,456**	**171**
Public dividend capital	64,679	64,679	0
Retained earnings	(5,594)	(5,796)	202
Revaluation reserve	98,542	98,573	(31)
Total Taxpayers' Equity	**157,627**	**157,456**	**171**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**

Overall, the value of the balance sheet is £0.2m away from plan. Variance explanations in each of the main categories are provided below:

- **Property, Plant & Equipment (PPE)** is £1.9m lower than plan for two reasons: (1) expenditure in 2018-19 is £0.8m less than plan. Month 2 was £0.1m behind plan, Month 1 £0.7m behind plan. (2) the opening balance was £1.1m below originally expected levels due to a change in planning assumptions;

- **Receivables (Debtors)** are £1.6m more than plan. This is largely driven by unpaid bonus STF funding (expected in June) offset by receipts for old debt from Islington CCG and Royal Free;

- **Payables (Creditors)** are currently £4m above plan. This relates primarily to delays in processing orders through the new procurement system.

- **Borrowings:** for the Trust's planning submission NHS Improvement (NHSI) requested a different treatment of loan repayments compared to the terms on the loan agreement. As a result there is currently a significant difference between the operating plan submission and the month 1 reporting of the split between the value of loans repayable in less than 1 year and those repayable in more than 1 year. The Trust is still in discussion with NHSI to clarify loan repayments terms.

- **Cash and cash flow:** the Trust is holding £7.3m in cash as at the end of May 2018 (£1.6m higher than plan) due to delays in processing orders. We expect this issue to be resolved in month 3. The Trust has modelled its cash flow for the whole of 2018-19 to assess whether/when cash support will be required. The chart above shows the results of the current modelling and reflects the assumptions used in the revised 2018-19 planning submission to NHSI in April 2018, and concludes that no cash support should be required during 2018/19.

Executive Offices
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Whittington Health Trust Board
Wednesday 27th June 2018

Title:	**Trust Performance report June 2018 (May 2018 data)**		
Agenda item:	**18/096**	**Paper**	**9**
Action requested:	To receive assurance of Trust performance compliance		
Executive Summary:	**Emergency Department (ED) four hours' wait:** Performance against the 95% target for May was 88.4%. This was unfortunately lower than May 2017 which was at 93.5%. Activity was up on last year by 5.7%, 9228 attendances (May 18) against 8700 (May 17). The situation this year was exacerbated by an increase in complex DTOCS and increase in number of over 75s admissions. **Cancer 62 days** The trust missed the target 84% against the national target of 85% predominantly due to Gynaecology and Urology specialties. The key actions are to improve better patient education (Gynaecology) and to progress improvement within the prostate pathway. **Community services** An extended community access report has been included. There is a significant amount of work in progress to improve community access and waiting times. This is overseen by the Community Services Improvement Group (CSIG). **Theatre Utilisation** Theatre utilisation fell below standard this is due to capacity within pre-operative assessment. Actions have been taken to correct the issue with recovery to standard by June 2018.		
Summary of recommendations:	That the board takes assurance the Trust is managing performance compliance and is putting into place remedial actions for areas off plan		
Fit with WH strategy:	Clinical Strategy		
Reference to related / other documents:	N/A		
Reference to risk and corporate risks on the BAF:	N/A		
Date paper completed:	20th June 2018		

Author name and title:		**Hester de Graag, Risk and Quality Manager**		**Director name and title:**		**Carol Gillen, Chief Operating Officer**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Integrated Performance Report

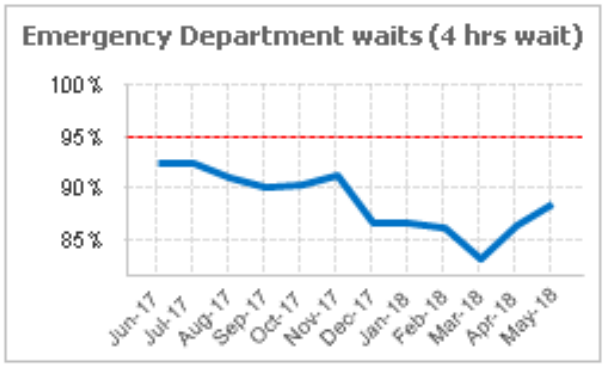
June 2018

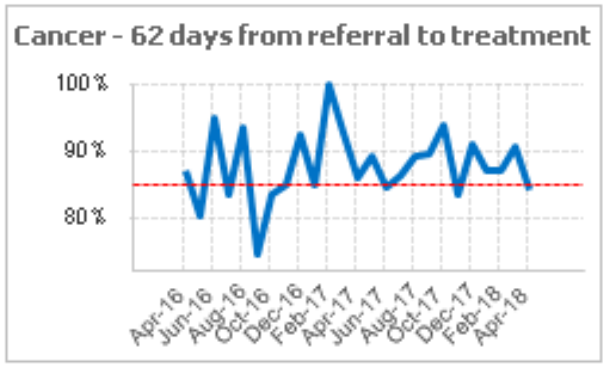
Month 2 (2018 – 2019)

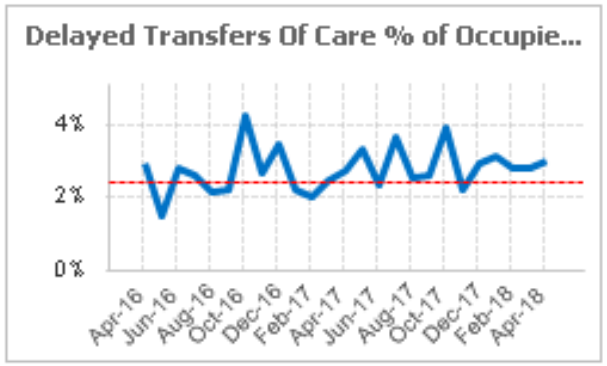
Date & time of production: 22/06/2018 15:52

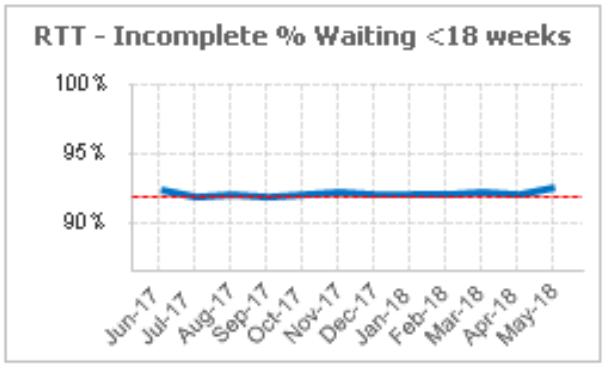
Summary Page - Indicators

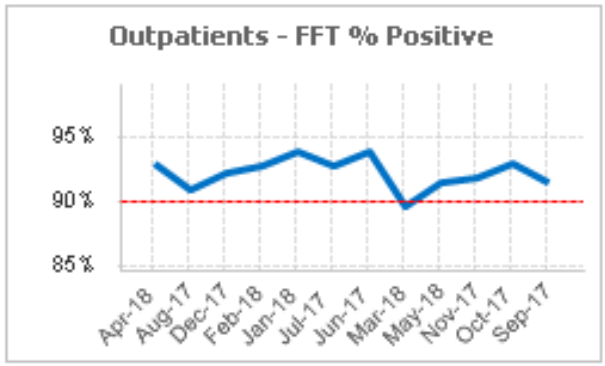
Category	Indicator	17_18 Target	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	2018-2019
ED	Emergency Department waits (4 hrs wait)	**>95%**	92.4%	92.3%	90.9%	89.9%	90.1%	91.3%	86.5%	86.5%	86.1%	83.1%	86.3%	88.4%	87.4%
ED	ED Indicator - median wait for treatment (minutes)	**<60 mins**	63	59	64	72	82	82	81	75	77	95	91	87	89
Cancer	Cancer - 14 days to first seen	**>93%**	95.3%	95.7%	94.7%	94.3%	93.7%	96.1%	96.0%	94.9%	94.2%	95.4%	94.3%		94.3%
Cancer	Cancer - 62 days from referral to treatment	**>85%**	84.4%	86.4%	89.4%	89.5%	93.8%	83.6%	91.2%	87.2%	87.2%	90.7%	84.1%		84.1%
Admitted	Non Elective Re-admissions within 30 days	**<5.5%**	5.8%	6.9%	7.1%	6.5%	7.0%	5.7%	7.3%	5.5%	6.0%	6.4%	6.3%	6.2%	6.2%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	**<2.4%**	2.3%	3.7%	2.6%	2.6%	3.9%	2.2%	3.0%	3.2%	2.8%	2.8%	3.0%		3.0%
Access	RTT - Incomplete % Waiting <18 weeks	**>92%**	92.4%	92.0%	92.1%	92.0%	92.1%	92.2%	92.1%	92.1%	92.1%	92.3%	92.1%	92.6%	92.4%
Outpatients	Outpatients - FFT % Positive	**>90%**	93.9%	92.8%	90.8%	91.5%	93.0%	91.9%	92.3%	93.8%	92.8%	89.6%	93.0%	91.5%	92.1%
Community	Community - FFT % Positive	**>90%**	93.9%	94.8%	96.7%	96.5%	95.3%	94.8%	96.0%	95.4%	94.6%	96.5%	96.2%	95.9%	96.0%
Staff	Staff - FFT % Recommend Care	**>70%**	69.0%			69.4%			70.6%			75.0%			

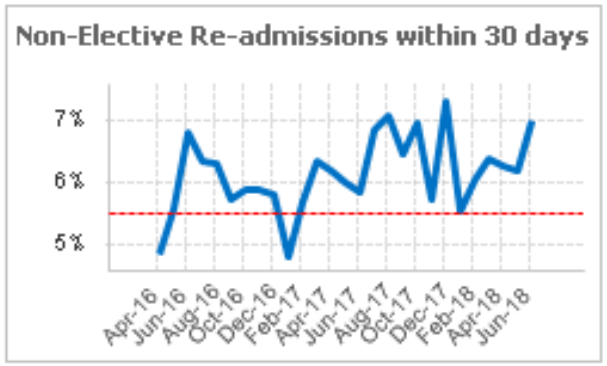












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Safe Services - Indicators and Performance

Category	Indicator	18_19 Target	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	2018-2019	Performance
Admitted	Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	0	1	0	0	0	0	0	0	0	0	
Admitted	HCAI C Difficile	<16	0	1	0	1	3	0	0	0	1	0	1	2	3	
All Areas	CAS Alerts Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
All Areas	Actual Falls	400	45	34	31	27	34	28	35	38	27	43	37	52	89	
All Areas	Avoidable Grade 3 or 4 Pressure Ulcers	0	3	2	2	3	3	3	3	9	3	3	2	5	7	
All Areas	Harm Free Care %	>95%	96.6%	93.5%	93.9%	95.1%	94.1%	93.5%	94.2%	93.4%	92.2%	93.9%	93.3%	95.8%	94.1%	
Maternity	Non Elective C-Section % Rate	<15%	19.7%	22.5%	18.8%	19.8%	20.8%	23.4%	21.7%	18.8%	22.0%	14.5%	17.2%	19.6%	18.5%	
All Areas	Medication Errors causing serious harm	0	0	0	0	0	1	0	0	0	0	0	0	0	0	
Admitted	MRSA Bacteraemia Incidences	0	1	0	0	0	0	1	0	1	0	0	0	0	0	
Admitted	Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
All Areas	Proportion of reported Patient Safety Incidents Causing Harm	N/A	18.3%	17.3%	21.7%	17.1%	16.5%	20.1%	17.2%	19.4%	18.6%	21.5%	19.8%	18.4%	19.1%	
All Areas	Serious Incidents	0	4	3	6	2	5	2	0	7	1	2	6	8	14	
Admitted	VTE Risk Assessment %	>95%	95.6%	95.3%	96.7%	96.0%	95.3%	96.0%	95.2%	95.1%	95.2%	96.2%	95.9%		95.9%	

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Safe Services - Commentary

HCAI C Difficile
The Trust had 2 Trust attributable C.diff cases in May 2018. Post infection review meetings have been held and action plans drafted.

Avoidable grade 3 or 4 pressure ulcers
There has been 4 avoidable category 3 and one avoidable category 4 pressure ulcers within District Nursing during May. NE Haringey, SE Haringey, Central Islington and North Islington teams.

They have been investigated as per process and the themes are:

1. Heel protectors being provided but not used
2. No reassessment of care package needs
3. One incident whereby the air cast boot was not removed therefore skin not assessed even when authorised to remove the boot by the specialist consultant.
4. Assessments not completed or patients not reassessed

An action plan is being developed for each incident an overarching District Nurse action plan is shared across the whole service.

Safe Services - Commentary

Non Elective C–Section % rate

Whittington Health has high risk pregnancies (twins). This is difficult to benchmark as it depends on caseload including in utero transfers from other units. This indicator is based on non –elective singleton cephalic.

Serious Incidents

1. 2018.12811 – [EUC] Delay in Diagnosing a lung malignancy
2. 2018.13561 – [EUC] Readmission to ED following attempted suicide
3. 2018.12153 – [SC] Return to theatre 5 days post anterior resection due to development of septic shock.
4. 2018.13332 - [SC] Return to theatre due to suspicion of a recurrence of giant hiatus hernia,
5. 2018.12155 - [SC] Return to theatre following laparoscopic appendicectomy
6. 2018.12146 – [SC} Delay in Diagnosing a bile duct injury during cholecystectomy.
7. 2018.13327 – [WH] Unexpected Admission to NICU
8. 2018.13530- [WH] Neonatal death at 8 hours and 37 minutes of age.

Actual Falls

There were 52 falls reported in May 2018, 12 were low harm and 1 was moderate. The moderate harm patient fall was investigated using the 72 hour report process and an Internal RCA will be completed.

Caring Services - Indicators and Performance

Category	Indicator	18_19 Target	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	2018-2019	Performance
ED	ED - FFT % Positive	>90%	84.0%	85.5%	83.0%	80.4%	81.6%	83.3%	83.1%	81.9%	82.6%	76.9%	78.7%	80.4%	79.6%	
ED	ED - FFT Response Rate	>15%	13.8%	13.1%	13.7%	12.6%	13.2%	12.3%	11.5%	12.8%	15.3%	14.1%	15.2%	14.1%	14.7%	
Admitted	Inpatients - FFT % Positive	>90%	97.0%	95.8%	95.2%	97.7%	98.3%	98.3%	97.2%	96.5%	96.4%	95.9%	96.3%	96.4%	96.3%	
Admitted	Inpatients - FFT Response Rate	>25%	19.8%	20.9%	14.9%	16.0%	18.0%	18.2%	16.1%	17.4%	17.9%	16.2%	16.4%	22.2%	19.4%	
Maternity	Maternity - FFT % Positive	>90%	88.1%	92.7%	89.4%	92.4%	94.9%	96.0%	95.9%	95.9%	99.3%	97.0%	95.8%	92.8%	94.3%	
Maternity	Maternity - FFT Response Rate	>15%	20.1%	23.5%	30.1%	18.5%	37.4%	36.2%	49.8%	56.3%	61.0%	18.7%	58.5%	49.4%	53.7%	
Outpatients	Outpatients - FFT % Positive	>90%	93.9%	92.8%	90.8%	91.5%	93.0%	91.9%	92.3%	93.8%	92.8%	89.6%	93.0%	91.5%	92.1%	
Outpatients	Outpatients - FFT Responses	400	537	485	338	433	569	593	336	420	461	249	327	445	772	
Community	Community - FFT % Positive	>90%	93.9%	94.8%	96.7%	96.5%	95.3%	94.8%	96.0%	95.4%	94.6%	96.5%	96.2%	95.9%	96.0%	
Community	Community - FFT Responses	1500	970	1224	858	940	731	638	605	875	1157	779	1206	1181	2387	
Staff	Staff - FFT % Recommend Care	>70%	69.0%			69.4%			70.6%			75.0%				
All Areas	Complaints responded to within 25 working day	>80%	93.9%	76.0%	81.0%	72.2%	72.7%	68.8%	88.2%	76.9%	87.5%	92.0%	71.4%	78.3%	74.5%	
All Areas	Complaints (including complaints against Corporate division)	N/A	38	32	24	25	26	24	18	30	21	33	33	30	63	

**Staff FFT % Recommended Care or Dec-17 is based on the Staff Survey results (not the Staff FFT).

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Caring Services - Commentary

Friends and Family Tests (FFT)

The maternity services continued to record an overall positive recommend rate of above 90% and a response rate of above 15%. This consistently strong performance is due in part to members of staff using follow-up telephone calls to patients, and collecting FFT in this manner.

The Emergency Department continued to record an improved response rate through the first half of 2018. The response rate of 14.1% is below the set KPI of 15%, but May marks the fourth month over the past twelve where the Emergency Department has recorded a response rate in excess of 14% (these four months being Feb-May 2018). An iPad has been allocated to the paediatric department in A&E to increase feedback, and the department has volunteer support three times a week with collecting FFT.

The inpatient areas maintained their positive recommend rate of 96% for the fourth consecutive month. There was a noted increase in response rate from 16% in April to 22% in May. This increase has been due to the increased efforts of nursing and administrative staff in FFT collection. Added volunteer support on the wards has also supported this increase.

The community continued to record FFT collection in excess of 1,000 responses for the third time in four months. The positive recommend rate is at 96%. Continued efforts for FFT collection in the community podiatry, physiotherapy and district nursing team has been supported by the patient experience and volunteer teams.

Outpatients exceeded their KPI of 400 responses with 445 in May, and a positive recommend rate of 91.5%.

Complaints responded to within 25 working days

During April 2018 the Trust closed 30 complaints; 23 complaints required a response with 25 working days and 7 were allocated 40 working days for investigation due to their complexity.

In regard to the 25 working day target of 80%, the Trust achieved a performance of 78%.

- Three complaints allocated 25 working days remain outstanding and overdue, i.e. IM (1), EUC (1) and PPP (1).
- In addition, one working day complaints also remains outstanding and overdue, i.e. Finance (1).
- 43% of complaints (3) allocated 40 working days hit their target.

The majority of complaints were allocated to EUC 27% (8), IM 20% (6) and S&C 20% (6).

Severity of complaints: 30% (9) were designated 'moderate', 67% (20) were designated 'low' risk and 3% (1) were designated 'high'.

- The complaint designated high risk related to 'nursing care' (i.e. inadequate monitoring provided).

A review of the complaints for May shows that 'medical care' 30% (9) and 'attitude 30% (9) were the main issue for patients. In May this was followed by 'nursing care' 17% (5).

- In regard to 'medical care,' 44% of patients (4) felt that 'inadequate treatment' had been provided, 44% (4) also felt that 'poor treatment' had been provided.
- In regard to 'attitude', 44% % of patients (4) stated that staff were 'rude' and/or 'disrespectful'; 33% (3) patients displayed 'inappropriate behaviour'.
- In regard to 'nursing care', the concerns raised were split evenly across EOLC, inadequate monitoring, poor nutrition, poor practice and poor standard of care being provided.

Of the 26 complaints that have closed, (including those allocated 40 working days), 69% (18) were 'upheld', and 11% (3) were 'partially upheld' meaning that, currently, 80% have been upheld in one form or another.

Effective Services - Indicators and Performance

Category	Indicator	18_19 Target	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	2018-2019	Performance
Maternity	Breastfeeding Initiated	>90%	93.3%	94.5%	92.3%	93.2%	91.7%	92.5%	90.7%	92.7%	92.0%	94.2%	95.8%	93.0%	94.3%	
Maternity	Smoking at Delivery	<6%	5.7%	7.5%	4.8%	7.1%	6.2%	6.3%	4.3%	3.8%	5.2%	4.5%	7.0%	5.1%	6.0%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	5.8%	6.9%	7.1%	6.5%	7.0%	5.7%	7.3%	5.5%	6.0%	6.4%	6.3%	6.2%	6.2%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	75.5	69.6	77.0	44.6	86.3	89.6	75.2							
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	104.5	71.8	91.6	38.2	98.9	96.9	44.6							
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont...	1.14	0.73			0.73										
Admitted	Mortality rate per 1000 admissions in-months	14.4	6.5	6.4	7.2	2.6	8.6	8.5	12.0	9.4	9.9	10.3	7.3	7.3	7.3	
Community	IAPT Moving to Recovery	>50%	56.4%	52.3%	56.5%	55.1%	50.8%	53.0%	50.9%	47.5%	51.4%	59.4%	56.3%		56.3%	
Community	% seen <=2 hours of Referral to District Nursing Night Service	>80%				84.2%	90.6%	86.7%	80.4%	96.1%	88.9%	90.2%	90.0%	94.1%	92.2%	
Community	% seen <=48 hours of Referral to District Nursing Service	>95%		100.0%		26.8%	52.6%	75.4%	86.0%	92.4%	91.4%	87.1%	82.5%	90.0%	86.2%	

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Effective Services - Commentary

Non Elective re-admission within 30 days

Re-admission rates have seen a decrease by 0.1% for the last 2 months. Discharge to assess pathway 1 (Islington and Haringey) readmissions are being audited on-going on a monthly basis and will be reported on a quarterly basis. This report will be available In July 2018. Lessons learned from the medical wards Service Improvement project (flow) completed in March 2018 have contributed to the minor reduction. Sharing details of the care agency on discharge has improved communication between the Trust and providers and also had a positive impact on Delayed Transfer of Care (DTOCs) and subsequent lengths of stay.

% seen < 48 hours of referral to District Nursing Service

There was a total of 4 patients not seen within the target of <48 hours. However there were viable clinical and case preferences that determined this was the correct patient outcome.

Of the 4 patients one patient did not meet District Nursing criteria and was rejected during triage, this has since been updated in RiO. One patient was discharged after triage following review by a Lead District Nurse and did not need to be seen. The third patient was admitted elsewhere and the system was not updated within 48 hours and the fourth patient had visits planned outside of the 48 hours which was a planned delay following conversations with the family.

Responsive Services - Indicators and Performance

Category	Indicator	18_19 Target	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	2018-2019	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	92.4%	92.3%	90.9%	89.9%	90.1%	91.3%	86.5%	86.5%	86.1%	83.1%	86.3%	88.4%	87.4%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	63	59	64	72	82	82	81	75	77	95	91	87	89	
ED	Ambulance handovers waiting more than 30 mins	0	40	27	23	35	38	15	34	34	37	69	22		22	
ED	Ambulance handovers waiting more than 60 mins	0	7	4	2	1	0	3	11	12	3	18	8		8	
ED	12 hour trolley waits in A&E	0	3	2	4	3	0	0	0	0	0	0	0	0	0	
Cancer	Cancer - 14 days to first seen	>93%	95.3%	95.7%	94.7%	94.3%	93.7%	96.1%	96.0%	94.9%	94.2%	95.4%	94.3%		94.3%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	100.0%	100.0%	95.9%	98.1%	98.9%	100.0%	100.0%	97.9%	95.0%	97.0%	97.7%		97.7%	
Cancer	Cancer - 62 days from referral to treatment	>85%	84.4%	86.4%	89.4%	89.5%	93.8%	83.6%	91.2%	87.2%	87.2%	90.7%	84.1%		84.1%	
Cancer	Cancer - 31 days to first treatment	>96%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Cancer	Cancer - 31 days to subsequent treatment - surgery	>94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Cancer	Cancer - 31 days to subsequent treatment - drugs	>98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Cancer	Cancer - 62 Day Screening	>90%	100.0%		100.0%											
Cancer	Cancer - 62 Day Upgrade															
Access	DM01 - Diagnostic Waits (<6 weeks)	>99%	99.1%	99.0%	99.0%	99.1%	99.1%	99.2%	99.1%	99.1%	99.1%	99.2%	99.1%	99.0%	99.1%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.4%	92.0%	92.1%	92.0%	92.1%	92.2%	92.1%	92.1%	92.1%	92.3%	92.1%	92.6%	92.4%	
Access	Referral to Treatment 18 weeks - 52 Week Waits	0	0	3	1	1	0	0	0	0	0	0	0	0	0	

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Responsive Services - Commentary

Emergency Department (ED) four hours' wait and Ambulance handover time
Performance against the 95% target for May was 88.4%. This was unfortunately lower than May 2017 which was at 93.5%.

Activity was up on last year by 5.7%, 9228 attendances (May 18) against 8700 (May 17). The situation this year was exacerbated by an increase in complex DTOCS and increase in number of over 75s admissions.

Ambulance activity was up by 10.5% compared to the same time last year; 1820 (May 18) compared to 1629 (May 17).

Actions: The trust has implemented bi-weekly MADE (Multiple Discharge Events), attended by senior representatives from both Haringey and Islington.

There is a continued focus on reducing stranded (over 7 days) and super stranded (over 21 days) there has been good progress in reducing the latter from 18% to 14% bed base. The expectation is for the trust is to reduce long stay patients by a further 25% by December 2018, this equates to 12 beds *(ref letter NHS E – reducing long stays in hospital – to reduce patient harm and bed occupancy)*

The following are the main areas of focus specific to Emergency Department:

- Increase streaming to primary care - trajectory agreed
- Increase streaming to ambulatory care - trajectory agreed
- Extended working time July – ED consultants and ENPs
- Increase effectiveness of frailty pathway
- Rapid assessment and treatment (RAT) refocus to achieve time to treat target
- ED Super week is scheduled for week commencing 9th July

Cancer Performance - 62D and 2WW by Tumour Group

Cancer – 2WW Performance by Tumour Group

		Q1	Q2	Q2	Q2	Q3	Q3	Q3	Q4	Q4	Q4	Q1	Q1		
Indicator	17_18 Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	2017-2018	Performance
Breast	>93%	98.6%	99.2%	93.9%	98.3%	98.7%	97.3%	99.0%	98.8%	95.1%	95.4%	97.8%		97.4%	
Childrens	>93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%		100.0%	
Gynaecological	>93%	96.5%	96.2%	100.0%	100.0%	96.5%	100.0%	100.0%	96.2%	98.5%	94.4%	90.0%		97.8%	
Haematological	>93%	100.0%	100.0%	100.0%	85.7%	100.0%	88.9%	100.0%	100.0%	50.0%	83.3%	100.0%		92.0%	
Lower Gastrointestinal	>93%	93.9%	89.3%	88.0%	89.7%	79.7%	93.9%	90.6%	87.2%	90.7%	91.8%	92.5%		89.6%	
Lung	>93%	92.9%	100.0%	100.0%	90.5%	100.0%	84.2%	100.0%	96.2%	95.2%	94.1%	100.0%		95.0%	
Other	>93%														
Skin	>93%	98.6%	99.4%	99.4%	98.7%	97.1%	100.0%	100.0%	98.0%	98.6%	99.3%	97.4%		98.9%	
Upper Gastrointestinal	>93%	77.6%	83.8%	79.5%	57.7%	77.8%	78.8%	60.0%	73.5%	80.8%	98.3%	82.4%		79.5%	
Urological	>93%	95.7%	98.2%	100.0%	95.9%	100.0%	98.5%	100.0%	98.9%	97.3%	95.5%	93.6%		97.9%	

Cancer
The cancer standard for 2 week wait (2ww) and 31 day has been achieved by the Trust but we achieved 84% against the national target of 85% for 62 day.

2 week wait report
Gynaecology: 90%, 8 breaches out of 80

Colorectal: 92.52%, 11 breaches out of 147

Upper GI: 82.35%, 6 breaches out of 34

62 day report
Colorectal: 80%, 1 breach out of 5, patient was on holiday & delayed diagnostic tests

Gynaecology: 66%, 2x 0.5 breaches out of 1.5, both patients chose to delay their diagnostic tests (1 x 3mths & 1x 5weeks).

Upper GI: 50%, 1 breach out of 2, Incidental findings from head & Neck SMDT then referred to Upper GI day 31.

Urology: 90%, 0.5 breach out of 5, patient came through the haematuria pathway, needed multiple tests then transferred to RFH.

Action: to review Gynaecology information leaflet, to improve communication with GP so that patients are prepared for their 1st appointment i.e. one stop clinic.

Community Average Waits

Community Average Waits from Referral Received Date to Date First Seen

	ROUTINE REFERRALS							URGENT REFERRALS						
SERVICE	% Threshold	Target Weeks	Mar-18	Apr-18	May-18	Avg Wait (Last Mth)	No. of Waiters	% Threshold	Target Weeks	Mar-18	Apr-18	May-18	Avg Wait (Last Mth)	No. of Waiters
CAMHS	>95%	8	70.5%	67.4%	67.1%	6.7	149	>95%	2	100.0%	100.0%		-	0
Child Development Services	>95%	8	67.0%	44.2%	62.3%	1.2	53	>95%	2				-	0
Community Children's Nursing	>95%	2	78.9%	83.3%	85.5%	7.9	83	>95%	1	100.0%	100.0%	100.0%	0.2	8
Community Paediatrics Services	>95%	12	80.6%	57.1%	84.2%	5.8	38	>95%	1	46.3%	37.8%	42.3%	5.8	52
Haematology Service	>95%	12	100.0%	100.0%	100.0%	1.0	8	>95%	2				-	0
Looked After Children	>95%	4	45.8%	75.0%	76.0%	4.9	25	>95%	2				-	0
Occupational Therapy	>95%	8	43.3%	19.2%	31.8%	13.5	22	>95%	2				-	0
Physiotherapy	>95%	8	54.7%	56.3%	46.8%	7.6	94	>95%	2				-	0
PIPS	>95%	12	100.0%	100.0%	100.0%	4.5	18	>95%	-				-	0
School Nursing	>95%	12	81.2%	88.6%	87.4%	5.4	95	>95%	-				-	0
Speech and Language Therapy	>95%	6	33.8%	35.8%	35.5%	9.5	214	>95%	2	11.1%		0.0%	4.0	1
Bladder and Bowel - Children	>95%	12	57.1%	28.6%	37.5%	13.8	16	>95%	-				-	0
Community Matron	>95%	6	98.6%	100.0%	95.7%	1.1	46	>95%	2				-	0
Adult Wheelchair Service	>95%	8	100.0%	87.1%	97.8%	3.7	46	>95%	2	0.0%			-	0
Cardiology Service	>95%	6	93.1%	100.0%	100.0%	2.7	18	>95%	2	0.0%	0.0%	100.0%	1.3	6
Community Rehabilitation (CRT)	>95%	12	94.5%	96.9%	95.4%	3.6	131	>95%	2	62.1%	62.9%	56.5%	2.2	23
Community Rehabilitation (ICTT)	>95%	12	84.5%	78.0%	84.9%	5.8	352	>95%	2	43.2%	29.3%	37.5%	3.7	88
Diabetes Service	>95%	6	66.4%	65.7%	71.3%	5.4	108	>95%	2	100.0%	100.0%	100.0%	0.5	2
Intermediate Care (REACH)	>95%	6	85.7%	86.3%	80.6%	5.0	93	>95%	2	81.4%	60.7%	41.4%	3.3	29
Paediatric Wheelchair Service	>95%	8	83.3%	80.0%	100.0%	5.6	2	>95%	2				-	0
Respiratory Service	>95%	6	80.3%	53.2%	36.1%	6.2	108	>95%	2	15.6%	6.5%	0.0%	8.2	6
Bladder and Bowel - Adult	>95%	12	51.2%	42.2%	50.0%	15.1	495	>95%	2	0.0%	0.0%		-	0
Musculoskeletal Service - CATS	>95%	6	94.9%	81.5%	76.0%	4.3	120	>95%	2	0.0%	0.0%	75.0%	2.0	4
Musculoskeletal Service - Routine	>95%	6	83.9%	89.4%	92.1%	3.5	1546	>95%	2				1.3	15
Nutrition and Dietetics	>95%	6	72.0%	74.2%	83.9%	3.5	211	>95%	2	72.0%			-	0
Podiatry (Foot Health)	>95%	6	58.4%	38.2%	59.7%	5.3	645	>95%	2	58.4%	38.2%	59.7%	3.0	9
Tissue Viability and Lymphodema...	>95%	6	83.3%	73.3%	95.2%	3.1	21	>95%	2	80.0%	75.0%	69.7%	-	99

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Community Services (wait times)
The above report includes the revised and agreed waiting time targets for community services.
There is still a significant amount of work to do in reducing waiting times and improving access within CYP and Adult services (Adult community ICSU for 1/7/18).

Challenges have included workforce with specific vacancies particularly in therapy services (CYP), an increase in referrals (Community Paediatrics) in particular for the ASD (Autistic spectrum disorder) pathway.

The Educational Health Care Plans (EHCP) has in addition placed increased demand on OT services.
These areas are being address at the Community Services Improvement Group (CSIG) working with commissioning and primary care colleagues.

Some progress has been made in redesigning services (Adult) and podiatry and Nutrition & Dietetics are showing steady progress in improving access.

Trajectories are being agreed with service leads and will be monitored at CSIG.

The service leads are also using be using benchmarking tools to further improve productivity and inform service redesign.
Whittington Health has expressed a keen interest to participate in the development of national benchmarking dashboards for services delivered in the community *(Carter Review of community productivity)*

Category	Indicator	18_19 Target	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	2018-2019	Performance
Theatres	Hospital Cancelled Operations	0	9	2	6	8	15	9	10	8	2	8	3		3	
Theatres	Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	5	1	1	0	0	0		0	
Theatres	Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0		0	
Admitted	Delayed Transfers Of Care - Days Lost	N/A	210	334	250	247	398	211	282	334	269	312	292		292	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<2.4%	2.3%	3.7%	2.6%	2.6%	3.9%	2.2%	3.0%	3.2%	2.8%	2.8%	3.0%		3.0%	
Maternity	Women seen by HCP / midwife within 10 weeks	>50%	48.7%	58.0%	61.4%	59.0%	56.8%	65.2%	64.0%	52.6%	47.5%	61.7%	59.3%	62.5%	60.8%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%	94.7%	94.7%	97.3%	98.8%	95.0%	97.5%	94.5%	95.0%	93.6%	94.5%	93.9%		93.9%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	91.9%	88.7%	89.3%	89.4%	91.6%	88.6%	86.1%	91.7%	93.4%	90.5%	89.4%		89.4%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	96.1%	91.7%	94.6%	94.8%	92.1%	96.6%	95.3%	96.2%	94.6%	96.4%	93.9%		93.9%	
Community	Haringey - HR1 % carried out before child aged 15 months		46.2%	45.5%	39.5%	33.3%	68.6%	66.7%	60.5%	66.8%	67.3%	65.2%	66.6%		66.6%	
Community	Haringey - HR2 % carried out before child aged 30 months		38.5%	49.0%	36.0%	51.1%	45.0%	44.1%	38.3%	61.0%	68.4%	61.2%	57.1%		57.1%	
Community	Islington - HR1 % carried out before child aged 15 mths		71.2%	60.9%	68.4%	72.5%	66.7%	67.8%	67.9%	72.5%	78.9%	81.5%	69.6%		69.6%	
Community	Islington - HR2 % carried out before child aged 30 mths		72.7%	79.8%	72.5%	72.6%	65.2%	75.3%	71.9%	71.6%	71.0%	76.8%	77.8%		77.8%	
Community	Haringey - 8wk Review % carried out before child aged 8 weeks		33.8%	42.3%	31.2%	35.3%	31.1%	32.8%	32.8%	26.7%	27.7%	40.3%	38.0%		38.0%	
Community	Islington - 8wk Review % carried out before child aged 8 weeks		44.6%	48.1%	48.4%	41.4%	55.7%	60.5%	60.5%	55.5%	71.1%	66.0%	68.2%		68.2%	

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Hospital Cancelled Operations

1 urgent patient gynaecology admin error patient was told to arrive at the wrong time and would not wait
2 patients gynaecology two separate theatre lists overran and as such a patient on each list had to be rebooked

Delayed Transfers of Care

Change in reporting of DTOCs show Improvement throughout the year and continues after winter period.. Overall occupied bed days delays has reduced from March to April 2018. MADE meetings have now increased to twice weekly. Across the 5 months the MADE event has been running (since Jan 2018 to May 2018), external bed capacity, this included Intermediate Bed (community hospital beds) and residential/nursing homes contributes to 50% of delays. In February 2018 there were capacity issues relating to completing external assessments.

Discharge to Asses

The trust now has 5 months data on 99 of 102 patients discharged Oct 2017 - Feb 2018 from Whittington Hospital to home via Islington D2A pathway-1. Re-admission rate in the first week i slow at 4% and the 30 day readmission rate is 17%. The 30 day readmission rate in this cohort of patients who require additional support on discharge compares favourably with the 22% 30 day readmission rate for all Islington adult (> 55yrs) with acute admissions in the same time period.

New Birth Visits
Islington: 93.9% Slight fall just below target of 95% (previous month 96.7%). Strong correlation between performance and vacancies; recruitment in process

Haringey: 89.4% Slight fall from previous months 90.2% - mainly down to vacancies; 3x Health Visitors in recruitment process. Improvement plan in place to achieve 95% target

Mandated HCP: Health Reviews at 8 weeks, 1 and 2 – 2 ½ years
1 year review at 15 months:

Islington 69.6% significant fall in performance following last month's high of 81.6%.

Haringey 66.6% improvement on month and plan in place to ensure on track to achieve trajectory of 80% by Q2

2 – 2 ½ review at 30 months:

Islington 77.8% continue to deliver upward trajectory

Haringey 57.1% disappointing consecutive fall; plan in place get back on track to achieve agreed trajectory.

6-8 week review

Islington 67.9% steady progress by Islington and remain on track.

Haringey 37.8% continued improved and on track to achieve target of 40% by Q2

Haringey is working to improve all aspects of the mandated HCP with a robust service improvement plan to achieve trajectories agreed below:

- NBV - 95%
- 6-8 weeks - 50% (40% by Q2)
- 1 year review at 15 months - 80% by Q2
- 2 year review at 30 months - 80% by Q2
- Integrated 2 year review at 30 months - 65% (30% by Q2)

Well Led Services - Indicators and Performance

Category	Indicator	18_19 Target	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	2018-2019	Performance
HR	Appraisals % Rate	>90%	79%	78%	78%	75%	71%	69%	71%	71%	72%	69%	70%	71%		
HR	Mandatory Training % Rate	>90%	82%	82%	82%	79%	80%	80%	81%	81%	81%	83%	83%	83%		
HR	Permanent Staffing WTEs Utilised	>90%	87.4%	86.1%	87.4%	87.3%	87.9%	87.6%	86.3%	87.3%	87.3%	87.3%	87.4%	87.2%	87.3%	
HR	Staff FFT % recommended work	>50%	54.5%			53.3%			59.5%			58.6%				
HR	Staff FFT response rate	>20%	18.2%			21.5%			39.1%			17.3%				
HR	Staff sickness absence %	<3.5%	3.54%	3.22%	3.40%	3.30%	3.61%	3.57%	3.65%	4.01%	3.73%	3.02%	3.27%		3.27%	
HR	Staff turnover %	<10%	14.0%	14.7%	15.0%	14.4%	14.1%	14.3%	14.5%	14.4%	14.7%	14.6%	13.9%		13.9%	
HR	Vacancy % Rate against Establishment	<10%	12.6%	13.9%	12.6%	12.7%	12.1%	12.4%	13.7%	12.7%	12.7%	12.7%	12.6%	12.8%	12.7%	
HR	Nursing Staff Average % Day Fill Rate - Nurses		85.7%	87.3%	85.9%	79.6%	85.2%	81.0%	80.7%	78.9%	78.8%	86.4%	93.5%	79.7%	85.8%	
HR	Nursing Staff Average % Day Fill Rate - HCAs		111.4%	114.3%	110.7%	122.8%	133.3%	129.9%	136.1%	131.5%	137.9%	159.4%	175.6%	141.9%	156.7%	
HR	Nursing Staff Average % Night Fill Rate - Nurses		92.4%	92.3%	92.8%	102.8%	96.0%	91.3%	92.0%	89.1%	89.3%	97.7%	101.1%	86.4%	93.0%	
HR	Nursing Staff Average % Night Fill Rate - HCAs		118.1%	128.2%	113.8%	136.7%	146.2%	143.9%	141.7%	148.2%	143.9%	161.8%	174.3%	145.1%	158.2%	
HR	Safe Staffing Alerts - Number of Red Shifts		0	0	121	55	32	16	33	31	12	19	18	8	26	

**Staff FFT % Recommended Work and Staff FFT Response Rate for Dec-17 is based on the Staff Survey results (not the Staff FFT).

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Average Staff Cost Per Patient

Category	Staff Type	17_18 Target	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Trend
Medical	Average staff cost per patient		95	96	97	97	95	94	93	98	104	96	101	
Nursing	Average staff cost per patient		169	171	171	164	165	167	198	167	182	181	182	
Other	Average staff cost per patient		194	209	205	209	196	193	214	191	195	166	203	

Well Led Services - Commentary

Human Resources

Indicator	April	May	Change from previous
Sickness absence	3.27%		Worsened (was 3.02% in March)
Turnover	Already reported	14.34%	Worsened (was 13.9% in April)
Vacancy	(Already reported) 12.6%	12.76%	Slight improvement
Mandatory training	(Already reported) 83%	83%	No change
Appraisal	(Already reported) 70%	71%	Slight improvement

Staff turnover increased between April and May. Vacancy factor has very slightly improved between April and May.

A range of retention initiatives are under development to tackle the issues to encourage staff to stay in post for longer and, as the Board is aware, recruitment remains a major corporate area of focus and developing practice, maximising opportunities for both UK based and international recruitment.

Due to the change in Board dates, sickness absence is now reported a month in arrears. In April sickness was at 3.27%; still above target at 3.27%.

Considerable work to data cleanse the appraisal figures (i.e. ensuring that specific staff groups whose appraisals are separately enforced such as junior doctors), along with a renewed focus on improving coverage by each ICSU has resulted in a small, but welcome, improvement in May to 71%. Mandatory training figures remain unchanged at 83% between last month and this.

Activity - Indicators and Performance

Category	Indicator	18_19 Target	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Q1 May-18	Activity
ED	ED Attendances	8285	8239	8537	7853	8051	8816	8549	8579	8897	8082	9217	8645	9228	
ED	ED Admission Rate %		16.0%	15.1%	15.8%	16.5%	17.0%	16.9%	15.4%	15.3%	14.7%	14.8%	15.6%	15.8%	
Community	Community DNA Rate %	<10%	7.6%	7.3%	7.8%	7.7%	8.1%	8.0%	6.8%	7.6%	7.6%	7.7%	7.8%	8.0%	
Community	Community Face to Face Contacts		61550	59822	51878	57506	57627	60661	50462	59992	54166	60196	55572	63258	
Admissions	Elective and Daycase		1931	1904	1830	1828	1907	2004	1587	1944	1735	1877	1716	1814	
Admissions	Emergency Inpatients		2131	2163	2136	2242	2455	2368	2180	2216	1908	2248	2179	2338	
Referrals	GP Referrals to an Acute Service		7044	6827	7141	6764	7436	7454	5747	7619	7151	7672	7008	7462	
Referrals	% of GP Referrals that were completed via ERS		21.5%	23.3%	29.1%	31.3%	33.9%	35.8%	39.0%	48.2%	46.0%	49.1%	60.4%	77.3%	
Referrals	% e-Referral Service (e-RS) Slot Issues	<4%	39.1%	35.7%	25.0%	22.4%	17.3%	14.7%	10.3%	13.3%	16.8%	17.4%	18.2%	12.2%	
Maternity	Maternity Births	333	322	314	319	344	347	337	332	321	253	315	291	325	
Maternity	Maternity Bookings	377	364	380	378	338	420	385	302	405	375	370	400	369	
Outpatients	Outpatient DNA Rate % - New	<10%	11.3%	11.8%	12.6%	11.4%	11.0%	10.3%	11.1%	10.9%	10.9%	10.7%	10.0%	10.9%	
Outpatients	Outpatient DNA Rate % - FUp	<10%	10.2%	11.7%	12.0%	11.1%	10.2%	10.2%	10.7%	12.1%	9.9%	10.9%	10.1%	12.2%	
Outpatients	Outpatient New Attendances		9115	8635	8755	8884	9777	10117	8005	10495	9209	9587	9296	10172	
Outpatients	Outpatient FUp Attendances		18941	17779	17369	17418	19454	19249	15879	18871	16533	17735	17342	18222	
Outpatients	Outpatient Procedures		6354	5747	5786	6470	7097	7451	5837	7410	6818	7066	6768	7385	
Theatres	Theatre Utilisation	>85%	82.7%	83.4%	80.8%	81.2%	86.1%	85.6%	85.7%	85.6%	87.2%	88.8%	85.3%	83.6%	

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Average Tariff by Point of Delivery (POD)

Category	Point of Delivery (POD)	17_18 Target	Q1 Jun-17	Q2 Jul-17	Q2 Aug-17	Q2 Sep-17	Q3 Oct-17	Q3 Nov-17	Q3 Dec-17	Q4 Jan-18	Q4 Feb-18	Q4 Mar-18	Q1 Apr-18	Trend
Average Tariff	Daycases		709	699	704	693	687	717	710	697	684	614	740	
Average Tariff	Elective		3726	4014	3535	4042	3959	3525	3526	3403	3550	3710	4033	
Average Tariff	Non-Elective		2356	2199	2335	1693	2188	2180	2561	2670	2362	2194	2484	

Activity - Commentary

Maternity bookings and Births
Booking showing as 369, low for May, however did have high number of 400 in April (>23 above plan)
Births show 325 (8 below plan) which is an increase from previous month of 291

Theatre Utilisation
In the middle of March the Trust had significant capacity issues within Pre – operative assessment which reduced the pool of available patients for theatre, in particular T&O and General Surgery.

Immediate action has been taken to correct this issue lead by the clinical lead and we are already now seeing an increase in activity and also in theatre utilisation.

The expectation is that the Trust will achieve 85% utilisation for June 2018.

Activity - Commentary

DNA rate

There has been a continued decrease in DNA rates across majority of the 17 services which are now using DrDoctor; however we have also seen a steady increase in last minute cancellations (LMC). A roll out date for the access centre has been agreed for October 2018. This delayed roll out date will allow eRS to transition to business as usual and not overload the access centre with additional work in terms of appointment management via a new system. In the time between now and October 2018, clinic codes will be migrated over from the old text reminder service (Remind+) to DrDoctor for text reminders only, with the plan to seamlessly switch on the rescheduling feature in October.

eRS

From 16th April Whittington Health have been accepting all GP referrals to and Consultant Led Outpatients Services via the NHS e-Referral System. All exception have been agreed and Whittington Health have weekly implementation group in place represented by all services, eRS leads in Haringey and Islington CCG and Local and regional NHS Digital.

GP's use of making referrals using eRS is increasing rapidly, showing over 80% in May 18. The ASI List is 12% for May 2018 a reduction of 1/3 from 18% in April 2018. All service managers are reviewing the services' slot capacity daily and the list is also checked at the Weekly PTL and eRS implementation Group Meetings.

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Trust Board

27th June 2018

Title:	Annual Report and Accounts 2017/18		
Agenda item:	**18/097**	**Paper**	**10**
Action requested:	For approval		
Executive Summary:	This paper accompanies the 2017/18 Annual Accounts and sets out: • Key judgements made as part of preparation of the financial statements; • Key movements and material variances between the 2017-18 and 2016-17 financial statements; • Commentary on material variances from plan during 2017-18; and • Significant changes made to the financial statements from the draft submitted to NHSI on 24 April 2018.		
Summary of recommendations:	The Trust Board is asked to approval and adopt following the recommendation from Audit Committee		
Fit with WH strategy:	Delivering efficient, affordable and effective services. Meet statutory duties		
Reference to related / other documents:	Audit Committee: October 2017 – Paper 11 Final Accounts Timetable & Plans January 2018 – Paper 10 Accounting Treatments (joint paper) January 2018 – Paper 11 Final Accounts Timetable & Plan May 2018 – Paper 12 Annual Accounts		
Date paper completed:	16 May 2018		

Author name and title:		**Jonathan Ware, Head of Financial Services**		**Director name and title:**		**Stephen Bloomer, Chief Finance Officer**	
Date paper seen by EC	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

1 Background

Annual accounts have been submitted to NHS Improvement.

1.1 The Trust has prepared its annual accounts on a going concern basis and submitted them to NHS Improvement (NHSI). The annual accounts have been audited by KPMG and the output of that was discussed during the Audit Committee meeting. The accounts were submitted to NHSI on 29 May 2018 (Noon).

The final stage of the process requires the submission of a single document to NHSI covering the final full annual report, including the full statutory accounts. The deadline for submission being Monday 16 July 2018.

2 Key judgements in the financial statements

Prior to compiling the accounts, key accounting issues were discussed with KPMG to ensure a clear view was presented to the Committee and to avoid any uncertainty over treatment.

2.1 At the October (2017) Audit Committee, a paper was presented setting out the plan to report a shared and agreed approach with KPMG in relation to key accounting issues. A further paper was presented to the January Audit Committee, which provided an update from the meeting held between representatives of KPMG and the Trust in December.

The agenda for this meeting was focused on the accounting considerations to be discussed, being:

- Adjustments to, or removal of, the holiday pay accrual;
- Treatment of deferred income;
- Income accruals for maternity and partially completed spells; and
- Matters connected to the valuation of land and buildings, particularly:
    - the inclusion of VAT on PFI buildings;
    - the potential change to a Modern Equivalent Asset valuation; and
    - the relifing of IT and medical equipment assets.

In addition to the accounting/judgement issues highlighted above, the Trust has also engaged with KPMG to discuss the treatment of costs associated with the (capital) development scheme for Maternity.

Most of the annual leave provision held on the Statement of Financial Position (SOFP) was released during the course of the financial year. An amount equivalent to a 1 day carry forward, previously 3.5 days, was retained.

2.2 **Removal of the annual leave accrual**

IAS19 (Employee Benefits), as interpreted in the Financial Reporting Manual (FReM) and the Group Accounting Manual (GAM), suggests that the Trust should, in the event that staff will not use their whole annual leave balance, hold a notional accrual on the SOFP to represent the value of annual leave not taken by staff.

In order to release this provision, evidence was required as to the clarification of policy in relation to staff members using their annual leave within the current financial year. This evidence was available and the Trust has released £1.5m of the provision, in-year, on a quarterly basis.

The proposed approach for the valuation of land and buildings remained unchanged from that highlighted in January, in that neither of the accounting policy changes were enacted.

2.3 **Valuation of land and buildings**

As previously highlighted to the Audit Committee there were two key issues for consideration, being:

- The treatment of VAT on the Trust's PFI buildings; and
- A potential move to a Modern Equivalent Asset valuation, which would significantly reduce the Trust's land footprint.

The proposed judgement, highlighted to the Committee in January, was unchanged when compiling the accounts. To confirm, the Trust elected not to enact either of these accounting policy changes in year. In respect of the MEA, KPMG has advised that the Trust we would need to demonstrate that it holds evidence to support three key tests:

- Ability to demonstrate plans show an 'alternative site';
- Ability to demonstrate the impact on patient flows and the modelling of these within an alternative site; and
- Provide governance reports where such a change has been discussed, for example at Trust Board or Finance Committee.

As the Trust moves forward with its Estate Strategy, the evidence base in relation to all three of these indicators is developing; this could potentially support a change in accounting policy in the future.

In relation to the treatment of VAT on PFI buildings, KPMG would accept a proposed treatment to exclude VAT provided that the Trust could provide a clarification from HMRC of its validity.

Revised life of appropriate assets will be undertaken in 2018-19, with a consistent application across asset categories based on feedback from KPMG.

2.4 **Revised life of IT and medical equipment assets**

The exercise undertaken to review the asset register identified several intangible and tangible asset groups, largely in IT and medical equipment. Where assets lives might have been inadvertently understated. Based on the conclusions of the review the Trust intends, for 2018-19, to revise useful economic lives of such assets from five years to seven years (or ten, if this is considered more appropriate).

Following feedback from KPMG, we will apply this consistently across asset categories, rather than reviewing on an asset by asset basis. As agreed with KPMG, we do not propose to 'revive' assets that have been fully depreciated.

The treatment of deferred income and income accruals was unadjusted.

2.5 **Other accounting policy areas**

As identified in the January Committee paper we did not adjust our treatment of either deferred income or income accruals from the 2016-17 financial year. In the case of deferred income, this was based on specific instruction from the granting authority. In the event of a change in policy from the counterparty, the Trust would reconsider its accounting policy.

The Trust would also consider changing its position in the event that specifically identified and signed off expenditure plans are in place to use the income being deferred.

Stranded costs in relation to the aborted redevelopments of the Trust's maternity unit were recognised in I&E at year end, £1.1m, with the remaining recyclable costs retained on the SOFP.

2.6 **Treatment of costs associated with the Trust's maternity development**

As previously advised the Trust was holding stranded costs in Assets Under Construction, on its SOFP, which relate to previous aborted redevelopments of the Trust's maternity unit.

In line with International Accounting Standard 16 on Property, Plant and Equipment, aborted costs relating to a scrapped project or asset should be written off to the Trust's Income and Expenditure Statement. We agreed with KPMG that the Trust would retain the recyclable costs identified by Currie & Brown on the SOFP, with the remainder being charged to the Income and Expenditure statement during 2017-18. To this end £1.1m was charged to I&E in Month 12.

3 Headlines from the 2017-18 annual accounts, including material variances

Main financial targets have been achieved in year by the Trust prompting eligibility for both incentive and bonus STF payments.

3.1 The Trust's financial control total requirement for 2017-18, taking into account A&E performance and additional funding for seasonal pressures, was a surplus of £0.6m.

Actual financial performance for the year bettered the control total requirement, meaning that the Trust was eligible for incentive and bonus STF (Sustainability and Transformation Funding) payments, totaling £4.7m. This is reflected within the Trust's Adjusted Financial Performance Surplus of £5.4m at year-end.

It should be noted that the financial performance in 2017-18 means the Trust has now bettered its control total requirement for three consecutive years, in an increasingly challenging financial environment.

Adjusting for non-recurrent items and the shortfall on the CIP programme the Trust's underlying position is a c. £11m deficit.

3.2 Whilst the Trust posted a surplus position for 2017-18, the underlying position is still one of a recurrent deficit.

Adjusting for non-recurrent STF funding, non-recurrent income to support seasonal pressures, the benefit of non-recurrent provision releases, and factoring in the shortfall on the Trust's CIP programme the underlying position is a c. £11m deficit. Although this is an improvement on 2016-17 there is still an ongoing need for increased efficiencies in the coming years to address the underlying position.

The main driver for the improved financial position compared to 2016-17 is a £14.1m increase in income, offset by a £4.9m increase in operating costs.

3.3 ***Statement of Comprehensive Income (SOCI)***
Against 2016-17 the Trust saw a £14.1m increase in income, inclusive of STF funding. Key areas of change being:

- CCGs + £9.7m. This related to increases in tariff and activity, particularly in North Central London.
- NHSE + £7.7m. This related to the receipt of additional Sustainability and Transformation Funding (STF) and the additional of the community dental contract.
- Foundation Trusts + £1.4m. This increase arose from the recognition of audiology income following the resolution of contract disputes.
- Local Authority - £4.2m. This resulted from the loss of a number of local authority contracts for 2017-18, notably sexual health.

NB – included within the above is an increase in STF income of £1.8m compared to 2016-17.

Offsetting the increase in income was a £4.9m increase in operating costs when comparing 2017-18 to 2016-17. Key components of the movement being:

- Supplies & Services (Clinical & General) + £2.3m. This increase relates to a range of small variances, including

on medical equipment maintenance.

- Premises inc. business rates + £1.1m. This relates primarily to uplifts in lease and rental contracts.
- Education & Training (non staff) + £1.2m. This relates in particular to teaching and training expenditure, driven by spend on nurse associate pilot scheme.
- Clinical Negligence costs + £1.0m. The value of our CNST contract with NHS Resolution increased from £9.7m in 2016-17 to £10.7m in 2017-18.
- Staffing Costs - £2.3m. This reflects the Trust's successful efforts to control both bank and agency costs.

Analysing the movement on pay costs further, agency and contract staff costs reduced by £3.9m with costs on salaries & wages (including Bank) increasing by £1.1m and the introduction of the apprenticeship levy increasing costs by £0.8m.

During the course of the year the Trust recorded CIP (savings) delivery of £11.7m against the operating plan target of £17.3m.

There have been significant movements on the SOFP, most notably a £6.4m increase in PPE.

3.4 ***Statement of Financial Position (SOFP)***

Key movements on the SOFP for 2017-18 include:

- £6.4m increase in PPE as a result of the year end valuation carried out by independent valuers Cushman and Wakefield, which added £5m; and the surplus of additions over depreciation, which was a further £1.5m.
- £4.9m increase in trade & other receivables. This is largely due to receipt of bonus and incentive STF funding, which we expect to be paid in either June or July 2018.
- £0.9m increase in cash. Cash at year end is in line with our planned figures and reflects improved payment of creditors during the year.
- £1.9m increase in trade & other payables. This relates primarily to the profiling of the capital programme, which was concentrated in the last three months of the year and increased creditors significantly at year end.
- £3.3m reduction in borrowings related to repayments on PFI and other DH loans.

The Trust carried out an impairment review during the year. In line with a prior year audit recommendation, Finance has agreed to feed back the results of the impairment review into the trust's governance structure.

In 2017-18 the Trust's asset base was subject to a desktop revaluation by Cushman and Wakefield. This involved

application of market indices to the net book values held on the Trust's balance sheet.

The valuation exercise resulted in the impairment of two blocks at the main hospital site, with a net impact of £25k to the Statement of Comprehensive Income and a further impact of £119k on the Revaluation Reserve. More widely, the valuation exercise reported an overall increase in balances of £5.0m.

Whittington Health
NHS Trust

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OVERVIEW

CHIEF EXECUTIVE AND CHAIRMAN

Welcome to our 2017/18 Annual Report. We are proud of the work our staff and volunteers do to support over 500,000 people living across north central London to live longer, healthier lives.

We want to thank all our colleagues for what we have achieved together in such a tough year. A year that was characterised by many improvements including our CQC result of 'Good' for hospital services, 'Good' overall and 'Outstanding' for caring. We delivered an in year surplus of £0.6m surplus whilst achieving a cost improvement of over £11.7m.

Like most trusts we struggled with increased demand, particularly in urgent and emergency care, both in our emergency department and our community services. We have in place recovery improvement plans that will enable us to meet the NHS constitution standards.

Making sure we deliver the right services, in the right place and at the right time is vital but we cannot do this alone. We want to deliver services that enable better independence and health for our diverse population which is why we are active partners in delivering the North Central London Health and Care Partnership. Together with our CCGs and other stakeholders, we share the same vision of improving our population's health. We are working to reorganise services, improve public health and achieve financial balance in the face of rising demand. Our work with Islington and Haringey Health and Wellbeing Partnership is helping us focus on bringing together health and social care services to support people living with long term conditions whether they are frail and elderly or the young.

We have further developed our clinical collaboration with University College London Hospitals NHS Foundation Trust. This builds on our work to develop more integrated care to our communities that is closer to their homes. This year we expanded our successful 'Hospital at Home' service, and now run a 'Virtual Ward' that enables the prompt discharge of medically optimised patients with high levels of care support in their own home. We will build more successful partnerships with our clinical teams to continuously improve the quality and safety of our services which includes maternity, cancer and surgery.

An important part of our planning is our estate and delivering our estates strategy. Through the year we have been considering how we might undertake the work to transform the way our estate delivers care to our patients, and how we might ensure the development of our estates is guided by estate development experts working with clinicians, residents, staff and patients, so that we can meet the changing needs of our workforce and our population.

Any significant changes we plan to implement to maintain delivering high quality and safe services will continue to be shared with our stakeholders. We are fully committed to open engagement and consultation with our local community.

The world in which we currently work is challenging with increasing numbers of patients needing our services, restricted financial resources and limited recruitment potential. To do as well as we have over the past year is an outstanding achievement and credit to all our staff and our many hundreds of volunteers. We hope that the individual achievements in every sector of our Trust across both community and acute services highlighted throughout this report are acknowledged and celebrated by everyone.

We will continue on this improvement pathway and are proud of our staff and the service that we are delivering to our community.

Siobhan Harrington
Chief Executive

Steve Hitchins
Chairman

Whittington Health is one of London's leading integrated care organisations – helping local people to live longer, healthier lives.

We provide hospital and community care services to over half a million people living in Islington and Haringey as well as those living in Barnet, Enfield, Camden and Hackney. Whittington Health provided 101 different types of health service (41 acute and 60 community services) in 2017/18.

Every day, we aim to provide high quality and safe healthcare to people either in our hospital, in their homes or in nearby clinics. We are here to support our patients throughout their healthcare journey – this is what makes us an integrated care organisation.

Our services and our approach are driven by our mission and vision

We have an excellent reputation for being innovative, responsive and flexible to the changing clinical needs of the local population. We are treating more patients than ever before and are dedicated to improving services to deliver the best care for our patients.

Our mission

Helping local people live longer, healthier lives.

Our vision

Provide safe, personal, co-ordinated care for the community we serve.

Our clinical strategy

Our five year Clinical Strategy was launched in 2015, and we continue to implement the service improvements agreed by the Trust Board, engaging with staff and stakeholders to help us collectively meet the challenges our community and local health and social economy face.

Our values

Our values underpin everything we do. Our staff are committed to upholding our values which we have collectively agreed:

Our services

Our priority is to deliver the right care, at the right time, and at the right place for our patients. We provide an extensive range of services from our main hospital site and run services from over 30 community locations in Islington and Haringey, and our dental services are run from sites across Camden, Islington, Haringey and Enfield.

As an integrated care organisation we bring safe and high-quality services closer to home and speed up communication between community and hospital services, improving our patients' experience. Key to our approach is partnering with patients, carers, GPs, social care, mental health and other healthcare providers.

Our organisation has a highly-regarded educational role. We teach undergraduate medical students (as part of UCL Medical School) and nurses and therapists throughout the year, alongside providing a range of educational packages for postgraduate doctors and other healthcare professionals.

Our strategic goals

Providing the best possible healthcare services to patients will be achieved by delivering our clinical strategy. We have six strategic goals that guide us in delivering safe and high-quality care for all.

- To secure the best possible health and wellbeing for all our community
- To integrate and coordinate care in person-centred teams
- To deliver consistent, high quality, safe services
- To support our patients and users in being active partners in their care
- To be recognised as a leader in the fields of medical and multi-professional education, and population based clinical research
- To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population.

KEY ISSUES

Increasing demand for our services, coupled with growing financial constraints, means that there are several key challenges and issues we must overcome to enable us to deliver the best possible services to our patients.

Recruitment and retention of staff

Recruiting the best possible staff underpins the successful delivery of our strategic goals. Retaining our staff is as important. Over the past year we have worked hard to introduce a number of improvements to help our staff feel more connected to the organisation these included; increasing our activity and improving how we understand and meet the needs of our staff through our equality, diversity and inclusion work, further addressing bullying and harassment, improving our health and wellbeing offer to our staff with mindfulness training, stress reduction workshops and exercise classes, as well as working to improve visible leadership of senior managers with frontline staff. We are determined that this year staff will feel a difference following the work we undertake to address the concerns they have raised in the staff survey.

Spending on agency and temporary staff

The Trust has successfully delivered on the NHSI target for agency staff reduction. However, we know that maintaining and improving our performance in relation to the use of agency and

temporary staff is key to delivering quality and financial sustainability. Agency and temporary staff are only used to help us maintain safe levels of staffing as a result of sickness or unplanned absences as a last resort. We have introduced more stringent financial controls that are closely monitored to help us to continue our reduced use of agency staff.

Emergency department performance

We saw a record number of visitors come to our emergency department – over 100,000 – against a very busy winter period. This was replicated in emergency departments across the whole of London. Patient safety remains our top priority and our teams have worked hard to ensure that despite these increasing pressures our performance remains in the top quartile of performance across London.

To help us meet this growing challenge we have worked closely with our CCG and Local Authority Partners to ensure:

- Further capacity is available in primary care systems to offer an alternative to patients other than attending the Emergency Department
- Improving the redirection rate from NHS 111, whereby extended access hub capacity is better utilised
- Increasing the number of patients who are discharged to assess, following national best practice
- Reducing the numbers of Delayed Transfers of Care (DTOCs)
- Improving the re-ablement capacity, to enable medically fit patients to be discharged to receive on-going re-ablement at home

Financial position

The Trust agreed a control total target of a £0.6m surplus in year with the Department of Health. We bettered the target, ending the year with a £0.8m surplus. This financial performance made the Trust eligible for £4.7m in additional incentive and bonus STP (Sustainability and Transformation Plan) funding from the Department of Health (DH). The result of this was a £5.4m surplus against control total. While we have been able to meet our financial targets for this year, the Trust still has a historic deficit to clear; and plans to do this further in 2018-19, with a forecast for a £4.7m surplus.

Going concern and value for money

As with previous years, we have prepared our annual accounts for 2017-18 on the going concern basis. This is in line with DH accounting guidance, which states that the Trust is a going concern if continuation of services exists. As the Trust's financial performance and circumstances have improved in 2017-18 our external auditors have not included an emphasis of matter paragraph in their opinion on the financial statements, which is an improvement on previous years.

However, because of historical losses, the Trust is unable to breakeven across a three-year period. As a result our external auditors are obliged to give a qualified opinion on the Trust's arrangements to provide value for money in its use of resources for 2017-18.

PERFORMANCE AND ACHIEVEMENTS SUMMARY

Overall demand for our services in 2017/18

- We had **101,814** visits to our emergency department
- There were **2,269** elective admissions
- Our maternity staff delivered **3,761** babies
- We had **797,634** contacts with patients in the community
- We had an annual turnover of **£323** million
- We employed over **4,200** staff
- We worked with over **150** volunteers who support us

We are proud of our staff and their commitment to delivering safe and high-quality care – over the past year our community and hospital teams have helped to pioneer new projects, secure numerous national professional awards and accolades that include leadership and education, diabetes, cancer and maternity services. The details of some of our staff achievements are set out within this report and below provides highlights of others:

- CQC ranked the Hospital 'Good', the Trust 'Good' overall and 'outstanding' for caring
- Placed 35 overall in the UK and **2nd in London** – behind the Royal Marsden from the **National Cancer Patient Experience Survey**
- Simmons House rated as **"excellent"** by the **Quality Network for Inpatient CAMHS.**

- June 2017 CHKS Top Hospital Award for the best performing Trust for '**quality of care'** across the UK
- Recognition from the national Medical Director for Clinical Effectiveness at NHS England for the **greatest improvements in timely identification and timely treatment of sepsis**
- **Highest quartile for reporting** incidents on the National Reporting Learning Services which demonstrates a strong culture of openness and reporting to **continuously improve patient safety**
- One of four teams across the country to **pilot a new model of supervision** for midwives
- Footprints social media project **'hearing women's voices on patient experience'** to improve care based on human rights principles; shortlisted for the Patient Experience National Network Awards
- **Shortlisted for the 2018 HSJ Value awards for Clinical support services**, for **improving the pharmacy outpatient service through design**
- **Shortlisted for the 2018 HSJ Value awards for Community health service redesign**, for **the implementation of the eCommunity** paperless system
- The Trust had the **second highest uptake of flu vaccine by our staff across London**
- The proportion of staff taking part in the annual staff survey rose to 42%
- **Patient self-management** partnership with Tottenham Hotspur
- Staff and supporters **raised over £21,000** in the London Marathon for our **charity**

PERFORMANCE

HOW WE MEASURE PERFORMANCE

To make sure we provide the best possible services to our patients, we are set a range of national targets. For a number of these we often apply a set of stretch targets, aiming higher than the minimum requirement of nationally set targets.

In 2017/18 we tracked and measured our progress against 21 targets, known as key performance indicators (KPIs), which are derived from our goals and national standards of care. Of these targets 12 were fully met and eight were missed.

Every month we review our progress against these targets to help understand and improve our performance. Our performance is published monthly in our board papers.

PERFORMANCE ANALYSIS

We believe it is important to set targets that fully reflect the service and care we want to provide to our patients, so whilst it is disappointing to see that we have missed some of our targets, we are working to understand the reasons why, making sure that progress is being made to meet all targets in the future.

Emergency department performance

We saw a record number of visitors come to our emergency department – over 100,000 – and a very busy winter period. This was replicated in emergency departments across the whole of London. Patient safety remains our top priority and our teams have worked hard to ensure that despite these increasing pressures our performance remains in the top quartile of performance across London.

To help us meet this growing challenge we have worked closely with our CCG and Local Authority Partners to ensure we make the necessary service and system changes to improve our performance against the constitution 4-hour standard. Our ED performance improved in 2017/18

with an outturn performance of 89.4% against 87.4% in 2016/17, against the significant increase in activity highlighted above.

Our performance improvement plan is detailed in our annual governance statement.

The following tables provide an overview of our performance against key performance indicators in 2017/18.

Table one: Performance against national targets 2017/18, at a glance

Goal	Standard/benchmark	Our performance
Emergency Department		
4 hour wait in emergency department	95% of patients to be seen within four hours of arriving at the emergency department to admission, transfer or discharge	89.4%
Average waiting time for treatment	No longer than 60 minutes	74 minutes
Admissions		
Non-elective readmissions within 30 days	Less than 5.5%	6.4%
Delayed transfers of care	Less than 4.5%	6.2%
Access to treatment		
18 weeks wait for patients waiting to be seen	92% of patients to be waiting within 18 weeks	92.2%
Urgent operations cancelled	0 cancellations	86
Waiting times for diagnostic tests	99% of patients waiting less than six weeks	99.1%
Hospital stays		
Zero mixed sex accommodation breaches	0 breaches	0 breaches
Cancer waiting times		
2 weeks wait from urgent referral to date first seen: all cancers	93% patients seen by a specialist within 2 weeks of referral for suspected cancer	94.7%
Diagnosis to first treatment	96% of patients treated began first treatment within 31 days of receiving their diagnosis	100%

Two month (62 day) wait from urgent GP referral to first definitive treatment	85% of patients treated began first definitive treatment within 62 days of being urgently referred for suspected cancer by their GP	88.1%
Maternity		
Smoking in pregnancy at delivery	Less than 6%	5.4%
Rate of breast feeding at birth	More than 90%	92.4%
New birth visits (Islington)	95% seen within 14 days	94.4%
New birth visits (Haringey)	95% seen within 14 days	90.0%
Friends and Family Test		
Outpatients recommending Whittington Health as a place to receive treatment to family and friends	90%	92.4%
Community patients recommending Whittington Health as a place to receive treatment to family and friends	90%	95.5%
Staff recommending Whittington Health as a place to receive treatment to family and friends	70%	71.0%
Complaints		
Complaints responded to within 25 working days	80%	82.7%
Complaints to Parliamentary Health Service Ombudsman	No benchmark	1 complaint (Still under investigation).
Workforce		
Staff sickness absence	Less than 3.5%	3.54% (Data up to February 2018)

OUR ACTIVITY

We are proud to serve our local community and over the forthcoming year we will continue to integrate and strengthen our hospital and community services to help local people live longer, healthier lives.

Table two: Our 2017/18 acute activity

Activity	2017/18	2016/17
Emergency department visits	101,814	97,136
Emergency inpatient admissions	17,449	16,593
First outpatient attendances	165,457	99,505
Follow-up outpatient attendances	214,520	218,028
Elective inpatient admissions	2,269	2,361
Day case admissions	19,674	20,090
Maternity deliveries	3,761	3,690

Table three: Our 2017/18 community activity

Activity	2017/18	2016/17
Community contacts (all face to face)	759,490	797,634
Community nursing	302,000	295,620
Health visiting and school nursing	84,001	74,703
Physiotherapy (adults)	79,532	82,213
Sexual health	4,980	28,113
Dental	39,899	28,630

STATEMENT OF FINANCIAL POSITION

Like many NHS Trusts, we continue to face a challenging financial future. However, the Trust achieved an in-year surplus for the first time since 2013-14. Due to historic deficits, the Trust failed to achieve its obligation to break even across a three-year period. However, in year we agreed and met a surplus target of £0.6m, finishing the year with a £0.8m surplus before incentive and bonus STF funding was allocated. As part of this process, we received an additional £4.7m, meaning that the Trust's reported surplus for 2017-18 is £5.4m against control total.

Our cumulative deficit at the end of the financial year was lower than planned at £9.8m against an expected figure of £14.6m – this is as a result of achieving the control total and the Trust's entitlement to the additional STF listed above. The Trust plans to report a surplus of £4.7m in 2018/19, and as a result, further reduce the cumulative deficit. Achievement of this target depends significantly on the success of the Trust's Cost Improvement Plan, which for 2018-19 is £16.5m. As such, it remains essential that we continue to reduce our overall expenditure and running costs so that our financial recovery plan remains on track.

Over the year we generated £323.4m in income, which was £10.9m above plan. This was the result of the following factors:

- STF awarded, described above;
- The Trust's financial plan included a high level of CCG QIPP delivery in the final quarter and this has not been achieved. This created an over-performance of approximately £1.5m;
- Recovery actions implemented with clinical ICSUs drove a positive trend in activity in the last three months of the year and created a recurrent benefit of approximately £1.0m;
- Receipt of £1.8m of additional education funding;
- Receipt of additional £1.2m of A&E tranche 1 and 2 funding; and
- Full recognition of £1.1m of income that had previously not been recognised due to a dispute with the counterparty. Having revisited contractual guidance, the Trust is confident that the outstanding balances will be paid. Therefore, the income has been recognised.

Our expenditure on pay costs exceeded our budgeted level by £2.2m, largely driven by the costs associated with the Trust's commitment to move from using temporary staff to substantive staff. The Trust spent £19.4m on bank staff and £9.3m on agency staff in 2017-18; these figures are both significantly lower than the comparative year 2016-17 and meant that the Trust remained within its agency ceiling for 2017-18. We continue to apply strict control on requests for temporary staffing.

Property, plant and equipment

£9.9m of capital expenditure has been incurred for the year against total capital allocations of £11.3m (excluding commitments on PFI and finance lease arrangements). The Trust was awarded £2.3m of additional funding from DH during the year for Fast Follower (£1.3m) and A&E Primary Care Streaming (£1.0m) projects. As such, we underspent our capital target by £0.5m while meeting our financial obligations and minimising our need for cash support borrowing.

Trade receivables

Our trade receivables are £2.4m higher than planned. This is the result of the £6.3m that the Trust is now owed in STF. Besides this, levels of debt collection during the year have been good; and management of relationships with key NHS and non-NHS partners has been improved.

Cash

We ended the year with £4.1m in cash, which was in line with our financial plans. Liquidity has been strong throughout 2017-18 - during the year, the Trust did not receive any additional cash support from Department of Health, and has continued to pay down historic cash support loans. We are conscious, however, that the Trust may face cash challenges in 2018-19 as it is operating in a financially challenged environment across the STP area. Our cash management plan is focused on collecting outstanding debt and managing our financial obligations over the year. We have agreed a minimum cash balance with NHS Improvement and the Department of Health, and are managing our cash flow in line with this position.

Payables

Payables balances as at the end of 2017-18 are £1.0m below plan. We are managing our creditor payments to ensure we meet our supplier obligations whilst maintaining an appropriate level of working capital. During the year, we have averaged 86.2% payment of creditors within 30 days, which is a significant improvement on 2016-17 (67.8%). We also expected to require cash support from DH, but due to the strong cash position throughout the year, this was not required during 2017-18.

OUR SUCCESSES

Helping local people live longer and healthier lives by providing safe, personal, co-ordinated care for the community we serve will be achieved by implementing our clinical strategy and delivering our six strategic goals. This report highlights examples of our achievements in delivering our goals throughout 2017/18

Strategic Goal One – Secure the best possible health and wellbeing for our community

To support the health and wellbeing of the communities we serve, it is important that we understand and evolve to meet their changing needs. Here are just some of the things we have achieved:

A Good Trust with Outstanding for Care

- CQC ranked the Hospital ‘Good’, the Trust ‘Good’ overall and ‘outstanding’ for caring

A ‘top hospital’

- June 2017 CHKS Top Hospital Award for the best performing Trust for **‘quality of care’** across the UK

Strategic Goal Two – Integrate care in patient centred teams

As a leading integrated care organisation, we provide care to our patients in hospital and closer to home. The services we provide should support patients along every step of their healthcare journey and we work closely with GPs and other primary care teams to help make that happen. Here are some of the steps we have taken in the last year to deliver on this goal.

Integrated Community Ageing Team

The ICAT is a consultant-led multidisciplinary team (MDT) specialising in Comprehensive Geriatric Assessments (CGA) for patients who are registered with an Islington GP. This is usually carried out in the patient’s own home, or special short notice clinic bookings are offered at Whittington Hospital and at University College Hospital which may be more appropriate where further investigations such as x-rays are required. The ICAT geriatricians and specialist pharmacists also provide visits and support to patients in Care Homes in Islington.

The ICAT (Care Homes) consists of a Consultant Geriatrician and Specialist Pharmacist who work with GPs and other community services to provide care for patients residing in care homes according to their wishes and needs.

Their objectives are as follows:

- Improve communication between secondary care and primary care for patients in care homes
- Maximise the number of days spent at home by reducing unnecessary hospital admissions and length of inpatient hospital stay
- Work closely with care home staff and support their education and development
- Work closely with allied GP practices to support ongoing professional development in complex geriatric case management

Respiratory Ward Board Rounds

Our respiratory team delivers an integrated service for people with long term conditions. They have taken a cultural approach to integration and include every member of the team in a weekly integrated Board Round. By reviewing the treatment and status of every patient under their care, be they at home or in the hospital, they ensure a truly holistic approach to helping people to manage their health. As well as the medical, they also take account of the wider physical, mental and emotional aspects of care as well as putting thought into how to patients and their carers are able to cope at home.

Extending our Hospital at Home

We have further developed our clinical collaboration with University College London Hospitals NHS Foundation Trust. This year we expanded our successful 'Hospital at Home' service, and now run a 'Virtual Ward' that enables the prompt discharge of medically optimised patients with high levels of care support in their own home. We will build more successful partnerships with our clinical teams to continuously improve the quality and safety of our services which includes maternity, cancer and surgery.

Strategic Goal Three – Deliver consistent, high quality, safe services

One of our biggest roles is to ensure that we are delivering the best possible services to our patients. We are committed to taking on this role and helping local people live longer, healthier lives.

The Trust is ranked in the highest quartile for reporting incidents on the National Reporting Learning Services which demonstrates a strong culture of openness and reporting to continuously improve patient safety. The latest data (October 2016-September 2017) shows that we have the lowest Standardised Hospital Mortality Index (SHMI) in the country.

Stopping sepsis in its tracks

Being able to spot the signs of sepsis early is key in stopping this potentially fatal condition in its tracks. We have made significant progress in tackling the number of people with sepsis we are able to treat successfully by monitoring and screening admissions to our emergency department so that we can spot the disease quickly. The Trust was recognised by the national Medical

Director for Clinical Effectiveness at NHS England for the greatest improvements in timely identification and timely treatment of sepsis

The sepsis CQUIN was launched in 2015 to improve the management of sepsis. Since then we have seen an increase in Emergency Department assessment for sepsis from 52% to 89%, and timely treatment increased from 49% to 76%. In-patient assessment for sepsis increased from 62% to 70%, and timely treatment has increased from 58% to 80% for these patients. Ms Ingham Clark Medical Director for Clinical Effectiveness, NHS England said "I would like to congratulate you and your colleagues for all the hard work and dedication you have shown, which has enabled these improvements in sepsis recognition and treatment to take place. Please pass my thanks on to the staff concerned for their achievements in improving the care for patients with sepsis. "

Top London Flu Fighters

During the winter months the flu virus can be particularly dangerous – especially for our older and more vulnerable patients. To make sure we are doing everything we can to keep the virus at bay and protect our patients, we encourage our staff to have their flu jab. In 2017/18 we were pleased to be the second highest Trust in London for our uptake of the flu vaccine. In total, 80.2% of our staff received a flu jab, compared with 79% in 2015. This is an excellent result and we are pleased to see so many colleagues taking this important step to protect themselves, their families and their patients from this potentially fatal virus.

Strategic Goal Four – Support our patients in being active partners in their care

Our commitment to listening to the needs of our patients and partners has driven many new projects throughout the year.

- Placed 35 overall in the UK and **2nd in London** – behind the Royal Marsden from the **National Cancer Patient Experience Survey**
- Simmons House rated as **"excellent"** by the **Quality Network for Inpatient CAMHS.**
- Footprints social media project **'hearing women's voices on patient experience'** to improve care based on human rights principles; shortlisted for the Patient Experience National Network Awards

Strategic Goal Five – To be recognised as a leader in the fields of medical and multi-professional education and population based research

Investing in education can make a clear difference to the lives of the patients we support. To ensure the best possible experience for all our patients, it is vital that we embrace education and research.

Commitment to multi-professional education and training

It is now a requirement for all students to have a learning portfolio to keep a log of education and training activities and reflective practice throughout their undergraduate training. As part of this process, all students need to have access to a mentor or supervisor.

Throughout the year, there are about 800 medical students, 550 nursing students and 190 midwifery students completing their clinical placements at the Whittington. All of them have access to 'NHS ePortfolio' or a 'Practice Assessment Document' and have an allocated mentor or educational/clinical supervisor.

We ran seven half day 'Learning together' inter-professional workshops in 2017/18 based on real patient stories from serious incidents that have happened at Whittington Health. Each workshop discussed a number of key themes and focused on shared learning and quality improvement. Themes such as adult safeguarding, cross-organisational working, discharge planning, end of life care, handover, information sharing, learning disability, mental and physical health, pressure ulcers, sepsis and team working were all explored in a positive and engaging learning environment. All workshops were facilitated by Whittington Health staff (from various professional backgrounds) and opened up to colleagues working in health, social care and the charity sector in Camden, Haringey and Islington. In total, the workshops were attended by 290 professionals from various backgrounds, with an average attendance of 40 people per workshop. Learning materials from all sessions have been made available on Whittington Moodle to share learning within Whittington Health and other local health and social care colleagues such as district nurses, GPs or social workers.

Excellence in medical education

As well as delivering first class care to our patients, we are committed to delivering the very best education and training to support our clinical student colleagues take the next steps in their careers. In recognition of this commitment, we were pleased to see the work of two of our

consultants celebrated with a Top Teacher Award from UCL Medical School; Dr Bernard Davis, Consultant Haematologist, and Dr Chee Yee Loong, Consultant Cardiologist, were presented with the awards in 2017.

Supporting our doctors in training

We had some outstanding feedback in the GMC survey of doctors in training, with some specialties receiving the highest rating in the country. This is a national survey, sent to all doctors in training, and it asks them about the hospital where they are working and the support and education that they receive there.

The trust continues to be recognised for its reporting culture – trainees feel able to report issues without repercussions, that there are systems in place to deal with issues or concerns, and that concerns will be acted upon.

The trust is committed to moving forward with the Faculty of Medical Leadership/ NHS Providers/ NHS Improvement 'Eight high impact actions to improve the working environment for junior doctors' and the Board will be exploring ways to implement these in 2018.

Research

Research at Whittington Health has had a successful year. The target set by North Thames Local Clinical Research Network (LCRN) was for 474 patients to be recruited in to National Institute of Health Research (NIHR) portfolio studies. This was met within the first six months of the year and overall we recruited 742 patients into these trials (56% over target). We continue to deliver a cost-effective service, with a low cost per patient recruited compared with other trusts in the North Thames CLRN. In addition we recruited the first patient in the UK into 'Asteroid 5', a commercial study of the treatment of fibroids.

In this study we have recruited over the originally agreed target, and we have had similar success with other commercial studies, such as the ECZTRA2 trial, looking at severe eczema in adults in which we recruited the required number of patients within 6 months and the BC Study which investigates prosthetic hip cups, in which we recruited the highest number of patients in the UK.

We have also increased the size of the research delivery team, allowing more capacity for recruiting and also more capacity for raising the profile of research within the trust. Securing CRN funding for additional posts has enabled significant growth and the introduction of a Trainee Research Practitioner role has been well received. Osinachi Egole (Research Midwife) and Sheik

Pahary (formerly Research Nurse) were both nominated for Trust excellence awards and Kayleigh Gilbert (Research Team Lead) was accepted onto the NIHR Advanced Leadership Programme. The increased size of our team has enabled us to expand the number of clinical specialities participating in research, and to raise the profile and the level of interest in research within the trust. As part of this, we have introduced face to face research training courses on site at Whittington Health, which we plan to continue in the future.

Strategic Goal Six – To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population

Innovation is key to transforming the services we deliver to our patients. We are focussed not only on how we treat illness, but also prevention and awareness that will empower our staff to deliver the best possible care.

Ambulatory Care

Our Ambulatory Care Centre is one of the largest and most innovative in the country. It sits between the Emergency Department, inpatient wards, community teams and local GPs to provide urgent care in a dedicated calm environment. They see patients referred by A&E, sent in by GPs or a community team and provide planned follow-up care for patients who have been discharged from hospital. Consultants in the Ambulatory Care Centre also provide senior, experienced advice and support to local GPs that can help to avoid patients needing to be referred to hospital. 75% of the patients sent to hospital by their GP can be seen straight by the Ambulatory Care Team and do not need to go to A&E and 95% of the 70 patients seen in the Ambulatory Care Centre every day are able to avoid being admitted to hospital altogether. Whittington Health is now sharing the success of its Ambulatory Care Centre and advises other trusts on establishing a similar model.

E-community district nursing

To improve the quality and capacity of our busy district nursing service we introduced an electronic system, e-community. This system has helped to not only increase the number of patient visits our nurses are able to make, but also helps to ensure that we are sending the right care team, with the right skills, to the right patients. By reducing the amount of time our nurses need to spend on administration, we now have the equivalent of around six extra nurses available to devote more time to delivering care to our patients in the community. The Trust has been Shortlisted for the

2018 HSJ Value awards for Community health service redesign, for the implementation of the eCommunity system.

Additionally, the Trust is shortlisted for the 2018 HSJ Value awards for Clinical support services, for improving the pharmacy outpatient service.

OUR WORKFORCE

At the heart of delivering high quality and safe care is our staff, both those who work directly with patients and those who provide the support they need to keep our services running.
Our workforce strategy, which was developed with our staff, outlines our ambition to nurture a dynamic and flexible workforce with the skills, expertise and equipment.

A great place to work

We want to make sure that we thank our staff for the work they do by providing a supportive and positive working environment.

Staff survey results

This is the seventh year in which Whittington Health as an Integrated Care Organisation (ICO) has conducted the national staff survey. This year the Trust opted to invite all eligible staff to complete the staff survey.

Of Whittington Health's (WH) 4102 eligible staff, 1704 staff took part in this survey. This is a response rate of **42%** which is **average** for combined acute and community trusts in England (43%) and compares with a response rate of 36% (441 eligible staff) out of a randomised sample of 1250 in the 2016 survey.

Like many parts of the NHS there has been an increase in the demand for our services and as we rise to meet this growing challenge, our teams are committed to providing the best care possible. Our latest staff survey demonstrates the commitment of our staff despite these increasing pressures:

- 77% of staff think that care of patients is the organisation's top priority

- 71% of staff would recommend the Trust to friends and family if they needed treatment
- 59% of staff would recommend the Trust to friends and family as a good place to work

Our top scoring areas are:

KF	Key Findings	Score Type	Trust	National
12	Quality of appraisals	1-5 scale summary – the higher score the better	3.27	3.11
22	Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	% score – the lower score the better	11%	14%
28	Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	% score – the lower score the better	27%	29%
4	Staff motivation at work	1-5 scale summary – the higher score the better	3.94	3.91
27	Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	% score – the higher score the better	49%	47%

It is encouraging to note improvements in areas such as the quality of appraisals, as these were targeted improvement actions from last year's survey. There has been a focus on incident reporting and feedback and this appears to have been reflected in the results. It is particularly encouraging to see 'staff motivation at work' appearing in the top five. Of note is the positive decrease of staff suffering physical violence from patients, relatives or the public which scored as one of the bottom ranking findings last year with a Whittington score of 31%.

Whilst our staff survey highlights many areas we can be proud of, there are some areas we must improve outlined in the table below:

KF	Key Findings	Score Type	Trust	National
17	Percentage of staff feeling unwell due to work related stress in the last 12 months	% score – the lower score the better	45%	38%
26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	% score – the lower score the better	31%	24%
21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	% score – the higher score the better	73%	85%
29	Percentage of staff reporting errors, near misses or incidents witnessed in the last month	% score – the higher score the better	87%	91%
20	Percentage of staff experiencing discrimination at work in	% score – the lower	19%	10%

	the last 12 months	score the better		

Disappointingly and for the second year running the percentage of staff experiencing discrimination or harassment, bullying or abuse from other staff are highlighted as concerns as is work related stress. Equally dissappointingly is the low percentage of staff who believe that the organisation provides equal opportunities for career progression or promotion.

Over the next year we will in particular, take active steps to address issues around bullying, harassment and discrimination, and introduce new measures to help colleagues manage workplace stress.

Health and wellbeing

Making sure we have a healthy and happy workforce is vitally important. Over the past year we have worked to improve the health and wellbeing of our staff. Our Health and Wellbeing Committee have supported several initiatives to improve working life, including mindfulness training, stress management workshops and encouraging staff getting moving through walking and fitness activities.

Supporting colleagues with disabilities

Whittington Health is committed to ensuring all existing staff, including newly appointed staff have equal access to opportunities relating to personal, educational and professional development opportunities.

Our overall approach continues to be governed by compliance with legislative and regulatory requirements and the maintenance and development of best practice in the fields of contracting and employment.

Our recruitment processes are robust, and we adhere with National NHS Employment standards ensuring that all development opportunities are promoted in an open and transparent manner to reinforce an inclusive working environment. Our commitment has been underlined by signing the NHS Learning Disability Employment Pledge.

Equality and Diversity training is a mandatory training module that must be completed by all our new employees, and is accessible via the e-learning. Further Equality, Diversity and Inclusion

training such as Unconscious Bias and Customer Care for a Diverse Client Group is also available.

We have an occupational health department who provide support to staff and managers in recommending reasonable adjustments to staff duties and their environment when they become disabled in employment. The Trust also has an employee assistance programme to support staff both practically and emotionally.

Modern Slavery Act

Whittington Health NHS Trust has a clear commitment to respect fundamental human rights and fully supports all initiatives to eradicate modern slavery and human trafficking. We are dedicated to ensuring that there is no modern slavery or human trafficking in any part of our business activity and in so far as is possible to holding our suppliers to account to do likewise. We will continue to support the requirements of the Modern Slavery Act 2015 and any future legislation. Our overall approach will be governed by compliance with legislative and regulatory requirements and the maintenance and development of best practice in the fields of contracting and employment.

Our recruitment processes are robust, and we adhere with National NHS Employment checks. This includes strict requirements in respect of identity checks, references, work permits and criminal records. Our pay structure is derived from national collective agreements and is based on equal pay principles with rates of pay that are nationally determined.

We are committed to maintaining and improving systems, processes and policies to avoid complicity in human rights violation and to prevent slavery and human trafficking in our supply chain.

Our response to human trafficking and modern slavery is coordinated by Safeguarding Team. The subject is included in all safeguarding training and will form a key work stream of our safeguarding strategy and associated work plan. Any identified concerns would be escalated as part of the organisational safeguarding process; and in conjunction with partner agencies such as the local authorities and police.

PROVIDING HIGH QUALITY AND SAFE CARE

We are committed to providing safe, effective and high-quality care to all our patients. Our patients and their experiences of our care drive everything we do, and we are working hard to make sure we deliver the best possible healthcare to all.

Our work to deliver excellent care to patients is underpinned by our key quality principles:

- Providing safe services
- Providing clinically effective services
- Providing the best experience of our services.

MRSA

We have a zero-tolerance approach towards MRSA and have an active infection control campaign across our hospital and community to help stop the spread of this potentially deadly infection. In 2017/18 we had three reported cases of MRSA, and in 2018/19 we hope to reduce the number of reported cases to zero.

Clostridium Difficile (C. difficile)

The number of reported cases of c. difficile remained consistent with last year, with a total of 11 cases against a target of no more than 17.

Mixed sex accommodation

We had zero mixed sex accommodation breaches in 2017/18.

For more a more in-depth review of how our services are working to improve safety and quality, refer to our Quality Account which is available at www.whittington.nhs.uk or communications.whitthealth@nhs.net.

SUSTAINABILITY REPORT

We are committed to delivering a clear programme of sustainable development across our services. Our plan aligns to the national strategy ‘Sustainable, Resilient, Healthy People and Places’.

Our plan

Our Sustainable Development Management Plan (SDMP) outlines the steps we are taking to reduce our emissions. Key points include:

- Helping staff and patients reduce carbon emissions by publishing green travel plans, and providing information on how to reduce carbon emissions in their personal lives
- Ensuring that our plans for the future include an assessment of their environmental impact
- Actively encourage and reward recycling as well as reducing the volume of waste through procurement and purchasing plans.

Reducing carbon emissions

The Trust has continued to invest in projects to reduce carbon emissions, including: investing in heating and ventilation controls and more efficient boiler plant in our community properties, and continuing to roll-out a programme of LED lighting installation in outpatients and staff residences. The Trust is also embarking on a project to implement automatic meter reading to improve the monitoring and targeting of further energy reductions.

Estates Strategy

An important part of our planning is our estate and delivering our estates strategy. Through the year we have been considering how we might undertake the work to transform the way our estate delivers care to our patients, and how we might ensure the development of our estates is guided by estate development experts working with clinicians, residents, staff and patients, so that we can meet the changing needs of our workforce and our population. In 2018/19 we will undertake a master planning exercise to enable the Board to take a holistic view of the estate across both Islington and Haringey, and to determine how we might maximise its full potential to benefit the people living in both Boroughs.

Affordability of estates development is key to our success and has been the limitation of progress with major developments over the past 17 years. Our work to date has demonstrated that if we develop the estate in a joined-up way over the next 10 years, the developments can be self-funding. A development plan that encompasses our whole estate will provide us with an overall view of the condition and future potential of the estate that is needed to finance the necessary work.

Waste disposal

In 2017/18 the Trust integrated the recycling centre onto the Hospital site and it is now directly managed by the Facilities Directorate. This has allowed for greater control in how our waste is processed and segregated.

A new initiative in 2017/18 is a food waste recycling scheme. The hospital now recycles all food waste through a dedicated food waste collection stream. Early indications are suggesting the Trust will recycle 1 tonne of food waste each week.

Alongside this we are recycling 6 tonnes of cardboard and approx. 5 tonnes of dry mixed recyclables materials per month.

Procurement

We continue our commitment to reduce the wider environmental and social impact associated with the procurement of goods and services, in addition to our focus on carbon.

Travel and transport

We have a plan in place that sets out our commitment to provide sustainable transport for our staff teams while providing front line services within our community. As part of this plan we operated a total of twenty one electric cars in 2017/18, issued approximately 350 Oyster cards to community staff to encourage the use of public transport while undertaking Trust business. Staff can take part in the Cycle2Work salary sacrifice scheme, and we have engaged with the London Borough of Islington's Zero Emission Network. Our transport staff have undertaken training that ensures they meet the requirements of Islington's anti-idling campaign.

In line with our clinical strategy, the Estates Strategy will reduce the number of locations we deliver clinical services from, ensuring they are demographically positioned to serve our community more efficiently. This will reduce the travel times of our patients and staff, therefore reducing the carbon impact of all associated journeys made.

EMERGENCY PREPAREDNESS

We have a dedicated team that brings our colleagues together to help us plan and prepare for a wide range of incidents and emergencies. This could be anything from extreme weather events,

infectious disease outbreaks, terrorist attacks or major transport accidents. We work closely with our partners in other hospitals and emergency services to ensure we have effective plans in place.

Over the past year we have:

- Updated our Business Continuity Plans
- Conducted a business continuity table top exercise
- Implemented new emergency response training programme for staff belonging to our on-call team.
- Implemented updated heatwave and cold weather plans in line with national guidance.
- Reviewed and updated our incident response and recovery plan

Over the next year we will continue to

- Work closely with our partners to ensure we have clear plans in place to respond to potential emergency situations
- Introduce a new hospital and full site evacuation plan
- Provide business continuity training and coaching for staff
- Staff to participate in major incidents exercises across London

Set in the context of increasing activity, restricted financial resources and a challenging recruitment potential, the Trust has performed well in 2017/18. This gives us a firm footing to look ahead to 2018/19, as we continue to deliver our Clinical Strategy and transform the services we are delivering to our community.

Siobhan Harrington, Chief Executive

25 May 2018

ACCOUNTABILITY REPORT

CORPORATE GOVERNANCE REPORT AND ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's mission, vision, goals, objectives and policies, whilst safeguarding standards and the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am responsible for ensuring that the Trust is administered prudently and economically, and the responsibilities set out in the NHS Accountable Officer Memorandum.

The system of internal control is designed to manage risk to a reasonable level, and as such can only provide reasonable level not absolute assurance of effectiveness.

The system of control is based on an on-going process designed to identify and prioritise the risks to achievement of Whittington Health NHS Trust's mission, vision, goals, objectives and policies, to evaluate the likelihood of those risks being realised and the impact should they be realised and to manage them efficiently, effectively and economically. This system has been in place at the Trust for the year ended 31 March 2018, and up to the date of approval of the Annual Report and Accounts.

The system of internal control is underpinned by the existence of several individual controls that are in place, executive and senior manager review, policies, procedures and clinical guidelines.

To align with the regulatory accountability framework the governance statement is structured against the domains of the well-led framework; strategy and planning; capability and culture; process and structures; and measurement. Well led is also one of the Care Quality Commission's domains (CQC) and the Trust uses these domains as a reporting structure.

In listing 'significant issues' a number of factors have been considered, including whether:

- it may prejudice the achievement of priorities;
- the significant issue outlined could undermine integrity or reputation;

- the issue may divert resources from another significant aspect of business; and
- the issue could have a material impact on the accounts.

Strategy and planning - how the Board sets the direction for the organisation

Our mission as a Trust is to help local people live longer, healthier lives and our vision is to provide safe, personal, co-ordinated care for the community we serve. To deliver the mission and vision, we need to achieve and sustain the following strategic goals:

- to secure the best possible health and wellbeing for all our community;
- to integrate and coordinate care in person centred teams;
- to deliver consistent, high quality, safe services;
- to support our patients and users in being active partners in their care;
- to be recognised as a leader in the fields of medical and multi professional education and population based clinical research; and
- to innovate and continuously improve the quality of our services to deliver the best outcomes for our local population.

The goals reflect our long-term commitment to continuously improve safety and quality of care, and to ensure that it is delivered to our patients by a skilled, motivated and diverse workforce. They are supported by our values and behaviours and will be delivered by our core strategies - clinical, estates, workforce, health and wellbeing, communication and engagement and finance.

The Trust health and wellbeing strategy sets out our commitment to staff and patients that their health and wellbeing matters. The strategy has three main priorities: improving healthy life expectancy, improving mental health and wellbeing and improving psychosocial working conditions. This is supported by a range of annual training and development courses available to staff which are promoted internally to encourage wide participation and engagement. Our values underpin everything we do, and these are; ICARE - innovation, compassionate, accountable, respectful and excellent. These have been embedded into our appraisal and planning processes and form part of our staff excellence awards.

The Trust Board has agreed an operational plan which describes how the Trust will look in the future and how it will operate. The Trust is in North Central London with a portfolio of services covering the populations of Haringey and Islington, with some community services in Camden,

Enfield, Barnet and Hackney. The Trust is an Integrated Care Organisation and delivers some of the most innovative models of ambulatory and integrated care in the region such as our Integrated Respiratory Services, Integrated Care of the Ageing, Integrated Care Hubs and TB centre. We have taken this further by signing a Memorandum of Understanding with University College London Hospitals NHS Foundation Trust which forms part of a clinical collaboration that will enable our collective services to meet the health care needs of our changing demographic.

We work closely with Haringey and Islington Clinical Commissioning Groups, Local Health Authorities, and other providers such as Mental Health trusts, in developing the Haringey & Islington Health and Wellbeing Partnership. The objective of this partnership is to work in an integrated and collaborative way to provide high quality health and social care for our local population. This work has been recognised, supported and integrated into the North Central London Sustainability and Transformation Plan (STP). As an Integrated Care Organisation with community and hospital services we are in a unique and important position to deliver the strategic objectives of the STP.

Aligned with this are other Trust top priorities which are to deliver financial sustainability, and to continue to increase the quality, safety, responsiveness and productivity of the care we provide to patients. Implementation of our clinical and estates strategies, developed through an engagement process with staff and stakeholders, will enable the Trust to improve services and deliver them in the most clinically and cost-effective setting to address the challenges and opportunities set out in our two-year Operational Plan.

Capacity to handle risk

The Trust Board has overall accountability for the Trust's risk management approach through the executive and associate directors. The framework and policy, approved at the Quality and Audit & Risk Committees and Trust Board, supports the development of an organisational style whereby effective risk management is an integral part of providing healthcare and day to day decision making.

Whilst executive and associate directors are full time employees who manage the daily running of the Trust, the entire Trust Board takes collective responsibility for setting out the strategic direction and for holding the executive to account for the Trust's performance. The Trust Board is

accountable for upholding high standards of governance and probity. The Chairman and non-executives provide strategic guidance and support.

The Board Assurance Framework provides a high-level assurance process which enables the Trust to focus on the principal risks to delivering its strategic priorities, determine its target risk score and risk appetite, and highlights the ways in which assurance is given that these risks are mitigated or managed to an acceptable level.

The Assurance Framework has been reviewed and updated during the year and continues to be developed to ensure it aligns with best practice and meets the evolving needs of the Trust. Accountability and responsibility for maintaining the Framework has rested with the Acting Director of Strategy and from May 2018 with the newly appointed Director of Strategy, Development and Corporate Affairs. The Framework is described further in the capability and culture section.

Annual Quality Account

The directors are required under the Health Act 2009 and the NHS (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Quality Account 2018/19 sets out our future goals for quality, under the domains of safe, caring, effective, responsive and well-led, and describes our vision and direction of travel ensuring quality is our number one priority. The Quality Account supports our work to ensure we are providing safe, high quality care. It aligns to our Sign up to Safety Plan and will help us build on our overall good rating from the CQC to achieve our aspiration to become outstanding in future years.

The Quality Account was developed following a consultation period with internal and external stakeholders to ensure it meets national, local and Trust priorities. The data included within the Quality Account is subject to audit by the external auditors KPMG.

The external auditor performs limited scope procedures on two of the indicators shown in the quality accounts. The indicators for the year ended 31 March 2018 subject to limited assurance consist of the percentage of patients risk-assessed for VTE and the rate of clostridium difficile infections. The external auditor performs a review of the consistency of the quality accounts in

relation to the Trust's performance and communication with regulators in the year. This is supplemented by regular clinical audits of data within specialities and national audits.

Significant issue: The Trust's financial position

For the financial year 2017-18, the Trust posted a surplus of £5.4m, by which we significantly outperformed our control total target of a £0.6m surplus. Within this position the Trust received core sustainability and transformation funding of £6.0m and an additional £4.6m in incentive and bonus funding. As in 2016-17, while this is an excellent result, several non-recurrent benefits needed to be used to achieve the target.

The Trust continues to face the challenge of reducing its underlying deficit. It aims to do this in 2018-19, with an agreed control total of a £4.7m surplus inclusive of £9.4m sustainability and transformation funding and a cost improvement target of £16.5m.

The Trust Board exercises much of its financial governance via the Finance and Business Development Committee and Audit and Risk Committee.

The Finance and Business Development Committee reviews financial performance, business development and investment decisions of the Trust. The Committee focuses on assurance around risks (financial, delivery and regulatory) in both plans and delivery of plans. The Committee seeks assurances, mitigations and recovery action plans where appropriate.

The Audit Committee reviews the comprehensiveness, reliability and integrity of assurances to meet the Board and the Accounting Officer's requirements. To support this, the Audit Committee oversees the work of Internal and External Audit and with financial reporting issues.

Significant issue: condition of the estate

As in previous years, this remains a significant issue for the Trust, and will not be fully resolved until the Trust is able to implement its estate strategy by rationalising its 49 sites and commence redevelopment and modernisation. The backlog maintenance needed to bring our existing buildings up to standard would cost c£23m. Most costs relate to the hospital site, The Northern, Hornsey Rise Health Centre, Highbury Grange Health Centre, Crouch End and Lansdowne Road.

The risk mitigation strategy includes continued investment in the high-risk items, pro-active risk surveys and targeted remedial works.

Significant issue: improving the flow of the emergency care patient pathway and achieving the emergency department target

We saw a record number of attendances to our Emergency Department – over 100,000 – in 2017/18. These extreme pressures within the emergency and urgent care pathway continued to be a challenge throughout 2017/18 however the Trust reported 89.4%% performance for the year against the target of 95% for 4hr waits.

A significant and increasing pressure for our emergency department is our changing population healthcare needs, such as acuity, complexity, age (elderly/frail) and high dependency of some patients. To respond to these changing population healthcare needs, we continue to work together in North Central London (NCL) Strategic Transformation Plan (STP) in a strong partnership of 21 health and social care organisations, to develop a whole emergency and urgent care system. This approach aligns with our focus on population health and delivering integrated care to provide more services closer to peoples' homes, as set out in our Clinical Strategy.

The ongoing challenge to delivering the 4-Hour Emergency care standard includes an overall increase in attendances with unpredictable spikes of emergency department attendances over short periods, and the usual winter pressures. This is reflective of national pressures on the entire emergency service system, with acute trusts, ambulance services, mental health and social services. We are also experiencing an impact from increased ambulance conveyances. There was an increase in ambulance conveyances of 8.8% in Q4, coupled with a rise in acuity with activity through our Majors area increasing by 12.3% in Q4 on previous years. Our A&E Delivery Board recovery plan includes the following priorities:

- Increasing flow through Ambulatory Emergency Care
- Greater emphasis on Fit 2 Sit quality improvement programme
- Criteria led nurse discharge
- Increased Social Services presence on the hospital site to improve rapid discharge decision making
- Weekly Multi-Agency Discharge Events (MADE) with partners

To further help to meet this growing challenge we have worked closely with our CCG and Local Authority Partners to ensure:

- Further capacity is available in primary care systems to offer an alternative to patients other than attending the Emergency Department
- Improving the redirection rate from NHS 111, whereby extended access hub capacity is better utilised
- Increasing the number of patients who are discharged to assess, following national best practice
- Reducing the numbers of Delayed Transfers of Care (DTOCs)
- Improving the re-ablement capacity, to enable medically fit patients to be discharged to receive on-going re-ablement at home

A recruitment initiative for additional consultant cover in the emergency department launched in the year has resulted in more consultants being appointed – although we continue to cover vacancies with locum staff.

Capability and culture: how the Board ensures it has the appropriate experience and ability and positively shapes culture

Trust Board

As outlined in the Directors' Report, the Trust Board is accountable through the Chairman to NHS Improvement and is collectively responsible for the strategic direction and performance of the Trust, and has a general duty, both collectively and individually, to act with a view to promoting the success of the organisation.

The Trust Board Committees undertake a self-assessment of performance and effectiveness each year and report the findings to members for discussion to agree revisions to their terms of reference or administrative functions to improve effectiveness. The Trust Board receives the committees' terms of reference each year to ratify alongside the annual review of the standing orders, standing financial instructions and scheme of delegation.

Risk assessment

The risk management strategy sets out how the Trust manages the process of identification, assessment, analysis and management of risks and incidents. The risk management strategy was

refreshed this year. Board members receive annual training in risk management and an overview of the risk systems. In year, the Trust Board held a workshop seminar to review the board's risks and risk appetite and the process for updating the Board Assurance Framework and Corporate Risk Register.

The appetite of the Board for risk is that all significant red risks are recorded on the Board committees' risk registers scored >15. This approach enables the Board to scrutinise in-depth risks being escalated from the Corporate risk register.

The Corporate Risk Register brings together all significant risks which are derived from a bottom up and top down process which escalates from a number of sources to ensure totality of risk management across the Trust. These include the Trust Board, Committees, Executive, Trust management group, ICSUs, corporate project management office, and working groups such as Capital, Investment. The Chief Nurse is the responsible lead for the corporate risk register.

The Board Assurance Framework ensures that there is clarity over the risks that may impact the Trust's ability to deliver its goals and objectives together with any gaps in the robustness of internal controls or assurance to reduce or manage the risks to an acceptable level. This year the deputy chief executive/director of strategy was the responsible lead for the board assurance framework, this will move in 2018/19 to the newly appointed Director for Strategy, Development and Corporate Affairs.

Strategic risks

The Trust Board discussed and agreed the strategic risks that are recorded on the board assurance framework 2017/18. The mitigating action plans for each risk are considered at the Trust Board, Committees, executive and Trust management group meetings, as well as the working groups who lead on the subject expert areas for each topic. As part of our ongoing risk management the risks will be further reviewed and refined over 2017/18 as mitigations are implemented and progressed.

The BAF risks at 31 March 2018 were as follows:

- Failure to meet performance targets in ED
- Failure to deliver safe and high quality urgent and emergency pathway

- Inability to increase substantive workforce capacity
- Failure to deliver CIPs and transformation savings for 2017/18 and failure to plan for 2018/19
- Failure to modernise the Trust's estate
- Failure to establish cyber security across the Trust
- Failure to deliver compliant junior doctor rotas across the Trust
- Failure to provide an ongoing service to LUTS patients
- Failure to sustain the breast service due to workforce changes
- Failure to align Whittington Health's population health model to the final NCL STP

The Trust management group comprises of the executive, associate and clinical directors and was established in late 2015. The executive and associate directors lead the corporate functions and the clinical directors lead the ICSUs. This group have significantly strengthened risk management and brings together a holistic overview of the strategic, corporate, governance, financial, operational, I&MT, estates and facilities, workforce and organisational development, medical, clinical, quality, safety, patient experience, educational and research risks.

The ICSUs have monthly boards which review their risks and mitigating action plans to report to the quarterly performance and review meetings led by the chief executive. The ICSUs ensure risks are operationally managed and each has their own local risk manager who works with the corporate head of integrated risk management who leads the overall Trust corporate risk management analysis, quality assurance and reporting.

Staff job descriptions set out their responsibilities for effective and efficient risk management. New staff receive risk training at corporate Induction, face to face workshops and online training. The head of integrated risk provides one to one and group training on a continual rolling programme throughout the year. Guidance for risk management is available on the Trust intranet and good practice is shared through multiple channels including a learning zone on the intranet, a patient safety newsletter, the Chief Executive monthly Staff Briefing and the weekly electronic staff Noticeboard.

The Trust is committed to a learning environment for all levels of staff, to ensure that good practice is developed and disseminated across the organisation and that there is effective and robust learning from incidents and near misses. This is achieved by:

- a commitment to individual appraisal and personal development planning for all staff;
- policies to encourage the open reporting and investigation of adverse incidents including near misses;
- a commitment to root cause analysis of problems and incidents and the avoidance of blame;
- learning from experience and good practice is disseminated across the organisation as set out above;
- annual patient safety masterclasses for staff and key stakeholders focused on listening, learning and sharing from the Trust feedback channels of complaints, concerns and serious incidents;
- a range of problem resolution policies and procedures, including capability, raising concerns or 'whistle-blowing', workplace stress, harassment and discipline which are designed to identify and remedy problems at an early stage;
- supporting operations teams with corporate expertise in developing their risk registers as an effective management tool;
- executive and associate directors detailed scrutiny of ICSU top risks in quarterly performance reviews;
- medical and nursing director and patient experience led quality and risk impact assessments for cost improvement schemes;
- direct recording of risks onto the Datix risk system to improve review and management; and
- a range of clinical and non-clinical audit, reviews and recommendations.

All staff are trained in these policies as part of the corporate induction and local induction policies and updated via regular staff briefings and the Trust intranet.

The Trust recognises that it is important to be outward looking and to learn and improve from the experience of other organisations and experts and where possible to benchmark the quality and performance of the services we provide to our patients. We do this through a variety of ways as follows.

Care Quality Commission

The Trust is registered with the Care Quality Commission (CQC) with no conditions. The CQC has not taken enforcement action against Whittington Health during 2017/18.

Between 31st October and 2nd November 2017, the CQC inspected four core services rated as requiring improvement in the last inspection in 2015; Outpatients, Critical Care, Community Children's and Young people's services and Simmons House (Children and Adolescent Mental Health Service). The findings identified that the trust's senior management team had the right skills and abilities to run a service providing high-quality sustainable care and therefore rated the trust Good for being Well-Led.

The inspection highlighted numerous areas of good and outstanding practice and found clear evidence of improvements since 2015. In particular, the outpatient department improved in three of the five domains and achieved an overall rating of good. It was clear that significant improvements had been made in relation to information governance, team working and leadership. The inspectors commended the outpatient department for the outstanding practice seen in the hospital one-stop breast and skin cancer clinics. The critical care unit also was deemed to have improved and achieved a rating of good in the domain of safety. Other highlighted areas of good practice include:

- Leaders and staff shared a common vision on supporting their local community
- Patient outcomes in critical care were in-line with or better than national averages
- Improvements in how the critical care team manage and learn from incidents
- Multidisciplinary and joint working for children, young people and their families
- Medicines management systems with medicines appropriately prescribed, administered, recorded and stored

The outcome of the improvements made by the trust and seen by the CQC is that the rating for the Hospital has increased from 'Requires Improvement' to 'Good' following the last inspection. The Whittington Health Trust, encompassing our community services and their individual ratings, maintains a rating of 'good' from the 2015 inspection.

The trust was issued with four regulatory actions that it must address and improve with priority. These are listed below alongside the actions that the trust has taken to reduce these risks.

"Must do" actions from the CQC:	Trust response
Critical Care – reduce length of time patients are delayed waiting for discharge from CCU	The trust has made this one of its Quality Account priorities for 2018/19 and we are aiming to meet the national target of 95% of ward-able patients being stepped down from CC within 4 hours. The focus is on embedding the FLOW improvement process throughout the hospital to improve capacity so that patients are not delayed in critical care. Our acute assessment units, care of elderly wards, general surgery and general medicine wards have been assigned dedicated FLOW co-ordinators to support with patient discharging by unblocking /escalating delays.
Critical Care – ensure equipment is safely maintained and ensure local oversight of risk is appropriate	Critical care have introduced a local servicing log of equipment on the unit in addition to the log kept by medical physics. CC staff now monitor the equipment service dates monthly and any delays are escalated to Medical Physics. Introducing this additional local oversite measure has created a more robust equipment maintenance and safety checking system and expedites early escalation to medical physics in the event of delays.
Critical care – ensure patients receive safe care and treatment in line with the faculty of intensive care medicine (FICM) core standards	The parenteral nutrition (PN) policy has been reviewed and updated to provide clearer guidance for CC staff on the expectations regarding the use of PN both in and out of hours to ensure the trust complies with FICM standards.
Simmons House – ensure ligature risk assessments are up to date and accurately identify all ligature anchor points on the unit. This must be supported by information in patient risk assessments	The Ligature risk assessment has been reviewed and updated to ensure that all ward areas are included. A targeted assessment has been completed of Simmons House to ensure all ligature anchor points have been included in the ligature risk assessment register. A revised process has been designed to ensure that all patient ligature risks are assessed and documented, and nursing care plans have been introduced for all patients who have been risk assessed as at risk of harm from ligature anchor points at Simmons house.

Looking ahead, the Trust's CQC compliance and quality improvement framework for 2018/19 will take account of:

- lessons learned from implementation of improvement plan actions in 2017/18
- learning from other trusts that have improved and achieved improved ratings following subsequent CQC inspections
- the outcomes and recommendations of internal and external audits
- the CQC new strategy for regulating trusts for 2016/21

- NHS Resolution claims scorecard and benchmarking for trust

Raising concerns and whistleblowing

The Trust policy encourages everyone to raise concerns openly as part of normal day to day practice so that action can be taken to ensure high quality and compassionate care based on individual human rights. The policy outlines the different steps to take for making a qualifying disclosure, as defined by the Public Interest Disclosure Act:

- step 1: raise concern with immediate management team
- step 2: contact the employee relations advisory service
- step 3: raise concern with executive and associate directors

The Trust continues to work to help staff make 'raising concerns' a normal part of day to day practice so that action is always taken to ensure high quality and compassionate care.

The Trust continues to employ a Freedom to Speak Up Guardian and ensuring this postholder is in place is now part of the national NHSE contract. The Trust Freedom To Speak Up Guardian reports to the Executive Lead for Speaking Up, the Chief Nurse, and has strong links with the Trust's NED for Speaking Up.

The Trust is part of the London Region Speaking Up Network and is actively engaged with the work and activity of the National Freedom to Speak Up Guardian Office.

Over the 2017-18 financial year, there have been 108 issues raised with the Trust's Speak Up Guardian. Of these 15% were raised anonymously, and 25% required further action. Of those issues requiring action, 2 have involved escalation outside of the organisation, with the 23 cases being resolved using internal Trust processes.

The themes of the 108 cases raised are: 19% were to do with attitude and bullying; 1% equipment; 28% staffing; 16% quality; 15% patient experience and 3% focused on stress.

The Trust has been further developing its resources to help staff raise concerns, and in May 2018 are launching the Speak Up Inclusion Champion network – a group of nine staff working across the Trust who will work with the Freedom To Speak Up Champion to establish new and wider

ways for staff to raise concerns without fear of reprisal. This network will also focus on making it easier for our BME and minority staff to raise concerns whilst at work.

Leadership development

The Trust has offered a series of leadership programmes in year for clinical leaders and managers across the Trust. During the year we rolled out a comprehensive learning and development programme of events and workshops to bring staff together for training, development and networking. We continue to offer training in appraisal, performance development review skills and coaching and mentoring.

Informal meetings of Board members took place each month during 2017/18. Where appropriate these took a developmental approach, either in learning or in enabling broader debate on key areas of interest. During 2017/18 these included the themes of:

- risk management and board assurance;
- equality and diversity – making equality work
- digital and IT strategy, innovations and resilience systems;
- Patient-Centred Care in managing Long-Term Conditions
- The Untreated Long-Term Condition: Tobacco Dependency
- Unions Q&A session
- strategic choices within the external policy context (five year forward view, sustainability and transformation plan, health and wellbeing partnership, community healthcare networks, NHSI and NHSE reporting requirements);
- strategic estates development;
- finance and cost improvements;
- Quality account;
- Health and Well Being
- Kaiser Permanente: Integration and Innovation in Health Care
- planning, contracting and commissioning;
- operational and capital plans; and
- mandatory training such as fire, H&S.

Emergency preparedness

Each year Whittington Health NHS Trust participates in the annual Emergency Preparedness, Resilience and Response (EPRR) assurance process by NHS England. The Core standards for EPRR are set out for NHS organisations to meet and the Trust's annual assessment was completed on the 9th of October 2017 by the North Central NHS England Assurance Team. The following results were achieved:

- 52 EPRR standards evidential measures. 52= Green (Fully Compliant), 0=Amber (Evidence of Progress), 0= (No evidence of progress)
- Chemical, Biological, Radiological, Nuclear and Explosive (CBRNE) standards evidential measures 13=Green (Fully Compliant) 1= Amber (Evidence of Progress)
- Governance- Deep Dive Questions 6 = Green (Fully Compliant)

The trust has made progress on last year increasing the level of resilience throughout the Trust. The EPRR action plan for 2018 addresses the one Amber score for CBRNE. The actions are reported through Executive Committee and in six-monthly reports to Trust Board.

In the 2017 assurance process Whittington Health Strategic Business Continuity Plan achieved good practice in relation to:

- Staff support and wellbeing following the event
- Information required to support making a mutual aid request.

Clinical audit and quality improvement

The Trust is committed to delivering effective clinical audit in all the services it provides. The organisation sees clinical audit as an integral part of its arrangements for developing and maintaining high quality patient centred services. When carried out in accordance with best practice, clinical audit improves quality of care and patient outcomes, provides assurance of compliance with clinical standards and identifies and minimises risk, waste and inefficiencies

The medical director has delegated responsibility from the Chief Executive for implementing effective governance arrangements for clinical audit activity and this work is delegated to the head of clinical governance. The medical director is responsible for high quality audit and ensuring that audit informs quality improvements in patient experience and effective care and treatment. The Trust's approach for national audits is to treat all projects sponsored by the National Clinical Audit and Patient Outcomes Programme as priority.

In addition to national clinical audits further audits are based on high risk or high profile areas. They may include national initiatives with Trust wide relevance including adherence to selected NICE guidance.

National audit

During 2017/18, 51 national clinical audits including 11 national confidential enquiries covered relevant health services that Whittington Health provides. During that period the Trust participated in 100% national clinical audits and 100% of national confidential enquiries of those it was eligible to participate in. The Trust will continue to improve the processes for monitoring the recommendations of national audits and confidential enquires in 2018/19 by ensuring:

- national audit and national confidential enquiries will continue as a key component of the ICSUs quality improvement programmes. Priority will be assigned to mandatory projects to maintain 100% participation rate;
- monthly compliance with these programmes will be monitored via reporting to each ICSU;
- performance outcome presentations for national audits will be given at senior ICSU and corporate level meetings, including speciality half day audit and quality improvement meetings; and
- optimal clinical and managerial leadership will remain essential to ensure national project completion and reflection.

Local audit

The reports of **89** local clinical audits were reviewed by the provider in 2017/18 and Whittington Health intends to take numerous actions to improve the quality of healthcare provided.

Whittington Health intends to continue to improve the processes for monitoring the recommendations of local clinical audits in 2018/19 by ensuring:

- Reactive audits, vital to patient safety, will be the local priority on the Trust Integrated Clinical Service Units (ICSU) Quality Improvement programmes;
- Project proposals will be subject to a weekly quality review, prior to formal registration, to prevent duplication and to ensure alignment to local speciality priorities;
- Re-launch of the Trust Clinical Audit Registration form. A new, succinct version will facilitate the registration of projects;

- Demonstrable improvements to patient care and/or service provision will be identified monthly, to support Trust Learning from Excellence initiatives;
- Multidisciplinary Quality Improvement sessions will continue to include reflective learning on local clinical audit findings;
- Clinical speciality performance in relation to local clinical audit will continue to be monitored on an ongoing basis, with regular reporting via the ICSU Board meetings.

Serious incidents

The Serious Incident Executive Approval Group (SIEAG) comprising the Executive Medical Director/Associate Medical Directors, Chief Nurse, Chief Operating Officer, the Head of Integrated Risk Management and SI Coordinator meet weekly to review Serious Incident investigation reports. In addition, high risk incidents are reviewed by the panel to ascertain whether these meet the reporting threshold of a serious incident as described within the NHSE Serious Incident Framework (March 2015).

All serious incidents are reported to North East London Commissioning Support Unit via StEIS and a lead investigator is assigned to each by the clinical director of the relevant ICSU. All serious incidents are uploaded to the NRLS (National Reporting and Learning Service) in line with national guidance and CQC statutory notification requirements.

For 2017/18 the Trust reported 38 serious incidents, and these included the themes of

- safeguarding;
- attempted self-harm;
- confidential information leak, loss, information governance breach;
- diagnostic incident including delay;
- failure to source a tier four bed for a child;
- failure to meet expected 12hr trolley breach target;
- maternity obstetric incident mother only;
- medical disposables incident meeting serious incident criteria;
- nasogastric tube;
- slip, trips and falls;
- sub optimal care;
- treatment delay;

- unexpected death; and
- retained foreign object.

Final investigation reports are reviewed at weekly SIEAG meetings and ICSU operational directors or their deputies are required to attend each meeting when an investigation from their service is being presented. The remit of SIEAG meetings is to scrutinise the investigation and findings to ensure that contributory factors have been fully explored, root causes identified and that actions are aligned with the recommendations. The panel discuss lessons learnt and appropriate action, both immediate if applicable, and planned, to prevent future harm occurrences.

On completion of the report the patient and/or relevant family member receives an outcome letter highlighting the key findings of the investigation, actions taken to improve services, what has been learnt and what steps are being put in place. A 'being open' meeting is offered in line with duty of candour recommendations.

Lessons learned following the investigation are shared with all staff and ICSUs involved in the patient's care through various means including the 'Big 4' in theatres, 'message of the week' in maternity, obstetrics and other departments. Learning from identified incidents is shared through corporate multi channels including a learning zone on the Trust intranet, a regular patient safety newsletter, the chief executive monthly team briefing and the weekly electronic all staff Noticeboard.

Never events

A never event is defined as a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented. The Trust reported one never event in 2017/18 and this related to:

- a retained foreign object

The never event occurred in Maternity Services and related to a retained foreign object (tampon) post birth. Specific changes in practice to ensure there is no re-occurrence of this type of Never Event included revising the swab count guidance within maternity, updating the maternity swab

needle and instrument checklists and performing live drills in maternity theatres & refresher training on swab counting.

Learning from deaths

During the period 1 April 2017 to 31 March 2018, 421 Whittington Health patients died whilst in hospital. This includes all deaths in our emergency department but excludes deaths post discharge. The following number of deaths occurred in each quarter of 2017/18:

- 99 in the first quarter (April-June 2017)
- 80 in the second quarter (July-Sept 2017)
- 152 in the third quarter (October-Dec 2017)
- 96 in the fourth quarter incomplete data (Jan – Feb 2018)

By the 31st March 2018 the number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 69/99 deaths in the first quarter
- 50/80 deaths in the second quarter

Quarter 3 and 4 death reviews are still in progress, so these figures are not available yet.

Key learning identified from the patient death review includes;

- Ensuring there are more robust mechanisms in place to ensure that when VTE prophylaxis is suspended in patients (for clinical reasons) that it is restarted as soon as possible.
- Ensuring all patient deaths that involve a possible/probable medical treatment omission are discussed with families/carers as part of our Duty of Candour processes and with the Coroner's office.
- Our trust based pulmonary embolism guidelines could be made easier to read for users by adding in an algorithm and highlighting two other sections.

Actions taken in response to the findings include;

- Presentation of the patient case as an educational case to a wide audience
- Re-issued the trust guidelines following a consultation and education period
- Shared the results of the investigation with the family and Coroner
- Enhanced education of issuing medical cause of death certificates

- Enhanced knowledge of the VTE guidelines by clinical teams
- Improved processes of maximising learning from all deaths

There were no case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period.

Information governance

Information governance (IG) is to do with the way organisations process or handle information. The Trust takes its requirements to protect confidential data seriously and in 2016/17 made improvements in many areas of information governance, including data quality, subject access requests, freedom of information and records management.

The IG Toolkit is a policy delivery vehicle produced by the Department of Health; hosted and maintained by NHS Digital. It combines the legal rules including the Data Protection Act 1998, the Freedom of Information Act 2000 and central government guidance including the NHS Code of Practice on Confidentiality and the NHS Code of Practice on Records Management. The framework ensures the Trust manages the confidential data it holds safely and within statutory requirements.

During the year the Trust implemented an improvement plan to achieve IG Toolkit level two and to improve compliance against other standards to level three. As a result, the Trust met level two and declared 77% compliance for 2017/18. The Trust's IG Toolkit submission can be viewed online at www.igt.hscic.gov.uk.

The Trust has received assurance from internal (BDO LLP) and external auditors (KPMG) that appropriate systems and processes are in place in order to safeguard confidentiality and information security in relation to patient and staff information.

All staff are required to undertake IG training. In 2017/18, the Trust reached an annual peak of 80% of staff being IG training compliant. The compliance rates are regularly monitored by the IG committee, including methods of increasing compliance. The IG department continues to promote requirements to train and targets staff with individual emails, includes news features in the weekly electronic staff Noticeboard and manage classroom-based sessions at induction.

Information governance serious incidents

IG serious incidents are reported to the Department of Health and Information Commissioner's Office (ICO). Serious incidents are investigated and reported to the Trust's SIEAG Panel, relevant executive directorate or ICSU and the Caldicott Guardian and the Senior Information Risk Owner (SIRO).

The IG committee is chaired by the SIRO who maintains a review of all IG serious incidents and pro-actively monitors the action plans. The IG serious incidents declared during 2017/18 were as follows:

Date of incident	Reported date	Nature of Incident	ICO Outcome
08/05/2017	07/06/2017	Lost unencrypted memory stick containing 4 CAMHS clinic letters	No further action
22/06/2017	06/07/2017	Paediatric handover sheet found in Whittington restaurant public toilet	No further action
08/09/2017	25/09/2017	Ward handover sheet on floor near Whittington entrance	No further action
08/03/2018	04/04/2018	Inappropriate access to staff members medical record	TBC
01/02/2018	26/04/2018	Lost patient records after retrieval from external storage	TBC

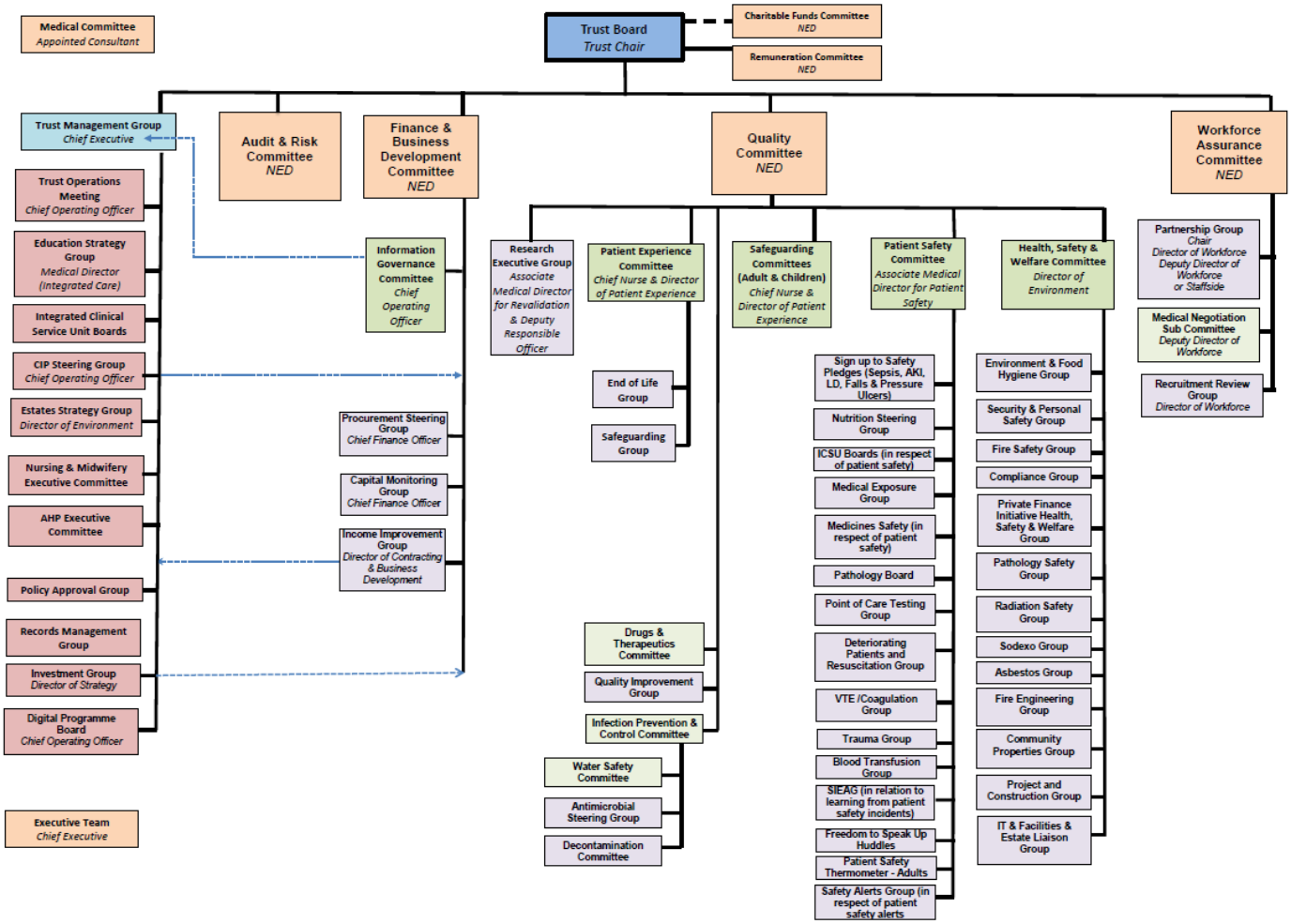
Process and structures: how reporting lines, structures and accountabilities support the effective oversight of the organisation

Trust Board

Details of the Trust Board and its committees are contained within the Directors' Report. As outlined, each of the committees and the Board undertake an annual self-assessment of effectiveness, areas requiring improvement are considered as part of Board development.

Risk and control framework

The Trust has a robust governance framework for ensuring effective reporting mechanisms from the Trust Board and its committees to the ICSU boards and other specialist working groups that report through to the Trust Board committees. The working groups include information governance, infection control, capital working, investment, patient safety and patient experience. The following outlines the Trust Board committee structure and details the underpinning working groups.



The Trust risk management strategy and policy describes the approach the Trust takes to identifying, managing and mitigating risks from across all levels of the organisation. All risks and potential hazards are identified and are recorded at directorate and ICSU level, which identify key controls and mitigating action plans to deal with these. Each risk is scored on a common basis across the Trust for likelihood and potential impact. If risks cannot be resolved or managed at a local level, they are considered for inclusion in the ICSU and executive directorate risk registers, with risks on these registers reviewed by the head of integrated risk management for inclusion in the corporate risk register.

Trust Board members receive annual training in risk management and an overview of the risk systems. In year, the Trust Board held a workshop seminar led by the internal auditors and this supported a review of the Board's risks and risk appetite and the process for updating the board assurance framework and corporate risk register.

The Trust Board reviews the most significant risks and the associated risk management plans on a regular basis. The head of integrated risk management collates the corporate risk register from the committee risk registers and ICSU boards and corporate project management office to assess the risks and produce reports for the Trust management group and Trust Board.

The Trust Board receives the Trust monthly performance scorecard which consists of a range of key performance indicators that are aligned to the five CQC domains. The report focuses on performance against quality, safety and operational targets.

The medical director's quarterly safety and quality report provides information to the Trust Board on a wider range of quality and safety indicators and this is also reviewed at the trust management group and Quality Committee. Detailed reviews are requested and undertaken for areas where potential issues are identified.

Measurement: how the Board receives appropriate, robust and timely information which supports the leadership of the Trust

The Trust Board ensures that the resources are used economically, efficiently and effectively by means of regular detailed finance and performance reports. These are considered in detail by the Finance and Business Development Committee.

The Audit and Risk Committee receives regular reports from the Trust's internal auditors, BDO LLP and external auditors KPMG. The Head of Internal Audit opinion for the Trust for 2017-18 provides moderate assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently. This represents a significant improvement on 2016-17, when limited assurance was awarded.

As part of the Care Act 2014, it has become a criminal offence to provide false or misleading information; this relates to commissioning data and other specified information including information in the quality accounts. The Trust has reviewed the requirements of the Act and has, ensured appropriate managers have been briefed and reviewed and the development of the internal audit plan ensures coverage of these data sets in planned audits.

Quality of Data

Reliable information is essential for the safe, effective and efficient operation of the organisation. This applies to all areas of the Trust's activity from the delivery of clinical services to performance management, financial management and internal and external accountability. Understanding the quality of our data means we can accurately measure our performance and enable healthcare improvements.

The Trust monitors the quality of data through the use of quarterly benchmark reports and has developed a data quality dashboard for hospital services to monitor their own data quality on a regular basis.

The Trust ICSUs have responsibility for data quality within their ICSU. The Trust has a data quality group which includes representation from both the community and acute services and the ICSUs. This group is chaired by the chief operating officer. This group is responsible for implementing an

annual data improvement and assurance plan and measures the Trust's performance against several internal and external data sources.

The Trust continues to improve data quality, through improving the coding of activity, the systematic use of benchmarking data and other reviews, and developing a programme of audits and action plans to improve data quality. Each ICSU is required to have a data quality improvement plan, which is reported against on a regular basis at the data quality group.

NHS IMPROVEMENT - SINGLE OVERSIGHT FRAMEWORK

The Single Oversight Framework has been designed to help NHS providers attain, and maintain, CQC ratings of 'Good' or 'Outstanding'. The Framework has replaced the former Monitor 'Risk Assessment Framework' and the former NHS Trust Development Authority 'Accountability Framework'. It covers five key themes:

- quality of care;
- finance and use of resources;
- operational performance;
- strategic change; and
- leadership and improvement capability.

NHS Improvement measures NHS trusts in segment ranges from one to four and trusts are segmented according to the level of support required to continuously improve. Our Trust has been segmented as a two which means we have been offered targeted support due to concerns in relation to one or more of the above themes.

ANNUAL GOVERNANCE STATEMENT - CONCLUSION

As Accountable Officer, I have responsibility for reviewing the effectiveness of the systems of internal control. My review of the effectiveness of the system of internal control is informed in several ways that are summarised below.

The annual 2017/18 internal audit programme ensured a range of audits were carried out that provided robust assurance across a wide range of operational areas. The internal audit plan is agreed and monitored at the audit and risk committee and where management control issues have been identified the lead executive presents a comprehensive action plan to provide assurance actions are being implemented in a timely manner.

The Board Assurance Framework provides me with robust evidence that the effectiveness of the controls used to manage the significant risks to the organisation achieving its strategic objectives have been reviewed and agreed by the Board. The corporate risk register provides me with further evidence that the effectiveness of the identification, controls, management and escalation of risks from across the organisation is sound.

The Trust's Committee structures provide effective monitoring and review mechanisms to ensure the systems of internal control are working effectively. Other sources of information including the views and comments of stakeholders, patient and staff surveys, internal and external audit reports, clinical benchmarking and audit reports, mortality monitoring, reports from external assessments, Royal College reviews and recommendations, accreditation of clinical services and the patient environment action team assessments assure me that we are compliant with good governance.

I can confirm, having taken all appropriate steps to be aware of potential breaches or failure to comply, that arrangements in place for the discharge of statutory functions have been checked for any irregularities, and that they are legally compliant. I consider that any significant issues are included in the report, namely: the Trust's financial position; condition of the Trust estate; improving the flow of the emergency patient pathway and achieving the emergency department performance target. Action to address each of these areas is detailed in the relevant section of the governance report.

Siobhan Harrington, Chief Executive

25 May 2018

THE DIRECTOR'S REPORT

The Trust Board

The Trust Board is accountable, through the Chairman, to NHS Improvement. The Trust Board at 31 March 2018, consisted of the Chairman, six non-executive director posts, the Chief Executive, Medical Director, Chief Nurse, Chief Operating Officer and Chief Financial Officer, as outlined below. They are collectively responsible for the strategic direction and performance of the Trust, and have a general duty, both collectively and individually, to act with a view to promoting the success of the organisation. The membership of the Trust Board is balanced and appropriate. Full biographies for each of the Trust's Board executive and non-executive directors are available on the website at www.whittington.nhs.uk.

The members of the Trust Board possess a wide range of skills and bring experience gained from NHS organisations, other public bodies (nationally and internationally) and the private sector. The Trust Board is confident that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance and ensuring management capacity and capability. The selection process, led by NHSI, and the Board seminars and development programme in place ensure that the non-executive directors have appropriate skills and experience.

The Trust Board has the capability and experience necessary to deliver the Trust's operational business plan, and the governance structure the Trust has in place (outlined in processes and structures below) is appropriate to assure the board of this delivery. The Board development programme has been largely incorporated into the normal working of the Board via its monthly meeting and development seminars. Its aims are to ensure that the Board is fit to govern the Trust, can set and review performance standards in all areas of responsibility, operates as a unitary function and is aware of, and successfully manages, competing priorities and future challenges against the Trust's strategic goals and corporate objectives and can assure itself on aspects of clinical quality and patient safety.

In compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, all Trust Board directors have been assessed as being a fit and proper person to be directors of the Trust. The performance of directors is reviewed in an annual appraisal which forms the basis

of their individual development; for executive directors, by the Chief Executive, for non-executive directors and the Chief Executive by the Chairman, and for the Chairman, by NHSI. The directors have been responsible for preparing this annual report and the associated accounts, statutory statements and quality account and are satisfied that, taken as a whole, they are fair, balanced and understandable, and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, and strategy.

Trust Board Changes

For the reporting year of 2017/18 the Board membership changed with a newly appointed Chief Executive and Chief Nurse.

The voting members of the Board are supported by non-voting director posts who attend Board meetings on a regular basis and these are the Medical Director of Integrated Care (lead for GP liaison), the Director of Workforce and Development and the Director of Communications and Corporate Affairs. A newly appointed Director of Strategy, Development and Corporate Affairs will attend in 2018/19.

A wider senior leadership team, the Trust Management Group, shares in responsibility for the day-to-day activities and delivery of the overall performance of the Trust.

Trust Board members - voting rights

Non-Executive Directors

- Steve Hitchins, Non-Executive Director Chair joined the Trust 1 January 2014
- Anu Singh, Non-Executive Director joined the Trust 14 January 2014, Vice Chair of Trust Board from 1 April 2016 and Chair of Quality Committee from 14 May 2014
- David Holt, Non-Executive Director joined the Trust 13 July 2015 and Chair of Audit and Risk Committee and Senior Independent Director
- Tony Rice, Non-Executive Director joined the Trust from 21 February 2014, Chair of Finance and Business Development and Charitable Funds Committees
- Professor Graham Hart, Non-Executive Director joined the Trust from 1 September 2014 and chair of Workforce Assurance Committee from
- Yua-haw Yoe, Non-Executive Director joined the Trust from 1 April 2016
- Deborah Harris-Ugbomah, Non-Executive Director joined the Trust from 1 May 2016

Executive Directors

- Siobhan Harrington, Chief Executive joined the Trust 1 September 2006, and was appointed CEO on 16 September 2017
- Stephen Bloomer, Chief Finance Officer joined the Trust 3 June 2015
- Dr Richard Jennings, Acting Medical Director from 1 June 2014 to 17 May 2015, substantive 18 May 2015
- Carol Gillen, Chief Operating Officer from 1 April 2016
- Philippa Davies, Interim Director of Nursing and Patient Experience joined the Trust from 1 August 2014, substantive from 1 June 2015 – December 2017
- Michelle Johnson, Chief Nurse joined the Trust on 12 Feb 2018

The accountabilities and responsibilities and roles of the Trust Board and its members are set out below.

Chairman

- Chairing the Board of Executive and Non-Executive Directors
- Ensuring the Board receive accurate, timely and clear information that is appropriate for their respective duties

Non-Executive Directors

- Challenging and supporting the Executive Directors in decision-making and on the Trust's strategy
- Holding collective accountability with the Executive Directors for the exercise of their powers and for the performance of the Trust

Chief Executive

- Leading the Executive and Trust Management Group in the day to day running of the Trust
- As Accountable Officer, working in partnership with the Board to deliver the Trust's strategy
- Ensuring that the Trust meets its statutory obligations and is fully compliant with external regulatory and statutory standards, as the Accountable Officer for the Trust
- Building effective working relationships with the community, Commissioners, Local Authorities, Universities, NHS provider organisations and other key stakeholders

Chief Financial Officer

- Meeting all organisational, statutory and regulatory requirements associated with Trust finances
- Leading the financial strategy and planning including developing the organisation's short, medium and long-term goals
- Ensuring efficiency and effectiveness of the overall finance function and the integrity of processes and systems

Chief Operating Officer

- Ensuring effective and efficient delivery of all operational, clinical and non-clinical support services
- Leading on performance delivery of national and local targets and on delivery of clinical efficiencies and service improvement work programmes
- Effectively engaging across all corporate and service delivery functions to ensure there are robust processes in place to agree and meet financial and activity targets

Medical Director

- Co-leadership with the Director of Nursing and Patient Engagement for clinical quality and patient safety
- Clinical strategy and planning; clinical service developments; contributions to wider Trust strategy and planning
- Medical leadership and clinical governance including management of all medical staff; medical-workforce planning; consultant appraisal; junior-doctor planning; clinical governance; clinical leadership in respect of NHSLA and CQC relationships
- Education and academia including medical education; relationships with Royal Colleges; and research and development

Chief Nurse

- Co-leadership with the Medical Director for clinical quality and patient safety
- Leading the Trust's registration of the Care Quality Commission and action plans
- Corporate Risk Register
- Whistleblowing Guardian
- Trust's risk management strategy and quality improvement work

- Safeguarding lead for adults and children
- Nursing, midwifery and allied health professional leadership for the organisation
- Patient and public engagement
- Complaints and litigation
- Chaplaincy services

Associate Board Attendees - Non-Voting Rights

- Dr Greg Battle, Medical Director of Integrated Care
- Norma French, Director of Workforce and Development
- Lynne Spencer, Director of Communications and Corporate Affairs (until November 2017)

Trust Board Code of Conduct and Code of Accountability

All Board members have signed the NHS Code of Conduct and Code of Accountability and this is presented in a public Board meeting on an annual basis.

Trust Board Registers of Declaration of Conflicts of Interest / Hospitality / Gifts

All Board members declare their interests where applicable and relevant. Registers are held, updated and reported to the Board in line with good governance practice, the NHS Standards of Business Conduct and NHS Improvement and NHS England guidance. During this year the Trust continued to include the interests of clinical and operational directors, including other key senior staff in positions of influence and authority. This has significantly strengthened the Board and public oversight of the Register which is available online at http://bit.ly/2qnxHQF.

Trust Board Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions

The key financial governance documents were all reviewed during 2017/18 – the outcome of this process and updated documents were presented to the Audit and Risk Committee. During 2018/19 the Trust plans to further promote good financial governance practices across the organisation.

Disclosure to the Auditor

As directors of the Trust, the directors confirm that, as far as they are aware, there is no relevant information of which the auditor is unaware. Each director has taken the steps that they ought to have taken as a director to make himself or herself aware of any relevant information and to establish that the auditor is aware of that information.

Attendance at Trust Board meetings: 1 April 2017 – 31 March 2018

The Board met a total of eleven times in public in 2017/18, every month except August. Attendance is monitored by the Chairman and all Trust Board meetings were quorate in line with the terms of reference.

The Trust Board met a total of eleven times in private in 2017/18 and the agendas were published on the Trust website to provide transparency of business items being discussed.

Trust Board Member Attendance

Member*	**Attendance (actual/possible)**
Non-executive directors	
Steve Hitchins, Chairman	11/11
David Holt	10/11
Deborah Harris-Ugbomah	11/11
Tony Rice	11/11
Anu Singh	11/11
Yua-Haw Yoe	11/11
Professor Graham Hart	11/11
Executive directors	
*Simon Pleydell, Chief Executive	5/5
*Siobhan Harrington, Deputy Chief Executive CE from Oct	11/11
Carol Gillen, Chief Operating Officer	10/11
Dr Richard Jennings, Medical Director	11/11
Stephen Bloomer, Chief Finance Officer	11/11
*Philippa Davies, Director of Nursing and Patient Experience	8/8
*Michelle Johnson, Chief Nurse (from February)	2/2

*Membership change in year

Board Committee meetings 1 April 2017 – 31 March 2018

The Board undertakes a proportion of its work through its committees. The structure below was in place throughout the year.

Each committee has its own terms of reference, formally adopted by the Trust Board that reviews all terms of reference annually. The non-executive Chairman of each committee presents a summary of each meeting or draft minutes to the Trust Board to ensure transparency and openness of Trust business to members of the public.

All committee meetings were quorate in line with their terms of reference.

The committees ensure the Trust Board, Chairman and Chief Executive discharge the Trust's statutory duties, accountabilities and responsibilities. During each year the Trust reviews the work and performance of each committee to ensure they remain fit for purpose as changes occur in line with Trust strategic intent and national policy directives.

The Trust Chairman attends all Trust Board committee meetings on at least an annual basis.
The Trust Chief Executive attends at least one Audit and Risk Committee at the end of the year.

The Trust Board Committees' terms of reference enable non-executive directors to substitute for each other.

Audit and Risk Committee

The Audit and Risk Committee assures the Board of Directors that probity and professional judgement are exercised. It advises the Board on the adequacy and effectiveness of the Trust's internal control systems, risk management arrangements, and governance processes, with a primary focus on finance.

The Committee prepares an Annual Report for the Board on these matters and receives and reviews the Annual Governance Statement, which describes and evaluates the Trust's control environment. The Chief Executive is the Trust's designated Accountable Officer who has the duty of preparing the Annual Accounts in accordance with the NHS Act 2006.

The Committee ensures the Trust is compliant with relevant regulatory, legal, and code of conduct requirements in conjunction with the Quality Committee and that the policies and procedures for all work related to fraud and corruption, are as set out in the Secretary of State Directions and NHS Protect.

The Committee is responsible for overseeing management's arrangements for ensuring sound financial systems; and leads on liaison and compliance with Internal Audit, External Audit and Local Counter Fraud Services.

The Committee approved the internal audit programme based on risks identified through the Board Assurance Framework, Corporate Risk Register and results of previous audit activities.

The Committee will receive and agree the report of external audit findings in May 2018.

The Audit and Risk Committee met four times in 2017-18. All meetings were quorate and in accordance with its terms of reference. In line with good governance principles, the Chairman of the Trust Board is not a member of the Audit and Risk Committee.

Membership

- David Holt, Non-Executive Director and Chair from 13 July 2015
- Tony Rice, Non-Executive Director from 1 April 2016
- Deborah Harris-Ugbomah, Non-Executive Director from 1 May 2016

Attendance

Member	**Attendance (actual/possible)**
Non-executive directors	
David Holt	4/4
Tony Rice	4/4
Deborah Harris-Ugbomah	4/4

The Chairman attended the January 2018 meeting of the Audit and Risk Committee.

Quality Committee

The Quality Committee assures the Trust Board on all issues of quality, patient safety, patient experience and clinical effectiveness. It seeks assurance from across the whole of the

organisation on systems, processes and outcomes relating to these areas including the environment. It and monitors compliance with the Trust statutory duties to comply and register with the Care Quality Commission and its quality and safety standards.

The Quality Committee met six times in 2017/18. All meetings were quorate and in accordance with its terms of reference. The Committee has embedded significant and improved changes to its management, administration and effectiveness in year.

Membership

- Anu Singh, Non-Executive Director Chair from 14 April 2014
- Deborah Harris-Ugbomah, Non-Executive Director from 1 May 2016
- Yua Haw-Yoe, Non-Executive Director from 1 April 2016
- Philippa Davies, Director of Nursing and Patient Experience, from 1 August 2014 to 1st January 2018
- Dr Richard Jennings, Medical Director, from 2 June 2014
- Carol Gillen, Chief Operating Officer from 1 April 2016
- Michelle Johnson, Chief Nurse, from 12th February 2018

Member*	Attendance (actual/possible)
Non-executive directors	
Anu Singh	05/06
Deborah Harris-Ugbomah	04/06
Yua-haw Yoe	05/06
Executive directors	
*Philippa Davies, *Executive Director of Nursing and Patient Experience*	04/04
*Michelle Johnson, Chief Nurse	01/01
Dr Richard M Jennings, *Executive Medical Director*	04/06
Carol Gillen, *Chief Operating Officer*	06/06

***membership change during the year**

The Chairman attended 1 meetings of the Quality Committee in 2017/18

Finance and Business Development

The Finance and Business Development Committee receives reports and verbal updates on issues relating to the delivery of the finance and business plan for the current year and future

periods. The Committee provides assurance to the Trust Board on all aspects of financial performance, including the operational financial performance, capital investment and working capital issues. The Committee also considers updates on the implementation of business development programmes and proposals for new development opportunities. The Committee ensures compliance with statutory and regulatory requirements placed on the Trust by relevant authorities.

The Finance and Business Development Committee met six times during 2017-18 and was quorate in line with its terms of reference. The Chair of the Committee was Tony Rice, non-executive director, who has continued in the role since 2013/14.

The Finance and Business Development Committee is responsible for seeking assurance as to the satisfactory management of the Trust's finances, cost improvement plan, cash management and capital programme. The Committee reviews and recommends to the Board for approval business cases that meet the scheme of delegation threshold for financial sign off and those of high-level strategic significance.

Membership

- Tony Rice, Non-Executive Director Chair from February 2014
- Deborah Harris-Ugbomah, Non-Executive Director from 1 May 2016
- Professor Graham Hart, Non-Executive Director from 1 April 2016
- *Simon Pleydell, Chief Executive from 1 April 2014, substantive from 1 January 2015 – Aug 2017
- *Siobhan Harrington, Chief Executive from 16 September 2017
- *Siobhan Harrington, Deputy Chief Executive and Director of Strategy from 1 September 2006 – September 2017
- *Helen Taylor, Interim Director of Strategy from September 2017 – May 2018
- Stephen Bloomer, Chief Finance Officer from 3 June 2015
- Carol Gillen, Chief Operating Officer from 1 April 2016

Member*	**Attendance (actual/possible)**
Non-executive directors	
Tony Rice	06/06
Deborah Harris-Ugbomah	06/06

Professor Graham Hart	04/06
Executive directors	
*Simon Pleydell, *Chief executive*	0/3
*Siobhan Harrington, *Deputy Chief Executive*	1/3
*Siobhan Harrington, *Chief Executive*	2/3
Stephen Bloomer, *Chief Finance Officer*	6/6
Carol Gillen, *Chief Operating Officer*	4/6
*Helen Taylor, Interim Director of Strategy	3/3

*Membership change in year

The Chairman attended three meetings of the Committee in December 2017 and February 2018.

Charitable Funds Committee

The Charitable Funds Committee manages the receipt and spending of the Trust's charitable donations, ensuring that donated funds are invested and spent in line with Trust policies and legal requirements. The Charitable Funds annual report and account is reported to the Charities Commission each year. The Committee met three times during 2017-18 and was quorate in line with its terms of reference. The Chair of the Committee was Tony Rice, non-executive director, who has continued in the role since 2013-14.

Membership

- Tony Rice, Non-Executive Director Chair from February 2014
- Steve Hitchins, Non-Executive Director from January 2014
- *Simon Pleydell, Chief Executive from 1 April 2014, substantive from 1 January 2015 – August 2017
- *Siobhan Harrington, Chief Executive from 16 September 2017
- Stephen Bloomer, Chief Finance Officer from 3 June 2015

Member*	**Attendance (actual/possible)**
Non-executive directors	
Tony Rice	4/4
Steve Hitchins, *Chairman of Trust*	3/4
Executive directors	
*Simon Pleydell, *Chief executive*	2/4
*Siobhan Harrington, Chief Executive	1/2
Stephen Bloomer, *Chief Finance Officer*	3/4

*Membership change in year

Remuneration Committee

The Remuneration Committee determines the appointment, remuneration, terms of service and performance of the Executive and Associate Directors. It considers issues relating to employees in line with its terms of reference such severance and redundancies. The Committee met once in 2017/18 to review the performance of the executive and associate directors and was chaired by Steve Hitchins, non-executive director.

The Remuneration Committee is a statutory Committee comprising of the non-executive directors that oversee the appointment, performance assessment and remuneration of the executive/associate directors and senior staff.

The Director of Workforce and Development attends at the request of the Chair in advisory capacity as relevant and appropriate. External advisors are invited to meetings where required.

Membership

- Steve Hitchins, Non-Executive Director Chair from January 2014
- Tony Rice, Non-Executive Director Chair from February 2014
- Deborah Harris-Ugbomah, Non-Executive Director from 1 May 2016
- Anu Singh, Non-Executive Director from January 2014
- Prof. Graham Hart, Non-Executive Director from September 2015
- Yua Haw-Yoe, Non-Executive Director from 1 April 2016
- David Holt, Non-Executive Director from 13 July 2016

Member*	**Attendance (actual/possible)**
Non-executive directors	
Steve Hitchins, *Chairman*	1/1/
Tony Rice	1/1
Deborah Harris-Ugbomah	1/1
Anu Singh	1/1/
Yua-haw Yoe	1/1/
Professor Graham Hart	0/1/
David Holt	1/1/

There were a further two virtual remuneration committees, one following the appointment of a new CEO in July 2017; and a second to agree a redundancy package in November 2017.

The Chief Executive attended part of the meeting to report on the executive team's objectives, appraisals and performance.

Workforce Assurance Committee

The Committee ensures an effective structure, process and system of control for workforce governance and risk management; that human resources services are provided in line with national and local standards and policy, in line with the Trust's corporate objectives; development and delivery of the Trust's workforce strategy and compliance with relevant equality, diversity and human rights legislation.

The Workforce Assurance Committee met four times during 2017/18 and was at all times quorate in accordance with its terms of reference. The Chair of the Committee was Professor Graham Hart. Attendance at meetings is shown below.

Membership

- Steve Hitchins, Non-Executive Director Chair from 1 April 2016 to 31 December 2016
- Prof. Graham Hart, Non-Executive Director from 1 April 2016 and Chair from January 2017
- Norma French, Director of Workforce from 1 April 2016
- *Philippa Davies, Director of Nursing and Patient Experience, from 1 August 2014 to 1st January 2018
- *Michelle Johnson, Chief Nurse, from 12th February 2018
- Philippa Davies, Director of Nursing and Patient Experience
- Steve Bloomer, Chief Finance Officer
- Carol Gillen, Chief Operating Officer from 1 April 2016
- Helen Gordon, Deputy Director of Workforce from 1 April 2016

Member	**Attendance (actual/possible)**
Non-executive directors	
Professor Graham Hart (Committee Chair)	4/4
Steve Hitchins, *Chairman of Trust*	4/4
Executive / Associate directors	
Norma French, *Director of Workforce*	4/4
Steve Bloomer, Chief Finance Officer	3 /4
*Philippa Davies, *Executive Director of Nursing and Patient Experience*	3 /4

*Michelle Johnson, Chief Nurse	0/0
Carol Gillen, *Chief Operating Officer from 1 April 2016*	3 /4
Helen Gordon, *Deputy Associate Director of Workforce*	3 /4
Helen Kent, HR	3/3
Jana Kristienova, *Education*	1/4

*change in membership through year

Other Disclosures

Interests

NHS employees are required to be impartial and honest in the conduct of their business and remain above suspicion. It is also the responsibility of all staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and NHS duties. The Trust is required to hold and maintain a register of details of company directorships and other significant interests held by Trust Board directors which may conflict with their management responsibilities. This register is updated at each Board meeting as a standing item for declaration invites members to update the Board so that the main register is continually updated with any changes in year; the register as at 31 March 2018 is available to the public on the website at http://www.whittington.nhs.uk/document.ashx?id=6207.

The Trust Board considers that all its non-executive directors are independent in character and judgement.

Pensions and remuneration

As an employer with staff entitled to membership of the NHS pension scheme, control measures are in place to ensure all employer obligations are complied with. This included ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations. Details of directors' remuneration are set out in the remuneration report. The Trust's external audit and details of their remuneration and fees are set out in the summary accounts, as are exit packages and severance payments, and the Trust off-payroll engagement disclosures in accordance with HMRC requirements.

Cost allocation and charges for information

The Trust complies with HM Treasury's guidance on setting charges for information required.

Equality disclosures

The Trust is committed to the promotion of equality of opportunity for all its employees. Our equal opportunities policy is to provide employment equality to all, irrespective of race, gender, disability, age, sexual orientation or religion. The Trust produces an annual workforce equality data report that provides information on how different groups of staff are affected by recruitment and human resources procedures and policies. This is available on our website www.whittingtonhealth.nhs.uk

Better payment for suppliers

The Trust supports the Prompt Payment Code which applies the following principle to payment practices: pay suppliers on time; give clear guidance to suppliers; and encourage good practice. The Trust's performance is summarised in the table in the accounts.

Emergency preparedness

The Trust is required, and has put in place, arrangements to respond to emergencies and major incidents as defined by the Civil Contingencies Act and the NHS Emergency Planning Guidance 2005. Details are included in the annual governance statement.

Principles for Remedy

The Trust handles all complaints in line with the Principle of Good Administration and aims to resolve complaints in line with the Principles for Remedy.

Siobhan Harrington, Chief Executive

25 May 2018

REMUNERATION AND STAFF REPORT

The salaries and allowances of senior managers who held office during the year ended 31 March 2018 are shown in Table 1 below.

The definition of 'Senior Managers' given in paragraph 3.35 of the Department of Health Group Accounting Manual (GAM) 2017-18 is: "…those persons in senior positions having authority or responsibility for directing or controlling the major activities within the group body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments". For the purposes of this report, senior managers are defined as the chief executive, non-executive directors and executive directors, all Board members with voting rights.

Table four: Salaries and allowances 2017-18

Name and title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
Non-executive						
Steve Hitchins, Chair	20-25	0	0	0	0	20-25
David Holt	5-10	0	0	0	0	5-10
Tony Rice (Note 2)	5-10	0	0	0	0	5-10
Anu Singh	5-10	0	0	0	0	5-10
Professor Graham Hart	5-10	0	0	0	0	5-10
Yua Haw Yoe	5-10	0	0	0	0	5-10
Deborah Harris-Ugbomah	5-10	0	0	0	0	5-10
Executive						
Simon Pleydell Chief executive to 15/9/2017	100-105	0	0	0	0	100-105
Siobhan Harrington, Director of Strategy / Deputy CEO to 15/9/2017 Chief Executive from 15/9/2017	140-145	0	0	0	127.5-130	270-275

Carol Gillen, Chief Operating Officer	120-125	0	0	0	0	120-125
Dr Richard Jennings, Medical Director	160-165	0	0	0	5-7.5	165-170
Dr Greg Battle, Executive medical director integrated care	35-40	0	0	0	2.5-5	40-45
Stephen Bloomer, Chief Finance Officer	145-150	0	0	0	10-12.5	155-160
Norma French, Director of Workforce	115-120	0	0	0	12.5-15	130-135
Philippa Davies, Director of Nursing / Patient Experience	90-95	0	0	0	0	90-95
Sarah Hayes, Acting Chief Nurse (15/12/2017 to 12/2/2018)	10-15	0	0	0	35-37.5	45-50
Michelle Johnson, Chief Nurse and Director of Patient Experience (from 12/2/2018)	10-15	0	0	0	180-182.5	195-200

(not all executives are members of the pension scheme)

Notes

1. The salary figures above represent the 2017-18 financial year and, therefore, reflect that some Directors were only in post for part of the year.
2. Tony Rice donated his salary to Whittington Hospital NHS Trust Charitable Funds.
3. Simon Pleydell was not a member of the NHS Pension Scheme.

Table five: Salaries and allowances 2016/17

Name and title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
Non-executive						
Steve Hitchins, Chair	20-25	0	0	0	0	20-25
David Holt	5-10	0	0	0	0	5-10
Tony Rice	5-10	0	0	0	0	5-10

Anu Singh	5-10	0	0	0	0	5-10
Professor Graham Hart	5-10	0	0	0	0	5-10
Yua Haw Yoe from 1 April 2016	5-10	0	0	0	0	5-10
Deborah Harris-Ugbomah from 1 May 2016	5-10	0	0	0	0	5-10
Executive						
Simon Pleydell, Chief executive	190-195	0	0	0	0	190-195
Siobhan Harrington, Director strategy/Deputy CEO	110-115	0	0	0	40-42.5	150-155
Carol Gillen, Chief operating officer	120-125	0	0	0	197.5-200	320-325
Dr Richard Jennings, Medical director	155-160	0	0	0	22.5-25	180-185
Stephen Bloomer, Chief finance officer	140-145	0	0	0	97.5-100	240-245
Philippa Davies, Director of nursing/patient experience	120-125	0	0	0	0	120-125

(not all executives are members of the pension scheme)

Statement of the policy on senior managers' remuneration

The remuneration committee follows national guidance on the salary of senior managers.

All elements of remuneration, including 'annual cost of living increases' (when applicable) continue to be subject to performance conditions. Executive directors were awarded a 1% cost of living increase by the remuneration committee in July 2017. This is subject to the achievement of goals being objectively assessed. The governance arrangements for the committee form part of the Whittington Health's standing orders, reservations and delegation of powers and standing financial instructions last updated in April 2017.

In line with the requirements of the NHS Codes of Conduct and Accountability, the purpose of the committee is to advise the Trust Board about appropriate remuneration and terms of service for the chief executive and other executive directors including

- all aspects of salary (including any performance-related elements/bonuses)
- provisions for other benefits, including pensions and cars

- arrangements for termination of employment and other contractual terms

Policy on duration of contracts, notice periods, termination payments

The contracts of employment for all senior managers are substantive (permanent), subject to market conditions when it may be imperative to consider other recruitment options. Senior managers are subject to regular and rigorous review of performance. All such contracts contain notice periods of either three months or six months. There is no provision for compensation for early termination in the contract of employment, but provision is made in the standard contract as follows

Clause 11: 'The Trust may at its discretion terminate a senior manager's contract with less or no notice by paying a sum equal to but no more than basic salary in lieu of notice less any appropriate tax and statutory deductions.'

Clause 12: 'Senior manager contracts may be terminated with immediate effect and without compensation for gross misconduct.'

Table six: Board members' pension entitlements for those in the pension scheme 2017-18

	Real increase in pension at pension age (bands of £2,500)	Real increase in lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Name and title Siobhan Harrington	5-7.5	17.5-20	35-40	115-120	609	169	795	21
Stephen Bloomer	0-2.5	0	45-50	115-120	687	58	765	21
Greg Battle	0-2.5	0-2.5	10-15	35-40	231	13	250	5
Carol Gillen	0-2.5	0-2.5	40-45	125-130	916	56	999	18
Richard Jennings	0-2.5	2.5-5	40-45	125-130	784	72	878	23
Philippa Davies	0	0	30-35	90-95	764	0	638	13
Norma French	0-2.5	0	20-25	55-60	448	29	489	17
Sarah Hayes	0-2.5	0-2.5	25-30	60-65	307	25	342	2
Michelle Johnson	7.5-10	22.5-25	25-30	85-90	376	159	547	2

Notes

The Trust's accounting policy in respect of pensions is described in Note 8.3 of the complete annual accounts document that will be uploaded to www.whittington.nhs.uk in September 2018. As non-executive directors do not receive pensionable remuneration, there are no entries in respect of pensions.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a point in time.
The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement, which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing of additional years of service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The real increase in CETV reflects the increase in the CETV effectively funded by the employer. It takes account of the increase in the accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

The membership of the remuneration committee comprises the chairman and all the non-executive directors of Whittington Health NHS Trust. The committee has agreed several key principles to guide the remuneration of directors of the Trust.

Simon Pleydell, Chief Executive was not enrolled in the pension scheme.

Pay multiples

Non-Executive Directors

The Trust follows NHS Improvement guidance for appointing non-executive directors.

The terms of the contract apply equally to all non-executive directors with the exception of the Chairman, who has additional responsibilities and accountabilities. The remuneration of a non-executive director is £6,157. The Chairman receives £21,105.

Salary range

The Trust is required to disclose the ratio between the remuneration of the highest-paid director in their organisation and the median remuneration of the workforce.

The mid-point remuneration of the highest paid director at Whittington Health in 2017-18 was £162,500 (2016-17 £191,900). This was 4.71 times the median remuneration of the workforce, which was £34,495 (2016-17 £34,154). The multiple has reduced from 2016-17 due to a change of the most highly paid individual.

In 2017-18, we had no employees (unchanged from 2016-17) who received remuneration in excess of the highest-paid director. Remuneration ranged from £6,157 to £159,950 (2016-17 £6,157 - £191,900).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind and severance payments. It does not include employer contributions and the cash equivalent transfer value of pensions.

Staff numbers and composition

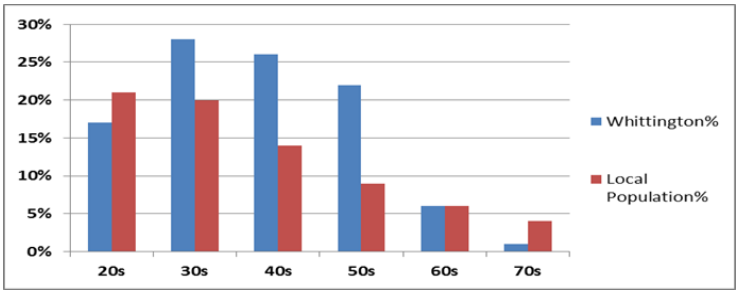
Equality, diversity and inclusion

We believe that employing a workforce that reflects the diverse nature of the communities we serve will make us better at meeting the needs of our patients.

At 31st March 2018 the Trust had 4,219 staff in post.

The graphs below indicate our staff profile by gender and age.

Graph one: Staff profile by age



Graph two: Staff profile by gender

The table below provides a breakdown of ethnicity across the Trust, the local population served by Whittington Health staff and a comparison of the NHS workforce.

Table seven: Breakdown of all ethnic groups

Breakdown of Ethnic group	Whittington Health %	Local Population %	NHS Workforce % *
White	48	64	78
Black or Black British	23	16	5
Asian or Asian British	13	9	9
Mixed	3	7	1
Any other ethnic group	6	4	2
Not stated/Unknown	7	-	4

* Source: NHS Digital – December 2017 Data

Empowering staff from black and minority ethnic (BME) backgrounds to take the next steps in their career with us remains key. To help us achieve this, a comprehensive equality, diversity and inclusion improvement plan, including Trust Board development, was implemented during the year.

The inaugural Staff Equalities Engagement Event held in September 2017 identified priority initiatives for addressing inequalities impacting the workforce. They are:

- Setting up the Trust's Staff Equality & Inclusion Network which has been meeting monthly since it was launched in January 2018.
- Nine Speak Up Inclusion Champions (SUICs) have been trained and actively working across the Trust.
- A campaign to recruit additional SUICs will take place over the summer period.

- During the month of May two master classes launched the work for newly set up Task & Finish Groups on issues relating to Recruitment, Selection and Appointment (RSA); and Disciplinary and Grievance (D&G). This will include investigating and seeking ways to address over-representation of BME staff facing disciplinary action compared to non-BME staff.
- A workshop for demystifying and enhancing your understanding of LGBT+ issues will be delivered in conjunction with colleagues from the Trust participating in this year's Pride in London Parade event on the 7th July.
- Created a working group to investigate, review, improve and promote effective use of the Trust's equalities monitoring data. This will include becoming part of a Pan-London initiative to explore models of better practices for addressing the WRES indicator 3 issues.
- Actively seeking to address and increase the low number of staff with disability status recorded on the Trust's Electronic Staff Record (ESR) and explore how individuals with disabilities workplace experiences can be improved through better understanding the results of the recent staff survey results and the Staff Equality & Inclusion Network.
- Refresh the equalities objectives under the Well-Led domain of the EDS2 in line with the six strategic goals articulated in the Workforce Strategy and the Trust's Corporate objectives.
- Ensure improved access and patient experience for all, regardless of their protected characteristic group identity, using equalities monitoring data and our organisational values, ICARE.

Table eight: Sickness absence data

Staff Sickness Absence	2017/18	**2016/17**
Total days lost (Calendar Days Lost)	49,323	30,098
Average working days lost	8	8
Number of persons retired early on ill health grounds	0	6

Table nine: Breakdown of band 8A – Very Senior Managers

Band/Grade	**Headcount**	**% of total B8A-VSM**	**% of Total substantive headcount (4,219)**
JQ00 Personal Salary	3	3	0.07
WCEX Chief Executive	1	1	0.02
WDIR Director	5	5	0.12

Band 8A	47	44	1.11
Band 8B	18	17	0.43
Band 8C	21	19	0.50
Band 8D	9	8	0.21
Band 9	4	4	0.09
Total	**108**	**101**	

Table ten: Breakdown of temporary and permanent staff members

	Average WTE	
	2016/17	**2017/18**
Permanent staff		
Administration and Estates	1017	993
Medical and Dental	441	458
Nurses & Midwives	1114	1069
Scientific, Therapeutic & Technical	675	680
Healthcare Assistants	508	516
Permanent staff total	**3754**	**3717**
Temporary staff		
Administration and Estates	229	201
Medical and Dental	49	47
Nurses & Midwives	263	222
Scientific, Therapeutic & Technical	44	48
Healthcare Assistants	87	113
Temporary staff total	**671**	**631**
All staff total	**4425**	**4348**

Table eleven: Breakdown of temporary and permanent staff members

	Costs (£k)
	2017/18
Permanent staff	
Administration and Estates	39,853
Medical and Dental	42,208
Nurses & Midwives	55,484
Scientific, Therapeutic & Technical	36,538
Healthcare Assistants	16,248
Permanent staff total	**190,331**
Temporary staff	
Administration and Estates	6,024

Medical and Dental	6,001
Nurses & Midwives	10,829
Scientific, Therapeutic & Technical	2,119
Healthcare Assistants	3,766
Temporary staff total	**28,739**
All staff total	**219,070**

Consultancy Spend

The Trust spent £1.2m on consultancy in 2017-18 (£0.9m in 2016-17). The majority of this expenditure was incurred with a partner organisation to help the Trust develop savings scheme ideas.

Off-payroll engagements

The Trust is required to disclose all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months. The Trust does not have any of these engagements.

Table eleven: Exit packages for 2017-18

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
		£s		£s		£s		£s
Less than £10,000	2	15,510	0	0	0	15,510	0	0
£10,000 -£25,000	1	21,455	0	0	0	21,455	0	0
£25,001 -£50,000	2	99,244	0	0	0	99,244	0	0
£50,001 - £100,000	2	159,117	0	0	0	159,117	0	0
£100,001 - £150,000	1	120,790	0	0	0	120,790	0	0
£150,001 - £200,000	1	170,560	0	0	0	170,560	0	0

>£200,000	0	0	0	0	0	0	0	0
Total	**9**	**586,677**	**0**	**0**	**9**	**586,677**	**0**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where Whittington Health has agreed early retirements, the additional costs are met by the Trust.

Siobhan Harrington, Chief Executive

25 May 2018

FINANCIAL SUMMARY STATEMENTS

Statutory financial duties

The Trust did not meet all its statutory financial duties in 2017/18. These are described below:

Breakeven duty

(Not achieved) – the Trust is required to break-even on its income and expenditure account over a rolling three-year period. This year, the Trust ended with a surplus of £5.4m against a control total of £0.6m surplus. However, due to losses reported in 2015-16 and 2016-17, the Trust still has a cumulative historic deficit of £9.1m. While financial performance has significantly improved, there is still work to be done to address the historic deficit. The Trust aims to continue its financial recovery and plans to make a £4.7m surplus in 2018-19.

External financing limit (EFL)

(Achieved) — this determines how much more (or less) cash can be spent by the Trust compared to that which is generated from its operations. The Trust is required by the Department of Health to maintain net external financing within its approved EFL. The Trust had an EFL of -£0.7million and undershot this limit by £32k.

Capital resource limit (CRL)

(Achieved) – this determines the amount that can be spent by the Trust each year on new capital purchases. The Trust had a revised CRL of £11.3m and used £9.9m of this.

Capital cost absorption duty

(Achieved) – The Trust is required to absorb a cost of capital at a rate of 3.5 per cent. This means the total dividends paid on the Public Dividend Capital (PDC) must be 3.5 per cent of average net relevant assets.

Principles for Remedy

The Trust has a policy for dealing with complaints and is supported by complaints procedures. The Trust Board receives regular reports concerning our compliance to the complaints policy. All

compensation and ex-gratia payments made are reported through to the Audit Committee. These payments are governed by the Trust's Standing Financial Instructions (SFI).

Going Concern

As with previous years, we have prepared our annual accounts for 2017-18 on the going concern basis. This is in line with DH accounting guidance, which states that the Trust is a going concern if continuation of services exists. However, because the Trust is unable to breakeven across a three-year period, our external auditors are obliged to give a qualified opinion on the Trust's arrangements to provide value for money in its use of resources for 2017-18.

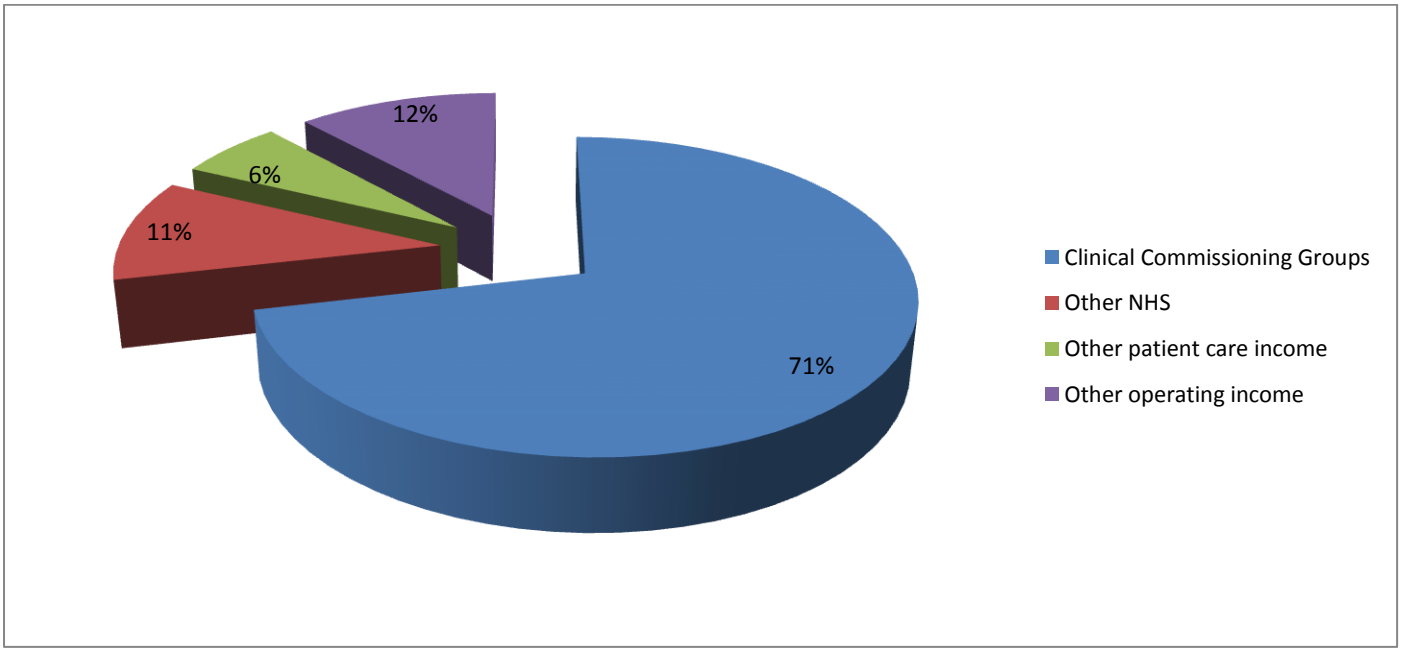
Financial Outlook

The Trust's financial performance in 2017-18 is significantly better than in 2016-17, making the first surplus at the Trust since 2013-14. The Trust has submitted an operating plan to NHS Improvement that shows achievement of a £4.7m surplus in 2018-19. To support delivery of this surplus, the Trust has a challenging but robust cost improvement programme to achieve in year.

FINANCIAL OVERVIEW

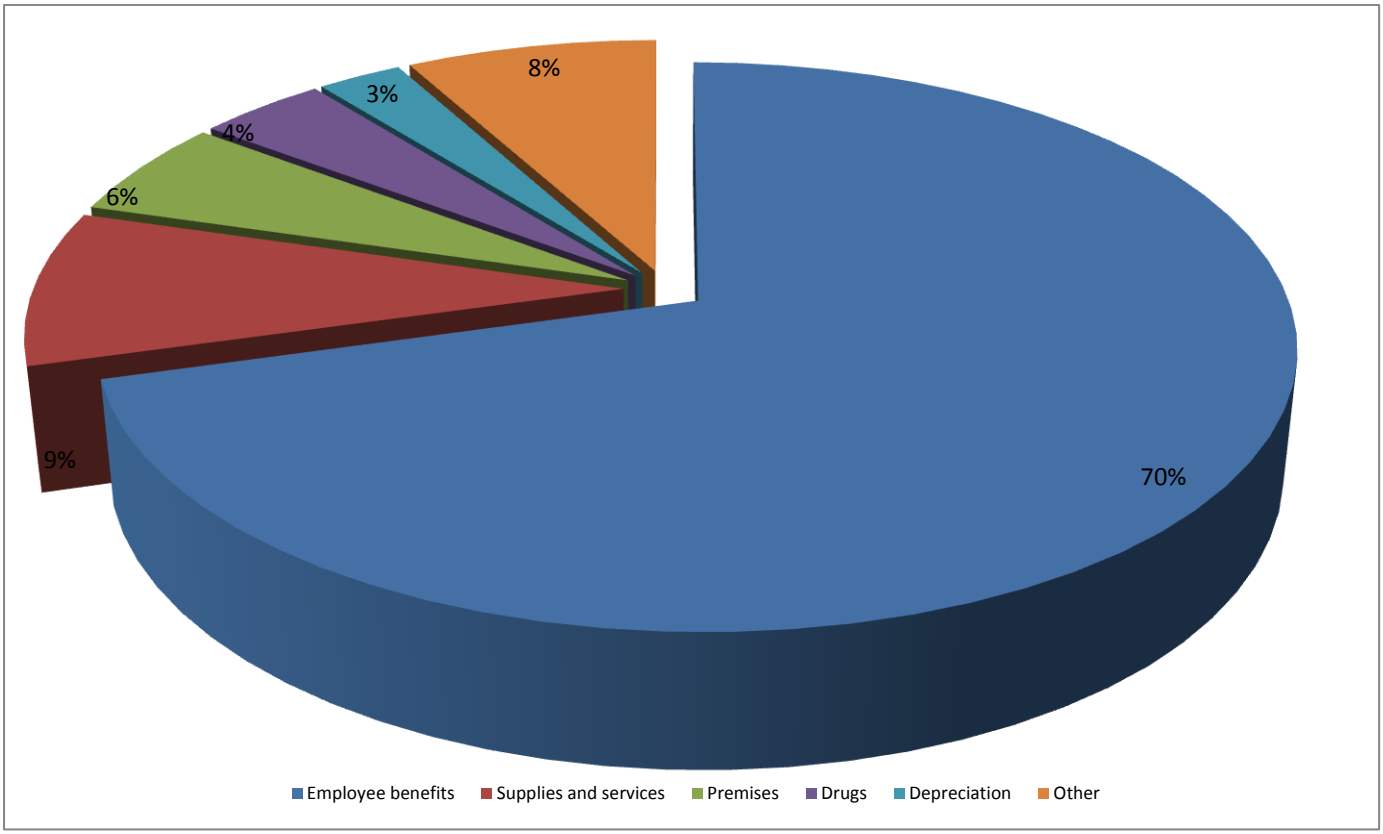
Like many NHS Trusts, we are facing a challenging financial future and have challenging financial plans to achieve for 2018-19. We finished 2017-18 with a £5.4m surplus against control total, which was £4.8m better than our planned position.

Fig 1: Our Income



In 2017-18, we received income of £323.4m, a 4.6% increase on the 2016-17 total of £309.3m. This increase was the result of improved contracts with CCG commissioners, expanded activity with NHS England, and Sustainability and Transformation Plan funding from NHS England. Around 71% of our income came from clinical commissioning groups (CCGs), much from the two main boroughs we work in. We also received significant income from NHS England, local authorities and from some other partner NHS Trusts.

Fig 2: where we spend our money



Our expenditure in 2017-18 was £310m, a 1.6% increase on our previous year's spending of £305m. Our spending on staffing has decreased slightly as a proportion of our total spend, decreasing from 73% to 70%. Non-pay expenditure has increased year on year.

Table twelve: Our break-even performance

	2017-18	2016-17	2015-16	2014-15	2013-14
	£'000	£'000	£'000	£'000	£'000
Revenue	323,394	309,255	294,211	295,007	297,397
Operating expenses (including depreciation)	(310,067)	(305,157)	(301,033)	(297,694)	(294,953)
Surplus before interest and dividends	13,327	4,098	(6,822)	(2,687)	2,444
Other losses				0	0
Net interest payable	(3,119)	(3,160)	(3,138)	(2,864)	(2,748)
Other gains and (losses)	(28)	(7)	(25)		
Dividends payable	(4,667)	(4,550)	(4,503)	(3,828)	(2,817)
Retained surplus / (deficit)	5,514	(3,619)	(14,488)	(9,379)	(3,121)
Adjustment for non-PFI impairments included in retained deficit	0	0	(248)	1,950	3,136
Adjustments in respect of donated gov't grant asset reserve elimination	(81)	(51)	(52)	87	
Adjustment for impact of IFRS accounting on PFI included in retained deficit	0	0	0	0	1,062
Position against statutory break-even duty	5,433	(3,670)	(14,788)	(7,342)	1,077

Payment of invoices

The Department of Health requires that invoices be paid in accordance with the Better Payments Practice Code. The target is to pay within 30 days of receipt of goods or a valid invoice, whichever is later, unless other terms have been agreed.

Our performance for the last two years, which is measured both in terms of volume and value of invoices, is shown below:

Table thirteen: Performance on payment of creditors

	2017-18		2017-18		2016-17		2016-17
	Number		£000s		Number		£000s
NHS Payables							
Total NHS Trade Invoices Paid in the Year	7,019		19,622		5,974		19,145
Total NHS Trade Invoices Paid Within Target	2,541		5,660		4,231		6,021
Percentage of NHS Trade Invoices Paid Within Target	36%		29%		71%		31%
Non-NHS Payables							
Total Non-NHS Trade Invoices Paid in the Year	88,858		130,706		85,572		137,226
Total Non-NHS Trade Invoices Paid Within Target	80,109		119,686		57,864		113,373
Percentage of NHS Trade Invoices Paid Within Target	90%		92%		68%		83%

Prompt payment code

We subscribe to the Prompt Payment Code.

Independent auditors report

KPMG signed off Whittington Health NHS Trust Accounts on 25 May 2018. The full accounts are available on request by emailing communications.whitthealth@nhs.net.

Whittington Health NHS Trust
The Whittington Hospital
Magdala Avenue
London
N19 5NF
020 7272 3070
Communications.whitthealth@nhs.net

Appendix A

The Whittington Health NHS Trust

Annual accounts for the year ended 31 March 2018

Statement of the chief executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

• there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

• value for money is achieved from the resources available to the Trust;

• the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

• effective and sound financial management systems are in place; and

• annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Siobhan Harrington
Chief Executive Officer

25 May 2018

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year.

In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent; and

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Siobhan Harrington
Chief Executive Officer

Stephen Bloomer
Chief Finance Officer

25 May 2018

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF THE WHITTINGTON HEALTH NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of The Whittington Health NHS Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2017/18. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2017/18.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 3, the directors are responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity . As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 2 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

Qualified conclusion

Except for the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

In considering the Trust's arrangements for securing financial resilience and its arrangements for challenging how it secures economy, efficiency and effectiveness we identified that the Trust achieved a surplus of £5.513 million in 2017/18 but has a cumulative deficit of £5.095 million as at 31 March 2018.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 2 the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

We are required to report to you if we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

On 3 May 2018 a referral was made to the Secretary of State under section 30(1)(b) of the Local Audit and Accountability Act 2014 in respect of the Trust's failure to achieve its statutory break even duty.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Board of Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of the Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Neil Hewitson
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square
Canary Wharf
London
E14 5GL

25 May 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Revenue from patient care activities (NHS providers)	3	285,506	270,966
Other operating revenue	4	37,889	38,289
Operating expenses	5, 7	(310,068)	(305,157)
Net operating surplus		**13,327**	**4,098**
Finance income	10	44	20
Finance costs	11	(3,163)	(3,180)
PDC dividends payable		(4,667)	(4,550)
Net finance costs		**(7,786)**	**(7,710)**
Other gains / (losses)	12	(28)	(7)
Surplus / (deficit) for the year from continuing operations		**5,513**	**(3,619)**
Surplus / (deficit) for the year		**5,513**	**(3,619)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(119)	-
Gain on revaluations	16	4,981	15,979
Other reserve movements		470	38
May be reclassified to income and expenditure when certain conditions are met:			
Total comprehensive income / (expense) for the period		**10,845**	**12,398**

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	13	4,144	3,985
Property, plant and equipment	14	215,731	209,356
Trade and other receivables	18	656	626
Total non-current assets		**220,531**	**213,967**
Current assets			
Inventories	17	1,354	1,702
Trade and other receivables	18	30,363	25,490
Cash and cash equivalents	19	4,051	3,161
Total current assets		**35,768**	**30,353**
Current liabilities			
Trade and other payables	20	(36,977)	(35,117)
Borrowings	22	(20,195)	(1,845)
Provisions	24	(1,343)	(691)
Other liabilities	21	(320)	-
Total current liabilities		**(58,835)**	**(37,653)**
Total assets less current liabilities		**197,464**	**206,667**
Non-current liabilities			
Borrowings	22	(38,448)	(60,112)
Provisions	24	(890)	(1,549)
Total non-current liabilities		**(39,338)**	**(61,661)**
Total assets employed		**158,126**	**145,006**
Financed by			
Public dividend capital		64,679	62,404
Revaluation reserve		98,542	94,093
Income and expenditure reserve		(5,095)	(11,491)
Total taxpayers' equity		**158,126**	**145,006**

The notes on pages 14 to 57 form part of these accounts.

Siobhan Harrington
Chief Executive Officer
25 May 2018

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Available for sale investment reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**62,404**	**94,093**	**-**	**-**	**-**	**(11,491)**	**145,006**
Surplus/(deficit) for the year	-	-	-	-	-	5,513	**5,513**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(413)	-	-	-	413	**-**
Other transfers between reserves	-	-	-	-	-	470	**470**
Impairments	-	(119)	-	-	-	-	**(119)**
Revaluations	-	4,981	-	-	-	-	**4,981**
Public dividend capital received	2,275	-	-	-	-	-	**2,275**
Transfer to FT upon authorisation	-	-	-	-	-	-	**-**
Taxpayers' equity at 31 March 2018	**64,679**	**98,542**	**-**	**-**	**-**	**(5,095)**	**158,126**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Available for sale investment reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**62,404**	**78,076**	**-**	**-**	**-**	**(7,872)**	**132,608**
Prior period adjustment	-	-	-	-	-	-	**-**
Taxpayers' equity at 1 April 2016 - restated	**62,404**	**78,076**	**-**	**-**	**-**	**(7,872)**	**132,608**
Surplus/(deficit) for the year	-	-	-	-	-	(3,619)	**(3,619)**
Revaluations	-	15,979	-	-	-	-	**15,979**
Other reserve movements	-	38	-	-	-	-	**38**
Taxpayers' equity at 31 March 2017	**62,404**	**94,093**	**-**	**-**	**-**	**(11,491)**	**145,006**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Available-for-sale investment reserve
This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		13,327	4,098
Non-cash income and expense:			
Depreciation and amortisation	5	8,375	7,991
Net impairments	6	25	-
Income recognised in respect of capital donations	4	(187)	(138)
Amortisation of PFI deferred credit		-	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase) / decrease in receivables and other assets		(4,696)	(1,888)
(Increase) / decrease in inventories		347	(298)
Increase / (decrease) in payables and other liabilties		(2,515)	(3,725)
Increase / (decrease) in provisions		(7)	(345)
Tax (paid) / received		-	-
Operating cash flows from discontinued operations		-	-
Other movements in operating cash flows		-	-
Net cash generated from / (used in) operating activities		**14,669**	**5,695**
Cash flows from investing activities			
Interest received		28	20
Purchase and sale of financial assets / investments		-	(47)
Purchase of intangible assets		(1,107)	(1,046)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(4,924)	(4,637)
Sales of property, plant, equipment and investment property		-	-
Receipt of cash donations to purchase capital assets		-	138
Prepayment of PFI capital contributions		-	-
Investing cash flows of discontinued operations		-	-
Cash movement from acquisitions/disposals of subsidiaries		-	-
Net cash generated from / (used in) investing activities		**(6,003)**	**(5,572)**
Cash flows from financing activities			
Public dividend capital received		2,275	-
Public dividend capital repaid		-	-
Movement on loans from the Department of Health and Social Care		(164)	8,736
Movement on other loans		-	-
Other capital receipts		-	-
Capital element of finance lease rental payments		(848)	-
Capital element of PFI, LIFT and other service concession payments		(1,121)	(1,084)
Interest paid on finance lease liabilities		(197)	-
Interest paid on PFI, LIFT and other service concession obligations		(2,437)	-
Other interest paid		(405)	(3,180)
PDC dividend (paid) / refunded		(4,879)	(4,031)
Financing cash flows of discontinued operations		-	-
Cash flows from (used in) other financing activities		-	-
Net cash generated from / (used in) financing activities		**(7,776)**	**441**
Increase / (decrease) in cash and cash equivalents		**890**	**564**
Cash and cash equivalents at 1 April - brought forward		**3,161**	**2,597**
Prior period adjustments			**-**
Cash and cash equivalents at 1 April - restated		**3,161**	**2,597**
Unrealised gains / (losses) on foreign exchange		**-**	**-**
Cash and cash equivalents at 31 March	19.1	**4,051**	**3,161**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis.

This year the Trust has continued to meet its financial targets, against a backdrop of increased financial pressure across the NHS. In achieving these, the Trust exceeded its agreed control total by £4.8m in delivering a surplus of £5.4m. By bettering the control total, the Trust became eligible for incentive and bonus Sustainability and Transformation Funding (STF) of £4.7m, which is included in our reported position. The reported surplus represents the Trust's first surplus since 2013-14. No cash support was required from DH to achieve this.

The Trust has agreed its control total for 2018-19, for an in-year surplus of £4.7m. The Trust's financial priority for the year is to further reduce its underlying deficit and generate a surplus, whilst further embedding processes for Quality and Cost Improvement, as part of its longer term financial strategy. At the time of writing, 2018-19 contracts with principal Clinical Commissioning Groups (CCGs) in North Central London have not yet been signed. The outstanding points to be resolved are ones of detail and the majority of the contract schedules are agreed therefore we do not believe there to be a risk to liquidity. In support of this point CCGs are continuing to pay the Trust based on 2017-18 contract values.

The Trust has a £18.3m loan with the Department of Health that expires in February 2019 and we expect to be extended. The Trust submitted its annual plan to NHSI having agreed that outstanding loans would be extended at the point they crystallise. The Trust has set a challenging £16.5m CIP target for 2018-19 (representing 5.2% of expenditure) of which there are plans in place for £14.5m (88%) which will improve the underlying deficit and underpin the achievement of the control total which will unlock the payment of STF funding.

In the event of a slowdown in liquidity, the Trust can take the following actions to ensure that cash continues to flow:
• Controls are in place to enable us to manage working capital through the capital programme and the speed of payment of creditors; and
• Access to an emergency working capital facility managed by the Department of Health.

Taking these factors into account the following factors, and the intention that the healthcare and other services will continue to be provided by the public sector for the foreseeable future, the Directors consider the Trust will continue to operate as a going concern.

Note 1.2 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Property, plant and equipment
The Trust's land and building assets are valued on the basis explained in note 16 to the accounts. Cushman & Wakefield (C&W), our independent valuer, provided the Trust with a valuation of land and building assets (estimated fair value and remaining useful life). The valuation, based on estimates provided by a suitably qualified professional in accordance with HM Treasury guidance, leads to revaluation adjustments. Future revaluations of the Trust's property may result in further changes to the carrying values of non-current assets.

Provisions
Provisions have been made for legal and constructive obligations of uncertain timing or amount as at the reporting date. These are based on estimates using relevant and reliable information as is available at the time the accounts are prepared. These provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made. The carrying amounts and basis of the Trust's provisions are detailed in note 24 to the accounts.

Impairment of receivables
The Trust impairs different categories of receivables at rates determined by the age of the debt. Additionally, specific receivables are impaired where the Trust deems it will not be able to collect the amounts due. Amounts impaired are disclosed in note 18.2 to the accounts.

Note 1.2.1 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods. We also refer to the following financial statement disclosure notes where further detail is provided on individual balances containing areas of judgement:

Notes 3 and 4: revenue - work in progress and credit note provisions;
Note 14.3: property, plant and equipment;
Note 18.2: provisions for credit notes and impairment of receivables.

Note 1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.4 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

The Trust has a local capitalisation threshold of £5,000, which applies unless a group of similar assets is purchased together with a combined value exceeding this threshold.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.6.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation:
● Land and non-specialised buildings – market value for existing use.
● Specialised buildings (hospital and community buildings with no open market) – depreciated replacement cost.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments
In accordance with the *GAM*, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.6.3 Derecognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable, i.e.:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.6.4 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.6.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM* , are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income. Lifecycle costs are capitalised in the same way as other capital expenditure.

Note 1.6.6 Useful economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	16	85
Dwellings	66	66
Plant & machinery	5	15
Information technology	3	10
Furniture & fittings	5	5

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.7 Intangible assets

Note 1.7.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the trust intends to complete the asset and sell or use it
• the trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
• the trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.7.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.7.3 Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	**Max life Years**
Software licences	5	5
Licences & trademarks	5	5
Patents	5	5
Other (purchased)	5	5

Note 1.8 Inventories
Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.9 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of [the entity]'s cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.10 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.11 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Regular purchases or sales are recognised and de-recognised, as applicable, using the trade date. All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as loans and receivables. The Trust does not hold any "available-for-sale financial assets" or assets held for trading.

Financial liabilities are classified as "other financial liabilities".

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The trust's loans and receivables comprise cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Financial liabilities
All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced.

Where a bad debt provision is used, the accounting policies should include the criteria for determining when an asset's carrying value is written down directly and when the allowance account is used, and the criteria for writing off amounts charged to the allowance account against the carrying amount of the financial asset.

Note 1.12 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.12.1 The trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.12.2 The trust as lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trusts' net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.13 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the trust is disclosed at note 24.2 but is not recognised in the trust’s accounts.

Non-clinical risk pooling
The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any “excesses” payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 25 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 25, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.19 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted

As required by IAS 8, trusts should disclose any standards, amendments and interpretations that have been issued but are not yet effective or adopted for the public sector and an assessment subsequent application will have on the financial statements.

IFRS 9
The Trust is reviewing the possible impact of IFRS 9 (Financial Instruments). As stated above, the majority of the Trust's financial instruments are simple in nature and will not be significantly impacted by the standard.

IFRS 15
The Trust is reviewing the possible impact of IFRS 15 (Revenue from Contracts with Customers). Our expectation is that the implementation of IFRS 15 may potentially have some impact on partially completed spells and maternity pathways, but these are not material in quantum, so the change in the timing of income recognition is also not likely to be material.

Note 2 Operating Segments

As in the previous financial year, the Trust's operational management structure is undertaken through seven clinical divisions covering both acute and community services, and the divisional structure is reflected in the Trust Board report. These divisions comprise Integrated Medicine; Children's Services; Surgery and Cancer; Emergency and Urgent Care; Patient Access, Prevention and Planned Care; Women's Health Services and Clinical Support Services.

The Trust has aggregated its operating segments in line with IFRS 8 on the basis that the nature of the services continue to be the same - the provision of healthcare.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Acute services		
Elective income	21,831	20,218
Non elective income	50,077	56,575
First outpatient income	10,604	10,012
Follow up outpatient income	9,909	11,470
A & E income	10,953	9,512
High cost drugs income from commissioners (excluding pass-through costs)	7,883	6,842
Other NHS clinical income	69,416	69,897
Community services		
Income from other sources (e.g. local authorities)	68,952	69,491
All services		
Patient care income from private patients	195	205
Other clinical income	35,685	16,745
Total income from activities	**285,505**	**270,966**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	30,953	23,279
Clinical commissioning groups	230,841	221,173
Other NHS providers	3,833	2,312
Local authorities	18,210	22,408
Non-NHS: private patients	62	22
Patient care income from overseas patients	120	84
Injury costs recovery	319	343
Other non-NHS patient care income	1,167	1,345
Total income from activities	**285,505**	**270,966**
Of which:		
Related to continuing operations	285,505	270,966
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18	2016/17
	£000	£000
Income recognised this year	120	84
Cash payments received in-year	98	155
Amounts added to provision for impairment of receivables	169	159
Amounts written off in-year	105	40

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research	186	-
Education and training	17,943	18,859
Receipt of capital grants and donations for capital expenditure	187	138
Non-patient care services to other bodies	6,048	6,587
Sustainability and transformation fund income (NHS providers)	10,640	8,833
Rental revenue from operating leases	875	904
Income in respect of staff costs (where treated gross)	253	332
Other income	1,757	2,636
Total other operating income	**37,889**	**38,289**
Of which:		
Related to continuing operations	37,889	38,289
Related to discontinued operations	-	-

Note 5 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from non-NHS bodies	626	541
Staff and executive directors costs	219,002	221,333
Remuneration of non-executive directors	60	60
Supplies and services - clinical	23,390	21,922
Supplies and services - general	4,159	3,495
Drug costs (NHS providers only)	12,601	12,709
Consultancy services	1,229	860
Establishment	2,084	2,756
Premises	12,425	12,013
Transport	378	361
Depreciation on property, plant and equipment	6,188	6,138
Amortisation on intangible assets	2,187	1,853
Net impairments	25	-
Increase/(decrease) in provision for impairment of receivables	136	(258)
Increase/(decrease) in other provisions	413	-
Audit fees payable to the external auditor		
Audit services	61	79
Other auditor remuneration	12	20
Internal audit expenditure	-	100
Clinical negligence	10,742	9,765
Legal fees	453	373
Insurance	188	176
Research and development	80	92
Education, training and conferences	1,982	758
Rentals under operating leases	5,169	4,552
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	1,037	1,029
Hospitality	23	32
Other	5,418	4,398
Total	**310,068**	**305,157**
Of which:		
Related to continuing operations	310,068	305,157
Related to discontinued operations	-	-

Note 5.1 Other auditor remuneration

	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	3
2. Audit-related assurance services	12	12
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	5
Total	**12**	**20**

The external audit fee paid to the auditors was £51,075 + VAT. The fee paid for non-audit services was £10,000 + VAT.

Note 5.2 Limitation on auditor's liability

The contract signed on 27/09/17 states that the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed £1 million, aside from where the liability cannot be limited by law. This is in aggregate in respect of all services.

Note 6 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	25	-
Other	-	-
Total net impairments charged to operating surplus / deficit	**25**	**-**
Impairments charged to the revaluation reserve	119	-
Total net impairments	**144**	**-**

Note 7 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	171,508	150,367
Social security costs	17,266	18,147
Apprenticeship levy	844	-
NHS Pension costs	20,314	20,369
Termination benefits	587	49
Temporary staff (including agency)	9,355	33,289
Total gross staff costs	**219,874**	**222,221**
Less: recoveries in respect of outward secondments (where treated net)	**-**	-
Total staff costs	**219,874**	**222,221**
Of which		
Costs capitalised as part of assets	872	888

In line with the GAM, employee benefits should be shown in the accounts note in a single column for all categories of staff, which matches those shown for employee benefits in the staff costs disclosure in the Staff Report part of the annual report. See paragraphs 5.32 - 5.36 in the GAM for more detail.

See the "Staff report tables" tab for the disclosure that is now required in the Staff Report section of the annual report.

Note 7.1 Retirements due to ill-health

During 2017/18 there were no early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £0k (£159k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation to be carried out is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 9 Operating leases

Note 9.1 The Whittington Health NHS Trust as a lessor

This note discloses income generated in operating lease agreements where The Whittington Health NHS Trust is the lessor.

Arrangements are related to leasing areas of the hospital and community sites for catering and other services.

	2017/18	2016/17
	£000	£000
Operating lease revenue		
Minimum lease receipts	875	904
Total	**875**	**904**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	875	869
- later than one year and not later than five years;	3,500	-
- later than five years.	-	-
Total	**4,375**	**869**

Note 9.2 The Whittington Health NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where The Whittington Health NHS Trust is the lessee.

The Trust has a number of operating leases for premises (buildings) for which the full leases are currently being negotiated. The premises are mainly properties owned by NHS Property Services Ltd or Community Health Partnerships. The premises are used in the provision of community services. Other operating leases are for medical and surgical equipment.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	5,169	4,552
Total	**5,169**	**4,552**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	4,868	4,910
- later than one year and not later than five years;	18,849	2,074
- later than five years.	34,795	1,361
Total	**58,512**	**8,345**
Future minimum sublease payments to be received	-	-

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	28	20
Other finance income	16	-
Total	**44**	**20**

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	530	-
Other loans	-	550
Overdrafts	-	-
Finance leases	197	207
Interest on late payment of commercial debt	-	-
Main finance costs on PFI and LIFT schemes obligations	1,513	1,517
Contingent finance costs on PFI and LIFT scheme obligations	923	888
Total interest expense	**3,163**	**3,162**
Unwinding of discount on provisions	-	18
Other finance costs	-	-
Total finance costs	**3,163**	**3,180**

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 12 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	-	-
Losses on disposal of assets	(28)	(7)
Total gains / (losses) on disposal of assets	(28)	(7)
Gains / (losses) on foreign exchange	-	-
Fair value gains / (losses) on investment properties	-	-
Fair value gains / (losses) on financial assets / investments	-	-
Fair value gains / (losses) on financial liabilities	-	-
Recycling gains / (losses) on disposal of available-for-sale financial investments	-	-
Total other gains / (losses)	**(28)**	**(7)**

Note 13.1 Intangible assets - 2017/18

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**11,394**	**-**	**11,394**
Transfers by absorption	-	-	**-**
Additions	1,054	1,292	**2,346**
Impairments	-	-	**-**
Reversals of impairments	-	-	**-**
Revaluations	-	-	**-**
Reclassifications	-	-	**-**
Transfers to/ from assets held for sale	-	-	**-**
Disposals / derecognition	-	-	**-**
Gross cost at 31 March 2018	**12,448**	**1,292**	**13,740**
Amortisation at 1 April 2017 - brought forward	**7,409**	**-**	**7,409**
Transfers by absorption	**-**	**-**	**-**
Provided during the year	2,187	-	**2,187**
Impairments	**-**	**-**	**-**
Reversals of impairments	**-**	**-**	**-**
Revaluations	**-**	**-**	**-**
Reclassifications	**-**	**-**	**-**
Transfers to / from assets held for sale	**-**	**-**	**-**
Disposals / derecognition	**-**	**-**	**-**
Amortisation at 31 March 2018	**9,596**	**-**	**9,596**
Net book value at 31 March 2018	**2,852**	**1,292**	**4,144**
Net book value at 1 April 2017	**3,985**	**-**	**3,985**

Note 13.2 Intangible assets - 2016/17

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**10,142**	**-**	**10,142**
Prior period adjustments	**-**	**-**	**-**
Valuation / gross cost at 1 April 2016 - restated	**10,142**	**-**	**10,142**
Transfers by absorption	-	-	**-**
Additions	1,252	-	**1,252**
Impairments	-	-	**-**
Reversals of impairments	-	-	**-**
Revaluations	-	-	**-**
Reclassifications	-	-	**-**
Transfers to/ from assets held for sale	-	-	**-**
Disposals / derecognition	-	-	**-**
Valuation / gross cost at 31 March 2017	**11,394**	**-**	**11,394**
Amortisation at 1 April 2016 - as previously stated	**5,556**	**-**	**5,556**
Prior period adjustments	**-**	**-**	**-**
Amortisation at 1 April 2016 - restated	**5,556**	**-**	**5,556**
Transfers by absorption	**-**	**-**	**-**
Provided during the year	**1,853**	**-**	**1,853**
Impairments	-	-	**-**
Reversals of impairments	-	-	**-**
Revaluations	-	-	**-**
Reclassifications	-	-	**-**
Transfers to/ from assets held for sale	-	-	**-**
Disposals / derecognition	-	-	**-**
Amortisation at 31 March 2017	**7,409**	**-**	**7,409**
Net book value at 31 March 2017	**3,985**	**-**	**3,985**
Net book value at 1 April 2016	**4,586**	**-**	**4,586**

Note 14.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**47,896**	**150,284**	**1,054**	**2,426**	**28,745**	**12,127**	**93**	**242,625**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Additions	-	2,267	-	-	3,981	1,463	43	**7,754**
Impairments	-	985	-	(1,147)	-	-	-	**(162)**
Reversals of impairments	-	18	-	-	-	-	-	**18**
Revaluations	-	4,919	62	-	-	-	-	**4,981**
Reclassifications	-	-	-	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(180)	-	-	**(180)**
Valuation/gross cost at 31 March 2018	**47,896**	**158,473**	**1,116**	**1,279**	**32,546**	**13,590**	**136**	**255,036**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**2,394**	**15**	**-**	**22,423**	**8,423**	**14**	**33,269**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	**-**	**2,598**	**17**	**-**	**2,151**	**1,402**	**20**	**6,188**
Impairments	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(152)	-	-	**(152)**
Accumulated depreciation at 31 March 2018	**-**	**4,992**	**32**	**-**	**24,422**	**9,825**	**34**	**39,305**
Net book value at 31 March 2018	**47,896**	**153,481**	**1,084**	**1,279**	**8,124**	**3,765**	**102**	**215,731**
Net book value at 1 April 2017	**47,896**	**147,890**	**1,039**	**2,426**	**6,322**	**3,704**	**79**	**209,356**

Note 14.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**42,459**	**138,368**	**938**	**2,602**	**26,683**	**10,793**	**70**	**221,913**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2016 - restated	**42,459**	**138,368**	**938**	**2,602**	**26,683**	**10,793**	**70**	**221,913**
Additions	-	3,274	11	335	150	963	-	**4,733**
Revaluations	5,437	10,426	116	-	-	-	-	**15,979**
Reclassifications	-	(1,784)	(11)	(511)	1,912	371	23	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	-	**-**
Valuation/gross cost at 31 March 2017	**47,896**	**150,284**	**1,054**	**2,426**	**28,745**	**12,127**	**93**	**242,625**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**-**	**-**	**-**	**20,111**	**7,020**	**-**	**27,131**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2016 - restated	**-**	**-**	**-**	**-**	**20,111**	**7,020**	**-**	**27,131**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	**-**	**2,394**	**15**	**-**	**2,312**	**1,403**	**14**	**6,138**
Accumulated depreciation at 31 March 2017	**-**	**2,394**	**15**	**-**	**22,423**	**8,423**	**14**	**33,269**
Net book value at 31 March 2017	**47,896**	**147,890**	**1,039**	**2,426**	**6,322**	**3,704**	**79**	**209,356**
Net book value at 1 April 2016	**42,459**	**138,368**	**938**	**2,602**	**6,572**	**3,773**	**70**	**194,782**

Note 14.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	47,896	75,207	1,084	1,279	6,663	3,765	89	**135,983**
Finance leased	-	4,465	-	-	1,441	-	-	**5,906**
On-SoFP PFI contracts and other service concession arrangements	-	72,894	-	-	-	-	-	**72,894**
PFI residual interests	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	**-**
Owned - donated	-	915	-	-	20	-	13	**948**
NBV total at 31 March 2018	**47,896**	**153,481**	**1,084**	**1,279**	**8,124**	**3,765**	**102**	**215,731**

Note 14.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned - purchased	47,896	79,078	1,039	2,426	3,500	3,704	79	**137,722**
Finance leased	-	3,880	-	-	2,822	-	-	**6,702**
On-SoFP PFI contracts and other service concession arrangements	-	64,932	-	-	-	-	-	**64,932**
PFI residual interests	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	**-**
Owned - donated	-	-	-	-	-	-	-	**-**
NBV total at 31 March 2017	**47,896**	**147,890**	**1,039**	**2,426**	**6,322**	**3,704**	**79**	**209,356**

Note 15 Donations of property, plant and equipment

Assets totalling £138k were donated by the Whittington Hospitals NHS Charitable Funds (Registered Charity 1056452). There were no restrictions placed on their use.

Note 16 Revaluations of property, plant and equipment

Land, buildings and dwellings were last valued by qualified valuers Cushman and Wakefield as at 31 March 2018. The assets were revalued on a fair value basis.

In line with the current valuation methodology, buildings have been recategorised as 'blocks' and the various components within each block grouped as one block. Each block is then considered as an individual item and depreciated over its estimated useful economic life.

Note 17 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	1,171	1,341
Work In progress	-	-
Consumables	43	66
Energy	26	26
Other	114	269
Total inventories	**1,354**	**1,702**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £12,670k (2016/17: £12,800k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £0k).

Note 18.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	18,999	23,457
Capital receivables (including accrued capital related income)	-	-
Accrued income	11,020	-
Provision for impaired receivables	(2,177)	(2,806)
Deposits and advances	-	-
Prepayments (non-PFI)	758	-
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	16	-
Finance lease receivables	-	-
PDC dividend receivable	-	-
VAT receivable	1,746	1,092
Corporation and other taxes receivable	-	-
Other receivables	-	3,747
Total current trade and other receivables	**30,363**	**25,490**
Non-current		
Trade receivables	-	-
Capital receivables (including accrued capital related income)	-	-
Accrued income	-	-
Provision for impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	-	-
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
VAT receivable	-	-
Corporation and other taxes receivable	-	-
Other receivables	656	626
Total non-current trade and other receivables	**656**	**626**
Of which receivables from NHS and DHSC group bodies:		
Current	22,461	16,519
Non-current	-	-

Note 18.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**2,806**	**3,064**
Prior period adjustments	-	-
At 1 April - restated	**2,806**	**3,064**
Transfers by absorption	-	-
Increase in provision	136	(258)
Amounts utilised	(765)	-
Unused amounts reversed	-	-
At 31 March	**2,177**	**2,806**

Note 18.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	£000	£000	£000	£000
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	-	-	-	-
Over 180 days	2,177	-	2,806	-
Total	**2,177**	**-**	**2,806**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	1,747	-	-	-
30-60 Days	1,268	-	-	-
60-90 days	350	-	2,151	-
90- 180 days	1,579	-	1,252	-
Over 180 days	1,088	-	5,144	-
Total	**6,032**	**-**	**8,547**	**-**

Note 19.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
At 1 April	**3,161**	**2,597**
Prior period adjustments	-	-
At 1 April (restated)	**3,161**	**2,597**
Transfers by absorption	-	-
Net change in year	890	564
At 31 March	**4,051**	**3,161**
Broken down into:		
Commercial banks and cash in hand	64	57
Government Banking Service	3,987	3,104
Deposits with National Loans Fund	-	-
Other short term investments	-	-
Total cash and cash equivalents as in SoFP	**4,051**	**3,161**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**4,051**	**3,161**

Note 19.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018	31 March 2017
	£000	£000
Bank balances	6	-
Monies on deposit	-	-
Total third party assets	**6**	**-**

Note 20.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	18,345	19,132
Capital payables	4,903	-
Accruals	8,010	12,493
Receipts in advance (including payments on account)	-	-
Social security costs	2,507	-
VAT payables	-	-
Other taxes payable	-	137
PDC dividend payable	95	307
Accrued interest on loans	55	51
Other payables	3,062	2,997
Total current trade and other payables	**36,977**	**35,117**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance (including payments on account)	-	-
VAT payables	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	9,167	16,977
Non-current	-	-

Note 20.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2018 £000	31 March 2018 Number	31 March 2017 £000	31 March 2017 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-
- outstanding pension contributions	-		-	

Note 21 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	320	-
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Total other current liabilities	**320**	**-**
Non-current		
Deferred income	-	-
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	**-**	**-**

Note 22 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from the Department of Health and Scoial Care	18,490	164
Other loans	-	-
Obligations under finance leases	655	655
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,050	1,026
Total current borrowings	**20,195**	**1,845**
Non-current		
Loans from the Department of Health and Scoial Care	11,192	29,682
Other loans	-	-
Obligations under finance leases	1,667	2,804
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts	25,589	27,626
Total non-current borrowings	**38,448**	**60,112**

Note 23 Finance leases

Note 23.1 The Whittington Health NHS Trust as a lessee

Obligations under finance leases where The Whittington Health NHS Trust is the lessee.

	31 March 2018 £000	31 March 2017 £000
Gross lease liabilities	**4,390**	**5,532**
of which liabilities are due:		
- not later than one year;	981	981
- later than one year and not later than five years;	2,782	3,924
- later than five years.	627	627
Finance charges allocated to future periods	(2,068)	(2,073)
Net lease liabilities	**2,322**	**3,459**
of which payable:		
- not later than one year;	655	655
- later than one year and not later than five years;	1,482	2,619
- later than five years.	185	185
Total of future minimum sublease payments to be received at the reporting date	**-**	**-**
Contingent rent recognised as an expense in the period	-	-

The Trust leases the Stroud Green Health Centre. The lease started in 1993 and is scheduled to last for 125 years. The Trust's main finance lease is for imaging equipment with our Managed Equipment Service contractor, Asteral. This arrangement started in 2007 and is currently scheduled to run until 2027.

Note 24.1 Provisions for liabilities and charges analysis

	Early departure costs	Legal claims	Re-structuring	Continuing care	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2017	**1,215**	**41**	**-**	**-**	**-**	**-**	**984**	**2,240**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Change in the discount rate	-	-	-	-	-	-	-	**-**
Arising during the year	-	37	-	-	-	-	395	**432**
Utilised during the year	(197)	(11)	-	-	-	-	(212)	**(420)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	**-**
Reversed unused	-	(19)	-	-	-	-	-	**(19)**
Unwinding of discount	-	-	-	-	-	-	-	**-**
At 31 March 2018	**1,018**	**48**	**-**	**-**	**-**	**-**	**1,167**	**2,233**
Expected timing of cash flows:								
- not later than one year;	176	-	-	-	-	-	1,167	**1,343**
- later than one year and not later than five years;	704	-	-	-	-	-	-	**704**
- later than five years.	138	48	-	-	-	-	-	**186**
Total	**1,018**	**48**	**-**	**-**	**-**	**-**	**1,167**	**2,233**

Other provisions include:
1. estimated employer's liability in relation to pending negligence claims with NHS Resolution.
2. ongoing and potential employment tribunal cases. The employment tribunal provision represents management's estimate (and that of our legal advisers) of liability based on experience.
3. potential dilapidations from the transfer of leased estates back to the lessor.
4. potential liability in the event that the Trust is unable to achieve a range of greenhouse gas reduction targets.

Note 24.2 Clinical negligence liabilities

At 31 March 2018, £99,506k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Whittington Health NHS Trust (31 March 2017: £75,726k).

Note 25 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	(18)	(15)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	**(18)**	**(15)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(18)**	**(15)**
Net value of contingent assets	-	-

Note 26 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	365	2,666
Intangible assets	3,530	207
Total	**3,895**	**2,873**

Note 27 On-SoFP PFI, LIFT or other service concession arrangements

Blocks A and L of the Trust's site are provided under a PFI arrangement and were brought onto balance sheet in 2007.

Note 27.1 Imputed finance lease obligations

The Whittington Health NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	**40,299**	**43,779**
Of which liabilities are due		
- not later than one year;	2,465	2,492
- later than one year and not later than five years;	10,040	9,883
- later than five years.	27,794	31,404
Finance charges allocated to future periods	(13,660)	(15,127)
Net PFI, LIFT or other service concession arrangement obligation	**26,639**	**28,652**
- not later than one year;	1,050	1,026
- later than one year and not later than five years;	4,966	4,569
- later than five years.	20,623	23,057

Note 27.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	94,173	99,435
Of which liabilities are due:		
- not later than one year;	5,285	5,261
- later than one year and not later than five years;	21,815	21,497
- later than five years.	67,073	72,677

Note 27.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2017/18:

	2017/18 £000	2016/17 £000
Unitary payment payable to service concession operator	5,261	5,214
Consisting of:		
- Interest charge	1,513	1,517
- Repayment of finance lease liability	1,089	1,084
- Service element and other charges to operating expenditure	1,037	1,029
- Capital lifecycle maintenance	699	696
- Revenue lifecycle maintenance	-	-
- Contingent rent	923	888
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	-
Total amount paid to service concession operator	**5,261**	**5,214**

Note 28 Financial instruments

Note 28.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with CCGs, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 28.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non financial assets	27,881	-	-	-	**27,881**
Other investments / financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	4,051	-	-	-	**4,051**
Total at 31 March 2018	**31,932**	**-**	**-**	**-**	**31,932**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non financial assets	23,457	-	-	-	**23,457**
Other investments / financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	3,161	-	-	-	**3,161**
Total at 31 March 2017	**26,618**	**-**	**-**	**-**	**26,618**

Note 28.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	29,682	-	**29,682**
Obligations under finance leases	2,322	-	**2,322**
Obligations under PFI, LIFT and other service concession contracts	26,639	-	**26,639**
Trade and other payables excluding non financial liabilities	34,470	-	**34,470**
Other financial liabilities	-	-	**-**
Provisions under contract	1,215	-	**1,215**
Total at 31 March 2018	**94,328**	**-**	**94,328**

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	29,846	-	**29,846**
Obligations under finance leases	3,459	-	**3,459**
Obligations under PFI, LIFT and other service concession contracts	28,652	-	**28,652**
Trade and other payables excluding non financial liabilities	31,625	-	**31,625**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2017	**93,582**	**-**	**93,582**

Note 28.4 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	55,879	31,853
In more than one year but not more than two years	2,791	18,899
In more than two years but not more than five years	4,499	2,292
In more than five years	31,159	40,538
Total	**94,328**	**93,582**

Note 29 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	12	11	12	9
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	104	123	34	104
Stores losses and damage to property	-	-	-	-
Total losses	**116**	**134**	**46**	**113**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	118
Extra-contractual payments	-	-	-	-
Ex-gratia payments	-	-	1	35
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**-**	**-**	**2**	**153**
Total losses and special payments	**116**	**134**	**48**	**266**
Compensation payments received		-		-

Note 30 Related parties

During the year no Trust Board members or members of key management staff, or parties related to them, has undertaken any material transactions with the Trust.

Dr Greg Battle is both Executive Medical Director for Integrated Care for the Trust and a GP with Goodinge Group Practice and Wish Health, which provides a service to the Trust's Urgent Care Centre.

In 2017-18, the Trust paid £22k to Goodinge. There were no balances outstanding. The Trust also paid £588k to Wish Health, of which £96k was outstanding at 31 March 2018.

The Department of Health is considered a related party. During the year the Trust has had a significant number of material transactions with the Department and with other entities for which the Department is the parent Department. For example material income was received from the following such entities:

	Income (£000s)	Expenditure (£000s)	Debtors (£000s)	Creditors (£000s)
Islington CCG	105,838	0	4,056	221
Haringey CCG	85,055	0	1,402	40
NHS England	43,135	0	6,661	0
Health Education England	16,932	16	382	3
Camden CCG	10,646	0	376	0
Barnet CCG	10,730	0	558	53
Enfield CCG	4,894	0	50	0
City and Hackney CCG	5,500	0	456	0

Material expenditure was incurred with the following other entity within the NHS:

	Income (£000s)	Expenditure (£000s)	Debtors (£000s)	Creditors (£000s)
NHS Resolution (formerly NHS Litigation Authority)		10,903		

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of the material transactions have been with:

	Income (£000s)	Expenditure (£000s)	Debtors (£000s)	Creditors (£000s)
London Borough of Haringey	8,394		167	
London Borough of Islington	7,798	1,509	411	

Another key related party is the Trust's linked charity. However, there have been no material transactions between the Trust and the Charity during the year.

Note 31 Events after the reporting date

The Trust has considered whether there are any material post balance sheet events to disclose.
We have concluded that there is nothing to disclose here.

Note 32 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	88858	130706	80447	116494
Total non-NHS trade invoices paid within target	80109	119606	72365	105876
target	90.15%	91.51%	89.95%	90.89%
NHS Payables				
Total NHS trade invoices paid in the year	7019	19622	6514	17446
Total NHS trade invoices paid within target	2541	5660	2181	4310
Percentage of NHS trade invoices paid within target	36.20%	28.85%	33.48%	24.70%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 33 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	**-748**	7088
Finance leases taken out in year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**(748)**	**7,088**
External financing limit (EFL)	-716	8,000
Under / (over) spend against EFL	32	912

Note 34 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	10,100	5,985
Less: Disposals	(28)	-
Less: Donated and granted capital additions	(166)	(138)
Plus: Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	9,906	5,847
Capital Resource Limit	11,314	7,869
Under / (over) spend against CRL	1,408	2,022

Note 35 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	5,432
Remove impairments scoring to Departmental Expenditure Limit	-
Add back income for impact of 2016/17 post-accounts STF reallocation	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	5,432

Note 36 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		139	508	1,120	3,614	1,165	(7,342)	(14,788)	(3,670)	6,158
Breakeven duty cumulative position	3,971	4,110	4,618	5,738	9,352	10,517	3,175	(11,613)	(15,283)	(9,126)
Operating income		176,853	186,300	278,212	281,343	297,397	295,007	294,211	309,255	323,394
Cumulative breakeven position as a percentage of operating income		2.32%	2.48%	2.06%	3.32%	3.54%	1.08%	-3.95%	-4.94%	-2.82%

CIO/CCIO Office

Direct Line: 020 7288 5124

Trust Board

27 June 2018

Title:	**Cyber Risk Update**		
Agenda Item	**18/098**	**Paper**	**11**
Action requested:	For review and action		
Executive Summary:	This report offers progress highlights on mitigating the Cyber Risk on the Risk Register and highlights a few remaining areas of work. It also makes some straight-forward recommendations to ensure the cyber risk remains mitigated.		
Summary of recommendations:	1. Acknowledge the progress to date 2. Acknowledge the recommendations 3. Approve the regulatory return		
Fit with WH strategy:	To deliver consistent, high quality, safe services To innovate and continuously improve the quality of our services to deliver the best outcomes for our local population Delivery of the Digital Strategy		
Reference to related / other documents:	Driving Digital Maturity programme - https://www.england.nhs.uk/digitaltechnology/info-revolution/ddm/ Whittington Health Digital Strategy http://whittnet.whittington.nhs.uk/document.ashx?id=11212		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Cyber Security Risk		
Date paper completed:	18/05/18		

Author name and title:		**Dr Leon Douglas** **CIO**		**Director name and title:**		**Steve Bloomer** **CFO**	
Date paper seen by EC	**Y**	**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

1. Context

The paper updates the Leadership Team on progress against the identified Cyber Security risks, as well as highlights the final elements of the current plan.

Overall excellent progress has been made in mitigating and resolving risks identified through the various audits and analyses that have been undertaken. It should be recognised that the Trust has made consistent and significant investment in this area to deliver a much higher level of security.

2. Progress

In summary the major areas of progress are this:

- **End User Hardware** - Computers running out of date operating systems have been eradicated and all connected computers are automatically patched regularly.
- **Servers** – all running compliant, fully patched operating systems with the exceptions noted in this paper
- **Networks** – new firewalls and scanning software including anti-encryption technology deployed
- **Processes** – revised and improved procedures from day to day maintenance up to emergency planning level
- **Staff** – excellent development of knowledge and skills in this area with clear ownership and interest within IM&T

We have two areas of active work remaining which are:

- **Oracle Patching** – this is the database technology a number of our suppliers use to store data. Where the Trust is responsible for the use of Oracle the databases have been patched and are part of the routine schedule. However, we have one remaining supplier – SECTRA – who are yet to apply the recommended patches to the PACS system. This has been escalated to their UK Executive Team. We are also consulting with other local Trusts who we believe use this product to bring together our collective influence.
- **Windows Server 2003** – At the outset of the plan most of the estate operated on this version. The IMT team and Trust suppliers are now finishing the final few implementation plans with the last server to be decommissioned by the end of June 2018.

3. Areas of Risk

- **Staff** – while generally our staff are vigilant and do their best to engage with IM&T on threats or potentially suspicious items we must recognise that they are, for the most part, the target of the most common attacks and the most common source of incidents. The majority of these come from either clicking

on content on the web or in emails that give a threat access to their machine or by leaving their machines unlocked and therefore available for others to access. We do have quite extensive secondary protective mechanisms such as traffic scanning systems and anti-virus they will never completely remove the threat from new variants of viruses and worms.

Recommendations:

1. Continue to support the engagement with Information Governance and Data Security Training for all staff
2. Continue to communicate with staff about the importance of vigilance for such threats

- **Medical Devices** – WH use a wide array of devices as is the case in most healthcare organisations. Our overall aim is to be able to connect these to integrate the data they capture for clinical use, back it up for legal and safety reasons and to ensure a productive and efficient experience for both staff and patients. The current estate is very mixed with many devices which would be considered insecure if connected to the network. However, significant progress was made in 2017/2018 in assessing as many devices as possible, replacing or upgrading those where connectivity was essential or highly desirable and putting procedures in place around the backlog. It should be noted that a number of pieces of key radiology equipment do fall into this category. Given their essential nature and the challenge of replacing these, a temporary secure network has been set up for these. This is an expensive and resource heavy mitigation which we will aim to close as soon as is feasible. It should be noted that considerable ongoing focus and effort will be needed in this area to reduce the risk adequately.

  Recommendations:

  1. Effort and focus continued in working through the backlog
  2. New devices are assessed for their security both inherent and contractual

- **New Threats** – the support and information available to Trusts has improved since the WannaCry incident. One challenge that remains is the ability to deal with innovative new threats. While our defences comply and in some areas exceed the national standards there are regular reports of novel threats, many of which have no initial protection or remediation protocol. This makes it incumbent upon the IM&T team to remain vigilant to new threats, engage with the national information warnings and to refresh their skills as required. It's crucial the Trust maintain sight on Cyber risk and continue to invest in this area as required.

- **Recommendations:**

  1. Continue to recognise the risk of Cyber Threats

2. Support the ongoing skills and investment required to respond to new threats.

While this report draws out some key areas for the reader it is intended that in future we use the report attached in Appendix A to provide ongoing assurance to all levels of the Trust leadership. It is based on the National Cyber Security Centre guidance and should therefore be recognisable both within the NHS and outside. The Trust wide patching schedule (Appendix B) is also included to give visibility.

4. Regulator Review

The regulators, in conjunction with NHS Digital, have recently asked Providers to confirm their status in relation to some elements of Cyber Security. They have used the ’10 steps to Cyber Security’ as the guide for their questions but have tailored them to their own needs. The proposed responses are available in Appendix C with the provided guidance in Appendix D. Please note that we can only select from the answer options as the responses have to be provided through the portal provided.

5. Conclusion

The Trust should be satisfied while not complacent that it has made significant demonstrable progress in mitigating its cyber risk status. The leadership team should note that focus will need to be maintained in this area. The leadership team are also asked to consider the recommendations as relevant to their areas of responsibility and to confirm there are happy with the regulator return options.

Appendix A – Cyber Security Update Paper

Appendix B – Trust Patching Schedule

Appendix C – Regulator Return

Appendix D – Guidance for Regulator Return

Whittington Health NHS

Appendix A

Whittington Health IM&T - Cyber Security Update

April 2018

Authors:
Steve Illingworth, Assistant Director of IM&T (Technical Services)
Tino Goncalves, Network Manager

1. Introduction

Whittington Health IM&T have reviewed its cyber security status following guidance from the '10 steps to Cyber Security' produced by the National Cyber Security Centre (part of GCHQ). The following areas are covered:

Set up your Risk Management Regime
Monitoring
Malware Prevention
User education and awareness
Managing user privileges
Network security
Secure configuration
Removable media controls
Incident management
Home and mobile working

These ten steps demonstrate that cyber security is multi-layered and ever evolving, requiring constant review and updating of internal processes.

2. Whittington Health's Current Cybersecurity Status

Set up your Risk Management Regime	
Description	Assess the risks to your organisation's information and systems with the same vigour you would for legal, regulatory, financial or operational risks. To achieve this, embed a Risk Management Regime across your organisation, supported by the Board and senior managers.
Risk	The Trust requires a corporate owned risk management regime for cybersecurity.
Mitigation	1) IM&T risk register maintained. 2) Key risks transferred to DATIX.

Network Security	
Description	Protect your networks from attack. Defend the network perimeter; filter out unauthorised access and malicious content. Monitor and test security controls.
Risk	We need to make sure we have current valid technologies to block against continuous evolving external threats.
Mitigation	1) Main firewalls have been replaced, with latest generation models during 2017-18. Providing enhanced protection 2) Intrusion Detection has been installed to monitor internal network traffic for threats. 3) Anti-virus scanning was added onto the web proxies for scanning of internet traffic 4) Firewall rules have been reviewed and updated. 5) The MTI IT security firm in 2017 -18 conducted external penetration tests of WH's network. Outcome successful - MTI

	failed to penetrate WH's systems. 6) Network Security Policy in place: http://whittnet.whittington.nhs.uk/search/?q=network+security+policy

Monitoring	
Description	Establish a monitoring strategy and produce supporting policies. Continuously monitor all systems and networks. Analyse logs for unusual activity that could indicate an attack.
Risk	No software in place to assist IM&T to monitor attempts of external attacks through internet hosted servers e.g. Moodle, CareCentric and EmployeeOnline
Mitigation	1) Advanced traffic monitoring has been implemented (2017) on new firewalls. 2) Application specific logs e.g. webserver logs to be collected and analysed by dedicated software to inspect for intrusion attempts. Software solution has been procured and is currently being implemented to be live in May 2018. 3) Network vulnerabilities scanning, being routinely performed, looking for network connected devices that could be at risk from Malware. 4) Log management of user and administrator activities via ManageEngine configured and implemented (2017).

Secure Configuration	
Description	Apply security patches and ensure the secure configuration of all systems is maintained. Create a system inventory and define a baseline build for all devices.
Risk	**Patching:** i) Internal – The current IM&T 'patch' update process for internally maintained software had problems with co-ordination across the multiple stakeholders. ii) External – a) Suppliers - Some suppliers (e.g. Astral for Imaging) are refusing to allow internal patching of externally maintained systems (threat of making existing warranties invalid if internal patching occurs although the supplier will not perform the required patches themselves). b) NHS Digital provided programmes e.g. ESR which require old unsupported vulnerable software versions (e.g. Java) in order to operate. Outside Trust's remit as national system. **Unsupported operating systems:** i) Medical devices attached to the network running unpatched or unsupported operating systems still an issue. Principally in pathology and imaging. These represent a cyber threat. ii) Small number of residual 2003 servers, unsupported and a cyber threat. iii) Support for Windows 7 devices and 2008 severs (the current main operating system for most devices and servers) only

	available for a further 2years. iv) Ongoing purchasing of new medical devices with out-of-date or near end of life Windows operating systems with no provision for upgrade/patch protection.
Mitigation	1) The Trust Network Security Policy has been updated to include mandatory monthly update of all operating system security patches. 2) A Trust wide co-ordinated patching schedule for all servers has been implemented (with locally maintained agreements on when patching should occur within the one month time limit). Principal exception to this is the Pathology system, where agreement for routine patching has not been reached. 3) Isolation Firewall solution has been installed to protect internal networks from unpatched and unsupported system this is particularly targeted at medical devices. This is now live and running (early 2018), but some systems still need to be migrated onto the isolation network. 4) Residual unsupported 2003 servers. Purchase order cover and active plans in place for these to be upgraded/removed from the network (target end of June). 5) Review and/or renegotiate contracts with suppliers which do not meet Trust's standard for maintenance of patching supported software. 6) TMG agreed escalation policy for stakeholders who still use XP devices and 2003 servers (an approved process for removing/isolating 'unsupported' devices from the network which pose an existential threat to the organisation). 7) Planning in place for replacement of all PCs and laptops from Windows 7 to windows 10 by end of 2019. Capital procurement program in place, and pilot rollout completed Mar 2018. 8) Planning to upgrade all windows 2008 Servers within the next 2 years is underway, associated licencing procurement and upgrade work has commenced.

Malware Prevention	
Description	Produce relevant policies and establish anti-malware defences across your organisation.
Risk	Active anti-malware defences required across organisation.
Mitigation	1) AV solution has been standardised across the whole organisation to a new version of Sophos (until 2017 community was running McAfee). 2) Perimeter protection scanning of web traffic for malware on the proxy gateway. 3) Sophos Anti encryption-ware protection implemented across network

Removable media controls	
Description	Produce a policy to control all access to removable media. Limit media types and use. Scan all media for malware before importing onto the

	corporate system.
Risk	Potential for software viruses to be brought into Trust network by 'removable media' used by staff e.g. memory sticks.
Mitigation	1) Antivirus solution in place that scans all removable media for software viruses before user is allowed to access memory stick. The policy for their use can be found here - http://whittnet.whittington.nhs.uk/document.ashx?id=2569

User education and awareness	
Description	Produce user security policies covering acceptable and secure use of your systems. Include in staff training. Maintain awareness of cyber risks.
Risk	Training on cybersecurity for all staff at WH. Nor is there a consistent regular campaign on maintaining staff awareness of cyber risks.
Mitigation	1) Mandatory annual training is now provided as part of the new Annual IG training which has been extended to include security awareness (implemented 2017). 2) Work with Communications Team on campaign for raising cyber risk awareness and basic protective measures for staff. Content to be owned and updated by IM&T technical services, communications team to advise on best communication routes for staff to be made aware.(still outstanding)

Managing user privileges	
Description	Establish effective management processes and limit the number of privileged accounts. Limit user privileges and monitor user activity. Control access to activity and audit logs.
Risk	Users should only have the access rights that they need to do the job. Any elevated or administrator rights are particularly dangerous if compromised by malware due to the access they permit.
Mitigation	1) A review of existing user privileges has been undertaken, to limit the number of staff with administrative rights, and ensure privileges granted are appropriate to work requirements. 2) User accounts now disabled after 60 days inactivity on a regular basis. 3) A log monitoring software (Manage Engine) has been implemented (2017) to enable monitoring of network domain activities by users. 4) Policy needs to be written on the process for recording and reviewing the admin account privileges of staff.

Incident Management	
Description	Establish an incident response and disaster recovery capability. Test your incident management plans. Provide specialist training. Report criminal incidents to law enforcement. Report cyber incidents to CareCert.
Risk	In the event of a major incident important that incident response and disaster recovery plans have been carefully worked up to minimise impact.

Mitigation	1) Revised Incident response plan signed off by emergency planning group. 2) Planned incident response scenario training has been undertaken facilitated by Lee Smith (2017). 3) Procedures are in place, and routine technical fail over testing/training is undertaken for disaster recover procedures within IM&T.

Home and Mobile Working	
Description	Develop a mobile working policy. Apply the secure baseline and build to all devices. Protect data both in transit and at rest.
Risk	Risk of insecure devices being used for mobile and remote working.
Mitigation	1) Secure Citrix access to trust systems for remote users. 2) Secure Direct Access solution for remote access from trust laptops 3) Encryption of all Laptops. 4) Mobile Device Management Policy which can be found here – http://whittnet.whittington.nhs.uk/document.ashx?id=7602 *all the above are in place at the Trust.

3. Summary

Whittington Health was not affected by 'WannaCry' Ransomware in May 2017, and this is largely due to measures which have been put in place since the KPMG audit in 2016.

However there are still gaps within Whittington Health's cyber security which do need to be addressed on an ongoing basis to ensure all reasonable measures are in place. The biggest work areas going forwards are.

- Upgrading and refreshing PCs, servers and software, to ensure that they fully supported and cyber safe, this requires ongoing capital investment.
- Working with 3rd party suppliers to ensure that Medical devices are kept patched and cyber safe and are isolated from the main network where appropriate.
- User education and awareness raising of cyber safety

National advice is given by NHS Digital, in the form of the Data Security Centre - CareCert initiative. This provides best practice guidance, an advisory service, and a helpline in the event of incidents around threats. We are fully signed up to the Carecert threat advisory service.

Major System Patching Calendar 2018

January	February	March	April	May	June
1 Mo New Year's Day 1					
2 Tu				1 Tu ICE Patching 4am-5am	
3 We System C patching 4am-7am				2 We System C patching 4am-7am	
4 Th System C patching 5pm-8am	1 Th	1 Th		3 Th System C patching 5pm-8am	
5 Fr ORMIS 3am-4am	2 Fr	2 Fr		4 Fr	1 Fr
6 Sa	**3 Sa**	**3 Sa**		**5 Sa**	**2 Sa**
7 Su	**4 Su**	**4 Su**	**1 Su**	**6 Su**	**3 Su**
8 Mo Sectra RIS 6am-7am 2	5 Mo Sectra RIS 6am-7am 6	5 Mo Sectra RIS 6am-7am 10	2 Mo Easter Monday 14	7 Mo Early May B. Hol. 19	4 Mo Sectra RIS 6am-7am 23
9 Tu ICE Patching 4am-5am	6 Tu ICE Patching 4am-5am	6 Tu ICE Patching 4am-5am	3 Tu Sectra RIS 6am-7am	8 Tu Sectra PACS 6am-7am	5 Tu ICE Patching 4am-5am
10 We	7 We System C patching 4am-7am	7 We System C patching 4am-7am	4 We System C patching 4am-7am	9 We	6 We System C patching 4am-7am
11 Th	8 Th System C patching 5pm-8am	8 Th System C patching 5pm-8am	5 Th System C patching 5pm-8am	10 Th JAC 1am-2am	7 Th System C patching 5pm-8am
12 Fr	9 Fr	9 Fr	6 Fr ICE Patching 4am-5am	11 Fr ORMIS 3am-4am	8 Fr
13 Sa	**10 Sa**	**10 Sa**	**7 Sa**	**12 Sa**	**9 Sa**
14 Su	**11 Su**	**11 Su**	**8 Su**	**13 Su**	**10 Su**
15 Mo Sectra PACS 6am-7am 3	12 Mo Sectra PACS 6am-7am 7	12 Mo Sectra PACS 6am-7am 11	9 Mo Sectra PACS 6am-7am 15	14 Mo Sectra Auxiliary Servers 7am-8am 20	11 Mo Sectra PACS 6am-7am 24
16 Tu	13 Tu	13 Tu	10 Tu	15 Tu	12 Tu
17 We	14 We	14 We	11 We	16 We	13 We
18 Th	15 Th JAC 1am-2am	15 Th JAC 1am-2am	12 Th JAC 1am-2am	17 Th	14 Th JAC 1am-2am
19 Fr	16 Fr ORMIS 3am-4am	16 Fr ORMIS 3am-4am	13 Fr ORMIS 3am-4am	18 Fr	15 Fr ORMIS 3am-4am
20 Sa	**17 Sa**	**17 Sa**	**14 Sa**	**19 Sa**	**16 Sa**
21 Su	**18 Su**	**18 Su**	**15 Su**	**20 Su**	**17 Su**
22 Mo Sectra Auxiliary Servers 7am-8am 4	19 Mo Sectra Auxiliary Servers 7am-8am 8	19 Mo Sectra Auxiliary Servers 7am-8am 12	16 Mo Sectra Auxiliary Servers 7am-8am 16	21 Mo Sectra PACS Archive 7am-8am 21	18 Mo Sectra Auxiliary Servers 7am-8am 25
23 Tu	20 Tu	20 Tu	17 Tu	22 Tu	19 Tu Winpath 7:30am-9am (01,03,05,06)
24 We	21 We	21 We	18 We	23 We	20 We Winpath 18:00-19:30 (02,04,07)
25 Th	22 Th	22 Th	19 Th	24 Th	21 Th
26 Fr	23 Fr	23 Fr	20 Fr	25 Fr	22 Fr
27 Sa	**24 Sa**	**24 Sa**	**21 Sa**	**26 Sa**	**23 Sa**
28 Su	**25 Su**	**25 Su**	**22 Su**	**27 Su**	**24 Su**
29 Mo Sectra PACS Archive 7am-8am 5	26 Mo Sectra PACS Archive 7am-8am 9	26 Mo Sectra PACS Archive 7am-8am 13	23 Mo Sectra PACS Archive 7am-8am 17	28 Mo Spring Bank Hol. 22	25 Mo Sectra PACS Archive 7am-8am 26
30 Tu	27 Tu	27 Tu	24 Tu	29 Tu	26 Tu
31 We	28 We	28 We	25 We	30 We	27 We Winpath SQL 08:00-09:00
		29 Th	26 Th	31 Th	28 Th
		30 Fr Good Friday	27 Fr		29 Fr
		31 Sa	**28 Sa**		**30 Sa**
			29 Su		
			30 Mo Sectra RIS 18		

Wednesday System C Carecentric, interface and DB patching 4am-7am
Thursday System C RIO, BI and Maternity patching 5pm-8pm

Major System Patching Calendar 2018

July	August	September	October	November	December
			1 Mo Sectra RIS 6am-7am 40		
			2 Tu ICE Patching 4am-5am		
	1 We System C patching 4am-7am		3 We System C patching 4am-7am		
	2 Th System C patching 5pm-8am		4 Th System C patching 5pm-8am	1 Th	
	3 Fr		5 Fr	2 Fr	
	4 Sa	**1 Sa**	**6 Sa**	**3 Sa**	**1 Sa**
1 Su	**5 Su**	**2 Su**	**7 Su**	**4 Su**	**2 Su**
2 Mo Sectra RIS 6am-7am 27	6 Mo Sectra RIS 6am-7am 32	3 Mo Sectra RIS 6am-7am 36	8 Mo Sectra PACS 6am-7am 41	5 Mo Sectra RIS 6am-7am 45	3 Mo Sectra RIS 6am-7am 49
3 Tu ICE Patching 4am-5am	7 Tu ICE Patching 4am-5am	4 Tu ICE Patching 4am-5am	9 Tu	6 Tu ICE Patching 4am-5am	4 Tu ICE Patching 4am-5am
4 We System C patching 4am-7am	8 We	5 We System C patching 4am-7am	10 We	7 We System C patching 4am-7am	5 We System C patching 4am-7am
5 Th System C patching 5pm-8am	9 Th	6 Th System C patching 5pm-8am	11 Th JAC 1am-2am	8 Th System C patching 5pm-8am	6 Th System C patching 5pm-8am
6 Fr	10 Fr	7 Fr	12 Fr ORMIS 3am-4am	9 Fr	7 Fr
7 Sa	**11 Sa**	**8 Sa**	**13 Sa**	**10 Sa**	**8 Sa**
8 Su	**12 Su**	**9 Su**	**14 Su**	**11 Su**	**9 Su**
9 Mo Sectra PACS 6am-7am 28	13 Mo Sectra PACS 6am-7am 33	10 Mo Sectra PACS 6am-7am 37	15 Mo 42	12 Mo Sectra PACS 6am-7am 46	10 Mo Sectra PACS 6am-7am 50
10 Tu	14 Tu	11 Tu	16 Tu	13 Tu	11 Tu
11 We	15 We	12 We	17 We	14 We	12 We
12 Th JAC 1am-2am	16 Th JAC 1am-2am	13 Th JAC 1am-2am	18 Th	15 Th JAC 1am-2am	13 Th JAC 1am-2am
13 Fr ORMIS 3am-4am	17 Fr ORMIS 3am-4am	14 Fr ORMIS 3am-4am	19 Fr	16 Fr ORMIS 3am-4am	14 Fr ORMIS 3am-4am
14 Sa	**18 Sa**	**15 Sa**	**20 Sa**	**17 Sa**	**15 Sa**
15 Su	**19 Su**	**16 Su**	**21 Su**	**18 Su**	**16 Su**
16 Mo 29	20 Mo Sectra Auxiliary Servers 7am-8am 34	17 Mo Sectra Auxiliary Servers 7am-8am 38	22 Mo Sectra Auxiliary Servers 7am-8am 43	19 Mo Sectra Auxiliary Servers 7am-8am 47	17 Mo Sectra Auxiliary Servers 7am-8am 51
n-9a Tu Winpath 7:30am-9am (01,03,05,06)	21 Tu Winpath 7:30am-9am (01,03,05,06)	18 Tu Winpath 7:30am-9am (01,03,05,06)	23 Tu Winpath 7:30am-9am (01,03,05,06)	20 Tu Winpath 7:30am-9am (01,03,05,06)	18 Tu Winpath 7:30am-9am (01,03,05,06)
18 We Winpath 18:00-19:30 (02,04,07)	22 We Winpath 18:00-19:30 (02,04,07)	19 We Winpath 18:00-19:30 (02,04,07)	24 We Winpath 18:00-19:30 (02,04,07)	21 We Winpath 18:00-19:30 (02,04,07)	19 We Winpath 18:00-19:30 (02,04,07)
19 Th	23 Th	20 Th	25 Th	22 Th	20 Th
20 Fr	24 Fr	21 Fr	26 Fr	23 Fr	21 Fr
21 Sa	**25 Sa**	**22 Sa**	**27 Sa**	**24 Sa**	**22 Sa**
22 Su	**26 Su**	**23 Su**	**28 Su**	**25 Su**	**23 Su**
23 Mo Sectra Auxiliary Servers 7am-8am 30	27 Mo August Bank Hol. 35	24 Mo Sectra PACS Archive 7am-8am 39	29 Mo Sectra PACS Archive 7am-8am 44	26 Mo Sectra PACS Archive 7am-8am 48	24 Mo Sectra PACS Archive 7am-8am 52
24 Tu	28 Tu Sectra PACS Archive 7am-8am	25 Tu	30 Tu	27 Tu	25 Tu Christmas Day
25 We Winpath SQL 08:00-09:00	29 We Winpath SQL 08:00-09:00	26 We Winpath SQL 08:00-09:00	31 We Winpath SQL 08:00-09:00	28 We Winpath SQL 08:00-09:00	26 We Boxing Day
26 Th	30 Th	27 Th		29 Th	27 Th
27 Fr	31 Fr	28 Fr		30 Fr	28 Fr
28 Sa		**29 Sa**			**29 Sa**
29 Su		**30 Su**			**30 Su**
30 Mo Sectra PACS Archive 7am-8am 31					31 Mo 1
31 Tu					

Appendix C

2017/18 Data Security Protection Requirements: guidance

April 2018

Background

In January 2018, to improve data security and protection for health and care organisations the Department of Health and Social Care, NHS England and NHS Improvement published a set of 10 data and cyber security standards – the 17/18 Data Security Protection Requirements (2017/18 DSPR) – that all providers of health and care must comply with.

The 2017/18 DSPR standards are based on those recommended by Dame Fiona Caldicott, the National Data Guardian (NDG) for health and care, and confirmed by government in July 2017.

We are asking all providers to confirm to us whether or not you are complying with the 2017/18 DSPR standards. To do this, you must submit a response using the web form.

The questions set out below are the same as those found in the web form. They are designed to test whether you have implemented (fully, partially or not) the 10 standards outlined in the 2017/18 DSPR.

As part of the assurance process, the board must sign off your response before it is submitted.

Any questions about the data collection process should be directed to nhsi.17-18dsprsubmission@nhs.net

Leadership obligation 1: People

1. Senior level responsibility

There must be a named senior executive responsible for data and cyber security in your organisation.

Ideally this person will also be your senior information risk owner (SIRO), and where applicable a member of your organisation's board.

Fully implemented	Partially implemented	Not implemented
The organisation has a named senior executive who reports to the board who is responsible for data and cyber security and this person is also the SIRO	The organisation has a named senior executive who reports to the board who is responsible for data and cyber security but this person is not the SIRO	The organisation does not have a named senior executive who is responsible for data and cyber security

Please provide the contact details of the named senior executive responsible for data and cyber security if they are in place.

Name	Carol Gillen
Job title	Chief Operating Officer
Name of organisation	Whittington Health NHS Trust
Email	carolgillen@nhs.net
Telephone number	0207 288 5255

2. Completing the Information Governance toolkit v14.1

By 31 March 2018 organisations are required to achieve at least level 2 on the Information Governance (IG) toolkit. More information about the IG toolkit v14.1 can be found here: www.igt.hscic.gov.uk/help.aspx

For more information on how to complete the toolkit, please refer to the guidance:

- NHS foundation trusts: acute trusts, mental health trusts, ambulance trusts, community health providers, commissioning support units, NHS England
- Independent providers: NHS business partners, commercial third parties, secondary use organisations, hosted secondary use teams, any qualified providers − clinical and any qualified providers − non clinical.

NOTE: the new Data Security and Protection toolkit is being introduced for 2018/19. This will replace the current IG toolkit.

Fully implemented	Partially implemented	Not implemented
The organisation has completed the IG toolkit, submitted its results to NHS Digital and obtained either level 2 or 3.	The organisation has completed the IG toolkit and submitted its results to NHS Digital but has not attained level 2.	The organisation has not completed the IG toolkit and submitted the results to NHS Digital

3. Preparing for the introduction of the General Data Protection Regulation in May 2018

The beta version of the Data Security and Protection toolkit was released in February 2018 and will help organisations understand what actions they need to take to implement the General Data Protection Regulation (GDPR) which comes into effect in May 2018.

Detailed information about the implementation of the GDPR can be found in the implementation checklist produced by the Information Governance Alliance (https://digital.nhs.uk/information-governance- alliance/General-Data-Protection-Regulation-guidance)

Fully Implemented	Partially Implemented	Not Implemented
By May 2018, the organisation will have an approved plan to detail how it will achieve compliance with the GDPR. This will have board-level sponsorship and approval.	By May 2018, the organisation will have a plan that has been developed but not yet sponsored and approved at board level on how it will achieve compliance with the GDPR.	A plan has not been yet been developed.

3. Training staff

All staff must complete appropriate annual data security and protection training.

As per the IG toolkit, staff are defined as: all staff, including new starters, locums, temporary, students and staff contracted to work in the organisation.

A new training programme has been introduced: https://www.e-lfh.org.uk/programmes/data-security-awareness/. This programme replaces the previous IG training whilst retaining key elements of it. More information about the previous IG training resources can be found at

https://www.igt.hscic.gov.uk/NewsArticle.aspx?tk=431663506918390&lnv=1&cb=6fa0a573-a4df-45f3-8af1-5c5ff58cce87&artid=170&web=yes

Providers must ensure staff have completed either the new IG training tool or the previous IG training tool.

Fully implemented	Partially implemented	Not implemented
At least 95% of staff have completed either the previous IG training or the new training in the last twelve months.	At least 85% of staff have completed either the previous IG training or the new training in the last twelve months.	Less than 85% of staff have completed either the previous IG training or the new training

Leadership Obligation 2: Processes

5. Acting on CareCERT advisories

Organisations must:

- Identify a primary point of contact for your organisation to receive and co-ordinate your organisation's response to CareCERT advisories, and provide this information through CareCERT Collect
- act on CareCERT advisories where relevant to your organisation
- confirm within 48 hours that plans are in place to act on High Severity CareCERT advisories, and evidence this through CareCERT Collect

Fully implemented	Not implemented
The organisation has registered for CareCERT Collect	The organisation has not registered for CareCERT Collect

Yes	No	Not applicable
The organisation has plans in place for all CareCERT advisories up to 31/3/2018 that are applicable to the organization (**Note**: the plan could be that the board accepts the residual risk)	The organisation does not have plans in place for all CareCERT advisories up to 31/3/2018 that are applicable to the organisation	The organisation has not registered for CareCERT Collect

Fully implemented	Partially implemented	Not implemented
The organisation has clear processes in place that allow it to confirm within 48 hours of a High Severity CareCERT advisory being issued that a plan is in place.	The organisation does not have clear processes in place that allow it to confirm within 48 hours of a High Severity CareCERT advisory being issued that a plan is in place, but is developing these processes	The organisation does not have clear processes in place that allow it to confirm within 48 hours of a High Severity CareCERT advisory being issued that a plan is in place, and these processes are not under development

Fully implemented	Partially implemented	Not implemented
The organisation has in post a primary point of contact who is responsible for receiving and co-ordinating CareCERT advisories.	The organisation does not have in post a primary point of contact who is responsible for receiving and coordinating CareCERT advisories, but is in the process of filling that role.	The organisation does not have in post a primary point of contact who is responsible for receiving and coordinating CareCERT advisories, and no plans are in place to fill that role.

6. Business continuity planning

Comprehensive business continuity plans must be in place to support the organisation's response to data and cyber security incidents.

Fully implemented	Partially implemented	Not implemented
The organisation has an agreed business continuity plan(s) for cyber security incidents in place. The plan(s) take into account the potential impact of any loss of services on external organisations in the health and care system.	The organisation is developing a business continuity plan(s) for data and cyber security incidents. The plan(s) will take into account the potential impact of any loss of services on external organisations in the health and care system.	The organisation does not have a continuity plan for data and cyber security incidents in place

If there is a business continuity plan in place has it been tested in 2017/18?

Yes	No
The business continuity plan for cyber security incidents in has been tested in 2017/18.	The business continuity plan for data and cyber security incidents has not been tested in 2017/18.

7. Reporting incidents

Staff across the organisation must report data security incidents and near misses, and incidents should be reported to CareCERT in line with reporting guidelines.

Incidents should be reported to CareCERT via carecert@nhsdigital.nhs.uk or 03003035222 if part of a national cyber incident response.

Fully implemented	Partially implemented	Not implemented
The organisation has a process or working procedure in place for staff to report data security incidents and near misses	The organisation is developing a process or working procedure for staff to report data security incidents and near misses	The organisation does not have a process or working procedure in place for staff to report data security incidents and near misses

Leadership obligation 3: Technology

4. Unsupported systems

Your organisation must:

- ☐ identify unsupported systems (including software, hardware and applications)
- ☐ have a plan in place by April 2018 to remove, replace or actively mitigate or manage the risks associated with unsupported systems.

NHS Digital's good practice guide on the management of unsupported systems is at: https://digital.nhs.uk/cyber-security/policy-and-good-practice-in-health-care.

Other guidance and general documents are on the main CareCERT website.

Fully implemented	Partially implemented	Not implemented
The organisation has reviewed all its systems and any unsupported systems have been identified and logged on organisation's relevant risk register	The organisation has reviewed all its systems and any unsupported systems have been identified but not logged on the organisation's relevant risk register	The organisation has not reviewed its systems to identify any that are unsupported

For any unsupported systems identified, has the organisation developed a plan for how it will remove, replace or actively mitigate or manage the risks of unsupported systems. Organisations are not required to submit a plan as part of this data collection process but should be prepared to submit their plan to NHS Digital if requested.

Fully implemented	Not implemented
By May 2018 the organisation will have developed a plan to remove, replace or actively mitigate or manage the risks associated with unsupported systems	By May 2018 the organisation will not have a plan in place to remove, replace or actively mitigate or manage the risks associated with unsupported systems

9. On-site cyber and data security assessments

Your organisation must:

- have undertaken or have signed up to an on-site cyber and data security assessment by NHS Digital
- act on the outcome of that assessment, including any recommendations, and share the outcome of the assessment with your commissioner.

Fully implemented	Partially implemented	Not implemented
The organisation has undergone an NHS Digital on-site cyber and data security assessment	Prior to 31 March 2018 the organisation signed up to undergo an NHS Digital on-site cyber and data security assessment but has not yet	Prior to 30 March 2018 the organisation has not signed up to an NHS Digital on-site cyber and data security assessment

For organisations who have undergone an NHS Digital on-site cyber and data security assessment:

WE HAVE HAD NO FEEDBACK YET FROM THE TEST THEY PERFORMED

Fully implemented	Partially implemented	Not implemented
The organisation has an improvement plan in place on the basis of the findings of the assessment, and has shared the outcome with the relevant commissioner(s)	The organisation has an improvement plan in place on the basis of the findings of the assessment, but has not yet shared the outcome with the relevant commissioner(s)	The organisation does not yet have an improvement plan in place on the basis of the findings of the assessment, and has not yet shared the outcome with the relevant commissioner(s)

Please tell us if the organisation has used an external organisation to audit the organisation's data and cyber security risks. Please note there is no requirement to use an external organisation to audit data and cybersecurity risks.

Yes	No
The organisation has used an external vendor to audit the organisation's data and cyber security risks	The organisation has not used an external vendor to audit the organisation's data and cyber security risks

10. Checking Supplier Certification

Organisation should ensure that any supplier of critical IT systems that could impact on the delivery of care, or process personal identifiable data, has the appropriate certification (suppliers may include other health and care organisations).

Depending on the nature and criticality of the service provided, certification might include:

- ISO/IEC 27001:2013 certification: supplier holds a current ISO/IEC27001:2013 certificate issued by a United Kingdom Accreditation Service (UKAS)-accredited certifying body and scoped to include all core activities required to support delivery of services to the organisation.
- Cyber Essentials (CE) certification: supplier holds a current CE certificate from an accredited CE certification body.
- Cyber Essentials Plus (CE+) certification: supplier holds a current CE+ certificate from an accredited CE+ Certification Body.

- Digital Marketplace: supplier services are available through the UK Government Digital Marketplace under a current framework agreement.

- Other types of certification may also be applicable. Please refer to Cyber Security Services 2 Framework via Crown Commercial (https://ccs-agreements.cabinetoffice.gov.uk/contracts/rm3764ii)

NHS Digital contracts for/supplies a number of IT systems and solutions in use by multiple NHS organisations. Please note that NHS Digital ensures in each of its system procurements that appropriate data security certifications are in place from its suppliers.

Fully implemented	Partially implemented	Not implemented
The organisation has checked that the suppliers of all its IT systems have appropriate certification, and can evidence that all suppliers have such certification.	The organisation has checked that the suppliers of IT systems that relate to patient data, involve clinical care or identifiable data have appropriate certification and can evidence that all suppliers have such certification.	The organisation has not checked whether its suppliers of IT systems have appropriate certification.

Whittington Health
NHS Trust

Trust Board

27th June 2018

Title:	**Provider Licence Self-Certification 2018: Condition FT4**		
Agenda item:	**18/099**	**Doc**	**12**
Action requested:	Agreement to certify compliance with the NHS Provider Licence Condition FT4 relating to governance arrangements		
Executive Summary:	This paper sets out the background to the required declaration in relation to the NHS Provider Licence. It involves a self-certification process to establish whether or not the Trust is compliant with Condition FT4 on corporate governance and if not, to provide an explanation of the reasons for non-compliance and a statement of remedial action. At its meeting on 12th June 2018 the Trust Management Group reviewed the evidence of compliance and the sources of assurance summarised in Appendices 1-3. It did not identify any additional assurances required in order to recommend that the Board makes a declaration of compliance in accordance with the template provided by the NHSI. (Appendix 1) This is the second stage of a two-stage process. The Board has already made a declaration of compliance with Condition 6 of the Provider Licence considered at the May meeting of the Trust Board, which has now been published on the Trust's website. If agreed, the declaration on Condition FT4 will also be published on the website. NHSI conducts spot check audits of Trusts' declarations commencing in July.		
Summary of recommendations:	It is recommended to the Trust Board that: o the Structure Chart in Appendix 2 is accurate o key sub-committees have appropriate and up-to-date Terms of Reference with clear reporting lines (those few missing outlined in appendix 2 will be brought up-to-date at their next meeting) o all risks to compliance have been identified o any mitigating action required has been recorded o Documentary evidence is accessible for audit The Trust Board is therefore asked to certify compliance.		

Fit with WH strategy:	The Trusts 4 key corporate objectives reflect the letter and the spirit of the NHS Provider Licence.		
Reference to related / other documents:	Self-certification: Guidance for NHS Trust (NHSI March 2018) Health and Social Care Act 2012 The NHS Constitution Well-led Framework for Governance Reviews (NHSI 2017) Single Oversight Framework (NHSI 2016 updated Nov 2017)		
Reference to areas of risk and on the BAF	Particular risks relating to the Provider licence are BAF3, BAF4, BAF5, BAF14		
Date paper completed:	15.06.2018		
Author name and title:	**Susan Sorensen Interim Corporate Secretary**	**Director name and title:**	**Jonathan Gardner Director of Strategy and Corporate Affairs**

Provider Licence Self-Certification:2018

Introduction

As reported to the Trust Board at its meeting on 30th May, all NHS Trusts are required to complete an annual self-certification in relation to the NHS Provider Licence. Last year was the first year that trusts self-certified. Although they are exempt from needing to hold the licence, they are required to comply with conditions equivalent to the licence that NHS Improvement has deemed appropriate. These are:

- Condition G6(3) - The provider has taken all precautions necessary to comply with the licence, the NHS Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and the NHS Constitution.
- Condition FT4 (8) – The provider has complied with required governance arrangements.

Trusts may use any process they consider appropriate and which ensures that the board as a whole fully understands whether or not they can confirm compliance.
A paper proposing a means of providing the Board with the necessary assurances was discussed by Executive Management Team on 14th May 2018. Board sign-off on Condition G6 was agreed at the meeting on 30th May and is required by the end of June for Condition FT4. In both cases the Trust must publish its declaration within a month of sign off. Although the declarations on compliance do not have to be submitted, NHSI are planning to carry out spot audits of selected Trusts commencing July 2018.

Condition FT4 – The provider has complied with required governance arrangements
This condition requires evidence that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.
In order to fulfil this condition the Trust shall need to demonstrate:

a) effective Board and Committee structures
b) clear responsibilities for its Board, committees reporting to the Board and for staff reporting to the Board and those Committees: and
c) clear reporting lines and accountabilities throughout its organisation.

The current review and update of the Board and committee structure should enable assurance to be given on compliance with this condition. It is important that in reviewing the terms of reference of all decision-making and advisory groups it is absolutely clear what the reporting arrangements are in place including their method and frequency.

Condition FT4 also requires Board assurance on

a) The duty to operate efficiently, economically and effectively
b) Timely and effective scrutiny and oversight by the Board of the Trust's operations

c) Compliance with health care standards specified by the Secretary of State and regulatory bodies

It is considered that the analysis contained in Board report on compliance with Condition 6 adequately covers this aspect of the Condition FT4.

Sources of assurance and identified risk are set out in the following Appendices:

Appendix 1: Template for Assessment of compliance with condition FT4
Appendix 2: Governance structure chart reviewed in June 2018
Appendix 3: Latest update of the Trust Board annual meeting plan

Conclusion and Recommendation

The Trust Board is asked to:

1. Consider the compliance evidence set out in Appendix 1
2. Approve the analysis of risks and mitigations
3. Receive assurance that the structure is accurate with up-to-date terms of reference and reporting line
4. Confirm that it is in a position to make the model declaration in the attached Appendix 1.

Appendix 1

NHS Provider Licence: 2018
Template for Assessment of Compliance with Condition FT4 – Governance Arrangements

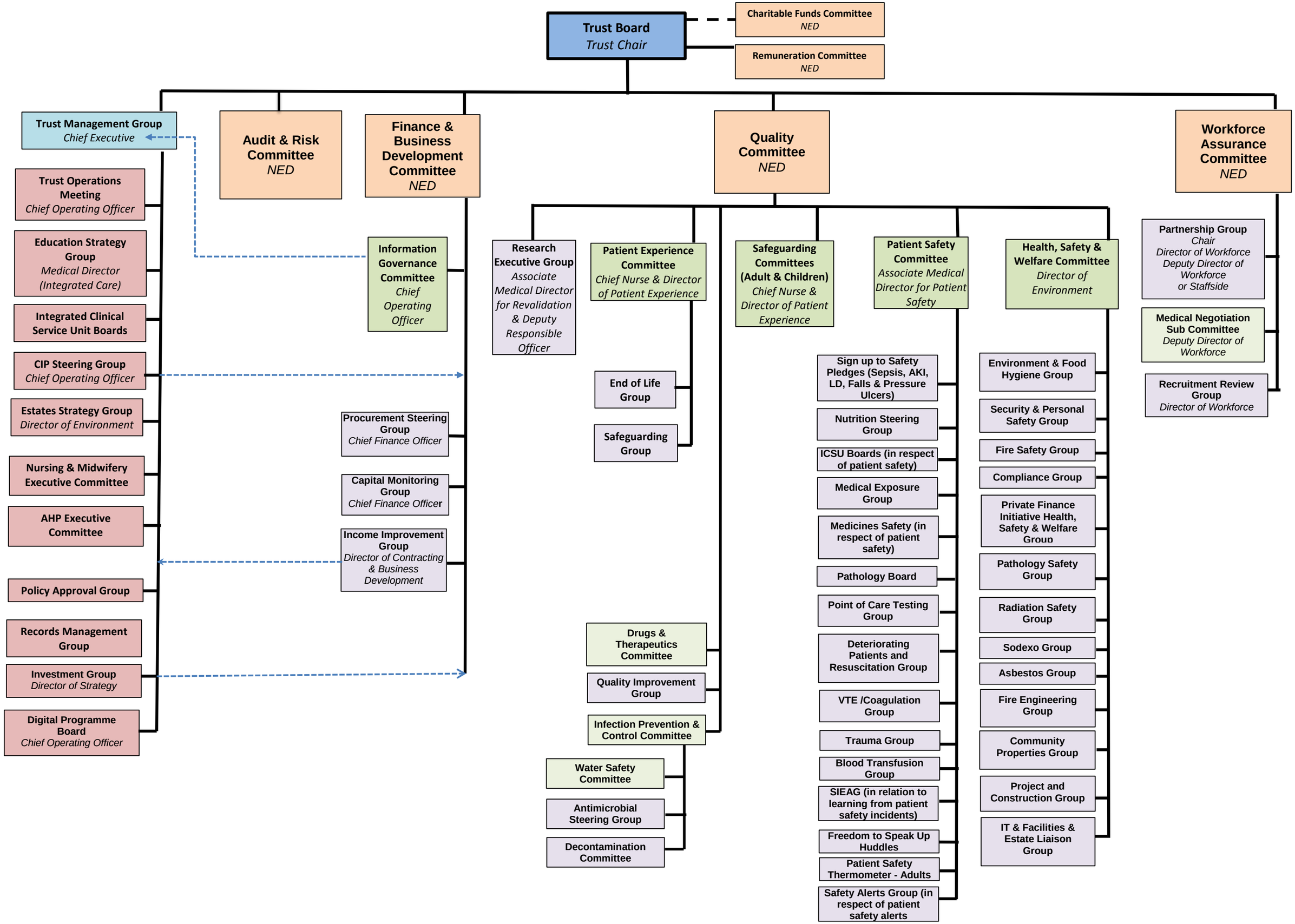
Statement	Assessment and evidence	Risks and Mitigating Actions
The Board is satisfied that the Licensee applies those principles, systems and standards of corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS	Confirmed CQC inspection and report 2017/18 Integrated Governance Document Visible Leadership Implementation Plan Annual Operational Plan Forward plan for Board meetings Statutory Reports	Failure to maintain an appropriate governance structure. Mitigation: Regular review of Integrated governance document and terms of reference of committees and working groups. See Appendix 2.
The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed Self assessment using NHSI Well-led Framework for Governance as used in CGC assessment process Board Assurance Framework and Risk Register reviewed by Board bi-annually	Failure to disseminate guidance on good practice Mitigation: Appointment of Director of Strategy and Corporate Affairs at Trust Board level. Appointment of Corporate Secretary.
The Board is satisfied that the Licensee has established and implements: (a) Effective Board and Committee structures (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees (c) Clear reporting lines and accountabilities throughout its organisation	Confirmed See Appendix 2. Detailed Governance structure and Committee Terms of Reference, including review dates Integrated Governance Document: SOs, Reservation and delegation of decisions, SFIs reviewed and updated annually. Job plans Staff appraisal system	Failure to ensure adequate reporting mechanisms throughout the structure. Mitigation: Minutes of all Board Committees reported to Trust Board. Introduction of practice of regular reports from Committees to Board. Annual review of terms of reference of all sub-committees and working groups (see end of document for list of TOR and review dates)

Statement	Assessment and evidence	Risks and Mitigating Actions
The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State and NHS regulatory bodies	Confirmed Finance report at every Board meeting in appropriate format. Scrutiny by Finance and Business Development Committee chaired by NED. Audit and Risk Committee chaired by NED Annual Audit Report Performance metrics produced for weekly Executive Team meeting. Quarterly Quality and Patient Safety reports to Trust Board. NHSI Monitoring within Single Oversight Framework Quality Committee chaired by NED Annual Reports on Quality CQC Inspection Report	As identified in BAF and Risk Register See BAF report to Trust Board 30th May 2018 BAF ID 5: Failure to deliver CIP and transformation savings for 2017/18 and 2018/19 BAF ID 3: Failure to meet performance targets in ED BAF ID 4: Inability to increase substantive workforce capacity BAF ID14: Failure to deliver safe and high quality urgent and emergency pathway for patients with mental health care needs

TERMS OF REFERENCE/COMMITTEE STRUCTURE 2018

Committee	Date of Issue	Review Date
Audit & Risk Committee	4/10/16	November 2018
Workforce Assurance Committee	May 2017	May 2018
Trust Management Group	27/02/18	February 2019
Finance & Business Dev. Committee	10/05/17	10 May 2018
Quality Committee	9/05/18	9 May 2019

Remuneration Committee	June 2018	June 2019
Information Governance Committee	June 2017	June 2018
Safeguarding Committees	April 2018	April 2019
Patient Safety Committee	1 March 2018	1 March 2019
Charitable Funds Committee	June 2017	July 2018
Medical Negotiation sub-committee	January 2016	Next mtg
Health and Safety and Welfare Committee		Next mtg
Patient Experience Committee		Next mtg
Drugs and Therapeutic Committee		Next mtg
Infection prevention and control committee		Next mtg



Note | The *Medical Committee* and *Executive Team Meeting* are discussion forums and advisory bodies and do not report to sub-committees or the Trust Board

DRAFT Trust Board Annual Meeting Plan 2018-19

As at June 2018

AGENDA ITEM	Lead	Action	April 25th	May 30th	June 27th	July 25th	Sept 26th	Oct 31	Nov 28th	Dec 19th	Jan 30th	Feb 27th	Mar 27th
Meeting in public													
Standing Agenda Items - opening													
♦ Introductions, apologies, declarations	Corp Sec	Receive	√	√									
♦ Minutes, matters arising, actions log	Corp Sec	Approve	√	√									
♦ Patient Story	CN	Receive	√	√									
♦ Chairman's Monthly Report	Chairman	Receive	√	√									
♦ Chief Executive's Monthly Report	CEO	Receive	√	√									
Quality and Patient Safety Reports													
♦ Serious Incident Monthly	MD	Review	√	√									
♦ Safer Staffing Monthly	CN	Review	**To be incorporated in performance report**										
♦ Quality and patient safety quarterly	MD	Review	√										
♦ Learning from mortality quarterly	MD	Review	x	√									
♦ Integrated Safeguarding bi-annual	CN	Review											
♦ Single Sex Accommodation Declaration	COO	Approve											
♦ 2017-18 Quality Account	MD/CN			√									
♦ Staff Survey - annual	DW	Discuss											
♦ Quality and Patient Safety Annual	CN	Approve		x									
♦ Infection Prevention and Control annual	DIPC/ CN	Review											
♦ Safeguarding Children Declaration	CN	Approve	√										
♦ Patient Survey Results - Picker	CN	Discuss											
♦ Freedom to speak up Guardian report	DW	Discuss											
♦ End of Life Care annual report	RJ	Receive											
♦ Improving Mental Health care ED: Verita review and trust response	RJ	Discuss	√										

AGENDA ITEM	Lead	Action	April 25th	May 30th	June 27th	July 25th	Sept 26th	Oct 31	Nov 28th	Dec 19th	Jan 30th	Feb 27th	Mar 27th
Strategy													
♦ Service Development Strategy	DS	Approve											
♦ Service Improvement Strategy	COO												
♦ Estates Development Plan	CFO	Approve											
♦ Nursing, Midwifery & AHP Strategy	CN	Approve											
♦ Capital Investment Strategy	CFO	Approve											
♦ Workforce Strategy	DW	Approve											
♦ Risk Management Strategy	CN	Approve	√										
♦ Update Health & Wellbeing Partnership	CEO	Review	x										
♦ Strategic Business Continuity Plan	COO	Approve											
♦ Section 75 LBI Annual Report	JB (LBI)	Review											
♦ LUTs Business Case	MD	Approve	March										
Operational Performance and Planning													
♦ Monthly Dashboard Report	COO	Review	√	√									
♦ Community Services Dashboard	COO	Review											
♦ Monthly Finance Report	CFO	Review	√	√									
♦ Annual Operational Plan & Budget	CFO	Approve	√										
♦ Capital update – bi-annual	CFO			x									
♦ Risks ≥ 15 quarterly	CEO	Review	√	√									
♦ "Fast Follower" Digital update	SB/LD	Review											
♦ Emergency Preparedness and Business Continuity Annual Report	COO	Review											
♦ Evacuation Plan annual	COO												
♦ Heatwave Plan	COO												
♦ Winter Plan	COO												
Governance													
♦ Board dates and plan bi-annual	Corp Sec	Approve											
♦ Corporate Objectives quarterly report	DSCA	Review	√										
♦ CQC Report	CN/MD												
♦ Board Assurance Framework Bi-annual	DS	Approve		√									
♦ Audit Committee Annual Report	NED/CFO	Review											
♦ Equality and Inclusion Annual Report	DW	Approve											
♦ R&D Annual Report	MD	Approve											
♦ Education Annual Update	RJ	Review											
♦ Register of Directors Interests	Corp Sec	Review											
♦ Register of Deed of Execution	Corp Sec	Review	√										

AGENDA ITEM	Lead	Action	April 25th	May 30th	June 27th	July 25th	Sept 26th	Oct 31	Nov 28th	Dec 19th	Jan 30th	Feb 27th	Mar 27th
♦ District Audit Annual Report	DoF	Review											
♦ Annual Accounts	DoF	Approve											
♦ Standing Orders Annual Statement	DoF	Approve		x									
♦ Statement of Internal Control annual	DoF	Approve											
♦ Annual Report	DS												
♦ Provider Licence self-certification	DS			√									
♦ Nursing & Midwifery Revalidation	CN	Approve											
♦ Charitable Funds Committee Report	CE0/CFO	Review											
♦ Committee ToRs annual review	Corp Sec												
♦ Remuneration Comm ToRs update	DW	Approve		√									
♦ Remuneration Committee	DW												
Standing Agenda Items - closing													
♦ Subcommittee minutes: Quality, Workforce, Finance and Business Development	Corp Sec	Receive	Quality CF	Quality WAC									
♦ Any other business	Chairman	Receive	√	√									
♦ Questions from the public on matters on the agenda	Chairman	Receive Respond	√	None									
Exclusion of press and public **Meeting in private**													
Standing Agenda Items - opening													

AGENDA ITEM	Lead	Action	April 25th	May 30th	June 27th	July 25th	Sept 26th	Oct 31	Nov 28th	Dec 19th	Jan 30th	Feb 27th	Mar 27th
♦ Welcome and Apologies	Chairman	Receive	√	√									
♦ Declaration of Conflicts of Interest	Corp Sec	Receive	√	√									
♦ Draft Minutes, actions, matters arising	Chair	Approve	√	√									
Safety and Quality													
♦ **Serious Case Reviews**	CN	Receive	√	√									
♦ **Reputational Issues**	MD	Receive	√	√									
♦ **Medical/Dental exclusions/restrict**	MD	Receive	√	√									
♦ **Haringey JTAI**	CN	Discuss		√									
♦ **Change of Responsible Officer**	MD			√									
Performance													
♦ Contract and Business Development	CFO	Discuss	√	√									
♦ Finance specific issues	CFO	Discuss	M12										
Strategy													
♦ Verbal Update – as required	CEO	Discuss											
♦ Update on delivery transformation of the Estate	CFO	Discuss		√									
♦ GP Federations MOI	CEO	Discuss											
Standing items – closing													
Audit & Risk Committee minutes	DH	Review	√										
Any Other Business													

Key:

	Standing Items		Regular reports		Annual Reports		Ad hoc reports